EMERGENCY MEDICAL SERVICES AUTHORITY
11120 INTERNATIONAL DR., SUITE 200
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

October 24, 2024

Andrew Holcomb, EMS Director
San Francisco County Emergency Medical Services Agency
333 Valenica Street, Suite 210
San Francisco, CA 94103

Dear Andrew Holcomb,

This letter is in response to San Francisco County Emergency Medical Service (EMS) Agency's 2024 EMS, Community Paramedicine (CP)/ Triage to Alternate Destination (TAD), Trauma, St-Elevation Myocardial Infarction (STEMI), Stroke, and Quality Improvement (QI) plan submissions to Emergency Medical Service Authority (EMSA) on July 9, 2024.

EMSA 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 the enclosed EMS area/subarea status, compiled by EMSA.

EMSA has also reviewed the CP/TAD, Trauma, STEMI, Stroke, and QI plans based on compliance with Chapters 5, 7, 7.1, 7.2, and 12 of the California Code of Regulations, Title 22, Division 9, and Title 22, Section §100183, and Section §100190 has been approved for implementation.

Per HSC § 1797.254, local EMS agencies must annually submit EMS plans to EMSA. San Francisco County EMS Agency will only be considered current if an EMS plan is submitted each year.

Your 2025 EMS plan will be due on or before October 24, 2025. Concurrently with the EMS plan, please submit an annual CP/TAD through submission of the Community Paramedicine Annex, Trauma, STEMI, Stroke, and QI plan.

If you have any questions regarding the EMS plan review, please contact Roxanna Delao, EMS Plans Coordinator, at (916) 903-3260 or roxanna.delao@emsa.ca.gov.

Sincerely,

Tom McGinnis

Tom McGinnis, MHA, EMT-P
Chief, EMS Systems Division

Enclosure:
AW: jg

EMERGENCY MEDICAL SERVICES AUTHORITY
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San Francisco 2024 EMS 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					

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF EMERGENCY MANAGEMENT

SAN FRANCISCO EMS AGENCY

2024 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: July 9, 2024

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Interim Chief Medical Officer, EMS Authority
Tom McGinnis, Chief, EMS Systems Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2024 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.

For the first time ever, also included are all of San Francisco's EMS Specialty Plan renewal documents under one submission including STEMI, Stroke, Trauma, EMS for Children, Triage to Alternate Destination, and Community Paramedicine.

SFEMSA remains dedication to our mission of oversight through directing, planning, monitoring, and evaluating the EMS system as the designated Local EMS Agency (LEMSA). Focusing on continuous improvement, open communication, and pursuit of innovation, we are excited at the opportunity to reflect on our achievements, describe our challenges, and look forward to the future as an EMS system. Put simply, 2023 was a rewarding, although incredibly challenging, year for the San Francisco EMS System. By working together, everyone in the EMS system achieves success.

Under the Community Paramedicine and Triage to Alternate Destination Act, the San Francisco EMS Agency was on a critical timeline to ensure compliance, develop, train, execute agreements, and submit documentation to maintain both pilot programs. To date, San Francisco is one of four LEMSAs with an approved Triage to Alternate Destination program and the only LEMSA with an approved Community Paramedicine program.

In November 2023, the San Francisco hosted the Asia-Pacific Economic Cooperation (APEC), which resulted in an unprecedented level EMS planning to support the event directly and City. Nearly two dozen heads of government attended the event along with world leaders and dignitaries. Through partnerships and planning, EMS support and response to the event was flawless. Local providers staffed with every available resource and strike teams from the Northernmost parts of California to the Central Valley provided 24/7 coverage during the event. For the first time in recent memory, strike teams responded to almost 300 9-1-1 calls in a dense urban populated center for over 72-hours.

SFEMSA continues to focus on ambulance offload and diversion initiatives to mitigate impacts to the EMS System. SFEMSA meets regularly and collaboratively with hospital leadership and executives to discuss ambulance offload challenges, which has also provided the added benefit of overall hospital and specialty-level EMS System engagement. In April 2024, a long-awaited report on ambulance patient offload times was released by the San Francisco Controller's Office to SFEMSA in support of addressing and recommending steps that can be used as a model for improvement.

In building out our organization, we continue to focus on data, transparency, and administrative requirements. A much-needed epidemiologist was brought on to the SFEMSA team resulting in a recently launched public-facing response times dashboard with another phase in development including ambulance patient offload times and diversion. Additionally, SFEMSA is in the mid-stage process of procurement and transition to an IT system for certifications, ambulance inspections, and incident reporting, which will greatly improve efficiency and administrative workload. Additionally, for the first time in years, San Francisco has no in-county outstanding or expired hospital or EMS Provider agreements.

San Francisco EMS planning for the future remains bright. Dr. John Brown, SFEMSA's long-tenured Medical Director, retired in March 2024 after 28 years of service. Dr. Andi Tenner, current Director of Public Health Emergency Preparedness and Response (PHEPR) under the Department of Public Health (DPH), assumed the Interim SFEMA Medical Director immediately to ensure no lapse in medical direction, expertise, and clinical oversight. SFEMSA and DPH are jointly working on recruitment for hiring of a permanent SFEMSA Medical Director in Summer 2024.

Under § 1797.153, the SFEMSA Director, under the Department of Emergency Management, and County Health Officer, under DPH, jointly support the Medical Health Operational Area Coordinator (MHOAC) program. Recognizing the scope of the program with 17 different functions, the MHOAC program has been transitioned to PHEPR for day-to-day management of planning and administrative work to support the program led by Tiffany Rivera, PHEPR Deputy Director and Primary MHOAC. Both departments have access to resource request portals, redundancy plans, and have formed a committee between the LEMSA and PHEPR to establish best practices, standard work, and enhance response capabilities.

SFEMSA will continue to show our commitment to excellence and continuous collaborative improvement with all partners. For any questions, concerns, or requests for additional information regarding our submission, please do not hesitate to contact me directly.

Andrew Holcomb
EMS Director, EMS Agency
andrew.holcomb@sfgov.org

Cc: Dr. Andi Tenner, Interim EMS Agency Medical Director
Rob Smuts, DEM Deputy Director
Mary Ellen Carroll, DEM Executive Director

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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	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			
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			
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	x	
5.02 Triage & Transfer Protocols		x			
5.03 Transfer Guidelines		x			
5.04 Specialty Care Facilities		x			
5.05 Mass Casualty Management		x	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			
6.07 Provider Participation		x			
6.08 Reporting		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	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			
Enhanced Level: Exclusive Operating Areas/Ambulance Regulations:					
8.19 Waiving Exclusivity		x			

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT

Reporting Year: _____**2023**_____

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)	____**6***____%
B. Limited Advanced Life Support (LALS)	____**0**_____%
C. Advanced Life Support (ALS)	____**94**____%

***Under BLS Pilot Tier, all of San Francisco is eligible for ALS response**

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 – ***FY23-24 Budget***

Salaries and benefits (All but contract personnel)	**$ 2,553,444_**
Contract Services (e.g. medical director)	**$92,793__**
Operations (e.g. copying, postage, facilities)	**$19,700___**
Travel	**$13,000___**
Fixed assets	**$278,695_**
Indirect expenses (overhead)	_____
Ambulance subsidy	_____
EMS Fund payments to physicians/hospital	_____
Dispatch center operations (non-staff)	_____
Training program operations	**$8,000___**
Other: **Contracts (Prof Services)**_____	**$366,500_**
Other: **Membership Fees**_____	**$2,500___**
Other: _____	_____
TOTAL EXPENSES	**$ 3,334,632_**

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	**$2,012,122***
***Estimate, CCSF requires balanced budget, EMSA balanced for FY23-24**	
Other local tax funds (e.g., EMS district)	_____
County contracts (e.g. multi-county agencies)	_____
Certification fees	**$83,458__**
Training program approval fees	**$4,029___**
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	**$24,911**___
Pediatric facility approval fees	_____
Pediatric facility designation fees	**$49,822**___
Other critical care center application fees	**$206,163**__
Type: **Receiving Hospital**_____	
Other critical care center designation fees	**$125,986**__
Type: **STEMI Center**_____	
Other critical care center designation fees	**$201,578**__
Type: **Stroke Center**_____	
Ambulance service/vehicle fees	**$393,015**__
Contributions	_____
EMS Fund (SB 12/612)	_____
Other grants: _____	_____
Other fees: **Medical Plan Fees**_____	**$33,550**___
Other (specify): **Community Paramedic Provider Fee**	**$200,000**__

TOTAL REVENUE $ **$3,334,632***

Non-General Fund Revenue $1,322,510

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 23-24****

_____ We do not charge any fees

__**x**___ Our fee structure is:

First responder certification	$ ____**No**_____
EMS dispatcher certification	____**No**_____
EMT-I certification	____**$193**____
EMT-I recertification	____**$143**____
EMT-defibrillation certification	____**No**_____
EMT-defibrillation recertification	____**No**_____
AEMT certification	____**No**_____
AEMT recertification	____**No**_____
EMT-P accreditation	____**$42**_____
Mobile Intensive Care Nurse/Authorized Registered Nurse certification	____**No**_____
MICN/ARN recertification	____**No**_____
EMT-I training program approval	____**$1,602**__
AEMT training program approval	____**No**_____
EMT-P training program approval	____**$2,399**__
MICN/ARN training program approval	____**No**_____
Base hospital application	____**No**_____
Base hospital designation	____**No**_____
Trauma center application	____**No**_____
Trauma center designation	____**$25,197**_
Pediatric facility approval	____**No**_____
Pediatric facility designation	____**$25,197**_
Other critical care center application Type: **Receiving Hospital**_____	____**$20,616**_
Other critical care center designation Type: **STEMI Center**_____	____**$25,197**_
Other critical care center designation Type: **Stroke Center**_____	____**$25,197**_
Ambulance service license	____**$13,517**_
Ambulance vehicle permits	____**$2,163**__
Other: **Annual Ambulance Renewal**_____	____**$6,758**__
Other: **Initial CE Program**_____	____**$805**____
Other: **Renewal CE Program**_____	____**$487**____
Other: **Renewal EMT-P Program**_____	____**$1,203**__

Other: **Renewal EMT Program_____**	**____$879____**
Other: **Critical Care Paramedic Endorsement_____**	**____$42_____**
Other: **Community Paramedic Accreditation_____**	**____$42____**
Other: **Lost/Duplicate Card_____**	**____$25____**
Other: **Professional Verification Form_____**	**____$25____**
Other: **Initial Community Paramedic Provider_____**	**____$200,000**
Other: **Renewal Community Paramedic Provider_____**	**____$100,000**
Other: **Event Medical Plan Review 1 to 999 Persons__**	**____$50_____**
Other: **Event Medical Plan Review 1,000 to 4,999 Persons__**	**____$150____**
Other: **Event Medical Plan Review 5,000 to 9,999 Persons__**	**____$500____**
Other: **Event Medical Plan Review 10,000 Persons or more__**	**____$1,000__**

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT (est. FY24-25)	TOTAL W/ BENEFITS (est. FY24-25)	COMMENTS
EMS Director	0933 Manager V	1.0	$224,914	$299,075	Andrew Holcomb
EMS Agency Medical Director	2233 Supervising Physician Specialist	1.0	n/a	n/a	Dr. John Brown (ret.) Q1 2024, Vacant as of Q3 2024, Interim Medical Director Dr. Andi Tenner (DPH funded)
EMS Deputy Director (Operations)	0923 Manager II	1.0	$180,166	$246,786	Kayleigh Hillcoat
EMS Deputy Director (QI)	0931 Manager III	1.0	$194,282	$263,282	Elaina Gunn
EMS Specialist (Operations)	2533 EMS Specialist	1.0	$159,807	$215,629	Sal Serrian
EMS Specialist (QI)	2533 EMS Specialist	1.0	$159,807	$215,629	Vacant as of July 1, 2024
EMS Specialist (Training)	2533 EMS Specialist	1.0	$159,807	$215,629	Ron Pike
EMS Specialist (Special Projects/QI)	2533 EMS Specialist	1.0	$159,807	$215,629	Leo Ishoda
EMS Specialist (Specialty Care)	2533 EMS Specialist	1.0	$159,807	$215,629	Gino Cifolelli
Info and Guidance	2593 Health Program Coordinator III	1.0	$144,010	$196,667	Erin Bachus
Epidemiologist	2803 Epidemiologist II	0.5	n/a	n/a	Will Godwin (DPH workorder)
Certification Specialist	8601 Emer. Services Coordinator I	1.0	$104,332	$148,183	Somersby Jenkins
Admin/Certification Specialist	1446 Secretary II	1.0	$96,487	$137,918	Camilla Arcia
EMS Disaster Medicine Fellow	n/a	*contract	n/a	n/a	Funded via $100,000 contract with UCSF

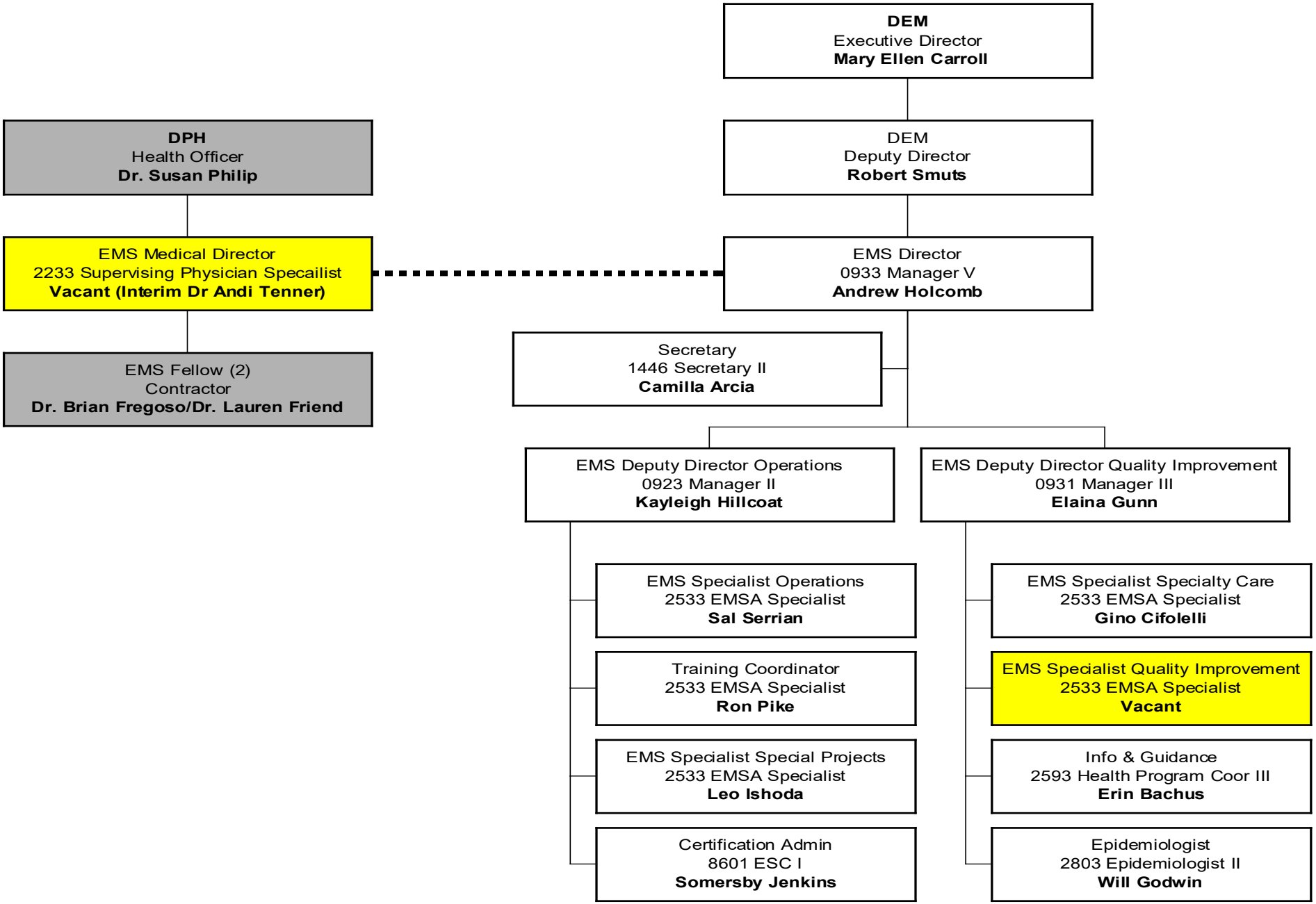

DEM
Executive Director
Mary Ellen Carroll
DPH
Health Officer
Dr. Susan Philip
DEM
Deputy Director
Robert Smuts
EMS Medical Director
2233 Supervising Physician Specailist
Vacant (Interim Dr Andi Tenner)
EMS Director
0933 Manager V
Andrew Holcomb
EMS Fellow (2)
Contractor
Dr. Brian Fregoso/Dr. Lauren Friend
Secretary
1446 Secretary II
Camilla Arcia
EMS Deputy Director Operations
0923 Manager II
Kayleigh Hillcoat
EMS Deputy Director Quality Improvement
0931 Manager III
Elaina Gunn
EMS Specialist Operations
2533 EMSA Specialist
Sal Serrian
EMS Specialist Specialty Care
2533 EMSA Specialist
Gino Cifolelli
Training Coordinator
2533 EMSA Specialist
Ron Pike
EMS Specialist Quality Improvement
2533 EMSA Specialist
Vacant
EMS Specialist Special Projects
2533 EMSA Specialist
Leo Ishoda
Info & Guidance
2593 Health Program Coor III
Erin Bachus
Certification Admin
8601 ESC I
Somersby Jenkins
Epidemiologist
2803 Epidemiologist II
Will Godwin

TABLE 3: STAFFING/TRAINING

Reporting Year: **2023**

NOTE: Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN
Total Certified	**2130**	**0**	**582**	**0**
Number newly certified this year	**223**	**0**	**42**	**0**
Number recertified this year	**898**	**0**	**542**	**0**
Total number of accredited personnel on July 1 of the reporting year	**2125**	**0**	**578**	**0**
Number of certification reviews resulting in (only AB2293 data):				
a) formal investigations	**15**			
b) probation	**2**			
c) suspensions	**0**			
d) revocations	**0**			
e) denials	**0**			
f) denials of renewal	**0**			
g) no action taken	**13**			

1. Early defibrillation:
   a) Number of EMT-I (defib) authorized to use AEDs **2130**
   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: **_2023**_____

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: **2023**_____

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%)	**00:06:23**	**n/a**	**n/a**	**00:06:23**
Early defibrillation responder (SF standard 4 min, 30 sec 90th%)	**00:06:23**	**n/a**	**n/a**	**00:06:23**
Advanced life support responder (SF standard 7 min 90th%)	**00:07:14**	**n/a**	**n/a**	**00:07:14**
Transport Ambulance (Code 3 SF standard 10 min 90th%) (Code 2 SF standard 20 min 90th%)	**00:11:08** **00:21:03**	**n/a**	**n/a**	**00:11:08** **00:21:03**

Public Facing Dashboard https://www.sf.gov/data/response-times-911-calls

TABLE 6: SYSTEM RESOURCES AND OPERATIONS
Facilities/Critical Care

Reporting Year: **2023**

NOTE: Table 6 is to be reported by agency.

Trauma

Trauma patients (includes both SF and SM County):	
1. Number of patients meeting trauma triage criteria	**2,436**
2. Number of major trauma victims transported directly to a trauma center by ambulance	**2,037**
3. Number of major trauma patients transferred to a trauma center	**237**
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	**10**
2. Number of base hospitals with written agreements	**1**

TABLE 7: DISASTER MEDICAL

Reporting Year: **2023**_____

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? **x** Yes ☐ 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: 30

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:	**If Public:**	**If Public:**	**If Air:**	**Air Classification:**
x Public ❒ Private	x Fire ❒ Law ❒ Other Explain: _____	x City x County ❒ State ❒ Fire District ❒ Federal	❒ Rotary ❒ Fixed Wing	❒ Auxiliary Rescue ❒ Air Ambulance ❒ ALS Rescue ❒ BLS Rescue

Transporting Agencies

117,293	Total number of responses	**64,769**	Total number of transports
64,179	Number of emergency responses	**5,691**	Number of emergency transports
53,114	Number of non-emergency responses	**59,078**	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: 47

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 Non-Transport	x ALS x 9-1-1 x Ground x BLS x 7-Digit ❑ Air x CCT ❑ Water x IFT
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

24,724	Total number of responses	**16,918**	Total number of transports
4,593	Number of emergency responses	**2,816**	Number of emergency transports
20,131	Number of non-emergency responses	**14,102**	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: 13

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 x 9-1-1 x Ground x BLS x 7-Digit ❑ Air ❑ CCT ❑ Water x IFT
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

18,478	Total number of responses	**10,765**	Total number of transports
8,695	Number of emergency responses	**1,476**	Number of emergency transports
9,783	Number of non-emergency responses	**9,289**	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: 5

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

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

926	Total number of responses	**563**	Total number of transports
280	Number of emergency responses	**197**	Number of emergency transports
646	Number of non-emergency responses	**366**	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: 32

Phone Number: 707-665-4280

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 12

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:	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

8,442	Total number of responses	**7178**	Total number of transports
429	Number of emergency responses	**249**	Number of emergency transports
0	Number of non-emergency responses	**6,749**	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: 22

Phone Number: 833-769-2599

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 17

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:	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

10,732	Total number of responses	**10,221**	Total number of transports
33	Number of emergency responses	**27**	Number of emergency transports
10,699	Number of non-emergency responses	**10,194**	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:**
x Yes ❒ 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

[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:**
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]	**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:**
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	❒ 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:**
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:**
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:**
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]	**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:**
❒ 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:**
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:**
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:**
x Yes ❒ 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:**
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:**
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:**
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: **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:**
x Yes ❒ 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		
EDAP[2]	❒ Yes **x** No		
PICU[3]	❒ Yes **x** No	❒ Yes **x** No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes **x** No	❒ Yes **x** No

**Transitioned to Triage to Alternate Destination in 2023 pursuant to AB 1544.*

[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: 2023**

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**

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:	**126**
Expiration Date:	**10/31/27**

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: 2023**

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**

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:	
Continuing Education:	**88**
Expiration Date:	**01/30/28**

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: 2023**

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: **$550**
Refresher: **n/a**

Number of students completing training per year:
Initial training: **109**
Refresher: **10**
Continuing Education: **n/a**
Expiration Date: **01/30/28**

Number of courses:
Initial training: **5**
Refresher: **1**
Continuing Education: **n/a**

*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: 2023**

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: **$4,500**
Refresher: **n/a**

Number of students completing training per year:
Initial training: **25**
Refresher: **n/a**
Continuing Education: **n/a**
Expiration Date: **01/30/28**

Number of courses:
Initial training: **1**
Refresher: **n/a**
Continuing Education: **n/a**

*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: 2023**

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:	**4**
Expiration Date:	**06/30/24**

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: 2023**

NOTE: Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution: **Project Heartbeat** Telephone Number: **510-452-1100**

Address: **350 Amber Dr.**
San Francisco, CA 94131

Student Eligibility*: **Law Enforcement**

Program Level **EMT-B

Cost of Program:
Basic: **n/a**
Refresher: **n/a**

Number of students completing training per year:
Initial training: **43**
Refresher: **n/a**
Continuing Education: **n/a**
Expiration Date: **03/31/27**

Number of courses:
Initial training: **2**
Refresher: **n/a**
Continuing Education: **n/a**

*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: 2023**

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**

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:	**n/a**
Expiration Date:	**12/31/25**

Number of courses:

Initial training:	**n/a**
Refresher:	**n/a**
Continuing Education:	**n/a**

*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: 2023**

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:	**417**
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 10: APPROVED TRAINING PROGRAMS

County: San Francisco **Reporting Year: 2023**

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 only**

Cost of Program:
Basic: **n/a**
Refresher: **n/a**

Program Level **Continuing Education

Number of students completing training per year:

CP Initial training:	**10**
Refresher:	**n/a**
Continuing Education:	**2,653**
Expiration Date:	**08/31/27**

Number of courses:

Initial training:	**1**
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: 2023**

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: **n/a**
Expiration Date: **02/28/26**

Number of courses:
Initial training: **n/a**
Refresher: **n/a**
Continuing Education: **n/a**

*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: 2023**

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:

__**167**_ 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, BLS, Interfacility Transfer)
- Norcal Ambulance (BLS, Interfacility Transfer)
- Royal Ambulance (ALS, 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 EMS Plan Submission 2024						
Tracking #	**Title**	**Description**	**Status**	**Estimate Completion Date**	**SFEMSA Division**	**2024 Plan Update**
FY24-1	Hiring Vacant Positions	As of July 1, 2024, San Francisco EMSA has two open vacancies. Both positions were filled in 2023, but need to be re-filled. SF EMSA was fully staffed for roughly 8 months in late 2023/early 2024.	Started	End of 2024	Executive	Estimated completion EOY 2024
FY24-2	Hospital MOUs	All San Francisco MOUs are complete. Outstanding are two out of county hospitals.	In Progress	End of 2024	Executive	2 out of county hospitals remaining.
FY24-3	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	Mid-2025	Operations	Mid-phase in procurement. Implementation phase expected in Fall 2024.
FY24-4	Public-facing Data and Dashboards	SFEMSA is consolidating data into dashboards for both external and internal-facing review of key EMS system metrics. Phase 1 is complete and Phase 2 is underway.	In Progress	Ongoing	Operations	Ongoing
FY24-5	Patient Offload and Diversion Improvement	Patient offload impacts and diversion have been a major focus with workgroups, recommendations, and policy development. This work is far from resolved or complete, but have been working continuously with key partners.	In Progress	Ongoing	Quality Improvement	Ongoing
FY24-6	BLS Pilot Program	SFEMSA would like to continue 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	Ongoing	Operations	Ongoing, continued evaluation.
FY24-7	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 2024	Quality Improvement	Expected completion EOY 2024. One hospital system is outstanding.
FY24-8	Develop AED Program and CPR Community Initiatives	SFEMSA launched PulsePoint in May 2022. SFEMSA is in process of building out communuity partnerships and initiatives.	In Progress	Ongoing	Operations	Ongoing with goal of one event per month.

SECTION II - Data

1/1/2019 12/31/2023

Year

All

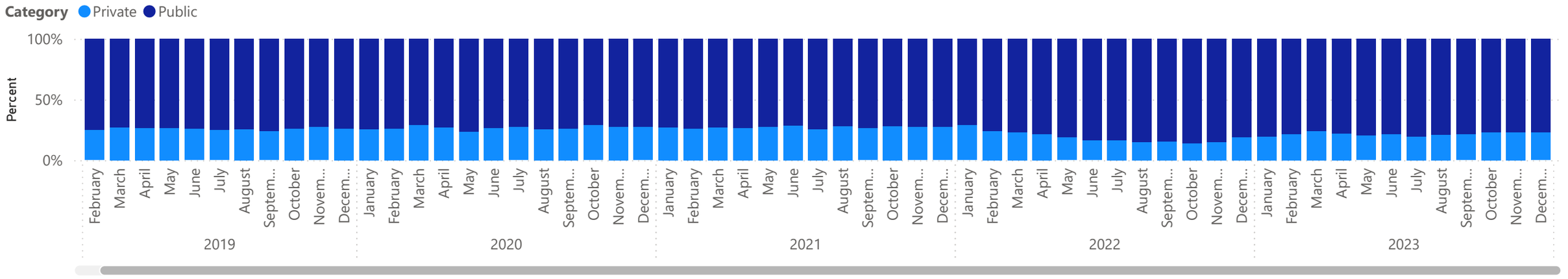
San Francisco EMS Call Share

Excludes responses to fire scenes

76.0%
Public

24.0%
Private

Call Share Public vs Private



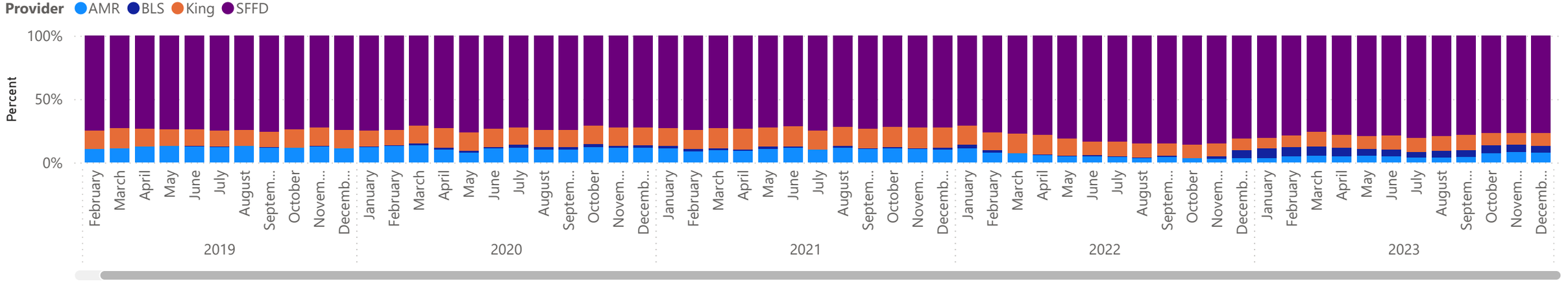
76.0%
SFFD

13.0%
King

8.8%
AMR

2.2%
BLS

Call Share by Provider



1/1/2023 12/31/2023

Year

All

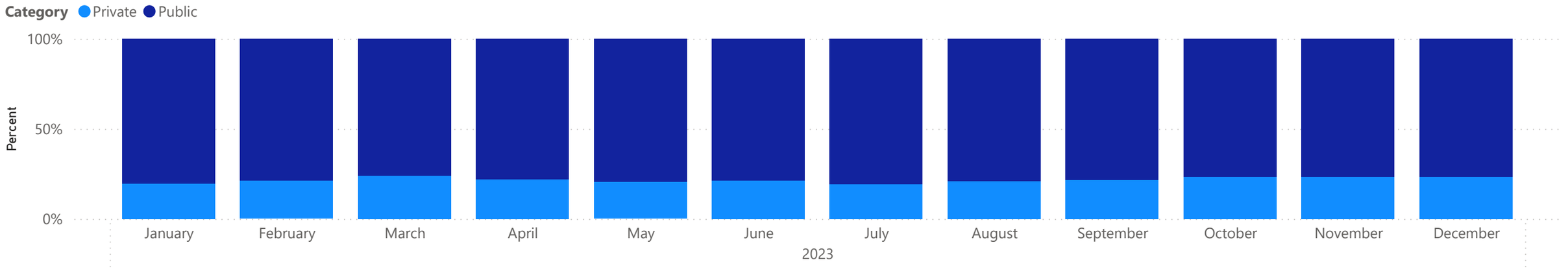
San Francisco EMS Call Share

Excludes responses to fire scenes

78.3%
Public

21.7%
Private

Call Share Public vs Private



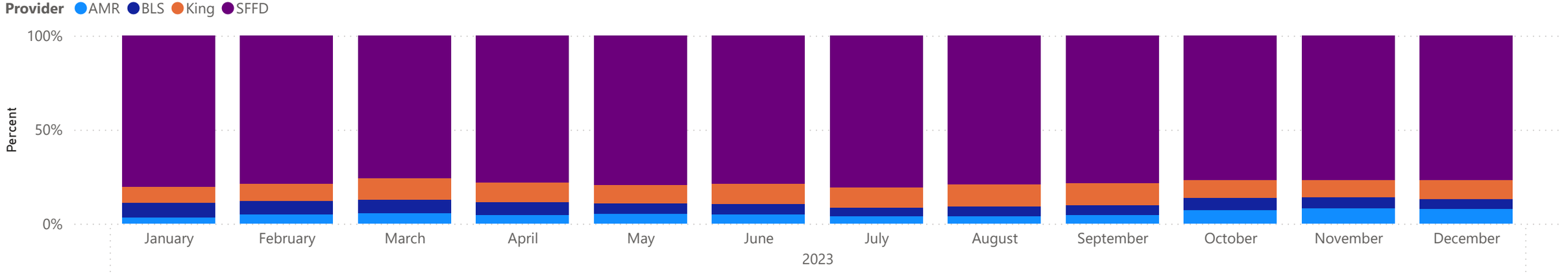
78.3%
SFFD

10.3%
King

5.4%
AMR

6.1%
BLS

Call Share by Provider



Response Times to Medical Incidents for BLS First Response Vehicles

• Includes engines, trucks, rescue squads, QRVs, and RCs

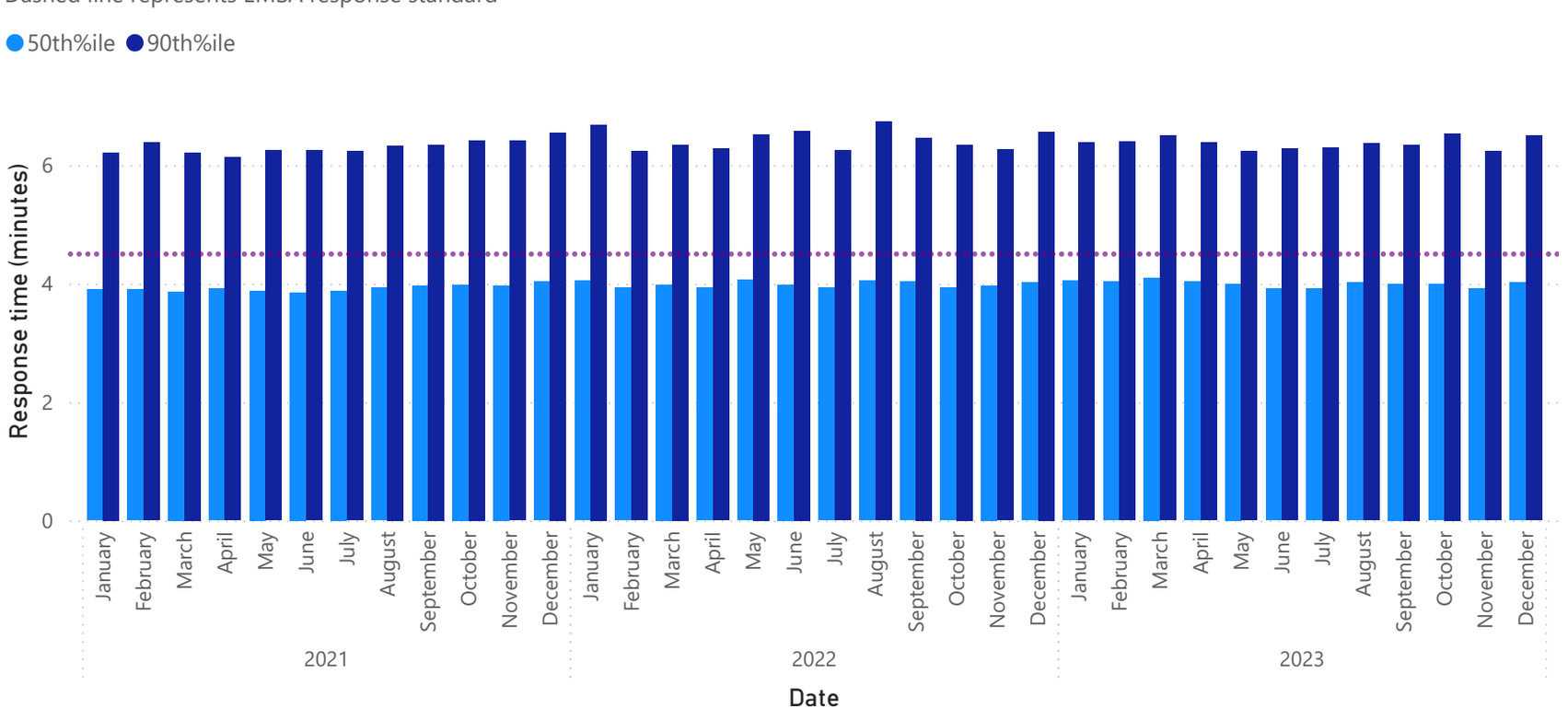
Data through: **07/08/2024**

Date

1/1/2021 12/31/2023

Response Time

Dashed line represents EMSA response standard



Year/Month	Total calls	90th%ile	OTP
2021	**55016**	**6.33**	**66%**
2022	**60295**	**6.45**	**64%**
2023	**65912**	**6.38**	**64%**
January	5321	6.38	63%
February	5001	6.40	63%
March	5509	6.50	61%
April	5440	6.38	63%
May	5409	6.23	63%
June	5379	6.28	66%
July	5338	6.30	66%
August	5747	6.37	64%
September	5757	6.35	64%
October	5972	6.53	63%
November	5303	6.23	66%
December	5736	6.50	62%
Total	**181223**	**6.38**	**64%**

Effective *September 1, 2011,* Prehospital Provider Standards mandate that responders capable of performing **Basic Life Support** and Defibrillation are **on scene of all presumptively defined life-threatening emergencies within 4 minutes and 30 seconds, 90 percent of the time** as measured each month within the Emergency Response Districts.

Response Times to Medical Incidents for ALS First Response Vehicles

• Includes engines, trucks, rescue squads, QRVs, and RCs

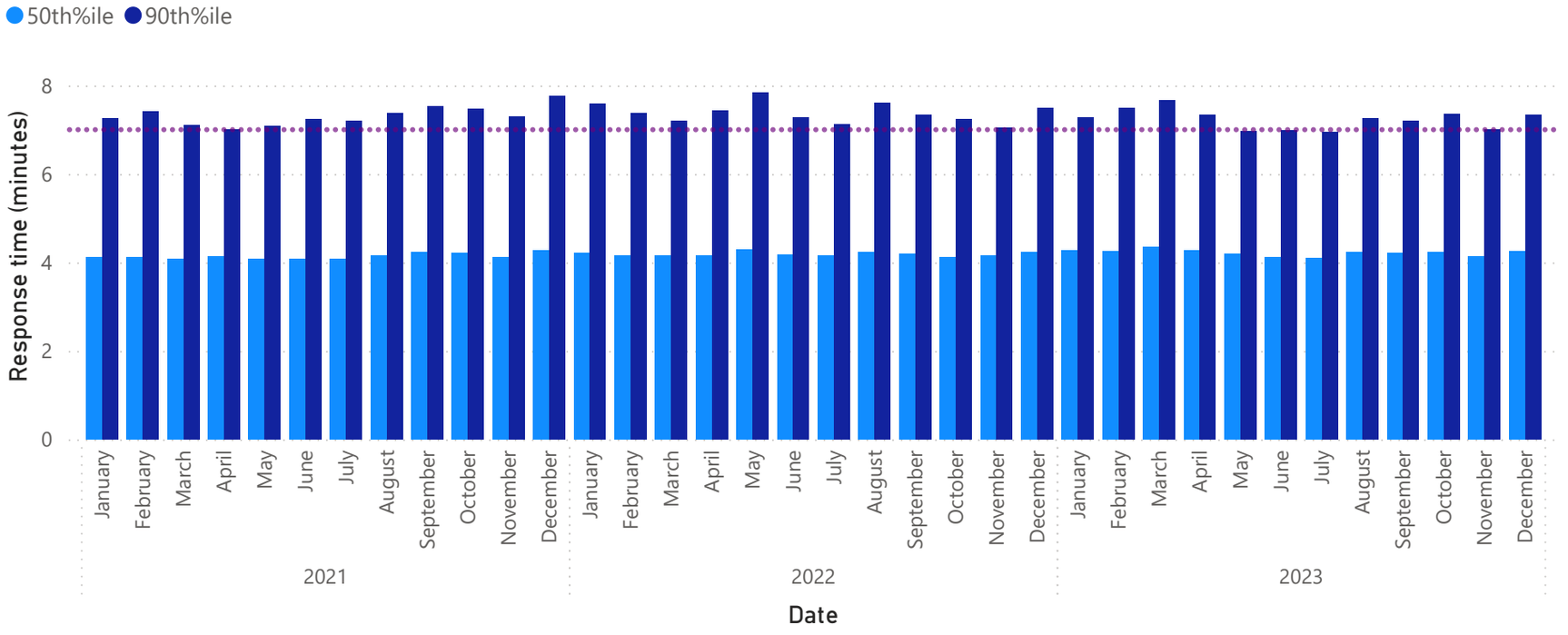
Data through: **07/08/2024**

Date

1/1/2021 12/31/2023

Response Time

Dashed line represents EMSA response standard



Year/Month	Total calls	90th%ile	OTP
2021	**54289**	**7.33**	**89%**
2022	**59514**	**7.37**	**88%**
2023	**64950**	**7.23**	**89%**
January	5263	7.28	89%
February	4928	7.48	88%
March	5442	7.67	87%
April	5363	7.34	89%
May	5323	6.97	90%
June	5307	6.98	90%
July	5257	6.95	90%
August	5666	7.27	89%
September	5649	7.20	89%
October	5879	7.35	88%
November	5222	7.02	90%
December	5651	7.33	88%
Total	**178753**	**7.30**	**89%**

Policy Standard: ALS first response vehicles arrive on the scene **within 7 minutes** of dispatch, 90% of the time.

Response Times to Medical Incidents for Ambulances

• Includes ALS and BLS vehicles

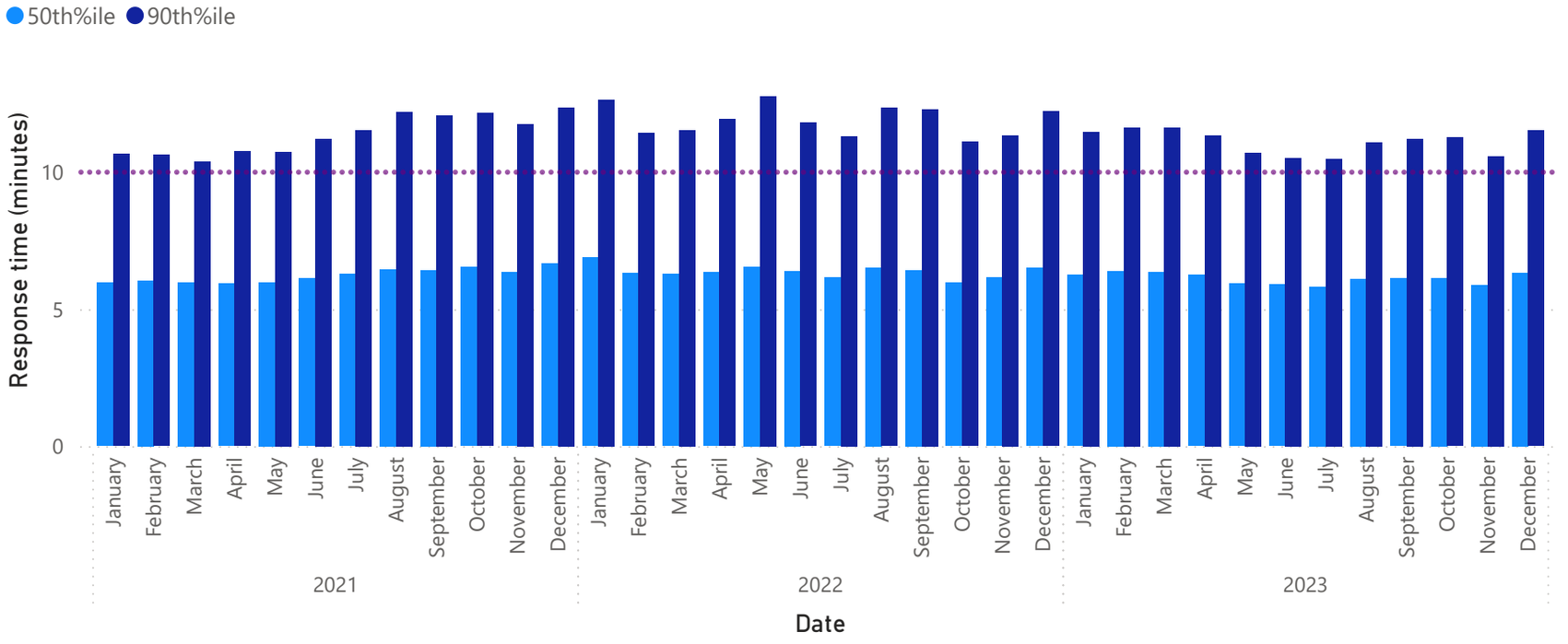
Data through: **07/08/2024**

Date

1/1/2021 12/31/2023

Response Time: Code 3

Dashed line represents EMSA response standard



Year/Month	Total calls	90th%ile	OTP
2021	**50290**	**11.43**	**85%**
2022	**54607**	**11.90**	**83%**
2023	**59337**	**11.13**	**86%**
January	4908	11.47	84%
February	4527	11.64	83%
March	5014	11.63	83%
April	4895	11.35	85%
May	4853	10.72	87%
June	4817	10.52	88%
July	4864	10.48	88%
August	5113	11.08	86%
September	5109	11.22	86%
October	5291	11.26	85%
November	4787	10.58	88%
December	5159	11.52	84%
Total	**164234**	**11.48**	**84%**

Policy Standard: Ambulances responding to Code 3 calls arrive on the scene **within 10 minutes** of dispatch, 90% of the time.

Response Times to Medical Incidents for Ambulances

• Includes ALS and BLS vehicles

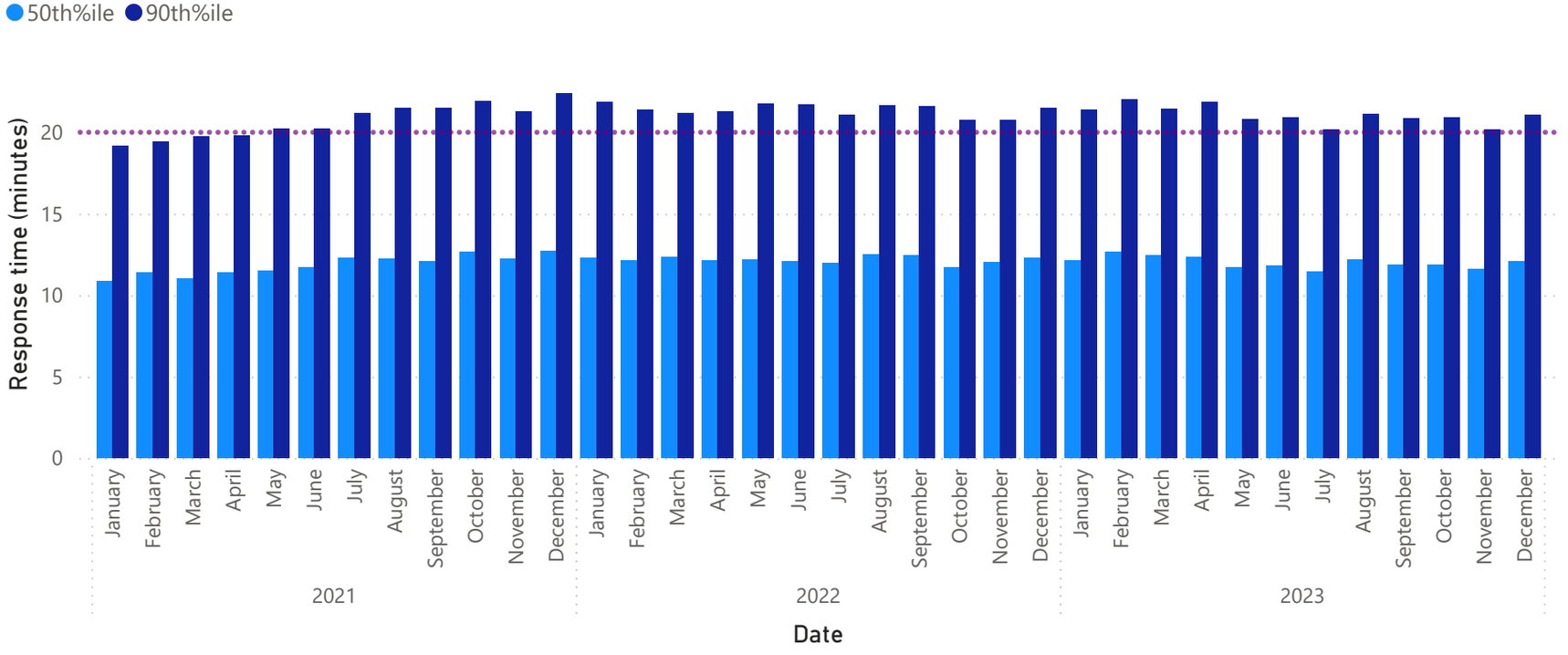
Data through: **07/08/2024**

Date

1/1/2021 12/31/2023

Response Time: Code 2

Dashed line represents EMSA response standard



Year/Month	Total calls	90th%ile	OTP
2021	**46863**	**20.75**	**88%**
2022	**51254**	**21.35**	**87%**
2023	**48117**	**21.05**	**87%**
January	4454	21.38	87%
February	4112	22.00	85%
March	4514	21.45	86%
April	4291	21.86	86%
May	3826	20.82	88%
June	3840	20.90	88%
July	3967	20.19	90%
August	3934	21.12	87%
September	3851	20.88	88%
October	3830	20.92	88%
November	3620	20.15	90%
December	3878	21.08	88%
Total	**146234**	**21.07**	**87%**

Policy Standard: Ambulances responding to Code 2 calls arrive on the scene **within 10 minutes** of dispatch, 90% of the time.

Hospital EMS Report - Diversion, Suspension & Trauma Override

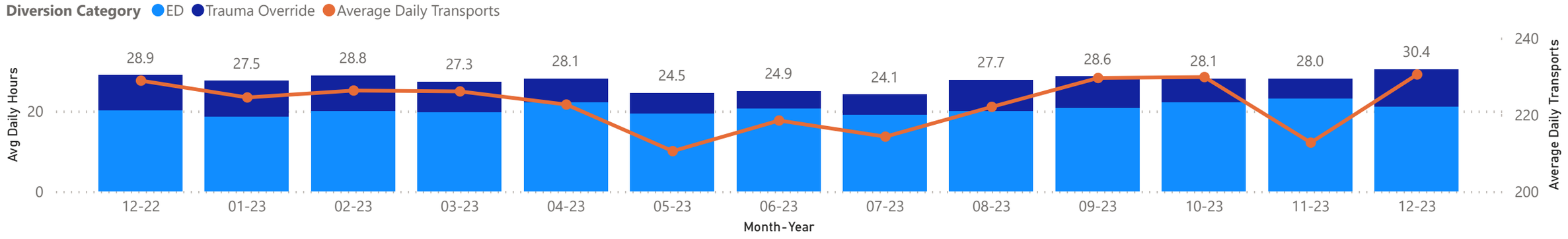
Percentage of hours in each month that a hospital was on Diversion. For ZSFG, this also includes Trauma Override. (+/- 1%)

Destination	12-22	01-23	02-23	03-23	04-23	05-23	06-23	07-23	08-23	09-23	10-23	11-23	12-23
Chinese	0.8%		0.2%	0.0%		0.2%	0.8%	0.0%	0.3%	1.6%	1.3%	0.4%	0.4%
CPMC-Bernal	1.7%	1.7%	1.2%	1.0%	3.6%	2.7%	2.9%	4.1%	2.0%	3.2%	5.2%	4.2%	2.8%
CPMC-Davies	1.8%	0.6%	1.1%	2.4%	1.1%	1.1%	3.3%	3.3%	1.3%	1.7%	3.0%	1.7%	2.0%
CPMC-Van Ness	12.2%	11.4%	18.3%	17.9%	14.3%	24.9%	17.3%	18.9%	20.8%	14.7%	13.8%	21.8%	19.1%
Kaiser SF	8.5%	12.8%	12.4%	12.2%	14.1%	12.9%	11.7%	9.7%	16.8%	13.1%	14.8%	16.4%	10.9%
St. Francis	1.4%	1.0%	0.4%	0.3%	0.3%	0.9%	0.7%	0.4%	0.0%	0.8%	1.0%	2.1%	1.4%
St. Marys	10.8%	7.3%	9.0%	9.6%	8.2%	1.8%	3.6%	1.0%	3.0%	3.5%	2.2%	2.5%	2.6%
UCSF Parnassus	24.4%	26.9%	31.4%	25.6%	26.2%	19.9%	25.6%	22.1%	19.3%	20.0%	29.7%	24.6%	26.4%
VA	0.7%	1.5%	1.1%	1.6%	1.9%	0.3%	0.4%	0.0%	0.2%	0.3%	0.6%	0.6%	1.4%
ZSFG	58.2%	51.4%	45.2%	43.1%	47.5%	37.4%	37.6%	40.8%	51.8%	60.5%	45.7%	42.7%	59.6%

Percentage of hours in each month that Diversion was suspended (4 hospitals on Diversion simultaneously). (+/- 1%)

Measure	12-22	01-23	02-23	03-23	04-23	05-23	06-23	07-23	08-23	09-23	10-23	11-23	12-23
Diversion Suspended	49.4%	54.7%	57.4%	46.8%	33.5%	32.5%	23.3%	31.4%	42.2%	40.9%	32.5%	29.6%	50.3%

Average daily diversion hours by month (left y-axis) is compared with average daily transports by month (right y-axis).



Hospital EMS Report - EMS Transports

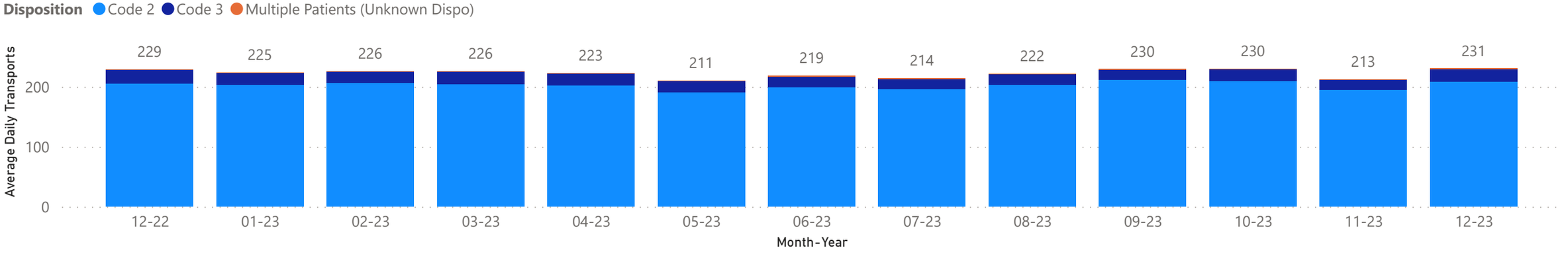
Total ambulance transports by month. Does not include IFT or other non-911 transports.

Destination	12-22	01-23	02-23	03-23	04-23	05-23	06-23	07-23	08-23	09-23	10-23	11-23	12-23	Total
Chinese	167	142	143	155	124	130	130	120	132	141	145	141	157	**1827**
CPMC-Bernal	759	775	697	782	740	688	700	693	786	791	777	689	839	**9716**
CPMC-Davies	379	381	352	379	378	323	337	349	378	375	427	346	420	**4824**
CPMC-Van Ness	1019	1027	874	948	982	832	886	923	945	994	1055	892	1072	**12449**
Kaiser SF	682	675	586	644	558	591	538	565	595	582	579	549	603	**7747**
Kaiser South SF	47	45	58	54	66	48	64	21	23	69	45	35	48	**623**
Seton	110	90	93	109	78	67	80	87	104	124	96	77	114	**1229**
St. Francis	1021	978	919	978	884	898	902	953	972	964	981	886	1014	**12350**
St. Marys	570	563	507	565	500	497	526	517	575	543	626	534	669	**7192**
UCSF Mission Bay	129	104	96	115	99	88	88	85	105	117	116	105	90	**1337**
UCSF Parnassus	889	829	725	850	845	815	807	831	923	905	860	822	890	**10991**
VA	124	104	95	97	98	104	108	105	85	75	110	76	76	**1257**
ZSFG	1131	1199	1149	1283	1272	1401	1301	1345	1210	1159	1241	1174	1102	**15967**
Total	**7027**	**6912**	**6294**	**6959**	**6624**	**6482**	**6467**	**6594**	**6833**	**6839**	**7058**	**6326**	**7094**	**87509**

Total Transport Volume: Change Since Previous Month

12.0%

Average Daily Transports by Month-Year and Disposition (All Destinations)



Hospital EMS Report - Ambulance Patient Offload Time (APOT-1)

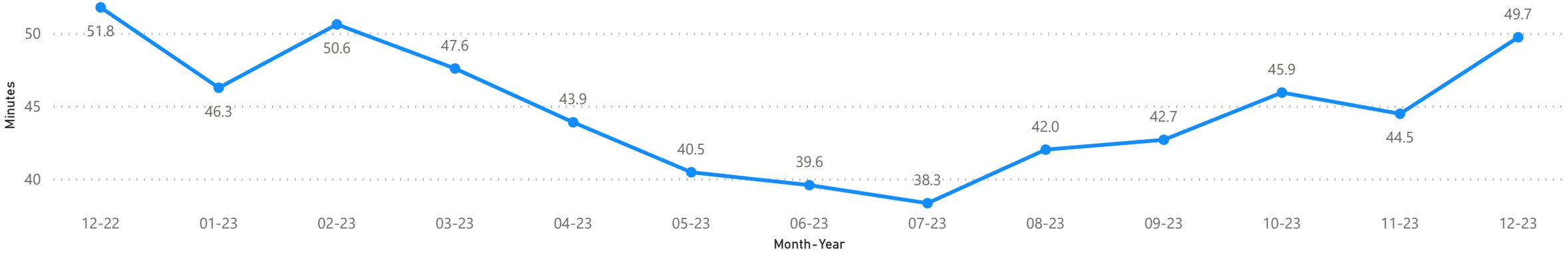
90th percentile APOT-1 times per month. APOT-1 is the interval between arrival at-hospital and transfer of patient care to Emergency Department staff, and is computed using standardized specifications outlined by the California EMS Authority.

