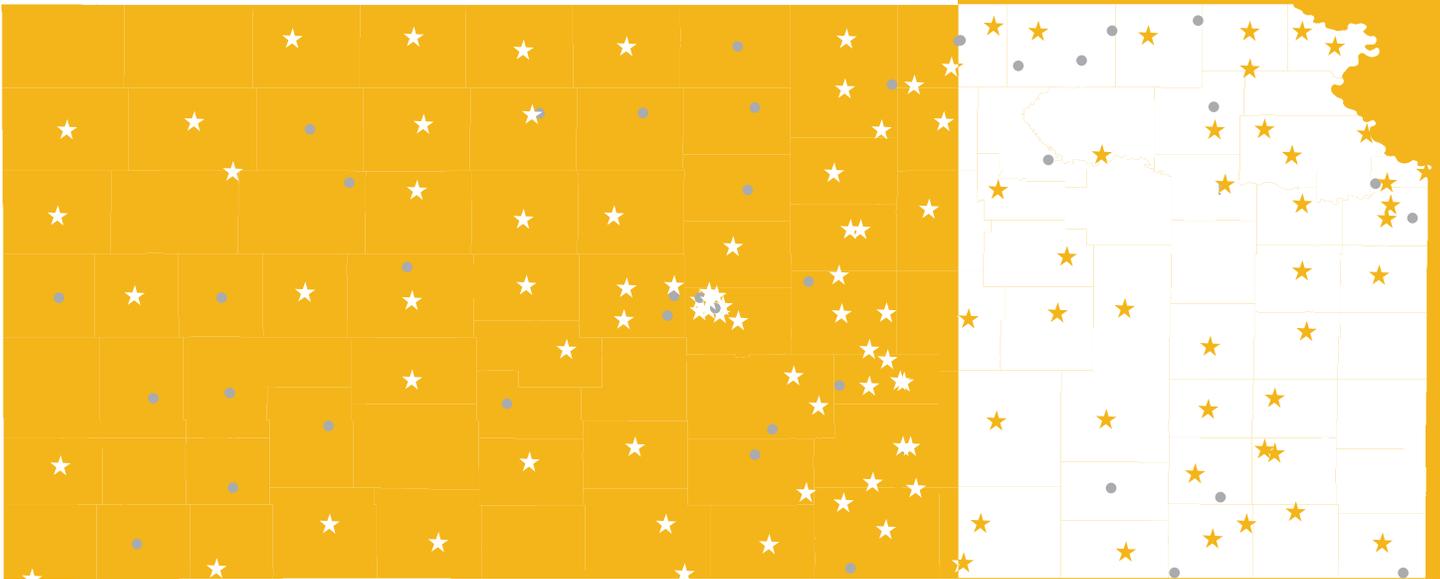


KANSAS AMBULANCE SERVICE ASSESSMENT



Report produced for the



2017

ACKNOWLEDGMENTS

The Wisconsin Office of Rural Health would like to thank the Kansas Department of Health and Environment's Office of Primary Care and Rural Health for the opportunity to collaborate on this important project and for their critical efforts in encouraging EMS agencies to participate; all of the ambulance service directors who completed a survey and contributed to the assessment; and Casey Kalman, GIS Intern, for assistance with numerous report elements.

JULY 2017

Report produced by the Wisconsin Office of Rural Health.



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INTRODUCTION

Emergency Medical Services (EMS) represent the intersection of public safety, public health, and health care systems in Kansas. Ambulance services provide critical services that communities throughout the state depend on. Despite EMS' important role, limited information is available regarding agencies' operational capacity - capacity on which sustainability of the EMS system depends.

The Kansas Ambulance Service Assessment, commissioned by the Kansas Department of Health and Environment's Office of Primary Care and Rural Health (KDHE), was conducted in March 2017. The purpose of the assessment was to determine the operational capacity of ambulance services throughout Kansas so that resources could be strategically targeted.

The assessment involved asking Service Directors to rate their agencies on the "Attributes of a Successful Ambulance Service" - 18 agency-level traits that contribute to providing effective, efficient, quality care. For each of the attributes, the assessment instrument describes five levels of performance, each level building on the previous.

ATTRIBUTES OF A SUCCESSFUL AMBULANCE SERVICE	
	Abbreviation
<u>Staff Support</u>	
A written call schedule	Schedule
Continuing education	Education
A written policy and procedure manual	Manual
Incident response and mental wellness	Incident
<u>Finance</u>	
A sustainable budget	Budget
A professional billing process	Billing
<u>Quality</u>	
Medical Director involvement	Med Dir
A quality improvement/assurance process	QI/A
Contemporary equipment and technology	Equipment
The agency reports data	Data
<u>Public Relations</u>	
A community-based and representative board	Board
Agency attire	Attire
Public information, education, and relations (PIER)	PIER
Involvement in the community	Community
<u>Human Resources</u>	
A recruitment and retention plan	R&R plan
Formal personnel standards	Personnel
An identified EMS operations leader with a succession plan	Leader
A wellness program for staff	Wellness

ABOUT THIS REPORT

The purpose of this report is to provide an overview of the assessment process and results. Supplemental and detailed information about the assessment can be found in the Appendices.

This report includes different types of information that are intended to be helpful to multiple audiences:

Information Type

- Identified needs
- Quantified disparities
- Benchmarks

Audience

- Decision makers looking to strategically target priorities and efforts
- Advocates of EMS working to strengthen the field
- EMS agencies that want to compare their performance to others

Caveats

The information in this report should not be interpreted as claims of causation or correlation. Procedures were put in place to make the assessment as valid and reliable as possible, but this was not formal research, and statistical tests of significance were not conducted on observed differences.

Attributes were organized in the assessment questionnaire and are organized in this report by category (see table on page 1). The order of the attributes is not intended to indicate importance, nor should it be assumed that all attributes are equal in weight or impact.

METHODOLOGY

SURVEY INSTRUMENT

The Attributes of a Successful Ambulance Service were developed by a national group of EMS leaders with input from professional questionnaire methodologists. Eighteen attributes of a successful rural ambulance service were identified and a five-point progressive scale of performance was created for each attribute (Appendix A: Assessment Instrument). The electronic questionnaire was built by WI-ORH in Qualtrics™, an online survey software platform.

SURVEY DISTRIBUTION

One week prior to survey launch, KDHE sent a pre-notice letter to Service Directors of all eligible ambulance services in Kansas. The pre-notice letter explained the purpose of the assessment, how the results would be used, and the email address that would contain the survey link (Appendix B: Pre-Notice Letter). Electronic invitations to participate in the assessment were sent one week after the pre-notice letter and included a unique survey link for each Service Director. An emailed reminder to participate was sent to non-respondents one week later and a second emailed reminder to participate was sent one week after that. In addition, KDHE sent a mailed postcard to non-respondents approximately two weeks after the initial survey invitation (Appendix C: Reminder Postcard).

PARTICIPANT ELIGIBILITY

The original list of ambulance services included 177 agencies, however, after consideration of the applicability of the assessment, air-service agencies and agencies based out-of-state were removed from the list (17 agencies), resulting in a total of 160 eligible agencies.

SURVEY ANALYSIS

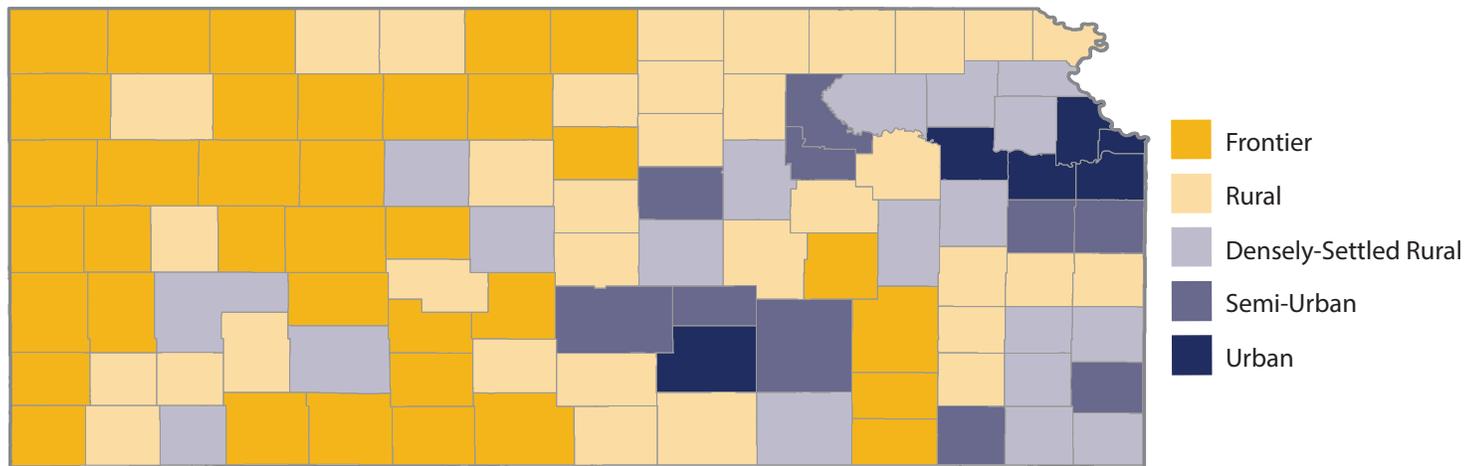
Average Attribute scores were calculated for all agencies (*overall*) and for groups of agencies based on geographic characteristics and agency characteristics.¹ Agency characteristic information was not available for three of the responding services; responses from these services were included in the overall and geographic-characteristic analyses, but were not included in the agency-characteristic analyses.

Geographic Characteristics

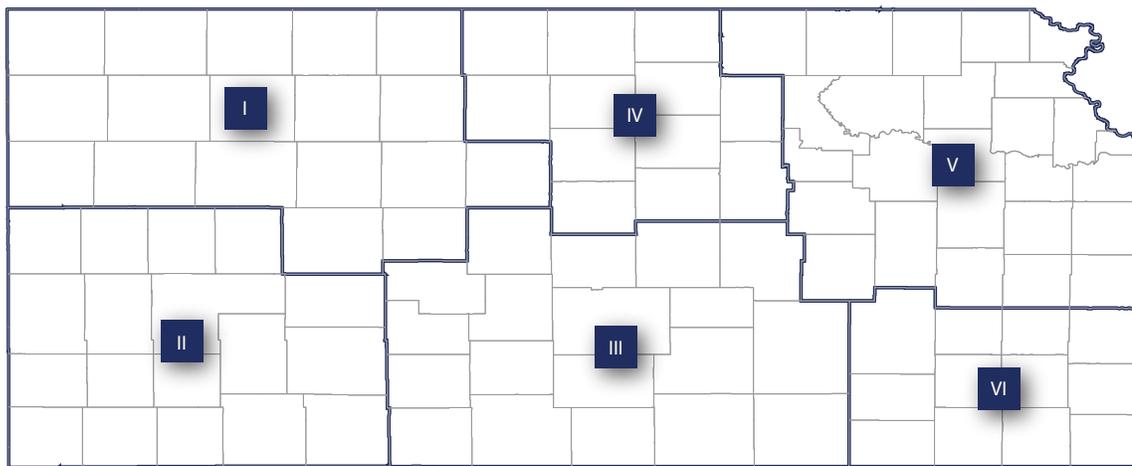
Based on their county locations, ambulance services were assigned a:

<u>Population-Density Peer Group</u> ²	and an	<u>EMS Region</u> ²
▪ Frontier		▪ I
▪ Rural		▪ II
▪ Densely-Populated Rural		▪ III
▪ Semi-Urban		▪ IV
▪ Urban		▪ V
		▪ VI

Population-Density Peer Groups



EMS Regions



Agency Characteristics

Based on data provided by KDHE, ambulance services were grouped by:

*Roster Size - # personnel*², *Roster Size - % volunteer*², and *Operator Type*²

- | | | |
|---------|----------|---------------|
| ▪ 1-15 | ▪ 100% | ▪ City/County |
| ▪ 16-25 | ▪ 50-99% | ▪ Fire |
| ▪ 26-50 | ▪ 1-49% | ▪ Hospital |
| ▪ 51+ | ▪ 0% | ▪ Private |

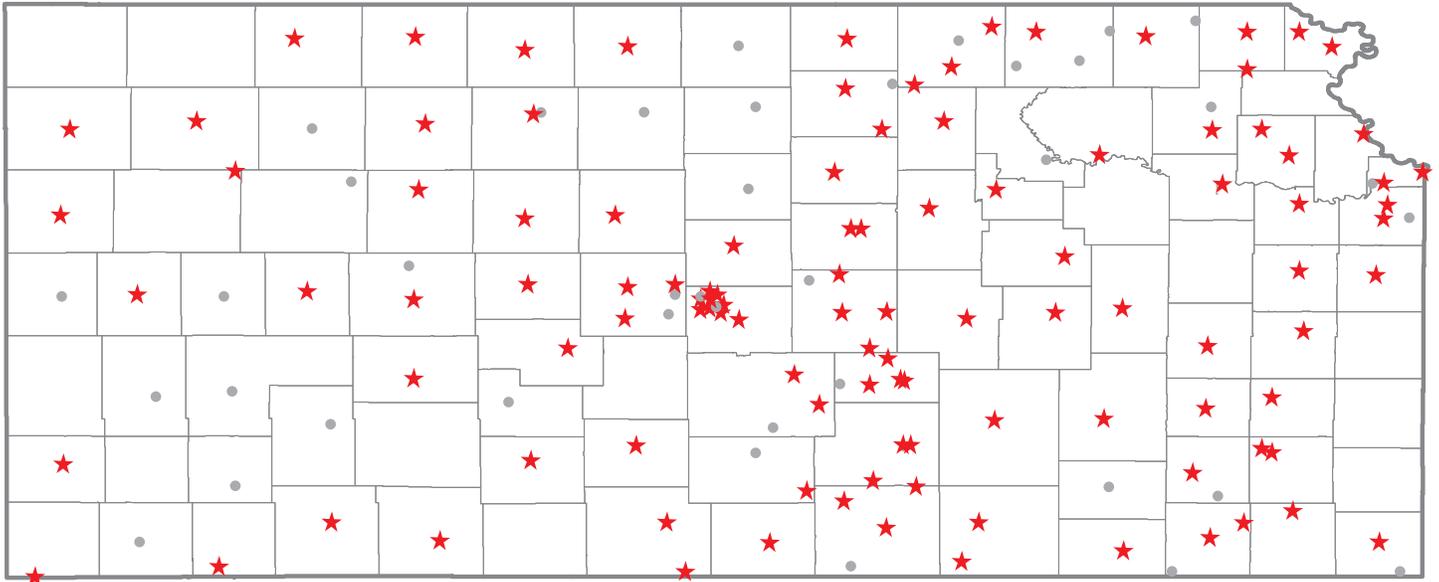
CITATIONS AND NOTES

1. Suppression Rule - When the number of agencies used to calculate average scores is small, those scores tend to have poor reliability. To discourage misinterpretation, average scores are not reported if the number of agencies represented in the score is fewer than ten. When responses were broken down by an agency characteristic and a geographic characteristic, more than half of the average scores were affected by the suppression rule; the decision was made to not include any cross-tabulated agency-and-geographic characteristic scores. See Appendix D for response frequencies.
2. Data provided by KDHE.

RESPONSES

RESPONDENT REPRESENTATIVENESS

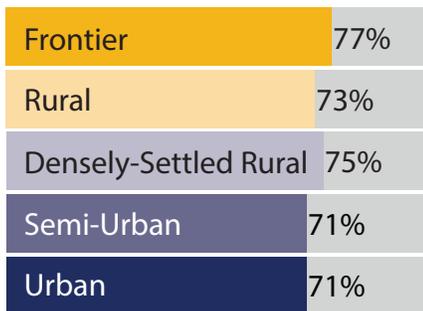
Of the 160 eligible ambulance services in Kansas, responses from 118 (74%) were received and are included in the assessment results. This high response rate allows us to confidently report the results of the assessment as representative of all services in the state, even those that did not complete a survey.



