Ventura County EMS System Assessment

Responses to Stakeholder Comments

November 12, 2019

Comments: **Would there be fines associated with the use of red lights and sirens by the fire department?**
Would fire departments be held to the hours worked requirements per shift? Example 48/72/96 hours in a row?
Would fire departments be fined for performance standards of patient care?

Response: Thank you for submitting these questions regarding the report and the recommendations contained therein. The recommendations in this report are made based on analysis of the local EMS system, but also based on best practices and evidence-based studies conducted in EMS systems of various sizes and complexity around the country. If there is evidence to suggest that changing response patterns or the number of hours worked per shift may help to improve system performance and/or the health of the workforce within a system, we feel we would be remiss in not including that information in the form of a recommendation.

The Ventura County EMS Agency, in collaboration with its operational partners, are going to make the final determination on which of these recommendations are adopted. While the recommendations made were written with all agencies and responders in mind, there is nothing that says their application cannot be limited to certain providers.

Comments: **The Assessment Report is concise and clear in its recommendations. It reflects the excellent work EMS and the system stakeholders have done. My expertise is from the first responder perspective. I would lean on the feedback of the members representing the hospitals, fire and ambulance service for impacts that would impact their services. Thanks for a chance to review this report since I will be out of the country on the 27th.**

Response: Thank you for the comments regarding the report being clear and concise. We agree that the EMS agency and stakeholders have done excellent work. We received a significant amount of input from stakeholders and a great deal of it is reflected in the report. Although we did not specifically reference each issue or recommendation back to a specific stakeholder, so as to protect individual stakeholder anonymity, many of the issues raised in the report came directly from stakeholder input.

Comments: **I held off on giving any comments or concerns until I had a chance to read the report. Thank you for including me, here are a couple of questions or concerns:**

1. **What is the benefit of eliminating the sub zones?**
2. **I have a few questions about the compliance numbers, how they are factored and how they are monitored. In the discussion tomorrow can we get a better explanation of what is used to monitor the 90% compliance and how the late fees are applied.**
3. **How do IFTs effect the resources available within the system for 911 calls and how does a "free market" as described in the report effect this availability.**
4. **Please explain the limiting of EMS providers to 24 hours.**
5. **A last concern and not a question. Unless someone can explain the benefits of a performance base system, eliminating a response metric is concerning.**

Thank you, I will continue to review the report and ask clarifying questions tomorrow.

Response: Thank you for these helpful comments.

1. We are not recommending eliminating the sub-zones in EOA 4 for response time data collection. We are recommending the discontinuation in each subzone of the application of a response time compliance rate of 92.5% and higher to reduce by at least 20% the monthly penalty in the sub-zone that is based upon individual response time violations. We believe this incentive should apply only if response time compliance for EOA 4 in its entirety meets or exceeds 92.5% rate as is the case for each of the other EOAs. This is the same standard by which the other EOA contractors earn incentives and we recommend that it also be applied in EOA 4.

2. The response times are captured by the Ventura County Regional Dispatch computer aided dispatch software and mobile data computers. All response times are submitted electronically to the FirstWatch Online Compliance Utility software, where responses outside of contracted standards are flagged. The flagged responses are evaluated by the contracted providers monthly and requests for exemptions, if applicable, are submitted to VCEMS via the FirstWatch tool for validation, verification and approval. Once the monthly evaluation process is completed, the FirstWatch system calculates the compliance rates by ambulance response area and fines are determined for each non-compliant response based on the penalty amounts established in the contracts. Penalties for non-compliance range from $20 - $250 per call. The contracts also offer Incentives for performance higher than 92.5% in the

form of penalty reductions. Late response penalty statements are generated by FirstWatch and emailed directly to the ambulance providers monthly. Fire Department ALS response time compliance is also monitored and evaluated through the FirstWatch system, however, no financial penalties are assessed for the ALS first responder agreements.

