2019

Washington State Department of Health
Office of Community Health Systems
Rural Health and Emergency Medical Services Sections

2019 Rural EMS Service Survey Results Report

2019

Washington State Department of Health

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Executive Summary

In Washington state, the Department of Health (department) has regulatory oversight of the emergency care system. The department leads statewide advisory groups in establishing and monitoring system trends and outcomes, and works with system partners to develop and implement strategic plans for system improvements. Establishing statewide priorities and advocating for system improvements requires collaboration among system partners at many levels, so the department prioritizes partner-informed decision-making. Statewide variability in geography, demographics, funding mechanisms, and other influences may affect access to care and patient outcomes in rural, urban, and suburban communities in different ways. Through efforts such as cross-pollination , horizon scanning, monitoring national trends, actively seeking grant funding, and working with system partners to innovate ways to address challenges, the department is better prepared and informed to make system changes and to participate in policy making activities.

The department's EMS and Rural Health sections have prioritized the need to acquire information to better understand the intricacies of the growing challenges in rural EMS systems. National and statewide trends continue to show a decline in volunteer in EMS workforce, which may have bigger impacts in rural communities. Seventy-seven percent of the counties in Washington state meet the definition of "rural" in WAC 246-976-010. Seventy-three percent of the counties that are rural use volunteer EMS workforce. In 2018, Washington state certified 16,523 EMS providers. About 30 percent of those providers reported on certification applications that they were volunteers. According to the number of certified EMS providers and the number of providers reporting that they are volunteers, the department estimates that Washington state has experienced a 10 percent decline in volunteer EMS providers between 2014 and 2018.

To learn more about workforce and other challenges our EMS services experience, the department sought grant funding from the Health Services Resource Administration (HRSA) Federal Office of Rural Health Policy to conduct a statewide survey to:

- Identify baseline strengths and weaknesses in various attributes of EMS services.
- Assist EMS services in developing a roadmap to improve targeted attributes.
- Inform strategic planning efforts at state, regional, and local levels.
- Educate policy-makers on challenges facing EMS services, particularly in rural communities.

In January 2019, the department distributed this survey to 481 licensed EMS services in Washington state. This report provides the preliminary outcomes of the statewide survey.

Background

Emergency Medical Services

There are 481 licensed EMS services in Washington state. The total number of licensed services includes ground and air aid, and ambulance categories. EMS services are classified as aid (first response-no transport) or ambulance (response and transport) services. EMS services are further classified by the level of service that they provide to the community. The level of service provided is directly correlated to the level of certified provider assigned to the aid and ambulance vehicles. The number and distribution of ambulance services is managed through regional plans developed by eight regional EMS and trauma care councils.

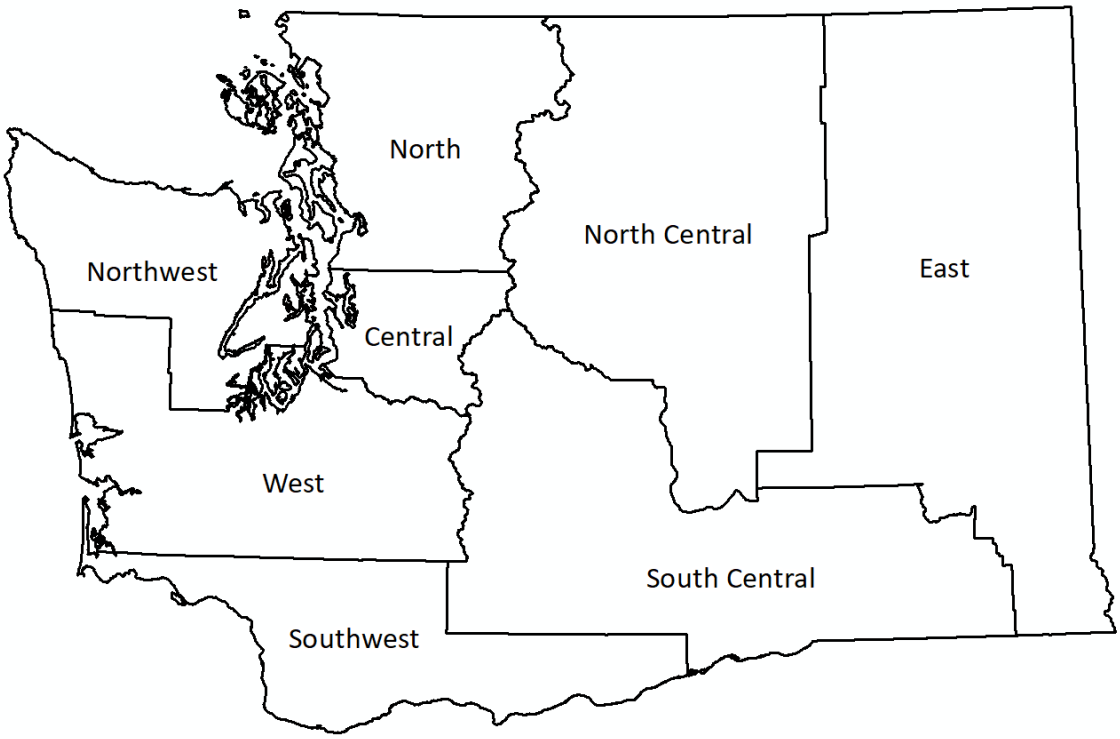
There are 16, 523 certified EMS personnel in Washington state. Washington state recognizes four levels of EMS certification: emergency medical responder (EMR), emergency medical technician (EMT), advanced emergency medical technician (AEMT), and paramedic.

The EMR and EMT provide basic life support (BLS) level care. BLS care includes activities such as recognizing illness and injury, performing patient assessment and taking a person's blood pressure, pulse and breathing rate, performing CPR, AED, splinting, bandaging, applying oxygen, and administering some medications such as epinephrine for allergic reactions, aspirin, naloxone for victims of suspected overdose, and glucose for patients with low blood sugar. The AEMT provides intermediate life support (ILS) level care. ILS care includes BLS activities, starting an IV, and administering a few more medications than BLS level. The paramedic provides advanced life support (ALS) care. ALS care includes BLS and ILS activities, starting an IV and interosseous infusion, performing high risk low frequency skills such as intubation and chest decompression, managing more complex cardiac conditions, and administration of many medications.

Certified EMS providers are authorized to perform only under the direction of a department-approved physician medical program director (MPD). An MPD provides oversight to each county in Washington state.

Most regulations related to the emergency care system are in RCW 18.71, RCW 18.73, RCW 70.168, and WAC 246-976.

Washington State EMS and Trauma Care Regions



Counties by EMS and Trauma Care Region							
Central	**East**	**North**	**North Central**	**Northwest**	**South Central**	**Southwest**	**West**
King	Adams	Island	Chelan	Clallam	Benton	Clark	Grays Harbor
	Asotin	San Juan	Douglas	Jefferson	Columbia	Cowlitz	Lewis
	Ferry	Skagit	Grant	Kitsap	Franklin	Klickitat	Pierce
	Garfield	Snohomish	Okanogan	Mason	Kittitas	Pacific	Pacific
	Lincoln	Whatcom			Walla Walla	Skamania	Thurston
	Pend Oreille				Yakima	Wahkiakum	
	Spokane						
	Stevens						
	Whitman						

Methodology

Survey Instrument

The survey instrument used for this work was developed by the Wisconsin Office of Rural Health, in consultation with a panel of national experts in rural EMS (**Appendix D**). The department monitored the preliminary reports and outcomes other states that have implemented this survey have completed. The department elected to use this survey instrument and made minor edits to include Washington state-specific vernacular. Using this survey instrument allows for comparisons to be made not only across EMS services in Washington state, but with other states using the same survey instrument.

The survey consists of questions categorized under 18 different attributes that experts agree establish the foundation for a successful rural ambulance service. The survey allows respondents to answer on a five-point scale; 1 indicating low performance, 5 indicating high performance.

The population data used to determine the rurality of each EMS service were self-reported data provided by the Washington Fire Chiefs Association. Note that this population data were collected separately from the responses collected in the survey.

Survey Distribution

The department used state licensing data from the Annual EMS Resource Report collated on December 31, 2018, to identify possible survey respondents. This report initially identified 497 possible survey respondents; this number was later adjusted to 481 possible survey respondents after reconciling any licensing updates. Using contact information provided by the EMS service on the department's EMS service licensing application, a list of the EMS service point of contacts was developed. An email was sent to each EMS service contact, providing an introduction to the project and its goals, an overview of how the results would be assessed, and an electronic copy of the survey instrument via Survey Monkey. Weekly reminders to complete the survey were sent via email to each EMS service that had yet to submit a response. Twenty-one calendar days after the initial survey distribution date, a reminder email with an attached copy of the survey was sent to each service that had not yet responded. Finally, physical copies of the survey instrument were mailed to the 194 EMS services that had not yet responded using the electronic copy of the survey sent 30 days prior. To reduce barriers to returning a completed survey, physical copies of the survey were mailed to EMS services with addressed and stamped return envelopes included.

Survey Analysis

Analysis was conducted at the EMS service level. Of the 481 actively licensed EMS services, 410 unique services (85.24 percent) returned the survey to the Department of Health. Of these returned surveys, 394 services (81.91 percent) provided enough information for their responses to be considered and represented in this survey. The average performance score for each of the 18 attributes is presented by the EMS service region and rurality designation. Performance scores have also been further refined by EMS service license level, roster size, level of volunteerism, and annual call volume.

Rural Definition

Distribution of EMS services is regulated in Washington state. State regulations require regional planning to prevent inefficient duplication of resources and to promote a system of coordinated EMS and trauma care. The minimum and maximum number of EMS services within a prescribed response area is determined through EMS and trauma care councils, and memorialized in department-approved EMS and trauma care regional plans. To assist in establishing clear parameters for work related to distribution of resources, EMS regulations establish the definition for rural, suburban, or urban. For the purposes of this survey, EMS services were classified in accordance with the definitions in WAC 246-976-010 as follows:

> *(69) "Rural" means an unincorporated or incorporated area with a total population of less than ten thousand people, or with a population density of less than one thousand people per square mile.*
>
> *(75) "Suburban" means an incorporated or unincorporated area with a population of ten thousand to twenty-nine thousand nine hundred ninety-nine or any area with a population density of between one thousand and two thousand people per square mile.*
>
> *(81) "Urban" means:*
>
> > *(a) An incorporated area over thirty thousand; or*
> >
> > *(b) An incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square mile.*

Under the provision of WAC 246-976-010, it is possible for a single EMS service to have two distinct rurality designations: one based on the size of the population served and the other based on the EMS service trauma response area's population density. Below is the breakdown of the survey respondent rurality when considering the possibility of multiple designations:

Rural	236
Rural + Suburban	49
Rural + Urban	52
Suburban	10
Suburban + Urban	18
Urban	29
Total	394

For the purpose of this analysis, EMS services have been categorized in three simplified rurality categorizations: rural, suburban, and urban. Agencies that fall under multiple rurality designations based on WAC 246-976-010 have been included in both of the categories for which they may fit. Below is the breakdown of the survey respondent rurality when EMS services with multiple designations are counted in both categories for which they may fit:

Rural	337
Suburban	77
Urban	99
Total	513

Small Numbers Guidelines

In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of EMS services represented in the score are fewer than 10.

Respondent characteristics

There are 481 licensed EMS services in Washington. Of those agencies, 394 agencies (81.9 percent) returned sufficient data for their responses to be represented in the survey results (**Figure 1**). As stated in the methodology, some services were counted under multiple geographic categories because of the rural definition outlined in WAC 246-976-010, resulting in a total of 513 responses for each attribute. The services that responded to the survey were representative of all Washington state services in terms of EMS service demographic type defined by WAC 246-976-010. (**Figure 2**).

Figure 1. Map of survey responding agencies

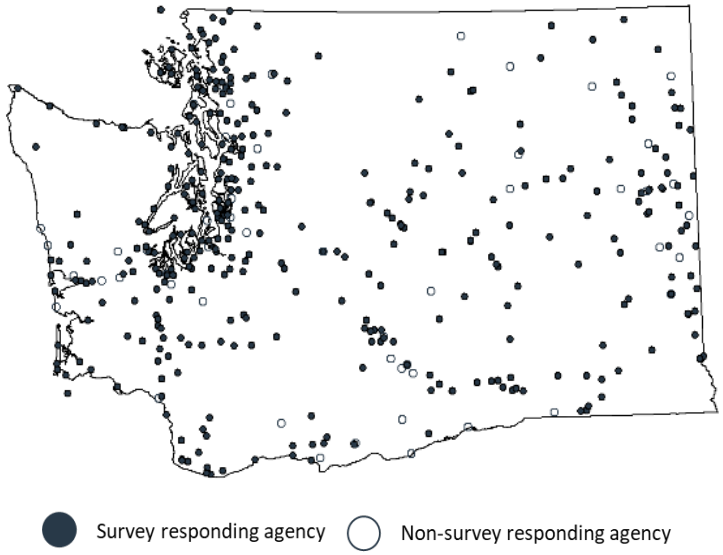


Figure 2. Representativeness of survey responding agencies

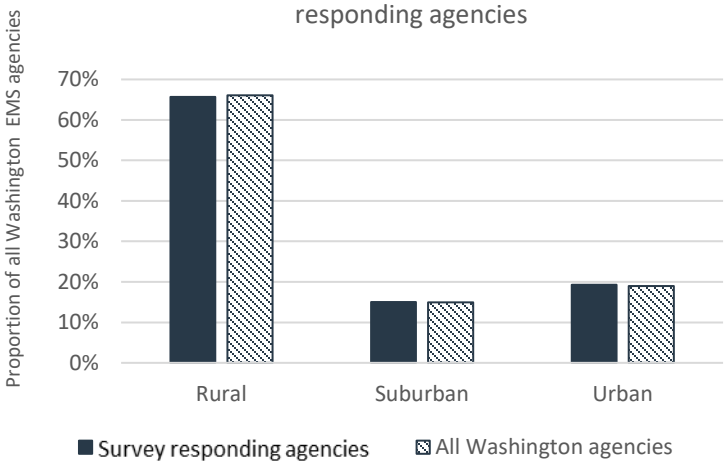
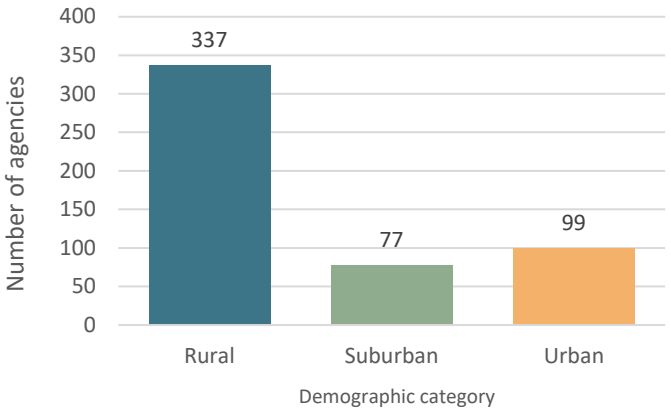
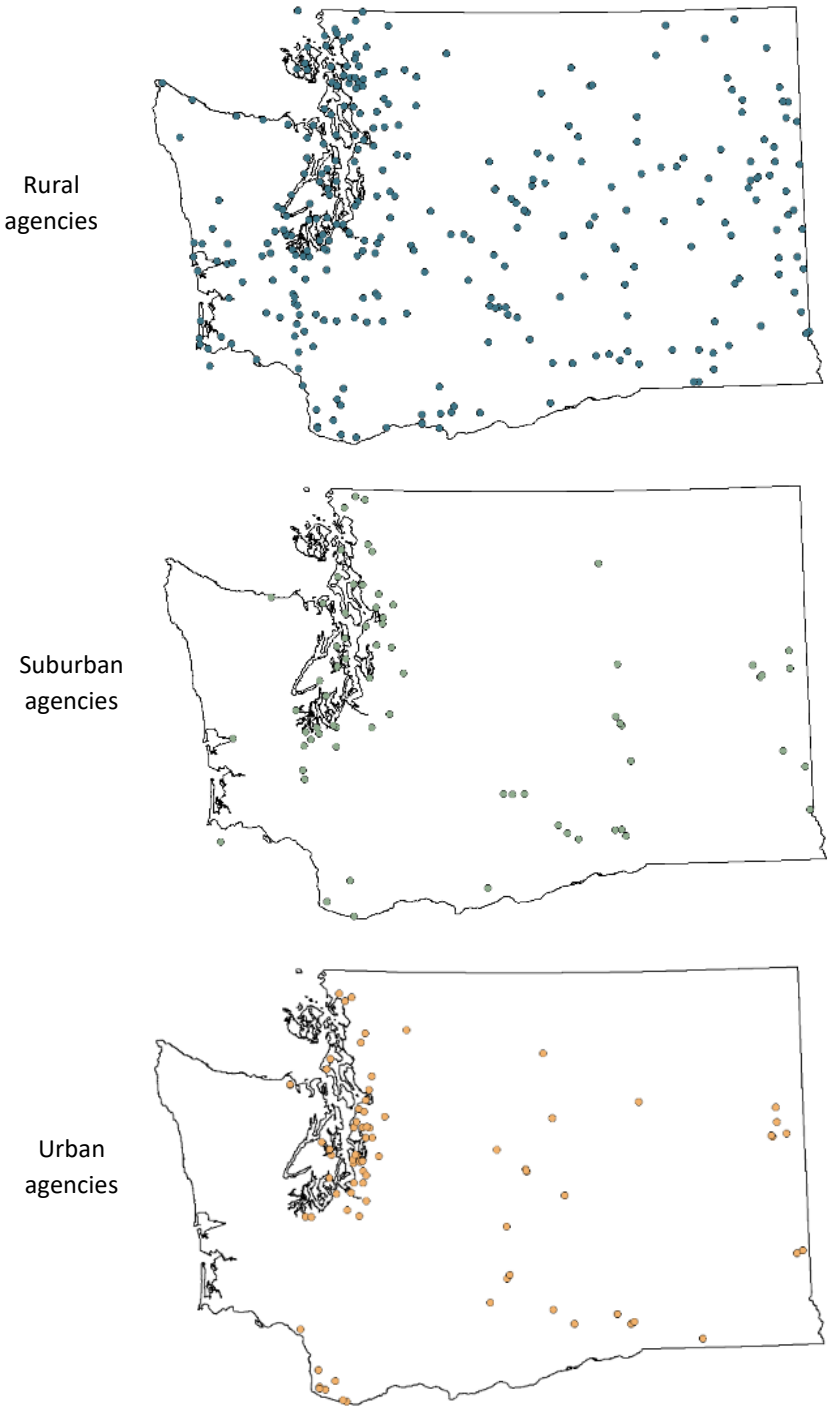


Figure 3. Survey responding agencies by rurality



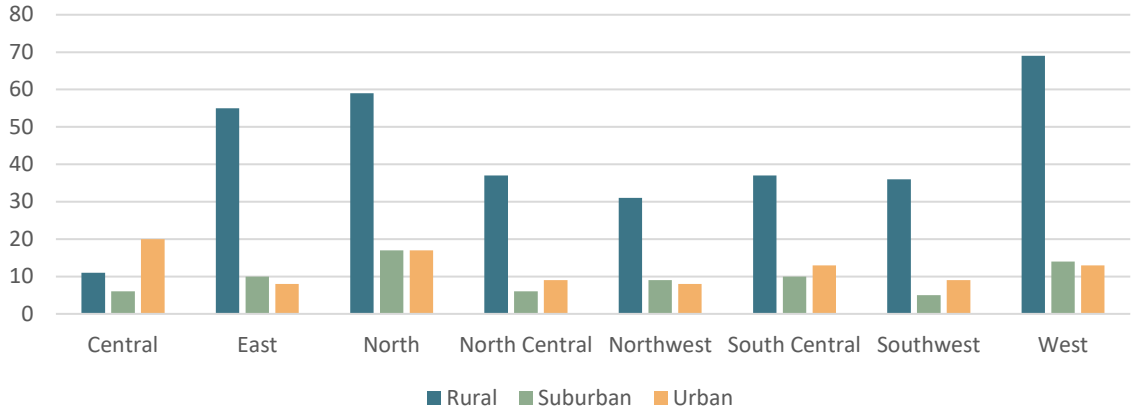
Overall, the majority of survey respondents were considered to be rural EMS agencies (**Figure 3**, **Figure 4**).

Figure 4. Map of survey responding agencies by demographic category



Across the EMS and trauma care regions, the majority of survey respondents were also rural EMS services, with the exception of Central region, which is composed of one largely urban county. (**Figure 5**).

Figure 5. Survey responding agency demographics by EMS region



Attributes

Below is a table of the attributes featured in the survey questions (**See Appendix D**). The attributes will be referred to in their shortened form, as listed in the first column, throughout the remainder of the report.

Shortened attribute name	**Full attribute name**
Call Schedule	Written Call Schedule
Continuing Education	Continuing Education
Policy Manual	Written Policy and Procedure Manual
Incident Response	Incident Response and Mental Wellness
Budget	Sustainable Budget
Billing	Professional Billing Process
MPD	County Medical Program Director Involvement
QI/QA	Quality Improvement/Assurance Process
Equipment and Technology	Contemporary Equipment and Technology for Patient Care Reporting Activities
Data	Agency Reports Data
Board	Community-Based and Representative Board
Attire	Agency Attire
PIER	Public Information, Education, and Relations (PIER)
Community Involvement	Involvement in the Community
Recruitment Plan	Recruitment and Retention Plan
Personnel Standards	Formal Personnel Standards
Operations Leader	Identified EMS Operations Leader with a Succession Plan
Wellness Program	Wellness Program for Agency Staff

Attributes, continued

Average scores for each of the attributes listed below are on a five-point scale: 1 indicating low performance, 5 indicating high performance. For the purpose of this survey, a score of 5 is considered excellent, 4 is good, 3 is fair, 2 is poor, and 1 is bad. Below are the average scores across all respondents for the 18 attributes, ranked highest to lowest.

Table 1. Average performance scores for all agencies

Budget	4.0	
Attire	4.0	
Policy Manual	4.0	
MPD	4.0	Good
Continuing Education	3.9	
QI/QA	3.7	
Personnel Standards	3.7	
Call Schedule	3.6	
Incident Response	3.5	
Billing	3.4	
Equipment and Technology	3.3	
Operations Leader	3.3	
Data	3.0	Fair
Recruitment Plan	2.8	
Community Involvement	2.6	
Wellness Program	2.5	
Board	2.4	
PIER	2.3	

Attributes, continued

Below are the average scores for each demographic type, ordered from highest to lowest performance for each category. The following page has a visual comparison of performance of each attribute, by demographic type (**Figure 6**).

Rural Agencies		Suburban Agencies		Urban Agencies	
MPD	4.0	Attire	4.5	Attire	4.7
Budget	3.9	Policy Manual	4.3	Call Schedule	4.6
Policy Manual	3.8	Call Schedule	4.3	Personnel Standards	4.6
Attire	3.8	MPD	4.3	Policy Manual	4.4
Continuing Education	3.7	Budget	4.2	Budget	4.3
QI/QA	3.6	Personnel Standards	4.1	Continuing Education	4.3
Incident Response	3.4	Continuing Education	4.1	QI/QA	4.2
Personnel Standards	3.3	QI/QA	3.6	MPD	4.1
Billing	3.2	Billing	3.6	Equipment and Technology	3.9
Call Schedule	3.1	Incident Response	3.5	Operations Leader	3.9
Operations Leader	3.1	Equipment and Technology	3.5	Billing	3.8
Equipment and Technology	3.1	Operations Leader	3.3	Incident Response	3.7
Data	2.8	Data	3.3	Data	3.4
Recruitment Plan	2.7	Wellness Program	2.9	Wellness Program	3.3
Community Involvement	2.4	Recruitment Plan	2.9	Recruitment Plan	3.2
Board	2.4	Board	2.6	Community Involvement	2.9
Wellness Program	2.1	Community Involvement	2.6	PIER	2.9
PIER	2.1	PIER	2.2	Board	2.4

Table 2. Average performance scores by demographic category

Attributes, continued

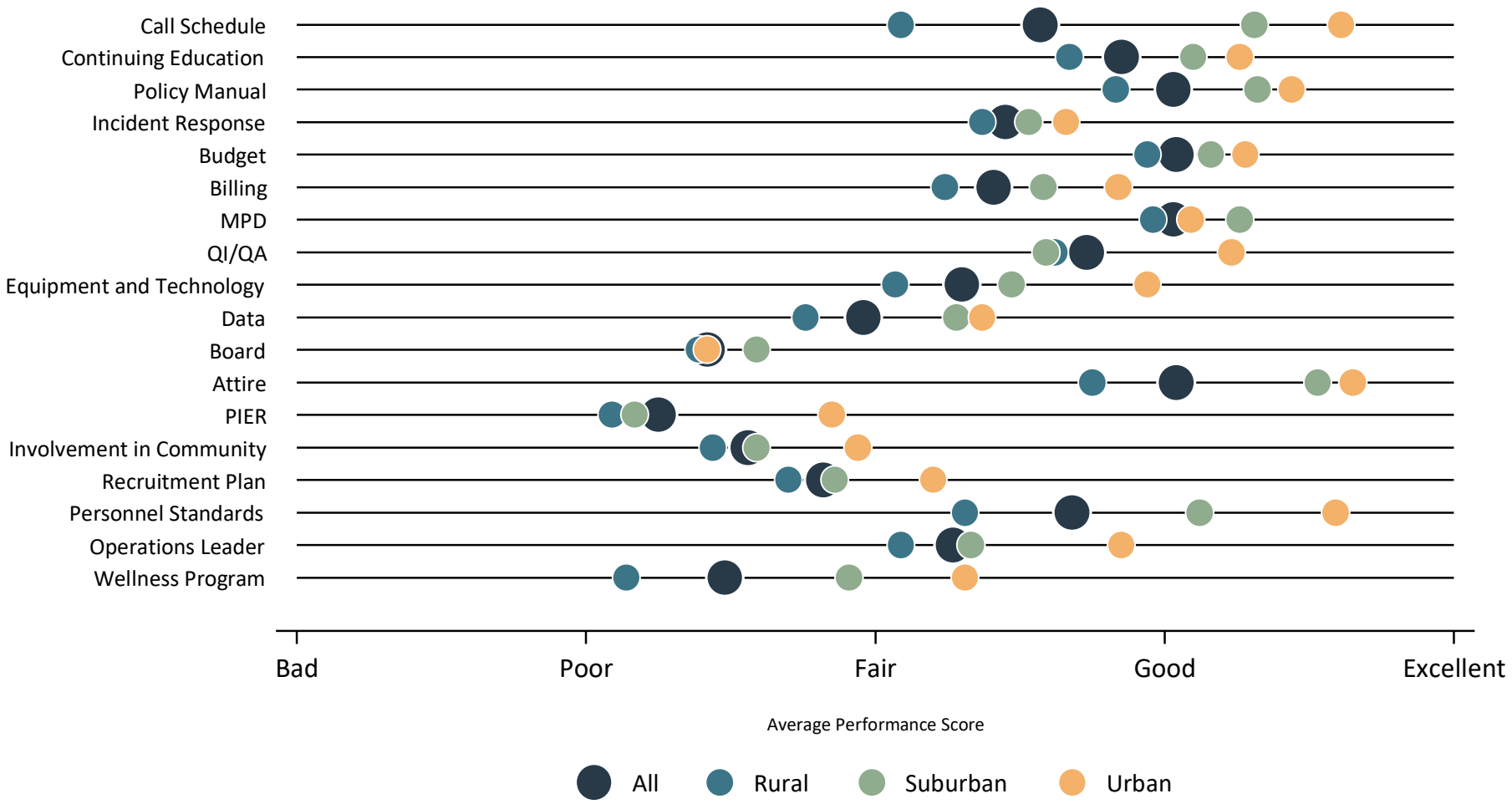


Figure 6. Average performance score for each attribute by demographic type
Under WAC related to EMS, agencies may be considered under more than one demographic distinction.

Results

For all but one attribute – having a QI/QA process – the average performance score reported for rural services was lower than scores reported by suburban and urban services (**Figure 6**). Urban services reported higher performance scores than both suburban and rural for all attributes except for MPD involvement and having a community-based and representative board. The disparity in performance between rural and urban services was greatest with regard to having a written and distributed call schedule, formal personnel standards, and a wellness program for staff members. Differences among demographic type were also observed within different EMS service characteristics. Generally, rural services reported lower level of performance than urban services, regardless of the annual call volume received by the service. When looking at EMS service license level, urban and suburban BLS services reported higher levels of performance than rural BLS services for each attribute except for the attribute regarding MPD involvement and having a community representative board. With respect to number of personnel on staff, rural services of all roster sizes reported lower levels of performance than suburban and urban services of all roster sizes for most of the attributes. Additionally, rural services that rely on volunteer staff members reported lower levels of performance than the suburban and urban services using volunteer personnel for most attributes.

Within each level of rurality, services with higher license levels, more personnel, smaller proportions of volunteerism, and higher annual call volume reported higher level of performance relative to their counterparts. It should be noted that the rural services who responded to the survey represent the majority of BLS agencies in this survey. Additionally, the rural services responding to the survey generally operate with fewer staff members and a higher proportion of volunteer personnel than their suburban and urban counterparts. See **Appendix A** for a more detailed summary of the survey results for all services. See **Appendix B** for a summary of the results for the rural agencies represented in this report.

Despite the varying levels of performance across the different levels of rurality, services of all three categories are considered to be operating at a high level in terms of the involvement of their county medical program director (MPD). Additionally, all services, regardless of rurality, reported poor levels of performance related to having a community-based and representative board and public information, education, and relations (PIER) (**Table 1, Table 2**).

Regionally, the Central and Northwest regions reported highest levels of performance for the majority of the attributes. See **Appendices A and C** for a detailed regional comparison for each of the attributes and a summary for each region.

Participant Feedback

Participant feedback is currently being collected and will be available as a part of the final report available in fall 2019.

Limitations

The data used in this survey are self-reported survey responses; the interpretation of each question was left to the person responding on behalf of each EMS service. Additionally, population data used to determine the rurality of the survey responding services were collected separately from the survey data, from self-reported service area population information. While the conclusions of this report can be used to identify strengths and gaps in the EMS system, the information in this report is not intended to be interpreted as claims of causation or correlation.

Summary and Next Steps

This report provides a brief overview of the results from the survey responses; future work may include a more detailed and in-depth look at patterns that may vary across EMS and trauma care regions, and EMS service characteristics.

The results of this survey will be used to:

- Identify baseline strengths and weaknesses in various attributes of EMS services across Washington state.
- Assist EMS services in developing a roadmap to improve targeted attributes.
- Inform strategic planning efforts at state, regional, and local levels.
- Educate policy-makers on challenges facing EMS services, particularly in rural communities.

The department is seeking additional grant funding from HRSA to continue the work of improving EMS service in rural communities and of addressing statewide system challenges.

List of Appendices

Appendix A- Results by survey attribute

A Written Call Schedule

1. Non-existent. Pager goes off and anyone available responds.

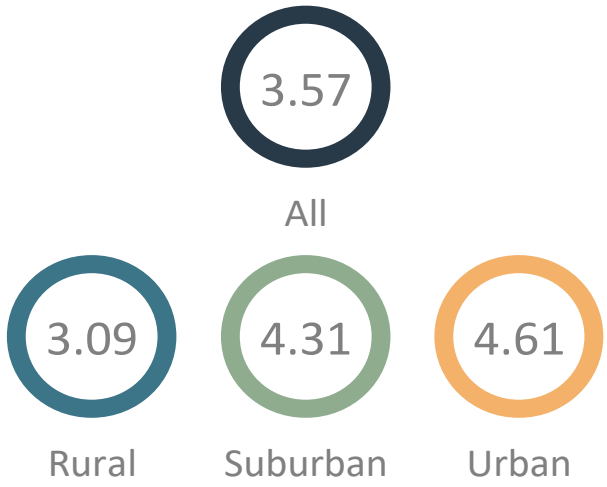
2. Informal, ad-hoc agreement exists among the crew.

