

ACKNOWLEDGEMENTS

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Vision Statement of FDCARES:

FDCARES has fully integrated EMS into the broader healthcare system to improve the health outcomes of individuals in need of non-emergency services. We provide the proper level of response, education, advocacy and medical systems navigation. Utilizing a combination of public and private resources, FDCARES has increased access to the appropriate level of healthcare and social services in a timely and cost effective manner.



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Executive Summary- Over the last 30 years, the fire service has expanded the number of stations and personnel in order to meet a 400 percent increase in the number of requests for Emergency Medical Services (EMS). The expansion of fire-based emergency medical response has inextricably linked the fire service and the U.S. health care system.

The U.S. healthcare system is currently under enormous public and congressional pressure to reform due to the lack of access to services, the poor quality of care, and the high costs of care. Critics of the US healthcare system cite fire-based EMS as an example of a public service that contributes to America's over utilization of EMS and increasing national healthcare expenditures amounting to 18 percent of the Gross Domestic Product (GDP). Is this criticism of fire-based EMS valid?

Fire departments respond to a wide array of requests for medical service. The fire service is well recognized for their capacity to respond rapidly to emergencies with quality care as demonstrated by recent increases in cardiac arrest survival rates nationwide. However, a large proportion (estimated up to 40%) of medical service requests are for non-emergent medical problems and a majority of these requests are attributed to a subset of frequent users of EMS. Despite these facts, fire-based EMS personnel, response times, and medical interventions are standardized for medical emergencies. Consequently, 911 callers with non-emergent issues typically receive emergency-oriented care, which often times results in the unnecessary transport of patients to an Emergency Department (ED) for more definitive care. The National Quality Forum (NQF) estimates that this response model contributes to an estimated \$38 billion in wasted health care expenditures each year. Moreover, because fire-based EMS and EDs are designed for the episodic treatment of emergent medical problems, clients with non-emergent medical problems, who often have multiple chronic diseases and psychosocial issues, experience poor quality outcomes, poor follow up care, and poor continuity of care. The result is subsequent and repeated use of the EMS system. Why now should the fire service change their medical response model?

The Patient Protection and Affordable Care Act (PPACA) is changing the landscape of the U.S. health care system. Provisions in the PPACA are making insurance payers and hospitals accountable for the quality and costs of EMS care, driving the adoption of healthcare delivery organizations and innovative solutions that improve the value of EMS. The PPACA directly challenges the inefficiencies of the fire service's "one-size-fits-all" response model. How can fire departments improve the value of fire-based EMS?

Fire departments should adopt a new tier within their current response model that responds directly to non-emergent medical and psychosocial problems and proactively contacts frequent callers of 911, frequent users of the ED, and patients at high-risk of hospital readmission. This Non-Emergency Medical Service (NEMS) division should be fully integrated into the operations of fire departments.

The Kent Fire Department Regional Fire Authority (KFD/RFA) in Washington State has developed a NEMS division, called FDCARES (Fire Department Community Assistance, Referral, and Education Services). FDCARES is staffed 24 hours per day, 365 days per year with an Emergency Medical Technician (EMT) and a Registered Nurse (RN), who are available to respond directly to 911 callers with non-emergent medical and psychosocial requests for service. Using a non-emergency response vehicle, FDCARES staff responds to non-emergent callers within 20 minutes. FDCARES staff delivers a wide range of services aimed at addressing clients' immediate and long-term medical and psychosocial needs. These services include medical stabilization, care navigation and coordination, transport to alternative care settings (e.g., urgent care, primary care, etc.), medication reconciliation, patient education, referrals to social services, and injury and illness prevention. When not responding to non-emergent 911 callers, FDCARES staff proactively contacts and delivers services to frequent 911 callers, frequent users of the ED, and individuals at high risk of hospital readmission.

Adopting and integrating FDCARES into a fire department's existing response model, improves emergency unit reliability and response times, reduces over-utilization of EMS and the associated costs, increases access to quality care, and improves outcomes for residents by ensuring that they receive the right service, at the right time, in the right place, and in the right way.

The Problem

Fire Departments for years, have allowed the public to identify their own emergency and utilize the emergency 911 system for their vast array of service requests. The fire service based EMS system to date, has not identified for the public the difference between a true medical emergency and what is not a true medical emergency. Instead, many fire departments across the nation and around the world have adopted slogans stating something similar to “if you call, we will respond”. Over the last 30 years, this approach has contributed to a 400 percent increase in the number of medical service requests to the fire service. Today, 70-80% of fire departments responses are related to requests for medical services. An estimated 10-40 percent of these incidents are non-emergent in nature (Kartner & Stein 2012). A large proportion of these requests for service are made by frequent users of the 911 system, defined as individuals that made 3 or more 911 requests in a 12-month period. A subset of these individuals utilizes fire-based EMS as their preferred provider for non-emergent care.

Despite this fact, fire-based EMS personnel, response times, and medical interventions remain standardized for medical emergencies. Within seconds of a 911 call, highly skilled Emergency Medical Technicians (EMTs) and/or paramedics are promptly dispatched to the incident. At the scene, skilled personnel address the patients immediate medical needs as efficiently as possible in order to maximize patient outcomes (e.g., survival rates) and make personnel available for additional incoming requests for service. Interventions delivered on scene are typically based on pre-determined care pathways that may culminate with a client transport for more definitive care at an acute healthcare facility. This transport is generally performed by a fee for service provider which will only take patients directly to an emergency department (ED). Patient transports to the ED are often initiated by client requests. In 2008, for example, U.S. fire-based EMS transported approximately 20 million individuals to the ED (FEMA 2012). This “one size fits all” response model ensures that patients with the highest level of acuity (e.g., cardiac arrest) achieve the best possible outcomes.

The current EMS delivery model is not designed to always appropriately address the needs of 911 callers with non-emergent conditions. First, fire department response times and unit reliability standards do not allow enough time for personnel to make holistic assessments and deliver time-intensive interventions to individuals with complex non-emergent needs, such as multiple chronic diseases, behavioral health issues, and psychosocial problems. Second, current liability concerns and EMS system policies only support the transport of patients to resource-intensive EDs, where they receive episodic treatment that is costly. The National Quality Forum (NQF) estimates that unnecessary utilization of the ED accounts for \$38 billion in wasteful healthcare expenditures each year. Third, the 911 response system and ED lack follow up and continuity of care, which causes repeated use of EMS. This system results in inappropriate utilization of the 911 system and the ED. It also creates an environment that has individual's access unnecessarily high costs of care which can lead to poor continuity of care.

The expansion of fire-based EMS has received considerable government funding and public support. The fire service has been well recognized for its achievements, which include improving response times and survival rates for medical emergencies, carrying out heroic rescues during natural disasters and terrorist attacks, and filling the gap in the medical safety net by providing medical care for uninsured and underinsured. In a 2001 Gallup poll, firefighters were recognized as the most trusted professionals in the U.S. (Moore 2001). However, with the changing national economic climate and the debate over whether to cut public services or raise taxes, fire-based EMS has become under growing congressional and public scrutiny. Increasingly, fire-based EMS is facing cuts in funding, declining public support, fire station closures and firefighter layoffs. For example, in 2012, voters in Contra Costa County, California voted against the fire district's parcel tax, a decisions that will shutter 10 of the 28 fire stations by 2015 and force a scaled back response to low-priority calls (Vordenbrueggen 2012). Fire departments around the nation are being faced with demands to prove that their fire-based EMS system offers residents the best value.

At the same time, the Patient Protection and Affordable Care Act (PPACA) is changing the landscape of the entire U.S. healthcare system and demanding better value from every sector of the healthcare industry, including the fire-based EMS system (Keckley 2013). The PPACA has three primary aims: ensure that most Americans have access to care through the expansion of insurance coverage and healthcare services; control the rising costs of healthcare through financial penalties that increase the efficiency of provider and patient utilization of healthcare resources; improve the quality of care by incentivizing value, or health outcomes achieved per dollar spent, over volume, or number of services per dollar spent. Provisions in the PPACA are changing the way medical services are accessed, paid for, and delivered.

Of particular importance is the mandate that virtually every citizen purchase health insurance and the mandate that every insurance plan include emergency medical services as an essential benefit. These mandates have two potentially significant effects. First, the previously uninsured and under-insured will have increased financial access to primary care services, potentially decreasing their need to access fire-based EMS for non-emergent conditions. Second, the source of EMS reimbursement may shift from a tax-based system to a health insurance-based system. As a result, fire-based EMS may face challenges related to decreasing public funding and growing competition seeking to access healthcare dollars.

Another set of significant provisions in the PPACA directly address inappropriate utilization and lack of quality outcomes associated with EMS and hospital-based care for individuals with chronic diseases and psychosocial issues. The PPACA penalizes hospitals that have a high rate of patients who readmit to the hospital or ED within 30 days of discharge for the same illness episode. In addition, the PPACA reduces Medicare payment to hospitals, which would otherwise be made for these readmissions. At this time, hospitals only face penalties and reduced payments for 30-day readmissions attributed to a heart attack, congestive heart failure, or pneumonia. However, on January 1, 2014, the provision expands to patients readmitted with a geriatric fall or any chronic obstructive pulmonary disease. These penalties and reduced reimbursements are expected to continue to expand to other medical conditions and be

adopted by private payers. Faced with multi-million dollar penalties and reduced reimbursements, hospitals are developing and adopting services that improve the quality of post-discharge care and that divert and prevent hospital readmissions. For example, hospitals have hired health outreach coordinators, who respond to emergent and non-emergent requests for service and proactively contact patients at high-risk of readmission. This type of innovative approach attempts to shift non-emergent 911 calls away from fire departments to a system better designed to appropriately navigate and coordinate care for these chronic and non-emergent patients.

The demands for efficient and effective care are expected to accelerate as provisions in the PPACA shift accountability costs of care from payers to hospitals and providers, and shift healthcare from a fee-for-service to a value-based reimbursement system. Two provisions in particular emphasize the delivery of value-based care: Medicare implementation of bundled payments for episodes of care; and incentives for the formation of Accountable Care Organizations (ACOs). Bundled payment is a method in which reimbursements to health care providers are predetermined according to the expected costs of a bundle of related health care services for an episode of care. This reimbursement mechanism shifts accountability from payers to hospitals and providers in an attempt to ensure that those fixed payments are utilized efficiently to deliver quality care. At the same time, hospitals and providers are establishing ACOs and partnerships that are collectively accountable for the costs and outcomes associated with patient care and are financially rewarded for improved patient outcomes per dollar spent. These ACOs are looking to establish or partner with EMS systems that demonstrate these same cost-effective values.

Fire departments are both financially dependent on a public who is increasingly skeptical of the value of fire-based EMS and who are firmly entrenched in a healthcare system that is demanding better value from EMS providers. With the ensuing shifts in reimbursement both from a tax based system to a health insurance based system and from fee-for-service to value-based reimbursement, the current fire-based EMS system will need to continue to improve their service delivery model to survive in this changing environment. Fire Departments will also want to stay on top of current trends to compete with

private companies who are already claiming to be providing better patient outcomes with a more cost effective model.

The Solution

In order to meet the demands for an efficient and effective EMS response system, fire departments should work toward a new response model that offers the services of the Fire Department, Community Assistance, Referrals, and Education Services (FDCARES). FDCARES is a non-emergency medical service (NEMS) division that was developed by the Kent Fire Department Regional Fire Authority (RFA), Kent Washington. FDCARES functions within the operations division of six fire departments in Western Washington and in Colorado Springs, Colorado (see Appendix “A”). FDCARES is working to integrate a fire department’s medical response system into the broader healthcare systems of any community and can easily be integrated into any fire department’s response system. FDCARES is designed to respond directly to clients with low-acuity medical problems and psychosocial issues through the 911 system and to proactively contact high-volume users of both the 911-EMS system as well as local area emergency departments. Proactive visits include a focus on individuals at high-risk of ED and/or hospital admission and readmission. This is a value-added service that more efficiently and effectively assists the residents within the local fire department's response area. FDCARES delivers a range of services aimed at improving clients’ health, wellbeing and their efficiency of resource utilization. Integrating FDCARES into an existing fire-based EMS system improves a fire department’s ability to deliver more efficient services that will ensure patients receive the proper care at the most appropriate care setting, and at an appropriate time with regards to each specific patient’s needs. This is completed with a response model that enhances the emergency service response of an organization while adding value for the residents within a given response area.

By incorporating a non-emergency tier into the fire department’s response model and smaller fire department response units, the overall fire service based EMS system is improved. With more

appropriate response time guidelines for low acuity, non-emergent incident types, these responses will continue to maintain the safety nets within the current emergency response system. This will work to ensure that patients with true medical emergencies will receive the appropriate, timely emergency response. FDCARES units will proceed (no lights or sirens) directly to low-acuity 911 requests for services. This response model will keep larger fire engines and ladder trucks available for incident types that the vehicles were designed to handle and keep aid and medic units available for emergent medical responses for which they were designed. This will also improve emergency unit reliability (i.e., the percentage of time during a 24-hour day in which an emergency unit is available), response times, and keep units within their first due response area. This response model also includes the addition of emergency incident down grading to a non-emergent status. This allows emergency units to return to service as soon as an incident is identified as low acuity or non-emergent in nature, a key part of providing the emergency medical safety net.

Staffing costs for FDCARES units are less costly than staffing additional emergency response units. Staffing an emergency aid unit with two firefighters 24/7/365 can cost a fire department approximately \$1.4 million in wages and benefits. Aid units are also not working to prevent future low acuity responses from taking place. FDCARES units are staffed utilizing medically trained personnel that work to prevent low acuity medical incidents from taking place. These individuals do not face many of the inherent risks that a firefighter faces in the course of their non-emergent response day. The staffing model at startup will save approximately \$400,000 annually over staffing an emergency response aid unit and will save upwards of \$2 million annually as 911 requests for service are shifted out of the emergency response division over the following years.

Compared to a response from an emergency aid car, FDCARES units are designed to achieve better long-term outcomes for clients with low-acuity medical problems and/or psychosocial issues, while preventing unnecessary ED visits and hospital admissions and readmissions. Under the direct supervision of the medical program director, FDCARES develops more appropriate response time standards for

patients requesting service for low-acuity care, giving personnel added time to address client needs. In addition, FDCARES employs specially trained personnel, who are well qualified to assess client healthcare and social service needs, provide on-site client stabilization, and deliver effective medical and psychosocial interventions. Moreover, FDCARES navigates clients to the most appropriate care setting, which includes a broad range of medical and social services: ED, urgent care, crisis clinic, sobering center, specialty provider, and primary care clinics. At the end of every client visit, FDCARES personnel will provide client-directed instructions educating individuals on their specific healthcare needs and work to connect them to the appropriate resources available. Patients are also provided a non-emergency number for the FDCARES division should they have any further questions regarding their visit or have a need in which they simply don't know where to turn for assistance.

FDCARES staff works to identify vulnerable community members through multiple channels. FDCARES leverages 911 data to determine high volume users of the fire-based EMS system in addition to obtaining referrals for patients in need from a wide variety of local agencies for patients within the community. In addition, partnerships with local EDs and hospitals include data share and patient information exchange agreements that help to identify high volume users. Each patient's 911 and ED use is monitored and their specific needs are assessed to prioritize the occurrence and frequency of proactive visits for each patient entered into the FDCARES system.

This response model includes providing non-emergency services for patients who have limited access to care and/or difficulty navigating the healthcare and social service system. Working through the partnership agreements with patient transporting companies, patients who don't have access to transportation will be assisted with scheduled transportation to necessary medical providers. Over the course of the visit, FDCARES personnel will collect important information regarding the client's health care and social service needs to direct future NEMS care. Because the FDCARES staff is a non-emergent team, they are able to utilize all the time necessary to address the patient's current and long term needs.

Additional services offered by the FDCARES staff are proactive phone contact and home visits, provided to prevent manifestation of an illness or injury to the level of a true emergency. We offer a wide variety of community assistance, referrals to appropriate existing care providers and social service workers, education on various medical conditions, and identifying the appropriate service provider for the individual patient needs. Often times we are able to provide preventative devices that allow our residents to live a safer, more independent life.

FDCARES staff works closely with local ED to prevent unnecessary hospital admissions by providing a resource that can stabilize patients in their home 24/7/365. Our care providers work directly with emergency room discharge planners to ensure that the care plan established at the time of discharge is understood and followed correctly by the patient in the days following discharge from the ED. FDCARES staff also works with members on the hospital side of the medical system to prevent avoidable readmissions to the ED and the hospital for the five specific patient types identified without reimbursements from Medicare.

By adopting an FDCARES program, hospitals and payers experience significant benefits as a result of the improved efficiency and effectiveness of the EMS system. For example, hospitals that partner with FDCARES achieve reduced uncompensated care (i.e., improved cost-to-care ratios), reduced penalties for unnecessary hospitalizations, reduced overcrowding of the ED, and improved staff and patient satisfaction. Similarly, payers that partner with FDCARES achieve reduced claims for costly ED and hospital care and an increased FD/EMS accountability for client outcomes. By documenting these benefits and increasing integration and accountability across the EMS system, fire departments have the capacity to solicit hospitals and payers for a “shared cost savings” benefit.

In short, FDCARES is a non-emergency response tier within an existing fire based EMS system. FDCARES responds with a more cost effective and efficient approach to non-emergency medical requests for service. FDCARES will work directly with residents who have low-acuity medical needs and psychosocial issues. FDCARES staff will advocate on the behalf of the resident with a timely, convenient,

local access to a broad range of medical and social services. We work directly with the local ED and hospital discharge planner to ensure that specific patient types of illness can be stabilized in their home safely in an effort to avoid hospital admissions and ED and hospital readmissions. Through various partnerships with other members of the healthcare sector, FDCARES will utilize appropriate resources to achieve high-levels of patient-determined value, generate new revenue streams for fire based EMS systems, reduce avoidable costs, improve health outcomes, and increase access to non-emergent care.

Background

In February of 2010, the Kent Fire Department RFA recognized we had many residents that utilized the system on a frequent basis. Generally speaking, they were believed to be people who were abusing the 911 system; the organization had no formal process to identify and manage the care of high utilizers. In addition, there was no mandate to address this issue. Although significant progress has been made in better understanding the issue at hand, there still is no mandate or policy to address the specific repetitive EMS request for services issue other than through the current 911 system with an emergency response. The more we understand the issue the less we feel there should be a mandate and realize that it is more of a moral obligation to better serve the members of our community.

The informal process consisted of firefighters recognizing that a particular resident was calling 911 repetitively and would simply send an email to the department's EMS officer to let them know that a problem existed. The system was not automated and required firefighters to take time to pass on information. With an informal process, it was not always easy for firefighters to recognize that they were dealing with a recurrent system user. This was generally due to the shift work of firefighters, station assignment rotations, and various reasons for leave, coupled with the fact that multiple responders would see the same patient but were unaware of this. If an email was sent and nothing was done to address the recurrent response problem, the emails would slowly stop being sent in. The firefighters would simply

“do their job”. That is, respond to the 911 incidents as dispatched and deal with the immediate, episodic problem at hand.

When an email was sent in suggesting that there was a recurrent user in the system, the EMS officer would deal with each email on a case-by-case basis. This meant gathering information from whatever resource was available and working to determine what the problem was. This generally consisted of bringing up the latest response to a particular individual and reading the reason that a patient called 911. The EMS officer may do some background work and try to determine how frequently response crews were going out to a particular individual rather than why crews were going out to an individual. They then had full discretion on how best to handle the situation. Because we were not familiar with available resources and dealing with a single patient took a great deal of time, most of the emails sent in went unaddressed. This was the original process of identifying and labeling patients as “frequent flyers”.

For our organization, we determined that the term frequent flyer was somewhat derogatory and we have worked to change the culture and thought process regarding this terminology. Although most companies appreciate having frequent flyers, the fire service is working to prevent people from needing our services. The term “high utilizer” was coined and deemed to be a more accurate description of the patients.

The Kent Fire Department also had a fall prevention program that lived under the code enforcement division and was assigned to public education. The operations crews were aware that it existed but didn’t have many details on the program. All information provided to this program was through the incident reporting system. This is one of the shortcomings of an injury and illness prevention program living outside of operations. As firefighters entered reports and selected the code that corresponded with a patient falling, the public educator was able to access the data and would pull out

some specific information on these patients. The fall prevention program was just one of the many assigned duties and responsibilities of the public educator that the program was assigned to.

Many fire departments in our area operated similarly and continue to do so. Although a very small portion of the public educator's time was dedicated to fall prevention, the program was considered one of the more active programs in the region. Reports would be created from the incident data that the fire crews would enter into the fire and medical incident reporting system. Information would then be collected on residents in the community that had been reported as having had a fall that required the 911 system for assistance. The department received grant dollars from the City of Kent's Human Services department and was supported with access of up to \$5,000 every two years to purchase prevention devices. Staff also worked to secure additional funds through injury and illness prevention grants. However, most had very strict eligibility criteria limiting the patient population we could serve. Without a dedicated revenue stream the ability to sustain this level of service was in constant jeopardy. These devices were installed for individual residents to aid in preventing similar incidents from occurring in the future. Tax dollars utilized for this purpose were considered as "a gifting of public funds".

After collecting the names of residents in the response area that had been entered into the system by response crews as having had a fall, the public educator would put together an informational packet for each individual with a description of what assistance would be provided to them, including offering fall prevention education and, as needed, the installation of prevention equipment. This information packet would be placed in the mail and forgotten about unless there was a response from the resident. This process would take place on a monthly basis with an estimated 800-1200 letters mailed annually. When a response was received back, contact would be made with the individual and efforts were taken to prevent future falls for these residents.

A great working relationship with the members of the city's Human Services Department was developed and the department would utilize their services whenever possible. They have a full time home

repair program and referrals could be made to them as regularly as deemed necessary. The Human Services department would also subjectively refer residents back to the department's fall prevention program who they felt would benefit from these services and the fall prevention devices.

There were both problems and benefits that existed within this process. The value was in identifying patients and working to assist them. One of the biggest problems was that firefighters who see these patients on a regular basis were not aware of available resources. There was also no feedback given to the firefighters on the results of the assistance.

The next problem was in how the report system works. With the reporting system that we utilized, fire crews could only enter one problem into the system and consistency among reporters is very difficult. For example, if a person gets light headed, falls, and breaks an arm and three different crews respond to a similar situation, each may enter the problem differently. The first crew could enter this incident as syncope, the second as a fall patient, and the third as a fracture. All of the crews would be correct but when a search was completed in an attempt to identify all fall patients, two thirds of them would go unidentified.

The third problem noted was the time and work it took to compile 800-1200 expensive letters, envelopes, and stamps that were sent out to residents offering in home assessments and a fall prevention analysis. With this process, only about sixty-five people per year would respond and take advantage of the offer. There was no patient follow up on those that did receive assistance to determine if this process proved effective and with the low number of residents assisted, the program could not measure any related cost savings of providing these services.

With approximately two thirds of the fall patients going unidentified, a lack of response from the residents, and little if any knowledge of the fire crews that this fall prevention program even existed, it was clear that some changes needed to be made. The first thing that needed to take place was to arrange a

meeting with the information technology staff to see if there was any way in which to better identify all of the residents who had suffered a fall that fire crews responded to.

Two members of our IT division were brought into a meeting to discuss this, which included those who had worked to get the fall patient data collection as far as it was. This meeting is where the concept of FDCARES originated though it wasn't even known at the time. The conversation went from fall patients and the way patients were assisted to the benefits for both the patients and the fire department for having this program. The IT staff was also very involved in what our organization called "unit reliability" (the percentage of time during a 24 hour day in which an emergency unit was available) and "unit response times". It was expressed that if more fall patients were assisted and 911 responses were avoided, it would have a large impact on the percentage of time an emergency unit was available. This would improve emergency unit response times as well. In dealing with recurrent users of the 911 system, it was asked, how many of the other recurrent patient type responses could potentially be prevented? With this a number of ideas began being tossed back and forth and definitions were being developed for the first time. This included defining a recurrent 911 user, system abusers, and putting specifics to other vague terms often used by emergency responders. This was the beginning of the thought that there was a potential to reduce the number of incidents that emergency units were responding to. It was further understood that this reduction could save organizations money and improve service delivery systems. The concept was developed and at the time it was called an Incident Reduction Program (IRP).

As meetings moved forward with discussions on definitions, data collection, and how to improve these two different programs, ideas were coming in from many different people. These ideas were evolving in many different directions. As with any program, idea, or concept, and especially with those that are new, there are going to be a number of different opinions on the specific direction that things should go. The biggest question at this point however, ended up being, "If the fall prevention program and

the recurrent user program were to be combined within our organization, how would that look and under what division should it live?”

