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Patrick Smith
Chief Executive Officer
Regional Emergency Medical Services Authority
450 Edison Way
Reno, NV 89502

December 21, 2012

Dear Mr. Smith:

Washko and Associates has completed a thorough review and evaluation of the EMS system assessment conducted by TriData Corporation.

Although specific items are listed in the pages that follow, Washko & Associates find many fundamental problems with the report:

1. There appear to be numerous erroneous statements and references throughout the report that seem to demonstrate:
    a. A significant misalignment of clinical and operational recommendations that are in direct opposition with the latest in published, peer-reviewed scientifically based research.
    b. A lack a full understanding of the emergency medical services industry, especially with regard to the fact that EMS is a healthcare function and the future of EMS is inextricably linked to the ability of EMS agencies to integrate more fully with the healthcare system.
    c. A failure to appreciate the current and future trends of the nation's rapidly changing healthcare environment.
    d. A failure to properly comprehend the laws of the State of Nevada, which pertain to the provision of emergency medical services.
    e. A lack of an understanding of the economic imperatives being faced by the government entities of Washoe County and the State of Nevada.
    f. A lack of a comprehensive understanding related to the breadth and scope of oversight and accountability systems that currently exist to measure and ensure Authority and Contractor performance by the District Board of Health. Few other EMS systems in the United States receive the level of independent and external scrutiny that REMSA does and the report does not delineate the actual processes or facts.

2. The report makes several recommendations and statements regarding the consolidation or virtual consolidation of the communications centers. This appears to demonstrate a failure to recognize the reality that EMS provision is a primary healthcare function, not a public safety function. Although there is some minimal role healthcare plays in public safety, REMSA is the

primary EMS healthcare provider and is tightly integrated with the regional healthcare community; REMSA is not a public safety agency. Attempts to combine these two functions, especially with regard to medical communications, clinical call taking, and resource allocation, are significantly problematic and not consistent with current trends and scientific literature in the public health and the healthcare market in general across the U.S. and other countries. Additionally, ***ALL*** of the concerns raised by the report related to call hand-off procedures, hand-off delays, missing data elements, lack of information exchange and lack of PSAP fault tolerance given two PSAPs can easily be addressed though the installation of an electronic CAD to CAD interface between PSAPs (Primary [Washoe County] and Secondary [REMSA]). This technology would ***IMMEDIATELY ELIMINATE*** all of the issues raised as well as provide a means to offer a backup center in the event the County's Primary PSAP had a catastrophic failure. We understand REMSA has attempted, on numerous occasions, to implement this critical piece of infrastructure and has even offered to pay for this technology, with the regional public safety agencies continuously unwilling to participate for unknown reasons.

3. The statistical comparisons, inferences and conclusions related to performance variables of the various system components used inconsistent measurement approaches, varying definitions, and questionable methodologies, which invalidates most recommendations and conclusions derived from this data, and draws into question the intent and independency (lack of bias) of this assessment.

4. Healthcare is changing rapidly under healthcare reform. Over the next few years, the traditional healthcare delivery system will evolve from a fee-for-service driven approach that rewards transportation of patients into the hospital, to a system that rewards treating the patient at the right place, within the right clinically appropriate timeframe, with the right level of accountable clinical quality and at the right cost. Given this, new models of reimbursement (such as Accountable Care Organizations or ACO's) will drive innovations and change that will decrease patient volumes across the healthcare continuum and will focus on treating patients on a preventative, primary and post acute level, thus keeping a majority of patients out of the emergency and in-patient realms of the healthcare system. EMS transports to the Emergency Department will decrease, and the primary role of EMS will shift from risk adverse urgent treatment and transportation to an ED, to a risk tolerant preventative, primary and post acute role with transportation options to all types of alternative clinical destinations (e.g. Urgent Care, MD Office Referrals, Clinics, etc.) REMSA has the honor of being chosen through President Obama's CMS Innovations Grant to be at the forefront and thought leaders of this change. This choice was not by accident, but because the Federal Government recognizes the value of REMSA's ***independent, accountable system design architecture***, talent sets, experience base and tight regional healthcare integration that exists in the ***current system***. REMSA has been chosen to be the lead EMS agency by which the rest of the United States will follow, therefore we find it absurd to make any type of change recommendation to what has been clearly been recognized as a best case / best practice scenario for change by the Federal Government.