3. Written and distributed schedule exists, but for less than one week at a time.

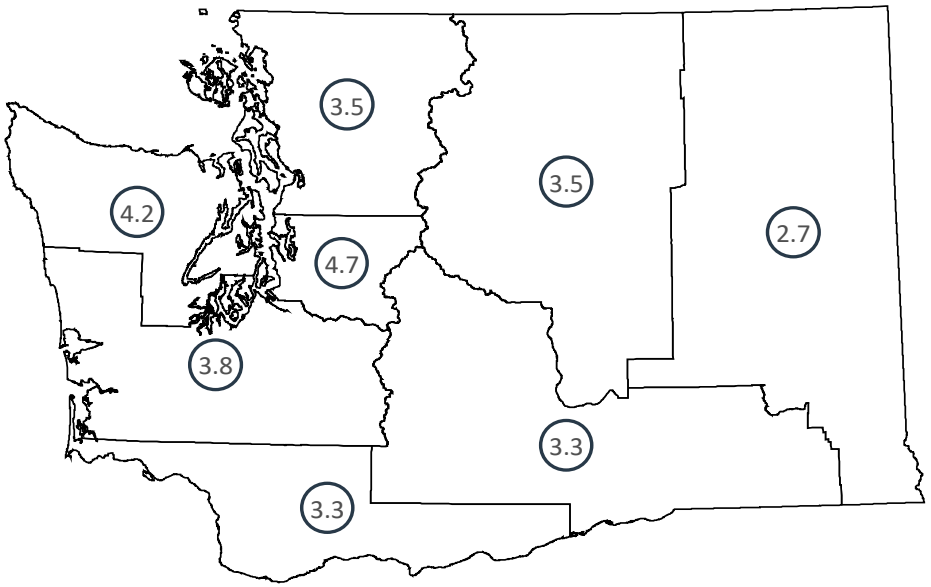
4. Written and distributed schedule is for one week or more, but empty spaces are not filled, waiting for personnel to show up.

5. Written and distributed schedule is for two weeks or more. Empty spaces are filled prior to shift beginning.

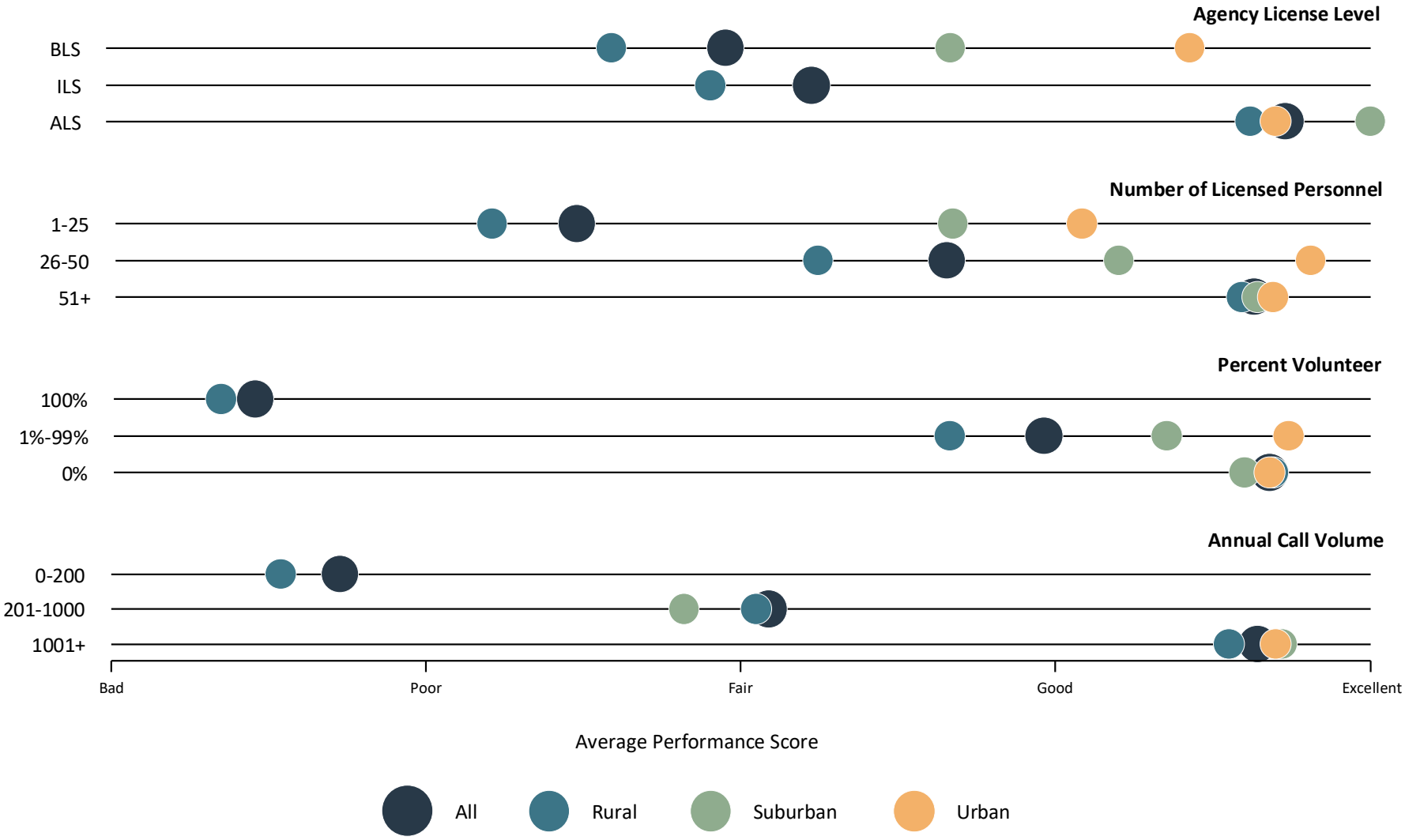
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics

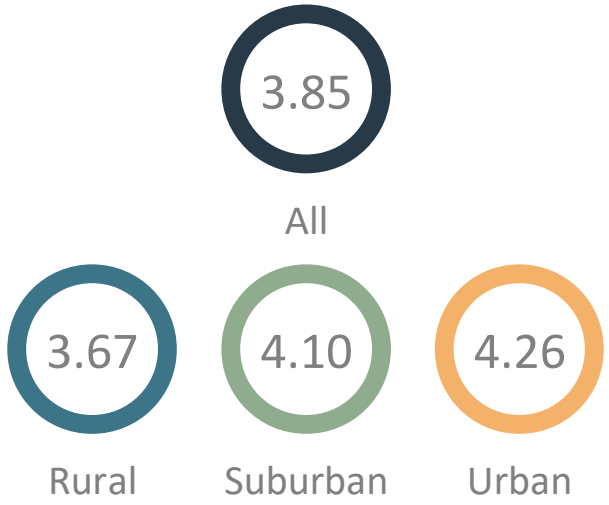


Under WAC related to EMS, agencies may be considered under more than one demographic distinction. In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than ten.

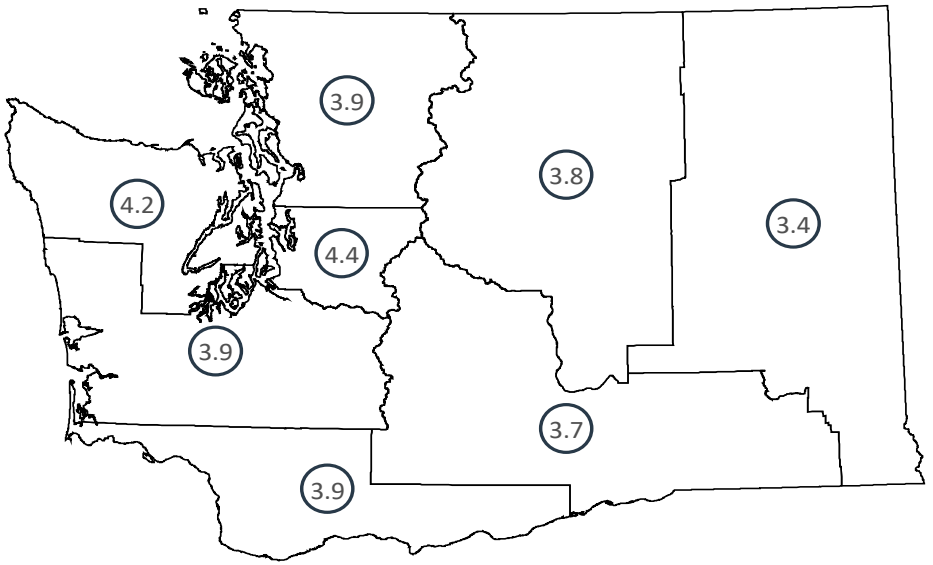
Continuing Education

1. No continuing education is offered.
2. Continuing education that meets minimum requirements needed to maintain licensure is offered (internally or externally).
3. Continuing education above minimum requirements needed to maintain licensure is offered.
4. Continuing education based on quality improvement and/or quality assurance findings is offered.
5. Continuing education based on quality improvement and/or quality assurance findings, with medical director and/or hospital input, and taught by a certified educator is offered.

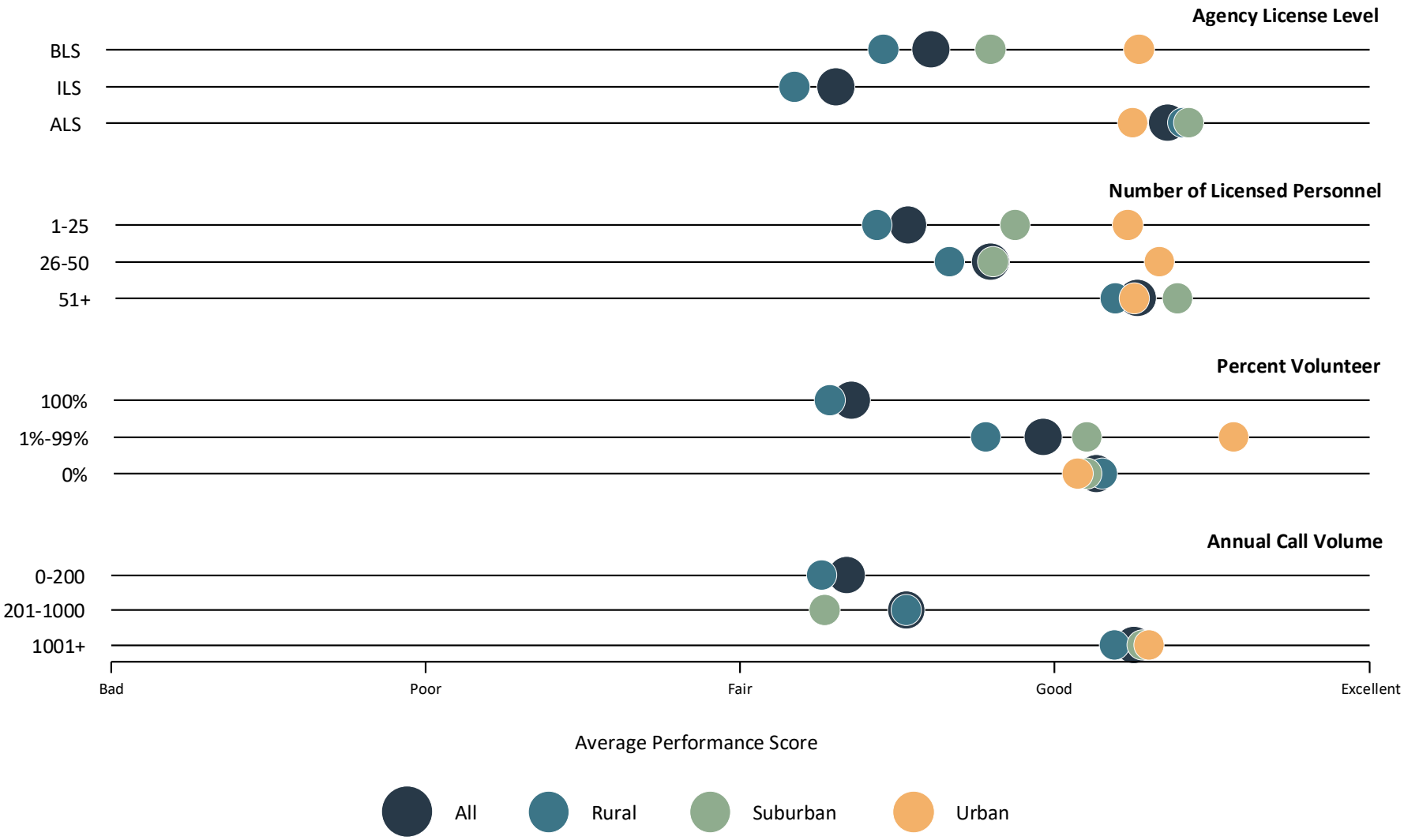
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



Under WAC related to EMS, agencies may be considered under more than one demographic distinction. In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than ten.

A Written Policy and Procedure Manual

1. There are no documented EMS policies and procedures.

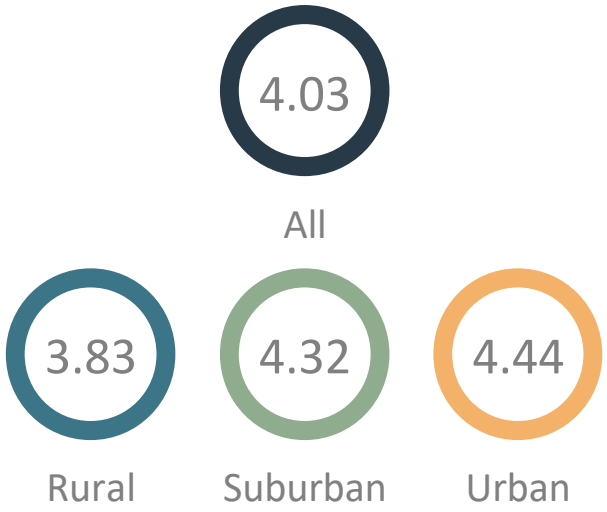
2. There are a few documented EMS policies and procedures, but they are not organized into a formal manual.

3. All EMS policies and procedures are documented in a formal manual but crew members don't refer to/use/update it systematically.

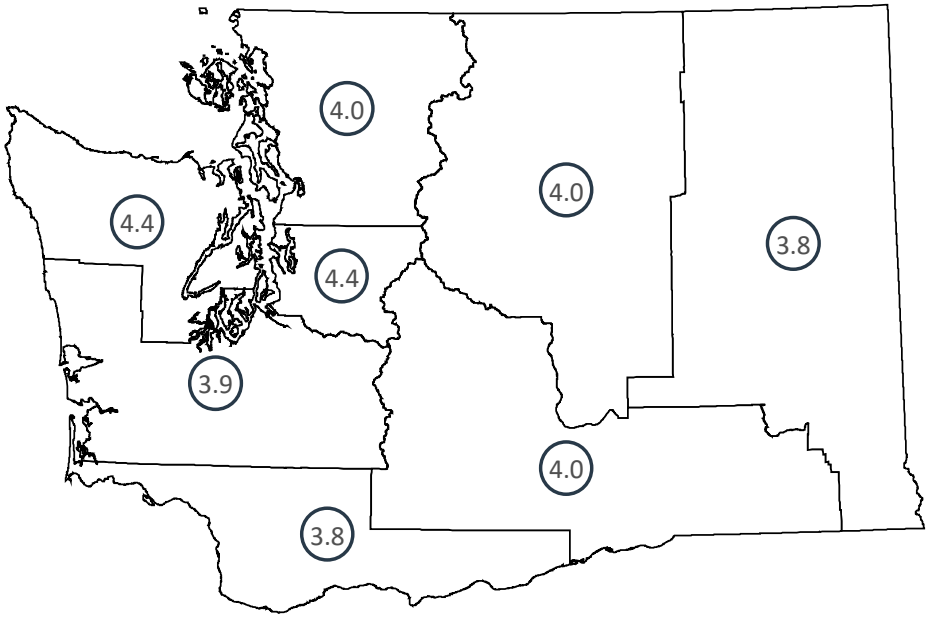
4. All EMS policies and procedures are documented in a formal manual, and crew members refer to and use it systematically. It is updated, but not on a schedule.

5. All EMS policies and procedures are documented in a formal manual, and crew members refer to/use/update it systematically. It is written to the level of detail necessary that anyone from the crew could step in and do the job correctly.

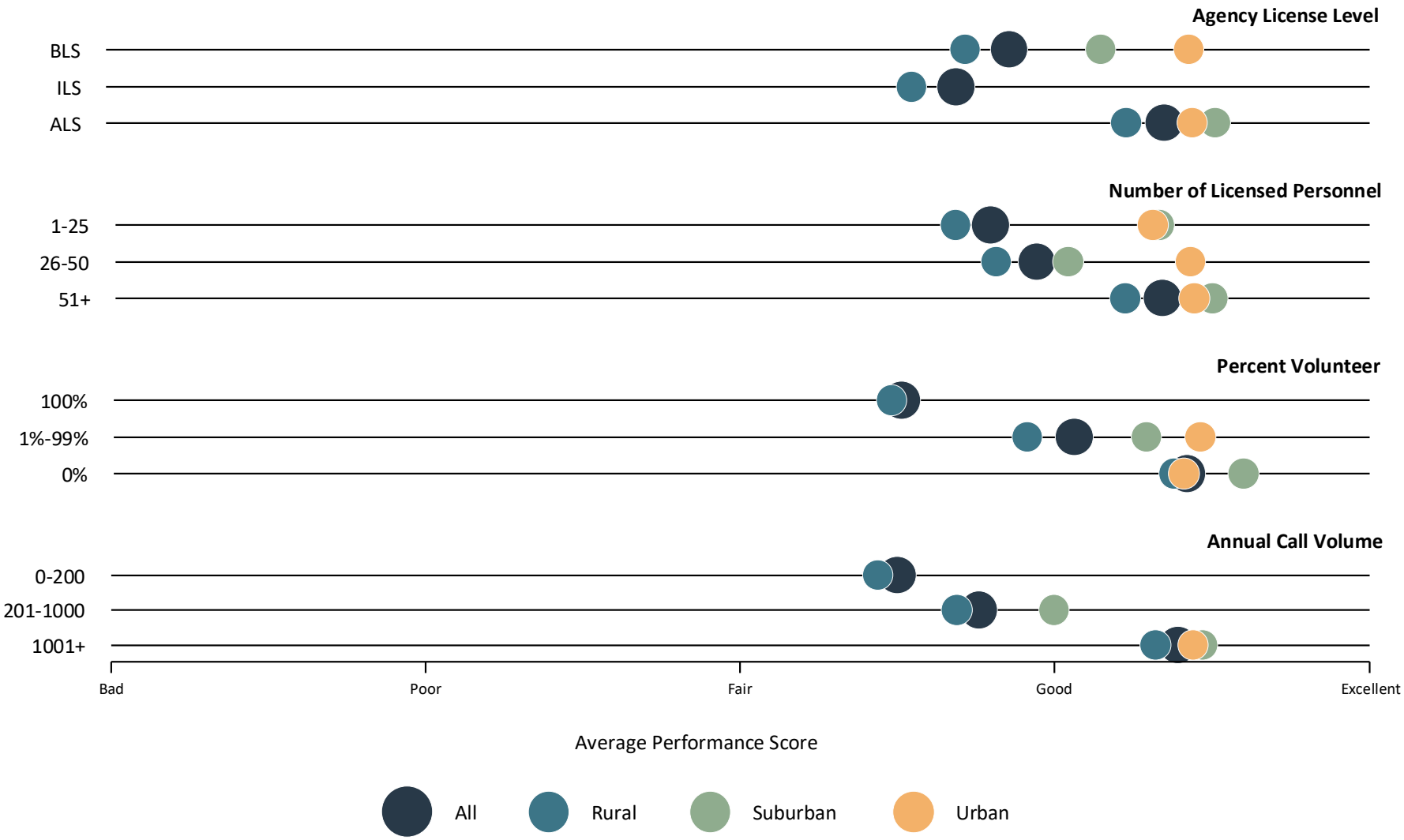
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



Under WAC related to EMS, agencies may be considered under more than one demographic distinction. In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than ten.

Incident Response and Mental Wellness

1. There is no incident response and mental wellness debriefing.

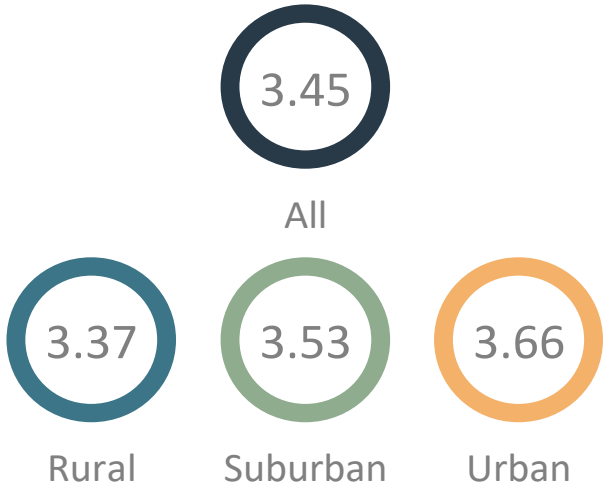
2. There is informal and positive debriefing, and support from more experienced crew members.

3. There is informal and positive debriefing, and support from more experienced crew members. Dispatch occasionally notifies the EMS agency on a predetermined set of calls (pediatric, suicides, fatalities, trauma, etc.), which are addressed informally by agency leadership.

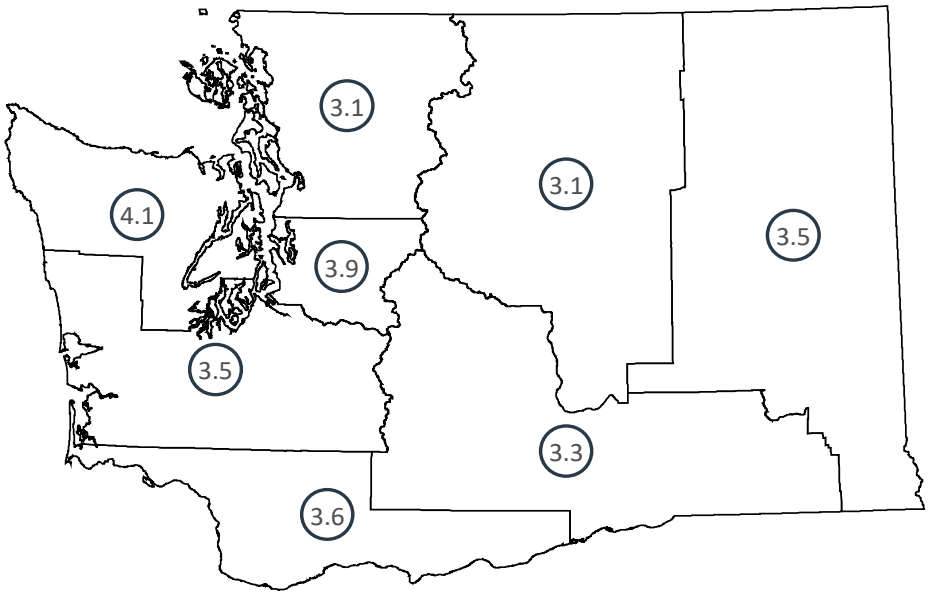
4. Agency leadership has training in incident response, is consistently notified by dispatch at the time of possible incident, and has a policy of debriefing affected crew member(s).

5. All of No. 4, plus professional counseling sessions are offered at reduced or no charge to affected crew members. Follow-up with affected crew members is standard procedure.

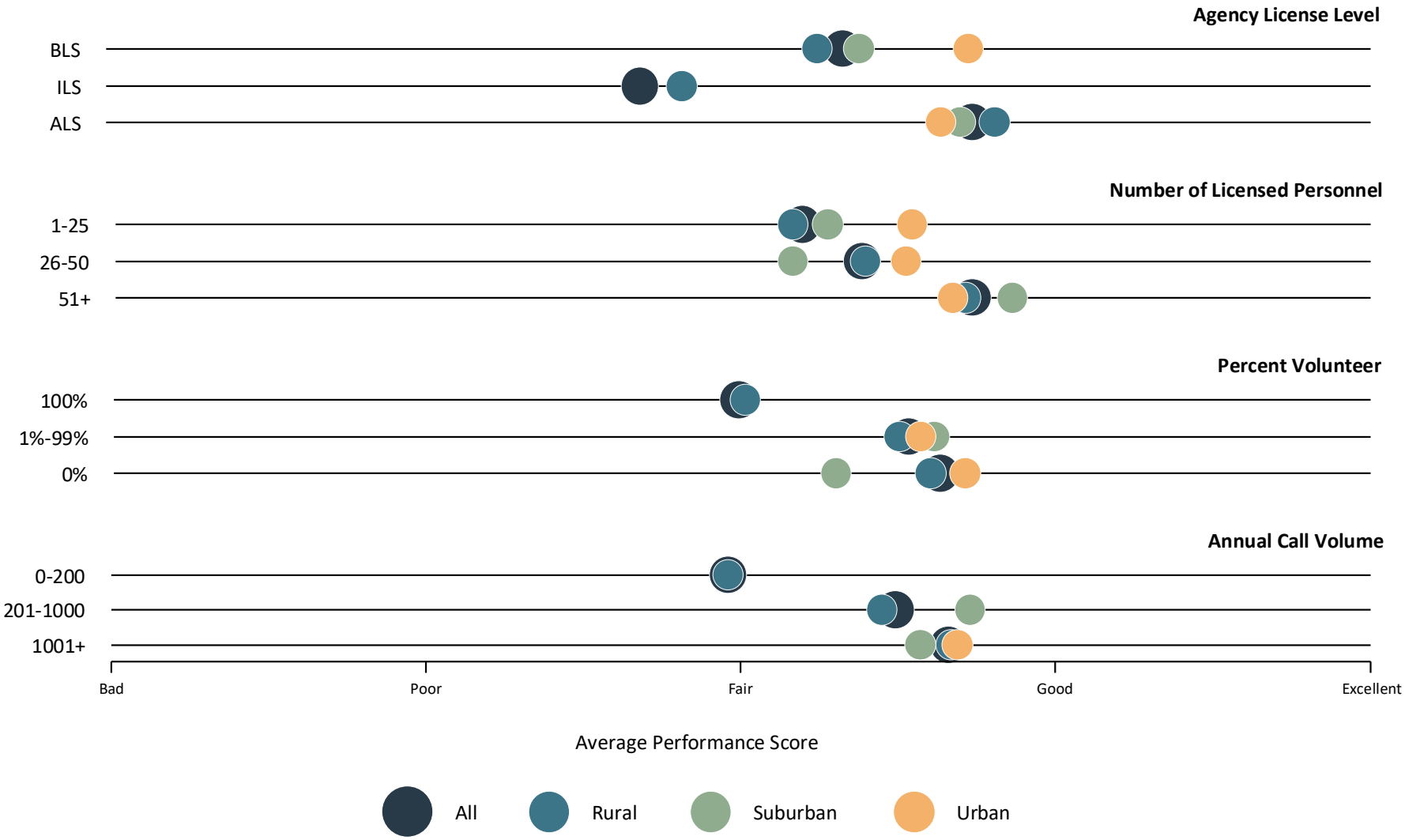
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



Under WAC related to EMS, agencies may be considered under more than one demographic distinction. In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than ten.

A Sustainable Budget

1. There is no written budget.

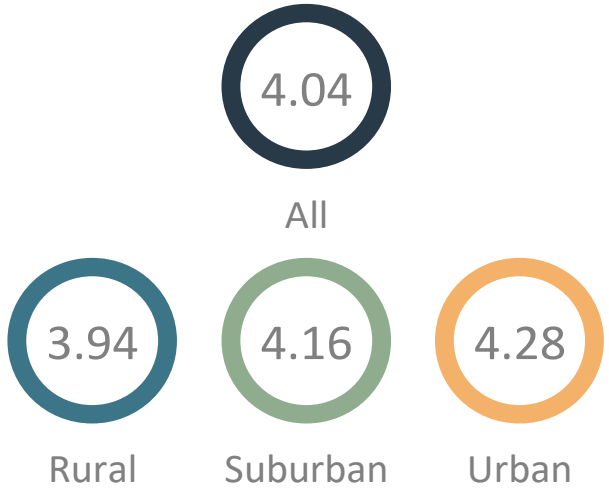
2. A budget has been developed; however, it is not followed.

3. A budget is in place, and financial decisions and actions are based upon it.

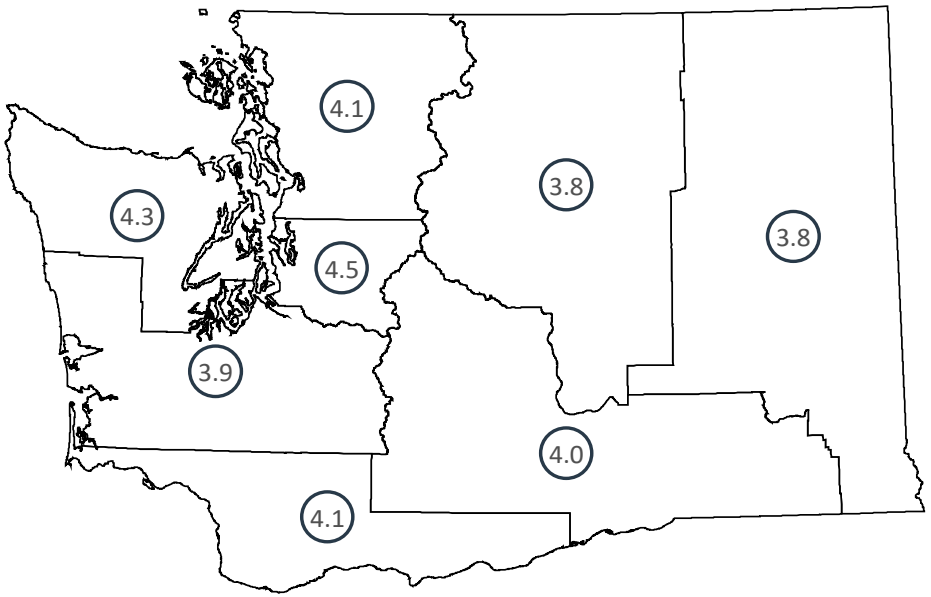
4. A budget and policies are in place regarding proper purchasing procedures, purchase limits and authorizations, and procedures for procuring equipment either not in the budget or over the stated budget. An operating reserve of at least three months is in the bank.

5. A budget and polices are in place regarding proper purchasing procedures, purchase limits and authorizations, and procedures for procuring equipment either not in the budget or over the stated budget. An operating reserve of at least six months is in the bank and the reserve has been in place for at least one year.

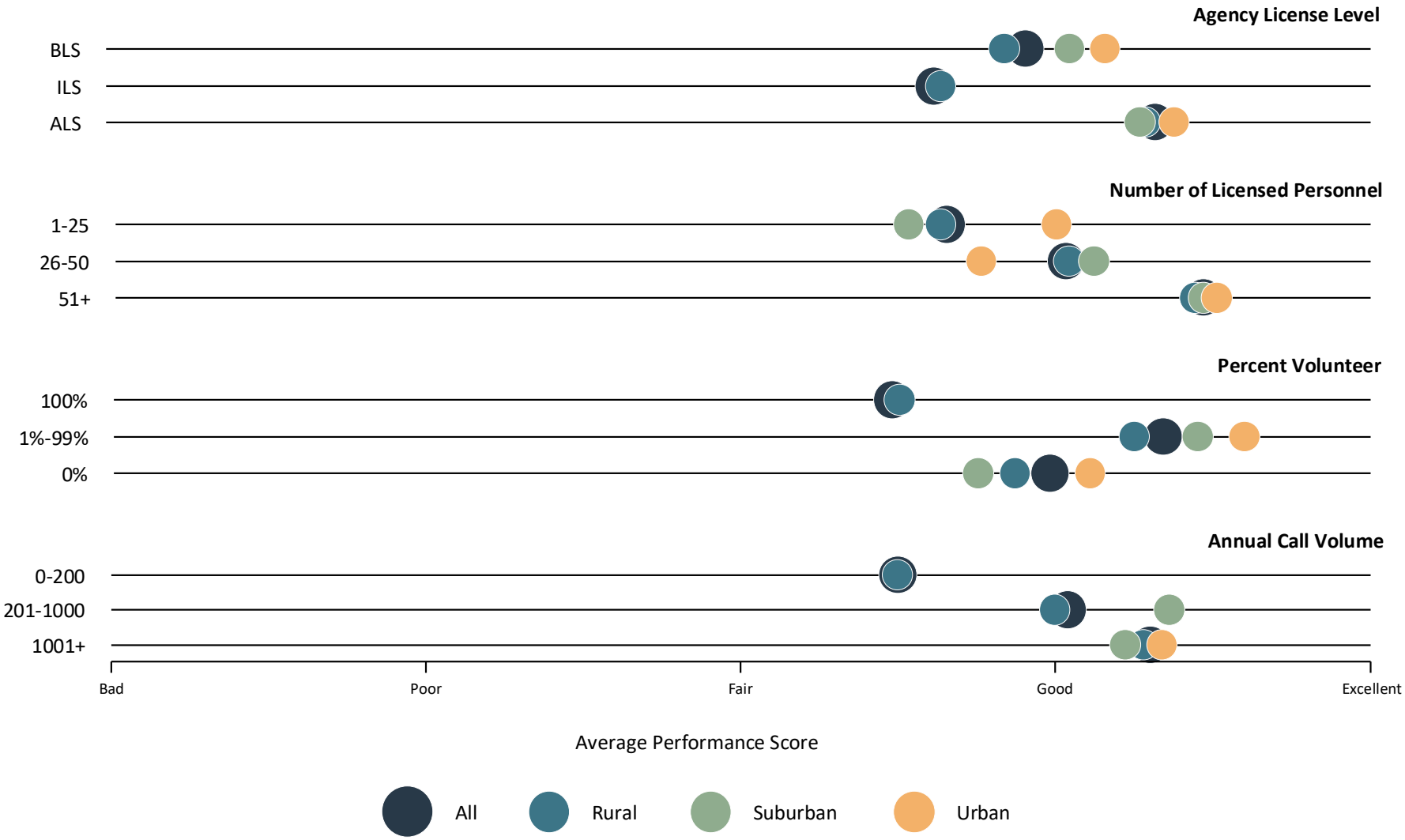
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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A Professional Billing Process

1. Services are not billed.

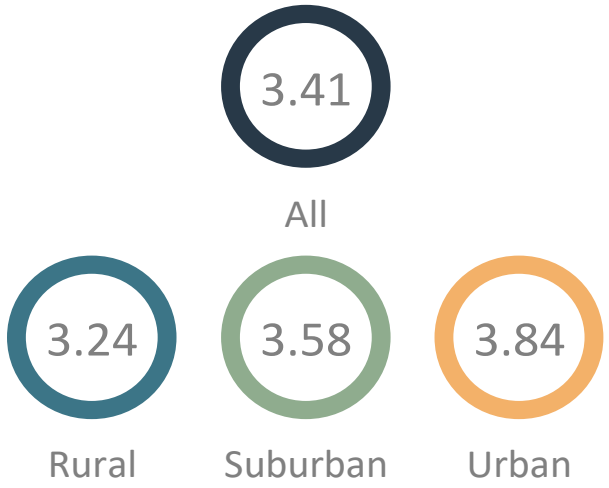
2. Services are billed, but claims are submitted by an individual (internal or external) with no formal training in healthcare billing.