Destination	12-22	01-23	02-23	03-23	04-23	05-23	06-23	07-23	08-23	09-23	10-23	11-23	12-23	Past Year
Chinese	23.4	22.1	27.2	22.9	25.6	24.8	23.0	23.5	24.8	22.9	24.9	29.1	30.6	**24.9**
CPMC-Bernal	54.9	50.0	48.9	48.2	53.2	42.9	41.5	45.5	41.6	41.9	57.0	54.9	53.3	**48.7**
CPMC-Davies	49.7	44.1	58.8	57.2	35.2	40.0	35.7	39.7	33.2	36.1	39.3	35.1	45.1	**42.2**
CPMC-Van Ness	64.0	52.5	72.5	60.1	45.1	54.7	42.5	45.0	59.0	52.4	53.6	56.0	56.4	**54.7**
Kaiser SF	40.3	44.5	47.1	52.6	54.6	48.0	42.0	42.0	63.6	50.9	54.1	50.1	67.0	**50.2**
St. Francis	34.5	34.8	35.6	33.8	31.7	29.9	29.1	28.4	31.5	35.1	34.7	34.0	42.3	**33.7**
St. Marys	65.2	42.2	70.0	54.0	50.5	33.7	34.1	33.0	40.0	44.2	45.1	35.2	42.4	**44.2**
UCSF Mission Bay	26.8	25.2	26.4	26.0	28.1	24.3	23.3	30.1	19.9	21.4	28.5	20.7	27.4	**24.3**
UCSF Parnassus	63.7	62.0	68.6	55.6	48.3	44.9	50.8	46.3	48.6	47.6	49.1	54.4	63.6	**54.0**
VA	20.1	21.7	21.7	24.8	21.5	25.4	20.3	22.7	21.7	18.0	23.0	29.6	20.0	**22.0**
ZSFG	53.2	44.8	39.1	40.2	39.9	39.0	39.7	35.8	35.2	40.9	40.0	38.9	38.6	**40.2**
System-Wide	**51.8**	**46.3**	**50.6**	**47.6**	**43.9**	**40.5**	**39.6**	**38.3**	**42.0**	**42.7**	**45.9**	**44.5**	**49.7**	**45.0**

System-Wide 90th% APOT-1: Change Since Previous Month

11.8%

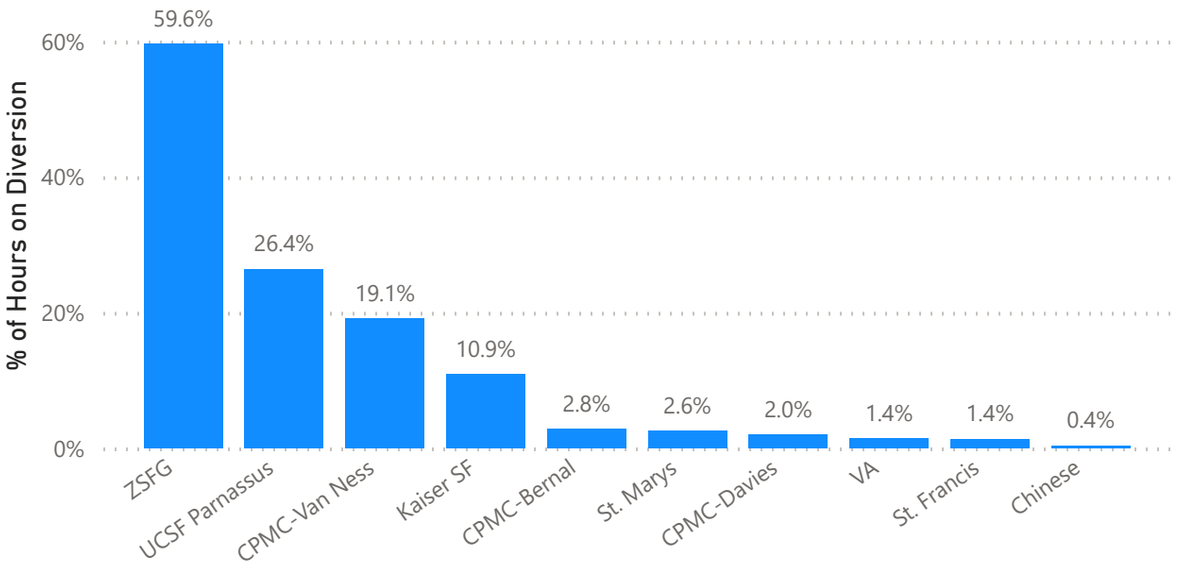
System-Wide 90th Percentile APOT-1



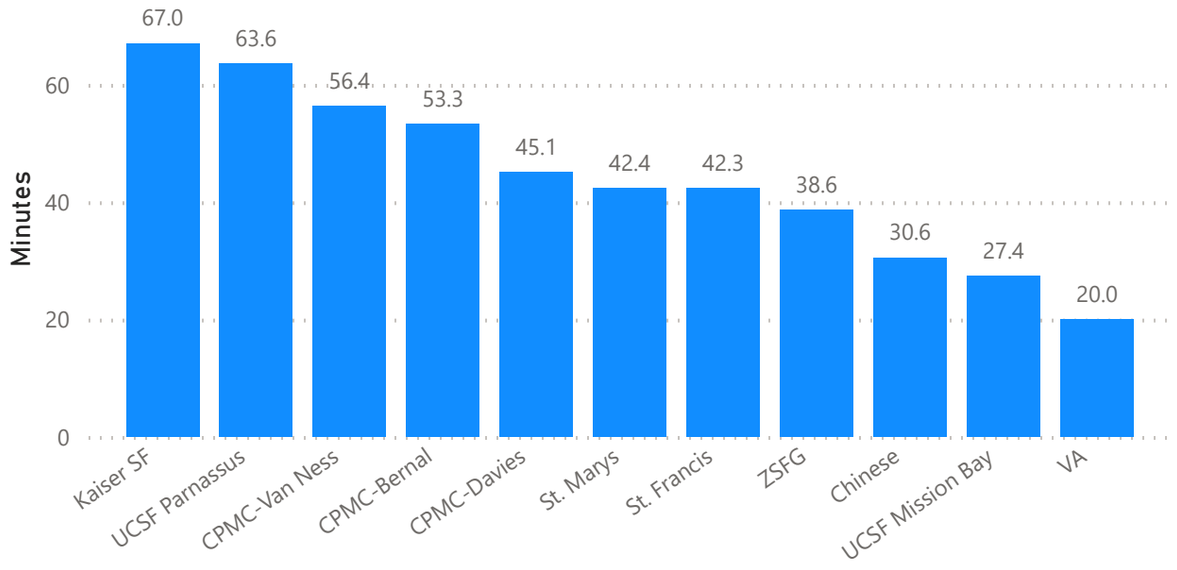
Hospital EMS Report - Current-Month Summary

The graphs on this page compare Diversion, APOT-1, and total EMS transport metrics for each of San Francisco's 10 adult-receiving hospitals during the most recent month covered in this report.

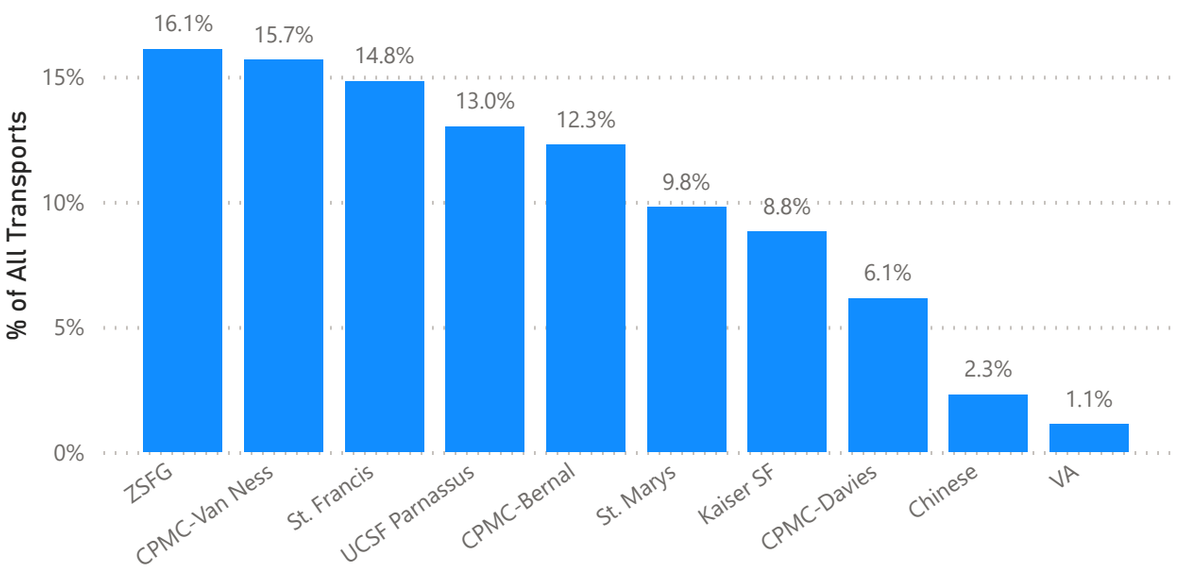
Percentage of Total Month Hours Spent on Diversion (or Trauma Override)



90th Percentile APOT-1 by Destination



Percentage of System-Wide Transports Received



Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St., Suite 210, San Francisco, CA 94103
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London Breed
Mayor

Mary Ellen Carroll
Executive Director

Date: July 9, 2024

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Interim Chief Medical Officer, EMS Authority
Tom McGinnis, Chief, EMS Systems Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2024 EMS Plan Annual Update – BLS Tier Pilot

The San Francisco EMS Agency (SFEMSA), as part of its 2022 EMS Plan Submission, instituted a 911 BLS Tier as Pilot Program for a 1-year period with existing EOA providers after increase in medic to follow events (ambulance availability), variability of call volume, and extended patient offload times. At the time, SFEMSA had a repeated and regular need for escalation to in-county BLS approval to support the EMS system and augment ALS response to 911 calls. The pilot officially started on November 11, 2022 to allow for a more proactive response to system needs.

While much work has been done to mitigate ambulance availability, ambulance offload times, variable call volume, and staffing, these challenges still exist. BLS support is a critical lifeline to the EMS System and ultimately patients who need emergency medical care. As SFEMSA's EMS Plan continues to be approved for exclusive 911 emergency response under emergency ambulance typing, SFEMSA is proposing continuing the pilot for the immediate future with regular reporting to the state through our annual EMS Plan.

Through evaluation and continuous improvement, SFEMSA and partners have developed some best practices for the BLS tier. Through this process, a few updates are planned including:

1. BLS response will continue to remain with EOA providers and for the immediate future a quantity of 4 EOA BLS ambulances at any given time will be allowed in the system for day-to-day operations. The quantity of BLS ambulances will be evaluated on a quarterly basis with 90 days notice of any changes of either an increase or decrease to support overall system metrics.
2. Should an EMS call surge occur, mutual aid escalation will include a new, additional step. BLS expansion above the day-to-day tier will be approved for EOA providers first followed by non-EOA providers. This time period is solely dependent on the needs of the EMS system. A pre-planned event a month in advance would have more time than an acute, immediate need in which this additional step may be simultaneous with both EOA and non-EOA providers to provide BLS support.

Specific to the BLS Tier, SFEMSA continues to review through quality improvement, system metrics, policy development and reported issues on a regular basis with partners. BLS response to calls is tracked with unique identifiers through dispatch. In addition, clarification memos are regularly reviewed and issued to the EMS System. 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. Overall, SFEMSA fully supports BLS utilization as healthy to the EMS System as BLS use provides critical experience to newer EMS Personnel and resiliency for both planned events and disaster response. The following dashboards include a snapshot of some of the metrics that are regularly reviewed from the pilot.

11/11/2022 12/31/2023

Year

All

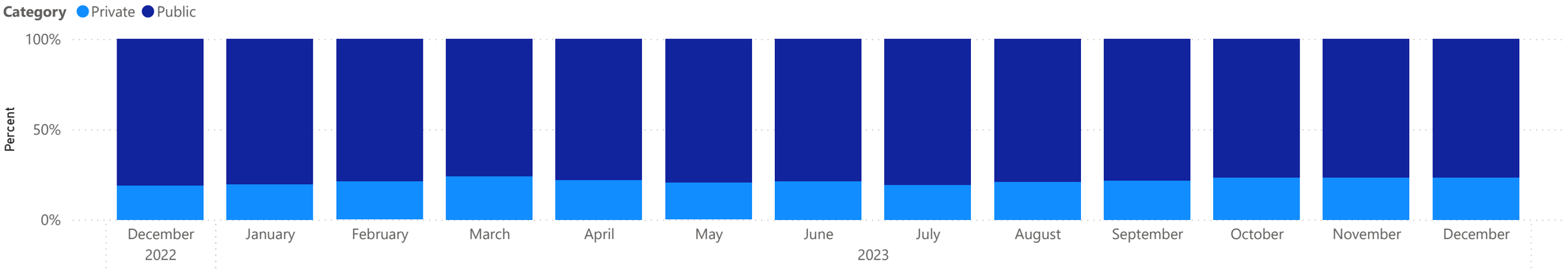
San Francisco EMS Call Share

Excludes responses to fire scenes

78.5%
Public

21.5%
Private

Call Share Public vs Private



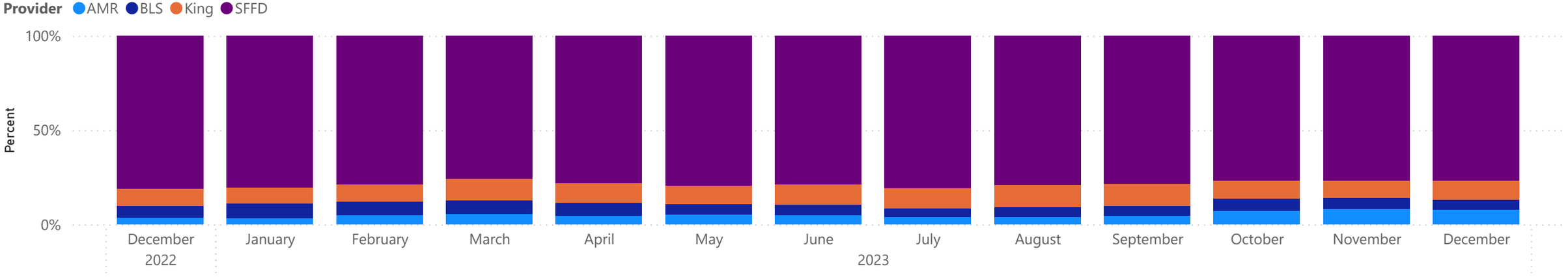
78.5%
SFFD

10.2%
King

5.2%
AMR

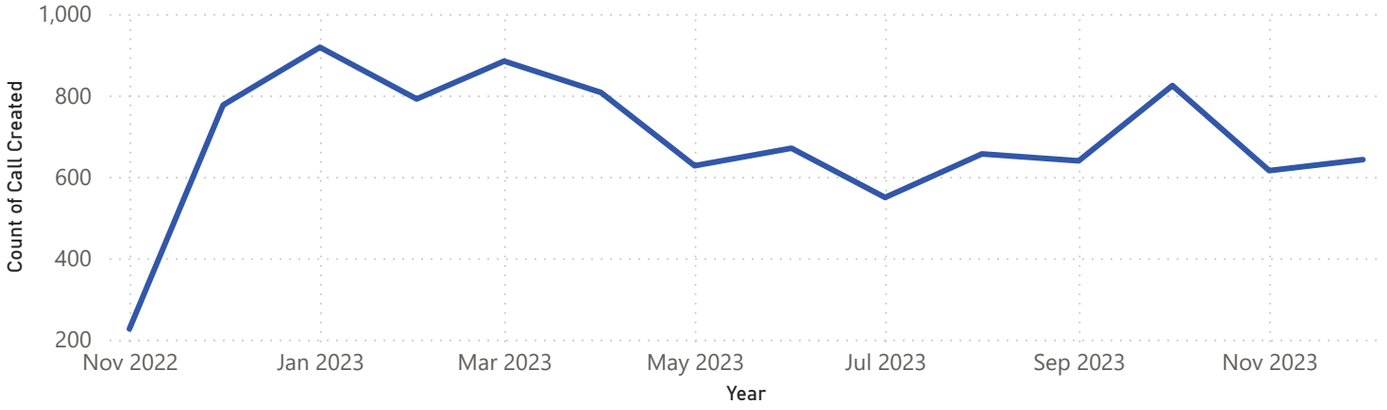
6.1%
BLS

Call Share by Provider

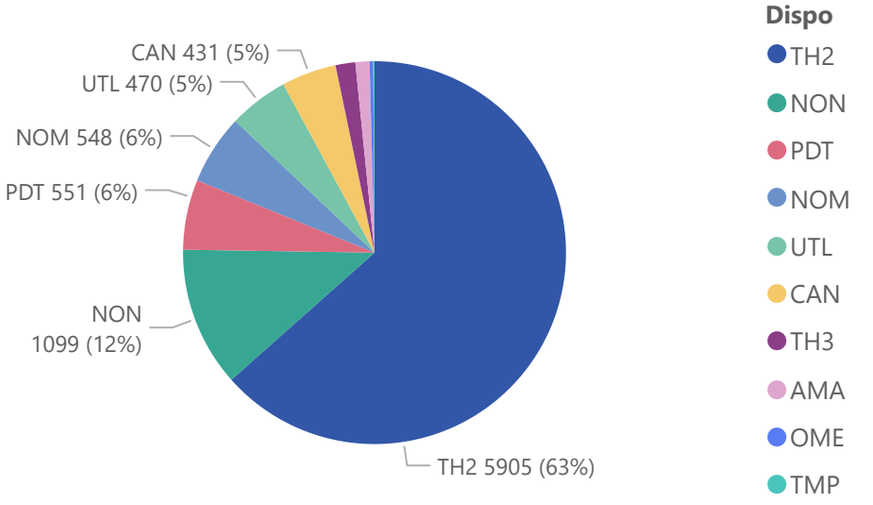


911 BLS Pilot Program - BLS Response

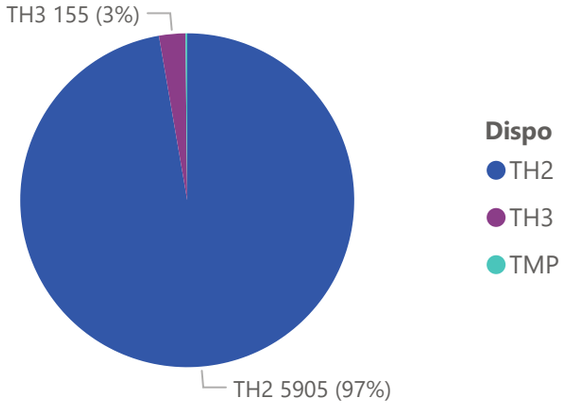
BLS Calls by Month



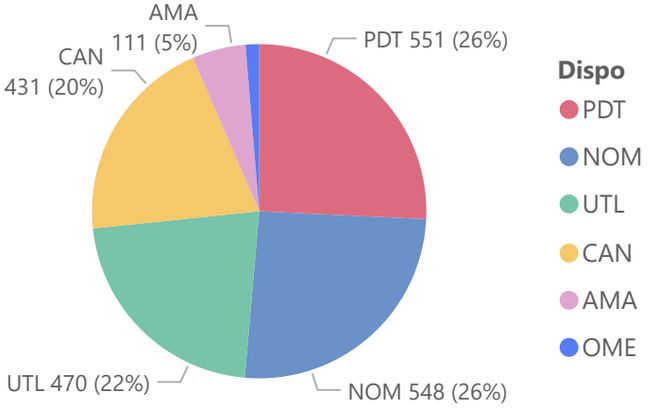
BLS All Dispositions



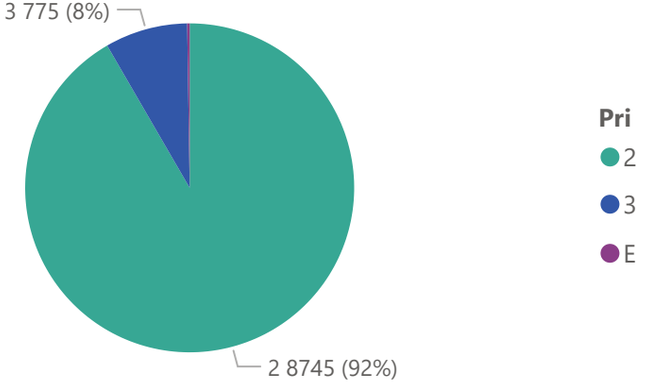
BLS Transports Disposition



BLS Non-Transport Disposition



BLS Dispatch Priority



23.2
Average Dispatches Per Day

14.7
Average Transports Per Day

63.1%
Transport Rate

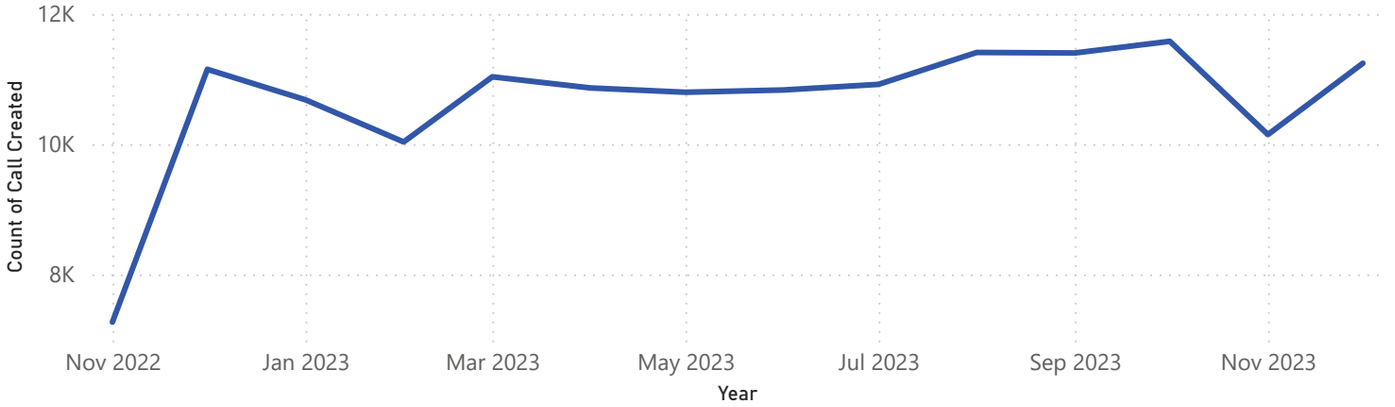
Date

Call Created

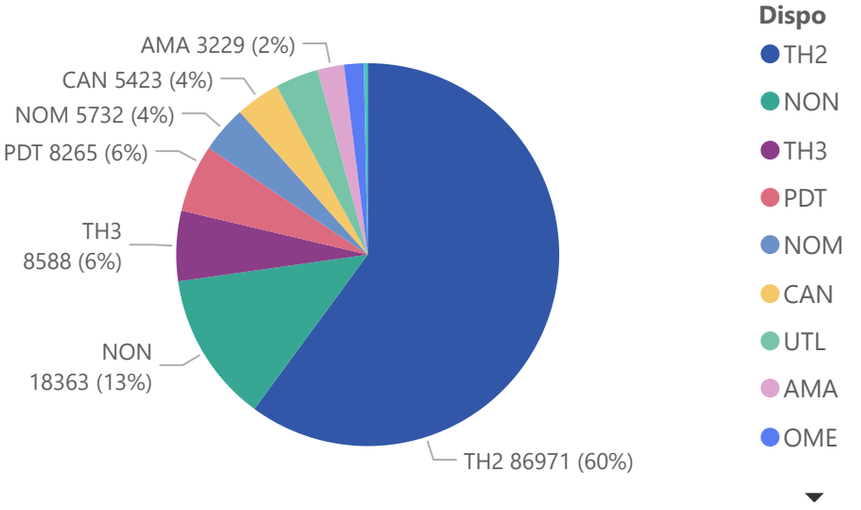
11/11/2022 — 12/31/2023

911 BLS Pilot Program - ALS Response

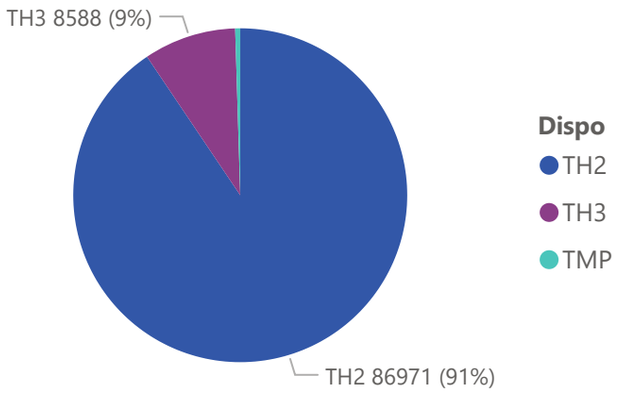
ALS Calls by Month



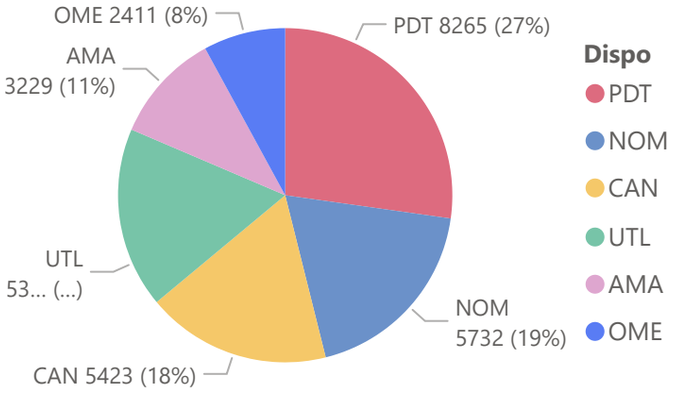
ALS All Dispositions



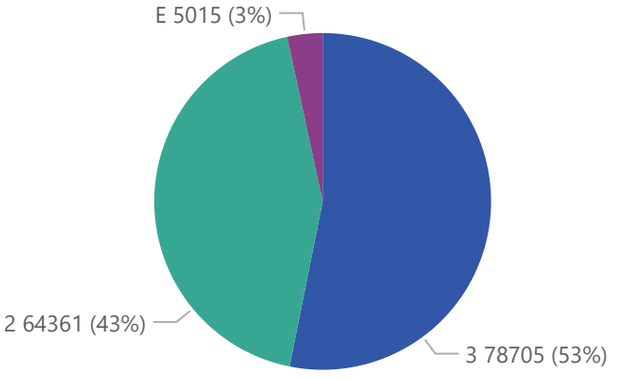
ALS Transports Disposition



ALS Non-Transport Disposition



ALS Dispatch Priority



359.0
Average Dispatches Per Day

230.8
Average Transports Per Day

64.3%
Transport Rate

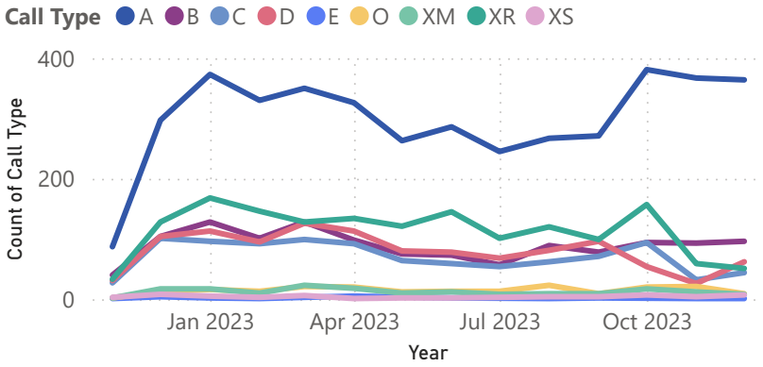
Date

Call Created

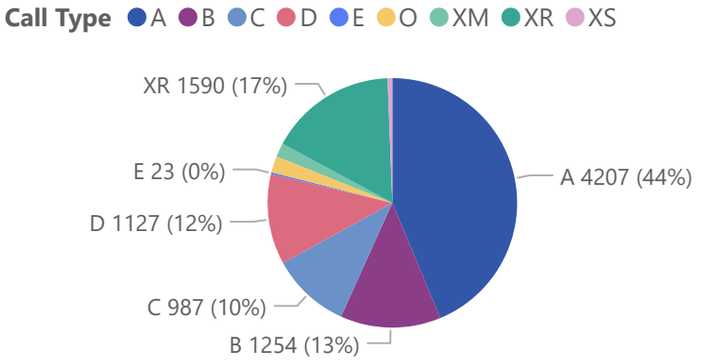
11/11/2022 12/31/2023

911 BLS Pilot Program - Call Types

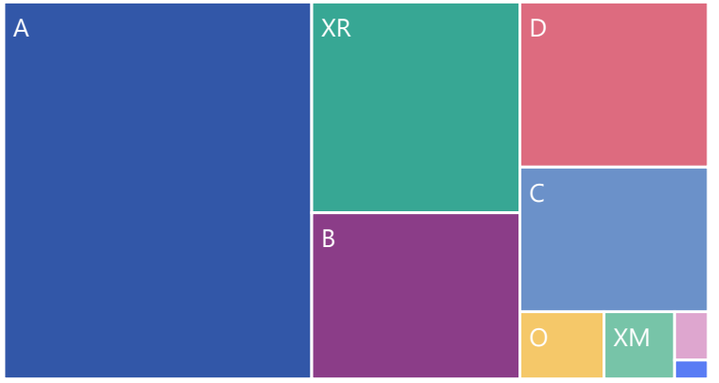
Call Type by BLS Response



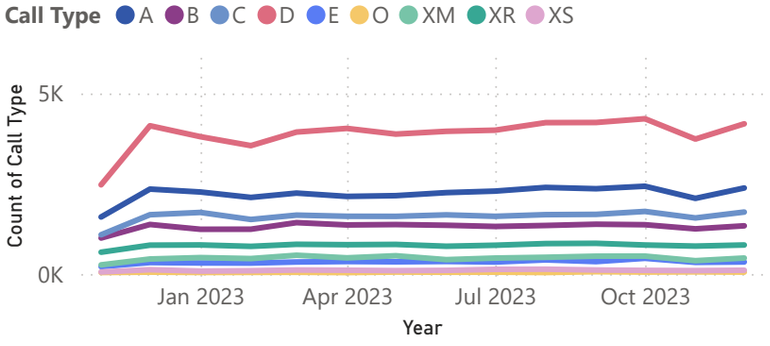
Call Type % BLS Response



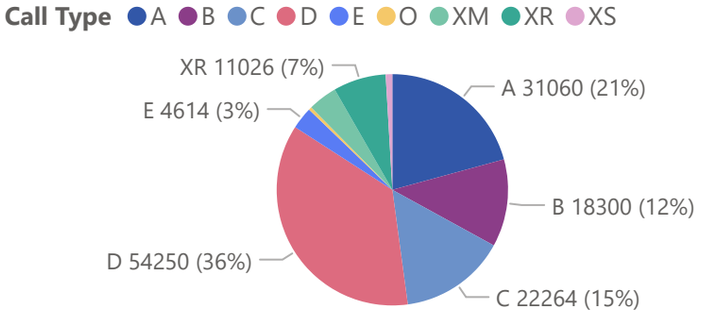
Call Type % BLS Response



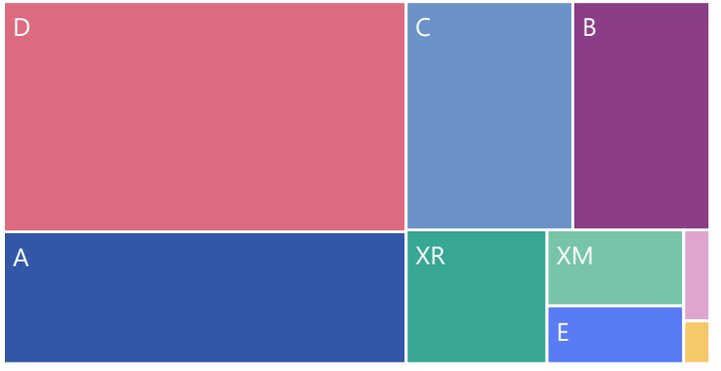
Call Type by ALS Response



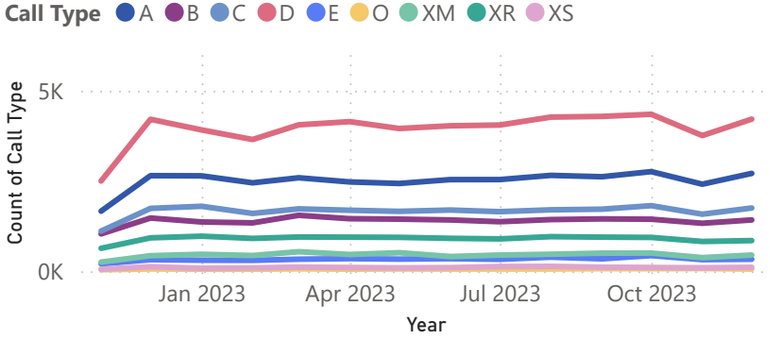
Call Type % ALS Response



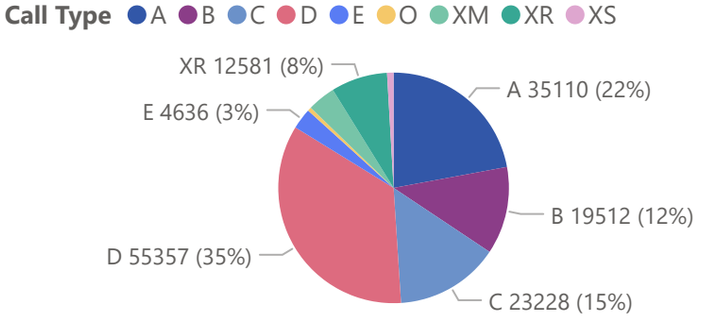
Call Type % ALS Response



Call Type by All Responses



Call Type % All Responses



Dashboard Maintenance:

Last Updated: 7/3/2023
FirstWatch Trigger: EMS All Responses

Date

Call Created

11/11/2022 12/31/2023

San Francisco EMS Agency (SF EMSA)

Out-of-Hospital Cardiac Arrests (OHCA) Strategic Initiatives

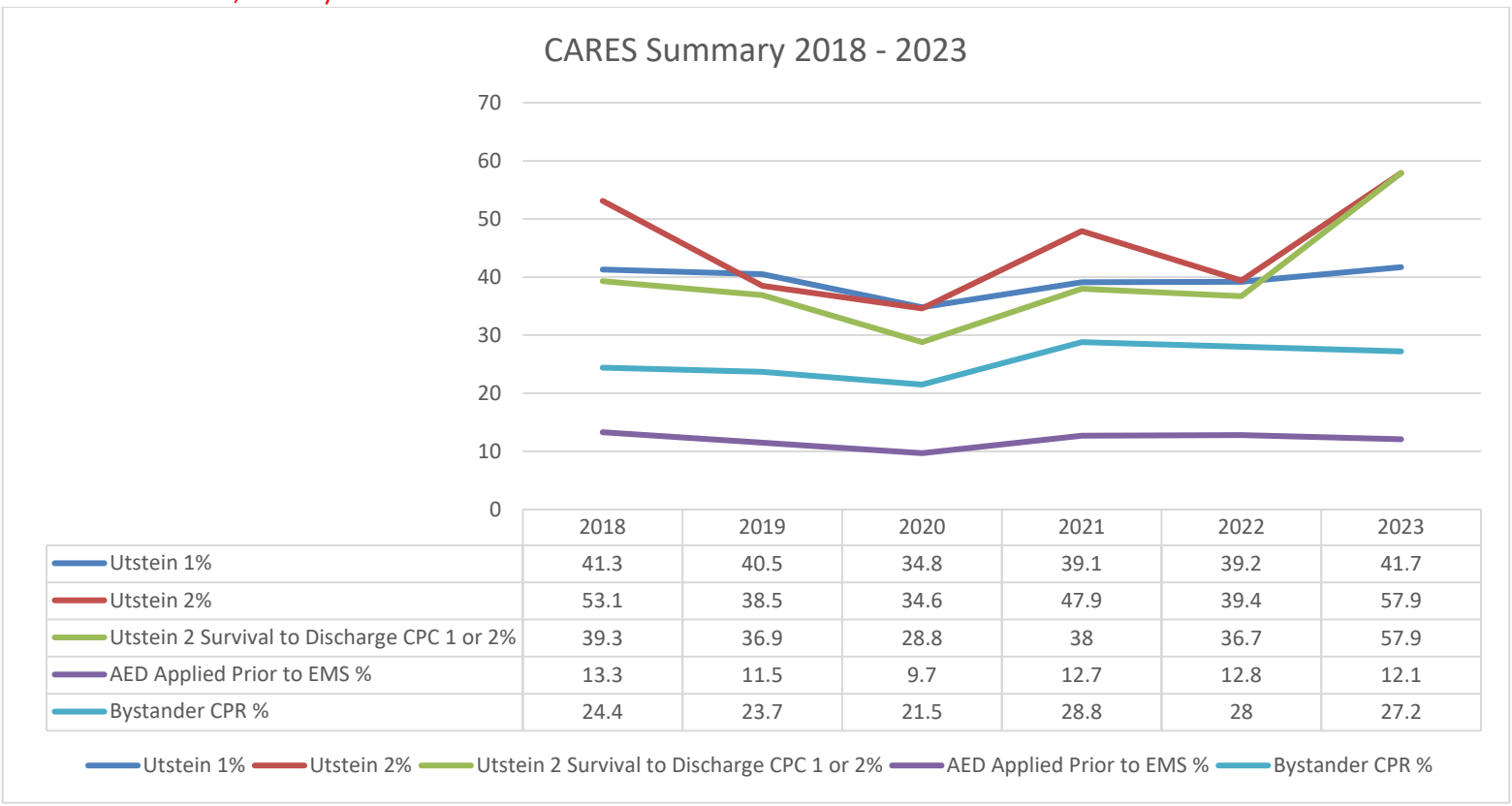
From 2019 to 2020, SF EMSA established improvement measures primarily focused on enhancing crew response and clinical skills in OHCA events. The cardiac arrest protocol was revamped to guide an organized and High-Performance CPR (HP CPR) team approach to treating OHCA, HP CPR classes were offered system 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 partnership 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.

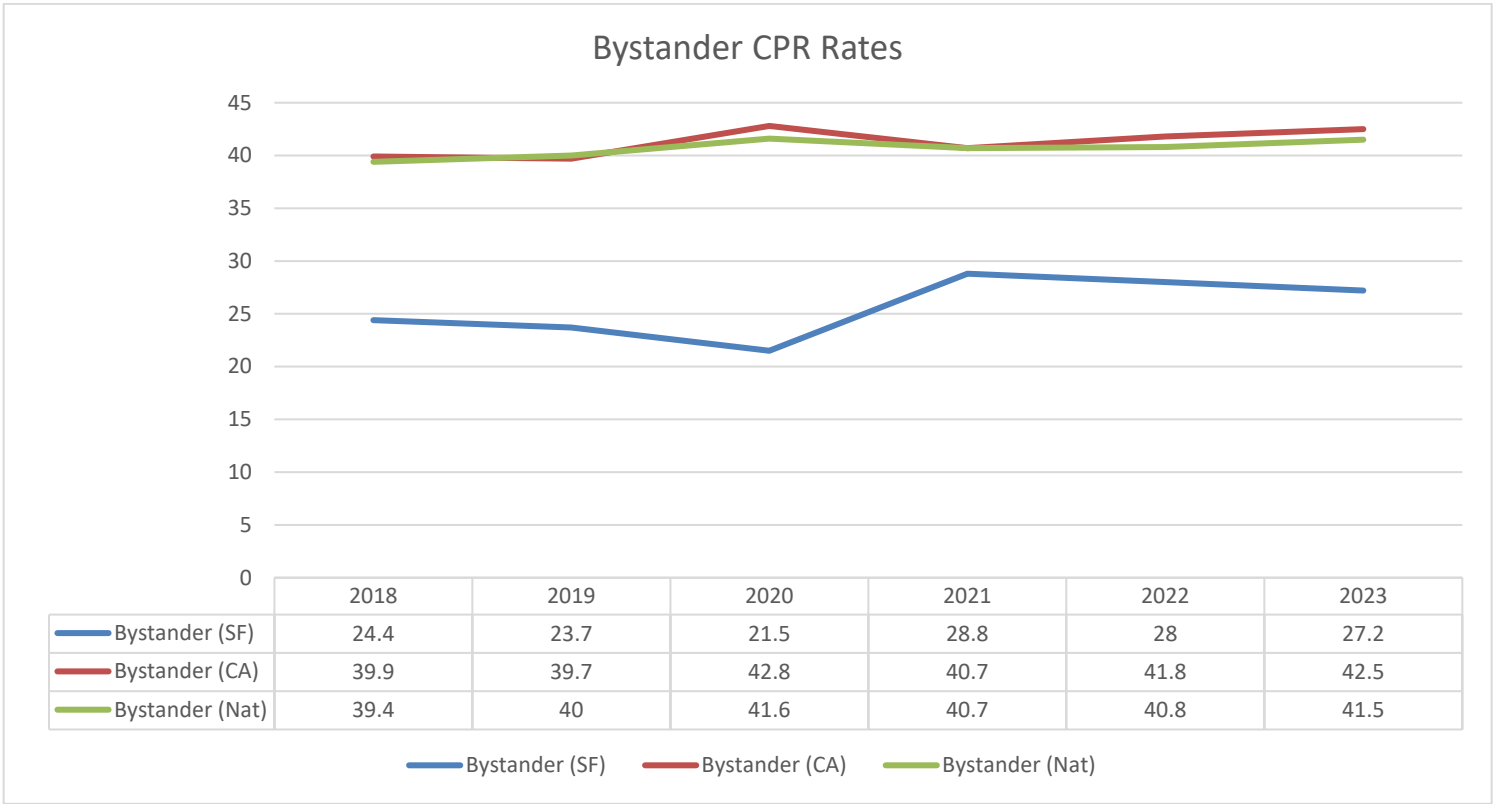
Additionally in 2019, SF EMSA secured funding to provide the city's EMS with 18 LUCAS devices tactically staged with SFFD Rescue Captain (RC) units, King American and AMR supervisor units, San Francisco Police Department (SFPD) Marine Unit, San Francisco Sheriff's Office (SFSO) medical units and at San 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 2023, 736 OHCA events occurred in the City and County of San Francisco, an increase of 13% from the previous year. The 2023 CARES Annual Summary Report revealed that San Francisco's Utstein[1] survival rate was at 41.7%, Utstein[2] was at 57.9% and the rate of Utstein[2] patients surviving to discharge with CPC of 1 or 2 was also 57.9%. San Francisco's rates in all three categories continued to measure above the state and national rates with 2023 revealing significant increases to all three rates, notably in Utstein[2] survival.

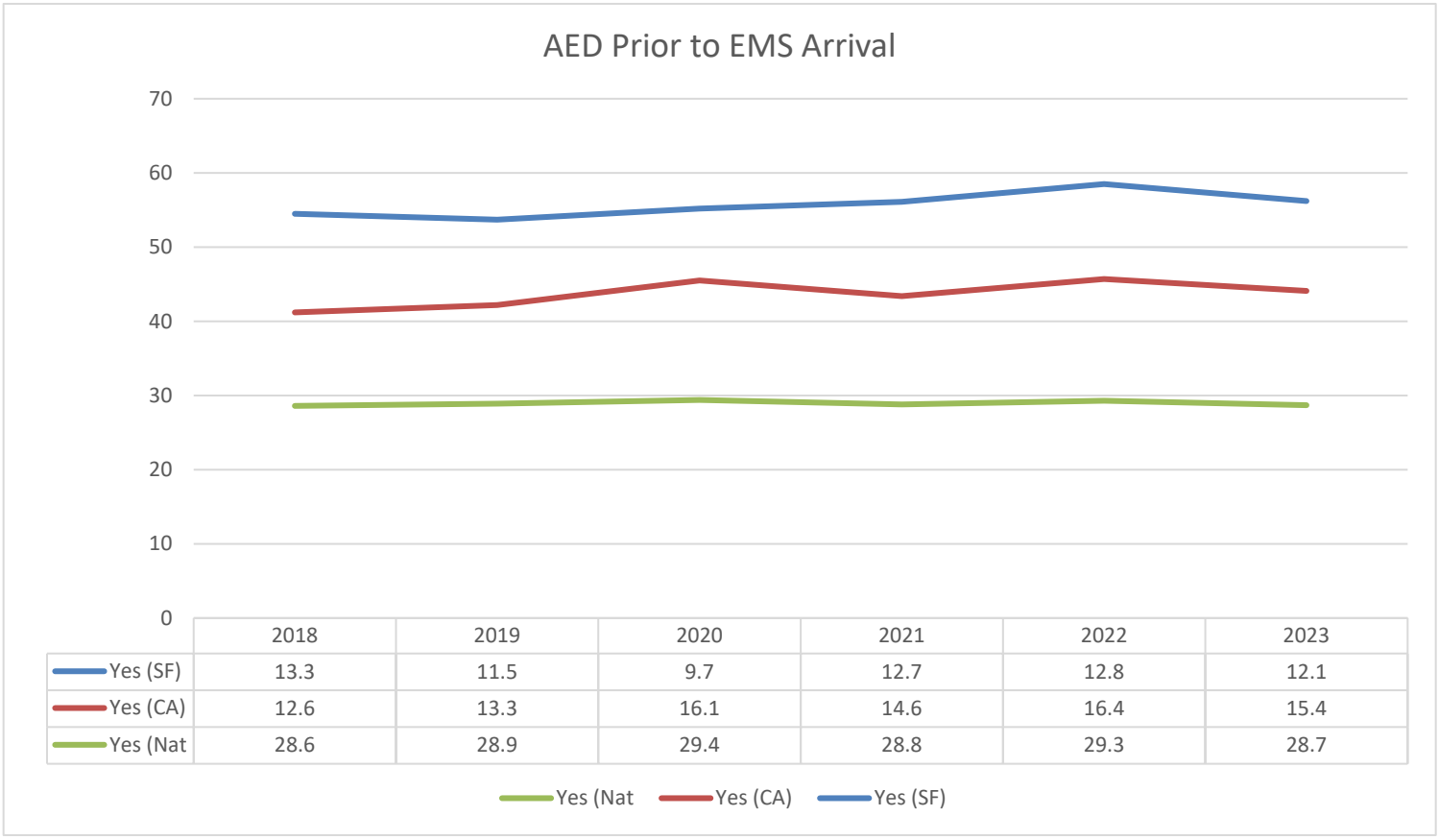


	2018	2019	2020	2021	2022	2023
Utstein 1%	41.3	40.5	34.8	39.1	39.2	41.7
Utstein 2%	53.1	38.5	34.6	47.9	39.4	57.9
Utstein 2 Survival to Discharge CPC 1 or 2%	39.3	36.9	28.8	38	36.7	57.9
AED Applied Prior to EMS %	13.3	11.5	9.7	12.7	12.8	12.1
Bystander CPR %	24.4	23.7	21.5	28.8	28	27.2

In 2023, San Francisco's bystander CPR was 27.2%, a slight decrease of 0.8% from 2022 and AED prior to EMS arrival was 12.1% in 2023, a 0.7% decrease from 2022.



	2018	2019	2020	2021	2022	2023
Bystander (SF)	24.4	23.7	21.5	28.8	28	27.2
Bystander (CA)	39.9	39.7	42.8	40.7	41.8	42.5
Bystander (Nat)	39.4	40	41.6	40.7	40.8	41.5

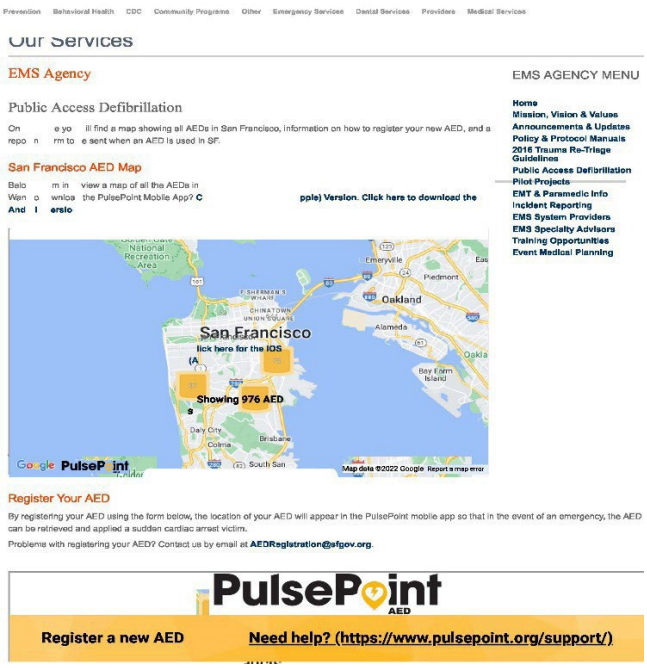


	2018	2019	2020	2021	2022	2023
Yes (SF)	13.3	11.5	9.7	12.7	12.8	12.1
Yes (CA)	12.6	13.3	16.1	14.6	16.4	15.4
Yes (Nat	28.6	28.9	29.4	28.8	29.3	28.7

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 through 2023:

- 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:

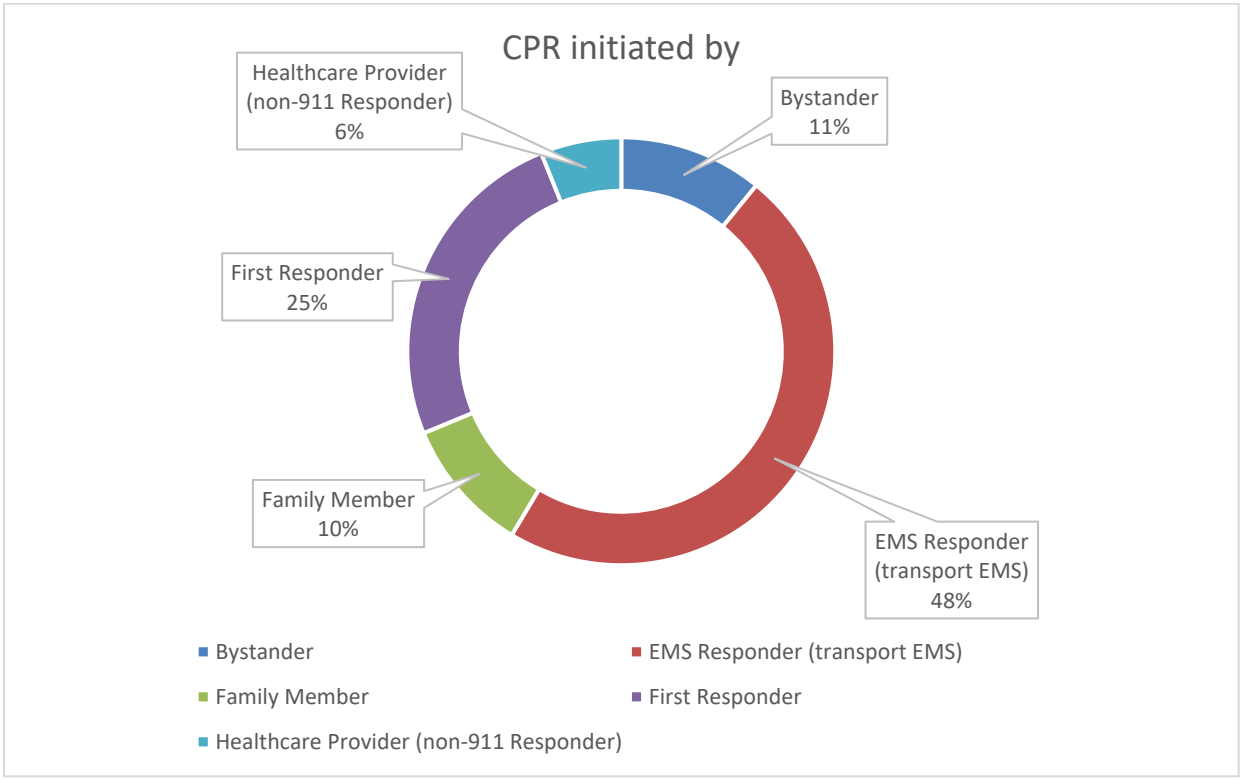
https://www.sfdph.org/dph/comupg/oservices/emergency/public-access-defibrillation.asp

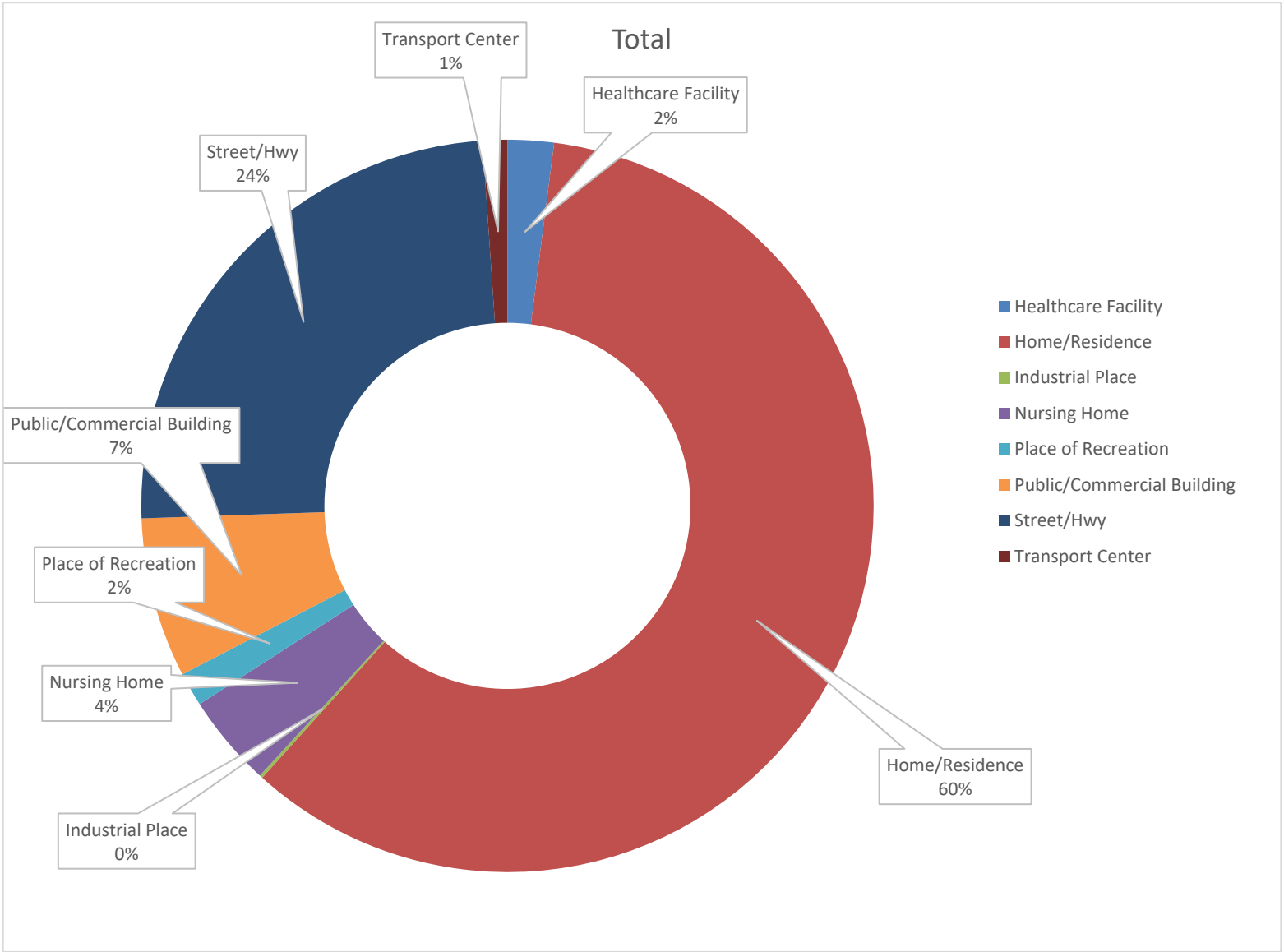
San Francisco launched its PulsePoint membership in May of 2022 and activated the utilization of the 911-connected app to help circulate nearby CPR-trained individuals to OHCA events throughout the city. Currently, San Francisco's PulsePoint lists a pool of 1,027 possible responders and 1,336 registered AEDs throughout the city. SF EMSA will continue to explore promotional opportunities to expand the pool of possible responders.

