



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



ICEMA
Training Rooms A & B
1425 South "D" Street
San Bernardino, CA 92408

May 17, 2012
9:00 a.m.

A G E N D A

I. CALL TO ORDER

II. APPROVAL OF MINUTES

January 19, 2012
February 23, 2012 (Special Meeting)

III. INTRODUCTION OF NEW MEMBERS

Membership Report

IV. ICEMA UPDATE

- A. Legislative Update
 - 1797.201 Stakeholders Work Group - Outcome Paper
- B. Urban EOA Contracts Completion
- C. EMS MISS I & II Status Report
- D. Update - Ground Based Ambulance Rate Setting Policy

INFO/ACTION

V. ICEMA MEDICAL DIRECTOR

- A. STEMI Center Update
- B. Stroke Receiving Centers Update
- C. Medication Shortage Update

INFO/ACTION

VI. STANDING EMS SYSTEM MANAGEMENT REPORTS

- A. Quarterly Trauma Hospital Reports
- B. Base Hospital Quarterly Reports
- C. Hospital Bed Delay Reports
- D. Hospital Surveillance
- E. STEMI Reports

INFO

Reports available at http://www.sbcounty.gov/ICEMA/sbcounty_reports.aspx

VII. OLD BUSINESS

- A. Utilization of PBC Trust Fund

ACTION/APPROVE

VIII. NEW BUSINESS

ACTION/APPROVE

- A. 2011 Annual Report - Final Reading
- B. Fines and Forfeitures - Funding for RFP - Consultant for Ground Medical System Design
- C. General Protocols
 - 1. 6070 - Cardiovascular “STEMI” Receiving Centers
 - 2. 8100 - Continuation of Trauma Care
 - 3. 15010 - Trauma - Adult
 - 4. Draft - Hospital Emergency Response Team (HERT)

IX. COMMITTEE/TASK FORCE REPORTS

X. OTHER/PUBLIC COMMENT

XI. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING

XII. NEXT MEETING DATE AND LOCATION

July 19, 2012
ICEMA
Training Rooms A & B
1425 South “D” Street
San Bernardino, CA

XIII. ADJOURNMENT

The San Bernardino County Emergency Medical Care Committee (EMCC) meeting facility is accessible to persons with disabilities. If assistive listening devices or other auxiliary aids or services are needed in order to participate in the public meeting, requests should be made through the Inland Counties Emergency Medical Agency at least three (3) business days prior to the EMCC meeting. The telephone number is (909) 388-5823, and office is located at 1425 South “D” Street, San Bernardino, CA.



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



**City of Rancho Cucamonga
Council Chambers
10500 Civic Center Drive
Rancho Cucamonga, CA 91730**

January 19, 2012

COMMITTEE	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> Jim Holbrook	EMS Training Institution	<input checked="" type="checkbox"/> Reza Vaezazizi	Medical Director
<input checked="" type="checkbox"/> Diana McCafferty	Private Ambulance Provider	<input checked="" type="checkbox"/> Virginia Hastings	Executive Director
<input checked="" type="checkbox"/> Margaret Peterson	Hospital Administrator	<input checked="" type="checkbox"/> Denice Wicker-Stiles	Assistant Administrator
<input checked="" type="checkbox"/> Stephen Miller	Law Enforcement	<input checked="" type="checkbox"/> George Stone	PBC Program Coordinator
<input type="checkbox"/> Michael Smith	Fire Chief	<input checked="" type="checkbox"/> Sherri Shimshy	EMS Nurse
<input checked="" type="checkbox"/> Troy Pennington	Physician -Level II	<input type="checkbox"/> Chris Yoshida-McMath	EMS Trauma Nurse
<input checked="" type="checkbox"/> Art Andres	EMT-P - Public Sector	<input checked="" type="checkbox"/> Ron Holk	EMS Nurse
<input checked="" type="checkbox"/> Rick Britt	Communication	<input checked="" type="checkbox"/> Mark Roberts	EMS Technical Consultant
<input checked="" type="checkbox"/> Allen Francis	Nurse - MICN	<input checked="" type="checkbox"/> Paul Easterling	EMS Specialist
<input checked="" type="checkbox"/> Roy Cox	Air Ambulance Provider	<input checked="" type="checkbox"/> John Mueller	EMS Specialist
<input checked="" type="checkbox"/> Art Rodriguez	EMT-P - Private Sector	<input checked="" type="checkbox"/> Georgann Smith	HPP Training & Exercise Specialist
<input checked="" type="checkbox"/> Richard Catalano	Physician - Level I	<input checked="" type="checkbox"/> Jacquie Martin	Secretary
<input type="checkbox"/> <i>Vacant</i>	City Manager		
<input type="checkbox"/> <i>Vacant</i>	Consumer Advocate		
<input type="checkbox"/> <i>Vacant</i>	Physician - ER		
Dimitrios Alexiou	HASC	Mike O'Toole	Chino Valley IFD
Patrick Apodaca	Barstow FD	Joy Peters	ARMC
Sandy Carnes	Rancho Cucamonga FD	Joe Powell	Rialto FD
Dana DeAntonio	CONFIRE	Ray Ramirez	Ontario FD
Sara Evans	SACH	Matthew Shafer	AHA
Ray Gayk	Ontario FD	Virginia Smith	SACH
Dale Gregory	SBSD - Aviation	Tim Thue	LLU
Joseph Guarrera	Apple Valley FD	Ryan Tworek	MCLB
Nancy Hernandez	LLUMC	Kathy Torres	LLU
Bill Jones	San Manuel FD	Bob Tyson	RDCH
Holly Kendall	Symons Ambulance	David Williams	LLU
Michael May	LLUMC	Randy Yergenson	SB County FD

I. CALL TO ORDER

The meeting was called to order at 9:00 a.m.

II. APPROVAL OF MINUTES

The September 19, 2011, EMCC meeting minutes were reviewed. Diana McCafferty motioned to approve minutes; Allen Francis seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

III. INTRODUCTION OF NEW MEMBERS

Jim Holbrook introduced Dr. Richard Catalano representing Physician - Level I Trauma Center and Art Rodriguez representing EMT/Paramedic - Private Sector as new members of the committee.

Virginia Hastings announced that Dr. Kachhi had resigned from the committee and that the application can be found on the County website.

Virginia Hastings introduced Georgann Smith as the new HPP Exercise & Training Specialist.

IV. ICEMA UPDATE

A. Legislative Update

Virginia Hastings reported that the second year of a 2-year legislative session has begun. Important bills being followed are as follows:

AB 1387 is being forged by a wide constituency group, and if successful, will make significant changes to statutes and subsequent relations relating to 197.201 and 1797.224. More information can be found on the website at www.leginfo.ca.gov.

AB 1245 relating to EMR training has resurfaced.

EMSA has organized a broad-based task force to address many issues, the most difficult being costs of background checks, testing, certification process at local LEMSA level and EMSA registry costs.

B. EOA Contract Extension Negotiations

Virginia Hastings noted that she has previously informed the EMCC that members from Fire Chiefs' Association and AMR had been negotiating extending the existing EOA contracts expiring on April 30, 2012. Legislation has been introduced that may significantly alter EOA system design. Additionally, the Authority's Chapter 13 Taskforce that was working on the regulatory language as a result of the Butte County decision, basically was put on hold while waiting to see the outcome of the AB 1387 work group. It is difficult to undergo a system re-design and enter into long-term contracts, especially in a

complex area such as San Bernardino County, without knowing statutory or regulatory changes that may occur over the next 18 - 24 months.

In her opinion, she thought the negotiating meetings were very productive. However, the Fire Chiefs' Association did not accept the recommendations and instead support language in the expiring contracts that requires the contractor to continue providing service in six-month increments until new providers are selected. She believes that the primary concern of the Fire Chiefs' Association was the proposed term (three (3) years with an option for one (1) additional year).

EMCC Comments:

Stephen Miller asked what the EMCC's role is and if they are required to provide input. Virginia responded that she has been keeping the EMCC informed on the progress and that the EMCC can always make comments and recommendations.

After a lengthy discussion, Jim Holbrook requested that the item be agendaized as an information item on the March meeting. Diana McCafferty noted that as a member of the negotiating group the goal was to send the documents to the Governing Board and expressed concern that waiting until March would delay the process.

Virginia Hastings stated that she would e-mail the proposed contract to the EMCC members and suggested a review/comment period of one (1) month.

Jim Holbrook requested a special single item meeting be held on February 23, 2012, at the new ICEMA building, with comments only on the changes due to ICEMA on Monday, February 20, 2012.

C. EMS MISS I & II Status Report

EMS MISS I & II Report is included in agenda packet for reference.

V. ICEMA MEDICAL DIRECTOR

A. STEMI System Update

Latest STEMI data is posted on the ICEMA website. There are no new trends to report at this time.

B. Stroke Receiving Centers Update

Dr. Vaezazizi reported that Stroke program was launched the middle of December 2011, with Arrowhead Regional Medical Center and Pomona Valley Hospital Medical Center the first hospitals to come on board. He stated that is it too early to report on the operation of the system but the EMS triage process is being monitored and that the major challenge is that not all potential stroke centers are on board yet. Loma Linda University Medical Center should be on board by the end of this month with San Antonio Community

Hospital, St. Mary Medical Center and Redlands Community Hospital to follow. ICEMA is currently monitoring the system via its ePCR data base and will begin CQI data reporting and monitoring later this year. More updates to come.

C. Medication Shortage Update

Dr. Vaezazizi discussed the ongoing problem with national pharmaceutical shortages. Latest medications effected are Magnesium Sulfate, Morphine, and Versed. ICEMA has been working with the affected providers, on a case-by-case basis with variety of solutions.

The topic of using medications beyond their expiration dates was addressed. ICEMA is aware that some LEMSAs in California have chosen to authorize the use of expired medications by EMS providers. However, after careful consideration, discussion with our legal counsel, and review of EMS Authorities' position statement, ICEMA does not feel that this is legally viable option for ICEMA providers at this time.

ICEMA will continue to monitor this situation and provide updates as needed. Sherri Shimshy is the point person for medication shortage issues.

VI. STANDING EMS SYSTEM MANAGEMENT REPORTS

The following reports are available for review at http://www.sbcounty.gov/sbcounty_reports.aspx:

- Trauma Reports (Quarterly)
- Base Hospital Statistics (Quarterly)
- Bed Delay Reports
- Prehospital Data Reports
- Reddinet Assessment Reports
- STEMI Center Reports

EMCC Comments:

Jim Holbrook asked if the link could be changed to other than the home page. He stated that he has students he is encouraging to use the data and is looking for an easier way to get to the reports.

Virginia Hastings and Denice Wicker-Stiles responded that they would work on a solution to simplify getting to the reports.

VII. OLD BUSINESS

A. Utilization of PBC Trust Fund

Utilization of PBC Trust Fund is included in agenda packet for reference.

Jim Holbrook noted that this is an information item only but that EMCC needed a motion to continue support.

Stephen Miller motioned to approve; Art Andres seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

VIII. NEW BUSINESS

A. Election of Chair and Vice Chair

Diana McCafferty made a recommendation that Jim Holbrook remain as the Chair and Margaret Peterson as the Vice Chair; Stephen Miller second the recommendation.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

B. 2011 Annual Report - First Reading

Jim Holbrook noted the report was included in the packet. Comments need to be sent to Jacquie Martin by March 1st. The report will be agendized for the next meeting on March 15th, for approval and then be sent to the Governing Board.

C. Special Event Authorization - Los Angeles Police Revolver and Athletic Club, Inc. (Challenge Cup Baker to Vegas Relay)

LAPRAC submitted an application to provide non-transport ALS service to participants of the annual Challenge Cup/Baker to Vegas Relay event scheduled for April 21 - 22, 2012. To accommodate the needs of the LAPRAC and to ensure mandated medical control, including proper accreditation over paramedics, ICEMA has developed a new ALS authorization classification - Special Event ALS Non-transport Authorization.

Staff has determined that this new classification will enable LAPRAC to meet the requirements as specified in the Health and Safety Code as well as the public health, safety, welfare, convenience and necessity requirement for the granting of ALS authorization.

Diana McCafferty motioned to approve; Art Andres seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

D. Field Treatment Site Plan

Staff Report is included in agenda packet for reference. Virginia Hastings noted that this is a joint requirement by the State EMS Authority and Public Health department (CDPH).

Stephen Miller motioned to approve; Roy Cox seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

E. General Protocols

The following protocols were approved after further discussion and no changes:

1. Draft Minimum Documentation Requirements for Transfer of Patient Care

Stephen Miller motioned to approve; Allen Francis seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

3. 7010 BLS/ALS Standard Drug and Equipment List

Diana McCafferty motioned to approve; Art Andres seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

4. 7020 EMS Aircraft Standard Drug and Equipment List

Stephen Miller motioned to approve; Roy Cox seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

The following protocol was approved after further discussion, with changes as noted and implementation in 30 days:

2. Draft ICEMA Abbreviation List
 - a. Page 9 - Add a line over "c" and "s" for with and without.
 - b. Page 10 - Capitalize "FROM" for full range of motion.

Stephen Miller motioned to approve; Allen Francis seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

VIII. COMMITTEE/TASK FORCE REPORTS

None

IX. OTHER/PUBLIC COMMENT

None

X. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING

2011 Annual Report - Second Reading

XI. NEXT MEETING DATE AND LOCATION

February 23, 2012

ICEMA

Training Rooms A & B

1425 South "D" Street

San Bernardino, CA

XII. ADJOURNMENT

EMCC Meeting was adjourned at 10:23 a.m.

VH/jlm



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



ICEMA
1425 South "D" Street
San Bernardino, CA

February 23, 2012

COMMITTEE	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> Jim Holbrook	EMS Training Institution	<input checked="" type="checkbox"/> Reza Vaezazizi	Medical Director
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<input checked="" type="checkbox"/> Roy Cox	Air Ambulance Provider	<input checked="" type="checkbox"/> John Mueller	EMS Specialist
<input checked="" type="checkbox"/> Art Rodriguez	EMT-P - Private Sector	<input checked="" type="checkbox"/> Jacquie Martin	Secretary
<input checked="" type="checkbox"/> Richard Catalano	Physician - Level I		
<input type="checkbox"/> Vacant	City Manager		
<input type="checkbox"/> Vacant	Consumer Advocate		
<input type="checkbox"/> Vacant	Physician - ER		

Mike Antonucci	Upland FD	Veronica Kennedy	Morongo Basin Ambulance
Patrick Apodaca	Barstow FD	Shawna Legarza	USFS/BDF
Sandy Carnes	Rancho Cucamonga FD	Ramon Lomeli	Morongo Basin Ambulance
Rosemary Dudeuvir	PMT/Premier	Pam Martinez	Ontario FD
Christine Eusoff-Alviz	Redlands Community Hospital	Michael May	LLUMC
Mat Fratus	Colton FD	Lewis Murray	BOS 2 nd District
Jeff Frazier	Redlands FD	Tim McClelland	CAL Fire
Jon Garber	Crest Forest FD	Tim McHargue	Colton FD
Tony Grabow	Running Springs FD	Dan Miulli	ARMC
Jeff Grange	LLUMC	Dan Odom	SB County Fire
Dale Gregory	SBSD Aviation	Leslie Parham	SB County Fire
Sandy Griffin	Rancho Cucamonga FD	Joy Peters	ARMC
Peter Grzeskowiak	CAL Fire	Joe Powell	Rialto FD
Joseph Guarrera	Apple Valley FD	Ray Ramirez	Ontario FD
Mark Hartwig	SB County FD	Tom Richards	Symons Ambulance
Nancy Hernandez	LLUMC	Jerry Ringhofer	Crest Forest FD
Bernie Horak	SB City Fire	Marcelino Ryan	Combat Center FD
Darrell Jauss	Barstow FD	Juan Sanchez	Symons Ambulance
James Johnson	Chino Valley Medical Center	Kirk Summers	Chino Hills FD
Holly Kendall	Symmons Ambulance		

I. CALL TO ORDER

The meeting was called to order at 9:00 a.m.

II. PROPOSED AMBULANCE CONTRACT EXTENSIONS

BACKGROUND - Virginia Hastings

- San Bernardino County developed Exclusive Operating Areas (EOA) under the provisions of 1797.224, “No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981.”
- There are 24 EOA’s in San Bernardino County and three additional operating areas that have No Designated Provider (NAP). There were no responders to an RFP for EMS transportation in these remote locations.
- On April 29, 2003, the Board of Supervisors acting as the Governing Board for ICEMA approved requirements for Performance Based Contracts (PBC). On April 20, 2004, the Board approved contracts for those EOA’s. Subsequently, the Board approved PBC contracts/MOU’s with Baker and Needles Ambulance, Morongo Valley Ambulance, Crest Forest Fire Department, Running Springs Fire Department and Bear Valley Community Healthcare District dba Bear Valley Paramedics. The urban EOA contracts expire on April 30, 2012. The MOU’s contain language for automatic renewal provided service is satisfactory.
- Following 25 years of disagreements, precedent setting legal actions, and various legislative efforts by different stakeholders, the California Emergency Medical Services Commission which has regulatory authority adopted a plan to pursue statutory clarifications and compromise (AB 1387) on the statutory citations noted earlier. This process will take one to two years to complete.
- The Butte County Appellate Court Decision requires the EMSA to promulgate EMSA Guidelines (Guideline 141) into formal Regulations. Due to the legislative efforts (AB 1387) and the mandate to develop regulations, ICEMA entered into discussions with first responders and EOA contractors to discuss extending the existing urban area contracts while we awaited anticipated statutory clarifications and promulgation of regulations (refer to EMCC Staff Report, “Status of Performance Based Contracting,” dated January 20, 2011).
- Following lengthy discussion at the EMCC meeting on January 19, 2012, the Chair requested that a special EMCC meeting be scheduled on February 23, 2012, to discuss the proposed contract extension and specifically to address the term of the agreement extension. Ms. Hastings informed the members that the existing contracts are due to expire April 30, 2012, and contain a provision requiring the contractor to continue to provide services in six-month increments. The draft proposes a three (3) year extension with the option of an additional one (1) year if needed. Further the Chair requested that the draft agreement be

forwarded to each EMCC member with a request to provide comments to ICEMA by February 20, 2012. Comments were received from two (2) EMCC members.

DISCUSSION

The Chair asked each EMCC member for initial comments on the contract extension, specifically the term language. Generally comments fell into the following:

- Focus should be on getting new system design through a transparent, competitive process as soon as possible.
- Utilizing language contained in the current contracts that requires contractors to continue providing service in six-month increments is not a good business or EMS system model.
- Acknowledged that the governmental processes relating to RFP and awarding of contracts proceed slowly and deliberatively.

Additional discussions include the following:

Stephen Miller opined that ICEMA has had eight (8) years' notice of the expiration date on current contracts, and is concerned that the RFP process did not begin earlier. Mr. Miller questioned the value of the contract extension vis-a-vis the term and enhancements contained in the draft agreement. Virginia Hastings explained that the enhancements in the draft agreement were at ICEMA's request. The specific dollar amount of the proposed enhancement to assist providers in implementing the ePCR system was still being negotiated.

Art Andres opined that the RFP for the new EOAs should be issued immediately to motivate the selection process to move quickly.

Margaret Peterson questioned how the money for the enhancements was being financed. Virginia Hastings advised that all costs for the enhancements will be borne by the contractor. Further Ms. Peterson asked for clarification on the language describing performance credits. George Stone explained that the language in the draft contract is identical to that contained in existing contracts and is intended to motivate contractors to perform at the highest level. Additionally, Mr. Stone explained that the insurance language in the draft agreement is standard County boilerplate language.

Public Comment:

Ray Ramirez echoed previous comments made by Chief Smith and Stephen Miller. He described EMSA's attempt to update Guideline 141, EOA Guidelines, and advised that the only real issue EMS Administrators had with the proposed update was EMSA's attempts to impose a 10 year term for EOA contracts. He also described his participation in the EMSA Chapter 13 task force before it was suspended.

Chief Ramirez stated he believes that the task force had reached consensus on sufficient issues to allow Transportation Plans and RFP processes to proceed, namely the contents of the Plan and

definitions of “manner” and “scope.” He also stated that for a smart business position, the term of the contract should match the anticipated timeframes for completion.

VOTING

Following all discussions, the Chair asked for motions to address the discussions. He also asked County Counsel, Alan Green, to advise members on the possible need to recuse themselves from voting. Mr. Green explained that there are both direct or indirect conflicts, depending upon the particular item; however, he advised that EMCC members utilize an abundance of caution in determining their potential conflicts. EMCC members Jim Holbrook, Diana McCafferty, and Art Rodriguez recused themselves.

1. Stephen Miller made a motion to begin development of the bid process with periodic status reports to the EMCC; Allen Francis seconded.

MSC:

Ayes - 11

Noes - 0

Abstaining - 0

2. Art Rodriguez made a motion to approve the proposed initial term of three (3) years plus one (1) year extension in the “draft” agreement (Page 30); Roy Cox seconded.

MS:

Ayes - 3

Noes - 3

Abstaining - 2

Recused - 3

3. Art Andres motioned to approve to go to bid immediately; Rick Britt seconded. Michael Smith amended the motion to approve an initial term of two (2) years plus one (1) year extension.

MS:

Ayes - 3

Noes - 3

Abstaining - 2

Recused - 3

4. Stephen Miller motioned to approve an initial term of three (3) years; Art Andres seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

Recused - 3

III. NEXT MEETING DATE AND LOCATION

March 15, 2012 (Meeting Cancelled)

ICEMA

Training Rooms A & B

1425 South "D" Street

San Bernardino, CA

IV. ADJOURNMENT

EMCC Meeting was adjourned at 11:22 a.m.

VH/jlm



SAN BERNARDINO COUNTY EMCC MEMBERS APPOINTMENTS/MANDATORY AB 1234 ETHICS TRAINING



SEAT #	MEMBER NAME	EMCC POSITION	APPOINT. DATE	APPOINT. EXPIRES	MEMBER STATUS	AB1234 COMP. DATE	AB1234 ETHICS EXPIRES
1	McCafferty, Diana	Private Ambulance Provider	3/22/2011	1/31/2013	CURRENT	7/15/2011	7/15/2013
2	Holbrook, Jim	EMT-P Training Program	3/22/2011	1/31/2015	CURRENT	6/27/2011	6/27/2013
3	Peterson, Margaret	Hospital Administrator	3/22/2011	1/31/2015	CURRENT	1/16/2012	1/16/2014
4	Henson, Travis, MD	ED Physician – Non-Trauma	3/27/2012	1/31/2016	CURRENT		
5	VACANT	City Manager, Deputy City Manager, or Assistant City Manager					
6	VACANT	Consumer Advocate					
7	Smith, Michael	Fire Chief	3/22/2011	1/31/2015	CURRENT	4/13/2012	4/13/2014
8	Miller, Stephen	Law Enforcement	1/10/2012	1/31/2016	CURRENT	7/01/2010	7/01/2012
9	Andres, Art	EMT/EMT-P - Public Sector	1/10/2012	1/31/2016	CURRENT	8/09/2011	8/09/2013
10	Britt, Rick	Emergency Medical Dispatch (PSAP)	3/22/2011	1/31/2015	CURRENT	7/28/2011	7/28/2013
11	Francis RN, Allen	Nurse - MICN	1/10/2012	1/31/2016	CURRENT	3/01/2012	3/01/2014
12	Pennington MD, Troy	Physician - Level II	6/07/2011	1/31/2014	CURRENT	7/14/2010	7/14/2012
13	Cox, Roy	Air Ambulance Provider	3/22/2011	1/31/2015	CURRENT	9/24/2010	9/24/2012
14	Catalano MD, Richard	Physician - Level I	12/06/2011	1/31/2015	CURRENT	1/19/2012	1/19/2014
15	Art Rodriguez	EMT/EMT-P - Private Sector	11/15/2011	1/31/2015	CURRENT	11/30/2011	11/30/2013

Updated 4/13/12
/jlm

1797.201 Stakeholders Work Group

Outcome Paper

1 – Background

Since the Emergency Medical Services (EMS) Act first became law in 1980, there has been considerable debate, controversy and even litigation surrounding various interpretations of California Health and Safety Code Division 2.5, Section 1797.201 (.201) and Section 1797.224 (.224). These two sections, often referred to as the “grandfather” provisions, describe how existing EMS providers receive continuing authorization from the local emergency medical services agency (LEMSA) to provide prehospital EMS services. Section 1797.201 pertains to cities and fire districts that have continuously contracted for or provided prehospital EMS as of June 1, 1980. Section 1797.224 describes the local EMS agency’s ability to establish exclusive operating areas for providers of emergency ambulance services, limited advanced life support, and advanced life support.

Because of the complexity of the issues, numerous concerns and apparent confusion over sections .201 and .224 have persisted. Several recent events have further escalated the debate and there have been several court decisions arising out of disputes regarding the diverse interpretations and various applications of this statutory language since 1980.

In March 2010, an ad hoc 1797.201/.224 subcommittee was appointed by the California EMS Commission representing the following organizations:

- California Chapter of the American College of Emergency Physicians (CalACEP)
- California Ambulance Association (CAA)
- California Fire Chiefs Association (CFCA)
- California Professional Firefighters Association (CPF)
- Emergency Medical Services Administrators Association of California (EMSAAC)

In May 2010, the California Emergency Medical Services Authority (EMSA) hosted a one day stakeholder workshop specifically on the meaning and interpretation of .201.

In December 2010, the EMSA issued a proposed update to EMSA Document No. 141 (8th Edition Draft, December 1, 2009) titled, “Review Criteria and Policy for Transportation and Exclusive Operating Area Components of the EMS Plan.” The proposed update addressed both .201 and .224, however, was subsequently withdrawn.

On December 1, 2010, the EMS Commission ad hoc 1797.201/.224 subcommittee submitted a consensus-based report to the EMS Commission based upon its review of the issues surrounding both .201 and .224. The subcommittee developed a set of recommendations as a road map for EMSA and the EMS community at-large to strengthen the EMS Act’s legislative and regulatory

framework and to assure that all California communities have a fully integrated and coordinated EMS delivery system.

In January 2011, EMSA convened the “Chapter 13 Task Force” to provide feedback regarding new regulations associated with local EMS system management and organization, local EMS plans and transportation component requirements. EMSA formed the Chapter 13 Task Force, in part, as a result of a decision by the California Court of Appeal (Butte Decision, 2010) that the process used by EMSA in determining whether a provider qualifies for grandfathering under Section 1797.224 is best set forth in regulations, formally adopted by the EMSA under the California Administrative Procedures Act, in order to use a generally applicable policy as part of that criteria. The Chapter 13 Task Force was also intended to provide feedback for new regulations regarding both .201 and .224.

Also in early 2011, a group of statewide organizations were invited to participate as a part of the EMS Commission ad hoc subcommittee work group (“work group”). The goal of the group was to develop new statutory language which would achieve consensus-based statutory clarifications specifically regarding .201. The group used the EMS Commission’s ad hoc subcommittee initial report as a beginning template. The following statewide organizations were represented on the work group:

- American Medical Response (AMR)
- California Ambulance Association (CAA)
- California Fire Chiefs Association (CFCA)
- California Professional Firefighters Association (CPF)
- California State Association of Counties (CSAC)
- Emergency Medical Services Administrators Association of California (EMSAAC)
- League of California Cities

The work of the Chapter 13 Task Force was temporarily suspended in September 2011 to avoid duplication of efforts the work group.

The work group concluded its work in February 2012 and developed proposed next steps appearing at the end of this report which are intended to follow the recommendations of the initial EMS Commission ad hoc subcommittee.

2 – Achieving Consensus

The work group defined consensus differently than a vote with a majority rule. Rather, the terms had to be acceptable to all parties. As each issue was considered, a consensus decision was reached to assure each party’s concerns were addressed, even if each party did not necessarily achieve their most desired outcome. When any party did not agree to any specific language, the party was asked to: 1) state their concern; and, 2) identify an alternative that would address their own concerns as well as the stated interests of the other stakeholders. This process was repeated

until all the parties agreed to the final language. Consensus meant that each group could support the proposed language.

All of the work group members worked diligently and in good faith to achieve consensus during dozens of meetings and conference calls over a period of nearly 12 months. The work group achieved consensus on purpose, principles and numerous key items. Ultimately, it was unanimously decided that it was not possible to achieve consensus on a number of key items. The remaining items of consensus are included in the recommendations section.

3 – Purpose & Principles

Since the work group was committed to successfully achieving consensus-based legislative language to clarify 1797.201, it was important to establish a clear purpose at the beginning. The group started by identifying major tenets upon which all work group members agreed. The discussions that followed were guided by the consensus principles below.

- LEMSAs, public providers and private providers are accountable to consistent and clear standards regarding their obligations and opportunities to participate in a local EMS system.
- Objective medical oversight of all EMS system components by LEMSAs is essential to achieve quality, efficient and integrated patient care services county-wide.
- Any legislative amendments to the EMS Act related to .201/.224 issues should be consistent with previous court decisions and opinions.
- All participants in the emergency medical services system are encouraged to enter into agreements with the LEMSA as part of the county's emergency medical services plan.
- Use of grandfathered providers as authorized under sections .201 and .224 has proven to be effective as long as existing providers can demonstrate that services are meeting the community's needs.
- The authorizations under .201 belong to the original geographic service area (i.e., "dirt" or land) as of June 1, 1980, not to the jurisdiction (i.e., city or fire district).
- LEMSAs should sponsor a local Emergency Medical Care Committee (EMCC), or equivalent; local EMS stakeholders are encouraged to actively participate in their local EMCC (or equivalent).
- Ground interfacility transports and air ambulance services are not included within the .201 authorization.
- The statutory language in California Health and Safety Code Section 1797.224 remains unchanged.

In addition to the above, the work group established specific goals associated with the rights and obligations of eligible cities and fire districts under .201. Specifically, eligible cities and fire districts:

- May retain .201 authorization to continue to provide the existing *type* of service (*type* means either first response, dispatch or transport service that was continuously contracted for or provided, as of June 1, 1980);
- May not expand to other types of services (that were not continuously contracted for or provided, as of June 1, 1980) without LEMSA authorization;
- May increase the level of clinical care within the eligible type of service with the authorization of the LEMSA;
- May retain .201 authorization for the original geographic service area (based upon the services that were continuously contracted for or provided, as of June 1, 1980);
- Are best served when agreements entered into between a city or fire district and a LEMSA are negotiated at the local level with both parties' participation, input and concurrence with the terms of the agreement; agreement terms are specified in writing and existing entities meeting HSC 1797.201 do not necessarily waive .201 rights by signing such agreements if the agreement states that .201 rights are not waived by the .201 entity or if the agreement is limited to medical control;
- Are required to operate in accordance with LEMSA medical control policies and procedures as well as the local EMS plan;
- May not use .201 authorizations to displace an existing EMS provider which is authorized by a LEMSA.

The aforementioned principles and goals were agreed to by members of the work group and do not represent consensus or agreements by the represented professional organizations. Consensus statutory language to achieve these principles and goals was not accomplished. Those areas where consensus was reached by the work group and represented organizations are included in the final recommendations for regulatory clarification and remedy.

4 – Summary of Policy Issues

Below is a list of the policy issues which were addressed in the most recent draft of the proposed legislative clarification of Healthy and Safety Code 1797.201. The stakeholders achieved consensus on numerous key items, however, were unable to achieve consensus on a number of small but important issues. These issues are indicated in italics in the outline of items below

1. Declarations
2. New Section 1797.201
 - a. Continuing Authorization
 - i. Disqualifying Agreements*
 - ii. Written Agreements Must Recognize*
 1. Medical Control
 2. Emergency Medical Dispatch Protocols

3. Minimum EMS Performance Criteria & Reporting Standards
4. Types and Levels of Prehospital EMS
5. Geographical Services Areas
 - b. Failure to Enter into an Agreement
 - c. *Impasse Resolution Process*
 - d. *Annexation*
 - e. LEMSA Recognition of Subcontracts
 - f. Formal Authorization Required
 - g. Local EMS Plan
 - h. Type of Prehospital EMS
 - i. First Response
 - ii. Dispatch (own resources)
 - iii. 911 Ambulance Transport
 - i. Increasing Level of Prehospital EMS
 - j. Reducing Level of Prehospital EMS
 - k. Authorization Required for New Type
 - l. Transfer to Successor Agency
3. Emergency Medical Care Committee (EMCC) – Established
4. Emergency Medical Care Committee (EMCC) – Annually review EMS system
5. Emergency Medical Care Committee (EMCC) – Annual report
6. Confirm Previous Court Decisions
7. Prohibit Displacement of Existing Authorized Providers
8. Personnel
9. State Mandates

5 – Recommendations & Next Steps

The work group believes consensus can be achieved under existing statute on a majority of outstanding issues by establishing newly written regulations. Therefore, the work group recommends that EMSA convene a “Regulatory Work Group” to address the previously established principles of agreement and the following issues:

1. The existing two-tiered state wide EMS system with both state and local oversight provides a mechanism for local EMS system design to evolve to meet community needs.

2. All providers should be integrated into the EMS system and all providers should be included in the EMS Plan.
3. All EMS system participants are part of an approved EMS Plan; EMS Plans require demonstration of broad-based stakeholder support; EMS Plans should address all phases of the EMS response system (first response, dispatch and transport).
4. A strong EMCC (or equivalent) is imperative; EMCCs should implement formal mechanisms to demonstrate stakeholder involvement and should promote involvement of system stakeholders in the EMS system design (including public and private, first response and transport, provider and other system components).
5. Using an EMCC (or equivalent), LEMSAs should establish a stakeholder-based impasse resolution process to be included in the local EMS Plan.
6. Existing entities meeting Health and Safety Code 1797.201 should not be arbitrarily or capriciously displaced.
7. The EMS Plan should address the process for providers to advance clinical levels (i.e., from BLS to ALS) with LEMSA approval.

At the conclusion of the regulatory process, it is recommended that EMSA embark on a statewide educational program to maximize understanding of the new regulations.

Staff Report - EMCC

STATUS OF GROUND MEDICAL PERFORMANCE BASED CONTRACTING

On May 8, 2012, the Board of Supervisors acting as ICEMA's Governing Board approved contracts with American Medical Response for urban Exclusive Operating Areas 1, 2, 3, 5, 6, 7, and 9. Attached to this status report is the Board Agenda Item that details the major changes and enhancements to the original agreements. The entire contract can be found at www.icema.net.

