

EMERGENCY MEDICAL SERVICES AUTHORITY

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



August 28, 2025

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 2025 EMS, Community Paramedicine (CP)/ Triage to Alternate Destination (TAD), Trauma, St-Elevation Myocardial Infarction (STEMI), Stroke, EMS for Children (EMSC), and Quality Improvement (QI) plan submissions to Emergency Medical Service Authority (EMSA) on July 3, 2025.

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, EMSC, and QI plans based on compliance with Chapters 5, 6.1, 6.2, 6.3, 6.4, and 10 of the California Code of Regulations, Title 22, Division 9, and Title 22, §100117.01, and §100124.01 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 2026 EMS plan will be due on or before August 28, 2026. Concurrently with the EMS plan, please submit an annual CP/TAD through submission of the Community Paramedicine Annex, Trauma, STEMI, Stroke, EMSC, 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,

Angela Wise, Branch Chief
EMS Quality and Planning
On behalf of Elizabeth Basnett, Director
Enclosure: AW: rd

The Seal of the State of California is a circular emblem. It features a central figure of a Native American holding a bow and arrow. Above the figure is a banner with the word "EUREKA". The outer ring of the seal contains the text "THE GREAT SEAL OF THE STATE OF CALIFORNIA".

2025 San Francisco Areas and Subareas

2025 San Francisco Areas and Subareas	Non-Exclusive		Method to Achieve Exclusivity	Emergency Ambulance			All Emergency Ambulance Services	9-1-1 Emergency Response				
	Exclusive			ALS				7-digit Emergency Response				
				LALS				ALS Ambulance				
								All CCT Ambulance Services				
								IFT				
								Standby Service with Transport Authorization				
Area	EXCLUSIVITY			TYPE			LEVEL					
City and County of San Francisco		X	Non Competitive	X				X				

CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF EMERGENCY MANAGEMENT

SAN FRANCISCO EMS AGENCY



2025 EMS PLAN ANNUAL UPDATE

**San Francisco EMS Agency
333 Valencia St. Ste 210
San Francisco, CA 94103
(628) 217-6000**

SF.GOV/EMSA



Daniel Lurie
Mayor

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



Mary Ellen Carroll
Executive Director

Date: July 3, 2025

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Chief Medical Officer, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2025 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 § 100253.

SFEMSA remains dedicated 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. By working together, everyone in the EMS system achieves success.

In March 2025, SFEMSA welcomed Dr. Amelia Breyre as SFEMSA's new Medical Director. Dr. Breyre comes to SFEMSA with extensive experience and expertise in EMS System design and leadership. Dr. Breyre graduated from the UCSF EMS Fellowship program with SFEMSA followed by serving as Associate Medical Director for 27 EMS Agencies in the Yale New Haven Health System. Dr. Breyre has worked at several Bay Area hospitals and will be starting at Zuckerberg San Francisco General in July 2025. With fresh perspective to SFEMSA, Dr. Breyre has already tackled EMS projects head-on with numerous initiatives in various stages of development.

From 2020 to 2023, many local EMS activities were paused due to the pandemic and push to meet requirements under AB 1544. In 2024, SFEMSA focused on "back to basics" as part of its core strategy. For example, SFEMSA had a huge backlog of legacy protocols that were not reviewed or updated in years. Through committees and workgroups, SFEMSA substantially reduced the backlog with implementation of dozens of revised clinical protocols. Outstanding policies are in development for 2025 and 2026. For the first time in many years, EMS partners had the opportunity to participate in Public Health-led functional and full scale disaster exercise to test and evaluate response to a mass casualty scenario.

2024 was not without significant challenges. Although SFEMSA has seen some improvement in 2025, Ambulance Patient Offload Times (APOT) remain a major issue for the EMS System. SFEMSA continues to meet regularly and collaboratively with hospital leadership and executives to discuss APOT. Significant local policy revision is ongoing with another version of the local APOT policy scheduled to go in effect in July 2025. Coupled with AB 40, SFEMSA is hopeful that additional progress is made with APOT in 2025. In October 2024, a critical patient specialty service abruptly paused in San Francisco for pediatric burn patients. After much effort and collaboration with hospital partners across the region, the specialty service was successfully restored in March 2025.

The future remains bright. Numerous national and international events are coming to San Francisco in 2025 and 2026 which have direct EMS involvement with anticipated coordination and collaboration with local, state, and federal partners. Additionally, SFEMSA is actively working on a new Triage to Alternate Destination site. Finally, a LEMSA management software system was successfully procured in early 2025 for certifications, ambulance inspections, and exception reporting. The platform is currently in development with rollout expected in late 2025.

SFEMSA will continue to be committed 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. Amelia Breyre, 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: 2024

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)	<u>6*</u> %
B. Limited Advanced Life Support (LALS)	<u>0</u> %
C. Advanced Life Support (ALS)	<u>94</u> %

*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)	<u>Yes</u>
Designation of trauma centers/trauma care system planning	<u>Yes</u>
Designation/approval of pediatric facilities	<u>Yes</u>
Designation of other critical care centers	<u>Yes - Burn</u>
Development of transfer agreements	<u>Yes</u>
Enforcement of local ambulance ordinance	<u>Yes</u>
Enforcement of ambulance service contracts	<u>No</u>
Operation of ambulance service	<u>No</u>
Continuing education	<u>Yes</u>
Personnel training	<u>Yes</u>
Operation of oversight of EMS dispatch center	<u>Yes</u>
Non-medical disaster planning	<u>Yes</u>
Administration of critical incident stress debriefing team (CISD)	<u>No</u>

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

Administration of disaster medical assistance team (DMAT)	<u> No </u>
Administration of EMS Fund [Senate Bill (SB) 12/612]	<u> No </u>
Other: _____	_____
Other: _____	_____
Other: _____	_____

5. EXPENSES – *FY24-25 Budget*****

Salaries and benefits (All but contract personnel)	\$ 2,397,560_
Contract Services (e.g. medical director)	\$95,516_
Operations (e.g. copying, postage, facilities)	\$17,730_
Travel	\$12,400_
Fixed assets	\$200,000_
Indirect expenses (overhead)	_____
Ambulance subsidy	_____
EMS Fund payments to physicians/hospital	_____
Dispatch center operations (non-staff)	_____
Training program operations	\$5,000_
Other: Contracts (Prof Services) _____	\$351,500_
Other: Membership Fees _____	\$2,500_
Other: License Fees _____	\$1,500_
TOTAL EXPENSES	\$ 3,083,706_

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	\$1,782,115*
<i>*Estimate, CCSF requires balanced budget, EMSA balanced for FY24-25</i>	
Other local tax funds (e.g., EMS district)	_____
County contracts (e.g. multi-county agencies)	_____
Certification fees	\$119,436_
Training program approval fees	\$0_
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	\$26,122 _____
Pediatric facility approval fees	_____
Pediatric facility designation fees	\$52,244 _____
Other critical care center application fees	\$213,726 _____
Type: Receiving Hospital _____	
Other critical care center designation fees	\$130,609 _____
Type: STEMI Center _____	
Other critical care center designation fees	\$208,974 _____
Type: Stroke Center _____	
Ambulance service/vehicle fees	\$412,029 _____
Contributions	_____
EMS Fund (SB 12/612)	_____
Other grants: HPP _____	\$86,350 _____
Other fees: Medical Plan Fees _____	\$34,781 _____
Other (specify): Community Paramedic Provider Fee	\$103,670 _____
TOTAL REVENUE	\$ \$3,170,056*
*Non-General Fund Revenue \$1,301,591	

*TOTAL REVENUE SHOULD EQUAL TOTAL EXPENSES.
IF THEY DON'T, PLEASE EXPLAIN.*

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

7. Fee structure **Fiscal Year 24-25******

☐ We do not charge any fees

☒ Our fee structure is:

First responder certification	\$ No
EMS dispatcher certification	No
EMT-I certification	\$200
EMT-I recertification	\$148
EMT-defibrillation certification	No
EMT-defibrillation recertification	No
AEMT certification	No
AEMT recertification	No
EMT-P accreditation	\$44
Mobile Intensive Care Nurse/Authorized Registered Nurse certification	No
MICN/ARN recertification	No
EMT-I training program approval	\$1,661
AEMT training program approval	No
EMT-P training program approval	\$2,487
MICN/ARN training program approval	No
Base hospital application	No
Base hospital designation	No
Trauma center application	No
Trauma center designation	\$26,122
Pediatric facility approval	No
Pediatric facility designation	\$26,122
Other critical care center application	
Type: Receiving Hospital	\$21,373
Other critical care center designation	
Type: STEMI Center	\$26,122
Other critical care center designation	
Type: Stroke Center	\$26,122
Ambulance service license	\$14,013
Ambulance vehicle permits	\$2,242
Other: Annual Ambulance Renewal	\$7,006
Other: Initial CE Program	\$834
Other: Renewal CE Program	\$505
Other: Renewal EMT-P Program	\$1,247

Other: Renewal EMT Program _____	\$911 _____
Other: Critical Care Paramedic Endorsement _____	\$44 _____
Other: Community Paramedic Accreditation _____	\$44 _____
Other: Lost/Duplicate Card _____	\$26 _____
Other: Professional Verification Form _____	\$26 _____
Other: Initial Community Paramedic Provider _____	\$207,340 _____
Other: Renewal Community Paramedic Provider _____	\$103,670 _____
Other: Event Medical Plan Review 1 to 999 Persons __	\$52 _____
Other: Event Medical Plan Review 1,000 to 4,999 Persons __	\$156 _____
Other: Event Medical Plan Review 5,000 to 9,999 Persons __	\$518 _____
Other: Event Medical Plan Review 10,000 Persons or more __	\$1,037 _____

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 37.6%)	COMMENTS
EMS Director	0933 Manager V	1.0	\$225,758	\$310,643	Andrew Holcomb
EMS Agency Medical Director	2233 Supervising Physician Specialist	1.0	n/a	n/a	Dr. Amelia Breyre started March 2025
EMS Deputy Director (Operations)	0923 Manager II	1.0	\$180,856	\$248,858	Kayleigh Hillcoat
EMS Deputy Director (QI)	0931 Manager III	1.0	\$195,026	\$268,356	Elaina Gunn
EMS Specialist (Operations)	2533 EMS Specialist	1.0	\$160,420	\$220,738	Sal Serrian
EMS Specialist (QI)	2533 EMS Specialist	1.0	\$160,420	\$220,738	Vacant as of May 2024
EMS Specialist (Training)	2533 EMS Specialist	1.0	\$160,420	\$220,738	Ron Pike
EMS Specialist (Special Projects/QI)	2533 EMS Specialist	1.0	\$160,420	\$220,738	Leo Ishoda
EMS Specialist (Specialty Care)	2533 EMS Specialist	1.0	\$160,420	\$220,738	Gino Cifoletti
Info and Guidance	2593 Health Program Coordinator III	1.0	\$144,560	\$198,915	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	\$104,754	\$144,142	Vacant as of May 2025
Admin/Certification Specialist	1446 Secretary II	1.0	\$96,850	\$133,266	Camilla Arcia
EMS Disaster Medicine Fellow	n/a	*contract	n/a	n/a	Funded via \$100,000 contract with UCSF, contract terminated April 2025

DPH
Public Health Emergency Response and Preparedness Director
Dr. Andrea Tenner

EMS Medical Director
2233 Supervising Physician Specialist
Dr. Amelia Breyre

EMS Fellow (2)
Contractor
Dr. Amelia Gurley/Dr. Mikaela Middleton

DEM
Executive Director
Mary Ellen Carroll

DEM
Deputy Director
Robert Smuts

EMS Director
0933 Manager V
Andrew Holcomb

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

Training Coordinator
2533 EMSA Specialist
Ron Pike

EMS Specialist Special Projects
2533 EMSA Specialist
Leo Ishoda

Certification Admin
8601 ESC I
Vacant

EMS Specialist Specialty Care
2533 EMSA Specialist
Gino Cifolelli

EMS Specialist Quality Improvement
2533 EMSA Specialist
Vacant

Info & Guidance
2593 Health Program Coor III
Erin Bachus

Epidemiologist
2803 Epidemiologist II
Will Godwin

TABLE 3: STAFFING/TRAININGReporting Year: 2024 **NOTE:** Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN
Total Certified	981	0	40	0
Number newly certified this year	208	0	40	0
Number recertified this year	773	0	n/a (no fee)	0
Total number of accredited personnel on July 1 of the reporting year	2013	0	544	0
Number of certification reviews resulting in:				
a) formal investigations	13			
b) probation	1			
c) suspensions				
d) revocations				
e) denials	2			
f) denials of renewal				
g) no action taken	10			

1. Early defibrillation:

a) Number of EMT-I (defib) authorized to use AEDs

 2013

b) Number of public safety (defib) certified (non-EMT-I)

 0

2. Do you have an EMR training program

☐ yes ☒ no

TABLE 4: COMMUNICATIONS

Note: Table 4 is to be answered for each county.

County: **San Francisco**_____

Reporting Year: **2024**_____

1. Number of primary Public Service Answering Points (PSAP)	<u>4*</u>
2. Number of secondary PSAPs	<u>1 (3-1-1)</u>
3. Number of dispatch centers directly dispatching ambulances	<u>6</u>
4. Number of EMS dispatch agencies utilizing EMD guidelines	<u>6</u>
5. Number of designated dispatch centers for EMS Aircraft	<u>None</u>
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?	☒ Yes ☐ No
a. Radio primary frequency _____	
b. Other methods _____	
c. Can all medical response units communicate on the same disaster communications system?	☒ Yes ☐ No
d. Do you participate in the Operational Area Satellite Information System	☒ Yes ☐ No
e. Do you have a plan to utilize the Radio Amateur Civil Emergency Services	☒ Yes ☐ No
1) Within the operational area?	☒ Yes ☐ No
2) Between operation area and the region and/or state?	☒ Yes ☐ No

***DEM CCSF, National Park Service (US Park Police), SF State University, UCSF**

TABLE 5: RESPONSE/TRANSPORTATION

Reporting Year: 2024

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%)	00:06:33	n/a	n/a	00:06:33
Early defibrillation responder (SF standard 4 min, 30 sec 90th%)	00:06:33	n/a	n/a	00:06:33
Advanced life support responder (SF standard 7 min 90th%)	00:07:32	n/a	n/a	00:07:32
Transport Ambulance (Code 3 SF standard 10 min 90th%) (Code 2 SF standard 20 min 90th%)	00:11:15 00:21:01	n/a	n/a	00:11:15 00:21:01

Public Facing Dashboard <https://www.sf.gov/resource--2024--emergency-medical-services-data-and-reports>

TABLE 6: SYSTEM RESOURCES AND OPERATIONS
Facilities/Critical Care

Reporting Year: **2024**

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	2735
2. Number of major trauma victims transported directly to a trauma center by ambulance **See below**	2495
3. Number of major trauma patients transferred to a trauma center	240
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	8
2. Number of base hospitals with written agreements	1

****Trauma patients from Outside SF County (San Mateo County):**

Total activations- 363

Total trauma patients directly transported to Trauma Center- 295

Total trauma patients re-triaged to Trauma Center- 33

TABLE 7: DISASTER MEDICAL

Reporting Year: 2024

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

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.

In 2024 and 2025, Emergency Service Function 8 (ESF-8) is currently being revised by the Department of Emergency Management.

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) Number of Ambulance Vehicles in Fleet: 58
San Francisco, CA 94124

Phone Number: 415-558-3200 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 28

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Medical Director:</u> ☒ Yes ☐ No	<u>System Available 24 Hours:</u> ☒ Yes ☐ No	<u>Level of Service:</u> ☒ Transport ☒ ALS ☒ 9-1-1 ☒ Ground ☒ Non-Transport ☐ BLS ☐ 7-Digit ☐ Air ☐ CCT ☒ Water ☒ IFT	
<u>Ownership:</u> ☒ Public ☐ Private	<u>If Public:</u> ☒ Fire ☐ Law ☐ Other Explain: _____	<u>If Public:</u> ☒ City ☒ County ☐ State ☐ Fire District ☐ Federal	<u>If Air:</u> ☐ Rotary ☐ Fixed Wing	<u>Air Classification:</u> ☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

98,352 Total number of responses
56,889 Number of emergency responses
41,463 Number of non-emergency responses

61,788 Total number of transports
5,383 Number of emergency transports
56,405 Number of non-emergency transports

Air Ambulance Services

n/a Total number of responses
n/a Number of emergency responses
n/a Number of non-emergency responses

n/a Total number of transports
n/a Number of emergency transports
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 Number of Ambulance Vehicles in Fleet: 40
San Francisco, CA 94107

Phone Number: 415-922-9400 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 15

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Medical Director:</u> ☒ Yes ☐ No	<u>System Available 24 Hours:</u> ☒ Yes ☐ No	<u>Level of Service:</u> ☒ Transport ☒ ALS ☒ 9-1-1 ☒ Ground ☒ Non-Transport ☒ BLS ☒ 7-Digit ☐ Air ☒ CCT ☐ Water ☒ IFT	
<u>Ownership:</u> ☐ Public ☒ Private	<u>If Public:</u> ☐ Fire ☐ Law ☐ Other Explain: _____	<u>If Public:</u> ☐ City ☐ County ☐ State ☐ Fire District ☐ Federal	<u>If Air:</u> ☐ Rotary ☐ Fixed Wing	<u>Air Classification:</u> ☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

28,507 Total number of responses
5,244 Number of emergency responses
23,263 Number of non-emergency responses

19,405 Total number of transports
80 Number of emergency transports
19,325 Number of non-emergency transports

Air Ambulance Services

n/a Total number of responses
n/a Number of emergency responses
n/a Number of non-emergency responses

n/a Total number of transports
n/a Number of emergency transports
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 Number of Ambulance Vehicles in Fleet: 13
San Francisco, CA 94115

Phone Number: 415-931-1400 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 7

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Medical Director:</u> ☒ Yes ☐ No	<u>System Available 24 Hours:</u> ☒ Yes ☐ No	<u>Level of Service:</u> ☒ Transport ☒ ALS ☒ 9-1-1 ☒ Ground ☒ Non-Transport ☒ BLS ☒ 7-Digit ☐ Air ☐ CCT ☐ Water ☒ IFT	
<u>Ownership:</u> ☐ Public ☒ Private	<u>If Public:</u> ☐ Fire ☐ Law ☐ Other Explain: _____	<u>If Public:</u> ☐ City ☐ County ☐ State ☐ Fire District ☐ Federal	<u>If Air:</u> ☐ Rotary ☐ Fixed Wing	<u>Air Classification:</u> ☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

18,858 Total number of responses
14,154 Number of emergency responses
4,700 Number of non-emergency responses

11,853 Total number of transports
821 Number of emergency transports
11,034 Number of non-emergency transports

Air Ambulance Services

n/a Total number of responses
n/a Number of emergency responses
n/a Number of non-emergency responses

n/a Total number of transports
n/a Number of emergency transports
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 Number of Ambulance Vehicles in Fleet: 5
Dublin, CA 94568

Phone Number: 866-755-3400 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 7

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Medical Director:</u> ☒ Yes ☐ No	<u>System Available 24 Hours:</u> ☒ Yes ☐ No	<u>Level of Service:</u> ☒ Transport ☐ ALS ☐ 9-1-1 ☒ Ground ☒ Non-Transport ☒ BLS ☒ 7-Digit ☐ Air ☒ CCT ☐ Water ☒ IFT	
<u>Ownership:</u> ☐ Public ☒ Private	<u>If Public:</u> ☐ Fire ☐ Law ☐ Other Explain: _____	<u>If Public:</u> ☐ City ☐ County ☐ State ☐ Fire District ☐ Federal	<u>If Air:</u> ☐ Rotary ☐ Fixed Wing	<u>Air Classification:</u> ☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

1,157 Total number of responses
333 Number of emergency responses
824 Number of non-emergency responses

821 Total number of transports
265 Number of emergency transports
556 Number of non-emergency transports

Air Ambulance Services

n/a Total number of responses
n/a Number of emergency responses
n/a Number of non-emergency responses

n/a Total number of transports
n/a Number of emergency transports
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 Number of Ambulance Vehicles in Fleet: 49
Cotati, CA 94931

Phone Number: 707-665-4280 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 22

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Medical Director:</u> ☒ Yes ☐ No	<u>System Available 24 Hours:</u> ☒ Yes ☐ No	<u>Level of Service:</u> ☒ Transport ☒ ALS ☐ 9-1-1 ☒ Ground ☒ Non-Transport ☒ BLS ☒ 7-Digit ☐ Air ☒ CCT ☐ Water ☒ IFT	
<u>Ownership:</u> ☐ Public ☒ Private	<u>If Public:</u> ☐ Fire ☐ Law ☐ Other Explain: _____	<u>If Public:</u> ☐ City ☐ County ☐ State ☐ Fire District ☐ Federal	<u>If Air:</u> ☐ Rotary ☐ Fixed Wing	<u>Air Classification:</u> ☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

12,714 Total number of responses
96 Number of emergency responses
12,810 Number of non-emergency responses

12,066 Total number of transports
96 Number of emergency transports
11,970 Number of non-emergency transports

Air Ambulance Services

n/a Total number of responses
n/a Number of emergency responses
n/a Number of non-emergency responses

n/a Total number of transports
n/a Number of emergency transports
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 Number of Ambulance Vehicles in Fleet: 45
San Leandro, CA 94577

Phone Number: 833-769-2599 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 15

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Medical Director:</u> ☒ Yes ☐ No	<u>System Available 24 Hours:</u> ☒ Yes ☐ No	<u>Level of Service:</u> ☒ Transport ☐ ALS ☐ 9-1-1 ☒ Ground ☒ Non-Transport ☒ BLS ☒ 7-Digit ☐ Air ☒ CCT ☐ Water ☒ IFT	
<u>Ownership:</u> ☐ Public ☒ Private	<u>If Public:</u> ☐ Fire ☐ Law ☐ Other Explain: _____	<u>If Public:</u> ☐ City ☐ County ☐ State ☐ Fire District ☐ Federal	<u>If Air:</u> ☐ Rotary ☐ Fixed Wing	<u>Air Classification:</u> ☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

14,262 Total number of responses
98 Number of emergency responses
14,164 Number of non-emergency responses

13,712 Total number of transports
83 Number of emergency transports
13,629 Number of non-emergency transports

Air Ambulance Services

n/a Total number of responses
n/a Number of emergency responses
n/a Number of non-emergency responses

n/a Total number of transports
n/a Number of emergency transports
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**
 Address: **1001 Potrero Avenue**
San Francisco, CA 94110

Telephone Number: **628-206-8000**

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Service:</u> ☐ Referral Emergency ☐ Basic Emergency ☐ Standby Emergency ☒ Comprehensive Emergency	<u>Base Hospital:</u> X* Yes ☐ No	<u>Burn Center:</u> ☐ Yes ☒ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u> ☒ Yes ☐ No	<u>If Trauma Center what level:</u> ☒ Level I ☐ Level III ☐ Level II ☐ Level IV

<u>STEMI Center:</u> ☒ Yes ☐ No	<u>Stroke Center:</u> ☒ Yes ☐ No

****Base Hospital communications from the field are done through the City-wide radio system. All EMS Providers are required to have and use City-wide radio system.***

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**

<u>Written Contract:</u>	<u>Service:</u>	<u>Base Hospital:</u>	<u>Burn Center:</u>
☒ Yes ☐ No	☐ Referral Emergency ☒ Basic Emergency	☐ Yes ☒ No	☐ Yes ☒ No
	☐ Standby Emergency ☐ Comprehensive Emergency		

Pediatric Critical Care Center¹ EDAP² PICU³	☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No	<u>Trauma Center:</u>	<u>If Trauma Center what level:</u>
		☐ Yes ☒ No	☐ Level I ☐ Level III
			☐ Level II ☐ Level IV

<u>STEMI Center:</u>	<u>Stroke Center:</u>
☒ Yes ☐ No	☒ 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

<u>Written Contract:</u>	<u>Service:</u>		<u>Base Hospital:</u>	<u>Burn Center:</u>
☒ Yes ☐ No	☐ Referral Emergency ☒ Basic Emergency	☐ Standby Emergency ☐ Comprehensive Emergency	☐ Yes ☒ No	☐ Yes ☒ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u> ☐ Yes ☒ No	<u>If Trauma Center what level:</u> ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

<u>STEMI Center:</u>	<u>Stroke Center:</u>
☐ Yes ☒ No	☒ 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 –** Telephone Number: **415-600-6000**
Mission Bernal Campus
 Address: **3555 Cesar Chavez Street**
San Francisco, CA 94110

<u>Written Contract:</u>	<u>Service:</u>	<u>Base Hospital:</u>	<u>Burn Center:</u>
☒ Yes ☐ No	☐ Referral Emergency ☒ Basic Emergency	☐ Yes ☒ No	☐ Yes ☒ No
	☐ Standby Emergency ☐ Comprehensive Emergency		

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u>	<u>If Trauma Center what level:</u>
		☐ Yes ☒ No	☐ Level I ☐ Level III
			☐ Level II ☐ Level IV

<u>STEMI Center:</u>	<u>Stroke Center:</u>
☐ Yes ☒ No	☐ 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 Medical Center**
 Address: **505 Parnassus Avenue**
San Francisco, CA 94143

Telephone Number: **415-353-1238**

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Service:</u> ☐ Referral Emergency ☒ Basic Emergency ☐ Standby Emergency ☐ Comprehensive Emergency	<u>Base Hospital:</u> ☐ Yes ☒ No	<u>Burn Center:</u> ☐ Yes ☒ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u> ☐ Yes ☒ No	<u>If Trauma Center what level:</u> ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

<u>STEMI Center:</u> ☒ Yes ☐ No	<u>Stroke Center:</u> ☒ 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**
 Address: **1975 4th Street**
San Francisco, CA 94158

Telephone Number: **415-353-1818**

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Service:</u> ☐ Referral Emergency ☒ Basic Emergency ☐ Standby Emergency ☐ Comprehensive Emergency	<u>Base Hospital:</u> ☐ Yes ☒ No	<u>Burn Center:</u> ☐ Yes ☒ No

Pediatric Critical Care Center¹ ☒ Yes ☐ No EDAP² ☒ Yes ☐ No PICU³ ☒ Yes ☐ No	<u>Trauma Center:</u> ☐ Yes ☒ No	<u>If Trauma Center what level:</u> ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

<u>STEMI Center:</u> ☐ Yes ☒ No	<u>Stroke Center:</u> ☐ 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: **Kaiser San Francisco**
 Address: **2425 Geary Blvd**
San Francisco, CA 94115

Telephone Number: **415-833-2000**

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Service:</u> ☐ Referral Emergency ☒ Basic Emergency ☐ Standby Emergency ☐ Comprehensive Emergency	<u>Base Hospital:</u> ☐ Yes ☒ No	<u>Burn Center:</u> ☐ Yes ☒ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u> ☐ Yes ☒ No	<u>If Trauma Center what level:</u> ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

<u>STEMI Center:</u> ☒ Yes ☐ No	<u>Stroke Center:</u> ☒ 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

<u>Written Contract:</u>	<u>Service:</u>	<u>Base Hospital:</u>	<u>Burn Center:</u>
☒ Yes ☐ No	☐ Referral Emergency ☒ Basic Emergency ☐ Standby Emergency ☐ Comprehensive Emergency	☐ Yes ☒ No	☒ Yes ☐ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u>	<u>If Trauma Center what level:</u>
		☐ Yes ☒ No	☐ Level I ☐ Level III ☐ Level II ☐ Level IV

<u>STEMI Center:</u>	<u>Stroke Center:</u>
☐ Yes ☒ No	☒ 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**
 Address: **450 Stanyan Street**
San Francisco, CA 94117

Telephone Number: **415-668-1000**

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Service:</u> ☐ Referral Emergency ☒ Basic Emergency ☐ Standby Emergency ☐ Comprehensive Emergency	<u>Base Hospital:</u> ☐ Yes ☒ No	<u>Burn Center:</u> ☐ Yes ☒ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u> ☐ Yes ☒ No	<u>If Trauma Center what level:</u> ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

<u>STEMI Center:</u> ☒ Yes ☐ No	<u>Stroke Center:</u> ☒ 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**
 Address: **845 Jackson Street**
San Francisco, CA 94133

Telephone Number: **415-982-2400**

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Service:</u> ☐ Referral Emergency ☒ Basic Emergency ☐ Standby Emergency ☐ Comprehensive Emergency	<u>Base Hospital:</u> ☐ Yes ☒ No	<u>Burn Center:</u> ☐ Yes ☒ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☒ Yes ☐ No ☐ Yes ☒ No	<u>Trauma Center:</u> ☐ Yes ☒ No	<u>If Trauma Center what level:</u> ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

<u>STEMI Center:</u> ☐ Yes ☒ No	<u>Stroke Center:</u> ☒ 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

<u>Written Contract:</u> ☒ Yes ☐ No	<u>Service:</u> ☐ Referral Emergency ☐ Basic Emergency ☒ Standby Emergency* ☐ Comprehensive Emergency	<u>Base Hospital:</u> ☐ Yes ☒ No	<u>Burn Center:</u> ☐ Yes ☒ No

Pediatric Critical Care Center¹ EDAP² PICU³	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No	<u>Trauma Center:</u> ☐ Yes ☒ No	<u>If Trauma Center what level:</u> ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

<u>STEMI Center:</u> ☐ Yes ☒ No	<u>Stroke Center:</u> ☐ Yes ☒ 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: CY 2024

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

Training Institution:		<u>AMR San Francisco CE#38-0004</u>		Telephone Number:	<u>415-922-9400</u>
Address:		<u>1300 Illinois Street</u>			
		<u>San Francisco, CA 94107</u>			
Student Eligibility*:		**Program Level	<u>Continuing Education</u>		
	<u>Personnel</u>	Cost of Program:			
		Basic:	<u>n/a</u>	Number of students completing training per year:	
		Refresher:	<u>n/a</u>	Initial training:	
				<u>n/a</u>	
				Refresher:	
				<u>n/a</u>	
				Continuing Education:	
				<u>200</u>	
				Expiration Date:	
				<u>10/31/27</u>	
				Number of courses:	
				Initial training:	
				<u>n/a</u>	
				Refresher:	
				<u>n/a</u>	
				Continuing Education:	
				<u>12</u>	

*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: CY 2024

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

Training Institution:		<u>City College of San Francisco CE# 38-0012</u>		Telephone Number:	<u>415-561-1938</u>
Address:		<u>1860 Hayes Street</u>			
		<u>San Francisco, CA 94117</u>			
Student Eligibility*:		Cost of Program:	**Program Level	<u>Continuing Education</u>	
	<u>Public</u>				
		Basic:	<u>n/a</u>	Number of students completing training per year:	
		Refresher:	<u>n/a</u>	Initial training:	<u>n/a</u>
				Refresher:	<u></u>
				Continuing Education:	<u>n/a</u>
				Expiration Date:	<u>01/31/28</u>
				Number of courses:	
				Initial training:	<u>n/a</u>
				Refresher:	<u>n/a</u>
				Continuing Education:	<u>n/a</u>

*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: CY 2024

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

Training Institution:		<u>City College of San Francisco</u>		Telephone Number:		<u>415-561-1938</u>	
Address:		<u>1860 Hayes Street</u>					
		<u>San Francisco, CA 94117</u>					
Student Eligibility*:	<u>Public</u>	Cost of Program:		**Program Level	<u>EMT</u>		
		Basic:	<u>\$550</u>	Number of students completing training per year:			
		Refresher:	<u>n/a</u>	Initial training:		<u>120</u>	
				Refresher:		<u>30</u>	
				Continuing Education:		<u>n/a</u>	
				Expiration Date:		<u>01/31/28</u>	
				Number of courses:			
				Initial training:		<u>5</u>	
				Refresher:		<u>1</u>	
				Continuing Education:		<u>n/a</u>	

*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: CY 2024

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

Training Institution: <u>City College of San Francisco</u>		Telephone Number: <u>415-561-1938</u>	
Address: <u>1860 Hayes Street</u>			
<u>San Francisco, CA 94117</u>			
Student Eligibility*: <u>Public</u>	Cost of Program:	**Program Level <u>Paramedic</u>	
	Basic: <u>\$4,500</u>	Number of students completing training per year:	
	Refresher: <u>n/a</u>	Initial training	<u>25</u>
		Refresher:	<u>n/a</u>
		Continuing Education:	<u>n/a</u>
		Expiration Date:	<u>01/31/28</u>
		Number of courses:	
		Initial training:	<u>1</u>
		Refresher:	<u>n/a</u>
		Continuing Education:	<u>n/a</u>

*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: CY 2024

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

Training Institution:		<u>Project Heartbeat</u>		Telephone Number:		<u>510-452-1100</u>	
Address:		<u>350 Amber Dr.</u>					
		<u>San Francisco, CA 94131</u>					
Student Eligibility*:	<u>Law Enforcement</u>	Cost of Program:		**Program Level	<u>EMT-B</u>		
		Basic:	<u>n/a</u>	Number of students completing training per year:			
		Refresher:	<u>n/a</u>	Initial training:		<u>29</u>	
				Refresher:		<u>n/a</u>	
				Continuing Education:		<u>n/a</u>	
				Expiration Date:		<u>03/31/27</u>	
				Number of courses:			
				Initial training:		<u>1</u>	
				Refresher:		<u>n/a</u>	
				Continuing Education:		<u>n/a</u>	

*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: CY 2024

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

Training Institution:		<u>Rock Medicine CE#38-0016</u>		Telephone Number:	<u>415-912-1253</u>
Address:		<u>1563 Mission Street</u>			
		<u>San Francisco, CA 94103</u>			
Student Eligibility*:		**Program Level	<u>Continuing Education</u>		
	<u>Personnel</u>	Cost of Program:			
		Basic:	<u>n/a</u>	Number of students completing training per year:	
		Refresher:	<u>n/a</u>	Initial training:	<u>n/a</u>
				Refresher:	<u>n/a</u>
				Continuing Education:	<u>n/a</u>
				Expiration Date:	<u>12/31/25</u>
				Number of courses:	
				Initial training:	<u>n/a</u>
				Refresher:	<u>n/a</u>
				Continuing Education:	<u>n/a</u>

*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: CY 2024

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

Training Institution:		<u>San Francisco EMS Agency CE#38-0001</u>		Telephone Number:	<u>628-217-6000</u>
Address:		<u>333 Valencia St. Suite 210</u>			
		<u>San Francisco, CA 94103</u>			
Student Eligibility*:	<u>Open to Public</u>	Cost of Program:	**Program Level	<u>Continuing Education</u>	
		Basic:	<u>\$0</u>	Number of students completing training per year:	
		Refresher:	<u>\$0</u>	Initial training:	<u>n/a</u>
				Refresher:	<u>n/a</u>
				Continuing Education:	<u>128</u>
				Expiration Date:	<u>n/a</u>
				Number of courses:	
				Initial training:	<u>n/a</u>
				Refresher:	<u>n/a</u>
				Continuing Education:	<u>5</u>

*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: CY 2024 _____

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*:	Cost of Program:	**Program Level	Continuing Education/Community Paramedic		
Personnel only		Basic:	n/a	Number of students completing training per year:	
	Refresher:	n/a	CP Initial training:		55
			Refresher:		n/a
			Continuing Education:		1,844
			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: CY 2024

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

Training Institution:		<u>Zuckerberg San Francisco General CE#28-0002</u>		Telephone Number:	<u>628-206-5050</u>
Address:		<u>1001 Potrero Avenue, Room H1017</u>			
		<u>San Francisco, CA 94110</u>			
Student Eligibility*:		**Program Level	<u>Continuing Education</u>		
	<u>Personnel</u>	Cost of Program:			
		Basic:	<u>n/a</u>	Number of students completing training per year:	
		Refresher:	<u>n/a</u>	Initial training:	
				<u>n/a</u>	
				Refresher:	
				<u>n/a</u>	
				Continuing Education:	
				<u>n/a</u>	
				Expiration Date:	
				<u>02/28/26</u>	
				Number of courses:	
				Initial training:	
				<u>n/a</u>	
				Refresher:	
				<u>n/a</u>	
				Continuing Education:	
				<u>n/a</u>	

*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: 2024

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:	Medical Director:	☒ Day-to-Day	Number of Personnel Providing Services:		
☐ Yes ☒ No	☒ Yes ☐ No	☒ Disaster			
Ownership:		If Public:			
☒ Public ☐ Private		☐ Fire			
		☐ Law			
		☒ Other			
		Explain: Emergency			
		Management			

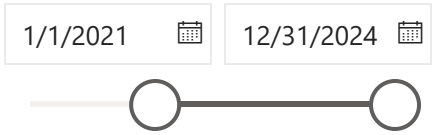
EMS PLAN
AMBULANCE ZONE SUMMARY FORM

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
FY25-1	Hospital MOUs	All San Francisco MOUs are complete. One out out of county hospital is remaining.	In Progress	TBD	Executive	1 out of county hospital remaining.
FY25-2	Electronic Certification Program	SFEMSA is moving to a new certifications platform in 2025 with full implementation by mid-2026. Rollout estimated to start in late 2025. Platform also includes exception report tracking and amulance inspections.	In Progress	Mid-2026	Executive and Operations	Procurement complete. LEMSA-configuration and testing.
FY25-3	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 (response times, APOT, diversion) and Phase 2 is underway (STEMI, Stroke).	In Progress	Ongoing	Quality Improvement	Ongoing
FY25-4	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	Operations	Ongoing
FY25-5	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 and data overview.	In Progress	Ongoing	Operations	Ongoing, continued evaluation.
FY25-6	Implement Get with the Guidelines	LEMSA is a super user for Get With The Guidelines. All hospitals are expected to be on Get with the Guidelines for STEMI and Stroke data collection in mid-2025.	In Progress	Mid-2025	Quality Improvement	Expected completion Summer 2025.
FY25-7	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	Quality Improvement	Ongoing with goal of one event per month.

SECTION II - Data



Year

All

San Francisco EMS Call Share

Excludes responses to fire scenes

76.7%

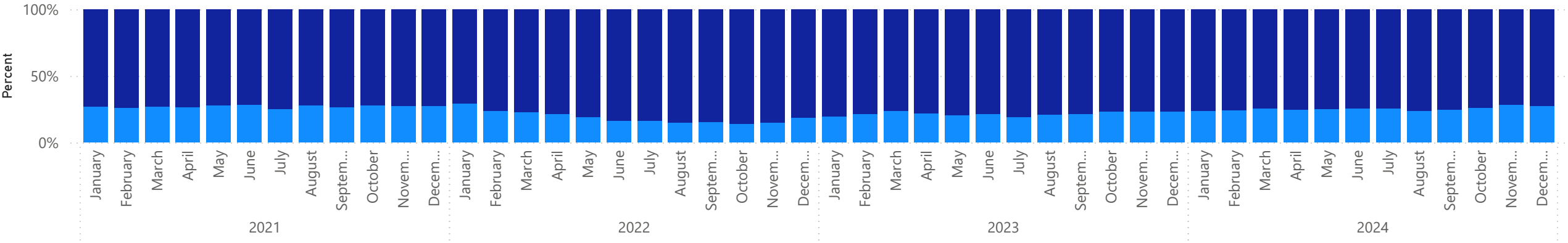
Public

23.3%

Private

Call Share Public vs Private

Category Private Public



76.7%

SFFD

11.5%

King

8.1%

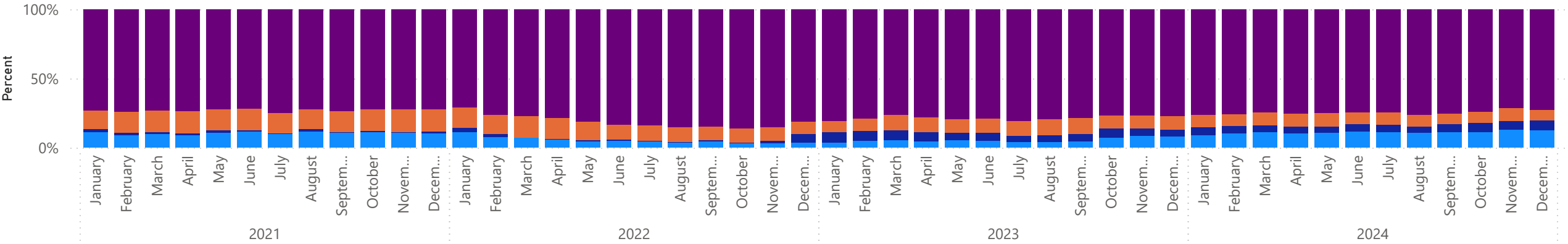
AMR

3.7%

BLS

Call Share by Provider

Provider AMR BLS King SFFD



1/1/2024

12/31/2024

Year

All

San Francisco EMS Call Share

Excludes responses to fire scenes

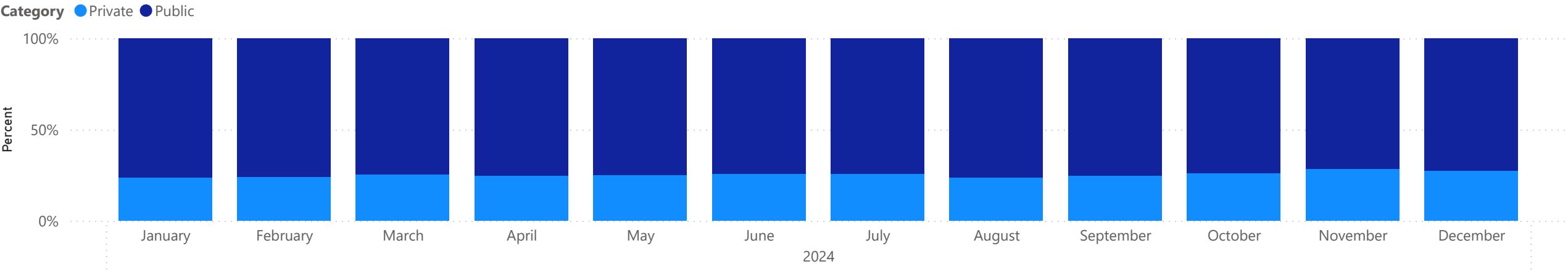
74.5%

Public

25.5%

Private

Call Share Public vs Private



74.5%

SFFD

8.7%

King

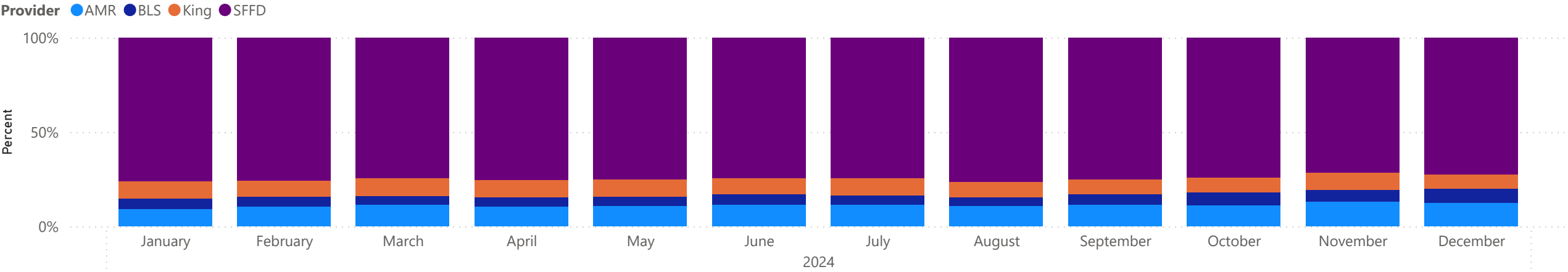
11.2%

AMR

5.6%

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: 6/15/2025

Date

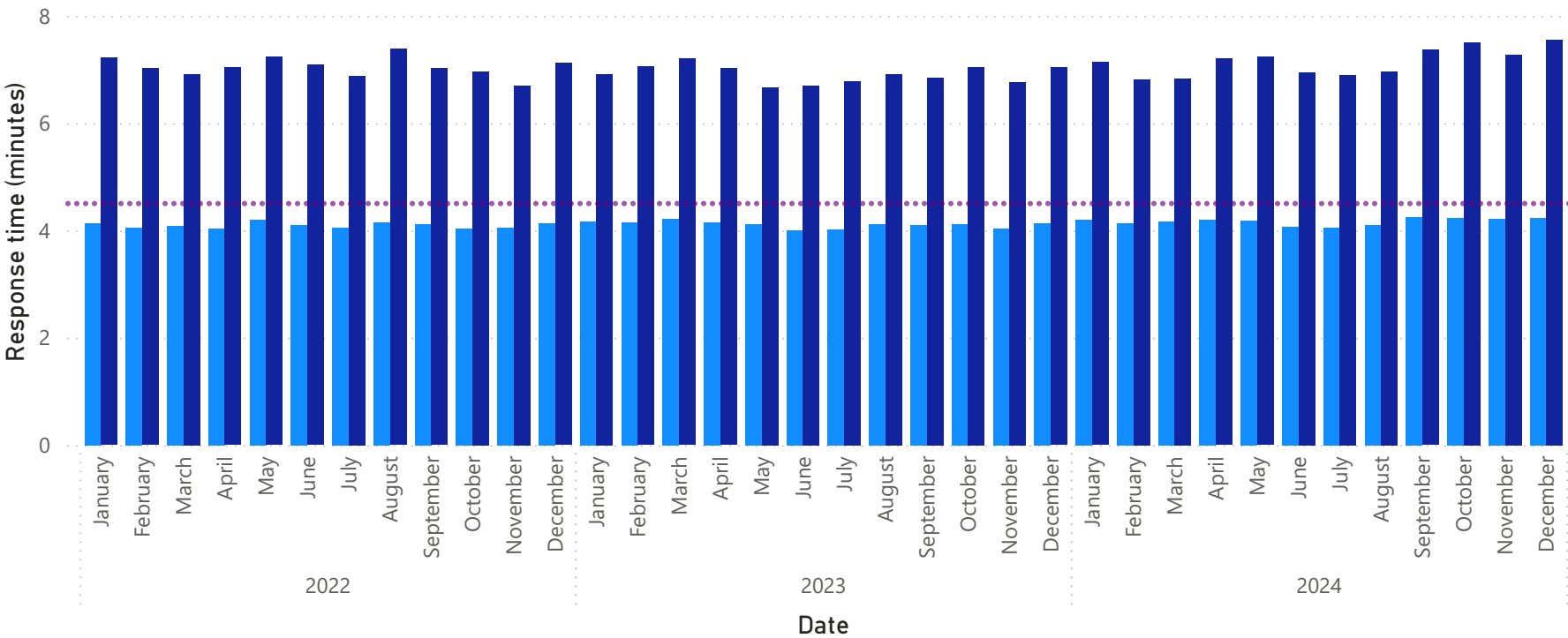
1/1/2022

12/31/2024

Response Time

Dashed line represents EMSA response standard

50th%ile 90th%ile



Year/Month	Total calls	90th%ile	OTP
+ 2022	61587	7.05	76%
+ 2023	67241	6.92	76%
- 2024	67597	7.13	74%
January	5855	7.14	74%
February	5261	6.82	76%
March	5725	6.83	75%
April	5376	7.20	74%
May	5757	7.23	74%
June	5396	6.95	76%
July	5679	6.90	76%
August	5687	6.97	76%
September	5433	7.37	73%
October	5948	7.50	73%
November	5550	7.28	74%
December	5930	7.55	73%
Total	196425	7.03	75%

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: 6/15/2025

Date

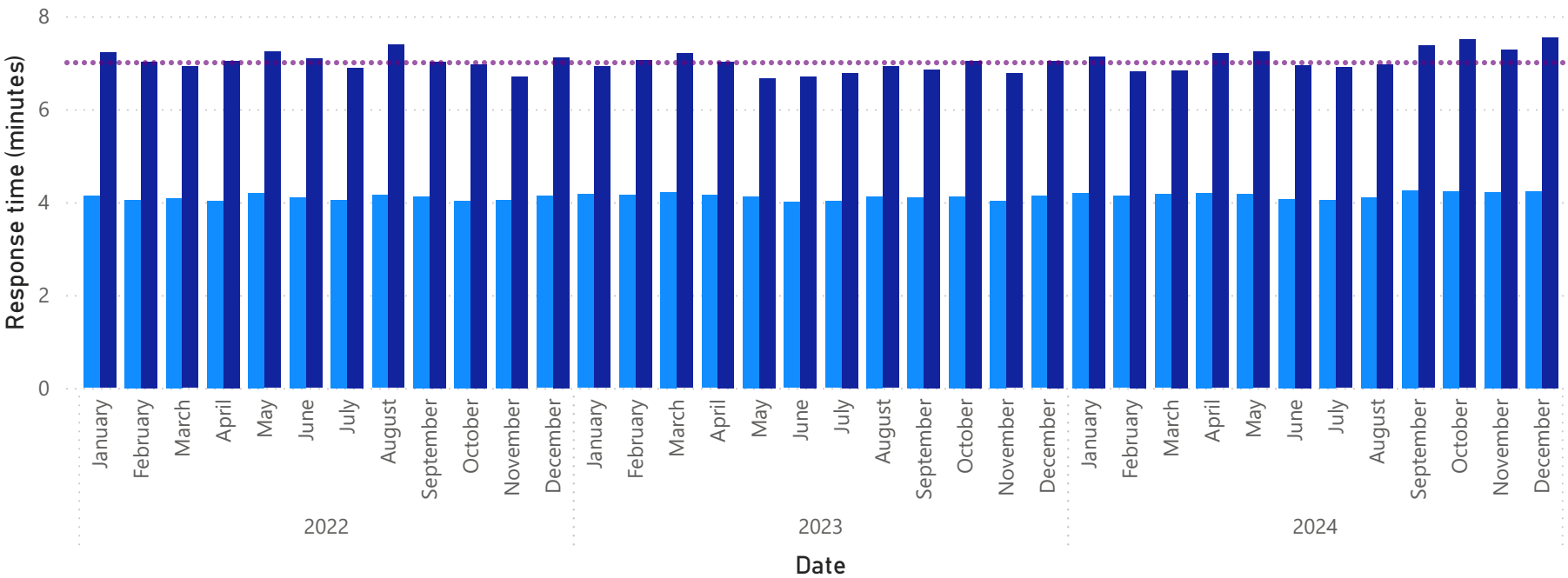
1/1/2022

12/31/2024

Response Time

Dashed line represents EMSA response standard

50th%ile 90th%ile



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

Year/Month	Total calls	90th%ile	OTP
+ 2022	61587	7.05	76%
+ 2023	67241	6.92	76%
- 2024	67597	7.13	74%
January	5855	7.14	74%
February	5261	6.82	76%
March	5725	6.83	75%
April	5376	7.20	74%
May	5757	7.23	74%
June	5396	6.95	76%
July	5679	6.90	76%
August	5687	6.97	76%
September	5433	7.37	73%
October	5948	7.50	73%
November	5550	7.28	74%
December	5930	7.55	73%
Total	196425	7.03	75%

Response Times to Medical Incidents for Ambulances

• Includes ALS and BLS vehicles

Data through: 6/15/2025

Date

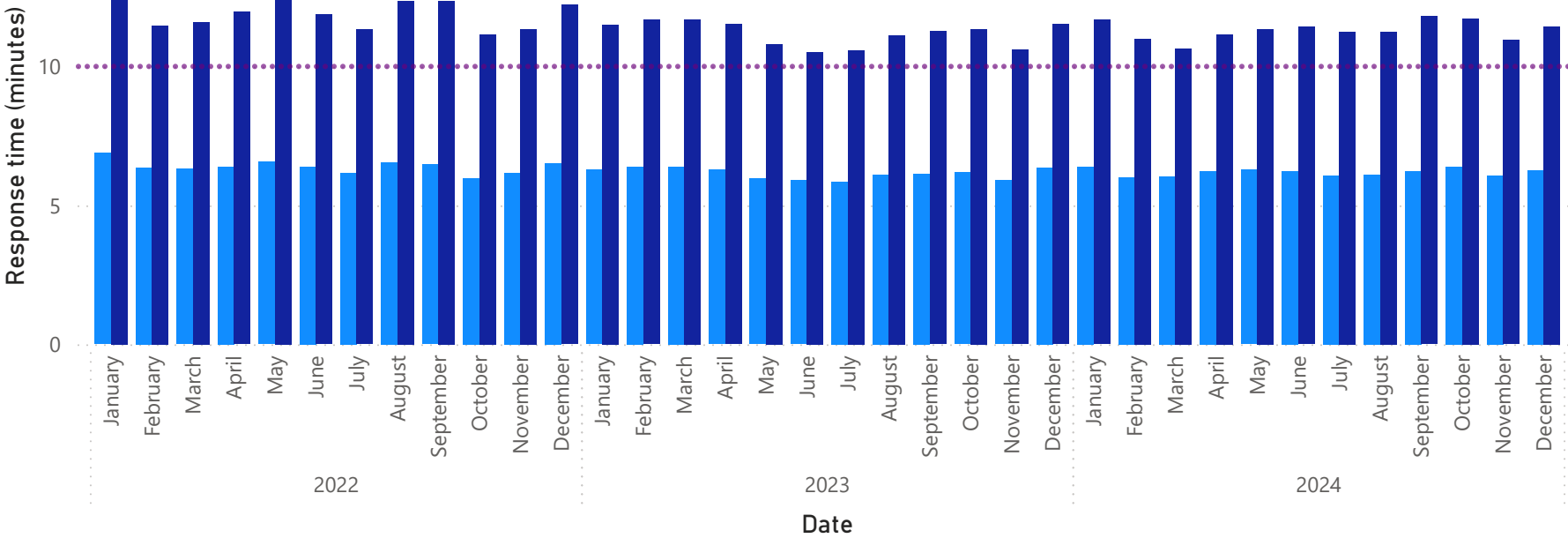
1/1/2022

12/31/2024

Response Time: Code 3

Dashed line represents EMSA response standard

50th%ile 90th%ile



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

Year/Month	Total calls	90th%ile	OTP
+ 2022	55858	11.93	83%
+ 2023	60584	11.20	86%
- 2024	59814	11.30	85%
January	5246	11.68	84%
February	4701	11.00	86%
March	5107	10.65	87%
April	4756	11.15	85%
May	5141	11.35	84%
June	4774	11.43	85%
July	5030	11.25	86%
August	5011	11.25	85%
September	4738	11.80	83%
October	5128	11.72	84%
November	4928	10.95	87%
December	5254	11.43	84%
Total	176256	11.45	84%

Response Times to Medical Incidents for Ambulances

• Includes ALS and BLS vehicles

Data through: 6/15/2025

Date

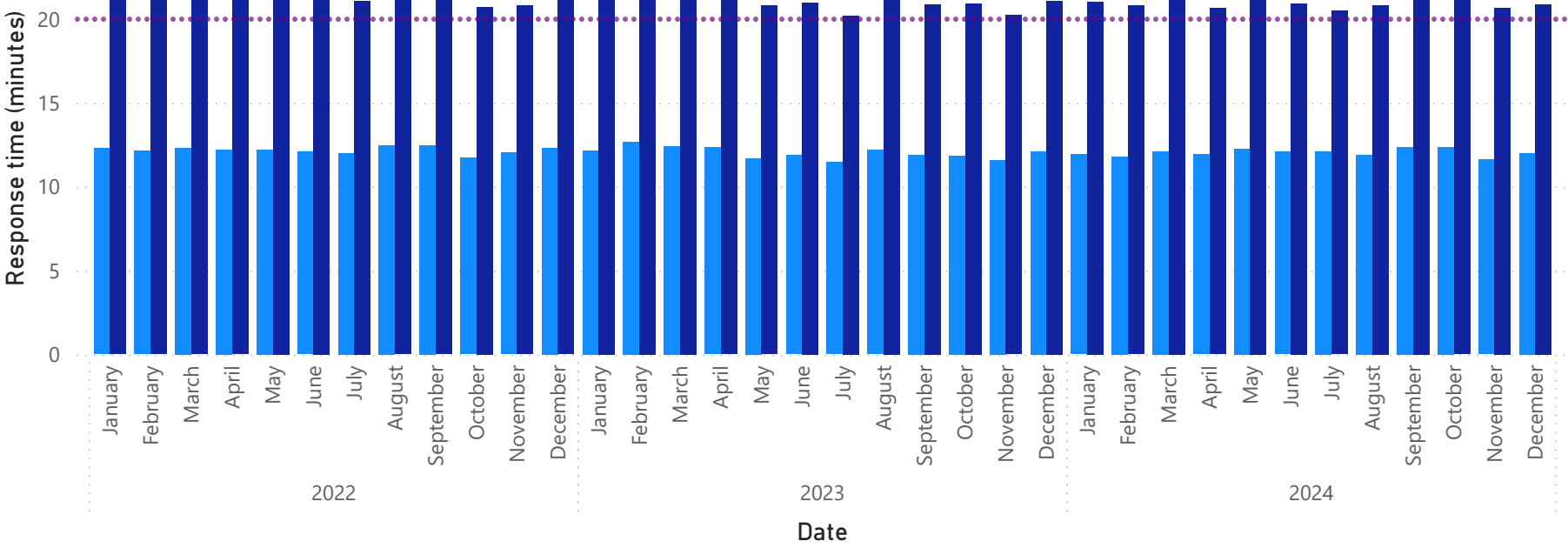
1/1/2022

12/31/2024

Response Time: Code 2

Dashed line represents EMSA response standard

50th%ile 90th%ile



Year/Month	Total calls	90th%ile	OTP
2022	52291	21.42	87%
2023	49400	21.08	87%
2024	46152	20.98	88%
January	3854	21.04	88%
February	3863	20.81	88%
March	4019	21.20	88%
April	3812	20.65	88%
May	3881	21.55	86%
June	3639	20.93	88%
July	3920	20.50	89%
August	3987	20.82	88%
September	3712	21.82	86%
October	3863	21.12	87%
November	3742	20.68	89%
December	3860	20.87	88%
Total	147843	21.17	87%

Policy Standard: Ambulances responding to Code 2 calls arrive on the scene **within 20 minutes** of dispatch, 90% of the time.