3. In our report, we found that IFTs did not have a measurably negative impact on 911 response in the county, and, in fact, constitute a vital source of revenue for IFT providers which benefits and subsidizes 911 availability. Because the BLS IFT market is open and competitive, availability is primarily driven by the availability of revenue and profit for services rendered. We found no evidence that the IFT market was not being effectively served by current providers.

4. Our recommendation is based on published research and national consensus guidelines – all of which is cited in our report – that EMS provider fatigue can affect patient and provider safety with shift lengths of 24 hours or more.

5. As it is traditionally known, a "performance based system" is one in which the primary measurement of "quality" is response times. However, much published research has convincingly established that, for the vast majority of conditions, response times do not impact patient outcomes. As a result, our recommendations focus on adding additional metrics that incentivize high-quality clinical care and correct medical treatment decision making. We do not advocate the elimination of response time measurement.

Comments:

Albeit data is exceptionally important when looking at trends and outcomes, we must not lose sight of or forget that we are talking about human beings. Much like the issue of 12 lead STEMI false positives. Statements have been made such as it was inconveniencing the doctors, the cardiologists were getting mad, etc - although I value the doctor's time, shouldn't we be much more concerned about the people that have false negatives?

This is about people, families, and overall our communities. Sometimes tough decisions have to be made to ensure that the people are taken care of. Numbers and statistics are exactly that - we may see how well we are doing in some aspects, but does it mean that the person, the patient felt that they were well taken care of? I believe that when someone is having a heart attack, the last thing on their mind is what my entire department's IV success rate is. Their only immediate concern is about if I can start the IV on them. Additionally, what they will remember is how I spoke to them, and how I took care of them. They will

remember much more about the affective domain of my work and unfortunately that is tough to measure through statistics.

People have emotions, and fire /ems brings calm to the chaos. Delaying response on calls to EMD process to determine BLS or ALS simply is unacceptable. We have something that works, we should not deviate. Additionally, the call taker EMS program is only so good. People with eyes, ears, and sometimes sheer gut instinct need to be able to engage a patient to determine what their immediate needs are. I think there is room to improve how we respond to calls at medical facilities where doctors and nurses are already actively engaged in the care of a patient (Kaiser Urgent Cares across the county could easily be locations that are much more like an IFT type of response). Fire and EMS should only be launched together to these types of locations for reported cardiac arrest or other high acuity calls which may require a fire rider to assist during transport.

No mention was made about utilization of BLS ambulances with supported medics (including chase vehicles) - I have worked in systems where this model has been very successful. It functionally reduces the number of staffing paramedics that are needed in field.

I feel that our fire agencies already have good communications with the FCC that helps them to determine calls that red lights and sirens are not needed. Overall utilization of emergency devices are likely under the purview of the response agency.

Although there is plenty of information to cite the importance of sleep in relationship to mental health in emergency services, where are the statistics specific to our county? Is there data to support that there is a significant need to decrease the amount of errors made by prehospital providers in Ventura County? Where is the data to support that because we have care providers working in excess of 24 hours that Ventura County clinical outcomes suffer in relationship to it? There is a heavy investment in "data" throughout the review; however, I did not see much too much local information in regard to this significant recommendation.

I will end with it appears that there is much room to grow through some fiscal reinvestment into the communities of this county.

Response: We appreciate this thoughtful set of comments and we agree with the commenter that it is vital to remember that the EMS system is here to serve people. There are three specific issues we will respond to in these comments:

(1) BLS ambulances with supported medics – on this issue, we do recommend tiered BLS/ALS implementation, although we did not recommend a specific response model. Certainly BLS ambulance + ALS chase car/fly car support is a viable option.
(2) Red lights and sirens – we believe that updating dispatch and response policies can help ensure even more appropriate red light and siren (RLS) utilization, which currently exceeds national consensus guidelines in Ventura County.
(3) Sleep/fatigue – the studies we cite in our report are nationally-published studies. The fact that these studies and reports were not specific to Ventura County does not make them inaccurate. The lessons of reducing provider fatigue are universally applicable.

