DRAFT

Ambulance Service Performance Standards

Feedback/Comments Version 3
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Topic</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>II.</td>
<td>Administrative</td>
<td>3 – 4</td>
</tr>
<tr>
<td>III.</td>
<td>Personnel</td>
<td>4 – 6</td>
</tr>
<tr>
<td>IV.</td>
<td>Facilities</td>
<td>6</td>
</tr>
<tr>
<td>V.</td>
<td>Vehicles</td>
<td>6 – 7</td>
</tr>
<tr>
<td>VI.</td>
<td>Dispatch-Communications</td>
<td>7 – 9</td>
</tr>
<tr>
<td>VII.</td>
<td>Ambulance Resource Availability and Deployment</td>
<td>##</td>
</tr>
<tr>
<td>VIII.</td>
<td>Ambulance Stand-By Services</td>
<td>##</td>
</tr>
<tr>
<td>IX.</td>
<td>Response-Time Performance</td>
<td>##</td>
</tr>
<tr>
<td>X.</td>
<td>Records and Reports</td>
<td>##</td>
</tr>
<tr>
<td>XI.</td>
<td>Customer Service Performance Measures</td>
<td>##</td>
</tr>
<tr>
<td>XII.</td>
<td>Annual Achievement Benchmarks</td>
<td>##</td>
</tr>
</tbody>
</table>

Versions:
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Kern County Ambulance Service Performance Standards

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 respond to emergency or medically necessary non-emergency calls. The ambulance provider is responsible for determining medical justification for non-emergent and long distance ambulance service requests according to Department requirements.

- Department requirements are not defined in the draft.
- The role of the transferring physician and receiving facility or physicians at the receiving facility in determining medical justification for transfer is not noted.
- Standards for transfer are not defined. – Kaiser Permanente

What are these “Department Requirements” for the medical justification for the non-emergent and long distant requests? – Ambulance Providers

We have concerns about the ambulance provider having sole responsibility to decide the medical determination for non-emergency and long distance ambulance service requests. These types of cases should have the involvement of the treating physician. – Mercy Hospitals

C. 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.
D. 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 within and under 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.

The ambulance provider’s quality improvement plan will function as part of 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. – Ambulance Providers

E. 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.

F. 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).

CA SEMS and NIMS needs to be taught to all responders and just written in policy - KCFD

G. 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.

H. 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.

I. Any program or practices that promotes an inappropriate incentive or kickback for any medical procedure or mode of transport are prohibited. Medical procedures and mode of transport will be determined by Department policies and procedures.
I. Any program or practices that promotes an inappropriate incentive or kickback for any medical procedure or mode of transport are prohibited. This is unnecessary and doesn’t make sense, not a Standard. This is already covered by other Department Policies. – Ambulance Providers

[H & I ] We support the prohibition of additional monetary gain to field personnel or inappropriate incentives or kickbacks. We recommend that a specific monitoring/audit system be established. – Mercy Hospitals

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.

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

3. Air Ambulance (medical staff only) – Why was this standard deleted from the document? – Ambulance Providers

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.

This section omits the provision for expanded scope trained paramedics. – Ambulance Providers

4. Ambulance Dispatch Center – Minimum of one (1) emergency medical dispatcher (EMD).

Minimum EMS staffing needs to spell out 24/7 coverage - KCFD

C. The Department can authorize deviation from this section during any "State of emergency" or "local emergency" as defined in the California Government Code.
D. 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.

E. 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, Emergency Medical Dispatcher, EMS manager, or EMT-P is terminated or suspended for disciplinary cause or reason.

2. An EMT-1, Emergency Medical Dispatcher, EMS manager, or EMT-P resigns following notice of an impending internal investigation.

3. An EMT-1, Emergency Medical Dispatcher, EMS manager, 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, Emergency Medical Dispatcher, or EMT-P and could be considered evidence of a threat to public health and safety. – Ambulance Providers
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.

-This is a good standard if it’s used.
-It needs to spell out “per response area” not just EOA.
-System status mgmt cancels this policy - KCFD

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), which 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.

Can ECC fill this role, replacing private dispatch centers? - KCFD

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.

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.

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 Basic Life Support (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.

G. **The ambulance provider shall not allow ALS level services to be provided from a Basic Life Support (BLS) ambulance unless staffed with a minimum of one paramedic and one EMT-1 or another paramedic.** – Ambulance Providers

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.

**Credentials need to be worn clearly for all to see – KCFD**

H. **The ambulance provider may provide ALS or BLS services from an ambulance authorized as a MICU. BLS staffing (defined as two EMT-1 level personnel and no paramedic) 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.** – Ambulance Providers

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.

VI. Dispatch-Communications:

A. The ambulance provider shall maintain dispatch procedures consistent with approved Department EMD and other related 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.