Hospital EMS Report - Diversion, Suspension & Trauma Override

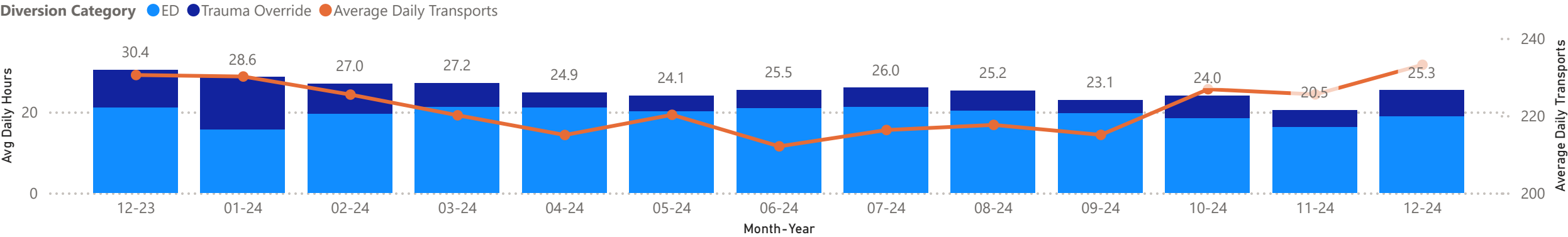
Percentage of hours in each month that a hospital was on Diversion. For ZSFG, this also includes Trauma Override. (+/- 1%)

Destination	12-23	01-24	02-24	03-24	04-24	05-24	06-24	07-24	08-24	09-24	10-24	11-24	12-24
Chinese	0.4%	0.6%	0.8%	0.8%	1.4%	1.2%	1.7%	0.9%	0.7%	0.8%	0.8%	0.9%	0.4%
CPMC-Bernal	2.8%	2.5%	3.3%	2.3%	5.8%	2.5%	2.6%	3.1%	2.3%	3.4%	2.1%	4.0%	4.3%
CPMC-Davies	2.0%	0.3%	1.9%	2.1%	1.8%	2.9%	1.9%	1.3%	1.4%	0.5%	2.2%	1.4%	1.3%
CPMC-Van Ness	19.1%	16.2%	26.9%	26.6%	19.9%	19.7%	15.0%	18.7%	20.3%	18.4%	18.4%	15.5%	18.1%
Kaiser SF	10.9%	9.4%	6.1%	13.8%	17.0%	15.5%	18.3%	14.5%	13.1%	14.9%	10.1%	11.9%	15.6%
St. Francis	1.4%	1.4%	0.9%	1.1%	0.8%	0.2%	0.5%	0.9%	0.9%	1.4%	1.3%	1.3%	1.2%
St. Marys	2.6%	3.6%	4.7%	3.3%	0.9%	0.7%	0.8%	0.2%	0.0%	0.3%	1.0%	0.1%	2.4%
UCSF Parnassus	26.4%	16.0%	19.4%	23.3%	24.8%	21.1%	20.0%	23.1%	18.2%	19.0%	19.0%	15.9%	14.3%
VA	1.4%		0.5%	0.3%	0.3%	0.5%		0.6%	0.3%	0.2%	0.5%		1.4%
ZSFG	59.6%	69.3%	47.7%	39.7%	31.1%	36.1%	45.3%	45.0%	47.9%	37.2%	44.8%	34.6%	46.6%

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

Measure	12-23	01-24	02-24	03-24	04-24	05-24	06-24	07-24	08-24	09-24	10-24	11-24	12-24
Diversion Suspended	50.3%	66.2%	45.0%	37.2%	25.7%	25.0%	26.8%	27.4%	28.3%	20.6%	29.7%	23.5%	34.9%

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

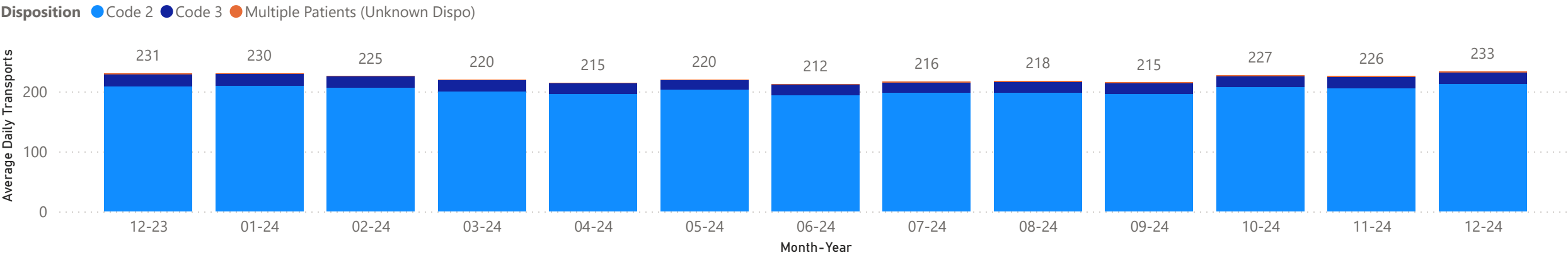
Total ambulance transports by month. Does not include IFT or other non-911 transports.

Destination	12-23	01-24	02-24	03-24	04-24	05-24	06-24	07-24	08-24	09-24	10-24	11-24	12-24	Total
Chinese	157	169	118	130	125	145	114	132	146	112	126	124	148	1746
CPMC-Bernal	839	835	730	701	711	716	692	776	753	731	799	737	834	9854
CPMC-Davies	420	400	349	363	330	339	341	342	366	347	378	342	391	4708
CPMC-Van Ness	1072	1030	834	873	938	921	969	1007	960	917	1000	1030	1048	12599
Kaiser SF	603	677	583	553	509	598	508	596	591	565	648	595	654	7680
Kaiser South SF	48	49	55	80	74	63	56	44	64	51	66	59	54	763
Seton	114	89	87	60	59	55	55	63	71	64	85	77	80	959
St. Francis	1014	1062	964	987	843	927	838	862	928	819	942	835	989	12010
St. Marys	669	605	589	618	539	609	542	531	534	560	663	583	677	7719
UCSF Mission Bay	90	104	111	118	107	106	73	89	109	77	106	101	95	1286
UCSF Parnassus	890	964	846	853	727	864	828	834	820	769	775	814	862	10846
VA	76	92	78	93	76	90	96	119	80	90	83	74	70	1117
ZSFG	1102	992	1134	1316	1357	1332	1186	1246	1259	1299	1299	1338	1265	16125
Total	7094	7068	6478	6745	6395	6765	6298	6641	6681	6401	6970	6709	7167	87412

Total Transport Volume: Change
Since Previous Month

6.8%

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





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

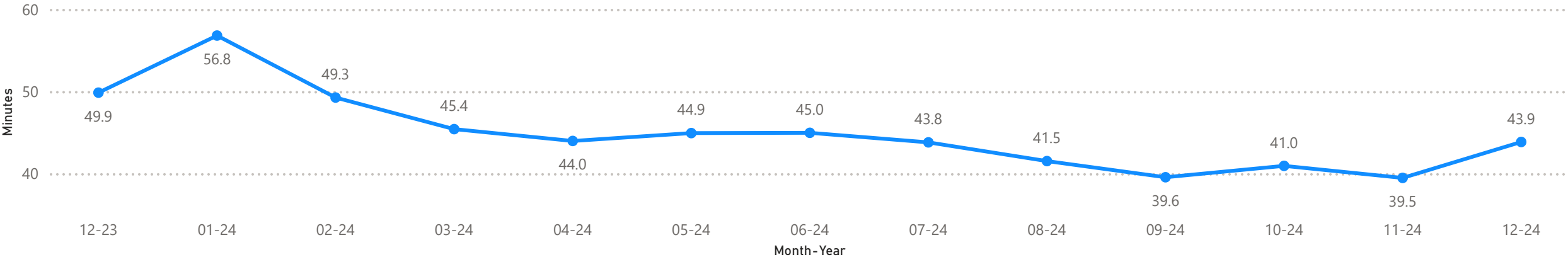
90th percentile APOT-1 times per month. APOT-1 is the interval between arrival at-hospital and transfer of patient care to Emergency Department staff, and is computed using standardized specifications outlined by the California EMS Authority.

Destination ▲	12-23	01-24	02-24	03-24	04-24	05-24	06-24	07-24	08-24	09-24	10-24	11-24	12-24	Past Year
Chinese	30.6	26.1	31.4	30.2	36.6	26.6	32.4	25.9	23.7	25.1	23.0	25.4	25.0	27.4
CPMC-Bernal	51.9	51.2	45.2	45.1	43.2	40.5	42.2	38.8	35.7	35.7	36.4	34.2	37.8	41.0
CPMC-Davies	46.5	47.3	40.7	40.5	40.7	41.5	38.3	36.5	36.0	31.9	35.0	31.0	40.0	39.4
CPMC-Van Ness	57.5	83.6	70.1	61.1	49.0	50.1	52.0	51.0	45.1	43.2	46.1	41.0	44.8	52.3
Kaiser SF	69.0	79.1	60.9	67.9	45.4	56.6	51.7	54.3	49.6	56.0	53.7	48.9	56.8	57.0
St. Francis	42.5	39.6	40.1	37.7	34.8	41.8	40.8	38.0	37.9	34.0	36.1	33.5	38.9	38.2
St. Marys	42.4	45.4	44.8	42.8	37.9	33.7	32.5	31.0	30.0	30.0	30.0	27.9	34.0	35.8
UCSF Mission Bay	24.6	27.5	24.5	23.1	26.0	24.9	25.0	20.9	20.1	22.8	19.0	22.1	27.4	23.0
UCSF Parnassus	64.5	76.1	60.9	55.7	61.6	63.3	63.0	78.7	67.8	65.1	76.2	58.6	70.9	66.0
VA	20.0	22.6	21.6	27.6	22.4	23.5	25.9	17.9	16.9	22.8	19.9	17.4	20.5	21.6
ZSFG	38.6	37.7	39.8	39.7	38.5	39.0	37.6	37.4	36.0	33.5	35.2	36.8	37.3	37.4
System-Wide	49.9	56.8	49.3	45.4	44.0	44.9	45.0	43.8	41.5	39.6	41.0	39.5	43.9	45.0

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

11.1%

System-Wide 90th Percentile APOT-1

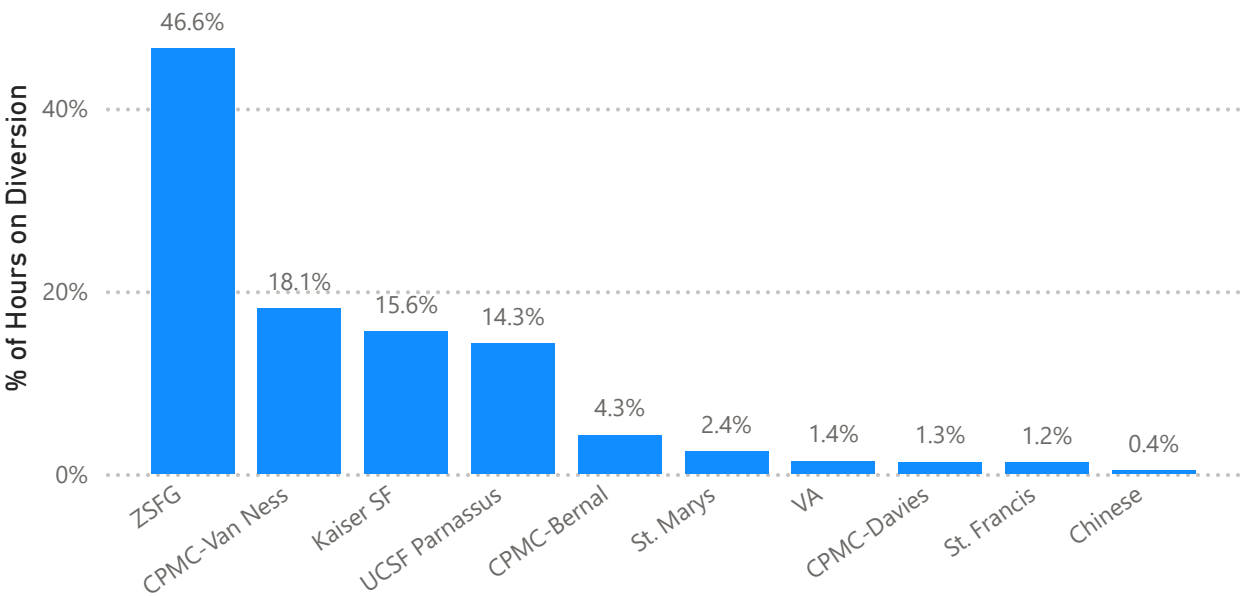




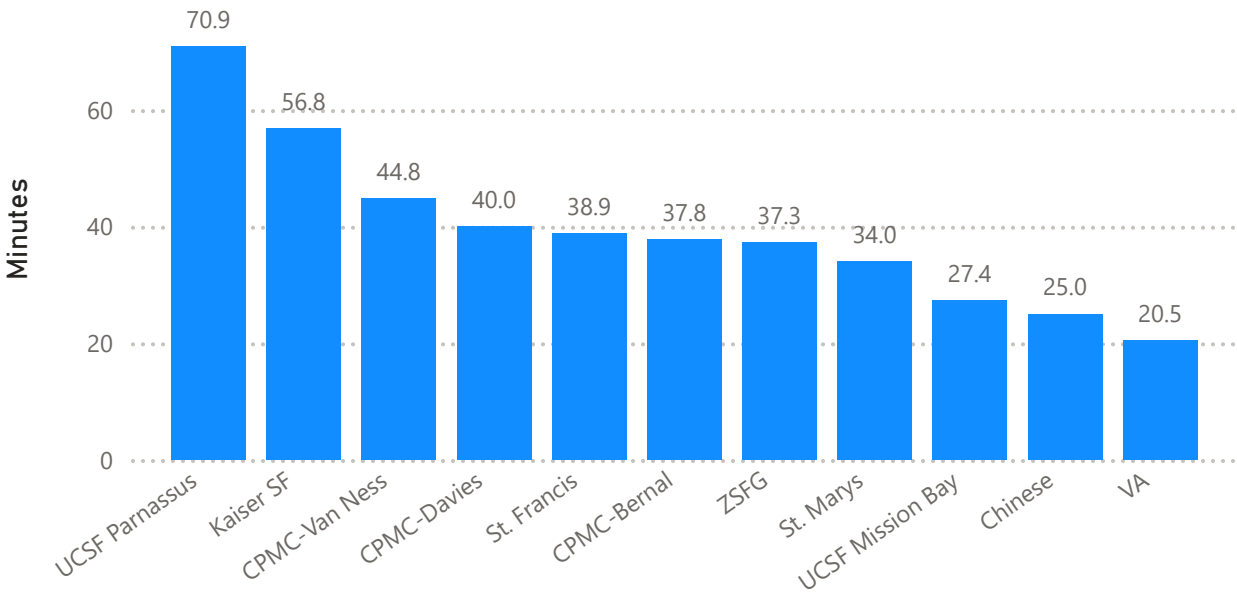
Hospital EMS Report - Current-Month Summary

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.

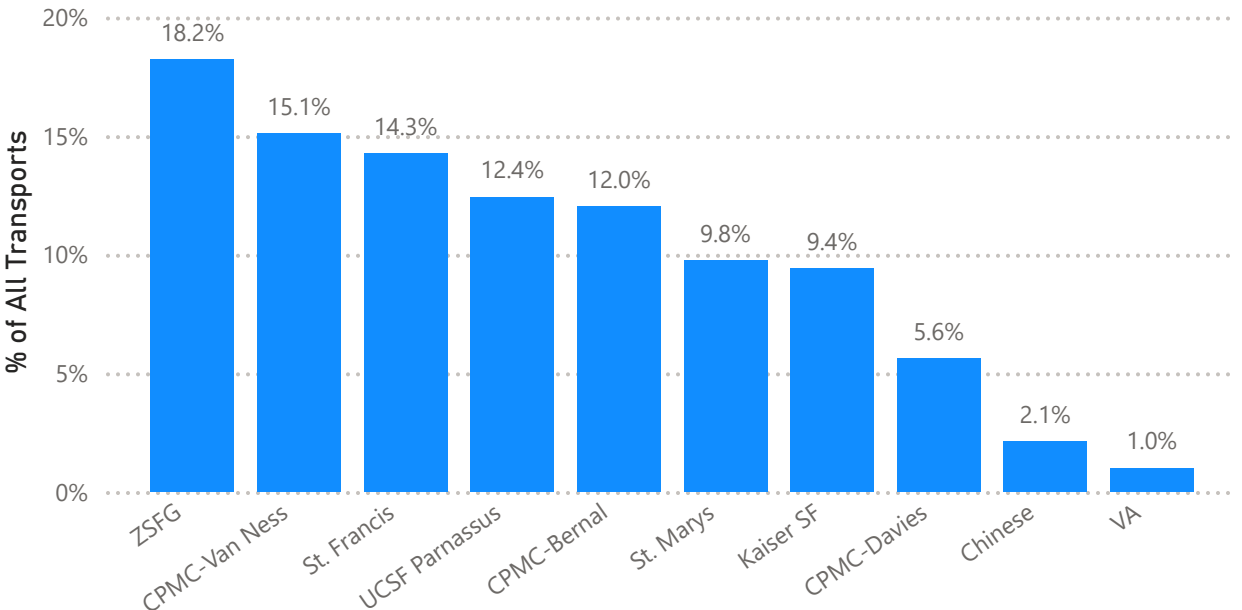
Percentage of Total Month Hours Spent on Diversion (or Trauma Override)

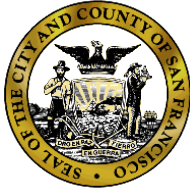


90th Percentile APOT-1 by Destination



Percentage of System-Wide Transports Received





Daniel Lurie
Mayor

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



Mary Ellen Carroll
Executive Director

Date: July 3, 2025

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Chief Medical Officer, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2025 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. This memo serves as an annual update.

No changes to the BLS Pilot are anticipated this year after the updates to last year's EMS Plan submission. 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. EMS surge escalation steps and decision-making for BLS expansion will remain consistent to the 2024 submission.

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

12/31/2024

Year

All

San Francisco EMS Call Share

Excludes responses to fire scenes

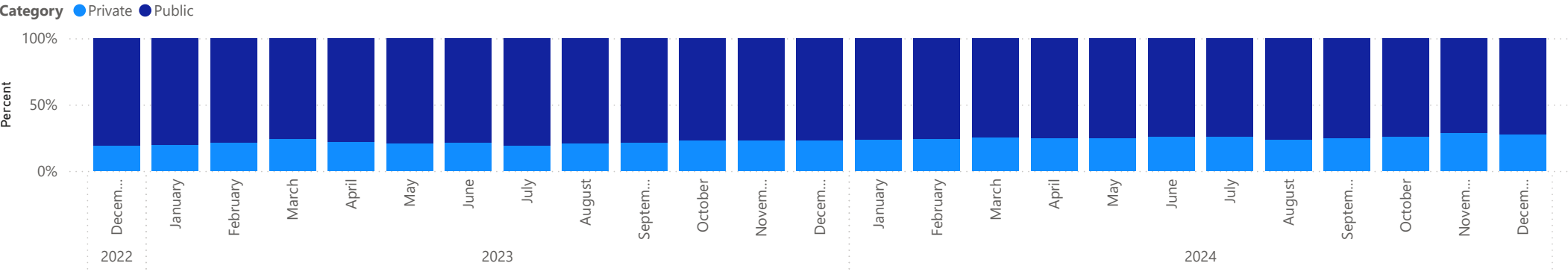
76.6%

Public

23.4%

Private

Call Share Public vs Private



76.6%

SFFD

9.5%

King

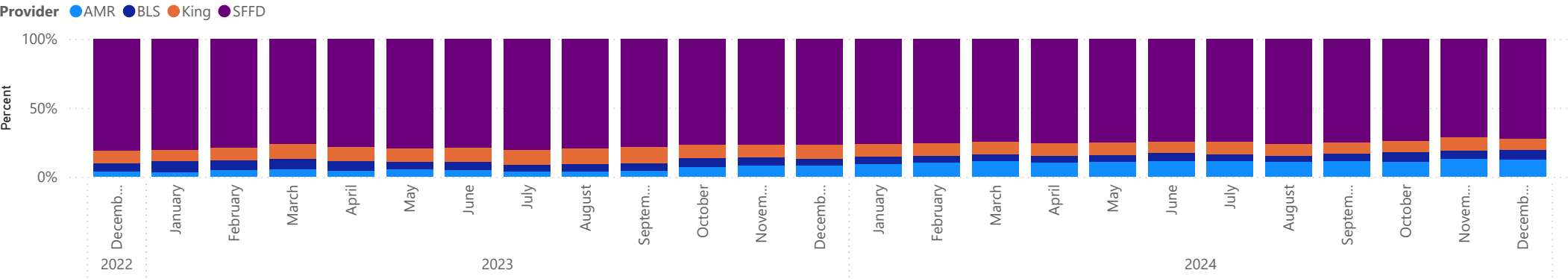
8.1%

AMR

5.8%

BLS

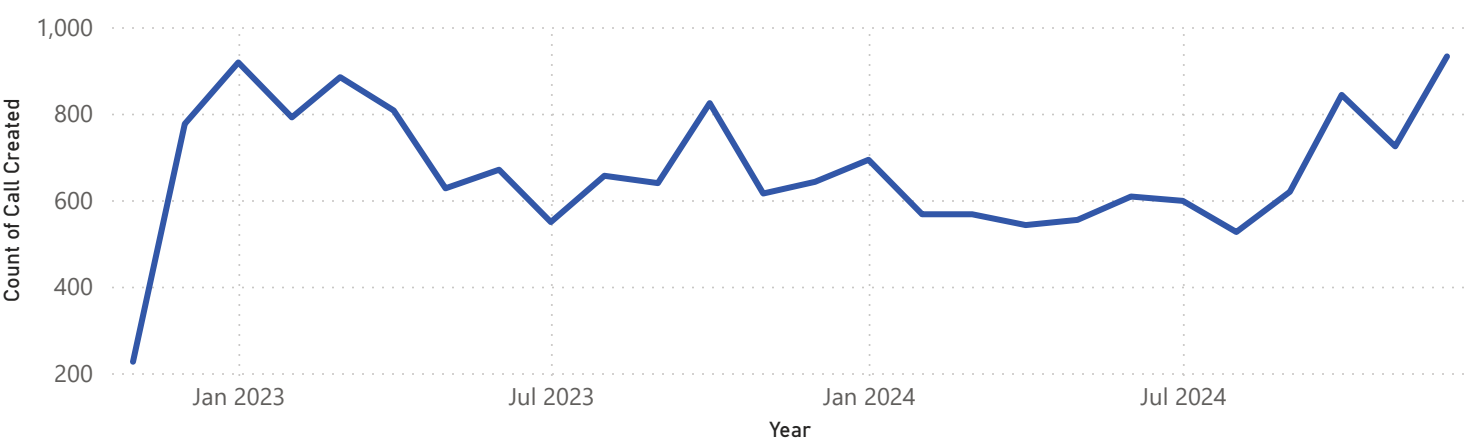
Call Share by Provider



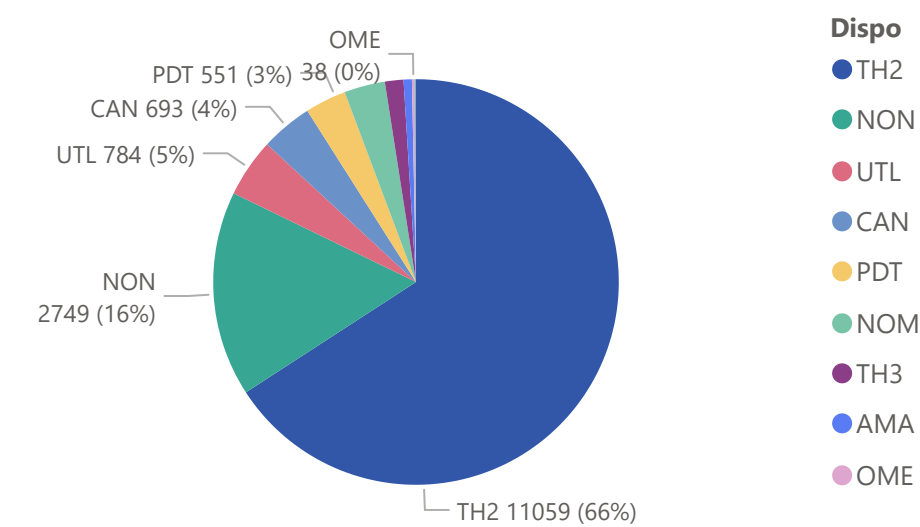


911 BLS Pilot Program - BLS Response

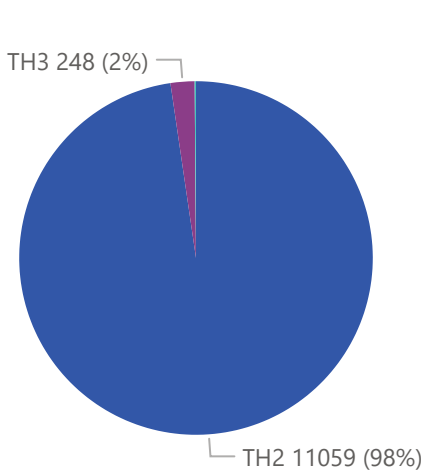
BLS Calls by Month



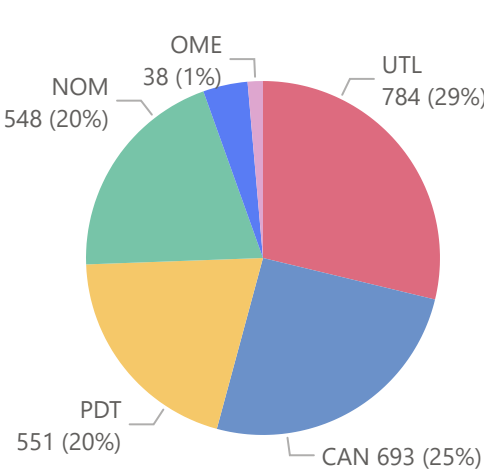
BLS All Dispositions



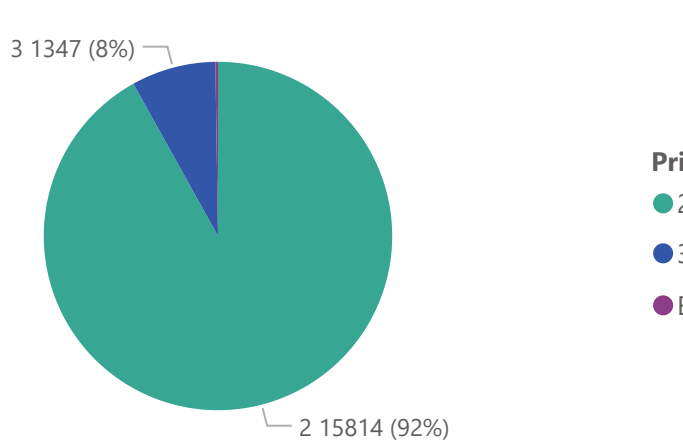
BLS Transports Disposition



BLS Non-Transport Disposition



BLS Dispatch Priority



22.3

Average Dispatches Per Day

14.5

Average Transports Per Day

65.1%

Transport Rate

Date

Call Created

11/11/2022



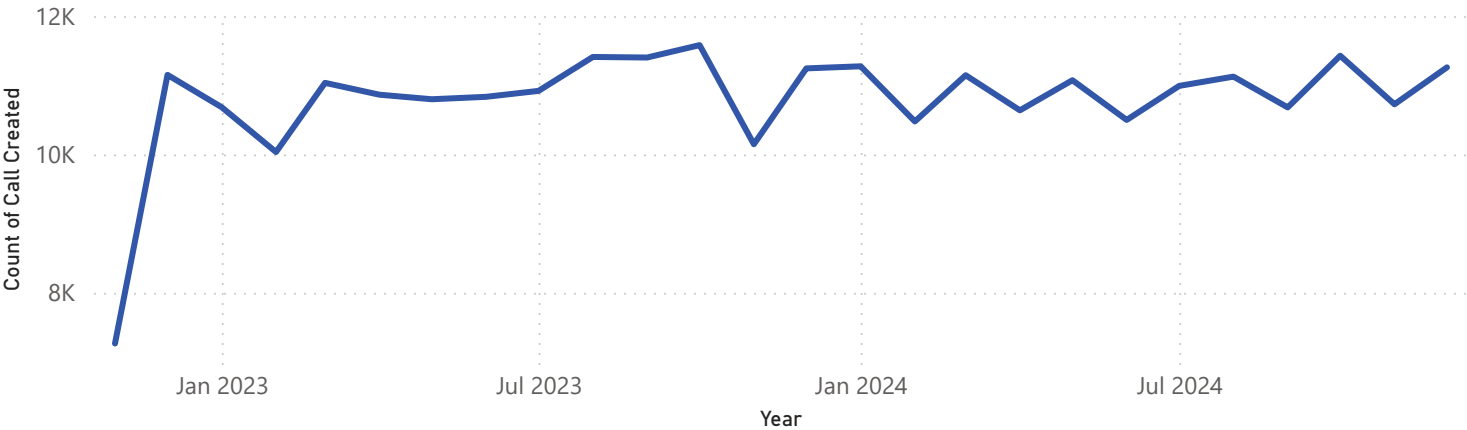
12/31/2024



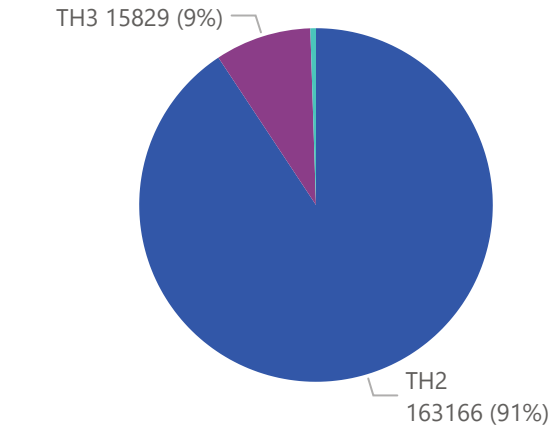


911 BLS Pilot Program - ALS Response

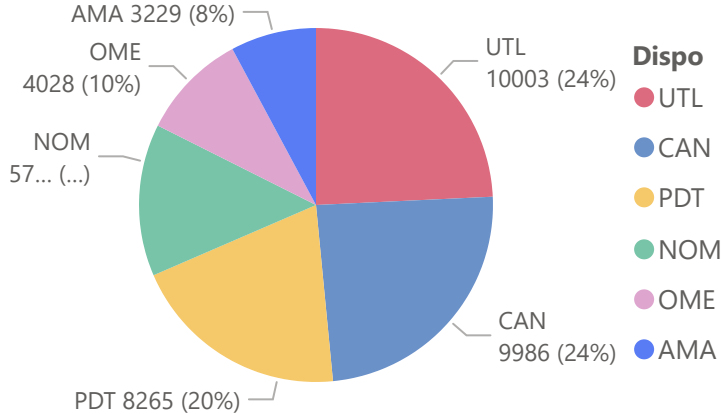
ALS Calls by Month



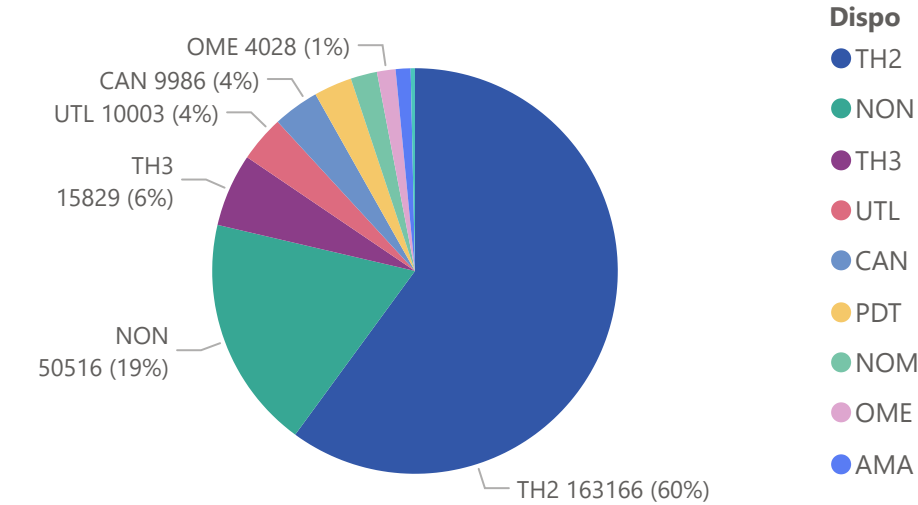
ALS Transports Disposition



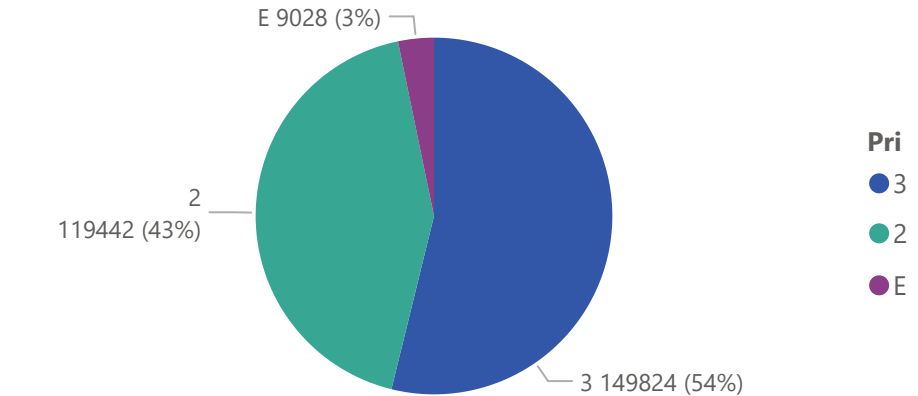
ALS Non-Transport Disposition



ALS All Dispositions



ALS Dispatch Priority



358.9

Average Dispatches Per Day

230.1

Average Transports Per Day

64.1%

Transport Rate

Date

Call Created

11/11/2022



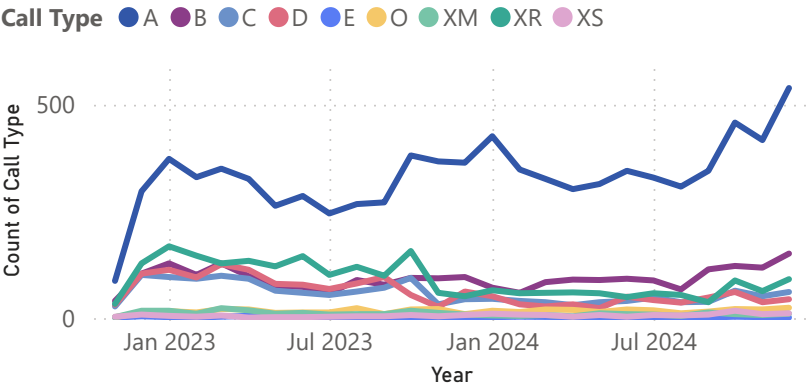
12/31/2024



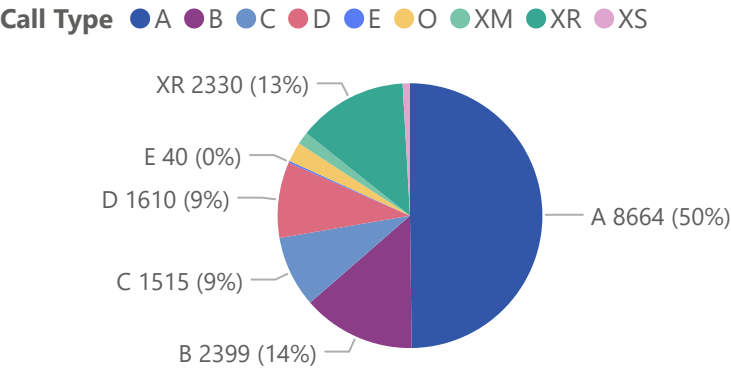


911 BLS Pilot Program - Call Types

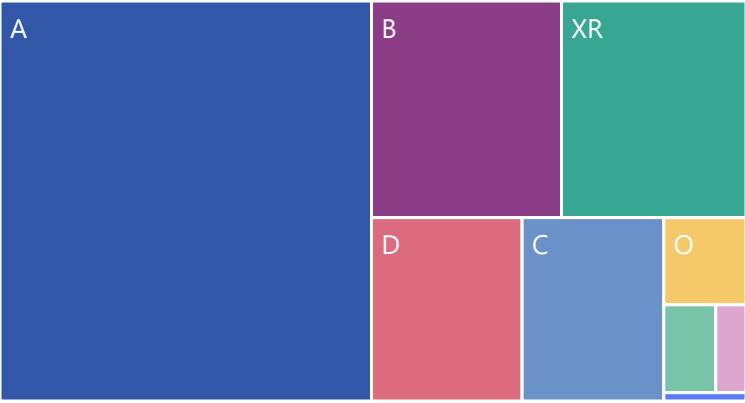
Call Type by BLS Response



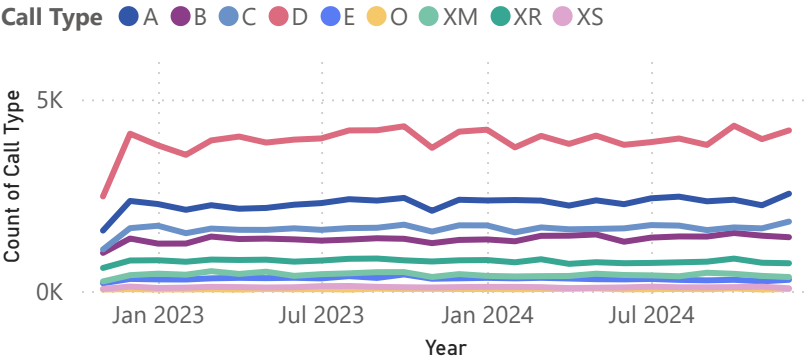
Call Type % BLS Response



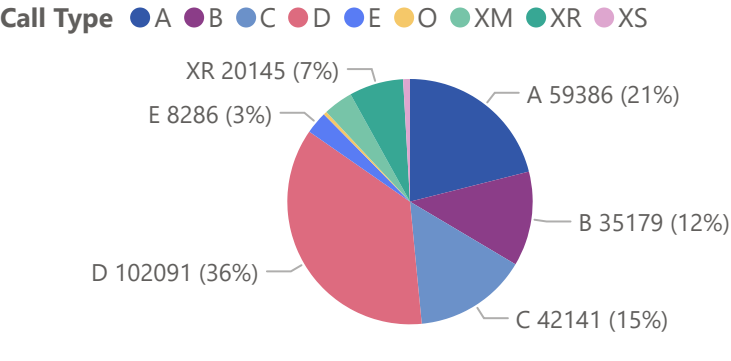
Call Type % BLS Response



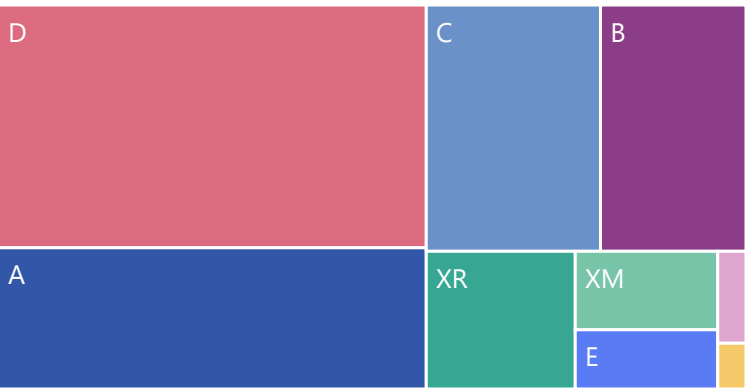
Call Type by ALS Response



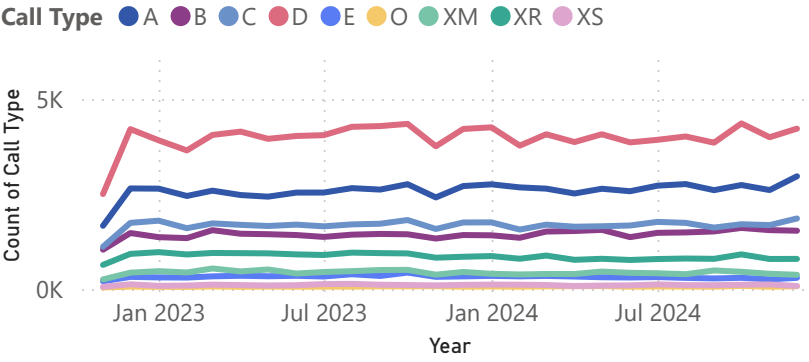
Call Type % ALS Response



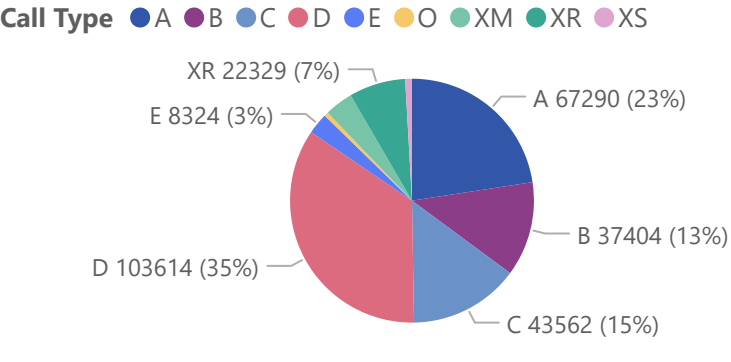
Call Type % ALS Response



Call Type by All Responses



Call Type % All Responses



Date

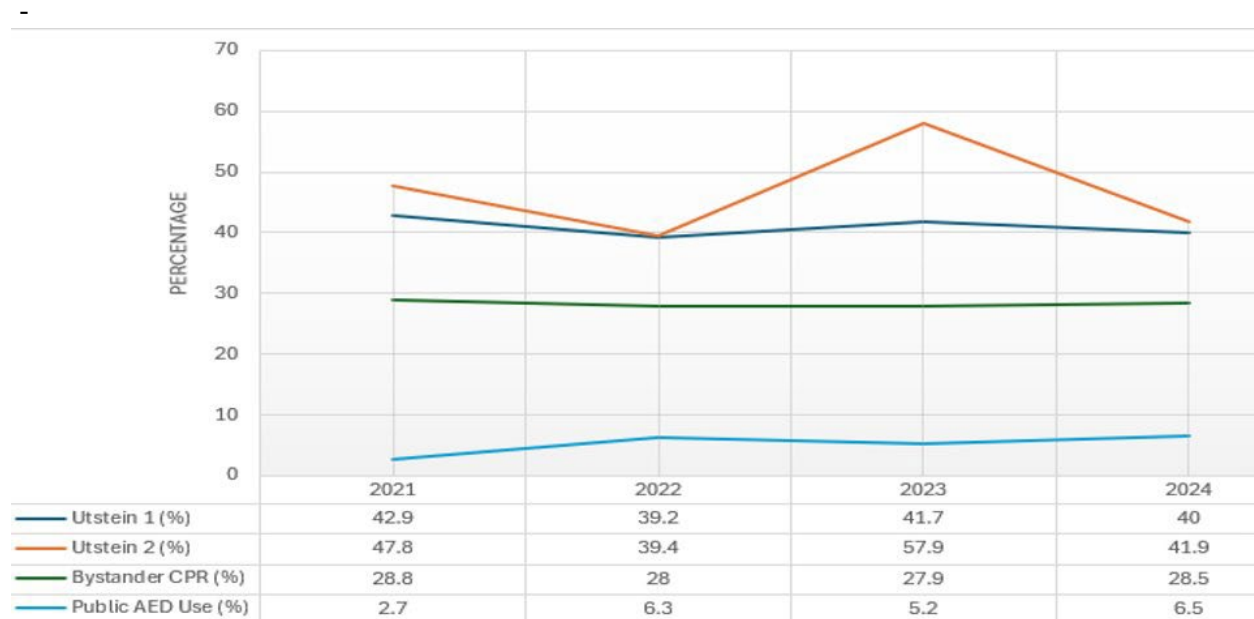
Call Created

11/11/2022

12/31/2024

Out of Hospital Cardiac Arrest (OHCA) Initiatives

In 2024, 634 Out of Hospital Cardiac Arrest (OHCA) events occurred in the City and County of San Francisco, a decrease of 15% from the previous year. The 2024 CARES Annual Summary Report revealed that San Francisco's Utstein1 survival rate was at 40%, Utstein2 was at 41.9%, Bystander CPR at 28.4% and Public AED use at 6.5%. San Francisco's rates in both Utstein survival rates continued to measure above the state and national rates.



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 SFEMSA's 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. SFEMSA has been actively verifying registry accuracy and transferring confirmed locations onto the electronic platform powered by PulsePoint.

Our Services

EMS Agency

Public Access Defibrillation

On the website, you will find a map showing all AEDs in San Francisco, information on how to register your new AED, and a report on the status of the PulsePoint Mobile App.

San Francisco AED Map

Below you can view a map of all the AEDs in San Francisco. You can also download the PulsePoint Mobile App? [Click here to download the PulsePoint Mobile App](#)



Register Your AED

By registering your AED using the form below, the location of your AED will appear in the PulsePoint mobile app so that in the event of an emergency, the AED can be retrieved and applied to a sudden cardiac arrest victim.

Problems with registering your AED? Contact us by email at AEDRegistration@sfgov.org.



Register a new AED **Need help? (<https://www.pulsepoint.org/support/>)**

EMS AGENCY MENU

- [Home](#)
- [Mission, Vision & Values](#)
- [Announcements & Updates](#)
- [Policy & Protocol Manuals](#)
- [2016 Trauma Re-Triage Guidelines](#)
- [Public Access Defibrillation](#)
- [Pilot Projects](#)
- [EMT & Paramedic Info](#)
- [Incident Reporting](#)
- [EMS System Providers](#)
- [EMS Specialty Advisors](#)
- [Training Opportunities](#)
- [Event Medical Planning](#)

SF EMSA AED Registration is now exclusively online and can be accessed publicly using below link:

https://aedviewer.pulsepoint.org/?agency_id=EMS1384

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 3,870 possible responders, 919 more than previous year. There are 1,343 registered AEDs throughout the City. SFEMSA will continue to explore promotional opportunities to expand the pool of possible responders.

In 2021, SFEMSA re-purposed disaster response AED devices and distributed for active staging at Community-Based Organizations (CBO) headquarters and San Francisco Sheriff's Office (SFSO) units.

In 2022, SFEMSA established partnerships with CBOs 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. A Point of

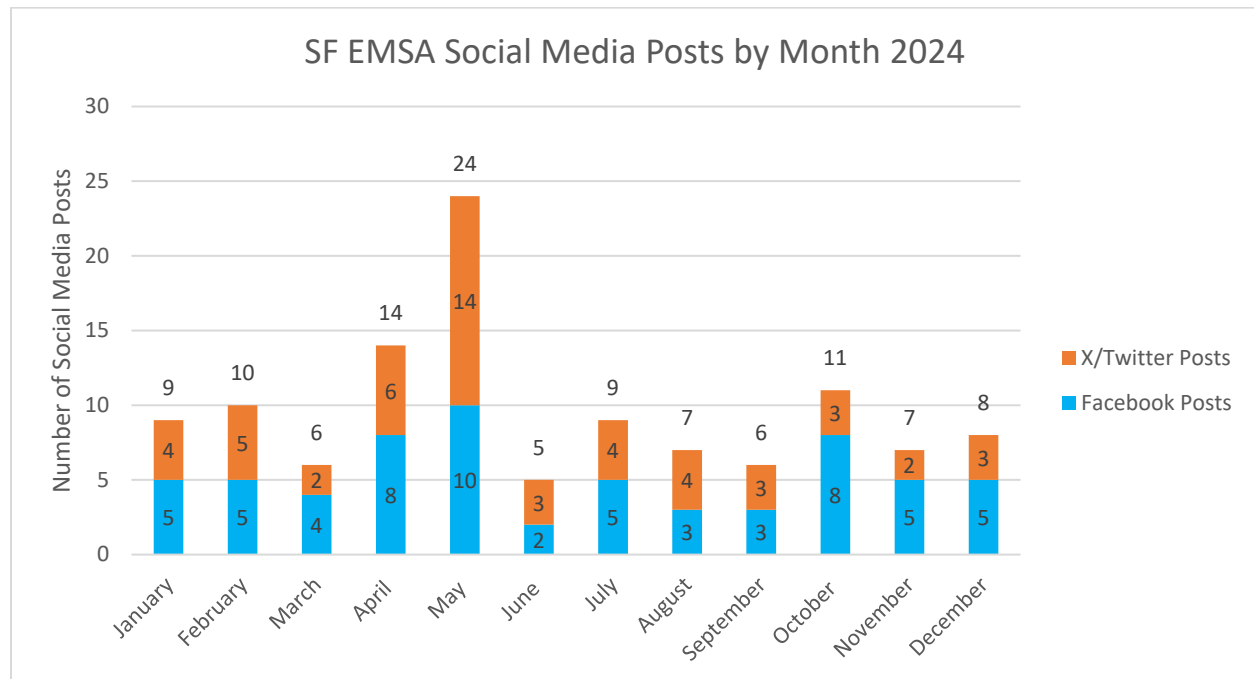
Contact network is now in place to share CPR training opportunities to groups such as youth programs, underserved communities, shelters, and church coalitions.