Comments: **Hello. Thanks for your well-prepared report. I have two recommendations for the final draft with regard to the Mental Health crisis in VC. 1. Please strongly recommend that the VC board of supervisors appropriate money for additional psychiatric beds (preferably in the East County). 2. Please recommend that transport of psychiatric (non-medical) patients from hospitals to psychiatric hospitals be done in properly outfitted cars, not ambulances. Thank you.**

Response: Thank you for the comment about the report being well-prepared.

1. An assessment and recommendations on hospital or psych facility bed capacity was beyond the scope of our engagement and of the report, though we do mention hospital bed trends generally in the demographic section of our report.
2. We agree that the vast majority of psychiatric patient transports can be safely done in non-ambulance vehicles and have mentioned this in the report.

Comments: **Does the report recommend a tiered response for fire first responders or just transport first responders?**

Why was Contra Costa County not used as a comparable County? They are probably the single most comparable county to ours. While total square miles is vastly different 804 v. 2208, when you remove mostly the mostly uninhabited federal responsibility areas (forests).

Why would you propose removing time based penalties? Can you give examples of outcome based penalties in existence that are effective? I would have rather seen a significant increase in penalties to force private providers to increase unit hours vs. paying additional penalties.

Why do you propose elimination of the sub zones in EOA 4? This seems to only benefit the private providers to the detriment of first responders and our constituents. Was this a recommendation from stakeholders? If so, who asked for this very specific change?

Why does the report not explore other options in depth? It seems to be centered around maintaining the grandfathered providers and the existing contract.

Response: Thanks for these questions and comments.

1. The tiered response recommendations are for the system, not for any particular aspect of the system. In other words, if a call is for an ALS-level patient, an ALS first response, where available (or a BLS first response when an ALS first response capability is not available) and an ALS ambulance would be appropriate. If it was for a low-acuity, BLS patient, only a BLS ambulance response may be warranted, and, in some cases, an accompanying BLS first response. But that is all subject to the choices made in the system design phase, either through a renegotiated set of contracts or RFP process as the County decides.

2. The basis for county comparison was demographic and geographic and the counties used were stated in the report, along with the rationale.

3. We do not advocate the elimination of response time standards but adding in new clinical metrics for penalty disincentives.

4. We are not recommending eliminating the sub-zones in EOA 4 for response time data collection. We are recommending the discontinuation in each subzone of the application of a response time compliance rate of 92.5% and higher to reduce by at least 20% the monthly penalty in the sub-zone that is based upon individual response time violations. We believe this incentive should apply only if response time compliance for EOA 4 in its entirety meets or exceeds 92.5% rate as is the case for each of the other EOAs. This is the same standard by which the other EOA contractors earn incentives and we recommend that it also be applied in EOA 4.

5. Our scope of work was to recommend whether the system should negotiate new contracts with existing providers vs. enter into an RFP process. That is what the analysis in our report centered on. Our scope of work was not to provide a blueprint for a new RFP if that option were to be selected. That would be a wholly separate and very detailed project requiring its own scope of work.

Comments: **As discussed in the initial draft review meeting, I would like the assessment review to discuss potential options in the report that encompass investment of funds back into the local first responder system from the transport providers. I feel as other first responder providers, a significant portion of revenue should be reinvested back into the entire system to best serve the local community. There does not seem to be much in the way of long term thought out improvements to the system that could be easily supported by the revenue generating sources under the current model.**

Response: Thank you for taking the time to submit these comments.

As discussed in our report, during the interviews some stakeholders did discuss their desire for "increased investment" in the system by its contractors. We invited all stakeholders to provide us with more specific input on what type and level of investment they thought was appropriate, but we did not receive any specific comments in this regard, other than suggestions by a few commenters for a general increase in the ambulances deployed by the contracted providers. We note that all current EOA response time standards are being met by all contractors. We believe that the level of required investment should be determined by the performance standards that are embodied in the provider contracts – and that those performance standards should be clinically valid and not merely based on the outdated concept of "shorter response times = quality." Those standards should be robust and carefully negotiated between VCEMSA and its contractors. We caution against requiring "investment" that only serves to increase the expense of the system without any proven benefits to patient outcomes.