John Slaughter, Chair
County Manager
Washoe County

Kevin Dick, Vice Chair
District Health Officer
Washoe County Health District

Steve Driscoll
City Manager
City of Sparks

Andrew Clinger
City Manager
City of Reno

Dr. Andrew Michelson
Emergency Room Physician
St. Mary's Regional Medical Center

Terri Ward
Administrative Director
Northern Nevada Medical Center

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

1001 East Ninth Street, Reno, Nevada 89512
P.O. Box 11130, Reno, Nevada 89520
Telephone 775.328-2400 • Fax 775.328.3752
www.washoecounty.us/health

MEETING NOTICE AND AGENDA

Emergency Medical Services Advisory Board

Date and Time of Meeting: Thursday, January 7, 2016, 9:00 a.m.
Place of Meeting: Washoe County Health District
1001 E. Ninth Street, Building B, South Auditorium
Reno, Nevada 89512

All items numbered or lettered below are hereby designated **for possible action** as if the words "for possible action" were written next to each item (NRS 241.020). An item listed with asterisk (*) next to it is an item for which no action will be taken.

***1. Call to Order**

***2. Roll Call and Determination of Quorum**

***3. Public Comment**
Limited to three (3) minutes per person. No action may be taken.

4. Approval of Agenda
January 7, 2016 Meeting

5. Approval of Draft Minutes
October 23, 2015 Meeting

***6. Program and Performance Data Updates**
Christina Conti

***7. Updates to the EMS Advisory Board**
- ILS Ambulance Response, REMSA
- ALS Implementation, Reno Fire Department
- Gerlach EMS/Fire Coverage

8. Presentation, discussion and possible approval for distribution the Washoe County EMS Oversight Program Data Report for Quarter 1 FY 15-16.
Heather Kerwin

9. **Discussion and possible acceptance of a presentation on the regional Fire EMS trainings by JW Hodge, REMSA Education and Community Outreach Manager.**
   Brittany Dayton

10. **Discussion and possible approval and recommendation to present the draft map response zones within the Washoe County REMSA ambulance franchise service area to District Board of Health.**
    Christina Conti

11. **Discussion and possible acceptance of a presentation on the proposed use of the IAED Omega determinant codes within the REMSA Franchise area.**
    Brittany Dayton

12. **Update and possible direction to staff on EMSAB assignment of Franchise Agreement review and Mutual Aid process within the region.**
    Christina Conti

*13. **Board Comment**
Limited to announcements or issues for future agendas. No action may be taken.

*14. **Public Comment**
Limited to three (3) minutes per person. No action may be taken.

15. **Adjournment**

Items on the agenda may be taken out of order, combined with other items, withdrawn from the agenda, moved to the agenda of a later meeting; or they may be voted on in a block. Items with a specific time designation will not be heard prior to the stated time, but may be heard later.

The Emergency Medical Services Advisory Board meetings are accessible to the disabled. Disabled members of the public who require special accommodations or assistance at the meeting are requested to notify Administrative Health Services at the Washoe County Health District, PO Box 1130, Reno, NV 89520-0027, or by calling 775.328.2415, at least 24 hours prior to the meeting.

Time Limits: Public comments are welcome during the Public Comment periods for all matters whether listed on the agenda or not. All comments are limited to three (3) minutes per person. Additionally, public comment of three (3) minutes per person may be heard during individual action items on the agenda. Persons are invited to submit comments in writing on the agenda items and/or attend and make comment on that item at the Board meeting. Persons may not allocate unused time to other speakers.

Response to Public Comments: The Emergency Medical Services Advisory Board can deliberate or take action only if a matter has been listed on an agenda properly posted prior to the meeting. During the public comment period, speakers may address matters listed or not listed on the published agenda. The Open Meeting Law does not expressly prohibit responses to public comments by the Emergency Medical Services Advisory Board. However, responses from the Board members to unlisted public comment topics could become deliberation on a matter without notice to the public. On the advice of legal counsel and to ensure the public has notice of all matters the Emergency Medical Services Advisory Board will consider, Board members may choose not to respond to public comments, except to correct factual inaccuracies, ask for Health District Staff action or to ask that a matter be listed on a future agenda. The Emergency Medical Services Advisory Board may do this either during the public comment item or during the following item: "Board Comments – Limited to Announcements or Issues for future Agendas."

Pursuant to NRS 241.020, Notice of this meeting was posted at the following locations:

Washoe County Health District, 1001 E. 9th St., Reno, NV
Reno City Hall, 1 E. 1st St., Reno, NV
Sparks City Hall, 431 Prater Way, Sparks, NV
Washoe County Administration Building, 1001 E. 9th St, Reno, NV
Washoe County Health District Website www.washoecounty.us/health
State of Nevada Website: https://notice.nv.gov

Supporting materials are available to the public at the Washoe County Health District located at 1001 E. 9th Street, in Reno, Nevada. Ms. Dawn Spinola, Administrative Secretary to the Emergency Medical Services Advisory Board, is the person

designated by the Emergency Medical Services Advisory Board to respond to requests for supporting materials. Ms. Spinola is located at the Washoe County Health District and may be reached by telephone at (775) 328-2415 or by email at dspinola@washoecounty.us. Supporting materials are also available at the Washoe County Health District Website www.washoecounty.us/health pursuant to the requirements of NRS 241.020.

John Slaughter, Chair
County Manager
Washoe County

Kevin Dick, Vice Chair
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Washoe County WCHD

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MEETING MINUTES

Emergency Medical Services Advisory Board

Date and Time of Meeting:	Friday, October 23, 2015, 2:30 p.m.
Place of Meeting:	Washoe County Health District 1001 E. Ninth Street, Building B, Conference Room B Reno, Nevada 89512

The Emergency Medical Services Advisory Board met on Friday, October 23, 2015, in the Health District Conference Room B, 1001 East Ninth Street, Reno, Nevada.

1. Call to Order

Chair Slaughter called the meeting to order at 2:32 p.m.

2. Roll Call and Determination of Quorum

The following members and staff were present:

Members present:	John Slaughter, Manager, Washoe County, Chair Kevin Dick, District Health Officer, Vice Chair Steve Driscoll, Manager, City of Sparks Andrew Clinger, Manager, City of Reno Dr. Andrew Michelson, Emergency Room Physician, St. Mary's
Members absent:	Terri Ward, Hospital Continuous Quality Improvement Representative, Northern Nevada Medical Center
Staff present:	Leslie Admirand, Deputy District Attorney Dr. Randall Todd, Division Director, Epidemiology & Public Health Preparedness

Christina Conti, EMS Program Manager
Brittany Dayton, EMS Program Coordinator
Dawn Spinola, Administrative Secretary, Recording Secretary

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3. Public Comment

Chair Slaughter opened the public comment period.

As there was no one wishing to speak, **Chair Slaughter closed the public comment period**.

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4. Approval of Agenda

October 23, 2015 Meeting

Mr. Driscoll moved to approve the agenda as written. Mr. Dick seconded the motion which was approved five in favor and none opposed.

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5. Approval of Draft Minutes

June 4, 2015 and August 31, 2015 Meetings

Mr. Driscoll moved to approve the minutes as presented. Mr. Clinger seconded the motion which was approved five in favor and none opposed.

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6. Program and Performance Data Updates

Staff representative: Ms. Conti

Ms. Conti presented the EMS Oversight Program and performance data updates. She reported that the EMS Statistician had met with regional partners several times to talk about data to ensure that everyone has the same definitions for data, that they are matching up appropriately between all the jurisdictions, and that everything is matched up when PSAP variables come through. The Program and regional partners also agreed which data elements will be sent and then how those will be reported through the data reports.

Ms. Conti reported that she and Ms. Dayton went to Gerlach on a site visit. She commented that Chief Gooch's coverage is impressive. It was an enlightening visit, because they learned more about Chief Gooch's response area, which helps the EMS Oversight Program in its role as Gerlach's oversight support agency. There are a couple of things Chief Gooch requested help with that Oversight staff was still trying to work through, such as agreements with surrounding jurisdictions. Chief Gooch is going into those jurisdictions right now, but has absolutely no coverage and is doing it because he deems it the right thing to do. Oversight Program staff are going to help him through that process.

Ms. Conti reported that the EMS Oversight Program had begun the process to try to obtain hospital outcome data. That would help them to go from PSAP call from the citizen all the way through to discharge at the hospital, looking at those really high impact, high acuity calls of cardiac, stroke, STEMI. Through their meetings, they decided to try to focus only on cardiac to start with and build out later. They are working with Northern Nevada Medical

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Center to draft what it that part of the report might look like, and then they will go to Renown and Saint Mary's to get their buy-in for this process. EMS Oversight staff is hoping that next year's annual report would include hospital outcome information and the purpose of that would just be to help bring regional awareness based on region-specific data, rather than only national level data.

Ms. Conti offered to answer questions about any other part of the program update. Mr. Driscoll stated that in the discussion regarding the Rib Cook-off and the EMS special services, it was his understanding that a third party came forward and it was made very clear that there was a franchise agreement, that between REMSA and local fire services, those special events would probably be taken care of. Mr. Driscoll asked how they would get the word out that third parties would necessarily be entertained when promoters try to bring those people in. Ms. Conti replied that this was an excellent question, and she was not quite sure how to get the word out other than perhaps through the special events meetings that each jurisdiction holds to permit events, and to just encourage event organizers to use their local resources before they go outside the region. It was a shock to the EMS Oversight Program, and it was implied that it was the event organizer that approached the third party vendor. Ms. Conti speculated that this was probably the only avenue available. She knew that City of Reno has those special event meetings and the Public Health Preparedness attends them for hospital partners. She believed that Sparks has similar meetings, but was not quite sure about Washoe County. She suggested that the route to take is through the permitting agency. Chair Slaughter thanked Ms. Conti and Ms. Dayton for going to Gerlach and noted that he had a chance to go there recently and was always impressed about how much that tiny volunteer fire department can do and that they do a great job.

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7. Presentation, discussion and possible direction to staff to present the use of the IAED Omega determinant codes and REMSA's alternative response process within the REMSA Franchise area to the District Board of Health.

Staff Representative: Ms. Dayton

Ms. Dayton noted that everyone on the EMS Advisory Board should have received an email the morning of October 23 with an updated report and should also have a hard copy in front of them as well as the Omega determinants that have potentially been approved by REMSA's medical director. Ms. Dayton explained that an Omega is a 9-1-1 call that is classified through emergency medical dispatch (EMD) as a non-emergent low acuity call that could be referred to the Nurse Health Line. They would receive assessment by an emergency communications nurse (ECN) to determine the most appropriate care or resource other than an ambulance response. She noted that she had a short presentation to demonstrate what the International Academy of Emergency Dispatch (IAED) has done. This was prepared by them and she had made a few modifications so that it would better fit the region. The fourth pillar of the IAED is the Omega protocol and they have created new low-code software that allows any ACE accredited dispatch center to use this process. You must be ACE accredited to use the Omega protocols. So this is an appropriately-structured process that manages lower acuity, non-emergent types of calls to get them resources in the community that are not a lights and sirens response by an ambulance. The protocols were established approximately 15 years ago and are being used currently in both the U.S. and internationally in countries such as Canada and Australia. The process in our region would be that the PSAP would transfer the medical call, REMSA would EMD the call in their medical dispatch. If it met the low acuity criteria, they would transfer the call to the ECN who would ask specific questions and get them the most appropriate care resource, such as scheduling an appointment with their primary care, getting a taxi to the caller's address to take them to an urgent care or primary care, etc. This provides patients with the most appropriate care for

their condition in a timely fashion. It has been proven to be safe and effective measures, and again, she noted that ACE accreditation is required to use this type of process. It improves care and connects patients with the appropriate resources. So what the ECN will be determining is how soon a patient contact should be provided. She noted that if a caller is EMD'd as an Omega and the nurse starts asking questions it is very possible for them to bounce back into the 9-1-1 system and get an ambulance response based on the information they are providing. But it then also looks at whether the patient requires assessment in person or remotely. The patient can have a few different ways to get to their care resource, whether that is by their own personal vehicle, whether it does need to go back into the 9-1-1 system and receive an ambulance response, possibly getting a taxi voucher or using public transportation; there is a variety of options that can meet the patient's needs, whether that is primary care, going to an urgent care, going to a pharmacy to get over-the-counter medicine, going to a dentist, or going to the ER. One thing that REMSA does have in their nurse health line is the directory of services which is a tool to identify resources in the community, including X-rays, hours of service, locations, etc. Again, it would match resources in the community to best fit the caller's needs. She reiterated that ACE accreditation would be required to use this Omega process. Ms. Dayton said that what the Oversight Program is proposing is their tiered implementation plan where REMSA would no longer immediately dispatch ambulances to Omega calls. How this would happen is the call goes into a PSAP, they determine it is a medical call, it is transferred to REMSA who goes through the EMD process and determines it is not a Priority 1, 2 or 3, that it is an Omega. They would then send it to their emergency communications nurse who would go through their questioning and determine which resource is best for the caller. While this is happening, Fire would be notified that this is an Omega and they would cancel as long as they had not made patient contact. It is a tiered response right now, because eventually REMSA will no longer send ambulances even if Fire does get on scene, but until we have an agreement settled between the responding agencies, REMSA would send an ambulance should Fire arrive on scene and make patient contact. So should Fire arrive on scene even though it was an Omega, the captain would call REMSA's dispatch and notify them that they have made patient contact and were on scene, and REMSA would send an ALS ambulance as a P3 response and to release Fire from the scene. Once the form and any remaining concerns about this process have been addressed, then fire agencies will use the form and the verbal confirmation from the ECN that they have established an alternative care pathway to release from scene. Mr. Driscoll said that going back to if a fire agency is on scene and then in order to be released it has to have an ALS medical response which would mean a REMSA ambulance, we would have a lot of discussions before we get this group together and data about the time differential about this Fire resource being on site, so REMSA can go anywhere else and that rig could be hung up for a period of time, including a long period of time, so is there a protocol in place that says we are engaged because we either didn't know in time or it got changed after we engaged that it's Omega, that there is going to some kind of REMSA priority so Fire resource can get back on line? Ms. Dayton replied that currently, it would be a P3 response that could potentially be diverted if there are higher priority calls that come in. Mr. Driscoll asked if we find that unreasonable, how would he deal with that. Ms. Dayton suggested it be discussed in the meeting. Mr. Driscoll told the Chair that he finds that unreasonable, that they are all doing what they are supposed to do in following the system, and they don't have a way, if they don't get released prior, that they are engaged, that Fire rig has needs as well as a REMSA ambulance might have needs. He opined that if that one is engaged it should be finished and the resources should be allowed to go from there. When they get past this, he said he wanted to talk about the agreement. And the sense of priority and what's right to get all those resources back. Ms. Dayton said the reason why this recommendation has changed and she did an update to her presentation to the Board of Health on October 22, is that she reached out to other regions that have Omega protocols that have been implemented for 3-5 years, depending on the agency, and they all suggested to her that Fire can be released from the scene verbally and they have not had any liability issues from that. They discussed that as a region, but our region felt more comfortable using the form release, and it was relayed to her that until that form is finished, they do not feel comfortable using the verbal release and want to use the form. This was an alternative to get

the ball rolling to implement the process so they can start gathering data to see how many types of Omega calls they actually have in this region and how many Fire is going on. Per your region it would be all of them, but for Reno, they might not necessarily be responding to these types of calls. The thought process was that if they did a tiered implementation plan and sent an ambulance while they were still working on the form and the process and getting some of the other issues addressed, they could start collecting data and looking at this, but if that is not an approach that pleases the Board, then we can certainly look at other options. In response to a question, Ms. Dayton clarified that verbal release is from the verbal communications nurse. The nurse would say that this has been identified as an Omega, that they have established an alternative care pathway, they are going to be visiting their primary care provider tomorrow. The reason the nurse needs to release them, and they are actually being released by a higher medical power than themselves, being paramedics or intermediates, depending on the Fire agency. So what they would do on the form is note the emergency communications nurse's identification number, they would note that the person is above 18, is not influenced by intoxications, has the ability to be sound and coherent to make this decision to choose the alternative care pathway. Mr. Dick stated he wanted to go back to Mr. Driscoll's concern about a fire crew getting stuck on scene with an Omega. He asked Ms. Dayton if Omegas are handled as Priority 3 calls and she replied in the affirmative. Mr. Dick asked if potentially every one of those has a fire crew and would be potentially stuck on scene as calls might be diverted to P1s or P2s. Ms. Dayton said yes, except with Reno, potentially. Mr. Dick said that with this Omega protocol that would reduce the number of fire crews that would be responding, because hopefully they would be alerted that it is an Omega call, so this should reduce the number of fire crews that would be stuck at a low priority call. Ms. Dayton said this is true as long as the Omega determination is made before they arrive on scene. It could take several minutes to determine if it is an Omega depending on the situation, so it is possible that a Fire unit could arrive on scene before the determination is made, which is why they wanted the form to be able to release them. Mr. Dick asked Ms. Dayton for confirmation that it is anticipated that with the Omega protocol, it would reduce the number of times that we have a fire crew at a low priority call waiting for a REMSA ambulance. Ms. Dayton replied in the affirmative. Mr. Driscoll said that it was his understanding that part of it is that we all agree that Omegas is the right thing to do and that we should do that, but where we are stuck is when we have engaged, for those that go, and in the Sparks situation, because we are ILS, if we were ALS, which is what REMSA is, that would be a higher level of medical service, that is how we have to get released. We kind of have two ways, either we are released before we get there, but once we are engaged, we either have to have an ALS ambulance show up or there is the suggestion that we have the release form. His understanding is that the hang-up on the form is really an indemnification process, to where it is saying that someone at a higher authority saying it is ok to go, but we are not willing to indemnify the organization that is going from that standpoint. He asked if they were making progress on that legal discussion. Ms. Dayton said they discussed this at length at the October 16 meeting, and it was determined that the people on scene do not have the ability/authority to indemnify, which is what they discussed, and what was determined is that those agencies' legal would get together and make an agreement separate of the form. The legal people will need to discuss and determine whether this is an indemnification agreement or would be an additional insured on REMSA's policy. A statement was made by Kevin Romero that REMSA's legal was briefed this morning and REMSA's legal will meet with the cities' legal. Mr. Driscoll stated that his understanding is that the legal discussion has gotten to that point, and the question is how long it would be for the separate legal minds to all come together. He asked that it be on the record that that is where we are because 1) it is very critical for us to have Omega for the entire area and 2) for those who are engaged and cannot release until a higher medical, if the ECN is the higher medical, it is good. Ms. Dayton said the ECN is a registered nurse, although they don't have eyes on the patient. Mr. Driscoll said that for him, the issue is that whether it is REMSA's ambulance crew releasing or whether it is the nurse releasing, and we are all working within our protocols, he is not sure he understands why there is an indemnification question that it should be easy to do. He stated that they should let the lawyers discuss it and they understand the issues. He opined that it is important to do that as soon as possible, that the Omega program is needed as soon

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as possible, we have made a lot of progress with the 52 out of the 200, and do this as soon as possible. He stated that either way, we could identify the quicker response for an ambulance crew or using the form to let us move on. Mr. Clinger asked if we have a legal opinion on this and what the time frame is. Ms. Dayton replied that they wanted to begin implementation on November 1, however as they have worked on this process, it has been pushed back a little. It would be up to the Board to decide when this starts rolling, because the program is still proposing November 1 for the tiered rollout. So as far as the form being finalized, she has been told by one agency that they are fine with using the form as it is now, but she's not sure if that would be their direction. Mr. Clinger shares Manager Driscoll's concern on the indemnification piece, but he isn't sure he is ready to move forward until that is in place. Ms. Conti reported that from the regional meeting the partners said they would have to get it back through Legal, but it was felt that the form by itself was good and usable, because they agreed that those on scene did not have the ability to indemnify and it would be a separate agreement that was outside of that patient contact, that the patient didn't need to be a part of that indemnification clause in discussion. So the form by itself has already reached a consensus and then just needs to be vetted in their organizations. It is the legal piece and whatever document that ends up being that is the pause. Mr. Driscoll said that he would give his impression and then he would ask his chief to give some detail, but stated an opinion that the indemnification comes from the higher source. It is not the fire resource on scene, it is the person providing the higher level, so it would be by the actions of the nurse that would allow the fire resources to leave, because they are deferring to that, that is the indemnification piece. So if he doesn't understand that properly he would need to have some legal background. He wanted to make sure he wasn't confused. Ms. Conti suggested that possibly Ms. Admirand could advise on this issue, but said that the way it was written on the form was that REMSA as the authority was indemnifying the City of Reno Fire Department and City of Sparks Fire Department, and so that was the nurse by her actions might be saying that was ok, but she was not at a level to indemnify them. The authority has to give her that authority, and that's what is not there right now. Mr. Driscoll said he feels that it is the action of the nurse and them following that action, that if there is a legal issue, then REMSA as the organization providing higher authority will take on the legal battle thus indemnifying Sparks who will not be involved in the legal battle. It is the authority in the field that may need indemnification later. His point is that because of the resource and REMSA's expertise as the higher medical, that if by the eyes on the ground, talking to the nurse, the nurse understanding the situation through EMD and other processes, there is a point where a decision is made that we can release. The Sparks jurisdiction says that when we rely on that and the higher source, usually after the fact, REMSA would fight the battle based on their expertise and we would step aside. Ms. Conti said that from discussions, that is exactly where the discussion has gone, and the only point was that the form itself that was a patient communication form as well as an internal form, and that's why it was felt that the indemnification language didn't need to be included on that form, that the patient was part of it and it needed to be something separate. She stated that how Mr. Driscoll was explaining the situation was also their understanding. Mr. Clinger asked if the form without the agreement on the indemnification was worthless. Mr. Driscoll said that whether the language was on the paper or in the agreement, there has to be a formal agreement that if we follow certain steps, then there are certain protections for those agencies. Mr. Driscoll requested that Chief Maples weigh in. Chief Maples, Division Chief of Sparks Fire Department, said that the form was created in a meeting held by three fire chiefs, representatives of REMSA and the Health District. Included in the original form was an indemnification clause by REMSA for the fire agencies that were responding. He gave that form to the City of Sparks legal counsel who reviewed it and said it would be an acceptable form for Sparks to use. In a subsequent meeting, REMSA indicated that they were not willing to do the indemnification clause. That is kind of where it stopped and that is when they came up with the tiered response, that until there is an agreement on the form, Fire will respond to the Omega calls and REMSA will not respond to them. As a fire chief, he is concerned that under those circumstances, they could be stuck on scene for a longer period of time than they are now. It seemed to him that while they are all in favor of implementing the Omega protocols, the first step should be resolving the indemnification issue, and if that could be done quickly, the

protocols could be implemented quickly. If not, then they will need to figure out if Sparks is comfortable signing some type of release without REMSA's indemnification. To him, the legal issue should be resolved first and then go from there. Mr. Dick asked Kevin Romero with REMSA if he could provide some additional information. Mr. Romero said that REMSA's legal team looked at the patient form, which they considered just a patient form, and in working with Leslie Admirand, concluded that the patient cannot indemnify nor can the nurse or firefighter, who are the only three people that sign that form. So what they had was an operational form for the patient and then they have the track of additional insured or indemnification which they decided as a group the legal teams needed to look at to figure that out. To not delay the process of the Omegas, which he agrees is an important process to them right now; we decided that they would respond that ambulance should the fire department get on scene in those occasions that are the 10%. For 90% of the calls, they will be notified that it is an Omega call and they can cancel the response. There is that 10% of calls that they may be a short response and they may get on scene prior to the determinant of an Omega. At which time once they arrive on scene, REMSA will then initiate a response from the ambulance. So there is no need if an ambulance is responding to have this indemnification to start this process. The legal teams can work on that, because you will have the higher medical authority on scene to relieve that fire engine. For the question about the response times, whether it is a Priority 3 or whatever it may need be, remember that 90% of those calls will go away because they are currently classified as Priority 3, and in your cities you will receive an engine response, so you will have less of those calls than you currently have where you are on scene waiting for an ambulance response. To reprioritize is probably not the best idea. You do not want to take a Priority 3 non-emergent response and make it a lights and sirens emergency so that we can get off scene quicker, because that's when you come into the case where you have a cardiac arrest just around the corner and you probably should have been treating that patient rather than the low acuity Omega. Mr. Driscoll thanked Mr. Romero for the clarification. Mr. Driscoll said the question he asked before was that they engaged prior to knowing it was an Omega. It has now been determined to be Omega, your operating protocols now allows you to go all sorts of other calls that are of a higher priority than Omega that could possibly have a resource stranded until you can get to them later. The fact that it started under one priority, if you will, what assurances can our jurisdictions have that you are going to finish that as if it was the original priority which is why a fire resource was engaged. To let them be done, you can then do what you need to do. If it's now an Omega, you can release whenever you want, but you have released the other resources first. What assurances does this body have that you are going to give it that priority? Mr. Romero responded that once it requires an ambulance response, it is reclassified back into the 9-1-1 system, back in the EMD as a Priority 3. So it is treated just as all Priority 3s are currently treated right now. So it will receive an ambulance response. It can get diverted as a low acuity non-emergency response. But currently in your city, we go to all those Priority 3s and all those Omegas, so there will be far less that your engine will be responding to and even less that your engine arrives on scene before the determinant has been made as an Omega. Once that ambulance arrives on scene with that Priority 3, then you are released from all liability, you have handed off to a higher medical authority. Mr. Driscoll said he understood and agreed with Mr. Romero's statement. Ms. Admirand commented on the form which is a patient consent and release of liability form. Having the statement in there that REMSA would indemnify the fire department does not create a binding duty on REMSA to indemnify Fire. It needs to be a separate legal document that is signed by REMSA as one party and Fire as the other party to create that duty on REMSA. Those were the thoughts behind removing that sentence from the patient release of liability form. Mr. Driscoll responded that he was not concerned about the language on the patient form, but that as he understands it today, there is no other agreement, and therefore to go forward with Omega protocol, for which his agency has to defer to a higher medical, they are going to get stuck and not be able to do anything. If they do walk away, the higher medical is not going to protect them, because they do not have whatever form it needs. He is not concerned about the language on a patient form. What he needs for his jurisdiction (and assumes for the other jurisdictions), somehow whatever the formal process is that says his agency is require to defer to a higher medical source, and when they do defer to a higher

medical source, are they going to take on the service of providing his jurisdiction with legal indemnification to fight the battle if something breaks. He wants to go forward with Omega, but is not willing to put the risk management back on his jurisdiction when it is as simple as deferring to REMSA to protect them, but he does understand the lawyers must agree. Mr. Dick requested an update on what occurred at the District Board of Health on October 22 on this topic. Ms. Dayton noted that she had presented the Omega topic to the District Board of Health before presenting it to the Advisory Board because of the potential implementation date of November 1. They normally would have gone to the EMS Advisory Board first. The District Board of Health tabled the item until receiving direction from the EMS Advisory Board. She will move forward with whatever direction is given to staff by the EMS Advisory Board. Mr. Dick reiterated that the item was tabled at the October 22 Board of Health meeting and that the proposed action at that meeting was contingent on the action by the EMS Advisory Board at the October 23 meeting, so it was not at all an attempt to preempt the Advisory Board. Mr. Dick expressed concern that the issue may be resolved in the coming few months, but it may then have to wait too long for the next regularly scheduled EMS Advisory Board meeting, thus delaying approval. He asked if there was a way of approaching this that would provide some ability for the District Board of Health to move forward based on the EMS Advisory Board providing their recommendation on what should occur for this to be implemented. Mr. Driscoll thanked Mr. Dick for his comments and stated he would be prepared as a member of the Board to participate in a meeting regarding the indemnification issue at the call of the Chair to be held as soon as possible and not defer the issue until the next quarterly meeting.

Mr. Driscoll moved to continue this item until the legal issue can be resolved. Mr. Clinger seconded the motion which was approved five in favor and none against.

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8. Presentation, discussion and possible approval for distribution the Washoe County EMS Oversight Program Data Report for Quarter 4.
Staff Representative: Ms. Kerwin

Ms. Kerwin noted that the purpose of the data report is to monitor the response and performance of EMS system wide, provide an analysis of system data and outcomes, and a general analysis of any additional items that partner agencies may want them to explore. It is hoped that regional decisions would be based upon those data.

