STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GAVIN NEWSOM, *Governor*

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 322-1441

November 7, 2022

Andrew Holcomb, EMS Director
San Francisco EMS Agency
333 Valencia St. Ste 210
San Francisco, CA 94103

Dear Mr. Holcomb,

This letter is in response to San Francisco County Emergency Medical Services (EMS) Agency's 2020 - 2022 EMS, Trauma, Quality Improvement (QI), and EMS for Children (EMSC) plan submissions to the EMS Authority on August 31, 2022.

The EMS Authority has reviewed the EMS plan, based on compliance with statutes, regulations, and case law. It has been determined that the plan meets all EMS system components identified in Health and Safety Code (HSC) § 1797.103 and is approved for implementation pursuant to HSC § 1797.105(b). Based on the transportation documentation provided, please find enclosed the ground exclusive operating area status, as compiled by the EMS Authority.

The EMS Authority has also reviewed the Trauma, QI, and EMSC plans, based on compliance with Chapters 7, 12, and 14 of the California Code of Regulations, Title 22, Division 9, and has approved for implementation.

In accordance with HSC § 1797.254, please submit an annual EMS plan to the EMS Authority on or before November 7, 2023. Concurrently with the EMS plan, please submit an annual Trauma, QI, and EMSC plan. If you have any questions regarding the EMS Plan review, please contact Mr. Mark Olivas, Interim EMS Plans Coordinator, at (916) 384-1925, or mark.olivas@emsa.ca.gov.

Sincerely,

//for//
Tom McGinnis
Chief, EMS Systems Division

Enclosure
AW: rd

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 322-1441

San Francisco 2022 EMS Plan Ground Exclusive Operating Area	Non-Exclusive	Exclusive	Method to Achieve Exclusivity	Emergency Ambulance	ALS	LALS	All Emergency Ambulance Services	9-1-1 Emergency Response	7-digit Emergency Response	ALS Ambulance	All CCT Ambulance Services	BLS Non-Emergency	Standby Service with Transport Authorization
ZONE	**EXCLUSIVITY**			**TYPE**			**LEVEL**						
City and County of San Francisco		X		X				X					

Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St., Suite 210, San Francisco, CA 94103
Phone: (628) 217-6000 Fax: (628) 217-6001

London Breed
Mayor

Mary Ellen Carroll
Executive Director

Date: October 26, 2022

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority
Angela Wise, Assistant Chief, EMS Systems, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2022 EMS Plan Additional Documents

The San Francisco EMS Agency (SFEMSA) is hereby submitting and attaching additional documentation as requested by the State EMS Authority on October 20, 2022.

1) EMS Provider Service Provider Agreements

   Please see enclosed documents.

2) Medical Health Operational Area Coordinator (MHOAC) Program information

   San Francisco maintains a MHOAC program under California Health and Safety Code § 1797.153. The MHOAC program in San Francisco is a joint effort between SFEMSA, as the Local EMS Agency, under the Department of Emergency Management and the Public Health Emergency Preparedness and Response (PHEPR) division under the Department of Public Health/County Health Officer. Dr. John Brown is the designated MHOAC representative in San Francisco with delegated authority to additional parties within SFEMSA and PHEPR to maintain the program with continuous 24/7 coverage.

3) Evaluation of the San Francisco EMS System

   Under California Health and Safety Code § 1797.204, a Local EMS Agency is required to evaluate EMS system readiness and response services. SFEMSA regularly reviews operational and clinical data impacting EMS services in San Francisco. Copies of these reports are included within our 2022 EMS Plan submission, Section II – Data and Section III – Quality Improvement.

Please feel free to contact me with any additional questions.

Andrew Holcomb
EMS Director, EMS Agency
andrew.holcomb@sfgov.org
628-217-6014

Encl: San Francisco EMS Provider Agreements

Cc: Dr. John Brown, EMS Agency Medical Director
Rob Smuts, DEC Deputy Director
Mary Ellen Carroll, DEM Executive Director
Christina Fletes-Romo, Deputy City Attorney

MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF EMERGENCY MANAGEMENT, THE DEPARTMENT OF PUBLIC HEALTH, AND THE FIRE DEPARTMENT OF THE CITY AND COUNTY OF SAN FRANCISCO FOR THE EMERGENCY MEDICAL SERVICES ("EMS") SYSTEM, MEDICAL CONTROL OF THE EMS SYSTEM, and PROVISION OF ADVANCED LIFE SUPPORT ("ALS") and 9-1-1 SERVICES

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into this 23d day of May, 2013, in the City and County of San Francisco, State of California ("CITY"), by and between the San Francisco Department of Emergency Management ("DEM"), the San Francisco Department of Public Health ("DPH"), and the San Francisco Fire Department ("SFFD") (collectively the "PARTIES").

Recitals

WHEREAS, pursuant to California Health and Safety Code, Section 1797.200, the CITY has established a local EMS Agency ("AGENCY"), and

WHEREAS, San Francisco Health Code Article 14 requires DPH to oversee Advanced Life Support Ambulances and routine medical transport vehicle services ("PROVIDER"), and

WHEREAS, San Francisco Charter § 3.100.14 establishes that the Mayor is Commander of Emergency Services, and

WHEREAS, in 1997 the Mayor directed and authorized DPH to transfer PROVIDER functions to SFFD, and

WHEREAS, in 2009, the Mayor directed and authorized DPH to transfer AGENCY functions, except for Medical Control functions, to DEM, which is now responsible for the regulation and administrative oversight of the EMS system; and,

WHEREAS, in 2012 the State of California EMS Authority approved the San Francisco EMS Plan which established San Francisco as an Exclusive Operating Area pursuant to the State of California Health and Safety Code Section 1797.224 for the purposes of EMS response to 9-1-1 calls for service and recognized the exclusive providers to include the City and two private ambulance companies, and

WHEREAS, the PARTIES enter into this MOU in order to recognize and implement the various roles and responsibilities necessary to continue provision of EMS as directed by the Mayor, and

WHEREAS, the PARTIES will continue to participate in the EMS system and comply with all applicable state and local laws, regulations, policies, and procedures;

Now, THEREFORE, the PARTIES agree as follows:

General Definitions

1. 9-1-1 Service - Responses to requests for service from any person dialing 9-1-1 to a Public Safety Answering Point ("PSAP") to request emergency medical services for anyone at any place. This includes calls using 7-digit phone numbers and non-telephone conveyed requests for service.

2. Advanced Life Support - Specialty services designed to provide pre-hospital care, including but not limited to cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specific drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency during transport to an acute care hospital, during an interfacility transfer and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff at the hospital. Advanced Life Support is also generally the treatment performed by accredited Emergency Medical Technician-Paramedics ("EMT-Ps") according to the Advanced Life Support Adult and Pediatric Treatment Protocols.

3. Advanced Life Support Ambulance ("ALS Ambulance") - A ground ambulance that provides transport of the sick and injured, and is staffed and equipped to provide advanced life support consistent with the California Health and Safety Code, Division 2.5, Section 1797.52 and AGENCY policies and procedures.

4. Agency Policies, Procedures and Protocols - All policy, procedure and protocol documents developed through the AGENCY.

5. ALS Emergency Service - Site to Facility patient transports, as well as Facility to Facility transports, originating from a private request; i.e., calls from a client/contractor, physician, private care facility, hospital, an on-viewed incident or any source other than from the City's PSAP. These services are to be provided within the legal boundaries of the City and County of San Francisco, as defined in the City's Charter, and may transport within or without the City. This type of service does not include response to any requests for service received through the City's 9-1-1 Dispatch Center at the Division of Emergency Communications in the Department of Emergency Management, including 7-digit phone numbers and non-telephone conveyed requests.

6. ALS Ground Ambulance Services - The provision of advanced life support services provided in an ambulance by an authorized ALS Provider pursuant to a Service Provider Agreement (SPA) consistent with the California Health and Safety Code, Division 2.5, Section 1797.52 and AGENCY policies and procedures.

7. Ambulance Permit - A permit issued by the EMS Medical Director for an ambulance or routine medical transport vehicle pursuant to the San Francisco Health Code, Article 14. This permit is required to operate an ambulance or routine medical transport vehicle within the City and County of San Francisco.

8. Authorized ALS Ambulance Provider - An ambulance provider that is authorized to provide ALS ambulance services within the CITY pursuant to a Service Provider Agreement (SPA) with the AGENCY.

9. Automatic Aid Provision – The authority to provide mutual aid to another jurisdiction without requiring the approval of the AGENCY prior to deploying.

10. Basic Life Support ("BLS") - Basic life support means emergency first aid and cardiopulmonary resuscitation procedures, which at a minimum, include: recognizing respiratory arrest and application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim can be transported or until Advanced Life Support is available.

11. Basic Life Support Ambulance ("BLS Ambulance") - An ambulance staffed and equipped to provide basic life support in full compliance with the California Health and Safety Code, Division 2.5, Section 1797.60, all regulations of the State of California, the CITY Ambulance Ordinance, and AGENCY Policies, Procedures and Protocols.

12. Certificate of Operation – Certificate issued under San Francisco Health Code Article 14 by the EMS Medical Director to a person who qualifies to operate an ambulance in the CITY. For purposes of this MOU, "person" means and includes an individual, proprietorship, firm, partnership, joint venture, syndicate, business trust, company, corporation, association, committee, governmental agency, or any other legal entity.

13. Clinical Practice – Those issues related to EMS that have a direct bearing on the medical practice of EMS providers (EMT's and Paramedics) or the medical outcomes of EMS patients.

14. Emergency Ground Ambulance Services - All ambulance services performed at the request of, and determined to be either a Code Two or Code Three level response by, an Authorized EMS Dispatch Center.

15. Emergency Medical Personnel - All public safety first responders, Emergency Medical Dispatchers, EMTs and EMT-Ps functioning within the EMS system.

16. EMS Medical Director - The Medical Director of the EMS Agency, responsible for the duties set forth in California Health and Safety Code, Section 1797.202.

17. Emergency Medical Technician – 1 – An individual whose authorized scope of practice is to provide BLS governed by standards prescribed by Division 2.5 of the Health & Safety Code and applicable regulations who has a valid certificate pursuant to said division as required by AGENCY.

18. Emergency Medical Technician – Paramedic - An individual whose authorized scope of practice is to provide ALS governed by standards prescribed by Division 2.5 of the Health and Safety Code and applicable regulations who has a valid license issued pursuant to said division and local accreditation as required by AGENCY.

19. Facility – A location where a patient or patient representative requests ambulance service in

which a physician, physician's assistant or nurse practitioner is physically present and assessed the patient's need for EMS.

20. Medical Control – The medical direction and management of the EMS system pursuant to the Health & Safety Code §1798.

21. Medical Emergency - The term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by public safety personnel or Emergency Medical Personnel at the scene of an emergency or dispatch personnel at a Designated EMS Dispatch Center.

22. National Incident Management System ("NIMS") – The incident management system developed by the US Department of Homeland Security, Federal Emergency Management Agency, as required by Homeland Security Presidential Directive 5 (HSPD-5).

23. Primary Public Safety Answering Point ("PSAP") - The location where the 911 request for service is first answered.

24. Response Codes - The dispatch term which denotes the level of priority for units responding to the scene as defined herein:
    a) Code One - Routine or scheduled transportation of patients.
    b) Code Two - A non-life threatening Medical Emergency requiring immediate response.
    c) Code Three - A Medical Emergency requiring immediate response with red light and siren.

25. Site - A location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is NOT physically present and has NOT assessed the patient's need for EMS.

26. Standardized Emergency Management System (SEMS) - The standardized emergency management system identified in California Government Code, Section 8607.

Agreement

General Terms

1. Effective Date: The effective date of this MOU shall be May 23, 2013.

2. Term: The MOU shall remain in effect until such time as it is terminated in writing by the PARTIES, executed in the same manner as this MOU.

3. Modifications: The provisions of this MOU may be amended or modified by written agreement of PARTIES.

4. Notice to the PARTIES
    a) Unless otherwise indicated elsewhere in this MOU, all written communications (except routine operations and quality improvement communications) sent by PARTIES may be sent by U.S. mail, by fax, or e-mail and shall be addressed as follows:
        i. To DEM: Director of Emergency Services Division, 30 Van Ness Avenue,

Suite 3300, San Francisco, CA 94102

ii. To DPH: San Francisco Health Officer, Department of Public Health, 101 Grove Street, Room 302, San Francisco, CA 94102

iii. To SFFD: Chief, San Francisco Fire Department, 698 Second Street, San Francisco, CA 94107

Roles and Responsibilities

1. DPH shall provide medical control and direction to the EMS system through the employment of an EMS Medical Director who will make regular reports to the Director of Public Health and the Health Commission. The EMS Medical Director will work collaboratively with DEM and SFFD while retaining authority as described in the State of California Health and Safety Code Section 1797.202.
2. DPH will continue to operate San Francisco General Hospital and serve as the Base Hospital pursuant to the State of California Health and Safety Code Section 1798.100 and a Trauma Center pursuant to the State of California Health and Safety Code Section 1798.165. Requirements and obligation of PARTIES relative to these functions are contained in separate agreements specific to the function.
3. DEM shall employ staff in the Division of Emergency Services who will serve as the AGENCY as described in the State of California Health and Safety Code Section 1797.204, responsible for the administration, planning, coordination and regulation of the San Francisco EMS System.
4. DEM shall continue to serve as the PSAP and primary dispatch for 9-1-1 services through the Division of Emergency Communications. Requirements and obligations of the PARTIES relative to that function are contained in an agreement specific to that function.
5. SFFD shall provide Emergency Ground Ambulance service and be recognized as an Authorized ALS Ambulance Provider with this MOU serving as the required Service Provider Agreement as required pursuant to California Code of Regulations, Title 22, Section 100168.
6. SFFD shall continue to provide EMS First Response services to 9-1-1 medical emergency calls in order minimize the response time interval to Code 3 responses and provide on scene assistance to EMS personnel on scene.

Obligations of the PARTIES

1. DPH responsibilities:
    a. Provide a qualified Emergency Physician to serve as the EMS Medical Director. The Medical Director shall be funded by DPH and assigned to the AGENCY a minimum of 20 hours per week,
    b. Provide qualified personnel on call 24 hours per day, 365 days per year to serve as the Medical Health Operational Area Coordinator (MHOAC) for medical mutual aid,
    c. Administer funds received from the State of California and provide those funds obligated to EMS specific purposes to the AGENCY, and
    d. Comply with San Francisco EMS Policies and Protocols where applicable to DPH programs and services.
2. DEM responsibilities:

a. Provide sufficient staff and management personnel to perform the functions of the AGENCY,
b. Prepare reports for, and answer inquiries of, the Health Commission, as directed by the Medical Director,
c. Develop, through AGENCY, EMS Policies and Protocols in an open and collaborative manner,
d. Upon request from any party, including insurance companies, fiscal intermediaries, and other third party payers, through AGENCY, report that SFFD is an authorized provider of ALS service,
e. Support, through AGENCY staff, the MHOAC in requesting, tracking, receiving, coordinating and providing resources to mutual aid requests,
f. Form and staff a 9-1-1 ALS Operations Committee for the purposes of managing the division of 9-1-1 call volume as required in the 2012 San Francisco EMS Plan approved by the State of California EMS Authority ("EMS Plan"),

3. SFFD responsibilities:
   a. Provide sufficient ALS Ground Ambulance resources to respond to the percentage of all 9-1-1 medical calls as set forth in the current San Francisco EMS Plan as approved by the California EMS Authority,
   b. Provide sufficient first response services for presumptive life-threatening calls in accordance with the San Francisco EMS Plan as approved by the California EMS Authority,
   c. Comply with San Francisco EMS Policies and Protocols as they pertain to the EMS functions of the SFFD,
   d. Respond to medical mutual aid requests and deployments in accordance with the San Francisco EMS Policies and Protocols and routed through the MHOAC, except in the case of an automatic aid or immediate need request made by a neighboring jurisdiction. At any time, and without further approval of the MHOAC, permitted field providers in San Francisco may dispatch up to five ambulances and one paramedic supervisor (known as an Ambulance Strike Team.) The SFFD shall notify the AGENCY once it has deployed single assets or an Ambulance Strike Team so that system adjustments may be made, if necessary,
   e. Maintain all records required pursuant to this MOU, including patient care, staffing, operations, fiscal and quality improvement records, make such records available for inspections, audit, or examination by AGENCY or by its designated representatives, consistent with federal, state and local confidentiality and privacy laws, and shall preserve such records for at least three (3) years from the termination of this MOU,
   f. Prepare, upon AGENCY's request, and submit written reports on incidents related to services provided under this MOU,
   g. Submit monthly operation reports to AGENCY, by the last day of the following month, in a form prescribed by AGENCY,
   h. Share electronic EMS data, in a form acceptable to the AGENCY, for the purposes of Quality Improvement and reporting,
   i. Post AGENCY notices and bulletins at all employee locations.
   j. Require, through written policy, all personnel to have knowledge of, and follow, AGENCY Policies, Procedures and Protocols,
   k. Ensure all EMTs and EMT-Ps are trained in AGENCY policies, procedures, and

protocols. Such training shall include cognitive, motor and retention skills that allow employees to properly perform EMS duties,

l. Provide at each SFFD location, in a location easily accessible to employees, a current AGENCY Policy and Procedure Manual and Protocol Manual.

m. Develop and enforce fatigue prevention policies acceptable to all PARTIES because fatigue prevention is of paramount importance to all PARTIES in the interest of personnel and patient safety,

n. Comply with all federal and state patient privacy laws, and enact and enforce a policy that prohibits SFFD employees from inappropriate sharing of protected patient information, to including sharing via personal communication devices, social media, and any other form of data transmission,

o. Enact and enforce a policy that prohibits SFFD employees from performing any ALS or BLS service under the influence of any alcoholic beverage, illegal drug, or narcotic. In addition, said policy shall prohibit SFFD employees from performing such services under the influence of any other substances, including prescription or non-prescription medication, which impairs their physical or mental performance,

p. Comply fully and timely with the requirements of California Health and Safety Code, Section 1799.112, which, among other things, mandates that EMT-P employers shall report in writing to the local EMS Agency medical director and the EMS Authority and provide all supporting documents within 30 days whenever an EMT-P receives certain disciplinary measures, resigns following an impending investigation based on evidence, or is removed from paramedic duties for disciplinary cause or reasons following the completion of an internal investigation,

q. Ensure that a primary representative or designated alternate attends at least 80% of EMS AGENCY advisory committee meetings,

r. Pay fees to the DEM, as required by applicable state and local law related to operating permits, licenses and certificates.

For DPH:	For DEM:	For SFFD
	5-23-2013	05/23/2013
Barbara Garcia Director of Public Health	Anne Kronenberg Executive Director	Joanne Hayes-White Chief

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City and County of San Francisco
San Francisco Department of Public Health
Emergency Medical Services Division
90 Van Ness Avenue
San Francisco, California 94102

Agreement between the City and County of San Francisco, acting by and through its Department of Public Health and American Medical Response West

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This emergency Service Provider Agreement ("SPA") is made this 1st day of July, 2020 in the City and County of San Francisco, State of California, by and between American Medical Response West ("Provider") and the City and County of San Francisco, acting by and through its Depaartment of Public Health.

Recitals

WHEREAS, the San Francisco Department of Public Health is the designated local Emergency Medical Services Agency ("LEMSA") for the City and County of San Francisco, under California Health and Safety Code Section 1797.200; and

WHEREAS, Provider possesses all requisite LEMSA approvals to participate in the LEMSA Emergency Medical Services ("EMS") system, including a current and valid Certificate of Operation and when necessary an Ambulance Permit, in accordance with San Francisco Health Code Article 14; and

WHEREAS, the San Francisco Emergency Medical Services Plan authorizes Provider to provide Advanced Life Support ("ALS"), Basic Life Support ("BLS"), and/or Special Ambulance Services within the LEMSA EMS service area; and

WHEREAS, California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168(b)(4), requires that authorized paramedic service Providers have a written service provider agreement ("SPA") with the LEMSA allowing the Provider to participate in the LEMSA EMS system and obligating the Provider to comply with all State regulations and local policies and procedures, including participation in the LEMSA's Emergency Medical Services Quality Improvement Program ("EMSQIP"); and

WHEREAS, the Parties wish to enter into this written SPA in compliance with Section 100168(b)(4), when required, or otherwise as required by the LEMSAs;

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this SPA:

1.1. **"Advanced Life Support (ALS)**" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency department or other medical staff of that hospital, as defined by California Health and Safety Code, Division 2.5, Section 1797.52, including the scope of practice of Paramedic as listed in Section 1797.52 and any LEMSA approved Local Optional Scope of Practice.

1.2. **"ALS Ground Ambulance Services"** means the provision of advanced life support services provided in an ambulance by an authorized ALS Provider pursuant to a Service Provider Agreement (SPA) consistent with the California Health and Safety Code, Division 2.5, Section 1797.52 and LEMSA policies and procedures.

1.3. **"Ambulance Permit"** means a permit issued by LEMSA's Medical Director for an ambulance or routine medical transport vehicle pursuant to the San Francisco Health Code, Article 14. This permit is required to operate an ambulance or routine medical transport vehicle within the City and County of San Francisco.

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1.4. **"Authorized ALS Ambulance Provider"** means an ambulance Provider that is authorized to provide ALS ambulance services within the City pursuant to a Service Provider Agreement with the LEMSA.

1.5. **"Basic Life Support (BLS)"** means emergency first aid and cardiopulmonary resuscitation procedures, which at a minimum, include: recognizing respiratory arrest and application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim can be transported or until advanced life support is available, as defined by California Health and Safety Code, Division 2.5, Section 1797.60, including the basic scope of practice as listed in Section 1797.60 and any LEMSA approved Local Optional Scope of Practice.

1.6. **"Authorized BLS Ambulance Provider"** means an ambulance Provider that is authorized, staffed and equipped to provide basic life support in full compliance with the California Health and Safety Code, Division 2.5, Section 1797.60, all regulations of the State of California, the City Ambulance Ordinance, and LEMSA Policies, Procedures and Protocols.

1.7. **"Certificate of Operation"** means a Certificate issued under San Francisco Health Code Article 14 by the LEMSA Medical Director to a Provider who qualifies to operate an ambulance in the City. To qualify for a Certificate of Operation, the Provider must hold three valid and current Ambulance Permits.

1.8. **"Confidential Information"** means confidential City information including, but not limited to, personally-identifiable information ("PII"), protected health information ("PHI'), or individual financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.9. **"Emergency Medical Personnel"** means all public safety first responders, Emergency Medical Dispatchers, EMTs and EMT-Ps functioning within the emergency medical services system.

1.10. **"Emergency Medical Services Quality Improvement Program (EMSQIP)"** means the continuing quality improvement program, procedures and protocol documents developed by the LEMSA.

1.11. **"Emergency Medical Technician (EMT)"** means an individual trained in all facets of basic life support according to standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.80, and who has a valid certification issued pursuant to said division and local training as required by LEMSA.

1.12. **"Emergency Medical Technician – Paramedic (EMT-P)"** means an individual whose scope of practice is to provide advanced life support governed by standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.84, and who has a valid license issued pursuant to said division and local accreditation as required by LEMSA.

1.13. **"Facility"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is physically present and assessed the patient's need for LEMSA.

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1.14. **"Ground Ambulance Services"** means all ambulance services performed at the request of and determined to be either a Code Two or Code Three level response by an Authorized LEMSA Dispatch Center.

1.15. **"LEMSA Medical Director"** means the San Francisco Director of Health, responsible for the duties set forth in California Health and Safety Code, Division 2.5, Section 1797.202.

1.16. **"Medical Emergency"** means the term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by public safety personnel or Emergency Medical Personnel at the scene of an emergency or dispatch personnel at a designated LEMSA Dispatch Center.

1.17. "**Medical Record**" means all patient care interaction and assessment data collected and/or generated by Provider and included in Provider's electronic medical record system, including but not limited to a record of a patient's medical information (such as medical history, care or treatments received, test results, diagnoses, and medications taken).

1.18. **"National Incident Management System (NIMS)"** means the incident management system developed by the US Department of Homeland Security, FEMA, as required by Homeland Security Presidential Directive 5 (HSPD-5).

1.19. **"Primary Public Safety Answering Point (PSAP)"** means the location where the 911 call is first answered.

1.20. **"Provider Program Director"** means the Medical Director of the Provider.

1.21. **"Response Codes"** means the dispatch term which denotes the level of priority for units responding to the scene as defined herein:

a) **Code One** - Routine or schedule transportation of patients.
b) **Code Two** - A non-life threatening Medical Emergency requiring immediate response.
c) **Code Three** - A Medical Emergency requiring immediate response with red light and siren.

1.22. **"Services"** means the provision of any and all services under this SPA.

1.23. **"Site"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is NOT physically present and has NOT assessed the patient's need for LEMSA.

1.24. **"Special Ambulance Service"** means any unit-type, providing Emergency Medical Services and patient care that can be dispatched to a medical call without the ability to provide patient transport.

1.25. **"Standardized Emergency Management System (SEMS)**" means the standardized emergency management system identified in California Government Code, Section 8607.

Article 2 Term of the Agreement

2.1 **Initial Term.**

The term of this SPA shall commence on July 1, 2020 and expire five years later on June 30, 2025, unless earlier terminated as otherwise provided herein.

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2.2 **Renewal of SPA.**

This SPA shall auto-renew for four additional one-year periods upon Provider's payment of all required Certificate of Operation and/or Ambulance Permit fees and conditioned on Provider's compliance with all Certificate of Operation and Ambulance Permit requirements. The renewed SPA shall automatically terminate should Provider fail to pay all required Certificate of Operation and/or Ambulance Permit fees.

Article 3 Audit

3.1 **Audit and Inspection of Records.**

Provider agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate books and records, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227). Provider will permit City to audit, examine and make excerpts and transcripts from such books and records related to all matters covered by this SPA. Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the local EMS agency. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider. To the extent required by applicable law or regulation, the State of California or any Federal agency having an interest in the subject matter of this SPA shall have the same rights as conferred upon City by this Section.

Article 4 Services and Resources

4.1 **Provider Shall Obtain All Necessary Permits and/or Approvals.**

4.1.1 Provider shall not commence the provision of any services under this SPA until all necessary permits and/or approvals have been issued. Specifically, before commencing work, Provider shall apply for and obtain from LEMSA a Certificate of Operation and when required an Ambulance Permit, and/or all other required regulatory permits and/or approvals in accordance with applicable law, including California Code of Regulations Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic); California Health and Safety Code, Division 2.5 (Emergency Medical Services); and San Francisco Health Code, Article 14 (Ambulances and Routine Medical Transport Vehicles). Nothing in this SPA is intended to imply that City will issue any permits and/or approvals.

4.1.2 Provider shall pay all fees required as a condition precedent to the issuance of any such permits and/or approvals in accordance with the applicable rates and charges then in effect as indicated in LEMSA's fee schedule. The payments made by Provider to City shall be less than or equal to the City's actual costs to provide the LEMSA administration and oversight services. No funds shall be used by the City in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute. .

4.2 **Services Provider Agrees to Perform.**

Provider agrees to perform the services detailed in Appendix A, "Statement of Work." Officers and employees of the City are not authorized to request services beyond the scope listed in Appendix A.

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4.3 **Qualified Personnel.**

Provider shall ensure all Emergency Medical Personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of Provider services.

4.4 **Subcontracting.**

Excluding services for 9-1-1 calls, Provider may subcontract services to be performed under this SPA to other San Francisco LEMSA permitted service providers. For clarity 9-1-1 services may not be subcontracted.

4.5 **Assignment.**

The services to be performed by Provider are personal in character. Neither this SPA, nor any duties or obligations hereunder, may be directly or indirectly assigned, novated, transferred, or delegated by Provider. Any purported Assignment made in violation of this provision shall be null and void.

4.6 **No Transfer of Certificate of Operation or Ambulance Permit.**

Each Certification of Operation and/or Ambulance Permit by the LEMSA is a privilege that is personal and specific to Provider. Neither a Certificate of Operation, an Ambulance Permit, nor any of the privileges conferred thereunder may be neither sold, conveyed, assigned, encumbered, nor otherwise transferred by Provider. Any attempt to sell, convey, assign, encumber or otherwise transfer a Certificate of Operation, any Ambulance Permit, or the privileges conferred thereunder may result in the City's termination of this SPA.

4.7 **Activities at Permittee's Expense.**

Any act that Provider performs under this SPA or applicable law shall be performed at Provider's expense and without cost to City, unless said Provider is a City agency or employee providing services under this SPA.

4.8 **Warranty.**

Provider warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this SPA as detailed in Appendix A (Statement of Work).

Article 5 Insurance and Indemnity (RESERVED FOR SFFD)

5.1 **Insurance.**

5.1.1 **Required Coverages.** Without in any way limiting Provider's liability pursuant to the "Indemnification" section of this SPA, Provider must maintain in force, during the full term of the SPA, insurance in the following amounts and coverages:

(a) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness; and

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(b) Commercial General Liability Insurance with limits not less than $10,000,000 each occurrence and $20,000,000 general aggregate for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; and

(c) Commercial Automobile Liability Insurance with limits not less than $10,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(d) Professional liability insurance, applicable to Provider's profession, with limits not less than $10,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services.

(e) Technology Errors and Omissions Liability coverage (RESERVED).

(f) Cyber and Privacy Insurance with limits of not less than $5,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.

(g) Provider shall be permitted to use umbrella or excess coverage to meet the required limits for insurance in this section.

5.1.2 Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to provide:

(a) Name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

(b) That such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this SPA, and that insurance applies separately to each insured against whom claim is made or suit is brought.

5.1.3 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

5.1.4 Should any of the required insurance be provided under a claims-made form, Provider shall maintain such coverage continuously throughout the term of this SPA and, without lapse, for a period of three years beyond the expiration of this SPA, to the effect that, should occurrences during the contract term give rise to claims made after expiration of the SPA, such claims shall be covered by such claims-made policies.

5.1.5 Should any of the required insurance be provided under a form of coverage that includes a general annual aggregate limit or provides that claims investigation or legal defense costs be included in such general annual aggregate limit, such general annual aggregate limit shall be double the occurrence or claims limits specified above.

5.1.6 Should any required insurance lapse during the term of this SPA, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this SPA, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this SPA effective on the date of such lapse of insurance.

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5.1.7 Before commencing any Services, Provider shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in form evidencing all coverages set forth above. Approval of the insurance by City shall not relieve or decrease Provider's liability hereunder.

5.1.8 The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Provider, its employees, agents and subcontractors.

5.1.9 If Provider will use any subcontractor(s) to provide Services, Provider shall require the subcontractor(s) to provide all necessary insurance and to name the City and County of San Francisco, its officers, agents and employees and the Provider as additional insureds.

5.1.10 City may, in its sole discretion, choose to reconsider the amounts and coverages above and require amendment of this SPA to update such amounts and coverages during the term of the SPA. Provider's execution of an amendment to this SPA to put changes to these amounts and coverages in effect shall not be withheld.

5.2 **General Indemnification.**

5.2.1 Provider shall indemnify and save harmless City and its officers, agents and employees from, and, if requested, shall defend them against any and all third party claims for loss, cost, damage, injury, liability, and claims thereof for injury to or death of a person (including but not limited to patient and/or patient's relative's claims for damages arising from medical malpractice), or loss of or damage to property, arising directly or indirectly from Provider's performance of this SPA, except to the extent that such indemnity is void or otherwise unenforceable under applicable law in effect on or validly retroactive to the date of this SPA and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City, in which case damages will be apportioned under the California doctrine of comparative fault. The foregoing indemnity shall include, without limitation, reasonable fees of attorneys, consultants and experts and related third party costs that the City necessarily incurs.

5.2.2 In addition to Provider's obligation to indemnify City, Provider specifically acknowledges and agrees that it has an immediate and independent obligation to defend City from any claim which actually or potentially falls within this indemnification provision, while such claim is in effect, even if the allegations are or may be groundless, false or fraudulent, which obligation arises at the time such claim is tendered to Provider by City and continues at all times thereafter.

5.3 **Infringement Indemnification.**

Provider shall indemnify and hold the City harmless from all third party claims, loss and liability, including attorneys' fees, court costs and all other litigation expenses for any infringement of United States patent rights, or any copyright, trade secret or any other proprietary right or trademark, and all other intellectual property claims of any person or persons, arising directly or indirectly from Provider's performance of this SPA.

Article 6 Liability of the Parties

6.1 **City's Liability Limit. (RESERVED)**

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6.2 Liability for Incidental and Consequential Damages. (RESERVED)

6.3 Liability for Use of Equipment.

City shall not be liable for any damage to persons or property as a result of the misuse of equipment used by Provider, or by any of their employees, even though such equipment is furnished, rented or loaned by City.

Article 7 Payment of Taxes (RESERVED FOR SFFD)

7.1 Provider Shall Collect and Remit Taxes.

Where required under applicable law, Provider shall collect and remit to City all applicable taxes in compliance with the City's Business and Tax Regulations Code. Provider shall provide such records to City as City may require to confirm its compliance with these requirements.

7.2 Possessory Interest Tax.

Provider understands that this SPA may create a possessory interest subject to property taxation and that Provider may be subject to the payment of such taxes.

Article 8 Termination and Default

8.1 Probation, Suspension, and/or Termination for Default; Remedies.

The City may terminate this SPA for material breach by Provider, including but not limited to, as detailed in the LEMSA's "Pre-Hospital Provider Standards" policy. Failure to comply with the terms of this SPA, local policies and protocols, and all applicable laws and regulations as determined by the LEMSA, may result in probation, suspension, or termination of Provider's authorization to operate in the LEMSA EMS service area. In the event that Provider defaults in the performance of any duties or obligations hereunder and the default or breach has not been cured within thirty (30) calendar days of receipt of written notice of default, such failure shall be cause for the LEMSA to effect any of the following, acting in its sole discretion: Revocation of Provider's Certificate of Operation and/or Ambulance Permit; placing Provider on probation with a LEMSA approved corrective action plan; suspension of Provider's Services under this Agreement; and/or termination of this Agreement.

8.2 Non-Waiver of Rights.

The omission by the City at any time to enforce any default or right reserved to it, or to require performance of any of the terms, covenants, or provisions hereof by Provider at the time designated, shall not be a waiver of any such default or right to which the City is entitled, nor shall it in any way affect the right of the City to enforce such provisions thereafter.

8.3 Rights and Duties upon Termination or Expiration.

This Section and the following Sections of this SPA listed below, shall survive termination or expiration of this SPA:

Article 3	Audit
Article 5	Insurance and Indemnity
Article 6	Liability of Parties
Article 7	Payment of Taxes
Article 11	General Provisions
Article 13	Data and Security

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Subject to the survival of the Sections identified above, if this SPA is terminated prior to expiration of the term specified in Article 2, this SPA shall be of no further force or effect.

Article 9 Rights In Deliverables (RESERVED)

Article 10 Additional Requirements Incorporated by Reference (RESERVED FOR SFFD)

10.1 Laws Incorporated by Reference.

Provider represents and warrants that it will comply with all applicable laws and regulations in performing the Services. Subject to the foregoing, the full text of the laws listed in this Article 10, including enforcement and penalty provisions, are incorporated by reference into this SPA. The full text of the San Francisco Municipal Code provisions incorporated by reference in this Article and elsewhere in the SPA ("Mandatory City Requirements") are available at http://www.amlegal.com/codes/client/san-francisco_ca/

10.2 Conflict of Interest.

By executing this SPA, Provider certifies that it does not know of any fact which constitutes a violation of Section 15.103 of the City's Charter; Article III, Chapter 2 of City's Campaign and Governmental Conduct Code; Title 9, Chapter 7 of the California Government Code (Section 87100 *et seq.*), or Title 1, Division 4, Chapter 1, Article 4 of the California Government Code (Section 1090 *et seq.*), and further agrees promptly to notify the City if it becomes aware of any such fact during the term of this SPA.

10.3 Consideration of Salary History.

Provider shall comply with San Francisco Administrative Code Chapter 12K, the Consideration of Salary History Ordinance or "Pay Parity Act." Provider is prohibited from considering current or past salary of an applicant in determining whether to hire the applicant or what salary to offer the applicant to the extent that such applicant is applying for employment to be performed on this SPA or in furtherance of this SPA, and whose application, in whole or part, will be solicited, received, processed or considered, whether or not through an interview, in the City or on City property. The ordinance also prohibits employers from (1) asking such applicants about their current or past salary or (2) disclosing a current or former employee's salary history without that employee's authorization unless the salary history is publicly available. Provider is subject to the enforcement and penalty provisions in Chapter 12K. Information about and the text of Chapter 12K is available on the web at https://sfgov.org/olse/consideration-salary-history. Provider is required to comply with all of the applicable provisions of 12K, irrespective of the listing of obligations in this Section.

10.4 Nondiscrimination Requirements

Provider does not as of the date of this SPA, and will not during the term of this SPA, in any of its operations in San Francisco, on real property owned by San Francisco, or where work is being performed for the City elsewhere in the United States, discriminate against an applicant for employment because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition, marital status, or citizenship, or otherwise, including in the provision of employee benefits between employees with domestic partners and employees with spouses and/or between the domestic partners and spouses of such employees, subject to the conditions set forth in San Francisco Administrative Code Section12B.2.

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10.5 **Minimum Compensation Ordinance.**

Provider shall pay covered employees no less than the minimum compensation required by San Francisco Administrative Code Chapter 12P, including a minimum hourly gross compensation, compensated time off, and uncompensated time off. Provider is subject to the enforcement and penalty provisions in Chapter 12P. Information about and the text of the Chapter 12P is available on the web at http://sfgov.org/olse/mco. Provider is required to comply with all of the applicable provisions of 12P, irrespective of the listing of obligations in this Section. By signing and executing this SPA, Provider certifies that it is in compliance with Chapter 12P.

10.6 **Health Care Accountability Ordinance.**

Provider shall comply with San Francisco Administrative Code Chapter 12Q. For each Covered Employee, Provider shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Provider chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission. Information about and the text of the Chapter 12Q, as well as the Health Commission's minimum standards, is available on the web at http://sfgov.org/olse/hcao. Provider is subject to the enforcement and penalty provisions in Chapter 12Q. Any Subcontract entered into by Provider shall require any Subcontractor with 20 or more employees to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section.

10.7 **Alcohol and Drug-Free Workplace.**

City reserves the right to deny access to, or require Provider to remove from performance of services under this SPA personnel of any Provider who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing, selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this SPA "controlled substance" includes cannabis and derivative products.

10.8 **Consideration of Criminal History in Hiring and Employment Decisions**

10.8.1 Provider agrees to comply fully with and be bound by all of the provisions of Chapter 12T, "City Provider/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions," of the San Francisco Administrative Code ("Chapter 12T"), including the remedies provided, and implementing regulations, as may be amended from time to time. The provisions of Chapter 12T are incorporated by reference and made a part of this SPA as though fully set forth herein. The text of the Chapter 12T is available on the web at http://sfgov.org/olse/fco. Provider is required to comply with all of the applicable provisions of 12T, irrespective of the listing of obligations in this Section. Capitalized terms used in this Section and not defined in this SPA shall have the meanings assigned to such terms in Chapter 12T.

10.8.2 The requirements of Chapter 12T shall only apply to a Provider's or Subcontractor's operations to the extent those operations are in furtherance of the performance of this SPA, shall apply only to applicants and employees who would be or are performing work in furtherance of this SPA, and shall apply when the physical location of the employment or prospective employment of

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an individual is wholly or substantially within the City of San Francisco. Chapter 12T shall not apply when the application in a particular context would conflict with federal or state law or with a requirement of a government agency implementing federal or state law.

10.9 Food Service Waste Reduction Requirements.

Provider shall comply with the Food Service Waste Reduction Ordinance, as set forth in San Francisco Environment Code Chapter 16, including but not limited to the remedies for noncompliance provided therein.

10.10 Distribution of Beverages and Water. (RESERVED)

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this SPA, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

To City:	Andrew Holcomb, MS, EMS Manager, San Francisco EMS Agency City and County of San Francisco 90 Van Ness Ave, San Francisco, CA 94102 415-487-5018 andrew.holcomb@sfdph.org
To Provider:	American Medical Response West 1300 Illinois Street San Francisco, CA 94107 Attention: Regional Director Law Department C/O American Medical Response, Inc. 6363 S. Fiddlers Green Circle, Suite 1500 Greenwood Village, Co 80111 legal@amr.net

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

11.2 Compliance with Americans with Disabilities Act.

Provider shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 Reserved.

11.4 Sunshine Ordinance.

Provider acknowledges that this SPA and all records related to its formation, Provider's performance of Services, and City's payment are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code

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Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.5 Modification of this SPA.

This SPA may not be modified, nor may compliance with any of its terms be waived, except as noted in Section 11.1, "Notices to Parties," except by written instrument executed by the Parties and approved in the same manner as this SPA.

11.6 Dispute Resolution Procedure.

11.6.1 The Parties will attempt in good faith to resolve any dispute or controversy arising out of or relating to the performance of services under this SPA in accordance with the LEMSA's "Pre-Hospital Provider Standards" policy.

11.6.2 During the course of any Dispute Resolution process, Provider shall comply with all directives issued by the LEMSA. In the event that the LEMSA identifies a deficiency that LEMSA acting in its sole discretion determines may cause a threat to public health and/or safety, the LEMSA may issue a written probation and/or suspension notice to the Provider. Upon receipt, the Provider shall immediately comply with the terms of that notice. If the notice calls for suspension, Provider shall immediately suspend Services under this SPA until the LEMSA verifies that Provider has implemented all required corrections. Provider's failure to implement all required corrections as determined by the LEMSA acting in its sole discretion may result in termination of this SPA for default.

11.7 Government Code Claim Requirement.

No suit for money or damages may be brought against the City until a written claim therefor has been presented to and rejected by the City in conformity with the provisions of San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq. Nothing set forth in this SPA shall operate to toll, waive or excuse Provider's compliance with the California Government Code Claim requirements set forth in San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq.

11.8 Agreement Made in California; Venue.

The formation, interpretation and performance of this SPA shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this SPA shall be in San Francisco.

11.9 Construction.

All paragraph captions are for reference only and shall not be considered in construing this SPA.

11.10 Entire Agreement.

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This SPA may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.11 Compliance with Laws.

Provider shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Provider's

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performance of this SPA, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.12 **Severability.**

Should the application of any provision of this SPA to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this SPA shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.13 **Order of Precedence.**

Provider agrees to perform the services described below in accordance with the terms and conditions of this SPA, and the Statement of Work attached as Appendix A. The terms of this SPA are to be read and interpreted together with all other documents, appendices, exhibits, and addenda attached to the SPA as a single agreement.

11.14 **Notification of Legal Requests.**

Provider shall immediately notify City upon receipt of any subpoenas, service of process, litigation holds, discovery requests and other legal requests ("Legal Requests") related to this SPA, and in no event later than 24 hours after it receives the request.

Article 12 Department Specific Terms

12.1 **Third Party Beneficiaries.**

No third parties are intended by the parties hereto to be third party beneficiaries under this SPA, and no action to enforce the terms of this SPA may be brought against either party by any person who is not a party hereto.

12.2 **Exclusion Lists and Employee Verification.**

Upon execution of this SPA and monthly thereafter, Provider will check the exclusion lists published by the Office of the Inspector General (OIG), General Services Administration (GSA), and the California Department of Health Care Services (DHCS) to ensure that any employee, temporary employee, volunteer, consultant, or governing body member responsible for oversight, administering or delivering state or federally-funded services who is on any of these lists is excluded from (may not work in) Provider's program or agency. Proof of checking these lists must be retained for seven years.

Article 13 Data and Security

13.1 **Nondisclosure of Private, Proprietary or Confidential Information.**

13.1.1 If this SPA requires City to disclose "Private Information" to Provider within the meaning of San Francisco Administrative Code Chapter 12M, Provider and subcontractor shall use such information only in accordance with the restrictions stated in Chapter 12M and in this SPA and only as necessary in performing the Services. Provider is subject to the enforcement and penalty provisions in Chapter 12M.

13.1.2 In the performance of Services, Provider may have access to City's proprietary or confidential information, the disclosure of which to third parties may damage City. If City discloses

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proprietary or confidential information to Provider, such information must be held by Provider in confidence and used only in performing the SPA, except as required by law, professional rule or regulation. Provider shall exercise the same standard of care to protect such information as a reasonably prudent Provider would use to protect its own proprietary or confidential information.

13.2 **Business Associate Agreement.**

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Provider will:

1. ☒ Do **at least one** or more of the following:
A. Create, receive, maintain, or transmit PHI for or on behalf of CITY/SFDPH (including storage of PHI, digital or hard copy, even if Provider does not view the PHI or only does so on a random or infrequent basis); or

B. Receive PHI, or access to PHI, from CITY/SFDPH or another Business Associate of City, as part of providing a service to or for CITY/SFDPH, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or

C. Transmit PHI data for CITY/SFDPH and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

FOR PURPOSES OF THIS SPA, PROVIDER IS A BUSINESS ASSOCIATE OF CITY/SFDPH, AS DEFINED UNDER HIPAA. PROVIDER MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS SPA AS THOUGH FULLY SET FORTH HEREIN:

a. **Appendix E** SFDPH Business Associate Agreement (BAA) (04-12-2018)
   1. SFDPH Attestation 1 PRIVACY (06-07-2017)
   2. SFDPH Attestation 2 DATA SECURITY (06-07-2017)

2. ☐ **<u>NOT</u> do any of the activities listed above in subsection 1;**
Provider is not a Business Associate of CITY/SFDPH. Appendix E and attestations are not required for the purposes of this SPA.
<u>This option requires review and approval from the Office of Compliance and Privacy Affairs.</u>

13.3 **Protected Health Information.**

Provider and all agents and employees Provider shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Provider by City in the performance of this SPA. Provider agrees that any failure of Contactor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of

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action, based on an impermissible use or disclosure of protected health information given to Provider or its subcontractors or agents by City, Provider shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 14 Data and Security

14.1 City Data

14.1.1 **Ownership of City Data.** The Parties agree that as between them, all rights, including all intellectual property rights, in and to the City Data and any derivative works of the City Data shall remain the exclusive property of the City.

14.1.2 **Use of City Data**. Nothing herein shall be construed to confer any license or right to the City Data, including user tracking and exception City Data within the system, by implication, estoppel or otherwise, under copyright or other intellectual property rights, to any third-party. Unauthorized use of City Data by Provider.

14.1.3 **Data Breach; Loss of City Data**. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Provider that relate to the protection of the security, confidentiality, or integrity of City Data, Provider shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

14.1.4 **Data Privacy and Information Security Program.** Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

14.1.5 **Data Transmission.** Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure that all data exchanged shall be used expressly and solely for the purposes stated in the SPA. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this SPA, unless otherwise permitted in this SPA. The Provider shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

Article 15 MacBride And Signature

15.1 MacBride Principles -Northern Ireland.

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this SPA. By signing this SPA, Provider confirms that Provider has read and understood that

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the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

IN WITNESS WHEREOF, the parties hereto have executed this SPA on the day first mentioned above.

City

San Francisco Department of Public Health

DocuSigned by:
Greg Wagner
28527524752940F...
7/13/2020 | 12:00:08 PDT

Grant Colfax, MD
Director of Health

Provider

American Medical Response West

DocuSigned by:
Thomas Wagner
3781CF687C684A8...
7/1/2020 | 12:10:37 PDT

Thomas R. Wagner, West Group President

Approved as to Form:

Dennis J. Herrera
City Attorney

By: DocuSigned by:
Louise Simpson
BD54168A4C3B452...
7/7/2020 | 12:18:12 PDT

Louise S. Simpson
Deputy City Attorney

Appendices

A: Statement of Work
B: Business Associate Agreement

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Appendix A

STATEMENT OF WORK

I. GENERAL REQUIREMENTS FOR APPROVED SERVICE PROVIDER:

Approved service Providers authorized to participate in the LEMSA EMS system shall perform as follows:

(1) (911 Providers, only) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA.

(2) Utilize and maintain telecommunications as specified by the LEMSA.

(3) Maintain medication solution, medical supplies, and equipment inventory as specified by the LEMSA commensurate with the basic and local optional scope of practice of the paramedic and EMT.

(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

1. controlled substance ordering and order tracking;

2. controlled substance receipt and accountability;

3. controlled substance master supply storage, security and documentation;

4. controlled substance labeling and tracking;

5. vehicle storage and security;

6. usage procedures and documentation;

7. reverse distribution;

8. disposal;

9. re-stocking procedures.

(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to;

10. controlled substance testing;

11. discrepancy reporting;

12. tampering, theft and diversion prevention and detection;

13. usage audits.

(5) Be responsible for assessing and ensuring current knowledge of their paramedics and EMTs in local policies, procedures and protocols and for assessing their EMT and/or paramedics' skills competency. Documentation of assessment results shall be made available to the LEMSA.

(6) If, through the EMSQIP the LEMSA Medical Director determines that an EMT and/or paramedic needs additional training, observation or testing, the LEMSA Medical Director may create a specific and targeted program of remediation based upon the identified needs of the EMT and/or paramedic. If there is disagreement between the Provider and the LEMSA Medical Director, the decision of the LEMSA Medical Director shall prevail.

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Provider understands and agrees that the LEMSA may deny, suspend, or revoke the approval of a service Provider for failure to comply with applicable policies, procedures, and regulations.

(7) Provider shall employ a Provider Medical Director who must be approved, in writing, by the LEMSA Medical Director.

II. BENEFITS GRANTED BY LEMSA TO PROVIDER

1. Boundaries:

Provider may provide ALS and/or BLS Ground Ambulance Services based upon a Certification of Operation, within the defined boundaries of the City and County of San Francisco (LEMSA EMS service area), to include Treasure Island, the Golden Gate National Recreational Area, and other Federal property within the contiguous borders of the LEMSA EMS service area, notwithstanding entry restrictions placed by Federal jurisdiction, during the period of this SPA. The ALS and/or BLS Ground Ambulance Services shall include Site to Facility patient transports, as well as Facility to Facility transports, originating from a private request and responses to 9-1-1 calls.

2. Availability of 9-1-1 Ambulances:

a) All 9-1-1 Providers shall ensure a minimum of two ambulances available to the 9-1-1 system twenty-four (24) hours per day, 365 days per year plus ambulance transport may include no more than 5 transports per month to cover unfilled service calls for patients being cared for within the DPH system.

b) Within 90 days after execution of the SPA, and t least annually thereafter, the LEMSA will notify Providers of the minimum overall number of staffed ambulances needed to meet the EMS system demand ("System Demand Analysis")

c) Within 90 days after execution of this SPA, and annually within 90 days of receipt of the System Demand Analysis, each 9-1-1 Provider shall provide their minimum Ambulance Deployment and Staffing Plan to the LEMSA, which shall be binding until receipt of the City's next System Demand Analysis.

d) Immediately upon the commencement of Services under this SPA, each Provider shall provide the LEMSA its daily staffing report.

3. City Facilities (Zuckerberg San Francisco General and Laguna Honda Hospital)

The LEMSA urges all Providers to respond to all Requests for Proposals issued by the San Francisco Department of Public Health for as-needed non-emergency services for Zuckerberg San Francisco General Hospital, Laguna Honda Hospital, the San Francisco Department of Public Health clinics, and other contracted Facilities, as well as urging City Providers to perform inter-Facility transports.

4. SPA Committees:

All Providers shall participate (attend a minimum of 75% of Committee meetings annually, as determined by the LEMSA acting in its sole discretion) in the following SPA Committees which shall be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

a) Emergency Medical Services Advisory Committee

b) Medical Director's Committee

c) Operations Committee

d) Quality Improvement Committee

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e) Trauma Committee

f) STAR Committee

g) Stroke Committee

h) Other Committees determined by the LEMSA

Ambulance Provider membership is listed in LEMSA Policy 1010.

5. Report of ALS Provider Status:

Upon request from any entity, including insurance companies, fiscal intermediaries, and other third party payers, LEMSA will identify currently authorized ALS Providers as an authorized Provider of ALS service, pursuant to California Code of Regulations, Title 22, Section, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

6. Coordination of EMS Mutual Aid Requests:

a) Outgoing 9-1-1 EMS Mutual Aid will be coordinated by the Medical Health Operational Area Coordinator (MHOAC) and will be planned in consultation with the LEMSA to minimize impact on the SF EMS System.

b) Incoming 9-1-1 EMS Mutual Aid assets will be requested by LEMSA through the MHOAC for state and regional resources. These EMS assets will be assigned to appropriate task forces, strike teams, or other assignments as determined necessary by the LEMSA in compliance with the emergency management practices outlined in LEMSA Policies and Protocols.

c) Intra-county mutual aid shall be authorized and requested by the LEMSA when the 9-1-1/PSAP generated demand exceeds, or is anticipated to exceed, the capacity of the 9-1-1/PSAP authorized ALS Providers, as determined by the LEMSA.

7. Non-Transport Treatment Fee:

The San Francisco Fire Department is authorized by local ordinance to charge a fee for on-scene treatment without a transport to a hospital. King-American Ambulance Company and American Medical Response West are authorized to charge a non-transport fee in an amount sufficient to cover the reasonable cost of this service and is agreed upon by the LEMSA.

III. OBLIGATIONS OF PROVIDER

1. Mutual Aid:

LEMSA may request mutual aid EMS resources during situations requiring additional EMS resources. Provider may provide resources, at the request of the LEMSA, in such numbers and durations as determined to be in the interest of the LEMSA**.**

2. Automatic Aid Provision:

With approval of the LEMSA, Providers may dispatch up to five ambulances and one paramedic supervisor (known as an Ambulance Strike Team), to a request for immediate aid from any geopolitical entity in California, upon approval of the appropriate manager from that Provider. The Provider shall notify the LEMSA once they have deployed single assets or an Ambulance Strike Team so that system adjustments may be made, if necessary.

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3. Performance Standards

a) Provider shall adhere to all requirements of state laws and regulations pertaining to the provision of EMS.

b) Provider shall adhere to City laws as set forth in San Francisco Health Code Articles 3 and 14, including any and all amendments thereto, if any, whether enacted before or during the term of this SPA and any extensions.

c) Provider shall adhere to all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d) Provider shall use the SEMS and the NIMS in the performance of all emergency services rendered under this SPA.

4. Document Review and Retention

a) All records maintained pursuant to this SPA, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227) shall be available for inspections, audit, or examination by LEMSA or by their designated representatives, consistent with federal, state and local confidentiality and privacy laws, and shall be preserved by Provider for at least three (3) years from the termination of this SPA.

b) All patient contacts, treatments, and interactions shall be documented by Provider, and, if a patient is transported to a Facility, sent with the patient to the Facility.

c) Upon execution of this SPA, Providers shall provide LEMSA and/or LEMSA's third-party designee an unfiltered and unaltered data stream and full access to each patient's Medical Record and Computer Aided Dispatch ("CAD") (California Health & Safety Code Section 1797.227). Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the LEMSA. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider.

d) Upon LEMSA request, Provider shall prepare and submit written reports on incidents based on Services provided under this SPA.

e) Provider shall submit monthly operation reports to the LEMSA, by the last day of the following month, in a form prescribed by the LEMSA.

f) Provider shall provide additional information and reports as requested by the LEMSA to monitor Provider performance, including but not limited to reports regarding response intervals, staffing, skilled intervention and/or performance reports, core measures reports/data, policy compliance reports, case reviews, continuing education, and/or others as required by the LEMSA acting in its sole discretion..

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5. Disaster Preparedness

a) Provider shall annually participate in a least one system-wide discussion based exercise and one system-wide functional exercise per calendar year to benefit coordination among Providers, the EMS system, and LEMSA, as determined by the LEMSA Medical Director.

b) Provider shall ensure staff, with appropriate authority to act on the behalf of Provider, are present in the City's Emergency Operations Center (EOC) when requested by LEMSA during activations or exercises involving Provider.

6. Incident Reporting

Provider shall file or caused to be filed, an Incident Report form consistent with LEMSA Policy in each instance as required by the LEMSA within timeframe reporting requirements as set forth in LEMSA policies.

7. Inspection Standards

Parties acknowledge and agree that inspection standards are governed by San Francisco Health Code Article 14, or any successor provisions.

8. Field Personnel Communication Standards

a) Provider shall post LEMSA notices and bulletins at all employee locations.

b) Provider shall require, through written policy, all personnel to have knowledge of, and follow, LEMSA Policies, Procedures and Protocols, and Directives.

c) Provider shall:

i. Ensure and assess that all EMT's and EMT-P's are trained in LEMSA policies, procedures, and protocols. Such training shall include cognitive, motor and retention skills that allow employees to properly perform EMS duties; and

ii. Provide at each Provider location, in a location easily accessible to employees, a current LEMSA Policy and Procedure Manual and Protocol Manual.

iii. Submit compliance reports quarterly to the LEMSA.

9. Fatigue Prevention

a) Provider shall develop and implement policies acceptable to LEMSA to minimize fatigue by EMT-Ps and EMTs.

b) Provider shall comply with California Code of Regulations Title 13, Section 1105 (e), which states: Driver Conditions: No person shall drive or be directed to drive an ambulance, when his/her ability to operate the ambulance safely is adversely affected by fatigue, illness or other cause nor when the vehicle is unsafe to operate.

c) Provider has informed, and agrees to continue to inform, employees of the regulation and will not retaliate against those complaining of fatigue, illness, or other cause that may affect that employee's ability to operate an ambulance safely.

10. Protected Patient Information

Provider shall comply with all federal and state patient privacy laws, and shall have and enforce a policy that prohibits Provider's employees from inappropriate sharing of protected patient

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information to include sharing via personal communication devices, social media, and any other form of data transmission.

11. Prohibition on Alcohol and Drug Use

Provider shall have and enforce a policy that prohibits Provider's employees from performing any ALS or BLS service under the influence of any alcoholic beverage, illegal drug, or narcotic. In addition, said policy shall prohibit Provider's employees from performing such services under the influence of any other substances, including prescription or non-prescription medication, which impairs their physical or mental performance.

12. Reporting of EMT and EMT-Paramedic Violations

Provider shall comply fully and timely with the reporting requirements of California Health and Safety Code Section, Division 2.5, Sections 1798.200, 1799.112, and LEMSA policies and protocols. Provider shall notify the LEMSA Medical Director within 24 hours when an allegation has been validated as a potential violation of 1798.200. Supporting documentation shall be provided within 72 hours. Notification shall be made to the LEMSA within 24 hours if an EMT and/or EMT-P is removed from patient care or resigns for an investigation based on evidence for disciplinary cause or reason.

16. LEMSA Emergency Medical Services Quality Improvement Program

Provider must participate in the LEMSA's EMSQIP as required by California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

17. Infection Control, Health and Safety:

a) Provider must have a Bloodborne Pathogen (BBP) Exposure Control plan for its employees, agents and subcontractors as defined in the California Code of Regulations, Title 8, Section 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and recordkeeping.

b) Provider must demonstrate personnel policies/procedures for protection of its employees, agents, subcontractors and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

c) Provider must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

d) Provider is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

e) Provider shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

f) Provider shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

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g) Provider assumes responsibility for procuring all medical equipment and supplies for use by its employees, agents and subcontractors, including safe needle devices, and provides and documents all appropriate training.

h) Provider shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

18. Aerosol Transmissible Disease Program, Health and Safety:

Provider must have an Aerosol Transmissible Disease (ATD) Program as defined in the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases (http://www.dir.ca.gov/Title8/5199.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, screening procedures, source control measures, use of personal protective equipment, referral procedures, training, immunization, post-exposure medical evaluations/follow-up, and recordkeeping.

19. Regional Training

Provider shall designate a minimum of one dedicated part-time staff member, hours based on need, to participate in LEMSA's regional training program to develop, teach, and implement consistent and quality prehospital education based upon LEMSA strategic objectives and quality improvement initiatives.

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APPENDIX B

San Francisco Department of Public Health

Business Associate Agreement

As applicable, this Business Associate Agreement ("BAA") supplements and is made a part of the contract by and between the City and County of San Francisco, the Covered Entity ("CE"), and Contractor, the Business Associate ("BA") (the "Agreement"). To the extent that the terms of the Agreement are inconsistent with the terms of this BAA, the terms of this BAA shall control.

RECITALS

A. CE, by and through the San Francisco Department of Public Health ("SFDPH"), wishes to disclose certain information to BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI") (defined below).

B. For purposes of the Agreement, CE requires Contractor, even if Contractor is also a covered entity under HIPAA, to comply with the terms and conditions of this BAA as a BA of CE.

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws, including, but not limited to, California Civil Code §§ 56, et seq., California Health and Safety Code § 1280.15, California Civil Code §§ 1798, et seq., California Welfare & Institutions Code §§5328, et seq., and the regulations promulgated there under (the "California Regulations").

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this BAA.

E. BA enters into agreements with CE that require the CE to disclose certain identifiable health information to BA. The parties desire to enter into this BAA to permit BA to have access to such information and comply with the BA requirements of HIPAA, the HITECH Act, and the corresponding Regulations.

In consideration of the mutual promises below and the exchange of information pursuant to this BAA, the parties agree as follows:

1. Definitions.

a. Breach means the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information, and shall have the meaning given to such term under the HITECH Act and HIPAA Regulations [42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402], as well as California Civil Code Sections 1798.29 and 1798.82.

b. Breach Notification Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.

c. Business Associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information received from a covered entity, but other than in the capacity of a member of the workforce of such covered entity or arrangement, and shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

d. Covered Entity means a health plan, a health care clearinghouse, or a health care provider who transmits any information in electronic form in connection with a transaction covered under HIPAA Regulations, and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

e. Data Aggregation means the combining of Protected Information by the BA with the Protected Information received by the BA in its capacity as a BA of another CE, to permit data analyses that relate to the health care operations of the respective covered entities, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. Designated Record Set means a group of records maintained by or for a CE, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. Electronic Protected Health Information means Protected Health Information that is maintained in or transmitted by electronic media and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103. For the purposes of this BAA, Electronic PHI includes all computerized data, as defined in California Civil Code Sections 1798.29 and 1798.82.

h. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

i. Health Care Operations shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

j. Privacy Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. Protected Health Information or PHI means any information, including electronic PHI, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Sections 160.103 and 164.501. For the purposes of this BAA, PHI includes all medical information and health insurance information as defined in California Civil Code Sections 56.05 and 1798.82.

l. Protected Information shall mean PHI provided by CE to BA or created, maintained, received or transmitted by BA on CE's behalf.

m. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. Security Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. Unsecured PHI means PHI that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute, and shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. Obligations of Business Associate.

a. Attestations. Except when CE's data privacy officer exempts BA in writing, the BA shall complete the following forms, attached and incorporated by reference as though fully set forth herein, SFDPH Attestations for Privacy (Attachment 1) and Data Security (Attachment 2) within sixty (60) calendar days from the execution of the Agreement. If CE makes substantial changes to any of these forms during the term of the Agreement, the BA will be required to complete CE's updated forms within sixty (60) calendar days from the date that CE provides BA with written notice of such changes. BA shall retain such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

b. User Training. The BA shall provide, and shall ensure that BA subcontractors, provide, training on PHI privacy and security, including HIPAA and HITECH and its regulations, to each employee or agent that will access, use or disclose Protected Information, upon hire and/or prior to accessing, using or disclosing Protected Information for the first time, and at least annually thereafter during the term of the Agreement. BA shall maintain, and shall ensure that BA subcontractors maintain, records indicating the name of each employee or agent and date on which the PHI privacy and security trainings were completed. BA shall retain, and ensure that BA subcontractors retain, such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

c. Permitted Uses. BA may use, access, and/or disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. Further, BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE [45 C.F.R. Sections 164.502, 164.504(e)(2). and 164.504(e)(4)(i)].

d. Permitted Disclosures. BA shall disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. BA shall not disclose Protected Information in any manner that would constitute a violation of the

Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2 (n) of this BAA, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)]. BA may disclose PHI to a BA that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit Protected Information on its behalf, if the BA obtains satisfactory assurances, in accordance with 45 C.F.R. Section 164.504(e)(1), that the subcontractor will appropriately safeguard the information [45 C.F.R. Section 164.502(e)(1)(ii)].

e. Prohibited Uses and Disclosures. BA shall not use or disclose Protected Information other than as permitted or required by the Agreement and BAA, or as required by law. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the Protected Information solely relates [42 U.S.C. Section 17935(a) and 45 C.F.R. Section 164.522(a)(1)(vi)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2), and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

f. Appropriate Safeguards. BA shall take the appropriate security measures to protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the CE, and shall prevent any use or disclosure of PHI other than as permitted by the Agreement or this BAA, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.306, 164.308, 164.310, 164.312, 164.314 164.316, and 164.504(e)(2)(ii)(B). BA shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316, and 42 U.S.C. Section 17931. BA is responsible for any civil penalties assessed due to an audit or investigation of BA, in accordance with 42 U.S.C. Section 17934(c).

g. Business Associate's Subcontractors and Agents. BA shall ensure that any agents and subcontractors that create, receive, maintain or transmit Protected Information on behalf of BA, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph 2.f. above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2) through (e)(5); 45 C.F.R. Section 164.308(b)]. BA shall mitigate the effects of any such violation.

h. Accounting of Disclosures. Within ten (10) calendar days of a request by CE for an accounting of disclosures of Protected Information or upon any disclosure of Protected Information for which CE is required to account to an individual, BA and its agents and subcontractors shall make available to CE the information required to

provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935 (c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents and subcontractors for at least seven (7) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an Electronic Health Record. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure [45 C.F.R. 164.528(b)(2)]. If an individual or an individual's representative submits a request for an accounting directly to BA or its agents or subcontractors, BA shall forward the request to CE in writing within five (5) calendar days.

i. Access to Protected Information. BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within (5) days of request by CE to enable CE to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. 164.524.

j. Amendment of Protected Information. Within ten (10) days of a request by CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA and its agents and subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment or other documentation to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R Section 164.526. If an individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request and of any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

k. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)]. BA shall provide CE a copy of any Protected Information and other documents and records that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

l. Minimum Necessary. BA, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the intended purpose of such use, disclosure, or request. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to

what constitutes "minimum necessary" to accomplish the intended purpose in accordance with HIPAA and HIPAA Regulations.

m. Data Ownership. BA acknowledges that BA has no ownership rights with respect to the Protected Information.

n. Notification of Breach. BA shall notify CE within 5 calendar days of any breach of Protected Information; any use or disclosure of Protected Information not permitted by the BAA; any Security Incident (except as otherwise provided below) related to Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by BA or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the BA to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. BA shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 42 U.S.C. Section 17932; 45 C.F.R. 164.410; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)]

o. Breach Pattern or Practice by Business Associate's Subcontractors and Agents. Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(iii), if the BA knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the contractual arrangement with its subcontractor or agent, if feasible. BA shall provide written notice to CE of any pattern of activity or practice of a subcontractor or agent that BA believes constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA within five (5) calendar days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

3. Termination.

a. Material Breach. A breach by BA of any provision of this BAA, as determined by CE, shall constitute a material breach of the Agreement and this BAA and shall provide grounds for immediate termination of the Agreement and this BAA, any provision in the AGREEMENT to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii).]

b. Judicial or Administrative Proceedings. CE may terminate the Agreement and this BAA, effective immediately, if (i) BA is named as defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. Effect of Termination. Upon termination of the Agreement and this BAA for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of Section 2 of this BAA to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

d. Civil and Criminal Penalties. BA understands and agrees that it is subject to civil or criminal penalties applicable to BA for unauthorized use, access or disclosure or Protected Information in accordance with the HIPAA Regulations and the HITECH Act including, but not limited to, 42 U.S.C. 17934 (c).

e. Disclaimer. CE makes no warranty or representation that compliance by BA with this BAA, HIPAA, the HITECH Act, or the HIPAA Regulations or corresponding California law provisions will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

4. Amendment to Comply with Law.

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the updated standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable state or federal laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

5. Reimbursement for Fines or Penalties.

In the event that CE pays a fine to a state or federal regulatory agency, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible access, use or disclosure of PHI by BA or its subcontractors or agents, then BA shall reimburse CE in the amount of such fine or penalties or damages within thirty (30) calendar days from City's written notice to BA of such fines, penalties or damages.

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APPENDIX B

San Francisco Department of Public Health

Business Associate Agreement

Attachment 1 – SFDPH Privacy Attestation, version 06-07-2017
Attachment 2 – SFDPH Data Security Attestation, version 06-07-2017

Office of Compliance and Privacy Affairs
San Francisco Department of Public Health
101 Grove Street, Room 330, San Francisco, CA 94102
Email: compliance.privacy@sfdph.org
Hotline (Toll-Free): 1-855-729-6040

DocuSign Envelope ID: 24712CFC-DF57-40CF-B272-21598A3207CA

Contractor Name:		Contractor City Vendor ID	

PRIVACY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions below in Section IV on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…	Yes	No*
A	Have formal Privacy Policies that comply with the Health Insurance Portability and Accountability Act (HIPAA)?		
B	Have a Privacy Officer or other individual designated as the person in charge of investigating privacy breaches or related incidents?		
	If yes: Name & Title:		
	Phone #:		
	Email:		
C	Require health information Privacy Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH privacy training materials are available for use; contact OCPA at 1-855-729-6040.]		
D	Have proof that employees have signed a form upon hire and annually thereafter, with their name and the date, acknowledging that they have received health information privacy training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]		
E	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?		
F	Assure that staff who create, or transfer health information (via laptop, USB/thumb-drive, handheld), have prior supervisorial authorization to do so **AND** that health information is **only transferred or created on encrypted devices approved by SFDPH Information Security staff**?		

II. Contractors who serve patients/clients and have access to SFDPH PHI, must also complete this section.

	If Applicable: DOES YOUR ORGANIZATION…	Yes	No*
G	Have (or will have if/when applicable) evidence that SFDPH Service Desk (628-206-SERV) was notified to de-provision employees who have access to SFDPH health information record systems within 2 business days for regular terminations and within 24 hours for terminations due to cause?		
H	Have evidence in each patient's / client's chart or electronic file that a Privacy Notice that meets HIPAA regulations was provided in the patient's / client's preferred language? (English, Cantonese, Vietnamese, Tagalog, Spanish, Russian forms may be required and are available from SFDPH.)		
I	Visibly post the Summary of the Notice of Privacy Practices in all six languages in common patient areas of your treatment facility?		
J	Document each disclosure of a patient's/client's health information for purposes other than treatment, payment, or operations?		
K	When required by law, have proof that signed authorization for disclosure forms (that meet the requirements of the HIPAA Privacy Rule) are obtained PRIOR to releasing a patient's/client's health information?		

III. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Privacy Officer or designated person	Name: (print)		Signature		Date	

IV. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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Contractor Name:		Contractor City Vendor ID	

DATA SECURITY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions in Section III below on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…							**Yes**	**No***
A	Conduct assessments/audits of your data security safeguards to demonstrate and document compliance with your security policies and the requirements of HIPAA/HITECH at least every two years? [Retain documentation for a period of 7 years]								
B	Use findings from the assessments/audits to identify and mitigate known risks into documented remediation plans?								
	Date of last Data Security Risk Assessment/Audit:								
	Name of firm or person(s) who performed the Assessment/Audit and/or authored the final report:								
C	Have a formal Data Security Awareness Program?								
D	Have formal Data Security Policies and Procedures to detect, contain, and correct security violations that comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)?								
E	Have a Data Security Officer or other individual designated as the person in charge of ensuring the security of confidential information?								
	If yes:	Name & Title:		Phone #		Email:			
F	Require Data Security Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH data security training materials are available for use; contact OCPA at 1-855-729-6040.]								
G	Have proof that employees have signed a form upon hire and annually, or regularly, thereafter, with their name and the date, acknowledging that they have received data security training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]								
H	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?								
I	Have (or will have if/when applicable) a diagram of how SFDPH data flows between your organization and subcontractors or vendors (including named users, access methods, on-premise data hosts, processing systems, etc.)?								

II. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Data Security Officer or designated person	Name: (print)		Signature		Date	

III. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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City and County of San Francisco
San Francisco Department of Public Health
Emergency Medical Services Division
90 Van Ness Avenue
San Francisco, California 94102

Agreement between the City and County of San Francisco, acting by and through its Department of Public Health and Allied Medical Services of California D.B.A. King-American Ambulance Company

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This emergency Service Provider Agreement ("SPA") is made this 1st day of July, 2020 in the City and County of San Francisco, State of California, by and between Allied Medical Services of California D.B.A. King-American Ambulance Company ("Provider") and the City and County of San Francisco, acting by and through its Depaartment of Public Health.

Recitals

WHEREAS, the San Francisco Department of Public Health is the designated local Emergency Medical Services Agency ("LEMSA") for the City and County of San Francisco, under California Health and Safety Code Section 1797.200; and

WHEREAS, Provider possesses all requisite LEMSA approvals to participate in the LEMSA Emergency Medical Services ("EMS") system, including a current and valid Certificate of Operation and when necessary an Ambulance Permit, in accordance with San Francisco Health Code Article 14; and

WHEREAS, the San Francisco Emergency Medical Services Plan authorizes Provider to provide Advanced Life Support ("ALS"), Basic Life Support ("BLS"), and/or Special Ambulance Services within the LEMSA EMS service area; and

WHEREAS, California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168(b)(4), requires that authorized paramedic service Providers have a written service provider agreement ("SPA") with the LEMSA allowing the Provider to participate in the LEMSA EMS system and obligating the Provider to comply with all State regulations and local policies and procedures, including participation in the LEMSA's Emergency Medical Services Quality Improvement Program ("EMSQIP"); and

WHEREAS, the Parties wish to enter into this written SPA in compliance with Section 100168(b)(4), when required, or otherwise as required by the LEMSAs;

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this SPA:

1.1. **"Advanced Life Support (ALS)**" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency department or other medical staff of that hospital, as defined by California Health and Safety Code, Division 2.5, Section 1797.52, including the scope of practice of Paramedic as listed in Section 1797.52 and any LEMSA approved Local Optional Scope of Practice.

1.2. **"ALS Ground Ambulance Services"** means the provision of advanced life support services provided in an ambulance by an authorized ALS Provider pursuant to a Service Provider Agreement (SPA) consistent with the California Health and Safety Code, Division 2.5, Section 1797.52 and LEMSA policies and procedures.

1.3. **"Ambulance Permit"** means a permit issued by LEMSA's Medical Director for an ambulance or routine medical transport vehicle pursuant to the San Francisco Health Code, Article 14. This permit is required to operate an ambulance or routine medical transport vehicle within the City and County of San Francisco.

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1.4. **"Authorized ALS Ambulance Provider"** means an ambulance Provider that is authorized to provide ALS ambulance services within the City pursuant to a Service Provider Agreement with the LEMSA.

1.5. **"Basic Life Support (BLS)"** means emergency first aid and cardiopulmonary resuscitation procedures, which at a minimum, include: recognizing respiratory arrest and application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim can be transported or until advanced life support is available, as defined by California Health and Safety Code, Division 2.5, Section 1797.60, including the basic scope of practice as listed in Section 1797.60 and any LEMSA approved Local Optional Scope of Practice.

1.6. **"Authorized BLS Ambulance Provider"** means an ambulance Provider that is authorized, staffed and equipped to provide basic life support in full compliance with the California Health and Safety Code, Division 2.5, Section 1797.60, all regulations of the State of California, the City Ambulance Ordinance, and LEMSA Policies, Procedures and Protocols.

1.7. **"Certificate of Operation"** means a Certificate issued under San Francisco Health Code Article 14 by the LEMSA Medical Director to a Provider who qualifies to operate an ambulance in the City. To qualify for a Certificate of Operation, the Provider must hold three valid and current Ambulance Permits.

1.8. **"Confidential Information"** means confidential City information including, but not limited to, personally-identifiable information ("PII"), protected health information ("PHI'), or individual financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.9. **"Emergency Medical Personnel"** means all public safety first responders, Emergency Medical Dispatchers, EMTs and EMT-Ps functioning within the emergency medical services system.

1.10. **"Emergency Medical Services Quality Improvement Program (EMSQIP)"** means the continuing quality improvement program, procedures and protocol documents developed by the LEMSA.

1.11. **"Emergency Medical Technician (EMT)"** means an individual trained in all facets of basic life support according to standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.80, and who has a valid certification issued pursuant to said division and local training as required by LEMSA.

1.12. **"Emergency Medical Technician – Paramedic (EMT-P)"** means an individual whose scope of practice is to provide advanced life support governed by standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.84, and who has a valid license issued pursuant to said division and local accreditation as required by LEMSA.

1.13. **"Facility"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is physically present and assessed the patient's need for LEMSA.

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1.14. **"Ground Ambulance Services"** means all ambulance services performed at the request of and determined to be either a Code Two or Code Three level response by an Authorized LEMSA Dispatch Center.

1.15. **"LEMSA Medical Director"** means the San Francisco Director of Health, responsible for the duties set forth in California Health and Safety Code, Division 2.5, Section 1797.202.

1.16. **"Medical Emergency"** means the term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by public safety personnel or Emergency Medical Personnel at the scene of an emergency or dispatch personnel at a designated LEMSA Dispatch Center.

1.17. "**Medical Record**" means all patient care interaction and assessment data collected and/or generated by Provider and included in Provider's electronic medical record system, including but not limited to a record of a patient's medical information (such as medical history, care or treatments received, test results, diagnoses, and medications taken).

1.18. **"National Incident Management System (NIMS)"** means the incident management system developed by the US Department of Homeland Security, FEMA, as required by Homeland Security Presidential Directive 5 (HSPD-5).

1.19. **"Primary Public Safety Answering Point (PSAP)"** means the location where the 911 call is first answered.

1.20. **"Provider Program Director"** means the Medical Director of the Provider.

1.21. **"Response Codes"** means the dispatch term which denotes the level of priority for units responding to the scene as defined herein:

a) **Code One** - Routine or schedule transportation of patients.
b) **Code Two** - A non-life threatening Medical Emergency requiring immediate response.
c) **Code Three** - A Medical Emergency requiring immediate response with red light and siren.

1.22. **"Services"** means the provision of any and all services under this SPA.

1.23. **"Site"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is NOT physically present and has NOT assessed the patient's need for LEMSA.

1.24. **"Special Ambulance Service"** means any unit-type, providing Emergency Medical Services and patient care that can be dispatched to a medical call without the ability to provide patient transport.

1.25. **"Standardized Emergency Management System (SEMS)**" means the standardized emergency management system identified in California Government Code, Section 8607.

Article 2 Term of the Agreement

2.1 **Initial Term.**

The term of this SPA shall commence on July 1, 2020 and expire five years later on June 30, 2025, unless earlier terminated as otherwise provided herein.

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2.2 **Renewal of SPA.**

This SPA shall auto-renew for four additional one-year periods upon Provider's payment of all required Certificate of Operation and/or Ambulance Permit fees and conditioned on Provider's compliance with all Certificate of Operation and Ambulance Permit requirements. The renewed SPA shall automatically terminate should Provider fail to pay all required Certificate of Operation and/or Ambulance Permit fees.

Article 3 Audit

3.1 **Audit and Inspection of Records.**

Provider agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate books and records, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227). Provider will permit City to audit, examine and make excerpts and transcripts from such books and records related to all matters covered by this SPA. Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the local EMS agency. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider. To the extent required by applicable law or regulation, the State of California or any Federal agency having an interest in the subject matter of this SPA shall have the same rights as conferred upon City by this Section.

Article 4 Services and Resources

4.1 **Provider Shall Obtain All Necessary Permits and/or Approvals.**

4.1.1 Provider shall not commence the provision of any services under this SPA until all necessary permits and/or approvals have been issued. Specifically, before commencing work, Provider shall apply for and obtain from LEMSA a Certificate of Operation and when required an Ambulance Permit, and/or all other required regulatory permits and/or approvals in accordance with applicable law, including California Code of Regulations Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic); California Health and Safety Code, Division 2.5 (Emergency Medical Services); and San Francisco Health Code, Article 14 (Ambulances and Routine Medical Transport Vehicles). Nothing in this SPA is intended to imply that City will issue any permits and/or approvals.

4.1.2 Provider shall pay all fees required as a condition precedent to the issuance of any such permits and/or approvals in accordance with the applicable rates and charges then in effect as indicated in LEMSA's fee schedule. The payments made by Provider to City shall be less than or equal to the City's actual costs to provide the LEMSA administration and oversight services. No funds shall be used by the City in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute. .

4.2 **Services Provider Agrees to Perform.**

Provider agrees to perform the services detailed in Appendix A, "Statement of Work." Officers and employees of the City are not authorized to request services beyond the scope listed in Appendix A.

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4.3 **Qualified Personnel.**

Provider shall ensure all Emergency Medical Personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of Provider services.

4.4 **Subcontracting.**

Excluding services for 9-1-1 calls, Provider may subcontract services to be performed under this SPA to other San Francisco LEMSA permitted service providers. For clarity 9-1-1 services may not be subcontracted.

4.5 **Assignment.**

The services to be performed by Provider are personal in character. Neither this SPA, nor any duties or obligations hereunder, may be directly or indirectly assigned, novated, transferred, or delegated by Provider. Any purported Assignment made in violation of this provision shall be null and void.

4.6 **No Transfer of Certificate of Operation or Ambulance Permit.**

Each Certification of Operation and/or Ambulance Permit by the LEMSA is a privilege that is personal and specific to Provider. Neither a Certificate of Operation, an Ambulance Permit, nor any of the privileges conferred thereunder may be neither sold, conveyed, assigned, encumbered, nor otherwise transferred by Provider. Any attempt to sell, convey, assign, encumber or otherwise transfer a Certificate of Operation, any Ambulance Permit, or the privileges conferred thereunder may result in the City's termination of this SPA.

4.7 **Activities at Permittee's Expense.**

Any act that Provider performs under this SPA or applicable law shall be performed at Provider's expense and without cost to City, unless said Provider is a City agency or employee providing services under this SPA.

4.8 **Warranty.**

Provider warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this SPA as detailed in Appendix A (Statement of Work).

Article 5 Insurance and Indemnity (RESERVED FOR SFFD)

5.1 **Insurance.**

5.1.1 **Required Coverages.** Without in any way limiting Provider's liability pursuant to the "Indemnification" section of this SPA, Provider must maintain in force, during the full term of the SPA, insurance in the following amounts and coverages:

(a) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness.

(b) Combined Commercial General Liability and Professional Liability Insurance with limits not less than $4,000,000 each occurrence and $6,000,000 general aggregate for

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Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations, and negligent acts, errors or omissions in connection with the Services.

(c) Commercial Automobile Liability Insurance with limits not less than $4,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(d) Technology Errors and Omissions Liability coverage (RESERVED).

(e) Cyber and Privacy Insurance with limits of not less than $5,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.

(f) Umbrella or Excess coverage shall be permitted to meet any of the insurance requirements in section.

5.1.2 Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to provide:

(a) Name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

(b) That such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this SPA, and that insurance applies separately to each insured against whom claim is made or suit is brought.

5.1.3 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

5.1.4 Should any of the required insurance be provided under a claims-made form, Provider shall maintain such coverage continuously throughout the term of this SPA and, without lapse, for a period of three years beyond the expiration of this SPA, to the effect that, should occurrences during the contract term give rise to claims made after expiration of the SPA, such claims shall be covered by such claims-made policies.

5.1.5 Should any of the required insurance be provided under a form of coverage that includes a general annual aggregate limit or provides that claims investigation or legal defense costs be included in such general annual aggregate limit, such general annual aggregate limit shall be double the occurrence or claims limits specified above.

5.1.6 Should any required insurance lapse during the term of this SPA, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this SPA, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this SPA effective on the date of such lapse of insurance.

5.1.7 Before commencing any Services, Provider shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in form evidencing all coverages set forth above. Approval of the insurance by City shall not relieve or decrease Provider's liability hereunder.

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5.1.8 The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Provider, its employees, agents and subcontractors.

5.1.9 If Provider will use any subcontractor(s) to provide Services, Provider shall require the subcontractor(s) to provide all necessary insurance and to name the City and County of San Francisco, its officers, agents and employees and the Provider as additional insureds.

5.1.10 City may, in its sole discretion, choose to reconsider the amounts and coverages above and require amendment of this SPA to update such amounts and coverages during the term of the SPA. Provider's execution of an amendment to this SPA to put changes to these amounts and coverages in effect shall not be withheld.

5.2 **General Indemnification.**

5.2.1 Provider shall indemnify and save harmless City and its officers, agents and employees from, and, if requested, shall defend them against any and all third party claims for loss, cost, damage, injury, liability, and claims thereof for injury to or death of a person (including but not limited to patient and/or patient's relative's claims for damages arising from medical malpractice), or loss of or damage to property, arising directly or indirectly from Provider's performance of this SPA, except to the extent that such indemnity is void or otherwise unenforceable under applicable law in effect on or validly retroactive to the date of this SPA and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City, in which case damages will be apportioned under the California doctrine of comparative fault. The foregoing indemnity shall include, without limitation, reasonable fees of attorneys, consultants and experts and related third party costs that the City necessarily incurs.

5.2.2 In addition to Provider's obligation to indemnify City, Provider specifically acknowledges and agrees that it has an immediate and independent obligation to defend City from any claim which actually or potentially falls within this indemnification provision, while such claim is in effect, even if the allegations are or may be groundless, false or fraudulent, which obligation arises at the time such claim is tendered to Provider by City and continues at all times thereafter.

5.3 **Infringement Indemnification.**

Provider shall indemnify and hold the City harmless from all third party claims, loss and liability, including attorneys' fees, court costs and all other litigation expenses for any infringement of United States patent rights, or any copyright, trade secret or any other proprietary right or trademark, and all other intellectual property claims of any person or persons, arising directly or indirectly from Provider's performance of this SPA.

Article 6 Liability of the Parties

6.1 **City's Liability Limit. (RESERVED)**

6.2 **Liability for Incidental and Consequential Damages. (RESERVED)**

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6.3 Liability for Use of Equipment.

City shall not be liable for any damage to persons or property as a result of the misuse of equipment used by Provider, or by any of their employees, even though such equipment is furnished, rented or loaned by City.

Article 7 Payment of Taxes (RESERVED FOR SFFD)

7.1 Provider Shall Collect and Remit Taxes.

Where required under applicable law, Provider shall collect and remit to City all applicable taxes in compliance with the City's Business and Tax Regulations Code. Provider shall provide such records to City as City may require to confirm its compliance with these requirements.

7.2 Possessory Interest Tax.

Provider understands that this SPA may create a possessory interest subject to property taxation and that Provider may be subject to the payment of such taxes.

Article 8 Termination and Default

8.1 Probation, Suspension, and/or Termination for Default; Remedies.

The City may terminate this SPA for material breach by Provider, including but not limited to, as detailed in the LEMSA's "Pre-Hospital Provider Standards" policy. Failure to comply with the terms of this SPA, local policies and protocols, and all applicable laws and regulations as determined by the LEMSA, may result in probation, suspension, or termination of Provider's authorization to operate in the LEMSA EMS service area. In the event that Provider defaults in the performance of any duties or obligations hereunder and the default or breach has not been cured within thirty (30) calendar days of receipt of written notice of default, such failure shall be cause for the LEMSA to effect any of the following, acting in its sole discretion: Revocation of Provider's Certificate of Operation and/or Ambulance Permit; placing Provider on probation with a LEMSA approved corrective action plan; suspension of Provider's Services under this Agreement; and/or termination of this Agreement.

8.2 Non-Waiver of Rights.

The omission by the City at any time to enforce any default or right reserved to it, or to require performance of any of the terms, covenants, or provisions hereof by Provider at the time designated, shall not be a waiver of any such default or right to which the City is entitled, nor shall it in any way affect the right of the City to enforce such provisions thereafter.

8.3 Rights and Duties upon Termination or Expiration.

This Section and the following Sections of this SPA listed below, shall survive termination or expiration of this SPA:

Article 3	Audit
Article 5	Insurance and Indemnity
Article 6	Liability of Parties
Article 7	Payment of Taxes
Article 11	General Provisions
Article 13	Data and Security

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Subject to the survival of the Sections identified above, if this SPA is terminated prior to expiration of the term specified in Article 2, this SPA shall be of no further force or effect.

Article 9 Rights In Deliverables (RESERVED)

Article 10 Additional Requirements Incorporated by Reference (RESERVED FOR SFFD)

10.1 Laws Incorporated by Reference.

Provider represents and warrants that it will comply with all applicable laws and regulations in performing the Services. Subject to the foregoing, the full text of the laws listed in this Article 10, including enforcement and penalty provisions, are incorporated by reference into this SPA. The full text of the San Francisco Municipal Code provisions incorporated by reference in this Article and elsewhere in the SPA ("Mandatory City Requirements") are available at http://www.amlegal.com/codes/client/san-francisco_ca/

10.2 Conflict of Interest.

By executing this SPA, Provider certifies that it does not know of any fact which constitutes a violation of Section 15.103 of the City's Charter; Article III, Chapter 2 of City's Campaign and Governmental Conduct Code; Title 9, Chapter 7 of the California Government Code (Section 87100 *et seq.*), or Title 1, Division 4, Chapter 1, Article 4 of the California Government Code (Section 1090 *et seq.*), and further agrees promptly to notify the City if it becomes aware of any such fact during the term of this SPA.

10.3 Consideration of Salary History.

Provider shall comply with San Francisco Administrative Code Chapter 12K, the Consideration of Salary History Ordinance or "Pay Parity Act." Provider is prohibited from considering current or past salary of an applicant in determining whether to hire the applicant or what salary to offer the applicant to the extent that such applicant is applying for employment to be performed on this SPA or in furtherance of this SPA, and whose application, in whole or part, will be solicited, received, processed or considered, whether or not through an interview, in the City or on City property. The ordinance also prohibits employers from (1) asking such applicants about their current or past salary or (2) disclosing a current or former employee's salary history without that employee's authorization unless the salary history is publicly available. Provider is subject to the enforcement and penalty provisions in Chapter 12K. Information about and the text of Chapter 12K is available on the web at https://sfgov.org/olse/consideration-salary-history. Provider is required to comply with all of the applicable provisions of 12K, irrespective of the listing of obligations in this Section.

10.4 Nondiscrimination Requirements

Provider does not as of the date of this SPA, and will not during the term of this SPA, in any of its operations in San Francisco, on real property owned by San Francisco, or where work is being performed for the City elsewhere in the United States, discriminate against an applicant for employment because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition, marital status, or citizenship, or otherwise, including in the provision of employee benefits between employees with domestic partners and employees with spouses and/or between the domestic partners and spouses of such employees, subject to the conditions set forth in San Francisco Administrative Code Section12B.2.

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10.5 **Minimum Compensation Ordinance.**

Provider shall pay covered employees no less than the minimum compensation required by San Francisco Administrative Code Chapter 12P, including a minimum hourly gross compensation, compensated time off, and uncompensated time off. Provider is subject to the enforcement and penalty provisions in Chapter 12P. Information about and the text of the Chapter 12P is available on the web at http://sfgov.org/olse/mco. Provider is required to comply with all of the applicable provisions of 12P, irrespective of the listing of obligations in this Section. By signing and executing this SPA, Provider certifies that it is in compliance with Chapter 12P.

10.6 **Health Care Accountability Ordinance.**

Provider shall comply with San Francisco Administrative Code Chapter 12Q. For each Covered Employee, Provider shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Provider chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission. Information about and the text of the Chapter 12Q, as well as the Health Commission's minimum standards, is available on the web at http://sfgov.org/olse/hcao. Provider is subject to the enforcement and penalty provisions in Chapter 12Q. Any Subcontract entered into by Provider shall require any Subcontractor with 20 or more employees to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section.

10.7 **Alcohol and Drug-Free Workplace.**

City reserves the right to deny access to, or require Provider to remove from performance of services under this SPA personnel of any Provider who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing, selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this SPA "controlled substance" includes cannabis and derivative products.

10.8 **Consideration of Criminal History in Hiring and Employment Decisions**

10.8.1 Provider agrees to comply fully with and be bound by all of the provisions of Chapter 12T, "City Provider/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions," of the San Francisco Administrative Code ("Chapter 12T"), including the remedies provided, and implementing regulations, as may be amended from time to time. The provisions of Chapter 12T are incorporated by reference and made a part of this SPA as though fully set forth herein. The text of the Chapter 12T is available on the web at http://sfgov.org/olse/fco. Provider is required to comply with all of the applicable provisions of 12T, irrespective of the listing of obligations in this Section. Capitalized terms used in this Section and not defined in this SPA shall have the meanings assigned to such terms in Chapter 12T.

10.8.2 The requirements of Chapter 12T shall only apply to a Provider's or Subcontractor's operations to the extent those operations are in furtherance of the performance of this SPA, shall apply only to applicants and employees who would be or are performing work in furtherance of this SPA, and shall apply when the physical location of the employment or prospective employment of

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an individual is wholly or substantially within the City of San Francisco. Chapter 12T shall not apply when the application in a particular context would conflict with federal or state law or with a requirement of a government agency implementing federal or state law.

10.9 Food Service Waste Reduction Requirements.

Provider shall comply with the Food Service Waste Reduction Ordinance, as set forth in San Francisco Environment Code Chapter 16, including but not limited to the remedies for noncompliance provided therein.

10.10 Distribution of Beverages and Water. (RESERVED)

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this SPA, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

To City:	Andrew Holcomb, MS, EMS Manager, San Francisco EMS Agency City and County of San Francisco 90 Van Ness Ave, San Francisco, CA 94102 415-487-5018 andrew.holcomb@sfdph.org
To Provider:	Allied Medical Services of California D.B.A. King-American Ambulance Company 2570 Bush Street San Francisco, CA. 94115 Attn: Josh Nultemeier Title: Operations Manager/Chief Paramedic Email: SFMedic847@yahoo.com

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

11.2 Compliance with Americans with Disabilities Act.

Provider shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 Reserved.

11.4 Sunshine Ordinance.

Provider acknowledges that this SPA and all records related to its formation, Provider's performance of Services, and City's payment are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

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11.5 **Modification of this SPA.**

This SPA may not be modified, nor may compliance with any of its terms be waived, except as noted in Section 11.1, "Notices to Parties," except by written instrument executed by the Parties and approved in the same manner as this SPA.

11.6 **Dispute Resolution Procedure.**

11.6.1 The Parties will attempt in good faith to resolve any dispute or controversy arising out of or relating to the performance of services under this SPA in accordance with the LEMSA's "Pre-Hospital Provider Standards" policy.

11.6.2 During the course of any Dispute Resolution process, Provider shall comply with all directives issued by the LEMSA. In the event that the LEMSA identifies a deficiency that LEMSA acting in its sole discretion determines may cause a threat to public health and/or safety, the LEMSA may issue a written probation and/or suspension notice to the Provider. Upon receipt, the Provider shall immediately comply with the terms of that notice. If the notice calls for suspension, Provider shall immediately suspend Services under this SPA until the LEMSA verifies that Provider has implemented all required corrections. Provider's failure to implement all required corrections as determined by the LEMSA acting in its sole discretion may result in termination of this SPA for default.

11.7 **Government Code Claim Requirement.**

No suit for money or damages may be brought against the City until a written claim therefor has been presented to and rejected by the City in conformity with the provisions of San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq. Nothing set forth in this SPA shall operate to toll, waive or excuse Provider's compliance with the California Government Code Claim requirements set forth in San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq.

11.8 **Agreement Made in California; Venue.**

The formation, interpretation and performance of this SPA shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this SPA shall be in San Francisco.

11.9 **Construction.**

All paragraph captions are for reference only and shall not be considered in construing this SPA.

11.10 **Entire Agreement.**

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This SPA may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.11 **Compliance with Laws.**

Provider shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Provider's performance of this SPA, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

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11.12 **Severability.**

Should the application of any provision of this SPA to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this SPA shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.13 **Order of Precedence.**

Provider agrees to perform the services described below in accordance with the terms and conditions of this SPA, and the Statement of Work attached as Appendix A. The terms of this SPA are to be read and interpreted together with all other documents, appendices, exhibits, and addenda attached to the SPA as a single agreement.

11.14 **Notification of Legal Requests.**

Provider shall immediately notify City upon receipt of any subpoenas, service of process, litigation holds, discovery requests and other legal requests ("Legal Requests") related to this SPA, and in no event later than 24 hours after it receives the request.

Article 12 Department Specific Terms

12.1 **Third Party Beneficiaries.**

No third parties are intended by the parties hereto to be third party beneficiaries under this SPA, and no action to enforce the terms of this SPA may be brought against either party by any person who is not a party hereto.

12.2 **Exclusion Lists and Employee Verification.**

Upon execution of this SPA and monthly thereafter, Provider will check the exclusion lists published by the Office of the Inspector General (OIG), General Services Administration (GSA), and the California Department of Health Care Services (DHCS) to ensure that any employee, temporary employee, volunteer, consultant, or governing body member responsible for oversight, administering or delivering state or federally-funded services who is on any of these lists is excluded from (may not work in) Provider's program or agency. Proof of checking these lists must be retained for seven years.

Article 13 Data and Security

13.1 **Nondisclosure of Private, Proprietary or Confidential Information.**

13.1.1 If this SPA requires City to disclose "Private Information" to Provider within the meaning of San Francisco Administrative Code Chapter 12M, Provider and subcontractor shall use such information only in accordance with the restrictions stated in Chapter 12M and in this SPA and only as necessary in performing the Services. Provider is subject to the enforcement and penalty provisions in Chapter 12M.

13.1.2 In the performance of Services, Provider may have access to City's proprietary or confidential information, the disclosure of which to third parties may damage City. If City discloses proprietary or confidential information to Provider, such information must be held by Provider in confidence and used only in performing the SPA, except as required by law, professional rule or

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regulation. Provider shall exercise the same standard of care to protect such information as a reasonably prudent Provider would use to protect its own proprietary or confidential information.

13.2 **Business Associate Agreement.**

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Provider will:

1. ☒ Do **at least one** or more of the following:
A. Create, receive, maintain, or transmit PHI for or on behalf of CITY/SFDPH (including storage of PHI, digital or hard copy, even if Provider does not view the PHI or only does so on a random or infrequent basis); or

B. Receive PHI, or access to PHI, from CITY/SFDPH or another Business Associate of City, as part of providing a service to or for CITY/SFDPH, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or

C. Transmit PHI data for CITY/SFDPH and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

FOR PURPOSES OF THIS SPA, PROVIDER IS A BUSINESS ASSOCIATE OF CITY/SFDPH, AS DEFINED UNDER HIPAA. PROVIDER MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS SPA AS THOUGH FULLY SET FORTH HEREIN:

a. **Appendix E** SFDPH Business Associate Agreement (BAA) (04-12-2018)
   1. SFDPH Attestation 1 PRIVACY (06-07-2017)
   2. SFDPH Attestation 2 DATA SECURITY (06-07-2017)

2. ☐ **NOT do any of the activities listed above in subsection 1;**
Provider is not a Business Associate of CITY/SFDPH. Appendix E and attestations are not required for the purposes of this SPA.
This option requires review and approval from the Office of Compliance and Privacy Affairs.

13.3 **Protected Health Information.**

Provider and all agents and employees Provider shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Provider by City in the performance of this SPA. Provider agrees that any failure of Contactor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Provider or its subcontractors or agents by City, Provider shall indemnify City for the amount of such fine or

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penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 14 Data and Security

14.1 City Data

14.1.1 **Ownership of City Data.** The Parties agree that as between them, all rights, including all intellectual property rights, in and to the City Data and any derivative works of the City Data shall remain the exclusive property of the City.

14.1.2 **Use of City Data**. Nothing herein shall be construed to confer any license or right to the City Data, including user tracking and exception City Data within the system, by implication, estoppel or otherwise, under copyright or other intellectual property rights, to any third-party. Unauthorized use of City Data by Provider.

14.1.3 **Data Breach; Loss of City Data**. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Provider that relate to the protection of the security, confidentiality, or integrity of City Data, Provider shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

14.1.4 **Data Privacy and Information Security Program.** Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

14.1.5 **Data Transmission.** Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure that all data exchanged shall be used expressly and solely for the purposes stated in the SPA. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this SPA, unless otherwise permitted in this SPA. The Provider shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

Article 15 MacBride And Signature

15.1 MacBride Principles -Northern Ireland.

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this SPA. By signing this SPA, Provider confirms that Provider has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to

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abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

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IN WITNESS WHEREOF, the parties hereto have executed this SPA on the day first mentioned above.

City

San Francisco Department of Public Health

DocuSigned by:
Greg Wagner 7/13/2020 | 12:00:30 PDT
28527524752949F...

Grant Colfax, MD
Director of Health

Provider

Allied Medical Services of California
D.B.A. King-American Ambulance Company

DocuSigned by:
Josh Nultemeier 7/1/2020 | 1:45:56 PDT
5C9BFEEE90ED46C...

Josh Nultemeier
Operations Manager/Chief Paramedic

Approved as to Form:

Dennis J. Herrera
City Attorney

By: DocuSigned by:
Louise Simpson 7/7/2020 | 11:55:53 PDT
BD54168A4C3B452...

Louise S. Simpson
Deputy City Attorney

Appendices

A: Statement of Work
B: Business Associate Agreement

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Appendix A

STATEMENT OF WORK

I. GENERAL REQUIREMENTS FOR APPROVED SERVICE PROVIDER:

Approved service Providers authorized to participate in the LEMSA EMS system shall perform as follows:

(1) (911 Providers, only) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA.

(2) Utilize and maintain telecommunications as specified by the LEMSA.

(3) Maintain medication solution, medical supplies, and equipment inventory as specified by the LEMSA commensurate with the basic and local optional scope of practice of the paramedic and EMT.

(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

1. controlled substance ordering and order tracking;

2. controlled substance receipt and accountability;

3. controlled substance master supply storage, security and documentation;

4. controlled substance labeling and tracking;

5. vehicle storage and security;

6. usage procedures and documentation;

7. reverse distribution;

8. disposal;

9. re-stocking procedures.

(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to;

10. controlled substance testing;

11. discrepancy reporting;

12. tampering, theft and diversion prevention and detection;

13. usage audits.

(5) Be responsible for assessing and ensuring current knowledge of their paramedics and EMTs in local policies, procedures and protocols and for assessing their EMT and/or paramedics' skills competency. Documentation of assessment results shall be made available to the LEMSA.

(6) If, through the EMSQIP the LEMSA Medical Director determines that an EMT and/or paramedic needs additional training, observation or testing, the LEMSA Medical Director may create a specific and targeted program of remediation based upon the identified needs of the EMT and/or paramedic. If there is disagreement between the Provider and the LEMSA Medical Director, the decision of the LEMSA Medical Director shall prevail.

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Provider understands and agrees that the LEMSA may deny, suspend, or revoke the approval of a service Provider for failure to comply with applicable policies, procedures, and regulations.

(7) Provider shall employ a Provider Medical Director who must be approved, in writing, by the LEMSA Medical Director.

II. BENEFITS GRANTED BY LEMSA TO PROVIDER

1. Boundaries:

Provider may provide ALS and/or BLS Ground Ambulance Services based upon a Certification of Operation, within the defined boundaries of the City and County of San Francisco (LEMSA EMS service area), to include Treasure Island, the Golden Gate National Recreational Area, and other Federal property within the contiguous borders of the LEMSA EMS service area, notwithstanding entry restrictions placed by Federal jurisdiction, during the period of this SPA. The ALS and/or BLS Ground Ambulance Services shall include Site to Facility patient transports, as well as Facility to Facility transports, originating from a private request and responses to 9-1-1 calls.

2. Availability of 9-1-1 Ambulances:

a) All 9-1-1 Providers shall ensure a minimum of two ambulances available to the 9-1-1 system twenty-four (24) hours per day, 365 days per year plus ambulance transport may include no more than 5 transports per month to cover unfilled service calls for patients being cared for within the DPH system.

b) Within 90 days after execution of the SPA, and t least annually thereafter, the LEMSA will notify Providers of the minimum overall number of staffed ambulances needed to meet the EMS system demand (“System Demand Analysis”)

c) Within 90 days after execution of this SPA, and annually within 90 days of receipt of the System Demand Analysis, each 9-1-1 Provider shall provide their minimum Ambulance Deployment and Staffing Plan to the LEMSA, which shall be binding until receipt of the City’s next System Demand Analysis.

d) Immediately upon the commencement of Services under this SPA, each Provider shall provide the LEMSA its daily staffing report.

3. City Facilities (Zuckerberg San Francisco General and Laguna Honda Hospital)

The LEMSA urges all Providers to respond to all Requests for Proposals issued by the San Francisco Department of Public Health for as-needed non-emergency services for Zuckerberg San Francisco General Hospital, Laguna Honda Hospital, the San Francisco Department of Public Health clinics, and other contracted Facilities, as well as urging City Providers to perform inter-Facility transports.

4. SPA Committees:

All Providers shall participate (attend a minimum of 75% of Committee meetings annually, as determined by the LEMSA acting in its sole discretion) in the following SPA Committees which shall be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

a) Emergency Medical Services Advisory Committee

b) Medical Director’s Committee

c) Operations Committee

d) Quality Improvement Committee

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e) Trauma Committee

f) STAR Committee

g) Stroke Committee

h) Other Committees determined by the LEMSA

Ambulance Provider membership is listed in LEMSA Policy 1010.

5. Report of ALS Provider Status:

Upon request from any entity, including insurance companies, fiscal intermediaries, and other third party payers, LEMSA will identify currently authorized ALS Providers as an authorized Provider of ALS service, pursuant to California Code of Regulations, Title 22, Section, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

6. Coordination of EMS Mutual Aid Requests:

a) Outgoing 9-1-1 EMS Mutual Aid will be coordinated by the Medical Health Operational Area Coordinator (MHOAC) and will be planned in consultation with the LEMSA to minimize impact on the SF EMS System.

b) Incoming 9-1-1 EMS Mutual Aid assets will be requested by LEMSA through the MHOAC for state and regional resources. These EMS assets will be assigned to appropriate task forces, strike teams, or other assignments as determined necessary by the LEMSA in compliance with the emergency management practices outlined in LEMSA Policies and Protocols.

c) Intra-county mutual aid shall be authorized and requested by the LEMSA when the 9-1-1/PSAP generated demand exceeds, or is anticipated to exceed, the capacity of the 9-1-1/PSAP authorized ALS Providers, as determined by the LEMSA.

7. Non-Transport Treatment Fee:

The San Francisco Fire Department is authorized by local ordinance to charge a fee for on-scene treatment without a transport to a hospital. King-American Ambulance Company and American Medical Response West are authorized to charge a non-transport fee in an amount sufficient to cover the reasonable cost of this service and is agreed upon by the LEMSA.

III. OBLIGATIONS OF PROVIDER

1. Mutual Aid:

LEMSA may request mutual aid EMS resources during situations requiring additional EMS resources. Provider may provide resources, at the request of the LEMSA, in such numbers and durations as determined to be in the interest of the LEMSA**.**

2. Automatic Aid Provision:

With approval of the LEMSA, Providers may dispatch up to five ambulances and one paramedic supervisor (known as an Ambulance Strike Team), to a request for immediate aid from any geopolitical entity in California, upon approval of the appropriate manager from that Provider. The Provider shall notify the LEMSA once they have deployed single assets or an Ambulance Strike Team so that system adjustments may be made, if necessary.

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3. Performance Standards

a) Provider shall adhere to all requirements of state laws and regulations pertaining to the provision of EMS.

b) Provider shall adhere to City laws as set forth in San Francisco Health Code Articles 3 and 14, including any and all amendments thereto, if any, whether enacted before or during the term of this SPA and any extensions.

c) Provider shall adhere to all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d) Provider shall use the SEMS and the NIMS in the performance of all emergency services rendered under this SPA.

4. Document Review and Retention

a) All records maintained pursuant to this SPA, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227) shall be available for inspections, audit, or examination by LEMSA or by their designated representatives, consistent with federal, state and local confidentiality and privacy laws, and shall be preserved by Provider for at least three (3) years from the termination of this SPA.

b) All patient contacts, treatments, and interactions shall be documented by Provider, and, if a patient is transported to a Facility, sent with the patient to the Facility.

c) Upon execution of this SPA, Providers shall provide LEMSA and/or LEMSA's third-party designee an unfiltered and unaltered data stream and full access to each patient's Medical Record and Computer Aided Dispatch ("CAD") (California Health & Safety Code Section 1797.227). Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the LEMSA. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider.

d) Upon LEMSA request, Provider shall prepare and submit written reports on incidents based on Services provided under this SPA.

e) Provider shall submit monthly operation reports to the LEMSA, by the last day of the following month, in a form prescribed by the LEMSA.

f) Provider shall provide additional information and reports as requested by the LEMSA to monitor Provider performance, including but not limited to reports regarding response intervals, staffing, skilled intervention and/or performance reports, core measures reports/data, policy compliance reports, case reviews, continuing education, and/or others as required by the LEMSA acting in its sole discretion..

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5. Disaster Preparedness

a) Provider shall annually participate in a least one system-wide discussion based exercise and one system-wide functional exercise per calendar year to benefit coordination among Providers, the EMS system, and LEMSA, as determined by the LEMSA Medical Director.

b) Provider shall ensure staff, with appropriate authority to act on the behalf of Provider, are present in the City's Emergency Operations Center (EOC) when requested by LEMSA during activations or exercises involving Provider.

6. Incident Reporting

Provider shall file or caused to be filed, an Incident Report form consistent with LEMSA Policy in each instance as required by the LEMSA within timeframe reporting requirements as set forth in LEMSA policies.

7. Inspection Standards

Parties acknowledge and agree that inspection standards are governed by San Francisco Health Code Article 14, or any successor provisions.

8. Field Personnel Communication Standards

a) Provider shall post LEMSA notices and bulletins at all employee locations.

b) Provider shall require, through written policy, all personnel to have knowledge of, and follow, LEMSA Policies, Procedures and Protocols, and Directives.

c) Provider shall:

i. Ensure and assess that all EMT's and EMT-P's are trained in LEMSA policies, procedures, and protocols. Such training shall include cognitive, motor and retention skills that allow employees to properly perform EMS duties; and

ii. Provide at each Provider location, in a location easily accessible to employees, a current LEMSA Policy and Procedure Manual and Protocol Manual.

iii. Submit compliance reports quarterly to the LEMSA.

9. Fatigue Prevention

a) Provider shall develop and implement policies acceptable to LEMSA to minimize fatigue by EMT-Ps and EMTs.

b) Provider shall comply with California Code of Regulations Title 13, Section 1105 (e), which states: Driver Conditions: No person shall drive or be directed to drive an ambulance, when his/her ability to operate the ambulance safely is adversely affected by fatigue, illness or other cause nor when the vehicle is unsafe to operate.

c) Provider has informed, and agrees to continue to inform, employees of the regulation and will not retaliate against those complaining of fatigue, illness, or other cause that may affect that employee's ability to operate an ambulance safely.

10. Protected Patient Information

Provider shall comply with all federal and state patient privacy laws, and shall have and enforce a policy that prohibits Provider's employees from inappropriate sharing of protected patient

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information to include sharing via personal communication devices, social media, and any other form of data transmission.

11. Prohibition on Alcohol and Drug Use

Provider shall have and enforce a policy that prohibits Provider's employees from performing any ALS or BLS service under the influence of any alcoholic beverage, illegal drug, or narcotic. In addition, said policy shall prohibit Provider's employees from performing such services under the influence of any other substances, including prescription or non-prescription medication, which impairs their physical or mental performance.

12. Reporting of EMT and EMT-Paramedic Violations

Provider shall comply fully and timely with the reporting requirements of California Health and Safety Code Section, Division 2.5, Sections 1798.200, 1799.112, and LEMSA policies and protocols. Provider shall notify the LEMSA Medical Director within 24 hours when an allegation has been validated as a potential violation of 1798.200. Supporting documentation shall be provided within 72 hours. Notification shall be made to the LEMSA within 24 hours if an EMT and/or EMT-P is removed from patient care or resigns for an investigation based on evidence for disciplinary cause or reason.

16. LEMSA Emergency Medical Services Quality Improvement Program

Provider must participate in the LEMSA's EMSQIP as required by California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

17. Infection Control, Health and Safety:

a) Provider must have a Bloodborne Pathogen (BBP) Exposure Control plan for its employees, agents and subcontractors as defined in the California Code of Regulations, Title 8, Section 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and recordkeeping.

b) Provider must demonstrate personnel policies/procedures for protection of its employees, agents, subcontractors and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

c) Provider must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

d) Provider is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

e) Provider shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

f) Provider shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

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g) Provider assumes responsibility for procuring all medical equipment and supplies for use by its employees, agents and subcontractors, including safe needle devices, and provides and documents all appropriate training.

h) Provider shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

18. Aerosol Transmissible Disease Program, Health and Safety:

Provider must have an Aerosol Transmissible Disease (ATD) Program as defined in the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases (http://www.dir.ca.gov/Title8/5199.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, screening procedures, source control measures, use of personal protective equipment, referral procedures, training, immunization, post-exposure medical evaluations/follow-up, and recordkeeping.

19. Regional Training

Provider shall designate a minimum of one dedicated part-time staff member, hours based on need, to participate in LEMSA's regional training program to develop, teach, and implement consistent and quality prehospital education based upon LEMSA strategic objectives and quality improvement initiatives.

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APPENDIX B

San Francisco Department of Public Health

Business Associate Agreement

As applicable, this Business Associate Agreement ("BAA") supplements and is made a part of the contract by and between the City and County of San Francisco, the Covered Entity ("CE"), and Contractor, the Business Associate ("BA") (the "Agreement"). To the extent that the terms of the Agreement are inconsistent with the terms of this BAA, the terms of this BAA shall control.

RECITALS

A. CE, by and through the San Francisco Department of Public Health ("SFDPH"), wishes to disclose certain information to BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI") (defined below).

B. For purposes of the Agreement, CE requires Contractor, even if Contractor is also a covered entity under HIPAA, to comply with the terms and conditions of this BAA as a BA of CE.

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws, including, but not limited to, California Civil Code §§ 56, et seq., California Health and Safety Code § 1280.15, California Civil Code §§ 1798, et seq., California Welfare & Institutions Code §§5328, et seq., and the regulations promulgated there under (the "California Regulations").

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this BAA.

E. BA enters into agreements with CE that require the CE to disclose certain identifiable health information to BA. The parties desire to enter into this BAA to permit BA to have access to such information and comply with the BA requirements of HIPAA, the HITECH Act, and the corresponding Regulations.

In consideration of the mutual promises below and the exchange of information pursuant to this BAA, the parties agree as follows:

1. Definitions.

a. Breach means the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information, and shall have the meaning given to such term under the HITECH Act and HIPAA Regulations [42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402], as well as California Civil Code Sections 1798.29 and 1798.82.

b. Breach Notification Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.

c. Business Associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information received from a covered entity, but other than in the capacity of a member of the workforce of such covered entity or arrangement, and shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

d. Covered Entity means a health plan, a health care clearinghouse, or a health care provider who transmits any information in electronic form in connection with a transaction covered under HIPAA Regulations, and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

e. Data Aggregation means the combining of Protected Information by the BA with the Protected Information received by the BA in its capacity as a BA of another CE, to permit data analyses that relate to the health care operations of the respective covered entities, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. Designated Record Set means a group of records maintained by or for a CE, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. Electronic Protected Health Information means Protected Health Information that is maintained in or transmitted by electronic media and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103. For the purposes of this BAA, Electronic PHI includes all computerized data, as defined in California Civil Code Sections 1798.29 and 1798.82.

h. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

i. Health Care Operations shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

j. Privacy Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. Protected Health Information or PHI means any information, including electronic PHI, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Sections 160.103 and 164.501. For the purposes of this BAA, PHI includes all medical information and health insurance information as defined in California Civil Code Sections 56.05 and 1798.82.

l. Protected Information shall mean PHI provided by CE to BA or created, maintained, received or transmitted by BA on CE's behalf.

m. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. Security Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. Unsecured PHI means PHI that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute, and shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. Obligations of Business Associate.

a. Attestations. Except when CE's data privacy officer exempts BA in writing, the BA shall complete the following forms, attached and incorporated by reference as though fully set forth herein, SFDPH Attestations for Privacy (Attachment 1) and Data Security (Attachment 2) within sixty (60) calendar days from the execution of the Agreement. If CE makes substantial changes to any of these forms during the term of the Agreement, the BA will be required to complete CE's updated forms within sixty (60) calendar days from the date that CE provides BA with written notice of such changes. BA shall retain such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

b. User Training. The BA shall provide, and shall ensure that BA subcontractors, provide, training on PHI privacy and security, including HIPAA and HITECH and its regulations, to each employee or agent that will access, use or disclose Protected Information, upon hire and/or prior to accessing, using or disclosing Protected Information for the first time, and at least annually thereafter during the term of the Agreement. BA shall maintain, and shall ensure that BA subcontractors maintain, records indicating the name of each employee or agent and date on which the PHI privacy and security trainings were completed. BA shall retain, and ensure that BA subcontractors retain, such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

c. Permitted Uses. BA may use, access, and/or disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. Further, BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE [45 C.F.R. Sections 164.502, 164.504(e)(2). and 164.504(e)(4)(i)].

d. Permitted Disclosures. BA shall disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. BA shall not disclose Protected Information in any manner that would constitute a violation of the

Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2 (n) of this BAA, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)]. BA may disclose PHI to a BA that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit Protected Information on its behalf, if the BA obtains satisfactory assurances, in accordance with 45 C.F.R. Section 164.504(e)(1), that the subcontractor will appropriately safeguard the information [45 C.F.R. Section 164.502(e)(1)(ii)].

e. Prohibited Uses and Disclosures. BA shall not use or disclose Protected Information other than as permitted or required by the Agreement and BAA, or as required by law. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the Protected Information solely relates [42 U.S.C. Section 17935(a) and 45 C.F.R. Section 164.522(a)(1)(vi)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2), and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

f. Appropriate Safeguards. BA shall take the appropriate security measures to protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the CE, and shall prevent any use or disclosure of PHI other than as permitted by the Agreement or this BAA, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.306, 164.308, 164.310, 164.312, 164.314 164.316, and 164.504(e)(2)(ii)(B). BA shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316, and 42 U.S.C. Section 17931. BA is responsible for any civil penalties assessed due to an audit or investigation of BA, in accordance with 42 U.S.C. Section 17934(c).

g. Business Associate's Subcontractors and Agents. BA shall ensure that any agents and subcontractors that create, receive, maintain or transmit Protected Information on behalf of BA, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph 2.f. above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2) through (e)(5); 45 C.F.R. Section 164.308(b)]. BA shall mitigate the effects of any such violation.

h. Accounting of Disclosures. Within ten (10) calendar days of a request by CE for an accounting of disclosures of Protected Information or upon any disclosure of Protected Information for which CE is required to account to an individual, BA and its agents and subcontractors shall make available to CE the information required to

provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935 (c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents and subcontractors for at least seven (7) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an Electronic Health Record. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure [45 C.F.R. 164.528(b)(2)]. If an individual or an individual's representative submits a request for an accounting directly to BA or its agents or subcontractors, BA shall forward the request to CE in writing within five (5) calendar days.

i. Access to Protected Information. BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within (5) days of request by CE to enable CE to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. 164.524.

j. Amendment of Protected Information. Within ten (10) days of a request by CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA and its agents and subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment or other documentation to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R Section 164.526. If an individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request and of any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

k. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)]. BA shall provide CE a copy of any Protected Information and other documents and records that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

l. Minimum Necessary. BA, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the intended purpose of such use, disclosure, or request. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to

what constitutes "minimum necessary" to accomplish the intended purpose in accordance with HIPAA and HIPAA Regulations.

m. Data Ownership. BA acknowledges that BA has no ownership rights with respect to the Protected Information.

n. Notification of Breach. BA shall notify CE within 5 calendar days of any breach of Protected Information; any use or disclosure of Protected Information not permitted by the BAA; any Security Incident (except as otherwise provided below) related to Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by BA or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the BA to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. BA shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 42 U.S.C. Section 17932; 45 C.F.R. 164.410; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)]

o. Breach Pattern or Practice by Business Associate's Subcontractors and Agents. Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(iii), if the BA knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the contractual arrangement with its subcontractor or agent, if feasible. BA shall provide written notice to CE of any pattern of activity or practice of a subcontractor or agent that BA believes constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA within five (5) calendar days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

3. Termination.

a. Material Breach. A breach by BA of any provision of this BAA, as determined by CE, shall constitute a material breach of the Agreement and this BAA and shall provide grounds for immediate termination of the Agreement and this BAA, any provision in the AGREEMENT to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii).]

b. Judicial or Administrative Proceedings. CE may terminate the Agreement and this BAA, effective immediately, if (i) BA is named as defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. Effect of Termination. Upon termination of the Agreement and this BAA for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of Section 2 of this BAA to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

d. Civil and Criminal Penalties. BA understands and agrees that it is subject to civil or criminal penalties applicable to BA for unauthorized use, access or disclosure or Protected Information in accordance with the HIPAA Regulations and the HITECH Act including, but not limited to, 42 U.S.C. 17934 (c).

e. Disclaimer. CE makes no warranty or representation that compliance by BA with this BAA, HIPAA, the HITECH Act, or the HIPAA Regulations or corresponding California law provisions will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

4. Amendment to Comply with Law.

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the updated standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable state or federal laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

5. Reimbursement for Fines or Penalties.

In the event that CE pays a fine to a state or federal regulatory agency, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible access, use or disclosure of PHI by BA or its subcontractors or agents, then BA shall reimburse CE in the amount of such fine or penalties or damages within thirty (30) calendar days from City's written notice to BA of such fines, penalties or damages.

