MULTNOMAH COUNTY
AMBULANCE SERVICE PLAN
2016

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1. CERTIFICATION BY GOVERNING BODY OF COUNTY AMBULANCE SERVICE PLAN

CERTIFICATION OF THE MULTNOMAH COUNTY AMBULANCE SERVICE PLAN

The undersigned certify that pursuant to Oregon Administrative Rules 333-260-0020 through 333-260-0070 that:

- Each ambulance service plan element contained in these rules has been addressed and considered in the adoption of this plan by the Board of County Commissioners, and
- In the Board's judgment, the ambulance service area established in the plan provides for the efficient and effective provision of ambulance services, and
- To the extent they are applicable, the County has complied with ORS682.031, 682.062, and 682.063, and with existing local ordinances and rules.

Dated at Multnomah County, _____.

_____
Deborah Kafoury
Chair, County Board of Commissioners

Reviewed:

_____
Bernadette D. Nunley
Assistant County Attorney

2. OVERVIEW OF COUNTY (DEMOGRAPHIC AND GEOGRAPHIC DESCRIPTION)

Geography

Multnomah County has the highest population of all Oregon counties, and is the most densely populated county in Oregon. The population is predominantly urban; 97% of the population resides within the urban growth boundary established by Metro. The County extends from the junction of the Willamette and Columbia Rivers on the West to the foothills of the Cascade Mountains on the East. The County covers 465 square miles.

Multnomah County is characterized by significant variations in terrain and transportation networks, both in urban and in non-urban areas. Hills, winding roads and traffic congestion present emergency response challenges in themselves. These challenges can be compounded by the effects of weather such as snow and ice, and landslides.

Multnomah County also has large areas that are agricultural, forested, or other types of open space. Some of these areas have barriers to access by emergency vehicles, so special response resources may be needed. While they are hard to reach, there are few calls for emergency medical services in these areas.

Population

2015 US Census Bureau data shows the following:

Jurisdiction	*Population*	*Percent of County*
City of Portland	632,309	80.0
City of Gresham	110,553	13.9
City of Troutdale	16,631	2.1
City of Wood Village	4,017	0.5

City of Fairview	9,280	1.1
City of Maywood Park	778	0.1
Unincorporated Areas (by subtraction)	16,726	2.1
Total Multnomah County	790,294	100.0

In addition to the population living in Multnomah County, there is a significant net influx of people that occurs during the day, increasing the population by roughly 16%

Emergency Medical Resources

There are a number of organizations within Multnomah County currently providing emergency medical services.

City fire departments and rural fire protection districts currently provide first response services for the entire county. Each fire department or district determines deployment patterns necessary to provide emergency responses for fires, rescue situations, and medical calls. These deployment patterns are based on each community's needs, and operational and financial priorities and constraints. Fire departments and districts respond on most 9-1-1 medical calls including time-critical calls, and all calls that require specialty rescue, extrication, or non-medical technical response. Currently, the two city fire departments provide a mix of BLS and ALS first response. There are five fire districts that currently provide service primarily at the BLS level. The scope and intensity of medical services provided by fire departments and districts evolve over time.

One contracted (franchised) private ambulance company provides response and ambulance transport for all 9-1-1 medical calls. This company provides non-emergency services as well. Three other private companies provide non-9-1-1 ambulance service. All ambulance provider agencies are licensed by the Division and regulated by Multnomah County EMS.

Because the service area is located centrally within the Portland metropolitan area, Multnomah County EMS responders have access to the wide range of hospital facilities in the metro area (Multnomah, Clackamas and Washington counties in Oregon, and Clark County in SW Washington). There are seventeen hospitals in the area; fifteen of the seventeen serve as receiving hospitals for emergency ambulances; two specialty hospitals do not receive 9-1-1 medical call patients. Seven of the fifteen receiving hospitals are in Multnomah County, including two pediatric hospitals and two level-one trauma centers.

There is one air ambulance service serving the County, providing both emergency scene response and inter-facility air transport. This service is licensed by the Division and must meet a variety of other state and federal regulatory requirements. County regulations assure that air ambulance care is consistent with Multnomah County medical care standards.

3. DEFINITIONS

“9-1-1 medical call” means a call requesting medical response received at the Primary Public Safety Answering Point (PSAP) that is determined by the Emergency Medical Dispatcher (EMD) to require medical triage be performed in order to determine the nature of medical need, and the appropriate response to, or disposition of, the call. All calls involving but not limited to apparent medical conditions and trauma are considered “9-1-1 medical calls”.

"Advanced Life Support" (ALS) means those medical services that may be provided within the scope of practice of a person licensed as a Paramedic as defined in OAR 333-265-0000.

"Ambulance" means any privately or publicly owned motor vehicle, aircraft, or water craft that is regularly provided or offered to be provided for the transportation of persons suffering from illness, injury, or disability. (Comparable definition as in OAR 333-260-0010). All vehicles capable of providing transportation to the sick or injured and staffed with personnel trained to care for such individuals and equipped with supplies and equipment necessary for the care of the sick or injured shall be considered an ambulance.

"Ambulance services" means the transportation of an ill, injured, or disabled individual in an ambulance and, in connection with, the administration of prehospital medical or emergency care, if necessary.

"Ambulance Service Area" (ASA) means a geographic area which is served by one ambulance service provider, and may include all or a portion of a county, or all or portions of two or more contiguous counties. (Comparable definition as in OAR 333-260-0010)

"Ambulance Service Plan" (ASP) means a written document which outlines a process for establishing a county emergency medical services system. A plan addresses the need for and coordination of ambulance services by establishing ambulance service areas for the entire county and by meeting the other requirements of these rules [i.e., OAR 333-260]. Approval of a plan will not depend upon whether it maintains an existing system of providers or changes the system. For example, a plan may substitute franchising for an open market system. (Comparable definition as in OAR 333-260-0010)

"Basic Life Support" (BLS) means those medical services that may be provided within the scope of practice of a person licensed as an EMT-Basic as defined in OAR 333-265-0000.

"Bureau of Emergency Communications" (BOEC) means the Bureau of the City of Portland that maintains the Primary Public Safety Answering Point (PSAP) 9-1-1 telephone answering system, and provides dispatch services for police, fire and EMS for the County.

"Contract Ambulance" means a private or public ground ambulance that is authorized by the County to respond to 9-1-1 medical calls.

