SAN LUIS OBISPO COUNTY EMERGENCY MEDICAL SERVICES

ASSESSMENT

Presented by
Healthcare Strategists
April 2025

HEALTHCARE STRATEGISTS

Introduction

- Goal: Implement the Triple Aim of Healthcare concept to optimize the performance of the San Luis Obispo County EMS system.

- Healthcare Strategists: Consultants represent EMS, fire, and clinical experts, each with at least 35 years of industry experience.

Assessment Process

- Interviews: Meetings with EMS, fire, hospital, dispatch, community leadership, and county leadership.
- Ride-Alongs: Completed time with first responder and ambulance crews observing the system.
- Data Analysis: Historical call volume, performance, agreements, and other materials were reviewed.
- Support: The San Luis Obispo County Local EMS Agency (LEMSA) and all stakeholders were open and engaging in sharing their agencies' demographics, strengths, and opportunities for improvement.

EMS System Highlights

- Highly trained EMS stakeholders demonstrate a shared mission and vision for the prehospital continuum of care.
- EMS stakeholders voiced their appreciation for the new LEMSA staff, recognizing the recent policy and procedure improvements and clinical innovation by the new EMS Medical Director.
- EMTs are allowed to use their full scope of practice.
- EMS stakeholders and community leaders value the improvement in response times overall since the start of the most recent contract; Los Osos was highlighted.
- Single patient care report (PCR) platform is a best practice leading to a single patient chart, preloading dispatch data, sharing data on scene, and enhanced continuous quality improvement (CQI).

EMS System Highlights
(continued)

- Non-emergency calls do not have an unnecessary response time standard.
- Field-level relationships between system participants are strong.
- Some fire departments match their equipment and supplies with SLA, improving patient care in the field.
- Day (12-hour) units are prioritized when possible, preventing fatigue of the 24-hour units due to overutilization.
- Ambulances and ambulance stations are clean and well-maintained.
- Cambria Ambulance provides interfacility transports (IFT) for its residents to get home sooner and at no expense (covered by parcel taxes).

DISCUSSIONS, FINDINGS, AND RECOMMENDATIONS

HEALTHCARE STRATEGISTS

Preface

- Findings and recommendations are based on best practices, industry trends, and service innovation.
- Recommendations may need to be part of an EOA bid, a new provider contract, or other process.
- Recommendations do not consider external factors such as financial resources, provider interest, or political support to implement.
- Key Findings/Recommendations are indicated in red and underlined.

1.

EMS Response and Transport

Transparency

Finding: Stakeholders expressed a desire for more balanced EMCC membership, noting there may be too many voting SLA members.

Recommendation: Review EMCC membership to ensure an appropriate balance of members.

Finding: Stakeholders noted that not all organizations share CQI data.

Recommendation: Ensure system-wide CQI for patient care using PCR data from all system participants by adding contract or policy language that requires data sharing.

1.

EMS Response and Transport
(continued)

Unit Hour Utilization (UHU)

Finding: **SLA provides stations for its staff, which is a positive benefit. Concerns were raised that crews rarely post at their stations due to the heavy workload. Data shows UHU rising, but it is within an acceptable range (i.e., less than 0.40) for the 24-hour units. It should be noted that UHU data captures responses and transports but not post moves.**

Recommendations:

- ✓ **Continue to provide rest stations. Evaluate and monitor UHU and implement a workload for personnel that enables appropriate rest and meal breaks.**
- ✓ **Consider adding a maximum response UHU requirement for 24-hour units to the next contract.**

Unit Hour Utilization

Unit	Hours	2020	2021	2022	2023	2024
M21	24	0.20	0.22	0.26	0.26	0.27
M22	24	0.14	0.17	0.19	0.20	0.21
M31	24	0.20	0.19	0.23	0.21	0.21
M32	24					0.17
M41	24	0.17	0.19	0.20	0.20	0.21
M51	24	0.21	0.23	0.26	0.26	0.28
M52	24	0.22	0.23	0.26	0.26	0.28
M61	24	0.21	0.26	0.26	0.37	0.26
M62	24	0.21	0.22	0.26	0.26	0.26
M71	24	0.13	0.14	0.17	0.16	0.17
M91	12	0.39	0.41	0.41	0.44	0.41
M92	12	0.40	0.40	0.39	0.50	0.43
M93	12	0.31	0.34	0.32	0.36	0.33
Average		**0.25**	**0.27**	**0.28**	**0.31**	**0.29**

Source: LEMSA CAD data

1.

EMS Response and Transport (continued)

Unit Hour Utilization (UHU), continued

Finding: **Monthly UHU data for 24-hour units do not exceed the recommended threshold of 0.40.**

Recommendation: **Monitor monthly UHU for 24-hour units to identify any fatigue concerns that may require changes to the deployment/system status plans.**

Unit Hour Utilization, 2024													
Unit	**Hours**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
M21	24	0.23	0.27	0.26	0.28	0.30	0.26	0.33	0.27	0.26	0.25	0.26	0.25
M22	24	0.20	0.20	0.22	0.24	0.21	0.18	0.23	0.21	0.20	0.20	0.20	0.20
M31	24	0.22	0.18	0.25	0.22	0.23	0.23	0.23	0.21	0.20	0.20	0.20	0.17
M32	24							0.17	0.15	0.15	0.17	0.17	0.18
M41	24	0.19	0.21	0.19	0.24	0.22	0.19	0.21	0.23	0.20	0.18	0.23	0.19
M51	24	0.28	0.23	0.24	0.27	0.29	0.27	0.28	0.28	0.29	0.29	0.30	0.27
M52	24	0.26	0.25	0.27	0.27	0.29	0.28	0.27	0.30	0.30	0.27	0.28	0.29
M61	24	0.27	0.23	0.25	0.28	0.26	0.29	0.26	0.26	0.25	0.26	0.24	0.29
M62	24	0.27	0.24	0.27	0.27	0.27	0.31	0.26	0.26	0.26	0.24	0.22	0.25
M71	24	0.17	0.17	0.21	0.17	0.19	0.16	0.19	0.13	0.17	0.18	0.16	0.17
M91	12	0.44	0.41	0.42	0.46	0.45	0.41	0.43	0.40	0.40	0.33	0.38	0.42
M92	12	0.40	0.40	0.51	0.42	0.48	0.35	0.49	0.43	0.51	0.38	0.46	0.36
M93	12	0.28	0.31	0.36	0.27	0.35	0.33	0.35	0.38	0.34	0.30	0.32	0.33
Average		**0.29**	**0.27**	**0.30**	**0.29**	**0.31**	**0.29**	**0.30**	**0.30**	**0.30**	**0.27**	**0.29**	**0.29**

Source: LEMSA CAD data

2.

Communications

Findings

- ✓ There are six dispatch centers in the County operating at different levels, leading to inefficiencies, inconsistent approaches, potential errors, and delays in resource dispatching.
- ✓ Stakeholders indicate that ambulance crews do not receive status or safety checks and are not required to acknowledge power lines down or staging for violent calls.
- ✓ Dispatch, fire, and EMS cannot see the unit locations for all resources.
- ✓ There is a plan to collocate law, fire, and EMS dispatch into one center.

Recommendations: Until a consolidated dispatch center is available, consider these interim improvements:

- ✓ Establish CAD-2-CAD links to quickly and accurately share information between centers.
- ✓ Ensure ambulance crews are properly warned and tracked during all calls.
- ✓ Select a common platform for sharing fire and EMS resources on the same system (e.g., Radio Mobile, Tablet Command, First Due)

2.

Communications
(continued)

Emergency Medical Dispatch (EMD)

Findings:

- ✓ Dispatch centers do not consistently use the EMD process. MedComm utilizes a homegrown version of EMD, seemingly based on APCO, using a static PDF guide that requires multiple steps. CAD data suggests there is minimal EMD completion due to this complexity.
- ✓ Primary public safety answering points (PSAPs) have inconsistent policies on when to transfer a caller to MedComm for EMD and pre-arrival instructions.
- ✓ There does not appear to be a formal CQI program for call review.
- ✓ There are nearly 1,700 chief complaint categories, which are not conducive to CQI processes or determining the proper use of lights and siren.

Recommendations:

- ✓ Implement an industry-standard EMD platform that seamlessly integrates with the CAD and allows for a robust CQI review.
- ✓ Develop a uniform decision-making approach to determining the triage of all medical calls regardless of PSAP.

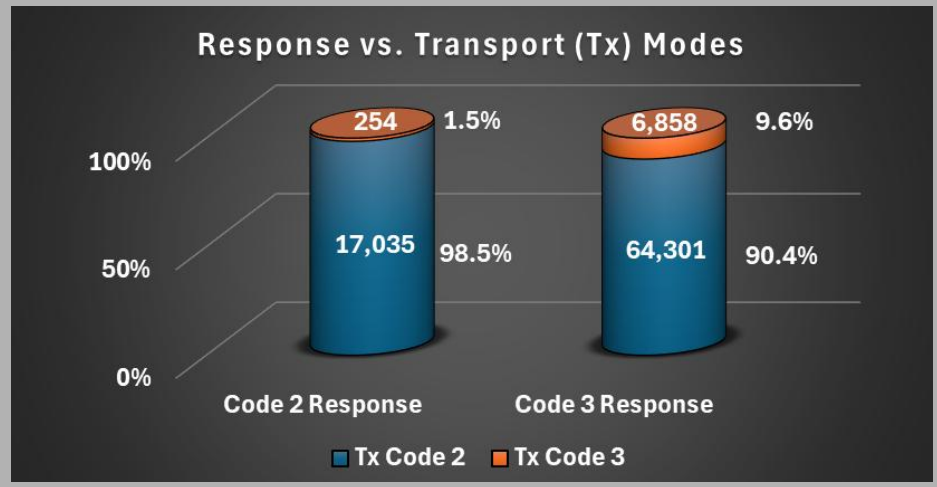
2.