There were two changes of note for Quarter 4. The first is that they now receive the PSAP time stamp for two of the three fire dispatch agencies, and the third has plans to come on board shortly. This provides them the time stamp of when the call first came in and the initial incident was created in the system. The second change is that they started receiving the Priority 9 or Omega calls, so they can now look at those numbers. These are calls which would have been or they are EMD'd as Priority 9, although the response is reflected as a P3. She referred to the tables showing the median response times. She reminded that they chose medians, because they are not affected as much as an average would be by the outliers, those calls that would be irregular. Ms. Kerwin presented a PowerPoint presentation that showed that the differences are not great between the City of Reno, City of Sparks and the unincorporated areas of Washoe County, and also showed that they are separated out as Priorities 1, 2 and 3, and then Omega or P9. She then said they will continue to watch agency performance relative to national standards, not just using the response times, but some other time stamps that they can start to utilize, and the changes for their agency response to those P9s. In her presentation, she pointed out a table that provides how the call moves through the system from the initial call. Alarm time is used for the jurisdiction for

whom they do not receive a PSAP time stamp, because that is the earliest time stamp available from Fire that can be utilized. The initial call could come through REMSA or through the Fire PSAP. The majority of the calls do come from the Fire PSAP, but this shows the interval from the initial call to Fire dispatch to REMSA's clock start, fire arrival and REMSA's clock stop. The EMS staff wanted to look at the impact of the delayed dispatch, which is when Fire's dispatch time occurs after REMSA's clock start time. They wanted to find out if it really impacts the patient when REMSA's wheels are rolling before Fire's. Ms. Kerwin pointed out the data relevant to this topic. The impact to a citizen if all calls had been Fire dispatch time first is a 25-second delay, for City of Reno there is a 15-second delay in response to the patient regardless of who arrives there, and then for unincorporated Washoe County, there is a 54-second delay. They also wanted to further explore all calls that have a delayed dispatch. They looked at those calls in which REMSA's clock start occurred before Fire's dispatch time. The idea was that all types of priorities would be impacted relatively equally. They found that P2s are more often impacted by delay in dispatch than other priorities. That was the only interesting finding from exploring those calls in delayed dispatch. They either enhanced or modified a few of the special interest areas with REMSA and explored those Omega calls further. TMFPD wanted some additional analysis for all stations, so EMS staff broke it down between the north and south batallions. They were able to include data from Gerlach's volunteer fire department as well as from the Pyramid Lake tribal lands. They now also have data to look into the Mt. Rose corridor areas. Mr. Driscoll made an observation on the top table of Page 50 of the report regarding the breakdown of the P9 calls where they talk about not sending ambulances. He found it interesting that 69% of the P9 calls end up in transport. He said he would be watching that one in reports to follow because that is a different story, in his opinion. Mr. Dick requested clarification on this report and on the annual report regarding the P9 Omega calls. He asked if those are the 52 determinants that Dr. Lee identified, or are they all 200 of the Omega. Ms. Kerwin replied that it is the 52 determinants. Ms. Conti clarified that those are receiving the ambulance response and not going through the Nurse Health Line. They are still going as if nothing has changed in the system; it just allows EMS staff to see how many calls there could be. Mr. Dick commented on Mr. Driscoll's comment regarding the number of Omega calls. He is aware that they have users of the EMS system who merely need transportation and not an ambulance, and this may contribute to the number of Omega calls. There were no further questions.

Mr. Clinger moved to accept the EMS Oversight Program Quarter 4 data report. Mr. Driscoll seconded the motion which was approved five in favor and none against.

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9. Presentation, discussion and possible approval for distribution the Washoe County EMS Oversight Program Annual Data Report.
Staff Representatives: Ms. Kerwin and Ms. Conti

Ms. Conti stated that the EMS Oversight Program was looking for ways to make the Annual Report more meaningful and different from the quarterly reports. They decided it may be beneficial to apply the national level standards to our region. Ms. Conti shared information learned from consulting with the National Fire Protection Association (NFPA) regarding Section 1710, because the NFPA provides these standards nationally. Section 1710 establishes minimum requirements for the organization deployment for services by career

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fire departments. The NFPA stated that these career fire departments should establish their own performance objectives, but they should be no less than 90% for the achievement of both turnout time and travel time objectives that are specified in 4.1.2.1. Their requirements are based on the general understanding that if someone has stopped breathing for 10 minutes, irreversible brain damage can occur. It is then critical for personnel trained to a minimum of the first level responder equipped with AED to arrive on scene and initiate life-saving measures within 10 minutes. They further stated that with their time stamps, the first responder would arrive on scene within seven minutes into the call, well within the 10 minutes for brain damage, and the ALS unit would arrive on scene approximately 10 minutes into the call for continued life care. Ms. Conti noted that from the fire partners' perspective and from REMSA dispatch's perspective, they were able to utilize the NFPA 1710 standards and for response were able to use the REMSA franchise agreement response map zones as listed in the report.

Ms. Conti presented a review of the Annual Report. There are four sections of the report. Section 1 looks at REMSA as a whole including all calls for service. The ambulance assignment time is outlined in NFPA. Section 2 looks at those calls that are matched and those used for analysis. Not all matched calls are used for analysis, because all the appropriate time stamps might not be included. Those were then broken down by priority. Section 3 looks at the median response times by zone and then by priority. Section 4 looks at the differences of arrivals between the median response times. While they do not always like doing comparative statistics, they help EMS Oversight staff see what the system is like in the region.

Ms. Conti stated that there are now 12 months of baseline data which provide a first opportunity for the region to really look at what is going on. It allows a way for agencies to internally look at their policies, processes and procedures to see if there is anything of relevance to them. As Ms. Kerwin mentioned earlier in the meeting, it also allows the region from a system perspective to build upon successes and look at areas of improvement and then develop those improvements as supported by the data. The EMS Oversight Program also recommend changing the quarterly reports to be more like the Annual Report. During the first year, the EMS Oversight Program answered a lot of questions from the Board and others, but now they are taking somewhat of a different direction, always comparing themselves back to the regional standards. Future opportunities highlighted by this report include dispatch, the inclusion of dispatch personnel and data for all the regional planning, as well as their data elements. It has been discussed that the region can build upon the regional-specific data gained from hospital outcome data for the purpose of community education and outreach and responder education and trainings. Changes can be based on the data. The data can prove that something needs to be enhanced, improved or changed dramatically. There are four things the region is discussing right now, and with this baseline data, it is possible to evaluate and potentially quantify those positives, and if they happen to be negative impacts, implement new things. Ms. Conti requested that Ms. Kerwin join her for possible questions.

Mr. Driscoll noted that the visuals demonstrate very well that there was a lot of time and effort put into the report and a lot of discussion of what to include and how to do it. If the quarterly reports become more like the annual report, it would provide continuity of reports, and they would have the ability to follow what is happening. Mr. Driscoll noted that he would entertain the idea of having quarterly reports look more like the annual report as long as the EMS Oversight Program maintains the ability for a jurisdiction to deep dive into the

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data. Ms. Conti responded that per the Inter Local Agreement, the EMS Oversight Program exists for them, and it would be the Program's privilege to help agencies with any type of statistical analysis, whether it is something they usually do or a special request. Because the code is written, the EMS Oversight Program can always run the full analysis report, but a 100-page report may not be necessary each quarter.

Mr. Dick noted that he found a typographical error in the report that he would show to Ms. Conti after the meeting. He expressed pleasure at the phenomenal number of calls matched in the fourth quarter (see Page 9 of Annual Report). He asked why Truckee Meadows Fire matches were lagging so much. Ms. Kerwin responded that the addressed for unincorporated Washoe County are often on rural or dirt roads. She often uses the date and initial time, allowing a two-hour window period when looking at a call in REMSA's call logs to match with Fire, and the address. They determined that some of these calls were outside Washoe County, such as Highway 34, and determined they would not be reported for Washoe County data for REMSA. They could not locate some of the addresses and that is the primary reason the numbers are lower. Ms. Conti explained that when Ms. Kerwin took over from the previous statistician, she removed some information from the addresses, such as street suffixes (place, drive, etc.) so that the system would not be searching for a specific suffix. Those subtle changes in Ms. Kerwin's methodology had made a difference.

Mr. Driscoll noted that there has been a lot of discussion by the agencies regarding geotagging. Sparks will be using geotagging with their business licenses and building permits. The AVL is a geotag capability. He asked if the three determinants currently used by the EMS Oversight staff might be replaced at some point by the geotag as a better tool for matching all the way through, because the geotag would be very precise and it would not matter if it were Highway 34, for example. Ms. Kerwin responded that if he were referring to latitude and longitude, she believed that that is based on the exact location where a unit stops. It may help if a vehicle is stopped across the corner. But the software and the code that she currently uses for analysis look for exact matches. It still would not be a hit unless the vehicles were on top of each other. She could do some rounding but would have to consult with the GIS department to make sure she is applying it properly. Mr. Driscoll noted that there are tools that would help. Ms. Kerwin noted she would look forward to learning about these tools.

Mr. Driscoll moved to finalize and distribute the EMS Oversight Program Annual Data Report. Mr. Dick seconded the motion which was approved five in favor and none against.

Ms. Conti noted that they will fix the typographical error prior to sending out the Annual Report.

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10. Discussion and possible approval of presentation on the progress of revising the response zones within the Washoe County REMSA ambulance franchise service area.
Staff Representative: Ms. Conti

Ms. Conti reported that since the last meeting of the EMS Advisory Board, considerable work had been done on the Washoe County response zones. She presented to the EMS Advisory Board a modified version of the presentation given at the Nevada GIS conference. She had given the presentation at the request of Gary Zaepfel of Washoe County GIS, who she stated

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was an integral partner in this process. Ms. Conti referred to the current map and explained that everything prior was either incorporated in through city annexations or the work group to determine if it met a criteria to become part of an A, B, C, or D response. The issue was brought to the Board at the last meeting with the objective to revise the current map and then develop and utilize a single methodology for developing and revising response maps.
The EMS Oversight Program and Mr. Zaepfel went to San Joaquin County for a site visit. San Joaquin County is set up similar to Washoe County with a fire-based EMS and a private ambulance transport provider who also does the EMD. Their phone call goes into their primary PSAP and they transfer it over just like it is done here. What is different is that the primary ambulance company contracts back with some of their regional fire partners and then dispatches the fire response partners, so that those jurisdictions are only going to fire responses that they want to go on. Stockton is the only area within San Joaquin County that dispatches their own fire units. San Joaquin County' methodology considers that data is important but also must be rational. They travel the County to ensure that the boundaries are appropriate. That is something that this region can take as a great idea and do the same when they get to the point of GIS coding response areas. On that trip, they also met with Inspironix, the contractor for the EMS Oversight Program. They discussed the project and methodologies, including developing and revising the map. Inspironix provided ideas for the Oversight staff to bring back to the region. They sat down with all the regional partners and came up with a proposed development methodology for maps. Using the census data as the driving force, not initially doing call data knowing that every citizen has the opportunity to use 9-1-1, and also splitting it out for the population for urban, suburban, rural, and wilderness. They ended up looking at three different definitions. Mr. Zaepfel took those definitions and ran the census data with it and produced a lot of maps to help visualize. The region decided to go with the ESCI designation. She pointed out the colors that match to a map she would show later in the meeting. They decided upon the ESCI is because there have been other studies done in their region using the ESCI classifications. This allowed them to stay with previous work and not deviate from that. Ms. Conti pointed out what the community would look like. They have a lot of metropolis areas based on their designations. She offered to share the maps produced by Mr. Zaepfel. They then looked at call volume. Inspironix noted that in addition to looking at the population base, they would overlay the call volume as a double check that there are no pockets within the region that have no people but a huge amount of calls. What is important with that is that there was no area in the region that was taken away from a higher priority response. If they didn't have call volume but had population, the graph shown on the right is all the calls plotted out. This ensures a consistency in the process as a double check. The region then came up with the draft methodology for what a revision could look like. They recommend that annually they map out all calls for the year using latitude/longitude. They ensure that consistently where the people are is where those calls are, that there are no pockets showing up that have a lot of call volume. They thought that at the five-year review, they would recommend getting the population density from the State Demographer. Evidently, at the five-year mark, the State Demographer takes the census data and then updates it to the best of their ability. This information would be used to make sure there are no areas within the jurisdiction that suddenly have a lot of population. They subcommittee of partners also recommended that they use the census again at the 10-year revision as if they were starting brand new and go through that process all over again. What is specific to this region is that there are islands of population in the region and this creates challenges in determining a consensus for response. There might be a lot of rural area and suddenly a densely populated area pops up. Inspironix recommends that the region follow San Joaquin's practice that three borders need to be the

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same response area for it to be defined as contiguous. This region determined that it also would like contiguous for the initial draft. The other challenge we have is the expectation of urban response by people living in a rural area.

One method Inspironix used to show the amount of calls was to use a heat map. When it is darker in color, there were more calls. Ms. Conti pointed out the various zones as indicated by color. There were three areas of concern by the region: Spanish Springs, Cold Springs and South Reno. All else on the map was deemed to be a great depiction of what a response could look like. In the first meeting, they were able to reach consensus with Spanish Springs, so they have recommended altering that one, following the street lines to increase the Zone A areas. In the meeting last week, there was consensus about Cold Springs. She pointed out an area that would become a B response as recommended and the rest will stay as Zone C. Then the other part where A dropped down will stay with the recommendation of B. They will get the map for the Board at a later date when it is developed by GIS. They are still working through the southern region. Ms. Conti asked Inspironix to take another look at the region's data to see if there were any other potential response makeups for the southern portion. If there are none, that is fine, but if there are other options, it would be good to see.

Dr. Michelson asked if, in general, Zone A was enlarged. What is the expected effect on the expectations for EMS? Ms. Conti responded that it drops down and skinnies up. The EMS Oversight Program asked GIS to look at it, and from a square mile perspective, there is a one-mile difference. There is concern about the impacts of the maps. The region has not yet done an impact analysis as recommended by Inspironix, because they need the map to be drafted out to include the impacts.

Mr. Dick asked if they had analyzed what the difference would be for the calls in Zone A in the existing map vs. the calls in the new Zone A. Ms. Conti responded that they have not, but will take a look at it. One of the proposals for the implementation phase is to code out what that shape file will look like and start dropping them in, and then they can pull those calls. They are working on calls from March 2014-March 2015, so one of their challenges is that they have nine months of data that they can match back to all partners, so they cannot do a complete look. They would like to do that with current data once they have a possible draft.

Mr. Clinger moved to approve the presentation on the progress of revising the response zones within the Washoe County REMSA ambulance franchise service area. Mr. Driscoll seconded the motion which was approved five in favor and none against.

Mr. Dick let staff know that he was pleased with the progress being made with the new map. They had originally talked about making changes to the old map, and there was a suggestion made that they should just look at the whole population. He thought this was a great path for the region.

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11. Discussion and possible direction to staff regarding investigation outcome referencing mutual aid requests permissible under the REMSA franchise agreement.
Staff Representative: Ms. Conti

Ms. Conti handed out copies of the Inter Local Agreement to the Board to refresh their memory regarding the EMS Oversight Program's duties. Article 1 of the Inter Local Agreement lists the duties of the program. This Article gives the Program the authority to

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monitor the response and performance of each agency providing emergency medical services and provide recommendations to each agency for the maintenance and improvement and long-range success of EMS. Article 4.1a lists the duties of the signatories in the Inter Local Agreement which is to provide information, records and data on EMS services' dispatch response from their respective PSAPs and Fire services, and review, study and evaluation of the District.

As part of a way to meet their duties, they would be asked to investigate complaints about partner agencies, whether it is the way a call was handled, a complaint from a citizen, etc. The Oversight Program needs a protocol in place that all the jurisdictions would be aware of, so they created the investigation procedures and expectations of EMS agencies that was handed out to all the agencies and signed by the Inter Local Agreement and REMSA on October 30. They also provided a courtesy copy to North Lake Tahoe Fire Protection District, even though they are not a part of the franchise service area or ILA, because they are a partner within our region. They also provided a copy to Chief Gooch, who is far removed from our region but might also be impacted. The procedures outline the Oversight Program's responsibility and steps. She noted that Item 3 on Page 2 states that if an investigation occurs and if deemed necessary, the EMS Oversight Program will present the investigation and findings to the EMS Advisory Board. The Program updates usually show those investigations that the Program has either been formally conducting or that they have been made aware of that are agency to agency.

Ms. Conti brought forward an issue that came to the Program that resulted in an investigation and determination by the Program. One of the parties did not agree with the review by the Program, so Ms. Conti brought it to the Board for discussion and decision. What was alleged is that Reno Fire Department was requesting mutual aid outside of the region for an ambulance transport within the Washoe County Franchise Service Area. The EMS Oversight Program initiated an investigation on May 22 and sent the information to Chief Cochran and Jim Gubbels. When the Program received everything back, they were able to line out what the call looked like based on audio logs and dispatch. It was their determination that it did in fact happen, and it is REMSA's responsibility, per the Franchise, to request mutual aid for ambulance transport, not a fire partner's responsibility, because the Franchise Agreement gives REMSA the exclusive right to transport. As part of that exclusivity, they can have mutual aid agreements. This was the Program's and Legal's interpretation. The Program sent letters with the findings back to the two impacted partners. Ms. Conti stated that Chief Cochran responded that that is not the City of Reno's interpretation of that clause, that they are able to have a fire partner request mutual aid from one of their partners that can provide ambulance transport. Ms. Conti, with the permission of the Chair, turned over the podium to Chief Cochran.

Fire Chief Dave Cochran of City of Reno recognized Tom Dunn who was the captain on Engine Four that day when the incident occurred that was the subject of the complaint. Engine Four had a patient in need of transport and they made several requests to REMSA through their dispatch for an ETA. They were on scene over 31 minutes, and REMSA reported that they did not have an ambulance available. So through his Battalion Chief, Firefighter Dunn requested mutual aid, and that prompted this complaint. Chief Cochran expressed his disappointment that when they made a decision that was best for the patient, it prompted a complaint against his department. That in itself needs examining. His objection was with the idea that only REMSA can request mutual aid. The idea that they have the

exclusive right does not appear in the language of the Franchise Agreement. A logical conclusion is that if Fire asks REMSA for mutual aid through their dispatch and they say no, there is no ability to transport the patient. Before one thinks this could never happen, this did happen two weeks later on May 30 when they made a request through their dispatch to REMSA who did not have an ambulance available and denied the request. Fortunately, that did not result in a negative patient outcome, but the fact that it could happen, and in fact did happen, is problematic. On an even deeper level, they should look at the idea of mutual aid under this agreement. He stated he was aware of the focus of the agenda item and is not trying to go outside of that, but if REMSA has a mutual aid request, we have North Lake Tahoe, maybe Storey County or Carson City. He does not think anyone in the room would be satisfied if they called 9-1-1 and were told they are getting mutual aid which is 25 minutes or half an hour away. He urged the board to examine other alternatives in conjunction with these issues that have been exacerbated or illuminated by this complaint. It prompts some questions that he urged the Board to look at and possibly consider other support alternatives for REMSA. This is not to say that REMSA's rights should be impaired, but maybe they should all examine those areas where they can offer help. Chief Cochran stated that he and Firefighter Dunn were available for questions. Mr. Clinger commented that as a city, they have the ultimate responsibility to the citizens for public safety, whether it is police or fire. They have delegated that authority to REMSA to a certain degree. However, at the end of the day, if they make a determination that REMSA, for whatever reason, cannot or will not show up, he opined that they have the right and obligation to the citizens to address that issue. In this case, that is exactly what they did.

Mr. Dick asked if it would be appropriate to provide REMSA an opportunity to respond from their perspective on what happened. Chair Slaughter asked Chief Cochran if he had anything to add. Chief Cochran responded that he had nothing else to add but would remain available for questions.

Mr. Kevin Romero stated that he agreed with everything Manager Clinger and the Chief of the Reno Fire Department said. It is important that there is ambulance transport for patients who require immediate transport. They have set up their region as a tiered system, whether it is fire based or private ambulance-based. One can go to Carson City, and if the engine is on scene and the patient does not require immediate transport and other calls are pending, they wait. Unfortunately, we must have the ability to divert an ambulance from a non-life threatening emergency to a life-threatening emergency. That is what happened in this case. The ambulance was diverted to a higher priority call to someone who required immediate ALS attention. This is an example of the things they are trying to do in this region with the assistance of the EMS Advisory Board with the implementation of Omegas and other means of ambulance transport, other than it always being an ALS-level transport to somebody that may require BLS-level service. He stated that REMSA's goal, which he had communicated to the Fire Chiefs of the region multiple times, is to decrease the amount of time that they are on scene with the patient. Unfortunately, and he did not know the exact length of time this was, sometimes those are 20-minute response zones, and they are getting complaints from the fire department after 25 minutes. Then REMSA arrives on scene soon thereafter. The reason for this is that they are diverting to a higher priority call. REMSA's policy is to request mutual aid to any life-threatening emergency. If it is in the south, they request aid from Carson City, for the Galena area, the request is to North Lake Tahoe, and for Verdi, they would request aid from Truckee. The minute they take an ambulance out of service in Carson

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City for a non-life-threatening emergency, and an emergency occurs in Carson City, there will be a bigger problem there.

Tom Dunn, Firefighter and Acting Company Officer for Reno Fire Department, provided pertinent details of the case. They were dispatched at 8:19 am to a location which is within REMSA's Response Zone A in metropolitan downtown Reno. The distance from Saint Mary's, the closest hospital, was approximately three road miles. So in talking about response times, they were not talking about a 20-minute response area, rather something in downtown Reno that REMSA is required to respond to under their Franchise Agreement. They were dispatched at 8:19 am and arrived on scene at 8:25 am. He pronounced on the radio that there was no REMSA ambulance on scene. At 8:31 am, six minutes after making contact with the patient, he requested an ETA for REMSA. Everything is documented within his incident narrative as well as his patient care report that they had a patient who in their estimation was worsening. They were dispatched on a call of altered level of consciousness, which was not the patient they arrived on. They arrived to a patient with abdominal pain with a serious medical condition, which is why he asked about the ETA for REMSA. At 8:34 am, which was approximately eight minutes after arrival on scene, REMSA advised Reno dispatch that there were no ambulances available at that time. He notified their dispatch that this was going to be a Priority 2 abdominal pain, which by REMSA's Franchise Agreement and protocols, would allow them to divert to a higher priority patient. Based on the questioning of why there were no ambulances available, a request was put in for mutual aid which was in the best interest of the patient. If REMSA's concern is that the City of Reno Fire Department requested mutual aid, and according to the investigation that was done by your committee, REMSA not only diverted an ambulance one time, but diverted an ambulance three times. Three ambulances were diverted before a request for mutual aid was put in. More importantly, if REMSA diverted three ambulances to a call in downtown Reno, according to REMSA's Franchise Agreement and exclusive rights to serve, why didn't REMSA request mutual aid from a mutual aid partner at that time? At 8:35 am, the Battalion Chief on duty requested mutual aid for an ambulance from either Carson Fire or Incline. This was 10 minutes after patient contact by Engine Four. At 8:49 am, 25 minutes after his crew made contact with the patient, the family members arrived on scene which the patient had requested using her cell phone, and the family transported her to Saint Mary's Hospital. At 8:51 am, REMSA was finally cancelled by Reno Emergency Communications, which was 32 minutes after the patient called 9-1-1 for help. Ultimately, no ambulance arrived on scene. Engine Four was on scene six minutes with the patient that they knew needed an ambulance for transport and they asked once again for REMSA's ETA. Once again, 10 minutes after the first patient contact, mutual aid was requested because it was in the best interest of the patient. Carson Fire is an ALS and transport fire agency. If there is no ambulance available in Carson, the patient just does not wait. Carson Fire has the ability to place a mutual aid request either to REMSA, Incline, Tahoe, Douglas, or East Fork Fire Protection District. They are the same as anyone else, as they can request mutual aid on a case-by-case basis.

Chair Slaughter asked if a mutual aid request from Reno Fire was made for either Carson or North Lake? Mr. Romero responded in the affirmative. Chair Slaughter asked Chief Mike Brown of North Lake Tahoe Fire Protection District if he was aware of the situation. Chief Brown responded in the affirmative. Chair Slaughter asked what his protocol was in this same situation. Chief Brown responded that they have a move-up process with automatic aid with their partners. Once they drop to a certain level with their ambulances, they bring in North Tahoe, Tahoe, Douglas, Carson City, East Fork, even REMSA. They have agreements with

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them. They would utilize them anytime they need to. Chair Slaughter asked if in this case, it was a mutual aid request and it was their choice to roll or not to roll. Chief Brown responded yes, that they have rolled. Mr. Dick asked Chief Brown if those mutual aid requests were all for priority calls. Chief Brown responded in the affirmative and added that mutual aid has been discussed in this community for quite a while, but they treat it just like automatic aid mutual aid. When they get a call and have the resources available, they honor those. If someone does not have the resources, they can turn down the request and the requester will go to the next provider. Mr. Dick further asked Chief Brown if their agreement with REMSA for mutual aid is that they could call REMSA in for a priority 3 call who would respond if an ambulance were available. Chief Brown answered in the affirmative and added that they have called for assistance from REMSA and also been told no because of their draw down. The same thing has happened with them to REMSA and with other providers.

Mr. Romero stated that the Captain was correct, that this call was in Response Zone A, which was in the core of the system. But that does not mean it was an 8-minute 59-second response. It was a priority 2 response, so it was a 15-minute 59-second response. Additionally, he mentioned that there were three diverts. If there was a concern with the patient deterioration, they could have upgraded the call to a Priority 1 response. The Fire Department is well aware that REMSA can divert an ambulance on anything other than a Priority 1. That could have been figured out at the beginning. He reminded the Board that when the lower acuity patient arrives at the hospital, they may not get a bed or immediate medical care, but may go to triage for 2-6 hours. The hurry to get them off scene is important to free up the Fire Department resource. He understands the concern and they are trying to address those concerns with lower acuity patients, but at no time did they make this a life-threatening emergency. Chair Slaughter asked Firefighter Dunn to clarify if his concern on this case was releasing his resources or patient care. Firefighter Dunn responded that he was not concerned about leaving the scene, but was concerned with patient care based on the chief complaint and their assessment they did with the patient in the field. Other pertinent facts in the case, other than the time line, included the weather, as it was a cold and windy day and was about to rain. They had concerns about the environmental hazards and concerns about the patient. He commented that Mr. Romero had said they could have upgraded to a Priority 1, but he said he would have been abusing the system to do that, as the patient was not in cardiac arrest, respiratory distress or respiratory arrest. Once again, they are talking about getting a patient from the point that they call 9-1-1 to definitive care. Regardless of whether or not it was a Priority 1 or Priority 2 call, if it is six minutes, eight minutes, 15 minutes, the bottom line is that it was 32 minutes after calling 9-1-1 for help, and no ambulance was available to take this patient to the hospital, and ultimately, the patient was transported by family members. Mutual aid was requested in the best interests of the patient, based on the medical priority of the three EMT Intermediates and the EMT paramedic that were on scene with the patient.

Chief Cochran noted that the details of the call are very important, but he did not want to lose sight of the fact of the bigger picture that he introduced at the beginning. When they have this situation, what is the fall back? They had the 32-minute scene time with ultimately no transport. Chief Cochran recalled that Chief Brown, as the Board heard earlier in the meeting, is more than willing to provide assistance, as is Carson. But when that situation arises, and there are no resources available, as happened in the current complaint and with another complaint that is being investigated by the Oversight Program, should they look at the system to determine a better way to handle these, given the parameters they have heard and issues that were raised in the Board meeting that afternoon? Mr. Clinger advised that it seems they

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are trying to balance doing what is in the best interests of the patient with REMSA's concerns about a jurisdiction's ability to call for mutual aid and not wanting the system to be abused or their franchise eroded. There should be some sort of provision in the Franchise agreement that allows a safety valve in some of these "extreme" cases that patient care comes first before any other interest. He did not know what that would look like in the Franchise agreement, but it is something that he urged the Board to direct staff to explore. Mr. Dick opined that what this really gets to is how to have a system that works effectively to get an ambulance to the scene and deal with situations when REMSA has maxed out their ambulance pool. They are exploring the Omega calls and the ILS response which should help with that, but thinks they should also be exploring and examining the mutual aid agreements that REMSA has and how they are used. One of the reasons he asked Chief Brown about his response on Priority 3 calls, is that he has been under the impression that REMSA has really been focused on using mutual aid response for those Priority 1 calls. He thinks they should look into how best to deal with those Priority 1 and 2 calls and is not convinced that is a matter of looking at changing the Franchise agreement, but of looking at how they can design a process that really responds to the needs in the community where they could be making a request to REMSA if there were no ambulance available, and there was a mechanism for it to be dealt with effectively in that manner. Mr. Clinger commented that he had mentioned Franchise agreement because he thinks the interpretation that came down based on the investigation is that they did not have the ability to do that; if there is some other process, that is fine, but his thought that if there were no process, there must be that safety mechanism in there for the first responder on the scene to make the assessment of the patient and stating in his or her opinion, this is the best for the patient without anyone being able to second guess that.

