



## **Request For Information**

### **EMS Service**

**RFI Number: 311-F-023**



**BID REQUIREMENTS FOR  
EQUAL EMPLOYMENT OPPORTUNITY**

All bidders seeking to do business with the City of Rockford are **REQUIRED** to submit with any formal, sealed bid all of the following documents and information, attached herewith, completed and signed:

1. Equal Employment Opportunity Affirmative Action Plan Statement of Policy.
2. The Statement of Non-Compliance and Certificate of Non-Segregated Facilities.
3. The Contractor or Vendor Workforce Data Form listing all current employees, by classification, directly employed by the bidder. All categories of information requested must be supplied.  
*Note: The number of employees must be entered under each category (no check marks)*

Below are the Federal definitions of the following racial groups accepted as minorities by the City of Rockford:

Black: A person having origins in any of the Black racial groups of Africa, not of Hispanic origin.

Hispanic: A person of Spanish or Portuguese culture with origins in Mexico, South or Central America, or the Caribbean Islands, regardless of race.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes for example, China, Japan, Korea, the Philippine Republic and Samoa.

American Indian or Alaskan Native: A person having origins in any of the original peoples of North America.

4. Your State of Illinois Pre-Qualification Certification Number, issued by the Illinois Department of Human Rights for the Illinois Department of Human Rights Act, must provide expiration date entered in the place provided therefore.
5. Certificate of Non-Barred Bidding
6. All executed Subcontractor/Leased Operator and Supplier forms.

**If you have not obtained your State of Illinois Pre-Qualification Number (item #4), by signing these documents you agree to make application for this number within 30 days from the date of bid opening.**

***ANY BID WHICH FAILS TO INCLUDE THE CITY OF ROCKFORD EEO PAGES 2, 4, 5, 6, AND 7, COMPLETED AND SIGNED WITH YOUR SEALED BID WILL NOT BE READ AND WILL NOT BE CONSIDERED – NO EXCEPTIONS.***

Falsification of any required Equal Employment Opportunity or Affirmative Action information on the part of the bidder could result in rejection of the bid submitted or in the case where a contract has already been awarded, in the cancellation of said contract.

Any questions pertaining to E.E.O. requirements should be addressed to Ron Moore, Diversity Procurement Officer, Legal Department, 425 East State Street, Rockford, Illinois 61104, Phone: (815) 987-5622 or [ron.moore@rockfordil.gov](mailto:ron.moore@rockfordil.gov)

**EQUAL EMPLOYMENT OPPORTUNITY**  
**AFFIRMATIVE ACTION PLAN**  
**STATEMENT OF POLICY**

It is the policy of this company, ATS Medical Services, Inc. to provide equal employment opportunity without regard to race, religion, color, national origin, handicap, age or sex through a program of positive action affecting all employees. In this program, our company carries out the requirements of Federal Executive orders 11246 and 11375, Civil Rights Act of 1964, Equal Employment Act of 1972, and all other applicable laws, and indicates its active support of the principle of equal opportunity in employment.

At present, 3.75 % of our work force are minorities and 28.75 % of our work force are females, and we will attempt to utilize minorities and females through a positive, continuing program in all jobs for which we contract in the future. Our company will utilize referrals from the City of Rockford's Diversity Procurement Officer for use of minorities and females regarding any future job vacancies.

It is also our intent to make efforts to purchase supplies or equipment from small business concerns located in the City of Rockford or counties of Winnebago or Boone and owned in substantial part (at least 51 per cent) by minorities or females.

Bradley Bull is the official who will be responsible for implementing this policy statement.

Bradley Bull will be designated as the Equal Opportunity Officer in our company, responsible for submission of all required equal employment opportunity documents.

In addition, No one is hereby authorized to sign payroll as well as this company's officers. (NOTE: If only officers will be authorized to sign payrolls, please fill in "No One" in this space.)

### **STATEMENT OF NONCOMPLIANCE**

If the equal employment opportunity hearing committee determines that a contractor, subcontractor/leased operator of equipment or bidder is not in compliance with this chapter, (also known as Chapter 11, Article III the City of Rockford Equal Opportunity Employment Ordinance), the hearing committee shall issue and serve upon such person a written statement of noncompliance setting forth the manner in which it finds such person has violated this chapter, and imposing and/or requiring appropriate sanctions, including, but not limited to any and/or all of the following:

- a. Denying, suspending or revoking qualifications, or declaring the contractor or subcontractor irresponsible and ineligible for future contracts or subcontracts until such time as the contractor or subcontractor shall demonstrate to the equal employment opportunity hearing committee that it is in compliance;
- b. Withholding or delaying payment on the contractor or;
- c. Suspending, avoiding or canceling contract work.

### **CERTIFICATION OF NON-SEGREGATED FACILITIES**

The bidder certifies that he/she does not maintain or provide for his/her employees any segregated facilities at any of his/her establishments, and that he/she does not permit his/her employees to perform their services at any location, under his/her control, where segregated facilities are maintained. The bidder agrees that a breach of this certification will be a violation of the Equal Opportunity clause in any contract resulting from acceptance of this bid.

The bidder agrees that (except where he/she has obtained identical certification from proposed subcontractors/leased operators of equipment for specific time periods) he/she will obtain identical certification from proposed subcontractors/leased operators of equipment from the provisions of the Equal Opportunity clause, and that he/she will retain such certification in his/her files.

**CONTRACTOR OR VENDOR WORKFORCE DATA FORM**

BIDDERS NAME:

ATS Medical Services

NUMBER OF ALL EMPLOYEES MUST BE ENTERED FOR EACH CATEGORY ---

(No Check Marks Or Bid Will Not Be Accepted)

ALL JOB CLASSIFICATIONS	MALES					FEMALES				
	W	B	H	A	I	W	B	H	A	I
Paramedic	27		2			6		1		
EMT	15					4				
wheelchair van	5					1				
Billing						2				
Administration	3					1				
RN						3				
Dispatch	2					2				
Business Development	1					1				
Supervisor	2					2				

W - WHITE B - BLACK H - HISPANIC A - ASIAN OR PACIFIC ISLANDER I - AMERICAN INDIAN

**ILLINOIS DEPARTMENT OF HUMAN RIGHTS CERTIFICATION**

Our Illinois Department of Human Rights Number is:

Applied For

Must Provide Expiration Date:

**CERTIFICATE OF NON-BARRED BIDDING**

The undersigned certifies that it is not barred from bidding on this contract as a result of a conviction for the violation of State laws prohibiting bid rigging or bid rotating. The undersigned also certifies that current or prospective employees, contractors, and subcontractors/leased operators of equipment are not listed as Excluded Individuals/Entities with the US Government, as maintained by the US General Services Administration.

By signing below, the firm agrees that all information provided in the previous pages is accurate, and that if the firm below does not currently have a Department of Human Rights number they will apply for one within thirty days with the State of Illinois.

  
\_\_\_\_\_  
Authorized Signature

Vice President, CEO  
\_\_\_\_\_  
Title

ATS Medical Services  
\_\_\_\_\_  
Firm

Our firm is a:

Minority Business Enterprise \_\_\_\_\_

Women Business Enterprise \_\_\_\_\_

Neither X

City-Certified? Yes \_\_\_\_\_ No \_\_\_\_\_

City Certified? Yes \_\_\_\_\_ No \_\_\_\_\_

(Revised 12/21/09)



**Subcontractor/Leased Operator of Equipment Detail Form**  
**City of Rockford**

Firms submitting bids must supply information on Subcontractors/Leased Operators of Equipment selected for work on the project specified. It is required that Subcontractors/Leased Operators of Equipment listed below will be utilized for actual construction should the firm be awarded a contract. Any deviations from the list below require notice in writing and approval by the Diversity Procurement Officer, Central Services Manager, or their designee. This form may be duplicated if additional space is necessary, all pages must be signed, and submitted.

Subcontractor/Leased Operator Information		Type of Work Supplied	MBE/WBE Business?	Dollar Amount	Subcontract Percent of Bid Total
Please provide business name and address, and a contact person.		Describe the work the subcontractor/leased operator will perform for this contract.			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			

The bidder intends to Subcontract/Lease Operators of Equipment for 0 % of the total contract with MBE/WBE firms. N/A

Signed [Signature] Title Vice President - CFO Date 4/5/2011

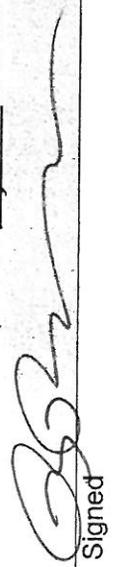
[Signature]

**Supplier Detail Form**  
**City of Rockford**

Firms submitting bids must supply information on suppliers selected for the project specified. It is required that suppliers listed below will be utilized during construction should the firm be awarded a contract. Any deviations from the list below require notice in writing and approval by the Diversity Procurement Officer, Central Services Manager, or their designee. This form may be duplicated if additional space is necessary, all pages must be signed, and submitted.

Supplier Information		Type of Product Supplied	MBE/WBE Business?	Dollar Amount of Supply Contract	Supplier Percent of Bid Total
Please provide business name and address, and a contact person.		Describe the product the supplier provides for this contract.			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			
Name	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>	\$ _____	_____ %
Address	_____	_____			
City, State	_____	_____			
Contact	_____	_____			

The bidder intends to procure 0 % of the total contract from MBE/WBE firms. - N/A

  
 Signed \_\_\_\_\_

Vice Pres. Dent-CFU  
 Title \_\_\_\_\_

4/5/2011  
 Date \_\_\_\_\_

**REQUEST FOR INFORMATION  
EMS SERVICE  
311-F-023**

**1.0 Scope**

- 1.1 The City of Rockford, Illinois is distributing this Request for Information (RFI) to evaluate potential vendors who are interested in providing professional and qualified Ambulance Service to the geographical area of the City of Rockford. Ambulance service shall include the provision of both Basic Life Support (BLS) and Advance Life Support (ALS) Care.
- 1.2 Contractor shall provide, twenty-four (24) hours a day, seven (7) days a week, Paramedic Level Ambulance Services and all labor, training, supplies, licenses, permits, equipment, transportation, pre-hospital emergency care personnel and every other item of expense required to transport patients.

**2.0 General Requirements - Please completely respond to the following**

**2.1 About the Company**

- 2.1.1 Company history.
- 2.1.2 Organizational chart and hierarchy identification.
- 2.1.3 Location(s).
- 2.1.4 Provide information about contractual arrangements with other communities.
- 2.1.5 Describe affiliations with local agencies (hospitals, institutions, etc.).
- 2.1.6 Bonding and insurance capacity, including Best's rating of current insurer.
- 2.1.7 Provide information on certifications and accreditations the firm holds.
- 2.1.8 Identify what state or Illinois EMS Region the vendor is with and what EMS System they are currently in. Identify what Region I EMS System they anticipate they will be in.
- 2.1.9 Provide a letter of "Good Standing" from their current EMS System.

**2.2 About the Staff**

- 2.2.1 Training and certification of staff.
- 2.2.2 Include each individual's years of employment to the vendor and years licensed as an EMT-P.
- 2.2.3 Provide letter of confirmation that all of vendor's EMS providers are in good standing within their EMS System and IDPH.

**2.3 About the Equipment**

- 2.3.1 Identify Ambulance vehicles currently used in similar markets (e.g., make, model, year, equipment).
- 2.3.2 Condition of current equipment and capital replacement policy.
- 2.3.3 Included in appendix A is statistical information on call volume in the City. Please provide information on the firm's deployment strategy in similar markets.
- 2.3.4 Identify and list all equipment that is maintained and is part of every ambulance's inventory.
- 2.3.5 Confirm that every cardiac monitor that is carried by the vendor is capable of taking and transmitting a 12-lead analysis to every local hospital.
- 2.3.6 Outline the vendor's current policy on providing equipment and medication replacement to fire apparatus companies used on patients being transported by the vendor.



- 2.4 About the Service
- 2.4.1 Identify experience providing Ambulance services as well as the contractual method employed with each client listed.
  - 2.4.2 If available, provide customer survey results for vendor's last three (3) years of service.
  - 2.4.3 Vendor must confirm that a Quality Assurance/Quality Improvement program is being utilized, and provide information on program details.
  - 2.4.4 Describe service provision approach (e.g., patrol, stationary).
  - 2.4.5 Describe contingency plan and any arrangements with public or private providers for emergency services.
  - 2.4.6 The City will require two (2) paramedics on the ambulance at all times. Describe current staffing strategy.
  - 2.4.7 Describe current billing practice for commercial and no-pay patients (How do you collect and to what extent.)
  - 2.4.8 Provide current and accurate cardiac arrest data, providing percentage of patients with return of spontaneous circulation and what parameters are used for "save rate" (i.e. Utstein Criteria).
  - 2.4.9 Describe current procedures and equipment for handling bariatric patients.
  - 2.4.10 Is standby service for training, police stand-offs, and fire ground included in pricing with current contracts? If not, detail pricing policy for this service.
  - 2.4.11 Identify what type of software is used for patient care reporting.

2.5 About Communications

- 2.5.1 Identify software and hardware for dispatch alerting system, radio infrastructure and CAD or Computer aided dispatch.
- 2.5.2 Identify back up plan for radio communication outages and CAD failure.
- 2.5.3 Identify mobile data terminals/computers software and hardware.
- 2.5.4 Outline conflict resolution procedures with current clients.
- 2.5.5 Outline internal investigation procedures.
- 2.5.6 Describe communication approach between your firm and the client in the contractual relationship. What is the typical reporting method and detail provided to the owner? Provide examples.

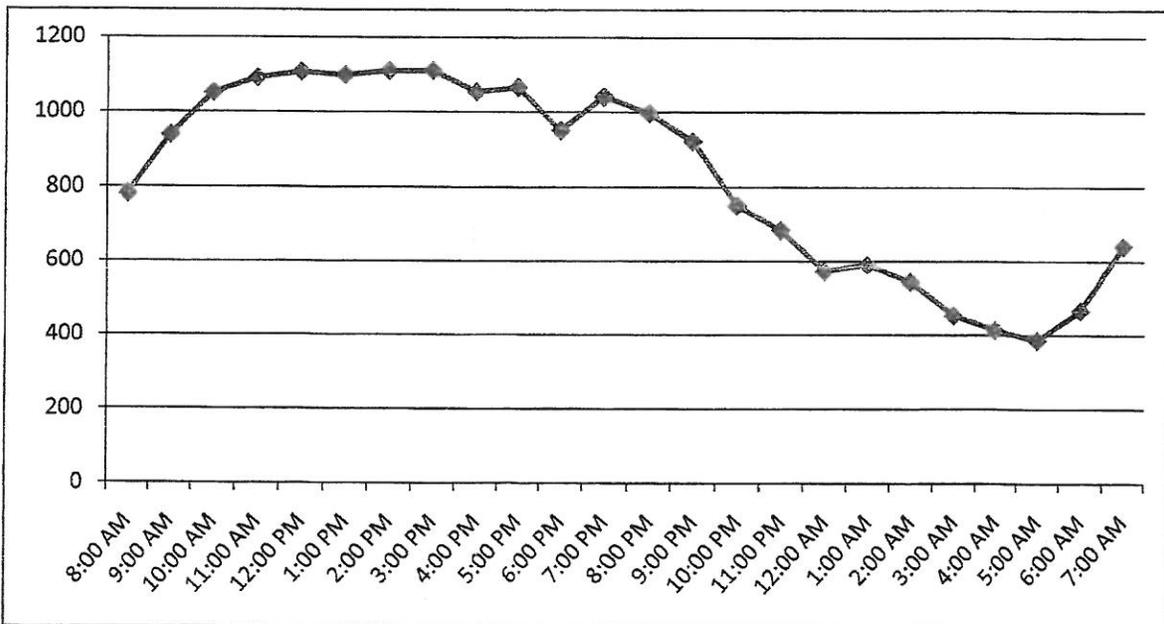
3.0 General

- 3.1 Contact. The contact for this RFI is Carrie Eklund, Central Services Manager, at 815-987-5565 or [carrie.eklund@rockfordil.gov](mailto:carrie.eklund@rockfordil.gov).
- 3.2 Copies. Please return an original and three (3) copies of your firm's full response.



2010 Ambulance Responses (Includes responses from 5 Rockford Ambulances and Private Ambulances)

Hour	Responses
8:00 AM	784
9:00 AM	940
10:00 AM	1,052
11:00 AM	1,092
12:00 PM	1,108
1:00 PM	1,099
2:00 PM	1,111
3:00 PM	1,111
4:00 PM	1,055
5:00 PM	1,067
6:00 PM	952
7:00 PM	1,042
8:00 PM	998
9:00 PM	923
10:00 PM	752
11:00 PM	687
12:00 AM	575
1:00 AM	592
2:00 AM	546
3:00 AM	454
4:00 AM	415
5:00 AM	387
6:00 AM	467
7:00 AM	643
<b>Total</b>	<b>19,852</b>



BB



**Request For Information**

**EMS Service**

**RFI Number: 311-F-023**



## **General Requirements:**

### **2.1 About the Company**

#### **2.1.1 – Company History**

ATS Medical Services Inc. (FEIN 37-1508264) was founded in April, 2005 by Andrew Schultz. Andy recognized a need for a private service that could provide both excellent customer service and phenomenal patient care. As a result, Andy founded ATS with 1 ambulance and a desire to stick with the aforementioned principals. Shortly thereafter, Bradley Bull joined the ownership team with ATS. Together, Andy and Brad evolved ATS from a 1 ambulance operation into the service it is today. A 2011 Fact Sheet is included as an attachment but the highlights are as follows:

- Provide Emergency and Non-Emergency Service to Northern Illinois
- ALS, BLS, Critical Care, and Wheelchair Service Provider
- In house billing, dispatch and IT support
- FEMA Disaster Responders
- 4 Local (Illinois) Fire Department staffing contracts
- 2 Federal Government Staffing Contracts (current and 1 completed/fulfilled)
- Expanding into Indiana May, 2011 with 2 additional locations slotted for Fall, 2011
- Industry Leaders in Patient Care and Technology

#### **2.1.2 – Organizational chart and hierarchy identification**

See attached organizational chart and hierarchy chart

#### **2.1.3 – Location(s)**

ATS Medical Services has locations as follows:

- ATS Medical Services, Inc., 6419 Material Ave., Loves Park, IL 61111 (Corporate Headquarters)
- ATS Staffing (FEIN 20-4129749), 6419 Material Ave., Loves Park, IL 61111
- ATS Medical Services, d/b/a Priority One, 5333 Commerce Square Drive, Suite D, Indianapolis, IN 46237
- WCFPD #1 (Durand Fire), Durand, IL
- Rockton Fire Department, Rockton, IL
- Polo Fire Protection District, Polo, IL
- WBS Fire Department, Winnebago, IL
- Keller Army Community Hospital, West Point Military Academy, West Point, NY
- Minot Air Force Base, Minot, ND

#### **2.1.4 – Provide information about contractual arrangements with other communities**

ATS Staffing has contractual agreements with the following communities:

- Durand, IL. ATS Staffing began providing Durand with Paramedics and EMT's in February, 2006 and is continuing to provide service. Durand supplies the vehicles and equipment, while ATS provides the manpower, training, benefits, education and human resources.
- Rockton, IL. ATS Staffing began providing Rockton with Paramedics in January, 2007 and is continuing to provide service. Rockton supplies the vehicles and equipment, while ATS provides the manpower, training, benefits, education and human resources.
- Polo, IL. ATS Staffing began providing Polo with Paramedics and EMT's in May, 2009 and is continuing to provide service. Polo supplies the vehicles and equipment, while ATS provides the manpower, training, benefits, education and human resources.
- Winnebago, IL. ATS Staffing began providing Winnebago with Paramedics and EMT's in August, 2009 and is continuing to provide service. Winnebago supplies the vehicles and equipment, while ATS provides the manpower, training, benefits, education and human resources.