The agreements will become effective July 1, 2012. The term of the agreements is two (2) years, plus the two (2) additional one-year extensions if approved by the Board of Supervisors. During the Board meeting, Supervisor Gonzales stated she wanted the redesign of the system and selection of providers through a transparent and competitive process to proceed as rapidly as possible. Additionally, Supervisor Mitzelfelt stated that the Board expected complete and reliable data upon which to make decisions from all segments of the EMS community.

The first portion of the redesign process will be issuance of an RFP for a consultant to study and make recommendations on system redesign, including a draft Transportation Plan. ICEMA estimates the cost of this consultant to be between \$125,000 and \$150,000. ICEMA proposes that this cost be covered by revenues from PBC Liquidated Damages. A separate agenda item requesting EMCC endorsement of utilization of this fund is under New Business. ICEMA has worked with the Chiefs Advisory Committee and current EOA contractors to develop a Purpose Statement and a Scope of Work. ICEMA anticipates that the request for approval and issuance of the RFP will be on the agenda for the June 19, 2012, meeting of the Governing Board.

Refer to minutes, dated February 23, 2012, relating to discussions during the EMCC special meeting called to discuss the agreement.

Virginia Hastings
05/17/12

Staff Report - EMCC

STATUS OF PERFORMANCE BASED CONTRACTING

CITATIONS:

Statutory:

- H&SC 1797.201 (Attachment A)
- H&SC 1797.224 “ ”
- H&SC 1797.226 “ ”

Emergency Medical Services Authority (EMSA):

- Guideline 141 “Review Criteria and Policy for Transportation and Exclusive Operating Area (EOA) Components of EMS Plan” February, 1987
Under Revision

BACKGROUND:

- San Bernardino County developed Exclusive Operating Areas (EOA) under the provisions of 1797.224, “No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since **January 1, 1981.**”
- There are 24 EOA’s in San Bernardino County and three additional operating areas that have No Designated Provider (NAP). There were no responders to an RFP for EMS transportation in these three remote locations.
- On April 29, 2003, the Board of Supervisors acting as the Governing Board for ICEMA approved requirements for Performance Based Contracts (PBC). On April 20, 2004, the Board approved contracts for those EOA’s listed on Attachment B. Subsequently, the Board approved PBC contracts/MOU’s with Baker and Needles Ambulance, Morongo Valley Ambulance, Crest Forest Fire Department, Running Springs Fire Department and Bear Valley Community Healthcare District dba Bear Valley Paramedics.
- The majority of the EOA contracts expire on April 30, 2012.
- Although there have been some expectations that the ICEMA/Governing Board will redraw existing EOA’s and enter into a competitive process to select transporters, there is no legal requirement to do so if the EOA’s are maintained in the same manner and scope in which the services have been provided without interruption since January 1, 1981.

- EMSA, to date, will not approve two of the existing EOA's:

- EOA 25 - Lucerne Valley Area - SB Co Fire

EMSA opines that there has been a change in the "manner and scope" of operations created by large annexations to the area.

- EOA 20 - Bear Valley Community Healthcare District dba Bear Valley Paramedics

An RFP was issued for this area in 1985 thereby making it ineligible for continued operation without a competitive process.

ICEMA continues to work with EMSA on the status of EOAs 20 and 25.

NOTE: Our legal analysis, supported by County Counsel, is that EMSA approval only confers anti-trust protection; it does not preclude a county's decision to maintain an EOA. However, if EMSA elected not to approve a county's **ENTIRE** Transportation Plan due to one or specific EOA's, the County could assume significant anti-trust risks.

CURRENT DISCUSSION:

ICEMA has entered into discussions with first responders and EOA contractors to determine whether to recommend to the Governing Board that existing EOA contracts be amended and extended through an agreed upon date, presumably three to five years. There are several valid reasons for these discussions:

- The existing contractors have met performance standards and other requirements outlined in the contracts. NOTE: San Bernardino County Fire has not entered into a contractual relationship with ICEMA.
- Sufficient experience with the PBC program has been gained to modify certain contract provisions that will facilitate interactions among contractors and first responders. Examples include but are not limited to the following:
 - Contracts currently require the contractor to resupply first responder units at no cost to the first responders with disposable medical supplies utilized in direct patient care where the patient is transported by contractor. The current one-for-one field exchange of supplies has created some logistical problems.
 - Certain exemptions are allowed for response time standards. These eligible exemptions can be significantly shortened.
- Following 25 years of contentiousness, precedent setting legal actions, and various legislative efforts by special interest groups, the California Emergency Medical Services Commission which has regulatory authority has adopted a plan to pursue statutory/regulatory compromise on the statutory citations noted earlier. This process will take one to two years to complete.

- EMSA Guidelines 141 noted earlier is under revision and in somewhat disarray. It is highly unlikely this document will be finalized before the statutory/regulatory activities discussed above are finalized.

The San Bernardino County Chiefs Association and the San Bernardino County Ambulance Association have each selected a negotiating team to work with ICEMA to address some issues that, based upon experience, have been identified as provisions that should be modified.

ICEMA will continue to keep the EMCC informed of progress in the PBC contract negotiations.

Virginia Hastings
01/20/11

**REPORT/RECOMMENDATION TO THE BOARD OF DIRECTORS
OF THE INLAND COUNTIES EMERGENCY MEDICAL AGENCY
AND RECORD OF ACTION**

47

May 8, 2012

**FROM: VIRGINIA HASTINGS, Executive Director
Inland Counties Emergency Medical Agency**

**SUBJECT: CONTRACT WITH AMERICAN MEDICAL RESPONSE FOR ADVANCED LIFE
SUPPORT AMBULANCE SERVICES**

RECOMMENDATION(S)

Acting as the governing body of the Inland Counties Emergency Medical Agency, approve a performance-based contract with American Medical Response to provide advanced life support ambulance services as detailed in the background information, effective July 1, 2012 through June 30, 2014

(Affected Districts: All)

(Presenter: Virginia Hastings, Executive Director, 388-5830)

BOARD OF SUPERVISORS COUNTY GOALS AND OBJECTIVES

Operate in a Fiscally-Responsible and Business-Like Manner.

Provide for the Health and Social Services Needs of County Residents.

FINANCIAL IMPACT

Approval of this item does not impact discretionary general funding (net county cost). A management/monitoring fee of approximately \$599,000 will be collected annually to cover Inland Counties Emergency Medical Agency's (ICEMA) costs related to monitoring and enforcing the provisions of this Agreement. In addition, ICEMA will receive one time funding in the amount of \$100,000 to assist in offsetting a portion of Electronic Patient Care Reporting (ePCR) hardware purchased by first responder agencies to enhance patient care documentation and reporting.

BACKGROUND INFORMATION

Approval of this item will authorize ICEMA to enter into an agreement with American Medical Response (AMR) to provide advanced life support (ALS) ambulance services, effective July 1, 2012 through June 30, 2014 as detailed below:

EXCLUSIVE OPERATING AREA (EOA)	GENERAL DESCRIPTION
EOA 1	Rancho Cucamonga and Upland
EOA 2	Montclair and Chino
EOA 3	Ontario and Chino Hills
EOA 4	Fontana and Lytle Creek

EXCLUSIVE OPERATING AREA (EOA)	GENERAL DESCRIPTION
EOA 5	Rialto - 9-1-1 calls in unincorporated areas; interfacility calls in entire area
EOA 6	San Bernardino
EOA 7	Grand Terrace
EOA 9	Loma Linda

ICEMA is the Local Emergency Medical Services Agency (LEMSA) for the Counties of San Bernardino, Inyo, and Mono. ICEMA is tasked with ensuring an effective system of quality patient care and coordinated emergency medical response by planning, implementing and evaluating an effective emergency medical services system including pre-hospital providers, specialty care hospitals and hospitals.

On April 20, 2004 (Item No. 51), the ICEMA Board of Directors approved performance based contracts with AMR in the above mentioned urban areas. These agreements expired on April 30, 2012 but the contracts provide automatic six (6) month extensions.

In early 2010, ICEMA entered into discussions with EMS providers, including AMR, to negotiate contract extensions with the understanding that an extensive EMS system evaluation and competitive bid process would be needed in the near future. Currently, ICEMA is developing a Request for Proposal (RFP) for EMS system evaluation and design, with input from transport providers, first responder providers, and other system participants. That process could take as long as four years given the complexity of the design and this contract extension will allow uninterrupted service until its completion.

The following enhancements were made to the previous agreements:

- ICEMA will receive one time funding in the amount of \$100,000 to assist in offsetting a portion of Electronic Patient Care Reporting (ePCR) hardware purchased by first responder agencies to enhance patient care documentation and reporting.
- AMR will resupply first responder agencies at an equal to cost basis flat rate reimbursement of eight dollars (\$8.00) per transported patient paid quarterly, in accordance with established ICEMA procedures for resupply of first responder units for disposable medical supplies.
- AMR will provide educational content for use with ICEMA's online educational program. Education will be available for over 5,500 ICEMA accredited and certified EMS personnel.
- AMR will provide hot spot/Wi-Fi coverage allowing first responder agencies to connect to the internet for the purpose of data transmission related to treatment and care of patients.
- AMR shall (within six months of execution of agreement) ensure and maintain Emergency Medical Dispatch certification for all AMR dispatchers.

- AMR agreed to a Mileage cap on existing fleet and replacement units of no greater than 265,000 miles.

The term of this agreement is for two years with two (2) one year extensions upon approval of the Board.

Currently, ICEMA is reviewing agreements with rural and wilderness providers and will return to the Board with recommendations at a later date.

REVIEW BY OTHERS

This item has been reviewed by County Counsel (Alan Green, Deputy County Counsel, 387-5288) on April 9, 2012; and the County Administrative Office (Steve Atkeson, Administrative Analyst 387-0294) on April 25, 2012.

FOR OFFICIAL USE ONLY

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<input type="checkbox"/>	Cancel								
ePro Vendor Number						ePro Contract Number			
						Dept.	Orgn.	Contractor's License No.	
INLAND COUNTIES EMERGENCY MEDICAL						ICM	ICM		
Contract Representative						Telephone		Total Contract Amount	
Virginia Hastings, executive Director						(909)388-5823			
Contract Type									
<input type="checkbox"/> Revenue			<input type="checkbox"/> Encumbered			<input type="checkbox"/> Unencumbered		<input checked="" type="checkbox"/> Other:	
If not encumbered or revenue contract type, provide reason: _____									
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Performance Based Contract with American Medical Response (AMR) for Exclusive Operating Areas				FY	Amount	I/D	FY	Amount	I/D
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**INLAND COUNTIES
EMERGENCY MEDICAL
AGENCY**

F A S

STANDARD CONTRACT

THIS CONTRACT is entered into in the State of California by and between the Inland Counties Emergency Medical Agency, hereinafter called the **ICEMA**, and

Name
American Medical Response of Inland Empire

Address
7925 Center Avenue

Rancho Cucamonga, CA 91729

Telephone
(909) 477 - 5000

Federal ID No. or Social Security No.
95-2223085

hereinafter called PROVIDER

IT IS HEREBY AGREED AS FOLLOWS:

(Use space below and additional bond sheets. Set forth service to be rendered, amount to be paid, manner of payment, time for performance or completion, determination of satisfactory performance and cause for termination, other terms and conditions, and attach plans, specifications, and addenda, if any.)

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**INLAND COUNTIES EMERGENCY MEDICAL AGENCY
 AGREEMENT FOR AMBULANCE SERVICES
 IN SAN BERNARDINO COUNTY**

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ATTACHMENTS

- 1. EOA DESCRIPTIONS
 - a. EOA 1 - Rancho Cucamonga and Upland
 - b. EOA 2 - Montclair and Chino
 - c. EOA 3 - Ontario and Chino Hills
 - d. EOA 4 - Fontana and Lytle Creek
 - e. EOA 5 - Rialto (9-1-1) calls in unincorporated areas: interfacility calls in entire area
 - f. EOA 6 - San Bernardino
 - g. EOA 7 - Grand Terrace
 - h. EOA 9 - Loma Linda

- 2. EOA MAPS/RESPONSE AND SUB-RESPONSE TIME ZONES
 - a. EOA 1 - Rancho Cucamonga and Upland
 - b. EOA 2 - Montclair and Chino
 - c. EOA 3 - Ontario and Chino Hills
 - d. EOA 4 - Fontana and Lytle Creek
 - e. EOA 5 - Rialto (9-1-1) calls in unincorporated areas: interfacility calls in entire area
 - f. EOA 6 - San Bernardino
 - g. EOA 7 - Grand Terrace
 - h. EOA 9 - Loma Linda

- 3. RESPONSE TIME MEASUREMENT AND METHODS
- 4. RESPONSE TIME TERMINOLOGY
- 5. MEASURING RESPONSE TIME STANDARD COMPLIANCE
- 6. MEASURING EOA COMPLIANCE
- 7. ICEMA POLICY NUMBER 5080
- 8. INTERFACILITY TRANSPORT RESPONSE TIMES

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**INLAND COUNTIES EMERGENCY MEDICAL AGENCY
 AGREEMENT FOR AMBULANCE SERVICES
 IN SAN BERNARDINO COUNTY**

THIS AGREEMENT, herein referred to as "Agreement", is made and entered into this first (1st) day of July, 2012, by and between the INLAND COUNTIES EMERGENCY MEDICAL AGENCY, (hereinafter referred to as "ICEMA"), as the local Emergency Medical Services Agency for the County of San Bernardino and American Medical Response of Inland Empire, (hereinafter referred to as "PROVIDER"), with regard to the following designate Exclusive Operating Areas:

EXCLUSIVE OPERATING AREA (EOA)	GENERAL DESCRIPTION
EOA 1	Rancho Cucamonga and Upland
EOA 2	Montclair and Chino
EOA 3	Ontario and Chino Hills
EOA 4	Fontana and Lytle Creek
EOA 5	Rialto - 9-1-1 calls in unincorporated areas; interfacility calls in entire area
EOA 6	San Bernardino
EOA 7	Grand Terrace
EOA 9	Loma Linda

WITNESSETH:

WHEREAS, ICEMA is authorized by law to develop an emergency medical services system pursuant to the Emergency Medical Services and Prehospital Care Personnel Act (California Health and Safety Code, Section 1797 et seq.), hereinafter, "the EMS Act"; and

WHEREAS, PROVIDER provides Basic and Advanced Life Support emergency ambulance services pursuant to the EMS Act in the area(s) referred to herein as Exclusive Operating Area (EOA) as described in Attachment 1 (Exclusive Operating Area Description) and which is incorporated herein as if

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fully set forth; and

WHEREAS, PROVIDER is willing to provide said services according to the terms and conditions herein stated; and

WHEREAS, the parties hereto recognize and agree that the creation and assignment of the EOA, as described, in Attachment 1 (Exclusive Operating Area Descriptions) under this Agreement shall not exclude providers of special events or industrial ambulance permits from operating within the boundaries of said EOA; and

WHEREAS, the parties hereto will utilize the best efforts to promote a good working relationship with first responder agencies and law enforcement agencies; and

WHEREAS, the parties hereto agree that nothing in this Agreement shall in any way restrict PROVIDER from maintaining or entering into partnerships or other cooperative agreements, approved by ICEMA, with public safety agencies for the purposes of augmenting or improving services contemplated by this Agreement; and

WHEREAS, the parties hereto acknowledge and agree that execution of this Agreement constitutes notice, in accordance with Section V (G) of the San Bernardino County EOA Plan, that the EOA being served under this Agreement shall lose its non-competitive status, if applicable, at expiration or termination of this Agreement; and

WHEREAS, it is the County's goal to develop a competitive bid process in accordance with State statutes and regulations.

NOW, THEREFORE, the parties hereto agree as follows:

I. DEFINITIONS

For the purpose of this Agreement, the following terms, phrases, words and the derivation shall have the meaning given herein. When not inconsistent with the context, words used in the present tense include the future, words used in the plural include the singular and words used in the singular include the plural. The words "include", "including", or other similar words of inclusion shall mean without

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limitation or restriction.

- A. **“Advanced Life Support”** or **“ALS,”** means special services designed to provide definitive prehospital emergency medical care as defined in California Health and Safety Code, Section 1797.52.
- B. **“ALS Ambulance”** means an emergency ambulance, as that term is defined herein, staffed and equipped to provide advanced life support and transport capabilities in compliance with ICEMA protocols/policies, authorized by ICEMA, and permitted by the County of San Bernardino.
- C. **“Ambulance”** or **“Ambulance Unit”** means any vehicle specially constructed, modified and/or equipped, and licensed by the California Highway Patrol, if required, pursuant to Title 13 CCR 1100 2(a), and used for the sole purpose of response readiness and transporting sick, injured, convalescent, infirmed or otherwise incapacitated person(s).
- D. **“Basic Life Support”** or **“BLS”** is defined as special services designed to provide definitive prehospital emergency medical care as defined in California Health and Safety Code, Section 1797.60.
- E. **“BLS Ambulance”** is defined as an emergency ambulance, as that term is defined herein, staffed and equipped, at a minimum, to provide basic life support and transport capabilities in compliance with ICEMA protocols/policies and permitted by the County of San Bernardino.
- F. **“Cancelled Call”** is defined as a 9-1-1 call, which has been canceled prior to arrival of an emergency ambulance at the scene.
- G. **“Critical Equipment Failure”** is defined as any piece of equipment or vehicle, which is essential for the daily operation, and/or performance of obligations under this Agreement that fails to perform normally, when operated.
- H. **“Deployment Plan”** is defined as a plan that identifies specific locations of ALS resources, ambulances, post locations, or provider dispatching procedures. The plan must also include the number of locations of vehicles to be deployed during each hour of the day, each day of the week for coverage and the minimum number of unit hours necessary to provide services under this Agreement.
- I. **“Emergency Ambulance”** is defined as an ambulance, which is staffed and equipped to provide EMS levels at BLS or higher at the scene of an emergency or during interfacility transfers.

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- J. **“Emergency Medical Dispatch” or “EMD”** is defined as a professional telecommunicator certified through the Association of Public-Safety Communications Officials International (APCO) or the National Academies of Emergency Dispatch, tasked with the gathering of information related to medical emergencies, the provision of assistance and instruction by voice, prior to the arrival of EMS, and the dispatching and support of EMS resources responding to an emergency call.
- K. **“Emergency Medical Service” or “EMS”** is defined as a type of emergency service dedicated to providing prehospital acute medical care, transport to definitive care, and other medical transport to patients with illnesses and injuries which prevent the patient from transporting themselves.
- L. **“Exclusive Operating Area” or “EOA”** is defined as a specific geographic area of the County of San Bernardino designated as authorized by the California Health and Safety Code, Sections 1797.6, 1797.85, 1797.224 and 1797.226.
- M. **“Force Majeure”** is defined as flood, earthquake, storm, fire, lightning, explosion, epidemic, war, national emergency, civil disturbance, sabotage, restraint by any governmental authority not due to violation by the party claiming force majeure of a statute, ordinance or regulation, or other similar circumstances beyond the control of such party, the consequences of which in each case, by exercise of the due foresight such party could not reasonably have been expected to avoid, and which by exercise of due diligence it would not have been able to overcome.
- N. **“Fractile Response Time”** is defined as a method of measuring response times in which all applicable response times are stacked in ascending length. The total number of calls generating response within a given response time standard (e.g., 9 minutes, 59 seconds) is calculated as a percent of the total number of calls.
- O. **“Mobile Hot Spot”** is a device that creates an area of Wi-Fi coverage allowing nearby Wi-Fi devices to connect to the internet. The device serves as a link between nearby Wi-Fi devices and a cellular data network.
- P. **“Multi-casualty Incident” or “MCI”** is defined as an incident consisting of five (5) or more vehicles or patients requiring assessment, care and/or transportation.
- Q. **“Mutual Aid”** is defined as a request, originating outside of PROVIDER’s EOA, for emergency ambulance at the scene. The request could be initiated through dispatch

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centers, public safety enforcement agencies, ICEMA or the San Bernardino County Health Officer.

- R. **“Provide, Operate, or Furnish”** - With regard to PROVIDER’s responsibilities set forth in this Agreement, the terms “provide”, “operate”, or “furnish” shall mean to perform, make available or utilize either directly through PROVIDER’s personnel and resources or through subcontracts or other agreements, which have been approved by ICEMA, the services, personnel, materials or supplies required herein.
- S. **“Preventable Mechanical Failure”** is defined as a failure of equipment and or vehicles to operate property due to lack of proper maintenance.
- T. **“PSAP”** is defined as Public Service Answering Point. The primary PSAP is the designated agency at which the 9-1-1 call is first received. The secondary PSAP is the designated agency to which the 9-1-1 call is directed for dispatching of appropriate resources.
- U. **“Special Event Services”** is defined as any situation where a previously announced event places a group or gathering of people in a general locale sufficient in number, or subject to activity that creates the need to have one (1) or more ambulances at the site.
- V. **“Specialty Care Transport” or “SCT”** is defined as a transport of an injured or ill patient by ground ambulance that require necessary supplies, equipment, or services that may be at a level of service beyond the scope of the EMT or Paramedic or their normal required equipment level. SCT must be furnished by one (1) or more healthcare professionals in an appropriate specialty area or utilizing specialty care equipment, e.g., bariatric transportation utilizing special equipment and vehicle equipped to handle the weight requirements of the patient or neonatal transportation requiring the possible use of additional gases, incubator, special mounting and attachment hardware, lift device, etc.
- W. **“Supervisor Support Vehicle”** is defined as a response vehicle for the purpose of providing support services in the field.
- X. **“Strike Team”** defined as five (5) ALS or (5) BLS ambulances plus one (1) strike team leader and unit may be augmented with the Disaster Ambulance Support Unit (DASU) but may not replace an ALS or BLS unit. A strike team must be made up of “like” units, i.e., all ALS or all BLS in level.
 - 1. **“Immediate”** is defined as an immediate request for resources which must be approved by the ICEMA Executive Director, their designee, or Duty Officer if after normal business hours, prior to releasing established San Bernardino County units from their assigned roles in this county.

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- 2. **"Delayed"** is defined as a request for resources that allows PROVIDER to assemble off-duty employees and non-assigned units for deployment outside of San Bernardino County.
- Y. **"Strike Team Leader"** is an individual who has completed a State of California approved Strike Team Leader training course and possesses a current certification for same.
- Z. **"Units"** are defined as ambulances and/or response vehicles.
- AA. **"Wi-Fi"** is a trademark of the Wi-Fi Alliance and the brand name for products using the IEEE 802.11 family of standards for wirelessly connecting electronic devices to the Internet via a wireless network access point.

II. GENERAL RESPONSIBILITIES AND DUTIES OF PROVIDER

- A. **General** - Provider shall respond to all 9-1-1 requests for service with an ALS ambulance unless exempted by ICEMA policy.
- B. **Personnel, Equipment and Materials Required** - PROVIDER shall provide the personnel, equipment and materials necessary to provide advanced life support and other services as described herein to persons in need thereof within their designated EOA. PROVIDER's obligations are set forth in detail in the provisions of this Agreement.
- C. **In-Service Training Required** - PROVIDER shall provide or contract for employee in-service training. Such in-service program shall include training on ICEMA policies and procedures, location of all hospital facilities, level of service of first responder agencies within the EOA, field care audits, grief support training, peer support, critical incident stress management, driver training, multi-casualty/disaster training, and Incident Command System training.
- D. **EMS System Interaction** - PROVIDER shall participate regularly in all aspects of development of the local EMS system including, but not limited to:
 - 1. Expanded scope of practice treatment and equipment programs.
 - 2. First Responder, EMT, Paramedic, MICN, Base Station physician and provider dispatcher education and training, and ride-along programs.
 - 3. San Bernardino County ALS training programs shall receive first right of refusal for paramedic preceptors.
 - 4. Continuing education programs.
- E. **Equipment Maintenance** - PROVIDER shall provide or contract for equipment maintenance.

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- F. **Response Standards** - PROVIDER shall be subject to any and all response time standards, which may be adopted by ICEMA with input from transporting agencies.
- G. **Materials and Supplies** - PROVIDER shall furnish all fuel, lubricants, repairs, initial supply inventory and all supplies necessary to fulfill its obligations pursuant to the standards as set forth herein. PROVIDER shall maintain sufficient supplies and equipment, excluding fuel, lubricants and repair items, to sustain local operations for a minimum of fifteen (15) days at its main operation location or its materials and supplies distribution center.
- H. **Policies and Working Relations** - PROVIDER shall develop and maintain personnel policies and patient care policies that are conducive to enhancements to patient care and provide a safe working environment for all employees.
- I. **Posting Locations** - PROVIDER shall maintain ambulance post locations, as PROVIDER deems necessary.
- J. **Professional Conduct of Personnel** - PROVIDER shall ensure courteous conduct and professional appearance of its personnel at all times. All ambulance crews shall at all times while on duty, wear an official uniform approved by ICEMA that clearly identifies company/agency, level of licensure/certification, name tag and badge.
- K. **Professional Equipment and Facilities** - PROVIDER shall maintain neat, clean, and professional appearance of equipment and facilities.
- L. **Mutual Aid Agreements** - PROVIDER shall develop and implement mutually beneficial support agreements with ICEMA approved emergency ambulance providers within one (1) year of the effective date of this Agreement. These agreements are subject to approval by ICEMA. If PROVIDER is unable to develop and implement mutual aid agreements, PROVIDER shall notify ICEMA in writing outlining reason(s) for inability to comply with this requirement. ICEMA shall assist in development and implementation of mutual aid agreements if requested.
- M. **Quality Improvement (QI)** - PROVIDER shall participate actively in and comply with the ICEMA QI audit process, provide special training and support to PROVIDER's personnel found in need of special assistance in specific skill or knowledge areas, and provide additional clinical leadership by maintaining a current and extensive knowledge of developments in equipment and procedures throughout the industry and by regularly reporting such developments to ICEMA. PROVIDER shall submit a QI Plan and subsequent revisions and update for approval to ICEMA.

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- N. **Permits and Certifications** - PROVIDER shall maintain all appropriate and required state and county permits.
- O. **Implementation of ICEMA Policies** - PROVIDER shall cause ICEMA policies to be properly implemented in the field. Where questions related to clinical performance are concerned, PROVIDER shall satisfy ICEMA's requirements. PROVIDER shall ensure that knowledge gained during the medical audit process is routinely translated into improved field performance by way of in-service training, amendments to the employee handbook, newsletters, new employee orientation, etc. PROVIDER shall also respond to all quality improvement and incident reports in accordance with established ICEMA policies.
- P. **Financial Implications of Operations** - When requested, PROVIDER shall advise ICEMA concerning financial implications of operational changes under consideration.
- Q. **Paramedic Preceptors** - In coordination with the approved training institutions, PROVIDER shall provide paramedic preceptors for prehospital training programs. The minimum ratio shall be ten (10) paramedic preceptors for every one hundred (100) full-time equivalent (FTE) paramedics employed by the PROVIDER for the EOA served.
- R. **Expanded Scope Programs** - PROVIDER shall assist ICEMA in evaluating and implementing expanded scope programs for paramedics, EMTs and first responder personnel.
- S. **Reports to ICEMA** - PROVIDER shall provide data, reports and records to ICEMA as set forth herein.
- T. **EMS Provider Dispatch Center** - PROVIDER shall provide the necessary personnel and materials to operate the EMS dispatch center as set forth herein.
- U. **Posting of Resources** - Posting of the PROVIDER's units and resources shall be in accordance with PROVIDER's Deployment Plan.

III. MEDICAL CONTROL

- A. **Medical Control Authority** - PROVIDER acknowledges that the ICEMA Medical Director has the authority to develop overall plans, policies, and medical standards to assure that effective levels of emergency ambulance services are maintained within the ICEMA region; and that the Medical Director has the authority for establishing the required drug inventories and medical protocols and that PROVIDER, its employees, and all personnel providing services under subcontract(s) or agreements are subject to said plan, policies, standards and protocols and applicable county ordinances and state laws.

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- B. **Adherence to Medical Control Standards** - ICEMA has an established system of medical control through the ICEMA Medical Director. The PROVIDER shall adhere to the standards of medical control established by ICEMA.
- C. **Compliance with Laws and Policies** - PROVIDER shall comply with the all ICEMA policies and protocols and applicable local County ordinances.
- D. **PROVIDER's Medical Director** - PROVIDER shall provide a medical director who will oversee and coordinate the PROVIDER's clinical performance. The PROVIDER's Medical Director shall be a physician, Board certified in emergency medicine or with equivalent emergency medicine experience and approved by ICEMA. The PROVIDER's Medical Director shall work with ICEMA's Medical Director and the physicians of the EMS system to ensure compliance by the PROVIDER with the clinical standards established for the regional EMS system.

IV. SCOPE OF SERVICE

- A. **Emergency Ambulance Services** - PROVIDER shall provide sufficient resources to ensure availability and response to all requests originating within its service area for emergency ambulance response on a continuous twenty-four (24) hour per day basis.
- B. **Specialized Care Transport (SCT) Services** - PROVIDER shall provide SCT services within the EOA for those calls requiring such services upon approval by ICEMA. SCT services, such as high-risk pregnancy, neonate, etc., may be authorized to operate in expanded geographic areas based on need and necessity.
- C. **EMS Aircraft** - PROVIDER does not have the right to provide air ambulance or air rescue services by virtue of this Agreement.
- D. **Standby Special Event Services** - PROVIDER may provide standby special event services. ICEMA expressly states that special events services are not subject to the EOA.
- E. **Indigent Transport Services** - PROVIDER shall provide emergency ambulance services to indigent patients pursuant to its contract with the County of San Bernardino for such services. In the event PROVIDER shall terminate its contract with the County, such termination shall be considered a major breach of this Agreement. However, if the County shall terminate the contract, PROVIDER shall not be required to continue to provide such services under this Agreement.

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V. FIRST RESPONDER COORDINATION

- A. **Resupply of Disposable Medical Supplies** - PROVIDER shall resupply first responder agencies at an equal to cost basis flat rate reimbursement of eight dollars (\$8.00) per transported patient paid quarterly, in accordance with established ICEMA procedures for resupply of first responder units for disposable medical supplies (BLS/ALS Standard Drug & Equipment List - Reference #7010) utilized in direct patient care where patient is transported by PROVIDER. This flat rate reimbursement will be subject to annual re-evaluation for fair market value of supply cost and utilization. Payment will be made to the first responder agency that has jurisdictional responsibility for service. ICEMA warrants and represents that the flat-rate reimbursement is less than or equal to the actual costs of re-supply of first responder units. No funds shall be used in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute.
- B. **Orientation Program** - PROVIDER shall implement and maintain a first responder orientation program designed to acquaint all hospital facilities and public safety agencies within the EOA with PROVIDER's equipment and response system, and shall, upon reasonable request, provide orientation presentations.
- C. **Stand-by Requests** - PROVIDER shall, at no charge, provide, if it does not jeopardize emergency ambulance service to the operating area, a non-dedicated unit to hazardous material incidents, fire, and law enforcement standbys upon request by any public safety agency or dispatch center within their EOA, excluding special event services. Provisions of this AGREEMENT shall not prevent PROVIDER from executing Emergency Equipment Rental Agreements (EERA) with federal, state, or local agencies.
- D. **Contact Number** - PROVIDER shall provide a contact and a telephone number to be made available to all public safety EMS agencies within PROVIDER's EOA. This number will be used for inquiries regarding lost equipment used in connection with a patient transported by PROVIDER.
- E. **Return of EMS Equipment** - PROVIDER shall make every reasonable effort to return equipment of other EMS providers in PROVIDER's possession within five (5) days. However, PROVIDER will not be held liable for loss of other EMS provider's equipment beyond their control.
- F. **Return of EMS Personnel** - PROVIDER, upon request, will return all first responder personnel who accompany PROVIDER to the hospital to their respective stations or closest

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station within their fire district in the event the ambulance is requested to respond to a 9-1-1 call.

- G. **Incident Command System** - PROVIDER shall coordinate pursuant to the California Health and Safety Code, Section 1798.6, with public safety agencies that work under the Incident Command System on all emergency incidents received through the 9-1-1 system or through a request for mutual aid.
- H. **Continuing Education Programs** - PROVIDER's internal continuing education programs authorized by the State in which PROVIDER issues a continuing education course number shall be made reasonably available to interested first responder personnel, provided that first responder personnel shall be responsible for the cost of the continuing education course.

VI. PROVIDER DISPATCH SERVICES

- A. **Location** - PROVIDER shall establish its dispatch facility within San Bernardino County.
- B. **Personnel** - PROVIDER shall provide the personnel, including appropriate supervisory personnel, to staff and operate their EMS dispatch on a twenty-four (24) hour per day basis.
- C. **Existing Dispatch Capabilities** - PROVIDER shall provide and maintain a provider dispatch system that does not fall below the level of the system in place at the time of the initiation of the Agreement. However, if the PROVIDER is currently operating a secondary PSAP, this paragraph shall not require the PROVIDER to continue to be designated as a secondary PSAP or have the equipment and training specifically required for them being designated as a secondary PSAP.
- D. **Equipment Requirements** - PROVIDER shall ensure that its EMS dispatch operations include the necessary equipment to maintain continuation of services during periods of disruption of normal services/operations.
- E. **Training Requirements** - PROVIDER shall, within six (6) months of execution of this Agreement, ensure and maintain EMD certification for all dispatchers in accordance with ICEMA's EMD policies.
- F. **Compliance with ICEMA Policies** - PROVIDER shall provide all dispatching of ambulance units in accordance with ICEMA policies and procedures.
- G. **Backup Dispatch Services** - PROVIDER shall establish a system, approved by ICEMA, to provide backup provider dispatch services as may be necessary for disaster incidents or any other circumstances, which impair the operation of their primary EMS dispatch center.