Mr. Driscoll stated that he has the ultimate responsibility for patient care in his jurisdiction, and that the elected officials who gave him that responsibility take this very seriously. He found it curious that they were having that conversation. He commented that there is a franchise agreement and processes to challenge items in it, but finds it offensive that there was a patient care situation in which their transportation provider made it very clear that they could not satisfy the transportation request, but then filed a complaint against the jurisdiction taking care of their patient at the best level they could, because Reno Fire called someone who was not that franchisee. Mr. Driscoll followed up on Mr. Clinger's comments that there should be a better process. They train all the providers in EMS to have field training and expertise, and they are the highest level professionals in what they do day in and day out. To challenge that kind of after the fact in what is almost a petty action and why he is offended. He stated an opinion that the Board should have staff take a look at the obligations and agreements and focus on the customer component, then bring it back to the Board for further direction or a change in the Inter Local Agreement or the Franchise Agreement to eliminate something he considered to be petty. Chair Slaughter asked if they should entertain a motion. Mr. Dick noted that one of the issues they have not addressed is that they do not have any legal opinion whether Reno is in the right or the wrong on this. The recommendation was made that they should not be making mutual aid requests, but Chief Cochran thought they were within their rights. Mr. Dick asked if it would be worthwhile to obtain a legal opinion or deal with the issue. Mr. Clinger said he did not care what the legal opinion is, that it is about patient care first. If they need to change the agreements so that it is legal, then they should do that. If they get a legal interpretation saying they were in the wrong, he stated he frankly did not care. He further stated that, as Mr. Driscoll said, it is ultimately their responsibility. If the legal opinion is that they were in the wrong, then they need to change the agreements to fix that. Mr. Dick stated his preference was to change the system so that it works effectively with the ability to

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make a request for mutual assistance to REMSA and for that to come when necessary, but understands what Mr. Clinger is saying if that does not work. Mr. Driscoll respectfully disagreed with the cadre on the Board, stating that if there is a legal issue, it should be dealt with, but their patients cannot wait to determine if it is alright for one person to make a phone call or another person to make the same phone call. He stated he would rather err on patient care and then get themselves in line with the efficiencies and details there. He would not instruct his providers to do something different than what they are doing, which is patient first. He agreed that they need to look at it and make some changes but is not willing to sacrifice patient care today for something that will not be solved for a period of time. Mr. Clinger offered to make a motion if they were finished with discussion, but Dr. Michelson requested permission to speak. He stated that he understands that the two EMS providers are both coming from positions, but ultimately if the patient had further decompensated within the 32 minutes, then the priority would have changed and the system probably would have worked without this issue being reported. However, as everyone is noting, as rare as this may be, there is a potential issue with the system. They do not have the foresight to know the patient's outcome. The system seems to need reevaluation, whether it is a legal term or a reevaluation of the ILA. Whichever route they go, one should seem appropriate, regardless of the positions held by the providers.

Mr. Clinger moved to direct staff to look at both the Inter Local Agreement and the Franchise Agreement and bring back to the Board recommendations and/or options for cases that arise when the Franchise ambulance transport provider either does not have the capability because they are out of ambulances or refuses, that there is a mechanism in place that puts patient care first and allows the jurisdictions to take action to address that. Mr. Driscoll seconded the motion.

Chair Slaughter stated that this is the exact reason the Board was put into place. Over the years, he had heard of many anecdotal stories such as this case, and this is the first time they have had the opportunity, on the record, to hear what had been in the past characterized as being a problem or not. He expressed his support for the motion. It was broad direction to staff and he was hopeful staff can come back with some options. Mr. Clinger stated that he intentionally made the motion broad, but looked to staff to not make it too broad. Ms. Conti requested clarification of the motion as to whether staff would be expected to look at mutual aid agreements. She asked if that should be part of the motion. Mr. Dick responded that he would appreciate it if the motion could also request that staff look at how the system could be improved and possible solutions, both within the existing framework and what they have asked for in changes.

Mr. Clinger amended his motion to add the request that staff look at how the system could be improved and possible solutions, both within the existing framework and what they have asked for in changes. Mr. Driscoll seconded the amended motion.

Chair Slaughter stated he was willing to accept quick public comment before taking a vote on this item. Mr. Romero had a question on the agenda item. Were they on Agenda item 11 or 12? At no time did he know they were going to have a discussion on the investigation, that the agenda item states they will discuss mutual aid requests. Chair Slaughter said he would read Agenda Item 11 and legal counsel may possibly advise them: "Discussion and possible direction to staff regarding investigation outcome referencing mutual aid requests permissible under the REMSA franchise agreement." The staff report talks about the specific case that is

at hand. Ms. Conti noted that she sent out the agenda packet with the information that should be read. She noted that this was all through Mr. Gubbels and Mr. Staffan, who were not in attendance, which may have made it difficult for Mr. Romero to feel prepared. Mr. Romero commented that understanding is that the authority filed the investigation, not the contractor, is why he was kind of unprepared for a dispute over an investigation. He stated his opinion that this is something that can be solved. Whatever engine is on scene, if they request REMSA to make a mutual aid request because of a lack of ambulances, which happens to all of them (police, fire, EMS), they will make the request. Chair Slaughter stated he wanted to check with legal counsel to make sure they were in bounds. Deputy District Attorney Leslie Admirand stated she understood the concerns of REMSA with the agenda item and discussion. However, there was no decision being made on the investigation by this Board. This Board was giving direction to staff regarding outcomes and referencing mutual aid requests permissible with the Franchise Agreement. So the action that the Board had made a motion to and a second to, would properly be allowable under this agenda item.

The motion was approved five in favor and none against.

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12. Discussion and possible direction to staff regarding the Investigation Procedures and Expectations of EMS Agencies.
Staff Representative: Ms. Conti

Ms. Conti stated that this item looks at the investigative process that the EMS Oversight Program has been employing for the last year. She handed out the Inter Local Agreement Article 1.2 that gives the Program the authority to ask for information and Article 4 that would require those agencies to give them what they are asking to complete their investigation. She wanted to bring it to the Board to determine if there are any adjustments they would like made to the investigation procedures and expectations. Recently, their authority has come under question as to whether they can even ask for the information to investigate the complaints. They felt it was timely to revisit this now that the Board has been in place for a year, so they can all move forward in the subsequent year understanding that they are doing their jobs on behalf of the EMS Advisory Board. Mr. Driscoll requested clarification that someone a party to the ILA questioned the Program's authority to do an investigation when the ILA clearly provides investigative powers. Ms. Conti responded in the affirmative, noting that she has a letter received from one of the signatories of the ILA in response to one of the Program's investigations that starts outlining the need to review the ability to respond and give me the requested information with their legal counsel. She was also aware that there was some legal discussion that determined if it would be appropriate to give her the information, that it might be redacted or partial. It was a signatory of the ILA, so she deemed it prudent to bring it forward to have discussion and direction from the EMS Advisory Board if the procedures need to be altered or if it is within the authority of the EMS Oversight Program to do what they are doing. Mr. Clinger stated he thought it was very clear that it was within the Board's authority to do that. He asked Ms. Conti if she had any recommended changes in the process or procedures based on her experience. Ms. Conti responded that they have been a part of eight "official" investigations and know about several others where the agencies were doing it among themselves and looped them in. From the Oversight Program's perspective, up until very recently, it was going extremely well. She stated that in her opinion, the way they approach it is systematic and is working. Mr. Clinger asked if she had any recommended changes. Ms. Conti responded that the only recommended change would be the support of the

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Board and the direction back down to their departments to comply with their requests. Mr. Driscoll requested clarification from Mr. Dick, regarding the discussions of these types of things in the working group. It was made clear that under HIPAA requirements, the Health Officer was able to gather information with HIPAA information on it, for purposes of review and interpretation. Then under the rules, it was the responsibility of the Health Officer to be careful on what was then published. Mr. Dick stated that he believed Mr. Driscoll was correct, and that there should be no legal impediment to the partner agency providing their records to him, even if they contain medical information. He requested affirmation from legal counsel on that point, and Ms. Admirand provided her affirmation. Ms. Conti stated that this is also why some of the information was redacted from the previous agenda item in their packet because it was public record. Chair Slaughter asked Ms. Conti if the October 30, 2014 date was correct on the memorandum that went out to regional EMS agencies and included in the current meeting packet. Ms. Conti responded that it was, and that the letter had been used numerous times. Chair Slaughter asked Ms. Conti if she received questions or if there was any discussion after sending out the letter. Ms. Conti replied that there were no questions, but there was appreciation that they had a process put in place. The process was not immediately utilized by all partners, because it was brand new. It was the EMS Oversight Program's impression that until recently, the process had been followed between partners and then elevated to the Oversight Program. There are some investigations that partners find so "egregious" that they go straight to the EMS Oversight Program and perhaps do not do the middle part. It is their hope that at some point, everything will be between the partners and will not elevate. She noted again that the Program had not heard any complaints back from the letter. Mr. Driscoll asked Ms. Conti for clarification as to whether this jurisdiction had been involved in one of the other eight investigations and did they participate fully with Ms. Conti in the past? Ms. Conti responded in the affirmative. Mr. Dick said that his impression of the investigation procedures in place is that they had served them well and were effective. He did not recommend any changes to the procedures, stating that the ILA covers the obligation of the participating entities in providing that information to the Oversight Program. He noted that the Board just saw in the last item that the Program brought information forward for the EMS Advisory Board to discuss which served a useful purpose. Mr. Dick recommended that they stick with what they have and look for some direction from the EMS Advisory Board regarding their agreement on the obligation of the partner district to be providing this information to the Program. Mr. Driscoll commented that the policies and procedures had now been in place for a year, and 11 months at the time of this particular incident and there had been numerous investigations. The Health Officer had shown that his direction and guidance and the policy and procedure done by his staff had been reasonable, fair and obtained proper results.

Mr. Driscoll moved to not change the investigation process that is in place as substantiated by the Inter Local Agreement. Mr. Clinger seconded the motion.

Chair Slaughter commented that both this item and the last item are part of their growing and understanding what they are doing as a region, now having a new Oversight Program. In his opinion, these are the reasons why the EMS Advisory Board was put into place. In the past, it was all dealt with in the field and anecdotal. Mr. Clinger asked Chair Slaughter if there is any other positive action they should take. Ms. Conti mentioned that she already had a letter drafted. She noted that this is just an example, that it is important for the Oversight Program to have the validation back from the Board that the Program is doing what they should be doing, and then the validation back to everyone in their jurisdictions that they should comply with

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their request as it is within their authority to make the request. The Program is dealing with the current example. Chair Slaughter asked if there was any discussion. Mr. Clinger asked if it was surprising that even a short review had not yet been reviewed by legal. Ms. Conti replied that she received information but not everything she had requested.

The motion was approved five in favor and none against.

Mr. Driscoll commented that the Health Officer and his team are to be commended on these rules and how it has worked to this point. For the past year, the Board has been asking questions as the Board is maturing, which shows him that there has been some good foundation work done, and all that is needed are some tweaks and adjustments. The Board has been successful. He thanked the Health Officer for that guidance and for his team.

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13. Discussion and possible approval for EMS Program Manager Christina Conti to present an annual update on accomplishments, current and future projects to the City Councils and the Board of County Commissioners.

Staff Representative: Ms. Conti

Ms. Conti noted that the Oversight Program is very proud of the work that the entire region has done with and for the Program to achieve the duties of the Inter Local Agreement. The Program thought it would be beneficial to go back to all the ILA signatories and share what has been going on to this point, because the agreement was signed well over a year ago by the jurisdictions. The Program thought it would be valuable to stand side by side with a partner from that jurisdiction to present what they have done so far, what they are currently working on, and what they hope to achieve in the coming fiscal year. Chair Slaughter asked Ms. Conti if the intention was to present the update to all the signatories. Ms. Conti responded that she would like to go to all the city councils and the District Board of Health and then seek the EMS Advisory Board's guidance as to whether she should present twice to the Board of County Commissioners, once at their regular meeting, and again when they are seated as the Truckee Meadows Fire Protection District. Chair Slaughter noted that they could accomplish it by arranging a concurrent meeting on a Tuesday when the fire board meets.

Mr. Dick moved to approve the EMS Program Manager to present an annual update on accomplishments, current and future projects to the City Councils and the Board of County Commissioners/Fire Board of Commissioners Mr. Driscoll seconded the motion which was approved five in favor and none opposed.

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14. Board Comment

Mr. Dick commented that he had noticed recently that the Truckee Meadows Fire Board took action regarding a new chest compression device that is being purchased for use by Truckee Meadows Fire Protection District, and he thought it may be useful for Truckee Meadows Fire to attend an EMS Advisory Board meeting and tell the Board a little more about the device. As new types of equipment are deployed within the system in the future, he would appreciate receiving updates on it. Chair Slaughter stated that it could be arranged and noted that this equipment was purchased through a request to a County Commissioner using his District funds. Chair Slaughter stated that updates on equipment will be made part of future agendas.

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15. Public Comment

Chief Cochran commended staff on the fantastic work they are doing on this one-year anniversary. What they are doing to ensure compliance and Ms. Conti's idea to present accomplishments to the various boards is laudable and they should be applauded for that. He noted that he does not always agree with Oversight staff, but they have a good working relationship. The Program has accomplished a lot, and he wanted to show appreciation for their work.

Mike Brown, as a resident of Reno, commented that the public does not understand the 9-1-1 system and the Omega calls. The public calls 9-1-1 for help. We trained the public on how to use 9-1-1, but now we are considering asking them to call a seven-digit number. The Board has talked about the Inter Local Agreement and the sharing of the system. He suggested doing a shared education program on when to use the 9-1-1 system rather than having it as an EMS Oversight Program enforcement issue. Mr. Brown advised that this is the perfect time for the City of Reno, City of Sparks, Washoe County Health District, and fire and law enforcement agencies to do a joint educational blitz. The public will understand that they are overloading the system and use the new seven-digit number to find a solution to their problem. We own the 9-1-1 system, and it is our responsibility to make sure every response is initiated. The Omega system can work, but education of our customers is also needed. He opined that it would be a good joint program. He noted that he worked in the system when the Health District had more control over the EMS services. That went away with the change of statute. It had to do with not having a neutral party working for them in Washoe County. He would like to maintain that neutrality and reduce the enforcement aspect of the Oversight Program. He felt it was a disservice to the Oversight Program staff and the system if there is an investigation taking place and the Oversight Program staff is looked upon as enforcement by his staff. He stated that he prefers to have a partnership with the Health District, working together, and that it be a totally neutral system. It does not go back to why they changed the law in the 90's to get away from the Health District control and move to state control, which was due in part to not having a neutral system in place. He noted that they are willing to help. **Chair Slaughter closed the public comment period.**

16. Adjournment

At 4:45 p.m., Mr. Driscoll moved to adjourn. Mr. Clinger seconded the motion.

Respectfully submitted,

____

Jeanne Harris, Administrative Secretary
Recording Secretary

Approved by Board in session on _____________, 2015.

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WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

STAFF REPORT
REGIONAL EMERGENCY MEDICAL SERVICES ADVISORY BOARD
MEETING DATE: January 7, 2016

TO: Regional EMS Advisory Board Members

FROM: Christina Conti, EMS Program Manager
775-326-6042, cconti@washoecounty.us

SUBJECT: Program and Performance Data Updates

Meetings with Partner Agencies:
In an effort to begin working on the assignment from the EMSAB on October 23, 2015, EMS staff have been meeting with regional partners. On October 27, 2015 EMS staff met with Storey County Fire Chief Hames. Additionally, EMS staff met with Carson City Chief Schreihans on Monday, December 7, 2015. The purpose of both meetings was to introduce the Oversight Program and learn more about the partnerships within Washoe County.

The EMS Coordinator and PHP staff are collaboratively organizing several evacuation tabletop exercises for Skilled Nursing and Long-Term Care facilities within the county. Many facilities identified the need to exercise their evacuation plans as well as the possibility of using the evacuation system in the Mutual Aid Evacuation Annex (MAEA). To date, three facilities have conducted tabletops and are considering the feasibility of becoming MAEA plan members.

EMS staff has joined the committee to help Washoe County become a HeartSafe Community. Several meetings have been held with involved regional partners. The designation would be given from Nevada Project Heartbeat. The purpose of the HeartSafe designation is to recognize collective efforts of agencies and organizations to enhance and improve their pre-hospital system, increase awareness of Sudden Cardiac Arrest, increase placement of AEDs, increase availability of CPR/AED training, promote heart-healthy behaviors, and make communities a healthier place to live and visit. Chief Mike Brown is a huge proponent of this project as Incline Village/Crystal Bay has attained this designation. The committee has set an internal goal of June 30, 2016 as the target date of completion.

On November 4, 2015 the EMS Coordinator observed a tabletop exercise held at the Reno-Sparks Tribal Health Center. The tabletop was focused on emergency management and response elements of an active assailant. Staff was able to gain a better understanding of the role the WCHD may have if a disaster occurs on tribal lands.

EMS Statistician sat in with Truckee Meadows Fire Protection Dispatch operators on November 4, 2015 to observe and learn the call taking processes at the 9-1-1 call center. This helped confirm

keystrokes which generate various time stamps used in the EMS Program Quarterly and Annual reports.

EMS staff held a Multi-Casualty Incident Plan (MCIP) Workshop on November 5, 2015 to gather community partners to discuss possible updates and changes to the MCIP during this revision cycle. There were several great suggestions for improvement of the plan; a sub-committee of fire, EMS and law enforcement will be established to edit the ICS language throughout the plan as well as develop a pre-identified communications plan.

The EMS Coordinator has attended several meetings as a member of the Statewide Medical Surge working group. Region 2 (seven Nevada counties) convened to discuss the development of a regional plan for medical surge, hospital evacuation and hospital MCIs on November 19, 2015. The EMS Coordinator along with staff from CCHHS and East Fork Fire Protection District are been tasked to develop draft plan(s) for the region.

The EMS Program Manager has begun working with regional representatives from dispatch, fire, REMSA, and radio to draft the 5-year strategic plan. The committee of ten individual has sent a goal of bringing preliminary information back to the EMS Advisory Board in July for input, direction and possible recommendations. The committee plans to meet monthly to ensure work on this item progresses.

The EMS Coordinator presented to the regional emergency managers on December 4, 2015 about the recent updates to the MAEA. The presentation focused on the development of the customized hospital evacuation tags and tracking system for Washoe County medical facilities.

The EMS Program Manager was able to present to the two City Councils and the Truckee Meadows Fire Protection District (TMFPD) Board of Fire Commissioners. The City of Reno presentation was on December 14, 2015, the City of Sparks presentation was on December 14, 2015 and the TMFPD Board of Fire Commissioners presentation was on December 15, 2015. The final presentation needed to complete is to the District Board of Health.

On an as needed basis, the District Health Officer (DHO) issues an exemption guidelines letter to REMSA, which includes allowable reasons that calls may be exempt. EMS staff has been working on proposed updates to the allowable exemptions. The EMS Coordinator researched types of exemptions offered/allowed in other regions across the countries and reviewed REMSA's frequency of use for all current exemptions. Based off the findings, EMS staff is proposing several revisions to exemptions, to include updating the language and/or process for 4 exemptions, and eliminating another 4 exemptions. Once a final draft is complete EMS staff with meet with regional EMS agencies to review and discuss the updates.

The EMS Oversight Program understands that the Public Service Answering Point (PSAP) for Reno, Washoe County and Sparks have completed their Tiberon upgrade and are utilizing the new CAD system. EMS staff reached out to regional partners to begin discussing the CAD to CAD link. It was confirmed that while the upgrade has occurred, the training is still being conducted. Therefore, the region has requested that a committee be formed to start looking at the CAD-to- CAD connection and to begin developing the steps and benchmarks for completing this project.

Mass Gathering Applications or Events:

There are currently no mass gathering applications or events being reviewed by EMS staff.

Inquiries or Investigations:

Investigations conducted by the EMS Oversight Program:

Date Received	Individual/Organization Requested Investigation	Reason for Request	Investigation Outcome
8/2015	Jim Gubbels	REMSA claims that TMFPD dispatch center is conducting EMD and not transferring citizen calls to REMSA. Additionally, it is claimed that NLTFPD is being dispatched to calls within the franchise service area.	Investigation still in progress; attorney's meeting for dispatch process is being scheduled.
10/2015	Reno EComm/RFD	Determination of appropriate staffing and EMD of call	No issue with EMD, system performance concerns regarding mutual aid requests. Recommendations were made regarding communication.
11/20/15	Private Citizen	Poor standards of care	Investigation in progress

Inquiries made agency to agency: ***(as known by the EMS Oversight Program)***

Date Received	Agency Requesting and to Whom the Request was Made	Reason for Request	Inquiry Outcome

Other Items of Note:

EMS Program Manager had the opportunity to audit an EMD Training on November 16, 2015. The course is three days long, but Christina was only able to attend the first day. The training on the first day reviewed the Pro QA process, the questions, the determinants, etc. It was a very valuable training that has provided a lot of background information for strategic planning.

EMS Program Manager worked on a regional team to develop a Behavioral Health Annex. This is an Annex to the Regional Emergency Operations Plan and provides a framework for response to an incident that has a mental health component. The plan was finalized on December 15, 2015 and will now be trained and exercised.

Agenda Item #8

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

STAFF REPORT
REGIONAL EMERGENCY MEDICAL SERVICES ADVISORY BOARD
MEETING DATE: January 7, 2016

TO: EMS Advisory Board Members

FROM: Heather Kerwin, EMS Statistician
775-326-6041, hkerwin@washoecounty.us

SUBJECT: Presentation, discussion and possible approval for distribution the Washoe County EMS Oversight Program Data Report for Quarter 1 FY 15-16.

SUMMARY

The purpose of this agenda item is to present for discussion and approval the EMS Oversight Program Quarter 1 Data Report. Some changes have been made to the report to include measuring agency performance relative to National Fire Protection Association Standards 1710 and 1221.

PREVIOUS ACTION

The Quarter 4 Data Report was approved for dissemination during the October 1, 2015 meeting.

BACKGROUND

Washoe County has a two tiered system response to medical emergency calls. The call routes through the Public Safety Answering Point (PSAP) and then is forwarded to REMSA for Emergency Medical Dispatch (EMD). The performance of the EMS System within Washoe County is dependent on all parties working together.

An Inter-local Agreement between the Cities of Reno and Sparks, Washoe County, Washoe County Health District and Truckee Meadows Fire Protection District created the EMS Oversight Program. There were eight identified tasks of the Oversight Program, a few specifically discussing data. Those are:

- ☐ Monitor the response and performance of each agency providing emergency medical services and provide recommendations for maintenance, improvement and long range success.
- ☐ Measure performance, analysis of system, data and outcomes of EMS and provide recommendations.
- ☐ Collaborate with regional partners on EMS data response and formulation of recommendations for modifications or changes.

- ☐ Identify sub-regions as may be requested by partners to be analyzed and evaluated for potential recommendations.

FISCAL IMPACT

There is no additional fiscal impact should the Advisory Board approve the Washoe County EMS Oversight Program Data Report for Quarter 1.

RECOMMENDATION

Outlined in the presentation Staff recommends the Board approve the distribution of the Washoe County EMS Oversight Program Data Report for Quarter 1.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: Move to approve the distribution of the Washoe County EMS Oversight Program Data Report for Quarter 1.

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Quarterly EMS Oversight Data Report

A performance analysis of the EMS system in Washoe County

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Washoe County Health District
Regional EMS Oversight Program
1001 E. Ninth Street
Reno, NV 89512

Quarter 1 FY 15-16
July –Sept 2015
January 2016

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Purpose of EMS Oversight Program Quarterly Reports

The purpose of the analyses contained within the EMS Oversight Program's Quarterly Reports is to achieve the goals outlined within the Inter Local Agreement, which established the EMS Oversight Program and helped guide the reporting of EMS data to the Program.

The objectives within the Inter Local Agreement which pertain to data analyses include:

- Monitoring of the response and performance of each agency providing Emergency Medical Services within Washoe County
- Measuring performance, analysis of system characteristics, data and outcomes of the Emergency Medical Services
- Providing analysis on sub-regions identified regarding EMS response services

It is the intention of the quarterly reports to provide data analyses which support regional decisions regarding the maintenance, improvement and long-range success of Emergency Medical Services in Washoe County.

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Table 5.9 Time difference between arrivals-when TMFPD arrived first

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Glossary of Terms

Delayed dispatch: When a fire agency is dispatched after REMSA to an EMS incident

Median: Middle value in the list of observations

Mean: Sum of all the observations of a variable, divided by the number of observations, also known as the average

Maximum: The largest observation of a given variable

NFPA 1221: National Fire Protection Association Standard 1221, Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems

NFPA 1710: National Fire Protection Association Standard 1710, Standards for the Organization and deployment for Fire Suppression Operations, Emergency medical Operations and, Special Operations to the Public by Career Fire Departments

NLTFPD: North Lake Tahoe Fire Protection District

PSAP: Public Safety Answering Point

P1: REMSA Priority 1 call; life threatening calls

P2: REMSA Priority 2 call; urgent calls

P3: REMSA Priority 3 call; emergent, non-life threatening calls

P9: REMSA Priority 9 or Omega call

Q1: Quarter 1, includes data for July, August and September

Q2: Quarter 2, includes data for October, November and December

Q3: Quarter 3, includes data for January, February and March

Q4: Quarter 4, includes data for April, May and June

RFD: Reno Fire Department

RTAA: Reno Tahoe Airport Authority

SFD: Sparks Fire Department

TMFPD: Truckee Meadows Fire Protection District

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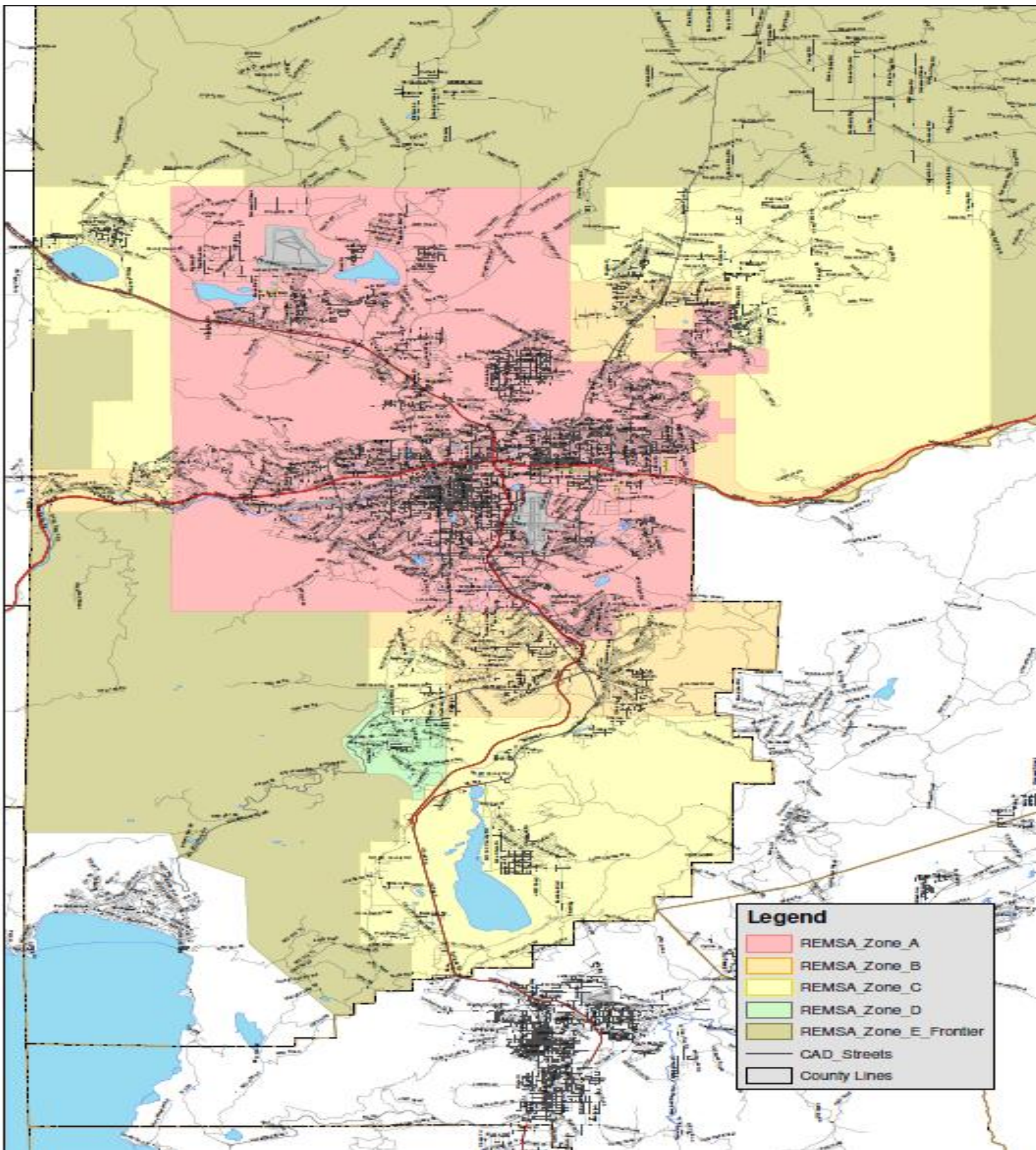
Jurisdiction Response Areas



Reno Fire Department – Zone A (primarily), B, C and E
Sparks Fire Department – Zones A, B, C and E
Truckee Meadows Fire Protect District **–** Zones A, B, C, D, and E

Data Changes from Previous Quarter

Measuring against NFPA Standards: Analyses in previous reports were requested by partner agencies to help evaluate basic questions, such as which agency arrives on scene first and how long a partner agency is on scene before the second responder arrives. After a year of analysis, the EMS Program has started to evaluate specific data elements against national standards to help identify areas for improvement in efficiency and system performance.