3. Services are billed, but claims are submitted by an individual (internal or external) with limited training in healthcare billing.

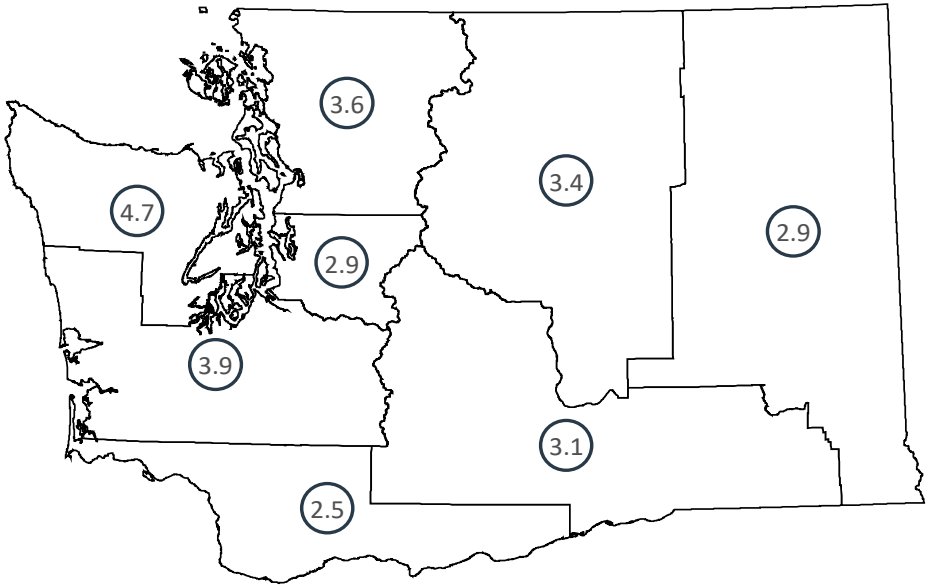
4. Services are billed and claims are submitted by someone with skills and training in healthcare billing, but without established HIPAA-compliant billing policies or policies to handle claims that have been denied or with a balance due.

5. Services are billed and claims are submitted by a certified biller (internal or external) or billing service, in a timely manner (fewer than 30 days), with established HIPAA-compliant billing policies and policies to handle claims that have been denied or with a balance due.

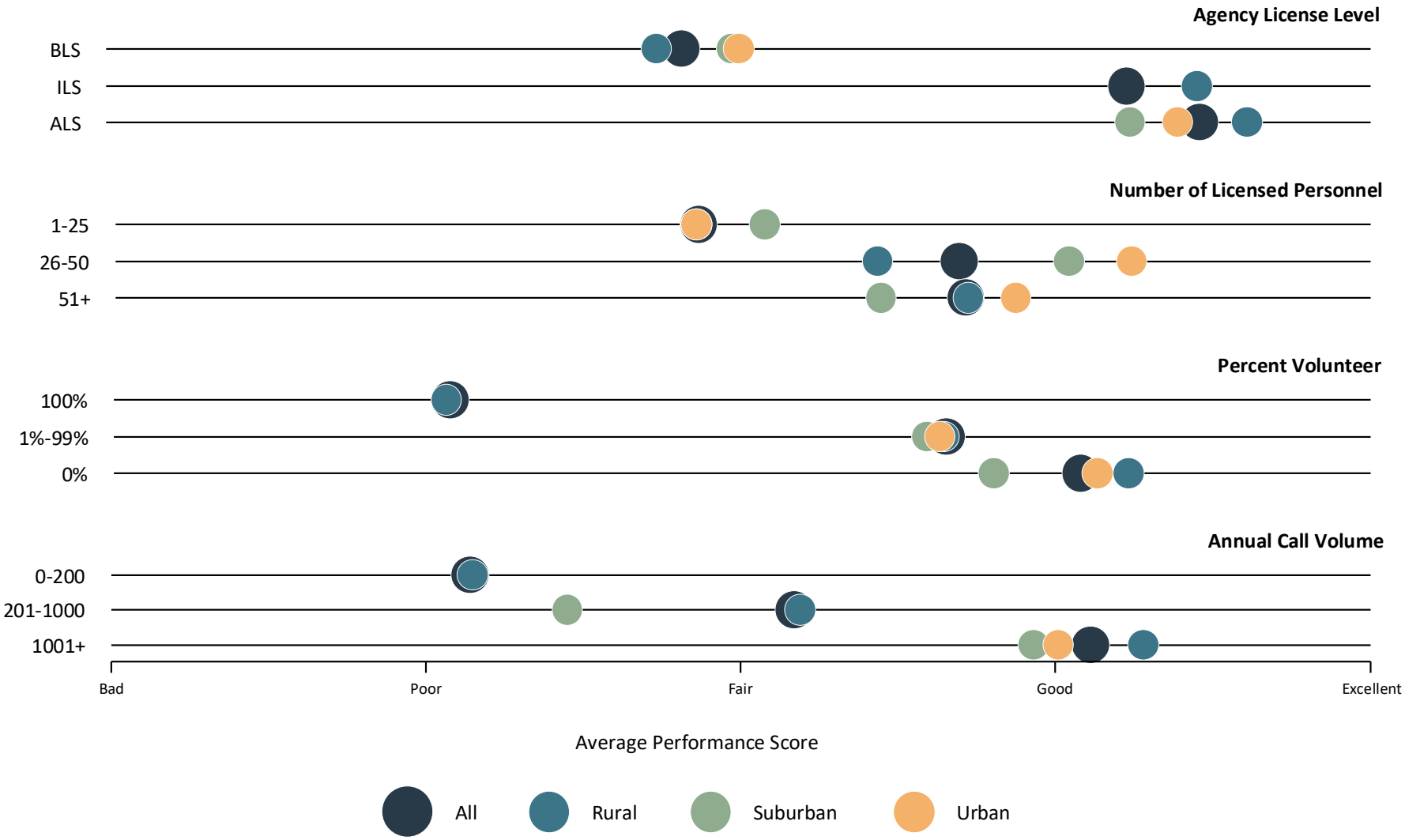
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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County Medical Program Director Involvement

1. There is a medical director in name only. He or she is not actively engaged with the EMS agency beyond signatures.

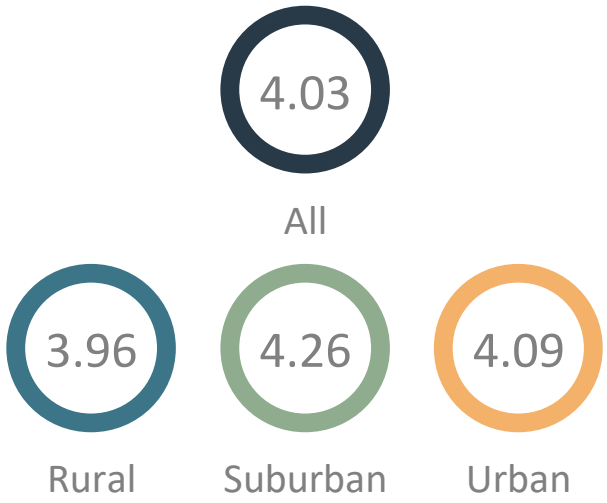
2. The medical director reviews cases but not within 30 days and provides very little feedback.

3. The medical director reviews cases within 30 days and provides very little feedback.

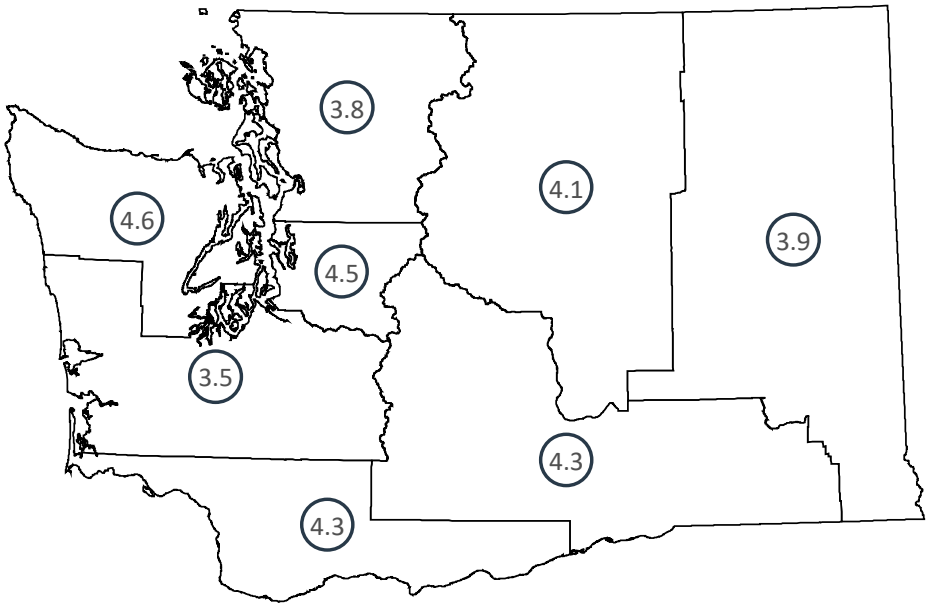
4. The medical director reviews cases within 30 days and provides a good amount of feedback, but waits for the EMS agency to engage him or her. When asked, he or she responds to hospital ED/ER contacts on behalf of the EMS agency regarding the agency's clinical protocols and actions.

5. The medical director is an integral part of EMS, pro-actively engaging the agency to review cases, providing a good amount of feedback; delivering education to the agency; and advocating for the agency to hospital ED/ER contacts.

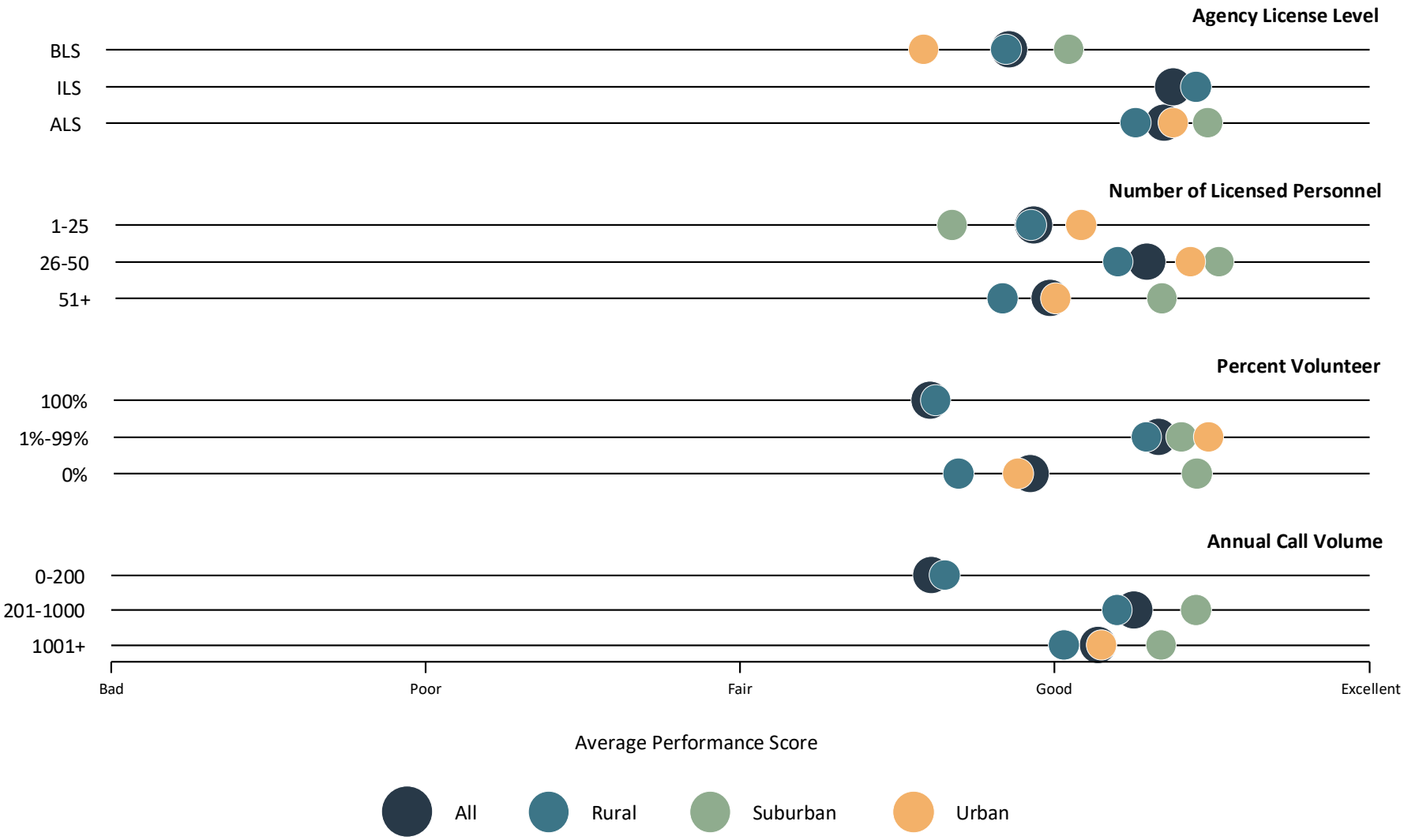
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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A Quality Improvement/ Assurance Process

1. There is no plan to collect, analyze, or report EMS agency performance measures.

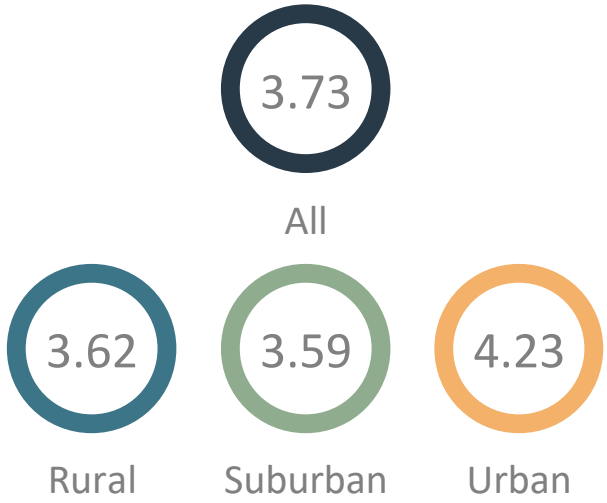
2. Performance measure data is collected about the EMS agency but not analyzed or reported.

3. Performance measures are analyzed and reported but no feedback loop exists for continual improvement of the EMS agency.

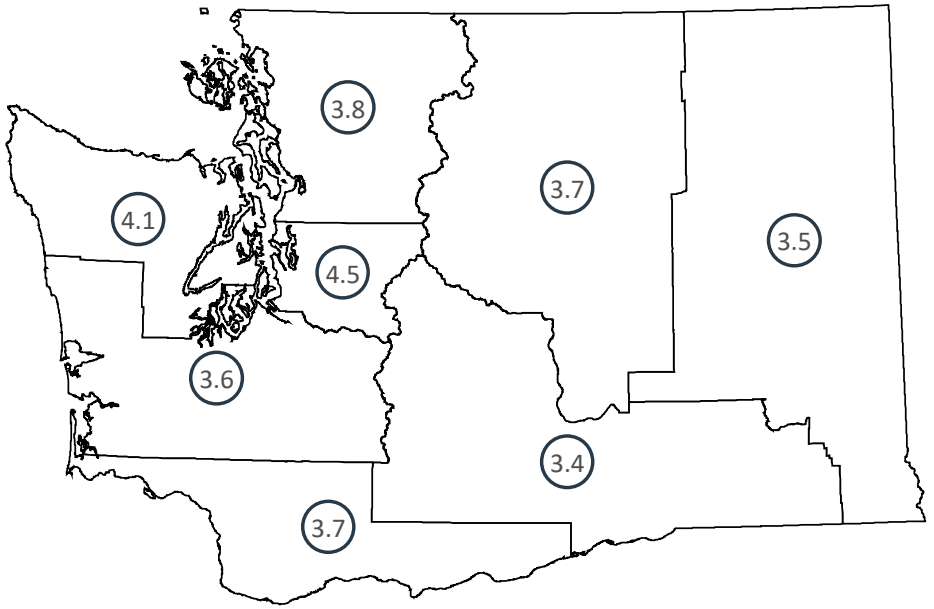
4. Performance measures are reported and a feedback loop exists for general improvements.

5. Feedback from performance measures is used to drive internal change to:
   (1) improve the patient experience of care (including quality and satisfaction),
   (2) improve the health of the community (e.g., success of screenings, education);
   (3) reduce the cost of health care services (e.g., reducing EMS costs, and/or using EMS to reduce overall healthcare costs).

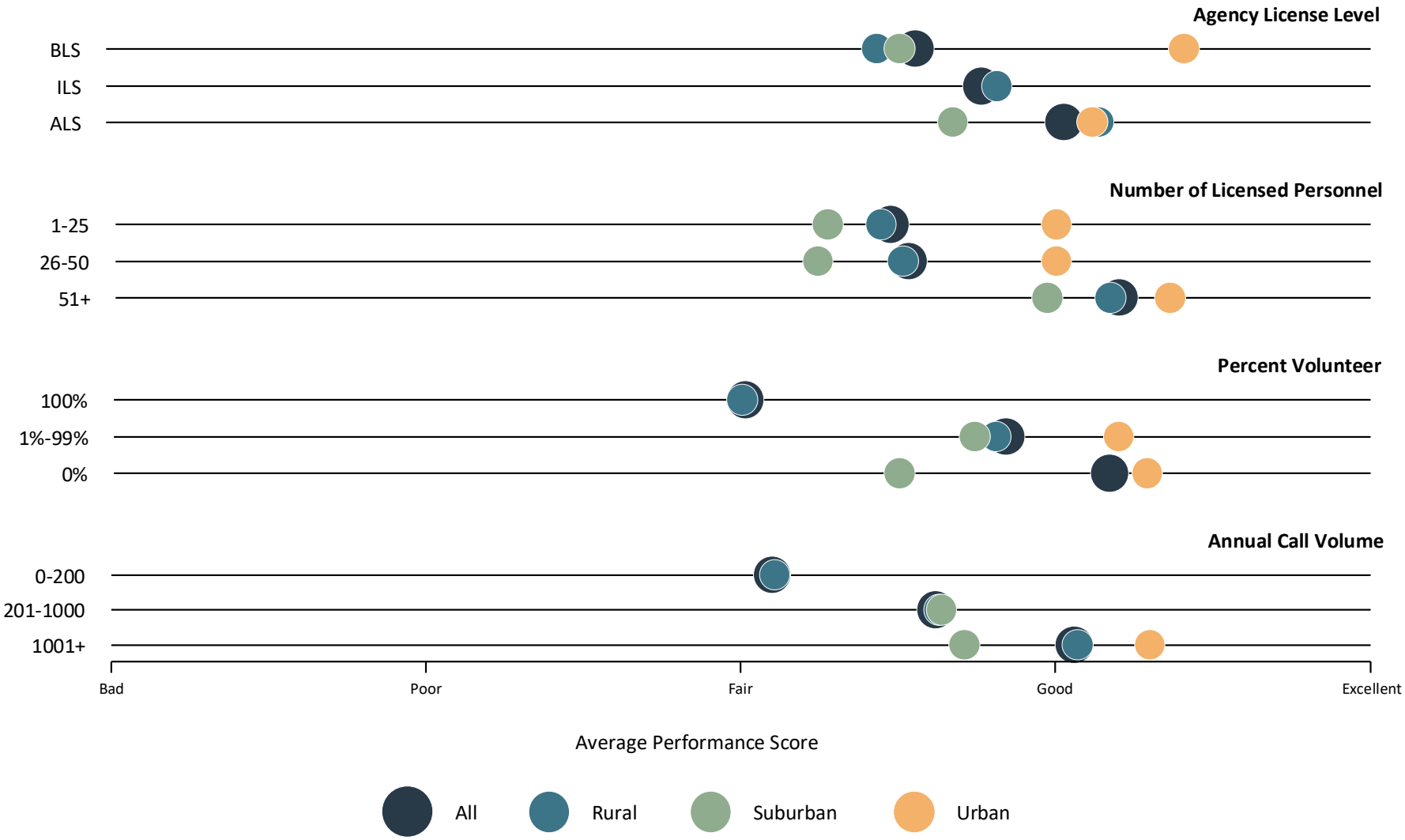
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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Contemporary Equipment and Technology for Patient Care Reporting Activities

1. The EMS agency has only the minimum equipment/technology. The budget does not allow additional equipment/technology acquisition.

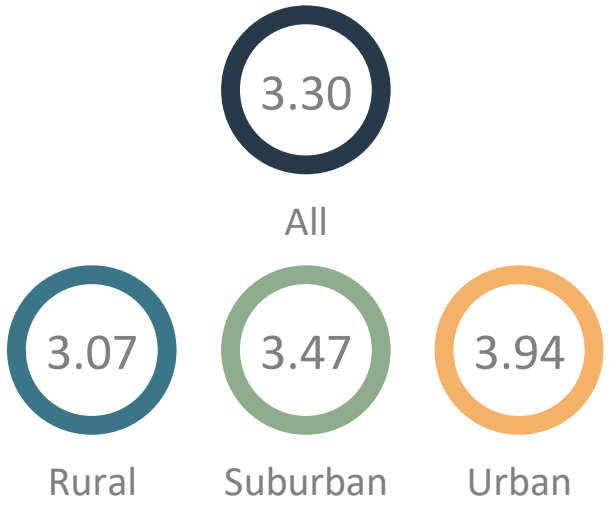
2. The EMS agency has the minimum equipment/technology, plus a minimal budget for additional equipment/technology acquisition.

3. In addition to the minimum equipment/technology, the EMS agency has some advanced equipment/technology. There is a minimal budget for new equipment/technology acquisition and a formal replacement plan.

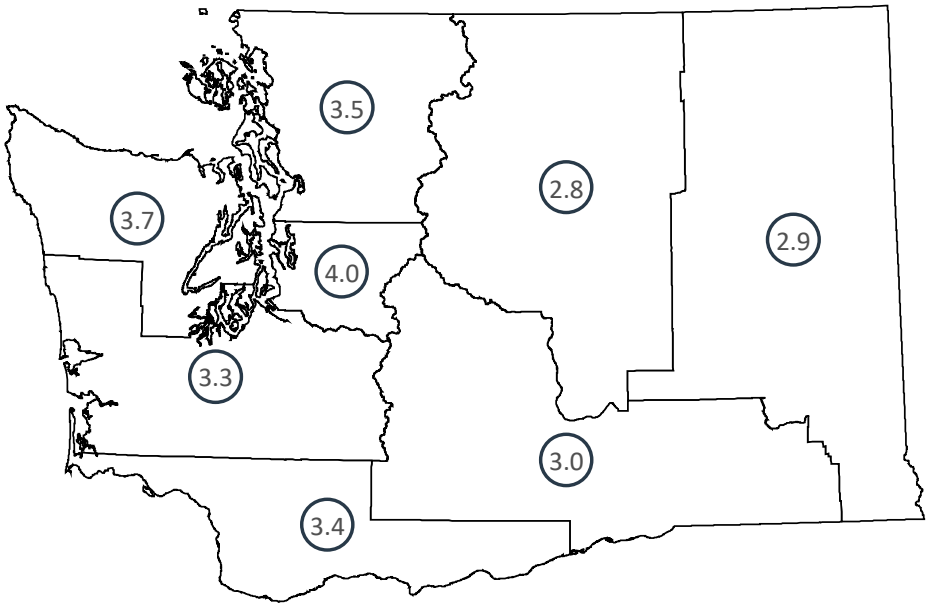
4. In addition to the minimum equipment/technology, the EMS agency has some advanced equipment/technology. There is an adequate budget for new equipment/technology acquisition and a formal replacement plan.

5. In addition to the minimum equipment/technology, the EMS agency has some advanced equipment/technology. There is an adequate budget for new equipment/technology acquisition and a formal replacement plan. There is a formal maintenance plan provided by trained/certified technicians or engineers.

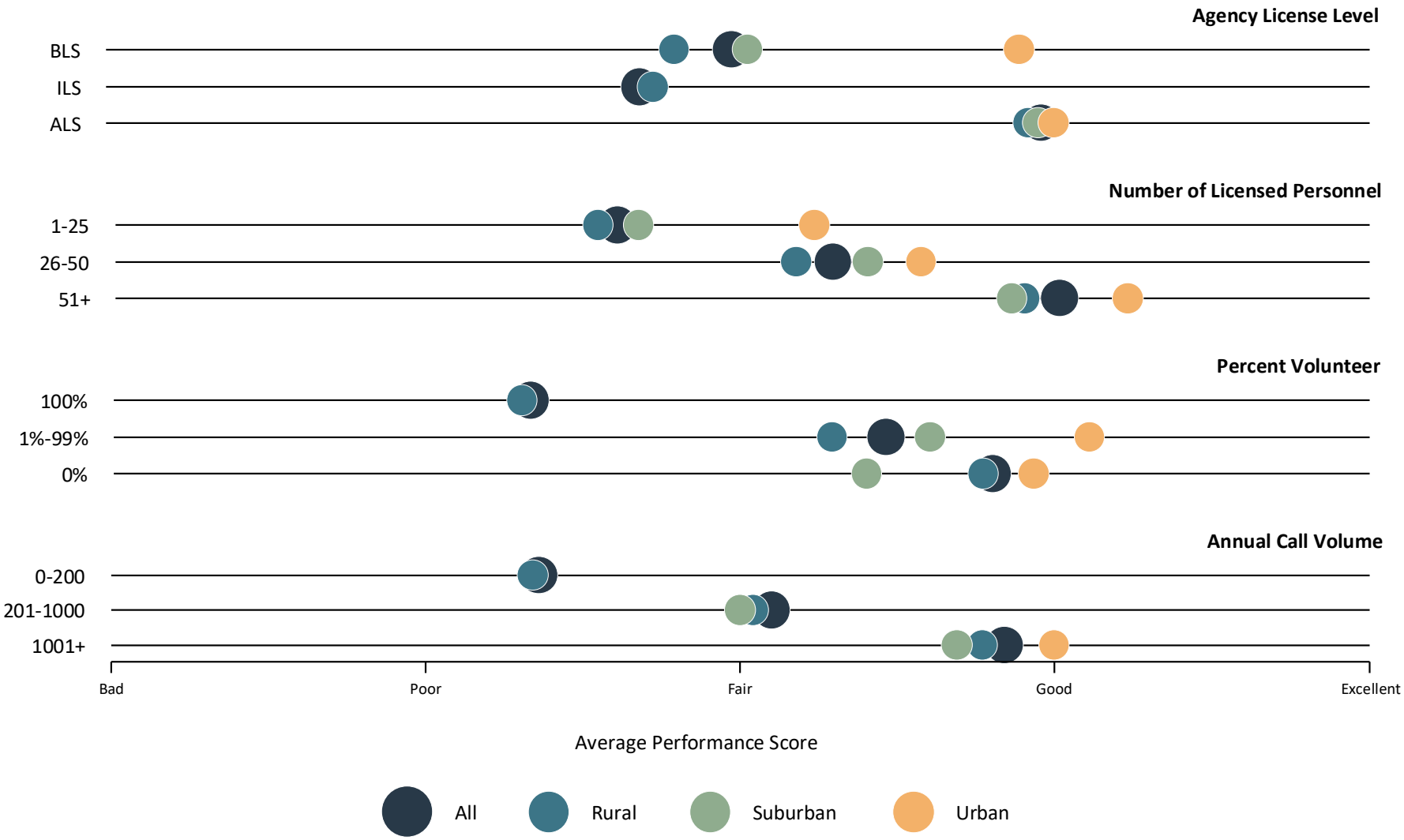
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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The Agency Reports Data

1. No operational/clinical data are submitted to WEMSIS/NEMSIS.

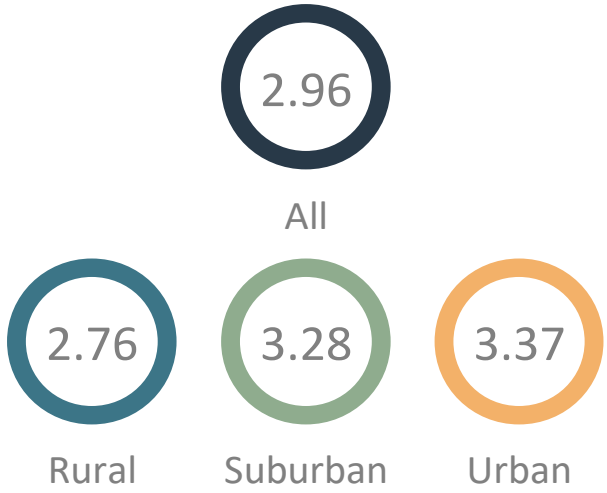
2. Operational/clinical data are submitted to WEMSIS/NEMSIS, but not often within the designated timelines (locally, statewide, or nationally).

3. Operational/clinical data are submitted to WEMSIS/NEMSIS within the designated timelines.

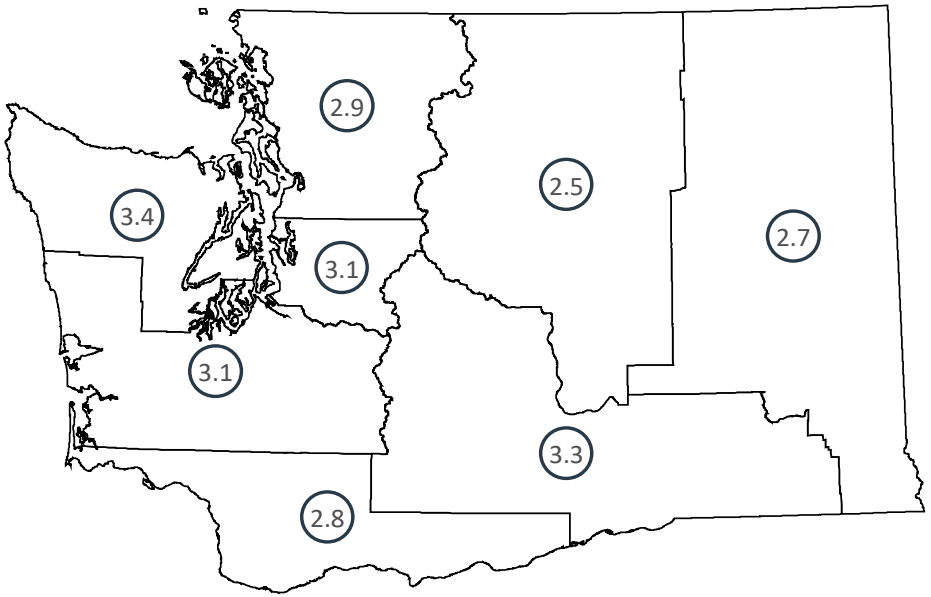
4. Operational/clinical data are submitted to WEMSIS/NEMSIS within the designated timelines. Areas for improvement are identified using an established quality improvement/quality assurance process by the EMS agency.

5. Operational/clinical data are submitted to WEMSIS/NEMSIS within the designated timelines. Areas for improvement are identified using an established quality improvement/quality assurance process, and goals and benchmarks are used to improve performance. Summary reports are regularly shared publicly with the community.