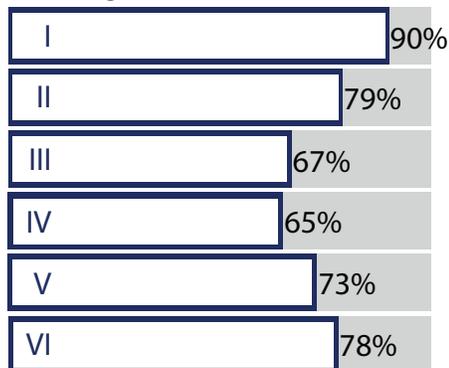
■ Non-responding agencies

Respondent and Non-Respondent Agencies by Geographic Characteristic

Population-Density Peer Groups

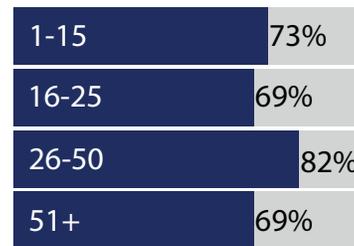


EMS Regions

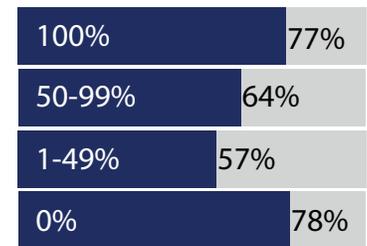


Respondent and Non-Respondent Agencies by Agency Characteristic

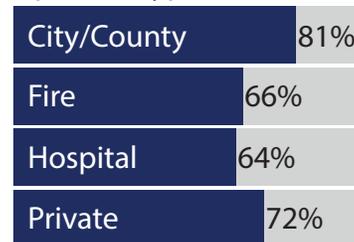
Roster Size - # personnel



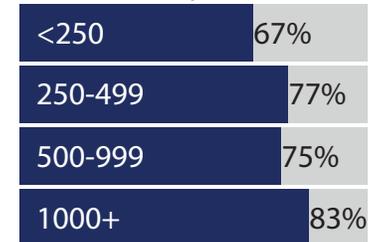
Roster Size - % volunteer



Operator Type

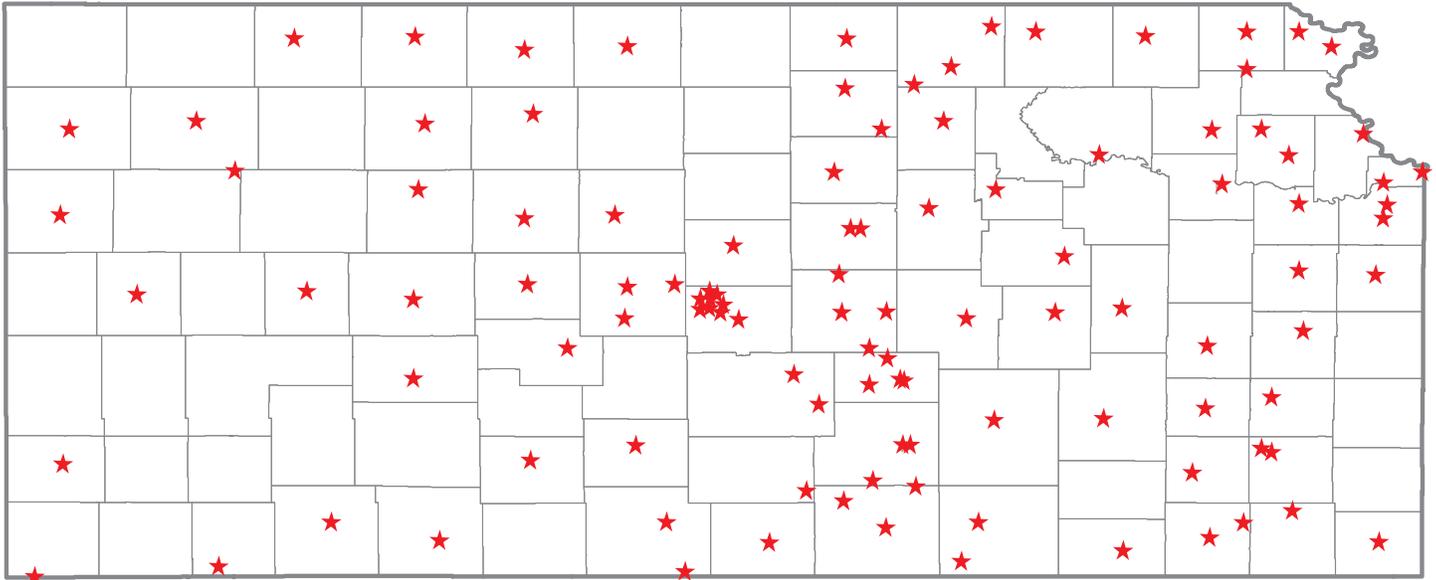


Annual Transports



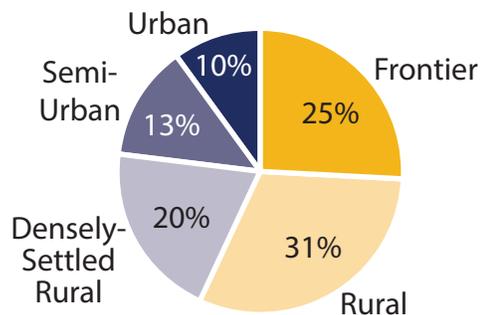
RESPONDENT CHARACTERISTICS

There are 118 ambulance service responses included in the assessment results. The distribution of responses within each characteristic closely aligns with the distribution of agency characteristics throughout the state, another indication that respondent agencies are representative of all Kansas agencies. For example, of all of the agencies in the state, 25% are in Frontier areas; of all of the respondent agencies, 24% are in Frontier areas.



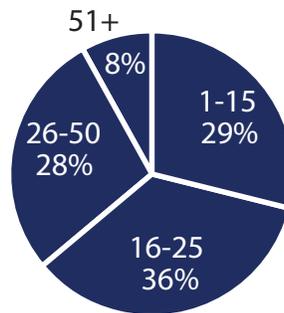
Respondent Agencies by Geographic Characteristic

Population-Density Peer Groups

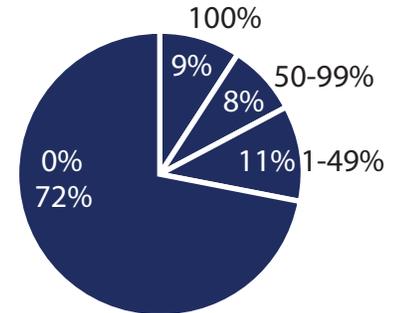


Respondent Agencies by Agency Characteristic

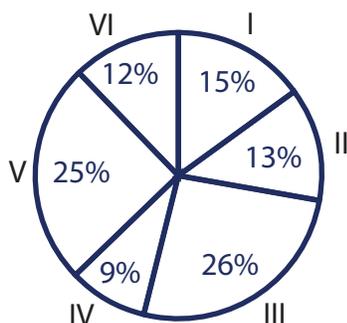
Roster Size - # personnel



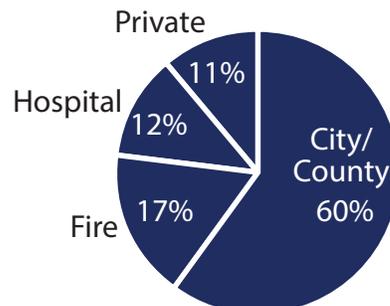
Roster Size - % volunteer



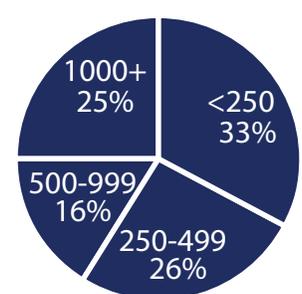
EMS Regions



Operator Type



Annual Transports



RESULTS

The results of the assessment are presented using two types of standards: absolute and relative. Absolute standards set a fixed level of performance against which agencies are compared; relative standards adjust levels of performance depending on the performance of cohort agencies. The results reveal differences and similarities between groups of EMS agencies in Kansas. A summary of these similarities and differences is below; Appendix E includes detailed attribute scores.

RESULTS USING ABSOLUTE STANDARDS

For the purpose of this assessment, agencies with average performance scores at or above 4.5 were classified as “*doing well*”, agencies with average performance scores below 3 were classified as “*struggling*”. Overall, EMS agencies in Kansas are doing well with two of the attributes and struggling with four.*

		Average Score - Overall	
A written call schedule	4.7	<i>doing well</i>	
A professional billing process	4.6		
A written policy and procedure manual	4.2		
A quality improvement/assurance process	4.1		
A sustainable budget	3.8		
Medical Director involvement	3.7		
Continuing education	3.7		
Agency attire	3.7		
The agency reports data	3.5		
Contemporary equipment and technology	3.5		
Incident response and mental wellness	3.2		
An identified EMS operations leader with a succession plan	3.2		
Formal personnel standards	3.1		
Involvement in the community	3.0		
A recruitment and retention plan	2.4	<i>struggling</i>	
A community-based and representative board	2.2		
A wellness program for staff	2.1		
Public information, education, and relations (PEIR)	2.1		

When responses were broken down by characteristic, additional attributes emerged with average scores at or above 4.5 and below 3 (see next page). Agencies with more than 51 personnel scored ≥ 4.5 in five attributes, the most out of all agency groups, and scored below 3 in only one attribute. Agencies with 100% volunteer rosters scored below 3 in 12 of the 18 attributes, indicating a need for improvement overall.

*Comparisons were made using values with two numbers after the decimal point. Values shown in the report are rounded.

Geographic Characteristics

	Population-Based Peer Group					EMS Region						
	F	R	DSR	SU	U	I	II	III	IV	V	VI	
Schedule		Yellow	Yellow	Yellow	Yellow			Yellow	Yellow	Yellow	Yellow	<i>doing well</i>
Billing	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	
Manual			Yellow									
QI/A												
Budget												
Med Dir												
Education												
Attire	Dark Blue				Yellow							
Data												
Equipment												
Incident		Dark Blue										
Leader	Dark Blue	Dark Blue					Dark Blue				Dark Blue	
Personnel	Dark Blue	Dark Blue				Dark Blue	Dark Blue		Dark Blue			
Community	Dark Blue	Dark Blue				Dark Blue	Dark Blue		Dark Blue		Dark Blue	
R&R plan	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	<i>struggling</i>
Board	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	
Wellness	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	
PIER	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	
	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	

F: Frontier R: Rural DSR: Densely-Settled Rural SU: Semi-Urban U: Urban

Agency Characteristics

	Roster Size - # personnel				Roster Size - % volunteer				Operator Type			
	1-15	16-25	26-50	51+	100%	50-99%	1-49%	0%	C	F	H	P
Schedule	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Billing	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Manual				Yellow							Yellow	
QI/A												
Budget					Dark Blue							Dark Blue
Med Dir				Yellow								
Education					Dark Blue							
Attire				Yellow								
Data					Dark Blue							
Equipment	Dark Blue				Dark Blue							
Incident	Dark Blue				Dark Blue							Dark Blue
Leader	Dark Blue				Dark Blue							Dark Blue
Personnel	Dark Blue	Dark Blue			Dark Blue	Dark Blue			Dark Blue			
Community	Dark Blue	Dark Blue			Dark Blue	Dark Blue			Dark Blue	Dark Blue		Dark Blue
R&R plan	Dark Blue	Dark Blue	Dark Blue		Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue
Board	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue
Wellness	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue
PIER	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue

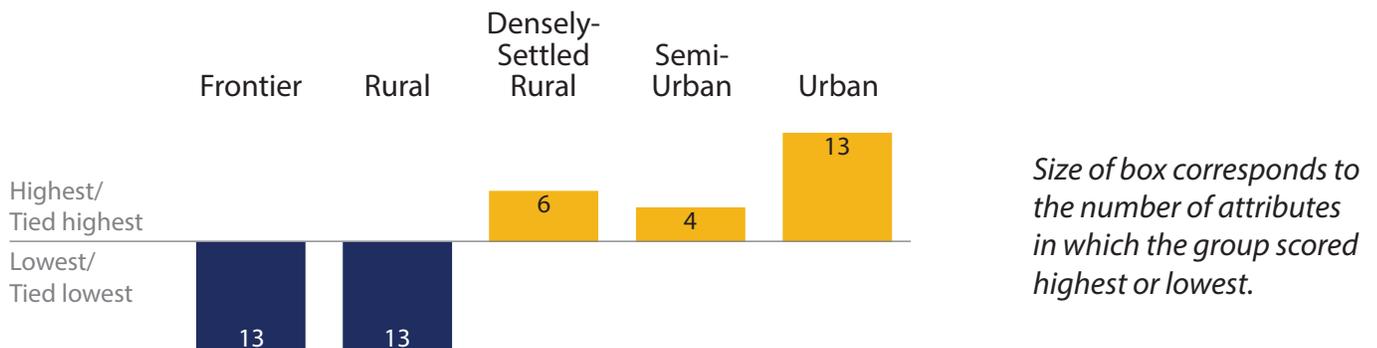
C: City/County F: Fire H: Hospital P: Private

RESULTS USING RELATIVE STANDARDS

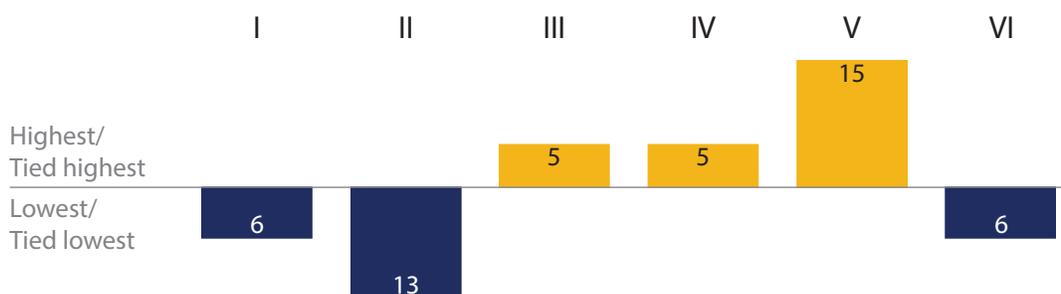
Within each characteristic, average scores were compared between categories. For example, within the Population-Density Peer Group characteristic, scores were compared between agencies in frontier areas and agencies in rural areas, rural and semi-urban, densely-settled rural and urban, and every other possible combination. For the purpose of this assessment, differences equal to or greater than 0.5 were considered a “large difference”. Large differences indicate disparities between groups and which groups might have the greatest needs. Groups with the most extreme results are highlighted below, see Appendix E for detailed information by attribute.

Geographic Characteristics

- Population-Density Peer Groups** - Agencies in frontier and rural areas scored lowest or tied for lowest in 13 attributes each; combined, these two groups scored lowest or tied for lowest in all 18 attributes. Large differences were observed between agencies in frontier/rural areas and agencies in urban areas (11 attributes), agencies in semi-urban areas (8 attributes), and agencies in densely-settled rural areas (9 attributes). Agencies in urban areas scored highest or tied for highest and with a score ≥ 0.5 higher than other groups in 13 attributes.

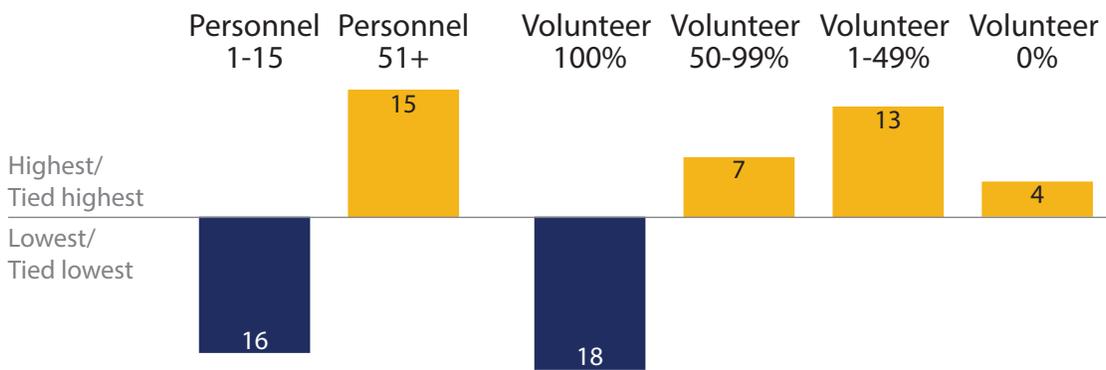


- EMS Regions** - Agencies in Region II scored lowest or tied for lowest in 13 attributes; 11 of those scores differed from other regional scores by ≥ 0.5 . Conversely, Region V scored highest or tied for highest in 15 attributes; 11 of those scores differed by ≥ 0.5 .

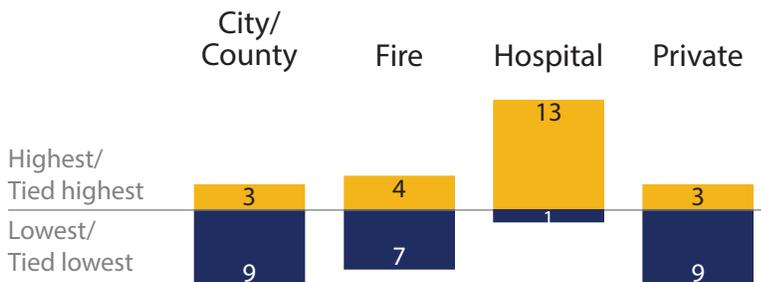


Agency Characteristics

- Roster Size- # personnel** - Agencies with 1-15 licensed personnel scored lowest or tied for lowest in 16 attribute with 15 of those scores differing by ≥ 0.5 . Agencies with 51+ licensed personnel scored highest or tied for highest in 15 attributes, all of those scores differing by ≥ 0.5 . Although agencies with 26-50 licensed personnel scored highest or tied for highest in only two attributes, they scored ≥ 0.5 higher than other groups in 11 attributes indicating there may be a relationship between roster size and agency attributes.
- Roster Size - % volunteer** - Agencies with 100% volunteer rosters scored lowest or tied for lowest in all 18 attributes; agencies with 1-49% volunteer rosters scored highest or tied for highest in 13 attributes. Large differences were observed between agencies with 0% volunteer rosters and other groups in 11 attributes; between agencies with 1-49% volunteer rosters and other groups in 13 attributes; and between agencies with 1-49% volunteer rosters and other groups in 12 attributes.



- Operator Type** - Unlike the other characteristics, highest and lowest scores were shared among groups. Large differences were observed in 11 of the 13 attributes in which hospital-based services scored highest or tied for highest. City/County-based agencies scored lowest or tied for lowest in 9 attributes; 8 of those scores differing by ≥ 0.5 . Private services scored lowest or tied for lowest in 7 attributes and scored ≥ 0.5 lower than other groups in 8 attributes.



CONCLUSIONS

EMS agencies in Kansas provide a necessary and valuable service to its communities. This assessment reveals that the operational capacity needed to provide this service varies across the state geographically and within groups of services with difference characteristics.

GREATEST NEED

The results of the assessment indicate the need for improvement in many attributes and these attributes differ, depending on the characteristics of agencies. Overall, attributes in which services throughout the state struggle include:

- A recruitment and retention plan
- A community-based and representative board
- A wellness program for staff
- Public information, education, and relations (PIER)

Groups of services that perform lowest on the attributes most frequently and severely include:

- Agencies with 100% volunteer rosters
- Agencies with rosters of 1-15 licensed personnel
- Agencies located in Frontier and Rural counties
- Agencies located in EMS Region II (which is largely frontier and rural)
- Agencies that are City/County- or Privately-operated

PARTICIPANT FEEDBACK

At the end of the survey, participants were invited to share their thoughts on what contributes to the success of an EMS agency. Although only a few participants took advantage of the opportunity, the comments were rich with ideas about success and areas of concern. A full list of comments can be found in Appendix F.