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APPENDIX B

San Francisco Department of Public Health

Business Associate Agreement

Attachment 1 – SFDPH Privacy Attestation, version 06-07-2017
Attachment 2 – SFDPH Data Security Attestation, version 06-07-2017

Office of Compliance and Privacy Affairs
San Francisco Department of Public Health
101 Grove Street, Room 330, San Francisco, CA 94102
Email: compliance.privacy@sfdph.org
Hotline (Toll-Free): 1-855-729-6040

DocuSign Envelope ID: 0546FA00-1F32-48FE-8047-1B9AEDCF19D5

Contractor Name:		Contractor City Vendor ID	

PRIVACY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions below in Section IV on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…	Yes	No*
A	Have formal Privacy Policies that comply with the Health Insurance Portability and Accountability Act (HIPAA)?		
B	Have a Privacy Officer or other individual designated as the person in charge of investigating privacy breaches or related incidents?		
	If yes: Name & Title:		
	Phone #:		
	Email:		
C	Require health information Privacy Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH privacy training materials are available for use; contact OCPA at 1-855-729-6040.]		
D	Have proof that employees have signed a form upon hire and annually thereafter, with their name and the date, acknowledging that they have received health information privacy training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]		
E	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?		
F	Assure that staff who create, or transfer health information (via laptop, USB/thumb-drive, handheld), have prior supervisorial authorization to do so **AND** that health information is **only transferred or created on encrypted devices approved by SFDPH Information Security staff**?		

II. Contractors who serve patients/clients and have access to SFDPH PHI, must also complete this section.

	If Applicable: DOES YOUR ORGANIZATION…	Yes	No*
G	Have (or will have if/when applicable) evidence that SFDPH Service Desk (628-206-SERV) was notified to de-provision employees who have access to SFDPH health information record systems within 2 business days for regular terminations and within 24 hours for terminations due to cause?		
H	Have evidence in each patient's / client's chart or electronic file that a Privacy Notice that meets HIPAA regulations was provided in the patient's / client's preferred language? (English, Cantonese, Vietnamese, Tagalog, Spanish, Russian forms may be required and are available from SFDPH.)		
I	Visibly post the Summary of the Notice of Privacy Practices in all six languages in common patient areas of your treatment facility?		
J	Document each disclosure of a patient's/client's health information for purposes other than treatment, payment, or operations?		
K	When required by law, have proof that signed authorization for disclosure forms (that meet the requirements of the HIPAA Privacy Rule) are obtained PRIOR to releasing a patient's/client's health information?		

III. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Privacy Officer or designated person	Name: (print)		Signature		Date	

IV. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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Contractor Name:		Contractor City Vendor ID	

DATA SECURITY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions in Section III below on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…	**Yes**	**No***
A	Conduct assessments/audits of your data security safeguards to demonstrate and document compliance with your security policies and the requirements of HIPAA/HITECH at least every two years? [Retain documentation for a period of 7 years]		
B	Use findings from the assessments/audits to identify and mitigate known risks into documented remediation plans?		
	Date of last Data Security Risk Assessment/Audit:		
	Name of firm or person(s) who performed the Assessment/Audit and/or authored the final report:		
C	Have a formal Data Security Awareness Program?		
D	Have formal Data Security Policies and Procedures to detect, contain, and correct security violations that comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)?		
E	Have a Data Security Officer or other individual designated as the person in charge of ensuring the security of confidential information?		
	If yes: Name & Title:		Phone #:		Email:
F	Require Data Security Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH data security training materials are available for use; contact OCPA at 1-855-729-6040.]		
G	Have proof that employees have signed a form upon hire and annually, or regularly, thereafter, with their name and the date, acknowledging that they have received data security training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]		
H	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?		
I	Have (or will have if/when applicable) a diagram of how SFDPH data flows between your organization and subcontractors or vendors (including named users, access methods, on-premise data hosts, processing systems, etc.)?		

II. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Data Security Officer or designated person	Name: (print)		Signature		Date	

III. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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City and County of San Francisco
San Francisco Department of Public Health
Emergency Medical Services Division
90 Van Ness Avenue
San Francisco, California 94102

Agreement between the City and County of San Francisco, acting by and through its Department of Public Health and NORCAL Ambulance

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This emergency Service Provider Agreement ("SPA") is made this 1st day of July, 2020 in the City and County of San Francisco, State of California, by and between NORCAL Ambulance ("Provider") and the City and County of San Francisco, acting by and through its Depaartment of Public Health.

Recitals

WHEREAS, the San Francisco Department of Public Health is the designated local Emergency Medical Services Agency ("LEMSA") for the City and County of San Francisco, under California Health and Safety Code Section 1797.200; and

WHEREAS, Provider possesses all requisite LEMSA approvals to participate in the LEMSA Emergency Medical Services ("EMS") system, including a current and valid Certificate of Operation and when necessary an Ambulance Permit, in accordance with San Francisco Health Code Article 14; and

WHEREAS, the San Francisco Emergency Medical Services Plan authorizes Provider to provide Advanced Life Support ("ALS"), Basic Life Support ("BLS"), and/or Special Ambulance Services within the LEMSA EMS service area; and

WHEREAS, California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168(b)(4), requires that authorized paramedic service Providers have a written service provider agreement ("SPA") with the LEMSA allowing the Provider to participate in the LEMSA EMS system and obligating the Provider to comply with all State regulations and local policies and procedures, including participation in the LEMSA's Emergency Medical Services Quality Improvement Program ("EMSQIP"); and

WHEREAS, the Parties wish to enter into this written SPA in compliance with Section 100168(b)(4), when required, or otherwise as required by the LEMSAs;

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this SPA:

1.1. **"Advanced Life Support (ALS)**" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency department or other medical staff of that hospital, as defined by California Health and Safety Code, Division 2.5, Section 1797.52, including the scope of practice of Paramedic as listed in Section 1797.52 and any LEMSA approved Local Optional Scope of Practice.

1.2. **"ALS Ground Ambulance Services"** means the provision of advanced life support services provided in an ambulance by an authorized ALS Provider pursuant to a Service Provider Agreement (SPA) consistent with the California Health and Safety Code, Division 2.5, Section 1797.52 and LEMSA policies and procedures.

1.3. **"Ambulance Permit"** means a permit issued by LEMSA's Medical Director for an ambulance or routine medical transport vehicle pursuant to the San Francisco Health Code, Article 14. This permit is required to operate an ambulance or routine medical transport vehicle within the City and County of San Francisco.

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1.4. **"Authorized ALS Ambulance Provider"** means an ambulance Provider that is authorized to provide ALS ambulance services within the City pursuant to a Service Provider Agreement with the LEMSA.

1.5. **"Basic Life Support (BLS)"** means emergency first aid and cardiopulmonary resuscitation procedures, which at a minimum, include: recognizing respiratory arrest and application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim can be transported or until advanced life support is available, as defined by California Health and Safety Code, Division 2.5, Section 1797.60, including the basic scope of practice as listed in Section 1797.60 and any LEMSA approved Local Optional Scope of Practice.

1.6. **"Authorized BLS Ambulance Provider"** means an ambulance Provider that is authorized, staffed and equipped to provide basic life support in full compliance with the California Health and Safety Code, Division 2.5, Section 1797.60, all regulations of the State of California, the City Ambulance Ordinance, and LEMSA Policies, Procedures and Protocols.

1.7. **"Certificate of Operation"** means a Certificate issued under San Francisco Health Code Article 14 by the LEMSA Medical Director to a Provider who qualifies to operate an ambulance in the City. To qualify for a Certificate of Operation, the Provider must hold three valid and current Ambulance Permits.

1.8. **"Confidential Information"** means confidential City information including, but not limited to, personally-identifiable information ("PII"), protected health information ("PHI'), or individual financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.9. **"Emergency Medical Personnel"** means all public safety first responders, Emergency Medical Dispatchers, EMTs and EMT-Ps functioning within the emergency medical services system.

1.10. **"Emergency Medical Services Quality Improvement Program (EMSQIP)"** means the continuing quality improvement program, procedures and protocol documents developed by the LEMSA.

1.11. **"Emergency Medical Technician (EMT)"** means an individual trained in all facets of basic life support according to standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.80, and who has a valid certification issued pursuant to said division and local training as required by LEMSA.

1.12. **"Emergency Medical Technician – Paramedic (EMT-P)"** means an individual whose scope of practice is to provide advanced life support governed by standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.84, and who has a valid license issued pursuant to said division and local accreditation as required by LEMSA.

1.13. **"Facility"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is physically present and assessed the patient's need for LEMSA.

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1.14. **"Ground Ambulance Services"** means all ambulance services performed at the request of and determined to be either a Code Two or Code Three level response by an Authorized LEMSA Dispatch Center.

1.15. **"LEMSA Medical Director"** means the San Francisco Director of Health, responsible for the duties set forth in California Health and Safety Code, Division 2.5, Section 1797.202.

1.16. **"Medical Emergency"** means the term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by public safety personnel or Emergency Medical Personnel at the scene of an emergency or dispatch personnel at a designated LEMSA Dispatch Center.

1.17. "**Medical Record**" means all patient care interaction and assessment data collected and/or generated by Provider and included in Provider's electronic medical record system, including but not limited to a record of a patient's medical information (such as medical history, care or treatments received, test results, diagnoses, and medications taken).

1.18. **"National Incident Management System (NIMS)"** means the incident management system developed by the US Department of Homeland Security, FEMA, as required by Homeland Security Presidential Directive 5 (HSPD-5).

1.19. **"Primary Public Safety Answering Point (PSAP)"** means the location where the 911 call is first answered.

1.20. **"Provider Program Director"** means the Medical Director of the Provider.

1.21. **"Response Codes"** means the dispatch term which denotes the level of priority for units responding to the scene as defined herein:

a) **Code One** - Routine or schedule transportation of patients.
b) **Code Two** - A non-life threatening Medical Emergency requiring immediate response.
c) **Code Three** - A Medical Emergency requiring immediate response with red light and siren.

1.22. **"Services"** means the provision of any and all services under this SPA.

1.23. **"Site"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is NOT physically present and has NOT assessed the patient's need for LEMSA.

1.24. **"Special Ambulance Service"** means any unit-type, providing Emergency Medical Services and patient care that can be dispatched to a medical call without the ability to provide patient transport.

1.25. **"Standardized Emergency Management System (SEMS)**" means the standardized emergency management system identified in California Government Code, Section 8607.

Article 2 Term of the Agreement

2.1 **Initial Term.**

The term of this SPA shall commence on July 1, 2020 and expire five years later on June 30, 2025, unless earlier terminated as otherwise provided herein.

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2.2 Renewal of SPA.

This SPA shall auto-renew for four additional one-year periods upon Provider's payment of all required Certificate of Operation and/or Ambulance Permit fees and conditioned on Provider's compliance with all Certificate of Operation and Ambulance Permit requirements. The renewed SPA shall automatically terminate should Provider fail to pay all required Certificate of Operation and/or Ambulance Permit fees.

Article 3 Audit

3.1 Audit and Inspection of Records.

Provider agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate books and records, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227). Provider will permit City to audit, examine and make excerpts and transcripts from such books and records related to all matters covered by this SPA. Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the local EMS agency. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider. To the extent required by applicable law or regulation, the State of California or any Federal agency having an interest in the subject matter of this SPA shall have the same rights as conferred upon City by this Section.

Article 4 Services and Resources

4.1 Provider Shall Obtain All Necessary Permits and/or Approvals.

4.1.1 Provider shall not commence the provision of any services under this SPA until all necessary permits and/or approvals have been issued. Specifically, before commencing work, Provider shall apply for and obtain from LEMSA a Certificate of Operation and when required an Ambulance Permit, and/or all other required regulatory permits and/or approvals in accordance with applicable law, including California Code of Regulations Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic); California Health and Safety Code, Division 2.5 (Emergency Medical Services); and San Francisco Health Code, Article 14 (Ambulances and Routine Medical Transport Vehicles). Nothing in this SPA is intended to imply that City will issue any permits and/or approvals.

4.1.2 Provider shall pay all fees required as a condition precedent to the issuance of any such permits and/or approvals in accordance with the applicable rates and charges then in effect as indicated in LEMSA's fee schedule. The payments made by Provider to City shall be less than or equal to the City's actual costs to provide the LEMSA administration and oversight services. No funds shall be used by the City in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute. .

4.2 Services Provider Agrees to Perform.

Provider agrees to perform the services detailed in Appendix A, "Statement of Work." Officers and employees of the City are not authorized to request services beyond the scope listed in Appendix A.

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4.3 **Qualified Personnel.**

Provider shall ensure all Emergency Medical Personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of Provider services.

4.4 **Subcontracting.**

Excluding services for 9-1-1 calls, Provider may subcontract services to be performed under this SPA to other San Francisco LEMSA permitted service providers. For clarity 9-1-1 services may not be subcontracted.

4.5 **Assignment.**

The services to be performed by Provider are personal in character. Neither this SPA, nor any duties or obligations hereunder, may be directly or indirectly assigned, novated, transferred, or delegated by Provider. Any purported Assignment made in violation of this provision shall be null and void.

4.6 **No Transfer of Certificate of Operation or Ambulance Permit.**

Each Certification of Operation and/or Ambulance Permit by the LEMSA is a privilege that is personal and specific to Provider. Neither a Certificate of Operation, an Ambulance Permit, nor any of the privileges conferred thereunder may be neither sold, conveyed, assigned, encumbered, nor otherwise transferred by Provider. Any attempt to sell, convey, assign, encumber or otherwise transfer a Certificate of Operation, any Ambulance Permit, or the privileges conferred thereunder may result in the City's termination of this SPA.

4.7 **Activities at Permittee's Expense.**

Any act that Provider performs under this SPA or applicable law shall be performed at Provider's expense and without cost to City, unless said Provider is a City agency or employee providing services under this SPA.

4.8 **Warranty.**

Provider warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this SPA as detailed in Appendix A (Statement of Work).

Article 5 Insurance and Indemnity (RESERVED FOR SFFD)

5.1 **Insurance.**

5.1.1 **Required Coverages.** Without in any way limiting Provider's liability pursuant to the "Indemnification" section of this SPA, Provider must maintain in force, during the full term of the SPA, insurance in the following amounts and coverages:

(a) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness; and

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(b) Commercial General Liability Insurance with limits not less than $10,000,000 each occurrence and $20,000,000 general aggregate for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; and

(c) Commercial Automobile Liability Insurance with limits not less than $10,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(d) Professional liability insurance, applicable to Provider's profession, with limits not less than $10,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services.

(e) Technology Errors and Omissions Liability coverage (RESERVED).

(f) Cyber and Privacy Insurance with limits of not less than $5,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.

(g) Provider shall be permitted to use umbrella or excess coverage to meet the required limits for insurance in this section.

5.1.2 Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to provide:

(a) Name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

(b) That such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this SPA, and that insurance applies separately to each insured against whom claim is made or suit is brought.

5.1.3 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

5.1.4 Should any of the required insurance be provided under a claims-made form, Provider shall maintain such coverage continuously throughout the term of this SPA and, without lapse, for a period of three years beyond the expiration of this SPA, to the effect that, should occurrences during the contract term give rise to claims made after expiration of the SPA, such claims shall be covered by such claims-made policies.

5.1.5 Should any of the required insurance be provided under a form of coverage that includes a general annual aggregate limit or provides that claims investigation or legal defense costs be included in such general annual aggregate limit, such general annual aggregate limit shall be double the occurrence or claims limits specified above.

5.1.6 Should any required insurance lapse during the term of this SPA, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this SPA, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this SPA effective on the date of such lapse of insurance.

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5.1.7 Before commencing any Services, Provider shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in form evidencing all coverages set forth above. Approval of the insurance by City shall not relieve or decrease Provider's liability hereunder.

5.1.8 The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Provider, its employees, agents and subcontractors.

5.1.9 If Provider will use any subcontractor(s) to provide Services, Provider shall require the subcontractor(s) to provide all necessary insurance and to name the City and County of San Francisco, its officers, agents and employees and the Provider as additional insureds.

5.1.10 City may, in its sole discretion, choose to reconsider the amounts and coverages above and require amendment of this SPA to update such amounts and coverages during the term of the SPA. Provider's execution of an amendment to this SPA to put changes to these amounts and coverages in effect shall not be withheld.

5.2 **General Indemnification.**

5.2.1 Provider shall indemnify and save harmless City and its officers, agents and employees from, and, if requested, shall defend them against any and all third party claims for loss, cost, damage, injury, liability, and claims thereof for injury to or death of a person (including but not limited to patient and/or patient's relative's claims for damages arising from medical malpractice), or loss of or damage to property, arising directly or indirectly from Provider's performance of this SPA, except to the extent that such indemnity is void or otherwise unenforceable under applicable law in effect on or validly retroactive to the date of this SPA and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City, in which case damages will be apportioned under the California doctrine of comparative fault. The foregoing indemnity shall include, without limitation, reasonable fees of attorneys, consultants and experts and related third party costs that the City necessarily incurs.

5.2.2 In addition to Provider's obligation to indemnify City, Provider specifically acknowledges and agrees that it has an immediate and independent obligation to defend City from any claim which actually or potentially falls within this indemnification provision, while such claim is in effect, even if the allegations are or may be groundless, false or fraudulent, which obligation arises at the time such claim is tendered to Provider by City and continues at all times thereafter.

5.3 **Infringement Indemnification.**

Provider shall indemnify and hold the City harmless from all third party claims, loss and liability, including attorneys' fees, court costs and all other litigation expenses for any infringement of United States patent rights, or any copyright, trade secret or any other proprietary right or trademark, and all other intellectual property claims of any person or persons, arising directly or indirectly from Provider's performance of this SPA.

Article 6 Liability of the Parties

6.1 **City's Liability Limit. (RESERVED)**

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6.2 Liability for Incidental and Consequential Damages. (RESERVED)

6.3 Liability for Use of Equipment.

City shall not be liable for any damage to persons or property as a result of the misuse of equipment used by Provider, or by any of their employees, even though such equipment is furnished, rented or loaned by City.

Article 7 Payment of Taxes (RESERVED FOR SFFD)

7.1 Provider Shall Collect and Remit Taxes.

Where required under applicable law, Provider shall collect and remit to City all applicable taxes in compliance with the City's Business and Tax Regulations Code. Provider shall provide such records to City as City may require to confirm its compliance with these requirements.

7.2 Possessory Interest Tax.

Provider understands that this SPA may create a possessory interest subject to property taxation and that Provider may be subject to the payment of such taxes.

Article 8 Termination and Default

8.1 Termination for Convenience

8.1.1 **City**. The City shall have the option, in its sole discretion, to terminate this SPA, at any time during the term hereof, for convenience and without cause. City shall exercise this option by giving Provider ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective.

8.1.2 **Provider.** Provider shall have the option, in its sole discretion, to terminate this SPA, at any time during the term hereof, for convenience and without cause. Provider shall exercise this option by giving City ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective.

8.2 Probation, Suspension, and/or Termination for Default; Remedies.

The City may terminate this SPA for material breach by Provider, including but not limited to, as detailed in the LEMSA's "Pre-Hospital Provider Standards" policy. Failure to comply with the terms of this SPA, local policies and protocols, and all applicable laws and regulations as determined by the LEMSA, may result in probation, suspension, or termination of Provider's authorization to operate in the LEMSA EMS service area. In the event that Provider defaults in the performance of any duties or obligations hereunder and the default or breach has not been cured within thirty (30) calendar days of receipt of written notice of default, such failure shall be cause for the LEMSA to effect any of the following, acting in its sole discretion: Revocation of Provider's Certificate of Operation and/or Ambulance Permit; placing Provider on probation with a LEMSA approved corrective action plan; suspension of Provider's Services under this Agreement; and/or termination of this Agreement.

8.3 Non-Waiver of Rights.

The omission by the City at any time to enforce any default or right reserved to it, or to require performance of any of the terms, covenants, or provisions hereof by Provider at the time designated, shall

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not be a waiver of any such default or right to which the City is entitled, nor shall it in any way affect the right of the City to enforce such provisions thereafter.

8.4 Rights and Duties upon Termination or Expiration.

This Section and the following Sections of this SPA listed below, shall survive termination or expiration of this SPA:

Article 3	Audit
Article 5	Insurance and Indemnity
Article 6	Liability of Parties
Article 7	Payment of Taxes
Article 11	General Provisions
Article 13	Data and Security

Subject to the survival of the Sections identified above, if this SPA is terminated prior to expiration of the term specified in Article 2, this SPA shall be of no further force or effect.

Article 9 Rights In Deliverables (RESERVED)

Article 10 Additional Requirements Incorporated by Reference (RESERVED FOR SFFD)

10.1 Laws Incorporated by Reference.

Provider represents and warrants that it will comply with all applicable laws and regulations in performing the Services. Subject to the foregoing, the full text of the laws listed in this Article 10, including enforcement and penalty provisions, are incorporated by reference into this SPA. The full text of the San Francisco Municipal Code provisions incorporated by reference in this Article and elsewhere in the SPA ("Mandatory City Requirements") are available at http://www.amlegal.com/codes/client/san-francisco_ca/

10.2 Conflict of Interest.

By executing this SPA, Provider certifies that it does not know of any fact which constitutes a violation of Section 15.103 of the City's Charter; Article III, Chapter 2 of City's Campaign and Governmental Conduct Code; Title 9, Chapter 7 of the California Government Code (Section 87100 *et seq.*), or Title 1, Division 4, Chapter 1, Article 4 of the California Government Code (Section 1090 *et seq.*), and further agrees promptly to notify the City if it becomes aware of any such fact during the term of this SPA.

10.3 Consideration of Salary History.

Provider shall comply with San Francisco Administrative Code Chapter 12K, the Consideration of Salary History Ordinance or "Pay Parity Act." Provider is prohibited from considering current or past salary of an applicant in determining whether to hire the applicant or what salary to offer the applicant to the extent that such applicant is applying for employment to be performed on this SPA or in furtherance of this SPA, and whose application, in whole or part, will be solicited, received, processed or considered, whether or not through an interview, in the City or on City property. The ordinance also prohibits employers from (1) asking such applicants about their current or past salary or (2) disclosing a current or former employee's salary history without that employee's authorization unless the salary history is publicly available. Provider is subject to the enforcement and penalty provisions in Chapter 12K. Information about and the text of Chapter 12K is available on the web at https://sfgov.org/olse/consideration-salary-history. Provider

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is required to comply with all of the applicable provisions of 12K, irrespective of the listing of obligations in this Section.

10.4 Nondiscrimination Requirements

Provider does not as of the date of this SPA, and will not during the term of this SPA, in any of its operations in San Francisco, on real property owned by San Francisco, or where work is being performed for the City elsewhere in the United States, discriminate against an applicant for employment because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition, marital status, or citizenship, or otherwise, including in the provision of employee benefits between employees with domestic partners and employees with spouses and/or between the domestic partners and spouses of such employees, subject to the conditions set forth in San Francisco Administrative Code Section12B.2.

10.5 Minimum Compensation Ordinance.

Provider shall pay covered employees no less than the minimum compensation required by San Francisco Administrative Code Chapter 12P, including a minimum hourly gross compensation, compensated time off, and uncompensated time off. Provider is subject to the enforcement and penalty provisions in Chapter 12P. Information about and the text of the Chapter 12P is available on the web at http://sfgov.org/olse/mco. Provider is required to comply with all of the applicable provisions of 12P, irrespective of the listing of obligations in this Section. By signing and executing this SPA, Provider certifies that it is in compliance with Chapter 12P.

10.6 Health Care Accountability Ordinance.

Provider shall comply with San Francisco Administrative Code Chapter 12Q. For each Covered Employee, Provider shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Provider chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission. Information about and the text of the Chapter 12Q, as well as the Health Commission's minimum standards, is available on the web at http://sfgov.org/olse/hcao. Provider is subject to the enforcement and penalty provisions in Chapter 12Q. Any Subcontract entered into by Provider shall require any Subcontractor with 20 or more employees to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section.

10.7 Alcohol and Drug-Free Workplace.

City reserves the right to deny access to, or require Provider to remove from performance of services under this SPA personnel of any Provider who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing, selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this SPA "controlled substance" includes cannabis and derivative products.

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10.8 Consideration of Criminal History in Hiring and Employment Decisions

10.8.1 Provider agrees to comply fully with and be bound by all of the provisions of Chapter 12T, "City Provider/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions," of the San Francisco Administrative Code ("Chapter 12T"), including the remedies provided, and implementing regulations, as may be amended from time to time. The provisions of Chapter 12T are incorporated by reference and made a part of this SPA as though fully set forth herein. The text of the Chapter 12T is available on the web at http://sfgov.org/olse/fco. Provider is required to comply with all of the applicable provisions of 12T, irrespective of the listing of obligations in this Section. Capitalized terms used in this Section and not defined in this SPA shall have the meanings assigned to such terms in Chapter 12T.

10.8.2 The requirements of Chapter 12T shall only apply to a Provider's or Subcontractor's operations to the extent those operations are in furtherance of the performance of this SPA, shall apply only to applicants and employees who would be or are performing work in furtherance of this SPA, and shall apply when the physical location of the employment or prospective employment of an individual is wholly or substantially within the City of San Francisco. Chapter 12T shall not apply when the application in a particular context would conflict with federal or state law or with a requirement of a government agency implementing federal or state law.

10.9 Food Service Waste Reduction Requirements.

Provider shall comply with the Food Service Waste Reduction Ordinance, as set forth in San Francisco Environment Code Chapter 16, including but not limited to the remedies for noncompliance provided therein.

10.10 Distribution of Beverages and Water. (RESERVED)

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this SPA, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

To City:	Andrew Holcomb, MS, EMS Manager, San Francisco EMS Agency City and County of San Francisco 90 Van Ness Ave, San Francisco, CA 94102 415-487-5018 andrew.holcomb@sfdph.org
To Provider:	Danielle Johnstone Operations Manager NORCAL Ambulance 3049 Independence Dr Suite I Livermore CA 94551 Djohnstone@norcalambulance.com

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

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11.2 **Compliance with Americans with Disabilities Act.**

Provider shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 **Reserved.**

11.4 **Sunshine Ordinance.**

Provider acknowledges that this SPA and all records related to its formation, Provider's performance of Services, and City's payment are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.5 **Modification of this SPA.**

This SPA may not be modified, nor may compliance with any of its terms be waived, except as noted in Section 11.1, “Notices to Parties,” except by written instrument executed by the Parties and approved in the same manner as this SPA.

11.6 **Dispute Resolution Procedure.**

11.6.1 The Parties will attempt in good faith to resolve any dispute or controversy arising out of or relating to the performance of services under this SPA in accordance with the LEMSA’s “Pre-Hospital Provider Standards” policy.

11.6.2 During the course of any Dispute Resolution process, Provider shall comply with all directives issued by the LEMSA. In the event that the LEMSA identifies a deficiency that LEMSA acting in its sole discretion determines may cause a threat to public health and/or safety, the LEMSA may issue a written probation and/or suspension notice to the Provider. Upon receipt, the Provider shall immediately comply with the terms of that notice. If the notice calls for suspension, Provider shall immediately suspend Services under this SPA until the LEMSA verifies that Provider has implemented all required corrections. Provider’s failure to implement all required corrections as determined by the LEMSA acting in its sole discretion may result in termination of this SPA for default.

11.7 **Government Code Claim Requirement.**

No suit for money or damages may be brought against the City until a written claim therefor has been presented to and rejected by the City in conformity with the provisions of San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq. Nothing set forth in this SPA shall operate to toll, waive or excuse Provider's compliance with the California Government Code Claim requirements set forth in San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq.

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11.8 Agreement Made in California; Venue.

The formation, interpretation and performance of this SPA shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this SPA shall be in San Francisco.

11.9 Construction.

All paragraph captions are for reference only and shall not be considered in construing this SPA.

11.10 Entire Agreement.

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This SPA may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.11 Compliance with Laws.

Provider shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Provider's performance of this SPA, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.12 Severability.

Should the application of any provision of this SPA to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this SPA shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.13 Order of Precedence.

Provider agrees to perform the services described below in accordance with the terms and conditions of this SPA, and the Statement of Work attached as Appendix A. The terms of this SPA are to be read and interpreted together with all other documents, appendices, exhibits, and addenda attached to the SPA as a single agreement.

11.14 Notification of Legal Requests.

Provider shall immediately notify City upon receipt of any subpoenas, service of process, litigation holds, discovery requests and other legal requests ("Legal Requests") related to this SPA, and in no event later than 24 hours after it receives the request.

Article 12 Department Specific Terms

12.1 Third Party Beneficiaries.

No third parties are intended by the parties hereto to be third party beneficiaries under this SPA, and no action to enforce the terms of this SPA may be brought against either party by any person who is not a party hereto.

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12.2 **Exclusion Lists and Employee Verification.**

Upon execution of this SPA and monthly thereafter, Provider will check the exclusion lists published by the Office of the Inspector General (OIG), General Services Administration (GSA), and the California Department of Health Care Services (DHCS) to ensure that any employee, temporary employee, volunteer, consultant, or governing body member responsible for oversight, administering or delivering state or federally-funded services who is on any of these lists is excluded from (may not work in) Provider's program or agency. Proof of checking these lists must be retained for seven years.

Article 13 Data and Security

13.1 **Nondisclosure of Private, Proprietary or Confidential Information.**

13.1.1 If this SPA requires City to disclose "Private Information" to Provider within the meaning of San Francisco Administrative Code Chapter 12M, Provider and subcontractor shall use such information only in accordance with the restrictions stated in Chapter 12M and in this SPA and only as necessary in performing the Services. Provider is subject to the enforcement and penalty provisions in Chapter 12M.

13.1.2 In the performance of Services, Provider may have access to City's proprietary or confidential information, the disclosure of which to third parties may damage City. If City discloses proprietary or confidential information to Provider, such information must be held by Provider in confidence and used only in performing the SPA, except as required by law, professional rule or regulation. Provider shall exercise the same standard of care to protect such information as a reasonably prudent Provider would use to protect its own proprietary or confidential information.

13.2 **Business Associate Agreement.**

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Provider will:

1. ☒ Do **at least one** or more of the following:
A. Create, receive, maintain, or transmit PHI for or on behalf of CITY/SFDPH (including storage of PHI, digital or hard copy, even if Provider does not view the PHI or only does so on a random or infrequent basis); or

B. Receive PHI, or access to PHI, from CITY/SFDPH or another Business Associate of City, as part of providing a service to or for CITY/SFDPH, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or

C. Transmit PHI data for CITY/SFDPH and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

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FOR PURPOSES OF THIS SPA, PROVIDER IS A BUSINESS ASSOCIATE OF CITY/SFDPH, AS DEFINED UNDER HIPAA. PROVIDER MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS SPA AS THOUGH FULLY SET FORTH HEREIN:

a. **Appendix E** SFDPH Business Associate Agreement (BAA) (04-12-2018)
   1. SFDPH Attestation 1 PRIVACY (06-07-2017)
   2. SFDPH Attestation 2 DATA SECURITY (06-07-2017)

2. ☐ **NOT do any of the activities listed above in subsection 1;**
Provider is not a Business Associate of CITY/SFDPH. Appendix E and attestations are not required for the purposes of this SPA.
This option requires review and approval from the Office of Compliance and Privacy Affairs.

13.3 **Protected Health Information.**

Provider and all agents and employees Provider shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Provider by City in the performance of this SPA. Provider agrees that any failure of Contactor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Provider or its subcontractors or agents by City, Provider shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 14 Data and Security

14.1 **City Data**

14.1.1 **Ownership of City Data.** The Parties agree that as between them, all rights, including all intellectual property rights, in and to the City Data and any derivative works of the City Data shall remain the exclusive property of the City.

14.1.2 **Use of City Data**. Nothing herein shall be construed to confer any license or right to the City Data, including user tracking and exception City Data within the system, by implication, estoppel or otherwise, under copyright or other intellectual property rights, to any third-party. Unauthorized use of City Data by Provider.

14.1.3 **Data Breach; Loss of City Data**. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Provider that relate to the protection of the security, confidentiality, or integrity of City Data, Provider shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

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14.1.4 **Data Privacy and Information Security Program.** Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

14.1.5 **Data Transmission.** Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure that all data exchanged shall be used expressly and solely for the purposes stated in the SPA. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this SPA, unless otherwise permitted in this SPA. The Provider shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

Article 15 MacBride And Signature

15.1 MacBride Principles -Northern Ireland.

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this SPA. By signing this SPA, Provider confirms that Provider has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

IN WITNESS WHEREOF, the parties hereto have executed this SPA on the day first mentioned above.

City

San Francisco Department of Public Health

DocuSigned by:
Greg Wagner 7/13/2020 | 12:00:43 PDT
28527524752940F...

Grant Colfax, MD
Director of Health

Provider

NORCAL Ambulance

DocuSigned by:
Danielle Johnstone 7/1/2020 | 2:52:51 PDT
255EA7E7D9524D7...

Danielle Johnstone
Operations Manager

Approved as to Form:

Dennis J. Herrera
City Attorney

By: DocuSigned by:
Louise Simpson 7/7/2020 | 11:22:46 PDT
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Louise S. Simpson
Deputy City Attorney

Appendices

A: Statement of Work
B: Business Associate Agreement

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Appendix A

STATEMENT OF WORK

I. GENERAL REQUIREMENTS FOR APPROVED SERVICE PROVIDER:

Approved service Providers authorized to participate in the LEMSA EMS system shall perform as follows:

(1) (911 Providers, only) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA.

(2) Utilize and maintain telecommunications as specified by the LEMSA.

(3) Maintain medication solution, medical supplies, and equipment inventory as specified by the LEMSA commensurate with the basic and local optional scope of practice of the paramedic and EMT.

(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

1. controlled substance ordering and order tracking;

2. controlled substance receipt and accountability;

3. controlled substance master supply storage, security and documentation;

4. controlled substance labeling and tracking;

5. vehicle storage and security;

6. usage procedures and documentation;

7. reverse distribution;

8. disposal;

9. re-stocking procedures.

(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to;

10. controlled substance testing;

11. discrepancy reporting;

12. tampering, theft and diversion prevention and detection;

13. usage audits.

(5) Be responsible for assessing and ensuring current knowledge of their paramedics and EMTs in local policies, procedures and protocols and for assessing their EMT and/or paramedics' skills competency. Documentation of assessment results shall be made available to the LEMSA.

(6) If, through the EMSQIP the LEMSA Medical Director determines that an EMT and/or paramedic needs additional training, observation or testing, the LEMSA Medical Director may create a specific and targeted program of remediation based upon the identified needs of the EMT and/or paramedic. If there is disagreement between the Provider and the LEMSA Medical Director, the decision of the LEMSA Medical Director shall prevail.

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Provider understands and agrees that the LEMSA may deny, suspend, or revoke the approval of a service Provider for failure to comply with applicable policies, procedures, and regulations.

(7) Provider shall employ a Provider Medical Director who must be approved, in writing, by the LEMSA Medical Director.

II. BENEFITS GRANTED BY LEMSA TO PROVIDER

1. Boundaries:

Provider may provide ALS and/or BLS Ground Ambulance Services based upon a Certification of Operation, within the defined boundaries of the City and County of San Francisco (LEMSA EMS service area), to include Treasure Island, the Golden Gate National Recreational Area, and other Federal property within the contiguous borders of the LEMSA EMS service area, notwithstanding entry restrictions placed by Federal jurisdiction, during the period of this SPA. The ALS and/or BLS Ground Ambulance Services shall include Site to Facility patient transports, as well as Facility to Facility transports, originating from a private request and responses to 9-1-1 calls.

2. Availability of 9-1-1 Ambulances:

a) All 9-1-1 Providers shall ensure a minimum of two ambulances available to the 9-1-1 system twenty-four (24) hours per day, 365 days per year plus ambulance transport may include no more than 5 transports per month to cover unfilled service calls for patients being cared for within the DPH system.

b) Within 90 days after execution of the SPA, and t least annually thereafter, the LEMSA will notify Providers of the minimum overall number of staffed ambulances needed to meet the EMS system demand ("System Demand Analysis")

c) Within 90 days after execution of this SPA, and annually within 90 days of receipt of the System Demand Analysis, each 9-1-1 Provider shall provide their minimum Ambulance Deployment and Staffing Plan to the LEMSA, which shall be binding until receipt of the City's next System Demand Analysis.

d) Immediately upon the commencement of Services under this SPA, each Provider shall provide the LEMSA its daily staffing report.

3. City Facilities (Zuckerberg San Francisco General and Laguna Honda Hospital)

The LEMSA urges all Providers to respond to all Requests for Proposals issued by the San Francisco Department of Public Health for as-needed non-emergency services for Zuckerberg San Francisco General Hospital, Laguna Honda Hospital, the San Francisco Department of Public Health clinics, and other contracted Facilities, as well as urging City Providers to perform inter-Facility transports.

4. SPA Committees:

All Providers shall participate (attend a minimum of 75% of Committee meetings annually, as determined by the LEMSA acting in its sole discretion) in the following SPA Committees which shall be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

a) Emergency Medical Services Advisory Committee

b) Medical Director's Committee

c) Operations Committee

d) Quality Improvement Committee

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e) Trauma Committee

f) STAR Committee

g) Stroke Committee

h) Other Committees determined by the LEMSA

Ambulance Provider membership is listed in LEMSA Policy 1010.

5. Report of ALS Provider Status:

Upon request from any entity, including insurance companies, fiscal intermediaries, and other third party payers, LEMSA will identify currently authorized ALS Providers as an authorized Provider of ALS service, pursuant to California Code of Regulations, Title 22, Section, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

6. Coordination of EMS Mutual Aid Requests:

a) Outgoing 9-1-1 EMS Mutual Aid will be coordinated by the Medical Health Operational Area Coordinator (MHOAC) and will be planned in consultation with the LEMSA to minimize impact on the SF EMS System.

b) Incoming 9-1-1 EMS Mutual Aid assets will be requested by LEMSA through the MHOAC for state and regional resources. These EMS assets will be assigned to appropriate task forces, strike teams, or other assignments as determined necessary by the LEMSA in compliance with the emergency management practices outlined in LEMSA Policies and Protocols.

c) Intra-county mutual aid shall be authorized and requested by the LEMSA when the 9-1-1/PSAP generated demand exceeds, or is anticipated to exceed, the capacity of the 9-1-1/PSAP authorized ALS Providers, as determined by the LEMSA.

7. Non-Transport Treatment Fee:

The San Francisco Fire Department is authorized by local ordinance to charge a fee for on-scene treatment without a transport to a hospital. King-American Ambulance Company and American Medical Response West are authorized to charge a non-transport fee in an amount sufficient to cover the reasonable cost of this service and is agreed upon by the LEMSA.

III. OBLIGATIONS OF PROVIDER

1. Mutual Aid:

LEMSA may request mutual aid EMS resources during situations requiring additional EMS resources. Provider may provide resources, at the request of the LEMSA, in such numbers and durations as determined to be in the interest of the LEMSA**.**

2. Automatic Aid Provision:

With approval of the LEMSA, Providers may dispatch up to five ambulances and one paramedic supervisor (known as an Ambulance Strike Team), to a request for immediate aid from any geopolitical entity in California, upon approval of the appropriate manager from that Provider. The Provider shall notify the LEMSA once they have deployed single assets or an Ambulance Strike Team so that system adjustments may be made, if necessary.

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3. Performance Standards

a) Provider shall adhere to all requirements of state laws and regulations pertaining to the provision of EMS.

b) Provider shall adhere to City laws as set forth in San Francisco Health Code Articles 3 and 14, including any and all amendments thereto, if any, whether enacted before or during the term of this SPA and any extensions.

c) Provider shall adhere to all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d) Provider shall use the SEMS and the NIMS in the performance of all emergency services rendered under this SPA.

4. Document Review and Retention

a) All records maintained pursuant to this SPA, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227) shall be available for inspections, audit, or examination by LEMSA or by their designated representatives, consistent with federal, state and local confidentiality and privacy laws, and shall be preserved by Provider for at least three (3) years from the termination of this SPA.

b) All patient contacts, treatments, and interactions shall be documented by Provider, and, if a patient is transported to a Facility, sent with the patient to the Facility.

c) Upon execution of this SPA, Providers shall provide LEMSA and/or LEMSA's third-party designee an unfiltered and unaltered data stream and full access to each patient's Medical Record and Computer Aided Dispatch ("CAD") (California Health & Safety Code Section 1797.227). Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the LEMSA. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider.

d) Upon LEMSA request, Provider shall prepare and submit written reports on incidents based on Services provided under this SPA.

e) Provider shall submit monthly operation reports to the LEMSA, by the last day of the following month, in a form prescribed by the LEMSA.

f) Provider shall provide additional information and reports as requested by the LEMSA to monitor Provider performance, including but not limited to reports regarding response intervals, staffing, skilled intervention and/or performance reports, core measures reports/data, policy compliance reports, case reviews, continuing education, and/or others as required by the LEMSA acting in its sole discretion..

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5. Disaster Preparedness

a) Provider shall annually participate in a least one system-wide discussion based exercise and one system-wide functional exercise per calendar year to benefit coordination among Providers, the EMS system, and LEMSA, as determined by the LEMSA Medical Director.

b) Provider shall ensure staff, with appropriate authority to act on the behalf of Provider, are present in the City's Emergency Operations Center (EOC) when requested by LEMSA during activations or exercises involving Provider.

6. Incident Reporting

Provider shall file or caused to be filed, an Incident Report form consistent with LEMSA Policy in each instance as required by the LEMSA within timeframe reporting requirements as set forth in LEMSA policies.

7. Inspection Standards

Parties acknowledge and agree that inspection standards are governed by San Francisco Health Code Article 14, or any successor provisions.

8. Field Personnel Communication Standards

a) Provider shall post LEMSA notices and bulletins at all employee locations.

b) Provider shall require, through written policy, all personnel to have knowledge of, and follow, LEMSA Policies, Procedures and Protocols, and Directives.

c) Provider shall:

i. Ensure and assess that all EMT's and EMT-P's are trained in LEMSA policies, procedures, and protocols. Such training shall include cognitive, motor and retention skills that allow employees to properly perform EMS duties; and

ii. Provide at each Provider location, in a location easily accessible to employees, a current LEMSA Policy and Procedure Manual and Protocol Manual.

iii. Submit compliance reports quarterly to the LEMSA.

9. Fatigue Prevention

a) Provider shall develop and implement policies acceptable to LEMSA to minimize fatigue by EMT-Ps and EMTs.

b) Provider shall comply with California Code of Regulations Title 13, Section 1105 (e), which states: Driver Conditions: No person shall drive or be directed to drive an ambulance, when his/her ability to operate the ambulance safely is adversely affected by fatigue, illness or other cause nor when the vehicle is unsafe to operate.

c) Provider has informed, and agrees to continue to inform, employees of the regulation and will not retaliate against those complaining of fatigue, illness, or other cause that may affect that employee's ability to operate an ambulance safely.

10. Protected Patient Information

Provider shall comply with all federal and state patient privacy laws, and shall have and enforce a policy that prohibits Provider's employees from inappropriate sharing of protected patient

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information to include sharing via personal communication devices, social media, and any other form of data transmission.

11. Prohibition on Alcohol and Drug Use

Provider shall have and enforce a policy that prohibits Provider's employees from performing any ALS or BLS service under the influence of any alcoholic beverage, illegal drug, or narcotic. In addition, said policy shall prohibit Provider's employees from performing such services under the influence of any other substances, including prescription or non-prescription medication, which impairs their physical or mental performance.

12. Reporting of EMT and EMT-Paramedic Violations

Provider shall comply fully and timely with the reporting requirements of California Health and Safety Code Section, Division 2.5, Sections 1798.200, 1799.112, and LEMSA policies and protocols. Provider shall notify the LEMSA Medical Director within 24 hours when an allegation has been validated as a potential violation of 1798.200. Supporting documentation shall be provided within 72 hours. Notification shall be made to the LEMSA within 24 hours if an EMT and/or EMT-P is removed from patient care or resigns for an investigation based on evidence for disciplinary cause or reason.

16. LEMSA Emergency Medical Services Quality Improvement Program

Provider must participate in the LEMSA's EMSQIP as required by California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

17. Infection Control, Health and Safety:

a) Provider must have a Bloodborne Pathogen (BBP) Exposure Control plan for its employees, agents and subcontractors as defined in the California Code of Regulations, Title 8, Section 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and recordkeeping.

b) Provider must demonstrate personnel policies/procedures for protection of its employees, agents, subcontractors and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

c) Provider must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

d) Provider is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

e) Provider shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

f) Provider shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

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g) Provider assumes responsibility for procuring all medical equipment and supplies for use by its employees, agents and subcontractors, including safe needle devices, and provides and documents all appropriate training.

h) Provider shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

18. Aerosol Transmissible Disease Program, Health and Safety:

Provider must have an Aerosol Transmissible Disease (ATD) Program as defined in the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases (http://www.dir.ca.gov/Title8/5199.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, screening procedures, source control measures, use of personal protective equipment, referral procedures, training, immunization, post-exposure medical evaluations/follow-up, and recordkeeping.

19. Regional Training

Provider shall designate a minimum of one dedicated part-time staff member, hours based on need, to participate in LEMSA's regional training program to develop, teach, and implement consistent and quality prehospital education based upon LEMSA strategic objectives and quality improvement initiatives.

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APPENDIX B

San Francisco Department of Public Health

Business Associate Agreement

As applicable, this Business Associate Agreement ("BAA") supplements and is made a part of the contract by and between the City and County of San Francisco, the Covered Entity ("CE"), and Contractor, the Business Associate ("BA") (the "Agreement"). To the extent that the terms of the Agreement are inconsistent with the terms of this BAA, the terms of this BAA shall control.

RECITALS

A. CE, by and through the San Francisco Department of Public Health ("SFDPH"), wishes to disclose certain information to BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI") (defined below).

B. For purposes of the Agreement, CE requires Contractor, even if Contractor is also a covered entity under HIPAA, to comply with the terms and conditions of this BAA as a BA of CE.

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws, including, but not limited to, California Civil Code §§ 56, et seq., California Health and Safety Code § 1280.15, California Civil Code §§ 1798, et seq., California Welfare & Institutions Code §§5328, et seq., and the regulations promulgated there under (the "California Regulations").

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this BAA.

E. BA enters into agreements with CE that require the CE to disclose certain identifiable health information to BA. The parties desire to enter into this BAA to permit BA to have access to such information and comply with the BA requirements of HIPAA, the HITECH Act, and the corresponding Regulations.

In consideration of the mutual promises below and the exchange of information pursuant to this BAA, the parties agree as follows:

1. Definitions.

a. Breach means the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information, and shall have the meaning given to such term under the HITECH Act and HIPAA Regulations [42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402], as well as California Civil Code Sections 1798.29 and 1798.82.

b. Breach Notification Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.

c. Business Associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information received from a covered entity, but other than in the capacity of a member of the workforce of such covered entity or arrangement, and shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

d. Covered Entity means a health plan, a health care clearinghouse, or a health care provider who transmits any information in electronic form in connection with a transaction covered under HIPAA Regulations, and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

e. Data Aggregation means the combining of Protected Information by the BA with the Protected Information received by the BA in its capacity as a BA of another CE, to permit data analyses that relate to the health care operations of the respective covered entities, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. Designated Record Set means a group of records maintained by or for a CE, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. Electronic Protected Health Information means Protected Health Information that is maintained in or transmitted by electronic media and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103. For the purposes of this BAA, Electronic PHI includes all computerized data, as defined in California Civil Code Sections 1798.29 and 1798.82.

h. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

i. Health Care Operations shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

j. Privacy Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. Protected Health Information or PHI means any information, including electronic PHI, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Sections 160.103 and 164.501. For the purposes of this BAA, PHI includes all medical information and health insurance information as defined in California Civil Code Sections 56.05 and 1798.82.

l. Protected Information shall mean PHI provided by CE to BA or created, maintained, received or transmitted by BA on CE's behalf.

m. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. Security Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. Unsecured PHI means PHI that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute, and shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. Obligations of Business Associate.

a. Attestations. Except when CE's data privacy officer exempts BA in writing, the BA shall complete the following forms, attached and incorporated by reference as though fully set forth herein, SFDPH Attestations for Privacy (Attachment 1) and Data Security (Attachment 2) within sixty (60) calendar days from the execution of the Agreement. If CE makes substantial changes to any of these forms during the term of the Agreement, the BA will be required to complete CE's updated forms within sixty (60) calendar days from the date that CE provides BA with written notice of such changes. BA shall retain such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

b. User Training. The BA shall provide, and shall ensure that BA subcontractors, provide, training on PHI privacy and security, including HIPAA and HITECH and its regulations, to each employee or agent that will access, use or disclose Protected Information, upon hire and/or prior to accessing, using or disclosing Protected Information for the first time, and at least annually thereafter during the term of the Agreement. BA shall maintain, and shall ensure that BA subcontractors maintain, records indicating the name of each employee or agent and date on which the PHI privacy and security trainings were completed. BA shall retain, and ensure that BA subcontractors retain, such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

c. Permitted Uses. BA may use, access, and/or disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. Further, BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE [45 C.F.R. Sections 164.502, 164.504(e)(2). and 164.504(e)(4)(i)].

d. Permitted Disclosures. BA shall disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. BA shall not disclose Protected Information in any manner that would constitute a violation of the

Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2 (n) of this BAA, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)]. BA may disclose PHI to a BA that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit Protected Information on its behalf, if the BA obtains satisfactory assurances, in accordance with 45 C.F.R. Section 164.504(e)(1), that the subcontractor will appropriately safeguard the information [45 C.F.R. Section 164.502(e)(1)(ii)].

e. Prohibited Uses and Disclosures. BA shall not use or disclose Protected Information other than as permitted or required by the Agreement and BAA, or as required by law. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the Protected Information solely relates [42 U.S.C. Section 17935(a) and 45 C.F.R. Section 164.522(a)(1)(vi)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2), and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

f. Appropriate Safeguards. BA shall take the appropriate security measures to protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the CE, and shall prevent any use or disclosure of PHI other than as permitted by the Agreement or this BAA, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.306, 164.308, 164.310, 164.312, 164.314 164.316, and 164.504(e)(2)(ii)(B). BA shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316, and 42 U.S.C. Section 17931. BA is responsible for any civil penalties assessed due to an audit or investigation of BA, in accordance with 42 U.S.C. Section 17934(c).

g. Business Associate's Subcontractors and Agents. BA shall ensure that any agents and subcontractors that create, receive, maintain or transmit Protected Information on behalf of BA, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph 2.f. above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2) through (e)(5); 45 C.F.R. Section 164.308(b)]. BA shall mitigate the effects of any such violation.

h. Accounting of Disclosures. Within ten (10) calendar days of a request by CE for an accounting of disclosures of Protected Information or upon any disclosure of Protected Information for which CE is required to account to an individual, BA and its agents and subcontractors shall make available to CE the information required to

provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935 (c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents and subcontractors for at least seven (7) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an Electronic Health Record. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure [45 C.F.R. 164.528(b)(2)]. If an individual or an individual's representative submits a request for an accounting directly to BA or its agents or subcontractors, BA shall forward the request to CE in writing within five (5) calendar days.

i. Access to Protected Information. BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within (5) days of request by CE to enable CE to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. 164.524.

j. Amendment of Protected Information. Within ten (10) days of a request by CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA and its agents and subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment or other documentation to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R Section 164.526. If an individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request and of any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

k. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)]. BA shall provide CE a copy of any Protected Information and other documents and records that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

l. Minimum Necessary. BA, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the intended purpose of such use, disclosure, or request. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to

what constitutes "minimum necessary" to accomplish the intended purpose in accordance with HIPAA and HIPAA Regulations.

m. Data Ownership. BA acknowledges that BA has no ownership rights with respect to the Protected Information.

n. Notification of Breach. BA shall notify CE within 5 calendar days of any breach of Protected Information; any use or disclosure of Protected Information not permitted by the BAA; any Security Incident (except as otherwise provided below) related to Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by BA or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the BA to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. BA shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 42 U.S.C. Section 17932; 45 C.F.R. 164.410; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)]

o. Breach Pattern or Practice by Business Associate's Subcontractors and Agents. Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(iii), if the BA knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the contractual arrangement with its subcontractor or agent, if feasible. BA shall provide written notice to CE of any pattern of activity or practice of a subcontractor or agent that BA believes constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA within five (5) calendar days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

3. Termination.

a. Material Breach. A breach by BA of any provision of this BAA, as determined by CE, shall constitute a material breach of the Agreement and this BAA and shall provide grounds for immediate termination of the Agreement and this BAA, any provision in the AGREEMENT to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii).]

b. Judicial or Administrative Proceedings. CE may terminate the Agreement and this BAA, effective immediately, if (i) BA is named as defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. Effect of Termination. Upon termination of the Agreement and this BAA for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of Section 2 of this BAA to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

d. Civil and Criminal Penalties. BA understands and agrees that it is subject to civil or criminal penalties applicable to BA for unauthorized use, access or disclosure or Protected Information in accordance with the HIPAA Regulations and the HITECH Act including, but not limited to, 42 U.S.C. 17934 (c).

e. Disclaimer. CE makes no warranty or representation that compliance by BA with this BAA, HIPAA, the HITECH Act, or the HIPAA Regulations or corresponding California law provisions will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

4. Amendment to Comply with Law.

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the updated standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable state or federal laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

5. Reimbursement for Fines or Penalties.

In the event that CE pays a fine to a state or federal regulatory agency, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible access, use or disclosure of PHI by BA or its subcontractors or agents, then BA shall reimburse CE in the amount of such fine or penalties or damages within thirty (30) calendar days from City's written notice to BA of such fines, penalties or damages.

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APPENDIX B

San Francisco Department of Public Health

Business Associate Agreement

Attachment 1 – SFDPH Privacy Attestation, version 06-07-2017
Attachment 2 – SFDPH Data Security Attestation, version 06-07-2017

Office of Compliance and Privacy Affairs
San Francisco Department of Public Health
101 Grove Street, Room 330, San Francisco, CA 94102
Email: compliance.privacy@sfdph.org
Hotline (Toll-Free): 1-855-729-6040

DocuSign Envelope ID: AB1222DC-8EA4-42DE-8F47-CBDF10101ABE

Contractor Name:		Contractor City Vendor ID	

PRIVACY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions below in Section IV on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…	Yes	No*
A	Have formal Privacy Policies that comply with the Health Insurance Portability and Accountability Act (HIPAA)?		
B	Have a Privacy Officer or other individual designated as the person in charge of investigating privacy breaches or related incidents?		
	If yes: Name & Title:		
	Phone #:		
	Email:		
C	Require health information Privacy Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH privacy training materials are available for use; contact OCPA at 1-855-729-6040.]		
D	Have proof that employees have signed a form upon hire and annually thereafter, with their name and the date, acknowledging that they have received health information privacy training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]		
E	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?		
F	Assure that staff who create, or transfer health information (via laptop, USB/thumb-drive, handheld), have prior supervisorial authorization to do so **AND** that health information is **only transferred or created on encrypted devices approved by SFDPH Information Security staff**?		

II. Contractors who serve patients/clients and have access to SFDPH PHI, must also complete this section.

	If Applicable: DOES YOUR ORGANIZATION…	Yes	No*
G	Have (or will have if/when applicable) evidence that SFDPH Service Desk (628-206-SERV) was notified to de-provision employees who have access to SFDPH health information record systems within 2 business days for regular terminations and within 24 hours for terminations due to cause?		
H	Have evidence in each patient's / client's chart or electronic file that a Privacy Notice that meets HIPAA regulations was provided in the patient's / client's preferred language? (English, Cantonese, Vietnamese, Tagalog, Spanish, Russian forms may be required and are available from SFDPH.)		
I	Visibly post the Summary of the Notice of Privacy Practices in all six languages in common patient areas of your treatment facility?		
J	Document each disclosure of a patient's/client's health information for purposes other than treatment, payment, or operations?		
K	When required by law, have proof that signed authorization for disclosure forms (that meet the requirements of the HIPAA Privacy Rule) are obtained PRIOR to releasing a patient's/client's health information?		

III. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Privacy Officer or designated person	Name: (print)		Signature		Date	

IV. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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Contractor Name:		Contractor City Vendor ID	

DATA SECURITY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions in Section III below on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…	**Yes**	**No***
A	Conduct assessments/audits of your data security safeguards to demonstrate and document compliance with your security policies and the requirements of HIPAA/HITECH at least every two years? [Retain documentation for a period of 7 years]		
B	Use findings from the assessments/audits to identify and mitigate known risks into documented remediation plans?		
	Date of last Data Security Risk Assessment/Audit:		
	Name of firm or person(s) who performed the Assessment/Audit and/or authored the final report:		
C	Have a formal Data Security Awareness Program?		
D	Have formal Data Security Policies and Procedures to detect, contain, and correct security violations that comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)?		
E	Have a Data Security Officer or other individual designated as the person in charge of ensuring the security of confidential information?		
	If yes: Name & Title:		Phone #:		Email:
F	Require Data Security Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH data security training materials are available for use; contact OCPA at 1-855-729-6040.]		
G	Have proof that employees have signed a form upon hire and annually, or regularly, thereafter, with their name and the date, acknowledging that they have received data security training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]		
H	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?		
I	Have (or will have if/when applicable) a diagram of how SFDPH data flows between your organization and subcontractors or vendors (including named users, access methods, on-premise data hosts, processing systems, etc.)?		

II. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Data Security Officer or designated person	Name: (print)		Signature		Date	

III. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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City and County of San Francisco
San Francisco Department of Public Health
Emergency Medical Services Division
90 Van Ness Avenue
San Francisco, California 94102

Agreement between the City and County of San Francisco, acting by and through its Department of Public Health and Pro Transport-1

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This emergency Service Provider Agreement ("SPA") is made this 1st day of July, 2020 in the City and County of San Francisco, State of California, by and between Pro Transport-1 ("Provider") and the City and County of San Francisco, acting by and through its Depaartment of Public Health.

Recitals

WHEREAS, the San Francisco Department of Public Health is the designated local Emergency Medical Services Agency ("LEMSA") for the City and County of San Francisco, under California Health and Safety Code Section 1797.200; and

WHEREAS, Provider possesses all requisite LEMSA approvals to participate in the LEMSA Emergency Medical Services ("EMS") system, including a current and valid Certificate of Operation and when necessary an Ambulance Permit, in accordance with San Francisco Health Code Article 14; and

WHEREAS, the San Francisco Emergency Medical Services Plan authorizes Provider to provide Advanced Life Support ("ALS"), Basic Life Support ("BLS"), and/or Special Ambulance Services within the LEMSA EMS service area; and

WHEREAS, California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168(b)(4), requires that authorized paramedic service Providers have a written service provider agreement ("SPA") with the LEMSA allowing the Provider to participate in the LEMSA EMS system and obligating the Provider to comply with all State regulations and local policies and procedures, including participation in the LEMSA's Emergency Medical Services Quality Improvement Program ("EMSQIP"); and

WHEREAS, the Parties wish to enter into this written SPA in compliance with Section 100168(b)(4), when required, or otherwise as required by the LEMSAs;

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this SPA:

1.1. **"Advanced Life Support (ALS)**" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency department or other medical staff of that hospital, as defined by California Health and Safety Code, Division 2.5, Section 1797.52, including the scope of practice of Paramedic as listed in Section 1797.52 and any LEMSA approved Local Optional Scope of Practice.

1.2. **"ALS Ground Ambulance Services"** means the provision of advanced life support services provided in an ambulance by an authorized ALS Provider pursuant to a Service Provider Agreement (SPA) consistent with the California Health and Safety Code, Division 2.5, Section 1797.52 and LEMSA policies and procedures.

1.3. **"Ambulance Permit"** means a permit issued by LEMSA's Medical Director for an ambulance or routine medical transport vehicle pursuant to the San Francisco Health Code, Article 14. This permit is required to operate an ambulance or routine medical transport vehicle within the City and County of San Francisco.

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1.4. **"Authorized ALS Ambulance Provider"** means an ambulance Provider that is authorized to provide ALS ambulance services within the City pursuant to a Service Provider Agreement with the LEMSA.

1.5. **"Basic Life Support (BLS)"** means emergency first aid and cardiopulmonary resuscitation procedures, which at a minimum, include: recognizing respiratory arrest and application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim can be transported or until advanced life support is available, as defined by California Health and Safety Code, Division 2.5, Section 1797.60, including the basic scope of practice as listed in Section 1797.60 and any LEMSA approved Local Optional Scope of Practice.

1.6. **"Authorized BLS Ambulance Provider"** means an ambulance Provider that is authorized, staffed and equipped to provide basic life support in full compliance with the California Health and Safety Code, Division 2.5, Section 1797.60, all regulations of the State of California, the City Ambulance Ordinance, and LEMSA Policies, Procedures and Protocols.

1.7. **"Certificate of Operation"** means a Certificate issued under San Francisco Health Code Article 14 by the LEMSA Medical Director to a Provider who qualifies to operate an ambulance in the City. To qualify for a Certificate of Operation, the Provider must hold three valid and current Ambulance Permits.

1.8. **"Confidential Information"** means confidential City information including, but not limited to, personally-identifiable information ("PII"), protected health information ("PHI'), or individual financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.9. **"Emergency Medical Personnel"** means all public safety first responders, Emergency Medical Dispatchers, EMTs and EMT-Ps functioning within the emergency medical services system.

1.10. **"Emergency Medical Services Quality Improvement Program (EMSQIP)"** means the continuing quality improvement program, procedures and protocol documents developed by the LEMSA.

1.11. **"Emergency Medical Technician (EMT)"** means an individual trained in all facets of basic life support according to standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.80, and who has a valid certification issued pursuant to said division and local training as required by LEMSA.

1.12. **"Emergency Medical Technician – Paramedic (EMT-P)"** means an individual whose scope of practice is to provide advanced life support governed by standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.84, and who has a valid license issued pursuant to said division and local accreditation as required by LEMSA.

1.13. **"Facility"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is physically present and assessed the patient's need for LEMSA.

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1.14. **"Ground Ambulance Services"** means all ambulance services performed at the request of and determined to be either a Code Two or Code Three level response by an Authorized LEMSA Dispatch Center.

1.15. **"LEMSA Medical Director"** means the San Francisco Director of Health, responsible for the duties set forth in California Health and Safety Code, Division 2.5, Section 1797.202.

1.16. **"Medical Emergency"** means the term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by public safety personnel or Emergency Medical Personnel at the scene of an emergency or dispatch personnel at a designated LEMSA Dispatch Center.

1.17. "**Medical Record**" means all patient care interaction and assessment data collected and/or generated by Provider and included in Provider's electronic medical record system, including but not limited to a record of a patient's medical information (such as medical history, care or treatments received, test results, diagnoses, and medications taken).

1.18. **"National Incident Management System (NIMS)"** means the incident management system developed by the US Department of Homeland Security, FEMA, as required by Homeland Security Presidential Directive 5 (HSPD-5).

1.19. **"Primary Public Safety Answering Point (PSAP)"** means the location where the 911 call is first answered.

1.20. **"Provider Program Director"** means the Medical Director of the Provider.

1.21. **"Response Codes"** means the dispatch term which denotes the level of priority for units responding to the scene as defined herein:

a) **Code One** - Routine or schedule transportation of patients.
b) **Code Two** - A non-life threatening Medical Emergency requiring immediate response.
c) **Code Three** - A Medical Emergency requiring immediate response with red light and siren.

1.22. **"Services"** means the provision of any and all services under this SPA.

1.23. **"Site"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is NOT physically present and has NOT assessed the patient's need for LEMSA.

1.24. **"Special Ambulance Service"** means any unit-type, providing Emergency Medical Services and patient care that can be dispatched to a medical call without the ability to provide patient transport.

1.25. **"Standardized Emergency Management System (SEMS)**" means the standardized emergency management system identified in California Government Code, Section 8607.

Article 2 Term of the Agreement

2.1 **Initial Term.**

The term of this SPA shall commence on July 1, 2020 and expire five years later on June 30, 2025, unless earlier terminated as otherwise provided herein.

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2.2 **Renewal of SPA.**

This SPA shall auto-renew for four additional one-year periods upon Provider's payment of all required Certificate of Operation and/or Ambulance Permit fees and conditioned on Provider's compliance with all Certificate of Operation and Ambulance Permit requirements. The renewed SPA shall automatically terminate should Provider fail to pay all required Certificate of Operation and/or Ambulance Permit fees.

Article 3 Audit

3.1 **Audit and Inspection of Records.**

Provider agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate books and records, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227). Provider will permit City to audit, examine and make excerpts and transcripts from such books and records related to all matters covered by this SPA. Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the local EMS agency. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider. To the extent required by applicable law or regulation, the State of California or any Federal agency having an interest in the subject matter of this SPA shall have the same rights as conferred upon City by this Section.

Article 4 Services and Resources

4.1 **Provider Shall Obtain All Necessary Permits and/or Approvals.**

4.1.1 Provider shall not commence the provision of any services under this SPA until all necessary permits and/or approvals have been issued. Specifically, before commencing work, Provider shall apply for and obtain from LEMSA a Certificate of Operation and when required an Ambulance Permit, and/or all other required regulatory permits and/or approvals in accordance with applicable law, including California Code of Regulations Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic); California Health and Safety Code, Division 2.5 (Emergency Medical Services); and San Francisco Health Code, Article 14 (Ambulances and Routine Medical Transport Vehicles). Nothing in this SPA is intended to imply that City will issue any permits and/or approvals.

4.1.2 Provider shall pay all fees required as a condition precedent to the issuance of any such permits and/or approvals in accordance with the applicable rates and charges then in effect as indicated in LEMSA's fee schedule. The payments made by Provider to City shall be less than or equal to the City's actual costs to provide the LEMSA administration and oversight services. No funds shall be used by the City in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute. .

4.2 **Services Provider Agrees to Perform.**

Provider agrees to perform the services detailed in Appendix A, "Statement of Work." Officers and employees of the City are not authorized to request services beyond the scope listed in Appendix A.

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4.3 **Qualified Personnel.**

Provider shall ensure all Emergency Medical Personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of Provider services.

4.4 **Subcontracting.**

Excluding services for 9-1-1 calls, Provider may subcontract services to be performed under this SPA to other San Francisco LEMSA permitted service providers. For clarity 9-1-1 services may not be subcontracted.

4.5 **Assignment.**

The services to be performed by Provider are personal in character. Neither this SPA, nor any duties or obligations hereunder, may be directly or indirectly assigned, novated, transferred, or delegated by Provider. Any purported Assignment made in violation of this provision shall be null and void.

4.6 **No Transfer of Certificate of Operation or Ambulance Permit.**

Each Certification of Operation and/or Ambulance Permit by the LEMSA is a privilege that is personal and specific to Provider. Neither a Certificate of Operation, an Ambulance Permit, nor any of the privileges conferred thereunder may be neither sold, conveyed, assigned, encumbered, nor otherwise transferred by Provider. Any attempt to sell, convey, assign, encumber or otherwise transfer a Certificate of Operation, any Ambulance Permit, or the privileges conferred thereunder may result in the City's termination of this SPA.

4.7 **Activities at Permittee's Expense.**

Any act that Provider performs under this SPA or applicable law shall be performed at Provider's expense and without cost to City, unless said Provider is a City agency or employee providing services under this SPA.

4.8 **Warranty.**

Provider warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this SPA as detailed in Appendix A (Statement of Work).

Article 5 Insurance and Indemnity (RESERVED FOR SFFD)

5.1 **Insurance.**

5.1.1 **Required Coverages.** Without in any way limiting Provider's liability pursuant to the "Indemnification" section of this SPA, Provider must maintain in force, during the full term of the SPA, insurance in the following amounts and coverages:

(a) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness; and

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(b) Commercial General Liability Insurance with limits not less than $5,000,000 each occurrence and $8,000,000 general aggregate for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; and

(c) Commercial Automobile Liability Insurance with limits not less than $10,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(d) Professional liability insurance, applicable to Provider's profession, with limits not less than $1,000,000 each occurrence and $3,000,000 general aggregate with respect to negligent acts, errors or omissions in connection with the Services.

(e) Technology Errors and Omissions Liability coverage (RESERVED).

(f) Cyber and Privacy Insurance with limits of not less than $5,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.

(g) Provider shall be permitted to use umbrella or excess coverage to meet the required limits for insurance in this section.

5.1.2 Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to provide:

(a) Name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

(b) That such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this SPA, and that insurance applies separately to each insured against whom claim is made or suit is brought.

5.1.3 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

5.1.4 Should any of the required insurance be provided under a claims-made form, Provider shall maintain such coverage continuously throughout the term of this SPA and, without lapse, for a period of three years beyond the expiration of this SPA, to the effect that, should occurrences during the contract term give rise to claims made after expiration of the SPA, such claims shall be covered by such claims-made policies.

5.1.5 Should any of the required insurance be provided under a form of coverage that includes a general annual aggregate limit or provides that claims investigation or legal defense costs be included in such general annual aggregate limit, such general annual aggregate limit shall be double the occurrence or claims limits specified above.

5.1.6 Should any required insurance lapse during the term of this SPA, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this SPA, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this SPA effective on the date of such lapse of insurance.

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5.1.7 Before commencing any Services, Provider shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in form evidencing all coverages set forth above. Approval of the insurance by City shall not relieve or decrease Provider's liability hereunder.

5.1.8 The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Provider, its employees, agents and subcontractors.

5.1.9 If Provider will use any subcontractor(s) to provide Services, Provider shall require the subcontractor(s) to provide all necessary insurance and to name the City and County of San Francisco, its officers, agents and employees and the Provider as additional insureds.

5.1.10 City may, in its sole discretion, choose to reconsider the amounts and coverages above and require amendment of this SPA to update such amounts and coverages during the term of the SPA. Provider's execution of an amendment to this SPA to put changes to these amounts and coverages in effect shall not be withheld.

5.2 **General Indemnification.**

5.2.1 Provider shall indemnify and save harmless City and its officers, agents and employees from, and, if requested, shall defend them against any and all third party claims for loss, cost, damage, injury, liability, and claims thereof for injury to or death of a person (including but not limited to patient and/or patient's relative's claims for damages arising from medical malpractice), or loss of or damage to property, arising directly or indirectly from Provider's performance of this SPA, except to the extent that such indemnity is void or otherwise unenforceable under applicable law in effect on or validly retroactive to the date of this SPA and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City, in which case damages will be apportioned under the California doctrine of comparative fault. The foregoing indemnity shall include, without limitation, reasonable fees of attorneys, consultants and experts and related third party costs that the City necessarily incurs.

5.2.2 In addition to Provider's obligation to indemnify City, Provider specifically acknowledges and agrees that it has an immediate and independent obligation to defend City from any claim which actually or potentially falls within this indemnification provision, while such claim is in effect, even if the allegations are or may be groundless, false or fraudulent, which obligation arises at the time such claim is tendered to Provider by City and continues at all times thereafter.

5.3 **Infringement Indemnification.**

Provider shall indemnify and hold the City harmless from all third party claims, loss and liability, including attorneys' fees, court costs and all other litigation expenses for any infringement of United States patent rights, or any copyright, trade secret or any other proprietary right or trademark, and all other intellectual property claims of any person or persons, arising directly or indirectly from Provider's performance of this SPA.

Article 6 Liability of the Parties

6.1 **City's Liability Limit. (RESERVED)**

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6.2 Liability for Incidental and Consequential Damages. (RESERVED)

6.3 Liability for Use of Equipment.

City shall not be liable for any damage to persons or property as a result of the misuse of equipment used by Provider, or by any of their employees, even though such equipment is furnished, rented or loaned by City.

Article 7 Payment of Taxes (RESERVED FOR SFFD)

7.1 Provider Shall Collect and Remit Taxes.

Where required under applicable law, Provider shall collect and remit to City all applicable taxes in compliance with the City's Business and Tax Regulations Code. Provider shall provide such records to City as City may require to confirm its compliance with these requirements.

7.2 Possessory Interest Tax.

Provider understands that this SPA may create a possessory interest subject to property taxation and that Provider may be subject to the payment of such taxes.

Article 8 Termination and Default

8.1 Termination for Convenience

8.1.1 **City**. The City shall have the option, in its sole discretion, to terminate this SPA, at any time during the term hereof, for convenience and without cause. City shall exercise this option by giving Provider ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective.

8.1.2 **Provider.** Provider shall have the option, in its sole discretion, to terminate this SPA, at any time during the term hereof, for convenience and without cause. Provider shall exercise this option by giving City ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective.

8.2 Probation, Suspension, and/or Termination for Default; Remedies.

The City may terminate this SPA for material breach by Provider, including but not limited to, as detailed in the LEMSA's "Pre-Hospital Provider Standards" policy. Failure to comply with the terms of this SPA, local policies and protocols, and all applicable laws and regulations as determined by the LEMSA, may result in probation, suspension, or termination of Provider's authorization to operate in the LEMSA EMS service area. In the event that Provider defaults in the performance of any duties or obligations hereunder and the default or breach has not been cured within thirty (30) calendar days of receipt of written notice of default, such failure shall be cause for the LEMSA to effect any of the following, acting in its sole discretion: Revocation of Provider's Certificate of Operation and/or Ambulance Permit; placing Provider on probation with a LEMSA approved corrective action plan; suspension of Provider's Services under this Agreement; and/or termination of this Agreement.

8.3 Non-Waiver of Rights.

The omission by the City at any time to enforce any default or right reserved to it, or to require performance of any of the terms, covenants, or provisions hereof by Provider at the time designated, shall

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not be a waiver of any such default or right to which the City is entitled, nor shall it in any way affect the right of the City to enforce such provisions thereafter.

8.4 Rights and Duties upon Termination or Expiration.

This Section and the following Sections of this SPA listed below, shall survive termination or expiration of this SPA:

Article 3	Audit
Article 5	Insurance and Indemnity
Article 6	Liability of Parties
Article 7	Payment of Taxes
Article 11	General Provisions
Article 13	Data and Security

Subject to the survival of the Sections identified above, if this SPA is terminated prior to expiration of the term specified in Article 2, this SPA shall be of no further force or effect.

Article 9 Rights In Deliverables (RESERVED)

Article 10 Additional Requirements Incorporated by Reference (RESERVED FOR SFFD)

10.1 Laws Incorporated by Reference.

Provider represents and warrants that it will comply with all applicable laws and regulations in performing the Services. Subject to the foregoing, the full text of the laws listed in this Article 10, including enforcement and penalty provisions, are incorporated by reference into this SPA. The full text of the San Francisco Municipal Code provisions incorporated by reference in this Article and elsewhere in the SPA ("Mandatory City Requirements") are available at http://www.amlegal.com/codes/client/san-francisco_ca/

10.2 Conflict of Interest.

By executing this SPA, Provider certifies that it does not know of any fact which constitutes a violation of Section 15.103 of the City's Charter; Article III, Chapter 2 of City's Campaign and Governmental Conduct Code; Title 9, Chapter 7 of the California Government Code (Section 87100 *et seq.*), or Title 1, Division 4, Chapter 1, Article 4 of the California Government Code (Section 1090 *et seq.*), and further agrees promptly to notify the City if it becomes aware of any such fact during the term of this SPA.

10.3 Consideration of Salary History.

Provider shall comply with San Francisco Administrative Code Chapter 12K, the Consideration of Salary History Ordinance or "Pay Parity Act." Provider is prohibited from considering current or past salary of an applicant in determining whether to hire the applicant or what salary to offer the applicant to the extent that such applicant is applying for employment to be performed on this SPA or in furtherance of this SPA, and whose application, in whole or part, will be solicited, received, processed or considered, whether or not through an interview, in the City or on City property. The ordinance also prohibits employers from (1) asking such applicants about their current or past salary or (2) disclosing a current or former employee's salary history without that employee's authorization unless the salary history is publicly available. Provider is subject to the enforcement and penalty provisions in Chapter 12K. Information about and the text of Chapter 12K is available on the web at https://sfgov.org/olse/consideration-salary-history. Provider

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is required to comply with all of the applicable provisions of 12K, irrespective of the listing of obligations in this Section.

10.4 **Nondiscrimination Requirements**

Provider does not as of the date of this SPA, and will not during the term of this SPA, in any of its operations in San Francisco, on real property owned by San Francisco, or where work is being performed for the City elsewhere in the United States, discriminate against an applicant for employment because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition, marital status, or citizenship, or otherwise, including in the provision of employee benefits between employees with domestic partners and employees with spouses and/or between the domestic partners and spouses of such employees, subject to the conditions set forth in San Francisco Administrative Code Section12B.2.

10.5 **Minimum Compensation Ordinance.**

Provider shall pay covered employees no less than the minimum compensation required by San Francisco Administrative Code Chapter 12P, including a minimum hourly gross compensation, compensated time off, and uncompensated time off. Provider is subject to the enforcement and penalty provisions in Chapter 12P. Information about and the text of the Chapter 12P is available on the web at http://sfgov.org/olse/mco. Provider is required to comply with all of the applicable provisions of 12P, irrespective of the listing of obligations in this Section. By signing and executing this SPA, Provider certifies that it is in compliance with Chapter 12P.

10.6 **Health Care Accountability Ordinance.**

Provider shall comply with San Francisco Administrative Code Chapter 12Q. For each Covered Employee, Provider shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Provider chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission. Information about and the text of the Chapter 12Q, as well as the Health Commission's minimum standards, is available on the web at http://sfgov.org/olse/hcao. Provider is subject to the enforcement and penalty provisions in Chapter 12Q. Any Subcontract entered into by Provider shall require any Subcontractor with 20 or more employees to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section.

10.7 **Alcohol and Drug-Free Workplace.**

City reserves the right to deny access to, or require Provider to remove from performance of services under this SPA personnel of any Provider who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing, selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this SPA "controlled substance" includes cannabis and derivative products.

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10.8 Consideration of Criminal History in Hiring and Employment Decisions

10.8.1 Provider agrees to comply fully with and be bound by all of the provisions of Chapter 12T, "City Provider/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions," of the San Francisco Administrative Code ("Chapter 12T"), including the remedies provided, and implementing regulations, as may be amended from time to time. The provisions of Chapter 12T are incorporated by reference and made a part of this SPA as though fully set forth herein. The text of the Chapter 12T is available on the web at http://sfgov.org/olse/fco. Provider is required to comply with all of the applicable provisions of 12T, irrespective of the listing of obligations in this Section. Capitalized terms used in this Section and not defined in this SPA shall have the meanings assigned to such terms in Chapter 12T.

10.8.2 The requirements of Chapter 12T shall only apply to a Provider's or Subcontractor's operations to the extent those operations are in furtherance of the performance of this SPA, shall apply only to applicants and employees who would be or are performing work in furtherance of this SPA, and shall apply when the physical location of the employment or prospective employment of an individual is wholly or substantially within the City of San Francisco. Chapter 12T shall not apply when the application in a particular context would conflict with federal or state law or with a requirement of a government agency implementing federal or state law.

10.9 Food Service Waste Reduction Requirements.

Provider shall comply with the Food Service Waste Reduction Ordinance, as set forth in San Francisco Environment Code Chapter 16, including but not limited to the remedies for noncompliance provided therein.

10.10 Distribution of Beverages and Water. (RESERVED)

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this SPA, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

To City:	Andrew Holcomb, MS, EMS Manager, San Francisco EMS Agency City and County of San Francisco 90 Van Ness Ave, San Francisco, CA 94102 415-487-5018 andrew.holcomb@sfdph.org
To Provider:	Alex Baker General Manager Pro Transport-1 Address 720 Portal St. Cotati, CA 94931 Alexb@protransport-1.com

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

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11.2 **Compliance with Americans with Disabilities Act.**

Provider shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 **Reserved.**

11.4 **Sunshine Ordinance.**

Provider acknowledges that this SPA and all records related to its formation, Provider's performance of Services, and City's payment are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.5 **Modification of this SPA.**

This SPA may not be modified, nor may compliance with any of its terms be waived, except as noted in Section 11.1, "Notices to Parties," except by written instrument executed by the Parties and approved in the same manner as this SPA.

11.6 **Dispute Resolution Procedure.**

11.6.1 The Parties will attempt in good faith to resolve any dispute or controversy arising out of or relating to the performance of services under this SPA in accordance with the LEMSA's "Pre-Hospital Provider Standards" policy.

11.6.2 During the course of any Dispute Resolution process, Provider shall comply with all directives issued by the LEMSA. In the event that the LEMSA identifies a deficiency that LEMSA acting in its sole discretion determines may cause a threat to public health and/or safety, the LEMSA may issue a written probation and/or suspension notice to the Provider. Upon receipt, the Provider shall immediately comply with the terms of that notice. If the notice calls for suspension, Provider shall immediately suspend Services under this SPA until the LEMSA verifies that Provider has implemented all required corrections. Provider's failure to implement all required corrections as determined by the LEMSA acting in its sole discretion may result in termination of this SPA for default.

11.7 **Government Code Claim Requirement.**

No suit for money or damages may be brought against the City until a written claim therefor has been presented to and rejected by the City in conformity with the provisions of San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq. Nothing set forth in this SPA shall operate to toll, waive or excuse Provider's compliance with the California Government Code Claim requirements set forth in San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq.

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11.8 Agreement Made in California; Venue.

The formation, interpretation and performance of this SPA shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this SPA shall be in San Francisco.

11.9 Construction.

All paragraph captions are for reference only and shall not be considered in construing this SPA.

11.10 Entire Agreement.

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This SPA may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.11 Compliance with Laws.

Provider shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Provider's performance of this SPA, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.12 Severability.

Should the application of any provision of this SPA to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this SPA shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.13 Order of Precedence.

Provider agrees to perform the services described below in accordance with the terms and conditions of this SPA, and the Statement of Work attached as Appendix A. The terms of this SPA are to be read and interpreted together with all other documents, appendices, exhibits, and addenda attached to the SPA as a single agreement.

11.14 Notification of Legal Requests.

Provider shall immediately notify City upon receipt of any subpoenas, service of process, litigation holds, discovery requests and other legal requests ("Legal Requests") related to this SPA, and in no event later than 24 hours after it receives the request.

Article 12 Department Specific Terms

12.1 Third Party Beneficiaries.

No third parties are intended by the parties hereto to be third party beneficiaries under this SPA, and no action to enforce the terms of this SPA may be brought against either party by any person who is not a party hereto.

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12.2 Exclusion Lists and Employee Verification.

Upon execution of this SPA and monthly thereafter, Provider will check the exclusion lists published by the Office of the Inspector General (OIG), General Services Administration (GSA), and the California Department of Health Care Services (DHCS) to ensure that any employee, temporary employee, volunteer, consultant, or governing body member responsible for oversight, administering or delivering state or federally-funded services who is on any of these lists is excluded from (may not work in) Provider's program or agency. Proof of checking these lists must be retained for seven years.

Article 13 Data and Security

13.1 Nondisclosure of Private, Proprietary or Confidential Information.

13.1.1 If this SPA requires City to disclose "Private Information" to Provider within the meaning of San Francisco Administrative Code Chapter 12M, Provider and subcontractor shall use such information only in accordance with the restrictions stated in Chapter 12M and in this SPA and only as necessary in performing the Services. Provider is subject to the enforcement and penalty provisions in Chapter 12M.

13.1.2 In the performance of Services, Provider may have access to City's proprietary or confidential information, the disclosure of which to third parties may damage City. If City discloses proprietary or confidential information to Provider, such information must be held by Provider in confidence and used only in performing the SPA, except as required by law, professional rule or regulation. Provider shall exercise the same standard of care to protect such information as a reasonably prudent Provider would use to protect its own proprietary or confidential information.

13.2 Business Associate Agreement.

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Provider will:

1. ☒ Do **at least one** or more of the following:
   A. Create, receive, maintain, or transmit PHI for or on behalf of CITY/SFDPH (including storage of PHI, digital or hard copy, even if Provider does not view the PHI or only does so on a random or infrequent basis); or

   B. Receive PHI, or access to PHI, from CITY/SFDPH or another Business Associate of City, as part of providing a service to or for CITY/SFDPH, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or

   C. Transmit PHI data for CITY/SFDPH and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

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FOR PURPOSES OF THIS SPA, PROVIDER IS A BUSINESS ASSOCIATE OF CITY/SFDPH, AS DEFINED UNDER HIPAA. PROVIDER MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS SPA AS THOUGH FULLY SET FORTH HEREIN:

a. **Appendix E** SFDPH Business Associate Agreement (BAA) (04-12-2018)
   1. SFDPH Attestation 1 PRIVACY (06-07-2017)
   2. SFDPH Attestation 2 DATA SECURITY (06-07-2017)

2. ☐ **NOT do any of the activities listed above in subsection 1;**
Provider is not a Business Associate of CITY/SFDPH. Appendix E and attestations are not required for the purposes of this SPA.
This option requires review and approval from the Office of Compliance and Privacy Affairs.

13.3 **Protected Health Information.**

Provider and all agents and employees Provider shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Provider by City in the performance of this SPA. Provider agrees that any failure of Contactor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Provider or its subcontractors or agents by City, Provider shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 14 Data and Security

14.1 **City Data**

14.1.1 **Ownership of City Data.** The Parties agree that as between them, all rights, including all intellectual property rights, in and to the City Data and any derivative works of the City Data shall remain the exclusive property of the City.

14.1.2 **Use of City Data**. Nothing herein shall be construed to confer any license or right to the City Data, including user tracking and exception City Data within the system, by implication, estoppel or otherwise, under copyright or other intellectual property rights, to any third-party. Unauthorized use of City Data by Provider.

14.1.3 **Data Breach; Loss of City Data**. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Provider that relate to the protection of the security, confidentiality, or integrity of City Data, Provider shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

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14.1.4 **Data Privacy and Information Security Program.** Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

14.1.5 **Data Transmission.** Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure that all data exchanged shall be used expressly and solely for the purposes stated in the SPA. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this SPA, unless otherwise permitted in this SPA. The Provider shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

Article 15 MacBride And Signature

15.1 MacBride Principles -Northern Ireland.

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this SPA. By signing this SPA, Provider confirms that Provider has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

IN WITNESS WHEREOF, the parties hereto have executed this SPA on the day first mentioned above.

City

San Francisco Department of Public Health

DocuSigned by:
Greg Wagner
28527524752949F...
9/2/2020 | 3:03:08 PDT

Grant Colfax, MD
Director of Health

Provider

Pro Transport-1

DocuSigned by:
Alex Baker
FE07A47ADE68468...
9/1/2020 | 3:59:50 PDT

Alex Baker
General Manager

Approved as to Form:

Dennis J. Herrera
City Attorney

By: DocuSigned by:
Louise Simpson
BD54168A4C3B452...
9/2/2020 | 8:20:54 PDT

Louise S. Simpson
Deputy City Attorney

Appendices

A: Statement of Work
B: Business Associate Agreement

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Appendix A

STATEMENT OF WORK

I. GENERAL REQUIREMENTS FOR APPROVED SERVICE PROVIDER:

Approved service Providers authorized to participate in the LEMSA EMS system shall perform as follows:

(1) (911 Providers, only) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA.

(2) Utilize and maintain telecommunications as specified by the LEMSA.

(3) Maintain medication solution, medical supplies, and equipment inventory as specified by the LEMSA commensurate with the basic and local optional scope of practice of the paramedic and EMT.

(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

1. controlled substance ordering and order tracking;

2. controlled substance receipt and accountability;

3. controlled substance master supply storage, security and documentation;

4. controlled substance labeling and tracking;

5. vehicle storage and security;

6. usage procedures and documentation;

7. reverse distribution;

8. disposal;

9. re-stocking procedures.

(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to;

10. controlled substance testing;

11. discrepancy reporting;

12. tampering, theft and diversion prevention and detection;

13. usage audits.

(5) Be responsible for assessing and ensuring current knowledge of their paramedics and EMTs in local policies, procedures and protocols and for assessing their EMT and/or paramedics' skills competency. Documentation of assessment results shall be made available to the LEMSA.

(6) If, through the EMSQIP the LEMSA Medical Director determines that an EMT and/or paramedic needs additional training, observation or testing, the LEMSA Medical Director may create a specific and targeted program of remediation based upon the identified needs of the EMT and/or paramedic. If there is disagreement between the Provider and the LEMSA Medical Director, the decision of the LEMSA Medical Director shall prevail.

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Provider understands and agrees that the LEMSA may deny, suspend, or revoke the approval of a service Provider for failure to comply with applicable policies, procedures, and regulations.

(7) Provider shall employ a Provider Medical Director who must be approved, in writing, by the LEMSA Medical Director.

II. BENEFITS GRANTED BY LEMSA TO PROVIDER

1. Boundaries:

Provider may provide ALS and/or BLS Ground Ambulance Services based upon a Certification of Operation, within the defined boundaries of the City and County of San Francisco (LEMSA EMS service area), to include Treasure Island, the Golden Gate National Recreational Area, and other Federal property within the contiguous borders of the LEMSA EMS service area, notwithstanding entry restrictions placed by Federal jurisdiction, during the period of this SPA. The ALS and/or BLS Ground Ambulance Services shall include Site to Facility patient transports, as well as Facility to Facility transports, originating from a private request and responses to 9-1-1 calls.

2. Availability of 9-1-1 Ambulances:

a) All 9-1-1 Providers shall ensure a minimum of two ambulances available to the 9-1-1 system twenty-four (24) hours per day, 365 days per year plus ambulance transport may include no more than 5 transports per month to cover unfilled service calls for patients being cared for within the DPH system.

b) Within 90 days after execution of the SPA, and t least annually thereafter, the LEMSA will notify Providers of the minimum overall number of staffed ambulances needed to meet the EMS system demand ("System Demand Analysis")

c) Within 90 days after execution of this SPA, and annually within 90 days of receipt of the System Demand Analysis, each 9-1-1 Provider shall provide their minimum Ambulance Deployment and Staffing Plan to the LEMSA, which shall be binding until receipt of the City's next System Demand Analysis.

d) Immediately upon the commencement of Services under this SPA, each Provider shall provide the LEMSA its daily staffing report.

3. City Facilities (Zuckerberg San Francisco General and Laguna Honda Hospital)

The LEMSA urges all Providers to respond to all Requests for Proposals issued by the San Francisco Department of Public Health for as-needed non-emergency services for Zuckerberg San Francisco General Hospital, Laguna Honda Hospital, the San Francisco Department of Public Health clinics, and other contracted Facilities, as well as urging City Providers to perform inter-Facility transports.

4. SPA Committees:

All Providers shall participate (attend a minimum of 75% of Committee meetings annually, as determined by the LEMSA acting in its sole discretion) in the following SPA Committees which shall be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

a) Emergency Medical Services Advisory Committee

b) Medical Director's Committee

c) Operations Committee

d) Quality Improvement Committee

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e) Trauma Committee

f) STAR Committee

g) Stroke Committee

h) Other Committees determined by the LEMSA

Ambulance Provider membership is listed in LEMSA Policy 1010.

5. Report of ALS Provider Status:

Upon request from any entity, including insurance companies, fiscal intermediaries, and other third party payers, LEMSA will identify currently authorized ALS Providers as an authorized Provider of ALS service, pursuant to California Code of Regulations, Title 22, Section, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

6. Coordination of EMS Mutual Aid Requests:

a) Outgoing 9-1-1 EMS Mutual Aid will be coordinated by the Medical Health Operational Area Coordinator (MHOAC) and will be planned in consultation with the LEMSA to minimize impact on the SF EMS System.

b) Incoming 9-1-1 EMS Mutual Aid assets will be requested by LEMSA through the MHOAC for state and regional resources. These EMS assets will be assigned to appropriate task forces, strike teams, or other assignments as determined necessary by the LEMSA in compliance with the emergency management practices outlined in LEMSA Policies and Protocols.

c) Intra-county mutual aid shall be authorized and requested by the LEMSA when the 9-1-1/PSAP generated demand exceeds, or is anticipated to exceed, the capacity of the 9-1-1/PSAP authorized ALS Providers, as determined by the LEMSA.

7. Non-Transport Treatment Fee:

The San Francisco Fire Department is authorized by local ordinance to charge a fee for on-scene treatment without a transport to a hospital. King-American Ambulance Company and American Medical Response West are authorized to charge a non-transport fee in an amount sufficient to cover the reasonable cost of this service and is agreed upon by the LEMSA.

III. OBLIGATIONS OF PROVIDER

1. Mutual Aid:

LEMSA may request mutual aid EMS resources during situations requiring additional EMS resources. Provider may provide resources, at the request of the LEMSA, in such numbers and durations as determined to be in the interest of the LEMSA**.**

2. Automatic Aid Provision:

With approval of the LEMSA, Providers may dispatch up to five ambulances and one paramedic supervisor (known as an Ambulance Strike Team), to a request for immediate aid from any geopolitical entity in California, upon approval of the appropriate manager from that Provider. The Provider shall notify the LEMSA once they have deployed single assets or an Ambulance Strike Team so that system adjustments may be made, if necessary.

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3. Performance Standards

a) Provider shall adhere to all requirements of state laws and regulations pertaining to the provision of EMS.

b) Provider shall adhere to City laws as set forth in San Francisco Health Code Articles 3 and 14, including any and all amendments thereto, if any, whether enacted before or during the term of this SPA and any extensions.

c) Provider shall adhere to all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d) Provider shall use the SEMS and the NIMS in the performance of all emergency services rendered under this SPA.

4. Document Review and Retention

a) All records maintained pursuant to this SPA, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227) shall be available for inspections, audit, or examination by LEMSA or by their designated representatives, consistent with federal, state and local confidentiality and privacy laws, and shall be preserved by Provider for at least three (3) years from the termination of this SPA.

b) All patient contacts, treatments, and interactions shall be documented by Provider, and, if a patient is transported to a Facility, sent with the patient to the Facility.

c) Upon execution of this SPA, Providers shall provide LEMSA and/or LEMSA's third-party designee an unfiltered and unaltered data stream and full access to each patient's Medical Record and Computer Aided Dispatch ("CAD") (California Health & Safety Code Section 1797.227). Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the LEMSA. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider.

d) Upon LEMSA request, Provider shall prepare and submit written reports on incidents based on Services provided under this SPA.

e) Provider shall submit monthly operation reports to the LEMSA, by the last day of the following month, in a form prescribed by the LEMSA.

f) Provider shall provide additional information and reports as requested by the LEMSA to monitor Provider performance, including but not limited to reports regarding response intervals, staffing, skilled intervention and/or performance reports, core measures reports/data, policy compliance reports, case reviews, continuing education, and/or others as required by the LEMSA acting in its sole discretion..

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5. Disaster Preparedness

a) Provider shall annually participate in a least one system-wide discussion based exercise and one system-wide functional exercise per calendar year to benefit coordination among Providers, the EMS system, and LEMSA, as determined by the LEMSA Medical Director.

b) Provider shall ensure staff, with appropriate authority to act on the behalf of Provider, are present in the City's Emergency Operations Center (EOC) when requested by LEMSA during activations or exercises involving Provider.

6. Incident Reporting

Provider shall file or caused to be filed, an Incident Report form consistent with LEMSA Policy in each instance as required by the LEMSA within timeframe reporting requirements as set forth in LEMSA policies.

7. Inspection Standards

Parties acknowledge and agree that inspection standards are governed by San Francisco Health Code Article 14, or any successor provisions.

8. Field Personnel Communication Standards

a) Provider shall post LEMSA notices and bulletins at all employee locations.

b) Provider shall require, through written policy, all personnel to have knowledge of, and follow, LEMSA Policies, Procedures and Protocols, and Directives.

c) Provider shall:

i. Ensure and assess that all EMT's and EMT-P's are trained in LEMSA policies, procedures, and protocols. Such training shall include cognitive, motor and retention skills that allow employees to properly perform EMS duties; and

ii. Provide at each Provider location, in a location easily accessible to employees, a current LEMSA Policy and Procedure Manual and Protocol Manual.

iii. Submit compliance reports quarterly to the LEMSA.

9. Fatigue Prevention

a) Provider shall develop and implement policies acceptable to LEMSA to minimize fatigue by EMT-Ps and EMTs.

b) Provider shall comply with California Code of Regulations Title 13, Section 1105 (e), which states: Driver Conditions: No person shall drive or be directed to drive an ambulance, when his/her ability to operate the ambulance safely is adversely affected by fatigue, illness or other cause nor when the vehicle is unsafe to operate.

c) Provider has informed, and agrees to continue to inform, employees of the regulation and will not retaliate against those complaining of fatigue, illness, or other cause that may affect that employee's ability to operate an ambulance safely.

10. Protected Patient Information

Provider shall comply with all federal and state patient privacy laws, and shall have and enforce a policy that prohibits Provider's employees from inappropriate sharing of protected patient

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information to include sharing via personal communication devices, social media, and any other form of data transmission.

11. Prohibition on Alcohol and Drug Use

Provider shall have and enforce a policy that prohibits Provider's employees from performing any ALS or BLS service under the influence of any alcoholic beverage, illegal drug, or narcotic. In addition, said policy shall prohibit Provider's employees from performing such services under the influence of any other substances, including prescription or non-prescription medication, which impairs their physical or mental performance.

12. Reporting of EMT and EMT-Paramedic Violations

Provider shall comply fully and timely with the reporting requirements of California Health and Safety Code Section, Division 2.5, Sections 1798.200, 1799.112, and LEMSA policies and protocols. Provider shall notify the LEMSA Medical Director within 24 hours when an allegation has been validated as a potential violation of 1798.200. Supporting documentation shall be provided within 72 hours. Notification shall be made to the LEMSA within 24 hours if an EMT and/or EMT-P is removed from patient care or resigns for an investigation based on evidence for disciplinary cause or reason.

16. LEMSA Emergency Medical Services Quality Improvement Program

Provider must participate in the LEMSA's EMSQIP as required by California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

17. Infection Control, Health and Safety:

a) Provider must have a Bloodborne Pathogen (BBP) Exposure Control plan for its employees, agents and subcontractors as defined in the California Code of Regulations, Title 8, Section 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and recordkeeping.

b) Provider must demonstrate personnel policies/procedures for protection of its employees, agents, subcontractors and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

c) Provider must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

d) Provider is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

e) Provider shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

f) Provider shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

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g) Provider assumes responsibility for procuring all medical equipment and supplies for use by its employees, agents and subcontractors, including safe needle devices, and provides and documents all appropriate training.

h) Provider shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

18. Aerosol Transmissible Disease Program, Health and Safety:

Provider must have an Aerosol Transmissible Disease (ATD) Program as defined in the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases (http://www.dir.ca.gov/Title8/5199.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, screening procedures, source control measures, use of personal protective equipment, referral procedures, training, immunization, post-exposure medical evaluations/follow-up, and recordkeeping.

19. Regional Training

Provider shall designate a minimum of one dedicated part-time staff member, hours based on need, to participate in LEMSA's regional training program to develop, teach, and implement consistent and quality prehospital education based upon LEMSA strategic objectives and quality improvement initiatives.

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APPENDIX B

San Francisco Department of Public Health

Business Associate Agreement

This Business Associate Agreement ("BAA") supplements and is made a part of the contract by and between the City and County of San Francisco, the Covered Entity ("CE"), and Contractor, the Business Associate ("BA") (the "Agreement"). To the extent that the terms of the Agreement are inconsistent with the terms of this BAA, the terms of this BAA shall control.

RECITALS

A. CE, by and through the San Francisco Department of Public Health ("SFDPH"), wishes to disclose certain information to BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI") (defined below).

B. For purposes of the Agreement, CE requires Contractor, even if Contractor is also a covered entity under HIPAA, to comply with the terms and conditions of this BAA as a BA of CE.

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws, including, but not limited to, California Civil Code §§ 56, et seq., California Health and Safety Code § 1280.15, California Civil Code §§ 1798, et seq., California Welfare & Institutions Code §§5328, et seq., and the regulations promulgated there under (the "California Regulations").

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this BAA.

E. BA enters into agreements with CE that require the CE to disclose certain identifiable health information to BA. The parties desire to enter into this BAA to permit BA to have access to such information and comply with the BA requirements of HIPAA, the HITECH Act, and the corresponding Regulations.

In consideration of the mutual promises below and the exchange of information pursuant to this BAA, the parties agree as follows:

1. Definitions.

a. Breach means the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information, and shall have the meaning given to such term under the HITECH Act and HIPAA Regulations [42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402], as well as California Civil Code Sections 1798.29 and 1798.82.

b. Breach Notification Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.

c. Business Associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information received from a covered entity, but other than in the capacity of a member of the workforce of such covered entity or arrangement, and shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

d. Covered Entity means a health plan, a health care clearinghouse, or a health care provider who transmits any information in electronic form in connection with a transaction covered under HIPAA Regulations, and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

e. Data Aggregation means the combining of Protected Information by the BA with the Protected Information received by the BA in its capacity as a BA of another CE, to permit data analyses that relate to the health care operations of the respective covered entities, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. Designated Record Set means a group of records maintained by or for a CE, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. Electronic Protected Health Information means Protected Health Information that is maintained in or transmitted by electronic media and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103. For the purposes of this BAA, Electronic PHI includes all computerized data, as defined in California Civil Code Sections 1798.29 and 1798.82.

h. Electronic Health Record means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

i. Health Care Operations shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

j. Privacy Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. Protected Health Information or PHI means any information, including electronic PHI, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Sections 160.103 and 164.501. For the purposes of this BAA, PHI includes all medical information and health insurance information as defined in California Civil Code Sections 56.05 and 1798.82.

l. Protected Information shall mean PHI provided by CE to BA or created, maintained, received or transmitted by BA on CE's behalf.

m. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. Security Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. Unsecured PHI means PHI that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute, and shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. Obligations of Business Associate.

a. Attestations. Except when CE's data privacy officer exempts BA in writing, the BA shall complete the following forms, attached and incorporated by reference as though fully set forth herein, SFDPH Attestations for Privacy (Attachment 1) and Data Security (Attachment 2) within sixty (60) calendar days from the execution of the Agreement. If CE makes substantial changes to any of these forms during the term of the Agreement, the BA will be required to complete CE's updated forms within sixty (60) calendar days from the date that CE provides BA with written notice of such changes. BA shall retain such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

b. User Training. The BA shall provide, and shall ensure that BA subcontractors, provide, training on PHI privacy and security, including HIPAA and HITECH and its regulations, to each employee or agent that will access, use or disclose Protected Information, upon hire and/or prior to accessing, using or disclosing Protected Information for the first time, and at least annually thereafter during the term of the Agreement. BA shall maintain, and shall ensure that BA subcontractors maintain, records indicating the name of each employee or agent and date on which the PHI privacy and security trainings were completed. BA shall retain, and ensure that BA subcontractors retain, such records for a period of seven years after the Agreement terminates and shall make all such records available to CE within 15 calendar days of a written request by CE.

c. Permitted Uses. BA may use, access, and/or disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. Further, BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE [45 C.F.R. Sections 164.502, 164.504(e)(2). and 164.504(e)(4)(i)].

d. Permitted Disclosures. BA shall disclose Protected Information only for the purpose of performing BA's obligations for, or on behalf of, the City and as permitted or required under the Agreement and BAA, or as required by law. BA shall not disclose Protected Information in any manner that would constitute a violation of the

Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2 (n) of this BAA, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)]. BA may disclose PHI to a BA that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit Protected Information on its behalf, if the BA obtains satisfactory assurances, in accordance with 45 C.F.R. Section 164.504(e)(1), that the subcontractor will appropriately safeguard the information [45 C.F.R. Section 164.502(e)(1)(ii)].

e. Prohibited Uses and Disclosures. BA shall not use or disclose Protected Information other than as permitted or required by the Agreement and BAA, or as required by law. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the Protected Information solely relates [42 U.S.C. Section 17935(a) and 45 C.F.R. Section 164.522(a)(1)(vi)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2), and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

f. Appropriate Safeguards. BA shall take the appropriate security measures to protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the CE, and shall prevent any use or disclosure of PHI other than as permitted by the Agreement or this BAA, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.306, 164.308, 164.310, 164.312, 164.314 164.316, and 164.504(e)(2)(ii)(B). BA shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316, and 42 U.S.C. Section 17931. BA is responsible for any civil penalties assessed due to an audit or investigation of BA, in accordance with 42 U.S.C. Section 17934(c).

g. Business Associate's Subcontractors and Agents. BA shall ensure that any agents and subcontractors that create, receive, maintain or transmit Protected Information on behalf of BA, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph 2.f. above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2) through (e)(5); 45 C.F.R. Section 164.308(b)]. BA shall mitigate the effects of any such violation.

h. Accounting of Disclosures. Within ten (10) calendar days of a request by CE for an accounting of disclosures of Protected Information or upon any disclosure of Protected Information for which CE is required to account to an individual, BA and its agents and subcontractors shall make available to CE the information required to

provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935 (c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents and subcontractors for at least seven (7) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an Electronic Health Record. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure [45 C.F.R. 164.528(b)(2)]. If an individual or an individual's representative submits a request for an accounting directly to BA or its agents or subcontractors, BA shall forward the request to CE in writing within five (5) calendar days.

i. Access to Protected Information. BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within (5) days of request by CE to enable CE to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. 164.524.

j. Amendment of Protected Information. Within ten (10) days of a request by CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA and its agents and subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment or other documentation to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R Section 164.526. If an individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request and of any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

k. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)]. BA shall provide CE a copy of any Protected Information and other documents and records that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

l. Minimum Necessary. BA, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the intended purpose of such use, disclosure, or request. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to

what constitutes "minimum necessary" to accomplish the intended purpose in accordance with HIPAA and HIPAA Regulations.

m. Data Ownership. BA acknowledges that BA has no ownership rights with respect to the Protected Information.

n. Notification of Breach. BA shall notify CE within 5 calendar days of any breach of Protected Information; any use or disclosure of Protected Information not permitted by the BAA; any Security Incident (except as otherwise provided below) related to Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by BA or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the BA to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. BA shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 42 U.S.C. Section 17932; 45 C.F.R. 164.410; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)]

o. Breach Pattern or Practice by Business Associate's Subcontractors and Agents. Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(iii), if the BA knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the contractual arrangement with its subcontractor or agent, if feasible. BA shall provide written notice to CE of any pattern of activity or practice of a subcontractor or agent that BA believes constitutes a material breach or violation of the subcontractor or agent's obligations under the Contract or this BAA within five (5) calendar days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

3. Termination.

a. Material Breach. A breach by BA of any provision of this BAA, as determined by CE, shall constitute a material breach of the Agreement and this BAA and shall provide grounds for immediate termination of the Agreement and this BAA, any provision in the AGREEMENT to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii).]

b. Judicial or Administrative Proceedings. CE may terminate the Agreement and this BAA, effective immediately, if (i) BA is named as defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any

standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. Effect of Termination. Upon termination of the Agreement and this BAA for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of Section 2 of this BAA to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

d. Civil and Criminal Penalties. BA understands and agrees that it is subject to civil or criminal penalties applicable to BA for unauthorized use, access or disclosure or Protected Information in accordance with the HIPAA Regulations and the HITECH Act including, but not limited to, 42 U.S.C. 17934 (c).

e. Disclaimer. CE makes no warranty or representation that compliance by BA with this BAA, HIPAA, the HITECH Act, or the HIPAA Regulations or corresponding California law provisions will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

4. Amendment to Comply with Law.

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the updated standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable state or federal laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

5. Reimbursement for Fines or Penalties.

In the event that CE pays a fine to a state or federal regulatory agency, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible access, use or disclosure of PHI by BA or its

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subcontractors or agents, then BA shall reimburse CE in the amount of such fine or penalties or damages within thirty (30) calendar days from City's written notice to BA of such fines, penalties or damages.

Attachment 1 – SFDPH Privacy Attestation, version 06-07-2017
Attachment 2 – SFDPH Data Security Attestation, version 06-07-2017

Office of Compliance and Privacy Affairs
San Francisco Department of Public Health
101 Grove Street, Room 330, San Francisco, CA 94102
Email: compliance.privacy@sfdph.org
Hotline (Toll-Free): 1-855-729-6040

DocuSign Envelope ID: FE14F44A-1F42-4E0C-889B-B858D0FFED40

Contractor Name:		Contractor City Vendor ID	

PRIVACY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions below in Section IV on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…	Yes	No*
A	Have formal Privacy Policies that comply with the Health Insurance Portability and Accountability Act (HIPAA)?		
B	Have a Privacy Officer or other individual designated as the person in charge of investigating privacy breaches or related incidents?		
	If yes: Name & Title:		
	Phone #:		
	Email:		
C	Require health information Privacy Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH privacy training materials are available for use; contact OCPA at 1-855-729-6040.]		
D	Have proof that employees have signed a form upon hire and annually thereafter, with their name and the date, acknowledging that they have received health information privacy training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]		
E	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?		
F	Assure that staff who create, or transfer health information (via laptop, USB/thumb-drive, handheld), have prior supervisorial authorization to do so **AND** that health information is **only transferred or created on encrypted devices approved by SFDPH Information Security staff**?		

II. Contractors who serve patients/clients and have access to SFDPH PHI, must also complete this section.

	If Applicable: DOES YOUR ORGANIZATION…	Yes	No*
G	Have (or will have if/when applicable) evidence that SFDPH Service Desk (628-206-SERV) was notified to de-provision employees who have access to SFDPH health information record systems within 2 business days for regular terminations and within 24 hours for terminations due to cause?		
H	Have evidence in each patient's / client's chart or electronic file that a Privacy Notice that meets HIPAA regulations was provided in the patient's / client's preferred language? (English, Cantonese, Vietnamese, Tagalog, Spanish, Russian forms may be required and are available from SFDPH.)		
I	Visibly post the Summary of the Notice of Privacy Practices in all six languages in common patient areas of your treatment facility?		
J	Document each disclosure of a patient's/client's health information for purposes other than treatment, payment, or operations?		
K	When required by law, have proof that signed authorization for disclosure forms (that meet the requirements of the HIPAA Privacy Rule) are obtained PRIOR to releasing a patient's/client's health information?		

III. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Privacy Officer or designated person	Name: (print)		Signature		Date	

IV. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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Contractor Name:		Contractor City Vendor ID	

DATA SECURITY ATTESTATION

INSTRUCTIONS: Contractors and Partners who receive or have access to health or medical information or electronic health record systems maintained by SFDPH must complete this form. Retain completed Attestations in your files for a period of 7 years. Be prepared to submit completed attestations, along with evidence related to the following items, if requested to do so by SFDPH.

Exceptions: If you believe that a requirement is Not Applicable to you, see instructions in Section III below on how to request clarification or obtain an exception.

I. All Contractors.

	DOES YOUR ORGANIZATION…	**Yes**	**No***
A	Conduct assessments/audits of your data security safeguards to demonstrate and document compliance with your security policies and the requirements of HIPAA/HITECH at least every two years? [Retain documentation for a period of 7 years]		
B	Use findings from the assessments/audits to identify and mitigate known risks into documented remediation plans?		
	Date of last Data Security Risk Assessment/Audit:		
	Name of firm or person(s) who performed the Assessment/Audit and/or authored the final report:		
C	Have a formal Data Security Awareness Program?		
D	Have formal Data Security Policies and Procedures to detect, contain, and correct security violations that comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)?		
E	Have a Data Security Officer or other individual designated as the person in charge of ensuring the security of confidential information?		
	If yes: Name & Title:	Phone #:	Email:
F	Require Data Security Training upon hire and annually thereafter for all employees who have access to health information? [Retain documentation of trainings for a period of 7 years.] [SFDPH data security training materials are available for use; contact OCPA at 1-855-729-6040.]		
G	Have proof that employees have signed a form upon hire and annually, or regularly, thereafter, with their name and the date, acknowledging that they have received data security training? [Retain documentation of acknowledgement of trainings for a period of 7 years.]		
H	Have (or will have if/when applicable) Business Associate Agreements with subcontractors who create, receive, maintain , transmit, or access SFDPH's health information?		
I	Have (or will have if/when applicable) a diagram of how SFDPH data flows between your organization and subcontractors or vendors (including named users, access methods, on-premise data hosts, processing systems, etc.)?		

II. ATTEST: Under penalty of perjury, I hereby attest that to the best of my knowledge the information herein is true and correct and that I have authority to sign on behalf of and bind Contractor listed above.

ATTESTED by Data Security Officer or designated person	Name: (print)		Signature		Date	

III. *EXCEPTIONS: If you have answered "NO" to any question or believe a question is Not Applicable, please contact OCPA at **1-855-729-6040** or compliance.privacy@sfdph.org for a consultation. All "No" or "N/A" answers must be reviewed and approved by OCPA below.

EXCEPTION(S) APPROVED by OCPA	Name (print)		Signature		Date	

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City and County of San Francisco
San Francisco Department of Public Health
Emergency Medical Services Division
333 Valencia St, Suite 210
San Francisco, California 94103

Agreement between the City and County of San Francisco, acting by and through its Department of Public Health and Royal Ambulance Inc.

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This emergency Service Provider Agreement ("SPA") is made this 15th day of June, 2021 in the City and County of San Francisco, State of California, by and between Royal Ambulance Inc. ("Provider") and the City and County of San Francisco, acting by and through its Depaartment of Public Health.

Recitals

WHEREAS, the San Francisco Department of Public Health is the designated local Emergency Medical Services Agency ("LEMSA") for the City and County of San Francisco, under California Health and Safety Code Section 1797.200; and

WHEREAS, Provider possesses all requisite LEMSA approvals to participate in the LEMSA Emergency Medical Services ("EMS") system, including a current and valid Certificate of Operation and when necessary an Ambulance Permit, in accordance with San Francisco Health Code Article 14; and

WHEREAS, the San Francisco Emergency Medical Services Plan authorizes Provider to provide Advanced Life Support ("ALS"), Basic Life Support ("BLS"), and/or Special Ambulance Services within the LEMSA EMS service area; and

WHEREAS, California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168(b)(4), requires that authorized paramedic service Providers have a written service provider agreement ("SPA") with the LEMSA allowing the Provider to participate in the LEMSA EMS system and obligating the Provider to comply with all State regulations and local policies and procedures, including participation in the LEMSA's Emergency Medical Services Quality Improvement Program ("EMSQIP"); and

WHEREAS, the Parties wish to enter into this written SPA in compliance with Section 100168(b)(4), when required, or otherwise as required by the LEMSAs;

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this SPA:

1.1. **"Advanced Life Support (ALS)**" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency department or other medical staff of that hospital, as defined by California Health and Safety Code, Division 2.5, Section 1797.52, including the scope of practice of Paramedic as listed in Section 1797.52 and any LEMSA approved Local Optional Scope of Practice.

1.2. **"ALS Ground Ambulance Services"** means the provision of advanced life support services provided in an ambulance by an authorized ALS Provider pursuant to a Service Provider Agreement (SPA) consistent with the California Health and Safety Code, Division 2.5, Section 1797.52 and LEMSA policies and procedures.

1.3. **"Ambulance Permit"** means a permit issued by LEMSA's Medical Director for an ambulance or routine medical transport vehicle pursuant to the San Francisco Health Code, Article 14. This permit is required to operate an ambulance or routine medical transport vehicle within the City and County of San Francisco.

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1.4. **"Authorized ALS Ambulance Provider"** means an ambulance Provider that is authorized to provide ALS ambulance services within the City pursuant to a Service Provider Agreement with the LEMSA.

1.5. **"Basic Life Support (BLS)"** means emergency first aid and cardiopulmonary resuscitation procedures, which at a minimum, include: recognizing respiratory arrest and application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim can be transported or until advanced life support is available, as defined by California Health and Safety Code, Division 2.5, Section 1797.60, including the basic scope of practice as listed in Section 1797.60 and any LEMSA approved Local Optional Scope of Practice.

1.6. **"Authorized BLS Ambulance Provider"** means an ambulance Provider that is authorized, staffed and equipped to provide basic life support in full compliance with the California Health and Safety Code, Division 2.5, Section 1797.60, all regulations of the State of California, the City Ambulance Ordinance, and LEMSA Policies, Procedures and Protocols.

1.7. **"Certificate of Operation"** means a Certificate issued under San Francisco Health Code Article 14 by the LEMSA Medical Director to a Provider who qualifies to operate an ambulance in the City. To qualify for a Certificate of Operation, the Provider must hold three valid and current Ambulance Permits.

1.8. **"Confidential Information"** means confidential City information including, but not limited to, personally-identifiable information ("PII"), protected health information ("PHI'), or individual financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.9. **"Emergency Medical Personnel"** means all public safety first responders, Emergency Medical Dispatchers, EMTs and EMT-Ps functioning within the emergency medical services system.

1.10. **"Emergency Medical Services Quality Improvement Program (EMSQIP)"** means the continuing quality improvement program, procedures and protocol documents developed by the LEMSA.

1.11. **"Emergency Medical Technician (EMT)"** means an individual trained in all facets of basic life support according to standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.80, and who has a valid certification issued pursuant to said division and local training as required by LEMSA.

1.12. **"Emergency Medical Technician – Paramedic (EMT-P)"** means an individual whose scope of practice is to provide advanced life support governed by standards prescribed by California Health and Safety Code, Division 2.5, Section 1797.84, and who has a valid license issued pursuant to said division and local accreditation as required by LEMSA.

1.13. **"Facility"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is physically present and assessed the patient's need for LEMSA.

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1.14. **"Ground Ambulance Services"** means all ambulance services performed at the request of and determined to be either a Code Two or Code Three level response by an Authorized LEMSA Dispatch Center.

1.15. **"LEMSA Medical Director"** means the San Francisco Director of Health, responsible for the duties set forth in California Health and Safety Code, Division 2.5, Section 1797.202.

1.16. **"Medical Emergency"** means the term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by public safety personnel or Emergency Medical Personnel at the scene of an emergency or dispatch personnel at a designated LEMSA Dispatch Center.

1.17. "**Medical Record**" means all patient care interaction and assessment data collected and/or generated by Provider and included in Provider's electronic medical record system, including but not limited to a record of a patient's medical information (such as medical history, care or treatments received, test results, diagnoses, and medications taken).

1.18. **"National Incident Management System (NIMS)"** means the incident management system developed by the US Department of Homeland Security, FEMA, as required by Homeland Security Presidential Directive 5 (HSPD-5).

1.19. **"Primary Public Safety Answering Point (PSAP)"** means the location where the 911 call is first answered.

1.20. **"Provider Program Director"** means the Medical Director of the Provider.

1.21. **"Response Codes"** means the dispatch term which denotes the level of priority for units responding to the scene as defined herein:

a) **Code One** - Routine or schedule transportation of patients.
b) **Code Two** - A non-life threatening Medical Emergency requiring immediate response.
c) **Code Three** - A Medical Emergency requiring immediate response with red light and siren.

1.22. **"Services"** means the provision of any and all services under this SPA.

1.23. **"Site"** means a location where a patient or patient representative requests ambulance service in which a physician, physician's assistant or nurse practitioner is NOT physically present and has NOT assessed the patient's need for LEMSA.

1.24. **"Special Ambulance Service"** means any unit-type, providing Emergency Medical Services and patient care that can be dispatched to a medical call without the ability to provide patient transport.

1.25. **"Standardized Emergency Management System (SEMS)**" means the standardized emergency management system identified in California Government Code, Section 8607.

Article 2 Term of the Agreement

2.1 **Initial Term.**

The term of this SPA shall commence on June 15, 2021 and expire five years later on June 14, 2026, unless earlier terminated as otherwise provided herein.

2.2 **Renewal of SPA.**

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This SPA shall auto-renew for four additional one-year periods upon Provider's payment of all required Certificate of Operation and/or Ambulance Permit fees and conditioned on Provider's compliance with all Certificate of Operation and Ambulance Permit requirements. The renewed SPA shall automatically terminate should Provider fail to pay all required Certificate of Operation and/or Ambulance Permit fees.

Article 3 Audit

3.1 Audit and Inspection of Records.

Provider agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate books and records, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227). Provider will permit City to audit, examine and make excerpts and transcripts from such books and records related to all matters covered by this SPA. Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the local EMS agency. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider. To the extent required by applicable law or regulation, the State of California or any Federal agency having an interest in the subject matter of this SPA shall have the same rights as conferred upon City by this Section.

Article 4 Services and Resources

4.1 Provider Shall Obtain All Necessary Permits and/or Approvals.

4.1.1 Provider shall not commence the provision of any services under this SPA until all necessary permits and/or approvals have been issued. Specifically, before commencing work, Provider shall apply for and obtain from LEMSA a Certificate of Operation and when required an Ambulance Permit, and/or all other required regulatory permits and/or approvals in accordance with applicable law, including California Code of Regulations Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic); California Health and Safety Code, Division 2.5 (Emergency Medical Services); and San Francisco Health Code, Article 14 (Ambulances and Routine Medical Transport Vehicles). Nothing in this SPA is intended to imply that City will issue any permits and/or approvals.