Communications
(continued)

Call Triage and Prioritization

Finding: 80.5% of calls are triaged as an emergency, with only 9.6% being transported with lights and siren. This creates an unnecessary risk to the field staff and the driving public without benefiting most patients.

Recommendation: When implementing the new EMD system, constantly review call types to determine response mode by likelihood of emergency transport or, even better, probability of critical intervention.



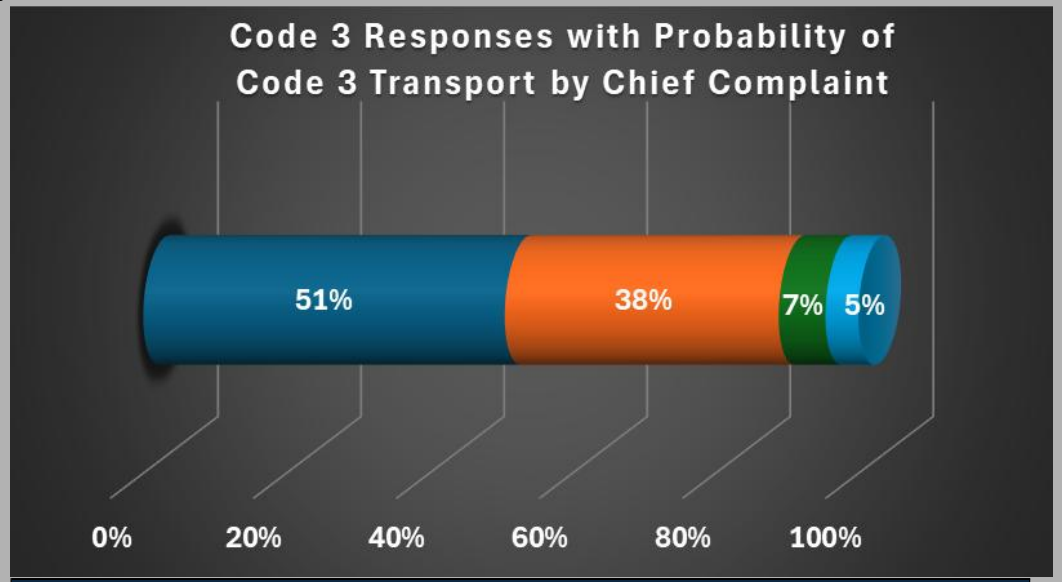
Response Mode	Transport Mode					
	Tx Code 2		Tx Code 3		Total	
Code 2 Response	17,035	98.5%	254	1.5%	17,289	19.5%
Code 3 Response	64,301	90.4%	6,858	9.6%	71,159	80.5%
Total	81,336	92.0%	7,112	8.0%	88,448	100.0%

2.

Communications
(continued)

Call Triage and Prioritization

Example: Of the 1,698 chief complaint (CC) types, 1,237 did not result in a Code 3 transport or roughly 5% of all responses. 4,657 (7%) of calls had less than a 1% chance of Code 3 transport.



Code 3 Responses vs. Transports by Chief Complaint			
Chief Complaint	**Categories**	**Calls**	**Percentile**
Total Complaints	1,698	71,159	100%
Complaints with >5% Code 3 Transports	402	35,971	51%
Complaints with 1-5% Code 3 Transports	51	27,257	38%
Complaints with 0.1-1% Code 3 Transports	8	4,657	7%
Complaints with 0% Code 3 Transports	1,237	3,274	5%

Source: CAD Data (for those calls with reported transport modes)

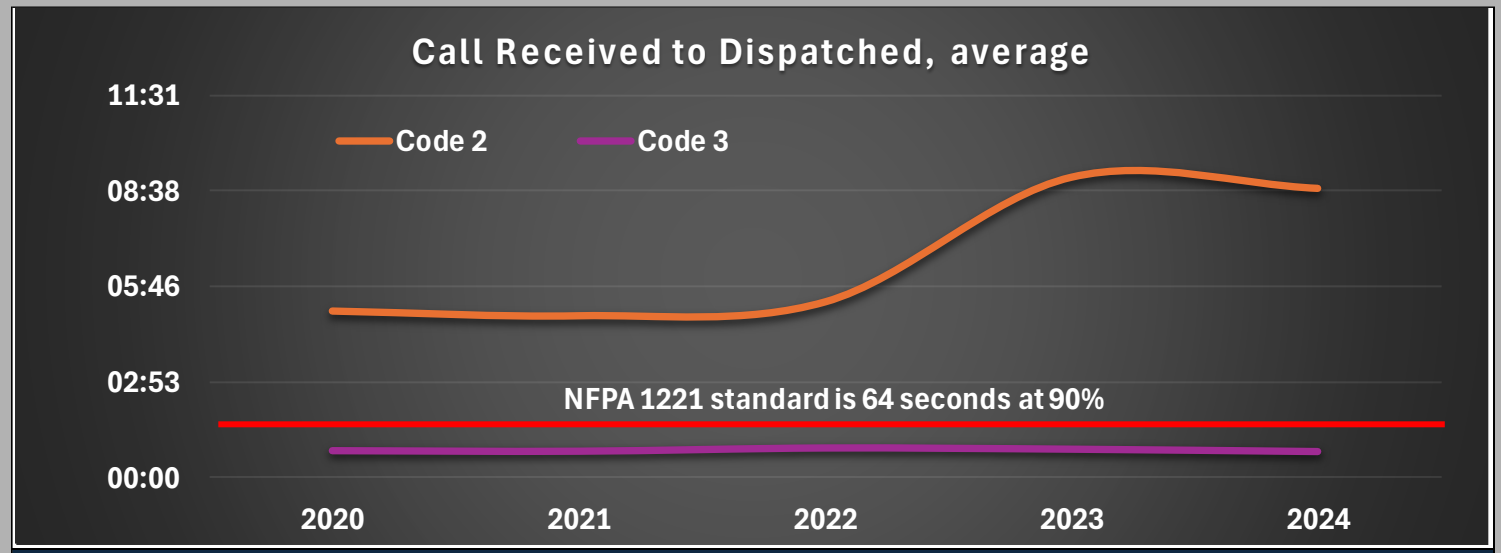
2.

Communications
(continued)

Ambulance Call Processing

Finding: Call processing times are longer than IAED and NFPA benchmarks, especially when using EMD infrequently, delaying fire and EMS resources.

Recommendation: Hire and train sufficient staff to meet industry standards.



Average Time from Call Received to Dispatched

911 Call Type	2020	2021	2022	2023	2024	Average	90% ile
Code 2	05:02	04:54	05:18	09:02	08:42	06:32	15:43
Code 3	00:49	00:48	00:53	00:52	00:48	00:50	01:36
Average	**01:38**	**01:30**	**01:37**	**02:05**	**01:59**	**01:46**	**02:02**

Source: LEMSA, 911 calls only; over 4,000 code 2 calls were longer than 5:00 minutes (possibly IFT calls, not 911)

2.

Communications
(continued)

Tiered Response

Finding: Stakeholders desire a robust tiered response, adding BLS units for low acuity calls. The EMS Medical Director supports this model.

Recommendation: Implement tiered response to match calls to the right resource. These programs require accurate EMD data; implementation will need to wait until there is a validated EMD system.

Finding: Nonemergency (Code 2) calls have no response time standards. This is an industry best practice for smoothing call demand without unnecessarily risking the public.

Recommendations:

- ✓ Develop a call-holding queue for low acuity calls at certain system levels to maintain sufficient 911 resources for high acuity calls.
- ✓ Consider medical policies for first responders to assess and release low acuity patients pending ambulance arrival

2.

Communications
(continued)

Resource Optimization

Finding: The system status plan (SSP) is not automated, which can result in inconsistent application and inefficient ambulance coverage.

Recommendation: Implement dispatch computer upgrades necessary to automate and expedite the SSP process.

Finding: Stakeholders noted that the ambulance dispatch center does not divert a closer ambulance to a code 3 call if assigned to a code 2 call.

Recommendation: Consider adding a procedure to send the closest resource to an emergency call, even if already committed.

Finding: Multiple fire resources can be sent to the same call when only one is needed.

Recommendation: Research opportunities to send only the necessary fire resources in coordination with relevant mutual aid agreements.

2.

Communications
(continued)

Communication Efficiencies

Finding: There is no paging interface between the CAD (CentralSquare) and radio (Avtec/Motorola).

Recommendation: Integrate CAD to radio paging to streamline unit notifications and reduce dispatcher workload.

Finding: Stakeholders report ambulance crews do not routinely monitor the appropriate frequency.

Recommendation: Until there is a single dispatch center with fire and EMS on the same frequency, assess and implement processes for ambulance crews to monitor the appropriate frequencies.

3.

Clinical Oversight and System Performance

Medical Direction

Finding: Stakeholders recognized protocol improvements with a renewed focus on patient care with the new LEMSA team, identifying Dr. Mulkerin as open-minded and innovative.

Recommendation: Support and expand this collaboration to optimize clinical benefits to the patient and patient-centered protocols.

Finding: The LEMSA Medical Director is also the Medical Director for every provider except SLA. Representing both the LEMSA and the provider agency's interests during an incident or investigation can be a conflict of interest.