In 2021, SF EMSA re-purposed disaster response AED devices and distributed for active staging at CBO headquarters and SFSO units

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.

2022 also introduced the SF EMSA Guardian of Life Award to be presented bystanders or members of the public who decide to act courageously prior to the arrival of EMS response crews and provide CPR interventions that significantly raise the survivability rate of OHCA patients. In 2023, 5 members of the community were recognized with this award. Additionally, one of the organizations in which one of these survival-success events occurred at was awarded the 2023 Community Organization of the Year for enacting a safety plan and CPR training program that resulted in the saving of a life.

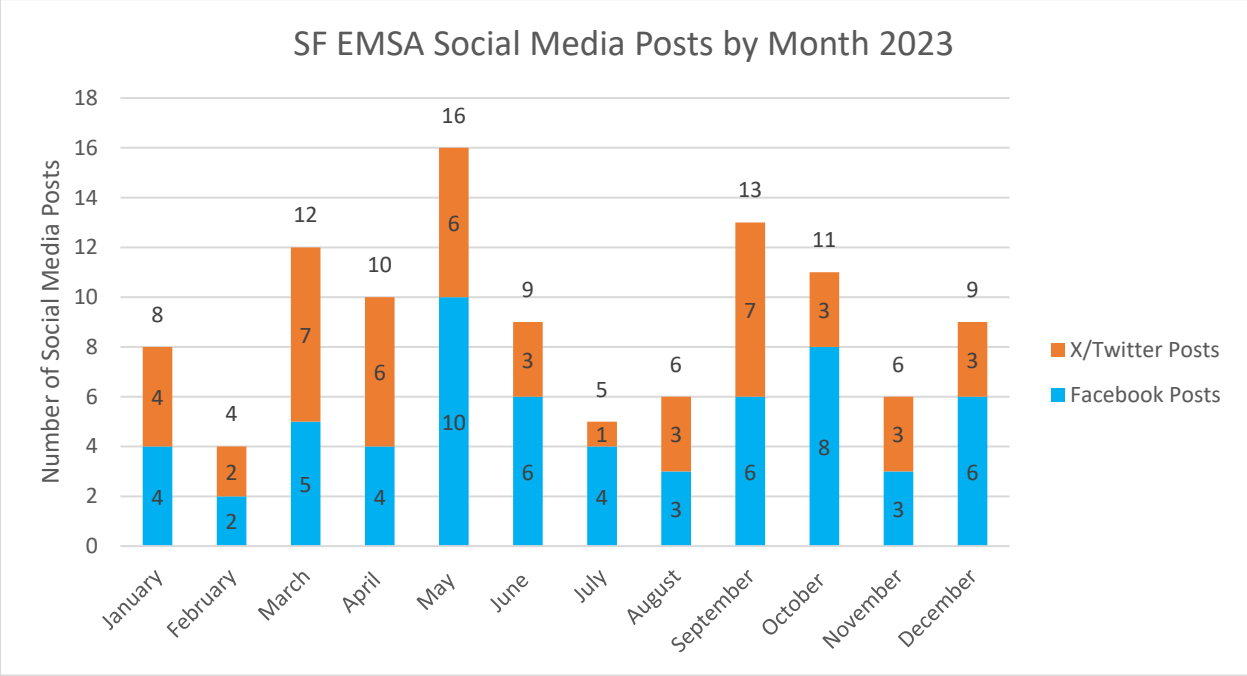

CPR initiated by
Healthcare Provider (non-911 Responder) 6%
Bystander 11%
First Responder 25%
Family Member 10%
EMS Responder (transport EMS) 48%
Bystander
EMS Responder (transport EMS)
Family Member
First Responder
Healthcare Provider (non-911 Responder)


Total
Transport Center 1%
Healthcare Facility 2%
Street/Hwy 24%
Public/Commercial Building 7%
Place of Recreation 2%
Nursing Home 4%
Industrial Place 0%
Home/Residence 60%
Healthcare Facility
Home/Residence
Industrial Place
Nursing Home
Place of Recreation
Public/Commercial Building
Street/Hwy
Transport Center

EMSA and Social Media

The graph below illustrates EMSA's social media presence in 2023. EMSA shared more than 100 unique posts combined on SF EMSA's Facebook and X accounts. In addition, SF EMSA increased its followers to 302 followers on X (259 in 2022) and 394 followers on Facebook (320 in 2022).

EMSA messaging targets both the general public and EMS providers. In 2023, we posted content on a wide variety of topics, including: heart health, fire prevention messages, bicycle safety, sun safety, car accident prevention, recognizing signs and symptoms of stroke, mental health and self-care messaging, and gratitude messages towards EMS providers, dispatchers, and nurses.



EMSA and Continuing Education

As discussed in Table 10, 417 people earned Continuing Education credits through the SF EMSA Learning Resource Center, our online e-Learning platform. A breakdown of course completion numbers is shown in the table below by Course Name.

Continuing Education via the EMSA Learning Resource Center 01.01.2023 to 12.31.2023	
Course Name	**Number of People Completing Course**
Triage to Alternate Destination	413
Paramedic Vaccination Administration Program Module 1	3
EMT Vaccination Administration Program Module 1	1

SECTION III – Quality Improvement

San Francisco Emergency Medical Services Agency

Annual EMS Quality Improvement Plan

Table of Contents

I. Introduction

The City and County of San Francisco, has a diverse and unique geography and population. Success of Emergency Medical Services (EMS) system of care depend on the collaboration and communication across multiple systems and providers.

To meet this goal of a success, the San Francisco EMS Agency (SF EMSA) assembled stakeholders across the system including first responders, 911 dispatch, emergency medical care providers, and hospitals. The purpose of the San Francisco County EMS Quality Improvement Program is to provide the highest level of care to all residents and visitors.

II. Structure and Organization

SFEMSA serves as the designated Local Emergency Medical Services Agency (LEMSA) for the City and County of San Francisco, under the Department of Emergency Management. The leadership structure within SFEMSA consists of an operations section and a clinical section, each with a designated deputy director, with oversight and leadership provided from both the EMS Director as well as the Medical Director.

Within San Francisco there are three approved 911 EMS Providers – San Francisco Fire Department (SFFD), American Medical Response (AMR) and King American. There are 10 critical care receiving hospitals, 8 designated stroke centers, 5 STEMI and Cardiac Arrest (STAR) receiving centers and 2 designated triage to alternate destinations (V.A. Hospital and SF Sobering Center).

Effective: October 1, 2023

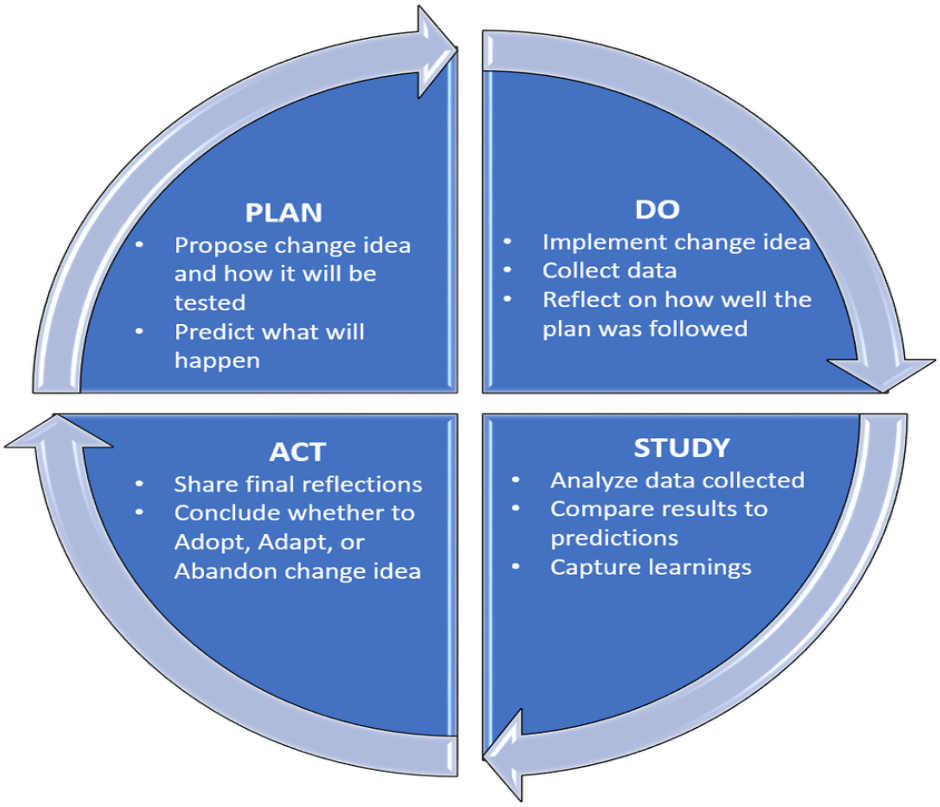
SAN FRANCISCO HOSPITAL DESIGNATIONS

	Critical Airway	Medical Adult	Critical Medical Adult	Medical Peds (include psych)	Critical Medical Peds	Psych Adult	Stroke	STAR	Trauma	OB	Replan-tation	Burns	LVAD	Post Sexual Assault	Sobering (Alt. Dest.)
ZSFG	X	X	X	X		x[1]	X	X	X	X	X	x[3]		X	
CPMC Van Ness	X	X	X	X	X	X	X	X		X			X		
Davies	X	X	X	X		X	X				x[2]				
St Francis	X	X	X	X		X	X					x[3]			
Kaiser	X	X	X	X		X	X	X		X					
St Mary	X	X	X	X		X	X	X							
CPMC Bernal	X	X	X	X		X									
UCSF	X	X	X	X		X	X	X			x[2]		X		
Chinese	X	X	X	X		X	X								
Seton	X	X	X	X (No Psych)											
South Kaiser	X	X	X	X (No Psych)			X								
VA Medical (Alt. Dest.)		x[4]													
UCSF Mission Bay	X			X	X					X					
Sobering Center															x[4]

Footnotes:
1. Psych pts. WITHOUT active medical complaints may go to PES at ZSFG if open and are appropriate (see criteria in Policy 5000 Section VI.K.1 - 5.)
2. Replantation patients WITH major trauma must be taken to ZSFG Trauma Center.
3. Burns (adult + pediatric) WITHOUT major trauma must go to St Francis Memorial Hospital.
4. Transport to a Triage to Alt. Destination site requires Paramedic Triage to Alternate Destiantion Accreditation credential.

III SFEMS Quality Improvement Program

SFEMS utilizes Deming's PDSA (Plan-Do-Study-Act) model ongoing quality improvement within our system. Utilizing trusted and vetted data sources, with collaboration and clear communication of objectives, SFEMSA seeks to promote a transparent and respectful environment that facilitates both best practices and data sharing between organizations. Under the direction of the Deputy Director, EMS Director, and Medical Director, and through a multi-level process of open feedback, review of updated standards of practice, and multidisciplinary partnerships, SFEMSA works to identify root-causes of problems or inconsistencies within our EMS System of care, intervening to reduce or eliminate these causes, and implement processes or protocols that minimize further issues or errors.



SFEMSA QI Program consists of multiple advisory committees and subcommittees, as well as informal feedback routes. Each of these groups, both formal and informal, feed into the EMS Advisory Committee (EMSAC). Advisory committees, composed of EMS system constituents, convene to review EMS system issues relevant to their scope of responsibility and recommend actions to the EMS Agency Medical Director concerning matters of policy, procedure, and protocol. [Reference: SFEMSA Policy 1010 Advisory Committees]

Emergency Medical Services Committee (EMSAC): this standing advisory committee is a multi-disciplinary forum for reviewing and making recommendations related to the following:

- Prehospital clinical policies and treatment protocol issues involving First Responder, Basic Life Support, Advanced Life Support, interfacility transport, and/or critical care transport personnel in the San Francisco EMS system,

- General system management and operational policies including communications, system performance, destination, ambulance diversion, and development of strategies to optimize the EMS System,
- Disaster medical emergency management, including mitigation, preparedness, response and recovery,
- Approval of prehospital pilot and research projects.

Meetings are held four to five times per year in even numbered months or more frequently by request of the Committee Chair, vote of the committee, or the request of the EMS Agency Medical Director or his/her designee. Representation includes each of the hospitals, EMS providers, and other key stakeholders within the EMS System. All policy, protocol, or research work done in other committees is approved through the EMSAC.

Quality Improvement Subcommittee: A standing subcommittee of the EMS Advisory Committee that advises on system quality improvement issues. The subcommittee's goal is to report and evaluate the EMS system and recommend any necessary changes. It assists the EMS Medical Director by evaluating topics and data about issues such as response capabilities, system structure, clinical performance, clinical outcomes, and professional training. Representation on this committee includes all hospitals, EMS and transport providers.

The QI Subcommittee reviews performance and practice from across the system that are not covered in other specialty care committees, including but not limited to:

- Community Paramedicine
- Triage to Alternate Destination
- Infrequently Used Skills
- Airway Management and Success
- 911 Dispatch QI
- Base Hospital Data and QI
- Burn care and burn center updates

Medical Directors Subcommittee: This committee is comprised of Medical Directors from each EMS Provider organization, the SFEMSA Medical Director, QI Dispatch Medical Director, and EMS QI Staff. The goal of this subcommittee is to assist and advise the EMSA Medical Director of ongoing or rising clinical issues within their respective organizations and how to potentially mitigate them.

Stroke Subcommittee: This subcommittee advises on Stroke prehospital care. The subcommittee's goals are the evaluation of Stroke policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital Stroke care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

STAR (STEMI and Cardiac Arrest) Subcommittee: A standing subcommittee of the EMS Advisory Committee advises on STEMI and post-cardiac arrest prehospital care. The subcommittee's goals are the evaluation of STEMI and cardiac arrest policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital STEMI and cardiac arrest care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Trauma System Audit Subcommittee (TSAC): A standing subcommittee of the EMS Advisory Committee advises on trauma system policy. Its goals are the evaluation and administration of the trauma system with oversight responsibility for system vulnerabilities, the development of policy and/or approaches to related issues such as major trauma and burn-related prehospital care, injury surveillance, trauma transfers, repatriation, and long-term outcomes.

EMS For Children Subcommittee: A standing subcommittee of the EMS Advisory Committee advises on pediatric prehospital care. The subcommittee's goals are the evaluation of pediatric policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital pediatric care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Research Committee: This committee, comprised of Medical Directors from each of the EMS providers, as well as base hospital physician leadership and hospital research advisors, convenes 2-3 times annually to review current research being conducted within San Francisco and across the state, as well as review proposals and opportunities for new research focused on EMS care. The research committee puts forward recommendations to the EMS Medical Director and EMSAC Committee for final approval.

Policy and Protocol Process

All clinical and operational policies and protocols are vetted and reviewed by stakeholders and the public, in an open and transparent process. Anyone within the EMS System can recommend review or changes to a given protocol or policy. These recommendations are then escalated through the respective committees or subcommittees and reviewed by specialty advisors when appropriate. All protocols are put forward for public comment on the SFEMSA website prior to being submitted for final review.

New or revised protocols are released on scheduled dates twice per year (with rare exception), and all revisions and changes are made available to EMS Providers 3 to 9 months prior to release. EMS Providers are responsible for ensuring their members are educated and trained on all changes at or before the “go live” release dates.

Training and Education

SFEMSA has an on-site simulation lab with a complete suite of training equipment and supplies, as well as a dedicated EMS Specialist for training. This lab enables SFEMSA to host providers for ongoing education, clinical practice, and “train the trainer” sessions for clinical skills. Additionally, SFEMSA has an online learning management platform for recorded trainings (such as triage to alternate destination) that all providers can utilize for both mandatory and optional education.

In the coming year, SFEMSA will be releasing both online and in-person trainings at a minimum of one per calendar quarter. Currently under review are learning needs and assessments from providers.

Public Outreach

SFEMSA, over the past three years, began a continuous public/community outreach program. Assessment of educational needs of the public, such as identification of a stroke or heart attack (STEMI), how to perform Hands Only CPR (HOCPR) or use of AEDs have been identified as opportunities for educating the community. SFEMSA currently offers free HOCPR/AED training upon request for any public or private organization. Additionally, the SFEMSA engages community organizations, faith-based organizations, and farmer's market/street festivals to participate in HOCPR/AED training at public events. SFEMSA also continues to partner with EMS Providers and hospitals to coordinate public outreach within different communities in San Francisco who may be most at risk for heart attack, stroke, and cardiac arrest.

San Francisco Fire Department Continuous Quality Improvement Plan

Last revised: May 14, 2024

Introduction

The San Francisco Fire Department 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.

Any activity related to EMS within the Fire Department is overseen for quality and improvement including, 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/ Re-education (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 follows the standard chain of command structure within the Department, with the input of the Medical Director(s).

Rescue Captains at the SFFD Airport Division review calls, as needed, and report to the Assistant Deputy Chief of the Airport Division who reports to the Deputy Chief of Operations. Of note, since the Airport resides in San Mateo County, they are overseen by San Mateo County EMS Agency and follows their policies and protocols and participate in their CQI activities, as needed.

Continuous Quality Improvement

The continuous quality improvement process will recognize individual and system-wide clinical and operational incidents and trends. The process will determine whether these trends are individual trends, systematic clinical trends, or operational trends and address the trends accordingly though retraining and re-education.

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

Training and Education includes informal discussions with members, as well as formal remediation 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 re-education will be administered as needed and directed by the EMS chain of command. The Remediation 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. Clinical remediation is generally separate from any applicable discipline and is considered training only.

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 (Vector 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. Microsoft Teams) and contribute and learn about pathophysiology, hospital treatment and outcome, along with feedback from the presenting provider. 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 advanced skills and low frequency/high risk topics will be done and occasionally recorded for distribution online.

Finally, in-person, in-service training will ideally be conducted every 6 months to mimic the protocol update schedule of the EMS Agency. The training will cover both the protocol updates and review advanced skills and other high-yield topics.

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 from any outside entity, that referral shall be forwarded to the San Francisco Fire Department Quality Improvement Office in a timely manner. 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 any necessary plan for improvement.

Audits

Audits are categorized by time frequency and incident scope and summarized in the chart 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.

Time Frequency	*Incident 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.

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, especially video and direct laryngoscopy
- Critical calls
- Field deliveries
- AMA/PDT refusals
- Cardiac arrests
- Advanced Skills Review
- Re-triage/repatriation after initial patient transport
- Repeat incidents/calls meeting certain criteria
- Major trauma
- Any skill related to a new policy, protocol or pilot project, as needed

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 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 siren response
- Request for service that included lights and siren transport

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
- Prioritize the risk
- Implement controls and mitigations strategies
- Evaluate and revise 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 minimize impact to our patient population and to our organization in order to mitigate similar potential incidents. In cooperation with the San Francisco Fire Department Command Staff, the San Francisco EMS/CP Command Staff, the San Francisco Fire Department Office of Continuous Quality Improvement, and the San Francisco Fire Department Investigative Services Bureau, 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. If, after the Risk Management Plan has identified any issues, 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 prehospital research. The research we do can directly contribute to improving clinical patient care. 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.

With the input from San Francisco Fire Department Administration, the San Francisco Fire EMS Administration, the Medical Director(s), as well as the San Francisco Fire Department Office of Continuous Quality Improvement, focused research will address such trends.

Community Paramedicine Quality Improvement and Oversight Plan

Introduction

The mission of the Community Paramedic 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), 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 Section again, follows the standard chain of command within the Department. 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 sets.

Pilot projects and/or new initiatives, will follow their specific QI plan submitted with their initial proposal.

Data Collection and Reporting

All Community Paramedicine 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 measure the following performance indicators/data points:

- 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
- Workplace violence incidents
- 5150's generated along with their indication
- ESO, encounter log and Avatar are reconciliation
- 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.*

In addition, there is regular tracking of the following variables: 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 transport within 24 hours of a community paramedic contact will be spot audited and reviewed.

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.

Our review process is designed to assess biopsychosocial parameters and patient outcomes and provide feedback to community paramedics in a standardized fashion. Our CQI also aims to provide learning opportunities by identifying available trainings, disseminating that information broadly and providing time on duty for training and CE's.

Spot audits are done weekly at various meetings, including our EMS 6 case conferences, Key Performance Indicator meetings, 5150 meetings, suboxone 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

June 1, 2024

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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 performances. However, some issues are clearly found to need individual feedback and improvement 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 Support Supervisor
3. AMR CES Specialist
4. AMR Operations Manager
5. 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 Support Supervisor

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. 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.

3. AMR CES Specialist
   Under general direction, oversees the FTO program and helps to identify learning gaps and areas for improvement. Coordinates new employee hiring, company orientation and training.

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
- Identify strengths and weaknesses of trainees
- Documentation of training phases
- 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

Mentorship

- 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.

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:**

- 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:**

- Perform 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. <u>Concurrent CQI:</u>

- Engagement in direct field response as necessary, 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)

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 are considered. 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 EPCR Reports as available 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, Meter Dose Inhalers, iGel Supraglotic Airways, epi auto injectors)

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
- Buprenorphine Case Reviews

Skills Maintenance/Competency

- Infrequent skills reporting to LEMSA QI Committee

Transportation/Facilities

- Ambulance patient offload times (APOT) reporting to LEMSA QI Committee

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 to evaluate charting and provide feedback to caregivers.

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, train the-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
- Increase patient satisfaction

For 2023, 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

Allied Medical Services of California, Inc.

D.B.A. King-American Ambulance

COMPANY POLICY BOOK
2024

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
POLICY BOOK

Policy Number: 0000
Date: July 1, 2024

Purpose: To establish a list of policies for usual company practice and procedures.

Content: This policy book is intended to establish rules, policies and procedures for Allied Medical Services of California, Inc. (D.B.A. King American Ambulance).

This policy book shall be a continuous "Work In Progress" with the ability to change and adapt on a continuous basis to fit company need.

The company reserves the right to update, change, amend or delete any or all of the policies herein at any time. The company will give notice to the employees about any change in this book by posting the new policy, amendment, change or deletion on the bulletin board for 10 days, and/or the company may email the policy to the employees. The day the new policy is posted is the day it takes affect, not 10 days later.

This policy book is the property of Allied Medical Services of California, Inc. Upon separation of employment this book, along with all other issued company equipment and uniforms shall be returned in good condition.

KING-AMERICAN AMBULANCE
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2. PARAMEDIC

3. EMT SUPERVISOR
4. PARAMEDIC SUPERVISOR
5. DISPATCHER
6. DISPATCH SUPERVISOR

Allied Medical Services of California, Inc.

Allied Medical Transport of California, Inc. would like to welcome you to our company. The company strives to maintain the highest quality employees, patient care, working conditions, equipment and training. Teamwork, respect, professionalism, and cooperation are keys to ensure a positive working environment.

Allied Medical Services of California, Inc. reserves the right to change, amend, delete or add to this policy book at any time. Notice will be given to the employees. The new policy will immediately go into effect.

If any part of this policy book is determined to be illegal or in disagreement with the Union's Collective Bargaining Agreement, then only that specific part of the policy itself shall be considered null and void until the policy can be modified to reflect the part in question. The rest of the policy in question and the remaining sections of the policy book shall always remain in full force and effect.

If any part of this policy book disagrees with the company's employee handbook, this policy book shall prevail.

Thank you,

Management

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
HARASSMENT POLICY

Policy Number 0001
Date: July 1, 2024

Purpose: To establish a harassment free work environment.

Content: Title VII of the Civil Rights Act of 1964, as amended, and California Fair Employment and Housing Act, prohibits employment discrimination on the basis of race, color, sex, age, national origin or religion. Sexual harassment is included among prohibitions.

King-American Ambulance Company is committed to providing a work environment that is free from unlawful discrimination and does not take this commitment lightly.

Therefore, the company hereby establishes the following guidelines:

Sexual Harassment consists of unwelcome sexual advances, requests for sexual favors or other verbal or physical acts of a sexual or sex based nature when (1) submission to that conduct is made either explicitly a term or condition of an individual's employment, (2) an employment decision is based on an individual's acceptance or rejection of that conduct or (3) that conduct interferes with an individual's work performance or creates an intimidating work environment. It is also unlawful to retaliate or take reprisals in any way against an employee who has articulated a good faith concern about sexual harassment or discrimination against him or her or against another individual.

Conduct that would be considered sexual harassment or constitute retaliation are presented in the "Statement of Prohibited Conduct" following. These examples are provided to illustrate the kind of conduct prescribed by this policy, but this list is not exhaustive.

Sexual harassment is unlawful, and the prohibited conduct exposes not only King-American Ambulance, but also the individuals involved in that conduct to significant liability under the law. The management of this company is committed to vigorously enforcing its sexual harassment policy at all levels within King-American Ambulance and AMT Companies.

All employees, members, volunteers, should treat other employees, members and volunteers with respect and dignity in a manner that does not offend the sensibilities of a co-worker.

STATEMENT OF PROHIBITED CONDUCT

King-American Ambulance considers the following conduct to be illustrative of some of the conduct that violates the Company's sexual harassment policy:

A. Physical assaults of a sexual nature such as
    1. Rape, sexual battery, molestation or attempts to commit the assaults, and,
    2. Intentional physical conduct that is sexual in nature.

B. Unwanted sexual advances, propositions or other sexual comments such as,
    1. Sexually oriented gestures, noises, remarks, jokes or comments about a

person's sexuality or sexual experience directed at or made in the presence of any employee.

2. Preferential treatment or promises of preferential treatment to an employee for submitting to sexual conduct, including soliciting or attempting to solicit any employee to engage in sexual activity for compensation or reward and,
3. Subjecting or threats of subjecting an employee to unwelcome sexual attention or conduct or intentionally making the performance of the employee's job more difficult because of the employee's sex.

C. Sexual or discriminatory displays or publications anywhere in the workplace by employees, members or volunteers, such as,

1. Displaying pictures, posters, calendars, graffiti, objects, promotional material or other material that is sexually suggestive, sexually demeaning, pornographic or brining into the Company's work environment or possessing any such material to read, display or view at work.

A picture will be presumed to be sexually suggestive if it depicts a person of either sex who is not fully clothed or in clothes that are not suited to or customarily accepted for the accomplishment of routine work in and around the workplace and who is posed for the obvious purpose of displaying or drawing attention to private portions of his or her body.

2. Reading publicly or otherwise publicizing in the work environment material that are in any way sexually revealing, sexually suggestive, sexually demeaning or pornographic.
3. Displaying signs or other materials purposely to segregate an employee by sex in an area in the workplace (other than restrooms and semi-private lockers and changing area that need to be marked Male or Female.)

D. Retaliation for sexual harassment complaints, such as,

1. Disciplining, changing work assignments, providing inaccurate work information to or refusing to cooperate or discuss work related matters with any employee because that employee has complained about or resisted harassment, discrimination or retaliation.
2. Intentionally lying about, falsely denying, exerting pressure or otherwise attempting to cover up conduct such as that described in any aforementioned items.

E. Other acts.

1. The illustrations stated heretofore are not to be construed as an "All Inclusive" list of prohibited acts under this policy.

PENALTIES FOR MISCONDUCT

Sexual harassment is unlawful and hurts other employees. Each incident of harassment contributes to a general atmosphere in which all persons suffer the consequences. Sexual oriented acts and sex based conduct has no legitimate business purposes. Accordingly, the employee who engages in that conduct should be and will be made to bare the full responsibility for that unlawful conduct.

Violation of this sexual harassment policy will be subject to disciplinary action. This disciplinary action may result in discipline up to and including termination.

Procedures for making, investigating and resolving harassment and retaliation complaints.

A. Complaints

King-American will provide its employees with convenient, confidential and reliable mechanisms for reporting incidents of harassment and retaliation.

Accordingly, the Companies designate the Chief Paramedic and/or the Assistant Chief Paramedic and/or Operations Manager and/or Assistant Operations Manager to serve as investigative officers for harassment issues. In addition, complaints may be made to a direct supervisor if an above named investigative officer is involved in the harassment or retaliation complaint.

If the complainant or subject objects to the investigative officer assigned to the investigation, he or she may request another investigating officer. The CEO, Chief or Assistant Chief will have the final decision on the investigating officer.

Investigative officers may appoint "Designees" to assist them in handling harassment complaints. Persons appointed as designees shall not conduct an investigation until they have received training equivalent to that received by the investigating officers. The purpose of having several persons to whom a complaint can be made is to avoid a situation in which an employee is faced with complaining to the person who would be the subject of the complaint.

Complaints of acts of harassment or retaliation that are in violation of the harassment policy will be accepted in writing or orally. Anyone who has observed harassment or retaliation should report it to a designated investigative officer. A complaint need not be limited to someone who was the target of harassment or retaliation.

Only those who have an immediate and legitimate need to know, including the investigative officers and/or designee, the alleged target of harassment or retaliation and any witnesses will or may find out the identity of the complainant. The President and

CEO of the companies shall be informed immediately of any oral or written harassment complaint and kept informed of the investigation process.

All parties contacted in the course of an investigation will be advised that the parties involved are entitled to respect. Should any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who was provided evidence in connection with a complaint is a separate actionable offense as provided in the schedule of penalties.

This complaint process will be administered in a manner consistent with all applicable laws.

B. Each investigative officer will receive training about harassment and the procedures under this policy and will have the responsibility for investigating complaints and having an appropriately trained and designated company investigator do so.

The investigative officer will maintain a file on the original complaint and any follow up investigation. This file is to be of confidential nature.

All complaints will be investigated expediently by an investigative officer or designee. The investigative officer will produce a written report, which together with the investigative file, will be shown to the complainant on request within a reasonable time. The investigative officer is empowered to recommend remedial measures based on results of the investigation and Company management will promptly consider and act on that recommendation. An employee, member or volunteer determined to have violated this policy shall have the right to a hearing. The company may choose to outsource the investigation to an outside agency.

C. Cooperation

An effective harassment policy requires support and example of Company personnel in positions of authority. Company agents, employees, members and volunteers who engage in harassment or retaliation or fail to cooperate with the Company sponsored investigations of harassment or retaliation may be sanctioned by suspension or dismissal. By the same token, officers who refuse to implement remedial measures obstruct the remedial efforts of the Company employee and/or retaliate against harassment complainants or witnesses may be sanctioned by suspension or dismissal.

D. Education and training for employees, members and volunteers at each level of the work force is critical to the success to this Company's harassment policy. To help the Company meet its goals in this area.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
DRIVING POLICY

Policy Number: 0002
Date: July 1, 2024

Purpose: To establish safe driving standards for all driving circumstances.

Content:
EVOC National Standards will prevail when there is a discrepancy between company policy and EVOC. EVOC National Standards shall be used as the company policy in the event that this company policy does not address a certain situation.
Every effort will be made to conform this policy to EVOC National Standards.

ALL CIRCUMSTANCES:
Seatbelts are mandatory unless it interferes with patient care
No cell phone use unless it's an emergency (i.e. talking to base hospital, receiving hospital, etc.)
No eating food while driving at anytime. (Coffee and sodas are acceptable)
Due regard for safety must be applied to all situations
Basic speed law must be adhered to at all times
Headlights are mandatory at all times
Posted speed limit must be obeyed at all times
Do not use the PA system to yell at people
Vehicle checkout sheets shall be completed daily prior to vehicle operation at the beginning of any shift.
Employees are not allowed to change flat tires on ambulances or vans
You can never pass a cable car while it is loading or unloading riders. You may pass if there is an island, and only at 10MPH, with extreme caution.

NORMAL DRIVING CONDITIONS:
When driving an ambulance or van it is required to follow all applicable vehicle codes.
All posted speed limits must be obeyed. Seatbelts must be worn.
Use the "4-12 rule" for following vehicles in front of you and looking ahead.
When stopped behind any vehicle you must be able to see the vehicles back tires and 10 feet of pavement.

CODE 3 DRIVING CONDITIONS:
All emergency warning systems must be activated.
Do not exceed the posted speed limit.
You must come to a complete stop at all red lights and stop signs. Stop signs are permissible for rolling stops of no greater than 5 MPH if you have a clear visual of the other lanes.
All stop signs, red lights and intersections must be cleared by making eye contact with the drivers of all stopped vehicles; empty lanes must have a minimum of ¼ mile clearance then proceed through at no greater than 10 mph. You may use you partner to help clear intersections at your own risk.

Policy Number: 0002
Date: July 1, 2024

Your partner should be helpful in map reading, giving directions, answering the radio and in all cases practicing driving awareness to help you, as the operator, see obstacles or other vehicles that you have not seen.
The siren must be activated in the "wail" mode or "yelp" modes only. The siren must be operated in "wail" mode at least 300 feet before any intersection. The Siren must be operated in the "yelp" mode at least 150 feet from any intersection and continued in yelp mode until completely through the intersection. No "Chirping" the siren on city streets. You may "Chirp" the siren in a parking lot such as 3-Com Park or Safeway to alert others.
Siren modes should be changed with the hands free capabilities of pressing on the horn, keeping both hands on the wheel.
You may drive over curbs no more than 4 inches in height.
Gridlock: If an ambulance gets into a situation during code 3 driving where it cannot move due to gridlock traffic, the operator must leave the warning lights going and turn the siren off until such time that the ambulance can maneuver again. Then the siren must be activated again as previously stated.
Taking the opposite lane of traffic must be done with extreme caution and is only allowed when the drivers in the oncoming lanes know that you are taking their lane(s).
Freeways: Ambulances shall only operate code 3 on freeways if traffic is slow and it is necessary to pass traffic on the shoulder or median. ***Code 3 operations at freeway speeds are not allowed***. All sirens and warning devices shall be turned off at the beginning of the entrance ramp and shall be turned back on again at the beginning of the exit ramp.
Air horns on the ambulances are NOT to be used during code 3 operations.
Passing: should only be done on the left. Passing cars on the right is not recommended, but is acceptable if EXTREME caution is used.
Passing cable cars should be avoided at all times for safety reasons. If it is necessary to pass a cable car you must make sure that all passengers are on the car and proceed at no more than 10MPH past the cable car. Do not pass if you are not sure the passengers are going to stay on the cable car.
Radio communication should be done by the passenger whenever possible so as not to distract the driver.
If you witness an accident and you are not directly involved with vehicle contact, then you must continue on your emergency response and report the accident to dispatch or ECD. If you are involved you must stop and inform dispatch (ECD if system 911 call) and another ambulance will be dispatched to the emergency call you were responding to.
Exception: Between he hour of 21:00 and 0600 the siren may be used only as necessary.

If you respond to a Code-3 call from base the following must be adhered to:
1. Pull to the end of the driveway without your warning lights and siren.
2. Wait for the passing traffic if any.
3. Turn on your emergency lights.
3. Pull out behind the traffic.
4. Do not sound your siren until you approach Scott St.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
DRIVING POLICY

Policy Number: 0002
Date: July 1, 2024

PRINCIPLE OF DUE REGARD:

Even when exempt from specified traffic laws a driver can be held criminally and/or civilly liable if involved in an accident where property damage, bodily injury or fatality occur. The use of emergency warning systems is only a REQUEST for the right of way. It is not a given right, but a privilege.
Speed does not save lives. A well-trained ambulance crew that arrives safely saves lives.

PARKING OF AMBULANCES:

It is prohibited to park in bus stops at any time unless there is an emergency in that particular bus stop that you are parked in.

The company prefers that you use regular parking spots just as any other vehicle would. The fact that we are an ambulance does not mean we are exempt from parking tickets. Red zones, white zones, yellow zones, etc., fire hydrants, construction zones, double parking and metered parking are all at your own risk. If the company receives a citation from any parking violation it will be the responsibility of the employee to bring it to the attention of the company. The employee may be responsible for paying the fines.

If a unit is on an emergency call the driver can park wherever he or she deems appropriate. If you receive a parking citation while on an emergency call bring it the supervisor's attention immediately. If you are on an emergency call it is suggested that you leave your rear warnings and emergency flashers on for safety and less possibility of a citation.

ALL ambulances and vans must be locked at all times when unattended. Keys are not to be left in the ambulances or vans while unattended.
In the case of an emergency the ambulance may be left running with the emergency lights or floodlights on so as to protect the scene, patient, crew or ambulance.

BACKING UP OF AMBULANCES

When backing units, a ground guide (backer) should be used at all times. If there is not one available then extreme caution should be used. If there is a patient in the back of the ambulance then the attendant should be looking through the rear window to assist the driver in backing provided it does not interfere with patient care. Personnel that are used as the backer or ground guide shall be 10-12 feet behind the ambulance on the driver's side in normal conditions. Do not place yourself between the ambulance and another object. If it is necessary to be on the passenger side while backing the vehicle then the driver should only move if he/she can see your hand signals clearly.

Policy Number: 0002
Date: July 1, 2024

ALLOWABLE PERSONNEL TO DRIVE

Only King American Ambulance Employees are allowed to drive ambulances and/or company vehicles. Employees must be cleared to drive through our insurance company. Please check with management if you are not sure of your driving status.

RADIO COMMUNICATION FOR RECEVING AND ACKNOWLEDGING CALLS

When dispatched to ANY call, code 2 or code 3, then you must read back the call information to the dispatcher. DO NOT say “copy” or “in route” or “10-4”. This does not ensure the dispatcher that you understand the nature and correct address of the incident.

VIDEO RECORDING SYSTEMS IN THE AMBULANCE

Drive-Cam video recording systems in the ambulances will be used to monitor vehicle activity. Some of the vehicle activity it will monitor includes, but is not limited to, acceleration, braking, speed, high speed turns, voice, and collisions. Cameras are GPS equipped and will monitor vehicle location as well. Cameras will be forward and rear facing. Crew members are not allowed to intentionally block the cameras from recording, nor are they allowed to adjust the mirror with the intention of moving the camera to not record them or any other event.

Cameras will be adjusted to record “excessive” maneuvering. Employees who trigger events that record excessive maneuvering will have those events reviewed by management for appropriateness. Typically, appropriateness is considered to be accident avoidance, not code 3 driving in general.

Events that are captured, recorded and uploaded will be reviewed and discipline will be considered based on the circumstances of the event.

Disciplinary scenarios include;

- Excessive speeding (>5mph over the speed limit)
- Unsafe Code-3 driving (speeding through stop signs/stop lights)
- Not wearing a seatbelt
- Reckless or distracted driving
- Tobacco use in the ambulance
- Talking on cell phone or texting while driving if it’s not an emergency
- Eating while driving
- Other violations of our company’s driving policy

Policy Number: 0002
Date: July 1, 2024

Using or viewing the tablet screen with GPS/mapping software will not be considered distracted driving.

For incidents that result in accidents, property damage, or injury, discipline will be in accordance with our discipline policy and the collective bargaining agreement.

For incidents that do not result in accidents, property damage, or injury, the first incident will result in the employee reviewing the recording with management so that corrective action can be taken and discipline avoided. Subsequent incidents of the same nature will result in discipline in accordance with our discipline policy and the collective bargaining agreement.

Crew members are allowed to record events manually for documentation purposes of any event they so choose.

The audio recordings in the ambulances are turned off. If the company determines that there is a need for audio recording in the future, employees will be updated as provided for in this policy book.

The company may share these events and recordings with the law enforcement, insurance companies, courts and any other entity necessary for the purposes of litigation or investigation. Private conversations may be shared with law enforcement if that conversation poses significant risk to the employee, their partner, the company or the public in general.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
DOCUMENTATION POLICY

Policy Number: 0003
Date: July 1, 2024

Purpose: To establish standards for completing Pre-Hospital Patient Care Reports.

Content:
In order to comply with HIPAA (Health Insurance Portability and Accountability Act) and San Francisco County Quality Assurance Guidelines there are minimum documentation requirements for all calls for service including 911 calls, inter-facility transfers, stand-by services, etc.

Q: When is a PCR necessary? A: Anytime there is a person that could be considered a patient.
Q: When can I claim that there is "No Merit" to a call? A: Never. There are only three options to choose from. (1. GOA) (2. Cancelled Enroute) (3. There is somebody that may be considered a patient and a complete PCR needs to be filled out to include their name and all other necessary information listed throughout this policy.)

It is important to document the following information on your PCR without exception.

Document and Describe – Narrative Area:
1. How the patient was found upon your initial encounter at your 97.
2. How was the patient moved and the method of movement used to move the patient to and from the gurney. Acceptable methods would be, but are not limited to, sit pick, draw sheet, stand and pivot, scoot with assistance, etc. Walking patients requires documentation supporting the need to walk the patient. Walking patients requires one person on each side of the patient at all times and must be documented.
3. The number of stairs or obstacles encountered during any part of the transfer.
4. To the best of your ability explain the medical necessity for ambulance transport by gurney by including past and present medical history and condition. Include OPQRST and/or PASTE documentation. Also include associated signs and symptoms related to the Chief Complaint.
5. The reason for the transfer if it is a prescheduled transfer. Medical Necessity and Appropriateness. Describe why the patient is being moved. What services are available at the other facility that are not available the sending facilty.
6. The services and treatments to be received at the 10-7 if it is a prescheduled transfer.
7. Do not use the words "WNL" or "STABLE" in your narrative.
8. Document what kind and where medical equipment and interventions are placed and located on the body, if applicable. (i.e. Oxygen, splints, IV's, etc.)
9. Tell a story. Make the narrative flow chronologically. Think about writing what the MD or the RN at the receiving hospital needs to know. (Not just what you think you need to write.)
10. Description of patient's complaint and medical history. Please be specific about the patient's condition at pick up, during transport and at destination. Include how patient was moved, immobilized (for fractures), weather RN was aboard, weather lift assist was

required and the patient's weight, how many patients were transported and ***try to limit abbreviations.***

Document and Describe – Treatment and Head to Toe Survey Area
1. Any medical interventions you initiated or continued from your 97 to your 10-7 in the treatment area.
2. If you render any treatment you should document the outcome and changes in the patient's condition and a set of vital signs. Treatment needs to be explained in detail. For example, "immobilized" by itself is not good enough documentation. "Immobilized left ankle with cardboard splint and tape" is more descriptive and stands a better chance of payment from insurance
3. All treatment must be listed in the PCR no matter how minor (i.e. icepack, etc).
4. Complete head to toe assessments must be completed for all patients without exception.

Document – Vital Signs Area:
1. A minimum of two (2) complete sets of vital signs must be documented.
2. Vitals must be documented after any and every treatment, medication or procedure at the 5 minute mark..

Document and Describe – Patient and Insurance Information:
1. All available information must be documented even if a patient face sheet is secured. The face sheet may be lost during its many exchanges enroute to our billing department.

Reminder: The entire PCR must be filled out completely and as accurately as possible prior to the end of your shift. Please place all accompanying paperwork (face sheet, med cert, etc.) with the PCR prior to turning it in. Electronic PCR's must be confirmed with dispatch for the correct run numbers and correct amount prior to syncing to the server.

PAPER PCR'S AREONLY ALLOWED UPON SUPERVISOR APPROVAL.

Signature:
The following reasons are valid reasons for not obtaining a signature from the patient, but are not limited to these reasons alone:
1. Unconscious/Unresponsive
2. Combative
3. Refusal
4. Altered Level of Consciousness
5. Patient in Restraints
6. Does not speak English
7. Contaminated with blood or other bodily fluids

8. Blind
9. Heavily sedated
10. Severe pain
11. Respiratory distress
12. Any life threatening condition that does not allow time for a signature
13. Patient is a minor
14. Physically unable due to loss of limb, paralysis, etc.

REMEMBER: It is NEVER acceptable for an employee to sign the PCR. It must be the patient, family member or receiving hospital only.

Each PCR must be completed with following dispatch information:
1. Location of pick up and destination including room numbers and dept. names
2. Date, unit number, dispatch number(s), completed times
3. Diagnosis for transfers ("Cancer" by itself is not good enough. "Cancer of the lung" needs to be written. Same idea for fractures. "Fracture of the tibia" needs to be written. Not just "fracture".) The diagnosis must match what is on the patient's face sheet. If the face sheet and dispatch diagnosis differ, use the one from the face sheet.
4. Reason for dispatch (Nature of Call) (Chest Pain, unconscious, etc.)
7. Signature of attendant and driver (observer/intern if applicable).
7a. Name of Attendant and Driver must also be PRINTED legibly in signature box if signatures are not readable.
8. Complete patient information: name, address including city, state and zip, date of birth, social security number, type of insurance and phone number.
9. HIPAA signatures must be obtained also. If unable to obtain you must document the good faith effort you made and then describe how you left the information with the patient.
10. Every narrative must start with First Medical Contact Time.

County Policy also describes mandatory information for certain types of calls. County policy will be enforced through or QA/QI process.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
DOCUMENTATION POLICY

Policy Number: 0003
Date: July 1, 2024

Signature/Acknowledgment

I _____, understand this policy and will follow its direction and intent. I understand that this policy will be part of the QA process during PCR review. I also understand that not following this policy may result in disciplinary action up to and including termination.

_____
Signature

_____
Print Name

_____
Date

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

INTERPERSONAL COMMUNICATION POLICY

Policy Number: 0004
Date: July 1, 2024

Purpose: To establish effective interpersonal communication.

Content: King-American Ambulance is committed to providing a work environment that is free of unlawful discrimination. Mutual respect and teamwork is of the highest concern to the Companies.

In keeping with this objective, the Company maintains a strict policy prohibiting any and all unlawful harassment, including but not limited to harassment based on any of the following: race, color, religion, sex, pregnancy, national origin, ancestry, age, sexual orientation, marital status, physical or mental disability or medical condition.
All personnel of the Company will address each other respectfully.
Harassment is prohibited. Forms of harassment may include, but are not limited to, the following:

A. Verbal Harassment. Re: Epithets, derogatory or offensive comments based on any of the above categories.
B. Physical Harassment. Re: Assault, blocking or impeding movement, physical interference with normal work or movement directed at an individual because of any of the above categories.
C. Visual Harassment. Re: Derogatory or offensive posters, cartoons, pictures, drawings or writings based on any of the above categories.
D. Sexual Harassment: Refer to Sexual Harassment Policy.
E. The use of vulgarity and profanity is inappropriate and is strongly discouraged.

(The Company recognizes that the Ambulance Service setting can cause some misunderstandings and the Company will not hold personnel to an unattainable standard. But, profanity directed at a specific individual and/or profanity with sexual connotation will not be tolerated.)
Any personnel that believes that he/she has been harassed or discriminated against should immediately report the facts of the incident and the name(s) of the individual(s) involved to their immediate supervisor or, in the alternative, to the Chief, Asst. Chief or other supervisor. Employees should not fear any reprisal.
After the Company receives a complaint, the Company's Investigative Officer or designee will conduct an investigation according to the Harassment Policy. The investigative officer or designee shall investigate the complaint and will produce a written report to the Chief Paramedic and Assistant Chief Paramedic who will make a recommendation based on the results of the investigation.
It is also in violation of this policy to retaliate or take reprisals in any way against any personnel who has filed any complaint concerning this policy.
Violation of this policy will be subject to progressive disciplinary action and may result in discipline up to and including termination.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
UNIFORM POLICY

Policy Number: 0005
Date: July 1, 2024

Purpose: To establish a Policy on acceptable uniform standards while on duty.

Content:

1. Uniform – only company issued uniforms can be worn; no personal outer clothing can be worn over uniform while on duty.
2. Uniform shirts are to be company issued dark/navy blue. Name tags and badges must be worn at all times. Supervisors have the option to wear white uniform shirts.
3. Undershirts: White short sleeve undershirts are allowed. Dark blue short or long sleeve undershirts are allowed. NO OTHER COLOR undershirts are allowed at any time.
4. Pants: only dark/navy blue pants are to be worn. May or may not have side pockets.
5. All uniforms are to be clean, odor free and wrinkle free with the proper patches in place. Heavy perfumes and colognes, and uniforms that smell of body odor are prohibited.
6. Hats and Hair Covering – Company issued hats are to be worn when available; otherwise dark blue baseball style hats without logos or writing. Bandanas, hairnets, non-authorized headwear are prohibited while on duty.
7. Rain coats – Yellow or blue, with or without hoods; rain pants only during heavy rain periods.
8. Uniform Coat – only company issued coats shall be worn while on duty. Company may authorize personal jackets/coats at it's discretion.
9. Jump Suits – Not allowed
10. Work Shirts (Sweatshirts) – Not allowed
11. Pins and Uniform Accessories – only company approved or issued pins are to be worn on your Blue Dress Shirt or Coat. No personal pins are to be worn on your uniforms.
12. Belts – Company issued style belts only (black basket weave). Duty belts purchased by employees are approved for use.
13. Pens – Black ink pens are to be used only. Blue or red pens are prohibited.
14. Socks – Dark color if low top shoe, white okay with high top boots.
15. Shoes or Boots – Must be solid black in color, no highlighted logos, CLEAN and POLISHED.
16. No personal clothing or hats are to be in the ambulance while on duty.
17. Any crewmember, on or off duty, shall wear appropriate sleeping attire within the crew's quarters if spending the night. Sleeping attire shall consist of, at a minimum, shorts or sweats, t-shirt or other clothing to cover the upper torso, or the employee may choose to wear and sleep in their uniform if on duty. Any crewmember working a night shift shall wear their complete uniform at all times when they are outside of the crew's quarters while on

duty. Sweats, jeans, shorts, sandals, slippers, t-shirts, head or hair coverings, or any combination thereof, are prohibited outside of the crew's quarters while on duty.

18. EXCEPTION: If a crewmember is participating in a particularly dirty job (i.e. vehicle maintenance, painting, using the leaf blower, etc.) then an alternate form of clothing may be worn at the discretion of the on duty supervisor or management during the period of that activity.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
DRESS CODE POLICY

Policy Number: 0006
Date: July 1, 2024

Purpose: To establish a standard for grooming and appearance.

Content:

Appearance

1. Facial Hair – Must not interfere with the seal of any mask.

2. Hair – normal length (bald is acceptable), above the collar and of natural color. Mohawks, colored hair or other style haircuts that attract attention are prohibited. Women who have long hair must wear it up as a safety precaution.

3. Facial Jewelry and Accessories – shall be limited to one small pair of earring studs, one on each lobe. All other external piercings such as eyebrows, lips, noses, etc. must be kept small so as not to attract attention. The company shall have the final say on what is acceptable.

4. Jewelry Accessories – Wristwatch, finger ring, necklace (under tee shirt - unable to be grabbed). The company prohibits the wearing of rings, other than wedding bands, as a precaution against tearing gloves.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
PROFESSIONAL CONDUCT POLICY

Policy Number: 0007
Date: July 1, 2024

Purpose: To establish a policy in which personnel shall conduct themselves

Content:
All personnel are to conduct themselves as professionals at all times. It is the employee's responsibility to make sound decisions and use good judgment.
Any behavior that would be negatively looked upon by any member of the public or another outside agency is strictly prohibited.
This policy will be at the discretion of the company.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
PARAMEDIC INTERN POLICY

Policy Number: 0008
Date: July 1, 2024

Purpose: To establish standards and guidelines for Paramedic Intern Students so they know what to expect when they are interning.

Content:

1. Interns are not allowed to keep copies of PCR's with patient information on them. Private information must be blacked out and unreadable or cut off and shredded. This is to maintain HIPAA compliance.

2. Interns are not employees and are not allowed to lift or carry patients. Even interns that are employees are not allowed to lift or carry patients during their internship hours.

3. Preceptors are still responsible for checking out their equipment. Do not rely on the student to check out all appropriate equipment.

4. Interns are to be in an approved uniform at all times and must wear a nametag identifying them as a Paramedic Intern from their school.

5. Interns need to acknowledge that if they are failed out of their field internship there is no appeal process through King-American Ambulance Management. The preceptor has the final say with no exceptions.

6. Preceptors are not allowed to accept gifts from interns, nor should interns be paying for food for the preceptor. (A cup of coffee is not unreasonable on occasion, but dinner is not acceptable)

7. Socializing after hours between interns and preceptors is discouraged. This puts undue pressure on the preceptors and an unrealistic expectation of a guaranteed pass by the intern and preceptor if the intern thinks they are buddies.

8. Interns will provide King-American Ambulance a non-refundable payment of $800.00 for internship privileges. (Will be waived for current employees) $800.00 will be paid to the preceptor upon completion.

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

PARAMEDIC PRECEPTOR POLICY

Policy Number: 0009
Date: July 1, 2024

Purpose: To establish rules for Paramedic Preceptors for qualifications and guidelines during the time they are precepting students.

Content:

Please refer to the City and County of San Francisco's Policy Manual for Paramedic Preceptors.

Please refer to State and Local EMS agencies for applicable laws, guidelines and regulations.

Please refer to King-American's Paramedic Intern Policy.

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

PARAMEDIC ACCREDITATION POLICY

Policy Number: 0010
Date: July 1, 2024

Purpose: To establish guidelines for determining an employee's ability to become accredited in the City and County of San Francisco, above the standard of the City and County's minimum acceptable standards.

Content: Please also refer to County Policy.

The following will be King-American's policy for accreditation of new paramedics in SF City & County:

-Demonstration of understanding & adherence to both EMS & company policies
-Demonstration of understanding & adherence to County protocols
-Demonstration of understanding of ALS equipment & procedures
-Completion of a field evaluation to include calls where the accreditation candidate performed patient care that was more than just oxygen and I.V. Medication pushes, procedures and special circumstance with demonstrated knowledge and correct documentation would be good examples.
-Training on infrequently used skills and optional scope of practice.
-Written protocol and policy test.

Field evaluations may be waived by the company if the candidate did their internship with the company not less than 6 months earlier, if allowed by the County.
TAD accreditation is required to work in the County.

If required by the county: A County sponsored EMS orientation class.

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

TRAINING POLICY

Policy Number: 0011
Date: July 1, 2024

Purpose: To establish a standard for EMT's and Paramedics to obtain independent assignment to a shift

Content:
EMT's and Paramedics will go through the company's initial training to be prepared and cleared for independent assignment to a shift.
Only after all training is completed and signed off by a supervisor may the employee work independently.
Paramedics must also complete a field 10 call, skills testing and TAD certification from the County.

OTHER TRAINING:

Other training may be offered on and off site to employees under the direction of the Continuing Education Program Director under the appropriate rules and guidelines of the City and County of San Francisco.

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

AMBULANCE CHECK OUT POLICY

Policy Number: 0012
Date: July 1, 2024

Purpose: To establish standards for checking out vehicles.

Content:

All vehicles shall have a pre-trip and post-trip shift inspections completed. Any abnormal finds must be reported to a supervisor immediately.

Personnel shall use the current method assigned for this purpose by the company.

All checkouts shall be completed prior to leaving base unless there is an emergency.

All vehicle checks should include, but are not limited to: tires, rims, glass, doors, physical damage, fuel, operating lights, emergency lights, horns, sirens, wipers, engine oil and all other fluids.

Ambulance crews shall receive and sign out for all equipment issued for the day.

All equipment that was signed out for must be returned by the end of the shift unless authorized by a supervisor to remain set up. Narcotics MUST be turned in at the end of the shift without exception.

Ambulances are NOT to be returned to base with less than 3/4 tank of fuel. Crews are to restock the equipment used and refuel prior to punching out, even if on overtime.

All personnel shall change their “Main” oxygen tanks at 400 psi. or below.

ALS Crews are allowed 30 minutes for set up, excluding vehicle washing.
BLS Crews are allowed 25 minutes for set up, excluding vehicle washing.

Crews may begin to break down in the last 10 minutes of their shifts. Controlled substances, radios and keys may only be turned in the last 5 minutes of a shift. Crews must clear with dispatch before returning to base.

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

AMBULANCE AVAILABILITY POLICY

Policy Number: 0013
Date: July 1, 2024

Purpose: To have units clear from their destination as soon as possible so as to be available for incoming emergent and to avoid long destination times.