2022 also introduced the SFEMSA Guardian of Life Award to be presented for bystanders or members of the public who acted courageously prior to the arrival of EMS response crews and provide CPR interventions, which significantly raise the survivability rate of OHCA patients. To date, 9 members of the community have been recognized with this award. Additionally, one of the organizations in which a cardiac arrest occurred with patient survival 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.

EMSA and Social Media

The graph below illustrates SFEMSA's social media presence in 2024. SFEMSA shared more than 100 unique posts combined on SFEMSA's Facebook and X accounts. In addition, SFEMSA maintained its followers on X (302 in 2023 and 2024) and increased its following to 408 followers on Facebook (394 in 2023).

SFEMSA messaging targets both the general public and EMS Providers. In 2024, we posted content on a wide variety of topics, including: heart health, hands only CPR messaging, fire prevention, recognizing signs and symptoms of stroke, and gratitude messages towards EMS providers, dispatchers, and nurses.



EMSA and Continuing Education

143 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 01.01.2024 to 12.31.2024	
Course Name	Number of People Completing Course
Triage to Alternate Destination	133
EMS Stroke Training Modules 1 and 2	7
EMS Burn Care	3

SECTION III – Quality Improvement

San Francisco Emergency Medical Services Agency

Annual EMS Quality Improvement Plan



Table of Contents

- I. Introduction
- II. Structure and Organization
- III. SFEMS Quality Improvement Program
 - a. Emergency Medical Services Advisory Committee (EMSAC)
 - b. Quality Improvement Subcommittee
 - c. Medical Directors Subcommittee
 - d. Stroke Subcommittee
 - e. STAR (STEMI and Cardiac Arrest) Subcommittee
 - f. Trauma System Advisory Committee (TSAC)
 - g. EMS For Children (EMSC) Subcommittee
 - h. Research Subcommittee
- IV. Policy and Protocol Process
- V. Training and Education
- VI. Public Outreach

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).

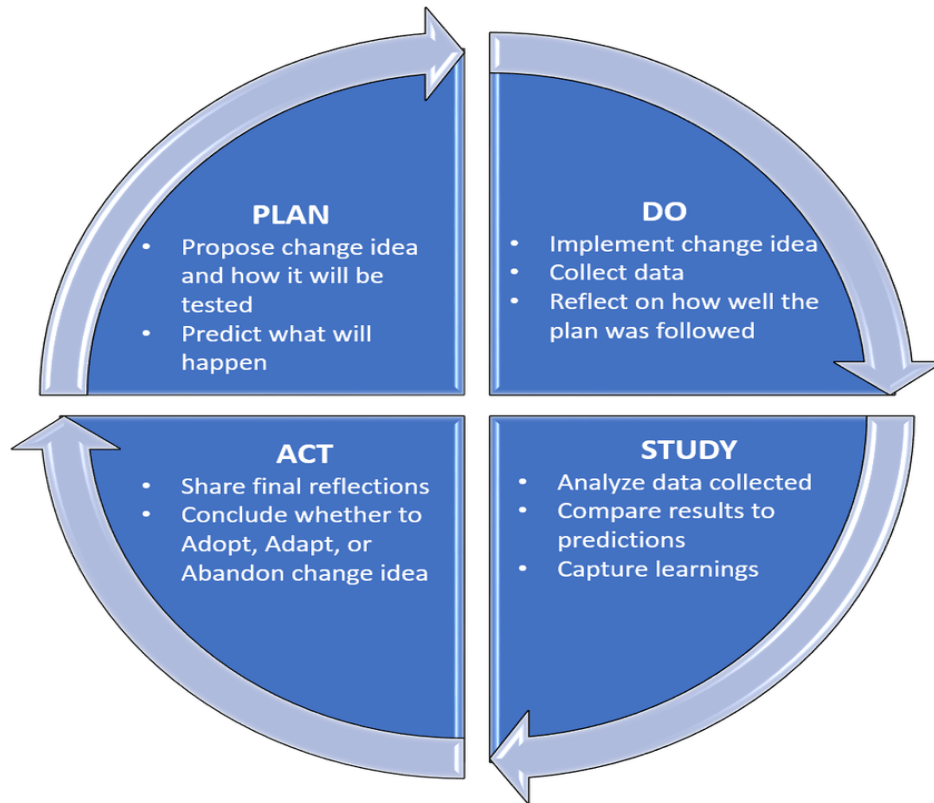
Effective: March 10, 2025

SAN FRANCISCO HOSPITAL DESIGNATIONS															
	Critical Airway	Medical Adult	Critical Medical Adult	Medical Peds (include psych)	Critical Medical Peds	Psych Adult	Stroke	STAR	Trauma	OB	Replantation	Burns	LVAD	Post Sexual Assault	Sobering (Alt. Dest.)
ZSFG	X	X	X	X		x ¹	X	X	X	X	X	x ⁴		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 ⁵

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. CRITICAL Burns (adult or pediatric) WITHOUT major trauma must go to St Francis Memorial Hospital.
4. CRITICAL Burns (adult or pediatric) WITH major trauma must go to ZSFG for initial stabilization.
5. Transport to a Triage to Alt. Destination site requires Paramedic Triage to Alternate Destination 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 times per year 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: A 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

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).

The SFFD Airport Division follows their command structure and resides in San Mateo and follows their CQI process.

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 through 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) to 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 follow the protocol update schedule of the EMS Agency. The training will cover both the protocol updates, 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.

<i>Time Frequency</i>	<i>Incident Scope</i>
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 San Francisco Fire Department Research Committee and 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
- EMS6 Medication Management enrolled patients and associated encounters
- 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.

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 depending on the topic.

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

April 21st, 2025

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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 LEMSAs). 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 Manager
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 Manager

Under general direction, oversees Clinical Education Services activities for the Operation. Represents AMR to local committees, medical and training institutions, and other related agencies. Responsible for the creation, implementation, and tracking of quality and education programs. Is responsible for collecting data for reporting to the LEMSA and manages the narcotic program.

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. Concurrent CQI:

- 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 Supraglottic 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 is 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 2025, 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
2025

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

Policy Number: 0000

Date: July 1, 2025

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
POLICY MANUAL
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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.
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HARASSMENT POLICY

Policy Number 0001

Date: July 1, 2025

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

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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 bringing 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.

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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

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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.
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DRIVING POLICY

Policy Number:
0002 Date: July 1,
2025

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.

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DRIVING POLICY

Policy Number:

0002 Date: July 1,
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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 the 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.

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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.

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Policy Number:
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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 RECEIVING 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

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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, 2025

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 facility.
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), whether RN was aboard, whether lift assist was

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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 ARE ONLY 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

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DOCUMENTATION POLICY

Policy Number: 0003

Date: July 1, 2025

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.

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DOCUMENTATION POLICY

Policy Number: 0003

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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, 2025

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,
2025

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

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UNIFORM POLICY

Policy Number:
0005 Date: July 1,
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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.

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D.B.A. King-American Ambulance
DRESS CODE POLICY

Policy Number: 0006

Date: July 1, 2025

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.

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D.B.A. King-American Ambulance
PROFESSIONAL CONDUCT POLICY

Policy Number: 0007

Date: July 1, 2025

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.

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PARAMEDIC INTERN POLICY

Policy Number:

0008 Date: July 1,
2025

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, 2025

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, 2025

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, 2025

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.

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AMBULANCE CHECK OUT POLICY

Policy Number: 0012

Date: July 1, 2025

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.

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D.B.A. King-American Ambulance
AMBULANCE AVAILABILITY POLICY

Policy Number: 0013

Date: July 1, 2025

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, 2025

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,
2025

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

Content:

PUNCHING IN:

1. You may punch in no more than 10 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.

PUNCHING 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.

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PUNCHING IN POLICY

Policy Number: 0015

Date: July 1, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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.

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

Policy Number:

0021 Date: July 1,

2025 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, 2025

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 weeks)

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 shifts)

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, 2025

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,
2025

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, 2025

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, 2025

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, 2025

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,
2025

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 bag 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, 2025

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.

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D.B.A. King-American Ambulance

DRUG AND ALCOHOL POLICY

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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.

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DRUG AND ALCOHOL POLICY

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- 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 Manager, 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.

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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 cannabinoids. The drug and/or alcohol test will consist of (1) a sample to be tested immediately for substances which

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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.

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D.B.A. King-American Ambulance

CREWS QUARTERS POLICY

Policy Number: 0028

Date: July 1, 2025

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, 2025

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, 2025

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)

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D.B.A. King-American Ambulance
OXYGEN AND AIR CASCADE SYSTEM POLICY

Policy Number:
0030 Date: July 1,
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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

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D.B.A. King-American Ambulance

EQUAL OPPORTUNITY EMPLOYMENT POLICY
FAIR EMPLOYMENT PRACTICES POLICY

Policy Number:
0031 Date: July 1,
2025

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.

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DISCIPLINARY ACTION POLICY

Policy Number: 0032

Date: July 1, 2025

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 on 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 policy's disciplinary action shall be used.

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LIGHT DUTY POLICY

Policy Number: 0033

Date: July 1, 2025

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 through 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.

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PERSONNEL ACCESS POLICY

Policy Number: 0034

Date: July 1, 2025

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.

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D.B.A. King-American Ambulance

HIRING PROCEDURES POLICY

Policy Number: 0035

Date: July 1, 2025

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.

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EMPLOYEE I.D. POLICY

Policy Number: 0036

Date: July 1, 2025

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.

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TRANSPORTING OF PATIENT'S BELONGINGS POLICY

Policy Number: 0037

Date: July 1, 2025

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.

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OUTSIDE EMPLOYMENT POLICY

Policy Number: 0038

Date: July 1, 2025

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.

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PRIVACY POLICY

Policy Number: 0039

Date: July 1, 2025

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:

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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

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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 patient's 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.

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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 policies 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: _____

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TOBACCO POLICY

Policy Number: 0040

Date: July 1, 2025

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.

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BIOHAZARD WASTE POLICY

Policy Number: 0041

Date: July 1, 2025

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.

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LAPTOP COMPUTER POLICY

Policy Number: 0042

Date: July 1, 2025

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.

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

Policy Number: 0043

Date: July 1, 2025

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.

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BILLING POLICY

Policy Number: 0044

Date: July 1, 2025

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.

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LONG DISTANCE TRANSPORTS POLICY

Policy Number: 0045

Date: July 1, 2025

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.

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SICK CALL OUT POLICY

Policy Number: 0046

Date: July 1, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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, 2025

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 as 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, 2025

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, 2025

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, 2025

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.

-
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

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, 2025

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.

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, 2025

- 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 SFPD 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, LEMS 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, 2025

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,
2025

Allied Medical Services of California, Inc.
D.B.A. King-American Ambulance
D.B.A. Allied Medical Transport
POLICY TO FOLLOW POLICIES

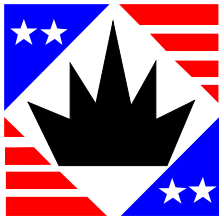
Policy Number: 0064

Date: July 1, 2025

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 2025 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: _____



KING-AMERICAN AMBULANCE CO.

2570 Bush St.

San Francisco, CA. 94115

Serving San Francisco since 1906

415-931-1400

2024 CQI Update:

Current Plan:

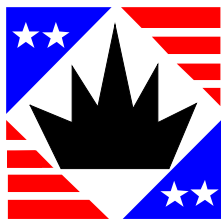
Updated last year. With large employee turnover we are still focusing on the basics by reviewing all chest pain, shortness of breath, all medication administration, and all code 3 returns to the hospital. We are focusing on vitals before and after medication and correct destination documentation. We 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 2024 we moved to Zoll's hosted environment for dispatch, began implementing EMSCharts for PCR's and switched to Zoll Billing for our billing office.



Serving San Francisco since 1906

KING-AMERICAN AMBULANCE CO.

2570 Bush St.
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2025 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 identified 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 Starbucks 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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2025

Dispatch Quality Assurance Report for 2025

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 2025.

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 2025.

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 2025.

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 2024.
12. Dispatch QA Plan update. The plan has been updated for 2025 and emphasis will be placed on the items listed in this report.



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2025 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 2025

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
2025

Purpose: To establish a set of goals and objectives for King American Ambulance through the process of the Quality Improvement Plan and process.

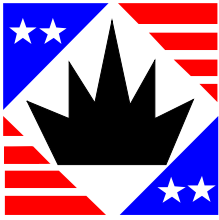
Content: The following are the goals and objectives for King American Ambulance Dispatch Center.

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 2025
STATUS REPORT
2024

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 2024
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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2025 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: _____

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: _____

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: _____

INTERVIEW REPORT

Summary: (use back of page if necessary) _____

[illegible]

King American Ambulance
Quality Improvement Plan
INVESTIGATION PROCEDURES
EMSA POLICY 6020
2025

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

King American Ambulance
Quality Improvement Plan
INVESTIGATION PROCEDURES
EMSA POLICY 6020
2025

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.

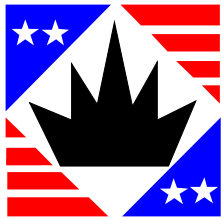
Root cause analysis will be completed by investigator and will inform management of findings and suggestive corrected action to take to avoid or minimize similar situations in the future.

Closing Process:

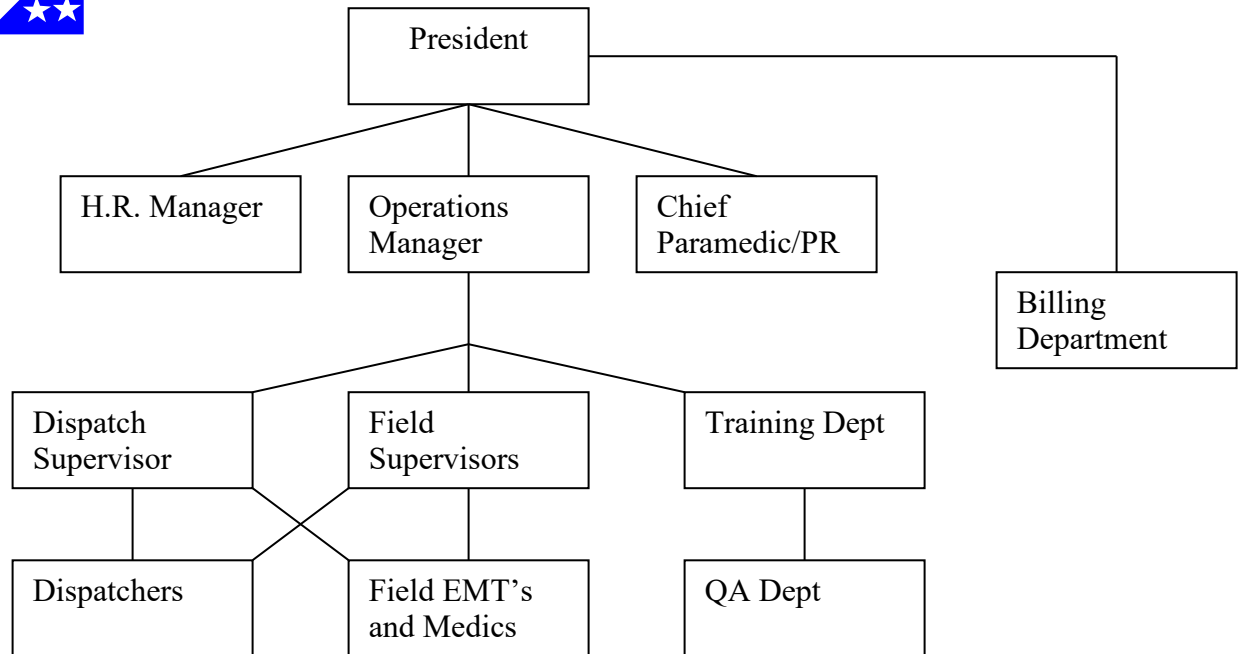
The investigation report checklist shall identify the loop closure and that the appropriate parties are notified of the conclusion of the investigation and if any action was or will be taken based on the outcome of the investigation.

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.



KING-AMERICAN



The above chain of command and organizational structure as of June, 1 2024.

President – Josette Mani

Human Resource – Michael Lopez

Operations Manager-- Frank Hudson

Chief Paramedic - Peter Jacoby

Billing Dept

1. Controller – Josh Mani, Managing Director
2. Supervisor – Joan Santilices

Supervisors/QA/Specialists – Peter Jacoby

Paramedic Supervisor, Supply and Safety Officer – Michael Moncla

Paramedic Supervisor – Michael Moncla, Ben Tapparo, Francis Kennedy

QA Director – Peter Jacoby

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/Evaluated: _____

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

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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.

Peter Jacoby

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 – Peter Jacoby

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 emphasize 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
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)	☐ Not authorized to operate equipment
☐ Unsafe behavior	☐ or proper footwear not provided/worn	☐ Inadequate lockout
☐ Failure to get help	☐ Unsafe storage arrangement	☐ Inadequate warning signs
☐ Overexertion	☐ Wet/Icy conditions	☐ Lack of guard/barrier/device
☐ Excessive workload	☐ Poor material flow	☐ Inadequate ventilation
☐ Poor work habits	☐ Inadequate housekeeping	☐ Inadequate maintenance
☐ Shortcut /Excessive speed	☐ Inadequate lighting	☐ 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 2025

Dispatch Manager / QI Coordinator
Peter Jacoby

Dispatch Supervisors
Ish Perez – QA/QI
Nikki Maples – Training

Dispatchers
David Szeto Burton Lee Bill Carpenter Iban Avila

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. Yes No
Additional paperwork also completed.
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 2025

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 2025 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 2025

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 were 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 Talkability (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!

King American Ambulance
Quality Improvement Plan
Documentation
January 2025

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

King American Ambulance
Quality Improvement Plan
Documentation
January 2025

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 2025

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 2025

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
2025
STATUS REPORT for 2024

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. Any 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 2024 we had many pages of notes for QA. In October 2024 we switched PCR vendors 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
2025
STATUS REPORT for 2024

Goals and Objectives REPORT for 2024:

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 2024 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 2024.
4. Prospective QA by field supervisors showed room for improvement in 2024. 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 through 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 to ICEMA using NEMSIS 3 criteria in 2024.
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 2025

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 2025.

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 emergency 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 LEMSAS.
9. Continue to maintain Zoll Dispatch Pro licenses and utilize PRO QA.

King American Ambulance
Quality Improvement Plan
Risk Management January
2025

RISK MANAGEMENT:

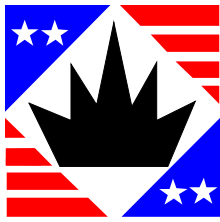
Issues related to risk management are taught during all aspects of employment. Topics include:

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 2025:

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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2025 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 2025.

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
2025

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 2025.

HIPAA will be adhered to at all times to protect patient confidentiality.

King American Ambulance
Quality Improvement Plan
Personnel
2025

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 2 personnel certified to complete QA reviews for dispatch. 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 Peter Jacoby. His experience includes 19 years in EMS as a paramedic and 13 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 Peter Jacoby 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
2025

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
2025

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 2025 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
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King American Ambulance
Quality Improvement Plan
Transportation / Facilities
2025

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.

2024 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

January 2025

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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.

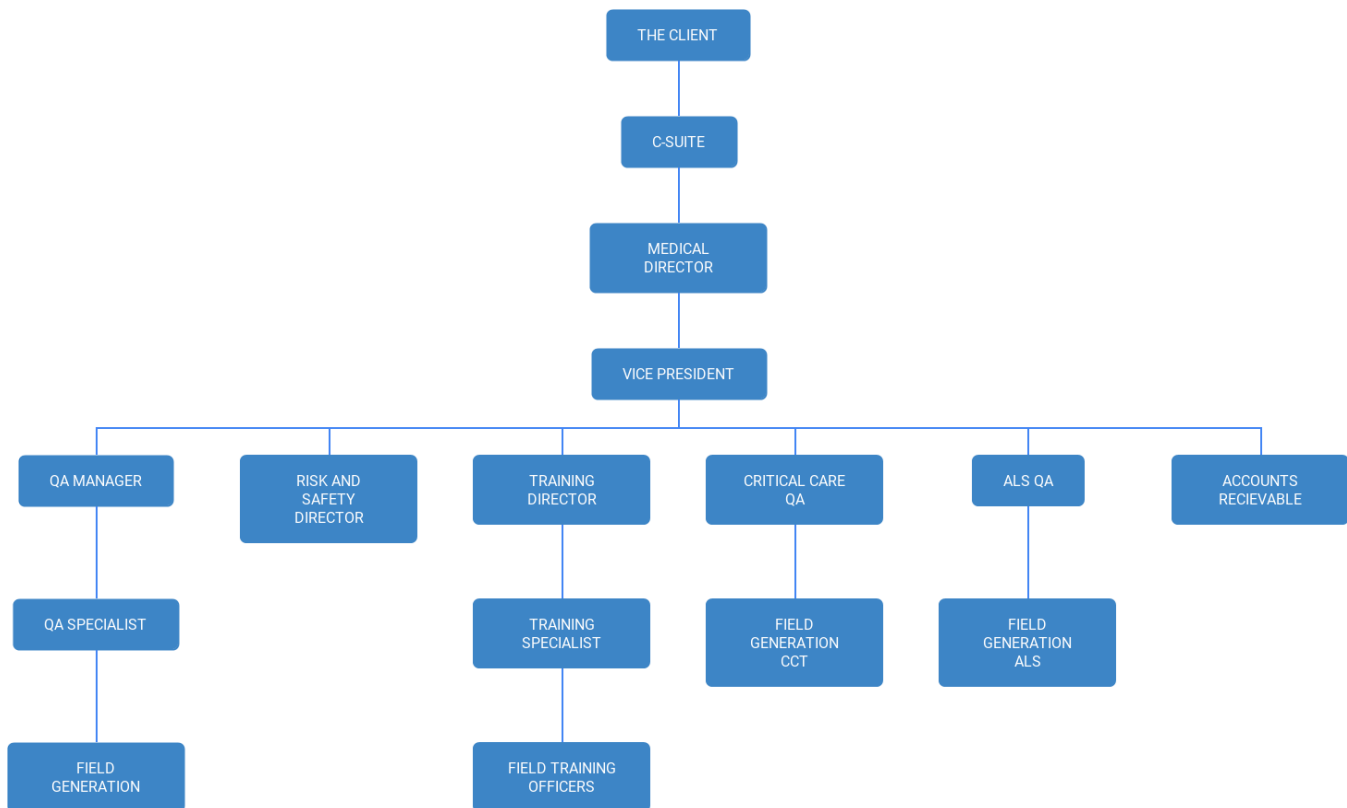
B. Introduction

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 Piedad, RN, CMTE
- 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: Natalia Gonzales EMT
- Quality Assurance Specialist: Viet Tran EMT
- Quality Assurance Specialist: Michael Booth, Paramedic
- Quality Assurance Specialist: Maya Anderson, RN

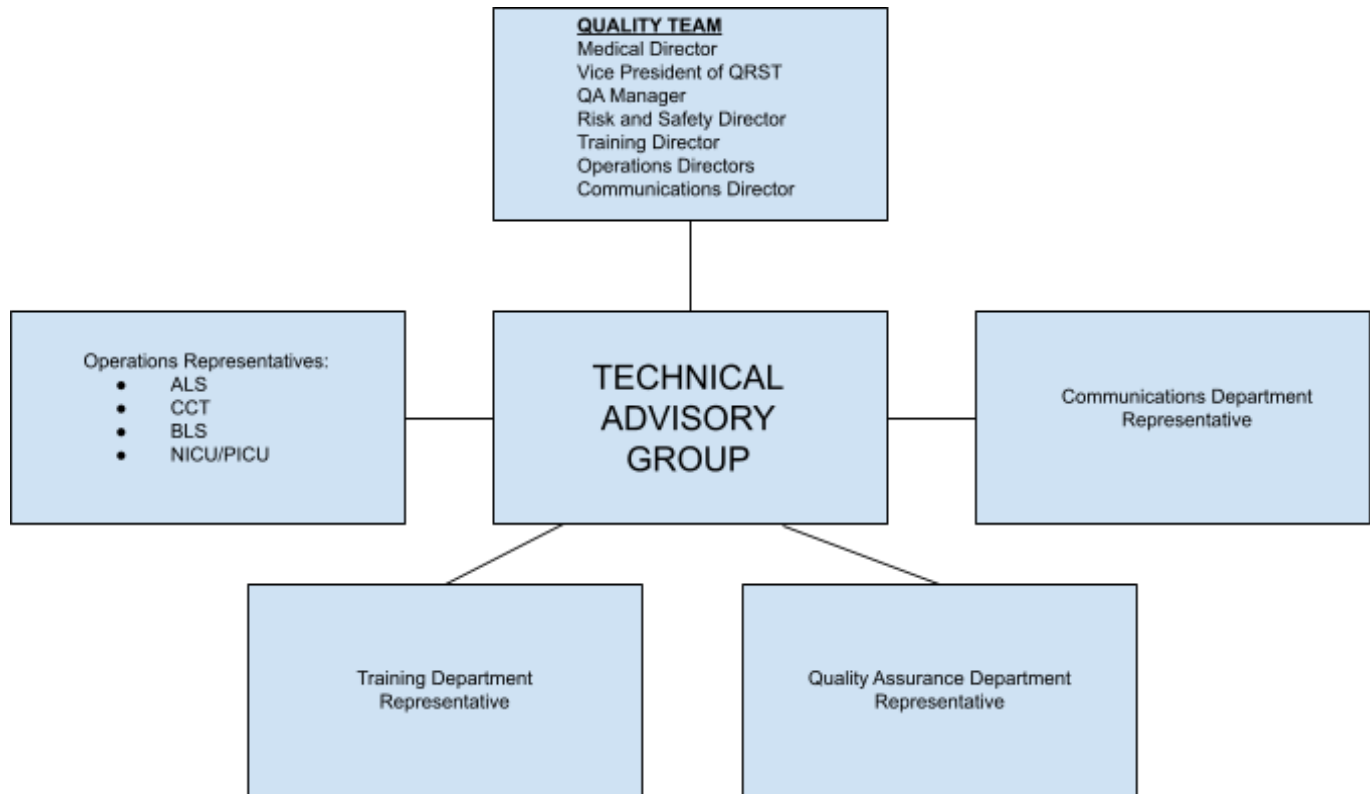


2. Technical Advisory Group

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.

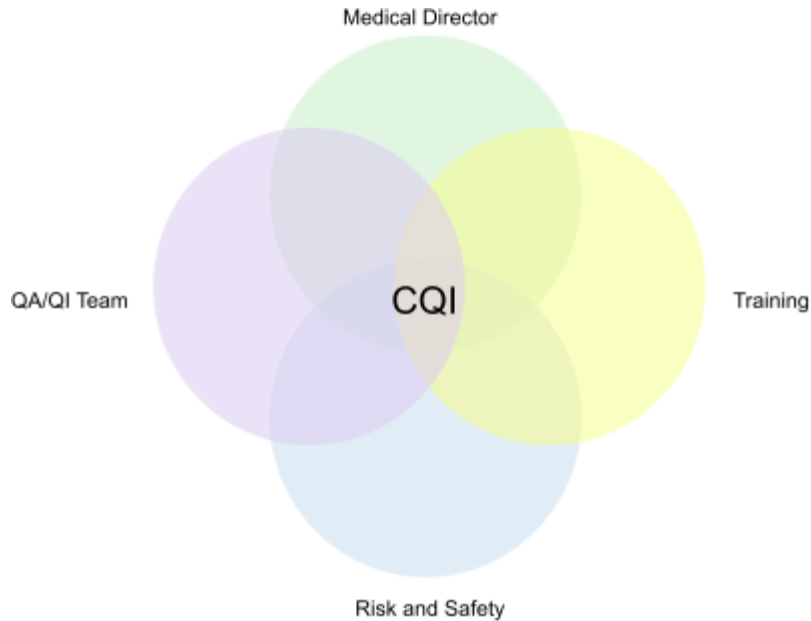


D. Organization Mission, Purpose, Services, and Goals

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 staff 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 stand-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.

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 Ambulance orientation and field training program. Probation and any local accreditation requirements applied by the LEMSA in which they will be working. RNs are required to maintain their state nursing license, current CPR, ACLS, and PALS. RNs 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 Quality Manager.

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-Suite.

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
- LEMSAs 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 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 in-house 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 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:** Gurney service and issues are tracked by the Supply Services Department.
- (3) Indicator Reporting Value:**
 - Equipment PM's are completed no less than annually.
 - All equipment services are completed by certified 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 – Biomedical Supply Manager

- Committee Members - QA representative, Risk and Safety representative, SSD representative, and Operations representatives.

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 alteration 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 v3.5 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
 - Mechanical Circulatory Support Devices
 - NICU patients
 - Code-3 calls
 - Psychiatric patients
 - Application of restraints
- ALS PCR review
 - 100% Code-2 calls
 - 100% Code-3 calls
 - 100% Controlled Substance Administration
 - 20% Randomized per provider

- CCT PCR Review
 - 100% Probationary PCR review
 - 100% Code-3 calls
 - 100% Controlled Substance Administration
 - 20% 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. Norcal's 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. Norcal's 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 Norcal's 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: Clinical Care Services Director**
- (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 on the premises of the primary 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:** Director Clinical Services
- (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 ensure proper compliance and reporting of unusual occurrences 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:**
 - 20% 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 caters to all learning styles. Training can be self-paced, psychomotor and rubric testing. The aim is to enhance the clinical application of a clinician's 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 of

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
 - Chute 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
 - Controlled Substance 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
- Mechanical Circulatory Support Devices
- Specific medication administration
- Acuity deemed appropriate

(b) Compliance: Data input from patient care records quarterly

(c) **Assigned:** Director Clinical 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
- Mexico Medical Outreach Project
- Lakota Well-being Project
- 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, Director of Clinical Services, 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

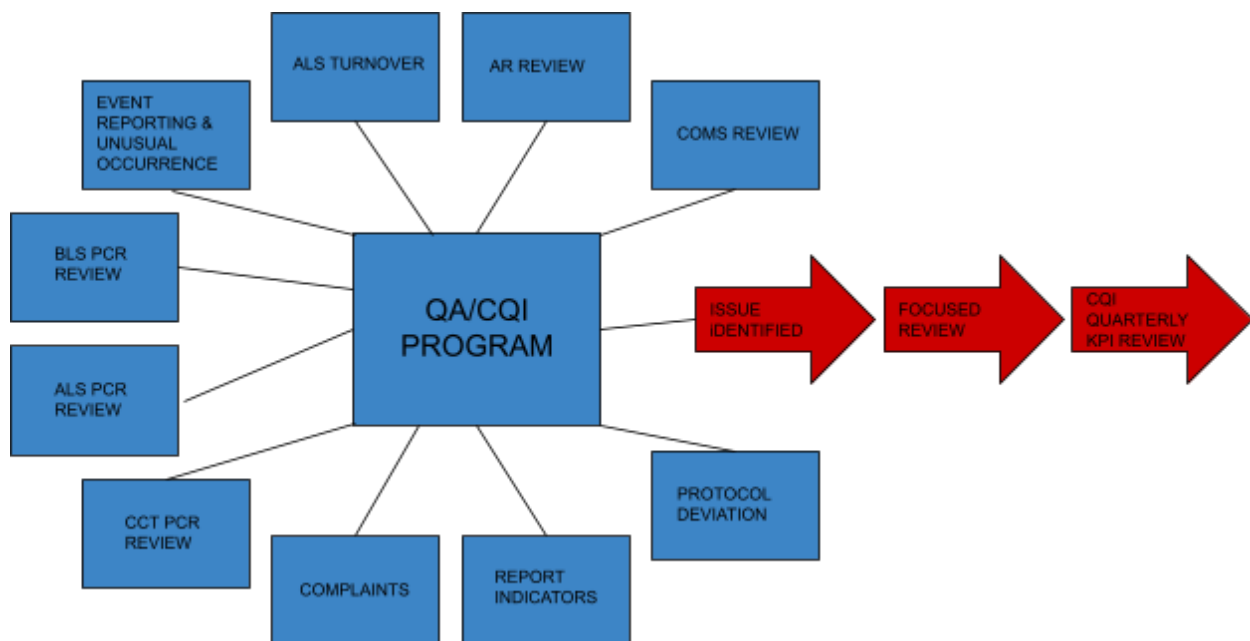
Norcal Ambulance adopts methods of quality improvement based on guidelines recommended by the state of California EMS authority. In particular, special attention to methods of data gathering, review, reporting and improvement in Appendix E and F in the CA EMSA policy # 164 (Emergency Medical Service 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

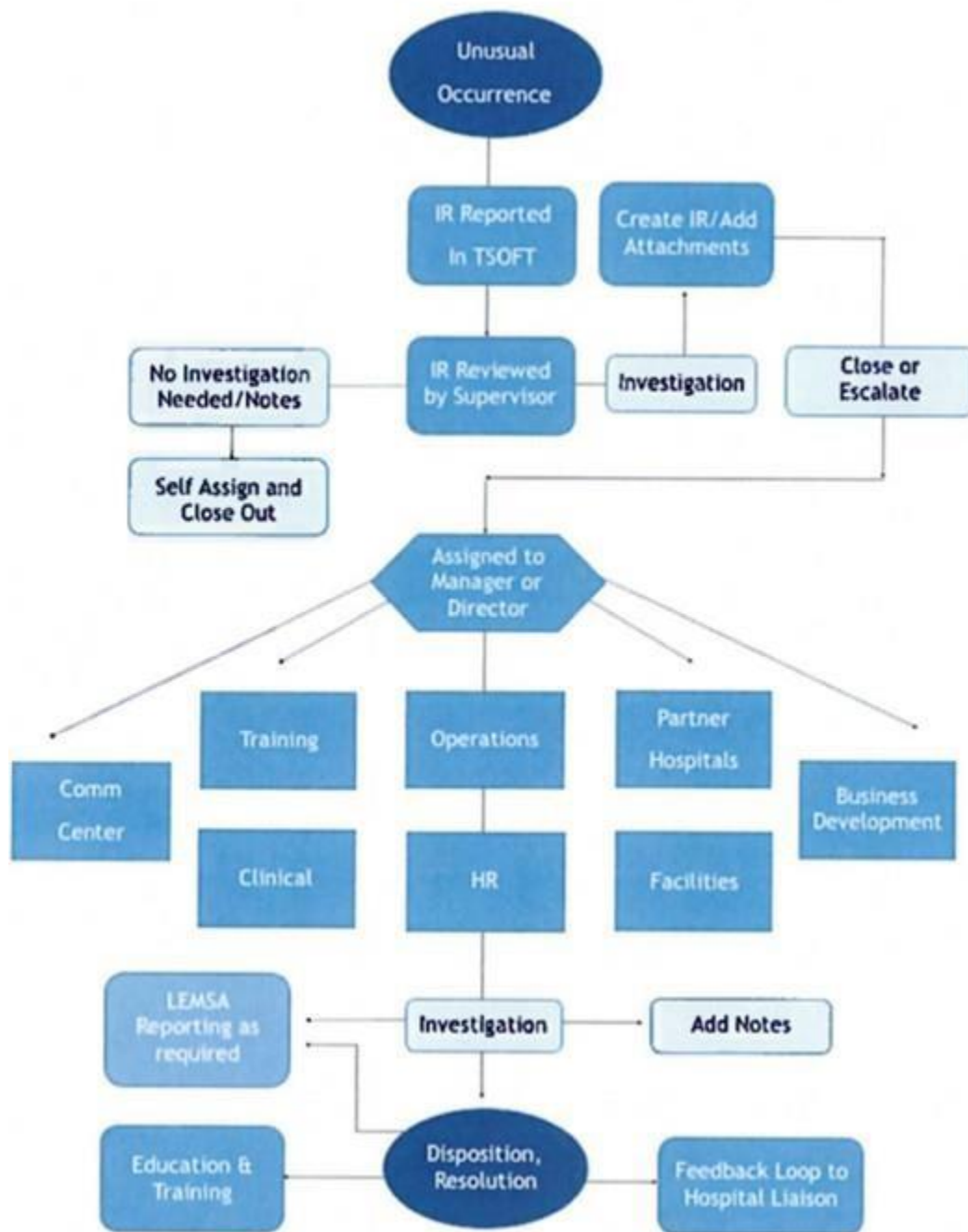
- Hospital diversion
- AMA release of patient
- Non AMA refusal of care/transport
- Accusation of negligence or wrongdoing against Norcal ambulance employee
- Delay in patient care without adverse outcome
- Any condition or situation that represents a threat to employee or public safety and health
- 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 Director of Clinical Services 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.

Norcal's 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 meetings, electronic mediums, posters, flyers, newsletters and TEAMS. 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. 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*)

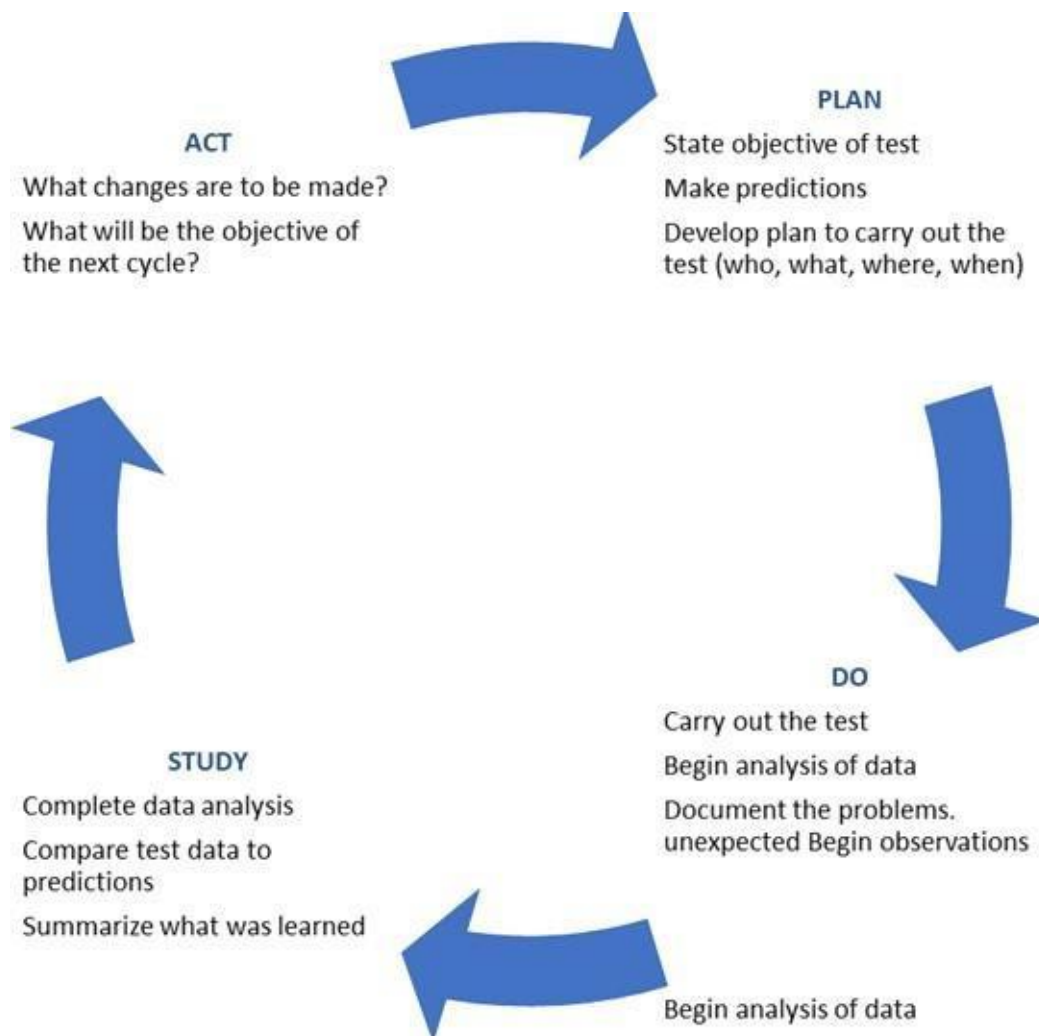
F - find a process to improve

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 Norcal's 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 or 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, Director of Clinical Services, 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 Director of Clinical Services. 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, Director of Clinical Services 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 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 Director of Clinical Services, 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

Norcal's 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 2024

The following was under review for all ALS, CCT, and BLS operations in 2024:

- 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 QA Specialist or CCT QA Specialist. All data gathered from these PCRs are tracked and recorded in the monthly QA Dashboard.

2024 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

2024 Issues Requiring Further Consideration in 2025

- 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.

2024 Findings and Outcomes

- **Psychiatric Transports -**
Overview: In 2024 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 transport 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 2025 year. QA is continuing to review psychiatric calls and tracking compliance. This is an ongoing KPI.

➤ **BLS Infrequent Skills**

In 2024 we had no instances where BLS infrequent skills were utilized in the field. Will continue to monitor for 2025.

2025 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 infield 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)

ProTransport-1, LLC
2025

In accordance with the standards of:

Emergency Medical Services Administrations Association of California

Effective Date: 01/2010

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Introduction

ProTransport-1 is a leading provider of inter-facility private ambulance services in California. Different from the traditional 911 EMS model, our goals and responsibilities are tailored to meet the unique needs of inter-facility patient transport. To support our commitment to quality, we have adopted a “Total Performance Score” (TPS) methodology, modeled after the approach used in hospitals and aligned with the standards set by the Centers for Medicare and Medicaid Services (CMS), as the foundation of our Continuous Quality Improvement (CQI) program.

Our TPS consists of five domains:

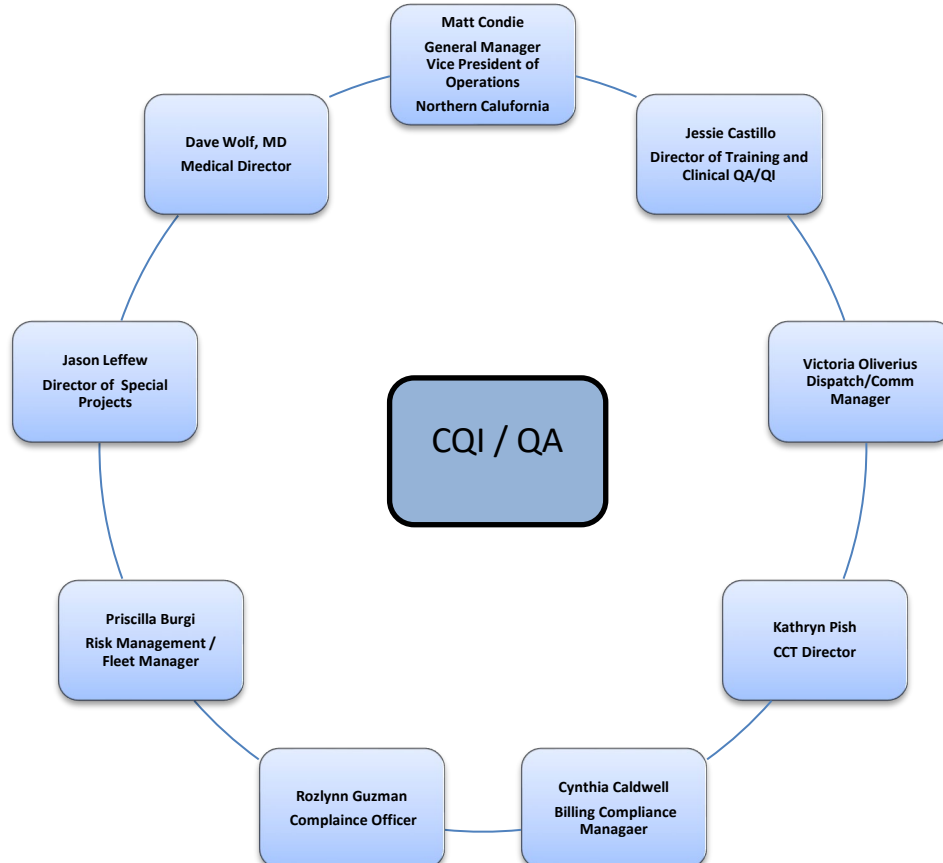
- Clinical Process of Care
- Patient Experience
- Outcome
- Efficiency
- Operational Effectiveness

I. Structure and Organizational Description

A. Organizational Structure

1. QA/CQI Committee

The QA/CQI committee, led by the Director of Training and Clinical QA/QI, is tasked with identifying areas for improvement through performance reporting, including patient chart data, accounts receivable success rates, and call center statistics. The committee analyzes data and trends, collaborating with department stakeholders to develop strategies that address challenges and uncover opportunities for growth. This team conducts individual employee audits, performs QA reviews, and evaluates data for patterns and trends. Serving as an advisory board for all departments, the committee provides trend analysis, insights, and recommendations to drive continuous improvement across the organization.



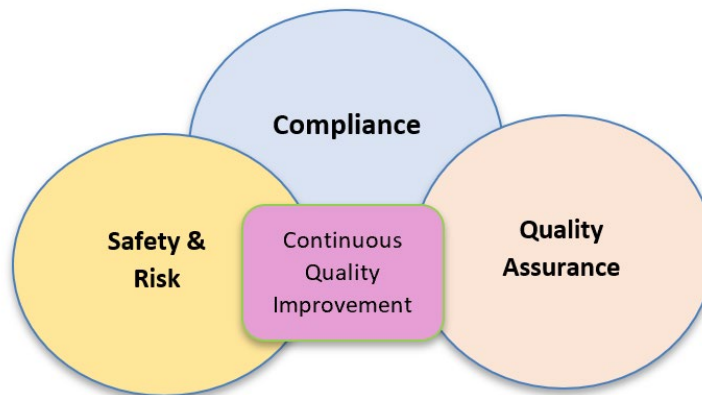
2. Leadership Group

The Leadership Group functions as the primary decision-making authority for proposed operational changes and financial strategies. This group is responsible for evaluating and resolving competing organizational priorities, addressing conflicts, formulating funding strategies, and overseeing logistical planning to ensure seamless coordination and alignment with organizational objectives.



3. Risk Management, Safety, 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, core values, and motto emphasize a commitment to fostering a culture of quality. Our unwavering dedication to "doing the right thing right the first time" drives us to pursue excellence in all aspects of our operations.

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:
 - o Partner, peer and station manager review
 - o PCR compliance review
 - o Unusual occurrence reporting system
 - o New hire, ongoing training program and continuing education program

- o Team member feedback forums
- o 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:
 - o ALS PCR review
 - o Station manager (OD) review
 - o Unusual occurrence reporting system for the company and county
 - o Continuing education program
 - o Base hospital run review participation
 - o 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:
 - o CCT PCR review
 - o Unusual occurrence reporting system for the company and county
 - o Continuing education program
 - o Participation in QA/CQI Committee
 - o 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:
 - o
 - o Unusual reporting system for the company and county
 - o 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.

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 NEMIS/CEMIS-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

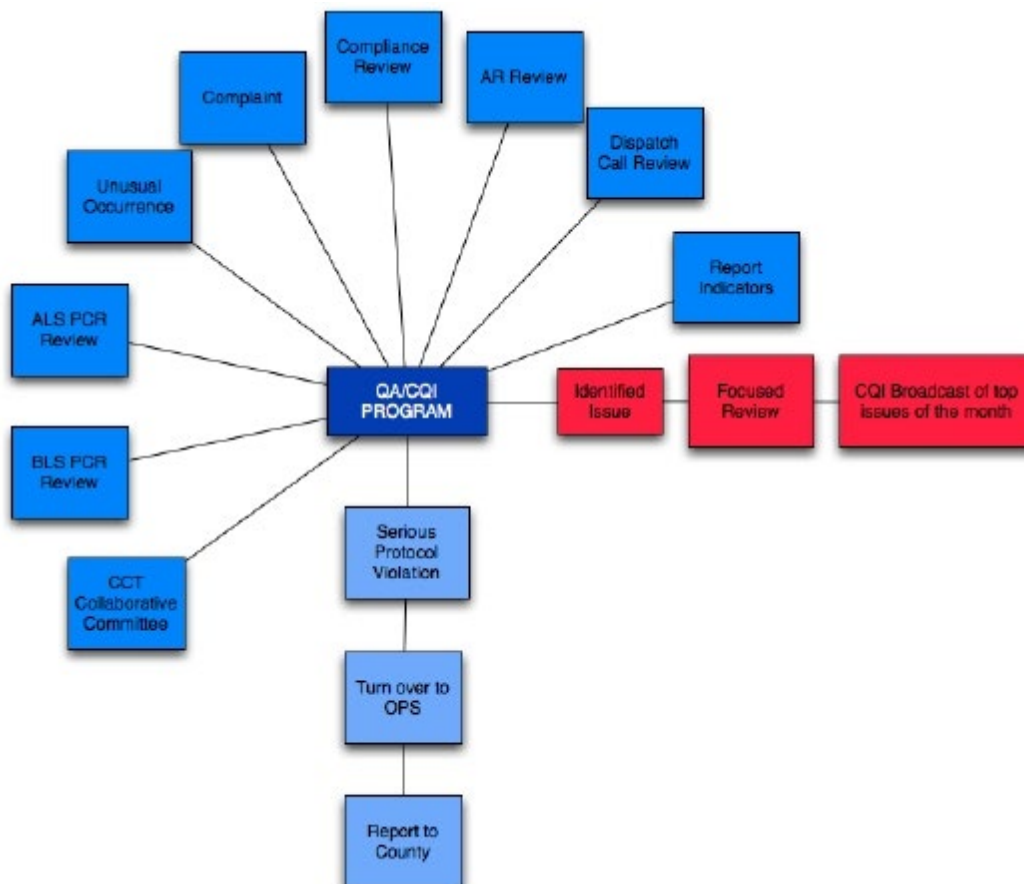
9. Other	Objective	Compliance	Department	Indicator
Vaccinations	Ensure employees comply with annual Flu vaccination	Employees obtain an annual Flu vaccination or mask in patient care areas.	• Human Resources • Clinical Operations • Marketing Communications	% of employees by station that do not get the Flu vaccination

B. Process

ProTransport-1's commitment to quality and exceptional customer service drives the selection of performance indicators that differ from those typically used in a 911 EMS model. Our focus is on providing seamless transportation for patients, many of whom are elderly, requiring efficient and appropriate connections between medical facilities. Our service philosophy is rooted in delivering the right care, at the right time, for the right reasons.