“Contract Compliance and Rate Regulation Committee (CCRRC)” means the Committee appointed by the Board to review contract compliance and to review and recommend rate adjustments.

"County" means Multnomah County, Oregon.

Critical Care Transport (CCT) means an ambulance providing transport between medical care facilities and providing care at the level of a hospital critical care unit.

"Division" or “State” means the Emergency Medical Services and Trauma Systems Program, Public Health Division, Oregon Health Authority.

"Effective provision of ambulance services" means ambulance services provided in compliance with the county ambulance service plan provisions for boundaries, coordination, and system elements.

"Efficient provision of ambulance services" means effective ambulance services provided in compliance with the county ambulance service plan provisions for provider selection.

Eight Hundred MHz (800 MHz) means a radio system used for emergency communications throughout the county.

"Emergency Medical Dispatcher" (EMD) means a person who is certified by the Board on Public Safety Standards and Training as defined in ORS 181A.355.

"Emergency" means a non-hospital occurrence or situation involving illness, injury, or disability requiring immediate medical services, wherein delay of such services is likely to aggravate the condition and endanger personal health or safety.

"Emergency Medical Services" (EMS) means those prehospital functions and services whose purpose is to prepare for and respond to medical and traumatic emergencies, including rescue and ambulance services patient care, communications, and evaluation, and public education. (Comparable definition as in OAR 333-260-0010)

"Emergency Medical Services (EMS) Agency" means any person, partnership, corporation, governmental agency or unit, sole proprietorship or other entity that utilizes emergency medical services providers to provide prehospital emergency or non-emergency care. An emergency medical services agency may be either an ambulance service or a nontransporting service. (Comparable definition as in OAR 333-265-0000)

"Emergency Medical Services Medical Director" (EMSMD) means a physician employed by the County to provide medical direction to the EMS system and medical supervision to EMS Providers providing emergency services within the County.

"EMS Program Office" means the organizational unit within the County Health Department that is responsible for the administration of the Ambulance Service Plan and EMS system in the County.

"Emergency Medical Services Provider (EMS Provider)" means a person who has received formal training in pre-hospital and emergency care and is state-licensed to attend to any ill, injured or disabled person. Police officers, fire fighters, funeral home employees and other personnel serving in a dual capacity, one of which meets the definition of "emergency medical services provider" are "emergency medical services providers" within the meaning of ORS chapter 682 and Oregon Administrative Rule. (Comparable definition as in OAR 333-265-0000) For the purposes of this Plan, “EMS Provider” does not include a person who is formally trained and licensed, but who is operating in a setting that does not involve a response with a licensed ambulance or does not involve a 9-1-1 medical call.

“Emergency Response” means an immediate response to a 9-1-1 medical call. An immediate response is one in which the EMS providers on an ambulance or other EMS unit begin as quickly as possible to take the steps necessary to respond to the call. An Emergency Response may involve responding with or without lights and siren.

"Expeditious (Best Effort) response" means responding to medical calls as soon as possible upon dispatch, but without a set response time requirement. An Expeditious Response may involve responding with or without lights and siren.

"First Responder" means an organization that provides rapid response to 9-1-1 medical calls utilizing licensed EMS provider personnel. First responders aim to arrive and provide care prior to arrival of an ambulance.

“Frontier” means those areas within the rural response zone that are designated by the EMS Program Office as exempt from the rural response time requirement because of extreme distance, inadequate roads, difficult terrain or other factors.

"HEAR" means the radio frequency that may be used for ambulance-to-hospital and hospital-to-hospital radio communications.

“HOSCAP” (also referred to as “CHORAL") means an on-line computer system that is provided and managed by the Oregon Health Authority. The purpose of HOSCAP is to create linkages among receiving hospitals for the purpose of communicating information on the status and capacity of those hospitals for receiving patients transported by ambulance.

"MCC 21.400” means the current Emergency Medical Services section of the Health chapter of the Multnomah County Code. Also cited as the Multnomah County Emergency Medical Services Code.

"Mass Casualty Incident" (MCI) means an emergency medical incident with enough injured or ill persons to meet the requirements for scene and medical management as defined in Multnomah County EMS Administrative Rules, MCI Plan.

"MED NET" means those radio frequencies that may be used for EMS dispatch, on-line medical control, and MCI communications.

"Medical Resource Hospital" (MRH) means a hospital operating under contract with the County to provide on-line medical control and advice to EMS Providers.

"Non-Emergency Ambulance" means an ambulance, licensed by the County and the Division, that provides medical transportation to patients who do not require an emergency response. The level of care provided is dependent upon the patient's need.

"Notification time" means the length of time between the initial receipt of the request for emergency medical service by either a provider or an emergency dispatch center (9-1-1), and the notification of all responding emergency medical service personnel. (OAR 333-260-0010)

"On-line Medical Control" means medical direction and advice given by a physician over radio, telephone or similar means to an Emergency Medical Services Provider as a supplement to written patient care protocols.

"Provider" means any public, private, or volunteer entity providing EMS (Comparable definition as in OAR 333-260-0010). Also referred to as “provider agency"

"Provider selection process" means the process established by the County for selection of an exclusive emergency ambulance service provider.

"Public Safety, Answering Point" (PSAP)/ 9-1-1 means the organization that answers calls for police, fire, and emergency medical assistance that are received from persons dialing 9-1-1.

"Response Time" means the length of time between the notification of each provider and the arrival of each provider's emergency medical service unit(s) at the incident scene. (Comparable definition as in OAR 333-260-0010)

"Rural" or "rural response zone" means those areas in the Multnomah County Ambulance Service Area that are outside the urban growth boundary.

“Time-critical medical call” means a request for medical service that is known or likely to represent a medical condition that could result in death or severe disability if effective treatment is not immediately provided. Examples include, but are not limited to, cardiac arrest, stroke, severe heart attack- ST Elevation Myocardial Infarction (STEMI), and severe trauma.

"Urban" or "urban response zone" means those areas in the Multnomah County Ambulance Service Area that are within the urban growth boundary.

4. BOUNDARIES

(a) ASA Map(s) with Response Time Zones

(See Attachment A - Urban Growth Boundary Map)

(b) ASA Narrative Description

All of Multnomah County comprises a single ambulance service area. Portions of the county are rural in nature and have a low population density that cannot support a ground response time standard that is appropriate for urban areas of the County.

