Attributes of a Successful Rural Ambulance

North Dakota
2016

As part of the 2016 Rural EMS Assistance Fund Grant process, the Division of Emergency Medical Systems asked ambulance services to rate/assess themselves on attributes of a successful rural ambulance service.

The tool was created by a group of rural EMS visionaries including partners from the Joint Committee on Rural Emergency Care and the National Organization of State Offices of Rural Health. The tool was created to help rural services assess their current capacity and next steps in achieving what is considered the gold standard for rural services.

Link to Assessment

- [Attributes of Successful Rural Ambulance Services](#)

1. 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, but for less than 1 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.

1. Schedule
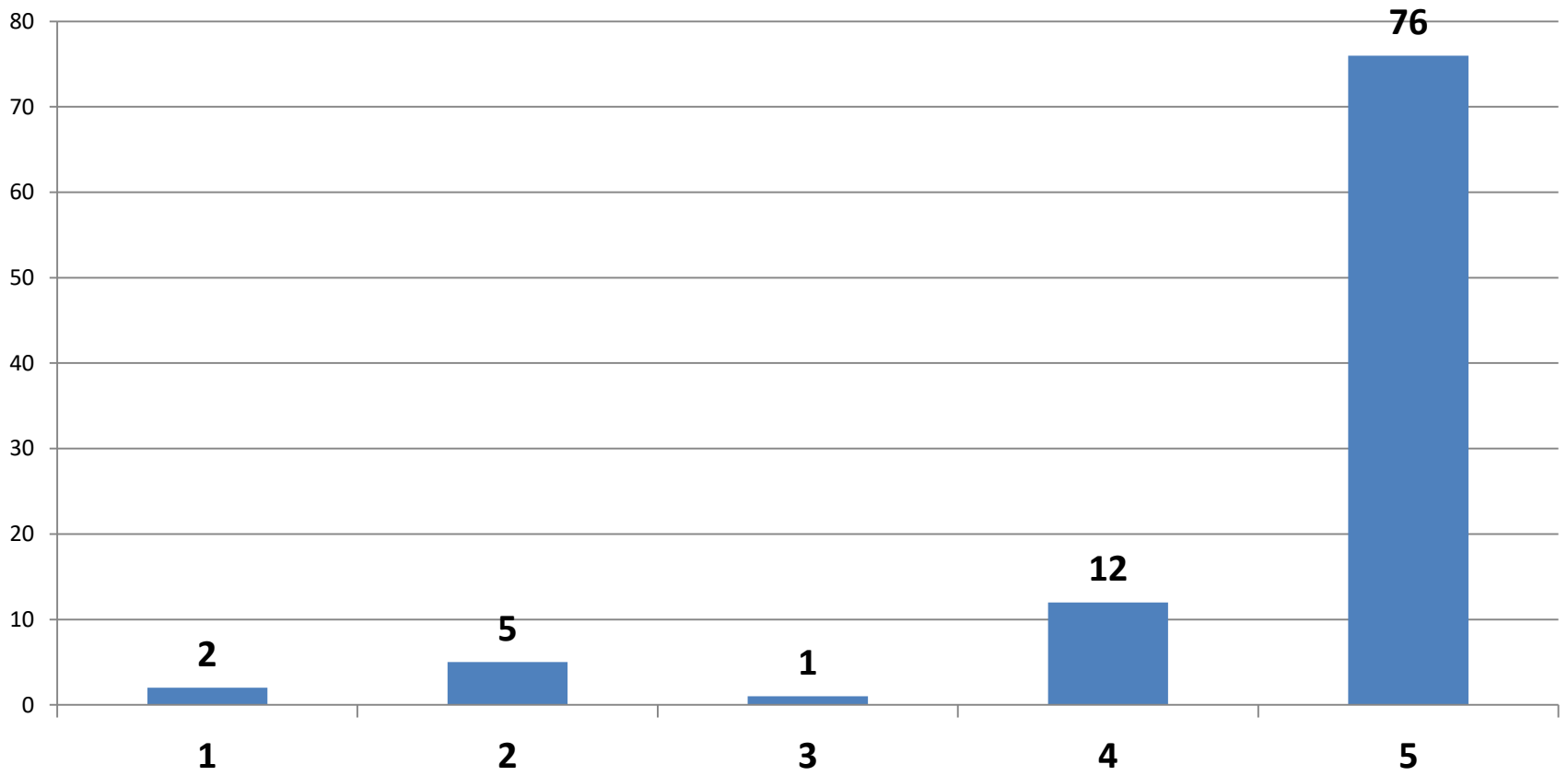
2. Community-Based Board

1. There is no formal board oversight.
2. Board consists of internal service members only.
3. Board voting members are from the agency AND some combination of elected officials, hospital leadership/staff, and/or governmental administrators.
4. Board voting members are ONLY some combination of elected officials, hospital leadership/staff, and/or governmental administrators PLUS business/financial member – no agency members have a voting capacity.
5. Board voting members include all of #4 AND at least one engaged patient representative.

2. Board
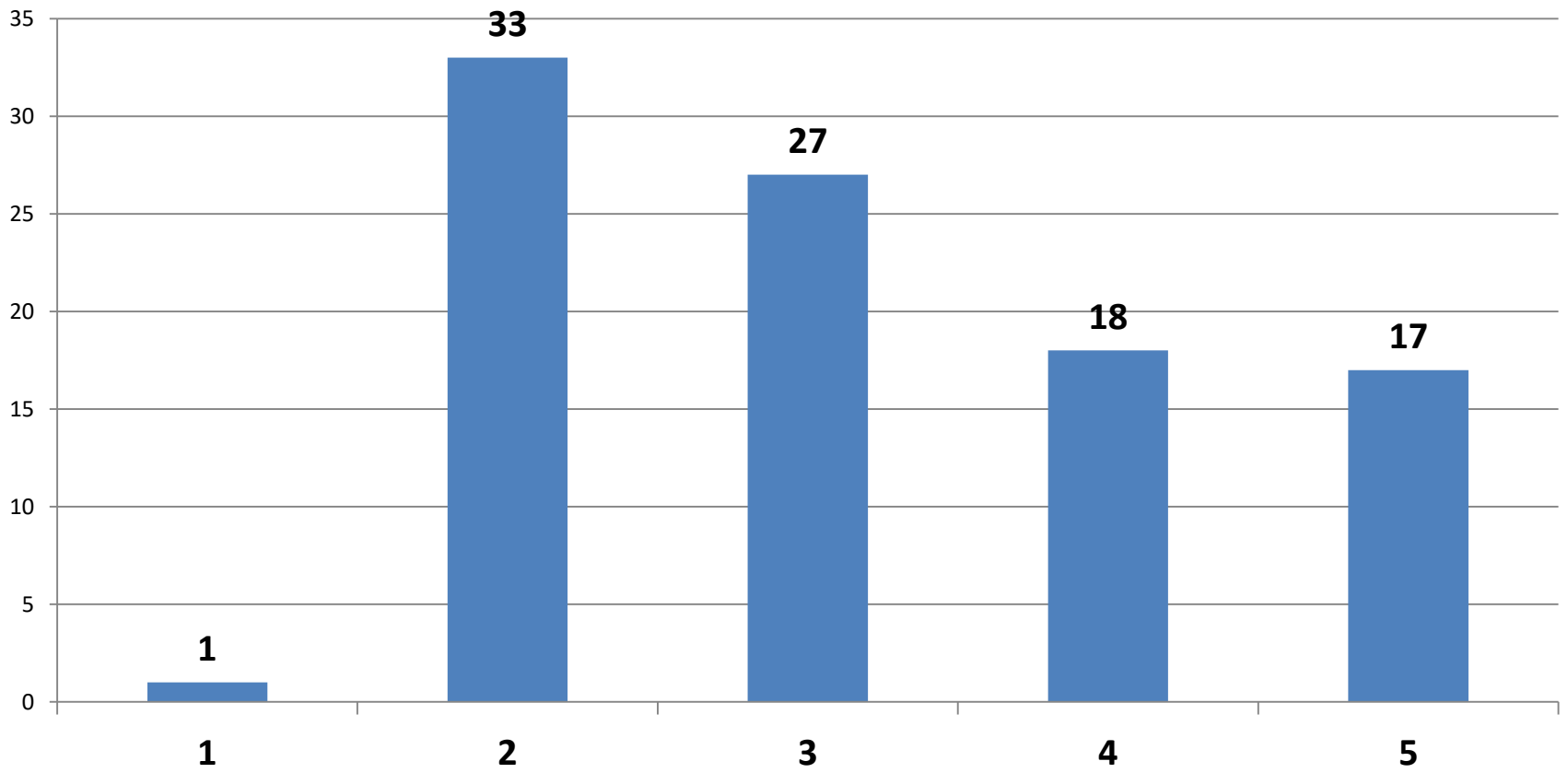
3. Medical Director Involvement

1. There is a medical director in name only. He/she is not actively engaged with agency beyond signatures.
2. The medical director reviews cases presented to him/her, but not within 30 days and/or with very little feedback.
3. The medical director reviews cases presented to him/her, within 30 days and/or with some feedback.
4. The medical director reviews cases within 7 days, provides good feedback, but waits for the (EMS) agency to engage her/him. When asked, he/she responds to hospital ED/ER contacts on behalf of the agency regarding their clinical protocols and actions.
5. The medical director is an integral part of EMS services, pro-actively engaging the agency to review cases within 7 days and provide regular feedback, is involved in planning and delivery of education to the agency, and advocates for the agency to hospital ED/ER contacts.