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- H. **Supervision** - The PROVIDER's dispatch operation will be supervised, monitored and subjected to the policies and procedures as established by ICEMA.
- I. **Execution of Updates/Modifications** - PROVIDER shall adapt to changes and work with ICEMA to ensure the future needs of the EMS system's evolution and the corresponding dispatch component.
- J. **CAD Requirements** - PROVIDER shall maintain a computer aided dispatch (CAD) system that includes the necessary hardware and software to provide EMS provider dispatch services.
- K. **Vehicle Locators** - PROVIDER shall provide, within one (1) year of execution of this Agreement, a mechanism for tracking and maintaining the status of emergency ambulances and support resources via Automatic Vehicle Locators approved by ICEMA (or other equivalent technology as approved by ICEMA).

VII. SERVICE AREA AND RESPONSE ZONES

- A. **SERVICE Area Defined** - A description of each EOA is set forth in Attachment 1 (Exclusive Operating Area Descriptions). Attachment 2 (Exclusive Operating Area Map) or "Service Area Map" sets forth the area of operation in map format. In the event of a conflict between Attachment 1 and Attachment 2, Attachment 1 will be controlling.
- B. **Resource Requirements** - PROVIDER shall locate an appropriate number and type of resources throughout the EOA in order to meet the performance standards as set forth herein.
- C. **Response Zones** - Population density based "response zones" (urban, suburban, rural and wilderness) and sub-response zones as established within each EOA or service area are depicted in Attachment 2 (EOA Map/Response and Sub-response Zones).

VIII. PERSONNEL

- A. **Administrative Representative** - PROVIDER shall provide an Administrative Representative or designee to attend the County Police Chiefs Association or County Fire Chiefs Association upon reasonable request.
- B. **Personnel Required** - PROVIDER shall provide the personnel necessary to provide emergency ambulance services and other support services as described herein within the

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PROVIDER's EOA in compliance with ICEMA protocols, policies and applicable county ordinances and state laws.

- C. **Emergency Vehicle Operations Course (EVOC)** - PROVIDER shall ensure that all of its field personnel complete an ICEMA approved emergency ambulance operations course. Paramedics and EMTs shall complete EVOC training prior to assignment in the field.
- D. **Supervisory Personnel System** - The PROVIDER shall establish a supervisory system to assure that employees are properly supervised, trained and evaluated in accordance with PROVIDER's policies and procedures and consistent with the ICEMA approved Quality Improvement Plan, and relevant ICEMA policies and requirements. PROVIDER shall maintain an employee hiring standards and practice program. Supervisory personnel shall provide field evaluation of PROVIDER's personnel in accordance with PROVIDER's Quality Improvement Plan and relevant ICEMA policies and requirements.
- E. **Certification and Licensure of Personnel** - PROVIDER shall ensure that all PROVIDER's employees functioning as paramedics and EMTs are appropriately certified, accredited and licensed by both the State EMS Authority and ICEMA.
- F. **Records** - PROVIDER shall maintain, and make available to ICEMA upon request, records and data pertaining to the certifications, licenses, and other applicable credentials of its employees and subcontracted personnel used to provide services under this Agreement.
- G. **Employee Handbook** - PROVIDER shall develop and maintain an Employee's Handbook describing the personnel policies and procedures utilized by PROVIDER in its operations. A copy of the current handbook shall be made available to ICEMA upon request.
- H. **Incidents Forms** - PROVIDER shall furnish to all employees approved ICEMA Incident Report Forms and shall require employees to utilize such forms, and shall furnish a copy of such completed form to ICEMA in accordance with ICEMA policies.
- I. **Competency and Conduct** - All persons utilized by PROVIDER in the performance of work under this Agreement shall be competent and holders of appropriate permits, licenses and certificates in their respective trades or professions. ICEMA may request, and PROVIDER shall take action in accordance with its personnel policies and procedures to effect the removal of, or take appropriate disciplinary remedial action against any certificate or license holder person utilized by the PROVIDER who engages in misconduct pursuant to Section 1798.200 of the California Health and Safety Code or has action taken by ICEMA pursuant to Section 100215 of Title 22, California Code of Regulations.

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- J. **Infectious Disease Exposure** - PROVIDER shall provide testing and counseling services to all employees exposed to serious infectious diseases at no cost to the employee. PROVIDER shall ensure that such services and program pertaining to infectious disease exposures are provided in accordance with the provisions of state and local public health requirements.
- K. **Employee Assistance Program** - PROVIDER shall assure availability to its employees an Employee Assistance Program that offers counseling services for mental health and substance abuse.
- L. **Peer Counseling** - The nature of work in EMS produces stress in the care provider from one-time events (e.g., MCI) and from being continually subjected to moderately stress producing incidents. PROVIDER shall have available a program to provide counseling to personnel for these stresses.
- M. **Modification or Replacement of Services** - As it pertains to the above personnel requirements, PROVIDER shall maintain such services as set forth above; however, PROVIDER may replace or modify any such services subject to written approval by ICEMA.

IX. RIGHTS AND RESPONSIBILITIES OF FIELD PERSONNEL

- A. **Certification, Licensure, Accreditation** - Field personnel are certified, licensed and accredited pursuant to the California Health and Safety Code, Section 1797 et seq. A linkage exists between field personnel and the system's physician leadership and medical control. Where issues involving questions of patient care are concerned, each of the certified personnel working in the system has not only a right, but also a legal obligation, to work under the direction of the EMS system's physician leadership on issues related to patient care.
- B. **Personal Responsibility** - The direct linkage, and personal responsibility, also applies to issues regarding compliance with regulations of vehicles, on-board equipment, collection and recording of primary data. EMS personnel are prohibited by the laws, rules and regulations which govern the EMS system from operating equipment that is substantially out of compliance with system standards, as well as from falsifying or omitting data from reports (e.g., patient care reports, provider dispatch records, incident reports, etc.). Provider dispatchers and field personnel have a personal professional responsibility with regards to issues related to the delivery of patient care, and the accurate reporting of primary data.
- C. **Management Practices** - While this Agreement is a "Performance Agreement" and while the PROVIDER is not only allowed but encouraged to employ its own methods and techniques for producing the required performance reliably and efficiently, PROVIDER is

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expressly required to utilize reasonable work schedules, shift assignments, and to provide adequate working conditions. The primary issue is patient care, and the PROVIDER is expected to utilize management practices, which ensure that field personnel working extended shifts, part-time jobs, voluntary overtime, or mandatory overtime, are not exhausted to an extent, which may impact patient care.

X. RESPONSE TIME STANDARDS

- A. **Performance Requirements** - The overall response time performance requirement for services under this Agreement is intended to ensure that PROVIDER responds to and arrives at each incident with an appropriate resource in accordance with ICEMA policies and procedures. The standards set forth herein establish the level of response time performance required by PROVIDER for calls within the designated EOA as depicted in Attachment 2 (EOA Maps/Response and Sub-response Zones). Additionally, PROVIDER will make best effort to respond to non-emergency calls within PROVIDER’s established policy guidelines (Attachment 8 – Inter-facility Transport Response Times).
- B. **Response Time Performance Calculation** - Response times are measured and calculated on a fractile basis using CAD data, where available, in conformity with Attachment 3 (Response Time Measurement and Methods), Attachment 4 (Response Time Terminology) and Attachment 5 (Measuring Response Time Standard Compliance) and Attachment 6 (Measuring EOA Compliance) on a monthly basis for the designated EOA incorporating all response zones. Cancelled calls will be included in determining compliance. Supervisory Support Vehicles are not EMS response vehicles for the purpose of calculating response time compliance.
- C. **Exemptions** - If PROVIDER believes that any run or group of runs should be exempt from response time standards due to unusual circumstances beyond PROVIDER’s reasonable control, PROVIDER may request, in writing, that these runs be exempted from response time performance calculations and late run assessments. If ICEMA concurs that the circumstances are reasonable to allow such exemption, ICEMA may allow such exemptions in calculating overall response time performance and/or in assessing late run liquidated damages. Equipment failure, provider dispatcher error, or lack of emergency ambulance shall not furnish grounds for release from late run assessment or response time standards.
- D. **Reporting Requirements** - PROVIDER shall provide to ICEMA, on a monthly basis, each instance wherein a call resulted in a response time in excess of the maximum response time

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as depicted in Attachment 3 (Response Time Measurement and Methods). This report shall include, at a minimum, the location, date, and time of said occurrence(s). PROVIDER will participate in quality improvement efforts relating to these instances.

- E. **Critical Equipment Failure Reporting** - PROVIDER shall immediately report any critical equipment failure to ICEMA in a form and/or format as set forth by ICEMA. This report shall be made within three (3) business days of failure and at a minimum shall include the nature of the failure, location of failure, date and time of failure, outcome and/or effect of failure. The mechanic's report of factor(s) causing failure must be received within three (3) business days of initial report.
- F. **Performance Committee** - PROVIDER shall establish and maintain a Performance Committee comprised of representatives of PROVIDER's management and field personnel and ICEMA staff, City Managers or their designated representative (within the EOA covered by this Agreement) and representative of the County supervisorial district(s) (within the EOA covered by this Agreement) which shall meet as necessary to review response compliance performance and to discuss operational matters.

XI. DEPLOYMENT PLAN

- A. **General** - PROVIDER shall operate its services to enhance response time performance throughout the various jurisdictions of the EOA.
- B. **Plan Development** - PROVIDER shall develop a Deployment Plan that shall be reviewed and approved by ICEMA and adhered to by PROVIDER.
- C. **ICEMA Review** - In addition to the aforementioned requirements, PROVIDER shall provide to ICEMA for review a copy of its Deployment Plan on at least an annual basis or upon any material changes in the deployment plan and upon implementation of changes in the System Management Plan which would result in reduction of ambulance resources or anticipated increase in response times.
- D. **Extent of Deployment Plan** - A Deployment Plan may incorporate more than one (1) EOA if the PROVIDER has contracted to provide service in more than one (1) EOA.
- E. **Reassignment of Resources** - A PROVIDER that serves multiple operating areas shall be permitted to move resources from one operating area to another operating area only if the moving of resources does not result in the operating area from which the resources are moved becoming non-compliant in that month.
 - 1. If upon review and analysis ICEMA determines that movement of resources from one

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operating area to improve compliance in an operating area causes the operating area sending resources to be out of compliance, the original out of compliance operating area shall be cited with an additional out of compliance month.

2. The PROVIDER shall provide notice to ICEMA of intent to reassign resources to an operating area where additional noncompliance status would result in a major breach.
3. The PROVIDER shall also indicate reassignment of resources in the monthly compliance report to ICEMA and provide a plan of correction.

XII. STAFFING OF AMBULANCE AND RESPONSE UNITS

- A. **ALS Minimum Staffing** - PROVIDER shall provide for staffing each ALS ambulance with a minimum of one (1) paramedic and one (1) EMT per unit.
- B. **BLS Minimum Staffing** - All BLS ambulances shall have at least two (2) certified EMT personnel per unit.
- C. **SCT Unit Staffing** - SCT staffing will be in accordance with ICEMA policy.

XIII. VEHICLES, EQUIPMENT AND MAINTENANCE

- A. **Minimum Vehicle Requirements** - PROVIDER shall provide at least a minimum number of vehicles, which is defined as one hundred twenty (120%) of the vehicles required in the Deployment Plan. Each transport vehicle shall meet Federal KKK-A-1822C standards or equivalent, at time of original manufacture, except where such standards conflict with State of California standards, in which cases the State standards shall prevail. Each transport unit shall be a Type I, II or III model. All vehicles must have current California Highway Patrol permits, unless exempted by California Highway Patrol.
- B. **Clean and Mechanically Safe** - PROVIDER shall ensure that all transport vehicles are safe, clean, well-maintained to ensure employee/patient safety.
- C. **Staffing, Equipment and Drug Requirements** - All vehicles utilized by PROVIDER in providing service under this Agreement shall be staffed and equipped in accordance with state law and ICEMA policies.
- D. **Vehicle Replacement/Refurbish Program** - PROVIDER shall maintain a vehicle replacement/refurbish program that ensures the replacement or refurbishing of PROVIDER's vehicles as follows: PROVIDER shall comply with ICEMA's requirement, within six (6) months of execution of this Agreement, to have removed from service and replaced any and

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all ambulances that have two hundred sixty-five thousand (265,000) miles or more. PROVIDER may petition ICEMA for consideration of an extension for unforeseen supply-chain issues beyond PROVIDER's control once PROVIDER has demonstrated exhaustion of all reasonable options to comply.

- E. **Maintenance, Replacement and Reporting** - PROVIDER shall adhere to a preventive maintenance program, equipment replacement schedule, and reporting system approved by ICEMA.
- F. **Equipment/Supplies Maintenance** - Each transport vehicle shall meet the ambulance equipment standards of the State of California and ICEMA. At the beginning of each shift, all ambulances shall have sufficient ALS and BLS equipment and supplies to prevent stock levels in the ambulance from falling below minimum requirements, under normal circumstances, which includes normal restocking during the shift.
- G. **Vehicle Identification** - Each transport vehicle shall display the location of its operation division.
- H. **Restocking** - PROVIDER shall have sufficient ALS and BLS equipment and supplies to prevent stock levels in the ambulance from falling below minimum requirements, under normal circumstances, which includes normal restocking during the shift.
- I. **Responsibility for Maintenance** - PROVIDER shall be responsible for furnishing all maintenance of PROVIDER's vehicles, on-board equipment, and facilities used by PROVIDER in the performance of services under the terms of this Agreement.
- J. **Odometer Certification** - Emergency ambulance odometers shall be certified within one (1) month of the effective date of this Agreement and each year thereafter by Department of Agriculture Weights and Measures.
- K. **PROVIDER's Equipment Replacement Program** - PROVIDER shall submit a proposed equipment replacement program, which shall include, in part, the equipment replacement policy. This policy shall state PROVIDER's operational assumptions regarding the anticipated safe useful life of equipment items, by category or type, and PROVIDER's general plan for equipment replacement in accordance with the plan.
- L. **Right to Required Replacement** - Throughout the term of this Agreement and any extension period, ICEMA may, after an inspection and for cause, require PROVIDER to replace any equipment at any time after that item's scheduled replacement date, as defined by the terms of PROVIDER's submitted and accepted equipment replacement program. However, if through superior maintenance or by other means, PROVIDER is able to extend the safe

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useful life of an equipment item beyond its time of scheduled replacement, ICEMA shall not, except for cause, require replacement of that item. These controls relate only to equipment kept in service beyond scheduled replacement date, and are in addition to regulatory requirements affecting equipment standards and inspections imposed by law or ICEMA.

XIV. DISASTER, MULTI-CASUALTY AND INSTANT AID RESPONSE

- A. **Personnel Recall** - PROVIDER shall develop and implement a plan for the immediate recall of personnel for the staffing of additional units in multi-casualty or disaster situations or times of peak overload.
- B. **Mutual Aid Response** - To the extent that PROVIDER may have resources available, PROVIDER shall respond to requests from neighboring jurisdictions and ambulance providers for mutual aid that require a Code 3 (lights and siren) response.
- C. **Declared State-of-Emergency** - During a declared state-of-emergency, locally or in a neighboring jurisdiction, the normal course of business may be interrupted from the moment the state-of-emergency is made known to PROVIDER by ICEMA. PROVIDER shall then, as provided for in approved disaster plans and protocols, commit such resources as are necessary and appropriate, given the nature of the disaster. During such periods, PROVIDER shall be exempted from response time performance requirements, including late run deductions, until notified by ICEMA that disaster assistance may be terminated. At the scene of such disasters, PROVIDER's personnel shall perform in accordance with ICEMA medical protocols and policies. When state-of-emergency has been terminated, PROVIDER shall resume normal operations as rapidly as is practical considering exhaustion levels of personnel, need for restocking, etc.
- D. **Multi-casualty Incidents** - Normal (i.e., not disaster related) multi-casualty incident calls rendered by PROVIDER shall be performed in accordance with approved ICEMA policies in support of the Incident Command System. In the course of rendering services, PROVIDER shall not be automatically exempt from late run assessments, but may appeal assessments for individual calls, otherwise imposed by this Agreement.

XV. SPECIFIC PROVISIONS

- A. **User Fees Rate Adjustment** - PROVIDER acknowledges that ICEMA has the authority to determine rates for services provided under this Agreement and has exercised that authority by establishing the rates. The rates shall remain in force and effect throughout the term of this

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Agreement but may be modified or adjusted pursuant to process as defined in ICEMA Policy #5080.

- B. **On-Scene Collections** - PROVIDER's personnel shall not request payment for services rendered under this Agreement in response to any 9-1-1 call either at the scene of the call, enroute, or upon delivery of the patient.
- C. **Billing and Collections** - PROVIDER's billing and collection program shall be managed in compliance with all applicable local, state and federal laws and regulations.

XVI. AGREEMENT MANAGEMENT/MONITORING FEE

PROVIDER shall , with other providers, pay a pro rata share of an annual management/monitoring fee in an amount estimated to be sufficient to cover ICEMA's costs related to monitoring and enforcing the provisions of this Agreement for the subsequent fiscal period. The annual fee shall amount to 1) staff directly responsible for the administration of this Agreement; 2) administrative and office costs; and 3) overhead. PROVIDER's pro rata share of cost will be determined based on the total management/monitoring cost for all EOAs serviced by PROVIDER divided by the total number of 9-1-1 transports within all of the EOAs serviced by PROVIDER and multiplied by the number of 9-1-1 transports within the EOA subject to this Agreement during the most recent 12-month period for which data is available at the time of cost estimate. Except for the initial partial fiscal year of this Agreement, ICEMA will provide an estimate of PROVIDER's share of cost for the coming fiscal period not later than thirty (30) days prior to the start of such period. Within ninety (90) days after the end of a fiscal year, ICEMA will determine actual cost for that period and determine whether revenues collected based on estimates resulted in over or underpayment by PROVIDER. Any over or under payments for the prior period will be credited or added to the provider payments in the current period. Additional adjustments to the fee can be made for other changes, such as, a change in monitored components (i.e., interfacility transports code 2 calls. Fees shall be paid to ICEMA within thirty (30) days of the beginning of the quarter. Any increases in the Management/Monitoring Fee imposed by ICEMA shall be considered an "Extraordinary Cost Increase" that shall be considered in any application for rate increase by PROVIDER under Section XV.A, "User Fees Rate Adjustment", above. ICEMA warrants and represents that the payments made by Provider to ICEMA shall be less than or equal to the ICEMA's actual costs to provide those ICEMA Services and/or oversight. No funds shall be used by ICEMA in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute.

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It is not the intent of either party that any remuneration, benefit or privilege provided for under this Agreement shall influence or in any way be based on the referral or recommended referral by either party of patients to the other party or its affiliated providers, if any, or the purchasing, leasing or ordering of any services other than the specific services described in this Agreement. Any payments specified herein are consistent with what the parties reasonably believe to be a fair market value for the services provided.

XVII. DATA COLLECTION AND REPORTING REQUIREMENTS

- A. **PROVIDER** shall maintain data collection and reporting systems that meet the following minimum standards:
 - 1. Response Reporting Requirements: PROVIDER agrees to submit, in a Response Report in a form and/or format as set forth by ICEMA to include all data necessary for ICEMA to analyze and report on PROVIDER’s performance by individual EOA. This report is due no later than the fifteenth (15th) day of the following month (or the following business day if the fifteenth (15th) falls on a non-business day). Failure to provide all data required for analysis will result in a one thousand dollar (\$1,000) penalty for every day the data is late.
 - 2. For each patient treated, PROVIDER’s personnel shall complete an ICEMA approved electronic patient care report (ePCR) to include a unique patient dispatch identifier in a format to be developed by ICEMA.
 - 3. PROVIDER shall establish and maintain, throughout the term of this Agreement, mobile hot spot access in each response unit for identified EMS first responders, fire departments, and other public safety entities for the specific purpose of the transfer of patient care related data to and from internal and/or external network(s) via Wi-Fi coverage zones.
 - 4. PROVIDER shall submit monthly data, including CAD data, for each response, and patient care data as specified by ICEMA. PROVIDER is required to comply with this requirement using ICEMA’s approved electronic data collection and submission format.
 - 5. Data Audits - ICEMA may require an audit of patient care records and response time data.
- B. **Financial Audits** - ICEMA may require an audit of books and records of the PROVIDER. Such audit shall be carried out by a person selected by the PROVIDER and approved by

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ICEMA. If agreement cannot be reached on a person to perform the audit, the financial audit shall be carried out by a Certified Public Accountant selected by ICEMA. If there is any charge, cost or fee for such an audit such shall be paid by the PROVIDER.

C. **On-site Disclosure** - In addition to the aforementioned reports and data, Provider shall maintain up-to-date records and data pertaining to its services specific to San Bernardino County, as listed below. PROVIDER shall make such reports and data available for on-site review and inspection, upon request of ICEMA.

1. Services by payor source.
2. Services provided by category (e.g., ALS, BLS and mileage) and by financial class.
3. Services by date of service.
4. Collections by payor source.

D. **Changes in Practices and Procedures** - PROVIDER shall adhere to said practices, procedures, schedules, and policies except as provided herein. The parties acknowledge and agree that certain of the items contained therein are dependent upon rules, regulations, policies, and procedures adopted by the Federal and State Governments, private insurance companies, and other third-party payors. Such rules, regulations, policies, and procedures may change from time to time and PROVIDER's practices and procedures must change in response to such changes. The parties agree that it would be impractical to amend this Agreement to reflect such changes each time they occur and therefore agree that PROVIDER may change the practices, procedures, schedules, and policies referred to above without a formal amendment to this Agreement, subject to the review and approval of the ICEMA Executive Director. Nothing in this section shall be construed as authorizing any increase in the user fees or rates without complying with such rate adjustment provisions as contained herein.

E. **System Enhancements**

1. PROVIDER shall pay one-time supplemental funding, to ICEMA, in the amount equal to one hundred thousand dollars (\$100,000) to assist in offsetting a portion of ePCR hardware purchased by first responder agencies to enhance patient care documentation and reporting as well as to provide efficient information for accurate and timely billing. This supplemental funding will be due and payable to ICEMA upon execution of this Agreement. ICEMA shall distribute the supplemental funds among the first responder agencies in accordance with the agencies' and ICEMA's needs. Any amount of supplemental funding not spent by ICEMA on ePCR hardware

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pursuant to this Section by the end of the term of this Agreement and any extensions thereto shall be refunded to PROVIDER. ICEMA warrants and represents that the payment made by Provider to ICEMA pursuant to this Section shall be less than or equal to the ICEMA's actual costs to provide those ICEMA Services, products and/or oversight. No funds shall be used by ICEMA in a manner that may violate 42 U.S.C. Section 1320a-7b, the federal Anti-Kickback Statute.

2. PROVIDER agrees to provide educational program content to ICEMA for utilization by all ICEMA certified/accredited EMS personnel.
3. PROVIDER agrees to utilize ICEMA's designated ePCR software vendor for continuity of data transfer between first responder agencies, AMR, and paramedic receiving hospitals.
4. PROVIDER agrees to provide mobile hot spots to create Wi-Fi coverage allowing first responder agencies to connect to the internet for purposes of data transmission related to the care and treatment of patients in the prehospital setting.
5. PROVIDER shall, within six (6) months of execution of this Agreement, ensure and maintain EMD certification for all dispatchers in accordance with ICEMA's EMD policies and protocols.

F. Ownership of Data

1. PROVIDER AND ICEMA agree that all data and records submitted to ICEMA under the terms of this Agreement, including but not limited to dispatch data and records, shall remain the property of ICEMA subject to disclosure by ICEMA pursuant to the California Public Records Act.
2. PROVIDER may assert that any portion of such data or records provided pursuant to this section should be treated as confidential, and is exempt from disclosure under the California Public Records Act. With each item claimed to be confidential, PROVIDER shall provide a statement as to the basis for the claim of confidentiality specifying any exemption in law (e.g., Uniform Trade Secrets Act, Civil Code Section 3426 et seq.). PROVIDER shall hold ICEMA harmless from any and all liability or damages resulting from ICEMA's release of such confidential records and/or information in response to a court order, or statutory or regulatory mandate.
3. ICEMA shall notify PROVIDER of any request for information. PROVIDER may pursue its legal remedies to prevent disclosure of such information.

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XVIII. LIQUIDATED DAMAGES

- A. This Agreement includes provisions for liquidated damages from PROVIDER relative to late runs occurring within a defined service area and other failures to meet required standards. These liquidated damage provisions have no application to the PROVIDER’s other duties under this Agreement, and do not limit ICEMA’s remedies or ability to recover damages against the PROVIDER in any other respect, and have no application to claims against the PROVIDER by third parties to this Agreement. PROVIDER shall pay ICEMA said liquidated damages as determined and assessed by ICEMA pursuant to the provisions contained herein.
- B. **EMS Trust Fund** - The liquidated damages and assessments as set forth in Section XVIII will be deposited in an EMS Trust Fund to be utilized for the purpose of enhancing, not supplanting, the EMS system as determined by ICEMA.
- C. **Liquidated Damages for Resource Performance** - For any month in which PROVIDER fails to meet the combined total of ninety percent (90%) response time for all runs within the EOA system wide, one hundred dollars (\$100) shall be assessed as liquidated damages for each one-tenth of a percentage point (or fraction thereof) less than ninety percent (90%). Non-emergency transports shall not be included in the determination of compliance with the 90% response time requirement and any assessment of liquidated damages.
- D. **Vehicle Break Downs**
 - 1. Any unit in-service that fails due to mechanical, electrical, technology or actions of personnel, will be considered a “Critical Failure.” All critical failures will be considered “Preventable” unless ICEMA receives conclusive facts or written evidence to the contrary.
 - 2. **Notification and Reporting Requirements to ICEMA** - Within three (3) business days of a vehicle breakdown, PROVIDER shall submit, in an approved format, a report that documents the nature of failure and vehicle’s location at time of breakdown. A mechanic’s report must be received within three (3) business days of initial report which must include last preventative maintenance date, mileage, vehicle vin, model year, mechanic’s report detailing failure inspection, and contributing factors.
 - 3. **Penalties:**
 - a. Critical failures deemed to have been “preventable” - two hundred fifty dollars (\$250) per incident

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- b. Critical failures not reported within three (3) business days of occurrence - two hundred fifty dollars (\$250) per occurrence

E. Liquidated Damages for Late Arrival

The following fees will be assessed on each late 9-1-1 arrival within the EOA:

Late	Assessment
0.01 – 1 min	\$5
1.01 – 2 min	\$10
2.01 – 3 min	\$20
3.01 – 4 min	\$50
4.01 – 5 min	\$70
5.01 – 6 min	\$90
6.01 – 7 min	\$110
7.01 – 8 min	\$140
8.01 – 9 min	\$160
9.01 – 10 min	\$180
10.01 – 15 min	\$200
15.01 – 20 min	\$250
20.01 – 30 min	\$300
30.01 – 60 min	\$600
>60 min	\$1000

F. Performance Credits

For each sub-response zone, defined in Attachment 3 as Metropolitan/Urban/Suburban, Rural and Wilderness, in which PROVIDER exceeds the 90% response time standards compliance, the following credits will apply against the liquidated damages for late 9-1-1 arrival assessments outlined above in Section XVIII.E.

% Compliance	Credit
91 – 92%	10%
92.01 – 93%	20%
93.01 – 94%	30%
94.01 – 95%	50%
95.01 – 96%	65%
96.01 – 97%	75%
97.01 – 98%	80%
98.01%+	90%

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In addition, if all response zones within the scope of the services of this Agreement exceed compliance, the following additional credits will apply against liquidated damages for late 9-1-1 arrival assessments:

% Compliance	Credit/zone
91 – 92%	10%
92.01 – 93%	20%
93.01 – 94%	30%
94.01 – 95%	50%
95.01 – 96%	65%
96.01 – 97%	75%
97.01 – 98%	80%
98.01%+	90%

- G. **Waiver of Liquidated Damages/Grievances** - ICEMA reserves the right to individually exclude calls from the response time standard of performance as it relates to liquidated damages and assessments. The response time of calls to areas that are inaccessible from the normal posting locations within the performance standard are appealable. ICEMA will waive response time liquidated damage assessments during an initial assessment phase of six (6) months from the date of Agreement approval by the ICEMA Governing Board.
- H. **Data Reporting Assessment** - In the event PROVIDER fails to furnish information required by this sub-section concerning a call, transport, or account, ICEMA staff shall notify PROVIDER of such failure and PROVIDER shall have three (3) business days to furnish the required information. If PROVIDER does not furnish the information within that period, then ICEMA, at its option, may impose upon PROVIDER a liquidated damage assessment of ten dollars (\$10) for each item of such information and five hundred dollars (\$500) for failure of the ambulance crew to report their arrival on-scene and on-scene time is not verifiable by other reliable means.
- I. For each incident in which a member of PROVIDER'S field staff willfully falsifies reportable data, the PROVIDER shall pay to ICEMA a penalty of one thousand dollars (\$1,000). If such falsification is committed by a member of PROVIDER'S Management staff, the penalty shall be five thousand dollars (\$5,000) and, if a member of PROVIDERS's management staff is not immediately removed from his or her position, PROVIDER will be subject to the major breach provisions of this Agreement as identified in Section XXIV, "MAJOR BREACH EMERGENCY TAKE OVER PROVISIONS."

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- J. **Exemptions** - ICEMA will exclude from the database utilized for calculating monthly compliance any approved exemptions. In order to be eligible for an exemption the PROVIDER must include a full explanation with substantiating documentation, of its reasons for requesting such exemptions as part of the PROVIDER's monthly report.
- K. **Payment of Assessed Liquidated Damages** - PROVIDER shall pay ICEMA, within thirty (30) days of receipt of written notice that any liquidated damages and assessments that have been assessed under this section.

XIX. COMPLIANCE

- A. PROVIDER shall comply with all ICEMA policies, procedures, protocols and directives issued in accordance with the law, including the EOA Plan for the County of San Bernardino. PROVIDER shall comply with all applicable federal, state and local laws and regulations, including but not limited to the requirements of the United States Department of Health and Human Services, Health Care Financing Administration, California Highway Patrol, California Department of Health Services, California Emergency Medical Services Authority, and County of San Bernardino.
- B. **Loss of Business** - PROVIDER understands that a loss of this Agreement in a future bid cycle means the loss of all business covered by the exclusivity provisions of this Agreement in the EOA during the term of this Agreement. PROVIDER accepts this as a reasonable solution to the problems of system-wide disruption that would otherwise occur.
- C. **Outside Work** - PROVIDER shall not be prohibited from doing outside work, which is unrelated to advanced life support or medical transportation, so long as such work does not detract from PROVIDER's primary emergency services responsibilities under this Agreement.

XX. AUDITS AND INSPECTIONS

- A. **Reasonable Inspection Notice** - In addition to ICEMA's authority under Section XVII, "DATA COLLECTION AND REPORTING REQUIREMENTS" at any time during normal business hours, and as often as may reasonably be deemed necessary, ICEMA's representatives may observe PROVIDER's operations. PROVIDER shall make available to ICEMA for its examination, its records with respect to all matters covered by this Agreement, and make excerpts or transcripts from such records, and may make audits of all Agreements, invoices, materials, inventory records, roster of all EMS licensed/certified and/or accredited personnel, daily logs, and other data related to all matters covered by this Agreement. ICEMA

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representatives may, at any time, and without notification, directly observe PROVIDER's operation at the PROVIDER's dispatching center, maintenance facility, and any ambulance post location. ICEMA representatives may ride as "third person" on any of the PROVIDER's units at any time, provided that in exercising this right to inspection and observation, ICEMA representatives shall conduct themselves in a professional manner, be courteous and shall not interfere in any way with PROVIDER's personnel in the performance of their duties.

- B. **Normal Business Hours Restriction** - ICEMA's right to inspect records in PROVIDER's business office shall, however, be restricted to normal business hours, and reasonable notification (24 hours) shall be given the PROVIDER in advance of any such visit. ICEMA's right to observe and inspect operations shall not be restricted by normal business hours and shall not require advance notification.
- C. **Authorized Observers** - This right to directly observe PROVIDER's field operations, provider dispatch operations, and maintenance shop operations shall also extend to authorized representatives of ICEMA or other persons authorized by ICEMA. Such persons shall conduct themselves in a professional manner, be courteous and shall not interfere in any way with PROVIDER's personnel in the performance of their duties.
- D. **Exception to Section** - The terms of Section XX of this Agreement shall not apply where ICEMA has a reasonable cause to believe that a significant and substantial violation of this Agreement has occurred, or is imminent to occur, that may endanger the general public health or is necessary to preserve records that relate to the enforcement provisions of this Agreement, and upon demand, ICEMA shall have immediate access to PROVIDERS' operations, data, and records."

XXI. GENERAL RESPONSIBILITIES AND DUTIES OF ICEMA

ICEMA shall:

- A. **Bed Delay** - Make every attempt to work with hospitals to reduce bed delay.
- B. **Monitoring and Enforcement** - Monitor and enforce performance under this Agreement to ensure service areas covered under this Agreement receive adequate emergency medical services including emergency ambulance service.
- C. **Rate Approval** - Review, reserving the right to approve, reasonable rates and charges by the PROVIDER.
- D. **Competitive Bid Process** - Develop, implement, and conduct a competitive bid process for the selection of emergency ambulance providers to serve EOAs, except as may be required under the California Health and Safety Code, Sections 1797.224 and 1797.226.
- E. **Medical Control** - Provide for system medical control/Medical Director.

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- F. **Default Provisions** - Conduct a competitive bid process for the selection of a PROVIDER to provide emergency ambulance services within the affected contracted EOA, in the event of default, taking over and managing all operations until a new PROVIDER can be secured.
- G. **Compliance Reports** - Provide monthly compliance reports for review by the Performance Committee. This report shall contain a summary of compliance to performance standards and summary of exemptions requested and granted.
- H. **Annual Audit** - Conduct an annual audit to verify accuracy of performance data to include, but not limited to, response time compliance data.
- I. **Annual Report** - Provide an annual compliance report for review to the San Bernardino County Emergency Medical Care Committee (EMCC) and the ICEMA Governing Board.

XXII. GENERAL PROVISIONS

This Agreement shall not be assigned or transferred, nor may the duties hereunder be delegated, without the express written permission from ICEMA. Similarly, any change in ownership equal to or greater than fifty percent (50%) of PROVIDER's company shall be considered a form of assignment of this Agreement, and must be approved by ICEMA, provided that ICEMA shall not unreasonably withhold its approval of such change in ownership.