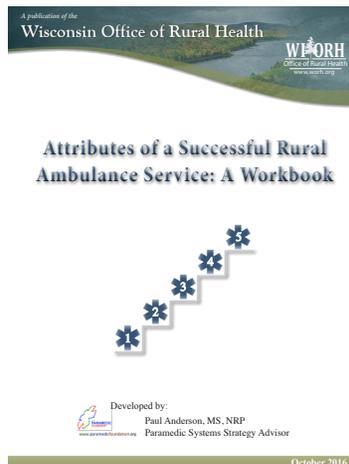
- "A successful EMS agency is about the attendants, their caring nature, their dedication, and their willingness to serve. We are a volunteer agency with only 2 full-time employees. I serve with the best. They give their all for very little pay, giving up family time in their busy lives to serve their community."
- "[A successful service] must have an established and communicated Mission, Vision and performance values. Community engagement from top level positions is key to success. Although EMS agencies need to meet regulatory standards, their focus must be on the local community needs. They must perform in a manner that allows them to build a service that they want taking care of their own family and friends."
- "My department is within a hospital, and having structured leadership that allows and empowers me to perform my job as an EMS Director is crucial. Having a viable and adequate budget is also key."
- "Ultimately it is about the employee, salary, benefits, workplace culture, employee input into equipment purchases as well as protocol development. The City of Salina and Salina Fire Department have invested many dollars into employee development, promotion guidelines, and detailed documentation of what the employee needs to do to be successful. All of these items had employee

input to gain employee buy in. We truly feel that the administrative staff and middle management (Captains, Medical Officers, etc) are leaders, not just managers.”

IMPLICATIONS

The identification of needs is inherently a call to action and this assessment is no exception. From state-level and regional perspectives, the assessment results can be used for prioritizing efforts, strategic program planning, and advocating for additional resources to improve EMS operational capacity. The results of the assessment point to not only intervention content, but also to a need for interventions that are local and customized to meet the needs of services with specific characteristics.

Individual services can also use the assessment in a variety of ways. Services can use the assessment results to compare their own scores to services that share similar characteristics or to Kansas EMS as a whole and set targets for improvement. The assessment instrument (Appendix A) lays out performance goals and benchmarks through the five-point scales. A toolkit has been developed that provides step-by-step guidance for moving from the lowest level of performance to the highest level of performance for each of the attributes. The [toolkit](#) is available for free from the Wisconsin Office of Rural Health.



APPENDICES

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APPENDIX A - SURVEY INSTRUMENT



Kansas Ambulance Service Assessment

Thank you for taking the time to complete this assessment. The information collected will be used to identify the needs of EMS agencies throughout the state and to target support and funding.

If you have questions about this assessment or how the information will be used, please contact Sara Roberts, Director of the Kansas Office of Primary Care and Rural Health, at ruralhealth@ks.gov.

The assessment should take approximately 15 minutes to complete. If you need to complete the assessment in more than one sitting:

1. Close the survey window to pause your progress.
2. Re-enter the survey by clicking on the survey link in the email invitation, using the same computer and the same internet browser.

Page Break

Please select the name of the EMS agency for which you serve as the Service Director.

This information will only be used to determine survey response rates and will not be included in the final results.

Display this question if "Other" is selected:

What is the name of the EMS agency for which you serve as the Service Director?

A national group of EMS providers and advocates have identified 18 attributes of a successful EMS agency. For the purpose of this assessment, each of those attributes has been described in 5 ways. Please read each description and then select the one that most closely matches [agency name].

OPERATIONS ATTRIBUTES

A Written Call Schedule

1. Non-existent. Pager goes off and anyone available responds.
2. Informal, ad-hoc agreement exists between 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.

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 (internally or externally).
4. Continuing education based on quality improvement and/or quality assurance findings is offered (internally or externally).
5. Continuing education based on quality improvement and/or quality assurance findings, with Medical Director and/or hospital input, and taught by a subject-matter expert is offered (internally or externally).

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.

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 trained 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 #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.

FINANCE ATTRIBUTES

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 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 six months is in the bank and the reserve has been in place for at least one year.

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.

QUALITY ATTRIBUTES

Medical Director Involvement

1. There is a medical director in name only. He/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/her. When asked, he/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.

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 of the EMS agency.
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); and (3) reduce the cost of health care services (e.g., reducing EMS costs, and/or utilizing EMS to reduce overall healthcare costs).

Contemporary Equipment and Technology

1. The EMS agency has only the minimum equipment/technology required by licensure. The budget does not allow additional equipment/technology acquisition.
2. The EMS agency has the minimum equipment/technology required by licensure, plus a minimal budget for additional equipment/technology acquisition.
3. In addition to the minimum equipment/technology required by licensure, 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 required by licensure, 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 required by licensure, 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.

The Agency Reports Data

1. No operational/clinical data are submitted to regulators.
2. Operational/clinical data are submitted to regulators, but not often within the designated timelines (locally, statewide, or nationally).
3. Operational/clinical data are submitted to regulators within the designated timelines.
4. Operational/clinical data are submitted to regulators 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 regulators 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

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 ONLY some combination of elected officials, hospital leadership/staff, and/or governmental administrators.
5. Voting board members include all of #4 AND at least one engaged patient representative.

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.

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.

Involvement in the Community

1. 911 emergency calls and inter-facility transports are responded to but no public education courses are offered.
2. Occasional basic public education courses, like CPR/AED and First Aid training, are offered.
3. Frequent basic public education courses, like 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.

HUMAN RESOURCE ATTRIBUTES

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.

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 #4 plus there is a process to resolve personnel issues.

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/she has not had any leadership training.
2. There is an identified EMS Operations Leader with some leadership training, but he/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.

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 #2 AND occasional educational programming regarding healthy lifestyles is offered, and there is policy support for healthy food options at meetings.
4. All of #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 like tobacco cessation.

Before you submit your assessment, please feel free to share anything else you would like us to know about attributes of a successful EMS agency.

APPENDIX B - PRE-NOTICE LETTER

Subject: Kansas Ambulance Service Assessment
Date: Wednesday, March 1, 2017 at 4:16:07 PM Central Standard Time
From: KDHE RuralHealth
To: House, Joe [BEMS]
CC: Sara Roberts
Attachments: image002.png, image004.jpg



March 1, 2017

Dear Emergency Medical Service Directors,

The Kansas Office of Rural Health and the Kansas Board of Emergency Medical Services are collaborating to perform a sweeping “snapshot” of EMS in Kansas.

We are interested in hearing from you! The information collected will be used to identify needs of EMS agencies throughout the state and to target support and funding. In addition to reporting aggregated statewide and regional numbers, we intend to provide each EMS agency with an individual summary report of the assessment results and helpful resources.

Next week, you will receive a link to the electronic survey from pblack@qualtrics-survey.com. If you are unable to find the email, please check your ‘junk’ and ‘spam’ folders. The survey should take approximately 15 minutes to complete.

It is our sincere hope that you participate in the survey and provide accurate information to make the results as useful as possible.

If you have any questions about this assessment or how the information will be used, please contact Sara Roberts, Director of the Kansas Office of Primary Care and Rural Health, at ruralhealth@ks.gov.

Thank you for your time and consideration.

Sincerely,

Office of Primary Care and Rural Health



APPENDIX C - REMINDER POSTCARD

Dear Emergency Medical Service Director,



Last week, we sent you an email with a link to our electronic survey, the Kansas Ambulance Service Assessment.

If you have already completed this survey, thank you, and please disregard this memo. If not, please complete the survey today. Your participation will help us and the Kansas Board of Emergency Medical Services accurately assess the needs of EMS agencies in your region.

If you did not receive an email, it was misplaced, or you have questions about the assessment, please contact Ashley Wallace at 785-296-5751 or ruralhealth@ks.gov.

Sincerely,

Office of Primary Care and Rural Health



APPENDIX D - RESPONSE FREQUENCIES

Responses by Population-Density Peer Groups

	Overall	Frontier	Rural	Densely-Settled Rural	Semi-Urban	Urban
EMS Region						
I	18	13	4	1	0	0
II	15	8	4	3	0	0
III	31	4	9	7	7	4
IV	11	2	6	1	2	0
V	29	1	11	6	3	7
VI	14	2	3	6	3	0
Roster Size - # personnel						
1-15	33	11	17	7	7	3
16-25	41	23	19	13	3	1
26-50	32	5	11	11	8	4
51+	9	0	2	0	3	8
Roster Size - % volunteer						
100%	10	1	6	0	2	1
50-99%	9	4	2	1	0	2
1-49%	13	2	2	2	4	3
0%	83	23	26	20	9	5
Operator Type						
City/County	69	24	27	7	6	5
Fire	19	1	2	7	5	4
Hospital	14	3	5	4	2	0
Private	13	2	2	5	2	2

Responses by EMS Region

	I	II	III	IV	V	VI
Population-Density Peer Groups						
Frontier	13	8	4	2	1	2
Rural	4	4	9	6	11	3
Densely-Settled Rural	1	3	7	1	6	6
Semi-Urban	0	0	7	2	3	3
Urban	0	0	4	0	7	0
Roster Size - # personnel						
1-15	3	5	14	4	13	6
16-25	11	10	16	9	7	6
26-50	5	4	12	3	9	6
51+	1	0	2	1	9	0
Roster Size - % volunteer						
100%	0	1	4	2	3	0
50-99%	5	0	3	0	1	0
1-49%	0	2	4	0	4	3
0%	13	12	19	9	19	11
Operator Type						
City/County	16	12	16	9	13	3
Fire	0	2	7	1	5	4
Hospital	1	1	4	0	5	3
Private	1	0	3	1	4	4

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APPENDIX E - PERFORMANCE BY ATTRIBUTE

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A written policy and procedure manual	31
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A WRITTEN CALL SCHEDULE

A written call schedule promotes stability and enables the agency to measure its staffing needs. Many other parameters of a successful agency hinge on staffing - which depends on a well-structured call schedule.

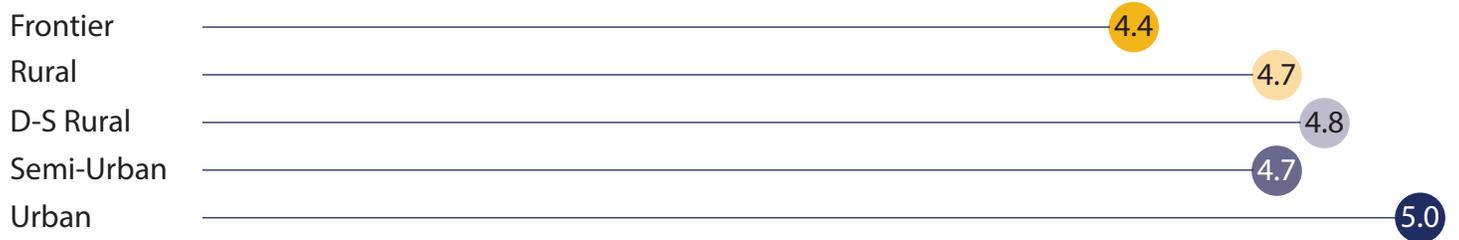
PERFORMANCE LEVELS

1. Non-existent. Pager goes off and anyone available responds.
2. Informal, ad-hoc agreement exists between 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.

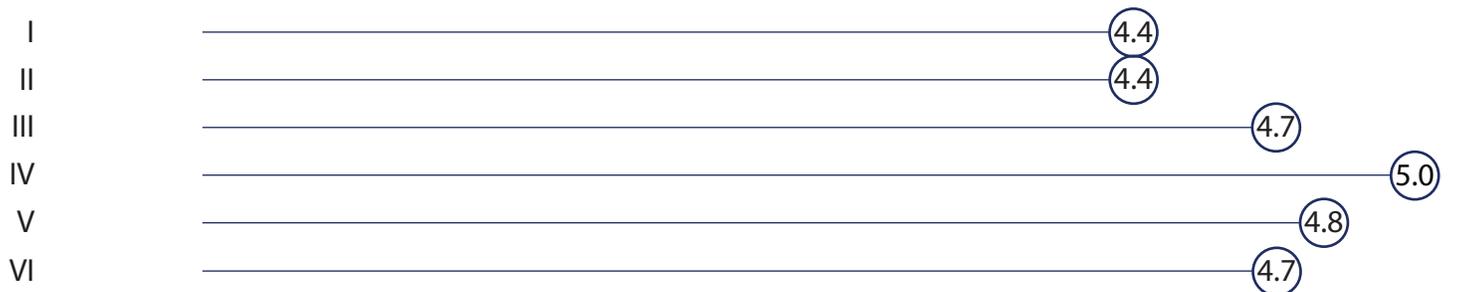


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

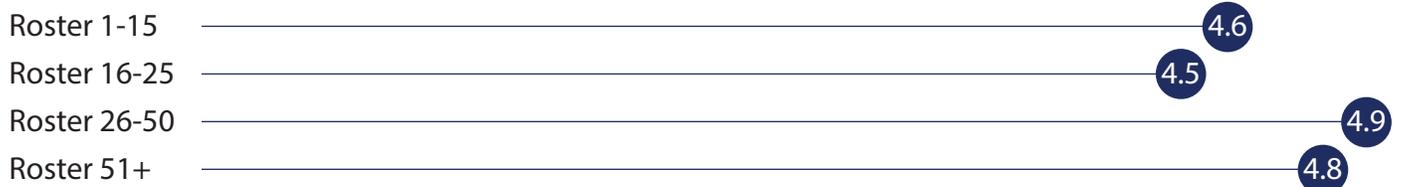


EMS Regions

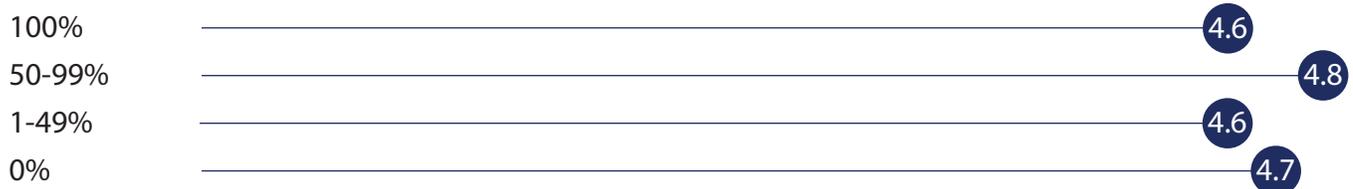


AVERAGE SCORE BY AGENCY CHARACTERISTIC

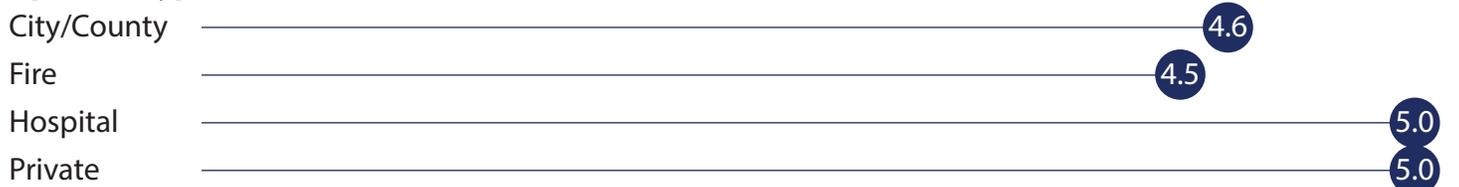
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

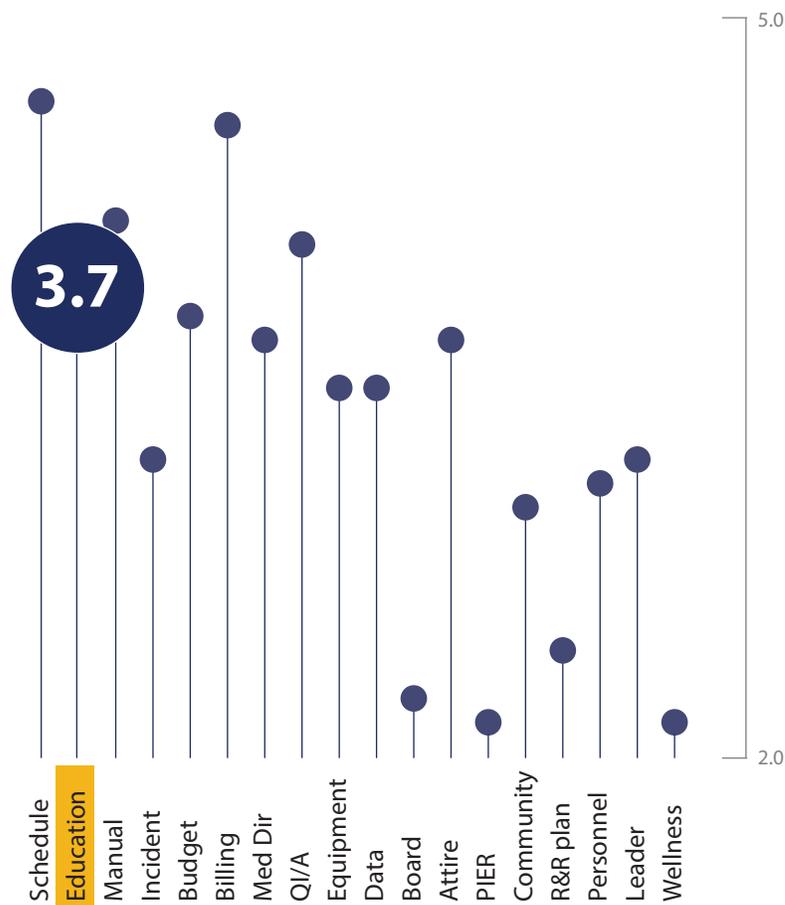
CONTINUING EDUCATION

Continued education of staff and volunteers helps the agency to improve and solidify the care they provide to their patients. Agency involvement in continuing education helps maintain a strong connection to the concepts and practices being taught and can improve coordinated care by the agency.