3. Medical Director Involvment
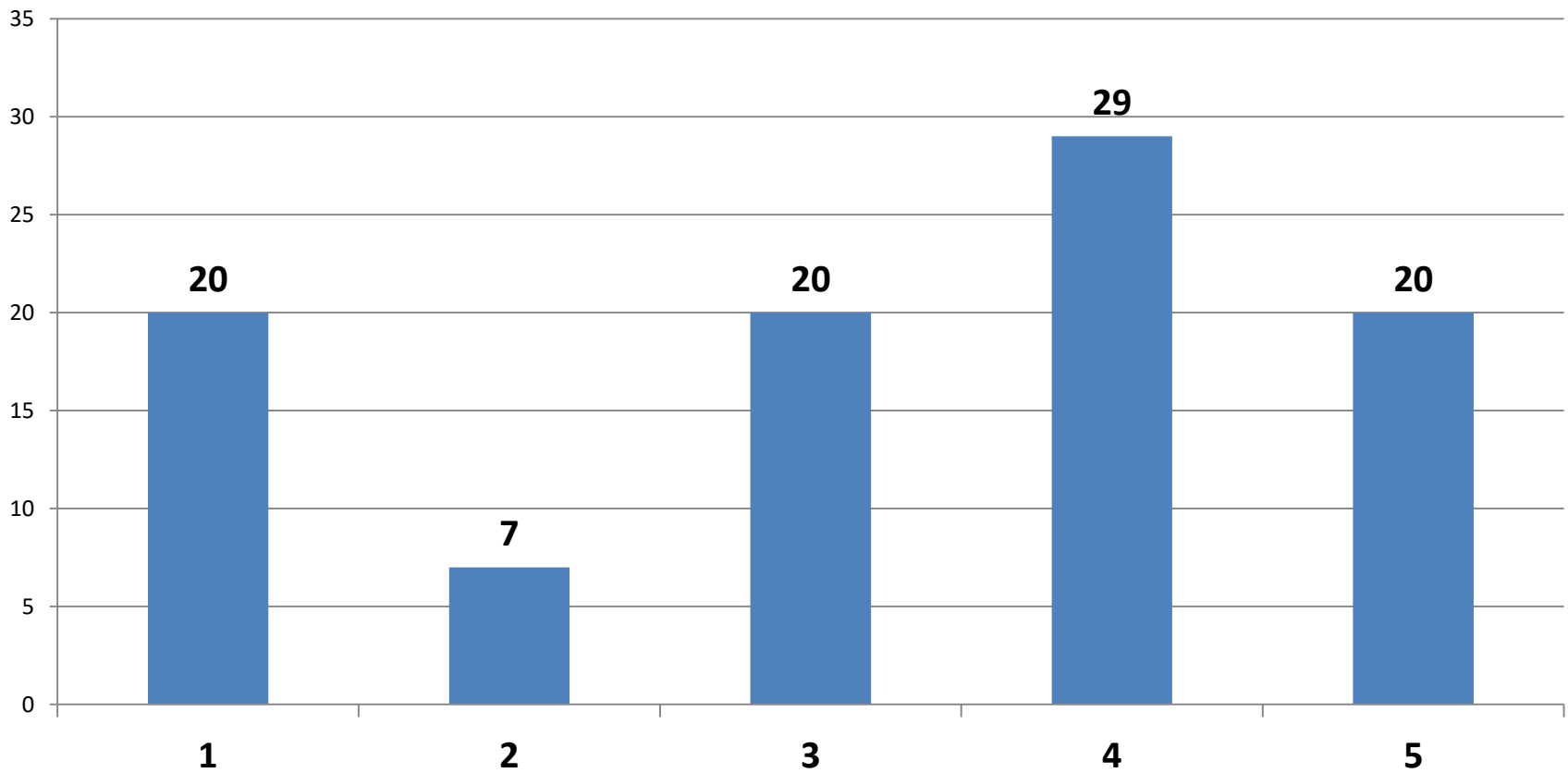
4. Continuing Education

1. Agency offers no continuing education.
2. Agency offers (internally or externally) only minimum requirements needed to maintain licensure.
3. Agency offers (internally or externally) education above minimum requirements needed to maintain licensure.
4. Agency offers (internally or externally) continuing education, which is based on QI/QA findings.
5. Agency offers (internally or externally) continuing education, which is based on QI/QA findings, with Medical Director and/or hospital input, and taught by a certified educator.

4. Continuing Education
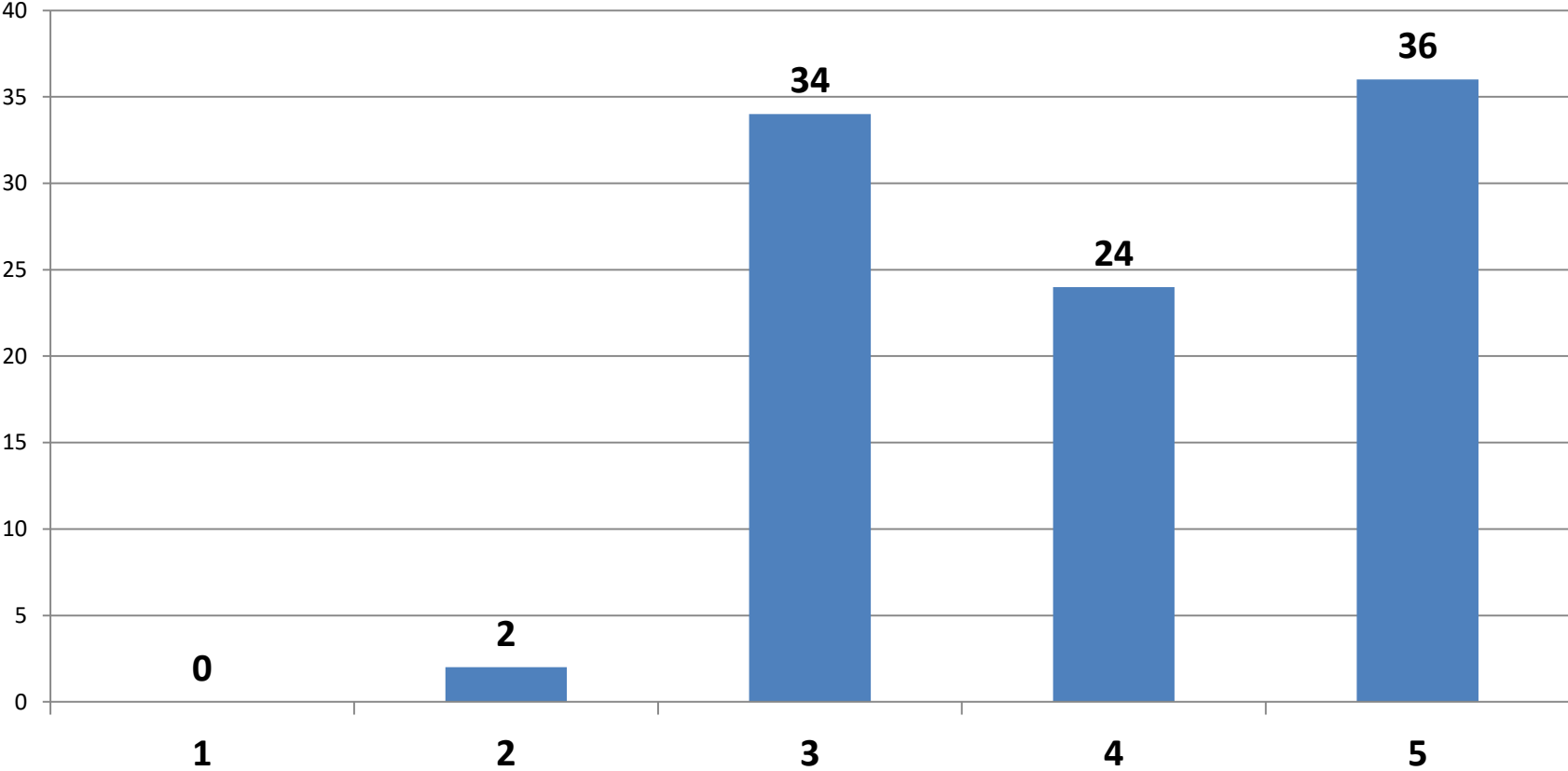
5. Quality (QA/QI) Process

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

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

3. Performance measures are calculated and reported but no feedback loop exists for continual improvement of the EMS system*.

4. Performance measures are reported and a feedback loop exists for general improvements of the EMS system*.

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).

5. QA/QI
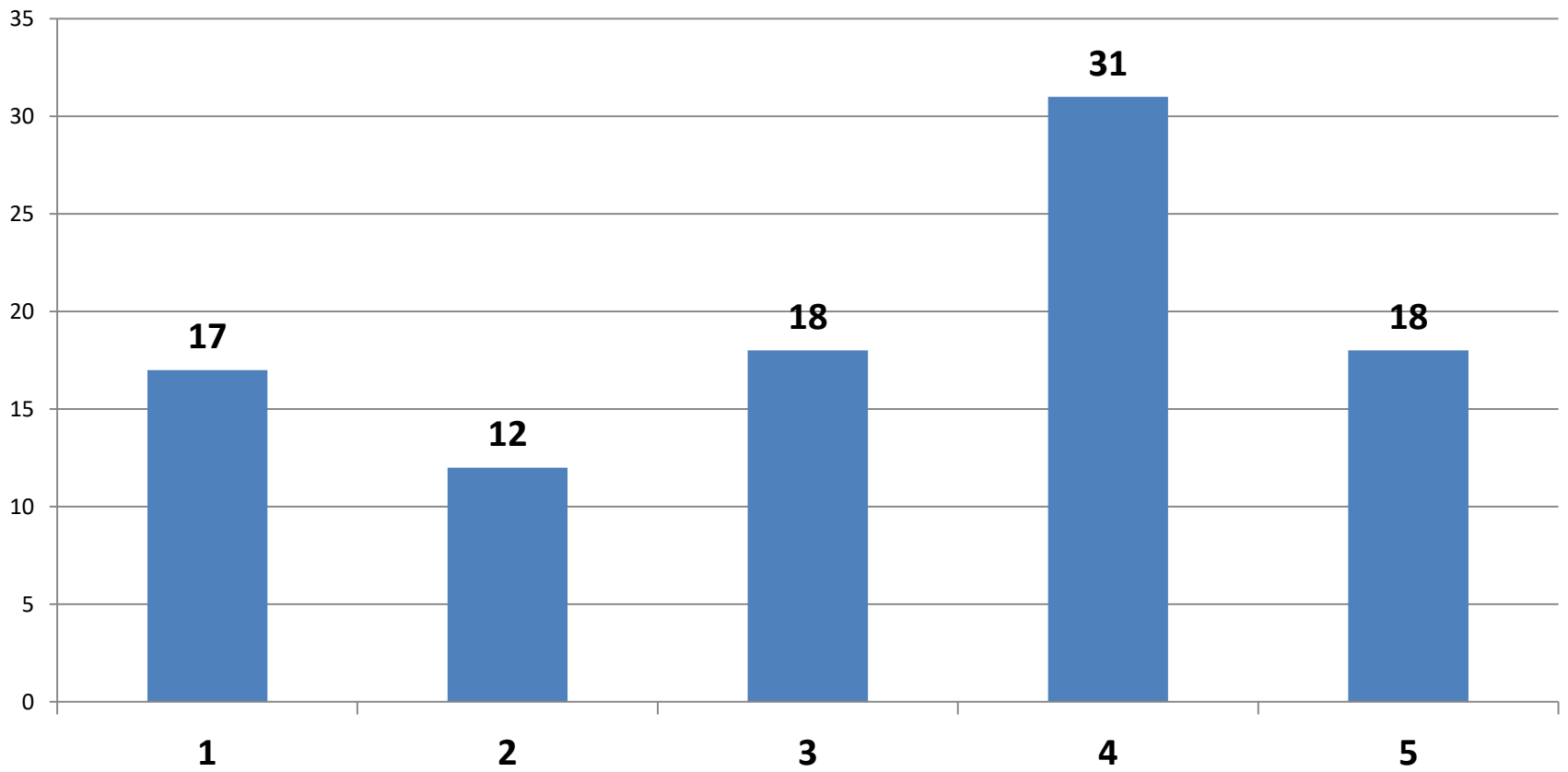
6. Recruitment and Retention Plan

1. There is no agreed-upon plan, nor substantive discussions on recruiting and retention.

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

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

4. There is a formal written plan, and people have been tasked with recruiting new members and strategizing methods to keep current 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 retention of existing staff. There is a full roster with a waiting list for membership.