A. TERM OF AGREEMENT AND RENEWAL PROVISIONS.

- 1. **Term** - The term of this Agreement shall be two (2) years commencing on July 1, 2012. Subsequent to the initial two (2) year term, this Agreement may be extended for two (2) additional one (1) year extensions. Each one (1) year extension must be approved by ICEMA's Governing Board. ICEMA shall provide PROVIDER no less than one hundred eighty (180) days' notice of its intent not to extend this Agreement for either of the two (2) one (1) year extensions.
- 2. **Continuity of Service** - ICEMA hereby declares and makes a finding that it is in the public's best interest to assure that persons needing emergency medical services will not be negatively impacted by changing providers of emergency ambulance services and that the public continues to receive high quality ambulance services. It is also in the best interest that PROVIDER provide an experienced and stable work force of supervisors, paramedics, EMT's, dispatchers and other support personnel; and that it is in the public best interest that PROVIDER establishes a systematic capital

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replacement policy that focuses on long term investment in the EOA and ensures their ability to comply with the terms of this Agreement.

B. END TERM PROVISIONS

1. **Transition Period** - In the event PROVIDER is not the winner of ICEMA's next bid competition, PROVIDER shall continue to provide services during the transition period, and shall assist both ICEMA and its new PROVIDER in effecting a safe and orderly transition. The following provisions are designed to protect the interests of both PROVIDER and ICEMA during the period of transition from one PROVIDER to another. In the event the bidding and Agreement process is not completed six (6) months prior to the termination date of this Agreement, the PROVIDER shall continue to provide services in six (6) month increments from the end date of this Agreement until such time that the process is finalized.
2. **Transfer of Goodwill** - Upon termination of this Agreement, PROVIDER shall assert no claim of rights to conduct business within the contracted EOA after the termination of this Agreement, nor shall PROVIDER assert any claim of compensation owed relative to the loss of such business.

XXIII. DISPUTE AND GRIEVANCE PROCEDURE

- A. **Dispute Resolution** - ICEMA's duties shall include monitoring the operation of this Agreement and ensuring that PROVIDER fulfills its obligations hereunder. In fulfilling this responsibility, ICEMA shall employ a staff member knowledgeable in issues concerning emergency medical services, emergency ambulance services and the terms of this Agreement.
- B. **Monthly Performance Reports** - ICEMA shall review monthly reports regarding PROVIDER's performance under the terms and conditions of this Agreement and shall assess liquidated damages to be paid by PROVIDER, if any, as specified herein and according to the terms hereof. Such reports shall include, but are not limited to, a summary report of all response time exemptions requested by PROVIDER. The reports shall provide a detailed explanation of all response time exception requests, which PROVIDER chooses to submit for consideration. PROVIDER shall have a full opportunity to present any exculpatory or mitigating evidence prior to ICEMA's determination concerning the assessment of any liquidated damages.

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- C. **Disputes and Grievances** - ICEMA shall attempt to resolve disputes or grievances concerning Agreement performance matters between PROVIDER and any city fire district, public agency, consumer of service, and any other interested person or party. ICEMA shall not consider a dispute and grievance unless it concludes that the person or party filing said dispute and grievance has exhausted all other remedies, which are reasonably available.
- D. **Strike Notification** - PROVIDER shall notify ICEMA, local hospitals, and area EMS providers upon reasonable knowledge of a strike by PROVIDER's personnel. This notification shall occur as soon as the information becomes verifiable prior to the effective strike date. An action plan will be provided to ICEMA as soon as possible, but not more than twenty-four (24) hours following ICEMA notification. The action plan must be acceptable to ICEMA.
- E. **Strike Mitigation** - PROVIDER shall take every reasonable action necessary to prevent the strike from adversely effecting the provision of emergency medical services. In the event of a strike, ICEMA may exercise the "emergency take over" provision contained within the Agreement until the PROVIDER can resume normal operations where (1) no action plan is provided and/or initiated by the PROVIDER; or (2) PROVIDER's action plan is unable to meet standards under this Agreement. ICEMA will not unreasonably withhold acceptance of PROVIDER's action plan.
- F. **Minor Breach of Agreement** - ICEMA shall also have the power to assess liquidated damages for PROVIDER's "minor breaches" of this Agreement. "Minor breaches" shall mean failure to fulfill any of the terms and conditions of this Agreement that do not amount to a major breach of the Agreement, as delineated in Section XXIV (A) "Major Breach Definitions.
- G. **Appeal to ICEMA** - ICEMA's decisions in the matters referred to above may be appealed by PROVIDER to the ICEMA Governing Board, in writing within fifteen (15) calendar days of receipt of notice relative to decision. If no appeal is taken, ICEMA 's decision is final. When such matters are appealed to the ICEMA Governing Board, the Chairperson shall conduct a hearing, consider such evidence, testimony, and argument as may be reasonably presented, and shall, within thirty (30) calendar days following the hearing, render written findings and decision to uphold, modify, or overturn the initial decision. The ICEMA Governing Board's and decision shall be final. Notwithstanding this provision, PROVIDER may utilize the Dispute Resolution provisions as set forth in Section XXIII "DISPUTE AND GRIEVANCE PROCEDURE" of this Agreement for final resolution of such disputes.

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- H. **Satisfaction of Liquidated Damages** - When decisions made under the above provisions become final, and PROVIDER is found at fault, PROVIDER shall pay to ICEMA, sums sufficient to fulfill the liquidated damages, if any, as set forth herein.

XXIV. MAJOR BREACH AND EMERGENCY TAKEOVER PROVISIONS

- A. **Major Breach Definitions** - Conditions and circumstances which, shall constitute a major breach of Agreement by the PROVIDER shall include the following:

1. Failure of the PROVIDER to operate its services in a manner which enables ICEMA and the PROVIDER to remain in compliance with the requirements of the applicable federal, state and local laws, rules and regulations. Minor infractions of such requirements shall not constitute a major breach of this Agreement. Once a takeover has been completed, ICEMA shall, as soon as reasonably possible, select a new ambulance provider, utilizing a competitive bid process.
2. Failure to comply with the 90% response time requirement for the EOA system wide for three (3) consecutive months or four (4) months in any twelve consecutive month periods shall be considered a major breach of Agreement.
3. Response time compliance falls below 80 percent (80%) for the EOA system wide for any month within the term of this Agreement.
4. Intentional falsification or omission of data or information supplied to ICEMA, which effects or has the effect of enhancing PROVIDER's performance under this Agreement.
5. Failure to report and comply when penalty provisions apply.
6. Failure to maintain in force throughout the term of this Agreement, including any extensions thereof, the insurance coverage required herein.
7. Multiple or unmediated failures to correct any minor breach within a reasonable period of time after written notice from ICEMA.
8. Any act or omission of PROVIDER, which, in the reasonable opinion of the ICEMA Medical Director, poses a serious risk to public health and safety.
9. PROVIDER terminates its contract with the County for provision of indigent transport services.

- B. **Notice to PROVIDER** - If it appears that any of the conditions or circumstances set forth above exists or has occurred, then the ICEMA Executive Director, in consultation with the ICEMA Medical Director, shall notify PROVIDER of such existence or occurrence.

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PROVIDER shall have a period of time, which shall be reasonable under the circumstances, to take appropriate remedial action to correct the deficiencies. PROVIDER and ICEMA staff shall attempt in good faith and with all reasonable effort to resolve the allegations between and among themselves without recourse to the other remedies available herein.

- C. **Unresolved Allegation** - If an allegation of major breach has not been resolved under the above provisions, the ICEMA Executive Director, in consultation with the ICEMA Medical Director, shall notify PROVIDER in writing and ICEMA shall immediately undertake an emergency takeover of PROVIDER's operations pursuant to the provisions herein.
- D. **ICEMA Discretion** - If ICEMA finds that only a minor breach has occurred, or that a major breach has occurred but the public health and safety would not be endangered by allowing PROVIDER to continue its operations, then ICEMA may require other actions, short of termination and takeover, as it deems appropriate under the circumstances.
- E. **ICEMA Governing Board Hearing**
 - 1. After PROVIDER is given reasonable notice of Minor Breach, and PROVIDER has not taken appropriate remedial action to correct the deficiency, the ICEMA Governing Board shall hold a hearing upon the ICEMA Executive Director's recommendations. The ICEMA Governing Board shall receive and consider any additional information and evidence on the matter which PROVIDER or others may wish to present, and determine whether a major breach of this Agreement has occurred and whether said breach is such that the public health and safety would be endangered by allowing PROVIDER to continue its operations under this Agreement. If the ICEMA Governing Board finds that a major breach has occurred and PROVIDER has failed to cure the deficiency, it shall declare this Agreement terminated and commence action to affect an immediate takeover by ICEMA of PROVIDER's operations.
 - 2. If the Governing Board finds that only a minor breach has occurred, or that a major breach has occurred but that allowing PROVIDER to continue its operations would not endanger the public health and safety, the ICEMA Governing Board may take such other actions, short of termination and takeover, as it deems appropriate under the circumstances.
- F. **Expedited Hearing Process** - If, in the judgment of the ICEMA Executive Director, it appears a condition or circumstance of major breach exists or has occurred and that such condition or circumstance presents an immediate danger to the public health and safety, the

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ICEMA Executive Director, after giving notice to PROVIDER, may take the matter directly and immediately to the Governing Board for its determination under the above provisions.

- G. **Notice of Default** - Pursuant to the above provisions, ICEMA shall have the right to terminate, cancel, or takeover services provided under this Agreement or to pursue any appropriate legal remedy in the event of a major breach. In such instance, ICEMA shall provide written notice to PROVIDER specifying the date and time of intended termination or takeover.
- H. **Emergency Takeover** - Without limiting ICEMA's rights as set forth herein, in the event ICEMA determines that a major breach, actual or threatened, has or will occur, or that another event has or will occur that prevents performance, and if the nature of the breach or inability to perform is, in the reasonable opinion of the ICEMA Executive Director, such that public health and safety are endangered, and after PROVIDER has been given notice and an opportunity deemed reasonable by the ICEMA Executive Director to correct the deficiency (which notice may be less than 30 days, depending on the circumstances and gravity of the breach), the matter may be presented to the Governing Board. If the Governing Board concurs that (1) a breach has occurred, (2) the PROVIDER has failed to cure the breach, and (3) that the health and safety would be endangered by allowing PROVIDER to continue its operations, PROVIDER shall cooperate fully with ICEMA to affect an immediate takeover by ICEMA of PROVIDER's EOA. Such takeover may be affected at any time after action by the Governing Board or within such time period as the Governing Board deems to be appropriate.
- I. **Takeover Cooperation**
1. PROVIDER shall not be prohibited from disputing any such finding of major breach through litigation, provided that such litigation shall not have the effect of delaying, in any way, the immediate takeover of operations by the ICEMA.
 2. These provisions are specifically stipulated and agreed to by both parties as being reasonable and necessary to the protection of public health and safety, and any legal dispute concerning the finding that a major breach has occurred shall be initiated and shall take place only after the emergency takeover has been completed, and shall not under any circumstances, delay the process of the emergency takeover by ICEMA.
 3. PROVIDER's cooperation with and full support of such emergency takeover shall not be construed as acceptance by the PROVIDER of the finding of major breach, and shall not in any way jeopardize PROVIDER's right to recovery should a court later find

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that declaration of major breach was made in error. However, failure on the part of the PROVIDER to cooperate fully with ICEMA to effect a safe and smooth takeover of operations shall itself constitute a major breach of this Agreement, even if it was later determined that the original declaration of major breach was made in error.

4. The ICEMA Governing Board shall be the final authority for ICEMA.

XXV. FORCE MAJEURE

- A. **Effect** - Except as otherwise expressly provided in this Agreement, no default in the performance of any obligations hereunder will be deemed to exist if such default is solely the result of a Force Majeure. In the event either party hereto is unable, by reason of Force Majeure, to carry out its obligations under this Agreement, it is agreed that on such party's giving prompt notice of the full particulars of such event of Force Majeure, to be confirmed in writing, to the other party as soon as possible after the occurrence of the event of Force Majeure relied upon, the obligations of the party giving such notice so far as they are affected by such event of Force Majeure, shall be excused during the continuance of such event of Force Majeure. A breach of this Agreement caused by an event of Force Majeure shall as far as practical be remedied with all reasonable dispatch.
- B. **Diligent Efforts** - During any period in which any party hereto is excused from performance by reason of the occurrence of an event of Force Majeure, the party so excused shall promptly, diligently, and in good faith take all reasonable action required in order for it to be able to commence or resume performance of its obligations under this Agreement. Without limiting the generality of the foregoing, the party so excused from performance shall, during any such period of Force Majeure, take all actions reasonably necessary to enable it to so commence or resume performance of its obligations under this Agreement.

XXVI. HOLD HARMLESS, INDEMNIFICATION AND INSURANCE REQUIREMENTS

A. Hold Harmless

- 1. PROVIDER agrees to defend, indemnify, hold harmless and release ICEMA, their officers, agents and employees, from and against any and all actions claims, damages, disabilities or expenses that may be asserted by any person or entity, to the extent arising out of the negligent acts or omissions or willful misconduct in the performance by PROVIDER hereunder, whether or not there is concurrent negligence on the part of ICEMA, but excluding liability due to the active negligence

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or willful misconduct of ICEMA. This indemnification obligation is not limited in any way by any limitation on the amount or type of damages or compensation payable to or for PROVIDER or its agents under workers' compensation acts, disability benefit acts, or other employee benefit acts. The duty of PROVIDER to indemnify and save harmless as set forth herein, shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

2. ICEMA agrees to indemnify, hold harmless and release PROVIDER, its officers, agents and employees, from and against any and all actions claims, damages, disabilities or expenses that may be asserted by any person or entity, to the extent arising out of the negligent acts or omissions in the performance by ICEMA hereunder, whether or not there is concurrent negligence on the part of the PROVIDER, but excluding liability due to the active negligence or willful misconduct of the PROVIDER. This indemnification obligation is not limited in any way by any limitation on the amount or type of damages or compensation payable to or for ICEMA or its agents under workers' compensation acts, disability benefit acts, or other employee benefit acts. ICEMA shall be liable to PROVIDER for any loss of or damage to PROVIDER's property arising from ICEMA's negligence. The duty of ICEMA to indemnify and save harmless as set forth herein, shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

B. Basic Requirements

1. **Indemnification** - Provider agrees to indemnify, defend (with counsel reasonably approved by ICEMA) and hold harmless ICEMA and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of this Agreement from any cause whatsoever, including the acts, errors or omissions of PROVIDER, its employees and/or agents, and for any costs or expenses incurred by ICEMA on account of any claim except where such indemnification is prohibited by law.
2. **Additional Insured** - All policies, except for the Workers' Compensation, Errors and Omissions and Professional Liability policies, shall contain endorsements naming ICEMA and its officers, employees, agents and volunteers as additional insureds with respect to liabilities arising out of the performance of services hereunder. The additional insured endorsements shall not limit the scope of coverage for ICEMA to vicarious liability but shall allow coverage for ICEMA to the full extent provided by the

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policy. Such additional insured coverage shall be at least as broad as Additional Insured (Form B) endorsement form ISO, CG 2010.11 85.

3. **Waiver of Subrogation Rights** - The PROVIDER shall require the carriers of required coverage to waive all rights of subrogation against ICEMA, its officers, employees, agents, volunteers, contractors and subcontractors. All general or auto liability insurance coverage provided shall not prohibit PROVIDER and PROVIDER's employees or agents from waiving the right of subrogation prior to a loss or claim. PROVIDER hereby waives all rights of subrogation against ICEMA.
4. **Policies Primary and Non-Contributory** - All policies required herein are to be primary and non-contributory with any insurance or self-insurance programs carried or administered by ICEMA.
5. **Severability of Interests** - PROVIDER agrees to ensure that coverage provided to meet these requirements is applicable separately to each insured and there will be no cross liability exclusions that preclude coverage for suits between PROVIDER and ICEMA or between ICEMA and any other insured or additional insured under the policy.
6. **Proof of Coverage** - PROVIDER shall furnish Certificates of Insurance to ICEMA Department administering the Agreement evidencing the insurance coverage, including endorsements, as required, prior to the commencement of performance of services hereunder, which certificates shall provide that such insurance shall not be terminated or expire without thirty (30) days written notice to the Department, and PROVIDER shall maintain such insurance from the time PROVIDER commences performance of services hereunder until the completion of such services. Within fifteen (15) days of the commencement of this Agreement, PROVIDER shall furnish a copy of the Declaration page for all applicable policies.
7. **Acceptability of Insurance Carrier** - Unless otherwise approved by Risk Management, insurance shall be written by insurers authorized to do business in the State of California and with a minimum "Best" Insurance Guide rating of "A- VII".
8. **Deductibles and Self-Insured Retention** - Any and all deductibles or self-insured retentions in excess of ten thousand dollars (\$10,000) shall be declared to and approved by Risk Management.
9. **Failure to Procure Coverage** - In the event that any policy of insurance required under this Agreement does not comply with the requirements, is not procured, or is

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canceled and not replaced, ICEMA has the right but not the obligation or duty to cancel the Agreement or obtain insurance if it deems necessary and any premiums paid by ICEMA will be promptly reimbursed by PROVIDER or County payments to PROVIDER will be reduced to pay for County purchased insurance.

10. **Insurance Review** - Insurance requirements are subject to periodic review by ICEMA. The Director of Risk Management or designee is authorized, but not required, to reduce, waive or suspend any insurance requirements whenever Risk Management determines that any of the required insurance is not available, is unreasonably priced, or is not needed to protect the interests of ICEMA. In addition, if the Department of Risk Management determines that heretofore unreasonably priced or unavailable types of insurance coverage or coverage limits become reasonably priced or available, the Director of Risk Management or designee is authorized, but not required, to change the above insurance requirements to require additional types of insurance coverage or higher coverage limits, provided that any such change is reasonable in light of past claims against ICEMA, inflation, or any other item reasonably related to ICEMA's risk.

Any change requiring additional types of insurance coverage or higher coverage limits must be made by amendment to this Agreement. PROVIDER agrees to execute any such amendment within thirty (30) days of receipt.

Any failure, actual or alleged, on the part of ICEMA to monitor or enforce compliance with any of the insurance and indemnification requirements will not be deemed as a waiver of any rights on the part of ICEMA.

C. Insurance Specifications

PROVIDER agrees to provide insurance set forth in accordance with the requirements herein. If PROVIDER uses existing coverage to comply with these requirements and that coverage does not meet the specified requirements, PROVIDER agrees to amend, supplement or endorse the existing coverage to do so. The type(s) of insurance required is determined by the scope of the Agreement.

Without in anyway affecting the indemnity herein provided and in addition thereto, PROVIDER shall secure and maintain throughout the Agreement term the following types of insurance with limits as shown:

1. **Workers' Compensation/Employers Liability** - A program of Workers' Compensation insurance or a state-approved, self-insurance program in an amount

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and form to meet all applicable requirements of the Labor Code of the State of California, including Employer's Liability with two hundred fifty thousand dollars (\$250,000) limits covering all persons including volunteers providing services on behalf of PROVIDER and all risks to such persons under this contract.

If PROVIDER has no employees, it may certify or warrant to ICEMA that it does not currently have any employees or individuals who are defined as "employees" under the Labor Code and the requirement for Workers' Compensation coverage will be waived by ICEMA's Director of Risk Management.

With respect to PROVIDERS that are non-profit corporations organized under California or Federal law, volunteers for such entities are required to be covered by Workers' Compensation insurance.

2. **Professional Liability** - Professional Liability Insurance with limits of not less than five (5) million (\$5,000,000) per claim or occurrence and ten million (\$10,000,000) aggregate limits.

If insurance coverage is provided on a "claims made" policy, the "retroactive date" shall be shown and must be before the date of the start of the contract work. The claims made insurance shall be maintained or "tail" coverage provided for a minimum of five (5) years after Agreement completion.

3. **Commercial/General Liability Insurance** - PROVIDER shall carry General Liability Insurance covering all operations performed by or on behalf of PROVIDER providing coverage for bodily injury and property damage with a combined single limit of not less than five (5) million dollars (\$5,000,000), per occurrence. The policy coverage shall include:

- a. Premises operations and mobile equipment.
- b. Products and completed operations.
- c. Broad form property damage (including completed operations).
- d. Explosion, collapse and underground hazards.
- e. Personal injury
- f. Contractual liability.
- g. Two (2) million dollars (\$2,000,000) general aggregate limit.

4. **Automobile Liability Insurance** - Primary insurance coverage shall be written on ISO Business Auto coverage form for all owned, hired and non-owned automobiles or symbol 1 (any auto). The policy shall have a combined single limit of not less than

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five million dollars (\$5,000,000) for bodily injury and property damage, per occurrence.

If PROVIDER is transporting one (1) or more non-employee passengers in performance of contract services, the automobile liability policy shall have a combined single limit of two million dollars (\$2,000,000) for bodily injury and property damage per occurrence.

If PROVIDER owns no autos, a non-owned auto endorsement to the General Liability policy described above is acceptable.

5. **Umbrella Liability Insurance** - An umbrella (over primary) or excess policy may be used to comply with limits or other primary coverage requirements. When used, the umbrella policy shall apply to bodily injury/property damage, personal injury/advertising injury and shall include a “dropdown” provision providing primary coverage for any liability not covered by the primary policy. The coverage shall also apply to automobile liability.
6. **Documentation**
 - a. The following documentation shall be submitted to ICEMA:
 - 1) Properly executed Certificates of Insurance clearly evidencing all coverage and limits. Said Certificates shall be submitted prior to the execution of this Agreement.
 - 2) Upon ICEMA's written request, certified copies of Declaration pages.
7. **Obligations Not Limited by Insurance** - PROVIDER's indemnity and other obligations, owed to ICEMA shall not be limited by the foregoing insurance requirements.
8. **Breach** - If PROVIDER, for any reason, fails to maintain insurance coverage, which is required pursuant to this Agreement, the same shall be deemed a breach of Agreement. ICEMA, at its sole option, may terminate this Agreement and obtain damages from the PROVIDER resulting from said breach.

XXVII. COMPENSATION TO PROVIDER

- A. **Compensation** - As compensation for the services, equipment, and materials furnished under this Agreement, PROVIDER shall receive the following as full compensation:
 1. Market rights as specified herein.

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2. Income from fee for service billing and other reimbursement mechanisms as specified.

B. **Exclusivity** - In consideration for all of the services, equipment, materials, and supplies to be furnished by PROVIDER, the ICEMA Governing Board has designated PROVIDER as an exclusive provider of ambulance services within the geographical areas defined by this Agreement. The parties further agree that by such designation and through the other provisions for PROVIDER compensation incorporated herein, ICEMA has fulfilled any and all obligations it may have presently or at any time during the term of this Agreement to compensate, reimburse, or otherwise pay PROVIDER for services provided to medically-indigent patients. Nothing in this section shall effect County's obligation to pay for services to medically indigent patients. Nothing in this Agreement is intended to create any duty on the part of ICEMA to pay for ambulance or emergency medical services rendered to any individual.

XXVIII. RIGHTS AND REMEDIES NOT WAIVED

The PROVIDER agrees and guarantees that the work herein specified shall be completed without further or additional compensation than that provided for in this Agreement; and that the acceptance of work herein and the payment thereof shall not be deemed to be a waiver by ICEMA of any breach of covenants or conditions, or any default which may then exist on the part of the PROVIDER, and the making of such payment while any such breach or default exists, shall in no way impair or prejudice any right or remedy available to ICEMA with respect to such breach or default.

XXIX. ENTIRE AGREEMENT; AMENDMENTS; INTERPRETATION; VENUE; NOTICES

A. **Entire Agreement/Amendments** - This Agreement and all Exhibits and Attachments, constitutes the entire Agreement between ICEMA and PROVIDER with respect to the subject matter hereof and supersedes any and all previous negotiations, proposals, commitments, writings, advertisements, publications, and understandings of any nature whatsoever unless specifically included or incorporated herein. No modification of this Agreement shall be effective unless it is in writing and executed by the duly authorized representatives of the parties hereto.

B. **Rights and obligations** - The rights and obligations of the parties and all interpretations and performance of this Agreement shall be governed in all respects by the laws of the

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State of California. The parties further acknowledge and agree that the rights and obligations established under this Agreement are subject to, and shall not supersede, the rights under California Health and Safety Code, Section 1797.201, provided to any city or fire protection district within the PROVIDER's assigned EOA under this Agreement.

- C. **Venue** - The parties agree that this Agreement shall be construed under the laws of the State of California and that any action relating to this Agreement shall be instituted in the San Bernardino County Superior Court.
- D. **Notices/Communications** - Notices and other communications required hereunder shall be transmitted in writing by certified mail, postage prepaid, return receipt requested, addressed to the parties as follows:

To PROVIDER:
American Medical Response, Inc.
Attn: Legal Department
6200 South Syracuse Way, Suite # 200
Greenwood Village, CO 80111

Second Copy:
American Medical Response of Inland Empire
General Manager
7925 Center Avenue
Rancho Cucamonga, CA 91730

To ICEMA:
Executive Director
ICEMA
1425 South "D" Street
San Bernardino, CA 92415-0060

Except as otherwise provided, any notice given pursuant to this Agreement shall be effective seven (7) days after the postmark or upon receipt as evidenced by the return receipt card, whichever is later.

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XXX. INDEPENDENT PROVIDER

- A. **Status of PROVIDER** - The parties intend that PROVIDER, in performing the services specified herein, shall act as an independent PROVIDER and shall control the work and the manner in which it is performed. PROVIDER is not to be considered an agent or employee of ICEMA and is not entitled to participate in any pension plan, insurance, bonus, or similar benefits ICEMA provides its employees.
- B. **Taxes** - PROVIDER agrees to file federal and state tax returns and pay all applicable taxes on amounts paid pursuant to this Agreement and shall be solely liable and responsible to pay such taxes and other obligations, including, but not limited to, state and federal income and FICA taxes. PROVIDER agrees to indemnify and hold ICEMA harmless from any liability which it may incur to the United States or to the State of California as a consequence of PROVIDER's failure to pay, when due, all such taxes and obligations. In case ICEMA is audited for compliance regarding any withholding or other applicable taxes, PROVIDER agrees to furnish ICEMA with proof of payment of taxes.

XXXI. PARTIAL INVALIDITY

In the event any provision of this Agreement shall be held invalid or unenforceable by a court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof.

XXXII. PREVENTION OF IMPLEMENTATION

The parties agree that in the event ICEMA, or PROVIDER, or both, are delayed or prevented due to legal action from implementing the provisions of the Governing Board's action, relating to the establishment of an EOA for service, the terms and conditions of this Agreement may be modified as mutually agreed upon by the parties.

XXXIII. NON-DISCRIMINATION

PROVIDER shall comply with all applicable federal, state and local laws, rules and regulations relating to non-discrimination in employment and services because of race, color, ancestry, national origin, religion, sex, marital status, age, medical condition and handicap.

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XXXVI. NON-TRANSFERABLE AGREEMENT

- A. **Consent of ICEMA** - This Agreement shall not be assigned or transferred, nor shall the duties hereunder be delegated without the express written permission of ICEMA, unless Agreement is assigned or transferred to PROVIDER’s subsidiary, with written notice to ICEMA.
- B. **Application of Health and Safety Code** - The consent of ICEMA to any assignment of this Agreement is independent of and will have no affect on the rights of PROVIDER and/or its assignee under Sections 1797.224 and 1797.226 of the California Health and Safety Code.

XXXV. SECTION HEADINGS AND TABLE OF CONTENTS

Section headings and Table of Contents are inserted for convenience only and shall not be used in any way to construe the terms of this Agreement.

XXXVI. COOPERATION

PROVIDER’s obligations of cooperation with the ICEMA hereunder shall survive termination of this Agreement and shall remain in force and effect until fulfilled.

XXXVII. CONFLICT OF LAWS

This Agreement shall not be construed to confer any further or additional rights on PROVIDER than may otherwise exist under the provisions of EMS Act (California Health and Safety Code, Section 1797, et seq.) and remains subject to the provisions of California Health and Safety Code, Sections 1797.201, 1797.224, and 1797.226, where applicable.

XXXVIII. FORMER COUNTY AND ICEMA OFFICIALS

PROVIDER agrees to provide or has already provided information on former County of San Bernardino administrative and ICEMA officials (as defined below) who are employed by or represent PROVIDER. The information provided includes a list of former County or ICEMA administrative officials who terminated County or ICEMA employment within the last five (5) years and who are now officers, principals, partners, associates or members of the business. The information also includes the employment with or representation of PROVIDER. For purposes of this provision, “County or ICEMA administrative official” is defined as a member of the Board of Supervisors, or such officer’s staff, County Executive Officer, or member of such officer’s staff,

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county department or group head, assistant department or group head, any employee in the Exempt Group, Management Unit or Safety Management Unit or any employee of ICEMA Emergency Medical Services Program. If during the course of the administration of this Agreement, ICEMA determines that the PROVIDER has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to ICEMA, this Agreement may be immediately terminated. If this Agreement is terminated according to this provision, ICEMA is entitled to pursue any available legal remedies.

XXXIX. REGULATORY PROVISIONS

- A. **Compliance** - The parties will comply in all material respects with all applicable federal and state laws and regulations including, the federal Anti-kickback statute.
- B. **Compliance Program and Code of Conduct** - PROVIDER has made available to each party a copy of its Code of Conduct, Anti-kickback policies and other compliance policies, as may be changed from time-to-time, at PROVIDER’s web site, located at: www.amr.net, and each party acknowledges receipt of such documents. PROVIDER warrants that its personnel shall comply with its compliance policies, including training related to the Anti-kickback Statute.
- C. **Non-Exclusion** - Each party represents and certifies that neither it nor any practitioner who orders or provides Services on its behalf hereunder has been convicted of any conduct that constitutes grounds for mandatory exclusion as identified in 42 U.S.C.§ 1320a-7(a). Each party further represents and certifies that it is not ineligible to participate in Federal health care programs or in any other state or federal government payment program. Each party agrees that if DHHS/OIG excludes it, or any of its practitioners or employees who order or provide Services, from participation in Federal health care programs, the party must notify the other party within five (5) days of knowledge of such fact, and the other party may immediately terminate this Agreement, unless the excluded party is a practitioner or employee who immediately discontinues ordering or providing Services hereunder.
- D. **Referrals** - It is not the intent of either party that any remuneration, benefit or privilege provided for under the Agreement shall influence or in any way be based on the referral or recommended referral by either party of patients to the other party or its affiliated providers, if any, or the purchasing, leasing or ordering of any services other than the specific services described in this Agreement. Any payments specified herein are consistent with what the parties reasonably believe to be a fair market value for the services provided.

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IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the day and year first above written.

INLAND COUNTIES EMERGENCY MEDICAL AGENCY

(Print or type name of corporation, company, contractor, etc.)

▶

Josie Gonzales, Chair, Board of Directors

By ▶ _____
(Authorized signature - sign in blue ink)

Dated: _____

Name _____
(Print or type name of person signing contract)

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD
Laura H. Welch, Secretary

Title _____
(Print or Type)

Dated: _____

By _____
Deputy

Address _____

Approved as to Legal Form

Reviewed by Contract Compliance

Presented to Board for Signature

▶

Counsel

▶

▶

Date _____

Date _____

Date _____

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**Description
Exclusive Operating Area #1**

Beginning at the intersection of the San Bernardino County line with the North line of Section 7, T.2N., R. 7W., S.B.M.; thence East along section lines to the Northeast corner of Section 8; thence South along section lines to the Northwest corner of Section 21; thence East along the North line of said Section 21 to the Northeast corner thereof; thence South along section lines to the Northwest corner of Section 34; thence East along the North line of said Section 34 to the Northeast corner thereof; thence South along section lines to the Northwest corner of Section 11, T.1N., R. 7W., S.B.M.; thence East along the North line of said Section 11 to the Northeast corner thereof; thence South along the East line of said Section 11 to the Northwest corner of Section 13; thence East along the North line of said Section 13 to the Northeast corner thereof; thence South along the East line of said Section 13 to the Northwest corner of Section 19, T. 1N., R.6W., S.B.M.; thence East along the North line of said Section 19 to the Northerly prolongation of the center line of Rochester Avenue; thence Southerly along said prolongation and center line to the Southerly city limits of Rancho Cucamonga; thence Westerly along said city limits to the city limits of Upland; thence Westerly along the Southerly city limits of Upland to the San Bernardino County line; thence Northerly along said County line to the Point of Beginning.

Description
Exclusive Operating Area #2

Beginning at the intersection of the San Bernardino County line with the city limits line of Upland and Montclair; thence Easterly and Southerly along the city limits of Upland and the city limits of Ontario; thence Southerly along said city limits of Ontario to the center line of Philadelphia Avenue, said point being also in the city limits of Chino; thence Easterly, Southerly, Westerly, and Northerly along said city limits of Chino, following all of its various courses to the Easterly prolongation of the South line of Section 7, T.25., R. 8W., S.B.M., as said Section would be extended into the Rancho Santa Ana Del Chino; thence West along said prolongation and South line to the San Bernardino County line; thence Northerly and Easterly along said County line, following all of its various courses to the Point of Beginning.

Description
Exclusive Operating Area #3

Beginning at the intersection of the center line of Benson Avenue with the common boundary of the cities of Montclair, Upland and Ontario; thence Easterly along the Northerly city limits of Ontario to the center line of Rochester Avenue; hence Southerly along said center line and its Southerly prolongation to the San Bernardino County line; thence Westerly, Southerly and Northerly along said County line, following all of its various courses to the Northwest corner of Section 18, T.2N., R.8W., S.B.W., as said Section would be extended into the Rancho Santa Ana Del Chino; thence East along the North line of said Section 18 and its Easterly prolongation to the city limits of Chino; thence Southerly, Easterly and Northerly along said city limits of Chino, following all of its various courses to the city limits of Ontario; thence Westerly and Northerly along said city limits of Ontario, following all of its various courses to the Point of Beginning.