4.1.2 Provider shall pay all fees required as a condition precedent to the issuance of any such permits and/or approvals in accordance with the applicable rates and charges then in effect as indicated in LEMSA's fee schedule. The payments made by Provider to City shall be less than or equal to the City's actual costs to provide the LEMSA administration and oversight services. No funds shall be used by the City in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute. .

4.2 Services Provider Agrees to Perform.

Provider agrees to perform the services detailed in Appendix A, "Statement of Work." Officers and employees of the City are not authorized to request services beyond the scope listed in Appendix A.

4.3 Qualified Personnel.

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Provider shall ensure all Emergency Medical Personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of Provider services.

4.4 Subcontracting.

Excluding services for 9-1-1 calls, Provider may subcontract services to be performed under this SPA to other San Francisco LEMSA permitted service providers. For clarity 9-1-1 services may not be subcontracted.

4.5 Assignment.

The services to be performed by Provider are personal in character. Neither this SPA, nor any duties or obligations hereunder, may be directly or indirectly assigned, novated, transferred, or delegated by Provider. Any purported Assignment made in violation of this provision shall be null and void.

4.6 No Transfer of Certificate of Operation or Ambulance Permit.

Each Certification of Operation and/or Ambulance Permit by the LEMSA is a privilege that is personal and specific to Provider. Neither a Certificate of Operation, an Ambulance Permit, nor any of the privileges conferred thereunder may be neither sold, conveyed, assigned, encumbered, nor otherwise transferred by Provider. Any attempt to sell, convey, assign, encumber or otherwise transfer a Certificate of Operation, any Ambulance Permit, or the privileges conferred thereunder may result in the City's termination of this SPA.

4.7 Activities at Permittee's Expense.

Any act that Provider performs under this SPA or applicable law shall be performed at Provider's expense and without cost to City, unless said Provider is a City agency or employee providing services under this SPA.

4.8 Warranty.

Provider warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this SPA as detailed in Appendix A (Statement of Work).

Article 5 Insurance and Indemnity (RESERVED FOR SFFD)

5.1 Insurance.

5.1.1 **Required Coverages.** Without in any way limiting Provider's liability pursuant to the "Indemnification" section of this SPA, Provider must maintain in force, during the full term of the SPA, insurance in the following amounts and coverages:

(a) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than $1,000,000 each accident, injury, or illness; and

(b) Commercial General Liability Insurance with limits not less than $10,000,000 each occurrence and $20,000,000 general aggregate for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; and

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(c) Commercial Automobile Liability Insurance with limits not less than $10,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(d) Professional liability insurance, applicable to Provider's profession, with limits not less than $10,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services.

(e) Technology Errors and Omissions Liability coverage (RESERVED).

(f) Cyber and Privacy Insurance with limits of not less than $5,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.

(g) Provider shall be permitted to use umbrella or excess coverage to meet the required limits for insurance in this section.

5.1.2 Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to provide:

(a) Name as Additional Insured the City and County of San Francisco, its Officers, Agents, and Employees.

(b) That such policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this SPA, and that insurance applies separately to each insured against whom claim is made or suit is brought.

5.1.3 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

5.1.4 Should any of the required insurance be provided under a claims-made form, Provider shall maintain such coverage continuously throughout the term of this SPA and, without lapse, for a period of three years beyond the expiration of this SPA, to the effect that, should occurrences during the contract term give rise to claims made after expiration of the SPA, such claims shall be covered by such claims-made policies.

5.1.5 Should any of the required insurance be provided under a form of coverage that includes a general annual aggregate limit or provides that claims investigation or legal defense costs be included in such general annual aggregate limit, such general annual aggregate limit shall be double the occurrence or claims limits specified above.

5.1.6 Should any required insurance lapse during the term of this SPA, requests for payments originating after such lapse shall not be processed until the City receives satisfactory evidence of reinstated coverage as required by this SPA, effective as of the lapse date. If insurance is not reinstated, the City may, at its sole option, terminate this SPA effective on the date of such lapse of insurance.

5.1.7 Before commencing any Services, Provider shall furnish to City certificates of insurance and additional insured policy endorsements with insurers with ratings comparable to A-, VIII or higher, that are authorized to do business in the State of California, and that are satisfactory to City, in

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form evidencing all coverages set forth above. Approval of the insurance by City shall not relieve or decrease Provider's liability hereunder.

5.1.8 The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Provider, its employees, agents and subcontractors.

5.1.9 If Provider will use any subcontractor(s) to provide Services, Provider shall require the subcontractor(s) to provide all necessary insurance and to name the City and County of San Francisco, its officers, agents and employees and the Provider as additional insureds.

5.1.10 City may, in its sole discretion, choose to reconsider the amounts and coverages above and require amendment of this SPA to update such amounts and coverages during the term of the SPA. Provider's execution of an amendment to this SPA to put changes to these amounts and coverages in effect shall not be withheld.

5.2 **General Indemnification.**

5.2.1 Provider shall indemnify and save harmless City and its officers, agents and employees from, and, if requested, shall defend them against any and all third party claims for loss, cost, damage, injury, liability, and claims thereof for injury to or death of a person (including but not limited to patient and/or patient's relative's claims for damages arising from medical malpractice), or loss of or damage to property, arising directly or indirectly from Provider's performance of this SPA, except to the extent that such indemnity is void or otherwise unenforceable under applicable law in effect on or validly retroactive to the date of this SPA and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City, in which case damages will be apportioned under the California doctrine of comparative fault. The foregoing indemnity shall include, without limitation, reasonable fees of attorneys, consultants and experts and related third party costs that the City necessarily incurs.

5.2.2 In addition to Provider's obligation to indemnify City, Provider specifically acknowledges and agrees that it has an immediate and independent obligation to defend City from any claim which actually or potentially falls within this indemnification provision, while such claim is in effect, even if the allegations are or may be groundless, false or fraudulent, which obligation arises at the time such claim is tendered to Provider by City and continues at all times thereafter.

5.3 **Infringement Indemnification.**

Provider shall indemnify and hold the City harmless from all third party claims, loss and liability, including attorneys' fees, court costs and all other litigation expenses for any infringement of United States patent rights, or any copyright, trade secret or any other proprietary right or trademark, and all other intellectual property claims of any person or persons, arising directly or indirectly from Provider's performance of this SPA.

Article 6 Liability of the Parties

6.1 **City's Liability Limit. (RESERVED)**

6.2 **Liability for Incidental and Consequential Damages. (RESERVED)**

6.3 **Liability for Use of Equipment.**

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City shall not be liable for any damage to persons or property as a result of the misuse of equipment used by Provider, or by any of their employees, even though such equipment is furnished, rented or loaned by City.

Article 7 Payment of Taxes (RESERVED FOR SFFD)

7.1 Provider Shall Collect and Remit Taxes.

Where required under applicable law, Provider shall collect and remit to City all applicable taxes in compliance with the City's Business and Tax Regulations Code. Provider shall provide such records to City as City may require to confirm its compliance with these requirements.

7.2 Possessory Interest Tax.

Provider understands that this SPA may create a possessory interest subject to property taxation and that Provider may be subject to the payment of such taxes.

Article 8 Termination and Default

8.1 Termination for Convenience

8.1.1 **City.** The City shall have the option, in its sole discretion, to terminate this SPA, at any time during the term hereof, for convenience and without cause. City shall exercise this option by giving Provider ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective.

8.1.2 **Provider.** Provider shall have the option, in its sole discretion, to terminate this SPA, at any time during the term hereof, for convenience and without cause. Provider shall exercise this option by giving City ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective.

8.2 Probation, Suspension, and/or Termination for Default; Remedies.

The City may terminate this SPA for material breach by Provider, including but not limited to, as detailed in the LEMSA's "Pre-Hospital Provider Standards" policy. Failure to comply with the terms of this SPA, local policies and protocols, and all applicable laws and regulations as determined by the LEMSA, may result in probation, suspension, or termination of Provider's authorization to operate in the LEMSA EMS service area. In the event that Provider defaults in the performance of any duties or obligations hereunder and the default or breach has not been cured within thirty (30) calendar days of receipt of written notice of default, such failure shall be cause for the LEMSA to effect any of the following, acting in its sole discretion: Revocation of Provider's Certificate of Operation and/or Ambulance Permit; placing Provider on probation with a LEMSA approved corrective action plan; suspension of Provider's Services under this Agreement; and/or termination of this Agreement.

8.3 Non-Waiver of Rights.

The omission by the City at any time to enforce any default or right reserved to it, or to require performance of any of the terms, covenants, or provisions hereof by Provider at the time designated, shall not be a waiver of any such default or right to which the City is entitled, nor shall it in any way affect the right of the City to enforce such provisions thereafter.

8.4 Rights and Duties upon Termination or Expiration.

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This Section and the following Sections of this SPA listed below, shall survive termination or expiration of this SPA:

Article 3	Audit
Article 5	Insurance and Indemnity
Article 6	Liability of Parties
Article 7	Payment of Taxes
Article 11	General Provisions
Article 13	Data and Security

Subject to the survival of the Sections identified above, if this SPA is terminated prior to expiration of the term specified in Article 2, this SPA shall be of no further force or effect.

Article 9 Rights In Deliverables (RESERVED)

Article 10 Additional Requirements Incorporated by Reference (RESERVED FOR SFFD)

10.1 Laws Incorporated by Reference.

Provider represents and warrants that it will comply with all applicable laws and regulations in performing the Services. Subject to the foregoing, the full text of the laws listed in this Article 10, including enforcement and penalty provisions, are incorporated by reference into this SPA. The full text of the San Francisco Municipal Code provisions incorporated by reference in this Article and elsewhere in the SPA ("Mandatory City Requirements") are available at http://www.amlegal.com/codes/client/san-francisco_ca/

10.2 Conflict of Interest.

By executing this SPA, Provider certifies that it does not know of any fact which constitutes a violation of Section 15.103 of the City's Charter; Article III, Chapter 2 of City's Campaign and Governmental Conduct Code; Title 9, Chapter 7 of the California Government Code (Section 87100 *et seq.*), or Title 1, Division 4, Chapter 1, Article 4 of the California Government Code (Section 1090 *et seq.*), and further agrees promptly to notify the City if it becomes aware of any such fact during the term of this SPA.

10.3 Consideration of Salary History.

Provider shall comply with San Francisco Administrative Code Chapter 12K, the Consideration of Salary History Ordinance or "Pay Parity Act." Provider is prohibited from considering current or past salary of an applicant in determining whether to hire the applicant or what salary to offer the applicant to the extent that such applicant is applying for employment to be performed on this SPA or in furtherance of this SPA, and whose application, in whole or part, will be solicited, received, processed or considered, whether or not through an interview, in the City or on City property. The ordinance also prohibits employers from (1) asking such applicants about their current or past salary or (2) disclosing a current or former employee's salary history without that employee's authorization unless the salary history is publicly available. Provider is subject to the enforcement and penalty provisions in Chapter 12K. Information about and the text of Chapter 12K is available on the web at https://sfgov.org/olse/consideration-salary-history. Provider is required to comply with all of the applicable provisions of 12K, irrespective of the listing of obligations in this Section.

10.4 Nondiscrimination Requirements

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Provider does not as of the date of this SPA, and will not during the term of this SPA, in any of its operations in San Francisco, on real property owned by San Francisco, or where work is being performed for the City elsewhere in the United States, discriminate against an applicant for employment because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition, marital status, or citizenship, or otherwise, including in the provision of employee benefits between employees with domestic partners and employees with spouses and/or between the domestic partners and spouses of such employees, subject to the conditions set forth in San Francisco Administrative Code Section12B.2.

10.5 **Minimum Compensation Ordinance.**

Provider shall pay covered employees no less than the minimum compensation required by San Francisco Administrative Code Chapter 12P, including a minimum hourly gross compensation, compensated time off, and uncompensated time off. Provider is subject to the enforcement and penalty provisions in Chapter 12P. Information about and the text of the Chapter 12P is available on the web at http://sfgov.org/olse/mco. Provider is required to comply with all of the applicable provisions of 12P, irrespective of the listing of obligations in this Section. By signing and executing this SPA, Provider certifies that it is in compliance with Chapter 12P.

10.6 **Health Care Accountability Ordinance.**

Provider shall comply with San Francisco Administrative Code Chapter 12Q. For each Covered Employee, Provider shall provide the appropriate health benefit set forth in Section 12Q.3 of the HCAO. If Provider chooses to offer the health plan option, such health plan shall meet the minimum standards set forth by the San Francisco Health Commission. Information about and the text of the Chapter 12Q, as well as the Health Commission's minimum standards, is available on the web at http://sfgov.org/olse/hcao. Provider is subject to the enforcement and penalty provisions in Chapter 12Q. Any Subcontract entered into by Provider shall require any Subcontractor with 20 or more employees to comply with the requirements of the HCAO and shall contain contractual obligations substantially the same as those set forth in this Section.

10.7 **Alcohol and Drug-Free Workplace.**

City reserves the right to deny access to, or require Provider to remove from performance of services under this SPA personnel of any Provider who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing, selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this SPA "controlled substance" includes cannabis and derivative products.

10.8 **Consideration of Criminal History in Hiring and Employment Decisions**

10.8.1 Provider agrees to comply fully with and be bound by all of the provisions of Chapter 12T, "City Provider/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions," of the San Francisco Administrative Code ("Chapter 12T"), including the remedies provided, and implementing regulations, as may be amended from time to time. The provisions of Chapter 12T are incorporated by reference and made a part of this SPA as though fully set forth herein. The text of the

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Chapter 12T is available on the web at http://sfgov.org/olse/fco. Provider is required to comply with all of the applicable provisions of 12T, irrespective of the listing of obligations in this Section. Capitalized terms used in this Section and not defined in this SPA shall have the meanings assigned to such terms in Chapter 12T.

10.8.2 The requirements of Chapter 12T shall only apply to a Provider's or Subcontractor's operations to the extent those operations are in furtherance of the performance of this SPA, shall apply only to applicants and employees who would be or are performing work in furtherance of this SPA, and shall apply when the physical location of the employment or prospective employment of an individual is wholly or substantially within the City of San Francisco. Chapter 12T shall not apply when the application in a particular context would conflict with federal or state law or with a requirement of a government agency implementing federal or state law.

10.9 Food Service Waste Reduction Requirements.

Provider shall comply with the Food Service Waste Reduction Ordinance, as set forth in San Francisco Environment Code Chapter 16, including but not limited to the remedies for noncompliance provided therein.

10.10 Distribution of Beverages and Water. (RESERVED)

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this SPA, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

To City:	Andrew Holcomb, MS, EMS Deputy Director, San Francisco EMS Agency City and County of San Francisco 333 Valencia St, Suite 210, San Francisco, CA 94103 628-217-6014 andrew.holcomb@sfdph.org
To Provider:	Hasieb Lemar Chief Operations Officer Royal Ambulance Inc. 14472 Wicks Blvd. San Leandro, CA 94577 Hasieb.Lemar@Royalambulance.com

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

11.2 Compliance with Americans with Disabilities Act.

Provider shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

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11.3 **Reserved.**

11.4 **Sunshine Ordinance.**

Provider acknowledges that this SPA and all records related to its formation, Provider's performance of Services, and City's payment are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.5 **Modification of this SPA.**

This SPA may not be modified, nor may compliance with any of its terms be waived, except as noted in Section 11.1, "Notices to Parties," except by written instrument executed by the Parties and approved in the same manner as this SPA.

11.6 **Dispute Resolution Procedure.**

11.6.1 The Parties will attempt in good faith to resolve any dispute or controversy arising out of or relating to the performance of services under this SPA in accordance with the LEMSA's "Pre-Hospital Provider Standards" policy.

11.6.2 During the course of any Dispute Resolution process, Provider shall comply with all directives issued by the LEMSA. In the event that the LEMSA identifies a deficiency that LEMSA acting in its sole discretion determines may cause a threat to public health and/or safety, the LEMSA may issue a written probation and/or suspension notice to the Provider. Upon receipt, the Provider shall immediately comply with the terms of that notice. If the notice calls for suspension, Provider shall immediately suspend Services under this SPA until the LEMSA verifies that Provider has implemented all required corrections. Provider's failure to implement all required corrections as determined by the LEMSA acting in its sole discretion may result in termination of this SPA for default.

11.7 **Government Code Claim Requirement.**

No suit for money or damages may be brought against the City until a written claim therefor has been presented to and rejected by the City in conformity with the provisions of San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq. Nothing set forth in this SPA shall operate to toll, waive or excuse Provider's compliance with the California Government Code Claim requirements set forth in San Francisco Administrative Code Chapter 10 and California Government Code Section 900, et seq.

11.8 **Agreement Made in California; Venue.**

The formation, interpretation and performance of this SPA shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this SPA shall be in San Francisco.

11.9 **Construction.**

All paragraph captions are for reference only and shall not be considered in construing this SPA.

11.10 **Entire Agreement.**

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This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This SPA may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.11 Compliance with Laws.

Provider shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Provider's performance of this SPA, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.12 Severability.

Should the application of any provision of this SPA to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this SPA shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.13 Order of Precedence.

Provider agrees to perform the services described below in accordance with the terms and conditions of this SPA, and the Statement of Work attached as Appendix A. The terms of this SPA are to be read and interpreted together with all other documents, appendices, exhibits, and addenda attached to the SPA as a single agreement.

11.14 Notification of Legal Requests.

Provider shall immediately notify City upon receipt of any subpoenas, service of process, litigation holds, discovery requests and other legal requests ("Legal Requests") related to this SPA, and in no event later than 24 hours after it receives the request.

Article 12 Department Specific Terms

12.1 Third Party Beneficiaries.

No third parties are intended by the parties hereto to be third party beneficiaries under this SPA, and no action to enforce the terms of this SPA may be brought against either party by any person who is not a party hereto.

12.2 Exclusion Lists and Employee Verification.

Upon execution of this SPA and monthly thereafter, Provider will check the exclusion lists published by the Office of the Inspector General (OIG), General Services Administration (GSA), and the California Department of Health Care Services (DHCS) to ensure that any employee, temporary employee, volunteer, consultant, or governing body member responsible for oversight, administering or delivering state or federally-funded services who is on any of these lists is excluded from (may not work in) Provider's program or agency. Proof of checking these lists must be retained for seven years.

Article 13 Data and Security

13.1 Nondisclosure of Private, Proprietary or Confidential Information.

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13.1.1 If this SPA requires City to disclose "Private Information" to Provider within the meaning of San Francisco Administrative Code Chapter 12M, Provider and subcontractor shall use such information only in accordance with the restrictions stated in Chapter 12M and in this SPA and only as necessary in performing the Services. Provider is subject to the enforcement and penalty provisions in Chapter 12M.

13.1.2 In the performance of Services, Provider may have access to City's proprietary or confidential information, the disclosure of which to third parties may damage City. If City discloses proprietary or confidential information to Provider, such information must be held by Provider in confidence and used only in performing the SPA, except as required by law, professional rule or regulation. Provider shall exercise the same standard of care to protect such information as a reasonably prudent Provider would use to protect its own proprietary or confidential information.

13.2 **Business Associate Agreement.**

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Provider will:

1. ☒ Do **at least one** or more of the following:
A. Create, receive, maintain, or transmit PHI for or on behalf of CITY/SFDPH (including storage of PHI, digital or hard copy, even if Provider does not view the PHI or only does so on a random or infrequent basis); or

B. Receive PHI, or access to PHI, from CITY/SFDPH or another Business Associate of City, as part of providing a service to or for CITY/SFDPH, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or

C. Transmit PHI data for CITY/SFDPH and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

FOR PURPOSES OF THIS SPA, PROVIDER IS A BUSINESS ASSOCIATE OF CITY/SFDPH, AS DEFINED UNDER HIPAA. PROVIDER MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS SPA AS THOUGH FULLY SET FORTH HEREIN:

a. **Appendix E** SFDPH Business Associate Agreement (BAA) (04-12-2018)
   1. SFDPH Attestation 1 PRIVACY (06-07-2017)
   2. SFDPH Attestation 2 DATA SECURITY (06-07-2017)

2. ☐ **NOT do any of the activities listed above in subsection 1;**
Provider is not a Business Associate of CITY/SFDPH. Appendix E and attestations are not required for the purposes of this SPA.

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This option requires review and approval from the Office of Compliance and Privacy Affairs.

13.3 **Protected Health Information.**

Provider and all agents and employees Provider shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Provider by City in the performance of this SPA. Provider agrees that any failure of Contactor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Provider or its subcontractors or agents by City, Provider shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 14 Data and Security

14.1 **City Data**

14.1.1 **Ownership of City Data.** The Parties agree that as between them, all rights, including all intellectual property rights, in and to the City Data and any derivative works of the City Data shall remain the exclusive property of the City.

14.1.2 **Use of City Data**. Nothing herein shall be construed to confer any license or right to the City Data, including user tracking and exception City Data within the system, by implication, estoppel or otherwise, under copyright or other intellectual property rights, to any third-party. Unauthorized use of City Data by Provider.

14.1.3 **Data Breach; Loss of City Data**. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Provider that relate to the protection of the security, confidentiality, or integrity of City Data, Provider shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

14.1.4 **Data Privacy and Information Security Program.** Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

14.1.5 **Data Transmission.** Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure that all data exchanged shall be used expressly and solely for the purposes stated in the SPA. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this SPA, unless otherwise permitted in this SPA. The

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Provider shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

Article 15 MacBride And Signature

15.1 MacBride Principles -Northern Ireland.

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this SPA. By signing this SPA, Provider confirms that Provider has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

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IN WITNESS WHEREOF, the parties hereto have executed this SPA on the day first mentioned above.

City

San Francisco Department of Public Health

DocuSigned by:
Greg Wagner 5/27/2021 | 1:59:46 PDT
28527524752949F...

Grant Colfax, MD
Director of Health

Provider

Royal Ambulance Inc.

DocuSigned by:
Hasieb Lemar 5/26/2021 | 2:54:04 PDT
EA93CF70813840D...

Hasieb Lemar
Chief Operations Officer

Approved as to Form:

Dennis J. Herrera
City Attorney

By: DocuSigned by:
Louise Simpson 5/26/2021 | 4:48:18 PDT
BD54168A4C3B452...

Louise S. Simpson
Deputy City Attorney

Appendices

A: Statement of Work
B: Business Associate Agreement

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Appendix A

STATEMENT OF WORK

I. GENERAL REQUIREMENTS FOR APPROVED SERVICE PROVIDER:

Approved service Providers authorized to participate in the LEMSA EMS system shall perform as follows:

(1) (911 Providers, only) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA.

(2) Utilize and maintain telecommunications as specified by the LEMSA.

(3) Maintain medication solution, medical supplies, and equipment inventory as specified by the LEMSA commensurate with the basic and local optional scope of practice of the paramedic and EMT.

(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

1. controlled substance ordering and order tracking;

2. controlled substance receipt and accountability;

3. controlled substance master supply storage, security and documentation;

4. controlled substance labeling and tracking;

5. vehicle storage and security;

6. usage procedures and documentation;

7. reverse distribution;

8. disposal;

9. re-stocking procedures.

(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to;

10. controlled substance testing;

11. discrepancy reporting;

12. tampering, theft and diversion prevention and detection;

13. usage audits.

(5) Be responsible for assessing and ensuring current knowledge of their paramedics and EMTs in local policies, procedures and protocols and for assessing their EMT and/or paramedics' skills competency. Documentation of assessment results shall be made available to the LEMSA.

(6) If, through the EMSQIP the LEMSA Medical Director determines that an EMT and/or paramedic needs additional training, observation or testing, the LEMSA Medical Director may create a specific and targeted program of remediation based upon the identified needs of the EMT and/or paramedic. If there is disagreement between the Provider and the LEMSA Medical Director, the decision of the LEMSA Medical Director shall prevail.

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Provider understands and agrees that the LEMSA may deny, suspend, or revoke the approval of a service Provider for failure to comply with applicable policies, procedures, and regulations.

(7) Provider shall employ a Provider Medical Director who must be approved, in writing, by the LEMSA Medical Director.

II. BENEFITS GRANTED BY LEMSA TO PROVIDER

1. Boundaries:

Provider may provide ALS and/or BLS Ground Ambulance Services based upon a Certification of Operation, within the defined boundaries of the City and County of San Francisco (LEMSA EMS service area), to include Treasure Island, the Golden Gate National Recreational Area, and other Federal property within the contiguous borders of the LEMSA EMS service area, notwithstanding entry restrictions placed by Federal jurisdiction, during the period of this SPA. The ALS and/or BLS Ground Ambulance Services shall include Site to Facility patient transports, as well as Facility to Facility transports, originating from a private request and responses to 9-1-1 calls.

2. Availability of 9-1-1 Ambulances:

a) All 9-1-1 Providers shall ensure a minimum of two ambulances available to the 9-1-1 system twenty-four (24) hours per day, 365 days per year plus ambulance transport may include no more than 5 transports per month to cover unfilled service calls for patients being cared for within the DPH system.

b) Within 90 days after execution of the SPA, and t least annually thereafter, the LEMSA will notify Providers of the minimum overall number of staffed ambulances needed to meet the EMS system demand ("System Demand Analysis")

c) Within 90 days after execution of this SPA, and annually within 90 days of receipt of the System Demand Analysis, each 9-1-1 Provider shall provide their minimum Ambulance Deployment and Staffing Plan to the LEMSA, which shall be binding until receipt of the City's next System Demand Analysis.

d) Immediately upon the commencement of Services under this SPA, each Provider shall provide the LEMSA its daily staffing report.

3. City Facilities (Zuckerberg San Francisco General and Laguna Honda Hospital)

The LEMSA urges all Providers to respond to all Requests for Proposals issued by the San Francisco Department of Public Health for as-needed non-emergency services for Zuckerberg San Francisco General Hospital, Laguna Honda Hospital, the San Francisco Department of Public Health clinics, and other contracted Facilities, as well as urging City Providers to perform inter-Facility transports.

4. SPA Committees:

All Providers shall participate (attend a minimum of 75% of Committee meetings annually, as determined by the LEMSA acting in its sole discretion) in the following SPA Committees which shall be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

a) Emergency Medical Services Advisory Committee

b) Medical Director's Committee

c) Operations Committee

d) Quality Improvement Committee

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e) Trauma Committee

f) STAR Committee

g) Stroke Committee

h) Other Committees determined by the LEMSA

Ambulance Provider membership is listed in LEMSA Policy 1010.

5. Report of ALS Provider Status:

Upon request from any entity, including insurance companies, fiscal intermediaries, and other third party payers, LEMSA will identify currently authorized ALS Providers as an authorized Provider of ALS service, pursuant to California Code of Regulations, Title 22, Section, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

6. Coordination of EMS Mutual Aid Requests:

a) Outgoing 9-1-1 EMS Mutual Aid will be coordinated by the Medical Health Operational Area Coordinator (MHOAC) and will be planned in consultation with the LEMSA to minimize impact on the SF EMS System.

b) Incoming 9-1-1 EMS Mutual Aid assets will be requested by LEMSA through the MHOAC for state and regional resources. These EMS assets will be assigned to appropriate task forces, strike teams, or other assignments as determined necessary by the LEMSA in compliance with the emergency management practices outlined in LEMSA Policies and Protocols.

c) Intra-county mutual aid shall be authorized and requested by the LEMSA when the 9-1-1/PSAP generated demand exceeds, or is anticipated to exceed, the capacity of the 9-1-1/PSAP authorized ALS Providers, as determined by the LEMSA.

7. Non-Transport Treatment Fee:

The San Francisco Fire Department is authorized by local ordinance to charge a fee for on-scene treatment without a transport to a hospital. King-American Ambulance Company and American Medical Response West are authorized to charge a non-transport fee in an amount sufficient to cover the reasonable cost of this service and is agreed upon by the LEMSA.

III. OBLIGATIONS OF PROVIDER

1. Mutual Aid:

LEMSA may request mutual aid EMS resources during situations requiring additional EMS resources. Provider may provide resources, at the request of the LEMSA, in such numbers and durations as determined to be in the interest of the LEMSA**.**

2. Automatic Aid Provision:

With approval of the LEMSA, Providers may dispatch up to five ambulances and one paramedic supervisor (known as an Ambulance Strike Team), to a request for immediate aid from any geopolitical entity in California, upon approval of the appropriate manager from that Provider. The Provider shall notify the LEMSA once they have deployed single assets or an Ambulance Strike Team so that system adjustments may be made, if necessary.

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3. Performance Standards

a) Provider shall adhere to all requirements of state laws and regulations pertaining to the provision of EMS.

b) Provider shall adhere to City laws as set forth in San Francisco Health Code Articles 3 and 14, including any and all amendments thereto, if any, whether enacted before or during the term of this SPA and any extensions.

c) Provider shall adhere to all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d) Provider shall use the SEMS and the NIMS in the performance of all emergency services rendered under this SPA.

4. Document Review and Retention

a) All records maintained pursuant to this SPA, including but not limited to patient care, staffing, operations, fiscal and quality improvement records, dispatch logs, training records, vehicle maintenance records, controlled substance logs, Medicare compliance records, and all other records relating to its Services (California Health & Safety Code Section 1797.227) shall be available for inspections, audit, or examination by LEMSA or by their designated representatives, consistent with federal, state and local confidentiality and privacy laws, and shall be preserved by Provider for at least three (3) years from the termination of this SPA.

b) All patient contacts, treatments, and interactions shall be documented by Provider, and, if a patient is transported to a Facility, sent with the patient to the Facility.

c) Upon execution of this SPA, Providers shall provide LEMSA and/or LEMSA's third-party designee an unfiltered and unaltered data stream and full access to each patient's Medical Record and Computer Aided Dispatch ("CAD") (California Health & Safety Code Section 1797.227). Provider must use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the LEMSA. Provider must ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider.

d) Upon LEMSA request, Provider shall prepare and submit written reports on incidents based on Services provided under this SPA.

e) Provider shall submit monthly operation reports to the LEMSA, by the last day of the following month, in a form prescribed by the LEMSA.

f) Provider shall provide additional information and reports as requested by the LEMSA to monitor Provider performance, including but not limited to reports regarding response intervals, staffing, skilled intervention and/or performance reports, core measures reports/data, policy compliance reports, case reviews, continuing education, and/or others as required by the LEMSA acting in its sole discretion..

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5. Disaster Preparedness

a) Provider shall annually participate in a least one system-wide discussion based exercise and one system-wide functional exercise per calendar year to benefit coordination among Providers, the EMS system, and LEMSA, as determined by the LEMSA Medical Director.

b) Provider shall ensure staff, with appropriate authority to act on the behalf of Provider, are present in the City's Emergency Operations Center (EOC) when requested by LEMSA during activations or exercises involving Provider.

6. Incident Reporting

Provider shall file or caused to be filed, an Incident Report form consistent with LEMSA Policy in each instance as required by the LEMSA within timeframe reporting requirements as set forth in LEMSA policies.

7. Inspection Standards

Parties acknowledge and agree that inspection standards are governed by San Francisco Health Code Article 14, or any successor provisions.

8. Field Personnel Communication Standards

a) Provider shall post LEMSA notices and bulletins at all employee locations.

b) Provider shall require, through written policy, all personnel to have knowledge of, and follow, LEMSA Policies, Procedures and Protocols, and Directives.

c) Provider shall:

i. Ensure and assess that all EMT's and EMT-P's are trained in LEMSA policies, procedures, and protocols. Such training shall include cognitive, motor and retention skills that allow employees to properly perform EMS duties; and

ii. Provide at each Provider location, in a location easily accessible to employees, a current LEMSA Policy and Procedure Manual and Protocol Manual.

iii. Submit compliance reports quarterly to the LEMSA.

9. Fatigue Prevention

a) Provider shall develop and implement policies acceptable to LEMSA to minimize fatigue by EMT-Ps and EMTs.

b) Provider shall comply with California Code of Regulations Title 13, Section 1105 (e), which states: Driver Conditions: No person shall drive or be directed to drive an ambulance, when his/her ability to operate the ambulance safely is adversely affected by fatigue, illness or other cause nor when the vehicle is unsafe to operate.

c) Provider has informed, and agrees to continue to inform, employees of the regulation and will not retaliate against those complaining of fatigue, illness, or other cause that may affect that employee's ability to operate an ambulance safely.

10. Protected Patient Information

Provider shall comply with all federal and state patient privacy laws, and shall have and enforce a policy that prohibits Provider's employees from inappropriate sharing of protected patient

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information to include sharing via personal communication devices, social media, and any other form of data transmission.

11. Prohibition on Alcohol and Drug Use

Provider shall have and enforce a policy that prohibits Provider's employees from performing any ALS or BLS service under the influence of any alcoholic beverage, illegal drug, or narcotic. In addition, said policy shall prohibit Provider's employees from performing such services under the influence of any other substances, including prescription or non-prescription medication, which impairs their physical or mental performance.

12. Reporting of EMT and EMT-Paramedic Violations

Provider shall comply fully and timely with the reporting requirements of California Health and Safety Code Section, Division 2.5, Sections 1798.200, 1799.112, and LEMSA policies and protocols. Provider shall notify the LEMSA Medical Director within 24 hours when an allegation has been validated as a potential violation of 1798.200. Supporting documentation shall be provided within 72 hours. Notification shall be made to the LEMSA within 24 hours if an EMT and/or EMT-P is removed from patient care or resigns for an investigation based on evidence for disciplinary cause or reason.

16. LEMSA Emergency Medical Services Quality Improvement Program

Provider must participate in the LEMSA's EMSQIP as required by California Code of Regulations, Title 22, Division 9, Chapter 4 (Emergency Medical Technical-Paramedic), Section 100168.

17. Infection Control, Health and Safety:

a) Provider must have a Bloodborne Pathogen (BBP) Exposure Control plan for its employees, agents and subcontractors as defined in the California Code of Regulations, Title 8, Section 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and recordkeeping.

b) Provider must demonstrate personnel policies/procedures for protection of its employees, agents, subcontractors and clients from other communicable diseases prevalent in the population served. Such policies and procedures shall include, but not be limited to, work practices, personal protective equipment, staff/client Tuberculosis (TB) surveillance, training, etc.

c) Provider must demonstrate personnel policies/procedures for Tuberculosis (TB) exposure control consistent with the Centers for Disease Control and Prevention (CDC) recommendations for health care facilities and based on the Francis J. Curry National Tuberculosis Center: Template for Clinic Settings, as appropriate.

d) Provider is responsible for site conditions, equipment, health and safety of their employees, and all other persons who work or visit the job site.

e) Provider shall assume liability for any and all work-related injuries/illnesses including infectious exposures such as BBP and TB and demonstrate appropriate policies and procedures for reporting such events and providing appropriate post-exposure medical management as required by State workers' compensation laws and regulations.

f) Provider shall comply with all applicable Cal-OSHA standards including maintenance of the OSHA 300 Log of Work-Related Injuries and Illnesses.

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g) Provider assumes responsibility for procuring all medical equipment and supplies for use by its employees, agents and subcontractors, including safe needle devices, and provides and documents all appropriate training.

h) Provider shall demonstrate compliance with all state and local regulations with regard to handling and disposing of medical waste.

18. Aerosol Transmissible Disease Program, Health and Safety:

Provider must have an Aerosol Transmissible Disease (ATD) Program as defined in the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases (http://www.dir.ca.gov/Title8/5199.html), and demonstrate compliance with all requirements including, but not limited to, exposure determination, screening procedures, source control measures, use of personal protective equipment, referral procedures, training, immunization, post-exposure medical evaluations/follow-up, and recordkeeping.

19. Regional Training

Provider shall designate a minimum of one dedicated part-time staff member, hours based on need, to participate in LEMSA's regional training program to develop, teach, and implement consistent and quality prehospital education based upon LEMSA strategic objectives and quality improvement initiatives.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF EMERGENCY MANAGEMENT

SAN FRANCICO EMS AGENCY

2022 EMS PLAN
ANNUAL UPDATE

San Francisco EMS Agency
333 Valencia St. Ste 210
San Francisco, CA 94103
(628) 217-6000

SF.GOV/EMSA

Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St., Suite 210, San Francisco, CA 94103
Phone: (628) 217-6000 Fax: (628) 217-6001

London Breed
Mayor

Mary Ellen Carroll
Executive Director

Date: August 31, 2022

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2022 EMS Plan Annual Update – Executive Summary

The San Francisco EMS Agency (SFEMSA) is hereby submitting and attaching its annual EMS Plan pursuant to California Health and Safety Code §§ 1797.103 and 1797.254, which includes Quality Improvement plan under Title 22, California Code of Regulations § 100404.

Recognizing San Francisco's inconsistencies in EMS Plan submission, moving forward, San Francisco will submit an EMS Plan by the end of August each year with clinical data being from the previous calendar year (2021) and operational/fiscal data from the previously fiscal year (FY22- June 1, 2021 – July 31, 2022). This plan submission reflects this new internal process.

SFEMSA has been extremely busy, dedicated, and is excited to showcase many of the new initiatives, changes, and ongoing work as part of planning, implementing, and evaluation pursuant to our obligation as a Local EMS Agency over the past year. SFEMSA continues to promote innovation and continuous improvement.

First and foremost, on July 1, 2021, the EMS Agency was formally transferred from the City and County San Francisco's Department of Public Health (DPH) to the Department of Emergency Management (DEM). Functionally and structurally, this was a major change moving SFEMSA from DPH with 8,000 employees to DEM with 300 employees. SFEMSA has been added as a 4th division within DEM, reporting directly to DEM Executive Director, Mary Ellen Carroll. Dr. John Brown, SFEMSA medical director, reports through the County Health Officer and San Francisco Health Commission. This new structure has enabled elevation of EMS System needs and problem solving to some of the highest levels city government as well as promotion of new initiatives.

This past EMS planning period has not been without significant challenges. Besides a departmental transition, SFEMSA responded to an unprecedented COVID-19 pandemic medical surge with the omicron variant and is still experiencing significant staffing challenges across the entire continuum of the EMS system from dispatchers all the way to hospital staffing. SFEMSA was not immune from state-wide major issues resulting in ambulance patient offload times, hospital diversion, call volume, and ambulance availability. In addition, SFEMSA supported city-wide responses to returning in-person planned special events such as Pride Celebration and Golden State Warriors parade within the same week. SFEMSA responded to multi-hazard events such as extreme heat significantly impacting the EMS System. Finally, SFEMSA continues to respond in a supportive role, maximizing EMS as a resource, to the crisis on the streets including persons experiencing homelessness, overdoses, sobering services, and behavioral health.

SFEMSA continues to expand its approach to clinical quality review through infrequently used skills data, research, cardiac arrest case review, specialty care such as STEMI and stroke, trauma, and most recently formation of an EMS for Childrens committee in July 2022. SFEMSA is in the process of submitting plans and implementation for specialty services as Memorandums of Understanding are drafted between SFEMSA and hospitals, CARES contract finalized, and final execution of American Heart Association – Get with the Guidelines for CAD and Stroke. This quality improvement work also includes massive data reporting overhaul and analysis leading to better reporting and operational management.

SFEMSA has embarked on many new initiatives and programs directly affecting patients and the community. SFEMSA has recently developed a program called “EMS Alert” to actively and automatically route ambulances based on hospital capacity and ambulance status. PulsePoint, a cardiac arrest notification system, was implemented in May 2022 after many years of delays. Extensive policy development in airway management, including transition to iGel and video laryngoscopy, has seen an increase in airway success. The LUCAS device program, managed by SFEMSA, has been deployed into unique settings such as marine unit and airport response.

These efforts are starting to show results. EMS Alert has reduced EMS surge events and impacts to hospitals. With hospital and prehospital provider consensus, four new groundbreaking hospital policies were developed to address diversion and patient offload issues. San Francisco continues to lead the charge with obtaining additional local optional scope of practice in vaccination efforts, burprenorphine, critical care, and soon ketamine. SFEMSA also witnessed promising trends in cardiac arrest metrics for 2021.

Finally, the City and County of San Francisco continues to invest in its EMS system. With upcoming FY23, SFEMSA received 3 positions including a management role, part-time epidemiologist, and full-time EMS Specialist position to address specialty programs. Furthermore, a fee increase was approved along with an additional fee to support specialty care through stroke center designation. In addition, San Francisco Fire Department (SFFD), the largest EMS Provider, received 60 additional Paramedic positions as well as continued investment Community Paramedicine. These additional investments by SFFD easily surpass 10 million dollars.

Through the COVID-19 pandemic, the San Francisco EMS system had to make several temporary changes to ensure availability of resources. This included use of BLS on a short-term basis within the 911 system to maintain services during critical resource availability. While BLS is used as part of our surge planning and preapproved for special events based on historical call volume, SFEMSA would propose a pilot for a 1-year period to augment ALS resources as part of the 911 system. After reviewing the data during this period, we have found that BLS utilization has had minimal effects on overall EOA percentages, but has provided critical relief during variability of call volume and surges. A full description of this program is included within our EMS Plan submission and would include only EOA providers pending consent from the state for implementation of the medium-term pilot.

As SFEMSA moves forward, dedicated to continuous improvement for the betterment of patient care and outcome, SFEMSA’s #1 priority for this upcoming planning period is submission of the Community Paramedicine and meeting Triage to Alternate Destination regulatory requirements. You will find our goals and timelines listed in the attachments for SFEMSA’s projects over the upcoming planning period.

SFEMSA looks forward to showcasing all of the tireless hours of hard work and dedication to EMS services for visitors and San Franciscans over the past year. For any questions, concerns, or requests for additional information regarding our submission, please do not hessite to contact me directly.

Andrew Holcomb
EMS Director, EMS Agency
andrew.holcomb@sfgov.org
628-217-6014

Cc: Dr. John Brown, EMS Agency Medical Director
Rob Smuts, DEC Deputy Director
Mary Ellen Carroll, DEM Executive Director
Christina Fletes-Romo, Deputy City Attorney

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SECTION I - Forms

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

A. SYSTEM ORGANIZATION AND MANAGEMENT

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Agency Administration:					
1.01 LEMSA Structure		x			
1.02 LEMSA Mission		x			
1.03 Public Input		x			
1.04 Medical Director		x	x		
Planning Activities:					
1.05 System Plan		x			
1.06 Annual Plan Update		x			
1.07 Trauma Planning*		x	x		
1.08 ALS Planning*		x			
1.09 Inventory of Resources		x			
1.10 Special Populations		x	x		
1.11 System Participants		x		x	
Regulatory Activities:					
1.12 Review & Monitoring		x			
1.13 Coordination		x			
1.14 Policy & Procedures Manual		x			
1.15 Compliance w/Policies		x			
System Finances:					
1.16 Funding Mechanism		x			
Medical Direction:					
1.17 Medical Direction*		x			
1.18 QA/QI		x	x		
1.19 Policies, Procedures, Protocols		x	x		

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

A. SYSTEM ORGANIZATION AND MANAGEMENT (continued)

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
1.20 DNR Policy		x			
1.21 Determination of Death		x			
1.22 Reporting of Abuse		x			
1.23 Interfacility Transfer		x			
Enhanced Level: Advanced Life Support					
1.24 ALS Systems		x			
1.25 On-Line Medical Direction		x	x		
Enhanced Level: Trauma Care System:					
1.26 Trauma System Plan		x			
Enhanced Level: Pediatric Emergency Medical and Critical Care System:					
1.27 Pediatric System Plan		x			
Enhanced Level: Exclusive Operating Areas:					
1.28 EOA Plan		x			

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

B. STAFFING/TRAINING

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Local EMS Agency:					
2.01 Assessment of Needs		x			
2.02 Approval of Training		x			
2.03 Personnel		x			
Dispatchers:					
2.04 Dispatch Training		x			
First Responders (non-transporting):					
2.05 First Responder Training		x	x		
2.06 Response		x			
2.07 Medical Control		x			
Transporting Personnel:					
2.08 EMT-I Training		x	x		
Hospital:					
2.09 CPR Training		x			
2.10 Advanced Life Support		x			
Enhanced Level: Advanced Life Support:					
2.11 Accreditation Process		x			
2.12 Early Defibrillation		x		x	
2.13 Base Hospital Personnel		x			

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

C. COMMUNICATIONS

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Communications Equipment:						
3.01	Communication Plan*		x	x		
3.02	Radios		x	x		
3.03	Interfacility Transfer*		x			
3.04	Dispatch Center		x			
3.05	Hospitals		x	x		
3.06	MCI/Disasters		x			
Public Access:						
3.07	9-1-1 Planning/ Coordination		x	x		
3.08	9-1-1 Public Education		x			
Resource Management:						
3.09	Dispatch Triage		x	x		
3.10	Integrated Dispatch		x	x		

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

D. RESPONSE/TRANSPORTATION

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
4.01 Service Area Boundaries*		x	x		
4.02 Monitoring		x	x		
4.03 Classifying Medical Requests		x			
4.04 Prescheduled Responses		x			
4.05 Response Time*		x			
4.06 Staffing		x			
4.07 First Responder Agencies		x			
4.08 Medical & Rescue Aircraft*		x			
4.09 Air Dispatch Center		x			
4.10 Aircraft Availability*		x			
4.11 Specialty Vehicles*		x	x		
4.12 Disaster Response		x			
4.13 Intercounty Response*		x	x		
4.14 Incident Command System		x			
4.15 MCI Plans		x			
Enhanced Level: Advanced Life Support:					
4.16 ALS Staffing		x	x		
4.17 ALS Equipment		x			
Enhanced Level: Ambulance Regulation:					
4.18 Compliance		x			
Enhanced Level: Exclusive Operating Permits:					
4.19 Transportation Plan		x			
4.20 “Grandfathering”		x			
4.21 Compliance		x			
4.22 Evaluation		x			

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

E. FACILITIES/CRITICAL CARE

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
5.01 Assessment of Capabilities		x		x	
5.02 Triage & Transfer Protocols*		x			
5.03 Transfer Guidelines*		x			
5.04 Specialty Care Facilities*		x			
5.05 Mass Casualty Management		x			
5.06 Hospital Evacuation*		x			
Enhanced Level: Advanced Life Support:					
5.07 Base Hospital Designation*		x			
Enhanced Level: Trauma Care System:					
5.08 Trauma System Design		x			
5.09 Public Input		x			
Enhanced Level: Pediatric Emergency Medical and Critical Care System:					
5.10 Pediatric System Design		x			
5.11 Emergency Departments		x	x		
5.12 Public Input		x			
Enhanced Level: Other Specialty Care Systems:					
5.13 Specialty System Design		x			
5.14 Public Input		x			

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

F. DATA COLLECTION/SYSTEM EVALUATION

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
6.01 QA/QI Program		x	x		
6.02 Prehospital Records		x			
6.03 Prehospital Care Audits		x		x	
6.04 Medical Dispatch		x			
6.05 Data Management System*		x		x	
6.06 System Design Evaluation		x		x	
6.07 Provider Participation		x			
6.08 Reporting		x		x	
Enhanced Level: Advanced Life Support:					
6.09 ALS Audit		x			
Enhanced Level: Trauma Care System:					
6.10 Trauma System Evaluation		x			
6.11 Trauma Center Data		x			

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

G. PUBLIC INFORMATION AND EDUCATION

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:						
7.01	Public Information Materials		x	x		
7.02	Injury Control		x			
7.03	Disaster Preparedness		x	x		
7.04	First Aid & CPR Training		x			

TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES

H. DISASTER MEDICAL RESPONSE

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
8.01 Disaster Medical Planning*		x			
8.02 Response Plans		x			
8.03 HazMat Training		x			
8.04 Incident Command System		x	x		
8.05 Distribution of Casualties*		x	x		
8.06 Needs Assessment		x	x		
8.07 Disaster Communications*		x			
8.08 Inventory of Resources		x			
8.09 DMAT Teams		x			
8.10 Mutual Aid Agreements*		x			
8.11 CCP Designation*		x			
8.12 Establishment of CCPs		x			
8.13 Disaster Medical Training		x			
8.14 Hospital Plans		x	x		
8.15 Interhospital Communications		x			
8.16 Prehospital Agency Plans		x	x		
Enhanced Level: Advanced Life Support:					
8.17 ALS Policies		x			
Enhanced Level: Specialty Care Systems:					
8.18 Specialty Center Roles		x		x	
Enhanced Level: Exclusive Operating Areas/Ambulance Regulations:					
8.19 Waiving Exclusivity		x			

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT

Reporting Year: _____**FY21-22**_____

NOTE: Number (1) below is to be completed for each county. The balance of Table 2 refers to each agency.

1. Percentage of population served by each level of care by county:
(Identify for the maximum level of service offered; the total of a, b, and c should equal 100%.)

County: ____**City and County of San Francisco**_____

A.	Basic Life Support (BLS)	____**0**_____%
B.	Limited Advanced Life Support (LALS)	____**0**_____%
C.	Advanced Life Support (ALS)	____**100**___%

2. Type of agency
   a) Public Health Department
   b) County Health Services Agency
   c) **Other (non-health) County Department (Department of Emergency Management)**
   d) Joint Powers Agency
   e) Private Non-Profit Entity
   f) Other: _____

3. The person responsible for day-to-day activities of the EMS agency reports to
   a) Public Health Officer
   b) Health Services Agency Director/Administrator
   c) Board of Directors
   d) Other: ___**Executive Director, Department of Emergency Management**_____

4. Indicate the non-required functions which are performed by the agency:

Implementation of exclusive operating areas (ambulance franchising)	____**Yes**_____
Designation of trauma centers/trauma care system planning	____**Yes**_____
Designation/approval of pediatric facilities	____**Yes**_____
Designation of other critical care centers	__**Yes - Burn**_
Development of transfer agreements	____**Yes**_____
Enforcement of local ambulance ordinance	____**Yes**_____
Enforcement of ambulance service contracts	____**No**_____
Operation of ambulance service	____**No**_____
Continuing education	____**Yes**_____
Personnel training	____**Yes**_____
Operation of oversight of EMS dispatch center	____**Yes**_____
Non-medical disaster planning	____**Yes**_____
Administration of critical incident stress debriefing team (CISD)	____**No**_____

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

Administration of disaster medical assistance team (DMAT)	**No**
Administration of EMS Fund [Senate Bill (SB) 12/612]	**No**_____
Other: _____	_____
Other: _____	_____
Other: _____	_____

5. EXPENSES – ***FY22-23 Budget***

Salaries and benefits (All but contract personnel)	**$ 2,311,186_**
Contract Services (e.g. medical director)	**$72,896__**
Operations (e.g. copying, postage, facilities)	**$13,500___**
Travel	_____
Fixed assets	**$274,839_**
Indirect expenses (overhead)	_____
Ambulance subsidy	_____
EMS Fund payments to physicians/hospital	_____
Dispatch center operations (non-staff)	_____
Training program operations	_____
Other: **Contracts (Prof Services)**_____	**$295,765_**
Other: **Membership Fees**_____	**$640_____**
Other: _____	_____
TOTAL EXPENSES	**$ 2,968,826_**

6. SOURCES OF REVENUE

Special project grant(s) [from EMSA]	$ _____
Preventive Health and Health Services (PHHS) Block Grant	_____
Office of Traffic Safety (OTS)	_____
State general fund	_____
County general fund	**$2,106,979***
Estimate, CCSF requires balanced budget, EMSA balanced for FY22-23	
Other local tax funds (e.g., EMS district)	_____
County contracts (e.g. multi-county agencies)	_____
Certification fees	**$106,847__**
Training program approval fees	_____
Training program tuition/Average daily attendance funds (ADA)	_____
Job Training Partnership ACT (JTPA) funds/other payments	_____

Base hospital application fees _____

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

Trauma center application fees	_____
Trauma center designation fees	_____
Pediatric facility approval fees	_____
Pediatric facility designation fees	_____
Other critical care center application fees	**$195,230**__
Type: **Receiving Hospital**_____	
Other critical care center designation fees	**$119,305**__
Type: **STEMI Center**_____	
Other critical care center designation fees	**$167,027**__
Type: **Stroke Center**_____	
Ambulance service/vehicle fees	**$341,458**__
Contributions	_____
EMS Fund (SB 12/612)	_____
Other grants: _____	_____
Other fees: _____	_____
Other (specify): _____	_____
TOTAL REVENUE	$ **$3,036,846***

Non-General Fund Revenue $929,876

TOTAL REVENUE SHOULD EQUAL TOTAL EXPENSES.
IF THEY DON'T, PLEASE EXPLAIN.

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

7. <u>Fee structure</u> ****Fiscal Year 22-23****

_____ We do not charge any fees

__**x**___ Our fee structure is:

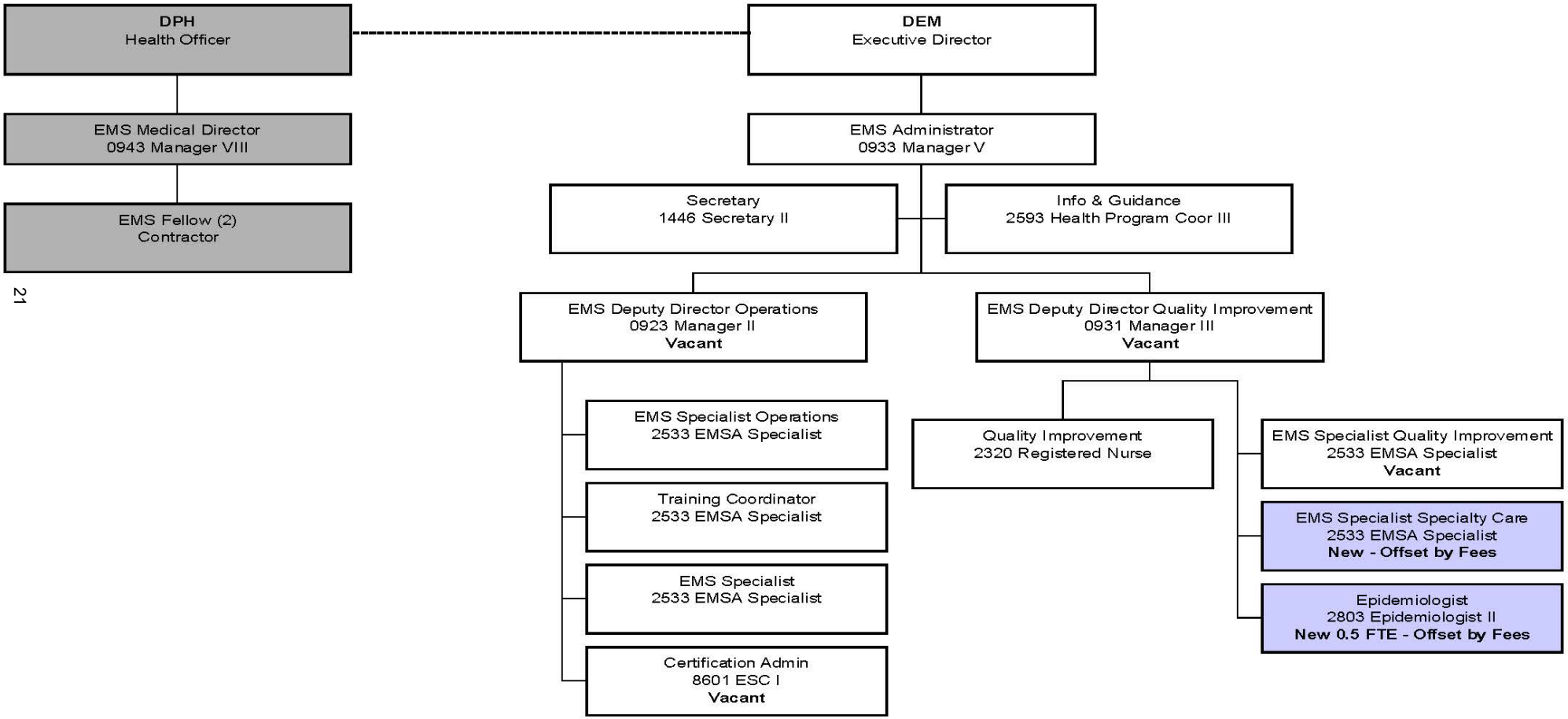
First responder certification	$ ____**No**_____
EMS dispatcher certification	____**No**_____
EMT-I certification	____**$183**____
EMT-I recertification	____**$135**____
EMT-defibrillation certification	____**No**_____
EMT-defibrillation recertification	____**No**_____
AEMT certification	____**No**_____
AEMT recertification	____**No**_____
EMT-P accreditation	____**$40**_____
Mobile Intensive Care Nurse/Authorized Registered Nurse certification	____**No**_____
MICN/ARN recertification	____**No**_____
EMT-I training program approval	____**$1,517**__
AEMT training program approval	____**No**_____
EMT-P training program approval	____**$2,272**__
MICN/ARN training program approval	____**No**_____
Base hospital application	____**No**_____
Base hospital designation	____**No**_____
Trauma center application	____**No**_____
Trauma center designation	____**No**_____
Pediatric facility approval	____**No**_____
Pediatric facility designation	____**No**_____
Other critical care center application Type: **Receiving Hospital**_____	____**$19,523**_
Other critical care center designation Type: **STEMI Center**_____	____**$23,861**_
Other critical care center designation Type: **Stroke Center**_____	____**$23,861**_
Ambulance service license	____**$12,800**_
Ambulance vehicle permits	____**$2,048**__
Other: **Annual Ambulance Renewal**_____	____**$6,400**__
Other: **Initial CE Program**_____	____**$762**____
Other: **Renewal CE Program**_____	____**$461**____
Other: **Renewal EMT-P Program**_____	____**$1,139**__

Other: **Renewal EMT Program_____** **____$832____**

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	TOTAL W/ BENEFITS	COMMENTS
EMS Director	0933 Manager V	1.0	$209,118	$277,406	Andrew Holcomb
EMS Agency Medical Director	0943 Manager VIII	1.0	n/a	n/a	Dr. John Brown – Funded via DPH
EMS Deputy Director (Operations)	0923 Manager II	1.0	$167,492	$228,486	Vacant
EMS Deputy Director (QI)	0931 Manager III	1.0	$180,622	$243,892	Vacant
EMS Specialist (Operations)	2533 EMS Specialist	1.0	$148,564	$200,143	Ryan Seymour
EMS Specialist (QI)	2533 EMS Specialist	1.0	$148,564	$200,143	Vacant
EMS Specialist (Communications)	8239 Public Safety Comm. Sup.	1.0	n/a	n/a	Temp. workorder from DEC Kayleigh Hillcoat
EMS Specialist (Training)	2533 EMS Specialist	1.0	$148,564	$200,143	Ron Pike
EMS Specialist (Special Projects/QI)	2533 EMS Specialist	1.0	$148,564	$200,143	Leo Ishoda
EMS Specialist (Specialty Care)	2533 EMS Specialist	1.0	$148,564	$200,143	Vacant – new position for FY23
Nurse	2320 Registered Nurse	1.0	$199,394	$259,477	Elaina Gunn
Info and Guidance	2593 Health Program Coordinator III	1.0	$143,962	$194,893	Erin Bachus
Epidemiologist	2803 Epidemiologist II	0.5	n/a	n/a	Vacant – new position for FY23 (workorder)
Certification Specialist	8601 Emer. Services Coordinator I	1.0	$97,006	$137,413	Vacant
Admin/Certification Specialist	1446 Secretary II	1.0	$89,700	$127,908	Camilla Arcia
EMS Disaster Medicine Fellow	n/a	*contract	n/a	n/a	Funded via $100,000 contract with UCSF

Department of Emergency Management
Emergency Medical Services Agency (EMSA)
Organizational Chart
FY 2022-2023



Notations:

General Funded Position | Interdepartment Coordination | New Position Request

Proposed for FY22-23

TABLE 3: STAFFING/TRAINING

Reporting Year: __**FY21-22**_____

NOTE: Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN
Total Certified	**1903**			
Number newly certified this year	**147**			
Number recertified this year	**652**			
Total number of accredited personnel on July 1 of the reporting year	**562**			
Number of certification reviews resulting in:				
a) formal investigations	**7**			
b) probation	**5**			
c) suspensions	**0**			
d) revocations	**2**			
e) denials	**0**			
f) denials of renewal	**0**			
g) no action taken	**0**			

1. Early defibrillation:
   a) Number of EMT-I (defib) authorized to use AEDs ____**1903**____
   b) Number of public safety (defib) certified (non-EMT-I) ____**0**____

2. Do you have an EMR training program ☐ yes **x** no

TABLE 4: COMMUNICATIONS

Note: Table 4 is to be answered for each county.

County: **San Francisco**_____

Reporting Year: **_FY21-22**_____

1.	Number of primary Public Service Answering Points (PSAP)	**4***
2.	Number of secondary PSAPs	**1 (3-1-1)**
3.	Number of dispatch centers directly dispatching ambulances	**6**
4.	Number of EMS dispatch agencies utilizing EMD guidelines	**6**
5.	Number of designated dispatch centers for EMS Aircraft	**None**
6.	Who is your primary dispatch agency for day-to-day emergencies? **Department of Emergency Management – Division of Emergency Communications (DEC)**	
7.	Who is your primary dispatch agency for a disaster? **Department of Emergency Management – Division of Emergency Communication (DEC)**	
8.	Do you have an operational area disaster communication system?	**x** Yes ☐ No
	a. Radio primary frequency _____	
	b. Other methods _____	
	c. Can all medical response units communicate on the same disaster communications system?	**x** Yes ☐ No
	d. Do you participate in the Operational Area Satellite Information System	**x** Yes ☐ No
	e. Do you have a plan to utilize the Radio Amateur Civil Emergency Services	**x** Yes ☐ No
	1) Within the operational area?	**x** Yes ☐ No
	2) Between operation area and the region and/or state?	**x** Yes ☐ No

***DEM CCSF, National Park Service (US Park Police), SF State University, UCSF**

TABLE 5: RESPONSE/TRANSPORTATION

Reporting Year: **FY21-22**_____

Note: Table 5 is to be reported by agency.

Early Defibrillation Providers

1. Number of EMT-Defibrillation providers **0**_____

SYSTEM STANDARD RESPONSE TIMES (90TH PERCENTILE)

Enter the response times in the appropriate boxes:

	METRO/URBAN	SUBURBAN/ RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder (SF standard 4 min, 30 sec 90th%)	**00:06:24**	**n/a**	**n/a**	**00:06:24**
Early defibrillation responder (SF standard 4 min, 30 sec 90th%)	**00:06:24**	**n/a**	**n/a**	**00:06:24**
Advanced life support responder (SF standard 7 min 90th%)	**00:06:31**	**n/a**	**n/a**	**00:06:31**
Transport Ambulance (Code 3 SF standard 10 min 90th%) (Code 2 SF standard 20 min 90th%)	**00:12:02** **00:21:36**	**n/a**	**n/a**	**00:12:02** **00:21:36**

Public Facing Dashboard http://sfemergencymedicalresponse.weebly.com/

TABLE 6: SYSTEM RESOURCES AND OPERATIONS
Facilities/Critical Care

Reporting Year: **2021**

NOTE: Table 6 is to be reported by agency.

Trauma

Trauma patients:	
1. Number of patients meeting trauma triage criteria	**2,826**
2. Number of major trauma victims transported directly to a trauma center by ambulance	**2,373**
3. Number of major trauma patients transferred to a trauma center	**236**
4. Number of patients meeting triage criteria who were not treated at a trauma center	**N/A**

Emergency Departments

Total number of emergency departments	**11**
1. Number of referral emergency services	**none**
2. Number of standby emergency services	**1**
3. Number of basic emergency services	**9**
4. Number of comprehensive emergency services	**1**

Receiving Hospitals

1. Number of receiving hospitals with written agreements	**1**
2. Number of base hospitals with written agreements	**0**

TABLE 7: DISASTER MEDICAL

Reporting Year: **FY21-22**

County: **San Francisco**

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? **Policy 4020 EMS Aircraft Utilization/MCI Plan**
   b. How are they staffed? **EMS/SFFD/SFPD Personnel**
   c. Do you have a supply system for supporting them for 72 hours? **x** Yes ☐ No

2. CISD
   Do you have a CISD provider with 24 hour capability? **x** Yes ☐ No

3. Medical Response Team
   a. Do you have any team medical response capability? ☐ Yes **x** No
   b. For each team, are they incorporated into your local response plan? ☐ Yes **x** No
   c. Are they available for statewide response? ☐ Yes **x** No
   d. Are they part of a formal out-of-state response system? ☐ Yes **x** No

4. Hazardous Materials
   a. Do you have any HazMat trained medical response teams? **x** Yes ☐ No
   b. At what HazMat level are they trained? **Awareness**
   c. Do you have the ability to do decontamination in an emergency room? **x** Yes ☐ No
   d. Do you have the ability to do decontamination in the field? **x** Yes ☐ No

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? **x** Yes ☐ No

2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? **1**

3. Have you tested your MCI Plan this year in a:
   a. real event? **x** Yes ☐ No
   b. exercise? **x** Yes ☐ No

TABLE 7: DISASTER MEDICAL (cont.)

4. List all counties with which you have a written medical mutual aid agreement:
   none_____

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? ☐ Yes **x** No

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? ☐ Yes **x** No

7. Are you part of a multi-county EMS system for disaster response? ☐ Yes **x** No

8. Are you a separate department or agency? ☐ Yes **x** No

9. If not, to whom do you report? **Department of Emergency Management**_____

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? **x** Yes ☐ No

TABLE 8: Response/Transportation/Providers

Note: *Table 8 is to be completed for each provider by county.* Make copies as needed.

County: San Francisco **Provider:** San Francisco Fire Department **Response Zone:** City and County of SF

Address: 2241 Jerrold Avenue (Station 49)
San Francisco, CA 94124

Number of Ambulance Vehicles in Fleet: 56

Phone Number: 415-558-3200

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 23

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:	
x Yes ❒ No	x Yes ❒ No	x Yes ❒ No	x Transport x ALS x 9-1-1 x Ground x Non-Transport ❑ BLS ❑ 7-Digit ❑ Air ❑ CCT x Water x IFT	
Ownership: x Public ❒ Private	**If Public:** x Fire ❒ Law ❒ Other Explain: _____	**If Public:** x City x County ❒ State ❒ Fire District ❒ Federal	**If Air:** ❒ Rotary ❒ Fixed Wing	**Air Classification:** ❒ Auxiliary Rescue ❒ Air Ambulance ❒ ALS Rescue ❒ BLS Rescue

Transporting Agencies

125,654	Total number of responses	**77,941**	Total number of transports
47,117	Number of emergency responses	**5,995**	Number of emergency transports
78,537	Number of non-emergency responses	**71,946**	Number of non-emergency transports

Air Ambulance Services

n/a	Total number of responses	**n/a**	Total number of transports
n/a	Number of emergency responses	**n/a**	Number of emergency transports
n/a	Number of non-emergency responses	**n/a**	Number of non-emergency transports

TABLE 8: Response/Transportation/Providers

Note: *Table 8 is to be completed for each provider by county.* Make copies as needed.

County: San Francisco **Provider:** AMR – San Francisco **Response Zone:** City and County of SF

Address: 1300 Illinois St
San Francisco, CA 94107

Number of Ambulance Vehicles in Fleet: 51

Phone Number: 415-922-9400

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 15

Written Contract:	**Medical Director:**	**System Available 24 Hours:**	**Level of Service:**	
x Yes ❒ No	x Yes ❒ No	x Yes ❒ No	x Transport x ALS x 9-1-1 x Ground x Non-Transport x BLS x 7-Digit ❑ Air x CCT ❑ Water x IFT	
Ownership: ❒ Public x Private	**If Public:** ❒ Fire ❒ Law ❒ Other Explain: _____	**If Public:** ❒ City ❒ County ❒ State ❒ Fire District ❒ Federal	**If Air:** ❒ Rotary ❒ Fixed Wing	**Air Classification:** ❒ Auxiliary Rescue ❒ Air Ambulance ❒ ALS Rescue ❒ BLS Rescue

Transporting Agencies

37,816	Total number of responses	**32,828**	Total number of transports
11,971	Number of emergency responses	**931**	Number of emergency transports
25,845	Number of non-emergency responses	**31,763**	Number of non-emergency transports

Air Ambulance Services

n/a	Total number of responses	**n/a**	Total number of transports
n/a	Number of emergency responses	**n/a**	Number of emergency transports
n/a	Number of non-emergency responses	**n/a**	Number of non-emergency transports

TABLE 8: Response/Transportation/Providers

Note: *Table 8 is to be completed for each provider by county.* Make copies as needed.

County: San Francisco **Provider:** King American **Response Zone:** City and County SF

Address: 2570 Bush St
San Francisco, CA 94115

Phone Number: 415-931-1400

Number of Ambulance Vehicles in Fleet: 14

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 5

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:	
x Yes ❒ No	x Yes ❒ No	x Yes ❒ No	x Transport x ALS x 9-1-1 x Ground x Non-Transport x BLS x 7-Digit ❑ Air ❑ CCT ❑ Water x IFT	
30 **Ownership:**	**If Public:**	**If Public:**	**If Air:**	**Air Classification:**
❒ Public x Private	❒ Fire ❒ Law ❒ Other Explain: _____	❒ City ❒ County ❒ State ❒ Fire District ❒ Federal	❒ Rotary ❒ Fixed Wing	❒ Auxiliary Rescue ❒ Air Ambulance ❒ ALS Rescue ❒ BLS Rescue

Transporting Agencies

21,718	Total number of responses	**15,934**	Total number of transports
10,414	Number of emergency responses	**1,883**	Number of emergency transports
11,304	Number of non-emergency responses	**14,051**	Number of non-emergency transports

Air Ambulance Services

n/a	Total number of responses	**n/a**	Total number of transports
n/a	Number of emergency responses	**n/a**	Number of emergency transports
n/a	Number of non-emergency responses	**n/a**	Number of non-emergency transports

TABLE 8: Response/Transportation/Providers

Note: *Table 8 is to be completed for each provider by county.* Make copies as needed.

County: San Francisco **Provider:** Norcal Ambulance **Response Zone:** City and County of SF

Address: 6761 Sierra Count, Suite G
Dublin, CA 94568

Number of Ambulance Vehicles in Fleet: 5

Phone Number: 866-755-3400

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 4

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:	
x Yes ❒ No	x Yes ❒ No	x Yes ❒ No	x Transport x Non-Transport	❑ ALS x BLS
			❑ 9-1-1 x 7-Digit x CCT x IFT	x Ground ❑ Air ❑ Water

31 Ownership:	If Public:	If Public:	If Air:	Air Classification:
❒ Public x Private	❒ Fire ❒ Law ❒ Other Explain: _____	❒ City ❒ County ❒ State ❒ Fire District ❒ Federal	❒ Rotary ❒ Fixed Wing	❒ Auxiliary Rescue ❒ Air Ambulance ❒ ALS Rescue ❒ BLS Rescue

Transporting Agencies

3,755	Total number of responses	**2,490**	Total number of transports
442	Number of emergency responses	**314**	Number of emergency transports
3,313	Number of non-emergency responses	**2,176**	Number of non-emergency transports

Air Ambulance Services

n/a	Total number of responses	**n/a**	Total number of transports
n/a	Number of emergency responses	**n/a**	Number of emergency transports
n/a	Number of non-emergency responses	**n/a**	Number of non-emergency transports

TABLE 8: Response/Transportation/Providers

Note: *Table 8 is to be completed for each provider by county.* Make copies as needed.

County: San Francisco **Provider:** ProTransport-1 **Response Zone:** City and County of SF

Address: PO Box 7260
Cotati, CA 94931

Number of Ambulance Vehicles in Fleet: 23

Phone Number: 707-665-4280

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 6

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:	
x Yes ❒ No	x Yes ❒ No	x Yes ❒ No	x Transport x Non-Transport	x ALS ❑ 9-1-1 x Ground x BLS x 7-Digit ❑ Air x CCT ❑ Water x IFT
Ownership: ❒ Public x Private	**If Public:** ❒ Fire ❒ Law ❒ Other Explain: _____	**If Public:** ❒ City ❒ County ❒ State ❒ Fire District ❒ Federal	**If Air:** ❒ Rotary ❒ Fixed Wing	**Air Classification:** ❒ Auxiliary Rescue ❒ Air Ambulance ❒ ALS Rescue ❒ BLS Rescue

32

Transporting Agencies

1,918	Total number of responses	**974**	Total number of transports
4	Number of emergency responses	**4**	Number of emergency transports
1,914	Number of non-emergency responses	**970**	Number of non-emergency transports

Air Ambulance Services

n/a	Total number of responses	**n/a**	Total number of transports
n/a	Number of emergency responses	**n/a**	Number of emergency transports
n/a	Number of non-emergency responses	**n/a**	Number of non-emergency transports

TABLE 8: Response/Transportation/Providers

Note: *Table 8 is to be completed for each provider by county.* Make copies as needed.

County: San Francisco **Provider:** Royal Ambulance **Response Zone:** City and County of SF

Address: 14472 Wicks Boulevard
San Leandro, CA 94577

Number of Ambulance Vehicles in Fleet: 21

Phone Number: 833-769-2599

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 10

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:	
x Yes ❒ No	x Yes ❒ No	x Yes ❒ No	x Transport ❑ ALS ❑ 9-1-1 x Ground x Non-Transport x BLS x 7-Digit ❑ Air x CCT ❑ Water x IFT	
33 Ownership:	If Public:	If Public:	If Air:	Air Classification:
❒ Public x Private	❒ Fire ❒ Law ❒ Other Explain: _____	❒ City ❒ County ❒ State ❒ Fire District ❒ Federal	❒ Rotary ❒ Fixed Wing	❒ Auxiliary Rescue ❒ Air Ambulance ❒ ALS Rescue ❒ BLS Rescue

Transporting Agencies

7,206	Total number of responses	**6,567**	Total number of transports
1,117	Number of emergency responses	**1,061**	Number of emergency transports
6,143	Number of non-emergency responses	**5,506**	Number of non-emergency transports

Air Ambulance Services

n/a	Total number of responses	**n/a**	Total number of transports
n/a	Number of emergency responses	**n/a**	Number of emergency transports
n/a	Number of non-emergency responses	**n/a**	Number of non-emergency transports

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **Zuckerberg San Francisco General** Telephone Number: **628-206-8000**
Address: **1001 Potrero Avenue**
San Francisco, CA 94110

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency ❒ Basic Emergency **x** Comprehensive Emergency	**x** Yes ❒ No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	❒ Yes **x** No		
EDAP[2]	**x** Yes ❒ No	**x** Yes ❒ No	**x*** Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[3]	❒ Yes **x** No		

STEMI Center:	**Stroke Center:**
x Yes ❒ No	**x** Yes ❒ No

For more info regarding Level I status, please see project plan

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **California Pacific Medical Center – Van Ness Campus** Telephone Number: **415-600-6000**

Address: **1101 Van Ness Ave.**
San Francisco, CA 94109

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	**x** Yes ❒ No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[2]	**x** Yes ❒ No		
PICU[3]	**x** Yes ❒ No		

STEMI Center:	**Stroke Center:**
x Yes ❒ No	**x** Yes ❒ No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **California Pacific Medical Center – Davies Campus** Telephone Number: **415-600-6000**

Address: **45 Castro Street**
San Francisco, CA 94114

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
x Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	❒ Yes **x** No		
EDAP[2]	**x** Yes ❒ No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[3]	❒ Yes **x** No		

STEMI Center:	**Stroke Center:**
❒ Yes **x** No	**x** Yes ❒ No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **California Pacific Medical Center – Mission Bernal Campus** Telephone Number: **415-600-6000**

Address: **3555 Cesar Chavez Street**
San Francisco, CA 94110

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	❒ Yes **x** No		
EDAP[2]	**x** Yes ❒ No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[3]	❒ Yes **x** No		

STEMI Center:	**Stroke Center:**
❒ Yes **x** No	❒ Yes **x** No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **UCSF Medical Center** Telephone Number: **415-353-1238**
Address: **505 Parnassus Avenue**
San Francisco, CA 94143

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	❒ Yes **x** No		
EDAP[2]	**x** Yes ❒ No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[3]	❒ Yes **x** No		

STEMI Center:	**Stroke Center:**
x Yes ❒ No	**x** Yes ❒ No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **UCSF Mission Bay** Telephone Number: **415-353-1818**
Address: **1975 4th Street**
San Francisco, CA 94158

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	**x** Yes ❒ No		
EDAP[2]	**x** Yes ❒ No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[3]	**x** Yes ❒ No		

STEMI Center:	**Stroke Center:**
❒ Yes **x** No	❒ Yes **x** No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **Kaiser San Francisco** Telephone Number: **415-833-2000**
Address: **2425 Geary Blvd**
San Francisco, CA 94115

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	❒ Yes **x** No		
EDAP[2]	**x** Yes ❒ No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[3]	❒ Yes **x** No		

STEMI Center:	**Stroke Center:**
x Yes ❒ No	**x** Yes ❒ No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco _____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **Saint Francis Memorial Hospital** Telephone Number: **415-353-6000**
Address: **900 Hyde Street**
San Francisco, CA 94109

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	**x** Yes ❒ No

Pediatric Critical Care Center[1]	❒ Yes **x** No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[2]	**x** Yes ❒ No		
PICU[3]	❒ Yes **x** No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes **x** No	**x** Yes ❒ No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **St Mary's Medical Center** Telephone Number: **415-668-1000**
Address: **450 Stanyan Street**
San Francisco, CA 94117

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	❒ Yes **x** No		
EDAP[2]	**x** Yes ❒ No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[3]	❒ Yes **x** No		

STEMI Center:	**Stroke Center:**
x Yes ❒ No	**x** Yes ❒ No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **Chinese Hospital** Telephone Number: **415-982-2400**
Address: **845 Jackson Street**
San Francisco, CA 94133

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency ❒ Standby Emergency **x** Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

Pediatric Critical Care Center[1]	❒ Yes **x** No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[2]	**x** Yes ❒ No		
PICU[3]	❒ Yes **x** No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes **x** No	**x*** Yes ❒ No

**Will be a Stroke Center as of October 1, 2022.*

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

County: San Francisco_____

Note: *Complete information for each facility by county.* Make copies as needed.

Facility: **San Francisco VA Medical Center** Telephone Number: **415-750-2052**
Address: **4150 Clement Street**
San Francisco, CA 94121

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
❒ Yes **x** No	❒ Referral Emergency **x** Standby Emergency ❒ Basic Emergency ❒ Comprehensive Emergency	❒ Yes **x** No	❒ Yes **x** No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[1]	❒ Yes **x** No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[2]	❒ Yes **x** No		
PICU[3]	❒ Yes **x** No		

STEMI Center:	**Stroke Center:**
❒ Yes **x** No	❒ Yes **x** No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **City College of San Francisco** Telephone Number: **415-561-1938**
Address: **1860 Hayes Street**
San Francisco, CA 94117

Student Eligibility*: **Public**

Program Level **EMT

Cost of Program:
Basic: **n/a**
Refresher: **n/a**

Number of students completing training per year:

Initial training:	**182**
Refresher:	**26**
Continuing Education:	**57**
Expiration Date:	**12/31/23**

Number of courses:

Initial training:	**6**
Refresher:	**1**
Continuing Education:	**2**

*Open to general public or restricted to certain personnel only.
** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **City College of San Francisco** Telephone Number: **415-561-1938**
Address: **1860 Hayes Street**
San Francisco, CA 94117

Student Eligibility*: **Public**

Program Level **Paramedic

Cost of Program:
Basic: **n/a**
Refresher: **n/a**

Number of students completing training per year:

Initial training:	**58**
Refresher:	**n/a**
Continuing Education:	**43**
Expiration Date:	**12/31/23**

Number of courses:

Initial training:	**2**
Refresher:	**n/a**
Continuing Education:	**2**

*Open to general public or restricted to certain personnel only.
** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **City College of San Francisco CE# 38-0012** Telephone Number: **415-561-1938**

Address: **1860 Hayes Street**
San Francisco, CA 94117

Student Eligibility*: **Public**

Program Level **Continuing Education

Cost of Program:

Basic: **n/a**

Refresher: **n/a**

Number of students completing training per year:

Initial training:	**n/a**
Refresher:	**26**
Continuing Education:	**57**
Expiration Date:	**12/31/23**

Number of courses:

Initial training:	**n/a**
Refresher:	**1**
Continuing Education:	**2**

*Open to general public or restricted to certain personnel only.

** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **San Francisco Fire Department CE#38-0003** Telephone Number: **415-318-4517**
Address: **600 Avenue M**
San Francisco, CA 94130

Student Eligibility*: **Personnel**

Program Level **Continuing Education

Cost of Program:
Basic: **n/a**
Refresher: **n/a**

Number of students completing training per year:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**1200**
Expiration Date:	**08/31/23**

Number of courses:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**Varies**

*Open to general public or restricted to certain personnel only.
** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **AMR San Francisco CE#38-0004** Telephone Number: **415-922-9400**

Address: **1300 Illinois Street**
San Francisco, CA 94107

Student Eligibility*: **Personnel**

Program Level **Continuing Education

Cost of Program:

Basic: **n/a**

Refresher: **n/a**

Number of students completing training per year:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**88**
Expiration Date:	**09/30/23**

Number of courses:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**3**

*Open to general public or restricted to certain personnel only.

** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **King American Ambulance Company CE#38-0005** Telephone Number: **415-931-1400**
Address: **2570 Bush Street**
San Francisco, CA 94115

Student Eligibility*: **Personnel**

Cost of Program:
Basic: **n/a**
Refresher: **n/a**

Program Level **Continuing Education

Number of students completing training per year:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**17**
Expiration Date:	**06/30/24**

Number of courses:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**3**

*Open to general public or restricted to certain personnel only.
** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **Rock Medicine CE#38-0016** Telephone Number: **415-912-1253**

Address: **1563 Mission Street**
San Francisco, CA 94103

Student Eligibility*: Personnel

Program Level **Continuing Education

Cost of Program:
Basic: n/a
Refresher: n/a

Number of students completing training per year:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**14**
Expiration Date:	**12/31/25**

Number of courses:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**4**

*Open to general public or restricted to certain personnel only.
** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **Zuckerberg San Francisco General CE#28-0002** Telephone Number: **628-206-5050**
Address: **1001 Potrero Avenue, Room H1017**
San Francisco, CA 94110

Student Eligibility*: **Personnel**

Program Level **Continuing Education

Cost of Program:
Basic: **n/a**
Refresher: **n/a**

Number of students completing training per year:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**8**
Expiration Date:	**02/28/26**

Number of courses:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**1**

*Open to general public or restricted to certain personnel only.
** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: FY21-22**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **San Francisco EMS Agency CE#38-0001** Telephone Number: **628-217-6000**

Address: **333 Valencia St. Suite 210**
San Francisco, CA 94103

Student Eligibility*: **Open to Public**

Program Level **Continuing Education

Cost of Program:

Basic: **$0**

Refresher: **$0**

Number of students completing training per year:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**11**
Expiration Date:	**n/a**

Number of courses:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**3**

*Open to general public or restricted to certain personnel only.

**** Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

TABLE 11: DISPATCH AGENCY

County: San Francisco **Reporting Year: FY21-22**

NOTE: Make copies to add pages as needed. Complete information for each provider by county.

Name: **Department of Emergency Management** Primary Contact: **Robert Smuts, Deputy Director**
Address: **1011 Turk St**
San Francisco, CA 94102
Telephone Number: **415-575-0737**

Written Contract:
☐ Yes **x** No

Medical Director:
x Yes ☐ No

x Day-to-Day
x Disaster

Number of Personnel Providing Services:

__**188**_ EMD Training _____ EMT-D _____ ALS
_____ BLS _____ LALS _____ Other

Ownership:
x Public ☐ Private

If Public:
☐ Fire
☐ Law
x Other
Explain: **Emergency Management**

If Public: **x** City **x** County ☐ State ☐ Fire District ☐ Federal

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: City and County of San Francisco

Area or subarea (Zone) Name or Title: City and County of San Francisco

Name of Current Provider(s):

- San Francisco Fire Department (9-1-1)
- King American (9-1-1 and Interfacility Transfer)
- American Medical Response (9-1-1 and Interfacility Transfer)
- Pro-Transport (ALS, Interfacility Transfer)
- Norcal Ambulance (BLS, Interfacility Transfer)
- Royal Ambulance (BLS, Interfacility Transfer)

Area or subarea (Zone) Geographic Description:

San Francisco, California is located at 37° 46' North latitude and 122 °27' West longitudes. The City forms the tip of a peninsula bounded by the Pacific Ocean to the West, the Golden Gate to the North, the San Francisco Bay to the East and San Mateo County to South. The boundaries of the City and County of San Francisco are one and the same, compromising 49 square miles roughly fitting within a 7 by 7 mile square. Treasure Island and the Presidio are also areas of San Francisco responsibility.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Emergency Ambulance (911 only). As mentioned the State EMS Authority notified the SF EMS Agency that the prior EOA would remain effect with an addendum that will allow future ALS/BLS provider to provide service to non 9-1-1 calls. This included Treasure Island and the Presidio as not substantially impacting EOA.

Method to achieve Exclusivity, if applicable (HS 1797.224):

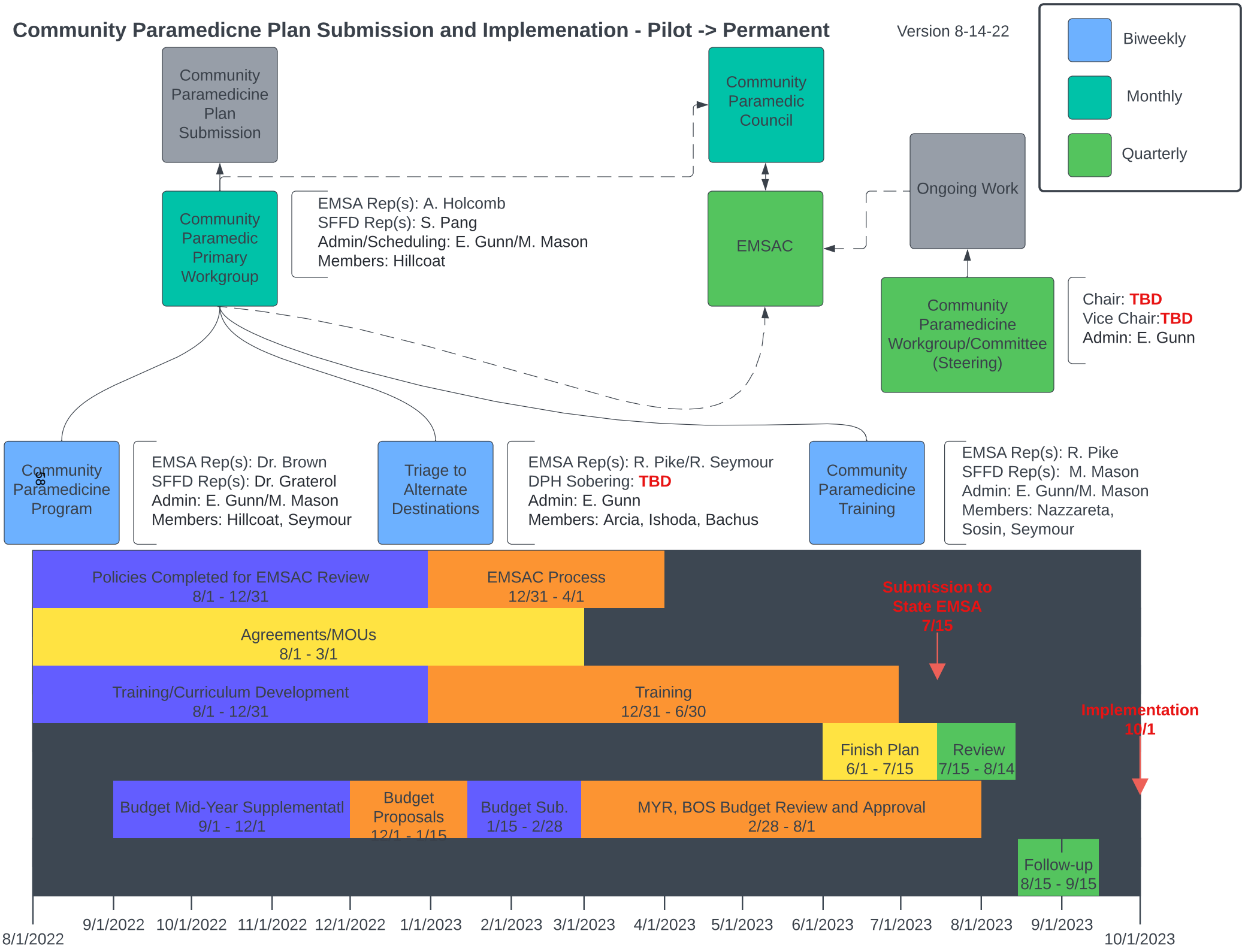
In January, 2012, the State of California EMS Authority notified the SF EMS Agency that the prior EOA from 2008 would remain effective with the providers being SFFD, King American and American Medical Response for the 9-1-1 response.

Outstanding Projects/Tasks for FY22-23 - (EMS Plan Submission 2022)						
Tracking #	**Title**	**Description**	**Status**	**Estimate Completion Date**	**SFEMSA Division**	**Minimum Guideline Reference**
FY23-1	EMS Planning Process	San Francisco EMSA traditionally has had inconsistencies in EMS Plan submission. Overview of new process listed in Executive Summary to ensure compliance with annual state requirement.	In Progress	End of Q4 FY23	Executive	6.06
FY23-2	Hiring Vacant Positions	San Francisco EMSA received additional positions for FY23 and has vacancies to fill from previous FY. This amounts to 6 positions and is a high priority for upcoming EMS planning period.	Not Started	End of Q4 FY23	Executive	6.06
FY23-3	Hospital MOUs	San Francisco EMSA hospital MOUs are in process to be revised based on new specialty standards. As of August 2022, hospitals are reviewing the draft documents.	In Progress	End of Q2 FY23	Executive	1.11, 5.01, 8.18
FY23-4	STEMI, Stroke, Trauma, EMS for Children Plans	San Francisco EMSA is continuously working on Specialty Care plans. An EMS Specialist has been approved in FY23 budget to manage these programs.	In Progress	End of Q4 FY23	Quality Improvement	6.05, 6.06, 8.18
FY23-5	Update Ambulance Ordinance	The ambulance ordiance has not been updated for a period of time and will likely need to be updated for Community Paramedicine implementation. Ordinance will also be updated with routine regulatory and statuatory changes.	Not Started	End of Q4 FY23	Executive	n/a
FY23-6	Community Paramedic and Triage to Alternate Destination Program Submission	The submission and compliance with community paramedic and triage to alternate destinations under new statuatory and regulatory requirements is the primary focus for SFEMSA in 2022/2023.	In Progress	July 2023	All Divisions	6.03, 6.05
FY23-7	Electronic Certification Program	SFEMSA is exploring moving from traditional paper process to online certification management system. SFEMSA received funding for this project in FY23.	In Progress	End of Q3 FY23	Operations	n/a
FY23-8	Re-evaluate Zuckerberg San Francisco General Trauma Center	In 2022, ACS updated trauma standards pertaining to Level I and Level II trauma centers. Currently ZSFG has cardiothoracic coverage 24/7 with 2 surgeons and an transfer agreement with UCSF for cardiac bypass equipment. ACS and SFEMSA site visit is next Summer 2023 from Trauma Center review. ZSFG is reviewing requirements as of August 2022.	In Progress	August 2023	Quality Improvement	8.18
FY23-9	Response Interval Improvements	SFEMSA is reviewing operational data, such as response intervals, based on recent hiring of 60 SFFD paramedics. SFEMSA is working towards news dashboards and QI review of calls based on response criteria.	In Progress	Ongoing	Operations	6.06, 6.08
FY23-10	Patient Offload and Diversion Improvement	With key partners, patient offload and diversion have been a major focus in FY22 with workgroups, recommendations, and policy development. This work is far from resolved or complete, but have developed a path and recommendations to move forward in FY23.	In Progress	End of Q4 FY23	Quality Improvement	6.06, 6.08, 8.18

FY23-11	BLS Pilot Program	SFEMSA would like to implement a BLS 911 tier with current EOA providers on a limited scale. A BLS tier would have minimal impact to EOA, however a high impact to overall EMS system stability. See pilot over and data overview.	In Progress	End of Q1 FY23	Operations	n/a
FY23-12	Implement Get with the Guidelines	SFEMSA is in final stages of contracting with AHA for get with the guidelines for Stroke and CAD. This will help with STEMI and Stroke programs. SFEMSA participates in CARES for cardiac arrest.	In Progress	End of Q1 FY23	Quality Improvement	6.05
FY23-13	Develop AED Program and CPR Community Initiatives	SFEMSA launched PulsePoint in May 2022. SFEMSA is in process of revamping the AED user program amongst public safety agencies via new policy and review process.	In Progress	End of Q4 FY23	Operations	2.12, 6.08

Community Paramedicne Plan Submission and Implemenation - Pilot -> Permanent

Version 8-14-22



Project Completion - (EMS Plan Submission 2022)			
Name	**Description**	**Status**	**Reference in EMS Plan**
Bay Area Critical Care Paramedic Standardized Guidelines	Alameda and San Francisco LEMSAs co-developed critical care paramedic guidelines that are identical between counties. There is also a reciprocity pathway for Paramedics to share resources between counties.	Completed, approved by Local SFEMSA Advisory Committee, waiting on LOSOP appproval for a few guidelines	Appendix A
iGel implementation	iGel is fully implemented amongst all Paramedics in San Francisco through a collaborative training effort between LEMSA, vendor, and EMS Providers. This was a change in airway device for supraglottic airways including pediatric.	Completed	Appendix B
EMS Alert	EMS Alert is an automatic patient distribution program for low acuity patients to limit surge events to Emergency Departments based on near real-time CAD data. This was developed with mulitple vendors and first of its kind in California.	Completed	Appendix C
PulsePoint implementation	PulsePoint was released in May 2022 during EMS Week with follow-up media release and videos. Future plans including ongoing public relations campaigns and verified responder utilization with the overall goal of improving cardiac arrest survival rates.	Completed with media release in August 2022	Appendix D
APOT/Diversion Policies and Recommendations	Ambulance Patient Offload Delays/Times and Hospital Diversion continue to be a major challenge. During this past period, SFEMSA worked with mulitple stakeholders to develop recommendations for acute as well as systematic issues. Policies development included major overhaul of 4 policies.	Ongoing work, policies approved by Local SFEMSA Advisory Committee	Appendix E
Air Medical Use Policy	The air medical access policy was revised with key partners as part of a city-wide effort to prepare for EMS events as well as large scale disasters.	Completed, will go into effect October 1, 2022	Appendix F
New Website	A new website was developed that is sleek and refreshed. Furthermore, the website has key features that promote access, especially to those with accessibility needs, and provides better transparency as a local government entity.	Completed	Appendix G
Training and Simulation Center	Upon moving to our new office space, a training area was allocated and is fully set-up for training with new equipment for EMS system use. The space was dedicated to a former EMS Agency staff during EMS Week in May 2022.	Completed	Appendix H
Buprenorphine LOSOP	Buprenorphine was approved for San Francisco as a LOSOP. The skills is in the process of being implemented.	Completed	Appendix I
MPX LOSOP	MPX vaccination efforts were approved for EMTs and Paramedics in San Francisco.	Completed	Appendix J

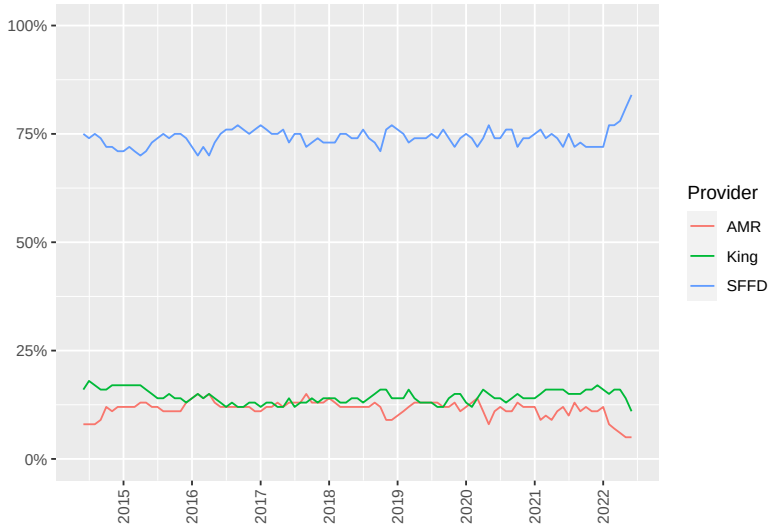
Base Hospital in the Field Program	The BASEMD program is a response capability for EMS response by a Base Hospital trained physician, SFEMSA staff member, and medical/paramedic students. The BASEMD program is an adjunct for complex medical cases and a training platform.	Completed, ongoing work	Appendix K

SECTION II - Data

San Francisco EOA Call Share

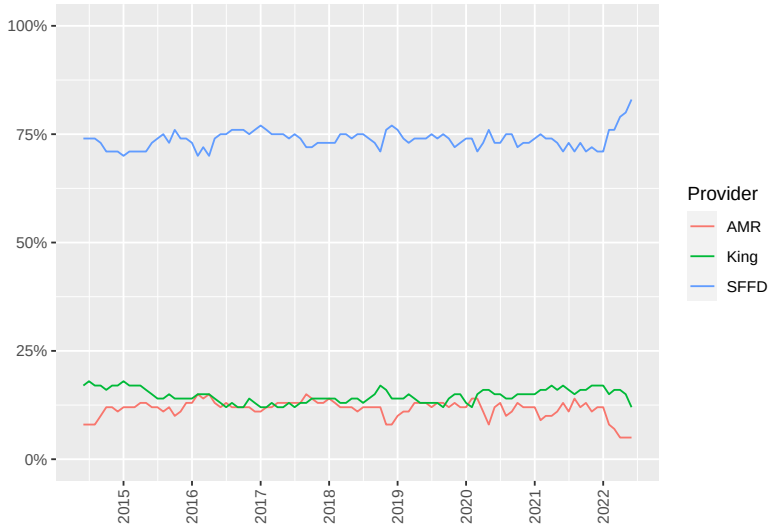
All years (June 2014 - May 2022)

Share of all 911 ambulance responses



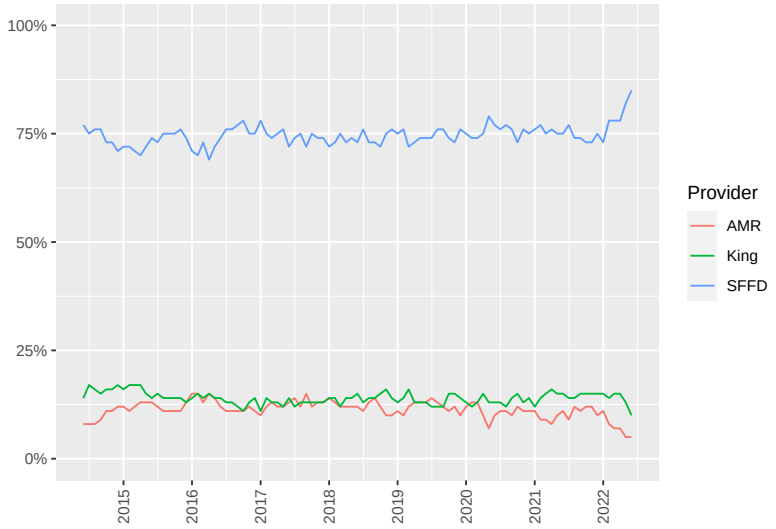
Provider	2014	2015	2016	2017	2018	2019	2020	2021	2022
AMR	6273	13954	15612	16438	15407	16222	13699	13419	4622
King	10677	17716	16442	16819	18497	18308	16480	18823	9295
SFFD	46375	85481	91419	96758	97048	99162	87240	88837	49806

Share of 911 ambulance responses resulting in transport



Provider	2014	2015	2016	2017	2018	2019	2020	2021	2022
AMR	4231	9456	10633	11209	10374	10882	9007	8697	2886
King	7306	12109	11178	11459	12645	12351	10931	12269	5953
SFFD	30666	57831	62230	65867	66361	66210	55461	55192	30485

Share of 911 ambulance responses resulting in non-transport

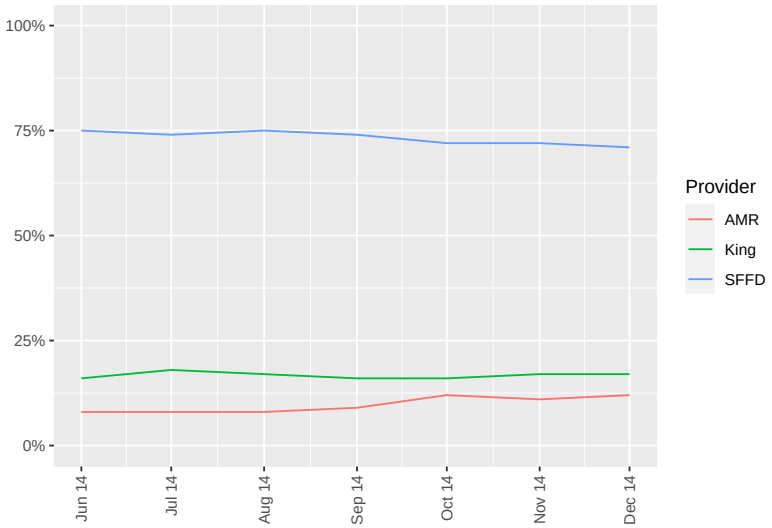


Provider	2014	2015	2016	2017	2018	2019	2020	2021	2022
AMR	2042	4498	4979	5229	5033	5340	4692	4722	1736
King	3371	5607	5264	5360	5852	5957	5549	6554	3342
SFFD	15709	27650	29189	30891	30687	32952	31779	33645	19321

2014

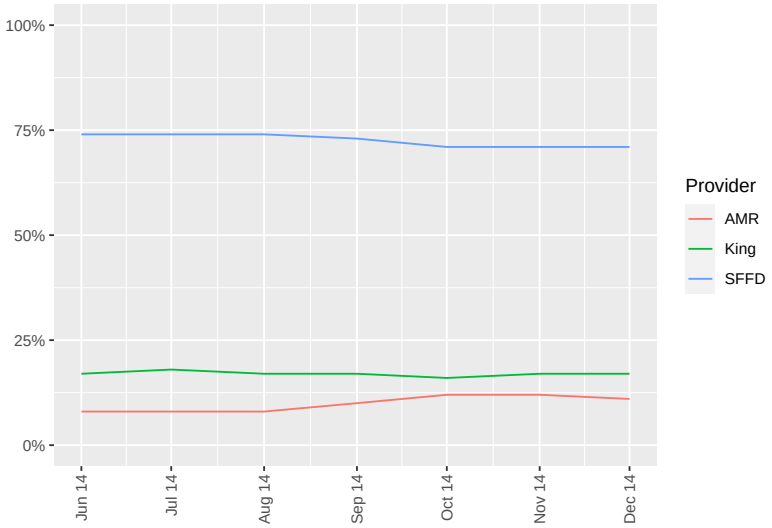
Note: this is a partial year due to data limitations

Share of all 911 ambulance responses



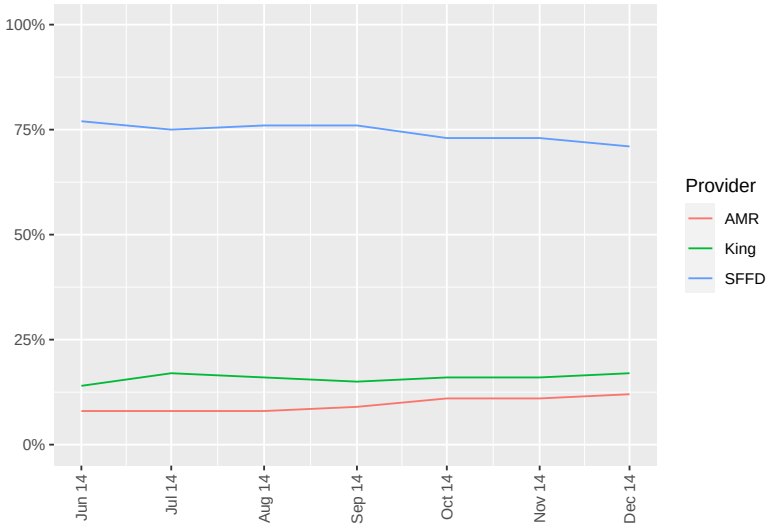
Provider	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	706	686	725	861	1125	1025	1145
King	1379	1504	1504	1492	1566	1517	1715
SFFD	6381	6289	6629	6718	6887	6417	7054

Share of 911 ambulance responses resulting in transport



Provider	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	473	473	486	581	772	692	754
King	968	1035	1034	1036	1056	1030	1147
SFFD	4171	4218	4415	4391	4581	4183	4707

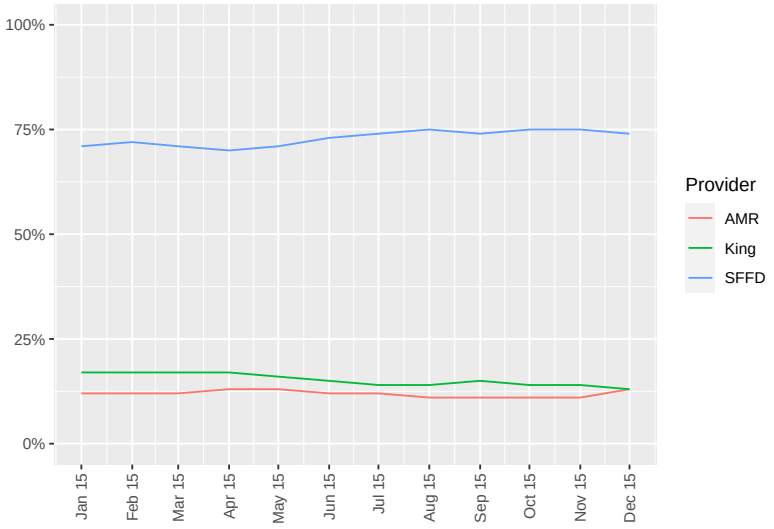
Share of 911 ambulance responses resulting in non-transport



Provider	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	233	213	239	280	353	333	391
King	411	469	470	456	510	487	568
SFFD	2210	2071	2214	2327	2306	2234	2347

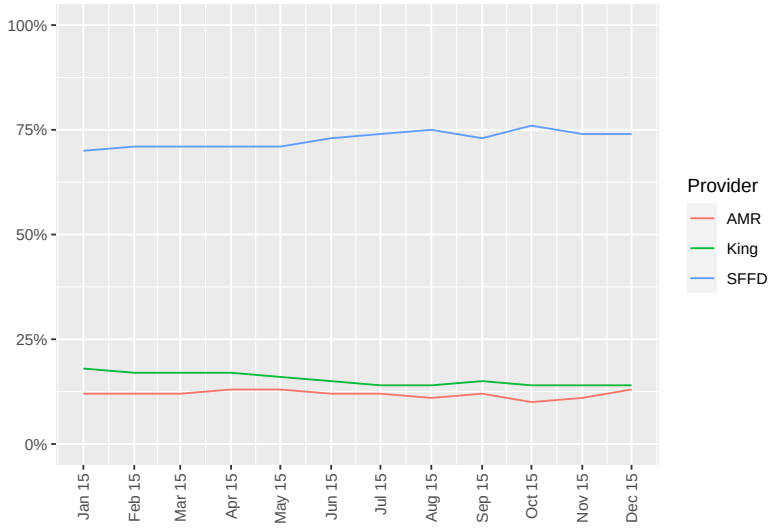
2015

Share of all 911 ambulance responses



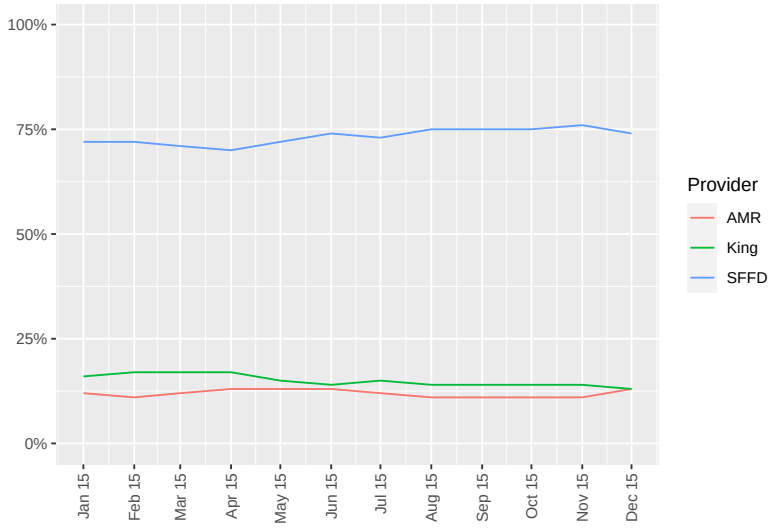
Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1238	1049	1182	1194	1295	1185	1159	1093	1118	1072	1056	1313
King	1722	1481	1672	1583	1544	1423	1378	1350	1445	1416	1346	1356
SFFD	7125	6431	7026	6610	7064	7144	7081	7498	7244	7612	7160	7486

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	843	720	793	798	880	785	780	734	771	714	740	898
King	1204	995	1115	1046	1084	988	918	913	1000	947	940	959
SFFD	4830	4301	4654	4407	4777	4783	4846	5066	4902	5195	4888	5182

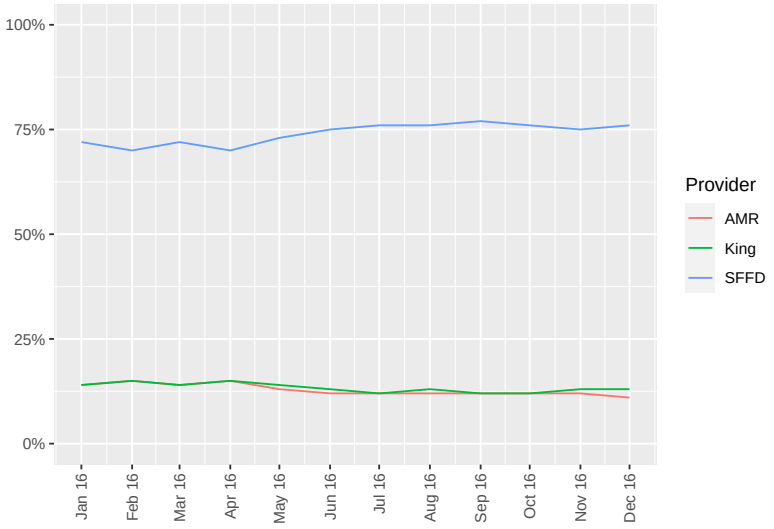
Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	395	329	389	396	415	400	379	359	347	358	316	415
King	518	486	557	537	460	435	460	437	445	469	406	397
SFFD	2295	2130	2372	2203	2287	2361	2235	2432	2342	2417	2272	2304

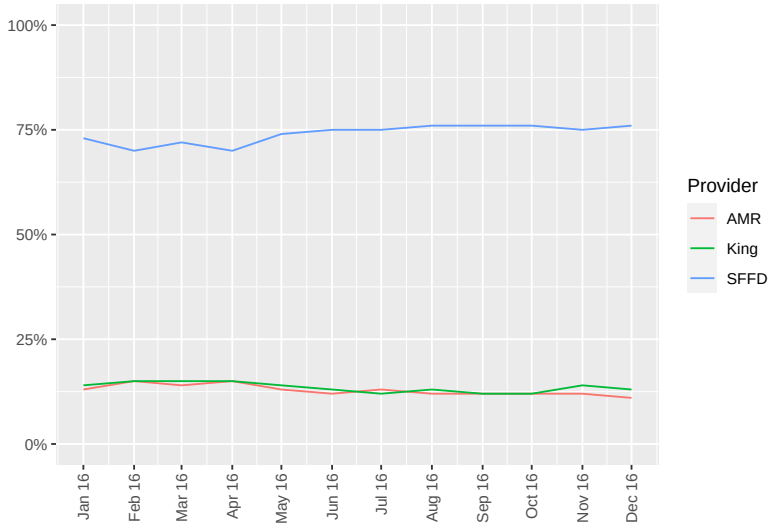
2016

Share of all 911 ambulance responses



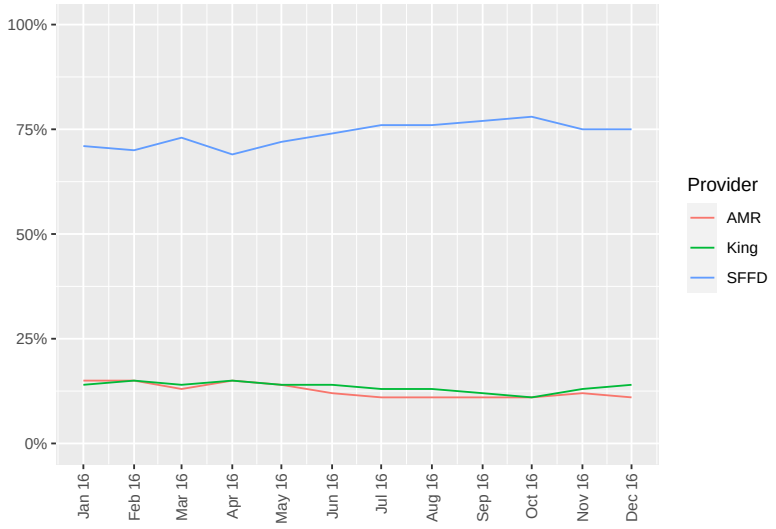
Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1396	1502	1382	1540	1314	1186	1192	1152	1249	1264	1201	1234
King	1425	1458	1471	1525	1368	1322	1228	1274	1245	1283	1370	1473
SFFD	7430	7007	7353	7134	7324	7548	7466	7556	8127	8247	7683	8544

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	917	1026	959	1032	863	804	845	805	861	876	802	843
King	980	1000	1019	1023	933	887	822	856	834	895	939	990
SFFD	5162	4834	5029	4854	5017	5174	5057	5120	5390	5543	5159	5891

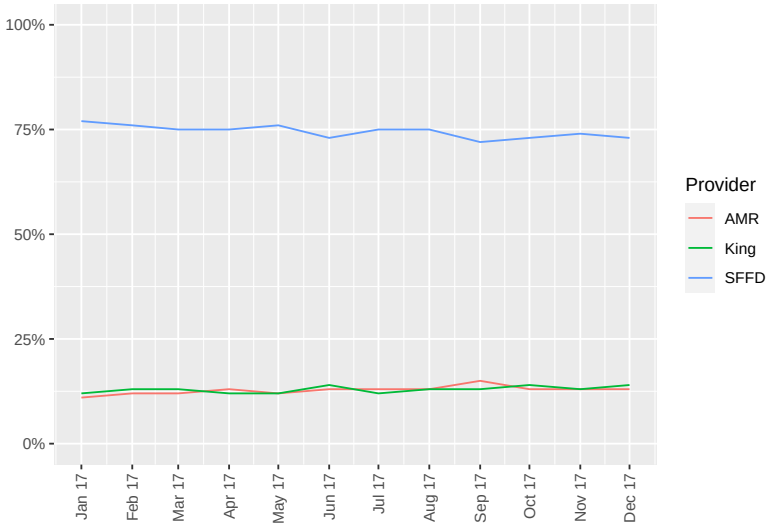
Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	479	476	423	508	451	382	347	347	388	388	399	391
King	445	458	452	502	435	435	406	418	411	388	431	483
SFFD	2268	2173	2324	2280	2307	2374	2409	2436	2737	2704	2524	2653

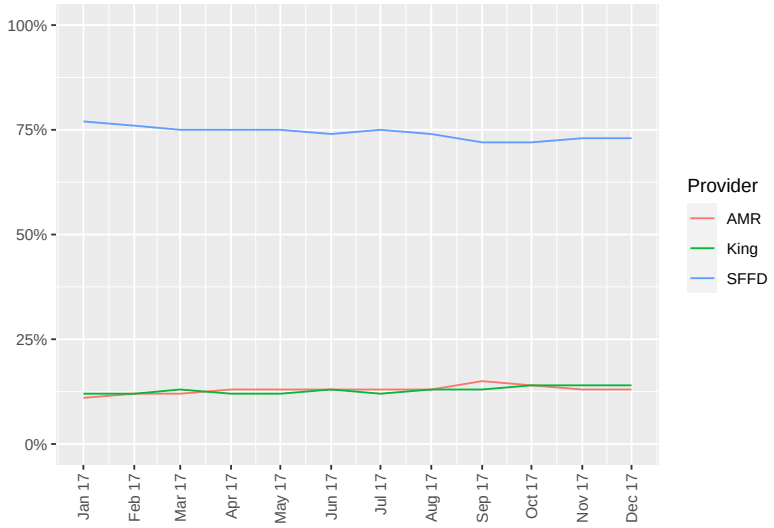
2017

Share of all 911 ambulance responses



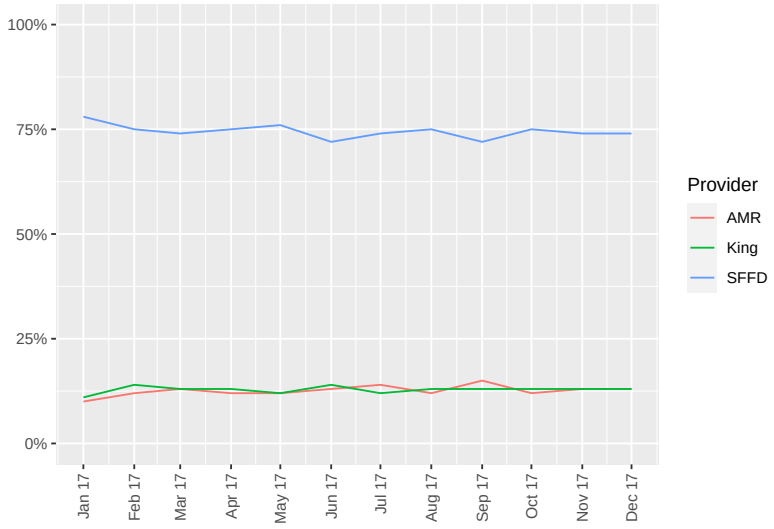
Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1189	1192	1375	1378	1352	1356	1366	1360	1675	1470	1331	1394
King	1353	1278	1498	1309	1312	1447	1250	1384	1507	1547	1388	1546
SFFD	8739	7646	8546	8123	8222	7717	7811	8076	8118	8161	7587	8012

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	848	809	890	942	942	903	899	925	1129	1020	921	981
King	966	835	1006	862	872	960	863	931	1017	1082	962	1103
SFFD	6095	5228	5830	5477	5528	5273	5364	5394	5514	5425	5167	5572

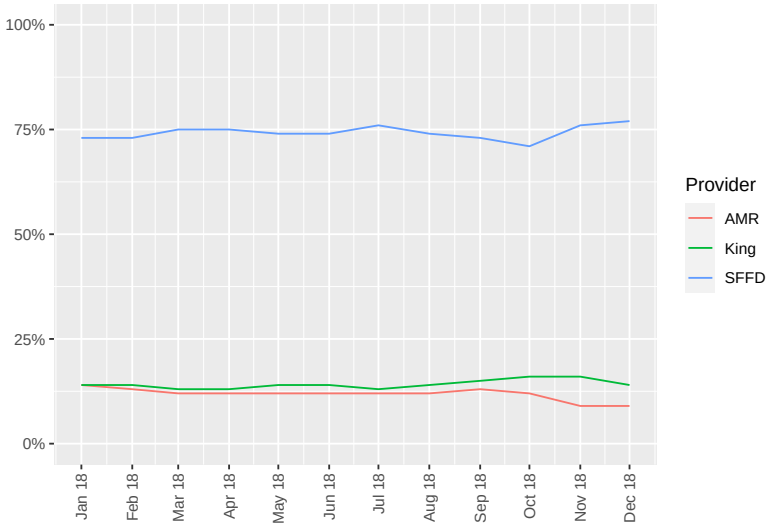
Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	341	383	485	436	410	453	467	435	546	450	410	413
King	387	443	492	447	440	487	387	453	490	465	426	443
SFFD	2644	2418	2716	2646	2694	2444	2447	2682	2604	2736	2420	2440