Inclusion of all calls: Unlike previous quarterly reports, all calls with valid time stamps were utilized in each analysis. Previous reports eliminated any incident for which either REMSA or a fire partner was cancelled enroute.

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National Fire Protection Association Standards

This section outlines the National Fire Protection Association (NFPA) standards evaluated in this report, including the formal definition and the time stamps used from each agency to measure performance relative to the NFPA standard.

Alarm Handling Standard: PSAP Created →REMSA phone pick up

NFPA 1710 (4.1.2.3.2)

"When the alarm is received at a public safety answering point (PSAP) and transferred to a secondary answering point or communication center, the agency responsible for the PSAP shall establish a performance objective of having an alarm transfer time of not more than 30 seconds for at least 95 percent of all alarms processed, as specified by NFPA 1221."

NFPA 1221 (7.4.4)

"Where alarms are transferred from the primary public safety answering point (PSAP) to a secondary answering point, the transfer procedure shall not exceed 30 seconds for 95 percent of all alarms processed."

Operating and Alarm Processing Standard: FIRE: PSAP Created →Fire dispatch

NFPA 1221 (7.4.2*)

"With the exception of the call types identified in 7.4.2.2, 80 percent of emergency alarm processing shall be completes within 60 seconds, and 95 percent of alarm processing shall be completed within 106 seconds."

**For those calls where PSAP or a Fire Partner indicates the call fits into one of the parameters outlined in 7.4.2.2, the EMS Program will apply the standards for 7.4.2.2 for those calls.*

Operating and Alarm Processing Standard: REMSA: REMSA phone pick up → ambulance assignment

NFPA 1221 (7.4.2.2 #1)

"Emergency alarm processing for the following call types shall be completed within 90 seconds 90 percent of the time and within 120 seconds 99 percent of the time:

1) ***Calls requiring emergency medical dispatch questioning and pre-arrival instructions***
2) *Calls requiring language translation*
3) *Calls requiring the use of a TTY/TDD device or audio/video relay services*
4) *Calls of criminal activity that require information vital to emergency responder safety prior to dispatching units*
5) *Hazardous materials incidents*
6) *Technical rescue"*

Response Time Standards NFPA 1710: Fire dispatch → Fire enroute **(4.1.2.1 #2);** Fire enroute → to Fire Arrival on Scene **(4.1.2.1 #2, #4 & #5)**

"The fire department shall establish the following objectives:

1) *Alarm handling time to be completed in accordance with 4.1.2.3*
2) ***80 seconds for turnout time for fire and special operations response and 60 seconds turnout time for EMS response***
3) **240 seconds or less travel time for the arrival of the first arriving engine company at a fire suppression incident and 480 second or less travel time for the deployment of an initial full alarm assignment at a fire suppression incident*
4) ***240 seconds or less travel time for the arrival of a unit with first responder with automatic external defibrillation (AED) or higher level capability at an emergency medical incident***
5) ***480 seconds or less travel time for the arrival of an advanced life support (ALS) unit at an emergency medical incident, where this service is provided by the fire department provided a fire responder with AED or basic life support (BLS) unit arrived in 240 seconds or less travel time"***

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Regional Analyses

Washoe County has a two-tiered system response to emergency medical calls. A 9-1-1 call is routed through the Public Safety Answering Point (PSAP) and then forwarded to REMSA for Emergency Medical Dispatch (EMD). The performance of the EMS System within Washoe County is dependent on all parties working together. Contained within this document are the data analyses for Washoe County Emergency Medical Systems calls for service during Quarter 1 (Q1), July-September 2015.

All EMS related calls are reported by the three major fire agencies in Washoe County: City of Sparks, City of Reno, and the Truckee Meadows Fire Protection District (unincorporated Washoe County), all of which are signatories to the Inter Local Agreement. The fire calls are matched to REMSA calls for service in order to evaluate system performance on EMS incident response, from the initial 9-1-1 call through each notified agency arriving on scene.

A total of 11,355 unique incidents were reported by the three fire agencies, of which 96 % (n =10,907) were considered to have a potential match to REMSA call data. Of the incidents considered for matching, 99.7% (n = 10,879) were matched to a REMSA call for service.

All of the 11,355 unique incidents reported by fire agencies were considered for any "Fire Only" analyses if the incident contained all necessary time stamps for the analysis. The total incidents used for each analysis are indicated within each table.

Regional Performance Summary Relative to NFPA Standards

- Alarm Handling: Measures the time interval between the PSAP 9-1-1 call taker answering the phone to the REMSA dispatcher answering the phone. NFPA Standards indicate this action should occur within 30 seconds or less at least 95% of the time. Regionally this is occurring 28.8% of the time and the median time it takes to complete this action is 0:49 seconds. There are certain calls which are not expected to be transferred within 30 seconds due to the need to collect additional information, including conditions which may impact the safety of the EMS responder. These types of calls are not currently identifiable and therefore not excluded from analysis.

- Operating and Alarm Processing: This is measured for each PSAP and their respective fire dispatchers (NFPA 1221-7.4.2) as well as REMSA (NFPA 1221-7.4.2.2 #1). The time measured for PSAP and fire dispatchers is the difference between the PSAP 9-1-1 call taker answering the phone to the fire dispatcher toning out the call to the fire station. The NFPA standard states 80% of emergency alarm processing shall be completed within 60 seconds and 95% shall be processed within 106 seconds. Regionally this is occurring 42.9% of the time within 60 seconds and 73.9% of the time within 106 seconds.

  The time measured for REMSA is the difference between REMSA's dispatcher answering the phone and an ambulance assignment being made. NFPA standard states 90% of calls should be processed within 90 seconds and 99% of calls shall be processed within 120 seconds. Regionally this is occurring 92.7% of the time within 90 seconds and 96.1% of the time within 120 seconds.

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- Response Time Standards: Includes fire agency data only and measures fire turn out time, which is the amount of time between fire dispatch and fire enroute. NFPA standards states on 90% of calls this should occur within 60 seconds. Regionally this is occurring 27.8% of the time within 60 seconds. The NFPA Response Time Standards also state the travel time (fire enroute to fire arrival) should occur 90% of the time within 4 minutes or less. Regionally this is occurring 52.9% of the time within 4 minutes or less.

Summary of Additional Performance Measures

- PSAP notification: Of the total matched calls, 74% (n=8,469) were analyzed to determine which agency receives the 9-1-1 call first, PSAP or REMSA. Washoe County's two-tiered EMS system is designed so any caller dialing 9-1-1 in the event of an emergency will ring directly into the PSAP closest to the incident location. There may be instances where a caller utilizes a number not intended for emergency use and the incident will be first reported to REMSA. Regionally 88.6% of measured calls were first reported to a PSAP, prior to being transferred to REMSA for EMD.

- Typical call response: A typical call response is outlined in Table 1.3 to illustrate wherever the first contact is made (PSAP or REMSA), how long it takes from the initial call to each agency's action of dispatching to an incident and arriving on scene. For all calls measured, the median time from the initial call to Fire dispatch is 1:04 minutes, from the initial call to REMSA dispatch (clock start) is 01:08 minutes, to Fire arrival is 06:40 minutes, and REMSA arrives 07:27 minutes after the initial call.

- First arriving agency: Of the total matched calls, 84% (n=9,529) were analyzed to determine which agency arrived on scene first, fire or REMSA. For approximately 58.7% of calls a fire agency was first on scene, for 41.1% of calls REMSA was on scene first and on less than 1% of calls fire and REMSA arrive at the same time (Table 1.4).

- Dispatched to scene: All matched calls were analyzed to determine which agency is dispatching to an incident first, fire or REMSA. The design of the Washoe County EMS system is that the PSAP should be notified of an incident first, which would place an expectation that their respective fire agency is dispatched to a call prior to REMSA's clock start (clock start is the REMSA equivalent to Fire Dispatch). Regionally Fire is dispatched to a call prior to REMSA on 56% of incidents, while REMSA is dispatched prior to Fire on 43.1% of incidents and less than 1% of incidents fire and REMSA are being dispatched simultaneously (Table 1.5).

- First arriving agency, when fire dispatched second: Understandably, a fire agency's ability to arrive on scene first decreases when fire is dispatched after REMSA. This concept is referred to as a delay in dispatch. Regionally, when fire is dispatched second they arrive first on scene 49.4% of the time, while REMSA arrives on scene first 50.4% of the time and fewer than 1% of incidents fire and REMSA arrive at the same time (Table 1.6).

- Patient perspective: The final regional table examines how the EMS response time from a patient's perspective is impacted by the delay in fire dispatch. Table 1.7 shows the median response time from the initial call to the first arriving unit is 05:57 minutes for all calls. When fire is dispatched first, the median response time is 05:54 minutes, and when fire is dispatched second, the median response time is 06:02 minutes. This indicates the patients' median wait

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time increases by 0:08 seconds when fire is dispatched second, compared to calls when fire is dispatched first.

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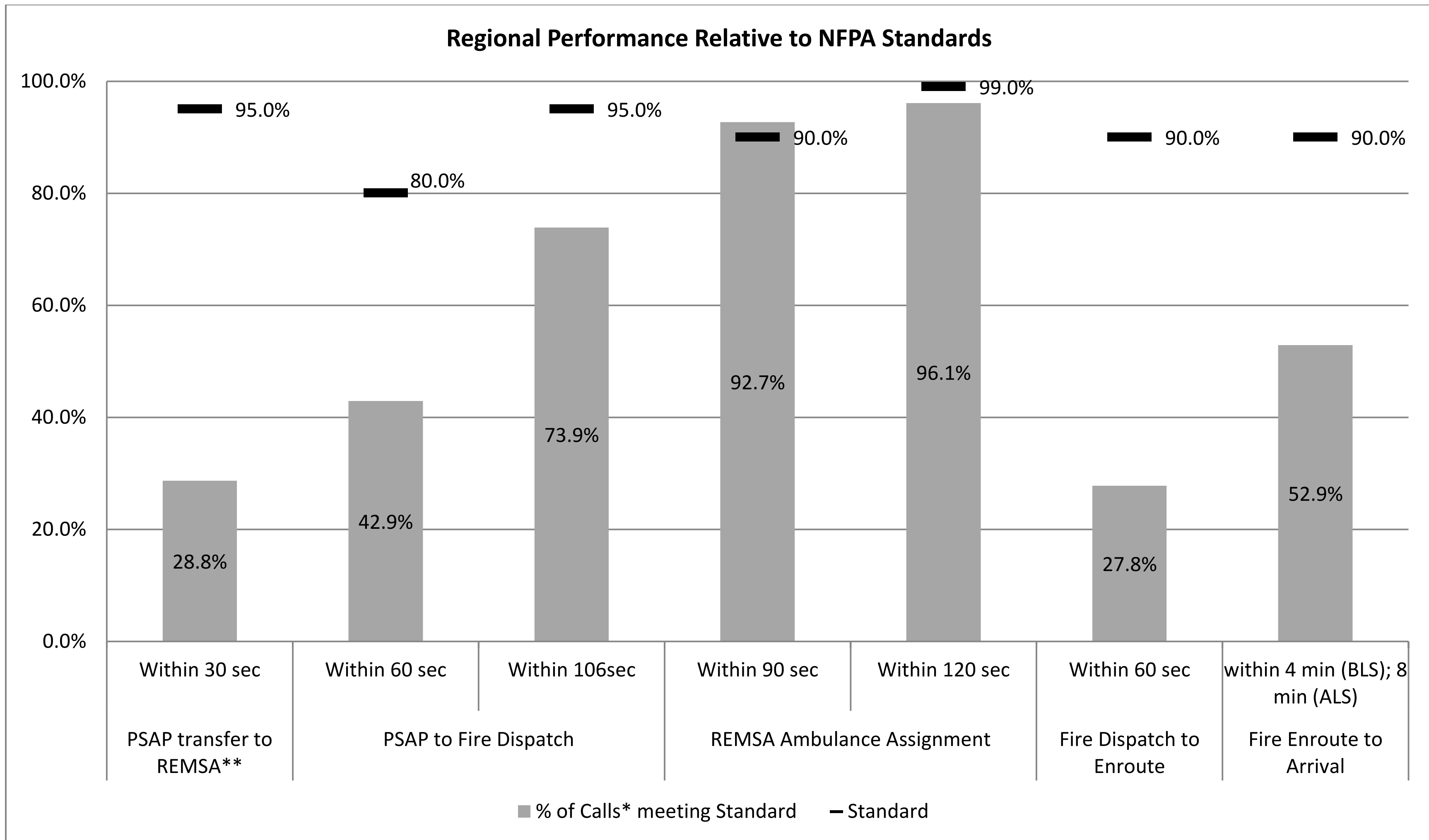


*Measured as a percent of those calls with valid time stamps
** Matched calls only; measured from PSAP dispatcher initial pick up of the phone to the REMSA dispatcher phone pick up
Detailed graphs and charts are provided in the regional breakdown as well as in each jurisdiction's section

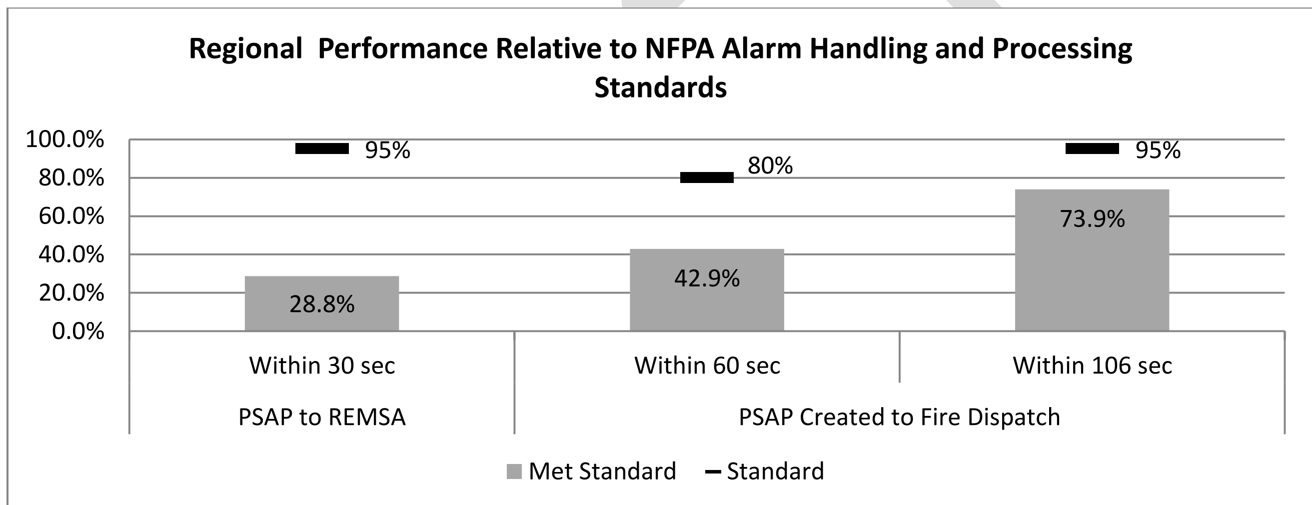
Detailed Regional Performance Relative to NFPA Standards (page iv)

Alarm Handling Standards

The NFPA alarm handling standard measures the time difference between a PSAP 9-1-1 call taker answering the phone to a REMSA dispatcher answering the phone. The standard indicates this action should occur within 30 seconds at least 95% of the time. Of those calls which matched to REMSA (7,502), 66% were able to be measured for alarm handling. Of those, 28.8% met the standard of transferring an EMS call from a jurisdiction's PSAP to REMSA within 30 seconds or less.

Operating and Alarm Processing Standard

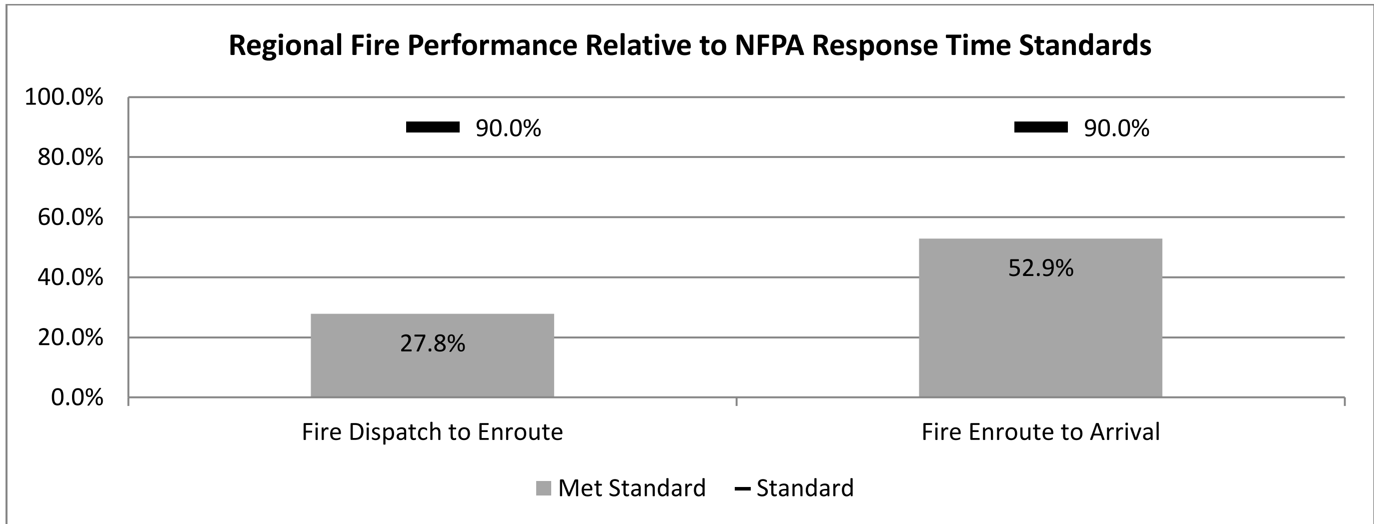
Among the 11,355 calls reported by the 3 main fire agencies (SFD, RFD, TMFPD) for Q1, 78% of calls were analyzed to evaluate performance on the operating and alarm processing standard. The time measured for PSAP and fire dispatchers is the difference between the PSAP 9-1-1 call taker answering the phone to the fire dispatcher toning out the call to the fire station. The standard states 80% of emergency alarm processing shall be completed within 60 seconds and 95% shall be processed within 106 seconds. Of the 8,888 calls measured, 42.9% met the 60 seconds or less standard and 73.9% met the 106 second standard.



Variables	Standard	Expected	Total Calls	Calls Used		Met Standard		Median
		%	#	#	%	#	%	Time
PSAP to REMSA	30 seconds or less	95%	11355	7,502	66%	2,159	28.8%	0:49
PSAP to Fire Dispatch	60 seconds or less	80%	11355	8,888	78%	3,809	42.9%	1:08
PSAP to Fire Dispatch	106 seconds or less	95%	11355	8,888	78%	6,569	73.9%	1:08

Response Time Standards

Nearly all fire calls (97.8%) were able to be measured for turnout time (dispatch to enroute). Of those, 27.8% met the NFPA standard for turnout time of 1 minute or less. The NPFA standard for travel time (enroute to arrival) was measured for 87.9% of calls. Of those, 52.9% met the standard for travel time of 4 minutes or less, the median time is 03:52 minutes.



Variables	Standard	Expected	Total Calls	Calls Used		Met Standard		Median
		%	#	#	%	#	%	Time
Fire Dispatch to Enroute	60 seconds or less	90%	11355	11108	97.8%	3088	27.8%	1:27
Fire Enroute to Arrival	240 seconds or less	90%	11355	9980	87.9%	5280	52.9%	3:52

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REGIONAL MACTHED CALLS ONLY

Table 1.1 Total number of Fire calls which were matched to a REMSA call by REMSA priority. The number used in each analysis is dependent on the time stamp validity for time stamps used in each table.

Priority	#	%
1	5201	47.8%
2	4026	37.0%
3	1446	13.3%
9	206	1.9%
Total	**10879**	100.0%

Table 1.2 The table below indicates the proportion of calls when PSAP received notification of a call prior to REMSA.

Since there is no PSAP data from SFD for Q1, all SFD calls were left out of this table, however the total still reflects the regional total calls reported for Q1, including SFD.

Agency	#	%
REMSA First	967	11.4%
PSAP First	7502	88.6%
Total N = 11355, Used N= 8469, (74%)		

Table 1.3 Typical call response using median time for each time stamp.

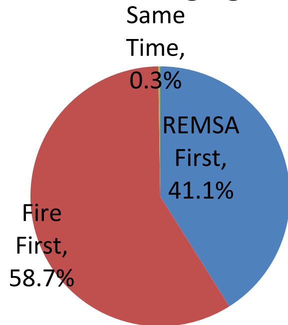
The initial call (IC) time was calculated using either REMSA call pick up time or PSAP Time, depending on which was first. If PSAP time was missing, then the earliest available Fire time stamp was used. Those calls excluded from the analysis did not have an arrival on scene time stamp for either a fire partner or REMSA.

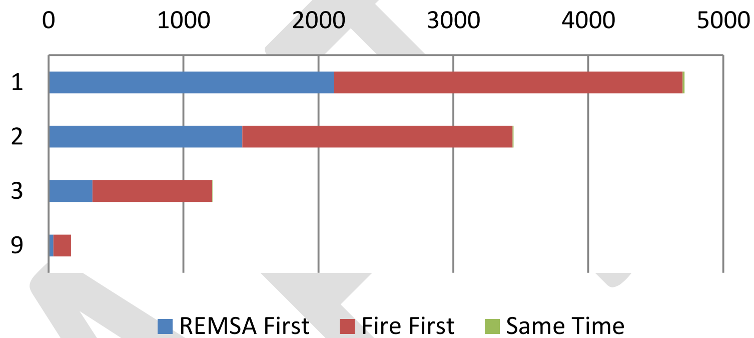
REMSA Priority	Median Time from Initial Call (IC) to Dispatch and On Scene			
	IC to Fire Dispatch	IC to REMSA Dispatch	IC to Fire Arrival	IC to REMSA Arrival
1	01:03	01:08	06:29	06:58
2	01:08	01:08	06:48	07:37
3	01:03	01:06	06:55	09:14
9	01:03	01:05	07:04	10:17
All	**01:04**	**01:08**	**06:40**	**07:27**
Total N = 11355, Used N = 9529, (84%)				

For all calls the median time from the initial call to Fire dispatch is 1:04 minutes, from the initial call to REMSA dispatch (clock start) is 01:08 minutes, to Fire arrival is 06:40 minutes, and REMSA arrives 07:27 minutes after the initial call.

Table 1.4 Jurisdictional information that indicates the first responding unit on scene, by priority.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	2114	45.0%	1437	41.7%	326	26.8%	37	22.2%	3914	41.1%
Fire First	2573	54.7%	2001	58.1%	887	73.0%	130	77.8%	5591	58.7%
Same Time	14	0.3%	8	0.2%	2	0.2%	0	0.0%	24	0.3%
Total	4701	100.0%	3446	100.0%	1215	100.0%	167	100.0%	9529	100.0%
Total N = 113355 Used N = 9529, (84%)										





The following tables and charts allow Fire partners to evaluate response in terms of the number and percent of calls, by REMSA priority, impacted when the Fire agency is not being dispatched prior to REMSA's clock start.

Table 1.5 Illustrates how many calls when Fire was dispatched before, after or at the same time as REMSA's clock starting, which is the equivalent to fire dispatch.

Dispatch First	#	%
REMSA	4699	43.1%
Fire	6097	56.0%
Same Time	101	0.9%
Total N = 11355, Used N = 10897 (95%)		

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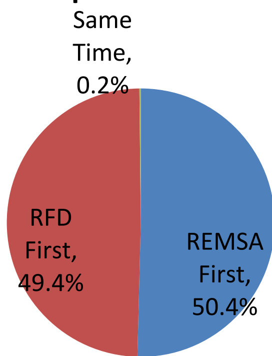
Table 1.6 Jurisdictional information that indicates the first responding unit on scene, when Fire is dispatched second.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	1060	54.8%	775	51.5%	182	34.8%	21	26.6%	2038	50.4%
Fire First	871	45.0%	728	48.4%	341	65.2%	58	73.4%	1998	49.4%
Same Time	5	0.3%	2	0.1%	0	0.0%	0	0.0%	7	0.2%
Total	1936	100.0%	1505	100.0%	523	100.0%	79	100.0%	4043	100.0%
Total N =11355, Used N = 4043, (35%)										

First Arriving Agency, when Fire Dispatched Second



First Arriving Agency, by Priority, when Fire Disaptched Second

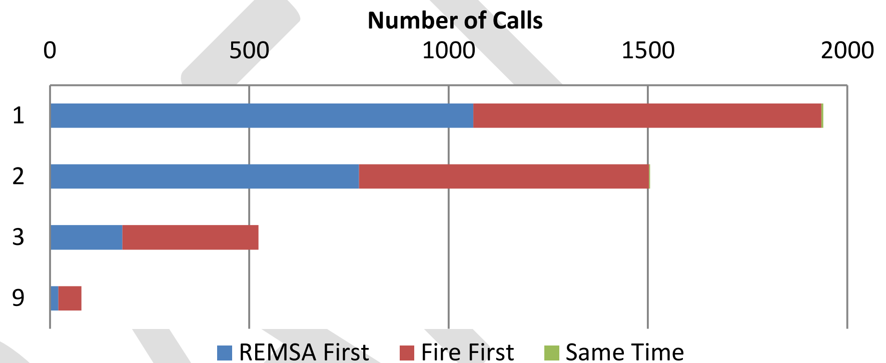


Table 1.7 The table below shows how long a patient is waiting from the initial call to the first arriving unit on scene and how those median times are impacted when the Fire agency is not being dispatched first.

Priority Number	Median Response Time: Initial call to First Arriving Unit		
	Patient's Perspective	Fire Dispatched First*	Fire Dispatched Second*
1	05:43	05:42	05:45
2	06:02	05:58	06:07
3	06:27	06:15	06:40
9	06:53	06:53	06:58
All	05:57	05:54	06:02
N calls used in each column	N = 9529 (83%)	N=5393 (56%)	N=4043 (42%)
**93 calls with same dispatch time not included in column 2 or 3.*			

For all calls, the patient's median wait time increases by 0:08 seconds when fire is not being dispatched first.

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Jurisdiction Specific Data Analysis

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REMSA Analyses

REMSA provides ambulance transport to the majority of Washoe County, excluding Gerlach and North Lake Tahoe Fire Protection District. REMSA reported a total of 15,790 incidents during Q1, 97.5% (n=15,390) of those calls were identified as a Priority 1, 2 or 3, while the remaining 2.5% (n=400) calls were Priority 9/Omega calls. The median response time for all calls is 06:00 minutes. Approximately 60% of calls resulted in an ambulance transport during Q1.