Recommendation: Providers may want to hire their own Medical Directors/Associates to represent their staff and interests (can be the same or different between providers).

3.

Clinical Oversight and System Performance (continued)

Quality Metrics

Finding: Stakeholders report generally good clinical care, but identified extended scene times, over/under-triage of trauma patients, and limited call reviews.

Recommendation: Require quality metric reporting for items that impact patient outcomes and ensure sufficient clinical management staff in the next contract for staff training/education.

3.

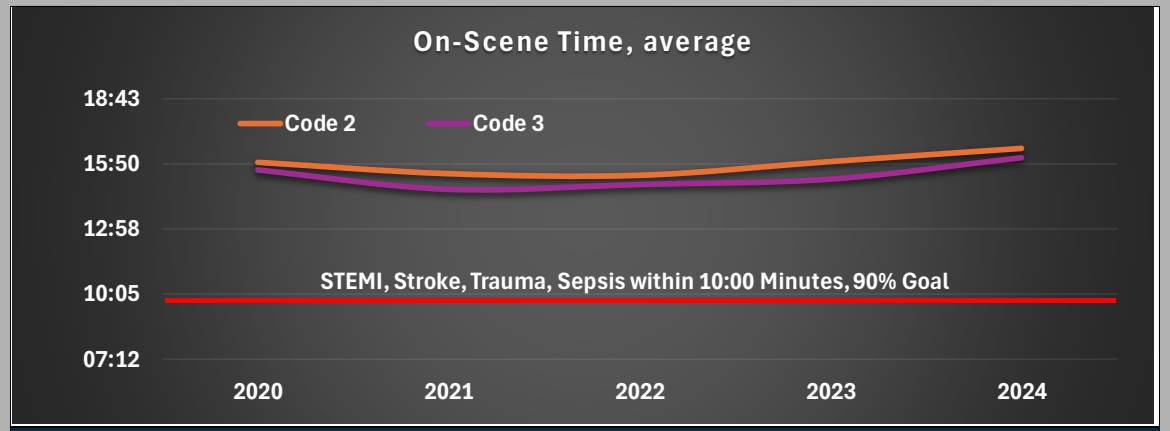
Clinical Oversight and System Performance (continued)

Findings:

- ✓ On-scene time for Code 3 transports averaged 15:18, and 23:13 at 90%
- ✓ Code 2 transports averaged only 31 seconds more, and 47 seconds more at 90%
- ✓ The industry benchmarks for high acuity calls is 10-15 minutes at 80-90% compliance

Recommendations:

- ✓ Evaluate realistic scene times by call type and determine local goals.
- ✓ Educate field staff on how reducing on-scene time benefits patients.
- ✓ Monitor on-scene times and add as a performance metric to the next contract.



Average On-Scene Time, by transport mode

Transport Mode	2020	2021	2022	2023	2024	Average	90% ile
Code 2	15:53	15:23	15:19	15:55	16:29	15:49	24:00
Code 3	15:33	14:41	14:54	15:08	16:06	15:18	23:13
Average	**16:20**	**15:49**	**15:51**	**16:23**	**16:56**	**16:17**	**24:36**

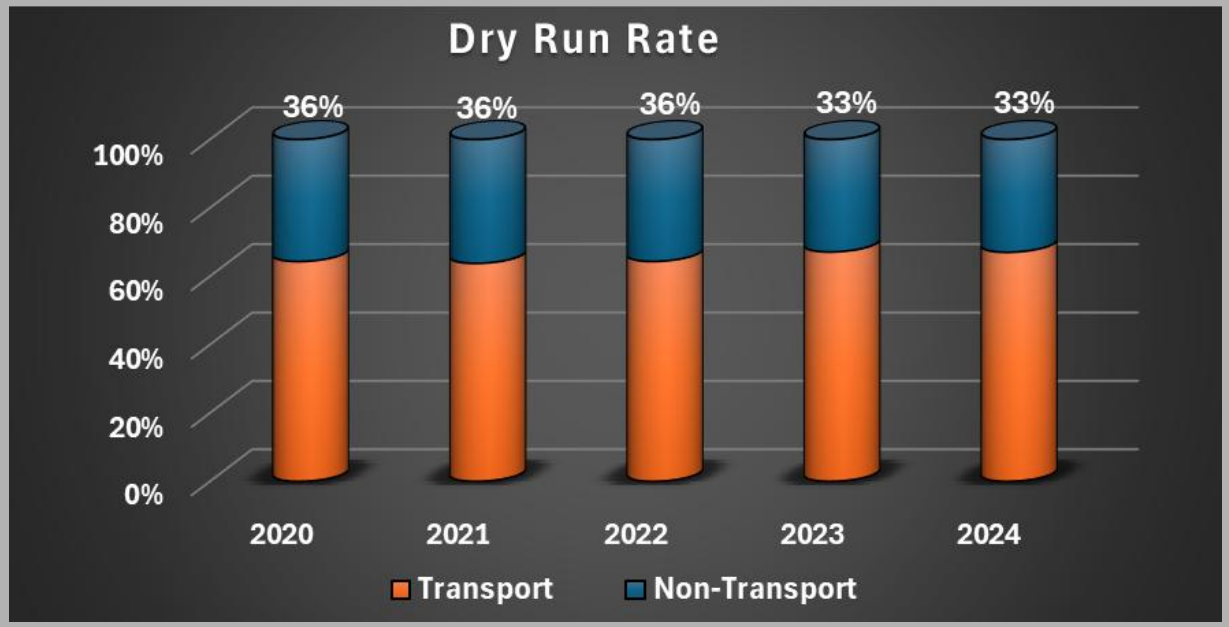
Source: LEMSA, 911 calls only; does not include "unknown" transport mode or on-scene times greater than 60 minutes

3.

Clinical Oversight and System Performance (continued)

Finding: Stakeholders perceive that patients who are not transported do not receive a quality assurance review. The data shows an industry-acceptable non-transport rate.

Recommendation: The next contract should include regular reports about overall non-transport rates, and providers should be reviewed by employee with periodic call audits and follow-up for outliers.



3.

Clinical Oversight and System Performance (continued)

Finding: **The Cardiac Arrest Registry to Enhance Survival (CARES) Report identified that the County has good survival outcomes compared to the State, and a bit below national numbers. It identified opportunities to improve survival by improving bystander CPR intervention.**

Recommendations:

- ✓ **Continue participation in the CARES program and compare data elements to identify and implement clinical improvement opportunities.**
- ✓ **All providers should consider offering more public CPR classes and possibly include a greater ambulance contract commitment to public CPR in the future.**

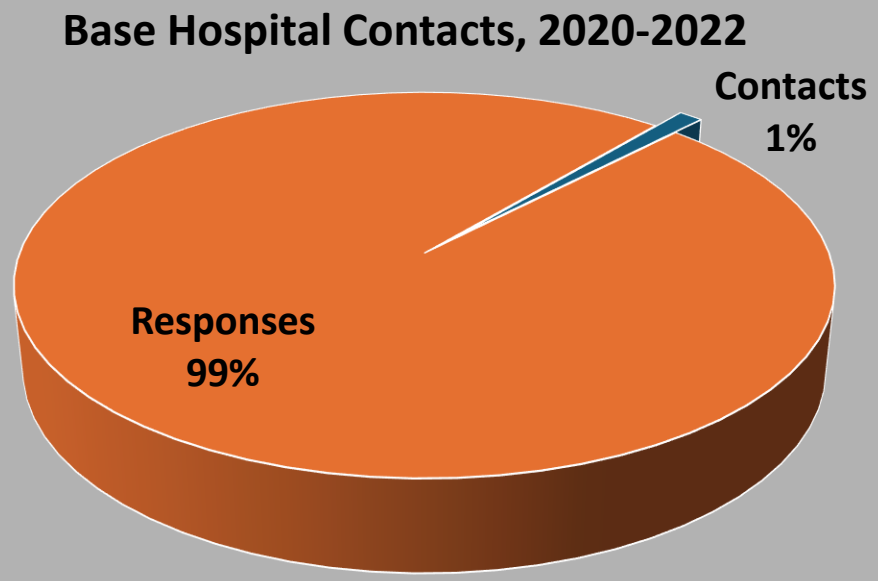
3.

Clinical Oversight and System Performance (continued)

Base Hospitals

Finding: Base hospital contacts were minimal from 2020 to 2022. Current data may reflect even fewer contacts with the newer, more progressive EMS protocols. Crews and hospital nurses mentioned the ED MD typically handles the requests, not the MICN nurse. Sometimes, no MICN is on duty.

Recommendation: Consider eliminating the base hospital program in favor of contacting the receiving hospital when needed. Transition base station committee to receiving hospital committee.



Base Hospital Contacts	
Transports, Code 2	398
Transports, Code 3	144
Field Death Declaration	46
Non-Transport	14
Total	**602**
Total Responses	**53,026**

3.

Clinical Oversight and System Performance (continued)

Finding: Stakeholders voiced mixed reviews about whether SLA is requesting too many exemptions. There were only seven exemptions requested between July 2024 and February 2025. Of the seven, four were granted, three were denied.

Recommendation: The current number of exemption requests is low and is managed using a manual process. First Watch has an automated process that may improve efficiencies for both the LEMSA and the provider, should exemption requests increase.

3.