5. The report clearly points out and then attempts to justify away a long-term, ***significant performance failure*** on behalf of many of the regional fire departments based on their reported turnout times (time the apparatus is alerted to respond until the apparatus is physically en route). The scientifically based, medical literature clearly states that survival of the most critical clinical situations where rapid first response (fire or police based) can make an impact (e.g. Cardiac Arrest response to include CPR and AED application, Uncontrolled

Hemorrhage and Choking) require the utmost in timely response (four to six minutes from time of onset) in order to reliably and consistently improve morbidity and mortality in these situations. It is also clear that pro-longed turnout times have a direct negative correlation to response time performance and is considered one of the ***easiest*** items to fix in the response time equation and can have a ***significant impact on improving survival rates***. We understand that this performance failure has been pointed out on numerous occasions with little to no improvement, and is a perfect example of the impact of a fundamental system design flaw that ***does not hold ALL of the system's components independently accountable for their clinical, operational and financial performance failures.***

6. While not addressed by the TriData report, the preponderance of available clinical evidence and research clearly states that the role of first response (fire or PD based) should be limited ONLY to a handful of critical clinical situations (cardiac arrest, severe uncontrolled hemorrhage and choking) and that the most important treatment interventions for these conditions (CPR, AED application, Direct Pressure and the Heimlich Maneuver) are basic skills that first responders AND lay people can be easily taught though public education and first responder training, but are also taught on demand when someone calls 9-1-1, as REMSA's call center based clinicians currently provide these clinical instruction sets over the phone to the caller to start treatment until additional help arrives (known as Dispatch Life Support or DLS). Next, there is substantial clinical evidence that the number of highly trained clinicians in an EMS system (e.g. Intermediates and Paramedics) has a direct correlation with skills competency and outcomes. The more skilled clinicians in an EMS system, the worse the outcomes, which is counter intuitive, but makes perfect sense due to skills dilution and lack of experience. Lastly, there is decades worth of research that clearly shows the lack of a need for resource intense "over" EMS response systems (where first response responds to a majority or all of a systems EMS calls) that end up putting responder and the public at risk due to unnecessary lights and siren responses and response exposures that have ***absolutely no clinical benefit*** where the risks associated with the additional response brings no value whatsoever other then to artificially over-inflate "demand" for such services.

7. We strongly suggest it should be the REMSA medical director whom should decide if medical first response is necessary for a particular response determinant and population density within the county as this provides an independent and ***patient clinical needs based alignment*** (not provider centric or political desire) of medical resources to the clinical conditions of the patient.

8. We believe any structural system oversight changes MUST include the following 5 components as found in the American Ambulance Association's "EMS Structured for Quality" manual for ***ALL stakeholder organizations*** within the EMS system (REMSA has all of these elements currently in place):

   - ✓ Hallmark 1 – Hold the entire EMS system accountable through sanctions and replacement potential
   - ✓ Hallmark 2 – Establish an independent oversight entity
   - ✓ Hallmark 3 – Account for all service costs, operational and clinical quality measures
   - ✓ Hallmark 4 – Require system features that ensure economic efficiency
   - ✓ Hallmark 5 – Ensure long-term high performance service

We also strongly believe that any EMS oversight agency changes should be an independent arm of government (quasi government based) and also should sit between all Fire Service and PSAP components to ensure a ***patient centric focus to system oversight*** and NOT allow for individual agency focused or politically influenced decision-making processes that exist in the current Fire and PSAP portions of the system today.

Based on these findings, the reviewers call the entire report into question and suggest that any actions based on the recommendations therein, be only conducted after a careful analysis of the potential consequences.

We appreciate the opportunity to provide this review and are prepared to discuss this in any forum requested.

Sincerely,

The Washko & Associates EMS Consulting Team

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Summary of TriData Recommendations with Washko & Associates Feedback