Content: King American units are part of the 911 system. In order to maintain a high call volume our delays at destinations need to be reduced.

ALS units shall not exceed a destination time of 30 minutes without notifying dispatch of the reason for the delay.

APOT policies from the County shall be adhered to without waiver.

Crews MUST check with dispatch before going available to City/County after a call.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
RADIO POLICY

Policy Number: 0014
Date: July 1, 2024

Purpose: To establish a standard for communicating with company radio equipment.

Content:
Base: Will be referred to as "CONTROL"

Units: Will be referred to as "Medic or BLS (assigned unit number)"

The volume must be turned up loud enough to hear the radio in the surrounding conditions.

When attempting to establish communications with another entity you must first activate the push to talk button on the microphone. State the person's identifier of who you want to talk to and then state your own identifier.

Example of M-7 attempting to talk to our base should sound like the following:
"Control, Medic 7"
Example of our dispatch center attempting to talk with M-8 should sound like the following:
"Medic 8, Control"

FCC Regulations prohibit the use of foul language. Please use clear text communication.

Avoid using patient names over the radio unless necessary.

800 MHz radios are for communicating with the 911 ECD Center. The channel on which you are attempting to establish communications identifies them. For example: if you are on channel B-16, then you would say "B-16, King Medic (+ unit number). King Dispatch is also on the 800 MHz radios and shall be referred to same as above.

Be sure to allow emergency traffic to have priority. Be patient and allow others to complete their radio communication before you begin. DO NOT try to "sneak in" a quick response during a break if you know there is emergency traffic on the radio.

Be aware that people other than us can monitor all the radio frequencies.

COMPANY 800 Mhz PORTABLE RADIOS:

It is mandatory that crewmembers carry the 800 Mhz portable radios with them at all times while on duty in the holster provided by the company. The volume must be turned up loud enough to hear the radio in the surrounding conditions. Loud or excessive noise may necessitate the portable radio volume to be turned up.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
PUNCHING IN POLICY

Policy Number: 0015
Date: July 1, 2024

Purpose: To establish guidelines and procedures for using the company's time clock.

Content:

PUNCHING IN:

1. You may punch in no more than 15 minutes early. You will not get paid prior to your scheduled starting time unless it is approved by a supervisor.
2. You must be in uniform when you punch in. Even if you punch in early.
3. If you are late, the company will provide a 6 minute grace period without penalty. At 7 minutes late the company will subtract 7 minutes and every minute thereafter.

PUNCHNIG OUT:

1. You may punch out as early, but you are not allowed to leave the premises until the actual end time of your shift.
2. You may punch out without penalty within the last eight minutes of your shift.
3. You must be in uniform when you clock out.
4. If you get held into overtime you must document the run number of the call that held you over or the reason that you were held over. The company pays overtime by the minute. If you clock out one minute past the end of your shift it will require you give a reason. You may write "NO OT" if OT is not due.

GENERAL INFORMATION:

Passwords for punching in or out shall NOT be shared. No employee is allowed to punch in or out for another employee.

All employees must report to base to punch in and punch out. No direct reporting to assignments is allowed unless the company sets up a geofence perimeter to allow punching in from a remote location for a long term stand by.

If the computer doesn't allow you to punch in or out for any reason, then you must bring it to the attention of a supervisor. If you do not bring it to the attention of a supervisor, then you may not get paid for that shift until you bring it to the supervisor's attention. It may take until the next regular paycheck before you get paid for any missed punch that was not immediately brought to a supervisor's attention.

Do not write silly or useless comments in the comments area. These comments are all recorded and a legal record. Random keystrokes will not be tolerated.

Anything outside of these guidelines may result in you not being paid appropriately and having to wait for the next regular payday for correction.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
PUNCHING IN POLICY

Policy Number: 0015
Date: July 1, 2024

BILLING DEPARTMENT PERSONNEL

It is hereby understood between King-American Ambulance Company and the Employee whose name appears below, as follows:

1. Employee is employed in the billing department during the hours of 0730 to 1600 Monday through Friday. Alternative working hours may be approved by management.
2. The nature of the work does not prevent the employee from being relieved from all duty for purposes of taking meal periods and breaks, in that:
    A. A biller is not required to be on duty at all times.
3. Accordingly, the employee shall take a meal period of 30 minutes between the 3rd and 5th hour of their punch in time.
4. There is no option for employees to skip a meal period and go home early.
5. In consideration of Item 3 above, any employee who is not able to take a 30 minute meal period for any reason shall be compensated with one (1) hour of straight time. In addition, if an employee is working an overtime shift and receiving 1 ½ times their hourly wage for the overtime, the company will pay one (1) additional hour of straight time, not time and one half. This provision must be approved by management as it will be an unusual circumstance.
6. Any employee who works more than 8 hours in any day shall receive overtime pay for any hours over 8 for the day at a rate of 1 ½ times their current wage.
7. The company shall consider any period of overtime more than 5 hours to be a new shift and the employee is entitled to the one (1) hour of straight pay if they are not able to be relieved for a lunch break. This rule shall be applied to overtime shifts that start at the end of a regular shift.
8. The use of electronic punching in and out with ESO is mandatory. The following rules apply:
    A. If you are late for work you have a 6 minute grace period. On the 7th minute the system will doc you 7 minutes and will continue to doc you for every minute thereafter. You must document why you were late.
    B. You may clock in early but will not get paid until your scheduled start time unless previously approved my management for the early start with the overtime.
    C. You may punch out as early as 8 minutes before the end of your shift without penalty.
    D. You must punch out and in for your 30 minute unpaid meal period. The system will doc by the minute for late returns from your meal period.
    E. You must see the administrator for any missed punches for any reason.
    F. If you work overtime at the end of your shift you must document any justification for the overtime to get it approved.
    G. Time off requests must be submitted through ESO or the administrator of the program.
    H. You are entitled to two (2) ten (10) minute breaks. You are not required to punch out for these breaks and will be monitored closely to ensure that abuse is not happening.

_____ _____

Employee Signature Date

_____

Print Name

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

INTERNET CODE OF CONDUCT POLICY

Policy Number: 0016
Date: July 1, 2024

Purpose: To establish guidelines as to the appropriate use of the Internet and computers in general.

Content:

Computers are for company business. Only managers, supervisors, dispatchers and billing personnel are allowed to use computers or the computer system. Crewmember may use the laptops for PCR documentation and vehicle checkouts. Crewmembers are NOT allowed to use the laptops to connect to the internet for any reason other than approved instances.

When looking up, viewing, downloading or reading material that is on your computer screen from the Internet or other forms of media devices, it needs to be in good taste and not offensive to other viewers. Users of the Internet need to be sensitive as to who else may be watching or reading that material. Do not print any material that could be perceived as offensive to any individual.

Under no circumstances is any employee allowed to download or view pornography, any nudity or any written material that could be considered offensive, on any computer. It is realized that e-mail may contain such items, however these items need to be immediately deleted permanently from the computer once recognized as pornography, etc.

Do not download any material from any source without first checking with the company's I.T. Director. Do not use outside disc's CD's, etc. without first checking with the company's I.T. Director.

Remember to use good judgment when using the Internet. Also, remember that all employees log onto the server computer that tracks everybody's movement in the computer system including Internet usage and sights visited.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
ON-CALL PERSONNEL POLICY

Policy Number: 0017
Date: July 1, 2024

Purpose: To establish a policy for On-Call personnel

Content:

Please also refer to the Union Contract.

On-Call personnel are used as an aid in filling shifts on a temporary basis when there are open positions in the schedule due to vacation, illness, leave, stand-by's, special assignments or a full-time employee vacating a full-time position.

There is no guarantee of any minimum number of hours for on-call employees. Shifts are available to be viewed and signed up for online through ESO.

On-Call employees are considered "at will" employees and their employment can be terminated at any time without notice.

It is the company's sole discretion with no outside influence to accept any employee as "On-Call" whether starting as on call or moving from full time status to on-call status.

If it is deemed by the employer that the on-call employee is not working enough hours to be a benefit to the company, then the on-call employee may be terminated to make room for an on-call employee who will. This is at the company's sole discretion.

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

VEHICLE ACCIDENT POLICY

Policy Number: 0018
Date: July 1, 2024

Purpose: To establish criteria for vehicle accidents we may be involved in.

Content:

Vehicle accidents need to be reported to dispatch immediately. Dispatch needs to notify a supervisor immediately. Crews are to follow the direction in the "Vehicle Accident" folders in the vehicles.

Pre-trip inspections need to be completed on all vehicles during the beginning of your shift.

Post-trip inspections need to be completed at the end of your shift before punching out.

Personnel involved in MINOR (less than $750.00 damage) at fault vehicle accidents may receive the following discipline procedures:

1. Official Written Warning.

2. Suspension for 5 days.

3. Termination.

Personnel involved in MAJOR (MORE than $750.00 damage) at fault vehicle accidents may receive the following discipline procedures:

1. Official Written Warning.

2. Termination

Personnel not reporting required pre and post inspection findings may receive the following disciplinary action:

1. Official Verbal Warning (this is to be documented in writing).

2. Official Written Warning.

3. Suspension for 1 day.

4. Termination

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
VEHICLE ACCIDENT POLICY

Policy Number: 0018
Date: July 1, 2024

DMV requires that any accident that involves $750.00 in damage or more, or has resulted in bodily injury or death, the driver files a SR-1 form with the DMV within 15 days. It is the responsibility of the employee to fill this form out as soon as physically possible. The company will file it on your behalf.

DISCLAIMER:

The company's insurance carrier looks at DMV records for personnel and determines whether or not they are insurable. This is separate from the Union and the 12 month rolling period. There is no 12 month rolling period for your insurability. If the company's insurance carrier deems you uninsurable then you will be taken off the list to drive. This may also affect your employment status with the company.

REMINDER: DMV records report your own vehicle driving history including on and off duty time.

REMINDER: The SFPD does not respond to non-injury vehicle accidents.

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

CONDITIONS OF EMPLOYMENT POLICY

Policy Number: 0019
Date: July 1, 2024

Purpose: To establish protocol for continued employment.

Content:
In order to maintain continued employment, the following items must be adhered to. The list may not include all of the required items but is intended to provide you with most of them.

1. Abide by the Union Contract if you are a Union employee and remain in good standing with the Union.
2. Maintain eligibility to work in the U.S. and California.
3. Must maintain certification or licensure as an EMT or Paramedic in regard to Federal, State and Local Laws. Including, but not limited to, local EMSA, EMS Authority, United States Government and the State of California.
4. Maintain all required certification and licenses and not allow them to expire for any length of time. You will not be allowed to work with any expired license or certificate.
5. Maintain an acceptable attendance record. Excessive tardiness and absences may result in disciplinary action up to and including termination.
6. Abide by the Job Descriptions.
7. Follow company policies.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
AMBULANCE WASHING POLICY

Policy Number: 0020
Date: July 1, 2024

Purpose: To establish when and how vehicles are to be washed.

Content:

As a general rule, ambulances that have odd numbers assigned to them are washed on odd numbered days of the month. Ambulances that have even numbers assigned to them are washed on even numbered days of the month. If an ambulance is dirty it needs to be washed regardless of the day.

Ambulances are to be washed with the company's current biodegradable non-toxic washing solution. In the event we are out contact a supervisor.

All vehicle washing equipment is to be stored under the staircase leading to the dispatch center.

Do not use the windowsill next to the staircase as a storage shelf.

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

CONTROLLED SUBSTANCES POLICY

Policy Number: 0021
Date: July 1, 2024

Purpose: To establish a policy and procedure for the tracking and issuing of controlled substances.

Content:

ALL EMPLOYEES MUST FOLLOW THESE PROCEDURES FOR CONTROLLED SUBSTANCES.

When a Paramedic comes on shift, they must obtain controlled substances from the Dispatcher.

The Dispatcher will open the safe and remove one of the locked boxes to give to the Paramedic.

The Paramedic will open the box and count the controlled substances in front of the Dispatcher. Open packages are okay to sign out if it is one or two of the manufacture's packaging. DO NOT sign out for any broken or uncapped medications. DO NOT open all of the manufacture's packaging to retrieve one medication out of the package.

The Paramedic will make sure that the administration log (control sheet) inside the box matches the number of controlled substances in the box. The Dispatcher will confirm it. The minimum number of required controlled substances listed in County Policy).

Controlled substances shall be kept in the safe in dispatch until signed out by a crew member.

Both the Paramedic and Dispatcher will sign the log in/out book on top of the safe.

Controlled substances are to be locked up in the ambulance when not in use. It will be up to the individual Paramedic to decide when to get them out for a scene call or stand by event. If they are taken out of the ambulance they are to be locked back up after the call or stand by event.

NO MORE STORING CONTROLLED SUBSTANCES IN PERSONAL JUMP BAGS, FIRST IN BAGS, PEDI BAGS, ETC. They are to be locked up in the secure lock box inside the ambulance.

There is no storing of any other material in the controlled substance box.

When signing these medications back in you must open the box with the Dispatcher and count the number of controlled substances and make sure the administration log (control sheet) matches.

If the number of controlled substances and the administration log (control sheet) do not match then no member of the crew will be allowed to punch out until the error is figured out and corrected or a supervisor has been contacted.

If you administer controlled substances to a patient remember to log all the information requested on the administration log (control sheet). This includes times, names, dates, etc. Make sure a witness signs for any wasted controlled substances. The paramedic's partner may sign wasted medications.

Wasted medications must be emptied into the sharps container. At no point is any medication to be wasted or discarded into any sink, garbage can or on the street.

FAILURE TO FOLLOW THESE PROCEDURES MAY RESULT IN DISCIPLINARY ACTION

Restock of Field medications shall be done by the supervisor in charge of the controlled substance program.

All Controlled substances shall remain in a secured and locked cabinet until the supervisor needs to restock the field boxes.

Ordering of controlled substances shall be done in compliance with all federal, state and local laws.

The supervisor in charge of the program shall keep records of the controlled substances ordered, how much is in the field and the returned control log sheets.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
Vacation Policy

Policy Number: 0022
Date: July 1, 2024

Purpose: This policy is to define vacation rules for non-union members. Union members shall refer to the collective bargaining agreement.

Content:

Vacation time will be awarded on the anniversary date of your "FULL TIME" hire date.
Only full time employees are entitled to vacation time.

Annual awards: 8 and 10 hour shift employees

All employees who have been in the service of the Employer for one (1) year shall be granted an annual vacation of 80 hours with pay. (2 weeks)

All employees who have been in the service of the Employer for three (3) years shall be granted an annual vacation of 120 hours with pay. (3 seeks)

All employees who have been in the service of the Employer for five (5) years shall be granted an annual vacation of 160 hours with pay. (4 weeks)

All employees who have been in the service of the Employer for ten (10) years shall be granted an annual vacation of 200 hours with pay. (5 weeks)

Annual awards: 12 hour shift employees

All employees who have been in the service of the Employer for one (1) year shall be granted an annual vacation of 84 hours with pay. (7 shifts)

All employees who have been in the service of the Employer for three (3) years shall be granted an annual vacation of 120 hours with pay. (10 shifts)

All employees who have been in the service of the Employer for five (5) years shall be granted an annual vacation of 168 hours with pay. (14 shifts)

All employees who have been in the service of the Employer for ten (10) years shall be granted an annual vacation of 204 hours with pay. (17 shifts)

Annual awards: 24 hour shift employees

All employees who have been in the service of the Employer for one (1) year shall be granted an annual vacation of 96 hours with pay. (2 tours / 4 shits)

All employees who have been in the service of the Employer for three (3) years shall be granted an annual vacation of 144 hours with pay. (3 tours / 6 shifts)

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
Vacation Policy

Policy Number: 0022
Date: July 1, 2024

Employees may roll over accrued vacation time to the next year up to a maximum of 2 years accrued total time. Any accrued time beyond that will be cashed out at the employees' current rate of straight time.

The company may restrict the number of employees on vacation at any given time based on the department the employee works in and the number of days requested.
Example: 3 billers will not be allowed to take vacation time for 3 weeks all at the same time. However, if one biller is on vacation for a week or more, and another wants to use one day, that will be permissible.

Vacation will be granted on a first come first served basis.

Dispatchers will be responsible for finding their own coverage using the assistance of the dispatch supervisors to help with scheduling and coordination. Only one dispatcher will be allowed to be on vacation at a time, unless suitable coverage is agreed to prior to getting approval.

Captains will be responsible for finding their own coverage using the assistance of the other supervisors to help with scheduling and coordination. Only one Captain will be allowed to be on vacation at a time unless suitable coverage is agreed to prior to getting approval.

All vacation requests must be submitted through ESO and approved by the operations manager. If you make plans, and did not get prior approval, the company is not responsible for any lost money you may have incurred.

Any employee may choose to cash out any or all of their accrued vacation time at their current rate of pay. The vacation pay will be on the employees next check, or the following check, depending on when the payroll cycle closes, unless an extreme circumstance exists.

An employee may receive more vacation time than listed if an agreement was made between the employee and the CEO of the company. IE: a past agreement for additional vacation time in lieu of a raise.

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

COMPLAINT POLICY

Policy Number: 0023
Date: July 1, 2024

Purpose: To establish a policy about filing official complaints regarding company business.

Content:

Any employee wishing to file or voice a complaint about our company, our personnel, other health care facilities or their personnel, other ambulance companies or their personnel need to do so in the following manor:

1. Either verbally or in writing tell your immediate supervisor. If it is an emergency the Dispatcher will call the on-call supervisor. If it is not an emergency it needs to be written in an incident report and turned in to the supervisor's office.

2. Under **NO** circumstances are the Employees of King-American Ambulance allowed to file or voice complaints about the above mentioned directly to the offending facility or offending company.

3. All employees should be as courteous as possible when dealing with other agencies. It is okay for employees to attempt to problems solve on their own but should be done in a positive way and not as a complaint.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
SHIFT RESPONSIBILITIES POLICY

Policy Number: 0024
Date: July 1, 2024

Purpose: To establish guidelines for different shifts and their duties and responsibilities during that shift.

Content:

ALL SHIFTS: are responsible for picking up after themselves, checking out equipment and restocking the ambulances after use. All employees are encouraged to empty garbage cans when they are full and to generally pick up the yard and crew's quarters, cascade system tank changing if necessary, cleaning of the basement and emptying garbage cans in the yard.

DAY SHIFTS: are responsible for ensuring that ambulances are cleared out of the yard or parked in a spot to immediately free up the west driveway. At the end of your shift, you need to park your ambulance in a spot so as to be cooperative with the next oncoming crew or for the following day crew. The on-duty supervisor or dispatcher may assist in this process.

NIGHT SHIFTS:
Same as day shifts.

WEEKEND CREW: is responsible for whatever tasks are assigned by the on-duty supervisor.

RULE OF THUMB: If you see something that needs to be done, do it. If you don't know how to do it, ask for help.

Let's keep our company CLEAN!

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

PARKING POLICY

Policy Number: 0025
Date: July 1, 2024

Purpose: To establish parking procedures for crews and their personal vehicles.

Content: Parking at base is prohibited during normal business hours unless permission from a supervisor is obtained prior to parking. Crews are encouraged to park on the streets or a parking garage. Be careful of street cleaning, two hour parking and red zones. Most crew members can advise other crew members of places that allow free all day parking that are within a 10 minute walking distance.

NIGHT CREWS: Are no longer allowed to park in the yard or in the west driveway.

RED ZONE: In the front of base is at your own risk. It is designed to allow units to have a clear view of the streets when they exit the driveway. Any vehicle can be towed or ticketed in the red zone.

CHURCH: The space behind the church van belongs to the church. It is prohibited to use this space for your personal vehicle. Ambulances may be stopped (not parked) there for no more than 5 minutes at a time as necessary to move ambulances around.

EAST DRIVEWAY: Is NEVER allowed to be blocked. No ambulances or personal vehicles are allowed to park outside the gate. The west driveway may be blocked with supervisor or management approval.

ALWAYS LEAVE YOUR KEYS WITH DISPATCH IF YOU ARE PARKED IN THE YARD OR BLOCKING THE WEST DRIVEWAY. THE COMPANY WILL TOW THE CAR AT THE OWNERS EXPENSE IF NECESSARY.

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

PARKING POLICY

Policy Number: 0025
Date: July 1, 2024

Purpose: To release the company of any and all liability due to an accident on company property between an employee's personal vehicle and any company owned vehicle and/or another personal vehicle.

Content: I _____ hereby release the company from any and all liability from any collision between my personal vehicle and any other vehicle while parked on or driving on company property. This includes ambulances, wheelchair vans, personal vehicles and motorcycles.

By signing below and marking the "I AGREE" box, I agree to hold harmless King American Ambulance Company and any driver of King American Ambulance Company. I agree not to file a claim with my insurance for any damage incurred to my personal vehicle and agree that the company and/or its driver(s) is not responsible for repairing, replacing or compensating for damages incurred.

By signing below and marking the "I DO NOT AGREE" box, I understand that I will no longer be able to park my personal vehicle on company property or drive my personal vehicle onto company property at any time during my employment. No "I AGREE" box checked and on file is the same as "I DO NOT AGREE" and you cannot park in the yard.

☐ I AGREE _____ (employee initials)

☐ I DO NOT AGREE _____ (employee initials)

_____
Employee Signature

_____
Print Name

_____
Date

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

PHYSICAL ABILITY POLICY

Policy Number: 0026
Date: July 1, 2024

Purpose: To establish a standard for conducting physical ability testing.

Content:
The physical ability test shall consist of the following and performed in the following order.

1. Chest compressions for 3 minutes on a mannequin.
2. Carry a cardiac monitor and jump bag from the east driveway gate, around the back of the building, to the west driveway gate and back again, 3 times.
3. Carry 1 – 25lb weight in each hand a walk up the crews quarters staircase and back down, 2 times.
4. Use a BVM on a mannequin to deliver 10 breaths with each hand.
5. The company may waive the lift test process if the candidate shows a current CPAT card within the last 12 months of completion.

Failure criteria:
Unable to perform uninterrupted chest compression for 3 minutes
Unable to carry the monitor and jump back as described in step 2. A candidate may stop and reposition their hands for a better grip only once per trip between gates and it must not take more than 5 seconds.
Unable to carry 25 pound weights in each hand, or failure to perform task 3 as described.
Unable to use a BVM to deliver 10 breaths with each hand.

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

DRUG AND ALCOHOL POLICY

Policy Number: 0027
Date: July 1, 2024

Purpose: To establish rules pertaining to drug and alcohol use and abuse.

Content:

1. Purpose.

1.1. The intention of this policy is to eliminate substance abuse and its effects in the workplace. The presence of drugs or alcohol on the job and the influence of these substances on personnel during working hours are not consistent with this policy. The Company has no intention of intruding into the private lives of its employees, but involvement with drugs or alcohol off the job becomes the Company's concern when job performance, personal safety and public safety is affected.

1.2. Therefore, the Company will act to eliminate any substance abuse, which increases the potential for accidents, absenteeism and sub-standard performance.

1.3. Employees are urged to voluntarily seek confidential assistance from an established drug and/or alcohol program. While the Company will be supportive of those who seek help voluntarily, it will be equally firm in identifying and disciplining those who continue to be substance abusers and do not seek help.

1.4. All employees need to be aware that violations of this policy may result in discipline, up to and including termination.

II. Policy.

2.1. It is the Company's policy that all personnel shall not be under the influence of any alcohol or controlled substance or in possession of alcohol, drugs or any controlled substance while in any Company vehicle, on Company property, at any worksite or location while on duty or paid stand-by. Exception; see 2.8.

2.2. No Personnel shall provide any alcohol or controlled substances to any person or persons on Company property in violation of any State or Federal laws.

2.3. No personnel shall possess or consume any alcohol or controlled substances in or on any Company property in violation of any State or Federal law.

2.4. An employee taking prescribed drugs or medication that have the potential to interfere with the safe work performance shall report this possibility to their supervisor. The employee may be required to provide a statement from a licensed physician that the employee is able to work safely while taking prescribed medication.

2.5. The Company representative may search, without employee consent, all work areas and property in which the Company maintains control or joint control with the employee, including, but not limited to, vehicles, desks, containers, files and storage lockers. Employees assigned lockers (those that are locked by the employee) are also subject to inspection after reasonable advance notice and in the presence of the employee and shop steward if available. The Company may notify the appropriate law enforcement agency that an employee may have illegal drugs in their possession or in an area not jointly or fully controlled by the Company.

2.6. Assistance and counseling for drug and/or alcohol problems can be obtained through the County Health Department. Also, most insurance companies provide some counseling and rehabilitation programs.
A list of rehabilitation or treatment organizations which provide counseling and rehabilitation is available upon request to the Union. (I.e. Teamsters Assistance Program)

2.7. The Company will be supportive of employees who have drug and/or alcohol problems and who seek help in overcoming these problems.

2.8. The President or Operations Manager may approve the possession and consumption of alcoholic beverages on Company property for special occasions. This policy does not include controlled substances issued to personnel by the Company for the sole purpose of pre-hospital emergency medicine.

III. Application.

This policy applies to all employees, solely for the purpose of this policy, includes all full time, part time, limited term, on-call and volunteers of the Company. This policy applies to alcohol and all illegal controlled substances as well as drugs or medications, legal or illegal, which could impair an employee's ability to effectively and safely perform the functions of the job.

IV. Reasonable Suspicion.

4.1. An employee may be considered to be under the influence of if there is reasonable suspicion by a supervisor, two if available.

4.2. Reasonable suspicion is a belief based upon subjective evidence sufficient to lead a reasonable, prudent supervisor to suspect that an employee may be under the influence of alcohol or controlled substances.

4.3. Any of the following, alone or in combination, may constitute reasonable suspicion.
A. Slurred speech.
B. Alcohol odor on breath.

C. Unsteady walking, disorientation or loss of balance.
D. Accident involving Company property.
E. Physical altercation.
F. Drastic change in behavior.
G. Possession of alcohol or illegal drugs.
H. Unexplained drowsiness or sleeping on the job.
I. Inability to respond appropriately to questions that the employee should be able to answer.

4.4. Supervisor is defined as the Chief, Assistant Chief, Captain, Lieutenant, Operations Manager, Assistant Operations Manger, Dispatch Supervisor or any other employee placed in charge of the company and/or group of other employees.

V. Employee Responsibility.

As a condition of employment an employee must:

5.1. Not report to work while their ability to perform their job is impaired due to the use of alcohol or drugs.

5.2. Not use, possess, provide or sell alcohol or illegal drugs while on Company property or on duty.

5.3. Notify a supervisor when taking any medications or drugs, prescription or non-prescription, which may interfere with the safe and effective performance of duties or operations of Company equipment.

5.4. Provide (within 24 hours of request) a bona fide verification of a current, valid prescription for any potentially impairing medication or drugs when requested. The prescription must be in the employee's name.

5.5. Submit to an alcohol and/or drug test when requested by a responsible supervisor (when reasonable suspicion is present) and to authorize the release of the results or examination and/or test to the designated Human Resource Representative of the company..

VI. Supervisional Responsibilities.

6.1. Supervisors (defined in 4.4) are responsible for the reasonable enforcement of this policy.

6.2. Supervisors may request an employee to submit to an alcohol and/or drug test when there is reasonable suspicion to believe that an employee is under the influence of alcohol or a controlled substance, drugs or medications.

6.3. Supervisors requesting an employee to submit to an alcohol and/or drug test shall document, in writing, the facts constituting reasonable suspicion that the employee is under the influence of alcohol, drugs or controlled substance to the degree that the employees ability to perform the functions of the job is impaired.

6.4. Supervisors requesting an employee to submit to a drug and/or alcohol test shall arrange for a confidential examination, evaluation and/or testing at a facility mutually agreed upon by the Union and the Company.

6.5. Supervisors encountering an employee who refuses to submit to a drug and/or alcohol analysis or test or to release the results upon request, shall remind the employee of this policy and could be subject to termination for refusing said tests.

6.6. When there is reasonable suspicion that the employee is under the influence of alcohol, drugs or controlled substance or prescription drugs to the degree that the employee's ability to perform the functions of the job are impaired, the company shall immediately relieve the employee from duty, provide safe transportation to a testing facility if employee is requested to submit a drug and/or alcohol analysis or test and then to home.

6.7. Supervisors shall not physically search the person of an employee; P.D. will be called if necessary. The Company has the right to search all lockers and items brought onto Company property with the presence of the shop steward if available.

6.8. Supervisors shall notify management when they have reason to believe that an employee may have alcohol and/or illegal drugs in his/her possession.

6.9. The Chief, Assistant Chief or Management may notify the appropriate law enforcement agency that illegal drugs are on the employee's person, personal property or Company property.

VII. Physical Examination and Testing Procedure.

7.1. Drug and/or alcohol testing may screen for substances, which could impair the employee's ability to effectively and/or safely perform the functions of the job including, but not limited to, prescription medication, heroin, cocaine, morphine, P.C.P., methadone, barbiturates, amphetamines, marijuana, and/or other cannibinoids. The drug and/or alcohol test will consist of (1) a sample to be tested immediately for substances which

could impair the employee's ability to effectively and safely perform the functions of the job and (2) a control sample which may, at the subsequent request of the affected employee, be tested to assist in the determination of the validity or invalidity of the results of the initial testing. The control sample will be maintained by the testing entity for a reasonable period of time. Drug and/or alcohol testing will be urine testing only.

7.2. A positive result from a drug and/or alcohol test may result in disciplinary action.

7.3. If a drug test is positive, an employee must provide within 24 hours of request, a bona fide verification of a valid prescription for the drug or related agent identified in the drug screen. The prescription must be in the employee's name. If the employee does not provide acceptable verification of a valid prescription, if the prescription is not in the employee's name or if the employee has not previously notified his/her supervisor of the valid use of a legally prescribed drug, the employee may be subject to disciplinary action.

7.4. If alcohol or drug testing is positive the Company shall conduct an investigation to gather all facts and determine appropriate rehabilitation action or discipline.

VIII. Confidentiality.

8.1. Laboratory testing results shall not appear in an employee's general personnel file. Such information will be contained in a separate confidential medical folder that will be securely kept by Human Resources. The reports or testing results may be disclosed to Human Resources on a strict need to know basis and to the tested employee upon request.

8.2. Disclosure, without consent, may also occur when (1) information is compelled by law, judicial or administrative process, (2) the information has been placed at issue in a formal dispute between the employer and employee, (3) the information is to be used to administer an employee's benefit plan or (4) the information is needed by medical personnel for the diagnosis or treatment of the patient who is unable to authorize disclosure.

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

CREWS QUARTERS POLICY

Policy Number: 0028
Date: July 1, 2024

Purpose: To establish guidelines for the safe and courteous use of the crews quarters.

Content:

1. Showers are for employee use only, not family or friends.
2. Be respectful and mindful of other employees who may be changing in our out of their uniform.
3. Lockers will be assigned and are to be locked by the employee and items stored are at your own risk. King American Ambulance will not replace any lost or suspected stolen items. Do not store any dangerous, illegal or offensive material in or on your assigned locker.
4. A kitchenette has been provided for you convenience. Please be respectful of others food and clean up after yourself.
5. The day room has couches for lounging and a television provided by the employees. Please treat the furniture with care and clean up after yourself.
6. Crews are not allowed into the bedrooms to use the beds during the day with permission from the n duty supervisor.
7. If there is any damage to the building or anything in need of repair, please bring it to the attention of management in writing. Feel free to replace a light bulb, but don’t replace the toilet.
8. Know your emergency escape routes in case of fire or earthquake.
9. Off duty personnel may use the bedrooms to sleep in between shifts only with the direct expressed consent of the on-duty supervisor.

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

OUTSIDE EQUIPMENT POLICY

Policy Number: 0029
Date: July 1, 2024

Purpose: To establish a policy for the use of outside equipment that is not company issued.

Content:

Outside equipment that is not company issued shall only be used with the expressed written consent of management.

Personal stethoscopes and blood pressure cuffs are okay to use without permission from management provided that the employee ensures that it is correctly calibrated.

Items that would need special permission include, but are not, limited to: Defibrillators, Pulse Oxymeters, Intubation equipment, IV Supplies, Medications, Batteries, Stairchairs, Transceiver Radios, etc.

If in doubt, ask management.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
OXYGEN AND AIR CASCADE SYSTEM POLICY

Policy Number: 0030
Date: July 1, 2024

Purpose: To establish a policy for the safe use of the oxygen and air cascade system.

Content:

1. **CONNECT METAL HOSES (3) ON LEFT SIDE TO EACH INDIVIDUAL OXYGEN CYLINDERS (H). MAKE SURE ALL CONNECTIONS ARE TIGHT.**

2. **CONNECT BOTTLE TO BE FILLED (E-D) TO PIN-INDEXED COLLAR TIGHTEN "T" HANDLE ONLY AFTER BOTTLE IS SEATED IN INDEX COLLAR.**

3. **NOW READY TO BEGIN TRANSFILLING OXYGEN**
   FIND (H) CYLINDER WITH LOWEST PRESSURE ABOVE BOTTLE TO BE FILLED
   SLOWLY, OPEN THE VALVE OF THE FIRST SUPPLY CYLINDER (H).
   SLOWLY OPEN (H) CYLINDER VALVE BY HAND.
   NOTICE THE REGULATOR CONTENTS GAUGE INCREASING AND READ THE SUPPLY TANK PRESSURE.

4. **SLOWLY OPEN VALVE TO THE BOTTLE TO BE FILLED WITH O2 WRENCH**

5. **WHEN COMPLETE (PRESSURE EQUAL IN EACH GAUGE),**
   TURN OFF (H) CYLINDER AND OPEN NEXT (H) CYLINDER
   (WITH HIGHER PRESSURE ABOVE BOTTLE PRESSURE).

6. **THIS ALLOWS THE OXYGEN TO TRAVEL FROM THE SUPPLY SIDE TO THE FILL SIDE. THE OXYGEN WILL FILL AT A RATE OF 200 PSI PER MIN. CONTROLLED BY FIXED ORIFICES IN THE GAUGE AND VALVE ASSEMBLY. THIS PREVENTS THE BOTTLES BEING FILLED TO QUICKLY AND HEATING UP.**

7. **CONTINUE TO SLOWLY FILL BOTTLES, STOPPING AT TIMES TO ALLOW THE GAS TO TRAVEL, UNTIL EQUILIBRIUM IS REACHED. (USUAL REQUIRED FILL PRESSURE IS 2015 PSI)**

Policy Number: 0030
Date: July 1, 2024

8. **IF EQUILIBRIUM IS NOT MET WITH THE FIRST CYLINDER, SLOWLY OPEN THE NEXT SUPPLY CYLINDER AND REPEAT PROCEDURE ABOVE WITH 2ND, 3RD, SUPPLY CYLINDERS. CONTINUE UNTIL THE FILL SIDE BOTTLE IS FULL. TURN OFF EACH SUPPLY SIDE VALVE I.E. 1ST CYLINDER BEFORE OPENING 2ND CYLINDER.**

9. **CONFIRM THAT THE PRESSURE IS CORRECT AND CLOSE ALL FILL SIDE BOTTLES.**

10. **CLOSE ALL FILL STATION VALVES ON FILL MANIFOLD AND ON ALL FILLED OXYGEN BOTTLES.**

11. **SHUT-OFF ALL SUPPLY CYLINDERS ON THE LEFT SIDE OF THE SYSTEM AND VENTILATE THE PRESSURE WITH THE RELIEF VALVE ON THE MANIFOLD.**

12. **PLACE OXYGEN BOTTLE, IN BOTTLE HOLDER WHILE FILLING OTHER CYLINDER(S)**

13. **REPEAT PROCEDURE ABOVE FOR AIR CYLINDERS ON RIGHT SIDE OF SYSTEM TO BE TRANSFILLED.**

14. **SAFETY SHIELD AND HEARING PROTECTION REQUIRED AT ALL TIMES**

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

EQUAL OPPORTUNITY EMPLOYMENT POLICY
FAIR EMPLOYMENT PRACTICES POLICY

Policy Number: 0031
Date: July 1, 2024

Purpose: To establish equal opportunity for perspective employees and establish fair hiring practices, fair disciplinary practices and fair termination practices.

Content: This Company is an Equal Employment Opportunity employer and it is the policy of the Company to be in compliance with all state and federal regulations relative to discrimination in employment. This Company follows the practice of promoting Equal Employment Opportunity.

The Company does not discriminate in compensation or conditions of employment, including recruitment, hiring, promotion, demotion, training, transfer, discipline or termination of any applicant or employee on the basis of race, color, religion, sex, national origin, age, ancestry, mental or physical disability, sexual orientation, medical condition, marital status or Veteran status. Employment decisions are based on merit and on our business needs, not on any mental or physical disability. This Company complies with the law regarding "reasonable accommodation" for disabled employees and applicants.

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

DISCIPLINARY ACTION POLICY

Policy Number: 0032
Date: July 1, 2024

Purpose: To establish a policy for the fair and equal disciplinary procedure for disciplining employees. Discharge or other disciplinary procedures shall be for just cause. The company shall follow any applicable sections of the Union's Collective Bargaining Agreement for union employees.

Content:

The company may issue any of the following types of discipline for just cause. Discipline shall follow a logical progressive pattern based of severity of the incident.

Verbal - Either on an official Disciplinary action form, an incident report, or other written documentation, documenting such verbal conversation and warning thereof.

Written – On official disciplinary action form.

Suspension – On official disciplinary action form. Number of days may vary based on severity of incident.

Termination – On official disciplinary action form.

Some employee(s) action(s) may be severe enough to skip verbal and/or written and/or suspension or any variation thereof. Investigations will be conducted and concluded prior to any disciplinary action being delivered to the employee. The decision will be made by management as to the appropriate level of discipline. There are other policies that refer specifically to disciplinary action. When a policy has specific disciplinary action within itself, that policies disciplinary action shall be used.

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

LIGHT DUTY POLICY

Policy Number: 0033
Date: July 1, 2024

Purpose: To establish guidelines for personnel requiring light duty during periods of work related injuries.

Content:
Employees who acquire work related injuries and are capable of performing light duty type work must check with management in regards to restrictions of light duty.

Light duty is typically available to employees given the restrictions of the light duty are not prohibitive in a fashion that the company cannot comply with. Management, within the limitations of the doctor's orders, will assign hours and tasks. Typical hours of light duty are Monday though Friday 07:30 to 16:00 with a thirty (30) minute lunch break. If these hours are not attainable by the employee, for whatever reason, alternative hours may be worked out. There are no permanent light duty assignments. Light duty assignments will be limited to three (3) months. Light duty assignments on the weekends are not typical and would be only be considered if there was a specific project in need of getting accomplished.

There are no light duty assignments for non-work related injuries.

Management reserves the right to stop all light duty assignments at anytime.

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

PERSONNEL ACCESS POLICY

Policy Number: 0034
Date: July 1, 2024

Purpose: To establish guidelines to the access that employees have in the building and on the property.

Content:

Field employees:

Not Allowed – Upstairs billing department
Not Allowed – Underneath building
Not Allowed – On Rooftops
Not Allowed – In Computer Room or Server Room
Not Allowed – In Phone Cage
Not Allowed – Into locked records storage areas
Not Allowed – in supervisor / management offices without the presence of a supervisor or manager

Permission to gain access to any of the above listed areas must be obtained by a supervisor or management prior to access.

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

HIRING PROCEDURES POLICY

Policy Number: 0035
Date: July 1, 2024

Purpose: To establish a procedure for the hiring of potential employees.

Content: The following is the procedure for all applicants to apply for employment.

1. Turn in completed application with copies of all required documents.
2. Application is reviewed by management as to the completeness and ensures minimum qualifications are met.
    A. Driver's License
    B. EMT or Paramedic Card (Ca. Paramedic Card)
    C. Ambulance Driver's License
    D. CPR Card
    E. Social Security Card
    F. ACLS Card (Paramedic only)
    G. PALS or PEPP (Paramedic only)
    H. BTLS or PHTLS (Paramedic only)
    I. Current DMV Printout
    J. DMV Medical Examiner's Certificate
    K. ICS 100
    L. ICS 200
    M. ICS 700
    N. Haz-Mat FRA or FRO
3. An interview is scheduled.
4. References are checked. (may be waived)
5. Past employment verification. (may be waived)
6. DMV printout is reviewed.
7. Applicant is offered employment contingent upon passing the following;
    A. Physical ability test
    B. Drug screening
    C. Pre-employment physical from MD.

New hire employees must sign the full time or part time job offer agreement.

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

EMPLOYEE I.D. POLICY

Policy Number: 0036
Date: July 1, 2024

Purpose: To establish a policy regarding the display of company identification.

Content:
All employees are required to visibly wear company issued identification while on duty at all times. This includes a company issued name tag for all employees. A badge must be worn for all paramedics and EMT's.

The company may implement the use of a picture ID to be used in special circumstances.

If the identification is lost or stolen it must be reported to a supervisor immediately for replacement.

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

TRANSPORTING OF PATIENT'S BELONGINGS POLICY

Policy Number: 0037
Date: July 1, 2024

Purpose: To establish a policy for transporting patient's personal belongings during routine/emergent medical transports.

Content:
Ambulances:

Shall make every effort to take all patients belongings that will fit into the ambulance. In the event that there are excessive belongings, arrangements should be made for a friend or other family members to take custody the remainder of the items. If nobody is around to take custody of the belongings, then we will leave the belongings behind so we can transport the patient to the hospital.

Large items such as televisions, rugs, etc. WILL NOT BE TRANSPORTED.

Electric Wheel Chairs from the field must be left with SFFD or SFPD prior to leaving the scene. No exceptions.

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

OUTSIDE EMPLOYMENT POLICY

Policy Number: 0038
Date: July 1, 2024

Purpose: To establish a policy regarding employment outside of Allied Medical Services of California, Inc.

Content:
It is the company's position that employees may hold outside employment as long as it does not interfere with, or create a conflict of interest with, his/her employment at Allied Medical Services of California, Inc.

Allied Medical Services of California, Inc. will not endorse, support or be held responsible for liability or other types of insurance during any outside employment.

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

PRIVACY POLICY

Policy Number: 0039
Date: July 1, 2024

Purpose: To establish a policy for securing Protected Health Information in compliance with State and Federal Laws and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Content:

Allied Medical Services of California, Inc. is responsible for ensuring the privacy and security of all patient information that we create (including copies of information), receive or use under both the Privacy Rule and the Security Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

An important aspect of protecting this information is to make clear to all staff members that the company takes privacy and security issues very seriously. Any breach of our privacy and security policies are very serious. Not only does the law require that we appropriately discipline staff members for violations, our patients and the public expect us to do just that.

This policy applies to all employees who have any degree of access to patient information, including those staff members who may learn of patient information indirectly and even if use of this information is not part of the employees responsibilities.

Discipline will not be issued to employees who, 1) file a complaint with the Federal Government about potential privacy violations, 2) testify, assist or participate in an investigation or compliance review proceeding or official government proceeding investigating privacy issues and 3) oppose any actions that are unlawful under the HIPAA Privacy Rule or the HIPAA Security Rule, when that opposition is made with the good faith belief that the company was violating privacy or security regulations (as long as the complaint did not result in improper disclosure of PHI or e-PHI).

Allied Medical Services of California, Inc. will impose disciplinary action to employees who violate the company's privacy policies and procedures or who violates any part of HIPAA. Disciplinary action will be based on the company's Disciplinary Action Policy.

Employees have a duty to report to management or the Privacy Officer or Information Officer and suspected violation of the company's policies or procedures.

In the event of a suspected or reported violation of the company's policies and/or procedures of either the privacy or the security rules, the company will initiate an objective investigation that will include:

1. Interviews of potential witnesses
2. Interviews of the alleged violator
3. Preparation of an investigative report
4. Presentation of the report to management with recommendations for discipline (if any) or changes in our policies and procedures or practices.

At all times, whenever there is a suspected violation of our policies and procedures or breach of privacy, the Privacy/Security Officer will recommend immediate action to be taken to mitigate the violation and its impact on the company.

The company understands that there will be times when there are incidental disclosures about PHI or e-PHI in the context of caring for a patient. The privacy laws were not intended to impede common health care practices that are essential in providing health care to the individual. Incidental disclosures are inevitable but these will typically occur in radio or face-to-face conversation between health care providers.

The fundamental principal is that all employees need to be sensitive about the importance of maintaining the confidence and security off all material we create or use that contains patient care information. Coworkers and other staff members should not have access to this information that is not necessary for the staff member to complete his or her job.

All personnel must be sensitive to avoid incidental disclosures to other health care providers and to others who do not have a need to know the information. Pay attention to who may be within listening distance when you make verbal statements about a patient's health information and follow some of these common sense procedures for avoiding incidental disclosures.

Verbal Security

Waiting or Public Areas: If patients are in waiting areas to discuss the service provided to them or to have billing questions answered make sure that there are no other persons in the waiting area or bring the patient into a private area to discuss the information.

Garage areas: Employees should be sensitive to the fact that members of the public and other agencies may be present in the garage and other easily accessible areas. Conversations about patients and their health care should not take place in areas where those without a need to know are present.

Other areas: Employees should only discuss patient care information with those who are involved in the care of the patient, regardless of your physical location. You should be

sensitive to your level of voice and to the fact that others may be in the area when you are speaking. This approach is not meant to impede anyone's ability to speak with other health care providers freely when engaged in the care of a patient. When it comes to treatment of the patient you should be free to discuss all aspects of the patients medical condition, treatment provided and any of their health information you may have in your possession with others involved in the care of the patient.

Physical Security

Patient care and other patient billing records: Patient care reports should be stored in safe and secure areas. When any paper records concerning a patient are completed, they should not be left in open bins, desktops or other open areas. Only those with a need to have the information to complete their job duties should have access to any paper records. Crew members that are given a paper copy of a PCR and asked to retrieve a face sheet from a hospital to obtain billing information will be considered an incidental disclosure and not a violation of any policy or State or Federal Laws.

Billing records, including all notes, remittance advices, charge slips or claim forms should not be left out in the open and should be stored in files or boxes that are secure and in an area with access limited to those who need access to the information for the completion of their job duties. This includes field crews' PCR's in the ambulance. No PCR's should be left out in the open that contain PHI. All PCR's that contain PHI must be secured so that no unauthorized persons may see it or have access to it. At the end of the shift the PCR's must be turned into dispatch and the dispatcher will place them into a locked box until the billing department picks them up. No field employee may retrieve any PCR from the locked box after the dispatcher has placed it there.

Computer and Entry Devices: Computer access terminals and other remote entry devices such as PDA's and laptops should be kept secure. Access to any computer device should be by password only. Employees should be sensitive to who may be in viewing range of the monitor screen and take simple steps to shield viewing of the screen by unauthorized persons. All remote devices such as laptops and PDA's should remain in the physical possession of the individual to whom it is assigned at all times.

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

PRIVACY POLICY

Policy Number: 0039
Date: July 1, 2024

Employee Acknowledgement Signature Page

Given the nature of our work it is imperative that we maintain the confidence of patient information that we receive in the course of our work and that we ensure security. Allied Medical Services of California, Inc. prohibits the release of any patient information to anyone outside the organization unless required for purposes of treatment, payment or health care operations, and discussions of Protected Health Care Information (PHI) or e-PHI within the organization should be limited. Acceptable uses of PHI and e-PHI within the organization include, but are not limited to, exchange of patient information needed for the treatment of the patient, billing and other essential health care operations, peer review, internal audits and quality assurance activities.

I understand that the company provides services to patients that are private and confidential and that I am a crucial step in respecting the privacy rights of the patients. I understand that it is necessary, in the performance of fulfilling my job requirements, that patients provide personal information and that such information may exist in a variety of forms such as electronic, verbal, written or photographic and that all such information is strictly confidential and protected by State and Federal Laws.

I agree that I will comply with all confidentiality and security policies and procedures set in place during my entire employment or association with Allied Medical Transport Services of California, Inc. If at any time I knowingly or inadvertently breach the patient confidentiality and security policies and procedures I agree to notify the Privacy Officer immediately.

In addition, I understand that a breach of patient confidentiality or of the policies or procedures established for the security of patient information and other confidential information may result in suspension or termination of my employment. Upon separation of employment, or at any time upon request, I agree to return any and all confidential information in my possession, as well as any passwords or other items used to access PHI or e-PHI.

I have read and understand all privacy and security polices that have been provided to me by Allied Medical Transport of California, Inc. I agree to abide by all policies or be subject to disciplinary action up to and including termination of employment.

Name: _____

Date: _____

Signature: _____

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

TOBACCO POLICY

Policy Number: 0040
Date: July 1, 2024

Purpose: To establish a policy for tobacco.

Content:
ANY employee who has direct patient contact may not smoke or use smokeless tobacco (chew/snuff) at any time while on duty.

For all other personnel:
Smokeless tobacco is prohibited at all times.
Smoking is prohibited inside of all buildings at all times.
Smoking is prohibited inside of all company owned vehicles at all times.
Smoking is prohibited on the upstairs deck/patio area off of the kitchen area.
Smoking is prohibited where prohibited by state law.
Smoking is prohibited on the porch next to dispatch.

Smoking is allowed in the yard.

Smoking is allowed on the front stairs only after 16:00 and only if the door remains closed at all times.

Please be courteous to those who do not smoke and/or have sensitivity to smoke.

Please dispose of all smoking materials in a manner that will not cause a fire, litter the streets or litter the yard.

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

BIOHAZARD WASTE POLICY

Policy Number: 0041
Date: July 1, 2024

Purpose: To establish a policy for the safe disposal of any biohazard waste.

Content:
Sharps: Are to be discarded immediately after use into an approved sharps container. When the sharps container becomes full the lid will be placed on it and then the entire container will be placed into the marked Biohazard waste container currently located near the supervisor's office.

The sharps container is picked up on a regular basis by Steri-Cycle and a list of the pickup dates are located on the wall near the container.

All contaminated objects other than sharps that are to be discarded are to be placed in a red biohazard bag and placed in the biohazard container. (NOT the same as sharps container) All non-disposable fabrics, linens or blankets are to be placed in the specially marked container for blankets. Place all contaminated items in a red bag. If it does not fit in a red bag then place it in a garbage bag and clearly mark it as biohazard contaminated.

All non-disposable contaminated equipment is to be placed in a red biohazard bag until the item can be cleaned appropriately. The crew who contaminated the equipment must keep track of the equipment until it can be cleaned. Do not leave it for somebody else to clean. Contact a supervisor or management for the current disinfecting procedures for cleaning non-disposable equipment.

For all contaminated uniforms, place in a bag, bring to the cleaners and advise them of the contamination.

All other waste (i.e. paint cans, etc.) shall be disposed of in accordance to Local, State and Federal Laws.

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

LAPTOP COMPUTER POLICY

Policy Number: 0042
Date: July 1, 2024

Purpose: To establish a policy for the laptop computers used for the company's pre-hospital patient care reports.

Content:

Computers will be checked out as equipment just as the 800mhz radios, narcotics, batteries, etc. are checked out in dispatch. Dispatch will have the responsibility to assign them to crews at the beginning of their shifts and to assure their return.

ANY DAMAGE, THEFT OR LOSS THAT IS A RESULT OF NEGLIGENCE WILL RESULT IN DISCIPLINARY ACTION STARTING AT A ONE (1)-TOUR SUSPENSION. A SECOND OFFENCE OF NEGLIGENCE RESULTING IN DAMAGE, THEFT OR LOSS WILL RESULT IN TERMINATION OF EMPLOYMENT. ANY THEFT, LOSS OR DAMAGE NEEDS TO BE REPORTED IMMEDIATELY TO MANAGEMENT. LAPTOPS ARE NOT TO BE LEFT UNATTENDED EXCEPT UNDER LOCK AND KEY.

The laptop computers are to be considered a tool and not a toy. Personal use of the laptop for games, Internet use, etc. is strictly prohibited. No employee is allowed to load, download, add, delete, modify, etc. any program or file without the expressed permission from the I.T. department or management.

The laptop computers contain personal and confidential information about employees and patients and should be guarded at all times against anybody viewing that does not have a need to know. They fall under the HIPAA protection laws.

The company is pleased to be able to provide good equipment for the employees. Please take care of the laptops (and any other equipment) as if it was your own. Make sure to lock all vehicles, keep laptop out of view and don't place the laptop on the gurney where it may fall off, etc. Common sense is the best way to prevent loss, theft or damage.

Computer generated PCR's will be mandatory for all calls. Paper generated PCR's may be used for those special events that require personnel to quickly get back in service to staff the event, and will be approved for use by a supervisor prior to the event.

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

Policy/Procedure for Identity Theft Prevention, Detection and Mitigation Program

Policy Number: 0043
Date: July 1, 2024

I. Purpose and Overview.

A. The purpose of this Policy/Procedure ("Policy") is to assure that King American Ambulance ("Provider") maintains compliance with the requirements regarding the prevention, detection and mitigation of Identity Theft as set forth in the federal regulations known as the "Red Flag Rules."[1]

1. "Identity Theft" means a fraud committed or attempted using the identifying information of another person without authority. This includes "Medical Identity Theft," i.e., Identity Theft committed for the purpose of obtaining medical services, such as the use of another person's insurance card or number. Although Medical Identity Theft may occur without the knowledge of the individual whose medical identity is stolen, in some cases the use of an individual's medical identity may occur with the knowledge and complicity of that individual.

B. This Policy sets forth the steps Provider will take in implementing a program for detecting, preventing and mitigating Identity Theft (the "Program") in connection with Covered Accounts, as required by the Red Flag Rules. "Covered Account" means:

1. An account that Provider offers or maintains, primarily for personal, family, or household purposes, that involves or is designed to permit multiple payments or transactions; and

2. Any other account that Provider offers or maintains for which there is a reasonably foreseeable risk to individuals or to the safety and soundness of Provider from identity theft, including financial, operational, compliance, reputation or litigation risks.

C. Section II of this Policy describes the risk assessment Provider shall conduct at the inception of the Program and annually thereafter. Section III sets forth the "Red Flags" (i.e., warning signs) that may alert Provider personnel to the possible existence of Identity Theft in the course of Provider's day to day operations. Section IV sets forth the procedures Provider will follow in attempting to detect

[1] See 16 C.F.R. § 681.2, as supplemented by the Interagency Guidelines on Identity Theft Detection, Prevention and Mitigation set forth in Appendix A of 16 C.F.R. Part 681 ("Guidelines") and the Supplement thereto.

those Red Flags. Section V sets forth the procedures Provider will follow in responding appropriately to Red Flags that are detected, in order to prevent and mitigate Identity Theft. Section VI sets forth the procedures Provider will take in responding to a claim by an individual that he has been a victim of Identity Theft. Section VII describes how Provider will administer the Program. Section VIII describes the annual updating of the Program.

D. Questions regarding this Policy or the Program shall be directed to the Program Compliance Officer designated pursuant to Section VII.

II. Risk Assessment

A. Upon initial implementation of the Program, and annually thereafter as a part of the annual update described in Section VIII of this Policy, Provider shall determine whether it maintains Covered Accounts. As part of that determination, Provider shall conduct a risk assessment to determine whether it offers or maintains Covered Accounts that carry a reasonably foreseeable risk of identity theft, including financial, operational, compliance, reputation or litigation risks. The risk assessment shall take into consideration:

1. The methods Provider provides to open its accounts;

2. The methods it provides to access its accounts; and

3. Its previous experiences with identity theft.

III. Identification of Red Flags

A. A "Red Flag" is a pattern, practice or specific activity that indicates the possible existence of Identity Theft. In other words, a Red Flag is a warning sign regarding the possibility of Identity Theft.

B. In identifying Red Flags relevant to its operations, Provider has:

1. Reviewed the examples of Red Flags found in the Red Flag Rules (see the Supplement to the Guidelines);

2. Considered the factors specified in Section II.A above; and

3. Incorporated Red Flags from sources such as changes in identity theft risks of which Provider becomes aware and applicable regulatory guidance.