VI. D. Since all ambulances will be equipped with radios that operate on the Kern County Fire Dept. frequencies, the dispatch center should also be required to maintain telecommunications equip. for communications on the Kern County Fire Dept. Channels. – ECC

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) Center that is authorized by the Department for receiving all prehospital calls that are not prescheduled transports. Said calls shall be managed in accordance with Department authorized EMS Dispatch Policies and Procedures. Prescheduled and non-emergency requests for service will be managed using EMD and/or transportation triage protocols approved by the Department.

F. The ambulance provider shall use an Emergency Medical Dispatch (EMD) Center that is authorized by the Department for receiving all prehospital calls that are not prescheduled transports. Said calls shall be managed in accordance with Department authorized EMS Dispatch Policies and Procedures. Triage Protocols do not exist, is the Department going to attempt to write these or do the Providers write them and submit to Department for approval? – Ambulance Providers

G. The ambulance provider shall maintain a dispatch log, in an electronic format approved by the Department, for all ambulance calls. At a minimum, the following information will be included in the log:

G. The ambulance provider shall maintain a dispatch log, in an electronic format approved by the Department, for all ambulance calls. At a minimum, the following information will be included in the log:

Doesn’t exist today. New formats will have to be worked out when required – Ambulance Providers
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.

10. [Delete entirely]
As we have explained, this is NOT possible in a CAD system. These occurrences are captured in the “Notes” section of a call, they are not in any report the CAD can produce. It cannot be a required data field. Can’t this be captured by the e-PCR system at the Department? – Ambulance Providers

11. Arrived at Scene Time: The time the assigned ambulance arrives at the requested call location or the scene, wheels stopped.

11. Arrived at Scene Time: The time the assigned ambulance arrives at the requested call location or the scene.
This isn’t operationally practical, there are too many calls that the location is vague or just an area is given. “Wheels stopped” needs to be removed. – Ambulance Providers

VI. G. 11: Arrived at Scene Time, shouldn’t this "at the requested call location or scene and in contact with the patient"? – ECC
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. 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.

16. [Delete entirely]

It isn’t possible to capture this as a data filed on a CAD without great difficulty. This is now captured on the e-PCR program and the Department has that information. Why can’t the Department run this report off the e-PCR program? This isn’t captured, why is it now being required?  - Ambulance Providers

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

18. 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.

18. [Delete entirely]

This is not electronically captured in any dispatch log. Current CAD systems allow these types of notes to be “tagged” to a call, but it does not become part of the log or is in any report format. They have to be accessed individually as needed – Ambulance Providers

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 permittee to have equipment repaired.

- Change last sentence to read, “...a reasonable time for ambulance provider to have equipment repaired". Ambulance provider should replace permittee. – Mercy Air

We recommend keeping audiotapes for one year and the dispatch log for three years. – Mercy Hospitals
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.

K. The ambulance provider shall not refuse to respond to any emergency, medically necessary interfacility transfer call, or stand-by unless approved by the Department.

L. The ambulance provider dispatch shall contact Department staff for coordination of ambulance response.

VI. The ambulance provider shall not refuse to respond to any emergency, medically necessary interfacility transfer call, or public safety emergency stand-by unless approved by the Department. – Ambulance Providers

Who determines what an emergency or medically necessary interfacility transfer call is? What situation, short of disaster, would justify a refusal? Is there an appeal process? And, what are the alternatives? – Mercy Hospitals

L. The ambulance provider dispatch shall contact ECC and request back up ambulance response if the provider has exhausted all immediately available resources. During Med-Alert incidents ambulance provider dispatch shall contact Department staff for coordination of ambulance response.

VI. Should stay as written. If amended should have ECC Notification added. – ECC

VII. Ambulance Resource Availability and Deployment:

A. An ALS ambulance shall be dispatched to prehospital emergency calls at least 97% of the time per month per EOA, applicable to EOA 1, 2, 3, 4, 5, 7, and 9. An ALS ambulance shall be dispatched to prehospital emergency calls at least 97% of the time per month per EOA sub-zone, applicable to EOA 6, 8, and 11. An EOA sub-zone is a separate area defined by the Department within an EOA for measuring ambulance performance. Prehospital emergency calls include all Priority 1, all Priority 2, and those Priority 3 calls that do not originate at a hospital. This shall not prohibit the ambulance provider from providing all ALS ambulance service.

Please explain the rational for this additional reporting requirement. – Ambulance Providers
B. The ambulance provider shall dispatch an ambulance that will provide the shortest possible response time to the call location for Priority 1, Priority 2, and Priority 3 calls. An available BLS ambulance may be dispatched when closest to an emergency call, however an ALS ambulance shall also be dispatched to the incident simultaneously. ALS ambulance response shall be used at least 97% of the time as defined above. BLS ambulance use on Priority 1, 2, or 3 calls, shall be subject to review.

- If another provider is closer, they should be responded if the provider responsible for serving the EOA is out of their response area.
- If BLS ambulance is responding, an ALS supervisor or first responder should be able to fill the role on the ambulance. - KCFD

B. An available BLS ambulance may be dispatched when closest to an emergency call, however an ALS ambulance may also be dispatched to the incident simultaneously. ALS ambulance response shall be used at least 90% of the time as defined above. BLS ambulance use on Priority 1, 2, or 3 calls, shall be subject to review.