6. Recruitment/Retention
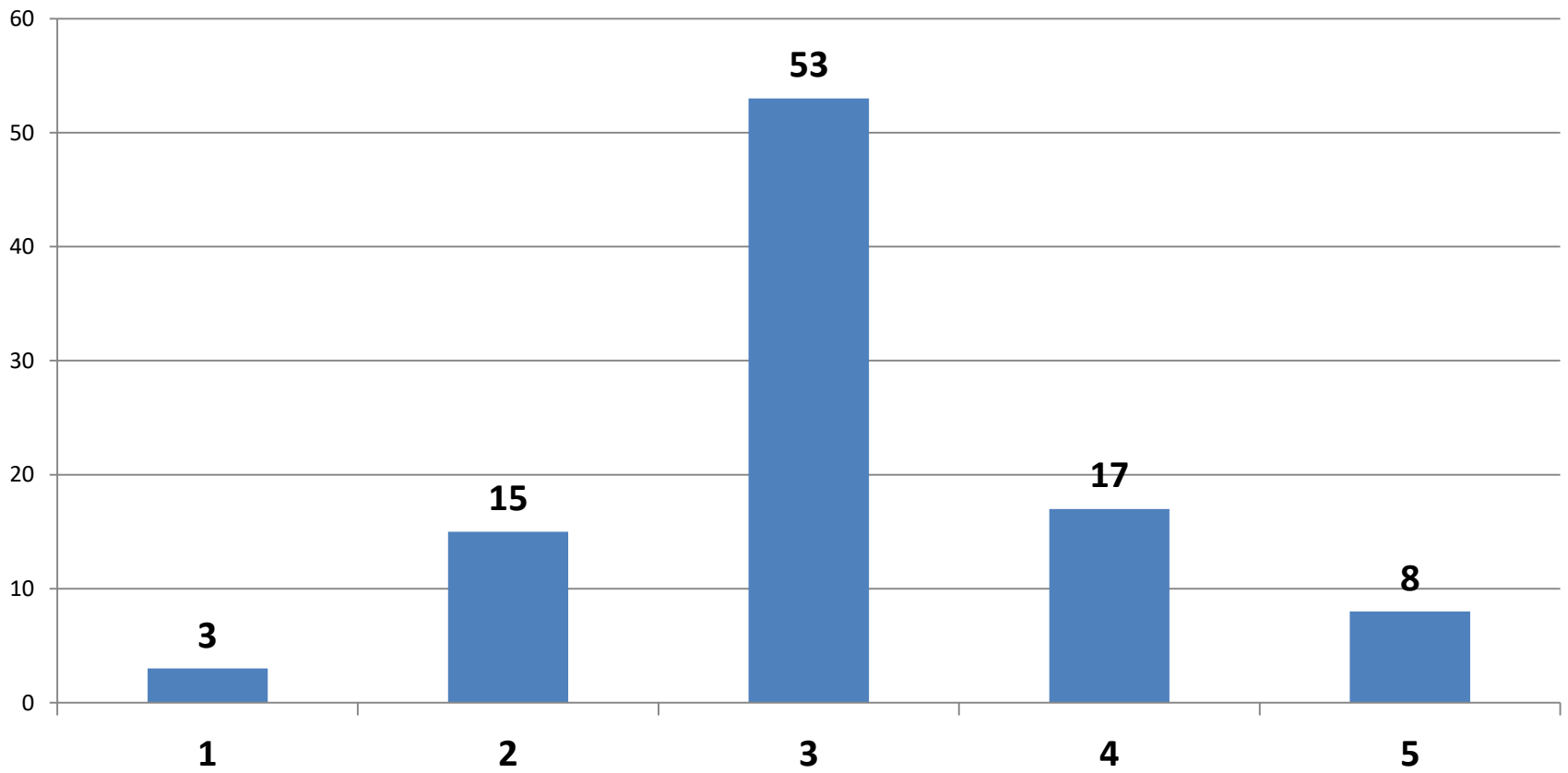
7. Personnel Standards

1. There is no official staffing plan and/or there is no 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 (that include background checks), an official new-hire orientation, and systematic performance reviews/work evaluations.
5. All of #4 plus a process to resolve personnel issues.

7. Standards
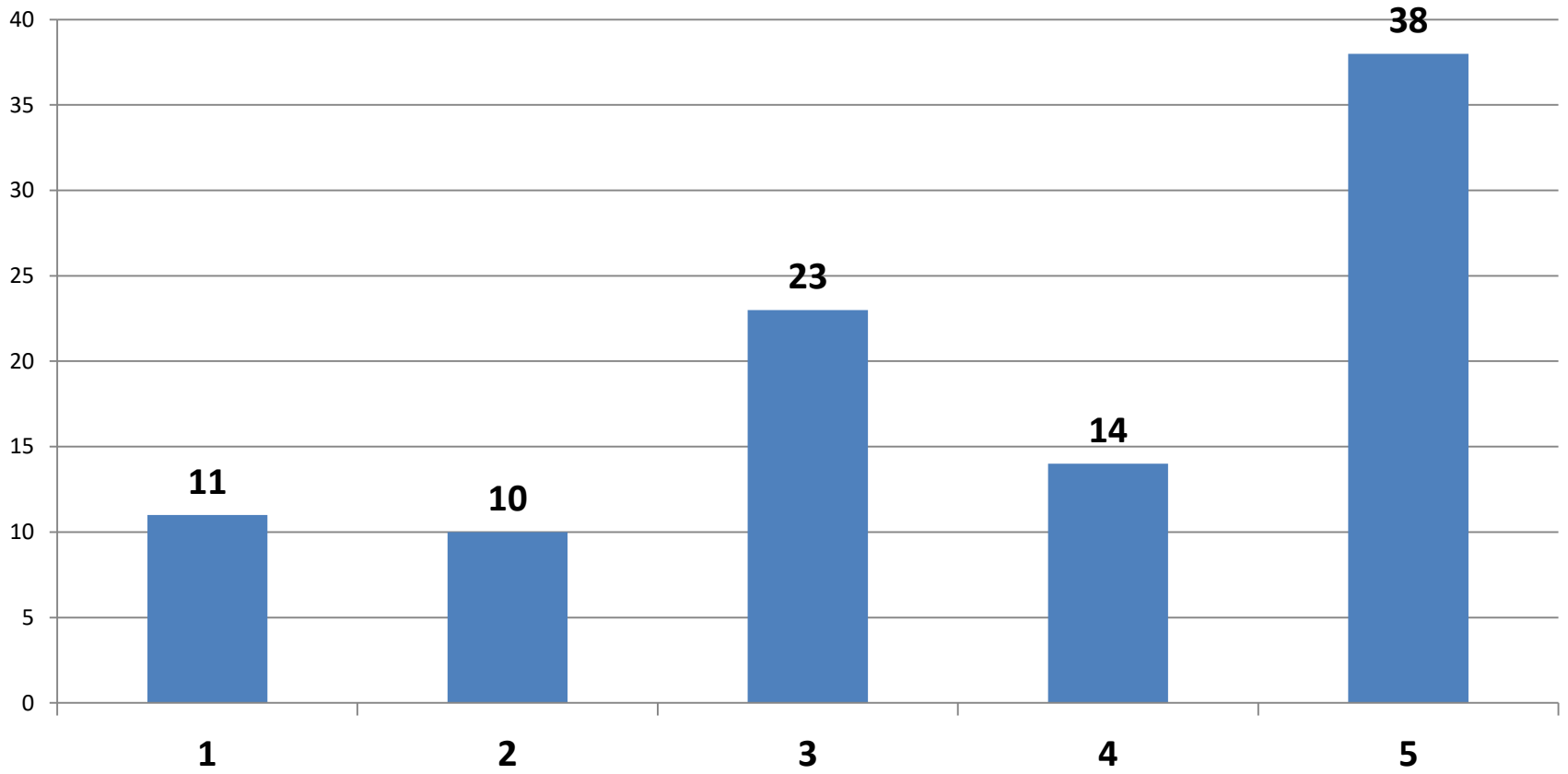
8. Written Policy and Procedure Manual

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 members don't refer to/use/update it systematically.