Clinical Oversight and System Performance (continued)

Performance and Quality Processes

Findings:

- ✓ Key performance indicators (KPIs) and CQI tracking tools are not automated to reduce LEMSA workload.
- ✓ Stakeholders believe clinical protocols are inconsistently applied.
- ✓ Stakeholders requested greater transparency with clinical KPIs and response time performance.
- ✓ When a possible issue is identified, there appear to be cooperation challenges during the investigation with the current provider.

Recommendations:

- ✓ Implement CQI tools, preferably automated, that identify clinical protocol compliance and EMS system performance.
- ✓ Share KPI and performance data for stakeholder access, possibly through the LEMSA website or an online portal.
- ✓ Strengthen the contract requirements for sharing employee information as necessary for LEMSA investigations.

4.

Acute Care Hospitals

Specialty or Advanced Care Centers

- 1 Level 3 trauma center
- 5 prehospital receiving hospitals, all of which are primary stroke centers
- 1 receiving hospital is a designated STEMI receiving center, with one located close by in Santa Barbara County as a STEMI receiving center for south San Luis Obispo County.
- No comprehensive stroke center
- No ECMO capability

4.

Acute Care Hospitals
(continued)

Finding: **77% of trauma cases are transported directly to trauma centers. A significant number of cases are transferred from French and Twin Cities Hospitals (some may be walk-in traumatic injuries). Transfers from a County hospital to a trauma center are minimal (6.1%) and within an acceptable range for under-triage.**

Recommendation: **Review trauma criteria and protocols, consider field education to increase the appropriate destination of a trauma center at least 90% of the time (some cases should go to the closest hospital, such as unstable airways).**

Specialty Care Destinations							
Trauma	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**	
Arroyo Grande	33	33	59	69	103	297	7%
French	17	21	35	32	179	284	6%
Marian*	67	83	94	92	126	462	10%
Sierra Vista*	520	595	593	650	635	2,993	67%
Twin Cities	73	82	90	96	118	459	10%
Total	**710**	**814**	**871**	**939**	**1,161**	**4,495**	**100%**
Trauma Transfers From	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**	
Arroyo Grande	3	2	4	3	4	16	5%
French	10	19	18	20	30	97	33%
Twin Cities	28	28	30	39	54	179	61%
Total	**41**	**49**	**52**	**62**	**88**	**292**	**100%**

Source: PCR data Note: * Designated Trauma Center

4.

Acute Care Hospitals (continued)

Findings:

- ✓ **Stroke – Cases are relatively constant, averaging 391 from 2020 to 2024. Roughly 130 are transferred out each year based on PCR data.**
- ✓ **STEMI – Scene activations are fairly constant at 109 annually, with the largest increase in 2024. PCR data indicate that 260 STEMI cases are transferred to a higher level of treatment annually. Therefore, more STEMI cases are arriving by private vehicle than by ambulance.**

Recommendations:

- ✓ **Assess opportunities to add capabilities (e.g., ECMO, Cath Lab, Neurosurgery) and retain more stroke and STEMI cases within the County to reduce time to definitive care and transfers.**
- ✓ **Increase public awareness of heart attack symptoms, to call 911 sooner, and not drive to the hospital.**

Specialty Care Destinations

Stroke	2020	2021	2022	2023	2024	Total	
Arroyo Grande	65	88	79	89	89	410	21%
French	34	28	39	52	43	196	10%
Marian	20	25	29	40	46	160	8%
Sierra Vista	88	112	107	108	102	517	26%
Twin Cities	117	133	137	163	120	670	34%
Total	**324**	**386**	**391**	**452**	**400**	**1,953**	**100%**

STEMI	2020	2021	2022	2023	2024	Total	
Arroyo Grande		2	5	1	7	15	3%
French	74	98	86	83	36	377	69%
Marian	5	13	14	12	9	53	10%
Sierra Vista			1	4	76	81	15%
Twin Cities	1		3	4	10	18	3%
Total	**80**	**113**	**109**	**104**	**138**	**544**	**100%**

Specialty Care Transfers Out

Stroke	2020	2021	2022	2023	2024	Total	
Arroyo Grande	9	13	4			26	5%
French	7	10	6	7		30	6%
Sierra Vista	3	1	7	6		17	3%
Twin Cities	11	9	10	13		43	8%
Total	**105**	**114**	**126**	**175**		**520**	**100%**

STEMI	2020	2021	2022	2023	2024	Total	
Arroyo Grande	34	39	32	51	28	184	14%
French			1	3	31	35	3%
Sierra Vista	17	15	24	20	62	138	11%
Twin Cities	51	45	66	71	43	276	21%
Total	**228**	**251**	**278**	**318**	**225**	**1,300**	**100%**

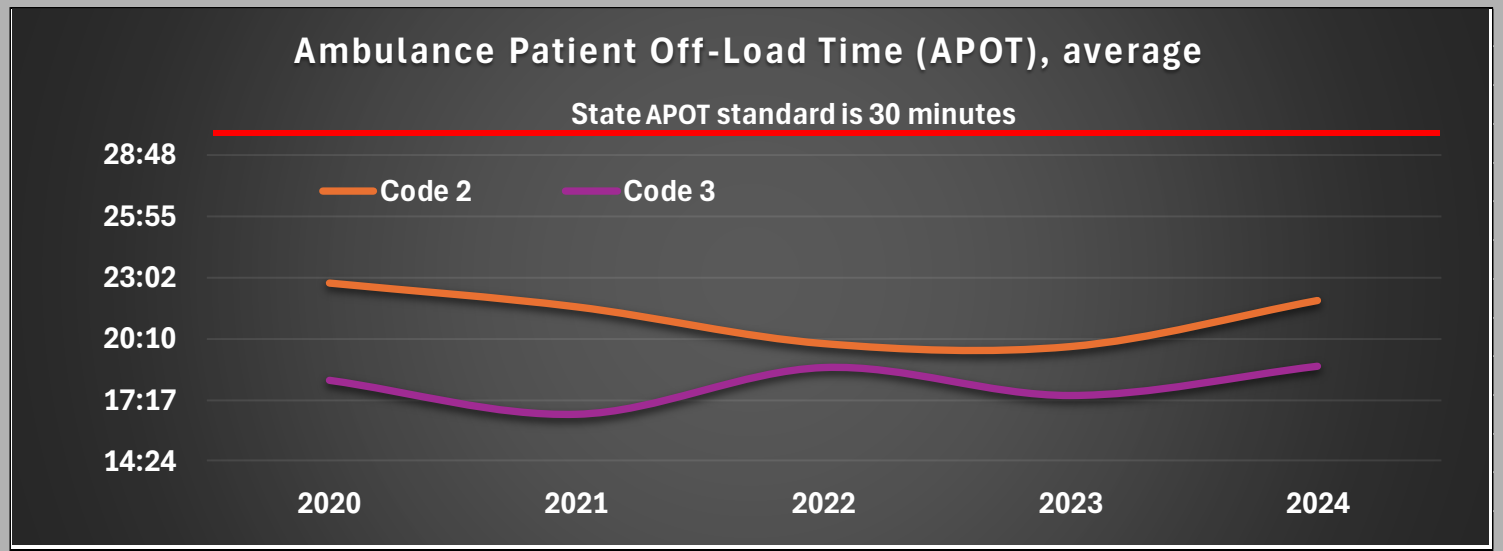
Source: PCR data

4.

Acute Care Hospitals (continued)

Finding: Ambulance Patient Off-Load Times (APOT) have been relatively consistent and within the State goal of 30 minutes at 90% compliance.

Recommendation: Maintain and continue to reduce off-load delays, capitalizing on best practices provided in the California Hospital Association (CHA)/ Emergency Medical Services Authority (EMSA) toolkit at Toolkit to Reduce Ambulance Patient Offload Delays.



Average Hospital Off-Load Time, response mode

Response Mode	2020	2021	2022	2023	2024	Average	90% ile
Code 2	22:47	21:39	19:54	19:46	21:57	21:12	27:26
Code 3	18:12	16:37	18:47	17:29	18:51	18:01	25:33
Average	**19:14**	**17:38**	**19:01**	**17:53**	**19:24**	**18:38**	**25:52**

Source: LEMSA, 911 calls only for hospital arrival to available; does not include "unknown" response mode

5.

First Responders Integration

Surge Capacity

Finding: **Fire stakeholders would like to staff ambulances to provide surge capacity during unusually high system demand.**

Recommendation: **Develop additional transport capacity through surge fire transport resources following clear protocols. Fire resources should be compensated per unit hour or strategy.**

5.

First Responders Integration

Incident Command and Scene Control

Finding: **Concerns were raised that SLA employees and field supervisors do not consistently follow ICS. Supervisors were reported to give direction and cancel units from calls without coordination with the scene incident commander (IC), possibly overriding the IC's decisions. It was noted during ride-alongs that the crew members were confused about their roles on scene.**

Recommendations:

- ✓ **Ensure the next contract contains requirements for all personnel to obtain relevant ICS training.**
- ✓ **Multi-casualty incidents (MCI) should have a multi-agency debrief to identify opportunities for improvement.**
- ✓ **Consider adding mandatory training for field personnel on MCI Policies 200 and 210.**
- ✓ **Provide education on scene control to ambulance providers.**

5.

First Responders Integration

Staffing

Finding: Los Osos service area has a low call volume. It is staffed with a dual-paramedic first responder ALS (FRALS) unit by CALFIRE. Research shows that ALS skills can weaken without sufficient call volume.

Recommendation: Adjust the FRALS contract to a paramedic/EMT unit to increase ALS skill proficiency through lesser skill dilution.

Finding: Fire stakeholders expressed interest in more involvement in the EMS system.