Nearly all (99.9%) of REMSA's calls were able to be measured for the NFPA Alarm Processing Standard. Of those 92.7% were processed within 90 seconds or less while 96.1% were processed within 120 seconds.

The response time standards utilized are the District Board of Health (DBOH) approved response zones for the franchise area. REMSA met the DBOH response time standards 95% of the time.

REMSA Franchise Response Zones

	ZONE A	ZONE B	ZONE C	ZONE D	ZONE E
Priority 1	8:59	15:59	20:59	30:59	Wilderness/Frontier
Priority 2	12:59	19:59	24:59	34:59	Wilderness/Frontier
Priority 3	19:59	24:59	29:59	39:59	Wilderness/Frontier

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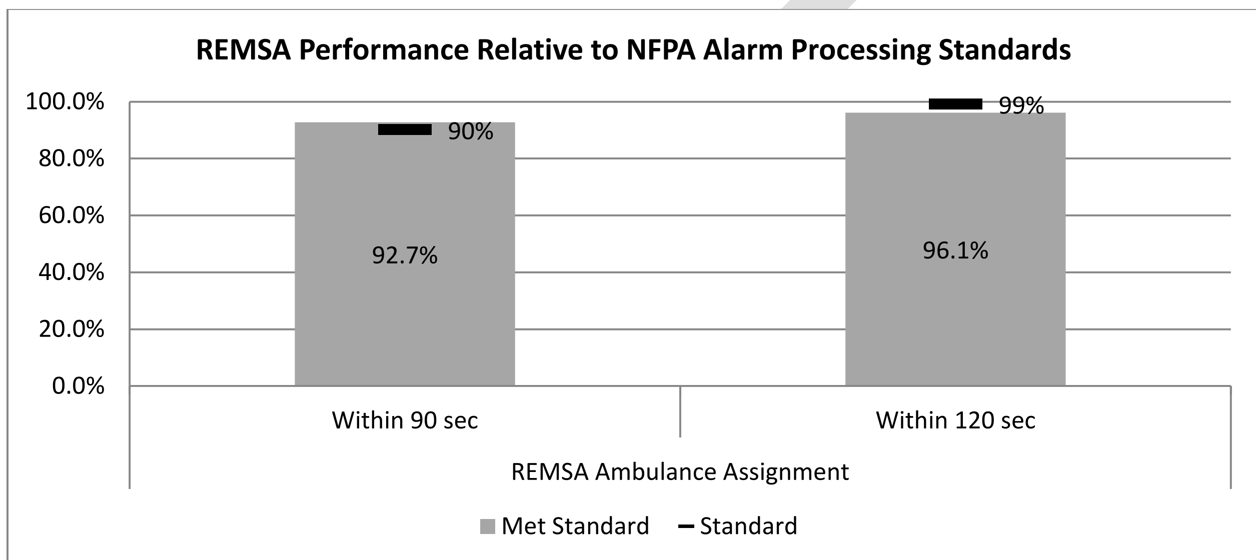
REMSA All Calls

Operating and Alarm Processing Standard

Among the 15,790 calls reported by REMSA for Q1, 99.9% of calls were analyzed to evaluate performance on the operating and alarm processing standard. The time measured for REMSA is the difference between the REMSA dispatcher answering the phone to the ambulance assignment being made. The standard states 90% of emergency alarm processing shall be completed within 90 seconds and 99% shall be processed within 120 seconds. Of the 15,788 calls measured, 92.7% met the 90 seconds or less standard and 96.1% met the 120 second standard. The median time to complete alarm processing was 0:31 seconds.



		Total Calls	Calls Used		Met Standard		Median
REMSA Ambulance Assignment	% Expected	#	#	%	#	%	Time
90 seconds or less	90%	15790	15788	99.99%	14629	92.7%	0:31
120 seconds or less	99%	15790	15788	99.99%	15176	96.1%	0:31

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Table 2.1 Clock Start – clock stop difference for REMSA

These response times include calls to rural, frontier, and wilderness areas within Washoe County. This includes calls to Gerlach, NV (2 hour drive northeast of Reno) as well as other locations which can be challenging to reach including mountainous areas.

REMSA Priority	Median	Mean	Max
1	0:05:28	0:06:12	0:56:35
2	0:05:53	0:06:39	1:08:04
3	0:07:46	0:09:14	1:12:40
9	0:08:42	0:10:32	1:16:35
All	0:06:00	0:07:02	1:16:35
Total N = 15790, Used N = 15060, (95%)			

Day (6am-6pm)			
REMSA Priority	**Median**	**Mean**	**Max**
1	0:05:41	0:06:21	0:48:23
2	0:06:20	0:07:06	1:08:04
3	0:08:29	0:10:04	1:12:40
9	0:09:19	0:11:16	1:02:08
All	0:06:22	0:07:27	1:12:40

Night (6pm-6am)			
REMSA Priority	**Median**	**Mean**	**Max**
1	0:05:12	0:05:59	0:56:35
2	0:05:23	0:06:04	0:54:57
3	0:06:56	0:07:57	0:32:11
9	0:08:27	0:09:46	1:16:35
All	0:05:36	0:06:27	1:16:35

This table depicts the difference between the clock start time and the clock stop time for all REMSA calls.

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Table 2.2 Provides a summary of all REMSA calls for service, cancelled enroute, calls resulting in transport by response zone and priority

Zone	Priority	Calls For Service	Calls For Service % by Zone	Cancel Enroute	Cancel At Scene	Calls Resulting in Transport	% Calls Resulting in Transport	Transport % by Zone	Total # Units Transporting	Avg Response Time	Avg Call Duration Non TX	Avg Call Duration TX
ZONE A	1	5552	35.16%	104	1697	3749	67.53%	39.02%	3779	00:05:36	00:09:22	00:42:00
	2	5883	37.26%	247	2580	3058	51.98%	31.83%	3110	00:06:14	00:11:57	00:32:41
	3	2694	17.06%	181	715	1800	66.82%	18.74%	1802	00:08:34	00:08:32	00:41:30
	9	368	2.33%	26	92	250	67.93%	2.60%	252	00:09:42	00:08:07	00:40:30
Total ZONE A		**14497**	**91.81%**	**558**	**5084**	**8857**	**61.10%**	**92.19%**	**8943**	**00:07:32**	**00:09:30**	**00:39:10**
ZONE B	1	262	1.66%	7	67	188	71.76%	1.96%	191	00:09:13	00:10:09	00:54:22
	2	259	1.64%	34	113	112	43.24%	1.17%	116	00:09:24	00:13:56	00:31:56
	3	105	0.66%	11	26	68	64.76%	0.71%	68	00:12:03	00:08:33	00:51:32
	9	20	0.13%	2	5	13	65.00%	0.14%	13	00:15:32	00:06:58	00:52:15
Total ZONE B		**646**	**4.09%**	**54**	**211**	**381**	**58.98%**	**3.97%**	**388**	**00:11:33**	**00:09:54**	**00:47:31**
ZONE C	1	191	1.21%	15	35	141	73.82%	1.47%	141	00:12:43	00:08:16	01:00:55
	2	160	1.01%	25	61	74	46.25%	0.77%	75	00:12:22	00:14:27	00:37:57
	3	65	0.41%	14	8	43	66.15%	0.45%	43	00:14:26	00:05:16	00:56:49
	9	10	0.06%	2	2	6	60.00%	0.06%	6	00:21:05	00:08:20	00:58:51
Total ZONE C		**426**	**2.70%**	**56**	**106**	**264**	**61.97%**	**2.75%**	**265**	**00:15:09**	**00:09:05**	**00:53:38**
ZONE D	1	12	0.08%	1	1	10	83.33%	0.10%	10	00:13:46	00:02:47	01:11:00
	2	13	0.08%	2	6	5	38.46%	0.05%	5	00:13:12	00:23:57	00:29:31
	3	5	0.03%	2	0	3	60.00%	0.03%	3	00:23:32	00:08:31	01:02:28
Total ZONE D		**30**	**0.19%**	**5**	**7**	**18**	**60.00%**	**0.19%**	**18**	**00:16:50**	**00:11:45**	**00:54:20**
ZONE E	1	93	0.59%	22	21	50	53.76%	0.52%	52	00:25:58	00:20:42	00:58:06
	2	75	0.47%	32	21	22	29.33%	0.23%	22	00:20:23	00:18:21	00:31:43
	3	21	0.13%	3	3	15	71.43%	0.16%	15	00:24:54	00:09:25	01:13:36
	9	2	0.01%	2	0	0	0.00%	0.00%	0	00:30:06	00:30:06	00:00:00
Total ZONE E		**191**	**1.21%**	**59**	**45**	**87**	**45.55%**	**0.91%**	**89**	**00:25:20**	**00:19:38**	**00:40:51**
Total		15790	100%	732	5453	9607	60.84%	100%	9703	00:15:12	00:11:59	00:46:43

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REMSA Priority 1, 2, and 3 Calls Only

The table below shows how many calls are classified in each of the priorities and what proportion of calls for each priority result in a transport.

REMSA Priority	Number of Calls	% of Calls	% Resulting in Transport*
P1	6110	39.7%	67.7%
P2	6390	41.5%	51.2%
P3	2890	18.8%	66.7%
All	**15390**	**100.0%**	**60.7%**

**represents the proportion of calls where at least one person was transported, not the number of people transported as a result of an incident*

The table below shows how many calls are classified in each of the REMSA Response Zones and what proportion of calls for each priority result in a transport.

REMSA Response Zones	Number of Calls	% of Calls	% Resulting in Transport*
Zone A	14129	91.8%	60.9%
Zone B	626	4.1%	58.8%
Zone C	416	2.7%	62.0%
Zone D	30	0.2%	60.0%
Zone E	189	1.2%	46.0%
All Zones	**15390**	**100.0%**	**60.7%**

**represents the proportion of calls where at least one person was transported, not the number of people transported as a result of an incident*

Indicates the number and percent of all REMSA calls which the clock start to clock stop time was within the denoted franchise response for each of the REMSA response zones.

REMSA Response Zone	Number of Calls	# of calls met response time standard	% of calls meeting response time standard
Zone A	14129	13320	94%
Zone B	626	604	96%
Zone C	416	401	96%
Zone D	30	30	100%
Zone E	189	189	100%
All Zones	**15390**	**14544**	**95%**

REMSA Priority 9/Omega Calls Only

In 2011, the International Academy of Emergency Dispatch (IAED) included Omega codes within the fourth pillar of their approved EMD protocols for Emergency Communication Nurses. This is termed the Omega determinant. The Omega determinant was designed to identify patients who may safely be transferred to an alternative care resource, like a Nurse Health Line, rather than receive an ambulance response. As part of the effort to establish an Omega protocol in the region, REMSA has been reviewing and reporting calls which would be determined Omegas through the EMD questioning process if implemented within Washoe County. A total of 400 P9/Omega calls were reported to the EMS Program during Q1.

The following table shows a breakdown of all P9 calls for reported for Q1.

Month	Total Calls	Transported (%)
July	132	64.4%
August	135	68.9%
September	133	68.4%
Total	**400**	**67.3%**

REMSA Response Zones	Number of Calls	% of Calls	% Resulting in Transport*
Zone A	368	92.0%	67.9%
Zone B	20	5.0%	65.0%
Zone C	10	2.5%	60.0%
Zone D	0	0.0%	0.0%
Zone E	2	0.5%	0.0%
All Zones	**400**	100.0%	**67.3%**

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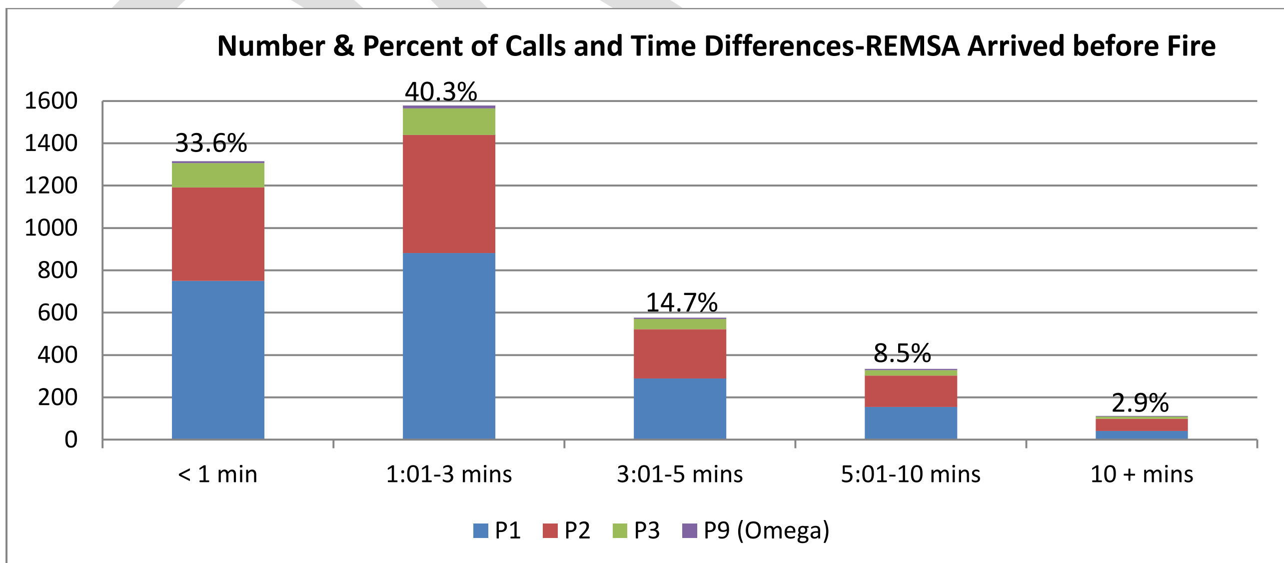
REMSA MATCHED CALLS ONLY

Table 2.3 Percent of calls and time differences –REMSA arrived before fire

REMSA Priority	Time Interval when REMSA arrives First							
	< 1 min	1:01-3 mins	3:01-5 mins	5:01-10 mins	10 + mins	Total	Median	Max
P1	35.4%	41.6%	13.7%	7.3%	2.0%	2117	0:01:33	0:36:49
P2	30.7%	38.8%	16.2%	10.3%	4.0%	1437	0:01:50	0:54:16
P3	35.3%	38.3%	15.0%	8.0%	3.4%	326	0:01:38	0:48:25
P9	24.3%	37.8%	16.2%	13.5%	8.1%	37	0:02:03	0:21:01
Total	33.6%	40.3%	14.7%	8.5%	2.9%	3917	0:01:40	0:54:16

Day (6am-6pm)								
REMSA Priority	Time Interval when REMSA arrives First							
	< 1 min	1:01-3 mins	3:01-5 mins	5:01-10 mins	10 + mins	Total	Median	Max
1	36.2%	43.3%	12.4%	5.9%	2.2%	1093	0:01:28	0:25:57
2	29.6%	42.7%	14.4%	9.4%	4.0%	703	0:01:47	0:54:16
3	34.9%	41.3%	11.6%	8.7%	3.5%	172	0:01:31	0:48:25
9	15.8%	47.4%	15.8%	10.5%	10.5%	19	0:02:03	0:21:01
Total	33.6%	42.9%	13.0%	7.4%	3.0%	1987	0:01:36	0:54:16

Night (6pm-6am)								
REMSA Priority	Time Interval when REMSA arrives First							
	< 1 min	1:01-3 mins	3:01-5 mins	5:01-10 mins	10 + mins	Total	Median	Max
1	34.6%	39.8%	15.0%	8.8%	1.8%	1024	0:01:39	0:36:49
2	31.7%	35.1%	18.0%	11.2%	4.0%	734	0:01:53	0:46:31
3	35.7%	35.1%	18.8%	7.1%	3.2%	154	0:01:47	0:28:34
9	33.3%	27.8%	16.7%	16.7%	5.6%	18	0:01:54	0:11:18
Total	33.6%	37.6%	16.5%	9.6%	2.7%	1930	0:01:47	0:46:31



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CITY OF SPARKS Analyses

The City of Sparks Fire Department (SFD) reported 2,426 unique incidents, of which 98% (n=2,382) were considered as having the potential to match to a REMSA incident. Of the 2,382 calls, 99.6% were matched to a REMSA incident.

The City of Sparks PSAP data was reported starting October 26, 2015 and any analyses which require PSAP time stamps will be included in future quarterly reports.

Nearly all reported incidents, (99.2%), were measured to evaluate SFD performance according to NFPA response time standards. The median turnout time (fire dispatch to fire enroute) for SFD is 01:33 minutes, resulting in 21.6% of calls that met the NFPA standard which states 90% of calls shall have a turnout time within 60 seconds. The travel time standard states 90% of calls will have a unit on scene within 240 seconds/4 minutes (fire enroute to fire arrival). Approximately 92.6 % of SFD incidents were measured for this guideline and 54.9% met the NFPA travel time standard. An additional analysis was run on only those calls SFD Dispatchers determined were a Priority 1 (emergent/lights and siren response necessary). Approximately 57% of SFD calls were a Priority 1, and of those 64.3% met the NFPA Standard for travel time.

Within the City of Sparks the median time from the initial call (earliest time stamp for any given incident) to each agency dispatching and arriving on scene is presented in Table 3.3. The median time from the initial call to SFD dispatching is 00:36 seconds, from the initial call to REMSA dispatching (clock start) is 00:39 seconds, to Fire arrival is 06:15 minutes, and REMSA arrives 07:17 minutes after the initial call.

SFD arrived first on scene for 64.5% of the matched incidents during Q1. SFD is dispatched after REMSA's clock start (dispatch delay), on 49.5% of matched incidents, and when this dispatch delay occurs, SFD arrives first on scene 56.3% of the time. Approximately 17% of all matched calls are impacted by a delay in dispatch over 1 minute (Table 3.7).

Table 3.8 shows the median response time from the initial call to the first arriving unit is 05:44 minutes for all calls. When fire is dispatched first, the median response time is 05:33 minutes, and when fire is dispatched second, the median response time is 06:00 minutes. This indicates the patients' wait time increases by 0:27 seconds when SFD is dispatched second, compared to calls when SFD is dispatched first.

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Table 3.1 Description of call data reported by SFD, de-duplicated, and matched by priority.

Description of Call Data	SFD
All calls reported (Original denominator)	2537
Duplicates Removed	111
Total Incidents Reported (Deduplicated)	**2426**
Outside Washoe County	-
Fire "611 cancelled enroute" calls not matched	24
REMSA not expected on scene	20
Training/test calls removed	-
New Number to Match	**2382**
LinkPlus Match*	2174 (91.3%)
Manually matched	198
FULL MATCH *	**2372 (99.6%)**
P1**	1038 (43.8%)
P2**	899 (37.9%)
P3**	373 (15.7%)
P9**	62 (2.6%)

*Calculated using "New Number to Match" as the denominator
**Percent of total "FULL MATCH" calls

DRAFT

Alarm Handling Standard

The alarm handling standard measures the time difference between PSAP 9-1-1 call taker answering the phone to REMSA dispatcher answering the phone. NFPA Standards indicate this action should occur within 30 seconds or less at least 95% of the time.

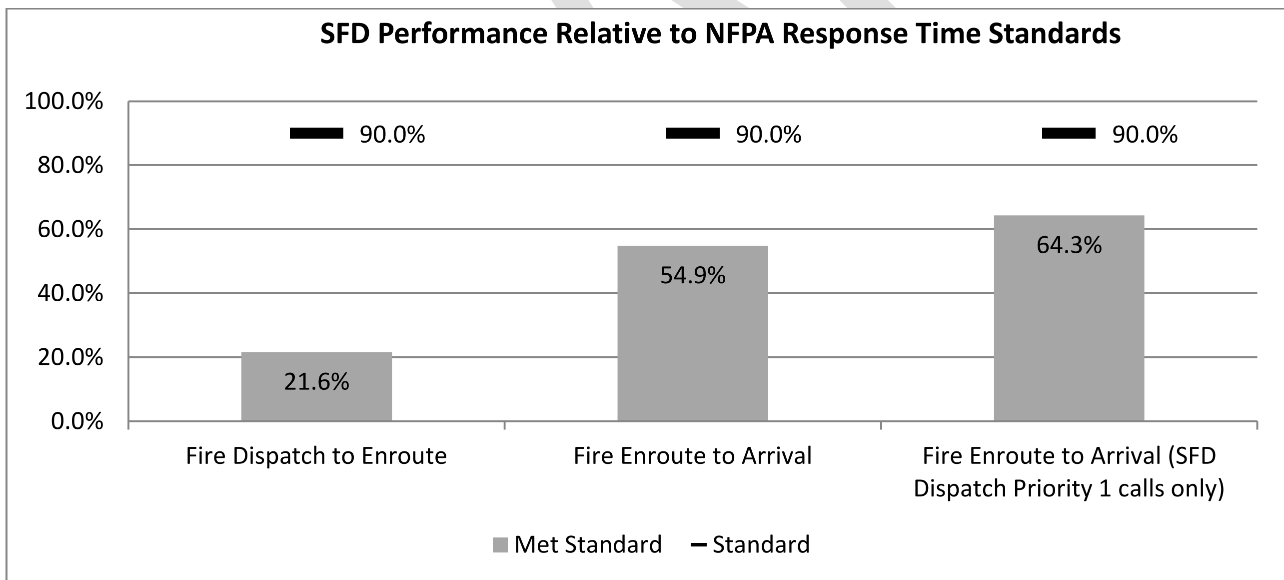
Operating and Alarm Processing Standard

The time measured for PSAP and fire dispatchers is the difference between the PSAP 9-1-1 call taker answering the phone to the fire dispatcher toning out the call to the fire station. The NFPA standard states 80% of emergency alarm processing shall be completed within 60 seconds and 95% shall be processed within 106 seconds.

These analyses above were unable to be calculated due to missing PSAP data from SFD. This data element has started to be submitted as of October 26, 2015 and will be available for analyses next quarter.

Response Time Standards

For this analysis, the measurement of Dispatch to Enroute utilized 99.2% (n=2,407) of the total submitted calls were used. Those excluded did not match or did not have a dispatch timestamp. Furthermore, the Fire Enroute to on scene analysis used 92.6% or 2,246 of the total submitted calls. Those excluded did not have a dispatch timestamp and/or an arrival on scene time stamp. An additional analysis was performed on those calls which were designated Priority 1 by SFD Dispatch and are shown in the third column.



Variables	Standard	Expected	Total Calls	Calls Used		Met Standard		Median
		%	#	#	%	#	%	Time
Fire Dispatch to Enroute	60 seconds or less	90%	2426	2407	99.2%	521	21.6%	01:33
Fire Enroute to Arrival	240 seconds (4 minutes) or less	90%	2426	2246	92.6%	1232	54.9%	03:49
Fire Enroute to Arrival*	240 seconds (4 minutes) or less	90%	2426	1396	57.5%	897	64.3%	03:30
* only those calls with a SFD Dispatch Priority of "1"								

SFD MATCHED CALLS ONLY

Table 3.2 The table below indicates the proportion of calls when PSAP received notification of a call prior to REMSA.

Not calculated due to lack of PSAP time stamp

Table 3.3 Typical call response using median time for each time stamp.

The initial call (IC) time was calculated using either REMSA call pick up time or Alarm Time, depending on which was first. For this analysis, 91% (n=2,218) of the total submitted calls were used. Those excluded did not have one or more time stamps available for utilization.

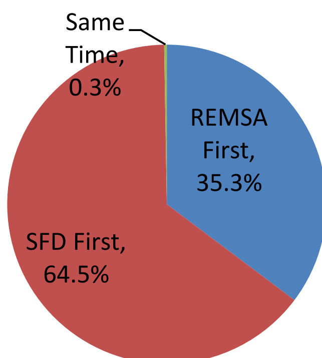
REMSA Priority	Median Time from Initial Call (IC) to Dispatch and On Scene			
	IC to Fire Dispatch	IC to REMSA Dispatch	IC to Fire Arrival	IC to REMSA Arrival
1	00:34	00:37	05:55	06:43
2	00:39	00:40	06:24	07:28
3	00:38	00:38	06:44	09:05
9	00:40	00:40	06:58	09:54
All	00:36	00:39	06:15	07:17
Total N = 2426, Used N =2218 (91%)				

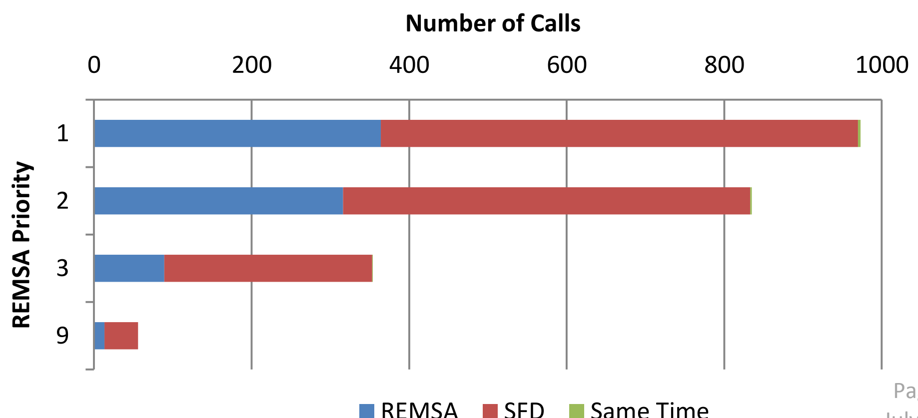
For all calls the median time from the initial call to Fire dispatch is 00:36 seconds, from the initial call to REMSA dispatch (clock start) is 00:39 seconds, to Fire arrival is 06:15 minutes, and REMSA arrives 07:17 minutes after the initial call.

Table 3.4 Jurisdictional information that indicates the first responding unit on scene, by priority.

For this analysis, 91% or 2,218 of the total submitted calls were used. Those excluded were calls that were cancelled enroute.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	364	37.4%	316	37.8%	89	25.1%	13	23.2%	782	35.3%
SFD First	606	62.3%	517	61.9%	264	74.6%	43	76.8%	1430	64.5%
Same Time	3	0.3%	2	0.2%	1	0.3%	0	0.0%	6	0.3%
Total	973	100.0%	835	100.0%	354	100.0%	56	100.0%	2218	100.0%
Total N =2426, Used N = 2218 (91%)										





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The following tables and charts allow SFD to evaluate response in terms of the number and percent of calls, by REMSA priority, impacted when SFD is not being dispatched prior to REMSA's clock start. SFD was dispatched second 1,173 out of the 2,218 matched calls (49.5%) with an arrival time during Q1.

Table 3.5 Illustrates how many calls SFD was dispatched before, after or at the same time as REMSA's clock starting.

For this analysis, 99.6% or 2,372 of the total submitted calls were used. Those excluded did not match.

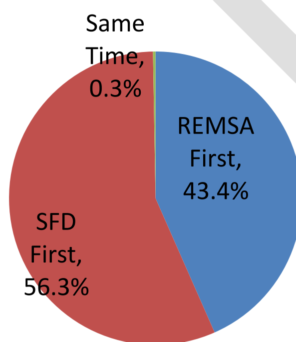
Agency	#	%
REMSA First	1173	49.5%
Fire First	1179	49.7%
Same Time	20	0.8%
Total N = 2426, Used N =2372 (99.6%)		

Table 3.6 Jurisdictional information that indicates the first responding unit on scene, when SFD is dispatched second.