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

8. Written Policy
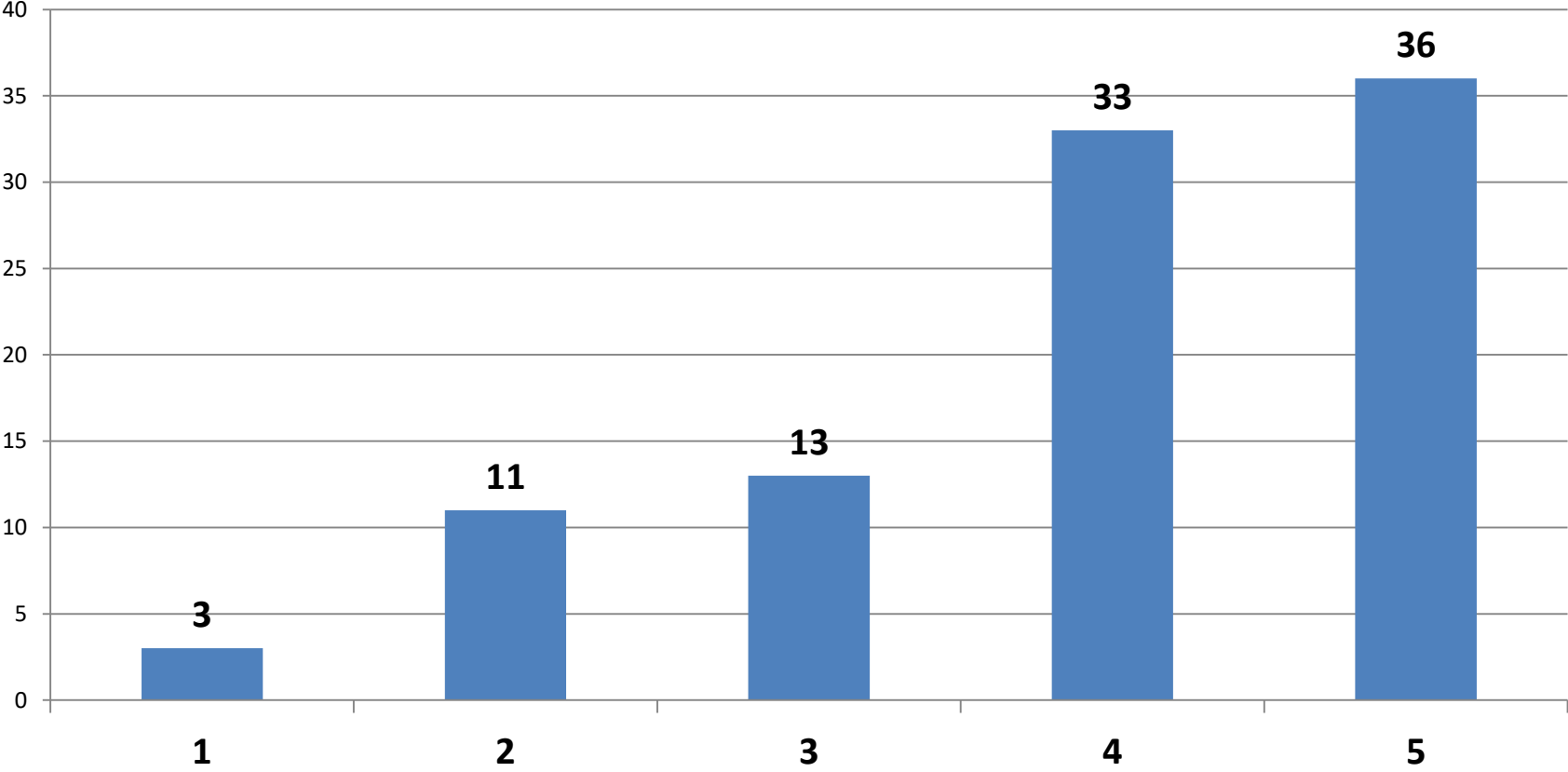
9. Sustainable Budget

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 3 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 6 months is in the bank, and the reserve has been in place for at least one year.

9. A Sustainable Budget
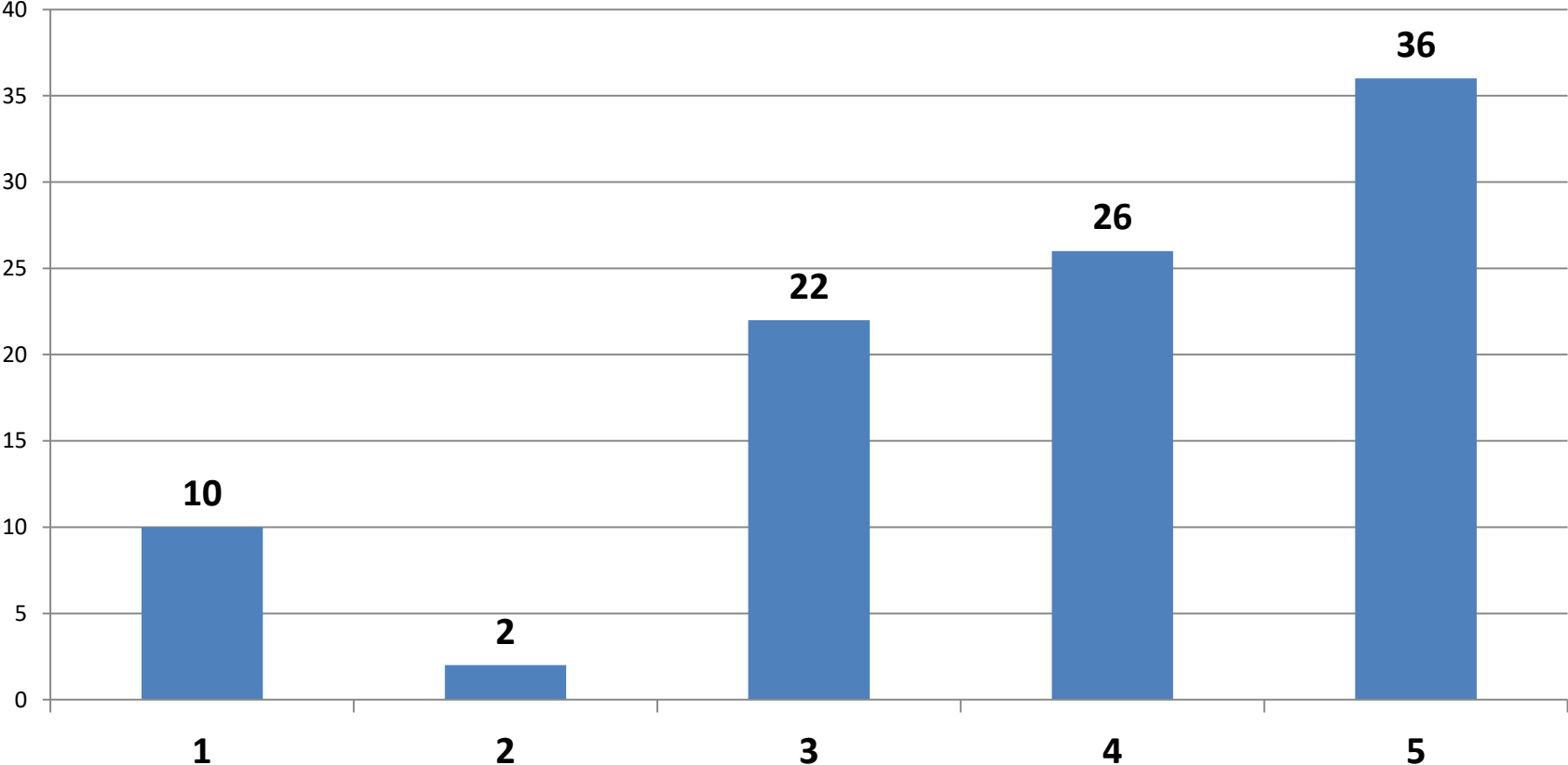
10. Identified EMS Operations Leader With A Succession Plan

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 they have not had any leadership training.

2. There is an identified EMS Operations Leader with some leadership training, but not selected by a recruitment process.

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

4. There is an identified EMS Operations Leader, with comprehensive leadership training and 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 and selected by a recruitment process 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.

10. Leader
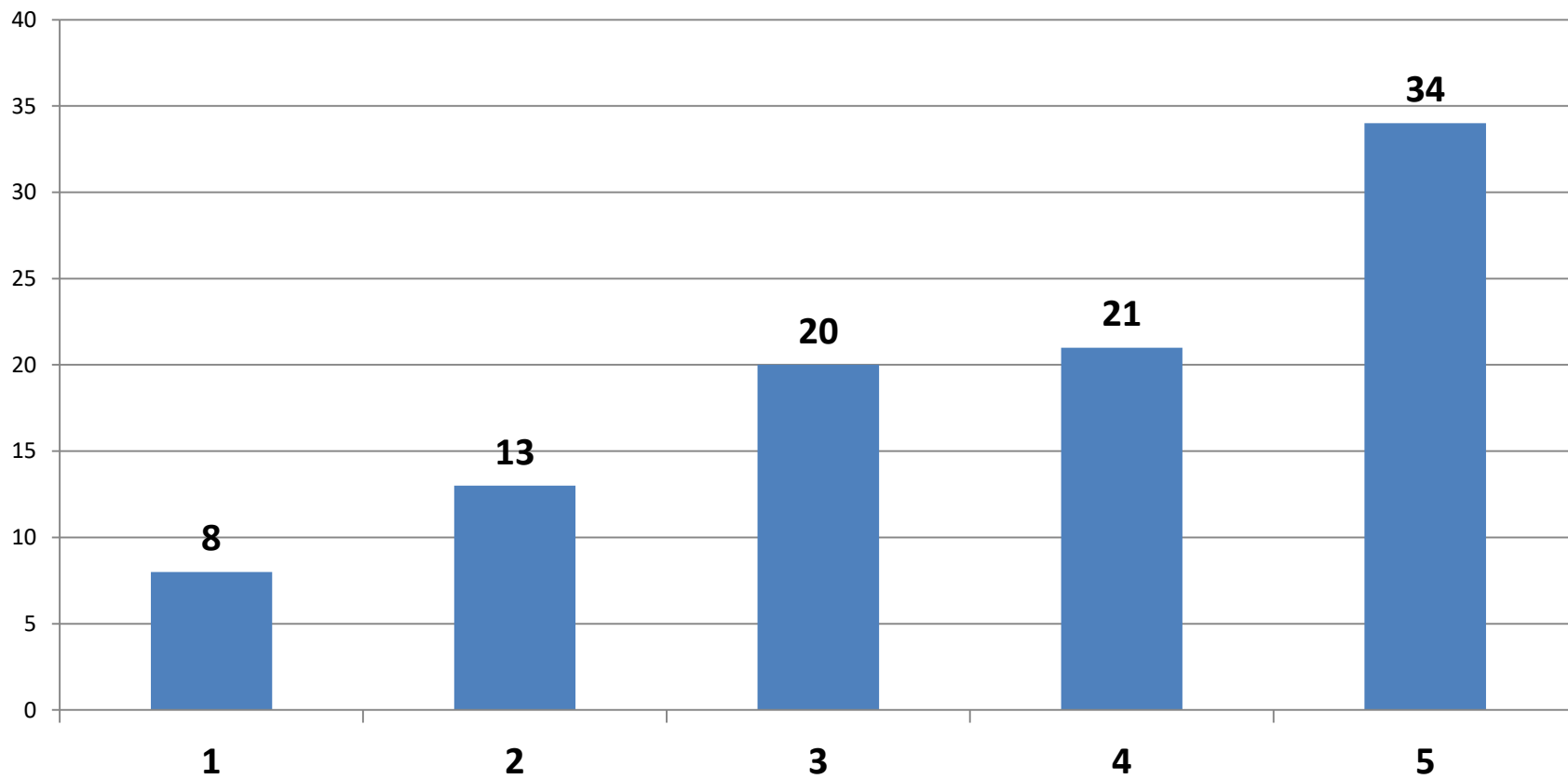
11. Professional Billing Process

1. Agency does not bill for services.
2. Agency bills for services, but claims are submitted by an (internal or external) individual who has no formal training in healthcare billing.
3. Agency bills for services, but claims are submitted by an (internal or external) individual with limited training in healthcare billing.
4. Agency bills for services, 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. Agency bills for services and claims are submitted by an (internal or external) certified biller or billing service, in a timely manner (less than 30 days), with established HIPAA compliant billing policies and policies to handle claims that have been denied or with a balance due.