Use of the Urban Growth Boundary developed by Metro as a demarcation between the County's urban and rural ambulance response time zones is intended to provide a realistic basis for response time standards.

(c) Map(s) Depicting "9-1-1", Fire Districts and Incorporated Cities

(See Attachment B - Map of Fire Districts and Map of Cities)

(d) Alternatives Considered to Reduce Response Times

Response Time Reduction

Because of the need to provide efficient and effective service to people within Multnomah County, certain areas of the County have been deemed better served by agencies responding from outside the County. These areas are considered to be within the County ambulance service area and intergovernmental agreements specify the details of service for each of these areas. The areas affected are:

- The community of Dunthorpe
- Portions of Multnomah County located in Lake Oswego.
- The area adjacent to Columbia County served by Highway 30.
- Eastern areas of Multnomah County contiguous to Clackamas and Hood River Counties.

In addition, Multnomah County EMS serves areas in other jurisdictions by similar agreements. These areas are:

- The north end of Sauvie Island located in Columbia County.
- Portions of the City of Portland located in Washington County.

It is the intent of this plan to foster cooperative inter-jurisdictional approaches to ambulance service area planning, management, and service to reduce negative effects on service that may be caused by jurisdictional boundaries.

Prevention

Reducing the number of inappropriate 9-1-1 medical calls will allow for better utilization of resources and improve cost efficiency of first responders and ambulance providers. The EMS Program Office will coordinate approaches that will have as their goal the appropriate use of 9-1-1 for emergency medical requests. These approaches can range from interactions with individual system users to broader system or public approaches. All provider agencies participate in these efforts to the extent they are appropriate to the services provided and the populations served.

In addition, as resources allow, the EMS Program Office will coordinate public education programs designed to address certain health conditions, and enhance 9-1-1 system access. This coordination can involve various EMS provider agencies, other health care providers, community organizations and others.

5. SYSTEM ELEMENTS

(a) 9-1-1 Dispatched Calls

Initial call taking will continue to be done by BOEC as the regional Public Safety Answering Point (“PSAP”) for Multnomah County. The PSAP or a secondary PSAP may be contracted to perform subsequent emergency medical triage of calls. Regardless of the entity performing emergency medical triage, triage for all calls will use a triage system approved by the County EMSMD. The triage system will include systematic mechanisms to determine the type and severity of medical emergency, provide pre-arrival instructions, and incorporate provisions to ensure the appropriate type and number of resources are used in a response. The system will include a comprehensive qualitative and quantitative quality improvement process that evaluates and addresses various aspects of medical call triage and dispatch.

(b) Pre-arranged Non-emergency Transfers and Interfacility Transfers

Ambulance services for requests other than 9-1-1 medical calls, including pre-arranged non-emergency transfers and inter-facility transfers, will be provided by ambulance providers licensed by the Division using ambulances licensed and regulated by Multnomah County.

See Section 6 (f) (B) for requirements for triage of request for ambulance services received by ambulance providers through channels other than 9-1-1.

(c) Notification and Response Times

Notification

Medical call-taking and dispatch will continue to be governed through a performance contract between Multnomah County EMS and BOEC. The contract is based on performance criteria that are implemented through protocols used for dispatch, triage requirements for calls, pre-arrival instructions to be given to callers, and the review and improvement processes to be used for the medical dispatch function. Development of these protocols is the responsibility of the EMS Medical Director. These protocols may be evaluated periodically to consider changes in system loads and expectations. If other agencies are engaged in triage (e.g., in a secondary PSAP role), Multnomah County EMS and these agencies will execute similar performance contracts.

At least ninety percent of responses to medical calls received by the PSAP will be dispatched within eighty seconds. This time will be periodically evaluated by EMSMD and EMS Administrator to consider whether the standard is appropriate in light of changes in triage, dispatch, response, and other EMS system characteristics.

Provider agencies that are dispatched by BOEC are required to participate in emergency medical dispatch quality improvement activities.

Response Time Standards

Response time will be measured from the time BOEC dispatches a unit and receives confirmation of dispatch until the unit reports arrival at the scene of the incident. Response time performance will be evaluated using data recorded by the BOEC dispatch computer. Response time performance is intended to be consistent throughout the respective urban or rural response zone. The following response time standards apply only to 9-1-1 medical calls. Non-emergency calls dispatched by BOEC, or turned over to non-emergency ambulances, will be run in an expeditious manner.

First Response

The response goal for urban First Responders is arrival on scene in four minutes, zero seconds or less in at least ninety percent of medical calls.

Rural First responders will respond in an expeditious "best effort" manner as soon as dispatched.

Ambulance Response

Ambulance Response - Urban Response Zone (within the Urban Growth Boundary):

Contract ambulances will be required to arrive on scene and report their arrival on ninety percent of time-critical 9-1-1 medical calls in eight minutes, zero seconds or less. This response time presupposes current approaches to triage and dispatch, and current first response time goals and staffing.

Contract ambulances will be required to arrive on scene and report their arrival on ninety percent of non-time-critical medical calls in twelve minutes, zero seconds or less. This standard is intended to ensure a responsible, safe, and rapid response to 9-1-1 medical calls that are not identified as an immediate threat to life or health.

These urban response times represent a change from the standards of the 1994 ASP. However, the impact of this change will primarily be felt in the future - i.e., after implementation of improved systems for caller interrogation, call triage, and application of validated determinant codes as a basis for call classification have been implemented. In the meantime, the

effective ambulance response time standard will not be changed for most calls. Prior to implementing validated determinant codes, it will be the EMS Medical Director's (EMSMD's) responsibility to classify sets of calls as non-time-critical. Absent reliable determinant code data, we anticipate that the EMSMD will make small and cautious changes to call classifications. We also anticipate that such changes will center on calls that are clearly low-acuity. As a result, the great majority of calls will be considered time-critical, and will continue to fall under the 8:00 minute/90% standard that is currently in place.

Ambulance Response - Rural Response Zone (outside the Urban Growth Boundary):

Contract ambulances will be required to arrive on scene and report their arrival on ninety percent of time-critical medical calls in twenty minutes, zero seconds or less.

Contract ambulances will be required to arrive on scene and report their arrival on ninety percent of non-time-critical medical calls in thirty minutes, zero seconds or less. This standard is intended to ensure a responsible, safe, and rapid response to these 9-1-1 medical calls for service.