ATS Medical Services has contractual agreements with the Federal Government for the following:

- West Point, NY. ATS began providing Keller Army Community Hospital at West Point Military Academy with Paramedics in July, 2009 and is continuing to provide service. West Point provides the vehicles and equipment, while ATS provides the manpower, training, benefits, education and human resources.
- Minot, ND. ATS began providing Minot Air Force Base with Paramedics in October, 2009 and is continuing to provide service. Minot provides the vehicles and equipment, while ATS provides the manpower, training, benefits, education and human resources.
- Fort Bliss, TX. ATS began providing Fort Bliss with Paramedics and EMT's in January, 2009 and our contract successfully completed April, 2009. Fort Bliss provided the vehicles and equipment, while ATS provided the manpower, training, benefits, education and human resources. We were awarded a 90 day contract which fulfilled the contract of a vendor who could not complete the requirements of the Government. Upon successful completion of our contract, we were underbid by a competitor on the next contract for that location.
- FEMA. ATS is a subcontractor to AMR for National Disaster Responses. We have responded to Hurricanes Gustav and Ike (Fall, 2008) and have been placed on high preparedness for the Presidential Inauguration and the February, 2011 snow storm.

#### **2.1.5 – Describe affiliations with local agencies (hospitals, institutions, etc.)**

ATS Medical Services has been a member in Good Standing with Rock River Region EMS System (RRREMS) since it began we began in 2005. ATS receives continuing education through RRREMS and credentials our staff through RRREMS as well. ATS also provides skilled nursing facilities in the Rockford area with Preferred Provider Agreements. These agreements outline our services that we can provide, while placing ATS at the top of their immediate call list. These are not exclusive "contracts" but more of an agreement to provide the closest available ambulance within the timeframe our Communications Center states. ATS Medical Services is a Preferred Provider for Van Matre HealthSouth and skilled nursing facilities that include Provena St Anne's, Provena Cor Mariae, Wesley Willows, Rockford Nursing

and Rehab, Rosewood, and Amberwood Care Center. We are also an associate member of MABAS Division 8. ATS provides service to whoever requests or assistance.

Priority One is affiliated with St Francis Hospital in Indianapolis, IN for our Medical Direction and ALS Affiliation. St Francis provides us with education, training, credentialing and audit and review of run sheets.

#### **2.1.6 – Bonding and insurance capacity, including Best’s rating of current insurer**

We have the ability to purchase a bond if necessary however, we do not anticipate subcontracting any portion of this contract. I have also included a Certificate of Liability (FEMA) as an example which lists our carriers and limits.

#### **2.1.7 – Provide information on certifications and accreditations the firm holds**

ATS Medical Services is licensed at the Advanced Life Support level with the Illinois Department of Public Health. We are completing ALS licensure with the Indiana Department of Homeland Security. ATS is certified by RRREMS to function at the Expanded Scope level which allows our crews to utilize mechanical ventilators and transport various medication drips via IV pumps. We are completing our application for CAAS accreditation and function as a CAAS compliant organization. We are NEMESIS Gold compliant and we are accredited with the Better Business Bureau. ATS has instructors for EVOC, CPR, ACLS, PALS, and ITLS and have several Nationally Registered Paramedics and Critical Care Paramedics.

#### **2.1.8 – Identify what state or Illinois EMS Region the vendor is with and what EMS System they are currently in. Identify what Region I EMS System they anticipate they will be in.**

ATS Medical Services (license 2521) is currently with Rock River Region EMS (Rockford Memorial Hospital) in Region I. We anticipate remaining a member of RRREMS as we have a positive, well-established relationship with the department. However, we work in conjunction with our current staffing contracts to determine what EMS System is best for them. For example, Rockton chose to work with Swedish American EMS.

#### **2.1.9 – Provide a letter of “Good Standing” from their current EMS System**

A letter of “Good Standing” has been requested as evidenced by the attached email to Anthony Cellitti. Mr. Cellitti advised that an original would be sent directly to the City of Rockford, Central Services Manager and he would also send a copy to us for our records. Please contact Mr. Cellitti directly for any further questions, comments, concerns or references. He can be reached at (815) 971-5205 or TCellitti@rhsnet.org.

### **2.2 About the Staff**

#### **2.2.1 – Training and Certification of staff**

All of our personnel undergo a rigorous and comprehensive training program. Upon hire, individuals complete the “Arrive Alive Do No Harm” training program through Thomco and the

“Operation Safe EMS” through Ferno. All crew members receive training on the Philips MRX monitor and the Stryker Stretchers. All personnel receive EVOC training in house and documentation training via Page, Wolfberg and Wirth. All persons receive pre-employment and annual criminal background checks, DMV checks, employee wellness screenings, TB screenings, Hepatitis B titres and influenza vaccines. All EMT’s are current in CPR and ITLS (or PHTLS) and all Paramedics are current in CPR, ITLS (or PHTLS), ACLS and PALS. Several individuals are Critical Care Certified, Nationally Registered and have training in Advanced Medical Life Support. Dispatchers are EMD Certified and our Medical Billers are Certified Ambulance Coders. All field EMS personnel are NIMS complaint and have at minimum Hazmat Awareness. Contract Paramedics and EMT’s are Illinois Certified Firefighter II. All ATS Paramedics must successfully pass a pre-employment written exam and must also successfully complete the RRREMS entrance exam to establish good standing.

### **2.2.2 – Include each individual’s years of employment to the vendor and years licenses as an EMT-P**

See attached list. This list is restricted to Illinois Paramedics only.

### **2.2.3 – Provide letter of confirmation that all of vendor’s Ems providers are in good standing within their EMS System and IDPH**

A letter of confirmation has been requested as evidenced by the attached email to Anthony Cellitti. Mr. Cellitti advised that an original would be sent directly to the City of Rockford, Central Services Manager and he would also send a copy to us for our records. Please contact Mr. Cellitti directly for any further questions, comments, concerns or references. He can be reached at (815) 971-5205 or [TCellitti@rhsnet.org](mailto:TCellitti@rhsnet.org).

## **2.3 About the Equipment**

### **2.3.1 – Identify Ambulance vehicles currently used in similar markets (e.g., make, model, year, equipment)**

ATS has a wide variety of ambulances in its fleet. Our primary vehicles are as follows:

- 2009 Chevy G3500, Medix, Type III modular. Purchased new in 2009. C-79
- 2009 Chevy G3500, Medix, Type III modular. Purchased new in 2009. C-78
- 1999 Ford E450, Braun, Type III, modular. Purchased used in 2006. C-76. Has a new engine and transmission as of 2009.
- 1996 Ford E350, Braun, Type III, modular. Purchased used in 2006. C-75. Has a new engine and transmission as of 2009.
- 1995 Ford E350, MedTec, Type III, modular. Purchased used in 2005. C-71. Well maintained reserve unit.
- 1995 Ford E350, MedTec. Type III, modular. Purchased used in 2005. C-74. Well maintained reserve unit.
- 2006 Ford E450 McCoy Miller. Type III modular. 1F28. Polo unit.
- 1993 Ford E350 MedTec, Type III modular. 1F19. Polo unit.

- 2006 Ford E450, Horton. Type III modular. C-22. Rockton unit.
- 2008 Ford E450, Horton. Type III modular. C-32. Rockton unit.
- 2004 Ford E450, MedTec. Type III modular. C-19. Durand unit.
- 2000 Ford E450, MedTec. Type III modular. C-18. Durand unit.
- 2004 Ford E450, PL Custom, Type III modular. C-81. Winnebago unit.
- 1998 Ford E450, PL Custom, Type III modular. C-80. Winnebago unit.
- 2003 Ford E450, Road Rescue, Type III modular. Purchased used in 2011. Medic 1 (Indy)
- 2002 Ford E450, MedTec, Type III modular. Purchased used in 2011. Medic 2 (Indy)

All vehicles are well maintained and preventive maintenance programs are currently in force and in place to ensure safe, effective operation. Also note that the Federal Government uses Type I ambulances that we do not have the vehicle information for.

### **2.3.2 – Condition of current equipment and capital replacement policy**

All equipment owned and/or otherwise operated by ATS and its crews are kept in top working condition. Despite the model year of some of our vehicles, the equipment is in like new condition. The equipment and vehicles are cosmetically appealing and mechanically in top condition. All vehicles are preventively maintained by an outsourced mechanic and/or dealership. ATS cardiac monitors are maintained daily via crew operations checks and further maintained annually by outsourced biomedical engineering. ATS stretchers are cleaned continuously but thoroughly decontaminated weekly during our “mock” inspections that are performed weekly. Stretchers are annually inspected by EMSAR.

ATS has a flexible capital replacement policy. The company chose to replace the engine and transmission in two of its older vehicles instead of replacing them because the rest of the vehicle was in excellent condition. The company adheres to manufacture recommendations for end of life time tables on equipment and adds cosmetic and mechanical wear and tear to the formula. When a piece of equipment reaches a mechanical and/or cosmetic liability (as evidenced by preventive maintenance findings and repairs), and is no longer fiscally economical to continue to repair, the equipment or item is replaced. The company budgets appropriately throughout the year for such capital replacements.

### **2.3.3 – Included in appendix A is statistical information on call volume in the City. Please provide information on the firm’s deployment strategy in similar markets**

System Status Management has been the EMS gold standard for deployment of emergency vehicles in EMS for the past 20 years. However, recent studies have proven otherwise (attached). ATS has firmly believed in a modified version of System Status. We feel strongly about a home base/station(s) that are strategically/geographically located throughout the response area. When vehicles are tied up on calls, we strategically move/relocate crews to a more “central” area to minimize response times. As an example, if we have crews in Rockford that typically post East, West and central, we strategically move vehicles to better accommodate the central area. Therefore if the East and central crews are running calls, we shift the west crew to a more central location to reduce geographical response times. We have found this to be a very effective method which works as a hybrid of the

traditional System Status Management. We reduce response times by reducing geographical mileage covered and adding vehicles to the more heavily populated areas. Factors that have an effect on this and cause variations in deployment strategy include construction, weather/hazards, trains, traffic and terrain. As an added tool, our CAD and mapping software help determine which crew is geographically closer based on their exact location and the location of the call.

#### **2.3.4 – Identify and list all equipment that is maintained and is part of every ambulance’s inventory**

See the attached RRREMS Inspection sheet, inventory list and vehicle check sheet.

#### **2.3.5 – Confirm that every cardiac monitor that is carried by the vendor is capable of taking and transmitting a 12-lead analysis to every local hospital**

Not only do all ATS monitors take and transmit 12-lead ECG’s to every receiving hospital, but we were the first in Northern Illinois to do this. Some agencies were able to transmit to only select hospitals but ATS has always had the ability to send to any hospital, fax or pda/smartphone. We were the first in Northern Illinois to use Philips MRX monitors and began using a receiving station in Seattle, WA to launch the pilot program in Rockford. We presently utilize the receiving/switch station located at Swedish American Hospital and continue to maintain the ability to transmit 12-lead ECG’s via Bluetooth and cellular technology. Additionally, all of our Paramedics are extensively trained and evaluated on 12-lead interpretation. ATS owns a 12-lead simulator that is routinely used by Paramedics for training.

#### **2.3.6 – Outline the vendor’s current policy on providing equipment and medication replacement to fire apparatus companies used on patients being transported by the vendor**

It is the policy of ATS to resupply the fire apparatus companies for any equipment and medication used on the call. ATS maintains a record of those supplies and in turn restocks from the receiving hospital. ATS is not charged by the receiving hospital for this service and therefore does not charge the fire apparatus companies either. This includes but does not limit to: medications, gauze, IV supplies, oxygen, dressings, gloves, etc.

### **2.4 About the Service**

#### **2.4.1 – Identify experience providing Ambulance services as well as the contractual method employed with each client**

Years of experience and scope of contract is outlined in section 2.1.4 above. Specific contract information can be obtained via Freedom of Information Request if necessary.

#### **2.4.2 – If available, provide customer survey results for vendor’s last three (3) years of service**

Specific customer satisfaction surveys are unavailable. However, an email from West Point is attached as well as a letter from Van Matre. Official letters of recommendation from Durand, Rockton and Winnebago are attached. Current letters of recommendation and reference from each contract may be available if requested and needed.

#### **2.4.3 – Vendor must confirm that a Quality Assurance/Quality Improvement program is being utilized, and provide information on program details**

In conjunction with RRREMS we will maintain an Audit and Review process. We have three different processes for internal QA/QI. Internally, all patient care reports are reviewed by a member of our billing staff without exception. Any report that is “flagged” by them is then transferred to a member of our management team for a secondary review. The second review process involves our QA/QI team in house. A random selection of patient care reports are selected for review by our field trainers and the reports are then reviewed for protocol compliance and proper documentation. Our patient care reporting software has our protocols installed within the program and automatically flags deviations from protocol. For example, a chest pain will prompt the Paramedic for the time they administered nitroglycerin. If they didn’t administer nitroglycerin and/or explain why they did not, then the system will automatically flag the chart for review. Any concerns are forwarded to the Operations Director and finally a member of the EMS office is contacted and advised of the problem as well as a plan of corrective action. The final review process is our external QA/QI as evidenced by the Fusion paperwork attached. Our EMS System has the ability to view reports in its current stage as opposed to a pdf. He can select charts based on provider impression, procedure, level of care and transport urgency.

Our patient care reports are selected by the methods as described above. When our management team is performing their internal QA/QI, they select based on the following criteria: All ALS 2 calls (three or more medications administered), all advanced airways, all cardiac arrest, all emergent trauma, all expanded scope/critical care calls, all OB and not less than 10% of remaining patient care reports. Crews also have the opportunity to “flag” their own call for review if they feel something on the call was in question. See attached RRREMS QI paperwork and Trittech QA/QI paperwork.

#### **2.4.4 – Describe service provision approach**

ATS rarely patrols the streets. In fact, we designate specific posting (stationary) assignments and crew quarters when calls are not being performed. However, as necessary for our method of status management, our crews will patrol to a more “middle” ground to better serve the geography and demographic population to reduce response times.

#### **2.4.5 – Describe contingency plan and any arrangements with public or private providers for emergency services**

ATS has mutual aid agreements with every department we provide staffing services for. Furthermore, we have a mutual aid agreement with the City of Rockford and frequently provide assistance in times of heavy call duty. ATS has also called upon Rockford Fire Department for emergency assistance as well. ATS has written mutual aid agreements with Advanced EMS of Dixon and Lifeline Ambulance of Rockford. We also refer calls to Metro Medical Services when other mutual aid providers are unavailable.

**2.4.6 – The City will require two (2) paramedics on the ambulance at all times. Describe current staffing strategy**

ATS currently functions in Rockford with one (1) EMT-Basic and one (1) EMT-Paramedic on each ambulance (at minimum). With newer Paramedics we function with two (2) Paramedics on each ambulance. We find that one (1) EMT and one (1) Paramedic is a cost effective solution since one person must drive the ambulance to the hospital at some point.

However, this is not the case everywhere we work. We allow the customer to determine their staffing needs based on their preference. If the customer desires two (2) Paramedics (such as Rockton) then that is what we do.

**2.4.7 – Describe current billing practice for commercial and no-pay patients (How do you collect and to what extent.)**

See attached billing practices summary.

**2.4.8 – Provide current and accurate cardiac arrest data, providing percentage of patients with return of spontaneous circulation and what parameters are used for “save rate” (i.e. Ulstein Criteria)**

See attached “Evaluation of Cardiac Arrest Outcome” white paper.

**2.4.9 – Describe current procedures and equipment for handling bariatric patients.**

ATS encounters bariatric patients on a daily basis, as the sheer size of the American person continues to grow. It is not uncommon to send two ambulances for one patient to provide lifting assistance for the crew. We believe in power by numbers and feel very strongly about the safety of our crew and patients. When we respond to a building such as a skilled nursing facility, we attempt to utilize as many of the in house staff members as possible for assistance. The in house staff is familiar with the patients and typically moves them on a routine basis. When we respond to a home, residence, business or any other scene type call where we find an obese person that requires bariatric provisions, we utilize the local Fire Department and/or First Responders for assistance.

ATS has recently purchased Ferno Powercots for use on bariatric patients. These stretchers have a weight limit of 1,000lbs in the down position and 700lbs in the up position. We utilize Stryker MX Pro stretchers as another vendor on our remaining fleet. The Stryker stretchers (non-power) have a weight limit of 1,200lbs in the down position and 650lbs in the up position.

**2.4.10 – Is standby service for training, police stand-offs, and fire ground included in pricing with current contracts? If not, detail pricing policy for this service.**

Every contract ATS has is different in some form. For example, we include up to 40 hours per month of education and training in North Dakota at no charge (billed monthly). In contrast, West Point reimburses by the hour worked. Therefore, we receive a flat hour fee for every hour worked in the performance of the contract at West Point, regardless of the scope of the job performed.

All Illinois staffing contracts include provisions for training, police stand-offs and fire ground standby; meaning that those are already included in our base service. ATS presently responds to mutual aid requests for Rockford and neighboring departments and provides the aforementioned services at no charge.

#### **2.4.11 – Identify what type of software is used for patient care reporting**

See attached Information Technology paperwork for details on our software. In brief, ATS uses Fusion ePCR from Tritech and we are NEMSIS Gold Compliant.

### **2.5 About Communications**

#### **2.5.1 – Identify software and hardware for dispatch alerting system, radio infrastructure and CAD or Computer aided dispatch**

See attached Information Technology paperwork for details on our software and hardware. In brief we use Sweet CAD from Tritech and AVL/Mobi-CAD for our dispatch alerting system and CAD. We are in the process of a near voiceless communication with our crews. At present, crews are still dispatched via VHF radio, frequency of 154.540 and PL of 131.8. Crews are alerted by an audible tone and radio/voice response. Crews carry portable radios with them at all times. Crews also carry mobile, cellular telephones as a secondary means of communication. As evidenced in our Information Technology paperwork, AVL/Mobi-CAD is going to be our primary means of communication to the crews. They can receive calls and call information while also acknowledging their vehicle status (ie. Enroute, on scene, transporting). As a secondary means of communication, crews will continue to carry cell phones for voice alerting and will maintain radio communications for a third and final method. Crews will maintain radio communication capabilities to communicate effectively with Departments we are responding with.

#### **2.5.2 – Identify back up plan for radio communication outages and CAD failure**

ATS has a 10kw generator (gas fueled) for emergency power backup that starts automatically during a power failure. All servers, phones and essential work stations such as Dispatch/Communications are tied to the generator. The generator automatically tests for one hour on a weekly basis. All servers, phones and work stations also have local battery backup. All data at ATS is backed up via "cloud" technology five (5) times daily and is also backed up locally to external hard drives five (5) times daily. CAD and scheduling is backed up to pdf once daily and any phone problems are automatically reported to our carrier. Locally, we are alerted to phone problems/failures by an audible and visual alarm which allows us to switch back to analog phone technology. In the event of a lengthy radio or phone failure, we are able to transfer our calls to cellular phones and communicate effectively via that method.

#### **2.5.3 – Identify mobile data terminals/computers software and hardware**

See attached Information Technology paperwork. In brief, ATS uses Panasonic CF-52 Scarab computers and AVL/Mobi-CAD for specific hardware and software.

#### **2.5.4 – Outline conflict resolution procedures with current clients**

What sets ATS apart from our competition is our attention to our customers. Any member of the ATS management team is available any time of day. When a customer service issue is reported to our Communications Center, the dispatcher completes an online incident report form (example attached). This form, once submitted, is automatically forwarded in email form to all members of our management team. Andy Schultz, CEO, (and or a member of the team he designates) is directly responsible for conflict resolution with clients. ATS routinely (at least monthly) communicates with all of our customers to ensure customer satisfaction. When a problem presents itself, we routinely work with the client to find the best solution for all parties as quickly as possible.

#### **2.5.5 – Outline internal investigation procedures**

Reporting of internal problems occurs in a similar fashion as described above. Crew members can report problems anonymously if they desire and also have the opportunity to report a problem while identifying themselves. ATS believes that nobody is guilty until all parties involved have been questioned and interviewed to obtain all of the facts. ATS uses driving cameras which record forward (roadway) and rear (driver and passenger). The information obtained from the cameras typically speaks for itself. ATS also has cameras within our facility that record based on motion. The cameras record our supply room, server room, garage and outside of the building. ATS believes in a progressive discipline model and we routinely “coach” personnel through problems that have been identified.