The first sentence is unneeded; this is covered in other areas of this document and other EMS Policies. – Ambulance Providers

Who shall conduct the review and how frequent shall the review occur? - Mercy Hospitals

C. BLS ambulance use is authorized for a prescheduled transport or prearranged special event stand-by where BLS care is appropriate for the continuum of patient care.

- Does the County intend to "authorize" a specific level for prescheduled transports?
- Doesn't the transferring physician determine the transport level?
- Will the County permit BLS utilization if ALS is not medically necessary?
- Appropriate BLS care is not defined. – Kaiser Permanente

C. BLS ambulance use is authorized for a prescheduled transport or prearranged special event stand-by or Alpha and Omega calls per EMD Protocols where BLS care is appropriate for the continuum of patient care. – Ambulance Providers

D. No individual EOA sub-zone will be subjected to chronic response of BLS ambulances to prehospital emergency calls. Chronic use is defined as more than three percent of prehospital emergency calls where a BLS ambulance is responded in any month within an EOA or EOA sub-zone.

- Providers should not be allowed to staff BLS until close to hitting the 3% max quota.
- Minimum staffing should be ALS 97% of the time. - KCFD
. No EOA will be subjected to chronic response of BLS ambulances to prehospital Priority 1 or 2 level emergency calls per the EMD Policies. Chronic use is defined as more than ten percent of prehospital emergency calls where a BLS ambulance is responded in any month within an EOA.

This is not a true Standard; it should have a trigger for minimum performance, i.e. two consecutive months or any 3 months in a calendar year. – Ambulance Providers

dd| E. BLS ambulance use is authorized for back-up responses for multi-patient transports or when requested by a paramedic who is physically on-scene and has examined the patient(s). – Ambulance Providers

E. The Department may find that extenuating circumstances, including, but not limited to those permissible for response time exemptions may excuse individual instances of BLS ambulance use. When it is determined that individual BLS responses should be exempted, those calls will not be counted in determining whether or not BLS use is “chronic.”

Please clarify what are other “permissible response time exemptions” for the use of BLS on pre-hospital calls. – Ambulance Providers

VIII. Ambulance Stand-By Services:

A. Upon request by first-responder public safety agencies, the ambulance provider shall furnish dedicated courtesy stand-by coverage at significant emergency incidents involving a potential danger to the personnel of the requesting agency or the general public. Once assigned to the standby, permission to release the unit(s) for other duties must be granted by the Incident Commander. The Department may release the ambulance(s) after consultation with the Incident Commander.

A. Upon request by public safety agencies, 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, Providers are permitted to bill third parties for standby services.

It is unreasonable to require the companies to commit to a “dedicated” standby that could take hours. The companies currently respond to these requests and provide the free service, but we must have the ability to control all resources to ensure meeting minimum compliance for these standards. – Ambulance Providers

B. Upon request of first-responder public safety agencies, the ambulance provider shall furnish non-dedicated units to participate in as many as six scheduled multi-agency training exercises each year.

. provider’s EOA and is scheduled within normal business hours. – Ambulance Providers
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, if possible.

C. This is not a measurable Standard, this should be removed. – Ambulance Providers

D. If the ambulance provider is requested to provide such services with a dedicated ambulance, then the ambulance provider may provide such services and charge for the services at the rate for standby services specified by the currently approved Kern County rates. Each dedicated event may have a two-hour minimum, plus an hour for set-up and an hour for clean up. Ambulance provider will secure all billing information required and seek payment from the event sponsors.

D. If the ambulance provider is requested to provide such services with a dedicated ambulance, then the ambulance provider may provide such services. Each dedicated event may have a two-hour minimum, plus an hour for set-up and an hour for clean up.. – Ambulance Providers

1. An ambulance provider may also make a paramedic available for scheduled stand-by and special events coverage at an hourly rate, if the Department has approved a specialty program for such service. No minimum or additional time for set-up and clean up will be allowed for paramedic-only events.

- Sec A says “courtesy” and Sec D says they can charge. All providers should be required to provide courtesy standby as stated in Sec A without fees, unless someone is transported. - This should be considered part of the cost of doing business in Kern County and not paid for by taxpayers if no service is actually given. - KCFD

How the Provider secures billing or payment is not a performance standard. Also, there is no specialty program like this that that we are aware of. – Ambulance Providers

E. For stand-by events other than those for public safety emergencies, 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 (ambulances, paramedics, 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.

This Performance Standard can only apply to For Hire Standbys, not community events, etc. – Ambulance Providers
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.