Ambulance Response - Frontier Rural Sub-zone (minimally populated areas)

In those areas designated by the EMS Program Office as Frontier, calls will be responded to in an expeditious, "best effort" manner as soon as the units are dispatched. The important element for response into these areas is the immediate response to the dispatch to ensure that help is moving toward the incident as soon as possible.

Future changes

In addition, in the future, improving triage, increasing the timeliness and intensity of first response, and other improvements may allow for longer ambulance response times.

This ASP intends to allow for the incorporation of longer response time requirements in lieu of the above urban and rural response requirements. Advice from the medical community - for example local EMS physicians,

the local chapter of the American College of Emergency Physicians (ACEP), and other interested medical providers - will be sought regarding the impact of changing ambulance response times in the context of improvements in triage and first response.

Equity of Service

Equity in access to health services is an important value for Multnomah County. In addition, the County anticipates that changes in population, population density, and EMS call volumes will occur over time. To address these factors, the County will have a dynamic process to ensure equity in responses to emergency medical services across the entire county. The EMS program will include dynamic evaluation methods in all performance based contracts for service to ensure the ability to address changes that occur over time. The goal is to enhance patient experience, improve population health, and decrease health care costs.

(d) Level of Care

Provider Response

Multnomah County's emergency medical services will be provided using a combined system of non-transporting first responders and transporting ambulances.

The goal of EMS dispatch is to send to each medical call the amount of response resources necessary to ensure patient safety and provide quality medical care. It is the intent of this ASP to avoid duplication or unnecessary use of response resources, and to continuously improve quality, response capability, and fiscal stability.

Specified 9-1-1 medical calls will receive a first response when appropriate according to EMS priority dispatch criteria and EMS Dispatch protocols.

Ambulance response to 9-1-1 medical calls will be provided by a single ambulance provider agency under contract with the County. The contracted provider agency may subcontract a limited amount of required ambulance services to established fire departments or districts that provide medical first response within the ASA. The contracted provider is accountable for all performance requirements for ambulance services required under the

contract whether the services are provided directly or through a subcontract.

Subcontracted services must be intended to address unique or unusual challenges in service delivery that the contracted provider faces. Examples include extreme short-term variations in demand, and unusual difficulties posed by geography or population distribution. This ASP intends that subcontracts provide the contracted provider with supplemental capacity and resources to meet unusual challenges. Subcontracting is not intended as a mechanism to share responsibility for routine or reasonably predictable service challenges. Any proposed subcontract must be approved by the County EMS Program Office; this approval is at the sole discretion of the EMS Program Administrator. Any subcontract must include clear provisions and processes that allow for the subcontract to be canceled by the single contracted ambulance provider if the County determines that the subcontract is detrimental to the overall EMS system.

City fire departments and fire districts that maintain vehicles licensed as ambulances may continue to provide ambulance response under unusual circumstances (e.g., inclement weather, extreme service demands, special public events, etc.) as allowed for by County EMS protocols. These services do not require subcontracting with the single contracted ambulance provider.

There will be a single system status dispatch plan for the entire ASA The appropriate first responder and appropriate ambulance as recommended by the dispatch computer (CAD) or other system will be dispatched to each call.

(e) Personnel

Staffing - First Response Rural Considerations

It is the goal of this system to have all first responders trained, at a minimum, to the EMT-Basic level. Rural first responders are encouraged to have at least one EMT-Basic at the scene of a medical call. It is recognized that because of the size and the volunteer nature of the Rural Fire Protection Districts serving parts of Multnomah County, this training level may not be feasible. The EMS program will assist rural providers in the development and provision of training necessary to meet this goal.

Staffing - First Response Urban Areas

Portland Fire and Gresham Fire currently have all response personnel trained to the EMT Basic level and also provide many ALS first response units with at least one (1) Paramedic responding on those units.

Emergency Ambulances

Currently all ambulances providing 9-1-1 medical call response are staffed with two (2) Paramedics.

This standard will be retained for the present time. However, the standard may be altered in the future - e.g., to allow one Paramedic and one EMT-Basic. Such a change may be considered only if there is sufficient clinical, operational and economic justification.

Any proposal to change staffing must be submitted to the EMS Administrator regardless of whether the proposal is developed by the contracted ambulance provider, another EMS provider, EMS Program staff, or another source.

With consultation from the EMSMD, the Administrator will screen each proposal to determine whether it has sufficient merit to justify more detailed consideration. If a proposal has sufficient merit, the EMS Administrator will charge a group of experts to evaluate the proposal in detail, report their findings, and make a recommendation to the EMS Administrator and EMSMD regarding approval and other considerations. The expert group can be an established EMS group (e.g. the EMS System Advisory Council, the Contract Compliance and Rate Regulation Committee, or an ad-hoc group appointed by the EMS Administrator). If a change in staffing level is recommended by the expert group, and the EMSMD concurs that the change is appropriate and desirable; the EMSMD will be required to notify the Board of County Commissioners of the proposed change, make a recommendation regarding adoption, and address the following issues:

- The major factors driving the proposed change - e.g., lack of personnel (paramedic) availability, unmanageable changes in call volume/demand, etc.
- Alternative solutions that have been considered.

- How quality of care will be maintained, and what quality assurance and improvement processes will be used to ensure quality.
- Anticipated adverse consequences of the proposed staffing change, and mechanisms to monitor for and respond to adverse consequences.

Alternatively, if the EMSMD determines that the proposed staffing change is not appropriate or, desirable, or that important issues have not been adequately addressed, s/he may reject the proposal.

If the Board approves the proposed change, the EMS Program Office will be responsible for preparing necessary changes to Multnomah County Code §21.406 Ambulance Staffing, and other relevant sections of the Code for Board approval.

Diversity

The diversity of personnel in Multnomah County's EMS system with regard to gender, race, and ethnicity and other dimensions leaves much to be desired. While there are many women working in the private ambulance sector, there are few in the fire services. Paramedics of African-American, Asian, Hispanic, Native American, and other minority backgrounds comprise an extremely low percentage of the EMS workforce. Addressing this issue will take a long term commitment from the providers of EMS care, the County EMS system, EMS Provider training programs, and others.

The EMS Program will work with local EMS providers, the Division, and EMS training programs, both in Multnomah County, and in other areas, to promote recruitment of training candidates from diverse backgrounds.

Preference

If the County replaces one ambulance service with another, Emergency Medical Services staffing will be maintained at least at the levels established by this ambulance service plan.