#### **2.5.6 – Describe communication approach between your firm and the client in the contractual relationship. What is the typical reporting method and detail provided to the owner? Provide examples.**

Despite not having a “contract” with Rockford Fire Department, ATS currently provides Chief Bergsten with our monthly calls and response times with the City. An example of this report is attached. For other contracts, such as Polo, Darin Longanecker (Chief Operations Officer) sits in on the monthly Board Meetings and provides a verbal report to the members of the Board. Most of our other clients prefer either monthly phone calls (Durand and Rockton) while others prefer email status updates (West Point). Each contact has specific requests for communication and frequency thereof.



Andrew Schultz, President, CEO



Bradley Bull, Vice President, CFO



# 2011 FACT SHEET

From auto accidents to natural disasters, critical care transports to hospital transfers, A.T.S.' quick response, commitment to clinical excellence and exceptional levels of care are synonymous with our reputation as being a leading provider of emergency and non-emergency medical services. That's because when seconds count, our patients and customers know they can always count on A.T.S. Medical Services and its years of experience in the medical and critical care transport industry.

Founded in 2005, A.T.S. Medical Services is a clinically progressive emergency medical transport program that is uniquely designed to provide unequalled response and high quality patient care. A.T.S. Medical Services provides emergency medical response services to communities and facilities in Illinois, North Dakota, New York, and in Indiana as Priority One, a division of A.T.S. Medical Services.

## ANNUAL STATISTICS

- Operates a fleet of over 20 vehicles.
- Employs over 125 EMT's and Paramedics.
- Performs over 25,000 patient transports annually.
- Responded to over 5,000 911 Requests in 2010.
- Operates in 4 states with expansion to 2 additional states expected in 2011.
- Operates a state-of-the-art communications center.

## HIGHLIGHTS

- 911 Provider for WestPoint Military Academy, N.Y.
- 911 Provider for Minot Air Force Base, N.D.
- 911 Provider for Polo, Ogle County, Illinois.
- 911 Provider for Rockton, Illinois.
- 911 Provider for Winnebago Fire District, Illinois.
- 911 Provider for Durand Fire District, Illinois
- Back-up 911 Provider for Rockford, Illinois.
- FEMA Ambulance Provider – National Disaster Response Team.
- NEMSIS Gold Compliant Software and Technology.

## SERVICES

Quality care means serving patients both inside and outside of the hospital. Whether a patient needs emergency service or transportation to a medical appointment, A.T.S. is here to serve the community.

- Emergency Ambulance Service
- Non-Emergency Ambulance Service
- Critical Care Transport
- Wheelchair Van Transport
- Medical Staffing & Contracting
- Municipality 911 Contracting
- Emergency Medical Dispatching
- Government Medical Staffing
- Public Safety Answering Point (PSAP)
- Dispatching EMS/Fire Apparatus
- EMS Information Technology
- EMS Billing Services



An A.T.S. Medical Services Advanced Life Support Ambulance stationed in Rockford, Illinois that provides both 911 response and interfacility services.

## EXPERTISE

We believe the key element in our equation for success is our unwavering commitment to our patients, customers and the communities we serve. In fact, we are known for tailoring our services to our customers' needs. Recognizing that not one A.T.S. or Priority One service area is alike – different individuals, different organizations, and different desires – we offer a variety of approaches to medical transportation and staffing needs. By working with and listening to the suggestions of community leaders, safety experts, healthcare specialists and residents, we conduct thorough analyses designed to forge solutions that fit each community perfectly.

It's also a commitment to excellence founded on a promise. Rigorous, high-performance service standards set the bar for continuing advancement, while at the same time solidifying the quality and value of our services.

How do we achieve such far-reaching objectives? Flexibility and innovation through newer and better approaches to problems, constantly evolving service models and solutions customized to specific circumstances and budgets. With an innovative, entrepreneurial spirit, we provide our employees with the tools and expertise to achieve our goals.

### CLINICAL SOPHISTICATION:

Unfortunately most private ambulance providers have little incentive to invest in the latest technology, often diverting funds for advancement to shareholder profits. A.T.S. has committed to setting a new standard for private ambulance providers. Since its inception, A.T.S. has maintained cutting edge technology that even most tax payer supported municipal agencies lack. A.T.S. technology includes:

- State-of-the-art ambulance fleet
- Power cots
- 12-Lead Equipped Philips MRx Cardiac Monitors
- Dispatched via Tritech Computer Aided Dispatch System.
- All Ambulances are Satellite Tracked using Automatic Vehicle Location (AVL) Technology.
- All Ambulances are guided to calls via MobiCAD GPS Navigation.
- All Ambulances have "Black-Box" On-Board Video/Audio Recording Systems.
- All Ambulances are equipped with In-Motion and Utility Rocket Gateway Technology.
- All Electronic Patient Care Reports utilizing Panasonic Toughbooks.
- In house billing and collections.
- Highly Trained and Well Compensated Staff.
- NEMSIS Gold Compliant Software.

### EMERGENCY 911

A.T.S. has the experience and expertise at providing contracted 911 services to Counties and Municipalities. A.T.S.' highly trained staff operates a state-of-the-art fleet in the communities we serve. A.T.S. has a solid record of response time compliance and adherence to contracted standards.



### NON-EMERGENCY TRANSPORTS:

Not all medical transport situations call for emergency lights and sirens. Many patients – particularly long-term care patients – require medical transportation for non-emergency situations such as pre-scheduled transfers between hospital and rehabilitation facilities. While these ambulance transports call for expert medical care, they generally do not require the emergency level response provided under a 911 scenario.

That's why A.T.S. offers a full spectrum of general medical transportation options that represent different degrees of medical attention and sophistication – each provided in accordance with our patient's conditions and medical needs.

We also strive to ensure our non-emergency, pre-scheduled medical transportation services are easy to access, with specially trained communications dispatchers ready 24 hours a day to provide the most appropriate ambulance transportation for each patient.

By providing a variety of transportation options, A.T.S. can add value to the operations of hospitals, long-term care facilities, healthcare maintenance organizations, and other managed care providers as a "gatekeeper" of ambulance services. We offer a full range of services to ensure patients receive the most appropriate assistance and care.

### CRITICAL CARE TRANSPORT:

A.T.S. Medical Services developed a Critical Care Transport Team concept to address the growing need among hospitals for highly specialized inter-facility transport services to patients who need care beyond the scope of practice of a regular paramedic. This program is designed to provide continuous intensive care to critically ill patients requiring transport from one location to another. CCT is based on the Emergency Medical Treatment & Active Labor Act (EMTALA) rules and regulations.

Specialized equipment has been added to paramedic ambulances to assure ICU level continuity of care in Monitoring & treatment. Specialized Critical Care equipment includes:

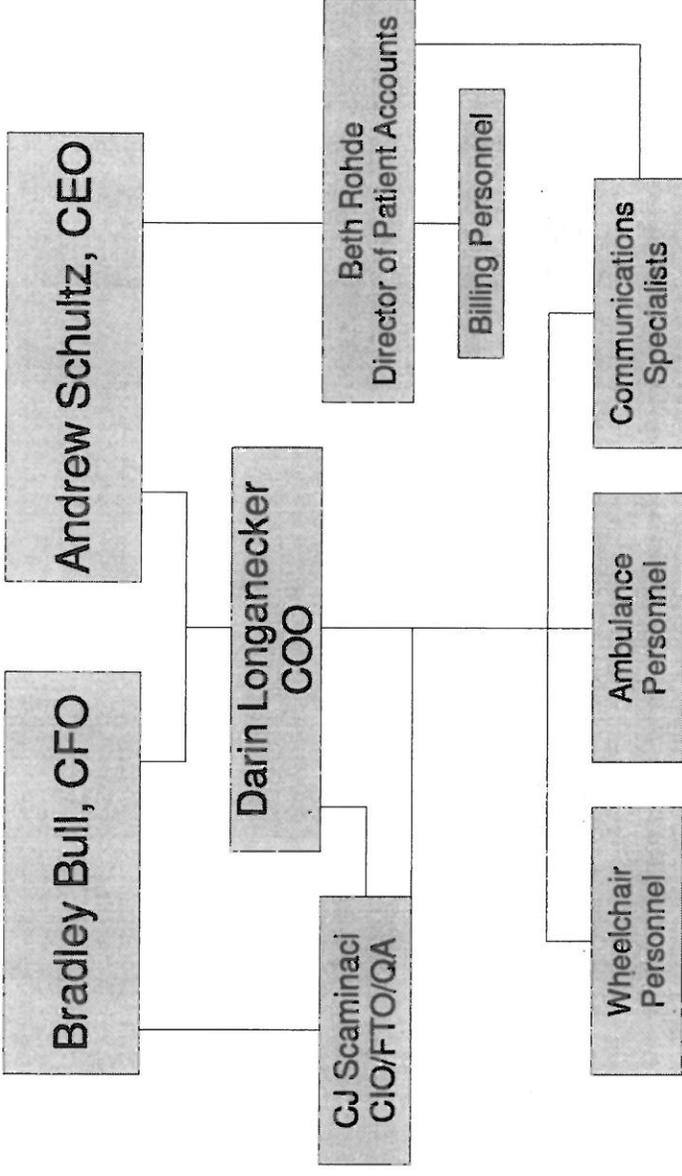
- Impact EMV+ Volume/Pressure Support Ventilator
- 12 Lead EKG Monitor/Defibrillators with End Tidal CO2
- Medsystem 3 Infusion Pump
- Sedative Medications
- Pain Management Medications
- Vasopressor Medications

### CONTACT INFORMATION:

A.T.S. Medical Services, Inc / Priority One EMS  
Corporate Office  
6419 Material Avenue  
Loves Park, Illinois 61111  
815-963-5001 Illinois Dispatch  
317-542-1111 Indiana Dispatch  
815-639-9521 Fax

[www.priorityoneems.net](http://www.priorityoneems.net)  
[www.atsambulance.com](http://www.atsambulance.com)

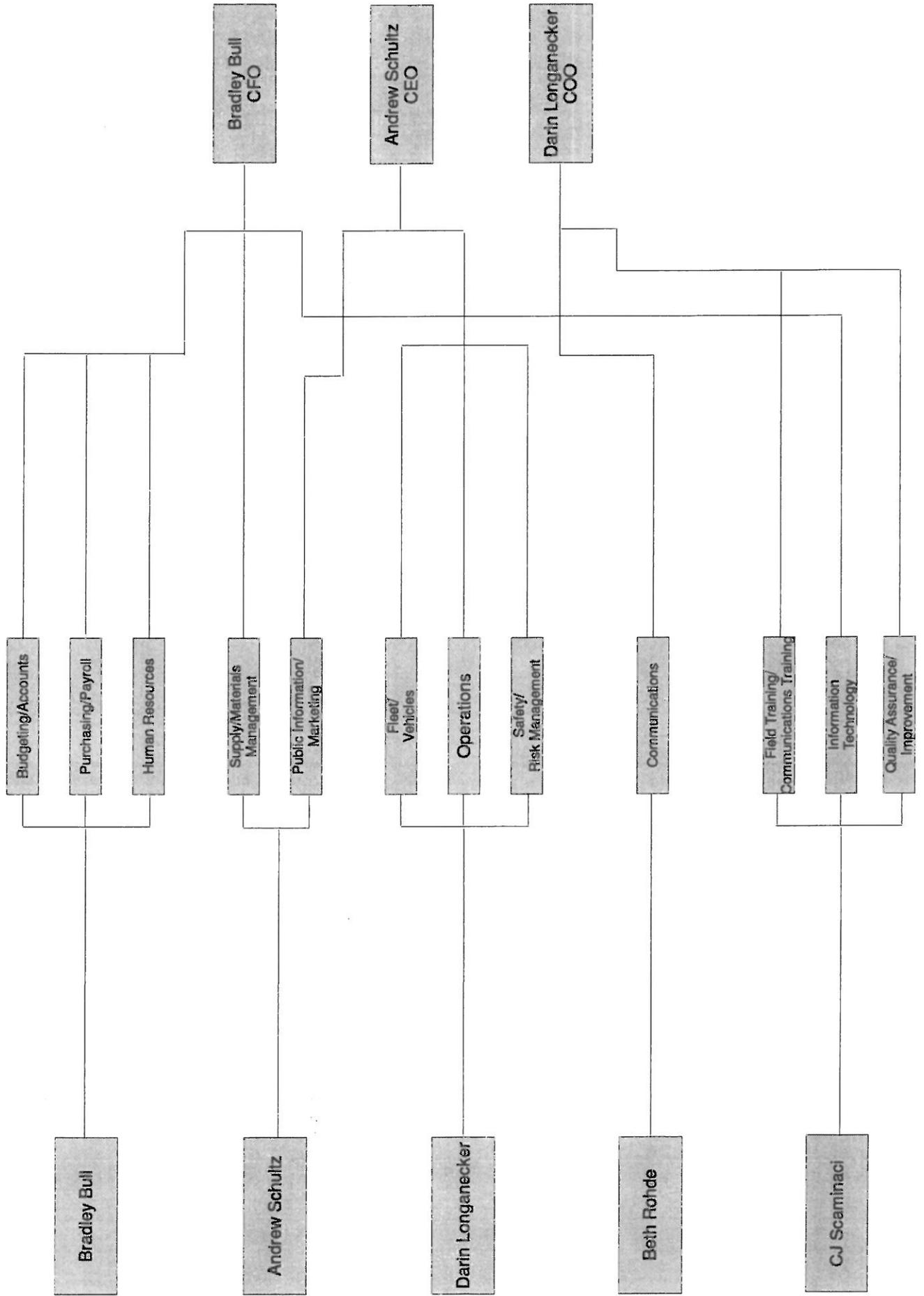




Person

Additional Duties

Reports To



## **Brad Bull**

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**From:** Kim Meyer [kimm@brinsurance.net]  
**Sent:** Tuesday, April 05, 2011 8:48 AM  
**To:** Brad Bull  
**Cc:** 'Mark Koch'  
**Subject:** FW: AM Best Rating - Empire and Zurich and United States Liab. Ins. Co. - ATS Medical Services

We really don't have any bond line setup for you – only bond is for your ERISA. Empire has the Package which includes Prop/Liab/Equipment Floater/Auto Zurich is the Work Comp United States Liab is the Employment Practices American Guarantee and Liab is the Umb and it is part of Zurich

If there is anything else that you need, please let me know.

**\* Please note new email address effective immediately! [kimm@brinsurance.net](mailto:kimm@brinsurance.net)**

Kim L. Meyer, CISR  
BETH & RUDNICKI INSURANCE AGENCY, INC.  
5411 E. State St., Suite 204  
Rockford, IL 61108  
P 815.399.6690  
F 815.399.6689

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# Best's Rating Center

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**Search Results**    Page 1 of 1    Results Per Page | 20

1 Rated or non-Rated companies found, results sorted by Company Name  
 Criteria Used: Company Name: Company names starting with Empire Fire and Marine  
 To refine your search, please use our [Advanced Search](#) or view our [Online Help](#) for more information.

[New Search](#) | [Empire Fire and Marine](#)    View results starting with: [A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#)    [Reset](#)

Company Information		Financial Strength Ratings		Issuer Credit Ratings			
AMB#	Company Name	Rating	Outlook / Implication	Long-Term	Outlook / Implication	Short-Term	Domicile
002147	<a href="#">Empire Fire and Marine Insurance Company</a> <small>Insurance - Property/Casualty (Operating Company)</small>	A+	Stable	aa-	Stable		US: Nebraska

**Note:** Financial Strength Ratings as of 04/05/2011 09:23 A.M.E.S.T.  
 † Financial Strength Ratings (FSR) are sometimes assigned to Property/Casualty - A.M. Best Consolidated Groups. Please note that Life/Health - A.M. Best Consolidated Gro and Company Consolidated Financial Statements are not assigned FSR ratings.

\* Denotes Under Review [Best's Ratings](#)  
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[Search Results](#) Page 1 of 1 Results Per Page 20

2 Rated or non-Rated companies found, results sorted by Company Name  
 Criteria Used: Company Name: Company names starting with zurich american insurance  
 To refine your search, please use our [Advanced Search](#) or view our [Online Help](#) for more information.

Company Information		Financial Strength Ratings		Issuer Credit Ratings		Outlook / Implication	
AMIB#	Company Name	Rating	Outlook / Implication	Long-Term	Short-Term	Outlook / Implication	Domicile
002563	Zurich American Insurance Company Insurance - Property/Casualty (Operating Company)	A+	Stable	aa-	aa-	Stable	US: New York
003565	Zurich American Insurance Company of IL Insurance - Property/Casualty (Operating Company)	A+	Stable	aa-	aa-	Stable	US: Illinois

Note: Financial Strength Ratings as of 04/05/2011 09:29 AM E.S.T.  
 Financial Strength Ratings (FSR) are sometimes assigned to Property/Casualty - A.M. Best Consolidated Groups. Please note that Life/Health - A.M. Best Consolidated Groups and Company Consolidated Financial Statements are not assigned FSR ratings.  
 \* Denotes Under Review [Best's Ratings](#)  
 Visit [Best's Rating Center](#) for a complete overview of our rating process and methodologies.

Rating Center

**Search Results** Page 1 of 1 Results Per Page 20

2 Rated or non-Rated companies found, results sorted by Company Name  
 Criteria Used: Company Name: Company names starting with United States Liability

Please note: information was found regarding the following company name change: 002541 United States Liability Insurance Company of Philadelphia was changed to 002541 United States Liability Insurance Company on 10/3/2007. Information on name changes, mergers, liquidations, and more is available in [Best's Corporate Changes and Retirements](#) database.

To refine your search, please use our [Advanced Search](#) or view our [Online Help](#) for more information.

New Search  [View results starting with: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z](#) [Reset](#)

Company Information		Financial Strength Ratings		Issuer Credit Ratings		Outlook/ Implication		Short-Term		Domicile	
AMB#	Company Name	Rating	Outlook / Implication	Long-Term	Outlook/ Implication	Short-Term	Short-Term	Short-Term	Short-Term	Short-Term	Domicile
002541	United States Liability Insurance Co Insurance - Fire/Property/Casualty (Cooperating Company)	A++	Stable	aa+	Stable	Stable	Stable	Stable	Stable	Stable	US: Pennsylvania
000936	United States Liability Insurance Group Insurance - Fire/Property/Casualty (Data Consolidation - A.M. Best Consolidated Sub-Group)	A++	Stable	aa+	Stable	Stable	Stable	Stable	Stable	Stable	US: Pennsylvania

Note: Financial Strength Ratings as of 04/05/2011 09:23 AM E.S.T.



# CERTIFICATE OF LIABILITY INSURANCE

OP ID KM  
ATSME-1

DATE (MM/DD/YYYY)

06/30/10

<b>PRODUCER</b> Beth & Rudnicki Insurance Agency, Inc. 5411 E. State Street, Ste 204 Rockford IL 61108 Phone: 815-399-6690 Fax: 815-399-6689	<b>THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.</b>	
	<b>INSURERS AFFORDING COVERAGE</b>	<b>NAIC #</b>
<b>INSURED</b>  A. T. S. Medical Services, Inc. 6419 Material Ave P O Box 2549 Loves Park IL 61132	INSURER A: Empire Fire & Marine Insurance	
	INSURER B: American Guarantee and Liab	
	INSURER C: United States Liability Ins Co	
	INSURER D: Zurich American Ins. Co.	
	INSURER E:	

## COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L LTR	INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
A	<b>GENERAL LIABILITY</b> <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR  <input checked="" type="checkbox"/> Professional Liab GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	CL317665	07/01/10	07/01/11	EACH OCCURRENCE \$ 1,000,000
					DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000
					MED EXP (Any one person) \$ 5,000
					PERSONAL & ADV INJURY \$ 1,000,000
					GENERAL AGGREGATE \$ 3,000,000
					PRODUCTS - COMPI/OP AGG \$ 3,000,000
A	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	CL317664	07/01/10	07/01/11	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
					BODILY INJURY (Per person) \$
					BODILY INJURY (Per accident) \$
					PROPERTY DAMAGE (Per accident) \$
	<b>GARAGE LIABILITY</b> <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$
					OTHER THAN AUTO ONLY: EA ACC \$
					AGG \$
B	<b>EXCESS / UMBRELLA LIABILITY</b> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE  <input type="checkbox"/> DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$10000	AUC9267722-00	07/01/10	07/01/11	EACH OCCURRENCE \$ 2,000,000
					AGGREGATE \$ 2,000,000
					\$
					\$
					\$
D	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> If yes, describe under SPECIAL PROVISIONS below	WC09595654-00	05/30/10	05/30/11	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER
					E.L. EACH ACCIDENT \$ 100000
					E.L. DISEASE - EA EMPLOYEE \$ 100000
					E.L. DISEASE - POLICY LIMIT \$ 500000
C	<b>OTHER</b> EPLI	EPL1018773	07/01/10	07/01/11	EPLI 1000000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Re: Contract#HSFEHQ-07-D-0589. Federal Emergency Management Agency is listed as an additional insured ATIMA.