11. Billing
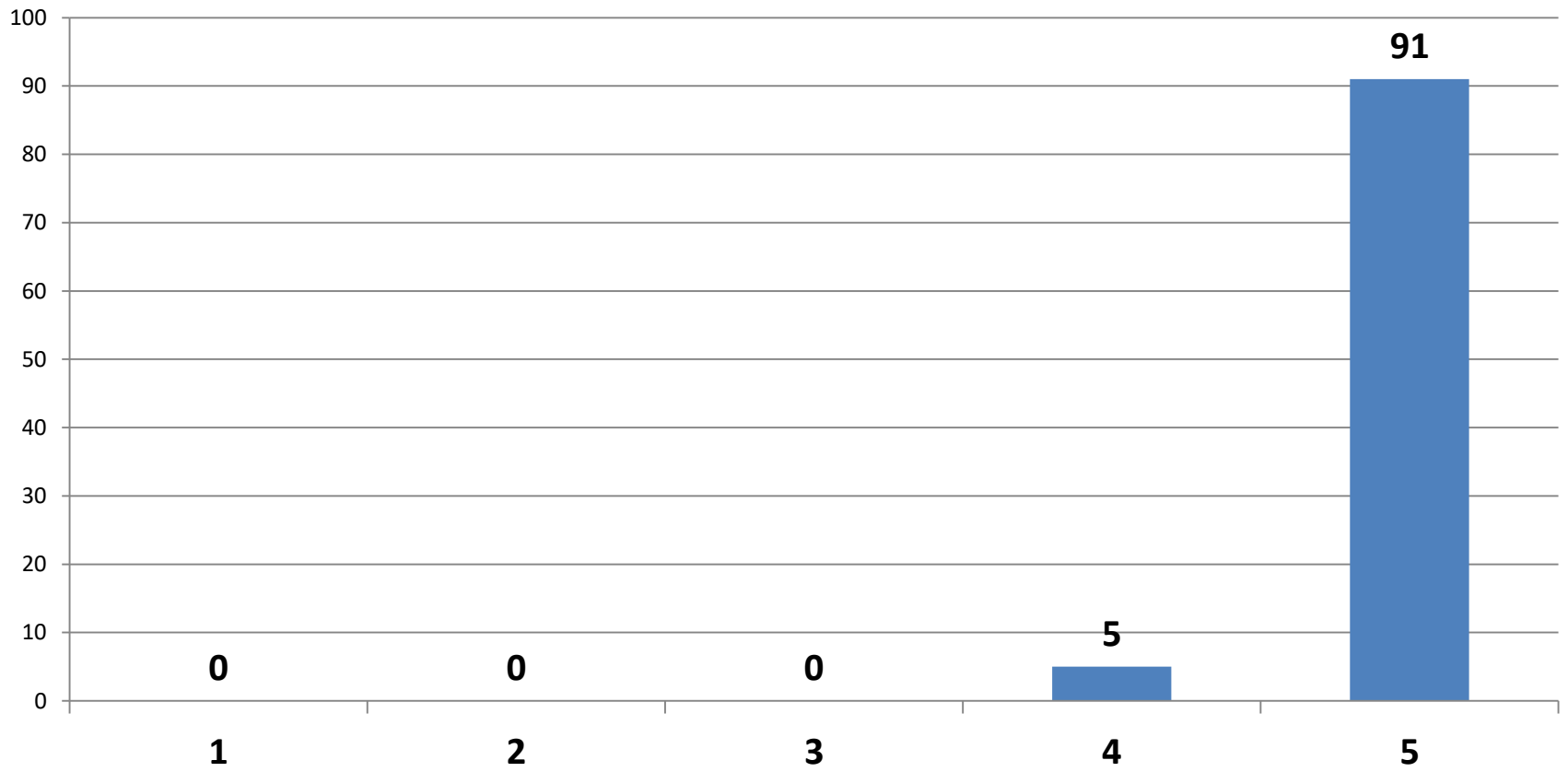
12. Contemporary Equipment and Technology

1. Agency has only the minimum equipment/technology required by licensure. The budget does not allow additional new equipment/technology acquisition.

2. Agency has primarily the minimum equipment/technology required by licensure, plus a minimal budget for additional new equipment/technology acquisition above that minimum.