E. Ambulance providers will cooperate with Department and Medical Director in establishing additional standards of coverage for special events and mass gatherings. The last sentence is not a Performance Standard; it would be a Department Policy. – Ambulance Providers

IX. Response-Time Performance:

A. The Department does not limit the ambulance provider’s flexibility in providing and improving current 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:

AT this time, Hall Ambulance does not provide transfers to skilled nursing facilities (SNF), lower levels of care, or home as they do not provide gurney van access. How will this then be accomplished? – Mercy Hospitals

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.
- Interfacility transfers from sub-acute and chronic care facilities to acute care hospitals is not addressed.
- Interfacility transfers from Medical Office (e.g. KP MOBs) to acute care hospitals is not addressed.
  – Kaiser Permanente

[Add] 4. Medically necessary transfer from an infirmary to an acute care hospital, or an acute care hospital to an infirmary, or an infirmary to an infirmary. – Ambulance Providers

D. Minimum Ambulance Response Time Standards:

1. Compliance is achieved when 90% or more 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.

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.

   a. 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 add, delete, or modify any or all of the zones. Ambulance providers shall be consulted prior to any changes in response time standards for any operating area.

A response zone cannot be “deleted or added”, it can only be modified. – Ambulance Providers
3. Maximum 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>
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<td>5(^1)</td>
<td>0:00</td>
<td>0:00</td>
<td>0:00</td>
<td>0:00</td>
<td>0:00</td>
</tr>
</tbody>
</table>

\(^1\)Code 5. 0:00 indicates “On-time” performance with scheduled time of call.

- 8 minutes should be 8 minutes, not 8:59.
- The :59 needs to be removed from all max response times. - KCFD

Interfacility transfers response times should be less than 45 minutes. – Mercy Hospitals

3. Maximum Response Times:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Zone A Metro</th>
<th>Zone B Urban</th>
<th>Zone C Suburban</th>
<th>Zone D Rural</th>
<th>Zone E Wilderness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8:59</td>
<td>15:59</td>
<td>25:59</td>
<td>50:59</td>
<td>75:59</td>
</tr>
<tr>
<td>5</td>
<td>60:59</td>
<td>60:49</td>
<td>60:59</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
</tr>
<tr>
<td>7</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
<td>On time(^1)</td>
</tr>
<tr>
<td>8</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- Ambulance Providers

\(^1\)Code 5. 0:00 indicates “On-time” performance with scheduled on-scene. – Ambulance Providers
4. 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.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Standard</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A set standard should be established for second-in units.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Minimum standards need to be raised to 93%.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>If an ambulance is required in an area, that should have an 8 minute response zone.</td>
<td></td>
</tr>
</tbody>
</table>

- Approved protocols for dispatcher to follow on non-emergency interfacility patient transfer is not defined. Does this mean the dispatcher can override the caller, ie. the ordering physician?
- For Priority 4 & 5 transfers (e.g. non-emergency interfacility patient transfers) advanced notification of 1 - 4 hours is required. In our experience such time requirements are unusual to have at all and, in any case, seem excessive. For example similar protocols in San Bernardino and Ventura Counties do not include advance notice requirements for these categories.
- Interfacility transfers from sub-acute and chronic care facilities to acute care hospitals is not addressed.
- Interfacility transfers from Medical Office (e.g. KP MOBs) to acute care hospitals is not addressed.
- The EOA could potentially hinder our timely ability to transport Members from Kern County to Los Angeles County - because the 911 provider may not want a unit to be "tied up" for a prolonged period of time on a long distance scheduled inter-facility transport. Would we have the option, in such cases, to permit other licensed ambulance providers to come into the designated EOA to pick up a patient as long as the intended destination is outside the EOA catchment zone? – Kaiser Permanente
<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>Cross-Walk of Priority Codes in Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Life-Threatening 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</td>
<td>Not less than ninety percent (90%) per month by EOA.</td>
<td>Metro – 8:59 Urban – 15:59 Suburban – 25:59 Rural – 50:59 Wilderness – 75:59</td>
<td>Hot, Code-3</td>
<td>Priority 1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Time-sensitive 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.</td>
<td>Not less than ninety percent (90%) per month, by EOA</td>
<td>Metro – 10:59 Urban – 15:59 Suburban – 25:59 Rural – 50:59 Wilderness – 75:59</td>
<td>Hot, Code-3</td>
<td>Priority 2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Urgent – 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; or requests from an acute care hospital for a hot response for an emergency interfacility transfer. • All Alpha and Bravo calls where cold response is authorized • All Omega calls • All acute care hospital emergency transfer requests for hot response</td>
<td>Not less than ninety percent (90%) per month, by EOA</td>
<td>Metro – 15:59 Urban – 25:59 Suburban – 30:59 Rural – 50:59 Wilderness – 75:59</td>
<td>Cold, Code-2 Prehospital Hot, Code-3 Interfacility</td>
<td>Priority 3, 4</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Unscheduled Transfer or Long Distance Transfer – All non-emergency interfacility patient transfer requests as determined by the dispatcher in strict accordance with Medical Director approved protocols, or as otherwise requested by the caller. 1-hour advanced notification to ambulance provider is required.</td>
<td>Not less than ninety percent (90%) per month, by EOA</td>
<td>Metro – 60:59 Urban – 60:59 Suburban – 60:59 Rural – 60:59 Wilderness – 75:59</td>
<td>Cold, Code-2</td>
<td>Priority 5, 7</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Scheduled Transfer, Long Distance Transfer, or Special Event Standby – All prescheduled interfacility patient transfer requests and special event standby requests 4-hour advanced notification to ambulance provider is required.</td>
<td>Not less than ninety percent (90%) per month, by EOA</td>
<td>On-Time</td>
<td>Cold, Code-2</td>
<td>Priority 6, 8, 9</td>
<td></td>
</tr>
</tbody>
</table>