PERFORMANCE LEVELS

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 (internally or externally).
4. Continuing education based on quality improvement and/or quality assurance findings is offered (internally or externally).
5. Continuing education based on quality improvement and/or quality assurance findings, with Medical Director and/or hospital input, and taught by a subject-matter expert is offered (internally or externally).

AVERAGE PERFORMANCE SCORE OVERALL

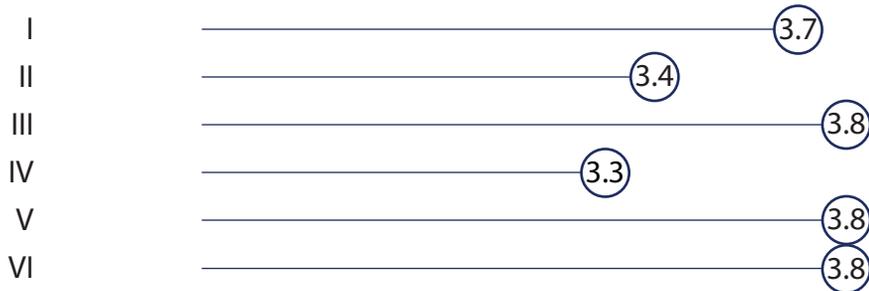


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

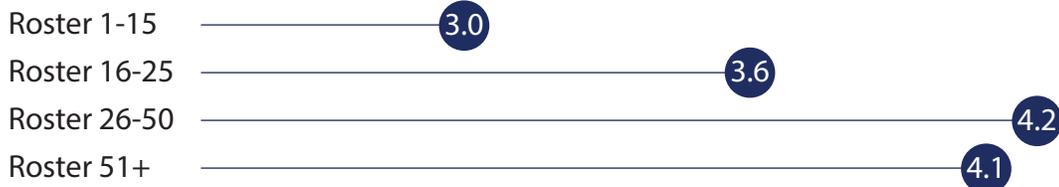


EMS Regions

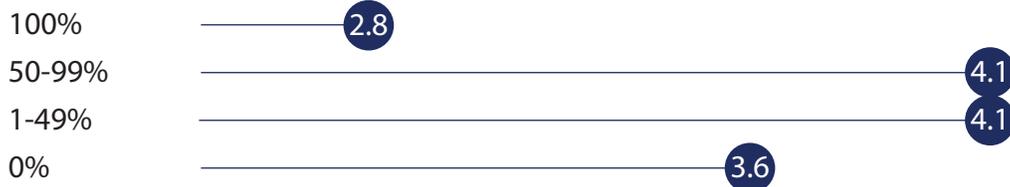


AVERAGE SCORE BY AGENCY CHARACTERISTIC

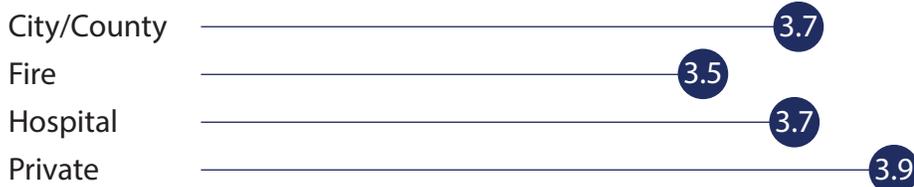
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

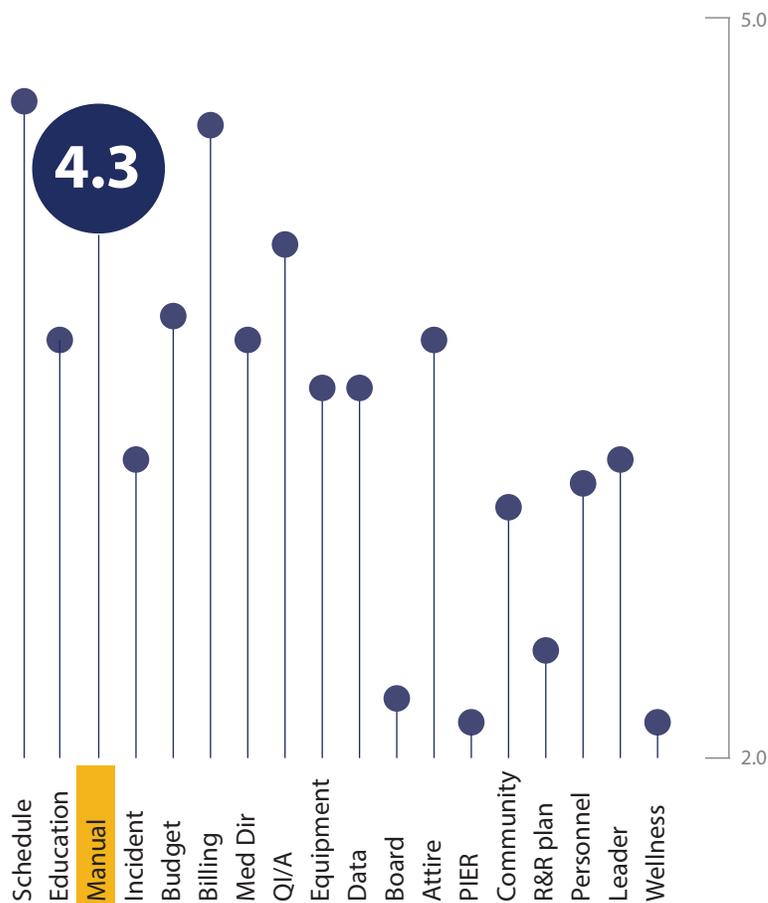
A WRITTEN POLICY AND PROCEDURE MANUAL

Maintaining a written policy and procedure manual helps lay a solid foundation for an agency focused on long-term stability and quality improvement, both maintaining and improving patient care.

PERFORMANCE LEVELS

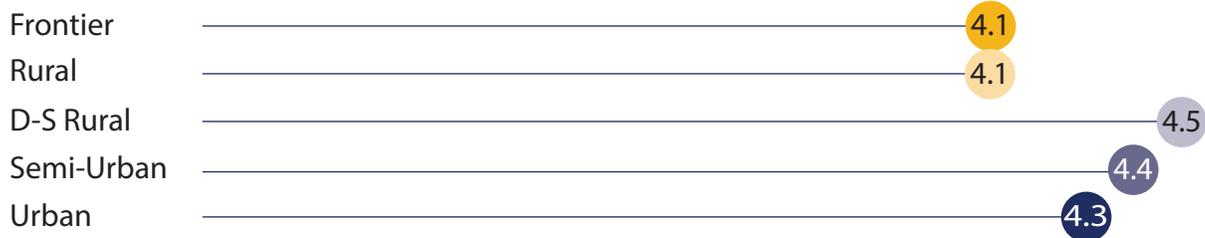
1. There are no documented EMS policies and procedures.
2. There are a few documented EMS policies and procedures, but they are not organized into a formal manual.
3. All EMS policies and procedures are documented in a formal manual but crew members don't refer to/use/update it systematically.
4. All 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 SCORE OVERALL

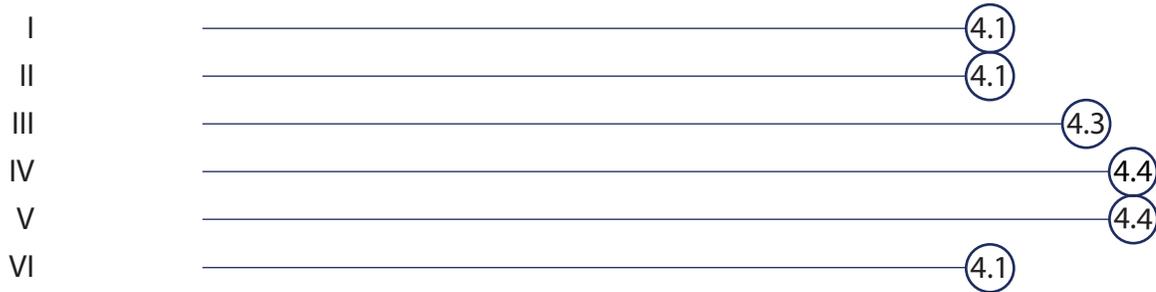


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

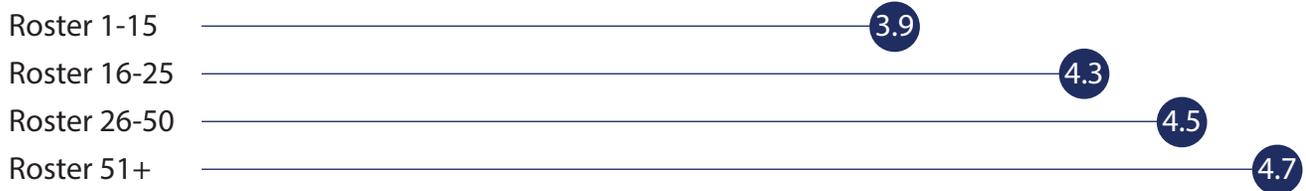


EMS Regions

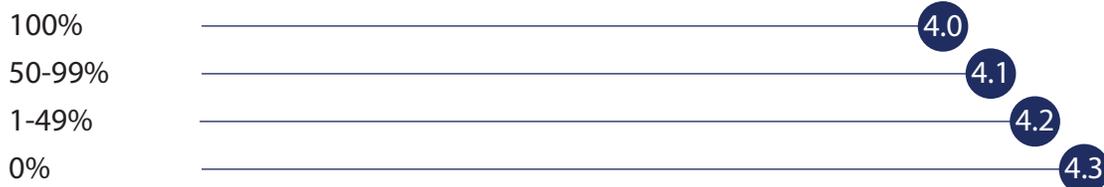


AVERAGE SCORE BY AGENCY CHARACTERISTIC

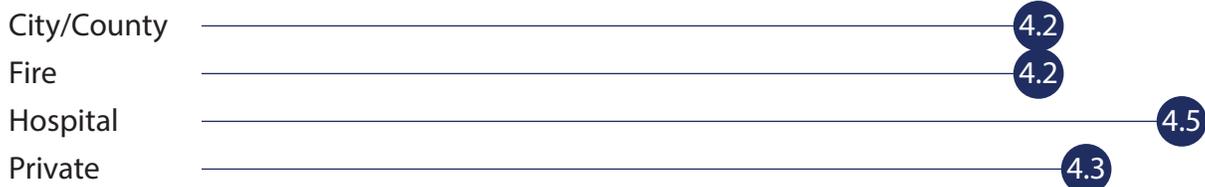
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

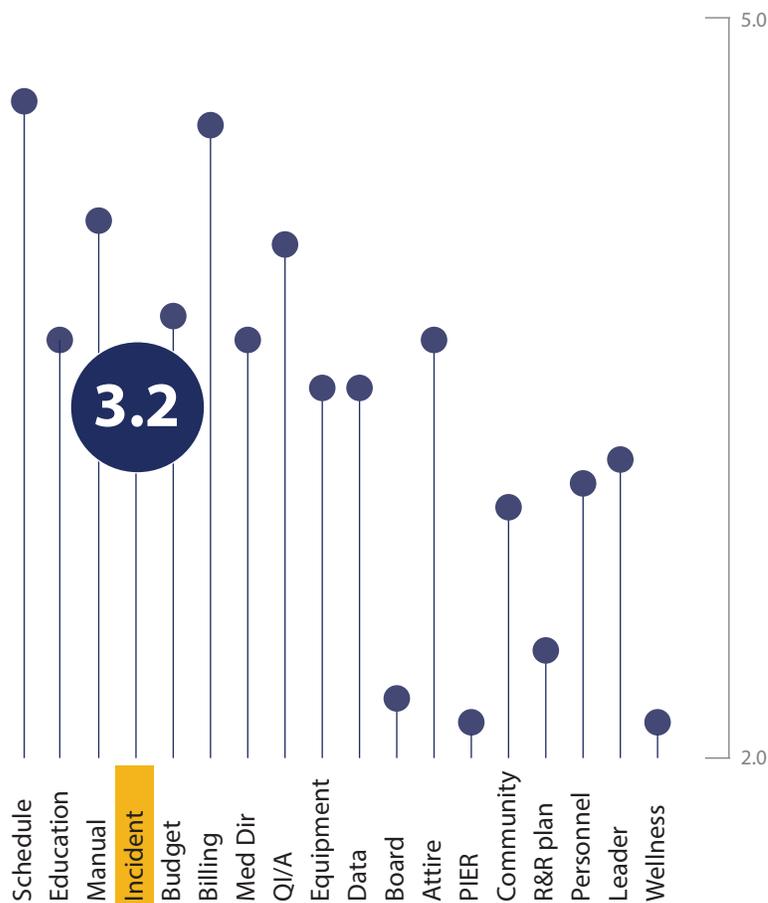
INCIDENT RESPONSE AND MENTAL WELLNESS

A plan for incident response and mental wellness helps the agency reduce the impact of incidents on members through specific actions, plans, and programs. Establishing a common understanding of incident response debriefing among all members ensures members are prepared to support their co-workers when needed.

PERFORMANCE LEVELS

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 trained 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 #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.

AVERAGE PERFORMANCE SCORE OVERALL



AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

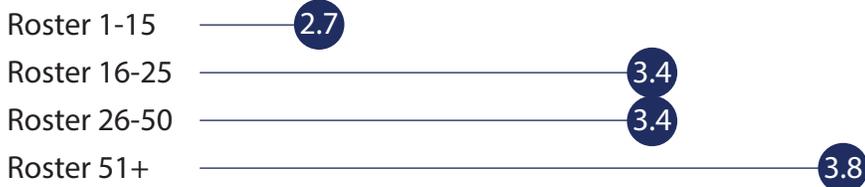


EMS Regions



AVERAGE SCORE BY AGENCY CHARACTERISTIC

Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

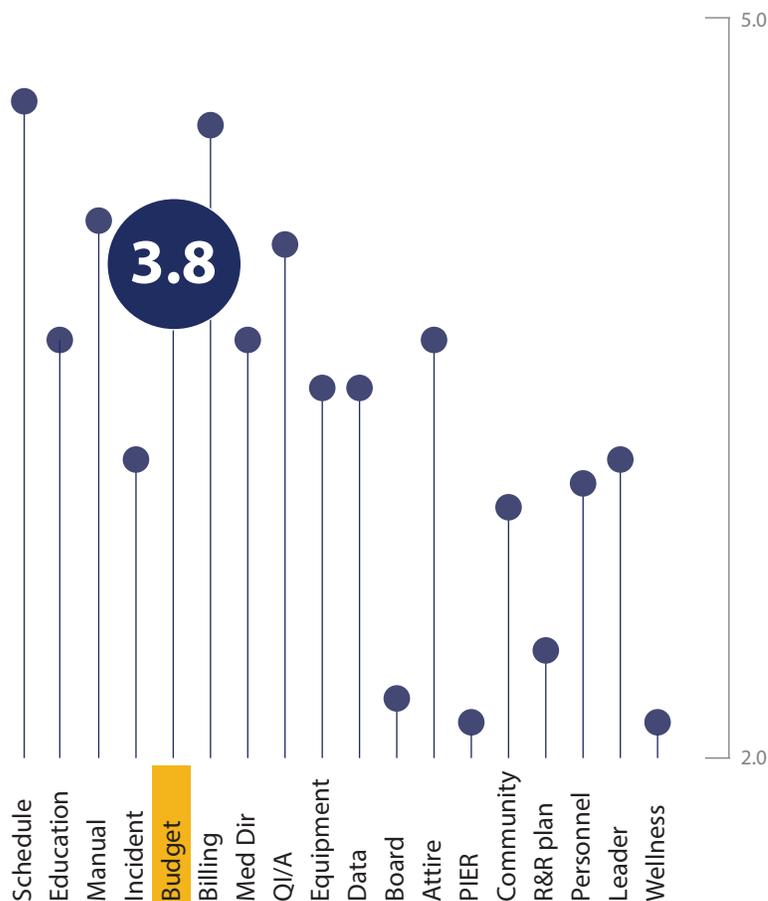
A SUSTAINABLE BUDGET

A written budget and financial policies ensures sustainability by establishing an understanding of available funds. Coupled with written financial policies and guidelines regarding spending decisions, an agency can guarantee funds are being allocated efficiently.