C. Based on the process specified in the Section III.B above, Provider has identified the following situations as Red Flags that should alert Provider personnel to the possibility of Identity Theft:

1. A patient submits a driver's license, insurance card or other identifying information that appears to be altered or forged;

2. The photograph on a driver's license or other government-issued photo I.D. submitted by a patient does not resemble the patient;

3. Information on one form of identification submitted by a patient is inconsistent with information on another form of identification, or with information already in Provider's records or information obtained from other sources such as a consumer credit data base;

4. A patient has an insurance member number but no insurance card;

5. The Social Security Number ("SSN") or other identifying information furnished by a patient is the same as identifying information in Provider's records furnished by another patient;

6. The SSN furnished by a patient has not been issued, is listed on the Social Security's Administration's Death Master file, or is otherwise invalid. The following numbers are always invalid:

    a. the first 3 digits are in the 800, 900 or 000 range, or in the 700 range above 772, or are 666;

    b. the fourth and fifth digits are 00; or

    c. the last four digits are 0000;

7. The address given by a patient does not exist or is a post office box, or is the same address given by an unusually large number of other patients;

8. The phone number given by the patient is invalid or is associated with a pager or an answering service, or is the same telephone number submitted by an unusually large number of other patients;

9. The patient refuses to provide identifying information or documents;

10. Personal identifying information given by a patient is not consistent with personal identifying information in Provider's records, or with information provided by another source such as an insurance company or consumer credit database;

11. A patient's signature does not match the signature on file in Provider's records;

12. A patient contacts Provider and indicates that he or she has received an invoice, explanation of benefits or other document reflecting a transport that the patient claims was never received;

13. Mail correspondence is returned to Provider despite continued activity associated with that mailing address;

14. Provider receives a warning, alert or notification from a credit reporting agency, law enforcement or other credible source regarding a patient or a patient's insurance information;

15. Provider or a Service Provider has suffered a security breach, loss of unprotected data or unauthorized access to patient information;

16. An insurer denies coverage due to a lifetime benefit limit being reached or due to an excessive volume of services;

17. A discrepancy exists between medical or demographic information obtained by Provider from the patient and the information found in health facility records;

18. Attempts to access an account by persons who cannot provide authenticating information;

D. Provider shall update the foregoing list of Red Flags as part of its annual update of the Program.

E. All Provider personnel have an affirmative obligation to be vigilant for any evidence of a Red Flag and to notify their immediate supervisor, or the Program Compliance Officer, to report the Red Flag.

IV. Procedures for Identifying Red Flags

Provider personnel will follow the following procedures in order to detect the Red Flags indicated above, which indicate the possibility of Identity Theft.

A. The process of confirming a patient's identity should never delay the delivery of urgently or emergently needed medical care. When a patient's condition permits collection of demographic information and documentation, medical transport crews shall request, in addition to an insurance card, a driver's license or other form of government issued photographic personal identification. If the patient lacks such photographic identification, medical transport personnel shall:

1. Request other form of identification, such as a credit card; and/or

2. Ask a family member or other person at the scene who knows the patient to verify the patient's identity.

B. Billing personnel, in the course of creating and processing claims, and verifying patient information, shall be alert for the existence of any of the Red Flags listed in Section III above.

C. Before providing information regarding an account, or making any change to an address or other information associated with an account, the requester shall be required to provide the social security number, full name, date of birth and address of the patient. If the requester makes the request in person, a driver's license or other government issued photographic identification shall be requested.

D. In the event medical transport personnel or billing personnel encounter a Red Flag, the existence of the Red Flag shall be brought to the prompt attention of the individual's supervisor or the Program Compliance Officer so that it can be investigated and addressed, as appropriate, in accordance with the procedures set forth in Section V below.

V. Responding to Red Flags

A. When a Red Flag is detected, Provider personnel shall investigate the situation, as necessary, to determine whether there is a material risk that Identity Theft has occurred or whether there is a benign explanation for the Red Flag. The investigation shall be documented in accordance with Provider's incident reporting policy. If it appears that Identity Theft has not occurred, Provider may determine that no further action is necessary.

B. Provider's response shall be commensurate with the degree of risk posed by the Red Flag. In determining an appropriate response, Provider shall consider aggravating factors that may heighten the risk of Identity Theft, such as a data security incident that results in unauthorized access to a patient's account records, or notice that a patient has provided information related to a Provider account to someone fraudulently claiming to represent Provider or to a fraudulent website.

C. If it appears that Identity Theft has occurred, the following steps should be considered and taken, as appropriate:

1. Except in cases where there appears to be obvious complicity by the individual whose identity was used, promptly notify the victim of Identity Theft, by certified mail, using the Identity Theft Patient Notice Letter developed by Provider. Notification may also be provided by telephone, to be followed by a mailed letter;

2. Place an Identity Theft Alert on all patient care reports ("PCRs") and financial accounts that may have inaccurate information as a result of the Identity Theft;

3. Discontinue billing on the account and/or close the account;

4. Reopen the account with appropriate modifications, including a new account number;

5. If a claim has been submitted to an insurance carrier or government program ("Payor") in the name of the patient whose identity has been stolen, notify the Payor, withdraw the claim and refund any charges previously collected from the Payor and/or the patient;

6. If the account has been referred to collection agencies or attorneys, instruct the collection agency or attorneys to cease collection activity;

7. Notify law enforcement and cooperate in any investigation by law enforcement;

8. Request that law enforcement notify any health facility to which the patient using the false identity has been transported regarding the Identity Theft;

9. If an adverse report has been made to a consumer credit reporting agency regarding a patient whose identity has been stolen, notify the agency that the account was not the responsibility of the individual;

10. Correct the medical record of any patient of Provider whose identity was stolen, with the assistance of the patient as needed;

11. If the circumstances indicate that there is no action that would prevent or mitigate the Identity Theft, no action need be taken.

VI. Investigation of Report by a Patient of Identity Theft

A. If an individual claims to have been a victim of Identity Theft (e.g., the individual claims to have received a bill for a transport he did not receive), Provider shall investigate the claim. Authentication of the claim shall require a copy of a Police Report and either:

1. The Identity Theft affidavit developed by the FTC, including supporting documentation; or

2. An identification theft affidavit recognized under state law

B. Provider personnel shall review the foregoing documentation and any other information provided by the individual and shall make a determination as to whether the report of Identity Theft is credible.

C. The individual who filed the report shall be informed in writing of Provider's conclusion as to whether Provider finds the report credible.

D. If, following investigation, it appears that the individual has been a victim of Identity Theft; Provider will take the appropriate actions as indicated in Section V of this Policy.

E. If, following investigation, it appears the report of Identity Theft was not credible, the individual shall be notified and Provider may continue billing on the account, upon approval of the Program Compliance Officer. The account shall not be billed without such approval.

VII. Administration of the Program

A. Provider's President and/or CEO thereto, shall approve the Program, and all material changes.

B. A designated employee at the level of senior management shall be designated by the Oversight Body as the Program Compliance Officer and shall be responsible for the oversight, development and implementation of the Program.

C. Provider shall train staff, as needed, to effectively implement the Program. The following categories of personnel shall be trained in the implementation of the Program:

1. All medical transport personnel;

2. All billing office personnel;

3. All management personnel;

4. All Dispatch Personnel.

D. Initial training shall occur no later than May 1, 2009 for all current personnel. Newly hired personnel shall be trained in the implementation of the Program as part of their standard compliance and HIPAA training. "Refresher" training shall be included in the annual compliance and HIPAA training given to Provider personnel, and may be given to specific employees from time to time on an "as needed" basis.

E. Provider shall exercise appropriate and effective oversight of all arrangements involving a service provider whose duties include opening, monitoring or processing patient accounts, or performing other activities which place them in a position to prevent, detect or mitigate Identity Theft ("Service Providers"). Each Service Provider shall be required to execute an amendment or addendum to its service agreement or business associate agreement which requires it to:

1. Implement a written Identity Theft Program that meets the requirements of the "Red Flags Rule";

2. Provide a copy of such Program to Provider no later than May 1, 2009;

3. Provide copies of all material changes to such Program on an annual basis; and

4. Either report all Red Flags, which it encounters to Provider, or take appropriate steps to prevent or mitigate Identity Theft itself.

F. The Program Compliance Officer shall report to the President and/or CEO, on an annual basis, on compliance with the Program. The report shall address material matters related to the Program and evaluate issues such as:

1. The effectiveness of the Program in addressing the risk of Identity Theft;

2. Service Provider arrangements;

3. Significant incidents involving Identity Theft and Provider's response;

4. Recommendations for material changes to the Program.

VIII. Annual Update of the Program

The Program will be reviewed, revised and updated on an annual basis. In performing such update, Provider shall consider:

A. Provider's experiences with Identity Theft over the period since the last revision of the Program;

B. Changes in methods of Identity Theft, or in methods to detect, prevent and mitigate Identity Theft;

C. Changes in Provider's technology and operations, including any new electronic health record or financial software programs implemented by Provider; and

D. Changes in business arrangements of Provider, including but not limited to changes in its relationships with Service Providers.

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

BILLING POLICY

Policy Number: 0044
Date: July 1, 2024

Purpose: To establish a policy for the billing department to follow local, state and federal laws.

Content:
The billing department will abide by all local, state and federal laws in regards to its billing practices.

The billing and collection procedures will abide with state and federal consumer protection and non-discrimination laws.

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

LONG DISTANCE TRANPORTS POLICY

Policy Number: 0045
Date: July 1, 2024

Purpose: To establish a policy for long distance transfers and define long distance.

Content:

Any transfer over 200 miles away from San Francisco will be considered long distance. The company will provide one meal not to exceed $20.00 per person. The company may, at its discretion, provide additional meals based on length of transport. Additional meals shall also not exceed $20.00 each meal per person.

During long distance transfers crews are to go from point to point both during transport and returning after the call. No “side trips” are allowed.

Hotel rooms will be rented upon the discretion of the company based on length of transport. Rule of thumb: Greater than 400 miles one way or greater than 7 hours driving time one-way. Management will make the final decision based on mileage, number of driving hours and time of day. If a hotel room is rented for rest periods it shall be for a period of not more than 8 hours.

When available, crews will take with them, fuel cards, credit cards and travel cash. Dispatch will issue those items to crewmembers.

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

SICK CALL OUT POLICY

Policy Number: 0046
Date: July 1, 2024

Purpose: To establish a policy sick call.

Content:

Any employee who calls out sick shall make every effort to give the company ample time to find a replacement.

Sick calls will be paged out through current scheduling system.

The Union's Collective Bargaining Agreement outlines acceptable attendance. This applies to both union and non-union employees.

Sick call pages will not be initiated between the hours of Midnight and 06:00.

This policy will be used on a rolling 12 month period. Not a calendar or fiscal year period.

Also refer to the Union's Collective Bargaining Agreement for sick call procedures and disciplinary action for excess and abuse. Any discrepancy between this policy and the Union's Collective Bargaining Agreement, the Union's Collective Bargaining Agreement shall prevail.

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

USE OF CARD 33 and CARD 26 OMEGA CALLS

Policy Number: 0047
Date: July 1, 2024

Purpose: To establish a policy for our dispatchers to follow after we have received an ambulance request for service that is a code 2 or code 3 request. Also, to determine which calls are appropriate for BLS ambulances to run.

Content:
Any call other than a 33Alpha call or 26 Omega call shall have an ambulance immediately dispatched. If any caller calls back due to a change in patient condition, we shall re-EMD the call and update the responding unit. In the event we do not have a unit to respond then we are to contact AMR for an ambulance. If AMR does not have one, then we turn the call over to DEC (911).

33Alpha calls shall be ran by BLS units.
CARD 26 OMEGA CALLS may send a BLS unit if available. If BLS is not available, give the call to ECD to dispatch a system ambulance.

King-American ALS units shall be posted in the 911 system and be pulled out of the 911 system for private calls when necessary. ALS transfers (Code 1,2 or 3) shall be ran by King-American Ambulance unless it is a Code 3 transfer and we DON'T have a unit. Then it shall be given to AMR or DEC, in that order.

To use Card 33:

Patient must be physically evaluated by an RN or MD at time of call. RN or MD must be with the patient or in the building (such as S.F. Towers, Jewish Home, Laguna Honda, Clinics, etc.)

Calls from a residence where there is an RN or MD may be triaged by CARD 33 and a BLS unit sent if there is no suspected reason to use another EMD card and it is not a code 3 response.
EXCPETION: A BLS unit may be sent to a residence for clogged/pulled peg tubes (also known as feeding tubes), regardless of whether or not a RN or MD is on scene.

If the call is determined to be coded as a "CARD 33 ALPHA" call, a BLS unit shall be sent. Any call other than a 33Alpha call shall be immediately dispatched.

33A1- This code is to be used for a BLS response requested for 60 minutes or less.
33A2- This code is to be used for a BLS response where the caller says they can wait between one hour and four hours.
33A3- This code is to be used for pre-scheduled calls greater the 4 hours.

NEVER HESITATE to use another EMD Card if any question exists.

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

USE OF CARD 33 and CARD 26 OMEGA CALLS

Policy Number: 0047
Date: July 1, 2024

Disclaimer and updates:
When the City and County of San Francisco develops new FRES Pattern response criteria, the company will refer to the FRES Pattern adopted for use by the 911 dispatcher center when it comes to making a decision as to send ALS or BLS.
The company will make every effort to dispatch appropriate level of ambulance service to any request for service.

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

POSTING POLICY

Policy Number: 0048
Date: July 1, 2024

Purpose: To establish guideline for ALS and BLS ambulances to participate in the EMS system. Also refer to policy 0047.

Content:
ALL ambulances shall make themselves available to the 911 system whenever possible.
Posting assignments will be decided by DEC.
Units must also advise King-American Dispatch center of all post moves, all assigned calls (code 2 / code 3, etc) by DEC, all status changes (on scene, enroute, etc,) and also must advise King-American Dispatch when you are clear the call and get permission to re-post for 911 calls.
Ambulances must post within a 6 block radius of the actual posting assignment given by ECD.
Units may be removed from the 911 system 45 minutes prior to end of shift time to re-fuel, re-stock and turn in paperwork and equipment if there are no calls pending.
Refer to Union contract for holdover policy.

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

TIME MANAGEMENT POLICY

Policy Number: 0049
Date: July 1, 2024

Purpose: To establish guidelines for running personal details on duty.

Content:
Field crews shall keep personal details, while on duty, to an absolute minimum. Any personal detail must be approved by the on duty dispatcher or company supervisor and must not exceed a 15 minute time period.
Coffee and food may be purchased by the field crews while in the 911 system at their own risk of the food not being ready and having to run a call. Under NO circumstances are employees allowed to delay response to ANY call because they are waiting for food or coffee.
Details at the cleaners should be performed on the employee's days off and take away from time the ambulance should be posted in the 911 system.

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

STAND BY EVENTS POLICY

Policy Number: 0050
Date: July 1, 2024

Purpose: To establish guidelines for standby services.

Content:
Field crews will abide by all standby event protocols and standard operating procedures designed for each specific event. If you are not familiar with an assigned task or assignment the employee must ask for an orientation to the event. Some training may be on the job, such as partnered with a more experienced employee and other training may include an overview of required paperwork and radio procedures. In all cases, please ask if you are not sure.

Since the stand by events are a dynamic and the requirements are changing all the time, the company will do its best to update the employees in a timely fashion about any changes in procedures for the special events.

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

AMBULANCE RESTOCKING POLICY

Policy Number: 0051
Date: July 1, 2024

Purpose: To establish guidelines for restocking ambulances.

Content:
All ambulances will restock equipment and supplies from our base. Ambulances are not allowed to restock from other ambulances (King-American or otherwise), hospitals or any other source.
Restock shall be completed at the end of every shift. If restocking is required during the middle of a shift the employee must obtain permission from the dispatcher to return to base and restock.
If supplies are running low please let a supervisor know immediately.
Restocking and refueling must be completed even if the crew is on overtime.

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

EQUIPMENT CLEANING POLICY

Policy Number: 0052
Date: July 1, 2024

Purpose: To establish guidelines for cleaning equipment.

Content:
If any item gets contaminated and needs to be cleaned. Please check with a supervisor for the current cleaning solution being used.
Most items can be washed with soap and water such as gurneys, ambulance floors, etc.
Surfaces can be sprayed with the appropriate cleaning solutions and wiped down.
Laryngoscope blades shall be soaked for the prescribed time listed and the current disinfectant solution. This is typically done in the basement.
Please refer to all manufacturers' recommendations for cleaning and decontaminating of any equipment or surfaces.
Gloves, masks and eye protection shall be worn at all times when cleaning contaminated equipment or surfaces.
Any items that can not be cleaned must be placed in red bio-hazard bag and disposed of appropriately.

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

WEAPONS POLICY

Policy Number: 0053
Date: July 1, 2024

Purpose: To establish a policy for weapons.

Content:
Knives: May be used for work purposes. Knives with blades more than 5.5 inches in length shall not be used for work or be carried while on duty.

Firearms: Absolutely NO loaded firearms are allowed on the property or in any ambulance at any time. Unloaded firearms may be allowed for exchange between personnel if they have prior approval from a supervisor.

Other: Any other item that may be considered a weapon is not allowed without the permission of a supervisor. This includes, but is not limited to, num-chucks, baseball bats, paint ball guns, swords, stun guns, tasers, etc.

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

PERSONAL CONTACT INFORMATION POLICY

Policy Number: 0054
Date: July 1, 2024

Purpose: To establish a policy regarding employee's personal contact information.

Content:
No employee shall give any personal contact information about another employee to any person that is not an employee of the company.
All employees are subject to other employees having their contact information. All employees agree not to share that information with non-employees.

If a non-employee wishes to contact an employee, you may take the non-employees name and number so that the employee can call that person back.

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

NON-TRANSPORT BILLING POLICY

Policy Number: 55
Date: July 1, 2024

Purpose: To establish a policy for billing non-transported patients which is allowed for under our service provider agreement with the City and County of San Francisco EMS Agency.

Content: It will be the policy of the company to bill for "response to call" under the following circumstances.

1. Ambulance crew responds to a call, evaluates the patient and the patient decides not to be transported. Usually this requires a response to a patient's house, but may include a restaurant, convention center, sports stadium or any other public area.
2. Calls resulting from 3rd party callers will not be billed. I.e. passer-by calls 911 for a man down on the sidewalk. Usually this would be if a person did not request the ambulance and had no legitimate reason for an ambulance response, but through no fault of their own, one was requested and responded to by a Good Samaritan.

Insurance:

Medicare: Bill the patient "response to call" if the patient REFUSED care. Do not bill Medicare for non-transported calls.

Medi-Cal: Bill claim for base rate.

Commercial HMO/PPO: Bill claim as "response to call".

Private Pay: Bill claim as "response to call".

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

RESPIRATORY PROTECTION POLICY

Policy Number: 56
Date: July 1, 2024

Purpose: To establish compliance with Cal-OSHA regulations for respiratory protection and aerosolized disease transmission prevention.

Content:
Employees will be fit tested annually and performed within industry standards and compliant with Cal-OSHA regulations. Fit testing and training will be done simultaneously. Record keeping and reporting logs shall be compliant with Cal-OSHA and other regulatory agencies as well as all applicable Federal, State and Local Laws.

This policy is in addition to and conjunction with other Personal Protective Equipment such as eye protection, gloves, etc. and the companies Exposure Control Plan.

N-95 Masks shall be worn at all times when an employee is in contact and/or close confined quarters when treating patients with a history of:

1. Hepatitis A, B, C and HIV
2. High risk patients in closed confined areas with a cough or fever

P-100 Mask shall be worn at all times when

1. Intubating
2. Using a BVM
3. Nebulization
4. Suctioning
5. Confirmed or suspected T.B. patients

If an N-95 mask is not available a P-100 mask may be worn. A P-100 mask may be worn at all times in place of the N-95 mask if the employee so chooses.
The P-100 mask may be used for 30 days from the date of first use on a repeated basis. No more than 8 hours of use if the exposure is to an oil-base. Discard the mask if it becomes compromised in any way due to wear or obvious contamination.

Employees are required to wear the company issued fanny pack with the P100 and N95 masks in them. There should also be scissors, gloves, gowns and eye protection in the pack at all times. Employees are to wear these packs on ALL CALLS or have them within the immediate area (such as on the jump bag). Crews are not allowed to leave them in the ambulance while attending to patients outside of the ambulance. This PPE must be immediately and readily accessible to the employees.

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

Dispatch Pay and Overtime POLICY

Policy Number: 57
Date: July 1, 2024

Purpose: To establish a policy for paying dispatchers due to varying shifts and inability to be 100% relieved for lunch breaks. To establish pay rates.

Content:
King-American Ambulance Company currently pays their dispatchers at the wages established by the company. Although the dispatchers are not union employees, they are at-will employees; the company will use the current approved scale for the purposes of calculating compensation and overtime wages. A copy of the wage scale is available upon request by a dispatcher.

It is understood that not all shift work is able to be relieved for meal periods of lunch breaks. Therefore, an agreement of understanding signed by the employee shall be obtained outlining the shift and inability to be relieved.

When an employee is unable to be relieved of all duty for the purposes of a 30 minute meal break, the company will pay 1 hour of straight time for each meal period missed. Meal breaks are not “optional”. If you are able to take a break, then you must take a break. Punching in and out for meal periods is mandatory.

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

MAINTENANCE of CERTIFICATION POLICY

Policy Number: 0058
Date: July 1, 2024

Purpose: To establish a policy and standard to ensure that employees have current certifications on file with the company.

Content: The Company will maintain records of certification on ESO. The software is designed to track all certifications and give employee and management notice of expiration dates. Employee's will be denied the ability to punch in if they have expired certifications.
The company maintains a "NO CERT NO WORK POLICY".
Exceptions could be made for driving certifications and the employee would not be allowed to drive.

Expired certifications may lead to disciplinary action.

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

Separation of Employment POLICY

Policy Number: 0059
Date: July 1, 2024

Purpose: To establish a policy for the cases of separation of employment.

Content:

Voluntary Separation:

The Company would appreciate at least two weeks notice of the employee's decision to separate employment.

Upon separation of employment the employee shall return all issued equipment that is the property of the company. This includes, but is not limited to, uniforms, radios, radio holders, scissors, intubation equipment, clipboards, cell phones, tools, etc. All equipment must be returned.

If the employee gives at least 72 hours notice, the company will have their final paycheck ready for them at the end of their last day, that includes their last day and any accrued vacation or sick time owed to them.

If the employee gives less than 72 hours notice, the employees final paycheck will be on the next regular payday and will include any accrued vacation and sick time owed to them.

Involuntary Separation:

In the event of an involuntary separation the company will provide the employee's final paycheck with all accrued regular and overtime hours, accrued vacation and sick time, along with any other payment due to the employee. This check will be provided at the time of termination of employment.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
GURNEY OPERATIONS

Policy Number: 0060
Date: May 2014

All employees are to follow manufacturer recommendations for the proper use of the gurneys. All employees shall remain familiar with all safety practices as provided by the in service video from the manufacturer.

All patients shall be restrained on the gurney with seatbelts and shoulder straps at all times. Anytime a patient is on the gurney the restraints must be in place and locked, this includes pushing the gurney to and from the ambulance with a patient on it, and also while the patient is on the gurney in the back of the ambulance during transport. Restraints may only be removed if they interfere with patient care and must be replaced as soon a possible for the safety of the patient.

Pediatrics: Employees may use the parent's car seat as a form of restraints if it is appropriately fitting the needs of the pediatric patient. In the case of no car being available the child may be restrained to the gurney to the best of the crew's ability. The company discourages the practice of having a parent sit on the gurney and hold the child. However, the company recognizes that there may be an appropriate time for such a decision. The company also uses a special device called a papoose. It is specifically designed for securing pediatrics to the gurney. Follow manufacturer recommendations and instructions for securing the papoose to the gurney. The papoose is the preferred method for securing pediatrics to the gurney.

Loading and Unloading: This task is a joint responsibility. It takes two personnel to safely and successfully load and unload a gurney with a patient on it. Constant communication is paramount in this operation. The safety hook should be used at all times unless you are in a position that does not allow it to work, such as a steep hill or side angle. Every attempt should be made to move the ambulance to an angle that allows the safety hook to work properly. Both crewmembers must communicate that the hook is latched before loading. During unloading, the wheels are not allowed to fall to the ground. The wheels must be carefully assisted to the ground to minimize disturbance to the patients. Remember, the safety hook is their for safety. It should not be used a "catch" while unloading a patient. If the safety hook fails to "catch" and you drop the gurney, it is your fault, not the equipment's fault.

Safety Precaution: At the point that one crew member has lifted the gurney wheels off the ground and squeezed the handle in preparation of the partner lifting the undercarriage of the gurney to load it into the ambulance, AT NO POINT is the employee allowed to pull or move the gurney backwards during the loading process. Once the gurney is lifted off the ground the employee must push the gurney forwards or set the gurney down to start all over. DO NOT PULL BACKWARDS WITH THE WHEELS OFF THE GROUND.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
GURNEY OPERATIONS

Policy Number: 0060
Date: May 2014

Maintenance: The Company will provide regular maintenance for the gurneys to ensure safety. All gurneys in need of repair shall be reported immediately to management and taken out of service for repairs.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
DRIVE-CAM POLICY

Policy Number: 0061
Date: July 1, 2024

Purpose: To establish a policy for the Drive-Cam recording system.

Content:

Drive-Cam video recording systems in the ambulances will be used to monitor vehicle activity. Some of the vehicle activity it will monitor includes, but is not limited to, acceleration, braking, speed, high speed turns, and collisions. Cameras are GPS equipped and will monitor vehicle location as well. Cameras will be forward and rear facing.

Cameras will be adjusted to record "excessive" maneuvering. Employees who trigger events that record excessive maneuvering will have those events reviewed by management for appropriateness. Typically, appropriateness is considered to be accident avoidance, not code 3 driving in general.

Events that are captured, recorded and uploaded will be reviewed and discipline will be considered based on the circumstances of the event. Obvious disciplinary scenarios include, but are not limited to, excessive speeding, reckless driving, not wearing a seatbelt, not being in uniform, talking on a cell phone if it's not an emergency, other distracted driving and any other violation of our company's driving policy. Discipline will be in accordance with our discipline policy and the collective bargaining agreement.

The company may share these events and recordings with law enforcement, insurance companies, courts and any other entity necessary for the purposes of litigation or investigation.

Voice recording shall be turned off.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
D.B.A. Allied Medical Transport
DURBAL MEDICAL EQUIPMENT POLICY

Policy Number: 0062
Date: July 1, 2024

Purpose: To establish a policy that addresses what to do with patient's durable medical equipment such as electric wheelchairs that cannot be taken in the ambulance with a patient.

Content:
The goal of this policy is to minimize the loss of expensive durable medical equipment and prevent it from being left on the street unattended to get stolen.

The SFFD has issued a general order that this policy is based on. It is listed at the end of this policy for reference.

The SFFD personnel on scene are responsible for securing the patient's durable medical equipment if they are on scene.

If SFFD is not on scene you need to use your radio to contact DEC and request PD to stand by with the equipment until DEC can dispatch the appropriate department to come pick up the equipment. It is DEC's responsibility to find the correct department to transport the equipment. The goal is to reunite the patient with their equipment by having it transported to the hospital that they were transported to.

No durable medical equipment shall be left behind unattended unless the patient requires a code 3 transport to the hospital due to a life threatening event.

This policy refers to incidents that happen on the street. Not in a residence. The goal of the policy is to SECURE the durable medical equipment so it doesn't get stolen. It is not the goal of this policy to transport durable medical equipment from a person's home to the hospital for convenience purposes.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
D.B.A. Allied Medical Transport
DURBAL MEDICAL EQUIPMENT POLICY

Policy Number: 0062
Date: July 1, 2024

SAN FRANCISCO FIRE DEPARTMENT
GENERAL ORDER

File Code 11 A-74
December 19, 2011

From: Chief of Department
To: Distribution List "A"
Subject: Transportation of Mobility Devices/ Durable Medical Equipment (DME)
Reference: Rules & Regulations, Sec. 402
Enclosure: None

Officer Endorsement:
Sec 1108 – R. & R.

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1. Department members may transport 911 EMS patients who use mobility devices or have durable medical equipment (DME). Mobility devices and DME include, but are not limited to, wheelchairs, power or motorized wheelchairs, motorized scooters, electric personal assistive mobility devices, (commonly known under the brand name "Segway"), canes, crutches, walkers, portable oxygen, and any other type of durable medical equipment owned/required by the patient.

2. It is the responsibility of each Department member to ensure that patient property, including mobility devices and DME, is secured in a safe and reasonable manner prior to transporting the patient to the hospital. On the occasion that a patient's medical condition warrants immediate transport, it is the responsibility of on-scene Department members to make appropriate arrangements for the securing of the patient's property and DME.

3. In cases where the patient requires the use of the same mobility device or DME at the hospital or upon discharge, whenever possible, that device or equipment shall be transported with the patient. Members are advised that Mobile Assistance Patrol (MAP) and the SF Paratransit contractor, through the SF Municipal Transit Authority, are designated providers for emergency back-up mobility device transportation. These services are available through the Division of Emergency Communications (DEC).

4. If the mobility device is too large, as in the case of power or motorized wheelchairs, Department members should not attempt to disassemble these types of mobility

devices. Department members should not unplug the power to the chair if they are not trained unless an extenuating circumstance exists.

5. If a Department member encounters a patient on the scene of an 911 call; and after assessing the situation determines that the transportation of the DME is not possible within normal department resources (ambulance); or encounters a power or motorized wheelchair /mobility device user in need of assistance due to a chair breakdown or other reason, he/she shall follow the following field procedures:

    - Contact the Department of Communications via radio and request a mobility device transportation provider. Department members shall relay the type of device to be transported and the location of the device.

- Members shall request a SFPD Officer through the DEC for a standby until the mobility device transportation service arrives to secure the device.
- DEC will contact the mobility device transport services in the order shown. The contact information is located in the DEC "help file"- Mobility (MOB). This contact information will be updated by the DEC no less than every six months and updates are to be provided to the DEC by the MTA.
    - Mobile Assistance Patrol – 2 mobility access resources
    - Paratransit contractor (SF MTA)
- On-scene personnel shall tag the mobility device with the owner's name, contact number, and hospital destination obtained from the paramedic ambulance crew.
- Department personnel may, with the patient's/owner's assistance, disengage the drive mechanism which allows the chair to be rolled or pushed.
- Biohazard contaminated mobility devices shall be bagged or covered as much as possible as to prevent additional contamination of Department members or transportation services personnel.
- On-scene personnel shall not, within reason, leave the scene until a SFPD Officer has secured the mobility device or the mobility device transport services have arrived. Extenuating circumstances may arise such as SFPD being unavailable due to a major incident, or a major incident in the immediate first alarm area of a SFFD company. In these circumstances, Department members will use all reasonable efforts to secure the device, notify DEC of their actions and respond to the incident. DEC will attempt to expedite SFPD, or the mobility device transport services.
- In the event that extenuating circumstances occurred and the durable medical equipment is reported missing, a Rescue Captain shall respond to the scene to meet with the reporting party of the missing DME. A police report shall be requested to be taken by SFPD. A SF EMSA Exception Report will be filed by the RC regarding the missing DME in accordance with Policy 4000. The police report, LEMSA Exception Report and a General Form from the RC documenting their actions taken shall be forwarded to the Deputy Chief of Operations.

7. When a patient's property (other than clothing) must be removed from their person in the course of patient care, the removed items should be secured, tagged with the patient's name and disposition documented on the PCR. Items should be logged on the PCR, and the name of the person accepting the items at the receiving facility documented.

8. This General Order review will become part of the training requirements for all Department members on an annual basis.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
D.B.A. Allied Medical Transport
FATIGUE MITIGATION POLICY

Policy Number: 0063
Date: July1, 2024

Purpose: To establish a policy that reduces the risk of endangering crew members and patients due to fatigue.
See also Policy 0045 (Long Distance Transport Policy)

Content:
It is our goal at King American to make sure we have a healthy workplace environment that promotes productivity and at the same time protects our employees from unnecessary mental and physical fatigue.
In order to prevent workplace mental and physical injury, King American has set forth these guidelines.

1. Normal street shifts are scheduled for 12 hour periods.
2. 24 hour shifts for union employees will have separate guidelines, yet to be developed.
3. If an employee chooses to work two 12 hours shifts making a 24 hour span, there must be a 12 hour break prior to returning to their next shift.
4. Our Union provides assistance to any member through its Teamsters Assistance Program (TAP) for Alcohol/Drugs or other person problems.
   They may be reached Monday through Friday 8 Am – 5 pm
   (510) 562- 3600
   (800) 253-8326
5. Water will be provided to all employees to ensure proper hydration. Employees must use their own container.
6. CISD will also be provided by SFFD stress relief program.
7. If an employee chooses so, due to extreme fatigue post shift, they may sleep in crew's quarters as opposed to driving home. Please get approval from supervisor.
8. Caffeine will be provided to crews as requested in supervisor's office as a fatigue countermeasure when deemed appropriate and as available.
9. 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 any other cause nor when the vehicle is unsafe to operate.
10. The company will not retaliate against those complaining of fatigue, illness or other cause that may affect the employee's ability to operate an ambulance safely.

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
D.B.A. Allied Medical Transport
FATIGUE MITIGATION POLICY

Policy Number: 0063
Date: July1, 2024

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
D.B.A. Allied Medical Transport
POLICY TO FOLLOW POLICIES

Policy Number: 0064
Date: July 1, 2024

Purpose: To fulfill the requirement in the Service Provider Agreement that took effect July 1, 2020 that requires us to have a policy, in writing, to follow the City and County's policies. (Attachment A, 8, b)

Content:
All employees are required to have knowledge of, and follow, LEMSA Policies, Procedures and Protocols, and Directives.

KING-AMERICAN

I, _____, have received the Allied Medical Services of California, Inc. company policy book 2024 version. I agree to read, understand, and abide by all rules of the company or I may receive disciplinary action up to and including termination.

I understand that this book is the property of Allied Medical Services of California, Inc. and agree to return any printed version in good condition upon separation of employment.

I agree not to reproduce, alter, or amend this book in any fashion.

Electronic copies will be made available to employees.

I understand that all changes, modifications, alterations, additions and/or deletions will come from management. I understand that management will advise the employees of the change and its effective date will be immediately. I understand that I may request a copy of the new or changed policy from management, and there will be an updated version available in electronic format.

I understand that ALL memos posted are also considered to be company policy.

Print Name: _____

Sign Name: _____

Date: _____

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2023 CQI Update:

Current Plan:
Updated last year. With large employee turnover we are still focusing on the basics by reviewing all chest pain, shortness of breath, all medication administration, and all code 3 returns to the hospital. We are focusing on vitals before and after medication and correct destination documentation. We continue to focus on the SFEMS agency's documentation requirements for certain call types such as CVA, etc.

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 at this time. It is small and random.

We continue to put all new hires through a rigorous skills training station.

New Projects:
In Q4 of 2023 we moved to Zoll's hosted environment for dispatch, began implementing EMSCharts for PCR's and switched to Zoll Billing for our billing office.

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2024 Quality Improvement Plan
DISPATCH OPERATIONS

Dispatch

Calls are reviewed for appropriate EMD codes and dispatch codes daily. Calls are also checked to make sure the appropriate unit was dispatched. Recordings of the calls are reviewed and taped for training purposes. A random selection of scene type emergency calls is then handed to all the dispatchers to review and see if they come up with the same EMD codes and units to dispatch. We will be using the AQUA for this process. We also do scenario-based training to focus on specific EMD Protocol usage.

Personnel / Training / Teaching

Training such as CPR, ACLS, PALS and EVOC other continuing education classes are performed on a regular basis. In June 2012 we started the "Card(s) of the Month" program and review the EMD cards that may not be used all the time. During periods of availability the dispatcher supervisor may sit and listen to call takers triage call and provide real time feedback during the call taking process.

LEMSIS

We are using ZOLL electronic PCR's and CAD system. We were a participating agency for the LEMSIS Steering Group and will continue our participation when it convenes again. We are working with other agencies to discover the best way to get a uniform data collection database.

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

A report will be filed with EMSA upon request for their review, to include QI and training activities, and any formal remediation and disciplinary action taken with employees. All records will be stored in a secure location and available upon request to EMSA. These records will be stored for a period of not less than 3 years.

Systematic methods for continually evaluating and improving services delivered using objective measures for structure, Process and outcome indicators and evaluations.

Continually evaluating and improving services: 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. Starting January 2012 we will be using the new NAEMD review sheets for this process. We also do scenario based training to focus on specific EMD Protocol usage.

Objective measures for structure, process and outcome indicators: NAEMD review sheets will be used for objectively measuring quality of the EMD process. These sheets allow an objective measurement of structure and process. Outcome indicators may be difficult to obtain as it is not common practice to follow up on patients from a dispatch point of view.

Specific Objective measures for structure, process and outcome: NAEMD review sheets will be used for objectively measuring structure, process, and if possible, outcome. The NAEMD-Q guidelines for reviewing calls and feedback will be utilized.

QA Feedback Loop: After a call is reviewed from the recording and the EMD-Q sheet is completed the reviewer, usually the dispatch supervisor if trained in QA, will review the call with the original call taker and provide them with the dispatch QA call review feedback sheet. The call will be discussed, notes provided on the sheet and then the call taker and reviewer will sign the form. Dispatch management will be advised of completion of call taker feedback. There is no internal medical dispatch review committee set up at this time to report to. We do not regularly report to other EMS providers unless a situation arises where there may joint responsibility for a specific incident or an indentified learning objective that may benefit the EMS system as a whole, or the other provider(s). The EMS agency may request reports or copies of our internal review process at any time. Timing and formatting issues will be worked out in future discussions mutually agreed upon by both entities.

Proving Tapes or Copies of Logs of EMD Calls: Tapes and/or copies of logs of EMD's calls shall be provided to the LEMSA at their request. Tapes are easily copied and pasted as wave files and can be listened to on any computer. Other agencies within the City and County of San Francisco that request copies of logs or tapes will need to show proof that the information requested is necessary and proof that the request is for quality improvement purposes. HIPAA forms and agreements shall be in place before such information is delivered. Information may be provided to agencies outside of the City and County of San Francisco such as the California Highway Patrol during yearly reviews and inspections and the California State EMS Authority upon written request. The company will ensure that all HIPAA compliance remains intact.

Reporting and follow up for Unusual Occurrences (UO's) to the EMS Agency: Any incident that does not sound right to a call taker or dispatcher will first review the incident with the dispatcher supervisor. The dispatch supervisor will determine if the incident needs to go to management. If the incident needs to be reported to management, management will determine if an unusual occurrence or sentinel event form needs to be filed with the EMS Agency. The EMS agency will be informed and they will follow their internal processes. The company shall provide feedback and follow up to the initial call taker or dispatcher that encountered and reported the incident. This process is

important so that management stays involved in the process and the employee doesn't arbitrarily file UO's with the EMS Agency without first using the internal chain of command.

Recognizing Excellence: The Company will provide acknowledgement of employees that do exceptional jobs. This could be anything from posting an acknowledgement on the hallway walls, to providing the employee with a Starbuck's card or some other means of telling the employee of a job well done. Such action of the company will be on a case by case basis. Usually this will be reserved for such cases as CPR instructions over the phone or giving instructions on childbirth.

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2024
Dispatch Quality Assurance Report for 2023

1. Dispatch Continuing Education Plan.
   All dispatchers are receiving continuing education. Their certificates remain current and are compliant with the National Academy of Emergency Medical Dispatch. All dispatchers have training folders and training is provided by Supervisor Nikki Maples and Ish Perez.

2. Corrective Action Plan.
   No dispatchers have been placed on any type of corrective action plan in 2023.

3. Dispatch CQI Meetings
   Meetings were not held quarterly. It did not appear to be necessary at the time. Although we did have a couple meetings, no regular notes or minutes were taken as prescribed in the plan. This will be addressed and corrected in 2024.

4. Dispatch Framework
   A. The goal of auditing over the required percent of all private emergency calls was met. Supervisor Ish Perez and Nikki Maples reviewed calls as necessary with the dispatchers and made minor corrections. NO major issues with call taking were reported or documented. This achieved the goal of improving dispatcher knowledge of the protocols. All recommendations of the National Academy of Emergency Dispatch were adhered to, to the best of our knowledge.
   B. Review of County policies that directly affect dispatch was done by the supervisors. It was not emphasized toward the dispatchers. This will be emphasized in future years.
   C. Protocol of the month training is being done. Not as fast as we would like to be. We are striving for more robust training for 2024.

5. Dispatch Operations

   A. Personnel, Training, Teaching is being post by post call tape review and EMD card review. More emphasis will be placed on this in future years.
   B. Participation. All personnel participate in the QA process.

6. Continuously evaluating and improving services. Calls are reviewed daily for appropriateness of EMD codes. Matching of PCR and dispatch records are done at end of each shift to ensure data integrity and accuracy. Scenario based training will have more emphasis in future years.

7. Object measures for structure, process and outcome. AQUA is being used for this process. Outcomes of patients are difficult to access and hospitals do not report outcomes to anybody in this county except for cardiac arrest through the CARES data base.

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8. Specific objective measures for structure, process, and outcome. AQUA for call review is used. King American private emergency calls are audited and reviewed.

9. QA feedback loop. This is being completed as necessary when the QA supervisor feels that it is important to correct major deviations of the NAEMD protocol. Only a handful of these were necessary in 2022. We have an excellent compliance rate for the most part.

10. Providing tapes or copies of logs to LEMSA. King American has provided copies of emergency tapes and logs several times in at the request of the LEMSA. No log was kept of the incidents requested

11. Reporting and follow up for Unusual Occurrences. No UO reporting was done or necessary for 2023.

12. Recognizing excellence. A few times in 2023 the president of King American recognized a job well done and Burton Lee was nominated for the Star Of Life Award. Other dispatchers have been told they did excellent on difficult calls as well throughout the year. Rewards were handed out such as Starbuck's cards, etc.

13. Dispatch QA Plan update. The plan has been updated for 2024 and emphasis will be placed on the items listed in this report.

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2024
CONTINUING EDUCATION
DISPATCH

PROGRAM: King-American Ambulance will provide continuous training in the following areas for current dispatchers.

1. ***Telephone Scenarios (3 hours minimum in 24 month period)***
   A. The dispatch supervisor will create scenarios for call takers to address. The supervisor will provide feedback and guidance during the scenario(s).
2. ***Tape Audits (3 hours minimum in 24 month period)***
   A. Supervisor will assign recordings for dispatchers to listen to and attempt to EMD as they follow along. Discussion will be had between the dispatcher and supervisor after completion.
3. ***Protocol Review (3 hours minimum in 24 month period)***
   A. The dispatch supervisor will review EMD protocols with the dispatchers and conduct evaluation on the selected protocol.
4. ***On Duty Work Experience (3 hours minimum in 24 month period)***
   A. The dispatch supervisor will monitor real time call taking and provide guidance and feedback as necessary to ensure the quality of the call taking.

The dispatcher / Call Taker will record 24 hours of continuing education in order to renew their EMD certification. A minimum of 3 hours shall be recorded in each category above. The remainder of the 24 hours can be in any subject approved for credit towards EMD recertification.

These training records shall be kept for a period of not less than 2 years.

King American Ambulance
DISPATCH QA – Corrective Action Plan

Employee Name: _____ Date: _____
QA Supervisor Name: _____

Description of action in need of correction:

_____
_____
_____
_____
_____

Date	Act / Omission
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Specific Identifiable Pattern established? Y / N

Corrective Action Plan

_____
_____
_____
_____
_____
_____

Date to be completed: _____

Consequences of non-compliance with Corrective Action Plan may result in disciplinary action in accordance with company policies and procedures.

_____	_____
Dispatcher Signature	QA Supervisor Signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date

King American Ambulance
DISPATCH CQI COMMITTEE MEETING STRUCTURE
January 2024

Purpose: To establish a CQI dispatch committee meeting schedule and structure.

Content:

1. Meetings will be held at least quarterly.
2. Content of the meeting will be as follows.
   A. Review of agenda
   B. Review of old minutes
   C. Discussion on old items and progress made if any
   D. New business/new issues that need discussion
   E. Action plan
3. Minutes will be taken with the following items
   A. Date
   B. Time
   C. Names of Attendees
   D. Notes for each item above
4. Items that need to be addressed/discussed with crew members will be done as needed
5. Meeting minutes will be retained for a minimum of 3 years.

King American Ambulance
QI GOALS / OBJECTIVES
DISPATCH FRAMEWORK
January 2024

Purpose: To establish a set of goals and objectives for King American Ambulance through the process of the Quality Improvement Plan and process.

Content: The following are the goals and objectives for King American Ambulance Dispatch Center.

1. To improve and reinforce protocol / policy knowledge to employees by reviewing EMD'd calls with them as needed. ***60% Call Audit goal***.
   Continue QI review process for EMD in our dispatch center and adhere to the recommendations of the National Academy of Emergency Dispatch for QI. Currently we have 2 trained employees in EMD-Q.
2. Participate in the LEMSIS reporting with EMSA (under development since 2007)
3. To Review County Policies and Protocols that directly or indirectly pertain to dispatch functions and operations such as disasters and MCI's.
4. Continue monthly in-house training via "protocol of the month" training.
5. Continue to facilitate time to dispatchers to work on and complete Online CDE's via College of Emergency Dispatch Online Courses

King American Ambulance
QI GOALS / OBJECTIVES
2024
STATUS REPORT 2023

Cases are reviewed for overall policy and protocol compliance based on what the National Academy of Emergency Medical Dispatch sets for call taking.

1. Calls are selected randomly for case review.
2. ED-Q reviews calls and gives feedback to call taker regardless of compliant and non-compliant cases
3. The goal of meeting 50% call audit was made in 2023
4. In-House continuing education provided by ED-Q goals met with “Protocol of the Month”, ProQA Review, Protocol Review and Universal Protocol Standards Review.

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2024 Quality Improvement Plan
DISPATCH QUALITY IMPROVEMENT
INSTRUCTION AND DISCLAIMER

This QI Plan shall be used in conjunction with the main QA plan for the company. If any conflict arises between the two plans, this plan shall prevail for purposes of dispatch functions and QA. This plan shall be reviewed at a minimum of every 2 years to ensure the latest versions of plans and QA processes.

King-American Ambulance

AFTER ACTION REPORT SUMMARY

Incident:_____ **Date:** _____

Person Completing Summary: _____

Summary: (use back of page if necessary) _____

Final Action Taken: _____

Signed: _____

Print: _____

Use back of page for additional information. (01/03)

King-American Ambulance

INVESTIGATION REPORT

Be sure to fill out completely

Person Reporting:_____ **Date of Report:** _____

Home Phone: _____ **Work Phone:** _____

Nature of incident: _____

Where did incident occur: _____**Job #:**_____

Address: _____ **City:** _____

Date of Incident: _____ **Time:** _____

Please describe incident fully: (use back of page if necessary) _____

_____

_____

_____

_____

_____

_____

_____

Supervisor Notified: Name: _____ **Date:** _____ **Time:** _____

Manager Notified: Name: _____ **Date:** _____ **Time:** _____

Reported immediately?: _____ **To Whom:** _____

Immediate Action Taken: _____

Witnesses Names: _____

Injuries Involved: _____

Was a police report filed? _____ **(#:** _____**)**

Date investigation Closed: _____

Use back of page for additional information. (01/03)

King-American Ambulance

INVESTIGATION REPORT CHECK LIST

_____ Date of event: _____

_____ Date of company's first knowledge of event: _____

_____ Date Investigation Began: _____

_____ Union Notified within 5 days of knowing about the event (if discipline is possible)
Date: _____ Time: _____ FAX or Certified Mail (circle one)
Fax Number – 415-467-5677

_____ Fax receipt attached (if not, then call union to verify receipt) 415-467-0450
Name of person who verified receipt: _____

_____ Investigation Report filled out

_____ Management Notified in timely fashion (Date: _____ Time: _____ Name: _____)

_____ LEMSA notification if necessary (Date: _____)

_____ Sentinel Event Form filled out and copy attached (Date: _____)

_____ Immediate action taken if necessary (Desc. _____)

_____ Police Report filed if necessary (Date: _____ Rpt # _____)

_____ Interview of person reporting incident (Date: _____)

_____ Interview of witnesses (#_____ of witnesses)

_____ After Action Report Summary filled out

_____ Appropriate personnel notified of conclusion of investigation

_____ Investigation Closed date filled out after Summary Report completed

_____ Date closed: _____

King-American Ambulance

INTERVIEW REPORT

Person Being Interviewed:_____ **Date:** _____

Time Started: _____ **Time Concluded:** _____

Person Conducting Interview: _____

Names of other person(s) Present: _____

Summary: (use back of page if necessary) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

King American Ambulance
Quality Improvement Plan
INVESTIGATION PROCEDURES
EMSA POLICY 6020
2024

Policy 6020:
This policy defines and categorizes incidents into 3 levels. They are as follows:

1. Peer to Peer
2. Exception Reporting
3. Mandatory

GOAL:
It shall be the goal of the investigator to complete the investigation within a 30 day period.

Refer to policy 6020 for definitions

Procedure:
All Incidents shall be investigated according to this format and EMSA Policy 6020 reporting guidelines.

Mandatory Paperwork:

1. Incident documented appropriate level log sheet for easy tracking.
2. Investigation Report Checklist.
3. Investigation Report Form.
4. Interview Report Form
5. After Action Report Summary

All forms must be filled out completely and as quickly as possible.

If the incident is a reportable issue to LEMSA then the supervisor reporting the incident shall be responsible for follow up and closure of LEMSA investigation.

Management shall be informed of the current status whenever a significant change or development occurs.

If investigation is too complex for an internal investigation to handle then the company may seek outside help to investigate. Outside help will usually come from the California Employers Association, an HR contracted company for King-American, or another outside agency such as law enforcement, if necessary.

Data Collection:
Data from incidents reports will be collected and aggregated for summarizing and analysis of trends and/or patterns according to:

1. Incident types
2. Frequency
3. Severity (level 1, level 2 or level 3)
4. Individual providers

5. Patient outcomes (if available)
6. Merit / No Merit
7. License or certificate actions
8. Investigation turnaround times

This shall be accomplished by supervisory or management personnel review at an annual interval the above incident logs and investigations.

Root cause analysis will be completed by investigator and will inform management of findings and suggestive corrected action to take to avoid or minimize similar situations in the future.

Closing Process:
The investigation report checklist shall identify the loop closure and that the appropriate parties are notified of the conclusion of the investigation and if any action was or will be taken based on the outcome of the investigation.

Tracking Process:
All investigations will be tracked and monitored by management. The investigating supervisor will give reports after any action during the process, I.E. interviews completed, etc. The open file will remain in the custody of the investigator until completion. Then shall be filed and marked as completed.

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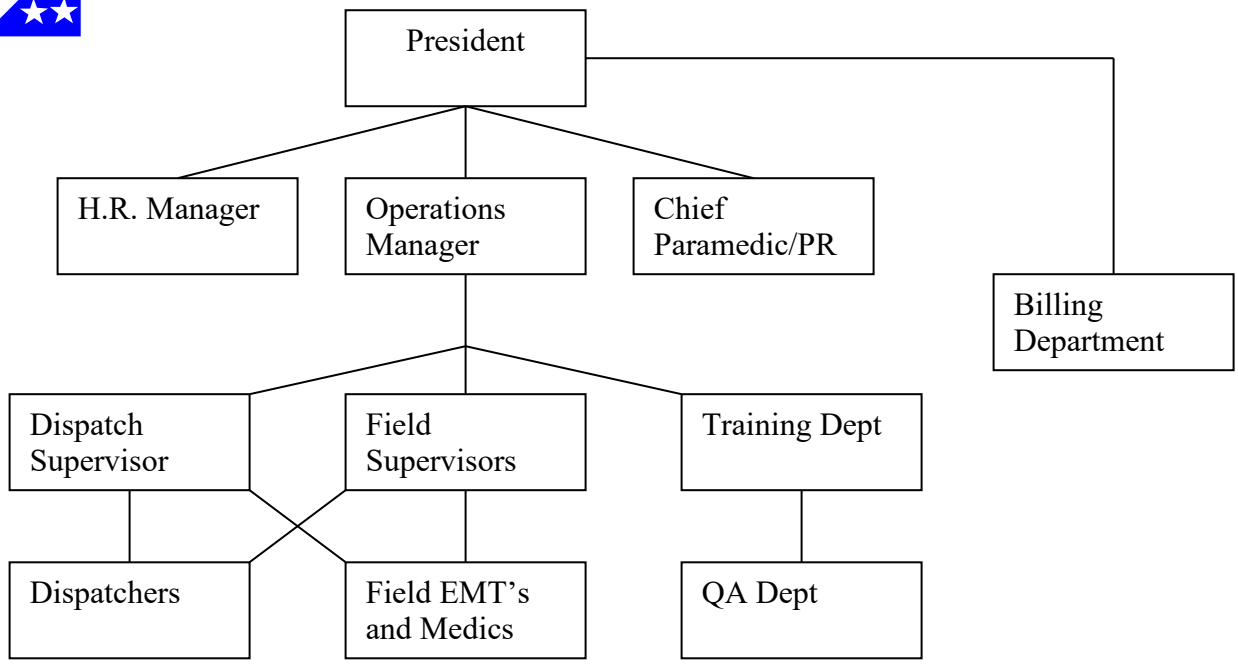

The above chain of command and organizational structure as of January 1, 2023.

President – Josette Mani

Human Resource – Josh Nultemeier

Operations Manager/Chief Paramedic/QA Director/Training – Josh Nultemeier

Public Relations Officer – Josh Nultemeier

Billing Dept

1. Controller – Josh Mani, Managing Director
2. Supervisor – Joan Santilices

Supervisors/QA/Specialists – Josh Nultemeier

Paramedic Supervisor, Supply and Safety Officer – Peter Jacoby

Paramedic Supervisor – Kiarra Grant, Peter Jacoby, Ian Collier, Ed Cienfuegos, Cassie Rashleger

QA Director – Josh Nultemeier

EMT Supervisor and Vehicle Maintenance – Bernard Galang

Communications Supervisors – Ish Perez and Nikki Maples

King American Ambulance
QA – Corrective Action Plan

Paramedic Name: _____ Date: _____
QA Supervisor Name: _____

Description of action in need of correction:

_____
_____
_____
_____
_____

Date	Act / Omission
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Specific Identifiable Pattern established? Y / N

Corrective Action Plan

_____
_____
_____
_____
_____
_____

Date to be completed: _____

Consequences of non-compliance with Corrective Action Plan may result in disciplinary action in accordance with company policies and procedures.

_____ _____
Paramedic Signature QA Supervisor Signature

_____ _____
Print Name Print Name

_____ _____
Date Date

Paramedic Field Evaluation

Date: _____
Evaluator: _____ Student/Intern/Evaluatee: _____
Run #: _____

1. Body Substance Isolation.……..……..…..
2. Scene Safety
    a. Determines Scene is safe……_____
    b. Determines mechanism of injury/nature of illness…….._____
    c. Determines number of patients……..……..……_____
    d. Requests additional help if necessary……..…_____
    e. Considers stabilization of C-Spine…….._____
3. Initial Assessment
    a. Verbalizes general impression of patient……_____
    b. Determines responsiveness/level of consciousness……_____
    c. Determines Chief Complaint/apparent life threats…….._____
    d. Assesses airway and breathing……_____
    e. Assures adequate ventilation……..._____
    f. Initiates appropriate oxygen therapy……..._____
    g. Assesses circulation via pulse and skin color, temp & condition……...._____
    h. Control major bleeding……...……_____
4. Focused history and physical exam
    a. History of present illness…….._____
    b. Onset, Provocation, Quality, Radiation, Severity, Time…..……_____
    c. Clarify questions of associated signs and symptoms related to OPQRST.._____
5. Past medical history
    a. Past pertinent history……..……._____
    b. Event leading to present illness…….……..._____
    c. Last oral intake…….……_____
    d. Medications……..._____
    e. Allergies……...…_____
6. Performs focused physical exam (assess affected body part/system or completes rapid assessment.
    a. Cardiovascular…….…….....____
    b. Pulmonary……_____
    c. Neurological……_____
    d. Musculoskeletal……_____
    e. Integumentary……...____
    f. GI/GU……_____
    g. Reproductive……..____
    h. Psychological/social……..____
7. Vital signs
    a. Blood Pressure……_____
    b. Pulse rate and rhythm…….…_____
    c. Respiratory rate, rhythm and effort……_____
    d. Lung sounds……..….____
    e. Pupils……..____
8. Diagnostics
    a. Monitor…….____
    b. Pulse oxymeter……_____
    c. Glucose check……..……_____
9. States field impression of patient…….____

Paramedic Field Evaluation

Date: _____

Evaluator: _____ Student/Intern/Evaluatee: _____

Run #: _____

10. Initiates appropriate interventions
    a. Interventions performed Interventions omitted

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

11. Initiates transport to appropriate receiving facility at appropriate time……_____
12. Repeat vitals performed after every intervention or treatment and/or every 5 minutes on critical patient & every 15 minutes on stable patient…….._____
13. Evaluates response to treatment…….._____
14. Followed appropriate protocol _____…….…….._____
15. Repeats focused assessment regarding patient complaint or injury as necessary……..._____
16. On scene time _____…….…….._____
17. Total on scene time _____ minutes……_____
18. Transport time _____ Appropriate Yes or No……..._____

Critical Failures

_____ Prolonged on scene time greater than 30 minutes unless justified
_____ No body substance isolation
_____ Failure to determine scene safety before approaching patient
_____ Failure to provide appropriate oxygen therapy
_____ Failure to provide/assess adequate ventilation
_____ Failure to find or appropriately manage problems associated with airway, breathing, hemorrhage or shock (hypoperfusion)
_____ Failure to differentiate patient's need for immediate transportation versus continued assessment and treatment on scene.
_____ Performed other detailed or focused history or physical examination before assessing and treating threats to airway, breathing and circulation.
_____ Failure to determine patient's primary problem
_____ Orders, completes or attempts to complete a dangerous or inappropriate intervention
_____ Failure to provide for spinal protection when indicated
_____ Followed inappropriate or wrong protocol
_____ Followed protocol incompletely or inaccurately
_____ Failed to complete ALS assessment on an ALS patient per county policy

_____
List items omitted
Explain any checked critical failure boxes

_____

_____

_____ _____
Evaluator Signature Student/Intern/Evaluatee Signature

_____ _____
Print Name Print Name

King-American Ambulance

Injury and Illness Prevention Program

January 1, 2021

Table of Contents

INTRODUCTION

King-American Ambulance believes that everyone benefits from a safe and healthy work environment. It is King-American Ambulance' policy to take all necessary and responsible steps to maintain a work place that is safe and healthy for its employees.