Description

Exclusive Operating Area #4

Beginning at the intersection of the San Bernardino County line with the North line of Section 6, T.2N., R.7W., S.B.M.; thence East along section lines to the Southwest corner of Section 35, T.3N., R.7W., S.B.M.; thence North along the west line of said Section 35 to a point due West of Stockton Flat Campground on the Lytle Creek Road; thence East to said camp ground; thence East to the East line of Section 35; thence South to the North line the South half of Section 36; thence East along said North line to the East line of said Section 36; thence South along said East line to the Northwest corner of Section 6, T. 2N., R.6W., S.B.M.; thence East along section lines to the Northeast corner of Section 5; thence South along the East line of said Section 5 to the Northwest corner of Section 9; thence East along section lines to the Northeast corner of Section 10; thence South along the East line of said Section 10 to the Northwest corner of Section 14; thence East along the North line of said Section 14 to the Northeast corner thereof; thence South along section lines to the Northwest corner of Section 25; thence East along the North line of said Section 25 to the Northeast corner thereof; thence South along section lines to the Northwest corner of Section 6, T.1N., R.5W., S.B.M.; thence East along the North line of said Section 6 to the Northeast corner thereof; thence South along the East line of said Section 6 to the Northwest corner of Section 8; thence East along the North line of said Section 8 to the Southeasterly right of way line of Interstate 15E; thence Southwesterly along said Southeasterly line to the city limits of Rialto thence Southerly along the Westerly city limits of Rialto, following all of its various courses to the East line of Riverside Avenue; thence Southerly along said East line to the San Bernardino County line; thence Westerly along said County line to the Southerly prolongation of the center line of Rochester Avenue; thence northerly along said prolongation and center line and its Northerly prolongation to the South line of Section 18, T.1N., R.6W., S.B.M.; thence West along said South line to the Southwest corner of said Section 18; thence North along the West line of said Section 18 to the Southeast corner of Section 12, T.1N., R.7W., S.B.M.; thence West along the South line of said Section 12 to the Southwest corner thereof;

thence North along the west line of said Section 12 to the Southeast corner of Section 2; thence West along the South line of said Section 2 to the Southwest corner thereof; thence north along section lines to the Southeast corner of Section 27, T.2N., R.7W., S.B.M.; thence West along the South line of said Section 27 to the Southwest corner thereof; thence north along section lines to the Southeast corner of Section 14; thence West along the South line of said Section 14 to the Southwest corner thereof ; thence North along section lines to the Southeast corner of Section 5;

thence West along section lines to the San Bernardino County line; thence Northerly along said county line to the POINT OF BEGINNING.

Description
Exclusive Operating Area #5

Beginning at the intersection of the Easterly line of Interstate I5E with the center line of the Lytle Creek Wash; thence Southeasterly along said center line of the Lytle Creek Wash to a point due North of the most Northeasterly corner of the City of Rialto; thence South to said Northeasterly corner; thence Southerly along the city limits of Rialto to the city limits of Colton; thence Southerly along said city limits of Colton to the Northerly line of Agua Mansa Road; thence Southeasterly along said Northerly line to the east line of Riverside Avenue; thence Northerly along said East line to the city limits of Rialto; thence Northerly and Westerly along the Westerly city limits of Rialto to the Southeasterly line of Interstate 15E; hence Northeasterly along said Southeasterly line to the POINT OF BEGINNING.

Description Exclusive Operating Area #6

Beginning at the intersection of the Northerly line of State Highway 138 with the Easterly line of Interstate 15; thence Southeasterly along said Easterly line of Interstate 15 to the North line of Section 35, T3N., R.6W., S.B.M.; thence East along section lines to the Northeast corner of Section 36; thence South along the East line of said Section 36 to the North line of Section 6, T.2N., R5W., S.B.M.; thence East along said North line to the Northeast corner of said Section 6; thence South along the East line of said Section 6 to the Northwest corner of Section 8; thence East along section lines to the Northeast corner of Section 9; thence South along the East line of said Section 9 to the Northwest corner of Section 15; thence East along section lines to the Northeast corner of Section 14; thence South along the East line of said Section 14 to the Northwest corner of Section 24; thence East along the North line of said Section 24 to the Northeast corner thereof; thence South along the East line of said Section 24 to the Southeast corner thereof; thence West along the South line of said Section 24 to the North quarter corner of Section 25; thence South to the San Bernardino National Forest Boundary; thence Southeasterly along said boundary, following all of its various courses to the west line of the East half of Section 19, T.1N., R.3W., S.B.M.; thence North along North-South center section lines to the North line of Section 6; thence East along said North line to the Northeast corner of said Section 6; thence South along the East line of said Section 6 to the North line of the South half of Section 5; thence East along said North line to the East line of said Section 5; thence South along said East line to the Northwest corner of Section 9; thence East along section lines to a point due North of the City Creek Forest Station and the West line of State Hwy 30; thence Southerly along the Westerly line of State Hwy 330, Boulder Avenue and Orange Street to the center line of the Santa Ana River; thence Westerly along said center line to the Westerly line of Interstate 215; thence Southerly along said Westerly line to the San Bernardino County line; thence West along said County line to the East line of Riverside Avenue; thence Northerly along said East line to the North line of Agua Mansa Road; thence Northeasterly along said North line to the city limits of Colton; thence Northerly along said city limits to the city limits of Rialto; thence Northerly along said city limits of Rialto to the most Northeasterly corner of the City of Rialto; thence North to the center line of the Lytle Creek Wash; thence Northwesterly along said center line to the Southeasterly line of Interstate 15E; thence Northeasterly along said Easterly line to the South line of Section 5, T.1N., R.5W., S.B.M.; thence West along said South line to the Southwest corner of said Section 5; thence North along the West line of said Section 5 to the Southeast corner of Section 31, T.2N., R.5W., S.B.M.; thence West along the South line of said Section 31 to the Southwest corner thereof; thence North along section lines to the Southeast corner of Section 24, T.2N., R.6W., S.B.M.; thence West along the South line of said Section 24 to the Southwest corner thereof;

thence North along section lines to the South line of Section 36, T.3N., R.6W., S.B.M.; thence West along said South line to the West line of the East half of said Section 35; thence North along the West line of the East half of Sections 35 and 26 to the North line of State Highway 138; thence Easterly along said North line to the POINT OF BEGINNING.

Description
Exclusive Operating Area #7

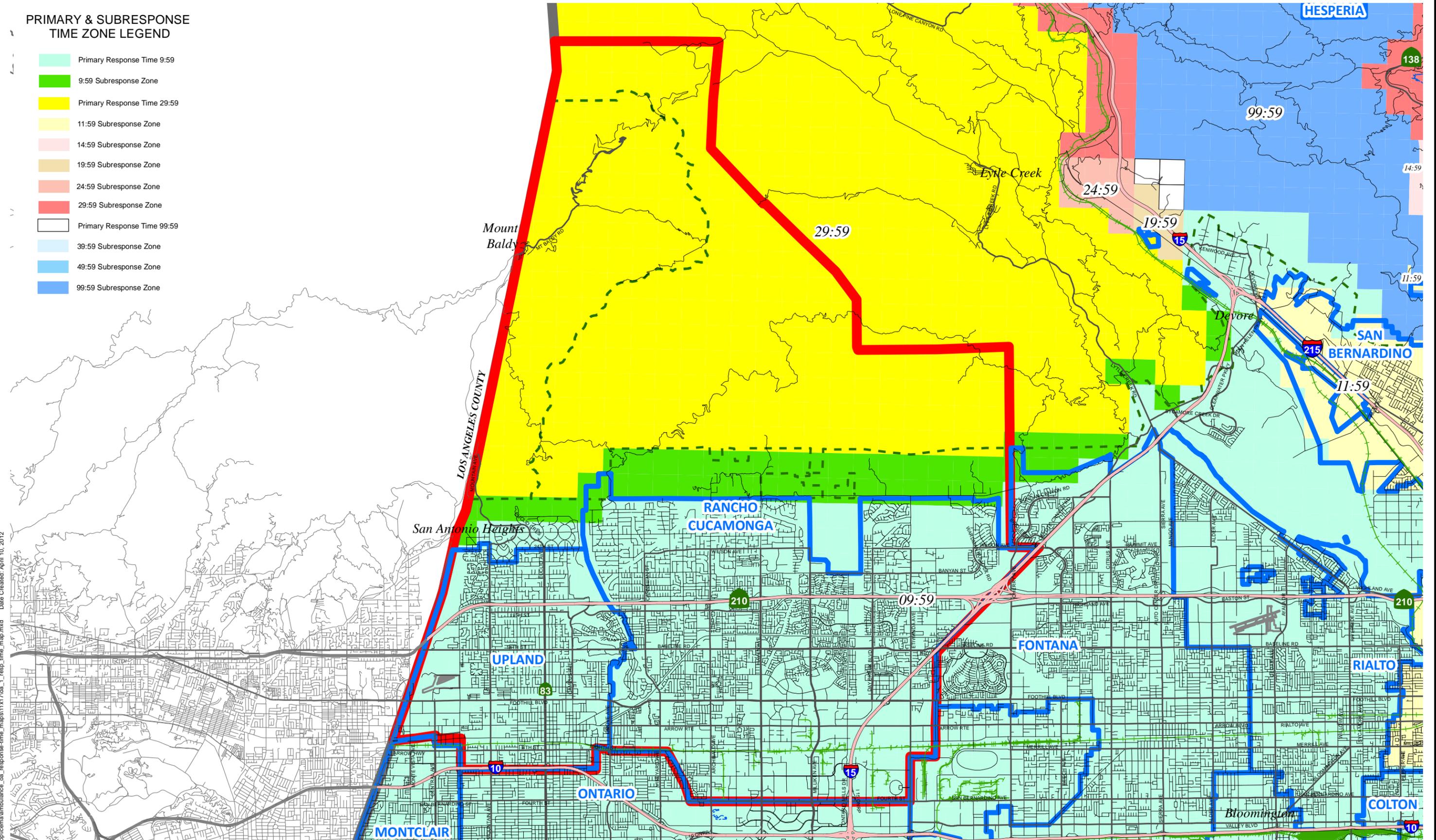
Beginning at the intersection of the San Bernardino County line and the Westerly right of way of Interstate 215; thence Northerly along said Westerly right of way to the center line of the Santa Ana River; thence Northeasterly along said center line to the West line of Orange Street; thence North along said West line to the West line of Boulder Avenue; thence Northerly along said West line to the Westerly line of State Highway 330; thence Northerly along said Westerly line to the City Creek Forest Station; thence due East to the East line of Section 10, T.1N., R.3W., S.B.M.; thence Southerly along section lines to the South line of Section 10, T.1S., R.3W., S.B.M.; thence West along section lines to the East line of Alabama Avenue; thence South along said East line to the South line of San Bernardino Avenue; thence West along said South line to the East line of California Street; thence South along said East line to the city limits of Loma Linda; thence Westerly along said city limits and continuing along said city limits to the South line of Section 35, T.1S., R.4W., S.B.M.; thence South to the San Bernardino County line; thence West to the POINT OF BEGINNING.

Description
Exclusive Operating Area #9

This area is comprised of the corporate limits of the City of Loma Linda, as said city now or in the future exists.

PRIMARY & SUBRESPONSE TIME ZONE LEGEND

- Primary Response Time 9:59
- 9:59 Subresponse Zone
- Primary Response Time 29:59
- 11:59 Subresponse Zone
- 14:59 Subresponse Zone
- 19:59 Subresponse Zone
- 24:59 Subresponse Zone
- 29:59 Subresponse Zone
- Primary Response Time 99:59
- 39:59 Subresponse Zone
- 49:59 Subresponse Zone
- 99:59 Subresponse Zone

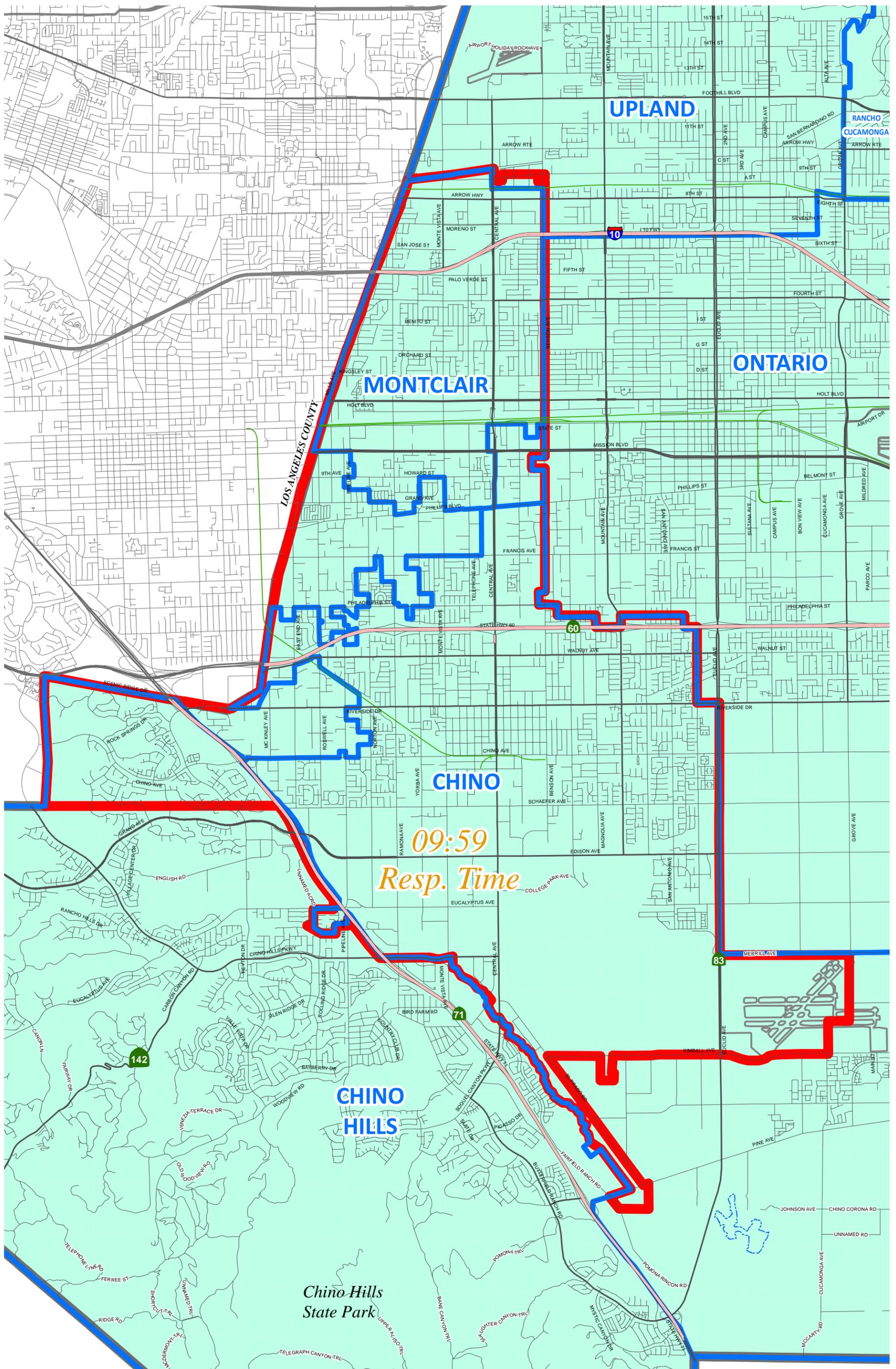


SAN BERNARDINO COUNTY AMBUCLANCE OPERATING AREA RESPONSE TIMES
Area 1 - Schaefer Amb. & American Med. Response

Map Prepared On: April 10, 2012

- Ambulance OA Boundary
- City Jurisdictions
- County Boundary
- Rail Roads
- National Forest Boundary

Document Name: g:\mappac\ambulance_03_resp_time_map\1171703_1_resp_time_map.mxd Date Created: April 10, 2012



SAN BERNARDINO COUNTY
 AMBUCLANCE OPERATING AREA RESPONSE TIMES
 Area 2 - Schaefer Amb. & American Med. Response

- Ambulance OA Boundary
- City Jurisdictions
- 9:59 Response Time Zone

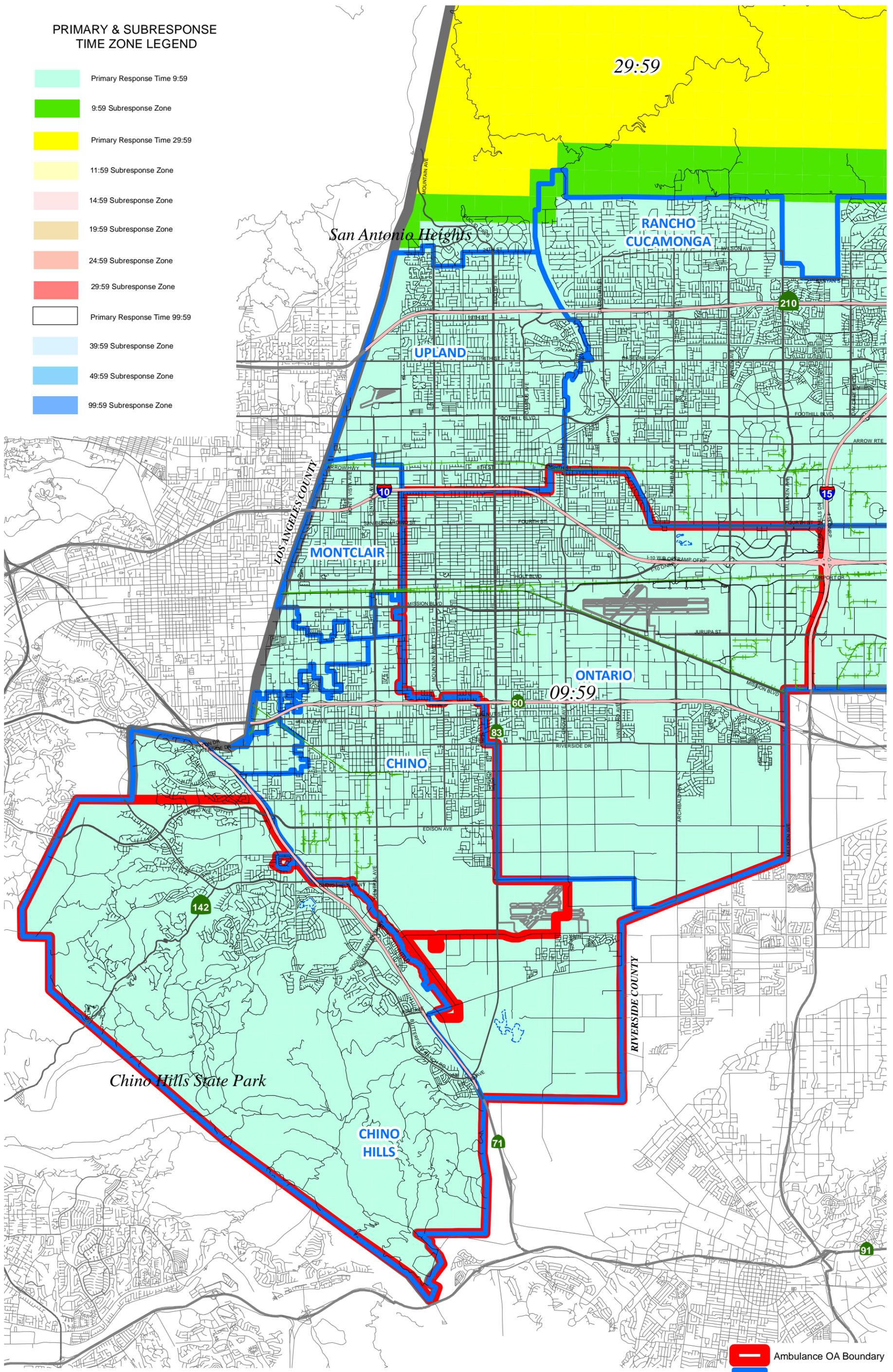
Map Prepared On: Mar. 19, 2012

Document Name: g:\m\app\cam\ambulance_02_resp_time_maps\11\11\03_2_map.mxd Date Created: Mar. 19, 2012



PRIMARY & SUBRESPONSE TIME ZONE LEGEND

- Primary Response Time 9:59
- 9:59 Subresponse Zone
- Primary Response Time 29:59
- 11:59 Subresponse Zone
- 14:59 Subresponse Zone
- 19:59 Subresponse Zone
- 24:59 Subresponse Zone
- 29:59 Subresponse Zone
- Primary Response Time 99:59
- 39:59 Subresponse Zone
- 49:59 Subresponse Zone
- 99:59 Subresponse Zone



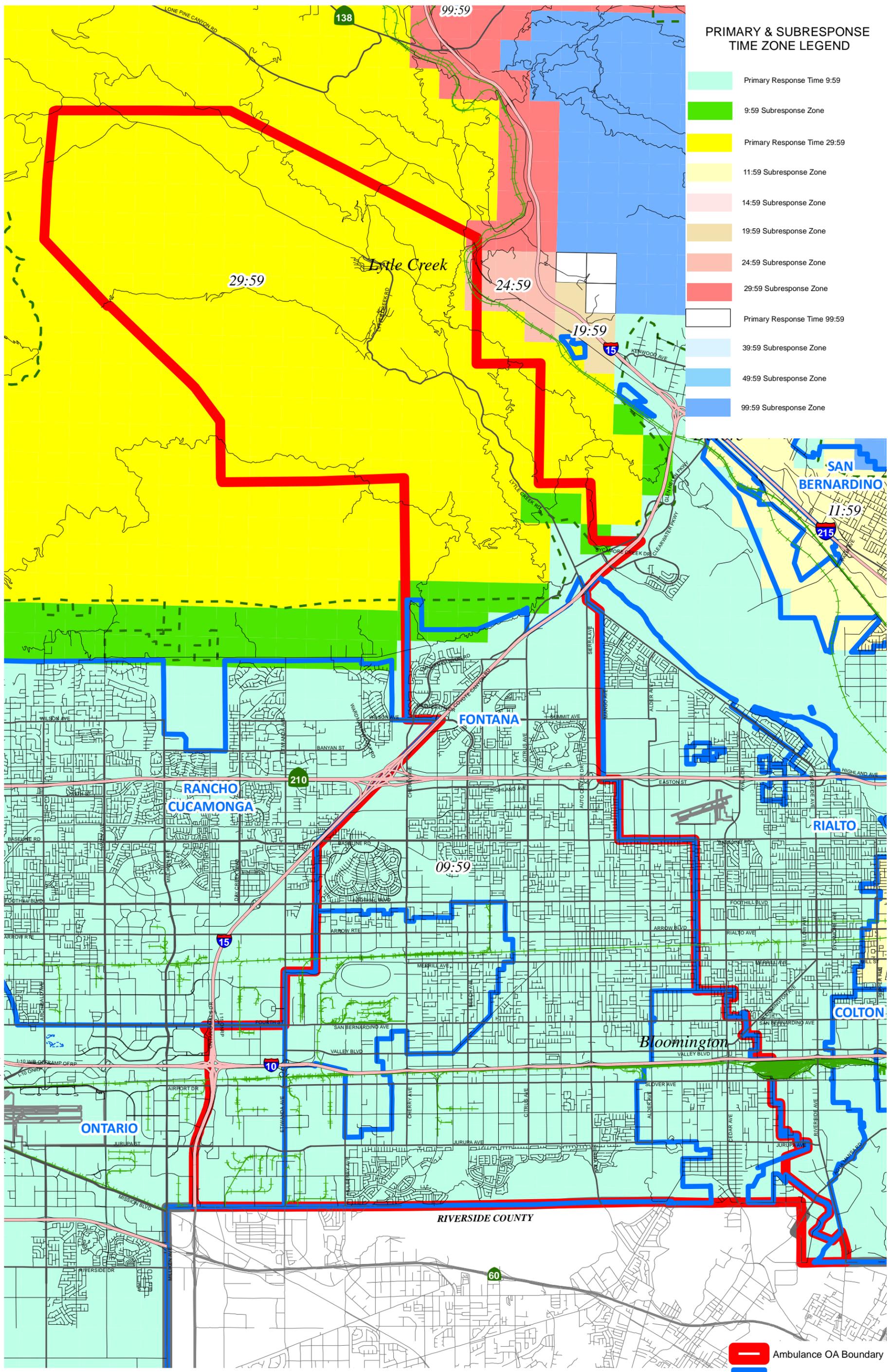
**SAN BERNARDINO COUNTY
AMBUCLANCE OPERATING AREA RESPONSE TIMES
Area 3 - American Medical Response**

- Ambulance OA Boundary
- City Jurisdictions
- County Boundary
- Rail Roads

Map Prepared On: April 10, 2012

Document Name: g:\m\ap\ambulance_03_map\11\03_3_map.mxd Date Created: April 10, 2012





PRIMARY & SUBRESPONSE TIME ZONE LEGEND

- Primary Response Time 9:59
- 9:59 Subresponse Zone
- Primary Response Time 29:59
- 11:59 Subresponse Zone
- 14:59 Subresponse Zone
- 19:59 Subresponse Zone
- 24:59 Subresponse Zone
- 29:59 Subresponse Zone
- Primary Response Time 99:59
- 39:59 Subresponse Zone
- 49:59 Subresponse Zone
- 99:59 Subresponse Zone

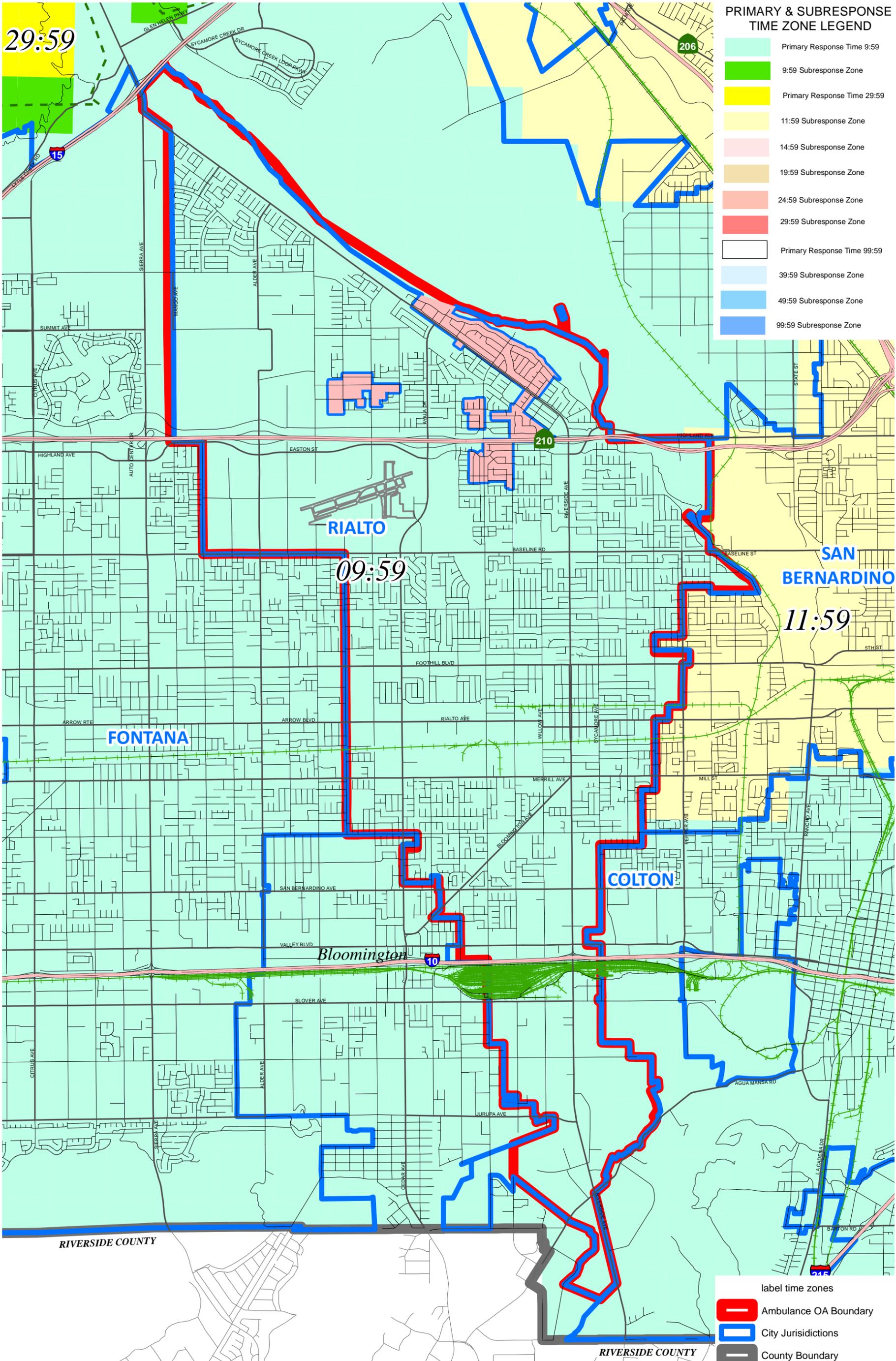
- Ambulance OA Boundary
- City Jurisdictions
- County Boundary
- National Forest Boundary

**SAN BERNARDINO COUNTY
AMBUCLANCE OPERATING AREA RESPONSE TIMES
Area 4 - American Medical Response**

Map Prepared On: April 10, 2012

Date Created: April 10, 2012
Document Name: g:\mapp\ambulance_04_response_time_maps\11111\04_4_resp_time_mmap.mxd





PRIMARY & SUBRESPONSE TIME ZONE LEGEND

[Light Green Box]	Primary Response Time 9:59
[Green Box]	9:59 Subresponse Zone
[Yellow Box]	Primary Response Time 29:59
[Light Yellow Box]	11:59 Subresponse Zone
[Pink Box]	14:59 Subresponse Zone
[Tan Box]	19:59 Subresponse Zone
[Light Orange Box]	24:59 Subresponse Zone
[Red Box]	29:59 Subresponse Zone
[White Box]	Primary Response Time 99:59
[Light Blue Box]	39:59 Subresponse Zone
[Blue Box]	49:59 Subresponse Zone
[Dark Blue Box]	99:59 Subresponse Zone

label time zones

[Red Line]	Ambulance OA Boundary
[Blue Line]	City Jurisdictions
[Grey Line]	County Boundary
[Pink Area]	City of Rialto Fire Dept. Operating Area-1797.201 City
[Green Dashed Line]	National Forest Boundary
[Green Plus Line]	Rail Roads

**SAN BERNARDINO COUNTY
AMBUCLANCE OPERATING AREA RESPONSE TIMES
Area 5 - Rialto Fire/American Med. Response**

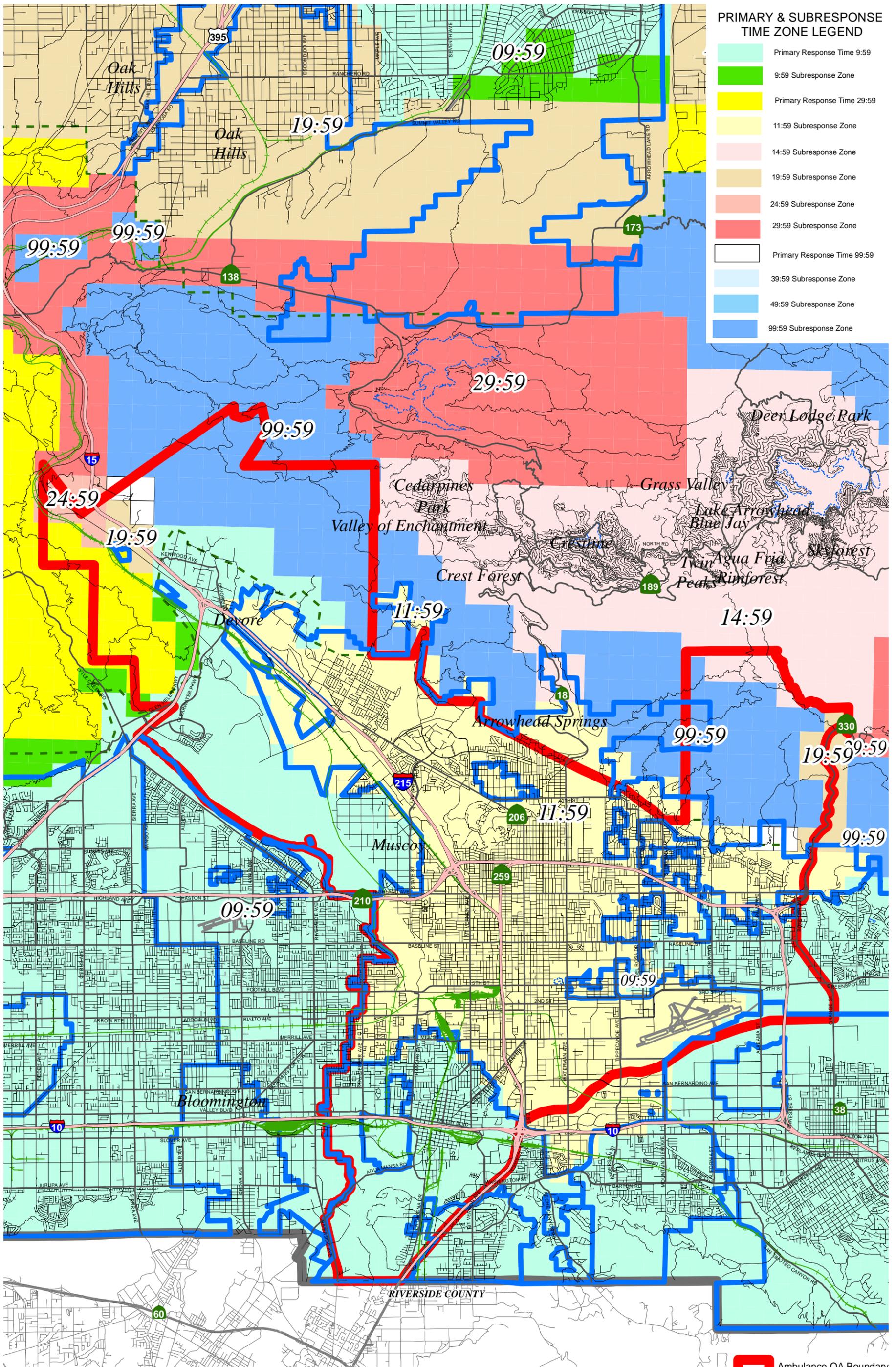
Map Prepared On: April 10, 2012

Document Name: g:\m\app\ambulance_0a_resp_time\maps\117170a_4_resp_time_map.mxd Date Created: April 10, 2012