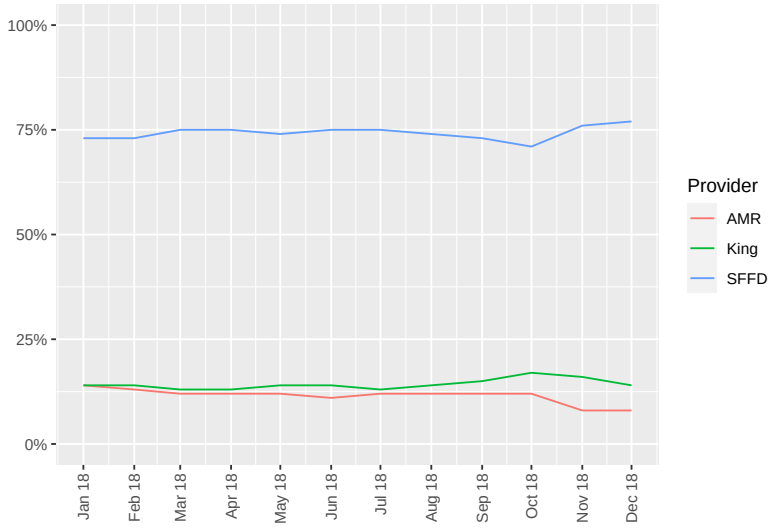
2018

Share of all 911 ambulance responses



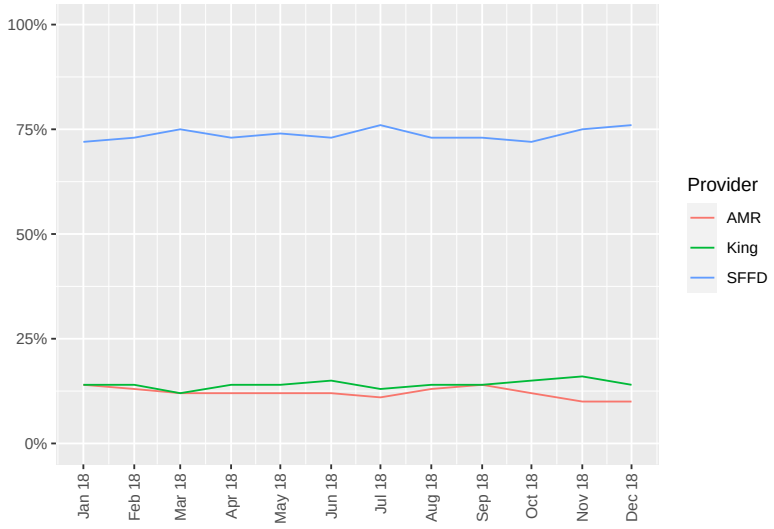
Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1555	1325	1386	1276	1396	1290	1254	1318	1333	1363	954	957
King	1588	1406	1462	1427	1590	1568	1395	1466	1544	1804	1682	1565
SFFD	8301	7406	8490	7910	8373	8217	8206	7915	7705	7885	8145	8495

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1098	924	944	869	950	829	871	874	862	910	616	627
King	1109	984	1018	957	1066	1020	962	1006	1064	1248	1132	1079
SFFD	5861	5195	5764	5489	5676	5538	5592	5448	5169	5248	5531	5850

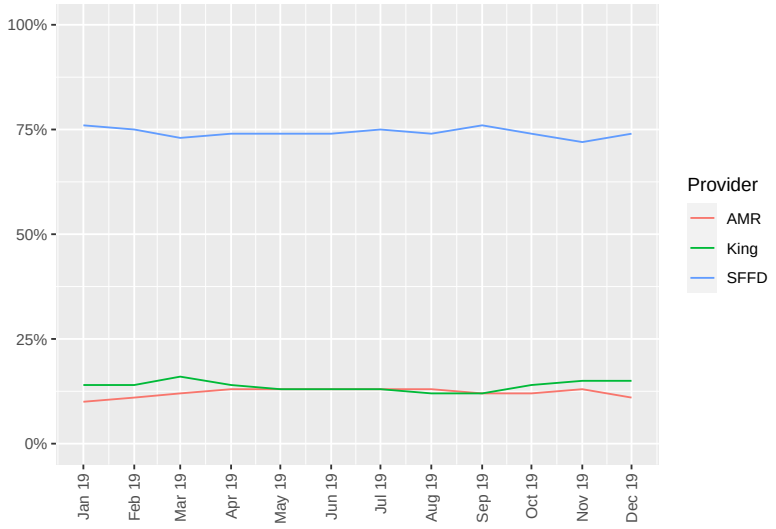
Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	457	401	442	407	446	461	383	444	471	453	338	330
King	479	422	444	470	524	548	433	460	480	556	550	486
SFFD	2440	2211	2726	2421	2697	2679	2614	2467	2536	2637	2614	2645

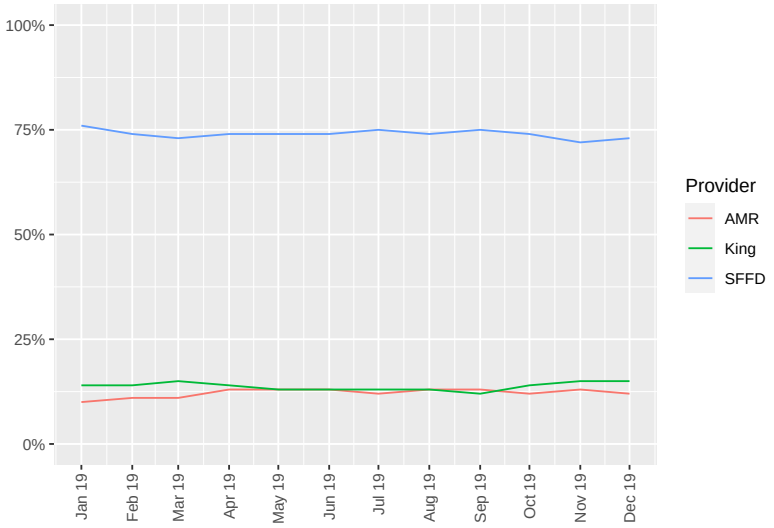
2019

Share of all 911 ambulance responses



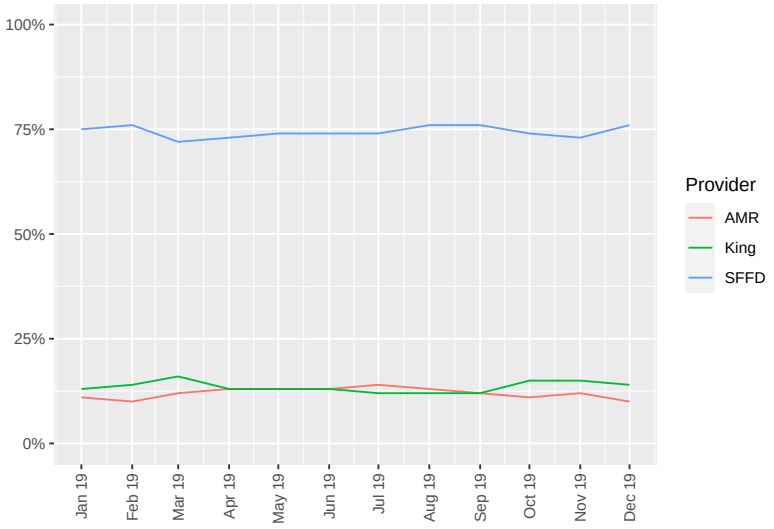
Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1087	1124	1335	1371	1464	1439	1339	1507	1421	1410	1410	1315
King	1525	1451	1799	1453	1468	1459	1342	1421	1402	1687	1588	1713
SFFD	8192	7662	8433	7844	8199	8239	7965	8531	8838	8776	7821	8662

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	723	797	895	919	977	935	855	1005	947	955	955	919
King	1100	1020	1227	998	980	958	902	956	910	1082	1034	1184
SFFD	5766	5279	5843	5337	5445	5387	5359	5538	5703	5698	5126	5729

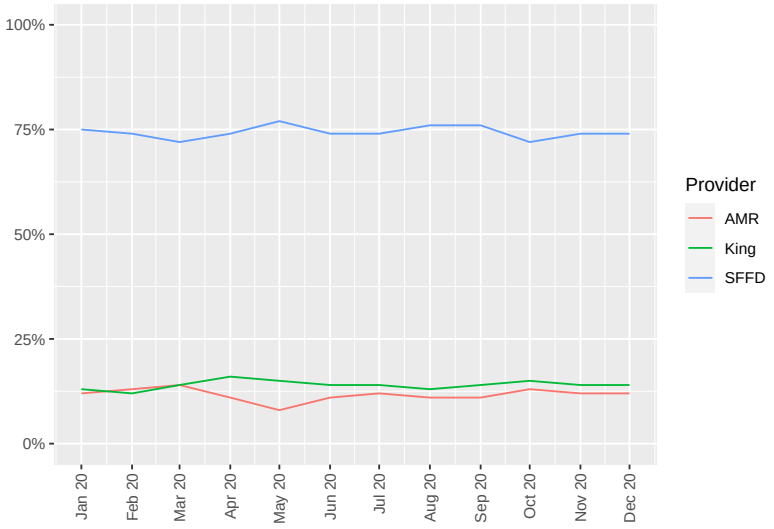
Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	364	327	440	452	487	504	484	502	474	455	455	396
King	425	431	572	455	488	501	440	465	492	605	554	529
SFFD	2426	2383	2590	2507	2754	2852	2606	2993	3135	3078	2695	2933

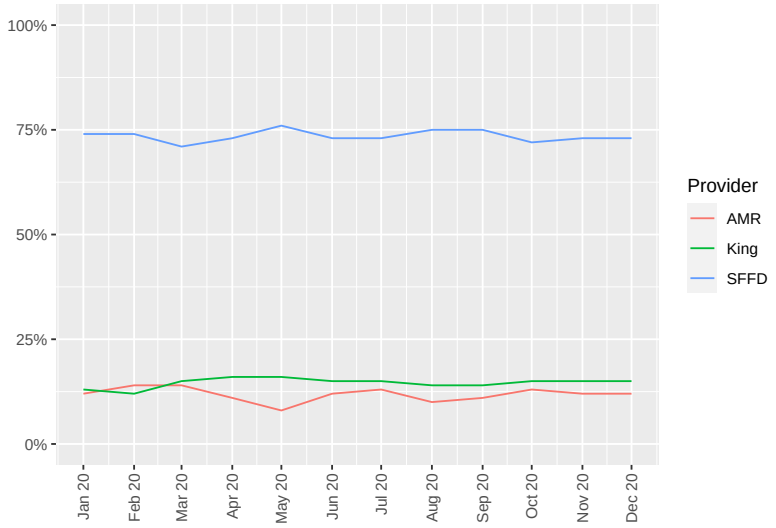
2020

Share of all 911 ambulance responses



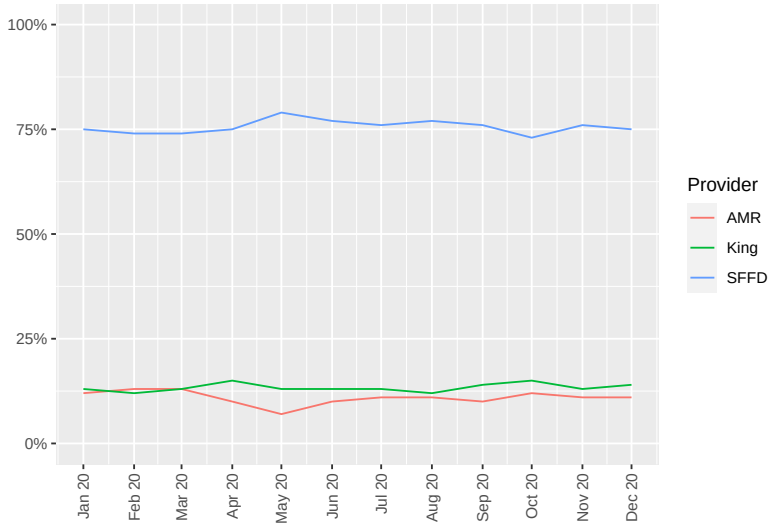
Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1446	1496	1473	966	741	998	1119	1019	1016	1234	1064	1127
King	1504	1377	1508	1418	1367	1259	1284	1296	1351	1476	1290	1350
SFFD	8679	8211	7714	6712	7200	6568	6815	7312	7303	7084	6639	7003

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	964	989	973	614	485	668	731	640	660	792	730	761
King	1018	911	999	893	903	839	859	880	885	956	893	895
SFFD	5762	5388	4907	4066	4434	4037	4237	4660	4682	4502	4309	4477

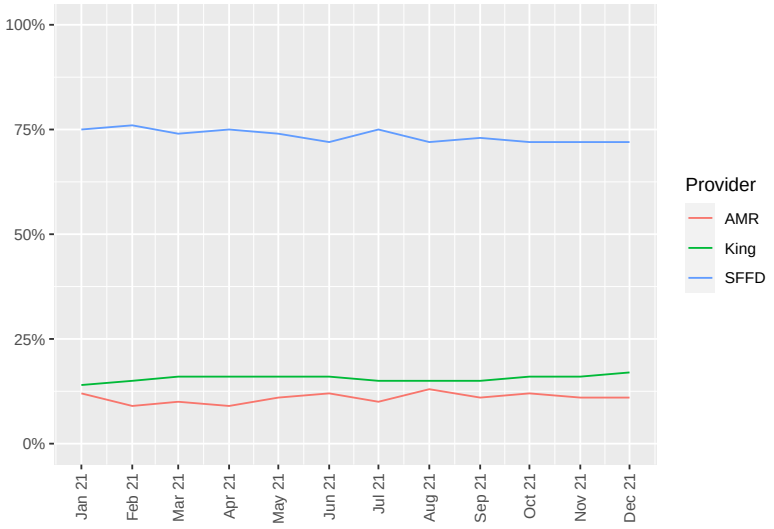
Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	482	507	500	352	256	330	388	379	356	442	334	366
King	486	466	509	525	464	420	425	416	466	520	397	455
SFFD	2917	2823	2807	2646	2766	2531	2578	2652	2621	2582	2330	2526

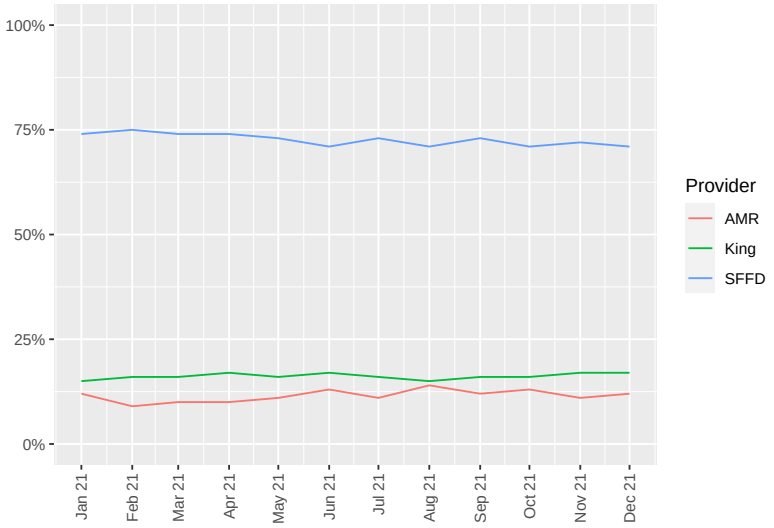
2021

Share of all 911 ambulance responses



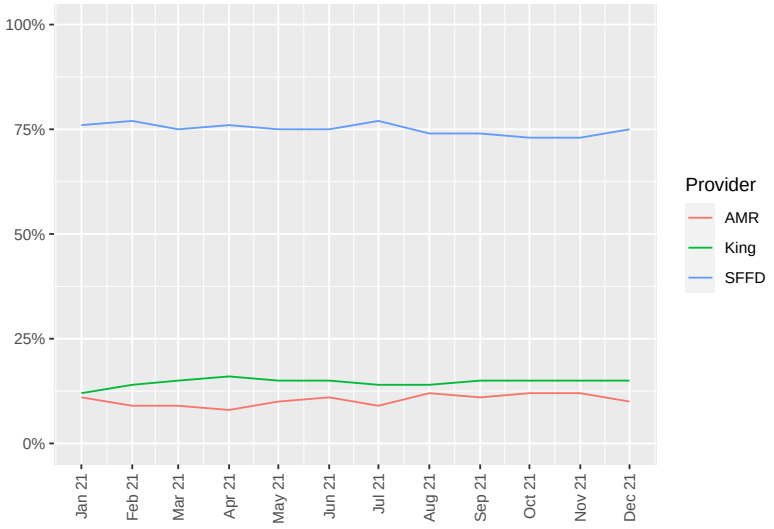
Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	1136	801	961	838	1063	1146	1052	1433	1196	1361	1192	1240
King	1364	1352	1534	1507	1512	1538	1552	1554	1616	1729	1715	1850
SFFD	7358	6647	7126	6853	7159	6970	7704	7677	7737	7922	7589	8095

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	739	525	642	561	688	770	707	918	753	867	717	810
King	933	902	1014	985	976	1021	1035	979	1009	1090	1097	1228
SFFD	4714	4242	4607	4313	4487	4334	4776	4642	4674	4809	4611	4983

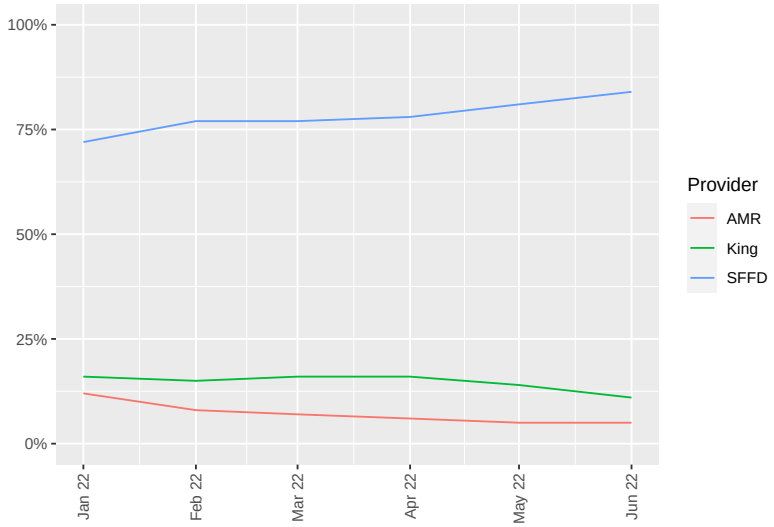
Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	397	276	319	277	375	376	345	515	443	494	475	430
King	431	450	520	522	536	517	517	575	607	639	618	622
SFFD	2644	2405	2519	2540	2672	2636	2928	3035	3063	3113	2978	3112

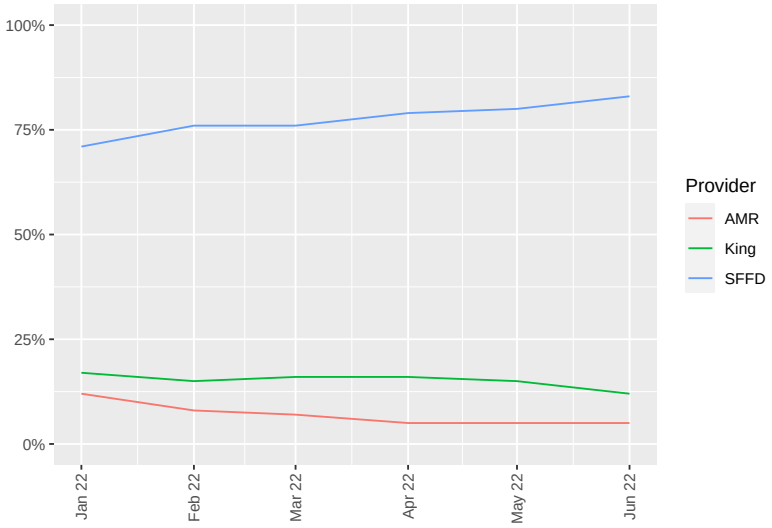
2022

Share of all 911 ambulance responses



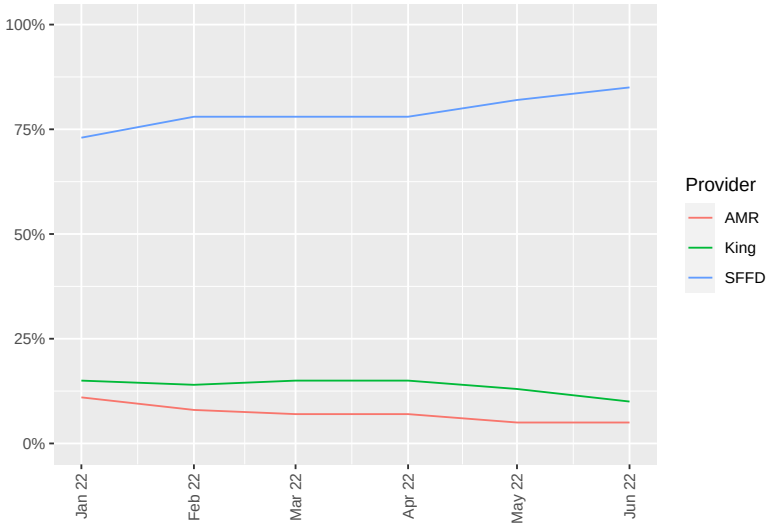
Provider	Jan	Feb	Mar	Apr	May	Jun
AMR	1325	795	764	606	583	549
King	1842	1417	1645	1602	1577	1212
SFFD	8005	7334	8065	8047	9152	9203

Share of 911 ambulance responses resulting in transport



Provider	Jan	Feb	Mar	Apr	May	Jun
AMR	859	504	476	340	373	334
King	1193	908	1059	1005	1016	772
SFFD	4913	4560	4971	5011	5537	5493

Share of 911 ambulance responses resulting in non-transport



Provider	Jan	Feb	Mar	Apr	May	Jun
AMR	466	291	288	266	210	215
King	649	509	586	597	561	440
SFFD	3092	2774	3094	3036	3615	3710

Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St., Suite 210, San Francisco, CA 94103
Phone: (628) 217-6000 Fax: (628) 217-6001

London Breed
Mayor

Mary Ellen Carroll
Executive Director

Date: August 31, 2022

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: BLS Pilot Program

The San Francisco EMS Agency (SFEMSA), as part of 2022 EMS Plan Submissions, plans to implement a 911 BLS Tier as Pilot Program for a 1-year period with existing EOA providers. Over the past year, approximately mid-summer 2021, medic to follow events and variability of call volume within the EMS system have led to the need for in-county BLS to be approved into the 911 system to augment response to 911 calls.

The San Francisco EMS System is not immune to nation, statewide, and local challenges with difficulty in EMS staffing, training pipelines for future EMTs and Paramedics, hospital staffing resulting in patient offload delays and diversion, and reopening issues from the COVID-19 pandemic. However, while not currently a 24/7 need, periods of BLS are needed to help support the San Francisco EMS System.

During the temporary 24/7 need for BLS during COVID-19, SFEMSA, 911 Dispatch, and EMS Providers found that even a few BLS units helped immensely especially with low acuity patients, mitigation of patient offload delays, staff BLS units when Paramedics were not available, and provide EMTs with the ability to run 911 calls. Overall, SFEMSA fully supports BLS utilization as healthy for the San Francisco EMS System as BLS use provides critical experience to newer EMS Personnel and resiliency for both planned events and disaster response.

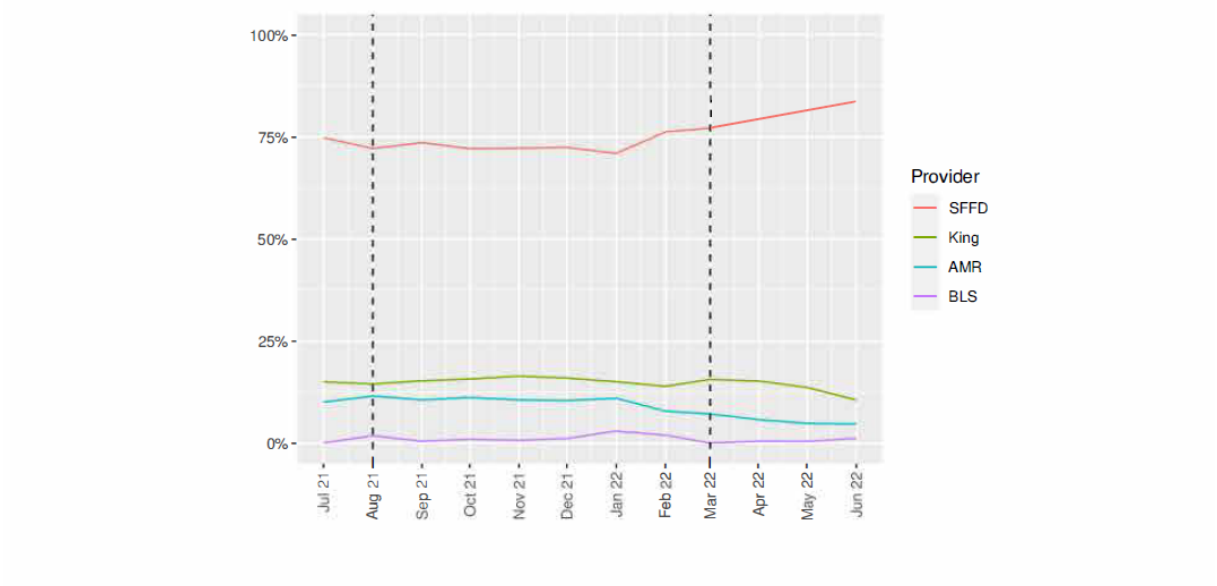
SFEMSA has been monitoring BLS utilization closely with authorization only by SFEMSA staff and with clear triggers. Secondly, all BLS units are assigned specific unit identifiers within the CAD system. BLS calls are pushed to 3rd party vendor to monitor BLS calls in near real-time and for retrospective review over time. Finally, if any question exists about appropriateness of a BLS response, an ALS first responder is added to the call. In short, SFEMSA has had minimal issues with BLS response to 911 calls.

For the 1-year Pilot, SFEMSA would implement the following tactics, many similar to previous use during COVID-19 response.

1. BLS Pilot would be 24/7 for a 1-year period upon approval of 2022 EMS Plan. Different from COVID-19, BLS 9-1-1 response would include only current 3 9-1-1 EOA EMS Providers for day-to-day operations. Only 4 EOA BLS ambulances will be allowed in the system at any given time. The option to add additional units may occur upon review of 1 year of data and feasibility.

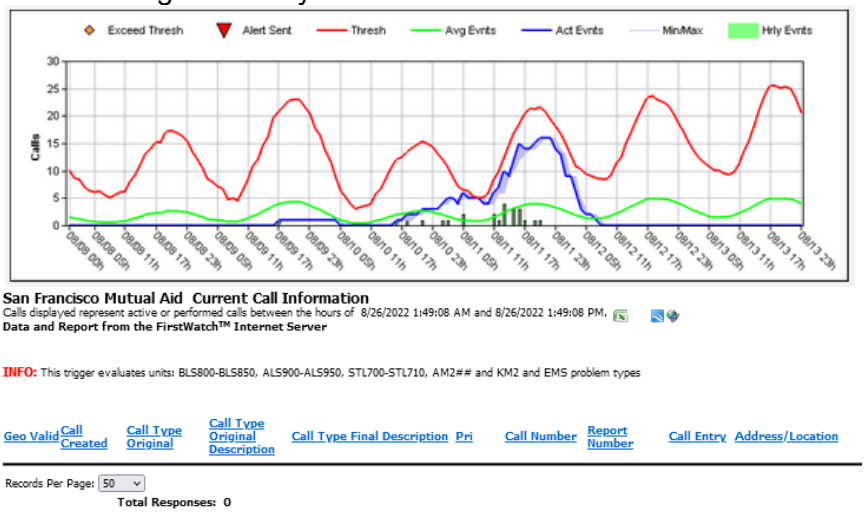
2. Should an EMS call surge occur, normal mutual aid escalation will occur with in-county, non-9-1-1 BLS providers being authorized and eligible for calls.
3. Review of call determinants for BLS response through continued Quality Improvement review.

Attached is a graph of BLS responses during COVID-19 response over the past year. Ambulance responses to 911 incidents were analyzed to compare the share of responses performed by conventional ALS 911 units - differentiated by provider agency - and BLS ambulances belonging to any provider agency that were activated in the 911 system. A 7-month period from August 2021 through February 2022 is shown between the dashed lines in the graph below. During this period, BLS ambulances were continuously activated in the 911 system. They responded to one or more calls on 122 of the 212 days in this time period (57%), which was the highest frequency of BLS ambulance utilization in recent years.



Provider	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
SFFD	74.8%	72.1%	73.6%	72.1%	72.2%	72.4%	71%	76.2%	77.1%	78.5%	81%	83.6%
King	15%	14.5%	15.3%	15.7%	16.4%	16%	15.1%	13.9%	15.6%	15.2%	13.7%	10.6%
AMR	10.1%	11.5%	10.6%	11.2%	10.6%	10.5%	11%	7.8%	7.2%	5.7%	4.9%	4.7%
BLS	0.1%	1.8%	0.5%	1%	0.7%	1.1%	3%	2%	0.1%	0.5%	0.5%	1.2%

Quality Improvement Tracking and Analysis:



City and County of San Francisco
London Breed, Mayor

Department of Emergency Management
Emergency Medical Services Agency

Date: November 18, 2021

To: San Francisco EMS Providers
DEM Division of Emergency Communications
San Francisco Receiving Hospitals

From: John Brown MD, MHOAC & San Francisco EMS Agency Medical Director
Andrew Holcomb, Acting EMS Director AC AHC

Cc: Mary Ellen Carroll, Executive Director, Dept. of Emergency Management
Robert Smuts, DEC Deputy Director, Dept. of Emergency Management
Jeanine Nicholson, Chief, San Francisco Fire Department
Dave Duncan, MD, EMS Authority Director

Subject: **Temporary BLS Authorization (December 1, 2021 – December 14, 2021)**

The San Francisco EMS Agency (EMSA) is closely monitoring a recent increase in "medic to follow" events in which a 911 call is pending without an assigned ambulance en route to the call. While reviewing the causal factors of these events and to maintain the health and safety of San Francisco residents and visitors, EMSA is approving a temporary BLS Authorization measure in the interim. With healthcare and EMS staffing considerations, COVID-19 Delta variant concerns, and transitional re-opening factors post-pandemic, EMSA wants to ensure availability of EMS resources and to have surge capacity. This measure provides EMS providers to review and revamp operations in a post-COVID era.

The temporary BLS Authorization measure is approved for a 2-week time period as listed above which will be extended as needed on the 1st and 15th of each month based on a review of response data. EMSA intends to provide 1-week notice of an extension. **The temporary BLS authorization is for a 24-hour operational period with a maximum of 4 BLS units within the 911 system at any given time.** Any BLS provider that is permitted in San Francisco may provide resources on a first-come, first-serve basis with an ambulance that has a permit issued by EMSA.

BLS units may be utilized in the following priority sequence:

1. Code 2 calls with or without an ALS engine
2. Code 3 calls with an ALS engine if no ALS ambulances are available
3. Code 3 calls without an ALS engine if no ALS engines and ambulances are available

ALS responders may turn over a patient after a full ALS assessment identifies the patient as requiring BLS transport and care only. Policy 8000, Appendix D can be used as a reference to assist with determination of ALS criteria. A ReddiNet message will not be posted for the temporary authorization as listed above. All other mutual aid escalation measures remain unchanged and a ReddiNet message will be posted should escalation be needed (ie In-county BLS, Out-of-county ALS/BLS, Strike teams). All BLS units shall follow Policy 8000, Appendix D for unit identifiers. Unit identifiers shall be assigned by DEC. Please call the Dispatch Supervisor 415-558-3268 for logging into EMS system. For any questions, please contact the EMS Agency.

San Francisco EMS Agency
333 Valencia, Suite 210 • San Francisco, CA 94103
Phone (628) 217-6000 • www.sfdem.org

Frequent Asked Questions (FAQs) Regarding Above BLS Authorization

EMSA has received a few clarification questions regarding current policies, how BLS authorization applies, and implementation. EMSA will address them as part of a FAQs. Should providers have additional questions, please email or contact EMSA. EMSA will update the FAQs every memo release. **This information shall remain in effect for duration of extended BLS authorization. Not all circumstances may be covered by EMSA Policies and FAQs when BLS is authorized. ***If a specific issue is not directly addressed within EMSA policy, providers shall use medical decision-making that supports professional judgement, patient advocacy, and consideration for the best interest of patient care.*** For unusual or unique occurrences, please complete an Exception Report.**

FAQs – Fire Crews:

Can a BLS Unit complete PDT (Patient Declines Transport) or AMA (Against Medical Advice) Documentation for a 911-call?
For the authorization period listed above, yes. However, BLS units shall make Base Hospital contact with the following script to identify the call as a PDT/AMA for a BLS unit.

"This is BLS Unit XX contacting you for a PDT. I am an BLS Provider. I am with a (insert patient details here per EMSA Policy 4020 – Field to Hospital Communications)…"

The Base Hospital has been notified and are expecting these call-ins. If the BLS crew has questions about capacity or determination of capacity of the patient, the crew shall contact the Base Hospital Physician and/or request an ALS Assessment. The Base Hospital has been notified that BLS units are limited to BLS level assessments.

Do I need to transport with a second Paramedic (EMT-P) as listed in Policy 4041, Section 3(c) if a BLS ambulance responds to a high-acuity call?

Every reasonable attempt should be made to have a second EMT-P with a condition listed in Policy 4041, Section 3(c). However, with limited ALS resources, if the response time of a second EMT-P delays an emergent patient transport to a Receiving Hospital, the BLS ambulance may transport with a single EMT-P. Please document a reason as to why a second EMT-P did not accompany the patient within prehospital documentation narrative.

What is considered an ALS call?

Refer to EMSA Policy 8000, Appendix D to determine the difference between an ALS and BLS call. If a provider is unsure if a patient is ALS or BLS, please call for ALS assistance.

What if ALS assistance is delayed or unavailable based on system ambulance levels and a BLS ambulance is on scene?

Please follow Policy 4041, Section III, 3(e) – "On-viewed" Incidents, BLS Units on Scene of ALS Acuity Patients.

Can an ALS responder turn over a BLS patient?

For authorization period listed above, yes. ALS responders may turn over a patient after a full ALS assessment identifies the patient requires BLS transport and care only.

Can a BLS provider stand-by for an OME case?

SAMPLE

OME cases should first request law enforcement to standby. Should EMS personnel need to standby at an OME case, transport ambulances should be prioritized to return to service. However, OME standby cases are more appropriate for ALS resources to pronounce with utilization of ALS equipment (ie cardiac monitor for EKG strip). BLS resources can standby following pronouncement from an ALS crew. If an ALS intervention is performed (ie determination of death via EKG strip), ALS should write the determination of death documentation. Should a BLS crew encounter a patient with obvious signs of death per EMSA Policy 4050 – Death in the Field, the BLS crew shall contact the Base Hospital for consultation.

How does an ALS engine know if an ambulance crew is ALS or BLS staffed?

A BLS ambulance crew shall identify themselves on scene to the ALS EMT-P as being a BLS ambulance. DEC will try to broadcast on air to an ALS engine that a BLS unit is en route to a medical call.

Does an ALS engine need to write a full Patient Care Report (PCR) if turning over care to a BLS crew for transport?

An ALS engine EMT-P can document the call utilizing the EMS 100 First Responder Form.

FAQs – <u>Dispatch Center</u>:

Do I dispatch ALS ambulances only and then BLS ambulances once no ALS are available?

No. BLS ambulances should be primarily dispatched to low-acuity code-two calls. If a call is appropriate for a BLS ambulance, the BLS ambulance can be dispatched regardless of how many ALS ambulances are available. Please avoid sending resources across San Francisco when closer and more appropriate units are available. Avoid using ALS ambulances on low acuity calls when BLS ambulances are in the area of the call.

If I dispatch a BLS ambulance, do I always need to assign an ALS engine?

No. Low acuity calls (*e.g.* alpha-determinant) are generally appropriate for BLS ambulances to handle. EM provides guidance on ALS vs BLS calls in policy as listed above. If in doubt or unsure whether a patient need an ALS assessment, care, and/or transport, consult the on-duty RC and/or call for ALS assistance.

Can I send a BLS ambulance to a Code 3 call?

A BLS ambulance may be dispatched to a Code 3 incident if no other resources are available or if the BLS ambulance is significantly closer than any other ALS ambulance to the incident. A non-transport ALS resource could ride with the BLS ambulance to a Receiving Facility as opposed to waiting for a long ALS ambulance response.

Does a known pediatric patient call need an ALS engine attached to the call?

Yes. A *known* pediatric patient (pediatric age as defined by EMSA policy) needs an ALS engine (or ALS resource) added to the call. An ALS resource may turn over care to for BLS transport for pediatric patients but should be present on all pediatric calls initially.

What about unit identifiers?

Please ask DEC supervisors about pre-selected unit identifiers for BLS. Generally, San Francisco AMR utilizes *AM200*-series, King American has unit *KM03 and KM06*, and all other BLS resources are *BLS800*-series.

SAMPLE

Due to a new data system, 4/2/22 - 4/11/22 is not reflected in the following 4 charts. Overall, this data discrepancy likely has a minimal impact on a year's worth of data and overall trends.

EMS Response Times

BLS First Response Units

Code 3

Figure 1. Quantiles of monthly BLS First Response intervals (minutes) for Code 3. Policy dictates that 90% of calls report a response time of 4 minutes and 30 seconds or less.

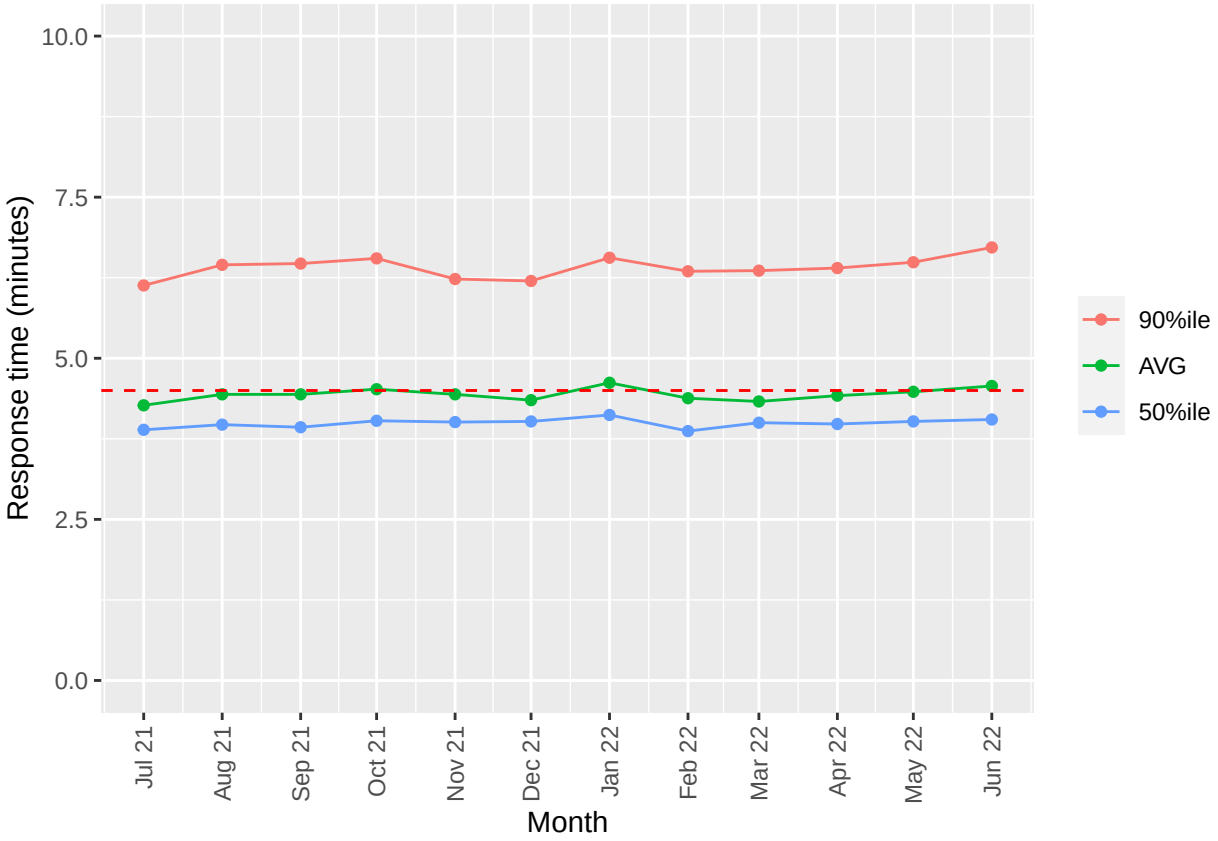


Table 1. OTP: on-time percentage. N: raw count of total calls.

Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
OTP	69%	64%	65%	62%	66%	65%	62%	69%	65%	66%	64%	63%
N	790	812	837	869	662	869	744	782	768	514	883	698
50%ile	3.89	3.97	3.93	4.03	4.01	4.02	4.12	3.87	4	3.98	4.02	4.05
AVG	4.27	4.44	4.44	4.52	4.44	4.35	4.62	4.38	4.33	4.42	4.48	4.57
90%ile	6.13	6.45	6.47	6.55	6.23	6.2	6.56	6.35	6.36	6.4	6.49	6.72

ALS First Response Units

Code 3

Figure 2. Quantiles of monthly ALS First Response intervals (minutes) for Code 3. Policy dictates that 90% of calls report a response time 7 minutes or less.

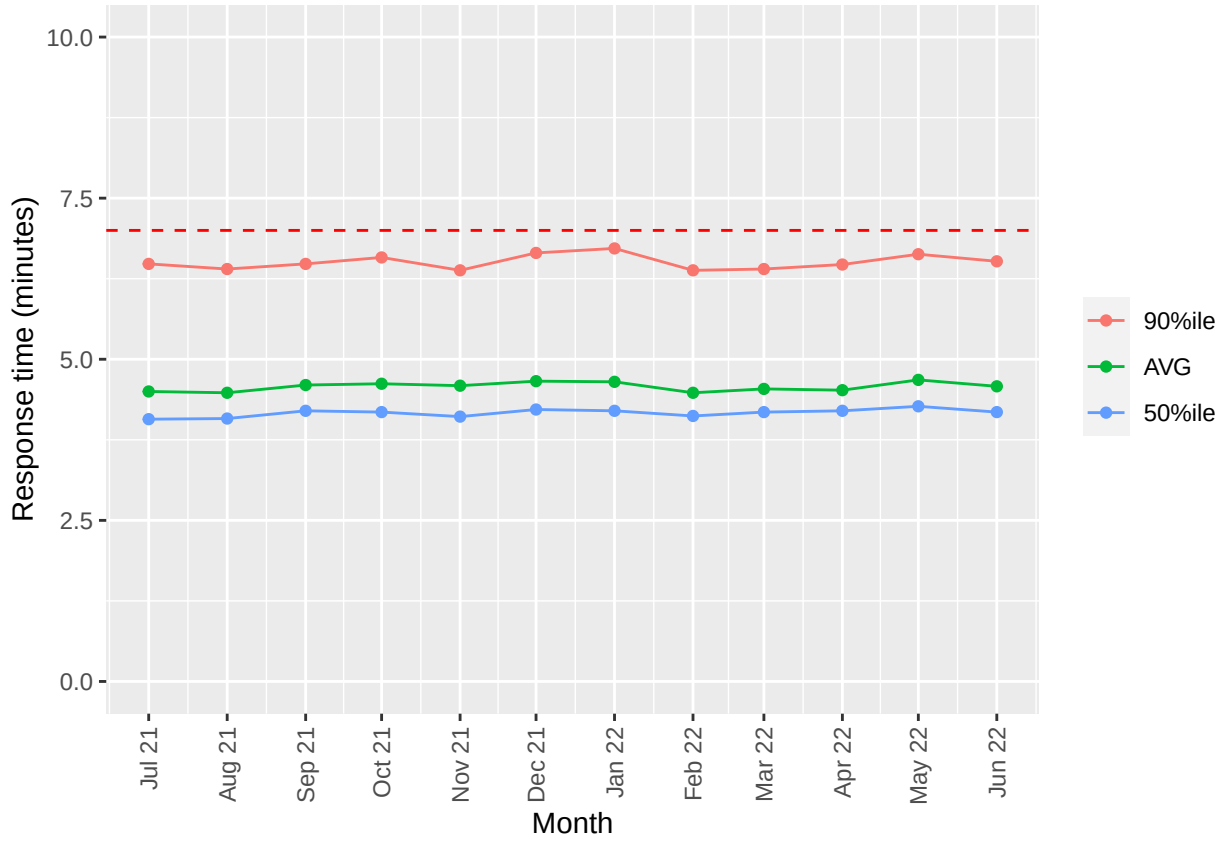


Table 2. OTP: on-time percentage. N: raw count of total calls.

Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
OTP	92%	93%	92%	92%	93%	92%	92%	93%	93%	93%	92%	93%
N	3661	3835	3682	3902	3722	3747	4142	3480	3813	2270	3893	4045
50%ile	4.07	4.08	4.2	4.18	4.11	4.22	4.2	4.12	4.18	4.2	4.27	4.18
AVG	4.5	4.48	4.6	4.62	4.59	4.66	4.65	4.48	4.54	4.52	4.68	4.58
90%ile	6.48	6.4	6.48	6.58	6.38	6.65	6.72	6.38	6.4	6.47	6.63	6.52

ALS Ambulance Response

Code 3

Figure 3. Quantiles of monthly 911 ambulance response intervals (minutes) for Code 3 calls. Policy dictates that 90% of calls report a response time of 10 minutes or less.

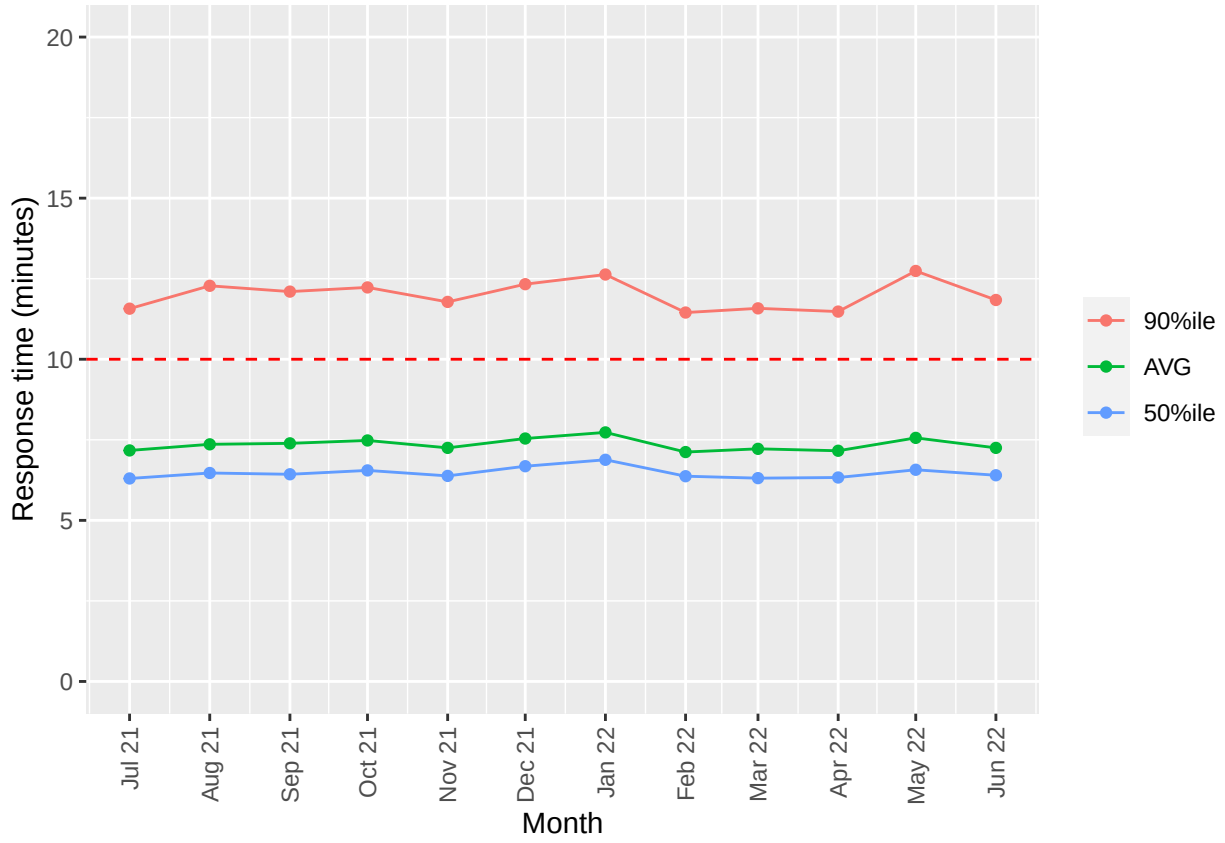


Table 3. OTP: on-time percentage. N: raw count of total calls.

Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
OTP	84%	81%	82%	81%	84%	80%	79%	84%	83%	83%	81%	83%
N	4306	4363	4278	4471	4346	4504	4673	4114	4402	2717	4704	4607
50%ile	6.3	6.47	6.43	6.55	6.38	6.68	6.88	6.37	6.31	6.33	6.57	6.4
AVG	7.17	7.36	7.39	7.48	7.25	7.54	7.73	7.12	7.22	7.16	7.56	7.25
90%ile	11.57	12.28	12.1	12.23	11.78	12.33	12.63	11.45	11.58	11.48	12.74	11.84

ALS Ambulance Response

Code 2

Figure 4. Quantiles of monthly 911 ambulance response intervals (minutes) for Code 2 calls. Policy dictates that 90% of calls report a response time of 20 minutes or less.

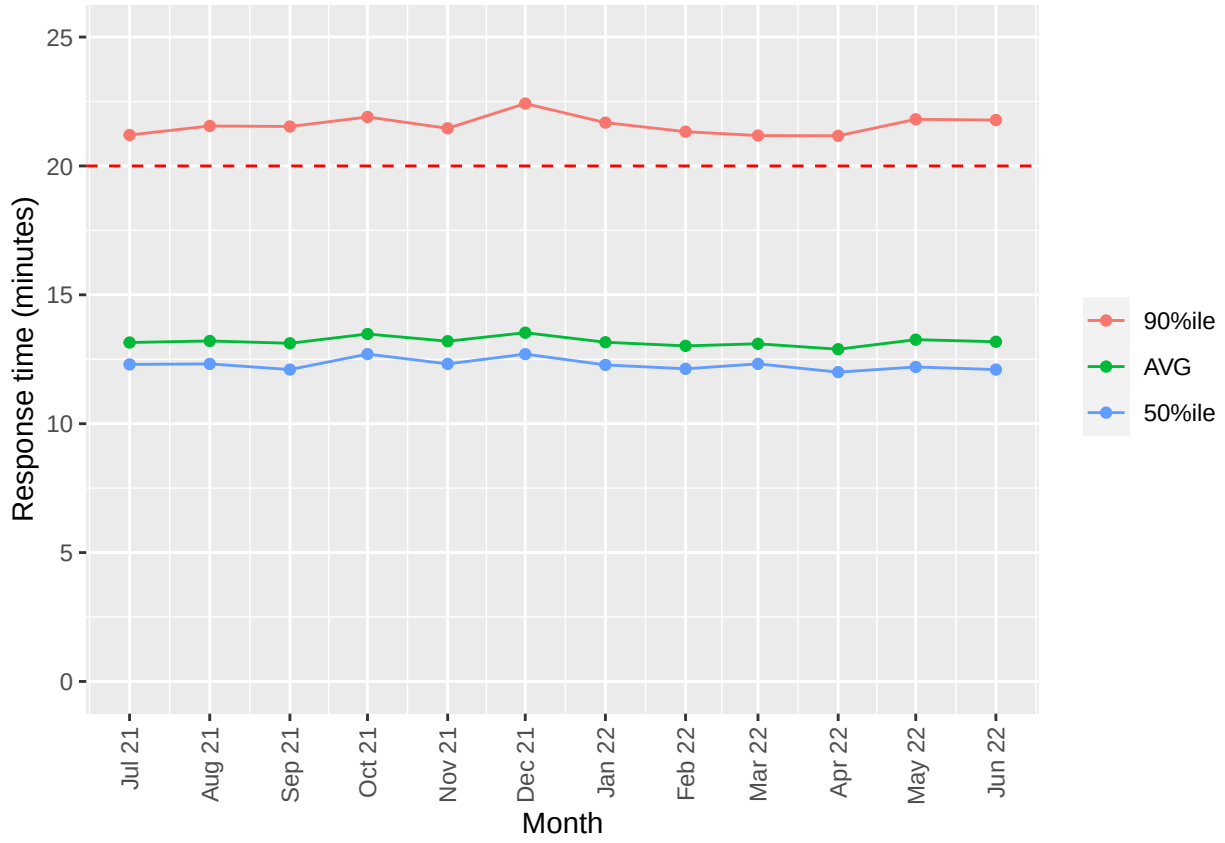


Table 4. OTP: on-time percentage. N: raw count of total calls.

Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
OTP	87%	86%	86%	86%	87%	84%	86%	87%	87%	87%	85%	86%
N	4190	4055	4176	4315	4077	4495	4161	3671	4152	2558	4426	4200
50%ile	12.3	12.32	12.1	12.7	12.32	12.7	12.28	12.13	12.32	12	12.2	12.1
AVG	13.15	13.21	13.12	13.48	13.2	13.53	13.16	13.02	13.1	12.89	13.26	13.18
90%ile	21.2	21.55	21.53	21.9	21.46	22.42	21.68	21.33	21.18	21.17	21.81	21.78

Hospital EMS Report – July 2022

San Francisco EMS Agency
333 Valencia Street, STE 210, San Francisco, CA 94103
Phone: (628) 217-6000

Diversion, EMS transport, and APOT-1 data were extracted and reported in compliance with EMSA Policy 5020.

The tables below contain diversion metrics over a prior 13-month period.

- San Francisco's 10 adult hospitals totaled **1152** hours of diversion. The first table below shows diversion hours for each hospital as a percentage of total month hours.
- **110** diversion suspension events occurred, totaling **364** hours. In the second table below, suspension hours are shown as a percentage of total month hours.
- ZSFG retains the ability to stay on diversion during suspension ("Trauma Override"). ZSFG utilized Trauma Override **81%** of the time diversion was suspended. Our goal is limiting Trauma Override to < 20% of this time.

Table 1

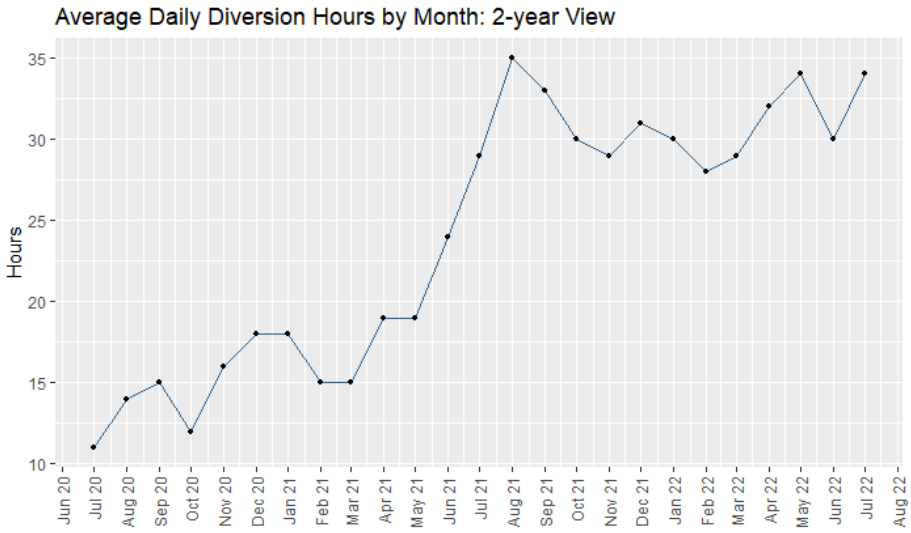
Hospital	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	Avg
Chinese	2.2%	0.3%	1.7%	2.9%	0.9%	0.8%	3.4%	1.3%	0.7%	0.3%	0.0%	0.0%	0.0%	1.1%
CPMC-Bernal	3.0%	6.6%	3.9%	1.6%	1.9%	2.8%	6.9%	1.9%	1.2%	2.6%	4.2%	4.5%	4.0%	3.5%
CPMC-Davies	2.4%	5.9%	5.0%	4.3%	8.7%	2.6%	1.7%	0.3%	1.4%	0.9%	0.7%	0.8%	0.9%	2.7%
CPMC-Van Ness	12.2%	26.5%	19.6%	14.7%	14.2%	18.9%	17.1%	13.2%	15.4%	26.2%	20.7%	13.4%	24.2%	18.2%
Kaiser SF	13.3%	7.4%	5.1%	6.3%	5.6%	11.5%	6.8%	8.7%	16.1%	12.4%	17.5%	11.7%	8.4%	10.1%
St. Francis	0.5%	0.8%	0.1%	0.9%	1.2%	0.5%	1.5%	2.7%	0.8%	1.6%	0.7%	0.7%	0.7%	1.0%
St. Marys	3.4%	5.0%	6.1%	4.6%	10.6%	8.8%	5.6%	4.0%	5.1%	3.7%	5.1%	6.9%	5.2%	5.7%
UCSF-Parnassus	17.6%	22.0%	21.1%	20.1%	18.0%	20.8%	14.1%	27.4%	19.8%	25.5%	15.8%	22.2%	23.8%	20.6%
VA	0.5%	1.1%	1.5%	0.5%	0.9%	0.5%	1.5%	0.3%	0.3%	0.0%	1.4%	1.3%	4.8%	1.1%
ZSFG	61.6%	69.6%	73.6%	67.5%	60.4%	60.5%	66.9%	57.7%	57.9%	60.5%	76.2%	65.6%	67.8%	65.1%

Table 2

System Measure	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	Avg
Diversion Hours	971	1209	1113	1007	991	1041	1040	881	983	1075	1177	1028	1152	1051
Suspension Hours	194	219	193	236	169	301	272	124	176	157	293	354	364	235
Suspension %	26.1%	29.4%	26.8%	31.7%	23.5%	40.5%	36.6%	18.5%	23.7%	21.8%	39.4%	49.2%	48.9%	32.0%
Transports	6430	6434	6334	6648	6314	6905	6864	5860	6425	6242	6822	6446	6613	6488

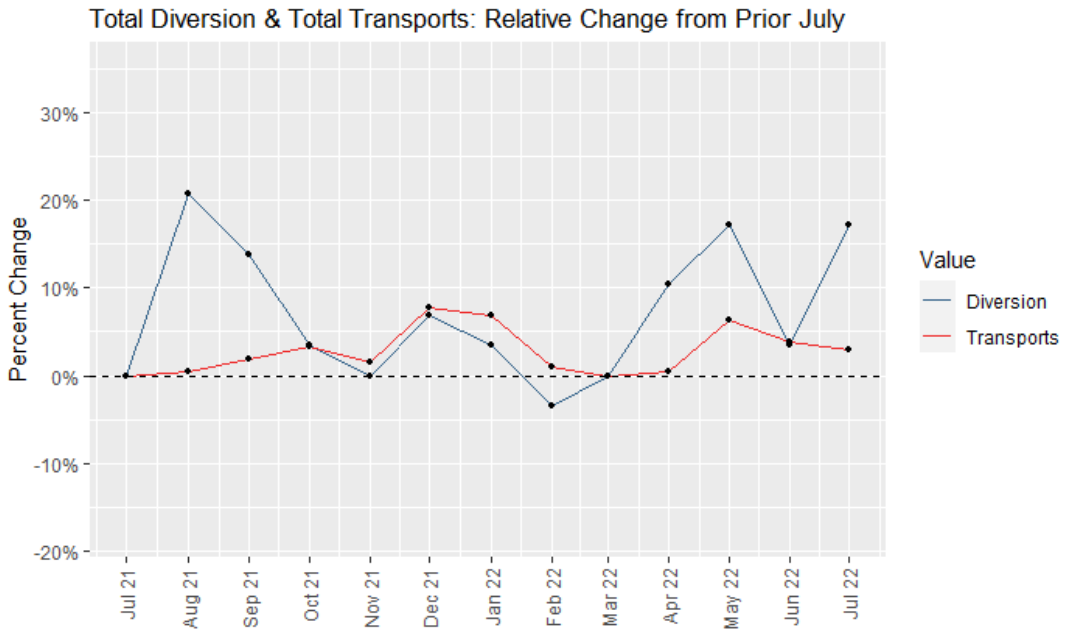
The plot below shows average daily system diversion, by month, over a 2-year period prior to July.

Figure 1



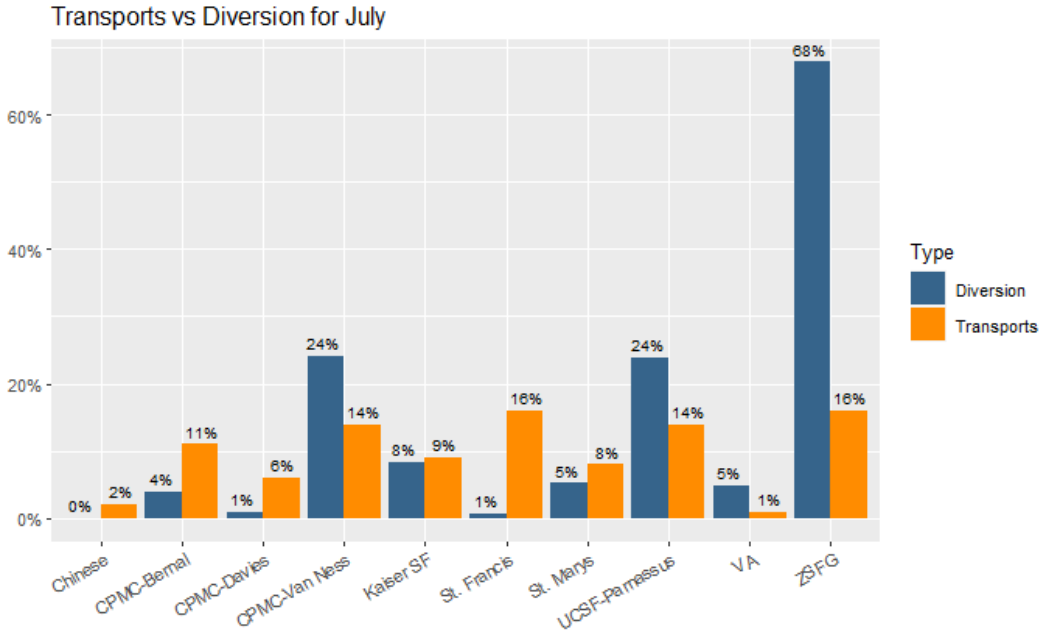
The plot below shows the change in system-wide diversion and EMS transports over the prior 13-month period, relative to their levels in July of the previous year. In other words, how diversion and transport volume has changed since this time last year.

Figure 2



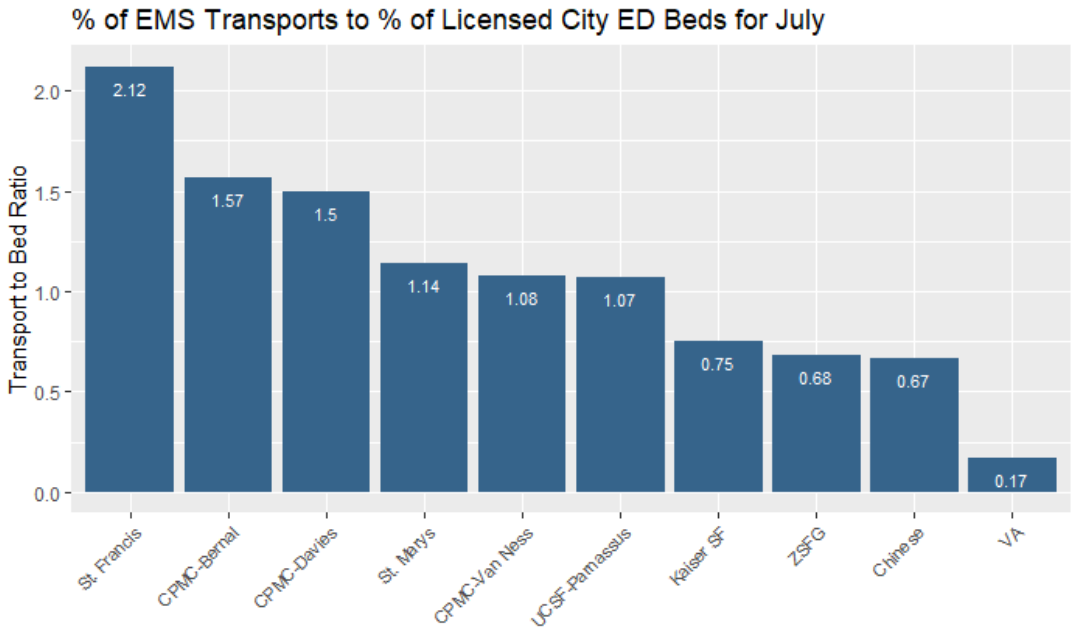
For the 10 adult hospitals, the percentage of time on diversion is compared with the proportion of total EMS transport volume they received. The total number of transports in July (**6,613**) includes transports to partial receiving hospitals, out-of-county ED transports, SF Sobering Center, UCSF-Benioff, or “missing” hospital names.

Figure 3



To provide additional context to “Transports vs Diversion,” the plot below shows a ratio of the following: the proportion of total 911 EMS transports received in relation to the proportion of total San Francisco licensed ED beds reported by each hospital.

Figure 3



The table below shows EMS transport volume to all receiving hospitals over the prior 13-month period. Heat mapping is done row-wise to show variance in EMS transports for each hospital individually.

Table 3

Destination	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	Avg	Avg %
Chinese	93	87	102	111	103	133	110	94	90	89	115	92	106	102	1.6%
CPMC-Bernal	712	717	737	751	693	714	736	651	705	721	815	711	724	722	11.1%
CPMC-Davies	362	394	406	326	329	367	412	309	350	379	429	364	377	370	5.7%
CPMC-Van Ness	848	763	840	872	904	867	903	846	867	815	899	894	895	863	13.3%
Kaiser SF	540	563	548	590	504	580	669	564	589	564	613	599	570	576	8.9%
Kaiser South SF	82	71	77	66	59	64	29	49	74	60	64	47	46	61	0.9%
Seton	61	66	62	74	76	83	84	57	50	77	92	49	60	69	1.1%
Sobering	62	40	36	37	36	32	31	36	51	50	92	79	38	48	0.7%
St. Francis	901	1028	968	952	919	1104	1084	855	931	929	1012	937	1051	975	15.0%
St. Marys	449	509	515	546	420	547	557	471	517	436	513	537	537	504	7.8%
UCSF-MB	92	109	88	129	100	93	127	83	107	114	128	102	103	106	1.6%
UCSF-Parnassus	928	854	834	864	867	948	1025	747	922	842	1012	893	930	897	13.8%
VA	124	105	94	113	87	110	104	92	82	88	108	110	88	100	1.5%
ZSFG	1176	1128	1027	1217	1217	1263	993	1006	1090	1078	930	1032	1088	1096	16.9%
Total	6430	6434	6334	6648	6314	6905	6864	5860	6425	6242	6822	6446	6613	6489	100.0%

Ambulance Patient Offload Time 1 (APOT-1) is a standard performance metric mandated by the California EMS Authority (Health and Safety Code 1797.120). This interval measures the time between an ambulance arrival at hospital and the moment patient care is transferred to hospital staff. APOT-1 is reported as the 90th percentile of aggregated time intervals for each hospital. Heat mapping is done row-wise to show variance in APOT-1 for each hospital individually.

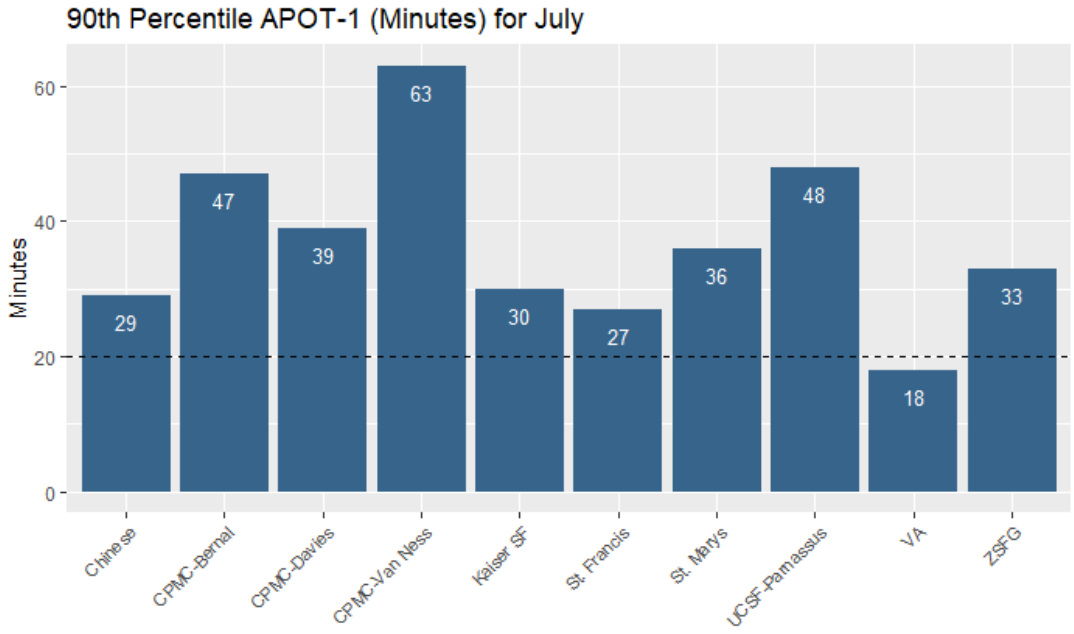
APOT-1 times were extracted from a state EMS data repository and filtered to only include 911 incident transports. Other transport types, such as inter-facility transports, are excluded.

Table 4

Hospital	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	Avg
Chinese	19	20	17	20	19	20	21	21	22	18	19	21	29	20.5
CPMC-Bernal	35	47	40	39	39	47	54	36	32	36	40	43	47	41.2
CPMC-Davies	30	34	33	32	37	39	52	35	30	30	31	34	39	35.1
CPMC-Van Ness	36	41	40	38	33	46	52	40	40	47	50	58	63	44.9
Kaiser SF	27	28	28	27	25	28	31	29	27	27	33	31	30	28.5
St. Francis	21	23	23	23	22	24	24	25	24	24	26	26	27	24
St. Marys	24	29	33	32	31	37	42	32	42	34	39	50	36	35.5
UCSF-Parnassus	40	48	44	43	38	40	49	40	38	36	39	45	48	42.2
VA	20	20	22	18	21	23	21	20	18	20	19	19	18	19.9
ZSFG	27	27	28	29	29	29	31	30	30	30	31	30	33	29.5

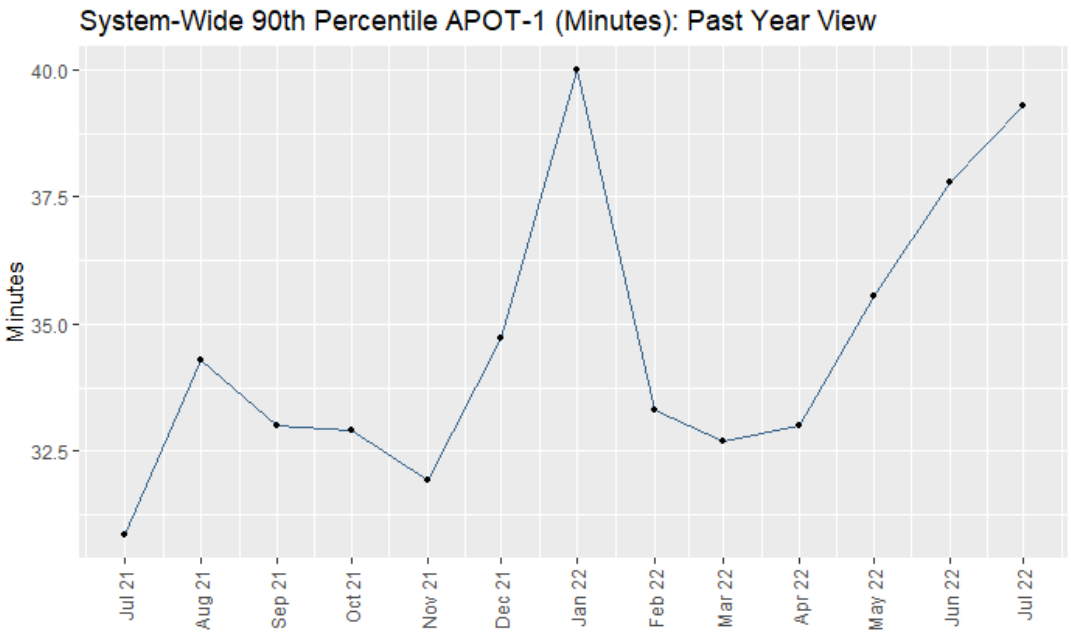
The plot below shows 90th percentile APOT-1 times by hospital in July. The dashed line represents the standard defined in EMSA *Policy 4000.1 - Ambulance Turnaround Time Standard* of 20 minutes for 90% of EMS arrivals.

Figure 4



The plot below shows aggregate 90th percentile APOT-1 for all 10 adult hospitals over the past year.

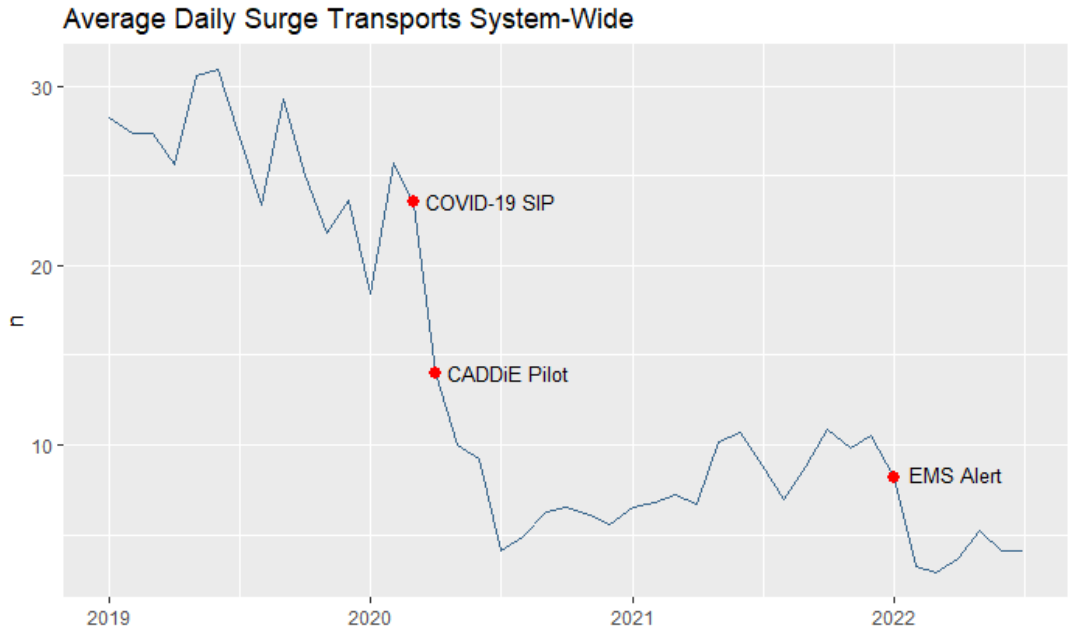
Figure 5



EMS Alert is a locally developed feature for preventing EMS surge events. It incorporates real-time EMS transport, arrival, and past-hour volume to redirect ambulances when hospitals reach a threshold relative to their ED size (more information on EMS Alert can be found here). “Surge Transports” are transports to a hospital after EMS Alert conditions were met or would have been met. This does not include the ambulance that triggered the Alert, only those transporting after.

The plot below looks at average daily Surge Transports for each month since January 2019. Noted with red points are the months in which the COVID-19 shelter-in-place order was issued in San Francisco, when the CADDiE Pilot began, and when EMS Alert became active in January 2022 (CADDiE ended this same month).

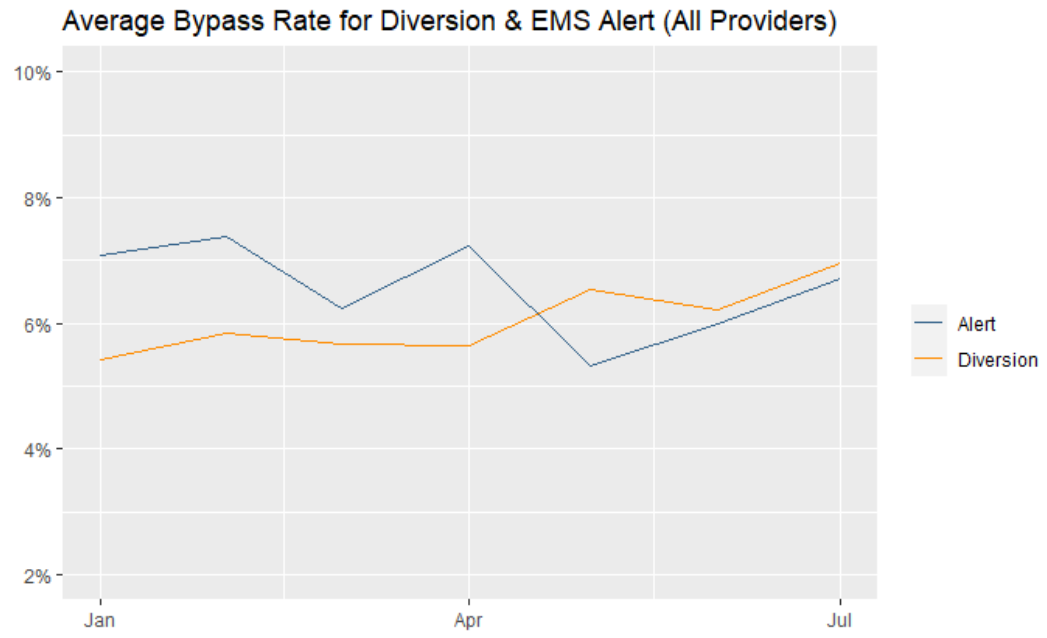
Figure 6



The two figures below look at compliance with EMS Alert. For the purpose of this report, a "non-compliant" transport is one that bypasses Alert with a patient who does not meet exemption criteria (e.g. specialty care, critical medical, etc.).

A challenge in measuring compliance is accurately identifying - at the individual patient level - whether a transport met qualifying bypass criteria given limited prehospital data. For this reason, the diversion bypass rate is used for comparison since criteria for bypassing both is similar. The plot and table below show the average bypass rate of Code 2 transports for both diversion and Alert during times when one or more hospitals is on diversion or Alert, respectively. We would expect similar bypass rates for both.

Figure 7



Shown below are EMS Alert bypass rates for each 911 EMS provider. Of all Code 2 transports performed by each provider that occurred when one or more hospitals were on EMS Alert, this is the percentage of transports that bypassed an EMS Alert.

Table 5

Provider	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	Avg
AMR	8.0%	8.1%	6.7%	8.4%	4.4%	8.4%	14.3%	8.3%
King American	7.9%	4.2%	6.6%	5.3%	3.8%	3.5%	4.9%	5.1%
SFFD	6.7%	8.0%	6.3%	7.6%	5.7%	6.2%	6.5%	6.7%

SECTION III – Quality Improvement

Quality Improvement and Clinical Reporting

The San Francisco EMSA QI Program is comprised of several specialty subcommittees made up of content-matter experts from all EMS providers and hospitals within San Francisco. Each of these committees meet between 2-4 times per year to review case presentations, best practice sharing, system wide data review, performance improvement goal setting, and policy and protocol review/revision. All recommendations, policy changes and guidelines from these subcommittees feed into the EMS Advisory Committee, which meets quarterly to approve any additions and changes.

Stroke Subcommittee

Meetings: Quarterly

Attendees: Medical Directors and Coordinators from 8 stroke centers, Medical directors and QI Staff from EMS Providers. All meetings have had an 85-90% attendance rate.

Case Presentations: Presented by hospitals on rotating schedule with input from dispatch and EMS providers. Case presentations done at each meeting highlight system successes as well as opportunities for improvement.

Successes: Developed LVO Triage Guideline to streamline the transfer of potential or confirmed LVOs to Thrombectomy-capable centers within the county (see attachment)

Goals for 2022-2023:

- Comprehensive and standard data set using Get with the Guidelines
- Ongoing review of transfer/LVO patients
- Development of targeted, evidence-based community outreach to high-risk areas of county
- Complete application submission to EMSA for Stroke Program

STAR Subcommittee

Meetings: Quarterly

Attendees: Medical Directors and Coordinators from 5 STEMI/Cardiac Arrest Receiving centers (see provider chart), Medical directors and QI Staff from EMS Providers. All meetings have had an 85-90% attendance rate.

Case Presentations: Presented by hospitals on rotating schedule with input and participation from dispatch and EMS providers and encompassing from 911 call through hospital course. Case presentations done at each meeting highlight system successes as well as opportunities for improvement.

Successes:

Revision of 3 clinical protocols and 1 policy to align with current standards of practice

Establishment of Community CPR Consortium – a coalition of community and public resources to encourage the support and training of the public in Hands Only CPR

Improvement of Bystander CPR rates from 22 to 28% in 1 year

Pulse Point Launch- May 2022

Goals for 2022-2023:

- Standard data set using GWTG-CAD for all STAR Sites
- Decrease overall STEMI Hospital dwell times
- Increase bystander CPR rates by 5% with ongoing Community CPR Efforts
- Complete application submission to EMSA for STEMI program

Quality Improvement Subcommittee

Meetings: Quarterly

Attendees: Medical directors from all EMS providers, Hospital ED directors/QI staff from all hospitals within SF County. Meeting attendance has been 80% or greater for all meetings

Case Presentations: Presented by EMS providers and focus on infrequently used skills (ex. needle cric) at each meeting

Successes: Overall revision of committee goals and format to include cross-system view of San Francisco Emergency Care

Goals for 2022-2023:

- Review/revise policies 6000 and 6010 (Overall EMSA QI Policies)
- Deeper dive into Behavioral Health with case studies and data
- Incorporate APOT/Diversion processes/recommendations into QI work

Trauma Systems Advisory Subcommittee

Meetings: Twice per year

Attendees: Medical directors from all EMS providers, ED Leadership from all hospitals within SF County, Trauma Leadership (Director, Coordinator, QI) from our only Trauma Center (SFGH).

Case Presentations: Trauma cases co-presented with field staff and trauma center at each meeting

Successes: This committee resumed its work in late 2021 after several years of being inactive. In the two meetings that have taken place, committee leadership (Co-Chairs) were selected, goals were

outlined and a revision of the Trauma Triage Policy (to align with 2021 ACS Guidelines) is currently in final review.

Goals for 2022-2023:

- Finalize Trauma Triage Policy updates
- Deepen work in Pediatric Trauma Care (see below)
- Work to establish a secondary Trauma facility within SF County

EMS for Children Subcommittee

EMS for Children Subcommittee resumed in Summer 2022 after being inactive for several years. In the initial meeting, the committee identified policy review of pediatric trauma and behavioral health as two of the potential goals in the coming year. Committee membership, meetings, and goals to be finalized Autumn 2022.

San Francisco EMS Agency (SF EMSA)

Out-of-Hospital Cardiac Arrests (OHCA) Strategic Initiatives

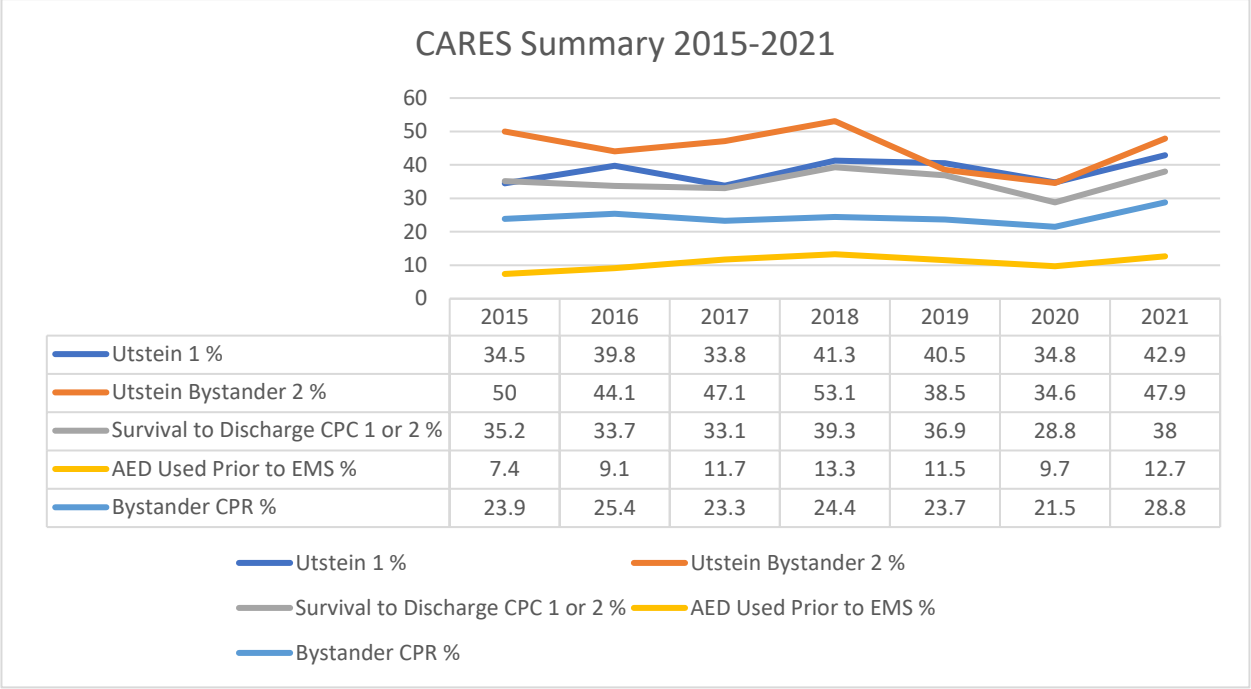
From 2019 to 2020, SF EMSA established improvement measures primarily focused on enhancing crew response and clinical skills in OHCA events. The cardiac arrest protocol was revamped to guide an organized and High-Performance CPR (HP CPR) team approach to treating OHCA, HP CPR classes were offered system wide and OHCA review and feedback process was centralized to within SF EMSA in order to deliver a standardized approach to OHCA throughout the system.

The case review and feedback process has since evolved and expanded through SF EMSA's partnerships with San Francisco Fire Department (SFFD), King American Ambulance and American Medical Response (AMR). 2022 launched the expanded OHCA review process and each of the providers are now providing timely performance feedback to their crews utilizing a standard form derived from SF EMSA review form. SF EMSA will collect summary logs of reviews and feedbacks from each of the provider agencies and conduct a sampling of isolated reviews.

A Highlight Case was added to the STAR Subcommittee's agenda and presented each quarter to recognize the efforts of bystanders or family members, EMS crews, STAR center staff and patients.

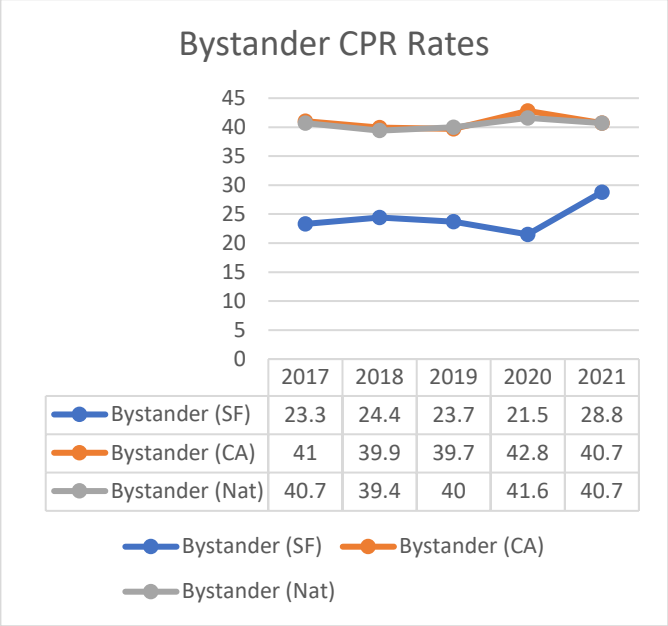
Additionally in 2019, SF EMSA secured funding to provide the city's EMS with 18 LUCAS devices tactically staged with SFFD Rescue Captain (RC) units, King American and AMR supervisor units, San Francisco Police Department (SFPD) Marine Unit, San Francisco Sheriff's Office (SFSO) medical units and at San Francisco International Airport. Staging of the devices have allowed for the utilization of mechanical compressors in all OHCA events that did not meet exclusion or contraindication criteria.

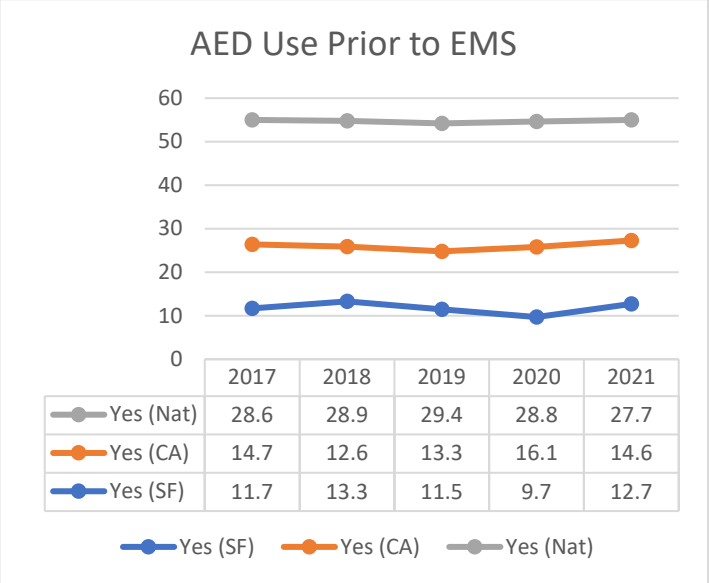
In 2021, 628 OHCA events occurred in the City and County of San Francisco. The 2021 CARES Annual Summary Report revealed that San Francisco's Utstein[1] survival rate was at 42.9%, Utstein[2] was at 48% and the rate of patients surviving to discharge with CPC of 1 or 2 was at 38%. San Francisco's rates in all three categories measured above the state and national rates.



	2015	2016	2017	2018	2019	2020	2021
Utstein 1 %	34.5	39.8	33.8	41.3	40.5	34.8	42.9
Utstein Bystander 2 %	50	44.1	47.1	53.1	38.5	34.6	47.9
Survival to Discharge CPC 1 or 2 %	35.2	33.7	33.1	39.3	36.9	28.8	38
AED Used Prior to EMS %	7.4	9.1	11.7	13.3	11.5	9.7	12.7
Bystander CPR %	23.9	25.4	23.3	24.4	23.7	21.5	28.8

San Francisco 2021 rates saw an increase in bystander CPR which went up by 6% and AED use which improved by 3%. San Francisco's bystander CPR rate in 2021 was the highest in five years. However, when compared against the state and national rates for both categories, San Francisco's rates have significantly been lower over the last five years.





2021 assessment of CARES data prompted a shift of focus and phased SF EMSA initiatives into improving the city and county's bystander CPR rates and AED use prior to EMS arrival. Strategic planning identified the following initiatives as the primary actionable items for 2022:

- Establish a CPR Training Network
- Overhaul AED registration
- Launch PulsePoint
- Distribute CPR Training Kits to community-engaged agencies and foster partnerships
- Supply law enforcement partners with AEDs
- Establish a CPR Coalition to periodically meet and review

San Francisco's AED Registry was restructured in 2021, eliminating a notification process that contained redundant gateways that consistently resulted in registration gaps. The process was streamlined onto an electronic platform that is directly aligned with the SF EMSA's 2022 OHCA strategies and initiatives. Previous registry was maintained on an Excel log sheet that has become outdated with no solid re-verification process to maintain accuracy through the years. SF EMSA has been actively verifying registry accuracy and transferring confirmed locations onto the electronic platform powered by PulsePoint.



SF EMSA AED Registration is now exclusively online and can be accessed publicly using below link:

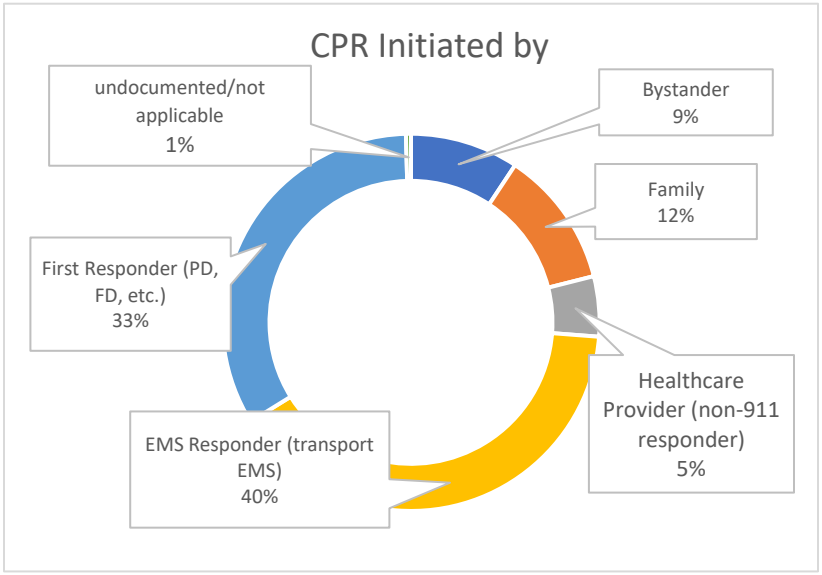
https://www.sfdph.org/dph/comupg/oservices/emergency/public-access-defibrillation.asp

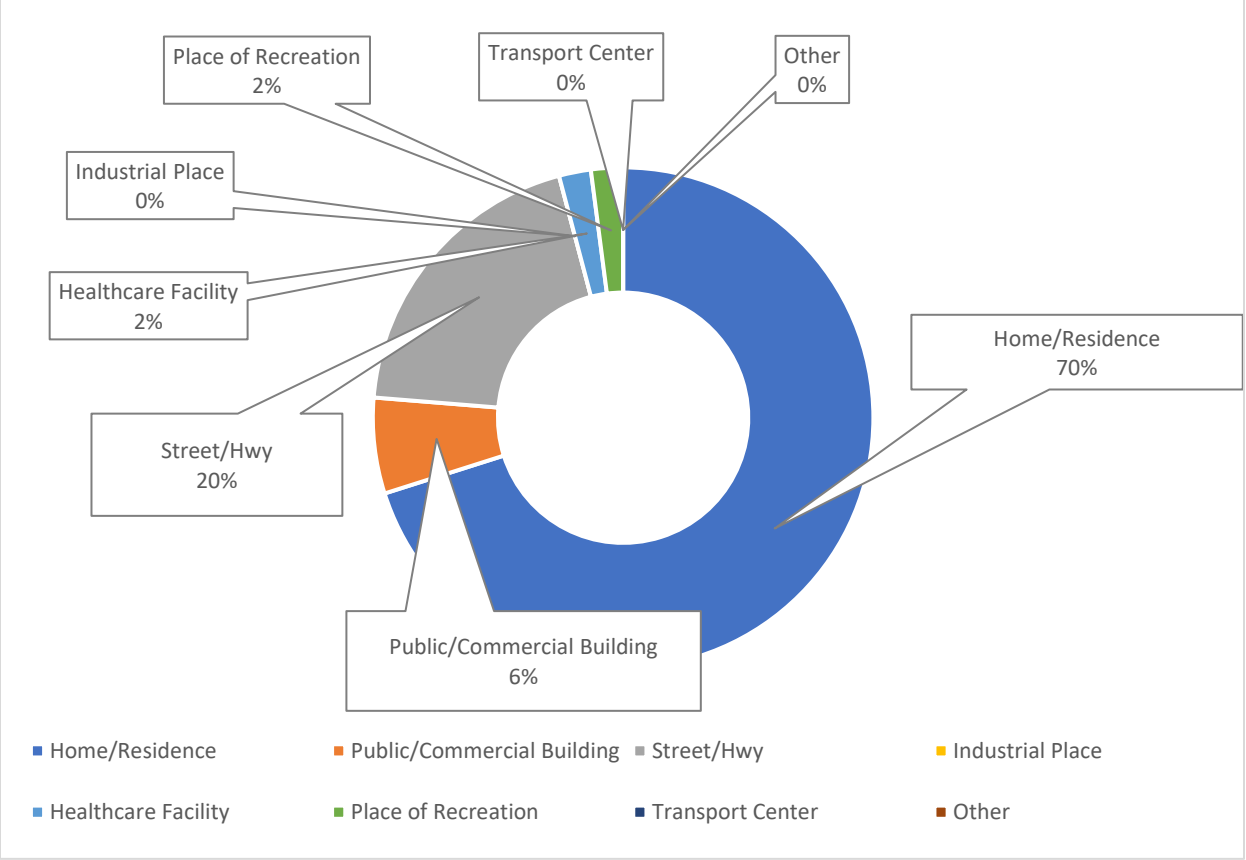
San Francisco launched it's PulsePoint membership in May of 2022 and activated the utilization of the 911-connected app to help circulate nearby CPR-trained individuals to OHCA events throughout the city. Currently, San Francisco's PulsePoint lists a pool of 1,027 possible responders. SF EMSA will continue to explore promotional opportunities to expand the pool of possible responders.

In 2022, SF EMSA established partnerships with Community-Based Organizations (CBO) throughout the city with the goal of accessing additional pathways to reach and offer bystander CPR training to various community groups. 12 AHA Hands-only CPR Training kits were distributed to 11 organizations and a Point of Contact network is now in place to share training and CPR exposure opportunities to groups such as youth programs and services, underserved communities, shelters, and church coalitions.

In 2021, SF EMSA re-purposed disaster response AED devices and distributed for active staging at CBO headquarters and SFSO units.

A CPR Coalition was created and hosted by SF EMSA to meet and review program progression and need for adjustments. The coalition can escalate findings as needed to STAR and QI Subcommittees to assure a systemic approach to improving bystander CPR and AED use prior to EMS arrival on scene.





Location	Bystander CPR		%	AED Prior	%	Witnessed	%	Moderate to Good CPC	
Healthcare Fac	10	0	0%	4	40%	6	60%	1	10%
Home	428	97	23%	42	10%	224	52%	19	4%
Industrial	2	1	50%	0	0%	1	50%	1	50%
Nursing Home	22	0	0%	8	36%	10	45%	1	5%
Other	1	0	0%	1	100%	1	100%	0	0%
Rec	10	0	0%	2	20%	7	70%	1	10%
Public Buildings	36	7	19%	7	19%	25	69%	7	19%
Street	117	24	21%	13	11%	59	50%	12	10%
Transport Center	1	0	0%	0	0%	1	100%	0	0%

Using the data dashboard, CPR Coalition can set or pivot the emphasis levels on each of the initiatives in our toolkits. Additionally, a pinpointed review of the data can also identify gaps in Health & Safety Code Compliance.

Areas to Improve Bystander CPR and AED Use				
Home (Single Residence/Apartment)	Public & Industrial Buildings	Streets & Public Areas	Nursing Homes/Health Facilities (Non-hospital)	Others
Initiatives Toolkit to Emphasize (Each Area)				
CPR Training Network CBO Training SFSO/SFPD Partnership AED Registry (Apartments if opted)	AED Registry (HSC Compliance) SFSO/SFPD Partnership PulsePoint CPR Training Network CBO Training	PulsePoint SFSO/SFPD Partnership AED Registry CPR Training Network CBO Training	AED Registry (HSC Compliance)	PulsePoint SFSO/SFPD Partnership AED Registry CPR Training Network CBO Training

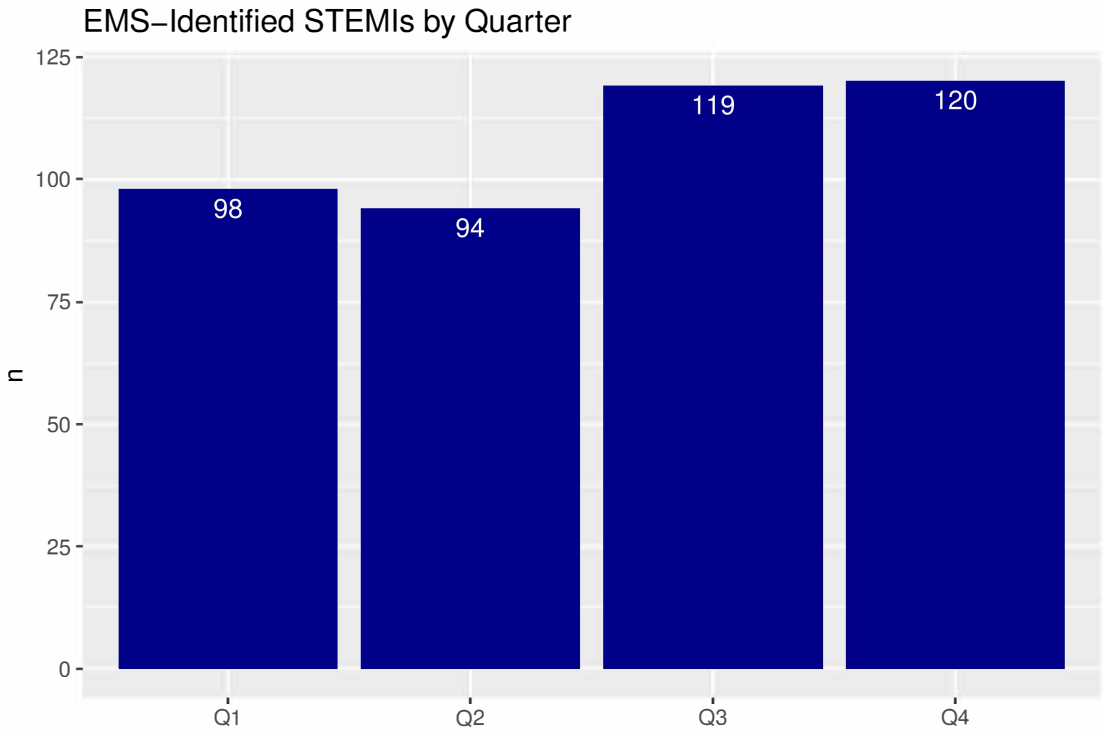
STEMI/STAR QI Goals				
Goal	Objectives to Achieve Goal	Metric	Status	2022 Update
Utilize state and national benchmarks to identify current performance and opportunities for improvement in STEMI and Cardiac Arrest systems of care	Implement a standard data collection platform	All sites to utilize Get With the Guidelines-Coronary Artery Disease (GWTG-CAD) and grant permission for EMSA to view	4 out of 5 STEMI sites currently entering data in Get With the Guidelines, one site pending contract approval	EMSA is currently utilizing GWTG-CAD Data from 4 out of 5 STEMI centers, and 5th center is in final phase of contracting to join GWTG. EMSA has made participation and data sharing as a STEMI center requirement in MOU. EMSA is also setting system benchmarks based on AHA Guidelines and Mission:Lifeline EMS Criteria, including Pre-arrival notification for STEMI, 12-Lead ECG Performed within 10 mintues of EMS arrival, Aspirin administration, and First Medical Contact to PCI within 90 minutes.
	Utilize Data Platform to identify gaps and opportunities to improve care	Evaluate current performance in national STEMI care standards (arrival to ECG, ECG transmission, STEMI Alert, etc)	Data currently being entered and shared, current performance to be reviewed and Quality Goals set within next 30 days	Over 2021-2022, using data from both GWTG-CAD and self-reported data (from one site not yet signed up for GWTG) the STAR Committee determined Door to Cath lab time (ED time) was the area across all hospital systems, with the greatest opportunity for improvement. Hospitals have been asked to assess their intake/admin processes and report out to committee with the goal of establishing recommendations by end of 2022 and re-assessing in 2023.
Improve outcomes for out-of hospital Cardiac Arrest in SF County	Utilize CARES Data registry to identify areas of improvement in bystander-assisted CPR	Current Bystander -assist CPR is 21%, below state and national benchmarks	2020 CARES Data to be presented and reviewed by STAR Subcommittee in May 2021	CARES Data presented at each (quarterly) STAR committee meeting. Of note: bystander CPR rates increased from 23%(2015-2020) to 28.8% in 2021 with the introduction/focus on bystander CPR efforts.
	Update county-wide AED registry	1100 AEDs are currently in SF County and need to be verified for location, functionality, appropriate placement	Working with EMS Providers to plan a deployment of providers to physically evaluate community AED and updating the AED registry by Fall of 2021	EMSA Fully transitioned AED registry to Pulse Point AED, cloud-based AED registry. Currently 900+ AEDs registered to site, and ongoing registration link available on EMSA website.
	Implement a public-facing notification for out of hospital CPR needs	Implement PulsePoint, a public-facing free application that notifies individuals who are trained in CPR if there is a current cardiac arrest nearby	Contracting completed with PulsePoint, currently working with Department of Emergency Management to connect application to dispatch system, goal to make public in Fall 2021	PulsePoint respond went live in May 2022, currently working with Public Relations/communications teams to increase users. Approximately 8-10 CPR NEEDED calls per day tracked on PulsePoint. EMSA expecting analytics re: usage and response of app to provide more insight by early 2023.

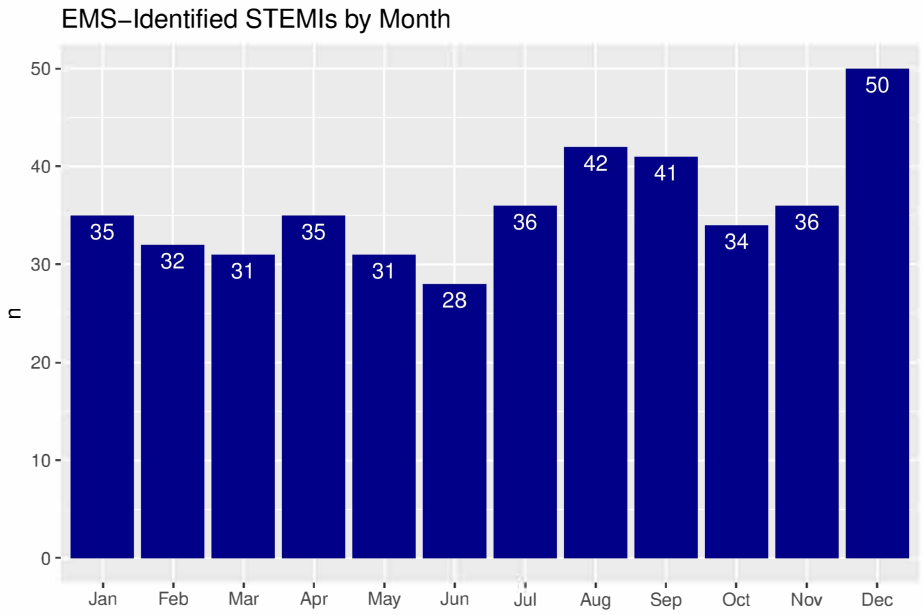
EMS STEMI Report - 2021

911 incidents in which STEMI's were identified by EMS in the prehospital setting were reviewed for 2021. The following inclusion criteria is used, based on ePCR fields for all San Francisco 911 EMS providers:

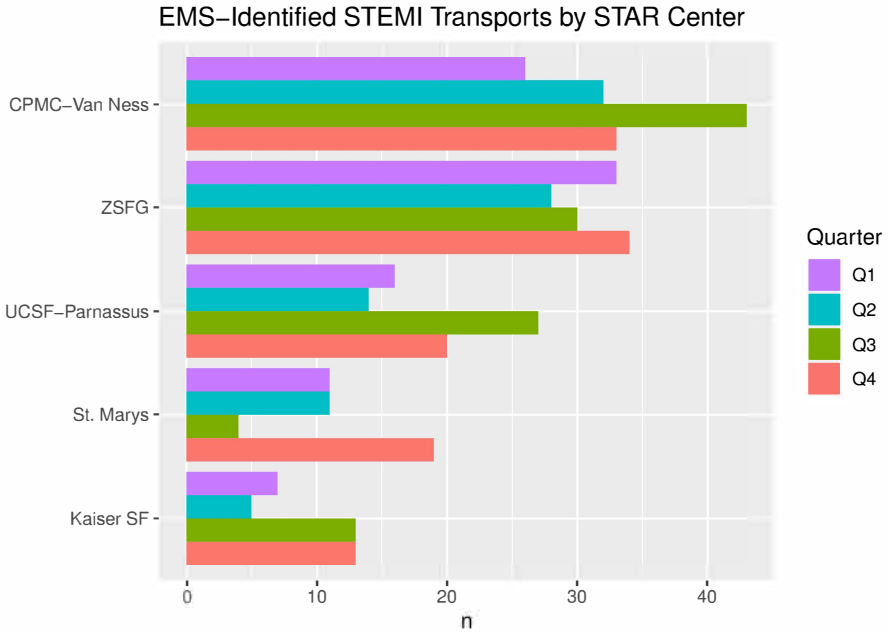
- Primary Impression of STEMI (NEMSIS eSituation.11, ICD-10: I21.3)
- Secondary Impression of STEMI (NEMSIS eSituation.12, ICD-10: I21.3)
- Destination Team Pre-Arrival Alert of Yes-STEMI (NEMSIS eDisposition.24, Code 4224013)
- ECG interpretation of STEMI (NEMSIS eVitals.03, Codes 9901051 - 9901057)

Incidents with a service type other than "911 Response" were excluded (e.g. interfacility transports). In total, 431 prehospital STEMI's were identified in 2021.





Of the 431 EMS-identified STEMI's, 419 were transported to San Francisco STAR hospitals.



12 patients with an EMS-identified STEMI had a disposition other than transport to a STAR center.

EMS Operations Metrics

The figures below examine “Scene Time” and “Transport Time” durations for the 419 STEMI patients transported to STAR hospitals. All times in minutes.

- Scene Time: Interval between ambulance arrival on-scene and initiation of transport.
- Transport Time: Interval between initiation of transport and arrival at hospital.

Table 1: On-Scene Times for STEMI Calls (minutes)

Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1	7.4	15.7	18.8	20.4	24.5	45.8
Q2	3.5	13.9	17.5	19.6	24.0	52.0
Q3	7.4	15.7	18.8	20.4	24.5	45.8
Q4	3.5	13.9	17.5	19.6	24.0	52.0

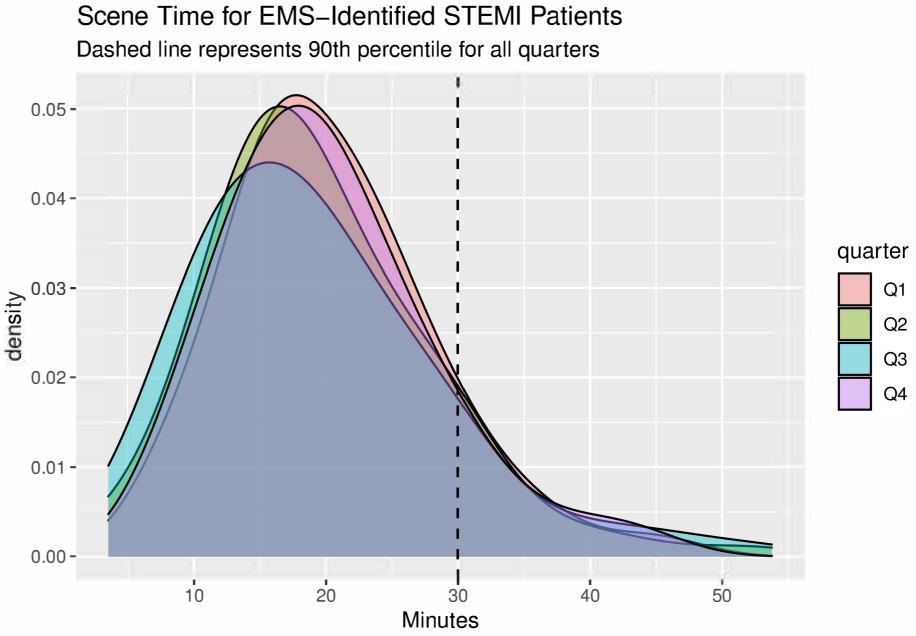
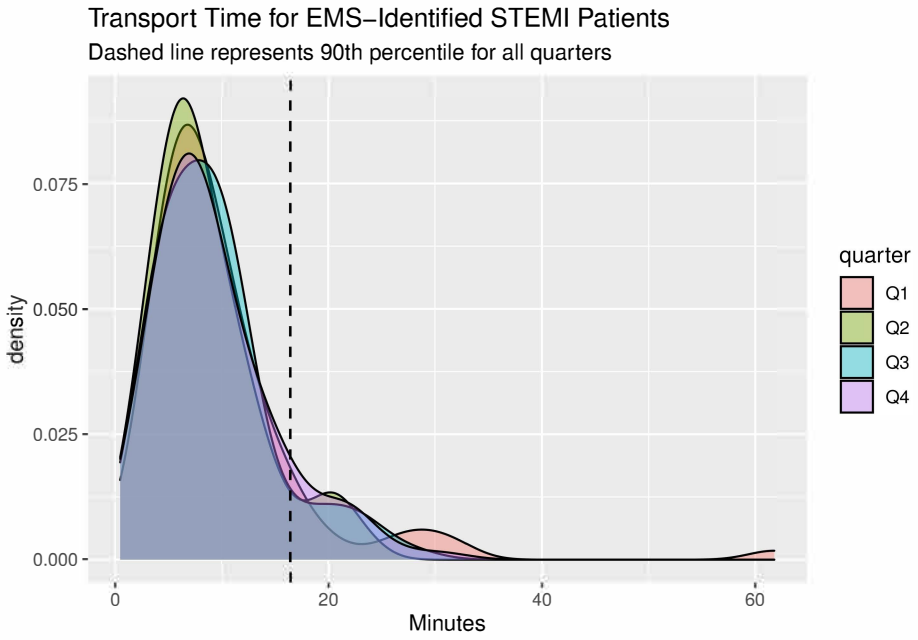


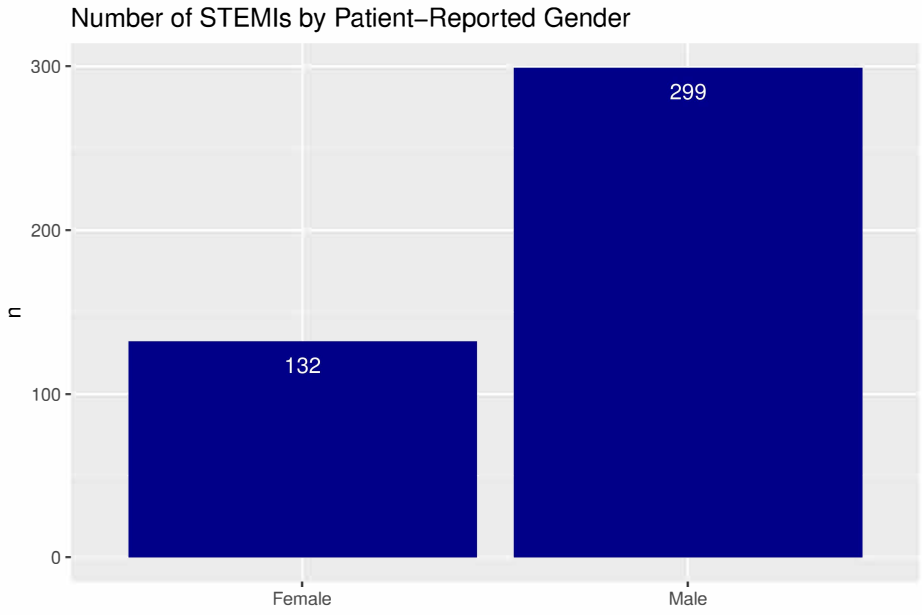
Table 2: Transport Times for STEMI Calls (minutes)

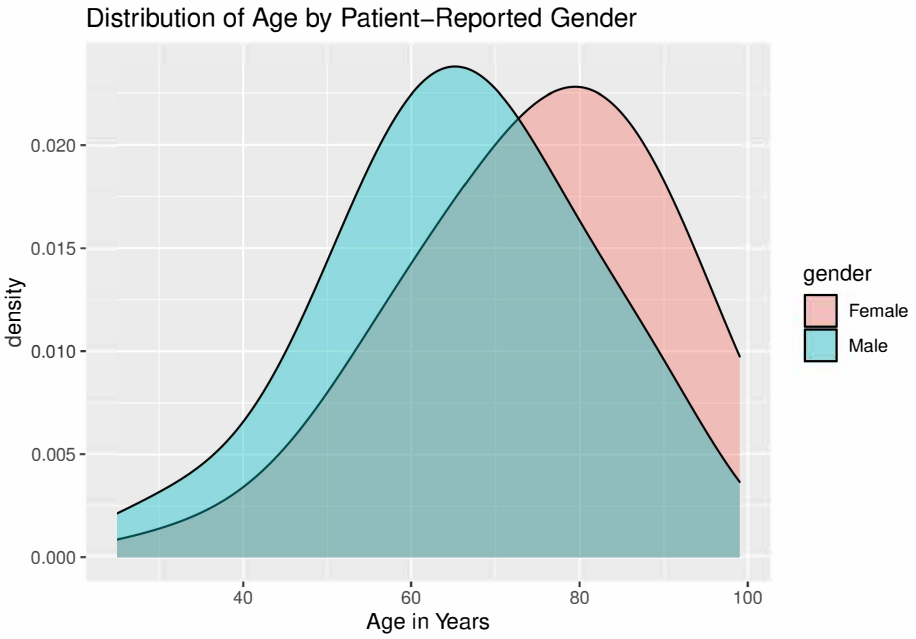
Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1	1.1	5.5	7.8	10.0	11.4	61.8
Q2	1.0	5.5	7.0	8.5	10.6	23.6
Q3	1.8	4.9	8.4	9.2	11.3	28.2
Q4	0.5	5.3	7.8	9.4	12.0	30.6

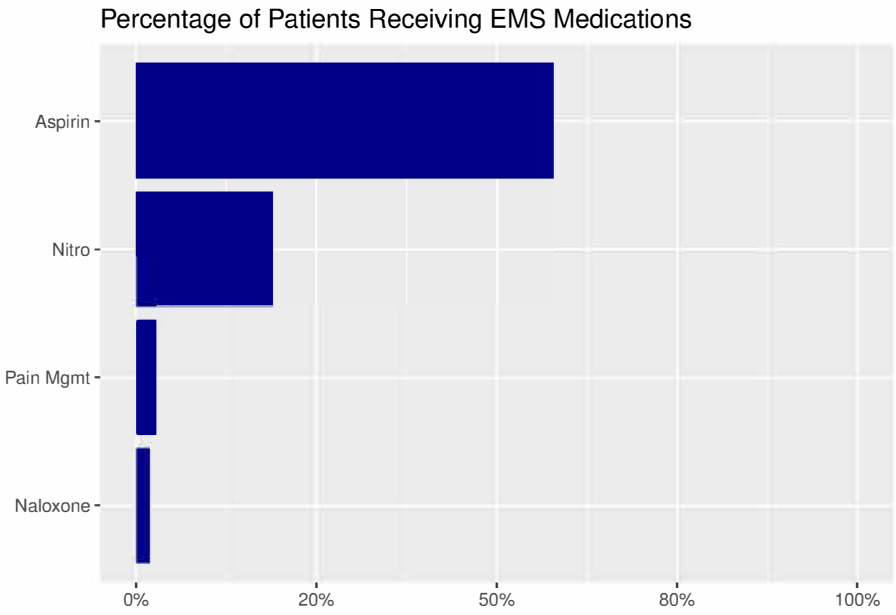


Total EMS Time is the interval between transporting EMS arrival on scene to arrival at a receiving Emergency Department - or the combination of the two intervals reviewed above. The average Total EMS Time for STEMI patients in 2021 was **29.19** minutes.