TriData Recommendation	Washko Feedback
Recommendation 1: Gerlach VFD should consider the possible benefits for charging fees for EMS transportation. Alternatively, they could make an agreement with REMSA for partial reimbursement.	Currently, REMSA bills for only its part of the transport. Perhaps it would be possible for REMSA to contract with Gerlach VFD to provide billing services on behalf of Gerlach VFD for its portion of the call.
Recommendation 2: All Emergency Dispatch Centers within Washoe County should begin to collect data on arrival at patient side. They should also collect data on the time that either CPR is started or an AED is deployed.	Washko and Associates believe that all emergency ***medical*** dispatching should be conducted by healthcare providers in a center accredited for ***medical*** dispatch functions by the National Academy of Emergency Dispatch. REMSA currently meets these requirements. CAD-to-CAD interfacing technology can easily be leveraged to solve this concern and should not be resolved through consolidation. We agree that data on all components of response time to include capture and reporting of all time increments from the time the 9-1-1 call hits the switch at the 1st PSAP until the time of patient contact should be collected and used to hold all stakeholders accountable.
Recommendation 3: Reno EComm (and successor organizations) and the Departments with volunteer fire services should develop a technological solution to decrease the impact of dispatch delays.	Agreed. The most efficient and effective way to accomplish the goal of eliminating dispatch delays is to eliminate steps in the process, especially call transfers. Washko and Associates believe that all emergency ***medical*** dispatching should be conducted by healthcare providers in a center accredited for ***medical*** dispatch functions by the National Academy of Emergency Dispatch. REMSA currently meets these requirements. CAD-to-CAD interfacing technology can easily be leveraged to solve this concern and should not be resolved through consolidation.
Recommendation 4: Review the incident reporting procedures between REMSA and all Fire Protection Districts and implement a unique identifier that allows for the reporting, integration, and analysis of an entire incident and not just the respective department's performance.	While a unique incident identifier would help ease analysis it falls short of an ideal recommendation. The recommendation does little to improve the overall call processing time. Rather, verbally communicating a unique identifier will increase the length of a hand-off between the various PSAP(s) and communications centers. If the goal is to reduce all processing times and allow easier analysis amongst the various responding agencies, Washoe county should insist on a CAD-to-CAD link allowing rapid sharing of incident

	information and the ability to track the information between agencies. This leads to a decrease in overall call processing time and improves ease of analysis. Washko and Associates believe that all emergency ***medical*** dispatching should be conducted by healthcare providers in a center accredited for ***medical*** dispatch functions by the National Academy of Emergency Dispatch. REMSA currently meets these requirements.
Recommendation 5: Create a lead EMS Agency, under the District Board of Health (and County Health Officer) to provide oversight over the entire EMS system, while maintaining the organizational identity of the individual provider services. This system should include a county EMS Manager, EMS Medical Director, and sufficient staff to provide regulation and oversight of access, clinical care, administration, quality management, education and training, disaster management, and evaluation. All organizations from PSAPs to healthcare systems that provide EMS in Washoe County should be part of the county-wide system.	Based on the data represented, suspect collection and analysis methods as well as the arguments made thus far In the consultancy report, we find it hard to draw the conclusions and recommendations found in this section of the report.
Recommendation 6: Create a lead EMS Agency, under the District Board of Health (and County Health Officer) to provide oversight over the entire EMS system, while maintaining the organizational identity of the individual provider services. This system should include an EMS Manager, EMS Medical Director, and sufficient staff to provide regulation and oversight of access, clinical care, administration, quality management, education and training, disaster management, and evaluation. All organizations from PSAPs to healthcare systems that provide EMS in Washoe County should be part of the county-wide system. Alternatively, oversight could be provided by another Washoe County public safety agency.	While we agree that additional external oversight is necessary for the ***unregulated*** system components (namely the fire service and primary PSAP), we are not in agreement that the REMSA structure should be changed. The design is a public utility model EMS system that is designed to provide high quality services at an affordable cost with an ability to terminate the contractor for failure to perform under the auspices of the agreement. Any structural changes associated with external governance of other system components should include this potential as this is the true motivator for performance versus what the report believes to be driven by financial penalties. The fact that any component could be replaced by private enterprise or another provider for failure to perform far outweighs any financial motivations or penalties.
Recommendation 7: Under no circumstances should the county, any city, or any fire protection district agree to provide an EMS contractor a government subsidy, or stipend to provide service.	We believe the community should get the highest level of accountable; quality based healthcare services for the dollars spent. Also, this is already the case and need not be a recommendation.
Recommendation 8: The DBOH should be given the authority to, and	We agree and further suggest that this should be provided by REMSA.