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

12. Technology
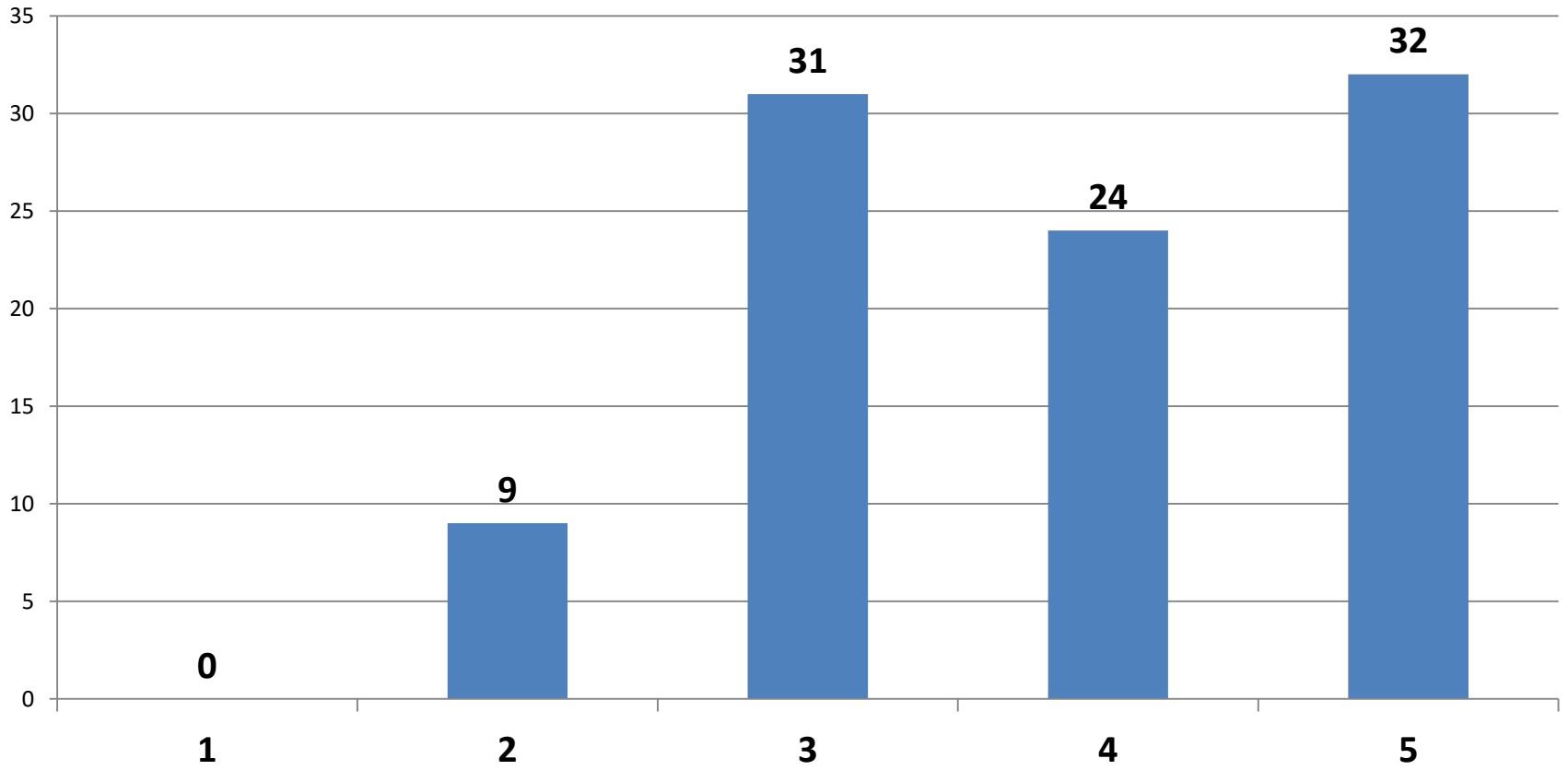
13. Agency Attire

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

13. Attire
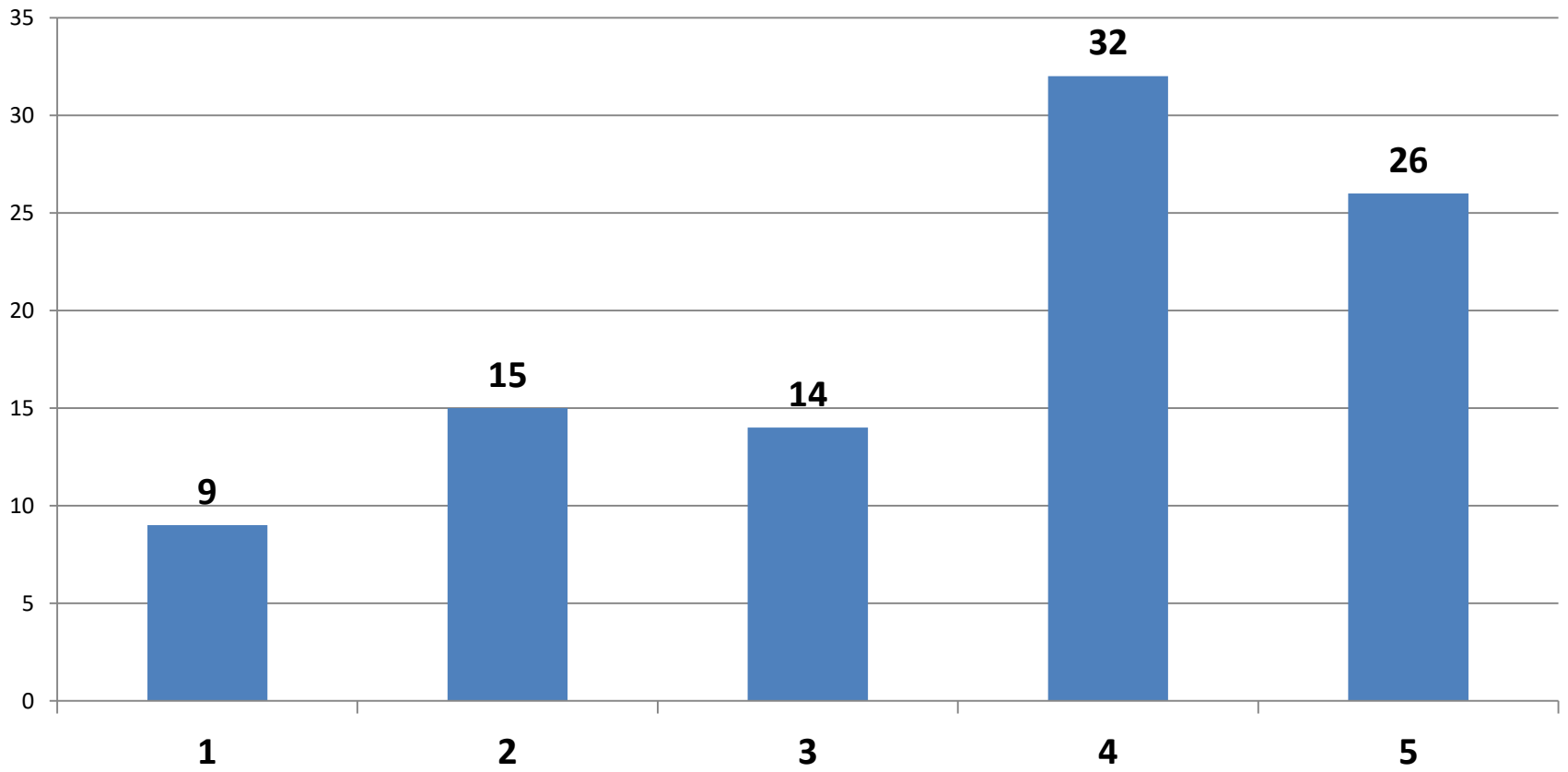
14. Public Information, Education, and Relations (PIER)

1. The agency has no plan for addressing PIER.
2. The agency is in the process of developing a PIER plan.
3. The agency has a PIER plan, but no funding dedicated to its implementation.
4. The agency has a PIER plan which has funding dedicated to its implementation.
5. The agency has a PIER plan which has funding dedicated to its implementation, with someone identified as responsible for PIER, and a recurring evaluation of its success.
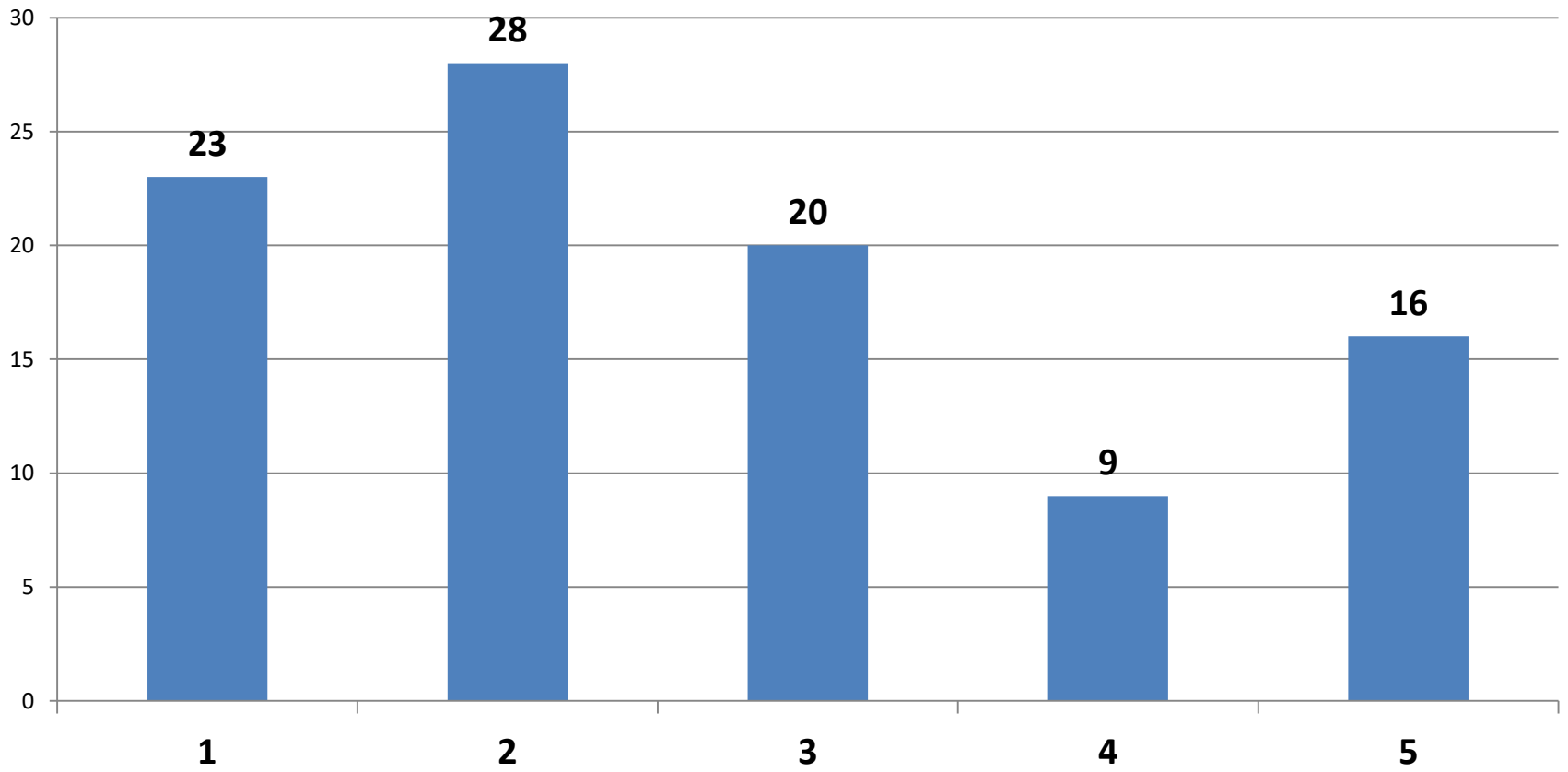
15. Involvement in the Community

1. The agency responds to 911 emergency calls and inter-facility transports but offers no public education courses.

2. The agency offers occasional basic public education courses, like CPR/AED and First Aid training.

3. The agency offers frequent basic public education courses like CPR/AED and First Aid training, plus other EMS-related training.

4. The agency offers a robust array of public education courses and other training, and 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, active partner with other public safety organizations, and seen as a leader for community health and well-being.

15. Community
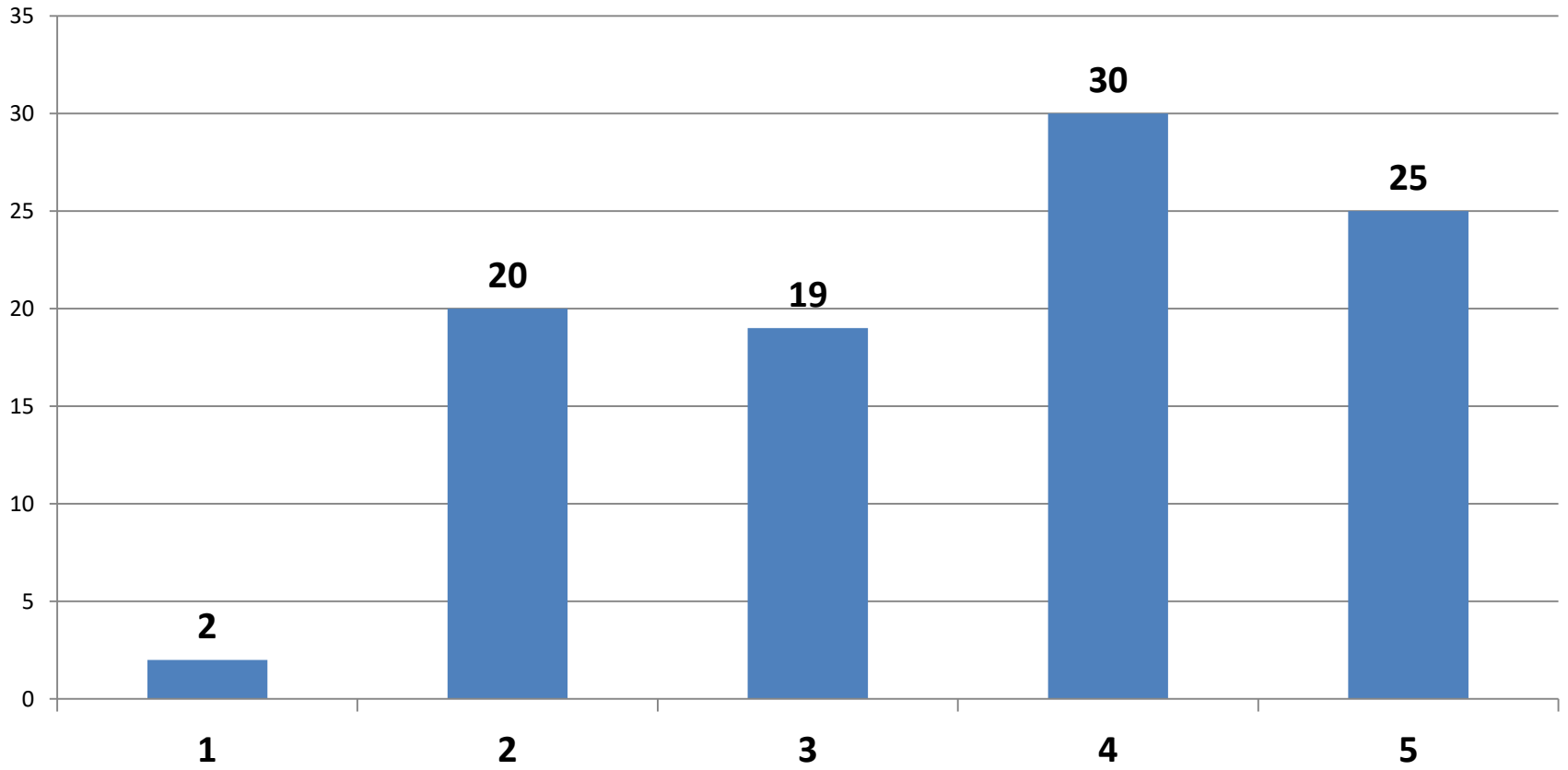
16. Reporting of Data

1. No operational/clinical data are submitted to regulators.

2. Data are submitted to regulators, but not often within the designated timelines (locally, statewide or national).

3. Data are submitted to regulators, within the designated timelines.

4. Data are submitted to regulators, within the designated timelines. Areas for improvement are identified using an established QA/QI process by the EMS agency.

5. Data are submitted to regulators, within the designated timelines. Areas for improvement are identified using an established QA/QI process by the EMS agency, and goals and benchmarks are used to improve performance. Summary reports are regularly shared publicly with the community.