PRIMARY & SUBRESPONSE TIME ZONE LEGEND

- Primary Response Time 9:59
- 9:59 Subresponse Zone
- Primary Response Time 29:59
- 11:59 Subresponse Zone
- 14:59 Subresponse Zone
- 19:59 Subresponse Zone
- 24:59 Subresponse Zone
- 29:59 Subresponse Zone
- Primary Response Time 99:59
- 39:59 Subresponse Zone
- 49:59 Subresponse Zone
- 99:59 Subresponse Zone



- Ambulance OA Boundary
- City Jurisdictions
- County Boundary
- National Forest Boundary

**SAN BERNARDINO COUNTY
AMBUCLANCE OPERATING AREA RESPONSE TIMES
Area 6 - American Medical Response**

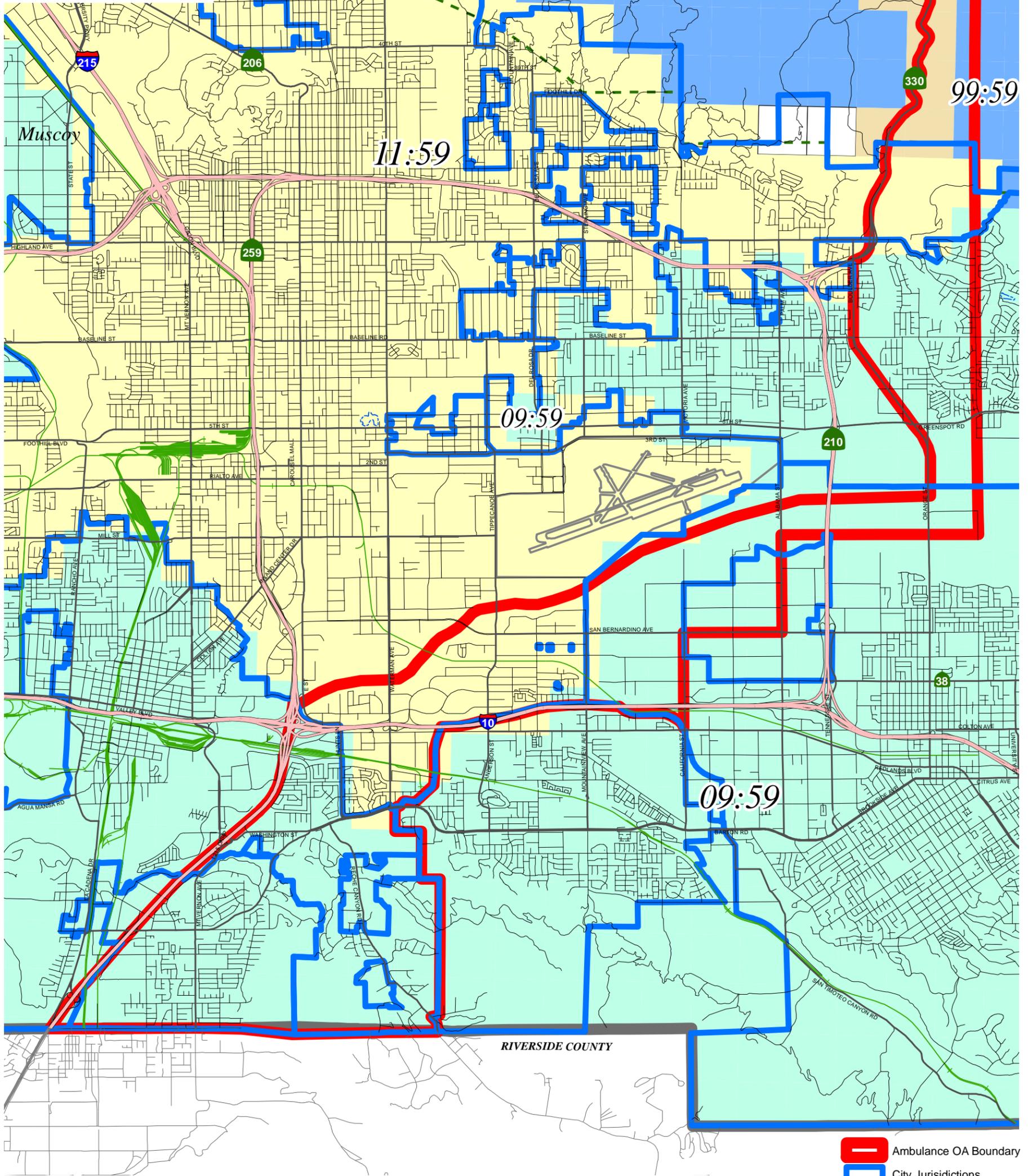
Map Prepared On: April 10, 2012

Document Name: g:\mapproj\ambulance_08_maps\1117\08_05_map.mxd Date Created: Sept. 14, 2010



PRIMARY & SUBRESPONSE TIME ZONE LEGEND

- Primary Response Time 9:59
- 9:59 Subresponse Zone
- Primary Response Time 29:59
- 11:59 Subresponse Zone
- 14:59 Subresponse Zone
- 19:59 Subresponse Zone
- 24:59 Subresponse Zone
- 29:59 Subresponse Zone
- Primary Response Time 99:59
- 39:59 Subresponse Zone
- 49:59 Subresponse Zone
- 99:59 Subresponse Zone



- Ambulance OA Boundary
- City Jurisdictions
- County Boundary
- Rail Roads
- National Forest Boundary

**SAN BERNARDINO COUNTY
AMBUCLANCE OPERATING AREA RESPONSE TIMES
Area 7 - American Medical Response**

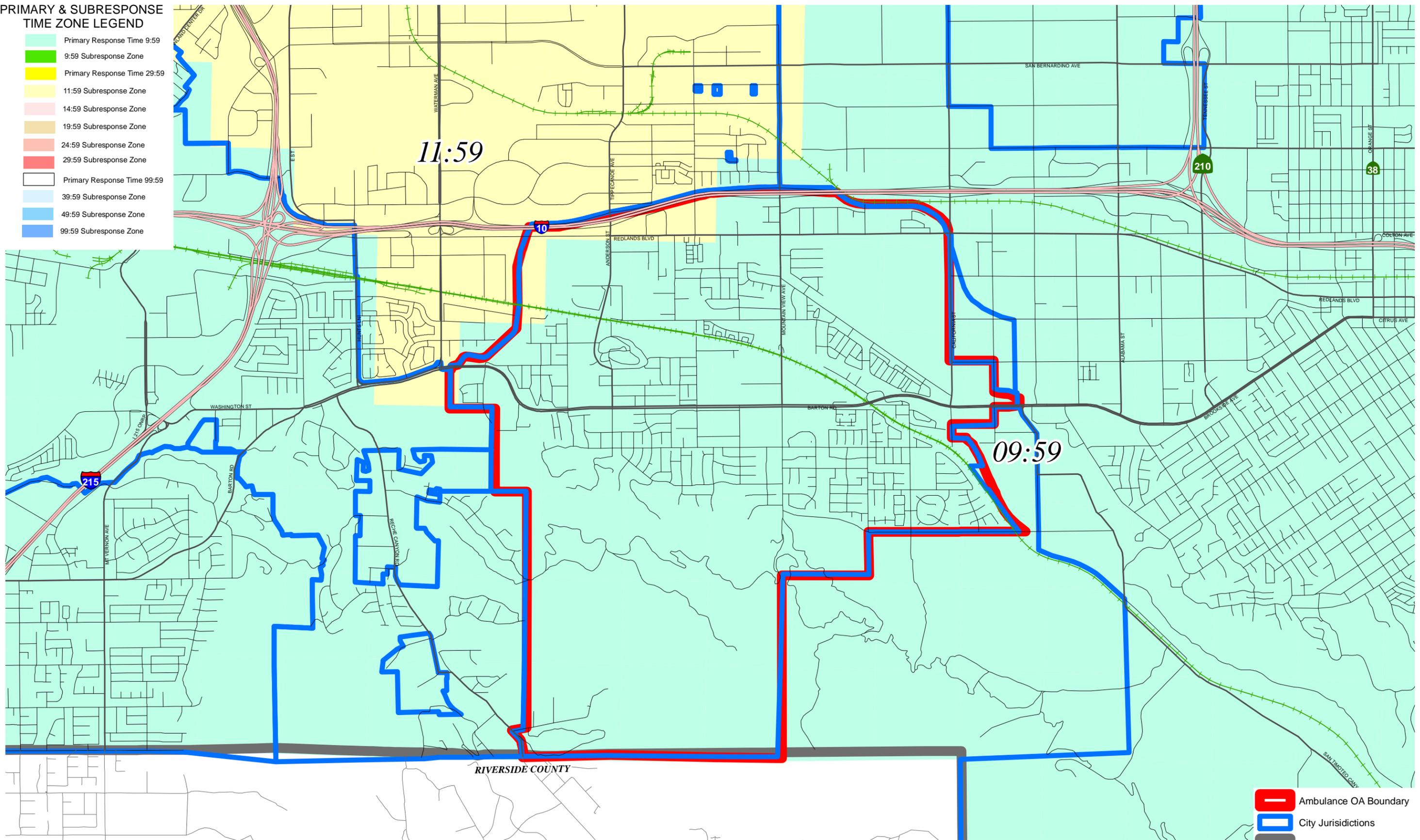
Map Prepared On: April 10, 2012

Document Name: g:\m\app\ambulance_0a.mxd; Date Created: April 10, 2012



PRIMARY & SUBRESPONSE TIME ZONE LEGEND

- Primary Response Time 9:59
- 9:59 Subresponse Zone
- Primary Response Time 29:59
- 11:59 Subresponse Zone
- 14:59 Subresponse Zone
- 19:59 Subresponse Zone
- 24:59 Subresponse Zone
- 29:59 Subresponse Zone
- Primary Response Time 99:59
- 39:59 Subresponse Zone
- 49:59 Subresponse Zone
- 99:59 Subresponse Zone



Document Name: g:\m\app\ambulance_09_m\maps\11x17\oa_9_map.mxd Date Created: April 10, 2012



SAN BERNARDINO COUNTY AMBUCLANCE OPERATING AREA RESPONSE TIMES
Area 9 - American Medical Response

Map Prepared On: April 10, 2012



- Ambulance OA Boundary
- City Jurisdictions
- County Boundary
- Rail Roads
- National Forest Boundary

Response Time Measurements and Methods

Inland Counties Emergency Medical Agency

Effective July 1, 2001

Preface

The Response Time Measurements and Methods are divided into the following areas:

- Reference Maps Designations;
- Response Zone Categories;
- Response Times Standards (Goals);
- Measurement Methods and Manners.

For public agencies the standards as specified below are recognized as goals.

Code 2 Response Times are not measured or recorded by all organizations at this time. ICEMA will monitor and evaluate available Code 2 response times for six months following the adoption of the Response Time Measurements and Methods. This analysis will be brought back to the Response Time Subcommittee. At that time the “Response Time Standards for Code 2 Response” and other definitions, which include Code 2 response may be changed to reflect conditions. The Response Time Subcommittee recognizes that Code 2 response times may be more available from Metropolitan/Urban/Suburban areas.

Reference Map Designation

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Response Zone Reference Designation</i>	The latest available U.S. census population maps, by census tract, shall be used as the point of reference baseline to categorize standard response times for the response zones. When necessary, the maps may be broken down to the block groups to determine the dividing line for response zones. These maps shall be updated every 3 years using California Department of Finance data and other reliable data sources.	Not included.
<i>Sub-Response Zone Reference Designation</i>	The latest available U.S. Census population maps, by census tract and block, shall be used as the point of reference baseline to categorize response times that may vary from the standard response time. These maps may also include specific geographical or population notations.	Not included.

Reference Map Designation con't.

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Sub-Response Zone Reference con't.</i>	The notations may include: a. Road conditions b. Seasonal weather conditions c. Unusual population distribution within the census tract d. City, County, State or Federal boundaries e. Other significant geographical features.	

Response Zone Population Categories

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Metropolitan/Urban/Suburban</i>	A single classification for a response zone which includes the following populated areas: Metropolitan =>500 people per square mile Urban = 101 to 500 people per square mile Suburban = 51 to 100 people per square mile	Not included.
<i>Rural</i>	Classification for a response zone which contains a population of 7 to 50 people per square mile.	Not included.
<i>Wilderness</i>	Classification of a response zone which contains a population of less than 7 people per square mile.	Not included.

Response Time Standards (Goals)

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Response Time Standards for Code 3 Response</i>	The Response Zone response time standard for Code 3 response corresponds to its population category. The Standard Response Time is the measured Call Response Interval. These response time standards are: Metropolitan/Urban/Suburban < or = 9:59minutes Rural <or =29:59 minutes Wilderness < or =99:59 minutes	Not included.

Response Time Standards (Goals) con't.

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Response Time Standard for Code 2 Response</i>	<p>The Response Zone response time per call for a Code 2 response corresponds to its population category. The Response Time is the measured Call Response Interval. These response time standards are:</p> <p style="padding-left: 40px;">Metro/Urban/Suburban < or = 22:59 minutes</p> <p style="padding-left: 40px;">Rural < or = 44:59 minutes</p> <p style="padding-left: 40px;">Wilderness < or = 99:59 minutes</p>	Not included.
<i>Response Time Standard for Code 3 Response Downgraded to Code 2</i>	<p>The Response Zone response time per call for a Code 3 response downgraded to a Code 2 response corresponds to its population category. The response time standard equals the Code 3 response time interval and the Code 2 response time interval. The response time standards are:</p> <p style="padding-left: 40px;">Metro//Urban/Suburban < or = 22:59 minutes (total time)</p> <p style="padding-left: 40px;">Rural < or = 44:59 minutes (total time)</p> <p style="padding-left: 40px;">Wilderness < or = 99:59 minutes (total time)</p>	Not included.
<i>Response Time Standard for Code 2 Response Upgraded to Code 3 Response</i>	<p>The Response Zone response time per call for a Code 2 response upgraded to a Code 3 response corresponds to its population category and the following time parameters. The total of these two intervals shall not exceed the response time standards for a Code 2 response.</p> <p>The response time standard equals the Code 3 response time interval at the time the response is upgraded from Code 2 to Code 3. These intervals are:</p> <p style="padding-left: 40px;">Metropolitan/Urban/Suburban < or = 9:59 minutes</p> <p style="padding-left: 40px;">Rural < or = 29:59 minutes</p> <p style="padding-left: 40px;">Wilderness < or = 99:59 minutes</p>	Not included.
<i>Sub-Response Zone Time Standard</i>	<p>Sub-Response Zone Time Standard corresponds to a defined Sub-Response Zone Reference with documented characteristics that may allow deviation from the Response Time Standard.</p>	Not included.

Measurement Methods and Manners

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Call Response Interval Calculation</i>	The elapsed time measured in minutes:seconds from the “Time Dispatch Notified-Provider” to “Time Arrival at Scene/Staging”.	Not included.
<i>Response Time Analysis for Code 3 Responses</i>	The fractile of the standard response times and subzone response times within 90% will be used for analyzing response time. Calls which fall outside the following times will be reviewed: Metropolitan/Urban/Suburban > 22:59 minutes Rural > 44:59 minutes Wilderness > 99:59 minutes	Not included.
<i>Response Time Analysis for Code 2 Responses</i>	The fractile of the standard response times and subzone response times within 90% will be used for analyzing response time.	Not included.
<i>Time Recordation</i>	Time recordation shall include date, hour, minutes and seconds in military time.	Not included.
<i>Recordkeeping</i>	Each reporting entity shall give a statement with reference to their record keeping method. These methods in order of preference are: CAD – The preferred recording method is through Computer Aided Dispatching (CAD). Time Data is automatically entered into a computer database with a telephone ringing at the dispatching entity. Measurement may vary from system to system; that is, one system may note the time at the first ring while another system may note the time at a second ring. Measurement systems also vary in time notation in that one system may note the time on the operator’s first keystroke while another system may record time at the completion of certain data fields.	Not included.

Measurement Methods and Manners con't.

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Recordkeeping con't.</i>	<p><i>Manual Electronic Recordation</i> - The second preferred recording method is manual recordation by the dispatching entity into a computer database through a keystroke or “clock stamp” mechanism during the time of the dispatch event. Measurement systems also vary in time notation in that one system may note the time on the operator’s first keystroke while another system may record time at the completion of certain data fields.</p> <p><i>Manual Recordation</i> – The third method is manual recordation onto paper during the dispatch event. These times are then input into a computer database during the call or at a later date.</p>	
<i>Failure to report “Time Arrival at Scene/Staging”</i>	The time of first communication from the on-scene unit to dispatching entity shall be used as the “Time Arrival at Scene/Staging” or time of communication failure, whichever is less.	Not included.
<i>Lights and Sirens to Scene</i>	<p>The use of lights and sirens enroute to scene.</p> <p>01 Emergent, with lights and sirens (Code 3)</p> <p>02 Initial emergent, downgraded to no lights and sirens</p> <p>03 Initial non-emergent, upgraded to lights and sirens</p> <p>04 Non-emergent, no lights and sirens</p> <p>88 Not applicable</p>	Data element 19.

Measurement Methods and Manners con't.

<u>Term</u>	<u>Definition/Justification</u>	<u>NHTSA Element</u>
<i>Type of Service Requested</i>	Type of service requested. 01 Scene 02 Unscheduled Interfacility Transfer 03 Scheduled Interfacility Transfer 04 Urgent Interfacility Transfer 05 Standby 06 Rendezvous 07 On Scene/Staging 08 Ground Rescue/Technical Assistance 10 Mutual Aid 88 Not Applicable 99 Unknown	Data element 20.
<i>Communications Failure-Time Notation Procedure</i>	In the event of communications failure time will be noted manually by onscene personnel.	Not included.

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Measurement Methods and Manners con't.

The following "Type of Service" terms require further definition.

01 Scene – Refers to direct response to scene of incident or injury, such as roadway, etc. (NHTSA standard)

02 Unscheduled Interfacility Transfer – Refers to transfer of patients from one facility to another facility. (NHTSA standard) Requested when a patient has a non-life threatening conditions.

03 Scheduled Interfacility Transfer – Refers to transfers of patients from one facility to another facility when the transfer is scheduled in advance. Requested when a patient requires service(s) that are not available at the emergency room facility.

04 Urgent Interfacility Transfer – Requested when a patient has a life threatening condition at the emergency room/clinic, requires a higher level of care, and the required service(s) is/are not available at the emergency room facility. This term includes pediatric transfers.

08 Ground Rescue/Technical Assistance – Requested when special equipment and/or preparation time is needed to retrieve and assist the patient.

10 Mutual Aid – Requested when additional resources are needed. The responding out-of-area resources may require more that the defined "Standard Response Time" to arrive at the call.

Response Time Terminology

Inland Counties Emergency Agency

Preface

The Response Time Subcommittee developed the definitions below which were subsequently recommended for approval by the ICEMA Response Time Task Force. The original subcommittee is comprised of San Bernardino County Fire Chiefs' Association and AMR/San Bernardino County Ambulance Association; the Task Force is comprised of representatives from the San Bernardino County Ambulance Association and the San Bernardino County Fire Chiefs' Association. Source materials included the original subcommittee's draft, October 20, 2000, for response time terminology and the National Highway Traffic Safety Administration's (NHTSA) 80 EMS data points and definitions.. The Subcommittee recognizes that, although NHTSA terminology is preferred, additional and more specific definitions are needed.

This document was distributed to all stakeholders for a 30-day comment period. The Emergency Medical Care Committees in Inyo, Mono, and San Bernardino County have recommended approval of this document. Minor changes were reviewed and recommended for approval by the San Bernardino County EMCC at their 9/20/01 meeting; those changes are incorporated in this document.

The terms are in a chronological order as they occur in an emergency medical incident.

Point- in-Time Terms:

<i>ICEMA DATA ELEMENT</i>	<i>TERM</i>	<i>DEFINITION</i>	<i>NHTSA DATA ELEMENT</i>
<i>1</i>	*Onset Date	Date of onset of symptoms or injury date.	6
<i>2</i>	*Onset Time	Time of onset of symptoms or injury time.	7
<i>3</i>	*Recognition Time	Time that an incident is recognized as a reportable emergency.	Not included
<i>4</i>	Date Incident Report	The date the call is received by the Public Service Answering Point or other designated entity.	8
<i>5</i>	*Time Incident Reported- Primary PSAP	Time call is first received by the Public Service Answering Point or other designated entity. (NHTSA recognizes one PSAP designation in their data set. The ICEMA Region uses primary and secondary PSAPs.)	9
<i>6</i>	*Time Dispatch Notified – Secondary PSAP	Time call is first received by the Secondary Public Service Answering Point or other designated entity. (The subcommittee agreed to use NHTSA definition and refine the definition for Secondary and Provider).	Not included
<i>7</i>	Time Dispatch Notified-Provider Dispatch	Time call is first received by the EMS provider agency dispatch.	10
<i>8</i>	Date Unit Notified	Date response unit is notified by EMS dispatch.	11
<i>9</i>	Time Unit Notified	Time response unit is notified by the EMS dispatch.	12

*Data element not currently reported on ICEMA Scantron Form

<i>ICEMA DATA ELEMENT</i>	<i>TERM</i>	<i>DEFINITION</i>	<i>NHTSA DATA ELEMENT</i>
<i>10</i>	Time Unit Responding	Time that the response unit begins physical motion, i.e. wheels begin to turn.	13
<i>11</i>	Time Arrival at Scene/Staging	Time EMS unit stops physical motion at scene or staging area, i.e. wheels stop turning.	14
<i>12</i>	*Time of Arrival at Patient	Time response personnel establish direct contact with patient.	15
<i>13</i>	Time Unit Left Scene	Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn.	16
<i>14</i>	Time Arrival at Destination	Time when patient arrives at destination or transfer point, i.e. wheels stop turning.	17
<i>15</i>	*Time of Receipt of Patient at Receiving Facility	Time when receiving facility or transfer agency accepts transfer and care of the patient.	Not included
<i>16</i>	Time Back in Service – not available	Time response unit back in service and not available for response.	Not included
<i>17</i>	Time Back in Service - available	Time response unit back in service and available for response.	18
<i>18*</i>	Time Unit Canceled Enroute	Time provider agency dispatch is notified that call is canceled.	Not included
<i>19*</i>	Time Unit Upgraded Code 3	Time when provider agency dispatch is notified that response is upgraded to Code 3 from Code 2.	Not included
<i>20*</i>	Time Unit Downgraded Code 2	Time when provider agency dispatch is notified that response is downgraded to Code 2 from Code 3.	Not included

*Data element not currently reported on ICEMA Scantron Form

Time Interval Terms:

Time intervals are recognized as cognitive measuring points; therefore while a true measuring point in some cases is the millisecond after the named data point, it is practical to use the recorded time (data point) as the measurement indicator for time interval terms.

TERM	ICEMA DATA ELEMENT	DEFINITION	NHTSA DATA ELEMENTS
Call Response Interval	7-11	The elapsed time, measured in minutes:seconds format, from the “Time Dispatch Notified-Provider Dispatch” to “Time Arrival at Scene/Staging”.	10-14
*Preresponse Interval	2-5	The elapsed time, measured in minutes:seconds format, from “Onset Time” to “Time Incident Reported”. This time measurement cannot be measured precisely.	7-9
*Activation Interval	5-7	The elapsed time, measured in minutes: seconds format, from the “Time Incident Reported” to “Time Dispatch Notified-Provider”.	9-10
Dispatch Interval	7-9	The elapsed time, measured in minutes: seconds format, from the “Time Dispatched Notified-Provider” to “Time Unit Notified”.	10-12
Reflex Interval	9-10	The elapsed time, measured in minutes: seconds format, from the “Time Unit Notified” to “Time Unit Responding”.	12-13
Travel Time Interval	10-11	The elapsed time, measured in minutes:seconds format, from the “Time Unit Responding” to the “Time Arrival On Scene/Staging”.	13-14
Scene Interval	11-13	The elapsed time, measured in minutes:seconds format, from the “Time Arrival at Scene” to the “Time Unit Left Scene”.	14-16
Transport Interval	13-14	The elapsed time, measured in minutes:seconds format, from the “Time Unit Left Scene” to the “Time Arrival at Destination”.	16-17
*Transfer of Care Interval	14-15	The elapsed time, measured in minutes:seconds format, from the “Time Arrival at Destination” to “Receipt of Patient at Receiving Facility”.	17-Not included
*Inservice Interval	15-16	The elapsed time, measured in minutes:seconds format, from the “Receipt of Patient at Receiving Facility” to the “Time Back in Service – not available”	Not included
Unit Recovery Available Interval	15-17	The elapsed time, measured in minutes:seconds format, from the “Receipt of Patient at Receiving Facility” to the “Time Back in Service and available”.	Not included - 18

*Data element not currently reported on ICEMA Scantron Form

Measuring Response Time Standard Compliance

Measurement of response time standards compliance by providers is accomplished for each Exclusive Operating Area (EOA) using the fractile method. Utilizing the fractile method, the response time standards are defined such that the amount of time from receipt of code 3 call to arrival on scene must be less than a specified number of minutes for 90% of provider runs within a particular EOA. Using fictitious run data for a ten minute response time zone, comparison of a simple average response time calculation with a fractile response time calculation is shown below.

Fictitious Run Data for 10 Minute Response Time Zone					
Run #	Response Time		Run #	Response Time	
	(min:sec)	(seconds)		(min:sec)	(seconds)
Run 1	8:56	536	Run 21	11:32	692
Run 2	12:13	733	Run 22	7:34	454
Run 3	4:49	289	Run 23	9:23	563
Run 4	11:10	670	Run 24	13:42	822
Run 5	13:55	835	Run 25	10:50	650
Run 6	4:25	265	Run 26	12:53	773
Run 7	13:09	789	Run 27	6:08	368
Run 8	14:39	879	Run 28	11:43	703
Run 9	0:57	57	Run 29	14:07	847
Run 10	10:54	654	Run 30	5:15	315
Run 11	12:51	771	Run 31	12:37	757
Run 12	3:12	192	Run 32	10:44	644
Run 13	14:29	869	Run 33	6:59	419
Run 14	2:42	162	Run 34	13:22	802
Run 15	6:24	384	Run 35	1:31	91
Run 16	11:59	719	Run 36	9:05	545
Run 17	12:20	740	Run 37	10:18	618
Run 18	3:35	215	Run 38	13:21	801
Run 19	9:51	591	Run 39	8:16	496
Run 20	10:33	633	Run 40	4:01	241
Total			22,584		
Average			9:25		565

Calculation of Average Response Time

Using data shown in table at left:

- Convert response times from minutes/seconds to seconds for each run.
In example, using Run #1,

$$8:56 = (8 \text{ minutes} \times 60 \text{ seconds/minute}) + 56 \text{ seconds} \\ = 480 + 56 = 536 \text{ seconds}$$

- Calculate total number of seconds for all runs.
In example, total for 40 runs = 22,584 seconds

- Calculate average number of seconds per run by dividing total number of seconds for all runs by the number of runs. In example,

$$22,584 \text{ seconds} / 40 \text{ runs} = 565 \text{ seconds per run}$$

- Convert average number of seconds per run from seconds to minutes:seconds. In example,

$$565 \text{ seconds} / 60 \text{ seconds per minute} \\ = 9 \text{ minutes and } 25 \text{ seconds.}$$

Result: In example, average response time is under 10 minutes.
MEETS 10 MINUTE RESPONSE TIME STANDARD.

Fictitious Data Grouped into Fractiles			
Response Time (Minutes)	Number of Runs	Percent of Total	Cumulative Percentage
<1	1	2.5%	2.5%
1 - <2	1	2.5%	5.0%
2 - <3	1	2.5%	7.5%
3 - <4	2	5.0%	12.5%
4 - <5	3	7.5%	20.0%
5 - <6	1	2.5%	22.5%
6 - <7	3	7.5%	30.0%
7 - <8	1	2.5%	32.5%
8 - <9	2	5.0%	37.5%
9 - <10	3	7.5%	45.0%
10 - <11	5	12.5%	57.5%
11 - <12	4	10.0%	67.5%
12 - <13	5	12.5%	80.0%
13 - <14	5	12.5%	92.5%
14 - <15	3	7.5%	100.0%
Total	40		
Fractile	13 - <14		

Calculation of Fractile Response Time

Using data shown in table above and demonstrated in table at left:

- Create whole-minute groupings or "fractiles" beginning with <1 minute.
For example, <1 minute, 1-<2 minutes, 2-<3 minutes, etc.
- Count number of runs with response times within range of each fractile response time.
In example, 3 runs had response times between 6 and 7 minutes.
- For each fractile, calculate the percentage of all runs having response times within that fractile response time.
In example, using the fractile response time 6 - <7 minutes,
$$(3 \text{ runs in fractile } 6-<7) / (40 \text{ total runs}) \times 100 = 7.5\%$$
- Beginning with the lowest fractile, calculate the cumulative percentage of runs having response times equal to or less than each fractile.
In example, using the fractile response time 6 - <7 minutes, sum percent of total for each fractile equal to or less than 6 - <7 minutes:
$$2.5\% + 2.5\% + 2.5\% + 5.0\% + 7.5\% + 2.5\% + 7.5\% = 30\%$$
- Determine the fractile where the cumulative % is greater than or equal to 90%.
This is the fractile response time. In example, cumulative percentage exceeds 90% in fractile 13 - <14 minutes, where it equals 92.5%.

Result: In example, fractile response time is 13 - <14 minutes.
DOES NOT MEET 10 MINUTE RESPONSE TIME STANDARD.

Summary: In the above example, the provider meets the ten minute response time standard when using the average response time calculation, but fails to meet the standard when the fractile response time calculation is used. **Use of the fractile calculation creates a more stringent response time standard.** In the above example using the fractile method, the cumulative percentage for the 9-<10 minute fractile would have to be greater than or equal to 90% in order to satisfy the response time standard.

Measuring EOA Compliance

The response time standard for a particular run is determined by the location of the event or scene where provider service is required. Census tract population densities are used to determine the response time standard for Primary Response Time Zones. Primary Response Time Zones act as the default standard for all locations and are classified as either urban (9:59 response time), rural (29:59 response time), or wilderness (99:59 response time). Recognizing that census tract population densities alone do not always accurately reflect reasonable response time standards, Subresponse Time Zone standards have been created which supercede the Primary Response Time Zones. Subresponse Time Zone standards were developed in 2002 by the Response-Time Subcommittee of the ICEMA Response Time Task Force and subsequently accepted by the Emergency Medical Care Committee. Detailed maps displaying response time standards for San Bernardino County were also created and are available through ICEMA.

The fractile method for measuring response time standard compliance can be utilized for each response time zone within a particular EOA; however, providers are ultimately responsible for meeting the response time standard for 90% of all runs within their EOA as a whole. Thus, the possibility exists that a provider may fail to meet the standard for a particular response time within the EOA, while satisfying the standard for the entire EOA. Using fictitious run data for an EOA with multiple response time zones, calculation of overall EOA response time compliance is shown below.

Fictitious Run Data for EOA With Multiple Response Time Standards									
Response Time (Minutes)	9:59 Zone			19:59 Zone			29:59 Zone		
	# of Runs	Cumulative # of Runs	Cumulative Percentage	# of Runs	Cumulative # of Runs	Cumulative Percentage	# of Runs	Cumulative # of Runs	Cumulative Percentage
<1	23	23	1.5%	0	0	0.0%	0	0	0.0%
1 - <2	133	156	10.4%	3	3	1.2%	0	0	0.0%
2 - <3	119	275	18.2%	2	5	1.9%	0	0	0.0%
3 - <4	285	560	37.2%	2	7	2.7%	2	2	0.4%
4 - <5	210	770	51.1%	0	7	2.7%	0	2	0.4%
5 - <6	178	948	62.9%	1	8	3.1%	1	3	0.7%
6 - <7	203	1,151	76.4%	5	13	5.0%	1	4	0.9%
7 - <8	121	1,272	84.4%	3	16	6.2%	2	6	1.3%
8 - <9	63	1,335	88.6%	6	22	8.5%	5	11	2.4%
9 - <10	46	1,381	91.6%	13	35	13.6%	2	13	2.8%
10 - <11	30	1,411	93.6%	8	43	16.7%	4	17	3.7%
11 - <12	25	1,436	95.3%	7	50	19.4%	11	28	6.1%
12 - <13	31	1,467	97.3%	12	62	24.0%	17	45	9.8%
13 - <14	18	1,485	98.5%	16	78	30.2%	12	57	12.4%
14 - <15	11	1,496	99.3%	16	94	36.4%	16	73	15.9%
15 - <16	7	1,503	99.7%	21	115	44.6%	25	98	21.4%
16 - <17	3	1,506	99.9%	31	146	56.6%	26	124	27.0%
17 - <18	1	1,507	100.0%	28	174	67.4%	18	142	30.9%
18 - <19				24	198	76.7%	14	156	34.0%
19 - <20				15	213	82.6%	19	175	38.1%
20 - <21				10	223	86.4%	28	203	44.2%
21 - <22				7	230	89.1%	37	240	52.3%
22 - <23				9	239	92.6%	33	273	59.5%
23 - <24				6	245	95.0%	48	321	69.9%
24 - <25				5	250	96.9%	22	343	74.7%
25 - <26				2	252	97.7%	27	370	80.6%
26 - <27				4	256	99.2%	15	385	83.9%
27 - <28				1	257	99.6%	12	397	86.5%
28 - <29				0	257	99.6%	18	415	90.4%
29 - <30				1	258	100.0%	12	427	93.0%
30 - <31							6	433	94.3%
31 - <32							7	440	95.9%
32 - <33							4	444	96.7%
33 - <34							5	449	97.8%
>=34							10	459	100.0%

Fractile Response Time Calculations

Fictitious EOA run data shown in table at left includes response times for three response time zones – 9:59, 19:59, and 29:59.

Calculating the fractile response time for each response time zone as described in the previous example yields the following results:

- Fractile response time for 9:59 zone is 9 - <10 minutes (shaded row) – meets response time standard.
- Fractile response time for 19:59 zone is 22 - <23 minutes (shaded) – does not meet response time standard.
- Fractile response time for 29:59 zone is 28 - <29 minutes (shaded) – meets response time standard.