As work continued in developing the initial program, proposals were written, presentations were made, and our organization elected to move forward with the recommendation request. This included time to be devoted to the project, though it would have to be done so without any budgeted funds. We were also directed by our supervisor to have the focus of this program be more on injury and illness prevention rather than incident reduction. If prevention efforts were successful, then incident reduction would be one of the many benefits that would be recognized. With this focus the name was changed from IRP and the establishment of the name “CARES” was created. It was an appropriate acronym as Community Assistance, Referral, and Education Services is exactly what the injury and illness prevention program would entail. After searching web domains, it was realized that the term “Cares” was a very common term to describe various programs around the world. At this point “Fire Department” was added in front of the word and the name FDCARES was created.

The debate continued on where the FDCARES program should live in the organization. It is common to have “prevention” programs under “fire prevention” and there is a big education portion involved with an injury and illness prevention program. It is no secret that public education typically lives under a fire department’s prevention division. The Kent Fire Department wanted to address the disconnect between response crews and the follow up assistance provided. The crews being intimately involved is an important focus here. Although there are many important areas that help to ensure the success of this type of program, three have been identified that are deemed to be essential in the program’s success.

First, responding crews need an easy method in which to refer a patient into the injury and illness prevention system. The easier it is to enter a patient into a system, the more likely it will be that the patients will be referred. If possible, removing subjectivity from the decision to refer a patient into the

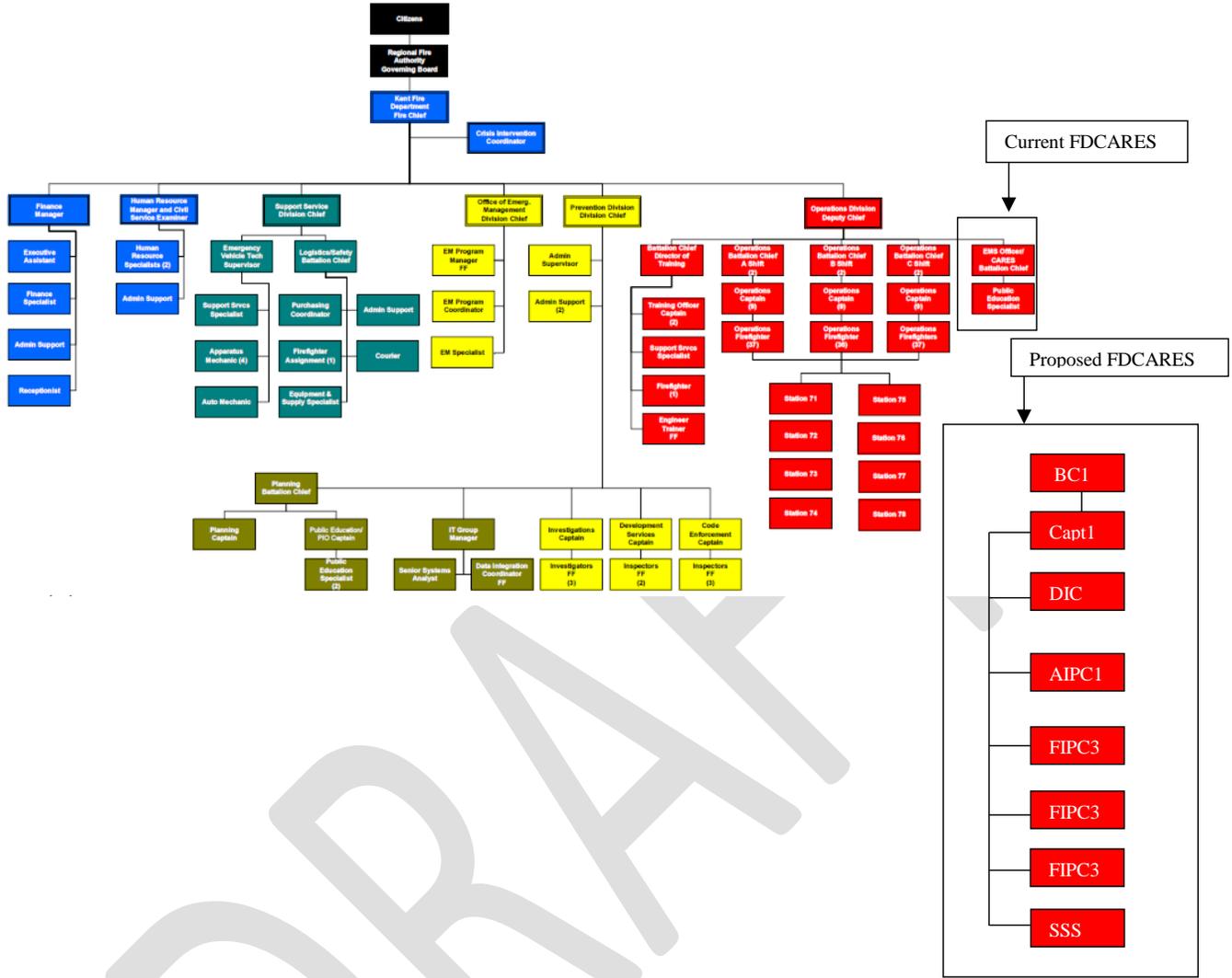
system would be optimal. Second, the response crews need to get feedback on their referrals. Not just the member of the crew that made the entry, but everyone on the crew and potentially every crew who works at the station that typically responds to the specific patient. It is our legal council's opinion that this feedback complies with HIPPA regulations and is a continuation of care for the individual patient.

Lastly, there needs to be measurable results. Crews who notice results in the form of decreased incident response to familiar residents within a community will continue to enter names of patients into the system. At the time of this writing, the Kent Fire Department has experienced over 95.8 percent of firefighters entering reports, are also making referrals into the FDCARES system.

Given these factors, it was decided that the program would live under the Operations Division of our organization. It is realized that this debate will likely continue to exist with other organizations and that there may be many different methods of moving forward successfully under different organizational structures. It is also believed that it is more important to have an injury and illness prevention program living anywhere within the fire department than to not have one at all. In the end, it has been found that these three issues will contribute to a program's success no matter where the program lands on an organizational chart.

As further development of the FDCARES program took place and low acuity or non-emergent response was added to the list of services provided by this division, it became clear that FDCARES is an operational, non-emergency division of our fire department.

KENT FIRE DEPARTMENT REGIONAL FIRE AUTHORITY
ORGANIZATIONAL CHART



Market Profile & Target Market

The success of FDCARES depends first and foremost on identifying the wants and needs of potential customers, targeting the most promising customer segments, and positioning FDCARES in their minds as a value-added service. Although FDCARES abstracts the most important customer information through direct client interactions, a preliminary conceptualization of customer needs can be attained through the research literature.

U.S. health care consumers are predominately dissatisfied with the current health care system. Seven out of ten adults believe the U.S. health system needs fundamental change or replacement with a new system, citing difficulties in accessing care, poor care coordination, and inefficient and wasteful delivery of health services (Commonwealth). U.S. consumers want a regular source of health care that is available on-demand, more patient-centered, more integrated, and more coordinated. Therefore, a potentially large consumer market is willing to access care directly through the convenience of the 911 system and, alternatively, through proactive phone calling and home visitation.

Important segments of FDCARES' consumer market are those individuals who already use expensive 911 and EDs as their preferred source of care. A 2010 study published in the *Annals of Emergency Medicine* found that frequent users comprise 4.5 to 8 percent of all emergency department (ED) patients, yet account for 21 to 28 percent of all ED visits (LaCalle & Rabin 2009). These frequent users of the EMS system were typically defined in the research literature as individuals using the ED four or more times in a given year. Frequent users were commonly between the ages of 20-40 or over the age of 65, non-white, low-income and insured through Medicare and/or Medicaid. They often had multiple chronic diseases, perceived their overall health status as poor, and reported that their medical needs were unmet by the health care system (LaCalle & Rabin, 2010). Frequent users were also affected by high rates of mental illness, alcohol-related disorders, chronic non-cancer pain, opioid-use disorders, and other substance abuse disorders (Peppe, Mays, Chang, Becker & DiJulio, 2007). Although many frequent users reported access to a primary care provider and high utilization rates of outpatient services, limited access

to care based on clinic hours and insurance type was as a primary reason for ED utilization (Long & Stockley, 2009).

Among the frequent users of the ED, FDCARES should target individuals with chronic disease(s) who perceive their health status as poor. In addition, given the financial penalties for 30-day hospital re-admissions, FDCARES should partner with hospitals and primary care clinics and serve as a response unit for individuals admitted to the hospital within the previous 30 days for a myocardial infarction, pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and geriatric fall patients who are in the early stages of illness manifestation. Often times, these patients contact a hospital or clinic consulting nurse for non-urgent issues and may not need emergency medical treatment, but instead, may require a non-emergent intervention. Also, in accordance with their successful fall prevention program, FDCARES should target individuals who are high utilizers of the 911 system and have recently called 911 due to a fall. Finally, FDCARES should prioritize individuals who are both interested in receiving medical and social stabilization and capable of learning self-management, and thus, more likely to achieve quality outcomes.

Additional insight about which consumers FDCARES should target for their proactive services can be gained by segmenting the market according to consumer behaviors and attitudes. In particular, Deloitte Inc. conducted a segmentation analysis of health care consumers that revealed how individuals make health care decisions and navigate the health care system in distinctive ways. In their analysis, they identified six unique segments that comprise the health care consumer market: “content and compliant,” “sick and savvy,” “casual and cautious,” “online and onboard,” “shop and save,” and “out and about” (Deloitte Center for Health Care Solutions 2012). Among the six segments outlined in the Deloitte survey, FDCARES should target the “Out & About,” who were characterized by their dissatisfaction with the healthcare system and self-reported low health status. This consumer segment demonstrated high rates of chronic disease, but preferred to make independent treatment decisions. They typically expressed a low level of trust in health care providers and believe a large amount of health care spending was wasted.

Only 38 percent reported that the healthcare system met their needs. Individuals in the “Out & About” segment believed that consumer behavior has a major influence on outcomes and cost. On average, they had annual incomes below \$50,000 and report being under-insured or insured through Medicare and/or Medicaid. Over the previous year, 21 percent received care in an ED, the highest proportion of the consumer groups, and 29 percent were satisfied with the care they received, the lowest proportion of the consumer groups (Deloitte Center for Health Care Solutions 2012). FDCARES should target this consumer group because of their dissatisfaction with the health care system, high rates of chronic disease, potential to be empowered and activated in self-care, and frequent use of the emergency department for care. Taking this into account, FDCARES has developed a patient priority algorithm (Appendix “N”) that helps direct the order in which patients are seen.

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Competitive Analysis

Fire Departments/EMS Agencies

There are approximately 25,947 fire departments across the country and 19,971 EMS agencies. The FD/EMS system is extremely fragmented: 60 percent operate from a governmental structure, 25 percent are non-hospital based, and 6 percent are hospital based. The large majority of FD/EMS systems operate a two-tiered emergency medical response system with Basic Life Support (BLS) and Advanced Life Support (ALS) services. That said, fire departments across the country are starting to reform their operations.

AMR, Inc.

This company provides a full range of medical transportation services and pre-hospital assistance, operating on emergency (911) response systems in large and small communities. AMR contracts services for health plans, hospitals, rehab, and skilled nursing facilities and offers clients' direct non-emergency medical transportation. AMR is starting a community paramedic specialist program to train paramedics to provide out-of-hospital evaluation and therapy that is integrated with the acute healthcare system and the patient's primary care medical home (American Medical Response 2011).

Rural/Metro Corp.

A leading provider of private ambulance and fire protection services to cities, counties and healthcare systems nationwide. Rural/Metro was recently purchased by a global private equity firm, Warburg Pincus, part of the trend of vertical and horizontal integration of EMS.

MedStar Mobile Health, Inc.

An EMS provider serving the Fort Worth, Texas area, using advanced-practice paramedics to provide in-home and telephone-based support to patients who frequently call 911. Paramedics conduct an

in-depth medical assessment, develop a customized care plan based on that assessment, and periodically visit and/or telephone the patient and family to support them in following of the care plan. A separate, but similar program serves individuals with congestive heart failure (AHRQ 2011).

Falck A/S

Falck has the world's largest ambulance fleet and is the world's largest provider of fire services. Just this year, Falck purchased Care Ambulance Service Inc. and Life Star Inc. and established corporate offices in Bothell, Washington. Falck is also the world's largest provider of safety training and services for the offshore industry and provides healthcare services to private, corporate, and public sector customers.

Carena, Inc.

Carena delivers medical care by phone, webcam and house call. Carena's doctors and nurse practitioners are available on demand, 24/7.

VREE Health, Inc.

A subsidiary of Merck Inc., that provides a post-discharge service for hospitals, connecting providers to clients once they transition home. Vree Health, Inc. works to reduce Medicare reimbursement penalties, improve performance and quality scores related to 30-day readmission rates, and enhances patient satisfaction.

Hospital Outreach Coordinator

Hospitals, such as Harborview Medical Center and some Multi-Care providers and Franciscan Health, have hired health outreach coordinators to follow-up and closely monitor clients discharged from the hospital within 30-days following a heart attack, pneumonia or congestive heart failure.

SWOT Analysis for FDCARES

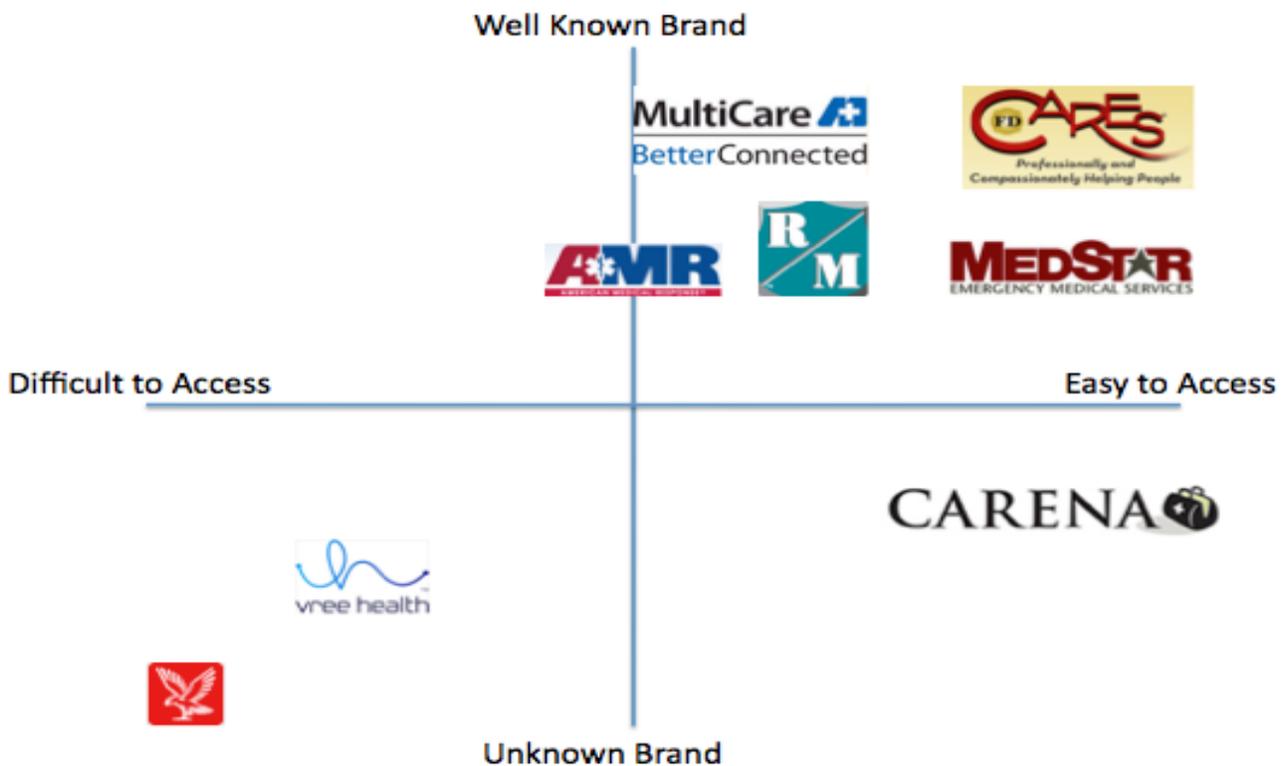
Strengths	Weaknesses
<ul style="list-style-type: none"> ▪ Accessible 24 hours a day, 7 days a week, 365 days a year in local community 	<ul style="list-style-type: none"> ▪ Union support required for FDCARES adoption. This may be considered a strength as unions recognize the need to adapt to the changing healthcare environment
<ul style="list-style-type: none"> ▪ Timely response at point of service request 	<ul style="list-style-type: none"> ▪ Well-established, bureaucratic system committed to one-size-fits-all response model
<ul style="list-style-type: none"> ▪ Large, established customer base (i.e., 911 callers) 	<ul style="list-style-type: none"> ▪ Fragmented, fire-based EMS system
<ul style="list-style-type: none"> ▪ Trusted, well-recognized brand 	<ul style="list-style-type: none"> ▪ Difficult to achieve economies of scale
<ul style="list-style-type: none"> ▪ Customer database and relationship with community members enables easy provider access to clients for proactive calling and follow-up 	<ul style="list-style-type: none"> ▪ Personnel trained to deliver wide array of non-emergency services and resource referral with minimal training for NEMS
Opportunities	Threats
<ul style="list-style-type: none"> ▪ Reduce inefficiency and waste in fire-based EMS and ED care 	<ul style="list-style-type: none"> ▪ Public vote against funding fire and EMS service levy
<ul style="list-style-type: none"> ▪ Client navigation to and coordination with medical and social service agencies across care continuum 	<ul style="list-style-type: none"> ▪ Municipalities adopt private EMS response for medical service requests
<ul style="list-style-type: none"> ▪ Electronic medical record systems are enabling client data tracking to improve quality, reduce waste (e.g., over-utilization, redundancies), and prove value of services 	<ul style="list-style-type: none"> ▪ Private industry alternatives to 911 (e.g., Carena, hospital outreach coordinators, VREE) capture fire-based EMS market share
<ul style="list-style-type: none"> ▪ New revenue streams from private industry hospitals and payers 	<ul style="list-style-type: none"> ▪ Liability and medical errors associated with non-transport of clients to ED

Positioning Map: graphic and written representation of how to position FDCARES in the minds of targeted customer segment as a value-added service

Variables: most influential trade-offs for customers' purchasing decisions

Ease of access: determined by the resources (e.g., scheduling, transportation, insurance) required and availability (e.g., hours of operation, geographic proximity) of health care services

Brand recognition: the extent to which the general public (or target market) is able to identify a brand by its attributes.



Strategic Positioning Statement

To: users of the emergency medical services who perceive that their health status is poor and their needs are unmet by the healthcare system

FDCARES is: a non-emergency medical service division of the fire department

That: improves the efficiency and effectiveness of the EMS system by delivering the right service, at the right time, in the right place, and in the right way

Because: FDCARES offers a wide range of medical and social services 24 hours-a-day, 7 days-a-week, 365 days-a-year in your local community

Objectives

The primary objective is to fully integrate FDCARES - NEMS system into the broader healthcare system to improve the health outcomes of individuals in need of non-emergency services. We provide the proper level of response, education, advocacy and medical systems navigation. Utilizing a combination of public and private resources, FDCARES will increase access to the appropriate level of healthcare and social services in a timely and cost effective manner. The overriding concern is to provide these services in a fashion that is responsive and economical for our community. Specific objectives are listed below.

- To provide injury and illness prevention outreach to the residents in our community.
- Work with high utilizers of the 911 system to address their underlying issue causing this need.
- Initiate a NEMS response in a more efficient, cost effective method.
- Stabilize patients at time of low acuity request for service to avoid unnecessary ED admissions.
- Navigate patients to appropriate level of care, during regular healthcare working hours.
- Work with partnership ED's to address their high utilizers within FD response area.
- Be a 24/7/365 field resource for ED's and hospital staff, to check on discharged patients, avoiding social admissions of independent patients to the hospital.
- Research various skilled employees' to perform proactive field care (i.e. Nurses, Paramedic's, and EMT's).

- To maintain high quality care by providing outstanding training opportunities and by participating in quality improvement processes.
- To develop new and cost-effective EMS funding options.
- Work with area hospitals to avoid readmissions of patients discharged with Pneumonia, CHF, Acute MI, COPD, and Geriatric fall patients.
- Work with payer groups to develop a cost savings sharing model to help fund the program.

Key Messages

1. FDCARES is a non-emergency service division of your local fire department that is available 24 hours a day, 7 days a week, 365 days a year.
2. FDCARES responds to non-emergency medical and social needs in a timely, appropriate manner.
3. FDCARES improves the efficiency and effectiveness of the EMS system by offering a tiered-response model (or adding a non-emergency tier to already tiered responses) that more appropriately responds to non-emergent requests.

Overall Goals

- 1) Fully integrate FDCARES into the fire department
- 2) Improve the efficiency of EMS delivery
- 3) Reduce unnecessary utilization of EMS resources
- 4) Improve access to care
- 5) Improve health outcomes
- 6) Partner with hospitals and payors to ensure the financial sustainability of FDCARES

• Goals Year One

- Gaining majority Fire Authority support and financing for implementing business plan
- Obtain a second FDCARES response unit and equipment
- Increase FDCARES staffing with one captain
- Further develop policies and procedures and training for future personnel

- Create transport partnership with revenue of \$100,000 to off-set Captain wage expenses with a net cost to the Regional Fire Authority of less than \$30,000
- Implement appropriate data-tracking system
- **Goals Year Two**
 - Determine appropriate level of staffing and certification level required for program
 - Hire the determined number of staff members necessary for full program start up
 - Complete full training of all new hired employee's
 - Develop formal partnerships with other health care providers
 - Develop formal partnerships with insurance payers
 - Generate funding through partnerships/grants/sponsors to help off-set program costs
 - Work toward a zero net cost to fire authority for two personnel 24/7/365 unit staffing
- **Goals Year Three**
 - Ensure full time staffing of FDCARES program of two personnel 24/7/365
 - Proceed to 90% or greater of all 911 BLS Y-type IDC's within response area
 - Implement a detailed "cost savings share" system with partnership agreements
 - Develop data systems with predictable outcomes and place on web based server
 - Provide 5000 proactive home visits to patients identified and tiered utilizing the patient priority algorithm
 - Fully develop and implement system to prevent ED/Hospital readmissions for 5 identifiable patient types

Keys to Success

- Gaining Kent Fire Department support to include both Labor and Management
- Gaining Regional Fire Authority Board support and approval
- Purchasing appropriate level and quality of capital and minor equipment
- Recruiting and retaining a qualified Fire Captain, and full time employee staffing
- Providing adequate pre-implementation training
- Developing the operations policy and procedures for the FDCARES services
- Having adequate administrative support from Fire Department Administration
- Continuing to support fire response crew and FDCARES through training

- Receive support from other county agencies, including King County Emergency Medical Services, County Medical Program Director, and Valley Communications Dispatch Center
- Partnerships with various healthcare providers to include, Tri-Med Ambulance, and one or more of the following: Valley Medical Center, MultiCare, Franciscan Health Systems, and a variety of health insurers which covers care for local area residents
- Developing and maintaining adequate run volume, proactive patient connections, emergency department and hospital discharged patient's
- Developing working relationships with various social service and both public and private care providers
- Obtain sponsorship agreements and funding support from various sectors of the local business community

Evaluation Metrics

Process Metrics

- Number of personnel trained to deliver NEMS services
- Number of non-emergent call types
- Number of direct FDCARES responses to non-emergent call types
- Average time of NEMS response
- Number of emergency responses for non-emergent call types
- Number of downgrade calls to FDCARES response unit
- Number of transports to the emergency department for non-emergent call types
- Number of clients transported to alternative care settings
- Number of referrals obtained from provider network and community agencies
- Number of frequent users of EMS identified
- Number of client enrollments in insurance via Health Benefits Exchange
- Number of client enrollments in a primary care medical home

Outcome Metrics

- Unit reliability
- Unit response times
- Percent of client contacts/visits for identified frequent users and referred clients
- Percent of needs assessments for identified frequent users and referred clients
- 30-day hospital re-admission rates for FDCARES clients with heart attack, pneumonia, and CHF
- Number of fire departments with FDCARES programs

Financial Metrics

- FDCARES program costs
- Fire department costs
- Costs associated with capital outlay expenses
- Projected costs of ED visits (including transport) and facilities of lower care cost comparisons

2010 – 2013 Highlights

- 2010 – January, the fall prevention program and frequent user program began to discuss benefits of merging.
- 2010 – July, the IT staff developed and implemented the FDCARES reporting tab within the department's records management system (RMS).
- 2010 – September, the EMS division was separated from the Logistics division and EMS combined with FDCARES under the supervision of a Battalion Chief.
- 2010 – November, Valley Communications (i.e., 911 dispatch) added the CARE 71 unit to its dispatch roster, and the fire department developed a policy regarding patient intervention safety.