16. Data
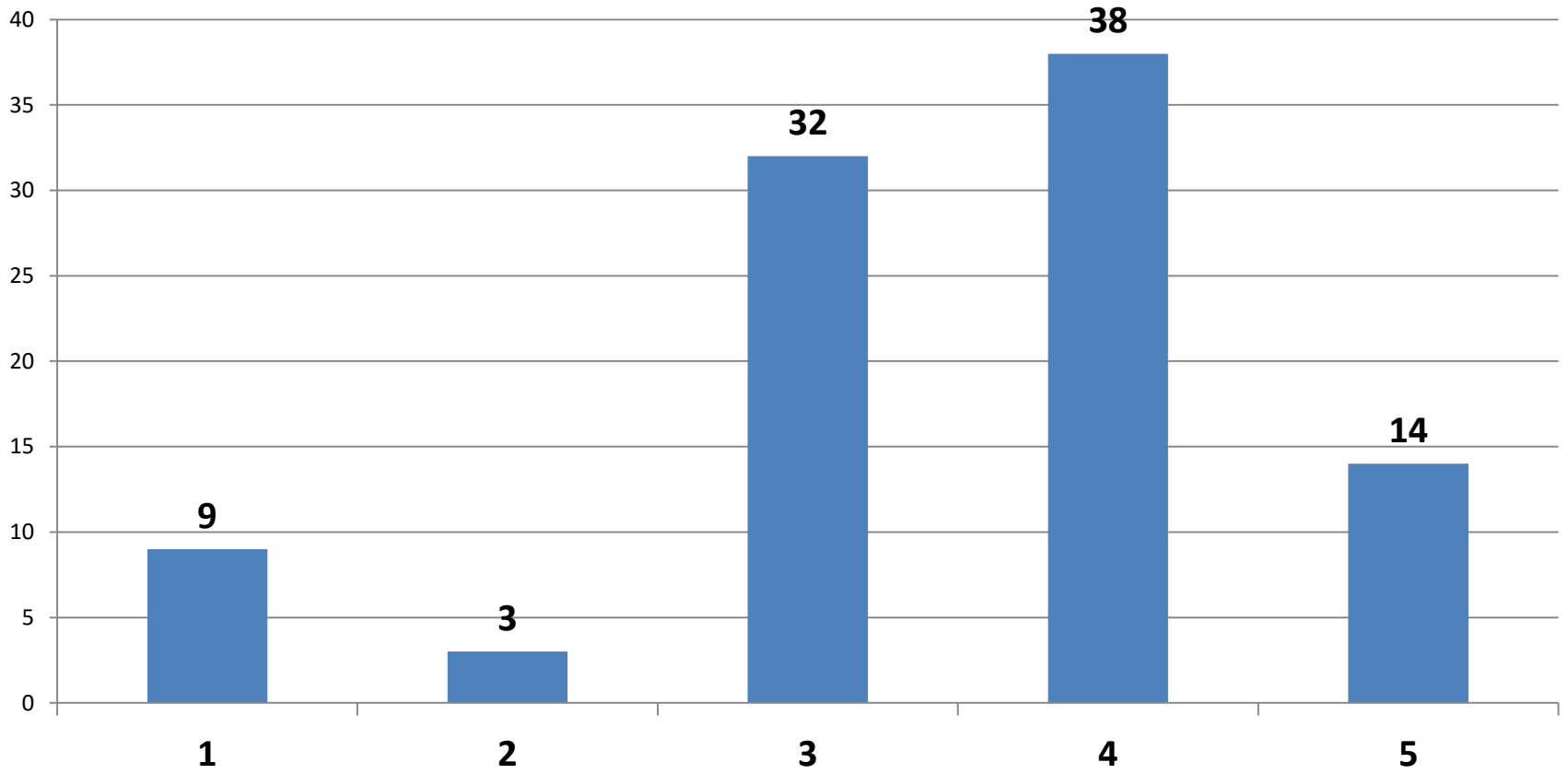
17. Wellness Program for Agency Staff

1. There is no wellness program for agency staff.

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

3. All #2 AND occasional educational programming regarding healthy lifestyles, and policy support for healthy food options at agency meetings.

4. All #3 AND policy support for healthy lifestyle opportunities during work time.

5. There is a structured wellness program, following national recommendations. Staff are actively encouraged by agency with fitness opportunities and healthy food choices at the agency headquarters, and agency-funded participation in disease-prevention programs like tobacco cessation.

17. Wellness
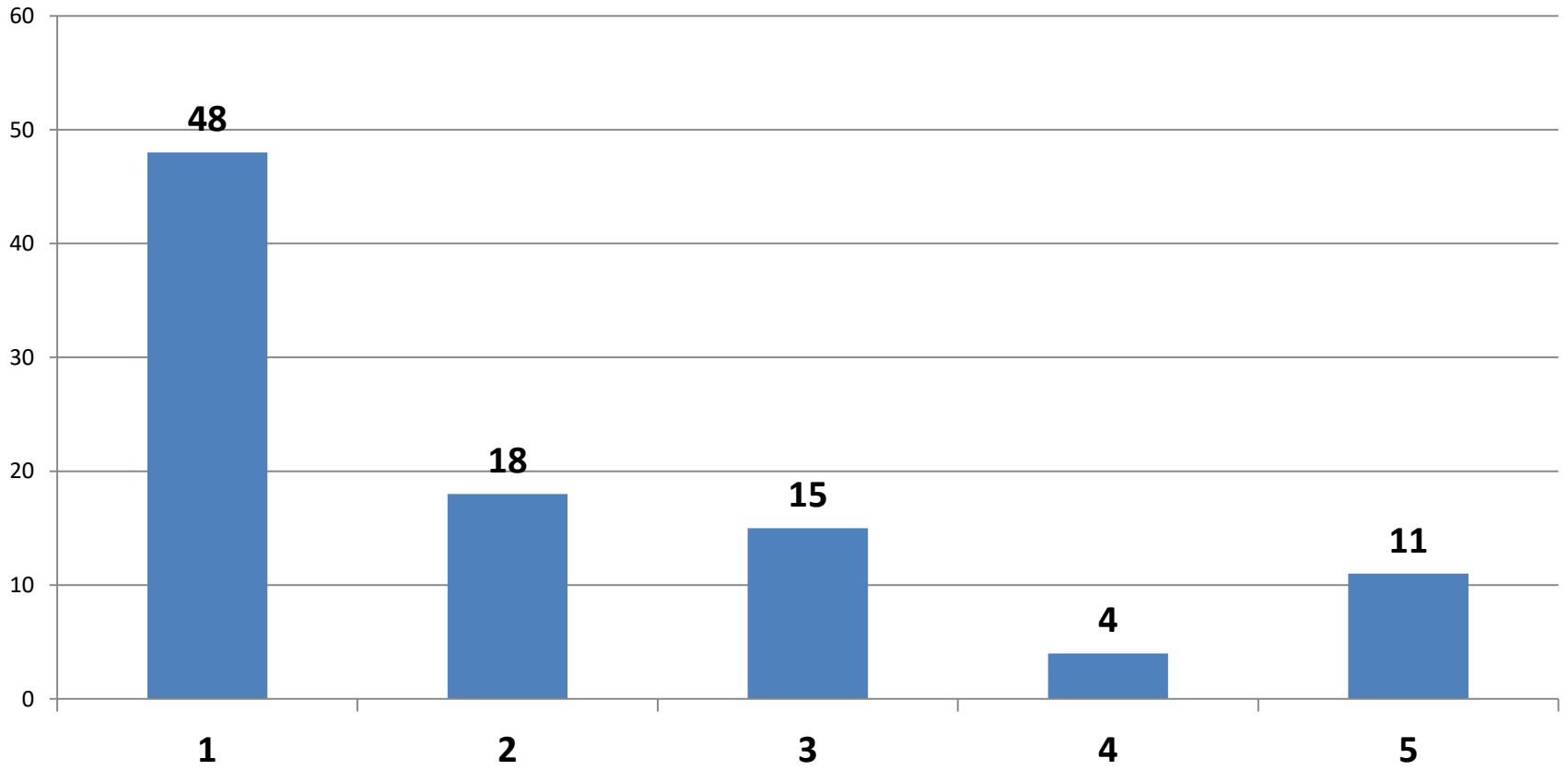
18. Incident Response and Mental Wellness

1. There is no incident response and mental wellness debriefing.
2. There is informal and positive debriefing and support from more experienced employees.
3. There is informal and positive debriefing and support from more experienced employees. Dispatch occasionally notifies agency on a predetermined set of calls (pediatric, suicides, fatalities, trauma, etc), with agency leadership addressing possible issues informally.
4. Agency leadership has training in Incident Response, is consistently notified by Dispatch at the time of possible incident, and has a policy of debriefing impacted member(s).
5. All of #4, plus professional counseling session(s) offered at reduced or no charge to member(s) impacted. Follow-up check-in with impacted member(s) is standard procedure.