Recommendations:

- ✓ Allow fire responders to "stop the clock" as appropriate, extend ambulance response times, and invest cost savings into the EMS system elsewhere.
- ✓ Maximize the full scope of practice for EMTs and consider optional scope items to optimize community benefits.
- ✓ Consider upgrading to paramedics for agencies with sufficient ALS call volume to maintain skill proficiency, especially those with longer response times.

5.

First Responders Integration

Financial Considerations

Finding: Historically, first responders exchanged medications close to expiration with the ambulance provider, saving approximately $1,500 per ALS engine.

Recommendation: Evaluate the cost implications of reinstating this program along with clear controls and limits.

Finding: The current first responder contract formula has not been reviewed in 10 years.

Recommendation: Analyze the current formula structure and consider adjusting for the benefits first responders provide.

5.

First Responders Integration

Collaboration

Finding: Some fire stakeholders desire greater EMS collaboration within the County fire agencies.

Recommendation: Consider forming a Fire/EMS Joint Powers Authority (JPA) or other partnership model for unified fire leadership of EMS needs.

Finding: Stakeholders reported a lack of joint training and education between ambulance and first responder staff. Example: Santa Barbara EMS Agency conducted a large-scale regional MCI airport drill and SLA did not attend.

Recommendation: The current contract requires collaborative training, and future agreements should continue this activity along with consequences for failure to do so, which will produce better patient care on scene.

6.

Deployment of Ambulance Resources and Response Times

System Status Plans

Finding: The APOT Committee manages the system status plan. Not all ambulance providers are involved, yet they are impacted.

Recommendation: Develop a System Status Committee with representatives from all system participants.

Call Downgrades

Finding: First responders shared a recent protocol change made it harder to downgrade ambulance response. Calls are rarely downgraded.

Recommendation: Review the protocol limiting downgrades and determine opportunities for fire to downgrade when appropriate.

6.

Deployment of Ambulance Resources and Response Times (continued)

Response Time Tracking

Finding: Ambulance times are pulled from ImageTrend PCR data, which ambulance crews can update.

Recommendation: Data for response time compliance should be pulled from the CAD to ensure objectivity.

Finding: The response time clock starts when the call is ready for dispatch, not when the unit receives the notification.

Recommendation: The provider response time standard should start upon unit notification. Dispatch performance should be measured separately.

Finding: The current contract removes canceled calls enroute from the denominator and counts them as compliant regardless of response time.

Recommendation: Consider counting all calls where crews are dispatched within the denominator and determine whether the canceled calls are on time or late, depending on the response time at cancellation.

6.

Deployment of Ambulance Resources and Response Times (continued)

Ambulance Response Times

Finding: The negotiated contract was unclear on response times, whether at the whole minute or at minutes and 59 seconds, creating longer response times than desired.

Recommendation: Future contracts should clearly state the intentions of the EMS system.

Finding: There are 26 compliance zones, which is significant for the county's size, and are matched to political boundaries.

Recommendations

- ✓ Consider fewer zones as too many create significant costs for the EMS system with questionable patient benefits.
- ✓ Consider unique response zones to prevent "us vs. them" compliance comparisons between elected officials

6.

Deployment of Ambulance Resources and Response Times (continued)

AMBULANCE RESPONSE TIMES (CONTINUED)

Finding: **Response times improved with the new agreement, but are below contract standards.**

Recommendation: **Encourage the contract provider to meet standards, enforce liquidated damages, and consider material breach for non-compliance.**

Urban Compliance

Zone	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Time Standard		9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	10:59	10:59	10:59	10:59	10:59	10:59	10:59	10:59	10:59
Arroyo Grande		83.2%	81.8%	96.0%	86.4%	93.5%	86.5%	92.0%	90.8%	93.9%	93.2%	91.3%	86.9%	94%	88.3%	96.3%	93.8%	94.8%	96.3%	95.1%	97.1%	96.3%	95.7%	96.3%
Atascadero		77.4%	79.7%	83.1%	77.4%	79.4%	80.8%	78.9%	79.4%	74.9%	80.5%	84.1%	79.4%	81%	84.9%	93.0%	91%	91%	94.7%	91.9%	95.4%	94.2%	93.9%	94.7%
Cal Poly		61.9%	69.2%	63.6%	76.2%	84.2%	100.0%	100.0%	77.3%	71.0%	60.7%	76.9%	92.3%	77.7%	92.3%	82.3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Grover Beach		85.9%	84.0%	95.3%	91.5%	89.9%	78.6%	78.7%	80.4%	91.5%	89.5%	89.9%	92.5%	90.1%	91.3%	97.2%	96.1%	98.3%	94.4%	97.7%	96.7%	95.8%	95.8%	94.4%
Los Osos		22.9%	15.9%	14.5%	18.9%	18.3%	60.6%	70.1%	60.9%	62.9%	50.7%	55.6%	60.6%	56.4%	62.1%	62.8%	67.1%	67.1%	96.7%	91.2%	85.7%	92.6%	91.0%	96.7%
Morro Bay		79.4%	88.1%	89.2%	81.0%	85.4%	85.5%	83.1%	82.9%	89.0%	83.9%	85.3%	81.1%	83.9%	84.3%	91.7%	92.8%	95.3%	98.1%	93.8%	95.4%	95.2%	95.0%	98.1%
Nipomo		74.5%	68.4%	75.0%	77.3%	85.0%	82.2%	81.4%	81.7%	85.2%	88.0%	85.2%	90.4%	91.2%	92.1%	96.2%	96.3%	94.0%	89.4%	92.3%	93.5%	90.3%	95.1%	89.4%
Oceano		62.5%	62.1%	81.2%	78.3%	62.9%	66.6%	66.7%	87.8%	70.0%	70.7%	83.3%	83.3%	82%	84.4%	91.0%	91.4%	91.4%	96.8%	77.5%	88.8%	94.2%	94.3%	96.8%
Paso Robles		82.9%	81.9%	90.8%	87.0%	85.9%	83.7%	83.8%	89.8%	87.9%	85.8%	90.2%	87.5%	86.6%	86.1%	91.7%	93.2%	95.5%	94.0%	93.4%	92.7%	95.2%	94.6%	94.0%
Pismo Beach		60.2%	80.2%	77.3%	76.5%	81.3%	68.0%	71.6%	79.8%	83.8%	78.7%	77.3%	73.6%	85%	78.8%	91.6%	98.0%	95.2%	93.0%	94.6%	90.4%	91.3%	90.7%	93.0%
San Luis Obispo		88.5%	82.6%	80.9%	84.8%	83.7%	83.0%	86.1%	74.2%	83.1%	88.0%	84.3%	84.3%	82.3%	86.5%	94.8%	94.7%	95.2%	96.1%	96.1%	94.2%	93.0%	94.4%	96.1%
Templeton		78.7%	84.8%	84.0%	90.0%	89.4%	88.2%	86.5%	91.8%	93.2%	92.3%	81.8%	89.8%	92.4%	84.2%	95.0%	96.2%	93.2%	95.3%	96.7%	97.1%	98.0%	95.1%	95.3%

Suburban Compliance

Zone	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Time Standard		19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	20:59	20:59	20:59	20:59	20:59	20:59	20:59	20:59	20:59
Avila		100.0%	100.0%	100.0%	100.0%	94.1%	94.7%	100.0%	95.2%	92.9%	86.7%	93.3%	94.4%	100.0%	94.1%	83.3%	92.0%	100.0%	100.0%	100.0%	93.7%	100.0%	100.0%	100.0%
Cayucos		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	96.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Country Club		100.0%	100.0%	100.0%	N/A	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Garden Farms		N/A	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	N/A	N/A	100.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%	100.0%
San Miguel		100.0%	100.0%	93.8%	92.3%	82.1%	92.9%	100.0%	94.4%	100.0%	90.9%	92.9%	100.0%	88.8%	100.0%	100.0%	100.0%	95.0%	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Santa Margarita		100.0%	100.0%	85.7%	71.4%	85.7%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%

Rural Compliance

Zone	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Time Standard		29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	30:59	30:59	30:59	30:59	30:59	30:59	30:59	30:59	30:59
Creston		100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	77.8%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%
Heritage Ranch		100.0%	100.0%	81.8%	83.3%	90.0%	94.7%	93.3%	100.0%	100.0%	86.7%	93.3%	100.0%	92.0%	65.2%	95.6%	95.2%	90.9%	100.0%	100.0%	100.0%	100.0%	88.2%	100.0%
Shandon		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.8%	100.0%	83.3%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Whitley Gardens		100.0%	N/A	100.0%	N/A	100.0%	100.0%	N/A	N/A	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