- 2011 – January, a 36-hour per week employee was hired as the department’s first Incident Prevention Coordinator to work with area residents in order to prevent or at least reduce their inappropriate use of emergency 911 services.



- 2011 – April – The FDCARES program received support from Dr. Mickey Eisenberg, the King County Medical Program Director.
- 2011 – May, the department received approximately \$80,000 in sponsorships for the FDCARES program. The FDCARES logo and the first promotional brochure for the program were created. The brochure included recognitions of the programs initial sponsors.

2011 Sponsors

- 2011 – December, by year’s end over 500 residents were entered into the CARES tab while data collection needs were being discovered and developed.
- 2012 – January, Senator Karen Keiser introduced FDCARES legislation.
- 2012 – June, Governor Christine Gregoire endorsed the program, and Senator Patty Murray supported the FDCARES CMS grant proposal.

- 2012 – September, FDCARES teamed up with KJR sports radio and Meridian Valley Country Club for - FDCARES fund-raising golf tournament and radio education campaign.



- 2012 – September, Tri-Med Ambulance presented the FDCARES program with a new Toyota FJ Cruiser vehicle. This vehicle is a non-transport, higher fuel economy vehicle that has the cargo space to carry a large supply of prevention equipment. A safety guard was designed and installed which separates the driver/passenger compartment from the equipment. The vehicle has also been equipped with a mobile data computer (MDC) equal to that of all of the department's response vehicles and is equipped with four-wheel drive, making this an all-weather response vehicle.
- 2012 – December, by years end over 1000 residents were entered into the CARES system, over 500 of which received assistance, and nearly \$50,000 in sponsorships were accepted. Kent Fire Department/RFA signed partnership agreements (i.e., Inner Local Agreements) with five Washington State Fire Departments who are starting to provide the FDCARES services.
- 2013 – April, the Kent Fire Department received from Tri-Med Ambulance \$100,000 to help increase staffing levels to assist with early program design.
- 2013 – May, Legislation allowing fire departments to operate a FDCARES program was passed unanimously through both the Washington State Senate and the House and subsequently signed into law by Governor Jay Inslee.



Washington State Governor Jay Inslee signing FDCARES legislation.

FDCARES Legislation

5145 AMH PS H2078.1

SB 5145 - H COMM AMD

By Committee on Public Safety

ADOPTED 04/03/2013

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** A new section is added to chapter 35.21 RCW to read as follows:

1) Any fire department may develop a community assistance referral and education services program to provide community outreach and assistance to residents of its district in order to advance injury and illness prevention within its community. The program should identify members of the community who use the 911 system for low acuity assistance calls (calls that are nonemergency or non-urgent) and connect them to their primary care providers, other health care professionals, low-cost medication programs, and other social services. The program may also provide a fire department-based, nonemergency contact in order to provide an alternative resource to the 911 system. The program may hire health care professionals as needed.

2) A participating fire department may seek grant opportunities and private gifts in order to support its community assistance referral and education services program.

3) In developing a community assistance referral and education services program, a fire department may consult with the health care personnel shortage task force to identify health care professionals capable of working in a nontraditional setting and providing assistance, referral, and education services.

4) Community assistance referral and education services programs implemented under this section must, at least annually, measure any reduction of repeated use of the 911 emergency systems and any reduction in avoidable emergency room trips attributable to implementation of the program. Results of findings under this subsection must be reportable to the legislature or other local governments upon request. Should include estimated amounts of Medicaid dollars that would have been spent on emergency room visits had the program not been in existence.

5) For purposes of this section, "fire department" includes city and town fire departments, fire protection districts organized under Title 52 RCW, and regional fire authorities organized under chapter 52.26 RCW."EFFECT: Specifies that low acuity assistance calls are calls such as those that are non-emergency or non-urgent.

Assignment Titles (Assignment Descriptions in associated Appendix)

Battalion Chief Assigned to EMS/FDCARES	See APPENDIX “B”
Captain Assigned to EMS/FDCARES	See APPENDIX “C”
Firefighter/Data Integration Coordinator	See APPENDIX “D”
Firefighter/EMT’s Field Incident Prevention Coordinator	See APPENDIX “E”
Administrative Incident Prevention Coordinator	See APPENDIX “F”
Nurse Field Incident Prevention Coordinator	See APPENDIX “G”
FDCARES Support Service Specialist	See APPENDIX “H”

DRAFT

Statistical Notes

The Kent Fire Department/RFA averages over 16,000 - 911 incidents each year, which includes both fire and EMS. Of those 16,000 plus 911 incidents, 75-80 percent of the responses are for EMS requests.

Of those 12,000 plus EMS incidents, records indicate:

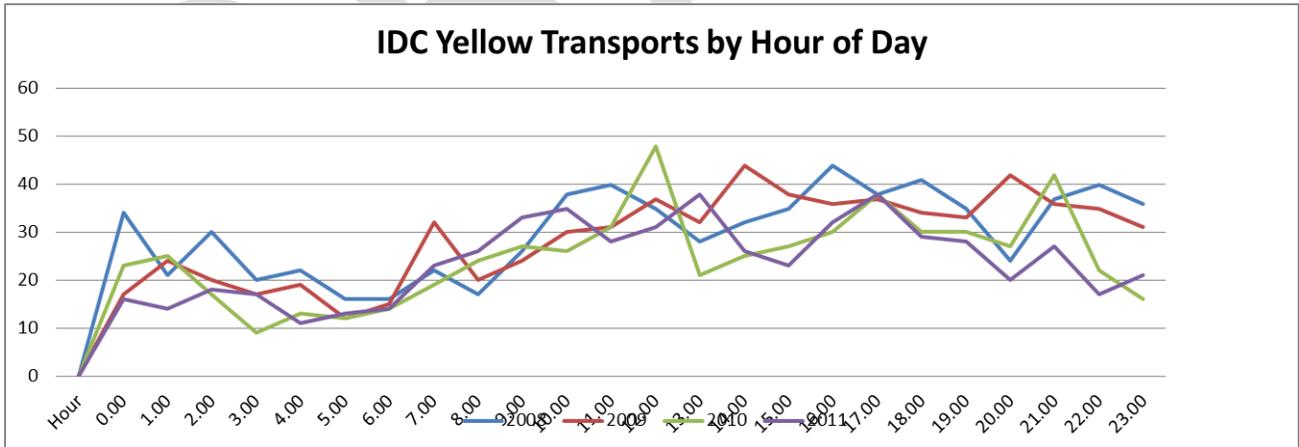
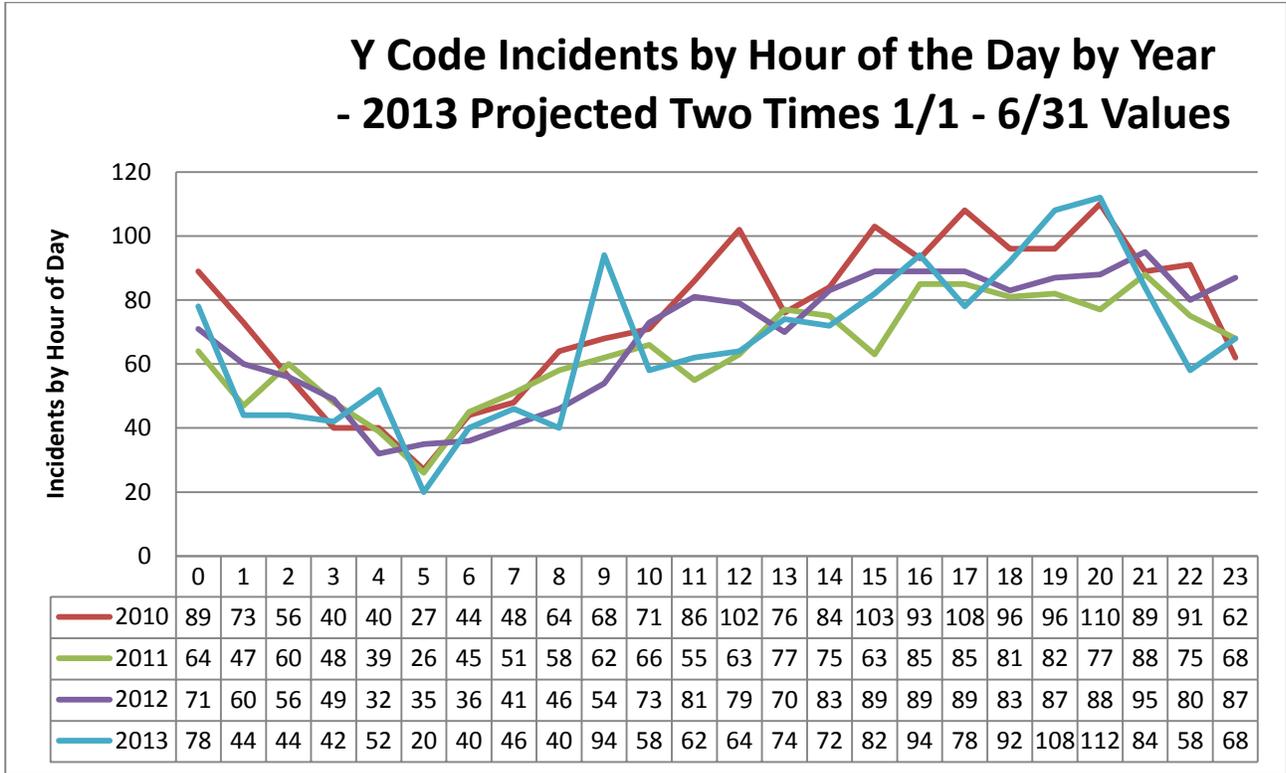
- For five years running, nearly 10% (approximately 800 incidents annually) of the patients seen were transported via advanced life support (ALS) by the South King County Paramedics.
- There are also 2,070 incidents that included an ALS response where the patient was not transported by the ALS crew. Both this and the previous bullet point include all ALS incidents whether they were dispatched as such or upgraded during the response.
- For the remaining, approximately 90% of 911 EMS incidents, the patients were either left at the scene or transported via basic life support (BLS) or private automobiles.
- The number of incidents given a Y code IDC at time of dispatch is between 10-15% (approximately 1800 plus, incidents annually).
- There are also approximately 9000 incidents annually that are left in the middle, and are not identified as ALS and not considered to be low acuity at time of dispatch.

This chart outlines the number transports and EMS incident totals for the last 5 years.

	2008	2009	2010	2011	2012
ALS Transports	860	759	727	722	722
BLS Transports	6009	6371	6350	6711	7117
Non - Transports	1,941	1,484	1,430	1,660	1,811
Y & TRP IDC's	3,373	3,116	2,304	1,948	2,204
Total Medical Responses	11,914	11,699	12,016	12,356	13,041

Total	EMS	Total Y Codes	Total TRP
2008	11,914	1,868	1,305
2009	11,699	1,841	1,078
2010	12,016	1,685	488
2011	12,356	1,540	408
2012	13,041	1,653	351

Y IDC's By Hour of Day



Emergency unit reliability comparison for year 2012 if FDCARES division were fully staffed

The following charts define the number of minutes, hours and days that would be added back into the emergency unit reliability if this FDCARES business plan were to be adopted. This is a year by year comparison of shifting *ONLY* the “Y” type IDC’s. These charts and graphs do not take into account the “T” or “P” IDC’s that would also be shifted to the FDCARES division or any of the incidents that would be downgraded to the FDCARES division. All of these will have measurable effects on unit reliability. As the following charts and graphs point out, for just the year 2012 there are over forty one thousand minutes of reliability added back into the emergency response system. This equates out to one out of service unit being put back in service for 684.65 hours, or over 28 full days during the year.

YEAR 2012 RELIABILITY BY FRONTLINE APPARATUS

	Reliability	Reliability- Y Codes	Total Minutes	Y-Code Minutes	%
A70	0.9853	0.9873	7,706.27	1,021.88	13.26%
A71	0.8438	0.862	82,117.38	9,585.18	11.67%
E71	0.9264	0.9296	38,668.37	1,650.44	4.27%
E72	0.9436	0.947	29,662.32	1,820.14	6.14%
E73	0.8992	0.9068	53,004.77	4,039.64	7.62%
E74	0.8955	0.9028	54,899.75	3,786.18	6.90%
A74	0.8821	0.8941	61,964.58	6,299.73	10.17%
L74	0.9486	0.9512	27,019.77	1,388.73	5.14%
E75	0.9185	0.9247	42,860.42	3,301.54	7.70%
E76	0.9268	0.9303	38,470.97	1,829.26	4.75%
E77	0.8978	0.9057	53,732.10	4,143.06	7.71%
E78	0.9444	0.9486	29,217.90	2,213.02	7.57%
			519,324.60	41,078.80	7.91%
			Hours	684.65	
			Days	28.53	

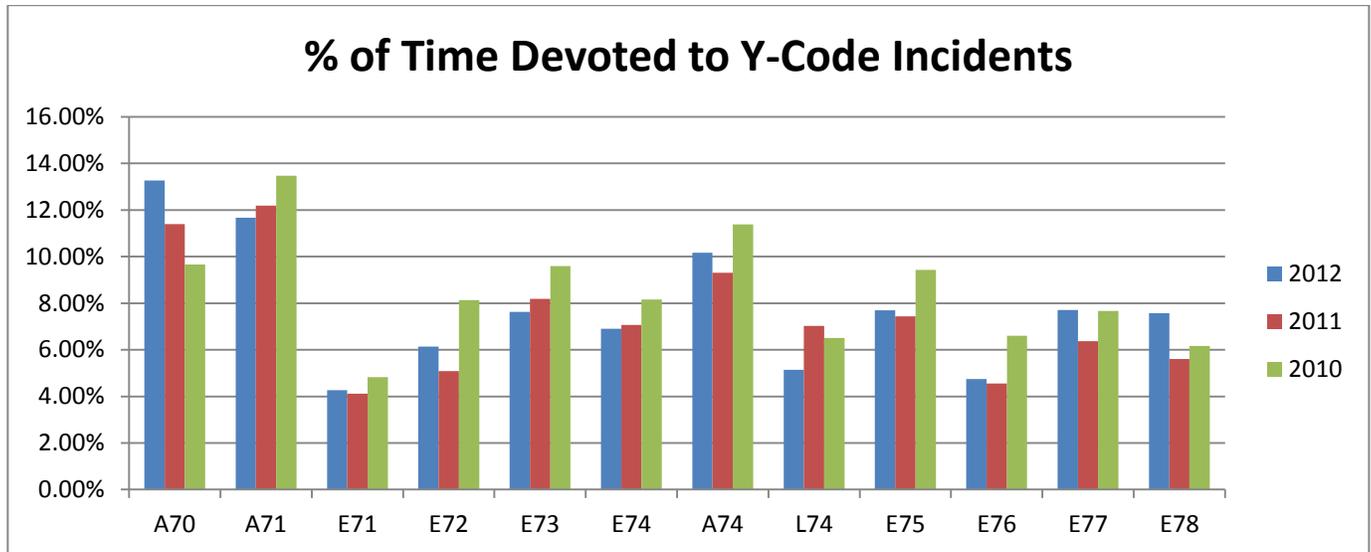
YEAR 2011 RELIABILITY BY FRONTLINE APPARATUS

	Reliability	Reliability- Y Codes	Total Minutes	Y-Code Minutes	%
A70	0.9719	0.9751	14,793.63	1,686.61	11.40%
A71	0.85	0.8682	78,861.79	9,602.76	12.18%
E71	0.9301	0.933	36,718.63	1,509.59	4.11%
E72	0.9644	0.9662	18,691.99	950.51	5.09%
E73	0.9164	0.9232	43,943.94	3,595.84	8.18%
E74	0.9114	0.9176	46,569.71	3,285.82	7.06%
A74	0.8509	0.8648	78,347.24	7,295.00	9.31%
L74	0.9539	0.9571	24,237.46	1,701.64	7.02%
E75	0.9219	0.9277	41,074.48	3,053.78	7.43%
E76	0.9282	0.9315	37,739.48	1,721.43	4.56%
E77	0.9153	0.9207	44,539.27	2,836.46	6.37%
E78	0.9506	0.9533	25,989.74	1,456.47	5.60%
			491,507.36	38,695.91	7.87%
			Hours	644.93	
			Days	26.87	

YEAR 2010 RELIABILITY BY FRONTLINE APPARATUS

	Reliability	Reliability- Y Codes	Total Minutes	Y-Code Minutes	%
A70	0.9716	0.9743	14,946.38	1,443.19	9.66%
A71	0.8518	0.8718	77,872.37	10,489.56	13.47%
E71	0.937	0.9401	33,103.30	1,599.22	4.83%
E72	0.9503	0.9543	26,127.16	2,124.68	8.13%
E73	0.9174	0.9253	43,421.55	4,165.07	9.59%
E74	0.8934	0.9021	56,044.34	4,575.30	8.16%
A74	0.8762	0.8903	65,077.14	7,405.62	11.38%
L74	0.9491	0.9524	26,776.73	1,743.14	6.51%
E75	0.9212	0.9287	41,400.61	3,905.70	9.43%
E76	0.9264	0.9312	38,706.36	2,554.69	6.60%
E77	0.9082	0.9152	48,263.41	3,698.66	7.66%
E78	0.9483	0.9514	27,196.66	1,677.72	6.17%
			498,936.01	45,382.55	9.10%
			Hours	756.38	
			Days	31.52	

The following chart displays the 2010, 2011, 2012 years, comparison of the percentage of response time devoted to “Y” type IDC’s.



Downgrade Initial Dispatch Code (IDC)

It would be helpful if the approximately 9000 incidents annually that are left in the middle of ALS and low acuity type responses, (those that are not identified as ALS and not considered to be low acuity) were better identified. This is a wide range of incidents where, by the end of the incident, the responders know if the patient could have been identified as a Y code or low acuity patient type.

Currently call receivers, dispatchers, and responders can upgrade incidents to an ALS response type at any point during the response if it is determined that the patient needs a higher acuity response. The frequency of this is tracked through the Valley Communications Dispatch Center and the IDC is changed for tracking purposes. These upgraded incidents are included in the total of all annual ALS responses.

As mentioned before, the Kent Fire Department/RFA currently responds to between 1800 and 2500 “Y-type” dispatch codes per year. Due to the changes in the definitions of the IDC’s over the years, it is difficult to utilize more than a single year of past data to estimate the future number of these code

types. “Y” type codes are given to 911 incidents that are considered to be of lower acuity medical requests for service at time of dispatch.

The problem is that a “down grade” code does not exist. This means that once an IDC is given by a call receiver in the dispatch center, if the code is initially higher than a “Y” type code it stays at the level given, even if the patient is found to be identified as a lower acuity type patient or one that could have been given a “Y” type code at any point after dispatch. The exception to this rule is when an ALS response is dispatched, in the King County tiered response system, responding paramedics which are the ALS tier, may be canceled and the response be handled with EMT’s which are the BLS providers.

The reality however is that a “down grade” code has never been deemed necessary. There has never been a need as field BLS medical responses typically don’t have a crew to down grade a medical incident to. The statement that a “one size fits all” type response exists is not completely true. There are many different types of responses, which is why there are over eighty (80) dispatch codes in existence. What doesn’t exist is a low acuity, lower cost response mode for the large numbers of non-emergent incidents. It is believed that there are many more incidents within the approximate 9000 incidents in the middle ground that would be appropriate for a downgraded response. These numbers are predicted to be over 3000 incidents as the repetitive utilizers of the 911 system create over 3400 incidents within the Kent Fire Department/RFA annually. With the development of a non-emergency division and a lower acuity response with a more cost effective response mode, it will be the goal of the Kent Fire Department/RFA’s FDCARES division to work with Valley Communications to create a downgrade code.

The down grade code will allow us to:

- Provide the safety net of the emergency response system while improving in service time (unit reliability) for incidents determined to be lower acuity at any point after dispatch.
- More accurately track data on the actual number of non-emergency medical requests for service that the fire department responds to.

- Track data on incidents that were given higher IDC's at time of dispatch which could be downgraded with a focus on call receiver training and efficiencies improvement.
- Shift a larger number of these incident types from the emergency response system to a more appropriate non-emergency response division.
- Build in more capacity for the current emergency response division by shifting these incidents to the non-emergency division.

Projections for FDCARES work capacity (based on above data and the hospitalcompare.gov website).

Number of 911 incidents projected to be shifted into the FDCARES non-emergency medical services division: This incident count is predicted to be between 1800 and 2200 incidents annually. Based on a 2000 annual incident call volume this would be 5.5 incidents per 24 hour shift.

Number of proactive home visits when fully staffed: This number is predicted to be approximately 5000 annually. This is based on three FIPC's performing 4.5 proactive home visits per 24 hour shift over a 365 day period.

The focus for proactive home visits can be complex, though through continual trial and error we have developed a "Patient Priority Algorithm" that assigns each patient seen through the 911 system, each patient that enters a partnering emergency department, and each FDCARES referred patient a priority tier number. The tier number is assigned to each patient within the KFD/RFA's response area by balancing an individual's 911 use, ED use, referrals, and medical disposition. The associated tier number is then utilized to determine the order in which patients are proactively visited. This order first addresses the patients that are the highest systems utilizers that can be the most easily addressed with the quickest possible resolution in preventing a patient's need for further 911 and ED use (See appendix "N").

Number of 911 incidents projected to be downgraded into the FDCARES non-emergency medical services division: As there is no current accurately measurable method to predict the number of incidents

to be downgraded. We believe that there will be capacity for up to 3000 incidents per year though we are going to start with a prediction of 6 per shift or an annual total of 2304 incidents to be downgraded.

Number of projected Medicare non-payment, readmission finable incidents projected to be referred to the FDCARES non-emergency medical services division is 276 incidents. Projections based on hospital compare website data for 5 patient types (Pneumonia, CHF, AMI, COPD, Geriatric Fall) discharged by Valley Medical Center, Auburn General (Multi-Care), and St. Francis (Franciscan Health System, FHS), 2012 data – applying a four community discharge catchment area and a 50% national average readmission rate for the 5 patient types. This is predicted to be less than one per 24 hour shift but likely to increase as the process and working relationships with the hospitals, emergency departments, and various other healthcare provider relationships are established. These incidents were not included in the annual calculations as this will be the last element of response processes to be developed.

Capacity Totals:	Daily	Annually
Initial Dispatch for CARES units =	5.47	2000
Proactive Home Visits =	13.69	5000
Downgraded Incidents =	6.3	2304
Readmission Prevention =	.75	276

Future Annual Data Reporting

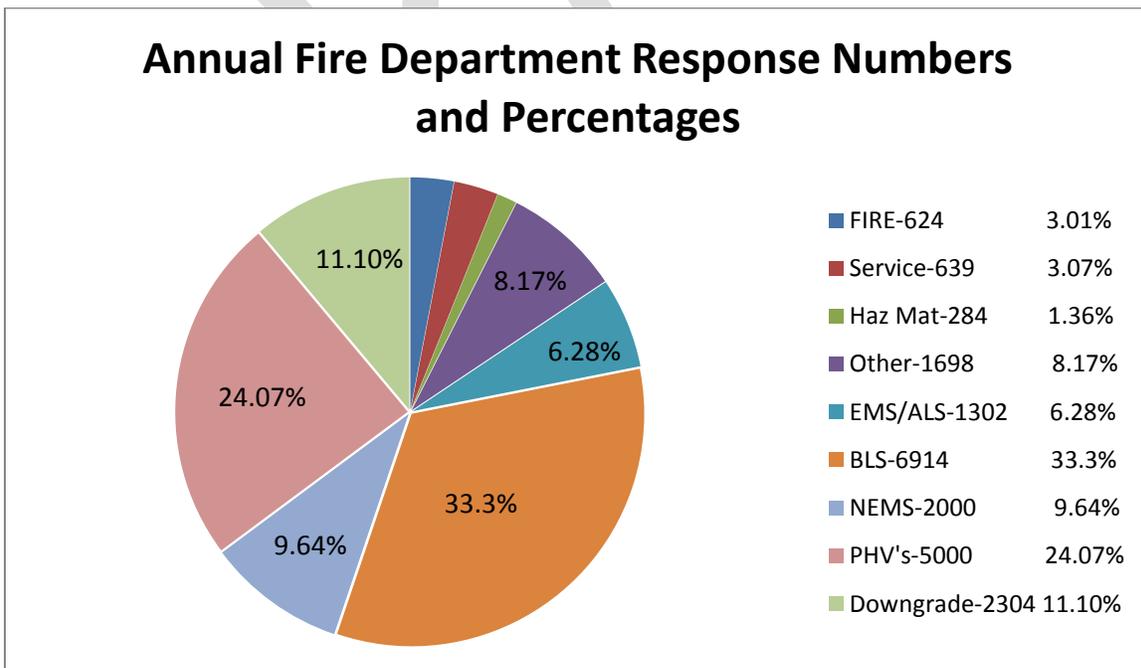
For data tracking purposes, it is suggested that EMS incidents be identified and reported differently for the annual organizational report. This means that we would no longer report all medical incidents as EMS incidents. Instead medical responses would be divided into three categories while adding a fourth category for proactive home visits and a fifth category for downgraded incidents. These five categories would be as follows:

- EMS = Emergency Medical Service Responses requiring advanced life support.