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

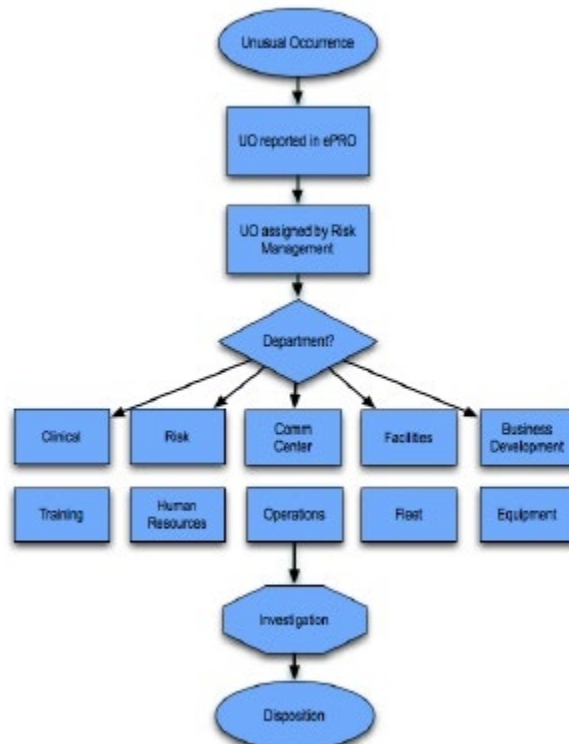
One such method is Unusual Occurrence reporting. Reports are generated in our online system. All team members have access to this method of reporting and can access it at anytime while on duty or not. UOs are reviewed on a daily basis and follow a strict reporting guideline dependent on the issue. Examples 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

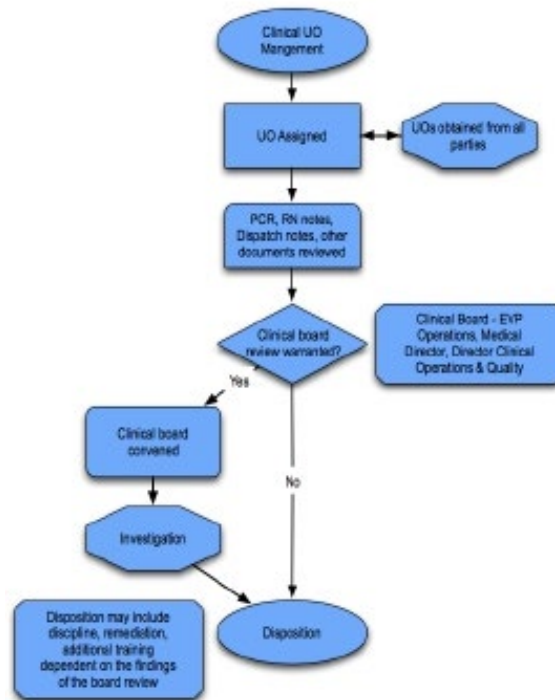
Advanced Life Support (ALS) mandated reporting requirements include those listed above and also the following:

- ☐ 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:

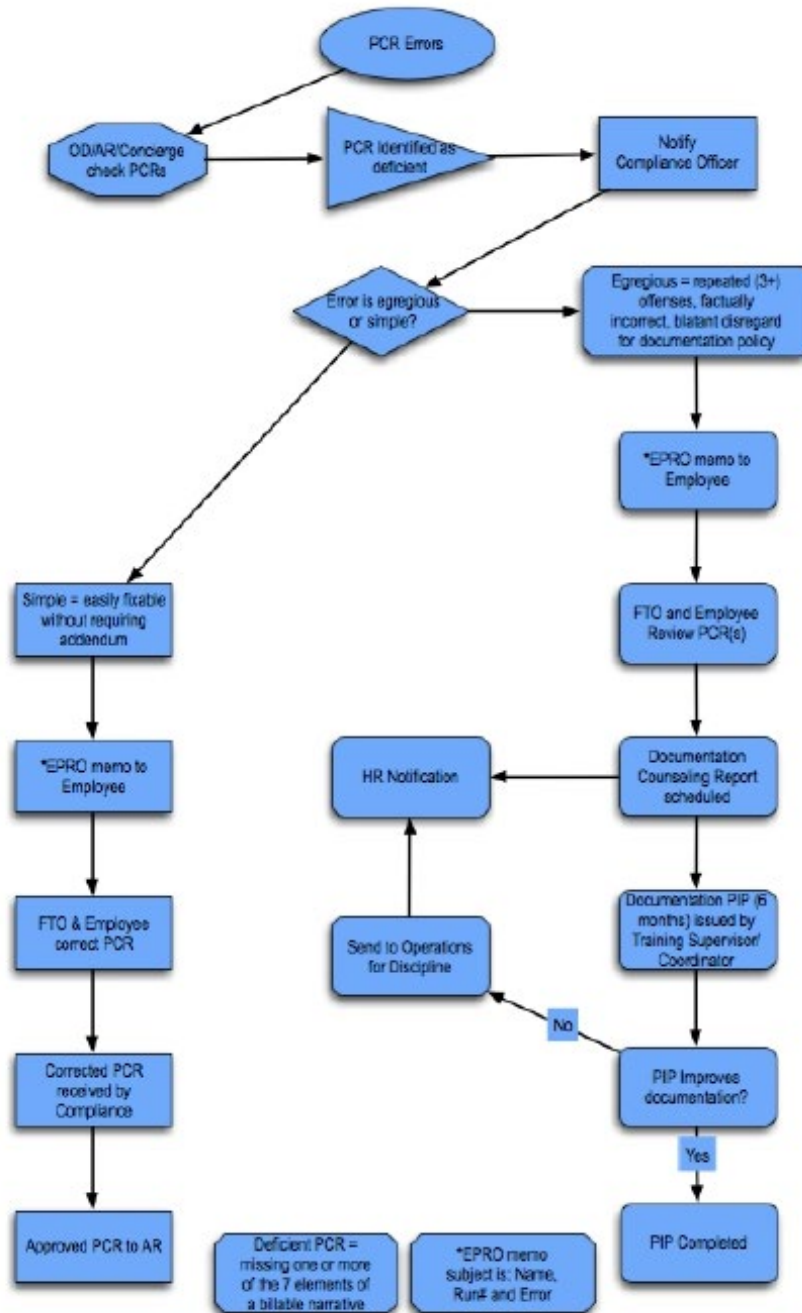


2. PCR Review Process

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 sentinel 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.

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:

III. Evaluation of Indicators

A. Indicators

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

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.

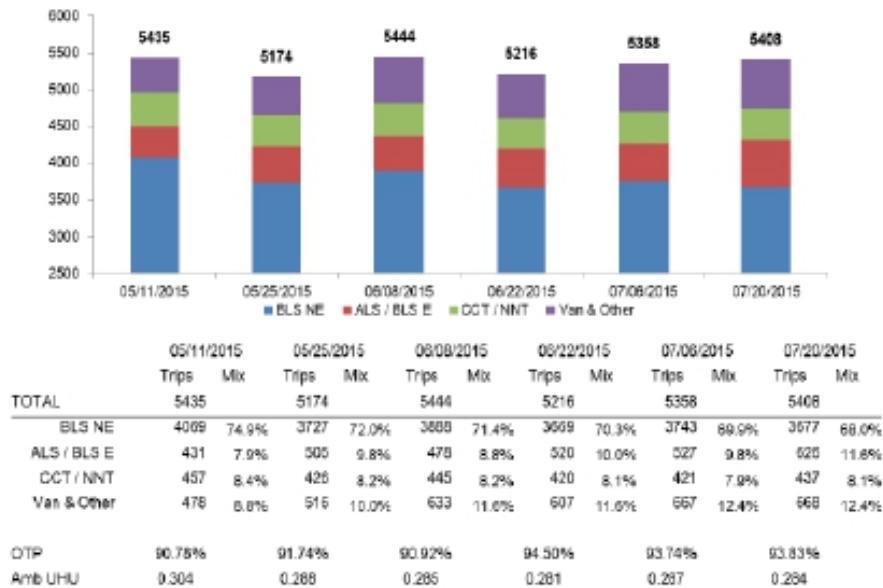
Department	Report	Frequency
Field Operations	Time and attendance	Daily
	Calls by LOS	Weekly, Monthly
Communications Center	Long distance transports – distance, time on task, frequency by facility	Monthly
	Incoming calls, faxes, electronic ordering	Weekly, Monthly
	Customer service quality	Daily, Weekly
	Time per call, per agent	Monthly
Compliance	PCR completion	Monthly
	PCR send backs	Monthly
	HIPAA training	Annually
	Code of conduct	Bi-annually

B. Analysis

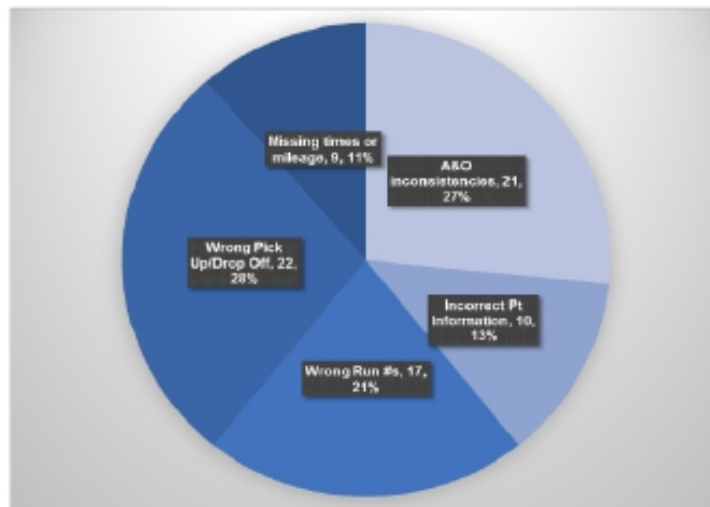
Data is presented in various forms depending on the report and the audience. Examples of reports from our monthly global leadership meeting presentation are below:

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)

Biweekly Volume & Performance



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:

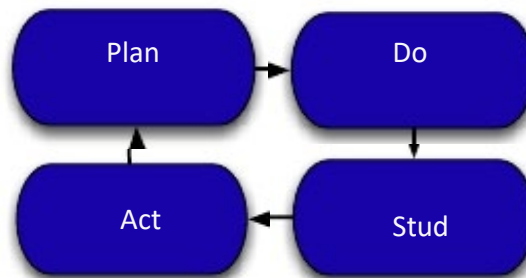
- ☐ Monthly station meetings
- ☐ Quarterly global leadership meetings
- ☐ Quarterly compliance meeting

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

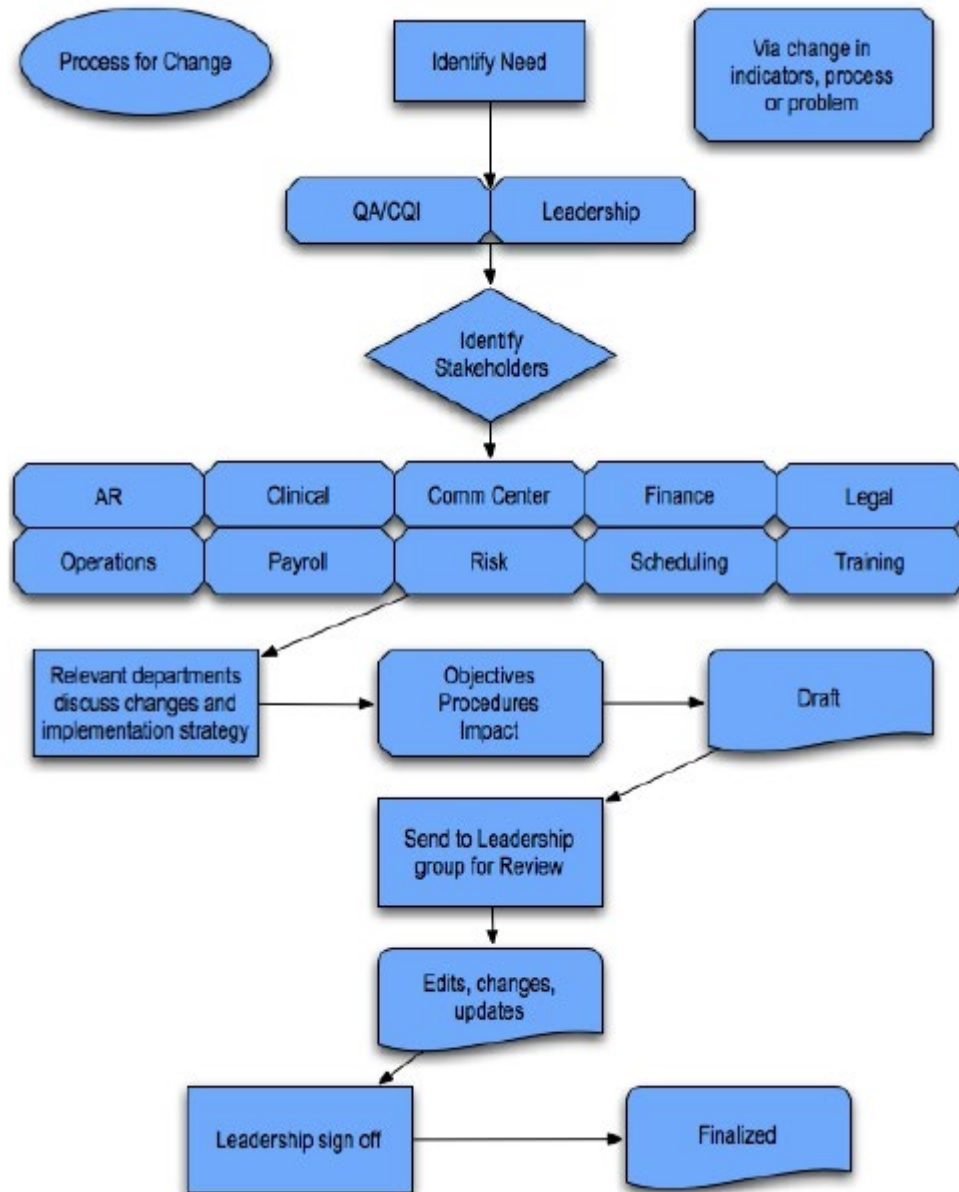
Contacts are made from the LEMSAs to the individual stations via the station managers. In ALS areas, the lead paramedics regularly attend EMS meetings to stay abreast of changing information and are the first point of contact regarding any EMS issues. Facilities and customers are contacted on a regular 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.

Our change process is outlined here:



V. Selection, Training and Education

A. Program Description

Selection: The selection and screening process for new team members is administered and monitored by the Human Resources Department. It involves recruitment, an application and screening process that seeks to match qualified applicants in a non-discriminatory manner through testing and matching needed skills.

New 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 safety requirements, CA Prop 11 components, emergency vehicle operations, local area/LEMSA requirements, back safety 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 LEMSAs.

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 and Clinical QA/QI

System for Developing and Maintaining Company Policy

New formatting has been put in place and policy has been separated from procedure and each department head has been tasked with a review of their policies and procedures.

System for Assuring Goals of Training and Education Are Met

Checklists have been created to ensure all team members complete necessary training and education as set forth by the Training Department. Human Resources ensures the receipt of training documents from all team members. Assignment, tracking and notification systems are largely automated online and in the HRIS system.

Integration of Trends and Recognized Training Opportunities Into the Training Program

Any identified opportunity for improvement will be reviewed. In collaboration with Operations, the Training Department will determine what action is needed. If the issue is an individual, it will be handled with a written Performance Improvement Plan (PIP).

Continuing Education Program

It is the responsibility of the Training Department to ensure continuing education is occurring at appropriate regular intervals. In addition, lead paramedics and the CCT Director in conjunction with the Clinical Operations will implement needed curriculum for the ALS and CCT divisions.

Training Program Evaluation and Validation

Evaluation of the Training Department will take place annually. The Training Department and Clinical Operations along with the Leadership group will evaluate the overall training program and its effectiveness. Service goals will be evaluated along with successful completion rates and any related issues reported within the year. The Quality Team and Training Department will develop strategies to ensure goals are met for the following year.

Changes to LEMSA guidelines, new equipment and any other changes will be reviewed and curriculum developed to integrate the changes for field personnel. On a rotating basis, Training, Risk and other department team members will attend conferences, classes and seminars to keep up to date with the newest methods and information.

VI. Annual Update

ProTransport-1 is primarily an inter-facility transport company with a focus on safety, customer service and integrity. Our CQI plan, while not in the traditional manner of an EMS focused agency, is comprehensive and focused on our mission statement, operating values and

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.

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
EMT Equipment Training for ALS/CCT	New EMTs have limited training on ALS and none on CCT	Training in relevant areas Starting with adding training 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
RTQ	Concierge/field ops/AR	Increase RTQ frequency	Ongoing
Medication Reassessment	Advanced providers documenting after interventions	1:1 training if necessary or annual training	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

Appendix A ePCR Validation Rules

Rule ID	Description	Level	Use	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 En Route Date/Time	The unit en route datetime 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 datetime 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	12/12/2013
45	Times: Arrive Destination > Leave Scene	National	-1	E9.10 - Patient Arrived at Destination Date/Time	Arrive datetime Destination is less than Leave Scene datetime.	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: Responding Unit		-1	E2.11 - EMS Unit/Vehicle Number	Responding 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	E3.1 - 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	06/03/2014
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
89	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 6.1: E05_10: Patient Arrived at Destination Date/Time	State	-5	E5.10 - Patient Arrived at Destination Date/Time	The patient arrived at destination datetime 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 datetime	Active	05/10/2007	03/08/2013
96	Times 4: Enroute > Unit Dispatched		-1	E5.5 - Unit En Route Date/Time	Enroute less than Unit Dispatched datetime	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 datetime 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 datetime 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 datetime 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 datetime is missing and needs to be completed.	Active	05/10/2007	03/08/2013

Rule ID	Description	Level	Use	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 datetime	Active	05/10/2007	03/08/2013
103	Times 9: Back in Service > Arrive Dest.	National	-1	E3.11 - Unit Back in Service Date/Time	In-Service less than Arrive Destination datetime	Active	05/10/2007	03/08/2013
104	Times 2: Dispatch Notified > PSAP		-1	E3.3 - Dispatch Notified Date/Time	Dispatch Notified less than PSAP datetime	Inactive	07/12/2007	03/08/2013
105	Times 3: Unit Dispatched > Dispatch Notified		-1	E4.4 - Unit Notified by Dispatch Date/Time	Unit Disp. less than Dispatch Notified datetime	Active	07/12/2007	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 datetime	Active	07/12/2007	03/08/2013
107	Times 2.1: Dispatch/Notified		-1	E3.3 - Dispatch Notified Date/Time	Dispatch Notified datetime is missing	Inactive	07/12/2007	03/08/2013
108	Incident Address 3: Incident County		-1	E8.13 - Incident County	Incident County is missing	Active	07/12/2007	03/08/2013
109	Incident Address 4: Incident State		-1	E8.14 - Incident State	Incident State is missing	Active	07/12/2007	03/08/2013
110	Patient Address 2: Patient City		-1	E6.5 - Patients Home City	Patient City is missing	Inactive	07/12/2007	03/08/2013
111	Patient Address 3: Patient County		-1	E6.6 - Patients Home County	Patient County is missing	Inactive	07/12/2007	03/08/2013
112	Patient Address 4: Patient State		-1	E6.7 - Patients Home State	Patient State is missing	Active	07/12/2007	12/11/2013
116	Call Info: Response Mode from Scene BUS		-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	09/30/2010	03/08/2013
127	Activities: Procedures	National	-10	E19.1 - Date/Time Procedure Performed Successfully	Can not have a procedure and not applicable procedure entered.	Active	09/30/2010	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 datetime must be Greater than or Equal to Unit Notified by Dispatch	Active	09/30/2010	03/08/2013
129	At Scene: MCI	National	-1	E6.6 - Mass Casualty Incident	If Mass Casualty is Yes, then the Number of Patients at Scene must be Multiple.	Active	09/30/2010	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	09/29/2010	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	09/29/2010	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	09/29/2010	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	E6.5 - 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	03/19/2011	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	05/25/2011	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 En Route 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 En Route Date/Time	Unit En Route Date is before Dispatch Notified Date.	Active	12/15/2011	03/08/2013

Rule ID	Description	Level	Use	Field	Error Message	Status	Date Entered	Date Updated
1009	Unit En Route Date Before PSAP Call Date (Logical)	Logical	-1	E5.5 - Unit En Route 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 En Route 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 is 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	Use	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	Use	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	12/17/2013
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 payer 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	12/12/2013	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 Position		-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	05/24/2014	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	08/27/2014	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 i.e., 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	E8.0 - 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	E16.2b - 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 Not Applicable 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 Restraints		-10	20 - RT Restraints	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. You must select an option from the drop down menu	Active	01/30/2015	01/30/2015
1182	Transport Mode From Scene		-5	E20.14 - Transport Mode From Scene	Destination Address is missing and needs to be added for each response.	Active	01/30/2015	01/30/2015
1187	Destination address		-25	E20.1 - Destination Transferred To, Name	You must pick a Purpose For Transport reason from the drop down window.	Active	03/16/2015	03/16/2015
1189	Purpose For Transport		-25	113 - Purpose For Transport		Active	05/07/2015	05/19/2015



Royal Ambulance Continuous Quality Improvement Plan (2025)

Executive Summary

Cal. Code Regs. tit. 22 §100402.(b); §100402.(b) (a)(1)

The goal of Royal Ambulance's Continuous Quality Improvement (CQI) Plan is to systematically evaluate and enhance patient care in pre-hospital and inter-facility transport settings.

CQI fosters collaboration among all levels of healthcare providers to improve the systems in which they work. Rooted in a commitment to excellence, it identifies areas for improvement, training opportunities, and outstanding clinical performance. Additionally, CQI assesses compliance with treatment protocols, adherence to operational guidelines, and the effectiveness of treatments for specific illnesses or injuries.

Through continuous review, analysis, and improvement, CQI supports our mission to deliver high-quality patient care.

Introduction

Cal. Code Regs. tit. 22 §100402.(b); §100402.(b) (a)(1)

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 the 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.

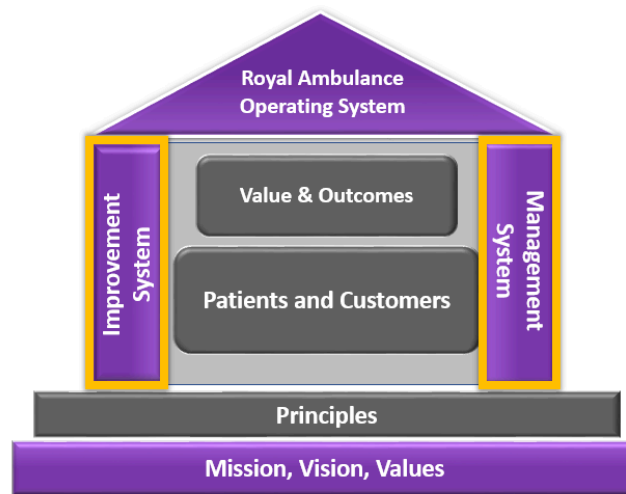
The Royal Ambulance Operating System has two pillars:

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 support improvement activities.



Royal Ambulance Continuous Quality Improvement Plan (2025)



Annual Update:

Cal. Code Regs. tit. 22 §100402(a)(5)

For Calendar Year 2024

Royal Ambulance stabilized its use of TraumaSoft which began in 2023.

Conducted reviews of all BLS calls:

- Resulting in a diversion
- Resulting in a code-3 response/transport
- Resulting in an ALS Upgrade
- Resulting from a first on scene
- Incident Review Boards for all accidents, injuries, and unusual occurrences

Conducted reviews of all CCT calls:

- Involving a code 3 transport/responses
- All acute CVAs
- All acute aortic emergencies
- All Pediatric transports
- All MCS transports
- All Obstetric transports
- Any advanced procedure (Intubation/LMA/Cric/IO/Needle decompression)

Royal transitioned from standing orders to standardized procedures in late 2023. These standardized procedures have enabled Royal CCT crew to provide heightened care to patients.



Royal Ambulance Continuous Quality Improvement Plan (2025)

We focused training on areas of high risk, low frequency skills and implemented several new policies and processes.

- Quarterly training was conducted that emphasized:
 - High risk pediatrics and pediatric ventilator management
 - Trauma training and scene management
 - Airway management (intubation, supraglottic airways, surgical and needle cricothyrotomy)
 - 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.



Royal Ambulance Continuous Quality Improvement Plan (2025)

Next Year's Work Plan - Key Goals for 2025

Cal. Code Regs. tit. 22 §100402.(b); §100402(a)(5)

BLS:

- Continue to review 100% of: Diversion from intended receiving facility, ALS upgrades (“911”), “code 3” responses, and first on scene.
- Provide additional training in new hire academy on documentation and legal protections,
- Incorporate issues discovered during CQI and IRB into the new hire academies and field training.

CCT & ALS:

- Continue the robust and revised CQI program CCT implemented in 2024.
- Focus on using metrics and data obtained from CQI to drive quarterly education and training.
- Develop a larger cadre of “Advanced level” CCT clinicians who are credentialed on additional procedures.
- Integrate elements of our ALS and CCT training together enabling paramedics to receive heightened education.

Organizational Overview

Cal. Code Regs. tit. 22 §100402(b); §100402(a)(1)

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 Quality Improvement Team *Cal. Code Regs. tit. 22 §100402.(b); §100402.(b) (a)(1)* includes, but is not limited to:

- Royal Ambulance Chief Administrative (RN Position)
- Royal Ambulance Medical Director (MD Position)
- Clinical Care Manager (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



Royal Ambulance Continuous Quality Improvement Plan (2025)

- 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.

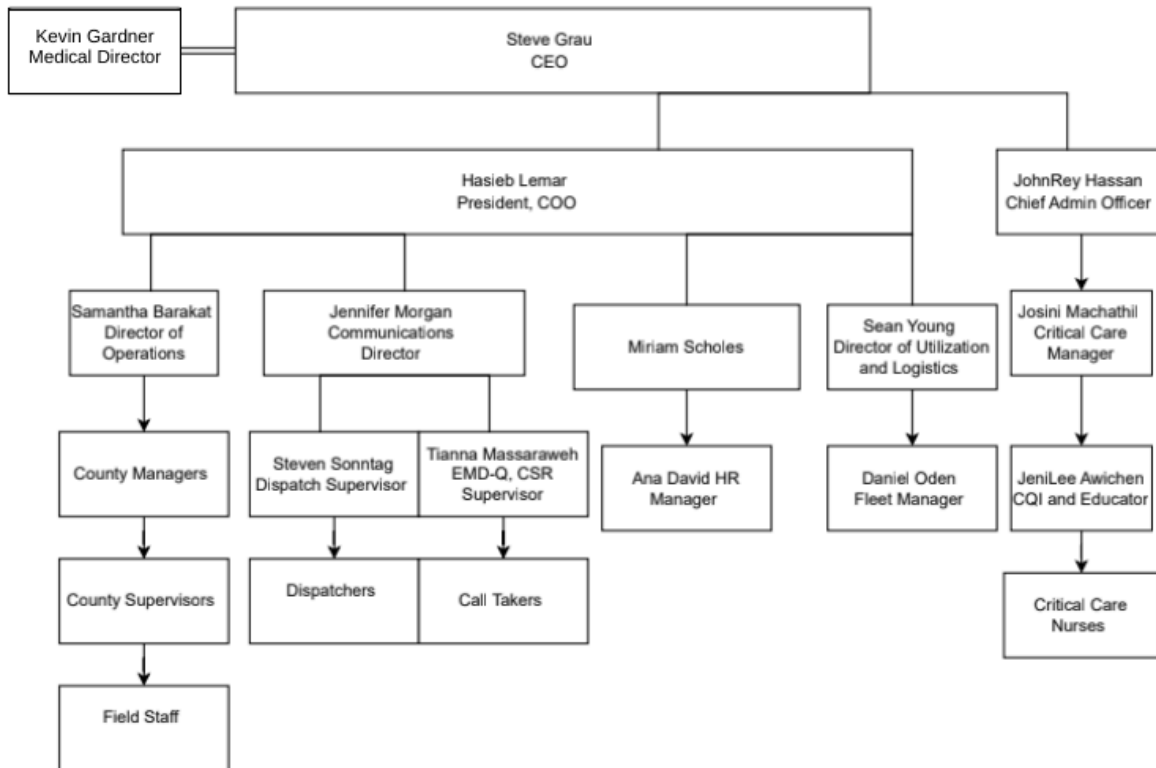
A “Just Culture” creates an organizational learning culture that enables us to see risk at the individual and organizational level, but does not rely on punitive reaction alone to prevent errors. We recognize that people make errors and by creating an environment of openness, employees are encouraged 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



Royal Ambulance Continuous Quality Improvement Plan (2025)





Royal Ambulance Continuous Quality Improvement Plan (2025)

I. Organizational Description - Mission, Vision, and Values

Cal. Code Regs. tit. 22 §100402.(b); §100402.(b) (a)(1)

VISION MISSION & VALUES

OUR VISION

To modernize healthcare transportation by inspiring and empowering a community of thousands of healthcare professionals who will impact 10s of millions of lives.

OUR MISSION

To positively impact the patient's journey, make our customer's jobs easier, and develop healthcare leaders.

OUR VALUES

Driven

Empathetic

Engaging

Adaptable

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:



Royal Ambulance Continuous Quality Improvement Plan (2025)

- Providing timely transport options
- Positively impacting the patient's journey
- Minimizing discomfort
- Reducing disability

II. Data Collection and Reporting

Data collection and reporting are two very important aspects for CQI. Data collected must be valid, reliable and standardized with all collaborating participants. The following information will be monitored, measured and evaluated for improvement. In addition to traditional methods of data collection, a Lean tool known as the Gemba Walk is incorporated. By definition, Gemba Walks are a purposeful “walk” done by leadership to “Go to the actual place, look at the actual process, and talk to the actual people.”

Indicator		Specific Information to be Monitored	Method of Collection	Frequency
Personnel		Education and training requirements compliant with specific operating counties	Provider records (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



Royal Ambulance Continuous Quality Improvement Plan (2025)

Documentation	25% retrospective review of random PCR's	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 predetermined destination or require a diversion	Patients taken to correct destinations based on primary impression and county protocols	TraumaSoft WorkFlow software	Daily
	100% retrospective review of all high risk calls	Review of high risk transports by primary impression ie. Stroke, STEMI, Trauma activations, cardiac arrest, advanced airway management, BLS Code 3 transports, ALS upgrades, application of restraints	TraumaSoft WorkFlow software	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	Airway management, medication administration, 12 lead interpretation, needle	TraumaSoft WorkFlow	Monthly



Royal Ambulance Continuous Quality Improvement Plan (2025)

	competency evaluations	decompression, tourniquet application		
	100% retrospective review	% infrequently used skills per individual clinician	TraumaSoft WorkFlow	Yearly
Transportation /Facilities		Response times per contract requirements	Standardized IT reports, Tableau	Daily
		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



Royal Ambulance Continuous Quality Improvement Plan (2025)

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 CAO, 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



Royal Ambulance Continuous Quality Improvement Plan (2025)

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.

III. **Data Collection, Analysis, and Reporting** EPCR System – TraumaSoft/Image Trend

Cal. Code Regs. tit. 22 §100402.(b); §100402(a)(1)(A-H)

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.



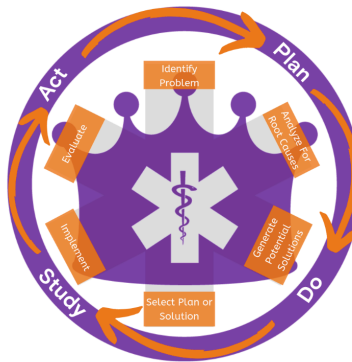
Royal Ambulance Continuous Quality Improvement Plan (2025)

Royal utilizes TraumaSoft to support the production of reports which CQI is based upon.

IV. Evaluations of Indicators - Actions to Improve and Procedures to Identify

*Cal. Code Regs. tit. 22 §100402.(a)(1)
§100402.(b) §48-20.004 (a)(4)*

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?



Royal Ambulance Continuous Quality Improvement Plan (2025)

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

V. Training and Education

§48-20.004 (a)(2) Verification and Audit of Skills - Description of methods utilized to verify and audit infrequent skills.

Upon hire, all Royal field employees are evaluated in both a classroom and field setting to ensure competence in all skills consistent with their scope of practice. Evaluation of skills continues during the FTO process and is documented by the new-hire's FTO. Annually, field employees complete a skills refresher based on their level of training, covering infrequently used skills as required by the LEMSA and Royal internal policies.

New Hire Training - §48-20.004 (a)(2) - New Hire Training - Description of content and delivery methods utilized for new hire training. Methods utilized for field evaluation of new hire staff's patient care. Description of how, how often, and who conducts new hire training.

EMT new-hires complete a robust forty-hour in-person EMS Academy which focuses on ensuring sound clinical practices and customer experience. Content is delivered in person in San



Royal Ambulance Continuous Quality Improvement Plan (2025)

Leandro, CA. New EMTs are then evaluated on their ability to provide patient care and perform in accordance with Royal Ambulance standards through a structured FTO process lasting between 40 -90 hours. Content covered includes a review of all basic and expanded EMT skills, Royal policies, county-specific policies, and extensive customer service training. During this process, the new hire EMT is evaluated daily and receives a structured daily evaluation report. Specific methods of evaluation include written and practical exams.

Training in the academy is conducted by Royal's experienced team of NAEMSE-certified EMS instructors. The average academy instructor has eight years of EMS experience.

New hire CCT-RNs complete a separate forty-hour in-person academy followed by a highly structured 90-120 hour (or more) critical care transport preceptorship. Content covered includes a detailed review of Royal CCT clinical protocols, standardized procedures, invasive skills education and testing, and transport physiology, and specific additional education in complex ventilatory management, high risk pediatrics, and high risk OB. Each shift, the new CCT-RN is evaluated on their ability to manage acutely ill patients in the transport environment and tested on Royal CCT clinical protocols and standardized procedures. The Royal CCT Academy is conducted by an experienced clinical educational team with an average of 14 years of critical care transport-specific experience. Specific methods of evaluation include written and practical exams.

Annually, all EMTs and RNs are required to complete a host of recurrent training courses and comply with all Contra Costa EMS Agency annual training requirements. In the event that a deficiency is identified through the CQI process, the EMT or RN will complete additional structure training in that specific area.

Field Evaluators - Method for selection of evaluators. Description of how and who qualifies to perform evaluations.

Evaluators, or FTOs, are selected based on their experience and ability to deliver educational content and provide evaluation to a diverse group or new hires. All FTOs complete an application process to become FTOs. All FTOs are required to have a minimum of six months of field experience at Royal, to be free of any disciplinary action, and to have the recommendation of their supervisor. New FTO's complete a two-day in-person FTO academy which focuses on effective evaluation methods, delivering feedback, and ensure that FTOs are prepared to fairly and effectively evaluate and mentor new trainees.

Minimum Standards for Field Evaluation - Documentation with definitions of minimum standards for field evaluation. To include time allotment for completion, areas of evaluation, and process for remediation when required.

At a minimum EMTs and RNs must complete forty hours or ninety hours of field training and evaluation, respectively, and receive satisfactory performance evaluations. EMTs and RNs are



Royal Ambulance Continuous Quality Improvement Plan (2025)

evaluated extensively on patient care, adherence to clinical protocols/policies, adherence to Royal standards, customer service, and local area knowledge.

When issues arise with training, EMTs and RNs are afforded the opportunity to remediate where appropriate. Prior to remediation, the trainee meets with their preceptor and an academy coordinator to review areas of concern. The specific time allotted for remediation is dependent on the situation and deficiency identified for the individual training but generally varies from an additional 10 to 50 or more hours.

Ongoing CQI AND PIPs

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.

VI. 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.



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All investigations shall be completed within 7 business days. Waivers may be granted for unusual cases and must be approved by the CAO or President.

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.

VII. 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 2024-2025, specific change indicators include:

Clinical Performance Indicators:

Clinical Performance Indicators	Bedside Time for Stroke Patients
	Pain management for pediatric patients
	Pediatric respiratory distress
Procedure Monitoring	Intraosseous (IO) Infusion Procedure
	12-Lead Electrocardiogram (CCT)
	Intubation and Advanced Airway (CCT)

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

VIII. QI Records Security



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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.

IX. 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.

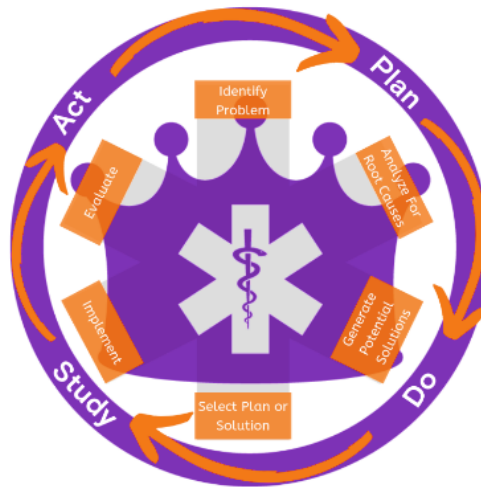
X. Annual Update

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 Update will be provided to all respective departments and employees. The Annual Update will include, but not limited to, the following:

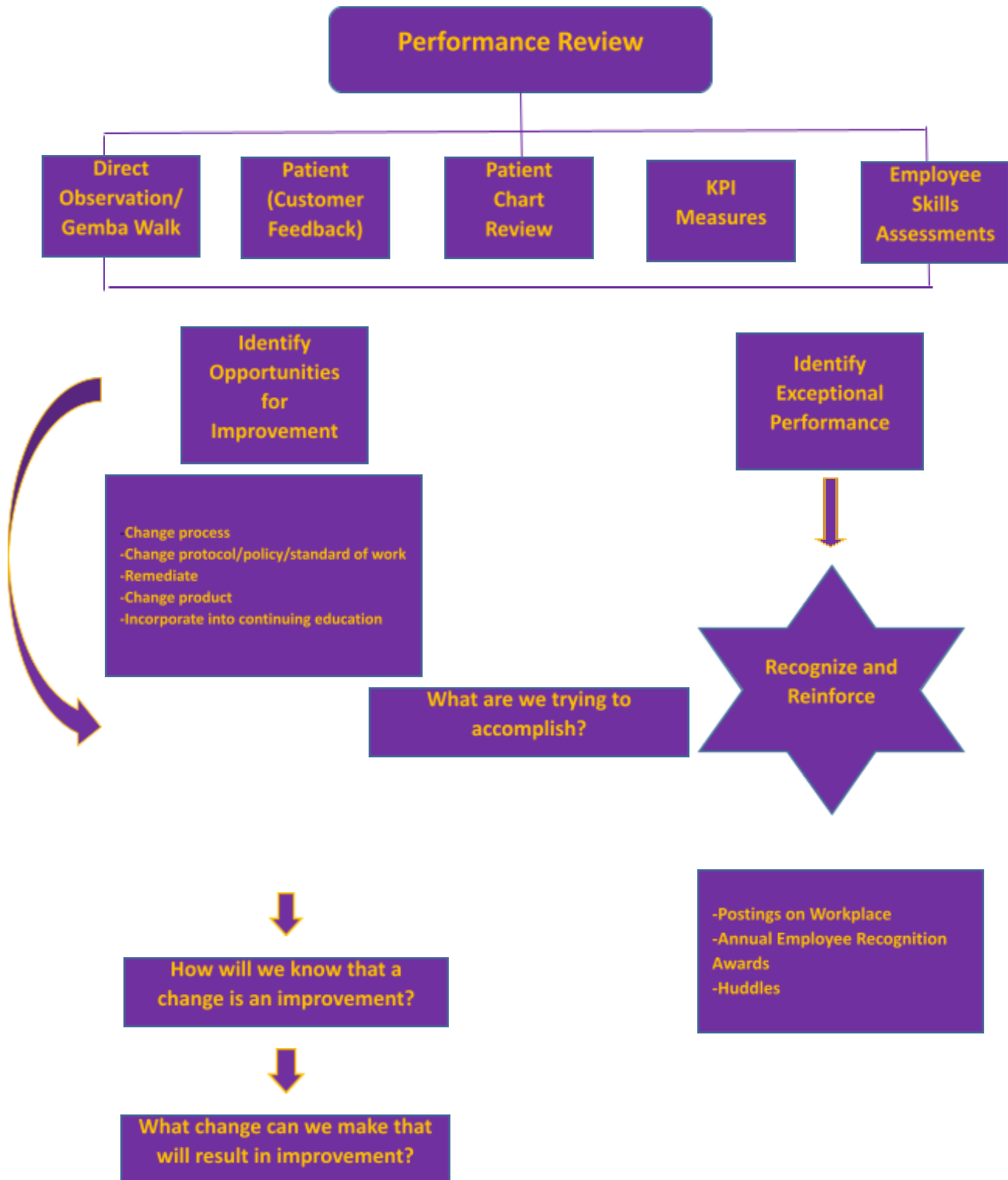
- Quality indicator monitors
- Key findings and priority issues identified

Royal Ambulance Continuous Quality Improvement Plan (2025)

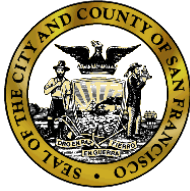
- o Identification of trends
- Improvement action plans and plans for further action
 - o Description of any policy and standard of work revisions
 - o Description of continuing education and skills training provided as a result of Performance Improvement Plans



Royal Ambulance Continuous Quality Improvement Plan (2025)



Appendix A



Daniel Lurie
Mayor

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



Mary Ellen Carroll
Executive Director

Date: July 3, 2025

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Chief Medical Officer, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2025 EMS Plan Annual Update – Agreements

As of the date of this memo, the San Francisco EMS Agency (SFEMSA) has had two changes to agreements or Memorandums of Understanding (MOU) in 2024. All other agreements for specialty programs, hospitals, EMS Providers, Community Paramedicine, and Triage to Alternate Destination provided to the EMS Authority are active, unexpired, and have not changed.

2024 Update:

- A newly MOU was executed between SFEMSA and Kaiser South San Francisco. Kaiser South San Francisco is located within the jurisdiction of San Mateo LEMSA but receives EMS patients from San Francisco EMS Providers including Specialty Care (Stroke).
- In 2024, UCSF acquired St Mary's Medical Center and St Francis Memorial Hospital (formerly Dignity Health). UCSF assumed the agreement between SFEMSA and Dignity Health. A legal document (Acknowledgement of Agreement) between SFEMSA and UCSF was signed.

Copies of both documents are attached.

A handwritten signature in black ink, appearing to read "A. Holcomb".

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

Cc: Dr. Amelia Breyre, EMS Agency Medical Director
Rob Smuts, DEM Deputy Director
Mary Ellen Carroll, DEM Executive Director

**City and County of San Francisco
San Francisco Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St, Suite 210
San Francisco, California 94103**

**Agreement between the City and County of San Francisco,
acting by and through its Department of Emergency Management
and
Kaiser Foundation Hospital-South San Francisco**

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This Memorandum of Understanding (“MOU”) is made October 16, 2024 in the City and County of San Francisco, State of California, by and between Kaiser Foundation Hospitals, a California nonprofit public benefit corporation, (“KFH”) and the City and County of San Francisco, acting by and through its Department of Emergency Management.

Recitals

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

WHEREAS, California Health and Safety Code §§ 1797.204, 1797.220, and 1797.222, authorize and require LEMSAs to plan, implement, and evaluate the EMS system, including destination and transport policies; and

WHEREAS, under California Health and Safety Code, §§ 1797.88, 1798.170 and 1798.172, LEMSAs establish guidelines and standards for transport and transfer of patients to hospitals; and

WHEREAS, Cal. Code Regs. Tit. 22, §§ 100170 and 100169 state that the local EMS Medical Director shall establish and maintain medical control by establishing policies regarding patient destination; and

WHEREAS, Parties wish to make Kaiser Foundation Hospital – South San Francisco (“Receiving Facility”) a recognized and approved receiving facility for ambulances permitted by LEMSAs; and

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

Article 1 Definitions

The following definitions apply to this MOU:

1.1. **“City”** means the City and County of San Francisco, a municipal corporation, acting by and through both its Department of Emergency Management.

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

1.3. **“Hospital”** means an acute care hospital licensed in California with at least a permit for basic emergency service.

1.4. **“Local EMS Agency (LEMSA)”** means the San Francisco EMS Agency having primary responsibility for administration of emergency medical services in the City and County of San Francisco as designated by California Health and Safety Code § 1797.200.

1.5. **“LEMSA Medical Director”** means the San Francisco Director of Health, or his or her designee, responsible for the duties set forth in California Health and Safety Code § 1797.202.

1.6. **“Medical Control”** means the medical direction and management of the EMS system pursuant to California Health and Safety Code § 1798.

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

1.8. **“Receiving Facility”** means Kaiser Foundation Hospital-South San Francisco, a hospital that has been designated to receive EMS patients by the LEMSA and, where appropriate, KFH as the owner and operator of Kaiser Foundation Hospital – South San Francisco.

1.9. **“Specialty Receiving Center”** means an approved Receiving Facility by LEMSA that has been designated by LEMSA to perform specified emergency medical services systems functions pursuant to regulations established by the authority.

Article 2 Term of the MOU

2.1 Initial Term.

The term of this MOU shall commence on October 16, 2024 and expire 5 years later on October 15, 2029, unless earlier terminated as otherwise provided herein.

Article 3 Fees

3.1 Fees.

As authorized by Sections 1798, 1798.2, and 1798.164 of the California Health and Safety Code, fees are due and payable annually in advance to the LEMSA by the following facilities (as defined in Section 901 of the San Francisco Health Code) that receive patients through ambulance service providers.

Receiving Facility fees may be adjusted each year. Annually LEMSA will publish a memorandum updating fees to be paid. Fees may not be applicable to Out of County Receiving Facility.

3.2 Audit

Receiving Facility agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours accurate records, including but not limited to patient care, staffing, operations, training records, and all other records relating to its Specialty Receiving Center services performed under this MOU. Receiving Facility will permit City to audit such books and records related to all matters covered by this MOU.

3.3 MOU Amendments.

3.3.1 **Formal Amendment.** This MOU may be amended only by a formal modification executed and approved in the same manner as the original MOU.

3.3.2 **No-Cost MOU:** This is a no-cost MOU. In no event may the City compensate Receiving Facility under this MOU.

Article 4 Services

4.1 Services

Receiving Facility must provide the general services detailed in: Appendix A (Out of County Receiving Facility Statement of Work)

4.2 Qualified Personnel.

Receiving Facility shall utilize only competent personnel under the supervision of, and in the employment of, Receiving Facility (or Receiving Facility's authorized subcontractors) to perform the Services. Subcontracting.

4.3 Independent Contractor.

For the purposes of this Article 4, "Receiving Facility" shall be deemed to include not only Receiving Facility, but also any agent or employee of Receiving Facility. Receiving Facility acknowledges and agrees that at all times, Receiving Facility or any agent or employee of Receiving Facility shall be deemed at all times to be an independent contractor and is wholly responsible for the manner in which it performs the services and work requested by City under this MOU. Receiving Facility, its agents, and employees will not represent or hold themselves out to be employees of the City at any time. Receiving Facility or any agent or employee of Receiving Facility shall not have employee status with City, nor be entitled to participate in any plans, arrangements, or distributions by City pertaining to or in connection with any retirement, health or other benefits that City may offer its employees. Receiving Facility or any agent or employee of Receiving Facility is liable for the acts and omissions of itself, its employees and its agents. Receiving Facility shall be responsible for all obligations and payments, whether imposed by federal, state or local law, including, but not limited to, FICA, income tax withholdings, unemployment compensation, insurance, and other similar responsibilities related to Receiving Facility's performing services and work, or any agent or employee of Receiving Facility providing same. Nothing in this MOU shall be construed as creating an employment or agency relationship between City and Receiving Facility or any agent or employee of Receiving Facility.

4.4 Assignment.

The Services to be performed by Receiving Facility are personal in character. Neither this MOU, nor any duties or obligations hereunder, may be assigned unless first approved by City by written instrument executed and approved in the same manner as this MOU.

4.5 Activities at Receiving Facility's Expense.

Any act that Receiving Facility performs under this MOU or applicable law shall be performed at Receiving Facility's expense and without cost to City.

4.6 Warranty.

Receiving Facility warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this MOU as detailed in the Appendices.

Article 5 Insurance and Indemnity

5.1 Insurance.

5.1.1 Required Coverages. Receiving Facility must maintain in force, during the full term of the MOU, insurance in the following amounts and coverages:

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

(b) Commercial General Liability Insurance with limits not less than \$5,000,000 each occurrence for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; policy must include Abuse and Molestation coverage, and

(c) Commercial Automobile Liability Insurance with limits not less than \$1,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable; and

(d) Professional liability insurance, applicable to Receiving Facility's profession, with limits not less than \$5,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services and

(e) Technology Errors and Omissions Liability Coverage (Reserved); and

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

(g) Receiving Facility shall be permitted to use umbrella, excess coverage and/or a program of self-insurance to meet the required limits for insurance in this section.

(h) Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to name as additional insured the City and County of San Francisco, its Officers, Agents, and Employees.

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

5.1.2 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal, unless the policy has been replaced with comparable coverage. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

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

5.2 General Indemnification.

Receiving Facility shall indemnify and hold harmless City and its officers, agents and employees from, and, if requested, shall defend them from and against any and all claims, demands, losses, damages, costs, expenses, and liability (legal, contractual, or otherwise), including all claims for breach of federal and/or state law regarding the privacy of health information, electronic records or related topics, including infringement and/or intellectual property claims ("Claims"), arising from Receiving Facility's performance of this MOU, except to the extent that such indemnity is void or otherwise unenforceable under applicable law, and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City, in which case damages shall be apportioned pro rata in proportion to each Party's percentage of fault.

Article 6 Liability of the Parties

6.1 Liability for Incidental and Consequential Damages.

IN NO EVENT EITHER PARTY BE LIABLE, REGARDLESS OF WHETHER ANY CLAIM IS BASED ON CONTRACT OR TORT, FOR ANY SPECIAL, CONSEQUENTIAL, INDIRECT OR INCIDENTAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES PERFORMED IN CONNECTION WITH THIS AGREEMENT

Article 7 Payment of Taxes (RESERVED)

Article 8 Termination and Default

8.1 Termination for Convenience

Either party may terminate this agreement for convenience by giving the other party ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective. Any pre-paid fees are nonrefundable

Article 9 Rights In Deliverables (RESERVED)

Article 10 Additional Requirements Incorporated by Reference

10.1 Alcohol and Drug-Free Workplace.

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

10.2 Nondiscrimination Requirements.

In the performance of this MOU, Receiving Facility agrees that it will not discriminate against any individual because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition (as defined in Section 12926 of the State of California Government Code), marital status, or citizenship because of habit, local custom, or otherwise.

Article 11 General Provisions

11.1 Notices to the Parties.

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

To City:	Andrew Holcomb, MS, EMS Director, San Francisco EMS Agency Department of Emergency Management City and County of San Francisco 333 Valencia St, Suite 210, San Francisco, CA 94103 628-217-6014 andrew.holcomb@sfgov.org
To Receiving Facility:	NICOLE THOMSON AREA FINANCE OFFICER, GOLDEN GATE SERVICE AREA KAISER FOUNDATION HOSPITAL-SAN FRANCISCO

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

11.2 Compliance with Americans with Disabilities Act.

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

11.3 Sunshine Ordinance.

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

11.4 MOU Made in California; Venue.

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

11.5 Construction.

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

11.6 Entire Agreement.

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

11.7 Compliance with Laws.

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

11.8 Severability.

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

11.9 Cooperative Drafting.

This MOU has been drafted through a cooperative effort of City and Contractor, and both Parties have had an opportunity to have the MOU reviewed and revised by legal counsel. No Party shall be considered the drafter of this MOU, and no presumption or rule that an ambiguity shall be construed against the Party drafting the clause shall apply to the interpretation or enforcement of this MOU.

11.10 Third Party Beneficiaries.

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

Article 12 Data and Security

12.1 Protected Health Information.

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

Article 13 Data and Security

13.1 City Data

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

13.1.2 Data Privacy and Information Security Program. Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative,

and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

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

Article 14 MacBride And Signature

14.1 MacBride Principles -Northern Ireland.

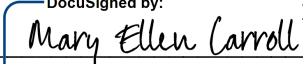
The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this MOU. By signing this MOU, Receiving Facility confirms that Receiving Facility has read and understood that the City urges companies doing business in Northern Ireland to resolve employment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

[SIGNATURES ON NEXT PAGE]

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

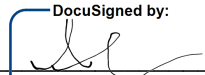
RECOMMENDED

Mary Ellen Carroll,
Executive Director
Department of Emergency Management

DocuSigned by: 10/21/2024

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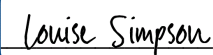
APPROVED

Andrea Tenner, M.D.
Interim Medical Director
San Francisco LEMSA

DocuSigned by: 10/27/2024

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APPROVED AS TO FORM

David Chiu
City Attorney

DocuSigned by: 11/3/2024

BD54168A4C3B452...
Louise S. Simpson
Deputy City Attorney

Receiving Facility

Kaiser Foundation Hospital- South San Francisco

Signed by: 10/16/2024

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SHASTA ADDESSI, MHSA
SENIOR VICE PRESIDENT & AREA
MANAGER
SAN MATEO SERVICE AREA

Appendices

A: Statement of Work– Out of County Receiving Facility

Appendix A – Out of County Receiving Facility

STATEMENT OF WORK

I. Out of County Receiving Hospital And Specialty Designation Approval Process

1. For the purposes of this MOU, San Mateo County LEMSA has jurisdictional oversight of Receiving Facility and Specialty Center designation. San Francisco LEMSA accepts San Mateo LEMSA's designations to the extent that approval is consistent with all applicable laws and regulations. Furthermore, should designations be modified, favorably or unfavorably, San Francisco will accept San Mateo LEMSA's determinations to the extent such determinations are made consistent with all applicable laws and regulations. The MOU describes how an Out of County Receiving Facility will receive patients from San Francisco via emergent or 9-1-1 field activation.

2. All San Francisco LEMSA policies can be found at <https://sf.gov/ems>. No Out of County Receiving Facility shall receive emergent or 9-1-1 patients from a field activation through San Francisco ambulance service providers without first obtaining a Certificate of Participation from the San Francisco LEMSA. Any Out of County Receiving Facility seeking to obtain a Certificate of Participation must:

a. **Application:** Apply to the San Francisco LEMSA, by submitting all necessary information and paying all applicable fees under San Francisco business and Tax Code § 249, and

b. **Inspections:** Allow inspections required by the LEMSA with jurisdictional oversight. For the purposes of this MOU, San Mateo County Local EMS Agency has jurisdictional oversight for inspections.

3. For specialty designation(s), Receiving Facilities must be approved by the LEMSA, with jurisdictional oversight, in compliance with the following to receive emergent and 9-1-1 patients from San Francisco EMS Providers:

a. **Base Hospital** – means a paramedic base hospital designated by the LEMSA to provide medical direction and supervision of paramedic personnel (LEMSA Policy No. 5011; and Cal. Code Regs. Tit. 22, § 100169).

b. **Emergency Medical Services for Children (“Pediatric Receiving Center”)** - means a licensed general acute care hospital with, at a minimum, a permit for standby, basic, or comprehensive emergency services that has been formally designated as one of four types of Pediatric Receiving Centers pursuant to Cal. Code Regs. Tit. 22, §§ 100450.218 - 100450.222, by the LEMSA for its role in an EMS system (LEMSA Policy No. 5012; and Cal. Code Regs. Tit. 22, § 100450.210).

c. **Trauma Receiving Center** - means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the LEMSA (LEMSA Policy Nos. 5013 and 5014; and Cal. Code Regs. Tit. 22, § 100248).

d. **Stroke Receiving Center** - means a hospital that treats stroke patients as designated by the LEMSA in the stroke critical plan (LEMSA Policy No. 5015; and Cal. Code Regs. Tit. 22, § 100270.220)

e. **STEMI/STAR Receiving Center** - means a licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to Section 100270.124 and is able to

perform percutaneous coronary intervention (“PCI”) (LEMSA Policy No. 5016; and Cal. Code Regs. Tit. 22, § 100270.117).