When hiring to fill vacant or new positions, the replacement ambulance service must give preference to qualified, comparably-licensed employees

of the previous ambulance service. This requirement applies to the period beginning when the County expresses its intent to reassign ambulance services, and ending when replacement service has been providing service for six months. Such hiring must be done with the understanding that persons hired from the previous ambulance provider are not required to leave employment with that provider until the replacement ambulance provider begins to provide ambulance services under agreement with the County.

Non-Emergency Ambulances

Licensed non-emergency ambulances may be staffed with EMT-Basic or Paramedic personnel, according to the level of service provided.

Additional staffing standards may be set by the EMS Medical Director for critical care transfers or other specialized ambulance services.

(f) Medical Supervision

EMS Medical Director (EMSMD)

Multnomah County Health Department will continue to employ an EMS Medical Director (EMSMD), who will serve as: a) the medical director for the EMS program, b) the physician supervisor for all EMS Providers in the employ of providers of ambulance services in the County. In addition and by agreement, the EMSMD shall serve in this same capacity for EMS Providers employed by other Providers.

The EMSMD will provide medical direction and advice to all components of the EMS system including but not limited to dispatch, first response, and ambulance transport. The EMSMD will have specific authority to set uniform standards for EMS patient care for the County. These standards will include, but not be limited to:

- Dispatch and pre-arrival protocols,
- Transport triage criteria and protocols,
- County specific EMS Provider requirements,
- Approved equipment, supplies and drugs,
- Patient care protocols,

- Medical criteria for response times, including designation of calls as time-critical, non-time-critical, or non-emergency, and
- Patient transfer criteria.

The EMSMD will develop and implement procedures for limiting the practice of individual EMS Providers to respond to deficiencies in that individual's clinical knowledge or skills, clinical performance, or professional behavior. The EMSMD will assure that these procedures are carried out with adequate due process protections.

The EMSMD will also set specific standards for training and continuing education for all EMS Providers and EMDs.

The EMSMD will assist rural volunteer fire districts in meeting the state standards for EMS Provider training.

The EMSMD will ensure that all providers within the system participate in a quality management program designed to provide for continuous quality improvement in patient care and all other aspects of emergency medical services. This process will provide the basis for changes in medical care protocols, and for the educational and training standards set forth by the EMSMD.

The EMSMD may, at his or her discretion, and as funding allows, appoint assistant medical directors to help carry out the duties assigned to the EMSMD. The EMSMD however, retains the sole responsibility for all assigned duties.

The EMS program will provide office and administrative support to the EMSMD.

(See Attachment C - EMSMD position description)

Emergency Medical System Advisory Council (EMSAC)

The purpose of the Emergency Medical System Advisory Council (EMSAC) is to advise the EMSMD and EMS Program Administrator on EMS System innovations and improvements, and when appropriate, make specific recommendations.

The EMS Program Administrator may appoint other standing committees or ad-hoc groups to provide advice to the EMSMD or the EMS program on specific EMS issue areas or services.

On-Line Medical Control

On-line medical control will be provided by a Medical Resource Hospital (MRH). Standards for on-line medical control and MRH operations will be set forth by the EMSMD and implemented through a performance contract with the hospital chosen as MRH. The EMSMD will monitor the performance of the MRH contract.

(g) Patient Care Equipment

Requirements for equipment and supplies will be determined according to the level of service provided (ALS, BLS, CCT, emergency, non-emergency) and will be set by the EMSMD.

First Responders

All first response vehicles will be required to carry medical equipment and supplies appropriate to their level of service, as defined by the EMS Medical Director.

Ambulances

All ambulances will be required to maintain equipment, supplies, and drugs appropriate for their level of service (ALS, BLS, or CCT) as required under Oregon Administrative Rules and as required by the EMSMD. Ambulances may be inspected on a regular basis, by the EMS office to determine compliance with these requirements.

Rural Considerations

The EMS program will assist rural first responders in obtaining the necessary equipment to maximize their response capabilities. (e.g., automatic defibrillators)

(h) Vehicles

First Responders

First response vehicle standards are the responsibility of the agency that operates them. The vehicles must meet any medical requirements of the EMSMD.

Ambulances

Ambulances will meet all relevant State and Federal statutes and rules and must meet any additional requirements of the EMSMD.

(i) Training and Education.

EMS Provider Levels

Training and certification required for those technicians providing ALS care will be at the level of Paramedic. In addition to the requirements for State licensure, the EMSMD may require additional training or education. Training and licensure for other EMS Providers will be at the level of EMT-Basic at a minimum.

In addition to the requirements for State licensure, the EMSMD may require additional training or education.

It is the goal of this plan to encourage EMT-Basic training and certification for all 9-1-1 medical call first responders. The EMS Program Office will work with the first response organizations to help realize this goal.

Continuing Education

All training and continuing education required for pre-hospital practice in the County's EMS system will be carried out through a single, coordinated educational program. Training resources that are currently available and additional training resources that become available will be pooled to allow for their maximum use. The EMSMD will establish system-wide criteria that meet the training needs of all levels of EMS Providers in both the urban and rural settings. These criteria will also help ensure that all personnel receive appropriate and consistent training. The content offered will meet

certification requirements and will reflect the outcomes and findings of the quality improvement process. In-service training may also address a range of equity issues including ethnic and cultural diversity as determined by Multnomah County EMS.

The EMS Program will continue to provide periodic in service sessions to introduce changes in patient care protocols, state and local administrative rules, state requirements, and other pertinent information. All EMS Providers will be required to attend to maintain their credentials as approved by the EMSMD.

The EMSMD may require individual EMS Providers to obtain additional training and education based on performance. Provider agencies will offer training and education to their employees and other EMS Providers in the system as approved by the EMSMD, and as part of the coordinated EMS educational program.

The EMS educational program will specifically assist rural first responders in obtaining the training necessary to meet system goals.

(j) Quality Improvement

(A) Structure

The basis for EMS system quality assurance in the County will be a Continuous Quality Improvement (CQI) process. CQI is an inclusive, multidisciplinary process that focuses on identification of system-wide opportunities for improvement. The County EMS CQI process will utilize evaluation methods that are based in system structure, processes, and outcomes. Improvement efforts focus on identification of the root causes of problems. The Multnomah County Emergency Medical Services System Quality Improvement Plan includes interventions to reduce or eliminate these root causes, and to develop steps to correct or improve inadequate or faulty processes. Additionally, the plan can assist constituent groups to recognize and support excellence in performance and delivery of care. County efforts are both proactive and retrospective, and draw upon quality improvement efforts from a variety of industries including the published sources of the National Association of EMS Physicians.