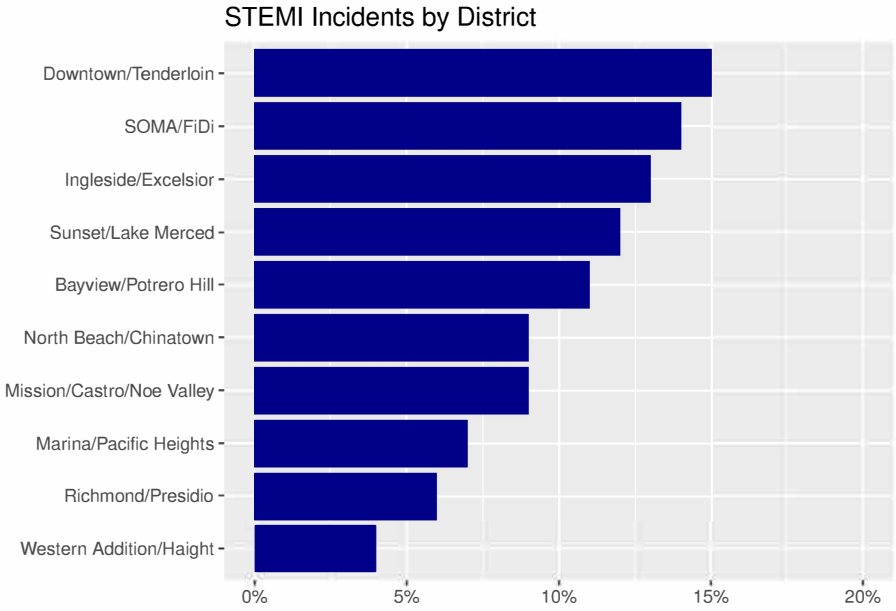
Patient Demographics and Treatment

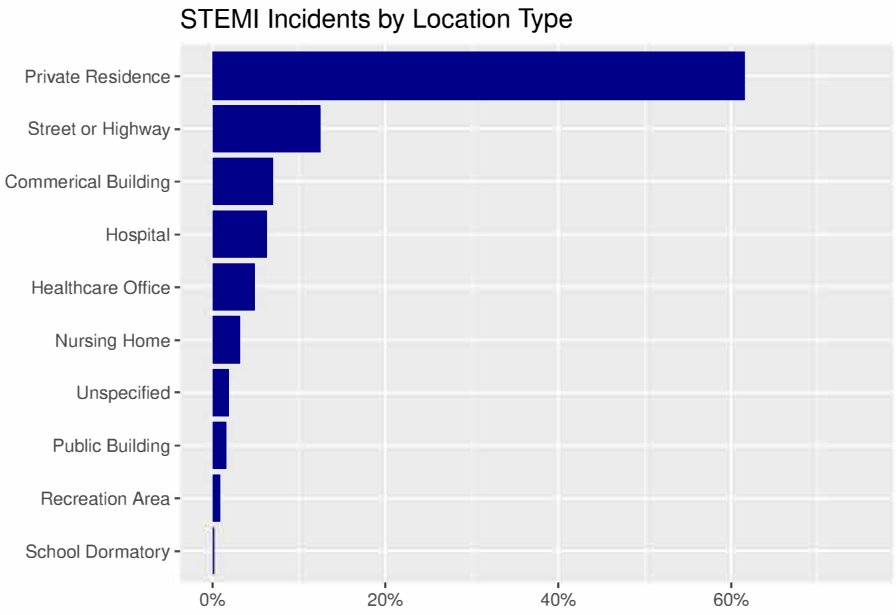






Incident Location




STEMI Incidents by Location Type
Private Residence
Street or Highway
Commerical Building
Hospital
Healthcare Office
Nursing Home
Unspecified
Public Building
Recreation Area
School Dormatory
0%
20%
40%
60%

Stroke QI Goals				
Goal	Objectives to Achieve Goal	Metric	Status	2022 Update
Utilize state and national benchmarks to identify current performance and opportunities for improvement in stroke system of care	Implement a standard data collection platform	All sites to utilize Get With the Guidelines and grant permission for EMSA to view	6 out of 7 sites currently using GWTG platform 5th site in contract discussion with AHA Contract for Super User with AHA currently in legal review	EMSA is in final phase of contracting with AHA for Stroke Super User. Of the 8 Stroke centers in SF County (one new Stroke Center certified in early 2022), 7 are currently utilizing Get With the Guidelines- Stroke. EMSA has made participation in and sharing data from GWTG-S a requirement for all stroke receiving centers and incorporated that language in our Hospital MOUs.
	Establish prehospital stroke performance benchmarks	Utilize GWTG prehospital tab to collect run sheet data	Hospital sites given access to EMS provider ePCR Stroke Subcommittee establishing data points based on AHA/National Guidelines	Benchmarks established using national AHA Mission: Lifeline and Stroke Guidelines. These include Pre-arrival Notification for Suspected Stroke, Documentation of Last Known Well, Stroke Screen performed and documented in the field, First Medical Contact to Thrombolytic Administration or Endovascular therapy. We expect to have all centers' data by the end of 2022 and will be able to assess the data in 2023.
Evaluate/Update Stroke Protocols	Utillize most recent guidelines and consensus statement from AHA/ASA with all shareholder consensus	Through consensus of Stroke Subcommittee as well as literature review, align SF EMS Stroke policies to reflect most updated guidelines	Stroke Subcommittee currently reviewing Routing Triage protocol, prehospital stroke screening. All stroke policies and procedures to be reviewed and updated in the next 12 months	Routing Triage protocol reviewed in late 2021 and determined that annually approximately 30 patients per year (less than 1% of all strokes) were transferred within the City and County of SF, from a Primary Stroke Centerto a Comprehensive/ Thrombectomy center. Of those, half were transferred within a particular health plan (Kaiser to Kaiser). Additionally, SF is 49 Sq. miles, and has 8 certified stroke centers within, with average IFT times of less than 15 minutes. It was then concluded that a revision to the routing protocol was not warranted. The committee did elect to develop a LVO Retriage Guideline (attached) as a resource to all hospitals within SF County who were facilitating transfer of stroke patients
Provide Standard education to EMS providers	Partner with hospitals to provide up to date education to EMS providers	Utilizing EMSA online platform as well as on-site locale to train 100% of EMS providers annually	Stroke Education Module developed and currently under review, to be available Summer 2021, additional educational programs to be developed with cooperation/input from Stroke Subcommittee	Stroke Education Module completed and available in late 2021.

Emergent LVO STROKE 911 RE-TRIAGE

1. Contact a Stroke Center capable of performing stroke thrombectomy to request "Emergent LVO Stroke 911 Re-triage":
    a. UCSF Parnassus: *Adult Transfer Center (415-353-9166) and "Request CODE LVO STROKE ED TRANSFER"*
    b. CPMC Van Ness Campus: *ED 415-600-3333*
    c. CPMC Davies Campus: *ED 415-600-0600*
    d. Zuckerberg San Francisco General - ED Attending in Charge: *628-206-8111*
2. Call 911 and request a "Code 3 EMERGENCY RESPONSE" ambulance for LVO Stroke Transfer to the receiving Stroke Center.

INDICATIONS FOR EMERGENT LVO STROKE 911 RE-TRIAGE:

All of the following criteria:

- Patient with Symptoms of Acute Ischemic Stroke
- Last Seen Well Time within 24h, AND
- CTA (or MRA) demonstrating Large Vessel Occlusion (defined as Carotid-T, M1, M2, or Basilar Artery Occlusion)

NOTE: Medications / interventions exceeding the Paramedic Scope of Practice must be stopped for transfer or an extended service provider (MD/NP/PA/RN/CCT-PM) must accompany the patient.

For stroke patients treated with alteplase, delays or interruptions in the infusion may significantly impact serum levels and reduce efficacy. Therefore, if an extended service provider is not available to accompany the patient, the patient may need to be held in ED until the alteplase infusion is complete. For stroke patients treated with tenecteplase, a continuous infusion is not required.

PATIENT MEDICAL RECORDS:

If possible, send the patient's medical record (includes paramedic records, ED records, images, lab tests and other pertinent diagnostic tests) with the patient.

Best practice is to have an established process for transferring images electronically (e.g. LifeImage or RAPID) AND to burn a disc with the relevant neuroimaging studies (CT/CTA and CTP if performed) immediately after the images are acquired to send with the patient in order to shorten the transfer process.

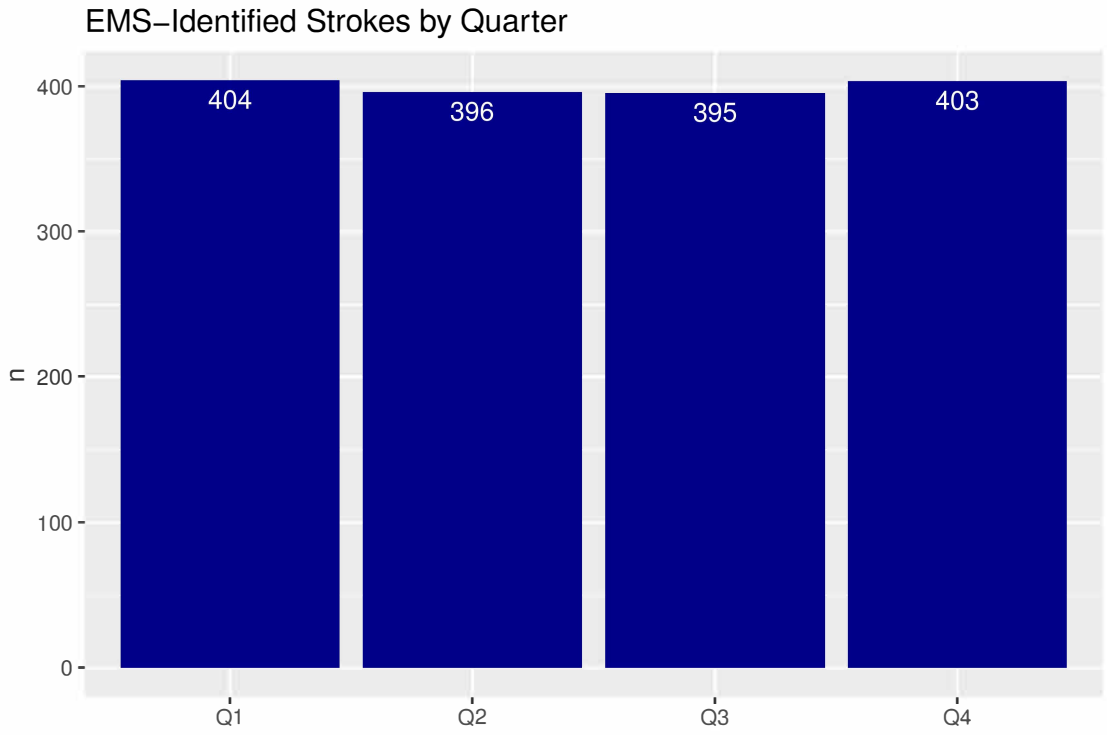
Note: The process above concerns re-triage of ED patients and does not apply to inter-facility transport of already admitted inpatients.

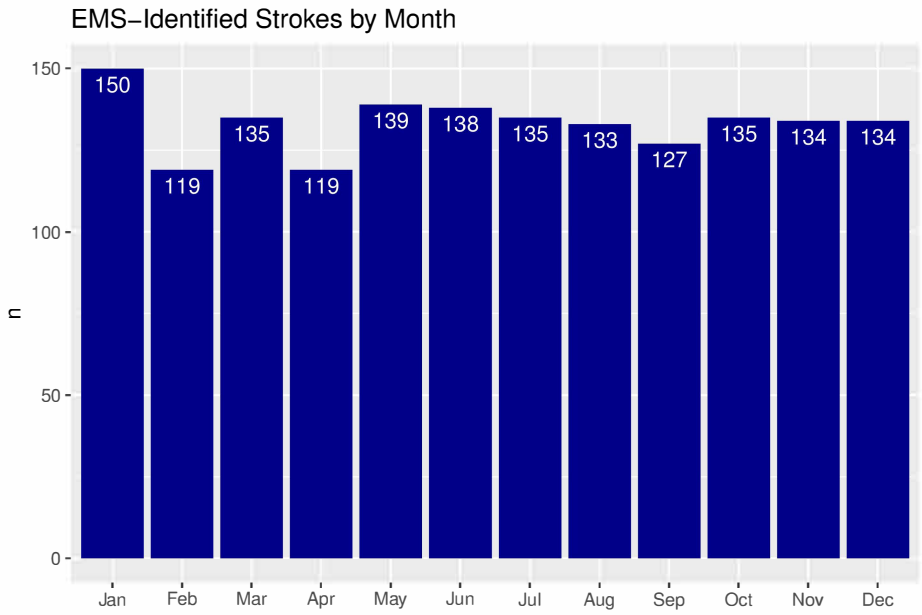
EMS Stroke Report - 2021

911 incidents in which strokes were identified by EMS in the prehospital setting were reviewed for 2021. The following inclusion criteria is used, based on ePCR fields for all San Francisco 911 EMS providers:

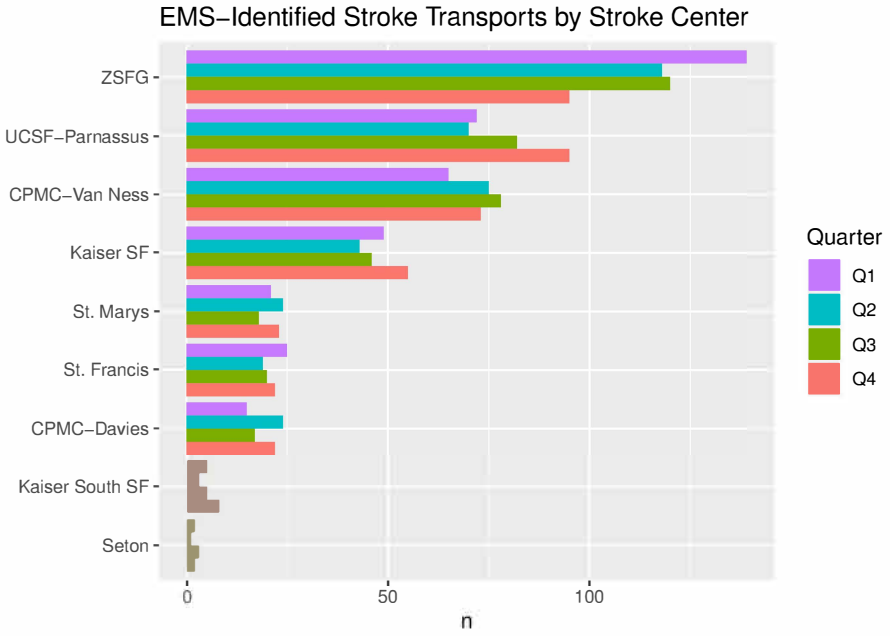
- Primary Impression of Stroke (NEMSIS eSituation.11, ICD-10: I60, I61, I63, G45, G46.3, G46.4)
- Secondary Impression of Stroke (NEMSIS eSituation.12, ICD-10: I60, I61, I63, G45, G46.3, G46.4)
- Stroke scale score (eVitals.29) indicates a positive stroke assessment

Incidents with a service type other than "911 Response" were excluded (e.g. interfacility transports). In total, 1598 prehospital strokes were identified in 2021.





Of the 1598 EMS-identified strokes, 1554 were transported to San Francisco Stroke-receiving hospitals.



44 patients with an EMS-identified stroke had a disposition other than transport to a Stroke Center.

EMS Operations Metrics

The figures below examine “Scene Time” and “Transport Time” durations for the 1554 stroke patients transported to Stroke Centers. All times in minutes.

- Scene Time: Interval between ambulance arrival on-scene and initiation of transport.
- Transport Time: Interval between initiation of transport and arrival at hospital.

Table 1: On-Scene Times for Stroke Calls (minutes)

Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1	2.6	14.0	18.4	19.5	23.7	59.5
Q2	4.2	13.4	17.4	18.7	22.7	81.7
Q3	2.6	14.0	18.4	19.5	23.7	59.5
Q4	4.2	13.4	17.4	18.7	22.7	81.7

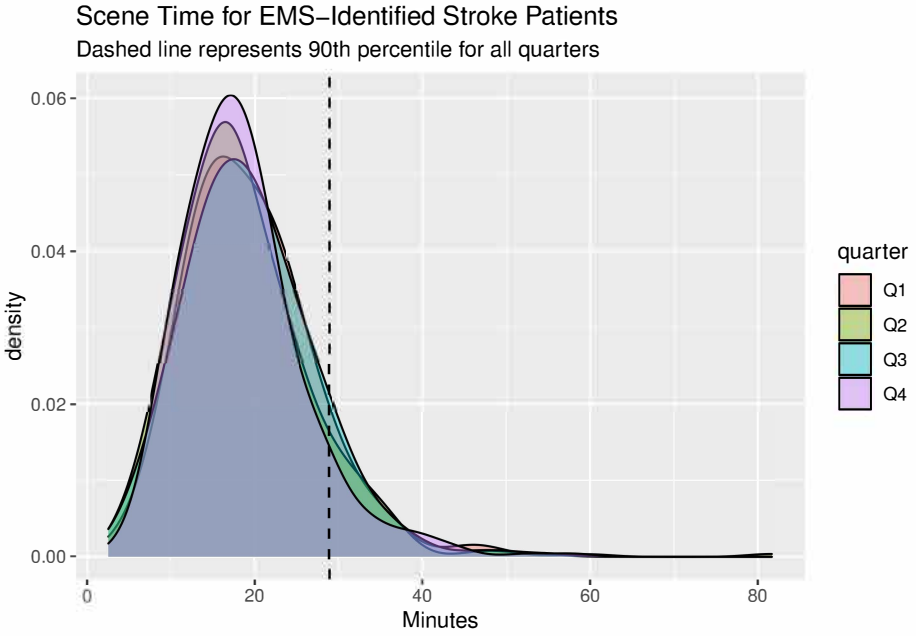
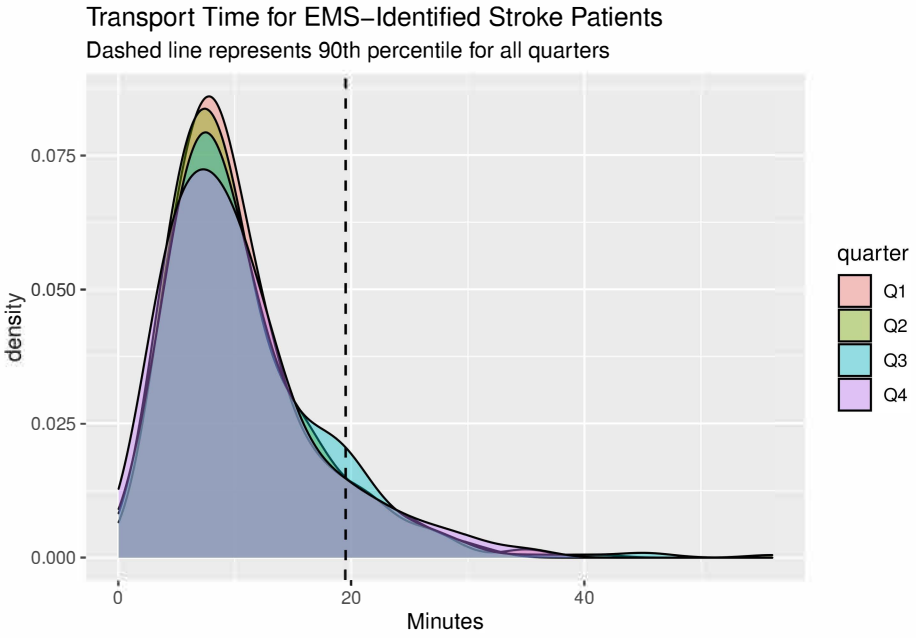


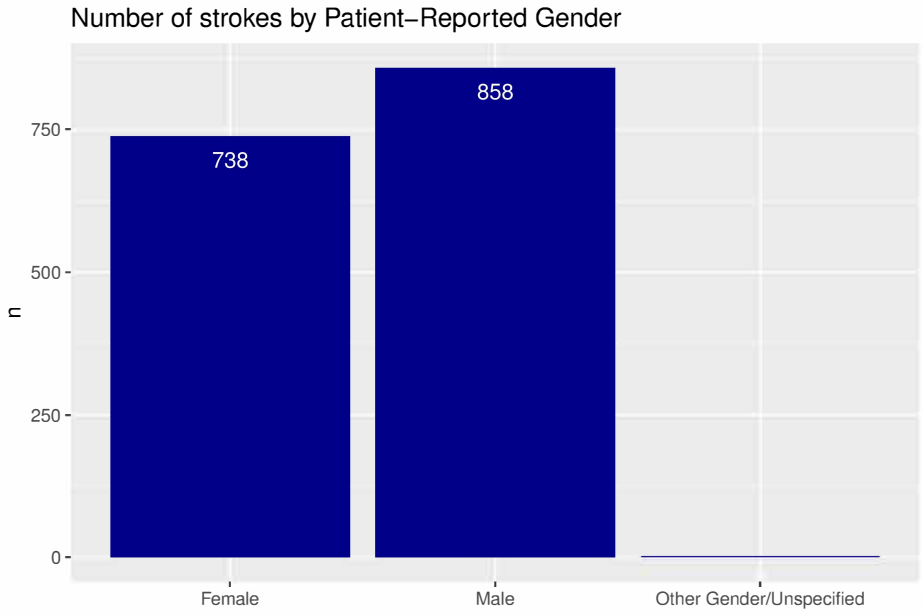
Table 2: Transport Times for Stroke Calls (minutes)

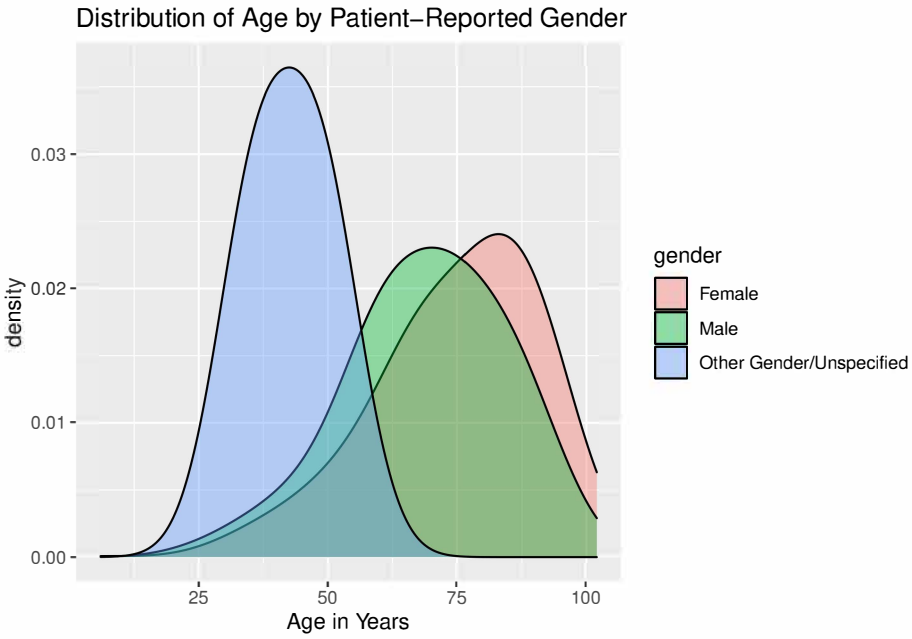
Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1	0.7	6.4	8.8	10.4	12.8	41.2
Q2	0.0	6.0	8.7	10.3	13.0	56.1
Q3	1.1	6.5	8.8	10.8	14.0	45.7
Q4	0.5	5.6	8.9	10.4	13.1	35.6



Total EMS Time is the interval between transporting EMS arrival on scene to arrival at a receiving Emergency Department - or the combination of the two intervals reviewed above. The average Total EMS Time for stroke patients in 2021 was **29.8** minutes.

Patient Demographics and Treatment





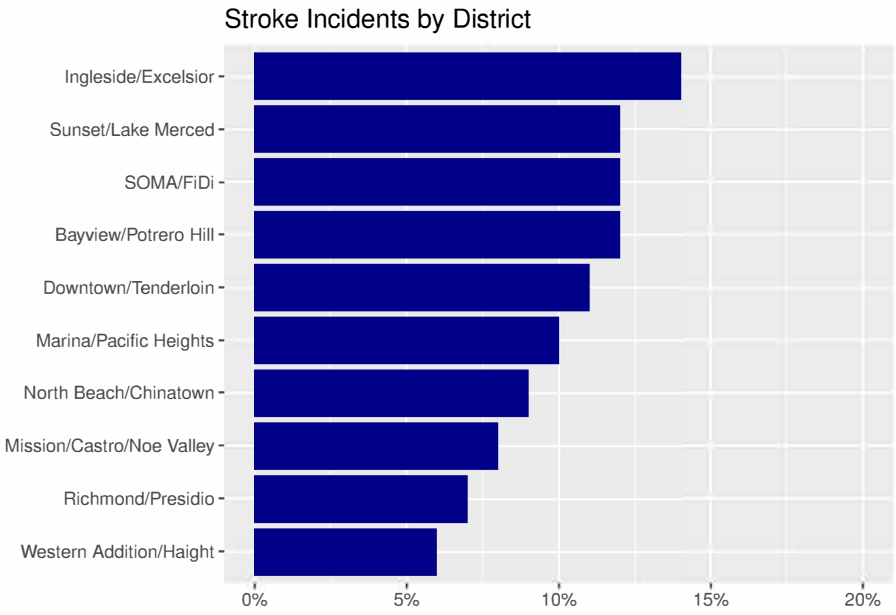
The table below looks at the percentage of stroke patients that presented with confounding syndromes. Criteria for the syndromes below are based on the NEMSIS data framework and subjective documentation by providers.

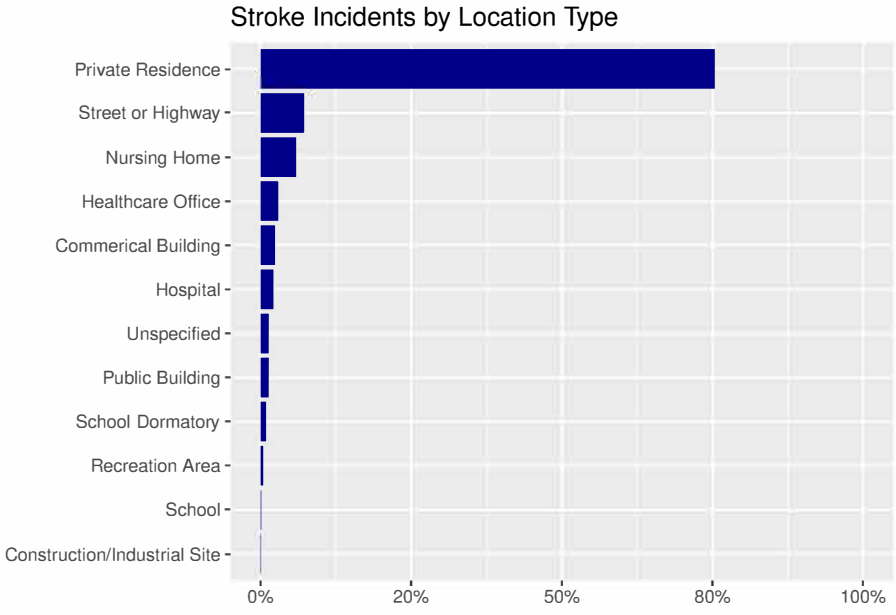
- **Alcohol**: Suspected alcohol use documented by Paramedic.
- **Fall**: Patient met categorical syndrome definition for Ground Level Fall or Fall From Height.
- **Overdose**: Patient met categorical syndrome definition for overdose (non-specific to substance) OR suspected drug use was documented by Paramedic.
- **Bevahioral**: Patient met categorical syndrome definition for behavioral health.

Table 3: Percentage of Stroke Patients with Confounding Syndromes

Confounder	n	Percent
Fall	260	16.27%
Alcohol	78	4.88%
Behavioral	69	4.32%
Overdose	60	3.75%

Incident Location





SECTION IV – Quality Improvement
EMS Provider Updates



San Francisco Fire Department Continuous Quality Improvement EMS Division

Last revised: July 26, 2022

Introduction

The San Francisco Fire Department, EMS Division, has developed and implemented this plan in cooperation with the San Francisco Emergency Medical Services Agencies' Policies and Protocols, as well as the Rules and Regulations of the San Francisco Fire Department. This plan and the oversight process involved are designed to oversee the prehospital medical care provided to the citizens and public of the City and County of San Francisco.

In collaboration with the San Francisco Fire Administration, the San Francisco Fire EMS Administration, the San Francisco Fire Division of Training, the San Francisco EMS Office of Continuous Quality Improvement (CQI), and San Francisco Fire Investigative Services, as it relates to emergency medical services, the following areas are overseen for quality and improvement include, but are not limited to:

- Organizational Structure
- Personnel (Facilitated through the San Francisco Department Division of Training by managing licensing and certifications of all members)
- Clinical Quality Improvement and Patient Outcomes
- Documentation
- Research and Development
- Retraining/ Reeducation (Facilitated with the San Francisco Fire Department Office of Continuous Quality Improvement and the San Francisco Fire Department Division of Training)
- Risk Management
- Data Collection and Reporting
- Public Education and Prevention (Facilitated in cooperation with the San Francisco Fire Department Fire Prevention, CORE Committee, PIO, and various other programs)
- Transportation and Facilitates (Facilitated in cooperation with the San Francisco Fire Department Division of Support Services and Bureau of Equipment)

Organizational Structure

Continuous Quality Improvement within the San Francisco Fire Department is overseen by the Medical Director of the San Francisco Fire Department and Rescue Captain(s), who report directly to the San Francisco Fire Department Section Chief of Emergency Medical Services Operations, who in-turn reports to the San Francisco Fire Department Assistant Deputy Chief of Emergency Medical Services. The structure of reporting for Community Paramedicine is mentioned separately below.

Continued Quality Improvement

The continued quality improvement process will recognize individual and system-wide clinical and operational trends. The process will determine whether these trends are individual trends, systematic clinical trends, or operational trends and address the trends accordingly through retraining and reeducation.

The trends will be determined through random and focused audits, in conjunction with the California Core Measures and the San Francisco Emergency Medical Services Agency / San Francisco Fire Department initiatives as agreed upon.

Training and Education

This process includes informal discussions with members, as well formal Remediation and Performance Improvement Plans. Minor concerns may be administered with informal discussions in the form of coaching sessions and/or "tailboard" trainings performed by San Francisco Fire Department Rescue Captains. More formal training and reeducation will be administered in the form of a Remediation or Performance Improvement Plan, which will be directed by the San Francisco Fire Administration, and/or the San Francisco Fire EMS Administration, and the San Francisco Fire Department's Medical Director. The Remediation or Performance Improvement Plan will be generated and administered by The San Francisco Fire Department Office of Continuous Quality Improvement or the San Francisco Fire Department Division of Training. The Remediation or Performance Improvement Plan template shall follow the template set forth by *Employee Relations, Department of Human Resources, City and County of San Francisco.*

We hope to expand training and education by increasing the number of presentations, both live and recorded. These presentations will be uploaded to the Department training module (Target Solutions) for providers to review. In addition, we hope to have focused lectures on relevant, high-yield, recent incidents where crews can join the lecture in person or by virtual platform (e.g., Zoom) and contribute and learn about pathophysiology, hospital treatment and outcome, along with feedback from the presenting physician. The Medical Director, as well as CQI and Training staff, EMS Fellows and Emergency Medicine residents needing to fulfill an EMS teaching requirement may participate in these lectures.

Additionally, rapid review lectures of infrequently used skills and low frequency/high risk topics will be done and occasionally recorded for distribution online.

Risk Management

Risk Management is paramount in providing a safe workplace for the members of the prehospital care system and the public we serve.

The five risk management steps are:

- Identify the risk
- Quantify the risk potential
- Prioritizing the risk
- Implementing controls and mitigations strategies
- Evaluating and revising the process

Frequency evaluation of the risk:

- **Very often:** A near-certainty to occur;
- **Often:** May occur regularly or periodically;
- **Not often:** Rare, or unlikely to occur;
- **Almost never:** Zero or near-zero probability.

Severity evaluation of the risk:

- **Catastrophic:** Death or permanently disabling injury or loss of work facility;
- **Serious consequences:** Severe debilitating injury or interruption of operations;
- **Moderate impact:** Significant injury or illness requiring more than first aid;
- **Minor impact:** No injury, lost work time or interruption of work.

After an event occurs, immediate steps will be taken to prevent similar incidents. In cooperation with the San Francisco Fire Department Administration, the San Francisco EMS Administration, the San Francisco Fire Department Office of Continuous Quality Improvement, and San Francisco Fire Department Investigative Services, these steps should include:

- Immediate investigation ordered
- Take statements
- Gather reports
- Consult with legal council
- Evaluation of the risks with all appropriate information gathered
- Take appropriate actions to mitigate and prevent recurrence

Focused audits occur twice per year on a rolling schedule, or as needed as concerns arise with the following schedule:

January:	Trauma
February:	STEMI / Stroke
March:	Critical Adult Medical
April:	Pediatric
May:	Cardiac Arrest
June:	Other including AMA/PDT
July:	Trauma
August:	STEMI / Stroke
September:	Critical Adult Medical
October:	Pediatric
November:	Cardiac Arrest
December:	Other including AMA/PDT

The results of these audits will ensure compliance or need for improvement. After the Risk Management Plan has identified issues which arise, Research and Development may be implemented to study systematic issues, and/or suggest operational and administrative changes for system changes and focused clinical improvements.

Research and Development

The San Francisco Fire Department supports the development and execution of evidence-based data. This data directly contributes to improving clinical patient care. More and more, treatment decisions are based on this type of data. Part of the Department's CQI data monitoring is to examine trends that support the continued use of care modalities based on current clinical findings versus suggesting the need for additional retrospective or prospective studies that could suggest different practice methodologies. The San Francisco Fire Department’s clinical research stance is to utilize data as a primary indicator of areas of interest, a guide to the safety and efficacy of research efforts and as a means of supporting or refuting hypotheses related to care.

At the direction of the San Francisco Fire Department Administration, the San Francisco Fire EMS Administration, as well as the San Francisco Fire Department Office of Continuous Quality Improvement, focused research will address such trends.

Data Collection and Reporting

Data is collected and stored for Continuous Quality Improvement from identified trends, both systemic and individual. In cooperation with the San Francisco Emergency Medical Services Agency, all reportable incidents, either systemic or individual, shall be analyzed and reported as

an Exception Report or Sentinel Event, as directed by the San Francisco Emergency Medical Services Agency's Policies and Protocols.

Should a referral be made for quality improvement to any outside entity, such as another 911 provider or the EMS Agency, that referral shall be forwarded to the San Francisco Fire Department Quality Improvement Staff in a timely matter. The Department will then review the case and take any necessary action. If referred by the EMS Agency, the Department will inform the agency of the results of our investigation and plan for improvement. The EMS Agency will not pursue cases until internal review has been done and reported back to the agency except in extenuating circumstances.

Audits

Audits are categorized by time frequency and incident scope and summarized below. The time frame is categorized as spot (one time or limited frequency) or continuous. Incident scope may be Department-wide (all incidents to which the San Francisco Fire Department responds) or focused on specific providers, locations, or situations. Audits will be done by CQI staff and reviewed by supervising staff and the Medical Director when appropriate.

Time Frequency	*Target Scope*
Spot: Performed at one time or on a limited frequency	**Focused:** limited to specific provider(s), locations, or situation
Continuous: Monitored at all times	**System:** all available SFFD incidents are audited

Spot audits are conducted when a case is referred to CQI by another person, whether it is a patient, hospital provider, EMS provider, supervisor, or outside agency, for review for any reason. The call will be reviewed comprehensively by CQI staff, with special attention to the reason for the referral.

In an effort to broaden the scope and breadth of spot audits and CQI, a Peer Review spot audit process was implemented in April 2021. Paramedics, especially those seeking promotion to position of Rescue Captain, will be selected to review and provide feedback for incidents using a provided rubric on an online management system with redacted provider and patient information. The rubric will be created by CQI staff and reviewed by the Medical Director. Calls of any type are eligible for review, especially cardiac arrest, STEMIs, stroke, pediatric calls, trauma, and others.

Focused QI will be done when potential issues are identified with high-risk situations, locations or providers, and especially providers who are on a Remediation or Performance Improvement Plan entailing CQI monitoring.

Continuous QI will be done for the following incidents:

- Advanced airway management
- Critical calls
- Field deliveries
- AMA/PDT refusals
- Cardiac arrests
- Infrequently used skills
- Major trauma

Additionally, reports are routinely done for Ambulance Patient Offload Times (APOT), Narcan administration, and California Core Measures. Time intervals including dispatch intervals, treatment/transport intervals, and hospital intervals will also be tracked.

California Core Measures include:

- Transport of trauma patients to a trauma center
- Aspirin for STEMI or suspected cardiac chest pain
- Advanced hospital notification for STEMI patients
- Treatment for administered for hypoglycemia
- Prehospital screening for suspected stroke patients
- Advanced hospital notification for suspected stroke
- Glucose testing for suspect stroke patients
- Respiratory assessment for pediatric patients
- Request for service that include lights and or siren
- Request for service that included lights and/or siren transport

In addition to reviewing airway management, special attention will be given to review our video laryngoscopy program, which has recently surpassed its one-year anniversary.

1. Ongoing CQI for video laryngoscopy will continue.
2. Video recordings from each video laryngoscope will be uploaded and reviewed by the CQI team and by the Medical Director and feedback given to the relevant providers.
3. Approved advanced airway reporting form will be completed within 24 hours for each incident where advanced airway is attempted and submitted to the CQI team.
4. Advanced airway interventions and attempts will be documented in electronic patient care record
    A. The duration of an intubation attempt will be defined as time from laryngoscope blade insertion to complete removal of the blade.

B. An intubation “attempt” will be defined as passage of the endotracheal tube past the patient’s lips. A successful attempt will be placement of the tube in the trachea. Unsuccessful attempt will be any attempt in which the tube passes the lips but is not secured in the trachea.

Community Paramedicine Quality Improvement and Oversight Plan

Introduction

The mission of the Community Paramedicine Division is to provide rapid, high-quality trauma informed care to San Francisco's most vulnerable residents through the EMS-6,Street Crisis Response Team (SCRT), Street Wellness Response Team (SWRT), and Street Overdose Response Team (SORT) programs.

All aforementioned CQI plans from the Emergency Medical Services Division also apply to the medical aspects of community paramedicine, including medical care rendered to clients and AMA/PDT refusals.

The purpose of the Community Paramedicine CQI Division is to ensure compliance with all state, local, and Department policies and protocols, and to ensure we are providing the highest quality care for our clients, while also reducing unnecessary 911 responses in San Francisco.

Organizational Structure

Continuous Quality Improvement within the San Francisco Fire Department Community Paramedicine Division is overseen by the Medical Director of the San Francisco Fire Department, the Medical Director of Community Paramedicine, and Section Chief, Community Paramedicine Administration, who report directly to the San Francisco Fire Department Assistant Deputy Chief, Community Paramedicine Division The Community Paramedicine CQI Captain and Data Analyst will perform the majority of CQI activities, with support from the EMS Continuous Quality Improvement staff as needed.

Clinical Quality Improvement and Patient Outcomes

Community Paramedicine CQI will identify and review high-risk events, areas of potential improvement, perform prospective, concurrent, and retrospective data analysis to identify trends, develop and adopt best practices, evaluate outcomes and provider competency, provide clinical supervision and feedback specifically regarding Community Paramedicine domains of the biopsychosocial assessment and the social determinants of health. We will promote excellence and pride within the Community Paramedicine Division by providing timely relevant feedback and training opportunities to enhance skill set.

Initiatives, such as 5150 holds and buprenorphine, will follow their specific QI plan submitted with their initial application.

Data Collection and Reporting

The CQI captain performs weekly reviews of a representative sample of encounters per team, performing spot and focused audits on cases requiring further review.

These audits are reviewed in committee by EMS Medical Director, CP Medical Director and EMS Section Chiefs and follow-up actions are determined by the group. Actions may include but are not limited to provider feedback, policy review, partner agency debriefs, disciplinary actions, referral to LEMSA QI, etc.

Both the EMS-6 and the Street Crisis Response Teams will have weekly review of encounter reports and patient care reports.

A monthly report will be created for both teams and CQI staff will track and ensure compliance for average times covering the following areas:

- Monthly call volume, volume of calls responded to
- Call source (911 call, special call, on view, other)
- Response time
- On scene time
- Disposition of clients without medical complaints
- Disposition of clients with medical complaints
- Most common medical complaints
- Use of chemical and physical restraints
- Review Workplace Violence Incidents
- 5150's generated
- Ensure ESO, encounter log and Avatar are reconciled weekly
- Track client, provider and community satisfaction
- Base hospital contacts and senior base physician contacts
- *Rate of alternate destination diversion, resulting in ED transport (i.e., Dore is full, so patient goes to a standard ED instead)*
- *Track amount of behavioral health calls, special calls by police and PDTs and AMAs after implementation of SCRT.*

Review and compliance assurance with San Francisco Emergency Medical Services Agency Policy 4040 and transfer of care policies will be performed on a regular basis. Audit of disposition of calls, with particular attention to those left in the community and/or with a disposition of AMA refusals will be performed and feedback will be provided to Community Paramedicine certified paramedics.

We will track the number of patients who have medical complications, re-triages from the original destination or repeat 911 activations within 24 and 72 hours for either police or medical care. Any transports within 24 hours of a community paramedic contact will be spot audited and reviewed.

We also track community satisfaction from the SCRT, SWRT, SORT and EMS-6 program, by formal and informal surveying of SFFD providers, ancillary providers, hospital personnel, ambulance providers, police, hospital providers, and clients/patients.

Spot audits are done weekly at various meetings, including EMS6 case conferences, Key Performance Indicator meetings, and CP CQI meetings.

Focused QI will be done when clients experience any adverse events, re-triages, enter the “red” category during a case conference illustrating decompensation, or when a case is referred to QI staff.



Quality Improvement Plan

Submitted by

American Medical Response
San Francisco County

July 1, 2022

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INTRODUCTION

American Medical Response-San Francisco provides Advanced Life Support (ALS) and Basic Life Support (BLS) within the jurisdiction of San Francisco County. As ALS and BLS providers, we are committed to active participation in the Continuous Quality Improvement (CQI) program established by the San Francisco County Local Emergency Medical Services Agency (herein referred to as LEMSA). AMR is responsible for conducting internal CQI activities by analyzing processes, structures, and outcomes in key areas of compliance with the identified State of California Core Measures. This CQI plan describes how they have developed the processes utilized for evaluating and improving the quality of pre-hospital care in San Francisco County.

This CQI plan is predicated on the belief that field personnel are highly skilled medical professionals empowered to make judgments that often have far-reaching and serious consequences for patients. With empowerment comes accountability. Our belief is that accountability for performance is enhanced through peer involvement. This CQI plan is committed to incorporating a peer approach to evaluating and implementing education programs, monitoring patient care practices, clinical research, program development, and strategic planning.

We are committed to creating a climate where caregivers are actively engaged in improving their EMS system and the overall quality of care delivered in it. The peer process is influenced by the different perspectives of those participating, which has a dynamic quality. It is the intent of this comprehensive plan to identify commendable performances and issues of concern and act as a model internal CQI plan with defined standards. It is the philosophy of AMR to provide the highest quality of pre-hospital care possible and to serve all customers to the best of our ability. It is also the intent of this CQI plan to provide monitoring carried out in an atmosphere of support, encouragement, and education.

PURPOSE

This CQI plan has been developed to meet the requirements of the ***California Code of Regulations, Title 22. Social Security, Division 9, Chapter 4, Articles 1 and 5 regarding Quality Improvement Programs.***

The purpose of this CQI plan is to create and sustain excellence in the pre-hospital environment utilizing a team approach and involvement of all personnel. An efficient CQI plan allows identification of opportunities to improve service and the system, identifies personnel needing additional training, and equipment necessary to improve productivity. Additionally, this CQI plan will support research projects with the LEMSA and assist in the planning process.

The goal of this CQI plan is to address the majority of instances where the problem is a system issue, not necessarily an issue of individual discipline. However, some issues are clearly found to need individual discipline through pathways established by each participating agency. Overall, the most important purpose of the CQI plan is to improve the health of EMS patients that AMR responds to, improve quality of EMS services, and improve efficiency of resources.

We conclude our CQI Plan with the affirmation, that our efforts are committed to quality by progressive and consistent reevaluation of our plan. It is our goal to ensure and reinforce our ability to continue the journey of quality. We believe quality is not an end, but rather, a continuous process of which we are all a part.

I. STRUCTURE AND ORGANIZATIONAL DESCRIPTION

In collaboration with the LEMSA, quality improvement (QI) is the responsibility of the clinical education department at AMR.

AMR San Francisco Clinical Education Services

1. AMR Medical Director
2. AMR Clinical Manager
3. AMR Clinical Support Supervisor
4. AMR CES Specialist
5. AMR Operations Manager
6. AMR Field Training Officers (FTOs)

AMR San Francisco Clinical Education Services

1. AMR Medical Director
   Under general direction, the AMR Medical Director oversees the clinical care provided to patients in both the 911/Emergency and Non-Emergency Inter-Facility BLS and ALS ambulances. This includes directing the Quality Improvement and Quality Assurance programs, reviewing data on such things as cardiac arrest outcomes and infrequently used skills, and working with AMR's Clinical Education Services staff to create targeted educational programs to help our providers improve in these areas.

2. AMR Clinical Manager
   Under general direction, oversees Clinical Education Services activities for the Operation. Represents AMR to local committees, medical and training institutions, and other related

agencies. Responsible for the creation, implementation, and tracking of quality and education programs.

3. AMR Clinical Support Supervisor
   Under general direction, is responsible for collecting data for reporting to the LEMSA, manages the narcotic program and is back-up to the Clinical Manager at LEMSA committee meetings.

4. AMR CES Specialist
   Under general direction, oversees the FTO program and helps to identify learning gaps and areas for improvement.

4. AMR Field Training Officers (FTOs)
   Under general direction, EMT and paramedic FTOs are responsible for all aspects of field training for employees.

Field Training Officer Program

The Field Training and Evaluation Program enables experienced personnel to provide appropriate individualized training, coaching, evaluation, and remediation to new and seasoned employees, and to participate in system development and quality improvement. Responsibilities of the FTO are listed below:

Training

- Conduct training programs for employees, to include but not limited to policies, protocols, procedures, regulations, and technologies
- Provide new hire accreditation and evaluation
- Testing to measure progress and evaluate effectiveness of programs

Evaluation

- Provide feedback on performance through annual report cards
- Identify strengths and weaknesses
- Documentation
- In field direct observation of quality performance

CQI

- Identify and reevaluate performance deficits

- Assist with continued improvement of employees and CQI programs, education of San Francisco County EMS and agency protocols and policies, and education of new equipment and procedures
- Evaluation of Patient Care Reports as requested

Supervisory Oversight

- Role model and mentor, being available to answer questions and provide guidance
- Coach and support field employees, new FTOs and Preceptors by providing education and training

OVERALL GOAL

The goal of this CQI Plan is to utilize cross-functional teams for constant process improvement. The peer process is influenced by the different perspectives of those participating, which encourages innovative ideas to make needed improvements. AMR utilizes the Model for Improvement – PDSA Cycle, which altogether reinforce pre-hospital service excellence.

Reference **Figure 1**

Model for Improvement

PDSA Cycle of Plan, Do, Study, Act



Additionally, this CQI Plan includes prospective, retrospective and concurrent review of all aspects of the systems that impact patient care.

1. **Prospective CQI:**

- Face-to-face meetings for in-service review
- Sharing clinical performance and engaging in prevention activities
- Applying clinical performance measure that center on high-impact clinical conditions utilizing process and outcome metrics
- Participation in LEMSA committees
- Continuing Education
- Participation in recertification classes
- Offer educational programs based on problem identification and trend analysis in conjunction with LEMSA QI Committee
- Establish procedures to inform all personnel of system changes

2. Retrospective CQI:

- Develop a process for retrospective analysis of field care, utilizing e-PCRs, to include but not limited to incidents as followed: a. High-Risk
  b. Problem-oriented calls
  c. Any call requested to be reviewed by LEMSA or other appropriate agency
  d. Specific audit topics established through the San Francisco County QI Committee and/or EMS Advisory Committees
- Participate in Incident Review Processes
- Comply with reporting and other quality improvement requirements as specified by the LEMSA
- Participate in prehospital research and efficacy studies requested by the LEMSA and/or the QI Committee

3. Concurrent CQI:

- Engagement in direct field response to observe personnel during patient care activities. (this will allow AMR to understand the potential challenges that providers face in the field, see how clinical protocols are implemented and detect opportunities for improvements)
- Provide patient information to facilitate obtaining patient follow-up information
- Evaluative oversight and consultation by AMR to provide field personnel assistance

II. DATA COLLECTION AND REPORTING

A. Specific performance indicators are selected on an ongoing basis by AMR, with regulation provided by California EMSA, Title 22, and the LEMSA. In addition, any other opportunities for improvement that present themselves through direct review, audit, and reporting incidents. Feedback and recommendations may be presented through the Quality Improvement Committee to provide additional indicators throughout the year, when data collection and trend has shown the need.

Generation of reports and their distribution flow include reporting to the LEMSA and currently occurs monthly/as requested. AMR will continue to use MEDS Reports and MEDS Data Extractor for Quality Improvement/Assurance and data review.

QUALITY INDICATORS

Personnel:

- Education and Training: Quarterly training opportunities in conjunction with REACH/AMR for all employees.
- Recertification courses through AMR's affiliate school, National College of Technical Instruction (NCTI)

Equipment and Supplies

- Refresher education on infrequently used equipment as well as any new equipment introduced to SF County Policy and Protocol (i.e. LUCAS devices, albuterol inhalers, iGel Supraglotic Airways)

Documentation

- Narcotic use and documentation compliance

Clinical Care and Patient Outcome

- Continue STEMI reporting to the LEMSA to identify areas for improvement
- Cardiac Arrest outcomes and improvement in collaboration with the LEMSA and Zoll online case review

Skills Maintenance/Competency

- Infrequent skills reporting to LEMSA QI Committee

Transportation/Facilities

- Ambulance patient offload times (APOT) reporting to LEMSA QI Committee

Public Education and Prevention

- Hands Only CPR and Stop The Bleed campaigns.

Risk Management

- We will continue to employ the Just Culture model when analyzing and managing risk.

III. EVALUATION OF INDICATORS

A. AMR will evaluate performance indicators in collaboration with the QI Committee as needed. Projects are delegated to the appropriate task group within the system, and then outcomes and findings are disseminated as appropriate, to carry out improvement and action plans.

B. AMR will utilize LEMSA QI Committee supported indicators and those that it develops and designs, based on needs identified throughout the year. Depending on the goals of the various groups, indicators will be added or changed, to make San Francisco County the most effective and successful, for the employees and customers.

C. AMR will set up processes for successful analysis and evaluation of its practices. With the goal to monitor quality, provide feedback and remediation, and demonstrate competency.

D. Data collection improves upon and replaces anecdotal management, with objective facts and information, only if the methods and design of the data collection and analysis are accurate. The following checklist will serve as a template for AMR:

1. For what purpose are we collecting the data?
    a. What question or questions do we need to answer?
2. What data points do we need to collect to answer the question?
3. Have we defined the parameters of the data to be collected?
    a. For example, if we are measuring time to defibrillation, what time period are we measuring?
    b. On-scene time to defibrillation, or patient contact time to defibrillation?

    Failure to define the parameters of the data to be collected will lead to inaccurate data.
4. How will the data be collected? What is our data source?
5. When and where will the data be collected?
6. What are our upper and lower control limits for system outliers?
    a. What will we do with these outliers?
7. What training is required prior to collecting the data?
8. Who needs the training?
9. What methods will be used for analysis of the data?
10. What time period or sample size will we use?
11. What methods will we utilize to validate our data?

12. How will the results be utilized?

After successful analysis and evaluation, AMR will collaborate with the QI Committee for further evaluation of the data outcomes. This evaluation will include:

- Identify the objectives of evaluation
- Present indicators and related EMS information
- Compare performance with goals or benchmarks
- Discuss performance with peers/colleagues
- Determine whether improvement or further evaluation is required
- Establish plan based upon decision
- Assign responsibility for post-decision action plan

E. With this process, AMR plans to utilize an internal QI mechanism called the Practice Improvement Tool (PIT), which is a comprehensive application to identify, assess, and track CQI events. The PIT seamlessly integrates with our PCR platform, MEDS, by quickly identifying potential issues and trends. Notes are easily added to the CQI PCR for communicating issues, questions, commendations, and are restricted by security access to prevent unauthorized viewing. PIT provides the mechanism to deliver direct feedback to the caregiver on the care provided, as well as a score card to show overall performance. If further review of a caregiver's performance is needed, PIT's Incident Tracking provides the ability to monitor, track, and escalate incidents for further review.

IV. Action to Improve

A. One of the basic principals in quality improvement is that one must make system decisions and choices based on information. In order to make measurable, good decisions and process improvements, EMS must incorporate research into the evaluation of protocols, procedures, medications, and equipment. Research is vital to the practice of EMS and is fostered and supported by the QI Committee.

This quality improvement is achieved through understanding and study of data. AMR plans to utilize the IHI Triple Aim Initiative which has three dimensions that are used to look at system performance and improvement. These three dimensions are: improving the patient care

experience, improving the health of populations, and reducing per capita cost of health care. While using the "Triple Aim" it is important to use the dimensions simultaneously and not individually when looking to improve.

B. Quality improvement in coordination with system and data management involves understanding of all contributing factors. Positive performance motivators are created when caregivers are provided the opportunity by the QI Committee to discuss their concerns and issues.

Interactive communication reinforces peer driven standards of care, while appreciating constraints and challenges of the field environment. Being available to the field is necessary for mutual respect and understanding.

C. Furthermore, we understand that we operate with individuals of various levels of experience, different attitudes and behaviors, and of varying personalities. Due to this, there in understanding that unwanted actions or behaviors will take place. Furthermore, we understand that while AMR strives for excellence, the development of a perfect system is not plausible, for these reasons, AMR and the JPA employs a "Just Culture" model.

AMR has fully adopted the collaborative culture of safety or "Just Culture." Just Culture has been embraced by the healthcare industry to reduce errors and deaths of patients. Just Culture starts with evaluating the system design to see if policies, equipment, procedures or guidelines contributed to the error. If the system design did not contribute to the error, you perform a behavioral risk analysis that categorizes the decision as human error, at-risk choice or reckless choice.

For example, if a medication error happens because two different medication vials look similar, the system design contributed to the error and we would switch to vials that look very different to prevent it from happening again. If human error contributed to the error, you evaluate if the person fully understood the policy or procedure and we provide the person with support, education and encouragement. At-risk and reckless choices may result in coaching and corrective action as a deterrent. Just Culture encourages not just focusing on the individual, but evaluating the system design first, interviewing other EMTs and Paramedics to see if they would or could make the same mistake or have the same understanding of the system. This encourages a culture of open error reporting in a less punitive environment.

V. Training and Education

A. It is the policy of AMR that all new employees receive and successfully complete an effective orientation process, on their date of hire. All employees who deliver patient care are required to successfully complete a program that includes a patient care and performance evaluation as defined by San Francisco County accreditation requirements, prior to release to independent duty.

The basis for providing safe, effective and state-of-the-art patient care is high quality, current, evidence-based, continuing education. This training and education also serve the purpose of meeting national, state, and county mandated requirements for re-registration, re-licensure and recertification.

B. It is the responsibility of AMR to ensure any changes to existing clinical policies, training expectations, or requirements resulting from QA/QI improvements, are successfully communicated. AMR is responsible for familiarizing themselves with any ongoing or new applicable Local, State and Federal laws, which affect prehospital care.

C. AMR evaluates education and training needs on an ongoing basis, gathered from retrospective data and clinical recommendations from the LEMSA. AMR maintains training records both electronically and in hard copy file jackets, assuring that verifiable, ongoing training is appropriate to the employee's skill level and service goal.

D. Through root cause analysis and using the "Just Culture" model, issues may be identified on how an event occurred and why it happened. This process allows AMR the ability to determine whether education or training is necessary to the field provider. Additionally, whether improvement is necessary for the overall system of program management. Once AMR has identified an employee's clinical deficiency, training and education are critical and are addressed through several processes which include:

- Review and education of standard clinical policy and protocol and knowledge.
- Notification to the LEMSA if appropriate.
- Training on the subject.
- Provide verbal and/or written information to involved individual(s)
- Consider a subject/topic audit
- Prepare a performance development plan
- Develop a re-evaluation process plan.

E. AMR is responsible for ensuring that continuing education are available to all field employees. AMR provides a variety of educational opportunities through its organization.

F. AMR assures that consistent and ongoing training occurs and is appropriately documented and tracked for compliance. Utilizing Local, State, and National guidelines for classroom education and psychomotor skills. Field Training Officers conduct examination-related activities, on an equal basis for all candidates. During training and skills verification, each field employee is objectively observed and documented. Both EMT's and Paramedics are offered educational opportunities along with electronic training programs, memorandum on policy changes, trainthe-trainer programs, and training facilitated by outside clinicians. Documentation for verification purposes is located electronically and in hard copy skills jacket.

G. Training and education are significant to the quality improvement process and is addressed in a collaborative manner with all of our partners throughout the EMS system.

AMR will be responsible for appropriate continuing education (CE) according to Title 22. Division 9. Chapter 11. All CE shall include the following objectives:

- Meet State licensure/certification requirement
- Be developed with educational content to address San Francisco County specific needs when applicable
- Provide standards-based training for all ambulance personnel
- Integrate prehospital skills/CE training into a county-wide system

H. AMR will perform a biannual EMT Infrequent Skills refresher/validation for all EMT's working in the San Francisco County EMS System.

VI. Annual Update

AMR is responsible for updating this CQI plan annually. Retrospective review identifying successes and areas for improvement dictate changes, which will be put in place for the upcoming plan. Coordination with the LEMSA and the California EMSA ensures the same goals and objectives are being implemented.

The goal for our updates:

- Develop evidence-based portfolio of projects and data that matches internal and external goals
- Improve clinical care processes

- Demonstrate strategies that improve patient experience or outcome and reduce cost
- Measurable reduction of preventable harm and care outcomes
- Achievement of results, which meet minimum or exceed nationally documented best practices
- Increase patient satisfaction

For 2022, the CQI plan continues its format and processes for data collection. Improvement goals and indicators are quantitative and less theoretical in nature, with outlined plans for implementing changes where necessary. In the next 12 months AMR will consistently use the Model for Improvement:

- Setting specific aims for improvement
- Measuring performance on those aims over time
- Identifying changes that will lead to improved performance
- Carrying out a series of testing cycles, to identify the most successful strategy for reliable improvement

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2022 Quality Improvement Plan

PCR's

A review of PCR's is done daily and weekly. Calls that are flagged for QI review are:

1. All Chest Pain and SOB Patients
2. All Medication administration
3. All code 3 transports to the hospital
4. All Resuscitations

Call types that include infrequently used skills will also be audited. These skills include

1. ET
2. NT
3. TCP
4. IO adult and child
5. PVAD
6. King Tube
7. Decompression
8. Needle Cricothyrotomy

All these skills shall have the "infrequently used skills" form filled out and turned in by end of shift.

100% chart audit on the above calls. Overall, more than 75% of total call volume is reviewed. In 2021-2022 we experienced an unusually high employee turnover rate. Maintaining this current plan is in the best interest of the patient we serve and the Paramedics we employ.

The PCR is read and analyzed. A review of the PCR is completed with the E-PCR program. Quality indicators listed above are automatically captured for review. QA markers and notes are added to each call as necessary. QA markers for the PCR's include documentation completeness, mileage, and adherence to protocols. After completion of the review, QI comments are directed to the crews through our ESO program and the calls reviewed with the employees in person, as deemed necessary and appropriate, after the QI comments. If an employee establishes a pattern that is in need of correction, then we will focus on that particular area for improvement. The areas of focus during the review include Policy and Protocol adherence, Response to ALS Care, Patient Assessment and Treatment Appropriateness, Documentation of Refusals and Destination Appropriateness. Attention to documentation technique is also noted and reviewed with the employee. Crewmembers are asked to review certain policies and protocols if a deficiency may have appeared in a certain area. Risk Management issues are addressed as they arise.

Verification of Data Accuracy

During the review of PCR's the QA personnel are verifying the accuracy of data. They are observing the times that crew members are inputting, run numbers, incident locations etc. This information is all recorded electronically with Zoll and the collection and organization of the data is formatted with

Zoll Rescue Net Reporting functions. Schematrons are in place in the EPCR systems for NEMSIS 3 verifications.

Prospective Quality Assurance measures

On duty supervisors respond to random calls and complete real time evaluations of field personnel during patient care activities. They observe, monitor and record information at the scene and then follow up with reviewing the PCR at the hospital. Forms are filled out and performance is discussed with the field personnel. All parties sign the forms. This is an area of emphasis for 2021.

Personnel / Training / Teaching

Training such as CPR, ACLS, PALS and other continuing education classes are performed on a regular basis. New Paramedics are partner matched so they work with paramedics that have experience in San Francisco.

In the beginning of 2022 we trained our entire staff on the used of I-Gels and placed that training into our new hire training packet to ensure all new hires get the same training. We continue to put all new hires through a rigorous skills training session.

Dispatch

Calls are reviewed for appropriate EMD codes and dispatch codes on a daily basis. Time compliance issues are looked at as well as if the appropriate unit was dispatched. Recordings of the calls are reviewed and taped for training purposes. A random selection of scene type emergency calls are then handed to all the dispatchers to review and see if they come up with the same EMD codes and units to dispatch. We also do scenario-based training to focus on specific EMD Protocol usage.

LEMSIS

We are using ZOLL electronic PCR's. We were a participating agency for the NEMSIS 3 submission to ICEMA. Data is submitted in an XML format. Additionally, our data is transferred to Beyond Lucid Technology who can generate custom reports in many different formats.

Participation

Participation will be mandatory for all employees. Employees will who have identifiable patterns of behavior or patterns of treatment that are not consistent with the current standard of care will be given the opportunity to change. The QI program coordinator will discuss with the employee the following:

1. The identified deficiency
2. A corrective action plan
3. Disciplinary action procedures for non-compliance of the remediation plan.

Other Reporting

Infrequently used skills reports are filed with EMSA on a quarterly basis.
QA Summary reports are filed on a yearly basis with EMSA.
Any employee placed on a corrective action plan will be reported to EMSA.
Level 2 and Level 3 incident investigations will be reported to EMSA.
We are collaborating with our medical director to get some patient outcomes on a small amount of calls. There is no focus on this area as of this time. It is small and random.

Secure records keeping

Only QA/QI personnel will have access to these records.
All records will be stored in a secure location and available upon request to EMSA.

New Projects for 2022-2023

We are going to focus on driving. We have created a framework using EVOC materials that will suit our needs and create a safer ride for patients in the ambulance.
We are looking into Fireline Certifications for employees that wish to be assigned to large fire incidents this summer.

Dispatch may begin exploring the process of getting ACE accreditation for our dispatch center.

Emergency Medical Services Quality Improvement Program (EQIP)

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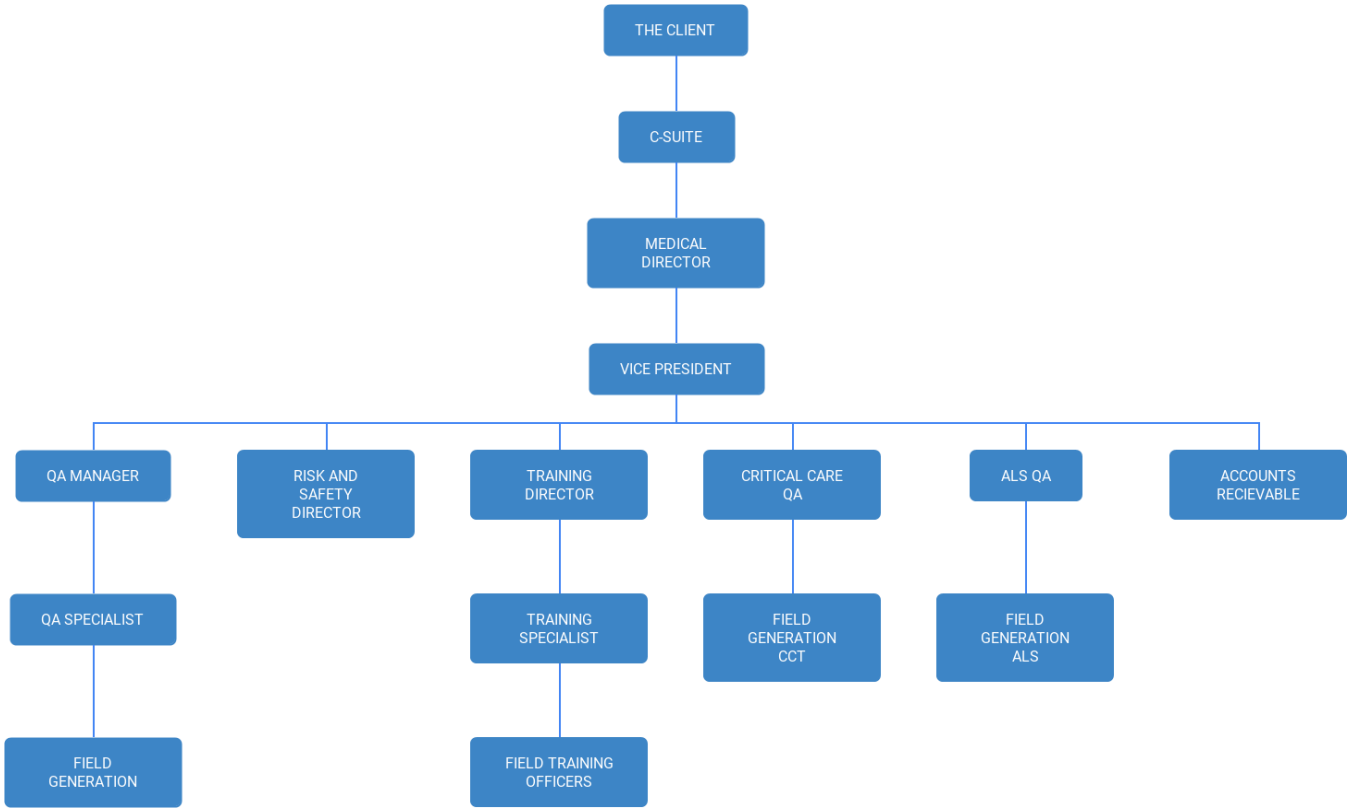
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I. Structure and Organization

A. Organizational Structure

1. Quality Improvement (QI) Team

- Medical Director: Gerald Nazareno, MD
- QI Program Coordinator / Vice President of Quality, Risk, Safety and Training: Christopher Seymour EMT-P
- Director of Critical Care Services: Anastasia Pieda RN
- Risk and Safety: Harris Hennig EMT-B
- ALS Supervisor: Mark Keenan EMT-P
- ALS Supervisor: Nicolas Scher EMT-P
- Quality Assurance Manager: Sara Feindel EMT
- Quality Assurance Specialist: Ivan Guzman EMT
- Quality Assurance Specialist: Hannah Reeves EMT



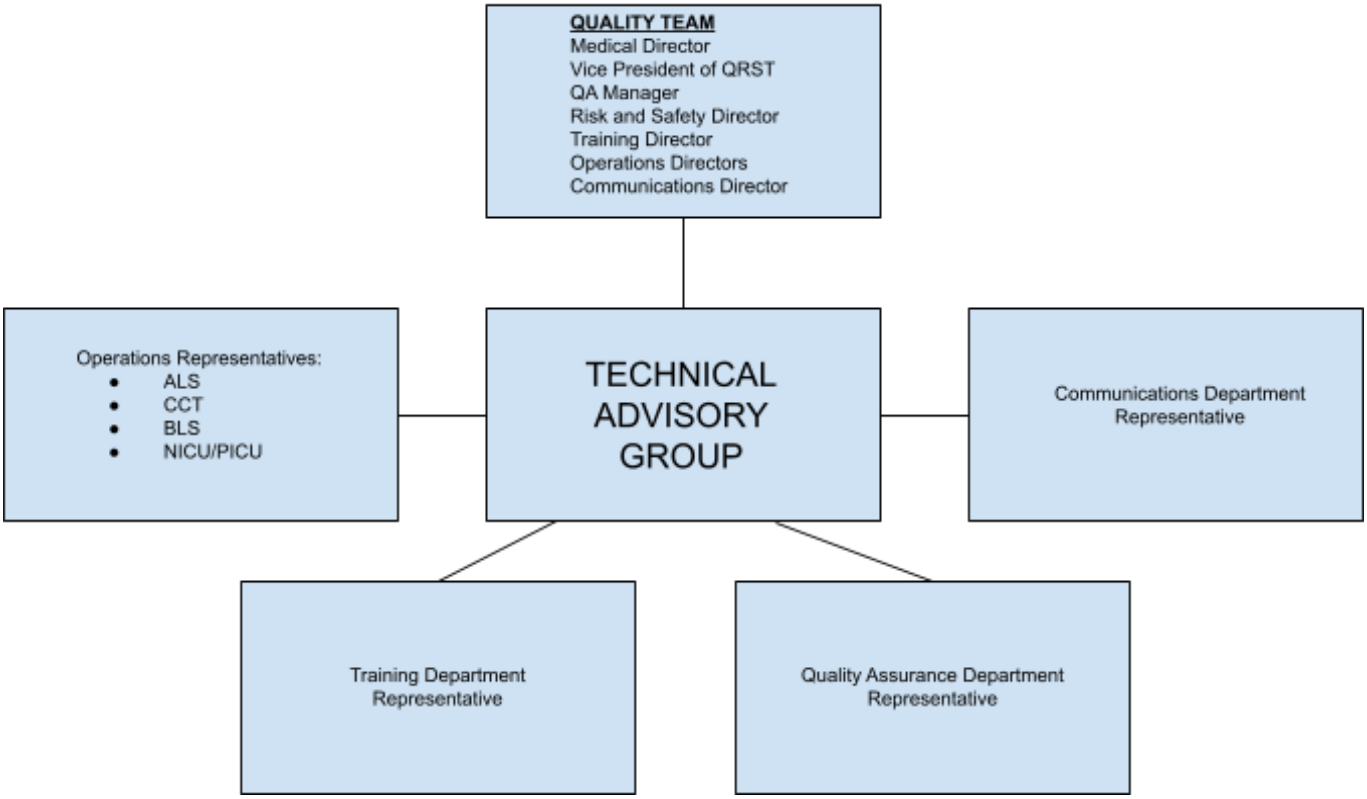
2. Technical Advisory Group

The Technical Advisory Group is comprised of representatives in the organization that perform QA/QI. The group is led by the VP of QA. The mission of the group is to interpret reports, data and trends in the company related to operations and develop strategies to meet challenges and

opportunities for improvement. This group may forward key agenda items to the Quality Leadership Group for final decision making, funding or input by executive company staff.

Lower level issues may be resolved by this group or commissioned to regional manager / supervisors for further refinement, proposal, or disposition.

Additionally, designees from each respective service area that NORCAL does business with, attends LEMSA specific QA/CQI meetings. They in turn participate in discussions, gather information and circulate it through the TAG for dissemination.

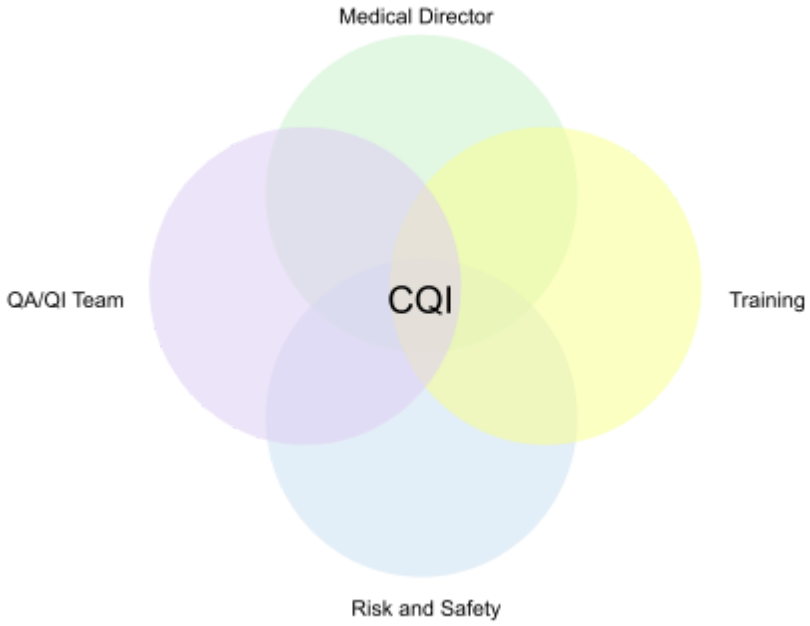


B. Organization Mission, Purpose, Services, and Goals

1. Mission and Purpose

Norcal Ambulance believes that the patients and families of the communities we serve deserve to be cared for with integrity, dignity, and compassion by a team committed to excellence in customer care.

Norcal Ambulance is committed to the provision of excellence in all elements of medical transportation and customer service. To achieve excellence, the company utilizes best industry standards for quality improvement and ongoing analysis of operational performance to intentionally seek opportunities for continuous improvement.



2. **EMS Services Provided**
   Wheelchair Transport
   Gurney Transport
   Basic Life Support Transport (BLS)
   Advanced Life Support Transport (ALS)
   Critical Care Transport (CCT)
   NICU/PICU Transport
   Medical Standby Services
   Dispatch Services
   a) **Description**
      Wheelchair Transport: A non-medical form of transportation for persons confined to a wheelchair but in no need of medical monitoring or care.

      Gurney Transport: A non-medical form of transportation. Staffed with two attendants with a minimum of current CPR Certification. This service is typically utilized for round-trip patient transport for doctor's appointments and procedures in a gurney (non-ambulance) van. (Service not available in SF)

Basic Life Support (BLS) Transport: Staff with two certified EMT-B's with current CPR, Medical Examiners and Ambulance Driving Certificates (for driving). Transports can be emergent and non-emergent, dependent on the nature of the call, and operation protocols per county. BLS transports are conducted on certified ambulances approved by county regulations for operation.

Advanced Life Support (ALS) Transport: Staffed with either one certified EMT-B with current CPR, Medical Examiners and Ambulance Driving Certificate (for driving) and one EMT-Paramedic with current EMT-P, CPR, ACLS, and PALS certifications; or two EMT-Paramedics with current medical and driving certifications. Transports can be emergent and non-emergent, dependent on the nature of the call, and operation protocols per county. ALS transports are conducted on certified ambulances approved by county regulations for operation. ALS ambulances carry all required and approved ALS equipment per county requirements.

Critical Care Transport (CCT): Staffed with two certified EMT-B's with current CPR, Medical Examiners and Ambulance Driving Certificates (for driving) and one CCT-RN with current RN License, CPR, ACLS, and PALS certifications. Transports can be emergent and non-emergent, dependent on the nature of the call, and operation protocols per county. CCT transports are conducted on certified ambulances approved by county regulations for operation. CCT ambulances carry all required and approved CCT equipment per county requirements. CCT-RN's function under written standing order developed by the Medical Director and answer directly to the Medical Director.

NICU/PICU Transport: Staffed with two certified EMT-B's with current CPR, Medical Examiners and Ambulance Driving Certificates (for driving). Accompanying staff is various stadd from contracted hospitals (Doctors, Nurses, Respiratory Therapists, etc).

Medical Stand-by: Ambulance stand-by can be provided at the BLS, ALS, and CCT service levels. The stand-by unit serves to handle all non-emergent care including the stabilization of acute medical conditions. Patients with non-emergent conditions requiring transport can be transported by another unit. If a patient's condition poses a threat to life or limb, the 9-1-1 system is activated and the stany-by unit will provide supportive care, until care can be transferred to 9-1-1 personnel. At no time during

stand-by operations are the units allowed to transport a patient and/or leave the designated area(s) unless local protocol dictates transport.

b) Education

Wheelchair Transport: There are no educational requirements for this job position other than possession of a current CPR certification. Drivers selected for this job must be affable and in possession of a clean driving record.

Gurney Transport: There are no educational requirements for this job position other than possession of a current CPR certification. Drivers selected for this job must be affable and in possession of a clean driving record.

Basic Life Support (BLS) Transport: Staffed with two certified EMT-B's with current CPR, medical examiners and ambulance drivers certificates (for driving). Mandatory attendance and passing of Norcal Ambulance orientation and field training program. Probation and any local accreditation requirements applied by the LEMSA in which they will be working.

Advanced Life Support (ALS) Transport: Staffed with one certified EMT-B with current CPR, Medical Examiners and Ambulance Drivers Certificates (for driving) and one certified EMT-Paramedic (CA State License required) or two certified EMT-Paramedics (CA State License required). Mandatory attendance and passing of Norcal Ambulance orientation and field training program. Probation and any local accreditation requirements applied by the LEMSA in which they will be working. Paramedics

Critical Care Transport (CCT): Staffed with two certified EMT-B's with current CPR, Medical Examiners and Ambulance Drivers Certificate (for driving) and one certified Registered Nurse (California State Licenses required). Mandatory attendance and passing of Norcal Ambulanceorientation and field training program. Probation and any local accreditation requirements applied by the LEMSA in which they will be working. RN's are required to maintain their state nursing license, current CPR, ACLS, and PALS or PEPP. RN's will cycle through lesser used skills updates a minimum of every two years or more frequently if required by the company or LEMSA.

c) Quality Improvement

Wheelchair Transport: QA is based on a combination of data analytics and customer feedback from sending facilities and persons utilizing the service. Monitoring of QI is largely based on trending of any unusual occurrences and monitoring.

Gurney Transport: QA is based on a combination of data analytics and customer feedback from sending facilities and persons utilizing the service. Monitoring of QI is largely based on trending of any unusual occurrences and monitoring.

Basic Life Support (BLS) Transport: The quality improvement activities associated with this level of service are much more stringent. EMT-B is the basis of Norcal Ambulance service and requires a higher level of medical knowledge and decision making, The following is a partial list of associated QA/QI activities:

- ➢ Partner/peer review
- ➢ Data analysis of BLS KPI's
- ➢ Education, coaching and PIP's
- ➢ Station supervisor/manager review
- ➢ PCR compliance review
- ➢ Customer feedback system
- ➢ Unusual occurrence reporting system
- ➢ Training program
- ➢ Continuing education program (24 hours in a 2 year cycle)
- ➢ Employee feedback forums

Advanced Life Support (ALS) Transport: The quality Improvement activities associated with this level of service are much more stringent than EMT-B. Paramedics are responsible for all of the company requirements for EMT-B (listed above) and for the additional quality improvement guidelines listed below:

- ➢ ALS PCR review
- ➢ Data analytics of ALS KPI's
- ➢ Education, coaching and PIP's
- ➢ Station manager/ paramedic supervisor review
- ➢ Customer feedback system
- ➢ Unusual occurrence reporting system company/county
- ➢ Continuing education program (48 hours in a 2 year cycle)
- ➢ Base hospital run review participation
- ➢ Participation in the Technical Advisory Group (as assigned)

Critical Care Transport (CCT): the quality improvement activities associated with this level of service are much more stringent than EMT-B and EMT-P. Registered Nursing staff are

responsible for all of the company requirements for EMT-P (listed above) and for the additional quality improvement guidelines listed below.

- ➢ CCT PCR review (by CQI-RN)
- ➢ Data analysis of CCT KPI's
- ➢ Education, coaching and PIP's
- ➢ Customer feedback system
- ➢ Unusual occurrence reporting system company/county
- ➢ Continuing education program (24 hours a year)
- ➢ Participation in Technical Advisory Group (as assigned)
- ➢ Medical Director review and case study

3. EMS System Goals and Process

The goal of the Norcal Ambulance Quality Assurance Department is the relentless pursuit of unending delivery of quality care. The QA Department is comprised of staff members in the organization tasked with leading quality improvement. The QA Department monitors trends in the organization, challenges and opportunities. It is responsible for generating and organizing information for the Technical Advisory Group to review, assimilate and act on, to drive enhanced performance.

The QA Department serves a dual-role and interacts with the executive management staff and other staff members, the executive management staff is not needed for all aspects of decision making related to quality improvement matters. Agenda items the QA team has acted on may be reported to the management group and any items requiring further discussion and / or disposition will be presented to the management group by the Vice President of Quality.

a) Norcal Ambulance Core Values

(1) Our team is our priority. We recognize that our team members are responsible for creating an excellent patient experience and are the heart of our company. Caring for our team results in exceptional service of our customers.

(2) Phenomenal patient experience. We treat every patient like a cherished family member. We advocate for their care and deliver service that surpasses expectation.

(3) Be the best. Innovation and a quest for excellence is the driving force behind our success. It is our desire to deliver the highest quality service possible.

(4) Safety without compromise. We promote a culture of safety, accountability, and continuous quality improvement throughout our workplace. We maintain the highest quality equipment and provide superior training.

(5) Celebrate diversity. We foster a culture that celebrates the unique contributions of each individual as we partner together, making Norcal Ambulance a great place to work, learn, and grow.

b) Data Analysis
All data generated by Norcal ambulance is scrutinized by various levels of the organization. Patient Care Reports are generated via field level staff and scrutinized for completeness by the QA Department. The QA Department reviews clinical data for adherence to protocol and sound clinical practices. All data is collected, analyzed and interpreted for reportable trends consistent with industry standards. All monthly data is then condensed for a reportable dashboard which is then shared with senior level management, risk and safety as well as the training department.

c) Evaluation of Indicators
Norcal relies on Key Performance Indicators in order to benchmark it's many successes. The QA department collects data the KPI's on a monthly basis and reports that data to the C-Suites.

d) Continuous Quality Improvement
Norcal utilizes the FOCUS-PDSA approach for performance improvements.

II. Data Collection and Reporting

A. Quality Indicators

1. Personnel

a) Qualifications / Certifications

(1) Objective: To ensure that all medical personnel will provide verification regarding their current and relevant certification levels. This includes but is not limited to: Nursing license, Paramedic license, EMT certification, CPR for BLS providers, Drivers license, Ambulance Drivers Certificate, Medical Examiners certification, DMV H6 motor vehicle report, as well as a criminal background check prior to commencing employment. All non-medical personnel will provide information regarding their education and criminal record.

(2) Compliance: All certifications are tracked by the Norcal Human Resources department and are monitored via TraumaSoft. TS automation will alert the employee should an employee fall within a 30day window for expiration status.

(3) **Indicator Reporting Value:** Certificates, licenses, records and documents will be retained by Human Resources and retained in personnel files.

- ➢ Copies of certifications that are renewed can be forwarded to HR via certs@norcalambulance.com.
- ➢ HR will place current copies in employee file.
- ➢ HR will update the expiration date in TraumaSoft.
- ➢ Employees will receive communication via TraumaSoft and email at pre-set intervals notifying them that a required certification is approaching its renewal date.

EMT Requirements (not limited to):

- ➢ CPR BLS for Healthcare Providers, AHA (or equivalent)
- ➢ Ambulance Drivers License
- ➢ California Drivers License
- ➢ LEMSA Specific: ICS 100, ICS 200, ICS 700, ICS 800, SEMS, AWR 160

EMT-Paramedic / RN Requirements (not limited to):

- ➢ ACLS
- ➢ PALS / PEPP (LEMSA specific)
- ➢ ITLS / PHTLS (LEMSA specific)

b) Wellness

(1) **Objective:** All personnel will be monitored for their well-being with regards to physical and mental health. All employees will have access to an Employee Assistance Program (EAP).

(2) **Compliance:**The Norcal scheduling department will track employee attendance and report any issues to both Operations and Human Resources. All employee/co-worker complaints will be forwarded to the Human Resources Department. Unusual Occurrences will be monitored and tracked by the QA Manager and forwarded to the appropriate department for review

(3) **Indicator Reporting Value:** Employee attendance, complaints and incidents will be tracked.

- ➢ Monitor and report number of sick calls
- ➢ Monitor and report number of absences
- ➢ Monitor and report co-worker complaints
- ➢ Monitor and report on unusual occurrences including accidents and exposures

c) Education and Training

(1) **Objective:** All patient care personnel will comply with the state required continuing education requirements, 24 hours every 2 years for EMT-B and 48 hours every 2 years for

EMT-Paramedics. Additional training will be recommended and recorded as needed. Non patients care personnel (i.e. dispatch, billing, admin personnel) will require education and training as deemed necessary in compliance with state employment laws, NAEMD, local EMS and Medicare provisions respectively.

(2) Compliance: Certifications and licensures as well as course completion certificates will be reviewed on a continuous basis. Required training will have records kept by Norcal's Human Resources or Training department.

(3) Indicator Reporting Value: Employee education and training records will be tracked.

- ➢ Number of expired certifications, licenses or non-completions per year.
- ➢ Number of CE hours logged per employee (average).
- ➢ Examination of demographics of program participants.

2. Equipment and Supplies

Norcal takes pride in having the most technologically advanced equipment available to EMS. It carefully monitors and complies with industry standards to ensure all supplies and equipment are in good working order, evaluated and if need be replaced.

A preventative maintenance plan exists to evaluate everything from stryker power gurneys and autoloads to emergency vehicles to ensure the highest maintenance standards.

a) Equipment / Supplies / Inventory

(1) Objective: To maintain equipment and supplies at a high level of availability and reliability for field personnel.

(2) Compliance: Norcal's equipment and supplies are monitored by our Supply Services department. SSD utilizes OperativeIQ for inventory control. The program is used for daily checkouts, tracking expiration dates, and requests for resupply.

(3) Indicator Reporting Value:

- ➢ Measurement and monitoring of equipment failures and breakdowns.
- ➢ Accurate inventory control to maintain necessary stock levels.
- ➢ Tracking of daily usage for supplies
- ➢ Employees report equipment and supplies issues to their on-duty supervisor and submit a ticket through OperativeIQ.

b) Vehicles

(1) Objective: Vehicles are maintained under an inhouse operational team with an available cadre of certified fleet mechanics.

(2) Compliance: The fleet manager is responsible for tracking vehicle services, completed maintenance, and scheduling PM services to keep our fleet running.

(3) Indicator Reporting Value:

- ➢ Tracking preventative maintenance according to manufacturer's recommendations.
- ➢ Use of OperativeIQ and Geotab GPS system to track mileage for service due.
- ➢ PM’s include an oil change, tire rotation and any additional services that are needed.
- ➢ Any mechanical anomalies during service are reported to fleet staff via OperativeIQ ticket or email to serviceticket@norcalambulance.com

c) Gurneys / Autoloads

(1) Objective: Have all Stryker equipment functional without issue. To have PM’s completed on time and to keep all equipment in a safe and operational state for crews.

(2) Compliance: Stryker service and issues are tracked by the Supply Services Department. Norcal has an evergreen service agreement for continual stryker services.

(3) Indicator Reporting Value:

- ➢ Equipment PM's are completed no less than annually.
- ➢ All Stryker equipment services are completed by certified Stryker representatives.

d) Pharmaceuticals

(1) Objective: Norcal has a Pharmaceutical Control Committee. The committee has the authority and mandate to oversee the usage, supply, disposal, and storage policies of pharmaceuticals for Norcal. Any pharmaceutical action or issue is under the purview of the pharmaceutical committee. Furthermore, the committee conducts regular meetings to discuss and resolve any pharmaceutical related issues or topics necessary. Issues and discipline will be referred to other committees and departments as needs arise.

(2) Compliance: Control Committee -

- ➢ Chairperson - Medical Director
- ➢ Organizer - Director of Critical Care Transport

- ➢ Committee Members - COO, QA representative, Director of Risk and Safety, SSD Director, and non-voting member: Bio-Medical Supply Specialist.

Members of BLS, ALS and CCT management may submit pharmaceutical related changes, inquiries, or issues to the pharmaceutical control committee in writing at any time. Submissions will be vetted and may be tabled until the next committee meeting or may be acted upon sooner as required.

The committee will meet at minimum two times per year with regular updates and correspondence in between meetings, or as often as needed

(3) Indicator Reporting Value:

- ➢ Weekly usage checks and reports
- ➢ Weekly restock of used and expiring medications
- ➢ Pharmaceutical policy review
- ➢ Form review - waste logs, tracking forms, etc.
- ➢ All pharmaceutical forms are stored on the company server to prevent altercation and preserve formatting.

3. Documentation

a) Patient Care Reports

(1) Objective: PCR consistent with provision of local EMS recording requirements, accurate times, accurate patient demographics, assessment, vital signs, interventions and any other unusual call occurrences.

(2) Compliance: Norcal is compliant with NEMSIS v3 data reporting requirements. PCR forms will be reviewed, amendments and revisions may be required as deemed necessary and maintained to a consistent level with state and national standard data elements. The QA Manager will oversee PCR compliance.

(3) Indicator Reporting Value:

- ➢ PCRs will be reviewed for accuracy and to measure compliance, education and consistency. Parameters measured and reported will include (not limited to):
  - ○ Call demographics
    - ■ Date
    - ■ Unit number
    - ■ Level of service
    - ■ Response code
    - ■ Transport code
    - ■ Run number

        - Time stamps
        - Origin facility/location
        - Destination facility
    - Patient demographics
        - Name
        - Address
        - Date of birth
        - Age
        - Sex
        - Phone number
        - PCP
    - Patient assessment
        - Reason dispatched
        - Chief complaint
        - Medical history
        - Medications
        - Allergies
        - Field impression
        - Physical assessment
        - Ambulance justification
        - Billing information
- Number of PCR revisions will be tracked and reported monthly via monthly QA Dashboard.
- Data source collection will be defined as:
    - Random for service
    - Specific outliers mandated by LEMSA
    - Epidemiology tracking
    - Usage of hemostatic dressing
    - Usage of epinephrine administration
    - Usage of glucometry
    - Usage of naloxone
    - Cardiac arrest
    - Respiratory arrest
    - Unstable patient airway
    - Usage of CPAP
    - ECMO
    - LVAD
    - NICU patients
    - Code-3 calls
    - Combative patients
    - Application of restraints
- ALS PCR review
    - 100% Code-2 calls
    - 100% Code-3 calls
    - 10% randomized per provider

- ➢ CCT PCR Review
  - 10% randomized PCR review
  - 10% randomized per provider

b) HIPAA Compliance

(1) Objective: To assure compliance, education and documentation of familiarity with the Health Information Privacy and Accountability Act for employees who handle sensitive information with regards to patient care.

(2) Compliance: Review of employment records for completion of HIPAA orientation and ongoing orientation. Norcals Privacy Officer will oversee HIPAA compliance.

(3) Indicator Reporting Value:

- ➢ Track number of non-completion of HIPAA orientation forms per total patient care, dispatch and billing personnel.
- ➢ Monitor any events related to compliance.
- ➢ Ongoing evaluation of need for continuing education related to this subject

c) Storage of Medical Records

(1) Objective #1: To provide a secure storage site of Patient Care Reports, that may be easily located and accessible. Secure storage site is defined as a designated locked storage room with compartments within the confines of the station. Only authorized personnel may access the medical records under HIPAA guidelines.

(2) Compliance: Annual review of measure enforced in station storage site, with regards to the accessibility and security parameters. Norcals PCR storage compliance will be overseen by the Compliance Officer.

(3) Indicator Reporting Value:

- ➢ Any failure to secure will be tracked and reported appropriately.
- ➢ Any loss of medical records will be tracked and reported appropriately
- ➢ Any inaccessibility of records on request will be tracked and reported appropriately

(4) Objective #2: To provide for safe and secure transfer of medical records and PCRs

(5) Compliance: Ongoing review of electronic reporting systems for security. Ongoing review of electronic systems and any reported problems. Transfer of medical records and PCR's will be overseen by Norcals Privacy Officer.

(6) Indicator Reporting Value: Absence of events related to security of electronic transfer and retention of secure data.

d) Narcotic Records

(1) Current DEA Licensure

(a) Objective: To maintain current DEA licensure for the procurement and storage and use of controlled substances for medical purposes. The licensure documentation will be available at the primary station where the controlled substances are stored.

(b) Compliance: Biannual review and renewal of licensure per DEA requirements.

(c) Assigned: Biomedical Supply Specialist SSD

(d) Indicator Reporting Value: Outlier, expiration, revocations, or loss of DEA licensure. Monitoring of controlled substance accounting system.

(2) DEA Form 222

(a) Objective: To possess and securely store a limited supply of DEA forms 22 on-site for the legal procurement of controlled substances. The forms will be locked in a secure safe (pharmacy) on the premises of the primary (Dublin) station with an active log of the form numbers and utilization.

(b) Compliance: Minimum quarterly review, maximum as needed on re-supply. Monitoring of the utilization of the DEA form 222.

(c) Assigned: Biomedical Supply Specialist SSD

(d) Indicator Reporting Value: Loss of accountability of forms, improper storage of forms and inability to account for controlled substances,

(3) Record Keeping

(a) Objective: To review and comply with the federal DEA recommended format of record keeping when procuring, utilizing and destroying

(b) Compliance: Annual review of DEA recommendations of record keeping requirements.

(c) Assigned: Medical Director

(d) Indicator Reporting Value: Non-compliance with DEA guidelines.

(4) Reporting of Unusual Occurrences

(a) Objective: To review and assure proper compliance and reporting of unusual occr]urrences when handling DEA defined controlled substances.

(b) Compliance: Immediate review of the unusual occurrence report form for controlled substances as they occur.

(c) Indicator Reporting Value: All cases as they occur, as soon as possible.

4. **Clinical Care and Patient Outcome**
   Norcal Ambulance is dedicated to the highest standards of patient care, from its robust training department to its quality assurance practices. All departments have been engineered to continually improve upon patient care. Norcal accomplishes this by identification of the following categories.
   - ➢ Scope of practice
   - ➢ Standard of care
   - ➢ LEMSA specific treatment protocols
   - ➢ Reporting qualitative data
   - ➢ Synthesizing data
   - ➢ Identification of trends
   - ➢ Formation of training
   - ➢ Medical oversight
   - ➢ Research
   - ➢ Best practices

   a) **Objective:** To review PCRs for adherence to scope-of-practice, local treatment protocols, expanded scope-of-practice and adherence to established program guidelines as set forth by company policy such as on-scene times, chute times and response codes for all medical and trauma calls.
   b) **Compliance:** Use of BLS, ALS, and CCT PCR review system and channeling of same to appropriate QA levels in the organization.
   c) **Assigned:** QA Manager
   d) **Indicator Reporting Value:**
      - ➢ 10% ALS and CCT provider review
      - ➢ 100% code-2 and code-3 call review
      - ➢ 10% BLS review by county (no less than 30 charts)
      - ➢ Development and implementation of education process and Personal Improvement Plans for incidents or training needs.

5. **Skills Maintenance/Competency**
   Skills Utilization: For skills utilization Norcal adheres to adult learning guidelines set forth by the National Association of EMS Educators and cater to all learning styles. Training can be self paced, psychomotor and rubric testing. The aim is to enhance the clinical application of a clinicians skills set that they may not use on a frequent basis due to the nature of the IFT business of Norcal.

   Infrequently used skills are offered no less than annually at all levels of clinical services. Each skills training is administered by the Norcal training department. This training is hosted in conjunction with the immediate supervisor of each respective Norcal department. As an example, when Critical Care training is hosted a NAEMSE accredited Norcal training instructor will work in conjunction with the Director od

CCT in order to facilitate effective training through use of specific and measurable benchmarks for skill success.

Success Rates: Clinical skills are continually monitored by all levels of the organization but carefully documented via the QA department. Any skills that are identified as below clinical expectations are immediately reported to operations in order to reeducate the employee, gain clinical proficiency and return to field duty.

a) **Objective:** To develop and maintain a system for retrospective review of BLS, ALS, and CCT PCR's to meet threshold requirements established by this program. This will include and not be limited to; scope-of-practice, infrequently used skills and local data set requirements.
b) **Compliance:** ePCR allows for smooth CQI and employee feedback as well as overall data capture. Compliance will be monitored by the QA Manager.
c) **Indicator Reporting Value:**
    - ➢ On-scene times
    - ➢ Chite times
    - ➢ Response times
    - ➢ APOT times
    - ➢ Code-3 transports and upgrades
    - ➢ Infrequently used skills
    - ➢ Use of advanced airways; attempts / successes
    - ➢ Cardiac arrest
    - ➢ Respiratory arrest
    - ➢ Field defibrillation
    - ➢ AED activations
    - ➢ Field CPR
    - ➢ R.O.S.C.
    - ➢ Delivery of pharmaceuticals in the field setting
    - ➢ Narcotic usage
    - ➢ IV success rates
    - ➢ Hemostatic dressing application
    - ➢ Naloxone administration
    - ➢ Epinephrine administration
    - ➢ Additional LEMSA specific reporting requirements as required
    - ➢ SOB, critical trauma and burns
    - ➢ High-risk pediatrics
    - ➢ Focused ALS audits from LEMSAs
    - ➢ Trauma center activations
    - ➢ STEMI activations
    - ➢ Stroke center activations

- ➢ Burn center activations
- ➢ Air ambulance utilization
- ➢ Others as identified as being required by CALEMSA or LEMSA

Norcal uses the ePCR platform company wide and Image Trend system in Marin County for county dispatched 911 calls. Norcal is fully integrated and is 100% ePCR compliant. Development of specific factors related to electronic EMS data collection and a system that can store, sort and generate reports is ongoing. Conceptually, an example of a standard would be 90% success rate on IV starts. IV success rates can be measured individually or in group comparison to evaluate need for remedial training. Another example would be 10 minutes scene times for trauma and 20 minute scene times for medical calls.

6. Transportation/Facilities

a) Response Times

(1) Objective: To measure the response times within designated zones, from the initiation of the call, dispatched of the call to the arrival at the order facility, based on the following parameters:

- ➢ Time of day
- ➢ Unit and/or crew
- ➢ Level of service
- ➢ Call priority using EMD standards

(2) Compliance: Data input from the Computer Aided Dispatch (CAD) software, reports are generated on a daily basis (global report). OTP is actively managed by the Director of Communications and EMD resources are added as needed to adjust for system spikes.

(3) Indicator Reporting Value:

- ➢ Global report is sent out early the following morning by dispatch to executive staff, directors, and supervisors.
- ➢ Response time compliance is reviewed daily and reported at regularly scheduled department leadership meetings.
- ➢ Any call out of standard zone response times each day. Standards:
  - ○ BLS code 1 - prescheduled
  - ○ BLS code 2 - 20 minutes (chute and response)
  - ○ BLS code 3 - N/A
  - ○ ALS code 1 - prescheduled
  - ○ ALS code 2 - 3 minutes (chute)

- ALS code 3 - immediate, < 2 minutes. Shall respond within 15 minutes or less for an achievable compliance of greater than 90%.
- CCT code 1 - prescheduled
- CCT code 2 - 3 minutes (chute)
- CCT code 3 - < 2 minutes (chute)

b) Lost Calls

(1) Objective: To measure the number of lost calls within given parameters for purposes of unit utilization. These parameters would include:

- ➢ Day of week
- ➢ Time of day
- ➢ Response areas
- ➢ Current staffing / availability

(2) Compliance: data input from CAD software and monitoring of system performance. Daily reporting on global report.

(3) Indicator Reporting Value: All calls lost within response areas per day; lost calls out of response areas evaluated case by case. Adjustments made to staffing patterns and utilization by systems manager and scheduling.

c) Critical Care Transport

(1) Downgrade of Level of Service

(a) Objective: To measure the percentage of CCT calls downgraded from CCT to ALS or BLS

(b) Compliance: Data input from the CAD software; reports generated quarterly

(c) Indicator Reporting Value: Number of downgraded calls per day

(2) ALS/CCT Equipment Utilization

(a) Objective: To determine the percentage of ALS and CCT calls requiring specialized equipment utilization defined under the following parameters:

- ➢ Ventilator
- ➢ IV pumps
- ➢ External pacemakers
- ➢ Cardiac monitors
- ➢ Pulse oximeters
- ➢ Capnography
- ➢ Balloon pumps
- ➢ ECMO
- ➢ Specific medication administration
- ➢ Acuity deemed appropriate

(b) Compliance: Data input from patient care records quarterly

(c) **Assigned:** Director of Critical Care Services
(d) **Indicator Reporting Value:** Percent of equipment utilization per call per quarter. Currently done manually by assigned managers. When additional equipment is needed it is ordered through purchasing.

d) **Center Destination**
(1) **Objective:** To determine the amount of calls to specialty facilities under the following parameters:
- ➢ Cardiac care
- ➢ Neurosurgical care
- ➢ STEMI protocol
- ➢ Stroke protocol
- ➢ Pediatric acuity care
- ➢ High risk OB care
- ➢ pulmonary/respiratory care
- ➢ Specialized diagnostic imaging
- ➢ Trauma care

(2) **Compliance:** Data input from PCRs. Compliance will be overseen by QA Manager
(3) **Indicator Reporting Value:** Percentage of calls to designated specialty facilities per month. Total number of requests, total number of assigned and missed calls.

7. Public Education and Prevention

Norcal takes pride in its involvement with the community and has business agreements in place with local public health education entities. Norcal is rooted in the community in which it serves and takes every opportunity to assist public health directives in order to spread a message of education and prevention to the community.

Community Involvement:
- ➢ Hands only CPR
- ➢ Charity programs and volunteer work
- ➢ Non profit sponsorship
- ➢ Kids against hunger
- ➢ St. Baldrick's cancer support
- ➢ Breast cancer awareness
- ➢ Prevention of slips, trips and falls
- ➢ Stop the bleed campaign
- ➢ Reward and recognition
- ➢ LEMSA directed prevention programs
- ➢ Patient education
- ➢ Customer satisfaction

a) **Objective:** Assess and monitor the companies outreach and community education initiatives and programs
b) **Compliance:** Program monitoring by VP of Business Development and the Norcal Culture department.
c) **Assigned:** VP of Business Development
d) **Indicator Reporting Value:**
    - ➢ Total number of persons reached by programs
    - ➢ Number and description of programs month/quarter/year
    - ➢ Diversity of programs
    - ➢ Geography
    - ➢ Community
    - ➢ Content
    - ➢ Customer and community feedback
    - ➢ Customer care program indicators
    - ➢ Customer satisfaction programs

8. Risk Management

Norcal employs a full-time risk and safety director to directly supervise and report on all aspects of safety.

Issue resolution process:

- ➢ Unusual occurrence reporting via TraumaSoft
    - ○ Incident reporting
    - ○ Unusual occurrence reporting
    - ○ Sentinel events
    - ○ Disease outbreaks
    - ○ General threats to public safety
- ➢ Root cause analysis and investigation
- ➢ Resolution
- ➢ Performance improvement tracking and feedback
- ➢ Record keeping
- ➢ Integration of incident review board (IRB) within 24 hours

OSHA Compliance (Risk and Safety Director / Human Resources)

- ➢ Work injury reporting
- ➢ Occupational exposures
- ➢ Safety meeting compliance
- ➢ Disaster preparedness
- ➢ Fit testing
- ➢ TB testing
- ➢ Certification tracking

a) **Objective:** To continually monitor company exposure to risk and evaluate measures to reduce risk.
b) **Compliance:** Continual monitoring of the following by inspection, evaluation, of events and input from staff related to risk.

- ➢ Work related injuries
- ➢ Vehicle accidents
- ➢ Occupational exposures
- ➢ Station safety
- ➢ Disaster preparedness
- ➢ Employee issues
- ➢ Hazmat business plans
- ➢ CERS reporting

c) **Assigned:** Human Resources, QA Manager, Director of Risk and Safety, Director of Training, VP of QRST, and C-Suites.

d) **Indicator Reporting Value:** The above activities are assigned to committee members to track, review and report to quality staff with recommendations for enhanced crew and patient safety.

9. Other

B. Indicator Selection

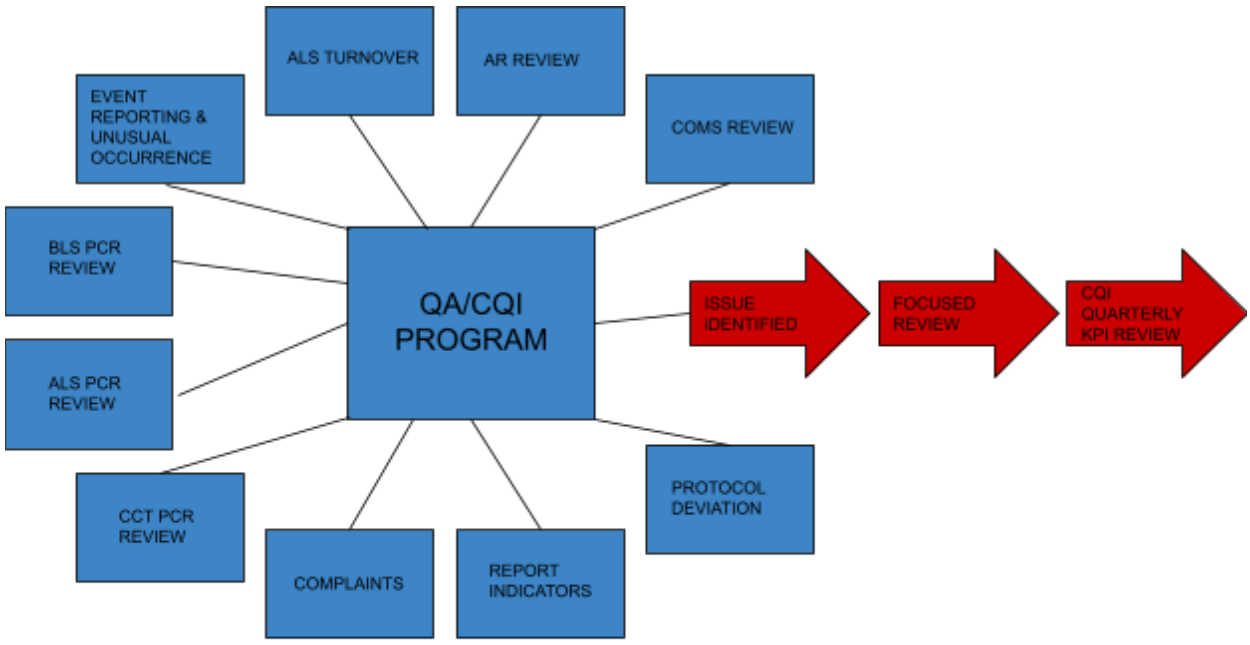
Norcal Ambulance adopts the methods of quality improvement based on guidelines recommended by the state of California EMS authority. In particular, special attention to methods of data gathering, review, reporting and improvement in Appendix E and F in the CA EMSA policy # 164 (Emergency Medical Service System Quality Improvement Program Model Guidelines).

The Technical Advisory Group meets to review reports and data collected by the mechanisms stated above. The group will also review trends identified by the QA process in incident reporting by field personnel. The Technical Advisory Group may form or assign a task force as needed depending on the complexity of the issue and the projected workload.

Duties of the Technical Advisory Group will include:

- ➢ Establish criteria for measurement and improvement
- ➢ Evaluation of information collected
- ➢ Decision making to take action to improve
- ➢ Establish criteria for improvement and / or methodology of measurement
- ➢ Identification of core problem, issues or challenges
- ➢ Identification of alternatives
- ➢ Establish and implement improvement plan
- ➢ measure/monitor results of improvement plan
- ➢ Standardize and integrate plan or change into the system
- ➢ Establish a plan for monitoring future activities.

The task force assignments will convene on an established interval with a projected timeline for completion and will function with some autonomy until the issue is resolved or refined enough to report to the committee.



C. Indicator Data Collection

All quality indicators are collected via field level transmission. ePCR data is then reviewed and scrutinized by QA department who looks at a variety of clinical data points and looks for overall adherence to standard of care. From there, the data points are synthesized by the QA Manager for further synthesis and reporting dashboard to the Vice President of Quality who conveys the information to the Executive Management Team.

The primary method used to identify trends and issues related to service is through the TraumaSoft Unusual Occurrence Reporting System. TS is online and is therefore accessible to field staff and managers 24/7. On-duty supervisors check the repository daily and escalate them to management as needed. Norcal Ambulance maintains policy that any of the following events are indicators for completing a UO for all employees:

- Non-injury or injury company vehicle accident
- Request by supervisor
- On the job injury
- Incident involving the facility
- Accident involving patient
- MCI/disaster
- On view emergency

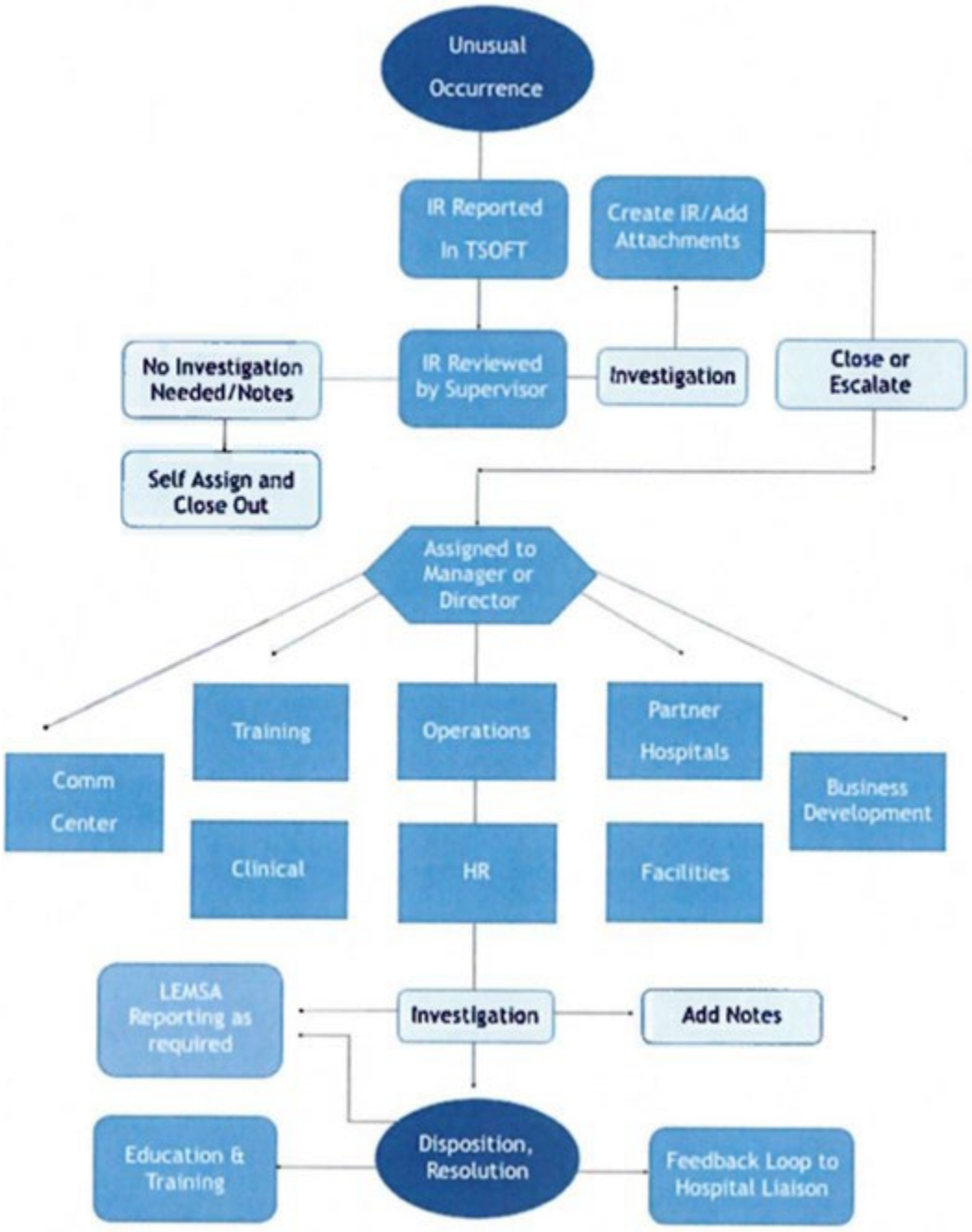
- ➢ Hospital diversion
- ➢ AMA release of patient
- ➢ Non AMA refusal of care/transport
- ➢ Accusation of negligence or wrongdoing against Norcal ambulance employee
- ➢ Delay in patient care without adverse outcome
- ➢ Any condition or situation that represents a threat to employee or public safety and health
- ➢ Any event which could be deemed as unusual in a patient care situation
- ➢ Disruption to continuity of operations.

These events are tracked and trended by the QA Manager; systems trends identified as contributing to the incident are analyzed and amended as needed. Training opportunities are identified and forwarded to the Training Director. Levels or thresholds relating to reporting requirements to the LEMSA are evaluated by the QA Manager and forwarded on the appropriate county notification form. Any systems issues identified in this process are also reported and become part of the global CQI process.

Advanced Life Support (ALS) mandated reporting requirements are as stated above and also include the following:

- ➢ Any circumstance adversely affecting patient outcomes
- ➢ Misplaced endotracheal tubes
- ➢ Injection of wrong medications
- ➢ Dosage errors
- ➢ Damaged / missing controlled substances
- ➢ Deviation from local protocol
- ➢ First responder transfer of care issues

This list is reportable to the LEMSA in which the ALS resource is operating. The QA Manager and ALS Supervisor will assure that the incident has been reported and that an investigation of the incident is carried out.



D. Indicator Reporting

The VP of QA receives all Quality Assurance related monthly dashboards. Indicator data can be collected in several forms; each will be specific to the reporting item. Data will be collected in the form of computer aided dispatch

(CAD) reports, personnel files, patient care reports (PCRs), surveys incident reporting forms and other items as deemed necessary.

Indicators have been assigned specific reporting values (time frames) regarding allotment of data collected. At minimum each indicator will be evaluated and reviewed monthly and transmitted to the executive staff.

Data will be collated and organized into reports by the QA department collaborating with the specific department managers or supervisors. (Example: Data elements for specific reports are identified by an assigned manager who will then work with the QA department to import data elements, format reports and create file hierarchy for future report generation.) Report data fields and formats will be adjusted as necessary to make the report more meaningful and user friendly.

Retrospective quality assurance and Norcal ambulance includes patient care data analysis, the identification of performance trends, performance improvement and or deficiencies feedback for personnel and policy development and remedial education or PIP.

- ➢ Evaluation of patient care
- ➢ Tape reviews
- ➢ One on one education
- ➢ Amendments to current training practices
- ➢ Equipment recommendation

Norcal ambulance currently employs trending and tracking tools to monitor identified performance trends and to document corrective actions to assure resolution, This currently includes PCR review, tape review, field training PIP date and mentoring. Information is systematically reviewed from each category and analyzed to determine system efficiency. Changes are recommended and or implemented after a review of events and trends.

Prospective QI is done by utilizing the time and resources available to evaluate our current systems and training programs to ensure we are on the cutting edge of patient care and customer satisfaction. This process includes participation on county EMS committees to stay updated in relevant information regarding updates in policies and clinical care issues in every county.

Norcals concurrent clinical quality improvement practices hinge upon three key components:

- ➢ Sharing of information
- ➢ Cyclic QI practices
- ➢ Field training and supervisor
- ➢ Reevaluation of practices

Concurrent quality improvement is guided by the continuous flow of quality information through all levels of the operation. Recommended actions steps

resulting from quality data gathering and analysis are communicated through meeting, electronic mediums, foster, flyers, newsletters and Slack. The QA department reports all findings and recommended actions to the training department who synthesizes best practices in order to convey operational changes to staff.

Our current methods for sharing the QA information, communication, analysis and quality improvement actions steps for Norcal managers and staff offer a mechanism to provide performance feedback to all personnel.

III. Evaluation of Indicators

A. Analyzing Indicators

Norcal is a data driven company and relies on key performance indicators in order to benchmark its many successes. Its many KPIs need to be transmitted to need to know personnel on a consistent basis. Data collected via CAD reports, personnel files, patient care reports, surveys and incident reports. In an effort to accomplish this aggregation of the data the Norcal QA department collects monthly data for dissemination to C-Suite personnel. Each month each respective department of QA, Risk, and Training is combined for the monthly report where the results are submitted to operational personnel and C-Suites in order to gain insight into comprehensive data based on operational performance.

The results and measurements of indicators are presented to the users of the information (i.e. applicable personnel) in a formal process and on a regular monthly basis. Typically updates are released in quarterly all-staff meetings where attendance is mandatory. Personnel that miss meetings are updated by their immediate supervisors or HR supervisor on items missed.

For more urgent information requests requiring immediate attention, the QA department will work with the department heads to create special reports specific to the indicator or issue needing improvement.

Information being routed to all employees is done via TraumaSoft notification or in person conversation with a read and sign document.



B. Presenting Indicators

The presentation of quality indicator analysis can be displayed in many formats. Norcal Ambulance will always try to provide an appropriate visual aid to demonstrate the data collected in an indicator analysis. Some cases will require comparison charts with historical data to compare improvement.

Appropriate presentations can include but are not limited to:

- ➢ Flow charts
- ➢ Fishbone - cause and effect diagram
- ➢ Pareto chart
- ➢ Histogram
- ➢ Scatter diagram
- ➢ Pie chart
- ➢ Run chart

C. Technical Advisory Group Indicator Evaluation

The technical advisory group meets at minimum quarterly to evaluate data collected in each indicator specific category. Meetings will occur sooner if indicators prove a more urgent change is needed in the system.

The following is the system Norcal has adopted to evaluate specific items, make decisions, and implement changes.

- ➢ Identify the objectives of evaluation
- ➢ Present indicators and related EMS information
- ➢ Compare performance with goals and/or benchmarks
- ➢ Discuss performance with peers/colleagues
- ➢ Determine whether improvements or further evaluation is needed
- ➢ Establish plan based upon decision

- ➢ Assign responsibility for post-decision action plan
- ➢ Follow up to assure post implementation is proceeding

Evaluation of Clinical Outcomes
The issue of having access to clinical outcomes related to emergency medical services and transportation has been a challenging issue for EMS to overcome. Some systems have fully integrated data systems that provide outcome information as it becomes available. In the past, systems have relied heavily on practitioner query and feedback. Within the spirit of this plan, practitioner feedback is strongly encouraged and recommended, Knowing that clinical outcomes and treatment plans are consistent with field treatment is invaluable. For the purposes of this plan, until a better system is designed, Norcal Ambulance will utilize the following two methods for discovery of clinical outcomes:

- ➢ Practitioner query and feedback from medical staff
- ➢ Quality improvement network with facilities

The quality improvement network will be built and maintained by the QA Manager. When clinical outcome information is needed for Quality Improvement, the manager will contact QA personnel at the specific facilities and determine outcome information on a case-by-case basis.

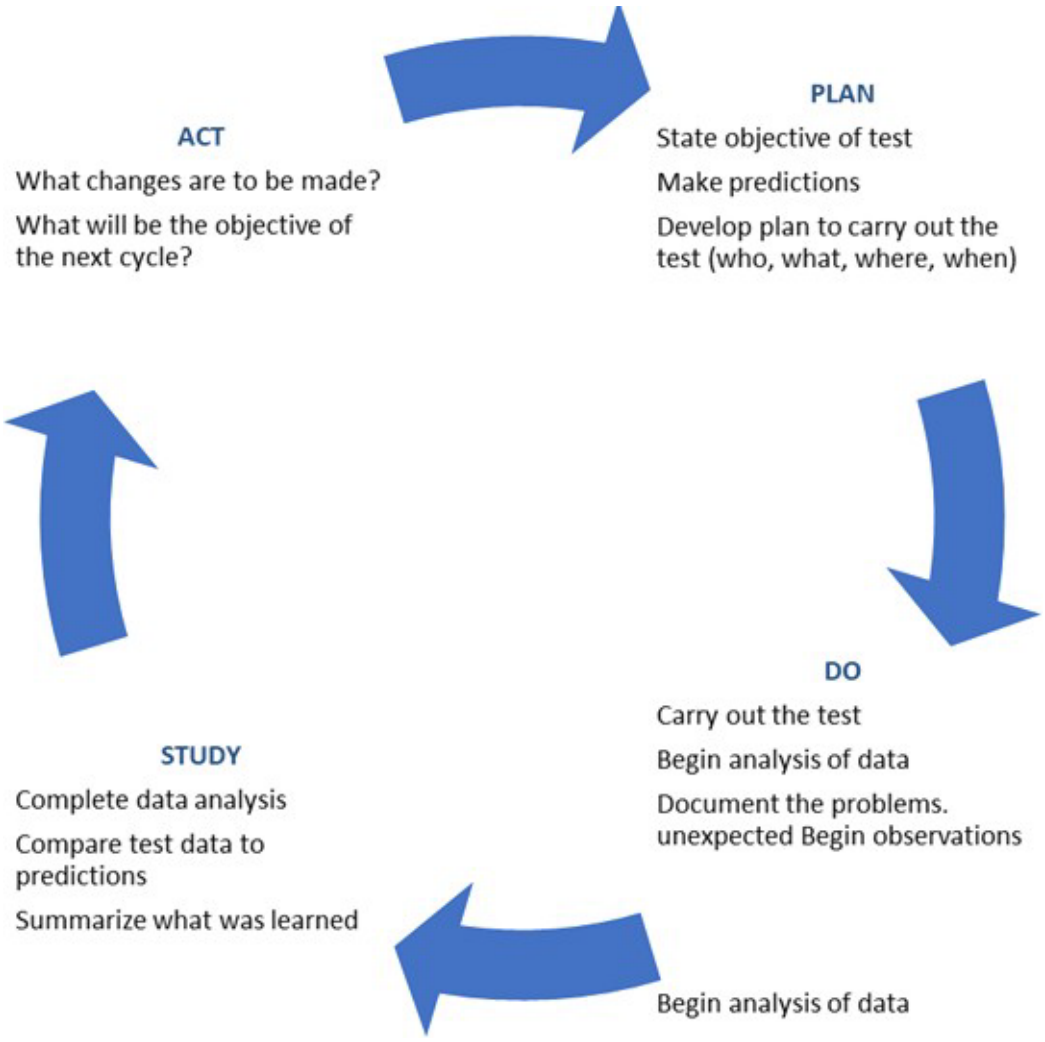
Customer Service Program
Norcal Ambulance maintains a system for customer service review that applies to all field personnel, accounts receivable and dispatch. This system involves all members of the organization. The system is designed to be used by our customers, crew members and office staff for direct feedback customer service or concerns. NorcalCares@getintouch.com

IV. Action to Improve

A. Performance Improvement

Norcal Ambulance approaches all standard performance improvements utilizing the FOCUS-PDSA model (*Source: "The Improvement Guide: A Practical Approach to Enhancing Organizational Performance", Langley, Nolan, Nolan, Norman & Povost 1996)*

F - find a process to improve
O - Organize a team that knows that process
C- Clarify the current knowledge of the process (collect data and other information)
U - Understand the causes of process variation
S - Select process improvement



B. Involvement in Improvement Planning and Implementation

Technical Advisory Group

This group is the fabric for making intentional changes to improve quality. This can be when external laws and/or regulations apply. Changes formed by outside agencies will be handled by appropriate personnel within /norcal Ambulance, additional consulting may be necessary by the acting outside agency. Specific examples include new driving laws (ex: cell phone law); or new local EMS requirements (background checks, etc). Assistance from technical advisory member may be utilized for the implementation of changes.