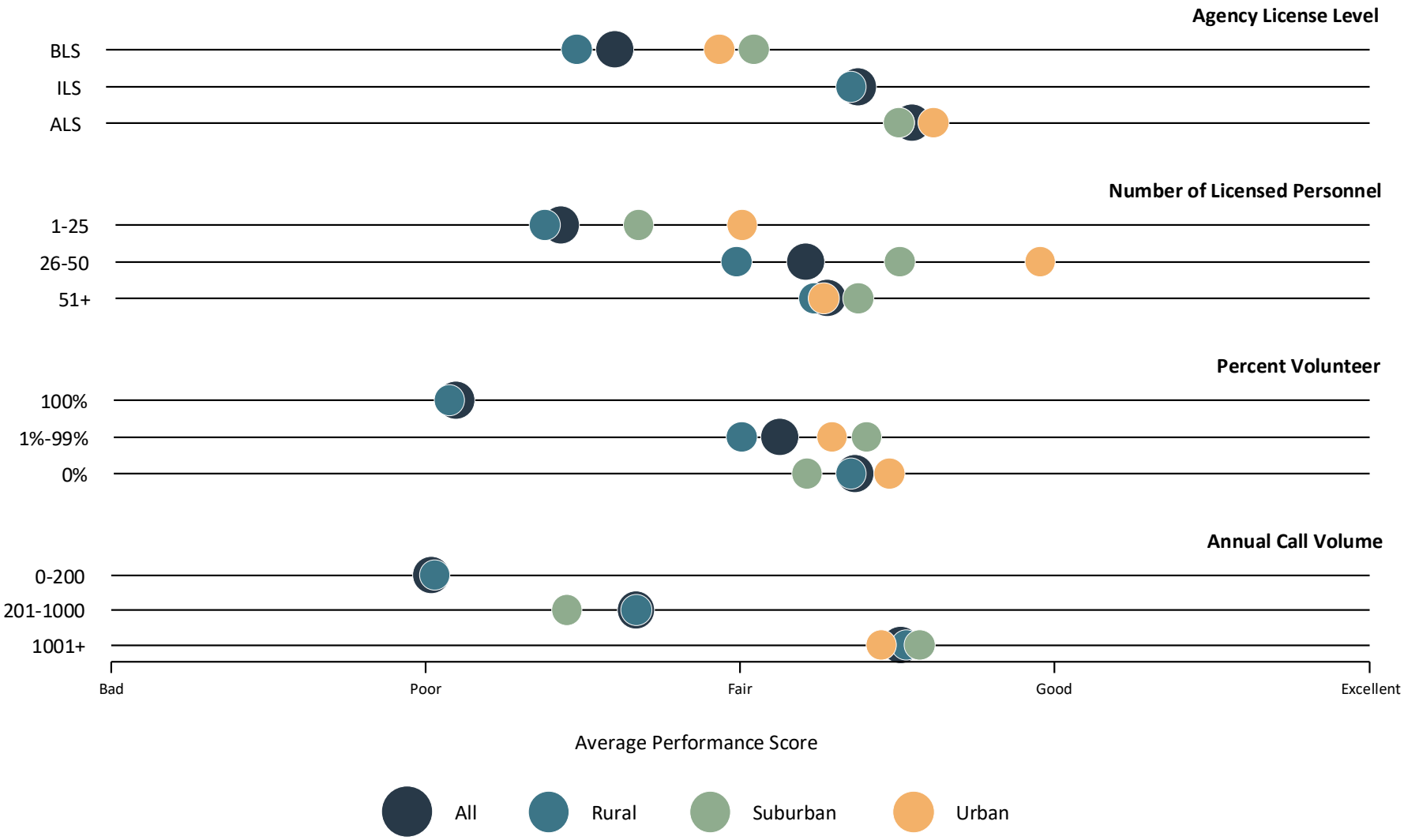
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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Community Based Representative Board

1. There is no formal board oversight.

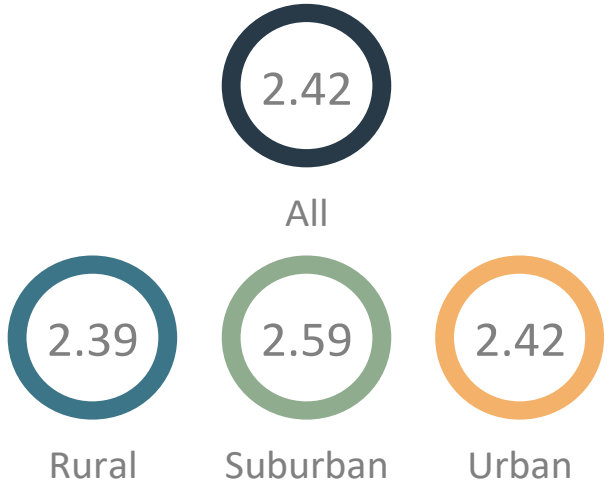
2. The board consists of internal EMS agency members only.

3. Voting board members are from the EMS agency and some combination of elected officials, hospital leadership/staff, and/or governmental administrators.

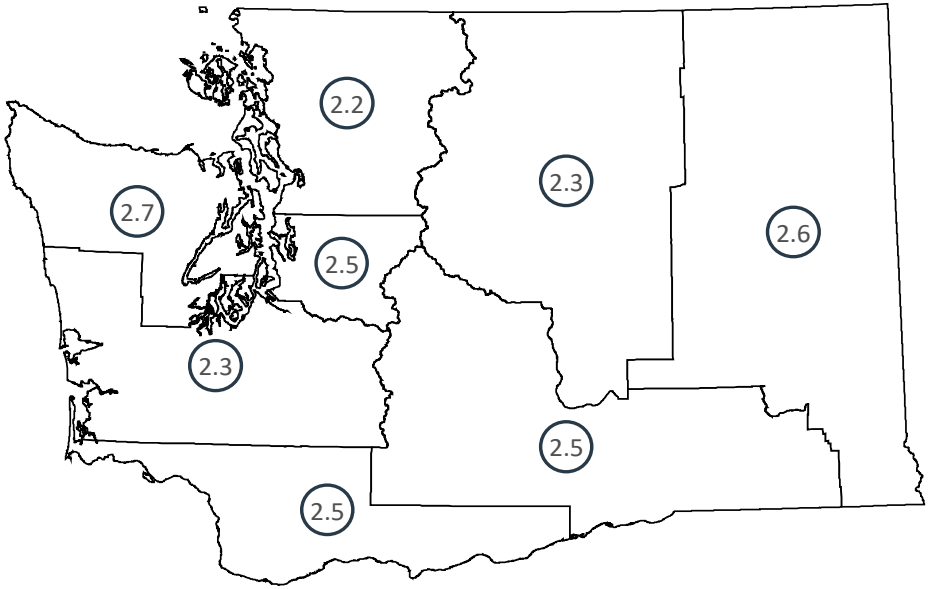
4. Voting board members are some combination of only elected officials, hospital leadership/staff, and/or governmental administrators.

5. Voting board members include all of No. 4 and at least one engaged patient representative.

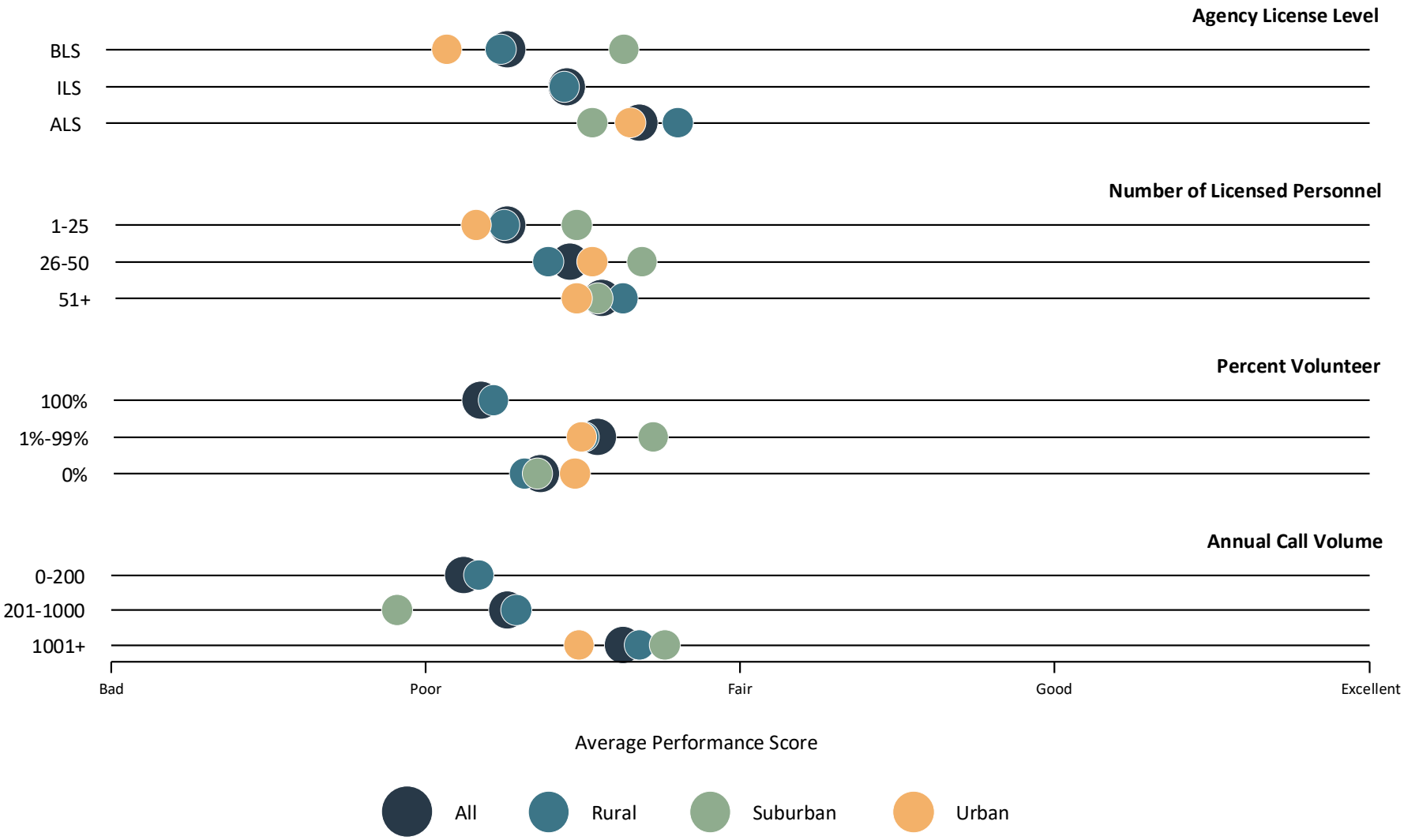
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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Agency Attire

1. There is no identifying EMS agency attire.

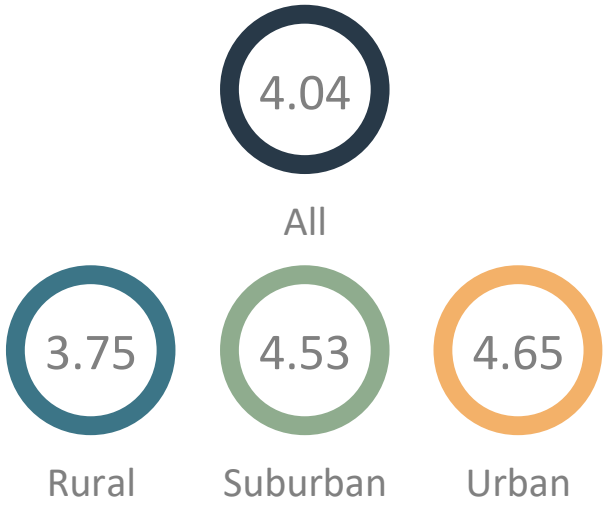
2. There is identifying EMS agency attire, but it is not adequately protective.

3. There is identifying EMS agency attire, which is adequately protective, but elements of it are purchased by the members.

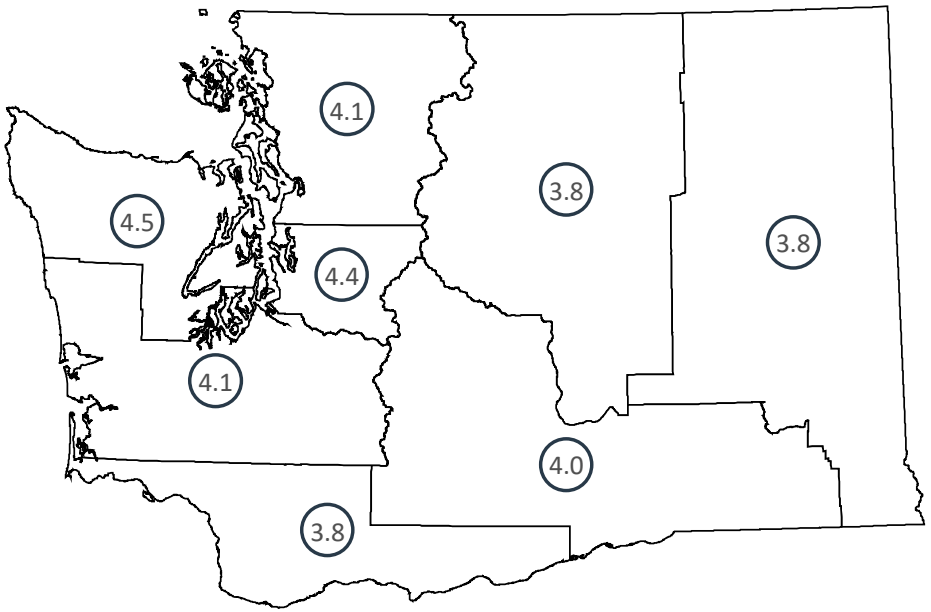
4. There is identifying EMS agency attire, which is adequately protective, and all of it is purchased by the agency.

5. There is identifying EMS agency attire, which is adequately protective and purchased by the agency. A written policy identifies what attire is required and how it is to be provided, cleaned, maintained, and replaced.

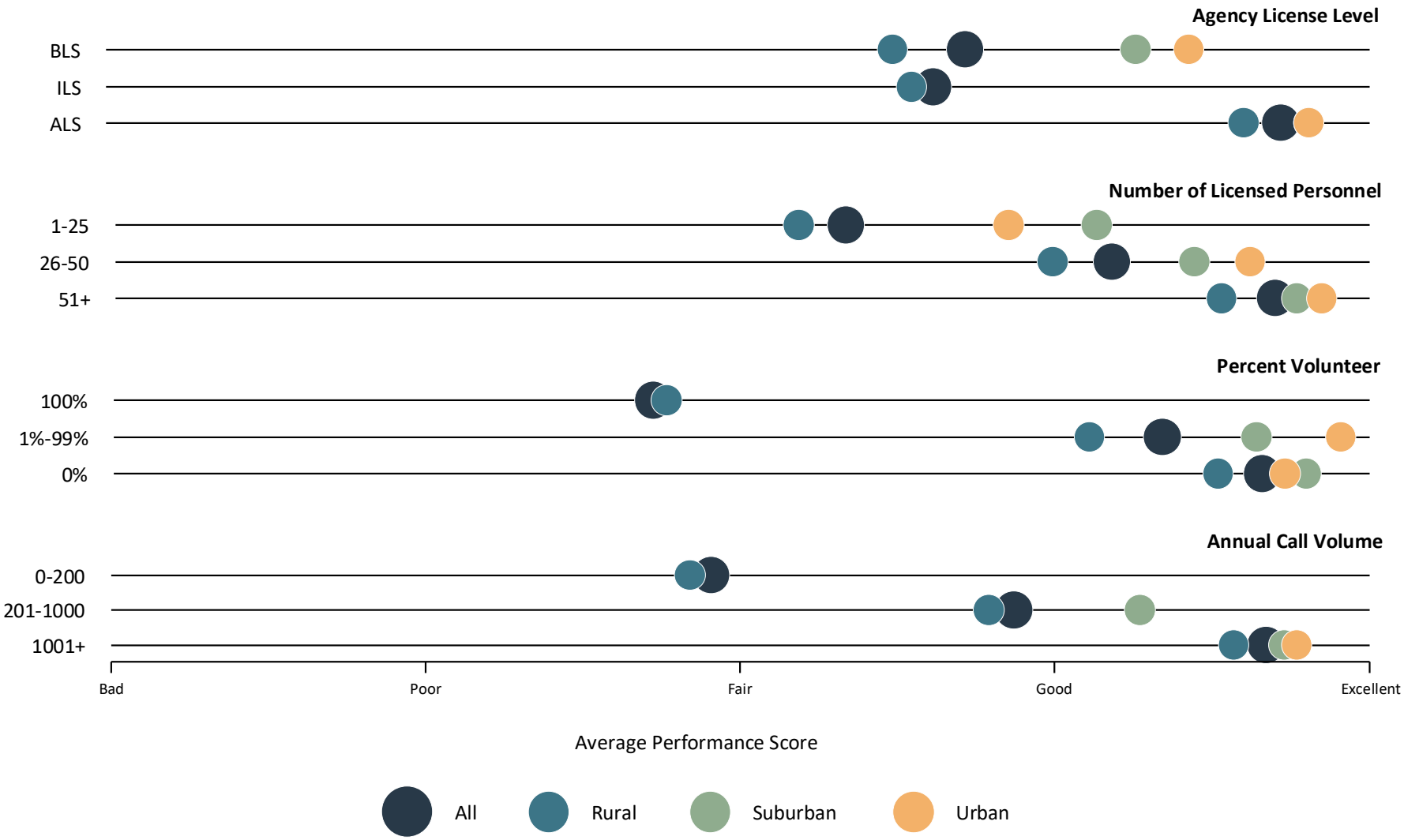
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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Public Information, Education and Relations (PIER)

1. There is no plan for addressing PIER.

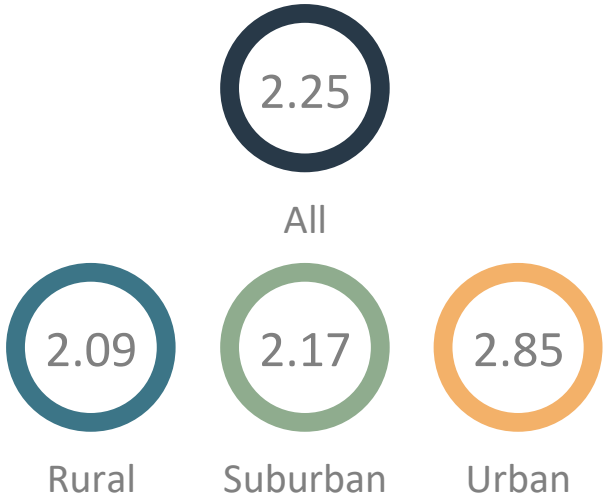
2. The EMS agency is in the process of developing a PIER plan.

3. There is a PIER plan, but no funding dedicated to its implementation.

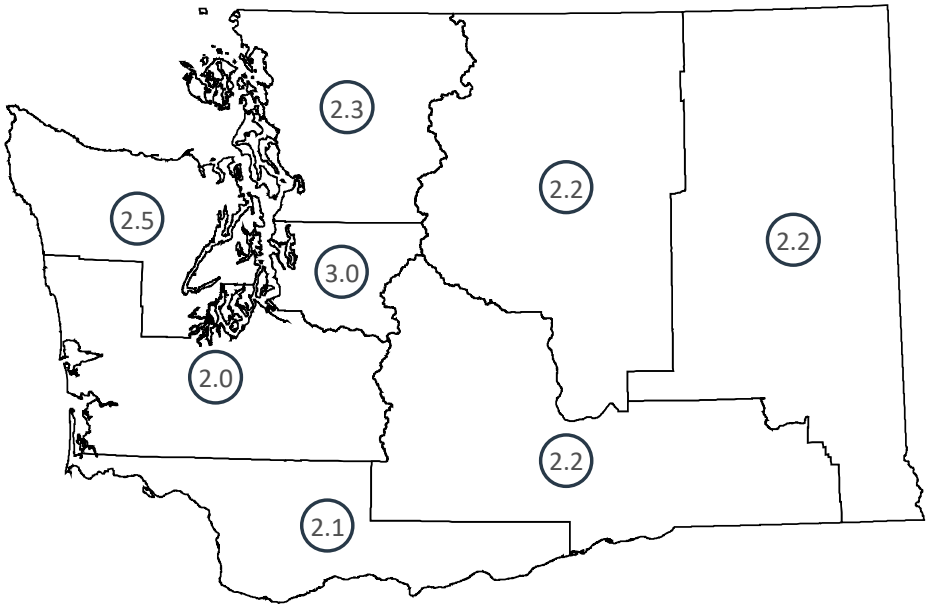
4. There is a PIER plan that has funding dedicated to its implementation.

5. There is a PIER plan that has funding dedicated to its implementation, someone identified as responsible for PIER, and a recurring evaluation of its success.

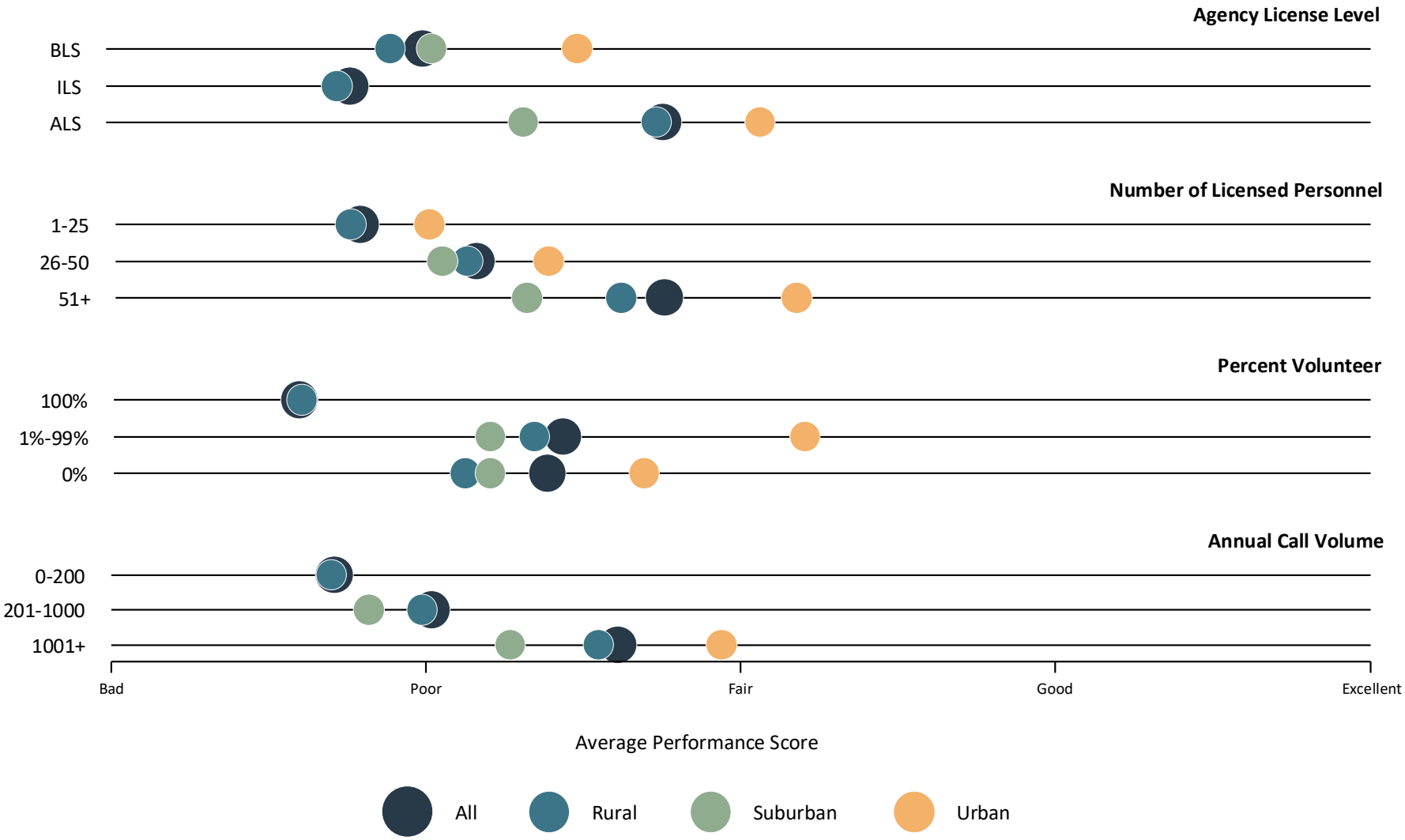
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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Involvement in the Community

1. No public education courses are offered.

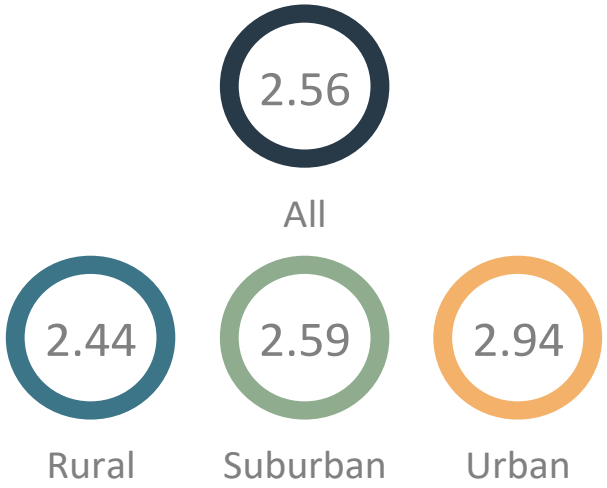
2. Occasional basic public education courses, such as CPR/AED and first aid training, are offered.

3. Frequent basic public education courses, such as CPR/AED and first aid training, plus other EMS-related training are offered.

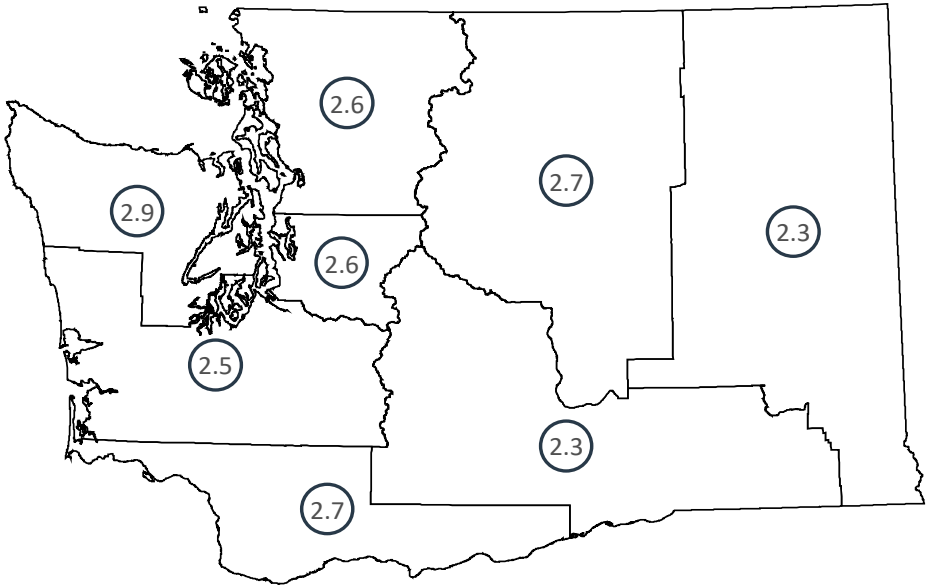
4. A robust array of public education courses and other training are offered and the EMS agency is active in community promotions at various events.

5. The EMS agency offers a robust array of public education courses and other training, organizes or assists in planning health fairs, is a champion for a healthy community, is an active partner with other public safety organizations, and is seen as a leader for community health and well-being.

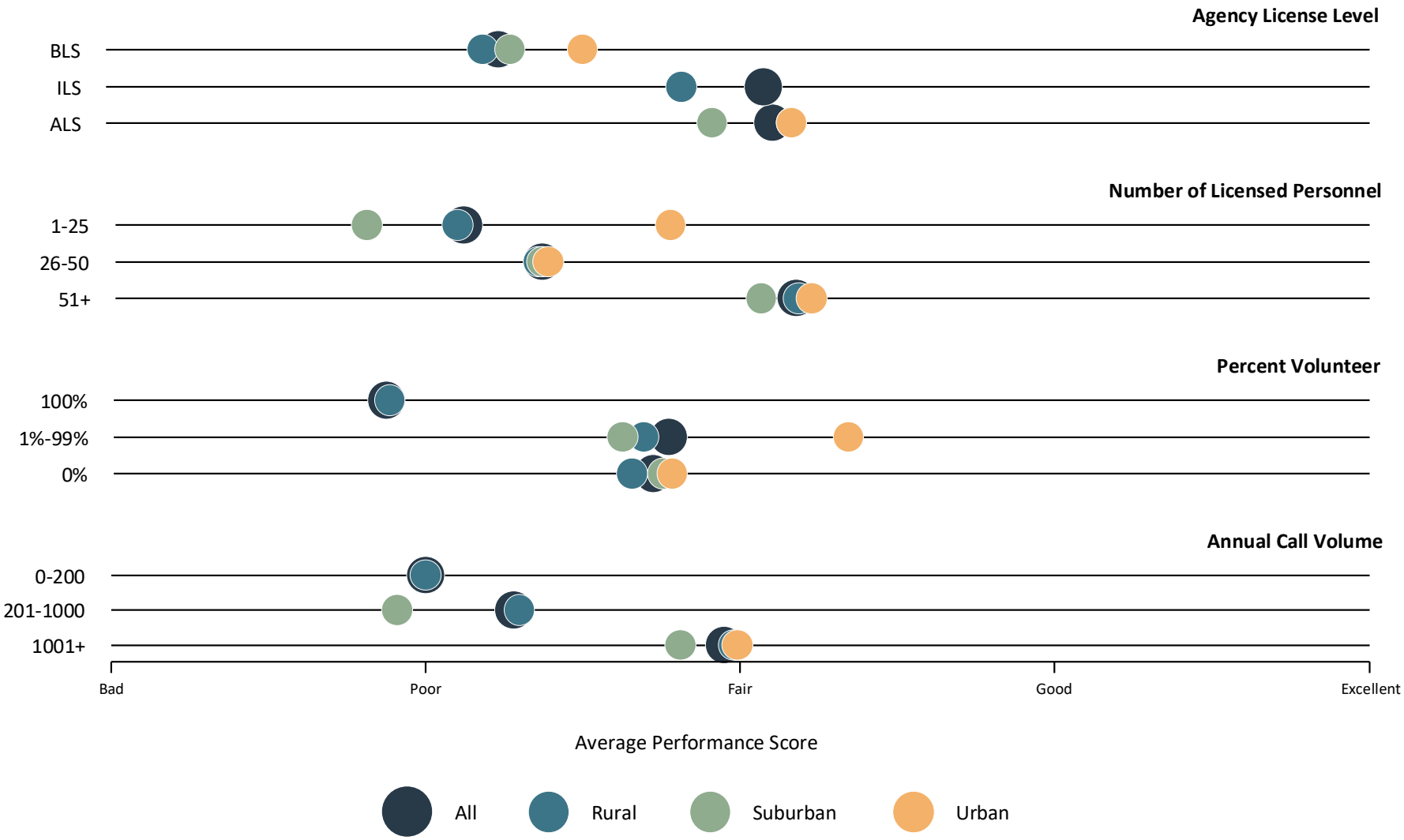
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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A Recruitment and Retention Plan

1. There is no agreed-upon plan nor substantive discussion on recruitment and retention.

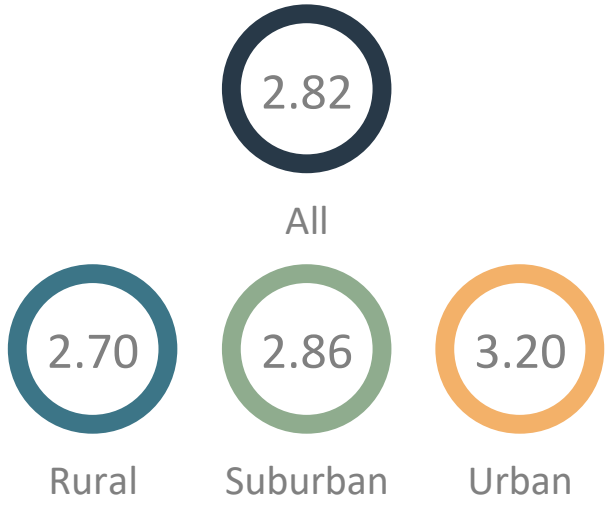
2. There is no agreed-upon plan but there have been substantive discussions on recruitment and retention.

3. There is an informal, agreed-upon plan, and people have been tasked with addressing the issues of recruiting new crew members and retaining existing crew members.