appoint an EMS Medical Director with oversight and authority over the quality of care for the entire system. The EMS Medical Director would report to the District Health Officer, and could be a classified or contracted employee.	
Recommendation 9: Work to assure the passage of legislation or administrative regulation providing legal protection to all constituents participating in local EMS quality management programs.	We agree.
Recommendation 10: Accept the listed qualifications for the position of County EMS Medical Director.	County-wide medical direction and the employment/contracting for a medical director should be provided by REMSA for all agencies, PSAP, First Response and Transport.
Recommendation 11: Rename the PMAC as the EMS Medical Director Task Force to be chaired by the County EMS Medical Director. The task force would be advisory in nature.	We disagree and believe the PMAC could be leveraged to provide system oversight if given the appropriate medical authority to standardized the clinical treatments within the EMS system. The scope of this group would be limited purely to provide clinical oversight and not regulate or oversee operational issues.
Recommendation 12: Within the Washoe County District Board of Health (or selected lead EMS agency), create a data management program to generate valid, reliable, accurate, and timely information to describe the entire EMS event for the county and provide real time feedback to response agencies and the community. Cooperate with other public health and public safety and community resources to produce injury and illness surveillance reports that can be used to focus EMS efforts.	Homogenized data systems are necessary in order to perform proper process improvement and would provide ability for the various constituencies to measure system performance. We are not in agreement this should be done under the structure represented in recommendation 12. Further, REMSA already has a syndromic monitoring system in place with FirstWatch, which could easily be leveraged to homogenize the remaining datasets for quality improvement and TRANSPARENT performance reporting for ALL agencies.
Recommendation 13: Combine 9-1-1/dispatch centers into one central county-wide resource so that all data is collected in one central location with singular methodology. Alternatively, develop a virtual consolidation between dispatch centers using a universal CAD or type of CAD for the county.	Washko and Associates believe that all emergency ***medical*** dispatching should be conducted by healthcare providers in a center accredited for ***medical*** dispatch functions by the National Academy of Emergency Dispatch. REMSA currently meets these requirements. While a nice suggestion, no current commercially available CAD system has the capability to meet the all the various stakeholder needs and thus is an unachievable recommendation given today's existing technology platforms. CAD-to-CAD interfacing technology can easily be leveraged to solve this concern and should not be resolved through CAD consolidation.

Recommendation 14: Implement a countywide EMS Records Management System that links CAD and dispatch data, and provides the necessary information so that system managers can make informed decisions about the EMS system based on fractile response data.	We agree, but also advise to assure that all reasonable steps are taken to assure patient confidentiality as required under the rules established by the HIPAA Privacy Rule. FirstWatch technologies could easily be leveraged to homogenize the remaining datasets for quality improvement and TRANSPARENT performance reporting for ALL agencies including CAD, RMS, ProQA and ePCR datasets.
Recommendation 15: Implement an Automatic Vehicle Locator (AVL) program throughout the county and adopt closest forces principles.	We agree. REMSA currently uses a "closest forces" principle for Ambulance deployment and agree that this should be extended to both Police and Fire assets for medical first response to the "critical" types of EMS calls (e.g. Cardiac Arrest, Uncontrolled Hemorrhage and Choking). The need for rapid first responder services for the remaining EMS call population is scientifically in doubt unless Ambulance response is significantly delayed and this is for customer satisfaction reasons, not clinical ones. Washko and Associates believe that all emergency ***medical*** dispatching should be conducted by healthcare providers in a center accredited for ***medical*** dispatch functions by the National Academy of Emergency Dispatch. REMSA currently meets these requirements.
Recommendation 16: Place all EMS Communications on the 800MHz radio system.	While the report did not provide an evaluation of the existing 800 MHz radio system, we understand the system to be broken and fraught with low bid engineering and frequent failures and moving all agencies onto the system could be detrimental from a public safety perspective. While we believe agency interoperability is important, tying these systems together would provide a better solution with fault tolerance in the event of an 800 MHz system's failure.
Recommendation 17: Section 1 should be redesigned to prohibit any REMSA board appointee, or their employer organization from being associated with RASI or any successor franchisees. All consumer board members should be directly appointed by the DBOH.	We agree in principle that the contract should prohibit any board appointee or their employer organization from being associated with any successor franchisee. We disagree however that the mix of the board and the procedures by which to elect or appoint the board are flawed.
Recommendation 18: If REMSA continues to use market analysis, it should include intra-model and extra-model comparisons. No more than seven years should elapse without conducting a full competitive bid.	It is clear that the report did not fully assess the process by which REMSA and the DBH conduct their market analysis. The most recent market survey assessed many different types of EMS systems including 3rd service, private and fire based systems providing an excellent cross section representation of the various EMS design types the report refers to. In this ***INDEPENDENT***