There are no criteria for interfacility transfer. Specific criteria needs to be established for the following:
1. From emergency department to inpatient
2. From emergency department to emergency department
3. From inpatient to inpatient
Additionally, these determinations need to be in conjunction with the treating physician and appropriate transfer care. – Mercy Hospitals
<table>
<thead>
<tr>
<th>Priority</th>
<th>Response Time Standard Definition</th>
<th>Response Level</th>
<th>Minimum Compliance Standard</th>
<th>Time Zone (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Life-Threatening Emergencies – All presumptively defined life-threatening emergency requests, as determined by the dispatcher in strict accordance with Department authorized EMD protocol, and originating within the Operating Area.</td>
<td>All Echo and Delta</td>
<td>Not less than ninety percent (90%) per month</td>
<td>Closest ALS A - 8, B - 15, C - 25, D 50, E - 75</td>
</tr>
<tr>
<td>2</td>
<td>Time Issue Emergencies – All presumptively defined non-life-threatening emergency requests, as determined by the dispatcher in strict accordance with Department authorized EMD protocol, and originating within the Operating Area.</td>
<td>All Charlie and select Bravo level responses;</td>
<td>Not less than ninety percent (90%) per month</td>
<td>A - 10, B - 15, C - 25, D 50, E - 75</td>
</tr>
<tr>
<td>3</td>
<td>Urgent – 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, or as requested from an acute care hospital, and originating within the Operating Area.</td>
<td>All Alpha, Omega select Bravo level responses</td>
<td>Not less than ninety percent (90%) per month</td>
<td>A - 15, B - 25, C - 30, D 50, E - 75</td>
</tr>
<tr>
<td>4</td>
<td>Emergency Level Interfacility Transports- Any medically necessary emergency transfer request involving a hot response.</td>
<td>All medically necessary immediate interfacility transfers request from a acute care hospital.</td>
<td>Not less than ninety percent (90%) per month</td>
<td>A - 15, B - 25, C - 30, D 50, E - 75</td>
</tr>
<tr>
<td>5</td>
<td>Urgent Interfacility Transports</td>
<td>All medically necessary immediate interfacility transfers request from a acute care hospital.</td>
<td>Not less than ninety percent (90%) per month</td>
<td>A - 60, B - 60, C - 60, D 75, E - 75</td>
</tr>
<tr>
<td>6</td>
<td>Scheduled Transfer or Scheduled Special Event Stand-By – All presumptively defined prescheduled interfacility patient transfer requests.</td>
<td>4-hour advanced notification too ambulance provider is required</td>
<td>Not less than ninety percent (90%) per month</td>
<td>On-Time</td>
</tr>
<tr>
<td>7</td>
<td>Unscheduled Transfer or Unscheduled Special Event Stand-By – All presumptively defined non-emergency interfacility patient transfer requests as determined by the dispatcher in strict accordance with Medical Director approved protocols or as requested by the caller, and originating within the Operating Area.</td>
<td>4-hour advanced notification too ambulance provider is required</td>
<td>Not less than ninety percent (90%) per month</td>
<td>On-Time</td>
</tr>
<tr>
<td>8</td>
<td>Long Distant Transfers</td>
<td>4-hour advanced notification too ambulance provider is required</td>
<td>Not less than ninety percent (90%) per month</td>
<td>On-Time</td>
</tr>
<tr>
<td>9</td>
<td>Miscellaneous Transports- Those patient responses that are outside of the above listed response codes handled as determined by the dispatcher in strict accordance with Medical Director approved protocols or as requested by the caller, and originating within the Operating Area.</td>
<td>N/A</td>
<td>Not less than ninety percent (90%) per month</td>
<td>On-Time</td>
</tr>
</tbody>
</table>

These need to go back to the nine (9) Priority Codes we agreed upon. By doing so, it enables the Providers to capture the needed data for the month end Performance Reporting. It will also make the EMS over sight inspection easier. - Ambulance Providers
5. In the event that the ambulance provider dispatch anticipates that the
maximum response time will be exceeded for prehospital Priority 1, 2 or
3 responses, ECC shall be notified per EMD Policies and Procedures.

Not necessary, the closest ambulance will be sent and if the response exceeds the standard, then
it will be reported. What is the reason for notifying ECC, it will not speed up the response. –
Ambulance Providers

IX. 5. Should stay as written. ECC will respond fire if not already en route. If fire is
responding or on scene, they need to be advised of ambulance delays. Since ECC is the primary
contact for the public on most medical aid calls we will be the dispatch center re contacted with
questions about the ambulance delay. Reporting delays is not the issue here. - ECC

6. In the event that the ambulance provider dispatch anticipates that the
maximum response time will be exceeded for Priority 4 or 5 responses,
the caller shall be notified and shall be given a reasonable estimate of the
time that the unit will arrive (ETA).