PERFORMANCE LEVELS

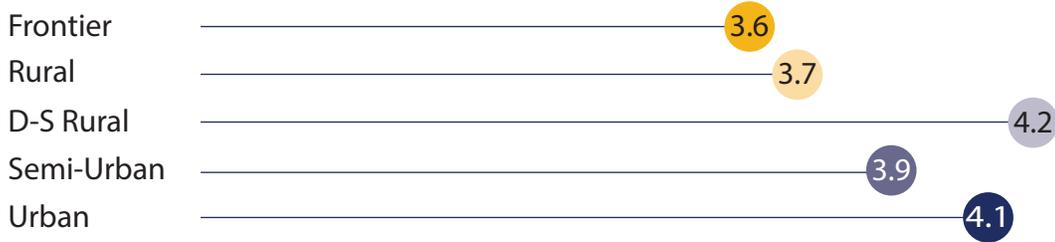
1. There is no written budget.
2. A budget has been developed; however, it is not followed.
3. A budget is in place and financial decisions and actions are based upon it.
4. A budget and policies are in place regarding proper purchasing procedures, purchase limits and authorizations, and procedures for 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 SCORE OVERALL

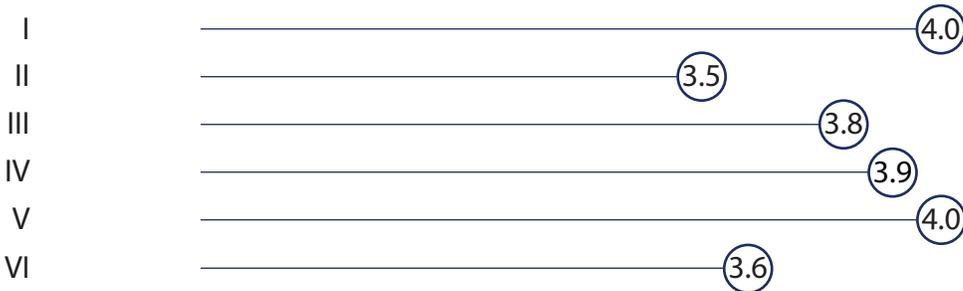


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

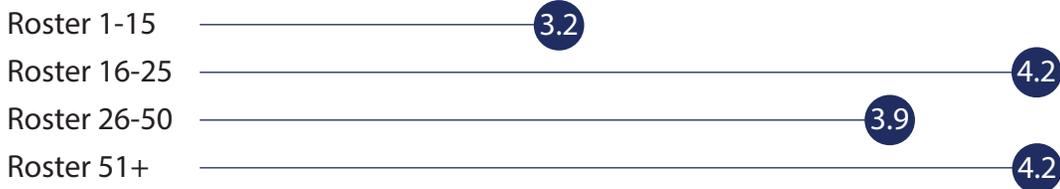


EMS Regions

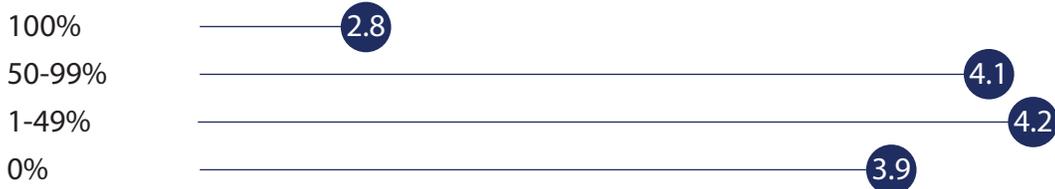


AVERAGE SCORE BY AGENCY CHARACTERISTIC

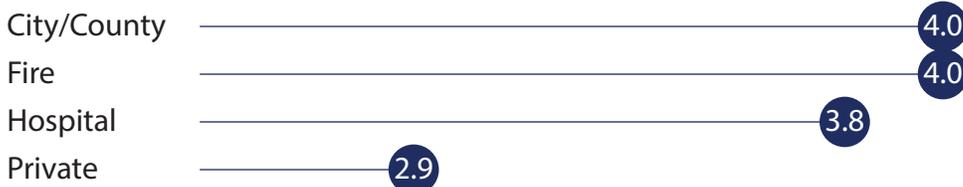
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

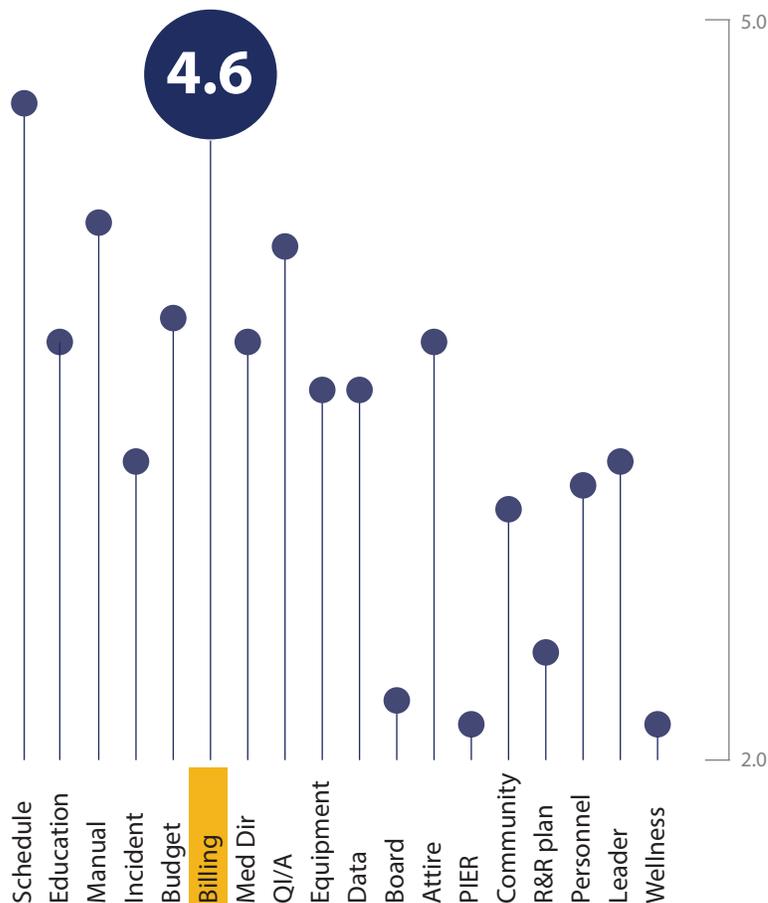
A PROFESSIONAL BILLING PROCESS

Billing for services provided contributes to the foundation needed for the agency to establish and maintain stability. In addition, establishing a professional billing process can help guarantee the billing process meets all requirements and restrictions placed on health care agencies.

PERFORMANCE LEVELS

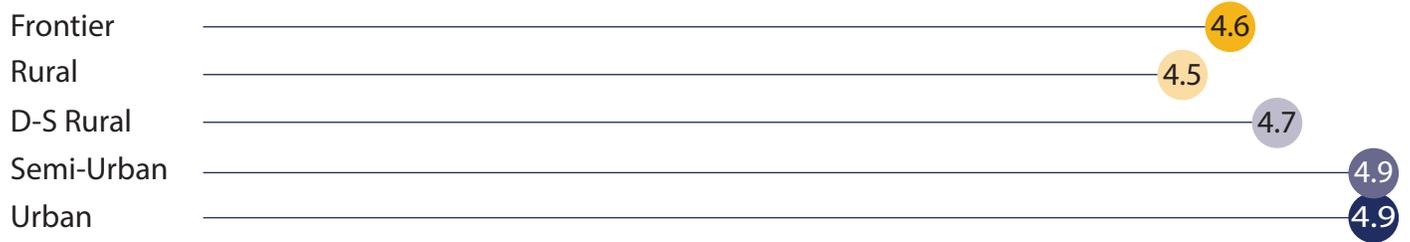
1. Services are not billed.
2. Services are billed, but claims are submitted by an individual (internal or external) with no formal training in healthcare billing.
3. Services are billed, but claims are submitted by an individual (internal or external) with limited training in healthcare billing.
4. 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 SCORE OVERALL

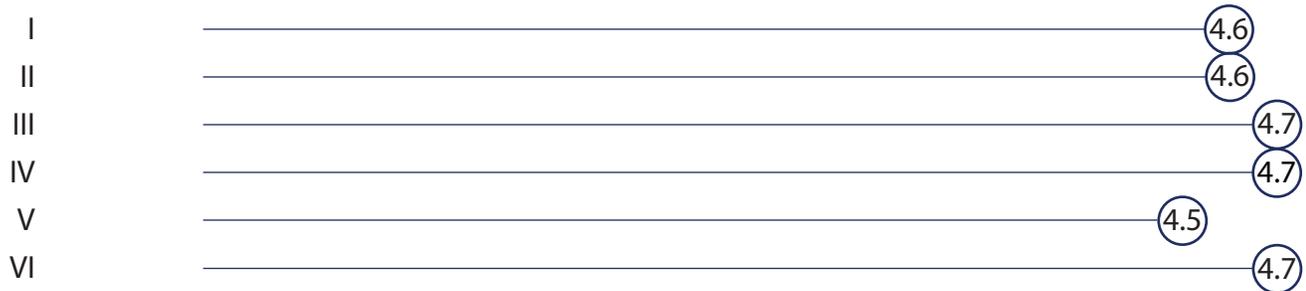


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

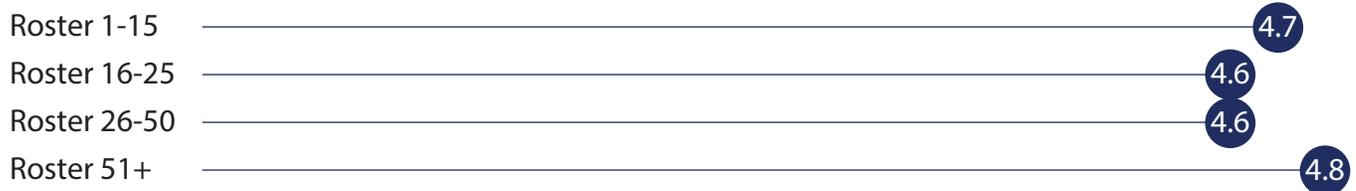


EMS Regions

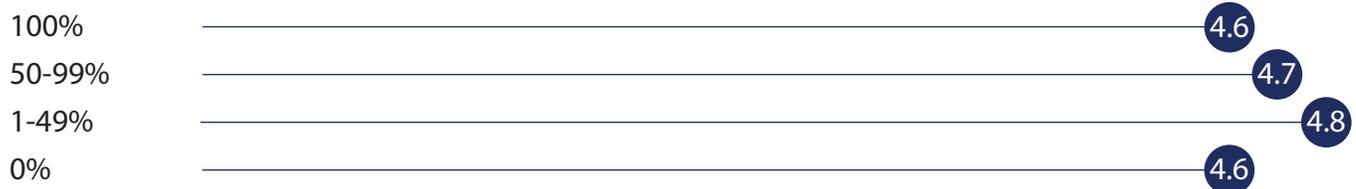


AVERAGE SCORE BY AGENCY CHARACTERISTIC

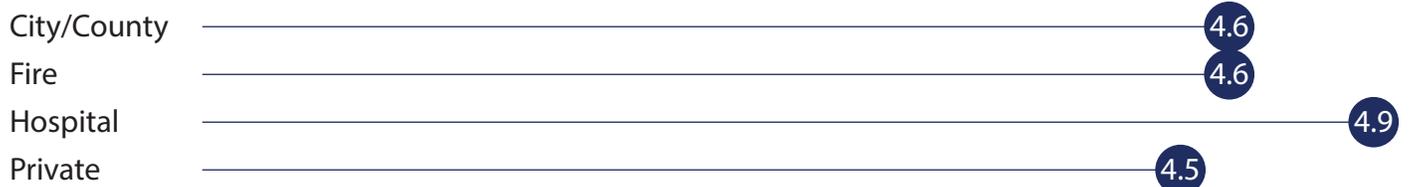
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

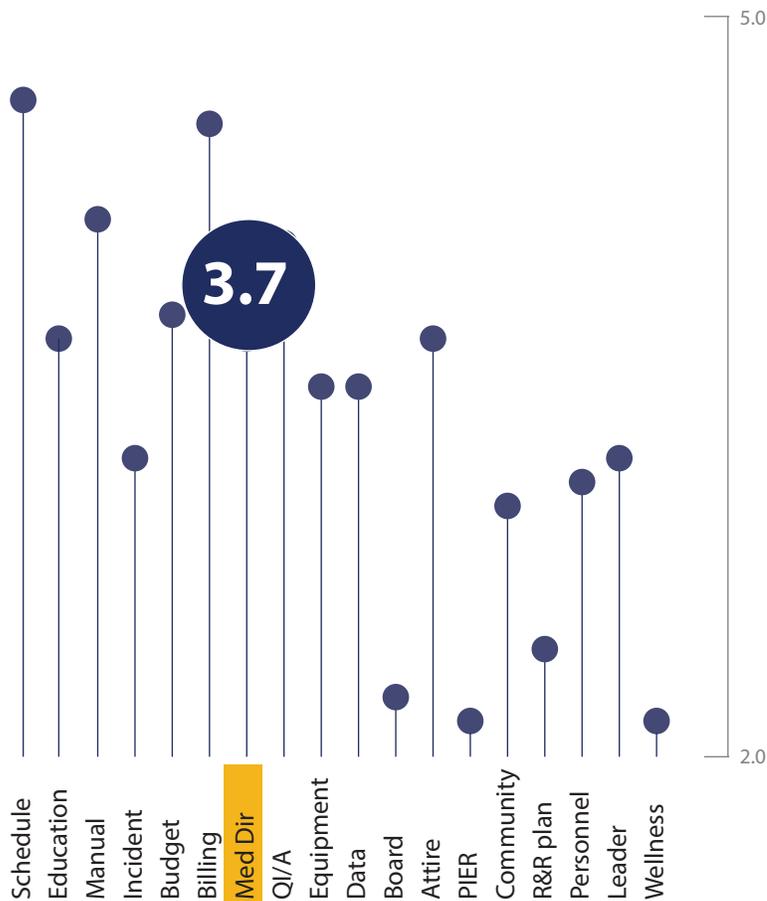
MEDICAL DIRECTOR INVOLVEMENT

An involved medical director can act as an advocate for the agency in multiple arenas while reviewing, understanding, formulating, and recommending patient care improvements and educational standards for agency members.

PERFORMANCE LEVELS

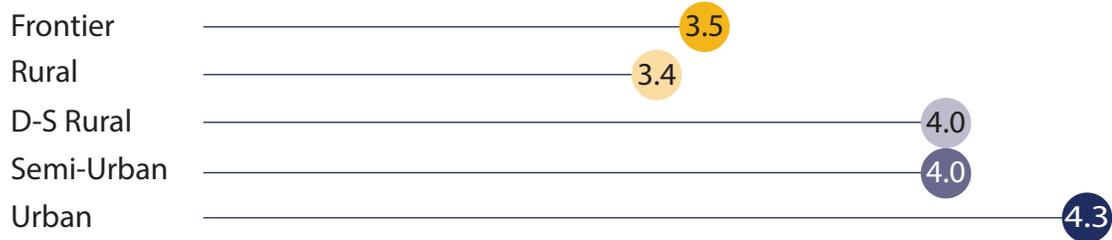
1. There is a medical director in name only. He/she is not actively engaged with the EMS agency beyond signatures.
2. The medical director reviews cases but not within 30 days and provides very little feedback.
3. The medical director reviews cases within 30 days and provides very little feedback.
4. The medical director reviews cases within 30 days and provides a good amount of feedback, but waits for the EMS agency to engage him/her. When asked, he/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 SCORE OVERALL



AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups



EMS Regions



AVERAGE SCORE BY AGENCY CHARACTERISTIC

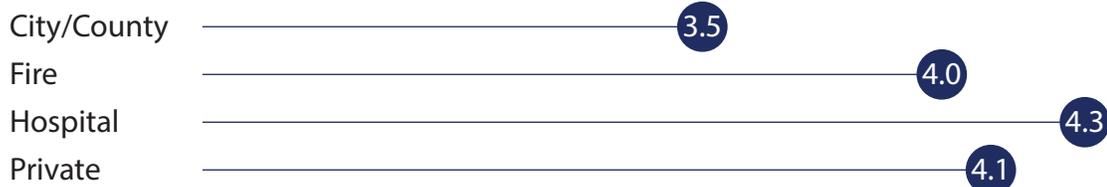
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

A QUALITY IMPROVEMENT/ASSURANCE PROCESS

The EMS agency can directly improve the patient experience by effectively using every avenue of feedback available. The feedback loop provides data the agency can use to measure and monitor performance in areas directly affecting the patient care experience.

PERFORMANCE LEVELS

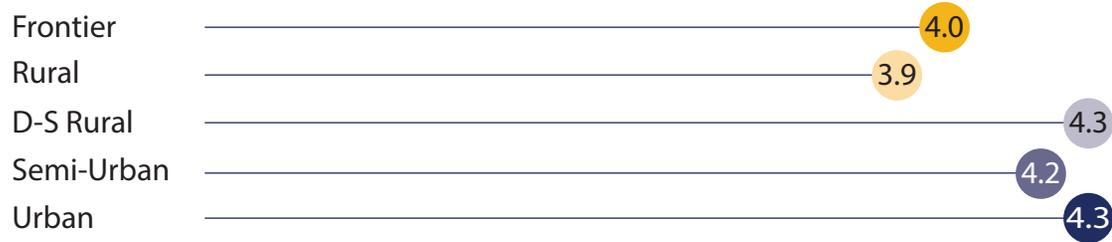
1. There is no plan to collect, analyze, or report EMS agency performance measures.
2. Performance measure data is collected about the EMS agency but not analyzed or reported.
3. Performance measures are analyzed and reported but no feedback loop exists for continual improvement of the EMS agency.
4. 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); and (3) reduce the cost of health care services (e.g., reducing EMS costs, and/or utilizing EMS to reduce overall healthcare costs).