King-American Ambulance has adopted this Injury and Illness Prevention Program (IIPP) to achieve this goal and to comply with applicable laws and regulations. However, it will take more than this health and safety program to achieve our goal - it will require the assistance and cooperation of every employee.

Thank you for your commitment and contribution.

Josh Nultemeier — January 1, 2021

DUTIES AND RESPONSIBILITIES

Injury prevention is the responsibility of all levels of management, as well as, every employee. It is every employee's responsibility to comply with applicable safety and health policies and procedures.

SAFETY COORDINATOR – JOSH NULTEMEIER

The Safety Coordinator has the authority and responsibility for implementing and maintaining King-American Ambulance' Injury and Illness Prevention Program. Responsibilities include:

- Establishing minimum health and safety standards, safe work practices, safety rules and regulations.
- Establishing active and sustained interest and effort in the prevention of accidents throughout the organization and promoting a culture of safety and accountability.
- Communicating King-American Ambulance health and safety management goals, objectives, programs, policies, rules and procedures and responding to employee safety and health questions and concerns.
- Ensuring that health and safety activities are effectively conducted and documented. This includes reviewing training records, accident investigation reports, safety inspection reports, and safety recommendations on a periodic basis to ensure that the activities are properly completed and that appropriate corrective action has been taken.
- Collecting and reviewing employee safety suggestions and taking corrective action. See the ***Safety Suggestion Program*** section.
- Reviewing and facilitating updating (at least annually) of King-American Ambulance health and safety programs (e.g., IIPP, Hazard Communication); then, communicating changes throughout the organization.
- Assuring that safety and health records are maintained. See the ***Recordkeeping*** section.

MANAGERS/SUPERVISORS

Managers/Supervisors are responsible for the prevention of accidents and illness in their area of responsibility. They are expected to be visibly involved in safety management and to motivate his/her staff to adopt safe work practices. Above all, he/she is expected to exhibit a positive attitude toward safety and to set an example through his/her work practices. Responsibilities include:

- Being familiar with workplace hazards and the safe work practices affecting employees under their direction.
- Assuring that each employee understands how to complete each job that he/she perform /she is assigned in a safe manner.
- Investigating and documenting all accidents involving employees under their direction. See the ***Accident Investigations*** section for details.
- Ensuring that all employees under their direction receive documented safety and health training specific to their department. (See the ***Training*** Section).
- Conducting Prospective Quality Assurance reviews of employees under their direction to ensure compliance with safety rules, policies and procedures including the use of safety devices and personal protective equipment, and counseling employees as needed. (see the ***Training*** section).
- Participating in documented, safety inspections. (See the ***Premises Inspection*** section).
- Assuring that equipment, machines, vehicles and tools are maintained in safe operating condition.
- Maintaining supplies of personal protective equipment (PPE).
- Reporting accidents to the Safety Coordinator or on duty supervisor and file work comp claim immediately if necessary.
- Initiating correction of unsafe conditions and work practices in a timely manner.
- Being familiar with the contents of the IIPP and other safety programs.

CLAIMS COORDINATOR

The Safety Coordinator is also designated as Claims Coordinator. Responsibilities include:

- Maintaining the OSHA 300 log
- Insuring the DWC-1 and 5020 Employer's Report, are completed and forwarded to the worker's compensation carrier in a timely manner.
- Referring injured employee to designated healthcare provider for evaluation and treatment.
- Conducting claims management and return to work activities.
- Communicating regularly with injured employees, and others to check their status and treatment progress.
- Assuring that claims (see ***Recordkeeping*** section) are maintained.

EMPLOYEE

Employee responsibilities include:

- Reporting all injuries and illness to their manager/supervisor immediately.
- Asking questions if you do not understand the safe way to perform a task, or are unfamiliar with a task.

- Knowing and following safety rules, policies and procedures and adopting safe and healthy work practices.
- Using safety devices and personal protective equipment and clothing.
- Following safety training.
- Exercising good judgment and refraining from any action that might create an unsafe situation (e.g., short cuts and hurrying can be dangerous).
- Responding to observed safety issues by either eliminating the hazard or by reporting it immediately to their manager/supervisor, so that corrective action can be taken. If corrective action is not taken in a timely manner, the unsafe condition should be reported to the Safety Coordinator. Hazards may also be reported through the Safety Suggestion Program. See the ***Safety Communication*** section).
- Familiarizing themselves with the contents of the Injury and Illness Prevention Program and other company safety programs.

SAFETY COMMUNICATION

Open two-way communication between management and employees on matters of safety and health is essential to maintaining a safe and healthy workplace. The Safety Coordinator and Managers/Supervisors are responsible for communicating safety and health matters in a form that is readily understandable to all employees (e.g., compensating for language and literacy challenges) and employees are encouraged to communicate safety and health suggestions or concern. Employees who do not feel comfortable communicating their concerns to management directly can communicate them anonymously (see the ***Safety Suggestion Program*** section. King-American Ambulance uses the following methods to communicate safety and health matters:

- Safety orientation for new employee;
- Health and safety programs;
- Job/task specific safety training;
- ESO Crew Scheduler training;
- Prospective Quality Assurance reviews;
- One-On-One Safety Meetings / Safety Discipline; and
- Safety Suggestion Program.

Safety Suggestion Program

The purpose of King-American Ambulance' Safety Suggestion Program is to provide employees with a convenient and, if desired, an anonymous means to report workplace hazards and to communicate safety and health suggestions, concerns, needs or complaints. Safety suggestions can be reported to managers/supervisors or the Safety Coordinator verbally or in writing.

Employees have the option of remaining anonymous. Employees that would like to remain anonymous can write down their suggestions or concerns and place them in safety coordinator's inbox. Safety suggestions will be reviewed upon receipt by the Safety Coordinator to assure that appropriate action is taken.

TRAINING

Safety and health training is a critical element of King-American Ambulance' safety management system. Training provides an opportunity to increase safety awareness, reduce injury and illness, and improve productivity. To achieve these goals, King-American Ambulance will provide all employees, including managers and supervisors, with training on general safety and job specific safety rules, policies, and procedures. Safety training will be provided:

- To all new employees;
- Through the ESO scheduling system;
- To all reassigned employees for which training was not previously received.
- Whenever new processes, hazardous materials, procedures, or equipment that present new hazards are introduced into the workplace;
- Whenever new personal protective equipment or different work practices are adopted;
- Whenever King-American Ambulance is made aware of a new, or previously unrecognized, hazard; and

NEW EMPLOYEE SAFETY ORIENTATION

The manager/supervisor will conduct and/or facilitate new employee safety orientation. Instruction and training on general and job-specific hazards, safety rules and procedures, and King-American Ambulance' safety programs and philosophy will be provided during new employee orientation. Safe work practices will be introduced and reinforced before assigning a new employee to duty.

The ***New Employee Company Orientation Checklist*** will be used to guide and to document this training. The Safety Coordinator will maintain safety-training records.

ONGOING TRAINING

Ongoing training will be provided through the ESO and Prospective/Retrospective Quality Assurance Reviews. These provide an opportunity to increase safety awareness, provide instruction/training, and address pertinent safety issues. Employees will be encouraged to participate and voice their safety concerns during safety meetings. The Safety Coordinator will maintain records.

RETRAINING

Individual employees may be retrained after the occurrence of a work-related injury or after an employee is observed performing unsafe acts, practices or behaviors. The **Error! Reference source not found.** form (see the *Forms* section) will be used to document this training.

MANAGER/SUPERVISOR TRAINING

Mangers/Supervisors will receive periodic training to assure that they are familiar with (1) the safety and health hazards encountered by the employees under their supervision or direction, and (2) the safe work practices to prevent injuries. In addition, these meetings provide an opportunity to review safety and health related responsibilities (summarized in the ***Duties and Responsibilities*** section) and how to communicate effectively this information to employees.

IDENTIFYING AND EVALUATING WORKPLACE HAZARDS

The purpose of King-American Ambulance' hazard inspection and evaluation activities is to identify and correct physical conditions, dangers, or unsafe work practices before an accident occurs.

Inspections will be performed:

- Vehicle and Equipment Inspections;
- Premises inspections;
- When new substances, processes, procedures, or equipment are introduced into the workplace that

present new potential hazards; and

- When new or previously unidentified hazards are recognized.

Whenever possible, immediately correct identified deficiencies identified. If more than one hazard is identified, prioritize them so that the most serious ones are corrected first. In addition, take action to protect employees from uncorrected hazards. *Imminent Hazards* are discussed in the **Error! Reference source not found.** section.

VEHICLE AND EQUIPMENT INSPECTIONS

Crews are responsible for conducting and/or coordinating documented pre-shift inspections of vehicles and equipment: Ambutrak system will be used to document these inspections.

PREMISES INSPECTIONS

The manager/supervisors are responsible for conducting documented hazard inspections of their areas of responsibility at least annually. They will be documented using the inspection checklist located in the see **Error! Reference source not found.** section.

Completed inspection reports will be signed by the person conducting the inspection and copies will be forwarded to the Safety Coordinator who is responsible for reviewing the reports to ensure that appropriate corrective action is taken in a timely manner. The Safety Coordinator is responsible for maintaining inspection records.

ONGOING OBSERVATIONS

Managers/Supervisors are responsible for the prevention of accidents and illness in the workplace. They must continually be on the lookout for potential hazards. Informal inspections of this nature do not require documentation; however, whenever unsafe conditions or unsafe work practices are observed, corrective action will be initiated in a timely manner.

Employees observing unsafe conditions or unsafe work practices should respond by either eliminating the hazard or by immediately reporting it to their Managers/Supervisors, so that corrective action can be taken. Hazards may also be reported through the Safety Suggestion Program (see ***Safety Communication*** section).

CORRECTING WORKPLACE HAZARDS

Throughout this program, responsibilities and procedures for identifying and correcting unsafe work practices and conditions have been established. Whether a workplace hazard is identified through inspection, employee safety suggestion, accident investigation, observation, or new hazard evaluation activities, King-American Ambulance goal is the same – to eliminate or control the hazard before an accident occurs.

When an imminent hazard is identified that cannot be immediately abated without endangering employee, customers, and/or property, all exposed individuals will be removed from the area except those necessary to correct the condition. Workers who are required to correct the hazardous condition will be provided with necessary training, equipment, and safeguards.

PROGRAM COMPLIANCE

King-American Ambulance is committed to providing a safe and healthy workplace; however, accomplishing this goal requires the assistance and cooperation of every employee. To encourage employees to adopt safe and healthful work practices and to ensure that safety rules, procedures and policies are followed, King-American Ambulance has established the following:

- Safety training programs;
- Disciplinary procedures for employees that perform unsafe and unhealthy work practices. And the Prospective Quality Assurance Reviews process.

DISCIPLINARY SYSTEM

Any employee found to be in violation of safety rules, policies or procedures or in violation of King-American Ambulance Injury and Illness Prevention Program will be subject to disciplinary action, up to and including termination. King-American Ambulance progressive disciplinary procedure may be implemented at any level depending on the severity of the action(s).

The best way for an employee to avoid disciplinary action is for him/her to understand applicable safety duties and responsibilities and to manage continuously their performance. Every attempt will be made to assist the employee in understanding applicable safety procedures and responsibilities before applying the disciplinary action. This includes training, re-training and personal counseling on safe work practices for their job.

King-American Ambulance complete disciplinary policy is contained in the Company Policy Book.

SUPERVISOR/MANAGER/SUPERVISOR DISCIPLINE

Managers/Supervisors are responsible for the prevention of accidents and illness in their area of responsibility. Managers/Supervisors who fail to perform their safety and health responsibilities are subject to disciplinary action (see prior section). Reasons for safety and health initiated disciplinary action include, but are not limited to:

- Repeat safety rule violations by employees under their direction;
- Failure to provide adequate training prior to job assignment;
- Failure to report and investigate accidents or to provide medical attention to employees injured at work;
- Failure to control unsafe conditions or work practices;
- Failure to maintain good housekeeping and cleanliness standards in their departments; and
- Failure to support King-American Ambulance safety programs.

IN CASE OF INJURY OR ILLNESS

Being prepared so that one can act quickly and decisively after an injury or illness can have a dramatic impact on an injured employee's recovery and morale, as well as the ultimate cost of injury. King-American Ambulance cannot emphasis enough that injured employees need special attention and consideration. It is King-American Ambulance policy to assure that injured employees receive prompt and appropriate medical care so that they can return to active duty as soon as safely possible.

To minimize the disruption and uncertainty that often accompanies an on-the-job injury or illness, King-American Ambulance maintains Workers' Compensation insurance to:

- pay for an injured employees' medical bills;
- provide temporary pay if the injured employee is unable to work; and
- provide "Permanent Disability" payments set forth by the state and/or retraining if an injured employee is unable to return to their regular employment.

King-American Ambulance supports a healthy return-to-work policy. Healthy return-to-work helps make the transition of returning to work after an injury as smooth and efficient as possible. See King-American Ambulance Return-to-Work Policy for details.

REPORTING INJURIES

Employees are to report all injuries to their manager/supervisor immediately. Failure to report an accident or injury is cause for disciplinary action, up to and including termination.

MEDICAL EMERGENCIES

Always call 911 first for any potential life-threatening situations.

Potentially life threatening conditions include:

- Choking
- Unconscious or disoriented
- Severe bleeding
- Off balance, unable to walk
- Hot, dry skin
- Any other problem you feel may be an emergency!
- Seizure or convulsions
- Difficulty breathing
- Chest pain or discomfort
- Profuse sweating
- Severe abdominal pain

TREATMENT AND WORKPLACE INJURY TRIAGE AND REPORTING

For non-emergencies, contact the on duty supervisor and direct the injured employee to a pre-designated medical facility, if needed. The Claims Coordinator or on duty supervisor can authorize medical treatment.

1. **When Employee Injury Occurs (non-emergency):** The injured employee should immediately contact his/her supervisor. The supervisor will determine immediate needs. The supervisor will then report the incident to our claims reporting line.

   Gallagher Bassett
   (800) 775-0769
   24 HOURS / 7 DAYS A WEEK

   Note that this service is only for employees who are injured at work, and should not be used for patients, residents, or guests.

2. **Injury Assessment**: The injured employee will be sent for care to the most appropriate facility.
3. **Treatment Recommendations:** After being seen by medical professionals, a report will be provided to the company with any work restrictions and/or follow up care.
4. **Triage Report Information:** Whenever a triage call is placed, information is collected to properly identify the employee and to complete reporting requirements. This information is kept confidential and is only released to those who have a right to access it.
5. **Post-Injury Resource:** Most all of care is followed through Concentra. They will be the guides to additional resources as necessary.
6. **Injury Reports:** After each new injury the on duty supervisor will ensure that all paperwork is filled out and the proper paperwork provided to the employee. Most importantly the DW-1 form.

NOTE: If the injury appears severe, call 911 immediately! DO NOT wait on hold for Concentra to open.

REPORTING INJURIES TO GALLAGHER BASSETT SERVICES

Reporting to Gallagher Bassett Services: The Claims coordinator will report work-related injuries to Alaska Nation Insurance **as soon as possible** using one of the following methods:

- Telephone: (800) 775-0769

- FAX: (866) 476-7430
- Website: www.risxfacs.com

Employers Report of Occupational Injury or Illness (Form 5020) – The Claims Coordinator or on duty supervisor will complete this form and forward a copy to Gallagher Bassett Services.

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS - DWC-1

The Claims Coordinator will provide employees injured on the job with an *Employee's Claim for Workers' Compensation Benefits,* form DWC-1 and instruct the employee to complete, sign and return the form. The DWC-1 should be provided to the injured employee as soon as possible and **not more than one working day following notice or knowledge of the injury.**

In addition, to minimize the disruption and uncertainty that often accompanies an on-the-job injury or illness the Claims Coordinator should explain what benefits worker's compensation provides and how the King-American Ambulance will help the injured employee.

The Claims Coordinator will document:

- The date and time of injury notification or knowledge;
- The date and time that the DWC-1 was given to the employee;
- The date and time that the DWC-1 was returned by the employee; and
- The date and time that a copy of the completed DWC-1 was sent to King-American Ambulance claims.

ACCIDENT INVESTIGATIONS

The reason for conducting an accident investigation is to determine the factors, conditions and work practices that contributed to the accident so that action can be taken to prevent a recurrence. The injured employee's manager/supervisor will conduct an accident investigation following every employee injury. In addition, timely action will be taken to correct unsafe conditions and/or work practices identified through an accident investigation.

Accident investigations will be documented using the ***Accident Investigation Report*** (see *Forms* section).

PROCEDURE: Accident investigations should be conducted as soon as possible following emergency medical treatment. Upon notification of an accident, the manager/supervisor will:

- Ensure appropriate first aid and/or medical treatment is rendered.
- See the ***Treatment and Workplace Injury Triage and Reporting*** section.
- Survey and document the scene of the accident. Items to note include the position and condition of equipment and tools, the presence of safety guards and personal protective equipment, posted warnings, spilled chemicals, and environmental conditions (lighting, heat, floor surface conditions, etc.).
- Take pictures of the accident site, as appropriate.
- Interview the injured person and witnesses. Interviews should be conducted one on one. Seek to identify accident causes, not fault. Ask open-ended questions such as who, what, when, where, how, and why.
- Once data has been gathered, attempt to reconstruct the sequence of events - what the injured person was doing, what went wrong, and what was the result.
- Record conclusions on the *Accident Investigation Report* (see ***Forms*** section), including corrective actions or recommended action.

RETURN- TO-WORK

King-American Ambulance supports a healthy Return-to-Work policy. Following an occupational injury or

illness King-American Ambulance will work in partnership with the injured employee, the treating physician and insurance company claims to help the employee return to productive employment as soon as safely possible, to minimize employee wage loss and to minimize worker's compensation costs.

Providing an opportunity for injured employees to return-to-work as early as safely possible benefits the employee and their family, our patients and King-American Ambulance. See King-American Ambulance Return-to-Work Policy for details.

Managers/Supervisors and Claims Coordinator are responsible for supporting the Healthy Return policy:

- Assuring that employees are directed to appropriate care;
- Assuring that employees receive appropriate benefits;
- Constructively communicating King-American Ambulance' goal for a quick and healthy recovery;
- Actively communicating with the injured employee, treating physician and King-American Ambulance insurance company;
- Accommodating work restrictions and assisting to arrange light duty, modified or alternative work, as needed; and
- Monitoring employee progress and following up until an injured worker returns to full, unrestricted duty.

INJURY AND ILLNESS RECORDKEEPING

The Claims Coordinator will maintain accident files that contain the following:

- Employers First Report of Injury (form # 5020).
- Log of Work-Related Injuries and Illnesses (form OSHA 300 log);
- Summary of Work-Related Injuries and Illnesses (form OSHA 300A);
- Employee's Claim for Workers' Compensation Benefits - DWC-1
- Accident Investigation Reports; and
- Employee's Claim For Workers Compensation Benefits (form # DWC-1).

The Summary of Work-Related Injuries and Illness (OSHA 300A) will be posted on the employee bulletin board from February 1 until April 30 (following the calendar year).

RECORDKEEPING

Inspection documentation - *Three (3) years*

Inspections will be documented as indicated in the *Identifying and Evaluating Workplace Hazards* section.

Safety Training Documentation - *Three (3) years*

Training will be documented as indicated in the *Training* section.

Accident Investigations Documentation - *Three (3) years*

Accident Investigations will be documented as indicated in the *In Case of Accident* section.

Safety Meeting Documentation - *Three (3) years*

Safety Meetings will be documented as indicated in the *Safety Communication* section.

Program Compliance - ***Three (3) years***

Program compliance issues (e.g., discipline, incentives) will be documented as indicated in the *Program Compliance* section.

Employee Exposure Records (e.g., Material Safety Data Sheets, Exposure Monitoring, Exposure/Medical Analysis and Records) - ***Thirty (30) years***

Employee Medical Records - *Duration of employment plus thirty (30) years*

Log of Work-Related Injuries and Illnesses (OSHA 300 LOG) - ***Five (5) years***

Summary of Work-Related Injuries and Illnesses (OSHA 300A) - *Five (5) years*
Employers First Report of Injury (5020) - *Five (5) years*
Employee's Claim for Workers Compensation Benefits* (DWC-1) - *Five (5) years
DWC-1's will be documented as indicated in the *In Case of Accident* section.

FORMS

ACCIDENT INVESTIGATION REPORT				
Completed by:			Date:	
WHO	Injured Worker's Name	Job title		
WHEN	Date of Injury	Date reported to you	By whom	Witness
WHERE	Department in which event occurred	Was employee doing regular job?		

Injury Information (Check all that apply)

☐ Hand	☐ Fingers	☐ Neck	☐ Thigh	☐ _____
☐ Wrist	☐ Thumb	☐ Back	☐ Knee	☐ _____
☐ Elbow	☐ Head	☐ Groin	☐ Calf	☐ _____
☐ Arm	☐ Eye	☐ Buttock	☐ Ankle	☐
☐ Shoulder	☐ Ear	☐ Chest	☐ Foot	
☐ Nose	☐ Mouth	☐ Abdomen	☐ Toe	

Activity Information (Check all that apply)

☐ Lifting	☐ Running	☐ Typing	☐ Operating equip	☐ _____
☐ Pushing/Pulling	☐ Walking	☐ Mousing	☐ Using chemicals	☐ _____
☐ Carrying	☐ Standing	☐ Sitting	☐ Maintenance	
☐ Twisting	☐ Climbing	☐ Driving	☐ Cleaning	
☐ Reaching	☐ Kneeling	☐ Riding	☐ Jumping	

Handling what and weight?	Struck by what?
Equipment operated?	

Incident Information

What happened? Provide as many details as possible.

Hazard Information (Check all that apply)

☐ Lack of training	☐ Failure to use lifting aid (e.g., lift, cart)	☐ Unsafe/defective equip
☐ Lack of safety rules/procedures	☐ Unsafe lifting technique	☐ Poor equip design/placement
☐ Didn't follow rules or procedures	☐ Unsafe body position	☐ Poor equipment setup
☐ Lack of supervision/enforcement	☐ Personal protective equipment (PPE) or proper footwear not provided/worn	☐ Not authorized to operate equipment
☐ Unsafe behavior	☐ Unsafe storage arrangement	☐ Inadequate lockout
☐ Failure to get help	☐ Wet/Icy conditions	☐ Inadequate warning signs
☐ Overexertion	☐ Poor material flow	☐ Lack of guard/barrier/device
☐ Excessive workload	☐ Inadequate housekeeping	☐ Inadequate ventilation
☐ Poor work habits	☐ Inadequate lighting	☐ Inadequate maintenance
☐ Shortcut /Excessive speed	☐ _____	☐ Inadequate inspection
☐ Horseplay	☐ _____	☐ Lack of detection/alarm
☐ Inattentive or distracted	☐ _____	☐ Too hot/cold

Corrective action(s)

OFFICE INSPECTION REPORT	
LOCATION:	
Inspection completed by:	Date:
Reviewed by:	Date:
• Indicate N/A if an item does not apply • Forward completed reports the Safety Coordinator who will file in the main office.	

AREA	OK	COMMENTS	ACTION TAKEN
LIFE SAFETY			
Are aisles/walkways obstructed?	☐		
Are exits easily accessible?	☐		
Are exits free from obstructions?	☐		
Are exit signs illuminated?	☐		
Are exit signs clearly visible from all employee areas?	☐		
Do emergency lights function?	☐		
WALKING/WORKING SURFACES			
Any slip/trip hazards from:			
• Electrical wiring and/or cables?	☐		
• Telephone wiring?	☐		
• Poor housekeeping?	☐		
Are carpets frayed or torn?	☐		
Are mat edges curled?	☐		
Are the floors wet and/or slippery?	☐		
Any floor damage, cracks, or holes?	☐		
WORK PRACTICES			
Are file or desk drawers open?	☐		
Step stool/ladder provided/used i.e., no standing on chairs?	☐		
Employees trained to immediately clean up spills?	☐		
LIGHTING			
Is lighting adequate?	☐		
Are there obstructions creating darkness or shadow areas?	☐		
OFFICE FURNITURE			
Chairs properly adjusted and maintained?	☐		
Are desk drawers operable?	☐		
Are file cabinets unstable or overloaded?	☐		
STORAGE TECHNIQUES (exposure to injury from falling objects or unnecessary lifting)			

AREA	OK	COMMENTS	ACTION TAKEN
Are heavy items, boxes, etc. stored at waist height to minimize lifting?	☐		
Cart/dollies available to move heavy items?	☐		
No heavy, bulky, or sharp material stored overhead?	☐		
Are bookcases/file cabinets anchored?	☐		
Are aisles in storage areas clear?	☐		
Is housekeeping adequate?	☐		
MACHINE/EQUIPMENT			
Machines operating properly and guarded?	☐		
No defective electric cords?	☐		
HAZARD COMMUNICATION			
Are Material Safety Data Sheets on file?	☐		
Are hazardous materials properly labeled, used, and stored?	☐		

BULLETIN BOARD			
Required employee posters and notices (e.g., Cal/OSHA, Workers Compensation, Department of Industrial Relations)?	☐		
OSHA 300 log posted February 1 to April 30?	☐		

OTHER OBSERVATIONS AND COMMENTS

KING-AMERICAN
AMBULANCE CO.
2570 Bush St.
San Francisco, CA. 94115
Serving San Francisco since 1906
415-931-1400

Organizational Call Center Chart
2024

Dispatch Manager / QI Coordinator
Josh Nultemeier

Dispatch Supervisors
Ish Perez – QA/QI
Nikki Maples – Training

Dispatchers
David Szeto Burton Lee Bill Carpenter Ben Tappero

King American Ambulance

PARAMEDIC SUPERVISOR FIELD EVALUATION

Quality Assurance Communication Form

Unit #_____ Crew 1_____ Crew 2_____

Crew 3_____

PCR#:_____ CMED#: _____

Date/Time of Call: _____ / _____ / _____ _____ hrs

Location: _____

Nature: _____ Code: _____

Other Responding Units: _____

1. Patient Care and Assessment: Appropriate and through treatment provided as observed on scene. Yes No
   Notes:

2. Documentation: Complete and accurate PCR documentation. Additional paperwork also completed. Yes No
   Notes:

3. Customer Service: Positive Feedback from both patient/family and facility personnel. (Explain if crew went "Above and Beyond.") Yes No
   Notes:

4. Safety: Crew operates using appropriate BSI and safety techniques. Yes No
(Was the crew wearing BSI fanny packs, and were shoulder straps on the gurney?)
Notes:

5. Teamwork: Crew works together well with good communication. Yes No
Notes:

6. Additional Comments/Concerns: _____

_____

_____

_____

_____

Person completing form: _____

Signature: _____ Title: _____

Date: _____ / _____ / _____ Time: _____

Crew Signatures: (Include employee number)

1. _____ 2. _____ 3. _____

King American Ambulance
Quality Improvement Plan
Documentation
January 2024

King American Ambulance has a documentation policy located in the King American Ambulance policy book.

The key points that are going to be focused on for 2024 are the following:

1. Signatures must be obtained by somebody other than a crew member. The name of the person signing must be typed into the PCR in the appropriate area.
2. 12-Lead EKG on all chest pain, SOB and AMS patients must be documented, with the monitor data attached to the PCR
3. 12 lead ECK data must have the correct fields filled out for transmission.
4. Vital signs after any medication push or any intervention performed. Vital signs and medication administration cannot be documented with the same time.
5. OPQRST or PASTE must be documented for all chest pain and/or SOB patients as appropriate.
6. Infrequently used skills documentation: (examples)
   A. ET Tube secured how and where
   B. TCP documented rate and milliamps
   C. IO documented location, pressure bag and lidocaine if appropriate.
7. Infrequently used skills: Forms completed as necessary.
8. Zoll X Series Data attached to all CPR calls for compression and CPR “puck” data.
9. Prospective QA done by Supervisors in the field.

King American Ambulance
Quality Improvement Plan
Documentation
January 2024

TRAINING HANDOUT
QUALITY ASSURANCE / QUALITY IMPROVEMENT PLAN – E-PCR

1. Billing information.
   A. Name
   B. Address
   C. Social Security Number
   D. Insurance information – Policy number, group number, Medicare # with a letter at the end.
   E. PHONE NUMBER
2. Chest Pain
   A. 12 lead must be done before medications
   B. O = Onset (gradual or sudden)
   C. P = Provoke (what where you doing when it started? Does anything make it better or worse?)
   D. Q = Quality (Describe the pain)
   E. R = Region, Radiate (where is the pain? Does it go anywhere or stay there?)
   F. S = Severity (on a scale of 1-10)
   G. T = Time (what time did this start?)
   H. Associated signs and symptom. Breaking out in a sweat, nausea vomiting, dizziness, etc.
3. Shortness of Breath
   A. 12 lead
   B. P = Progression (sudden or gradual)
   C. A = Associated chest pain (if yes, then OPQRST also. And, which came first)
   D. S = Sputum (coughing anything up?)
   E. T = Time, Temp and Talkabiliity (how many word sentences can you speak?)
   F. E = Exercise Tolerance (can you get up without getting short of breath?)
4. Signatures
   A. Employees are NEVER allowed to sign the patient signature area.
   B. Best to get the patient to sign it
   C. If the patient cannot sign the PCR then it MUST BE DOCUMENTED why the patient could not sign
   D. If you get any other person to sign the PCR the first and last names must be obtained and their relationship to the patient must be documented.
   E. HIPAA – You may write “left with patient” in the signature area.
5. All medication administration must have vitals taken within 5 minutes after each administration. You may have 9 sets of vitals for a chest pain patient!
6. All significant procedures must have vitals taken with 5 minutes after each procedure.
7. Narrative – Must be complete and thorough. Has to describe the medical necessity of the patient and justify the need for the ambulance. Details are important for reimbursement!

8. DO NOT WRITE – Vital WNL, Vitals Stable, etc. in the narrative. Vitals signs are an objective finding and we don't need a subjective interpretation of an objective finding.
9. DO NOT WRITE – All time approximate. Use your watch, or buy one.
10. Original 5150 paperwork must always accompany the patient. A copy is not legal.
    A. Only a MD, Police or social worker with the appropriate card authorizing them to do 5150's may place patient on 5150's.
11. AMA's require base hospital contact and 2 paramedic signatures.
12. PDT requires two signatures. One paramedic and EMT okay for PDT.

An emphasis will be made to ensure policy 6050 that became effective on 10-1-2020 will be adhered to in the 6 categories from appendix A of the policy.

1. Cardiac Arrest
a) Accurate intervention and medication times
b) Patient response to interventions
c) ROSC or termination time
d) AED/CPR prior to arrival, including name of provider

2. Chest Pain/Acute Coronary Syndrome a) Time of Aspirin administration
b) Detailed EKG findings
c) Room-air SpO2
d) Time of symptom onset (in HH:MM format)
e) Time of hospital notification for STEMI Alert

3. Stroke a) Cincinnati Prehospital Stroke Scale findings
b) Blood glucose reading
c) Time of symptom onset (in HH:MM format)
d) Time last seen normal (in HH:MM format)
e) Time of hospital notification for Stroke Alert

4. Advanced Airway a) Time of adjunct placement
b) Reason for advanced airway placement
c) Room-air SpO2
d) End tidal CO2 (waveform and ETCO2 number)
e) Reconfirmation of adjunct placement after all patient movement

5. Severe Agitation and Use of Restraints a) Patient behavior that necessitated restraint usage
b) Type of restraint or adjunct used
c) Time restraint was applied
d) Reassessment of patient condition every 5 minutes post-restraint
e) Respiratory monitoring using end tidal CO2 (if chemical sedation performed)
f) Blood glucose reading

6. Near Drowning a) Description of fluid (salt or fresh water, temperature, etc.)
b) Duration of submersion
c) Height of fall/mechanism of injury
d) Evidence of head/spinal trauma or other associated injuries
e) Neurological status
f) Respiratory findings

King American Ambulance
Quality Improvement Plan
Education and Training
January 2024

Education and Training:
A minimum standard set forth by local and State authorities as the minimum qualifications as EMT, Paramedic and Dispatchers are followed. Found in CCR Title 22, Health and Safety Code Division 2.5 and Local EMS Policy. Education and certifications are verified prior to employment.

In House Education:
King American Ambulance offers continuous education in the areas of drivers training, CPR, QI Chart Reviews, focused audits of call taking and PCR reviews, skills and protocol/policy review, EMD Training, ACLS and PALS.

A copy of any of the programs is available upon request.

King American Ambulance is a certified continuous education provider authorized by SFEMSA; provider # 38-0005.

King American Ambulance
Quality Improvement Plan
Equipment and Supplies
January 2024

Equipment and supplies:
Restocking is all done from our base at 2570 Bush St. in S.F.
A minimum standard ambulance-stocking list is in SFEMSA policy 4001.
Restock supplies are monitored by a supervisor and supplies ordered as needed.
Equipment is checked in and out for every shift.
The on duty crews, prior to every shift, perform equipment checks in accordance to the manufacturer's recommendations.
Preventative maintenance is performed on a regular basis with such companies as STRYKER for the gurneys and Zoll Corp. to do preventative maintenance on the Zoll X series monitors.

King American Ambulance
QI GOALS / OBJECTIVES
2024
STATUS REPORT for 2023

PCR's are reviewed for overall policy and protocol compliance on a specific basis. PCR's that meet the following criteria are reviewed.

1. Any call where there is a medication push.
2. Ay code 3 return to the hospital.
3. Any "code" or resuscitation
4. Any chest pain or shortness of breath call
5. Infrequently used skills such as ET, NT, Pacing, IO, Decompression and Needle Cric.

These 5 types of calls are reviewed for the following:

1. Signatures must be obtained by somebody other than a crew member. The name of the person signing must be typed into the PCR in the appropriate area.
2. 12 EKG on all chest pain, SOB and AMS patients must be documented.
3. Vital signs after any medication push or any intervention performed. Vital signs and medication administration cannot be documented with the same time.
4. OPQRST or PASTE must be documented for all chest pain and/or SOB patients as appropriate.

As appropriate calls are reviewed with employees when the QI process recognizes that there is a pattern of documentation that stands out and is in need of corrective action or guidance.

Paperwork for infrequently used skills is being completed and turned in at the end of each shift. Reports to LEMSA are generated monthly on these skills.

We have reviewed countless PCR's with field employees and received positive feedback from them. Nobody has been placed on a corrective action plan in 2014.

Field supervisors are also doing prospective QA in the field with real time monitoring of crews running calls and providing feedback on documentation and other areas. This area of the QA plan needs to have more attention given to it, as not a lot of prospective QA paperwork has been generated.

In 2020 the focus was on retrospective QA (reviewing PCR's). Through September 2023 we had many pages of notes for QA. In October 2023 we switched PCR venders to EMSCharts and are now focusing on some of the new details about where to find interventions and the quarks of the program.

King American Ambulance
QI GOALS / OBJECTIVES
2024
STATUS REPORT for 2023

Goals and Objectives REPORT for 2023:

1. A review of the selected criteria was done and reports show a decline in documentation errors over the last 1 year.
2. Crews are understanding policy and protocols better as they are discussed through the feedback process. An improved feedback process was implemented in October 2023 through EMSCharts. Calls are automatically directed to supervisors for QI and based on certain criteria, automatically go to our medical director for review.
3. Improvement of high risk / low frequency skills by reviewing PCR's and sign off sheets when the skill is used. This process was discovered to not work to increase the skills of the medic. A retrospective chart review and additional paperwork does not increase the medic's skill or ability. This process has been changed to tailored scenario based training for 2023.
4. Prospective QA by field supervisors showed room for improvement in 2023. A focused effort on documentation was implemented for 2020 and we had a significant decrease in documentation errors. This resulted in higher quality patient care, better protocol knowledge by the medic and increased revenue though the billing process. We are continuing this process.
5. We accomplished the goal of maintaining 3 EMD-Q personnel. We also certified Ian Collier, Paramedic Captain, in EMD.
6. Participation in LEMSIS reporting. King American was able to successfully submit data is ICEMA using NEMSIS 3 criteria in 2023.
7. We continuously are involved and participate in the LEMSA QA meetings. A record of attendance can be found by the LEMSA QA coordinator.

King American Ambulance
QI GOALS / OBJECTIVES
January 2024

Purpose: To establish a set of goals and objectives for King American Ambulance through the process of the Quality Improvement Plan and process.

Content: The following are the goals and objectives for King American Ambulance for calendar year 2024.

1. Review all code three returns to hospitals, medication pushes, chest pain and shortness of breath calls; reviewing for appropriateness and adherence to policy / protocol (and adherence to policy 6050).
2. To improve and reinforce protocol / policy knowledge through ongoing training and by reviewing PCR's with them as needed.
3. To improve high risk / low use skills by reviewing PCR's for adherence to policy / protocol and continuing the use of sign off sheets when the skill is used. This process has been enhanced through tailored scenario-based training for 2021.
4. Continuing the utilization of field supervisors to respond to calls as part of the QI process to watch crews "real time" and provide constructive feedback immediately as needed.
5. To meet the 2 minutes gold standard for EMDing emgernecy calls.
6. Continue to maintain the 3 trained employees in EMD-Q from NAEMD.
7. Participate in the LEMSIS reporting with EMSA and the electronic PCR data collection process.
8. Participate in the new and improved QA Meetings that are sponsored by LEMSA.
9. Continue to maintain Zoll Dispatch Pro licenses and utilize PRO QA.

King American Ambulance
Quality Improvement Plan
Risk Management
January 2024

RISK MANAGEMENT:
Issues related to risk management are taught during all aspects of employment. Topics include:
Patient Care (treatment, transport and refusals)
Driving (normal and code 3 driving)
Lifting and Carrying of equipment and patients
Documentation and reporting (continuous PCR reviews)
Exposure control and reporting methods (yearly training)
Haz-Mat issues (yearly training)
BBP (yearly training)

Focused areas for 2024:
Injury and Illness Prevention Program
Hazardous Communications Plan and training
Harassment training for all supervisors and managers
Aerosolized Transmission policy update and training
Cyber Security training

Other issues related to Risk Management are addressed as they arise.

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2024 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.

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 EMSCharts 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 EMSCharts and the collection and organization of the data is formatted with EMSCharts 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 2024.

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.

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's EMSCharts electronic PCR's. We were a participating agency for the NEMSIS 3 submission to ICEMA. Data is submitted in an XML format.

Participation

Participation will be mandatory for all employees. Employees 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.

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.

King American Ambulance
Quality Improvement Plan
Clinical Care and Patient Outcome
2024

Refer to QI plan overview for clinical care.

Patient Outcome:
At times a case may be interesting enough for crewmembers to follow up on their own. Other times it may be necessary to do follow ups due to case reviews, exposure reporting, disease control, etc. King American Ambulance does not regularly follow up on patient outcomes after transfer of care from field personnel to hospital personnel.

Currently in San Francisco there is no reliable structure in place for patient outcome reporting from the hospitals to any given entity. This process relies solely on the provider agency to put forth the effort and time to research outcomes.

The company will try to obtain outcomes of patients on a per request basis from crew members wishing to follow up on a particular case. When outcomes are received the information will then be communicated to the crew member. The company will try to process outcomes as received and appropriate.

With the addition of Get With the Guidelines, CARES reporting and the STEMI/STAR reports submitted to the LEMSA, we hope to gain more patient outcomes for 2024.

HIPAA will be adhered to at all times to protect patient confidentiality.

King American Ambulance
Quality Improvement Plan
Personnel
2024

Personnel:
Personnel are categorized as EMT, Paramedic and Dispatcher. Supervisors and Management personnel may be trained to do all functions if trained and certified. Job descriptions are located in the company policy book.

Currently, in 2024, we have 3 personnel certified to complete QA reviews for dispatch. Josh Nultemeier, Nikki Maples and Ish Perez both are EMD-Q certified by the National Academy of Emergency Dispatch.

The quality assurance program manager for the company is Josh Nultemeier. His experience includes 35 years in EMS, 29 years as a paramedic and 20+ years in management at King-American doing QA reviews and training of documentation for PCR's. The Paramedic Supervisors are trained in QA PCR Chart Review also and Josh Nultemeier oversees the QA process on a random basis to ensure the quality of the QA program itself.

The QA program does not have a full time employee devoted to QA activities. The company is small and utilizes 4 personnel as part of their job activities to perform the QA functions of the company. The company has had full time employees in the past and found that it was not necessarily a full time position and the wages paid vs. benefit did not meet the company's expectations. This model of sharing duties and worked well and the current communication is exceptional.

Hiring process of personnel is outlined in our company policy book as well as the employee handbook and union collective bargaining agreement.

Please refer to the company policy book, employee hand book for more information on personnel.

In 2020 we contracted with UCSF for a company medical director. Currently that position has been assigned to Eric Silverman, MD. Our contract with UCSF provides security, in that, in Dr. Silverman decides to vacate that position, UCSF will provide us with another MD.

King American Ambulance
Quality Improvement Plan
Public Education / Prevention
2024

Public Education:

King-American Ambulance performs training in First Aid and CPR for groups outside of its immediate employees. Some of the groups trained in the past are SF Giant's employees, Hotel workers, The Carlisle, other board and care home and assisted living facilities, etc. King American Ambulance management works hard at participating in groups and policy making for public safety such as the management of ETOH patients in large sporting events such as the Giants. We participate in "show and tell" for San Francisco Schools such as the Star of the Sea School, Mission High School and other local High Schools.

King American Ambulance
Quality Improvement Plan
Skills Maintenance and Competency
2024

Skills maintenance is preformed by on the job activities and training. Training and review for lesser-used skills is done annually or through ACLS and PALS. If necessary, a supervisor will evaluate an employee using national standard guidelines for employee performance evaluations. This is the same skill sheet used during the paramedic accreditation process. Skills are reinforced during ACLS and PALS classes that are taught throughout the year several times. In 2024 regular training is scheduled to ensure constant training and employer/employee interaction in regards to patient care and treatment. A month-to-month training program has also been put in place to keep up with compliance and ensure all employees are trained and up to date on county policy and protocol. Additionally, the EMS agency has recently required annual skills competency verification sign off. We continue to maintain compliance.

King American Ambulance
Quality Improvement Plan
TABLE OF CONTENTS
2024

King American Ambulance
Quality Improvement Plan
Transportation / Facilities
2024

Transportation:
Training for driving is provided by King American Ambulance in the form peer review and is informal. Multiple attempts of section 3 of EVOC have been attempted and unsuccessful, as it doesn't meet our complete needs.
Most employees have EVOC certification from an outside source. King-American is considering offering the classroom portion of EVOC, however, due to lack of facilities, the cone course section can not be offered.

Facilities:
A list provided by SFEMSA in regards to destination for patients. SFEMSA details out what type of patient can go to what hospital based on the hospital's capabilities.

Employees are oriented to hospitals during their 24 hour (or more) third person ride-a-long on the job training. All EMT's have an additional 72 hours of ALS partner training where they are again oriented to facilities. Paramedics usually take 4 to 5 days after there initial 24 hours of 3rd person orientation. All employees were also trained on the most current destination protocol updates.

2023 included new training due to State requirements for alternative destinations for all of our field employees. Newly hired paramedics are also required to complete this training.

Emergency Medical Services Quality Improvement Program (EQIP)

NORCAL Ambulance

Sara Feindel
QA Manager
EQIP Program Manager
925-413-1905
SFeindel@NorcalAmbulance.com

Revised March 2024

Table of Contents

I. Structure and Organization

A. Summary

The Norcal Ambulance QIP outlines our structure and process for data collection, evaluation, QI plans and initiatives, and ongoing analysis.

We have a robust Quality Management department that works in tandem with our Operations leadership, Training Team and Risk and Safety to ensure our data collection can be utilized in a way to promote change and improvement.

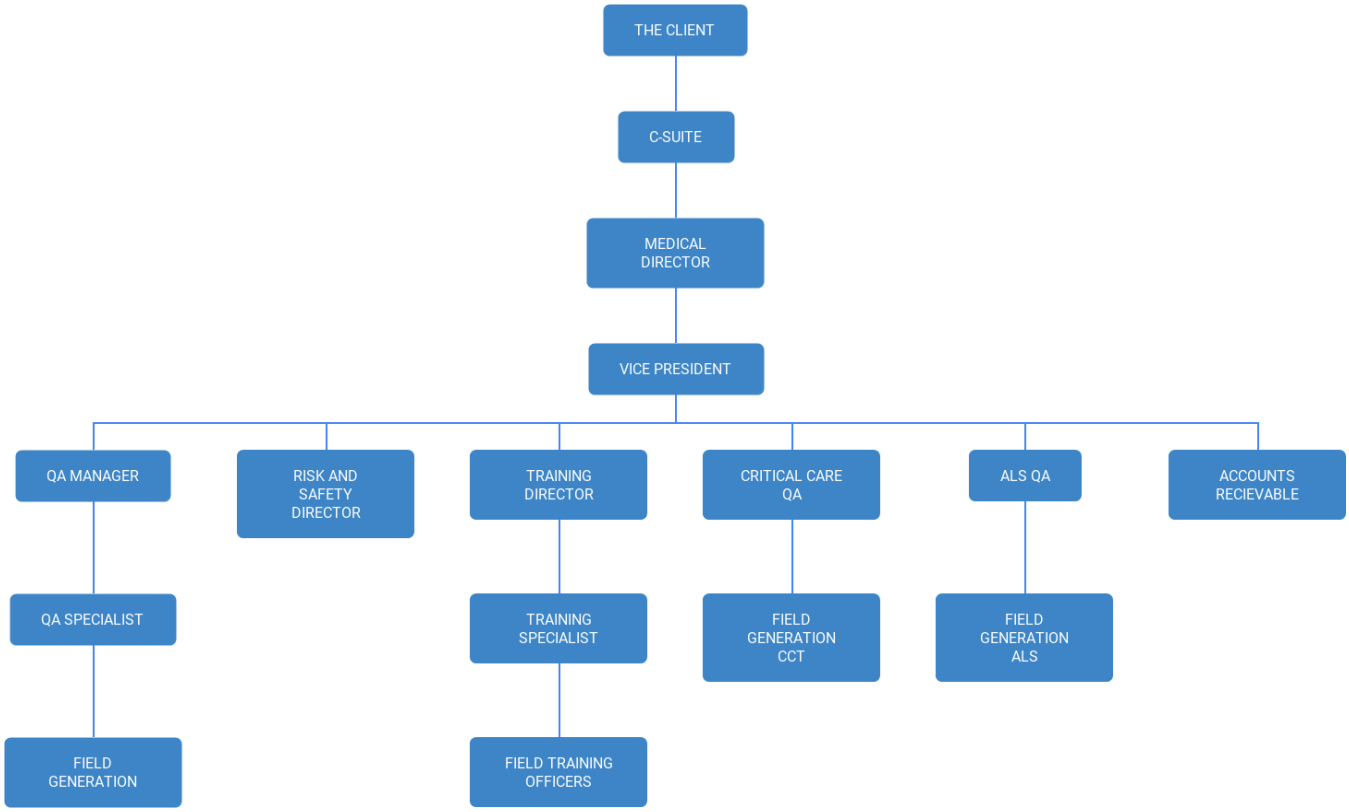
B. Introduction

In striving for excellence, Norcal Ambulance is committed to the ongoing enhancement of our services through our comprehensive Quality Improvement Program. Our dedication to continuous improvement stems from our unwavering commitment to providing the highest standard of care to the communities we serve. Through data-driven analysis, stakeholder collaboration, and a culture of continuous learning, we aim to not only meet but exceed the expectations of those who rely on us.

C. Organizational Structure

1. Quality Improvement (QI) Team

- Medical Director: Gerald Nazareno, MD
- QI Program Manager/Quality Assurance Manager: Sara Feindel EMT
- Director of Clinical Services: Anastasia Pieda RN
- Risk and Safety: Harris Hennig EMT
- Director of Training and Education: Melissa Popnoe, EMT
- Quality Assurance Specialist: Bobby Barger EMT
- Quality Assurance Specialist: Yevgeniy Sinkevich EMT
- Quality Assurance Specialist: Jean Kuilan EMT
- Quality Assurance Specialist: Natalia Gonzales EMT
- Quality Assurance Specialist: Viet Tran EMT
- Quality Assurance Specialist: Michael Booth Paramedic
- Quality Assurance Specialist: Maya Anderson RN

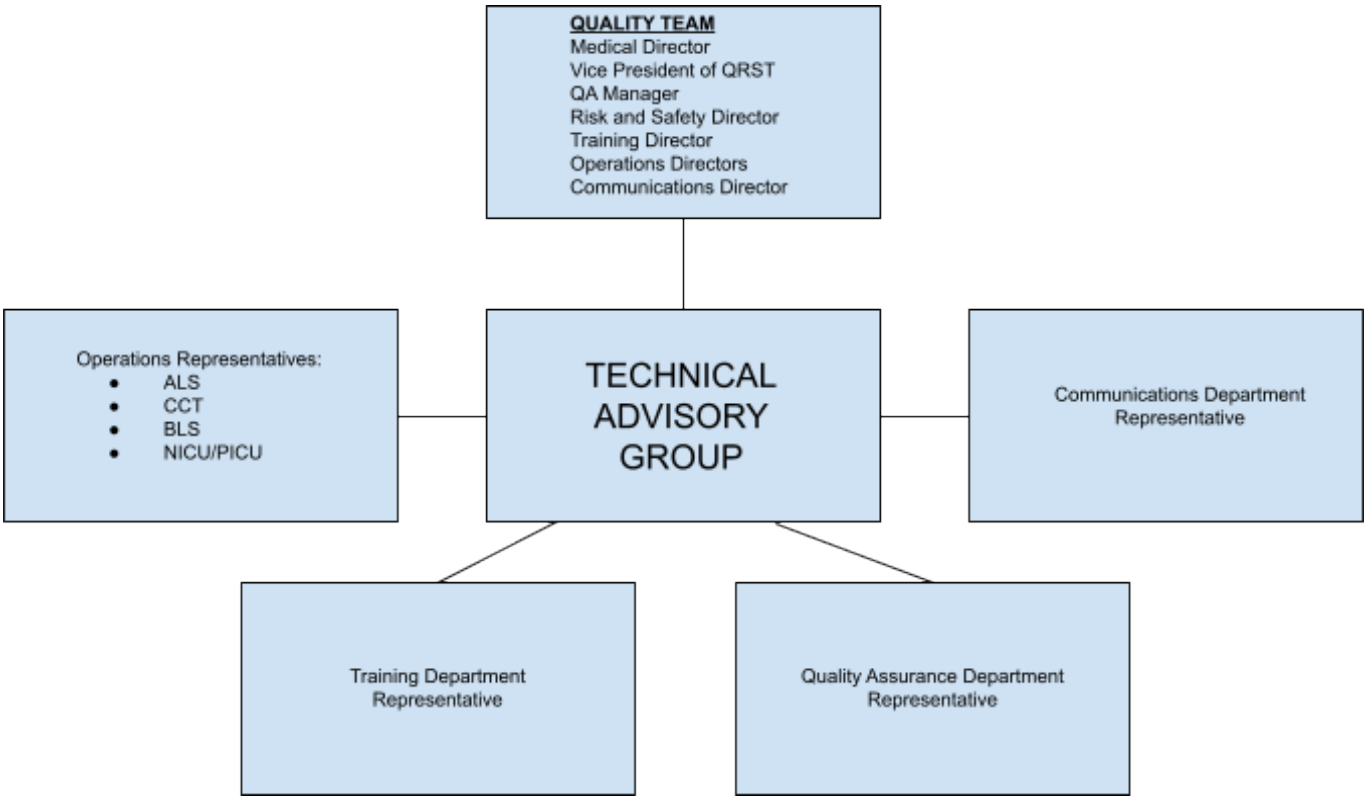


2. Technical Advisory Group

The Technical Advisory Group is comprised of representatives in the organization that perform QA/QI. The group is led by the Manager 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.