[Add] 7. Providers with written contractual response time performance standards will be
responsible to adhere to those standards. Written contractual standards will supersede these
minimum response standards. – Ambulance Providers

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 4 requests, call time will begin upon the transferring facility
supplying the ambulance provider dispatch with all normal and
customary documentation needed by the ambulance provider for billing
purposes and 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 4 response if the difference in the times is less than 61 minutes.

The priority for call start time should be when the request is made. Additionally, the
measurement should be either (a) independent of the insurance paperwork; or, (b) a standard
packet should be used. – Mercy Hospitals

3. For Priority 5 requests, 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, 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. The response time standard to staging area shall not be relaxed.

   - Staging response is code 2 and therefore the standards need to be relaxed.   - KCFD

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, or vehicle tracking programs, i.e. the Road Safety Program. If no alternative 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 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 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 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 sub-contractor shall be responsible for response time compliance and reporting as if that segment is within the sub-contractor’s EOA.

[Add] 8. When a Provider is required to move ambulance resources to another Provider’s EOA under mutual aid, then the Response Time Standards shall be relaxed in the Provider’s EOA that sent resources into another Provider’s EOA, until either another ALS ambulance can be deployed or the ambulance resource is cleared from the mutual aid assignment and is back in its EOA response zone. – Ambulance Providers

- If a provider has multiple EOAs, they should be required to maintain standards by posting from another of their response areas. - KCFD

Service outside the ambulance provider’s EOA should be tracked and reported. If a sub-contracted ambulance provider is employed, the primary ambulance provider should be held accountable for the quality in their EOA. There is a typographical error in the paragraph numbering. The number seven (7) paragraph on page 15 is duplicative to paragraph seven (7) on page 14. – Mercy Hospitals

IX. 8. If provider is sub-contracting in another providers EOA the response time standard should still be required. - ECC

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.

F. Response Time Exceptions and Exemption Requests:

F. Response Time and BLS Exceptions and Exemption Requests: - Ambulance Providers

1. The ambulance provider shall use best efforts to maintain mechanisms for reserve production capacity and to increase production 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 unexpected weather, or periods of unusually high demand for ambulance services. Authorized categories for minimum response time standards exceptions are as follows:

[Delete ‘unexpected’ before weather] - Ambulance Providers

- a. Local declared disaster involving mass casualties.
- b. A Department authorized Ambulance Strike Team medical mutual aid deployment outside Kern County.
- Add “or inside” for ambulance strike teams. - KCFD

- c. Unpredictable severe weather conditions, at the discretion of the Department.
- d. Period of unusually high demand, as described below.

[Delete a., b., c., and d.] - Ambulance Providers
[Add] a. Med-Alert where one or more ambulance(s) were deployed out of the operating area by an authorized agency.

b. Back up ambulance response to a call where provider already has deployed one ambulance to the same call location.

c. Two or more emergency response calls occurring within one (1) hour in the provider’s operating area for designated single available ambulance permittee areas authorized by Department. A single available provider area is defined as an area which includes an eight (8) minute response zone which has only one ambulance operating in it sixty percent (60%) of the time or more.

d. Two or more emergency response calls occurring within two (2) hours in the provider’s operating area for designated single available ambulance permittee areas authorized by Department.

e. Certain weather or roadway conditions which prohibit safe ambulance operation to meet response time standard or specified call location inaccessible by conventional ground ambulance as authorized by Department.

f. A local declared emergency, local declared emergency in another county or state of emergency where permittee ambulance(s) and certified personnel are sent for authorized mutual aid response

g. Emergency Department(s) saturation or patient overload that cause excessive delays and interferes with an ambulance providers abilities to off load patients and become available for calls.

h. Reassignments of ambulances from lower priority service requests to higher priority emergency calls that result in the original service request exceeding its minimum response time standard.

i. Other appropriate exceptions such as unavoidable mechanical breakdown, impassable roadway obstruction, adverse weather conditions or others as determined and authorized by Department.

- Ambulance Providers
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:

\[
\text{Overload Score} = (1.5 \times \text{Sample Standard Deviation}) + \text{Sample Mean for the entire population of emergency call volume for that hour for the past 20 weeks rounded up to the nearest whole call.}
\]

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 to 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.

This is not sufficient to address the operational dilemmas facing the rural areas. The current Policies and Regulations provide for realistic exemptions that are necessary given the remote operating areas. We believe they should remain as written. The same provisions should be applied to the issue of utilizing BLS units in the pre-hospital setting. Also, there is no provision for the off load delays at the EDs. We believe off load delays of greater than 15 minutes should be added as an exemption. – Ambulance Providers

The exclusion review report should be published publicly and include accepted and denied requests. – Mercy Hospitals

G. Aggregate Monthly Response Time and ALS Ambulance Use 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 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 there were 357 Priority 1 Metro Zone (8:59 minutes) responses. 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 each priority code and response time zone in each EOA. Any priority code, by zone, resulting in less than the 90% response time performance is non-compliant with the Standards.