AVERAGE PERFORMANCE SCORE OVERALL

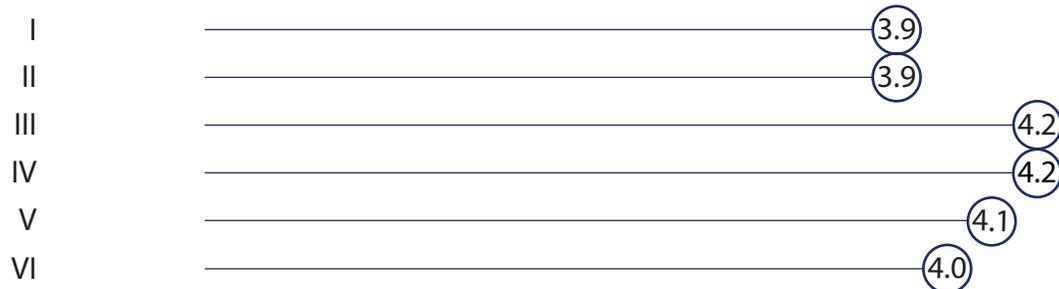


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups



EMS Regions

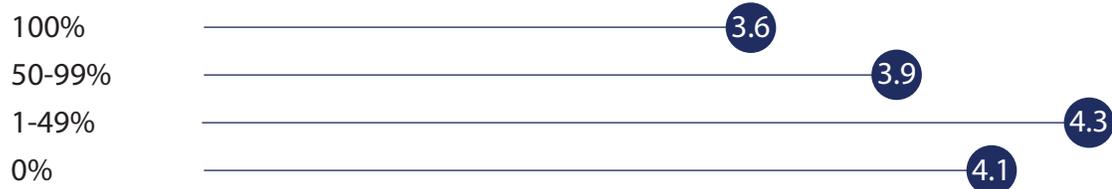


AVERAGE SCORE BY AGENCY CHARACTERISTIC

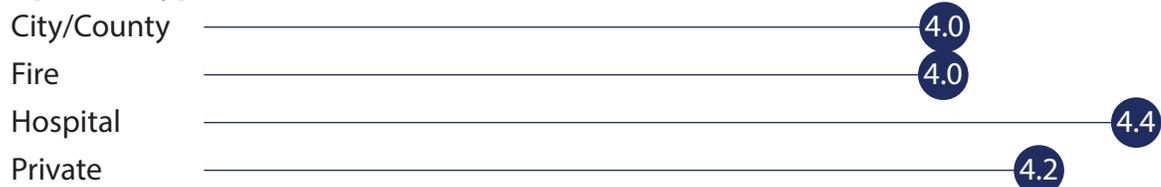
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

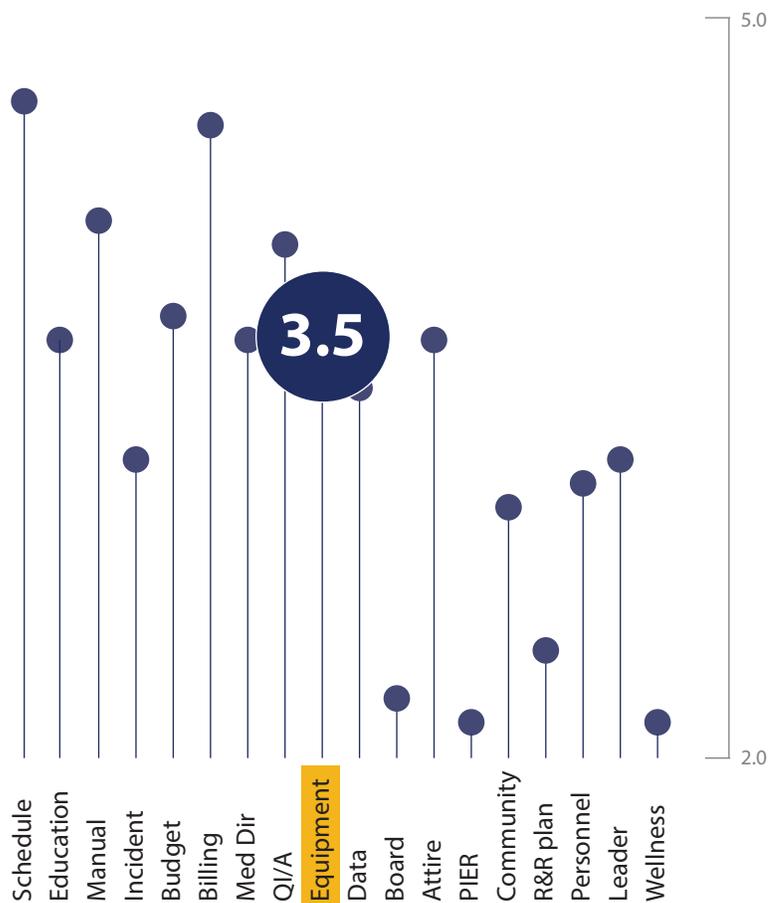
CONTEMPORARY EQUIPMENT AND TECHNOLOGY

Having contemporary and well-maintained equipment and technology can ensure an agency is responsive to the ever-changing needs of the patient.

PERFORMANCE LEVELS

1. The EMS agency has only the minimum equipment/technology required by licensure. The budget does not allow additional equipment/technology acquisition.
2. The EMS agency has the minimum equipment/technology required by licensure, plus a minimal budget for additional equipment/technology acquisition.
3. In addition to the minimum equipment/technology required by licensure, 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 required by licensure, 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 required by licensure, 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 SCORE OVERALL



AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

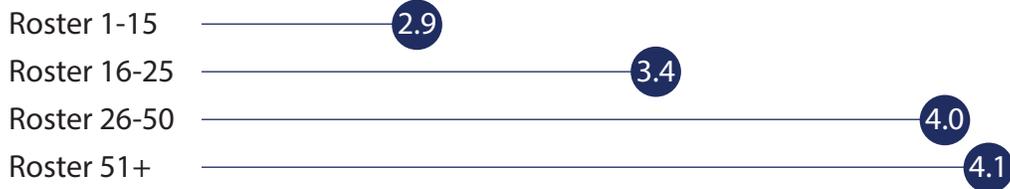


EMS Regions



AVERAGE SCORE BY AGENCY CHARACTERISTIC

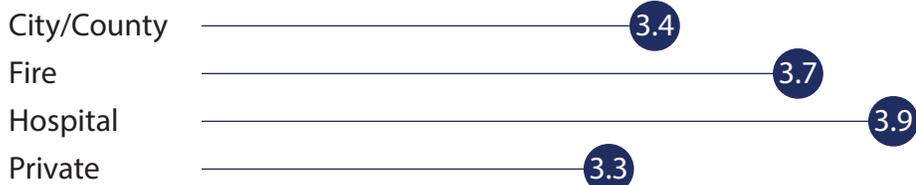
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

THE AGENCY REPORTS DATA

Proper collection and reporting of data, as required by regulators, can lead to improvement of patient care by allowing analysis of larger bodies of data.

PERFORMANCE LEVELS

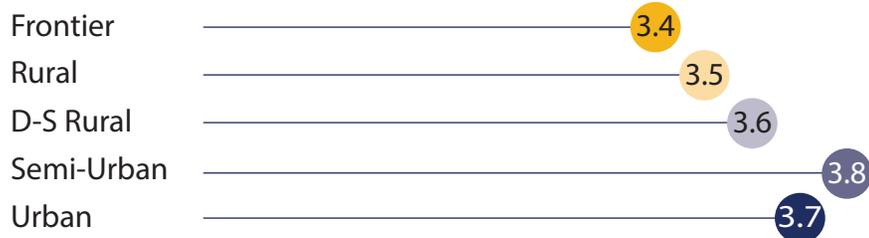
1. No operational/clinical data are submitted to regulators.
2. Operational/clinical data are submitted to regulators, but not often within the designated timelines (locally, statewide, or nationally).
3. Operational/clinical data are submitted to regulators within the designated timelines.
4. Operational/clinical data are submitted to regulators 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 regulators 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 SCORE OVERALL

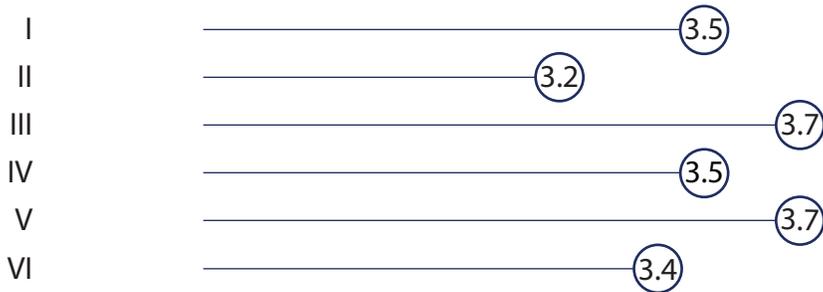


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups



EMS Regions

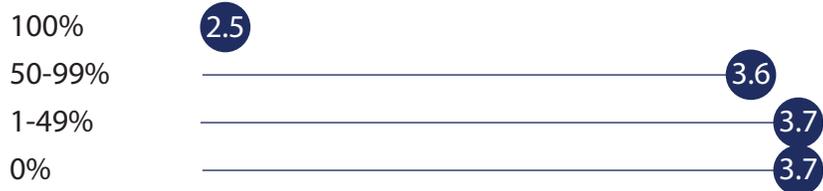


AVERAGE SCORE BY AGENCY CHARACTERISTIC

Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

A COMMUNITY-BASED AND REPRESENTATIVE BOARD

A community-based and representative board allows for accountability to the communities being served, increased transparency and credibility, and increased engagement of the community in improving and sustaining the agency. Most importantly, a community-based board enables key stakeholders to understand, review, provide insights, and effectively make recommendations to improve care.

PERFORMANCE LEVELS

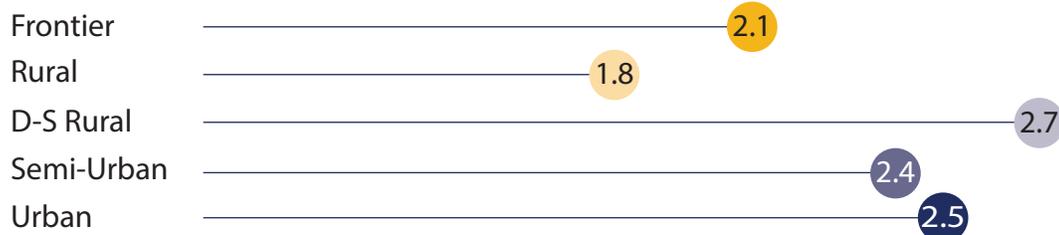
1. There is no formal board oversight.
2. The board consists of internal EMS agency members only.
3. Voting board members are from the EMS agency AND some combination of elected officials, hospital leadership/staff, and/or governmental administrators.
4. Voting board members are ONLY some combination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

AVERAGE PERFORMANCE SCORE OVERALL

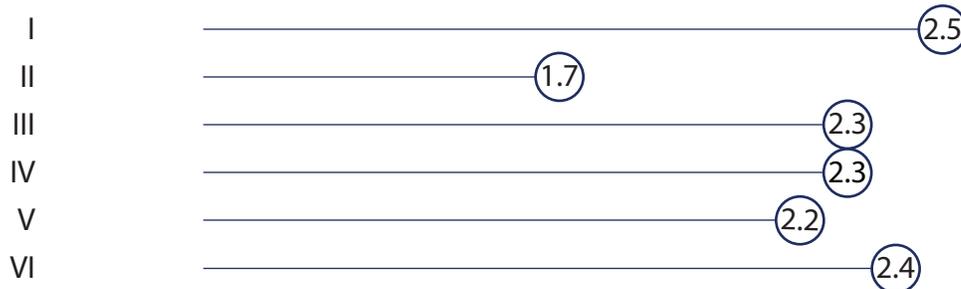


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

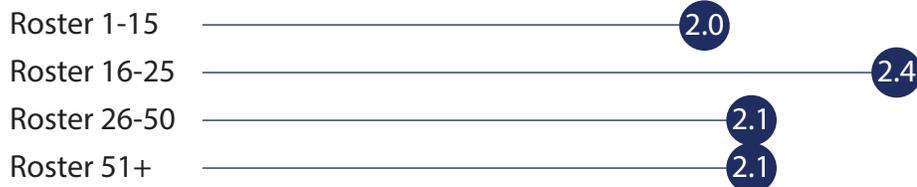


EMS Regions

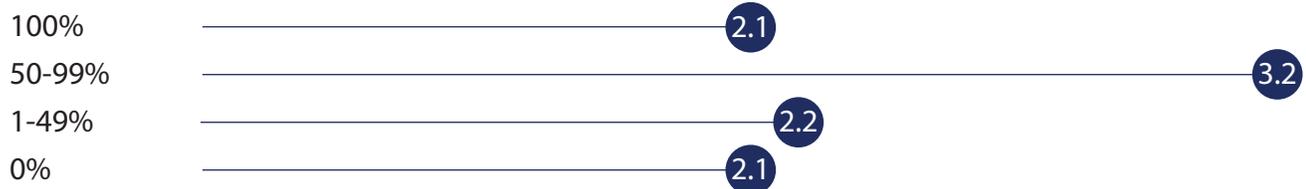


AVERAGE SCORE BY AGENCY CHARACTERISTIC

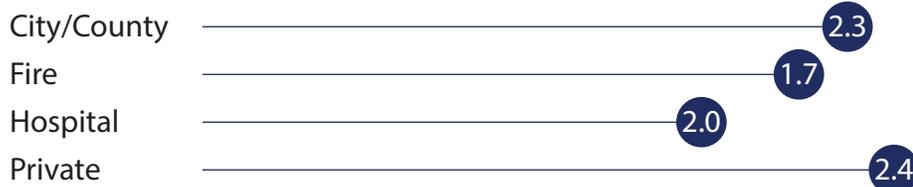
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



1.0 3.5

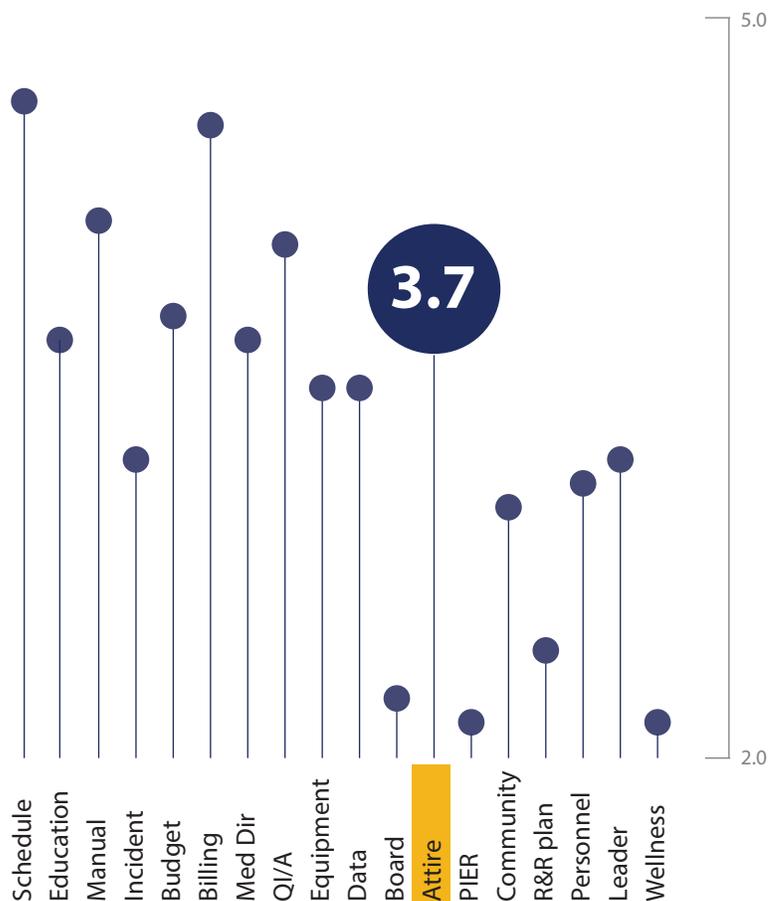
AGENCY ATTIRE

Identifying service attire for agency members helps project a professional image while improving safety in certain situations.

PERFORMANCE LEVELS

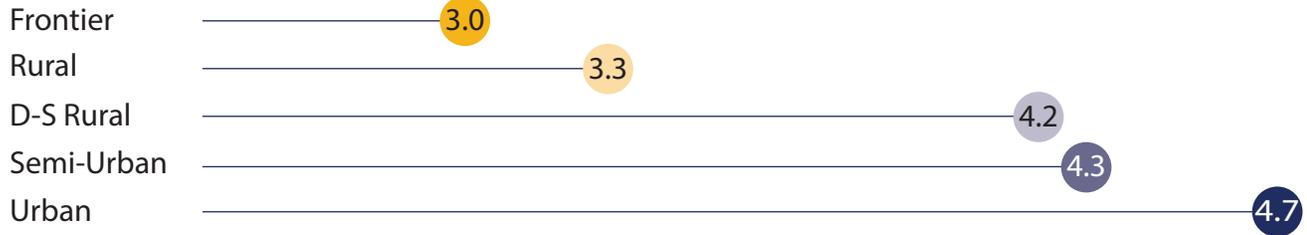
1. There is no identifying EMS agency attire.
2. There is identifying EMS agency attire, but it is not adequately protective.
3. There is identifying EMS agency attire, which is adequately protective, but elements of it are purchased by the members.
4. There is identifying EMS agency attire, which is 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 SCORE OVERALL

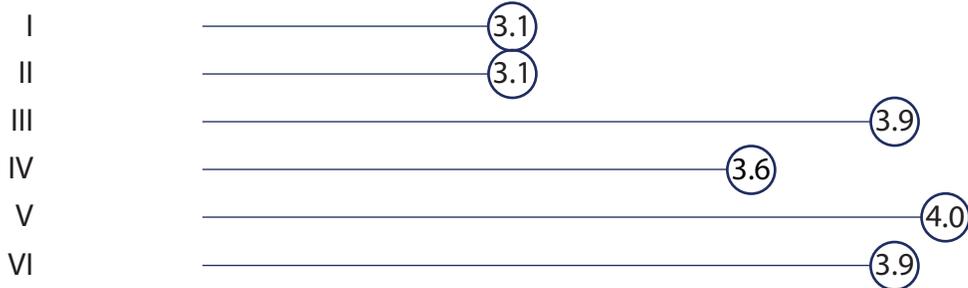


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

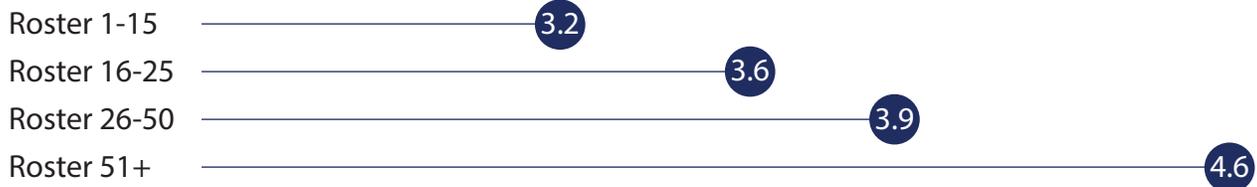


EMS Regions



AVERAGE SCORE BY AGENCY CHARACTERISTIC

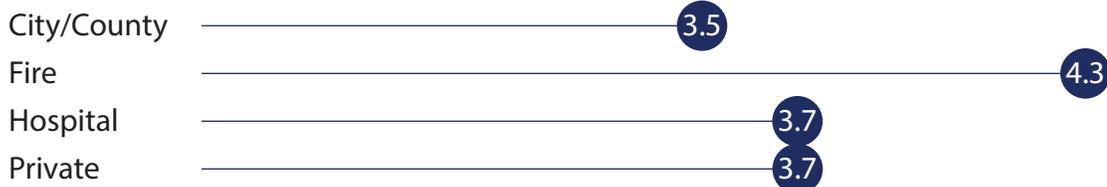
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.5 5.0