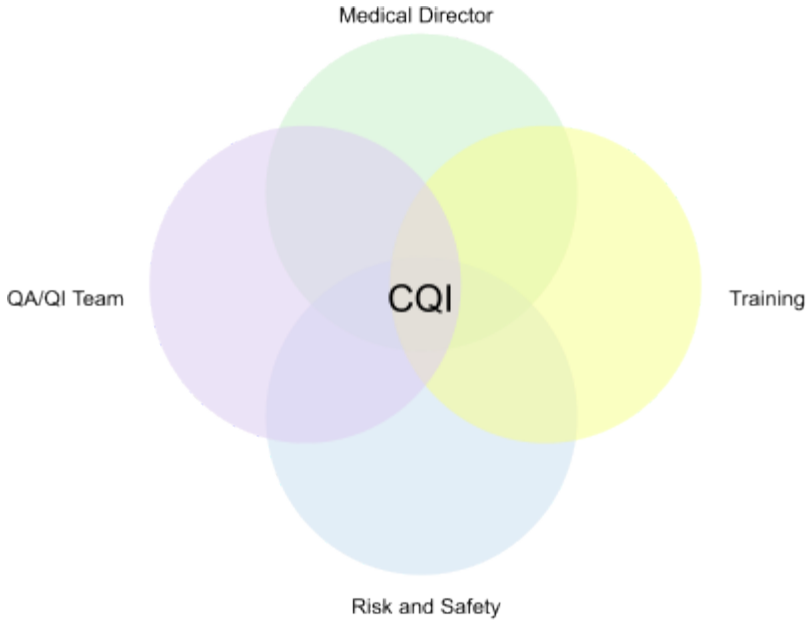

QUALITY TEAM
Medical Director
Vice President of QRST
QA Manager
Risk and Safety Director
Training Director
Operations Directors
Communications Director
Operations Representatives:
ALS
CCT
BLS
NICU/PICU
TECHNICAL ADVISORY GROUP
Communications Department Representative
Training Department Representative
Quality Assurance Department Representative

D. 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

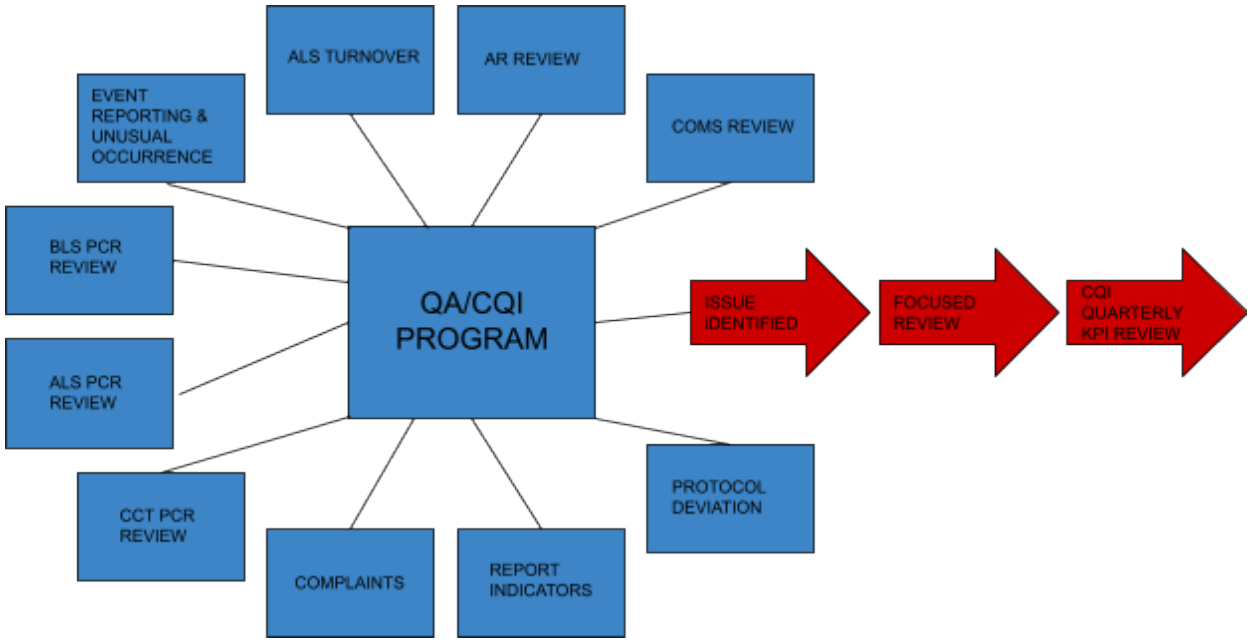
Norcal Ambulance adopts the methods of quality improvement based on guidelines recommended by the state of California EMS authority. In particular, special attention to methods of data gathering, review, reporting and improvement in Appendix E and F in the CA EMSA policy # 164 (Emergency Medical Service 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

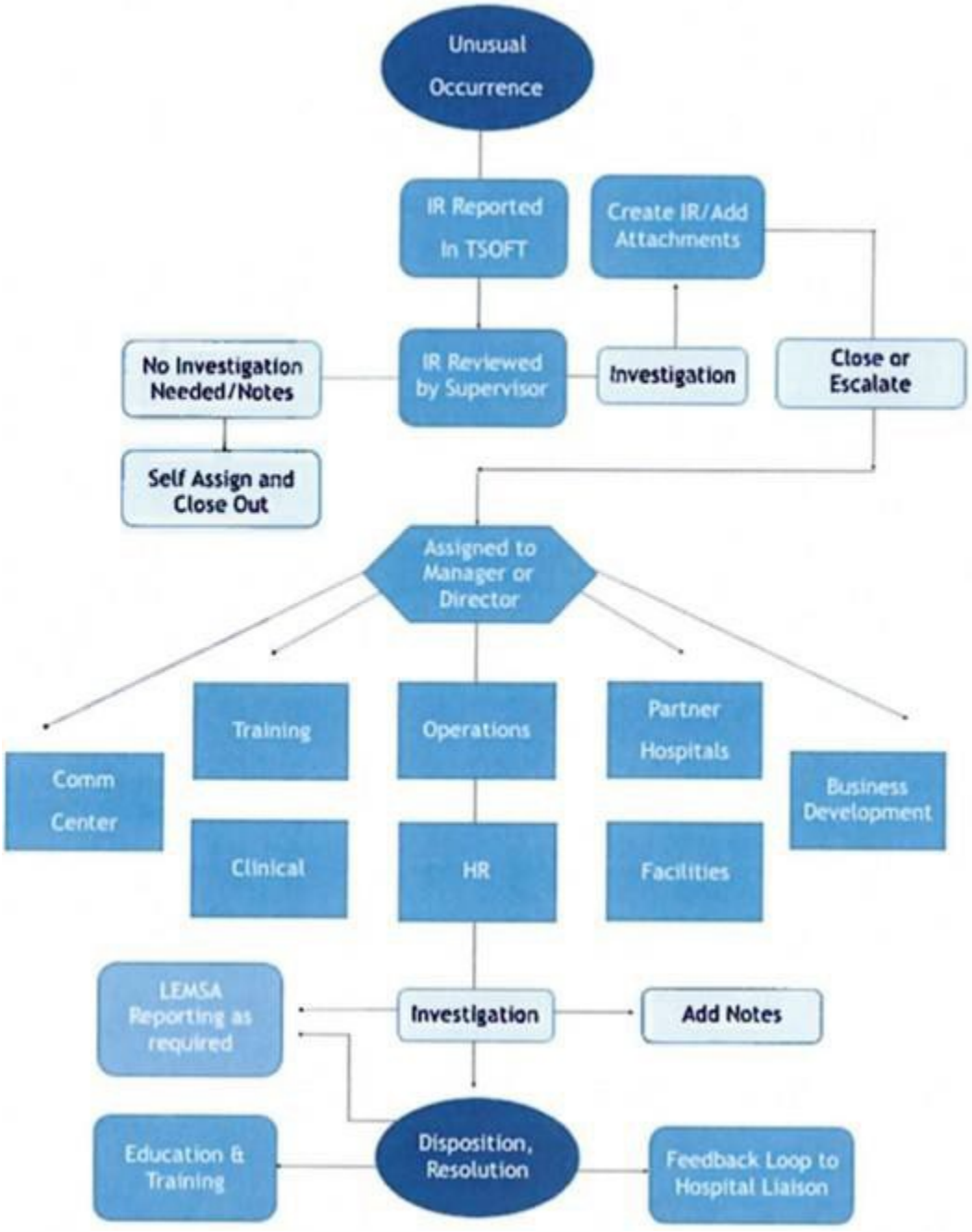
- ➢ Hospital diversion
- ➢ AMA release of patient
- ➢ Non AMA refusal of care/transport
- ➢ Accusation of negligence or wrongdoing against Norcal ambulance employee
- ➢ Delay in patient care without adverse outcome
- ➢ Any condition or situation that represents a threat to employee or public safety and 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.

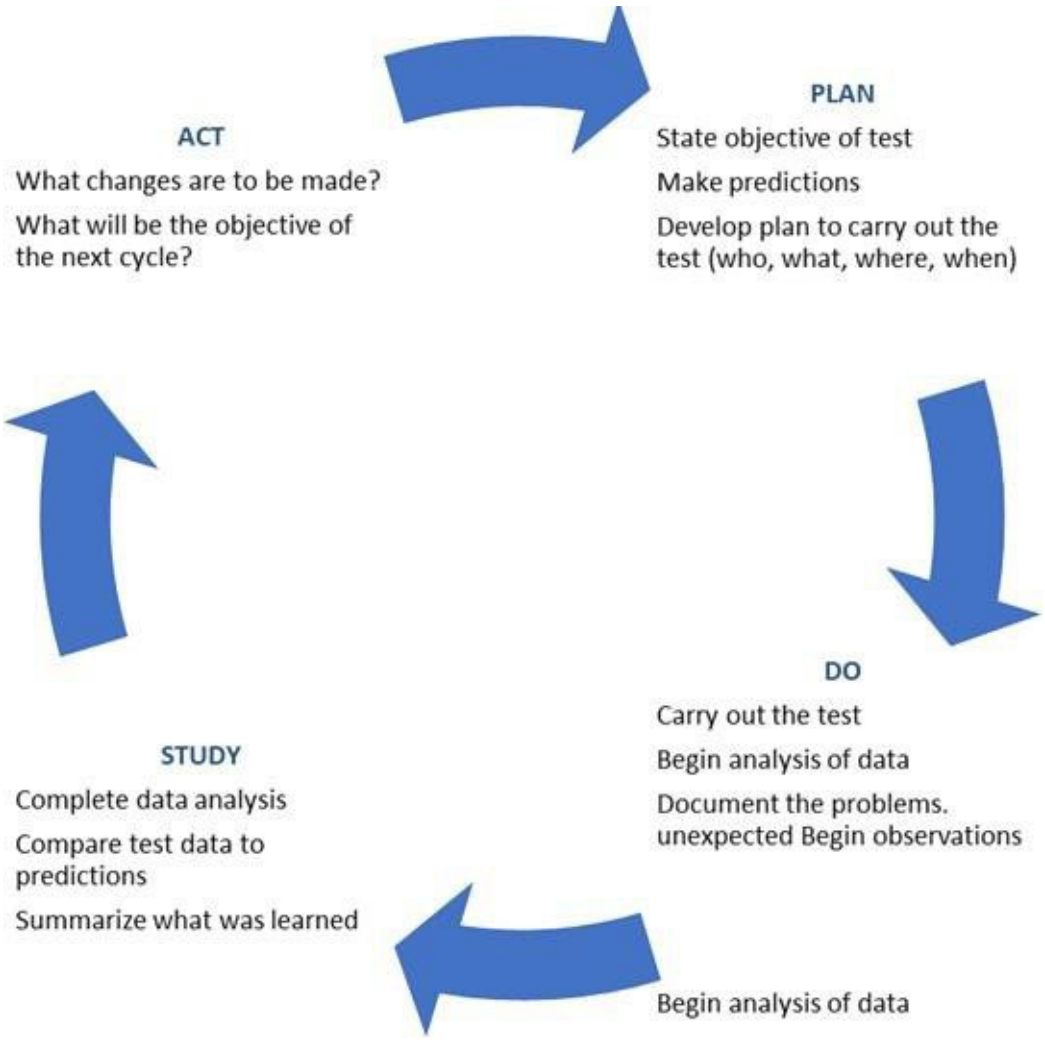
Customer Service Program
Norcal Ambulance maintains a system for customer service review that applies to all field personnel, accounts receivable and dispatch. This system involves all members of the organization. The system is designed to be used by our customers, crew members and office staff for direct 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:

- Melissa Popnoe, Director of Training
- Natasha Branson, Training Manager
- Keith Brooks, Senior Training Specialist
- Arianna Roberts, Senior Training Specialist

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 QA Manager.

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 2023

The following was under review for all ALS, CCT, and BLS operations in 2023:

- ➢ 5150 Transports
- ➢ 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

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.

2023 Policy Updates and Revisions

- New Policies:
  - Policy 100.824 Internal Escalation Policy

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

2023 Issues Requiring Further Consideration in 2024

- 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
- Enhance completeness of charting from both a clinical and AR perspective
- Monitor safe transportation practices, patient safety and body mechanics.
- Track all documented unusual occurrences to create education for quality improvement and best practices.

2023 Findings and Outcomes

- **Psychiatric Transports -**
  Overview: In 2023 the QA Department continued to track psychiatric transport data. We tracked all attempted and successful elopements for the year, documentation of risk assessments, etc.

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 LEMSA 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 2023 year. QA is continuing to review psychiatric calls and tracking compliance. This is an ongoing KPI.

- **BLS Infrequent Skills**
  In 2023 we had no instances where BLS infrequent skills were utilized in the field. Will continue to monitor for 2024.

2024 and Beyond

Norcal Ambulance will continue to monitor our defined KPIs with a focus on improving our processes and data capture. With the introduction of our new LMS system, we are hoping to provide more education for our crew members and improve both our in field clinical care and our documentation practices.

Internally, our QA Department is working on improving the configurations for our PCR, reducing TOT for our field crews, and capturing pertinent information more easily.

Over the next several years, Norcal plans to:

1. **Expand Data Analytics:** we plan to enhance our data collection and analysis capabilities by leveraging advanced analytics tools and technologies. This will allow us to gain deeper insights into trends, patterns, and outliers, facilitating more targeted and proactive quality improvement efforts.
2. **Enhance Training and Education:** We are committed to providing ongoing training and education opportunities to ensure that our personnel remain at the forefront of best practices and clinical advancements.
3. **Quality Improvement Culture**: Building upon our existing culture of continuous improvement, we will further cultivate a sense of ownership and accountability among our personnel at all levels. By empowering our team members to actively participate in quality improvement initiatives and share their ideas for innovation, we can foster a culture of excellence that drives sustained performance improvement over time.
4. **Regular Review and Adaptation**: We recognize that the landscape of prehospital care is constantly evolving, and as such, we are committed to regularly reviewing and adapting our quality improvement program to align with emerging trends, regulatory requirements, and best practices in the field. This iterative approach ensures that Norcal remains responsive, adaptable, and resilient in the face of change.

Below are the ongoing metrics we will be monitoring in 2024.

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

2024

In accordance with the standards of:

Emergency Medical Services Administrations Association of California

Effective Date: 01/2010

ProTransport-1
P.O. Box 7260
Cotati, CA 94931

Table of Contents

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.

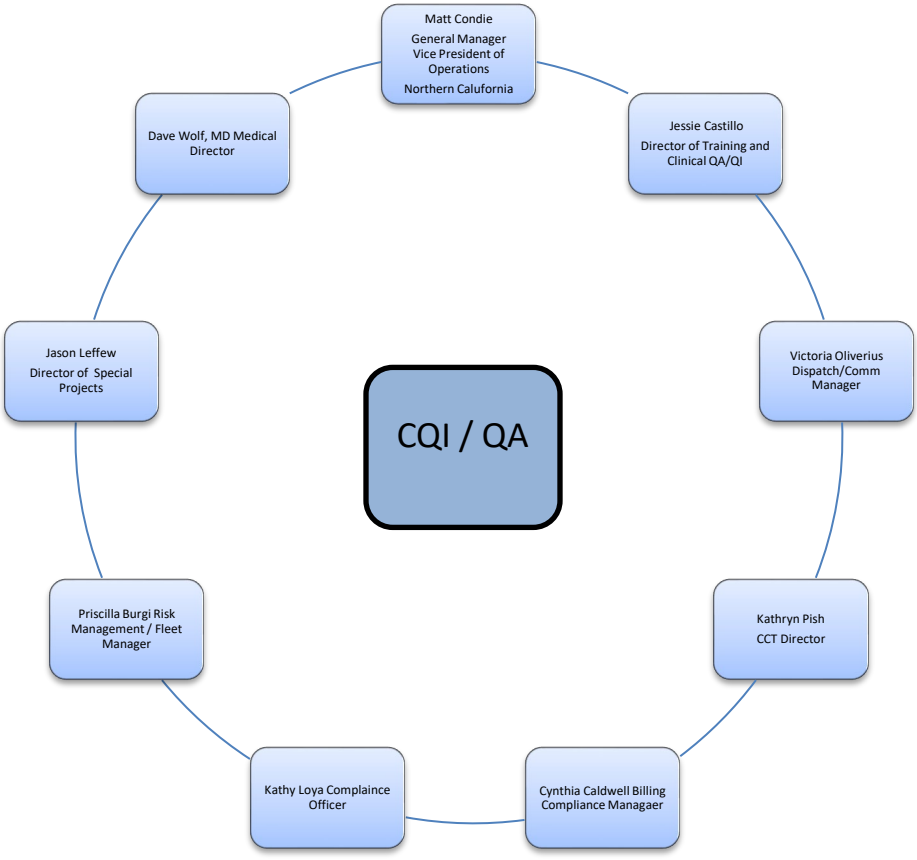
Our TPS consists of five domains:

- Clinical Process of Care
- Patient Experience
- Outcome
- Efficiency
- Operational Effectiveness

I. Structure and Organizational Description

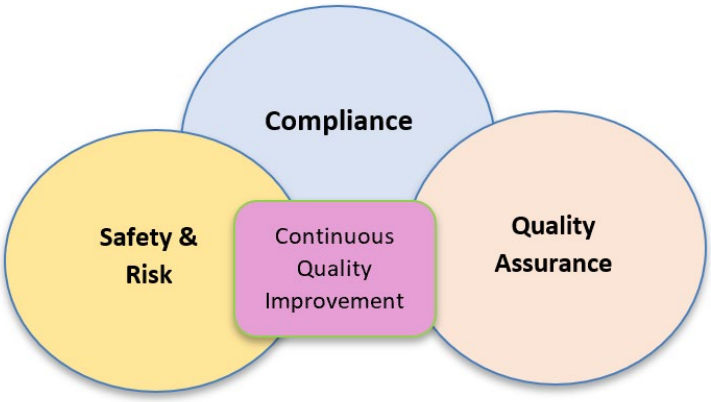
A. Organizational Structure

1. QA/CQI Committee
Led by the Director of Training 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

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 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 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 review
  - PCR compliance review
  - Unusual occurrence reporting system
  - New hire, ongoing training program and continuing education program

- 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, 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 OD) review
  - Unusual occurrence reporting system for the company and county
  - Continuing education program
  - 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
  - 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:
  -
  - 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/
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 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

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.

®

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	• Support Services	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; 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	• Support Services	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 • Operations	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	• Compliance • Communications Center • IT	Data reports; Logis input; 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	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	RTQ (Repetitive Transport Questionnaire) completion	• Compliance	Number of RTQs completed by month

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
PCR Review	Ensure tracking of interventions and procedures	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	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	• Operations	On-time %
Response Times	Ensure response time performance meets the parameters set by contract, LEMSA	Track response time performance	• Operations	% 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	• Operations	Amount of time per call by type

7. Public Education & Prevention	Objective	Compliance	Department	Indicator
Customer Satisfaction Contracted facilities	To maintain high levels of customer satisfaction	Active tracking of complaints	• Marketing Communications • Business Development	, 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.	• Human Resources • Clinical Operations • Marketing Communications	% of employees by station that do not get the Flu vaccination

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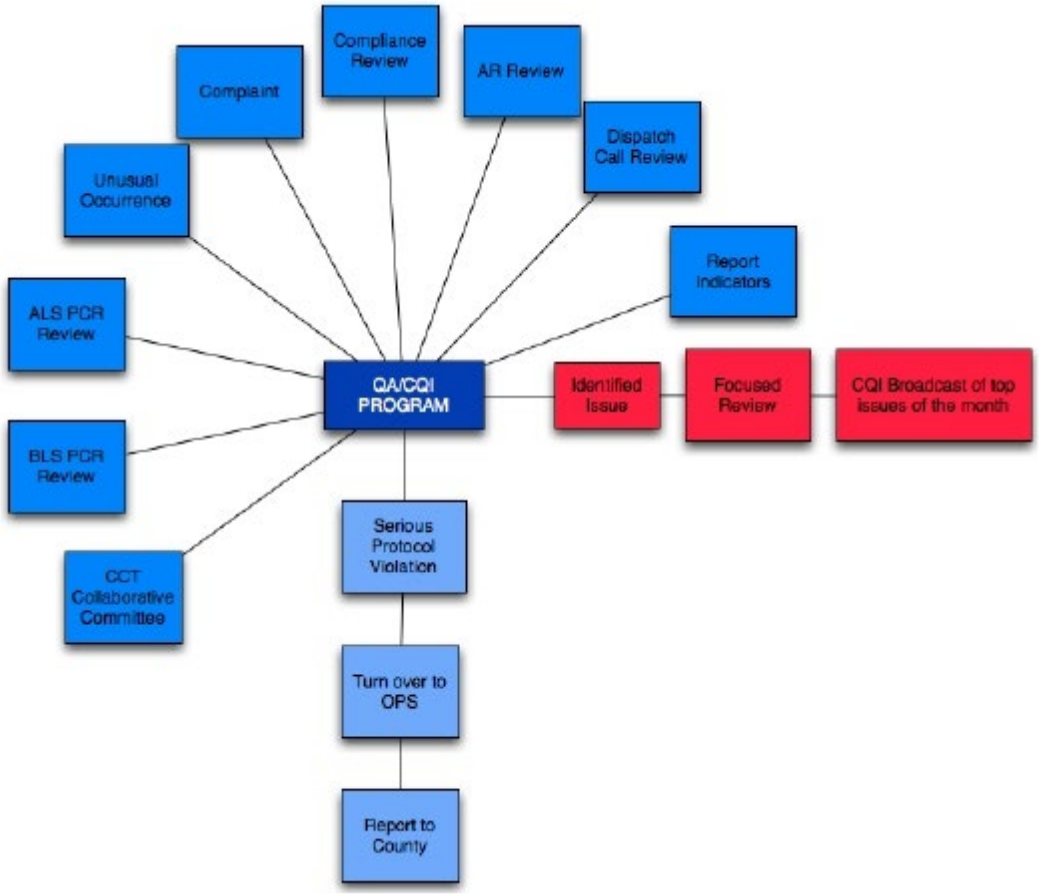
B. Process

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

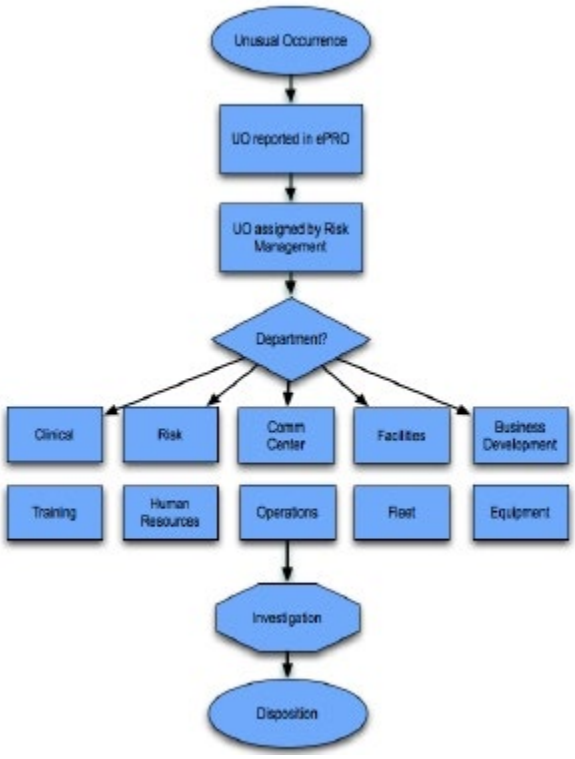
One such method is Unusual Occurrence reporting. Reports are generated in our online system. All team members have access to this method of reporting and can access it at anytime while on duty or not. UOs are reviewed on a daily basis and follow a strict reporting guideline dependent on the issue. Examples 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

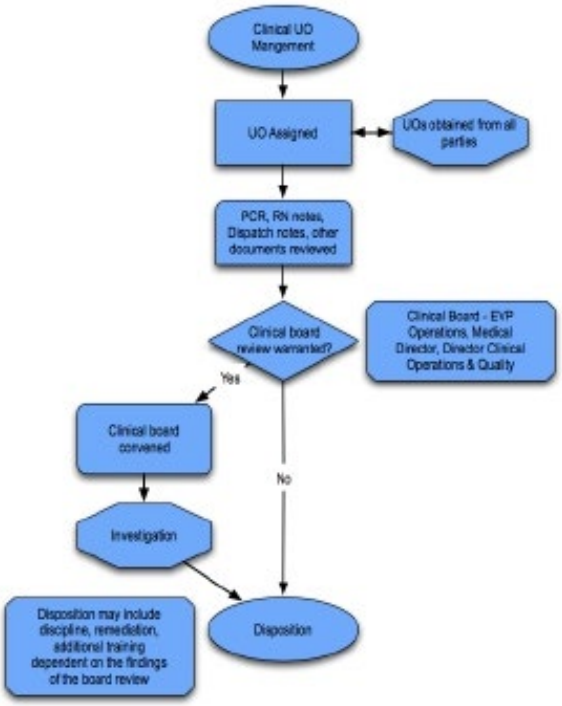
Advanced Life Support (ALS) mandated reporting requirements include those listed above and also the following:

- 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 Director of Training and Clinical QA/QI . Currently, ProTransport-1 provides ALS services in three areas, each under a different LEMSA. Issues identified are reviewed and followed up by the Director of Training and Clinical QA/QI if a serious issue arises, a UO report will be generated and the incident moved up to the Clinical Review Board. 100 percent of emergent transports and/or sentinal events are flagged and reviewed due too their lower overall occurrence 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.

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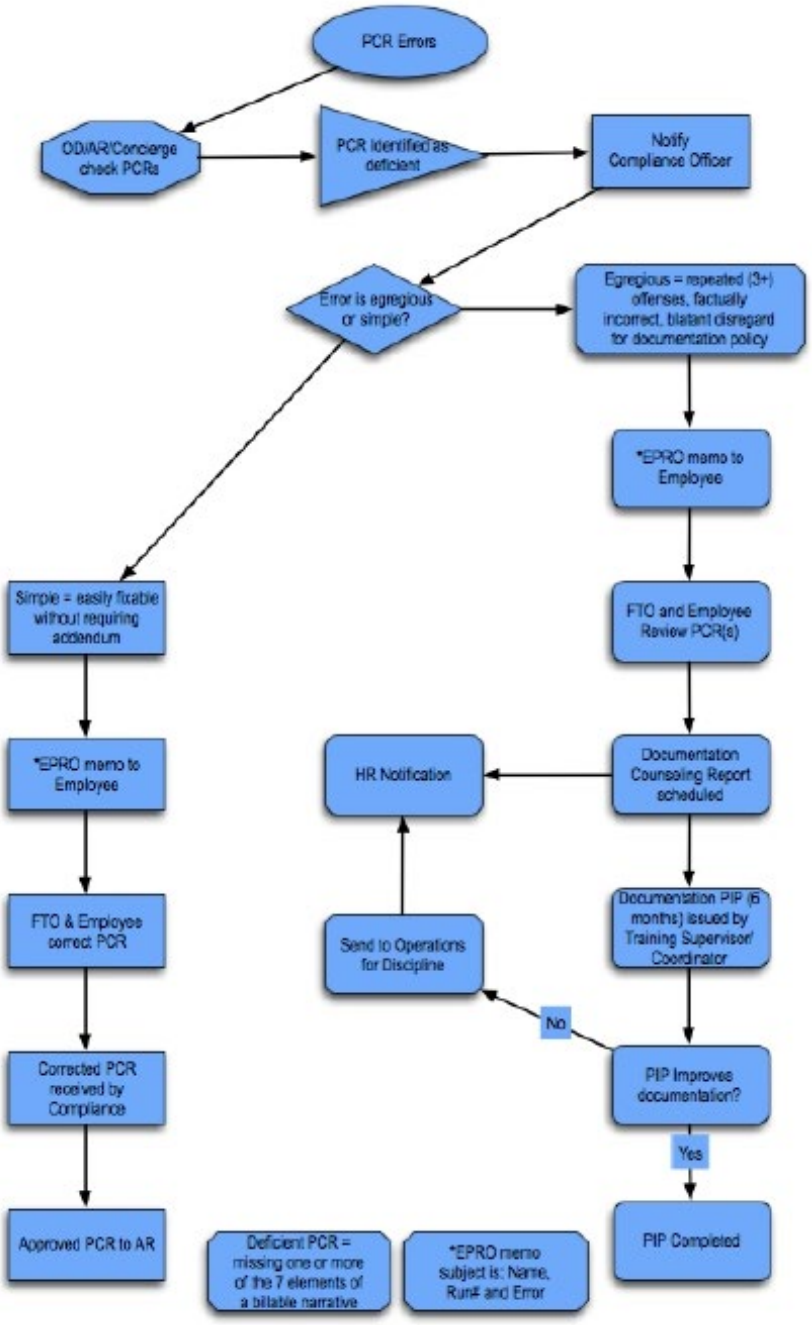
The Compliance Department has a meticulous program for correcting PCRs, following up on training issues and instituting PIP plans for documentation. This process is outlined here:



C. Data Collection Responsibilities

ProTransport-1's Performance Management Department as well as Operations 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
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	Comm Center, Operations	OTP by region
PCR Completion	Daily	Compliance	
Unit Hour Utilization	Daily, Weekly, Monthly	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

Department	Report	Frequency
Clinical Operations	Narcotic tracking	Weekly
	PCR audits	Weekly
	Cardiac arrest	Monthly
	STEMI transports	Quarterly
Operations	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:

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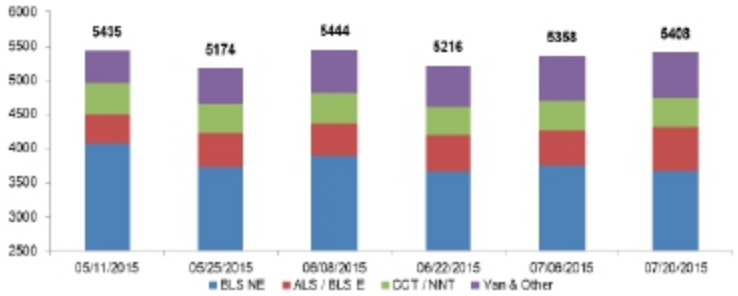
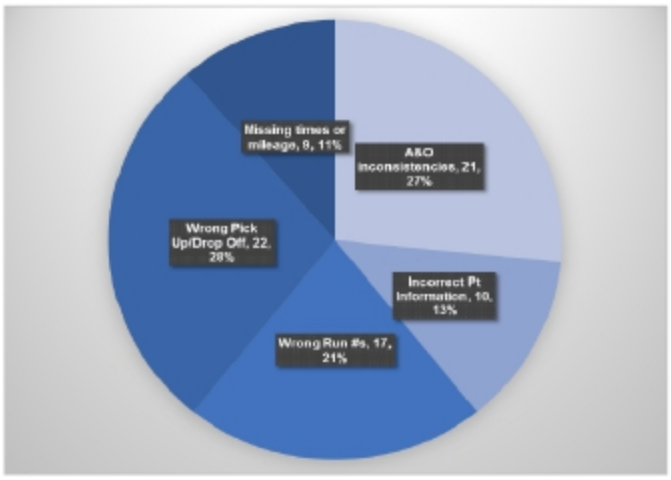
Biweekly Volume & Performance



	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%	3889	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%	
Amb 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:

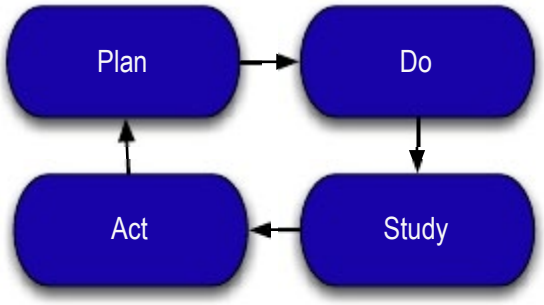
- Monthly station meetings
- Quarterly global leadership meetings
- Quarterly compliance meeting

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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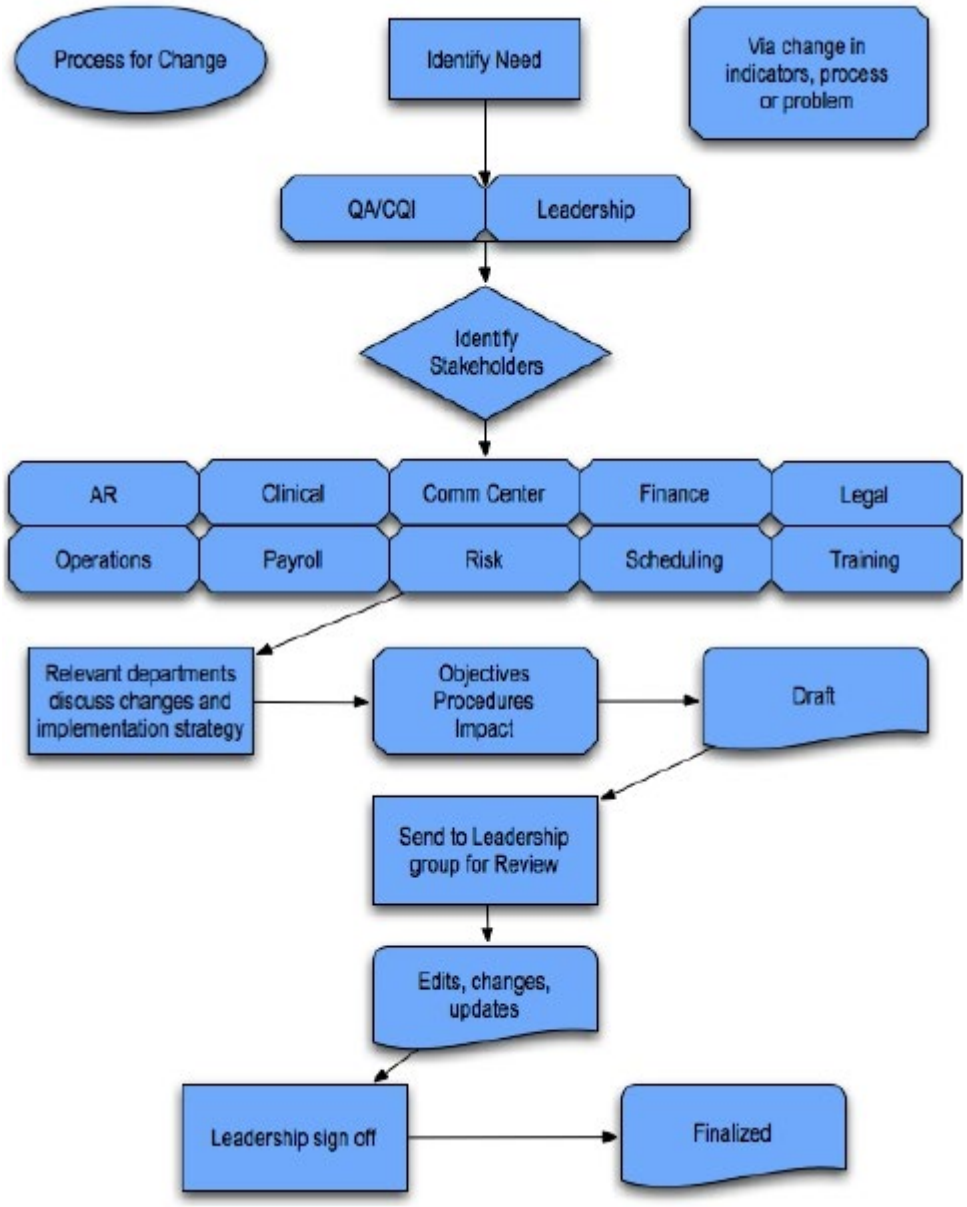
Our change process is outlined here:



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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 Hire Academy 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 24-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 24-hour introductory class and, after successfully passing, the team member is assigned a Field Training Officer (FTO) for a minimum of 4 shifts . 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.

Continuing Education Program: The Continuing Education Program is organized, administered and reviewed by the Training Director and Training Coordinators. 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, 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 Director of Training andClinical QA/QI

System for Developing and Maintaining Company Policy

New formatting has been put in placeand 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

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.

ProTransport-1
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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

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 shoot 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

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	09/24/2014	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	08/27/2014
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	E20.3 - 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	Neuro Medical 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

2024 San Francisco Continuous Quality Improvement Plan

For Calendar Year 2023:

Royal Ambulance transitioned to the TraumaSoft Application for all of our CAD, Billing and ePCR functions.

Conducted reviews of all BLS calls:

- Resulting in a diversion
- Resulting in a code-3 response
- Resulting in an ALS Upgrade
- Resulting from a First On Scene
- Incident Review Boards for all accidents, injuries, and unusual occurrences

As a result, BLS New Hire Training was modified, and monthly deployments (huddles) were conducted with training bulletins, etc.

Conducted reviews of all CCT calls:

- Involving a code 3 transport
- Where medication was given from the Royal Ambulance Formulary
- All Pediatric Transports
- All MCS Transports
- All Obstetric Transports

As a result:

- TraumaSoft ePCR was modified to include additional "required" fields
- Order Sets were modified/created for:
    - Burn Patients
    - MCS Patients
    - Neurotrauma/stroke patients
- Quarterly training was conducted that emphasized:
    - ECMO Transports
    - IABP Transports
    - Impella Transports
    - Ventilator Refresher including high flow and bubble CPAP/BiPAP for Pediatric Populations

This plan was updated to integrate our new TraumaSoft Platform into our CQI Process.

2024 San Francisco Continuous Quality Improvement Plan

Key Goals for 2023/2024:

- Utilize software (First Pass) to do chart review of all electronic patient care charts.
- Utilize software to conduct chart audits (100%) for KPI's involving CVA, STEMI, medication administration charting, ensure compliance with vital signs and intervention.
- Identify and utilize features embedded in our new TraumaSoft CAD/ePCR Software to automate many of these processes.

BLS:

- Increase the number of ePCR charts audited by 50%: Goal of 200 charts reviewed.
- Continue to review 100% of: Diversion from intended receiving facility, ALS upgrades ("911"), "code 3" responses, and first on scene.
- Improve "code 2" response times so that we arrive at the sending facility within 30 minutes at least 75% of the time.
- Incorporate issues discovered during CQI and IRB into the new hire academies and field training.

ALS:

- Audit 100% of all paramedic ePCRs within the first 90 days of the ALS program.
- Audit 100% of all code 3 transports.
- Audit all transports of patients from a less than acute care location to an emergency department.
- Audit all ALS incidents that originate at a special event.
- Bring annual paramedic training to what is required for CCT-RNs.

CCT:

- Continue to review all records of controlled substance administration and all medication administrations from standing order sets.
- Improve the quality of CCT charting and patient care by auditing all cases where pediatric patients and pregnant patients are transported.
- Implement recommendations from comprehensive CCT CQI reports.
- Increase our annual CCT Training to 32 hours per RN
- Increase our New Hire RN Onboarding to a minimum of 80 hours
- Audit all Mechanical Support Services transports (ECMO, IABP, Impella).
- Audit all Trauma or Code 3 transports and:
    - Bruns
    - Neurotrauma
    - Aortic Dissection
    - Stroke/Stemi

Purpose

2024 San Francisco Continuous Quality Improvement Plan

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, analysis 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.

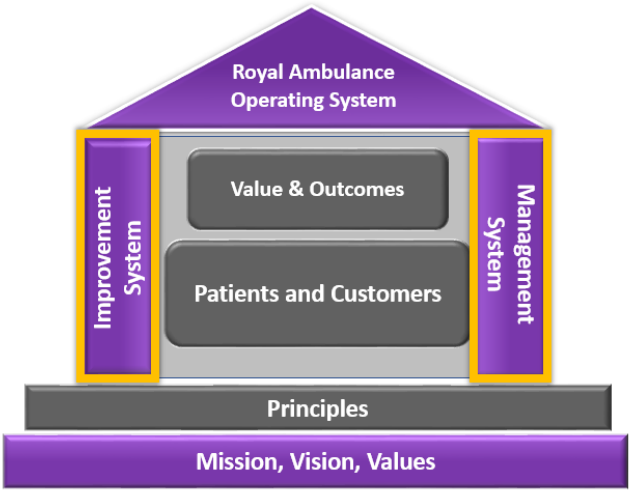
To achieve this mission, Royal Ambulance participates in an ongoing and systematic quality assurance and quality improvement program utilizing Lean Thinking and Lean Management Systems. Lean is a philosophy that shortens the time between the customer desire for a product or service and delivery of that 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.

2024 San Francisco Continuous Quality Improvement Plan



Structure

The CQI Team at Royal Ambulance is under the direction of the Director of Clinical Operations with medical oversight provided by our Medical Director. The CQI Team includes, but is not limited to:

- Royal Ambulance Chief Administrative (RN Position)
- Royal Ambulance Medical Director (MD Position)
- Director of Clinical Operations (RN Position)
- 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

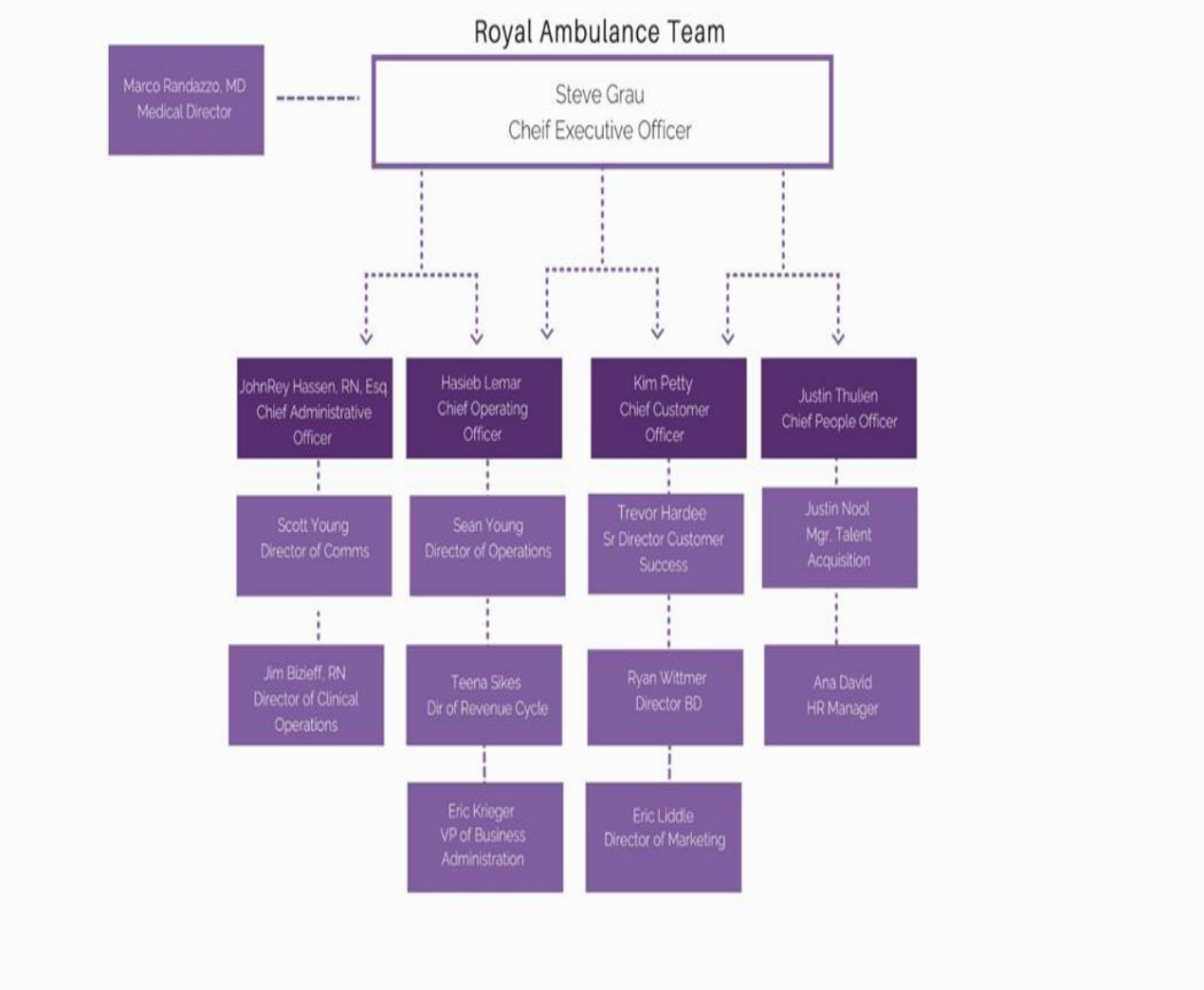
Our approach to quality management and quality improvement will be to implement best practices as identified by evidence-based research within the healthcare industry and the California EMS System Core Quality Measures. Utilization of the "Just Culture" philosophy will be demonstrated in the investigation 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
- Provider Meetings – hosted by local EMS agencies
- Hospital Review Meetings – hosted by hospital partners
- Account Managers Meetings – hosted by Royal Ambulance
- Skilled Nursing Facility Collaborative Meetings – hosted by hospital and SNF partners

2024 San Francisco Continuous Quality Improvement Plan



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, Advanced 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. BLS/ALS/CCT Staffing

Royal Ambulance's staffing goals for 2024-2024 are listed in the chart below. Royal will modify our goals based on our Patients and customers' needs to maintain service level agreements with our contracted facilities. Staffing goal are reviewed monthly and adjusted as necessary

Service Level	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
BLS	13	22	23	24	21	25	16
ALS	2	2	2	2	2	2	2
CCT	2	2	2	2	2	2	2

III. 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."

2024 San Francisco Continuous Quality Improvement Plan

Indicator		Specific Information to be Monitored	Method of Collection	Frequency
Personnel		Education and training requirements compliant with specific operating counties	Provider records (TraumaSoft) and hard copy files	Monthly
		Currency of provider's license, certifications and accreditations.	Provider records (TraumaSoft), 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 TraumaSoft, LEMSA requirements, adhering to manufacturer's PM recommendations, and Gemba walks	Daily
		Equipment/vehicle failures	Field employee feedback and TRAUMASOFT software	Daily
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 interfacility transports that do not have a	Patients taken to correct destinations based on primary impression and county protocols	TraumaSoft WorkFlow software	Daily

	predetermined destination or require a diversion			
	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, application of restraints	TraumaSoft WorkFlow software	Monthly
	100% retrospective review of medications administered	Medication administration oversight to include medications administered by EMTS, TXA by Paramedics, and all narcotic usage.	TraumaSoft WorkFlow	Monthly
	100% retrospective review of infrequently used skills	% of infrequently used skills per number of transports. Skills to include, needle decompression, advanced airway management, and tourniquet application.	TraumaSoft WorkFlow	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	TraumaSoft WorkFlow	Monthly
	100% retrospective review	% infrequently used skills per individual clinician	TraumaSoft WorkFlow	Yearly
Transportation /Facilities		Response times per contract requirements	Standardized IT reports, Tableau	Daily

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		Response times for on scene at pick-up	Standardized IT reports, Tableau	Monthly
		Response times for patient drop off	Standardized IT reports. Tableau	Monthly
	100% retrospective review	% of diversions r/t change in patient condition	TraumaSoft Work Flow software and TraumaSoft, Tableau	Daily
	100% retrospective review	% ALS upgrades	TraumaSoft Workflow and TRAUMASOFT, Tableau	Daily
	100% retrospective review	% Code 3 transports	TraumaSoft Workflow and TRAUMASOFT, Tableau	Daily
Public Education and Prevention		Provision of field experience for EMT students	Computer data collection	Monthly
		Provision of public health education	Computer data collection	Monthly
Risk Management	100% retrospective review	Controlled substance usage and documentation	TraumaSoft WorkFlow and standardized report	Monthly
	100% retrospective review of high risk transports, narcotic administration, and infrequent skills. Random audit of 25% other call types	Adherence to treatment protocols	TraumaSoft WorkFlow	Monthly
		Customer satisfaction	Surveys utilizing NPS and CSAT	Periodic
		Unusual occurrences (UO) and field report of UO	Field direct report, facility direct report, report through local EMS agency	Daily
		Personnel exposures	TRAUMASOFT	Daily
		Personnel on-the-job injuries	Computer data collection	Daily
	100% retrospective review	Medication errors	TraumaSoft Work Flow	Monthly

	100% retrospective review	High risk-low incidence procedures	TraumaSoft Work Flow and TRAUMASOFT 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'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 Director of Clinical Operations obtains data on the above indicators periodically (daily, monthly, quarterly, etc.) depending on the nature of the indicator. Information is obtained through TraumaSoft WorkFlow software, specialty reports developed in conjunction with IT and TraumaSoft 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 Director of Clinical Operations will be responsible for the initial analysis of the quality indicators. Findings and trends will be further shared and discussed with the various departments Presentation of the quality indicator analysis will be 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 at 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 Director of Clinical Operations 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 Director of Clinical Operations 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.

IV. EPCR System – TraumaSoft/Image Trend

Our EPCR System is at the core of our ability to effectively capture actionable data, patient information, and a comprehensive record for patient care to be utilized for CQI purposes. Royal utilizes the TraumaSoft EPCR platform. This system allows for Royal to capture all required NEMSIS 3.5 data and near instantly transfers the EPCR to the following bridge portals:

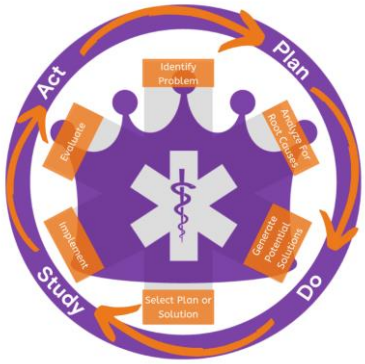
1. Image Trend
2. First Watch
3. Any necessary regulatory body.

Royal utilizes TraumaSoft to support the production of reports which CQI is based upon.

2024 San Francisco Continuous Quality Improvement Plan

V. Action to Improve

Royal Ambulance's standard approach to performance improvement is – 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 (TRAUMASOFT)
- 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

VI. 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 Director of Clinical Operations 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 TRAUMASOFT.

The Clinical Operations Coordinator is responsible for assuring that continuing education is scheduled and recurring at established time intervals. The Director of Clinical Operations will assure that verifiable, ongoing training is appropriate to the EMT, Paramedic and Registered Nurse level of care and ensure our organizational goals are met.

VII. Complaints

All complaints are entered into TraumaSoft by the receiving supervisor.

If no supervisor is available, the receiving employee shall send an email to “Incident” with sufficient information that the appropriate supervisor can return the call.

The respective County Manager or Director of Clinical Operations 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.

VIII. Change Indicators

In order to effectively implement change, we capture a variety of indicators that we utilize to develop educational content, remediate employees, and ensure sustainable change of process. For 2023-2024, specific change indicators include:

Clinical Performance Indicators	Suspected Cardiac Ischemia
	Suspected Stroke or TIA
	Suspected Trauma
Procedure Monitoring	Intraosseous (IO) Infusion Procedure
	12-Lead Electrocardiogram
	Therapeutic Hypothermia

Indicators and benchmarks are evaluated and reported per calendar year quarter, or more frequently as required, then summarized in a year end report. Data trends and information are compared against benchmarks and presented to staff in the form of video conference and or publication each month or more frequently as required. Data and information is presented via:

1. PowerPoint
2. Lecture
3. Charts
4. Graphs
5. Reports

IX. QI Records Security

It is the responsibility of the Director of Clinical Operations to maintain records security for data used for QI and Employee Coaching. Data shall be redacted to eliminate identifying patient information as outlined in HIPAA.

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 Director of Clinical Operations 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.

X. Individual Employee Occurrences

All unusual occurrences shall be logged into TRAUMASOFT 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.

XI. Unusual Occurrences and Infrequently Used Skills San Francisco LEMSA Reporting

The County Manager is responsible to follow the reporting protocols and reporting regulations specific to the San Francisco EMS Agency. Medics are individually instructed on the requirements to report infrequently used skills.

XII. Annual Update

The Director of Clinical Operations 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 organization's 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

2024 San Francisco Continuous Quality Improvement Plan

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

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Performance Review

- Direct Observation/ Gemba Walk
- Patient (Customer Feedback)
- Patient Chart Review
- KPI Measures
- Employee Skills Assessment

Identify Opportunities for Improvement

- -Change process
- -Change protocol/policy/standard of work
- -Remediate
- -Change product
- -Incorporate into continuing education

What are we trying to accomplish?

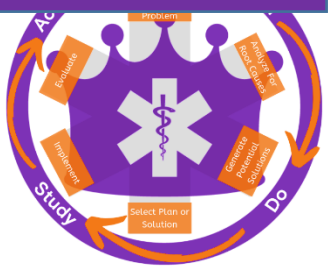
How will we know that a change is an improvement?

What change can we make that will result in improvement?

Identify Exceptional Performance

Recognize and Reinforce

- -Postings on Workplace
- -Annual Employee Recognition Awards
- -Huddles



Appendix A

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: July 9, 2024

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Interim Chief Medical Officer, EMS Authority
Tom McGinnis, Chief, EMS Systems Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2024 EMS Plan Annual Update – Specialty Care Programs

The San Francisco EMS Agency (SFEMSA) has all six available specialty programs including:

- Trauma
- STEMI
- Stroke
- EMS for Children
- Community Paramedicine
- Triage to Alternate Destination

The following appendices include San Francisco's specialty program updates. At a high-level, the following includes major updates for each program:

Trauma:

SFEMSA conducted a full site visit and review of Zuckerberg San Francisco General in November 2023 to ensure compliance with additional Title 22 requirements to be re-designated as a Level I Trauma Center. SFEMSA continues to explore back-up trauma capabilities as only one Trauma Center is located with SFEMSA's jurisdiction.

STEMI:

SFEMSA submitted the initial plan in late 2023 to the EMS Authority, which remained largely the focus of this specific specialty plan in 2023. Ongoing work includes getting all hospitals on a single data system and working on an out-of-county facility MOU.

Stroke:

SFEMSA submitted the initial plan in late 2023 to the EMS Authority, which remained largely the focus of this specific specialty plan in 2023. Ongoing work includes getting all hospitals on a single data system and working on an out-of-county facility MOU.

EMS for Children:

SFEMSA focused on revision and overhaul of almost all pediatric policies in 2023 and early 2024. A number of the policies have gone or will be going into effect soon.

Community Paramedicine and Triage to Alternate Destination:

SFEMSA's focus was largely dedicated to preserving local pilots for Community Paramedicine and Triage to Alternate Destination. Both programs were approved in September 2023. As both programs are under new regulations, SFEMSA continues to improve both programs, seek clarity, and look forward to future opportunities including the potential of an additional Triage to Alternate Destination site.

For any questions, concerns, or requests for additional information regarding our specialty programs, please do not hesitate to contact SFEMSA.

Appendix B

Trauma Specialty Care

Trauma Program Agreement

STEMI Receiving Facility	Agreement Expiration Date
Zuckerberg San Francisco General	June 30, 2028

Trauma Program Summary

The San Francisco trauma system functions with one (1) Level 1 trauma center – Zuckerburg San Francisco General (ZSFG). The catchment area for ZSFG encompasses approximately 49 square miles on a peninsula between the Pacific Ocean, San Francisco Bay and the northern region of the San Mateo County. During a typical business weekday, the catchment population of San Francisco and northern San Mateo County residents, commuters, and visitors' peaks at approximately 1.5 million. Pre-hospital care providers based in San Francisco follow the San Francisco EMS Agency Policy 5001 Trauma Triage Criteria to identify patients needing trauma center care. Providers based in San Mateo County following San Mateo County EMS Agency's Operations 22, Trauma Triage Policy.

Trauma System Data Summary

In 2023, ZSFG treated a total 3256 trauma patients. Of that number 1701 were admitted with the remaining 1555 treated and released directly from the Emergency Department. San Mateo County's pre-hospital care providers transported a total of 445 trauma patients from the northern section of San Mateo County to ZSFG. Of these, 245 were admitted for hospitalized trauma care at ZSFG.

Trauma Transport Times (source: Biospatial) – CY 2023

Mean scene to destination time: 17.01 minutes
Median scene to destination time: 15 minutes

Trauma Identification and Destination Determination

Policy 5000 – Destination Policy
Policy 5000.1 – San Francisco Hospital Designations Chart
Policy 5010 – Receiving Hospital Standards
Policy 5013- Trauma Center Designation
Policy 5014- Level I Trauma Care Standards
Policy 5021- Trauma Center Bypass Policy

Trauma Field to Hospital Communications

Policy 3020 – Field to Hospital Communications

Trauma Interfacility Transfers

Policy 5030 – Interfacility Transfers
Trauma Re-Triage Guidelines

Trauma Data Collection

Data collection for the SF Trauma System is obtained from 2 sources: 1) ZSFG Trauma Registry, maintained by the trauma center and reported to the EMSA monthly 2) CEMSIS prehospital data via Biospatial. The prehospital registry enables SFEMSA to review scene and transport data for field-activated trauma, and the hospital registry data allows for a deep-dive into confirmed trauma patients, type of injury, outcomes and other data.

Neighboring Trauma Receiving Centers

Currently, San Francisco has no out-of-county Trauma Receiving Centers that providers are able to transport to.

Trauma-related Committees

Policy 1010 – Advisory Committees

SFEMSA has a Trauma Systems Advisory Subcommittee, which meets three times per year, and representation includes Medical Directors and QI Staff from all three 911 EMS Providers, the Trauma Center Director, QI team, Base Hospital, and all other hospitals in SF. Goals for 2024 include revision and overhaul of all Trauma-related protocols (4.01-4.06, 9.01-9.02) to include treatment algorithms and updated.

Quality Improvement Process

Monthly Performance Improvement meetings are hosted by ZSFG. Attendees include both the EMS Agency's Medical Director and QI Deputy Director, hospital and clinical department representatives and ALS pre-hospital care providers. The Performance Improvement members review all trauma cases: transfers in and out of ZSFG; outcomes from the quarterly Morbidity & Mortality meetings, and departmental or pre-hospital and non-trauma center incidents. The TSAC meetings are devoted to trauma Quality Improvement and revising or developing trauma protocol/ policies/ guidelines as necessary. In addition, TSAC members designate one meeting per year to review the prior year's pre-hospital burn cases. St. Francis Memorial Hospital is designated Burn Center and the major participant at that meeting, as well as providing EMS providers with burn-focused training and education several times per year. In 2023, there were 3 TSAC meetings held by the SFEMSA. Each meeting included a clinical case presentation that included field EMS staff as well as hospital staff, data review, and protocol/policy revisions and discussions with 85% attendance for each meeting.