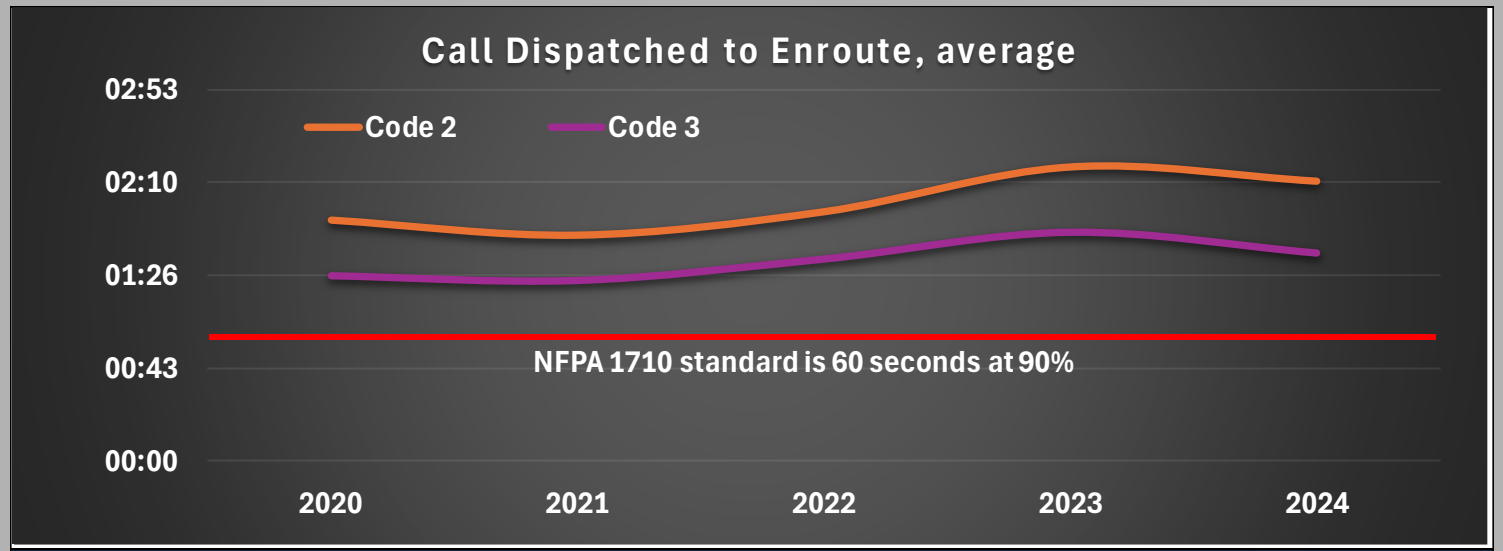
6.

Deployment of Ambulance Resources and Response Times (continued)

Turnout Times

Finding: 911 call dispatched to enroute (i.e., chute/turnout time) averages 98 seconds and over 3 minutes at 90% compliance.

Recommendation: Match NFPA and industry standards of 60 seconds during the day, and 90 seconds for 24-hour units at night.



Average Time from Call Dispatched to Enroute							
911 Call Type	2020	2021	2022	2023	2024	Average	90% ile
Code 2	01:52	01:45	01:56	02:17	02:10	02:00	03:59
Code 3	01:26	01:24	01:34	01:47	01:37	01:34	03:00
Average	**01:31**	**01:28**	**01:38**	**01:51**	**01:42**	**01:38**	**03:08**

Source: LEMSA, 911 calls only

6.

Deployment of Ambulance Resources and Response Times (continued)

Specialty Units

Finding: Two four-wheel drive ambulances are required for the dunes area.

Recommendation: Maintain specialty ambulances to meet this unique need.

Use of Mutual Aid

Finding: Stakeholders noticed that mutual aid resources are not utilized when they are the closest unit.

Recommendation: Consider defining mutual aid in EMS policy and provider contract in greater detail to prioritize patient care.

7.

Interfacility Transportation

BLS and ALS Interfacility Transportation (IFT)

Finding: Emergent IFT (i.e., Code 3) ambulance availability is generally thought to be adequate; hospital stakeholders identified timely non-emergency IFT units as the highest priority need.

Recommendations

- ✓ **Conduct a demand study of IFT call volume and resources needed to ensure that patients receive the most appropriate level of care in a timely, safe, and efficient manner.**
- ✓ **LEMSA could facilitate IFT improvements by collaborating with hospitals and ambulance providers to prioritize IFT calls based on patient acuity.**
- ✓ **BLS units in a tiered-response model could enhance IFT availability.**
- ✓ **Allow hospitals to use other ambulance providers if the EOA provider is unavailable within a predefined response time. This may require a contract change.**
- ✓ **Identify other strategies for managing IFT, especially long-distance transfers, that reduce impact on the 911 system and transfer delays.**

7.

Interfacility Transportation
(continued)

Critical Care Transportation

Findings

- ✓ There is roughly one CCT call per day, but an out-of-county transport can last several hours.
- ✓ Some hospitals will send their nurses when the CCT-RN is committed.
- ✓ The SLA contract includes BLS and ALS IFT but not CCT.
- ✓ CCT transfers by helicopter are sometimes unavailable due to weather.

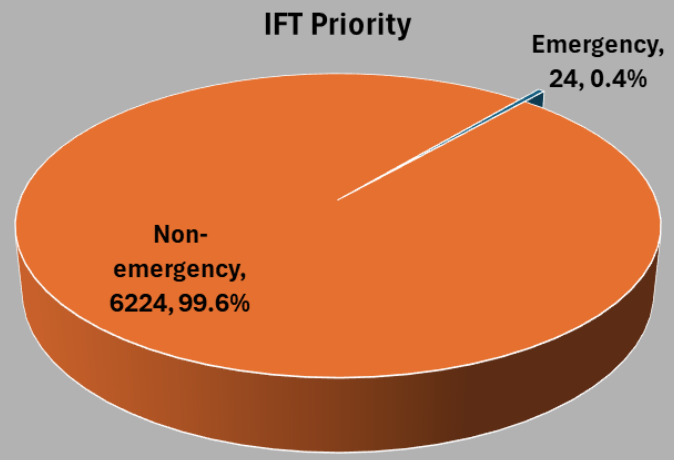
Recommendations

- ✓ Permit additional CCT providers to enhance availability.
- ✓ Consider optional scope additions to increase what paramedics can transport (e.g., vent patients, already established blood, statins, antibiotics).
- ✓ Explore CCT-Paramedic training as allowed by the California Code of Regulations to increase capabilities and decrease CCT-RN demand.
- ✓ Investigate partnerships to use the helicopter crews with an ambulance when grounded due to weather.

7.

Interfacility Transportation
(continued)

Interfacility Transports (IFT)							
Transports	2020	2021	2022	2023	2024	Total	
BLS/ALS	957	1,051	858	815	794	4,475	72%
Critical Care	328	357	336	375	377	1,773	28%
Total	**1,285**	**1,408**	**1,194**	**1,190**	**1,171**	**6,248**	**100%**



IFT Origin	
Hospital	95.6%
Clinic/MD	2.7%
Jail/Prison	0.6%
Other	1.1%
Total	**100.0%**

SLO Sending Hospital Destinations, 2020-2024									
Sending Hospital	Clinic/ Dr. Office	Hospital	Jail/ Prison	Private Res.	Res. Care	SNF	Other	Total	
Arroyo Grande Community Hospital		1,622		45	9	21	10	1,707	28.6%
French Hospital	11	510	1	110	10	83	21	746	12.5%
Sierra Vista Hospital	94	694	24	214	31	600	69	1,726	28.9%
Twin Cities Community Hospital	66	1,121	19	184	40	307	39	1,776	29.8%
Total	**171**	**3,959**	**44**	553	**90**	**1,011**	**139**	**5,967**	**100.0%**
	2.9%	**66.3%**	**0.7%**	**9.3%**	**1.5%**	**16.9%**	**2.3%**	**100.0%**	

8.

Staffing and Schedules

Ambulance Staffing

Finding: Stakeholders identified that SLA pays more and is busier, while Cambria pays less and is slower. Staffing is more stable at Cambria, likely due to the slower pace.

Recommendations

- ✓ To increase employee recruitment and retention, SLA may want to consider staffing patterns and system status plans with slower 24-hour units (i.e., promote retention) and busier day units.
- ✓ Monitor employee turnover as a metric for system health.
- ✓ 24-hour or longer shifts should be monitored for an acceptable UHU, as they are associated with lower performance, medication errors, vehicle crashes, and increased injuries.
- ✓ Any employee working more than 24 consecutive hours should be monitored for signs of fatigue. Consider a maximum number of successive hours before a reasonable rest period is required.
- ✓ All providers should have a fatigue policy.
- ✓ Prioritize long-distance transfers with day units and avoid causing crews to work past the end of their shift.

8.

Staffing and Schedules (continued)

Recruitment

Finding: SLA reimburses EMTs to attend paramedic school, which has increased its local workforce. This is an industry best practice.

Recommendation: Consider looking at similar opportunities to partner with high schools and the junior college to identify candidates who cannot afford the EMT class (e.g., Alameda County has a successful program).

9.

Health Information Exchange

Findings

- ✓ **Patient hospital diagnosis and disposition is not automatically available to prehospital staff. This feedback can be an important tool for staff education and CQI efforts.**
- ✓ **The PCR does not automatically become part of the patient's hospital record. Hospital staff are required to log into a separate system to view the PCR.**

Recommendation: Consider a health information exchange (HIE) solution that automates sharing information bi-directionally between pre-hospital providers and receiving hospitals.

10.

Community Paramedicine & Mobile Integrated Healthcare

Finding: Stakeholders, including the EMS medical director and fire stakeholders, are open to opportunities for innovation in the system.

Recommendation: Consider exploring opportunities that benefit the health needs of the community and the EMS system.

On-Scene Treatment Opportunities

Finding: EMS systems across California have benefited from not transporting patients with minor issues.

Recommendation: Research opportunities for providers to have options other than just transporting patients (e.g., telemedicine, referrals). This will reduce ED saturation and improve offload times.

Finding: SLO does not have a field paramedic program providing suboxone to overdose patients.

Recommendation: Consider implementation of a suboxone treatment program.

10.

Community Paramedicine & Mobile Integrated Healthcare
(continued)

911 Triage and Referral

Finding: Many common 911 call complaints could be redirected to more appropriate resources.