	analysis, REMSA and their contractor came out on top in almost every category.
Recommendation 19: Require REMSA or the contracted agency to post a surety bond, or secure an irrevocable line of credit for at least $1,000,000. The franchise agreement should also include a clause that upon declaration of default by the District Health Officer or DBOH, either REMSA or any service contractor cannot bring legal action to delay the DBOH's access to the funds.	It is our understanding that the Franchise Agreement allows REMSA to offer a contractual right of offset against its ground ambulance, dispatch and rotary wing vendors. This is the option that REMSA uses and it provides the DBH with access to all of the receivables of REMSA and RASI which amount to much more than the $200,000 required in Section 7 and has no additional cost. Security bonds and irrevocable letters of credit cost money that would have to be unnecessarily passed on to the patients without any demonstrable benefit to the system.
Recommendation 20: The eight minute and 59 second response time requirement should be required for all calls classified by the PSAP as Charlie, Delta, or Echo (Priority 1 or 2).	The report opines that the eight minute response time requirement should be required for all calls classified by the PSAP as Charlie, Delta or Echo by stating that second-level priority calls are often of a serious nature and require quick response and transfer. The report does not cite ***any*** medical literature or studies to support the recommendation. To the contrary, current literature and studies on the topic would differ with the report's recommendation. The report also states that easing of expectations will likely increase reliance on fire departments who are not compensated for providing their service. Most EMS agencies' compensation is the fees that they generate and collect from their transports, while most fire departments are supported by tax dollars. In most cases, fire department first response is accomplished with ***existing*** FD personnel that would be paid and working ***regardless*** of whether they responded to medical emergencies as first responders. The only added expenses would be the minimal cost of fuel, wear and tear to vehicles, and medical supplies. Further, many fire departments respond unnecessarily with the inappropriate type of vehicle to low acuity calls. Another significant fact not revealed by the consulting group that REMSA arrives at the scene prior to the fire department on the majority of medical calls. This fact provides clear evidence that the attempt to show that REMSA is

	failing in its response times is in fact a false assumption and that the evidence actually shows that the fire service is in dire need of performance improvement with both dispatch times and turnout times. It also appears by way of this recommendation that the consultant group is unfamiliar with Medical Priority Dispatch System (MPDS) response determinate and prioritization system. Under the MPDS system, the ***medical director*** is responsible for setting the response priority for the particular response determinate. This typically includes a mix of the various acuity levels based upon the local medical directors Input as well as other clinical considerations. Given that REMSA is an Accredited Center of Excellence by the International Academy of Emergency Dispatch, the categorization of priority 1 and 2 responses is deemed appropriate with current standards of care and practice. Lastly, we strongly suggest it should be the REMSA medical director whom should decide if medical first response is necessary for a particular response determinant and region as this provides an independent and patient based alignment of medical resources to the clinical conditions of the patient regardless of other provider's political or budgetary justification desires.
Recommendation 21: The downgrading of call priority classifications may only be done by the PSAP, PDAP, or on scene first responder. If the District Health Officer wishes to allow REMSA or the contracted agency the privilege of downgrading call classifications, it must occur prospectively (prior to ambulance dispatch), and include an explanation within the call software. The District Health Officer should monitor compliance and disqualify those downgrading without good reason or documentation. The DBOH annual franchise report should contain a summary of downgrade requests and determinations.	It appears by way of this recommendation that the consultant is unfamiliar with the actual downgrading oversight process. Any downgrades performed in the system are reviewed retrospectively by independent clinical audit to ensure appropriateness and therefore are not suspect. Additionally, the report's recommendation does not take into account the appropriateness or effectiveness of the medical triage programs used at the various call answering points throughout the County.
Recommendation 22: Response time compliance should be based on the entire population instead of sampling.	It appears by way of this recommendation that the consultant is unfamiliar with the actual process performed in the calculation of response times. While the oversight auditing is performed based on random sampling, 100% of the calls are reported and calculated for use in response time calculations and therefore is not a sample representation of performance.