- BLS = Basic life support responses that would not require advanced life support.
- NEMS = Non-emergency medical responses that are not life threatening and will not become immediate life threatening if left uncared for over the next twelve hours.
- PHV = Proactive Home Visits that were generated by the non-emergency medical services division.
- Downgrades = Incidents that emergency response crews shift to the non-emergency FDCARES division.

Response Pie Chart with NEMS Incidents Identified

The following pie chart represents how the Kent Fire Department/RFA 2012 chart would be calculated utilizing an average annual number of Y-type incidents, an estimated number of downgraded incidents, and a projected number of proactive home visits. Displaying these incidents as separate responses, will more accurately depict the role of the fire department. It should also be noted that ALS and BLS incidents are separated on this chart, as are the downgraded incidents. Although separated, BLS crews respond to both ALS and BLS incidents and may initially respond to downgraded incidents.



Staffing Levels

The Kent Fire Department/RFA will need to complete a “lean start up” of the FDCARES program staffing. This startup will include adding a CARES Captain Program Specialist to the division during year 1. The Job description for this position will transition from a development/training role to a full time system’s evaluation and program quality assurance coordinator (see FDCARES Captain Assignment description which includes responsibilities through the transition).

Staff development goals are as follows:

- Increase total FDCARES Staff to 3 during the first year (year 1) of this business plan by adding a CARES Capt. Program Specialist to the division.
- Shift the department’s incident records management system (RMS) under the responsibility of the EMS division by creating a full time Data Integration Coordinator position. This position shifts the responsibilities of current department staff from the IT division to the EMS/FDCARES division. This will streamline reporting processes that are required of the department and needed for EMS/FDCARES. It is acknowledged that the position in IT will likely need to be back filled to cover other responsibilities currently assigned to this position and new duties that are needed within the IT division. Due to this shift, the cost of this position was not added into this business plan.
- Increase the division with FDCARES trained firefighter/EMT’s that will remain on shift and rotate onto the FDCARES service vehicles to start during year 2. This includes a total of 15 Firefighters/EMT’s, or, five - Firefighter/EMT’s per shift, trained in FDCARES services. Year two also includes the addition of 6, field Incident Prevention Coordinator’s (IPC’s). These are full time personnel that are assigned to the FDCARES non-emergency division. This recommendation is to staff the Kent Fire Department Regional Fire Authorities, FDCARES division with two nurses per shift to fill the role of the IPC’s.

Note: The IPC positions could be filled with firefighter EMT's, Paramedic's, Nurses, and/or potentially a variety of trained social service individuals. Filling the position with other than nurses would limit some of the service abilities that the non-emergency division would be able to perform. This is due to current Washington State Legislation; Washington State approved education curriculum, and acceptance of the curriculum by the Department of Health and county Medical Program Director's.

- Re-evaluation of the FDCARES staffing and training level would need to occur after the first full year of staffing to ensure predicted efficiencies, response capacity and patient outcomes are achieved. Any adjustments would be subject to the KFD/RFA recommendation request process.

	Year 1	Year 2	Year 3
Total FDCARES Staff	3/4	19/25	25
Battalion Chief	1	1	1
Capt. Program Specialist	1	1	1
Firefighter/EMT	0	15	15
Administrative IPC	1	1	1
Field (Nurse) IPC's	0	6	6
Data Integration Coord.	1	1	1

Scheduling

The Kent Fire Department RFA utilizes TeleStaff as their scheduling program. The FDCARES division is currently utilizing this system with the current staffing level of one Battalion Chief working a forty-hour workweek and one IPC working a thirty-six hour workweek. TeleStaff will continue to be utilized as the scheduling system through the lean startup of FDCARES, through the full staffing of this proposal.

This business plan expands the operation of the FDCARES division from its current level. The goal with the scheduling system is a minimum of two FDCARES certified personnel staffed 24 hours per day in the FDCARES division as IPC's, with a minimum of one 24 hour per day firefighter/EMT and one full time IPC, with committed staffing as follows:

1. One 40 hour per week Battalion Chief in charge of the EMS/NEMS-FDCARES division.
2. One 40 hour per week Captain as CARES Program Specialist in the EMS/NEMS-FDCARES division.
3. One 40 hour per week Firefighter Data Integration Coordinator.
4. One 36 - 40 hour per week Administrative Incident Prevention Coordinator (IPC's).
5. Fifteen - firefighter/EMT's trained in the FDCARES services. Five assigned on each shift and continuing to work as shift firefighters, with a minimum of one assigned in the FDCARES division every day, 24 hours per day/365 days per year.
6. Six – Field IPC's assigned full time to the NEMS-FDCARES division. Two IPC's per shift with a minimum of one on duty every day, 24 hours per day/365 days per year.
7. One 40 hour per week Support Technician.

Response Plan:

The Kent Fire Department Non-Emergency Medical Services response plan is as follows:

Valley Communications is the dispatch center for the Kent Fire Department. Incidents identified by call receivers at the dispatch center as low acuity requests for medical services and given a predetermined initial dispatch code (IDC) will be given a NEMS response at time of dispatch.

Both of the CARES units would need to be in-service for an incident to receive a non-emergency response. Should either one of the CARES units be out-of-service, the regular dispatch BLS unit pecking order will be automated as it always has been allowing for no delay in unit dispatching to incidents at any level.

The NEMS response through the 911 system will always require two fire department staff members to make contact with the patient. A minimum of one EMT level trained person and an additional staff member who may have a varied level of medical certifications or social service training. The

response will be a dispatch of two CARES units, CARE71 & CARE72, or CARE73. Each of these units will be staffed with a minimum of one trained and qualified fire department member.

The NEMS 911 response procedure (no lights or sirens) standards would be established for these incident types. These standards will be predetermined, acceptable non-emergency time standards with the current suggested maximum time from dispatch to on scene would be twenty minutes.

Should the call receiver, dispatchers, or responders at any time feel that the response time should be shortened or that the patient may need a more urgent level of care, the incident shall be upgraded from a non-emergency response, to a BLS or ALS response as deemed appropriate. An upgrade IDC to a BLS unit may be necessary to track the number of times that an upgrade to a BLS unit takes place.

If an IDC is issued that requires a higher than a NEMS response mode (ALS or BLS) the currently established dispatch process will take place. If a call receiver is unsure of the acuity level or on the fence between a higher than NEMS and a NEMS response, they should error on the higher response IDC. If it is determined at any point during the response by a call receiver, dispatcher, or response crew member that the incident is more accurately deserving of a lower acuity, Y type IDC, the incident may be downgraded at that time. If either the dispatcher or the responding crew feels that this response should continue until confirmed, the higher acuity response shall continue. If the incident is downgrade, all emergency response units may immediately return to an in service status. This will assist in more accurately tracking the effect on emergency unit reliability. It will be up to the emergency unit officer to determine the crew action from the point of downgrade. A number of unpredictable factors will play into a decision to leave a patient's side once downgraded or to stay and wait the arrival of the FDCARES staff or to continue to the patient if still in route.

Once the FDCARES staff is with a patient that has requested services through the 911 system, the staff will first need to make a determination on the appropriate manner to handle the episodic issue or reason causing the patient to activate the emergency response system. The second determination that will

need to take place if appropriate will be the level of the many services that are offered to patients during proactive home visits. The following is an overview of the list of services that may be provided.

1. Upgrade to an emergency BLS or ALS response.
2. Request for a private BLS transport.
3. Arrange for a scheduled FD department transport.
4. Arrange for a private auto transport.
5. Navigate the patient to other than emergency department medical facility.
6. Stabilize patient in place.
7. Arrange for a scheduled appointment to other than emergency department facility.
8. Provide social service outreach and referral to available resources.
9. Provide in home assessment and injury/illness prevention devices.
10. Provide education on various medically related services to include use of the 911 system.

Financial Figures

Program Expense Related to Personnel Annual Salary

Proposed	ANNUAL BASE SALARY	MONTHLY BASE SALARY	* % OF
Nurse FIPC - Probationary (Step A)	\$55,016.00	\$4,584	64.26
Nurse FIPC - 3rd Class (Step B)	\$59,275.84	\$4,939	69.23
Nurse FIPC - 2nd Class (Step C)	\$64,009.92	\$5,334	74.76
Nurse FIPC 1st Class (Step D)	\$69,135.04	\$5,761	80.74
Administrative IPC	\$80,120	\$6,677	93.58
Updated 1/1/13	ANNUAL BASE SALARY	MONTHLY BASE SALARY	* % OF
FDCARES/EMS Captain (assignment)	\$103,512	\$8,626	120.9
Battalion Chief	\$122,262	\$10,189	142.8
Firefighter - Probationary (Step A)	\$64,213	\$5,351	75
Firefighter - 3rd Class (Step B)	\$71,919	\$5,993	84
Firefighter - 2nd Class (Step C)	\$78,340	\$6,528	91.5
Firefighter 1st Class (Step D)	\$85,618	\$7,135	100

All FIPC's and firefighters positions in the above spreadsheet work a 48-hour shift. The average hourly workweek for the current 48-hours on and 96 hours off schedule (48/96), averages out to 56-hours per week. Firefighters are able to work this schedule without overtime compensation beyond the 40-hour workweek due to the US Department of Labor – Fair Labor Standards Act (See appendix “J”). Nurses however do not fall within this exemption, creating the need for their wage to be figured on an hourly basis. The above spreadsheet salary figures are for all Nurse FIPC's working the 48/96 work schedule with a 40-hour per week wage per hour and 16 additional overtime hours per week. The following calculations are to clarify how the salary numbers have been established.

Nurse FIPC – Probationary (step A): \$16.53 per hour for first 40 hours of week = \$661.20, plus \$24.80 per hour for 16 additional overtime hours = \$396.80. Weekly base of \$661.20 + weekly overtime of \$396.80 = \$1,058 per week X 52 weeks = \$55,016 annually.

Nurse FIPC – Third class (step B): \$17.81 per hour for first 40 hours of week = \$712.40, plus \$26.72 per hour for 16 additional overtime hours = \$427.52. Weekly base of \$712.40 + weekly overtime of \$427.52 = \$1,139.92 per week X 52 weeks = \$59,275.84 annually.

Nurse FIPC – Second class (step C): \$19.23 per hour for first 40 hours of week = \$769.20, plus \$28.86 per hour for 16 additional overtime hours = \$461.76. Weekly base of \$769.20 + weekly overtime of \$461.76 = \$1,230.96 per week X 52 weeks = \$64,009.92 annually.

Nurse FIPC – First class (step D): \$20.77 per hour for first 40 hours of week = \$830.80, plus \$31.17 per hour for 16 additional overtime hours = \$498.72. Weekly base of \$830.80 + weekly overtime of \$498.72 = \$1,329.52 per week X 52 weeks = \$69,135 annually.

(Note: The firefighter’s union contract reduces their hourly work schedule from 56 to approximately 50 hours per week. The FIPC’s salary is based on a 56 hour work week that is not reduced.)

Total Annual Employee Salary Cost for Corresponding years

Year One	\$924,948.50
Year Two	\$985,184.54
Year Three	\$1,042,483.50
Year Four	\$1,105,985.20

Annual Employee Associated Benefits Expense

	Ret	Def.	5.24%	9.21%	1.45	Health	Life	Disability	L&I
	Med	Comp	LEOFF	PERS	Medicare	Insurance	Insurance		
Battalion Chief	900	2,568.48	7,572.40	n/a	2,205.22	33,300.80	102	n/a	3,369.60
Captain	900	2,568.48	6,202.42	n/a	1,806.25	33,300.80	102	n/a	3,369.60
Administrative IPC 90%	n/a	n/a	n/a	5,302.97	1143.37	33,300.80	102	492.96	514.38
Nurse IPC Probationary A	n/a	n/a	n/a	5,066.97	797.73	33,300.80	102	492.96	514.38
Nurse IPC Third Class B	n/a	n/a	n/a	5,459.30	859.50	33,300.80	102	492.96	514.38
Nurse IPC Second Class C	n/a	n/a	n/a	5,895.31	928.14	33,300.80	102	492.96	514.38
Nurse IPC First Class D	n/a	n/a	n/a	6,367.33	1,002.46	33,300.80	102	492.96	514.38
FF FIPC Probationary (step A)	900	2,568.48	3,364.76	5,914	931.08	33,300.80	102	n/a	3,369.60
FF FIPC Third Class (step B)	900	2,568.48	3,768.56	6,624	1,042.82	33,300.80	102	n/a	3,369.60
FF FIPC Second Class (step C)	900	2,568.48	4,105.01	7,215	1,135.93	33,300.80	102	n/a	3,369.60
FF FIPC First Class (step D)	900	2,568.48	4,486.38	7,885	1,241.46	33,300.80	102	n/a	3,369.60

Total Annual Employee Benefit Cost for Corresponding years (all years calculated at current rate increases.)

Year One	\$607,829.05
Year Two	\$616,069.58
Year Three	\$623,689.00
Year Four	\$632,173.09

Uniform and Equipment Costs

Uniform/ Equipment Subtotal for FF IPC			\$8,150.00
FF IPC Subtotal		Sub total	\$8,315.00
		Tax	\$789.93
		Total	\$9,104.93
		Number of projected New Hires	5
4.5 FF IPC Positions		TOTAL PROJECTED COST	\$40,972.19
Uniform/ Equipment Subtotal for NF IPC			\$2,331.00
FF IPC Subtotal		Sub total	\$2,331.00
		Tax	\$221.45
		Total	\$2,552.45
		Number of projected New Hires	6
6 NF IPC Positions		TOTAL PROJECTED COST	\$15,314.70
Total overall Uniform & Equipment Costs			\$56,286.89

See appendix “L” for a complete breakdown on uniform and equipment totals. There will be additional uniform and equipment totals over the four year process. These numbers have not been calculated into years two, three, and four.

FDCARES Vehicles

Currently the Kent Fire department FDCARES program has three personnel assigned to this division.

Each person has a vehicle assigned to them. The vehicles are:

- App. 7103, 2012 Toyota FJ Cruiser – Currently assigned to the IPC.
- App. 7606, 2000 Crown Victoria – Currently assigned to the EMS/FDCARES Battalion Chief.
- App. 7610, 2000 Chevrolet Lumina – Currently assigned to the EMS/FDCARES Captain.

The Crown Victoria will remain assigned to the EMS/FDCARES Battalion Chief. The Chevrolet Lumina will continue to add value for the FDCARES division should one of the vehicles need to be serviced, or a light duty personnel or volunteer be assigned to the division.

This plan includes the purchase of three new FDCARES vehicles. The Ford Connect is a small van that is more suited for carrying the equipment for non-emergent proactive home visits. The FJ would be assigned to the EMS/FDACARES Captain as the FDCARES supervisory vehicle. One of the vans will be assigned to the Administrative Incident Prevention Coordinator and the other two vans will be in service vehicles for the 24 hour on duty Firefighter EMT Field Incident Prevention Coordinator and the 24 hour on duty Nurse Field Incident Prevention Coordinator.



This three year plan is fully staffed at the beginning of the third year. For purposes of spreading the capital cost over the three year period, the capital cost of one van is included in each of the first three years of the financial summary. Should the 24 hour staffing, two person model be up and in full operation before year three, it is recommended that all of these vehicles are purchased and placed in service at that time.

Ford Connect vehicle cost to include the vehicle, the vehicle wrap, the cargo/passenger safety separator, and the cargo storage shelving. The total cost for each completed vehicle is \$40,000 with a total of \$120,000 in capital vehicle expense.

The vehicle inventory contains both capital expenditures and expendables such as injury prevention items. Capital costs are onetime expenses and expendables are ongoing costs from the annual program budget. For the purpose of fully understanding initial startup costs the vehicle inventory to include both capital and expendable costs have been added to this portion of the three year plan.

FDCARES Response Vehicle Inventory and Pricing

1.	Mobile Data Device:	I-Pad with mount and keyboard	1 EA	\$1,200
		a. Optional MCD (laptop) \$2700		
2.	Portable Radio	With spare battery	2 EA	\$3,600
3.	Basic Aid Kit:	Combination airway and trauma kit	1 EA	\$3,200
4.	AED		1 EA	\$1,200
		a. Optional LP15 (\$12,000)		
5.	Tool Box		1 EA	\$500
	a.	Tool Box Case		
	b.	Cordless articulating drill/screwdriver w/attachments		
	c.	Basic standard wrench set		
	d.	Basic metric wrench set		
	e.	3 standard screw drivers		
	f.	3 Phillips head screw drivers		
	g.	Hammer		
	h.	2 adjustable wrenches		
	i.	Measuring tape		
	j.	Level		
6.	Pocket accordion file		1 EA	\$25
7.	Fall Prevention Kits (see inventory below)		4 EA	\$5,588
	a.	Bed assist railing ``		\$48
	b.	Elevated toilet seat		\$16
	c.	Elevated Toilet Seat with lock and arms		\$36
	d.	Elevated toilet seat with lock, no arms		\$26

e. Non slip bath mat	\$7
f. 26" Reacher	\$20
g. Shower bench (w/out back)	\$24
h. Shower chair (w/back)	\$31
i. Heavy duty bench (w/back)	\$48
j. Heavy duty bench (w/out back)	\$38
k. Shower head 84" hose	\$17
l. Toilet Safety Frame	\$26
m. Transfer bench	\$52
n. Heavy duty transfer bench	\$97
o. Tub bar	\$26
p. Single point canes	\$10
q. Quad canes	\$14
r. Front wheeled walker	\$33
s. Pick up walker	\$31
t. Transport chair steel	\$115
u. 19" lightweight chair	\$175
v. 22" lightweight chair	\$234
w. 20" lightweight w/c	\$231
x. Grab bar 18" Chrome	\$12
y. Grab bar 18" White	\$10

Each kit: \$1,397

TOTAL INVENTORY COST: \$15,313

Financial Summary

The following summarizes the financial information:

- First full year (year three) implementation investment of providing full time FDCARES services:
- Employee wages \$924,984.50
- Employee Benefits \$607,829.05
- Employee Clothing \$56,286.89
- Capital for vehicles \$165,939.
- **TOTAL \$1,755,039.93**

The numbers above relate to the FDCARES entire operations. This accounts for all of the administrative and EMS salaries based on current collective bargaining agreement and national average salary standards.

Yearly totals for staffing (wages + benefits) only of the FDCARES response vehicles versus staffing a fire engine:

Total year 1 staffing expense	\$1,087,733	Total Year 1 Engine expense	\$1,547,950
Total year 2 staffing expense	\$1,156,208	Total Year 2 Engine expense	\$1,668,533
Total year 3 staffing expense	\$1,221,130	Total Year 3 Engine expense	\$1,768,986
Total year 4 staffing expense	\$1,293,101	Total Year 4 Engine expense	\$1,882,858

The annual cost savings to staff three FDCARES vehicles, 24/7/365 versus staffing a fire engine, 24/7/365:

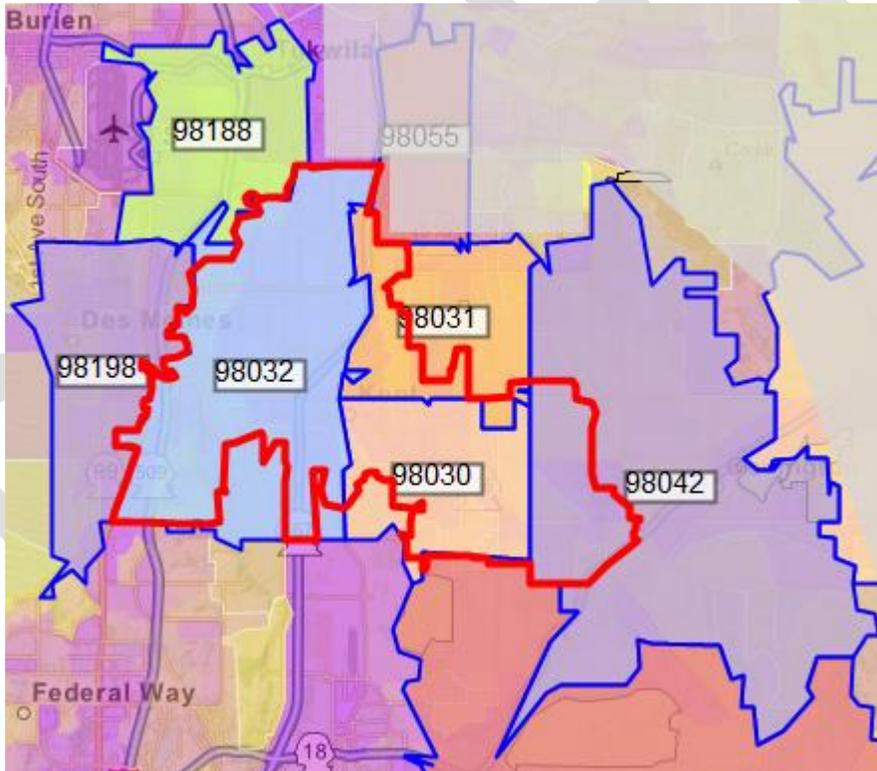
Total year 1 savings	\$460,217
Total year 2 savings	\$512,325
Total year 3 savings	\$547,856
Total year 4 savings	\$589,757

Total four year COST SAVINGS = \$2,110,155

It should be noted for fire departments considering when to implements a non-emergency response division such as FDCARES, response times, unit availability, and work capacity drives unit staffing. It is estimated that a fire department that is currently staffed to meet response time standards within their jurisdictional boundaries when all units are in service and responds to around 10,000 incidents per year could benefit from fully staffing a non-emergency response division. It is recommended that sufficient emergency units be staffed first to meet response time standards within the jurisdictional boundaries of an organization when all units are in service. Secondly, it is recommended that workload capacity of staffed emergency units be utilized to provide FDCARES services when organizational incident volume is below 10,000 incidents per year. When both of these standards are met it is recommended to consider staffing an FDCARES division over an additional emergency response unit.

FDCARES Service Boundaries

FDCARES units will provide services within the Kent Fire Department/RFA response boundaries. Because response boundary lines do not follow any other specific identifiable boundaries, the zip code map is utilized to give a view of the approximate response boundary lines. The zip codes covered by the KFD/RFA are 98030, 98031, 98032, 98042, and 98188. Because these zip code lines do not follow response boundary lines exactly, hospital staff, emergency room staff, healthcare staff, and residents close to these zip code boundary lines should confirm with the KFDRFA FDCARES division for specific determination on service provided.



The red outline signifies the City of Kent boundary lines though the KFDRFA response boundaries include, the City of Kent, the City of Covington, the City of SeaTac, and some unincorporated areas of King county.

Sustainability

The goal of FDCARES is to provide a mechanism to improve the efficiencies of emergency and non-emergency services that are provided to the residents of our community. FDCARES will assist the Kent Fire Department/RFA to continue to improve on and maintain the high level of public safety that the contracted cities and unincorporated areas served are already provided. FDCARES services also have a reaching affect for the patients of local area healthcare providers. This includes the patients of Hospitals, Emergency Departments, Urgent and Primary Care Providers as well as patients of local area General Practitioners. This is accomplished by direct connection to the appropriate level of care provider at the appropriate time through direct interaction with patients. With the increase in access to care comes the cost savings related to reduced repetitive care being provided at the most costly level of care.

As patient experiences, care, and outcomes are improved and healthcare costs are reduced for the individual patients, care providers, and insurance payers, the potential for fire departments to develop partnerships with these agencies is increased. These partnerships have the potential to generate new revenue streams through “shared cost savings” that is measured for the related companies.

The Fire Department will see the following improvements:

- More cost effective low acuity medical response model.
- Reduced unnecessary, repetitive use of the 911 system for low acuity service.
- Improved patient outcomes for both emergency and non-emergency services.
- Improved patient satisfaction through improved services and reduced patient cost.
- Improved unit reliability (availability) for all emergency units.
- Improved emergency unit response times.
- Improved employee morale.

The Emergency Departments will see the following improvements:

- Reduced repetitive admissions for low acuity medical requests.
- Improved Press Ganey patient survey scores.
- Reduced uninsured low acuity patients entering the ED.
- Reduced readmissions of discharged patients.
- Patients being directly connected to care providers of parent company.
- Reduced costs associated with repetitive and uninsured ED use.
- Reduced uncollectable billing associated with repetitive utilizers of the ED.