The QA Department

This team will be the first point of contact for improvement action planning and data collection. The QA department may make decisions independent of the Technical Advisory Group as determined by the Quality Manager. Action items

may be tabled until the next committee meeting and agenized for same. Some challenges may be best suited for Task Force of "Work Group" assignment. (Example: changing BLS paperwork signatures may involve a task force of EMT, FTO, Supervisors, Directors, Managers and billing representatives).

Task Force or Work Group
One of the greatest resources in action planning and implementation will be Norcals specialty task forces. Specialty task forces will be created as needed and as appropriately as possible (see example above). The members of the task force will represent the different functions of the action item being planned and implemented, task force members will be assigned different responsibilities within plan implementation and utilized for continuing follow up on plan success.

C. Communication with EMS Stakeholders

Norcal Ambulance makes every effort possible to communicate QA issues and changes to all involved EMS stakeholders. Issues will be reviewed internally to find cause and affect relationships with the issue. If issues can be resolved internally without affecting outside agencies and/or EMS stakeholders internal communications channels will be used to distribute information within the company.

For issues involving other agencies and EMS stakeholders, the Quality Manager keeps an updated contact list for all EMS stakeholders and QI personnel in the areas of operation. At minimum Norcal Ambulance will contact by phone or email any issues or changes in quality related matter. Urgent issues will be handled via phone or email within 48 hours of notification.

D. Planning Process for Change Implementation

- ➢ Establish criteria for measurement and evaluation
- ➢ Evaluate information
- ➢ Make a decision to take action to improve
- ➢ Establish criteria for improvement
- ➢ Establish an improvement plan
- ➢ Measure the results of the improvement plan
- ➢ Standardize or integrate change (plan) into system
- ➢ Establish a plan for monitoring future activities

V. Training and Education

A. Training of Patient Care Staff

The EMS QI Team and/or the technical advisory group shall have input into the content and delivery methods of related training and education of employees at Norcal.

Oversight for directing clinical training and education shall be at the highest level of medical knowledge based on industry trends, best practices and LEMSA protocols.

Training Department Staff:

- Christopher Seymour, Vice President
- Melissa Popnoe, Director of Training
- Natasha Branson, Senior Training Specialist
- Mike Olmos, Senior Training Specialist
- Brendan Anderson, Training Specialist
- Field Training Officers (FTOs)

The QA team directly influences

- New Employee Orientation Training: New employees undergo various levels of training in order to prepare them to function competently in the field. Orientation training is a forty hour (40) overview of the company and its organization. Employees are introduced to the functioning and resources of the various departments. This training is conducted in a classroom setting. The training consists of a variety of lectures, presentations, hands on skills and a simulation lab.
- Initial Field Training: Initial training is conducted by a Field Training Officer who has been trained by the company Operational Designees. Initial training has been formatted by upper management and is constantly reviewed to ensure effectiveness in delivery. Initial training for field personnel is a minimum of five classroom days and six field shifts with an FTO/preceptor. Specific county requirements may mandate longer initial training periods. New hire trainees are evaluated daily using a standard training evaluation. New hires are not allowed to work a regular shift until training has been completed. Training consists of all aspects of patient care including: patient assessment, patient treatments/interventions, lifting, equipment operations (gurney, cardiac monitor, etc), charting, driving, radio operations, local requirements and reporting.
- Probation Evaluation: Before a field employee can pass from probation (90 day period from hire date); they must undergo a probationary period training evaluation and attend the 90 day orientation. This is conducted by an FTO and department leadership. The probation evaluation covers all aspects of patient care that the employee has received training on during the initial training phase. If an employee fails a probationary evaluation they will either be assigned remedial training or face possible termination.
- Safety Meetings: Quarterly (or more often as needed), NORCAL, conducts safety meetings, station inspections and workshops. Field Training Officers (FTO) and station safety officers are required to attend. At the meetings a particular skill(s) is discussed of practiced among staff. This can be a part of OSHA requirements, station safety review and follow-up, assessment, treatment, reporting or any patient care component that the supervisory staff feels needs improvement or

refreshing (infrequent skills). Safety and skill workshops are presented by the Medical Director, VP of QA, Operations Director and Paramedic Field Supervisors. Disaster preparedness may be practiced at this level as assigned.

- ➢ Educational Topics: At quarterly OSHA required staff meetings, NORCAL's Medical Director will present a medical educational topic for field and administrative personnel. Topics include issues/concerns often encountered in the field including: communicable diseases, specific medical conditions (signs, symptoms, diagnosis and treatment), Mass Casualty Incidents (triage and treatment protocols) as well as many other relevant field topics.
- ➢ Continuing Education Program: The continuing education program will be organized, administered and reviewed by the Director of Training and Vice President of Quality. The program may be offered in the classroom and or consist of hands-on skills for development of skill sets for practitioners. Continuing Education Units (CEU's) will be assigned consistent with state curriculum guidelines. (01-0016). NORCAL Ambulance is an approved CEU provider and delivers educational content consistent with all applicable rules and regulations via Program Director and the Clinical Coordinator.
- ➢ ALS Additional Requirements: The additional requirements for Advanced Life Support operations will vary from region to region. For the most part, NORCAL Ambulance will require maintenance of ALS skills consistent with national standards. This includes but is not limited to ACLS, PALS or PEPP, ITLS or PHTLS and periodic attendance at Lesser Used Skills courses or other requirements established by the company or LEMSA.
- ➢ Personal Improvement Plans (PIP): Personal Improvement Plans may be created for clinical personnel found in need of remedial training. CQI staff will make the determination for creation of a PIP based on the circumstances. Once lack of competency has been addressed a PIP recommendation will be forward to the Training, Human Resources and QA Department for creation. The PIP will be correlated with measurable skills erosion and hopeful improvement or other medical indicators as selected by the Technical Advisory Group. The PIP Plan is found in the Attachments of this plan.Failure to participate and follow a PIP or failure to change behaviors may cross over into a disciplinary process. If an employee cannot successfully fulfill the requirements necessary in order to achieve benchmarks, the employee may be subject to termination .

In addition, evaluation of quality indicators through the course of review may call for remediation plans or for enhanced training. These issues may be identified by the Quality Director, Medical Director. QA and the Training will work in concert to allow opportunities for practitioners to enhance or refine skills.

The EMS QA Team and the Technical Advisory Group shall have input into the content and delivery methods of related training and education. Oversight for directing clinical training and education shall be the responsibility of the Training Director, Training VP and Medical Director.

B. Changes to Policies and Procedures

Yearly, the Director of Human Resources, QA Department, and the Medical Director review all policies and procedures. Policies and procedures needing further review and/or change may be amended as necessary and subjected to a strict review process as a DRAFT document. Changes to a policy or procedure will be highlighted in the draft policy and posted for review. It is the responsibility of the QA Manager to ensure policies and procedures are standardized, kept current and reviewed at least once a year. If any changes occur, draft copies will be distributed to all affected employees for a specified period of review and input unless the changes are minor in nature.

C. QI Training and Education

Checklists have been created to ensure all employees complete necessary training and education as set forth by the QA and Training Departments. The HR department ensures that receipt of training documents from all employees. Assignment, tracking and notification systems are largely automated in Traumasoft. Traumasoft allows for the electronic dissemination of memorandums that require competency training which all employees must complete and acknowledge. Records of the completion are maintained by the Training Department.

D. Process for Identifying Training Issues

This step is done by HR and QA group. If the issue at hand is related to training, the group will specify to the training department what is needed. If the issue is an individual issue, it will be handled with a written PIP and administered by the QA representative in the region and/or the division management.

Further issues can be identified to trend analysis, for example if it has been noted that destination mileage has been omitted from multiple PCRs and the QAS identifies this as a trend, the TAG will make a recommendation to operational support that the need for training exists. From there the training department will complete an analysis to determine where a training gap exists and then formulate training. Training will then be delivered to all applicable staff with information and evaluation for competency.

E. Continuing Education

It is the responsibility of the VP, Clinical Coordinator and Training Director to ensure continuing education is occurring at appropriate regular intervals. The training director will ensure that the proper person is training on specific subjects and that the minimum requirements for education and training are met and compliance with Title 22 requirements governing education.

F. Ongoing Training

Yearly , the Training Director, QA Team and HR Team will evaluate the overall training program and its effectiveness. Service goals will be evaluated along with successful completion rates and any related issues reported within the year. The QA Team and Training Team will develop training strategies to ensure that goals

are met for the following year. This may include utilization of FTO's and other trainers in the organization to carry out the goals.

G. Data Validation

Daily and retrospectively, Norcal dispatch maintains a system of review to assure data accuracy; dispatch supervision and the data group maintain accuracy and requests for data.

H. Program Review

Norcal Ambulance will at minimum yearly, conduct a program review by the Quality Committee and dispatch supervisor.

I. HIPAA Compliance

The Quality and Compliance Officer will monitor dispatch to ensure compliance with all HIPAA requirements. Dispatch supervisor will maintain continuous real time ongoing monitoring of personnel compliance.

J. Records Storage

Norcal Ambulance maintains policies for the retention of medical dispatch call logs, records, tapes, and PCRs for a minimum of 180 days, or as required by Federal, State, Departmental or Company record retention and destruction policies, whichever is greater.

Through internal policies and procedures for collecting QA data. All required data reports will be submitted to the LEMSA as requested.

K. Reporting of Unusual Occurrence Events

Norcal Ambulance has established internal policies and procedures for collecting QA data. All required data reports will be submitted to the LEMSA as requested.

Sentinel event and exception reports shall be submitted to the EMS agency as required in LEMSA policy.

Internal policies and procedures for providing tapes or call logs to the EMS agency have been established for quality improvement review.

L. Employee Recognition Program

Norcal Ambulance maintains a formal process to recognize excellence through employee recognition programs and initiatives. Furthermore, all employee recognition is managed by the Culture department.

VI. Annual Update

The EQIP will be reviewed yearly by the Quality Committee and Medical Director. The plan will be revised as needed at least once a year. The EQIP is to be reviewed by the LEMSA or the EMSA at least every five (5) years or sooner if requested. Maintenance of the EQIP is the responsibility of the VP of Quality.

A. Norcal QI Goals and Objectives

Norcals QI mission is to ensure that quality emergent and non-emergent medical transport is readily available and done so with excellent customer and patient service.

More specifically Norcal Ambulance has the following goals and objectives:

- ➢ Steadily improve as the company grows and expands by measurable means (indicators)
- ➢ Continue to find areas that need improvement and make the company more streamlined and efficient
- ➢ Review clinical data for adherence to protocols and clinical practices
- ➢ Improve our educational access and provide more continuing education opportunities for our employees
- ➢ Maintain and enhance open lines of communication with outside agencies for quality communication

B. Norcal 2021

The following was under review for all ALS, CCT, and BLS operations in 2021:

- ➢ 5150 Transports
- ➢ Covid-19 calls
- ➢ High risk epidemiology calls
- ➢ High acuity calls
- ➢ BLS epi usage
- ➢ BLS Naloxone usage
- ➢ BLS Glucometry
- ➢ Patient assist device tracking
- ➢ High acuity CCT calls
- ➢ High acuity ALS calls
- ➢ Track accident data
- ➢ Cardiac arrest / ROSC
- ➢ PCR Amendments/Doc Errors
- ➢ Vaccine Administration Shifts

Data Retrieval and Reporting

Norcal attends all required LEMSA QA/CQI meetings and reports as requested all relevant data. We keep open communication with key hospital staff and can request feedback/information as needed in compliance with HIPAA guidelines.

Critical Skills
Critical skills are flagged through either ePCR report or TS unusual occurrence forms. When they are identified the PCRs are then reviewed by either the QA Manager, ALS Supervisor or CCT management. All data gather from these PCRs are tracked and recorded in the monthly QA Dashboard.

2021 Policy Updates and Revisions

- New Policies:
  - Policy 200.319 EMResource/Reddinet Monitoring
  - Policy 300.421 Patient Destination Determination
  - Policy 300.422 Do Not Resuscitate Orders (DNRs)
  - Policy 500.414 COVID-19 Vaccination
- Revised Policies:
  - Policy 300.501 Mandated Reporting
    - Revised to include the reporting of suspected abuse in non-patients.
  - Policy 300.503 Patient Care Report
    - Revised to include language about leaving a copy of the PCR / EHR with the receiving provider.

In house policies are currently undergoing a full annual review as stated above. All information has been provided to the relevant staff, all policy amendments will be submitted and then reviewed by the board.

Trending Issues
Norcal monitors all relevant trends for mitigation of risk and enhancement of clinical provision. All trends are aggregated monthly via dashboard

2021 Issues Requiring Further Consideration in 2022

- Continue to track and monitor psychiatric calls as they have the propensity for high risk, elopement and potential EMS worker harm.
- Continue to monitor high risk epidemiology calls (i.e. COVID-19)
- Enhance completeness of charting from both a clinical and AR perspective
- Monitor safe transportation practices, track all code-3 driving.
- Track all documented unusual occurrences to create education for quality improvement and best practices.

2021 Findings and Outcomes

- **Psychiatric Transports -**
  Overview: In 2021 the QA Department reviewed 100% of all 5150 PCRs at Norcal. We continued to track buckle guard compliance in the counties in which they are utilized. We tracked all attempted and successful elopements for the year.

Issue: Attempted and successful patient elopements. Crews not identifying patients who should have the consideration of the use of restraints. Crews not knowing the protocols for the area they are operating in when it comes to psychiatric transports and restraints.

Improvement Plan: The QA Manager and the Risk and Safety Officer will work together to identify the main issue and create a plan to better improve the overall safety of our crews and patients.

Result: Hoping to decrease the amount of attempted elopement for the 2022 year. QA is continuing to review 100% of all psychiatric calls and tracking compliance. This is an ongoing KPI.

- **High Risk Epidemiology -**

  Overview: With the ongoing pandemic, we had the opportunity to learn as we go to develop the best practices for EMS providers and patients as the situation evolved. We added both COVID testing and COVID vaccination shifts in 2021

  Issue: As time progressed and new information / guidelines changed we had to consistently change our practices, tracking, PPE and care. With the COVID testing and vaccination shifts, this added an additional risk for the crews involved.

  Improvement Plan: Clear communication between all departments. Keeping everyone informed on any changes was key to keeping our crews safe. Dispatch had continuous tracking of PUI vs. confirmed diagnosis patients. As the severity of the situation appears to be getting better, we will continue to track our Company numbers and be able to quickly identify if we begin to see a surge in high risk calls. Employees are required to recertify both 'Aerosol Transmissible Disease' and 'Bloodborne Pathogens' certifications annually.

  Result: This is an ongoing KPI. As things evolve, we adapt. We are now also tracking Norcals participation with Covid vaccinations.

- **BLS Infrequent Skills**

  In 2021 we had 2 instances where a BLS crew utilized an infrequent skill. Both times our crew was FOS to a possible overdose and was able to administer Naloxone. Full QA investigation were completed and Operations reported the incident to the LEMSA.

- **Cardiac Arrest / ROSC**

  One documented cardiac arrest in the field with ROSC once at the diverted destination. A full CCT review was completed.

➢ **Medication Error**
In 2021 we had 2 documented medication errors. One CCT LOS and one ALS LOS. Both were investigated, reported and the involved employees were educated.

➢ **Vaccination Error**
We had two Covid-19 vaccination errors. Both were investigated and reported to the counties in which we were assisting.

Indicators Monitored	**Key Findings/Priority Issues Identified**	**Improvement Action Plan for Further Action**	**Were Goals Met? Follow-up Needed?**
5150 Transports	Policy compliance and safety practices	Evaluate industry standards and exceed them	Continual follow up needed
BLS EPI use	Monitor use	Track and evaluate	Ongoing
BLS Naloxone use	Monitor use	Track and evaluate	Ongoing
BLS Glucometer use	Monitor use	Track and evaluate	Ongoing
High Acuity CCT Transports	ECMO, LVAD, balloon pump	Track, evaluate, and educate RN personnel	Ongoing
High Acuity ALS Transports	Monitor response metrics and compliance	Track, evaluate, and educate ALS personnel	Ongoing
Track Accident Data	Mitigate risk	Track, evaluate, and have weekly reviews	Ongoing
Cardiac Arrest / ROSC	Code review, dispatch, clinical, definitive care	Track, evaluate, crew debrief, educate if needed	Ongoing
FOS Tracking	Mitigate risk	Track, evaluate, educate if needed	Ongoing
BLS to ALS Turnover	Review dispatch and clinical care	Track, evaluate, educate if needed	Ongoing
Code 3 Tracking	Mitigate risk	Track, evaluate, risk mitigation	Ongoing
Patient Incidents	Mitigate risk and ensure safety practices	Track, evaluate, risk mitigation	Ongoing



Emergency Medical Services
Quality Improvement Program (EQIP)

Submitted by:
ProTransport-1, LLC

2022 - 2023

In accordance with the standards of:

Emergency Medical Services Administrations Association of California

Effective Date: 01/2010

ProTransport-1
P.O. Box 7260
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ProTransport-1
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Introduction
ProTransport-1 is a leading inter-facility private ambulance provider in California. As such, our goals and responsibilities differ from a traditional 911 EMS model. We have implemented a "Total Performance Score" (TPS) methodology similar to that used in hospitals and the standard set by Centers for Medicare and Medicaid (CMS) as our CQI model.

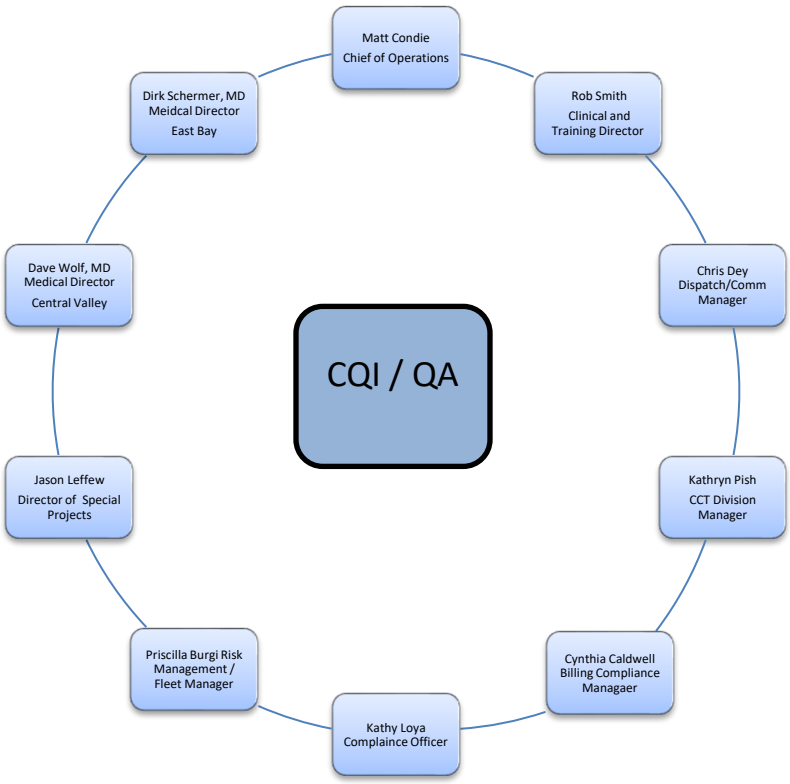
Our TPS consists of five domains:

- Clinical Process of Care
- Patient Experience
- Outcome
- Efficiency
- Operational Effectiveness

I. Structure and Organizational Description

A. Organizational Structure

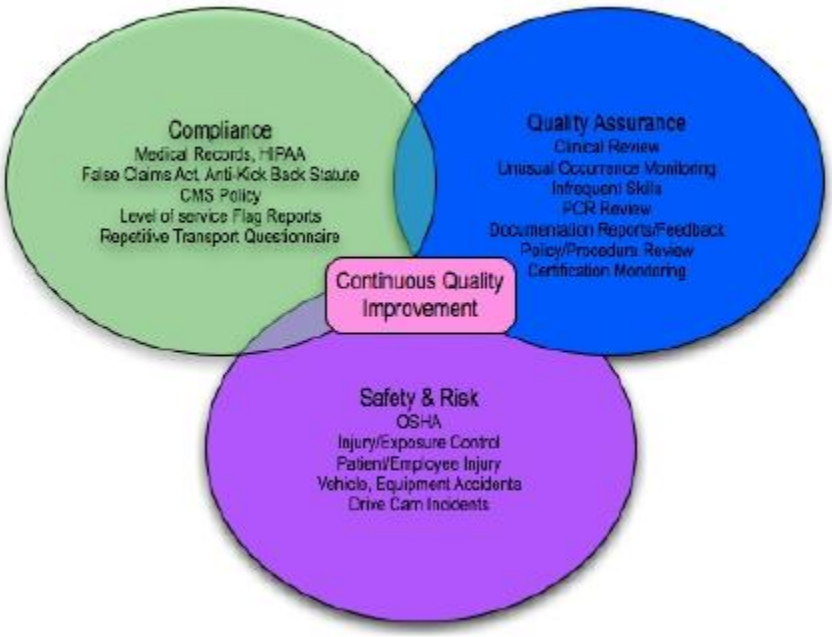
1. QA/CQI Committee
Led by the Director of Clinical Operations and Quality, the QA/CQI committee's primary duties are to identify through performance reporting (patient chart data, Accounts Receivable success rates, Call Center statistics, etc.) areas that can be improved in a collaborative manner to the betterment of the company overall. The committee interprets data and trends, working with department stakeholders to develop strategies to meet challenges and identify opportunities for improvement. This team audits individual employees, conducts QA reviews and evaluates data for trends. The committee acts as an advisory board to all departments in the company, offering trend data, insight and suggestions for improvement.



2. Leadership Group
The Leadership Group is the final decision making group for suggested operational changes or financial decisions. All competing organizational demands, conflicts, funding strategies and other logistical planning issues will be coordinated.



3. Risk Management, Saftey, Compliance and Quality Assurance
These three departments act in conjunction to reduce company risk and implement improvement plans.



4. Regulatory Management
Led by the Regulatory Manager with assistance from Operations, Fleet and Risk Management, this department ensures compliance with all applicable regulations and legislation.

- Maintains relationships with LEMSAs to ensure changes to policy are implemented in a timely manner
- Ensure all requirements for ambulance permitting and employee requirements are met
- Facilitate information exchanges with the appropriate departments and the LEMSAs

Field Operations and Regulatory Management along with Business Development seek and maintain relationships outside of our agency, specifically all EMS participants and facilities:

- Local EMS agencies
- Hospital and other healthcare facility partners
- EMS service providers
- Base hospitals
- EMS dispatch centers
- Labor and management
- Local departments of health
- Local, state and federal law enforcement
- Public safety answering points (PSAP)

B. Quality Improvement Mission:

QA/CQI Mission Statement: "The Quality Committee is responsible for identifying, overseeing and monitoring performance improvement activities of the company".

- Primary Duties: Identify through performance reporting (patient chart data, Accounts Receivable success rates, Call Center statistics, etc.) areas that can be improved in a collaborative manner to the betterment of the company overall

The company's mission, operating values and motto all reflect the central responsibility of developing a culture of quality. A continuous drive toward "doing the right thing right the first time" allows us to strive for excellence throughout all processes.

1. Services Provided

Sedan Services: Non-medical transportation for ambulatory patients to and from scheduled appointments and to home when other transportation is not available.

- Drivers selected for this position must have a clean driving record and be professional, courteous and customer service oriented. QA is based on customer feedback from sending/receiving facilities and from persons utilizing the service as well as UHU and OTP.

Wheelchair Services: Non-medical transportation for persons confined to a wheelchair but in no need of medical monitoring.

- This job position requires current CPR certification and a clean driving record. Drivers selected for this job must be professional, courteous and customer service oriented. QA is based on customer feedback from sending/receiving facilities and from persons utilizing the service. Monitoring of QA is largely based on trending of any unusual occurrences and the C.A.R.E.® Program as well as UHU and OTP.

Gurney Transportation: Non-medical transportation staffed with two attendants, this service is utilized for round-trip patient transport to doctor's appointments and procedures in a gurney (non-ambulance) van.

- This job position requires current CPR certification and a clean driving record. Drivers selected for this job must be professional, courteous and customer service oriented. QA is based on customer feedback from sending/receiving facilities and from persons utilizing the service. Monitoring of QA is largely based on trending of any unusual occurrences and C.A.R.E.® Program as well as UHU and OTP.

Basic Life Support (BLS): An ambulance staffed with two EMTs, these transports can be emergent or non-emergent, depending on the nature of the call and operational protocols determined by the LEMSA. BLS transports are conducted on ambulances certified by state (CHP) and county regulations for operation.

- EMTs must have current CPR certification, ambulance driver's license and DMV Medical Examination Report (DL51). Mandatory attendance and passing of ProTransport-1 field training program is required, as are ongoing training and any local accreditation requirements applied by the LEMSA in which they will be working. The BLS level of service requires a higher level of medical knowledge and decision-making ability. A list of associated QA activities include but are not limited to:
  - Partner, peer and station manager off-duty (OD) review
  - PCR compliance review
  - Unusual occurrence reporting system
  - C.A.R.E.® Program
  - New hire, ongoing training program and continuing education program (12 hours per year)

- Team member feedback forums
- Participation in QA/CQI Committee

Advanced Life Support (ALS): An ambulance staffed by one licensed paramedic as well as either another paramedic or an EMT. Transports can be emergent or non-emergent, depending on the nature of the call and operational protocols determined by the LEMSA. ALS transports are conducted on ambulances certified by state (CHP) and county regulations for operation.

- A licensed paramedic with current CPR certification, Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS) or Pediatric Education for Pre-Hospital Professionals (PEPP), trauma and hazardous materials training and either one EMT or an additional paramedic. Mandatory attendance and passing of ProTransport-1 field training program is required, as are ongoing training (including "lesser used skills") and any local accreditation requirements applied by the LEMSA in which they will be working. Paramedics are responsible for all of the company requirements for EMT and other QA guidelines listed below:
  - ALS PCR review
  - Station manager off-duty (OD) review
  - Unusual occurrence reporting system for the company and county
  - Continuing education program (24 hours per year)
  - Base hospital run review participation
  - Participation in QA/CQI Committee

Critical Care Transport (CCT): An ambulance staffed with two EMTs or one EMT and one paramedic as well as one CCT-RN. Transports can be emergent or non-emergent, depending on the nature of the call and operational protocols determined by the LEMSA. CCT transports are conducted on ambulances certified by state (CHP) and county regulations for operation.

- A licensed registered nurse (California State license required) with current CPR certification, Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS). Mandatory attendance and passing of ProTransport-1 field training program is required, as are ongoing training (including "lesser used skills") and any local accreditation requirements applied by the LEMSA in which they will be working. Adherence to QA guidelines listed below:
  - CCT PCR review
  - Unusual occurrence reporting system for the company and county
  - Continuing education program (30 hours per year)
  - Participation in QA/CQI Committee
  - Medical Director review and medical review participation

NICU/PICU & Specialized Team Transport: Specialized transport teams using ProTransport-1 team members and intensive care unit facility staff. This service is offered by contract with facilities having a recurrent need to transfer critically ill and injured neonates and children. NICU/PICU utilizes a designated NICU/PICU ambulance with specialized equipment and is staffed with two EMTs or paramedics and at least one specialty care RN from the sending facility to attend the patient and monitor equipment. Team transports are conducted on specially equipped ambulances designed by the facility and maintained by PT-1.

- Staffed with two certified EMTs with current CPR certification, an ambulance drivers license and DMV Medical Examination Report (DL51) as well as a specialized team from the sending facility (dependent on patient acuity; multiple team members may be sent including RN/RT/MD). Mandatory attendance and passing of ProTransport-1 field training program along with any local accreditation requirements applied by the LEMSA in which the EMTs will be working, orientation to NICU/PICU Unit and adherence to QI guidelines listed below:
  - CCT RN review
  - Medical director review
  - Unusual reporting system for the company and county
  - Integration with facility QI network

Medical Standby: Ambulance standbys can be provided at the BLS, ALS and RN service levels. The standby unit handles all care including the stabilization of acute medical conditions. If allowable by service area, patients may be transported by other ProTransport-1 units or the 911 system and the standby unit will provide supportive care and treatment until care can be transferred to transport personnel.

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2. Certifications - Required licensure, certifications and DMV qualifications (by position):

	CCT–RN	Paramedic	EMT	Wheelchair/Gurney/ Sedan Driver
RN License	■			
Paramedic License		■		
EMT Certificate			■	
ACLS	■	■		
PALS or PEPP	■	■		
NRP	■			
PHTLS or ITLS		■		
CPR	■	■	■	■
First Aid				■
County Accreditation		■	■	
Ambulance Driver License		■	■	
DMV Medical Examination Report (DL51)		■	■	
Hazmat FRA/FRO (First Responder Awareness/Operations)		■	■	
SEMS (Standardized Emergency Management System)		■	■	
AWR-160 (Terrorism Awareness)		■	■	
ICS (National Incident Command System - NIMS)		■	■	
IS-3 (Radiological Emergency Management)		■	■	
IS-704 (NIMS Communication and Information Mgmt.)		■	■	

3. System Goals

At the core of ProTransport-1's strong client relationships is a robust quality improvement and employee values system grounded in client service excellence, which is unique within the medical transportation market. The company's C.A.R.E.® program provides customers and patients with service surveys at the time of each transport, allowing ProTransport-1 to report statistics on a frequent, consistent schedule. To the patient population, the ambulance service is an extension of the hospital; the C.A.R.E.® program ensures patients and their families continue to receive high quality care on their way to and from the hospital. The system is also merit-based, rewarding and promoting team members who demonstrate compassion, attitude, responsibility and overall excellence in performing their duties as medical professionals. This creates a culture of positive, peer-based reinforcement among team members.

PT-1 Mission Statement, Operating Values and C.A.R.E.®

We bring patients and medical professionals together through mobile healthcare solutions and reliable transportation services.

We rank order four operating values so we can define, order and live by our beliefs.

Safe - Our actions are safe for ourselves, our colleagues, other professionals and the public.
Accountable - Our actions in private honestly match our publicly stated values and promises.
Friendly - Our actions are pleasing, agreeable, demonstrate respect and create harmony.
Efficient - Our actions improve through constant, collaborative fine-tuning, limiting resources and maximizing results for all.

We believe C.A.R.E.® encompasses our "professional, courteous, on time" promise to customers, and it is the heart around which our operating values were developed.

Compassion - A feeling of sympathy for one who is suffering in regard to patients, coworkers, facilities' staff and others.
Attitude - Positive, can-do, enthusiastic approach to interaction, communication and contact.
Responsibility - Being accountable to patients, the company, job duties, coworkers and facilities.
Excellence - Providing superior care to patients by going above and beyond duties consistently and continuously.

II. Data Collection and Reporting

A. Specific Quality Indicators

The tables below outline the Specific Quality Indicators measured by this program. Each indicator is followed by the objective that is being measured, how compliance to the indicator is measured, who is assigned to measure it and what specifically will be utilized in its measurement.

1. Personnel	Objective	Compliance	Department	Indicator
Continuing Education	All team members will comply with CE hour requirements; 24 for EMT, 48 for Paramedic, 30 for RN. Lesser-used skills training will take place annually or as mandated by the LEMSA. Communications center team members will maintain NAEMD certification.	Certifications, licenses and CE hours will be monitored on a regular basis	• Human Resources	Number of expired certifications, licenses per year, and CE hours per team member per year
Education and Training	To conduct ongoing training for all staff members Ensure compliance with HIPAA, bloodborne/airborne pathogens and LEMSA recommendations	Track the number of personnel who complete training	• Training	Number of personnel who meet quarterly/ annual training standards
Qualifications	Ensure all personnel will provide verification regarding their current licensure, certification and DMV qualifications as well as a criminal background prior to commencing employment	All candidates will submit certificates, licenses, records and documents during the application process, verified during the interview by the Human Resources Department. Team members receive automatic renewal reminders at intervals that a required certification is due for renewal; scheduling receives daily "expired" certifications report.	• Human Resources • Scheduling	Monitor number of delinquencies per year and number of days lost due to expired certifications
Well Being	All team members will be monitored for their well being with regard to physical and mental health	Number of sick calls, absences, workers' compensation claims, accidents, fatigue, complaints will be monitored on an ongoing basis	• Human Resources • Risk Management	• Number of lost days and injuries

2. Equipment & Supplies	Objective	Compliance	Department	Indicator
Inventory Control Systems, Pharmaceuticals	Ensure all equipment and supplies are available ensuring the most efficient use of assets; communicate information promptly regarding recalls, expirations and changes to medication protocols are promptly and accurately disseminated to all stakeholders; Ensure availability of medications to meet LEMSA requirements; track "Nationwide Shortage" information for preplanning of inventory needs	Implementation of OPIQ to all stations; quarterly inventory tracking; station to station transfers for increased efficiency; input of inventory by Lot # and Expiration to maintain notification of expired, low inventory items	• Vendor Relationship Manager	Number of urgent supply orders; % over budget for supplies; number of equipment failures
Narcotics Control	Adherence to all DEA regulations	Implementation of "Narc Logic" RFID tracking; 100% review of calls utilizing narcotic administration	• Clinical Operations	• Any discrepancy in Data logs, cards, Usage followed up to verify compliance
Preventive Maintenance	Ensure all PM is completed on all equipment	Regular PM schedules will be maintained and updated	• Vendor Relationship Manager	Number of PM items that do not get completed annually
Technology	Utilize secure, cutting-edge technology Ensure our customers and patients receive the safest and most efficient care	Implementation of the next phase of ImageTrend ePCR; good utilization of ePRO; implementation of new HRIS system	• Director of IT	Good user feedback, more efficient communications; implementation of NEMSIS/CEMSIS-compliant data
Vehicles	Fleet Maintenance is ensured at a high level and PM performed on a regular basis; good system in place to handle replacement vehicle needs	OPIQ tracking of Fleet Performance, maintenance; black box in ambulances utilized to its fullest extent for proactive notification of issues	• Risk Management	Number of PM visits per vehicle/year; number of breakdowns

3. Documentation	Objective	Compliance	Department	Indicator
ePCR Compliance and Medical Necessity	Implement new ImageTrend templates; bring CCT Division online PCRs consistent with LEMSA requirements; accurate/complete documentation	Validation rule compliance; implementation of others as needed. Increase narrative specificity to comply with ICD-10	• IT • Operations • Compliance • Clinical Operations • CCT	Validation %, Narrative specificity increase to ICD-10 guidelines; # PCRs sent back to field providers
HIPAA Compliance	Ensure compliance with HIPAA regulations	Completion of annual HIPAA training; continuing education as needed	• Compliance	% of personnel to complete HIPAA training; # HIPAA violation incidents (zero tolerance)
Medical Records	Ensure all PHI is secure	Annual review of storage sites, transport of medical records, security of technology	• Compliance	Any failure to secure records –loss of records or inaccessibility
Patient Care Report – Data Accuracy	Accurate data reporting	Regular review of data accuracy, "report card" from AR and Performance management	• Compliance • Communications Center • IT	Data reports; Logis input; AR LOS downgrades due to data error

4. Clinical Care & Patient Outcomes	Objective	Compliance	Department	Indicator
Adherence to Policy and Protocols	Review of PCRs Ensure adherence to LEMSA guidelines, best practices	50% of ALS, 10% of CCT 30% of BLS and 15% overall; all PCRs where narcotics were administered	• Compliance • Clinical Operations	Development and implementation of Personal Improvement Plans (PIP) for incidents or identification of training opportunities.
Clinical Competency	Ensure 100% review of any untoward patient outcomes, complaints, problems	Clinical review of any UO related calls, PCRs	• Clinical Operations	Clinical Review Board meetings on any UO related calls; outcomes determined on a case by case basis
Frequency Patients	Ensure frequency patients are evaluated monthly to ensure LOS requirements are met	Monthly RTQ (Repetitive Transport Questionnaire) completion	• Compliance	Number of RTQs completed by month
Patient Outcome Tracking	Call to all home discharged patients for follow up	90% of all discharged to home patients are called	• Business Development	Any issue related to patient discharge

5. Skills Maintenance & Competency	Objective	Compliance	Department	Indicator
EMT	Ensure skills sets are maintained and competency assured through usage, review, training	Ensure training completion; ensure training parameters meet cognitive, affective and psychomotor parameters	• Training	Completion success rates and amount of training completed annually per employee; maintenance of CE requirements
Paramedic	Ensure skills are maintained and competency assured through usage, review, training; adherence to lesser used skills review	Ensure training completion; ensure training parameters meet cognitive, affective and psychomotor parameters	• Training	Completion success rates and amount of training completed annually per employee; maintenance of CE requirements
Retrospective PCR Review	Review of ALS/CCT PCRs Ensure tracking of skills	Track success rates of IV starts, advanced airway maneuvers, medication administration, defibrillation, TCP; any lesser used or expanded scope of practice skills	• Clinical Operations	Success rates of all evaluated skill sets
RN	Ensure skills are maintained and competency assured through usage, review, training; adherence to lesser used skills review	Ensure training completion; ensure training parameters meet cognitive, affective and psychomotor parameters	• Director of CCT	Completion success rates and amount of training completed annually per employee; maintenance of CE requirements

6. Transportation & Facilities	Objective	Compliance	Department	Indicator
Long Distance Transport	Evaluation of all LDT calls to meet LEMSA guidelines	100% of calls follow LEMSA guidelines	• Communications Center	Any issue with pick up location or call
Lost Calls	Track lost calls due to unavailability, incompatible ETA, LOS availability	CAD monitoring, Medlert data to track turned over or not run calls	• Communications Center	Number of lost calls during reporting period
On-scene Downgrades to LOS	To determine the number of calls that are downgrading upon arriving on scene (CCT to ALS or BLS, ALS to BLS, BLS to Gurney or WC)	Track number of calls subjected to downgrade at the time of service; number of calls downgraded at the AR level	• Compliance • Communications Center • AR	Number of downgraded calls

On-time Performance	To determine global, county, facility on- time performance	On-time performance is managed by the Logis CAD and resources are added as needed to adjust for system changes	• Utilization and Resource Management	On-time %
Response Times	Ensure response time performance meets the parameters set by contract, LEMSA	Track response time performance	• Utilization and Resource Management	% of calls that meet response time contractual obligations, LEMSA requirements
Time on Task	Ensure that time on task is not affected by factors within our control	Track time spent on each call to ensure unit efficiency	• Utilization and Resource Management	Amount of time per call by type

7. Public Education & Prevention	Objective	Compliance	Department	Indicator
Customer Satisfaction	To maintain high levels of customer satisfaction	Active tracking of C.A.R.E.® cards, complaints	• Marketing Communications • Business Development	C.A.R.E.® card %, numbers of complaints and resolution
Reward and Recognition	To maintain high levels of employee satisfaction	Inclusion of employees in satisfaction surveys, follow up on complaints, regular feedback	• Marketing Communications • Human Resources	Feedback from exit interview survey, FTO survey, employee turnover

8. Risk Management	Objective	Compliance	Department	Indicator
Disaster Preparedness	Ensure all stations, HQ and personnel have a disaster preparedness plan; ensure a notification plan is in place in the event of an emergency; ensure cooperation with LEMSAs regarding disaster management	Prepare disaster plan, ensure compliance of all stations, review HR/communications center notification plan	• Risk Management	Number of plans in place; notification plan in place
Injury/Exposure Reporting	Ensure all injuries/exposures are reported	Follow up on any report of injury or exposure Ensure correct reporting and notification guidelines are followed	• Clinical Operations • Risk Management	Number of injuries/exposures not reported in a timely manner

OSHA Compliance	Ensure 100% of operations are compliant with all OSHA standards	Follow up on any reports, incidents, exposures for possible global issues related to safety; retrain any personnel, update procedures for increased safety compliance	• Risk Management	Number of injuries/exposures
Safety Meeting Compliance	Ensure monthly safety meetings are held at each station	100% of stations conduct monthly safety meeting	• Risk Management	Number of safety meetings conducted per month
Unusual Occurrence Reporting	100% review of all UO reports; ensure sentinel events are reported up the chain of command	Ongoing tracking of UO system, notifications	• Risk Management • Clinical Operations	Number of UOs not reported in a timely manner, increase in the number of sentinel events
Vehicle Accidents	Reduce the number of vehicle accidents; reduce $ amount of insurance reserves	Ongoing tracking of number of vehicle accidents, incidents, DriveCam incidents	• Risk Management	#/$ accidents, resulting WC claims, patient injuries, $ reserve
Workers' Compensation	Reduce the number of employee injuries	Ensure RTW program is working; institute IPP, ensure retraining of employees takes place	• Risk Management • Human Resources	Number of injuries/exposures

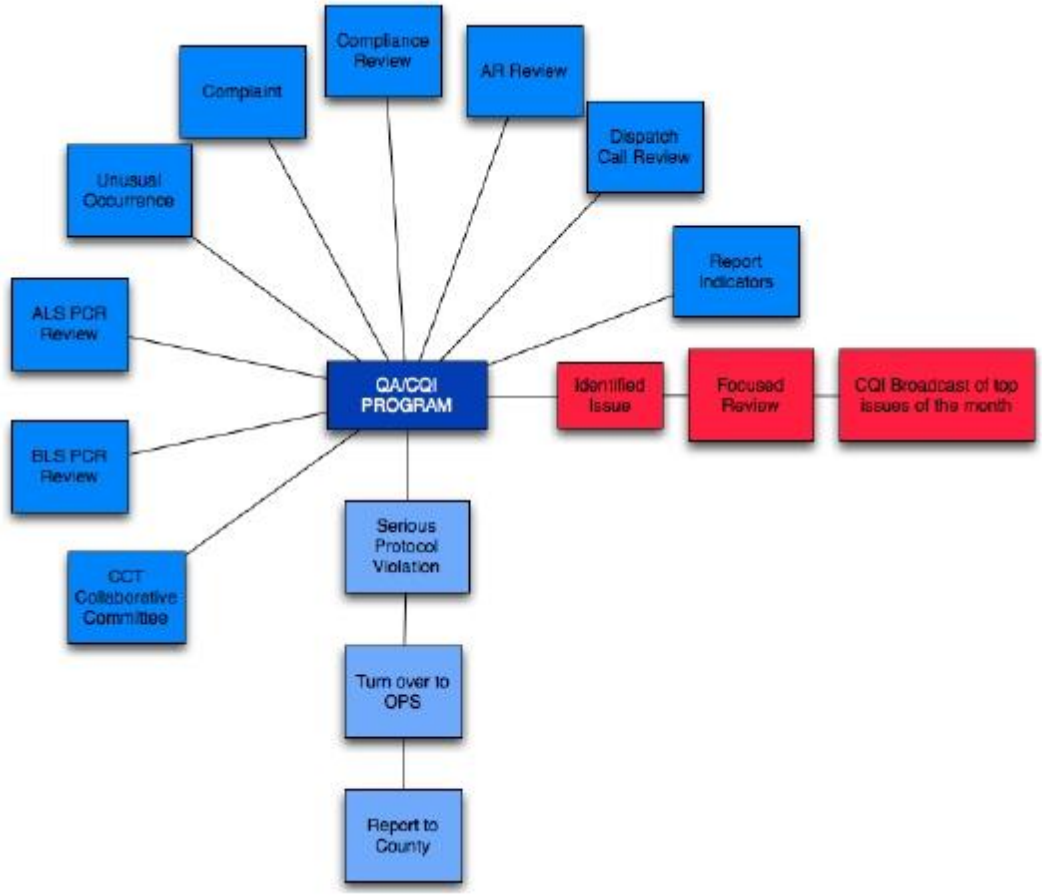
9. Other	Objective	Compliance	Department	Indicator
Vaccinations	Ensure employees comply with annual Flu vaccination	Employees obtain an annual Flu vaccination or mask in patient care areas; 90% vaccination rate in line with CA regulations	• Human Resources • Clinical Operations • Marketing Communications	% of employees by station that do not get the Flu vaccination

B. Process

ProTransport-1's quality and customer service focus leads us to choose indicators that may not be traditional in a 911 EMS model. We focus on serving patients, many of them elderly, who need transportation between medical facilities, efficiently connecting each with the right level of service. Doing the right thing, at the right time, for the right reasons is our service commitment.

Our Continuous Quality Improvement model looks at the process while improving performance on an individual level. Specific Quality Indicators are chosen with this in mind. The steps in the process are:

- Establish criteria for measurement and improvement
- Evaluation of information
- Identification of core problem or area for improvement
- Identification of alternatives
- Plan development – criteria to be measured, methodology
- Implementation, measurement of results
- Determine if changes are adequate to address issue
- Integrate plan changes into the system
- Establish monitoring guidelines for future activities



The QA/CQI Committee reviews reports and data from these indicators. Reviews of incident or unusual occurrence reporting will reveal deficiencies in a process that will require improvement. Analysis may reveal that a particular issue should result in a new or improved process.

Systems identified as contributing to the incident are analyzed and amended as needed. Training and remediation opportunities are identified and forwarded to the Training Department. Levels or thresholds relating to reporting requirements of the LEMSA are evaluated by the Director of Clinical Operations and Quality and forwarded to the applicable county notification forum.

1. Unusual Occurrence Reporting

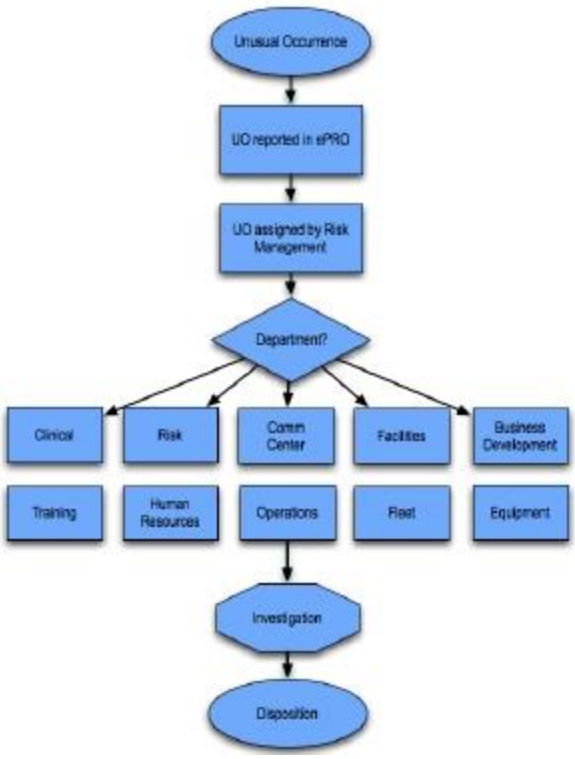
One such method is Unusual Occurrence reporting. Reports are generated in our online system. All team members have access to this method of reporting and can access it at anytime while on duty or not. UOs are reviewed on a daily basis and follow a strict reporting guideline dependent on the issue. Examples of the types of issues reported are:

- Injury or non-injury vehicle accident
- Patient or employee injury or exposure
- Incident with a facility, customer, patient
- MCI/disaster involvement
- APS/CPS Notification
- “On view” incidents
- Hospital diversion
- AMA/RAS, non-AMA refusal of care or transport
- Delay in patient care
- Accusation of wrongdoing
- BLS Code 3 response or transport
- Any condition or situation that represents a threat to team members, public safety or health
- Any event deemed unusual or a report requested by a supervisor

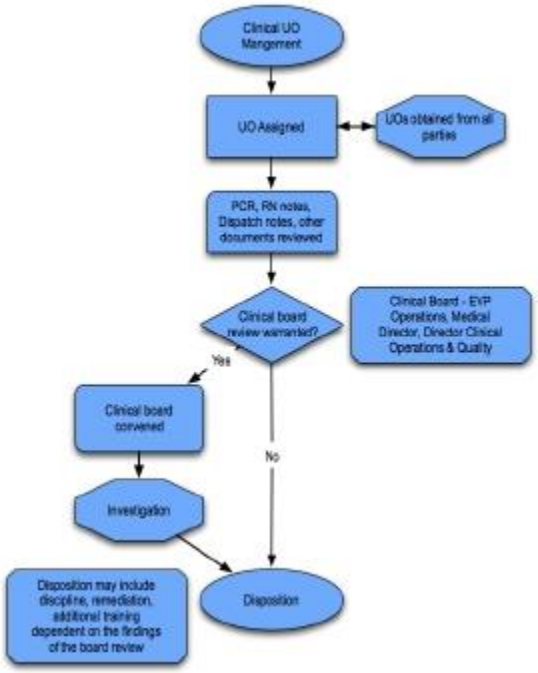
Advanced Life Support (ALS) mandated reporting requirements include those listed above and also the following:

- Any circumstances adversely affecting patient outcomes
- Misplaced endotracheal tubes
- Delivery of an incorrect medication
- Dosage errors
- Damaged/missing controlled substances
- Deviation from local protocol
- First responder transfer of care issues

The UO process flow is charted to the right:



As an example of the UO management process, the chart below outlines the Clinical Review process. This process is initiated anytime a clinical patient care issue arises:



2. PCR Review Process
The ALS review process is conducted by the QA coordinator. Currently, ProTransport-1 provides ALS services in three areas, each under a different LEMSA. 50 percent of these PCRs are reviewed. Issues identified are reviewed and followed up by the QA coordinator; if a serious issue arises, a UO report will be generated and the incident moved up to the Clinical Review Board. The CCT Division reviews 10 percent of CCT PCRs by double review – first by a peer and then the CCT Supervisor. 100 percent of emergent transports and/or sentinal events are flagged and reviewed due too their lower overall occurence

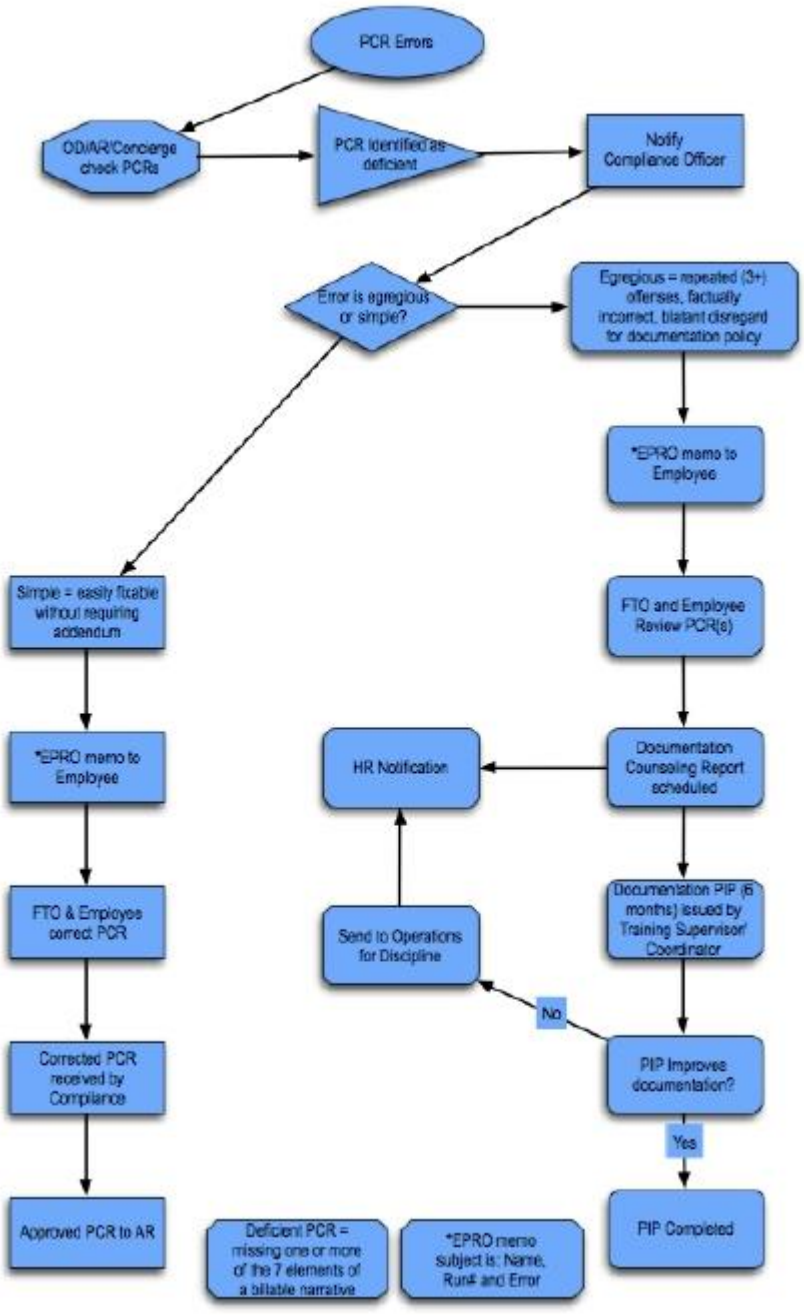
In 2015 we completed the rollout of ePCR for our BLS and ALS divisions. The ePCR review process is based on predetermined validation rules. Currently, there are 249 validation rules (Appendix A). The validation process only allows PCRs meeting 95 percent or better compliance to be turned in.

In 2018 we implemented the UltraForm ePCR, which is essentially a single ePCR worksheet that expands as needed based on treatment level of service (BLS, ALS, CCT). This allowed for better implemntation of core measure tracking and validation as single rules would apply across all levels of service.

Crewmembers are eligible for a status symbol of their good documentation. The Compliance Department's "Pink Shears of Perfection" program awards colored trauma shears to crewmembers whose reviewed documentation scores at least 22 points out of 25 for three months. If they demonstrate a high score for three months, they are awarded pink trauma shears. At six months, they receive coveted camouflage trauma shears.

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The Compliance Department has a meticulous program for correcting PCRs, following up on training issues and instituting PIP plans for documentation. This process is outlined here:



C. Data Collection Responsibilities

ProTransport-1's Performance Management Department as well as Utilization and Resource Management perform the company's data analysis. Reports are generated daily, weekly, monthly and annually in accordance with company needs and requirements. See the specific quality indicators in section II for examples of reports. Frequency of reporting is dependent on the need.

The Performance Management Department can create reports specific to the indicator or issue needing improvement. Pertinent information will be forwarded to necessary personnel should remediation be necessary.

D. Reporting

Examples of regular reporting:

Report	Frequency	Delivery	Data
UO	Daily	Risk, Field Operations, Clinical, Comm Center, Business Development	Injury/exposure, patient outcome/complaint/dispatch issue, facility issue
Accidents	Daily	Risk	Type, injury, cost
C.A.R.E.®	Monthly	MarCom, HR, Operations, Business Development	Employee ranking, comments
CAD Facility analysis	Daily	Operations, Business Development	Types, calls, volume
CAD Volume	Daily, Weekly, Monthly	All Departments	Calls by level of service
Certifications	Daily	Scheduling, HR	Expired certifications
LOS Downgrades	Monthly	Compliance, AR	Downgrades to level of service
Employee Time & Attendance	Daily	Scheduling, Payroll, HR	Late, absent, no show
Late Calls	Daily, Weekly, Monthly	Operations, Comm Center	Late calls by region
Narrative Quality	Monthly	Compliance, Clinical	
On-time Percentage	Daily, Weekly, Monthly	Utilization, Comm Center, Operations	OTP by region
PCR Completion	Daily	Compliance, Off-Duty	
Unit Hour Utilization	Daily, Weekly, Monthly	Utilization, Comm Center, Operations	UHU by region
Workers' Compensation	Weekly, Monthly, Annual	Risk, HR, Operations	Types, cost

III. Evaluation of Indicators

A. Indicators

Reports are evaluated by department directors on a regular basis: daily, weekly and/or monthly, depending on the indicator. Various departments compile reports while data is gathered, analyzed and produced by the Performance Management Department. See "Specific Quality Indicators" in Section II.

Department	Report	Frequency
Field Operations	Time and attendance	Daily
	Calls by LOS	Weekly, Monthly
Communications Center	Long distance transports – distance, time on task, frequency by facility	Monthly
	Incoming calls, faxes, electronic ordering	Weekly, Monthly
	Customer service quality	Daily, Weekly
	Time per call, per agent	Monthly
Compliance	PCR completion	Monthly
	PCR send backs	Monthly
	HIPAA training	Annually
	Code of conduct	Bi-annually

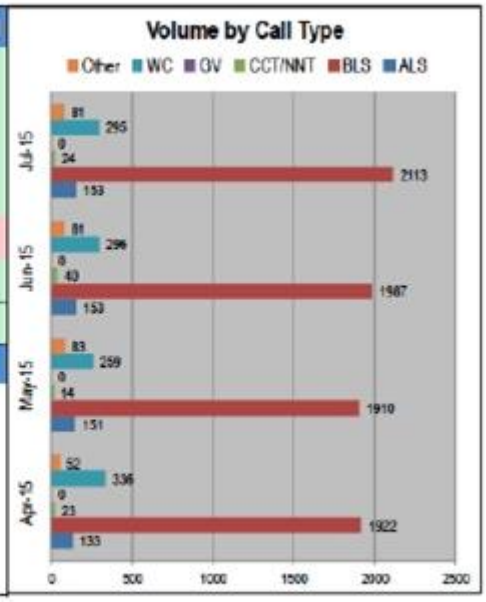
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Department	Report	Frequency
Clinical Operations	Narcotic tracking	Weekly
	PCR audits	Weekly
	Cardiac arrest	Monthly
	STEMI transports	Quarterly
Utilization and Resource Management	On-time performance	Weekly, Monthly
	Unit hour utilization	Previous Day, Month to Date, Weekly, Monthly
	Time on task – on-scene time, time at destination	Weekly, Monthly (by region)

B. Analysis

Data is presented in various forms depending on the report and the audience. Examples of reports from our monthly global leadership meeting presentation are below:

Volume	Apr-15	May-15	Jun-15	Jul-15	4-Month Trend
ALS	133	151	153	153	15%
BLS	1922	1910	1987	2113	10%
CCT/NNT	23	14	40	24	4%
GV	n/a	n/a	n/a	n/a	n/a
WC	336	259	296	295	-12%
Other	52	83	81	81	56%
TOTAL	2466	2417	2557	2666	8%
KPIs	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**4-Month Avg**
UHU	0.40	0.37	0.39	0.41	0.39
Units	679.00	733.00	761.00	753.00	731.50
Time on Scene	32.14	24.39	39.47	39.92	33.98
Time on Task	81.03	70.48	96.10	100.40	87.00
On Time %	96%	94%	95%	96%	95%
C.A.R.E. %	90%	98%	97%	0%	71%

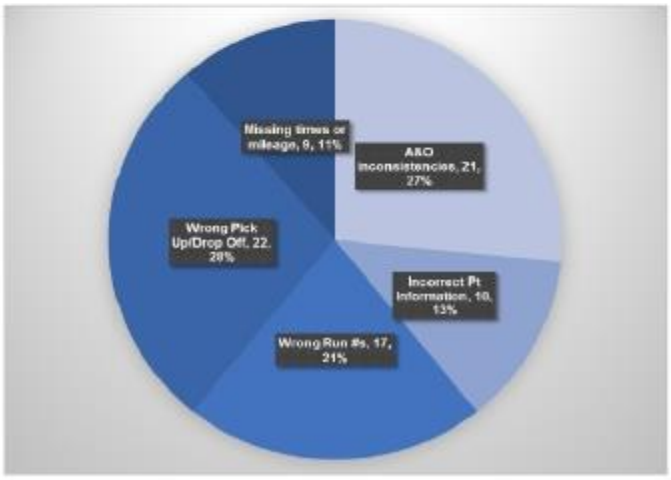


Biweekly Volume & Performance



	05/11/2015		05/25/2015		06/08/2015		06/22/2015		07/06/2015		07/20/2015	
	Trips	Mix	Trips	Mix	Trips	Mix	Trips	Mix	Trips	Mix	Trips	Mix
TOTAL	5435		5174		5444		5216		5358		5408	
BLS NE	4069	74.9%	3727	72.0%	3888	71.4%	3669	70.3%	3743	69.9%	3677	68.0%
ALS / BLS E	431	7.9%	505	9.8%	478	8.8%	520	10.0%	527	9.8%	626	11.6%
CCT / NNT	457	8.4%	426	8.2%	445	8.2%	420	8.1%	421	7.9%	437	8.1%
Van & Other	478	8.8%	516	10.0%	633	11.6%	607	11.6%	667	12.4%	668	12.4%
OTP	90.75%		91.74%		90.92%		94.50%		93.74%		93.83%	
A/hb UHU	0.304		0.288		0.285		0.281		0.287		0.284	

PCR Send Back Reasons



QA/CQI Committee

QA/CQI meets quarterly and on an as needed basis to deal with urgent issues. Examples of meetings are as follows:

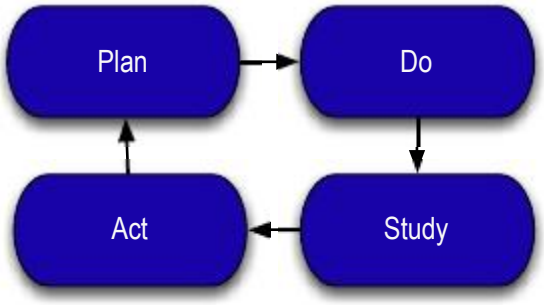
- Weekly clinical and compliance meeting
- Monthly station meetings
- Quarterly global leadership meetings
- Quarterly compliance meeting

IV. Action to Improve

A. Approach to Performance Improvement

At ProTransport-1, we are in a continuous cycle evaluating daily, weekly, monthly and overall to determine if our goals, both strategic and tactical, are met.

We utilize the PDSA model of CQI which is divided into the following four phases:



Plan: Planning is the most rigorous part of the CQI plan. Options are considered and reconsidered before a concrete plan is formed. In order to determine the focus of the project, multiple steps will be taken in this phase.

Determine the focus of the project:

- What is the target of the improvement effort?
- What needs to be improved?
- What is the most problematic or costliest area?
- What are the costs – time, resources, and money?
- What is the data telling us?
- Is there an easier or more cost-effective option?

Establish the team:

- Who will lead?
- Who are the stakeholders both in and out of the organization?
- Who should facilitate the process?

Establish goals:

- Set the goal or target to define the result or purpose
- Establish accountability

Define the current process:

- What are the problems we are trying to solve?
- Are there workarounds in place?
- Flow chart the current process

Examine solutions:

- Avoid doing more of the same thing that isn't working
- Look beyond the obvious – think creatively

Select a change:

- What do we do next?
- What are we trying to accomplish?
- Does the proposed change meet these goals?

Do: This is where implementation takes place. The actions proposed by the plan are put in place and information is collected about the change.

Study: The CQI team will study the results of the change, and analyze data and observations of the changes the "Do" phase implemented.

Act: This phase decides what the next step is. What did we learn? Did the data support our plan or not? From here, we will review the planning phase again implementing change based on the data that was collected and analyzed.

B. Improvement Action Planning and Implementation

QA/CQI Committee: This group is the fabric for making intentional changes to improve quality. Changes implemented by outside agencies will be reviewed and assigned depending on the issue. If necessary, we will seek consult by the agency requiring the change. Specific examples include new driving laws or new local EMS requirements.

This group will also be the first point of contact for improvement action planning and data collection.

Specialty Task Forces: One of the greatest resources in action planning and implementation will be specialty task forces that are created to deal with specific issues that arise. The members of the task force will represent the different functions of the action item being planned and implemented. Task force members will be assigned responsibilities according to their area of expertise and utilized for continuing follow up on plan success.

C. Systems to Communicate Issues Regarding CQI to Stakeholders

Contacts are made from the LEMSAs to the individual stations via the station managers. In ALS areas, the lead paramedics regularly attend EMS meetings to stay abreast of changing information and are the first point of contact regarding any EMS issues. Facilities and customers are contacted on a regular basis through our Business Development Department at the Regional Relationship Manager level as well as the BD-EMT level. For example, our San Francisco operation has regular contact via email or phone at different intervals with the Department of Emergency Management:

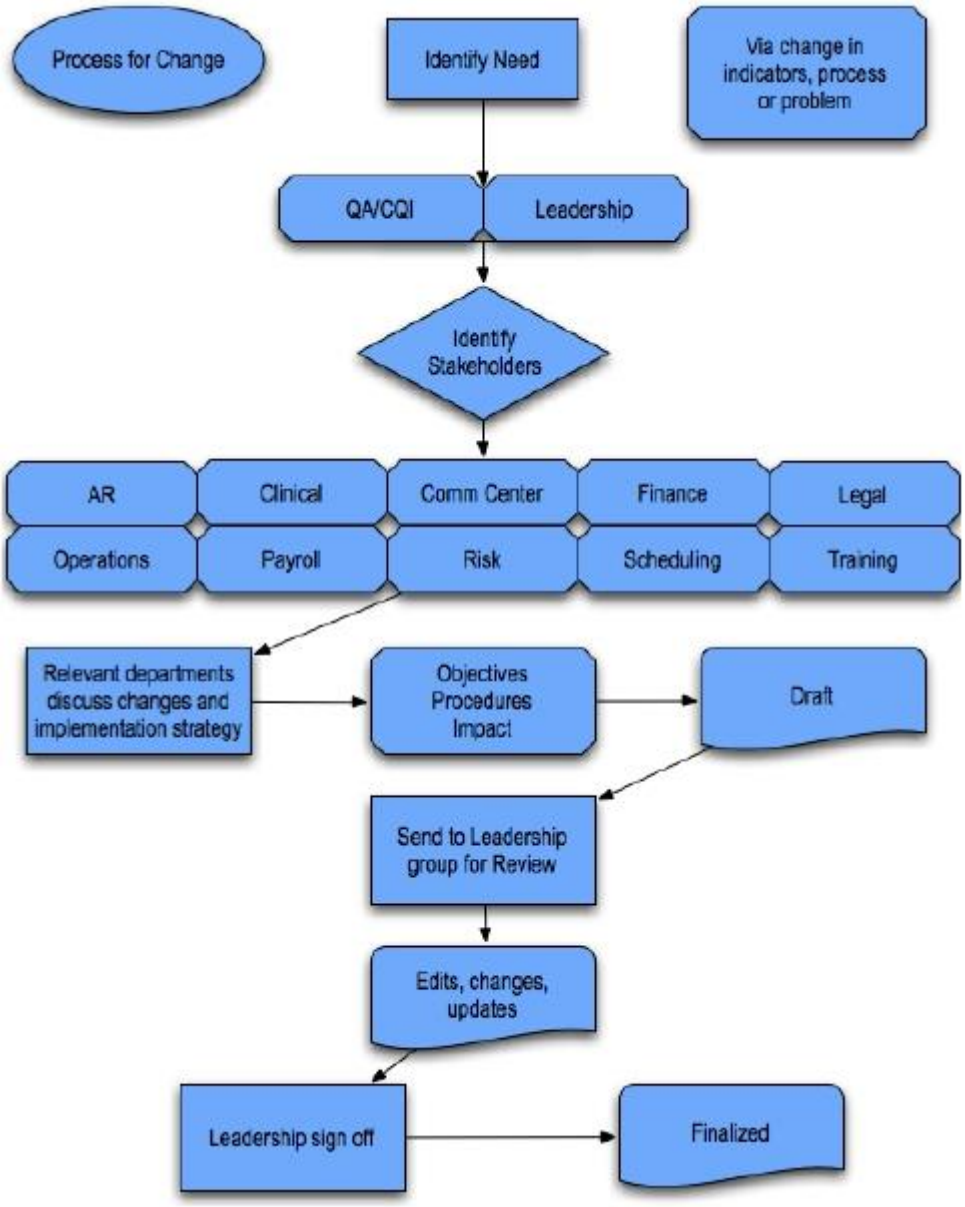
- Deputy Director of Division of Emergency Services
- Division of Emergency Services QI Manager
- Emergency Services Agency Hospital Liaison
- Emergency Medical Services Administrator
- Pre-Hospital Coordinator
- Medical Director

D. Planning Process for Change

Identification of issues to change can come from any area. The QA/CQI committee is the oversight body that will analyze and determine what indicators are trending. As an advisory body they will make recommendations for improvement and pass along this information to the affected department. Once issues have been identified in any of the above listed indicators the department head will convene a group to implement the changes that are required.

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Our change process is outlined here:



V. Selection, Training and Education

A. Program Description

Selection: The selection and screening process for new team members is administered and monitored by the Human Resources Department. It involves recruitment, an application and screening process that seeks to match qualified applicants in a non-discriminatory manner through testing and matching needed skills.

New Team Member Orientation Program: New team members undergo various levels of training in order to prepare them to function competently in the field. The orientation is a 16-hour training that consists of the company overview, basic health and saftey requierments, CA Prop 11 components, emergency vehicle operations, local area/LEMSA requierments, back saftey and lifting, ALS and CCT overview.

Initial Training: Field team members attend the 16-hour introductory class and, after successfully passing, the team member is assigned a Field Training Officer (FTO) for a minimum of 4 shifts or 40 hours. Additional classroom training takes place specific to each county requirement. New hire trainees are evaluated daily using a standard training evaluation and do not work a regular shift until training has been completed. Training consists of all aspects of patient care, including: patient assessment, patient treatments/interventions, lifting, equipment operations (gurney, cardiac monitor, etc.), charting, driving, radio operations, local requirements and reporting.

Structured Probationary Training Program: This is a structured program consisting of training assignments, testing and evaluations that allow the new hire more detailed information regarding the job in order to be successful. Some of the items included in this program are knowledge of company policies, geography, knowledge of facilities, county regulations, injury prevention and protocols. Assignments must be signed off by the team member and an FTO, supervisor or manager once the team member has completed each assignment, taken the online test and is able to demonstrate competency.

Probation Evaluation: Before a field team member can pass from probation (1,040 hours or one year from hire date), they must undergo a probationary period training evaluation. At this time, the team member undergoes a review of documentation, attendance and customer service.

Safety Workshops: Quarterly (or more often as needed) safety workshops are conducted for all team members. This can be a part of assessment, treatment, reporting or any patient care component that needs improvement or refreshing, such as infrequently used skills.

Monthly Focus: The Training Division assigns “Monthly Focus” topics which are assigned companywide. These are topics identified by the Training Department, Quality Improvement Program, Risk Management, Compliance or other aspects of operations needing additional training and/or focus.

Continuing Education Program: The Continuing Education Program is organized, administered and reviewed by the Training Director and Manager. The program may be offered through online, classroom or hands-on training for maintenance and development of skill sets for practitioners. Continuing Education Units (CEUs) will be assigned consistent with state curriculum guidelines.

Certifications: We have contracted with Cascade Health Systems to provide certification training for our existing employees. They will provide both initial and ongoing certifications such as HAZMAT, EVOC, ACLS, PALS, and Bike Medic. They will also provide online and classroom CE opportunities for our employees.

ALS Additional Requirements: The additional requirements for Advanced Life Support operations will vary from region to region. ProTransport-1 requires maintenance of ALS skills consistent with national standards. This includes but is not limited to ACLS, PALS or PEPP, ITLS or PHTLS, and periodic attendance at lesser-used skills courses or other requirements established by the LEMSA.

Performance Improvement Plans (PIP): Performance Improvement Plans may be created for personnel needing remedial training. In coordination, CQI staff or the Training Department will make the determination for creation of a PIP based on the particular team member’s needs. Failure to participate and follow a PIP, or failure to change behaviors, may result in a disciplinary process. If a team member cannot pass a PIP, the failure to pass may result in termination.

Quality Indicators and training:

In addition, evaluation of quality indicators may call for remediation plans or enhanced training. As these issues are identified, Clinical and the Training Department will work in concert to allow opportunities for practitioners to enhance or refine skills. Oversight for directing clinical training and education shall be the responsibility of the Training Manager and the Director of Clinical Operations.

System for Developing and Maintaining Company Policy

Company Policy and Procedure underwent a top to bottom overhaul in 2015-2016. New formatting has been put in place and policy has been separated from procedure and each department head has been tasked with a review of their policies and procedures.

System for Assuring Goals of Training and Education Are Met

Checklists have been created to ensure all team members complete necessary training and education as set forth by the Training Department. Human Resources ensures the receipt of training documents from all team members. Assignment, tracking and notification systems are largely automated online and in the HRIS system.

Integration of Trends and Recognized Training Opportunities Into the Training Program

Any identified opportunity for improvement will be reviewed. In collaboration with Operations, the Training Department will determine what action is needed. If the issue is an individual, it will be handled with a written Performance Improvement Plan (PIP).

Continuing Education Program

It is the responsibility of the Training Department to ensure continuing education is occurring at appropriate regular intervals. In addition, lead paramedics and the CCT Director in conjunction with the Clinical Operations will implement needed curriculum for the ALS and CCT divisions.

Training Program Evaluation and Validation

Evaluation of the Training Department will take place annually. The Training Department and Clinical Operations along with the Leadership group will evaluate the overall training program and its effectiveness. Service goals will be evaluated along with successful completion rates and any related issues reported within the year. The Quality Team and Training Department will develop strategies to ensure goals are met for the following year.

Changes to LEMSA guidelines, new equipment and any other changes will be reviewed and curriculum developed to integrate the changes for field personnel. On a rotating basis, Training, Risk and other department team members will attend conferences, classes and seminars to keep up to date with the newest methods and information.

VI. Annual Update

ProTransport-1 is primarily an inter-facility transport company with a focus on safety, customer service and integrity. Our CQI plan, while not in the traditional manner of an EMS focused agency, is comprehensive and focused on our mission statement, operating values and C.A.R.E.® program.

Our organization will be undergoing changes in the coming years as growth, efficiency, expanded service and technology enable us to bring our future vision to reality. Our overall strategic initiatives will enable us to plan and organize the goals we have set and the metrics we will use to measure our success.

Undoubtedly our CQI plan will change as we refine our initiatives. We will look at all the areas of the company and review our strengths, weaknesses, opportunities and threats. We will determine what our key issues are and what organizational obstacles we have to overcome.

A. Goals Met and Objectives 2019/2020:

During 2019/2020 we have met goals both tactical and strategic:

- The COVID-19 pandemic shut down posed significant changes to our 2020/21 planning.
- Added improved competency checks for our CCT division.
- ePCR format was rebuilt to be more end user friendly and allow for more focused reporting functionality.
  - The format was also implemented at our sister company PRN allowing for greater oversite and accountability.
- Implemented a new HRIS system
- Broadened the scope of QA/CQI to include more departments.
- Continued adapted HER system to allow PCR access to requesting facilities, specific to those facilities.
  - This allows for specific designated individuals to log in for access to facility specific PCRs in order to maintain security and HIPAA compliance.
- Added annual EMT skills training beyond CA EMS skills check, with a focus on HD CPR, Pit Crew CPR and/or AHA CPR as designated by county or region.
- PCR data brought fully in-line with core measures with low error range

During 2021/22 we met the expanded goals of:

- Successful transition of Director of Clinical, Training, QA/QI, DICO to Rob Smith.
- Implemented Narc Logic/ Narc Box RFID system in Modesto, Pleasant Hill & Rancho Cordova Stations
- Increased New Hire Training with the addition of a FTO lead, group “hands on” day.

B. 2022/2023 Goals:

- Update ATD Exposure Control Plan
- Add monthly focus training for all divisions
- Revamp surge procedures
- Review and improve surge cache stocking procedures
- Review existing policies and consider CAAS certification
- Increase accountability reporting through use of the new ePCR UltraForm format
- Implement Advanced Airway course for CCT RNs and ALS Paramedics
- Install Narc Logic/ Narc Box system in Santa Clara Station
- Increase training department staff by one additional training coordinator.
- Addition of Station Field Educators one (1) for each station.

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Indicators Monitored	Key Findings/Priority Issues Identified	Improvement Action Plan/Plans for Further Action	Were Goals Met? Is Follow-Up Needed?
AR LOS downgrades	Downgrades increased	LOS reviews increased	Ongoing
ePCR validation	Validation % low	Increase quality of ePCR	Increased validation rules
ePCR training	New, ongoing training	Increase hours of new hire training to incorporate ePCR	Follow-up needed; increase number of training hours
CAD	Increase efficiency	Logis implemented, ongoing adjustment necessary	Complete, some ongoing adjustment
LEMSA reporting	Inefficiency of reporting	ImageTrend increasing reporting abilities for all departments	Ongoing
Cardiac/CPR training tracking	Limited field practice of CPR	Schedule regular training Add hot wash for any CPR events.	Ongoing Regular Training added Q4 2020
EMT Equipment Training for ALS/CCT	New EMTs have limited training on ALS and none on CCT	Training in relevant areas Starting with adding thraining In new hire process	On going
PCR drop-off - ER	Some PCRs not being dropped off to ER	Implement internet access for hospitals	Ongoing
Policy separated from procedure	Overhaul of entire body of work	Departments assigned, master plan completed	Ongoing, complete by beginning Q4 2021
RTQ	Concierge/field ops/AR	Increase RTQ frequency	Ongoing

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Glossary

ACE	Accredited Center of Excellence
ACLS	Advanced Cardiac Life Support
ALS	Advanced Life Support
AMA	Against Medical Advice
Base Hospital	Designated Hospital EMS providers contact regarding patient care
BSC	Balanced Scorecard
BD	Business Development
BLS	Basic Life Support
CAD	Computer Aided Dispatch
CCT	Critical Care Transport
CMS	Centers for Medicare and Medicaid Services
CPR	Cardio Pulmonary Resuscitation
CQI	Continuous Quality Improvement
EMT	Emergency Medical Technician
EMSA	Emergency Medical Services Agency
EMTALA	Emergency Medical Treatment and Labor Act
ePRO	ePRO Net Scheduler Plus
HIPAA	Health Insurance Portability and Accountability Act
ICON	Unicorn Human Resources Information System (HRIS)
ITLS	International Trauma Life Support
LEMSA	Local Emergency Medical Services Agency
LDT	Long Distance Transport
Logis IDS	Logis Intelligent Dispatch Solution
MD	Doctor of Medicine
I/NAEMD	International/National Academies of Emergency Dispatch
NICU	Neonatal Intensive Care Unit
NRP	Neonatal Resuscitation Program
OPIQ	Operative IQ Inventory Management system
OSHA	Occupational Safety and Health Administration
PALS	Pediatric Advanced Life Support
PCR	Patient Care Report
PDSA	Plan, Do, Study, Act
PEPP	Pediatric Education for Pre-Hospital Professionals
PHTLS	Pre-Hospital Trauma Life Support
PICU	Pediatric Intensive Care Unit
PIP	Performance Improvement Plan
QA	Quality Assurance
RAS	Release at Scene
RN	Registered Nurse
RT	Respiratory Therapist
RFT	Reason for Transport
RTQ	Repetitive Transport Questionnaire
SMMM	Strategic Management Maturity Model
TPS	Total Performance Score

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Appendix A
ePCR Validation Rules

Rule ID	Description	Level	ue	Field	Error Message	Status	Date Entered	Date Updated
27	Odometer 3: Destination Odometer	Logical	-1	E2.16 - Patient Destination Odometer Reading of Responding Vehicle	Destination Odometer is invalid	Active	03/10/2005	01/03/2014
30	Demographic 2: E06_01; Patient Last Name	State	-25	E6.1 - Last Name	The patient's Last Name is missing and needs to be entered.	Active	03/11/2005	12/11/2013
32	Call Info: E20_17; Destination Type	State	-5	E20.17 - Type Of Destination	Destination Type is missing and is required for a patient that was transported.	Active	03/14/2005	03/08/2013
37	Times 4.1: E05_06; Unit En Route Date/Time	State	-5	E5.5 - Unit EnRoute Date/Time	The unit en route date/time is missing and needs to be completed.	Active	03/15/2005	03/08/2013
38	Incident Address: E08_11; Incident Address	State	-25	E8.11 - Incident Address	Incident Address is missing and needs to be added for each response.	Active	03/15/2005	12/13/2013
39	Demographic 1: Patient First Name		-25	E6.2 - First Name	First Name is missing	Active	03/15/2005	12/11/2013
40	Patient Address 5: Patient Postal Code		-1	E6.8 - Patient's Home Zip	Patient Postal Code is missing	Active	03/15/2005	03/08/2013
41	Patient Address 1: Patient Address		-10	E6.4 - Patient's Home Address	Patient Address is missing	Active	03/15/2005	12/13/2013
42	Times 5.1: E05_06; Unit Arrived on Scene Date/Time	State	-5	E5.6 - Unit Arrived on Scene Date/Time	The unit arrived on scene date/time is missing and needs to be completed.	Active	03/15/2005	03/08/2013
43	Call Info: Destination Name	State	-1	E20.1 - Destination Transferred To, Name	Destination Name is missing.	Active	03/15/2005	12/20/2013
44	Demographic 6: Patient Telephone Number		-10	E6.17 - Primary or Home Telephone Number	Telephone Number is missing.	Active	03/15/2005	12/13/2013
45	Times: Arrive Destination > Leave Scene	National	-1	E5.10 - Patient Arrived at Destination Date/Time	Arrive date/time Destination is less than Leave Scene date/time.	Active	03/15/2005	03/08/2013
46	Incident Address 5: Incident Postal Code		-1	E8.15 - Incident Zip Code	Incident Postal Code is missing.	Active	03/15/2005	03/08/2013
47	Demographic 5: Patient Social Security Number		-1	E6.10 - SSN	Social Security Number is missing.	Inactive	03/15/2005	03/08/2013
51	Rule #51: Incident Identifier: Call Number or EMS Unit Response Number (E02_03)	State	-25	E2.3 - EMS Unit (Vehicle) Response Number	Rule #51: The Call Number or EMS Unit Response Number is blank or contains a "Not" value. A valid value must be entered.	Inactive	03/15/2005	07/09/2014
52	Incident Address 2: Incident City		-1	E8.12 - Incident City	Incident City is missing.	Active	03/15/2005	03/08/2013
72	Incident Info: Crew Members		-10	E4.1 - Crew Member ID	Minimum of two Crew Members	Active	03/30/2005	12/13/2013
73	Odometer 1: Starting Odometer		-1	E2.16 - Beginning Odometer Reading of Responding Vehicle	Starting Odometer is invalid	Active	05/09/2007	03/08/2013
74	Odometer 2: At Scene Odometer		-1	E2.17 - On-Scene Odometer Reading of Responding Vehicle	At Scene Odometer is invalid	Active	05/09/2007	03/08/2013
75	Odometer 4: Ending Odometer		-25	E2.19 - Ending Odometer Reading of Responding Vehicle	Ending Odometer is invalid	Active	05/09/2007	12/13/2013
76	Rule #76: Incident Identifier: Incident Number (E02_02)	State	-25	E2.2 - Incident Number	Rule #76: The Incident Number is blank or contains a "Not" value. A valid value must be entered.	Active	05/10/2007	11/25/2013
77	Rule #77: Incident Information, Patient Care Report Number (E01_01)	National	-5	E1.1 - Patient Care Report Number	Rule #77: The Patient Care Report Number is blank or contains a "Not" value. A valid value must be entered.	Inactive	05/10/2007	01/07/2014
78	History: E05_01; Onset Date/Time	State	-5	E5.1 - Incident or Onset Date/Time	The Onset Date/Time is missing and needs to be completed.	Active	05/10/2007	03/08/2013
79	Incident Info: Reponding Unit		-1	E2.11 - EMS Unit/Vehicle Number	Reponding Unit is missing	Active	05/10/2007	03/08/2013
80	Incident Info: Response Urgency		-1	E7.33 - Response Urgency	Response Urgency is missing	Active	05/10/2007	03/08/2013
81	Incident Info: Dispatch Reason		-1	E9.1 - Complaint Reported By Dispatch	Dispatch Reason is missing	Active	05/10/2007	03/08/2013
82	Call Info: Destination Determination	State	-1	E20.16 - Reason For Choosing Destination	Destination Determination is missing.	Active	05/10/2007	03/08/2013
83	Rule #83: Call Info: Type of Service Requested (E02_04)	National	-25	E2.4 - Type Of Service Requested	Rule #83: The Type of Service Requested is blank or contains a "Not" value. A valid value must be entered.	Inactive	05/10/2007	06/30/2014
84	Rule #84: To Scene: Primary Role of the Unit (E02_05)	National	-25	E2.5 - Primary Role Of The Unit	Rule #84: The Primary Role of the Unit is blank or contains a "Not" value. A valid value must be entered.	Active	05/10/2007	03/08/2013
85	Rule #85: Call Info: Incident/Patient Disposition or Response Disposition (E20_10)	National	-25	E20.10 - Incident/Patient Disposition	Rule #85: The Incident/Patient Disposition or Response Disposition is blank or contains a "Not" value. A valid value must be entered.	Active	05/10/2007	03/08/2013
86	Rule #86: Call Info: Response Mode to Scene (E02_20)	National	-25	E2.20 - Response Mode To Scene	Rule #86: The Response Mode to Scene is blank or contains a "Not" value. A valid value must be entered.	Active	05/10/2007	03/08/2013
87	Call Info: Response Mode from Scene ALS		-1	E20.14 - Transport Mode From Scene	Response Mode from Scene is missing	Active	05/10/2007	03/08/2013
88	Demographic 3: Patient Gender		-10	E6.11 - Gender	Patient Gender is missing	Inactive	05/10/2007	06/11/2014
89	Demographic 4: Patient DOB		-25	E6.16 - Date Of Birth	Patient DOB is missing	Active	05/10/2007	12/11/2013
90	Incident Info: Location Type		-1	E8.7 - Incident Location Type	Location Type is missing	Active	05/10/2007	03/08/2013
91	History: E09_05; Chief Complaint	State	-25	E9.5 - Chief Complaint	The Chief Complaint is missing and needs to be completed.	Inactive	05/10/2007	07/07/2014
92	History: Primary Symptom		-1	E9.13 - Primary Symptom	Primary Symptom is missing	Inactive	05/10/2007	03/08/2013
93	Narrative: Provider Primary Impression		-1	E9.15 - Providers Primary Impression	Provider Primary Impression is missing	Active	05/10/2007	03/08/2013
94	Times 8.1: E05_10; Patient Arrived at Destination Date/Time	State	-5	E5.10 - Patient Arrived at Destination Date/Time	The patient arrived at destination date/time is missing and needs to be completed.	Active	05/10/2007	03/08/2013
95	Times 5: Arrive Scene < Enroute		-1	E5.6 - Unit Arrived on Scene Date/Time	Arrive Scene less than Enroute date/time	Active	05/10/2007	03/08/2013
96	Times 4: Enroute > Unit Dispatched		-1	E5.5 - Unit EnRoute Date/Time	Enroute less than Unit Dispatched date/time	Active	05/10/2007	03/08/2013
97	Rule #97: Times: Unit Back In Service Date/Time (E05_11)	National	-25	E5.11 - Unit Back in Service Date/Time	Rule #97: The Unit Back in Service date/time is blank and requires a valid value.	Active	05/10/2007	03/08/2013
98	Times 7.1: Leave Scene		-1	E5.9 - Unit Left Scene Date/Time	Leave Scene date/time is missing	Active	05/10/2007	03/08/2013
99	Rule #99: Times: Unit Notified by Dispatch Date/Time (E05_04)	National	-25	E5.4 - Unit Notified by Dispatch Date/Time	Rule #99: The Unit Notified by Dispatch Date/Time is blank and requires a valid value.	Active	05/10/2007	03/08/2013
100	Times 6.1: E05_07; Arrived at Patient Date/Time	State	-5	E5.7 - Arrived at Patient Date/Time	The arrived at patient date/time is missing and needs to be completed.	Active	05/10/2007	03/08/2013

Rule ID	Description	Level	ue	Field	Error Message	Status	Date Entered	Date Updated
101	Times 6: Arrive Patient Side > Arrive Scene		-1	E5.7 - Arrived at Patient Date/Time	Arrive Patient less than Arrive Scene date/time	Active	05/10/2007	03/08/2013
103	Times 9: Back in Service > Arrive Dest.	National	-1	E5.11 - Unit Back in Service Date/Time	In-Service less than Arrive Destination date/time	Active	05/10/2007	03/08/2013
104	Times 2: Dispatch Notified > PSAP		-1	E5.3 - Dispatch Notified Date/Time	Dispatch Notified less than PSAP date/time	Inactive	07/13/2007	03/08/2013
105	Times 3: Unit Dispatched > Dispatch Notified		-1	E5.4 - Unit Notified by Dispatch Date/Time	Unit Disp. less than Dispatch Notified date/time	Active	07/13/2007	03/08/2013
106	Times 7: Leave Scene > Arrived Patient Side		-1	E5.9 - Unit Left Scene Date/Time	Leave Scene less than Arrived Patient date/time	Active	07/13/2007	03/08/2013
107	Times 2.1: Dispatch Notified		-1	E5.3 - Dispatch Notified Date/Time	Dispatch Notified date/time is missing	Inactive	07/13/2007	03/08/2013
108	Incident Address 3: Incident County		-1	E8.13 - Incident County	Incident County is missing	Active	07/13/2007	03/08/2013
109	Incident Address 4: Incident State		-1	E8.14 - Incident State	Incident State is missing	Active	07/13/2007	03/08/2013
110	Patient Address 2: Patient City		-1	E6.5 - Patient's Home City	Patient City is missing	Inactive	07/13/2007	03/08/2013
111	Patient Address 3: Patient County		-1	E6.6 - Patient's Home County	Patient County is missing	Inactive	07/13/2007	03/08/2013
112	Patient Address 4: Patient State		-1	E6.7 - Patient's Home State	Patient State is missing	Active	07/13/2007	12/11/2013
116	Call Info: Response Mode from Scene BLS		-1	E20.14 - Transport Mode From Scene	"Response Mode from Scene is missing"	Active	01/27/2009	03/08/2013
119	Condition: Possible Injury Primary Impression	State	-10	E9.4 - Possible Injury	Possible Injury must be Yes if Provider Primary Impression is injury related.	Active	09/30/2010	03/08/2013
120	Condition: Possible Injury Secondary Impression	State	-10	E9.4 - Possible Injury	Possible Injury must be Yes if Provider Secondary Impression is injury related.	Active	09/30/2010	03/08/2013
121	To Scene: Response Delay	National	-1	E2.7 - Type Of Response Delay	For Type of Response Delay, Not Applicable and another value cannot be selected together.	Active	09/30/2010	03/08/2013
122	To Scene: Dispatch Delay	National	-1	E2.6 - Type Of Dispatch Delay	For Type of Dispatch Delay, Not Applicable and another value cannot be selected together.	Active	09/30/2010	03/08/2013
123	To Scene: Scene Delay	National	-1	E2.8 - Type Of Scene Delay	For Type of Scene Delay, Not Applicable and another value cannot be selected together.	Active	09/30/2010	03/08/2013
124	To Scene: Transport Delay	National	-1	E2.9 - Type Of Transport Delay	For Type of Transport Delay, Not Applicable and another value cannot be selected together.	Active	09/30/2010	03/08/2013
125	To Scene: Turnaround Delay	National	-1	E2.10 - Type Of Turn-Around Delay	For Type of Turnaround Delay, Not Applicable and another value cannot be selected together.	Active	09/30/2010	03/08/2013
126	At Scene: Barriers to Patient Care	National	-1	E12.1 - Barriers To Patient Care	For Barriers to Patient Care, Not Applicable and another value cannot be selected together.	Active	09/31/2010	03/08/2013
127	Activities: Procedures	National	-10	E19.1 - Date/Time Procedure Performed Successfully	Can not have a procedure and s/not applicable procedure entered.	Active	09/31/2010	03/08/2013
128	Times: Back in Service > Unit Notified by Dispatch	National	-1	E5.11 - Unit Back in Service Date/Time	Back In-Service date/time must be Greater than or Equal to Unit Notified by Dispatch	Active	09/31/2010	03/08/2013
129	AT Scene: MCI	National	-1	E8.6 - Mass Casualty Incident	If Mass Casualty is Yes, then the Number of Patients at Scene must be Multiple.	Active	09/03/2010	03/08/2013
130	Times: Arrive Patient Side > Enroute	National	-1	E5.7 - Arrived at Patient Date/Time	Arrive patient must be greater than Enroute time.	Active	09/20/2010	03/08/2013
131	Times: Arrive Patient Side < Unit Notified by Dispatch	National	-1	E5.7 - Arrived at Patient Date/Time	Arrive patient must be greater than Unit Notified by Dispatch time.	Active	09/20/2010	03/08/2013
132	Demographic: Patient Age Units	National	-2	E6.15 - Age Units	If you document a patient age, age units must also be documented.	Active	09/20/2010	03/08/2013
133	Times: Leave scene < Arrive scene	National	-1	E5.9 - Unit Left Scene Date/Time	Arrive scene is less than leave scene. Please correct.	Active	11/04/2010	03/08/2013
134	Possible Injury	State	-5	E9.4 - Possible Injury	If a cause of injury is documented, injury present must be yes.	Active	12/17/2010	03/08/2013
135	Activities: Procedure Crew Member	State	-10	E19.9 - Procedure Crew Members ID	Crew member must be documented on every procedure	Active	03/09/2011	03/08/2013
136	Crew Member Level	State	-1	E4.3 - Crew Member Level	Crew member level is required.	Active	03/09/2011	03/08/2013
137	Patient: Ethnicity	National	-1	E6.13 - Ethnicity	The patient's ethnicity is missing and needs to be documented.	Active	03/09/2011	03/08/2013
138	Patient: Race	National	-1	E6.12 - Race	Patient race must be documented	Active	03/09/2011	03/08/2013
139	At Scene: Number of patients at scene	National	-1	E8.5 - Number Of Patients At Scene	Document number of patients if patient contact is established.	Inactive	03/11/2011	03/08/2013
141	History: Complaint Anatomic Location	National	-1	E9.11 - Chief Complaint Anatomic Location	Must document complaint of anatomic location.	Inactive	03/18/2011	03/08/2013
142	Patient Condition: Organ System of Complaint	National	-1	E9.12 - Chief Complaint Organ System	Must document organ system of complaint.	Inactive	03/24/2011	03/08/2013
144	Rule #144: To Scene: EMS Unit Call Sign (Radio Number) (E02_12)	National	-25	E2.12 - EMS Unit Call Sign (Radio Number)	Rule #144: The EMS Unit Call Sign (Radio Number) is blank or contains a "Not" value. A valid value must be entered.	Active	05/26/2011	12/12/2013
145	Narrative: E13_01: Run Report Narrative	Local	-10	E13.1 - Run Report Narrative	A narrative must be written on each response.	Active	06/16/2011	03/08/2013
1001	PSAP Call Date Before Incident Onset Date (Logical)	Logical	-1	E5.2 - PSAP Call Date/Time	PSAP Call Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1002	Dispatch Notified Date Before PSAP Call Date (Logical)	Logical	-1	E5.3 - Dispatch Notified Date/Time	Dispatch Notified Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1003	Unit Notified Dispatch Date Missing (Logical)	Logical	-1	E5.4 - Unit Notified by Dispatch Date/Time	Unit Notified Dispatch Date has not been entered.	Active	12/15/2011	03/08/2013
1004	Unit Notified Dispatch Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.4 - Unit Notified by Dispatch Date/Time	Unit Notified Dispatch Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1005	Unit Notified Dispatch Date Before PSAP Call Date (Logical)	Logical	-1	E5.4 - Unit Notified by Dispatch Date/Time	Unit Notified Dispatch Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1006	Unit Notified Dispatch Date Before Incident Onset Date (Logical)	Logical	-1	E5.4 - Unit Notified by Dispatch Date/Time	Unit Notified Dispatch Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1007	Unit En Route Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.5 - Unit EnRoute Date/Time	Unit En Route Date is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1008	Unit En Route Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.5 - Unit EnRoute Date/Time	Unit En Route Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013

Rule ID	Description	Level	ue	Field	Error Message	Status	Date Entered	Date Updated
1009	Unit En Route Date Before PSAP Call Date (Logical)	Logical	-1	E5.5 - Unit EnRoute Date/Time	Unit En Route Date before PSAP Call Date.	Active	12/15/2011	03/08/2013
1010	Unit En Route Date Before Incident Onset Date (Logical)	Logical	-1	E5.5 - Unit EnRoute Date/Time	Unit En Route Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1011	Unit Arrived Scene Date Before Unit En Route Date (Logical)	Logical	-1	E5.6 - Unit Arrived on Scene Date/Time	Unit Arrived Scene Date is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1012	Unit Arrived Scene Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.6 - Unit Arrived on Scene Date/Time	Unit Arrived Scene Date is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1013	Unit Arrived Scene Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.6 - Unit Arrived on Scene Date/Time	Unit Arrived Scene Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1014	Unit Arrived Scene Date Before PSAP Call Date (Logical)	Logical	-1	E5.6 - Unit Arrived on Scene Date/Time	Unit Arrived Scene Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1015	Unit Arrived Scene Date Before Incident Onset Date (Logical)	Logical	-1	E5.6 - Unit Arrived on Scene Date/Time	Unit Arrived Scene Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1016	Arrived Patient Date Before Unit Arrived Scene Date (Logical)	Logical	-1	E5.7 - Arrived at Patient Date/Time	Arrived Patient Date is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1017	Arrived Patient Date Before Unit En Route Date (Logical)	Logical	-1	E5.7 - Arrived at Patient Date/Time	Arrived Patient Date Before Unit En Route Date	Active	12/15/2011	03/08/2013
1018	Arrived Patient Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.7 - Arrived at Patient Date/Time	Arrived Patient Date is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1019	Arrived Patient Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.7 - Arrived at Patient Date/Time	Arrived Patient Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1020	Arrived Patient Date Before PSAP Call Date (Logical)	Logical	-1	E5.7 - Arrived at Patient Date/Time	Arrived Patient Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1021	Arrived Patient Date Before Incident Onset Date (Logical)	Logical	-1	E5.7 - Arrived at Patient Date/Time	Arrived Patient Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1022	Transfer Patient Care Date Before Arrived Patient Date (Logical)	Logical	-1	E5.8 - Transfer of Patient Care Date/Time	Transfer Patient Care Date is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1023	Transfer Patient Care Date Before Unit Arrived Scene Date (Logical)	Logical	-1	E5.8 - Transfer of Patient Care Date/Time	Transfer Patient Care Date is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1024	Transfer Patient Care Date Before Unit En Route Date (Logical)	Logical	-1	E5.8 - Transfer of Patient Care Date/Time	Transfer Patient Care Date is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1025	Transfer Patient Care Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.8 - Transfer of Patient Care Date/Time	Transfer Patient Care Date is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1026	Transfer Patient Care Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.8 - Transfer of Patient Care Date/Time	Transfer Patient Care Date Before Dispatch Notified Date	Active	12/15/2011	03/08/2013
1027	Transfer Patient Care Date Before PSAP Call Date (Logical)	Logical	-1	E5.8 - Transfer of Patient Care Date/Time	Transfer Patient Care Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1028	Transfer Patient Care Date Before Incident Onset Date (Logical)	Logical	-1	E5.8 - Transfer of Patient Care Date/Time	Transfer Patient Care Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1029	Unit Left Scene Date Before Arrived Patient Date (Logical)	Logical	-1	E5.9 - Unit Left Scene Date/Time	Unit Left Scene Date is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1030	Unit Left Scene Date Before Unit Arrived Scene Date (Logical)	Logical	-1	E5.9 - Unit Left Scene Date/Time	Unit Left Scene Date is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1031	Unit Left Scene Date Before Unit En Route Date (Logical)	Logical	-1	E5.9 - Unit Left Scene Date/Time	Unit Left Scene Date is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1032	Unit Left Scene Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.9 - Unit Left Scene Date/Time	Unit Left Scene Date is before Unit Notified Dispatch Date	Active	12/15/2011	03/08/2013
1033	Unit Left Scene Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.9 - Unit Left Scene Date/Time	Unit Left Scene Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1034	Unit Left Scene Date Before PSAP Call Date (Logical)	Logical	-1	E5.9 - Unit Left Scene Date/Time	Unit Left Scene Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1035	Unit Left Scene Date Before Incident Onset Date (Logical)	Logical	-1	E5.9 - Unit Left Scene Date/Time	Unit Left Scene Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1036	Patient Arrived Dest Date Before Unit Left Scene Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before Unit Left Scene Date.	Active	12/15/2011	03/08/2013
1037	Patient Arrived Dest Date Before Arrived Patient Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1038	Patient Arrived Dest Date Before Unit Arrived Scene Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1039	Patient Arrived Dest Date Before Unit En Route Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1040	Patient Arrived Dest Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1041	Patient Arrived Dest Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1042	Patient Arrived Dest Date Before PSAP Call Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1043	Patient Arrived Dest Date Before Incident Onset Date (Logical)	Logical	-1	E5.10 - Patient Arrived at Destination Date/Time	Patient Arrived Dest Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1044	Unit Back Service Date Missing (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date has not been entered.	Active	12/15/2011	03/08/2013
1045	Unit Back Service Date Before Unit Cancelled Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Unit Cancelled Date.	Active	12/15/2011	03/08/2013
1046	Unit Back Service Date Before Patient Arrived Dest Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Patient Arrived Dest Date.	Active	12/15/2011	03/08/2013
1047	Unit Back Service Date Before Transfer Patient Care Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Transfer Patient Care Date.	Active	12/15/2011	03/08/2013
1048	Unit Back Service Date Before Unit Left Scene Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Unit Left Scene Date.	Active	12/15/2011	03/08/2013
1049	Unit Back Service Date Before Arrived Patient Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1050	Unit Back Service Date Before Unit Arrived Scene Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1051	Unit Back Service Date Before Unit En Route Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1052	Unit Back Service Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Unit Notified Dispatch Date	Active	12/15/2011	03/08/2013

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Rule ID	Description	Level	ue	Field	Error Message	Status	Date Entered	Date Updated
1053	Unit Back Service Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1054	Unit Back Service Date Before PSAP Call Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1055	Unit Back Service Date Before Incident Onset Date (Logical)	Logical	-1	E5.11 - Unit Back in Service Date/Time	Unit Back Service Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1056	Unit Cancelled Date Before Patient Arrived Dest Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Patient Arrived Dest Date.	Active	12/15/2011	03/08/2013
1057	Unit Cancelled Date Before Transfer Patient Care Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Transfer Patient Care Date.	Active	12/15/2011	03/08/2013
1058	Unit Cancelled Date Before Unit Left Scene Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Unit Left Scene Date.	Active	12/15/2011	03/08/2013
1059	Unit Cancelled Date Before Arrived Patient Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1060	Unit Cancelled Date Before Unit Arrived Scene Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1061	Unit Cancelled Date Before Unit En Route Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1062	Unit Cancelled Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1063	Unit Cancelled Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1064	Unit Cancelled Date Before PSAP Call Date (Logical)	Logical	-1	E5.12 - Unit Cancelled Date/Time	Unit Cancelled Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1065	Unit Back Home Loc Date Before Unit Cancelled Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Unit Cancelled Date.	Active	12/15/2011	03/08/2013
1066	Unit Back Home Loc Date Before Patient Arrived Dest Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Patient Arrived Dest Date.	Active	12/15/2011	03/08/2013
1067	Unit Back Home Loc Date Before Transfer Patient Care Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Transfer Patient Care Date.	Active	12/15/2011	03/08/2013
1068	Unit Back Home Loc Date Before Unit Left Scene Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Unit Left Scene Date.	Active	12/15/2011	03/08/2013
1069	Unit Back Home Loc Date Before Arrived Patient Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1070	Unit Back Home Loc Date Before Unit Arrived Scene Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1071	Unit Back Home Loc Date Before Unit En Route Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1072	Unit Back Home Loc Date Before Unit Notified Dispatch Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1073	Unit Back Home Loc Date Before Dispatch Notified Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1074	Unit Back Home Loc Date Before PSAP Call Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1075	Unit Back Home Loc Date Before Incident Onset Date (Logical)	Logical	-1	E5.13 - Unit Back at Home Location Date/Time	Unit Back Home Loc Date is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1076	Time Initial Resp Scene Before Incident Onset Date (Logical)	Logical	-1	E8.4 - Date/Time Initial Responder Arrived on Scene	Time Initial Resp Scene is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1077	Time Initial Resp Scene After Unit Back Service Date (Logical)	Logical	-1	E8.4 - Date/Time Initial Responder Arrived on Scene	Time Initial Resp Scene is after Unit Back Service Date.	Active	12/15/2011	03/08/2013
1078	Date Vital Signs Taken Before Arrived Patient Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1079	Date Vital Signs Taken Before Unit Arrived Scene Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1080	Date Vital Signs Taken Before Unit En Route Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1081	Date Vital Signs Taken Before Unit Notified Dispatch Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1082	Date Vital Signs Taken Before Dispatch Notified Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1083	Date Vital Signs Taken Before PSAP Call Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1084	Date Vital Signs Taken Before Incident Onset Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1085	Date Vital Signs Taken After Unit Back Service Date (Logical)	Logical	-1	E14.1 - Date/Time Vital Signs Taken	Date Vital Signs Taken is after Unit Back Service Date.	Active	12/15/2011	03/08/2013
1086	Assess Date Time Before Arrived Patient Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1087	Assess Date Time Before Unit Arrived Scene Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1088	Assess Date Time Before Unit En Route Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1089	Assess Date Time Before Unit Notified Dispatch Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1090	Assess Date Time Before Dispatch Notified Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1091	Assess Date Time Before PSAP Call Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1092	Assess Date Time Before Incident Onset Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1093	Assess Date Time After Unit Back Service Date (Logical)	Logical	-1	E16.3 - Date/Time of Assessment	Assess Date Time is after Unit Back Service Date.	Active	12/15/2011	03/08/2013
1094	Date Medic Admin Before Arrived Patient Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1095	Date Medic Admin Before Unit Arrived Scene Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1096	Date Medic Admin Before Unit En Route Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is before Unit En Route Date.	Active	12/15/2011	03/08/2013

Rule ID	Description	Level	ue	Field	Error Message	Status	Date Entered	Date Updated
1097	Date Medic Admin Before Unit Notified Dispatch Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1098	Date Medic Admin Before Dispatch Notified Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1099	Date Medic Admin Before PSAP Call Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1100	Date Medic Admin Before Incident Onset Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1101	Date Medic Admin After Unit Back Service Date (Logical)	Logical	-1	E18.1 - Date/Time Medication Administered	Date Medic Admin is after Unit Back Service Date.	Active	12/15/2011	03/08/2013
1102	Date Proc Performed Before Arrived Patient Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is before Arrived Patient Date.	Active	12/15/2011	03/08/2013
1103	Date Proc Performed Before Unit Arrived Scene Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is before Unit Arrived Scene Date.	Active	12/15/2011	03/08/2013
1104	Date Proc Performed Before Unit En Route Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is before Unit En Route Date.	Active	12/15/2011	03/08/2013
1105	Date Proc Performed Before Unit Notified Dispatch Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is before Unit Notified Dispatch Date.	Active	12/15/2011	03/08/2013
1106	Date Proc Performed Before Dispatch Notified Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013
1107	Date Proc Performed Before PSAP Call Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is before PSAP Call Date.	Active	12/15/2011	03/08/2013
1108	Date Proc Performed Before Incident Onset Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is before Incident Onset Date.	Active	12/15/2011	03/08/2013
1109	Date Proc Performed After Unit Back Service Date (Logical)	Logical	-1	E19.1 - Date/Time Procedure Performed Successfully	Date Proc. Performed is after Unit Back Service Date.	Active	12/15/2011	03/08/2013
1110	Response Urgency Check	State	-10	E7.33 - Response Urgency	Response Urgency is required.	Active	01/27/2012	03/08/2013
1111	Insurance - Insurance Number	Logical	-1	E7.10 - Insurance Policy ID Number	Insurance must have an insurance number.	Inactive	11/25/2013	12/19/2013
1112	Medicare Number		-1	E7.10 - Insurance Policy ID Number	Medicare Number....	Inactive	11/25/2013	12/17/2013
1113	Primary Insurance	Logical	-15	E7.3 - Insurance Company ID/Name	Must have at least one payor to complete PCR	Inactive	12/09/2013	12/19/2013
1114	GCS		-25	E14.19 - Total Glasgow Coma Score	Must have at least one GCS Assessment	Active	12/13/2013	02/26/2015
1115	Advanced Directives	Logical	-10	14 - DNR	All advanced directive fields must have a yes or no designation	Inactive	12/18/2013	12/19/2013
1116	Destination Address	Logical	-25	E20.1 - Destination Transferred To, Name	Destination address is missing.	Active	12/20/2013	12/20/2013
1117	Signature	Local	-25	IT4.1 - Signature	Crew member signature is missing	Inactive	05/06/2014	07/11/2014
1118	Medical Necessity Signature	Local	-25	IT4.1 - Signature	If a Doctor signs they must print their name and provide their Medical License Number	Active	06/03/2014	06/09/2014
1119	Gender Master		-25	E6.11 - Gender	Patient Gender must be selected	Active	06/11/2014	06/19/2014
1132	Patient Moved To Ambulance		-10	E20.11 - How Patient Was Moved to Ambulance	Must select an option from the drop down	Active	06/19/2014	06/19/2014
1133	Patients Position In Transport		-10	E20.12 - Position Of Patient During Transport	Must select an option from the drop down	Active	06/19/2014	06/19/2014
1134	Patient Moved From Ambulance		-10	E20.13 - How Patient Was Transported From Ambulance	Must Select An Option From The Drop Down	Active	06/19/2014	06/19/2014
1135	Patient Found Location		-10	46 - Patient Found: Location	Must Select an Option from the Drop Down	Active	06/19/2014	06/19/2014
1136	Patient Found Postion		-10	47 - Patient Found: Position	Must Select an Option from the Drop Down	Active	06/19/2014	06/19/2014
1137	Transferred to Gurney		-10	48 - Transferred to Gurney	Must Select an Option from the Drop Down	Active	06/19/2014	06/19/2014
1138	Transferred from Gurney		-10	51 - Transferred From Gurney	Must Select an Option from the Drop Down	Active	06/19/2014	06/19/2014
1139	Patient Location Destination		-10	49 - Patient Location: Destination	Must Select an Option from the Drop Down	Active	06/19/2014	06/19/2014
1140	Patients Position Destination		-10	50 - Patient Position: Destination	Must Select an Option from the Drop Down	Active	06/19/2014	06/19/2014
1141	Medication		-1	E12.14 - Current Medications	If medication is given you must add the medication tracking # in the comment field from the power tool	Active	08/24/2014	03/20/2015
1143	Master Chief Complaint		-25	E9.5 - Chief Complaint	Chief Complaint can't be left blank	Active	07/07/2014	07/07/2014
1146	Crew Signature		-25	IT4.1 - Signature	You must sign the Signature Box	Active	07/11/2014	08/08/2014
1147	Pick Up Location		-25	E8.11 - Incident Address	Pick Up Location can't be blank	Active	07/16/2014	07/16/2014
1150	ALS EKG required	Local	-5	IT2.1 - EKG Interpretation	If this is an ALS transport an EKG is required	Active	09/27/2014	09/27/2014
1152	Transferred to Gurney Explanation	Local	-1	76 - Transferred to Gurney Explanation	Transferred to Gurney Explanation is required	Active	10/09/2014	10/09/2014
1153	Transferred from Gurney Explanation	Local	-1	77 - Transferred From Gurney Explanation	Transferred from Gurney Explanation is required	Active	10/09/2014	10/09/2014
1156	Hospital Receiving Agent		-25	IT4.1 - Signature	You must get the signature of the receiving agent	Active	10/16/2014	10/16/2014
1157	Insurance Info needed	Local	-1	E7.10 - Insurance Policy ID Number	Insurance info is required if the disposition is BLS	Active	11/17/2014	02/23/2015
1159	Destination address		-25	E30.3 - Destination Street Address	Destination Address is missing and needs to be added for each response.	Active	12/30/2014	03/16/2015
1160	Vital Signs		-25	E14.1 - Date/Time Vital Signs Taken	You must have two sets of vital signs per transport	Active	12/31/2014	02/26/2015
1162	Narrative Requirement	Local	-25	E13.1 - Run Report Narrative	Your Narrative must contain a minimum of 300 characters	Active	01/07/2015	02/26/2015
1163	Authorized Representative Signature		-25	IT4.2 - Signature Type	You must allocate the legal relationship of the Authorize Representative ie... Patients Legal Guardian etc.	Active	01/08/2015	03/13/2015
1164	Why is the patient unable to ride in a car		-25	78 - Why is the patient unable to ride in a car?	You must document why patient was unable to ride by car in the text box	Active	01/13/2015	01/13/2015
1165	Pick up facility		-25	E8.6 - Incident Facility Code	Pick up facility can't be blank	Active	01/15/2015	01/15/2015
1166	Responding Unit		0	E2.12 - EMS Unit Call Sign (Radio Number)	You must pick your rig # from the drop down list	Active	01/15/2015	01/15/2015
1167	Past Medical History		-1	E12.10 - Medical/Surgical History	You must provide a minimum of 1 item from the drop down.	Active	01/15/2015	01/16/2015
1168	Patient Medication		-1	E12.14 - Current Medications	You must provide a minimum of 1 medication	Active	01/15/2015	01/16/2015

Rule ID	Description	Level	ue	Field	Error Message	Status	Date Entered	Date Updated
1169	Skin Medical Assessment		-1	E16.4 - Skin Assessment	You must have 1 Medical Assessment for Skin	Active	01/16/2015	01/16/2015
1170	NeuroMedical Assessment		-1	E16.2d - Neurological Assessment	you must have 1 Neuro Medical Assessment	Active	01/16/2015	01/16/2015
1171	Mental Medical Assessment		-1	E16.23 - Mental Status Assessment	You must have 1 Mental Medical Assessment	Active	01/16/2015	01/16/2015
1172	Patient Medication Allergies		-25	E12.8 - Medication Allergies	Must document patients allergies if patient has no known allergies type in NotApplicable in the name field to clear the validation	Active	01/16/2015	01/16/2015
1174	Initial oxygen use		-25	37 - Initial Oxygen Use	You must pick Yes or No	Active	01/16/2015	01/16/2015
1175	Required Treatment Oxygen		-10	16 - RT Oxygen	You must pick Yes or No	Active	01/16/2015	03/19/2015
1176	Required Treatment Suctioning		-10	17 - RT Suctioning	You must pick Yes or No	Active	01/16/2015	01/16/2015
1177	Required Treatment Positioning		-10	18 - RT Positioning	You must pick Yes or No	Active	01/16/2015	01/16/2015
1178	Required Treatment Pain Control		-10	19 - RT Pain Control	You must pick Yes or No	Active	01/16/2015	01/16/2015
1179	Required Treatment Restaints		-10	20 - RT Restaints	You must pick Yes or No	Active	01/16/2015	01/16/2015
1180	Required Treatment Wound Treatment / Precaution		-10	21 - RT Wound Treatment / Precaution	You must pick Yes or No	Active	01/16/2015	01/16/2015
1181	Response Mode		-25	E2.20 - Response Mode To Scene	Please make sure that you picked the appropriate response mode to scene for this call.	Active	01/30/2015	01/30/2015
1182	Transport Mode From Scene		-5	E20.14 - Transport Mode From Scene	You must select an option from the drop down menu	Active	01/30/2015	01/30/2015
1187	Destination address		-25	E20.1 - Destination Transferred To, Name	Destination Address is missing and needs to be added for each response.	Active	03/16/2015	03/16/2015
1189	Purpose For Transport		-25	113 - Purpose For Transport	You must pick a Purpose For Transport reason from the drop down window.	Active	05/07/2015	05/19/2015

Royal Ambulance
Continuous Quality Improvement Plan

Purpose

The goal of Royal Ambulance's Continuous Quality Improvement (CQI) Plan is to establish a systematic process for evaluating and improving the quality of patient care within the pre-hospital and inter-facility transport environment.

CQI is a process that invites all levels of healthcare providers to collaborate together to develop and enhance the system in which they work. Based on a shared commitment to excellence, CQI reveals the potential areas for improvement of the system, can identify training opportunities, and can highlight outstanding clinical performance. CQI can also identify compliance with treatment protocols, adherence to operational guidelines, and can provide an evaluation of specific illnesses or injuries along with associated treatment modalities. The goal of this systematic process for review, analyzation and improvement contributes to our continued pursuit of fulfilling our mission.

Introduction

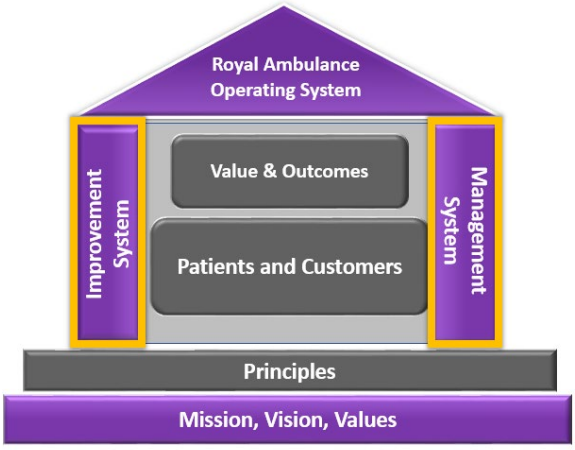
Our mission at Royal Ambulance is to "Positively impact the patient's journey, make our customer's jobs easier, and develop healthcare leaders." Coupled with our values to be driven, empathetic, engaging and adaptable, Royal Ambulance strives to connect patients and providers in the healthcare continuum through transportation, technology and seamless experiences.

To achieve this mission, Royal Ambulance participates in an ongoing and systematic quality assurance and quality improvement program utilizing Lean Thinking and Lean Management Systems. Lean is a philosophy that shortens the time between the customer desire for product or service and delivery of that product or service, by eliminating waste. Program efforts will focus on direct patient care delivery and support processes that promote optimal patient outcomes and efficient financial accountability. Recognizing that we are part of a healthcare system, we strive to collaborate with our partners to develop and implement innovative, quality patient care. The CQI program, reinforced through the Lean philosophy, demonstrates our commitment to ensuring patient and provider safety, delivering optimal care and achieving high patient and customer satisfaction.

The Royal Ambulance Operating System has two pillars:

1. The Improvement System and
2. The Management System

The Improvement System is made up of all the process improvement concepts, methods and tools. The Management System creates the environment to best support improvement activities.



Royal Ambulance
Continuous Quality Improvement Plan

Structure

The CQI Team at Royal Ambulance is under the direction of the Clinical Operations Manager with medical oversight provided by our Medical Director. The CQI Team includes, but is not limited to:

- Royal Ambulance Chief Operating Officer
- Royal Ambulance Medical Director
- Clinical Operations Manager
- Clinical Operations Coordinator
- County Managers
- County Supervisors
- Lead Field Training Officer
- Lead CCT EMTs
- Information Technology Specialist

Additionally, participation by field employees, logistics, fleet management, account managers and communications center will be included when appropriate.

Our CQI Team has expertise in the following areas:

- EMS Evaluation and quality improvement
- Patient experience
- Data systems
- Clinical aspects of EMS patient care and transport
- Clinical aspects of ICU, CCU, and ER care.
- Technology utilization
- Lean Thinking and Management Systems

Our approach to quality management and quality improvement will be to implement best practices as identified by evidence-based research within the healthcare industry and the California EMS System Core Quality Measures. Utilization of the "Just Culture" philosophy will be demonstrated in the investigation and resolution process for overall quality improvement.

A "Just Culture" creates an organizational learning culture that enables us to see risk at the individual and organizational level, but does not rely on punitive reaction alone to prevent errors. We recognize that people make errors and by creating an environment or openness, employees are encouraged to admit and report mistakes so that contributing causes can be better understood and lead to system and process improvements. The environment of openness allows for individual accountability, but also focuses on determining the root cause for the incident or error to prevent repeat occurrences.

Responsibilities of the CQI Team include attendance and participation in a variety of committees:

- Royal Ambulance Quality Improvement Team – includes participation by field employees, logistics, fleet management, account managers and communications center will be included when appropriate
- Royal Ambulance Safety Committee - participation by field employees, logistics, fleet management, account managers and communications center will be included when appropriate
- Royal Ambulance Incident Review Board
- Pre-Hospital Care Systems Quality Improvement Committees – hosted by local EMS agencies
- Receiving Hospital Meetings – hosted by local EMS agencies
- BLS Provider Meetings – hosted by local EMS agencies
- Hospital Review Meetings – hosted by hospital partners
- Account Managers Meetings – hosted by Royal Ambulance

Royal Ambulance
Continuous Quality Improvement Plan

- Skilled Nursing Facility Collaborative Meetings – hosted by hospital and SNF partners

I. Organizational Description

Royal Ambulance's mission is to "Positively impact the patient's journey, make our customer's jobs easier, and develop healthcare leaders".