Recommendation 23: Determine ambulance response time fines based on both the act of lateness and degree of lateness. Assess a $100.00 penalty for being late and an additional $15.28 (as per CPI changes) per minute to a maximum of $250.00.	We disagree that ambulance fines need to be adjusted and the consulting group provides no justification for this recommendation. Increasing fines to the ambulance provider will increase the cost to the patient, since these fees will be built into the cost structure used to develop ambulance rates. This recommendation appears to be nothing but a revenue-producing move to finance the report's recommended County oversight system. Additionally, the fire department first responders should be held to response standards as well with penalties for non-compliance.
Recommendation 24: Funds collected for EMS contract performance standard violations should be used to offset system wide EMS oversight costs incurred by the Washoe County DBOH.	Since we believe that Recommendation #23 is not in the best interests of the patient, nor the system, we believe this recommendation to be moot.
Recommendation 25: Remove the arbitration clause from Section 11. If ADR is considered, professional mediation is the method of choice. The District Board of Health should have the ultimate decision power over ambulance rate regulation.	The process for arbitration in the agreement appears to be voluntary. As such, the parties would need to mutually agree to this process for dispute resolution. Arbitration is a cost effective step between ADR and Litigation in most communities. The clause can be modified to allow for ADR without being removed completely as an option to prevent unnecessary costs. The most commonly disputed issue is rates. The average bill and the methods to increase the average bill are very clear in the franchise agreement. Except for the CPI adjustment, the DBH has to agree to any increase.
Recommendation 26: Require REMSA to submit their annual report to the DBOH within 90 days of the fiscal year end.	We disagree and believe the existing 180-day timeframe should remain. Given the time it takes to financially close the books and then also provide for independent external auditing of REMSA's financial and performance metrics, this time period is in alignment with other industries and is acceptable practice.
Recommendation 27: Cities within Washoe County should consult their legal services to provide guidance on the implications of REMSA Franchise Agreement Section 30. EMS agencies must understand that there may be no single answer to their concern.	We agree that all stakeholders should completely understand the REMSA franchise. However, it is our understanding that these types of reviews have been performed in the past by each of the member entities, so we are not exactly sure what re-looking at the franchise would accomplish other then to waste tax-payer dollars.
Recommendation 28: Restructure REMSA to assure greater separation of the public utility oversight group (REMSA), and the contractor (RASI).	It appears based on the comments and recommendations in this section that the report is biased in its evaluation of the overall REMSA system and does not clearly understand all the facts. We believe the report's findings to be conjecture, opinion and not founded on facts or scientifically based peer-

	reviewed accurate research methods. It appears that the consultant did not perform enough due diligence to be able to make any of these recommendations regarding the REMSA system or its architecture. We are also unaware of any issues raised in the past, or as part of the consultant's report that indicates this is a substantive issue that needs to be addressed.
Recommendation 29: The County Commissioners should authorize the District Health Board (or other lead agency) to create a countywide EMS oversight authority. The District Health Officer (or designated department head) would be responsible for day-to-day oversight. The DHOH would need a staff to accomplish this oversight.	Any structural changes associated with external governance of other system components should include this potential as this is the true motivator for performance versus what the consultants believes to be driven by financial penalties. The fact that any component could be replaced by private enterprise or another provider for failure to perform far outweighs any financial motivations or penalties. We believe any structural oversight changes MUST include the following 5 components as found in the American Ambulance Association's "EMS Structured for Quality" manual for ***ALL stakeholder organizations*** within the EMS system (REMSA currently has all of these elements in place): • Hallmark 1 – Hold the EMS system accountable through sanctions and replacement potential • Hallmark 2 – Establish an independent oversight entity • Hallmark 3 – Account for all service costs, operational and clinical quality measures • Hallmark 4 – Require system features that ensure economic efficiency • Hallmark 5 – Ensure long-term high performance service
Recommendation 30: The chosen lead agency should appoint an EMS Staff that includes: an EMS Manager, EMS Medical Director, EMS Information Specialist, EMS Quality Manager, and EMS Education and Training Manager.	While we agree that additional external oversight is necessary for the ***unregulated*** system components (namely the fire service and primary PSAPs), ***we are not in*** agreement that the REMSA structure should be changed. The design is a Public Utility Model EMS system that is designed to provide high quality services at an affordable cost with an ability to terminate the contractor for failure to perform under the auspices of the agreement. Any structural changes associated with external governance of other system components should include this potential, as this is the true motivator for

	performance versus what the consultants believes to be driven by financial penalties. The fact that any component could be replaced by private enterprise or another provider for failure to perform far outweighs any financial motivations or penalties. We also strongly encourage that a independent agency should sit between all Fire Service and PSAP components and government to ensure a ***patient centric focus to system oversight*** and NOT individual agency focused or politically influenced decision-making processes that exist in the Fire and PSAP portions of the system today.
Recommendation 31: The designated Washoe County EMS agency should enter into an agreement with REMSA for the provision of county-wide EMS Education and Training. Granting of function privileges would remain under control of the local agency and its medical director. Local agencies could "opt-out" of or augment REMSA provided education and training. Regulatory oversight of the education and training processes would be the responsibility of the Washoe County EMS Manager and EMS Medical Director. REMSA could provide these services cost-free in exchange for EMS first responder services being provided by Cities and Fire Districts.	REMSAs educational programs have always been available to all providers in the system, both out of hospital personnel and in-hospital personnel. The Medical Director contemplated by Washko & Associates under these recommendations should provide oversight for this component as well. We disagree that REMSA should provide "free" services as these services do come at a cost and the current federal and state reimbursement mechanisms do not account for these added expenses. The FD's should pay for any services used. Fire departments are funded by tax payer dollars and part of their duty is to provide emergency services to the people in their community. In today's modern world, that includes limited EMS first response services, the current majority of most local fire department activity. The fire departments themselves created this paradigm shift and proved that these additional tasks could be accomplished without the need of additional revenues. This was done in an effort to substantiate budgets, unsustainable benefit packages, manpower and extensive layers of infrastructure which have little to no impact on patient care or patient outcomes, except in the rarest of circumstances.
Recommendation 32: REMSA should continue to be the primary EMS transport provider for its current areas. NLTFPD and Gerlach Volunteer Fire Company should also be permitted to continue its current operation as prescribed by law or policy.	We agree.
Recommendation 33: Truckee Meadows/Sierra should continue to be	We agree with the component of continued service delivery by REMSA.