Calculation of EOA Compliance

Using summary data from table below & left:

- Compute total number of runs in all response time zones:
 $1,507 + 258 + 459 = 2,224$
- Compute total number of runs at or below response time (fractile) standard from each response time zone:
 $1,381 + 213 + 427 = 2,021$

- Compute total percentage of runs in entire EOA that were at or below standard response time:
 $2,021 / 2,224 \times 100 = 90.9\%$

Result: Over 90% of runs meet response time standard.
PROVIDER IS COMPLIANT AT EOA LEVEL.

Summary: In the above example, fractile response time standards are met for the 9:59 and 29:59 response time zones, but not for the 19:59 zone. The provider is compliant at the EOA level since over 90% of EOA runs were at or below the designated response time standard.

Measurement of Overall EOA Compliance				
Response Time Zone	Total Number of Runs	# of Runs at or Below Fractile Standard	% of Runs at or Below Fractile Standard	Compliance with Standard?
9:59	1,507	1,381	91.6%	Pass
19:59	258	213	82.6%	Fail
29:59	459	427	93.0%	Pass
EOA Total	2,224	2,021	90.9%	Pass

REFERENCE: 5080
EFFECTIVE: 03/01/10
REVIEW: 03/01/12
Page 1 of 3



ICEMA AMBULANCE RATE SETTING POLICY - SAN BERNARDINO COUNTY

PURPOSE

To provide for maximum charges that San Bernardino County ambulance providers may charge for the care and transport of patients.

No ambulance service shall charge more than the following rates:

- (a) **ONE PATIENT:** The schedule of maximum rates that may be charged for ambulance service for one (1) patient shall be as initially set adjusted thereafter by ICEMA.
- (b) **RATES FOR MULTIPLE LOADS:**
 - (1) Each additional stretcher or gurney patient carried at the same time may be charged the full base rate for the response to the call and half the mileage rate.
 - (2) Each additional sit-up patient shall be charged half the base rate for response to the call and half the mileage rate.
 - (3) The provider may prorate all mileage charges between all patients transported so that all patients are charged the same fee for mileage.
 - (4) This section does not apply to contractual agreements.
- (c) **NO CHARGE TRANSPORTS:** No charge shall be made for transporting uninjured or well persons who accompany a patient.
- (d) **COMPUTATION OF RATES:** All rates are to be computed from the time the ambulance arrives for hire until the ambulance delivers the patient to the appropriate destination, and is discharged by the patient or his representative, attending physician, or emergency receiving facility.
- (e) **FEES FOR SERVICE, SUPPLIES AND EQUIPMENT:**
 - (1) When a ground ambulance has been dispatched and ambulance personnel and/or equipment are directly involved with patient care in situations where an EMS aircraft transports, then the ambulance service shall be entitled to charge an appropriate fee for its service, supplies and equipment.

- (2) Under no circumstances shall ambulance personnel dispatched on a Code 3 call attempt to collect for the service prior to the delivery of the patient at an appropriate medical facility.
- (f) ANNUAL RATE ADJUSTMENT: At the direction ICEMA, the ambulance rates established under this section shall apply to all providers of ambulance services.
- (1) ICEMA shall be responsible for calculating the rate adjustments.
 - (2) The CPI adjustment shall be calculated by April 15 of each year. The CPI adjustment shall be effective as of the first day of July of each year.
 - (3) If the selected CPI is discontinued or revised, such other government index or computation with which it is replaced shall be used in order to obtain substantially the same result as would be obtained if the CPI had not been discontinued or revised.
 - (4) The current rates shall be adjusted in an amount necessary to properly compensate ambulance providers for changes in their direct and indirect costs based on the change in the Consumer Price Index (CPI) as set forth herein. The adjustments shall be made on July 1 of each year based upon the change in the CPI from January 1 of the proceeding year to January 1 of the adjustment year. The first rate adjustment shall be made effective January 1, 2010 based on the change of CPI, not seasonally adjusted, from January 1, 2009 to January 1, 2010. The CPI adjustment shall be determined by multiplying the base amounts by adding five percent (5%) of the changes of the transportation index plus ninety five percent (95%) of the medical index of the CPI for All Urban Consumers, Western Region, Los Angeles, Riverside, Orange Counties, California, as compiled and reported by the Bureau of Labor Statistics for the 12-month period up to January 1 of the adjustment year. The percentage change, (rounded to the nearest hundredth) will be multiplied by 1.5 to calculate the annual rate adjustment percentage. The rate adjustment shall then be applied to each charge category by ICEMA. Yearly CPI adjustments shall not exceed five percent (5%) or less than zero percent (0%) for any single year.
- (g) ANNUAL RATE COMPARISON STUDY: The maximum base rates shall be reviewed in accordance with the following procedures, and adjusted annually, if appropriate, effective on March 1, 2010 and on July 1 every year thereafter. After the rate adjustment has been made pursuant to Section 31.0820(e) the local EMS agency shall review the ALS and BLS ambulance base rates of counties with similar demographics. To determine the ALS and BLS average base rates in effect for these counties as of the review date. If the San Bernardino County Rates are at

the average or greater, no adjustment to the ambulance rates will be made under this provision. If the San Bernardino County rates are less than the average, an appropriate adjustment to the ambulance rates shall be made to bring them to the average. No ambulance rate comparison adjustment shall be greater than five percent (5%).

- (h) **MILEAGE CHARGE RATE ADJUSTMENT:** In addition to, and not in lieu of, annual CPI adjustments, rate increases or decreases in an amount equal to the ambulance providers' fuel price extraordinary increases or decreases may also be granted. The local EMS agency shall determine the application process of such increases or decreases. The mileage charge may be reviewed quarterly effective January 1, 2010, and adjusted, if appropriate.
- (i) **EXTRAORDINARY RATE ADJUSTMENTS:**
 - (1) In addition to, and not in lieu of, annual CPI adjustments, rate increases or decreases in an amount equal to the ambulance providers' extraordinary increases or decreases in their revenue or expenses may also be granted. ICEMA shall determine the application process of such extraordinary revenue or expenses increases or decreases. Such extraordinary costs increases or decreases shall be subject to ICEMA Governing Board approval. The ambulance provider must demonstrate actual or reasonably projected, substantial financial hardship as a result of factors beyond its reasonable control and provide records deemed necessary to verify such hardship. This procedure may also be used to obtain rate adjustments due to changes in the CPI that are greater than the five (5%) cap under the yearly CPI adjustment, above.
 - (2) ICEMA, at the time of any extraordinary adjustment under subsection (1), above, may request an audit of books and records of a permittee for the purpose of verifying revenue and cost data specifically associated with the extraordinary rate increase request. Such an audit shall be carried out by a person selected by the permittee and approved by ICEMA. If ICEMA and permittee cannot agree on a person to perform the audit, then the audit shall be carried out by a Certified Public Accountant selected by the ICEMA Executive Director. If there is any charge, cost or fee for such an audit, such shall be paid by the permittee. ICEMA may deny any adjustment if an audit is requested and not produced. Every audit shall be done promptly and within thirty (30) days of the time it is requested so there should be no undue delay.

ATTACHMENT 8

INTERFACILITY TRANSPORT RESPONSE TIMES

FACILITY NAME	RESPONSE PRIORITY	RESPONSE TERM	RESPONSE DEFINITION	COMPLIANCE STANDARD
Interfacility Response Times	1	Emergency	life threatening	0:09:59
	2	Urgent	non-life threatening	0:19:59
	3	Scheduled	emergency room	0:29:59
	4	Schedule > 2 hours	pre-scheduled	schedule time
	5	Scheduled < 2 hours	pre-scheduled	best effort (2 hours Max)
	6	Special Event	stand-by	schedule time
	7	Long Distance	> 50 miles	best effort (2 hours Max)

Staff Report - EMCC

EMS Management Information & Surveillance System - MISS I and MISS II (ImageTrend)

MISS II

IMAGETREND ePCR SOFTWARE

The purchase of ImageTrend Software was approved by the ICEMA's Governing Board in November 2011 and is scheduled for implementation and roll out during latter half of 2012. Our Pilot phase is scheduled to begin the week of June 18th with AMR Redlands and San Bernardino City Fire. Training is planned for agency administrators and field providers during the third and fourth quarters of 2012.

San Bernardino County Fire Chief's Association has appointed a working task force to help with the implementation lead by Chief Ray Gayk of Ontario Fire.

CAD INTERFACES PENDING ePCR IMPLEMENTATION

AMR
San Bernardino City Fire
Ontario Fire
Confire
Desert Ambulance

MISS I

ICEMA SERVER

ICEMA has received the follow:

1. 2010 - 196,506 ePCRs
2. 2011 - 223,844 ePCRs
3. July 1, 2011 - December 31' 2011 - 113,748 ePCRs
4. April 2012 - 18,884 ePCRs

PENDING MOUs

CAL FIRE - Yucaipa and San Bernardino (received May 7, 2012)
CAL FIRE - Highland and San Bernardino

PENDING DEPLOYMENTS

Sheriff's Search and Rescue - San Bernardino County

THIRD PARTY INTERFACE TO MISS

Currently, ICEMA is working with third party vendors to receive data from ePCR systems other than HealthWare Solutions. Below is the current status for providers who are sending or attempting to send data to ICEMA.

1. Desert Ambulance (Zoll tabletPCR) - data is being received daily.
2. Mercy Air (emsCharts) - data is being received daily.

Mark Roberts
05/17/12

Staff Report - EMCC

ICEMA GROUND BASED AMBULANCE RATE SETTING POLICY - SAN BERNARDINO COUNTY

“ICEMA Ground Based Ambulance Rate Setting Policy - San Bernardino County” - Reference #5080 was scheduled for its two (2) year review. Following discussions with public and private sectors, an updated policy was forwarded to the Governing Board for approval. The policy was approved by the Board on May 8, 2012, and contains no major formula changes. It is reformatted in some sections for clarification purposes.

Virginia Hastings
05/17/12

**REPORT/RECOMMENDATION TO THE BOARD OF DIRECTORS
OF THE INLAND COUNTIES EMERGENCY MEDICAL AGENCY
AND RECORD OF ACTION**

46

May 8, 2012

**FROM: VIRGINIA HASTINGS, Executive Director
Inland Counties Emergency Medical Agency**

SUBJECT: ICEMA AMBULANCE RATE SETTING POLICY

RECOMMENDATION(S)

Acting as the governing body of the Inland Counties Emergency Medical Agency, approve amended Ambulance Rate Setting Policy No. 5080, effective July 1, 2012 through June 30, 2014.

(Affected Districts: All)

(Presenter: Virginia Hastings, Executive Director, 388-5823)

BOARD OF SUPERVISORS COUNTY GOALS AND OBJECTIVES

Provide for the Health and Social Services Needs of County Residents.

FINANCIAL IMPACT

Approval of this item does not impact discretionary general funding (net county cost) and will allow Inland Counties Emergency Medical Agency (ICEMA) to amend existing policy for ambulance rates. Any rates increases or decreases as established under this new policy will be paid by insurance providers, including Medicare and Medi-Cal, or by patients in cases where the insurance companies deny the claim.

BACKGROUND INFORMATION

Approval of this item will authorize ICEMA to amend ICEMA's Ambulance Rate Setting Policy No. 5080, effective July 1, 2012 through June 30, 2014.

ICEMA is the local Emergency Medical Services (EMS) Agency (LEMSA) for the Counties of San Bernardino, Inyo, and Mono. ICEMA is tasked with ensuring an effective system of quality patient care and coordinated emergency medical response by planning, implementing and evaluating an effective emergency medical services system including pre-hospital providers, specialty care hospitals and hospitals.

On February 23, 2010 (Item No. 69), through advice from County Counsel, the Board approved the ICEMA Rate Setting Policy after determining that the County Ambulance Code needed revision to reflect the implementation of Exclusive Operating Areas, organizational changes within the County, and to reflect that ICEMA is a Joint Powers Agency with oversight by a Governing Board, the rate setting authority was separated and implemented as an ICEMA policy.

ICEMA Policy No. 5080 currently allows annual rate adjustments in an amount necessary to properly compensate ambulance providers for changes (increases) in their direct and indirect costs based on the average percentage change in the Medical Care and Transportation Consumer Price Indexes (CPI), All Urban Consumers, Western Region, Los Angeles, Riverside, and Orange Counties. Rate increases in excess of 10% require approval by ICEMA's Governing Board (San Bernardino County Board of Supervisors).

If approved, the revisions to ICEMA's Ambulance Rate Setting Policy No.5080 will clarify the following items:

- Requires utilization of the "Annual" column for calculation thereby providing a yearly average instead of a two (2) month sampling
- Clearly identifies which selections to make in acquiring the data i.e. "Not Seasonally Adjusted", "Current", "Monthly."

In addition to the above clarifying items, the following changes are implemented:

- Identifies a specific fuel CPI for any mileage rate adjustments
- Provides a specific formula for mileage rate calculations
- For Extraordinary cost rate increase requests, Provider must demonstrate actual and substantial financial hardship prior to Governing Board approval

REVIEW BY OTHERS

This item has been reviewed by County Counsel (Alan Green, Deputy County Counsel, 387-5288) on April 9, 2012; and the County Administrative Office (Steve Atkeson, Administrative Analyst, 387-0294) on April 25, 2012.



ICEMA GROUND BASED AMBULANCE RATE SETTING POLICY - SAN BERNARDINO COUNTY

PURPOSE

To establish the maximum charges that San Bernardino County ground ambulance providers may charge for the care and transport of patients and outline the mechanism for calculating annual ground ambulance rates.

POLICY

No ambulance service shall charge more than the following rates:

1. **RATES FOR ONE PATIENT:** The schedule of maximum rates that may be charged for ambulance service for one (1) patient shall be reviewed by ICEMA on an annual basis.
2. **RATES FOR MULTIPLE PATIENTS:**
 - a. Each additional stretcher or gurney patient carried at the same time may be charged the full base rate for the response to the call and half the mileage rate.
 - b. Each additional sit-up patient shall be charged half the base rate for response to the call and half the mileage rate.
 - c. The provider may prorate all mileage charges between all patients transported so that all patients are charged the same fee for mileage.
 - d. This section does not apply to contractual agreements.
3. **NO CHARGE TRANSPORTS:** No charge shall be made for transporting uninjured or well persons who accompany a patient.
4. **COMPUTATION OF RATES:** All rates are to be computed from the time the ambulance arrives for hire until the ambulance delivers the patient to the appropriate destination, and is discharged by the patient or his representative, attending physician, or emergency receiving facility.
5. **FEES FOR SERVICE, SUPPLIES AND EQUIPMENT:**
 - a. When a ground ambulance has been dispatched and ambulance personnel and/or equipment are directly involved with patient care in situations where

an EMS aircraft transports, then the ambulance service shall be entitled to charge an appropriate fee for its service, supplies and equipment.

- b. Under no circumstances shall ambulance personnel dispatched on an emergency 9-1-1 call attempt to collect for the service prior to the delivery of the patient at an appropriate medical facility.

PROCEDURE

1. ANNUAL RATE ADJUSTMENT: At the direction of ICEMA, the ambulance rates established under this section shall apply to all providers of ground based ambulance services.
 - a. ICEMA shall be responsible for calculating rate adjustments.
 - b. The Consumer Price Index (CPI) adjustment shall be calculated by March 15 of each year. The CPI used shall be compiled and reported by the Bureau of Labor Statistics for the preceding 12-month period (January through December) utilizing the "Annual" column of the adjustment year. The following CPI selections shall be utilized:
 - All Urban Consumers
 - Not Seasonally Adjusted
 - Western Region, Los Angeles, Riverside, Orange Counties, CA
 - Medical Index
 - Transportation Index

The CPI adjustment shall be effective as of the first day of July of each year.

- c. If selected CPI's are discontinued or revised, another government index or computation which replaces it shall be used in order to obtain substantially the same result.
- d. The current rates shall be adjusted for changes in the CPI as set forth herein. The adjustments shall be made on July 1 of each year based upon the change in the CPI from January 1 of the preceding year to December 31 of the same calendar year.

The CPI adjustment shall be determined by taking the difference between the annual CPI's (*previous and adjustment years*) then by multiplying the result by zero point zero five (0.05) for the Transportation Index. The same process is applied to the Medical Index multiplying the result by zero point ninety-five (0.95). The two (2) sums are then added together and multiplied by one point five (1.5) to arrive at the total amount of the change in CPI for the annual base rate comparison. Yearly CPI adjustments shall not exceed five percent (5%) or less than zero for any single year.

2. ANNUAL RATE COMPARISON STUDY: The maximum base rates shall be reviewed in accordance with the following procedures, and adjusted annually, if appropriate, on July 1 every year. In conjunction with the rate adjustment and pursuant to Section 31.0820(e), the local EMS agency (ICEMA) shall review the ALS and BLS ground ambulance base rates of counties with similar demographics to determine the ALS and BLS average base rates in effect for these counties as of the review date.

If the San Bernardino County rates are at the average or greater, no adjustment to the ambulance rates will be made under this provision. If the San Bernardino County rates are less than the average, an appropriate adjustment to the ambulance rates shall be made to bring them towards the average. No ambulance rate comparison adjustment shall be greater than five percent (5%).

3. MILEAGE CHARGE RATE ADJUSTMENT: In addition to, and not in lieu of, annual CPI adjustments may be made, in an amount equal to the ambulance providers' extraordinary increase or decrease in fuel costs using the following CPI selections:

- Average Price Data
- A421 Los Angeles-Riverside-Orange County, CA
- Table, 7471A
- Gasoline, all types, per gallon/3.785 liters

This value will be reduced by the corresponding sub-value in the CPI transportation index used above in the annual comparison.

4. EXTRAORDINARY RATE ADJUSTMENTS:
 - a. Extraordinary costs increases or decreases shall be subject to ICEMA Governing Board approval.
 - b. Requests must be made in writing and use most recent specific CPI and include the previous calendar year plus the sum of the most recent CPI for the current year, divided by the number of total months, for an average.
 - c. Extraordinary cost rate increase requests may be requested quarterly and will be reviewed within thirty (30) days of receipt. Any approved implementation will become effective upon the beginning of the next calendar quarter and will not be retroactive.
 - d. The ambulance provider must demonstrate actual and substantial financial hardship as a result of factors beyond its reasonable control and provide records deemed necessary to verify such hardship. This procedure may also be used to obtain rate adjustments due to changes in the CPI that are greater than the five percent (5%) cap under the yearly CPI adjustment, above.

- e. ICEMA, at the time of any extraordinary adjustment under subsection (1), above, shall request an audit of books and records of an ambulance service provider for the purpose of verifying revenue and cost data specifically associated with the extraordinary rate increase request. Audits shall be carried out by a person selected and approved by ICEMA. If ICEMA and ambulance service provider cannot agree on a person to perform the audit, then the audit shall be carried out by a Certified Public Accountant selected by the ICEMA Executive Director.

Any charge, cost or fee, shall be paid by the ambulance service provider. ICEMA may deny any adjustment if an audit is requested and not produced. Every audit shall be done promptly and within thirty (30) days of submission.

Staff Report - EMCC

UTILIZATION OF PBC TRUST FUND (LIQUIDATED DAMAGES)

Current Balance (May 11, 2012): \$537,958

Incidental Expenses:

During the October 2010 meeting, the EMCC approved the use of liquidated damages for incidental expenses related to the MISS project or performance based contracts not to exceed \$5,000.

APPROVED INCIDENTAL BUDGET			\$5,000
Expenses:			
Item	Vendor	Date	Amount
Toughbook batteries	Sarcom	12/14/11	\$3,450.22
Total Spent			\$3,450.22
Incidental Account Balance Remaining			\$1,549.78

Additional Expenses for FY 2011-12:

APPROVED EXPENDITURES BUDGET	Vendor	Amount	\$40,000
Expenses FY 2012:			
Paper	Staples	\$7,877	\$7,877
Toner	Daisy Wheel	\$22,047	\$22,047
Subtotal			\$29,924
Remaining Balance			\$10,076

APPROVED IMAGETREND BUDGET	Vendor	Amount	\$717,546
Expenses FY 2012:			
	ImageTrend	\$161,640	\$161,640
	Sarcom	\$12,014	\$12,014
	ISD	\$24,045	\$24,045
Subtotal			\$197,699
Remaining Balance			\$519,847

Trust Fund Expenditure History

September 2009	Printer Paper and Toner	\$28,000
January 2010	150 Ruggedized Flash Drives	\$5,000
May 2010	Printer Paper and Toner	\$25,000
July 2010	Additional Printers	\$5,177
January 2011	Printer Paper and Toner Increase	\$15,000
May 2011	Additional Printers	\$12,500

Ed Segura
05/17/12



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE

2011
ANNUAL REPORT



INTRODUCTION

This writing is to document the San Bernardino County Emergency Medical Care Committee (EMCC) processes for 2011. Essentially the focus of the EMCC was to provide a platform for the diverse groups and individuals which form the Emergency Medical Services System. It also acts as an advisory group to the Board of Directors for Inland Counties Emergency Medical Agency (ICEMA).

The local EMS system continues to mature and is formally exploring patient outcomes and other evidence based processes. San Bernardino County Emergency Services continues to advance the care and other services to the ill or injured.

EMCC MEMBERSHIP

The 2011 EMCC members were:

SEAT NO.	MEMBER	POSITION
1	Diana McCafferty	Private Ambulance Provider (Vice-Chair)
2	Jim Holbrook	EMT-P Training Institution (Chair)
3	Margaret Peterson	Hospital Administrator
4	Pranav Kachhi, MD	ED Physician - Non-Trauma
5	Vacant	City Manager/Deputy City Manager/Assistant Manager
6	Vacant	Consumer Advocate
7	Michael Smith	Fire Chief
8	Stephen Miller	Law Enforcement
9	Art Andres	EMT/Paramedic - Public Sector
10	Rick Britt	Emergency Medical Dispatch/Communications
11	Allen Francis	Nurse – MICN
12	Troy Pennington, MD	Physician - Level II
13	Roy Cox	Air Ambulance Provider
14	Vacant	Physician - Level I
15	Vacant	EMT/Paramedic - Private Sector

The EMCC positions representing City Manager and Consumer Advocate continued to be unfilled during the 2011 sessions. These vacancies originated during the 2009 sessions, and ICEMA has been working to fill these positions. On April 5, 2011, the Board of Supervisors approved revisions to the EMCC ordinance. The EMCC bylaws were revised to reflect these approved changes. These changes will result in two accredited field paramedics, one representing public and one representing private agencies. Art Andres continues to serve in the public sector role and the new position for accredited EMT/Paramedic private sector will be filled during the 2012 sessions. The other change to the EMCC membership will be the addition of a physician from a Level I Trauma Center.

EMCC members are required to be in compliance with the requirements for Ethics training as defined by Article 2.4 of Chapter 2 of Title 5 of the Government code (AB 1234).

MANPOWER AND TRAINING

Both on-line and off-line medical control protocols continue to assure medical control of emergency medical care. A series of protocols, both regular updates and emergency protocols, were discussed during the 2011 EMCC sessions. The protocol changes were stimulated by

changes in scientific or local system needs. Additionally, an AD HOC Committee was formed to evaluate minimum data requirements for patient care records and to standardize abbreviations. Emergency medical care and quality patient outcomes and the measurements of those outcomes are continuing to advance within the system. The implementation of an accurate measure and documentation of outcomes of emergency medical care were more fully realized system wide and will remain a dynamic process. Following the full system wide implementation of electronic data collection, the review of system and quality assurance measures will need to be added to the processes already instituted.

The local training institutions, Victor Valley and Crafton Hills College, have implemented student training sessions on the use of electronic patient care documentation. The system continues through local provider and hospital based agency processes to forward the educational and training needs of the basic and advanced life support personnel system wide.

COMMUNICATIONS

The ability to communicate system issues including waiting to off load patients has shown progress as our larger system continues to meet these system challenges. The entire EMS system continues to explore and advance communications among all groups.

TRANSPORTATION

ICEMA reported on discussions of transportation issues during the 2011 sessions. These committee deliberations were to extend existing performance based contract scheduled to expire during the 2012 session. External confounding issues at the state level have influence these discussions. Continued funding from the performance based contract fines was added to other funding sources to augment the system needs of the region. The EMCC endorsed the expenditure of \$750,000 for the purchase of a new EMS data system from ImageTrend.

ASSESSMENT OF HOSPITALS AND CRITICAL CARE CENTERS

The EMCC received standing emergency medical services system management reports at each of the scheduled meetings. These standing reports included quarterly reports for Trauma systems and base hospital statistics and the monthly reports of electronic patient care reports, hospital bed delays, medication / procedures / and type of patient summary reports, and hospital surveillance reports. These standing reports assist the overall system as it continues to explore and advance in communication and systems knowledge between all groups.

MEDICAL CONTROL

The medical control protocols and system processes continue to assure overall medical control of system. Twenty-two (22) protocols, both regular updates and new protocols, were discussed during the 2011 EMCC sessions. The protocol changes were stimulated by changes in scientific or local system needs. Based on State level regulatory changes, an entire medical control system for the Advanced Emergency Medical Technician (AEMT) was discussed and the EMCC endorsed thirty-three (33) protocols for this level of practitioner. The system continues through local provider and hospital based agency processes to forward the educational, training, and personnel needs of the basic and advanced life support personnel system wide.

Additionally, MEDCOR implemented a process to enhance the remote EMS services to include advanced life support to the employees of the Molycorp Mountain Pass Mine near the Nevada border

DATA COLLECTION AND EVALUATION

The EMS system continued to document progress in data collection and analysis during the 2011 sessions. Substantial agency(s) and personnel time were required in order to accurately collect, review, analyze, and compile reports for various discussions and decision making loops. Continuing efforts have been made toward fully implementing electronic collection system wide. The system is moving out of the initial phase and some system outcome data exists.

The transportation industry continues to be further along on the continuum of electronic transfer than public response agencies. During the 2011 session the following San Bernardino County providers are sending data to the ICEMA server on a daily basis:

- 1) American Medical Response (AMR) Rancho
- 2) AMR Redlands
- 3) AMR Victorville
- 4) Baker EMS - Baker
- 5) Baker EMS - Needles
- 6) Barstow Fire Department
- 7) Big Bear City Fire Valley Paramedic Service
- 8) Big Bear Lake Fire Protection District
- 9) Desert Ambulance
- 10) Fort Irwin Fire Department
- 11) Mercy Air
- 12) Morongo Basin Ambulance Association
- 13) Morongo Valley Fire Department
- 14) Running Springs Fire Department
- 15) San Bernardino City Fire Department
- 16) San Bernardino County Sheriff's Aviation
- 17) San Manual Fire Department
- 18) Upland Fire Department - Air
- 19) Upland Fire Department - Ground

Memorandum of Understandings and full implementation is expected for the following agencies:

- 1) Crest Forest Fire Department
- 2) Sheriff's Search and Rescue

Despite a great deal of effort the transfer and receipt of CONFIRE data was not successful.

The following fire departments remain outside of the ICEMA Management Information and Surveillance System (MISS):

- 1) Apple Valley Fire Department
- 2) CAL FIRE - City of Highland Fire Department
- 3) CAL FIRE - City of Yucaipa Fire Department
- 4) Chino Valley Fire Department
- 5) Colton Fire Department

- 6) Combat Center Fire Department - Twentynine Palms
- 7) Loma Linda Fire Department
- 8) Marine Corp Logistics Base - Barstow
- 9) Montclair Fire Department
- 10) Ontario Fire Department
- 11) Rancho Cucamonga Fire Department
- 12) Redlands Fire Department
- 13) Rialto Fire Department
- 14) San Bernardino County Fire Department

PUBLIC INFORMATION AND EDUCATION

The EMS system continues to provide quality care with the STEMI system processes and the implementation of a new Stroke receiving process. Both of the system construct highlight successful regionally based programs. The EMCC had presentations from the Crest Forest Fire Department on a multiple patient incident and ImagineTrend on issues impacting the electronic documentation system.

DISASTER RESPONSE

During this past year our local agencies responded to significant regional and state-wide large scale issues including the potential for significant threats. Crest Forest presented an overview of a multi-casualty response.

CONCLUSION

It has been the goal of the EMCC to allow broad-based system participation and discussions and believe these activities have advanced the local EMS system. The EMCC applauds the EMS system and the participants as an amazing collection of the best and brightest in California.

Staff Report - EMCC

UTILIZATION OF PBC TRUST FUND FOR GROUND MEDICAL TRANSPORTATION SYSTEM DESIGN CONSULTANT (LIQUIDATED DAMAGES)

	Account Amount
PERFORMANCE BASED FINES Fund Balance as of 5/10/12	\$537,958
ImageTrend cost for FY 12/13	(\$77,120)
Anticipated Collection Amount for FY 12/13	\$134,025
Budgeted Amount for Paper and Toner for FY 12/13	(\$40,000)
Budgeted Amount for Incidentals	(\$5,000)
Cost for RFP Consultant	(\$150,000)
Remaining Balance in Liquidated Damages	\$399,863

Staff Recommendation:

EMCC endorse expenditures up to \$150,000 for the cost associated for a Ground Medical Transportation System Design consultant.

Ed Segura
5/17/12



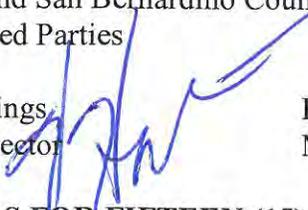
Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

*Virginia Hastings, Executive Director
Reza Vaezazizi, M.D., Medical Director*

DATE: April 17, 2012

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Virginia Hastings, Executive Director  Reza Vaezazizi, MD Medical Director 

SUBJECT: PROTOCOLS FOR FIFTEEN (15) DAY COMMENT

The following new and revised protocols have been reviewed by the: Trauma System Advisory Committee (TSAC), STEMI CQI Committee, Protocol Education Committee (PEC) and electronically reviewed by the Medical Advisory Committee (MAC) and are now available for public comment and recommendations. Due to the extensive reviews, we have shortened the comment period to fifteen (15) days.

Protocol Reference #:

- 6070 Cardiovascular “STEMI” Receiving Centers
- 8100 Continuation of Trauma Care
- 15010 Trauma – Adult
- DRAFT Hospital Emergency Response Team (HERT)

ICEMA encourages all system participants to submit recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until Wednesday, May 2, 2012, at 5 pm.** Comments may be sent via hardcopy, faxed to (909) 388-5825 or via e-mail to c.yoshida-mcmath@cao.sbcounty.gov. Comments submitted and any revisions made will be presented at the May 17, 2012, Emergency Medical Care Committee (EMCC) meeting. The protocols will also be presented at the Inyo and Mono Counties EMCC meetings.

VH/RV/CYM/mae

Enclosures

c: File Copy



CARDIOVASCULAR “STEMI” RECEIVING CENTERS

PURPOSE

A Cardiovascular STEMI Receiving Center (SRC) will be the preferred destination for patients who access the 9-1-1 system meeting defined criteria and show evidence of a ST-elevation myocardial infarction on a 12 Lead electrocardiogram. These patients will benefit from rapid interventions via cardiac catheterization interventions.

DEFINITIONS

1. **STEMI** - ST Elevation Myocardial Infarction.
2. **PCI** - Percutaneous Coronary Intervention.
3. **STEMI Receiving Center (SRC)** - Facilities that have emergency interventional cardiac catheterization capabilities.
4. **STEMI Referring Centers** - Facilities that do not have emergency interventional cardiac catheterization capabilities.
5. **STEMI Base Station**- Facilities that have emergency interventional cardiac catheterization capabilities that also function as a Base Station
6. **CQI** - Continuous Quality Improvement.
7. **EMS** - Emergency Medical Services.
8. **CE** -Continuous Medical Education.

POLICY

The following requirements must be met for a hospital to be designated as a Cardiovascular STEMI Receiving Center by ICEMA:

1. An ICEMA approved paramedic receiving hospital which is a full service acute care facility.
2. Licensure as a Cardiac Catheterization Laboratory.
3. Intra-aortic balloon pump capability.

4. Cardiovascular surgical services permit.;

~~*This requirement may be waived by the EMS Agency Medical Director when appropriate for patient or system needs. The Medical Director will evaluate conformance with existing American College of Cardiology/American Heart Association or other existing professional guidelines for standards.*~~

5. Communication system for notification of incoming STEMI patients, available twenty four (24) hours per day, seven (7) days per week. (i.e. in-house paging system)
6. Provide CE opportunities for EMS personnel in areas of 12 Lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.

7. **STAFFING REQUIREMENTS**

The hospital will have the following positions designated and filled prior to becoming a SRC:

- a. Medical Directors

The hospital shall designate two physicians as co-directors of its SRC program. One physician shall be a board certified interventional cardiologist with active PCI privileges. The co-director shall be a board certified emergency medicine physician with active privileges to practice in the emergency department.

- b. Nursing Director

The hospital shall designate a SRC Nursing Director who is trained or certified in Critical Care nursing.

- c. On-Call Physician Consultants and Staff

A daily roster of the following on-call physician consultants and staff that must be promptly available within thirty (30) minutes of notification.

1. Cardiologist with percutaneous coronary intervention (PCI) privileges.
2. Cardiovascular Surgeon, if cardiovascular surgical services are offered.

~~If cardiovascular surgical services not available in house the facility must have a rapid transfer agreement in place with a facility that provides this service. The agreement must be on file with the local EMS agency. Additionally, the facility must have a rapid transport agreement in place with a local transport agency.~~

3. Cardiac Catheterization Laboratory team.
4. Intra-aortic balloon pump nurse or technologist.

8. INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

- a. Fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI of an STEMI patient is not possible.
- b. Diversion of STEMI patients **only** during times of Internal Disaster in accordance to protocol # 8060, Requests for Hospital Diversion, (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues i.e. bomb threat, earthquake damage, hazardous material or safety and security of the facility.) A written notification describing the event must be submitted to ICEMA within twenty four (24) hours.
- c. Prompt acceptance of STEMI patients from other STEMI referral centers that do not have PCI capability. Refer to ICEMA Policy Reference # 8040.
- d. Cath lab team activation policy which requires immediate activation of the team upon EMS notification when there is documented STEMI patient en-route to the STEMI center, based on machine algorithm interpretation.