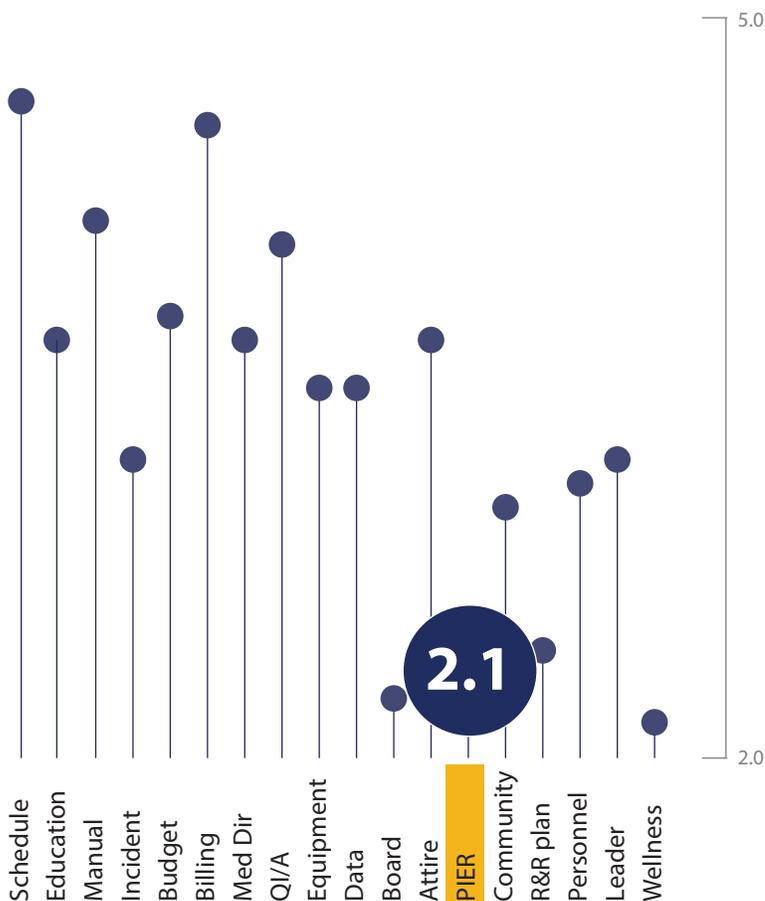
PUBLIC INFORMATION, EDUCATION, AND RELATIONS (PIER)

Establishing a communications plan with the community can allow the agency to avoid false perceptions of the agency, guarantee community support for various programs, and help to gain favorability with local decision-makers.

PERFORMANCE LEVELS

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 SCORE OVERALL

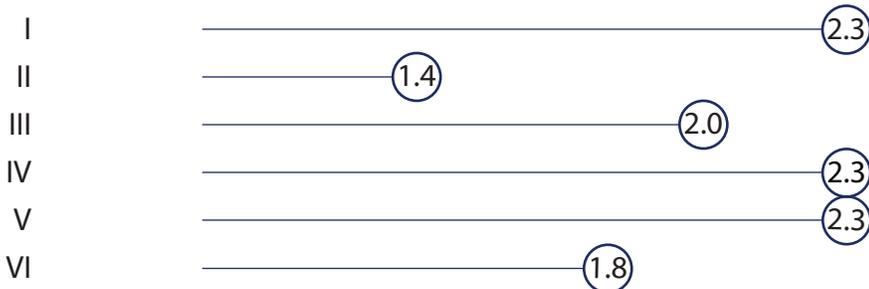


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups



EMS Regions



AVERAGE SCORE BY AGENCY CHARACTERISTIC

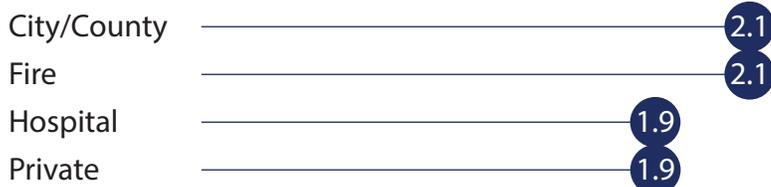
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



1.0 3.5

On a rare occasion, the difference between groups is too large to fit on the scale. Where these differences occur, the highest scores are placed outside the graph and highlighted in green.

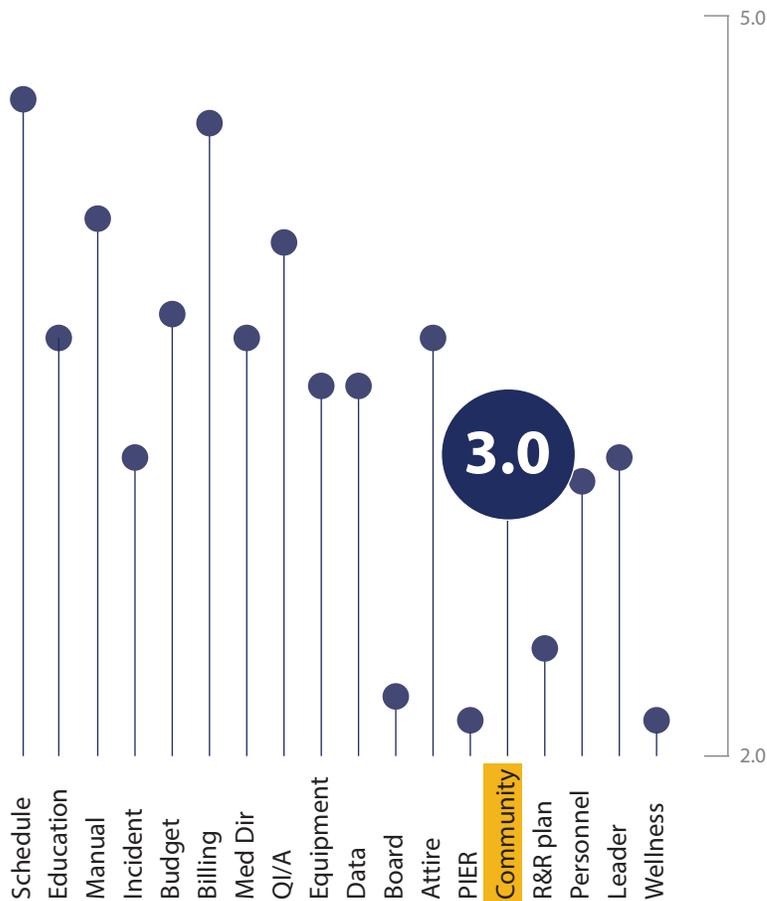
INVOLVEMENT IN THE COMMUNITY

Community involvement can increase the wellbeing of the community while further establishing the value and credibility of the agency within the community.

PERFORMANCE LEVELS

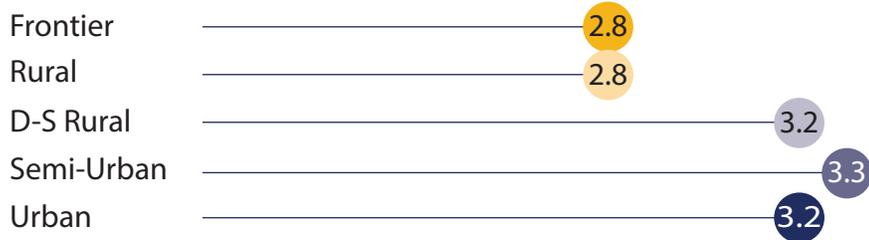
1. 911 emergency calls and inter-facility transports are responded to but no public education courses are offered.
2. Occasional basic public education courses, like CPR/AED and First Aid training, are offered.
3. Frequent basic public education courses, like CPR/AED and First Aid training, plus other 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 SCORE OVERALL

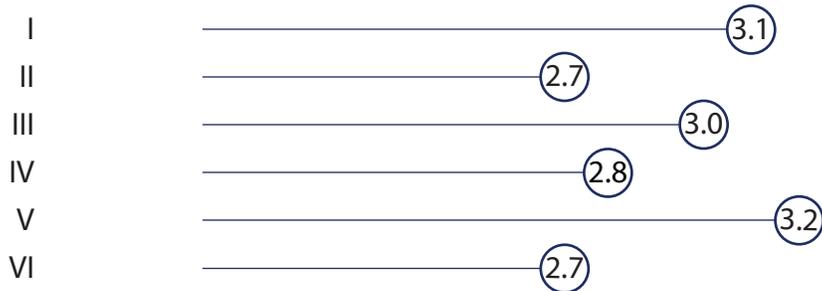


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups



EMS Regions

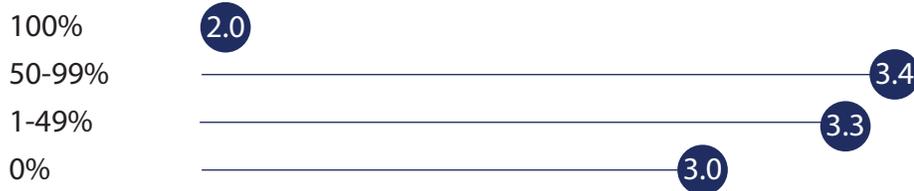


AVERAGE SCORE BY AGENCY CHARACTERISTIC

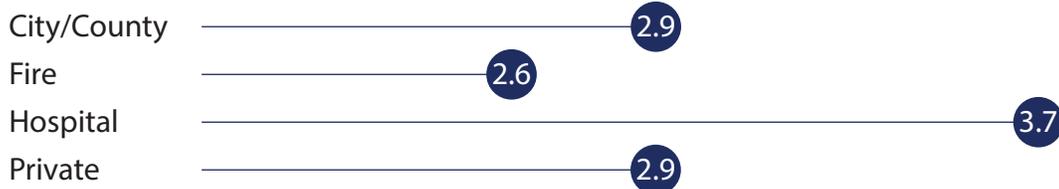
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.0 4.5

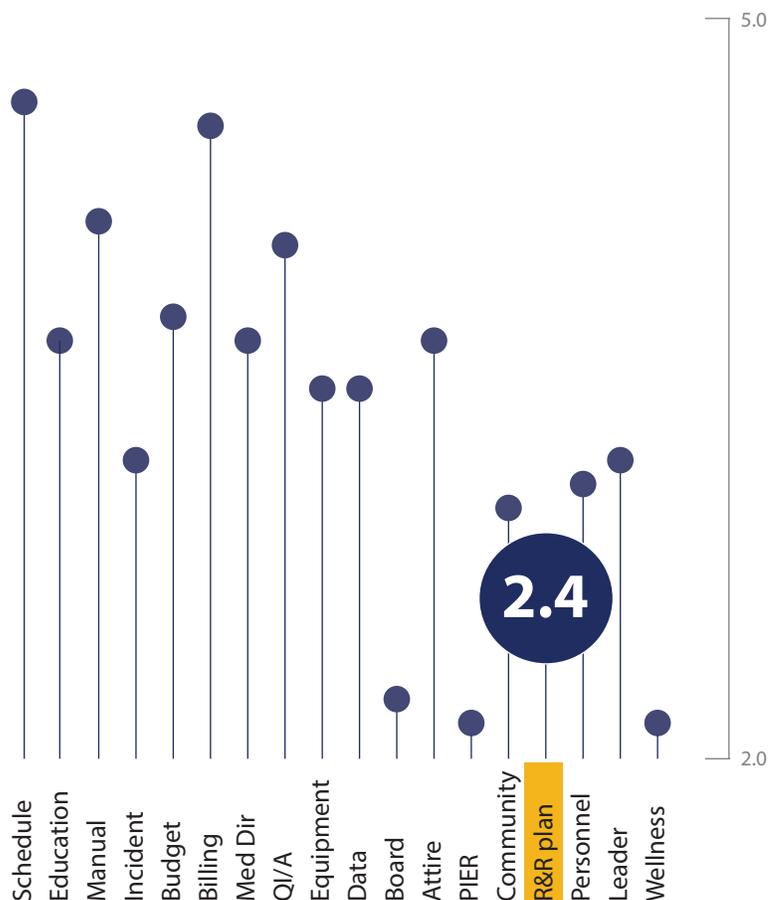
A RECRUITMENT AND RETENTION PLAN

Establishing a recruitment and retention plan allows agencies to increase the sustainability of the organization by guaranteeing qualified volunteers and employees are always available to respond to an emergency.

PERFORMANCE LEVELS

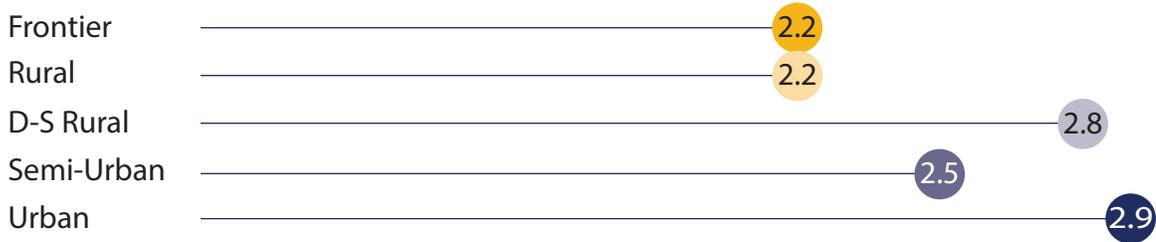
1. There is no agreed-upon plan nor substantive discussion on recruitment and retention.
2. There is no agreed-upon plan but there have been substantive discussions on recruitment and retention.
3. There is an informal, agreed-upon plan and people have been tasked with addressing the issues of recruiting 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 SCORE OVERALL

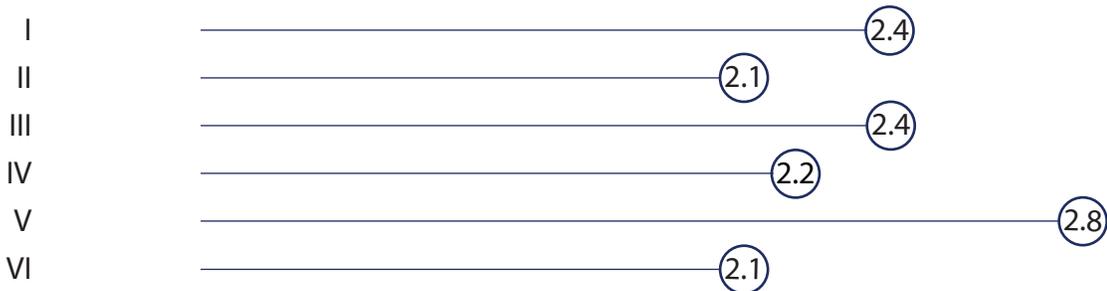


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

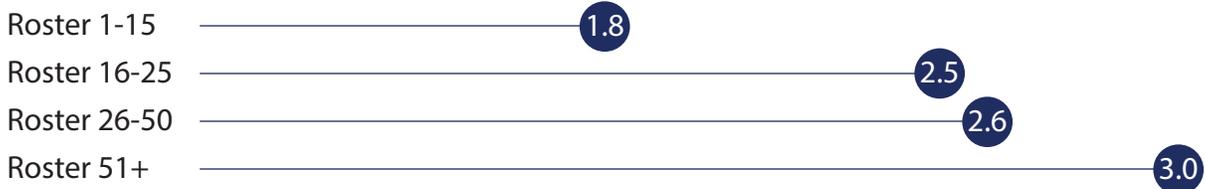


EMS Regions

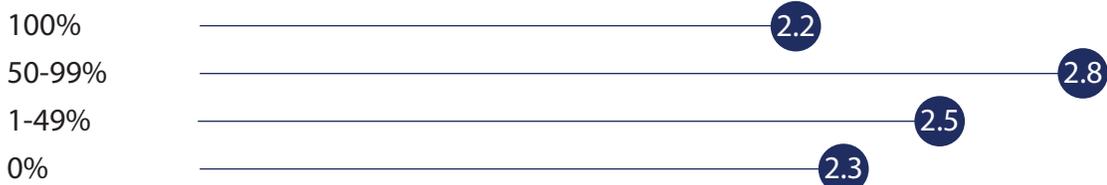


AVERAGE SCORE BY AGENCY CHARACTERISTIC

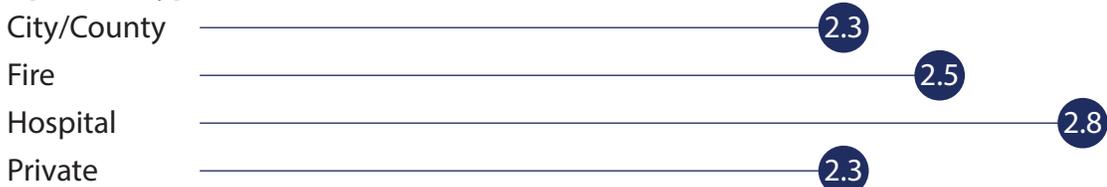
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



1.0 3.5

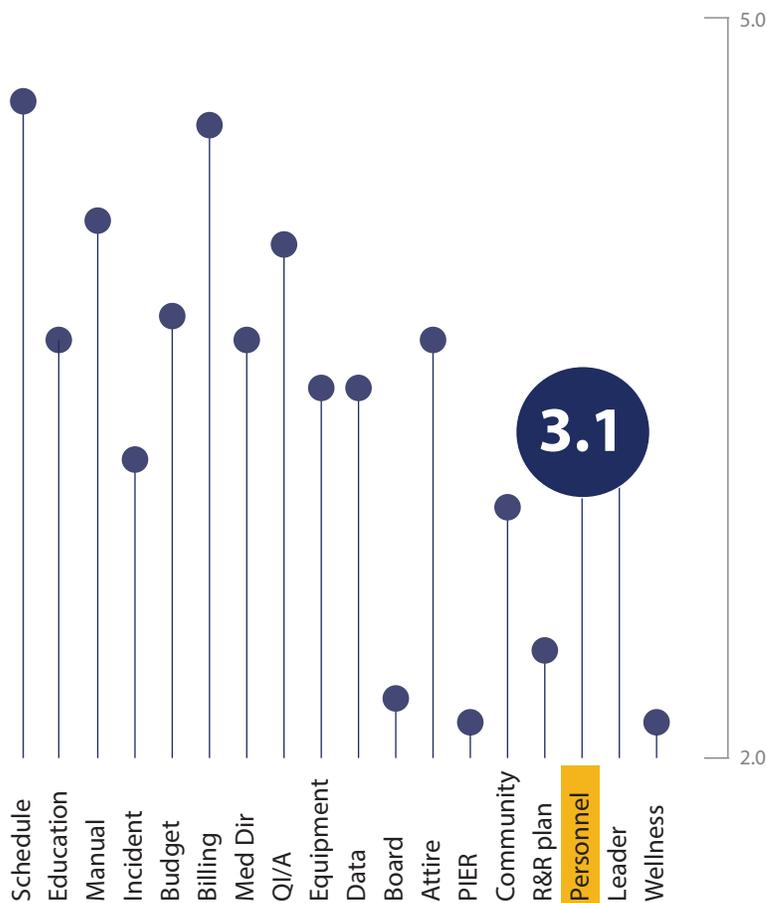
FORMAL PERSONNEL STANDARDS

When there is no staffing plan or formal process for hiring new personnel, stability within the EMS agency will suffer. Uncertainty related to what staffing is needed and who will provide that staffing at any given hour of the day quickly translates into service failures that will be experienced by the EMS agency's patients.