(B) Process and Problem Resolution

Implementation of CQI will involve the education of EMS personnel in the CQI process, development of data, and implementation of data analyses to support the process.

The CQI process will analyze data on all aspects of the EMS system including dispatch, response times, medical supervision and control, patient care, EMS Provider and EMD performance, and other components. The data will come from a variety of sources - the dispatch agency, first responder and ambulance provider agencies, and hospitals. Specific data can include computer databases, patient care charts and chart reviews and audits, patient complaints and patterns of complaints, patient outcomes, and others. The outcomes of the process are information, problem solving, and system improvement. These outcomes will serve as the basis for system change.

The EMS office will provide staff support for the CQI process.

(C) Sanctions for Non-Compliant Personnel or Providers

Sanctions imposed for inadequate performance on the part of provider agencies, or for violations of County laws or rules are identified in the contracts with providers, or MCC 21.441. Any remedies directed to individual EMS Providers will be the responsibility of the EMSMD.

The contract with the single contracted emergency ambulance provider will specify fines or other sanctions that will be imposed if certain contract conditions are not met. In addition, the contract will identify conditions that will constitute a breach of contract, and the conditions and procedures for termination of the agreement.

MC Code and EMS administrative rules currently allow for sanctions for non-compliance. Sanctions include fines, license suspension, and license revocation. These sanctions may continue as part of the licensing process for both contract and non-emergency ambulances.

It is not the purpose of the CQI process to impose sanctions or other remedies on non-compliant providers.

6. ADMINISTRATION AND COORDINATION

(a) The Entity That Shall Administer and Revise the ASA Plan

MCC 21.400 documents the findings of the Multnomah County Board of County Commissioners that it is necessary for the County "...to regulate providers of emergency medical services and ambulance services to assure that the citizens of the County receive prompt, effective, efficient, coordinated, and consistently high levels of pre hospital care before and during transport to a medical facility." Through MCC 21.400, the Board delegates authority and responsibility "…for the implementation, regulation, coordination, and enforcement of this subchapter and the ambulance service plan and other EMS planning, and the administration of the ambulance service contract" to the Health Department's EMS Program Office. Similarly, MCC 21.400 establishes the position of EMS Medical Director and outlines the duties, authorities and responsibilities of that position.

Specific relationships with contract ambulance providers, 9-1-1 dispatch, and MRH will be delineated in intergovernmental agreements and contracts. These contracts will be performance-based, and will specify the duties, responsibilities, compensation, remedies, and other aspects of the relationship between the County and its contractors. The County will encourage first responders to enter into similar agreements; these agreements may include compensation. Any such compensation will be contingent on the agreement by the first responder to use EMS system standards as the responder's response time goals.

The EMS Program Office will administer and monitor these agreements and make recommendations on the continuation, renewal, or termination of the agreements.

Non-emergency ambulances will be regulated through the licensing requirements specified by Multnomah County Code. There is no restriction on the number of licensed non-emergency ambulance provider agencies.

Rate Regulation

The Board of County Commissioners, as part of the ambulance contracting process, will approve all rates for emergency ambulance services provided under this plan.

There will be a single charge schedule that will apply uniformly throughout the service area for services provided to 9-1-1 medical call patients. The initial rates incorporated in the exclusive ambulance service contract shall be included in the recommendation to the Board by the RFP Evaluation Committee.

Rate adjustment formulas, for example based on the Consumer Price Index (CPI), may be included in the agreement with the contacted ambulance provider.

The Board of County Commissioners will appoint a Contract Compliance and Rate Regulation Committee (CCRRC). Membership will include a person with expertise in ambulance operations, an attorney with health care expertise, and a person in the business of health care administration or health care financing, an accountant, an EMS provider not doing business in the County, a citizen residing within the county, and representatives of the cities of Portland and Gresham.

The CCRRC will review response times and other performance requirements of the ambulance service contract, and make recommendations to the EMS administrator.

The CCRRC will also review all requests for non-routine rate adjustments and make recommendations to the EMS administrator.

The CCRRC will develop criteria to be used to evaluate decisions on non-routine rate adjustments requested by the contracted ambulance provider. These criteria must be approved by the Board of County Commissioners. The CCRRC will also adopt specific guidelines for the rate regulation process.

The CCRRC will also review any proposed system requirements that may have a significant financial impact on the contracted provider. If the

CCRRC determines that such an impact is present, it may recommend a rate adjustment to compensate for the requirement.

Non-emergency ambulances will not be subject to the rate determination process. Fees charged for their services will be driven by the market for such services. They will however, continue to charge only those fees that are on file with the EMS Program Office.

(b) Complaint Review Process

Standards for the fair and equitable handling of complaints concerning pre-hospital patient care and ambulance service will be adopted by the EMS Program Office and the EMS Medical Director.

Each EMS provider agency is required to forward any complaints it receives regarding its actions or services to the EMS Program Office, regardless of the source of the complaint.

The EMS Program Office will forward any complaint received about an EMS provider agency to that agency on a timely basis.

EMS provider agencies are required to notify the EMS program of the agency's final resolution or disposition of the complaint within thirty (30) days.

The EMS Program Office will also track each complaint. The Office may conduct an independent review of the complaint, and take additional steps to resolve the complaint if appropriate. Information relevant to the complaint will be collected and reviewed by EMS staff. Information may include dispatch records, patient care reports, invoices for service, incident reports, hospital records, interviews, and other information. The EMS Program Office will resolve complaints through three mechanisms:

1. Medical care complaints will be referred for Medical Case Review, currently conducted by the EMS Quality Assurance Committee. This Committee reviews the case from an EMS system perspective, and makes procedural and system-level recommendations.
2. Dispatch and system response complaints will be initially reviewed by EMS staff. Complaints may be referred to the

Dispatch Committee for review and recommendation. Individual case dispositions will be handled by the EMS Program Office.

3. Complaints about ambulance charges and other non-medical provider-related complaints will be reviewed by the EMS Program Office staff that will be responsible for the disposition of each case.

If the EMS Program Office determines that it is appropriate, it may refer a complaint to other agencies for review and resolution (e.g., complaints that may involve criminal conduct may be referred to the District Attorney).