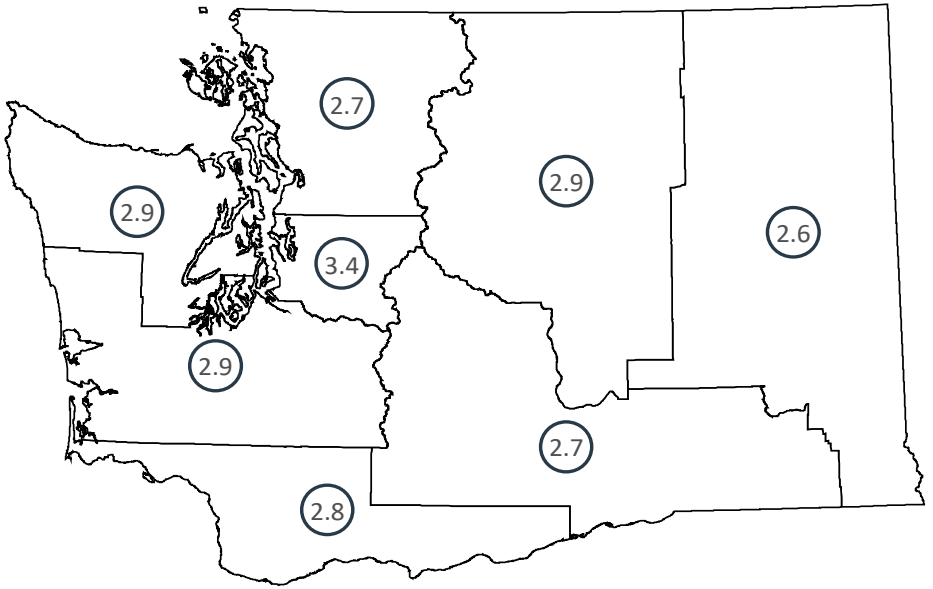
4. There is a formal written plan, and people have been tasked with recruiting new crew members and strategizing methods to keep current crew members active (such as compensation, recognition and reward program, management of on call time, adequate training).

5. There is a formal written plan, and people have been tasked with recruiting new members and retaining existing crew members. There is a full roster with a waiting list for membership.

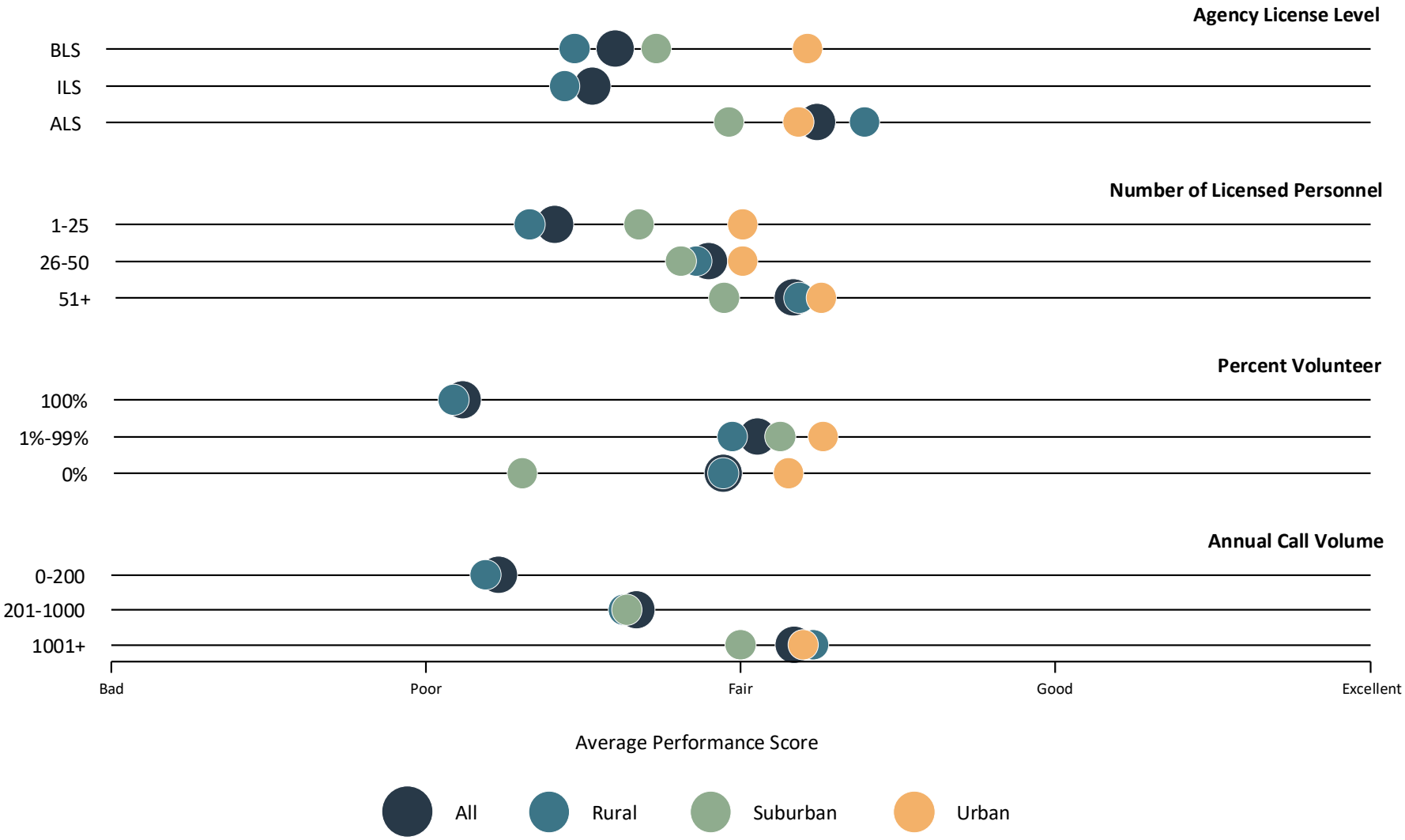
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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Formal Personnel Standards

1. There is no official staffing plan or formal process for hiring new personnel (paid and/or volunteer).

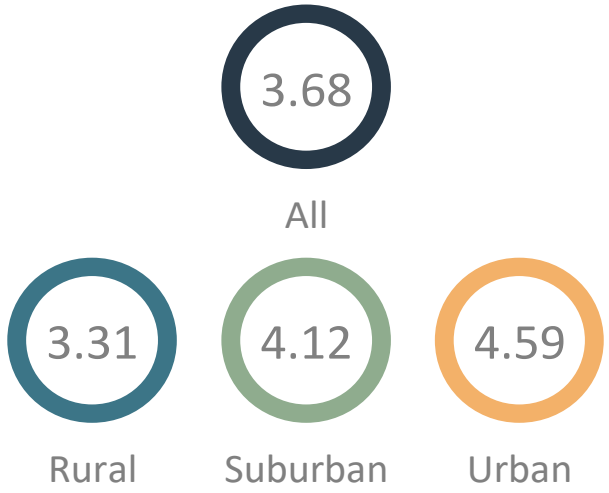
2. There is a staffing plan and documented minimum standards for new hires.

3. There is a staffing plan, documented minimum standards for new hires, and an official new-hire orientation.

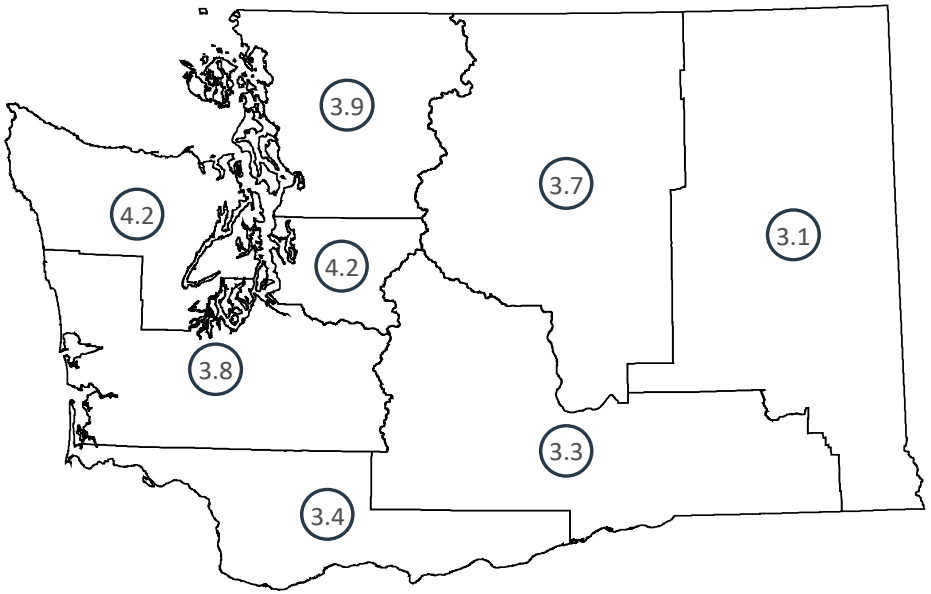
4. There is a staffing plan, documented minimum standards for new hires (including background checks), an official new-hire orientation, and systematic performance reviews/work evaluations.

5. All of No. 4, plus there is a process to resolve personnel issues.

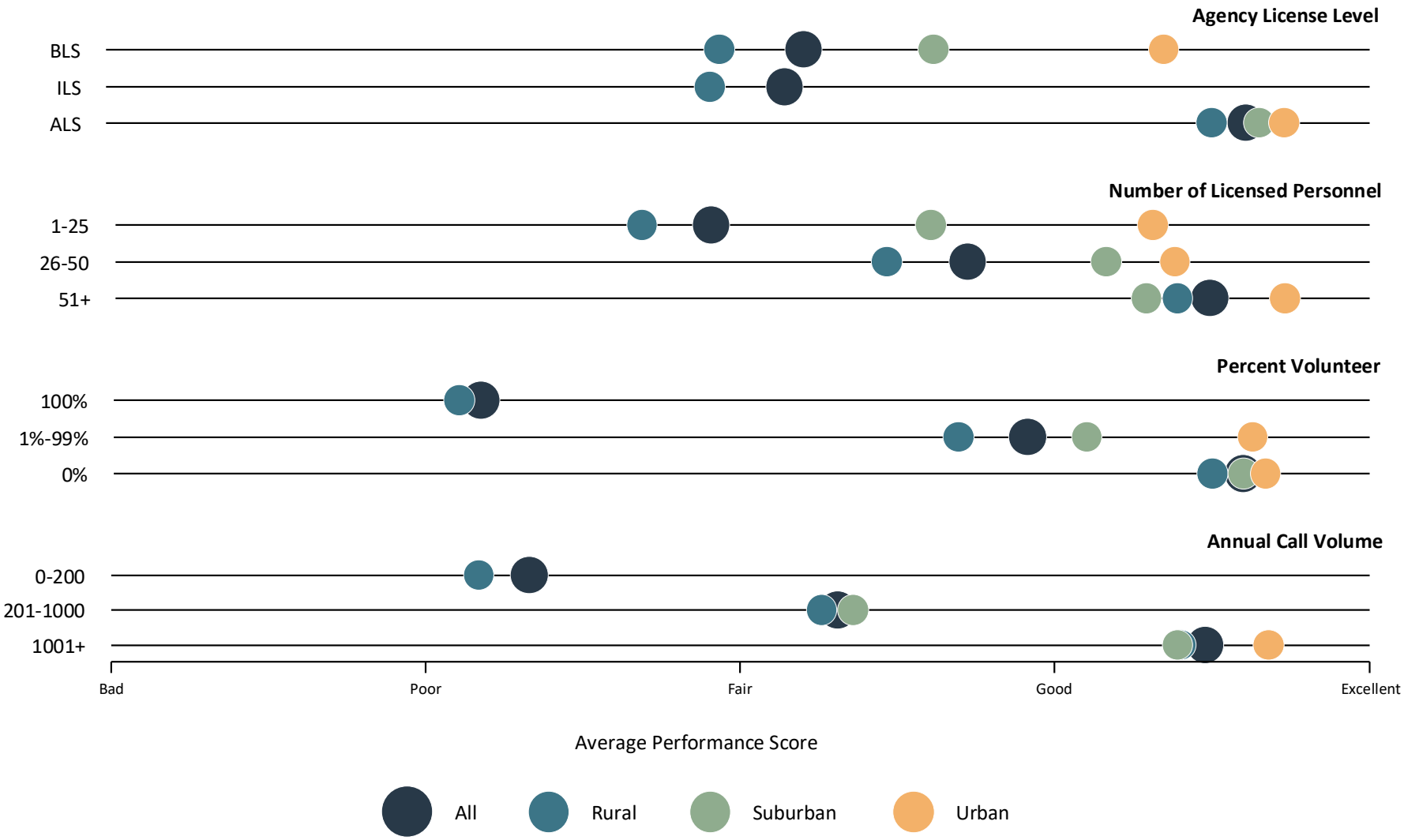
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



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An Identified EMS Operations Leader with a Succession Plan

1. There is an identified EMS operations leader (e.g., chief, director, director of operations, EMS deputy chief or captain within a fire agency), but he or she has not had any leadership training.

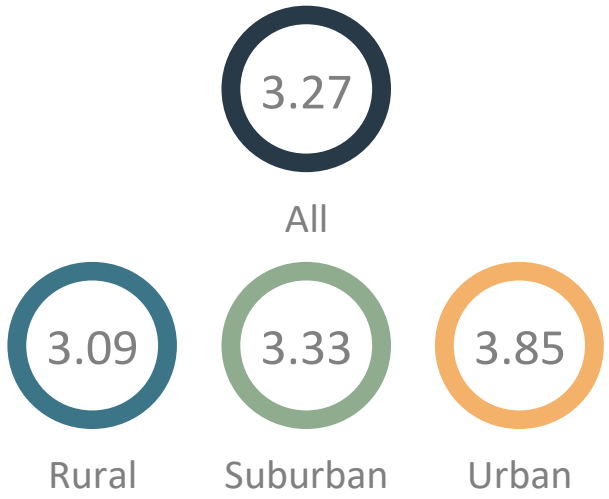
2. There is an identified EMS operations leader with some leadership training, but he or she was not selected by a recruitment process.

3. There is an identified EMS operations leader with some leadership training and who was selected by a recruitment process, but there are obstacles to full functioning (such as lack of funding or no succession plan).

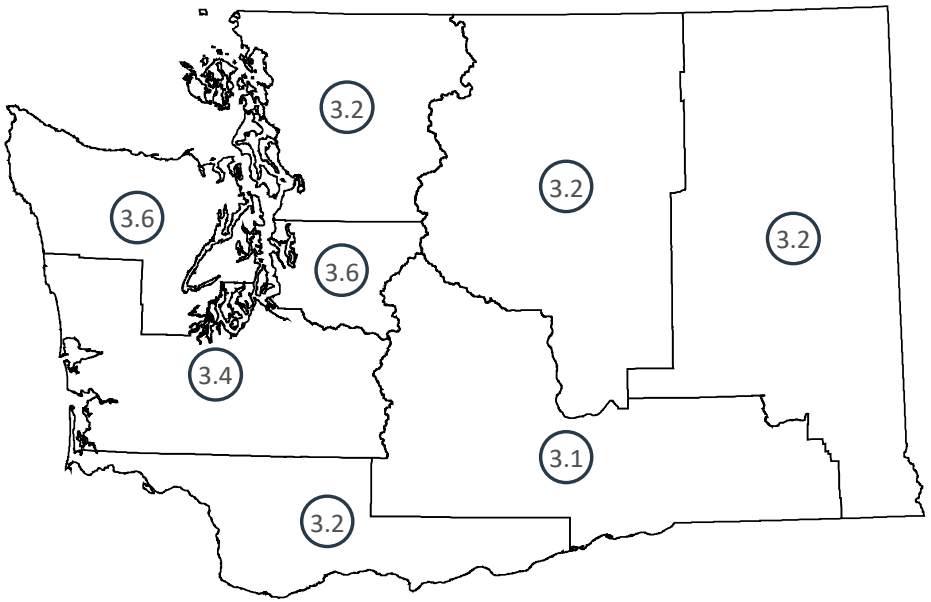
4. There is an identified EMS operations leader with comprehensive leadership training and who was selected by a recruitment process, but there are obstacles to full functioning (such as lack of funding, no succession plan).

5. There is an identified EMS operations leader with comprehensive leadership training, who was selected by a recruitment process, and who is fully capable and prepared to effectively lead the service. There is also a succession plan in place to appropriately handle the transition of the leadership role.

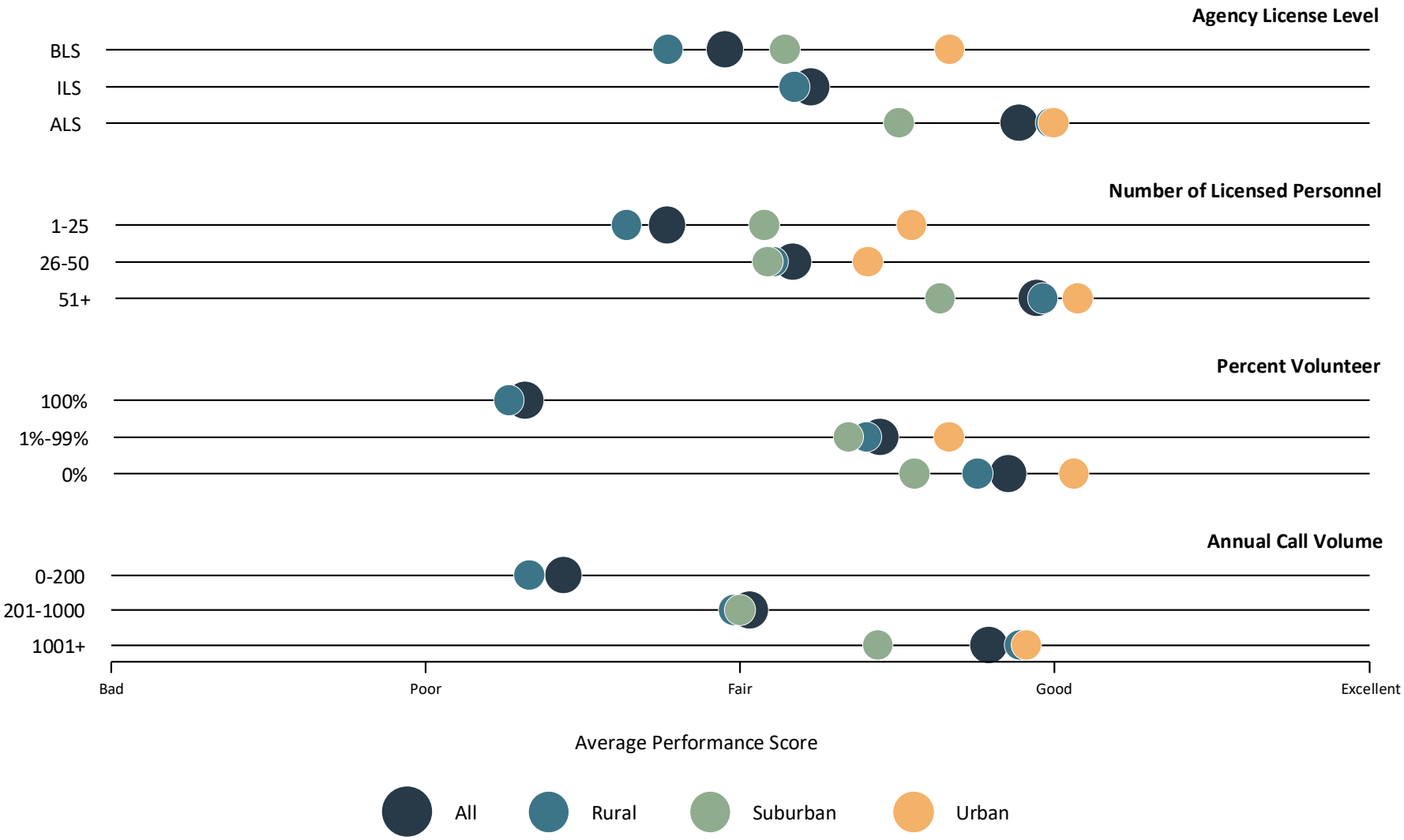
Average Performance Scores



Average Performance Scores by EMS Region



Average Performance Scores by Agency Characteristics



Under WAC related to EMS, agencies may be considered under more than one demographic distinction. In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than ten.

A Wellness Program for Agency Staff

1. There is no wellness program for crew members.

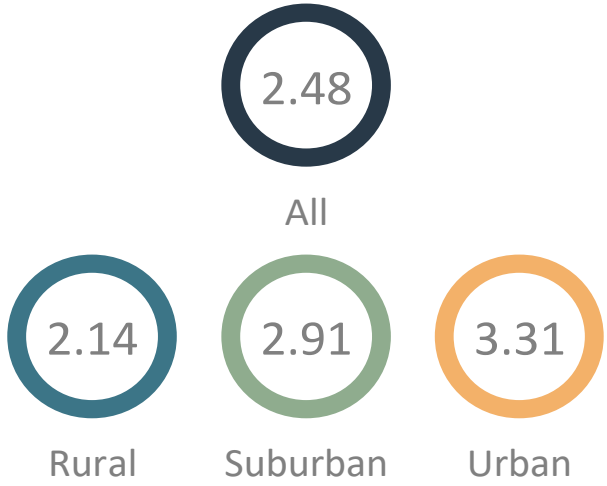
2. Written information is available for crew members regarding physical activity, healthy food options, and tobacco cessation.

3. All of No. 2 and occasional educational programming regarding healthy lifestyles is offered, and there is policy support for healthy food options at meetings.

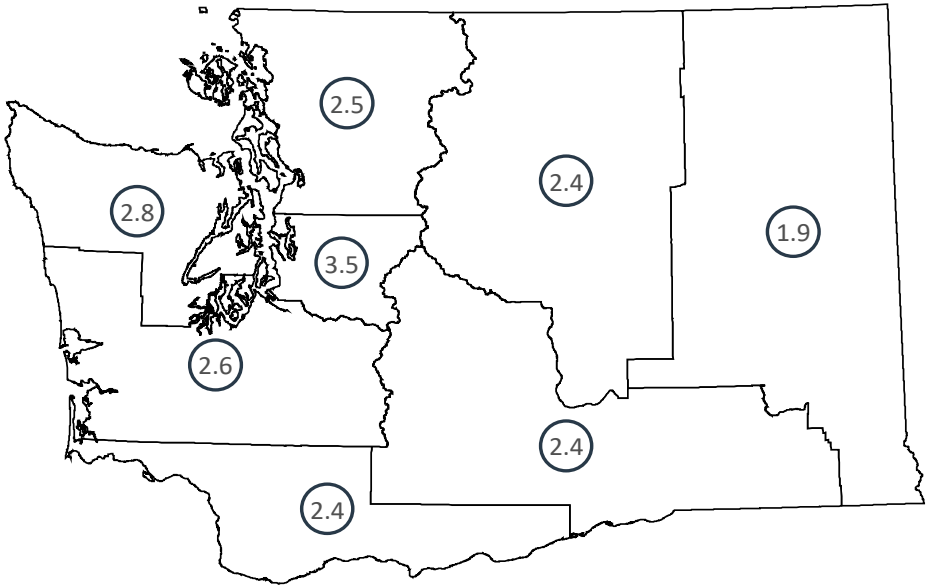
4. All of No. 3 and there is policy support for healthy lifestyle opportunities during work time.

5. There is a structured wellness program following national recommendations. Crew members are actively encouraged with agency-funded fitness opportunities, healthy food choices, and disease-prevention programs such as tobacco cessation.

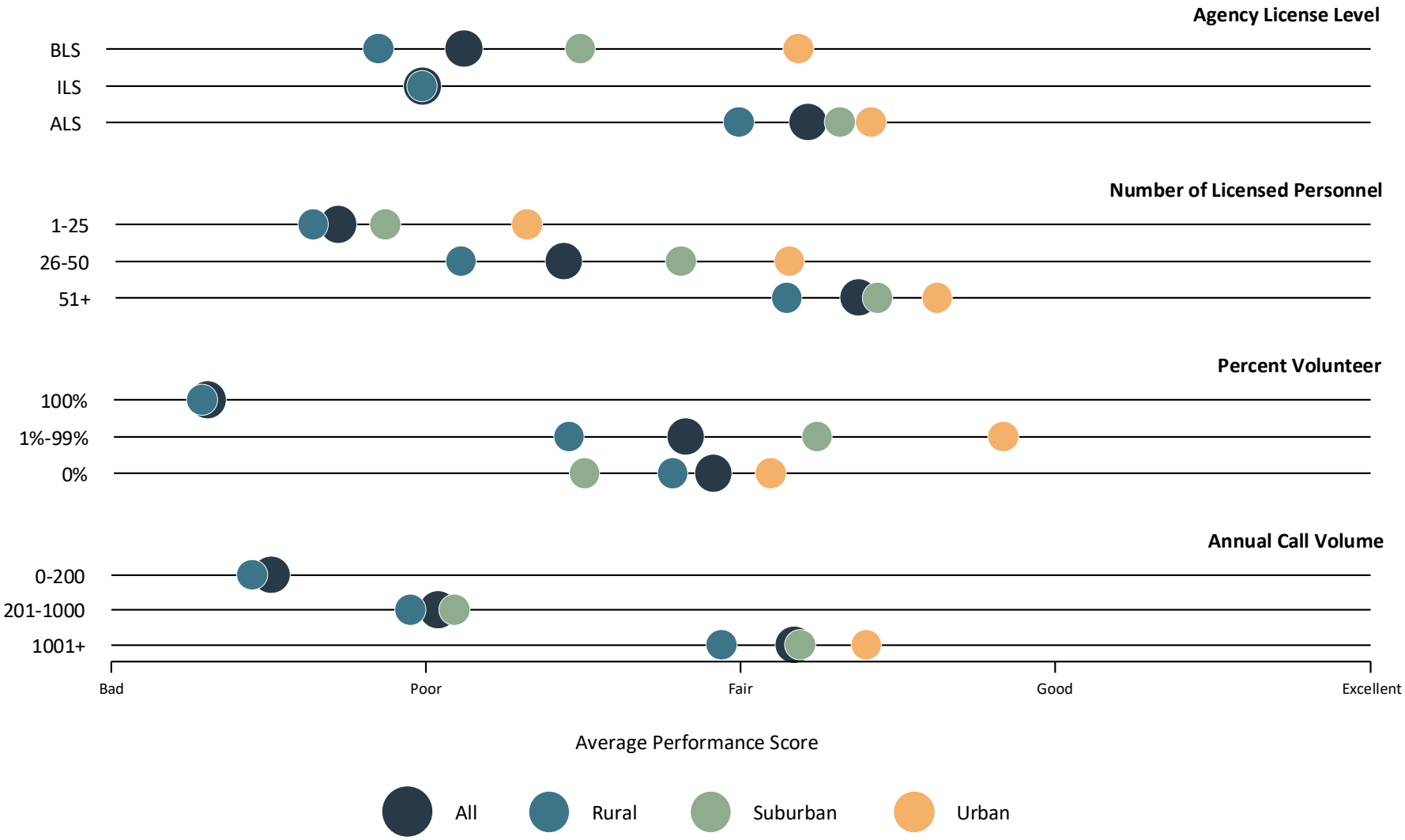
Average Performance Scores



Average Performance Scores by EMS Region



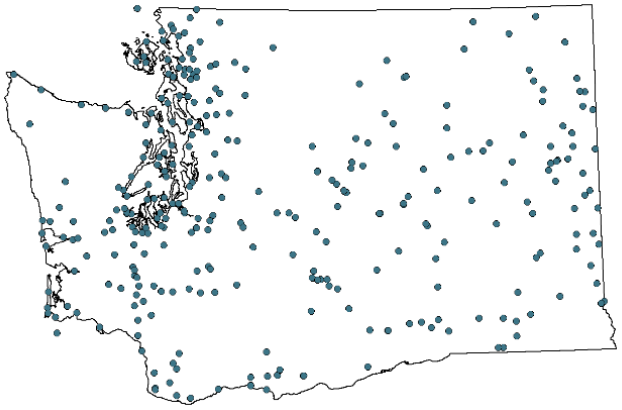
Average Performance Scores by Agency Characteristics



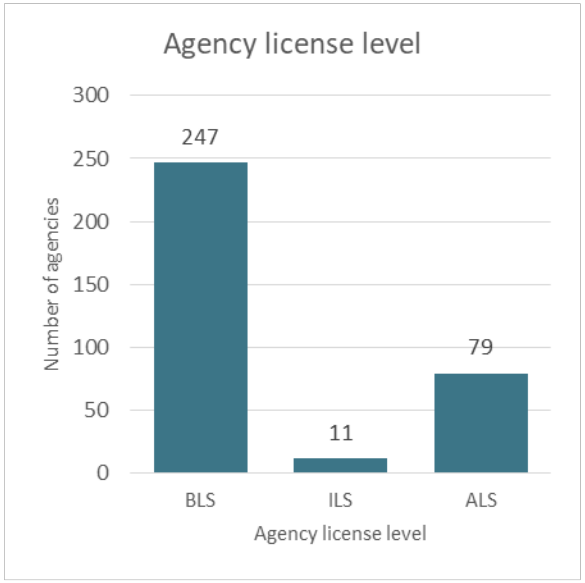
Under WAC related to EMS, agencies may be considered under more than one demographic distinction. In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than ten.