Recommendation: Research partnerships to connect 911 callers with the right resources for their medical needs.

Post-discharge Follow-up

Finding: Patients being readmitted shortly after discharge financially impact the hospital.

Recommendation: Discuss with hospitals the current impact and interest in community paramedics supporting follow-up care to avoid readmissions.

10.

Community Paramedicine & Mobile Integrated Healthcare
(continued)

Behavioral Health

Finding: Behavioral health (BH) patients have prolonged ED stays awaiting transfer to a facility. Direct transport to a BH facility can save hundreds of ED hours. Currently, there is no such ambulance receiving facility for BH patients within the County.

Recommendation: As resources become available in the County, explore ways to avoid taking BH patients to EDs and transfer directly to that facility.

Finding: Some homeless and behavioral health outreach occurs in the County, a sobering center is being opened, and a crisis stabilization unit is being developed. Despite the many resources available, stakeholders continue to feel the impact of patients with BH needs and homelessness.

Recommendation: Continue and expand the programs available as needed. To better meet the demands of this population, a psychiatric ED/crisis center and a specialized field response team could be established.

10.

Community Paramedicine & Mobile Integrated Healthcare

(continued)

Cambria Area Example

Findings

- ✓ EMS providers have a low UHU rate, allowing crews to provide additional services between 911 calls.
- ✓ Hospital transport times are at least an hour from the Cambria area.

Recommendations:

- ✓ Cambria residents would benefit from community paramedicine and telemedicine programs to stay closer to home.
- ✓ Consider obtaining a waiver to transport patients to the Cambria Community Health Center when open and appropriate. This will reduce lengthy transports, increase return-to-service time, and minimize inappropriate hospital ED use.
  Example: Coast Life Support and Redwood Coast Medical Services, Mendocino County)

11.

EMS System Financial Analysis

Cost Containment Strategies

Finding: Ambulance reimbursements continue to lag behind expenses, which may worsen as various government programs are cut back. This may include Ground Emergency Medical Transport (GEMT), which is receiving scrutiny at the federal level. Cambria Ambulance is a current benefactor of GEMT

Recommendations

- ✓ Consider innovative concepts, such as telemedicine to reduce transports, alternate transportation for non-medical needs (e.g., prescription refills), use of a nurse navigator program to prevent responses, strategic partnerships with fire, hospitals, others, etc.
- ✓ Continue identifying ways for the EMS system to be more efficient, match response times to EMD acuity, find alternative funding sources, reduce call volume, etc., to meet the financial reality of EMS.
- ✓ Cambria should have contingency plans if GEMT funding changes/stops for necessary modifications in service delivery, if any.

11.

EMS System Financial Analysis (continued)

Oversight Fees

Finding: It is unclear if the designation fees for heart attack (STEMI) and trauma centers provide full cost recovery.

Recommendation: Explore the related expenses for oversight and adjust hospital fees accordingly.

Finding: The current contract contains no LEMSA fees for its oversight role.

Recommendation: Consider adding LEMSA cost recovery fees, specifically related to its oversight role.

Medicare Reimbursement

Finding: The County is in a lower Medicare reimbursement tier based on the believed cost of living, which lowers Medicare payments.

Recommendation: Work with federal legislators to confirm the accuracy of the Medicare reimbursement tier data and possibly increase reimbursement with undervalued.

12.

Medical Helicopter Utilization

Findings

- ✓ Helicopters provide remote area responses and IFT. A new air provider has become available, increasing capacity and volume.
- ✓ There is a stakeholder perception that SLA crews are hesitant to request helicopters for remote areas and may get in trouble if they do.

Recommendations

- ✓ Predetermine remote areas that would benefit from automated helicopter dispatch.
- ✓ Compare the current dispatch and EMS policies to the 911 system needs, focusing on auto-launch protocols to reduce lift-off times.
- ✓ Review and incorporate stakeholder feedback on the current helicopter policy to balance the need and availability of air resources to serve the community.
- ✓ Conduct periodic audits to validate the optimal use of helicopters.

Air Ambulance Call Volume							
Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**
Transports	20	4	9	13	16	22	84
Cancelled	78	52	69	63	56	75	393
Total	**98**	**56**	**78**	**76**	**72**	**97**	**477**

12.

Medical Helicopter Utilization

Finding: **Helicopters can be unavailable due to weather.**

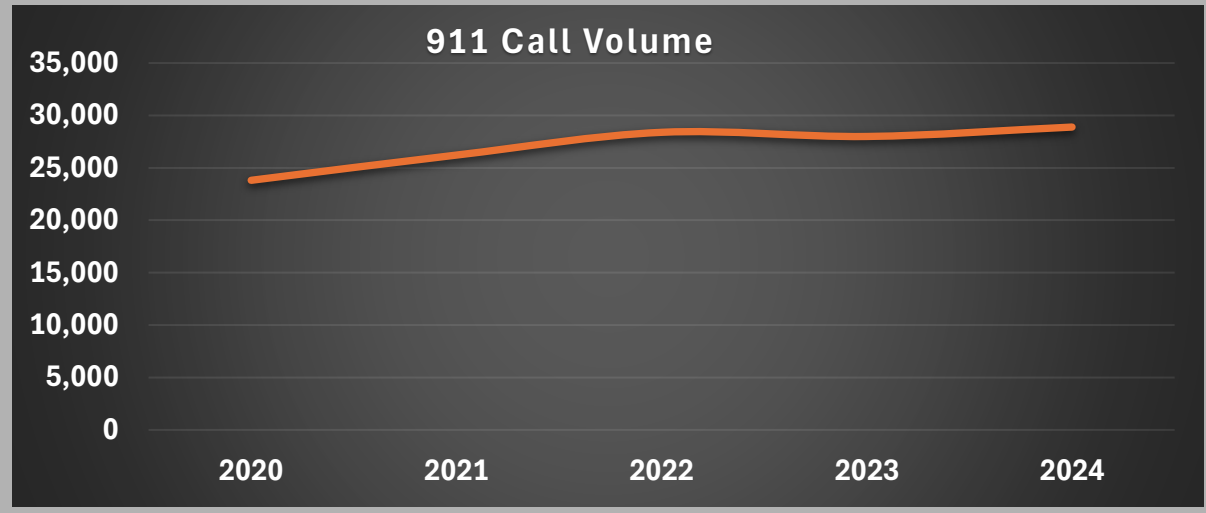
Recommendation: **Work with helicopter providers to determine if obtaining Instrument Flight Rules (IFR) capability at the hospital landing pads during inclement weather would be beneficial.**