II. General Requirements For All Approved Out of County Receiving Facilities

1. Approved Out of County Receiving Facilities shall perform as follows:

- a. Maintain acute care hospital licensure from the California Department of Public Health (“CDPH”) with a permit from CDPH for basic emergency services or greater.
- b. Provide emergency services on a continuous twenty-four (24) hours per day basis.
- c. Use and maintain telecommunications as specified by San Francisco LEMSAs Policy No. 3010.
- d. Train and ensure competency of hospital staff, who receive EMS patients (e.g., physicians, nurses, and other hospital staff), in LEMSAs policies, procedures and protocols, as specified by LEMSAs Policy No. 5010.
- e. Understand that the LEMSAs may deny, suspend, or revoke the approval of an Out of County Receiving Facility, including any Specialty Designation, for failure to comply with applicable LEMSAs policies, procedures, and regulations.
- f. Provide, in a location easily accessible to employees, a current San Francisco LEMSAs Policy and Procedure Manual and Protocol Manual.

2. Emergency Medical Services (“EMS”) System Committees:

All Out of County Receiving Facilities must participate (attend a minimum of 75% of Committee meetings annually, as determined by the LEMSAs acting in its sole discretion) in the following San Francisco EMS System Committees which will be convened on a periodic basis, but not greater than a six-month interval, by the LEMSAs:

- a. Emergency Medical Services Advisory Committee (“EMSAC”)
- b. Quality Improvement Committee
- c. STAR Committee (Specialty Designations Only)
- d. Stroke Committee (Specialty Designations Only)
- e. Other Committees determined by the LEMSAs

3. Performance Standards – Out of County Receiving Facility Shall:

- a. Comply with all state laws and regulations regarding the provision of EMS.
- b. Comply with all provisions, including fee provisions, of San Francisco Health Code, Articles 3 (Hospitals) and 14 (Ambulances and Routine Medical Transport Vehicles), including any and all amendments thereto, if any, whether enacted before or during the term of this MOU and any extensions.
- c. Comply with all LEMSAs EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d. Comply with the Emergency Medical Treatment and Labor Act (“EMTALA”) (42 U.S.C § 1395dd) and the regulations promulgated thereunder for any receipt or transfer of a patient.

e. Submit STEMI and/or Stroke data to the San Francisco LEMSAspecified data system(s) in a timely manner until such time as a Bidirectional Healthcare Data Exchange network is established by San Francisco LEMSAs and Out of County Receiving Center enabling the same, for the purposes of continuous quality improvement and training to enhance the level of care. Currently, the San Francisco LEMSAspecified data system is American Heart Association Get with the Guidelines. Failure to participate or submit data in the San Francisco LEMSAspecified data system(s) is a material breach of Out of County Receiving Center standards and this MOU and may result in suspension and/or revocation of Out of County Receiving Facility designation.

4. Document Development, Retention, and Release:

a. In compliance with California Health and Safety Code Section 1797.122, Out of County Receiving Facility shall Release patient-identifiable medical information to:

- i. An EMS provider, information regarding a patient who was treated, or transported to the hospital by that EMS provider, to the extent that specific data elements are requested for quality assessment and improvement purposes.
- ii. The LEMSAs, to the extent that specific data elements (including but not limited to patient contacts, turnover reports, and interactions) are requested for quality assessment and improvement purposes.

b. Out of County Receiving Facility shall document all patient contacts, turnover reports, and interactions if patient is received by EMS personnel.

5. Disaster Preparedness

a. Out of County Receiving Facility shall annually participate in a least one system-wide discussion-based exercise and one system-wide functional exercise to facilitate coordination among EMS Receiving Facilities, the EMS system, and LEMSAs, as determined by the LEMSAs Medical Director.

b. Out of County Receiving Facility shall ensure that staff (i) are logged into ReddiNet twenty-four (24) hours per day with an unobstructed screen view; and (ii) respond to drill and real-time events such as Mass Casualty Incident polls within 5 minutes, in accordance with LEMSAs Policy No. 8000. Failure to do so shall result in a material breach, and immediate termination, of this MOU, as determined by San Francisco LEMSAs acting in its sole discretion.

6. Incident Reporting

a. Out of County Receiving Facility shall file (by email exceptionreport@sfgov.org) an Exception Report form (form is located at <https://sf.gov/ems>) consistent with San Francisco LEMSAs Policy No. 6020 within time frame reporting requirements set forth in San Francisco LEMSAs Policy No. 6020.

7. Ambulance Patient Offloads

a. Out of County Receiving Facility shall offload patients in the time interval and standards as listed San Francisco LEMSAs Policy Nos. 4000.1 and 5010. Ambulance patient offload time is defined as the interval between arrival of an ambulance patient at an emergency department and the time that the

patient is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient.

b. Out of County Receiving Facility understands that failure timely to offload patients may result in progressive sanctions to the Out of County Receiving Facility, imposed by the San Francisco LEMSA, acting in its sole discretion, under San Francisco LEMSA Policy No. 5010.

8. Hospital Notification of Exposure

a. Out of County Receiving Facility shall comply with California Health and Safety Code § 1797.188, which requires hospitals to provide timely notification to prehospital emergency medical care personnel who rendered emergency medical or rescue services, or were knowingly or unknowingly exposed, to a patient afflicted with a communicable disease or condition listed as reportable that can be transmitted through physical or oral contact or secretions of the body, including blood.

b. Out of County Receiving Facility shall comply with all time and posting standards in California Health and Safety Code Section § 1797.188 for exposure reporting.

9. Liability for Use of Equipment

a. City shall not be liable for any damage to persons or property as a result of the use of equipment by Out of County Receiving Facility, or by any of their employees, even though such equipment is furnished, rented or loaned by City. This includes utilization of a mechanical CPR device purchased by LEMSA.

**City and County of San Francisco
Office of Contract Administration
Purchasing Division
City Hall, Room 430
1 Dr. Carlton B. Goodlett Place
San Francisco, California 94102-4685**

ACKNOWLEDGEMENT OF AGREEMENT

THIS ACKNOWLEDGEMENT OF AGREEMENT (“***Acknowledgment of Agreement***”) is made as of December 18, 2024, in San Francisco, California, by and between the UCSF Health Community Hospitals, a California nonprofit public benefit corporation (“***UCSF***” or “***UCSF Community Hospitals***”) and the City and County of San Francisco, a municipal corporation (“***City***”).

RECITALS

WHEREAS, effective August 1, 2024 (“***Effective Date***”), UCSF Community Hospitals assumed control of two general acute care hospitals in San Francisco formerly known as St. Mary’s Medical Center (“***St. Mary’s***”) and Saint Francis Memorial Hospital (“***Saint Francis***”), respectively;

WHEREAS, as of the Effective date St. Mary’s became UCSF Health St. Mary’s and Saint Francis became UCSF Health Saint Francis.

WHEREAS, prior to the Effective Date, the City, Dignity Health, a California nonprofit public benefit corporation (“***Dignity Health***”) and Saint Francis Memorial Hospital, a California nonprofit public benefit corporation (“***Saint Francis Hospital Corporation***”), were parties to that certain Receiving Hospital Agreement, dated as of December 1, 2022 (attached hereto) (the “***Agreement***”);

WHEREAS, as of the Effective Date the Saint Francis Hospital Corporation formally changed its name to “UCSF Health Community Hospitals,” but the contracts held by the entity continued in effect unless terminated or transferred to a Dignity Health affiliate;

WHEREAS, UCSF and the City wish to formally acknowledge the Agreement remains in effect as of the Effective Date;

NOW, THEREFORE, in consideration of the promises and the mutual covenants contained in this Acknowledgment of Agreement, and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, City and UCSF Community Hospitals agree as follows:

Article 1 Transfer of Agreement

1.1 **Transfer.** In accordance with the terms and conditions of that certain Assignment and Assumption Agreement, dated July 30, 2024, between Dignity Health and the Saint Francis Corporation (the “***Assignment***”), Dignity Health irrevocably assigned, transferred, and conveyed to the Saint Francis Corporation all of Dignity Health’s rights, title, and interest in and to the Agreement and all of Dignity Health’s duties and obligations thereunder arising on or after the Effective Date.

1.2 **Acknowledgment of UCSF Community Hospitals.** UCSF Community Hospitals acknowledges that it is a party to the Agreement and that it has assumed all of Dignity Health’s duties and obligations arising under the Agreement on or after the Effective Date.

1.3 **Acknowledgment of City.** The City hereby formally acknowledges the Assignment, based on the evidence provided herein, which indicates that the UCSF Community Hospitals shall fully perform all obligations that may and will exist under the Agreement on or after the Effective date, as defined above.

1.4 **Successor.** The City further recognizes the UCSF Community Hospitals as the Dignity Health's successor in interest in and to the Agreement. Accordingly, the UCSF Community Hospitals has assumed all responsibilities and is entitled to all rights, titles, and interests of the Dignity Health in and to the Agreement arising on or after the Effective Date.

[Signature Page Follows]

IN WITNESS WHEREOF, UCSF and City have each duly executed this Acknowledgement of Assignment and Assumption of Agreement as of the date first referenced above.

RECOMMENDED

Mary Ellen Carroll
Executive Director
Department of Emergency Management

By DocuSigned by:
Mary Ellen Carroll 2/13/2025
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RECEIVING HOSPITAL

UCSF Community Hospitals

By DocuSigned by:
James Brennan 1/21/2025
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Chief operating officer, UCSF Health Community Ho
Title _____

LEMSA

City and County of San Francisco

By DocuSigned by:
Andrea Tenner 2/6/2025
8CA74C7C0B654A9...
Andrea Tenner
Interim LEMS Medical Director

Approved as to Form:

David Chiu
City Attorney

By DocuSigned by:
Louise Simpson 2/12/2025
BD54168A4C3B452...
Louise S. Simpson
Deputy City Attorney

Attached:

Exhibit 1: SMMC / SFMH Receiving Facility Agreement

Exhibit 2: Documents of Transfer

EXHIBIT 1

**City and County of San Francisco
San Francisco Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St, Suite 210
San Francisco, California 94103**

**Agreement between the City and County of San Francisco,
acting by and through its Department of Emergency Management
and**

**Saint Francis Memorial Hospital, a California nonprofit public benefit corporation (“SFMH”) and
Dignity Health, a California nonprofit public benefit corporation d/b/a St. Marys’ Medical Center
(“SMMC”)**

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This Memorandum of Understanding (“MOU”) is made on December 1, 2022 in the City and County of San Francisco, State of California, by and between Saint Francis Memorial Hospital, a California nonprofit public benefit corporation (“SFMH”) and Dignity Health, a California nonprofit public benefit corporation d/b/a St. Marys’ Medical Center (“SMMC”) (“Receiving Facility”) and the City and County of San Francisco, acting by and through its Department of Emergency Management.

Recitals

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

WHEREAS, California Health and Safety Code §§ 1797.204, 1797.220, and 1797.222, authorize and require LEMSA to plan, implement, and evaluate the EMS system, including destination and transport policies; and

WHEREAS, Under California Health and Safety Cod, §§ 1797.88, 1798.170 and 1798.172, LEMSA establishes guidelines and standards for transport and transfer of patients to hospitals; and

WHEREAS, Cal. Code Regs. Tit. 22, §§ 100170 and 100169 state that the local EMS Medical Director shall establish and maintain medical control by establishing policies regarding patient destination; and

WHEREAS, Parties wish to make Receiving Facility a recognized and approved receiving facility for ambulances permitted by LEMSA; and

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

Article 1 Definitions

The following definitions apply to this MOU:

1.1. **“Base Hospital”** means a designated Receiving Facility providing online medical direction based on LEMSA Medical Control, policies, and protocols via California Health and Safety Code Section 1798.100 and 1797.58.

1.2. **“City”** means the City and County of San Francisco, a municipal corporation, acting by and through both its Department of Emergency Management.

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

1.4. **“Hospital”** means an acute care hospital licensed in California with at least a permit for basic emergency service.

1.5. **“Local EMS Agency (LEMSA)”** means the San Francisco EMS Agency having primary responsibility for administration of emergency medical services in the City and County of San Francisco as designated by California Health and Safety Code, Division 2.5, Section 1797.200.

1.6. **“LEMSA Medical Director”** means the San Francisco Director of Health, or his or her designee responsible for the duties set forth in California Health and Safety Code, Division 2.5, Section 1797.202.

1.7. **“Medical Control”** means the medical direction and management of the EMS system pursuant to California Health and Safety Code, Division 2.5, Section 1798.

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

1.9. **“Receiving Facility”** means Saint Francis Memorial Hospital, a California nonprofit public benefit corporation (“SFMH”) at 900 Hyde St, San Francisco, CA 94109 and Dignity Health, a California nonprofit public benefit corporation d/b/a St. Marys’ Medical Center (“SMMC”) 450 Stanyan St., San Francisco, CA 94117, a hospital that has been designated to receive EMS patients by the LEMSAs.

1.10. **“Specialty Receiving Center”** means an approved Receiving Facility by LEMSAs that has been designated by LEMSAs to perform specified emergency medical services systems functions pursuant to regulations established by the authority.

Article 2 Term of the MOU

2.1 Initial Term.

The term of this MOU shall commence on December 1, 2022 and expire 5 years later on November 30, 2027, unless earlier terminated as otherwise provided herein.

Article 3 Fees

3.1 Fees.

As authorized by Sections 1798, 1798.2, and 1798.164 of the California Health and Safety Code, fees are due and payable annually in advance to the LEMSAs by the following facilities (as defined in Section 901 of the San Francisco Health Code) that receive patients through ambulance service providers:

- (1) Receiving Hospital;
- (2) STEMI (ST segment elevation myocardial infarction) Center;
- (3) Stroke Center.

Receiving Facility fees may be adjusted each year. Annually LEMSAs will publish a memorandum updating fees to be paid.

3.2 Audit

Receiving Facility agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours accurate records, including but not limited to patient care, staffing, operations, training records, and all other records relating to is Specialty Receiving Center

services performed under this MOU. Receiving Facility will permit City to audit such books and records related to all matters covered by this MOU.

3.3 **MOU Amendments.**

3.3.1 **Formal Amendment.** This MOU may be amended only by a formal modification executed and approved in the same manner as the original MOU.

3.3.2 **No-Cost MOU:** This is a no-cost MOU. In no event may the City compensate Receiving Facility under this MOU.

Article 4 Services

4.1 **Services**

Receiving Facility must provide the general services detailed in:

4.1.1 Appendix A (Receiving Facility Statement of Work)

and may provide the Specialty Designation Center services detailed in:

4.1.2 Appendix C (STEMI Receiving Center Statement of Work);

4.1.3 Appendix D (Stroke Receiving Center Statement of Work);

4.2 **Qualified Personnel.**

Receiving Facility shall utilize only competent personnel under the supervision of, and in the employment of, Receiving Facility (or Receiving Facility's authorized subcontractors) to perform the Services. Subcontracting.

4.3 **Independent Contractor.**

For the purposes of this Article 4, "Receiving Facility" shall be deemed to include not only Receiving Facility, but also any agent or employee of Receiving Facility. Receiving Facility acknowledges and agrees that at all times, Receiving Facility or any agent or employee of Receiving Facility shall be deemed at all times to be an independent contractor and is wholly responsible for the manner in which it performs the services and work requested by City under this MOU. Receiving Facility, its agents, and employees will not represent or hold themselves out to be employees of the City at any time. Receiving Facility or any agent or employee of Receiving Facility shall not have employee status with City, nor be entitled to participate in any plans, arrangements, or distributions by City pertaining to or in connection with any retirement, health or other benefits that City may offer its employees. Receiving Facility or any agent or employee of Receiving Facility is liable for the acts and omissions of itself, its employees and its agents. Receiving Facility shall be responsible for all obligations and payments, whether imposed by federal, state or local law, including, but not limited to, FICA, income tax withholdings, unemployment compensation, insurance, and other similar responsibilities related to Receiving Facility's performing services and work, or any agent or employee of Receiving Facility providing same. Nothing in this MOU shall be construed as creating an employment or agency relationship between City and Receiving Facility or any agent or employee of Receiving Facility.

4.4 **Assignment.**

The Services to be performed by Receiving Facility are personal in character. Neither this MOU, nor any duties or obligations hereunder, may be assigned unless first approved by City by written instrument executed and approved in the same manner as this MOU

4.5 Activities at Receiving Facility's Expense.

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

4.6 Warranty.

Receiving Facility warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this MOU as detailed in the Appendices.

Article 5 Insurance and Indemnity

5.1 Insurance.

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

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

(b) Commercial General Liability Insurance with limits not less than \$5,000,000 each occurrence for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; policy must include Abuse and Molestation coverage, and

(c) Commercial Automobile Liability Insurance with limits not less than \$1,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(d) Professional liability insurance, applicable to Receiving Facility's profession, with limits not less than \$5,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services.

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

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

(g) Receiving Facility shall be permitted to use umbrella, excess coverage and/or a program of self-insurance to meet the required limits for insurance in this section.

(h) Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to name as additional insured the City and County of San Francisco, its Officers, Agents, and Employees.

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

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

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

5.2 General Indemnification.

Receiving Facility shall indemnify and hold harmless City and its officers, agents and employees from, and, if requested, shall defend them from and against any and all claims, demands, losses, damages, costs, expenses, and liability (legal, contractual, or otherwise), including infringement and/or intellectual property claims ("Claims"), arising from Receiving Facility's performance of this MOU, except to the extent that such indemnity is void or otherwise unenforceable under applicable law, and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City and is not contributed to by any act of, or by any omission to perform some duty imposed by law or agreement on Receiving Facility, its subcontractors, or either's agent or employee. Contractor shall also indemnify, defend and hold City harmless from all Claims for breach of federal and/or state law regarding the privacy of health information, electronic records or related topics.

Article 6 Liability of the Parties

6.1 Liability for Incidental and Consequential Damages.

IN NO EVENT EITHER PARTY BE LIABLE, REGARDLESS OF WHETHER ANY CLAIM IS BASED ON CONTRACT OR TORT, FOR ANY SPECIAL, CONSEQUENTIAL, INDIRECT OR INCIDENTAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES PERFORMED IN CONNECTION WITH THIS AGREEMENT

Article 7 Payment of Taxes (RESERVED)

Article 8 Termination and Default

8.1 Termination for Convenience

Either party may terminate this agreement for convenience by giving the other party ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective. Any pre-paid fees are nonrefundable

Article 9 Rights In Deliverables (RESERVED)

Article 10 Additional Requirements Incorporated by Reference

10.1 Alcohol and Drug-Free Workplace.

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

10.2 Nondiscrimination Requirements.

In the performance of this MOU, Receiving Facility agrees that it will not discriminate against any individual because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition (as defined in Section 12926 of the State of California Government Code), marital status, or citizenship because of habit, local custom, or otherwise.

Article 11 General Provisions

11.1 Notices to the Parties.

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

To City:	Andrew Holcomb, MS, EMS Director, San Francisco EMS Agency Department of Emergency Management City and County of San Francisco 333 Valencia St, Suite 210, San Francisco, CA 94103 628-217-6014 andrew.holcomb@sfgov.org
To Receiving Facility:	DARYN J. KUMAR, PRESIDENT AND CEO SAINT FRANCIS MEMORIAL HOSPITAL, A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION ("SFMH") 900 HYDE ST., SAN FRANCISCO, CA 94109 415-353-6000 <u>DARYN.KUMAR@DIGNITYHEALTH.ORG</u> DARYN J. KUMAR, PRESIDENT AND CEO Dignity Health, a California nonprofit public benefit corporation d/b/a St. Marys' Medical Center ("SMMC") 450 Stanyan St., San Francisco, CA 94117 415-668-1000 daryn.kumar@dignityhealth.org

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

11.2 Compliance with Americans with Disabilities Act.

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

11.3 Sunshine Ordinance.

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

11.4 MOU Made in California; Venue.

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

11.5 Construction.

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

11.6 Entire Agreement.

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

11.7 Compliance with Laws.

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

11.8 Severability.

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

11.9 Cooperative Drafting.

This MOU has been drafted through a cooperative effort of City and Contractor, and both Parties have had an opportunity to have the MOU reviewed and revised by legal counsel. No Party shall be considered the drafter of this MOU, and no presumption or rule that an ambiguity shall be construed against the Party drafting the clause shall apply to the interpretation or enforcement of this MOU.

11.10 Third Party Beneficiaries.

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

Article 12 Data and Security

12.1 Protected Health Information.

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

Article 13 Data and Security

13.1 City Data

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

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

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

Article 14 MacBride And Signature

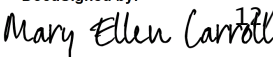
14.1 MacBride Principles -Northern Ireland.

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

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

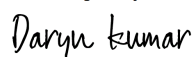
RECOMMENDED

Mary Ellen Carroll
Executive Director
Department of Emergency Management

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Receiving Facility

Saint Francis Memorial Hospital, a California
nonprofit public benefit corporation
("SFMH")

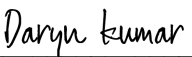
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Daryn J. Kumar
President and CEO

APPROVED

John F. Brown, M.D.
Medical Director
San Francisco LEMSA

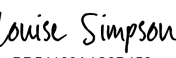
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Dignity Health, a California nonprofit public
benefit corporation d/b/a St. Marys' Medical
Center ("SMMC")

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Daryn J. Kumar
President and CEO

APPROVED AS TO FORM

David Chiu
City Attorney

DocuSigned by:
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Louise S. Simpson
Deputy City Attorney

Appendices

- A: Statement of Work–Receiving Facility
- C: Statement of Work–STEMI Receiving Center
- D: Statement of Work–Stroke Receiving Center

Appendix A – Receiving Facility

STATEMENT OF WORK

I. Receiving Hospital And Specialty Designation Approval Process

1. Pursuant to San Francisco Health Code § 914.5, and LEMSA Policy No. 5010 (all LEMSA policies can be found at <https://sf.gov/emsa>), no Receiving Facility shall receive patients through ambulance service providers without first obtaining a Certificate of Participation from the LEMSA. Any Receiving Facility seeking to obtain a Certificate of Participation must:

a. **Application:** Apply to the LEMSA, by submitting all necessary information and paying all applicable fees under San Francisco business and Tax Code § 249, and

b. **Inspections:** Allow inspections required by the LEMSA.

2. For specialty designation(s), Receiving Facilities must be approved by the LEMSA in compliance with the following:

a. **Base Hospital** – means a paramedic base hospital designated by the LEMSA to provide medical direction and supervision of paramedic personnel (LEMSA Policy No. 5011; and Cal. Code Regs. Tit. 22, § 100169).

b. **Emergency Medical Services for Children (“Pediatric Receiving Center”)** - means a licensed general acute care hospital with, at a minimum, a permit for standby, basic, or comprehensive emergency services that has been formally designated as one of four types of Pediatric Receiving Centers pursuant to Cal. Code Regs. Tit. 22, §§ 100450.218 - 100450.222, by the LEMSA for its role in an EMS system (LEMSA Policy No. 5012; and Cal. Code Regs. Tit. 22, § 100450.210).

c. **Trauma Receiving Center** - means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the LEMSA (LEMSA Policy Nos. 5013 and 5014; and Cal. Code Regs. Tit. 22, § 100248).

d. **Stroke Receiving Center** - means a hospital that treats stroke patients as designated by the LEMSA in the stroke critical plan (LEMSA Policy No. 5015; and Cal. Code Regs. Tit. 22, § 100270.220)

e. **STEMI/STAR Receiving Center** - means a licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to Section 100270.124 and is able to perform percutaneous coronary intervention (“PCI”) (LEMSA Policy No. 5016; and Cal. Code Regs. Tit. 22, § 100270.117).

II. General Requirements For All Approved Receiving Facilities

1. Approved Receiving Facilities shall perform as follows:

a. Maintain acute care hospital licensure from the California Department of Public Health (“CDPH”) with a permit from CDPH for basic emergency services or greater.

b. Provide emergency services on a continuous twenty-four (24) hours per day basis.

c. Use and maintain telecommunications as specified by LEMSA Policy No. 3010.

d. Train and ensure competency of hospital staff, who receive EMS patients (e.g., physicians, nurses, and other hospital staff), in LEMSA policies, procedures and protocols, as specified by LEMSA Policy No. 5010.

e. Understand that the LEMSA may deny, suspend, or revoke the approval of a Receiving Facility, including any Specialty Designation, for failure to comply with applicable LEMSA policies, procedures, and regulations.

f. Provide, in a location easily accessible to employees, a current LEMSA Policy and Procedure Manual and Protocol Manual.

2. Emergency Medical Services (“EMS”) System Committees:

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

- a. Emergency Medical Services Advisory Committee (“EMSAC”)
- b. Quality Improvement Committee
- c. Trauma Committee (Specialty Designations Only)
- d. STAR Committee (Specialty Designations Only)
- e. Stroke Committee (Specialty Designations Only)
- f. EMS for Children (Specialty Designations Only)
- g. Other Committees determined by the LEMSA

3. Performance Standards – Receiving Facility Shall:

- a. Comply with all state laws and regulations regarding the provision of EMS.
- b. Comply with all provisions, including fee provisions, of San Francisco Health Code, Articles 3 (Hospitals) and 14 (Ambulances and Routine Medical Transport Vehicles), including any and all amendments thereto, if any, whether enacted before or during the term of this MOU and any extensions.
- c. Comply with all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.
- d. Comply with the Emergency Medical Treatment and Labor Act (“EMTALA”) (42 U.S.C § 1395dd) and the regulations promulgated thereunder for any receipt or transfer of a patient.

4. Document Development, Retention, and Release:

- a. In compliance with California Health and Safety Code Section 1797.122, Receiving Facility shall Release patient-identifiable medical information to:
 - i. An EMS provider, information regarding a patient who was treated, or transported to the hospital by that EMS provider, to the extent that specific data elements are requested for quality assessment and improvement purposes.

- ii. The LEMSA, to the extent that specific data elements (including but not limited to patient contacts, turnover reports, and interactions) are requested for quality assessment and improvement purposes.

b. Receiving Facility shall document all patient contacts, turnover reports, and interactions if patient is received by EMS personnel. If a patient is transferred between Receiving Facilities or other licensed healthcare facilities by ambulance, the Receiving Facility shall send medical records with the patient.

5. Ambulance Use For Patient Transfers:

a. Receiving Facility shall use only Authorized ALS and BLS Ambulance Services in San Francisco for patient transfers that start within the City and County of San Francisco and end within the City and County of San Francisco. Authorized ALS and BLS Ambulance Services within the City and County of San Francisco are issued a Certificate of Operations by the LEMSA.

b. Receiving Facility shall enter into rapid ambulance transport agreement(s) with permitted ambulance service provider(s) for patient transfers for emergency services that Receiving Facility does not provide or provides on an intermittent basis, only, such as pediatrics, burns, and/or trauma.

c. Receiving Facility shall use the 911-system for patient transfers only if failure to obtain ambulance services would result in a significant chance of patient morbidity or mortality.

d. Receiving Facility shall use ambulance services providing the appropriate level of care for patient transfers in compliance with LEMSA Policy No. 5030.

e. Receiving Facility shall prepare and submit to LEMSA written exception reports on patient receipt and/or transfer incidents involving EMS personnel.

f. Receiving Facility shall provide additional information and reports as requested by LEMSA for quality improvement, including but not limited to reports regarding policy compliance, case reviews, continuing education, and/or others as required by the LEMSA acting in its sole discretion.

6. Disaster Preparedness

a. Receiving Facility shall annually participate in a least one system-wide discussion-based exercise and one system-wide functional exercise to facilitate coordination among EMS Receiving Facilities, the EMS system, and LEMSA, as determined by the LEMSA Medical Director.

b. Receiving Facility shall ensure that staff (i) are logged into ReddiNet twenty-four (24) hours per day with an unobstructed screen view; and (ii) respond to drill and real-time events such as Mass Casualty Incident polls within 5 minutes, in accordance with LEMSA Policy No. 8000. Failure to do so shall result in a material breach, and immediate termination, of this MOU, as determined by LEMSA acting in its sole discretion.

7. Incident Reporting

a. Receiving Facility shall file (by email exceptionreport@sfgov.org) an Exception Report form (form is located at <https://sf.gov/emsa>) consistent with LEMSA Policy No. 6020 within time frame reporting requirements set forth in LEMSA Policy No. 6020.

8. Ambulance Patient Offloads

a. Receiving Facility shall offload patients in the time interval and standards as listed LEMSA Policy Nos. 4000.1 and 5010. Ambulance patient offload time is defined as the interval between arrival of an ambulance patient at an emergency department and the time that the patient is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient.

b. Receiving Facility understands that failure timely to offload patients may result in progressive sanctions to the Receiving Facility, imposed by the LEMSA, acting in its sole discretion, under LEMSA Policy No. 5010.

9. Ambulance Diversion

a. Receiving Facility shall follow LEMSA Policy Nos. 5010 and 5020, as they relate to declaration of ambulance diversion, internal disaster, and/or monthly utilization of ambulance diversion.

b. Receiving Facility understands that failure to minimize ambulance diversion may result in progressive sanctions to the Receiving Facility, imposed by the LEMSA, acting in its sole discretion, under LEMSA Policy No. 5010.

10. Hospital Notification of Exposure

a. Receiving Facility shall comply with California Health and Safety Code § 1797.188, which requires hospitals to provide timely notification to prehospital emergency medical care personnel who rendered emergency medical or rescue services, or were knowingly or unknowingly exposed, to a patient afflicted with a communicable disease or condition listed as reportable that can be transmitted through physical or oral contact or secretions of the body, including blood.

b. Receiving Facility shall comply with all time and posting standards in California Health and Safety Code Section § 1797.188 for exposure reporting.

Appendix C –STEMI Receiving Center

Applicable to Dignity Health, a California nonprofit public benefit corporation d/b/a St. Marys' Medical Center ("SMMC")

STATEMENT OF WORK

I. GENERAL REQUIREMENTS FOR APPROVED STEMI RECEIVING CENTER:

1. Approved STEMI Receiving Center authorized to participate in the LEMSA EMS system shall perform as follows:

- a. Maintain status as a Receiving Facility
- b. Provide STEMI Receiving Center services on a continuous twenty-four (24) hours per day basis to the capability as specified in Cal. Code Regs. Tit. 22, §§ 100270.101 – 100270.127.
- c. Use and maintain telecommunications as specified by LEMSA Policy Nos. 3010 and 3020, including use of field to hospital 12-lead transmission.
- d. Train and ensure competency of hospital staff, who participate in STEMI Receiving Center activities (e.g., physicians, nurses, and other hospital staff), in LEMSA policies, procedures and protocols, as specified by LEMSA Policy No. 5010 and 5016.
- e. Follow all LEMSA policies for implementation, approval, quality improvement, and training for STEMI Receiving Center designation, as specified in Cal. Code Regs. Tit. 22, §§ 100270.101 – 100270.127.
- f. Understand that the LEMSA may deny, suspend, or revoke the approval of a STEMI Receiving Center designation for failure to comply with LEMSA policies, procedures, and regulations.

2. Hospital Obligations

- a. Hospital shall provide all services, equipment, and personnel including maintenance of adequate staffing levels, equipment, and facilities according to STEMI designation criteria as specified in LEMSA policy No. 5016 and Cal. Code Regs. Tit. 22, §§ 100270.101 – 100270.127.
- b. Accept all City and County of San Francisco EMS patients triaged as having a suspected STEMI transported to Receiving Facility designated as a STEMI Receiving Center and provide appropriate medical management for said patients without regard to race, color, national origin, religious affiliation, age, sex, or ability to pay.
- c. STEMI Receiving Center acknowledges that LEMSA does not guarantee STEMI patients will be delivered or diverted to STEMI Receiving Center for care and cannot assure that a minimum number of STEMI patients will be delivered to STEMI Receiving Center during term of this MOU.
- d. STEMI Receiving Center acknowledges that Receiving Facility may be placed on Internal Disaster should critical STEMI equipment or personnel not be available. STEMI Receiving Center also acknowledges that extended periods or reoccurring intervals of Internal Disaster due to lack of consistent STEMI Receiving Center capabilities may lead to suspension and/or termination of STEMI Receiving Center designation.
- e. STEMI Receiving Center shall comply with all LEMSA policies, procedures, and

protocols including, but not limited to, LEMSA Policy No. 5016 [STEMI and ROSC (“STAR”)] Receiving Center Standards. STEMI Receiving Center shall monitor compliance with LEMSA standards for STEMI Receiving Center on a regular and ongoing basis. Documentation of such efforts shall be made available to LEMSA upon request.

f. STEMI Receiving Center shall notify LEMSA, in writing, within 24-hours of any failure to meet LEMSA standards and take corrective actions within a reasonable period of time to correct the failure. Failure to notify LEMSA and/or take corrective actions may result in suspension and/or revocation of STEMI Receiving Center designation.

g. STEMI Receiving Center shall immediately notify LEMSA of any circumstances that will prevent STEMI Receiving Center from providing STEMI services and immediately update its status in the ReddiNet system if unable to provide STEMI services.

h. STEMI Receiving Center shall comply with any LEMSA corrective action plan regarding any identified failure to meet STEMI Receiving Center standards within the timeframes established by LEMSA.

i. STEMI Receiving Center shall maintain a designated telephone number to facilitate rapid access to an on-site physician for consultation with EMS personnel, community physicians, and other providers regarding care and transfer of STEMI patients.

j. Hospital shall actively and cooperatively participate in any committees, such as STAR Committee, as listed in Appendix A (Receiving Facility).

k. STEMI Receiving Center shall submit STEMI data and CARES data to LEMSA specified data system(s) in a timely manner until such time as a Bidirectional Healthcare Data Exchange network is established by LEMSA and STEMI Receiving Center enabling the same, for the purposes of continuous quality improvement and training to enhance the level of care. Currently, the LEMSA specified data system is American Health Association Get with the Guidelines CAD. Failure to participate or submit data in the LEMSA specified data system(s) is a material breach of STEMI Receiving Center standards and may result in suspension and/or revocation of STEMI Receiving Center.

l. STEMI Receiving Center shall, at a minimum, collect and maintain the data specified in Cal. Code Regs. Tit. 22, §§ 100270.101 – 100270.127, unless additional data points are adopted via LEMSA committees.

3. Liability for Use of Equipment

City shall not be liable for any damage to persons or property as a result of the misuse of equipment used by Receiving Facility, or by any of their employees, even though such equipment is furnished, rented or loaned by City. This includes utilization of a mechanical CPR device purchased by LEMSA.

Appendix D – Stroke Receiving Center

STATEMENT OF WORK

I. GENERAL REQUIREMENTS FOR APPROVED STROKE RECEIVING CENTER:

1. Approved Stroke Receiving Center authorized to participate in the LEMSA EMS system shall perform as follows:

- a. Maintain status as a Receiving Facility
- b. Provide Stroke Receiving Center services on a continuous twenty-four (24) hours per day basis to the capability as specified in Cal. Code Regs. Tit. 22, §§ 100270.200 – 100270.229.
- c. Use and maintain telecommunications as specified by LEMSA Policy Nos. 3010 and 3020.
- d. Train and ensure competency of hospital staff, who participate in Stroke Receiving Center activities (e.g., physicians, nurses, and other hospital staff), in LEMSA policies, procedures and protocols, as specified by LEMSA Policy No. 5010 and 5015.
- e. Follow all LEMSA policies for implementation, approval, quality improvement, and training for Stroke Receiving Center designation as specified in Cal. Code Regs. Tit. 22, §§ 100270.200 – 100270.229.
- f. Understand that the LEMSA may deny, suspend, or revoke the approval of a Stroke Receiving Center designation for failure to comply with LEMSA policies, procedures, and regulations.

2. Hospital Obligations

- a. Hospital shall provide all services, equipment, and personnel including maintenance of adequate staffing levels, equipment, and facilities according to Stroke designation criteria which as specified in LEMSA policy No. 5015 and Cal. Code Regs. Tit. 22, §§ 100270.200 – 100270.229.
- b. Accept all City and County San Francisco EMS patients triaged as having a suspected stroke transported to Receiving Facility designated as a Stroke Receiving Center and provide appropriate medical management for said patients without regard to race, color, national origin, religious affiliation, age, sex, or ability to pay.
- c. Stroke Receiving Center acknowledges that LEMSA does not guarantee stroke patients will be delivered or diverted to Stroke Receiving Center for care and cannot assure that a minimum number of stroke patients will be delivered to Stroke Receiving Center during term of this MOU.
- d. Stroke Receiving Center acknowledges that Receiving Facility may be placed on Internal Disaster should critical stroke equipment or personnel not be available. Stroke Receiving Center also acknowledges that extended periods or reoccurring intervals of Internal Disaster due to lack of consistent Stroke Receiving Center capabilities may lead to suspension and/or termination of Stroke Receiving Center designation.
- e. Stroke Receiving Center shall comply with all LEMSA policies, procedures, and protocols including, but not limited to, Policy No. 5015 Stroke Center Standards. Stroke Receiving Center shall monitor compliance with LEMSA standards for Stroke Receiving Center on a regular and ongoing basis. Documentation of such efforts shall be made available to LEMSA

upon request.

f. Stroke Receiving Center shall notify LEMSA, in writing, within 24-hours of any failure to meet LEMSA standards and take corrective actions within a reasonable period of time to correct the failure. Failure to notify LEMSA and/or take corrective actions may result in suspension and/or revocation of Stroke Receiving Center status.

g. Stroke Receiving Center shall immediately notify the LEMSA of any circumstances that will prevent Stroke Receiving Center from providing stroke services and immediately update its status in the ReddiNet system if unable to provide stroke services.

h. Stroke Receiving Center shall comply with any LEMSA corrective action plan regarding any identified failure to meet Stroke Receiving Center standards within the timeframes established by LEMSA.

i. Stroke Receiving Center shall maintain a designated telephone number to facilitate rapid access to an on-site physician for consultation with EMS personnel, community physicians, and other s regarding care and transfer of stroke patients.

j. Hospital shall actively and cooperatively participate in any committees, such as Stroke Committee, as listed in Appendix A.

k. Stroke Receiving Center shall submit stroke data to the LEMSA specified data system(s) in a timely manner until such time as a Bidirectional Healthcare Data Exchange network is established by LEMSA and Stroke Receiving Center enabling the same, for the purposes of continuous quality improvement and training to enhance the level of care. Currently, the LEMSA specified data system is American Health Association Get with the Guidelines Stroke. Failure to participate or submit date in the LEMSA specified data system(s) is a material breach of Stroke Receiving Center standards and may result in suspension and/or revocation of Stroke Receiving Center.

l. Stroke Receiving Center shall, at a minimum, collect and maintain the data specified in Cal. Code Regs. Tit. 22, §§ 100270.200 – 100270.229, unless additional data points are adopted via LEMSA committees.

EXHIBIT 2

SFO CLOSING CERTIFICATE

August 1, 2024

The undersigned, being a duly elected, qualified, authorized and acting officer of UCSF Health Community Hospitals, a California nonprofit public benefit corporation ("UCSF Health Community Hospitals"), of which The Regents of The University of California, a corporation described in Article IX, Section 9, of the Constitution of the State of California, on behalf of The University of California – San Francisco Health, is the sole corporate member ("UCSF Health"), hereby certifies as an officer thereof and not in his personal capacity, pursuant to Section 2.4.1 of that certain Assignment and Assumption Agreement dated July 30, 2024 (the "Assignment") by and between Dignity Health dba St. Mary's Medical Center, a California nonprofit public benefit corporation ("Dignity Health"), Saint Francis Memorial Hospital, a California nonprofit public benefit corporation ("Saint Francis"), and City and County of San Francisco, a municipal corporation, that:

1. Affiliation Agreement dated as of January 31, 2024 (the "Agreement") by and among the UCSF Health, Dignity Community Care, a Colorado nonprofit corporation, Saint Francis Memorial Hospital, a California nonprofit public benefit corporation, Dignity Health, Dignity Health Medical Foundation, a California nonprofit public benefit corporation, for the limited purposes set forth in the Agreement, CommonSpirit Health, a Colorado nonprofit corporation, was properly affected under applicable law in the manner described and represented in the Agreement.
2. UCSF Health is the sole corporate member of UCSF Health Community Hospitals, formerly known as Saint Francis Memorial Hospital, a California nonprofit public benefit corporation, and Assignee under the Assignment, and is able to assume all liabilities and obligations of the Assignee under the Assignment.
3. UCSF Health is the employer of the employees providing services in the clinic described in the Assignment.

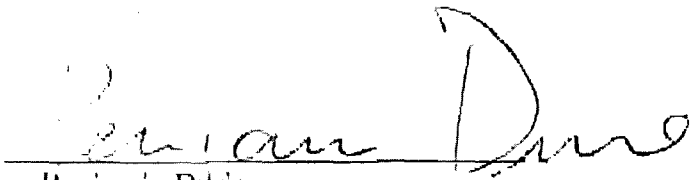
This certificate may be delivered by facsimile transmission or .pdf, and any photocopy, .pdf, facsimile copy, or photocopy of a facsimile copy of this certificate shall be admissible into evidence in any proceeding as though the same were an original.

[Remainder of page intentionally left blank; signature page follows.]

IN WITNESS WHEREOF, the undersigned has signed this Closing Certificate to be effective as of the August 1, 2024.

UCSF:

UCSF HEALTH COMMUNITY HOSPITALS

By: 

Name: Benjamin Durie

Title: Secretary

BILL OF SALE AND ASSIGNMENT AND ASSUMPTION AGREEMENT

THIS BILL OF SALE AND ASSIGNMENT AND ASSUMPTION AGREEMENT (this “Agreement”) is made and entered into as of July 31, 2024, and shall be effective as of 12:00:01 a.m. Pacific Time on August 1, 2024 (the “Effective Time”) by and among (i) Dignity Health, a California nonprofit public benefit corporation and Dignity Health Medical Foundation, a California nonprofit public benefit corporation (collectively, “Assignors”, and each individually, an “Assignor”); and (ii) Saint Francis Memorial Hospital, a California nonprofit public benefit corporation (“Assignee”). Assignors and Assignee may be referred to in this Agreement individually as a “Party” and, collectively, as the “Parties”.

RECITALS:

WHEREAS, Assignors, Assignee, certain affiliates of Assignors and Assignee, and The Regents of The University of California, on behalf of The University of California – San Francisco Health are parties to that certain Affiliation Agreement, dated as of January 31, 2024, (the “Affiliation Agreement”) and to that certain Side Letter Agreement, dated as of July 31, 2024 (the “Side Letter”). Capitalized terms used but not defined herein have the respective meanings for such terms as defined in the Side Letter and Affiliation Agreement; and

WHEREAS, pursuant to the Affiliation Agreement and the Side Letter, Assignors agreed to sell, assign, transfer, convey and deliver all Assignors’ right, title and interest in the Assumed Assets, including the Assumed Contracts, and the Assumed Liabilities but excluding the DHMF Clinic Assets and DHMF Clinic Liabilities (as defined in the Side Letter) to Assignee, and Assignee agreed to accept the same and to assume the Assumed Liabilities.

NOW, THEREFORE, for and in consideration of the above premises, the mutual covenants contained in this Agreement, in the Affiliation Agreement, and in the Side Letter , and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. Sale, Assignment and Assumption. Effective as of the Effective Time, Assignors hereby sell, assign, transfer, convey and deliver to Assignee all of Assignors’ right, title, and interest in and to all of Assumed Assets, including the Assumed Contracts and the Assumed Liabilities but excluding the DHMNF Clinic Assets and DHMF Clinic Liabilities, pursuant to and in accordance with the Affiliation Agreement and the Side Letter. Assignee hereby assumes and accepts assignment of such Assumed Assets, including the Assumed Contracts, and the Assumed Liabilities, pursuant to and in accordance with the Affiliation Agreement.

2. Reference to the Affiliation Agreement. The provisions of this Agreement are subject in all respects to the terms of the Affiliation Agreement and the Side Letter, and all of the representations, warranties, covenants and agreements contained therein shall survive the execution and delivery of Agreement in accordance with the terms thereof. Nothing contained in this Agreement shall be deemed or construed to alter, modify, add to or waive any of the rights, obligations, terms, covenants, conditions, or other provisions contained in the Affiliation Agreement.

3. Closing; Further Actions. The closing of the transactions contemplated hereunder (the “Closing”) shall be deemed to have occurred as of the Effective Time. Each Party will, at its own expense, execute, acknowledge and deliver or cause to be executed, acknowledged and delivered, all such further acts, deeds, assignments, transfers, conveyances, powers of attorney, assurances and such other action as such other Party may reasonably request to more effectively consummate the transactions contemplated by this Agreement.

4. Remedies. The Parties’ remedies with respect to any claim arising from a breach of this Agreement shall be as set forth in the Affiliation Agreement.

5. Governing Law. This Agreement shall be governed by and construed in accordance with the applicable Legal Requirements of the State of California without giving effect to any choice or conflicts of law provision or rule thereof that would result in the application of the applicable Legal Requirements of any other jurisdiction other than the applicable Legal Requirements of the United States of America, where applicable. To the full extent permitted by applicable Legal Requirements, the Parties hereby waive any and all right to a trial by jury on the issue to enforce any term or condition of this Agreement.

6. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. The facsimile signature of any Party to this Agreement or a PDF copy of the signature of any Party delivered by electronic mail for purposes of execution or otherwise, is to be considered to have the same binding effect as the delivery of an original signature on an original contract.

7. Amendment; Waiver. No amendment of any provision of this Agreement shall be valid unless the same shall be in writing and signed by the Parties. No waiver by any Party of any provision of this Agreement or any default or breach of covenant hereunder, whether intentional or not, shall be valid unless the same shall be in writing and signed by the Party against whom the waiver is to be effective nor shall such waiver be deemed to extend to any prior or subsequent default or breach of covenant hereunder or affect in any way any rights arising by virtue of any prior or subsequent such occurrence.

8. No Third Party Beneficiary. The terms and provisions of this Agreement are intended for the sole and exclusive benefit of the Parties hereto and their respective and permitted successors and assigns, and it is not the intention of the Parties to confer, and this Agreement shall not confer, third party beneficiary rights upon any other person or entity.

9. Binding Agreement. This Agreement shall be binding upon, and shall inure to the benefit of, the Parties hereto and their respective successors and assigns.

10. Severability; Invalid Provisions. If any provision of this Agreement is held to be illegal, invalid or unenforceable under any present or future Legal Requirements, and if the rights or obligations of Assignors or Assignee under this Agreement will not be materially and adversely affected thereby, (a) such provision will be fully severable, (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part hereof, (c) the remaining provisions of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance here from and

(d) in lieu of such illegal, invalid or unenforceable provision, there will be added automatically as a part of this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

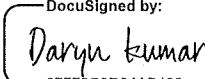
11. Conflicts. This Agreement is made pursuant to the Side Letter and to the Affiliation Agreement and is subject to the terms and conditions thereof. If any conflict exists between this Agreement and the Side Letter or the Affiliation Agreement, this Agreement shall control solely with respect to the subject matter intended to be covered by this Agreement.

[Remainder of this page is intentionally left blank. Signatures follow on next page.]

IN WITNESS WHEREOF, Assignee has caused this Bill of Sale and Assignment and Assumption Agreement to be effective as of the Effective Time.

ASSIGNEE:

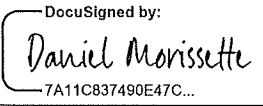
SAINT FRANCIS MEMORIAL HOSPITAL

DocuSigned by:

By: 07778C9D94AB493...
Name: Daryn Kumar
Title: President

IN WITNESS WHEREOF, Assignors have caused this Bill of Sale and Assignment and Assumption Agreement to be effective as of the Effective Time.

ASSIGNORS:

DIGNITY HEALTH

DocuSigned by:

By: 7A11C837490E47C...
Name: Daniel Morissette
Title: Senior Executive Vice President,
CommonSpirit Health

DIGNITY HEALTH MEDICAL FOUNDATION

By: _____
Name: Robert Quinn, M.D.
Title: President

IN WITNESS WHEREOF, Assignors have caused this Bill of Sale and Assignment and Assumption Agreement to be effective as of the Effective Time.

ASSIGNORS:

DIGNITY HEALTH

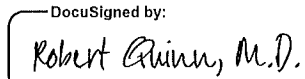
By: _____

Name: Daniel Morissette

Title: Senior Executive Vice President,
CommonSpirit Health

DIGNITY HEALTH MEDICAL FOUNDATION

DocuSigned by:

Robert Quinn, M.D.

By: _____
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Name: Robert Quinn, M.D.

Title: President

**DIGNITY HEALTH
WRITTEN CONSENT OF THE BOARD OF DIRECTORS**

November 6, 2023

(Approving Proposed Transaction with University of San Francisco Health with respect to St. Mary's Medical Center and Saint Francis Memorial Hospital)

The undersigned, constituting all of the members of the board of directors (the "Board") of Dignity Health, a California public benefit nonprofit corporation ("Dignity Health"), do hereby consent to the adoption of, and do hereby adopt, the following resolutions and declare them to be in full force and effect as if they were adopted at a meeting of the Board duly called, noticed and held, and by executing this written consent do hereby waive any requirement to receive written notice of a meeting:

WHEREAS, CommonSpirit Health, a Colorado nonprofit corporation ("CommonSpirit"), is the sole member of Dignity Health, which operates Saint Mary's Medical Center as one of its operating divisions;

WHEREAS, Dignity Community Care, a Colorado nonprofit corporation ("DCC"), is the sole member of (a) Saint Francis Memorial Hospital, a California nonprofit public benefit corporation ("Saint Francis"), and (b) Dignity Health Medical Foundation, a California nonprofit public benefit corporation ("DHMF");

WHEREAS, Dignity Health, DCC, DHMF, and Saint Francis are considering entering into a proposed transaction with the University of California—San Francisco Health ("UCSF Health") so that UCSF Health or one of its affiliates would become the sole member of Saint Francis upon DCC's resignation as the sole member of Saint Francis upon the closing of such transaction;

WHEREAS, Dignity Health, DCC, DHMF, and Saint Francis are intending a transaction structure in which Saint Francis would receive and accept certain assets used in the operation of Saint Mary's Medical Center from Dignity Health and certain assets used in the operation of the related clinics from DHMF, and Saint Francis would, effective upon the closing of the transaction, amend its articles and bylaws to, among other matters, address the resignation by DCC as the sole member of Saint Francis and the succession by UCSF Health or one of its affiliates as the sole member of Saint Francis (the "Proposed Transaction");

WHEREAS, the Proposed Transaction would be effectuated pursuant to and in accordance with a Transaction Agreement to be entered into by and among Dignity Health, DCC, DHMF, Saint Francis, UCSF Health, and, for the limited purposes set forth therein, CommonSpirit (the "Transaction Agreement"); and

WHEREAS, based on information currently available to the Board, the Board finds the Proposed Transaction to be in the best interests of Dignity Health and, therefore, the Board desires to (a) authorize and approve the Transaction Agreement, (b) authorize and approve the consummation of the Proposed Transaction all substantially in accordance with the Summary of Terms and Conditions of the Proposed Transaction attached hereto as Exhibit A and made a part of these resolutions (the "Transaction Summary"), and (c) recommend that CommonSpirit, in its capacity as the sole member of Dignity Health, authorize and approve DHMF's entry into the Transaction Agreement and consummation of the Proposed Transaction, all substantially in accordance with the Transaction Summary and pursuant to and in accordance with the CommonSpirit Governance Matrix.

NOW, THEREFORE, IT IS RESOLVED, that the Board hereby approves Dignity Health entering into the Transaction Agreement and approves the consummation of the Proposed Transaction, all substantially in accordance with the terms of the Transaction Summary;

FURTHER RESOLVED, that the Board hereby recommends that CommonSpirit, in its capacity as the sole member of DignityHealth, authorize and approve Dignity Health's entry into the Transaction Agreement and consummation of the Proposed Transaction, all substantially in accordance with the Transaction Summary and pursuant to and in accordance with the CommonSpirit Governance Matrix;

FURTHER RESOLVED, that each of the President of Dignity Health, the Secretary of Dignity Health, the Chief Executive Officer, Chief Financial Officer, President and Chief Operating Officer, any Senior Executive Vice President, or Executive Vice President of CommonSpirit, or any other officer of CommonSpirit or Dignity Health who is designated by the Chief Executive Officer of CommonSpirit (each, an "Authorized Officer") are authorized to execute and deliver, for and on behalf of Dignity Health, the Transaction Agreement, any agreement or document contemplated thereby, and any amendments thereto in such form and with such changes as such Authorized Officer deems necessary or advisable and shall approve in order to consummate the Proposed Transaction, the execution thereof by such Authorized Officer to be conclusive evidence of such approval, and for and on behalf of Dignity Health, to do all such other acts and to execute and deliver all such other agreements, documents, certificates, and instruments that such Authorized Officer deems necessary or advisable to carry out the Proposed Transaction and to comply with the provisions of these resolutions, the Transaction Agreement, and any other agreements, documents, and transactions described therein or contemplated thereby, the execution thereof by such Authorized Officer to be conclusive evidence of such approval; and

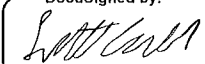
FURTHER RESOLVED, that any prior actions taken reasonably and in good faith by the officers and/or directors of Dignity Health and CommonSpirit in this regard are hereby ratified and approved; and

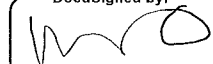
FURTHER RESOLVED, that this consent may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which shall constitute one instrument, notwithstanding that all persons are not signatories to the same counterpart. This consent may be delivered by facsimile or electronic transmission. This consent shall be considered to have been executed by a person if there exists a photocopy, facsimile copy or electronic copy of an original hereof or of a counterpart hereof that has been signed by such person. Any photocopy, facsimile copy or electronic copy of this consent or a counterpart hereof shall be admissible into evidence in any proceeding as though the same were an original.