The Hospitals will see the following improvements:

- Reduced readmissions of discharged patients.
- Reduced admissions related to early access to appropriate levels of care.
- Improved Press Ganey patient survey scores.
- Reduced admissions related to uninsured patients.
- Reduced costs associated with uninsured patients.
- Reduced uncollectable billing associated with reduced uninsured admissions.

Insurance Payers will see the following improvements:

- Reduced costs associated with low acuity patient transportation.
- Reduced costs associated with low acuity emergency department use.
- Reduced costs associated with repetitive low acuity transportation and ED use.
- Reduced costs associated with early access to appropriate level care providers.
- Reduced costs associated with patient access to appropriate lower cost providers.
- Reduced costs associated with low acuity repetitive patient billings.

Patients will see the following improvements:

- Improved access to long term care.
- Improved long term health care and health outcomes.
- Advocates for the care of individual patients.
- Improved and lengthened independent lifestyle.
- Reduced co-payments associated with office visits.
- Reduced co-payments associated with transportation.
- Reduced co-payments associated with ED admissions.

Additional possible revenue sources exist and will be pursued as the FDCARES program is further developed. Beyond cost saving share agreements, there are currently a number of potential foreseeable services that can be provided to improve customer services and patient care, while generating revenues. We will continue to search for grants associated with patient care, improved care access, and healthcare cost savings. With the addition of nurses within the fire department, this can open up a number of new opportunities. Twenty-four hour staffing improves access to this nurse for patient transition assessments to care facilities. Partnerships with the various care facilities, which could include over 300 adult family homes (AFH) within the KFDRFA response area, are possible. AFH's are required to have contractual agreements with nurses to be familiar with their company, their patients, to provide quarterly checks and be available should a patient require in home care. These services are typically provided through private contracts with nurses that work independently. These service providers are not always readily available which often times has the care providers requesting assistance through the 911 system and utilizing avoidable transportation via ambulance to an emergency department.

It is believed that other possible revenue streams will present themselves as the FDCARES business plan is fully up and running. All reasonable possibilities will be examined and balanced against the FDCARES mission and vision statements and workload capacity.

The following is an excerpt of a letter received that describes the interest of other healthcare providers in partnering with and expanding the FDCARES program to other fire departments in areas served by the provider.

“The ED's and Fire Departments don't have the resources to care for the influx of patients that will have access to health insurance and wanting to use the ED as their primary care provider. I would like to work with you and the local area fire department to get it to at least the level you have with the Kent area and by doing that, we get you the additional resources and bring to fruition the actual vision that you talked with me about. Having worked with physicians and hospital leaders for many years, approaching them with the historical information of all they you have done already, what is happening

nationally, and supportive research will be necessary. I would like to write up a plan/vision of how I could work with you and the local fire department to not only get this program going in the local area but how it will ultimately benefit your jurisdiction to implement the ideas you have been working on.

This is just such an exciting program and really a much needed element for providers of healthcare to collaborate with FDCARES and vested stakeholders. It will be a win-win for all of Washington and its citizens if a best practice can be implemented and shared with other regions.”

Kara, RN, MN

Clinical Core Measures
Department of Clinical Effectiveness
Tacoma, WA

Training

Injury Prevention Coordinator Training Plan

All IPC will need to complete the following training elements. The outline below will provide both Firefighter IPC’s and Nurse IPC’s with the base knowledge, skills, and abilities to operate in the FDCARES program.

1. FD Cares program overview
 - a. Mission of FD Cares
 - b. Program overview
 - c. Organizational structure/staffing of the division
 - d. Role and responsibility of the IPC
2. Patient intake procedure overview
 - a. CARES Database/Data collection overview
 - b. Crew referral intake procedure
 - c. EMS 911 data intake procedure
 - i. Intake procedure for all EMS 911 calls
 - d. Emergency Departments high utilizer referrals
 - e. CARES phone line referral procedures
 - f. Proactive home visit (PHV) workload distribution
3. Proactive home visit (PHV) procedures

- a. Creating an incident/dispatch procedures
- b. Overall safety/safety policy review
 - i. Scene safety
 - 1. Before the PHV or Low acuity response
 - a. Importance of daily apparatus check
 - b. Procedure for “Caution” requiring a 2 IPC minimum
 - ii. When dispatched
 - 1. Call type
 - 2. Response route
 - 3. Premise and incident history
 - iii. When arriving and on-scene (response or PHV)
 - 1. Approach
 - 2. Making contact
 - 3. Positioning for safety and fatal funnel awareness
 - iv. Scene size-up (interior)
 - 1. Exits
 - 2. Personnel
 - 3. Hazards
 - v. Departments safety policy review
 - vi. EMS CARES Citizen Contact Procedures for IPC’s
 - vii. Requesting PD/
 - 1. Code 1
 - 2. Code 2
 - 3. Code 3
 - viii. “Emer” (Emergency) button procedures
 - ix. Distress code word training
 - x. Use of Force
 - 1. OC application
 - xi. Scenario based safety training
 - c. Home needs assessment procedure.
 - d. Patient/resident needs assessment procedure
 - e. Available resources/use of resources
 - i. Fall prevention resources and equipment

- ii. Mental health professional resources and processes
 - iii. Adult protective service resource and process
 - iv. Other appropriate area resources
4. Low acuity response training
- a. Initial dispatch code overview. Low acuity call defined.
 - b. Response procedures
 - i. Response when 2 IPC's are working at same location.
 - ii. Response when IPC's are working independently.
 - 1. How the IPC's meet to accomplish the response
 - 2. Response time expectations
 - c. Alternate transport options
 - d. Alternate destination options
 - e. Downgrade and by request procedures
 - i. Emergency response crews process for downgrading to a low acuity call.
 - ii. Emergency crews requesting a CARES response based on findings once on location.
 - f. Documentation
5. Daily expectations
- a. Rig check procedure per department policy
 - b. Receive proactive home visit daily workload
 - c. Proactive home visit route planning
 - d. Perform proactive home visits
 - e. Post incident procedures
 - i. Completed PHV work procedure
 - ii. Incomplete PHV work procedure
 - iii. Completing the incident report
 - iv. Updating information in the CARES data system
6. CARES task book overview
- a. Review task book
 - b. Review the 5 ride-a-long requirements

Nurse Injury Prevention Coordinator (N-IPC):

The Nurse IPC will need the all of the above training in addition the training outlined below:

1. Fire Department Overview
 - a. Personnel and station location overview
 - b. Fire department culture and history
 - c. Fire department rank and organizational structure
2. General department knowledge
 - a. Applicable policy and procedure overview
 - b. Additional mobile data computer training
 - c. Additional incident report system training
 - d. Additional mobile radio use training
3. Nurse IPC scope of practice in the field
 - a. Detail of the Nurse's medical control
 - b. Detail of the Nurse's scope of practice
4. Field experience ride along observation.

As this is very new and no FIPC has been put through a formal training program to include all safety and service training, it is possible that the training outline and hours will be adjusted as specific scenarios present themselves. This current training plan requires a Total minimum number of training hours needed for the Firefighter FIPC as 80 hours and the Nurse FIPC as 160 hours. This difference takes into account that firefighters already have response and safety experience in the field that nurses coming into the program will not have.

HIPAA

In providing outreach and follow up to the members of the community, it is important to have a collaborative team approach. The Health Insurance Portability and Accountability Act (HIPAA) regarding the patient's privacy is of the utmost importance for the patients that we serve. Some health care professionals are uncertain or uncomfortable as to what information can be shared among medical professionals. Because of this, the department's legal counsel has created an "Authorization to Use or

Disclose Health Information” form (see appendix “N”). As patients are visited our IPC’s review this form with all patients and request a signature on this form that provides permission for the FDCARES staff to share the patient’s medical information with other healthcare providers. When patient information exchange is required to improve the care, upon request, the signed form is provided to the medical care provider prior to engaging in conversations about the patient.

Very few patients or their guardian prefer not to sign the release. This is typically noted in cases that include Adult or Child Protective Services (APS and CPS). In the unlikely event that a client’s signature is unable to be obtained and the patient’s health and safety are being compromised, FDCARES staff works to educate other medical professionals on the fire services authority to exchange information. Fire departments in Washington State have the legal ability to share patient information without the consent of the patient as part of the patient’s continuation of Care. The department’s legal counsel has created a “Statement of Authority” to address these specific incidents. It states: The Kent Fire Department Regional Fire Authority provides emergency medical services to its citizens and is considered a health care provider under state and federal health information acts including Chapter 70.02 RCW and HIPAA. The Kent Fire Department Regional Fire Authority CARES program is designed to provide ongoing injury and illness prevention services to the citizens it serves. Such services represent a continuation of health care services. In order to provide services, Kent Fire Regional Fire Authority personnel may need to discuss patient health information and medical history with the patient’s health care providers. As a health care provider engaged in ongoing treatment of its patients, patient consent is not required for other health care providers to share health information with Kent Fire Department Regional Fire Authority personnel. See RCW 70.02.050 (1)(a) and 29 CFRs164.506. This however is a very rare scenario as most healthcare providers see the value in collaboration and appreciate our willingness to provide outreach and information for their patients.

Exit Strategy

While we do not foresee failure of this venture, all good business plans include a provision for exiting the business. Should the operation not succeed as planned, and pivoting the operational system of the plan in an effort to succeed not be feasible, there are several steps that can be taken.

The capital investment in this plan is relatively small and in large part associated with the purchase of three FDCAERS vehicles. The vehicles could be utilized in the current, non-response FDCARES format with either light duty or community volunteer staff. The vehicles could also be shifted into other divisions such as the public education division. It is also possible that in an effort to recoup part of the financial investment, the vehicles and related equipment could be sold at the best possible price. Much of the supplies and equipment purchased can still be utilized by the fire department as part of its FDCARES services.

The four and one half fire personnel associated with this program can be redistributed out of the FDCARES program and used to fill vacant firefighter positions within the emergency response operations of the fire department. These positions would likely be used to backfill positions through attrition.

The six nurse positions could be filled through a temporary agency (this is not the recommended hiring method) in an effort to avoid unemployment costs should the need to lay off said employees exist. If a temporary agency were not utilized, a temporary signed contract should be utilized when hiring the nurse's contingent on the success of the program. This would however, should the program fail and the nurses be laid off, create the need for unemployment benefits to be paid.

Contractual agreements established with other existing agencies in order to provide services would contain exit clauses.

Intangibles

The Kent Fire Department Regional Fire Authority board understands that providing public safety is of key importance for the community. With this proposal the fire department in conjunction with the Authority Board, will be providing an additional public safety service to the community. The fire

department's mission is: "Professionally and Compassionately Helping People". In order to fulfill this mission, improve efficiencies, and to establish our organization as a leader in the industry of emergency and non-emergency services, offering the FDCARES services will play a big role in doing so. The FDCARES program has the ability to be a model for other departments and become a unique way for Fire departments to add a new level of service while offsetting program expenses with healthcare partnerships.

The natural growth of the fire department is to allow 911 call volume to grow at an unmanaged rate of rise. This rate may increase with many factors, such as the jurisdictions population, the age of the population, the changes in access to healthcare within the community and many other variables. If left unattended, this natural growth will continue at an unmanaged rate. As the incident volume increases, the authority will be faced with addressing the service level needs in a similar way to what is historically the case with nearly all fire service organizations over the years. To maintain current response time standards without any improvement in efficiencies, the Authority Board will need to build more fire stations, purchase more equipment, and hire more firefighters to keep up with the increases in demand. This will likely be the case at some point in the future should the FDCARES services be implemented or not. The difference is that with the FDCARES program comes a method to manage incident growth, provide new services, generate healthcare partnerships, improve efficiencies, reduce cost per incidents, and stall the needs of costly fire department expenses associated with unmanaged growth in incident volume. All of these will contribute to millions of dollars in savings over the course of just a few years. As outlined in this plan, these savings will start to be recognized during the first year of full implementation and will continue to multiply through the years to come.

Fire departments can be viewed similarly to insurance companies in that nobody wants to have a fire or medical emergency, but most are happy to have the services available should the need arise. As our code enforcement program and fire prevention programs have become successful, the role of the FD as "firefighters" is being reduced. However, our role in other areas, including EMS is continually increasing. With continued public support, we will be able to provide and have the capability to deliver

fire protection. Scaling back the fire department would likely not be an appropriate choice for the community as national standards for effective firefighting forces will still be extremely important to life and property. Providing emergency medical prevention services and all of the non-emergency services associated with the FDCARES program is the next logical step in expanding and redefining the role of the fire department.

This proposal has the ability to generate a revenue stream at a time when the Kent Fire Department Regional Fire Authority is healthy in all ways, including that from a budgetary standpoint. It makes sense to start the program now and make the necessary adjustments over the three to four year implementation period established within this plan. Taking advantage of this time to be able to pivot and adjust as necessary to provide the services in the most efficient manner and in a method that makes doing so cost effective. It may become more difficult to start the business as time goes on should tax revenues become unavailable to make this investment or if private providers position themselves early enough to become the primary providers of non-emergent services.

Morale

Most people join the fire department in order to serve and protect. Medical calls make-up nearly 80 percent of the current services provided. Increasing our involvement in these calls, from simply providing patients with low acuity requests for service with a quick fix for their current episode by sending them in an ambulance to an emergency department, to fixing the underlying issue causing the problem will help improve emergency responder morale. Preventing the patient's need for emergency services has a satisfying effect for response crews. When the underlying problem is corrected rather than only addressing the current episode, responders feel satisfaction and are encouraged to continue with this level of care. Providing a multitude of new and additional services will improve morale, and will increase the skill and knowledge level of our response staff.

Firefighters have a tendency to take on a feeling of personal responsibility to protect the members of the community of those they serve. Each patient's needs are just as important as the next, and fire

response crews have taken an oath of office to provide for the needs of each resident's request for service. Although each resident's request for service is just as important as the next, some requests are more urgent in nature than others. When firefighters find themselves unavailable for emergent life threatening emergencies such as a fire or cardiac arrest due to assisting an individual for non-emergent needs, the firefighters feel responsible for the unfortunate outcomes of those situations.

The following is an excerpt of an extreme example of this that played out with Seattle firefighters.

The local news headlines read: **“5 killed in Fremont apartment fire”**

The following photo was included in the article with this caption printed below it. “Distraught firefighters gather on the sidewalk after a fire in a Fremont apartment building killed five people, including four children.”



The fire Chief was quoted in this same article stating: "Our firefighters believe they can save everybody, so they're beating themselves up right now trying to figure out what happened." One of the contributing factors to this incident was the fact that the first due Engine Company was out of service assisting a non-injured patient that had fallen and was unable to get up. Although the outcome of the fire fatalities would likely not have been different, this caused frustration with firefighters that played out in the media. Having a solution like FDCARES to assist in preventing this and similar type situations from taking place will also help prevent the negative impact that these incidents have on firefighters.

Many firefighters both within the Kent Fire Department and with other organizations have expressed their appreciation for the FDCARES program and vision. The following is just one of many letters written to express how this program is changing the perspective of our responding fire department members.

“I just wanted to express my great appreciation for you folks having the courage and vision to put the FDCARES program into practical application. I’ve long thought we had created an untenable situation trying to be all things to all people. We are first and foremost an emergency response apparatus that must be available for the citizen’s real emergencies. Realistically though, the Fire Department has become the face of service in our communities and we can’t just abandon them in their time of need...no matter what that need might be. The other end is the firefighters who have to continually respond to alarms that just aren’t what we train or prepare for. It is frustrating and saps the motivation from even the most dedicated of emergency responders.

This program addresses the needs of citizens that don’t know where to turn in a compassionate, holistic manner that achieves the dual goal of being able to focus on the things we’re best at (fire, rescue, medical emergencies), and ensure those citizens have the appropriate support and advocacy that gets them off the 911 addiction. Well done!

While my time in the fire service is coming to an end after over thirty years, I am going to advocate for this program and urge both the Training Chief and my replacement study understand the benefits and implement as much of the plan as practicable. With your guidance and gentle nudging our department can be the collaborator you want and probably need. The great example you set will surely help integrate it into our organization, and the savings alone compel us to take a serious look at it.

Great work and thanks for taking the time to explain it to all of us.”

Tom

Captain Tom
Training/Safety/EMS Officer
Rescue Manager, WATF-1 FEMA USAR

Summary:

The Fire Department Community Assistance, Referral, and Education Services (FDCARES) program is a non-emergency medical services (NEMS) division within the fire department. The program concept originated from the recognition that there are many 911 medical requests for service that are not life threatening emergencies in which the reaction/response to these patients is treated the same as those that are true emergencies. The larger the number of low acuity medical requests that enter a system, the more it affects a fire department's ability to continue to efficiently deliver emergency services. With this recognition comes the realization that this very effective response model for emergent situations may not be the most efficient or the most cost effective model that could be utilized for non-emergent situations.

It has been noted that there is a ripple effect starting with the patient's continuation of care when non-emergent requests for service are handled as a true emergency when it is not. There is also an associated ripple effect on the broader healthcare system, access to the system, and the associated expense of the entire healthcare continuum. In a capitalistic society there will always be competition working to provide emergency services that are more effective, less expensive, quicker, and with better outcomes. This competition should encourage all providers, whether public or private, to constantly evaluate the services that they are providing, evaluate new and/or additional services that fit within the entities mission and vision statements, and to evaluate the efficiencies of each of these services. If any organization is interested in becoming or remaining the leading provider of services they must continually strive to provide their associated services with the best outcomes, at the lowest cost, and with the highest level of customer service. To do this the leaders of the organization must stay on top of current issues facing their industry and track trends and indicators of how the needs of their services will likely be delivered, not just for today or tomorrow, but for many years into the future. Tracking trends and following indicators is only the first step. Predictions must be made, goals must be set, the evaluation process must be continual, outcomes must be analyzed, and customer satisfaction must be monitored to ensure that they remain at the highest possible levels. The only way to accomplish this is to have well organized accurate data systems

in place and ensure that the information being entered into these systems is accurate, specific, consistent, and measurable.

The FDCARES business model has taken all of this into account throughout the development process. From the beginning of identifying which of the current fire department's services can be improved upon, what services can be added, how costs can be reduced while outcomes are improved, and how each of these are measured and evaluated. This includes the shifting of low acuity or non-emergent incidents out of the emergency response system, evaluating the patient's underlying cause for requesting services, connecting these individuals to appropriate social service providers, and navigating them to more appropriate, more cost effective care providers at the appropriate time. This also includes a medical prevention system that takes into account both high utilizers of the 911 system and high utilizers of the local emergency departments. The program targets individuals that have a higher likelihood of reutilizing and readmitting to the emergency department and hospital. Once identified, these individuals will require more direct assistance with understanding their individual circumstances and direction on how best to prevent manifestation of their illness along with when and where to access care. This direct interaction takes place through proactively visiting each of these patients, multiple times per year, advocating on their behalf, while educating them about their situation and the services and providers available to them within the community in which they live.

The development of partnerships within the broader healthcare community will improve the exchange of information necessary to better identify these patients and to provide for their care long before issues are allowed to rise to the level of an emergency. These partnerships will also help to improve the access to the appropriate levels of care within the community while improving the financial situations of all involved. This will start with the savings of co-payments for patients and will prevent lengthy waiting room visits in order to access their needed care. Fire departments will save the costs of increased staffing associated with uncontrolled and unidentified non-emergency medical requests for services while improving their emergency unit reliability. Transport companies, both public and private

that are fee-for-services providers will see improved patient/pay ratios and improved reliability for their responding units as less time is spent out of service with lengthy, non-emergent transportations and the associated transfer of a patients care. These cost savings will translate into tax savings throughout the community. Emergency departments will see higher patient satisfaction scores, an improvement in the availability of beds for emergent patients, the reduction of low acuity, repetitive utilization by patients, improved patient/pay ratios, and the associated hospitals will recognize reduced readmissions for the patients that they care for. Medical insurance companies will appreciate a reduction in payments associated with not only unnecessary care, but in reduced repetitive care, and in lower cost care provided to those patients with non-emergent medical needs. This should translate into a reduced rate of rise in health insurance premiums for all of us that are fortunate enough to have health insurance coverage.

At the end of the day taking care of our patients to ensure that they all live long, healthy, independent lifestyles is our primary goal. These patients are not people without faces and names. They are people that we all care about. They are our loved ones. These people are all of our families, our friends, our coworkers, and families and friends of the people that we care about and care for. The mission of the Kent Fire Department Regional Fire Authority and the FDCARES program is professionally and compassionately helping people. This is our mission and this is what we do, because doing so is the right thing to do for the residents that we serve.

APPENDIX “A”

FIRE DEPARTMENTS CURRENTLY DELIVERING FDCARES THROUGH THE INNER AGENCY AGREEMENT

Washington State

1. Kent Fire Department/RFA
2. Olympia Fire Department
3. SeaTac Fire Department
4. South King Fire Department
5. Tacoma Fire Department
6. Whatcom County Fire Dist. #7

Colorado State

1. Colorado Springs

FIRE DEPARTMENTS REQUESTING INFORMATION ABOUT FDCARES

1. Chandler Arizona
2. Mesa Arizona
3. Bellevue Washington
4. Bellingham Washington
5. Bremerton Washington
6. LA City California
7. LA County California
8. San Diego California
9. West Vancouver BC Canada
10. Central Kitsap Fire and Rescue Washington
11. Central Pierce Washington
12. Centralia/Riverside/RFA Washington
13. Clallam County Fire Dist. #3 Washington
14. Coal City Fire Illinois
15. Four Mile Fire Protection District Colorado
16. Willimantic Fire Department Connecticut
17. East Pierce Fire and Rescue Washington
18. Eastside Fire Washington
19. Fire District #20 King County Washington
20. Fisher Fire Department Indianapolis
21. Grays Harbor Fire Dist. #11 Washington
22. East Peoria Illinois
23. King County Fire Dist. #44 Washington
24. Kirkland Fire Department Washington
25. Lacey Washington
26. Rockland Fire Massachusetts
27. Mount Vernon Washington
28. Rio-Rancho New Mexico
29. Orcas Island Washington
30. Pasco Fire Washington
31. Poulsbo Fire Washington
32. Redmond Fire Washington
33. Renton Fire Washington
34. Richland Fire Washington
35. Seattle Fire Washington
36. Shoreline Fire Washington
37. Sioux Falls Fire S. Dakota
38. Everett Fire Washington
39. Snohomish Fire Dist. #1 Washington
40. Snohomish Fire Dist. #5 Washington
41. Midland Fire Texas
42. Salt Lake City Fire Utah
43. Vancouver Fire Washington
44. Valley RFA Washington
45. West Pierce Fire Washington
46. Whatcom County #5 Washington
47. West Ellis Fire Wisconsin
48. Woodinville Fire Washington

APPENDIX "B"

KENT FIRE DEPARTMENT ASSIGNMENT DESCRIPTION

Classification Specification:	Battalion Chief / EMS Officer / FDCARES
Assignment Description:	Program Coordinator
Salary Range:	
Incumbent:	
Location:	As assigned

GENERAL PURPOSE

The Battalion Chief assigned to this position will perform a variety of technical and administrative work in planning, organizing, directing, developing and implementing a majority of the strategic innovations of the EMS function within the Kent Fire Department. The person in this position will oversee and research developments relating to emergency medical services (EMS), and will coordinate with the Training Unit on overseeing EMS training. The person is responsible for communication of EMS issues related to safety and health to members of the agency. The person in this position is responsible for the maintenance of the Pandemic Plan. The individual will represent the Kent Fire Department on local, zone, regional, and county committees and work groups involved in coordination and advancement of strategic EMS issues.

The Battalion Chief assigned to this position will perform a variety of technical and administrative work in planning, organizing, directing and implementing a majority of the innovations of the FDCARES program within the Kent Fire Department. The person in this position will oversee research, acquisition, purchase, disbursement and inventory control relating to injury and illness preventive equipment. This individual will coordinate with the Training Unit and other department work groups on issues related to the FDCARES program. The person in this position is responsible for the development and presentation of budget documents related to assigned programs. The individual will represent the Kent Fire Department on local, zone, regional, county committees and work groups involved in coordination and advancement of the FDCARES program and related issues.

REPORTS TO

This position reports to the Deputy Chief of Operations. Performance will be evaluated by the Deputy Chief of Operations based upon such things as the ability of the incumbent to:

- interact with the public and department members with a high level of professionalism
- utilize department resources in a cost effective manner
- participate in all assigned projects relative to area(s) of responsibility
- complete set goals and ensure quality results of programs coordinated and scheduled in a timely manner

SUPERVISORY RESPONSIBILITIES

The EMS Officer is a program manager who provides direct supervision of personnel. The EMS Officer is responsible to provide supervision for all personnel assigned to the EMS/FDCARES division and programs.