The services provided by Royal Ambulance include:

- Basic Life Support and Critical Care transport of patients received through contracts with various healthcare entities.
- Non-Medical Transportation
- Multi-casualty resource for local EMS agencies.
- Provision of ride-along opportunities for students of various EMT schools.
- Community Education
- Customer Partnership and education

Royal Ambulance's clinical goals are derived from both internal and external expectations that provide guidance to our organization. These goals include, but are not limited to:

- Providing timely transport options
- Positively impacting the patient's journey
- Minimizing discomfort
- Reducing disability

II. Data Collection and Reporting

Data collection and reporting are two very important aspects for CQI. Data collected must be valid, reliable and standardized with all collaborating participants. The following information will be monitored, measured and evaluated for improvement. In addition to traditional methods of data collection, a Lean tool known as the Gemba Walk is incorporated. By definition. Gemba Walks are a purposeful "walk" done by leadership to "Go to the actual place, look at the actual process, and talk to the actual people."

Indicator		Specific Information to be Monitored	Method of Collection	Frequency
Personnel		Education and training requirements compliant with specific operating counties	Provider records (EPRO) and hard copy files	Monthly
		Currency of provider's licensure, certifications and accreditations.	Provider records (EPRO), hard copy files and online state licensing boards verification	Monthly
Equipment and Supplies		Ease of equipment utilization	Field employee feedback via surveys	Daily
		Current and well-maintained equipment and supplies	Field employee feedback via EPRO, LEMSA requirements, adhering to manufacturer's PM recommendations, and Gemba walks	Daily
		Equipment/vehicle failures	Field employee feedback and EPRO software	Daily

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Continuous Quality Improvement Plan

Documentation	25% retrospective review of random PCRs	Quality of documentation	Royal Ambulance CQI Team	Monthly
	100% retrospective review of all high risk calls, and 25% retrospective review of Code 1 and Code 2 calls	Quality of patient care/adherence to treatment protocols	Royal Ambulance CQI Team	Monthly
		Integration of data and reporting systems	PCR data fields and print compliance	Daily
Clinical Care and Patient Outcomes	100% retrospective review of all inter-facility transports that do not have a predetermined destination or require a diversion	Patients taken to correct destinations based on primary impression and county protocols	Zoll Work Flow software, EPRO	Daily
	100% retrospective review of all high risk calls	Review of high risk transports by primary impression ie. Stroke, STEMI, Trauma activations, cardiac arrest, advanced airway management, BLS Code 3 transports, ALS upgrades.	Zoll Work Flow software, EPRO	Monthly
	100% retrospective review of medications administered	Medication administration oversight to include medications administered by EMTS, TXA by Paramedics, and all narcotic usage.	Zoll Work Flow software, LOGRX	Monthly
	100% retrospective review of infrequently used skills	Number of infrequently used skills per number of transports. Skills to include, needle decompression, intubation, EZIO, and tourniquet application.	Zoll Work Flow software	Monthly
Skills Maintenance/Competency	All clinicians will receive, at a yearly minimum, skills refresher and competency evaluations	Airway management, medication administration, 12 lead interpretation, needle decompression, tourniquet application	Zoll Work Flow software	Monthly

	100% retrospective review	Review of PCR's with infrequently used skills.	Zoll Work Flow software	Yearly
Transportation /Facilities		Response times per contract requirements	Standardized IT reports, Tableau	Daily
		Response times for Code 2 requests	Standardized IT reports, Tableau	Monthly
		Number of diversions r/t change in patient condition	Zoll Work Flow software and EPRO, Tableau	Daily
		Number of ALS upgrades	Zoll Workflow software and EPRO, Tableau	Daily
		Number of Code 3 transports	Zoll Workflow software and EPRO, Tableau	Daily
Public Education		Provision of field experience for EMT students	EMT Ride Logs, Waivers	Monthly
Risk Management	100% retrospective review	Controlled substance usage and documentation	Zoll Work Flow software and standardized report, LOGRX	Monthly
	100% retrospective review of high risk transports, narcotic administration, and infrequent skills. Random audit of 25% other call types	Adherence to treatment protocols	Zoll Work Flow software, LOGRX	Monthly
		Customer satisfaction	Surveys	Periodic
		Unusual occurrences (UO) and field report of UO	Field direct report, facility direct report, report through local EMS agency, EPRO	Daily
		Personnel exposures	EPRO software	Daily
		Personnel on-the-job injuries	EPRO Software	Daily
	100% retrospective review	Medication errors	Zoll Work Flow software	Within 7 days
	100% retrospective review	High risk-low incidence procedures	Zoll Work Flow software and EPRO software	Monthly

The process for selection of the above-listed indicators includes those mandated by the California Code of Regulations Title 22. Social Security Division 9, Pre-Hospital Emergency Medical Services Chapter 12. EMS System Quality Improvement, as well as the following:

- Meeting our goals of providing high-quality, appropriate care to our patients
- Key performance measures
- Knowledge of high-risk, low-incidence interventions and the potential impact on patient care
- Maintaining contract compliance with the healthcare facilities we serve
- Maintaining compliance with the local EMS agencies operating expectations
- Questions generated by stakeholders
- Gemba Walks

Royal Ambulance
Continuous Quality Improvement Plan

Royal Ambulance's CQI Team continually asks questions about the EMS systems we operate in and of the various healthcare facilities we serve to gain insight into opportunities for improvement. Questions are prioritized based on the level of importance to the local EMS system or the customers we serve.

The Clinical Operations Manager obtains data on the above indicators periodically (daily, monthly, quarterly, etc.) depending on the nature of the indicator. Information is obtained through Zoll Work Flow software, specialty reports developed in conjunction with IT and EPRO generated reports. Reports on clinical indicators are shared throughout the organization beginning with the Vice President of Operations, Medical Director and other leadership positions.

The Clinical Operations Coordinator and the County Supervisors will be pivotal in receiving the reports and creating action plans as related to report content. Depending on the type of report, some are generated daily (license renewals, injuries, etc.), monthly, quarterly (PCR audit), or annually. The specific content being analyzed is shared throughout the organization as it pertains to the overall operation. Monthly reports of key indicators will be sent to the LEMSA as outlined in their EMS QIP policy. A yearly system report will be prepared by aggregating monthly data collected and provided to the EMS agency.

The Clinical Operations Manager will be responsible for the initial analyzation of the quality indicators. Findings and trends will be further shared and discussed with the various departments Presentation of the quality indicator analysis will provided most frequently in the form of pivot tables, a Pareto chart or a histogram format. These formats will aid in the organization to easily interpret the data and identify trends. The CQI team will meet are least Quarterly to evaluate and discuss the data provided. CQI meeting agendas will consist of the following:

- Review of previous meeting action items
- Presentation of indicators and results/trends
- For each indicator reviewed, the following process will be followed:
    - Identify the objectives of the evaluation.
    - Present indicators and related information.
    - Compare performance with goals or benchmarks.
    - Discuss performance with peers and colleagues.
    - Determine whether improvement or further evaluation is required.
    - Establish a plan based upon the decisions listed.
    - Assign responsibility for the action plan.
- Examine correlations between and among trends.
- Acknowledge positive trends and "shout-outs"; discuss unsatisfactory trends.
- Discuss changes needed to indicators
- Summarize action items.
- Recommend training, educational needs and delivery.

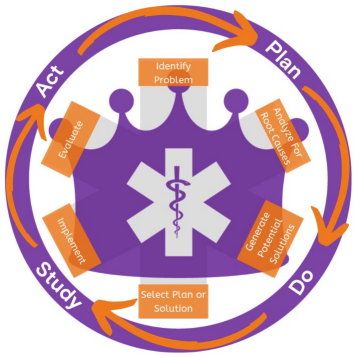
The Clinical Operations Manager is responsible for ensuring all data elements required by NEMSIS are collected, validated, and extracted into QI software (First Pass). The information shall be combined with chart reviews and incident reports. And compiled into a summary written report.

The Clinical Operations Manager is responsible for preparing a summary report of the QI review outlined above. The report shall be completed on an annual basis and shall be available for inspection to any EMSA requesting it.

Royal Ambulance
Continuous Quality Improvement Plan

III. Action to Improve

Royal Ambulance's standard approach to performance improvement the FOCUS – Plan, Do, Check, Act (PDCA) model.



The following steps are utilized:

- Find a process to improve – The CQI Team will identify improvement needs
- Organize – The CQI Team will identify the work group best suited to review the process documents.
- Clarify the current knowledge of the process – Review the indicator trends relevant to the process and collect any other information that will be useful.
- Understand causes of process variation utilizing tools such as charts or graphs.
- Select a process improvement to reduce or eliminate cause(s).
- Plan – State what the test objective will be and make predictions. Develop the plan to carry out the test (who, what, where, when).
- Do – Carry out the test, document problems and unexpected observations, and begin the data analysis process.
- Check – Complete the data analysis and compare the test data with the predictions. Summarize the findings and what is learned.
- Act – What changes need to be made? What will be the objective of the next PDCA cycle? What is needed to effect the desired change?

For LEMSA specific mandatory reporting indicators, PIPs will be developed and presented to the EMS agency for approval, along with the timeline for updates and final closure of the event. Once the Performance Improvement Plan (PIP) has been implemented, the results of the improvement will be measured. Changes to the system will be integrated and a standard of work will be updated or developed. A plan for continued monitoring will be established to sustain the change process.

In addition to utilizing the information and changes within Royal Ambulance, we share our findings, as appropriate with our various healthcare partners, local EMS agencies and customers.

Communication of issues surrounding QI activities and findings will be delivered to our employees, healthcare partners, local EMS agency, and customers in various forms, such as:

- Newsletter
- Huddles
- Educational sessions for new or refresher skills
- Annual update trainings for protocol changes and new skills
- Online educational offerings (EPRO)
- Staff meetings with Field Training Officers

- Department specific meetings
- Academy sessions for new hires
- Company bulletin boards and social media platforms
- Presentations at healthcare partner meetings
- Formal reports to local EMS agencies

IV. Training and Education

The effectiveness of our CQI program is dependent on the critical components of training and education as they relate to solving the problem and/or making a change within the system. The members of the CQI Team will meet to determine the type(s) of training needed. Leadership will have input into the content and method of delivery.

Once a PIP is recommended by the CQI Team or Work Group, the process will be updated/developed into a protocol, policy and/or standard of work. If additional training is required, time will be allotted for the training to occur prior to policy implementation.

Incorporation of training issues will be addressed by annual updates, training memos, train-the-trainer programs, in-house continuing education classes, online educational sessions and issue-specific instruction.

The Clinical Operations Manager is responsible for educational oversight and will ensure that employees submit documentation of all required education and training. Monitoring of training and education requirements is done utilizing EPRO.

The Clinical Operations Coordinator is responsible for assuring that continuing education is scheduled and reoccurring at established time intervals. The Clinical Operations Manager will assure that verifiable, ongoing training is appropriate to the EMT, Paramedic and Registered Nurse level of care and ensuring our organizational goals are met.

V. Complaints

All complaints shall be entered into EPRO by the receiving supervisor.

If no supervisor is available, the receiving employee shall send an e-mail to “Incident” with sufficient information that the appropriate supervisor can return the call.

The respective County Manager or Clinical Operations Manager shall be assigned the investigation of the complaint.

All investigations shall be completed within 7 business days. Waivers may be granted for unusual cases and must be approved by the COO.

It is the County Manager’s responsibility, in all cases where the complaining party is an EMSA, to provide a written response to the EMSA within time periods outlined in EMSA Policies.

VI. QI Records Security

It is the responsibility of the Clinical Operations Manager to maintain records security for data used for QI and Employee Coaching. Data shall be redacted to eliminate identifying patient information as outlined in HIPPA.

Data shall be stored on secured servers.

Only those employees with a need to know and a right to know will be allowed access to the respective databases.

Server access shall be granted through the Operations Manager or Clinical Operations Manager as outlined above.

PCR hard Copies shall be secured in secured boxes in a secured location. Access to records will be based on the above requirements.

VII. Individual Employee Occurrences

All unusual occurrences shall be logged into EPRO Software and investigated. If, during an Incident Review Board and/or internal investigation it is determined that the root cause is systemic or organizational, action shall be taken as outlined above. If it is determined that the occurrence is directly related to an employee failing to follow a policy, procedure, standard of care, protocol, or any LEMSA policy or procedure, the following progressive corrective actions may be taken in accordance with the severity of the violation:

- Additional coaching or training for the involved employee(s)
- Performance Improvement Plan
- Verbal or written warnings
- Suspensions without pay
- Termination

It is not required that each and every step be followed; Supervisors and Managers have the discretion to begin at the appropriate step based on the severity of the violation.

VIII. Unusual Occurrences LEMSA Reporting

Each County Manager is responsible to follow the reporting protocols and reporting regulations specific to that county. These protocols will be included in the New Hire Academy for the respective counties.

IX. Annual Update

The Clinical Operations Manager will evaluate the CQI program with the members of the CQI Team at least annually. This group will be tasked with ensuring that the CQI Plan is in alignment with the organizations strategic goals and mission statement. Review of the CQI Plan will be done to determine strengths and opportunities from improvement. From this information, an Annual Update will be provided to all respective departments and employees. The Annual Update will include, but not limited to, the following:

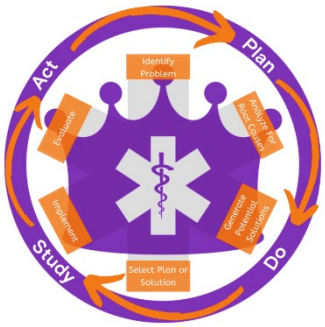
- Quality indicator monitors
- Key findings and priority issues identified
    - Identification of trends
- Improvement action plans and plans for further action
    - Description of any policy and standard of work revisions
    - Description of continuing education and skills training provided as a result of Performance Improvement Plans

Royal Ambulance
Continuous Quality Improvement Plan

Performance Review

- Direct Observation/ Gemba Walk
- Patient (Customer Feedback)
- Patient Chart Review
- KPI Measures
- Employee Skills Assessment

Identify Opportunities for Improvement



Identify Exceptional Performance

Recognize and Reinforce

- -Postings on Workplace
- -Annual Employee Recognition Awards
- -Huddles

- -Change process
- -Change protocol/policy/standard of work
- -Remediate
- -Change product
- -Incorporate into continuing education

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Emergency Medical Dispatch
Continuous Quality Improvement Program (EMD-QI)

Royal Ambulance Medical Director: Marcos Randazzo, MD
Royal Ambulance CQI Program Director/Clinical Operations Manager: Jim Bizieff, RN
Royal Ambulance CQI /Clinical Operations Coordinator: Jenilee Awichen, RN
EMD-CQI Coordinator/Communication Center Director: Shahil Patel, NAEMD-Q, EMD
EMD-Q / Dispatch Center Leads: Tianna Mott & Richard Malachek, NAEMD-Q, EMD

Purpose
Royal Ambulance's EMD-CQI Plan is part of an overall comprehensive CQI program. The purpose of the EMD-QI program is to establish a systematic process for evaluating and improving the quality of call taking for emergency and non-emergency requests for service.

In order to maintain accreditation from the National Academy of Emergency Medical Dispatch (NAEMD), and International Academy of Emergency Medical Dispatch (IAEMD) Standards, Communications must maintain monthly compliance scores as required by the Academy. Individuals must maintain quarterly standards based on a calculated formula which contributes to the overall compliance of the company.

Scope
This policy applies to all Communications personnel and supervisors and is to be carried out by the EMD-Q under the direction of the Communications Director.

Structure
The EMD-CQI program falls under the scope of Royal Ambulance's CQI program, Clinical Operations Manager and Clinical Operations Coordinator. EMD-CQI is maintained under the direction of the Director of Communications. Medical oversight is provided by the Royal Ambulance Medical Director.

Software for QA Review
Only the ProQA Software shall be used for call review.

Procedure

A. Agency Compliance

1. In order to maintain Royal Ambulance compliance levels in accordance with NAEMD Standards, it must report agency compliance percentages to the Academy each quarter.

2. These requirements state that the total of scored EMD calls must not exceed allowed percentages in the Partial, Low and Non-compliant categories:

    a. Partial Compliance: 10%
    b. Low Compliance: 10%
    c. Non-Compliant 7%

B. Quantity and Timing of Case Review

1. The number of AMD cases to be reviewed shall be determined based on call volume to meet IAED standards (50%) of medical calls shall be reviewed.
2. Calculator is available at https://www.emergencydispatch.org/what-we-do/case-review-calculator
3. All reviews shall be completed within 5 business days of the call.
4. Any coaching shall be conducted within 7 business days of the call.

C. Individual Compliance

1. For an individual to successfully contribute towards agency compliance requirements, a formula is established to determine if individual compliance levels are achieved. The minimum acceptable protocol average is nine (9) points for each quarter of the year.

2. The individual's weighted score will include the total of all calls randomly reviewed with the appropriate weights, divided by the total number of calls reviewed to determine the average score.
    a. High Compliance: 10
    b. Compliant: 9
    c. Partial Compliance: 7
    d. Low Compliance: 6
    e. Non-Compliant: 5

3. The individual will receive monthly summaries and feedback for each Incident Performance Report, the averaging of scores will only occur on a quarterly basis.

4. If an individual has fewer than four (4) cases in a single quarter, and the minimum average of nine (9) is not achieved, the EMD QIC will work with the employee and the employee's supervisor to increase time at EMD positions to increase the likelihood of random audit selections. If the subsequent quarter still does not have more than 4 cases, the two quarters will be added together for averaging.

D. Weekly Case Review

The EMD-Q will review randomly selected calls (from call recordings and CAD documentation) for each Customer Service Representative (CSR) and Dispatcher (full-time, part-time). The Number of calls per week are as follows:

- Worked 90 days or less will be monitored and review a minimum of 1 call per shift (4 total in a week).
- Worked 180 days or less will monitor and review a minimum of 2 calls per week.
- Worked 180 days or more will monitor and review a minimum of 1 call per week.

Each call will be scored using the NAEMD QA score sheet and applied a grade of 0-100%. See Appendix A

E. Weekly Feedback Process

1. Procedure for review of calls

a. Completed QA Grade sheets with either an Exemplary Dispatcher Performance Report or a Dispatcher Non-Compliance Report will be emailed to the Dispatch Leads and Dispatch Manager.
b. Manager, Leads and EMD -Q will meet weekly to review area of excellence and improvements needed
c. Manager or Lead may request for further investigation, or request for a specific topic to be reviewed with the EMD. This Request can also be for commendation letters or opportunity to bring up topics during weekly, monthly, or quarterly meetings (as appropriate).
d. The EMD-Q will meet with each Customer Service Representative or Dispatcher to review their scores:
    i. Highlighting areas of success.
    ii. Reviewing areas where errors and omissions may have occurred.
    iii. Offering the opportunity for a third part review if requested/required is available and agents have that option to request if they feel that their score merits a second review.
    iv. If necessary develop an action plan to outline a timeline for improvements to occur
    v. Copy of the QA Grade Sheet will be filed in the QA & EMDs folder

2. Scores
    a. Each call monitored and reviewed will have a final score outlined:
    b. Level 3 – Below 95%
    c. Level 2 – Between 96% and 99%
    d. Level 1 – 100%
    e. CSRs or dispatchers who average below 95%, regardless of their tenure, in any one month, will be automatically moved to 5 calls monitored per week until such time as their scores increase.
    f. A Level 3 score for any single month will result in additional coaching and counseling
    g. A Level 3 for 2 consecutive months will result in a verbal warning
    h. A Level 3 average for 3 consecutive months will result in a written warning.

F. <u>Trainee, Newly Qualified EMD and Employee Compliance</u>

1. Realizing that achievement of these compliance rates is not immediately feasible for newly qualified EMDs, the procedures, as listed below, outline a systematic approach to reach that objective:
    a. Within 3 months of starting an EMD specific academy, all Emergency Medical Dispatchers should be certified through the IAEMD
    b. Possess a current CPR certification including AED
    c. Submit a valid IAEMD Advanced Certification card or confirmation from the IAEMD regarding valid EMD certification status.
    d. Complete an On-the-Job Training program with a Communications Training officer.
    e. Complete documentation of training through daily, bi-weekly and final training documents.

2. After IAEMD Certification all EMD's shall meet the following compliance levels within the specified time frames:
    a. Within two months of becoming certified EMDs, all dispatcher's average monthly compliance score will be above eight (8).
    b. Any dispatcher not achieving an average score of eight (8) will receive additional training sessions.
    c. Within three months of becoming certified EMDs, all dispatcher's average monthly compliance score will be above nine (9).
    d. Any dispatcher not achieving an average score of nine (9) will receive additional training sessions.
3. Within four months of becoming certified EMDs, all dispatchers shall maintain the quarterly average of nine (9).
4. Any dispatcher not maintaining these compliance rates in any one quarter shall receive one or more of the following:
    a. Intervention: QAU/employee session(s) designed to identify barhers to expected compliance rates and discussion of solutions/ideas. Employee participation is required in this intervention process.
    b. Supervisor Action plan: A formal education/training plan developed to address a particular concept which is preventing the required compliance score.
    c. Remediation plan: A formal education/training plan developed to address multiple concepts which are preventing the achievement of the required compliance score.

G. <u>Discipline vs Quality Assurance</u>

1. This policy does not exclude the need or discipline when considering individual cases of gross negligence and/or gross improper behavior, or cases of persistent failure to apply Royal Ambulance Policy and Procedure; nor does it exclude any other existing disciplinary process.
2. The EMD QIC shall coordinate and manage all quality improvement reviews. The goal is to provide education and feedback to individual EMD's through ongoing review of EMD performance, and to provide consistent feedback on performance for every EMD dispatcher.
3. When compliance becomes a discipline versus quality improvement problem, the EMD QIC will work with the Communications Supervisors for the appropriate course of action.
4. The individual's direct supervisor shall coordinate all Action Plans or Remedial Training requirements in conjunction with the EMD QIC.
5. All discipline cases shall be handled according to current and procedures via corrective and disciplinary action policy.
6. Trigger points for disciplinary action:
    a. In the first six months after EMD certification, failure to achieve the required compliance levels as detailed in section above for two out of three months.
    b. Following a six-month period of certification as an EMD:
    c. Failure to achieve the required compliance levels as detailed above two or more quarters in a row.

d. Failure to complete a Supervisors Action Plan or recommended training.
e. Continued failure to achieve EMD compliance levels or completion of a Supervisor's Action Plan and Identified Training.

H. Monthly

Each month the EMD-Q with the assistance of the Director of Communications will review the monthly findings and discuss improvement opportunities. The team will discuss the following:

- Average QA Score for the team
- Identify common problem areas & develop action plans
- Review Critical Failures and Unusual Occurrences
- Discuss Training Opportunities
- Celebrate successes
- Formally recognize members of the team who are consistently setting the bar for high performance by maintaining "High Compliance" on all calls taken.

I. Quarterly

1. Each Quarter the Director of Communications will meet with the Chief Operating Officer, Chief Executive Officer, Medical Director, and any other team member as appropriate.
2. The purpose of the quarterly review is to discuss policy or protocol changes, review the QA reports compiled by the EMD-Q and Director of Communications. Additionally, the Quarterly review is used to discuss strategic improvements to the communications center.

J. Ad Hoc Reviews

Ad Hoc QA reviews will be completed for any unusual occurrence or critical failure. Unusual Occurrences include the following:

- Customer Complaints
- Upset Customer/Hang ups
- Crew advising customer upset
- Billing requests for info (internal)
- Incorrect scheduled pickups
- Missing Pickups
- Crews late to calls for unusual reasons (not traffic delays)
- County EMS request
- As requested by Operations or Customer Success

K. Submitting Data to SF EMS Agency

1. Each month Royal Communications Center will submit QI Data Reports reviewing compliance metrics from weekly QI reports reporting partial, low and non-compliant Transports with Deviations marked appropriately.

2. Sentinel Event – in the event that a critical incident occurs which was a result of deviation(s) during call intake are considered Mandatory Reporting events.
3. Any event that is actionable pursuant to Health & Safety Code Section 1798.200 shall be reported, within 24 hours, to the EMS Agency Duty Officer (refer to Procedure IV.D.).
4. Reportable events include, but are not limited to:
    a. Use of intoxicants or impaired ability due to alcohol or drugs while on duty as an EMD provider.
    b. Clinical acts or omissions that may be considered negligent or possibly contributed to a poor patient outcome.
    c. Deviation from EMD policy or protocol that may result in a poor patient outcome.
    d. Any act or omission that constitutes a threat to public health and safety.
    e. Any event where recurrence would have a significant chance of adverse outcome.
5. Written reports, using a form developed by the EMS Agency, shall be completed and submitted to the EMS Agency within 72 hours.
    a. The written report must include copies of all pertinent documentation, including but not limited to:
        i. Patient care records
        ii. Dispatch logs
        iii. Written statements by involved personnel
        iv. Summary of initial investigation and actions taken by agency (when applicable and available).
6. Exception Reports - Any incident or event which the reporting party believes warrants reporting to another EMS system participant shall be documented and forwarded by the reporting party to all other agencies involved.
7. Reportable incidents or events include, but are not limited to:
    a. Policy or protocol violations not related to clinical care or patient outcome;
    b. Deviation from authorized use of supplies or equipment;
    c. Documentation error or omission not related to patient care;
    d. Communication errors;
    e. Destination errors with no impact on patient outcome;
    f. Near miss incidents;
    g. Operational (non-clinical) issues.
8. Commendations may also be submitted to communicate exceptional care by an individual or group of providers.
9. Exception will be documented using a form developed by the EMS Agency.
10. Copies of all supporting documents, such as PCRs, hospital records, dispatch logs, etc. must be included.
11. The EMS Agency shall log all Exception Reports for the purposes of data collection and analysis.
12. In the event that a recipient of an Exception Report fails to respond, or provides an inadequate response, the reporting party may inform EMSA of the failure and request follow-up action on closure reporting.
13. Tapes will be provided to the EMS Agency with all reports submitted.

Appendix A

BAY AREA

CRITICAL CARE PARAMEDIC (BACCP)

2022 FIELD MANUAL
TREATMENT GUIDELINES

DRAFT

Alameda County EMS Agency
1000 San Leandro Blvd. Ste 200
San Leandro, CA 94577
(510) 618-2050

San Francisco EMS Agency
333 Valencia St. Ste 210
San Francisco, CA 94103
(628) 217-6000

2022 Bay Area Critical Care Paramedic (BACCP) Field Manual

CCP policies and protocols should be used as guidelines and are not intended as a substitute for sound medical judgement. Unusual patient presentations make it impossible to develop a policy or protocol for every patient situation.

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CRITICAL CARE PARAMEDIC (CCP) – PROGRAM STANDARDS

1. PURPOSE

The Critical Care Paramedic Program has been developed to provide a means of transporting patients who require, or who may require, care within the CCP Scope of Practice during care. CCP units may be used to transfer patients from or to acute care facilities, scene calls, or other medical facilities approved by the EMS Medical Director.

The local EMS agency authorizes and contracts with interested ambulance providers that meet the training, staffing, equipment, and oversight requirements for providing this level of service and that agree to comply with program standards. Program authorization may be denied or withdrawn for failure to comply with program standards or failure to submit required fees.

(California Health and Safety Code, Division 2.5, 1797.214; California Code of Regulations, Title 22, Chapter 4 § 100142, 100144, 100145, 100148, 100155, 100166, 100168, 100172, 100173; Alameda County EMS, Policy# 2000; San Francisco EMS, Policy# 4070).

2. STAFFING

A CCP unit is a fully equipped advanced life support Quick Response Vehicle "QRV" vehicle and/or ambulance, staffed with A) a minimum of one (1) qualified staff of a Critical Care Transport Paramedic; and/or B) a minimum of two (2) qualified staff with one (1) Critical Care Transport Paramedic and (1) another local EMS agency accredited EMT/EMTP.

2.1. **Critical Care Paramedic Accreditation**

Paramedics assigned to CCP units shall meet the following minimum qualifications:

- 2.1.1. Current California Paramedic License
- 2.1.2. Current Board of Critical Care Paramedic Certification CCP-C (BCCTPC/IBSC)
- 2.1.3. At least two (2) years full time field experience as a paramedic in an ALS system within the past five (5) years
- 2.1.4. Completion of an approved CCP training program (Title 22, Ch. 4 *§100137*) OR at the discretion of the EMS Medical Director, equivalent education (as specified in Title 22, Ch. 4, *§100155 (b)*) and/or experience in critical care transport
- 2.1.5. Accreditation as required by local EMS agency
- 2.1.6. Successful completion of a local EMS agency approved provider education orientation and skills competency testing specific scope of practice skills used on critical care interfacility transfers (Title 22, Ch. 4, *§100146(1)(S)*)

2.2. **Emergency Medical Technician (EMT)**

EMT's regularly assigned to CCP units shall meet the following minimum qualifications:

- 2.2.1. Current and valid California EMT certification
- 2.2.2. Current provider status in Healthcare Provider BLS
- 2.2.3. Successful completion of the local EMS agency approved training program specific to skills used to assist the CCP with patient care during interfacility transfer

2.3. Employer shall provide the local EMS agency with a list of all regular staff working on a CCP unit and shall see that the list is updat4ed whenever there is a change in personnel.

2.4. Employer shall retain on file, always, copies of current and valid credentials for all personnel performing services under this program.

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3. MEDICAL DIRECTION

Personnel assigned to a CCP unit work under the existing medical control system and follow local EMS agency policies and procedures as approved by the EMS Medical Director.

3.1. CCP Scope of Practice

The CCP scope of practice includes the local EMS agency's basic and local optional scopes of practice for paramedics listed in the agency's EMS protocols. In addition, CCP's have an expanded scope that includes the administration of medications and procedures as outlined in the CCP Treatment Guidelines:

- Set up and maintain thoracic drainage systems
- Set up and maintain mechanical ventilators
- Set up and maintain IV fluid delivery pumps and devices
- Calcium channel blockers
- Blood and blood products*
- Fluid Administration
- Glycoprotein IIB/IIIA inhibitors*
- Heparin IV*
- Nitroglycerin IV*
- Norepinephrine*
- Thrombolytic agents*
- Maintain total parental nutrition*

*These medications are CCP basic scope of practice if the CCP has completed a Critical Care Paramedic training program as specified in (*Title 22, Ch.4, §100146(1)(S), §100155 (b)*).

3.2. Transferring Physician Orders/Scene Medical Direction

3.2.1. For interfacility transfers:

3.2.1.1. Standing orders approved by the CCP provider's Medical Director is the gold standard of patient care

3.2.1.2. When the transferring physician or base hospital physician is contacted, specific orders must be based on skills and medication that are in accordance with the local EMS agency's CCP scope of practice

3.2.1.3. Clearly written physician orders are preferred and must be uploaded into the electronic patient care record (ePCR)

3.2.1.4. Clearly written physician orders may be obtained from the hospital's medication administration record and uploaded into the ePCR

3.2.2. In special circumstances (e.g., scene/private residence responses) verbal physician orders may be written down and read back to assure clarity. Document physician orders in the ePCR.

3.2.3. When radio communications are not possible, the CCP will provide care per the local EMS agency's ALS protocols and CCP field manual treatment guidelines until radio contact can be made with the base hospital physician.

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3.3. **Patient Care Outside of the Paramedic Scope of Practice**

3.3.1. When a patient's treatment/care is beyond the CCP scope of practice, that patient may transported by a CCP unit only when:

3.3.1.1. A licensed medical professional (e.g., RN, NP, Nurse midwife, PA, or MD) is in attendance and assumes control and responsibility for providing patient care outside the CCP scope of practice; AND:

3.3.1.2. Medication and/or equipment needed by the patient, that is not stocked on the unit, is provided by the sending facility or CCP program.

3.3.2. Accompanying licensed medical personnel providing care function under their own written standing orders/protocols and document any care provided.

3.4. **Exceptional Situations**

3.4.1. **Critical Patients and "on views":**
If the CCP unit either responds to a private request for transport and finds a patient that requires immediate ALS care, or "on views" an emergency scene, the CCP:

3.4.1.1. Shall notify the appropriate dispatch communication center

3.4.1.2. Shall provide appropriate patient care, which may include any indicated ALS interventions following appropriate EMS agency protocols

3.4.1.3. May initiate transport of acute patients in accordance with local EMS agency policy

3.4.1.4. An exception report shall be filed per jurisdictional EMS agency policy

3.4.2. **Patient Deterioration During Transport:**
If the CCP unit responds to a private request for transport, and the patient begins to deteriorate after transport has begun, personnel shall:

3.4.2.1. Provide appropriate care that may include any indicated BLS, ALS, and CCP interventions following appropriate EMS protocols

3.4.2.2. Make base hospital contact for any patient deterioration

3.4.2.3. Divert to a closer facility, if necessary and appropriate, based on patient condition and base hospital direction

3.4.2.4. CCP personnel shall submit a written report fully explaining the circumstances of any exceptional situations including those described above together with a copy of the patient care report and related dispatch records to the local EMS agency within 24 hours of the incident

4. **STANDARD OF CARE**

4.1. All patients shall be placed on continuous EKG, NIBP, and SpO2 monitoring.

4.2. End-Tidal CO2 monitoring shall be utilized for:

4.2.1. All invasive and non-invasive ventilated patients

4.2.2. All patients receiving sedation and/or pain medications

4.2.3. Strongly recommended for non-intubated patients at high risk for airway, ventilatory, and/or circulatory compromise

4.3. Vital signs shall be recorded at a minimum of every 15 minutes for all stable patients and a minimum of every 5 minutes for unstable patients or patients on titrating vasoactive medications.

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4.4. All medication infusions shall be crosschecked with hospital staff and/or CCT crewmembers.
4.5. Infusions must be regulated by a mechanical pump familiar to the CCP. If a pump failure occurs, and cannot be corrected, the CCP is to notify the transferring physician or, the base physician if the transferring physician is unavailable, to discuss alternative options.
4.6. Medications within the paramedic's scope of practice and protocols normally given by IV push but, are being administered via infusion pump, may be transported if parameters for the infusion are obtained and understood by the CCP.
4.7. If medication administration is interrupted (infiltration, accidental disconnection, malfunctioning pump, etc.), the CCP may restart the line and continue use.

5. DOCUMENTATION

5.1. **Electronic Patient Care Report (ePCR)**
An ePCR format of which has been approved by the local EMS agency shall be accurately completed on each patient in accordance with the jurisdictional EMS agency (origin of transport).
5.1.1. The ePCR shall contain available and relevant information regarding call demographics, patient assessment, care rendered, and patient response to care.
5.1.2. A copy of, or access to, the patient's ePCR shall also be available to the receiving facility prior to departing the facility.
5.1.3. If base contact is initiated, a copy of, or access to, the patient's ePCR shall be available to the base hospital within 24 hours.

6. CCP STAFF PREPARATION AND COURSE APPROVAL PROCESS

6.1. Submit a Paramedic Interfacility Transfer Program form, complete checklist, and supporting documentation to the local EMS agency for approval at least two (2) weeks prior to the course start date.

6.2. CCP didactic and clinical education requirements shall be conducted in accordance with the standards for CCP's as specified in Title 22, Chapter 4, §100155 (b).

6.3. **Critical Care Emergency Medical Technician:**
6.3.1. A minimum of 750 hours of clinical field experience as an EMT must be achieved before working as a Critical Care Transport EMT.
6.3.2. Minimum of eight (8) hours didactic and clinical instruction specific to the skills needed to assist asingle paramedic in-patient care delivery during Expanded Scope of Practice Paramedic Interfacility Transfer calls.
6.3.3. Method for assessing successful course achievement/evaluation must be described.
6.3.4. Principal instructor of paramedic training must be CCP, registered nurse, or physician knowledgeable in the subject matter.
6.3.5. Instruction course to include:
6.3.5.1. **Role of the Critical Care EMT**:
- Critical Care vs. BLS system
- EMTALA
- COBRA
- EMT scope of practice

6.3.5.2. **Infusion Pumps**:
- Operation of and troubleshooting
- Discussion of various pumps that may be encountered

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6.3.5.3. **Indwelling Tubes/Catheters**:
- Discuss, describe, demonstrate, and/or view:
  - Urinary Foley Catheters
  - Suprapubic Catheters
  - Nasogastric Tubes
  - Orogastric Tubes

6.3.5.4. **Non-Invasive Monitoring**:
- NIBP
- Pulse Oximetry
- Capnography

6.3.5.5. **12-Lead EKG**
- Correct lead placement and importance of same

6.3.5.6. **Recognition of proper equipment for procedural assisting the CCP during**:
- Intubation
- Emergent Synchronized Cardioversion or Defibrillation
- Pleural Decompression

6.3.5.7. **Infectious Disease Precautions**:
- Common Pathogens to include:
  - HIV
  - Hepatitis
  - VRE
  - MRSA
  - TN
  - C-Diff
- Procedures for self-protection, decontamination, and exposures

6.3.5.8. **Documentation**
- Patient Consent Forms
- EMTALA Forms

6.3.5.9. **Dispatch, Deployment, Operational, and County Policy and Procedure Review**

7. CONTINUOUS QUALITY IMPROVEMENT (CQI) PLAN

7.1. A CCP program shall have a written CQI plan approved by the local EMS agency. This plan shall complement the EOA provider's existing CQI plan. CQI plans shall include provisions for continuing education including types of activities, frequency, and required hours.

7.2. A registered nurse or physician shall have clinical involvement and ove4rsight of the CCP CQI plan.

7.3. Provider's CQI staff shall evaluate CCP transfers for appropriateness.

7.4. Specific review for use of intravenous expanded scope medications will include:
- Review of transferring physician orders and evidence of compliance with orders
- Documentation of vital signs per policy including frequency
- Documentation of any side effects/complications including hypotension, bradycardia, increasing chest pain, arrhythmia, altered mental status, and interventions with these events

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- Documentation of unanticipated discontinuation or rate adjustments of infusions along with rationale and outcome
- Review of any base hospital or transferring physician contact for orders during transport

7.5. The CCP provider shall provide to EMS, at its sole expense, all hardware and software necessary for reviewing and monitoring ePCR.

7.6. The CCP provider shall use software in the ePCR and Data Collection System to allow for real-time access in the format specified by the local EMS agency. The software shall also provide detailed operations, clinical, and administrative data in a manner that facilitates retrospective analysis.

7.7. The local EMS agency will receive quarterly reports summarizing CQI activity and identified trends and resolutions.

8. **CCP COMPETENCY STANDARDS**

All critical care transport paramedics shall meet the following requirements to maintain their local EMS agency approval in order to function with their advanced CCP scope of practice:

8.1. Minimum of six (6) shifts per quarter on a CCP unit unless specifically waived by the local EMS agency.

8.2. Completion of annual CCP policy and skills competency education with evaluation including the following:

- Oral intubation (Adult)
- Supraglottic airway insertion
- Bougie insertion
- Needle thoracostomy
- Intraosseous insertion
- Ventilator application
- CCP drip calculations
- CCP clinical policies

8.3. Compliance with Paramedic and CCP policy and skills competency standards is required to maintain standing as an active CCP. Any variance requires approval of the local EMS Medical Director. Skill list may be expanded at the discretion of the local EMS agency. Educational standards time requirements must be approved by the local EMS agency for all CCP unit staff.

9. **CCP UNIT EQUIPMENT**

9.1. CCP units are required to comply with the local EMS agency's local ordinances, service provider agreements, etc.

9.2. CCP units are required to comply with ALS Transport Equipment and Supply Standards, Inspections and Specifications defined in the local EMS agency's EMS policies.

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9.3. The following additional equipment is required and must be approved by the local EMS agency's Medical Director:

- AC Power Inverter (if applicable)
- Mechanical Ventilator (with associated accessories including HME and extra power source)
- Mechanical Infusion Pump (multiple channels and/or a back-up device)
- Portable Doppler
- Oral Thermometer (or other temperature monitoring device such as a cardiac monitor temp cable)
- Additional equipment as required by the local EMS agency and/or EMS provider's EMS Medical Director(s)

DRAFT

APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

APPROVED:_____ **DATE:** _____
EMS DIRECTOR

AMIODARONE HYDROCHLORIDE

1. PURPOSE

To authorize CCP's to initiate or monitor existing intravenous Amiodarone Hydrocholoride infusions

2. POLICY

2.1. CCP's are permitted to initiate or monitor Amiodarone Hydrochloride infusions

3. PRECAUTIONS

3.1. Y injection incompatibility with the following will precipitate with Amiodarone Hydrochloride:
  3.1.1. Heparin Sodium
  3.1.2. Sodium Bicarbonate
3.2. Amiodarone should not be given in the presence of ventricular escape rhythm or other bradycardias.
3.3. Amiodarone concentrations should not exceed 2 mg/ml unless a preexisting central venous catheter is used in infusions being administered greater than 1 hour in duration.

4. PROCEDURE

4.1. The following parameters shall apply to all patients with Amiodarone infusions:
  4.1.1. Due to initial bolus given over time an IV infusion pump must be used
  4.1.2. Vital signs must be monitored more frequently than every 15 minutes

5. ADMINISTRATION

5.1. **Pulsing monomorphic V-Tach**:
  5.1.1. **Adults** – 150 mg mixed in 100 ml NS over 10 minutes and may repeat q 10 minutes prn.
  5.1.2. **Peds** – 5 mg/kg (max 300 mg) mixed in 100 ml NS over 20 mins. Pediatric patients with a pulse, bolus and/or continuous infusion, requires a physician consult to obtain direction and dosing.
5.2. For patients who have received bolus doses of Amiodarone, it may be appropriate to establish an infusion by mixing 450 mg in 250 ml D5W (not NS) and initiate at 1 mg/min to a maximum cumulative dose of 2.2 grams IV over 24 hours.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

BLOOD/BLOOD PRODUCTS

1. PURPOSE

To authorize CCP's to monitor existing blood/blood product infusions during transport

2. POLICY

2.1. CCP's are permitted to monitor/infuse blood and blood products during interfacility transports.
2.2. CCP's may not adjust blood/blood product infusions without specific transferring physician parameters or base hospital physician consult.
2.3. Use of a buddy light or other warming measure is preferred.

3. ADVERSE REACTIONS

3.1. **Hemolytic Reactions:** The most life-threatening and manifestations may vary considerably as: fever, headache, chest or back pain, pain at the infusion site, hypotension, nausea, generalized bleeding or oozing from surgical site, or shock. The most common cause is from ABO incompatibility due to clerical error or transfusion to the wrong patient. Chances of survival are dose dependent; therefore, it is important to stop the transfusion immediately if a hemolytic reaction is suspected.
3.2. **Febrile Non-Hemolytic Reaction**: Chills and fever with a rise from baseline temperature of 1° C or 1.8 ° F.
3.3. **Allergic Reaction**: Characterized by appearance of hives, urticaria, and itching.
3.4. **Anaphylaxis**: May occur after administration of only a few ml's of a plasma containing component. Symptoms include coughing, bronchospasms, respiratory distress, vascular instability, nausea, abdominal cramps, vomiting, diarrhea, shock, and altered mental status.
3.5. **Volume Overload**: Characterized by dyspnea, headache, peripheral edema, coughing, frothy sputum or other signs of congestive heart failure occurring during or soon after transfusion.

4. PROCEDURE

4.1. Identify the patient and blood by checking the patient ID band against the blood/blood product label and the actual order for name, blood type, unit identifying number, and expiration date.
4.2. Monitor the patient's condition and vital signs before, during, and after blood product infusion.
4.3. Blood/blood products infusion parameters:
4.3.1. Infusion will be through filtered blood tubing. Stable patients shall have blood infused via IV infusion pump. Unstable patients may have blood infused via a pressure bag without a pump.
4.3.2. Infusion rate will occur within the parameters as defined by the transferring physician. No other flow adjustments may be made by the CCP other than to discontinue the infusion in the event of complications.
4.4. In cases of a suspected adverse transfusion reaction, discontinue the blood/blood product infusion. Notify the transferring physician and/or base hospital. Treat signs/symptoms per local EMS agency protocol as needed. Keep blood/blood products and deliver with the patient for possible testing.

APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

DRAFT

CALCIUM CHANNEL BLOCKERS

1. PURPOSE

To authorize the CCP to monitor and adjust existing Calcium Channel Blocker (CCB) infusions

2. POLICY

2.1. CCP's are permitted to monitor and adjust Calcium Channel Blocker infusions.
2.2. CCP's may not initiate Calcium Channel Block infusions.

3. PRECAUTIONS

3.1. Use caution with patients with liver and renal disease.
3.2. Side effects can include dizziness, palpitations, fatigue, headache, and nausea.

4. PROCEDURE

4.1. Calcium channel blockers are used for a variety of reasons to include lowering blood pressure, relaxation of blood vessels, slow and/or regulate heart rate, relieve angina, and for CAD.
4.2. CCB's prevent calcium from entering the cells of the heart and arteries. Calcium causes the heart and arteries to contract more strongly. By blocking calcium, CCB's allow blood vessels to relax and open. Some CCB's are also used to slow down and regulate the heart rate.
4.3. Regulation of the infusion rate will occur within the parameters as defined by the transferring physician or base hospital orders.

5. ADMINISTRATION

5.1. Common Calcium Channel Blockers and doses include, but not limited to, the following:
- Cardizem: 5 -15 mg/hr
- Nicardipine: 5 mg/hr and titrate q 10 mins by increments of 2.5 mg/hr for desired MAP
- Nifedipine: 10 mg PO q 20 mins and may repeat up to a max of 30 mg
- Clevidipine: 1-2 mg/hr with a max of 16 mg/hr

5.2. These medications and doses are for reference only. Transferring physician will select the medication and dose for infusions with orders for transport guidelines and titration, if applicable.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

DOPAMINE HYDROCHLORIDE

1. PURPOSE

To authorize CCP's to initiate, monitor and adjust existing intravenous Dopamine infusions

2. POLICY

2.1. CCP's are permitted to monitor and adjust Dopamine infusions.
2.2. CCP's may not initiate Dopamine infusions without transferring or base physician consult.

3. PRECAUTIONS

3.1. Use caution in patients who may be volume depleted. Focus is on sufficient volume replacement first.
3.2. Patients on Dopamine may experience tachydysrhythmias and treat as indicated.

4. PROCEDURE

4.1. Indications include cardiogenic and/or distributive shock. Norepinephrine is preferred first line vasopressor over Dopamine.
4.2. For septic shock, Dopamine is used only as an alternative to Norepinephrine in a select group of patients, specifically those with a low risk of tachyarrhythmias and absolute or relative bradycardia.
4.3. Regulation of the infusion rate will occur within the parameters as defined by the transferring physician, but in no instance, will rate changes be greater than 5 mcg/kg/min increments q 5 mins.
4.4. Typical concentration for Dopamine is 400 mg/250 ml D5W. Caution that double strength concentrations do exist in some hospitals.
4.5. Typical Dopamine infusion dose range is 5-20 mcg/kg/min.
4.6. The maximum Dopamine dose is 20 mcg/kg/min in most circumstances.
4.7. In cases of severe hypertension, the medication infusion will be slowly titrated down and, if necessary, discontinued and the transferring physician or base hospital physician notified.

5. ADMINISTRATION

5.1. CCP's may initiate Dopamine infusions in conjunction with transferring or base physician consult.
5.2. Titrate to achieve a MAP of >65 mmHg or heart rate > 70 bpm depending on indication of use

APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

DRAFT

EPINEPHRINE

1. PURPOSE

To authorize CCP's to initiate, monitor, and adjust existing intravenous Epinephrine infusions

2. POLICY

2.1. CCP's are permitted to initiate, monitor, and adjust Epinephrine infusions.
2.2. CCP's are permitted to administer push dose Epinephrine.

3. PRECAUTIONS

3.1. Use caution in patients who may be volume depleted.
3.2. Use caution in patients who are on multiple vasopressors.

4. PROCEDURE

4.1. **Epinephrine Infusion Parameters**

4.1.1. Regulation of the infusion rate will occur within the parameters as defined by the transferring or base hospital physician or by standing orders.
4.1.2. CCP's may titrate Epinephrine to achieve a MAP > 65 mmHg q 5 mins increments.
4.1.3. Typical initial Epinephrine dose range is 0.03 mcg/kg/min to 1 mcg/kg/min.
4.1.4. The maximum Epinephrine dose is 1 mcg/kg/min.
4.1.5. **Adult Infusion**: Mix by adding 10 mg Epi 1:1,000 (10 ml) to 90 ml NS, D5W, or D10W. This will provide a total volume of 100 ml and a concentration of 100 mcg/ml.
- For patient's in excess of 100 kg, consideration for the length of transport should be made to determine the amount of infusion necessary to complete the transport.
  - Example - 40 kg patient at a rate of 1 mcg/kg/min and the 100 ml infusion will last ~ 80 mins

4.1.6. **Pediatric Infusion**: Mix by adding 2 mg Epinephrine 1:1,000 (2 ml) to 98 ml of NS, D5W. This will provide a total volume of 100 ml and a concentration of 20 mcg/ml.
4.1.7. In cases of severe hypertension, the infusion will be titrated down and, if necessary, discontinue, and notify the transferring physician or base hospital.

5. ADMINISTRATION

5.1. Epinephrine infusion initiation should be considered for hypotensive shock states after ensuring adequate patient ventilation, oxygenation, and volume repletion.
5.2. Initiate Epinephrine at 0.03 mcg/kg/min and titrate to achieve a MAP > 65 mmHg.
5.3. Infusion alternate is to administer push dose Epi per EMS ALS treatment guidelines OR as follows:
5.3.1. Must ensure patient preload has been optimized with crystalloid and/or colloid prior to utilization of push dose Epi
5.3.2. Dilute Epinephrine by mixing 1 ml Epi 1:10,000 in 9 ml NS to equal a concentration of 10 mcg/ml. This will yield 10 doses in a 10 ml syringe as each dose is 10 mcg or 1 ml
5.3.3. **Adult Dose:** 10 mcg (1 ml) q 5 min
5.3.4. **Peds Dose**: 1 mcg/kg q 5 mins with a max single dose of 50 mcg

APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

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FLUID MANAGEMENT

1. PURPOSE

To authorize CCP's to initiate, monitor, and adjust existing intravenous fluid administration

2. POLICY

2.1. CCP's are permitted to initiate, monitor, and adjust fluid administration infusions.
2.2. CCP's may utilize fluids to mix medication infusions as needed per protocol.

3. PRECAUTIONS

3.1. Use with caution in patients who may be volume overloaded.
3.2. Use with caution in patients with congestive heart failure.
3.3. Use with caution in patients with renal failure.

4. PROCEDURE

4.1. **Fluid Infusion Parameters**

4.1.1. CCP's may use dextrose and balanced solutions per Title 22 for fluid administration and for mixing necessary medication infusions.
4.1.2. CCP's may administer, or mix medication infusions, in the following fluid types: 0.45% NS, 0.9% NS, 3% NS, Lactated Ringers, Plasmalyte, and dextrose-based fluids such as D5%, D5½ NS, D5NS, and D10%. Other fluid types require transferring physician or base hospital orders.
4.1.3. For patients receiving a dextrose-based fluid a blood glucose level should be checked every 30 mins.
4.1.4. See each individual medication policy for mixing of infusion guidelines.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

GLYCOPROTEIN IIB/IIIA INHIBITORS

1. PURPOSE

To authorize CCP's to monitor existing glycoprotein receptor inhibitor infusions

2. POLICY

2.1. CCP's are permitted to monitor glycoprotein receptor inhibitor infusions.
2.2. CCP's may not initiate glycoprotein receptor inhibitor infusions.

3. PRECAUTION

3.1. Glycoprotein IIb/IIIa receptor inhibitors are incompatible with Diazepam if given in the same line.

4. PROCEDURE

4.1. Medication concentration will not exceed the standard manufacturer concentrations.
4.2. Infusion rates must remain constant during transport with no regulation of rates being performed by the CCP, except for the discontinuation of the infusion (e.g., as in the case of bleeding).
4.3. Documentation of calculation of the physician ordered infusion rate based on recent patient weight(kgs).
4.4. Documentation of the following lab values: Blood Urea Nitrogen, Creatinine, Hemoglobin, Hematocrit, Platelet count, and Coagulation studies at a minimum.
4.5. Vital Signs are to be monitored as indicated in transfer or physician orders. If no specific orders are obtained, document per protocol.

5. ADMINISTRATION

5.1. Common glycoprotein IIb/IIIa receptor inhibitors and doses include, but not limited to:
- Integrillin – 2 mcg/kg/min
- Aggrastat – 0.1 mcg/kg/min
- Reopro – 0.125 mcg/kg/min

5.2. These medications and doses are for reference only. Transferring physician will select medication and dose for infusion with orders for transport guidelines, if applicable.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

HEPARIN

1. PURPOSE

To authorize CCP's to monitor existing intravenous Heparin infusions

2. POLICY

2.1. CCP's are permitted to monitor Heparin infusions during transport and care.
2.2. CCP's may not initiate Heparin infusions.

3. PROCEDURE

3.1. **Heparin Infusion Parameters**

3.1.1. Medication concentration will not exceed 100 units/ml. Examples of concentrations used:
- 25,000 units/250 ml
- 50,000 units/500 ml

3.1.2. Infusion rates must remain constant during transport with no regulation of rates being performed by the CCP, except for the discontinuation of the infusion (e.g., as in the case of bleeding).

3.1.3. Typical infusion rate is 12 units/kg/hr.

3.2. In the event of the patient developing bleeding, the CCP shall discontinue the infusion and notify the transferring and/or base hospital physician.

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EMS MEDICAL DIRECTOR

LIDOCAINE

1. PURPOSE

To authorize CCP's to monitor and adjust existing intravenous Lidocaine infusions during transport

2. POLICY

2.1. CCP's are permitted to monitor and adjust Lidocaine infusions during transport and care.
2.2. CCP's may not initiate Lidocaine infusions.

3. PROCEDURE

3.1. **Lidocaine Infusion Parameters**

3.1.1. Infuse fluid will be either NS or D5W.
3.1.2. Typical concentrations are 1 gm/250 ml or 2 gm/500 ml.
3.1.3. Regulation of the infusion rate will occur within the parameters as defined by the transferring physician but no greater than 1 mg/min increments q 3-5 mins.
3.1.4. CCP's may institute two (2) infusion rate changes prior to consulting with the transferring physician or base hospital.
3.1.5. Any additional changes MUST be made only after contact with the transferring physician or base hospital.

Standard Strength

1 Gram/250 cc D5W or NSor 2 Gm/500 cc

cc/hr	mg/min
15	1
30	2
45	3
60	4

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

LORAZEPAM

1. PURPOSE

To authorize CCP's to monitor, adjust, and administer intravenous Lorazepam

2. POLICY

2.1. CCP's are permitted to monitor and adjust Lorazepam established infusions
2.2. CCP's are permitted to administer Lorazepam IV push doses
2.3. CCP's may not initiate Lorazepam infusions

3. PROCEDURE

3.1. The infusion concentration and regulations of the infusion rate will occur within the parameters as defined by the transferring physician, but may be titrated to the individual's response, during transport.
3.2. In cases of an adverse event, the medication infusion will be discontinued, and the transferring physician and/or base hospital are to be notified.
3.3. Typical Lorazepam infusion concentration is 100 mg/100 ml at a rate of 2-4 mg/hr.
3.4. In case of severe alcohol withdraws, significantly higher doses may be required.

4. ADMINISTRATION

4.1. CCP's shall be permitted to administer Lorazepam as a second line medication in situations where Midazolam is contraindicated, has been ineffective, or is preferred over Midazolam by the transferring, receiving, or base hospital physician.
4.2. **Standard Dose**:
  4.2.1. 1 mg IV/IM q 5 mins to a max of 5 mg prn. IN preferred dose volume 0.25-0.5 ml per nare not to exceed 1 ml of volume per nare per dose.
  4.2.2. If concern for hypotension or respiratory depression you may administer ½ dose (0.5mg).
4.3. **Weight-Based Dose – Pediatrics less than 25 kg**:
  4.3.1. Administer 0.1 mg/kg IV/IM/IN as q 5 mins prn.
  4.3.2. Maximum single dose is 2 mg.
  4.3.3. Larger doses may be needed than typical adult dosing.
  4.3.4. Must be diluted with NS for IV administration to a strength of 1 mg/ml for all patients weighing less than 25 kg.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

MAGNESIUM SULFATE

1. PURPOSE

To authorize CCP's to initiate, monitor, and adjust existing intravenous Magnesium Sulfate infusions

2. POLICY

2.1. CCP's are permitted to initiate, monitor, and adjust existing Magnesium infusions

3. PRECAUTIONS

3.1. Patients who have rhythm disturbances with hemodynamic instability should be cardioverted prior to initiation of Magnesium Sulfate infusion.
3.2. Magnesium Sulfate attenuates catecholamine release augmenting its antidysrhythmic properties.
3.3. CCP's should record FHT's, if applicable, using a handheld doppler along with vitals per protocol.
3.4. Magnesium Sulfate overdose signs include hypoventilation and hyporeflexia
3.5. If signs of overdose develop, discontinue the infusion and administer 500 mg Calcium Chloride slow IV push.

4. PROCEDURE

4.1. Infusions shall be maintained at the rate specified by the transferring physician for interfacility transfers. Any changes in rate or a bolus necessary, and no orders obtained, contact transferring physician or base hospital for direction.
4.2. Do not use one (1) liter volumes for Magnesium Sulfate infusions.

5. ADMINISTRATION

5.1. **Pre-Eclampsia**:
  5.1.1. Initial bolus dose is 4 gm in 100 ml LR or NS over 15-30 minutes.
  5.1.2. After initial bolus is completed, initiate an infusion at the rate of 2 gm/hr. To mix add 20 gm to 500 ml LR or NS.
5.2. **Torsades de Pointes (Polymorphic V-Tach):**
  5.2.1. Dilute 2 grams Magnesium Sulfate in 10 ml LR or NS and administer over 5 mins.
5.3. **Severe Asthma/Reactive Airway Disease**:
  5.3.1. Administer 50 mg/kg Magnesium Sulfate diluted in 50 ml NS over 20 mins. Maximum dose is 2 grams. Consult with transferring physician or base hospital if a higher dose is needed.
5.4. **Eclampsia Seizures**:
  5.4.1. Administer 2 grams Magnesium Sulfate IV/IO/IM/IN. Repeat q 5 mins x 2 to a max of 6 mg.
  5.4.2. Initiate Magnesium Sulfate infusion at 2 gm/hr and contact transferring physician or base hospital.

APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

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NITROGLYCERIN

1. PURPOSE

To authorize CCP's to initiate, monitor and adjust existing Nitroglycerin infusions

2. POLICY

2.1. CCP's are permitted to monitor and adjust Nitroglycerin infusions during interfacility transports.
2.2. CCP's may initiate Nitroglycerin infusions with a physician consult.

3. PROCEDURE

3.1. Regulation of the infusion rate will occur within parameters as defined by the transferring or base hospital physician, but in no case will changes be greater than 10 mcg/min increments q 5 mins.
3.2. In cases of severe hypotension, the medication infusion will be discontinued, and the transferring or base hospital physician notified.
3.3. Severe hypotension (MAP<65 mmHg) that does not improve following discontinuation of the infusion should be treated with a 500-1,000 ml fluid bolus as appropriate based on patient condition.

4. ADMINISTRATION

4.1. Initiate infusion at 10 mcg/min and increase dose by 5-10 mcg/min q 5 mins until marked decrease or elimination of pain while maintaining MAP > 65mmHg.
4.2. To mix the infusion add 50 mg Nitroglycerin in 250 ml D5W or NS to equal concentration of 200 mcg/ml.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

NOREPINEPHRINE

1. PURPOSE

To authorize CCP's to initiate, monitor and adjust existing Norepinephrine infusions

2. POLICY

2.1. CCP's are permitted to monitor and adjust Norepinephrine infusions during interfacility transports.
2.2. CCP's may initiate Norepinephrine infusions with a physician consultation.

3. PRECAUTIONS

3.1. Use caution in patients who may be volume depleted.
3.2. Although Norepinephrine has a lower rate of dysrhythmias than Dopamine, patients on Norepinephrine may still experience tachydysrhythmias.

4. PROCEDURE

4.1. Regulation of the infusion rate will occur within parameters as defined by the transferring physician, or standing orders, but in no case will changes be greater than 5 mcg/min increments q 5 mins.
4.2. CCP's may titrate Norepinephrine by increments of 1-5 mcg/min q 5 mins as needed to achieve a MAP > 65mmHg.
4.3. Typical Norepinephrine dose range is 2-12 mcg/min.
4.4. The maximum Norepinephrine dose is 30 mcg/min.
4.5. In cases of severe hypertension, the Norepinephrine infusion will be titrated down and, if necessary, discontinued, and the transferring physician or base hospital notified.

5. ADMINISTRATION

5.1. Initiation should be considered for hypotensive shock states after ensuring adequate volume repletion.
5.2. Norepinephrine is the first line vasopressor to initiate unless other orders received from the transferring or base hospital physician.
5.3. CCP's may initiate Norepinephrine infusions in conjunction with transferring physician or base hospital consultation.
5.4. To mix infusion add 4 mg Norepinephrine in 250 ml D5W for a concentration of 16 mcg/ml. Caution – always check concentration since can vary at each facility.
5.5. Initiate Norepinephrine infusion at 5 mcg/min and titrate to achieve a MAP > 65 mmHg or to a target MAP per transferring or base hospital physician orders.

APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

DRAFT

POTASSIUM CHLORIDE

1. PURPOSE

To authorize CCP's to monitor existing Potassium Chloride infusions

2. POLICY

2.1. CCP's are permitted to monitor Potassium Chloride infusions during interfacility transports.
2.2. CCP's may not initiate Potassium Chloride infusions.

3. PROCEDURE

3.1. In all instances a Potassium Chloride infusions must be regulated by a mechanical pump.
3.2. Medication concentration will **NOT** exceed 40 meq per liter of IV fluid.
3.3. A more concentrated solution that contains no more than 10 meq Potassium Chloride total in the infusion bag is allowable.
3.4. Infusion rates may not exceed 10 meq/hr.
3.5. Infusion rates must remain constant during transport with no regulation of rate allowed unless per specific transferring or base hospital physician.

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APPROVED:_____ DATE: _____
EMS MEDICAL DIRECTOR

SEDATION AND ANALGESIA

1. PURPOSE

To provide chemical sedation and analgesia for ventilator dependent and agitated patients

2. POLICY

2.1. CCP's are permitted to administer chemical sedation and analgesia without transferring physician or base hospital contact.
2.2. CCP's are permitted to monitor, **NOT** initiate, Fentanyl, Midazolam, and Morphine infusions.
2.3. CCP's may administer Fentanyl, Midazolam, and Morphine boluses.
2.4. **Fentanyl, Midazolam, and Morphine will be used, as appropriate, for**:
- 2.4.1. Ventilator dependent and/or agitated patients requiring chemical sedation, analgesia, or restraint due to agitation, restlessness, and/or anxiety that is compromising patient stability
- 2.4.2. Patients requiring pain management
- 2.4.3. Other objective patient considerations:
  - Need for an invasive procedure
  - Increase in level of distress
  - Change in vital signs
  - Change in pulse oximetry and/or EtCO2
  - Change in cardiac monitor

3. PROCEDURE

3.1. **Ventilator Dependent and/or Agitated Patients**
- 3.1.1. Apply soft, four-point restraints if needed.
- 3.1.2. Continuously monitor oxygen saturation, EtCO2, heart rate, blood pressure and GCS.
- 3.1.3. Focus on management of patient's pain and discomfort in conjunction with sedation.
- 3.1.4. Administer Fentanyl and/or Midazolam per physician orders. If no orders obtained, use guidelines below.
- 3.1.5. If the transferring physician discontinues Propofol to allow for a CCP level transport and, initiates other sedation, consider trialing the new infusion at facility to check effectiveness prior to transport.

4. ADMINISTRATION

4.1. Fentanyl

- 4.1.1. **Fentanyl Bolus Guidelines**:
  - Administer Fentanyl boluses in accordance with local EMS agency policy OR guidelines below:
    - **Adult**:
      - Standard dose: 50 mcg IV/IO/IN/IM q 5 mins.
      - Weight-based dose: 1 mcg/kg IV/IO/IN/IM with single dose max 100 mcg q 5 mins.
    - **Pediatric**:
      - Standard dose: 50 mcg IV/IO/IN/IM for patients weighing 50 kg or more.
      - Weight-based dose: 1-2 mcg/kg IV/IO/IN/IM to a max dose of 100 mcg q 5 mins.
  - Standard or weight-based dose may be repeated q 5 mins at initial dose or at ½ dose if concern for hypotension. May not switch between standard and weight-based dosing.

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- For patients weighing less than 25 kg, dilute by taking 2 ml Fentanyl (100 mcg) and 8 ml NS to equal a concentration of 10 mcg/ml.

4.1.2 **Fentanyl Infusion Guidelines**:
- Typical dosing range is 25-200 mcg/hr.
- May titrate by 25 mcg/hr q 5 mins as needed.

4.2 Midazolam

4.2.1 **Midazolam Bolus Guidelines**:
- Administer Midazolam boluses in accordance with local EMS agency policy OR guidelines below:
  - **Adult**:
    - Standard Dose: 2 mg IV/IO/IN for patients weighing 40 kg or more q 5 mins.
    - Weight-Based Dose: 0.05 mg/kg IV/IO/IN with a max single dose of 5 mg q 5 mins.
    - IM Dose: 0.1 mg/kg IM with a single max dose if 10 mg. May repeat once in 5 mins.
  - **Pediatric: (Not to be used in neonates)**
    - Standard Dose: 2 mg IV/IO/IN for patients weighing 40 kg or more q 5 mins.
    - Weight-Based Dose: 0.05 mg/kg slow IV push q 5 mins with max single dose of 5 mg
- Standard or weight-based dose may be repeated q 5 mins at initial dose or at ½ dose if concern for hypotension. May not switch between standard and weight-based dosing.
- For patients weighing less than 25 kg, dilute IV/IO/IM doses to 1 mg Versed in 1 ml NS. Do not dilute IN doses.

4.2.2 **Midazolam Infusion Guidelines**:
- Typical dosing is 2-10 mg/hr.
- May titrate by 2 mg/hr q 5 mins to a maximum of 10 mg/hr.
- Patients requiring rapidly escalating doses of Midazolam should be considered for concurrent Fentanyl administration.

4.3 Morphine

4.3.1 **Morphine Bolus Guidelines**:
- Morphine boluses may be administered as a second line narcotic in situations where Fentanyl is contraindicated, has been ineffective, or Morphine is preferred by transferring, receiving, or base hospital physician AND the CCP unit stocks.
- Administer Morphine boluses in accordance with local EMS policy OR guidelines below:
  - **Adult**:
    - Standard Dose:
    - 4 mg IV/IO/IM unless AMI or ACS patient.
    - 1 mg IV/IO/IM for AMI or ACS patient. If no relief with morphine strongly consider an alternative analgesia.
    - May repeat IV/IO q 5 mins and IM q 10 mins at the initial dose or half dose.
    - Weight-Based Dose: 0.1 mg/kg IV/IO/IM q 5 mins for IV/IO and q 10 mins for IM with max single dose of 10 mg.

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- **Pediatric**:
  - 0.1 mg/kg IV/IO/IM q 5 mins.
  - For patients weighing less than 25 kg, dilute IV/IO/IM doses to 1 mg Morphine in 1 ml NS.

4.3.2 **Morphine Infusion Guidelines**:

- The infusion concentration and regulation of the infusion rate will occur within the parameters as defined by the transferring physician but may be titrated to the patient response during transport per transferring or base hospital physician orders only.

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APPROVED:_____ DATE: _____

EMS MEDICAL DIRECTOR

SODIUM BICARBONATE

1. PURPOSE

To authorize CCP's to monitor and adjust existing Sodium Bicarbonate infusions

2. POLICY

2.1. CCP's are permitted to monitor or discontinue Sodium Bicarbonate infusions during transport
2.2. CCP's may not initiate Sodium Bicarbonate infusions
2.3. CCP's may administer intravenous push dose Sodium Bicarbonate for crush injuries

3. PRECAUTIONS

3.1. Extravasation into subcutaneous tissues may cause small vein sclerosis and local chemical burns.
3.2. Use only 4.2% Sodium Bicarbonate in newborns due to intracranial hemorrhage concerns
3.3. In cases of overcompensation resulting in metabolic alkalosis presenting as impaired tissue perfusion, hypokalemia, hypocalcemia, decrease in patient's fibrillation threshold, sodium and water overload, the infusion will be discontinued, and the transferring physician or base hospital notified.

4. PROCEDURE

4.1. The infusion concentration and regulation of the infusion rate will occur within the parameters as defined by the transferring physician or base hospital.
4.2. For crush injuries and transport times >30 minutes, CCP may consider a bolus dose of 50-100 meq.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

THORACOSTOMY TUBES

1. PURPOSE

To authorize CCP's to monitor existing surgically placed thoracostomy tubes

2. POLICY

2.1. CCP's are permitted to monitor thoracostomy tubes during interfacility transports.
2.2. CCP's may not perform placement of thoracostomy tubes.

3. PRECAUTIONS

3.1. Avoid pulling on the thoracostomy tube to prevent accidental dislodging of the tube.
3.2. Do not permit dependent loops or kinks to form in the tubing, as this will interfere with the flow of drainage leading to increased pleural pressure or formation of clots.
3.3. Do not disconnect the drainage system or puncture the tubing. Tape all connections securely to prevent violation of sterility and loss of negative pressure.

4. PROCEDURE

4.1. The collection receptacle must be kept below the level of the chest to prevent drained fluid from re-entering the pleural space. Do not allow the collection receptacle to tip over.
4.2. If hemorrhage occurs through the chest tube, observe for signs and symptoms of shock and treat according to local EMS agency protocols.
4.3. Mechanical suction rate4s must remain constant during the transport with no regulation of the rate being performed by the CCP.
4.4. Patients shall be placed and maintained on cardiac and pulse oximetry monitors during transport.
4.5. Signed order guidelines from the transferring physician must be obtained prior to transport.
4.6. Transfer order guidelines must provide for specifying the maintenance of the chest tube either to gravity or mechanical suction drainage. The amount of mechanical suction must be specified.

5. COMPLICATIONS

5.1. If the thoracostomy tube is partially pulled out:
- Do not push the tube back in the chest
- Secure the site

5.2. If the thoracostomy tube is completely pulled out:
- Place an occlusive dressing over the insertion site.

5.3. If air leaks are present:
- check all connections

5.4. If the patient becomes dyspneic:
- Assess breath sounds
- Contact the base hospital (needle thoracostomy may need to be performed)

APPROVED:_____ DATE: _____
EMS MEDICAL DIRECTOR

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THROMBOLYTIC AGENTS

1. **PURPOSE**

To authorize CCP's to monitor and discontinue, as needed, thrombolytic agent infusions

2. **POLICY**

2.1. **Precautions**
- Large stroke with NIH Stroke Scale score > 22 as reported by sending facility
- CT shows evidence of large middle cerebral artery (MCA) territory infarction

2.2. **Function** - Thrombolytic agent

2.3. **Circumstances** under which CCPs may perform thrombolytic infusion:
- Interfacility transports
- Infusion must be initiated prior to departure

2.4. **Setting** - Interfacility CCP transports
- A thrombolytic agent is not to be given without written orders from the referring physician. These orders must be specifically followed.
- CCPs must verify that a neurologic exam has been completed prior to administration
- Supervision: The transferring physician must be present at patient's bedside or by telemedicine when facility initiated thrombolytic infusion

2.5 **Patient Conditions** Patients with signs and symptoms of acute ischemic stroke

3. **PROCEDURE**

3.1. **Definition**: Thrombolytic agents are plasminogen activators that convert the zymogen plasminogen to the active enzyme plasmin, which degrades fibrin.

3.2. **Subjective**: Any symptoms communicated by the patient.

3.3. **Objective**:
- Acute ischemic stroke onset within 4.5 hours of drug administration.
- Measurable deficit on NIH Stroke Scale examination as reported by sending facility. The Cincinnati Stroke Scale or EMS agency approved scale can be utilized in transport to monitor patient status.
- Patient's CT scan does not show intracranial hemorrhage or non-stroke cause of deficit.

3.4. **Diagnosis**: Acute ischemic stroke confirmed by physician examination and CT scan.

3.5. **Plan**:
- To monitor thrombolytics: receipt from the transferring physician of specific orders for the continuation of thrombolytic infusion, including remaining dose, route, and time of administration must be obtained.
- If a thrombolytic has been given, or is being administered upon CCP arrival, it is imperative that blood pressure parameters are obtained from the transferring physician.

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3.6. **Discontinue infusion immediately if any of the following occur:**

- Acute worsening of neurologic signs/symptoms
- Decline in the level of consciousness
- New onset of headache
- Nausea and vomiting
- Sudden acute rise in blood pressure
- Symptomatic intracranial hemorrhage

3.7. **Thrombolytic Agent Dose**:

- Dose widely varies based on thrombolytic agent ordered by physician and below are common medications/doses for reference only. Administer per transferring physician orders only.
    - **TNKase**: a one-time, weight based IV bolus with a range of 30-50 mg.
    - **Alteplase/tPA**: 0.9 mg/kg (max dose of 90 mg) given over 60 mins with 10% of the total dose given initially as a bolus over 1 min.
    - **Reteplase**: 10 units IV over 2 mins and repeat dose in 30 mins.
    - **Sttreptokinase**: 1,500,000 units infused over 60 mins.

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APPROVED:_____ DATE: _____
EMS MEDICAL DIRECTOR

TOTAL PARENTERAL NUTRITION (TPN)

1. PURPOSE

To authorize CCP's to monitor existing Total Parenteral Nutrition (TPN) Infusions

2. POLICY

2.1. CCP's are permitted to monitor and infuse TPN during transports.
2.2. CCP's may not initiate TPN infusions.

3. PRECAUTION

3.1. When transporting a patient receiving TPM, or who has received TPN within the last hour prior to transport, maintain the head of the bed elevated at a minimum of 30 degrees to minimize the risk of aspiration whenever possible.

4. PROCEDURE

4.1. Infusion rates must remain constant during transport with no regulation of rates being performed by the CCP except for the discontinuation of the infusion (e.g., as in the case of infiltration).
4.2. All patients who have insulin as a part of their TPN solution shall have documentation of the most recent blood sugar analysis from the transferring facility.
4.3. The CCP shall check a blood sugar prior to departure from the sending facility.
4.4. TPN solution with lipid emulsion must be infused through special filtered tubing compatible with the CCP infusion device.
4.5. TPN solution intravenous line shall not be used for any medication or fluid administration.

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APPROVED:_____ **DATE:** _____
EMS MEDICAL DIRECTOR

VENTILATOR MANAGEMENT

1. PURPOSE

To authorize CCP's to initiate, monitor, and adjust ventilators

2. POLICY

2.1. CCP's are permitted to initiate non-invasive and invasive ventilator management.
2.2. CCP's are permitted to monitor and adjust ventilator settings in all modes.

3. 3. PRECAUTIONS

3.1. The CCP is responsible for all airway management and must frequently reassess ETT placement, breath sounds, and EtCO2 plus with each patient movement.

4. PROCEDURE

4.1. Ventilator support must be regulated by a ventilator familiar to the CCP and approved by local EMS agency.
4.2. In the event of a ventilator failure that cannot be corrected, the CCP will discontinue use of the ventilator and initiate ventilation by BVM with a PEEP valve device and notify the transferring or base hospital physician.
4.3. CCP's may utilize the transport ventilator to initiate BiPAP/CPAP/RAM cannula in NIPPV mode or ventilator support for intubated patients in IPPV mode.
4.4. Personnel shall monitor PSI level in the main and portable oxygen cylinder(s).
4.5. Patients shall be placed and maintained on the cardiac monitor, EtCO2, and pulse oximetry monitored during transport. VTE's and PIP's must be documented along with vital signs per protocol.
4.6. CCP's shall continually observe the patient and document patient response to any changes.
4.7. CCP's shall chart the initial vent settings and any subsequent changes.
4.8. CCP's may adjust ventilator settings consistent with the patient's ABG values and current practice standards to maximize oxygenation, ventilation, and compliance. In general, appropriate settings are as follows:

- Consider use of pressure control (PC) at 10-15 for all patients with interstitial lung disease.
- **Mode**: SIMV, not AC, is the preferred mode of transport. AC can cause inadvertent breath stacking/triggering.
- **Rate**: Typically set between 12-20 for adults, 20-40 for peds, and 30-60 for infants. Monitor and adjust for target EtCO2.
- **Tidal Volume** (Vte): Set at 6 ml/kg of ideal body weight. For ARDS or excessive pressure etiologies consider 4-6 ml/kg.
- **Inspiratory Time** (I-times):
  - Neonate 0.30-0.40
  - Infant 0.40-0.50
  - Pediatric 0.60-0.80
  - Adult 0.8-1.0 (max 1.5)
  - Based on age and disease process. Longer I-times can help contribute to recruitment and an increased mean airway pressure (Paw).
- **FiO2**: Set to maximize oxygenation and keep SpO2 between 94-99%. Patients should not routinely be set on, and maintained at, 100% FiO2.

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- **Alarms**: High pressure set 10 above actual PIPs and low pressure set 10 below PIP's.
- **PEEP**: Set at a minimum of 5cm H2O (intrinsic PEEP) for adults/pediatrics and at 3cm H2O for infants. Patients with pulmonary edema, ARDS, and poor oxygenation may require higher PEEPS.

5. SPECIAL INFORMATION

5.1. The ventilator that the provider is to use should be able to match the existing ventilator settings. The following minimum device features (including circuit) must be present for this category:

- Set rate of ventilations
- Adjustable delivered tidal volume
- Adjustable inspiratory and expiratory ratios (I:E ratio)
- Positive End-Expiratory Pressure (PEEP)
- Peak airway pressure gauge
- **Modes**:
  - Assist Control (AC)
  - Pressure Control (PC)
  - Pressure Regulated Volume Control (PRVC)
  - Synchronized Intermittent Mandatory Ventilation (SIMV)
  - Controlled Mechanical Ventilation (CMV)
  - Continuous Positive Airway Pressure (CPAP)
  - Bi-Level Positive Airway pressure (BiPAP)
- **Alarms**:
  - Peak airway pressure
  - Disconnect
- Strongly recommended option: Blend percentage oxygen

5.2. Agencies using this equipment must be certain to follow the manufacturer's instructions regarding use, maintenance, cleaning, and regular testing of the device.

- The units must be inspected and tested after every patient use.
- The units must be disinfected after use unless a disposable unit is used.
- The units shall undergo preventative resting and maintenance by qualified personnel annually.
  - Agencies shall arrange for (at least) annual inspections and testing of the equipment by a manufacturer's representative (or designee). Documentation of this service shall be maintained in a service log. This record shall be kept by each agency using ATV's.

5.3. CCP's must receive a thorough initial and continual ventilator training. Such training shall occur, at a minimum, annually. Training shall be documented and on file with provider.

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APPROVED:_____ DATE: _____
EMS MEDICAL DIRECTOR

Appendix B

iGel Pediatric LOSOP/iGel implementation

At the beginning of 2022, SFEMSA made the change from the King LT-D Airway to the iGel Supraglottic airway. Prior to getting the iGel into the EMS system a LOSOP was designed, submitted, and approved for iGel for pediatric use. Once the LOSOP was approved, several train-the-trainer events were held at the San Francisco EMS Agency with the assistance of the iGel manufacturer. San Francisco EMS providers trained their staff. All hospitals that receive EMS patients were given literature on the iGel device and training was also provided to hospitals that requested iGel training. The iGel was then introduced into the EMS system with positive feedback coming from the field providers and receiving facilities.



7.03 SUPRAGLOTTIC AIRWAY (iGel)

INDICATIONS

iGel insertion may be performed on those patients who meet ALL of the following criteria:

- Are unconscious and without purposeful movement.
- Do not have a gag reflex.
- Apnea

INSERTION PROCEDURE

1. Prepare, position, and pre-oxygenate the patient.
1. Select an appropriately sized device.
2. Apply water-soluble lubricant to distal end of tube.
3. Place patient's head in a neutral position.
4. With non-dominant hand, hold mouth open and apply chin lift.
5. Position device so the cuff faces the patient's chin.
6. Introduce the leading tip into the mouth in a direction towards the hard palate.
7. Glide the device downward and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.
8. Attach BVM and initiate ventilation.
9. Assess ventilation:
    - Rise and fall of the chest
    - Bilateral lung sounds
    - Confirm placement with CO2 detector
    - Gastric auscultation
    - If breath sounds are present continue to ventilate.
10. If there is any question about the proper placement of the iGel, remove device and ventilate the patient with BVM for 30 seconds and repeat.
11. Secure the tube with commercial device or tape.
12. Secure the tube with commercial device or tape.
13. Continue to monitor the patient for proper tube placement throughout prehospital treatment and transport.

Appendix C

ReddiNet EMS Alert Feature
Information and Training Guide

Beginning 01/03/2022, the San Francisco EMS system will implement a new feature in ReddiNet to replace the current version of the CADDiE pilot program with an automated ambulance routing function. **CADDie call-ins will remain in effect until January 17, 2022. Please follow normal procedures. The EMS Alert procedures will start at 0700 on January 18, 2022. However, you may see EMS Alert featuring in ReddiNet starting January 3, 2022.**

Analysis of EMS transport data and collaborative efforts with both hospital and EMS partners have identified "ambulance bunching" as a primary issue contributing to increasing ambulance offload delays and Diversion. This is when a hospital receives a disproportionate number of ambulances at a single point in time, causing a surge event at their emergency department. During a 6-month sample period in 2021, 47% of EMS surge events were followed by Diversion at that hospital within the following 2 hours.

The goal of the EMS Alert is to provide a fluid, point-in-time reflection of each hospital's EMS impact, and supplement Diversion with a system that routes ambulances based on a set of defined conditions.

WHAT IS AN EMS ALERT?

EMS data, like responses and transports, are captured by a software service called FirstWatch via our CAD database. Inside FirstWatch, a set of triggers continuously measure a ratio of EMS volume and ED capacity.

60-Minute EMS Volume : ED Surge Cap (aka "EMS Surge Ratio")

60-Minute EMS Volume	Sum of the following, updated on-the-minute (all EMS transports, Code 2 & Code 3): Units En-Route + Units At-Hospital + Units Cleared in Past 60 Minutes
ED Surge Cap	Determined by the "30% or 6 Rule": 30% of a hospital's licensed ED bed count or 6, whichever is lowest. This represents a reasonable number of EMS patients that a hospital can intake within a 60-minute time window. Large hospitals default to 6 (30% of ZSFG's ED bed count is 18, resulting in a default cap of 6) while smaller hospitals will use 30% of their licensed beds (CPMC-Davies = 3, St. Mary's = 5).

An EMS Alert will activate when the following condition is satisfied for any hospital:

If current 60-Minute EMS Volume ≥ ED Surge Cap → EMS Alert is activated

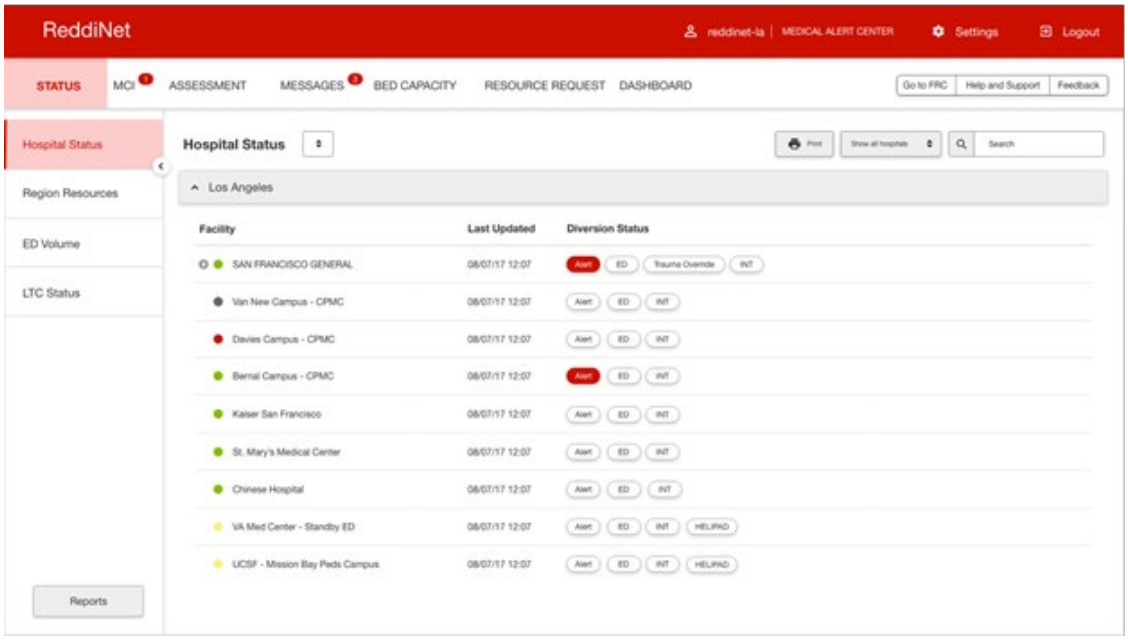
An interface has been established between FirstWatch and ReddiNet. When the condition is satisfied in any of the hospital triggers a signal is sent to ReddiNet placing that hospital on EMS Alert. Similar practices exist in other EMS systems throughout the state. While alert conditions may differ, the model is essentially the same.

GUIDELINES FOR FIELD OPERATIONS

You will now have access to a special ReddiNet account where you are able to see San Francisco's Hospital Status Dashboard. ReddiNet is the software service hospitals use to manage Diversion status. When you check Diversion on your MDT, for example, this is where the information comes from (side note: you will also be able to directly check Diversion status yourself now via ReddiNet).

Use the following instruction when determining a destination:

1. Log-in to ReddiNet (reddinet.net) via browser or App and view the Hospital Status Dashboard
    - Username: Field_User
    - Password: ready123
2. Check the status of the desired hospital. In the Diversion Status column, "ED" indicates regular Diversion and "Alert" indicates EMS Alert (both when highlighted in red). You'll also notice that "Trauma Override" is displayed for ZSFG only.



If <u>Diversion</u> is Activated: No change from current practice. Diversion may only be bypassed when patients meet qualifying criteria per policy.

If <u>EMS Alert</u> is Activated: Generally treated the same as Diversion – ambulances are <u>not</u> permitted to transport to that destination while EMS Alert is active. There are two exceptions:

- Patients who meet any criteria which would allow them to bypass Diversion (e.g. trauma, stroke, STEMI, in-custody).
- Extenuating circumstances where a patient has specific clinical needs that require care at a certain facility (e.g. recent transplant or <48 hour surgical patient requesting transport to the hospital that performed the procedure). <u>These situations require approval from the Dispatch Rescue Captain or King American/AMR On-duty Supervisor prior to transport. EMS Alert bypass requires documentation of the extenuating circumstances within the PCR and the name of the supervisor who approved the bypass.</u>

Notes on field guidance:

- Diversion Suspension has no effect on EMS Alerts. This is actually when the EMS Alert system is most crucial, as hospitals are currently unable to signal to the system if they are heavily impacted by EMS.
- Expect an EMS Alert Suspension feature sometime in the future…still in development.
- **It is important to know this is not a pilot program and is not a recommendation. EMS Alert is based on an EMS Memo from the Medical Director and shall be followed as any other EMS Agency policy until replaced with a permanent policy.**

EXAMPLE SCENARIO	
UCSF has 34 licensed beds in their ED. 30% of this count is ~10. Since 30% of their licensed bed count is > 6, their ED Surge Cap defaults to 6.	
4:00PM	3 ambulances are currently at UCSF waiting to offload patients. In the past 60 minutes, between 3:00PM and 4:00PM, two other ambulances had cleared from UCSF. The first of these was Medic 50, which cleared at 3:40PM. UCSF's current EMS Surge Ratio is **5/6** *Units En-Route (**0**) + Units At-Hospital (**3**) + Units Cleared in Past 60 Min (**2**) = **5***
4:05PM	Medic 60 puts themselves transporting to UCSF on their MDT and this information is captured in FirstWatch. UCSF's EMS Surge Ratio is now **6/6** *Units En-Route (**1**) + Units At-Hospital (**3**) + Units Cleared in Past 60 Min (**2**) = **6*** This information is automatically fed from FirstWatch to ReddiNet, and an EMS Alert is **activated** for UCSF.
4:41PM	At this point, the following has occurred: • Medic 60 has arrived at-hospital • The three units that were waiting to offload have now cleared UCSF • The interval between Medic 50's clear time (3:40PM) and the current time is now 61 minutes, meaning they no longer factor into UCSF's 60-Minute EMS Volume. UCSF's updated EMS Surge Ratio is now **5/6** *Units En-Route (**0**) + Units At-Hospital (**1**) + Units Cleared in Past 60 Min (**4**) = **5*** EMS Alert at UCSF is **deactivated** after diverting routine ambulance traffic for the past 35 minutes. While it would be easy for UCSF to go back on EMS Alert if another unit goes en-route immediately after, their capacity will quickly increase when the units that recently cleared drop off their 60-Minute EMS Volume count. This helps ease the hospital back open to EMS traffic and helps maintain level distribution in the system.

FREQUENTLY ASKED QUESTIONS

How is this different than Diversion?

Functionally, they are very similar for the end user, but there are some key differences:

- Diversion is activated manually at the discretion of hospital staff. EMS Alert is automated on system data, and no individual can manually activate it.
- Diversion can remain on for hours at a time. EMS Alerts will automatically de-activate once the condition of the EMS Surge Ratio is no longer satisfied.
- EMS Alert addresses EMS impact only, while Diversion can account for conditions inside the hospital. In theory, EMS Alert would prevent the need for most EMS-related Diversion events, allowing Diversion to be used for hospital-end issues only.

How much will this impact my day-to-day work?

We project a relatively minor impact. Currently, most hospitals are averaging 0 – 1 hour of "surge" per day. The exception is ZSFG, averaging closer to 4 hours. This is still far fewer hours than Diversion, and EMS Alerts activate on/off more fluidly.

How should we talk to patients who cannot go to their hospital of choice when it is on EMS Alert?

Just as Diversion shuts off EMS when a hospital's internal conditions prevent them from caring for more patients, EMS Alerts serve the same function. Nearly half the time an SF hospital has an EMS surge, they go on divert within the following 2 hours. As Diversion rates increase, the number of available ED's decreases, making it harder to "level load" the system. This domino effect tends to continue, and we see increased offload delays.

While we strive to get patients to their hospital of choice it is not sound practice when doing so could jeopardize the quality of care for themselves and others. Explain to patients that for most complaints they can get equal care at a different facility, and patient information can be communicated across hospitals. Ultimately, we cannot afford to put a hospital on divert for one patient when the downstream system effects will negatively impact many patients and multiple hospitals.

Limitations set by the ED Surge Cap were established in cooperation with hospital leaders. Patients may also be informed that contacting the hospital itself with feedback or questions is another option for them.

What will a Rescue Captain consult be like if I think a patient should bypass EMS Alert?

RC's will balance the clinical needs of the patient with current system status. Explain why it is critical that your patient be transported to a certain hospital and provide necessary information. They are essentially taking responsibility for the bypass and have the ultimate say.

How will the EMS Agency evaluate this system?

Most metrics relevant to the EMS Alert system are already tracked in existing reports (rates of surge, ambulance distribution, Diversion, etc.). We will also look at compliance with EMS Alerts, similar to transports against Diversion not permitted by policy.

MESSAGE TO OUR FIELD PROVIDERS

Your flexibility and cooperation as we tackle complex EMS system issues is greatly appreciated. We realize changes like these can be a lot to adapt to, and San Francisco Paramedics and EMT's are the ones who shoulder the burden of putting these efforts into practice.

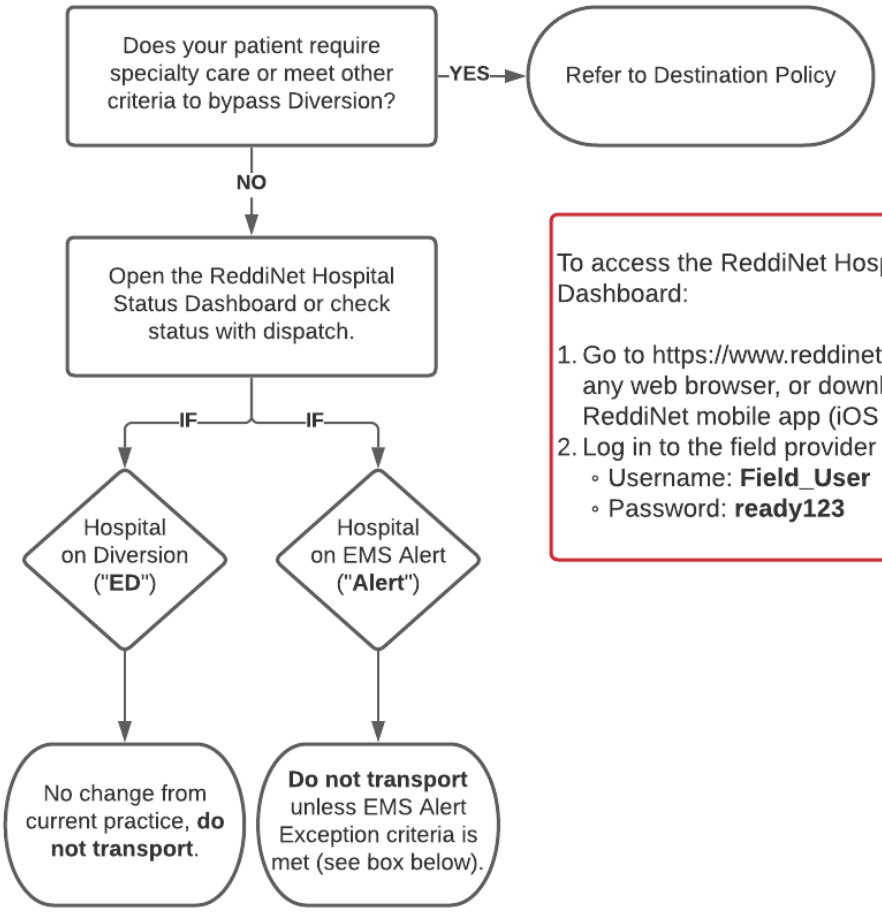
Providers at any level, working in any capacity, are welcome to reach out with questions on this new system. For additional information, contact EMS Specialist Ryan Seymour at ryan.seymour@sfgov.org.

“EMS Alert” Guide Sheet

Beginning **January 18, 2022**, the San Francisco EMS system will begin use a new feature in ReddiNet to replace the current CADDiE Pilot Program with an automated function for preventing ambulance surge on hospitals. CADDiE call-ins will remain in effect until this time.

EMS Alert is a parallel system to Diversion. It provides a fluid, point-in-time reflection of each hospital’s EMS impact based on current EMS activity in relation to a hospital’s capacity. Background information, technical details, and FAQ can all be found in the EMS Alert section of the Policy & Protocol App, as well as on the EMS Agency webpage.

Instructions for using EMS Alert are below and are based on current guidance from the EMS Agency Medical Director. The EMS Memo with this information can also be found on the Policy & Protocol App and webpage.



To access the ReddiNet Hospital Status Dashboard:

1. Go to https://www.reddinet.net/app/login in any web browser, or download the ReddiNet mobile app (iOS only).
2. Log in to the field provider account:
   - Username: **Field_User**
   - Password: **ready123**

EMS Alert Exception

Paramedics shall contact the Radio RC (SFFD ambulance) or King/AMR Supervisor (Private ambulance) if the patient meets the specialty cases outlined below. These personnel can only approve a patient going to an ED on EMS Alert in these specific cases.

- Recent organ transport patient going to the hospital that performed the procedure
- Patient <48-hours post-surgery requesting transport to the hospital that performed the procedure
- Patient recently discharged (<2-hours) from an ED returning to the hospital they were initially seen at
- Patient with an EMS6 care plan, in which EMS6 feels another hospital is not appropriate

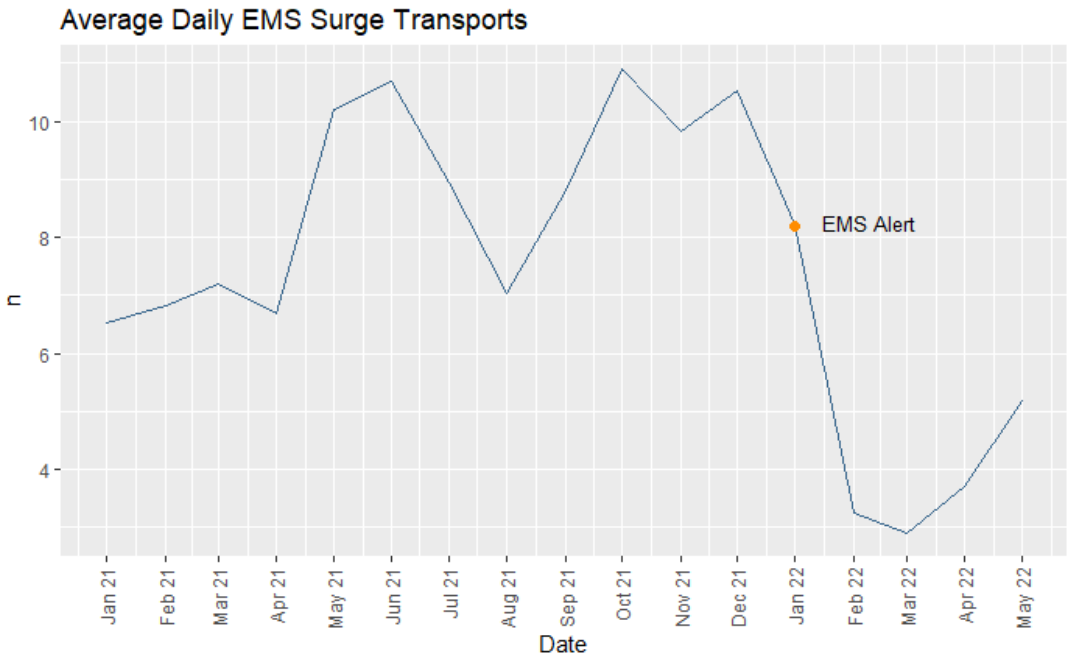
In the event that a provider cannot contact a supervisor after 2 attempts, EMS Alert bypass may be initiated. For other clinical scenarios not listed above, in which a Paramedic feels a patient should bypass, Base Hospital contact is required. This should be treated the same as Base Hospital destination consultation while a hospital is on Diversion. Bypass of EMS Alert requires documentation of extenuating circumstances and supervisor/physician name.

EMS Alert

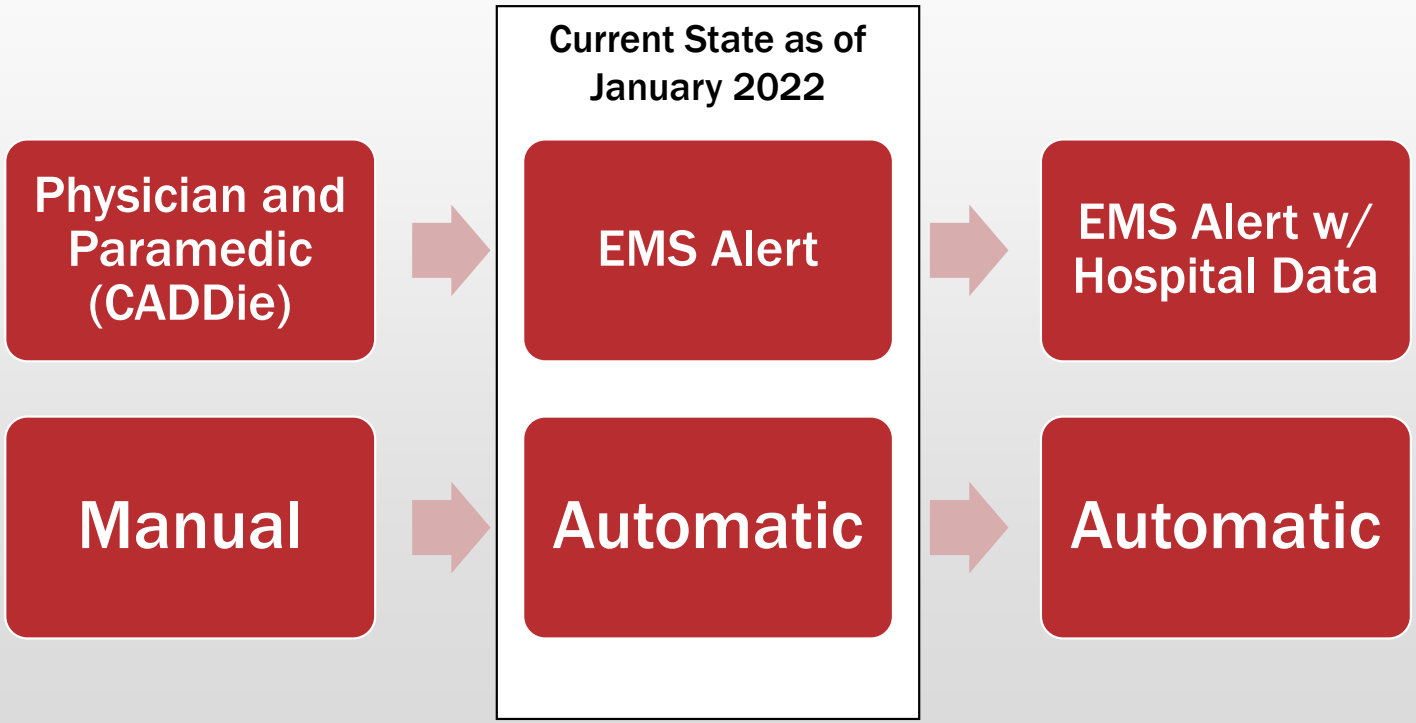
EMS alert is a locally developed ambulance routing feature intended to re-direct transports away from hospitals experiencing an ambulance "surge." Its goal is to decrease instances of long APOT times, diversion events, and adverse impacts on Emergency Department operations that often result from throughput delays when many ambulances arrive at the same hospital in a short period of time.

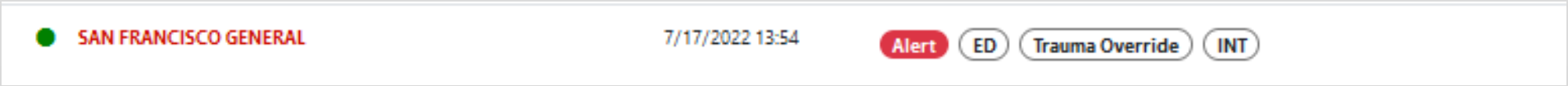
Retrospective data analysis and feedback from hospital partners was used to develop an algorithm for this purpose. Utilizing near-real time 911 data in the software service FirstWatch, EMS Alert continuously recalculates the sum of ambulances currently at-hospital, currently en-route to hospital, and cleared from a hospital within the past 60 minutes. It computes this total for each hospital then compares it to a hospital's unique "Surge Cap," which is a number representing capacity based on licensed bed count. When the sum of ambulance activity meets or exceeds the Surge Cap, FirstWatch sends that message to ReddiNet and an Alert is activated. EMS Alert remains active as long as the conditions are satisfied and cannot be activated arbitrarily by hospital or EMS staff.

EMS Alert went live on January 19, 2022. In the previous year (2021) the San Francisco EMS system averaged 7.5 surge transports per day. These are transports that would have exceeded the Surge Cap if EMS Alert had been in place. Since implementing this feature our daily average has been 3.7, a 50.6% reduction in surge transports.

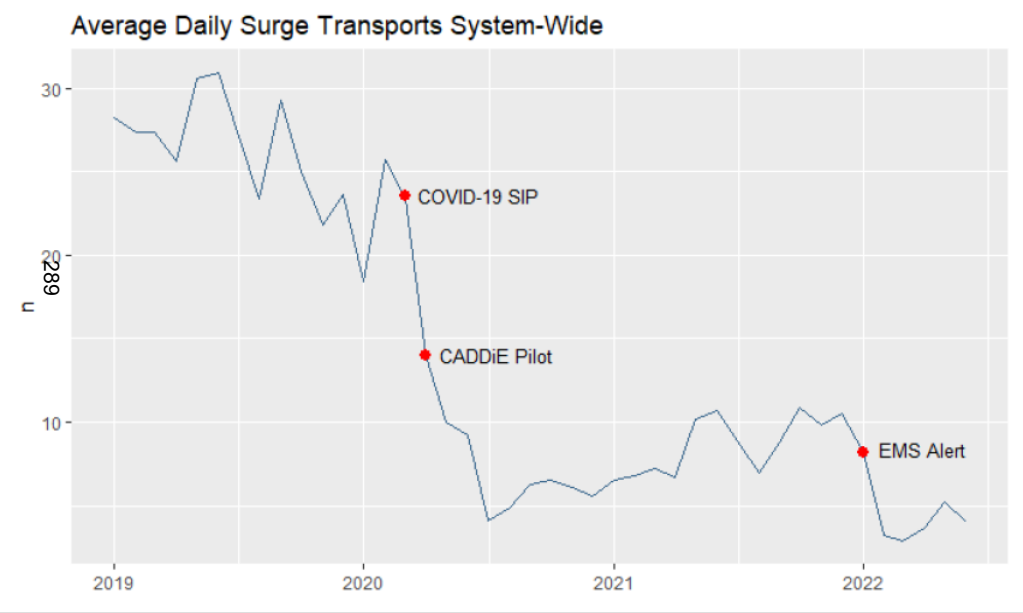


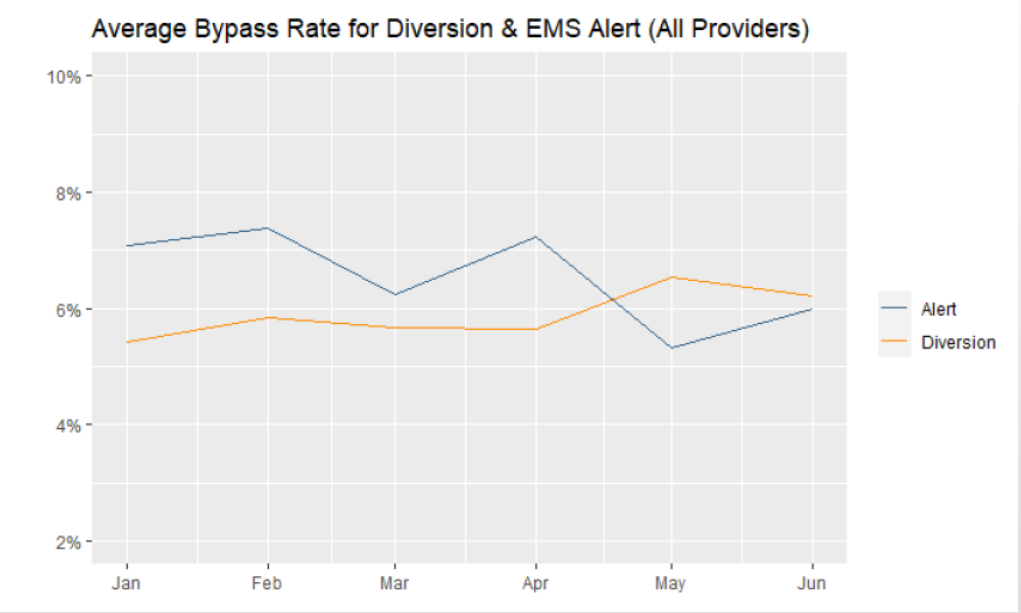
CADDie (Centralized Ambulance Destination and Determination)





EMS Alert Data and Compliance





Provider	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	Avg
AMR	8.0%	8.1%	6.7%	8.4%	4.4%	8.4%	7.1%
King American	7.9%	4.2%	6.6%	5.3%	3.8%	3.5%	5.4%
SFFD	6.7%	8.0%	6.3%	7.6%	5.7%	6.2%	6.9%

Appendix D

Department of Emergency Management
1011 Turk Street, San Francisco, CA 94102
Phone: (415) 558-3800 Fax: (415) 558-3843

London Breed
Mayor

Mary Ellen Carroll
Executive Director

FOR IMMEDIATE RELEASE
Monday, August 22, 2022
Contact: dempress@sfgov.org

PRESS RELEASE
San Francisco Launches Use of PulsePoint Mobile App to Help Save Lives

The PulsePoint Respond mobile phone application will increase community awareness of medical emergencies and alert and direct CPR-trained individuals nearby to cardiac arrest victim

San Francisco, CA – The San Francisco Department of Emergency Management and City officials today announced the launch of PulsePoint, a mobile phone application (PulsePoint app) designed to support public safety agencies increasing cardiac arrest survival rates through improved bystander performance and active resident support.

San Francisco's 9-1-1 dispatch center has formally integrated the use of the PulsePoint application with the 9-1-1 computer-aided dispatch (CAD) system. When a 9-1-1 dispatcher receives and identifies a call related to sudden cardiac arrest (SCA), the information on the CAD system will automatically trigger a PulsePoint application push notification.

"When someone experiences sudden cardiac arrest, help must arrive as soon as possible to increase their chances of survival," said San Francisco Department of Emergency Management Executive Director Mary Ellen Carroll. "The PulsePoint app provides 9-1-1 dispatchers with an additional tool to notify individuals nearby to respond, perform lifesaving CPR quickly, and provide AED assistance until first responders arrive."

Anyone with the app who is located within a six-block radius of the incident can receive a push notification to the location of the closest publicly accessible automated external defibrillator (AED) to render aid.

"Time is of the upmost importance when it comes to helping someone experiencing a cardiac arrest. The PulsePoint app provides this critical element: closing the time gap between when CPR is started," said San Francisco Fire Department Chief Jeanine Nicholson. "We want anyone willing and able to conduct CPR on someone experiencing cardiac arrest to download the PulsePoint app. This way bystanders and emergency medical first responders can work together to save lives."

In the past three months, DEM's Emergency Medical Services Agency (EMSA) staff have received three CPR-needed alerts from the PulsePoint app. EMSA staff were able to respond in person with an AED within five minutes, arriving before or at the same time as paramedics.

DEM conducted a soft launch of the app on May 19, 2022 and has seen a steady increase in the number of registered users. There are 1027 registered monthly active users as of July 2022. The PulsePoint app is available for download on Google Play, iPhone App Store, or by scanning the QR code below.

To learn more please watch DEM's public service announcement video about the app: https://youtu.be/Afhr6nDs9U4

About the San Francisco Department of Emergency Management
The San Francisco Department of Emergency Management (DEM) leads the City in planning, preparedness, communication, response, and recovery for daily emergencies, large scale citywide events, and major disasters. DEM is the vital link in emergency communication between the public and first responders, and provides key coordination and leadership to City departments, stakeholders, residents, and visitors.

About the PulsePoint Foundation
PulsePoint is a public 501(c)(3) non-profit foundation that builds applications for use by public safety agencies to increase community awareness during critical events. The PulsePoint Respond mobile app notifies trained individuals of the nearby need for CPR and the PulsePoint AED registry identifies AED (automated external defibrillator) locations for use by the public and 9-1-1 telecommunicators during emergency call taking. PulsePoint also provides specialized mobile apps for professional responders. Learn more at pulsepoint.org or join the conversation at Facebook and Twitter. The free app is available for download on the App Store and Google Play.

About Sudden Cardiac Arrest
Although a heart attack can lead to sudden cardiac arrest (SCA), the two are not the same. SCA is when the heart malfunctions and suddenly stops beating unexpectedly, whereas a heart attack is when blood flow to the heart is blocked, but the heart continues to beat. Each year, more than 350,000 out-of-hospital cardiac arrests occur, making it the leading cause of death in the United States. Survival rates nationally for SCA are less than eight percent, but delivery of CPR can sustain life until paramedics arrive by maintaining vital blood flow to the heart and brain. However, only about a third of SCA victims receive bystander CPR. Without CPR, brain damage or death can occur in minutes. The average EMS response time is nine minutes, even in urban settings; after 10 minutes there is little chance of successful resuscitation. The American Heart Association estimates that effective bystander CPR, provided immediately after SCA, can double or triple a person's chance of survival.

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Appendix E

Department of Emergency Management
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Phone: (628) 217-6000 Fax: (628) 217-6001

London Breed
Mayor

Mary Ellen Carroll
Executive Director

San Francisco APOT/Diversion Workgroup 2021-2022 Recommendations for Improvement of APOT/Diversion Rates in San Francisco County

Mission

The mission of the San Francisco Ambulance Patient Offload (APOT) and Diversion Workgroup, a result from the January 2022 immediate policy release for EMS Agency (EMSA) polices 5010 and 5020, was charged with providing the EMS Advisory Committee (EMSAC) measurable, implementable, and feasible policy recommendations for public comment by June 1, 2022, to reduce APOT and Diversion metrics to current immediate release policy standards (<35 min 90th %ile APOT and <50% diversion).

Objectives

The workgroup identified 4 objectives:

1. Review policy goals for EMSA Policy 4000.1, 5000, 5010, and 5020
2. Review and develop metrics around Hospital data, APOT/Diversion metrics, Patient Volume (inpatient, behavioral health, and outcomes), EMS Alert Impacts to system as it pertains to licensed vs. staffed beds data sharing
3. Establish criteria for current policy use of Ambulance Diversion, Trauma Override, patient distribution and opportunities for pilot projects
4. Identify up to 10 recommendations to share with EMS System key partners and external stakeholders

Purpose and Timeline

Workgroup convened twice monthly from January through April 2022, and weekly in May and June of 2022 to finalize objectives in anticipation of presentation at the July 6 EMSAC Meeting

Voting Members

Committee members comprised representation designated by the Hospital Council of Northern California (UCSF, SFGH and CPMC), one representative from each EMS Provider (SFFD, AMR and King American), one member of the public, one member

from Division of Emergency Communications, and support (non-voting) from the SF EMSA.

Committee Roster:

Mary Mercer, MD	ZSFGH ED	EMS Base Hospital Medical Director	Committee Chair
Maria Raven, MD	UCSF ED	Chief of Emergency Medicine	
Tina Bray RN	CPMC	CNO	
Cassandra Madeiros, EMT-P	AMR	Clinical and Education Manager	
Josh Nultemeier	King American	Chief Paramedic/Ops Manager	
Niels Tangherlini	SFFD	EMS Captain	
Rich Pekelney	Public Representative		
John Brown, MD	EMSA	Medical Director	
Rob Smuts	EMSA/DEC	Deputy Director	
Andrew Holcomb	EMSA	Acting EMS Director	
Ryan Seymour	EMSA	EMS Specialist-Operations	

Planning Assumptions

- Extended APOT time impacts EMS Providers' ability to respond to 911 calls in a timely manner
- Extended response times may increase morbidity and mortality of critical care patients
- Increased individual hospital diversion rates decrease the number of hospitals available to receive patients, therefore increasing patient volumes to fewer hospitals (potentially assisting with distribution if facility has capacity)
- Increased patient volumes on a smaller number of hospitals contributes to increased APOT times

Process

Potential recommendations compiled and sent to workgroup members to rate in order of priority, complexity, and ability to be initiated within 12 months. Committee then divided recommendations into two areas : 1) Systemic changes requiring advocacy, new resources or regulatory changes and 2) Local pilots, PDSAs and process modifications.

Recommendations

SYSTEMIC CHANGES:

- Expand Acute Behavioral Health capacity (at PES or other institutions)
- Increase Inpatient Behavioral Health beds
- Increase intensive outpatient programs for Psychiatric/Mental Health in San Francisco
- Increase Skilled Nursing Facility (SNF), respite, or Residential Care Facility (RCF) beds in San Francisco

LOCAL WORK:

- City-wide EMS Acute care system process improvement effort with executive sponsorship from hospital medical and nursing executives
- Expand/codify criteria for ambulance off-load to waiting room
- Post-ED Disposition actively facilitated by Community Paramedicine Program (including transport)
- Nurse triage from dispatch to schedule and refer outpatient resources (urgent vs acute)
- Revise destination protocol for patients in custody
- EMTs or Paramedics at hospitals to monitor patients awaiting offload
- Ensure technologic platforms and systems are aligned/maximized and reducing steps/manual processing needed for front-line EMS Staff

City and County of San Francisco
London Breed, Mayor

Department of Emergency Management
Emergency Medical Services Agency

Date: July 11, 2022

To: San Francisco EMS Providers
San Francisco Receiving Hospitals
EMS Advisory Committee Members

From: John Brown MD, San Francisco EMS Agency Medical Director
Andrew Holcomb, Acting EMS Director

Cc: Mary Ellen Carroll, Executive Director, Dept. of Emergency Management
Robert Smuts, DEC Deputy Director, Dept. of Emergency Management

Subject: **Implementation of Ambulance Patient Offload and Diversion Policies**

On July 6, 2022, the EMS Advisory Committee (EMSAC) convened and reviewed several EMS policies and protocols including:

- Policy 4000.1 – Ambulance Turnaround Time Standard
- Policy 5000 – Destination Policy
- Policy 5010 – Receiving Hospital Standards
- Policy 5020 – Diversion Policy

At the EMSAC meeting, all 4 policies were adopted unanimously after months of intensive workgroup meetings, policy development, and feedback from key stakeholders. As the above policies have no EMS training requirements for field providers and both 5010 and 5020 are currently operating under immediate release provisions, all the above policies will go into effect on July 11, 2022 to maintain continuity of this important work.

I want to thank everyone for their feedback, input, and dedication to improving our EMS system. For any questions, please contact Acting EMS Director, Andrew Holcomb, at the EMS Agency by emailing andrew.holcomb@sfgov.org.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4000.1
Effective Date: July 11, 2022
Supersedes: December 1, 2021

AMBULANCE TURNAROUND TIME STANDARD

I. PURPOSE

To define the goals for ambulance turnaround and patient offload times.

II. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.220, 1797.224, 1797.225 1797.252, and 1798.

III. BACKGROUND

Patient transfer from ambulance to hospital is a critical part of emergency care, both for the individual patient at the hospital and to preserve the availability of ambulances to answer 911 calls for medical assistance throughout the San Francisco EMS System.

IV. DEFINITIONS

Ambulance arrival at the emergency department – The time the ambulance stops (actual wheel stop) at the location outside the hospital emergency department where the patient is unloaded from the ambulance.

Ambulance patient offload time (APOT-1) – The time when a patient is physically removed from the ambulance gurney to hospital equipment and transfer of care has been completed, as recorded by a signature from an emergency department nurse or doctor in a patient's EMS electronic health record.

Ambulance return to service time – The time the ambulance is response ready after transporting a patient to a hospital emergency department.

Offload time interval - The period of time between ambulance arrival at emergency department and ambulance patient offload time.

Ambulance turnaround interval - The period of time between ambulance arrival at emergency department and ambulance return to service time.

V. POLICY

The goal for the offload time interval is 20 minutes or less, 90 percent of the time (APOT-1).

The goal for the ambulance turnaround interval is 30 minutes or less, 90 percent of the time.

VI. ACUTE OFFLOAD DELAYS

A. An EMS Supervisor may be dispatched for the following APOT-1 offload delays:
    a. 3 or more ambulances delayed for 60 minutes or greater
    b. 2 or more ambulances delayed for 90 minutes or greater
    c. 1 or more ambulances delayed for 120 minutes or greater
    d. Any combination of the above
B. Upon arrival to the facility, the EMS Supervisor shall identify themself and check-in with Emergency Department Charge Nurse and/or Hospital Supervisor to confer about the cause of the ambulance offload delay.
C. The EMS Supervisor shall work collaboratively with hospital staff to identify offload delays, identify solutions, and formulate a plan for patients currently waiting on gurneys. Every attempt shall be made to triage patients to alternative waiting spaces such as waiting areas, fast track areas, wheelchairs, or hallways spaces.
D. Should all reasonable attempts to offload patients to other areas fail AND EMS system levels are less than 5 ambulances, the EMS Supervisor may declare an "APOT Alert:"
    a. An APOT Alert:
        i. Has no impact on ambulance diversion or distribution of patients.
        ii. Is for situational awareness only for all field ambulance crews.
        iii. Is in effect until ambulances are cleared from the Receiving Facility
    b. Steps for DEC:
        i. When announcing Diversion, advise of "APOT Alert" declaration
        ii. Send a notification to all crews via CAD Mobile Data Terminals
        iii. Post banner on ReddiNet announcing the APOT Alert at the affected Receiving Facility
        iv. Sent ReddiNet message to EMS Providers, EMSA, and affected Receiving Facility announcing APOT Alert declaration
        v. Notify DEM Duty Officer (to notify EMS Agency)
        vi. Send follow-up message when APOT Alert secured
    c. Steps for Receiving Facility:
        i. Immediately notify House Supervisor and Administrator on Call
        ii. Consider activation of HICS (Hospital Incident Command System)
        iii. Consider activation of emergency surge plans including use of:
            1. Alternate treatment spaces (ie tents, unoccupied hospital wards/floors)

2. Staff call-ins, modification of nursing ratios

E. Upon declaration of an APOT Alert the following options may be utilized:
    a. The EMS Supervisor shall directly inform the Emergency Charge nurse that ambulances are transitioning care and immediately offload patients to a hospital bed or other suitable hospital sitting space if appropriate for a patient's condition based on the following criteria:
        i. Stable vital signs
        ii. Alert and oriented
        iii. No ALS intervention in place
        iv. Not on a 5150 hold
        v. 18 years of age or older
    b. Immediately re-triage patients to other Receiving Facilities that are less impacted if the time to transport and transfer care to another Receiving Facility is less than the estimated time to transfer care at the facility with the declared APOT Alert.
        i. For any re-triage of patients to other Receiving Facilities, the EMS Agency shall review the incident and forward to California Department of Public Health for Emergency Medical Treatment and Active Labor Act (EMTALA) violations.
    c. Consider use of bypass services (ie Trauma Bypass, burns) if the Receiving Facility experiencing an APOT Alert is the only Specialty Receiving Center in San Francisco.