[Remainder of this page intentionally blank.]

The undersigned, constituting all of the members of the Board of Dignity Health, do hereby approve and adopt the foregoing actions and resolutions, in lieu of holding a meeting of the Board of Dignity Health, effective as of the date first above written.

BOARD OF DIRECTORS:

DocuSigned by:

C394CC6271CC456...
Scott Carswell

DocuSigned by:

5261F4BEBC95471...
Michelle Johnson-Tidjani

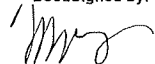
DocuSigned by:

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Mitch Meli

Exhibit A

SUMMARY OF TERMS AND CONDITIONS

Summary of the terms and conditions of the Transaction Agreement (the “**Transaction Agreement**”) by and among Saint Francis Memorial Hospital, a California nonprofit public benefit corporation (“**Saint Francis**”), Dignity Health, a California nonprofit public benefit corporation (“**Dignity Health**”), Dignity Community Care, a California nonprofit public benefit corporation (“**DCC**”), Dignity Health Medical Foundation, a California nonprofit public benefit corporation (“**DHMF**”), The Regents of the University of California, a corporation described in Article IX, Section 9 of the Constitution of the State of California, on behalf of the University of California—San Francisco Health (“**UCSF**”), and for the limited purposes set forth in the Transaction Agreement, CommonSpirit Health, a Colorado nonprofit corporation (“**CommonSpirit**”). Saint Francis, Dignity Health, DCC, DHMF, and UCSF are referred to herein collectively as the “**Parties**” and each individually as a “**Party**”.

Timing of the Contemplated Transaction:	The projected closing of the Proposed Transaction (the “ Closing ”) is the first quarter of 2024 (the “ Closing Date ”). The Closing will be effective as of 11:59 p.m. on the Closing Date (the “ Effective Time ”).
Structure of Contemplated Transaction:	The Proposed Transaction will be effectuated through a series of steps that will occur in a simultaneous time frame as set forth in the Transaction Agreement: 1. Dignity Health, as the owner of St. Mary’s Medical Center located at 450 Stanyan St., San Francisco, CA (“SMMC”), will transfer certain assets used in the operation of SMMC to Saint Francis. 2. DHMF, as the owner of the following clinics will transfer certain assets used in the operation of those clinics to Saint Francis: (a) 1199 Bush St, #400, San Francisco, CA 94109; (b) 1 Shrader St., Suite 650, San Francisco, CA 94117; and (c) 2250 Hayes St., Suite 302, San Francisco, CA 94117 (collectively, the “Clinics”). 3. Pursuant to amendments to the articles of incorporation and bylaws of Saint Francis, DCC will resign as the sole member of Saint Francis and UCSF or one of its affiliates will become the sole member of Saint Francis. Each current member of the Saint Francis board of directors will resign from the board effective as of the Effective Time. 4. As a result of the Closing, Saint Francis, with UCSF or one of its affiliates as its sole member, will own and operate SMMC and Saint Francis Memorial Hospital located at 900 Hyde St., San Francisco, CA (“SFMH” and together with SMMC, the “Hospitals”) and the Clinics.
Purchase Price:	The consideration for the Proposed Transaction is \$97,000,000, which is subject to an adjustment for certain net working capital assets and liabilities (the “ Closing Net Working Capital Adjustment Amount ”), which is currently estimated to result in a reduction such that the net consideration is anticipated to be approximately \$45,000,000. This amount would be used in order to partially pay down Dignity Health’s, DCC’s, and Saint Francis’ significant loans from

	CommonSpirit over the last several years when funds were needed to support the missions of the Hospitals.
Payment of Purchase Price:	It is currently anticipated that fifty percent (50%) of the net Purchase Price will be paid in cash at the Closing by UCSF and the balance would be paid under terms that have not yet been finalized.
Assumed Assets:	The Assumed Assets to be transferred by Dignity Health relating to the operations of SMMC and the assets to be transferred by DHMF relating to the operations of the Clinics, include the following assets used in the operation of SMMC or the Clinics, as applicable: Owned Real Property, leases, inventory and supplies, prepaid expenses, payor agreements (to the extent assignable), governmental authorizations and healthcare permits (to the extent assignable), governmental provider agreements, equipment, furniture, and fixtures, contracts, employee records, certain IT systems, accreditation records, medical records and patient files, restricted gifts held by St. Mary's Medical Foundation, specific intellectual property, and other assets that are reflected as Assumed Assets in the calculation of the Closing Net Working Capital Adjustment Amount (defined below).
Excluded Assets:	The following assets would be retained by Dignity Health, DHMF, or their affiliates (collectively, the " Excluded Assets "): cash, cash equivalents, accounts receivables, system contracts, insurance policies, benefit plans, taxes, Dignity Health's and DHMF's corporate records, any Catholic and religious artifacts and symbols, rights to refunds of taxes prior to the Closing Date, cost report settlements, unrestricted gifts held by St. Mary's Medical Foundation, three parcels of land located on Hayes St., and other assets set forth in the Transaction Agreement.
Assumed Liabilities / Excluded Liabilities:	As of the Effective Time, Saint Francis will assume only the following liabilities: (a) post-Effective Time contractual obligations for the Assumed Contracts; (b) post-Effective Time liabilities and obligations for taxes; (c) ownership or operation of the SMMC, the Clinics, and the Assumed Assets arising after the Effective Time; (d) all liabilities and obligations related to the Restricted Gifts; (e) all Seismic Liabilities (as defined below); (f) amounts in excess of the amount attributed to asbestos remediation as set forth in the calculation of the Closing Net Working Capital Adjustment Amount; (g) all liabilities and obligations for Collective Bargaining Agreements applicable to SMMC and DHMF; and (h) the other liabilities included in the calculation of the Closing Net Working Capital Adjustment Amount (collectively, the "Assumed Liabilities"). Except for the Assumed Liabilities, Saint Francis will not assume, and Dignity Health and DHMF, as applicable, will remain responsible for, any and all other liabilities of Dignity Health and DHMF relating to their respective operations of SMMC, the Clinics, and the Assumed Assets prior to the Effective Time (collectively, the "Excluded Liabilities").
Seismic Liabilities:	From and after the Effective Time, UCSF shall be responsible for the seismic compliance for the Hospitals consistent with applicable law (the " Seismic Liabilities ").

Representations and Warranties of the Parties and CommonSpirit	The Transaction Agreement contains representations and warranties of the Parties that are standard and appropriate for a transaction of the size, nature and structure of the Proposed Transaction. The representations and warranties of Saint Francis and Dignity Health and Saint Francis as it relates to the Assumed Assets include the following: (a) organization and good standing; (b) authority and non-contravention; (c) binding agreement; (d) legal and regulatory compliance, (d) financial statements, (e) significant changes; (f) licenses and permits, (g) transaction affiliates and joint ventures, (h) Medicare participation/accreditation, (i) real property; (j) employee benefit plans; (k) litigation; (l) environmental laws; (m) taxes; (n) employee relations; (o) agreements and commitments; (p) insurance; (q) third-party payor cost reports; (r) medical staff matters; (s) intellectual property; systems; and privacy; (t) experimental procedures; (u) experimental procedures and research; (v) compliance program and related matters; (w) endowments and funds; (x) tax-exempt and public charity status; (y) no outstanding rights; (z) brokers and finders; (aa) personal property; (bb) inventory; (cc) debt; and (dd) sufficiency of assets. The representations and warranties of UCSF include the following: (a) organization and good standing; (b) authority and non-contravention; (c) binding agreement and (d) brokers and finders. The representations and warranties of CommonSpirit include the following: (a) organization and good standing; (b) authority and non-contravention; (c) binding agreement; and (d) debt.
Indemnification:	Dignity Health and DCC, jointly and severally, will indemnify, defend and hold UCSF, its affiliates and its and their respective affiliates, directors, officers, employees, agents, and other representatives from and against any and all losses incurred by UCSF as a result of (a) any breach of the representations and warranties of Dignity Health, DCC, and DHMF contained in the Transaction Agreement, (b) any breach of any covenants or other agreements of Dignity Health, DCC, and DHMF contained in the Transaction Agreement, (c) any Fraud of Dignity Health, DCC, and DHMF or their respective directors, trustees, officers, employees, agents, or other representatives, (d) the Excluded Liabilities, or (e) any liability in connection with the operation of Saint Francis that arises from or is related to matters that occurred prior to the Effective Time (other than Asbestos Liabilities and the liabilities included in the calculation of the Closing Net Working Capital Adjustment Amount. UCSF will indemnify, defend and hold Dignity Health, DCC, DHMF, their respective affiliates, and its and their respective directors, trustees, officers, employees, agents, and other representatives harmless from and against any liabilities incurred as a result of (a) any breach by UCSF of its representations and warranties contained in the Transaction Agreement, (b) any breach of any covenants or other agreements of UCSF contained in the Transaction Agreement or any Transaction Document, (c) any Fraud of UCSF or its directors, trustees, officers, employees, agents, or other representatives, (d) the Assumed Liabilities, (e) the Seismic Liabilities, (f) the Specified Current Liabilities, (g) any breach or violation of the restricted gifts transferred by St. Mary's Medical Foundation to

	Saint Francis; or (h) any liability in connection with the operation of Saint Francis occurring after the Effective Time.
Limitations on Indemnity:	<u>Threshold</u>: No claim for indemnity is payable until losses exceed \$500,000 (the “Threshold”), at which point the indemnity is payable for all losses back to dollar one; provided, however, that the Threshold does not apply to Fundamental Representations or Excluded Liabilities. <u>Representations Cap</u>: Dignity Health and DCC’s aggregate cap on liability in respect of indemnity claims for breaches of non-Fundamental Representations is \$12,000,000 (the “Representation Cap”). <u>Indemnity Cap</u>: Dignity Health and DCC’s aggregate cap on liability in respect of other indemnity claims (other than Fundamental Representations, Excluded Liabilities, and the pre-Closing liabilities and obligations of Saint Francis) is \$97,000,000. The “Fundamental Representations” are (a) organization and good standing, (b) authority, non-contravention; binding agreement, (c) binding agreement, (d) tax-exempt and public charity status, and (e) brokers and finders.
Guaranty:	In addition to other limited sections of the Transaction Agreement for which it is a party, CommonSpirit is a party to the Transaction Agreement to unconditionally guarantee the prompt and faithful performance by Dignity Health and DCC of their indemnification obligations in the Transaction Agreement if, after completing the dispute resolution procedures in the Transaction Agreement, Dignity Health and DCC do not pay on an indemnification claim.
Conditions to Closing:	Subject to each Party satisfying or waiving conditions listed in the Transaction Agreement, the Closing will take place as soon as practicable after all required regulatory and other approvals for the Proposed Transaction have been obtained. The closing conditions are set forth in the Transaction Agreement and include the following: • The accuracy of the representations and warranties of the Parties contained in the Transaction Agreement as of the date thereof and as of the Closing Date; • The performance by the Parties of all their respective covenants, obligations and agreements contained in the Transaction Agreement to be performed at or prior to the Closing, including delivery of all closing documents; • Absence of any Material Adverse Effect (as defined in the Transaction Agreement); • Receipt of certain approvals, including, without limitation, consents and approvals required by third parties to material contracts, governmental authorities and, with respect to the alienation of any stable patrimony, approval by the Roman Catholic Church; • No proceeding shall have been commenced that would challenge or prevent the Proposed Transaction, or seeks to restrain or prohibit the consummation of the Proposed Transaction; • Saint Francis shall have been withdrawn as an obligated group member from

	the CommonSpirit Master Trust Indenture; • Certain closing documents shall have been delivered by the Parties or their respective affiliates, including the Transition Services Agreement; • The medical staffs of the Hospital shall have voted to approve a set of combined medical staff bylaws to be effective as of the Effective Time.
Post-Closing Transition Services:	Pursuant to a to-be negotiated Transition Services Agreement, CommonSpirit or Dignity Health will provide certain transition services, including IT and corporate services, to UCSF (and Saint Francis with UCSF or one of its affiliates as its sole member) for a period of time following the Effective Time.
Post-Closing Commitments:	<u>Employees:</u> In general, UCSF has agreed to commit to (a) retain substantially all employees of SMMC and Saint Francis, (b) no layoffs or reduction in force for a period of six (6) months following the Effective Time, and (c) comply with all applicable collective bargaining agreements. <u>Hospital and Service Commitments:</u> UCSF has agreed to the following post-Closing commitments: • Continuing to operate the Hospitals as acute care hospitals for no less than a five (5) year period of time following the Effective Time. • For an indefinite period of time, but in all events no less than a five (5) year period of time following the Effective Time, UCSF will continue to operate the following programs and services at substantially equivalent or greater levels to those operated immediately prior to the Effective Time: the burn unit, adolescent behavioral health; services to support transgender communities (including the Saint Francis Memorial Hospital Gender Institute); and graduate medical education programs. • To the extent applicable, continuing to comply with the conditions imposed on the Hospitals by the California Attorney General in connection with the Ministry Alignment Agreement by and between Dignity Health and Catholic Health Initiatives, while those conditions remain in effect and with the understanding that such conditions may be modified in the future. • Notwithstanding its specific commitments, UCSF shall retain post-Closing flexibility consistent with UCSF's then-current strategic and programmatic initiatives and operations in the region, to restructure or relocate programs of the Hospitals, services or facilities, to facilitate repairs, improvements, and construction, including, for example, conducting seismic abatement and remediation projects, improving patient access, or responding to evolving applicable legal or regulatory mandates. <u>Community Advisory Group:</u> UCSF plans to invite representatives from the Hospitals' community, including members of the Saint Francis board of directors, to participate in UCSF's Community Advisory Group. UCSF's Community Advisory Group is an existing community advisory body and sounding board for UCSF's administration that assists UCSF in strengthening communication with and engagement of the public on broader issues of community concern and

	provides essential and relevant feedback on programs, campus planning and development activities. <u>Medical Staff</u>: UCSF anticipates that Saint Francis (with both Hospitals) will retain a medical staff that is distinct from the existing UCSF medical staff infrastructure for UCSF Medical Center. Physicians from both Hospitals will be an important part of local governance quality oversight.

Certificate Of Completion

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Document Pages: 9

Certificate Pages: 3

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Time Zone: (UTC-08:00) Pacific Time (US & Canada)

Signatures: 3

Initials: 0

Status: Completed

Envelope Originator:

Laurie Schwartz

185 Berry Street, Suite 300

San Francisco, CA 94107

laurie.schwartz@commonspirit.org

IP Address: 162.135.0.69

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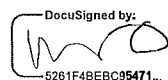
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Location: DocuSign

Signer Events

Michelle Johnson-Tidjani

michelle.johnson-tidjani@commonspirit.org

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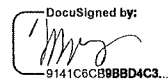
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Mitch Melfi

Mitch.Melfi@commonspirit.org

CLO, CSH and Chairperson, DHHC Board

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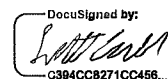
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Scott Carswell

scott.carswell@commonspirit.org

SVP Market Strategy and Development

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Payment Events	Status	Timestamps
Electronic Record and Signature Disclosure		

Consent to Electronic Signatures and Communications

This consent form is provided by CommonSpirit Health. By indicating your consent below, you agree to the following terms, as regards your transactions with CommonSpirit Health and its subsidiaries and affiliates.

Electronic Signatures

You agree that any electronic signatures you provide, including the one on this document, are legally binding signatures with the full legal force of a handwritten signature, and do not need to be verified, validated or certified by any third party. An "electronic signature" may be clicking a check box, typing or writing your name, or any other action indicating your consent.

Electronic Communications

You agree to receive documents, communications, and notices (including this form) from CommonSpirit Health electronically, rather than in paper. You affirm that you have the hardware and software required to do so, as described below. All such electronic communications will be provided to you by email or as a downloadable file. If you indicate consent below, you will not receive a paper copy of this or any other document, but you are free to print the electronic copies or save them in any way you see fit.

Non-Consent

You do not have to agree to electronic signatures and communications. If you do not agree, do not sign this form. Instead, please ask your contact at CommonSpirit Health for paper documents, and they will be provided without charge, although this may result in a processing delay. If you do consent, you may withdraw your consent at any time by notifying CommonSpirit Health, and your withdrawal will take effect after a reasonable time for processing. Withdrawal of consent will not affect the validity of documents signed electronically when your consent was in effect.

Hardware and Software Required

You understand that your consent to electronic signatures and communications requires the following software and hardware, to which you have access. These requirements are subject to change. Required: *An email address, internet access, Adobe PDF reader or other software capable of opening and displaying a document in PDF format, and a computer device capable of running that software.*

Summary

If you agree to use electronic signatures and communications as described above, please check "I Agree." If not, please contact us for an alternative way to submit your paperwork.

SAINT FRANCIS MEMORIAL HOSPITAL

CERTIFICATE

November 13, 2023

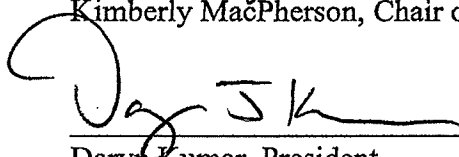
The undersigned, the duly elected, qualified, and incumbent officers of Saint Francis Memorial Hospital, a California nonprofit public benefit corporation ("Saint Francis Memorial Hospital"), hereby certify as of the date first written above, in his or her capacity as an officer of Saint Francis Memorial Hospital, and not individually:

1. Attached hereto as Exhibit A are true and correct copies of resolutions adopted by the Saint Francis Memorial Hospital Board of Trustees on November 2, 2023. The resolutions have not been amended, modified, or repealed since the adoption thereof and remain in full force and effect as of the date hereof.

This certificate may be delivered by facsimile transmission or .pdf, and any photocopy, .pdf, facsimile copy, or photocopy of facsimile copy of this certificate shall be admissible into evidence in any proceeding as though the same were an original.



Kimberly MacPherson, Chair of the Board of Trustees



Daryn Kumar, President

EXHIBIT A

BOARD OF TRUSTEES RESOLUTIONS

See attached.

**SAINT FRANCIS MEMORIAL HOSPITAL
RESOLUTIONS OF THE BOARD OF TRUSTEES**

November 2, 2023

*(Approving and Recommending Matters Relating to the Resignation of Dignity Community Care as the
Sole Member of Saint Francis Memorial Hospital)*

WHEREAS, the board of trustees (the “Board”) of Saint Francis Memorial Hospital, a California nonprofit public benefit corporation (the “Corporation”), has determined that it is in the best interests of the Corporation to approve and recommend, as applicable, the matters set forth in these resolutions and delegate certain authority with respect to such matters to the Corporation’s sole member, Dignity Community Care, a Colorado nonprofit corporation (“DCC”), with respect to the Corporation and DCC entering into a proposed transaction with The Regents of the University of California, on behalf of the University of California—San Francisco Health (“UCSF Health”) so that UCSF Health or one of its affiliates would become the sole member of the Corporation upon DCC’s resignation as the sole member of the Corporation upon the closing of such transaction.

WHEREAS, the Board’s review or approval, as applicable, of the matters set forth in these resolutions and its decision to recommend those matters to, and delegate certain authority to, DCC is based, in part, on the Board’s evaluation of the strengths of UCSF Health as a healthcare provider of the highest quality that is uniquely dedicated to the San Francisco Bay area and the other communities served by UCSF Health.

WHEREAS, DCC and its affiliates are intending a transaction structure in which the Corporation would receive and accept certain assets used in the operation of Saint Mary’s Medical Center, an operating division of Dignity Health, a California nonprofit public benefit corporation (“Dignity Health”), and the Corporation would, effective upon the closing of the transaction, amend its articles and bylaws to, among other matters, address the resignation by DCC as the sole member of the Corporation and the succession by UCSF Health or one of its affiliates as the sole member of the Corporation (the “Proposed Transaction”), and, should the structure of the Proposed Transaction change, this Board would need to approve any such change.

WHEREAS, the Proposed Transaction would be effectuated pursuant to and in accordance with a Transaction Agreement to be entered into by and among the Corporation, DCC, UCSF Health, Dignity Health, and the other parties thereto (the “Transaction Agreement”).

WHEREAS, as set forth in the Transaction Summary (as defined below), any cash, cash equivalents, and accounts receivables of the Corporation (collectively, “Cash”) would be transferred to either DCC, Dignity Health or one of their respective affiliates, which Cash would be used to pay down the debt, pension, and other obligations owed by the Corporation to either DCC, Dignity Health or, Dignity Health’s sole member, CommonSpirit Health, a Colorado nonprofit corporation (“CommonSpirit Health”), as applicable.

WHEREAS, in order to address the resignation of DCC as the sole member of the Corporation and UCSF Health becoming the sole member of the Corporation effective as of the effective time of the consummation of the Proposed Transaction as contemplated by the Transaction Agreement (the “Effective Time”), the following will occur: (a) the Second Amended and Restated Articles of Incorporation of the Corporation will be amended and restated to, among other matters, designate UCSF Health or one of its affiliates as the sole member of the Corporation, and (b) the Second Amended and Restated Bylaws of the Corporation will be amended and restated to, among other matters, designate UCSF Health or one of its

affiliates as the sole member of the Corporation and make other changes in order to effectuate the terms of the Proposed Transaction (collectively, the foregoing amendments and restatements to the Second Amended and Restated Articles of Incorporation and the Second Amended and Restated Bylaws of the Corporation, each in substantially the forms attached hereto as Exhibit A, the "Amended Governing Documents").

WHEREAS, each member of the Board will resign, and the Amended Governing Documents would only be effective, in each case as of the Effective Time.

WHEREAS, because the Board has determined that having UCSF Health or one of its affiliates as the sole member of the Corporation and the consummation of the Proposed Transaction is in the best interests of the Corporation, the Board deems it to be in the best interests of the Corporation to (a) authorize, approve, and delegate to the Chair of the Board, the President of the Corporation, DCC, in its capacity as the sole member of the Corporation, or DCC's officers, the authority to execute, deliver, and consummate the Transaction Agreement and any transaction documents contemplated thereunder on behalf of the Corporation substantially in accordance with the summary of the key terms of the Transaction Agreement the "Transaction Summary"), which is attached to and made part of these resolutions; provided, however, that the Transaction Agreement and such transaction documents do not place the Corporation at financial risk to indemnify UCSF Health or its affiliates after the Effective Time; (b) authorize and approve the Amended Governing Documents, to be effective as of the Effective Time; and (c) recommend that DCC, in its capacity as the sole member of the Corporation, authorize and approve all of the foregoing pursuant to applicable law and the CommonSpirit Health Governance Matrix.

NOW, THEREFORE, BE IT RESOLVED, that the Board hereby (a) approves, authorizes, and delegates to the Chair of the Board, the President of the Corporation, DCC, in its capacity as the sole member of the Corporation, and DCC's management to: (i) use the Corporation's Cash to pay down any debt or amounts owed to DCC, Dignity Health, or CommonSpirit Health, as applicable; and (ii) execute, deliver, and consummate the Transaction Agreement and any transaction documents contemplated thereunder on behalf of the Corporation, all substantially in accordance with the Transaction Summary; provided, however, that the Transaction Agreement and such transaction documents do not place the Corporation at financial risk to indemnify UCSF Health or its Affiliates after the Effective Time; and (b) authorizes and approves the Amended Governing Documents to be effective as of the Effective Time;

FURTHER RESOLVED, that the Board hereby recommends and submits to DCC, in its capacity as the sole member of the Corporation, to authorize and approve the foregoing resolution pursuant to applicable law and the CommonSpirit Health Governance Matrix;

FURTHER RESOLVED, that each of the Chair of the Board, the President of the Corporation, or any officer of DCC (following consultation with and direction of the Chair of the Board of the Corporation), in DCC's capacity as the sole member of the Corporation (each, an "Authorized Officer") are authorized to execute and deliver, for and on behalf of the Corporation, the Transaction Agreement and the Amended Governing Documents in such form and with such changes as such Authorized Officer deems necessary or advisable in order to consummate the Proposed Transaction, the execution thereof by such Authorized Officer to be conclusive evidence of such approval, and for and on behalf of the Corporation, to do all acts and to execute and deliver all such other agreements, documents, certificates, and instruments, which such Authorized Officer deems necessary or advisable to carry out and comply with these resolutions, the Proposed Transaction, the Transaction Agreement, the Amended Governing Documents, and any other agreements, documents, and transactions described therein or contemplated thereby, the execution thereof by such Authorized Officer to be conclusive evidence of such approval;

FURTHER RESOLVED, that each member of the Board hereby agrees to resign from the Board of the Corporation effective as of the Effective Time, and to execute any and all instruments necessary to effectuate such resignations; and

FURTHER RESOLVED, that any prior actions taken reasonably and in good faith by the officers, members, and/or directors of the Corporation, DCC, Dignity Health, or CommonSpirit Health with respect to the foregoing are hereby ratified and approved.

[The remainder of this page is left intentionally blank.]

Exhibit A

AMENDED GOVERNING DOCUMENTS

See attached.

**THIRD AMENDED AND RESTATED
ARTICLES OF INCORPORATION
OF
SAINT FRANCIS MEMORIAL HOSPITAL**

The undersigned certify that:

1. They are the chair of the board and the secretary, respectively, of Saint Francis Memorial Hospital, a California nonprofit public benefit corporation.
2. The Articles of Incorporation of the corporation, which shall have a delayed effective date of _____ at [11:59 p.m.] Pacific Standard Time, are amended and restated to read as follows:

ARTICLE I

The name of this corporation is SAINT FRANCIS MEMORIAL HOSPITAL.

**ARTICLE II
MEMBERSHIP**

The sole member of this corporation for all purposes under the California Nonprofit Corporation Law shall be The Regents of the University of California of which the University of California – San Francisco Health is a constituent part (the “Sole Member”).

The powers of the corporation shall be exercised by its board of directors as provided in the Bylaws of the corporation and subject to the rights granted to the sole member in such Bylaws.

**ARTICLE III
ORGANIZATION**

This corporation is organized and operated exclusively for the purposes set forth in Article IV hereof within the meaning of Internal Revenue Code section 501(c)(3).

No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and this corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of any candidate for public office.

The property of this corporation is irrevocably dedicated to the purposes in Article IV hereof and no part of the net income or assets of this corporation shall ever inure to the benefit of any director, officer or member thereof or to the benefit of any private person.

**ARTICLE IV
PURPOSES**

A. This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

B. The specific purposes for which this corporation is organized are exclusively charitable within the meaning of Section 501(e)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding provisions of any future United States revenue laws (the "Code"). Its principal purpose shall be the promotion of health through the ownership, management and operation of such acute care hospitals and other health care facilities that provide medical care as deemed appropriate by this corporation's Board of Directors. Its purposes may further include, without limitation, ownership, operation, management, control and support of skilled nursing facilities, outpatient health and wellness facilities and programs, home care, social service organizations, medical offices and clinics, medical research or education organizations and activities. In addition, this corporation is authorized, to the extent permissible under applicable *statutes*, to conduct *activities* contributing to the overall health of the communities which it serves, through the provision of economic and other support to certain community organizations for purposes of healthcare, education, housing and other social services and related activities operated under the auspices and/or authority of the Regents of the University of California, expressly including, but not limited to, the University of California, San Francisco Health; and to do all things necessary and proper to achieve the foregoing purposes.

ARTICLE V

POWERS

In carrying out its activities, this corporation shall have all the powers of a natural person, including all of the powers conferred on a corporation by the applicable sections of the California Corporations Code.

ARTICLE VI

DISSOLUTION

Upon the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to a nonprofit fund, foundation or corporation which is organized and operated exclusively for charitable, educational and/or religious purposes and which has established its tax-exempt status under Internal Revenue Code section 501(c)(3) [or the Sole Member].

1. The foregoing amendment and, restatement of Articles of Incorporation has been duly, approved by this corporation's Board of Trustees.
2. The foregoing amendment and restatement of Articles of Incorporation has been duly approved by the required vote of the sole corporate member.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our knowledge.

Date:

Date:

**SECOND AMENDED AND RESTATED
BYLAWS
of
SAINT FRANCIS MEMORIAL HOSPITAL**

**SECOND AMENDED AND RESTATED BYLAWS
OF
SAINT FRANCIS MEMORIAL HOSPITAL**

**ARTICLE I. - DEFINITIONS AND CONSTRUCTION; ATTORNEY GENERAL
CONDITIONS**

Section 1.1 Except where the context otherwise requires, the following terms shall have the meanings assigned to them:

“the corporation”	- Saint Francis Memorial Hospital, a California nonprofit public benefit corporation.
“the Hospitals”	- Saint Francis Memorial Hospital and St. Mary’s Medical Center (“SMMC”), the hospitals owned and operated by the corporation.
“the Board”	- The Board of Trustees of the corporation.
“the Trustee” or the “Trustees”	- The member or members of the Board.
“the Corporate Member”	- The Regents of the University of California, a corporation described in Article IX, Section 9, of the Constitution of the State of California, on behalf of the University of California – San Francisco Health.
“Active Medical Staff”	- Those members of the Hospitals’ Medical Staff who have been granted Active Staff status as opposed to Emeritus, Courtesy or Associate Staff status.
“the Statute”	- The California Nonprofit Corporation Law for the time being in effect.

Section 1.2 Subject as aforesaid and except where the context otherwise requires, the general provisions, rules of construction and definitions in the Statute shall govern the construction of these Bylaws. Should any portion of these Bylaws conflict with the corporation’s Articles of Incorporation, the Articles of Incorporation shall govern.

Section 1.3 The Corporate Member and the corporation shall comply with the Conditional Consent issued to the Hospital by the California Attorney General on November 21, 2018 (the “Conditional Consent”), solely to the extent that the terms and conditions of such Conditional Consent remain in effect by their terms.

ARTICLE II. - OFFICES

Section 2.1 Principal Office. The principal office of the corporation shall be 900 Hyde Street, San Francisco, California.

ARTICLE III. - MEMBERSHIP

Section 3.1 Corporate Membership. The corporation shall have only one member as the term “member” is defined in Section 5056 of the California Nonprofit Corporation Law. The Corporate Member of the corporation shall be The Regents of the University of California, a corporation described in Article IX, Section 9, of the Constitution of the State of California, on behalf of the University of California – San Francisco Health. The Corporate Member shall have and be entitled to exercise fully all rights and privileges of members of nonprofit corporations under the Statute, as amended, and under all other applicable laws, except as otherwise provided in these Bylaws.

Section 3.2 Transfer of Membership. The Corporate Member may not transfer its membership or any rights arising there from.

Section 3.3 Appointment of Officer or Director or Others to Act on Behalf of Corporate Member. Subject to applicable law and to the Corporate Member’s Articles of Incorporation and Bylaws, the Corporate Member’s Board of Regents may, either through direct resolution or delegation of authority, appoint one or more officers or directors of the Corporate Member or one or more other persons to act on its behalf, in its capacity as Corporate Member.

ARTICLE IV. - BOARD OF TRUSTEES

Section 4.1 Powers. Subject to any limitations in the Articles of Incorporation of the corporation or in these Bylaws and to any provision of the Statute requiring the authorization or approval of the Corporate Member for a particular action, the business and affairs of the corporation shall be managed and all corporate powers shall be exercised by or under the direction of the Board.

Section 4.2 Reserved Approval Powers. The Corporate Member shall have the power to initiate and undertake the following actions or give final approval to the following actions first adopted and approved by the Board:

4.2.1 Appointment and removal of Trustees of the Board with or without cause.

4.2.2 Any adoption of or change in the philosophy and mission of the corporation.

4.2.3 All long-range and strategic plans adopted by the Board.

4.2.4 Any merger or consolidation to which this corporation is a party, the sale, transfer or relocation of all or substantially all of the assets of this corporation, or the dissolution of the corporation.

4.2.5 All amendments to the Articles of Incorporation or Bylaws of the corporation.

4.2.6 The capital and operating budgets of the corporation; provided that the Corporate Member's approval of such budgets shall be pursuant to terms agreed upon by the corporation and the Corporate Member and as part of the aggregate system budget that incorporates the operating budget of the corporation.

4.2.7 Any expenditure of the corporation which is not contained in a budget approved by the Corporate Member (other than capital projects wholly funded by Saint Francis Foundation) and which is in excess of a transaction threshold determined by the Corporate Member's policies and procedures.

Section 4.3 Reserved Audit Power. The Corporate Member shall have the power to select and remove outside auditors who shall periodically audit the finances of the corporation. Notwithstanding the preceding sentence, the Board may retain a Certified Public Accountant of its choosing to conduct an independent audit of the finances of the corporation at the corporation's own expense, and to the extent the Board deems advisable to fulfill its fiduciary duties, the Board may retain independent professional advisors (e.g., attorneys and accountants).

Section 4.4 Number. The authorized number of Trustees of the Board shall be three (3) appointed members.

Section 4.5 Election and Qualifications of Members of Board of Trustees. The Corporate Member, in its sole discretion, shall elect and appoint the members of the Board.

Section 4.6 Term. Except for ex officio members, each Trustee shall serve for a term as determined by the Corporate Member at the time of appointment or re-appointment, which term shall not exceed three (3) years in length and which shall end on the effective date of appointment of his or her successor who is duly elected and qualified at the annual meeting of the Corporate Member pursuant to the procedures set forth in Sections 4.5 and 4.7 of these Bylaws. Generally, terms shall be for a three (3) year period of time, except that terms of shorter periods may be utilized in order to provide for the staggering of terms and the orderly rotation of Board Members. Any Trustee may be removed without cause pursuant to the provision of Section 5222 of the Statute.

Section 4.7 Vacancies. If a Trustee ceases to serve as a Trustee for any reason prior to the expiration of the term for which he or she was elected, a successor Trustee shall be elected at the next annual meeting of the Corporate Member pursuant to Section 4.5 to serve for the balance, if any, of such term. Prior to such annual meeting, the remaining Trustees may fill such vacancy by electing a Trustee, subject to approval by the Corporate Member, to serve until the next annual meeting of the Corporate Member.

Section 4.8 Resignation and Termination for Non-Attendance. Any Trustee may resign at any time by giving written notice of such resignation to the Chair, the President or the Secretary of the corporation. The office of any Trustee whose absence from three consecutive

regular meetings of the Board is not excused by the Chair or the Board shall thereupon automatically be vacated.

Section 4.9 Compensation. Trustees shall not receive any compensation as such but shall be entitled to reimbursement of any out-of-pocket expenses reasonably incurred by them in the execution of their duties.

Section 4.10 Executive Sessions. The Chair of the Board may exclude any persons who are not Trustees from any meeting or portion of a meeting of the Board if he or she determines that the subject matter of such meeting or portion of a meeting would be most appropriately discussed in the absence of such individuals.

ARTICLE V. - TRUSTEES' MEETINGS

Section 5.1 Regular Meetings. The Board shall hold regular meetings at least quarterly. The Board may provide for such regular meetings by resolution specifying the time and place of such regular meetings. Such regular meetings may be held without call or notice apart from such resolution.

Section 5.2 Special Meetings. Special meetings of the Board may be called at any time by the Chair or any five (5) Trustees with voting rights. Special meetings shall be held upon not less than four (4) days' notice given by first-class mail or forty-eight (48) hours' notice delivered personally or by telephone, telex or telegraph. Such notice shall specify the time and place but need not specify the purpose of the meeting.

Section 5.3 Waiver of Notice. The transactions of any meeting of the Board, however called and noticed and wherever held, are as valid as though had at a meeting duly held after regular call and notice if a quorum is present and if, either before or after the meeting, each of the Trustees not present signs a written waiver of notice, a consent to the holding of the meeting or an approval of the minutes thereof. All such waivers, consents and approvals shall be filed with the corporate records or made a part of the minutes of the meeting. Notice of any meeting of the Board need not be given to any Trustee who attends the meeting without protesting the lack of notice to such Trustee prior thereto or at its commencement.

Section 5.4 Action Without Meeting. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as the unanimous vote of such directors.

Section 5.5 Quorum. A majority of the authorized number of Trustees shall constitute a quorum for the transaction of business. In the absence of a quorum, a majority of the Trustees present may adjourn any meeting to another time and place. If a meeting is adjourned for more than forty-eight (48) hours, notice of any adjournment to another time or place shall be given prior to the time of the adjourned meeting to the Trustees who were not present at the time of the adjournment.

A meeting at which a quorum is initially present may continue to transact business notwithstanding the departure of all but two (2) Trustees provided that any action taken is approved by at least a majority of the authorized number of Trustees.

ARTICLE VI. - CORPORATE OFFICERS

Section 6.1 Number; Election; Term.

6.1.1 The officers of the corporation shall be a Chair, a President/Chief Executive Officer, a Secretary and a Treasurer. Any two offices may be held concurrently by the same person except that neither the Chair nor the President/Chief Executive Officer may also serve as the Secretary or the Treasurer. The Chair, the Treasurer and the Secretary shall be chosen from the members of the Board. The President/Chief Executive Officer shall be chosen in the manner established in Section 6.5 hereof.

6.1.2 Except for the President, the officers shall be elected annually by the Board at the regular meeting of the Board held after the annual meeting of the Corporate Member or as soon thereafter as may be convenient. Each officer shall hold office until his successor shall have been duly chosen or until his removal or resignation.

Section 6.2 Removal and Resignation. Any officer chosen by the Board may be removed at any time, with or without cause, by the Board or the corporate member whenever in its judgment the best interests of the corporation would be served thereby. Any officer may resign his office at any time by giving written notice of his or her resignation to the Chair or Secretary of the corporation. Unless a different time is specified therein, such resignation shall be effective upon its receipt by the Chair, the President or Secretary, as the case may be. The removal or resignation of any officer shall be subject to the rights (if any) vested in such officer or in the corporation under any contract of employment.

Section 6.3 Vacancies. Except for the office of President, a vacancy in any office from whatever cause may be filled by the Board for the unexpired portion of the term.

Section 6.4 Chair. The Chair shall generally supervise all of the business and affairs of the corporation. In the absence of the President or in the event of the President's inability or refusal to act, the Chair shall be the chief executive officer of the corporation. The Chair shall be a member, with the right to vote, of all committees created pursuant to Article VII of these Bylaws. The Chair shall preside at all meetings of the Board and of the Executive Committee. The Chair may sign, with the Secretary or any other proper officer of the corporation authorized by the Board, any deeds, mortgages, bonds, contracts, or other instruments which the Board has authorized to be executed, except where the signing and execution thereof shall be expressly delegated by the Board or by these Bylaws or by statute to some other officer or agent of the corporation; and in general he or she shall perform all duties incident to the office of Chair and such other duties as may be prescribed by the Board from time to time.

Section 6.5 .

Section 6.6 President. The President shall be the Chief Executive Officer of the corporation. The President shall be appointed by the Corporate Member. In his or her capacity as

the President, the President shall perform such duties as are from time to time assigned or required by the Board. The President shall report to the Board. The Board shall establish performance expectations and measurable goals for the President and shall jointly conduct periodic evaluations of the President based on the performance measures so established. As President and Chief Executive Officer of the corporation, the President shall be accountable for performing his or her duties in accordance with all policies, procedures and standards of conduct and performance adopted by the Board.

Section 6.7 Treasurer. The Treasurer shall supervise all of the financial affairs of the corporation. If required by the Board, the Treasurer shall give a bond for the faithful discharge of the duties of office in such sum and with such surety or sureties as the Board shall determine. The Treasurer shall have charge and custody of and be responsible for all funds and securities of the corporation; receive and give receipts for moneys due and payable to the corporation from any source whatsoever; deposit all such moneys in the name of the corporation with such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article IX of these Bylaws and may delegate the same to a chief financial officer or other qualified individual as authorized by the Board; and in general perform all the duties incident to the office of Treasurer and such other duties as may from time to time be assigned to him or her by the Chair, the President or by the Board.

Section 6.8 Secretary. The Secretary shall keep the minutes of the meetings of the Corporate Member and of the Board in one or more books provided for that purpose, shall see that all notices are duly given in accordance with the provisions of these Bylaws or as required by law, shall be custodian of the corporate records and seal and shall see that the seal is affixed to all documents the execution of which on behalf of the corporation under its seal has been duly authorized in accordance with the provisions of these Bylaws, shall keep a register of the post office address of each Trustee which shall be furnished to the Secretary by such Trustee, and in general shall perform all duties incident to the office of Secretary and such other duties as may from time to time be assigned to the Secretary by the Chair or by the Board.

ARTICLE VII. - COMMITTEES

Section 7.1 Committees Generally. The Board may, by resolution adopted by a majority of the Trustees then in office, establish one or more committees, as needed or required to conduct and transact the business of the corporation. Except as otherwise provided in these Bylaws, the Board may set the qualifications for membership on any committee it may establish; provided that each committee shall consist of at least two (2) Trustees of the corporation, including the Chair. Except for the Executive Committee, committees may include persons other than Trustees, except that a committee that has the authority to act on behalf of the Board must include only Trustees who are appointed by the Board. Minutes of all committee meetings shall be recorded and copies of such minutes shall be provided to the Board. Such committees shall take no action except upon specific delegation by the Board.

Section 7.2 Standing and Special Committees. The following shall be the standing committees of the Board: the Executive Committee, the Finance Committee, and such other standing committees as may be established by the Board from time to time. Special or ad hoc committees may be established by the Board for such finite tasks as circumstances warrant. A

special or ad hoc committee shall limit its activities to the accomplishment of the tasks for which it was appointed and shall have no power to act except as specifically conferred by action of the Board. Upon completion of the tasks for which it was created and after making a final report to the Board, special and ad hoc committees shall stand discharged. The Board may in addition create purely advisory or administrative committees including persons who are not Trustees for such purposes as the Board shall determine. No such committee shall have or exercise any authority of the Board.

Section 7.3 Executive Committee. The members of the Executive Committee shall be the Chair, , the Chair of the Finance Committee, the President, , such other officers of the corporation as are members of the Board, and not less than two (2) other members of the Board elected by the Board. The Executive Committee shall take no action except upon specific delegation by the Board.

Section 7.4 Finance Committee. The members of the Finance Committee shall be such persons, whether or not members of the Board, as are elected by the Board; provided, however, that members shall include the Chair and not less than one (1) other member of the Board, who shall be designated as Chair of the Finance Committee. The Finance Committee shall take no action except with the prior approval of the Board.

Section 7.5 Committee Meetings. Meetings of committees shall be held at such times and places with notice to committee members pursuant to the requirements for Trustees' Meetings in Article V, and in such manner as may be determined by the Chair or the chairs of the committee unless otherwise provided in the resolution of the Board establishing such committee.

ARTICLE VIII. - SECURITIES, CONTRACTS, CHECKS, DEPOSITS AND FUNDS

Section 8.1 Voting Securities. The Chair, the President and the Secretary, or such other officers as the Board may designate for the purpose, are authorized to vote, represent and exercise on behalf of the corporation all rights incident to any and all voting securities of any other corporation or corporations standing in the name of the corporation. This authority may be exercised either in person or by proxy or power of attorney duly executed by the officers concerned.

Section 8.2 Contracts. The Board may authorize any officer or officers, or agent or agents of the corporation in addition to the officers so authorized by these Bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the corporation, and such authority may be general or confined to specific instances.

Section 8.3 Checks, Drafts, etc. All checks, drafts or orders for the payment of money, notes or other evidences of indebtedness issued in the name of the corporation shall be signed by such officer or officers, agent or agents of the corporation and in such manner as shall from time to time be determined by resolution of the Board. In the absence of such determination by the Board, such instruments shall be signed by the Treasurer or his designee and countersigned by the Chair, or the President.

Section 8.4 Deposits. All funds of the corporation shall be deposited from time to time to the credit of the corporation with such banks, trust companies or other depositaries as the Board may specify.

Section 8.5 Gifts. The Board may accept on behalf of the corporation any contribution, gift, bequest, or devise for the general purposes or for any special purpose of the corporation.

ARTICLE IX. - RECORDS, REPORTS, ETC.

Section 9.1 Records. The corporation shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its Board of Trustees and committees having or exercising any of the authority of the Board.

Section 9.2 Reports. The corporation shall distribute to the Corporate Member a copy of its annual reports within 120 days of the close of its fiscal year.

The corporation shall supply such information and make such returns and reports to the Secretary of State of the State of California, to the Attorney General of the State of California, to the Internal Revenue Service, to the California Franchise Tax Board and to such other persons, bodies or authorities as may from time to time be required by law.

Section 9.3 Fiscal Year. The fiscal year of the corporation shall end on the last day of June in each year.

Section 9.4 Corporate Seal. The corporation may have a corporate seal in such form as shall be prescribed and adopted by the Board.

ARTICLE X. - INDEMNIFICATION

Section 10.1 Indemnification of Corporate Agents. To the fullest extent permissible by the provisions of Section 5238 of the Statute, the corporation shall indemnify each of its agents against expenses, judgments, fines, settlements and other amounts, actually and reasonably incurred by such person by reason of such person's having been made or having been threatened to be made a party to a proceeding and the corporation shall advance the expenses reasonably expected to be incurred by such agent in defending any such proceeding upon receipt of the undertaking required by subdivision (f) of such Section. The terms "agent", "Proceeding" and "expenses" used in this Article shall have the same meaning as such terms in said Section 5238.

Section 10.2 Insurance. The corporation shall purchase and maintain insurance on behalf of any director, officer or employee of the corporation against any liability asserted against or incurred by the director, officer or employee in such capacity or arising out of the directors, officer's or employee's status as such, whether or not the corporation would have the power to indemnify the director, officer or employee against such liability under the provisions of Section 5238 of the Statute.

ARTICLE XI. - MEDICAL STAFF

Section 11.1 Medical Staff Qualifications and Responsibilities. The Hospitals shall have a single Medical Staff, the members of which shall be restricted to physicians, whether licensed as doctor of medicine or doctor of osteopathy, licensed dentists and licensed podiatrists competent in their respective fields, worthy in character and in professional ethics, selected in accordance with the Bylaws, Rules and Regulations of the Hospitals' Medical Staff and appointed by the Board in accordance with such procedures, qualifications and conditions as the Board may determine.

Section 11.2 Medical Staff Organization. The Medical Staff shall maintain such form or organization as shall be provided in its Bylaws, Rules and Regulations. The Medical Staff may recommend changes in its Bylaws, Rules and Regulations but such Bylaws, Rules and Regulations shall be adopted by the Board.

Pursuant to the Bylaws, Rules and Regulations of the Medical Staff or policies adopted by the Board, the Medical Staff shall be required to establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that periodically all physicians may be required to demonstrate their ability to perform surgical and other procedures competently and to the satisfaction of an appropriate committee or committees of the Medical Staff.

ARTICLE XII. - SAINT FRANCIS MEMORIAL HOSPITAL ASSOCIATES

The Saint Francis Memorial Hospital Associates (the "Associates") is an unincorporated association of those members of the community who have indicated an interest in aiding and assisting the work and development of the Hospital. The Associates shall maintain such form of organization as shall be approved by the Board.

ARTICLE XIII. - SAINT FRANCIS MEMORIAL HOSPITAL AUXILIARY

The Saint Francis Memorial Hospital Auxiliary (the "Auxiliary") is a California nonprofit corporation the principal purpose of which is to aid and assist the maintenance of the Hospital and the members of which are interested in the Hospital. The Auxiliary shall maintain such form of organization as shall be provided by its Articles of Incorporation and Bylaws as approved by the Board.

ARTICLE XIV. - [RESERVED]

ARTICLE XV. - [RESERVED]

ARTICLE XVI. - AMENDMENT

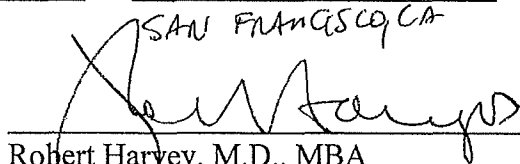
Subject to any applicable provisions of the Statute, these Bylaws or any part thereof may be amended or repealed or new Bylaws may be adopted by the approval of the Corporate Member.

**CERTIFICATE OF SECRETARY OF
SAINT FRANCIS MEMORIAL HOSPITAL**

I, the undersigned, do hereby certify:

- (1) That I am presently the duly elected and acting Secretary of the corporation; and
- (2) That the foregoing Second Amended and Restated Bylaws has been approved by the Board of Trustees of the corporation as of 11.2.2023.

Executed on this 15 day of November 2023, at SAINT FRANCIS MEMORIAL HOSPITAL

SAN FRANCISCO CA

Robert Harvey, M.D., MBA
Saint Francis Memorial Hospital

CERTIFICATE OF SECRETARY OF THE CORPORATE MEMBER

I, the undersigned, do hereby certify:

- (1) That I am presently the appointed and acting [Assistant Secretary] of the Corporate Member; and
- (2) That the foregoing Second Amended and Restated Bylaws has been approved by the governing body of the Corporate Member as of [_____].

Executed on this ____ day of _____, _____, at San Francisco, CA.

[Name, Title]
Dignity Community Care

The Regents of the University of California

HEALTH SERVICES COMMITTEE

July 19, 2023

The Health Services Committee met on the above date at the UCSF–Mission Bay Conference Center, San Francisco campus and by teleconference at 106 E. Babcock Street, Bozeman, Montana.

Members present: Regents Makarechian, Park, Pérez, Reilly, Sherman, and Sures; Ex officio members Drake and Leib; Chancellors Hawgood and Khosla

In attendance: Regents Anguiano, Cohen, Elliott, Ellis, Hernandez, Lee, Raznick, and Tesfai, Regents-designate Beharry and Pack, Faculty Representatives Cochran and Steintrager, Secretary and Chief of Staff Lyall, General Counsel Robinson, Interim Senior Vice President Reese, Vice President Leasure, Chancellors Christ, Larive, Muñoz, Wilcox, and Yang, and Recording Secretary Johns

The meeting convened at 4:25 p.m. with Committee Chair Pérez presiding.

1. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of May 17, 2023 were approved, Regents Drake, Leib, Makarechian, Pérez, Reilly, Sherman, and Sures voting “aye.”¹

2. ACQUISITION OF GENERAL ACUTE CARE HOSPITAL ASSETS, SAN FRANCISCO CAMPUS

The President of the University recommended that:

- A. Subject to satisfactory completion of due diligence and the requirements set forth in Section B below, the following actions are authorized:
- (1) UCSF Health (UCSFH) may acquire certain assets controlled by CommonSpirit Health (CSH), including St. Mary’s Medical Center (SMMC), Saint Francis Memorial Hospital (SFMH), select supporting outpatient clinics, and select real property assets as listed in Attachment 1.
 - (2) At conclusion of the Proposed Transactions the Regents, through UCSFH, will control all operations of SMMC, SFMH and the other assets included as described above either directly or through an entity controlled by the Regents.

¹ Roll call vote required by the Bagley-Keene Open Meeting Act [Government Code § 11123(b)(1)(D)] for all meetings held by teleconference.

- B. The following business terms will be required in connection with the closing of the Proposed Transactions:
- (1) Purposes/Mission: The Proposed Transactions shall be in furtherance of UCSFH's mission of promoting health and expanding access to healthcare services for a broad cross-section of the community and consistent with its clinical and academic purposes.
 - (2) Capital Commitment: UCSFH will commit no more than \$100 million in consideration to acquire the assets included as part of the Proposed Transaction. In the event UCSFH does not commit to pay the total negotiated consideration at closing, UCSFH will pay the balance of the total consideration, as may be adjusted by customary post-closing adjustments and indemnification obligations, over no longer than a seven-year term.
 - (3) Excluded Liabilities: Except for the specific liabilities negotiated in connection with the definitive agreements executed to effectuate the Proposed Transactions, UCSF will not assume or be liable or responsible for any of the liabilities of CSH (or any affiliate of CSH), including debt and other liabilities relating to the assets included in the Proposed Transaction, incurred prior to the closing of the Proposed Transaction.
 - (4) Policies Applicable to Acquired Assets: As a condition to closing the Proposed Transaction, all assets will be deconsecrated. Thus, as of the closing date, neither the Ethical and Religious Directives nor the Statement of Common Values will apply to the facilities nor govern facility operations, policies, or staff.
 - (5) Systemwide Initiatives: Nothing in any agreement signed in connection with the Proposed Transaction shall bind the University as a whole, UC Health, or any UC campus or medical center other than UCSF; and all definitive agreements shall preserve UCSF's right to participate directly or through new companies in systemwide (i.e., UC Health) initiatives.
- C. The President or his designee, after consultation with the Office of the General Counsel, and following action pursuant to the California Environmental Quality Act, be authorized to approve and execute any agreements reasonably required to implement the foregoing, including any subsequent agreements, modifications, or amendments thereto, provided that such agreements, modifications, amendments or related documents are materially consistent with the terms above, and do not otherwise materially increase the obligations of the Regents or materially decrease the rights of the Regents.

[Background material was provided to the Committee in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Chancellor Hawgood described this action item as an exciting moment in the history of UCSF Health that would allow UCSF to maintain critically needed programs for the City of San Francisco and, in general, to increase patient access to healthcare services in Northern California.