## CERTIFICATE HOLDER

<b>FEDEREM</b>  Federal Emergency Management Agency/Office of the Chief of Procurement Officer 500 C Street, S.W. PP 5th Floor Washington DC 20472
--

## CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE <i>Mark Koch</i>
--

ACORD 25 (2009/01)

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## Brad Bull

---

**From:** Brad Bull  
**Sent:** Sunday, April 03, 2011 4:26 PM  
**To:** TCellitti@rhsnet.org  
**Cc:** Andy Schultz  
**Subject:** Letter of Good Standing

Tony,

The City of Rockford has a request for information that they have distributed. We are in the process of completing their request. As part of the process, they are requesting a letter of "Good Standing" from our current EMS System. Would it be possible to get a letter from you either Monday or Tuesday?

Brad

## Brad Bull

---

**From:** Brad Bull  
**Sent:** Monday, April 04, 2011 9:07 AM  
**To:** 'Cellitti, Tony'  
**Subject:** Rockford RFI; Letter of Good Standing  
**Attachments:** rfd rfi.pdf

Tony,

See specifically page 9, section 2.1.9 for the letter of Good Standing request.

RFI number and address information is on page 1. Please send original to the city and a copy to me via email.

Bradley Bull, CFO, BS, NREMT-P, CCEMT-P

ATS Medical Services, Inc.  
6419 Material Ave.  
Loves Park, IL 61111

815.963.5001 office (IL)  
317.542.1111 office (IN)  
815.639.9521 fax  
815.739.7921 cell

[bbull@atsambulance.com](mailto:bbull@atsambulance.com)  
[bbull@priorityoneems.net](mailto:bbull@priorityoneems.net)  
[www.atsambulance.com](http://www.atsambulance.com)  
[www.priorityoneems.net](http://www.priorityoneems.net)

This electronic mail message is intended only for the use of the person or entity to whom it is addressed and may contain information that is privileged, confidential, and/or exempt from disclosure. The information intended only for the individual or entity named as Addressee above and subject to the Standards for Privacy of Individual Health Information, (45 CFR Parts 160 & 164). Distribution or copying by anyone other than the intended recipient is expressly prohibited. If you receive this message in error, please call ATS Medical Services 815.963.5001 to notify us promptly and then destroy/delete this communication and any copies thereof. If you are the intended recipient of this message and the transmission you received was incomplete or illegible, please contact me at 815.963.5001. Thank you.

### Application Phase

1. Online Application ( if they filled one out )
2. Company Application with signed last page
3. Copies of Certs ( including FF certs and no hand written cards)
4. Resume ( reference phone numbers )
5. Interview Notes form
6. Company Entrance Exam

### Job Offer Phase

7. Second interview ( 2 Managers or a Peer interview )
8. Job Offer Letter ( signed copy scanned to file )
9. PIC form filled out for new applicant
10. Background check ( copy printed and scanned to file )
11. Uniform form filled out and signed ( by a manager )
12. Videos ( Cot/Thomco/Documentation/Phillips )

### Post Background check and accepted position Phase

13. Handbook to new employee ( signature page scanned to file )
14. Tax forms ( State and Federal )
15. I9 form ( copy of DL and Soc Sec card )
16. Payroll forms ( copy of voided check )
17. Health Ins. Packet

18. EMS Data form ( schedule entry exam if not in region 1 or RRREMS )
19. Hep-B form and TB ( proof if already have )
20. Letter of good standing and proof of intubations ( for Paramedics )

### Orientation Phase

( Day 1 )

21. New Hire Orientation Packet ( assign to a preceptor )
22. User name/Password/Fuel Card/Domain/Email/CAD/Billing/PCR/Scheduler
23. Overview of Net-Scheduler
24. PCR software overview
25. State Inspection of an Ambulance
26. Slide presentation of EVOC and written test ( driving portion to be scheduled )
27. Hospital visit for parking/Report room/restocking
28. Protocol Review
29. Radio Operations
30. Department Introductions and explanation of department duties
31. Phone numbers to Dispatch and Managers

### Orientation Phase

( Day 2 )

32. 25 Pt. contacts, 5 Emergent driving calls, 10 PCR reports ( for Completion )
33. Map reading review, Facility overview and quizzing

## Orientation Phase

( Day 1 )

1. New Hire Orientation Packet ( assign to a preceptor )
2. User name/Password/Fuel Card/Domain/Email/CAD/Billing/PCR/Scheduler
3. Overview of Net-Scheduler
4. PCR software overview
5. State Inspection of an Ambulance
6. Slide presentation of EVOG and written test ( driving portion to be scheduled )
7. Hospital visit for parking/Report room/restocking
8. Protocol Review
9. Radio Operations
10. Department Introductions and explanation of department duties
11. Phone numbers to Dispatch and Managers

## Orientation Phase

( Day 2 )

12. 25 Pt. contacts, 5 Emergent driving calls, 10 PCR reports ( for Completion )
13. Map reading review, Facility overview and quizzing
14. Hands-on training with preceptor



## New Field Employee Orientation Checklist

Employee Information			
Name:		Start date:	
Position:		Manager:	
Administrative Procedure			
<input type="checkbox"/> Complete New Employee Paperwork Packet, <input type="checkbox"/> Assign Field Training Officer. <input type="checkbox"/> Review key policies. <input type="checkbox"/> Picture ID Badge. <input type="checkbox"/> Time Clock Setup. <input type="checkbox"/> Computer Login for CAD/Reporting.			
Introduction to ATS Medical Services, Inc.			
<input type="checkbox"/> Give introductions to department staff and key personnel during tour.			
<input type="checkbox"/> Tour of facility including:	<ul style="list-style-type: none"> <li>• Restrooms</li> <li>• Mail Drop Off</li> <li>• Copy/Fax Machine</li> </ul>	<ul style="list-style-type: none"> <li>• Bulletin board</li> <li>• Parking</li> <li>• Printers</li> </ul>	<ul style="list-style-type: none"> <li>• Kitchen</li> <li>• Vending machines</li> <li>• Bedroom and Dayroom</li> </ul>
Position Information			
<input type="checkbox"/> Review initial job assignments and training plans. <input type="checkbox"/> Review job description and performance expectations and standards. <input type="checkbox"/> Review job schedule and hours. <input type="checkbox"/> Review system protocols.			
Computers			
<input type="checkbox"/> Info Tech Review.	<ul style="list-style-type: none"> <li>• E-mail</li> <li>• Schedules</li> <li>• Time Clock</li> </ul>	<ul style="list-style-type: none"> <li>• Internet Use</li> <li>• Data on shared drives</li> <li>• Mobicad</li> </ul>	
Verification of Completion			
Trainee:		Date:	
Trainer:		Date:	



**Online Training**

**Vehicle Operations**

- NETSPAP Online Training Completion.
- Thomco Online Training Completion.
- ATS Emergency Vehicle Operations Course.
- ATS Emergency Vehicle Operations Practical Driving Course.

**Stryker Equipment Use**

- Review Stryker Stair Chair Multimedia.
- Complete Stryker Stair Chair Operation Test.
- Review Stryker MXPro Multimedia.
- Complete Stryker MXPro Operation Test.

**Phillips HeartStart MRX Use**

- Register for Phillips HeartStart Training Account.
- Complete Phillips HeartStart Training Modules.
- Complete Phillips HeartStart Module Test with 70% or better score.
- Complete in-house 12-lead training.

**Corporate University Training**

- Radio Communications
  - Map Reading
  - NIMS 100                       NIMS 200
  - NIMS 700                       NIMS 800
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Annual OSHA<br>Online Training | <ul style="list-style-type: none"> <li>• Blood-borne Pathogens</li> <li>• Cylinder Safety</li> <li>• Egress Fire Protection</li> </ul> | <ul style="list-style-type: none"> <li>• Accident Investigation</li> <li>• Workplace Violence</li> <li>• Hazard Communication</li> </ul> |
|---|--|--|

**Verification of Completion**

Trainee:	Date:
Trainer:	Date:



## Practical Training

### Ambulance Knowledge

- Location of Supplies in Exterior Compartments.
- Location of Supplies in Interior Compartments.
- Location of Main Battery Power Switch.
- Proper Procedure for starting the Ambulance and Checking Gauges.
- Emergency Lighting and Siren Switchboard Operation and Rear Module Switch.
- Proper Fueling Procedure.
- Proper Parking Areas and Shoreline Use.

### Medicar Knowledge

- |   |   |
|---|---|
| <input type="checkbox"/> Medicar Pre-shift Check.         | <input type="checkbox"/> Proper Fueling Procedure.                              |
| <input type="checkbox"/> Braun Wheelchair Lift Operation. | <input type="checkbox"/> Proper Paperwork Procedure.                            |
| <input type="checkbox"/> Proper Q-Straint Tie-Down Use.   | (Knows where to find paperwork, how to fill it out and when to get a signature) |

### Hospital Knowledge

- Knows the Rockford Memorial Hospital Entrances and Restock Procedures.
- Knows Swedish American Hospital Entrances and Restock Procedures.
- Knows St Anthony Medical Center Entrances and Restock Procedures.
- Knows Beloit Memorial Hospital Entrances and Restock Procedures. (Durand and R)
- Knows Monroe Clinic Entrances and Restock Procedures. (Durand)

### Final Training Day Double Check

- Understands how to use Net-Scheduler.
- Understands crew change procedure.
- Understands how to do a complete truck check.
- Knows where the supplies are located in all ambulances.
- Understands ATS paperwork including how and when to use the forms.
- Understands how to use the portable and mobile radios.

### Verification of Completion

Trainee:	Date:
Trainer:	Date:





Practical – Patient Care				
Run Number	Run Type	Emergent	Non-Emergent	Satisfactory
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Verification of Completion	
Trainee:	Date:
Trainer:	Date:



Field Training Officer Daily Comments		
Employee Attribute	Satisfactory	Needs Improvement
Personal Appearance	<input type="checkbox"/>	<input type="checkbox"/>
Uniform Appearance	<input type="checkbox"/>	<input type="checkbox"/>
Cleanliness	<input type="checkbox"/>	<input type="checkbox"/>
Attitude	<input type="checkbox"/>	<input type="checkbox"/>
Willingness to Learn	<input type="checkbox"/>	<input type="checkbox"/>
Bed Side Manor	<input type="checkbox"/>	<input type="checkbox"/>
Customer Service	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrated Medical Knowledge	<input type="checkbox"/>	<input type="checkbox"/>
Daily Tasks Completed Timely	<input type="checkbox"/>	<input type="checkbox"/>

Field Training Officer Written Comments

Trainee Written Comments

Verification of Completion	
Trainee:	Date:
Trainer:	Date:

Add Edit Delete Detail Summary Import Timeoff Credentials Documents

Info Select An Employee Profile From The Employee List to Edit

(A=Active, L=LOA, N=Inactive, X=Terminated) Quick Lookup

Filter List

Employees Bull, Bradley A (A)

Active

Personal Profile

Save Profile

Employee ID 6892

Home Phone ( 815 ) 739 - 7921

Status  Active  LOA  InActive  Terminated

Work Phone ( 815 ) 963 - 6885

First Name MI Last Name [Info](#)

Pager ( ) -

Name Bradley A Bull

Pager Service Verizon (vtext.com)

SSN -

Cell Phone ( 815 ) 739 - 7921

Date of Birth

Emergency Phone ( 815 ) 739 - 7910

Employee Note

Emergency Contact Katie Bull

Address 11578 Comly Road

EEmail Address bbull@atsambulance.com

City Winnebago

Employee Class Admin - No PTO

State IL

Zip 610550088

Photo

Upload Photo

Notes

Date/Time

Entered By

Note

Add Note

Professional Profile

Last Logged In Monday, April 04, 2011 -- 9:20:33 AM

Pay Rates [Edit List](#)

Include In Payroll?  Yes  No  Leased

Rate Category Qualification Cost Center Rate

Hire Status Full Time

Full Time Hire Date 6/1/2005

Qualifications [Edit List](#)

Hire Date 6/1/2005

Qualification

Termination Date

IL Expanded Scope Paramedic

Home Cost Center 001 - Rockford Ambulance

Dispatcher II

Pay Rate 0 Pay Type Bi-Weekly

Billing Analyst

User Groups Basic

Admin

Full

Medicar

Supervisor Groups

Certifications [Edit List](#)

Message Groups IL Employee's  
Rockford Admin  
Rockford Crews

Certification	Number	Effective Date	Expires
ACLS	N/A		11/30/2011
ACLS Instructor	N/A		11/30/2011
AMLS	N/A		7/31/2013
BCLS/BLS CPR	N/A		5/31/2011
BCLS/BLS CPR Instructor	N/A		5/31/2011
CAC	CAC00002870		5/27/2012
Critical Care Paramedic/CCEMTP	56504		3/4/2013
EMD	1045426		6/30/2012
EMT - P	902866		4/30/2014
EVOC Instructor	N/A		9/9/9999
Firefighter II	N/A		9/9/9999
HazMat First Responder Awareness	N/A		9/9/9999
ICS 100 / NIMS 100	N/A		9/9/9999
ICS 200 / NIMS 200	N/A		9/9/9999
ICS 300 / NIMS 300	N/A		9/9/9999
ICS 400 / NIMS 400	N/A		9/9/9999
ICS 700 / NIMS 700	N/A		9/9/9999
ICS 800 / NIMS 800	N/A		9/9/9999
Illinois Emergency Medical Dispatcher (EMD)	000902866		7/31/2014
ITLS	N/A		8/30/2011
ITLS Instructor	N/A		11/30/2011
NREMT - Paramedic	P8052469		3/31/2013
PALS	N/A		1/31/2012
PALS Instructor	N/A		1/31/2012
PHTLS	N/A		8/31/2011
PSID	6310-8110		9/9/9999
State Drivers License	B400-0618-2170		6/15/2012

Save Profile

## View My Education Record

▼ Show Page Description

In Process Courses	Completed Courses	Credentials	Forms
<b>Credentials</b>			
Certification	View Activity	Expiration Date	Document
ACLS		11/30/2011	 (462.34 KB)
ACLS Instructor		11/30/2011	 (462.34 KB)
AMLS		7/31/2013	 (462.34 KB)
BCLS/BLS/CPR		5/31/2011	 (462.34 KB)
BCLS/BLS/CPR Instructor		5/31/2011	 (152.69 KB)
CAC (Company defined)		5/27/2012	 (282.79 KB)
Critical Care Paramedic/CCEMTP		3/4/2013	 (204.81 KB)
EMD		6/30/2012	 (74.52 KB)
Illinois: EMT - P		4/30/2014	 (286.91 KB)
EVOC Instructor			 (420.82 KB)
Firefighter II			 (616.44 KB)
HazMat First Responder Awareness			 (616.44 KB)
ICS 100 / NIMS 100			 (677.58 KB)
ICS 200 / NIMS 200			 (677.58 KB)
ICS 300 / NIMS 300			 (677.58 KB)
ICS 400 / NIMS 400			 (677.58 KB)
ICS 700 / NIMS 700			 (677.58 KB)
ICS 800 / NIMS 800			 (677.58 KB)
Illinois: Illinois Emergency Medical Dispatcher (EMD)		7/31/2014	 (285.55 KB)
ITLS		8/30/2011	 (1.09 MB)
ITLS Instructor		11/30/2011	 (523.57 KB)
NREMT - Paramedic	 	3/31/2013	 (64.49 KB)
PALS		1/31/2012	 (462.34 KB)
PALS Instructor		1/31/2012	 (462.34 KB)
PSID (Indianapolis defined)			 (299.93 KB)
State Drivers License: Illinois		6/15/2012	 (152.69 KB)

⏪ < 1 > ⏩ Page size: 50 ▾

26 items in 1 pages

To view the National Registry Re-registration worksheet, click on the  icon.

**Info** Welcome to ePro Scheduler. Make a selection to begin.

ATS Medical Services/Staffing	
<p><b>ePro Scheduler Statistics</b></p> <p>Pay Period 8 - 3/28/2011 - 4/10/2011</p> <p>Active Employees 79</p> <p>Open Shifts 3</p> <p>Pending Pickup Requests 0</p> <p>Pending Shift Swaps 10</p> <p>Pending Timeoff Requests 1</p> <p>Active Units 34</p> <p>Staffing Templates 67</p>	Winnebago, IL
<b>Certification Warnings</b>	
	Your BCLS/BLS/CPR certification expires in 57 days. Resolve soon.
	Your BCLS/BLS/CPR Instructor certification expires in 57 days. Resolve soon.
<b>Messages and Notifications</b>	
<u>Posted</u>	<u>Message</u>
<u>Message Center</u>	
Total Messages: 14	

## View My Education Record

▼ Show Page Description

In Process Courses	Completed Courses	Credentials	Forms	
<b>Completed Courses</b>				
Course	Registered	Exam Start	Completion Date	Online Course
BBP 2011			2/28/2011	No
Blood Borne Pathogens			1/25/2010	No
Bloodborne Pathogens	2/28/2011 3:49:06 PM	3/11/2011 2:47:06 PM	3/11/2011 2:51:09 PM	Yes
Bloodborne Pathogens	3/27/2011 11:23:59 AM	3/27/2011 12:19:36 PM	3/27/2011 12:23:08 PM	Yes
EIR - Emergency Incident Rehab			7/26/2010	No
EMS Billing - Do It Yourself or Outsource?	10/22/2010 3:07:58 PM	10/22/2010 3:09:50 PM	10/22/2010 3:10:39 PM	Yes
EVOC 5.2010			5/23/2010	No
Geriatrics			9/27/2010	No
Illinois State Ambulance Association 2010 Conference			9/23/2010	No
Pediatrics Con Ed			8/23/2010	No
Pharmacology Con Ed			10/25/2010	No
REDS Exercise			9/16/2010	No



Page size: 20 ▼

12 items in 1 pages

## View Certification Activity Record

▼ Show Page Description

[Back To Individual Record](#)

**Individual:** Bradley Bull

**Certification:** Illinois: EMT - P (4/30/2010 - 4/30/2014)

**Required Credits:** 120

**Period:** Four (4) years

### Requirements

Category	Media	Minimum Credit	Maximum Credit	Earned	Need
EMT Paramedic USDOT National Standard Curriculum		120	0	47	73
<b>Category Credit Total:</b>				<b>47</b>	<b>73</b>

### Completed Courses

Course	Completion Date	Category	Media	Credits
BBP 2011	2/28/2011	EMT Paramedic USDOT National Standard Curriculum		2
EIR - Emergency Incident Rehab	7/26/2010	EMT Paramedic USDOT National Standard Curriculum		3
EVOG 5.2010	5/23/2010	EMT Paramedic USDOT National Standard Curriculum		16
Geriatrics	9/27/2010	EMT Paramedic USDOT National Standard Curriculum		2
Illinois State Ambulance Association 2010 Conference	9/23/2010	EMT Paramedic USDOT National Standard Curriculum		12
Pediatrics Con Ed	8/23/2010	EMT Paramedic USDOT National Standard Curriculum		4
Pharmacology Con Ed	10/25/2010	EMT Paramedic USDOT National Standard Curriculum		2
REDS Exercise	9/16/2010	EMT Paramedic USDOT National Standard Curriculum		6

Page size: 20  8 items in 1 pages

Categories in red will not earn new credit because credit has already been earned.