3. An ALS ambulance shall be dispatched to no less than 97 percent of all Priority 1, Priority 2, and Priority 3 calls originating within the EOA zone or EOA substation zone for each month. ALS ambulance use below 97 percent is non-compliant with the Standards.

3. An ALS ambulance shall be dispatched to all calls meeting the EMD ALS Protocols no less than 90 percent of all Priority 1, Priority 2, and Priority 3 calls that do not originate at a acute care hospital or infirmary originating within the EOA zone for each month. ALS ambulance use below 90 percent is non-compliant with the Standards. – Ambulance Providers

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% 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, the ambulance provider will be required to meet 90% compliance for the month for Priority 1, while Priority 2 will be subject to the 100-response rule. The requirement for 90% response time compliance is not applicable to a zone until that zone accumulates 100 responses.

- This is simple math, there is no need to set a new standard to calculate standard compliance. - KCFD

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:

   The electronic format doesn’t exist; it will have to be developed jointly between the Department and the Providers. – Ambulance Providers
All ambulance providers’ performance reports should be publicly reported. - Mercy Hospitals

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. Additionally, all “service requested, failed to respond” calls shall be listed. Each response to incidents outside the assigned EOA(s) shall be listed. All monthly reports shall be submitted to the Department before the 15th of the current month for the previous month.

[Add] ‘within Kern County’ after EOA(s). – Ambulance Providers

b. Monthly Resource Use Reports: Monthly reports showing the number of ALS ambulance responses and BLS ambulance responses to prehospital emergency calls per EOA, applicable to EOA 1, 2, 3, 4, 5, 7, and 9. Monthly reports showing the number of ALS ambulance responses and BLS ambulance responses to prehospital emergency calls per EOA sub-zone, applicable to EOA 6, 8, and 11.

b. Monthly Resource Use Reports: Monthly reports showing the number of ALS ambulance responses and BLS ambulance responses to prehospital emergency calls per EOA. – Ambulance Providers

c. Monthly Quality Improvement Reports:

1) Monthly Operation Report providing a monthly total complete report of unit-hour utilization, incidence of first responder “ride-ins,” dispatch compliance with protocols, continuing medical education, public education and information activities, and investigations and inquiries by source types, outcomes, and resolution.

1) Monthly Operation Report providing a monthly total complete report of” EMD Activity and QA Report, continuing medical education, These are not QI functions. – Ambulance Providers

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.

2) Removed, data already collected on e-PCR system. – Ambulance Providers
XI. **Customer Service Performance Measurements**:

A. Ambulance providers will initiate an approved complaint resolution form for each and every complaint received from the general public, patients, patients’ families, healthcare facilities, or providers and public safety agencies.

   *Ambulance providers will initiate an approved complaint resolution form * **and process** for each and every *written* complaint received from the general public, patients, patients’ families, healthcare facilities, or providers and public safety agencies. – Ambulance Providers

XI. A. EMS should provide a standard complaint form and it should be given to the patient along with the "patients rights form". – ECC

B. Ambulance providers will initiate internal complaint resolution processes and report the results to the Department.

   - Does this mean the public agencies need to file all complaints with the provider instead of EMS?  - KCFD

   *Delete entirely* This is not a *performance issue, it is a Department Policy*. – Ambulance Providers

C. Complaints of a significant or chronic nature may be referred by the Department to the EMCAB for review and recommendations.

D. All complaints of a clinical nature will be reviewed by the Medical Director.

   **Clinical complaints need to be reviewed by the EMS Medical Director and reported in aggregate as to outcomes.** – Mercy Hospitals

XI. D. Complaints will be reviewed by the EMS Dept., complaints of a clinical nature will be forwarded to the Medical Director. - ECC

E. Complaints will be categorized as follows:

1. Minor - Non-clinical, non-safety related complaints of a procedural or administrative nature. (i.e., sloppy uniform, dirty ambulance, minor billing issues, etc.)

2. Significant - More serious complaints including those possibly related to minor clinical or safety issues and those of higher customer service significance. (i.e., rude crew behavior, speeding, poor interaction with other responders or facility staff, seatbelt use, etc.)
3. Major - Significant safety, clinical or customer service complaints. (i.e.: deviations from protocols, transport destination error, refusal of service, extremely inappropriate behavior, accidents, reckless driving, etc.)

[Delete E. entirely] None of these examples relate to clinical performance and are purely subjective. – Ambulance Providers

F. The Department may investigate complaints. If the Department determines that any complaint has not been adequately addressed, the ambulance provider will be required to take further action to resolve the issue. Instances of failure to resolve significant or major complaints, after a reasonable period of time may result in a determination of non-compliance with this standard.