PERFORMANCE LEVELS

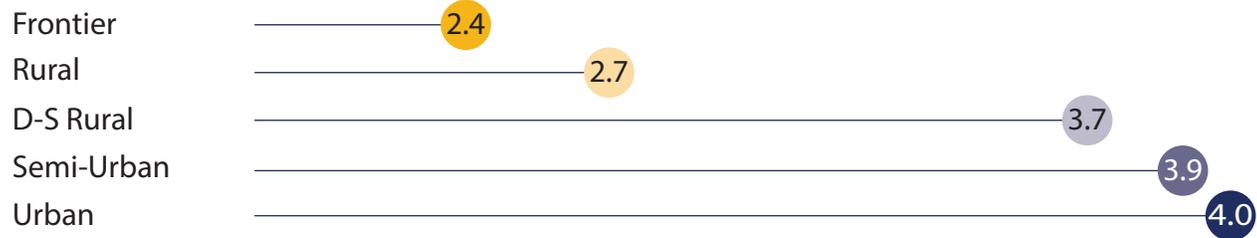
1. There is no official staffing plan or formal process for hiring new personnel (paid and/or volunteer).
2. There is a staffing plan and documented minimum standards for new hires.
3. There is a staffing plan, documented minimum standards for new hires, and an official new-hire orientation.
4. There 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 #4 plus there is a process to resolve personnel issues.

AVERAGE PERFORMANCE SCORE OVERALL



AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

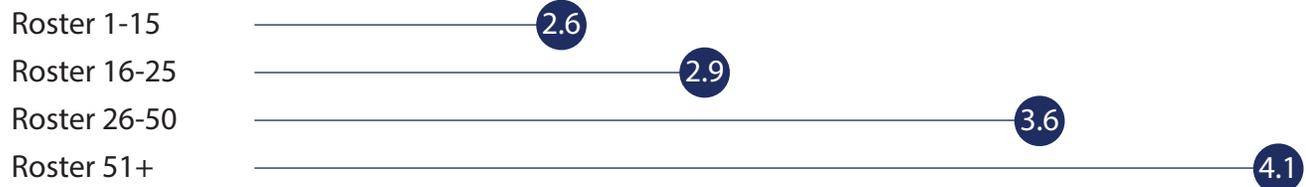


EMS Regions

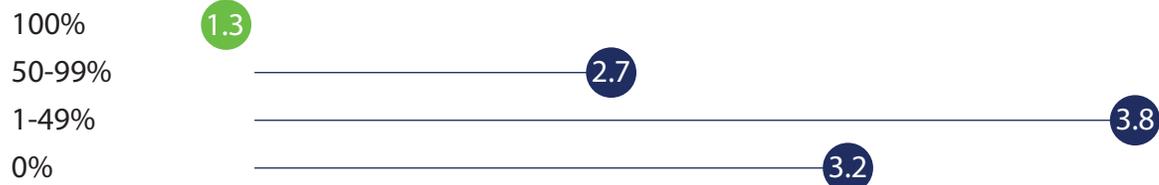


AVERAGE SCORE BY AGENCY CHARACTERISTIC

Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.0 4.5

On a rare occasion, the difference between groups is too large to fit on the scale. Where these differences occur, the highest scores are placed outside the graph and highlighted in green.

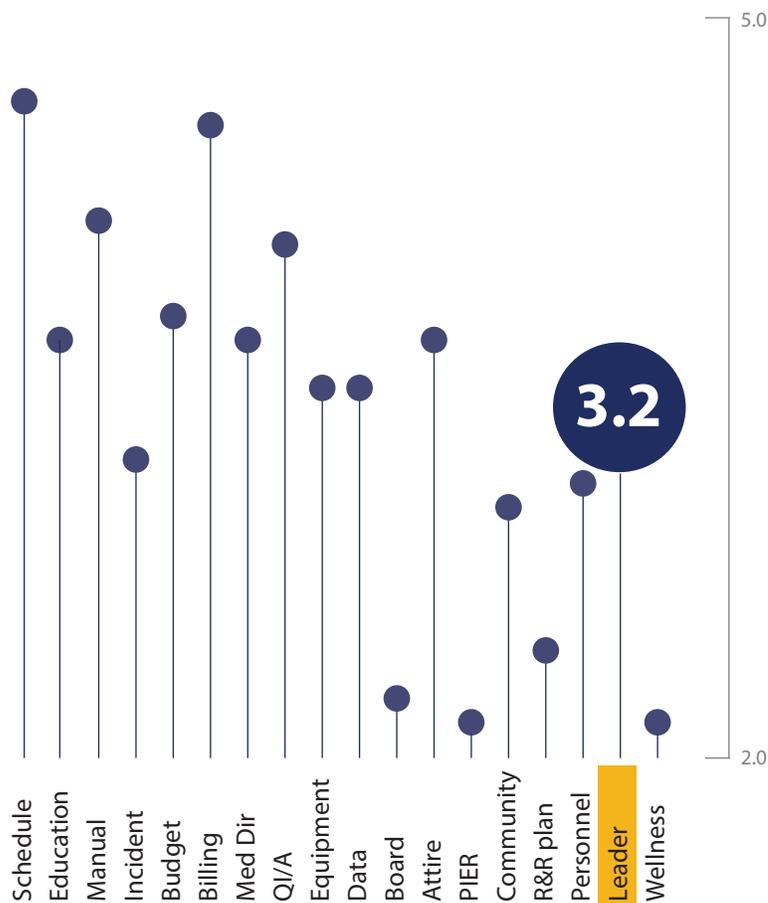
AN IDENTIFIED EMS OPERATIONS LEADER WITH A SUCCESSION PLAN

Establishing effective leadership can help an organization become more sustainable as the leader helps the agency become more organized, improves coordination, and establishes strategies for improvement.

PERFORMANCE LEVELS

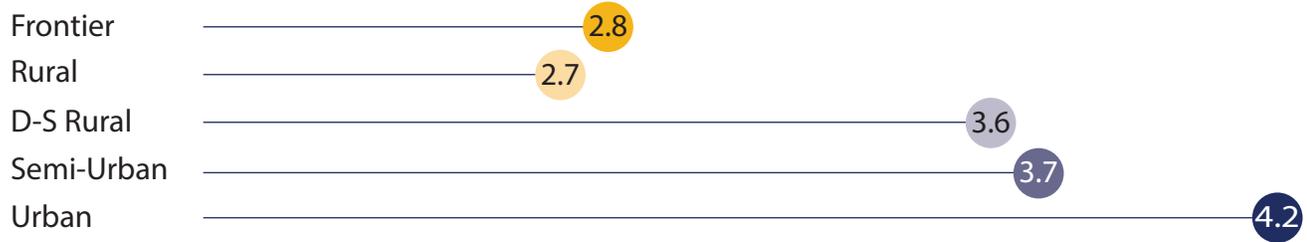
1. There is an identified EMS Operations Leader (e.g., Chief, Director, Director of Operations, EMS deputy chief or captain within a fire agency), but he/she has not had any leadership training.
2. There is an identified EMS Operations Leader with some leadership training, but he/she was not selected 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 SCORE OVERALL

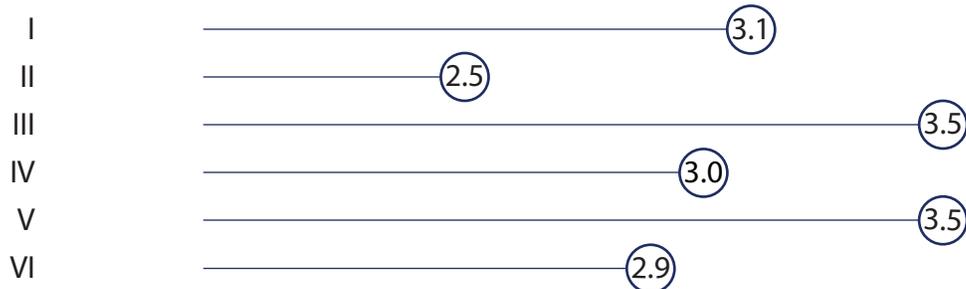


AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups



EMS Regions



AVERAGE SCORE BY AGENCY CHARACTERISTIC

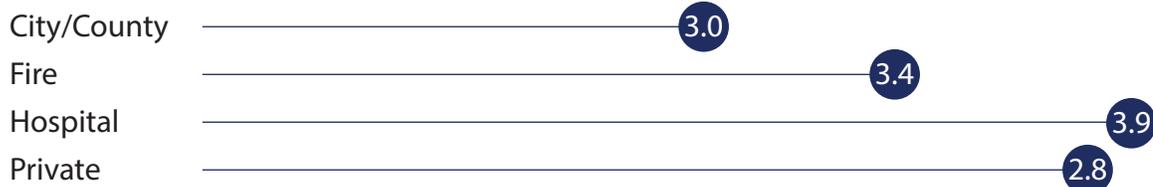
Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



2.0 4.5

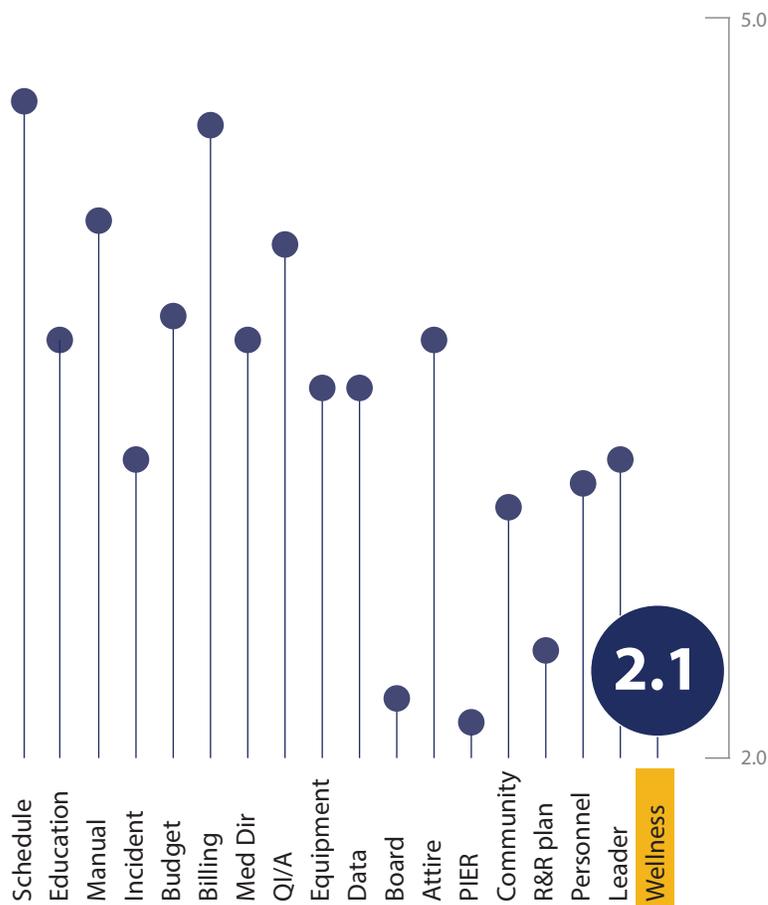
A WELLNESS PROGRAM FOR AGENCY STAFF

Physical and mental health often suffer as EMS workers find themselves with irregular schedules, eating habits, and sleeping patterns. Assuring the health of the agency's members will help to improve and maintain quality of care for community members.

PERFORMANCE LEVELS

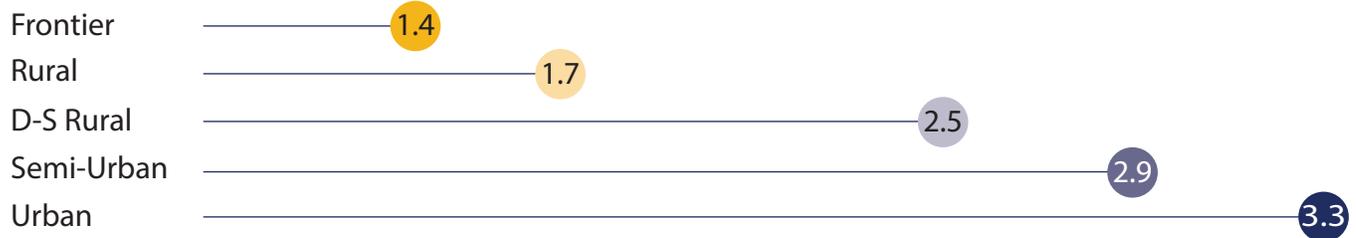
1. There is no wellness program for crew members.
2. Written information is available for crew members regarding physical activity, healthy food options, and tobacco cessation.
3. All of #2 AND occasional educational programming regarding healthy lifestyles is offered, and there is policy support for healthy food options at meetings.
4. All of #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 like tobacco cessation.

AVERAGE PERFORMANCE SCORE OVERALL



AVERAGE SCORE BY GEOGRAPHIC CHARACTERISTIC

Population-Density Peer Groups

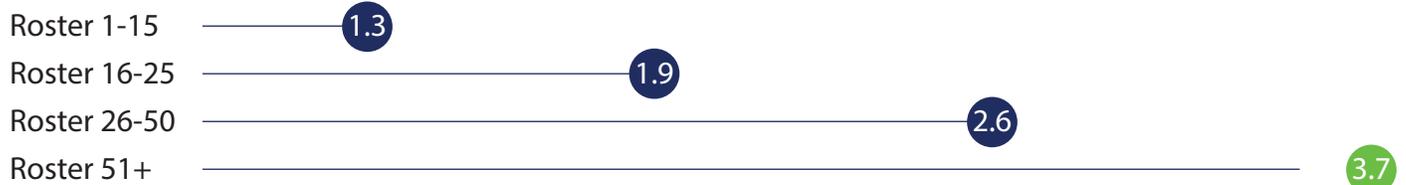


EMS Regions



AVERAGE SCORE BY AGENCY CHARACTERISTIC

Roster Size - # licensed personnel



Roster Size - % volunteer



Operator Type



1.0 3.5

On a rare occasion, the difference between groups is too large to fit on the scale. Where these differences occur, the highest scores are placed outside the graph and highlighted in green.

APPENDIX E - RESPONDENT COMMENTS

- A successful Agency is about the attendants, their caring nature, their dedication, and their willingness to serve. We are a volunteer agency with only 2 fulltime employees. I serve with the best. They give their all for very little pay, giving up family time in their busy lives to serve their community.
- They must have an established and communicated Mission, Vision and performance values. Community engage from top level positions is key to success. Although EMS agencies need to meet regulatory standards, their focus must be the local community needs. They must perform in a manner that allows them to build a service that they want taking care of their own family and friends.
- In county situation it is sometimes difficult to get county officials to understand the EMS role, regulations and guidelines it must follow.
- My department is within a hospital, and having structured leadership that allows and empowers me to perform my job as an EMS Director is crucial. Having a viable and adequate budget is also key.
- I UNDERSTAND THERE MAY BE A ISSUE ABOUT TO'S BEING DROPPED. US IN THE RURAL COMMUNITIES NEED OUR TO'S AND IC'S. IM AFRAID IF THEY DO AWAY WITH OUR TO'S WE WILL LOSE OUR SERVICES. WE NEED THE TO'S.
- Volunteer services such as ours cover a very unique, out in the middle patch of earth. Everyone on my roster does this in addition to other obligations. The successful service will have new people coming in with a desire to carry on into the future the blessing that is the local ambulance. But the trouble is, where are those new people? Folks aren't answering the call for help.
- Treating your employees with respect.
- Ultimately it is about the employee, salary, benefits, workplace culture, employee input into equipment purchases as well as protocol development. The City of Salina and Salina Fire Department have invested many dollars into employee development, promotion guidelines, and detailed documentation of what the employee needs to do to be successful. All of these items had employee input to gain employee buy in. We truly feel that the administrative staff and middle management (Captains, Medical Officers, etc) are leaders, not just managers.
- Thanks for the pro activity in this area.
- Trego County EMS is regulated by the county board of commissioners who have very little if any knowledge of how EMS should be structured or operate. There is somewhat of a barrier when it comes to the necessities of EMS and the knowledge and background of the individuals making definitive decisions (particularly about staffing, finance, and equipment) for the EMS department. I believe that a successful EMS agency may benefit from having leadership beyond the supervisory staff who is educated or experienced in prehospital medicine.

JULY 2017

Report produced by the Wisconsin Office of Rural Health.