ESSENTIAL DUTIES AND RESPONSIBILITIES

- Works with the training division to ensure the preparation of various records and reports related to medical incidents and training for assigned shifts. Supervises the preparation of various records and reports related to the FDCARES programs.
- Monitors research, selection, purchase, ordering, inventory control, disbursement, of all equipment and supplies inventory acquired through department FDCARES program. Monitors control and maintenance of all preventative medical equipment and medical supplies inventory acquired through department FDCARES program.
- Monitors EMS performance in the field as necessary.
- Coordinates with the department Planning Unit and King County Department of Emergency Medical Services to assemble and analyze EMS statistics and prepare reports as required.
- Seeks opportunities through research and development projects and programs to improve FDCARES service to the department to ensure the best equipment, supplies and practices are used within the budget available.
- Ensures compliance and documentation with laws, protocols, policies and guidelines, including those related to blood borne and airborne pathogens.
- Provides a liaison to regional and local committees and agencies related to EMS and FDCARES function planning.
- In cooperation with the Department Safety Officer and department Training Officer, develops and implements risk management steps to ensure patient and firefighter safety through application of appropriate procedures and guidelines related to use, maintenance and servicing of equipment handled in connection with EMS services. Develops and implements risk management steps to ensure patient and firefighter safety through application of appropriate standards of care and good medical judgment.
- Assists in taking risk management steps to ensure safe use and necessary maintenance of department equipment.
- Responds to Multiple Casualty Incidents (MCI) and other fire/medical related events and functions within the Incident Management System as directed by the Incident Commander.
- Attends training schools, seminars and conferences relative to the position, as approved by the Deputy Chief of Operations.
- Makes public presentations to citizen groups and others to educate the public and clarify Kent Fire Department EMS and FDCARES programs and procedures.
- Prepares studies and recommendations on EMS and FDCARES issues as requested by the Deputy Chief of Operations.

- Prepares, submits and justifies the EMS and FDCARES budgets related to projects assigned.
- Coordinates EMS and FDCARES matters within Kent Fire Department.
- Works with the department, and a variety of companies to ensure appropriate development and execution of private contracts.
- Evaluates ambulance response times and determines their level of compliance within the ambulance contract.
- Maintains liaison with ambulance companies in regards to complaints and concerns from citizens and department members.
- Participates in and/or provides EMS and FDCARES input to various department committees.
- Assists the Fire Chief in representing the department on major policy issues and changes on the county level related to EMS and FDCARES issues. Examples: Regional Committee, King County EMS Committee.
- Acts as department liaison between hospitals and clinics.
- Coordinates with the Training Unit to determine appropriate EMS curriculum such as EMT/CE, CBT and Defibrillation
- Attends appropriate EMS meetings, including but not limited to: King County Emergency Medical Services, and King County EMS Advisory Committee, Zone 3 EMS Officers.
- Participates in and/or provides EMS input to various department committees.
- Represents the Department on healthy community committees in Covington and Kent.
- Assists the Fire Chief in representing the department on major policy issues and changes on the county EMS level. Example: King County EMS Strategic Plan.
- Works with the training division to ensure that there is a quality assurance program for the EMS Medical Incident Report Forms emphasizing completeness, accuracy and content.
- Provides input to the Deputy Chief of Operations regarding equipment and supplies carried on FDCARES apparatus, including injury and illness prevention equipment and EMS equipment.
- Performs related duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

Knowledge of:

- All aspects of inventory control, purchasing, service and purchase contracts, warehouse management, and other FDCARES system components.
- All aspects of Emergency Medical Services (EMS), including EMS system components, ambulance contracts, EMT training and FDCARES supplies purchasing.

Skilled in:

- Dealing with people from within and outside of the department in various disciplines.
- Collaborative work relationships; able to communicate effectively and to represent the department in a positive manner.
- Managing work time so that assignments can be carried out in a timely manner in order to fulfill the department's mission and EMS/Logistics needs.
- Oral and written communication skills.
- Use of the computer and City approved software programs.

Ability to:

- Interpret federal, state and local laws and regulations affecting EMS and FDCARES operations.
- Work independently and be self-motivated. Able to be productive and effective with limited supervision.
- Evaluate EMS/FDCARES program costs and make recommendations to the Fire Chief.
- Prepare and explain the EMS/FDCARES budget including individual components of the budget.
- Work effectively with officials of other jurisdictions, EMS and FDCARES staff, agents of regulatory agencies, private company employees, and the general public.
- Operate audiovisual equipment.

MINIMUM EDUCATION AND EXPERIENCE REQUIRED

- Rank of Battalion Chief
- Instructor – Level 1 Certification
- Current Incident Safety Officer training
- Current Hazardous Materials Incident Commander training

DESIRABLE EDUCATION

An Associate Degree in areas of fire science, supervision and/or management is desirable.

LICENSES AND OTHER REQUIREMENTS

Possess current, valid Washington State Driver's License and successfully complete the employer's defensive driving program.

MACHINES, TOOLS AND EQUIPMENT USED

Operates or works around the following machines and equipment: chain saws, circular saws, hydraulic rescue tools, exhaust fans, generators, mobile air compressors, fire apparatus, ladder trucks, aid cars, suction units, defibrillator units, winches, computers, communications equipment, portable pumps, vacuums, outboard motors, boats and other fire related equipment.

Typical business office machinery and equipment including, but not limited to computers, and other office equipment appropriate to the position. Driving, operating, and maintaining motorized vehicles, including but not limited to fire department equipment and apparatus.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is; frequently required to sit and talk or hear. The employee is regularly required to stand; walk; use hands and fingers to handle, or operate objects, controls, or tools listed above; reach with hands and arms; climb or balance; stoop, kneel, crouch, or crawl; and taste or smell.

Drives or rides fire department apparatus to alarms, places equipment, lays and connects hoses and nozzles, raises and climbs ladders, uses chemical extinguishing agents and other tools and equipment as required.

The employee must occasionally lift and/or move more than 100 pounds.

Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus.

Employees must be able to mentally and physically perform the described duties and/or tasks as a firefighter.

WORKING CONDITIONS

The working environment characteristics here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. Works both in and out-of-doors, subjected to adverse weather conditions and rapid temperature changes. Often works in hazardous environments under high stress.

Incumbent's Signature

Date

Supervisor's Signature

Date

Department Head Signature

Date

Note: This document will be reviewed and updated periodically, when position becomes vacant, or if position duties are changed significantly.

DRAFT

APPENDIX “C”

KENT FIRE DEPARTMENT ASSIGNMENT DESCRIPTION

Classification Specification: Captain assigned to FDCARES
Assignment Description: FDCARES Program Coordinator
Salary Range:
Incumbent:
Location: As assigned

GENERAL PURPOSE

The Battalion Chief assigned to this position will perform a variety of technical and administrative work in planning, organizing, directing and implementing a majority of the strategic innovations of the EMS function within the Kent Fire Department. The person in this position will oversee and research developments relating to emergency medical services (EMS), and will coordinate with the Training Unit on overseeing EMS training. The person is responsible for communication of EMS issues related to safety and health to members of the agency. The person in this position is responsible for the maintenance of the Pandemic Plan. The individual will represent the Kent Fire Department on local, zone, regional, and county committees and work groups involved in coordination and advancement of strategic EMS issues.

The Battalion Chief assigned to this position will perform a variety of technical and administrative work in planning, organizing, directing and implementing a majority of the innovations of the FDCARES program within the Kent Fire Department. The person in this position will oversee research, acquisition, purchase, disbursement and inventory control relating to injury and illness preventive equipment. This individual will coordinate with the Training Unit and other department work groups on issues related to the FDCARES program. The person in this position is responsible for the development and presentation of budget documents related to assigned programs. The individual will represent the Kent Fire Department on local, zone, regional, county committees and work groups involved in coordination and advancement of the FDCARES program and related issues.

REPORTS TO

This position reports to the Deputy Chief of Operations. Performance will be evaluated by the Deputy Chief of Operations based upon such things as the ability of the incumbent to:

- interact with the public and department members with a high level of professionalism
- utilize department resources in a cost effective manner
- participate in all assigned projects relative to area(s) of responsibility
- complete set goals and ensure quality results of programs coordinated and scheduled in a timely manner

SUPERVISORY RESPONSIBILITIES

The EMS Officer is a program manager who provides direct supervision of personnel. The EMS Officer is responsible to provide supervision for all personnel assigned to the EMS/FDCARES division and programs.

ESSENTIAL DUTIES AND RESPONSIBILITIES

- Works with the training division to ensure the preparation of various records and reports related to medical incidents and training for assigned shifts. Supervises the preparation of various records and reports related to the FDCARES programs.
- Monitors research, selection, purchase, ordering, inventory control, disbursement, of all equipment and supplies inventory acquired through department FDCARES program. Monitors control and maintenance of all preventative medical equipment and medical supplies inventory acquired through department FDCARES program.
- Monitors EMS performance in the field as necessary.
- Coordinates with the department Planning Unit and King County Department of Emergency Medical Services to assemble and analyze EMS statistics and prepare reports as required.
- Seeks opportunities through research and development projects and programs to improve FDCARES service to the department to ensure the best equipment, supplies and practices are used within the budget available.
- Ensures compliance and documentation with laws, protocols, policies and guidelines, including those related to blood borne and airborne pathogens.
- Provides a liaison to regional and local committees and agencies related to EMS and FDCARES function planning.
- In cooperation with the Department Safety Officer and department Training Officer, develops and implements risk management steps to ensure patient and firefighter safety through application of appropriate procedures and guidelines related to use, maintenance and servicing of equipment handled in connection with EMS services. Develops and implements risk management steps to ensure patient and firefighter safety through application of appropriate standards of care and good medical judgment.
- Assists in taking risk management steps to ensure safe use and necessary maintenance of department equipment.
- Responds to Multiple Casualty Incidents (MCI) and other fire/medical related events and functions within the Incident Management System as directed by the Incident Commander.
- Attends training schools, seminars and conferences relative to the position, as approved by the Deputy Chief of Operations.
- Makes public presentations to citizen groups and others to educate the public and clarify Kent Fire Department EMS and FDCARES programs and procedures.

- Prepares studies and recommendations on EMS and FDCARES issues as requested by the Deputy Chief of Operations.
- Prepares, submits and justifies the EMS and FDCARES budgets related to projects assigned.
- Coordinates all EMS and FDCARES matters within Kent Fire Department.
- Works with the department, City and private ambulance companies to ensure appropriate development and execution of transport contracts.
- Evaluates ambulance response times and determines their level of compliance within the ambulance contract.
- Maintains liaison with ambulance companies in regards to complaints and concerns from citizens and department members.
- Participates in and/or provides EMS and FDCARES input to various department committees.
- Assists the Fire Chief in representing the department on major policy issues and changes on the county level related to EMS and FDCARES issues. Examples: Regional Committee, King County EMS Committee.
- Acts as department liaison between hospitals and clinics.

Coordinates with the Training Unit to determine appropriate EMS curriculum such as EMT/CE, CBT and Defibrillation

- Attends appropriate EMS meetings, including but not limited to: King County Emergency Medical Services, and King County EMS Advisory Committee, Zone 3 EMS Officers.
- Participates in and/or provides EMS input to various department committees.
- Represents the Department on healthy community committees in Covington and Kent.
- Assists the Fire Chief in representing the department on major policy issues and changes on the county EMS level. Example: King County EMS Strategic Plan.
- Works with the training division to ensure that there is a quality assurance program for the EMS Medical Incident Report Forms emphasizing completeness, accuracy and content.
- Provides input to the Deputy Chief of Operations regarding equipment and supplies carried on response apparatus, including EMS equipment.
- Performs related duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

Knowledge of:

- All aspects of inventory control, purchasing, service and purchase contracts, warehouse management, and other FDCARES system components.
- All aspects of Emergency Medical Services (EMS), including EMS system components, ambulance contracts, EMT training and FDCARES supplies purchasing.

Skilled in:

- Dealing with people from within and outside of the department in various disciplines.
- Collaborative work relationships; able to communicate effectively and to represent the department in a positive manner.
- Managing work time so that assignments can be carried out in a timely manner in order to fulfill the department's mission and EMS/Logistics needs.
- Oral and written communication skills.
- Use of the computer and City approved software programs.

Ability to:

- Interpret federal, state and local laws and regulations affecting EMS and Logistics operations.
- Work independently and be self-motivated. Able to be productive and effective with limited supervision.
- Evaluate EMS/FDCARES program costs and make recommendations to the Fire Chief.
- Prepare and explain the EMS/FDCARES budget including individual components of the budget.
- Work effectively with officials of other jurisdictions, EMS and FDCARES staff, agents of regulatory agencies and the general public.
- Operate audiovisual equipment.

MINIMUM EDUCATION AND EXPERIENCE REQUIRED

- Rank of Battalion Chief
- Instructor – Level 1 Certification
- Current Incident Safety Officer training
- Current Haz Mat Incident Commander training

DESIRABLE EDUCATION

An Associate Degree in areas of fire science, supervision and/or management is desirable.

LICENSES AND OTHER REQUIREMENTS

Possess current, valid Washington State Driver's License and successfully complete the employer's defensive driving program.

MACHINES, TOOLS AND EQUIPMENT USED

Operates or works around the following machines and equipment: chain saws, circular saws, hydraulic rescue tools, exhaust fans, generators, mobile air compressors, fire apparatus, ladder trucks, aid cars, suction units, defib units, winches, computers, communications equipment, portable pumps, vacuums, outboard motors, boats and other fire related equipment.

Typical business office machinery and equipment including, but not limited to computers, and other office equipment appropriate to the position. Driving, operating, and maintaining motorized vehicles, including but not limited to fire department equipment and apparatus.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is; frequently required to sit and talk or hear. The employee is regularly required to stand; walk; use hands to finger, handle, or operate objects, controls or tools listed above; reach with hands and arms; climb or balance; stoop, kneel, crouch, or crawl; and taste or smell.

Drives or rides fire department apparatus to alarms, places equipment, lays and connects hoses and nozzles, raises and climbs ladders, uses chemical extinguishing agents and other tools and equipment as required.

The employee must occasionally lift and/or move more than 100 pounds.

Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus.

Employees must be able to mentally and physically perform the described duties and/or tasks as a firefighter.

WORKING CONDITIONS

The working environment characteristics here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. Works both in and out-of-doors, subjected to adverse weather conditions and rapid temperature changes. Often works in hazardous environments under high stress.

Incumbent's Signature

Date

Supervisor's Signature

Date

Department Head Signature

Date

Note: This document will be reviewed and updated periodically, when position becomes vacant, or if position duties are changed significantly.

DRAFT

APPENDIX "D"

KENT FIRE DEPARTMENT / REGIONAL FIRE AUTHORITY **ASSIGNMENT DESCRIPTION**

Classification Specification: Firefighter
Assignment Description: Data Integration Coordinator
Salary Range: \$_____ - \$_____
Incumbent:
Location: EMS / FDCARES DIVISION

GENERAL PURPOSE

Primary responsibility of the Data Integration Coordinator will be to analyze, evaluate implement, document, and maintain various data sets, computers and technology programs geared toward business intelligence that assesses historical data and current conditions with the end state of predicting future performance and business needs. The position will operate and maintain the Kent Fire Department RFA's electronic incident reporting information systems and the CARES database, to include but not limited to maintaining all systems that help identify 911 high utilizers. The position will be required to act as an integral member of a multidisciplinary team and will also have administrative duties including research, organization, and directing and implementing activities/services related to the department's incident reporting system and all CARES program data needs.

Work is characterized by the incumbent's leading role in the implementation and support of Fire Department records management and data base systems and analysis. The position will assume a functional responsibility for moderately complex projects from development through completion. This may involve analysis of existing systems and databases, systems and technologies available on the market, coordination with vendor for implementation and training, assisting users in developing systems and/or specifying changes, and generally doing what is needed to implement records management and other data systems which best meet the current and future needs of the FD CARES program and the Fire Department.

REPORTS TO

Under the general supervision of the EMS/CARES Captain, day to day operational tasks and work will be performed with independence in accordance with department policies and the general administrative direction of the EMS/CARES Captain.

ESSENTIAL DUTIES AND RESPONSIBILITIES May include, but not limited to the following:

- Maintain a leadership role in conducting needs analysis assessments with users to determine Fire Department data requirements; communicate with users to facilitate discussion and study use, application and enhancement of computer and records management and data systems; provide technical expertise and input.
- *Perform project coordination duties which include working with vendors and department personnel to develop a project statement of work; coordinating vendor and department personnel to accomplish project tasks.*

- Perform a variety of technical duties related to the design, development, implementation, production support, system administration, database administration, and maintenance of fire based records management systems; provide IT Group Manager with design specifications as needed.
- Coordinate and/or provide training to other department personnel in the use of computer systems and equipment essential to records management.
- Develop and maintain appropriate documentation, including necessary updates on Fire Department records management and data systems.
- Provide assistance to the Planning Unit Captain; research new equipment and applications; assist with future growth plans; and provide recommendations and justification as requested.
- Participate in and support team activities in a constructive, open and positive manner.
- As project leader, chair meetings and/or committees, prepare agendas and coordinate project activities.
- Attend meetings, training, conferences and seminars as appropriate to maintain current knowledge of technological advancements.
- Prepare accurate and timely reports and other written documents as directed.
- Maintain Liaison with Valley Communications to assure Fire Department input on Computer Aided Dispatching requirements, maintaining resource and apparatus pick lists as well as fire box management.
- Performs incident research for individual incidents and individual patients to support the needs of the CARES division and needs of the department.
- Assists in establishing protocols, procedures and work flow processes for incident reporting systems and CARES information systems.
- Maintain systems and processes that identify high utilizers of the 911 system.
- Maintain and operate systems that identify high utilizers of local Emergency Departments.
- Construct and operate information systems that control inventory of purchased and donated equipment.
- Develops and delivers training to all department personnel on the use and operation of all computer systems and programs that relate to the department's reporting system.
- Develops and delivers training to all Incident Prevention Coordinators on all CARES computer systems and processes that relate to the CARES information systems.
- Maintain files and correspondence adhering to HIPPA guidelines.
- Assist the FD CARES staff with other duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

KNOWLEDGE OF:

- Principles and techniques of analysis, design, development, and implementation of computer and communications systems
- Principles, policies and procedures of the Kent Fire Department
- *Principles, policies and procedures of Valley Communications*
- *Principles of wireless data systems*
- *Project management issues and techniques*
- *Fundamental techniques of programming and experience with programming languages, tools, report writers, SQL, etc.*
- *SunPro records management system, National Fire Incident Reporting Requirements*
- *Performance measures established by the Commission on Accreditation International and other nationally recognized standards.*

- *Web-enabled database applications*
- Geographic Information Systems (GIS) technology, applications, software and hardware
- Relational database models and issues related to database maintenance
- Computer operating systems
- Capabilities and operations of computers and peripheral equipment including, but not limited to, minicomputers, PCs, terminals, printers, software, operating systems
- Microsoft operating systems
- Microsoft Office Suite
- Geographic Information Systems (GIS)
- Oral and written communications skills
- Correct usage of English grammar, spelling, punctuation and vocabulary
- Municipal government policies, procedures, and structure; applicable local, state and federal laws, codes, regulations, and ordinances
- Modern office practices, procedures and equipment
- Record-keeping techniques

ABILITY TO:

- Develop, operate, and maintain the department's incident reporting systems.
- Develop, operate, and maintain the CARES information systems.
- Work in cooperation with other FIPC's and Nurse IPC's
- Demonstrate critical thinking skills and knowledge of local and network information systems.
- To communicate well with firefighter, police officers, and medical professionals.
- Demonstrate a working knowledge of the EMS delivery system within the department and King County.
- To organize prioritizes, multi-task, and manage time.
- Demonstrate strong interpersonal skills as well as to build agency relationships.
- Conduct research and make clear and concise recommendations with big picture view to issues.
- Evaluate user needs, system requirements, and cost effectiveness to develop cost-saving alternatives.
- Provide technical expertise and assistance to the FD CARES Unit and other department units or divisions.
- Learn computer software packages and adapt for specific user application quickly and effectively.
- Develop and maintain clear and concise user documentation.
- Operate a personal computer, GIS stations, file servers, scanners, plotters, printers and general office equipment.
- Read GIS data and system manuals, maps, technical reports, cartographic references, engineering data, maps, and user manuals.
- Prepare reports, correspondence, maps and forms.
- Establish and maintain cooperative and effective working relationships with others.
- Work effectively on several projects concurrently.
- Record and deliver information to explain procedures.
- Follow oral and written instructions.
- Work independently with minimal direct supervision and make decisions within broad guidelines.
- Plan and organize work to meet project schedules and time lines.
- Work in a team environment to solve complex problems.

MINIMUM EDUCATION AND EXPERIENCE REQUIRED

- Graduation from high school, GED or equivalent.
- 1st Class Firefighter
- Knowledge of Information Technology Systems
- **DESIRABLE EDUCATION**
- Associates degree in Information Technology Systems or similar related field.

LICENSES AND OTHER REQUIREMENTS

- Must be at least 18 years of age at time of employment.
- Must be a United States citizen.
- Must possess a valid Washington State driver's license and successfully complete the employer's defensive driving program within six months of employment.

MACHINES, TOOLS AND EQUIPMENT USED

Possesses the ability to operate computers and communication equipment appropriate to the position. This is to include typical business office machinery and equipment but is not limited to; computers and other office equipment, miscellaneous patients medical equipment, and small repair tools as appropriate to the position.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk and hear. The employee is regularly required to stand, walk, use hands to finger, handle, or operate objects, controls, or tools as listed above, reach with hands and arms, climb or balance, stoop, kneel, or crouch.

WORKING CONDITIONS

Work is performed in a general office environment. Incumbent may be called away to an emergency site or to an on-site special event. While performing the duties of this job, the employee may be exposed to individuals who are irate or hostile, may occasionally work near moving mechanical parts. The individual may be called upon to perform physical work at an emergency scene and will be subject to the risks associated with such situations. The noise level in the work environment is usually moderate.

Work schedule will be made based on the needs of the service but may be adjusted based the incumbents request, the particular task and its anticipated duration, as long as overall responsibilities of the position can be met.

SIGNATURES:

Incumbent's Signature

Date

Supervisor's Signature

Date

Department Director/Designee

Date

Employee Services Director

Date

Note: This document will be reviewed and updated as necessary and or at the time of the employee's performance appraisal. When the position becomes vacant, or if the duties of this position are changed significantly.

DRAFT

APPENDIX "E"

KENT FIRE DEPARTMENT / REGIONAL FIRE AUTHORITY **ASSIGNMENT DESCRIPTION**

Classification Specification: Firefighter
Assignment Description: Field Incident Prevention Coordinator
Salary Range: \$_____ - \$_____
Incumbent:
Location: EMS / FDCARES DIVISION

GENERAL PURPOSE

Primary responsibility of the Field Incident Prevention Coordinator (FIPC) is to provide direct incident intervention and post incident follow up to citizens who access emergency medical services by utilizing the 911 system. On a daily basis the FIPC will be responding directly to patients utilizing the 911 system for low acuity problems, dispatched to the CARES division, and to reports generated based on patients identified by firefighter-patient contact. The patient reports will be triaged and prioritized based on severity of needs and patient contact will be made through phone call and or face-to-face follow-up. The FIPC will work to identify the citizen's non-emergent care needs and assist in navigating them to the appropriate community resources. The FIPC will act as an integral member of a multidisciplinary team, working with members of our community, including other EMS providers and other healthcare professionals to provide patients with interdisciplinary, coordinated care. The position will include acting as a liaison between hospitals, primary care facilities, community resources, long term care, adult family homes, senior housing and assisted living facilities within the response area. The FIPC will also have administrative duties including research, organization, and directing and implementing activities/services related to the department's CARES program.

REPORTS TO

Under the general supervision of the EMS/CARES Captain, day to day operational tasks and work will be performed with independence in accordance with department policies and the general administrative direction of the EMS/CARES Captain.

ESSENTIAL DUTIES AND RESPONSIBILITIES May include, but not limited to the following:

- Perform the duties of an Emergency Medical Technician per department policies.
- Assists in establishing protocols, procedures and work flow processes.
- Ensures the CARES unit is response ready by conducting daily apparatus and inventory checks.
- Respond to low acuity 911 responses per department policies.
- Performs incident research for individual patients and patient addresses.
- Conducts proactive home visits.
- Conducts follow-ups with firefighters, police officers, patients, patient's families and other health care professionals.
- Initiate referrals to appropriate social service agencies as deemed necessary for patients on a case by case basis.