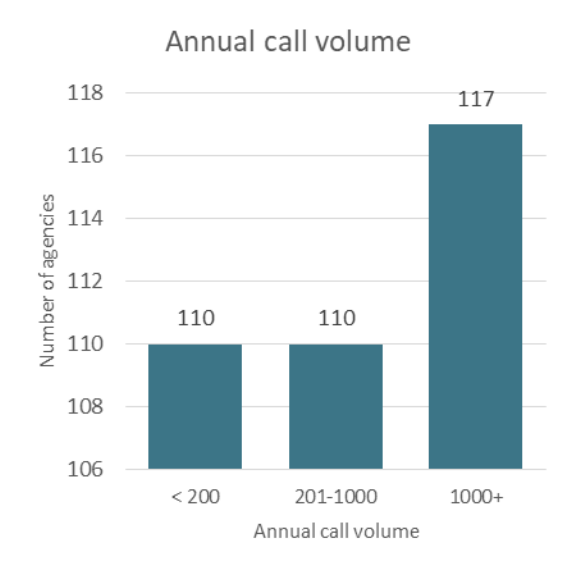
Appendix B- Rural Agency Summary

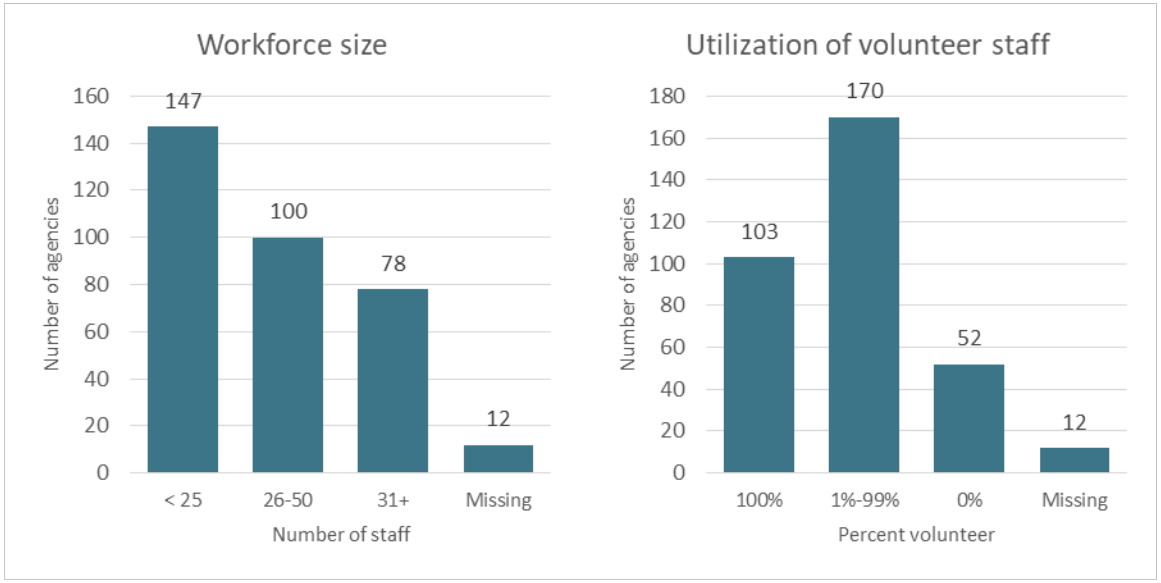
Rural Agency Summary

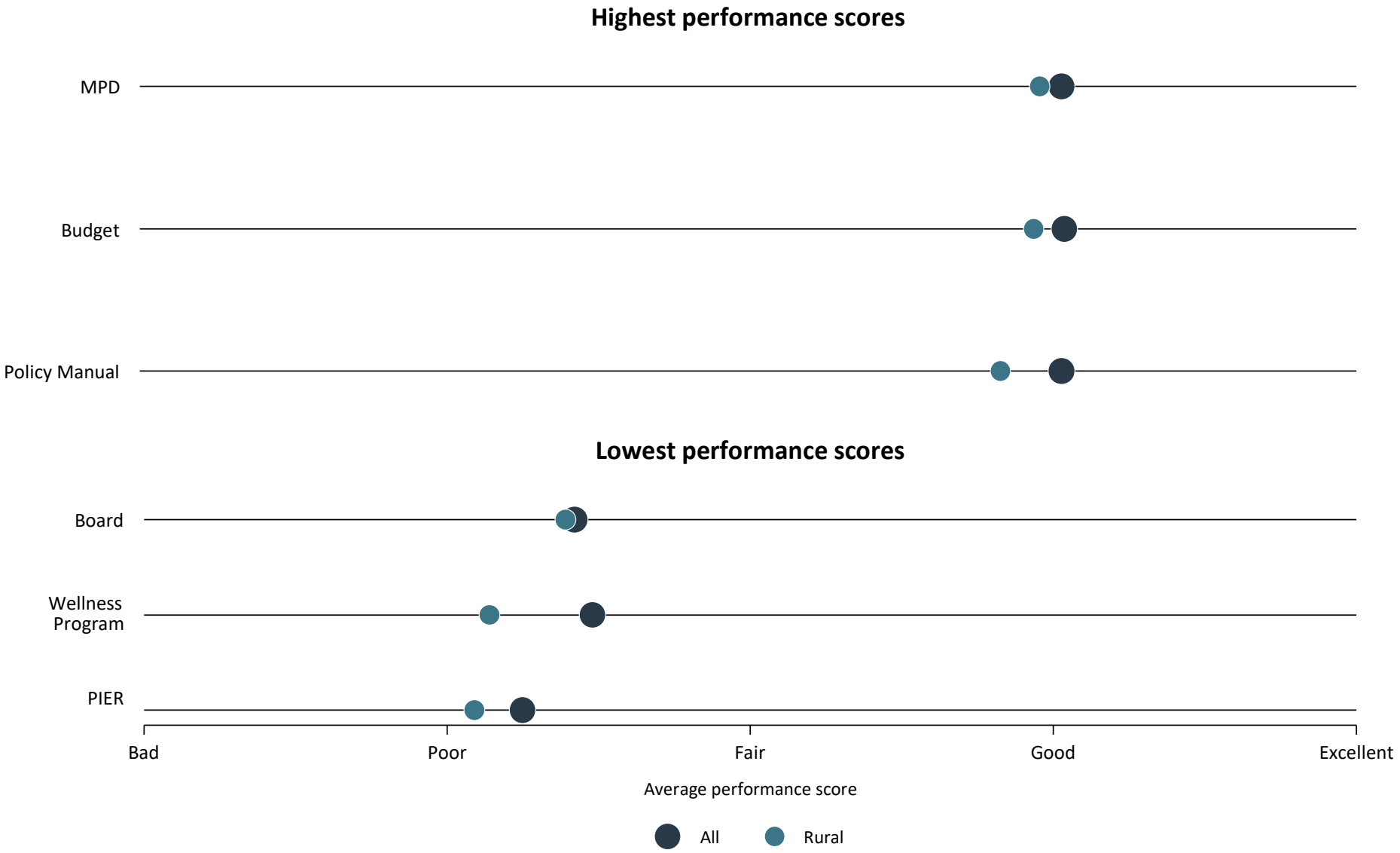


The map above represents the 337 agencies that responded to the survey and who meet the definition of "rural" according the WAC. The rural agencies responding to the survey are generally BLS agencies with smaller numbers of staff members, and rely heavily on volunteer workforce. On average, the rural agencies responding to the survey reported the highest performance with regard to MPD involvement, having a sustainable budget, and having a written policy and procedure manual. The biggest areas of improvement for rural agencies are PIER, having a wellness program for staff members, and having a community-based board. For both the highest and lowest performing attributes, rural agencies reported lower levels of performance than what was observed at the state level.








Highest performance scores
MPD
Budget
Policy Manual
Lowest performance scores
Board
Wellness Program
PIER
Bad
Poor
Fair
Good
Excellent
Average performance score
All
Rural

Appendix C- Results by EMS Region

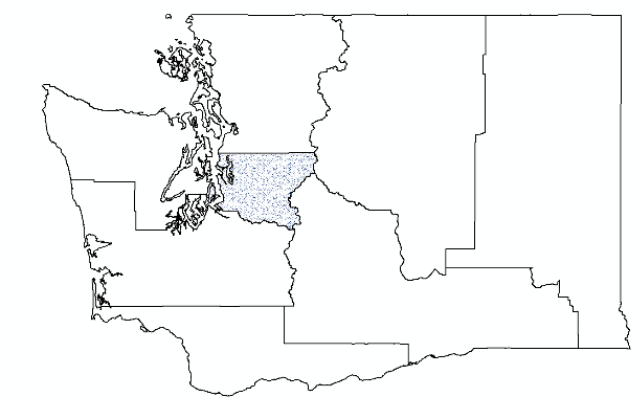
Average performance scores by EMS region

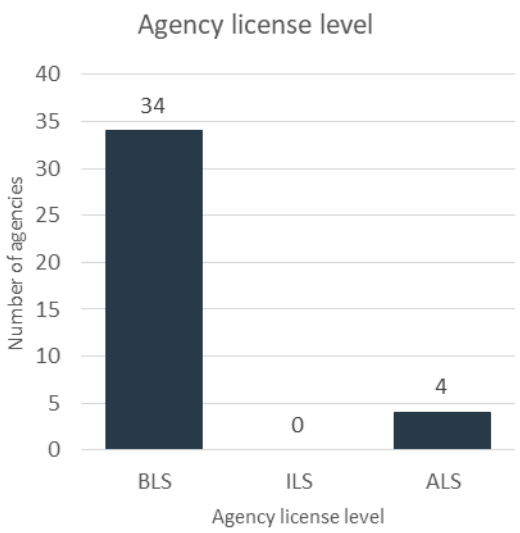
	Central				East				North				North Central			
	All	Rural	Suburban	Urban	All	Rural	Suburban	Urban	All	Rural	Suburban	Urban	All	Rural	Suburban	Urban
Call Schedule	4.7	4.5	*	4.7	2.7	2.6	3.4	*	3.5	2.9	4.7	4.4	3.5	3.2	*	*
Continuing Education	4.4	3.9	*	4.7	3.4	3.2	4.1	*	3.9	3.8	4.0	3.9	3.8	3.6	*	*
Policy Manual	4.4	4.4	*	4.5	3.8	3.7	3.9	*	4.0	3.8	4.3	4.4	4.0	3.8	*	*
Incident Response	3.9	3.8	*	4.1	3.5	3.4	4.2	*	3.1	3.3	2.8	2.5	3.1	3.0	*	*
Budget	4.5	4.1	*	4.7	3.8	3.7	3.8	*	4.1	4.1	4.5	3.9	3.8	3.8	*	*
Billing	2.9	2.9	*	2.7	2.9	2.9	2.6	*	3.6	3.1	4.1	4.5	3.4	3.2	*	*
MPD	4.5	4.3	*	4.5	3.9	3.7	4.0	*	3.8	3.7	4.2	3.8	4.1	4.2	*	*
QI/QA	4.5	4.0	*	4.8	3.5	3.5	4.0	*	3.8	3.8	3.3	4.0	3.7	3.5	*	*
Equipment and Technology	4.0	3.8	*	4.2	2.9	2.8	2.8	*	3.5	3.1	4.1	4.0	2.8	2.7	*	*
Data	3.1	3.1	*	3.1	2.7	2.4	3.4	*	2.9	2.6	3.1	3.4	2.5	2.3	*	*
Board	2.5	2.1	*	2.7	2.6	2.6	2.9	*	2.2	2.2	2.2	2.4	2.3	2.4	*	*
Attire	4.4	3.8	*	4.7	3.8	3.7	4.1	*	4.1	3.8	4.7	4.5	3.8	3.6	*	*
PIER	3.0	2.2	*	3.5	2.2	1.9	2.7	*	2.3	2.3	1.9	2.5	2.2	2.1	*	*
Community Involvement	2.6	2.4	*	2.8	2.3	2.1	2.5	*	2.6	2.6	2.5	2.6	2.7	2.6	*	*
Recruitment Plan	3.4	3.0	*	3.7	2.6	2.5	2.7	*	2.7	2.6	2.8	2.4	2.9	2.9	*	*
Personnel Standards	4.2	3.7	*	4.6	3.1	2.8	3.4	*	3.9	3.6	4.3	4.4	3.7	3.5	*	*
Operations Leader	3.6	3.2	*	3.8	3.2	2.9	3.7	*	3.2	3.0	3.2	3.8	3.2	3.2	*	*
Wellness Program	3.5	2.5	*	4.2	1.9	1.6	2.4	*	2.5	2.2	3.0	2.8	2.4	2.3	*	*

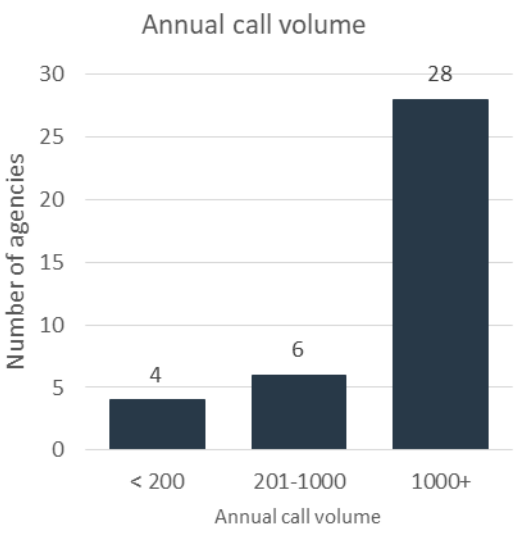
Average performance scores by EMS region, continued

	Northwest				South Central				Southwest				West			
	All	Rural	Suburban	Urban	All	Rural	Suburban	Urban	All	Rural	Suburban	Urban	All	Rural	Suburban	Urban
Call Schedule	4.2	3.7	*	*	3.3	2.6	3.4	5.0	3.3	2.7	*	*	3.8	3.4	4.7	5.0
Continuing Education	4.2	4.1	*	*	3.7	3.7	3.1	4.2	3.9	3.6	*	*	3.9	3.7	4.5	3.8
Policy Manual	4.4	4.3	*	*	4.0	3.8	4.4	4.5	3.8	3.5	*	*	3.9	3.8	4.6	4.1
Incident Response	4.1	3.9	*	*	3.3	3.1	3.6	3.3	3.6	3.5	*	*	3.5	3.4	4.0	3.7
Budget	4.3	4.4	*	*	4.0	4.0	4.1	4.2	4.1	3.9	*	*	3.9	3.8	4.1	4.2
Billing	4.7	4.5	*	*	3.1	2.7	3.0	4.4	2.5	2.5	*	*	3.9	3.7	3.6	5.0
MPD	4.6	4.6	*	*	4.3	4.3	4.3	4.3	4.3	4.1	*	*	3.5	3.6	3.9	2.5
QI/QA	4.1	4.0	*	*	3.4	3.4	3.2	3.7	3.7	3.5	*	*	3.6	3.6	3.0	4.1
Equipment and Technology	3.7	3.5	*	*	3.0	3.0	2.7	3.4	3.4	3.1	*	*	3.3	3.1	3.5	4.2
Data	3.4	3.3	*	*	3.3	3.1	2.9	4.1	2.8	2.7	*	*	3.1	2.9	3.9	3.4
Board	2.7	2.6	*	*	2.6	2.8	2.0	2.3	2.5	2.3	*	*	2.3	2.2	2.6	2.6
Attire	4.5	4.3	*	*	4.0	3.7	4.7	4.5	3.8	3.4	*	*	4.1	3.8	4.8	4.8
PIER	2.5	2.5	*	*	2.2	2.1	2.1	2.6	2.1	2.0	*	*	2.0	1.9	1.8	2.9
Community Involvement	2.9	2.8	*	*	2.3	2.2	2.1	2.7	2.7	2.6	*	*	2.5	2.4	2.8	2.9
Recruitment Plan	2.9	2.8	*	*	2.7	2.5	3.0	3.0	2.8	2.6	*	*	2.9	2.8	2.9	3.5
Personnel Standards	4.2	3.9	*	*	3.3	2.8	3.7	4.5	3.4	2.9	*	*	3.8	3.5	4.6	4.7
Operations Leader	3.6	3.6	*	*	3.1	2.9	3.3	3.5	3.2	2.8	*	*	3.4	3.2	3.1	4.4
Wellness Program	2.8	2.7	*	*	2.4	2.1	2.8	2.8	2.4	1.9	*	*	2.6	2.2	3.3	3.8

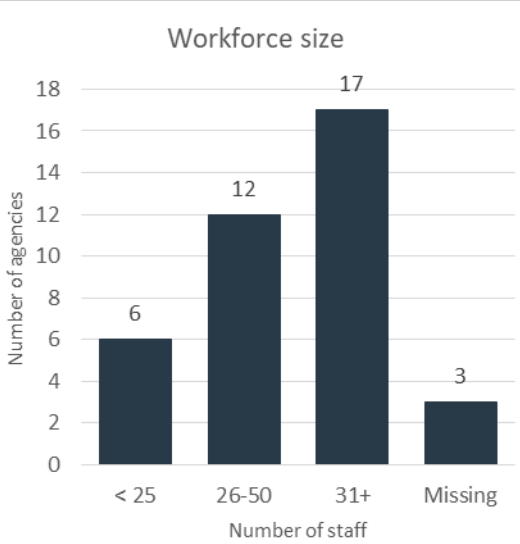
Central Region

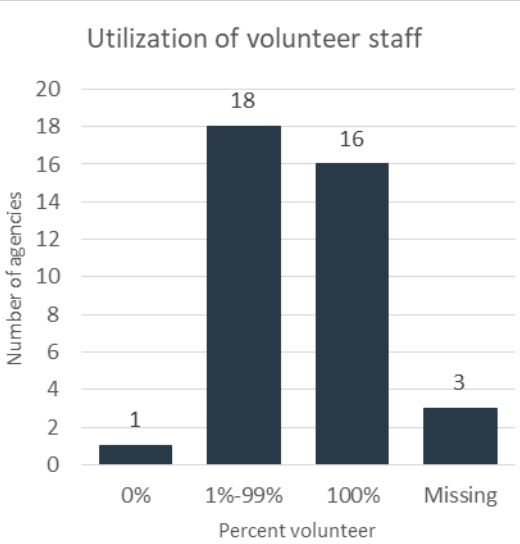




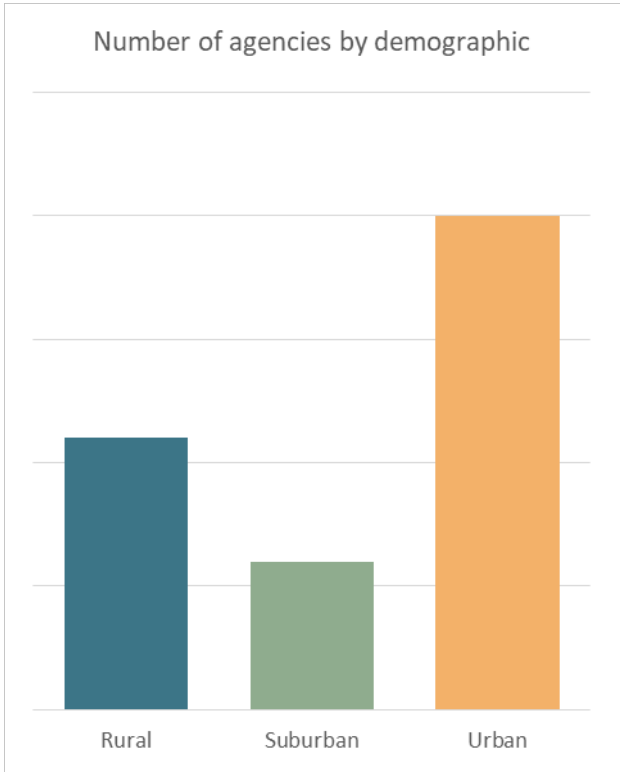


Central region is composed of one largely urban county, and is the only region whose survey responding agencies were not mostly rural. Central region agencies reported highest level of performance for the attributes related to having a written call schedule, the involvement of their MPD, and having a QI/QA process. For each of these high performing attributes, Central region agencies performed at a higher level than what was observed statewide. The lowest level of performance was reported for the attributes in regard to having a professional billing process, involvement in the community, and having a community-based and representative board.



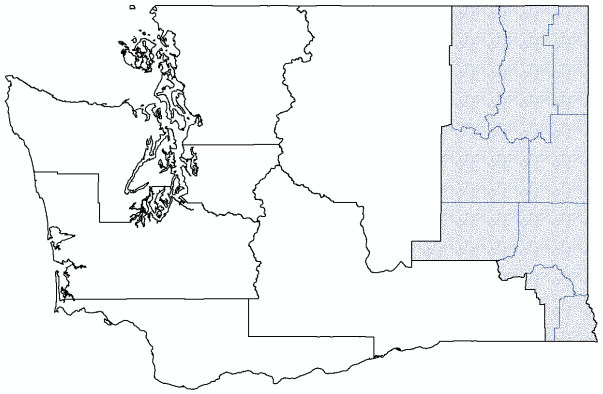


Central Region, continued

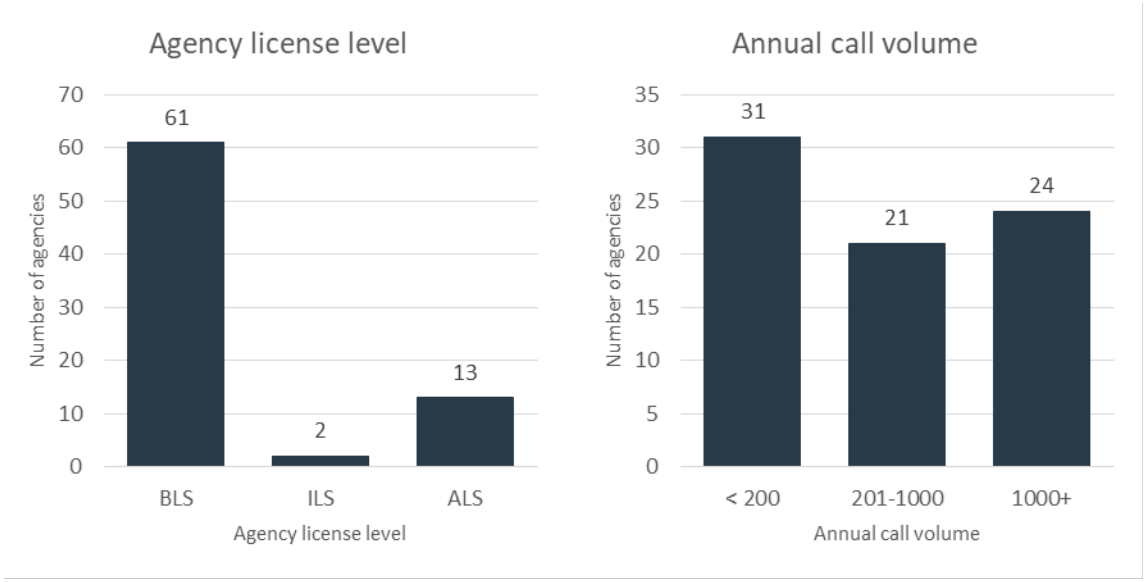


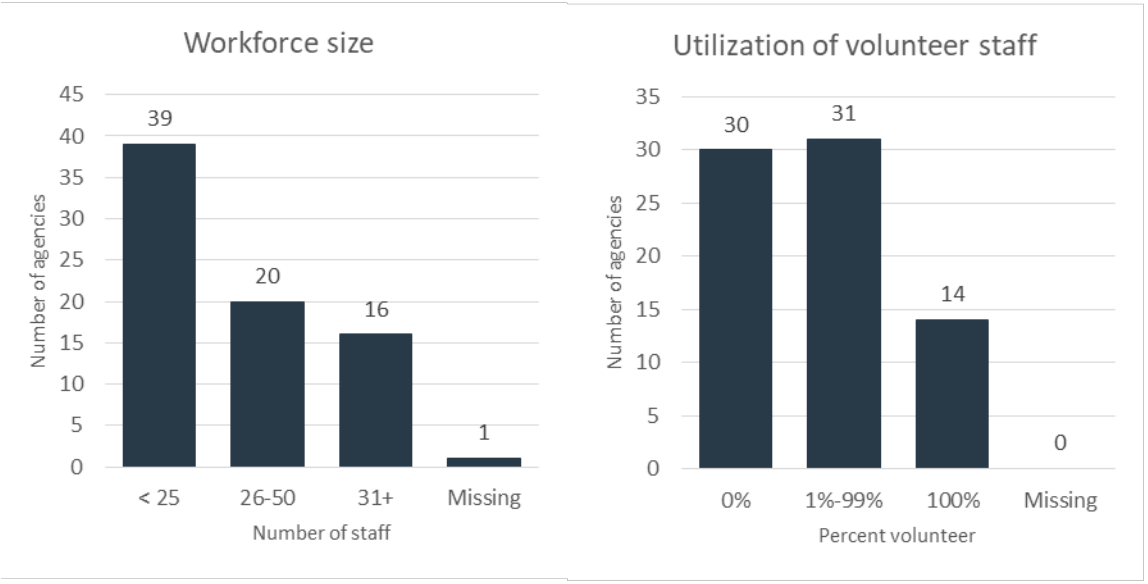
In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than 10.

East Region

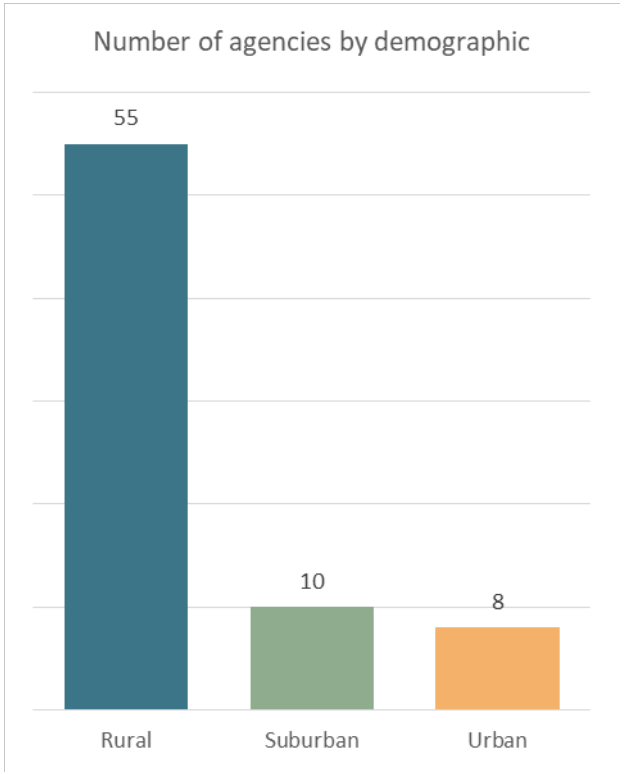


East region is composed of nine counties, and largely represented by rural agencies in this survey. The highest areas of performance reported by East region agencies were for the attributes related to MPD involvement, having agency attire for personnel, and having a written policy and procedure manual; East region agencies performed at a similar level as all agencies statewide for these attributes. Areas for improvement for East region are developing a wellness program for agency staff, PIER, and more agency involvement in the community. For each of the attributes listed above, the rural agencies in East region reported lower levels of performance than the suburban and urban East agencies.

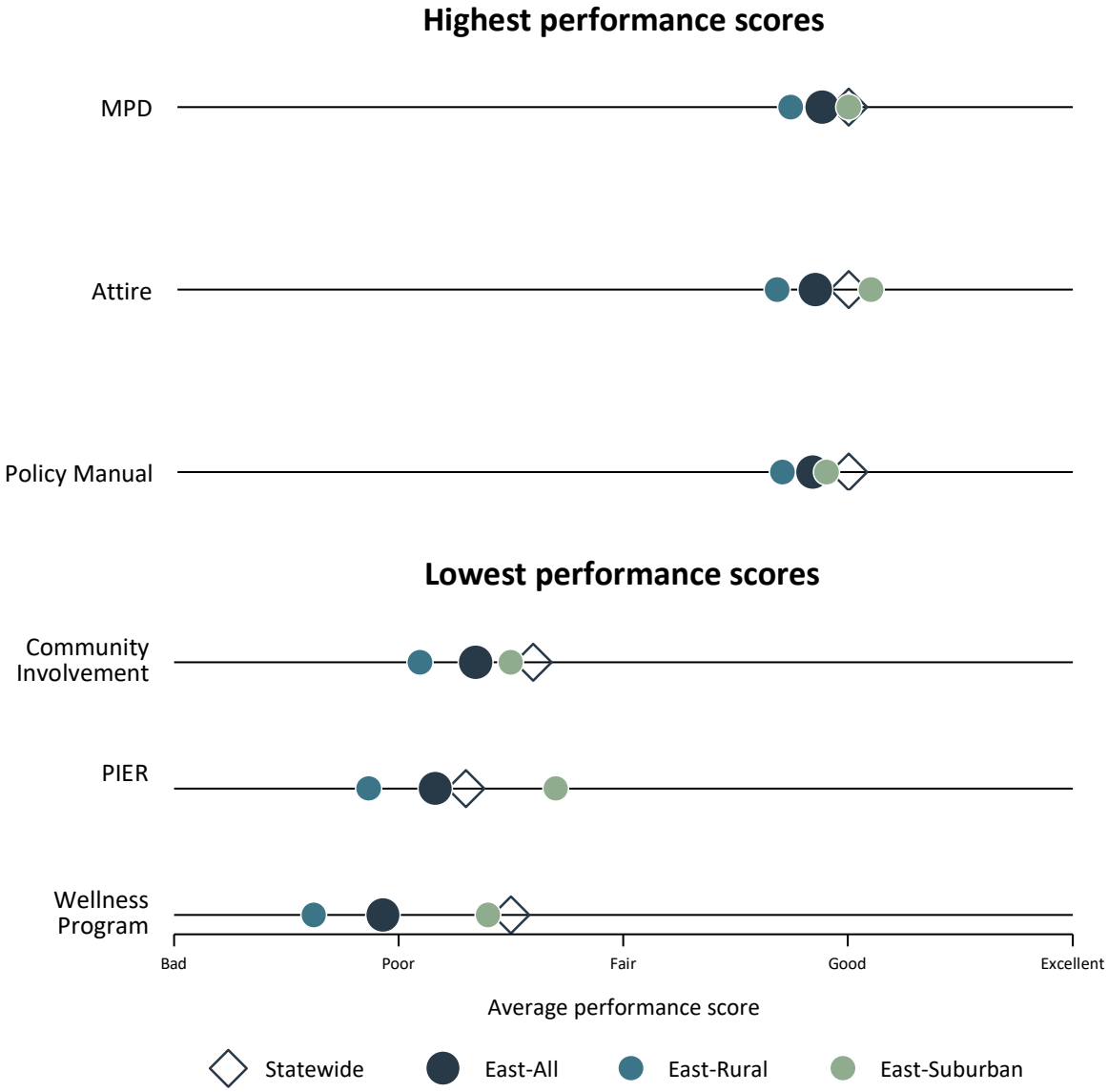




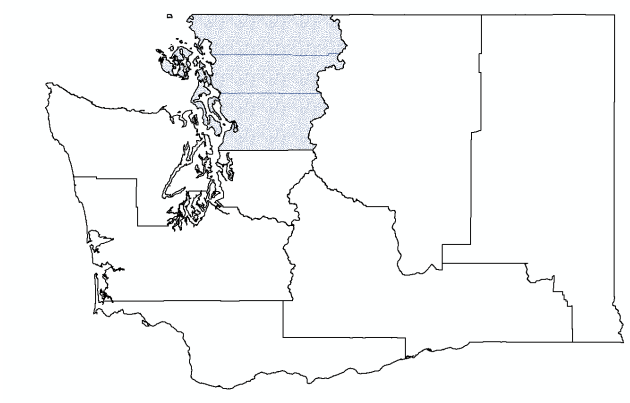
East Region, continued

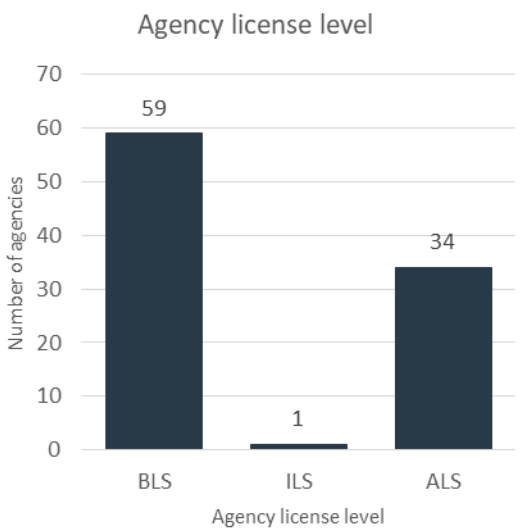


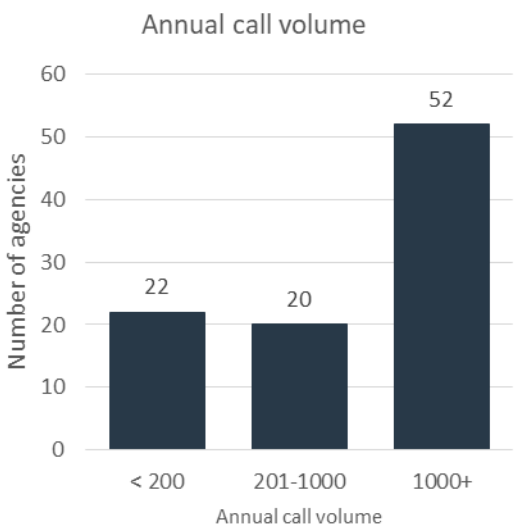
In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than 10.



North Region

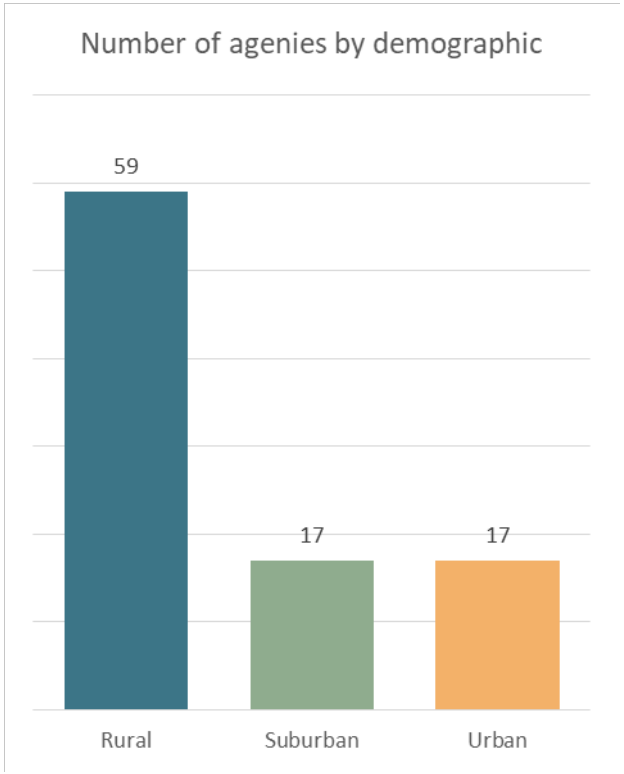




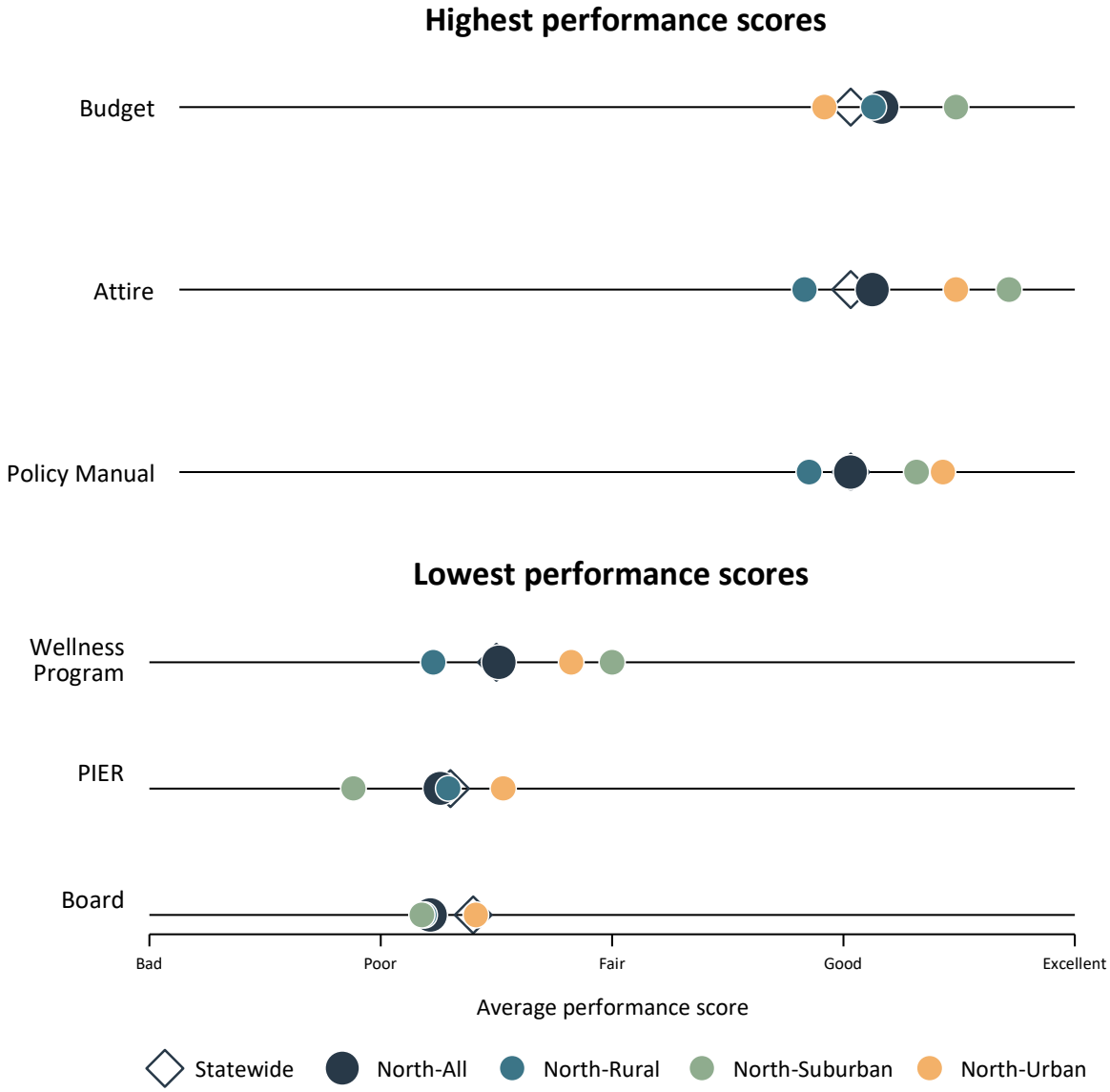


The agencies representing North region in this survey were mostly rural agencies, and were generally BLS or ALS agencies. North region agencies reported highest level of performance in regard to having a sustainable budget, standard agency attire for personnel, and having a written policy and procedure manual. The lowest level of performance were reported for the attributes with regards to having a community-based and representative board, PIER, and having a wellness program for agency staff. For each of the attributes listed above, there level of performance varied by agency demographic, as seen in the chart on the following page.