9. DATA COLLECTION

~~The following data shall be collected on an on-going basis and available for review by ICEMA:~~

All required data elements shall be collected and entered in an ICEMA approved STEMI registry on a regular basis and submitted to ICEMA for review.

- a. ~~Total number of EMS STEMI patients transported to a designated SRC. (Source data: ICEMA approved patient care record.)~~

- b. ~~Total number of EMS STEMI patients that bypass the most accessible receiving hospital (not approved as a SRC) and are transported to a SRC. (Source data: base hospital logs.)~~
- c. ~~Total number EMS STEMI patients who received primary PCI. (Source data: STEMI center logs.)~~
- d. ~~Door to dilation times for primary PCI of all STEMI patients. (Source data: STEMI center logs.)~~
- e. ~~Total number of patients admitted with the diagnosis of myocardial infarction per year. (Source data: STEMI center logs.)~~
- f. ~~Total number of PCI procedures performed per year per facility. (Source data: STEMI center logs.)~~

10. **CONTINUOUS QUALITY IMPROVEMENT PROGRAM**

SRC shall develop an on-going CQI program which monitors all aspect of treatment and management of STEMI cardiac patients and identify areas needing improvement. The program must, at a minimum, monitor the following parameters:

- a. Morbidity and mortality related to procedural complications.
- b. Detail review of cases requiring emergent rescue CABG.
- c. Tracking of door-to-dilation time and adherence to minimum performance standards set by this policy.
- d. Active participation in each ICEMA STEMI CQI committee and STEMI regional peer review process. This will include a review of selected medical records as determined by CQI indicators and presentation of details to peer review committee for adjudication~~Active participation in ICEMA STEMI CQI Committee activities.~~

11. **PERFORMANCE STANDARD**

In accordance with *D2B: An Alliance for Quality* guidelines, SRCs must achieve and maintain a door-to-balloon time of less than or equal to ninety (90) minutes in 75% of primary PCI patients with STEMI. If this standard is not achieved, SRC may be required to submit an improvement plan to ICEMA addressing the deficiency with steps being taken to remedy the problems.

12. DESIGNATION

- a. The Cardiovascular STEMI Receiving Center applicant shall be designated after satisfactory review of written documentation and an initial site survey by ICEMA or its designees and completion of an agreement between the hospital and ICEMA.
- b. Documentation of current accreditation from The Society of Chest Pain Centers as “Chest Pain Center with PCI” shall be accepted in lieu of a formal site visit by ICEMA.
- c. Initial designation as a SRC shall be for a period of two (2) years. Thereafter, re-designation shall occur every four (4) years, contingent upon satisfactory review.
- d. Failure to comply with the criteria and performance standards outlined in this policy may result in probation, suspension or rescission of SRC designation.

13. PATIENT DESTINATION

- A. The STEMI Base Station should be considered as the destination of choice if all of the following criteria are met:
 1. Identified STEMI patients based on machine interpretation of field 12 Lead ECG, verified by paramedics and approved by a Base Station physician.
 2. Total transport time to the Base Station SRC is thirty (30) minutes or less. Base hospital physician may override this requirement and authorize transport to the SRC with transport time of greater than thirty (30) minutes.
 3. STEMI Base Station contact is **mandatory** for all patients identified as possible STEMI patient. The STEMI Base Station confirms an SRC as the destination.
 4. The STEMI Base Station is the only authority that can direct a patient to a STEMI receiving center.
 5. The STEMI Base Station, if different from the SRC, will notify the SRC of patient’s pending arrival as soon as possible, to allow timely activation of Cardiac Cath lab team at the SRC.

6. If the patient chooses bypass the recommended system STEMI center, EMS must obtain an AMA and notify the STEMI base station.

B. The following factors should be considered with regards to choice of destination for STEMI patients. STEMI Base Station contact and consultation is mandatory in these and similar situations:

1. Patients with unmanageable airway, unstable cardiopulmonary condition, or in cardiopulmonary arrest should be transported to the closest receiving hospital.
2. Patients with malignant ventricular fibrillation, ventricular tachycardia, second degree type II heart block and third degree heart blocks should be considered for transport to the closest receiving hospital.
3. Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to the closest SRC.
4. Patients with hemodynamic instability as exhibited by blood pressure less than 90 systolic and/or signs of inadequate tissue perfusion should be transported to the closest receiving hospital.
5. Patients with *sustained* ROSC should be strongly considered for transport to the closest SRC.



CONTINUATION OF TRAUMA CARE

~~THIS POLICY IS FOR TRANSFER OF TRAUMA PATIENTS FROM A REFERRAL HOSPITAL (RH) TO AN ICEMA DESIGNATED TRAUMA CENTER (TC) AND TRANSFER OF PATIENTS BETWEEN TC WHEN A HIGHER LEVEL OF CARE IS REQUIRED; AND SHALL NOT BE USED FOR ANY OTHER FORM OF INTERFACILITY TRANSFER OF PATIENTS.~~

THIS POLICY IS FOR CONTINUATION OF TRAUMA CARE PATIENTS FROM A REFERRAL HOSPITAL (RH) TO AN ICEMA DESIGNATED TRAUMA CENTER (TC) AND CONTINUATION OF TRAUMA CARE PATIENTS BETWEEN TC WHEN A HIGHER LEVEL OF CARE IS REQUIRED; AND SHALL NOT BE USED FOR ANY OTHER FORM OF INTERFACILITY TRANSFER OF PATIENTS.

PURPOSE

To support a system of trauma care that is consistent with [American College of Surgeons \(ACS\)](#) standards and ensures the minimal time from patient injury to receiving the most appropriate definitive trauma care.

DEFINITIONS

Trauma Center (TC) - a licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws, regulations and ICEMA policies.

Referral Hospital (RH) - any licensed general acute care hospital that is not an ICEMA designated TC.

INCLUSION CRITERIA

Any patient meeting ICEMA Trauma Triage Criteria, (Reference ICEMA Policy #15030) arriving at a non-trauma hospital by EMS or non-EMS transport.

INITIAL TREATMENT GOALS (at RH)

1. Initiate resuscitative measures within the capabilities of the facility.
2. Ensure patient stabilization is adequate for subsequent ~~transfer~~ transport.

3. Transfer timeline goal is <30 minutes door-to-~~transfer~~ door-out.
4. DO NOT DELAY ~~TRANSFER~~ **TRANSPORT** by initiating any diagnostic procedures that do not have direct impact on IMMEDIATE resuscitative measures.
5. RH ED physician will make direct physician-to-physician contact with the ED physician at the TC.
6. The TC will accept all referred trauma patients unless they are on Internal Disaster as defined in ICEMA Policy #8060.
7. The TC ED physician is the accepting physician at the TC and will activate the internal Trauma Team according to internal TC protocols.
8. RH ED physician will determine the appropriate mode of transportation for the patient. If ground transportation is >30 minutes consider the use of an air ambulance. Requests for air ambulance shall be made to 9-1-1 and normal dispatching procedures will be followed; however, the air ambulance continuation of trauma run patient will be transported to the TC identified by the RH.
9. Simultaneously call 9-1-1 and utilize the following script to dispatch:

“This is a Continuation of Trauma Run ~~Interfacility—Transfer~~ from ___ hospital to ___ Trauma Center”

Dispatchers will only dispatch transporting paramedic units without any fire apparatus.
10. RH must send all medical records, test results, radiologic evaluations to the TC. DO NOT DELAY ~~TRANSFER~~ **TRANSPORT**- these documents may be FAXED to the TC.

SPECIAL CONSIDERATIONS

1. If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH.
2. The RH may consider sending one of its nurses with the transporting paramedic unit if deemed necessary due to the patient’s condition or scope of practice.
3. Nurse staffed critical care (ground or air) transport units maybe used; but may create a delay due to availability. Requests of nurse staffed critical care transport units must be made directly to the transporter agency by land line.



TRAUMA - ADULT (15 Years of Age and Older)

Any critical trauma patient (CTP) requires effective communication and rapid transportation to the closest trauma center. If not contacted at scene, the receiving trauma center must be notified as soon as possible in order to activate the trauma team.

In Inyo and Mono Counties, the assigned base station should be contacted for determination of appropriate destination.

FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030

ADULT TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	ALS INTERVENTIONS
<ul style="list-style-type: none"> • Ensure thorough initial assessment • Ensure patent airway, protecting cervical spine • Axial spinal stabilization as appropriate • Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped) • Keep patient warm • For a traumatic full arrest, an AED may be utilized, if indicated • Transport to ALS intercept or to the closest receiving hospital 	<ul style="list-style-type: none"> • Advanced airway as indicated. <i>Unmanageable Airway:</i> -If an adequate airway cannot be maintained with a BVM device; AND -The paramedic is unable to intubate or if indicated, perform a successful needle cricothyrotomy, Then, transport to the closest receiving hospital and follow Continuation of Trauma Care, Protocol Reference #8100. • Monitor ECG • IV/IO Access: Warm IV fluids when avail <i>Unstable:</i> -BP<90mmHG and/or signs of inadequate perfusion, start 2nd IV access. <i>Stable:</i> -BP>90mmHG and/or signs of adequate tissue perfusion.

BLS Continued**ALS Continued****Blunt Trauma:**

Unstable: IV NS open until stable or 2000ml maximum is infused

Stable: IV NS TKO

Penetrating Trauma:

Unstable: IV NS 500ml bolus one time

Stable: IV NS TKO

Isolated Closed Head Injury:

Unstable: IV NS 250ml bolus, may repeat to a maximum of 500ml

Stable: IV NS TKO

- Transport to appropriate hospital.
- Insert nasogastric/orogastric tube as indicated.

MANAGE SPECIAL CONSIDERATIONS:**MANAGE SPECIAL CONSIDERATIONS:**

Abdominal Trauma: Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.

Amputations: Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.

- **Partial amputation:** Splint in anatomic position and elevate the extremity.

Bleeding:

- Apply direct pressure and/or pressure dressing.
- To control life-threatening bleeding of a severely injured extremity consider application of tourniquet when direct pressure or pressure dressing fails.

BLS Continued

Chest Trauma: If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax.

Flail Chest: Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.

Fractures: Immobilize above and below the injury. Apply splint to injury in position found except:

- **Femur:** Apply traction splint if indicated.
- **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
- **Check and document distal pulse before and after positioning.**

Genital Injuries: Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

ALS Continued

Chest Trauma: Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.

Fractures:

Isolated Extremity Trauma: Trauma without multisystem mechanism.

Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured – e.g. dislocated shoulder, hip fracture or dislocation.

IV Pain Relief:

-Morphine Sulfate 5mg IV slowly and may repeat every 5 minutes to a maximum of 20mg when the patient maintains a

-BP>90mmHG and signs of adequate tissue perfusion. Document BP's every 5 minutes while medicating for pain and reassess the patient.

-Consider Ondansetron 4mg slow IVP/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration.

***NOTE:** Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Morphine.*

-Administer IV NS 250ml bolus one time.

BLS Continued

Head and Neck Trauma: Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock.

- **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
- **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

Impaled Object: Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.

Pregnancy: Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females \geq 24 weeks of gestation.

Traumatic Arrest: CPR if indicated. May utilize an AED if indicated.

Determination of Death on Scene: Refer to Protocol # 12010 Determination of Death on Scene.

ALS Continued**IM Pain Relief:**

- Morphine Sulfate 10mg IM. Document vital signs and reassess the patient.
- Consider Ondansetron 4mg IM/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration.

Head and Neck Trauma: Immediately prior to intubation, consider prophylactic Lidocaine 1.5 mg/kg IV for suspected head/brain injury.

- **Base Station Orders:**

- When considering nasotracheal intubation (\geq 15 years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, trauma base hospital contact is required.

-Impaled Object: Remove object upon trauma base physician order, if indicated.

Traumatic Arrest: Continue CPR as appropriate.
Follow Protocol # 11070 Adult Cardiac Arrest

Determination of Death on Scene: Refer to Protocol # 12010 Determination of Death on Scene.

ALS Continued**-Severe Blunt Force Trauma Arrest:**

IF INDICATED: transport to the closest receiving hospital.

-Penetrating Trauma Arrest:

IF INDICATED: transport to the closest receiving hospital.

If the patient does not meet the “Obvious Death Criteria” in the “*Determination of Death on Scene*” Protocol #12010, contact the trauma base station for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact.

Precautions and Comments:

- Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.
- **Unsafe scene may warrant transport despite low potential for survival.**
- Whenever possible, consider minimal disturbance of a potential crime scene.

Base Station: May order additional:

- medications;
- fluid boluses.

REFERENCE PROTOCOLS

<u>Protocol Number</u>	<u>Protocol Name</u>
8100	Continuation of Trauma Care
9010	General Patient Care Guidelines
10150	External Jugular Vein Access
10030/10040	Oral Endotracheal Intubation
10080	Insertion of Nasogastric/Orogastric Tube
10060	Needle Thoracostomy
10140	Intraosseous Infusion IO
10050	Nasotracheal Intubation
10070	Needle Cricothyrotomy
10160	Axial Spinal Stabilization
10010/10020	King Airway Device
11070	Adult Cardiac Arrest
15030	Trauma Triage Criteria and Destination Policy
12010	Determination of Death on Scene



HOSPITAL EMERGENCY RESPONSE TEAM (HERT)

PURPOSE

To establish a formal mechanism for providing rapid advanced surgical care at the scene, in which a higher level of on-scene surgical expertise, physician field response, is requested by the on-scene prehospital care provider.

AUTHORITY

Health and Safety Code, Division 2.5, Section 1798. (a) provides that “Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, ...at the scene of an emergency who is most medically qualified specific to the provision of rendering emergency medical care.”

DEFINITIONS

Hospital Emergency Response Team (HERT): Organized group of health care providers from a designated Level I or II Trauma Center, with Emergency Medical Services (EMS) Agency approval as a HERT provider, who are available twenty-four (24) hours/day to respond and provide a higher level of on-scene surgical expertise.

Incident Commander: Highest-ranking official of the jurisdictional agency at the scene of the incident and responsible for the overall management of the incident.

PRINCIPLES

1. In general, a HERT is utilized in a situation where a **life-saving** procedure, such as an amputation, is required due to the **inability to extricate** a patient. Life before limb, utilized as a life-saving measure not as a time saving measure.
2. HERT should be assembled and ready to respond within 20 minutes of a request with standard life-saving equipment in accordance with the HERT provider’s internal policy on file with the ICEMA.
3. The standard life-saving equipment referenced above shall be predetermined, preassembled, readily available, clearly labeled, and stored in a predetermined location. Based upon the magnitude and nature of the incident, the standard life-saving equipment may require augmentation.

POLICY

1. Composition of a Hospital Emergency Response Team
 - a. The composition of the HERT team, and the identification of a Physician Team Leader, shall be in accordance with the approved HERT provider's internal policy on file with the ICEMA.
 - b. The Physician Team Leader:
 1. Is responsible for organizing, supervising, and accompanying members of the team to a scene where a physician field response has been requested.
 2. Shall be familiar with base hospital operations and the ICEMA's policies, procedures, and protocols.
 3. Is responsible for retrieving the life-saving equipment and determining if augmentation is required based upon the magnitude and nature of the incident.
 4. Will determine the ultimate size and composition of the team based upon the magnitude and nature of the incident.
 5. Will report to, and be under the authority of, the Incident Commander or their designee. Other members of the team will be directed by the Physician Team Leader.
2. Activation of a Hospital Emergency Response Team
 - a. The anticipated duration of the incident should be considered in determining the need for a HERT. Before requesting a HERT, the Incident Commander should take into account that it may be a minimum of 30 minutes before a team can be on scene.
 - b. The Incident Commander shall contact the appropriate Communications Center. The determination of the appropriate mode of transportation of the team (ground versus air) will be mutually agreed upon.
 - c. The appropriate Communication Center shall contact the approved HERT provider regarding the request. The Team Leader will organize the team and equipment in accordance with the HERT provider's internal policy, and the magnitude and nature of the incident.

- d. The Physician Team Leader shall inform the Communication Center once the team has been assembled and indicate the number of team members.
 - e. Communication Center will notify the Incident Commander of the ETA of the HERT if they are arriving by ground transportation. When air transport is utilized the Communication Center will dispatch the air ambulance resource and indicate the time that the HERT is assembled with the standard life-saving equipment, prepared to leave the helipad.
3. Transportation of a Hospital Emergency Response Team
 - a. When either ground or air transportation is indicated, Communication Center will arrange emergency response vehicle transportation for HERT through the Central Dispatch Office.
 - b. Consider use of larger (CCT or bariatric) ground or air units for transport of patient and HERT team to paramedic receiving facility.
 - c. Upon the conclusion of the incident, HERT will contact the Communication Center to arrange transportation of the team back to the originating facility.
 4. Responsibilities of a Hospital Emergency Response Team on Scene
 - a. Upon arrival of the HERT, the Team Leader will report directly to the on-scene Incident Commander. HERT members will, at a minimum, have visible identification that clearly identifies the individual as a health care provider (physician, nurse, etc.) and a member of the HERT.
 - b. Documentation of care rendered will be completed on hospital approved trauma flow sheets (nursing notes) and physician progress notes.
 5. Approval Process of a Hospital Emergency Response Team

Trauma Centers interested in providing a HERT must develop internal policies to comply with all requirements and submit evidence of the ability to meet all requirements of this policy to the ICEMA for review and approval as a HERT provider.

PROTOCOLS FOR FIFTEEN (15) DAY COMMENT FORM
Protocol Reference #'s 6070, 8100, 15010 and
New Protocol "Hospital Emergency Response Team (HERT)"

DUE: May 2, 2012 at 5 p.m.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
8100	Mercy Air	Initial Treatment Goals #3, page 2 of 2. Shouldn't the Transfer timeline goal be from door-in to door-out?	Changed. "Transfer timeline goal is <30 minutes door-in to door out."
8100	Crafton Hills College Paramedic Intern Gustavo Aguirre	Initial Treatment Goals (at RH) 1. Transfer timeline goal is <30 minutes door-to-door-out. Comment: Suggesting clarification, is this from the Referral Hospital (RH) to Trauma Center (TC)? Specifics are needed.	No Change. States in the heading of the section in bold: "INITIAL TREATMENT GOALS (at RH)". Redundant.
8100	Crafton Hills College Paramedic intern Philip Nageotte	Special Considerations 2. The RH may consider sending one of its nurses with the transporting paramedic unit if deemed necessary due to the patient's condition or scope of practice. Comment: Will the RH have nurses designated for transport of these types of patients and will they be trained for critical care transport?	No Change. RH will manage as an internal hospital process.
8100	Crafton Hills College, Paramedic Intern, William Carlson	Special Considerations – 1. If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH.	No Change Required.

PROTOCOLS FOR FIFTEEN (15) DAY COMMENT FORM
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PROTOCOL #	AGENCY	COMMENT	RESPONSE
		Comment: This will benefit the patient overall by limiting time outside of the necessary trauma center. Also, the initial change in wording to this protocol clearly spells out what situations this policy is for.	
8100	Mammoth Hospital	Similar concerns to 6070. Our closest ACS trauma center is in Reno, NV. Please place additional language that allows us to send patients to a non-ICEMA trauma center. Dr. Swisher, ED Attending, Mammoth Hospital.	No Change. This is not a compulsory policy. It is available for RH to use if needed.
8100	Joseph Gerardi Crafton Hills College Paramedic Student Class 78	Special Considerations- 1: If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH. - What is time frame allotted for the RH ED physician to request the transport team to stay on site with the patient?	No Change Required. The timeline goal for the RH door-in to door-out is <30 min.
8100	Crafton Hills College Paramedic Class 78, Paramedic Intern Garry Lingafelter	SPECIAL CONSIDERATIONS 1. "If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with the patient and immediately transport them once the minimal stabilization is done at the RH."	No Change Required.

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
		In the event that the RH ED physician requests the transporting team remain with the patient, the transporting team "must" accommodate.	
8100	Crafton Hills College Paramedic Intern Ernie Mullenax	INITIAL TREATMENT GOALS 3. Transfer timeline goal is <30 minutes door-to-door-out <u>Comment:</u> Suggest clarification. Example: Time between entering and leaving receiving hospital, Door-in-door-out	Changed. "Transfer timeline goal is <30 minutes door-in to door out."
8100	Richard Valenti Crafton Hills College Paramedic Student Class 78	Special Considerations- 1: If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH. Comment: Is there a maximum time frame the RH ED physician can keep a transport team on site? Holding EMS units at RHs can quickly deplete the EMS system.	No Change Required. The timeline goal for the RH door-in to door-out is <30 min.
8100	Ontario FD	Opening paragraph addition of continuation of trauma care patients between TC – TC should be pleural? TCs – when a higher level of care is	Changed. "THIS POLICY IS FOR CONTINUATION OF TRAUMA CARE PATIENTS FROM A REFERRAL HOSPITAL (RH) TO AN ICEMA DESIGNATED TRAUMA CENTER (TC) AND

PROTOCOLS FOR FIFTEEN (15) DAY COMMENT FORM
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PROTOCOL #	AGENCY	COMMENT	RESPONSE
			CONTINUATION OF TRAUMA CARE PATIENTS BETWEEN TCs WHEN A HIGHER LEVEL OF CARE IS REQUIRED; AND SHALL NOT BE USED FOR ANY OTHER FORM OR INTERFACILITY TRANSFER OF PATIENTS.:
8100	Ontario FD	Page 2 #3 Transfer timeline goal is <30 minutes door-to-door. Remove out	Changed. "Transfer timeline goal is <30 minutes door-in to door out."
8100	San Manuel Fire Department	Agree with changes	No Change Required.
8100	Crafton Hills College Paramedic Class 78 paramedic intern Joseph A. Sandoval	Special Consideration 1. If the patient has arrived at the RH via EMS, the RH ED physician may request that the transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH. Comment: I agree fully with this	No Change Required.
8100	Chris Gerardi Crafton Hills College Paramedic Student Class 78	Special Considerations- 1: If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH.	No Change Required.

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DUE: May 2, 2012 at 5 p.m.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		- Comment: I agree with this consideration only if there is a designated amount of time the hospital can withhold EMS units in order to maintain a sufficient system status. If it may take a significant amount of time to stabilize the patient's condition it may restrict units from responding to medical aids in a low status EMS system.	
6070	Mammoth Hospita 1	13. A. 3: The Mono County Paramedics need to contact the SME(Mammoth Hospital) base station> They do NOT need to contact a STEMI center in a county 200 miles away, particularly since we send our STEMI's to Nevada. Please see protocol 15010 for a statement that would adequately address Inyo and Mono counties. Dr. Swisher, ED Attending, Mammoth Hospital.	Added. In Inyo and Mono Counties, the assigned bas station should be contacted for determination of appropriate destination.
6070	Mammoth Hospital	13. A.4.: SME will direct the paramedics to a STEMI center. In addition, our paramedics need the ability to contact Nevada-based EMS services and independent flight services as needed to provide the most rapid transport to Nevada STEMI centers. Please see protocol 15010 for a statement that would adequately address Inyo and Mono counties. Dr. Swisher, ED Attending, Mammoth Hospital.	Added. In Inyo and Mono Counties, the assigned bas station should be contacted for determination of appropriate destination.
6070	Crafton Hills College Paramedic Class 78 paramedic intern Joseph A.	Patient Destination A. The STEMI Base Station should be considered as the destination of choice if all of the following criteria are met:	No Change Required.

PROTOCOLS FOR FIFTEEN (15) DAY COMMENT FORM
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PROTOCOL #	AGENCY	COMMENT	RESPONSE
	Sandoval	<p>1) Identified STEMI patients based on machine interpretation of field 12 Lead ECG. Verified by paramedics and approved by a Base Station physician.</p> <p>- Why is a monitor needed for interpretation? Paramedics are trained to identified STEMI as well as other rhythms. Paramedics are the ones that need to identifies a STEMI and appropriately notify the Base Station. Paramedics must not rely on the interpretation of a machine, for the machine could miss a possible myocardial infarction.</p>	A monitor is needed for the ECG tracing. The destination decision is based on 3 factors. Machine interpretation, medic interpretation and base station physician.
6070	Crafton Hills College Paramedic Class 78 paramedic intern Joseph A. Sandoval	<p>Patient Destination The STEMI Base Station should be considered as the destination of choice if all of the following criteria are met:</p> <p>6)If the patient chooses bypass of the recommended system STEMI center, EMS must obtain an AMA and notify the STEMI Base Station.</p> <p>-I agree fully with this addition.</p>	No Change Required.
6070	Crafton Hills College Paramedic Class 78 paramedic intern Joseph A. Sandoval	<p>B. The following factors should be considered with regards to choice of destination for STEMI patients. STEMI Base Station contact and consultation is mandatory in these and similar situations</p> <p>1) Patients with unmanageable airway, unstable cardiopulmonary condition or in cardiopulmonary arrest should be transported to the closest receiving hospital.</p> <p>-The patient having been identified as meeting</p>	<p>No Change.</p> <p>Allows for the medic interpretation</p>

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		STEMI criteria would be by nature be unstable. Clarification is needed for this unstable cardiopulmonary condition.	as consideration; so that medics can divert to closest if the patient condition changes and becomes unstable.
6070	Crafton Hills College Paramedic Class 78, Paramedic Intern Garry Lingafelter	<p>PATIENT DESTINATION</p> <p>A. The STEMI Base Station should be considered as the destination of choice if all of the following criteria are met.</p> <p>1. "Identified STEMI patients based on machine interpretation of field 12 Lead ECG, verified by paramedics and approved by a Base Station Physician."</p> <p>Machine interpretation is a helpful tool, but should not serve as the basis for STEMI Base Station contact. Instead, machine interpretation "or" paramedic interpretation, verified and approved by a Base Station physician should serve as criteria for STEMI Base Station contact.</p>	<p>No Change Required.</p> <p>The destination decision is based on 3 factors: Machine interpretation, medic interpretation and base station physician. STEMI base contact is required for all EMS patients with suspected STEMI.</p>
6070	San Manuel Fire Department	Agree with changes	No Change Required.
6070	Chris Gerardi Crafton Hills College Paramedic Student Class 78	<p>Patient Destination-</p> <p>A1: Identified STEMI patient's based on machine interpretation of field 12 Lead ECG, verified by paramedics and approved by Base Station physician.</p> <p>-I believe the interpretation should be left</p>	<p>No Change Required.</p> <p>The destination decision is based on</p>

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		to the paramedic and reinforced by the machines printed interpretation. In the field artifact and patient movement may lead to false and "unconfirmed" readings.	3 factors. Machine interpretation, medic interpretation and base station physician.
6070	Chris Gerardi Crafton Hills College Paramedic Student Class 78	Patient Destination- A6: If the patient chooses bypass the recommended system STEMI center, EMS must obtain an AMA and notify the STEMI base station. I agree with and support this addition.	No Change Required.
6070	Redlands Community Hospital	See attached document.	The impact of such bill on our STEMI system, even if it was to pass and become regulation, is still unclear since the reference is to "Elective" procedures. Also, even with the study being complete by projected date of August of 2013, any regulatory changes will take an additional 12-24 months. We will definitely have multiple opportunities to review the policy by then and update in relation to any new regulations that may come about. The retention of current language provides no benefit at this time.
15010	San Manuel Fire Department	Agree with changes	No Change Required,

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
15010	Crafton Hills College Paramedic Class 78, Paramedic Intern Garry Lingafelter	BLS INTERVENTIONS Chest Trauma: If a wound is present, cover it with an occlusive dressing. If the patients ventilations are being assisted, dress the wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax. Occlusive dressings must be consistently reassessed for good seal in the presence of diaphoresis. Additionally, in the presence of a tension pneumothorax, occlusive dressings must be burped to remove trapped air from the chest cavity.	No Change Required.
15010	Crafton Hills College Paramedic Class 78 paramedic intern Joseph A. Sandoval	Adult Treatment protocol: Trauma IV/IO Access: Warm IV fluids when avail. Unstable: -BP<90mmHg and/or signs of inadequate perfusion, start 2nd IV access. -Could It be better practice, as well as beneficial to have two IV lines established on every trauma patient even if they are stable for prophylactic reasons.	No Change Required. Comments not consistent with latest clinical practice recommendations.
15010	Chris Gerardi Crafton Hills College Paramedic Student Class 78	Adult Treatment Protocol: Trauma ALS Interventions: 2 nd IV access should be obtained for unstable patients. -Bilateral IV's should be obtained in unstable patients for prophylactic access.	No Change Required. Comments not consistent with latest clinical practice recommendations.
HERT Draft	Crafton Hills College Paramedic Class 78	Principles 2) HERT should be assembled and Ready to respond within 20 minutes of request with standard	No Change Required.

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	paramedic intern Joseph A. Sandoval	<p>life-saving equipment in accordance with the HERT provider's internal policy on file with the ICEMA</p> <p>-Would 20 minutes be too long for a team to assembled and be ready to respond to an incident? Quicker assembly would be accentual, for an unknown amount of time has past as EMS attempts to extricate the victim. With time being a major factor with rescue and transport to the operating room, that expedited response time would be needed. To help with this response, Hospital Emergency Response Team could be selected each day, and be ready at any time to respond. Trauma Hospitals could alternate between each other and be updated in readynet on the status and availability of the team.</p>	<p>This is the estimated time that it takes to assemble a team. Can be reassessed after more experience with this policy.</p>
HERT Draft	<p>Crafton Hills College Paramedic Class 78 paramedic intern Joseph A. Sandoval</p>	<p>Policy</p> <p>2) Activation of a Hospital Emergency Response Team</p> <p>a) The anticipated duration of the incident should be considered in the determining the need for a HERT. Before requesting a HERT, the Incident Commander should take into account that it may be a minimum of 30 minutes before a team can be on scene.</p> <p>-To better utilize the HERT and increase response time, could the Incident Commander activate the HERT when first arriving on scene and assessing the possible need to speed up HERT</p>	<p>No Change Required.</p>

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
		response time. Then have the option to cancel the HERT if not needed.	
HERT DRAFT	Crafton Hills College Paramedic Class 78, Paramedic Intern Garry Lingafelter	<p>POLICY</p> <p>2. Activation of a Hospital Emergency Response Team.</p> <p>b. "The Incident Commander shall contact the appropriate Communications Center. The determination of the appropriate mode of transportation of the team (ground versus air) will be mutually agreed upon.</p> <p>Transportation of the Hospital Emergency Response Team (HERT) should be predetermined to combat extended arrival times. In circumstances where ground transport will extend HERT arrival, air transport should be considered.</p>	<p>No Change.</p> <p>The circumstances/environment will determine the mode of transportation. IC will determine the most effective method of transport at the time of incident.</p>
DRAFT HERT	San Manuel Fire Department	<p>Agree with draft protocol.</p> <p>If this is adopted, it represents a significant new EMS program, so it should be addressed with EMS providers in some structured update format (ALS and BLS as this is something that IC's need to know as well).</p>	<p>No Change Required.</p> <p>Will provide some update.</p>
HERT Draft	Chino Valley Fire	<p>1. B. ii.</p> <p>With a HERT physician on-scene, will medics be permitted to work outside of their scope of practice? Or remain within our current guidelines?</p>	<p>Medics will work within the scope of practice.</p>
HERT Draft	Chino Valley Fire	<p>II. B.</p>	<p>Closest available.</p>

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
		If the appropriate mode of transport is air, will the airship be dispatched on a rotation or closest available?	
HERT Draft	Chino Valley Fire	III. B. If Paramedics work a scene with a HERT team, are we as medics still required to fill out an O1A for our legal documentation? And if so, does the on-scene physician accept all responsibility?	Medics are required to fill out an O1A/ePCR. The HERT Team will document on their hospital paperwork.
HERT Draft	Chris Gerardi Crafton Hills College Paramedic Student Class 78	Principles- 1:HERT should be assembled and ready to respond within 20 minutes of a request with standard life-saving equipment in accordance with the HERT provider's internal policy on file with the ICEMA. -The HERT team should be assembled and able to respond within 20 minutes, they should be identified for each day prior to the day of the shift. A backup team or additional team members should be available in case of a call off of other team members.	No Change Required. 20 minute is the estimated time that it takes to assemble a team. Can be reassessed after more experience with this policy.



April 25, 2012

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Virginia Hastings
Executive Director
Inland Counties Emergency Medical Agency
1425 South "D" Street
San Bernardino, CA 92415

Re: Proposed Revisions to Protocol 6070, Cardiovascular "STEMI" Receiving Centers

Dear Ms. Hastings,

This is a recommendation to maintain the existing language in Policy item 4 and Policy item 7.c.2 in the above referenced Protocol. The reason for this recommendation is the California Department of Public Health is in the process of evaluating, per SB 891 (Health and Safety Code, Section 1256.01), the safety of elective PCI in hospitals without cardiovascular services. CDPH undertook this evaluation in response to published studies elsewhere that indicate favorable results and safe outcomes in a variety of settings, including in hospitals without on-site cardiovascular surgery services.

The SB 891 pilot study and evaluation will continue through August 2013. It would be prudent and appropriate for ICEMA to maintain current language, as indicated above, until at least such time as the CDPH evaluation results are published and the State determines what changes, if any, will be allowed with regard to elective PCI. It seems reasonable that ICEMA would not want to create changes in ICEMA policy at this time that could be contrary to what may result from the pilot program.

Thus, it is recommended that Policy items 4 and 7.c.2 read as follows:

Policy

The following requirements must be met for a hospital to be designated as a Cardiovascular STEMI Receiving Center by ICEMA:

4. Cardiovascular surgical services permit:

This requirement may be waived by the EMS Agency Medical Director when appropriate for patient or system needs. The Medical Director will evaluate conformance with

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existing American College of Cardiology / American Heart Association or other existing professional guidelines for standards. (No change from existing)

7. Staffing Requirements

c. On-Call Physician Consultants and Staff

2. Cardiovascular Surgeon, if cardiovascular surgical services are offered. *If cardiovascular surgical services are not available in house the facility must have a rapid transfer agreement in place with a facility that provides this service. The agreement must be on file with the local EMS agency. Additionally, the facility must have a rapid transport agreement in place with a local transport agency. (No change from existing)*

Thank you for your thoughtful consideration of these recommendations.

Sincerely,



Harvey S. Hansen
Vice President, Professional and General Services

cc Jim Holmes
Lauren Spilsbury

MAY 01 2012