- Will assist with tracking and provide varying levels of case management for citizens referred for assistance.
- Assists the Administrative Incident Prevention Coordinator with the departments fall prevention program and conduction of home safety assessments and installations.
- Maintain files and correspondence adhering to HIPPA guidelines.
- Works with outside agencies, including DSHS, APS, Home and community services, etc...
- Works with staff from long term care, adult family home, senior housing and assisted living facilities to assist with incident prevention within their facilities.
- Provide educational presentations to independent living facilities to increase awareness of social services in an effort to reduce non-emergent incidents through the 911 system to these facilities.
- Assist the EMS officer with other duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

KNOWLEDGE OF:

- Emergency medical incident reporting system.
- HIPPA rules and regulations as related to the continuation of care.
- Department rules, regulations, policies, and procedures.
- Personal computer systems as applicable.
- Social services available within the community, greater King County, and the State of Washington as well as any federally related programs.

ABILITY TO:

- Generate reports for patients needing follow-up care out of the incident reporting system.
- Respond to low acuity 911 responses with additional IPC's
- Work in cooperation with other FIPC's and Nurse IPC's
- Perform research for patients identified by fire crews and establish patient non-emergent needs.
- Demonstrate critical thinking skills and knowledge of medical terminology.
- To communicate well with firefighter, police officers, and medical professionals.
- Demonstrate a working knowledge of the EMS delivery system within the department and King County.
- To organize prioritizes, multi-task, and manage time.
- Properly manage, and document patient's follow-up care as provided.
- Demonstrate strong interpersonal skills as well as to build agency relationships.

MINIMUM EDUCATION AND EXPERIENCE REQUIRED

- Graduation from high school, GED or equivalent.
- Certified as a Washington State Emergency Medical Technician (EMT)
- 1st Class Firefighter
- **DESIRABLE EDUCATION**
- Associates degree in related health care occupation or social services.

LICENSES AND OTHER REQUIREMENTS

- Must be at least 18 years of age at time of employment.

- Must be a United States citizen.
- Must possess a valid Washington State driver’s license and successfully complete the employer’s defensive driving program within six months of employment.

MACHINES, TOOLS AND EQUIPMENT USED

Possesses the ability to operate computers and communication equipment. This is to include typical business office machinery and equipment but is not limited to; computers and other office equipment or miscellaneous patients medical equipment as appropriate to the position.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk and hear. The employee is regularly required to stand, walk, use hands to finger, handle, or operate objects, controls, or tools as listed above, reach with hands and arms, climb or balance, stoop, kneel, or crouch.

WORKING CONDITIONS

Work is performed with in the Fire Departments EMS/CARES division, apparatus bay and within an office environment. Employee will work indoors and outdoors, and in private facilities, private residences, and both public and commercial facilities.

SIGNATURES:

_____	_____	_____	_____
Incumbent’s Signature	Date	Supervisor’s Signature	Date
_____	_____	_____	_____
Department Director/Designee	Date	Employee Services Director	Date

Note: This document will be reviewed and updated as necessary and or at the time of the employee’s performance appraisal. When the position becomes vacant, or it the duties of this position are changed significantly.

APPENDIX "F"

KENT FIRE DEPARTMENT / REGIONAL FIRE AUTHORITY **ASSIGNMENT DESCRIPTION**

Classification Specification: Civilian
Assignment Description: Administrative Incident Prevention Coordinator
Salary Range: \$_____ - \$_____
Incumbent:
Location: EMS / FDCARES DIVISION

GENERAL PURPOSE

Primary responsibility of the Administrative Incident Prevention Coordinator (AIPC) is to provide post incident follow up to citizens who access emergency medical services utilizing the 911 system and/or frequently utilize a hospital's Emergency Department (ED). On a daily basis reports will be generated based on patients identified by firefighter / patient contact as entered into the CARES tab in the incident reporting system, reports based on frequent 911 users, and reports based on frequent ED use of participating hospitals. The patient reports will be triaged and prioritized based on severity of needs as determined by the patient priority algorithm. The patient information will be entered into the CARES database. The reports will be forwarded to the EMS/CARES Captain. Other activities include phone calling and or face to face follow ups with patients, proper identification of the citizen's non-emergent care needs, work in cooperation with Field Incident Prevention Coordinators, and working with members of our community, both civilians, EMS providers, and other healthcare professionals. The position will include acting as one of the liaisons to the long term care, adult family home, senior housing and assisted living facilities within our response area as well as a variety of administrative duties in researching, organizing, directing and implementing activities and programs related to the departments CARES program.

REPORTS TO

Under the general supervision of the EMS/CARES Captain, day to day operational tasks and work will be performed with independence in accordance with department policies and the general administrative direction of the EMS/CARES Captain.

ESSENTIAL DUTIES AND RESPONSIBILITIES May include, but not limited to the following:

- Assists in establishing protocols, procedures and work flow processes.
- Runs daily reports for patient identification from the incident reporting system(s).
- Performs incident research for individual patients and patient addresses.
- Conducts follow-ups with firefighters, police officers, patients, patient's families and other health care professionals.
- Supports and assists the Field Incident Prevention Coordinators as needed.
- Initiate referrals to appropriate social service agencies as deemed necessary for patients on a case by case basis.
- Will track and provide varying levels of case management for citizens referred for assistance.

- Manage the departments fall prevention program, to include associated grant report writing requirements and conduction of home safety assessments and installations.
- Maintain files and correspondence adhering to HIPPA guidelines.
- Builds relationships with outside agencies, including DSHS, APS, Home and community services, etc...
- Works with staff from long term care, adult family home, senior housing and assisted living facilities to assist with incident prevention within their facilities.
- Provide educational presentations to independent living facilities to increase awareness of social services in an effort to reduce non-emergent incidents through the 911 system to these facilities.
- Assist the EMS officer(s) with other duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

KNOWLEDGE OF:

- Emergency medical incident reporting system.
- HIPPA rules and regulations as related to the continuation of care.
- Department rules, regulations, policies, and procedures.
- Personal computer systems as applicable.
- Social services available within the community, greater King County, and the State of Washington as well as any federally related programs.

ABILITY TO:

- Generate reports for patients needing follow-up care out of multiple the incident reporting systems.
- Properly enter and manage information in an existing database.
- Perform research for patients identified by fire crews and establish patient non-emergent needs.
- Demonstrate critical thinking skills and knowledge of medical terminology.
- To communicate well with firefighter, police officers, and medical professionals.
- Demonstrate a working knowledge of the EMS delivery system within the department and King County.
- To organize prioritizes, multi-task, and manage time.
- Properly manage, and document patient's follow-up care as provided.
- Demonstrate strong interpersonal skills as well as to build agency relationships.

MINIMUM EDUCATION AND EXPERIENCE REQUIRED

- Graduation from high school, GED or equivalent.
- Certified in first aid and CPR.
- **DESIRABLE EDUCATION**
- Associates degree in related health care occupation or social services.

LICENSES AND OTHER REQUIREMENTS

- Must be at least 18 years of age at time of employment.

- Must be a United States citizen.
- Must possess a valid Washington State driver’s license and successfully complete the employer’s defensive driving program within six months of employment.

MACHINES, TOOLS AND EQUIPMENT USED

Possesses the ability to operate computers and communication equipment. This is to include typical business office machinery and equipment but is not limited to; computers and other office equipment or miscellaneous patients medical equipment as appropriate to the position.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk and hear. The employee is regularly required to stand, walk, use hands to finger, handle, or operate objects, controls, or tools as listed above, reach with hands and arms, climb or balance, stoop, kneel, or crouch.

WORKING CONDITIONS

Work is performed with in the Fire Departments EMS/CARES division, apparatus bay and within an office environment. Employee will work indoors and outdoors, and in private facilities, private residences, and both public and commercial facilities.

SIGNATURES:

_____	_____	_____	_____
Incumbent’s Signature	Date	Supervisor’s Signature	Date
_____	_____	_____	_____
Department Director/Designee	Date	Employee Services Director	Date

Note: This document will be reviewed and updated as necessary and or at the time of the employee’s performance appraisal. When the position becomes vacant, or it the duties of this position are changed significantly.

APPENDIX "G"

KENT FIRE DEPARTMENT / REGIONAL FIRE AUTHORITY **ASSIGNMENT DESCRIPTION**

Classification Specification: Civilian
Assignment Description: Nurse FIPC
Salary Range: Competitive pay and benefits; salary is commensurate with experience
Incumbent:
Location: EMS / CARES DIVISION

GENERAL PURPOSE

Primary responsibility of the Nurse Field Incident Prevention Coordinator (NFIPC) is to provide direct incident intervention and post incident follow up to citizens who access emergency medical services by utilizing the 911 system. On a daily basis the IPC will be responding directly to patients utilizing the 911 system for low acuity problems, dispatched to the CARES division, and to reports generated based on patients identified by firefighter-patient contact. The patient reports will be triaged and prioritized based on severity of needs and patient contact will be made through phone call and or face-to-face follow-up. The NFIPC will work to identify the citizen's non-emergent care needs and assist in navigating them to the appropriate community resources. The NFIPC will act as an integral member of a multidisciplinary team, working with members of our community, including other EMS providers and other healthcare professionals to provide patients with interdisciplinary, coordinated care. The position will include acting as a liaison between hospitals, primary care facilities, community resources, long term care, adult family homes, senior housing and assisted living facilities within the response area. The NFIPC will also have administrative duties including research, organization, and directing and implementing activities/services related to the department's CARES program.

REPORTS TO

Under the general supervision of the EMS/CARES Captain, day-to-day operational tasks and work will be performed with independence in accordance with department policies and the general administrative direction of the EMS/CARES Captain.

ESSENTIAL DUTIES AND RESPONSIBILITIES May include, but not limited to the following:

- Perform the duties of an Emergency Medical Technician per department policies.
- Assists in establishing protocols, procedures and work flow processes.
- Respond to low acuity 911 responses per department policies.
- Runs daily reports for patient identification from the incident reporting system.
- Performs intake assessments including identification of patients referred and enrolled in the program, medical needs/barriers to care, determine plan for care management and coordination care plan and delegates tasks to team members as needed.
- Initiate referrals to appropriate social service agencies as deemed necessary for patients on a case-by-case basis.
- Builds relationships with outside agencies, including DSHS, APS, Home and community services, etc...

- Promote wellness and the management of acute and chronic diseases
- Enter and maintain electronic records, compile reports and complete other program documentation in a timely manner, adhering to HIPPA guidelines.
- Play a consistent and active role in identifying project inefficiencies and finding collaborative solutions to the problem.
- Manage the departments fall prevention program, to include associated grant report writing requirements and conduction of home safety assessments and installations.
- Provide educational presentations to independent living facilities to increase awareness of social services in an effort to reduce non-emergent incidents through the 911 system to these facilities.
- Works with staff from long term care, adult family home, senior housing and assisted living facilities to assist with incident prevention within their facilities.
- Assist with other duties and responsibilities as directed

KNOWLEDGE, SKILLS AND ABILITIES

KNOWLEDGE OF:

- Emergency medical incident reporting system.
- HIPPA rules and regulations as related to the continuation of care.
- Department rules, regulations, policies, and procedures.
- Personal computer systems as applicable, including MS Office Suite.
- Social services available within the community, greater King County, and the State of Washington as well as any federally related programs.

ABILITY TO:

- Generate reports for patients needing follow-up care out of the incident reporting system.
- Respond to low acuity 911 responses with additional IPC's
- Work in cooperation with other FIPC's and Nurse IPC's
- Perform research for patients identified by fire crews and establish patient non-emergent needs.
- Demonstrate critical thinking skills and knowledge of medical terminology.
- Effectively provide clinical care to socially and medically complex patients in a variety of non-traditional settings.
- Work collaboratively in a team and manage multiple priorities, utilize effective time management skills, and exercise sound administrative and clinical judgment.
- Communicate well with firefighter, police officers, and medical professionals.
- Demonstrate a working knowledge of the EMS delivery system within the department and King County.
- Independently organize, prioritize and manage time.
- Properly manage and document patient care coordination in the community setting.
- Maintain accurate/current patient records for purposes of continuity of care
- Demonstrate strong interpersonal skills as well as to build agency relationships.
- Travel to multiple office locations; valid drivers license required

MINIMUM EDUCATION AND EXPERIENCE REQUIRED

- Current RN license in the State of Washington
- 2 years of experience providing clinical services

- Certified in first aid and CPR.

DESIRABLE EDUCATION

- Spanish language ability
- Experience in a community/outpatient setting providing care management/coordination

LICENSES AND OTHER REQUIREMENTS

- Must be at least 18 years of age at time of employment.
- Must be a United States citizen.
- Must possess a valid Washington State driver’s license and successfully complete the employer’s defensive driving program within six months of employment.

MACHINES, TOOLS AND EQUIPMENT USED

Possesses the ability to operate computers and communication equipment. This is to include typical business office machinery and equipment but is not limited to; computers and other office equipment or miscellaneous patients medical equipment as appropriate to the position.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to sit and talk and hear. The employee is regularly required to stand, walk, use hands to finger, handle, or operate objects, controls, or tools as listed above, reach with hands and arms, climb or balance, stoop, kneel, or crouch.

WORKING CONDITIONS

Work is performed with in the Fire Departments EMS/CARES division, apparatus bay and within an office environment. Employee will work indoors and outdoors, and in private facilities, private residences, and both public and commercial facilities.

SIGNATURES:

_____ Incumbent’s Signature	_____ Date	_____ Supervisor’s Signature	_____ Date
_____ Department Director/Designee	_____ Date	_____ Employee Services Director	_____ Date

Note: This document will be reviewed and updated as necessary and or at the time of the employee’s performance appraisal. When the position becomes vacant, or it the duties of this position are changed significantly.

APPENDIX "H"

KENT FIRE DEPARTMENT / REGIONAL FIRE AUTHORITY **ASSIGNMENT DESCRIPTION**

Classification Specification: Civilian
Assignment Description: CARES Support Service Specialist
Salary Range: \$_____ - \$_____
Incumbent:
Location: EMS / FDCARES DIVISION

GENERAL PURPOSE

Primary responsibility of the CARES Support Service Specialist (CSS Specialist) include but are not limited to providing scheduled and unscheduled transports for patients from the scene of low acuity 911 responses to appropriate medical destinations. The position will include acting as a liaison between hospitals, primary care facilities, community resources, long term care, adult family homes, senior housing and assisted living facilities within the response area to collect identified medical equipment that is donated to the FD CARES program. The CSS Specialist will decontaminate, evaluate, repair, and maintain the inventory of all donated and purchased medical equipment. The CSS Specialist will act as an integral member of a multidisciplinary team, working with members of our community, including other EMS providers and other healthcare professionals to provide patients with interdisciplinary, coordinated care.

REPORTS TO

Under the general supervision of the EMS/CARES Captain, day to day operational tasks and work will be performed with independence in accordance with department policies and the general administrative direction of the EMS/CARES Captain.

ESSENTIAL DUTIES AND RESPONSIBILITIES May include, but not limited to the following:

- Performs transports of low acuity patients to approved appropriate medical destinations.
- Works with staff from hospitals, long term care, adult family home, senior housing and assisted living facilities to collect any medical equipment that is donated to the CARES program from residents in their facilities.
- Performs maintenance and evaluation on all donated medical equipment to ensure it is properly decontaminated and in safe working order prior to being redistributed to members in the community.
- Assist the EMS officer with other duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

KNOWLEDGE OF:

- HIPPA rules and regulations as related to the continuation of care.
- Department rules, regulations, policies, and procedures.
- Basic knowledge and use of small hand tools.

ABILITY TO:

- Work in cooperation with other FIPC's and Nurse IPC's
- Demonstrate critical thinking skills and knowledge of use and repair of general medical equipment.
- Maintain and repair commonly used medical equipment such as wheelchairs, walkers, and other similar equipment.
- To communicate well with firefighter, police officers, and medical professionals.
- Demonstrate a working knowledge of the EMS delivery system within the department and King County.
- To organize prioritizes, multi-task, and manage time.
- Demonstrate strong interpersonal skills as well as to build agency relationships.

MINIMUM EDUCATION AND EXPERIENCE REQUIRED

- Graduation from high school, GED or equivalent.

LICENSES AND OTHER REQUIREMENTS

- Must be at least 18 years of age at time of employment.
- Must be a United States citizen.
- Must possess a valid Washington State driver's license and successfully complete the employer's defensive driving program within six months of employment.

MACHINES, TOOLS AND EQUIPMENT USED

Possesses the ability to operate typical business office machinery and equipment but is not limited to; computers and other office equipment, miscellaneous patients medical equipment, and small repair tools as appropriate to the position.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk and hear. The employee is regularly required to stand, walk, use hands to finger, handle, or operate objects, controls, or tools as listed above, reach with hands and arms, climb or balance, stoop, kneel, or crouch.

WORKING CONDITIONS

Work is performed with in the Fire Departments EMS/CARES division, apparatus bay and within an office environment. Employee will work indoors and outdoors, and in private facilities, private residences, and both public and commercial facilities.

SIGNATURES:

Incumbent's Signature

Date

Supervisor's Signature

Date

Department Director/Designee

Date

Employee Services Director

Date

Note: This document will be reviewed and updated as necessary and or at the time of the employee's performance appraisal. When the position becomes vacant, or if the duties of this position are changed significantly.

DRAFT

APPENDIX “I”

Washington Paramedic versus Registered Nurse

This chart is a comparison of deliverable skills between a Washington state Paramedic and a Registered Nurse. Items in Green are authorized by law. Items in yellow are authorized by law, but not practiced or authorized by local standing orders. Items in red are not authorized.

Airway/ Ventilation/ Oxygenation	P	RN
Airway- Esophageal/ Tracheal - Multi Lumen	P	NA
Airway- Nasal	P	P
Airway- Oral	P	P
Bag-Valve-Mask (BVM)	P	P
Chest Decompression - Needle	P	NA
Cricoid Pressure (Sellick)	P	P
Cricothyroidotomy - Needle	P	NA
Demand Valve - Oxygen powered	P	NA
End Tidal CO2 Monitoring/ Capnometry	P	P
Gastric Decompression - NG Tube	ANP	P
Gastric Decompression - OG Tube	ANP	P
Head-tilt/ Chin-lift	P	P
Intubation - Lighted Stylet	ANP	NA
Intubation - Medication Assisted (Non-paralytic)	P	NA
Intubation - Orotracheal	P	NA
Obstruction - Direct Laryngoscopy	P	NA
Obstruction - Manual	P	NA
Oxygen Therapy	P	P
Pulse Oximetry	P	P
Suctioning - Tracheobronchial	P	P
Ventilators - Auto Transport (ATV)	ANP	ANP

Cardiovascular/ Circulation

Cardiac Monitoring - Multi Lead (non-interpretive)	P	P
Cardiac Monitoring - Single Lead	P	P
Cardiopulmonary Resuscitation (CPR)	P	P
Cardioversion - Electrical	P	P
Carotid Massage	ANP	ANP
Defibrillation - Automated/ Semi-Automated (AED)	P	P
Defibrillation - Manual	P	P
Hemorrhage Control - Direct Pressure	P	P
MAST/PASG	ANP	ANP
Mechanical CPR Device	ANP	ANP
Transcutaneous Pacing	P	P

IV Initiation/ Maintenance/ Fluids

Blood/ Blood By-Products	ANP	P
Crystalloid - (D ₅ W, LR, NS)	P	P
Intraosseous - Initiation	P	P
Peripheral - Initiation	P	P

Medication Administration - Routes	P	RN
Aerosolized/ Nebulized	P	P
Buccal	P	P
Endotracheal Tube (ET)	P	P
Intramuscular (IM)	P	P
Intravenous (IV) Piggyback	P	P
Intravenous (IV) Push	P	P
Nasogastric	ANP	P
Oral	P	P
Rectal	P	P
Subcutaneous	P	P
Sub-lingual	P	P

Miscellaneous

Initiation of IV at Central Line Port	ANP	P
Thrombolytic Therapy - Monitoring	ANP	P
Uninary Catheterization	ANP	P
Venous Blood Sampling - Obtaining	ANP	P

Skills & Medications Not Practiced by Paramedic

Intubation - Digital	P	NA
Intubation - Retrograde	P	NA
BiPAP	P	NA
CPAP	P	NA
Intubation - Medication Assisted (Paralytics) (RSI)*	P	NA
Intubation - Nasotracheal	P	NA
Colloids - (Albumin, Dextran)	P	P
Thrombolytic Therapy - Initiation	P	P
PEEP - Therapeutic (>6cm H ₂ O pressure)	P	ANP
Cardiac Monitoring - Multi Lead (interpretive) (12-Lead EKG)	P	P
Spinal Immobilization - Assessment Based	P	P

P = Authorized AND Practiced under current standing orders

ANP = Authorized or Trained, but not practiced under orders

NA= Not Authorized.

- 1) Skills listed but not authorized by either level practiced by
- 2) Authorization based on State of Washington Scope of Practice
- 3) Standing Orders based on King County Washington as of 10-20-2013
- 4) This list is abbreviated to skills normally only assigned to advanced level providers

Maintenance - Medicated IV Fluids	P	P
Maintenance - Non-Medicated IV Fluids	P	P

DRAFT

RCW 18.79.040

"Registered nursing practice" defined — Exceptions.

(1) "Registered nursing practice" means the performance of acts requiring substantial specialized knowledge, judgment, and skill based on the principles of the biological, physiological, behavioral, and sociological sciences in either:

(a) The observation, assessment, diagnosis, care or counsel, and health teaching of individuals with illnesses, injuries, or disabilities, or in the maintenance of health or prevention of illness of others;

(b) The performance of such additional acts requiring education and training and that are recognized by the medical and nursing professions as proper and recognized by the commission to be performed by registered nurses licensed under this chapter and that are authorized by the commission through its rules;

(c) The administration, supervision, delegation, and evaluation of nursing practice. However, nothing in this subsection affects the authority of a hospital, hospital district, in-home service agency, community-based care setting, medical clinic, or office, concerning its administration and supervision;

(d) The teaching of nursing;

(e) The executing of medical regimen as prescribed by a licensed physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or advanced registered nurse practitioner, or as directed by a licensed midwife within his or her scope of practice.

(2) Nothing in this section prohibits a person from practicing a profession for which a license has been issued under the laws of this state or specifically authorized by any other law of the state of Washington.

(3) This section does not prohibit (a) the nursing care of the sick, without compensation, by an unlicensed person who does not hold himself or herself out to be a registered nurse, (b) the practice of licensed practical nursing by a licensed practical nurse, or (c) the practice of a nursing assistant, providing delegated nursing tasks under chapter [18.88A](#) RCW.

RCW 18.79.280

Medication, tests, treatments allowed.

It is not a violation of chapter [18.71](#) RCW or of chapter [18.57](#) RCW for a registered nurse, at or under the general direction of a licensed physician and surgeon, or osteopathic physician and surgeon, to administer prescribed drugs, injections, inoculations, tests, or treatment whether or not the piercing of tissues is involved.

(Retrieved October 29, 2013 from <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.040>)

WAC 246-976-162

The CME method of recertification.

To complete the CME method of recertification, an EMS provider must:

- (1) Complete and document the requirements, indicated in Table A of this section, appropriate to the level of certification for each certification period.

Table A
Education Requirements for Recertification

	EMR	EMT	AEMT	Paramedic
Annual Requirements				
Cardiovascular education and training	X	X	X	X
Spinal immobilization	X	X	X	X
Patient assessment	X	X	X	X
Certification Period Requirements				
Infectious disease	X	X	X	X
Trauma	X	X	X	X
Pharmacology		X	X	X
Other pediatric topics	X	X	X	X
Total minimum education hours per certification period:	15 hrs	30 hrs	60 hrs	150 hrs

"X" Indicates an individual must demonstrate knowledge and competency in the topic or skill.

- (2) Complete and document the skills maintenance requirements, indicated in Table B of this section, appropriate to the level of certification.

Table B
Skills Maintenance Requirements for the CME Method

	EMR	EMT	AEMT	Paramedic
First Certification Period or Three Years				
<input type="checkbox"/> First Year				
IV starts		EMT w/IV therapy skill 36	36	36

	EMR	EMT	AEMT	Paramedic
Endotracheal intubations (4 must be performed on humans)				12
Intraosseous infusion placement		EMT w/IV therapy skill X	X	X
<input type="checkbox"/> Second and Third Years				
IV starts over the two-year period		EMT w/IV therapy skill 72	72	72
Endotracheal intubations over the two-year period (4 per year must be performed on humans)				24
Intraosseous infusion placement		EMT w/IV therapy skill X		
During the Certification Period				
Pediatric airway management				X
Supraglottic airway placement		EMT w/supraglottic airway skill X	X	X
Defibrillation	X	X	X	X
Later Certification Periods				
<input type="checkbox"/> Annual Requirements				
IV starts		EMT w/IV therapy skill X	X	X
Endotracheal intubations (2 per year must be performed on humans)				4

	EMR	EMT	AEMT	Paramedic
Intraosseous infusion placement		EMT w/IV therapy skill X	X	X
<input type="checkbox"/> During the Certification Period				
Pediatric airway management				X
Supraglottic airway placement		EMT w/supraglottic airway skill X	X	X
Defibrillation	X	X	X	X

"X" Indicates an individual must demonstrate proficiency of the skill to the satisfaction of the MPD.