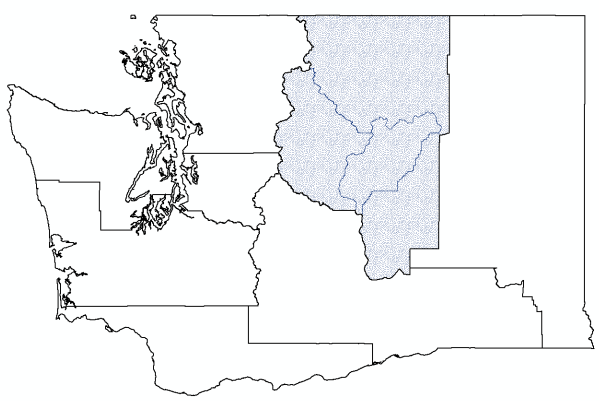
North Region, continued



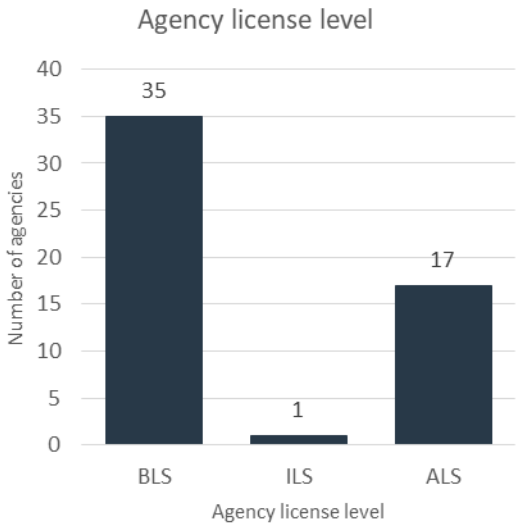
In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than 10.

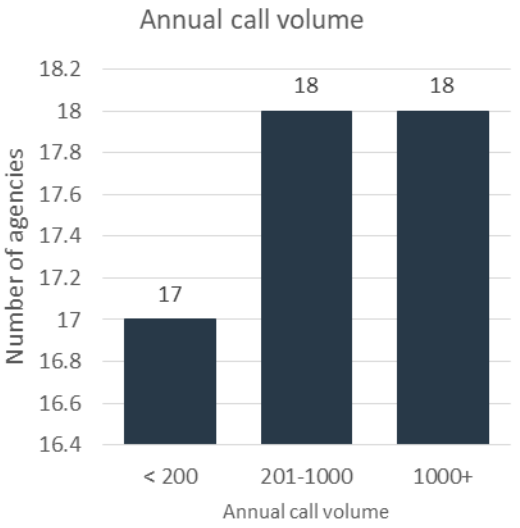


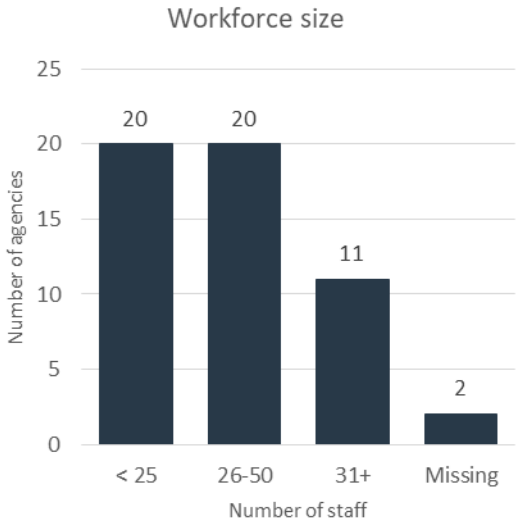
North Central Region



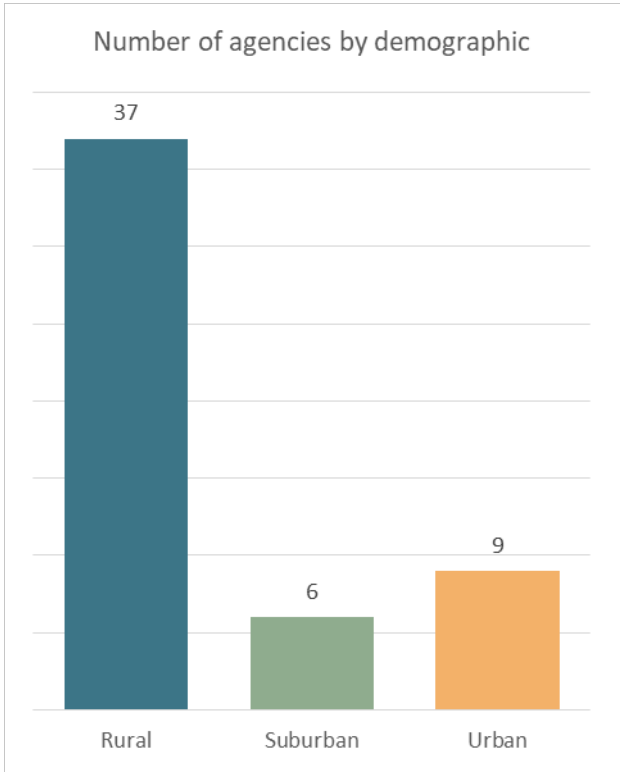
North Central is composed of four counties, and represented mostly by rural agencies. North Central agencies reported highest level of performance for MPD involvement, having a written policy and procedure manual, and offering continuing education, while lowest level of performance was observed for the attributes related to PIER, having a community-based board, and having a wellness program for agency staff members. For all of these attributes, North Central agencies performed at a level similar to what was observed at the state level.



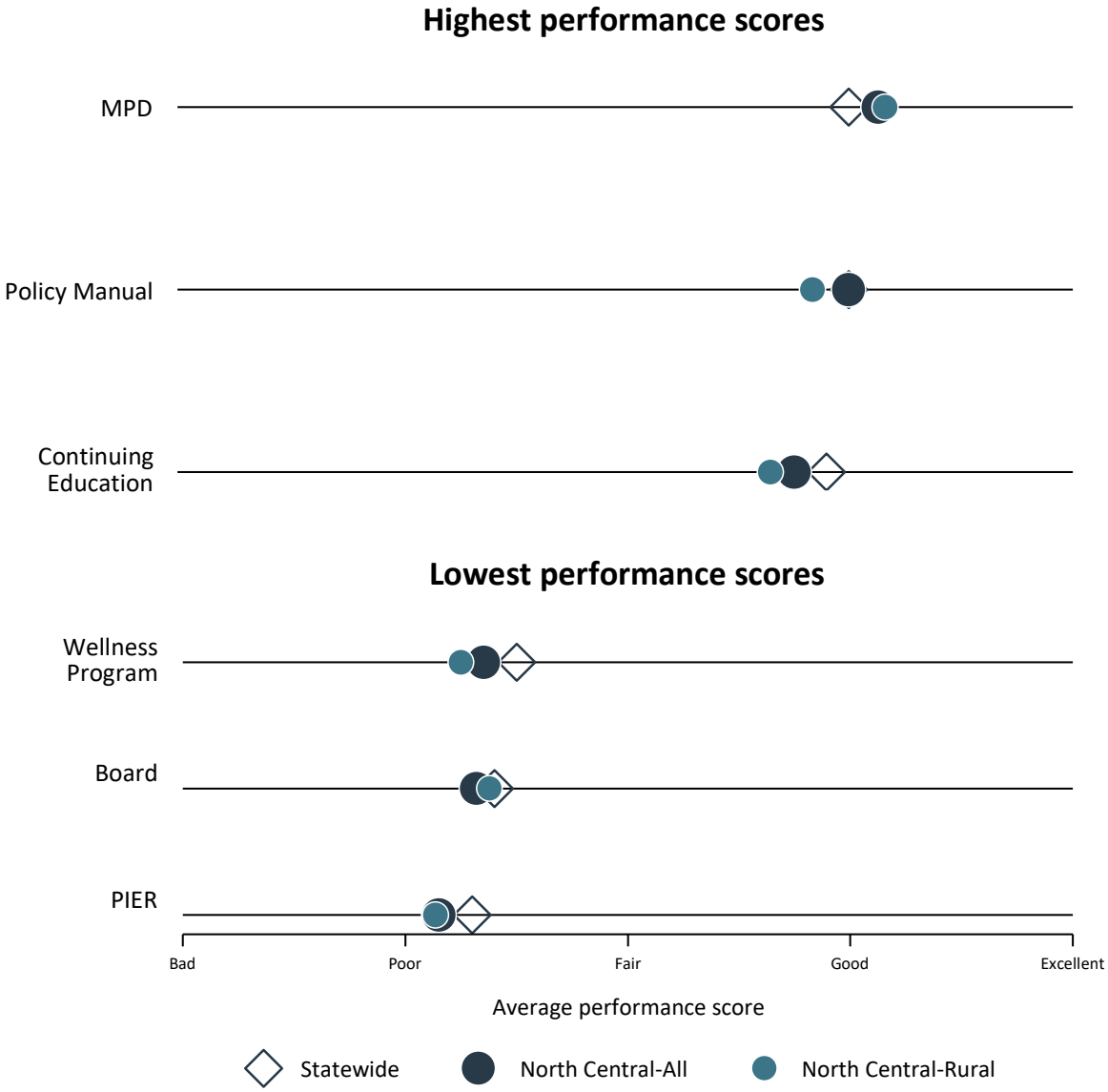




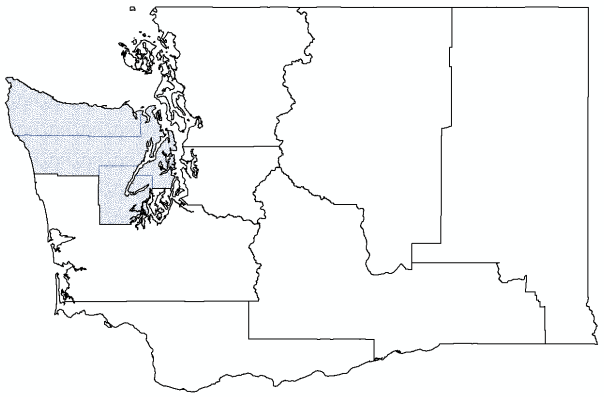
North Central Region, continued



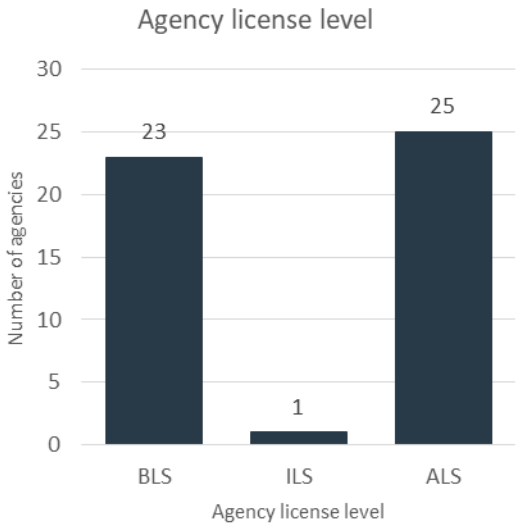
In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than 10.

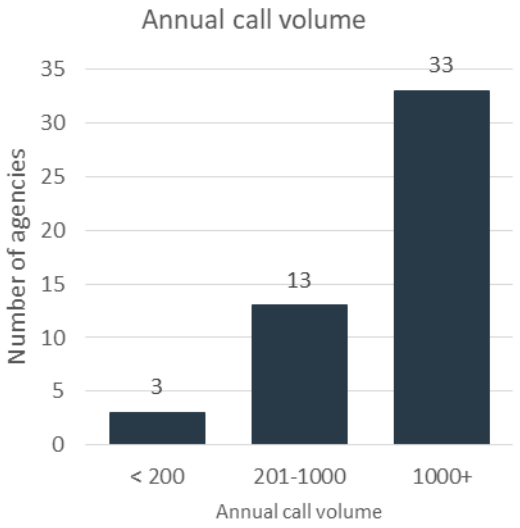


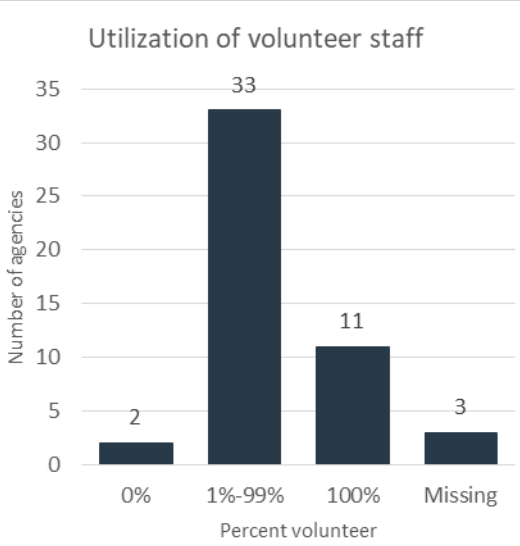
Northwest Region



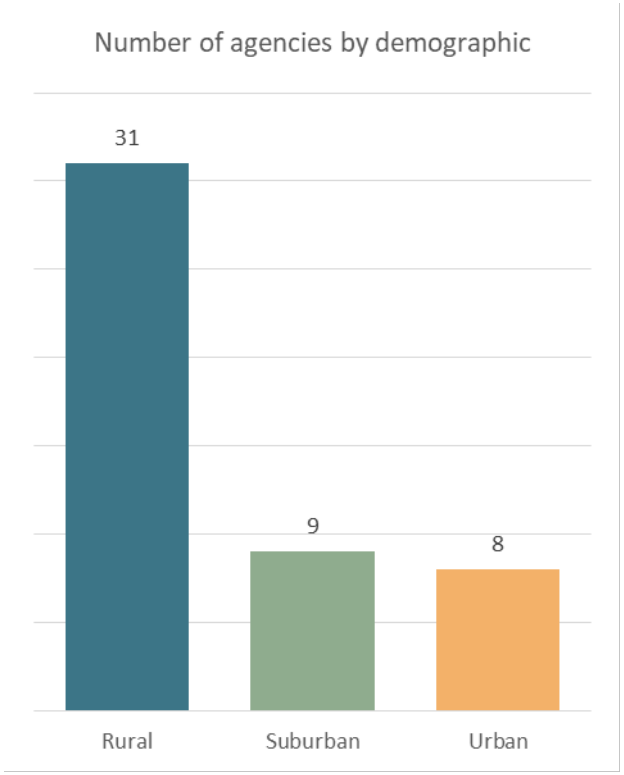
Northwest region is represented by mostly ALS and BLS rural agencies. Northwest region reported the highest level of performance for having a professional billing process, MPD involvement, and having standard attire for agency personnel; agencies in this region also performed at a higher level in each of these areas than what was observed at the state level. The priority areas of improvement for Northwest region are PIER, having a community-based and representative board, and a wellness program for agency personnel.



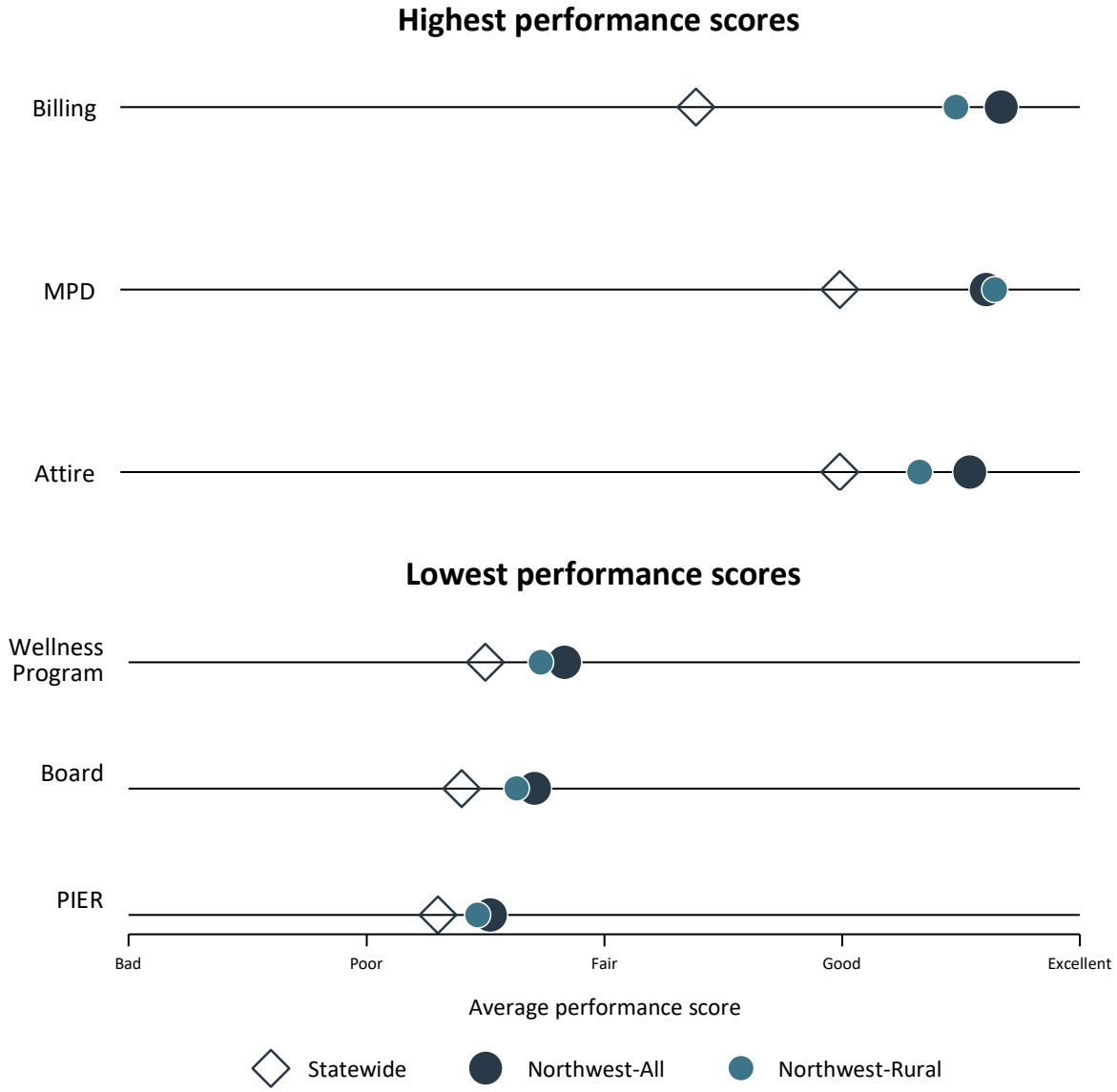




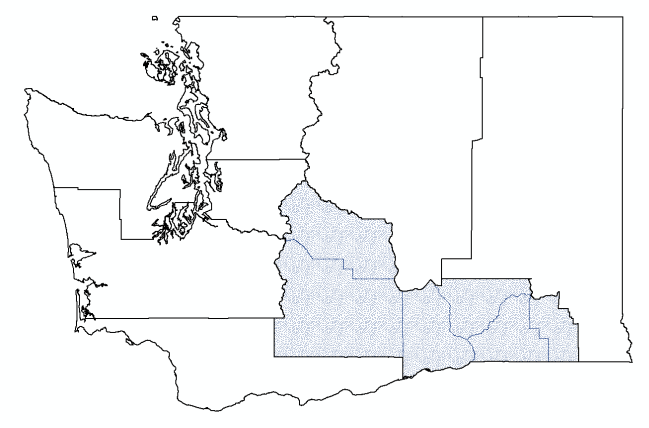
Northwest Region, continued



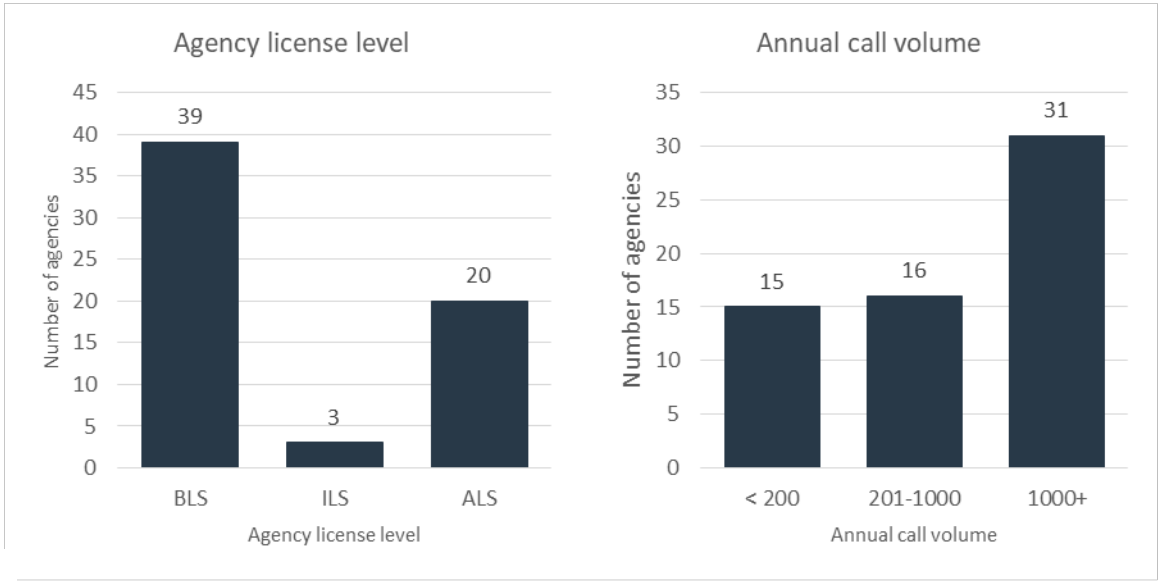
In accordance with the Department of Health Standards for Reporting Data with Small Numbers, average performance scores are suppressed if the number of agencies represented in the score are fewer than 10.

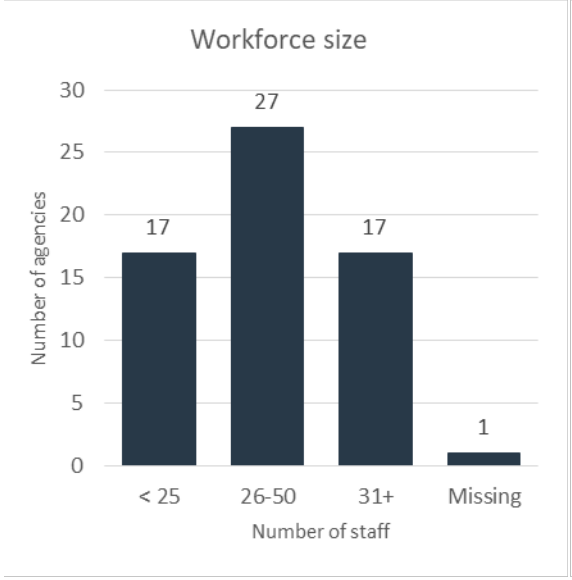


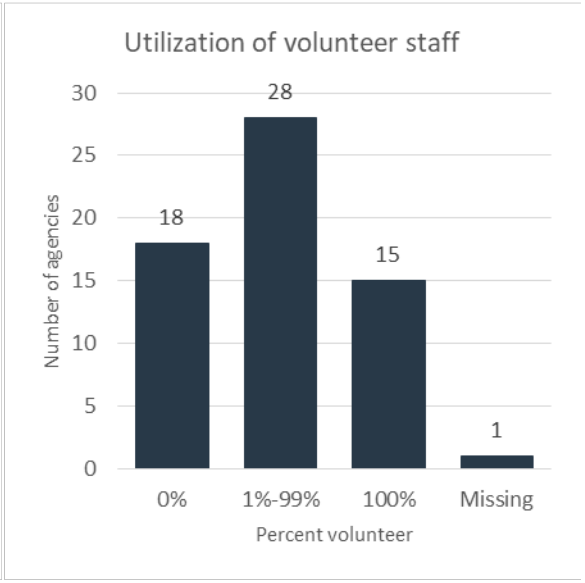
South Central Region



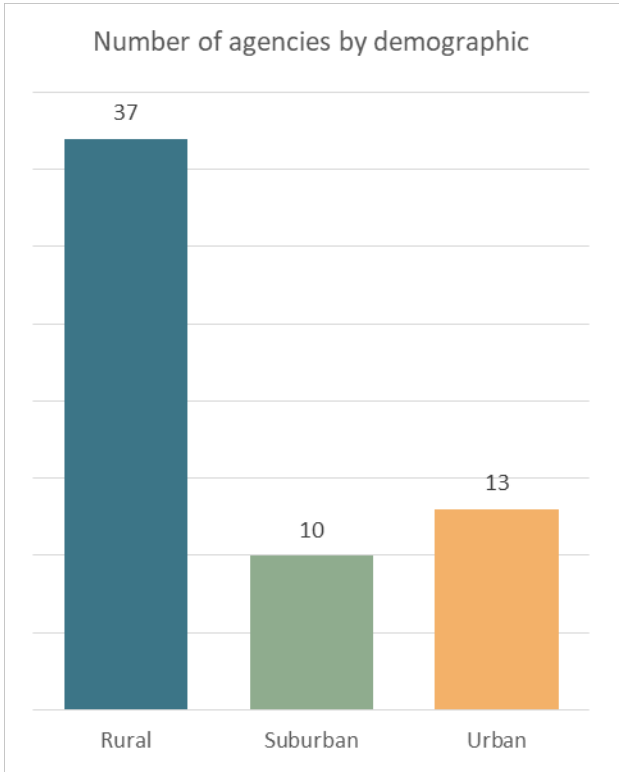
South Central region is made up of six counties and represented mostly by rural agencies in this survey. Overall, the three areas of highest performance in this region are MPD involvement, having a written policy and procedure manual, and having a sustainable budget. The three lowest performance areas are with regard to PIER, agency involvement in the community, and having a wellness program for agency staff members. In all but MPD involvement, the urban agencies in South Central reported higher levels of performance than their rural and suburban counterparts, as seen on the chart on the following page.