Review and resolution of complaints that include Protected Health Information or other sensitive information about identifiable individuals will be considered as functions of the Quality Assurance process for purposes of protecting confidentiality. Such confidentiality protections are intended to apply only to patients' medical information, and do not preclude the release of other information as allowed or required by law.

Complaints and their resolutions will constitute a data source available to the Quality Improvement process. In addition, all complaint information will be available to the EMS Medical Director for use in the medical supervision of EMS Providers.

(c) Mutual Aid Agreements.

For certain portions of Multnomah County, intergovernmental agreements will allow for response from agencies outside the County. Multnomah County providers will respond into other jurisdictions under similar agreements. The areas are described earlier in this document.

(d) Disaster Response

(A) County Resources Other Than Ambulances

UNUSUAL CIRCUMSTANCES (MCI, DISASTER)

Mutual aid agreements with fire departments and districts are in place for events that overtax the resources of a given fire district.

Similar agreements will be executed on a regional basis to allow ambulances from outside the County to respond at the request of EMS Dispatch.

In addition, all County-licensed contract and non-emergency ambulances are required to respond to disasters and MCIs when requested to do so by the EMS Program Office through BOEC dispatch.

(B) Out of County Resources

In the event that resources exceeding those normally available for EMS service to the County are needed, additional ALS and BLS ambulances and other resources within the County may be used. The EMS Administrator (or BOEC, per protocol) may request out-of-county resources through those jurisdiction's emergency managers. Normal staffing requirements for ambulances may be waived under these circumstances. A resource list of potential responders is maintained at BOEC.

(C) Mass-Casualty Incident Plan.

The County's Mass Casualty Incident (MCI) plan is developed by a multidisciplinary, tri-county committee and is adopted and codified in MCC 21.439. This plan, and similarly adopted plans used by the counties surrounding Multnomah County, provides the direction for the organization and use of resources if there is an MCI. This plan is also incorporated as an appendix in the emergency management disaster plans of the County and other local jurisdictions.

In an MCI, medical communication and patient destination is the responsibility of the Regional Hospital. Regional hospital is designated by the EMS Program Office in conjunction with other affected counties.

(D) Response to Terrorism and Disasters

Disaster planning is cooperative in nature. The EMS Program and EMS Medical Director are a part of the Tri-County Health Officer’s Division within the Health Department. This facilitates integrated approaches with the Regional Hospital Preparedness Organization, Health Department Emergency Preparedness, and County Emergency Management. This Program integration allows for comprehensive plans to be coordinated and

developed at the highest level within the County. The intent is to have continued communication and involvement in all planning and operational activities. EMS providers have an established role and responsibility and coordinate activities under the National ICS model.

(e) Personnel and Equipment Resources

(A) Non-transport EMS Provider

City fire departments and rural fire protection districts currently provide first response services for the entire county. Each fire department or district determines deployment patterns necessary to provide emergency responses for fires, rescue situations, and medical calls. These deployment patterns are based on each community's needs, and operational and financial priorities and constraints. Fire departments and districts respond on all time-critical 9-1-1 medical calls, and all calls that require specialty rescue, extrication, or non-medical technical response. Currently, the two (2) city fire departments provide a mix of BLS and ALS first response. There are five (5) fire districts that currently provide service primarily at the BLS level. The scope and intensity of medical services provided by fire departments, districts, and jurisdictions may evolve over time.

(B) Hazardous Materials

HAZ-MAT response is the responsibility of the fire districts and departments within Multnomah County. HAZ-MAT response plans include identifying the hazard, its effect on people, and the appropriate actions for neutralizing the hazard, decontaminating exposed people and environments, and providing necessary medical care in the pre-hospital and hospital settings.

Transport and receiving hospital standards for exposed patients are coordinated through HAZ-MAT, special operations teams, and the receiving hospitals. Hazard evaluation is done on a frequent basis with involvement from the specialty teams, EMSMD, and Hospital representatives. The standards and procedures vary based on the nature of the exposure.

(C) Search and Rescue

Search and rescue operations are the responsibility of the Multnomah County Sheriff. The Sheriff's Office serves as incident commander for search and rescue operations. EMS and fire responders provide resources as required by the incident commander. Along with the governmental and associated volunteer resources, there is a specialized team (Reach and Treat) available from a local ambulance provider.

(D) Specialized Rescue

Multnomah County, through the fire districts, has the following specialized rescue abilities:

- High Angle Rescue
- Trench Rescue
- Dive Rescue

There are no specialized medical components to these rescue services. Medical care is provided by Fire EMS Providers assigned to the rescue teams.

(E) Extrication

Multnomah County, through the fire districts, has access to extrication capabilities:

Other

SPECIAL EMERGENCY RESPONSE TEAM (SERT)

In addition to the standard EMS response, specialized paramedics from the fire services provide emergency medical service to the Police SERT team members. This is a function controlled by the police and not part of the normal EMS response. SERT Liaisons will coordinate with EMS Program.

(f) Emergency Communication and System Access.

(A) Telephone

Multnomah County is served through a single Public Safety Answering Point (PSAP, 9-1-1 center) accessible by callers through 9-1-1. EMS contracts with the City of Portland Bureau of Emergency Communications (BOEC) for emergency medical triage, pre-arrival instructions, and contract ambulance dispatch. In addition, BOEC provides similar services for all police departments and fire departments and districts in the county.

(B) Dispatch Procedures

Current EMS call-taking and dispatch is governed by a set of protocols and procedures, developed by a committee of dispatchers, first responders, EMS Providers, provider representatives, and physicians. EMS Dispatch at BOEC (and any other ambulance dispatch) is required to use these protocols and procedures. In the future, a “criteria based dispatch" system of protocols and procedures may be recommended by the EMS Medical Director and promulgated through contracts and as formal County EMS administrative rules.

BOEC will continue to dispatch all first responders and contract ambulances.

BOEC will also dispatch any fire ambulances. Ambulances may, in the future, be dispatched by the ambulance provider if approved by the EMS Program Office.

9-1-1 medical calls are initially processed by a call-taker who is certified as an Emergency Medical Dispatcher (EMD). The call-taker uses the EMS-approved call triage guide to determine the nature of the call and the level of emergency or non-emergency response required. Call information is then sent (via computer) to an EMS dispatcher who is also EMD-certified. Through a computer aided dispatch system (CAD), the status of all fire units and ambulances is available to the dispatcher. The dispatcher will send fire or ambulance units, as appropriate per protocol, depending on the nature and location of the incident/request. All calls will be triaged appropriately per county dispatch agreement and protocols.