For this analysis, 45% or 1,081 of the total submitted calls were used. Those excluded did not have either a dispatch or an arrival time.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	214	45.3%	198	47.9%	50	30.1%	7	23.3%	469	43.4%
SFD First	256	54.2%	214	51.8%	116	69.9%	23	76.7%	609	56.3%
Same Time	2	0.4%	1	0.2%	0	0.0%	0	0.0%	3	0.3%
Total	472	100.0%	413	100.0%	166	100.0%	30	100.0%	1081	100.0%
Total N =2426, Used N = 1081 (45%)										

First Arriving Agency, when Fire Dispatched Second



First Arriving Agency, by Priorioty, when Fire Dispatched Second

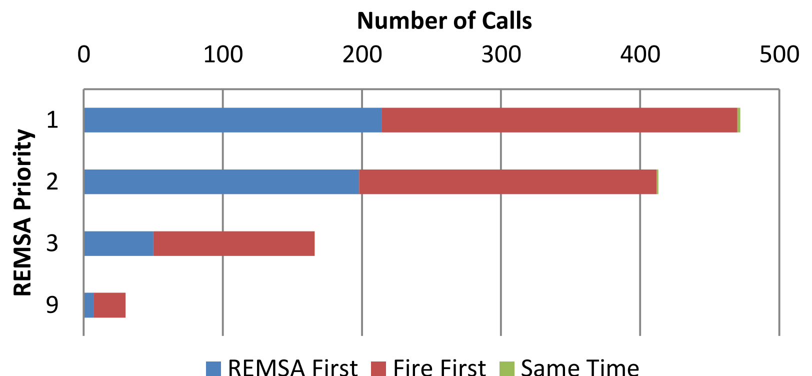


Table 3.7 Call volume breakdown by minutes/seconds for calls when Fire is dispatching second

Time in Delay	#	%
<= 1:00 min	766	34.5%
1:01 to 2:00 min	261	11.8%
2:01 to 3:00 min	76	3.4%
3:01 to 4:00 min	35	1.6%
4:01 to 5:00 min	15	0.7%
5:01 to 6:00 min	8	0.4%
6:01 to 7:00 min	5	0.2%
7:01 to 8:00 min	1	0.0%
8:01 to 9:00 min	0	0.0%
9:01 to 10:00 min	2	0.1%
over 10:00 min	4	0.2%
Total N = 2426, Used N = 1,173 (48%)		

The total number of calls with a dispatch delay over 1 minute was 407, which represents 17.1% of all matched calls for service.

Table 3.8 The table below shows how long a patient is waiting from the initial call to the first arriving unit on scene and how those median times are impacted when the Fire agency is not being dispatched first.

For this analysis, 91% or 2,218 of the total submitted calls were used. Those excluded did not match or did not have a fire dispatch and/or arrival timestamp.

Priority Number	Median Response Time: Initial call to First Arriving Unit		
	Patient's Perspective	**Fire Dispatched First***	**Fire Dispatched Second***
1	05:25	05:16	05:39
2	05:51	05:34	06:10
3	06:19	06:13	06:34
9	06:54	06:58	06:54
All	05:44	05:33	06:00
N calls used in each column	N = 2218 (91%)	N=1118 (46%)	N=1081 (45%)
**19 calls with same dispatch time not included in column 2 or 3.*			

For all calls, the patient's median wait time increases by 0:27 seconds when fire is not being dispatched first.

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CITY OF RENO Analyses

The City of Reno Fire Department (RFD) reported 7,170 unique incidents, of which 95% (n=6,847) were considered as having the potential to match to a REMSA incident. Of the 6,847calls, 99.7% were matched to a REMSA incident.

Approximately 88.3% of RFD's reported incidents were measured to evaluate the City of Reno PSAP performance according to NFPA Alarm Handling Standards. The standard states the PSAP 9-1-1 call taker will transfer 95% of calls to REMSA within 30 seconds. Of the calls measured, 28.4% of calls were transferred to REMSA within 30 seconds. The median time for PSAP answering a call and transferring to REMSA is 0:49 seconds.

Nearly all of RFD's reported calls (99.97%) were analyzed to measure performance relative to NFPA Operating and Alarm Processing Standards. The standard states 80% of calls will result in fire dispatched to a scene within 60 seconds of the PSAP 9-1-1 call taker answering the phone and 95% of calls will result in fire dispatching within 106 seconds. Of the 99.97% of calls measured, 41% resulted in fire dispatch within 60 seconds and 72.1% within 106 seconds. The median time for PSAP answering a call and RFD Dispatching is 01:10 minutes.

The median turnout time (fire dispatch to fire enroute) for RFD is 01:32 minutes, resulting in 22.8% of calls that met the NFPA standard which states 90% of calls shall have a turnout time within 60 seconds. The travel time standard states 90% of calls will have a unit on scene within 240 seconds/4 minutes (fire enroute to fire arrival). Approximately 85.9 % of RFD incidents were measured for this guideline and 56.8% met the NFPA travel time standard. The median travel time for RFD is 03:40 minutes.

Of the total matched calls, nearly 100% (n=6,823) were analyzed to determine which agency received the 9-1-1 call first, PSAP or REMSA. Approximately 88.6% of analyzed calls were first reported to a PSAP, prior to being transferred to REMSA for EMD.

Within the City of Reno the median time from the initial call (earliest time stamp for any given incident) to each agency dispatching and arriving on scene is presented in Table 4.3. Median time from the initial call to RFD dispatch is 1:14 minutes, from the initial call to REMSA dispatch (clock start) is 1:17 minutes, to RFD arrival is 06:44 minutes, and REMSA arrives 07:02 minutes after the initial call.

RFD arrived first on scene for 52.7% of the measured incidents during Q1. RFD is dispatched after REMSA's clock start (dispatch delay), on 42.8% of measured incidents, and when this dispatch delay occurs, RFD arrives first on scene 43.3% of the time. Approximately 16.5% of all matched calls are impacted by a delay in dispatch over 1 minute (Table 4.7).

Table 4.8 shows the median response time from the initial call to the first arriving unit is 05:52 minutes for all calls. The median response time is not impacted when RFD is dispatched first versus when RFD is dispatched second.

DRAFT

Table 4.1 Description of call data reported by RFD, de-duplicated, and matched by priority.

Description of Call Data	RFD
All calls reported (Original denominator)	7314
Duplicates Removed	144
Total Incidents Reported (Deduplicated)	**7170**
Outside Washoe County	-
Fire "611 cancelled enroute" calls not matched	171
REMSA not expected on scene	152
Training/test calls removed	-
New Number to Match	**6847**
LinkPlus Match*	5934 (86.7%)
Manually matched	890
FULL MATCH *	**6824 (99.7%)**
P1**	3401 (49.8%)
P2**	2507 (36.7%)
P3**	809 (11.9%)
P9**	107 (1.6%)

*Calculated using "New Number to Match" as the denominator

**Percent of total "FULL MATCH" calls

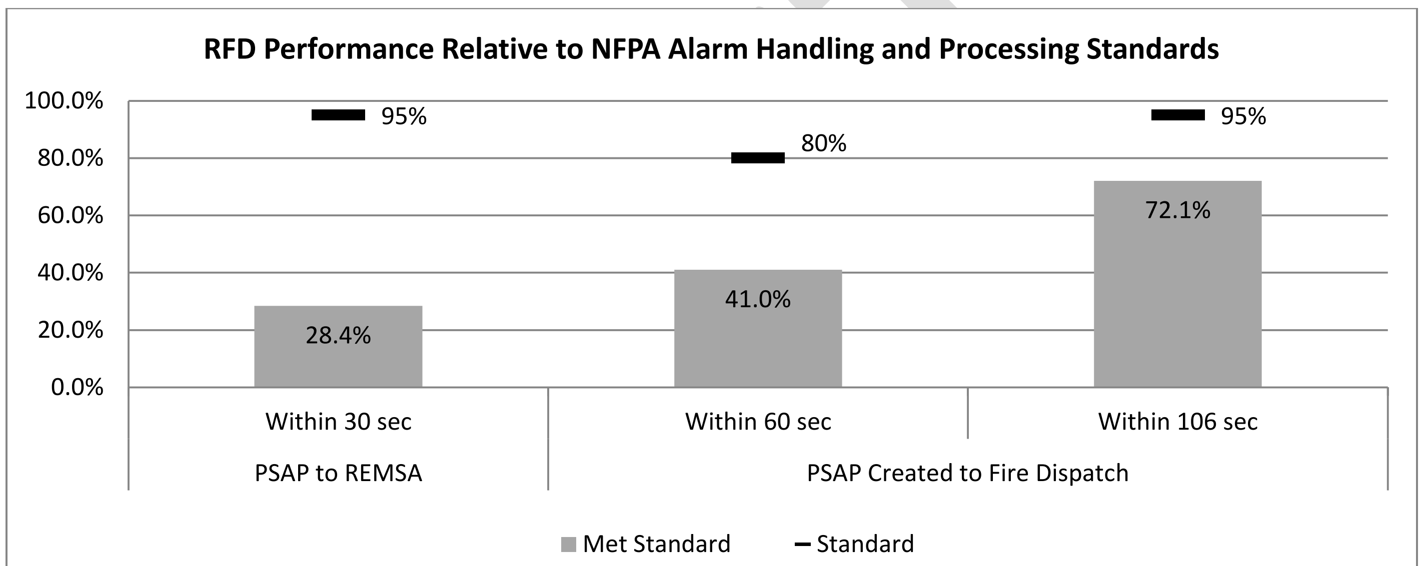
DRAFT

Alarm Handling Standard

The alarm handling standard measures the time difference between a PSAP 9-1-1 call taker answering the phone to a REMSA dispatcher answering the phone. NFPA Standards indicate this action should occur within 30 seconds or less at least 95% of the time. For this analysis, 88.3% or 6,048 of the total submitted calls were used, and of those 28.4% of alarms were transferred within 30 seconds. The median time for this process is 0:49 seconds. Those excluded from analysis did not match to REMSA or did not have a PSAP timestamp.

Operating and Alarm Processing Standard

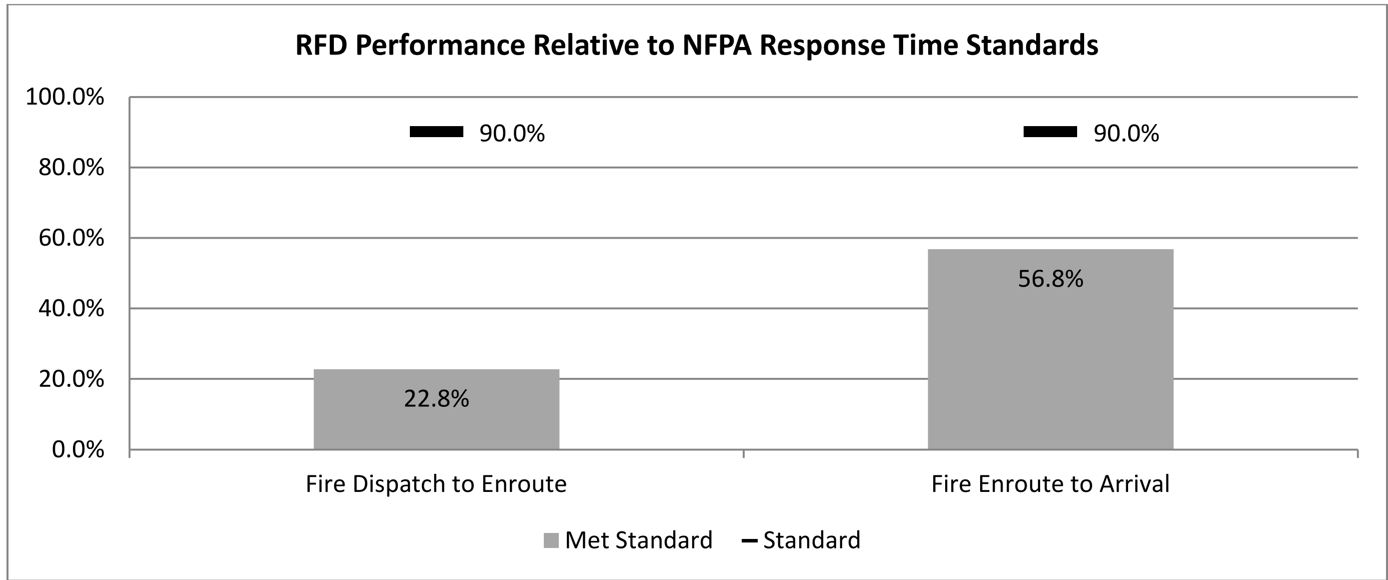
The time measured for PSAP and fire dispatchers is the difference between the PSAP 9-1-1 call taker answering the phone to the fire dispatcher toning out the call to the fire station. The NFPA standard states 80% of emergency alarm processing shall be completed within 60 seconds and 95% shall be processed within 106 seconds. RFD processed 41% of alarms within 60 seconds and 72.1% within 106 seconds. The median time to process an alarm is 01:10 minutes.



Variables	Standard	Expected	Total Calls	Calls Used		Met Standard		Median
		%	#	#	%	#	%	Time
PSAP to REMSA	30 seconds or less	95%	6824	6048	88.3%	1715	28.4%	0:49
PSAP to Fire Dispatch	60 seconds or less	80%	7170	7168	99.97%	2939	41.0%	1:10
PSAP to Fire Dispatch	106 seconds or less	95%	7170	7168	99.97%	5167	72.1%	1:10

Response Time Standards

Includes fire agency data only and measures fire turn out time, which is the amount of time between fire dispatch and fire enroute. NFPA standards states on 90% of calls this should occur within 60 seconds. For this analysis, 96.9% (n=6,949) of the total submitted calls were used, of those, 22.8% met the standard. The median time was 01:32 minutes. Those excluded did not match or did not have a dispatch timestamp. The travel time standard states from fire enroute to fire arrival, 90% of should arrive within 4 minutes. Approximately 85.9% of the total submitted calls were measured, of those 56.8% met the standard. The median travel time was 03:40 minutes. Those excluded from analysis did not have a dispatch timestamp and/or an arrival on scene time stamp.



Variables	Standard	Expected	Total Calls	Calls Used		Met Standard		Median
		%	#	#	%	#	%	Time
Fire Dispatch to Enroute	60 seconds or less	90%	7170	6949	96.9%	1585	22.8%	1:32
Fire Enroute to Arrival	240 seconds (4 minutes) or less	90%	7170	6157	85.9%	3496	56.8%	3:40

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RFD MATCHED CALLS ONLY

Table 4.2 The table below indicates the proportion of calls when PSAP received notification of a call prior to REMSA.

For this analysis, 95% or 6,823 of the total submitted calls were used. Those excluded did not match or did not have a PSAP timestamp.

Agency	#	%
REMSA First	775	11.4%
PSAP First	6048	88.6%
Total N = 7170, Used N= 6823, 95%		

Table 4.3 Typical call response using median time for each time stamp.

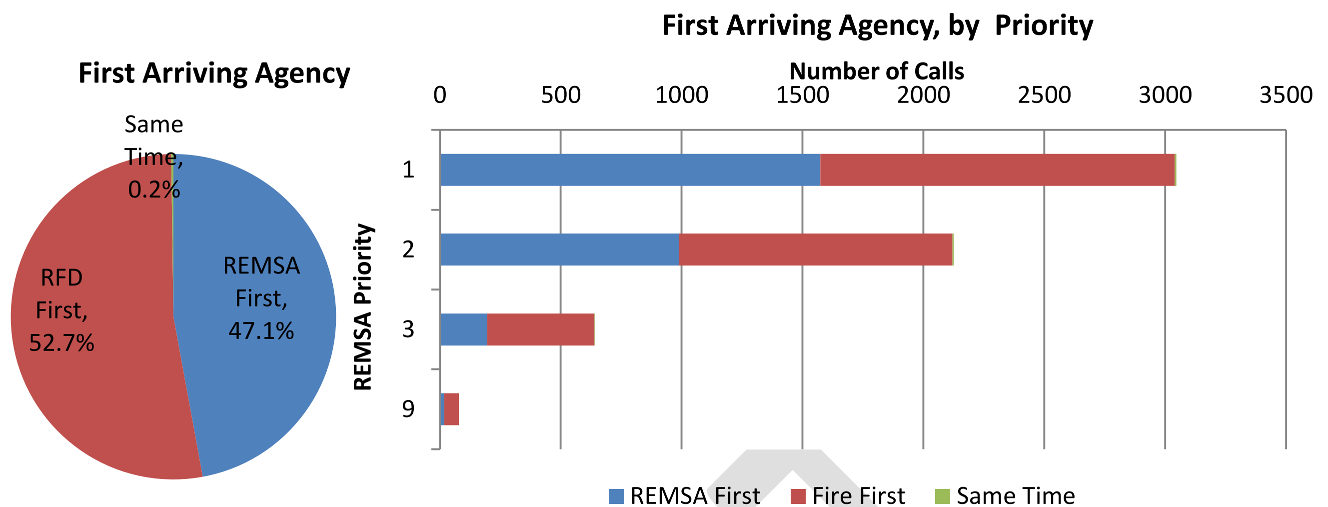
The initial call (IC) time was calculated using either REMSA call pick up time or PSAP Time, depending on which was first. If PSAP time was missing, then the earliest available Fire time stamp was used. For this analysis, 82% or 5,892 of the total submitted calls were used. Those excluded did not have one or more time stamps available for utilization.

REMSA Priority	Median Time from Initial Call (IC) to Dispatch and On Scene			
	IC to Fire Dispatch	IC to REMSA Clock Start	IC to Fire Arrival	IC to REMSA Clock Stop
1	01:11	01:16	06:34	06:37
2	01:17	01:18	06:52	07:14
3	01:14	01:19	06:52	08:34
9	01:24	01:13	07:00	09:39
All	01:14	01:17	06:44	07:02
Total N = 7170, Used N = 5892, (82%)				

For all calls the median time from the initial call to Fire dispatch is 1:14 minutes, from the initial call to REMSA dispatch (clock start) is 1:17 minutes, to Fire arrival is 06:44 minutes, and REMSA arrives 07:02 minutes after the initial call.

Table 4.4 Jurisdictional information that indicates the first responding unit on scene, by priority.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	1574	51.7%	989	46.5%	195	30.4%	18	23.1%	2776	47.1%
RFD First	1466	48.1%	1132	53.2%	445	69.4%	60	76.9%	3103	52.7%
Same Time	7	0.2%	5	0.2%	1	0.2%	0	0.0%	13	0.2%
Total	3047	100.0%	2126	100.0%	641	100.0%	78	100.0%	5892	100.0%
Total N =7170, Used N = 5892, (82%)										



The following tables and charts allow RFD to evaluate response in terms of the number and percent of calls, by REMSA priority, impacted when RFD is not being dispatched prior to REMSA's clock start. RFD was dispatched second 2,923 out of the 6,824 matched calls (42.8%) during Q1.

Table 4.5 Illustrates how many calls RFD was dispatched before, after or at the same time as REMSA's clock starting.

For this analysis, 99.6% or 2,372 of the total submitted calls were used. Those excluded did not match or did not have a fire dispatch timestamp.

Agency	#	%
REMSA First	2923	42.8%
Fire First	3837	56.2%
Same Time	64	0.9%
Total N = 7170, Used N = 6824, (95%)		

Table 4.6 Jurisdictional information that indicates the first responding unit on scene, when RFD is dispatched second.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	763	61.7%	516	55.8%	106	39.3%	13	33.3%	1398	56.6%
RFD First	472	38.2%	407	44.0%	164	60.7%	26	66.7%	1069	43.3%
Same Time	2	0.2%	1	0.1%	0	0.0%	0	0.0%	3	0.1%
Total	1237	100.0%	924	100.0%	270	100.0%	39	100.0%	2470	100.0%
Total N = 7170, Used N = 2470, (34%)										

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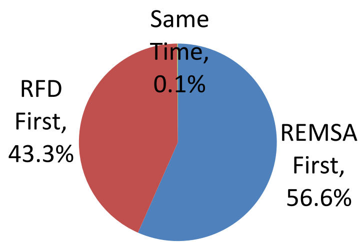

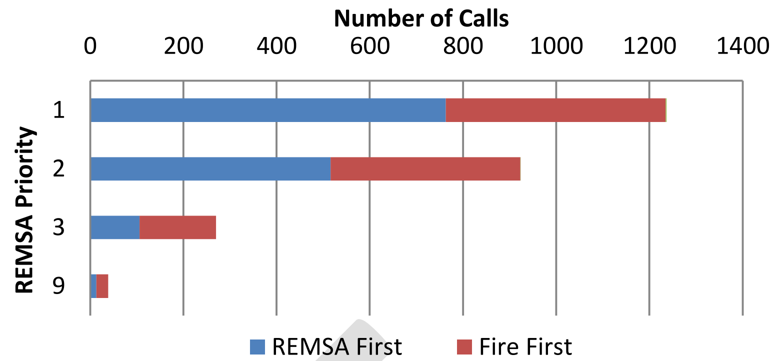

Table 4.7 Call volume breakdown by minutes/seconds for calls when Fire is dispatching second

Time in Delay	#	%
<= 1:00 min	1794	26.3%
1:01 to 2:00 min	513	7.5%
2:01 to 3:00 min	281	4.1%
3:01 to 4:00 min	126	1.8%
4:01 to 5:00 min	66	1.0%
5:01 to 6:00 min	38	0.6%
6:01 to 7:00 min	24	0.4%
7:01 to 8:00 min	13	0.2%
8:01 to 9:00 min	11	0.2%
9:01 to 10:00 min	11	0.2%
over 10:00 min	46	0.7%
Total N =7170, Used N =2923 (40%)		

The total number of calls with a dispatch delay over 1 minute was 1,129, which represents 16.5% of all matched calls for service.

Table 4.8 The table below shows how long a patient is waiting from the initial call to the first arriving unit on scene and how those median times are impacted when the Fire agency is not being dispatched first.

Priority Number	Median Response Time: Initial call to First Arriving Unit		
	Patient's Perspective	Fire Dispatched First*	Fire Dispatched Second*
1	05:39	05:42	05:36
2	05:58	06:00	05:57
3	06:21	06:09	06:32
9	06:40	06:35	06:53
All	05:52	05:52	05:52
N calls used in each column	N = 5892 (82%)	N=3363 (47%)	N=2470 (34%)
**59 calls with same dispatch time not included in column 2 or 3.*			

For all calls, the patient's median wait time does not change when fire is not being dispatched first.

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The following tables only include those matched calls when RFD arrived on scene prior to REMSA.

Table 4.9 Time difference between arrivals, by RFD and REMSA priority when RFD arrives on scene first

Incident District Number	All REMSA Priorities (P1-P3, P9), Time Interval when RFD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total	Median	Max
1	31.3%	41.2%	15.4%	8.2%	3.9%	662	01:45	35:54
2	29.4%	40.9%	16.4%	9.4%	3.9%	330	01:52	37:12
3	25.7%	40.0%	17.0%	12.5%	4.9%	530	02:04	24:31
4	31.1%	36.9%	18.3%	11.6%	2.1%	241	01:59	50:27
5	27.5%	35.9%	21.6%	13.1%	2.0%	153	02:22	19:26
6	23.9%	33.5%	18.6%	19.7%	4.3%	188	02:24	29:00
7	40.5%	32.4%	10.8%	10.8%	5.4%	37	01:37	14:02
8	28.6%	33.9%	17.7%	12.5%	7.3%	192	02:06	25:53
9	19.7%	31.6%	18.8%	19.7%	10.3%	117	02:59	32:30
10	25.2%	36.9%	23.3%	11.7%	2.9%	103	02:21	13:50
11	20.7%	24.3%	29.7%	20.7%	4.5%	111	03:16	18:21
12	19.2%	27.2%	26.5%	18.5%	8.6%	151	03:23	19:04
19	23.5%	23.5%	23.5%	29.4%	0.0%	17	03:36	09:33
21	30.5%	38.0%	12.8%	14.3%	4.5%	266	01:56	31:57
Other	0.0%	0.0%	100.0%	0.0%	0.0%	2	03:44	04:09
Total	**27.7%**	**37.2%**	**17.9%**	**12.7%**	**4.6%**	**3100**	**02:07**	**50:27**
**3 calls without incident district number not included*								

This table depicts the proportion of calls and the difference (in minutes) for arrival at an incident location, when RFD arrives before REMSA, as well as the median and maximum times before a REMSA unit arrives. Incident location is defined as “Incident District Number”, not the station responding.

The following tables show the same information as above, split by each of the priorities

District Number	Priority 1 calls, Time Interval when RFD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total	Median	Max
1	138	155	48	18	4	363	01:28	35:07
2	46	60	27	7	3	143	01:36	14:18
3	67	105	38	20	3	233	01:48	15:19
4	42	48	17	9	0	116	01:35	09:20
5	21	36	14	4	0	75	02:11	06:22
6	25	32	21	9	2	89	02:01	13:11
7	7	7	1	3	1	19	01:37	14:02
8	28	33	17	12	1	91	01:45	22:07
9	12	18	15	7	3	55	02:53	18:36
10	11	22	7	6	1	47	02:17	13:33
11	14	10	17	10	1	52	03:11	11:00
12	15	26	19	9	2	71	02:40	12:10
19	2	3	2	1	0	8	02:03	09:33
21	40	46	11	5	0	102	01:18	07:49
Other	0	0	1	0	0	1	03:19	03:19
Total	**468**	**601**	**255**	**120**	**21**	**1465**	**01:45**	**35:07**

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Incident District Number	Priority 2 calls, Time Interval when RFD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total	Median	Max
1	48	81	40	20	8	197	02:04	27:21
2	39	57	22	11	2	131	01:52	12:18
3	47	74	33	29	9	192	02:11	24:31
4	24	30	19	10	2	85	02:17	50:27
5	17	16	13	9	2	57	02:36	19:26
6	15	23	8	14	2	62	02:22	24:29
7	6	2	3	1	1	13	02:12	10:02
8	20	22	13	6	5	66	02:06	25:53
9	6	15	6	13	7	47	03:56	16:37
10	13	16	11	6	1	47	02:15	13:50
11	8	13	16	10	3	50	03:39	18:21
12	13	12	15	13	4	57	03:38	18:27
19	2	0	1	2	0	5	03:36	09:10
21	35	46	14	19	8	122	02:03	23:20
Total	**293**	**407**	**214**	**163**	**54**	**1131**	**02:15**	**50:27**

Incident District Number	Priority 3 calls, Time Interval when RFD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total	Median	Max
1	19	35	12	15	8	89	02:19	26:09
2	10	14	5	10	8	47	02:46	37:12
3	20	32	18	13	12	95	02:51	23:36
4	9	11	8	8	3	39	02:31	12:01
5	4	3	6	7	1	21	04:19	13:14
6	4	7	2	10	4	27	05:13	29:00
7	2	3	0	0	0	5	01:26	01:50
8	8	9	3	5	4	29	02:32	22:09
9	4	3	0	3	1	11	01:06	32:30
10	2	0	6	0	0	8	03:45	04:25
11	1	4	0	3	0	8	02:57	07:36
12	1	3	6	4	7	21	05:01	19:04
19	0	1	1	2	0	4	04:57	09:00
21	6	8	8	13	4	39	03:40	31:57
Other	0	0	1	0	0	1	04:09	04:09
Total	**90**	**133**	**76**	**93**	**52**	**444**	**03:00**	**37:12**

Incident District Number	Priority 9 calls, Time Interval when RFD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total	Median	Max
1	3	3	2	2	3	13	03:04	35:54
2	2	4	1	3	0	10	02:34	06:53
3	2	3	2	4	0	11	03:28	09:26
4	0	0	0	1	0	1	07:02	07:02
6	1	1	4	4	0	10	04:36	06:41
8	0	2	1	1	0	4	03:16	08:22
9	1	1	1	0	1	4	03:28	10:31
10	0	0	0	0	1	1	13:33	13:33
11	0	0	0	0	1	1	11:16	11:16
12	0	0	0	2	0	2	06:31	07:32
21	0	1	1	1	0	3	03:58	07:44
Total	**9**	**15**	**12**	**18**	**6**	**60**	**03:42**	**35:54**

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ALL RFD CALLS

RFD Station by Station Response Times for Calls In and Out of District

The following maps depict median response times, per station, for when a station is responding to calls within the district versus when they respond to calls out of their district. The tables below provide each station's median response time for all EMS calls which matched to REMSA calls for service for Quarter 1.

**response times for these maps was measured from dispatch to arrival on scene, which according to NFPA Standards should be within 5 minutes or less for a BLS responder. This includes the measureable timestamp of 1 minute from dispatch to enroute and 4 minutes from enroute to on scene.

Station #9 had only 1 call out of district, so was not included in the Out of Station District map.

Station Number	Total Calls Per Station	% of Calls In District	# of Calls In District	In District Median Response Time	# of Calls Out of District	Out of District Median Response Time
1	1450	90.0%	1305	03:46	145	05:48
2	578	97.2%	562	05:17	16	09:03
3	1042	92.3%	962	04:55	80	07:06
4	551	92.2%	508	04:49	43	05:30
5	337	77.7%	262	06:02	75	07:42
6	355	94.9%	337	05:47	18	06:53
8	374	96.8%	362	05:55	12	08:09
9	219	99.5%	218	07:09	1	07:26
10	193	93.3%	180	06:16	13	06:28
11	228	67.1%	153	05:29	75	10:00
12	255	96.1%	245	06:38	10	08:42
21	596	93.3%	556	05:25	40	07:27
TOTAL	6178	91.5%	5650	05:07	528	07:08
Total N =7170; Used N = 6178 (86%); 990 calls cancelled enroute/no arrival time; 3 calls with no district number						

The majority of calls for service are within each station's district (91.5%), ranging from 67.1% for Station #11 to 99.5% for Station #9. Median response times were shorter for each station when they respond to calls within the station's respective district.