## Submit An Incident

▼ Show Page Description

[Back to Dashboard](#)

[Save](#)

◆ Incident Type:

◆ Date of Incident:

Case/Run Number:

Unit:

Location:

Incident Notes:

- Employees Involved:
- Assereto, Midian
  - Baldoni-Lake, Ramona
  - Blankenship, Cody
  - Brahmstedt, Adam
  - Branney, Shaun
  - Brown, Gary
  - Brule, Patrick

### Documents

Number of Documents:

## Setup

▼ Show Page Description

Incidents	Custom Incident Types	Dropdowns	Preferences	Statement	Plans	U Define Alerts
Security						
Incident Types	Security	Alerts				

Save

### Employee Submission Options

- Allow Employee Submission:  Yes  No
- Allow Employee to Select Incident Type:  Yes  No
- Allow Anonymous Submission:  Yes  No
- Allow Document Attachment to Submissions:  Yes  No

### Select Incident Types

Incident Type	
<input checked="" type="checkbox"/>	Commendation
<input checked="" type="checkbox"/>	Complaint
<input checked="" type="checkbox"/>	Crew Conflict
<input checked="" type="checkbox"/>	Documentation
<input checked="" type="checkbox"/>	Employee Injury
<input checked="" type="checkbox"/>	Equipment
<input checked="" type="checkbox"/>	Equipment Failure
<input checked="" type="checkbox"/>	General Issue
<input checked="" type="checkbox"/>	Item Found
<input checked="" type="checkbox"/>	Item Lost
<input checked="" type="checkbox"/>	Medication Error
<input checked="" type="checkbox"/>	Patient Care/Run Report
<input checked="" type="checkbox"/>	Patient Injury
<input checked="" type="checkbox"/>	Policy Issue
<input checked="" type="checkbox"/>	Procedure Issue
<input checked="" type="checkbox"/>	Protocol Issue
<input checked="" type="checkbox"/>	Treatment Issue
<input checked="" type="checkbox"/>	Uniform & Appearance
<input checked="" type="checkbox"/>	Vehicle Issue

designates a custom incident type

Employee	Date.of.Hire	Years/Months with ATS	Years As Paramedic
SCHULTZ, ROBERT W.	10/16/2006	4 years 6 months	10
ROMINE, SCOTT D.	1/17/2007	4 years 3 months	5
STIEN, JEFFREY R.	1/26/2007	4 years 3 months	15
EBANY, ROBBY L.	3/27/2007	4 years 1 months	12
LYNCH, STEPHANIE L.	5/23/2007	3 years 11 months	RN
VON SCHROTT, NICHOLAS G.	6/27/2007	3 years 10 months	3
SPHATT, TIMOTHY M.	7/20/2007	3 years 9 months	2
LEONARD, GREGORY J.	1/21/2008	3 years 3 months	5
CAMERON, STEVEN J.	1/28/2008	3 years 3 months	5
KISER, MARY E.	6/11/2008	2 years 10 months	RN
SORENSEN, JEFFERY A.	7/16/2008	2 years 9 months	8
EWERS, DANIEL	8/6/2008	2 years 8 months	3
SCHEIDER JR, WILLIAM C.	9/3/2008	2 years 7 months	15
DOBSON, KATHLEEN M.	11/5/2008	2 years 5 months	15
CRAWFORD JR, DON D.	12/8/2008	2 years 4 months	18
MORGART, JAMES R.	4/30/2009	2 years 0 months	3
MAXWELL, AMBER L.	6/1/2009	1 years 10 months	5
BALDONI-LAKE, RAMONA L.	7/23/2009	1 years 9 months	5
FORD, DEVYN	6/1/2010	0 years 10 months	1
PITEL, THOMAS E.	9/20/2010	0 years 7 months	1

✦ Staffing + Rockford

Employee	Date.of.Hire	Years/Months with Co	Years as Paramedic
SCHULTZ, ANDREW T.	4/26/2005	6 years 0 months	25
BULL, BRADLEY A.	6/1/2005	5 years 10 months	10
MULLINS, CHARLES E.	6/27/2005	5 years 10 months	14
SELL, JON P.	10/23/2005	5 years 6 months	7
LONGANECKER, DARIN	5/15/2007	3 years 11 months	15
PRIGNANO, ANTHONY M.	8/14/2008	2 years 8 months	0.33
BROWN, GARY D.	8/17/2009	1 years 8 months	9
COMBS, JAMES H.	2/16/2010	1 years 2 months	25
SHERIDAN, DANIELLE A.	6/1/2010	0 years 10 months	0.25
SCAMINACI, CHRISTOPHER J.	6/21/2010	0 years 10 months	1
BERGSTROM, RHONDA	1/4/2011	0 years 3 months	RN
QUINN, EVAN M.	1/18/2011	0 years 3 months	0.5

\* Primary Rockford

## Brad Bull

---

**From:** Brad Bull  
**Sent:** Monday, April 04, 2011 5:57 PM  
**To:** 'Cellitti, Tony'  
**Subject:** Addiional RFI request

Tony,

Section 2.2.3 on page 9 also asks for us to “provide letter of confirmation that all of vendor’s EMS providers are in good standing within their EMS System and IDPH.” Can you please send an original to the City and a copy to me as well?

Thanks,

Bradley Bull, CFO, BS, NREMT-P, CCEMT-P

ATS Medical Services, Inc.  
6419 Material Ave.  
Loves Park, IL 61111

815.963.5001 office (IL)  
317.542.1111 office (IN)  
815.639.9521 fax  
815.739.7921 cell

[bbull@atsambulance.com](mailto:bbull@atsambulance.com)  
[bbull@priorityoneems.net](mailto:bbull@priorityoneems.net)  
[www.atsambulance.com](http://www.atsambulance.com)  
[www.priorityoneems.net](http://www.priorityoneems.net)

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# EMSAR Equipment Report - WO 00040978

Report No. 00059435

**Customer**  
A.T.S MEDICAL SERVICES  
**Address**  
ATS MEDICAL SERVICE  
6419 MATERIAL AVE  
LOVES PARK  
IL

Phone: 6082 MX PRO  
Model: 011739309  
Serial: 011739309  
AssetID:

Truck: 4/18/2010  
Date: BYRON SHORT  
Tech: Reason for Call:

- Scheduled Maintenance
- On Demand Service
- Warranty

**Customer Evaluation of Product:**  
pm only

**Accessories Evaluation:**

Pass	Fail	N/A
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Product Disinfection Complete**

**Usage Evaluation**

Normal	Heavy	Abuse
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**UPDATES**

Pre Repair  GOOD  
Post Repair  Pass  
 Need Updates  Fail

**BACKREST/HEAD ASSEMBLY**

Pre Repair  Backrest Adj. Assy  
Post Repair  Pass  
 Frame Tubing  Fail  
 Gas Spring  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**DROP/TELESCOPE ASSEMBLY**

Pre Repair  Hinges  
Post Repair  Pass  
 Frame Tubing  Fail  
 Sleeves  
 Springs  
 Load Wheels  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**SHOCK & FOOTREST ASSEMBLY**

Pre Repair  Frame Tubing  
Post Repair  Pass  
 Castings  Fail  
 Supports  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**MAIN FRAME/SEAT ASSEMBLY**

Pre Repair  Frame Tubing  
Post Repair  Pass  
 Sheet Metal  Fail  
 Rod/Bearings  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**SIDE ARM ASSEMBLIES**

Pre Repair  Tubing  
Post Repair  Pass  
 Pin/Knob/Spring  Fail  
 Castings  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair  
 Right  Left  Both

**CONTROL ASSEMBLY**

Pre Repair  Handles  
Post Repair  Pass  
 Slides/Slide Covers  Fail  
 Actuator/Touchpad/Button  
 Battery/Charger/Indicator  
 Linkage/Release Bars/Cables  
 Ratchet Bars/Rack-System  
 Springs  
 Lock Pin Assembly  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**LEG ASSEMBLIES**

Pre Repair  Load Leg  
Post Repair  Pass  
 X-frame Tubing  Fail  
 Operator End Leg  
 Leg Braces  
 Scuff Strips/Tubes  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**LOWER FRAME ASSEMBLY**

Pre Repair  Tubing  
Post Repair  Pass  
 Corner Castings  Fail  
 Weldments  
 Rods/Bearings  
 Telescoping Frame  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**WHEEL ASSEMBLIES**

Pre Repair  Wheel  
Post Repair  Pass  
 Shank Pin  Fail  
 Shank Casting  
 Hardware/Lube  
 Bearings  
 Right  Left  Both

**FOOT END**

Wheel  
 Shank Pin  
 Shank Casting  
 Hardware/Lube  
 Bearings  
 Right  Left  Both  
 Not Applicable  
 GOOD  
 Needs Other Repair

**SAFETY LOCK ASSEMBLIES**

Pre Repair  Lock Levers  
Post Repair  Pass  
 Lock Bars  Fail  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

**FASTENER SYSTEM (Vehicle)**

Pre Repair  Tubing  
Post Repair  Pass  
 Springs  Fail  
 Castings  
 Latch/Release  
 Labels/Lube/Hardware  
 Not Applicable  
 GOOD  
 Needs Other Repair

S/N:

**ADDITIONAL COMMENTS**

**TECH EVALUATION**

Pre Repair  Pass  
Post Repair  Pass  
 Fail  
 Non-Repairable  
Equipment marked Fail must be repaired prior to returning it to service. All equipment should be regularly serviced.

**REPAIR ESTIMATE**

Parts:  
Labor:  
Tax:  
Total:

**CUSTOMER AUTHORIZATION**

- Yes, I authorize complete repair.
  - No, I do not authorize all repairs as recommended. If, after the repairs I authorize, the equipment remains in fair or unacceptable condition, I understand that the use of the equipment may cause serious injury or death.
  - No, I do not authorize any repair. I understand that the use of this equipment may cause serious injury or death.
- Note: For continued use of this equipment, the user should follow the manufacturer's suggested inspection procedures as outlined in the owner's/user's maintenance manual.

Customer Signature  
or Verbal OK by:

**Quality Assurance Evaluation**

- Cleaning and Lubrication Completed
- Rolling Pass
- Rolling Fail
- \*If Power Cot Check Both Modes
- Height Adjustment Pass
- Height Adjustment Fail
- Cycle Test - No Weight Pass
- Cycle Test - No Weight Fail
- Cycle Test - With Wgt (if reqd.) Pass
- Cycle Test - With Wgt (if reqd.) Fail With lbs. \*(id reqd)

**Acknowledgement of Repairs/Service**

The authorized repair/service work has been completed and the equipment was then evaluated.

*[Signature]*  
EMSAR Service Technician

## ATS Narcotic Log

◆ **ATS Daily Narcotic Log**

◆ **Unit:**

◆ **Tag Number**

◆ **Morphine**

*Please enter at least one response for this question.*

Lot #	<input type="text"/>
Expiration-	<input type="text"/>
Lot #	<input type="text"/>
Expiration-	<input type="text"/>

◆ **Versed**

*Please enter at least one response for this question.*

Lot #	<input type="text"/>
Expiration-	<input type="text"/>
Lot #	<input type="text"/>
Expiration-	<input type="text"/>

◆ **Valium**

*Please enter at least one response for this question.*

Lot #	<input type="text"/>
Expiration-	<input type="text"/>
Lot #	<input type="text"/>
Expiration-	<input type="text"/>

**Reason tag changed or Call # used on**

*Please include medication used and dispatch number*

◆ **Check Completed by:**

*By selecting your name below, you are electronically signing this form that all information you have supplied is true to the best of your knowledge.*

Save and Close

DEFIBILLATOR INSTRUCTIONS  
 Cables/connectors  
 Paddles/pads  
 Computer/printer/printer  
 Compression sensor/pressure  
 Monitoring electrodes  
 Chopped battery  
 AC/DC power source  
 Printer paper  
 Data card  
 5002 Sensor  
 NBP GATES & LOGGING  
 CO. FILTER LINE

Qty/Check List :

Operational Check Report

Model Number : M51367  
 Serial Number : 0500200039  
 Mfg. No. : 00 00 American English  
 Current Operational Check :  
 11 Jan 2011 08:04 Pass  
 Last Operational Check :  
 02 Jan 2010 08:13 Pass

Current Test Results :

General System Test : Pass  
 Therapy Mode : Pass  
 Charge Station : Pass  
 Shock Button : Pass  
 Audio Test : Pass  
 Defib Test : Pass/Pads  
 Printer Test : Pass  
 Compression Sensor Test : No Sensor  
 5002/ECG Cable : Pass/ECG Cable  
 5002/Address ECG Test : Pass/Pass  
 Battery Compartment A Test : Pass  
 Battery Compartment B Test : None  
 5002 Test : Pass  
 NBP Test : Pass  
 CO2 Test : Pass

PHILIPS

HEARTSTART MRX

REORDER NO: 98980313817



Operational Check Report

Model Number : K5536A  
Serial Number : U500209833  
SW Rev : 0.00 (W American English)

Current Operational Check :  
20 Jan 2011 07:27 Pass

Last Operational Check :  
19 Jan 2011 11:56 Pass

Current Test Results :

General System Test : Pass  
Therapy Knob : Pass  
Charge Button : Pass  
Work Station : Pass  
Audio Test : Pass  
Defib Test : Pass/Pass  
Pacer Test : Pass  
Compression Sensor Test : NO SENSOR  
Leads ECG Test : Pass/ECG Cable  
Pads/Paddles ECG Test : Pass/Pass  
Battery Compartment A Test : Pass  
Battery Compartment B Test : No  
SpO2 Test : Pass  
NIBP Test : Pass  
CO2 Test : Pass

HEARTSTART MRx

REORDER NO: 989803138171 / 989803138181

Operational Check Report

Model Number : M3536A  
Serial Number : 0500208833  
SW Rev : 9-00-00 Amer Tech English

Current Operational Check  
20 Jan 2014 08:20 Pass

Last Operational Check  
20 Jan 2014 07:47 Pass

Current Test Results :

General System Test : Pass  
Therapy Knob : pass  
Charger Button : Pass  
Shock Button : Pass  
Audio Test : Pass  
De-Id Test : Pass/Pass  
Pacer Test : Pass  
Compression Sensor Test : M Sensor  
Leads ECG Test : Pass/ECG cable  
Pads/Paddles ECG Test : Pass/Pads  
Battery Compartment A Test : Pass  
Battery Compartment B Test : None  
SpO2 Test : Pass  
NBP Test : Pass  
CO2 Test : Pass

Bluetooth Test  
Printer Test : Pa

PHILIPS

HEARTSTART MRX

REORDER NO: 989803138171 / 989803138181

Operational Check Report

Model Number : M3536A  
Serial Number : US00210463  
SW Rev : F-01.01 American English

Current Operational Check  
28 Jan 2011 07:50 Pass

Last Operational Check :  
27 Jan 2011 16:11 Pass

Current Test Results :

General System Test : Pass  
Therapy Knob : Pass  
Charge Button : Pass  
Shock Button : Pass  
Audio Test : Pass  
Defib Test : Pass/Pads  
Pacer Test : Pass  
Leads ECG Test : Pass/ECG Cable  
Pads/Paddles CG Test : Pass/Pads  
Battery Compartment A Test : Pass

CHART NO. 8047001 PRINTED IN U.S.A.

Current Test Results

General System Test : Pass  
 Therapy Knob : Pass  
 Charge Button : Pass  
 Shock Button : Pass  
 Audio Test : Pass  
 Buzzer Test : Pass/Pass  
 Pacer Test : Pass  
 Compression Sensor Test : No Sensor  
 Leads ECG Test : Pass/ECG Cable  
 Pad/Paddles ECG Test : Pass/Pads  
 Battery Compartment A Test : Pass  
 Battery Compartment B Test : None  
 SpO2 Test : Pass  
 MP3 Test : Pass  
 CO2 Test : Pass

007

P

Operational Check Report

Unit Number : W3535A  
 Serial Number : B500209824  
 Serial Rev : 0100 American Controls  
 Current Operational Check :  
 25 Jan 2011 : Pass  
 Last Operational Check :  
 26 Jan 2011 : 08:40 Pass

REORDER NO: 989803138171 / 989803138181

ART MRX

# System Status Management & Ambulance Design:

## Negative Effects on Paramedics ©

UNIVERSITÉ D'OTTAWA • UNIVERSITY OF OTTAWA

Sciences de la santé • Health Sciences

École des sciences de l'activité physique

School of Human Kinetics



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Faculty of Health Sciences-School of Human Kinetics

2) J. Peter Stothart, PhD (University of Ottawa)

Faculty of Health Sciences-School of Human Kinetics

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## Abstract

Many paramedics across North America are required to sit in their ambulances for extended periods of time. The increasing use of "System Status Management" (i.e.: Stand-by's, Roaming, Balanced Emergency Coverage) has led to increased back injuries amongst paramedics. A survey of paramedics from the Ottawa-Carleton region of Ontario, Canada was carried out to assess the effects of long periods of sitting and riding in an ambulance on the incidence of back injuries in paramedics. In addition, an evaluation was made of the characteristics of space and seats in the crew compartments of ambulances which are currently in service in Ontario. The results of the survey indicate that there is a reason for concern. Other research on the subject would suggest that paramedics should limit the duration of time sitting in a vehicle. The evaluation of seating for paramedics, in ambulance vehicles currently in service, clearly shows the seating to be inadequate. Research literature indicates that paramedics should have adjustable and supportive

vehicle seats with adequate leg room in the front cab area. These results indicate that significant health and safety issues exist and should be corrected to allow paramedics to carry out their critical functions without needlessly jeopardizing their own safety.

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### **Introduction**

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Emergency Medical Service (E.M.S.) providers across North America have been faced with shrinking budgets and funding which has not kept up with the increasing demand for their services. This has led to the ever increasing use of "System Status Management." (S.S.M.). S.S.M. involves distributing emergency personnel in such a way as to maintain a balance in emergency coverage to an area when the number of available ambulances is decreased. The Ontario Ministry of Health (M.O.H.) has been deploying ambulances in the Province of Ontario, Canada in this fashion. This has historically involved placing an ambulance on "stand-by" between two areas when one area's ambulance(s) have/has been sent on a call. In addition to this long standing practice of stand-bys, a new policy has been recently tested which involves deploying ambulances and paramedics in the Ottawa-Carleton region. This new system is referred to as "Roaming." These methods, which involve greater amounts of time spent by paramedics sitting/riding in their ambulances, are becoming a common phenomenon in North American E.M.S.

In the recent past, Ontario's ambulances would normally respond to emergency calls from various stations across their region or from a stand-by location. Paramedics would remain at their respective stations or at the designated stand-by location between calls. This was changed after a study of the "call volume" in Ottawa-Carleton was completed by the Ottawa Hospital-"Base Hospital Program" (BHP) (A.R.I.S., 1996). The BHP determined statistically dominant zones within the region of Ottawa-Carleton. These zones are numerically classified and indicate which areas contain the highest volume of most critical calls (code 4). For instance, "Zone 1" indicates the geographical area (downtown Ottawa) which has the most critical calls, most often. Zone 2 has the next highest volume of critical calls and so on. The result of the BHP study showed that many of the ambulance stations were not necessarily well positioned to respond to these zones and therefore the response

times to critical calls were longer than they needed to be. Also, the BHP suggested that a mobile ambulance crew is more likely to have a quicker response time than an ambulance crew that has to leave from a station. They suggested that the time between crew notification and the crew being mobile is decreased, if not eliminated, when the crew is mobile. These assumptions have led to the addition of "Roaming" to the current daily practices of a paramedics duties.