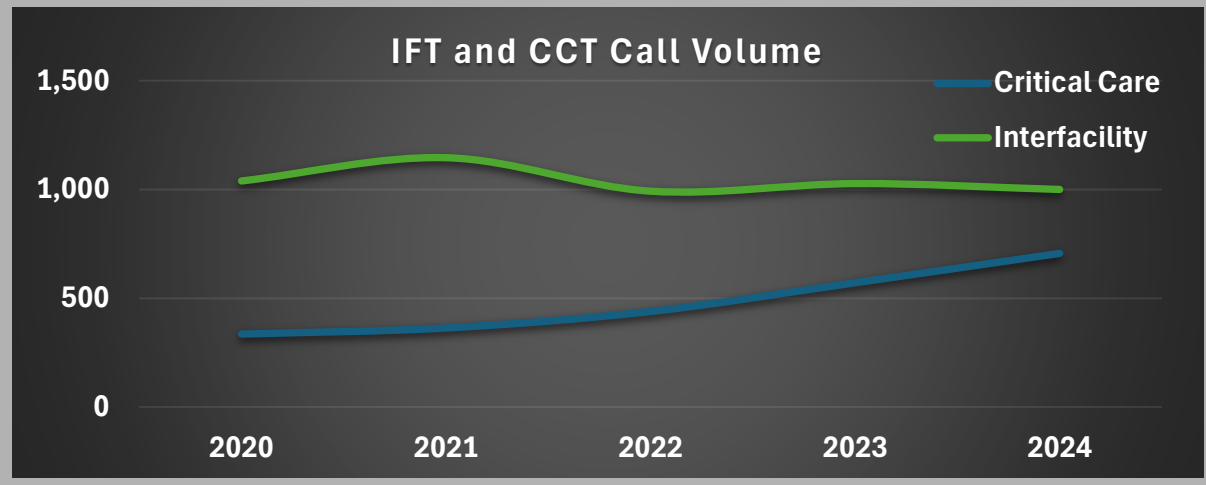
Data Analysis

EMS System Data

Findings

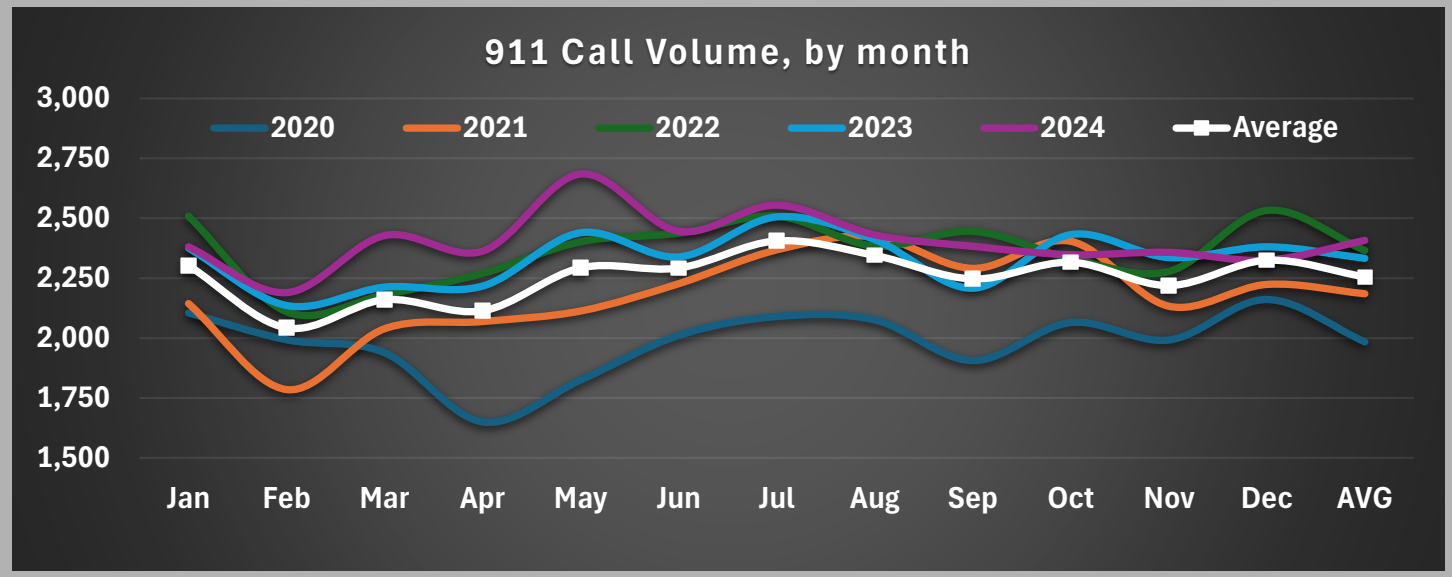
- 911 volume is climbing since the decline during 2020 (COVID)
- IFT volume is consistent
- CCT volume is growing





Annual Call Volume						
Call Type	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**
911 Call	23,813	26,221	28,393	27,995	28,893	135,315
Critical Care	335	363	439	571	706	2,414
Interfacility	1,039	1,146	992	1,027	1,000	5,204
Standby			1	2	1	4
Unknown	7	11	66	259	542	885
Total	**25,194**	**27,741**	**29,891**	**29,854**	**31,142**	**143,822**

Seasonal Call Volume



Findings

- **Feb-Apr, Sep, and Nov are typically slower months**

911 Call Volume, by month						
Month	**2020**	**2021**	**2022**	**2023**	**2024**	**Average**
Jan	2,105	2,144	2,509	2,376	2,381	2,303
Feb	1,993	1,785	2,110	2,136	2,190	2,043
Mar	1,939	2,039	2,181	2,213	2,428	2,160
Apr	1,650	2,069	2,270	2,217	2,363	2,114
May	1,825	2,113	2,402	2,440	2,685	2,293
Jun	2,011	2,227	2,438	2,339	2,446	2,292
Jul	2,090	2,368	2,509	2,506	2,555	2,406
Aug	2,076	2,424	2,384	2,411	2,431	2,345
Sep	1,906	2,291	2,446	2,208	2,383	2,247
Oct	2,065	2,404	2,333	2,432	2,348	2,316
Nov	1,992	2,133	2,278	2,336	2,358	2,219
Dec	2,161	2,224	2,533	2,381	2,325	2,325
AVG	**1,984**	**2,185**	**2,366**	**2,333**	**2,408**	**2,255**

Ambulance Response Times

New contract implemented

Urban Compliance

Zone	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Time Standard		9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	9:59	10:59	10:59	10:59	10:59	10:59	10:59	10:59	10:59	10:59
Arroyo Grande		83.2%	81.8%	96.0%	86.4%	93.5%	86.5%	92.0%	90.8%	93.9%	93.2%	91.3%	86.9%	94%	88.3%	96.3%	93.8%	94.8%	96.3%	95.1%	97.1%	96.3%	95.7%	96.3%
Atascadero		77.4%	79.7%	83.1%	77.4%	79.4%	80.8%	78.9%	79.4%	74.9%	80.5%	84.1%	79.4%	81%	84.9%	93.0%	91%	91%	94.7%	91.9%	95.4%	94.2%	93.9%	94.7%
Cal Poly		61.9%	69.2%	63.6%	76.2%	84.2%	100.0%	100.0%	77.3%	71.0%	60.7%	76.9%	92.3%	77.7%	92.3%	82.3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Grover Beach		85.9%	84.0%	95.3%	91.5%	89.9%	78.6%	78.7%	80.4%	91.5%	89.5%	89.9%	92.5%	90.1%	91.3%	97.2%	96.1%	98.3%	94.4%	97.7%	96.7%	95.8%	95.8%	94.4%
Los Osos		22.9%	15.9%	14.5%	18.9%	18.3%	60.6%	70.1%	60.9%	62.9%	50.7%	55.6%	60.6%	56.4%	62.1%	62.8%	67.1%	67.1%	96.7%	91.2%	85.7%	92.6%	91.0%	96.7%
Morro Bay		79.4%	88.1%	89.2%	81.0%	85.4%	85.5%	83.1%	82.9%	89.0%	83.9%	85.3%	81.1%	83.9%	84.3%	91.7%	92.8%	95.3%	98.1%	93.8%	95.4%	95.2%	95.0%	98.1%
Nipomo		74.5%	68.4%	75.0%	77.3%	85.0%	82.2%	81.4%	81.7%	85.2%	88.0%	85.2%	90.4%	91.2%	92.1%	96.2%	96.3%	94.0%	89.4%	92.3%	93.5%	90.3%	95.1%	89.4%
Oceano		62.5%	62.1%	81.2%	78.3%	62.9%	66.6%	66.7%	87.8%	70.0%	70.7%	83.3%	83.3%	82%	84.4%	91.0%	91.4%	91.4%	96.8%	77.5%	88.8%	94.2%	94.3%	96.8%
Paso Robles		82.9%	81.9%	90.8%	87.0%	85.9%	83.7%	83.8%	89.8%	87.9%	85.8%	90.2%	87.5%	86.6%	86.1%	91.7%	93.2%	95.5%	94.0%	93.4%	92.7%	95.2%	94.6%	94.0%
Pismo Beach		60.2%	80.2%	77.3%	76.5%	81.3%	68.0%	71.6%	79.8%	83.8%	78.7%	77.3%	73.6%	85%	78.8%	91.6%	98.0%	95.2%	93.0%	94.6%	90.4%	91.3%	90.7%	93.0%
San Luis Obispo		88.5%	82.6%	80.9%	84.8%	83.7%	83.0%	86.1%	74.2%	83.1%	88.0%	84.3%	84.3%	82.3%	86.5%	94.8%	94.7%	95.2%	96.1%	96.1%	94.2%	93.0%	94.4%	96.1%
Templeton		78.7%	84.8%	84.0%	90.0%	89.4%	88.2%	86.5%	91.8%	93.2%	92.3%	81.8%	89.8%	92.4%	84.2%	95.0%	96.2%	93.2%	95.3%	96.7%	97.1%	98.0%	95.1%	95.3%

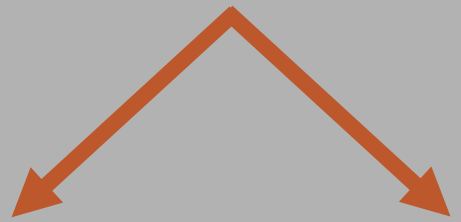
Suburban Compliance

Zone	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Time Standard		19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	19:59	20:59	20:59	20:59	20:59	20:59	20:59	20:59	20:59	20:59
Avila		100.0%	100.0%	100.0%	100.0%	94.1%	94.7%	100.0%	95.2%	92.9%	86.7%	93.3%	94.4%	100.0%	94.1%	83.3%	92.0%	100.0%	100.0%	100.0%	93.7%	100.0%	100.0%	100.0%
Cayucos		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	96.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Country Club		100.0%	100.0%	100.0%	N/A	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Garden Farms		N/A	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	N/A	N/A	100.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%	100.0%
San Miguel		100.0%	100.0%	93.8%	92.3%	82.1%	92.9%	100.0%	94.4%	100.0%	90.9%	92.9%	100.0%	88.8%	100.0%	100.0%	100.0%	95.0%	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Santa Margarita		100.0%	100.0%	85.7%	71.4%	85.7%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%

Rural Compliance

Zone	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Time Standard		29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	29:59	30:59	30:59	30:59	30:59	30:59	30:59	30:59	30:59	30:59
Creston		100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	77.8%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%
Heritage Ranch		100.0%	100.0%	81.8%	83.3%	90.0%	94.7%	93.3%	100.0%	100.0%	86.7%	93.3%	100.0%	92.0%	65.2%	95.6%	95.2%	90.9%	100.0%	100.0%	100.0%	100.0%	88.2%	100.0%
Shandon		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.8%	100.0%	83.3%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Whitley Gardens		100.0%	N/A	100.0%	N/A	100.0%	100.0%	N/A	N/A	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Next Steps



Ambulance RFP

EMS Agency to work with Healthcare Strategists team to draft and release a competitive RFP process to secure emergency ambulance service through County Purchasing.

EMS System

The EMS Agency, with input from the EMS Advisory Committee, will review and prioritize the identified system recommendations.

SAN LUIS OBISPO COUNTY EMERGENCY MEDICAL SERVICES ASSESSMENT

Questions & Answers

HEALTHCARE STRATEGISTS