(3) An EMS provider must successfully complete department-approved knowledge and practical skill examinations as identified in WAC [246-976-171](#).

(4) An EMS provider changing from the CME method to the OTEP method must meet all requirements of the OTEP method.

(5) Definitions of selected terms used in Tables A and B of this section:

(a) Cardiovascular education and training for adults, children, and infants includes:

(i) Nationally recognized training programs for CPR, foreign body airway obstruction (FBAO), and defibrillation and patient care appropriate to the level of certification;

(ii) The use of airway adjuncts appropriate to the level of certification;

(iii) The care of cardiac and stroke patients.

(b) Endotracheal intubation: Proficiency includes the verification of proper tube placement and continued placement of the endotracheal tube in the trachea through procedures identified in county MPD protocols.

(c) Infectious disease: Infectious disease training must meet the requirements of chapter [70.24](#) RCW.

(d) Intraosseous infusion: Proficiency in intraosseous line placement.

(e) IV starts: Proficiency in intravenous catheterization performed on sick, injured, or preoperative adult and pediatric patients. With written authorization of the MPD, IV starts may be performed on artificial training aids.

(f) Supraglottic airway placement: Proficiency includes the verification of tube placement and continued placement of the supraglottic airway, in a skill lab setting, through procedures identified in county MPD protocols.

(g) Other pediatric topics: This includes anatomy and physiology and medical problems including special needs patients appropriate to the level of certification.

(h) Patient assessment: This includes adult, pediatric and geriatric patients appropriate to the level of certification.

(i) Pharmacology: Pharmacology specific to the medications approved by the MPD (not required for EMRs).

(j) Proficiency: Ability to demonstrate and perform all aspects of a skill properly to the satisfaction of the MPD or delegate.

(k) Spinal immobilization and packaging: This includes adult, pediatric, and geriatric patients appropriate to the level of certification

(l) Trauma: For adult, pediatric, and geriatric patients appropriate to the level of certification.

Retrieved October 29, 2013 from <http://apps.leg.wa.gov/wac/default.aspx?cite=246-976-162>)

APPENDIX “J”

U.S. Department of Labor

Wage and Hour Division

(Revised March 2011)

Fact Sheet #8: Law Enforcement and Fire Protection Employees Under the Fair Labor Standards Act (FLSA)

This fact sheet provides general information concerning the application of the FLSA to law enforcement and fire protection personnel of State and local governments.

Characteristics

Fire protection personnel include firefighters, paramedics, emergency medical technicians, rescue workers, ambulance personnel, or hazardous materials workers who:

1.

are trained in fire suppression;

have the legal authority and responsibility to engage in fire suppression;

are employed by a fire department of a municipality, county, fire district, or State; and

are engaged in the prevention, control and extinguishment of fires or response to emergency situations where life, property, or the environment is at risk.

There is no limit on the amount of nonexempt work that an employee employed in fire protection activities may perform. So long as the employee meets the criteria above, he or she is an employee “employed in fire protection activities” as defined in section 3(y) of the FLSA.

Law enforcement personnel are employees who are empowered by State or local ordinance to enforce laws designed to maintain peace and order, protect life and property, and to prevent and detect crimes; who have the power to arrest; and who have undergone training in law enforcement.

Employees engaged in law enforcement activities may perform some nonexempt work which is not performed as an incident to or in conjunction with their law enforcement activities. However, a person who spends more than 20 percent of the workweek or applicable work period in nonexempt activities is not considered to be an employee engaged in law enforcement activities under the FLSA.

Coverage

Section 3(s)(1)(C) of the FLSA covers all public agency employees of a State, a political subdivision of a State, or an interstate government agency.

Requirements

Hours of work generally include all of the time an employee is on duty at the employer's establishment or at a prescribed work place, as well as all other time during which the employee is suffered or permitted to work for the employer. Under certain specified conditions time spent in sleeping and eating may be excluded from compensable time.

The FLSA requires that all covered nonexempt employees be paid the statutory minimum wage of not less than \$7.25 per hour effective July 24, 2009.

FS 8 The FLSA requires that all covered nonexempt employees be paid overtime pay at no less than time and one-half their regular rates of pay for all hours worked in excess of 40 in a workweek.

Section 13(b)(20) of the FLSA provides an overtime exemption to law enforcement or fire protection employees of a public agency that employs less than five employees during the workweek in law enforcement or fire protection activities.

Section 7(k) of the FLSA provides that employees engaged in fire protection or law enforcement may be paid overtime on a "work period" basis. A "work period" may be from 7 consecutive days to 28 consecutive days in length. For work periods of at least 7 but less than 28 days, overtime pay is required when the number of hours

worked exceeds the number of hours that bears the same relationship to 212 (fire) or 171 (police) as the number of days in the work period bears to 28. For example, fire protection personnel are due overtime under such a plan after 106 hours worked during a 14-day work period, while law enforcement personnel must receive overtime after 86 hours worked during a 14-day work period.

Under certain prescribed conditions, a State or local government agency may give compensatory time, at a rate of not less than one and one-half hours for each overtime hour worked, in lieu of cash overtime compensation.

Employees engaged in police and fire protection work may accrue up to 480 hours of compensatory time.

An employee must be permitted to use compensatory time on the date requested unless doing so would “unduly disrupt” the operations of the agency.

At the time of termination an employee must be paid the higher of (1) his or her final regular rate of pay or (2) the average regular rate during his or her last three years of employment for any compensatory time remaining “on the books” when termination occurs. For more information on state and local governments under the FLSA, see Fact Sheet #7.

No covered employer may employ any minor in violation of the youth employment provisions of the FLSA. The Act establishes specific provisions concerning prohibited occupations and/or hours of employment of minors under age 18.

Covered employers must make, keep and preserve payroll-related records as described by regulations 29 CFR Part 516.

Where to Obtain Additional Information

For additional information, visit our Wage and Hour Division Website: <http://www.wagehour.dol.gov> and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations. U.S. Department of Labor Frances Perkins Building 200 Constitution Avenue, NW Washington, DC 20210	1-866-4-USWAGE TTY: 1-866-487-9243 Contact Us
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APPENDIX “K”

Issued Gear Costs

*	Based on 2014 pricing		
Work Uniform	number issued	Price Each	Issued total
Shirts	4	\$91.36	\$365.44
Pants	4	\$82.00	\$328.00
Shoes/Boots	1	\$250.00	\$250.00
Belt	1	\$20.00	\$20.00
Soft Coat	1	\$225.00	\$225.00
Sweater/fleece	1	\$80.00	\$80.00
Badge FF	2	\$45.00	\$90.00
Work Uniform Total			\$1,315.00
Dress Uniform			
Shirt	1	\$40.00	\$35.00
Pant	1	\$85.00	\$85.00
Blouse	1	\$210.00	\$210.00
Cap	1	\$53.00	\$53.00
Belt	1	\$20.00	\$15.00
Shoes	1	\$50.00	\$42.00
Tie	1	\$5.00	\$5.00
Dress Cap Badge	1	\$45.00	\$45.00
Name plate metal	1	\$10.95	\$12.00
FF Collar Brass	1	\$20.00	\$20.00
Dress Uniform Total			\$522.00
Misc. Equipment			
T-shirts	4	\$10.00	\$40.00
Sweat Shirt	1	\$25.00	\$25.00
Sweat Pants	1	\$21.00	\$21.00

Athletic Shorts	2	\$12.00	\$24.00
Bed Sheets	2	\$20.00	\$40.00
Pillow & Pill Case	1	\$20.00	\$20.00
Coveralls	3	\$40.00	\$120.00
White T-shirts - for Bates	5	\$10.00	\$50.00
Ball Cap	1	\$10.00	\$25.00
Misc Total			\$319.00
Uniform Sub Total			\$2,156.00
Radio			
Radio Wire	1	\$25.00	\$25.00
Ear Piece Wire	1	\$75.00	\$75.00
Molded Ear Pieces	1	\$75.00	\$75.00
Radio Sub Total			\$175.00
PPE			
Bunker Coat	2	\$1,250.00	\$2,500.00
Bunker Pant	2	\$840.00	\$1,680.00
Turn-out Boots	2	\$200.00	\$400.00
Turn-out Hood	2	\$40.00	\$80.00
Microphone Keeper	1	\$25.00	\$25.00
Flashlight - Right Angle	1	\$90.00	\$90.00
Leatherman tool	1	\$90.00	\$90.00
Hose Belt	2	\$5.00	\$10.00
Spanner Wrench	1	\$20.00	\$20.00
Gear Bag	1	\$20.00	\$20.00
Academy Gloves	3	\$75.00	\$225.00
Structural Gloves	2	\$75.00	\$150.00
Passport Tags	6	\$4.00	\$24.00
Structural Helmet	1	\$210.00	\$210.00
Helmet Flashlight	1	\$30.00	\$30.00
Brush Fire Jacket	1	\$150.00	\$150.00
Brush Fire Pants	1	\$100.00	\$100.00

Brush Gear Bag	1	\$15.00	\$15.00
PPE Subtotal			\$5,819.00
New Hire SubTotal		Sub total	\$8,150.00
		Tax	\$774.25
		Total	\$8,924.25

APPENDIX “L”

Summary of Proposed FDCARES Client-Directed Activities

Client-Directed Activities	Examples
Receive referrals from community agencies	Hospital discharge planners,
Identify high-volume users of EMS	Three or more 911 calls in 1 year; 3 or more ED visits in 1 year
Proactive contact of referred and identified clients	Contact via phone or home visits within 1 week of referral
Direct NEMS response to 911 callers with low-acuity medical and psychosocial conditions	Twenty-minute response times for medical director-approved conditions; downgrade dispatch codes for emergency responders to divert to NEMS
Needs assessment	Housing, insurance status, health-seeking behavior, access to primary care, barriers to access (e.g., transportation), mental health problems (look at EDIE)
Medical stabilization and self-management support	Medication reconciliation, motivational interviewing, health coaching, client empowerment and activation,
Care coordination and navigation to appropriate care setting	Contacting providers to schedule appointments, schedule transport, navigate to urgent care, primary care, sober center, or crisis clinic
Enrollment in insurance coverage via Health Benefits Exchange	Personnel undergo Health Benefits Exchange training to utilize health insurance exchange/marketplace as a resource to determine most appropriate insurance coverage plan for individuals and families. FDCARES is reimbursed for client enrollment.
Enrollment in primary care medical “home”	Establish partnerships with primary care clinics to schedule clients For initial visit, consider filling out intake form or attending first visits with clients to ensure that needs are met by PCP.

APPENDIX "M"

Authorization to Use or Disclose Health Information

Patient name: _____ Date of birth: _____

The Kent Fire Department CARES program provides injury and illness prevention services to the citizens it serves. In order for the Fire Department to assist you it may be necessary for the Fire Department to communicate with your health care providers, insurance company and social service agencies. By signing this authorization you are allowing these communications to occur.

I. Authorization:

I authorize my health care providers, insurance company and social service organizations to disclose to Kent Fire Department Regional Fire Authority personnel any health information that will assist in providing me with injury and illness prevention services provided under the CARES program.

I further authorize Kent Fire Department Regional Fire Authority personnel to disclose to my health care providers and to social service organizations any health information necessary to provide me with injury and illness prevention services provided under the CARES program.

Authorization Expiration: This Authorization shall expire on _____ . If not filled in this authorization shall expire one year from the date signed.

II. My Rights:

I understand that I may revoke this authorization in writing by providing the revocation to the health care provider. I further understand that a revocation will not affect any actions already taken in reliance on this authorization and that once Health Information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

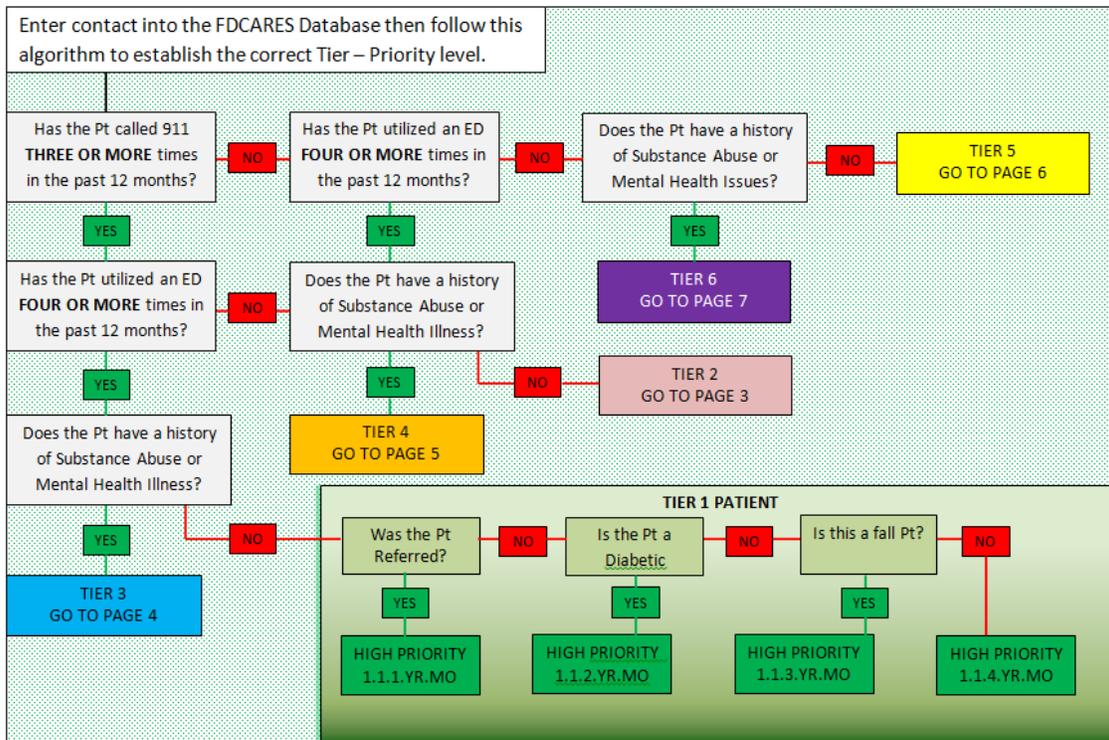
APPENDIX “N” Proactive Visit Algorithm

FD CARES

[PATIENT PRIORITY ALGORITHM]

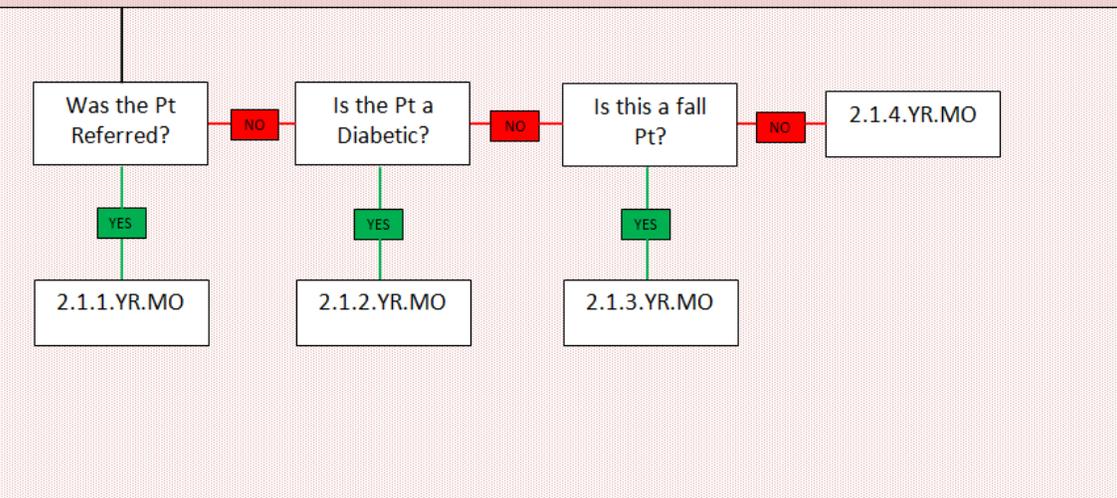
- ❖ The following algorithm will establish a patient’s (client’s) priority level in the FD CARES program. Patients will be prioritized into the appropriate Tier, Category, and Group, with 1 being the highest priority and 6 the lowest priority.
- ❖ Tier definitions:
 - Tier 1: The patient has called 911 three or more times in the past 12 months AND has utilized an ED four or more times in the past 12 months. The patient has no past history of substance abuse or mental health illness.
 - Tier 2: The patient has called 911 three or more times in the past 12 months OR has utilized an ED four or more times in the past 12 months. The patient has no past history of substance abuse or mental health illness.
 - Tier 3: The patient meets the definition of a Tier 1 patient but has a history of substance abuse and/or mental health illness.
 - Tier 4: The patient meets the definition of a Tier 2 patient but has a history of substance abuse and/or mental health illness.
 - Tier 5: The patient does not meet the definition of a high utilizer (Tier’s 1-4) but has been referred to the program. The patient has no past history of substance abuse or mental health illness.
 - Tier 6: The patient does not meet the definition of a high utilizer (Tier’s 1-4) but has been referred to the program. The patient has a history of substance abuse and/or mental health illness.
- ❖ Category definitions:
 - Category 1: The patient has no past history of substance abuse or mental health illness.
 - Category 2: The patient has a history of mental health illness and is currently under a physician’s care for that illness.
 - Category 3: The patient has a history of substance abuse.
 - Category 4: The patient has a history of mental health illness and is not currently being treated for that illness.
- ❖ Group definitions:
 - Group 1: The patient has been referred to the program.
 - Group 2: The patient is a diabetic.
 - Group 3: The patient has a history of falls.
 - Group 4: The patient has any other medical injury or illness.
- ❖ The priority level of a patient will be written and entered into the system by TIER.CATEGORY.GROUP.YEAR.MONTH
Example: A patient referred into the program in January of 2013 and meets the definition of Tier 1, Category 1, and Group 1 will be written and entered in the system as 1.1.1.13.01
- ❖ A patient’s priority level can be recalculated at any point if they receive a referral, their 911 or ED usage changes, or at a specified interval determined by the FD CARES staff.

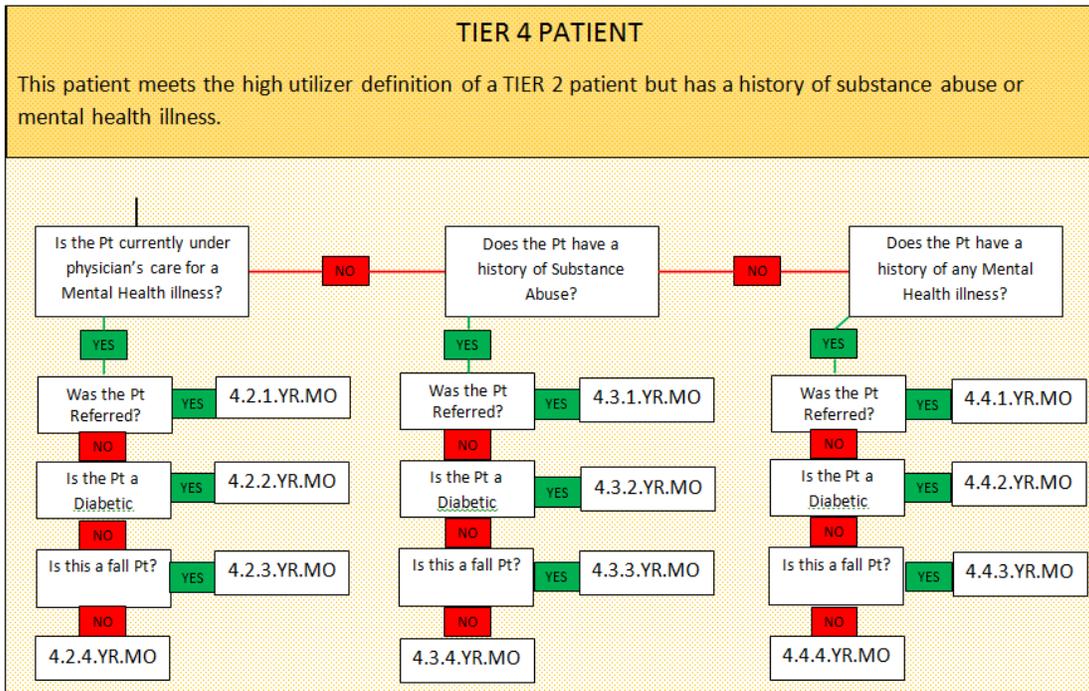
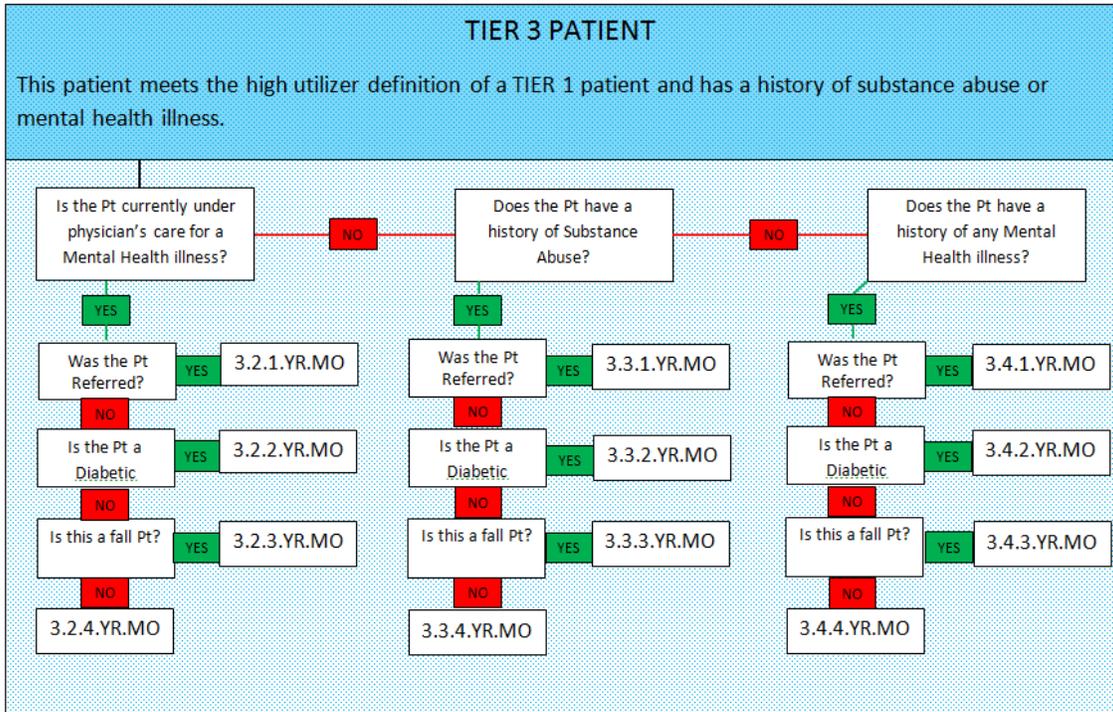
FOLLOW THE ALGORITHM ON THE FOLLOWING PAGES TO ESTABLISH A PATIENTS PRIORITY



TIER 2 PATIENT

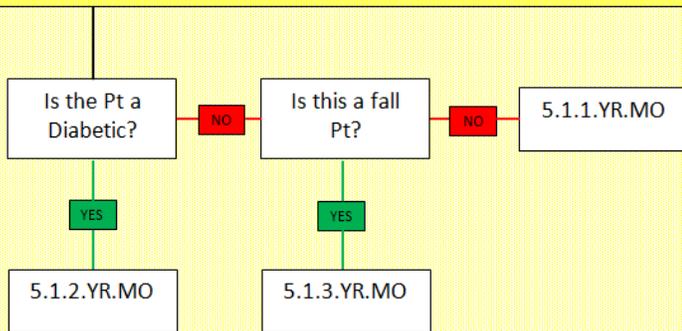
This patient meets the high utilizer definition by calling 911 three or more times in the last 12 months OR by utilizing an ED four or more times in the last 12 months but not both. This patient has no past history of substance abuse or mental health illness.





TIER 5 PATIENT

This patient is referred and does not meet the definition of a high utilizer. This patient has NO history of substance abuse or mental health illness.



DRAFT