18. Mental
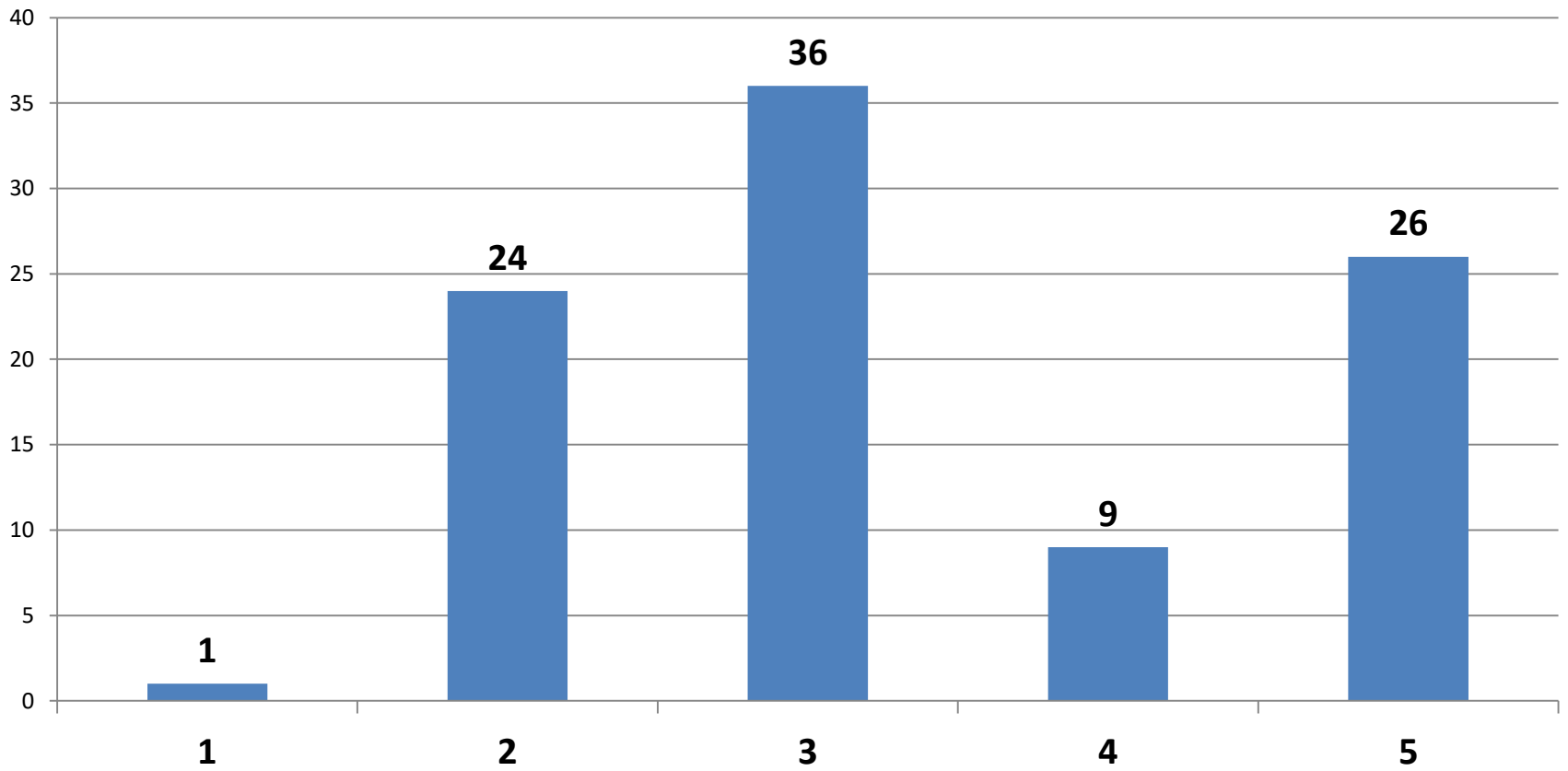
19. Patient Reporting After Response

1. There is no report given at the transfer of care.
2. Radio report and verbal report given to staff.
3. Radio report and written synopsis to staff.
4. Radio and verbal report to staff with written synopsis and written/epcr report sent to hospital within 24 hours.
5. Radio report and completed written/epcr left with hospital at end of response unless another emergency exists.

19. Patient Reporting
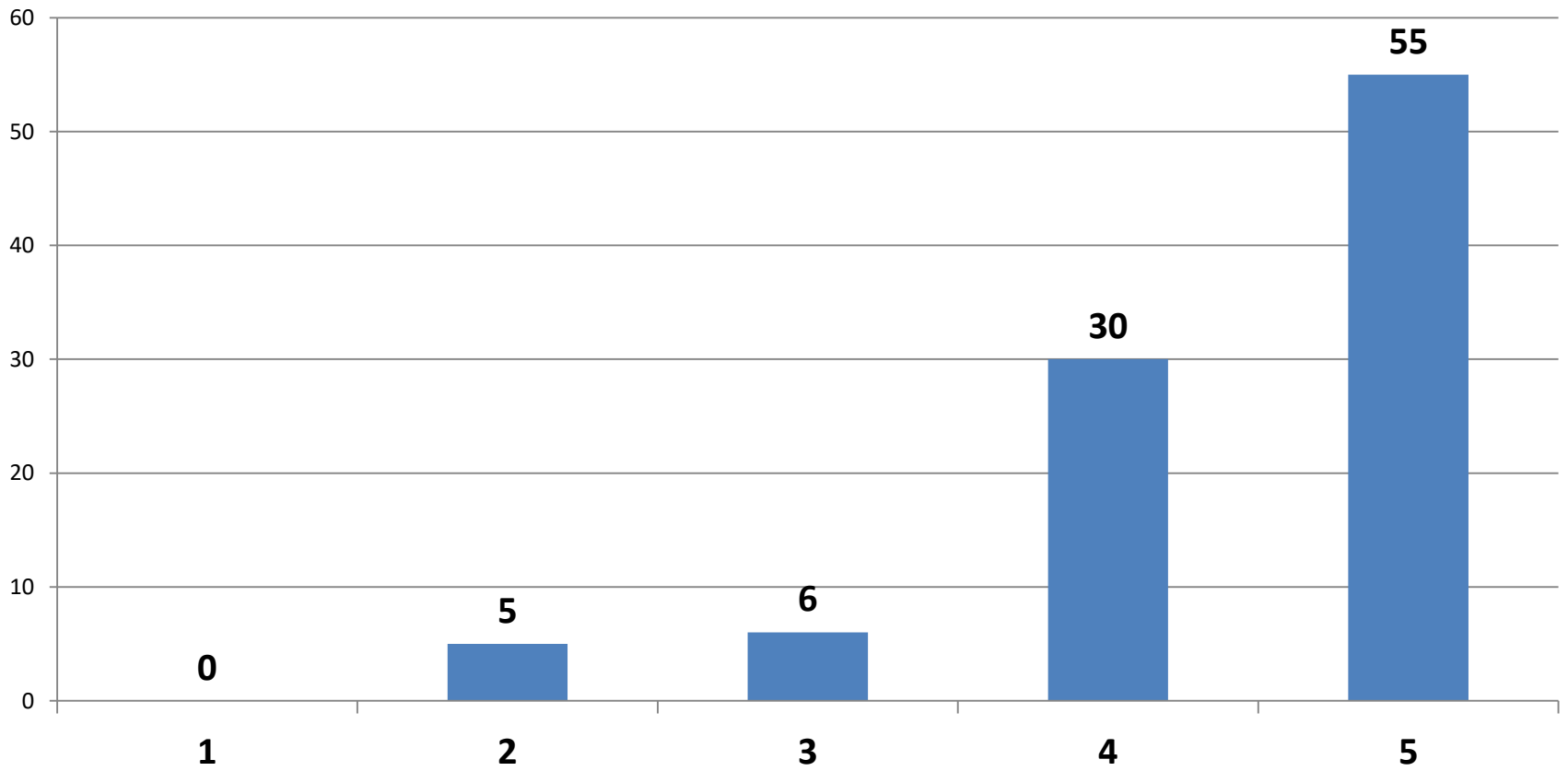
20. System Integrations

1. Operating totally independent.
2. At least one signed MOU with neighboring ambulance and function independently.
3. Utilizes ALS intercept according to transport plan and relies on assistance when called for.
4. Meets with the healthcare continuum within region to better facilitate collaboration.
5. Fully collaborates within region and state for tiered response, system integration and quality improvement.

20. System integration
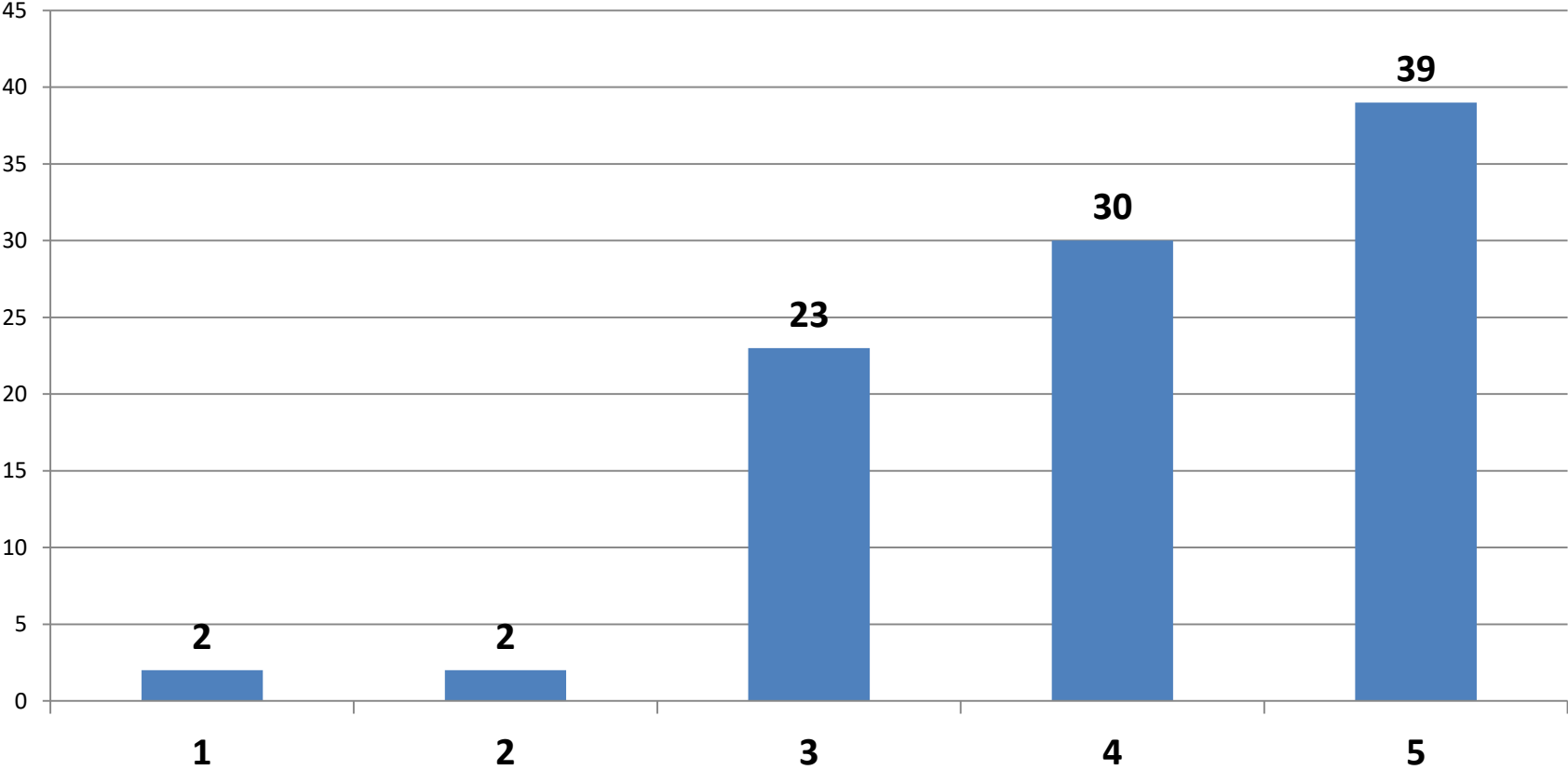
	1	2	3	4	5
1. Schedule	2	5	1	12	76
2. Board	1	33	27	18	17
3. Medical Director Involvment	20	7	20	29	20
4. Continuing Education	0	2	34	24	36
5. QA/QI	17	12	18	31	18
6. Recruitment/Retention	3	15	53	17	8
7. Standards	11	10	23	14	38
8. Written Policy	3	11	13	33	36
9. A Sustainable Budget	10	2	22	26	36
10. Leader	8	13	20	21	34
11. Billing	0	0	0	5	91
12. Technology	0	9	31	24	32
13. Attire	9	15	14	32	26
14. PIER	23	28	20	9	16
15. Community	2	20	19	30	25
16. Data	9	3	32	38	14
17. Wellness	48	18	15	4	11
18. Mental	1	24	36	9	26
19. Patient Care	0	5	6	30	55
20. System integration	2	2	23	30	39