UCSF Health Chief Executive Officer Suresh Gunasekaran provided background to this request to allow UCSF to acquire CommonSpirit Health/Dignity Health assets in San Francisco: St. Mary's Medical Center, Saint Francis Memorial Hospital, and related outpatient assets. CommonSpirit/Dignity's current operations in San Francisco were complementary to UCSF Health operations. This was an outstanding opportunity for UCSF to advance the health of the community and preserve valuable and essential services at these hospitals, which had a long history in the city. This acquisition would allow UCSF to meet unprecedented demand on its capacity in a way that would benefit the community. UCSF had been in negotiations with CommonSpirit/Dignity for the past several months. These hospitals had a history of caring for all members of the community, partnerships with civic agencies, and unique approaches to outreach. It was currently very challenging to operate a community hospital, including recruitment of staff and financial management. These hospitals had been experiencing these difficulties and diminished patient volumes.

UCSF Senior Vice President Shelby Decosta observed that this transaction not only responded to immediate needs of UCSF; it was also consistent with UCSF Health's strategic plan. Both hospitals had served San Francisco for over 100 years. In addition to investments made in programs that are utilized widely throughout San Francisco, the hospitals have collaborated with many agencies and entities, including UCSF. There was a large number of UCSF faculty working at the hospitals collaboratively with independent physicians. The two hospitals had about 569 beds with average occupancy of about 25 percent. They were operating at a loss, which was putting critical programs and jobs at risk. There were almost 800 physicians and advanced practice providers in place there today, three residency programs, as well as about 1,900 employees across all sites. Ms. Decosta outlined some key terms of the negotiated deal. This would be an outright acquisition of the hospitals and associated assets. The price would be less than \$100 million, debt-free, with payment terms to be negotiated. Once transferred to UCSF, the hospitals would have no Catholic affiliation and no restrictions on care of any kind. Regarding employees, UCSF would plan to maintain the existing workforce, subject to vetting. UCSF had committed to maintain the important programs that the hospitals had provided for many years.

Mr. Gunasekaran explained that UCSF intended to invest over \$300 million over the next six years in upgrading these facilities, integrating them into UCSF Health, and ensuring that they are able to provide the community high-quality and efficient services. UCSF would financially stabilize these two facilities from an operating margin loss to a positive margin by the 24th month. UCSF anticipated maintaining the profit margin and slightly improving it over time. UCSF believed that its investment of over \$300 million would be renewed in terms of positive margins, both in the growth of these facilities and in the backfill opportunity through moving patients from UCSF's main campus facilities and refilling those spaces with patients needing more complex care. Any transaction of this size

has risks, and UCSF was going into this transaction very much aware that there were numerous risks. UCSF would work through the transition and integration process to mitigate these risks. There would be risks associated with creating one collaborative team and leveraging the existing workforce. There would be issues of concern regarding the physical facilities, anticipated and unanticipated, that could be a challenge to operations. UCSF understood that it needs to provide a high quality of service at these locations. An integration of this scale, affecting thousands of employees and tens of thousands of patients, would be difficult. UCSF would have to make improvements and work diligently with the community, listening to stakeholders and working with existing physicians and existing staff to understand how best to move these facilities forward. Ultimately, UCSF believed that it could mitigate these risks.

Ms. Decosta outlined the next steps. UCSF would finalize due diligence, begin integration planning, which would include both UCSF and Dignity-affiliated leaders, staff, and faculty, and finalize the agreements. The campus anticipated that this would take several months and that the hospitals would transition to UCSF in 2024. Mr. Gunasekaran added that the nature of the timeline would allow UCSF to incorporate significant stakeholder feedback on the future of the hospitals. UCSF would be deeply involved in working with the community to ensure that the services provided at these hospitals meet community needs.

President Drake recalled that, as a faculty member, he had worked at St. Mary's Medical Center. The cooperation between St. Mary's Medical Center and UCSF had traditionally been very good. The acquisition seemed a natural step, and given, the challenges faced by UCSF in meeting patient demand, this was a tremendous opportunity that would benefit San Francisco.

For the record, Committee Chair Pérez asked UCSF to state its commitment to maintain the core community benefit services provided at St. Mary's Medical Center and Saint Francis Memorial Hospital. Mr. Gunasekaran responded that UCSF was committed to preserving these services, which included the burn unit at Saint Francis and behavioral health services for adolescents at Saint Mary's. UCSF was very much interested in preserving these community services.

Committee Chair Pérez emphasized his expectation that UCSF would preserve not just the services mentioned by Mr. Gunasekaran, but the broad-based services that are provided at these hospitals. Regarding the large employee base at both hospitals, Committee Chair Pérez wished to ensure that UCSF made a commitment to keep the current employees in their current capacity. Mr. Gunasekaran responded that this was UCSF's commitment.

Committee Chair Pérez wished to ensure that there would be no disruption or degradation of wages and benefits and asked if this would be the case. Mr. Gunasekaran responded that this was correct.

Regent Park expressed optimism about and support for this transaction. The healthcare market was complex. This was an opportunity to expand UCSF's work to communities that needed UCSF care.

With respect to physicians and other employees at these hospitals, Regent Hernandez encouraged UCSF to bring these stakeholders into the process and into decision-making early on. He referred to comments made earlier by speakers during the public comment period.

Regent Reilly emphasized that these hospitals are two important San Francisco institutions and care for many patients in need in the city and county. She expressed confidence that UCSF would continue this mission of caring for the underserved.

Regent Makarechian asked why patient volumes at these hospitals were at 25 percent and about UCSF's plans to increase occupancy. Mr. Gunasekaran responded that in the not too distant past, occupancy rates at these hospitals were much higher, around 50 percent to 60 percent. UCSF felt confident that this 50 percent to 60 percent demand still existed and that this occupancy rate would be realized if UCSF were able to comprehensively offer services that are needed in the community. This was simply a matter of providing care in a structure that was convenient for patients, close to home, and comprehensive. Providing community care would substantially increase occupancy. Another factor was that existing UCSF hospitals were full, with many patients receiving secondary care. These patients could be moved from the Parnassus and Mission Bay hospitals, and the main campuses could receive patients who require more complex care. Ms. Decosta added that UCSF would not be seeking to fill these hospitals completely. UCSF would hope to serve San Francisco patients closer to home in locations that can provide all the services they need. Growth would be moderate and appropriate.

Upon motion duly made and seconded, the Committee approved the President's recommendation and voted to present it to the Board, Regents Drake, Leib, Makarechian, Park, Pérez, Reilly, Sherman, and Sures voting "aye."

The meeting adjourned at 4:45 p.m.

Attest:

Secretary and Chief of Staff

Real Property Included in the Proposed Transaction

The combined owned parcels on the St. Mary's Medical Center and Saint Francis Memorial Hospital campuses to be included in the Proposed Transaction reflects a total of 7.95 acres.

Dignity Health, SMMC, owns the following parcels, to be included in the Proposed Transaction:

Address	Type	Building Size (Sq ft)	Key Features
450 Stanyan St., San Francisco, CA	Acute Care Hospital	402,799	<u>Licensed Space:</u> 167 Med Surg Beds 37 Intensive Care Beds 36 Acute Rehabilitation Beds 9 Operating Rooms 3 Cath Labs <u>Leased Space:</u> - Kentfield Long Term Acute Care Unit: Lease Expires in 2026; Space - 27,297 sq ft; 60 beds (6th floor) - Crestwood Stabilization Unit: Lease Expires in 2028; Space – 26,857 sq ft; 54 beds (5th floor)
2200 Hayes St., San Francisco, CA	Psychiatric Hospital	41,198	35 Beds
One Shrader St., San Francisco, CA	Medical Office Building	55,000	10 medical offices/clinics; parking
2250 Hayes St., San Francisco, CA	Medical Office Building	75,362	24 clinic / administrative spaces; parking

Dignity Community Care, SFMH owns the following parcels, to be included in the Proposed Transaction:

Address	Type	Building Size (Sq ft)	Key Features
900 Hyde St., San Francisco, CA	Acute Care Hospital	470,856	<u>Licensed Space:</u> 205 Medical/Surgical Beds 20 Acute Rehabilitation Beds 10 Intensive Care Beds 8 Coronary Care Beds 16 Intensive Burn Care Beds 11 Operating Rooms 35 Psychiatric Beds
909 Hyde St., San Francisco, CA	Medical Office Building	93,796	35 medical offices/clinics; administrative spaces; parking
1199 Bush St., San Francisco, CA	Medical Office Building	80,987	21 medical offices/clinics; administrative spaces; parking
1234 Pine St., San Francisco, CA	Parking Lot	11,600	Freestanding, attended parking garage

St. Mary's Medical Center



Saint Francis Memorial Hospital



Dignity Health, St. Mary's Medical Center, leases the following parcels, which will be included as a lease transfer in the Proposed Transaction:

- San Francisco International Airport, International Terminal, Level 3, San Francisco, CA: Medical Clinic

Dignity Community Care, Saint Francis Memorial Hospital leases the following parcels, which will be included as a lease transfer as part of the Proposed Transaction:

- 24 Willie Mayes Plaza, San Francisco, CA: Medical Clinic known as "Saint Francis Health Center at the Ballpark" which currently has three clinic units: (1) Occupational Health Center (lease expires 12/2029), (2) Outpatient Physical Therapy Clinic (lease expires 11/2024), and (3) the Dignity Health Medical Foundation Clinic (lease expires 11/2024)
- 1777 Botelho Drive, Walnut Creek, CA: Medical Clinic that is a Center for Sports Medicine and Therapy.

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SECOND AMENDED AND RESTATED
ARTICLES OF INCORPORATION
Of
SAINT FRANCIS MEMORIAL HOSPITAL

FILED *CS*
SECRETARY OF STATE
STATE OF CALIFORNIA

12 JAN 28 2019 *CS*

EFFECTIVE
DATE

2-1-19

The undersigned certify that:

1. They are the chair of the board and the secretary, respectively, of Saint Francis Memorial Hospital, a California nonprofit public benefit corporation.
2. The Articles of Incorporation of the corporation, which shall have a delayed effective date of February 1, 2019 at 12:01 a.m. Pacific Standard Time, are amended and restated to read as follows:

ARTICLE I

The name of this corporation is SAINT FRANCIS MEMORIAL HOSPITAL.

ARTICLE II
MEMBERSHIP

This corporation shall have one member, Dignity Community Care, a Colorado nonprofit corporation (the "Sole Member"), and in addition to the general powers of members as set out in the California Corporations Code, the specific powers, rights and obligations of the Sole Member shall be as set out in Article VII hereof and in the bylaws of this corporation.

ARTICLE III
PURPOSES

A. This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

B. The purposes for which this corporation is organized are exclusively charitable within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding provisions of any future United States revenue laws (the "Code"). Its principal purpose shall be the promotion of health through the ownership, management and operation of such acute care hospitals and other health care facilities that provide medical care as deemed appropriate by this corporation's Board of Trustees. Its purposes may further include, without limitation, ownership, operation, management, control and support of skilled nursing facilities, outpatient health and wellness facilities and programs, home care, social service organizations, medical offices and clinics, medical research or education organizations and activities. In addition, this corporation is authorized, to the extent permissible under applicable statutes, to conduct activities contributing to the overall health of the communities which it serves, through the provision of economic and other support to certain community organizations for purposes of healthcare, education, housing and other social services.

C. Notwithstanding any other provisions of these Articles, this corporation shall not carry on any activities not permitted to be carried on by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or by a corporation the contributions to which are deductible under Section 170(c)(2) of the Code.

D. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and this corporation shall not participate in or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office.

E. The property, assets, profits and net income of this corporation are dedicated irrevocably to charitable purposes within the meaning of Section 501(c)(3) of the Code and meeting the requirements for exemption provided by Section 214 of the California Revenue and Taxation Code, and no part of the profits or net income of this corporation shall inure to the benefit of any director, trustee, officer, shareholder or member thereof, or to the benefit of any private individual.

ARTICLE IV **POWERS**

In carrying out its activities, this corporation shall have all the powers of a natural person, including all of the powers conferred on a corporation by the applicable sections of the California Corporations Code.

ARTICLE V **TRUSTEES**

Subject to the limitations of the laws of the State of California, the bylaws of this corporation and these articles of incorporation, the powers of this corporation shall be exercised and its affairs conducted by a board of trustees (the "Board of Trustees"), as provided in the Bylaws of this corporation. The number of trustees and the manner of their nomination and selection shall be fixed from time to time by the Bylaws of this corporation.

ARTICLE VI **DISSOLUTION**

The property and assets of this corporation are irrevocably dedicated to charitable purposes. Upon the winding up and dissolution of this corporation, its assets remaining, after payment or adequate provision for payment of all debts and obligations of this corporation, shall be distributed in accordance with a plan of liquidation approved by the Board of Trustees and the Sole Member to such organization or organizations determined by the Board of Trustees and approved by the Sole Member which is or are organized and operated exclusively for charitable or scientific purposes as shall at the time qualify as an exempt organization or organizations under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law). No assets shall be distributed to any organization if any part of the net earnings of such organization inures to the benefit of any private person or individual, or if a substantial part of the activities of such organization is the carrying on of propaganda or otherwise attempting to influence legislation, or if the organization participates in, or intervenes in (including the publishing or distribution of statements), any political campaign on behalf of any candidate for public office, or if the organization carries on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law) or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law).

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ARTICLE VII
RESERVED POWERS OF THE SOLE MEMBER

The Sole Member shall have the power to give final approval to the following actions first adopted and approved by the Board of Trustees of this corporation:

- A. Any adoption of or change in the philosophy and mission of this corporation.
- B. All long-range and strategic plans adopted by the Board of Trustees.
- C. Any merger or consolidation to which this corporation is a party, the sale, transfer or relocation of all or substantially all of the assets of this corporation, or the dissolution of this corporation.
- D. All amendments to the Articles of Incorporation or Bylaws of this corporation.
- E. Such other and further actions as to which the Sole Member retains final approval rights as specified in the Bylaws of this corporation.

ARTICLE VIII
AMENDMENT

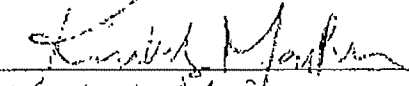
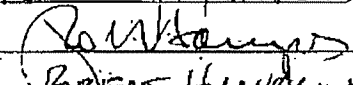
These Articles shall be amended only upon approval by this corporation's Board of Trustees and the Sole Member.

- 3. The foregoing amendment and restatement of Articles of Incorporation has been duly approved by this corporation's Board of Trustees
- 4. The foregoing amendment and restatement of Articles of Incorporation has been duly approved by the required vote of the sole corporate member.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our knowledge.

Date: 12/6/18

Date: 12/6/18


Kimberly Morrison, Chair of the Board

Robert Harvey, Secretary

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 – Zuckerberg 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. EMS Providers based in San Francisco follow the San Francisco EMS Agency [Policy 5001 Trauma Triage Criteria](#) to identify patients needing trauma center care. EMS Providers based in San Mateo County following San Mateo County EMS Agency's Operations 22, Trauma Triage Policy.

In October of 2024, ZSFG appointed a new Trauma Medical Director, Dr. Timothy Browder.

Trauma System Data Summary

In 2024, ZSFG treated a total 3,414 trauma patients. Of that number, 1,377 were admitted with the remaining treated and released directly from the Emergency Department. San Mateo County's pre-hospital care providers transported a total of 501 trauma patients from the northern section of San Mateo County to ZSFG. Of these, 209 were admitted for hospitalized trauma care at ZSFG.

Trauma Transport Times (source: Biospatial) – CY 2024

Mean scene to destination time: 16.41 minutes

Median scene to destination time: 15.01 minutes

Trauma Identification and Destination Determination

[Policy 5000 Destination Policy](#)
[5000.1 Hospital Destination Chart](#)
[5010 Receiving Hospital Standards](#)
[5013 Trauma Center Designation](#)
[5014 Level 1 Trauma Care Standards](#)
[5021 Trauma Center Bypass Policy](#)

Trauma Field to Hospital Communications

[3020 Field to Hospital Communications](#)

Trauma Interfacility Transfers

[5030 Interfacility Transfer](#)

Other Trauma-Related Policies

1010 Advisory Committees

Trauma-Related Clinical Protocols

4.01 General Trauma Evaluation and Overview

4.02 Traumatic Cardiac Arrest

4.03 Head, Neck and Facial Trauma

4.04 Chest, Abdominal and Pelvic Trauma

4.05 Extremity Trauma

4.06 Burns

4.07 Trauma in the Obstetric Patient

9.01 Pediatric Trauma

9.02 Pediatric Burn

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 SFEMSA 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 thorough review 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

SFEMSA has a Trauma Systems Advisory Subcommittee, which meets three times per year, and representation includes Medical Directors and Quality Improvement (QI) Staff from all three 911 EMS Providers, the Trauma Center Director, QI team, Base Hospital, and all other hospitals in San Francisco. Goals for 2025 include review of Trauma Triage and Re-Triage protocols.

Quality Improvement Process

Monthly Performance Improvement (PI) meetings are hosted by ZSFG. Attendees include both the EMS Agency's Medical Director and QI Deputy Director, hospital clinical department representatives, and ALS EMS Providers. PI members review trauma cases, transfers in and out of ZSFG, outcomes from the quarterly Morbidity & Mortality meetings, and -trauma center incidents. The SFEMSA-led Trauma System Audit Subcommittee (TSAC) meetings are devoted to trauma Quality Improvement and revising or developing trauma protocol, policies, and guidelines as necessary. In addition, TSAC members designate one meeting per year to review the prior year's pre-hospital burn cases. St. Francis Hospital is designated Burn Center and a major participant at that specific meeting. St. Francis also provides EMS providers with burn-focused training and education. In 2024, there were 3 TSAC meetings held by 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 discussion 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, the EMS Agency completed the ZSFG site survey. Although state regulations recommend a site survey every two years, SFEMSA believes that ZSFG's continued success with re-verification by the American College of Surgeons (ACS) every three years, ongoing TSAC to provide engagement, 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 and the EMSA conducted an on-site Trauma Site survey in December of 2023. SFEMSA previously filed a summary of findings in last year's EMS Plan submission. ZSFG is due for their ACS Survey in 2026, and SFEMSA will take part in the survey as an observer.

Trauma-Related Public Education

SFEMSA's goal is to participate or host an EMS public education event on a monthly basis. SFEMSA's 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. The yearly Bike Rodeo event was cancelled then postponed in 2024, however SFEMSA participated in 2025. SFEMSA also has ability to give letters and awards for providers and members of the public who perform life-saving interventions.

Trauma Statistics – ZSFG Volume

2-Year Review: CY 2023 – 2024

2023 Volume: **3,256**

2024 Volume: **3,413**



Source: ZSFG Trauma Registry

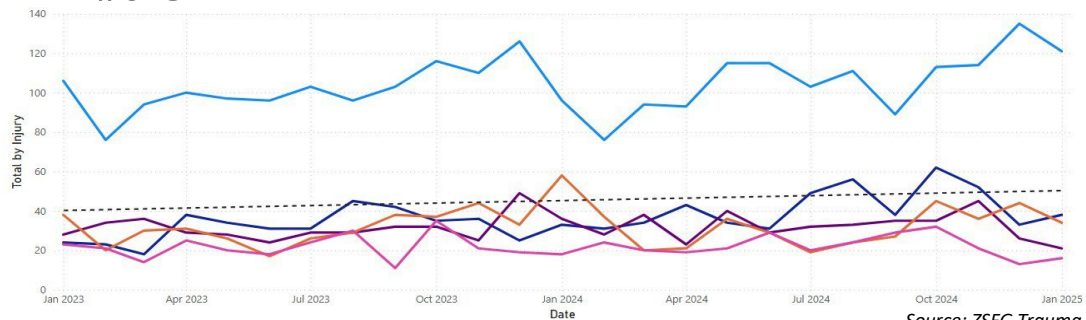
Annual Injury Trends

2-Year Average (CY 2023 – CY 2024)

- Top 5 MOI

- #1 Falls
- #2 MCC
- #3 MVC
- #4 PVA
- #5 SW

NTDB Final	2023	2024	2025	Total
Fall	1223	1254	121	2598
MCC	382	496	38	916
PED	369	396	34	799
MVC	375	400	21	796
SW	261	270	16	547



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](#) (Revised 10/1/25)

[Policy 5000.1 San Francisco Destination Chart](#)

[Policy 5010 Receiving Hospital Standards](#)

[Policy 5016 STEMI and ROSC \(STAR\) Receiving Center Standards](#)

[Protocol 2.06 Chest Pain/Acute Coronary Syndrome](#) (Revised 4/1/25)

[Protocol 7.10 12-Lead Electrocardiogram Procedure](#) (Revised 4/1/25)

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 CEMISIS/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. 4 out of 5 STAR Centers are utilizing this program. As of January 2025, Get With The Guideline users are currently entering data quarterly. The non-Get With The Guidelines user is submitting data quarterly in their current format. The goal of 2025 and 2026 is to continue 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.

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 continues updating field protocols each calendar quarter in collaboration with STAR committee members.

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:

- February 5, 2025 APA Mothers Support-Hands Only CPR Community Event
- March 11, 2025 Federal Bureau of Investigations-Hand Only CPR
- May 10, 2025 Bike Rodeo-Hands Only CPR Community Event

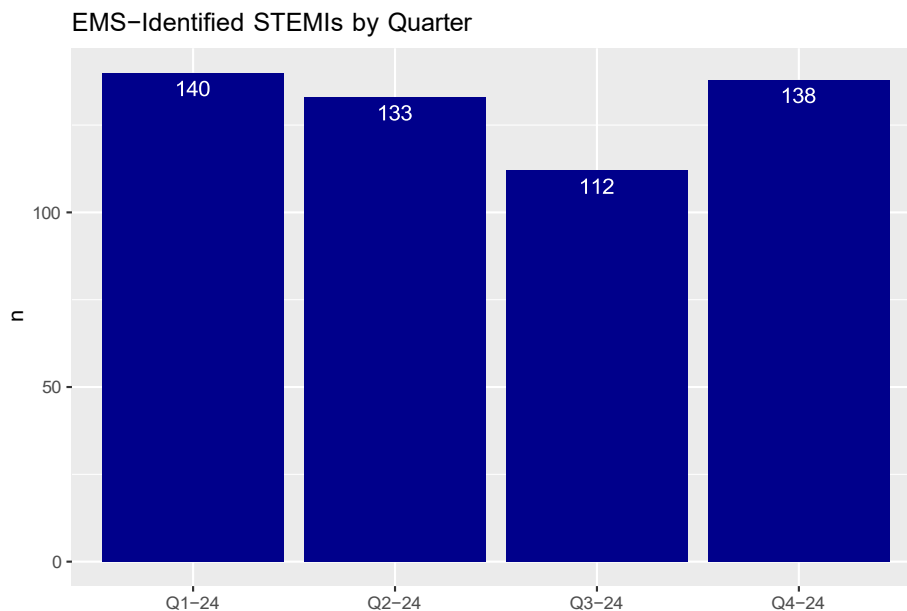
SFEMSA has ability to give letters and awards for providers. SFEMSA also has a program named "Guardian of Life" where members of the public are recognized by letters and awards who perform life-saving interventions.

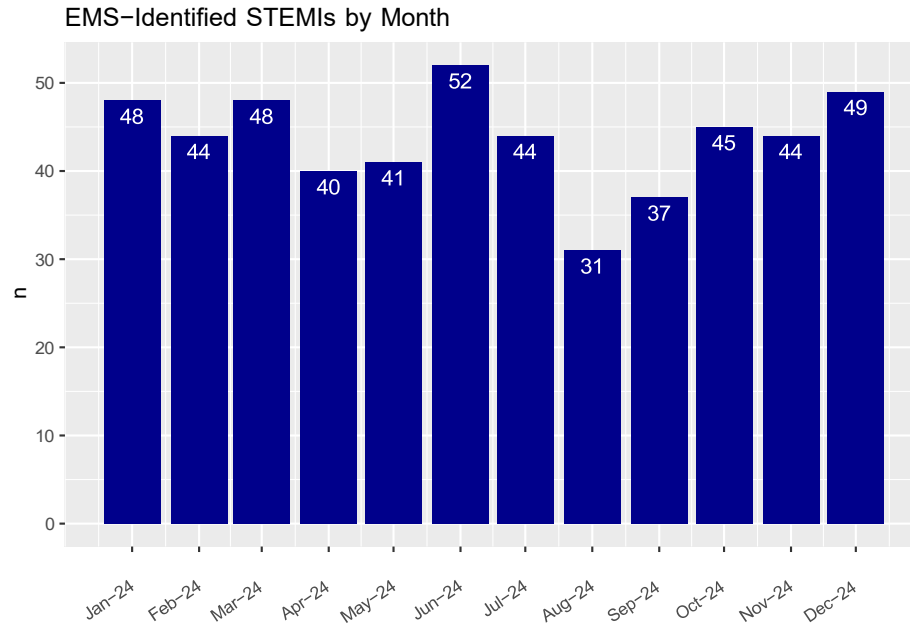
EMS STEMI Report - Q1 2024-Q4 2024

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:

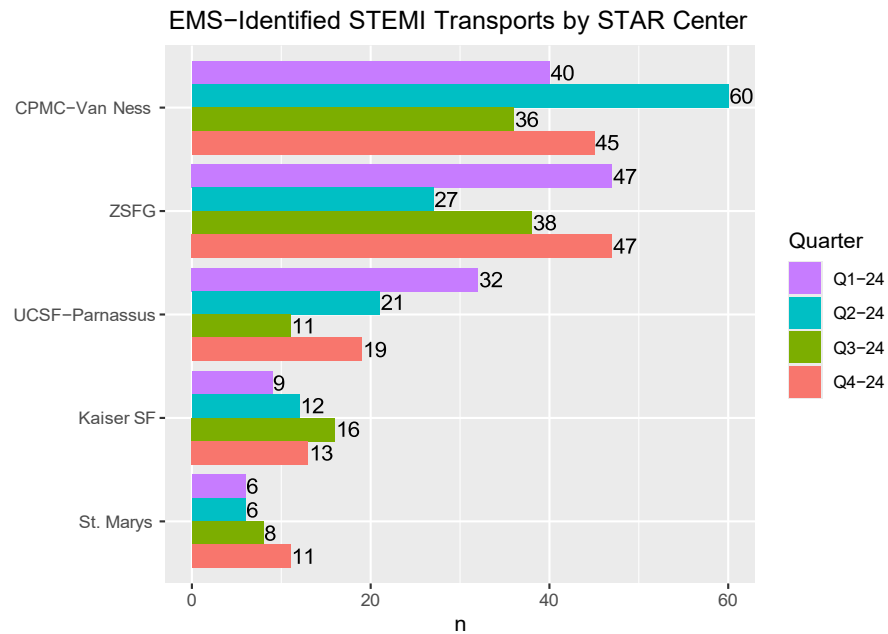
- Primary Impression of STEMI (NEMSIS eSituation.11, ICD-10: I21.3) or;
- Secondary Impression of STEMI (NEMSIS eSituation.12, ICD-10: I21.3) or;
- Destination Team Pre-Arrival Alert of Yes-STEMI (NEMSIS eDisposition.24, Code 4224013) or;
- ECG interpretation of STEMI (NEMSIS eVitals.03, Codes 9901051 - 9901057)

Incidents with a service type other than "911 Response" were excluded (e.g. interfacility transports). In total, 523 prehospital STEMI's were identified.





Of the 523 EMS-identified STEMI's, 504 were transported to San Francisco STAR hospitals.



19 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 504 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	Q1-24	4.2	14.4	17.9	20.5	24.3	59.0
Q2.scene	Q2-24	5.8	13.0	16.8	18.7	22.0	48.7
Q3.scene	Q3-23	2.4	12.9	18.7	18.5	24.0	37.5
Q4.scene	Q4-23	4.1	12.4	17.9	20.4	25.2	80.4

Scene Time for EMS-Identified STEMI Patients

Dashed line represents 90th percentile for all quarters

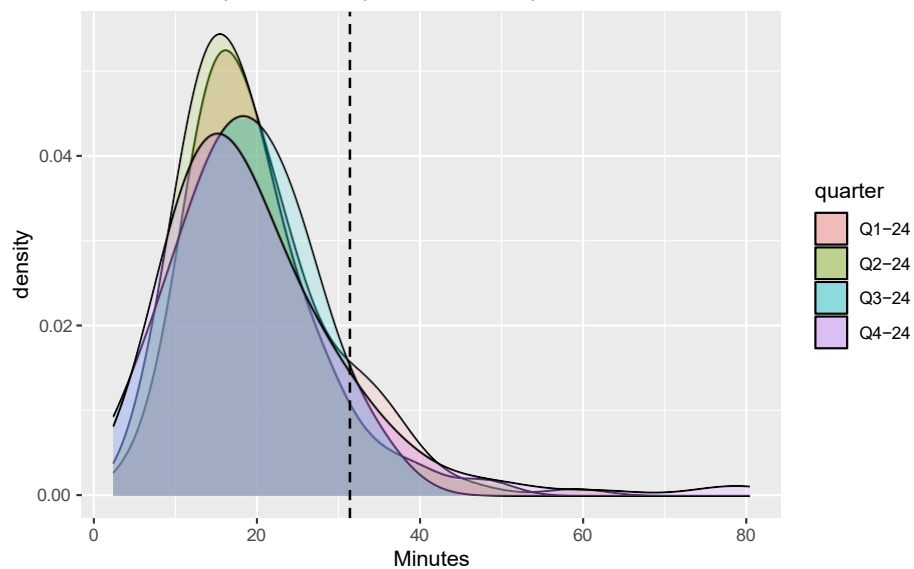
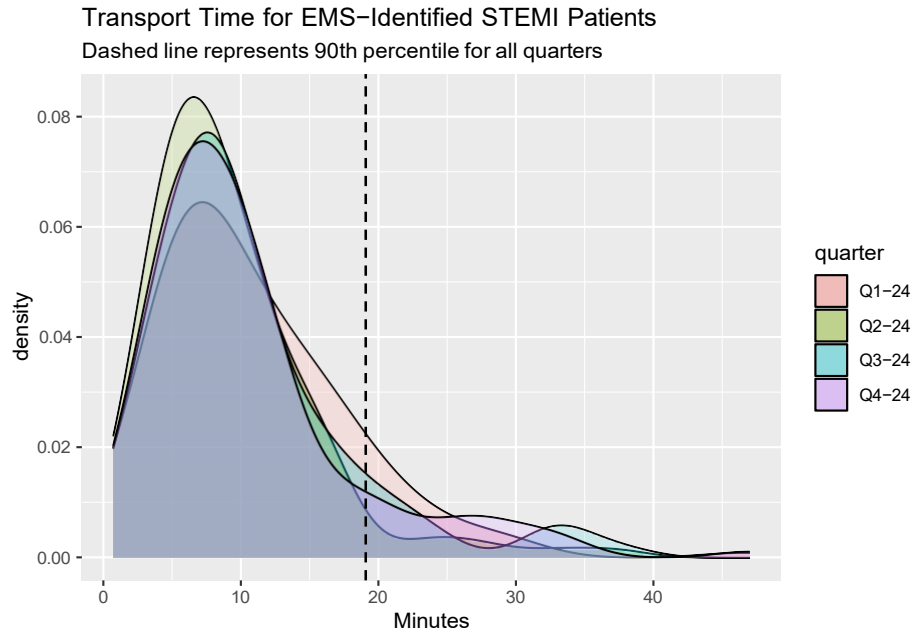


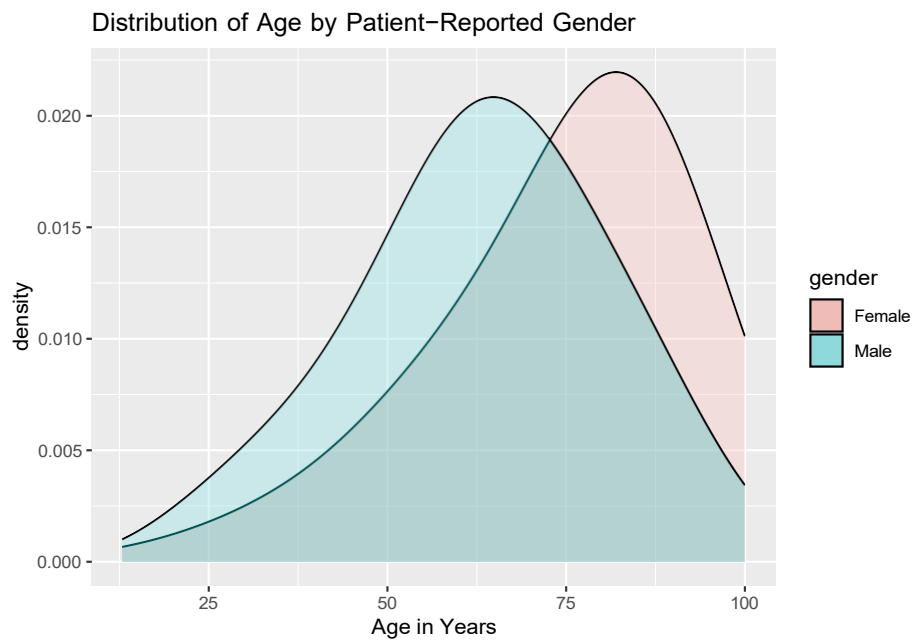
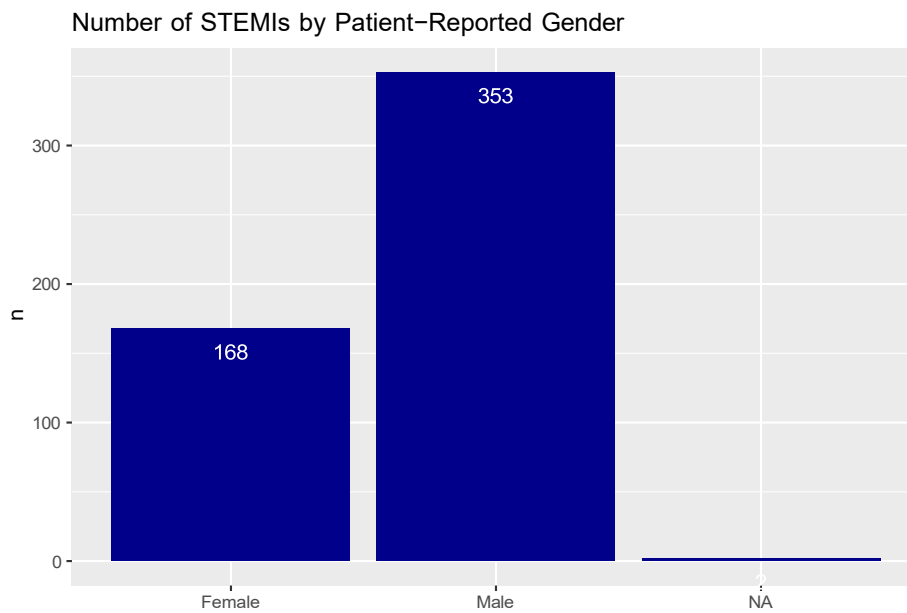
Table 2: Transport Times for STEMI Calls (minutes)

	Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1.trans	Q1-24	1.4	6.0	9.2	11.0	14.5	46.5
Q2.trans	Q2-24	1.7	5.2	8.0	9.2	11.4	37.2
Q3.trans	Q3-23	1.0	6.3	8.6	10.5	12.5	37.8
Q4.trans	Q4-23	0.8	5.7	8.7	10.6	12.5	47.0

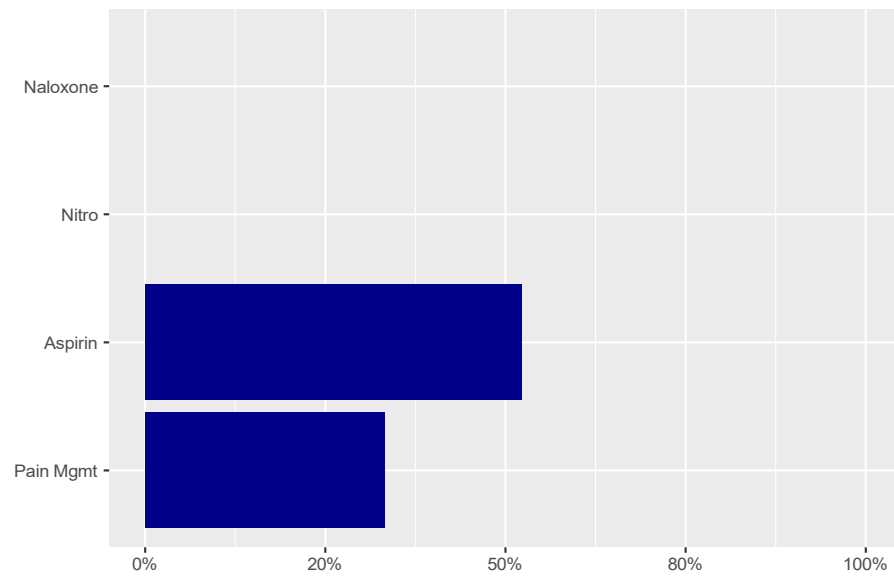


Total EMS Time is the interval between transporting EMS arrival on scene to arrival at a receiving Emergency Department - or the combination of the two intervals reviewed above. The average Total EMS Time for STEMI patients in 2021 was **30.28** minutes.

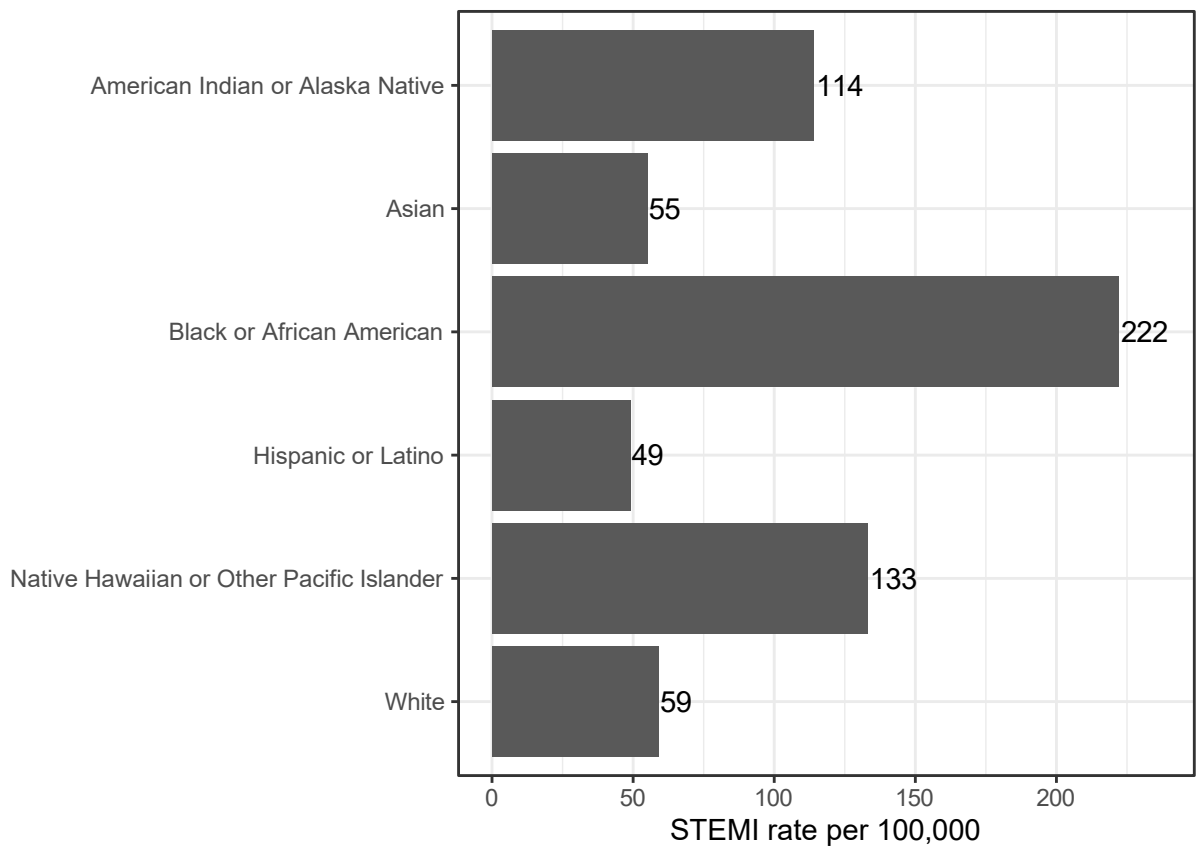
Patient Demographics and Treatment



Percentage of Patients Receiving EMS Medications



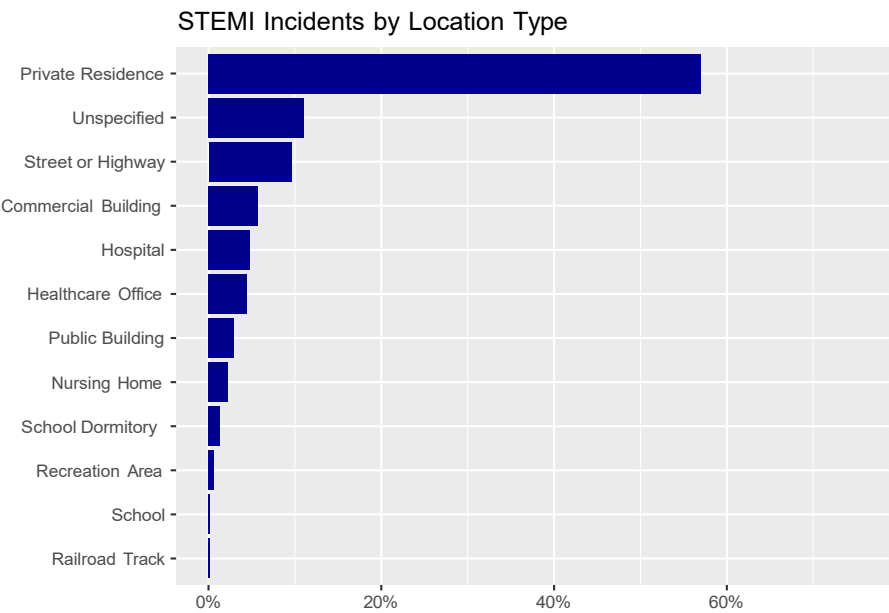
STEMI rate by race/ethnicity



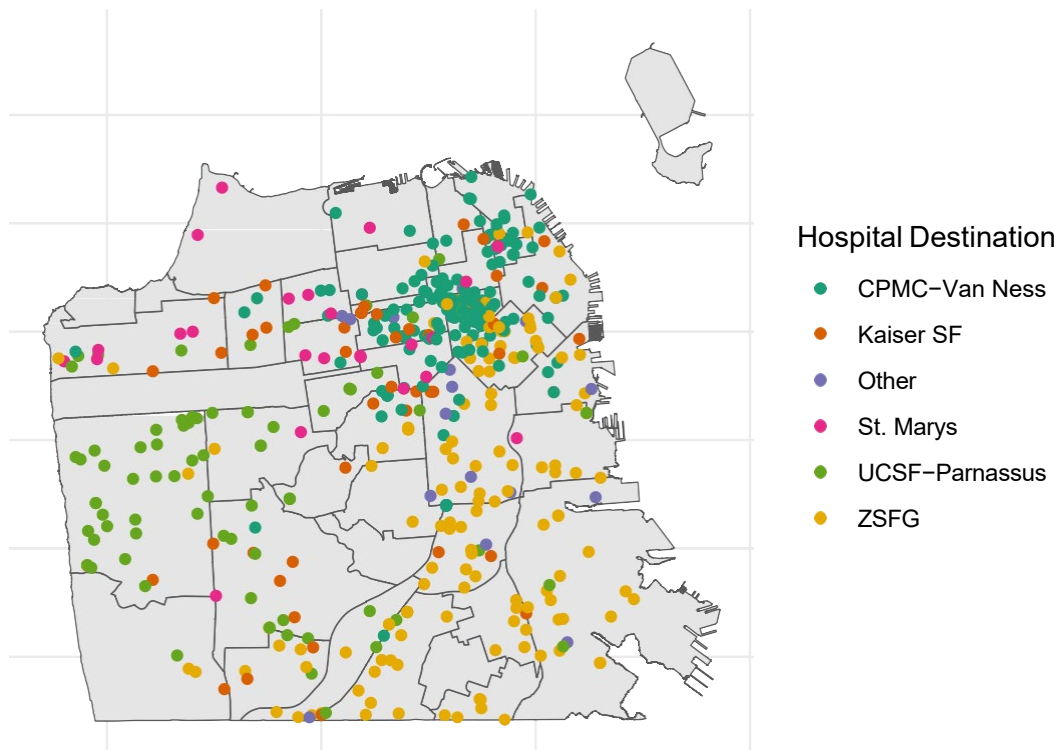
Race/Ethnicity	STEMI Incidents	SF Population	Rate per 100,000
American Indian or Alaska Native	2	1758	114
Asian	163	294027	55
Black or African American	93	41934	222
Hispanic or Latino	65	131517	49
Native Hawaiian or Other Pacific Islander	4	3010	133
White	192	325900	59

Population statistics are from the 2022 American Community Survey 5-year estimates provided by U.S. Census Bureau.

Incidents by Location Type



Incident Location by Destination Hospital



Please note that 6% of calls did not report GPS coordinates and were excluded from the map above.

Hospital	EMS-identified STEMI (N)
CPMC-Van Ness	171
ZSFG	143
UCSF-Parnassus	79
Kaiser SF	48
St. Marys	30
NA	8
CPMC-Bernal	4
St. Francis	4
CPMC-Davies	2
Seton	1

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	October 15, 2029

Stroke Identification and Destination Determination

[Policy 5000 Destination](#) (Revised 10/1/25)
[Policy 5000.1 San Francisco Destination Chart](#)
[Policy 5010 Receiving Hospital Standards](#)
[Policy 5015 Stroke Center Standards](#)
[Protocol 2.04 Stroke](#)

Stroke Field to Hospital Communications

[Policy 3020 Field to Hospital Communications](#)

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. 4 out of 5 Stroke Centers are utilizing this program. As of January 2025, Get With The Guidelines users are currently entering data quarterly. The non-Get With The Guidelines user is submitting data quarterly in their current format. The goal of 2025 and 2026 is to continue 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 can transport to in San Mateo County (Kaiser South San Francisco).

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 few public outreach events include:

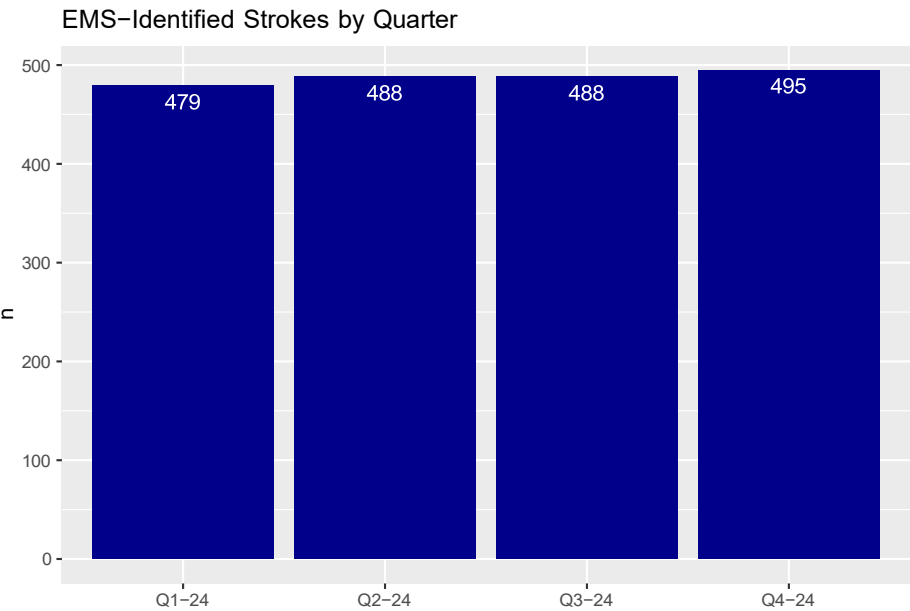
- May 14, 2024 Ferry Building Farmers Market
- May 28, 2025 Heart of the City Farmers Market (including hands only CPR)

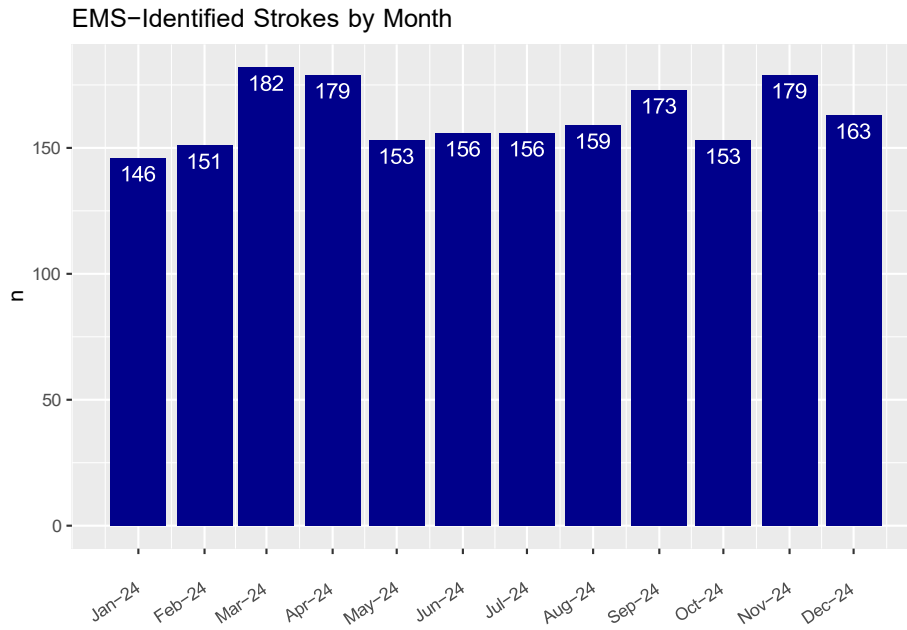
EMS Stroke Report - Q1 2024-Q4 2024

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:

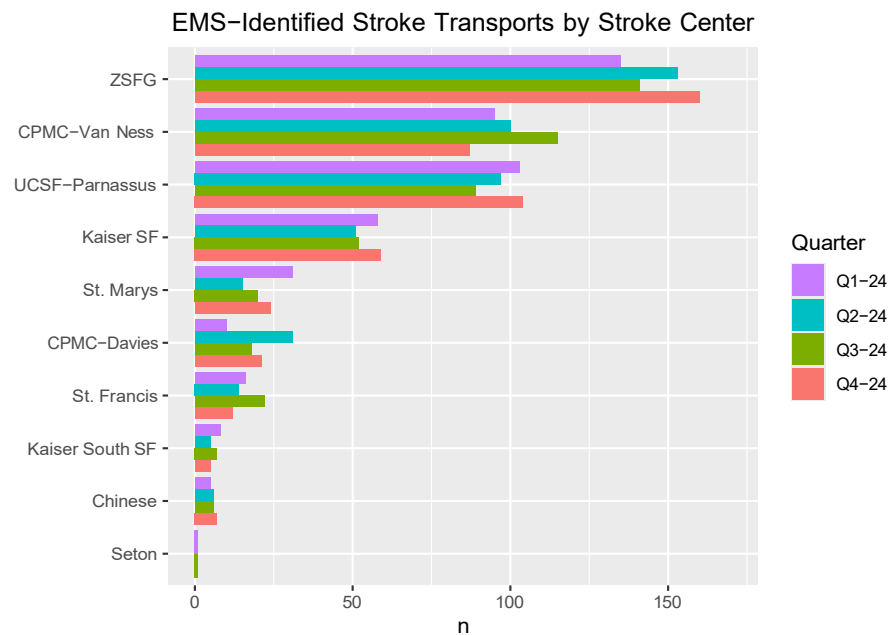
- Primary Impression of Stroke (NEMSIS eSituation.11, ICD-10: I60, I61, I63, G45, G46.3, G46.4) or;
- Secondary Impression of Stroke (NEMSIS eSituation.12, ICD-10: I60, I61, I63, G45, G46.3, G46.4) or;
- Stroke scale score (eVitals.29) indicates a positive stroke assessment

Incidents with a service type other than “911 Response” were excluded (e.g. interfacility transports). In total, 1950 prehospital strokes were identified.





Of the 1950 EMS-identified strokes, 1884 were transported to San Francisco Stroke-receiving hospitals.