The new system that has been implemented requires that paramedics remain mobile in their ambulances between calls for at least half of their shift (shifts are usually twelve hours long). Along with the "Roaming" policy paramedics have always had to respond to stand-by's. When an ambulance station is depleted of ambulance crews an ambulance crew from a neighboring station is positioned on "stand-by" somewhere between the two stations. The ambulance crew that is placed on "stand-by" is required to leave their station, drive to a particular intersection and wait for a call. Stand-bys are *usually* located at an intersection that is relatively equidistant between two stations.

Regardless of the terminology used the simple fact is that the increasing use of System Status Management has resulted in Paramedics sitting in either an idling or moving ambulance for longer periods of time resulting in a static posture with increased exposure to vehicular vibrations.

The major concern of this increasing use of System Status Management is the potentially deleterious effects on paramedics. Paramedics are sitting for longer periods of time, in idling or moving ambulances and the question is does this result in an increased incidence of back discomfort, back pain or back injuries?

Several studies in the research literature have looked at questions related to time spent riding/sitting in a vibrating environment (for example a vehicle). Pope & Wilder (1996) have shown deleterious effects of vibration and seated posture on the backs of people. Kelsey et al (1984) concluded that "the greater the number of hours spent in a motor vehicle, the higher the risk for an acute prolapsed lumbar intervertebral disc." Their study showed that men who spend more than half their workday in a car have a threefold increased risk of disk herniation

Other research on exposure to vibration in the workplace supports these results. The static seated posture and vehicular vibration lead to fatigue in those who are exposed to it. Fatigue occurs as a result of increased postural muscle use. Seat design can play a big role in how much postural musculature is recruited. Seats that lack proper design will necessitate the recruitment of the erector spinae and lateral flexor muscles among others. Continuous recruitment of these muscles is required when a vehicles seat offers little or no support (Zacharkow, 1988).

Stoohart and McGill (1996) in their work on spinal shrinkage using stadiometry, have identified "static work posture" and "exposure to vibration" as known risk factors leading to back injuries. Klingenstierna and Pope (1987) completed a study that showed how disc "creep" or compression is accelerated when exposed to vibration.

In light of the broad spectrum of research indicating the connection between exposure to seated postures and vibration in vehicles in combination with an apparent large increase in paramedic exposure to vibration and long periods of time sitting in seats not designed to provide adequate support for their work conditions, the present study sought to determine the conditions experienced by paramedics in the Ottawa-Carleton region.

---

## Methodology

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The following protocol has been undertaken to determine the effects on paramedics of sitting for longer periods of time in an ambulance.

The first part of the study involved a survey of paramedics from the Ottawa-Carleton area who work regularly on ambulances (currently there are approximately 220 paramedics employed in Ottawa-Carleton). The survey was designed to determine: a) whether the amount of time spent in the ambulance by paramedics has increased since roaming has been implemented, b) whether there has been an increase in back injuries or pain/discomfort, and c) what factors might exacerbate the situation.

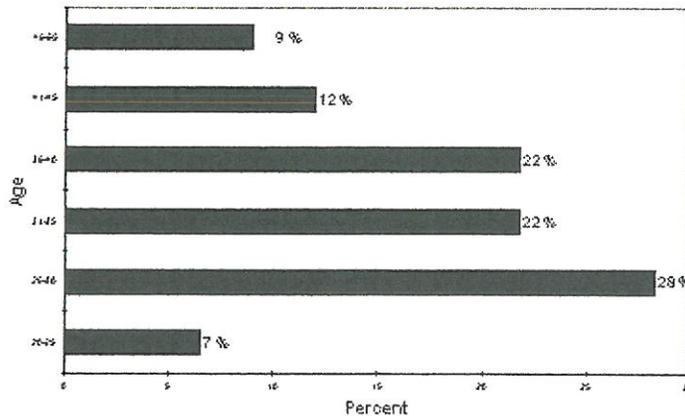
The survey was initially pretested with a subgroup of paramedics and E.M.S. administrators to determine whether any changes in its structure were warranted. The survey was then refined and distributed to as many paramedics in the Ottawa-Carleton region as possible.

In addition to seeking paramedic responses to the survey, an evaluation was made of the physical characteristics of space and seats in the crew compartments of ambulances in use in Ontario. The evaluation was based on the characteristics of: leg room, backrest adjustment, armrest support, lumbar support, lateral support, and vibration damping devices.

## Results

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In order to explore the question of sitting for extended periods of time in an ambulance and exposure to vehicular vibrations a survey was distributed to Paramedics from various ambulance stations across Eastern Ontario, most from within the Regional Municipality of Ottawa-Carleton (which currently has approximately 220 paramedics employed within its boundaries). Ninety-two surveys were returned. The subjects that responded consisted of 80 males and 12 females between the ages of twenty and fifty-five (Figure 1).



**Figure 1** Age of Respondents

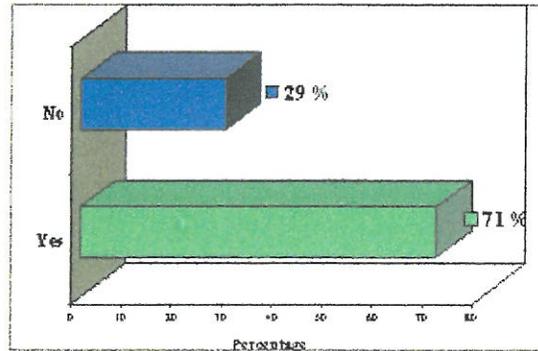
### **The Effects of Stand-bys and Roaming:**

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The average shift length worked by the paramedics was 11.7 hours. Most paramedics who were surveyed regularly work a twelve-hour shift. During their shift, paramedics estimated that they

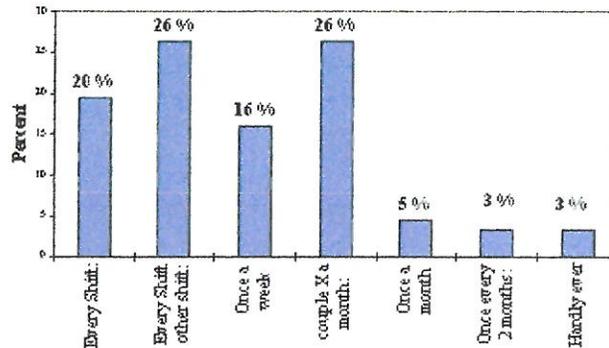
spend 56% of their day "roaming" or on stand-bys.

Seventy-one percent of respondents reported suffering from back pain or back discomfort more often now than before "roaming" was initiated (Figure 2).



**Figure 2** Amount of respondents reporting more back pain since the implementation of roaming

Ninety-three percent of the paramedics said that they suffer from back pain or discomfort while simply sitting in the ambulances (this was not pain/discomfort due to a lifting injury). When they were asked to rate how often this pain/discomfort from just sitting occurred, 62% stated that it occurred at least once a week or more often (Figure 3).



**Figure 3** Frequency of back pain/discomfort indicated by paramedics

Interestingly, 88% of paramedics within their first six years of employment complained of suffering from this back pain/discomfort at least once a week or more often. Even more revealing was the fact that 90% of all respondents thirty years of age or younger complained of this pain/discomfort at least every other shift or more often.

Ninety-five (95) percent of respondents were unhappy with the way that "roaming" and/or stand-bys have been implemented. They had several different concerns of which the most common will be discussed here. The most common complaint was that stand-bys are too long. Many subjects suggested that the application of stand-bys was very inconsistent. In some areas, stand-bys are not

maintained after certain hours while in other areas they are maintained 24 hours a day. Some stand-bys are only a few kilometers from the paramedics' stations, leading them to wonder why bother placing them there for such long periods of time in the first place. Others suggested that they worked in a significantly busier area than their neighboring area. While on stand-by, they would end up responding to calls back to their own area the majority of the time. They suggested that this resulted in longer response times to more calls, more often. Others wondered why they would often be placed on stand-by so far away from their station to only end up leaving *their own area* without *balanced* emergency coverage.

Many paramedics suggested that stand-bys were used excessively as a result of a lack of sufficient numbers of ambulances staffed in the area. They said that more ambulances should be placed into service instead of continually compromising two areas with one ambulance placed on stand-by between them. They went on to discuss how the ever increasing use of stand-bys was a clear indication of a serious lack of ambulances in the area(s). They felt that stand-bys should be a rare occurrence and that if they become too prevalent then more ambulances should be staffed in those areas. Some suggested that if this could not be done then the human cost involved with maintaining too many stand-bys was too high. Others thought that it was ironic that more ambulances were not being staffed on the road when, in reality, the taxpayers ended up paying so much money in increased vehicle maintenance costs, fuel costs and "Workers Compensation" (WSIB) costs due to the prevalence of stand-bys. They said that if that money would be used towards more staffed ambulances, then there would be less need to put ambulances on stand-by in the first place and also less incidences of WSIB claims.

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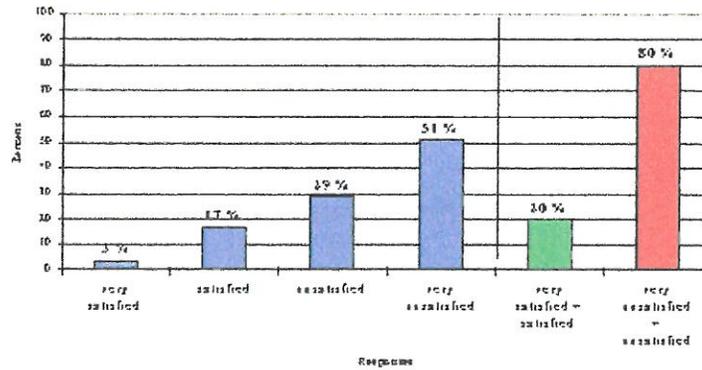
## **Survey Responses to Ambulance Vehicle Design:**

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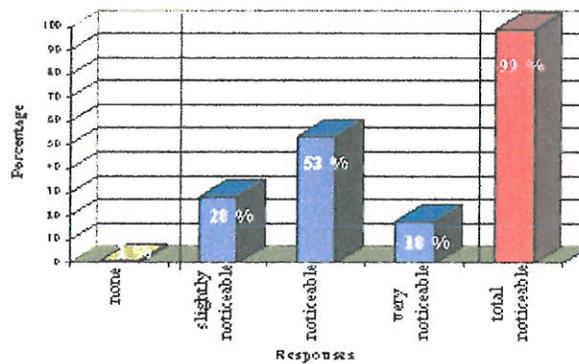
Some other issues that were mentioned dealt with the lack of comfort within the current ambulance designs. Eighty-nine percent of paramedics felt that the seats in the front of the ambulances were not comfortable.

They commented about a lack of ability to get out of the vehicle and move around while on stand-by. Reasons for this were such things as: poor radio systems that have unreliable portable communications thereby forcing the crew to stay in the vehicle in order to avoid missing a call; being forced to park at remote intersections late into the night or early into the morning where walking around might be hazardous (i.e.: dark, risk of violence); severely cold or hot weather conditions forcing them to remain in the ambulance with it running the entire time while on stand-by; lack of proper facilities to stretch or exercise "If we are lucky there maybe a coffee shop open at 3 am but that is hardly a place to walk around in circles or to do stretching exercises" (survey respondent, 1998). The paramedics also complained about the constant inhalation of vehicle exhaust fumes while on stand-by.

More specifically, in regard to the vehicle design, Figure 4 shows that 80% of the paramedics were either unsatisfied or very unsatisfied with the leg room in the front cab of the ambulance. It's important to note that the average height of those "very satisfied" (3%) with the leg room in the front cab of the ambulances was 166cm (5'5") compared to the average height of those "very unsatisfied" (51%) being 179cm (5'11").



**Figure 4** Responses to the question about the leg room in the front cab of the ambulance



**Figure 5** Degree of vibration felt by paramedics in ambulances

Eighty-seven percent of respondents were either unsatisfied or very unsatisfied with the ability to recline the driver's seat of the ambulances. Ninety-nine percent of respondents noticed at least some vibration while sitting in the ambulances (Figure 5).

Finally, 100% of the paramedics that returned surveys would prefer to have armrests installed in the ambulances. All of the recent vehicle models in Ontario ambulances have had armrests discontinued. A few older Dodge van ambulances have armrests, but they represent only a small percentage of the front-line fleet and are quickly being phased out (see Figure 9)

## A look at Ontario's Ambulances

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The consensus, after studying the literature on the effects of sitting in vibrating (moving or idling) vehicles, is that a strong relationship with a higher incidence of back injuries to people who work under these conditions. Paramedics work under these conditions in Ontario and in many other places across North America. They are required to "roam" or be on stand-bys for excessive periods of time in combination with all the regular lifting and driving duties that they normally perform. In a study on injuries among emergency services workers, it was determined that the most commonly injured area was the lower back. This has been found to be true in several other North American

studies of ambulance personnel (Gershon, 1995). This is probably due largely to lifting injuries. However, these lifting injuries are far more likely to happen when exposure to excessive vehicular sitting and vehicular vibrations are part of the equation.

The survey of paramedics validates published research findings relative to vehicular sitting exposure and vehicular vibration exposure in that it shows that paramedics, in the population studied, demonstrate significant back problems. Lower back pain can result from several factors, however, the greatest risk is the combination of long-term exposure to vibrations and frequent lifting. (Magnusson, 1996) "Prolonged exposure to vibration when seated has been shown to lead to muscle fatigue, particularly of the erector spinae and oblique abdominal musculature" (Wilder et al., 1982) "Individuals involved in lifting activities directly after prolonged driving in a flexed sitting posture would therefore be at a very high risk for developing low back pain" (Adams & Hutton, 1988) The results of the survey agree with this conclusion.

Does the vehicle design help or hinder the problems faced by paramedics? The ambulance vehicle designs worsens the problems faced by paramedics. The two areas of vehicle design that exacerbates the problems associated with back injuries are: *front cab space* and *seat design*.



**Figure 6** Ford seat in Ontario ambulance

The front cab space in ambulances is very confined-so much so that many paramedics cannot recline the backrest of the seat and drive in an optimal position (figure 6). In fact, many of the Dodge ambulance conversions do not provide a backrest that will recline at all (figure 7).

As mentioned earlier, 80% of respondents to the survey felt unsatisfied or very unsatisfied with the amount of leg room in the front cab of the ambulances. Of those that were satisfied, their average height was 166cm (5'5") as compared to the average height of the "very unsatisfied" being 179cm (5'11"). So, in general, the very few "satisfied" respondents tended to be much shorter people. These people would be able to move the seat more forward, thereby enabling them to recline the backrest to a more ergonomically correct position.



**Figure 7** Dodge seat in an Ontario Ambulance

The quality of seats currently in Ontario ambulances vary between make, model and year. The seats that are installed in the crew compartment are not sufficient for the ambulance environment. Although the vehicle manufacturers have insisted that the seats have passed safety testing this does not mean that they are designed well ergonomically or are practical for paramedics. (Figures 8 & 9) The goal of a good vehicle seat should be to limit the amount of postural stress caused by static muscular contractions. (Zacharkow, 1988) In general, the following problems exist with the seats in Ontario's ambulances:

- many backrests lack sufficient lumbar support (5cm),
- many have immovable backrests (Dodge conversions),
- most do not have armrests (including the latest 1998 Ford conversions),
- many lack lateral support or have soft lateral support, and
- none of the seats have vibration dampening devices (beyond the seat cushion).



**Figure 8** Ford seat characteristics



**Figure 9** Dodge seat characteristics

The general quality of space and seating (in providing protection against back pain/discomfort) for paramedics in Ontario ambulances is lacking. This statement is made based on the fact that paramedics are required more often to drive in this space and on these seats for extended periods of time every shift they work. These seats, along with the limited front cab space, do very little to limit the amount of postural stresses caused by sitting in them for prolonged periods. Furthermore, the trend in Ontario's ambulances is toward seat designs of even lesser quality. The Ford truck is the base model being purchased by the Ontario Ministry of Health for ambulance conversions.

## Conclusions

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The literature is clear-exposure to a static seated position and to vehicular vibrations do result in increased back discomfort/pain/injuries. The survey of paramedics is also clear-paramedics are suffering from back discomfort/pain/injuries at an unacceptable rate. The seats that are currently installed in the crew compartment of Ontario's ambulances and many throughout North America do not provide adequate safeguards for paramedics against back pain/injury in the workplace. The seats lack lumbar support, lateral support, and minimal damping against vibration. The crew compartment space in ambulances lacks leg room and restricts reclining of seatbacks which has a serious impact on postural muscle fatigue.

## Recommendations

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Recommendations which will help ensure the health and safety of paramedics with regard to vehicular vibration exposure and vehicular sitting exposure can be made in two general categories. The first category involves initiating administrative controls relative to policies and procedures for the use of roaming and stand-bys. The second category involves initiating engineering controls to ensure the best possible vehicular environment so as to maximally reduce the risks to the paramedics' health and safety.

### Administrative Controls

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Both the literature and the survey suggest that the current policies and procedures practiced by ambulance dispatch centers (authorized by the Ontario Ministry of Health), with respect to System Status Management (stand-bys and roaming), pose a serious risk to the health and safety of paramedics. Paramedics are forced to increase their normal exposure to vehicular vibration and vehicular sitting to a significant extent by the use of System Status Management principles (stand-bys and roaming). The use of stand-bys and roaming should be limited in the following ways:

- Ideally, stand-bys in vehicles could be eliminated and replaced with stand-bys at other ambulance stations, fire stations or other suitable facilities which would allow the paramedics time away from their vehicles. This is important in order to enable better posture and a greater opportunity to stretch and exercise.
- Roaming should be optional with consideration given to the individual paramedics depending upon how fatigued they are and how busy their shift is that particular day. A roaming crew should avoid forcing another crew to be placed on stand-by. This creates a "ripple effect"-as more paramedics move to stand-bys, or roam out of their areas, they necessitate the requirement for additional paramedics to be placed on stand-bys.
- Statistics should be used to show *when* and where the most "return critical calls" (in which an ambulance transports the patient to a hospital on the highest priority because there is an immediate threat or potential immediate threat to his/her life) occur. Those statistically dominant zones should only get stand-by coverage during the hours that indicate there is still a significant chance to get a "return critical call." This has already been done to some extent by the BHP prior to the implementation of "roaming." However, the statistic of *when* these calls occur was not considered when implementing policies and procedures on roaming. For instance, an area may be designated as "Zone 4", the fourth most likely place to get critical calls overall. The problem is that these statistics may be accurate between certain hours but may not be accurate outside of those hours. The situation then arises where a crew is spending a large portion of their shift roaming or on stand-by and rarely ever responds to a "return critical call" within the area they are covering at certain times of the day/night. One must consider the human cost to the paramedics when considering to what extent System Status Management will play a role in maintaining "balanced emergency coverage." Surely, a system of "balanced emergency coverage" can be obtained while at the same time providing appropriate conditions for paramedics. A lack of appropriate facilities should then be a good argument for making the stand-by at the statistically busier station-not somewhere in between two stations. If this is administratively prohibited in some areas (i.e.: different services providers) then this health and safety argument would suggest that the stand-by not be assigned until appropriate facilities are obtained for the paramedics.
- It would seem that much thought went into the roaming policies, however, the combination of vehicular movements based on statistical data (roaming) combined with the stand-by mind set of placing an ambulance in the middle of a *statistically low call volume* area has led to greater health and safety risks to paramedics relative to their increased exposure to vehicular vibrations and the static seated posture. The statistical data gathered prior to the implementation of roaming policies is useful information. If that information is further analyzed to include the times of the day that return critical calls happen then the statistics will yield more valid results. Moreover, it is important to understand that while encouraging the statistical and scientific methods in determining where and when calls happen it is vitally important that the Ontario Ministry of Health, Upper Tier Municipalities, Dispatch Centers, Base hospitals, ambulance Owners/Operators, and the labor unions realize that these statistics should be used to determine where to position ambulance stations and to determine the number of vehicles needed at particular times at these stations. Administrators must be made aware of the health and safety risks associated with any activity that increases the amount of time the paramedic is exposed to vehicular vibrations and the static seated posture.
- Identify the critical area(s) during the night shifts and provide stand-bys for those areas only.