Site Review and Needs Assessment

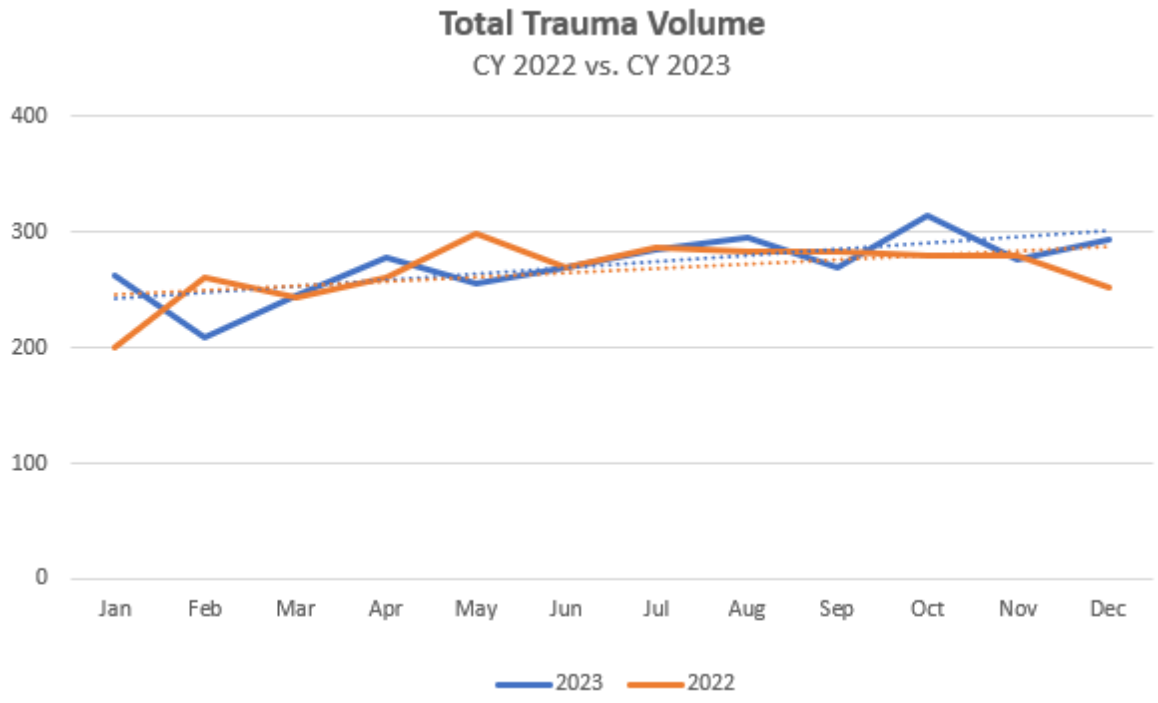
There is one designated Level 1 Trauma Center within the City and County of San Francisco. In November 2023, SFEMSA completed the ZSFG site survey. Although State regulations recommend a site survey every two years, the Agency believes that ZSFG's continued success with re-verification by the American College of Surgeons (ACS) every three years, ongoing TSAC to provide overview, and monthly Performance Improvement (PI) meetings, less frequent site surveys are required. ZSFG was re-verified by the ACS as a Level 1 Trauma Center in 2023. In November 2023, SFEMSA conducted an on-site Trauma Site survey (attached is survey letter and findings).

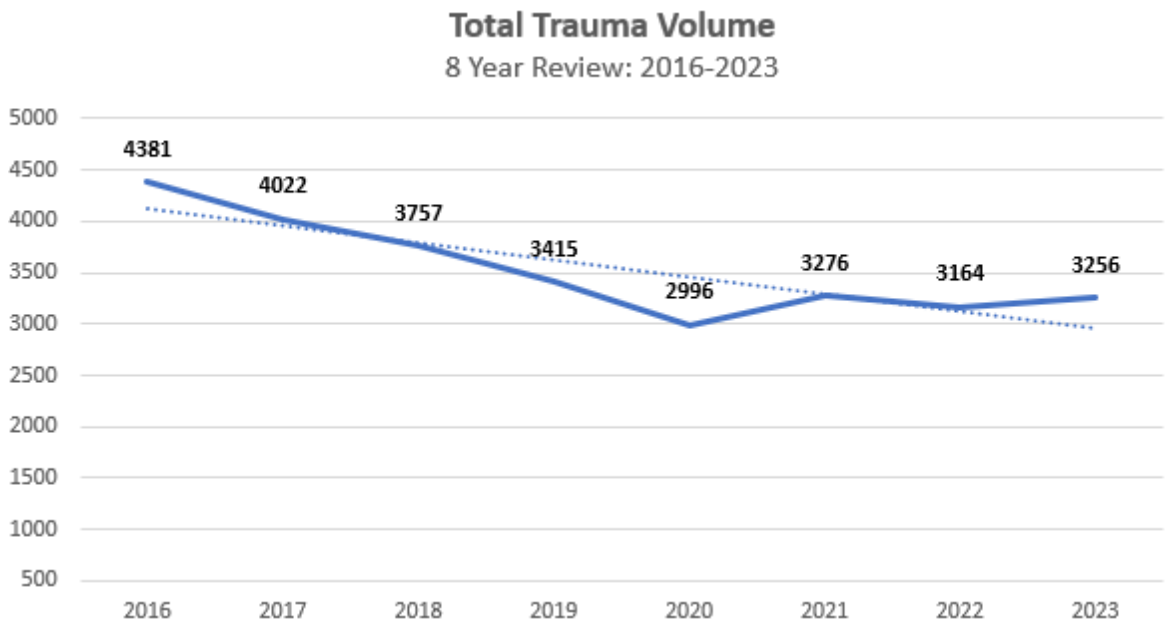
Trauma-Related Public Education

SFEMSA's goal is to participate or host an EMS public education event on a monthly basis. Our strategy is to join with other organizations' programs to maximize the impact and public contact, with a focus on injury prevention and safety for trauma, as well as Stroke and STEMI awareness.

- October 2023 – Fleet Week Hands-only CPR Booth
- May 2023 – Bike Rodeo Hands-only CPR Booth
- April 2023 – Get Ready, Stay Ready CPR Booth

SFEMSA also has ability to give letters and awards for providers and members of the public who perform life-saving interventions.




Total Trauma Volume
8 Year Review: 2016-2023
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
4381
4022
3757
3415
2996
3276
3164
3256
2016
2017
2018
2019
2020
2021
2022
2023

City and County of San Francisco
London Breed, Mayor

Department of Emergency Management
Emergency Medical Services Agency

Date: January 4, 2024

To: Dr. Susan Ehrlich, Chief Executive Officer, ZSFG

From: Dr. John Brown, EMS Agency Medical Director
Andrew Holcomb, EMS Director

RE: **ZSFG Level I Trauma Designation**

We are pleased to inform you that Zuckerberg San Francisco General (ZSFG) meets all requirements under California Code of Regulations, Title 22, Division 9, Chapter 7, and the San Francisco Emergency Medical Services Agency regulatory requirements for re-designation as a Level I Trauma Center. Listed below are key summary strengths as well as recommendations for improvement from the November 20, 2023, Site Survey:

Strengths:

- Extensive and ongoing research work with 100+ publications last year in peer-reviewed journals.
- Ongoing and collaborative work with the community, including the trauma wrap-around project.
- ZSFG has excellent collaboration and communication to partners about successes, improvements and challenges in trauma care.
- Near real-time QI with video recording for process improvement.
- A hospital configuration to allow for rapid assessment, advanced care and imaging, and pathway to surgical services.

Recommendations:

- Recommend a standard and routine process for ongoing EMS Provider education. Suggest standardized “close the loop” Quality Improvement (QI) communication tools to document clinical care by the EMS personnel. QI information and findings provided by the Trauma Coordinator should enhance and support refresher training for EMS personnel on the Shock Trauma Alert early notifications, crew coaching, and improvements in clinical care.
- ZSFG does not have direct access to an air medical helipad for trauma patients especially in trauma surge or bypass events. Recommend exploring options to mitigate this issue including practice of the EMS Agency air medical access policy and construction of a permanent helipad on campus.
- Currently, ZSFG does not have the ability to provide Extra Corporeal Membranous Oxygenation (ECMO)/Cardiopulmonary Bypass on in-hospital equipment to critical patients. Recommend the development and exploration of capital investment to support an ECMO program within ZSFG.
- For patients needing ECMO/cardiopulmonary bypass, recommend standard work practices to support documentation of consent to transfer forms and routine training and practice on contingency plans to avoid any delays. With designation as a Level I Trauma Center and approval of ZSFG’s contingency plans, ZSFG and the EMS Agency must review 100% of these infrequent patients.

- For pediatric transfer patients, recommend consent from patient guardian/caregiver for transfer be documented in chart either with case-specific transfer language on consent form or by adding additional fields to the standard EMTALA transfer form.

ZSFG has a remarkable and long-standing history of leadership, academic excellence, and clinical performance in trauma care as well as a consistent and active partnership with the EMS Agency and greater-EMS System partners. We look forward to continued collaboration in providing excellent trauma care to San Franciscans, visitors, and patients.

Sincerely,

Dr. John Brown, EMS Agency Medical Director, DPH

DocuSigned by:
John Brown
DD821142FB724F0...

1/5/2024

Andrew Holcomb, EMS Director

DocuSigned by:
[signature]
CF303502B1748...

1/5/2024

Cc: Dr. Grant Colfax, Director of Health, DPH
Dr. Laurie Green, President, San Francisco Health Commission
Dr. Joseph Cuschieri, Chief or Surgery and Trauma Medical Director, ZSFG
Dr. Christopher Colwell, Chief of Emergency Medicine, ZSFG
Mary Ellen Carroll, Executive Director, DEM
Elaina Gunn, EMS Deputy Director, DEM

Appendix C

STEMI Specialty Care

STEMI Program Agreements

STEMI Receiving Facility	Agreement Expiration Date
Zuckerberg San Francisco General	June 30, 2028
UCSF – Parnassus Campus	September 30, 2028
St. Mary's Medical Center	November 30, 2028
Kaiser San Francisco	March 30, 2028
CPMC – Van Ness Campus	February 5, 2028

STEMI Identification and Destination Determination

Policy 5000 – Destination Policy
Policy 5000.1 – San Francisco Hospital Designations Chart
Policy 5010 – Receiving Hospital Standards
Policy 5016 – STEMI and ROSC ("STAR") Receiving Center Standards

STEMI Field to Hospital Communications

Policy 3020 – Field to Hospital Communications STEMI

Interfacility Transfers

Policy 5030 – Interfacility Transfers

STEMI Data Collection

SFEMSA has Policy 6050 – Documentation of Prehospital Care to guide notable documentation points and elements for STEMI care. At STAR subcommittee meetings, quarterly metrics are reviewed via CEMSIS/NEMSIS data elements downloaded from Biospatial (see example in attachments). As of July 2023, SFEMSA has a 9-year Super User contract with American Heart Association – Get With The Guidelines Coronary Artery Disease. Within the scope of work for STEMI Receiving Center agreements, each STEMI Receiving Center is required to use Get With The Guidelines. The goal for 2024 is to ensure each STEMI Receiving Center is using this program and finalizing permission configurations for SFEMSA access. As of May 2024, all but 1 STAR Centers are utilizing this program, and it is the continued goal for 2024 to finalize all agreements. This will allow for standardized data collection and metric review across the STEMI program.

Neighboring STEMI Receiving Centers

Currently, San Francisco has no out-of-county STEMI Receiving Centers that providers are able to transport to. However, SFEMSA is actively engaged in conversations to add a STEMI Receiving Center at a San Mateo County Receiving Facility that already receives San Francisco patients under Policy 5000. As a goal for 2024, SFEMSA anticipates to add this facility and will be reflected in 2025 STEMI Plan update.

STEMI-related Committees

Policy 1010 – Advisory Committees

SFEMSA has 3 committees in which STEMI care is addressed (Quality Improvement, STAR, EMSAC). The subcommittee specially addressing STEMI care is the STAR committee and meets quarterly.

EMS Field Protocols

Beginning in January 2024, SFEMSA is transitioning to algorithm format including cardiac related field protocols for EMS personnel. As an ongoing goal, SFEMSA anticipates updating field protocols each calendar quarter.

Cardiac Care Public Education

SFEMSA's goal is to participate or host an EMS public education event at a minimum of one event per calendar quarter. For cardiac care education, the focus has been on hands-only CPR, use of AEDs, and PulsePoint registration. A few public outreach events include:

- April 12, 2024-Mission Farmers Market-Hands only CPR-Booth
- May 20, 2024-La Cocina-Hands-only CPR Booth
- May 24, 2024-Mission Women's Center-Hands-only CPR Booth

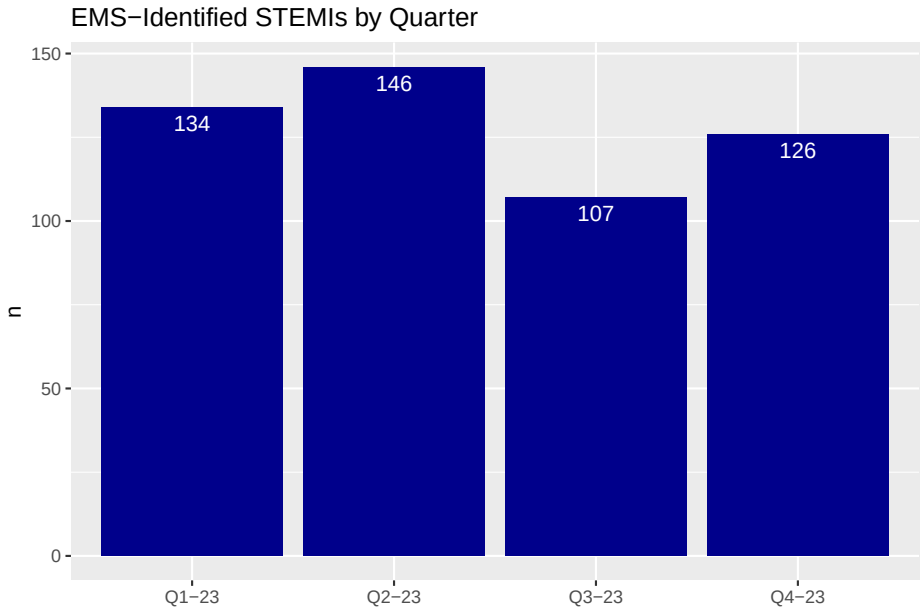
SFEMSA also has ability to give letters and awards for providers. SFEMSA also has a program named "Guardian of Life" where members of the public are recognized by letters and awards who perform life-saving interventions.

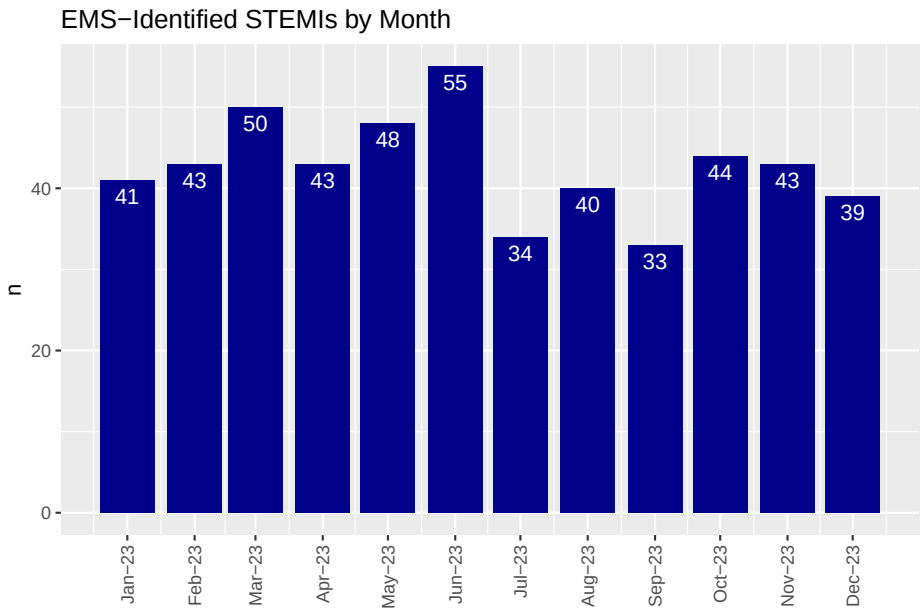
EMS STEMI Report - 2023 (All Quarters)

911 incidents in which STEMI's were identified by EMS in the prehospital setting were reviewed for the period between October 1, 2021 and September 30, 2022. The following inclusion criteria is used, based on ePCR fields for all San Francisco 911 EMS providers:

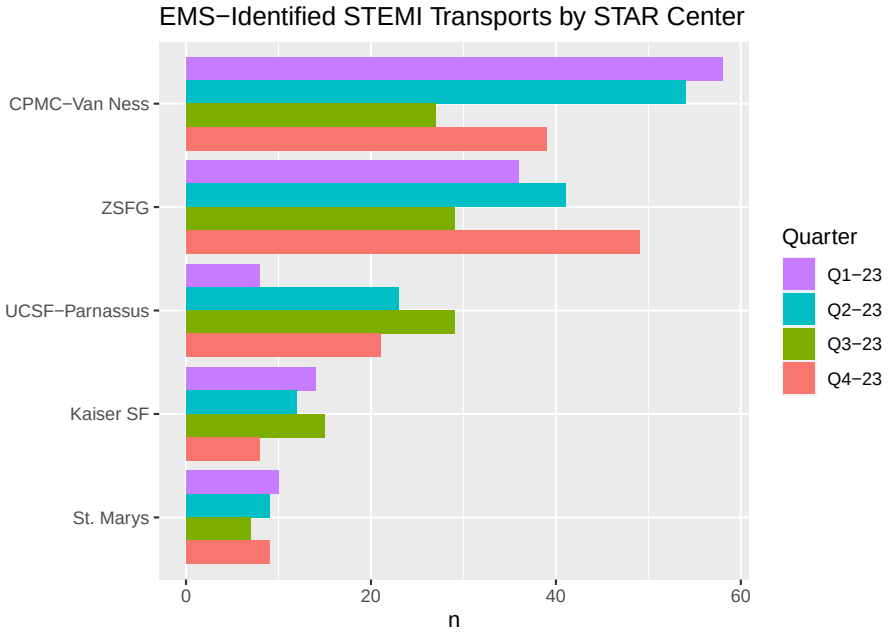
- Primary Impression of STEMI (NEMSIS eSituation.11, ICD-10: I21.3) or;
- Secondary Impression of STEMI (NEMSIS eSituation.12, ICD-10: I21.3) or;
- Destination Team Pre-Arrival Alert of Yes-STEMI (NEMSIS eDisposition.24, Code 4224013) or;
- ECG interpretation of STEMI (NEMSIS eVitals.03, Codes 9901051 - 9901057)

Incidents with a service type other than "911 Response" were excluded (e.g. interfacility transports). In total, 513 prehospital STEMI's were identified.





Of the 513 EMS-identified STEMI's, 498 were transported to San Francisco STAR hospitals.



15 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 498 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.scene	Q1-23	6.0	14.7	18.6	20.3	25.3	56.4
Q2.scene	Q2-23	5.9	14.7	18.9	20.3	24.4	52.9
Q3.scene	Q3-23	5.7	14.0	18.3	20.5	24.8	55.6
Q4.scene	Q4-23	6.3	14.0	20.0	20.9	25.5	58.9

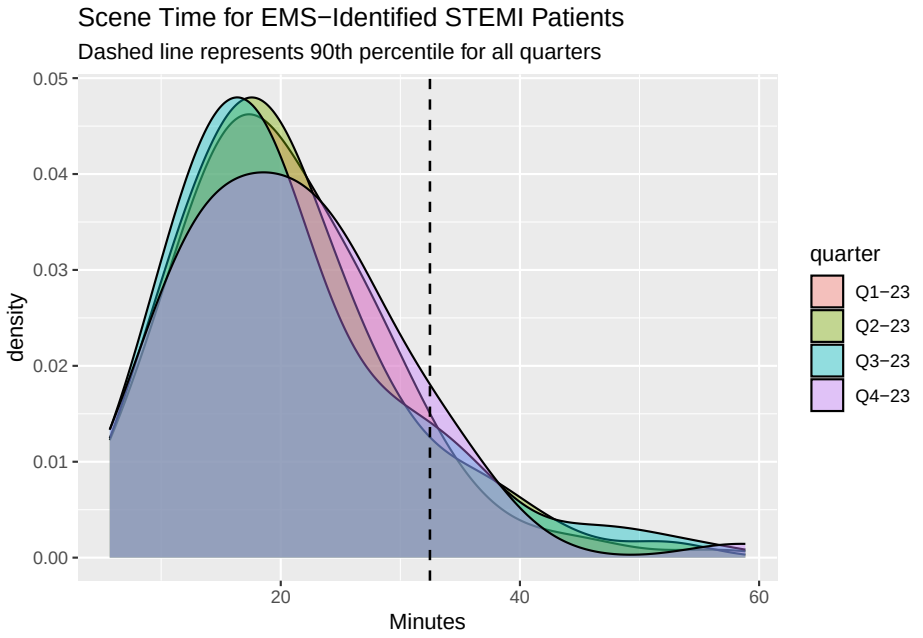
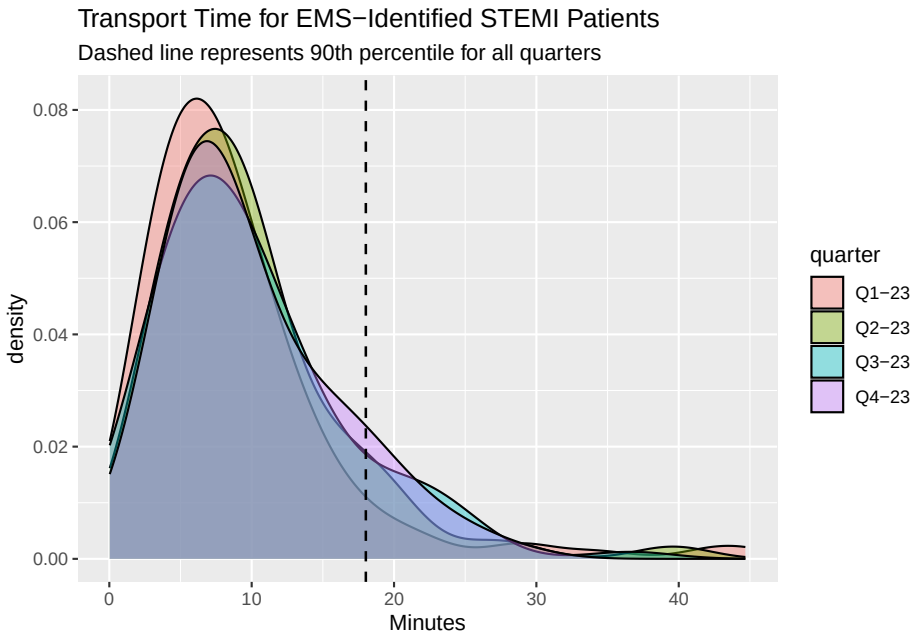


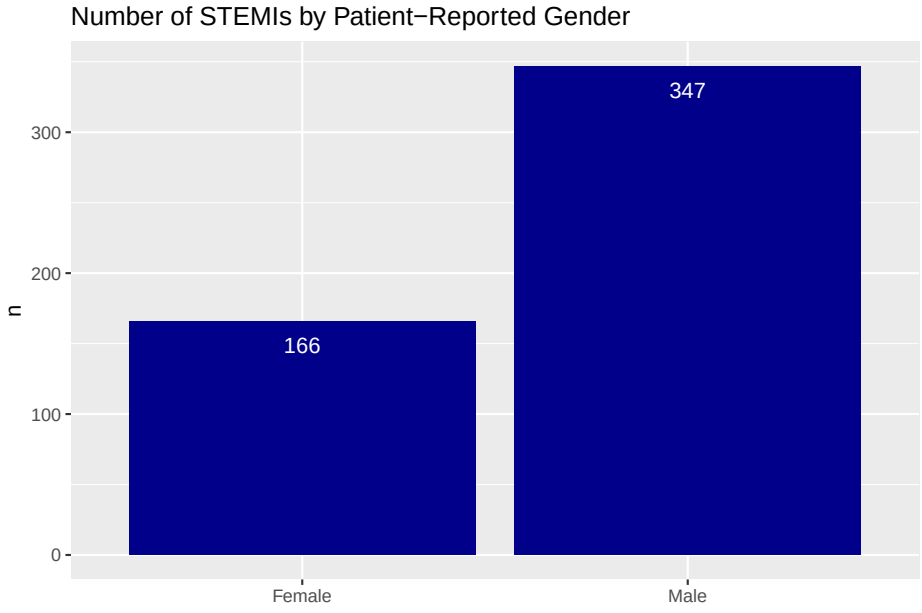
Table 2: Transport Times for STEMI Calls (minutes)

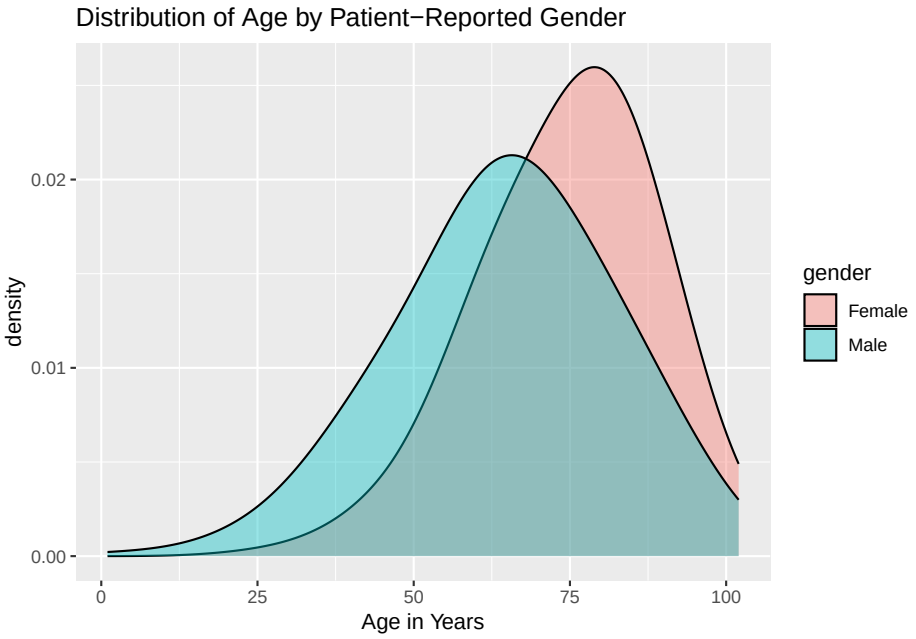
	Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1.trans	Q1-23	1.4	4.7	7.5	9.0	11.0	44.7
Q2.trans	Q2-23	0.0	5.5	8.7	9.8	12.0	40.5
Q3.trans	Q3-23	0.0	5.3	8.3	9.9	12.9	36.6
Q4.trans	Q4-23	0.7	5.7	8.0	10.0	13.3	29.0

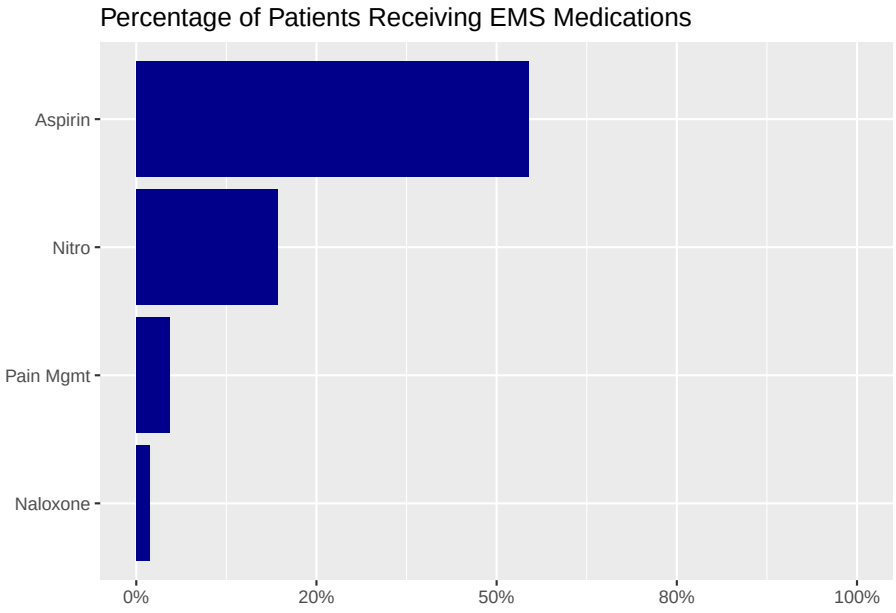


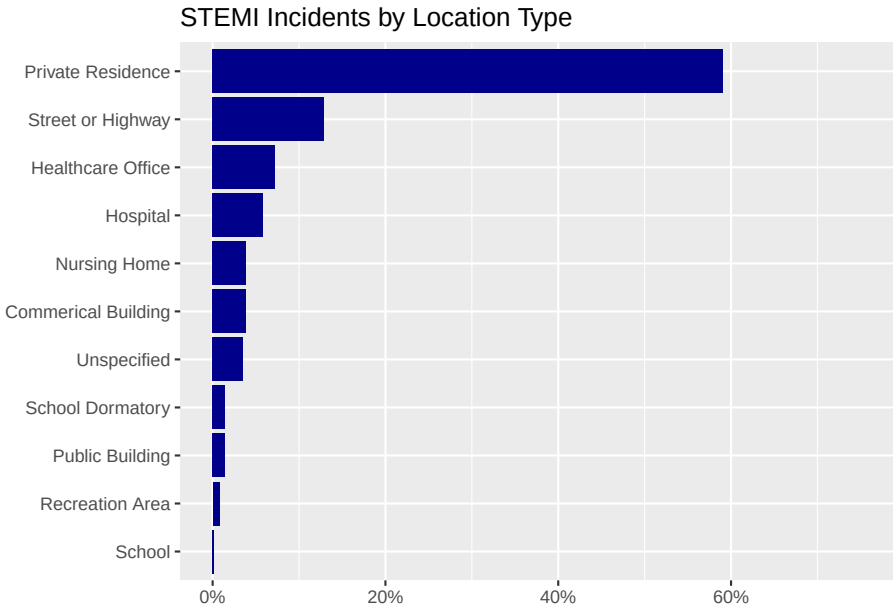
Total EMS Time is the interval between transporting EMS arrival on scene to arrival at a receiving Emergency Department - or the combination of the two intervals reviewed above. The average Total EMS Time for STEMI patients in 2021 was **30.19** minutes.

Patient Demographics and Treatment






Percentage of Patients Receiving EMS Medications
Aspirin
Nitro
Pain Mgmt
Naloxone
0%
20%
50%
80%
100%


STEMI Incidents by Location Type
Private Residence
Street or Highway
Healthcare Office
Hospital
Nursing Home
Commerical Building
Unspecified
School Dormatory
Public Building
Recreation Area
School
0%
20%
40%
60%

Appendix D

Stroke Specialty Care

Stroke Program Agreements

Stroke Receiving Facility	Agreement Expiration Date
Zuckerberg San Francisco General	June 30, 2028
UCSF – Parnassus Campus	September 30, 2028
St. Mary's Medical Center	November 30, 2028
St. Francis Memorial Hospital	November 30, 2028
Kaiser San Francisco	March 30, 2028
CPMC – Van Ness Campus	February 5, 2028
CPMC – Davies Campus	February 5, 2028
Chinese Hospital	March 12, 2028
Kaiser South San Francisco	*Out of County Hospital, plan to work on agreement for 2025 submission

Stroke Identification and Destination Determination

Policy 5000 – Destination Policy
Policy 5000.1 – San Francisco Hospital Designations Chart
Policy 5010 – Receiving Hospital Standards
Policy 5015 – Stroke Center Standards
Protocol 2.14 – Stroke

Stroke Field to Hospital Communications

Policy 3020 – Field to Hospital Communications STEMI

Stroke Interfacility Transfers

Policy 5030 – Interfacility Transfers
Emergency LVO Stroke Re-Triage Guideline

Stroke Data Collection

SFEMSA has Policy 6050 – Documentation of Prehospital Care to guide notable documentation points and elements for stroke care. At stroke subcommittee meetings, quarterly metrics are reviewed via CEMSIS/NEMSIS data elements downloaded from Biospatial (see example in attachments). In mid-2023, SFEMSA has a 9-year Super User contract with American Heart Association – Get With The Guidelines Stroke. Within the scope of work for Stroke Receiving Center agreements, each Stroke Receiving Center is required to use Get With The Guidelines. The goal for 2024 is to ensure each Stroke Receiving Center is using this program and finalizing permission configurations for SFEMSA access. As of May 2024, all but 1 Stroke Centers are utilizing this program, and it is the continued goal for 2024 to finalize all agreements. This will allow for standardized data collection and metric review across the stroke program.

Neighboring Stroke Receiving Centers

Currently, San Francisco has one Stroke Receiving Center that providers are able to transport to in San Mateo County (Kaiser South San Francisco). As a goal for 2024, SFEMSA anticipates finalizing an agreement and be reflected in the 2025 Stroke Plan update.

Stroke-related Committees

Policy 1010 – Advisory Committees

SFEMSA has 3 committees in which stroke care is addressed (Quality Improvement, Stroke, EMSAC). The subcommittee specially addressing stroke care is the stroke committee and meets quarterly.

Stroke Public Education

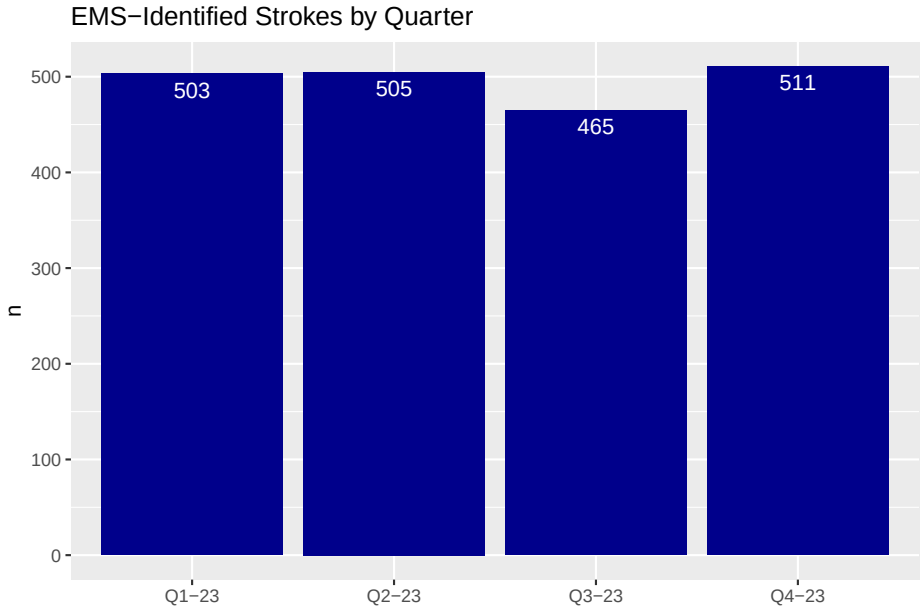
SFEMSA's goal is to participate or host an EMS public education event at a minimum of one event per calendar quarter. For stroke care education, the focus has been early recognition. A very successful outreach event occurred in May 2024 at a farmers' market in the Embarcadero. Every Stroke Center had a representative present and translation services were available. SFEMSA also has ability to give letters and awards for providers. SFEMSA has a program named "Guardian of Life" where members of the public are recognized by letters and awards who perform life-saving interventions.

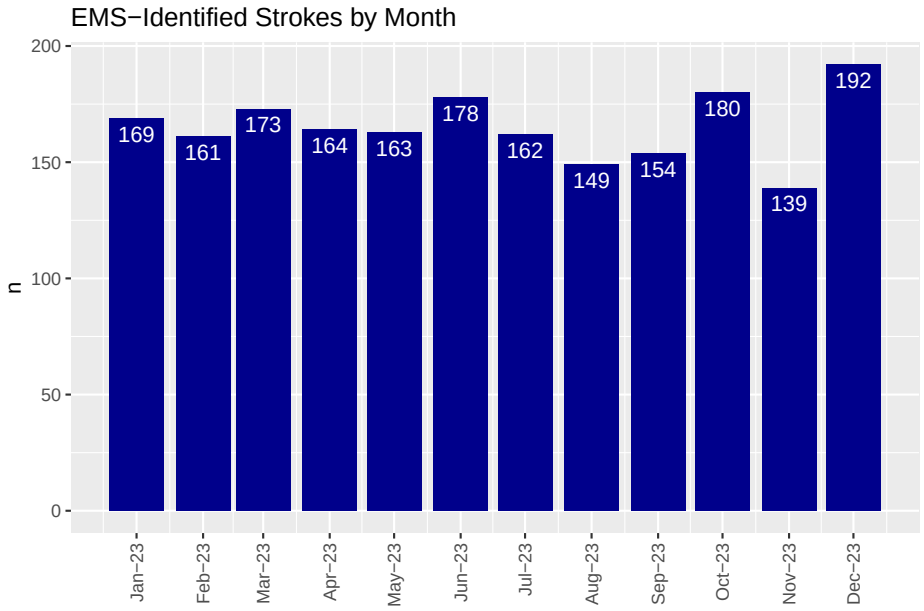
EMS Stroke Report - Q1 2023 - Q4 2023

911 incidents in which strokes were identified by EMS in the prehospital setting were reviewed for all quarters in 2022. The following inclusion criteria is used, based on ePCR fields for all San Francisco 911 EMS providers:

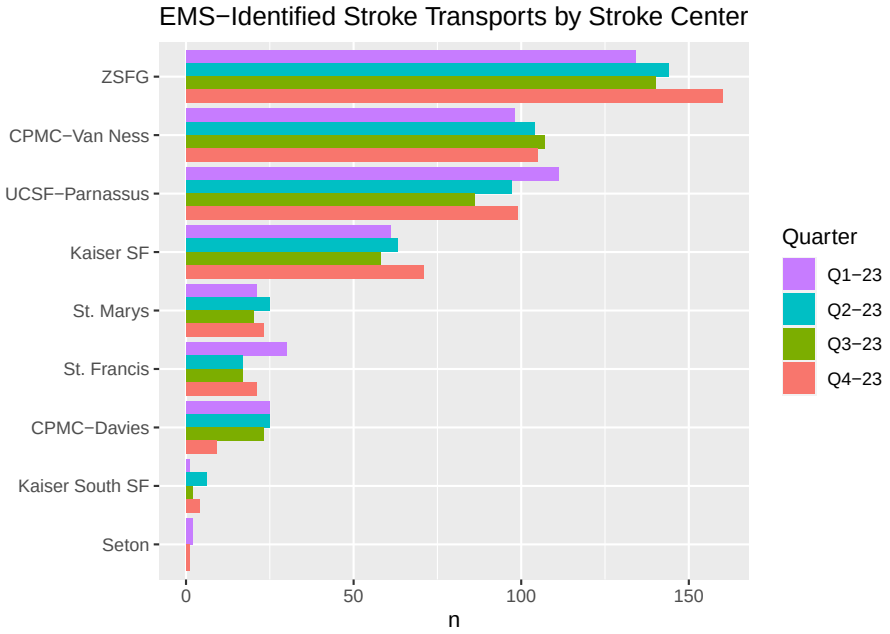
- Primary Impression of Stroke (NEMSIS eSituation.11, ICD-10: I60, I61, I63, G45, G46.3, G46.4) or;
- Secondary Impression of Stroke (NEMSIS eSituation.12, ICD-10: I60, I61, I63, G45, G46.3, G46.4) or;
- Stroke scale score (eVitals.29) indicates a positive stroke assessment

Incidents with a service type other than "911 Response" were excluded (e.g. interfacility transports). In total, 1984 prehospital strokes were identified.





Of the 1984 EMS-identified strokes, 1910 were transported to San Francisco Stroke-receiving hospitals.



74 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 1910 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
Q1-23	4.0	14.7	19.1	19.9	24.0	73.3
Q2-23	4.0	14.7	19.1	19.9	24.0	73.3
Q3-23	1.8	13.7	18.2	19.3	23.4	51.2
Q4-23	3.4	13.8	18.3	19.0	23.0	58.9

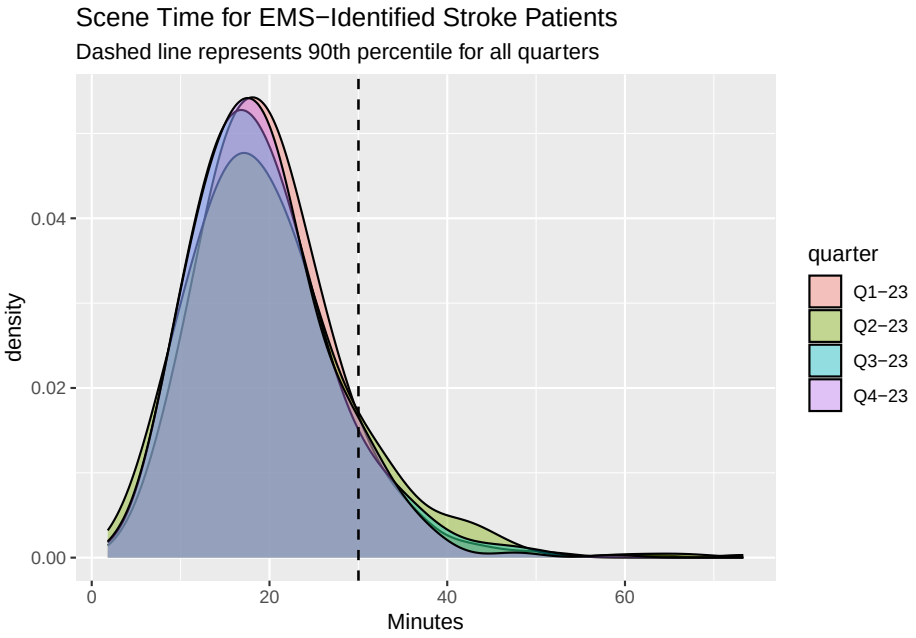
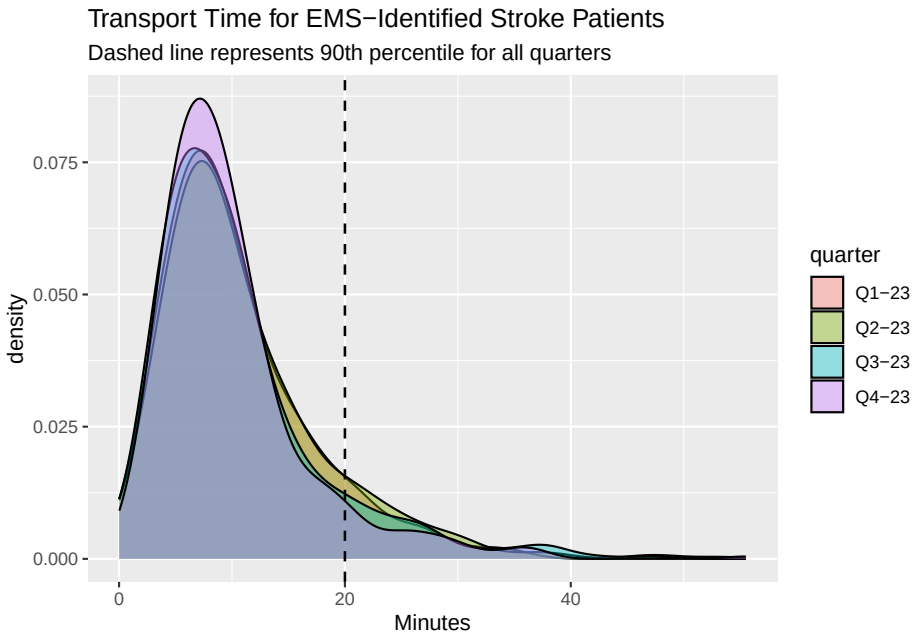


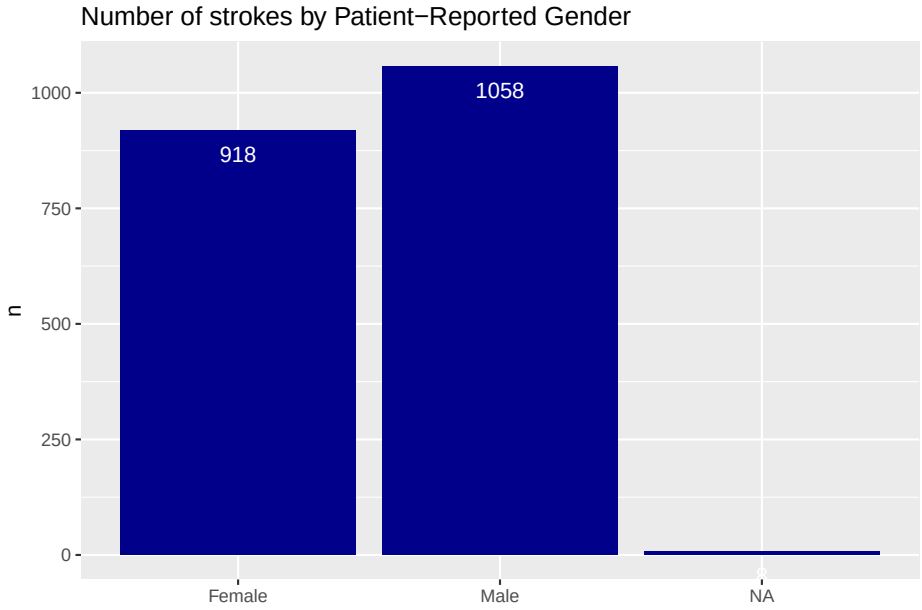
Table 2: Transport Times for Stroke Calls (minutes)

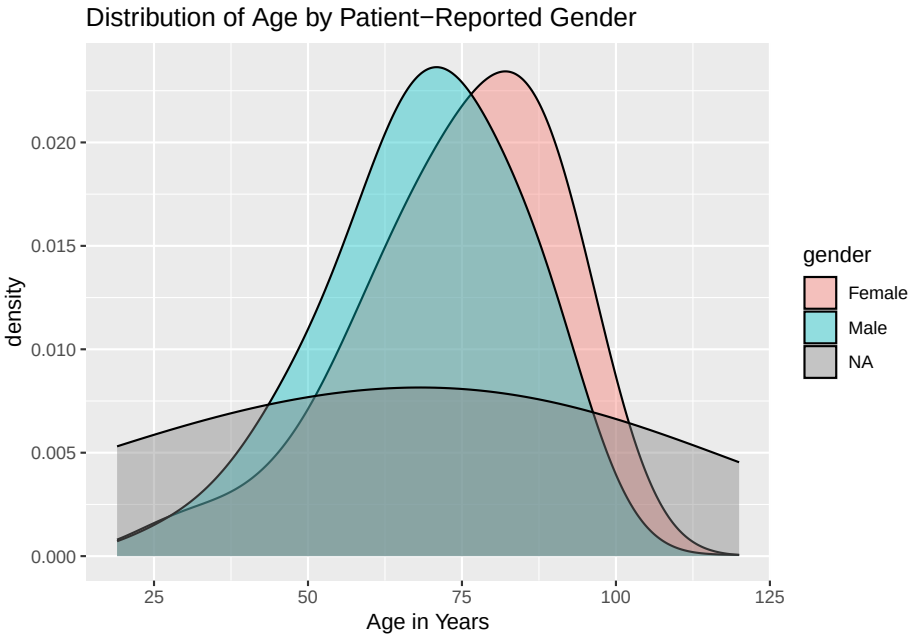
Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1-23	0	5.9	8.8	10.4	13.4	47.1
Q2-23	0	6.2	8.9	11.0	14.0	53.3
Q3-23	0	5.5	8.8	10.4	12.5	47.2
Q4-23	0	5.8	8.4	9.9	12.0	55.5



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 was **30.12** minutes.

Patient Demographics and Treatment





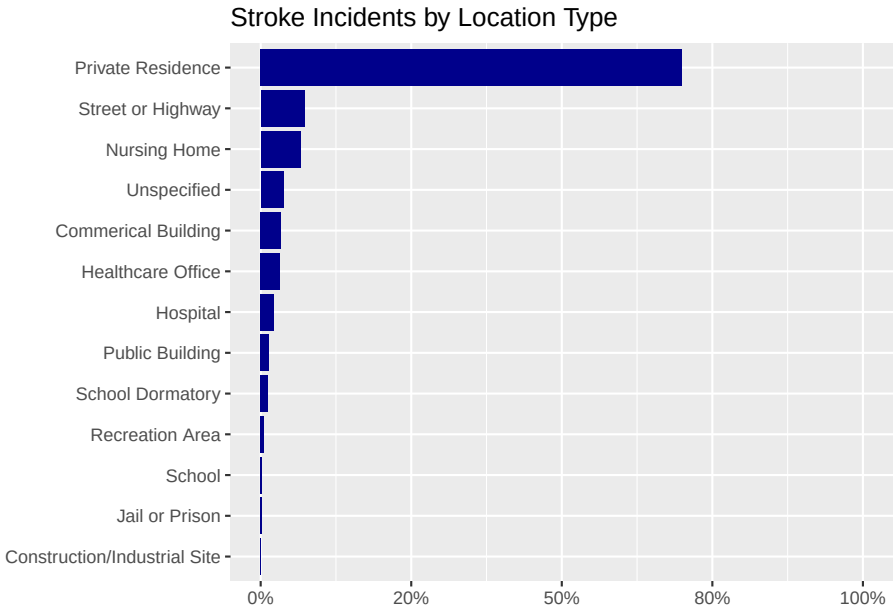
The table below looks at the percentage of stroke patients that presented with confounding syndromes. Criteria for the syndromes below are based on the NEMSIS data framework and subjective documentation by providers.

- 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	372	18.8%
Behavioral	131	6.6%
Overdose	115	5.8%
Alcohol	96	4.8%

Incident Location



Appendix E

EMS for Children (EMSC) Specialty Care

EMSC Program Agreements

STEMI Receiving Facility	Agreement Expiration Date
UCSF – Mission Bay	September 30, 2028
CPMC – Van Ness Campus	February 5, 2028

EMSC Overview

San Francisco has 10 active Emergency Departments, all of whom can receive pediatric patients. Additionally, there are two hospitals within San Francisco who have been designated to receive Critical Medical Pediatric patients. Pediatric Emergency Care comprises approximately 2.9% of all 911 care annually in San Francisco.

EMSC Committee Work

EMSC is a standing subcommittee that advises on pediatric prehospital care. The subcommittee's goals are the evaluation of pediatric policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital pediatric care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes. Meetings occur three times per year. In 2023, this committee undertook the work of a full review and revision of all pediatric clinical protocols, with the addition of treatment algorithms when applicable. Once vetted and approved by the EMSC Subcommittee, protocols were further vetted through the EMSAC approval process, and went active in April of 2024.

SF EMSA actively participates in the California EMS Authority EMS for Children Technical Advisory Committee (EMSC TAC). In anticipation of the EMSC Regulations being revised in 2024, SFEMSA is developing a data set from hospital providers that will allow us greater understanding of pediatric emergency care from 911 through hospital discourse. 2024 goals for the EMSC will be to finalize this dataset and begin collecting hospital outcome date by the end of the year.

EMSC Data (age 0-14)

Total Pediatric Transports: 1531
Trauma: 412
Fall from Ground Level: 206
Fall from Height: 97
MVC Non-severe: 107
MVC Severe or Unknown Severity: 22

Appendix F

Community Paramedicine (CP) and Triage to Alt. Destination (TAD) Specialty Care

CP/TAD Program Agreements and Resources

CP/TAD Facility/Provider	Agreement Expiration Date	Ownership
San Francisco Fire Department (CP/TAD)	July 20, 2032	Public/City
American Medical Response (TAD)	July 31, 2032	Private
King American Ambulance (TAD)	July 31, 2032	Private
San Francisco VA Medical Center (TAD)	June 30, 2032	Public/Federal
Dept. Public Health Sobering Center (TAD)	June 30, 2032	Public/City

CP/TAD Policies and Protocols

Policy 1010 – Advisory Committees
Policy 2050 – Paramedic Accreditation
Policy 5000 – Destination Policy
Section 13 – CP and TAD Programs

Sobering Center Annual Update

An annual update was provided via email on June 25, 2024 to SFEMSA detailing a list of 24/7 staff coverage including 25 Registered Nurses, 1 Nurse Practitioner, and 2 physicians. In addition, the Sobering Center reported via email: *The San Francisco Sobering Center has Standardized Sobering Protocols for Medical/Nursing Staff. These protocols are reviewed annually, and new staff are orientated to these policies and procedures. Protocols are accessible in the RN clinical station and all new staff are oriented to and provided a copy of the protocols. The San Francisco Sobering Center is a 12-bed facility. Each patient admitted to the Sobering Center is given an individual bed and has access to shower and food services. In addition, the Sobering Center is stocked with emergency equipment including but not limited to, an automatic external defibrillator (annual inspection), supplemental oxygen, ambu bags, and other emergency equipment and medications.*

2023 Annual Data

Responses and Transports	
Community Paramedicine	
Total number of responses	6778
total number of transports to general acute care hospitals	493
Triage to Alternate Destination Provider	
Total number of responses	125266
Total number of transports to general acute care hospitals	86487
Total number of transports to alternate destination facilities	360
number of transports to VA	1133
number of transports to sobering center	360

Community Paramedic Training Program

SFEMSA received an email from San Francisco Fire Department (SFFD) on June 18, 2024 that there have been no changes to community paramedic training curriculum.

SFEMA approved SFFD's CP Training Program for 4 years expiring on September 30, 2027.

Triage to Alternate Destination Program

SFEMSA currently administers the TAD training program as the LEMSA for all TAD providers. There have been no changes to the online class other than Ron Pike, EMS Specialist is transitioning to be Program Director for CE issuance after Dr. John Brown's retirement in early 2024.

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: September 26, 2023

To: Dr. Joseph Graterol, SFFD, Medical Director, Community Paramedicine
Assistant Deputy Chief Simon Pang, SFFD, Community Paramedicine
Captain Daniel Nazzareta, SFFD, Community Paramedicine

From: Dr. John Brown, EMS Agency Medical Director
Ron Pike, EMS Specialist, Training

Re: Community Paramedicine Training Program – Preliminary Approval

On July 28, 2023, the San Francisco EMS Agency (SFEMSA) reviewed and provided preliminary approval of San Francisco Fire Department's (SFFD) Community Paramedic (CP) Training Program. Final approval was contingent on overall CP Program approval by the EMS Authority with Dr. Joseph Graterol as CP Program Director/Program Clinical Director and Captain Daniel Nazzareta as CP Program Instructor.

On September 7, 2023, SFEMSA received approval of the CP Program submission by the EMS Authority.

Therefore, **SFFD's CP Training Program is approved for four (4) years as of the date of this letter with an expiration date of September 30, 2027**. Please ensure to start the renewal process six months in advance of your expiration date.

Congratulations, and thank you for continuing to provide these educational and training opportunities to San Francisco.

DocuSigned by:
John Brown
D5B21D1EFB724F0...

Dr. John Brown
EMS Agency Medical Director
john.brown@sfdph.org
628-217-6013

DocuSigned by:
Ron Pike
636EA711C63941F...

Ron Pike
EMS Specialist, Training
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628-217-6017

Cc: Chief Jeanine Nicholson, SFFD
Deputy Chief Sandy Tong, SFFD, EMS and Community Paramedicine
Section Chief Michael Mason, SFFD, Community Paramedicine
Section Chief April Sloan, SFFD, Community Paramedicine
Dr. Jeremy Lacocque, SFFD, Medical Director
Andrew Holcomb, EMS Director
Kayleigh Hillcoat, EMS Deputy Director, Operations

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London Breed
Mayor

Mary Ellen Carroll
Executive Director

Date: October 8, 2024

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Interim Chief Medical Officer, EMS Authority
Tom McGinnis, Chief, EMS Systems Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2024 EMS Plan Annual Update – Communications

The San Francisco EMS Agency (SFEMSA) has established and maintains online medical control through Zuckerberg San Francisco General (ZSFG), which is the only Base Hospital for EMS personnel in San Francisco. SFEMSA has a current agreement with ZSFG for Base Hospital services. Furthermore, the City and County of San Francisco maintains an integrated public safety communications radio system through numerous city departments and public safety agencies. Both public and private EMS Providers shall use the City and County of San Francisco radio system in addition to any other EMS Provider-specific communication systems. Under SFEMSA Vehicle Equipment and Supply List, Policy 4001, II, E:

Each ALS and BLS first response vehicle, ambulance and supervisory units, shall have an 800MHz radio in compliance with Policy 3010 EMS Communications Equipment and Procedures and have the ability to communicate with a Base Hospital Physician.

For any questions, concerns, or requests for additional information, please do not hesitate to contact me directly.

Andrew Holcomb
EMS Director, EMS Agency
andrew.holcomb@sfgov.org

Cc: Dr. Andi Tenner, Interim EMS Agency Medical Director
Rob Smuts, DEM Deputy Director
Mary Ellen Carroll, DEM Executive Director