G. During the first 6 months after implementation of this standard, ambulance provider and the Department will record the number of complaints each month in each category. A statistical control chart will be developed for complaints in each category and in total. The ambulance provider will initiate Quality Improvement processes designed to address the frequency and severity of complaints. It is the goal of this standard that over the life of the contract, complaints (expressed as complaints per 1,000 calls) should be reduced in frequency and severity.

[Delete F. and G. entirely] The Providers believe the current system is appropriate and that it requires the providers’ full cooperation. The attempt to “categorize” complaints is subjective and simply doesn’t work. A sloppy uniform, seat belt infractions, and reckless driving are subjective and not objective. We believe the language from the old ordinance, section 8.12.190, that deals with complaints should continue to be used. – Ambulance Providers

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.

- All studies should be at the cost of the provider as a cost of doing business in Kern County. – KCFD

A. By April 15th of each contract year, each ambulance provider will receive from the Department a report of contract compliance and achievement for the previous calendar year. The Department’s report will indicate the extent of compliance with all performance provisions of the contract and these standards. The report must contain: - Ambulance Providers
At a minimum the report must contain:

1. Call volume including responses and transports reported as prehospital vs. interfacility and emergency vs. non-emergency.

   **1. Response and transport volumes, by priority codes. – Ambulance Providers**

2. Response time compliance by month, by priority, and by zone.

3. ALS ambulance response rate for Priority 1, 2, and 3 by EOA zone or EOA substation zone.

   **3. ALS ambulance response rate for Priority 1, 2, and 3. by EOA Zone. – Ambulance Providers**

Add standard for participating in at least two (2) joint training exercises with the Department and/or public safety agencies. This is measurable. – Ambulance Providers

4. Mutual aid given and received by ambulance provider.

   **[Delete entirely] – Ambulance Providers**

5. Standbys and special events by month including on time compliance.


7. Numbers of complaints with resolution rate.

   **Remove, not measurable and all complaints would be “resolved”. – Ambulance Providers**

8. Community Service and Public Education events conducted by month.

   **Not a standard, this cannot be measured. – Ambulance Providers**

   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. Questionnaires will be returned directly to the Department for processing.

   - Who designs, approves, and provides this questionnaire?  - Mercy Air

   **[Delete B. entirely] Too encompassing and costly. Responses should be mailed to provider, not EMS. – Ambulance Providers**

Annual reports must be a requirement, not an option. – Mercy Hospitals
XII. B. EMS Dept should provide the questionnaire. - ECC

C. During each contract year, the Department will conduct one or more surveys of hospital and healthcare facilities to determine customer satisfaction with each provider’s performance.

D. During each contract year, the Department will survey public safety agencies to solicit input regarding each provider’s performance.

[Delete C. and D. entirely] – Ambulance Providers

XII. C. D. Should be retained in policy. - ECC

E. 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 - Demonstrating each provider’s level of contract compliance, any notices of exceptions or instances of non-compliance and provider’s performance in curing those deficiencies.

2. Complaints and resolution - Including numbers and categories of complaints and each provider’s performance in resolving them.

3. Customer Service Grade - Compiled from customer surveys (including patient, facility, and public safety agencies). Grades will be issued as A, B, C, D or Failure based on a statistical evaluation of customer responses.

This report card is to be a statistical evaluation from surveys obtained from three different sources. How are these sources to be weighed or will they have equal weight? The grades A, B, C, D, and F; what is their percentage ranges? These grades will be extremely important when the contract is renewed. - Mercy Air

4. Clinical Report Card - Prepared by the Medical Director and grading the clinical performance of each provider in the following categories:

a. Provision of adequate clinical equipment.

[Delete a.] Define this, what does it mean? – Ambulance Providers

b. Adherence to clinical protocols.

[Delete b.] This is part of the QI process and not a measurable performance. – Ambulance Providers
XII. 4.b. Should be retained, adherence to protocols is measurable. - ECC

c. Quality Improvement Processes.
d. Qualifications of clinical personnel (including certifications and continuing education).
e. Clinical performance of dispatch center.
f. Participation in County clinical processes.

5. Grades will be issued as A, B, C, D or Failure based on a statistical evaluation of provider performance.

[Delete 2., 3., 4., and 5.] – Ambulance Providers

G. The Department will compile the grades and issue a combined grade for each provider. Grades will be issued as A, B, C, D or Failure based on a weighted calculation of items A through D above.

H. Providers achieving an overall grade of A or B are automatically eligible for contract extension. Providers receiving a C or below are not. Providers receiving a D may be given notice of inadequate performance. Those receiving a grade of F and those receiving a grade of D in two consecutive years may be found in non-compliance with these standards.

- After one year below standard, there should be quarterly checks.
- After 2 below standards (annually or quarterly/non-consecutive), the contract should be revoked with a 5-year no bid clause. - KCFD

[Delete G. and H. entirely] It is impractical and unheard of to use a completely subjective grading system not based on knowledge and actual and tangible measurable performance standards. – Ambulance Providers