- Ensure that the statistically significant stations with a high rate of return critical calls are staffed with enough ambulances at the proper time so as to limit the amount of times another neighboring ambulance must be on stand-by for them.
- Individual stand-bys should be limited to no longer than 2 hours at which time the paramedics must be relieved by a "fresh" crew or be directed back to their station or to another **facility**. This will allow them to get out of their vehicles, stretch, exercise, and rest in a place that is more appropriate and that protects them from the various environmental factors. In 1959, Slechta did a study on how long someone could sit in a chair (similar to the specifications of the chairs currently used in Ontario ambulances and abroad) before the onset of discomfort would set in. Discomfort tended to become evident after 134.5 minutes. (as cited in Zacharkow, 1988). The amount of time that a crew spends on a stand-by should also be influenced by the amount of previous exposures to stand-bys or roaming earlier in the same shift. The more often someone is exposed to bouts of stand-bys, the more often they will require breaks from it. Sitting for long periods of time in an ambulance results in fatigue due to excessive postural muscle activity. "Normally, fatigue recovery occurs by means of work-rest breaks during the day..." (Zacharkow, 1988). In other words, it is important to realize that an ambulance crew should not be left on stand-by for 2 hours then told to change to another stand-by location without a rest period between them.
- Give control of the Ministry of Health run dispatch centers to the local ambulance management personnel. If this is not done then the dispatch centers must be made more accountable to the local ambulance operators. Currently, local ambulance operators in Ontario have limited input in the movements of their own vehicles. The ambulance dispatch centers determine where and when ambulances will move. Consequently, local ambulance operators often lack the ability to effect any changes within the dispatch center and yet remain accountable to the employees in regard to paying for the ever increasing worker's compensations claims. This is a critical issue which currently limits the effectiveness and ability of ambulance operators to make administrative changes in Ontario.

## Engineering Controls:

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Engineering controls to limit the amount of exposure to vibration and to limit the effects of the static seated posture involve changes to the crew compartment of the ambulances and primarily to the seat design (see Table 1).

**Table 1. Summary of recommendations for ambulance seats. (Adapted from Pope, 1991)**

Recommendation	Specifications
Vibration dampening	
Firm, contoured seat cushion	
Firm lateral support	Contoured backrest
Damped, rigid lumbar support	
Adjustable forward posture and height	Increased front cab space
Tilted seat pan	14 degrees (from horizontal)
	120 degrees from seat pan (while driving) more while just sitting on stand-by
Ability to recline backrest	To accommodate various driver weights
Adjustability of vibrational dampening	So seat doesn't "bottom out"
Adequate travel	
Adjustable armrest	
High backrest to support neck & head as well as back	At least 62cm (28")

The front cabs of the ambulances are too small. In particular the length of the cab is too short. This results in inadequate room for most paramedics to correctly position their seat to be able to drive and to still be able to adjust the backrest of the seat to an ideal angle (120 degrees from the seat pan) (Andersson, 1974). This lack of adequate space forces paramedics to maintain a more hazardous static posture. Eighty percent of paramedics that responded to the survey stated that they are unsatisfied or very unsatisfied with the leg room in the ambulances. Eighty-seven percent of paramedics are either unsatisfied or very unsatisfied with the ability to recline the backrest of the seats in the ambulances. The average height of this group is 180cm (5'11") which, coincidentally is also the mean height of the males who responded to the survey. Eighty-seven percent of the population studied were males. One can make a connection then to the fact that these taller people, who make up the vast majority of the workforce, do not have the means to adjust their seats appropriately because the ambulance cab length is too short.

Actual crew compartment space was decreasing. Since 1992 changes in (ambulance) vehicle design and chassis had taken away personal space and increasingly pushed the seats up against the rear wall of the cab. Further, with the introduction of the diesel turbo-charged chassis in 1995, another 1 ½ inches of crew space was lost, creating a tight fit for medics of any size. (Allen, 1997)

The length of the cab must be increased in such a way as to allow the back rest to recline to at least 120 degrees from the seat pan (which should be at an angle of 10-14 degrees from the horizontal) (Zacharkow, 1988) The length of the cab should preferably allow the seats backrest to recline to an even greater degree in order to accommodate a semi-fowler or an "as close to supine" position as possible for the paramedic when they are not driving but required to be on stand-by. "When the backrest inclination increased, a larger proportion of the body weight was transmitted to the backrest and thus the stresses on the spine were reduced" (Andersson, 1974). The semi-fowler position and the supine positions allow for decreased postural muscle usage and therefore less fatigue and risk of injury.

...as a direct result of fatigue (with faulty posture in regards to sitting) an individuals ability to perform is reduced; his output is diminished; the quality of his production is lowered; his mental aptitude is reduced; his susceptibility to disease is increased...; he is much more likely to commit errors, and his likelihood to sustain personal injuries is greatly enhanced. (Zacharkow, 1988)

These semi-fowler to supine positions also result in less effect on the compression of the Intervertebral disc while sitting.

*Health Span Transportation* of St. Paul, Minnesota along with their regional *Braun Industries* distributor-*North Central Ambulance Sales* devised an innovative technique to solve the problem of decreasing front cab space in their ambulances. They developed the idea of inserting a 20-inch fibre glass extender between the crew cab and the patient compartment. "The extra 20 inches was gained during a remount without significant chassis modification by using a 158 inch chassis instead of the usual 138 inch chassis" (Allen, 1997).

The seat backrest needs to be made of firm material with firm lumbar support to encourage the normal lordotic curve of the lumbar spine and thus better able to distribute the vertical forces on the spine. The backrest must also have **firm** lateral support in order to limit the back's lateral flexor activity (Pope, 1991). Some of the seats in current ambulances have lateral support but it is composed of a soft "foam like" material which has limited effect. Firm, adjustable lumbar support in the backrest will assist in maintaining the lordotic curve of the lumbar spine thereby decreasing intervertebral disc pressure.

Armrests are very basic features of a good chair and yet result in a dramatic increase in comfort and should be installed in the ambulances. Armrests assist in lowering intervertebral disc pressures by taking much of the weight of the arms and upper body off of the spine and thus allowing for some

relief for the postural muscles of the back. Several studies have shown that both arms together make up between 9.8 to 12 percent of the total body weight (Zacharkow, 1988). Armrests act to allow the arm musculature to relieve some of the postural stresses and also help to prevent a slumped posture. They can also assist by providing some lateral support.

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**It is clear that administrative controls are needed to limit the amount of time that paramedics are kept roaming or on stand-bys. This, along with engineering controls, to improve seat and cab space designs, will go a long way toward safeguarding the health and safety of paramedics. Administrators *must* consider *all* the human costs involved with maintaining the current practices of roaming and stand-bys (System Status Management).**

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# Appendix "A"

- Information Letter
- Survey

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*Information Sheet*

*for*

*Survey of Paramedics*

Research Project on the  
Effects of Sitting and Vibration

Dear Participant,

Thank you for choosing to complete this survey. By filling out this survey you are consenting to its use in the tabulation of results for this study. Your identity will remain confidential. Please **do not** write your name on the survey. At any time, you may choose to withdraw or refuse to complete the survey. The only persons who will handle the surveys will be: Dr. Pete Stothart, a few assistants and myself. All those handling the surveys have agreed to maintain the confidentiality in regards to the subjects involved in the survey. All surveys will be secured in a locked cabinet with no way to identify the individual who filled it out. Your only requirement is to complete the survey once. There will be no subsequent contact with you. There is no risk in completing this survey as your name is not required.

This is a research project being carried out by Paul Morneau from the University of Ottawa, School of Human Kinetics. Your assistance in volunteering to fill out this survey is greatly appreciated and will ensure that the results more accurately represent the situation here in Eastern Ontario. The results may potentially benefit your working environment as copies of the completed research project will be shared with the Ontario Ministry of Health, your employer, and your Union. You may contact myself for a copy of the completed research project if you wish. There will be no compensation or remuneration of any kind for participation in this research.

This is a survey being used in conjunction with research on the effects of *the seated posture and vibration* on the spine. The purpose is to determine what, if any, problems exist in the ambulance field in regards to posture and vibration in ambulances.

If you require any more information please contact: Paul Morneau.

Thank you,

Paul Morneau

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## Survey of Ambulance Personnel

This is a sample survey-do not fill it out

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1a) What is your gender?

Male  Female

1b) What is your height? \_\_\_\_\_

1c) What city do you work in (or close to)? \_\_\_\_\_

2) What age category do you fall into?

Under 20  20 - 25  26 - 30  31 - 35

36 - 40  41 - 45  45 or older

3) How many years have you been working as an ambulance attendant? (total, including those with a previous ambulance employer)

0 - 3 years  4 - 6 years  7 - 9 years

10 - 15 years  16 - 20 years  more than 20 years

4) Do you experience back pain or back discomfort more often now than you did before "Roaming" came into effect?

Yes  No  Not Applicable

1. While on the job do you ever experience back pain or any back discomfort while just sitting in the vehicle (not due to a lifting injury)?  Yes  No

6) If you answered **yes** to Question #5 then how often does this back pain or back discomfort occur? (check one)

Every shift

Every other shift

- Once a week
- A couple of times a month
- Once a month
- Once every two months
- Hardly ever

7a) How long is your average shift? \_\_\_\_\_ hours

7b) On your average shift, how long do you spend:

- Roaming \_\_\_\_\_ hours
- On Stand-by \_\_\_\_\_ hours
- Driving \_\_\_\_\_ hours
- Other \_\_\_\_\_ hours

8) Are you in any way unhappy with the way "Roaming" and/or "Standby's" (Code 8's) are implemented? What are the main problems with "Roaming" and/or "Standby's" in your mind?

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9a) In general do you find the seats in the front cab of the ambulances comfortable?

- Yes  No

9b) Which vehicles do you find most comfortable (Year & Make)

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10) Please answer the following in regards to the comfort or discomfort of seats currently provided in Ambulances:

	Very satisfied	Satisfied	Unsatisfied	Very unsatisfied
How do you feel about the leg room in the front cab of the ambulances?				
How do you feel about the ability to recline the back rest of the driver's seat?				

	None	Slightly noticeable	Noticeable	Very Noticeable
How much vibration do you feel while in the ambulances?				

Would you prefer to have arm rests installed in the ambulances?	Yes		No	
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If you would like a copy of the completed study e-mailed to you please indicate your e-mail address below and what kind of word processing software and version you are using (ie: MS Word v.7.0 or WordPerfect v.6.0 etc.)

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## EMS Myth #7: System Status Management lowers response times and enhances patient care

**Posted:** January 12th, 2011 10:18 AM CDT

I was actively involved in prehospital care from 1974 until 1983 in various capacities. During the summer after my freshman year of medical school, I worked full time as a paramedic, but, for the next six years, I was overwhelmed with medical school and residency responsibilities. When I finally finished my residency in 1990, I found EMS had changed drastically while I was away. For one thing, the practice of system status management (SSM) had been instituted in many EMS systems. It was a strange concept. Ambulance crews really didn't have fixed stations; they were continuously moved around the city, presumably to decrease response times. Likewise, crew shifts were varied. Some crews came in at peak hours as others left. Somewhere behind it all must be some science, I thought. But is there? Or is SSM built on a foundation of sand?

### History

The concept of SSM was introduced to EMS by consultant Jack Stout. It is a computer-based system where historical call data are used to deploy the ambulance fleet for optimal response times and to predict where the next cluster of calls is likely to occur. In most systems, call response data for the previous 20 weeks are entered into a computer and, based on that historical data, systems believe they can predict when and where calls will occur—or at least establish trends. This is usually broken down into two categories: chronological demand and geographical demand history. Chronological demand is defined as the volume of calls to expect at any given hour or day of the week—basically to try and predict when calls are likely to occur. Again, this is determined from the previous 20 weeks' call activities, although some systems use historical data from the past year. Geographical demand history uses the same methodology to try and predict where calls will occur.

SSM is most commonly used by so-called "high-performance systems." In reality, it is pretty much limited to public utility model (PUM) operations and a few private ambulance services (SSM and PUMs were both invented by Jack Stout). In the larger systems, a specially designated system status controller monitors the system and directs fleet movement in response to perceived future call locations and volume. The SSM feature is built into several of the more popular computer-aided dispatch (CAD) software packages.

### The Scientific Evidence

When I began my literature search into the science of SSM, I was surprised that there was no scientific evidence to support the practice. All of the writings pertaining to SSM were in EMS trade magazines or were written as though the process was based on science.<sup>1</sup> Most were

written by people who had a proprietary interest in implementing the practice.<sup>2-5</sup> The only numbers published relative to SSM were from the city of Tulsa, OK. Following implementation of SSM, response time dropped from 6 minutes, 46 seconds to 6 minutes, 9 seconds—a saving of 37 seconds. However, this savings is clinically insignificant, and furthermore, ambulance maintenance costs were increased by 46% after implementation of SSM because the ambulance fleet was constantly on the road.<sup>6</sup>

In reality, it is impossible to predict where and when calls will occur with any degree of certainty. Historical data from a 20-week interval, or even a one-year interval, are statistically insufficient to make any reasonable prediction of call location or timing.

In preparing for this article, I discussed this concept with two university-based statisticians. One figured that it would take 20–40 years of historical data to make a reasonably accurate probability prediction as to call location and timing. The other stated that it would probably take 100 or more years of data before any predictions would approach significance in terms of probability. He likened it to predicting the weather. Even with over 100 years of weather data, temperature predictions are still relatively inaccurate. The meteorologists get close, but they are rarely correct. And, predicting temperatures is a lot less complicated than predicting EMS calls. The statistical calculation necessary to determine the probability of where and when a particular EMS call will occur is massive and would require a super computer to solve.

There are some meaningful data, but these are often not integrated into SSM models. Demand for EMS is higher for certain subsets of the population. For example, persons of low income are more likely to access EMS than those of higher income. Likewise, elderly patients are more likely to summon EMS than their younger counterparts. Thus, the demand will be greater in areas where there is more poverty and more elderly. We can state that the probability of an ambulance responding to a nursing home, assisted-care facility or neighborhood with a high percentage of elderly residents is greater than in other areas. Likewise, the probability of an ambulance responding to an impoverished neighborhood, public housing project or homeless shelter is greater than you would see in an affluent neighborhood.<sup>7</sup> But, over the last two decades, there has been a federal and state mandate to relocate economically disadvantaged folks throughout the community rather than concentrating them in rows of public housing or "projects." This throws a wrench into predicting where the poor folks are. Finally, and this will be a great revelation for many, most traffic accidents occur on busy roadways. Thus, we can reasonably predict that the probability of an accident occurring on a major highway during morning rush will be greater than at midnight on a lonely neighborhood street. Do we really need a computer to tell us that we will have more EMS calls at nursing homes, in impoverished neighborhoods or on major thoroughfares during rush hour?

In an interesting study, researchers in Ontario, Canada, evaluated the impact of SSM on EMS personnel following its implementation. They found that SSM resulted in employees being forced to sit in idling or moving ambulances for extended periods of time. In fact, during a 12-hour shift, EMS personnel spent 56% of their time roaming or on standby (exclusive of responding to calls). After implementation of SSM, a survey found that 71% of EMTs and paramedics reported an increase in back pain, while 93% reported back pain or discomfort from simply sitting in the ambulance.<sup>8</sup>

SSM is purported to: Optimize response times, maximize use of personnel and equipment (a cost-saving measure), increase skills retention by exposing personnel to a variety of calls, decrease potential for the EMS system to become "swamped," limit exposure to high-stress areas and provide a shorter travel distance to the scene. Whether these are true is open to conjecture. But I think I can safely say, as have others, that SSM does result in unruly and overly tight staffing schedules due to projected system demands and status.<sup>9</sup> It does not provide any significant leeway in the event of a MCI or disaster. In these cases, mutual aid must be obtained from neighboring agencies or personnel called in from home. Furthermore,

with SSM, there is less chance that field personnel will have a "light shift" where they can relax, catch up on paperwork, stock the ambulance or review cases. It is important to remember that there is a lot more to EMS than simply running calls. One of the big problems is that you never have any real place to call home—a station where you can relax, grab a bite to eat, lie down, read, watch television, exercise or take care of basic human needs (shower, toilet, sink). This was evident to me one day when I stopped into a Texaco station in south Fort Worth where ambulance crews frequently "post." After fueling my car, I went into the bathroom. There, beside the toilet, was a copy of *Emergency Medical Services Magazine*.

It seems reasonable to assume that SSM increases work stress due to constantly changing assignments that make it harder for EMS providers to learn the geography of their response areas or become familiar with the neighborhoods they are entering. Furthermore, anticipating the call that never comes can also be stressful. I have known paramedics working in an SSM system who spent nine hours of an 11-hour shift in the ambulance, on the road, and were only dispatched to three calls. The rest of the time they were "posting" or being relocated for coverage. Also, SSM causes an increase in vehicle maintenance and miles traveled. This is a real cost that must be considered by any EMS operation considering implementing SSM. Finally, and this may be among the most important factors, SSM discriminates against low-volume areas (read affluent, sparsely populated, away from major roadways) due to long response times. If the SSM system is operating as it should, ambulances should be constantly directed to perceived high-volume areas and away from low-volume areas. I'll bet that the taxpayers would not like to hear this! Is this practice really fair for EMS providers and consumers?

### **Conclusion**

If you look through all of the SSM-related smoke and mirrors, you will see the true story. Fixed ambulance stations are costly. This is especially so if you make a commitment to respond to all service areas in a predetermined time, at least 90% of the time, or pay a monetary penalty. It costs nothing more than increased vehicle costs to "post" the ambulance at the Texaco station or the local 7-11 convenience store. Ambulances and personnel are much cheaper than fixed ambulance stations. Thus "high-performance" systems, most notably public utility models, use SSM, although others have adopted it or one of its variations. I can't document the following statement with science—just with experience and emotion. I believe that employee satisfaction, morale and pay are generally lower in systems that use SSM, while employee turnover, stress and physical ailments are higher. If SSM is such a great deal, why has not a single major fire department adopted the practice? Phoenix, Los Angeles, Seattle, New York, Chicago, Dallas, Houston and virtually all other large U.S. fire departments use fixed stations for their fire and EMS operations. This is not to say they don't move assets around in response to system demand. But, they always have a home base. That is what I grieve most about SSM. As I think back to my career in EMS, some of the best days of my life were spent in ambulance and fire stations with friends and coworkers. We were kindred spirits. SSM has killed that camaraderie and that, my friends, is a shame.

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*Bryan Bledsoe, DO, FACEP, EMT-P, is an emergency physician, author and former paramedic whose writings include: Paramedic Care: Principles and Practice and Paramedic Emergency Care.*

**Related:**

- [EMS Mythology](#)



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# Rock River Region EMS System

## Ambulance Inspection Check-List

An ambulance functioning in the Rock River Region EMS System should meet the following requirements at all times. Please review and validate that your ambulance meets the listed equipment and medications, as referred in the State and Federal guidelines.