F. Documentation
    a. The following shall be documented in the Patient Care Record (PCR):
        i. Detailed description of attempts to offload patient and transfer care to hospital staff
            1. Reasonable attempts include but not limited to:
                a. Multiple attempts to obtain a signature for the PCR
                b. Multiple attempts to provide a patient report either written or verbal
                c. Attempt to interact with an Emergency Department supervisor, charge nurse, and/or hospital administrator
                d. Attempt to utilize EMS Supervisor in offloading patient
        ii. Any additional transports to other facilities
        iii. Patient deterioration due to delays in patient transfer
        iv. Should hospital staff be unwilling to speak with EMS Personnel or sign PCR acknowledging transfer of care, the following statement shall be made by EMS personnel and documented within PCR.
            1. An APOT alert has been declared. All reasonable attempts to offload this patient have failed. I am transferring this patient to your care with or without a verbal patient report

as you are a higher level of medical care. I will provide written patient care report via a copy of my PCR once complete. I am documenting that I have made every attempt to transfer the patient.

G. Upon conclusion of the APOT Alert, the EMS Supervisor shall:
    a. Announce the APOT Alert is secured.
    b. File an exception report to the EMS Agency within 12 hours.

VII. DATA COLLECTION

A. All interval measurements shall be reported monthly (on the first business day of the month) to the EMS Agency in an approved electronic format.
B. Turnaround time data submitted by providers shall include date, time, location, call disposition (Code 2 or Code 3), arrival time at hospital, ambulance patient offload time and ambulance return to service time.

VIII. QUALITY IMPROVEMENT

A. The EMS Agency will report monthly the following ("Hospital Report"):
    1. Offload time interval for each provider at each emergency department.
    2. Ambulance turnaround interval for each provider at each emergency department.
    3. System aggregate intervals for patient offload and ambulance turnaround intervals at each emergency department
B. The EMS Agency will focus on identifying the root causes for delays, surges in demand and to what extent diversion impacts offload and turnaround intervals.

IX. QUALITY ASSURANCE

A. Based on the Hospital Report, the EMS Agency may take action on a Receiving Facility, as detailed in Policy 5010, who have a:
    a. 90th percentile APOT-1 time under 30 minutes, but greater than the 20-minute standard, the EMS Agency will continue to monitor via quality improvement in subsequent months
    b. 90th percentile APOT-1 time over 30 minutes for two (2) consecutive months
        i. The EMS Agency shall refer to corrective action plan process as detailed in Policy 5010

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5000
Effective Date: July 11, 2022
Supersedes: March 3, 2019

DESTINATION POLICY

I. PURPOSE

A. To identify the approved ambulance-transport destinations for the San Francisco EMS System.

B. To delineate clinical criteria when patients should be transported to a general or specialty care hospitals or other alternate destinations.

II. DEFINITION

Decision Maker: Generic term used in this policy to refer to whoever is making the transport destination decision for the EMS patient. This may include the patient, family, or medical personnel managing the patient's care. For patients with psychiatric illness, this may also include the custodian placing the 5150 involuntary hold.

III. POLICY

A. The Emergency Medical Services (EMS) Agency designates hospitals approved to receive ambulances according to Policy 5010 – Receiving Hospital. The EMS Agency Medical Director may approve Specialty Care Facilities or alternate destinations that support the mission of the EMS System to receive ambulance patients as either temporary or permanent additions to the EMS System.

B. Ambulances may only transport patients to the approved destinations listed in this policy. Prearranged inter-facility transports, as defined in Policy 5030 – Interfacility Transfers are exempt from this policy.

C. When a patient is in need of specialty treatment (e.g. OB/GYN, STEMI, etc), the ambulance crew may bring the patient directly to that hospital's specialty care department if directed to do so by hospital staff.

IV. DESTINATION DECISION

A. Hospital destination decisions for EMS patients shall be prioritized based on the following:
   1. Patient medical need;
   2. Hospital diversion status and/or EMS Alert status (see section V);
   3. Patient preference;
   4. Family or private physician preference (if patient unable to provide information);

5. Patients without a preference who require no specialty care shall be transported to the closest open general medical designated hospital.

B. All patients who are in law enforcement custody (defined as "under arrest," "detained," or "incarcerated") must be taken to Zuckerberg San Francisco General Hospital for evaluation.

C. Patients with medical needs meeting any of the Clinical Field Triage Criteria listed in Section IV below will be transported to the most appropriate specialty care facility. Specialty care designations includes:
   1. Pediatric Medical
   2. Pediatric Critical Medical
   3. STAR (STEMI and/or Post Arrest with ROSC)
   4. Replantation (Microvascular Surgery)
   5. Burns
   6. Obstetrics
   7. Stroke
   8. Trauma
   9. LVAD
   10. Post-Sexual Assault
   11. Sobering

D. Destinations other than those listed in this policy require approval from the Base Hospital Physician prior to transport except in instances as noted in Policy 4030 - Intercounty and Bridge Response.

E. In the event of a Multi-Casualty Incident (MCI), destinations will be determined in accordance with Policy 8000 – Multi-Casualty Incident.

V. EMS ALERT

A. **EMS Alert:** Automatic ambulance routing function to supplement Hospital Diversion. EMS Alert looks at a ratio of current EMS volume and ED size to provide a fluid, point-in-time reflection of each hospital's EMS impact.
   1. EMS Alert ratio is calculated as follows:
      a) 60-Minute EMS Volume (Numerator): The sum of the units en route + units at-hospital + units cleared in the past 60 minutes.
      b) ED Surge Cap (Denominator): Determined by the "30% or 6 Rule" which is 30% of a hospital's licensed ED bed count or 6, whichever is lowest.
      c) Receiving Facilities that have changes to their licensed ED bed count shall notify the EMS Agency within 30 days.

B. EMS Alert status shall be followed by EMS Personnel, consistent with Diversion Policy 5020. EMSA shall add a dashboard to the monthly Hospital Report for EMS Provider compliance with EMS Alert.

C. Ambulances are not permitted to transport to a Receiving Facility while on EMS Alert except (ref. Destination Decision above section IV, A):

1. Patients who meet any criteria which would allow bypass of diversion (e.g. Trauma, stroke, STEMI, in-custody)
2. Extenuating circumstances where a patient has specific clinical needs that require care at a certain facility (e.g. recent transport or <48 hour surgical patient requesting transport to the hospital that performed the procedure). These situations required approval from the Dispatch Rescue Captain or King American/AMR On-duty Supervisor prior to transport. EMS Alert bypass requires documentation of the extenuating circumstances within the Patient Care Record (PCR) and the name of the supervisor who approved the bypass.
    a) Examples include, but not limited to:
        - Recent organ transplant patient going to the hospital that performed the procedure
        - Patient <48-hours post-surgery requesting transport to the hospital that performed the procedure
        - Patient recently discharged (<2-hours) from an ED returning to the hospital where they were initially seen
        - Patient with an EMS6 care plan in which EMS6 feels another hospital is not appropriate
        - Patient with cancer receiving specialized care such as chemotherapy

D. EMS Alert Suspension: diversion suspension has no effect on EMS Alert. EMS Alert is suspended when the sum of hospitals on Diversion, Trauma Override, or EMS Alert is equal to or greater than 5. When EMS Alert is suspended, hospitals might receive 1 additional ambulance transport above their designated ratio each time EMS Alert is suspended.

E. In order to obtain EMS Alert and Hospital Diversion status, review of ReddiNet via mobile data terminal shall be the primary tool by EMS personnel. Calling DEC shall be a secondary option, such as in cases of equipment failure, to minimize radio traffic and routing errors.

VI. CLINICAL FIELD TRIAGE CRITERIA

A. **Critical Airway:** Patients in whom EMS personnel cannot obtain adequate airway control should be transported to the closest Receiving Hospital regardless of diversion status. For patients under age 18, the preference is for a critical pediatric medical hospital

(CPMC Van Ness or UCSF Mission Bay) if ETA is equal to or less than any other receiving facility.

B. **Adult Critical Medical:** Patients with one (1) or more of the following conditions should be transported to the closest Receiving Hospital:
    1. Airway obstruction or respiratory insufficiency with inadequate ventilation;
    2. Hypotension with shock;
    3. Status epilepticus;
    4. Acute deteriorating level of consciousness without trauma.

C. **Adult Medical:** Patients who do not meet any of the following: critical airway, critical medical adult or specialty criteria, may be transported to any Receiving Hospital or Standby Receiving Hospital.

D. **Pediatric Critical Medical:**
    1. Pediatric definition of <18 years old applies only to this policy for selection of a hospital destination. It does NOT apply to any patient treatment policies or protocols.
    2. Patients under age 18 with 1 or more of the following conditions should be transported to the closest Pediatric Critical Medical receiving hospital):
        a) Cardiopulmonary arrest or post-arrest;
        b) Hypotension with shock;
        c) Status epilepticus;
        d) Acute deteriorating level of consciousness without trauma

E. **Pediatric Medical:** Pediatric definition of <18 years old applies only to this policy for selection of a hospital destination. It does NOT apply to any patient treatment policies or protocols. Patients under age 18 years not meeting the criteria for Critical Medical Pediatric may be transported to any Receiving Hospital listed as "pediatric medical."

F. **ST Elevation Myocardial Infarction / Post Arrest with ROSC (STAR):** Patients are considered to be STEMI patient if they meet the STEMI criteria as defined in Protocol 2.06 – Chest Pain/Acute Coronary Syndrome. Patients experiencing a STEMI shall be transported to a designated **ST** Elevation Myocardial Infarction / Post **A**rrest with **R**OSC (**STAR**) Center according to the following hierarchy:
    1. Cardiopulmonary arrest - Patients who are age 18 or over and are in cardiac arrest or those who are post-arrest with return of spontaneous circulation in the field;
    2. Patients who are unstable and would experience a significant delay in their care by transport to a preferred STAR Center shall be transported to the closest, designated STAR Center;
    3. Patient preference for transport to a specific Receiving Hospital that is designated as a STAR Center;

4. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a STAR Center;
5. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a STAR Center.

G. **Stroke:** Patients who are age 18 or over and are experiencing the symptoms of acute stroke (last seen normal 24 hours or less prior to 911 call) and exhibiting an "abnormal" result on the Cincinnati Prehospital Stroke Scale (see Protocol 2.14 – Stroke) shall be transported to a designated Stroke Center according to the following hierarchy:
   1. Patients who are unstable and would experience a significant delay in their care by transport to a preferred Stroke Center shall be transported to the closest designated Stroke Center;
   2. Patient preference for transport to a specific Receiving Hospital that is designated as a Stroke Center;
   3. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a Stroke Center;
   4. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a Stroke Center.

H. **Replantation:** If the patient has any of the following amputations or devascularization injuries, they may be taken to the Replantation (Microsurgical)Facility of their choice or to the closest Replantation Center if the patient has no preference:
   1. Isolated amputation or partial amputation distal to the ankle or wrist;
   2. Extensive facial, lip, or ear avulsion;
   3. Penile amputation;
   4. If the patient meets trauma triage criteria, transport to a Trauma Center;
   5. Simple avulsion lacerations of the distal phalanx will be transported to any open Receiving Hospital or the closest open Receiving Hospital if the patient has no preference.

I. **Burns:** Patients with the following criteria shall be transported to the Saint Francis Hospital Burn Center:
   1. Partial thickness burns **>** 10% of the total body surface area (TBSA);
   2. Burns involving the face, eyes, ears, hands, feet, perineum or major joints;
   3. Full thickness or 3rd degree burns in any age group;
   4. Serious electrical burns;
   5. Serious chemical burns;
   6. Inhalation injuries (including burns sustained in a closed space for purposes of facial burns);
   7. Pediatric burn patients who do not meet trauma triage criteria shall be transported to Saint Francis Memorial Hospital;

8. Transport to Zuckerberg San Francisco General Hospital Trauma Center if the burned patient meets trauma triage criteria.

J. **Obstetrics:** Pregnant patients who are over 20 weeks gestation (by patient history) with any condition that does not fall under other specialty center should be transported to the Obstetrics Specialty Care Facility of their choice or the closest open Obstetrics Specialty Care Facility if the patient has no preference.

K. **Psychiatric** (see 5000.2 Flowchart):
The psychiatric criteria listed below apply to patients with signs and symptoms of a psychiatric illness and / or who are on a 5150 involuntary hold:

1. All patients with signs and symptoms of a psychiatric illness who are under law enforcement custody (defined as "under arrest," "detained," or "incarcerated") must go to Zuckerberg San Francisco General Hospital.

2. For (not incarcerated, detained or under arrest) patients with signs and symptoms of a psychiatric illness, the destination is based on the following:
    a) Patient age;
    b) Patient medical need;
    c) Hospital diversion status;
    d) For involuntary patients, the patient decision maker placing the hold will identify hospital destination.
    e) Patient preference;
    f) Family/guardian or private physician preference;
    g) If no preference, hospital location ("geographically closest").

3. Patients with signs and symptoms of a psychiatric illness less than 18 years old must go to medically appropriate pediatric designated Receiving Hospital.

4. Patients with signs and symptoms of a psychiatric illness AND WITH suspected or active medical complaints must go to medically appropriate Receiving Hospital. This includes:
    a) Patients who are severely agitated or combative and whose combativeness prevents an assessment (vital signs or examination) and / or requires field sedation with midazolam.
    b) Patients with any medication overdose or who show signs of potential toxicity from drugs or alcohol.

5. Patients with signs and symptoms of a psychiatric illness **may** go to directly Psychiatric Emergency Services (PES) at Zuckerberg San Francisco General (ZSFG) if it is open (not on divert) and are medically appropriate by meeting **ALL** of the following criteria:
    a) Age 18 – 65 years.

b) Glasgow Coma Score of 13 or greater;
c) Pulse rate between 55 - 120;
d) Systolic blood pressure between 90 - 190;
e) Diastolic blood pressure between 60 - 110;
f) Respiratory rate between 12 - 24;
g) Temperature between 96.5 and 100.5°F (or 35 to 38°C);
h) Oxygen saturation greater than 94%;
i) Blood glucose level between 60 – 250;
j) No active bleeding;
k) No bruising or hematoma above clavicles;
l) No active seizure; and
m) No lacerations that have not been treated.

L. **Trauma:** Emergent patients meeting the criteria described in Policy 5001 – Trauma Triage Criteria will be transported to a Trauma Center. For non-emergent patients who meet Trauma Triage Criteria, Base Hospital contact is required prior to transport to establish appropriateness of Trauma designation and to receive approval to transport to Zuckerberg San Francisco General Hospital.

M. **LVAD**: Any patient with a left ventricular assist device (LVAD) should be transport the patient to the LVAD Center that implanted the device (UCSF or CPMC Van Ness). You are authorized to BYPASS the closest San Francisco LVAD Center to get the patient to the LVAD Center that implanted their device no matter the patient's condition. If the LVAD Center that implanted the device is not in San Francisco, take the patient to the closest San Francisco based LVAD Center.

N. **Post-Sexual Assault:** Any patient who self-identifies as a victim of sexual assault or abuse within the 72 hours prior to their activation of 911 services AND does not have an overriding medical complaint or meet any special care criteria listed in this policy should go to Zuckerberg San Francisco General Hospital. This also applies to pediatric patients who are identified as being victims of sexual assault or abuse.

O. **Sobering Services:** Intoxicated patients with no acute medical condition(s) or co-existing medical complaints may go to an approved sobering service, if the patient meets the following criteria:
    1. Be at least 18 years or older;
    2. Voluntarily consents or has presumed consent (when not oriented enough to give verbal consent) to go to an approved sobering service;
    3. If going to the San Francisco Sobering Center, must not be on their "Exclusion List."
    4. Be medically appropriate by meeting **ALL of the following criteria:**
        a) Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle found on person);

b) Glasgow Coma Score of 13 or greater;
c) Pulse rate between 55 - 120;
d) Systolic blood pressure between 90 - 190;
e) Diastolic blood pressure between 60 - 110;
f) Respiratory rate between 12 - 24;
g) Temperature between 96.5 and 100.5°F (35 and 38°C);
h) Oxygen saturation greater than 94%;
i) Blood glucose level between 60 – 250;
j) No active bleeding;
k) No bruising or hematoma above clavicles ;
l) No active seizure; and
m) No lacerations that have not been treated.

VII. AUTHORITY

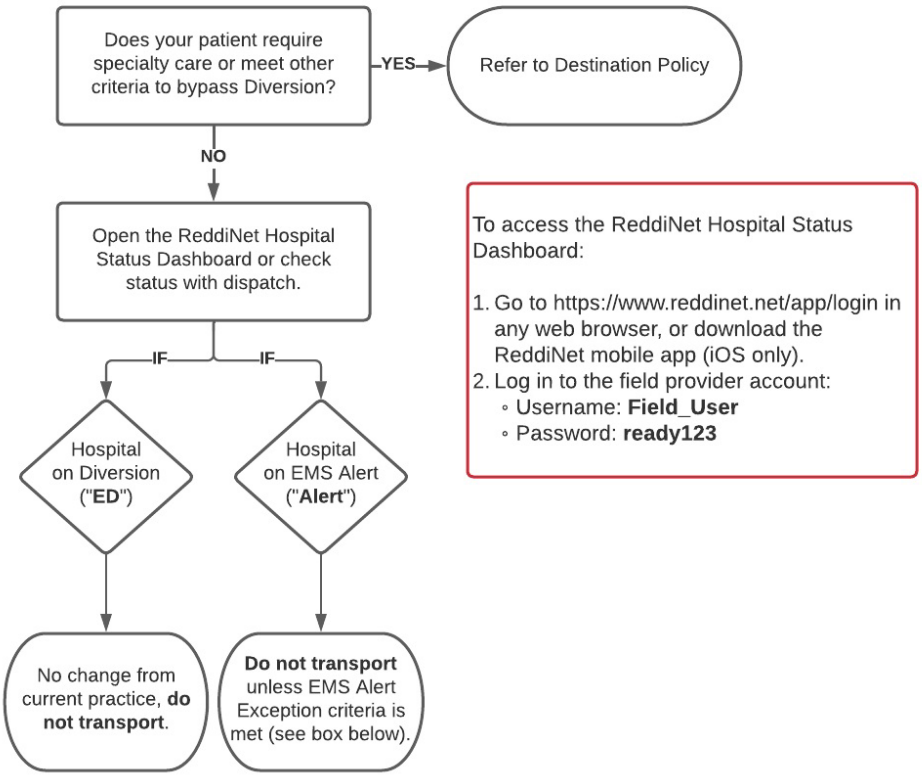
California Health and Safety Code, Division 2.5, Sections 1798 and 1798.163

Appendix A

"EMS Alert" Guide Sheet

EMS Alert is a parallel system to Diversion. It provides a fluid, point-in-time reflection of each hospital's EMS impact based on current EMS activity in relation to a hospital's capacity. Background information, technical details, and FAQ can all be found in the EMS Alert section of the Policy & Protocol App, as well as on the EMS Agency webpage.

Instructions for using EMS Alert are below and are based on current guidance from the EMS Agency Medical Director. The EMS Memo with this information can also be found on the Policy & Protocol App and webpage.



EMS Alert Exception

Paramedics shall contact the Radio RC (SFFD ambulance) or King/AMR Supervisor (Private ambulance) if the patient meets the specialty cases outlined below. These personnel can only approve a patient going to an ED on EMS Alert in these specific cases.

- Recent organ transplant patient going to the hospital that performed the procedure
- Patient <48-hours post-surgery requesting transport to the hospital that performed the procedure
- Patient recently discharged (<2-hours) from an ED returning to the hospital where they were initially seen
- Patient with an EMS6 care plan, in which EMS6 feels another hospital is not appropriate
- Patients with cancer receiving specialized care such as chemotherapy

In the event that a provider cannot contact a supervisor after 2 attempts, EMS Alert bypass may be initiated. For other clinical scenarios not listed above, in which a Paramedic feels a patient should bypass, Base Hospital contact is required. This should be treated the same as Base Hospital destination consultation while a hospital is on Diversion. Bypass of EMS Alert requires documentation of extenuating circumstances and supervisor/physician name.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5010
Effective Date: July 11, 2022
Supersedes: January 3, 2022

RECEIVING HOSPITAL STANDARDS

I. PURPOSE

A. Establish minimum standards for all San Francisco EMS approved receiving hospitals.
B. Integrate receiving hospitals into the EMS system as stakeholders in the planning, design, and delivery of Emergency Medical Services.
C. Provide a mechanism for receiving hospitals to communicate with the EMS Agency and other system participants.

II. AUTHORITY

A. Code of Federal Regulations, Title 45, Section 164.512 (b) (l) (i)
B. California Health and Safety Code, Division 2.5, Sections 1797.67, 1797.204, 1797.222, 1797.250, 1797.252, 1798, 1798.150, and 1799.205.
C. California Code of Regulations, Title 22, Sections 100172, 100175, 70411-70419, and 70451 – 70459.
D. Joint Commission on Accreditation of Health Care Organizations, Emergency Department Standards

III. POLICY

A. General Requirements
    1. All receiving hospitals must have a written agreement with the San Francisco EMS Agency to be recognized as an approved destination for ambulances transporting prehospital patients.
    2. All receiving hospitals shall meet all Federal, State, and local requirements to be recognized as a Comprehensive Emergency Department, Basic Emergency Department, or Standby Emergency Department.
    3. Receiving Hospitals shall be accredited by the Joint Commission on Accreditation of Health Care Organizations.
    4. Medical Control of Advanced Life Support personnel shall be the sole responsibility of the Base Hospital.
    5. Receiving hospitals shall comply with all EMS Agency Policies and develop internal policies compelling hospital personnel to comply with EMS Agency policies when their work relates to the EMS system.
    6. Receiving Hospitals that are not designated Specialty Receiving Centers, e.g. STAR Receiving Centers, Stroke Centers, Trauma Centers or Pediatric Critical Care Centers, shall have in place rapid transfer

protocols, policies or procedures so that patients who need theses specialty receiving centers can access them rapidly.

7. Receiving Hospitals shall pay all required and associated fees within 30 days of being invoiced by the EMS Agency.

B. Personnel
   1. Medical Director
      a) The ED Medical Director shall be a physician certified or qualified by training and experience for examination by the American Board of Emergency Medicine.
   2. ED Physicians with direct patient care responsibilities
      a) Must be Board Eligible, Board Prepared, or Board Certified in Emergency Medicine, Internal Medicine, Surgery, or Family Practice and maintain current recognition in the following curricula:
         (1) Advanced Cardiac Life Support (or equivalent)
         (2) Pediatric Advanced Life Support (or equivalent)
         (3) Current certification in Emergency Medicine may be held in lieu of III, B, 2, a, 1 – 2.
   3. Direct Supervision of Nursing and Medical Support Personnel
      a) A Registered Nurse qualified by training and experience in emergency room nursing care shall be responsible for nursing care within the ED at all times.
   4. Nursing
      a) All regularly scheduled nurses in the ED shall maintain recognition in the following curricula:
         (1) Basic Life Support, Health Care Provider
         (2) Advanced Cardiac Life Support (or equivalent)
         (3) Pediatric Advanced Life Support (or equivalent)
      b) Nurses newly hired or assigned to the ED shall have current recognition in the above curricula within 6 months of hire or assignment.
   5. At least one person trained to operate all EMS communications equipment shall be on duty at all times.
   6. Each facility shall designate a person or person(s) to represent the hospital at EMS System Advisory Committee meetings, Trauma System Audit Committee meetings, act as a liaison to the EMS System, and disseminate information regarding EMS within the facility.

C. EMS Specific Training
   1. All regularly scheduled full time employees, to include physicians, nurses, and support staff with patient care or ambulance interface duties, shall complete training in the following areas:
      a) EMS Agency Policies
      b) EMS Agency Exception Reporting
      c) Diversion, EMS Agency and internal hospital policy

d) Operation of all communication and diversion monitoring equipment
e) San Francisco Department of Public Health Emergency Operations Plan
f) Internal disaster plans

2. All receiving hospitals will work cooperatively with the EMS Agency and the Base Hospital to provide Continuing Education for prehospital and ED personnel.

IV. SPECIFIC SERVICES AND EQUIPMENT REQUIREMENTS

A. Data Collection and Sharing
   1. Record keeping
      a) The Emergency Department shall maintain a medical record for each patient in accordance with Joint Commission standards.
         (1) The record will include the Prehospital Care Report, if applicable;
         (2) The records shall be immediately available to ED staff.
      b) The Emergency Department shall maintain a register that includes all data elements defined by Joint Commission, Title 22, and will also include the name and unit number of the transporting ambulance, when applicable.
   2. Hospitals will collect and report such information as determined necessary by the EMS Medical Director for the purposes of public health surveillance and injury prevention activities.
   3. Hospitals shall comply with the data reporting components of the EMS Agency Quality Improvement plan.

B. Referrals and Resources
   1. In addition to the required referrals listed in State law, receiving hospitals shall maintain names, addresses, and telephone numbers for the following:
      a) Sexual assault victim referral
      b) Elder, dependent adult, or child abuse
      c) Battered intimate partner or spouse referral
      d) Detoxification unit
      e) Drug and Alcohol abuse counseling and support services
      f) Psychiatric services
      g) Hyperbaric chamber
      h) Physician referral
      i) Outpatient medical services
      j) Resources for the homeless
      k) Other city and county designated specialty care centers
      l) Regional poison control center

2. All receiving hospitals shall maintain access to the current EMS Agency Policy Manual in the Emergency Department.
3. Contact information for the following shall be available in the ED:
    a) EMS Agency Duty Officer
    b) Department of Emergency Management Division of Emergency Communications (DEC) supervisor
    c) Ambulance providers supervisor and/or communications center
    d) Department of Public Health Emergency Preparedness and Response (PHEPR)
4. All hospitals shall have transfer agreements with EMSA designated specialty receiving centers (if such services are not available internally) including, but not limited to the following facilities:
    a) Trauma Center
    b) Pediatric Critical Care Center
    c) Burn Center
    d) Stroke Center
    e) STAR Center

C. Pediatric Services
1. All receiving hospitals shall have the capability to resuscitate and provide immediate, short-term post resuscitation care for pediatric patients (< 14 years of age) in the Emergency Department.
2. Appropriately sized and specialized equipment and pharmacological agents necessary to resuscitate and care for pediatric patients in accordance with current recommendations by the National Emergency Medical Services for Children Resource Alliance shall be immediately available in the Emergency Department.

V. STANDARDS COMPLIANCE

A. Each receiving hospital will complete a self-assessment at least once every 3 years to ensure compliance with EMS Agency requirements.
1. The self assessment may be performed concurrent with Joint Commission review.
2. Results of the self-assessment must be sent to the EMS Agency.

B. Receiving hospitals shall permit announced and unannounced visits by EMS Agency staff for the purposes of monitoring compliance.

C. Suspension/Revocation
1. The EMS Medical Director may suspend or revoke approval of any given receiving hospital for cause.
2. The EMS Agency shall notify the hospital administration in writing of its intent to deny, revoke, or suspend approval and give the hospital sixty (60) days to submit a corrective action plan.
3. The EMS Agency shall respond to the corrective action plan within thirty (30) days.

a) If the EMS Agency requests any modifications to the Corrective Action Plan, the hospital shall have thirty (30) days to respond to those requests.

4. The EMS Agency will monitor the hospital's compliance with the Corrective Action Plan and take action as indicated.
5. If, in the opinion of the EMS Medical Director, non-compliance or failures on the part of a hospital constitute an immediate and substantial hazard to the health, safety, or welfare of the public, the EMS Agency may immediately suspend approval of that hospital.
    a) The hospital may appeal such a decision to the Director of Public Health.
    b) The EMS Agency may continue a suspension pursuant to this section until the noted deficiencies are corrected.

VI. PATIENT OFFLOAD DELAY MITIGATION

1. For Receiving Facilities meeting Quality Assurance criteria of Policy 4000.1, Section IX, the Receiving Facility shall select a corrective option listed below and submit selection in writing to the EMS Agency within 30 days of issuance of the Hospital Report.
2. Option 1 – Traditional Pathway: Receiving Facility acknowledges that changes can be made by the Receiving Facility AND will eventually meet the APOT-1 standard, with 5% improvement month on month.
3. Receiving Facility shall submit a corrective action plan to reduce APOT-1 delays within 30 days of corrective option selection.
    a. The EMS Agency shall review the corrective action plan within 10 business days.
    b. The plan shall include, but not limited to, the following topics:
        i. Current data and patient trends
        ii. Patient surge measures implemented such as HICS (Hospital Incident Command System), alternative treatment spaces, emergency staffing
        iii. Identification of communication pathways and plans
        iv. Objectives, measurements, and metrics for improvement
    c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall have a minimum of 30 days to reduce APOT-1 times below 90th percentile of 30 minutes.
    d. **This section (VI, 3(d) i-iii) is RESERVED until January 1, 2023.** Upon subsequent release of the monthly Hospital Report, allowing a minimum of 30 days for corrective actions for mid-month submission, hospitals with continued APOT-1 times greater than 30 minutes shall be subject to the following adverse actions. A Receiving Facility may choose **one** of the following, in consultation with EMSA:

i. Mandatory implementation of an EMS offload plan that allows EMS providers to directly place a stable, noncritical patient into a waiting room to ensure a 30-minute offload time based on criteria for an APOT Alert in Policy 4000.1.
    1. The temporary implementation will last for 30 calendar days.
ii. Temporary suspension of the hospital's prehospital specialty care designation pursuant to Policy 5000 if the specialty care destination has three (3) or more receiving centers in San Francisco (ie STAR, stroke).
    1. The temporary suspension will last for 14 calendar days
iii. The Receiving Facility may choose to cancel a percentage of nonemergent, patient choice, elective surgeries as an adverse action in lieu of two adverse action options above. If the Receiving Facility chose this adverse action, the Receiving Facility would notify EMSA. EMSA would consider this decision a substantial step in lieu of some of the other adverse actions.

e. Any actions taken against a Receiving Facility shall be posted to the EMS Agency website, including notice of any Receiving Facilities on a Corrective Action Plan.
f. If a Receiving Facility does not make progress after implementation of one of the above adverse actions, the Receiving Facility may be subject to additional adverse actions.

4. Option 2 – Root Cause Analysis and Adjudication: Receiving Facility acknowledges that all changes that can be implemented have been implemented, resources have been exhausted, and external factors do not allow the Receiving Facility to meet the APOT-1 standard.
5. Receiving Facility submit a corrective action plan to reduce APOT-1 delays within 30 days of corrective option selection.
    a. The EMS Agency shall review the corrective action plan within 10 business days.
    b. The plan shall include, but not limited to, the following topics:
        i. Prominent dashboards on homepage of public facing Receiving Facility websites
        ii. Data submission and analysis as determined by the EMS Agency
        iii. Quarterly reports to the San Francisco Health Commission and Board of Supervisors (San Francisco Controllers Office, if applicable or determined by EMS Agency)

c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall comply with the plan or may be subject to adverse actions as listed in Section VI, 3(d)(i-iii).

VII. DIVERSION MITIGATION

1. For Receiving Facilities meeting Quality Assurance criteria of Policy 5020, Section X,C, the Receiving Facility shall select a corrective option listed below and submit selection in writing to the EMS Agency within 30 days of issuance of the Hospital Report.
2. Option 1 – Traditional Pathway: Receiving Facility acknowledges that changes can be made by the Receiving Facility AND will eventually meet the diversion standard, with 5% improvement month on month.
3. Receiving Facility shall submit a corrective action plan to reduce ambulance diversion within 30 days of corrective option selection.
    a. The EMS Agency shall review the corrective action plan within 10 business days.
    b. The plan shall include, but not limited to, the following topics:
        i. Current data and patient trends
        ii. Patient surge measures implemented such as HICS, alternative treatment spaces, emergency staffing
        iii. Identification of communication pathways and plans
        iv. Objectives, measurements, and metrics for improvement
    c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall have a minimum of 30 days to reduce ambulance diversion monthly percentage times below 30%.
    d. Upon subsequent release of the monthly Hospital Report, allowing a minimum of 30 days for corrective actions for mid-month submission, hospitals with continued >30% ambulance diversion shall be subject to the following adverse actions. A Receiving Facility may choose **one** of the following, in consultation with EMSA:
        i. Temporary allocation of a maximum of eight (8) hours of ambulance diversion in a 24-hour period (midnight to midnight), including the use of Trauma Override, if applicable.
            1. The temporary implementation will last for 30 calendar days.
        ii. Temporary suspension of the hospital's prehospital specialty care designation pursuant to Policy 5000 if the specialty care destination has three (3) or more receiving centers in San Francisco (ie STAR, stroke).
            1. The temporary suspension will last for 14 calendar days.

iii. The Receiving Facility may choose to cancel a percentage of nonemergent, patient choice, elective surgeries as an adverse action in lieu of two adverse action options above. If the Receiving Facility chose this adverse action, the Receiving Facility would notify EMSA. EMSA would consider this decision a substantial step in lieu of some of the other adverse actions.

e. Any actions taken against a Receiving Facility shall be posted to the EMS Agency website, including notice of any Receiving Facilities on a Corrective Action Plan.

f. If a Receiving Facility does not make progress after implementation of one of the above adverse actions, the Receiving Facility may be subject to additional adverse actions.

4. Option 2 – Root Cause Analysis and Adjudication: Receiving Facility acknowledges that all changes that can be implemented have been implemented, resources have been exhausted, and external factors do not allow the Receiving Facility to meet the diversion standard.
5. Receiving Facility submit a corrective action plan to reduce diversion within 30 days of corrective option selection.
    a. The EMS Agency shall review the corrective action plan within 10 business days.
    b. The plan shall include, but not limited to, the following topics:
        i. Prominent dashboards on homepage of public facing Receiving Facility websites
        ii. Data submission and analysis as determined by the EMS Agency
        iii. Quarterly reports to the San Francisco Health Commission and Board of Supervisors (San Francisco Controllers Office, if applicable or determined by EMS Agency)
    c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall comply with the plan or may be subject to adverse actions as listed in Section VII, 3(d)(i-iii).

VIII. EXCEPTIONS AND IMPLEMENTATION

1. **Sections VI and VII are considered a pilot policy and will undergo formal outcomes review in June 2023, with formal reporting of outcomes at July 2023 EMSAC to determine if this will be adopted into full policy. If an outcomes review does not occur or obtain consensus for any changes, sections VI and VII shall become adopted in full.**

2. For Receiving Facilities that meet criteria as listed in Section VI(1) and/or VII(1) AND are required to submit a correction action plan, the following is in effect from July 1, 2022 until January 1, 2023.
    a. If Receiving Facility, in which is out of compliance, reduces APOT 90th Percentile metric by 5% over previous month, the corrective action plan requirement and adverse action process is stayed.
    b. If Receiving Facility, reduces monthly ambulance diversion by 5% over previous month, the corrective action plan requirement and adverse action process is stayed.
    c. The EMS Agency shall take into consideration external factors that affect the entire San Francisco healthcare system in corrective action plan requirements over a monthly period such as a pandemic surge or increased levels of EMS patients.
    d. Upon completion of the listed implementation period, the above section VIII is removed from EMSA policy.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5020
Effective Date: July 11, 2022
Supersedes: January 3, 2022

DIVERSION POLICY

I. PURPOSE

To establish procedures for hospitals to divert 911 ambulance patients.

II. HOSPITAL STATUS DEFINTIONS

Open: A hospital is able to receive patients transported via 911 ambulances.

Ambulance Diversion: A hospital is temporarily closed to select patients transported via 911 ambulances due to an overload of patients in the Emergency Department.

Internal Disaster: A hospital is completely closed to ALL patients transported via 911 ambulances due to a compromised specialty center function or when an internal disaster status with the Hospital Incident Command System (HICS) is activated.

Diversion Suspension: A temporary halt to the use of ambulance diversion.

III. POLICY

A. *ReddiNet* is an internet-based communications system that is used to communicate a hospital's diversion status to the EMS System (911 Dispatch [Division of Emergency Communications (DEC)], hospitals and ambulances). Each EMS organization shall have personnel trained to operate ReddiNet on-duty 24 hours a day, seven days a week.

B. EMS personnel shall utilize *EMS Agency Policy #5000 Ambulance Destination* to determine a hospital destination for ambulance transported patients. The Base Hospital Physician is the final authority in determining a destination for a patient during an ambulance transport.

C. **Ambulance Divert / Diversion** may only be declared by a hospital when its Emergency Department has an overload of patients and it cannot safely provide care to any additional 911 ambulance patients. A hospital may NOT declare Diversion due to the lack of staff or in-patient medical/surgical or critical care beds.

D. Ambulance Diversion **ONLY** applies to general medical patients. Diversion does **NOT** apply to:
   1. Critical airway patients
   2. Adult critical medical patients,
   3. Patients meeting the following Specialty Care triage criteria (listed below **except** in the instance of APOT or diversion mitigation measures are in effect):

a) Pediatric Medical
b) Pediatrics Critical Medical
c) STAR (STEMI and/or Post Arrest with ROSC)
d) Reimplantation (Microvascular Surgery)
e) Burns
f) Obstetrics
g) Stroke
h) Trauma
i) LVAD
j) Post-Sexual Assault

4. Patients originating from a hospital-based clinic. Such patients shall be considered to have arrived on hospital property and must be transported to that hospital's Emergency Department.
5. Patients who are incarcerated or in police custody that are taken to Zuckerberg San Francisco General Hospital.

E. **Internal Disaster** is the declaration of a complete closure of the Emergency Department to ALL 911 ambulance traffic due to a compromised specialty center function (e.g. cardiac catheterization lab is down and not available for a 911 ambulance patient) OR when an internal disaster status with the Hospital Incident Command System (HICS) is activated.
1. A hospital may not declare an internal disaster due to the lack of staff or in-patient medical/surgical or critical care beds or Emergency Department beds.
2. The following physical plant issues must exist during a declared internal disaster status:
a) Compromised power supply,
b) Fire,
c) Flooding,
d) Hazmat (contamination of patient care areas), or
e) Safety and security compromised (e.g. imminent threat of violence or active violent incident), **and**
f) Hospital Incident Command System (HICS) is activated.
3. A hospital declaring Internal Disaster is REQUIRED to notify the Department of Emergency Management (DEM) Duty Officer. The DEM Duty Officer must be contacted through the 911 Dispatch [DEC].

IV. DIVERSON SUSPENSION

A. Diversion Suspension is a temporary halt in the use of ambulance diversion. Diversion suspension requires Receiving Hospitals to accept all 911 ambulance transported patients. The intent of Diversion Suspension is to "open up" hospitals that are on diversion to allow for the safe and efficient function of the EMS system.

B. Diversion suspension is initiated by automatically via ReddiNet when **four (4)** or more of the following full Receiving Hospitals***** are on Diversion:
    1. San Francisco General Hospital
    2. CPMC-St Lukes
    3. UCSF – Parnassus
    4. St Mary's Medical Center
    5. Kaiser San Francisco
    6. CPMC – Van Ness
    7. CMPC – Davies Campus
    8. St Francis Memorial Hospital
    9. Chinese Hospital

    "Full Receiving Hospitals" receive both critical (Code 3 lights and sirens) and non-urgent (Code 2 non-lights and sirens) 911 ambulance traffic.*

C. When diversion suspension is initiated, it shall remain in effect for a **four-hour** time period.

D. If four (4) or more full Receiving Hospitals are on Ambulance Diversion at the end of the four-hour diversion suspension, will continue the diversion suspension for another **four-hour** time period.

E. Diversion suspension does **NOT** apply to:
    1. The pediatric Emergency Departments at UCSF Mission Bay, or CPMC – Van Ness .
    2. Hospitals located in other counties (Seton Medical Center and Kaiser South San Francisco in San Mateo County).
    3. When a hospital is on "INTERNAL DISASTER the hospital remains completely closed to all 911 ambulance traffic even during a diversion suspension.

V. ZUCKERBERG TRAUMA OVERRIDE

A. ZSFG is the only Trauma Center for San Francisco. During Diversion Suspension, ZSFG may elect to invoke "Trauma Override" which continues the diversion of medical (non-trauma) patients away from ZSFG. The intent of Trauma Override is to preserve the ZSFG Emergency Department capacity for trauma patients.

B. Trauma Override does **NOT** apply to:
    1. Critical airway patients,
    2. Adult critical medical patients,
    3. Patients meeting Specialty Care criteria listed in III.D.
    4. Patients originating from a hospital-based clinic. Such patients shall be considered to have arrived on hospital property and shall be transported to the ZSFG Emergency Department.
    6. Patients who are incarcerated or in police custody.

7. ZSFG will follow *Policy 5021 Trauma Bypass* for any internal disaster situation that closes it to trauma patients.

VI. HOSPITAL PROCEDURES

A. A hospital is considered OPEN for receiving 911 ambulance patients if the diversion status is not displayed on the ReddiNet status screen.

B. A hospital is on AMBULANCE DIVERT when the ReddiNet status page displays a red "ED" next to the facility name.

C. **ZSFG is on TRAUMA OVERRIDE when "Trauma Override" appears in red next to facility name on the the ReddiN**et status page

D. A specialty center designated receiving hospital or receiving hospital is on INTERNAL DISASTER when a red "IN" appears next to the facility name on the ReddiNet status page.

E. Hospitals shall change their diversion status to OPEN on the ReddiNet screen immediately upon relieving the situation that necessitated the use of any divert status. **Diversion status updates on ReddiNet should be made even during periods of diversion suspension.**

VII. AMBULANCE PROCEDURES

A. When hospital is on "AMBULANCE DIVERT," no general medical patients may be transported to that hospital. Ambulance Diversion does **NOT** apply to:
   1. Critical airway patients
   2. Critical medical adult patients, or
   3. Patients meeting Specialty Care triage criteria.
   4. Patients originating from a hospital-based clinic.

B. When a hospital is on "INTERNAL DISASTER," NO patient will be transported via 911 ambulance to that hospital. The hospital is completely closed to ALL 911 ambulance traffic even during a diversion suspension.

C. Zuckerberg San Francisco General Hospital is always open to incarcerated or in-custody patients except when an "INTERNAL DISASTER and TRAUMA BYPASS" are declared.

D. Ambulances that are en route to any hospital or have arrived on hospital property must complete the patient transport to that facility when its Emergency Department goes on Diversion except when a "INTERNAL DISASTER is declared.

E. Ambulances may go to a hospital during a declared INTERNAL DISASTER if they are needed for the evacuation of patients in that facility.

VIII. BACK UP TELEPHONE COMMUNICATIONS IF REDDINET FAILS

A. Hospitals must notify DEC via telephone of any diversion status changes.

B. DEC may enter the hospital status into the ReddiNet if the hospital is unable to access the web site.

C. All ReddiNet users (hospitals/911 dispatch) must contact their IT staff and / or the ReddiNet Technical Support line for assistance in getting the website back up.

IX. QUALITY ASSURANCE

A. The EMS Agency shall report monthly diversion activity for all San Francisco Receiving Hospitals (referred to as “Hospital Report”).

B. Problems related to the implementation of this policy shall be reported to the EMS Agency through the Exception and Sentinel Events Report System.

C. Based on the Hospital Report, the EMS Agency may take action on a Receiving Facility, as detailed in Policy 5010, who have a:
    a. Monthly diversion percentage less than 30%, but greater than 20%, the EMS Agency will continue to monitor via quality improvement in subsequent months
    b. Monthly diversion percentage greater than 30% for two (2) consecutive months
        i. The EMS Agency shall refer to corrective action plan process as detailed in Policy 5010

X. AUTHORITY

California Health and Safety Code, Section 1798

Appendix F

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4020
Effective Date: October 1, 2022
Supersedes: February 1, 2015

EMERGENCY MEDICAL SERVICES (EMS) AIRCRAFT UTILIZATION
EMSAC June 2022

I. PURPOSE

A. To minimize morbidity and mortality, by ensuring the timely availability of air medical resources for the City and County of San Francisco.

B. To define the scope and manner with which the EMS System will use EMS aircraft for emergency transport of critically ill and injured patients.

C. To provide for coordinated air medical operations with ground responders and hospital resources.

II. AUTHORITY

A. California Public Utilities Code, Sections 21662.1 – 21662.5,
B. California Code of Regulations, Title 21, Division 2.5, Sections 3527 and 3533
C. California Code of Regulations, Title 22, Division 9, Chapter 8, Sections 100276 – 100306
D. California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100144

III. POLICY

A. Availability of Air Medical Services

1. Primary response of EMS aircraft shall be made available to sick and injured persons in the City and County of San Francisco whenever it is safe, appropriate, and necessary to optimize the care of the patient.

2. The pilot in command of the EMS aircraft shall have the full authority to abort or decline response to any request for service when mechanical, geographic, or flight conditions might endanger the crew or others.

3. For incident scene operations where air response is requested, the closest available, and most appropriate air ambulances shall be considered to be the air response asset of choice. Rescue aircraft may be used to supplant or extend the availability of air medical transportation.

B. Authorization of EMS Aircraft Service Providers

1. All EMS aircraft operators routinely offering services to or from hospitals located in the City and County of San Francisco shall have a written agreement with the EMS Agency and be authorized to operate by the EMS Agency within the aircraft operator's jurisdiction of origin.

2. A request from a designated dispatch center shall be deemed as authorization of aircraft operated by the California Highway Patrol, Department of Forestry, National Guard, or the Federal Government.

3. All EMS aircraft authorized to operate within the City and County of San Francisco shall be classified. Verification by the San Francisco EMS Agency of classification of an EMS aircraft within the aircraft's jurisdiction of origin shall constitute classification of the EMS aircraft within the City and County of San Francisco. EMS aircraft classification shall be limited to the following categories:
    a) Air Ambulance
    b) ALS Rescue Aircraft
    c) BLS Rescue Aircraft
    d) Auxiliary Rescue Aircraft

4. The San Francisco EMS Agency retains the right to inspect EMS Aircraft Providers, including EMS aircraft, and training, quality improvement, and operations policies, procedures, and records, to assure compliance with State law and local policies and procedures.

5. The San Francisco EMS Agency shall maintain an inventory of the number and type of authorized EMS aircraft, the jurisdiction of origin of authorized EMS aircraft, the patient capacity of authorized EMS aircraft, and the level of patient care provided by EMS aircraft personnel, and Receiving Hospitals with landing sites approved by the State Department of Transportation, Aeronautics Division.

6. Authorized EMS aircraft operators and service providers will comply with all EMS Agency Policies, Procedures, and Protocols.

C. Medical Flight Crew Requirements

1. All members of the medical flight crew of an EMS aircraft shall be trained in aeromedical transportation as specified in California Code of Regulations (CCR), Title 22, Division 9, Chapter 8, Section 100302.

2. Flight Paramedics shall complete a training program as listed in 22 CCR 100155(c), hold a current certification as a flight paramedic by the International

Board of Specialty Certification (IBSC), licensed in California, and accredited in San Francisco if the aircraft is based within the City and County of San Francisco.

4. All medical flight crew members shall participate in such continuing education requirements as required by their licensure or certification.

D. Ground Crew Requirements

1. All providers operating in the vicinity of helicopters must be regularly trained in standard helicopter safety operations.

2. The EMS Agency must review and approve helicopter safety training standards used by field providers in San Francisco. See Policy 8000, Air Ambulance Coordinator.

3. EMS personnel shall follow all flight crew instructions such as securing patient for loading and approaching/departing the aircraft.

E. Patient Management

1. Medical control for flight crew members shall be supplied by the air ambulance operator's Medical Director.

2. EMS aircraft staffed by registered nurses will utilize the standardized procedures of the Air Ambulance service provider. If the air ambulance service provider is based in San Francisco, these standardized procedures will be submitted for review by the San Francisco EMS Agency Medical Director.

3. In situations where the medical flight crew is less medically qualified than the ground personnel from whom they receive patients, the medical flight crew may assume patient care responsibility only as directed by the Base Hospital Physician.

4. EMS aircraft that do not have a medical flight crew shall not transport patients except under direction of the Base Hospital Physician. Rescues involving short haul, long-line, and/or hoist operations may be completed without a medical crew for momentary movement of a patient.

5. Upon request, prehospital care records will be submitted to the San Francisco EMS Agency by the EMS Aircraft provider within 2 working days of each operation.

F. EMS Aircraft Space and Equipment

1. All EMS aircraft shall be configured according to specifications in California Code of Regulations, Title 22, Division 9, Chapter 8, Section 100306 (a-c).

G. Representation of Provision of Air Ambulance Services

1. No person or organization shall provide or hold themselves out as providing prehospital Air Ambulance services unless that person or organization has aircraft which have been classified by the local EMS agency within the jurisdiction of origin, with the exception of State or Federal aircraft.

H. Authorized Landing Sites

1. EMS Aircraft shall only land at landing sites meeting 1 of the following criteria:
   a. Heliports permitted by the California Department of Transportation (Caltrans).

   b. Pre-designated EMS landing sites. The Department of Emergency Management shall maintain a list of pre-designated city-wide landing sites under the Aviation Support Plan with specifications of latitude and longitude (see Appendix B).

   c. Emergency helispots at or near the scene of a Multi-Casualty Incident (MCI), disaster, or other critical incident. The Incident Commander (IC) shall designate appropriate helispots at emergency scenes.

I. Communication Policy

1. EMS aircraft operators shall adhere to EMS Agency Policy #3010, *EMS System Communications Standards*.

2. EMS Aircraft shall maintain the capacity to communicate with the San Francisco Department of Emergency Management: Division of Emergency Communications (DEC), Landing Zone Operations, and the Base and Receiving Hospitals.

3. The EMS Agency retains the right to inspect EMS aircraft communications equipment of any Air Ambulance provider based in San Francisco to ensure compliance with standards set forth in this policy.

IV. Procedure

A. Patient Clinical Conditions Warranting Air Medical Transport

EMS aircraft may be used in the following clinical situations:

1. The patient's condition warrants rapid transport, and transport by land would be hazardous or delayed because of road or traffic conditions (> 20 minutes);

2. The patient meets trauma center destination criteria, but Zuckerberg San Francisco General Hospital (ZSFG) is unavailable and there is an extended (> 20 minutes) ground transport time interval to a regional designated trauma center;

3. Air transport is recommended for patients who meet trauma center destination criteria if the time from the initial incident to the patient's expected arrival at the trauma center via ground ambulance will exceed 30 minutes, **AND** the length of ground transport would pose additional risk to morbidity or mortality;

4. Critical trauma patient interfacility transfers from ZSFG to another Level I Adult (Stanford Medical Center) or Pediatric Trauma Center (such as UCSF Benioff Children's Hospital – Oakland or Stanford Medical Center);

6. Other conditions, such as prolonged extrication, as deemed warranted by the IC and Medical Group Supervisor (MGS or IC designee). For questions regarding applicability of other conditions, MGS may contact the Base Hospital Physician.

B. Field Situations Warranting Air Medical Transport

The following field situations warrant the use of air medical transport:

1. MCIs and/or incidents involving trauma when ZSFG trauma center capacity is saturated, on Internal Disaster, and/or Trauma Center Bypass is activated;

2. Inaccessibility to the scene by ground personnel or equipment;

3. Air ambulance service may be initiated for MCIs involving one or more of the following:

   a. Five or more patients meeting trauma center physiologic and/or anatomic triage criteria (reference EMS Agency Policy #8000, *EMS MCI Policy*);
   b. Five or more patients with partial thickness burns greater than 10% total body surface area or third-degree burns;

   c. A large number of casualties such that Receiving Hospitals in San Francisco will be saturated and Mutual Aid from other Bay Area counties will be requested by the IC

C. Initiating EMS Aircraft Response

1. Field Emergency Response

a. For field emergency responses, the decision to request an EMS aircraft is based on the medical and scene management considerations in Section IV.A and IV.B.

b. During an MCI, the IC oversees all emergency operations on scene.

c. The decision to request an EMS aircraft for a field emergency response shall be made by the IC or his/her designee, upon:

1) the advice of on-scene medical personnel such as the Medical Group Supervisor or lead Paramedic; and/or,

2) the suitability of the scene for helicopter operations; and/or

3) IC and Medical Group Supervisor consultation with the Base Hospital Physician/designee.

d. All requests for an EMS aircraft field response shall be made through San Francisco DEC's Fire (SFFD) Dispatch (phone: 415-558-3291 or 415-558-3268). The following information must be provided to DEC by the IC or his/her designee:
1) Number of patients;
2) Type and extent of injuries;
3) Location of nearest landing site (use Appendix B, if possible);
4) Nearest landmarks (e.g., highways, railroad tracks, water towers);
5) Weather conditions as reported from the landing site (especially high winds, fog or visibility problems);
6) Radio frequency and call sign of the requesting agency/provider.

e. The IC will determine the EMS landing site from the list of pre-designated sites (see Appendix B) or an ad-hoc site based on scene management considerations.

2. Out-of-County Field Emergency Response

a. For transfer of critical patients from scene calls originating outside of San Francisco to a San Francisco Receiving Hospital:

1) The EMS aircraft will contact DEC Fire Dispatch (415-558-3291 or

415-558-3268) and identify the EMS landing site to be used.

2) Personnel may use the UCSF Benioff Mission Bay (UCB) helipad following established agreements and procedures by the Regents of the University of California.

3. **Interfacility Transfers**

a. Interfacility transfers to and from UCB may utilize the UCB helipad following established agreements and procedures by the Regents of the University of California.

b. For all other interfacility transfers of critical patients from San Francisco to an out-of-county Receiving Hospital, the transferring facility will contact DEC Fire Dispatch (415-558-3291 or 415-558-3268) and identify the EMS landing site to be used for patient pickup in San Francisco. Critical pediatric trauma patient transfers from ZSFG Trauma Center to a regional Pediatric Trauma Center may require use of Rolph Field EMS Landing site if ground transport is extremely delayed. EMS landing sites are reserved as "backup" for ground transport in rare circumstances when ground transport is extremely delayed. Without a ZSFG hospital helipad, secondary ground transport time intervals to and from an EMS landing site make interfacility air transport a remote fall-back option, if delayed ground transport or non-transfer clearly present a threat to the life of the patient.

c. Interfacility transfers from out-of-county to San Francisco (excluding UCB) will use the San Francisco International Airport (SFO) or other out-of-county heliports. EMS landing sites are reserved for emergency landings only.

d. Transferring/receiving air ambulance companies or hospitals with incoming patients will arrange for interfacility ground transfers prior to departure from point of origin. San Francisco 911 ambulance service is not available for interfacility transports from SFO or out-of-county heliports.

D. Notification

1. DEC Fire Dispatch will notify all responding agencies when an EMS aircraft has been requested for response to an EMS landing site/helispot (SFFD, San Francisco Police Department [SFPD], or other first responder agency).

2. Cancellations shall only be made through the IC or designee.

E. Activation

1. DEC Fire Dispatch will contact the closest, most appropriate air ambulance company as noted in ReddiNet. These numbers are also listed in Appendix A of this policy.

F. Mobilization

1. The closest, most appropriate EMS aircraft (on the primary provider list approved by the EMS Agency) will respond within a 15-minute call to arrival time interval. If the 15-minute ETA is not possible for the initial air ambulance company, the company will notify DEC Fire Dispatch (415-558-3291 or 415-558-3268) or transferring facility, and another air ambulance company listed in ReddiNet will be called. (These contact numbers are also listed in Appendix A of this policy.)

G. Deployment of Ground Crews

1. A Battalion Chief and engine company of the SFFD will respond to the designated EMS landing site/helispot for fire suppression support, and to clear the area of people, animals, and any temporary obstructions.

2. A SFFD Rescue Captain (RC) will respond as Landing Site Manager under direction of the Battalion Chief. The RC - Landing Site Manager is responsible for aircraft communications and oversight of ground to air patient transfer.

3. Law enforcement should send officers to the designated EMS landing site/helispot to secure the landing site perimeter for safety considerations.

4. Transferring/receiving air ambulance companies or hospitals with incoming patients will arrange interfacility ground transfers from SFO or an out-of-county heliport.

H. Destination

1. During an MCI or disaster, the EMS aircraft crew will determine the destination for patients requiring air medical evacuation. The EMS aircraft and/or its dispatch center will contact DEC Fire Dispatch with the Receiving Hospital information. Enroute the EMS aircraft will relay pertinent patient information to the Receiving Hospital.

2. Determination for destination will be based on the shortest ETA to a facility best suited for definitive care of the patient.

3. The EMS aircraft pilot will have the final decision as to destination based on weather and flight safety considerations.

I. Communication Procedure

1. General
   a. For field emergency air response, DEC Fire Dispatch will contact the closest, most appropriate air ambulance company dispatch listed in ReddiNet . These contact numbers are also listed in Appendix A of this policy.

2. Frequency Assignments
   a. DEC to/from EMS Aircraft

      1) The EMS aircraft responding to field emergencies will contact DEC Fire Dispatch on landline (415-558-3291 or 415-558-3268) while enroute to the scene to confirm radio frequency and ground contact/incident identifier.

      2) Once confirmed, EMS Aircraft with access to San Francisco's public safety talk groups may communicate directly with Incident Command over those talk groups.

      3) Backup frequency on the 800 MHz system is CAFIRE2 (806.91250 Transmit CTCSS 156.7 and 851.9125 Receive CTCSS 156.7)

      4) An additional backup channel for initial contact is VFIRE21 (154.2800 CTCSS 156.7 Transmit AND 154.2800 CTCSS 156.7 Receive)

   b. Landing Zone Operations to/from EMS Aircraft

      1) EMS Aircraft with access to San Francisco's public safety talk groups may communicate directly with Incident Command over those talk groups.

      2) EMS Aircraft with no access to San Francisco talk groups shall utilize CALCORD (156.075 transmit; 156.075 receive (TX/RX TONE 6 [156.7]) for non-repeated air to ground communication.

      3) Backup frequency on the 800 MHz system is CAFIRE2 (806.91250 Transmit CTCSS 156.7 and 851.9125 Receive CTCSS 156.7)

4) An additional backup channel for initial contact is VFIRE21 (154.2800 CTCSS 156.7 Transmit AND 154.2800 CTCSS 156.7 Receive)

5) The ground crew will be referred to as _____LZ (call name determined by specific location of landing site).

c. Base Hospital and Receiving Hospitals to/from EMS Aircraft

1) EMS Aircraft with access to San Francisco Hospital talk groups may utilize them to "ring down" the receiving facility

2) The dispatch center for the EMS Aircraft may also relay ringdown reports on the crew's behalf

3) VMED28 (formerly known as HEARNet, 155.34 [PL-156.7]) may also be utilized for limited communications between hospitals and air ambulances

4) If other channels are unsuccessful, a backup channel for EMS Aircraft to Base Hospital is UHF Med-9, 462.95 (PL-167.9) 467.9500 transmit / 467.9500 receive (CTCSS – 167.9).

d. Air to Air

1) The air-to-air communications should be coordinated on the designated air traffic control (ATC) channel assigned by ATC at SFO.

J. Quality Assurance

1. Activation of this policy requires an Exception Report and will be reviewed by the EMS Agency's QI Committee.

Appendix A: AIR AMBULANCE PROVIDERS CONTACT INFORMATION

Air Ambulance Dispatch phone numbers are listed below and in ReddiNet.

AIR AMBULANCE PROVIDERS:

REACH

1. Concord (REACH 32 & REACH 100)
2. Napa (REACH 3)
3. Santa Rosa (REACH 1)
4. Gilroy (REACH 33/CALSTAR 2)
5. Salinas (REACH 36/CALSTAR 5)
6. Modesto (REACH 41/CALSTAR 12)
7. Merced (REACH 42/CALSTAR 13)

Dispatch number: 800-338-4045

LIFE FLIGHT OF STANFORD HEALTHCARE

Stanford Health Care, Palo Alto
Dispatch number: 800-321-7828

BAY AREA AIR AMBULANCE and AIR RESCUE PROVIDERS

Air Ambulances

COMPANY	DISPATCH PHONE	CLASS	STAFF	RESCUE CAPABILITIES	HOURS OF OPERATION
REACH (based in Concord, Santa Rosa, Napa)	1-800-338-4045	Air Ambulance	Flight Nurse (CFRN) Flight Paramedic (FP-C)	None	24/7
Stanford Lifeflight (based at Stanford Hospital)	1-800-321-7828	Air Ambulance	2 Flight Nurses (CFRN)	None	24/7

Air Rescue Units

COMPANY	DISPATCH PHONE	CLASS	STAFF	RESCUE CAPABILITIES	HOURS OF OPERATION
CHP (ALS and BLS units based in Napa.	(Confidential allied agency line published at dispatch)	ALS Rescue (Napa); BLS Rescue (Napa)	EMT-P (ALS) EMT (BLS)	Hoists baskets, people—cable that runs down and back up to helicopter, vertical line up to 150 ft.; can carry 1 patient only; can do cliff/boat/water rescue (have to pick up a rescue swimmer in San Francisco to do water rescue) Hover and 1-skid operations	Medical missions: 10am – 4am, 7 days per week. Non-medical missions: 24/7

Air Rescue Units (cont'd.)

COMPANY	DISPATCH PHONE	CLASS	STAFF	RESCUE CAPABILITIES	HOURS OF OPERATION
Coast Guard Air Station (based at SFO)	(published at Dispatch) Water rescue missions OK to request directly; All other requests must have a mission number issued by State OES through SF OES and Homeland Security.	Rescue (mission specific; can get EMT rescue swimmer, otherwise crew is not medical capable)	EMT rescue swimmer (must be requested at time of dispatch—mission specific)	Hoist baskets, people; designed to pull people off water or off boats; HH-65 Dolphin aircraft	24/7
EAST BAY REGIONAL PARK FIRE	510-881-1833	ALS/BLS Rescue (Do not always have a paramedic—volunteer flight paramedic program; can take ground paramedic from scene)	EMT-1 or EMT-P	Do search; do not do short haul (with a line attached to the helicopter); no hoist; can land, get out and try to help. Can transport 1 patient at a time.	Day only; on-call at night but need some ambient light for operations
SONOMA COUNTY SHERIFF'S DEPT	707-565-2121	ALS Rescue	EMT and Paramedic (ALS)	Vertical long-line—up to 200 ft.	10 hours per day; nocs on-call
California AIR NATIONAL GUARD (stationed at Moffett Field)	(published at Dispatch) Request must have a mission number issued by State OES through SF OES& Homeland Security.	Auxiliary Rescue	No medical staff	Do not search, but will rescue; can transport rescue teams on Hueys, Blackhawk, Pavehawk (goes 1000 miles; carries more than 20,000 lbs.)	24/7

Appendix B: EMS LANDING SITES

THIS SECTION IS RESERVED FOR THE UPDATED EMS LANDING SITE LISTING FROM THE DEM AVIATION SUPPORT PLAN

Appendix C: REGIONAL TRAUMA CENTERS
Contact Information and Flight Time Intervals

TRAUMA CENTER	PHONE CONTACT	FLIGHT TIME INTERVAL from central San Francisco
Zuckerberg San Francisco General (air transport to/from Rolph Field EMS Landing site)	ED CHARGE NURSE: 628-206-8111	3 minute air time (to Rolph Field @ C Chavez and Potrero [addt'l 3 minute ground transport interval]
UCSF Benioff Children's Hospital Oakland (Level II pediatric)	ED: 510-428-3240	5 min.
Eden Hospital (Level II) (Castro Valley)	ED: 510-889-5015	10 min.
John Muir Hospital (Level II) (Walnut Creek)	ED: 925-939-5800	10 min.
Stanford Medical Center (Level I adult & Level I pediatric)	ED: 650-723-7337	12 min.
Regional Medical Center (Level II adult)	ED: 408-729-2841	20 min.
Santa Clara Valley Medical Center (San Jose) (Level I)	ED: 408-885-6912	20 min.
Providence Santa Rosa Memorial (Level II)	ED: 707-525-5207	25 min.
UC Davis (Level I adult & pediatric)	ED: 916-734-3790	35 min.

Appendix G

EMSA Website

In the summer of 2021, we began the process of converting our website to an improved, user-centered resource on sf.gov, the site that houses web content for many departments and programs that are run by the City and County of San Francisco. We chose to do this for several reasons:

1. To improve accessibility for all San Franciscans looking to find information online about the SF EMS Agency. This includes:
    a. EMT certification and Paramedic accreditation
    b. Creating event medical plans
    c. Reporting incidents involving prehospital care
    d. CPR training and AED access
    e. Policies and protocols for EMS
    f. Meeting details for EMS committees, including the Emergency Medical Services Advisory Committee (EMSAC)
    g. Emergency Medical Response Data Dashboards
    h. And much more!

2. SF.gov's design allows access to users of assistive technologies, non-English speakers, and the broader public.
3. Improved functionality allows EMSA to better highlight the work being done by our committees and subcommittee to improve EMS care in San Francisco.
4. We now can more easily showcase life-saving campaigns, such as the Community CPR Initiative (https://sf.gov/community-cpr-initiative).

Please visit our new website to learn more https://sf.gov/emsa . Included in this plan are screenshots of the new EMSA homepage.

https://sf.gov/emsa

English Español 中文 Filipino

SF.GOV

Services Departments Search

Emergency Medical Services Agency

The Emergency Medical Services Agency (EMSA) provides oversight for the Emergency Medical Services System in San Francisco. We direct, plan, monitor, and evaluate the San Francisco EMS System in collaboration with system and community providers.

In this page: Services Resources Contact

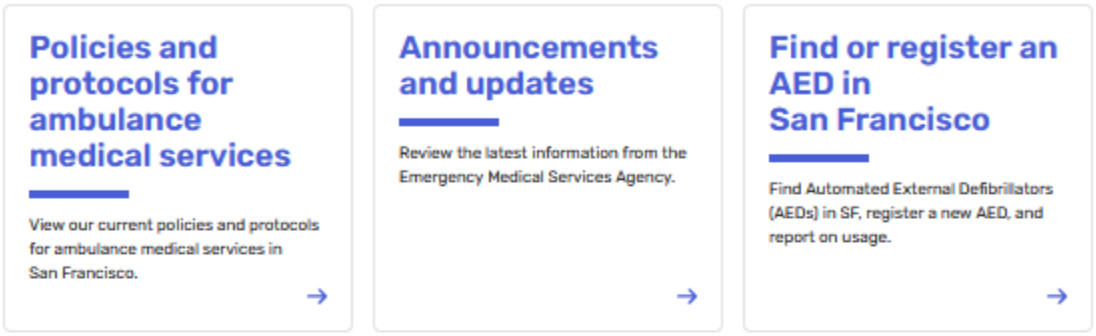


Community CPR initiative

Save lives through CPR and proper use of Automated External Defibrillators (AEDs).

Learn more

https://sf.gov/emsa



Services

Get certified as an EMT: Start here

Get certified as a new EMT in San Francisco

Get your initial certification to work as an Emergency Medical Technician.

Renew your certification as an EMT in San Francisco

Get your certification as an Emergency Medical Technician renewed.

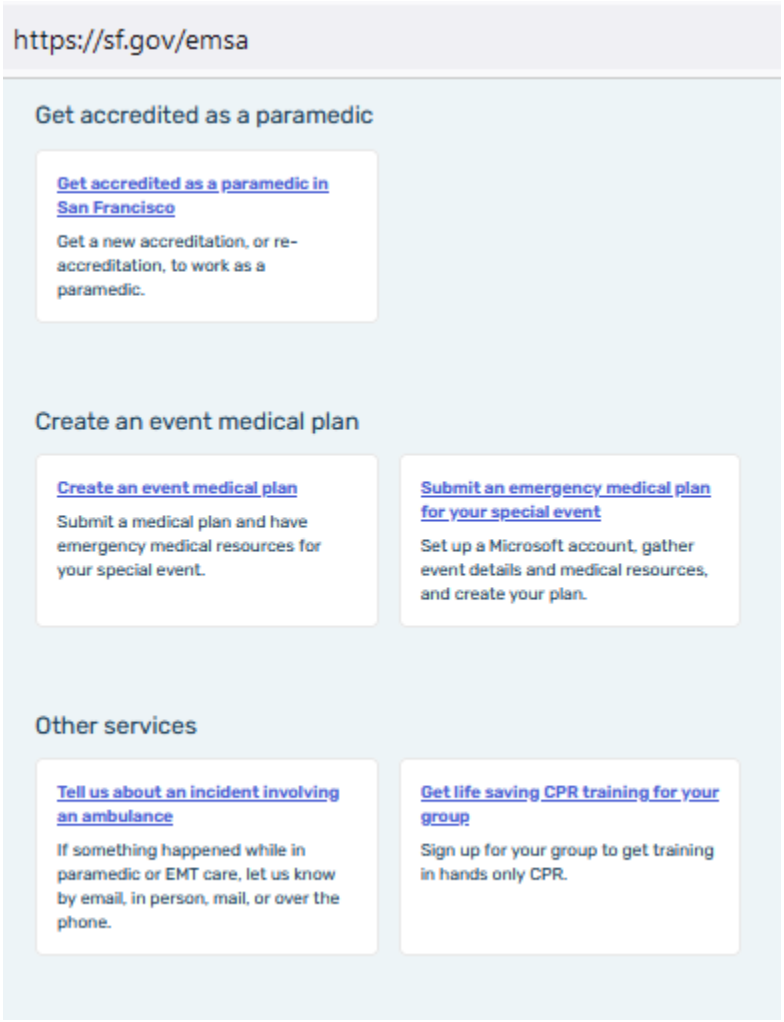
Review additional information for EMT certification

Complete a background check for EMT certification

To get certified as an EMT in San Francisco, get fingerprinted for a background check.

Submit your application for an EMT license or renewal

Fill out and send in your application for EMT certification in San Francisco.


https://sf.gov/emsa
Get accredited as a paramedic
Get accredited as a paramedic in San Francisco
Get a new accreditation, or re-accreditation, to work as a paramedic.
Create an event medical plan
Create an event medical plan
Submit a medical plan and have emergency medical resources for your special event.
Submit an emergency medical plan for your special event
Set up a Microsoft account, gather event details and medical resources, and create your plan.
Other services
Tell us about an incident involving an ambulance
If something happened while in paramedic or EMT care, let us know by email, in person, mail, or over the phone.
Get life saving CPR training for your group
Sign up for your group to get training in hands only CPR.

https://sf.gov/emsa

Get life saving CPR training for your group

Sign up for your group to get training in hands only CPR.

Get started



Resources

Resources from EMSA

Permitted ambulance providers

See the only ambulance providers approved in San Francisco and each of their capabilities.

Where to get training as an EMT or paramedic in San Francisco

Find out where to get training for your initial or renewal certification or accreditation, or to further your knowledge within EMS.

Get answers about EMS care from a specialty advisor

EMSA Announcements and Updates

Review the latest information from the Emergency Medical Services Agency.

Protocols and policies for emergency medical services

See all policy documents for emergency medical services in San Francisco.

Find or register an AED in San Francisco

Register your new Automated External Defibrillator or find existing ones.

https://sf.gov/emsa

2016 Trauma Retriage Guideline

2016 Trauma Retriage Guideline from EMSA

LVO Stroke Retriage Guideline April 2022

Guideline for Large Vessel Occlusion (LVO) Retriage from EMSA.

Emergency Medical Response Data Dashboards

This website shows all the public facing data available regarding Emergency Medical Services in San Francisco.

Resources from external sources

Health Alerts for health care providers from the San Francisco Department of Public Health

SF Department of Public Health sends out health alerts regarding communicable disease prevention and control

Emergency Preparedness from SF72

SF72.org City Now provides real time information during a special event or emergency.

Neighborhood Emergency Response Team (NERT)

NERT is a free training program for individuals, neighborhood groups and community-based organizations in SF.

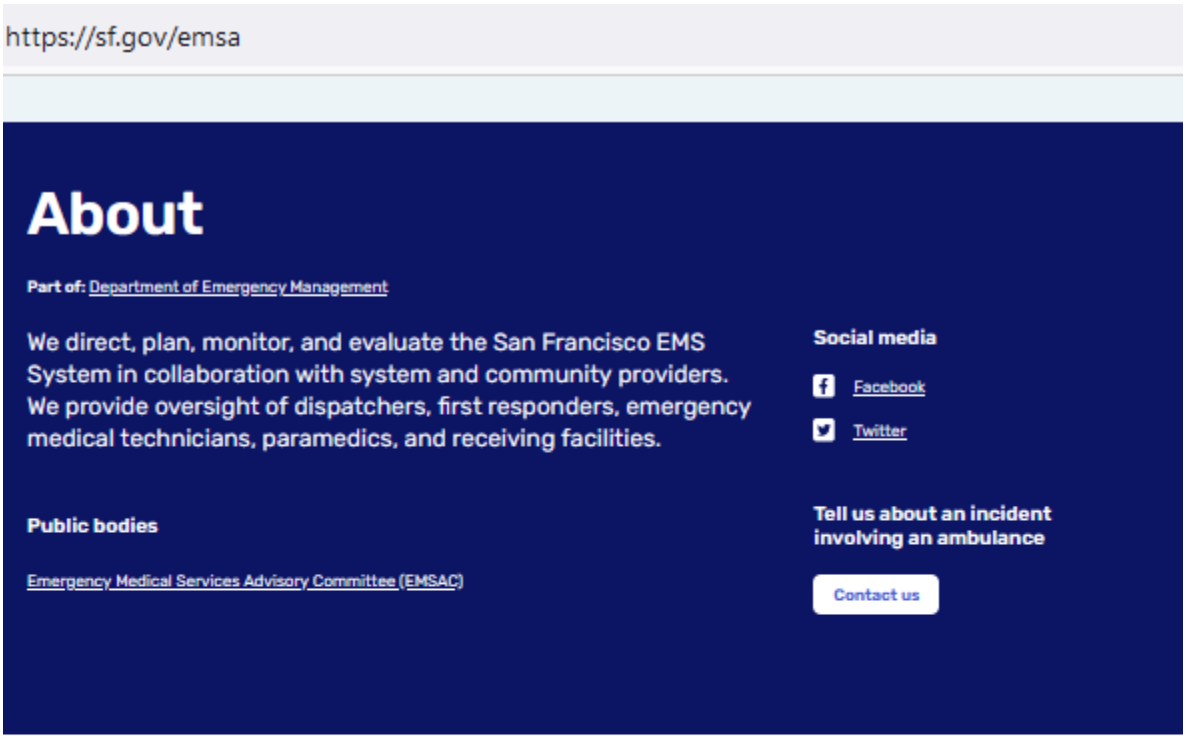
Cal OES California Governor's Office of Emergency Services

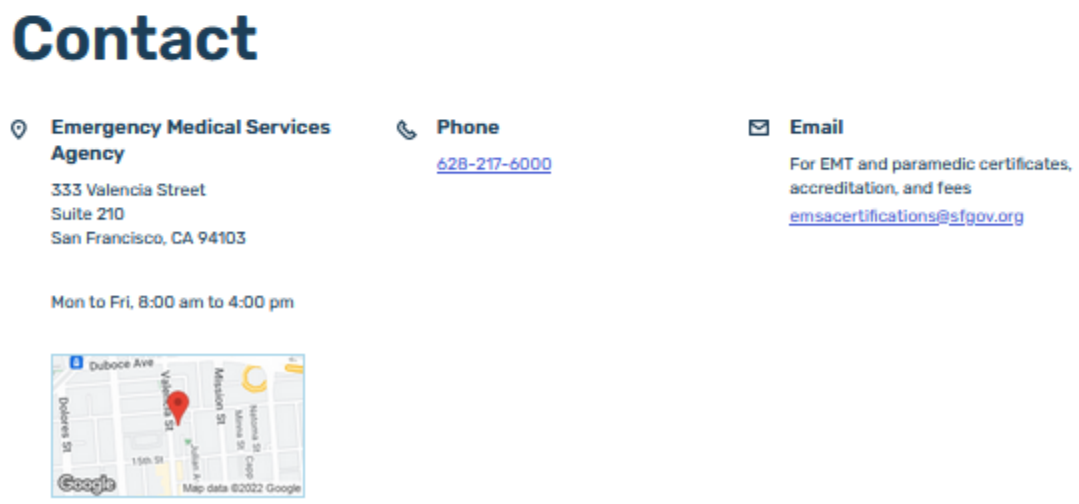
Cal OES California Governor's Office of Emergency Services

Department history

Archived EMSA website

Visit the archived Emergency Medical Services Agency website, pre-June 2022.



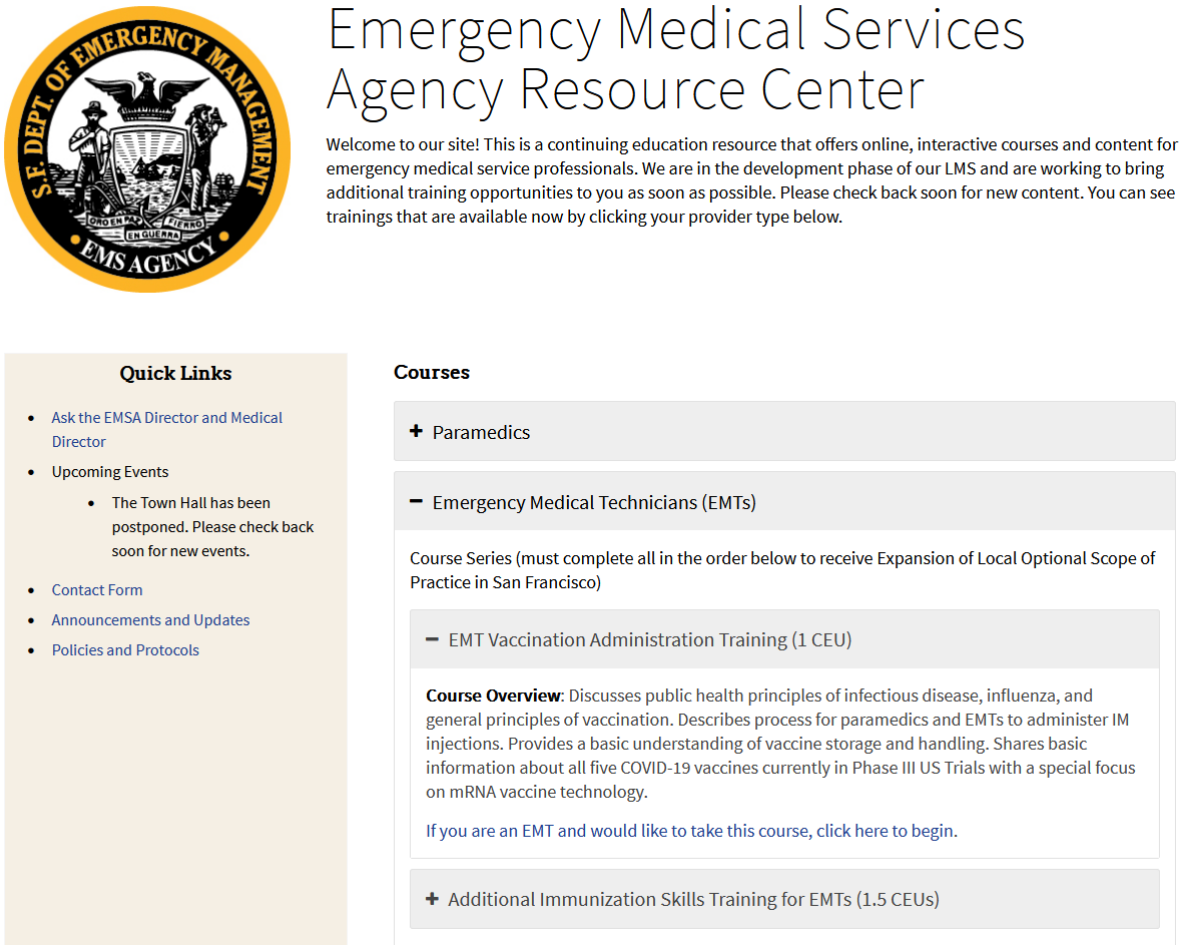


LMS Augmentations

After launching our online learning management system (LMS) (http://emsonlinesf.com/) in December of 2020, we wanted to utilize FY 2021 – 2022 to design and implement some additional augmentations that improve access and functionality for all learners. The following sections of our LMS are ready to launch:

- Video library: allows users to have quick skills refreshers or intros to new topics via short, 3 – 5 minute videos
- Improved reports for the back end of the site: allows trainers and course developers to have easy access to course completion data, quiz results, and more
- Certificates for in-person courses: allows the EMS Agency to create electronic certificates for in-person courses and allows learners to have the courses linked to their LMS profile to better track their CEUs earned in a central location
- New page for EMS learners: keeps all course history in one central location for each learner
- New page for password reset for EMS users
- Course Completion Certificate emails to EMSA: automatically sent to designated EMSA email address each time a learner successfully completes a course
- Contact Us page for EMS Users
- Below are a few screenshots from our LMS:

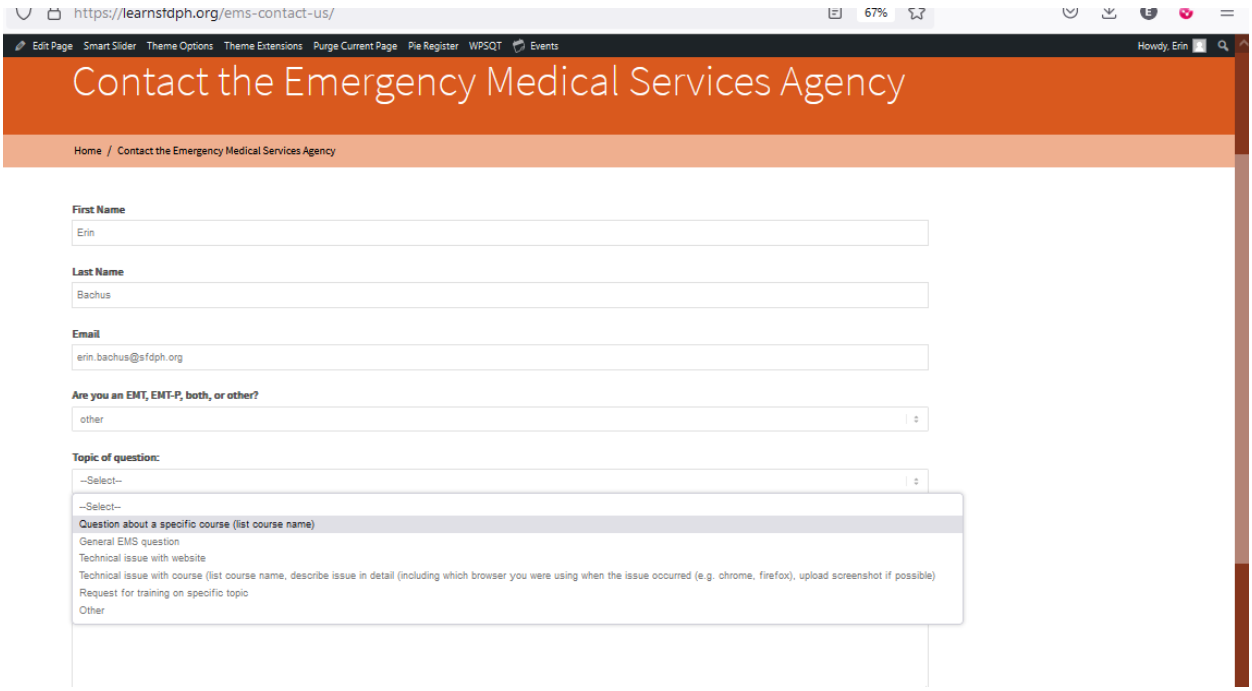
Example of LMS Landing Page Course Overview:



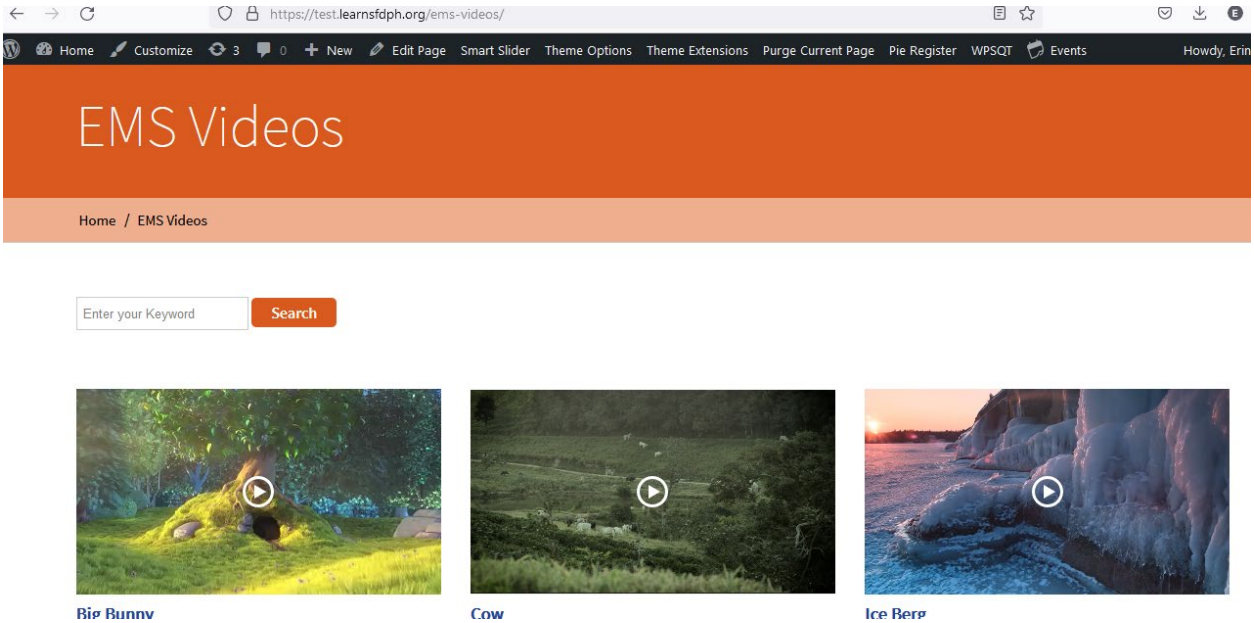
LMS Landing Page After Login Showing “Print Transcript” Option:



Contact Us Form:



EMS Video Library (test version only):



EMS Week 2022

- Hosted our annual EMS Awards Ceremony after a two year, pandemic hiatus
- Added the inaugural Mary Magocsy Excellence in EMS and Disaster Leadership Award to our list of annual awards
- Hosted a dedication ceremony and interactive in-person and virtual (hybrid) tour of our new Mary Magocsy Simulation and Training Center at the EMS Agency
- Worked with our larger department, the Department of Emergency Management to create a series of videos and social media posts to highlight and honor field providers during EMS week, resulting in our largest social media engagement campaign thus far

Social Media Engagement

To improve engagement between SF EMSA, EMTs, Paramedics, and the broader SF community, EMSA opened social media accounts on Twitter and Facebook in February 2020. Since then, our engagement has grown significantly. See details below for insights:

<u>Twitter (@SF_EMSA):</u>

- 181 followers
- Summaries by month:

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

Jun 2022 · 30 days

TWEET HIGHLIGHTS

Top Tweet earned 5,345 impressions

CPR saves lives. Learn more at the link below! twitter.com/HeartCPR/statu...

2 9

View Tweet activity View all Tweet activity

Top Follower followed by 730 people



Nathan Allen
@nathan_a_allen FOLLOWS YOU

Arkansas born | Bay Area living |
@aidslifecycle rider x3 | Cover photo: @arlofiel |
Comms @netflix

View profile

Top mention earned 240 engagements



Andrew Holcomb
@andrewholcomb · Jun 26

It takes a massive massive EMS effort, teamwork, and coordination for a safe PRIDE weekend. Special @SF_EMSA thank you to @SF_emergency @SFFDPIO @RoyalAmbulance @Kingamerican @SF_DPH and many many more. pic.twitter.com/FAs6CWrlrS



1 2 21

View Tweet

Top media Tweet earned 25 impressions

Happy National Nurses Week to all of the awesome nurses out there. A special shout out to EMSA's only nurse, Elaina! Elaina is a voice of reason, a planning extraordinaire, a funny & thoughtful human, and so many other things. We are so grateful to have you on the team, Elaina. pic.twitter.com/jVjq2h5yIg



1 3

View Tweet activity View all Tweet activity

JUN 2022 SUMMARY

Tweets	Tweet impressions
4	9,051
Profile visits	**Mentions**
1,038	114
New followers	
13	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

May 2022 • 31 days

TWEET HIGHLIGHTS

Top Tweet earned 6,620 impressions

Congrats once again to our 2022 EMS Award Recipients, commended today by @SFBOS to recognize and honor these individuals for their heroic acts and incredible contributions to the EMS System. Thanks to @SF_emergency for your efforts to ensure #EMSWeek honored those who save lives.
pic.twitter.com/IfaYuLoEmO



View Tweet activity View all Tweet activity

Top Follower followed by 443 people



Robert Vallejos
@Rob_Vallejos FOLLOWS YOU
Civil Servant @SFHumanServices @sfgov

View profile

Top mention earned 127 engagements

SAN FRANCISCO FIRE DEPARTMENT MEDIA
@SFFDPIO · May 15

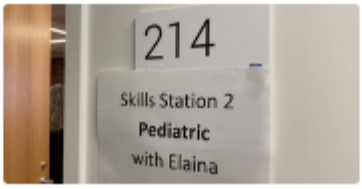
Today, medical and rescue professionals with @flySFO #SFFDSFO are trained on advanced medical care during technical rescues with one goal, your safety. We are happy to kick off #EMSWEEK2022 with pre-hospital training and safety awareness. @SF_EMSA
pic.twitter.com/Qrop5FbLWu



View Tweet

Top media Tweet earned 2,180 impressions

Thank you to everyone who joined us today to celebrate the dedication of our new SIMulation and Training Center to the honorable former EMSA Nurse, the late Mary Magocsy. #EMSWeek2022 @SF_emergency
pic.twitter.com/ZjL1V0wuyW



View Tweet activity View all Tweet activity

MAY 2022 SUMMARY

Tweets 10	Tweet impressions 18.5K
Profile visits 1,553	Mentions 114
New followers 12	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

Apr 2022 • 30 days

TWEET HIGHLIGHTS

Top Tweet earned 3,357 impressions

Elizabeth Basnett, Acting Director of the CA Emergency Medical Services Authority (CA EMSA), has announced the recipients of California Emergency Medical Services Awards for 2021. Congratulations to our own Dr. John Brown for receiving the Medical Director of the Year award!

1 2 15

View Tweet activity View all Tweet activity

Top Follower followed by 383 people



Rick Skewes

@RickSkewes FOLLOWS YOU

San Francisco by way of Texas. Exhausted by the state of the world. Debt still large, but getting better. Cash App: $RickSkewes

View profile

Top mention earned 67 engagements

San Francisco Department of Emergency Management

@SF_emergency · Apr 15

The @SF_EMSA team give a special thanks to all our San Francisco 9-1-1 Dispatchers across for being the unsung heroes. Our dispatchers are the First, First Responders and the calm voice everyone needs at a time of need. Thank you @andrewholcomb! pic.twitter.com/hvPJbVPTnv

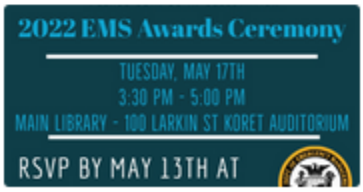


2 5

View Tweet

Top media Tweet earned 1,891 impressions

The 2022 EMS Awards Ceremony is almost here! You can register now by visiting sf-ems-awards.eventbrite.com . pic.twitter.com/Wn2B25nZWe



2 6

View Tweet activity View all Tweet activity

APR 2022 SUMMARY

Tweets 7	Tweet impressions 7,766
Profile visits 733	Mentions 7
New followers 9	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

View Tweet activity View all Tweet activity

Mar 2022 · 31 days

TWEET HIGHLIGHTS

Top Tweet earned 2,623 impressions

Were you thinking of nominating a fellow first responder for an EMS award?The deadline has been extended to March 18th!Don't delay. Nominate today!Download the fillable PDF here: sfdph.org/dph/files/EMS/...

@AMR_Social @RoyalAmbulance @SFFDPIO @Kingamerican @ZSFGCare @UCSFHospitals

2 2

View Tweet activity View all Tweet activity

Top Follower followed by 32.3K people

PulsePoint

@pulsepoint FOLLOWS YOU

PulsePoint is a 911-connected app that can immediately inform you of emergencies occurring in your community and can request your help when CPR is needed nearby

View profile

Top mention earned 32 engagements

San Francisco Department of Emergency Management

@SF_emergency · Mar 30

Today, we spotlight the woman behind the EMT & Paramedic Certification for the whole city! Camilla Arcia is the Lead Certification Specialist for @SF_EMSA with over 30 years of experience. Camilla's career in Civil Service follows her family's legacy in public service. pic.twitter.com/mk4CVbrhn6



2 14

View Tweet

Top media Tweet earned 234 impressions

Last call to nominate someone for an EMS Award! Go here and send in that form today: sfdph.org/dph/files/EMS/... pic.twitter.com/VcsYl1fQT0



2

View Tweet activity View all Tweet activity

MAR 2022 SUMMARY

Tweets 4	Tweet impressions 3,467
Profile visits 159	Mentions 8
New followers 4	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

Feb 2022 · 28 days

TWEET HIGHLIGHTS

Top Tweet earned 1,603 impressions

There is still time to nominate a fellow EMT, Paramedic, First Responder (e.g. police), Hospital Provider, Dispatcher, or Community Member who went above and beyond on an EMS call for a 2022 SF EMS Award. Don't delay, nominate today here: sfdph.org/dph/files/EMS/... . Due March 4th! pic.twitter.com/rmoatrFgDY



2 3 7

View Tweet activity View all Tweet activity

Top Follower followed by 32.3K people

PulsePoint

GET THE APP. SAVE A LIFE.

PulsePoint

@pulsepoint FOLLOWS YOU

PulsePoint is a 911-connected app that can immediately inform you of emergencies occurring in your community and can request your help when CPR is needed nearby

View profile

Top mention earned 50 engagements

Andrew Holcomb

@andrewholcomb · Feb 10

Know of an EMT, Paramedic, first responder, dispatcher, or community member that went above and beyond on an EMS call??? Please visit the @SF_EMSA to nominate for EMS Week Awards in May. sfdph.org/dph/comupg/ose... @SF_emergency @SF_DPH @SFFDPIO @SheriffSF @SFPD pic.twitter.com/dZ4iQf5TB9



2 2 10

View Tweet

Top media Tweet earned 245 impressions

Did you know that an all Black ambulance service inspired today's EMS system? Check out the history of the Freedom House Enterprises Ambulance Service, a program that trained black citizens during the 1960s & 70s to provide then state of the art prehospital care. Link in comments pic.twitter.com/11z7pqDuII



1 2 5

View Tweet activity View all Tweet activity

FEB 2022 SUMMARY

Tweets 7	Tweet impressions 3,878
Profile visits 293	Mentions 19
New followers 3	

Jan 2022 • 31 days

TWEET HIGHLIGHTS

Top Tweet earned 74 impressions

Did you know that SF recently implemented a new system called EMS Alert to improve centralized ambulance distribution? In this photo, EMSA staff Leo & Erin are shown at ZSFG after filming some B roll video related to EMS Alert. To find out more, visit sfdph.org/dph/comupg/ose... . pic.twitter.com/I0NWNXSsQ0



1 1 2

View Tweet activity | View all Tweet activity

Top Follower followed by 3 people



opinionator
@pensivepolson FOLLOWS YOU
unoriginal. ideas are not my own.

View profile

Top mention earned 145 engagements

SAN FRANCISCO FIRE DEPARTMENT MEDIA
@SFFDPIO · Jan 1

Our EMS operations Chief is spreading cheer by delivering meals to some of our EMS staff tonight. From our EMS teams to you, happy New Year's! @NYCEMSwatch @SF_EMSA pic.twitter.com/ICEMSp1dRG



1 3 46

View Tweet

JAN 2022 SUMMARY

Tweets 1	Tweet impressions 579
Profile visits 552	Mentions 31
New followers 2	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

Dec 2021 · 31 days

TWEET HIGHLIGHTS

Top Tweet earned 5,189 impressions

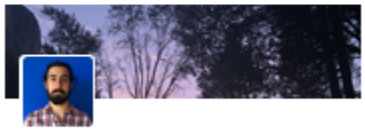
This week, EMSA hosted over a dozen trainings on the iGel supraglottic airway device. Thanks to everyone who attended to learn about this awesome technology! A big thanks to the trainers who traveled here and spent the whole week with us! Check out team @SFFDPIO gaining knowledge pic.twitter.com/Epubg8EjPK



1 1 12

View Tweet activity View all Tweet activity

Top Follower followed by 464 people



Matt Goldman, MD, MS

@MattG_PsychMD FOLLOWS YOU

Public Psych, Crisis Response, Services Research, MH Policy | Alum of @ColumbiaPsych @HAPFellows @UCSFMedicine @JointMedPrgrm | he

View profile

Top mention earned 18 engagements



Andrew Holcomb

@andrewholcomb · Dec 30

Congrats to CityEMT Cohort 2 EMTs on graduating today! @SF_EMSA wishes you success on your upcoming @NREMT exams and can't wait to see you responding to calls in SF. @SF_emergency @SFFDPIO @OfficialCCSF pic.twitter.com/3sVigYFAII



2 8

View Tweet

Top media Tweet earned 1,805 impressions

Today, Dr. Brown and Medical Student Stephen Ettinger are spending their day @CityEmt to provide training on the LUCAS Device, Supraglottic Airway (iGel), and Trauma Triage. EMSA is here for you as we provide EMS related training and support! pic.twitter.com/iWWwL8yO1y



2 8

View Tweet activity View all Tweet activity

DEC 2021 SUMMARY

Tweets	Tweet impressions
2	7,566
Profile visits	**Mentions**
512	9
New followers	
5	

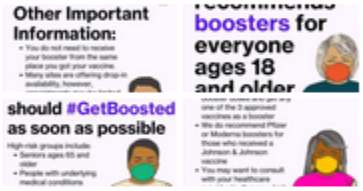
Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

Nov 2021 • 30 days

TWEET HIGHLIGHTS

Top Tweet earned 2,642 impressions

Booster doses are now recommended for everyone age 18+ who have completed their primary COVID-19 vax series.If it has been >2 months since your dose of J&J or >6 months since your 2nd dose of Pfizer/Moderna, get a booster!Make sure you are protected going into the holiday season. pic.twitter.com/WkGbyxFFjn



1 6

View Tweet activity View all Tweet activity

Top mention earned 43 engagements

SAN FRANCISCO FIRE DEPARTMENT MEDIA
@SFFDPIO · Nov 29

Members from @SFFDPIO and @SF_EMSA provided the Mission High School Fire and EMS class with a school CPR training kit today, enhancing the students ability to learn life saving skills. @OfficialCCSF
pic.twitter.com/6RZ2pS4GZq



5 13

View Tweet

Top Follower followed by 2,647 people



SF Department of Children, Youth & Their Fam FOLLOWS YOU

Making San Francisco a great place to grow up!

View profile

Top media Tweet earned 300 impressions

Happy belated #NationalFirstRespondersDay to all of the first responders out there who save lives each and every day. We appreciate you! EMSA joined @SFDEM_MEC in celebrating last night with BE CHINATOWN San Francisco.
twitter.com/SFDEM_MEC/stat...
pic.twitter.com/mdvDUWnqyv



2 2

View Tweet activity View all Tweet activity

NOV 2021 SUMMARY

Tweets 2	Tweet impressions 4,002
Profile visits 232	Mentions 1
New followers 3	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

Oct 2021 • 31 days

TWEET HIGHLIGHTS

Top Tweet earned 5,464 impressions

Today, EMSA transferred Automated External Defibrillators to the SF Sheriff's Office. These AEDs will put lifesaving tools in the hands of Deputies all over the City. Thank you @SheriffSF for being excellent EMS partners! @SF_emergency pic.twitter.com/jtQAJyXXy9



6 19

View Tweet activity View all Tweet activity

Top Follower followed by 5,415 people



SF Sheriff's Office

@SheriffSF FOLLOWS YOU

This SF Sheriff Twitter account is not monitored 24/7. To report a crime, call 9-1-1 in an emergency. Our public social media policy: https://t.co/AJeIUZgfYo

View profile

Top mention earned 214 engagements

SAN FRANCISCO FIRE DEPARTMENT MEDIA

@SFFDPIO · Oct 19

Thank you to @SF_EMSA for enhancing our communities safety by providing @SheriffSF with Automatic External Defibrillators (AED). These AED's and the professionally trained men and women of the #SFSO will save lives. pic.twitter.com/bxSJo4vuDj



7 28

View Tweet

Top media Tweet earned 1,151 impressions

Yesterday at City Hall, EMSA transferred a LUCAS device to @SheriffSF. Two EMSA EMS Specialists, Ron and Leo also led a Train the Trainer class for EMT and Paramedic trained deputies to ready them to assist someone having cardiac arrest.Mechanical chest compression devices rock! pic.twitter.com/VUbwOTHitm



3 10

View Tweet activity View all Tweet activity

OCT 2021 SUMMARY

Tweets	Tweet impressions
4	8,559
Profile visits	**Mentions**
513	15
New followers	
11	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

Sep 2021 · 30 days

TWEET HIGHLIGHTS

Top Tweet earned 3,455 impressions

Thanks to everyone who made it out to the National EMS Memorial Bike Ride. Such a meaningful way to honor those in EMS who have lost their lives. Locally, we honored SFFD Firefighter and Paramedic Jason Cortez and King American Paramedic Gabe Salvador. pic.twitter.com/wGgQBWPdQX



4 15

View Tweet activity View all Tweet activity

Top Follower followed by 1,417 people



Disaster Dude

@Disasterdude_VT FOLLOWS YOU

Dad, emergency mgr, podcaster, gamer, avgeek, grad student. All stupid thoughts and opinions are my own and I have to live with that. Follow4BFF

View profile

Top mention earned 124 engagements

SAN FRANCISCO FIRE DEPARTMENT MEDIA

@SFFDPIO · Sep 23

Join us to pay tribute to FF/PM Cortez and Paramedic Salvador on Saturday as a group of bicyclists concludes their memorial ride in those honor of Sacramento. @CA_EMSA @SF_EMSA @Kingamerican @AMR_Social pic.twitter.com/x5rxiZaX0p



NEWS RELEASE

San Francisco Fire to host a commemoration of fallen EMS heroes

6 12

View Tweet

Top media Tweet earned 418 impressions

In honor of Overdose Awareness Day on 8/31, we'd like to recognize ProjectFRIEND, a program aimed at increasing naloxone utilization in SF by effectively training first responders in naloxone administration and distribution. To learn more, visit projectfriend.org . pic.twitter.com/QDugCDGspH



1

View Tweet activity View all Tweet activity

SEP 2021 SUMMARY

Tweets	Tweet impressions
3	4,436
Profile visits	**Mentions**
173	7
New followers	
4	

Analytics Home Tweets More San Francisco Emergency Medica... Sign up for Twitter Ads

View Tweet activity View all Tweet activity

Aug 2021 • 31 days

TWEET HIGHLIGHTS

Top Tweet earned 6,032 impressions

EMSA staff were excited to join @SFFDPIO and @SheriffSF at today's Coffee With a Deputy at the Mariposa Starbucks. Thanks to the community members who joined us to share their thoughts and concerns. pic.twitter.com/LBiXy2SAgO



1 6

View Tweet activity View all Tweet activity

Top Follower followed by 14 people

CartWright Education

@BougleLuv FOLLOWS YOU

Paramedic faculty for Tacoma Community College and airway enthusiast!

View profile

Top mention earned 6 engagements

david ebarle

@DavidEbarle_911 · Aug 28

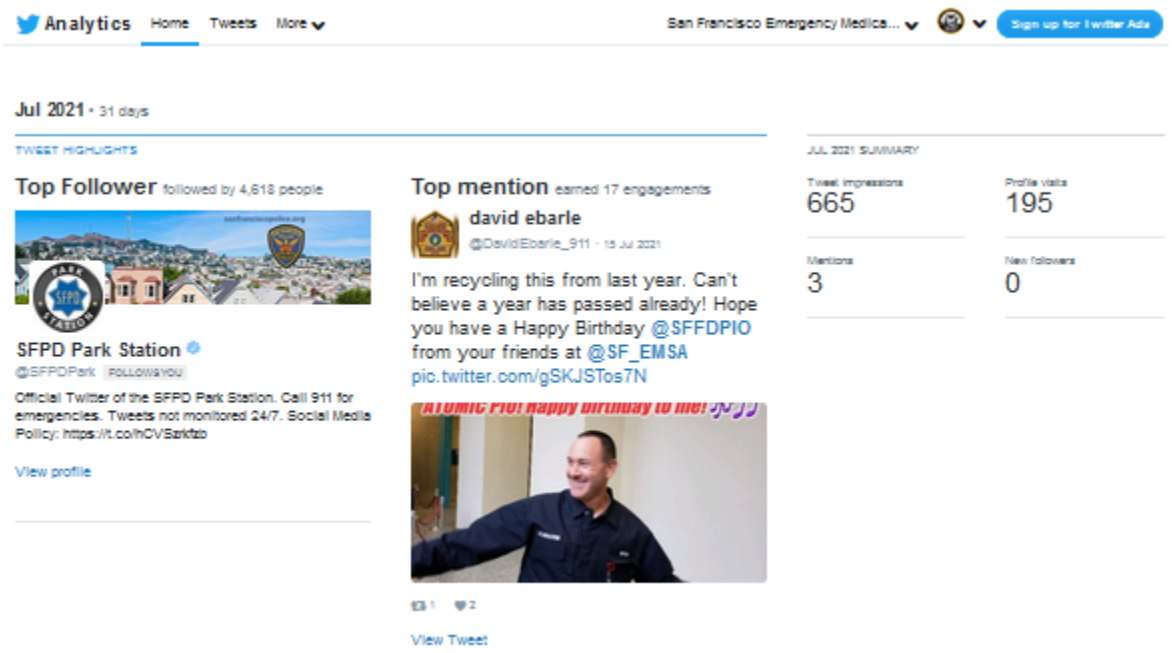
Congratulations @sfpublicworks @SFFDPIO @SFFFLocal798 @SF_EMSA. The facility is exceptional. 🚒🚒🚒 twitter.com/sfpublicworks/…

4

View Tweet

AUG 2021 SUMMARY

Tweets 1	Tweet impressions 6,713
Profile visits 105	Mentions 1
New followers 1	



As you can see, May 2022 was the month that we had the most engagement with over 18.5K Tweet impressions. This highlights the impact that social media can have when posts are more frequent and engaging to users. EMS Week is the perfect opportunity to highlight the incredible work that EMS providers do every day.

The SF EMS Agency plans to increase our engagement and social media following by posting new and innovative content, such as highlighting our commitment to CPR and proper AED use through our Community CPR Initiative and PulsePoint app launch (https://sf.gov/community-cpr-initiative).

Facebook (@EMSASF):

- 299 followers
- In the previous 90 days:
  - 18 posts
  - Post reach: 940
  - Engagement: 160
  - Here is a look at more detailed insights from our most popular post which highlighted EMS Award Recipients during EMS Week 2022:

Post Insights



Congratulations once again to our 2022 EMS Award Recipients, commended today by SF Board of...

May 24 ·

Post Impressions	Post Reach	Post Engagement
237	217	86

Interactions

22	2	0	0	0	0

Reactions	24
Comments	7
Shares	2
Other Clicks	8

San Francisco Emergency Medical Services Agency

May 24 ·

Congratulations once again to our 2022 EMS Award Recipients, commended today by SF Board of Supervisors to recognize and honor these individuals for their heroic acts and incredible contributions to the EMS System. Thanks to San Francisco Department of Emergency Management, San Francisco Fire Department, King-American Ambulance, SF Public Health, American Medical Response - San Francisco, Royal Ambulance,
and many others for your efforts to ensure #EMSWeek honored those who save lives.



See insights and ads

Boost post

13

2 Shares

Equipment and supply purchases related to field provider training and public health education

The EMS Agency was fortunate to be able to purchase broadcast quality audio and video equipment to aide in the development of online trainings, videos, social media posts, flyers, posters, and reports. This equipment purchase includes a DSLR camera, video camera, room lighting, microphones for both live event recording and online training recording, tripods, microphone stands, and other specialized recording equipment and accessories.

Appendix H

EMS Agency Simulation Center

Dedicated in Honor of
Mary A. Magocsy, RN, BSN, MBA
November 1, 2021

Mary Magocsy started her career with the City and County of San Francisco in 1995. Her first assignment was with the Department of Public Health as an infectious Disease Emergency Response Coordinator. She developed and implemented programs related to bioterrorism, disease outbreak, and other public health emergencies.



As an EMS Agency Specialist, she managed various Programs in support of the EMS Mission in San Francisco. Coordinating the EMS Advisory Committee (EMSAC) was a central part of Mary's responsibilities and she lent her experience to the various EMSAC initiatives and policy decisions.

In her spare time, she was known for her avid interests in all things San Francisco Bay related – being a long time member of the Dolphin Swimming and Rowing Club of San Francisco.

Sadly, we lost Mary on November 1, 2020, to glioblastoma cancer. The EMS Agency hereby dedicates this Simulation and Training Center both in honor of Mary Magocsy, and as a living memorial to her dedication to Emergency Medical Services in our city.





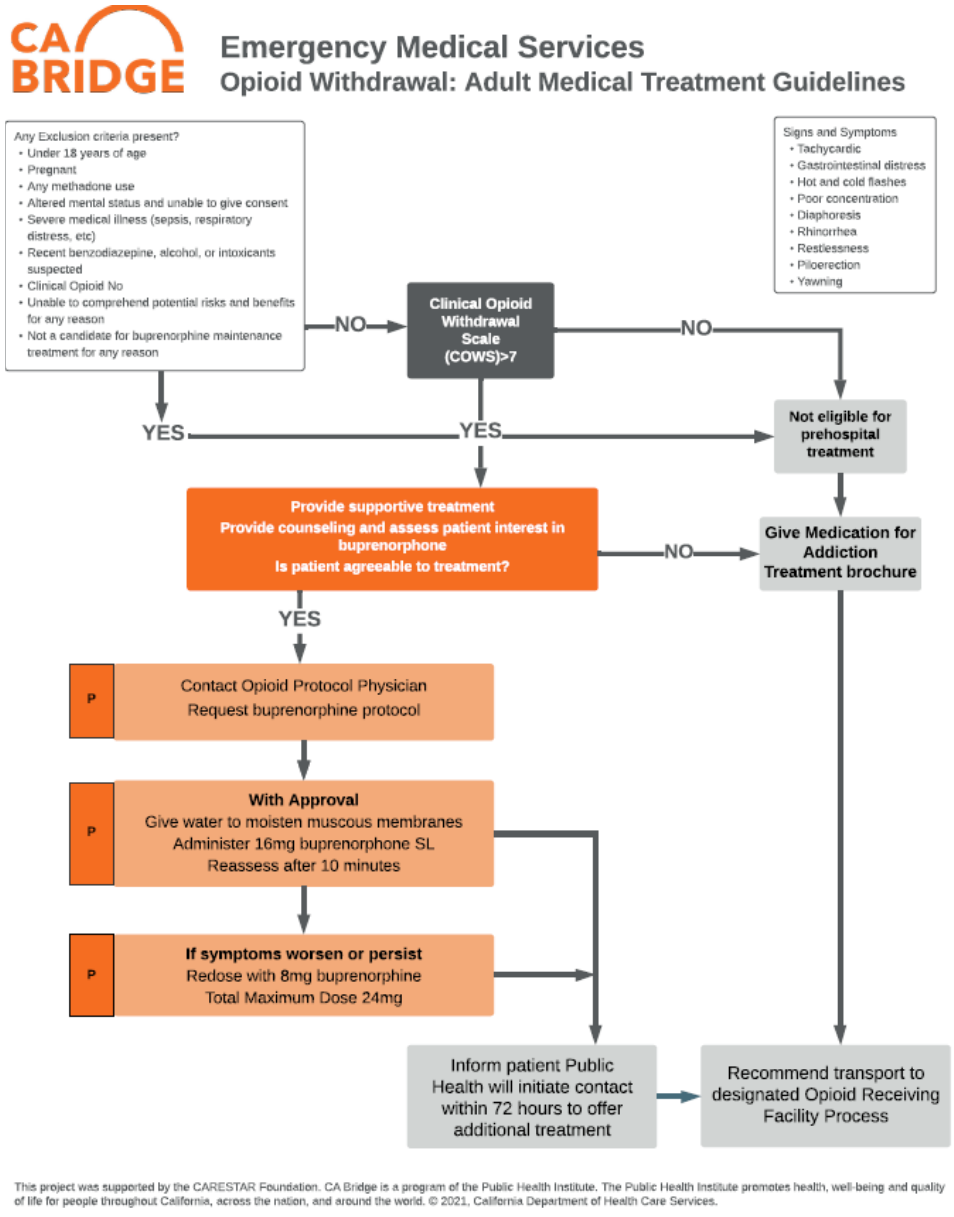




Appendix I

Buprenorphine Trial Study

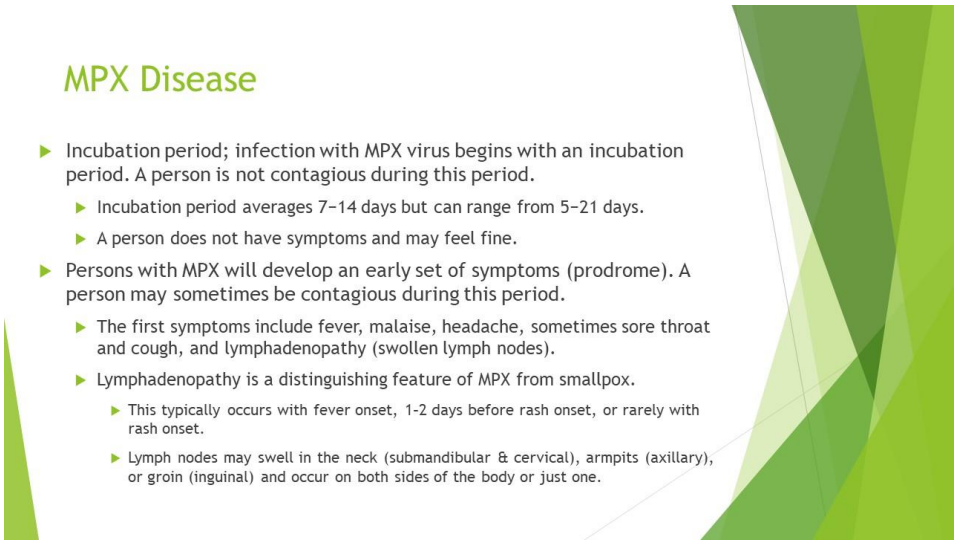
In San Francisco, many patients suffer from opioid use within our community. We recently joined Contra Costa County and Alameda County in starting the Buprenorphine trial study to address the opioid crisis. Buprenorphine will allow San Francisco to treat those suffering from opioid withdrawals and help them move towards treatment and recovery. Our trial study application was just approved, and we are in the training phase for the EMS providers. Based on early results from Alameda and Contra Costa counties, SFEMSA is excited to get this trial up and running as we know that this will make a difference to the community.

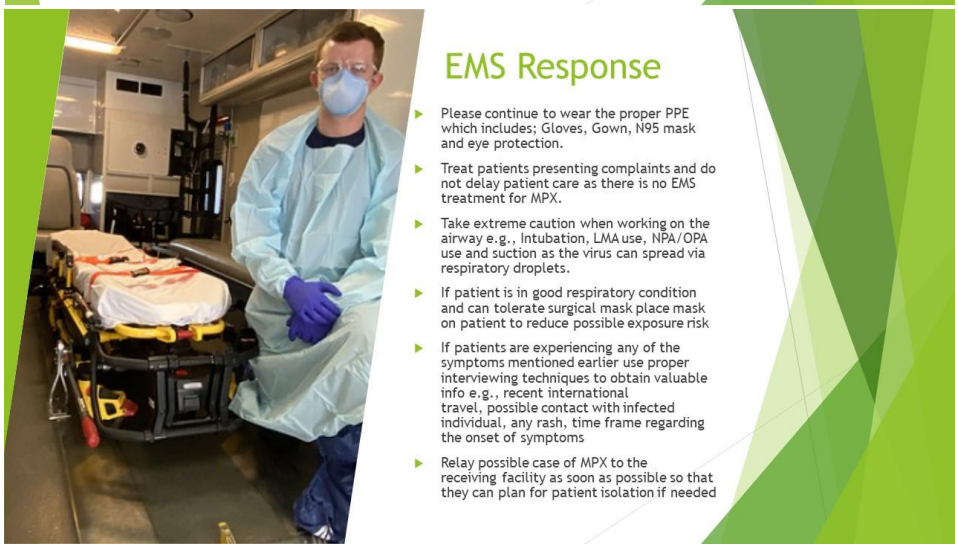


Appendix J

MPX Just in Time Training and Response Efforts

After outbreaks of MPX throughout different countries and then several cases in San Francisco, an immediate need to rapidly disseminate information to EMS providers existed in order to educate EMS personnel. A just in time training was created to give the EMS crews within the City and County of San Francisco a better understanding of the MPX virus. Using information from the CDC as well as consulting with Communicable Disease physicians within the SF Department of Public Health, SFEMSA created a training describing how the virus spreads, the best PPE to be used, best cleaning supplies to use for disinfection and how to report possible cases to the receiving facility in order to prepare for isolation. SFEMSA distributed this training over several different platforms such as our Protocol App for smartphones, PowerPoint, and online learning systems. San Francisco also obtained a LOSOP for EMTs and Paramedics to administer vaccinations in response to MPX in San Francisco.





Appendix K

Base Hospital MD in Field Program

Starting in July 2019, the San Francisco EMSA began the EMS Physician/Base Hospital Physician in the Field Program. This program allows for direct EMS medical oversight to patients and providers, which is valuable to the EMS system. This program also allows for direct presence on scene rather than radio calls to understand the situation for which the provider is requesting assistance as well as saving base hospital resources from having to interrupt medical care to provide radio-based direction. Since the start of the program there have been over 100 patient contacts resulting in assisting crews with EKG interpretation, assisted with patient destination decision-making, and provided physician-led education to crews.

Currently, the program staffs up the QRV style EMSA response vehicle with 1 EMS Specialist as the driver, 1 MDs/EMS Fellow, and up to 2 learners (paramedic students or MD residents) per shift. The shifts run weekly and mainly on Friday afternoon when call volume may be the highest. During the shift, EMS dispatches are monitored for possible response to:

- Complex medical cases where the MD input might assist crews
- Complex/higher risk AMA scenarios ex. Elderly patients or questions regarding altered mental status
- Prolonged scene calls such as medical resuscitations or difficult extrications of a patient
- Specialty-type calls such as pediatrics
- Any dispatcher or Rescue Captain requests

This shift may also be used for deployment of anticipated surge or MCIs. At the completion of the shift a log is kept for all patient contacts made by the team including any clinical decision making or education given. We anticipate this program to only grow and add more shifts in the future.

City and County of San Francisco
London Breed, Mayor

Department of Emergency Management
Emergency Medical Services Agency

Date: April 15, 2022

To: San Francisco EMS Providers
DEM Division of Emergency Communications
San Francisco Receiving Hospitals

From: John Brown MD, San Francisco EMS Agency Medical Director
Andrew Holcomb, Acting EMS Director

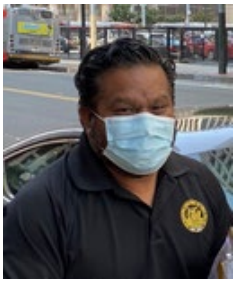
Subject: **New EMS/Base Hospital Physician in the Field Program**

The San Francisco EMS Agency (EMSA) developed a new EMS resource designed to augment our system's prehospital response capabilities: the EMS/Base Hospital Physician in the Field Program. While in service, this resource will be referred to as "BASEMD" in CAD and over radio. This unit responds to higher-complexity calls and provides extra support to working EMS crews through real-time education, feedback, as well as base hospital consultation when needed. Secondarily, also serves as a training platform for paramedic students and base hospital physicians. The Base MD in the Field Program is a Pilot Program of the EMSA Research Committee, and will become gradually more available in the coming weeks, generally on Fridays. The resource is staffed at minimum with an EMS physician and specially-designated EMSA staff member. For any questions or feedback, feel free to contact the EMS Agency.


Dr. John Brown
EMSA Medical Director


Dr. Timothy Hong
EMS/D Medicine Fellow


Dr. Courtney Shay
EMS/D Medicine Fellow


Leo Ishoda
EMS Specialist, EMSA


Ron Pike
EMS Specialist, EMSA


BASEMD response vehicle