served by REMSA. The current levels of first responder care should continue. After data are analyzed, a decision can be made to consider what level of care is necessary in the new Truckee Meadows/Sierra FPD. Washoe County officials should encourage agencies that may possess the necessary data to forward it to the TriData project manager for analysis.	We are unclear on the continuing role TriData should have in any further work in Washoe County. While not addressed by the Tri-data report, the preponderance of available clinical evidence and research clearly states that the role of first response (fire or PD based) should be limited ONLY to a handful of critical clinical situations (cardiac arrest, severe uncontrolled hemorrhage and choking) and that the most important treatment interventions for these conditions (CPR, AED application, Direct Pressure and the Heimlich Maneuver) are basic skills that first responders AND lay people can be easily taught though public education and first responder training, but are also taught on demand when someone calls 9-1-1, as REMSA's call center based clinicians currently provide these clinical instruction sets over the phone to the caller to start treatment until additional help arrives (known as Dispatch Life Support or DLS). Next, there is substantial clinical evidence that the number of highly trained clinicians in an EMS system (e.g. Intermediates and Paramedics) has a direct correlation with skills competency and outcomes. The more skilled clinicians in an EMS system, the worse the outcomes, which is counter intuitive, but makes perfect sense due to skills dilution and lack of experience. Lastly, there is decades worth of research that clearly shows the lack of a need for resource intense "over" EMS response systems (where first response responds to a majority or all of a systems EMS calls) that end up putting responder and the public at risk due to unnecessary lights and siren responses and response exposures that have ***absolutely no clinical benefit*** where the risks associated with the additional response brings no value whatsoever other then to artificially over-inflate "demand" such services. What should also be assessed in the more rural areas of the county are substantial efforts for layperson education on CPR and use of an AED which has been scientifically proven to improve survival.
Recommendation 34: At the current time, evidence is lacking to support first responder upgrade to paramedic. Current EMTs and EMT-Is should provide the maximum care available for their current level of certification.	There is significant peer-reviewed research that proves the more advanced clinicians (Intermediates and Paramedics) in an EMS system leads to ***diminished*** patient care experienced and ***worse patient outcomes***. We believe it would be in the best interest of patient care and economic efficiency to have REMSA provide ALS EMS service to the entire county and keep First Response

	at the BLS level of care.
Recommendation 35: REMSA should discontinue using the statement that their service is provided at no cost to the citizens.	We disagree. No city or county tax subsidies are used by REMSA for the provision of EMS services but are used to majority fund the fire service that is know to have large excess capacities with little to no demand for these services. We believe the best solution here is to reduce the number of clinically unnecessary Fire based EMS responses, and use these services only for true dire emergencies where response times actually make a difference (cardiac arrest, uncontrolled hemorrhage and choking). Based on the financial analysis provided, it appears that the consultant is unfamiliar with EMS finance as it does not take into account payer mix, contractual obligations or collection rates into their revenue analysis. There is little rationale to the report's recommendation as REMSA's operation is funded through sources other than municipal tax dollars. Fire department first response is no different than when a police officer responds to an EMS call in certain jurisdictions. The response is an additional duty of theirs with police considered part of the "system."
Recommendation 36: Municipal first responders should be reimbursed by REMSA for providing first responder services.	***REMSA already indirectly subsidizes*** the Fire First Responder programs with medical supply exchanges, provisioning of backboards and other equipment and training opportunities all at ***NO COST*** to the fire service. The report assumes the services provided by the first responder agencies are valuable, cost effective and lead to improved patient outcomes. Medical research clearly suggests first responder services improve patient outcomes on a small percentage of the requests for emergency medical services. These presumptive life-threatening emergencies are easily identified through effective **medical** triage programs that REMSA currently uses and is accredited in its use. There is little rationale as to how or why municipal first responders should be reimbursed for the services they provide. Also, the current federal and state reimbursement mechanisms do not account for these expenses.
Recommendation 37: The Reno Fire Department, IAFF, and the volunteer service should work out any issues assure that the closest, qualified unit will be sent to a medical emergency.	We agree and again recommend that these resources be dispatched from a single medical communications center accredited by the National Academy of Emergency Dispatch.