66 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 1884 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
Q1-24	2.1	13.3	17.0	18.9	23.1	97.3
Q2-24	2.9	13.4	17.0	18.2	21.7	50.7
Q3-24	0.8	14.2	17.8	19.7	23.0	81.1
Q4-24	3.8	13.2	18.3	19.3	23.3	107.2

Scene Time for EMS-Identified Stroke Patients

Dashed line represents 90th percentile for all quarters

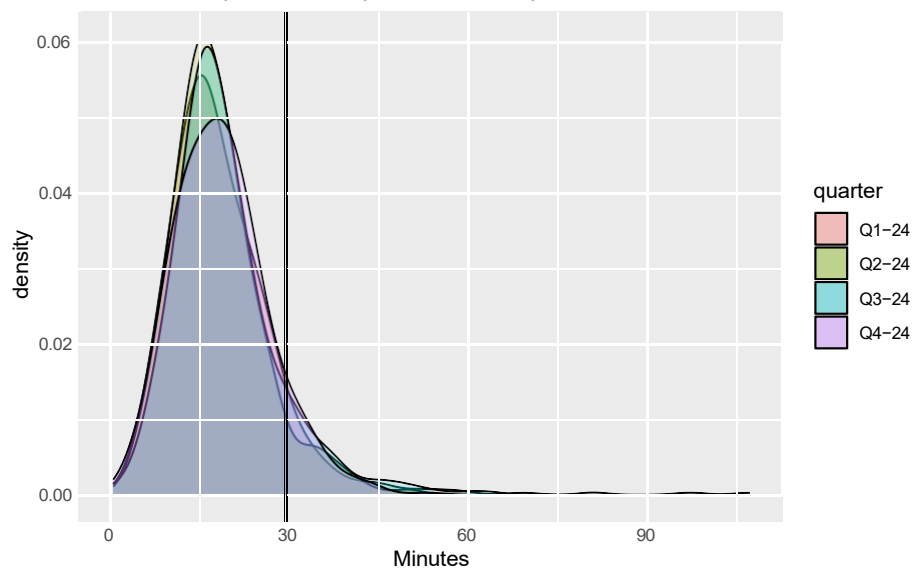
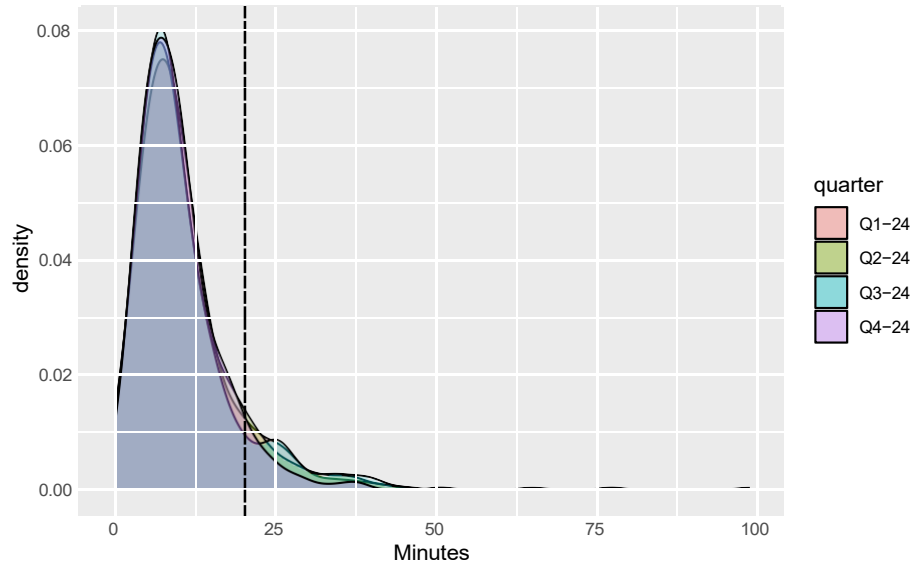


Table 2: Transport Times for Stroke Calls (minutes)

Quarter	Min Time	Quartile 1	Median	Mean	Quartile 3	Max
Q1-24	0.1	6	9.0	10.7	13.2	43.0
Q2-24	0.1	6	8.9	11.1	13.5	99.0
Q3-24	0.0	6	8.5	10.9	13.0	77.6
Q4-24	0.6	6	8.9	10.2	12.7	51.0

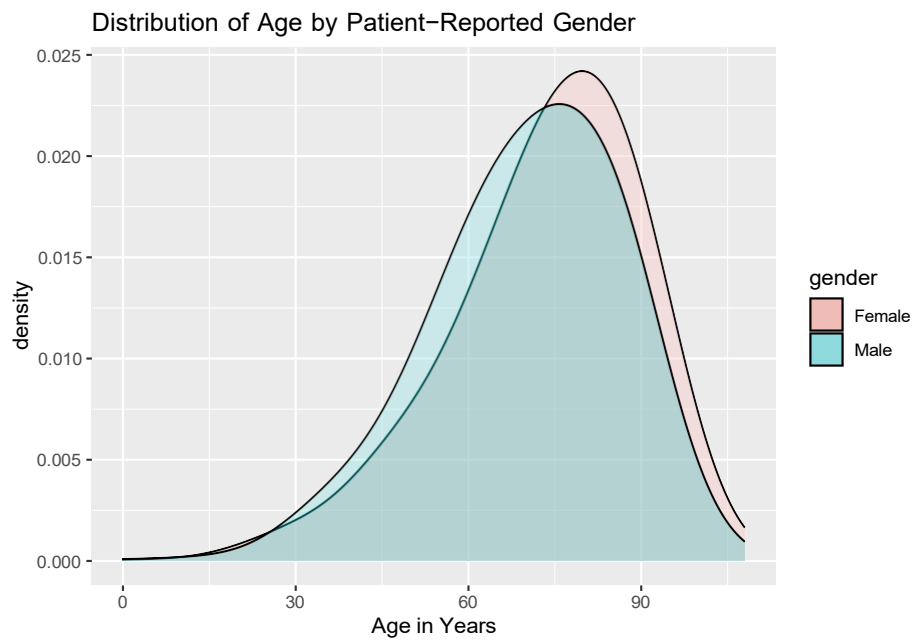
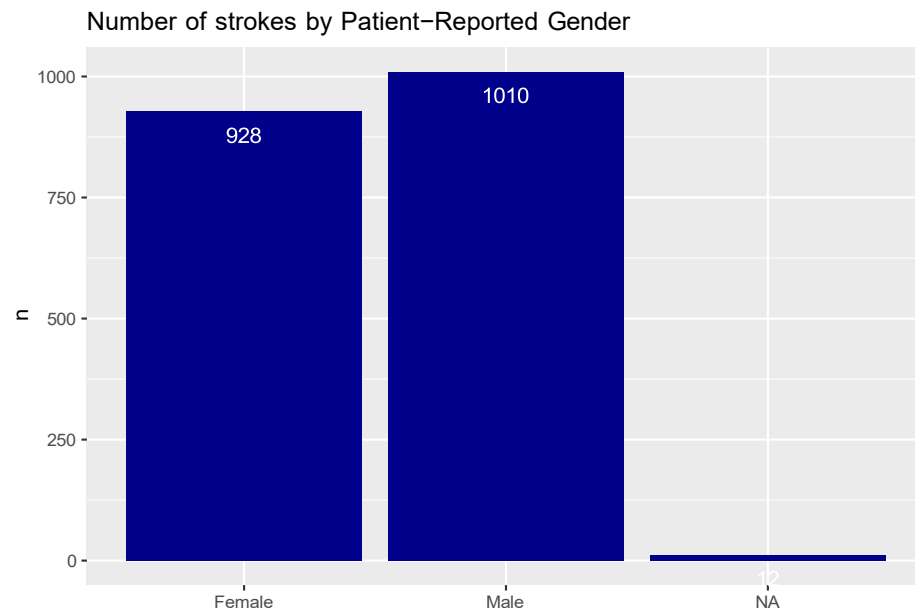
Transport Time for EMS-Identified Stroke Patients

Dashed line represents 90th percentile for all quarters

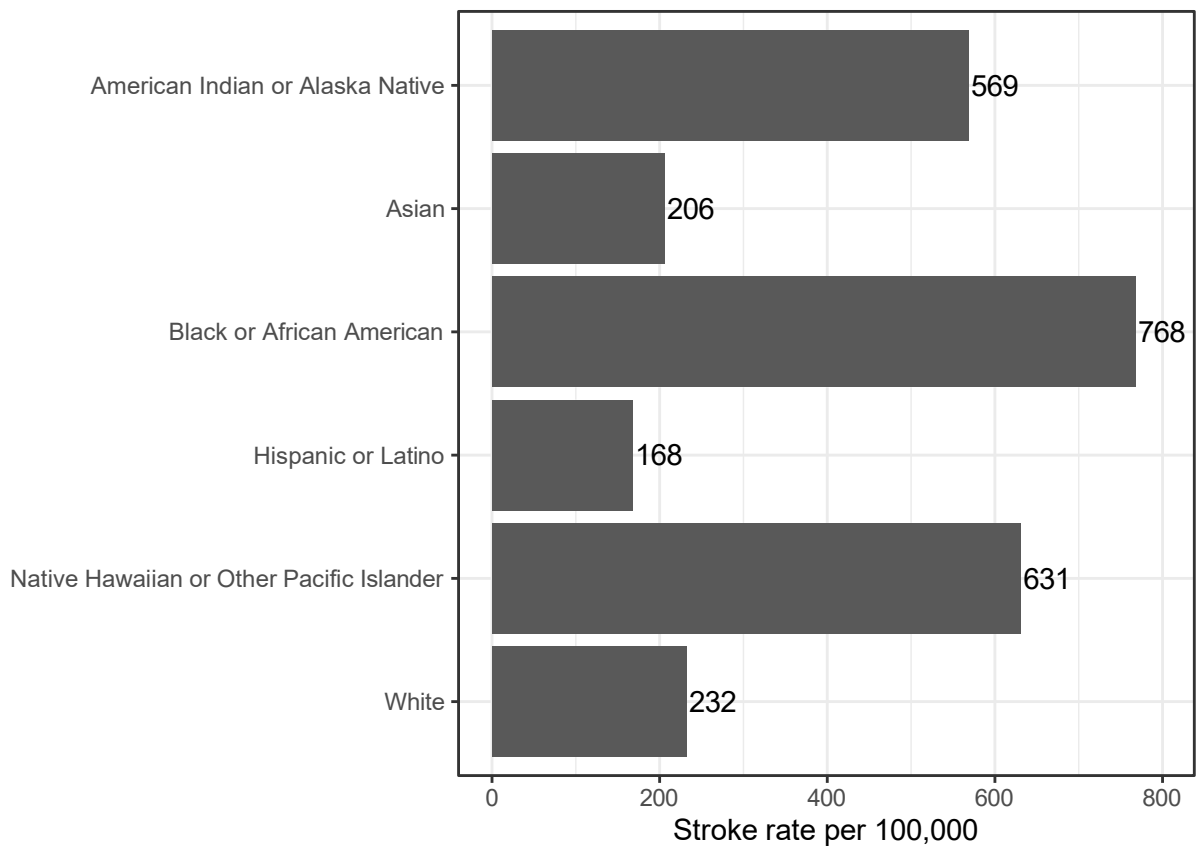


Total EMS Time is the interval between transporting EMS arrival on scene to arrival at a receiving Emergency Department - or the combination of the two intervals reviewed above. The average Total EMS Time for stroke patients was 29.9 minutes.

Patient Demographics and Treatment



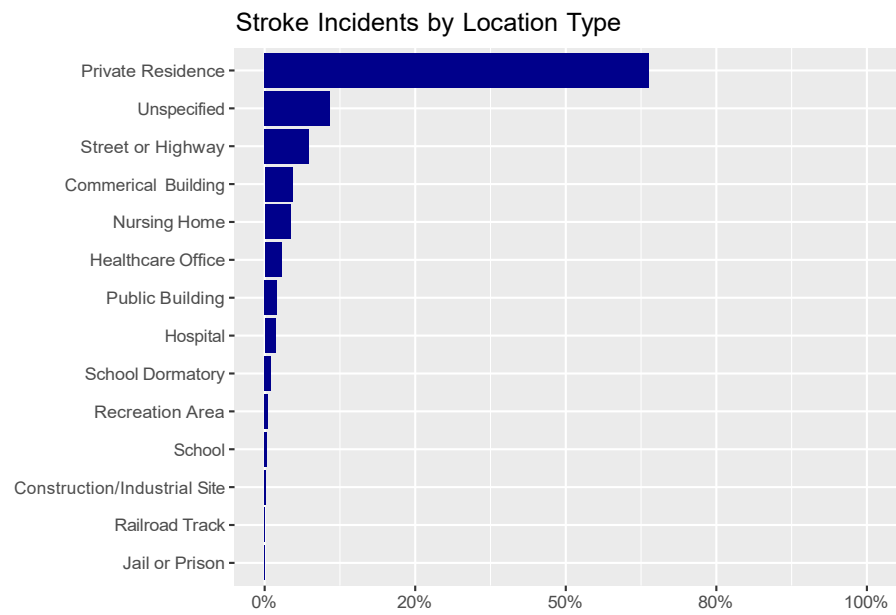
Stroke rate by race/ethnicity



Race/Ethnicity	Stroke Incidents	SF Population	Rate per 100,000
American Indian or Alaska Native	10	1758	569
Asian	607	294027	206
Black or African American	322	41934	768
Hispanic or Latino	221	131517	168
Native Hawaiian or Other Pacific Islander	19	3010	631
White	757	325900	232

Population statistics are from the 2022 American Community Survey 5-year estimates provided by U.S. Census Bureau.

Incident Location



Appendix E

San Francisco Emergency Medical Services Agency

EMS for Children (EMSC) Plan



Goals and Objectives

The City and County of San Francisco has a long-standing commitment to our pediatric population with a primary goal of providing the best possible emergency medical care at the right time, every time.

To meet this goal, San Francisco Emergency Medical Services Agency (SFEMSA) assembled stakeholders across the system including first responders, 9-1-1 dispatch, EMS Providers, and hospitals to align our commitment to the best possible care for San Francisco's pediatric population.

This EMS for Children plan has been written in accordance with California Code of Regulations, Title 22, Division 9, Chapter 6.4.

SFEMSA EMSC Agency Staff

Title	Name	Role Related to Program	Frequent or Occasional
EMS Medical Director	Dr. Amelia Breyre	Medical Direction, strategic planning, clinical evaluation, research	Frequent
EMS Director	Andrew Holcomb	Policy decisions, strategic planning, plan submission, agreements/contracts	Frequent
EMS Deputy Director, Operations	Kayleigh Hillcoat	Operational issues, adverse outcome review	Occasional
EMS Deputy Director, QI	Elaina Gunn	Program Manager: Quality Improvement, policy development, public outreach	Frequent
EMS Specialist (QI)	TBD	Program specialist: Quality Improvement, policy development, committee representative	Frequent
EMS Specialist (Training)	Ron Pike	Training development and delivery	Occasional
Epidemiologist	Will Godwin	Quality Improvement data analysis and dashboard development	Occasional
EMS Info and Guidance Specialist	Erin Bachus	Training development and delivery	Occasional

Hospital and Prehospital Information

The City and County of San Francisco has a population of 808,000 residents and a mean age of 40.4 years. Of these residents, 8% are between the age of 0 and 9 years and 7% between the age of 10 and 19 years*. Source: U.S. Census Bureau, Vintage 2020 Population Estimates. Figure prepared by MCAH Epidemiology.

San Francisco has ten Receiving Facilities, which are designated to all receive EMS pediatric patients. Of the ten Receiving Facilities, two are identified by SFEMSA as Pediatric Critical Medical Receiving Facilities (CPMC Van Ness and UCSF Mission Bay) and one Level 1 Trauma Center (ZSFG). Both UCSF and CPMC have pediatric rehabilitation and physical therapy resources available for both inpatient and outpatient.

SFEMSA is currently revising policies pertaining to EMSC to align hospital designation with current state regulations for Basic, Advanced, and Comprehensive Pediatric Receiving Centers standards. Site reviews have a goal of completion by mid-to-end of 2026. At that time, SFEMSA anticipates having at least one Advanced Pediatric Receiving Center and one Comprehensive Center designated in San Francisco.

Pediatric transports in San Francisco remain between 1.5 and 2% of all 9-1-1 transports annually. This percentage remains consistent with overall volume trends. In 2024, there were a total of 2,137 pediatric transports that made up 1.89% of overall transports in SF.

All 9-1-1 calls are routed through the Department of Emergency Management's 9-1-1 call center, where a call taker directs it to the appropriate dispatcher based on location of emergency and then dispatches nearest available unit to the call. Patients under age 18 with 1 or more of the following medical conditions are transported to the closest Pediatric Critical Medical Receiving Facility:

- Cardiopulmonary arrest or post-arrest
- Hypotension with shock
- Status epilepticus
- Acute deteriorating level of consciousness without trauma

Under [Policy 3020](#) (Field to Hospital Communications), any patient meeting Pediatric Critical Care Destination Criteria, receiving critical care centers will receive a Pediatric Critical Alert from EMS field personnel prior to arrival.

Pediatric patient meeting [Trauma Triage Criteria](#) are transported to ZSFG for initial stabilization and potential referral to a pediatric trauma center, case dependent. For Pediatric Mass Casualty Incident Triage, SFEMSA uses the Jump START Pediatric MCI Triage Algorithm as the first triage system, followed by additional applicable scoring systems (such as Trauma Triage Criteria, GCS, Burn Rule of Nines, etc.), all of which are clearly outlined in the SFEMSA MCI [Policy 8000 Section 3.9](#). Additionally, Policy 8000 [Section 3.10](#) outlines that the assigned distribution of pediatric patients and when pediatric patients are distributed out-of-county.

San Francisco has three 9-1-1 EMS providers: SFFD, AMR and King American. EMS Providers utilize SFEMSA's [policies and protocols](#) to assess stability and initiate treatment of pediatric patients. All 9-1-1 EMS Providers have representation on the SFEMSA EMSC Subcommittee.

EMSC Data Management and Quality Improvement

In 2021, SFEMSA re-established the EMSC Subcommittee, a multidisciplinary subcommittee of the EMS Advisory Committee that advises on pediatric prehospital care. Membership of this subcommittee includes representation from each of the Pediatric Critical Medical Facilities, 911 EMS Providers, ZSFG trauma center, and EMS for Children advisor, Dr. Efrat Rosenthal. The subcommittee's goals are the evaluation of pediatric policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. The subcommittee assists the SFEMSA Medical Director by evaluating topics and data about pediatric-specific issues such as clinical research on prehospital pediatric care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes. This

subcommittee reviews all cardiopulmonary or respiratory arrests, child maltreatment cases, deaths, ICU, OR and trauma admissions, and transfers.

The EMSC subcommittee meets three times per year. Over 2023 and 2024 SFEMSA was able to conduct a complete review and revision of all pediatric-related clinical protocols to align them with current clinical practice guidelines. Revised protocols were distributed for training to EMS Providers in early 2024 and are currently in effect.

Prehospital data elements are collected through submission to CEMSIS by all 9-1-1 EMS providers and include (but are not limited to):

- Arrival time/date to the ED
- Date of Birth
- Mode of arrival
- Gender
- Primary Impression
- Residence zip code

Additionally, the EMSC Subcommittee established a baseline data set with a data collection process to close the gap on patient outcomes from hospitals. Beginning in early 2025, each hospital will submit the following elements monthly to SFEMSA. These elements will be integrated into the existing prehospital data collection to present a complete picture of patient care and outcomes. These elements include:

- Age
- Mode of arrival
- Time/date of arrival
- Admitting Hospital
- Discharge or Transfer Diagnosis
- Time/date of discharge or transfer from ED
- Disposition from ED
- External cause of injury
- Injury location
- Additional notes/narrative as appropriate

Policy and Protocol Process

All policies and protocols are vetted and reviewed by stakeholders, including members of the public, in an open and transparent process. Anyone can recommend review and propose 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. The review and revision of all [pediatric clinical protocols](#) followed the above process.

Personnel Training and Education

All EMS Providers in San Francisco are responsible for providing prehospital pediatric training and education while being subject to oversight by the SFEMSA Medical Director. Requirements for training are supported by SFEMSA policies and protocols, pediatric-specific equipment requirements, and collaboration with the SFEMSA Medical Director.

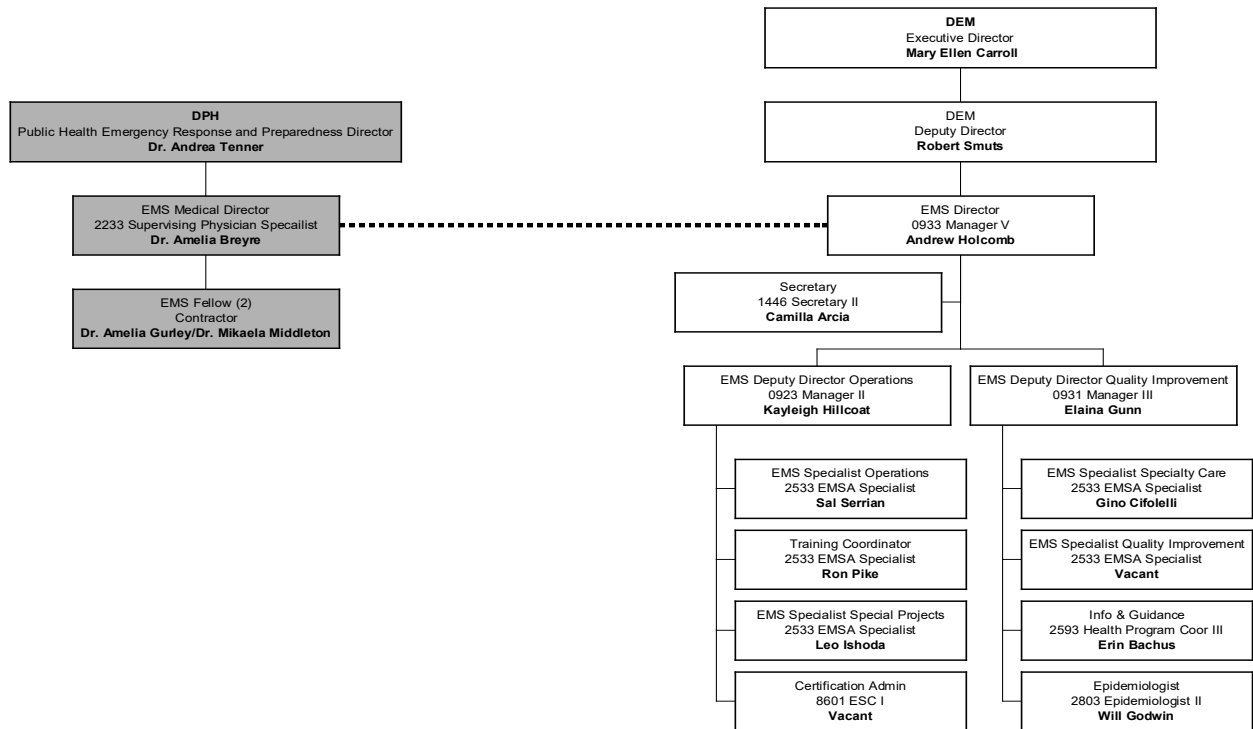
Injury and Illness Prevention

Since 2021, SFEMSA has been working with ZSFG Level 1 Trauma Center staff as well as community organizations within San Francisco to identify and provide public education centering on injury prevention and child safety. Events include participating in the annual San Francisco Bike Rodeo, which is a bike safety event sponsored by the Boy Scouts. Our goal in the coming year is increase partnerships with community organizations for illness and injury prevention public outreach as well as data collection. Through social media, SFEMSA routinely posts safety-specific content pertinent to the pediatric population and has recognized EMTs and Paramedics for their high-quality EMS care in the field at an annual EMS awards event.

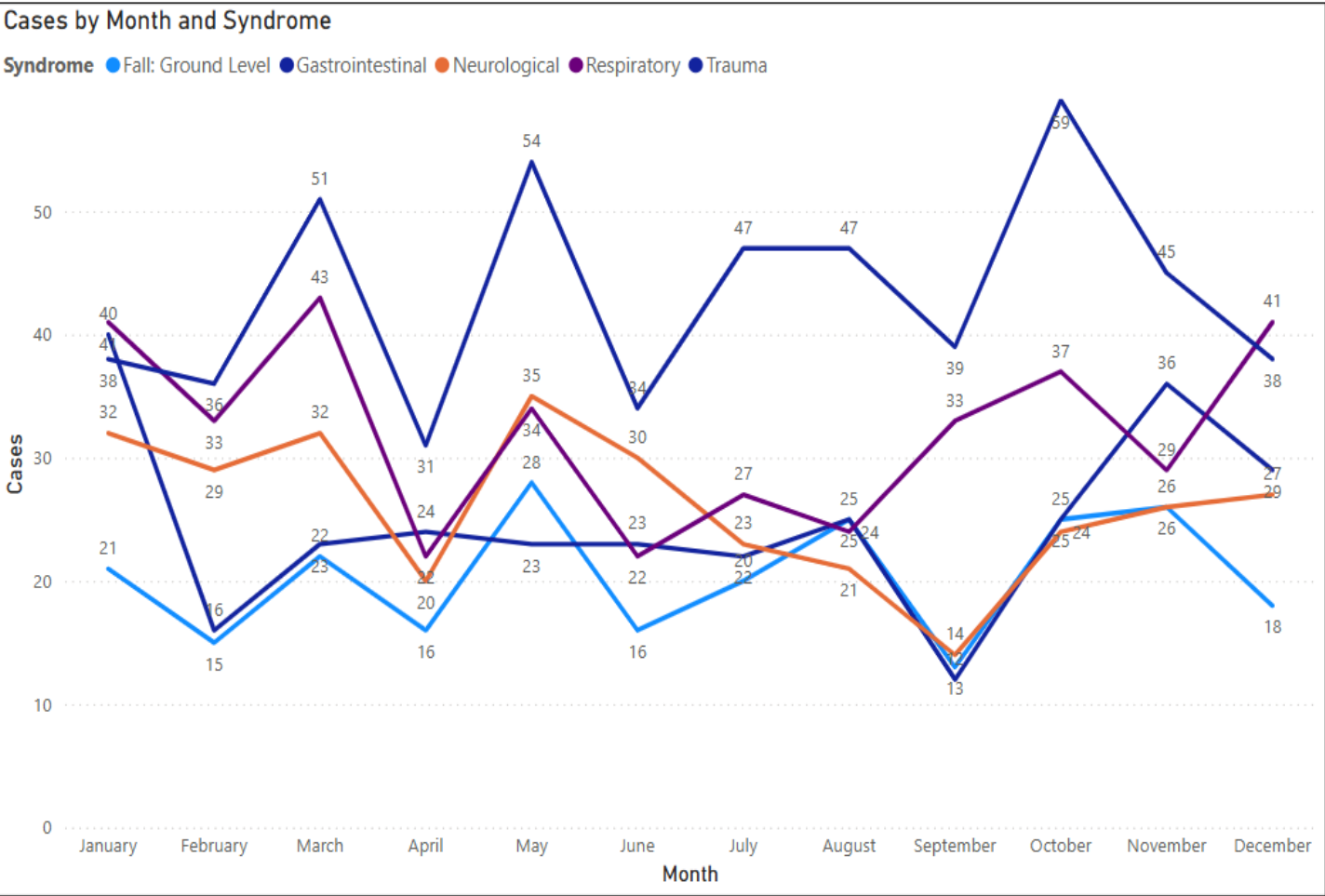
Receiving Facilities Agreements

Receiving Facility	Agreement Expiration Date	Type of Pediatric Services
Zuckerberg San Francisco General	June 30, 2028	Pediatric Emergency, Trauma
UCSF – Parnassus Campus	September 30, 2028	Pediatric Emergency
UCSF-Mission Bay Campus	September 30, 2028	Pediatric Critical Care
St. Mary’s Medical Center	November 30, 2028	Pediatric Emergency
St. Francis Memorial Hospital	November 30, 2028	Pediatric Emergency
Kaiser San Francisco	March 30, 2028	Pediatric Emergency
CPMC – Van Ness Campus	February 5, 2028	Pediatric Critical Care
CPMC – Davies Campus	February 5, 2028	Pediatric Emergency
CPMC – Mission Bernal Campus	February 5, 2028	Pediatric Emergency
Chinese Hospital	March 12, 2028	Pediatric Emergency
Kaiser South San Francisco	October 15, 2029	Pediatric Emergency

San Francisco Emergency Medical Services Agency Organizational Chart



Data from January 1, 2024 to December 31, 2024



TOP Pediatric Syndromes- CY 2024

Syndrome	Cases
Trauma	519
Respiratory	386
Neurological	313
Gastrointestinal	298
Constitutional	281
Fall: Ground Level	245
Mental Health	231
MVC Non-Severe	168
Influenza-like Illness	107
Fall: From Height	103
Substance Use Disorder	92
MVC Severe	65
Self-Harm	52
Chest Pain	49
Cardiovascular	46
Overdose (DOSE) - EMS Pilot	46
Suicide Ideation	45
Alcohol	42

Pediatric Equipment List

Nasal Cannulas - Pedi
Simple Oxygen Masks - Infant
Non-Rebreather Masks - Pedi
Bag Valve Masks - Pedi
Bag Valve Masks - Infant
Oral Airway Set With Sizes 0 - 6
Pediatric Suction Bulb (Sterile)
Suction Catheters 6, 8, 10, 12, & 14 Fr
Supra-Glottic Laryngeal Airway (iGel), Pedi/Infant, Sizes 1, 1.5, 2, & 2.5
Uncuffed Endotracheal Tubes, Sizes 2, 2.5, & 3
Meconium Aspirator
Laryngoscope Blades w/ Extra Bulbs, Miller Type: 0, 1, 2, 3, & 4
Laryngoscope Blades w/ Extra Bulbs, Macintosh Type: 1, 2, 3, & 4
(Optional) Video Laryngoscope Blades (Approved by EMSA), Adult and Child Sizes
Small Laryngoscope Handle
Magill Forceps, Pedi
Pediatric Finger Probes For Pulse Oximetry
Infant Finger Probes For Pulse Oximetry
Semi-automatic defibrillator pads - Pedi
Blood Pressure Cuff - Pedi
Blood Pressure Cuff - Infant
Multi-function defibrillation pads - Pedi, Compatible With Monitor With Compression
Feedback Puck
Cervical Collars: Pedi
Traction Splints: Sager or HARE (adult and pedi size) OR Kendrick Traction Device (one size)
Pediatric Spinal Immobilization Device
Pediatric Gurney Restraint/Seatbelt Device
Pediatric Length-Based Resuscitation Tape
Stuffed toy for children
Obstetrical Kit w/ umbilical cord clamps; receiving blanket; infant bunting blanket; infant warming cap; sterile scissors or scalpel; suction bulb; OB pad; plastic bag for placenta
Pediatric Fluid Volume Limiter
3-way stopcock
EZ-IO Needles, small, medium, & large (or other approved mechanical insertion needles)
EZ-IO Driver (or other approved insertion device)
Oral Airways, sizes 0, 1, 2, & 3

Pediatric Data Collection Form for Hospitals

Admitting Hospital	Discharge or Transfer Diagnosis	Time/Date of Discharge or Transfer from ED	Disposition from ED	External Cause of Injury	Injury Location	Residence ZIP Code	Notes/Narrative

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 27, 2025, to SFEMSA detailing a list of 24/7 staff coverage including 29 Registered Nurses, 3 Nurse Practitioners, 1 Physician and 1 Physician's Assistant. 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.*

2024 Annual Data

Responses and Transports	
Community Paramedicine	
Total number of Responses	20,766
Total number of transports to general acute care hospitals	4,330
Triage to Alternate Destination Provider	
Total number of responses	135,912
Total number of transports to general acute care hospitals	81,302
Total number of transports to alternate destination facilities	1,632
number of transports to VA	1175
number of transports to Sobering Center	457

Community Paramedic Training Program

SFEMSA received an email from San Francisco Fire Department (SFFD) on June 27, 2025, reporting there have been no changes to community paramedic training curriculum. SFEMSA assessed this curriculum upon initial review in 2023 and submission of the program to the EMS Authority.

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. Recertification training is currently in development for delivery in fall of 2025.

Appendix G

Local Optional Scope of Practice Tracker



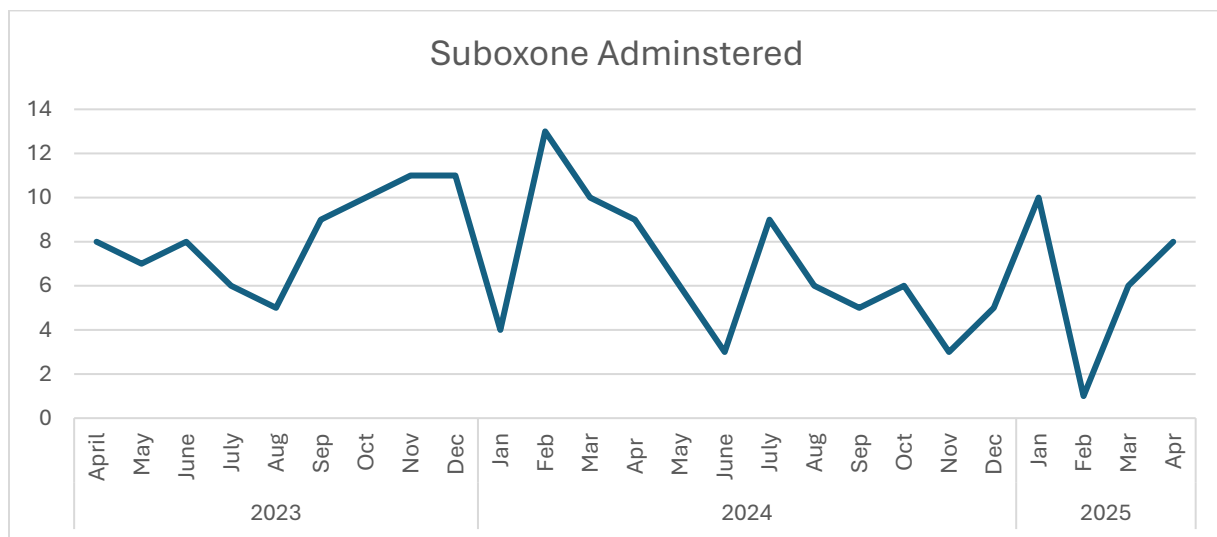
Program	Approval Date	Expiration Date	Draft Due Date
Burprenorphine	12/14/2022	12/31/2025	8/21/2025
Calcium Channel Blockers and Fluid Management CCP	9/28/2022	9/30/2025	5/30/2025
Hydroxocobalamin	9/21/2021	9/30/2027	5/30/2027
COVID-19 Nasopharyngeal Swab Testing	9/21/2021	9/30/2027	5/30/2027
Droperidol	Submitted 6.15.25	6/30/2028	2/30/2028
Olanzipine	Submitted 6.15.25	6/30/2028	2/30/2028
IFT 911 Retriage Blood Products	Submitted 6.15.25	6/30/2028	2/30/2028

Buprenorphine (Suboxone) in San Francisco

In April 2023, San Francisco began Paramedic-administration of Buprenorphine, utilizing the guidelines of the California EMS Bridge Project and under authorization of a Limited Optional Scope of Practice (LOSOP) granted by the California EMS Authority.

The program was championed by Paramedics from San Francisco Fire Department's Community Paramedicine program. The process began with collecting a log of all administrations of suboxone as well as all base hospital calls requesting to give suboxone, as the initial protocol required base hospital contact prior to administration.

Since this program's initiation, 179 total Buprenorphine doses have been administered in San Francisco, with minimal adverse reactions. Ongoing Quality Improvement for this program collected by the SFEMSA on a quarterly basis and reported out at the Quality Improvement Subcommittee meeting, as well as participation in the California EMS Bridge monthly collaborations.



Appendix H



AMBULANCE TURNAROUND TIME STANDARD

EFFECTIVE DATE: 7/1/25

POLICY REFERENCE NO: 4000.1

SUPERSEDES: 4/1/24

1. PURPOSE

- 1.1. To define the goals for ambulance turnaround and patient offload times.

2. BACKGROUND

- 2.1. Patient transfer from ambulance to hospital is a critical part of emergency care, both for the individual patient at the hospital and to preserve the availability of ambulances to answer 911 calls for medical assistance throughout the San Francisco EMS System.

3. DEFINITIONS

- 3.1. **Ambulance arrival at the emergency department** – The time the ambulance stops (actual wheel stop) at the location outside the hospital emergency department where the patient is unloaded from the ambulance.
- 3.2. **Ambulance patient offload time (APOT-1)** – The time when a patient is physically removed from the ambulance gurney to hospital equipment and transfer of care has been completed, as recorded by a signature from an emergency department nurse or doctor in a patient's EMS electronic health record.
- 3.3. **Ambulance return to service time** – The time the ambulance is response ready after transporting a patient to a hospital emergency department.
- 3.4. **Offload time interval** - The period of time between ambulance arrival at emergency department and ambulance patient offload time.
- 3.5. **Ambulance level** – The quantity of available ambulances in the EMS system.
- 3.6. **Ambulance turnaround interval** - The period of time between ambulance arrival at emergency department and ambulance return to service time.
- 3.7. **Ambulance decontamination delay** – Notification is made to Division of Emergency Communications (DEC) by EMS personnel that excessive post-call cleaning or decontamination is needed to place ambulance back into service. This may apply to Code 3 transports and some Code 2 calls in which excessive body fluids, infestation, or hazards (e.g. glass) are present that could potentially expose a EMS personnel or patient on a subsequent call. A decontamination delay is not declared for routine Code 2 transports or patient care.
- 3.8. **Ambulance delayed in triage** – Notification is made to DEC by ambulance crew that a back-up is occurring at hospital triage, intake, or with movement of patient off gurney. Declaration may be made after: 10 minutes from the time the ambulance parks at a hospital as noted in CAD.

Once patient is physically moved off gurney, subsequent notification to DEC is required to indicate there is no longer a delay.

- 3.9. Medic to Follow** – An event where a 911 call is pending and no ambulance is available to respond.

4. POLICY

- 4.1.** The goal for the offload time interval is 20 minutes or less, 90 percent of the time (APOT-1). Under Health and Safety Code 1979.120.5 and upper threshold under Section X, the APOT-1 standard shall not exceed 30 minutes, 90 percent of the time.
- 4.2.** The goal for the ambulance turnaround interval is 30 minutes or less, 90 percent of the time.
- 4.3.** Receiving facility staff may perform minimal risk procedures (e.g. blood draw etc), while the staff continues to work on finding a location for the patient in the ED or waiting room. Hospitals shall not administer medications.

5. PARAMEDIC/EMT-INITIATED OFFLOAD (ACUTE DELAY)

- 5.1.** EMS personnel, Paramedic or EMT, may offload patients directly to a San Francisco hospital ED waiting room under the following conditions and an offload delay greater than 20 minutes is expected:
 - 5.1.1.** The patient is logged and/or registered on the Emergency Department patient tracking board.
 - 5.1.2.** The patient meets the following criteria:
 - 5.1.2.1.** No complaint or assessment finding that is suggestive of the need for time-sensitive intervention.
 - 5.1.2.2.** Patient is 18 years or older or is a minor accompanied by a parent/guardian who has decision-making capacity.
 - 5.1.2.3.** A minimum of two sets of stable vital signs (age appropriate, at patient's baseline or within alternate destination criteria)
 - 5.1.2.4.** Alert and oriented to person, place, time, and situation and has capacity.
 - 5.1.2.5.** No medications were administered by prehospital personnel (including bystander use of Naloxone) with the exception of an anti-emetic or oral medications that do not require close monitoring (e.g. ibuprofen).
 - 5.1.2.6.** In the judgement of the Paramedic, the patient does not require continuous cardiac monitoring.
 - 5.1.2.7.** The patient does not require a saline lock or intravenous (IV) line. If a saline lock or IV line was placed in the prehospital setting, it can be removed by the paramedics. No patient with IV access shall be placed in an ED waiting room.
 - 5.1.2.8.** The patient can maintain a sitting position without adverse impact on their medical condition, dignity, or obvious risk of fall. The patient should have the ability to ambulate by walking or with an assistive device (wheelchair, walker).
 - 5.1.2.9.** The patient is not on a 5150 hold, expressing suicidal ideation to self or thoughts/intent to harm others.
 - 5.1.2.10.** A verbal report and a copy of the prehospital run sheet is provided or available

to a charge nurse or their designee prior to leaving the patient at the hospital. Should a hospital representative refused to sign for transfer of care, please follow the same guidance for APOT Alert documentation. The location to which the patient was triaged must be clearly documented in the prehospital ePCR.

5.1.2.11. If a patient does not immediately meet above criteria, the patient should be reassessed every 15 minutes. If the patient eventually meets criteria to offload to ED waiting room with two consecutive 15-minute assessments (30 minutes minimum), offload to waiting room may occur.

5.1.2.12. By electing to use this option, the ambulance shall return to service within 10 minutes of patient movement off gurney and turnover to ED waiting room.

6. APOT ALERT DECLARATION

6.1. EMS personnel shall work collaboratively with hospital staff to identify offload delays, develop solutions, and formulate a plan for patients currently waiting on gurneys. Every attempt shall be made to triage patients to alternative waiting spaces such as waiting areas, fast track areas, wheelchairs, or hallways spaces.

6.2. The on-duty EMS Supervisor (e.g. Rescue Captain at DEC), monitoring APOT, shall call the Emergency Department Charge Nurse to confirm ambulance offload delays and obtain an ETA to transfer care.

6.3. Should all reasonable attempts to offload patients to other areas fail AND criteria is met below, the EMS Supervisor shall declare an "APOT Alert:"

6.3.1. APOT Alert Criteria:

6.3.1.1. 1 or more ambulances delayed for 60 minutes or greater regardless of Ambulance Level.

6.3.1.2. 1 or more ambulances delayed for 30 minutes or greater with Medic to Follow event(s).

6.3.2. An APOT Alert:

6.3.2.1. Is a formal declaration, similar to an MCI Yellow or Red Alert.

6.3.2.2. Is for situational awareness to all field ambulance crews.

6.3.2.3. During a declared APOT Alert, a Receiving Facility's Stroke and STEMI specialty care designation is temporarily suspended if a patient is equidistant to another facility by traffic or distance. Crews should avoid transporting these patients to the impacted Receiving Facility if at all possible and safe to do so based on patient condition and other equidistant Receiving Facilities with the same specialty care designation.

6.3.2.4. Is in effect until ambulances are cleared from the Receiving Facility.

6.3.3. Steps for DEC:

6.3.3.1. When announcing Diversion, advise of "APOT Alert" declaration.

6.3.3.2. Send a notification to all crews via CAD Mobile Data Terminals advise of APOT Alert and to avoid taking Stroke and STEMI patients to the affected Receiving Facility with an active APOT Alert if equidistant to other Receiving Facilities.

6.3.3.3. Post banner on ReddiNet announcing the APOT Alert at the affected

Receiving Facility.

6.3.3.4. Sent ReddiNet message to EMS Providers, EMSA, and affected Receiving Facility announcing APOT Alert declaration.

6.3.3.5. Notify DEM Duty Officer (to notify EMS Agency).

6.3.3.6. Send follow-up message when APOT Alert secured.

6.3.4. Steps for Receiving Facility:

6.3.4.1. Charge nurse shall immediately notify House Supervisor and Administrator on Call.

6.3.4.2. Consider activation of HICS (Hospital Incident Command System)

6.3.4.3. Consider activation of emergency surge plans including use of:

- Alternate treatment spaces (ie tents, unoccupied hospital wards/floors)
- Staff call-ins, modification of nursing ratios

6.4. Steps for field EMS Supervisor:

6.4.1. A field EMS Supervisor should be dispatched after an APOT Alert is declared.

6.4.2. Upon arrival to the facility, the EMS Supervisor shall identify themselves and check-in with Emergency Department Charge Nurse and/or Hospital Supervisor to confer about the cause of the ambulance offload delay.

6.4.3. EMS Supervisor shall ensure any EMS patients meeting Section 5 criteria are offloaded to waiting room. EMS Supervisor shall notify Emergency Department Charge Nurse and/or Hospital Supervisor that continued delays may lead to re-triage to other Receiving Facilities should all other options fail.

6.4.4. Immediately re-triage patients to other Receiving Facilities that are less impacted if the time to transport and transfer care to another Receiving Facility is less than the estimated time to transfer care at the facility with the declared APOT Alert. The patient shall be asked and must consent prior to re-triage to another Receiving Facility. Re-triage of any patient must be done as a last resort in order to protect public safety and health (e.g. no ambulances available to respond to 911 call).

6.4.4.1. For any re-triage of patients to other Receiving Facilities, the EMS Agency shall review the incident and forward to California Department of Public Health for Emergency Medical Treatment and Active Labor Act (EMTALA) violations.

6.5. Documentation

6.5.1. The following shall be documented in the Patient Care Record (PCR):

6.5.1.1. Detailed description of attempts to offload patient and transfer care to hospital staff

- Reasonable attempts include but not limited to:
 - Multiple attempts to obtain a signature for the PCR
 - Multiple attempts to provide a patient report either written or verbal
 - Attempt to interact with an Emergency Department supervisor, charge nurse, and/or hospital administrator
 - Attempt to utilize EMS Supervisor in offloading patient

- 6.5.1.2. Any additional transports to other facilities
- 6.5.1.3. Patient deterioration due to delays in patient transfer
- 6.5.1.4. Should hospital staff be unwilling to speak with EMS Personnel or sign PCR acknowledging transfer of care, the following statement shall be made by EMS personnel and documented within PCR.
 - An APOT alert has been declared. All reasonable attempts to offload this patient have failed. I am transferring this patient to your care with or without a verbal patient report as you are a higher level of medical care. I will provide written patient care report via a copy of my PCR once complete. I am documenting that I have made every attempt to transfer the patient.

6.6. Upon conclusion of the APOT Alert, the EMS Supervisor shall:

- 6.6.1. Announce the APOT Alert is secured.
- 6.6.2. File an exception report to the EMS Agency within 12 hours.

7. DATA COLLECTION

- 7.1. All interval measurements shall be reported monthly (on the first business day of the month) to the EMS Agency in an approved electronic format.
- 7.2. Turnaround time data submitted by providers shall include date, time, location, call disposition (Code 2 or Code 3), arrival time at hospital, ambulance patient offload time and ambulance return to service time.

8. QUALITY IMPROVEMENT

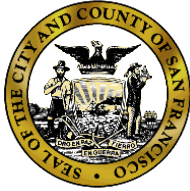
- 8.1. The EMS Agency will report monthly the following ("Hospital Report"):
 - 8.1.1. Offload time interval for each provider at each emergency department.
 - 8.1.2. Ambulance turnaround interval for each provider at each emergency department.
 - 8.1.3. System aggregate intervals for patient offload and ambulance turnaround intervals at each emergency department
- 8.2. The EMS Agency will focus on identifying the root causes for delays, surges in demand and to what extent diversion impacts offload and turnaround intervals.

9. QUALITY ASSURANCE

- 9.1. Based on the Hospital Report, the EMS Agency may take action on a Receiving Facility, as detailed in Policy 5010, who have a:
 - 9.1.1. 90th percentile APOT-1 time under 30 minutes, but greater than the 20- minute standard, the EMS Agency will continue to monitor via quality improvement in subsequent months
 - 9.1.2. 90th percentile APOT-1 time over 30 minutes for two (2) consecutive months
 - 9.1.2.1. The EMS Agency shall refer to corrective action plan process as detailed in Policy 5010

10. AUTHORITY

10.1. California Health and Safety Code, Division 2.5, Sections 1791.120, 1791.120.5-7, 1797.204, 1797.206, 1797.220, 1797.224, 1797.225, 1797.252, and 1798.



Daniel Lurie
Mayor

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



Mary Ellen Carroll
Executive Director

Date: August 26, 2025

To: Elizabeth Basnett, Director, EMS Authority
Hernando Garzon, MD, Chief Medical Officer, EMS Authority

From: Andrew Holcomb, EMS Director

Re: 2025 EMS Plan Annual Update – Addendum

Cal. Code Regulations (CCR) Title 22 § 100096.03(c)(2):

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.

9-1-1 calls are recorded in addition to base hospital call-ins. SFEMSA requests and reviews both 9-1-1 calls and base hospital calls for quality improvement case review and when an exception report is filed for a sentinel event.

Health and Safety Code (HSC) § 1797.152:

SFEMSA participates locally in the Medical Health Operational Area Coordinator (MHOAC) program via an internal committee and through after-hours on-call communications between key stakeholders. Additionally, SFEMSA attends Region II meetings led by the Regional Disaster Medical Health Specialists (RDMHS) and coordinates key information-sharing via the local MHOAC program to the RDMHS. As the current Regional Disaster Medical Health Coordinator (RDMHC) in Region II is a Local EMS Administrator in a neighboring county to San Francisco, SFEMSA is in close communication for EMS-related matters which includes planned special events, unplanned incidents, and regional impacts such as specialty hospital status changes.

CCR 22 § 100162.01(8):

Both UCSF and CPMC have pediatric rehabilitation and physical therapy resources available for both inpatient and outpatient services.

CCR 22 § 100162.01(12):

As San Francisco has 2 pediatric specialty care centers which receive patients from across Northern California, SFEMSA has not identified a need to designate out-of-county hospitals for pediatric centers since San Francisco is a hub for pediatric care. For pediatric trauma patients, ZSFG provides initial stabilization. In the rare case further specialty emergent care is needed, an ambulance will emergently transfer to UCSF Benioff Children's Hospital Oakland, which is a Level 1 Trauma Center. If there were a need to establish an out-of-county pediatric receiving center, SFEMSA would work with the neighboring Local EMS Agency and Receiving Facility.

CCR 22 § 100162.01(13):

Please see attached excerpt from SFEMSA Policy 8000 for pediatric patient distribution, triage, and surge plan for a Mass Casualty Incident.

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. Amelia Breyre, EMS Agency Medical Director
Rob Smuts, DEM Deputy Director
Mary Ellen Carroll, DEM Executive Director

Section 3.10 Assigned Patient Distributions

Below is the initial distribution plan for MCI patients to hospitals by the Patient Transport Officer. **This list does NOT imply that patients must be sent to the hospitals according to any specific sequence.** DEC or the Patient Transport Officer adjust based on the MCI situation or reported hospital availability.

Assigned Distribution - Adult Trauma/Medical and Pediatric Trauma ¹				
Hospital	Immediate (Red)	Delayed (Yellow)	Minor (Green)	ONLY Green
ZSFG Trauma Center	1 ST 10 major traumas	4	6	20
UCSF Parnassus	2	4	6	12
Van Ness – CPMC	2	4	6	12
Kaiser	2	4	6	12
St. Francis Memorial	2	4	6	12
Bernal - CPMC	2	4	6	12
St. Mary’s Medical Center	2	4	6	12
Davies - CPMC	2	4	6	12
(pediatric preferred) UCSF- Mission Bay	2	4	6	12
Seton – Daly City	2	4	6	12
South Kaiser – So. SF	2	4	6	12
(only delayed + minor) Chinese Hospital	0	4	6	12
(only delayed + minor) VA Medical Ctr	0	4	6	12
Subtotals:	30	52	78	160
Total:	160			
1. Hospitals may receive either a combination of Red, Yellow, Green patients or “Only Green” patients. 2. “Only Green” refers to bulk transport of minor (green) patients via bus. In this situation, a hospital will receive “Only Green” patients due to the large number arriving at the same time.				
Assigned Distribution Pediatric Medical ³				
Hospital	Immediate (Red)	Delayed (Yellow)	Minor Green	ONLY Green
UCSF – Mission Bay	1 st 10 medical patients	4	6	12
Van Ness – CPMC	1 st 10 medical patients	4	6	12
SF Receiving Hospitals	2	4	6	12
Stand-by SF Receiving Hospitals	0	4	6	12
3. Preference to keep families together if possible.				

Critical trauma patients may be distributed to regional Trauma Centers through the mutual aid process. The Medical Health Operational Area Coordinator (MHOAC) will notify the Regional Disaster Medical Health Coordinator (RDMHC) about any situation requiring out-of-county

transport of critical trauma patients. Either ground or air medical transport may be used to move patients. *EMS Policy 4020 EMS Aircraft Utilization* lists regional trauma centers with helipads and describes the use of air medical resources.

Triage and Disposition of Medical and Trauma Patients

Patient Type	Triage	Disposition
Medical	Immediate (Red)	Start with hospitals with those farthest away from the incident.
	Delayed (Yellow)	Start with hospitals with those farthest away from the incident after all Red medical patients have been transported.
	Minor (Green)	Start with hospitals with those farthest away from the incident after all Yellow medical patients have been transported.
Trauma ¹ Meeting Physiologic or Anatomic Criteria	Immediate (Red) or Delayed (Yellow)	• 1st Ten trauma patients to ZSFG. ZSFG will indicate their ability to take additional patients. • When ZSFG is at capacity, remaining trauma patients may go to regional trauma centers via ground or air medical services – which ever has the shortest travel time. • Trauma patients may be transported to SF community hospitals if it is determined that a patient is unlikely to survive travel time to an out-of-county trauma center.
Trauma ¹ Meeting Mechanism Criteria	Minor (Green)	May be transported to community hospitals.
Deceased	Deceased (Black)	Medical Examiner
¹ Trauma patients will be re-triaged in the Treatment or Transport Area using the Trauma Triage Criteria when possible to identify critical patients requiring trauma center care.		

Section 3.11 Managed Patient Distribution

Managed Distribution is when the Patient Transport Officer actively determines the hospital distribution for MCI patients when Emergency Department capacity is available on Reddinet and/or the total number of patients from an incident **exceeds** the total number of pre-assigned slots. Patients will be distributed to San Francisco hospitals until they reach capacity. Managed distribution will also be used to move patients to other Bay Area hospitals or beyond through the Medical Mutual Aid process facilitated by the Medical Health Operational Area Coordinator (MHOAC) located at the Emergency Operations Center (EOC).

3.11.1 Role of EOC Operations Section – Health & Human Services Branch, Public Health & Medical Services Group

Figure 2: JUMP START TRIAGE FLOWCHART

JumpSTART Pediatric MCI Triage®