As dispatch is under way, the EMD (who has remained on the line) may provide the caller with pre-arrival instructions for patient care as specified in the protocols.

Depending upon the location of the call and the availability of ambulances, an out-of-county unit may be dispatched. This is accomplished by direct radio contact or by telephone to the appropriate dispatch center.

In addition, under current County EMS rules, if a person directly calls any ambulance company and requests service, the company must triage that request using the same triage system that is used at BOEC. In the future, if a “criteria based dispatch" system of protocols and procedures is adopted ambulance companies will be required to triage direct request for service using either the County-adopted system, or a County-specified alternative triage system that is aligned with the nationally-validated system. In both the current and future situations, if a request is determined to be an emergency according to the triage system, the ambulance company must pass the call information to BOEC for dispatch and response.

(C) Radio System

All emergency medical responders will have the capability of operating on the BOEC radio frequencies. This is an 800 MHz system and is used as the primary communication mode for day-to-day operations. Backup capability is available through a Very High Frequency (VHF) radio system.

Agencies will ensure that interoperability (access to the same radio frequencies) with neighboring mutual aid responders is accessible at all times - i.e., in addition to the normal everyday operations on the 800 MHz radio system.

All EMS Providers will ensure they have access to the Medical Resource Hospital (MRH) radio frequency when working.

All Ambulances will have access to the Hospital Emergency Access Radio (HEAR) system.

All EMS personnel will have access to the VHF disaster interoperability frequencies as directed by the EMS Program.

Non-Emergency providers are required to ensure at a minimum HEAR and MRH interoperability with emergency providers for the coordination of activities in the event of a disaster within the County.

Receiving Hospital Availability

The availability of hospitals to receive ambulance patients is communicated on a computer link network HOSCAP (formerly CHORAL). This system displays a number of hospital status conditions that may result in the diversion of ambulances. Receiving hospitals are required to use the HOSCAP system if they wish to divert ambulances from their hospital.

(D) Emergency Medical Dispatcher (EMD) Training

All Emergency Medical Dispatchers (EMDs) at both BOEC and at the ambulance companies are trained to meet Emergency Medical Dispatcher standards set forth by the State Board on Public Safety Standards and Training (BPSST). The EMS Medical Director is responsible for the medical protocols used by these dispatchers and for the medical supervision of their performance and may set forth additional requirements.

7. PROVIDER SELECTION AND EVALUATION

(a) Initial Assignment

AMBULANCE PROVIDER

The Board of County Commissioners delegates responsibility for assuring appropriate Emergency Medical Services in the County to the County Health Department EMS Program Office. The County will contract for services it deems necessary for the efficient and effective provision of EMS, including a single contracted provider for ambulance transport of 9-1-1 medical call patients.

The contracted provider of emergency ambulance services is chosen through a competitive bid process (Request for Proposals - RFP). The RFP is developed with the assistance of an independent consultant retained by the County. All aspects of the RFP and evaluation process will be carried out in a manner consistent with County purchasing rules and procedures. Evaluation of submitted proposals will be carried out by an independent

panel, appointed by the County Health Officer in consultation with the EMS Medical Director. All contracts require the approval of the Board of County Commissioners.

Any proposal submitted by a public or private potential ambulance provider must disclose the full cost of the services requested in the RFP. These include, but are not limited to, materials, labor, administration, employee benefits, retirement, disability funding, capital expenses, public relations, property and malpractice liability reserves, and other applicable operating expenses. Costs must be submitted in the format required by the RFP process.

The RFP will require disclosure of any history of conviction or pending claims regarding unfair employment practices, involvement with Medicare fraud, violations of the Americans with Disabilities Act, antitrust activities, or violations of any other federal, state, or local civil or criminal laws or administrative rules. This information may be considered in making a decision regarding the recipient of the contract.

First Response

The County will enter into intergovernmental agreements with all fire departments and districts within the County that are interested in providing EMS first response. These agreements may include compensation. Compensation will be contingent upon the agreement by the first responder to use EMS system standards as its target response time. Response times and levels of service will be specified in these agreements.

(b) Reassignment

Should the contracted emergency ambulance provider agency resign its interest in providing ambulance services, or should the County terminate the agreement for service, the County will exercise the “fail-safe” provisions of the contract and other contingencies that allow for the continuation of ambulance service while a replacement provider is selected. A replacement provider will be chosen through a competitive bid process (Request for Proposals - RFP).

At the end of the term of the initial contract, or at the end of each contract extension or renewal, the Board may exercise its option of renewing the contract or seeking a replacement Provider.

(c) Application for ASA

Applications from prospective ambulance providers will be accepted according to the provisions of the RFP process. These provisions will include specific qualifications for prospective providers.

(d) Notification of Vacating the ASA

A notice of termination by the contracted ambulance provider will be required in accordance with the provisions of the initial contract.

(e) Maintenance of Level of Service

To ensure that emergency ambulance services are not interrupted should the contracted provider vacate its interest in the ASA, the contracted provider will be required to provide a one year notice of its intent to terminate the contract. Penalties for insufficient notice and "fail safe" provisions will be specified in the contract.

Contract Evaluation

The contract for the transporting ambulance services will be for a term of five (5) years, with potential for renewals totaling five years if the provider meets the contract requirements. Renewal is at the option of the Board of County Commissioners. The Board of County Commissioners is not obligated to renew a contract.

Sanctions tied to the performance conditions in the contract and the termination of the contract for cause may be exercised at any time during the contract period. If the financial considerations agreed to by the parties fail to meet the explicit expectations in contract-related documents, the contract may be terminated.

A complete review of the ambulance contract provider's performance will be required before contract renewal. The contract will include the specifics of the review process. This review will include, but not be limited to:

- Adherence to response time requirements.
- Compliance with other performance requirements.
- Meeting workforce goals such as diversity and others outlined on page 18.
- Complaints concerning service.
- Meeting the financial goals of the agreement.
- "Street level" relationships of the contracted provider's staff with others in the system.
- Participation in the quality improvement program and an assessment of the quality of services performed.
- Complaints concerning workforce issues.

8. COUNTY ORDINANCES AND RULES

(See Multnomah County Code Section 21)