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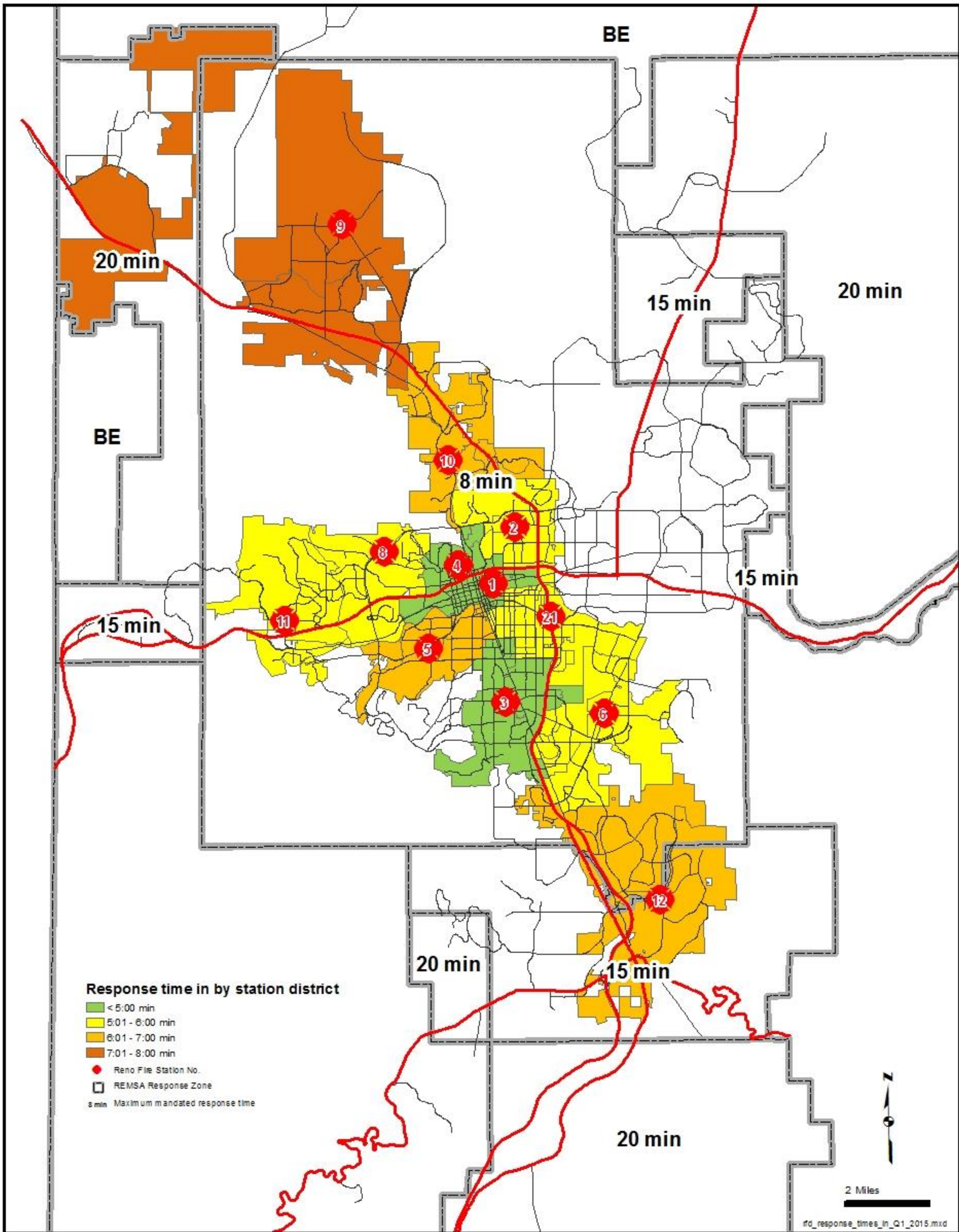
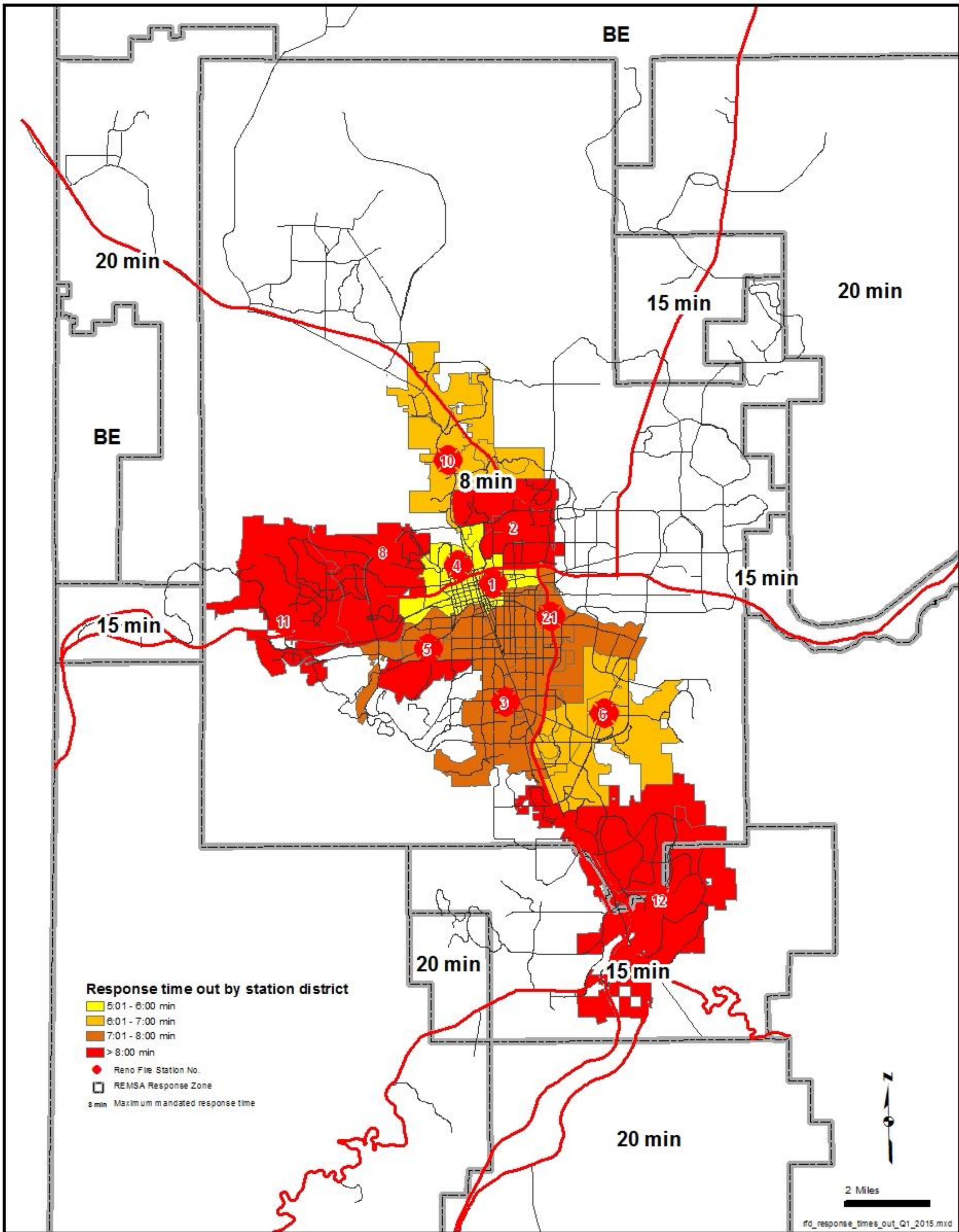
RFD SBS Q1 2015 - Response Time In



RFD SBS Q1 2015 - Response Time Out



Unincorporated Washoe County Analyses

Unincorporated Washoe County is served by Truckee Meadows Fire Protection District (TMFPD). TMFPD reported 1,803 unique incidents, of which 95% (n=1,722) were considered as having the potential to match to a REMSA incident. Of the 1,722 calls, 99.4% were matched to a REMSA incident. There were 44 incidents which were not included in any of the Regional or Jurisdictional analyses, as those incidents occurred outside of the TMFPD response area. This includes Gerlach, Pyramid Lake and other areas outside of the Truckee Meadows Fire Protection District response area.

Approximately 86.4% of TMFPD's reported incidents were measured to evaluate the Washoe County PSAP performance according to NFPA Alarm Handling Standards. The standard states the PSAP 9-1-1 call taker will transfer 95% of calls to REMSA within 30 seconds. Of the calls measured, 30.5% of calls were transferred to REMSA within 30 seconds. The median time for PSAP answering a call and transferring to REMSA is 0:47 seconds.

Approximately 97.8% of TMFPD reported calls were analyzed to measure performance relative to NFPA Operating and Alarm Processing Standards. The standard states 80% of calls will result in fire dispatched to a scene within 60 seconds of the PSAP 9-1-1 call taker answering the phone and 95% of calls will result in fire dispatching within 106 seconds. Of the 97.8% of calls measured, 50.6% resulted in fire dispatch within 60 seconds and 81.5% within 106 seconds. The median time for PSAP answering a call and TMFPD Dispatching is 01:00 minute.

The median turnout time (fire dispatch to fire enroute) for TMFPD is 0:55 seconds, resulting in 55.9% of calls which met the NFPA standard which states 90% of calls shall have a turnout time within 60 seconds. The travel time standard states 90% of calls will have a unit on scene within 240 seconds/4 minutes (fire enroute to fire arrival). Although TMFPD is licensed to provide Advanced Life Support services to their citizens, the NFPA standard for ALS response is applicable only if a responder with an AED or a BLS unit arrived within 240 seconds or less. Therefore, with the Washoe County system being two-tiered, TMFPD is measured against the BLS standard as the first responder on scene. Approximately 89.6 % of TMFPD incidents were measured for this guideline and 35% met the NFPA travel time standard. The median response time for TMFPD was 04:57 minutes.

Of the total matched calls, 96% (n=1,646) were analyzed to determine which agency received the 9-1-1 call first, PSAP or REMSA. Approximately 88.3% of analyzed calls were first reported to a PSAP, prior to being transferred to REMSA for EMD.

Within the Unincorporated Washoe County the median time from the initial call (earliest time stamp for any given incident) to each agency dispatching and arriving on scene is presented in Table 5.3. The median time from the initial call to TMFPD dispatch is 01:02 minutes, from the initial call to REMSA dispatch (clock start) is 01:14 minutes, to TMFPD arrival is 07:23 minutes, and REMSA arrives 10:50 minutes after the initial call.

TMFPD arrived first on scene for 74.6% of the measured incidents during Q1. TMFPD is dispatched after REMSA's clock start (dispatch delay), on 63.2% of measured incidents, and when this dispatch delay occurs, TMFPD arrives first on scene 65% of the time. Approximately 13.5% of all matched calls are impacted by a delay in dispatch over 1 minute (Table 5.7).

Table 5.8 shows the median response time from the initial call to the first arriving unit is 06:53 minutes for all calls. When TMFPD is dispatched first, the median response time is 06:44 minutes, and when dispatched second, the median response time is 07:12 minutes. This indicates the patients' median wait time increases by 0:28 seconds when TMFPD is dispatched second, compared to calls when SFD is dispatched first.

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Table 5.1 Description of call data reported by TMFPD, de-duplicated, and matched by priority.

Description of Call Data	TMFPD
All calls reported (Original denominator)	1846
Duplicates Removed	43
Total Incidents Reported (Deduplicated)	**1803**
Outside Washoe County	13
Fire "611 cancelled enroute" calls not matched	10
REMSA not expected on scene	46
Training/test calls removed	-
Non-career (volunteer) fire calls removed	44
New Number to Match	**1690**
LinkPlus Match*	1461
Manually matched	222
FULL MATCH *	**1683 (99.6%)**
P1**	762 (45.3%)
P2**	620 (36.8%)
P3**	264 (15.7%)
P9**	37 (2.2%)

*Calculated using "New Number to Match" as the denominator
**Percent of total "FULL MATCH" calls

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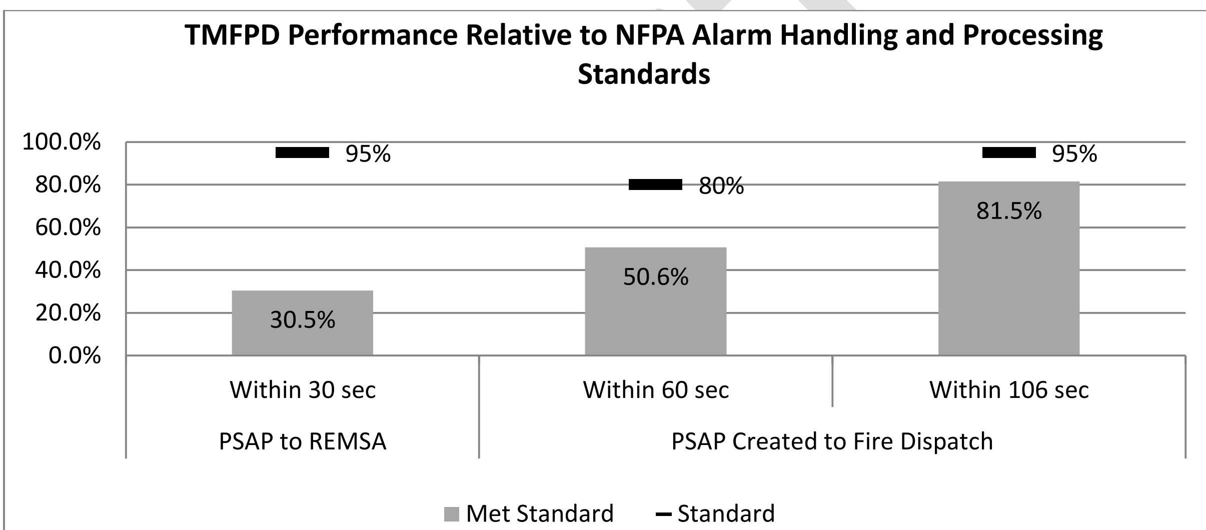
Alarm Handling Standards

The alarm handling standard measures the time difference between a PSAP 9-1-1 call taker answering the phone to a REMSA dispatcher answering the phone. NFPA Standards indicate this action should occur within 30 seconds or less at least 95% of the time. For this analysis, 86.4% or 1,454 of the total submitted calls were used, and of those 30.5% of alarms were transferred within 30 seconds. The median time for this process is 0:47 seconds. Those excluded from analysis did not match to REMSA or did not have a PSAP timestamp.

Operating and Alarm Processing Standard

The time measured for PSAP and fire dispatchers is the difference between the PSAP 9-1-1 call taker answering the phone to the fire dispatcher toning out the call to the fire station. The NFPA standard states 80% of emergency alarm processing shall be completed within 60 seconds and 95% shall be processed within 106 seconds. RFD processed 50.6% of alarms within 60 seconds and 81.5% within 106 seconds. The median time to process an alarm is 01:00 minute.



Variables	Standard	Expected	Total Calls	Calls Used		Met Standard		Median
		%	#	#	%	#	%	Time
PSAP to REMSA	30 seconds or less	95%	1683	1454	86.4%	444	30.5%	0:47
PSAP to Fire Dispatch	60 seconds or less	80%	1759	1720	97.8%	870	50.6%	1:00
PSAP to Fire Dispatch	106 seconds or less	95%	1759	1720	97.8%	1402	81.5%	1:00

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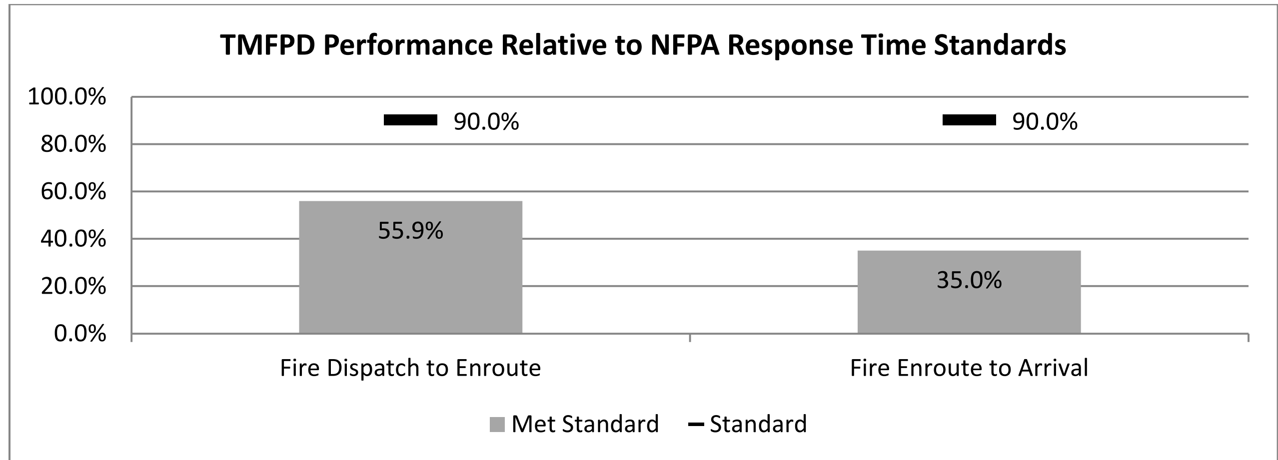
Response Time Standards

Includes fire agency data only and measures fire turn out time, which is the amount of time between fire dispatch and fire enroute. NFPA standards states on 90% of calls this should occur within 60 seconds. For this analysis, 99.6% (n=1,752) of the total submitted calls were used, of those, 55.9% met the standard. The median time was 0:55 seconds. Those excluded did not match or did not have a dispatch timestamp. The travel time standard states from fire enroute to fire arrival, 90% of should arrive within 4 minutes. Approximately 89.6% of the total submitted calls were measured, of those 35% met the standard. The median travel time was 04:57 minutes. Those excluded from analysis did not have a dispatch timestamp and/or an arrival on scene time stamp.



Variables	Standard	Expected	Total Calls	Calls Used		Met Standard		Median
		%	#	#	%	#	%	Time
Fire Dispatch to Enroute	60 seconds or less	90%	1759	1752	99.60%	982	55.90%	0:55
Fire Enroute to Arrival	240 seconds (4 minutes) or less	90%	1759	1577	89.65%	552	35.00%	4:57

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TMFPD MATCHED CALLS ONLY

Table 5.2 The table below indicates the proportion of calls when PSAP received notification of a call prior to REMSA.

For this analysis, 93% or 1,646 of the total submitted calls were used. Those excluded did not match or did not have a PSAP timestamp.

Agency	#	%
REMSA First	192	11.7%
PSAP First	1454	88.3%
Total N = 1690, Used N= 1646, 97%		

Table 5.3 Typical call response using median time for each time stamp.

The initial call (IC) time was calculated using either REMSA call pick up time or PSAP Time, depending on which was first. If PSAP time was missing, then the earliest available Fire time stamp was used. For this analysis, 84% or 1,419 of the total submitted calls were used. Those excluded did not have one or more time stamps available for utilization.

REMSA Priority	Median Time from Initial Call (IC) to Dispatch and On Scene			
	IC to Fire Dispatch	IC to REMSA Dispatch	IC to Fire Arrival	IC to REMSA Arrival
1	01:01	0:01:12	0:07:13	0:10:25
2	01:02	0:01:15	0:07:29	0:10:54
3	01:03	0:01:14	0:07:28	0:12:18
9	01:05	0:01:21	0:08:09	0:12:30
All	01:02	0:01:14	0:07:23	0:10:50
Total N = 1,690, Used N = 1,419 (84%)				

For all calls the median time from the initial call to Fire dispatch is 01:02 minutes, from the initial call to REMSA dispatch (clock start) is 01:14 minutes, to Fire arrival is 07:23 minutes, and REMSA arrives 10:50 minutes after the initial call.

Table 5.4 Jurisdictional information that indicates the first responding unit on scene, by priority.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	176	25.8%	132	27.2%	42	19.1%	6	18.2%	356	25.1%
TMFPD First	501	73.6%	352	72.6%	178	80.9%	27	81.8%	1058	74.6%
Same Time	4	0.6%	1	0.2%	0	0.0%	0	0.0%	5	0.4%
Total	681	100.0%	485	100.0%	220	100.0%	33	100.0%	1419	100.0%
Total N = 1690, Used N = 1419 (84%)										

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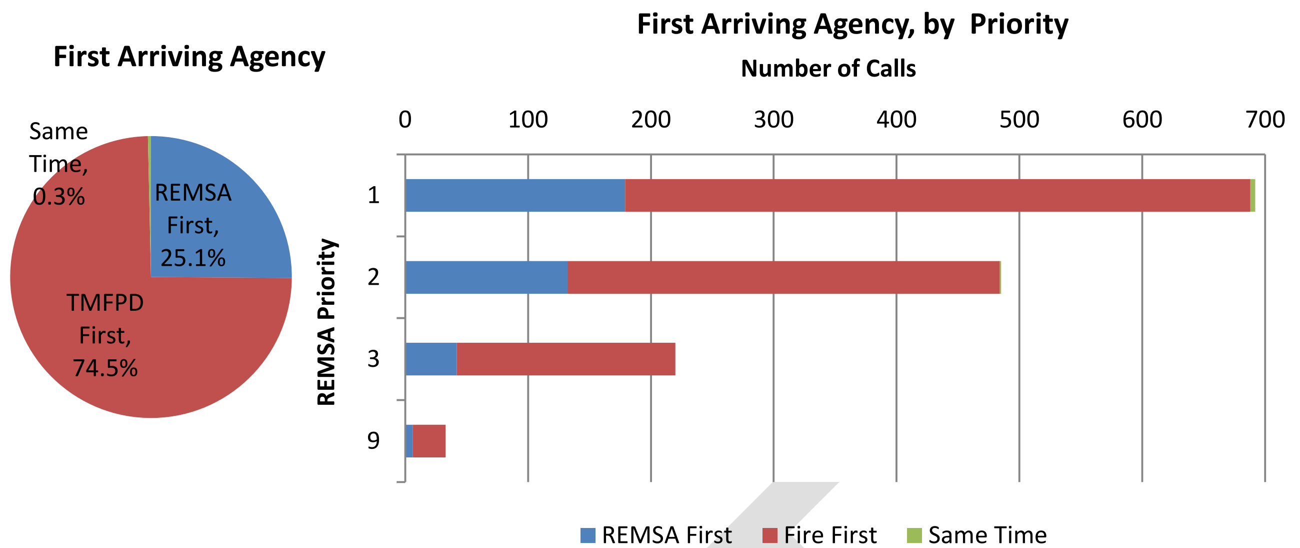

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The following tables and charts allow TMFPD to evaluate response in terms of the number and percent of calls, by REMSA priority, impacted when TMFPD is not being dispatched prior to REMSA's clock start. TMFPD was dispatched second 603 out of the 1683 matched calls (35.8%) during Q1.

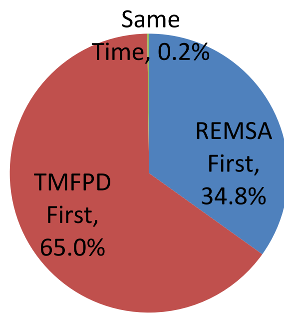
Table 5.5 Illustrates how many calls TMFPD was dispatched before, after or at the same time as REMSA's clock starting.

For this analysis, 99.5% or 1,683 of the total submitted calls were used. Those excluded did not match or did not have a fire dispatch timestamp.

Agency	#	%
REMSA First	603	35.80%
Fire First	1063	63.20%
Same Time	17	1.01%
Total N = 1690, Used N = 1683, (99.5 %)		

Table 5.6 Jurisdictional information that indicates the first responding unit on scene, when TMFPD is dispatched second.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	83	36.6%	61	36.3%	26	29.9%	1	10.0%	171	34.8%
TMFPD First	143	63.0%	107	63.7%	61	70.1%	9	90.0%	320	65.0%
Same Time	1	0.4%	0	0.0%	0	0.0%	0	0.0%	1	0.2%
Total	227	100.0%	168	100.0%	87	100.0%	10	100.0%	492	100.0%
Total N = 1690, Used N = 492 (29%)										



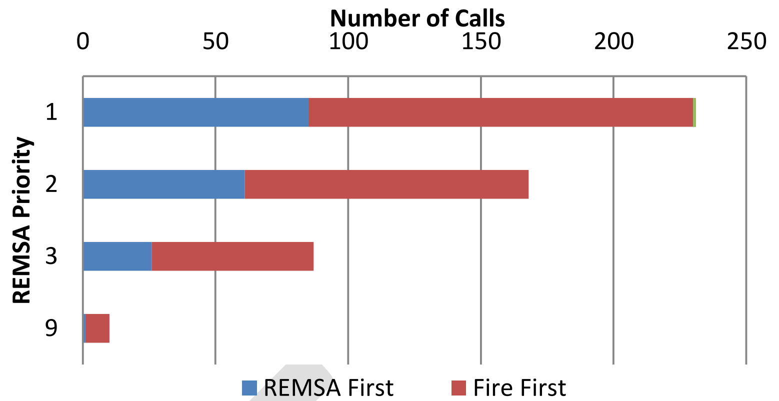


Table 5.7 Call volume breakdown by minutes/seconds for calls when Fire is dispatching second

Time in Delay	#	%
<= 1:00 min	376	22.3%
1:01 to 2:00 min	76	4.5%
2:01 to 3:00 min	56	3.3%
3:01 to 4:00 min	28	1.7%
4:01 to 5:00 min	23	1.4%
5:01 to 6:00 min	7	0.4%
6:01 to 7:00 min	6	0.4%
7:01 to 8:00 min	4	0.2%
8:01 to 9:00 min	3	0.2%
9:01 to 10:00 min	4	0.2%
over 10:00 min	20	1.2%
Total N =1690, Used N =603 (35%)		

The total number of calls with a dispatch delay over 1 minute was 227, which represents 13.5% of all matched calls for service.

Table 5.8 The table below shows how long a patient is waiting from the initial call to the first arriving unit on scene and how those median times are impacted when the Fire agency is not being dispatched first.

Priority Number	Median Response Time: Initial call to First Arriving Unit		
	Patient's Perspective	**Fire Dispatched First***	**Fire Dispatched Second***
1	0:06:48	0:06:39	0:06:53
2	0:06:53	0:06:38	0:07:22
3	0:07:08	0:06:53	0:07:51
9	0:07:58	0:07:25	0:08:34
All	0:06:53	0:06:44	0:07:12
N calls used in each column	N = 1419 (83%)	N=912 (64%)	N=492 (34%)
** 15 calls with same dispatch time not included in column 2 or 3.*			

For all calls, the patient's median wait time increases by 00:28 seconds when fire is not being dispatched first.

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The following tables only include those matched calls when TMFPD arrived on scene prior to REMSA.

Table 5.9 Time difference between arrivals, by TMFPD and REMSA priority when TMFPD arrives on scene first

Incident District Number	All calls (P1-P9) Time Intervals when TMFPD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total Number of Calls	Median	Max
TM13	15.4%	29.7%	20.9%	23.1%	11.0%	91	0:03:57	0:06:08
TM14	16.4%	32.8%	19.4%	23.9%	7.5%	67	0:03:23	0:40:03
TM15	17.0%	31.2%	19.1%	28.8%	3.9%	330	0:03:01	1:06:44
TM16	0.0%	4.1%	6.1%	44.9%	44.9%	49	0:03:07	0:26:28
TM17	10.2%	27.0%	20.4%	33.2%	9.3%	226	0:09:41	0:41:01
TM18	0.9%	5.2%	13.0%	44.3%	36.5%	115	0:04:18	0:43:54
TM30	0.0%	7.7%	15.4%	7.7%	69.2%	13	0:08:22	0:29:09
TM35	15.4%	30.8%	33.3%	17.9%	2.6%	39	0:12:19	0:38:30
TM36	7.5%	16.4%	17.9%	40.3%	17.9%	67	0:03:08	0:15:06
TM37	5.7%	22.9%	14.3%	40.0%	17.1%	35	0:05:37	0:16:29
TM39	25.0%	5.0%	5.0%	30.0%	35.0%	20	0:05:31	0:16:36
Other	16.7%	16.7%	33.3%	33.3%	0.0%	6	0:06:40	0:46:00
Total	**11.7%**	**24.1%**	**18.3%**	**31.9%**	**14.0%**	**1058**	**0:04:29**	**1:06:44**

This table depicts the proportion of calls and the difference (in minutes) for arrival at an incident location, when TMFPD arrives before REMSA, as well as the median and maximum times before a REMSA unit arrives. Incident location is defined as "Incident District Number", not the station responding.