South Central Region, continued



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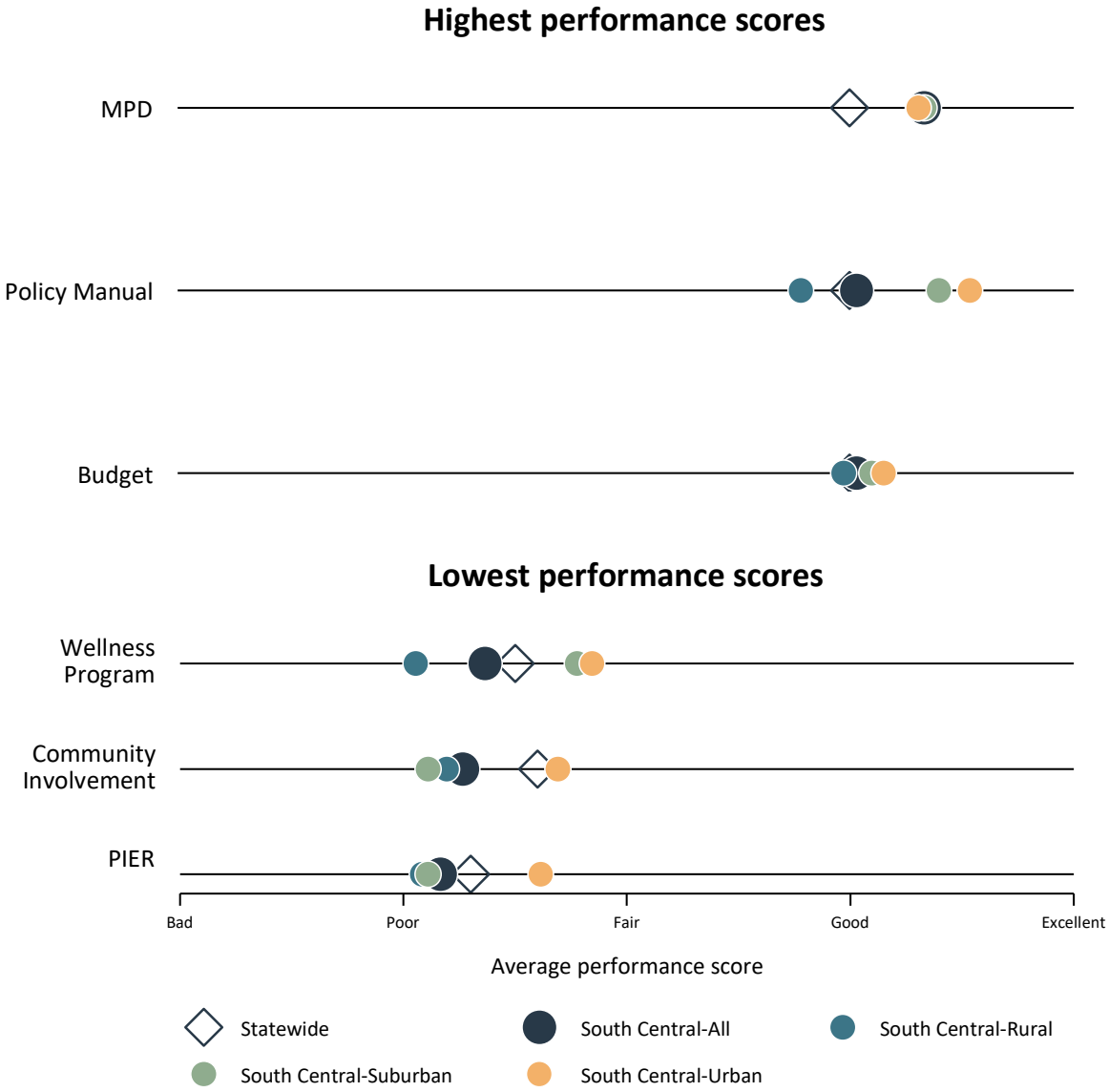
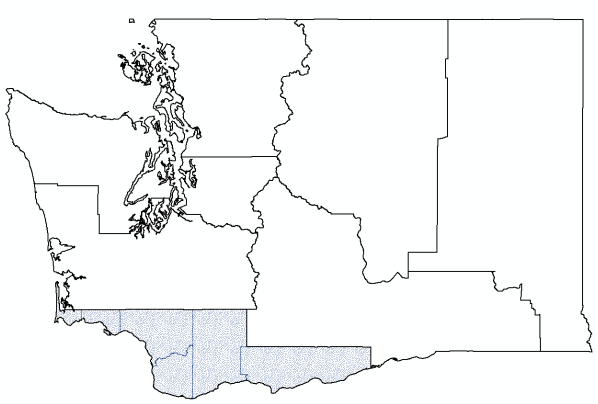
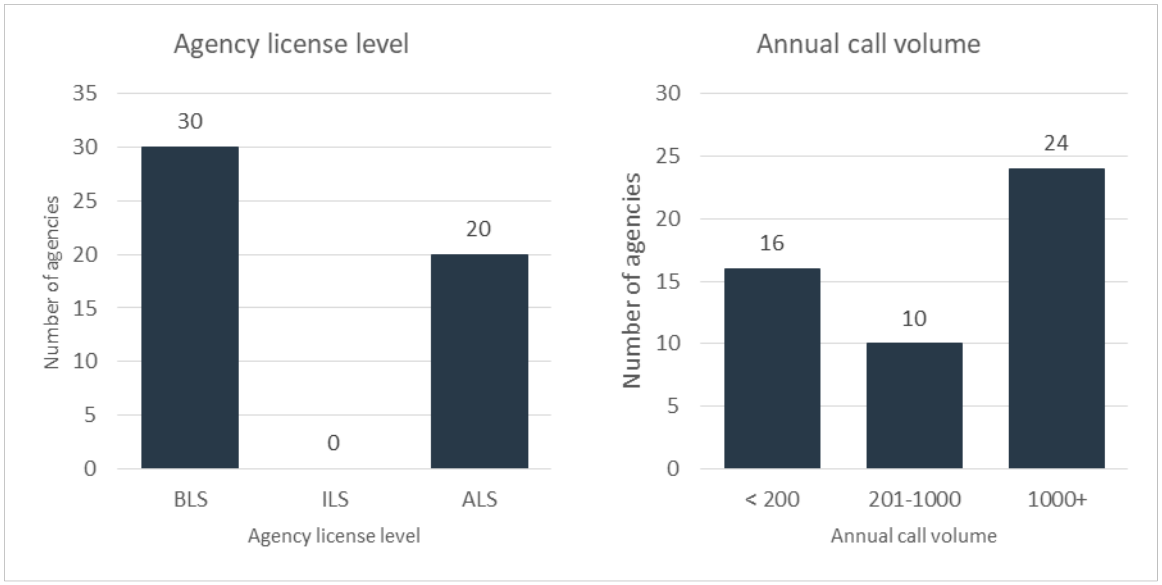


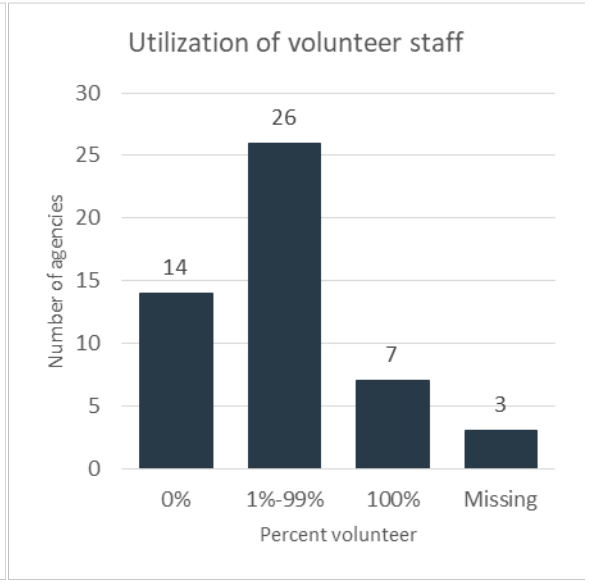
Southwest Region



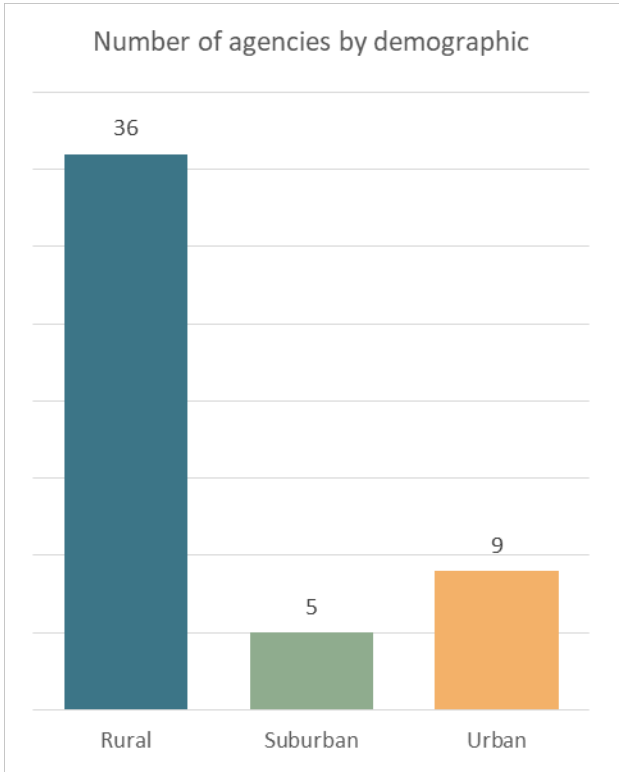
Southwest region is represented by mostly rural agencies. MPD involvement, having a sustainable budget, and opportunities for continuing education were reported to be the highest levels of performance in the region. The largest need for improvement are in the attributes related to PIER, wellness program for staff members, and having a community-based and representative board.

*Note that the agencies in the southern part of Pacific County are part of Southwest region, while agencies in the northern part are considered to be part of West Region.





Southwest Region, continued



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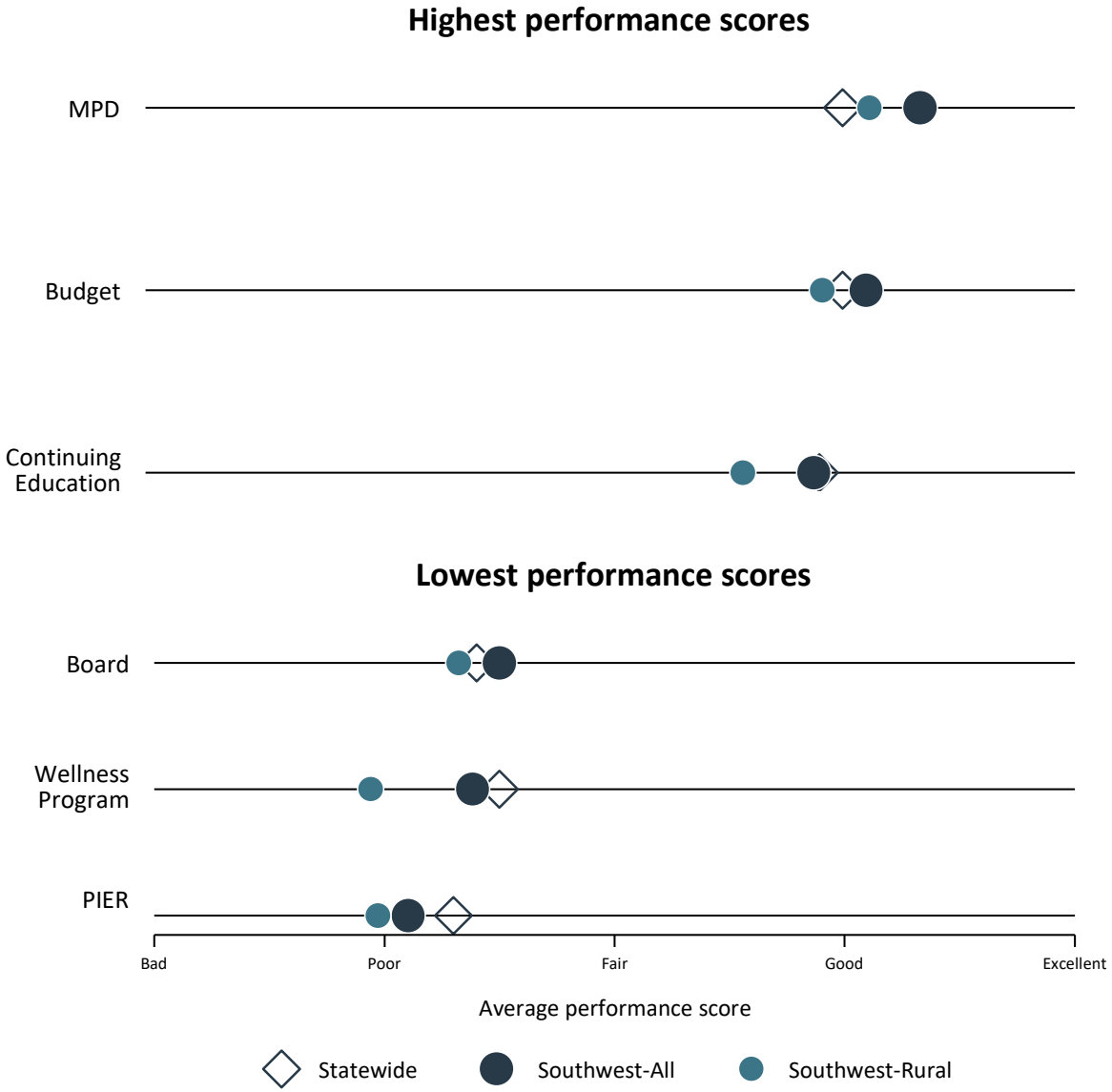
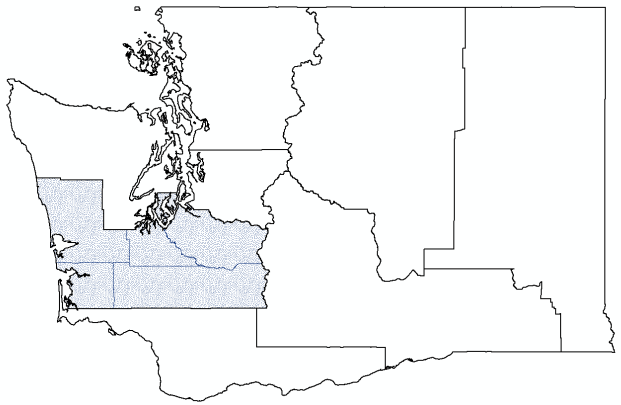
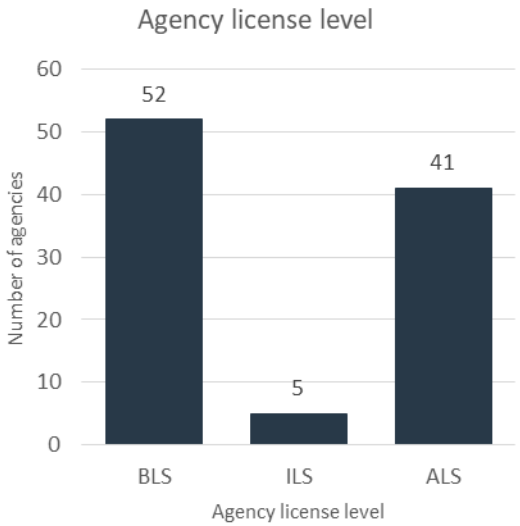
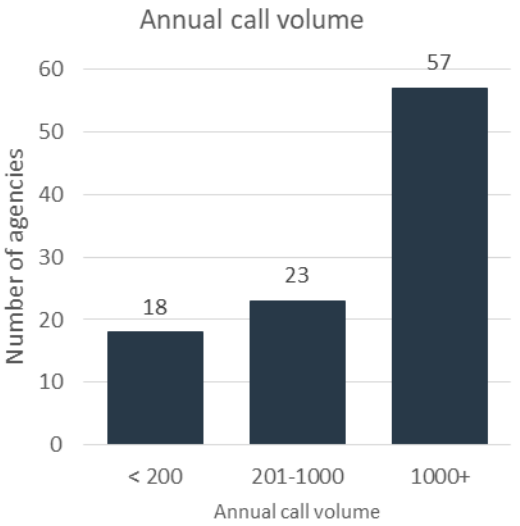


West Region

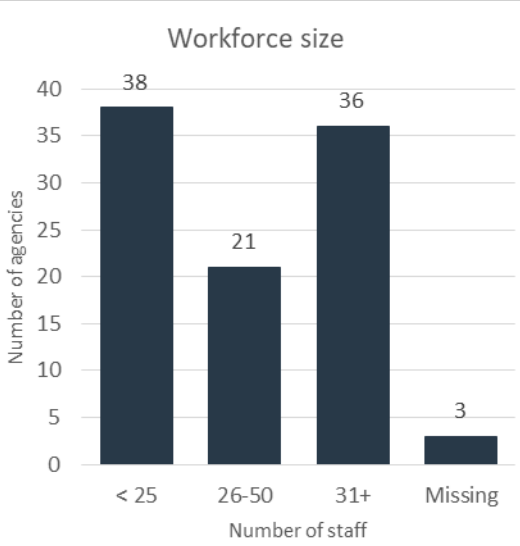


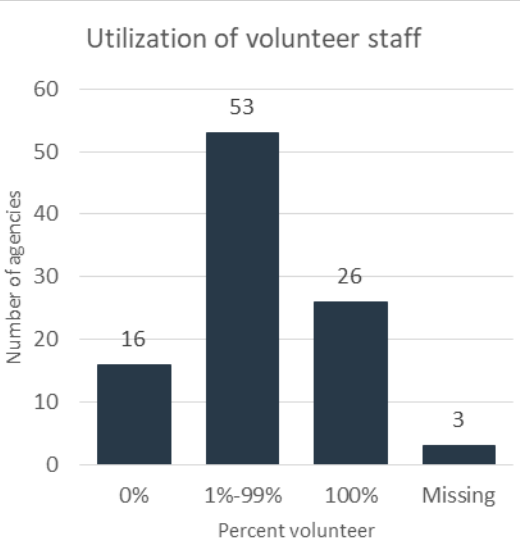




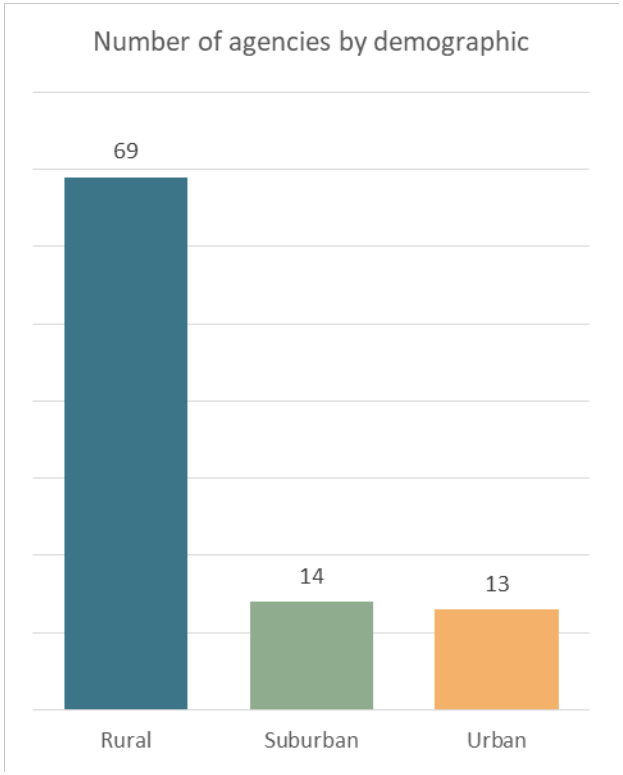
West region is largely represented by rural agencies in this survey. Overall, highest performance was reported for the attributes related to standard agency attire, having a written policy and procedure manual, and having a sustainable budget. It should be noted, however, that for the attribute with the overall top performance for the region – having standard agency attire – the suburban and urban agencies in the region performed at higher level than that of the rural agencies. The priority areas of improvement for West region are PIER, having a community-based board, and agency involvement in the community.

*Note that the agencies in the southern part of Pacific County are part of Southwest region, while agencies in the northern part are considered to be part of West Region.





West Region, continued



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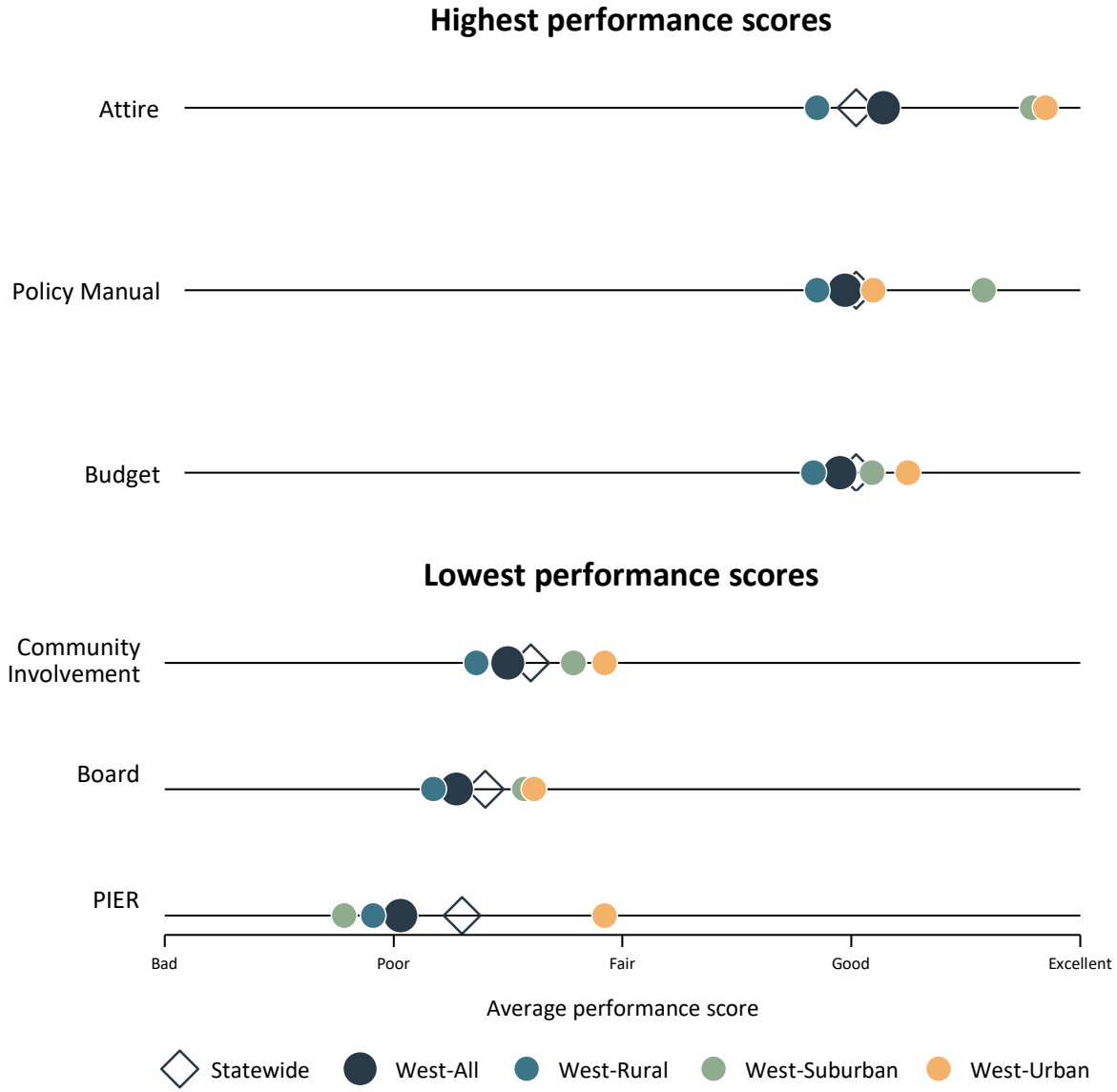

Appendix D- Survey Instrument

WASHINGTON STATE AMBULANCE 2019 RURAL EMS SERVICE SURVEY

Thank you for taking the time to complete 2019 Rural EMS Service Survey. The information collected will be used to:

- Help inform where best to allocate any available funding
- Educate policy-makers on challenges facing rural, suburban, and urban communities,
- Inform strategic planning efforts at state, regional and local levels, and
- Provide agencies with a roadmap for improvement.

If you have questions about this survey or how we'll use the information, please contact Christy Cammarata at christy.cammarata@doh.wa.gov or 360-236-2808

A national group of EMS providers and advocates have identified 18 attributes of a successful EMS agency. For the purpose of this survey, each of those attributes has been described in five ways. Please read each description and then select the one that most closely matches your agency.

ACKNOLWEDGEMENTS

The Washington State Office of Rural Health (SORH) in collaboration with the Department of Health's Office of Community Health System's would like to thank the Wisconsin Office of Rural Health for the opportunity to use the 18 Attributes of a Successful Ambulance Service Survey. Additionally, the Department would like to thank all of the licensed EMS agencies who complete a survey and contribute to the survey.

AGENCY INFORMATION

1. Agency Name:

Click here to enter text.

EMS Legacy Number:

Click here to enter text.

Person Completing the Survey:

Click here to enter text.

Position:

Click here to enter text.

Phone Number:

Click here to enter text.

Email Address:

Click here to enter text.

Agency Annual Call Volume:

Click here to enter text.

Number of Paid Personnel:

Click here to enter text.

Number of Volunteer Personnel:

Click here to enter text.

2. A Written Call Schedule

- ☐ 1. Non-existent. Pager goes off and anyone available responds.
- ☐ 2. Informal, ad-hoc agreement exists among the crew.
- ☐ 3. Written and distributed schedule exists, but for less than one week at a time.
- ☐ 4. Written and distributed schedule is for one week or more, but empty spaces are not filled, waiting for personnel to show up.
- ☐ 5. Written and distributed schedule is for two weeks or more. Empty spaces are filled prior to shift beginning.

3. Continuing Education

- ☐ 1. No continuing education is offered.
- ☐ 2. Continuing education that meets minimum requirements needed to maintain licensure is offered (internally or externally).
- ☐ 3. Continuing education above minimum requirements needed to maintain licensure is offered.
- ☐ 4. Continuing education based on quality improvement and/or quality assurance findings is offered.
- ☐ 5. Continuing education based on quality improvement and/or quality assurance findings, with medical director and/or hospital input, and taught by a certified educator is offered.

4. A Written Policy and Procedure Manual

- ☐ 1. There are no documented EMS policies and procedures.
- ☐ 2. There are a few documented EMS policies and procedures, but they are not organized into a formal manual.
- ☐ 3. All EMS policies and procedures are documented in a formal manual but crew members don't refer to/use/update it systematically.
- ☐ 4. All EMS policies and procedures are documented in a formal manual, and crew members refer to and use it systematically. It is updated, but not on a schedule.
- ☐ 5. All EMS policies and procedures are documented in a formal manual, and crew members refer to/use/update it systematically. It is written to the level of detail necessary that anyone from the crew could step in and do the job correctly.

5. Incident Response and Mental Wellness

- ☐ 1. There is no incident response and mental wellness debriefing.
- ☐ 2. There is informal and positive debriefing and support from more experienced crew members.
- ☐ 3. There is informal and positive debriefing and support from more experienced crew members. Dispatch occasionally notifies the EMS agency on a predetermined set of calls (pediatric, suicides, fatalities, trauma, etc.), which are addressed informally by agency leadership.
- ☐ 4. Agency leadership has training in incident response, is consistently notified by dispatch at the time of possible incident, and has a policy of debriefing impacted crew member(s).
- ☐ 5. All of No. 4, plus professional counseling sessions are offered at reduced or no charge to crew members impacted. Follow-up with impacted crew members is standard procedure.

6. A Sustainable Budget

- ☐ 1. There is no written budget.
- ☐ 2. A budget has been developed; however, it is not followed.
- ☐ 3. A budget is in place and financial decisions and actions are based upon it.
- ☐ 4. A budget and policies are in place regarding proper purchasing procedures, purchase limits and authorizations, and procedures for procuring equipment either not in the budget or over the stated budget. An operating reserve of at least three months is in the bank.
- ☐ 5. A budget and polices are in place regarding proper purchasing procedures, purchase limits and authorizations, and procedures for procuring equipment either not in the budget or over the stated budget. An operating reserve of at least six months is in the bank and the reserve has been in place for at least one year.

7. A Professional Billing Process

- ☐ 1. Services are not billed.
- ☐ 2. Services are billed, but claims are submitted by an individual (internal or external) with no formal training in healthcare billing.
- ☐ 3. Services are billed, but claims are submitted by an individual (internal or external) with limited training in healthcare billing.
- ☐ 4. Services are billed and claims are submitted by someone with skills and training in healthcare billing, but without established HIPAA-compliant billing policies or policies to handle claims that have been denied or with a balance due.
- ☐ 5. Services are billed and claims are submitted by a certified biller (internal or external) or billing service, in a timely manner (fewer than 30 days), with established HIPAA-compliant billing policies and policies to handle claims that have been denied or with a balance due.

8. County Medical Program Director Involvement
9. Please select County Medical Program Director: Choose an item.

☐ 1. There is a medical director in name only. He or she is not actively engaged with the EMS agency beyond signatures.

☐ 2. The medical director reviews cases but not within 30 days and provides very little feedback.

☐ 3. The medical director reviews cases within 30 days and provides very little feedback.

☐ 4. The medical director reviews cases within 30 days and provides a good amount of feedback, but waits for the EMS agency to engage him or her. When asked, he or she responds to hospital ED/ER contacts on behalf of the EMS agency regarding the agency's clinical protocols and actions.

☐ 5. The medical director is an integral part of EMS, proactively engaging the agency to review cases, providing a good amount of feedback; delivering education to the agency; and advocating for the agency to hospital ED/ER contacts.

10. A Quality Improvement/Assurance Process

☐ 1. There is no plan to collect, analyze, or report EMS agency performance measures.

☐ 2. Performance measure data is collected about the EMS agency but not analyzed or reported.

☐ 3. Performance measures are analyzed and reported but no feedback loop exists for continual improvement of the EMS agency.

☐ 4. Performance measures are reported and a feedback loop exists for general improvements.

☐ 5. Feedback from performance measures is used to drive internal change to:
(1) improve the patient experience of care (including quality and satisfaction),
(2) improve the health of the community (e.g., success of screenings, education);
(3) reduce the cost of health care services (e.g., reducing EMS costs, and/or using EMS to reduce overall healthcare costs).

11. Contemporary Equipment and Technology for Patient Care Reporting Activities
*In accordance with WAC 246-976

☐ 1. The EMS agency has only the minimum equipment/technology. The budget does not allow additional equipment/technology acquisition.

☐ 2. The EMS agency has the minimum equipment/technology, plus a minimal budget for additional equipment/technology acquisition.

☐ 3. In addition to the minimum equipment/technology, the EMS agency has some advanced equipment/technology. There is a minimal budget for new equipment/technology acquisition and a formal replacement plan.

☐ 4. In addition to the minimum equipment/technology, the EMS agency has some advanced equipment/technology. There is an adequate budget for new equipment/technology acquisition and a formal replacement plan.

☐ 5. In addition to the minimum equipment/technology, the EMS agency has some advanced equipment/technology. There is an adequate budget for new equipment/technology acquisition and a formal replacement plan. There is a formal maintenance plan provided by trained/certified technicians or engineers.

12. The Agency Reports Data
*In accordance with WAC 246-976-430

☐ 1. No operational/clinical data are submitted to WEMSIS/NEMSIS.

☐ 2. Operational/clinical data are submitted to WEMSIS/NEMSIS, but not often within the designated timelines (locally, statewide, or nationally).

☐ 3. Operational/clinical data are submitted to WEMSIS/NEMSIS within the designated timelines.

☐ 4. Operational/clinical data are submitted to WEMSIS/NEMSIS within the designated timelines. Areas for improvement are identified using an established quality improvement/quality assurance process by the EMS agency.

☐ 5. Operational/clinical data are submitted to WEMSIS/NEMSIS within the designated timelines. Areas for improvement are identified using an established quality improvement/quality assurance process, and goals and benchmarks are used to improve performance. Summary reports are regularly shared publicly with the community.

PUBLIC RELATIONS ATTRIBUTES

13. A Community-Based and Representative Board

- ☐ 1. There is no formal board oversight.
- ☐ 2. The board consists of internal EMS agency members only.
- ☐ 3. Voting board members are from the EMS agency and some combination of elected officials, hospital leadership/staff, and/or governmental administrators.
- ☐ 4. Voting board members are some combination of elected officials, hospital leadership/staff, and/or governmental administrators only.
- ☐ 5. Voting board members include all of No. 4 and at least one engaged patient representative.

14. Agency Attire

- ☐ 1. There is no identifying EMS agency attire.
- ☐ 2. There is identifying EMS agency attire, but it is not adequately protective.
- ☐ 3. There is identifying EMS agency attire, which is adequately protective, but elements of it are purchased by the members.
- ☐ 4. There is identifying EMS agency attire, which is adequately protective, and all of it is purchased by the agency.
- ☐ 5. There is identifying EMS agency attire, which is adequately protective and purchased by the agency. A written policy identifies what attire is required and how it is to be provided, cleaned, maintained, and replaced.

15. Public Information, Education, and Relations (PIER)

- ☐ 1. There is no plan for addressing PIER.
- ☐ 2. The EMS agency is in the process of developing a PIER plan.
- ☐ 3. There is a PIER plan, but no funding dedicated to its implementation.
- ☐ 4. There is a PIER plan that has funding dedicated to its implementation.
- ☐ 5. There is a PIER plan that has funding dedicated to its implementation, someone identified as responsible for PIER, and a recurring evaluation of its success.

16. Involvement in the Community

- ☐ 1. No public education courses are offered.
- ☐ 2. Occasional basic public education courses, such as CPR/AED and first aid training, are offered.
- ☐ 3. Frequent basic public education courses, such as CPR/AED and first aid training, plus other EMS-related training are offered.
- ☐ 4. A robust array of public education courses and other training are offered and the EMS agency is active in community promotions at various events.
- ☐ 5. The EMS agency offers a robust array of public education courses and other training, organizes or assists in planning health fairs, is a champion for a healthy community, is an active partner with other public safety organizations, and is seen as a leader for community health and well-being.

17. A Recruitment and Retention Plan

- ☐ 1. There is no agreed-upon plan nor substantive discussion on recruitment and retention.
- ☐ 2. There is no agreed-upon plan but there have been substantive discussions on recruitment and retention.
- ☐ 3. There is an informal, agreed-upon plan, and people have been tasked with addressing the issues of recruiting new crew members and retaining existing crew members.
- ☐ 4. There is a formal written plan, and people have been tasked with recruiting new crew members and strategizing methods to keep current crew members active (such as compensation, recognition and reward program, management of on-call time, adequate training).
- ☐ 5. There is a formal written plan, and people have been tasked with recruiting new members and retaining existing crew members. There is a full roster with a waiting list for membership.

18. Formal Personnel Standards

- ☐ 1. There is no official staffing plan or formal process for hiring new personnel (paid and/or volunteer).
- ☐ 2. There is a staffing plan and documented minimum standards for new hires.
- ☐ 3. There is a staffing plan, documented minimum standards for new hires, and an official new-hire orientation.
- ☐ 4. There is a staffing plan, documented minimum standards for new hires (including background checks), an official new-hire orientation, and systematic performance reviews/work evaluations.
- ☐ 5. All of No. 4, plus there is a process to resolve personnel issues.

19. An Identified EMS Operations Leader with a Succession Plan

☐ 1. There is an identified EMS operations leader (e.g., chief, director, director of operations, EMS deputy chief or captain within a fire agency), but he or she has not had any leadership training.

☐ 2. There is an identified EMS operations leader with some leadership training, but he or she was not selected by a recruitment process.

☐ 3. There is an identified EMS operations leader with some leadership training and who was selected by a recruitment process, but there are obstacles to full functioning (such as lack of funding or no succession plan).

☐ 4. There is an identified EMS operations leader with comprehensive leadership training and who was selected by a recruitment process, but there are obstacles to full functioning (such as lack of funding, no succession plan).

☐ 5. There is an identified EMS operations leader with comprehensive leadership training, who was selected by a recruitment process, and who is fully capable and prepared to effectively lead the service. There is also a succession plan in place to appropriately handle the transition of the leadership role.

20. A Wellness Program for Agency Staff

☐ 1. There is no wellness program for crew members.

☐ 2. Written information is available for crew members regarding physical activity, healthy food options, and tobacco cessation.

☐ 3. All of No. 2 and occasional educational programming regarding healthy lifestyles is offered, and there is policy support for healthy food options at meetings.

☐ 4. All of No. 3 and there is policy support for healthy lifestyle opportunities during work time.

☐ 5. There is a structured wellness program following national recommendations. Crew members are actively encouraged with agency-funded fitness opportunities, healthy food choices, and disease- prevention programs such as tobacco cessation.


Washington State Department of
Health