Recommendation 38: The Reno Fire Department should not suspend responding to EMS calls, even during high volume fire responses. If reduced response is necessary, EMS first response could be limited to Priority D or E level calls.	We agree in concept, however the practice of sending First Response on any medical call should be made in conjunction with the EMS Medical Director and community stakeholders to determine the most appropriate resource type and response configuration. It may not be necessary to send a full engine to medical calls when a split duty light response vehicle can be staffed using ***existing personnel*** with a vehicle less expensive to operate. We also reiterate the fact that medical research shows little to no clinical value of first response services other than in instances of true life-threatening situations. Given this, we believe the Fire service should overwhelmingly adopt this type of response complement and always limit Fire-based EMS resource use to only those clinical situations that truly need these level of services no matter if a major fire is occurring or not.

Jonathan Washko started in the EMS industry in 1986 at the early age of 16 in the suburbs of Philadelphia where he was a volunteer fire fighter, police dispatcher and EMS provider. In 1990, Mr. Washko attended Hahnemann University where he received his Paramedic Certification and Bachelor degree in Emergency Medical Services Administration with focused studies on EMS system design, adult education and studied under Jack Stout, father of System Status Management. Upon graduating in 1994, Mr. Washko has held various progressive leadership positions at local, regional and corporate levels with small, medium and large sized EMS agencies and is considered the leading industry expert on EMS system design, System Status Management and High Performance EMS concepts.

Robert Nadolski has broad experience in the areas of communications, operations, deployment and administration. His career in emergency services spans nearly 20 years, beginning as an EMT for a volunteer ambulance service in Northfield, Vermont. Over the years, he has held senior leadership positions in major emergency services and healthcare organizations. Mr. Nadolski understands the perspective of the field EMT and paramedic as well as the needs of leading non-profit and for-profit emergency service agencies. Mr. Nadolski also serves as a director of clinical operations with a large healthcare system in Atlanta, Georgia.

Scott A. Matin, MBA, NREMT-P is the Vice President of Clinical, Education & Business Services for a large EMS service in Wall Township, New Jersey. Prior to this position, Scott served as Executive Director of Clinical, QA and Education Services, Regional Director of Operations, EMS Coordinator and EMS Supervisor. Mr. Matin is also adjunct faculty for the School of Administrative Science at Fairleigh Dickinson University, site review team leader for the Commission on Accreditation of Ambulance Services (CAAS), and is on the Board of Directors for the National Association of EMTs (NAEMT). Mr. Matin has been involved in Emergency Medical Services for over 25 years and is an established manager, educator and nationally registered Paramedic.

Matt Zavadsky, MS-HSA, EMT is the Director of Public Affairs for a Public Utility Model system in North Texas. He holds a Master's Degree in Health Service Administration and has 30 years' experience in EMS including volunteer, fire department, public and private sector EMS agencies. He is a former paramedic and has managed private sector ambulance services from 10,000 to more than 100,000 annual call volume in locations including Fairfield, Connecticut; Augusta, Georgia; Orlando, Florida and La Crosse, Wisconsin. He has also served as a regulator in Lincoln, Nebraska and Volusia County (Daytona Beach), Florida. Mr. Zavadsky has done consulting in numerous EMS issues, specializing in high performance EMS system operations, public/media relations, public policy, employee recruitment and retention, data analysis, costing strategies and EMS research. He has served the American Ambulance Association as Chair of the Industry Image Committee and membership on the Professional Standards, Strategic Development and Management Training Institute Committees. Mr. Zavadsky is an Adjunct Faculty for the University of Central Florida's College of Health and Public Affairs teaching courses in Healthcare Economics and Policy, Healthcare Finance, Ethics, Managed Care and US Healthcare Systems.

Alan Schwalberg started his career in emergency services over 35 years ago. Mr. Schwalberg serves as Vice President for the largest health system-based regional EMS service in the New York City metropolitan area and continues to provide patient-centric care to thousands of patients each year. During the past ten years, Mr. Schwalberg has been the driving force behind developing one of the most advanced and progressive EMS systems in the Northeastern United States centered on patient care, operational and financial performance with quality driven results. Mr. Schwalberg was instrumental in developing the first public/private EMS partnership in the region that has resulted in significant savings for the local municipality along with increased operational efficiency, outstanding patient care and exceptional customer service.