The following tables show the same information as above, split by each of the priorities

Incident District Number	Priority 1 Calls, Time Intervals when TMFPD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total Number of Calls	Median	Max
TM13	7	11	11	10	2	41	0:03:09	0:18:19
TM14	8	12	5	9	0	34	0:02:36	0:09:42
TM15	31	52	34	38	2	157	0:02:57	0:15:12
TM16	0	1	1	12	8	22	0:09:31	0:22:56
TM17	10	32	19	30	3	94	0:03:26	0:15:38
TM18	1	2	10	26	18	57	0:07:02	0:16:57
TM30	0	0	0	1	5	6	0:13:34	0:17:16
TM35	3	7	9	2	1	22	0:03:05	0:15:06
TM36	3	7	6	16	7	39	0:05:37	0:16:29
TM37	1	6	2	4	1	14	0:03:04	0:13:20
TM39	5	0	0	3	3	11	0:05:49	0:18:01
Other	1	1	0	2	0	4	0:04:11	0:06:08
Total	**70**	**131**	**97**	**153**	**50**	**501**	**0:04:05**	**0:22:56**

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Incident District Number	Priority 2 Calls, Time Intervals when TMFPD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total Number of Calls	Median	Max
TM13	5	11	6	9	4	35	0:03:25	0:40:03
TM14	1	7	5	5	0	18	0:03:21	0:08:45
TM15	17	36	16	38	4	111	0:03:08	0:26:28
TM16	0	0	2	7	6	15	0:09:35	0:29:54
TM17	7	21	18	27	5	78	0:04:10	0:12:41
TM18	0	3	4	16	16	39	0:09:22	0:24:45
TM30	0	1	2	0	3	6	0:08:31	0:19:07
TM35	1	5	2	3	0	11	0:02:49	0:08:42
TM36	2	1	5	9	4	21	0:05:39	0:15:20
TM37	1	1	2	6	0	10	0:05:39	0:09:43
TM39	0	1	1	2	2	6	0:06:31	0:23:20
Other	0	0	2	0	0	2	0:03:57	0:04:39
Total	**34**	**87**	**65**	**122**	**44**	**352**	**0:04:38**	**0:40:03**

Incident District Number	Priority 3 Calls, Time Intervals when TMFPD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total Number of Calls	Median	Max
TM13	0	5	1	2	3	11	0:03:29	0:28:32
TM14	2	3	3	2	3	13	0:03:37	0:28:38
TM15	8	12	12	16	7	55	0:04:07	0:19:16
TM16	0	1	0	3	6	10	0:12:21	0:20:07
TM17	6	6	8	16	13	49	0:05:48	0:43:54
TM18	0	1	1	8	6	16	0:09:09	0:23:27
TM30	0	0	0	0	1	1	0:38:30	0:38:30
TM35	1	0	2	2	0	5	0:04:35	0:06:39
TM36	0	2	1	1	1	5	0:03:02	0:10:25
TM37	0	1	0	4	5	10	0:10:09	0:16:36
TM39	0	0	0	1	2	3	0:25:15	0:46:00
Total	**17**	**31**	**28**	**55**	**47**	**178**	**0:06:01**	**0:46:00**

Incident District Number	Priority 9/Omega Calls, Time Intervals when TMFPD arrives First							
	<1 min	1:01-3:00 mins	3:01-5 mins	5:01-10 mins	10+ mins	Total Number of Calls	Median	Max
TM13	2	0	1	0	1	4	0:03:00	0:30:22
TM14	0	0	0	0	2	2	0:51:48	1:06:44
TM15	0	3	1	3	0	7	0:03:45	0:07:13
TM16	0	0	0	0	2	2	0:34:33	0:41:01
TM17	0	2	1	2	0	5	0:03:27	0:06:44
TM18	0	0	0	1	2	3	0:13:09	0:29:09
TM35	1	0	0	0	0	1	0:00:38	0:00:38
TM36	0	1	0	1	0	2	0:04:48	0:07:21
TM37	0	0	1	0	0	1	0:04:38	0:04:38
Total	**3**	**6**	**4**	**7**	**7**	**27**	**0:05:26**	**1:06:44**

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Special Areas

DRAFT

REMSA & TMFPD Tribal Lands Q1 Summary
(non-Wadsworth calls only)

July REMSA Tribal calls:

- 6 calls to Nixon, none matched to TMFPD
  - 4 cancelled enroute
  - 2 completed calls
  - 0 transports by REMSA
- 8 calls to Sutcliffe, none matched to TMFPD
  - 4 cancelled enroute
  - 4 completed calls
  - 3 transport by REMSA
- 7 calls in "Washoe County", 3 matched to TMFPD/cancelled enroute on all 3
  - 2 cancelled enroute
  - 5 completed calls
  - 5 transports by REMSA

August REMSA Tribal calls:

- 4 calls to Nixon, none matched to TMFPD
  - 2 cancelled enroute
  - 2 complete
  - 2 transports by REMSA
- 10 calls to Sutcliffe, 3 matched to TMFPD/cancelled enroute on 1 call
  - 5 cancelled enroute
  - 5 completed calls
  - 2 transports by REMSA
- 5 calls in "Washoe County", 3 matched to TMFPD/cancelled enroute on all 3
  - 3 cancelled enroute
  - 2 completed calls
  - 2 transports by REMSA

September REMSA Tribal calls:

- 2 calls to Nixon, none matched to TMFPD
  - 1 cancelled enroute
  - 1 completed call
  - 0 transports by REMSA
- 4 calls to Sutcliffe, none matched to TMFPD
  - 2 cancelled enroute
  - 2 completed calls
  - 2 transports by REMSA
- 1 call in "Washoe County", 1 matched to TMFPD/cancelled enroute
  - 1 cancelled enroute
  - 0 completed calls
  - 0 transports

DRAFT

Gerlach Volunteer Fire Department

Summary: The Gerlach Volunteer Fire Department (GVFD) responds to approximately 50 EMS calls per year, the majority of which occur during the summer months. The town of Gerlach is located in the rural region of Washoe County, which leads to some unique challenges surrounding EMS calls and responses. The incident location is not often designated by an address, but instead a general vicinity. As illustrated in the table below, the average response distance is much greater than a typical city fire department, which impacts the total travel time, time spent on scene and time to transport the patient to higher level of care for any given incident.

Below is a table summary of the EMS calls for service during Q1.

Month	Number of Incidents	Fire Calls	EMS Calls	Other Calls	Cancelled Enroute	Average Response Distance	Maximum Response Distance	Number of Careflight/REMSA Responses
July	6	3	3	0	1	35 miles	70 miles	1
August	14	4	8	2	2	20 miles	60 miles	3
September	14	4	8	2	1	16 miles	72 miles	2
Total	**34**	**11**	**19**	**4**	**4**	**23 miles**	**72 miles**	**6**

REMSA Summary of Gerlach calls

July REMSA Gerlach calls:

- 1 cancelled enroute
- 1 completed calls
- 1 transport by REMSA

August REMSA Gerlach calls:

- 2 cancelled enroute
- 0 completed calls
- 0 transports by REMSA

September REMSA Gerlach calls:

- 4 cancelled enroute
- 2 completed calls
- 2 transports by REMSA

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Map of Wadsworth

Tribal Land

1 in = 1 miles

REMSA & TMFPD Wadsworth Calls

REMSA reported 30 calls for service in Wadsworth, NV, while TMFPD reported 23 calls for service in Wadsworth. Between the two agencies, 14 calls matched and were included in the analysis in the previous sections. Of the remaining TMFPD calls, 6 did not match, and 3 calls that REMSA was not expected on scene.

REMSA Wadsworth Calls				
Month	**Total REMSA Calls**	**REMSA Cancelled**	**REMSA Completed**	**REMSA Transports**
July	11	5	6	4
August	11	1	10	6
September	8	2	6	2
Total	**30**	**8 (26.6%)**	**22 (73.3%)**	**12 (40.0%)**

REMSA and TMFPD Wadsworth Calls				
Month	**Total REMSA Calls**	**Matched**	**TMFPD Cancelled**	**TMFPD Completed Call**
July	11	3	2	1
August	11	9	6	3
September	8	2	2	0
Total	**30**	**14 (46.6%)**	**10 (33.3%)**	**4 (13.3%)**

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Reno Tahoe Airport Authority

SUMMARY:

There were a total of 67 known calls to the Reno Tahoe International Airport (RTAA) during Quarter 1. Of the 57 calls reported by REMSA and 59 calls reported by Reno Tahoe Airport, 49 calls matched. The matched calls represent 86.0% of all known REMSA calls for service to the airport and 83.1% of the RTAA's calls to REMSA for service during Q1. The table below depicts call details.

Call Details	Total Calls (% calculated using total known calls, n=67)	Matched (% calculated using total number matched, n=49)	Unmatched (% calculated using total number unmatched, n=18)
RTAA calls	59	49	10
REMSA calls	57	49	8
Priority 1	18 (26.8%)	17 (34.7%)	1 (5.5%)
Priority 2	28 (41.7%)	22 (44.9%)	6 (33.3%)
Priority 3	11 (16.4%)	10 (20.4%)	1 (5.5%)
Priority Unknown	10 (14.9%)	NA	10 (55.5%)
REMSA Cancelled	12 (17.95)	11 (22.4%)	1 (5.5%)
REMSA Median Response Time	6:21	6:36	5:21
REMSA Transported	17 (25.3%)	17 (34.7%)	0 (0.0%)

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WASHOE COUNTY
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Agenda Item #9

STAFF REPORT
EMS ADVISORY BOARD MEETING DATE: January 7, 2016

TO: EMS Advisory Board Members

FROM: Brittany Dayton, EMS Coordinator
775-326-6043, bdayton@washeocounty.us

SUBJECT: Discussion and possible acceptance of a presentation on the regional Fire EMS trainings by JW Hodge, REMSA Education and Community Outreach Manager.

SUMMARY
In accordance with article 11.4 of the Amended and Restated Franchise for Ambulance Services, EMS staff is working with EMS agencies to deliver quarterly training for first responders, provided by REMSA. JW Hodge, REMSA Education and Community Outreach Manager, will provide a brief presentation on the Fire EMS trainings that occurred during the first two quarters of fiscal year 2014-2015.

PREVIOUS ACTION
The EMS Advisory Board heard a presentation on Fire EMS trainings during the March 4, 2015 Board meeting and directed staff to work with the regional EMS agencies to develop a process and training topics.

At the following EMS Advisory Board meeting on June 4, 2015, the Board heard a subsequent presentation on the planning, structure and topics for Fire EMS trainings. The Board directed staff to present to the District Board of Health (DBOH) for possible approval.

EMS staff presented to the DBOH on June 25, 2015 and the Board moved to accept the Fire EMS training framework.

BACKGROUND
In August 2012 TriData completed an analysis of the emergency medical services in Washoe County. This report included 38 recommendations to enhance the EMS system. One of the recommendations (number 31) suggested the WCHD enter into an agreement with REMSA for the provision for county-wide EMS education and training with the opportunity for local agencies to "opt-out" of, or augment REMSA provided education and training.

Based on TriData recommendation 31 and Principle of Agreement 5a, regional Fire EMS training was included in article 11 of the Amended and Restated Franchise Agreement for Ambulance Service. REMSA offers continuing education units (CEUs) and other training opportunities that are available to all first responders; however according to the Franchise language, Fire EMS trainings are to be determined based on recommendations of the Regional EMS Advisory Board as approved by the District.

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The region met in April 2015 to outline the structure and content of the Fire EMS trainings. It was determined that REMSA would offer quarterly trainings simulating the response of real world EMS calls. Fire and REMSA crews will "respond" with appropriate units/apparatus and practice all elements of the call from arrival to possible transport.

The training topics focus on types of calls that do not occur as often in our region. The first several trainings include topics like drowning, MCI/triage, hyperthermia, long bone fractures and full cardiac arrest. These trainings will allow participating first-responders the opportunity to practice and maintain certain skills they do not use on a frequent basis in the field.

REMSA held the first quarterly Fire EMS training on August 3 and 5, 2015, which included 56 participants from REMSA, RFD and TMFPD. The crews responded to a simulation of a drowning victim and had the opportunity to review and practice CPAP and PEEP skills. The initial feedback was very positive; the crews enjoyed the opportunity to train with their own personnel and get to know some of the REMSA responders better.

The second quarter training simulated a response to an altered adult hypothermic patient. RFD completed the training on December 15 and currently TMPFD is scheduled for December 30.

FISCAL IMPACT
There is no additional fiscal impact to the budget should the Board accept the presentation and update on the regional Fire EMS trainings.

RECOMMENDATION
Staff recommends the EMS Advisory Board accept the presentation on the regional Fire EMS trainings.

POSSIBLE MOTION
Should the Board agree with staff's recommendation, a possible motion would be:

"Move to accept the presentation on the regional Fire EMS trainings."

WASHOE COUNTY
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STAFF REPORT
REGIONAL EMERGENCY MEDICAL SERVICES ADVISORY BOARD
MEETING DATE: January 7, 2016

TO: Regional EMS Advisory Board Members

FROM: Christina Conti, EMS Program Manager
775-326-6042, cconti@washoecounty.us

SUBJECT: **Discussion and possible approval and recommendation to present the draft map response zones within the Washoe County REMSA ambulance franchise service area to District Board of Health.**

SUMMARY

The purpose of this agenda item is report on the progress the region has made with regards to the revision of the response zones within the Washoe County REMSA ambulance franchise service area. Consensus has been reached inside the franchise service area.

PREVIOUS ACTION

During the March 2015 EMS Advisory Board (EMSAB) meeting, as part of the program update, staff reviewed the meeting held between EMS personnel, District Health Officer Kevin Dick and REMSA staff on Monday, February 23, 2015. The purpose of the meeting was to discuss the franchise service area and propose changes to the response map.

EMSAB members recommended a meeting with regional partners to discuss the proposed changes. The recommended changes to the map included Sparks special zone 5.1 as well as the Mount Rose corridor.

During the June 2015 EMSAB, EMSAB members approved the project charter that outlined the process for revising the response zones within the Washoe County REMSA ambulance franchise service area.

EMSAB members approved a presentation on the revision process during the October 23, 2015 meeting.

BACKGROUND

During the March 2015 EMSAB meeting, it was recommended that the EMS Working Group reconvene to discuss the proposed map revisions. This meeting was held on April 15, 2015 and had representatives from all regional fire partners, WCSO, WCHD, and REMSA. During this meeting it was determined that the historical method of updating the map should include more specific criteria such as standards of coverage. Previously map revisions were based on compliance calculations of specific study zones for a six month period. This is not a viable method as it does not include specific and quantifiable measures that should be included in the process.

After extensive discussion, the regional partners recommended that the antiquated map be updated. The recommendation is that the current map remains and the currently suggested revisions should cease in lieu of developing a new population density driven map that factors in call volume.

The EMS Program staff developed a project charter (attached) that would provide a structure to the project, to include objectives and a timeline for the revision process. The charter will be used by the EMS Working Group subcommittee to modernize the Washoe County REMSA ambulance franchise response zones, based on specific criteria and quantifiable measures.

The first subcommittee meeting was held on May 19, 2015. During the meeting, recommendations to the project charter were discussed and the document was approved. The next steps were proposed, to include obtaining the approval of the proposed path by the EMS Advisory Board.

EMS staff, along with Gary Zaepfel from Washoe County GIS, went to San Joaquin County, Stockton, CA, to meet with their EMS Oversight Program. The meeting was excellent and the EMS Oversight Program was able to learn about several different processes that could be explored regionally.

EMS staff met with regional fire/REMSA partners on June 22, 2015 to review the Stockton trip and the information obtained from contractor Insprionix. During this meeting, the methodology for map development was agreed to and the process for developing the maps was established. The region would primarily utilize population density, provided by the census report, and not call data. In addition, a methodology for future reviews of the map was discussed.

EMS staff, along with Mr. Zaepfel, have met with or corresponded with regional partners several times over the last four months to develop a revised franchise area response map. With the assistance of Mr. Zaefpel, the region sent several data layers to Inspironix for review, analysis and recommendation. Inspironix developed a draft response map that the region began reviewing on August 26, 2015. During the meeting, the methodology for developing the draft map was reviewed and the proposed changes to the existing map were reviewed.

Mr. Zaepfel developed a PDF map with layers that included the draft zones, existing zones and call data for a 20 week period of time. The region met on September 25, 2015 to review the interactive map. The region determined that there were three areas of specific concern to review, the Spanish Springs and Cold Springs designations as well as the Southern Reno extension.

Over the course of the next three months, the region met on several different occasions to review the areas. Consensus was reached in both Spanish Springs and Cold Springs before the October 23, 2015 EMSAB meeting. Concerns regarding the feasibility of the Zone A extending as far south as recommended were listened to by regional partners. The EMS Oversight Program reached back out to Inspironix for some options to apply to the Southern Reno area. Inspironix provided seven options for the region to consider, with the caveat that the first four options should be strongly considered before moving on to the more aggressive options of the last three.

The last meeting was held on Monday, December 14, 2015. Regional consensus was reached for the South Reno extension. Inspironix options A and B have been included as a modification to the original recommendation. The original methodology of looking at the population density with a call volume overlay supports the reduction of a Zone A response in those areas.

The zones within the franchise area have reached a regional consensus. The final area that needs to be completed is the Mount Rose corridor. A couple meetings have been held and the EMS Oversight Program produced a report for FY 14-15 and the calls in that identified region. The proposal being discussed is to keep the franchise boundary at the 1982 voter approved ambulance service area line, but to employ an automatic aid agreement to improve service the corridor.

The next steps are the implementation process. The EMS Oversight Program is working with Inspironix and REMSA to draft a reasonable process that the region will support. The desired timeframe would be full implementation before July 1, 2016 so that the regional data reports can capture the changes being made in the system at the beginning of the fiscal year.

FISCAL IMPACT

There is no additional fiscal impact should the EMS Advisory Board approve and recommend the draft map response zones within the Washoe County REMSA ambulance franchise service area be presented to District Board of Health.

RECOMMENDATION

Staff recommends the Board approve and recommend EMS Oversight Program to present the draft map response zones within the Washoe County REMSA ambulance franchise service area to District Board of Health.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be: "Move to approve and recommend EMS Oversight Program to present the draft map response zones within the Washoe County REMSA ambulance franchise service area to District Board of Health."

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Agenda Item #11

STAFF REPORT
EMS ADVISORY BOARD MEETING DATE: January 7, 2016

TO: EMS Advisory Board Members

FROM: Brittany Dayton, EMS Coordinator
(775) 326-6043, bdayton@washoecounty.us

SUBJECT: Discussion and possible acceptance of a presentation on the proposed use of the IAED Omega determinant codes within the REMSA Franchise area.

SUMMARY

Omegas are 911 calls that are classified through the Emergency Medical Dispatch (EMD) process as non-emergent low acuity calls that can be referred to the Nurse Health Line (NHL) for assessment and evaluation by an Emergency Communications Nurse (ECN) to determine the most appropriate care resource, other than an ambulance response.

EMS staff coordinated and facilitated a meeting with the legal representatives of all EMS agencies to discuss Omegas on December 9, 2015. The meeting concluded with the legal representatives agreeing to develop an agreement/MOU between REMSA and the jurisdictions that states REMSA assumes patient care and legal responsibility of the patient once the call is determined an Omega and is transferred from the 911 system to the NHL. Additionally, the agreement should include fire agency protocols should a crew arrive on scene and disagree with the over the phone assessment.

PREVIOUS ACTION

REMSA presented to the EMS Advisory Board on June 4, 2015. The presentation reviewed the proposed use of the IAED Omega determinants codes and the procedure of referring these callers to the Nurse Health Line prior to dispatching an ambulance. The EMS Advisory Board directed EMS staff to work with regional partners to develop a comprehensive process for handling Omega calls.

EMS staff presented to the District Board of Health (DBOH) concerning Omegas on October 22, 2015. Members of the DBOH determined it was necessary to table the item until the EMS Advisory Board had an opportunity to discuss the topic and provide direction.

EMS staff then presented to the EMS Advisory Board on October 23, 2015. Members of the board voted unanimously to continue the item until the legal issue is resolved.

BACKGROUND

In 2011 the International Academy of Emergency Dispatch (IAED) included Omegas as part of the fourth pillar of the Academy when used in the ENC system. The IAED Omega determent is designed to identify patients who may safely be transferred to alternative care resources. These non-emergent low acuity calls do not need an ambulance response; however, if at any time a patient requests an ambulance, one will be dispatched.

The IAED has approved 200 Omega determinant codes; however, REMSA's Medical Director, Dr. Brad Lee, has initially approved 52 of the 200 for our region. The 52 selected Omega determinants have been discussed with the regional fire partners' Medical Directors and a consensus was reached on the use of these 52 Omega determinants codes.

At the direction of the EMS Advisory Board, EMS staff scheduled a meeting to discuss the Omega protocols for REMSA' s Franchise service area. The initial meeting was held on June 30, 2015 with regional agencies including REMSA, City of Reno, City of Sparks, Truckee Meadows Fire Protection District, North Lake Tahoe Fire Protect District and Pyramid Lake Fire Rescue. During the meeting, several items were discussed to include review of EMD process to ensure accurate determination of Omega calls, communication challenges, and the most effective methods for implementing an Omega protocol in the REMSA franchise service area.

On July 21, 2015 the region met to review a draft policy and release form developed by one of the partners. During this meeting it was requested that Health District EMS staff develop a universal form for all fire agencies if a crew arrives on-scene of an Omega call, since REMSA would not be dispatching an ambulance. The group also set a target implementation date of October 1, 2015 to allow for meetings with legal, training of crews and the approval of the EMS Advisory Board and DBOH.

EMS staff reached out to other regions to learn about other agencies' responses to Omega calls and used that information to develop recommendations for our region. In separate meetings with both fire and District Attorney's Office representatives, the recommendation of a verbal release first and a form second was supported. However, each regional agency's legal personnel would need to have a final review and approval of the process and release form prior to regional implementation.

An additional meeting was held on September 16, 2015. EMS staff presented the recommendations to the regional partners in attendance and they supported the practice of verbal or written release from the scene. The group made several revisions to the draft release form to simplify the process. Finally, it was decided that the implementation date should be changed to November 1, 2015 to allow additional time for legal review and approval, and training of personnel.

EMS staff scheduled a meeting on Friday, October 16, 2015 to discuss the feedback from the agencies' legal team and possible next steps for implementation. During this meeting the region agreed to a tiered implementation response plan for Omegas.

EMS staff met with legal representatives in December 2015 to discuss the concerns related to the proposed alternative response process for Omegas. During this meeting the legal representatives agreed to work together to write an agreement/MOU for Omega calls. They also requested staff to do some additional research and analysis on Omegas, and hold a meeting in January 2016 with legal and operational staff from the EMS agencies.

FISCAL IMPACT

There is no additional fiscal impact should the Board accept a presentation on the proposed use of the IAED Omega determinant codes within the REMSA Franchise area.

RECOMMENDATION

EMS staff recommends the EMS Advisory Board accept the presentation on the proposed use of the IAED Omega determinant codes within the REMSA Franchise area.

Depending on the timeline for the development of an agreement/MOU, the EMS Advisory Board Chair may call an additional meeting prior to April 2016 for further direction to staff and/or possible approval of the proposed alternative response process for Omegas within the REMSA Franchise area.

POSSIBLE MOTION

Should the Board agree with staff's recommendation a possible motion would be:

"I move to accept the presentation on the proposed use of the IAED Omega determinant codes within the REMSA Franchise area."

Staff Report
REGIONAL EMERGENCY MEDICAL SERVICES ADVISORY BOARD
MEETING DATE: January 7, 2016

TO: Regional EMS Advisory Board Members

FROM: Christina Conti, EMS Program Manager
775-326-6042, cconti@washoecounty.us

SUBJECT: **Update and possible direction to staff on EMSAB assignment of Franchise Agreement review and Mutual Aid process within the region.**

SUMMARY

The purpose of the staff report is to inform the EMS Advisory Board (EMSAB) on progress of the assignments given during the October 23, 2015 meeting. Direction was given to staff to: (1) look at both the Inter Local Agreement and the Franchise Agreement to bring back recommendations and/or options for a mechanism that puts patients care first and allows the jurisdictions to take action to address that topic, and (2) look at how the mutual aid system could be improved and possible solutions.

PREVIOUS ACTION

No previous action has been taken by this Board.

BACKGROUND

At the October 23, 2015 EMSAB meeting, the EMS Oversight Program (Program) brought an investigation to the Board for review and possible action. During the discussion, the Board provided direction to staff to review regional agreements and bring recommendations back to the Board.

The assignments given were two fold – review the Inter Local Agreement and Franchise agreement and also look at the mutual aid system for EMS in Washoe County.

The Inter Local Agreement, (ILA) upon review, does not have information relevant to mutual aid usage within the Washoe County EMS system. It is an administrative document that provides the framework for the development of the Program, EMSAB and the ability to review data from all partner agencies to measure the performance of the EMS system and be able to make recommendations for improvement. It is with the authority of the ILA that the Program has been able to begin looking into the usage of mutual aid.

With regards to reviewing the Amended and Restated Franchise Agreement for Ambulance Service, Article 2 grants REMSA the exclusive rights to contract for and through a contractor to provide both emergency and non-emergency ambulance service by ground on an exclusive basis within the Franchise Service Area. This right on an exclusive basis by its plain meaning naturally excludes other ground ambulance providers from the service area. The Franchise Agreement contains specific and

limited exceptions to the exclusive rights granted to REMSA. These exceptions include: (a) long-distance, inter-facility transports which originate outside the Franchise Service Area; (b) disaster mutual aid, as requested by REMSA; (c) mutual aid employed by REMSA; and (d) federally-operated ambulances. Pursuant to the terms of article 2.1, mutual aid is directed by REMSA.

Currently, REMSA has six agreements for mutual aid with surrounding regional partners. These agreements are for Priority 1 or Priority 2 calls within Washoe County and are only activated by the request of REMSA to the regional partner. The Program has recommendations to improve the mutual aid agreement usage within Washoe County as follows:

(1) Rewrite mutual aid agreements to include all priorities.

If the regional partner is not amenable to this, then the mutual aid agreement would remain P1 and P2 only. However, citizens of Washoe County benefit with the ability to call for mutual aid on P3 calls when it appears extended wait times are possible.

(2) Develop a "trigger" mechanism for requesting mutual aid.

Internally developing a mechanism that would automatically trigger the use of mutual aid partners would benefit Washoe County citizens and the partner agencies. A possible trigger could be the time associated with assigning an ambulance. For example, the NFPA standard for ambulance assignment is 120 seconds, 99% of the time. A possible trigger could be 180 seconds, or 3 minutes, for requesting mutual aid. When the 9-1-1 system is overloaded, wait times for transferring care at the hospitals is also impacted. The developed trigger should be able to incorporate all aspects of the system.

(3) Update Agreements

Currently, the practice for updating the mutual aid agreements is when a new Fire Chief is appointed. The Program recommends mutual aid agreements be reviewed on an annual basis and re-signed if one or both parties would like to change the terms. This annual review will ensure that system enhancements both in and around Washoe County are able be incorporated and utilized in the mutual aid agreements.

The Program also recommends a communications plan be developed specifically for mutual aid requests to ensure the partner working with the citizen is aware of the estimated arrival for transport to a hospital. Next steps on this assignment include meeting with REMSA administration to discuss these options and any other enhancements recommended by the Board. Additionally, working with the regional partners to identify any additional concerns they may have so that regionally the mutual aid system is utilized appropriately.

FISCAL IMPACT

There is no additional fiscal impact should the EMS Advisory Board accept the update and provide direction to staff on EMSAB assignment of Franchise Agreement review and mutual aid process within the region.

RECOMMENDATION

Staff recommends the Board accept the update and provide possible direction to staff on EMSAB assignment of Franchise Agreement review and mutual aid process within the region. Possible direction could include meeting with REMSA and regional EMS partners to develop an improved mutual aid process.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be:

"Move to accept the update on EMSAB assignment of Franchise Agreement review and Mutual Aid process within the region."