### Standard Equipment:

- 1 Wheeled multi-level cot w / 3 sets of straps and over the shoulder straps
- 1 3-point fastener for cot
- Cot fits securely in fasteners
- 1 Secondary stretcher w / 3 sets of straps
- 2 Pillows
- 2 Pillow cases
- 2 Bed Sheets
- 2 Blankets
- 1 Operating battery powered flashlight
- 1 Wrecking Bar – 24 inches
- 2 Pair of safety goggles
- 2 5 lb ABC Fire Extinguishers
- 10 Patient care reports
- 1 Radio with MERCI
- 1 Cellular phone with telemetry ability – ILS / ALS

### On-Board Oxygen Equipment:

- 1 3000 psi "M" size cylinder or larger
- 1 Reducing valve from 2000 psi to 50 psi
- Is secured with a crash stable device
- 2 Wall mounted oxygen flow meters / MUST be able to flow 2, 4, 6, 10, 15 lpm
- 2 7 foot oxygen delivery tubes
- 1 Adult oxygen mask (partial or total non-rebreather)
- 1 Child oxygen mask (partial or total non-rebreather)
- 1 Infant oxygen mask (partial or total non-rebreather)
- 3 Adult nasal cannula
- 2 Child nasal cannula
- 2 Infant nasal cannula

### Portable Oxygen Equipment:

- 1 D or E cylinder - FULL
- 1 D or E spare - FULL
- Quick release, crash stable, mounting bracket for cylinders
- 1 Oxygen Regulator with pressure gauge and must flow 2, 4, 6, 10, 15 lpm
- 1 7 foot oxygen delivery tubes
- 1 Adult oxygen mask (partial of total non- rebreather)
- 1 Child oxygen mask (partial of total non- rebreather)
- 1 Infant oxygen mask (partial of total non- rebreather)

### On-Board Suction Equipment:

- Can obtain 300 mmHg within 4 seconds of clamping tube
- Able to adjust vacuum levels (0 to 500 mmHg)
- 2 10 foot transparent non-kink tubing – ¼ inside diameter
- 2 Collection bottle – 1000ml
- 2 Sterile / single use 6 to 8 Fr soft tip suction catheters
- 2 Sterile / single use 10 to 12 Fr soft tip suction catheters
- 2 Sterile / single use 14 to 18 Fr soft tip suction catheters
- 6 Sterile rigid suction catheter with control vent

### Portable Suction Equipment:

- MANUAL SUCTION UNIT**

1 Manually operated suction device with all attachments (V-VAC / Res-Q-Vac)

- OR -

**PORTABLE POWERED**

Can obtain 300 mmHg within 4 seconds of clamping tube
- Able to adjust vacuum levels (0 to 500 mmHg / >20 lpm)
  - 2 10 foot transparent non-kink tubing – ¼ inside diameter
  - 1 Collection bottle – 1000ml
  - 2 Sterile / single use 6 to 8 Fr soft tip suction catheters
  - 2 Sterile / single use 10 to 12 Fr soft tip suction catheters
  - 2 Sterile / single use 14 to 18 Fr soft tip suction catheters
  - 3 Sterile rigid suction catheter with control vent
  - Gas powered portable unit meets the above requirements
  - Battery powered unit meets the above requirements and:
    1. Capable of charging from the vehicles 12 volt system and 115 VAC
    2. Operates from an internal re-chargeable battery source
    3. Operates for 20 continuous minutes

**ALS / BLS Airway Equipment:**

- 2 CPR mask w/ safetyvalves (NOT A MICROSHIELD)
- 2 Adult BVM with mask
- 2 Child BVM with mask
- 2 Infant BVM with mask
- 2 40 mm Oropharyngeal
- 2 50 mm Oropharyngeal
- 2 60 mm Oropharyngeal
- 2 70 mm Oropharyngeal
- 2 80 mm Oropharyngeal
- 2 90 mm Oropharyngeal
- 2 100 mm Oropharyngeal
- 2 110 mm Oropharyngeal
- 2 12 F Nasopharyngeal
- 2 14 F Nasopharyngeal
- 2 16 F Nasopharyngeal
- 2 18 F Nasopharyngeal
- 2 20 F Nasopharyngeal
- 2 22 F Nasopharyngeal
- 2 24 F Nasopharyngeal
- 2 26 F Nasopharyngeal
- 2 28 F Nasopharyngeal
- 2 30 F Nasopharyngeal
- 1 tube of lubricating jelly
- 2 BIAD Airways:  
- King Airway / Combi-tube
- 2 Bite sticks

**ALS Airway Equipment:**

- 2 2.0 Uncuffed ET tubes
- 2 2.5 Uncuffed ET tubes
- 2 3.0 Uncuffed ET tubes
- 2 3.5 Uncuffed ET tubes
- 2 4.0 Uncuffed ET tubes
- 2 4.5 Uncuffed ET tubes
- 2 5.0 Uncuffed ET tubes
- 2 5.5 Uncuffed ET tubes
- 2 5.0 Cuffed ET tubes
- 2 5.5 Cuffed ET tubes
- 2 6.0 Cuffed ET tubes
- 2 6.5 Cuffed ET tubes
- 2 7.0 Cuffed ET tubes
- 2 7.5 Cuffed ET tubes
- 2 8.0 Cuffed ET tubes
- 2 8.5 Cuffed ET tubes
- 2 9.0 Cuffed ET tubes
- 2 10.0 Cuffed ET tubes

- 2 6.0 Endotrol ET tubes
- 2 Size 6 FR stylettes
- 2 Size 10 FR stylettes
- 2 Size 14 FR stylettes
- 2 Laryngoscope handles
- 2 Appropriate spare batteries
- 2 Spare bulbs – if applicable
- 1 size “0” Miller blade
- 1 size “1” Miller blade
- 1 size “2” Miller blade
- 1 size “3” Miller blade
- 1 size “4” Miller blade
- 1 size “0” Macintosh blade
- 1 size “1” Macintosh blade
- 1 size “2” Macintosh blade
- 1 size “3” Macintosh blade
- 1 size “4” Macintosh blade
- 2 2 inch 14 g angiocaths (needle cricothyrotomy)
- 2 Scalpels (open cricothyrotomy)
- 1 Magill Forceps – Adult 11”
- 1 Magill Forceps – Child 8”

**BLS Cardiac Equipment:**

- 1 AED w/ battery
- 1 AED spare battery
- 2 sets of AED pads (adult)
- 2 disposable razors

**ALS Cardiac Equipment:**

- 1 Cardiac monitor able to perform:  
- lead II EKG's  
- Defibrillation 5 – 360 j  
- Cardiac pacing  
- Synchronized cardioversion
- 2 compliments of batteries
- 2 sets of EKG leads
- 2 sets of pacer leads
- 1 spare roll of monitor paper
- 4 sets of 3 electrodes (EKG)

**HANDS FREE UNIT**

- 2 sets of Defibrillation pads - Adult (hands free units)
- 2 sets of Defibrillation pads - Peds (hands free units)

- OR -

**MANUAL UNIT**

- 1 pair of adult defib paddles
- 1 pair of ped defib paddles
- 2 sets of Defib paddle pads or Defib gel

**IV / Needles / Syringes Equipment for ALS:**

- 2 500 cc 0.9% NS IV bag
- 6 1000cc 0.9% NS IV bag
- 4 Microdrip tubing w/ 2ports
- 4 Macrodrop tubing w/2 ports
- 4 7 inch extension tubing
- 6 14 g – 1 ¼ angiocath
- 6 16 g – 1 ¼ angiocath
- 6 18 g – 1 ¼ angiocath
- 6 20 g – 1 ¼ angiocath
- 6 22 g – 1 ¼ angiocath
- 6 24 g – 1 ¼ angiocath

- 2 15 g – Intraosseous
  - 4 18 g – Intraosseous
- OR -**
- EZ IO / BIG IO system
- 2 Adult Intraosseous
  - 2 Pediatric Intraosseous

- 2 19 g – butterfly needles
- 2 23 g – butterfly needles
- 2 25 g – butterfly needles
- 4 1 cc TB syringes
- 4 5 cc syringes
- 4 10 cc syringes
- 2 30 cc syringes
- 6 18 g 1 ½ syringe needles
- 6 25 g 1 ½ syringe needles
- 6 tourniquets
- 2 padded IV arm boards

**Needles / Syringes Equipment for BLS:**  
**(N/A for Glucagon pre-fills)**

- 2 3 cc syringes
- 4 Mucosal Atomization Devices
- 4 23 g 1 syringe needles (for Glucagon injections)
- 2 20 cc NS vials

**BLS / ALS Medications:**

- 2 Oral Glucose – 15 G
- 4 Albuterol – 2.5mg / 3ml
- 2 Nebulizers
- 2 Epi Pens - .3mg
- 2 Epi Pens Jr. - .15mg
- 2 Glucagon – 1 mg
- 8 Baby ASA – 81 mg

### ALS Medications:

- 4 20 cc NS vials
- 5 Adenocard – 6mg
- 3 Atropine – 1mg
- 2 Benadryl – 50 mg
- 2 Dextrose 50% - 50 G
- 1 Dextrose 25% - 25 G
  
- 2 Dopamine – 400 mg

**- OR -**

2 Dopamine IV bags  
(400 mg / 500 cc)

- 2 Epi 1:1000 – 1 mg
- 4 Epi 1:10000 – 1 mg
- 4 Furosemide – 40 mg
- 6 Lidocaine 2% - 100 mg
- 2 Lidocaine Jelly 2% - 200mg
- 2 Morphine – 10 mg
- 5 Narcan - .4mg
- 2 Nitroglycerine .4 mg / dose  
(bottle or spray)
- 2 Ondansetron 4mg / 2 ml
- 2 Procainamide – 1G
- 2 Sodium Bicarb 8.4% - 50mEq
- 2 Diazepam – 10 mg
- 2 Midazolam – 10 mg
- 2 Tetracaine – 2 ml

### BLS / ALS Medical Equipment:

- 1 Adult B/P cuff w / gauge
- 1 Child B/P cuff w / gauge
- 1 Infant B/P cuff w / gauge
- 2 Stethoscopes
- 1 set of 4 point soft restraints
- 2 boxes of non-porous /  
non-latex gloves
- 6 Face / eye shields
- 2 Red bio-hazard bags
- 1 Sharps container
- 1 Bedpan
- 1 Urinal
- 2 Emesis basins
- 1 Drinking water (quart)
- 1 Child / infant car seat
- 1 Plastic baby bottle w/ nipple
- 1 Pediatric height / weight /  
length dosage chart
- 1 Adult & Ped Trauma Score #
- 12 alcohol prep pads
- 2 1000cc sterile water
- 2 Sterile OB Kits (sealed)  
(contents listed on box)
- 4 Cold packs
- 4 Hot packs

### Other Equipment:

- 1 Glucometer
- 1 Pulse oximeter  
(optional)
- 1 RAD 57  
(optional)
- 1 MAST – Adult  
(optional)
- 1 MAST – Pediatric  
(optional)

### BLS / ALS Trauma Equipment:

- 2 Trauma shears
- 2 Long extremity splints (adult)
- 2 Short extremity splints (adult)
- 2 Long extremity splints (Peds)
- 2 Short extremity splints (Peds)
- 1 Adult traction splint
- 1 Pediatric traction splint  
or an adult Sager, Kendrick
- 2 Long backboards w / 3 straps  
each or spider straps each
- 1 Short backboard or KED  
w / straps
- 4 sets of head immobilizers
  
- Cervical Collars**

2 Tall size c-collars

2 Regular size c-collars

2 Short size c-collars

2 No-Neck size c-collars

2 Pediatric size c-collars

2 Infant size c-collars

**- OR -**

4 Adult adjustable c-collars

4 Pediatric adjustable c-collars
  
- 6 Sterile Multi-trauma  
dressings (12" x 30")
- 20 Sterile 4" x 4" gauze pads
- 10 Sterile 8" x 10" Abdominal  
pads
- 10 Sterile 4" x 5 yards kling
- 2 Sterile 3" x 8" Vaseline  
gauze
- 2 Sterile Burn Sheets  
(60" x 90")
- 5 Triangular bandages  
(40" x 40" x 56")
- 1 Box of band-aids (50 ct)
- 1 Roll of Aluminum foil
- 2 Rolls of adhesive tape  
(10 yards / each)

## **Vehicle and Patient Care Area requirements for inspection:**

1. The patient care area floor is flat and unencumbered with a non-skid surface that is easily cleaned.
2. Power outlets for 115 volt AC are two-wire grounded receptacles and are working correctly.
3. Ambulance has flood and loading lights capable of illuminating the area around the vehicle for a distance of 50 feet.
4. There are provisions for transporting a secondary patient on the squad bench platform with three working seat belts.
5. Minimum space between the head of the primary cot and the rear wall (or backrest of the EMT seat) is 25 inches. Minimum space from the foot of the primary cot and the rear door is 10 inches.
6. Heating, cooling and ventilation equipment is in operating condition.
7. Patient care area has storage cabinets which do not impinge on the cot or access area, and are designed or installed to avoid projections into the working area. All items not stowed in these storage cabinets MUST be securely fastened to prevent causing injury to the patient in the event of a sudden start, stop or collision.
8. Make sure your ambulance's patient care area is very clean. This should be a daily operation and not a pre-inspection step.
9. Posted "Poison Control" phone number, "NO SMOKING" and "FASTEN SEAT BELT" stickers in the front and patient care area near the radio / cell phone.

## **"TIP's" for your ambulance inspection:**

1. Make sure that someone with a complete knowledge of your ambulance is present to answer questions and locate items requested.
2. Make sure that you have copies of your current EMS roster and their certificates (IDPH EMS, CPR, ACLS, PALS, BTLs, etc), and your FCC license.
3. Have a copy of your "MOCK" EMS coverage schedule done for each ambulance.
4. Any open, broken-seal, or expired medical supplies need to be removed and replaced. There should be NO open items to be used with patient care on your ambulance.
5. Make sure that your two 5 lb fire extinguishers are not expired. One should be accessible to the patient care area and the other behind the front seats.
6. Make sure that your patient care area is very neat and organized. Again, this should not be done due to the fact of an upcoming inspection, but a daily task.
7. Make sure that your "OB kit" is sealed / not open and that all items found inside the kit are clearly listed on the outside. If your kit does not list items found inside, you need to consider replacing it before your inspection.
8. Blood pressure equipment:
  - a. Make sure that each size of blood pressure cuff (I, C, A) is in working order.
  - b. Make sure that your stethoscopes are clean and in working order.

9. Airway and Oxygen delivery equipment:
  - a. Make sure that you have each required size of Bag-Valve-Masks, and that the masks are not deflated. Each mask needs to have enough air to form a seal when in use.
  - b. Make sure that your CPR mask is also inflated and clean.
  - c. Make sure that each oral and nasal airway is sealed in an individual "snack-pac" zip lock bag or seal them with a vacuum food sealer. This way you can prevent contamination of these airways.
  - d. Laryngoscope blades MUST be sealed the same way as the oral and nasal airways.
10. A backboard with at least three seatbelts or "Spider Straps" will constitute as a secondary stretcher.
11. Make sure that all mechanical equipment (i.e.: Traction Splint) needs to be complete and in working order.
12. Make sure that any electrical device used for patient care (i.e.: cardiac monitor, glucometer, automatic blood pressure unit) has a maintenance (daily or shift check sheet) folder or binder. This maintenance folder / binder should include the manufacture check-sheet and suggested steps for daily maintenance.
13. Check and double check your required equipment / medical supplies list. Review the equipment / medical supplies list and verify that you have the correct sizes, age group (Adult, child, infant).
14. Make sure that your required car seat is not expired: For more information please review the following web-site: (<http://www.childrestraintsafety.com/manufacture-expiration.html>)
  - \*\* EMS brand car seats will expire 6 years after manufactured date

Brand	Life Span	Safety Standard
Baby Trend	6 years	USFMVSS213 + "S" mark
Babylove	10 years	ASNZS 1754
Babywise	10 years	ASNZS 1754
Brio	10 years	ECE R44-04 + Swedish T approval
Century (USA)	6 years	USFMVSS213 + "S" mark
Century (AUS)	10 years	ASNZS 1754
Cosco	5-7 years	USFMVSS213 + "S" mark
Dorel	5-7 years	USFMVSS213 + "S" mark
Evenflo	6 years	USFMVSS213 + "S" mark
Go Safe	10 years	ASNZS 1754
Graco	5 years	ECE R44-04
HiPod	10 years	ASNZS 1754
IGC	10 years	ASNZS 1754
Mother's Choice	10 years	ASNZS 1754
Nania - Car Seat Speciality	7 years	USFMVSS213 + "S" mark
Recaro	10 years	ECE R44-04
Safety 1st	6 years	USFMVSS213 + "S" mark
Safe-n-Sound	10 years	ASNZS 1754
Vita	10 years	ASNZS 1754

**PLEASE REMBER THAT THIS SHOULD BE A DAILY ACTIVITY. NOT JUST A PRE-INSPECTION CHECK-LIST.**

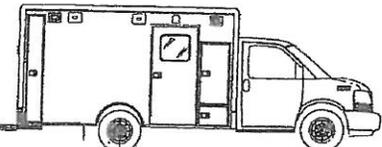


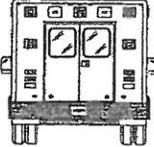
# Daily Vehicle Check Form

DATE	UNIT	UNDER HOOD	GOOD	FLUID ADDED	FUEL LEVEL
1/14/11	C-79	Anti-Freeze	✓		FULL
CREW	Thomas Pytel	Oil	✓		3/4
CREW	Adam Brahmsted	Brake Fluid	✓		1/2
MILEAGE	56,966	Power Steering	✓		1/4
SAFETY LANE DATE	2/11	Trans Fluid	✓		
OIL CHANGE DATE		Washer Fluid	✓		
OIL CHANGE MILEAGE	60,000				

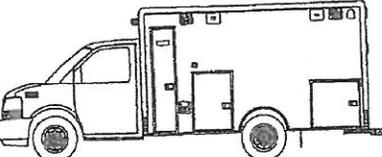
OUTSIDE	GOOD	REPAIR	INSIDE CAB	GOOD	REPAIR	CLIP BOARD CONTENT
HEADLIGHTS	✓		HORN	✓		✓ 10 - IDPH PT. CARE REPORTS
SCENE LIGHTS	✓		GAS CARD	✓		✓ 10 - REFUSAL FORMS
TURN SIGNALS	✓		INTERIOR LIGHTS	✓		✓ 10 - RRREMS 12 LEAD FORMS
BRAKE LIGHTS	✓		SIREN	✓		✓ 10 - ABN FORMS
TAIL LIGHTS	✓		HEAT / AC	✓		✓ 10 - PCS FORMS
GRILL LIGHTS	✓		DISPATCH RADIO	✓		✓ 10 - SIGNATURE FORMS
INTERSECTION	✓		I-PASS	✓		DECONTAMINATION
BACK UP ALARM	✓		INSURANCE CARD	✓		COT AFTER EACH USE
TIRE PRESSURE	✓		SWEDES CARD	✓		MRX AFTER EACH USE
COMPART. LIGHTS	✓		TOUGH BOOK	✓		PT CARE AREA DONE WEEKLY

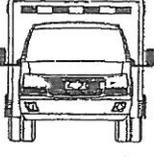
AMBULANCE STANDARD EQUIPMENT	CARDIAC MONITOR
✓ 1 - COT WITH 3 SETS OF STRAPS	✓ 1 - ADULT DEFIB PADS
✓ 1 - STAIR CHAIR WITH STRAPS	✓ 1 - PED'S DEFIB PADS
✓ 2 - PILLOWS	✓ 1 - BAG OF SPLINTS
✓ 4 - FULL SHEETS	✓ 1 - KED
✓ 4 - BLANKETS	✓ 1 - C COLLAR BAG WITH 2 OF EACH SIZE
✓ 4 - PILLOW CASES	✓ 1 - ALS JUMP BAG
✓ 2 - PAIR SAFETY GLASSES	✓ 1 - GLUCOMETER
✓ 2 - ANSI SAFETY VESTS	___ GLUCOMETER VALUE EACH WEDNESDAY
✓ 2 - 5# FIRE EXTINGUISHERS	✓ 2 - ON BOARD O2 REGULATORS
✓ 2 - BACK BOARDS WITH STRAPS	✓ 1 - M 125 O2 TANK 600 PSI MINIMUM
✓ 1 - PED'S BACK BOARD	✓ 2 - D SIZE TANKS WITH REGULATORS
✓ 1 - PHILIPS MRX CARDIAC MONITOR	✓ 1 - NARCOTIC CHECK LOG COMPLETED
	✓ BLINKING HOURGLASS
	✓ GREEN CHARGE LIGHT ON
	✓ ECG CABLES / 12 LEAD CABLES
	✓ DEFIB CABLE PRESENT, INSPECT
	✓ DEFIB SIMULATOR
	✓ 25 ECG ELECTRODES
	✓ CHARGED SPARE BATTERY
	✓ AC/DC POWER CORD
	✓ 2 PRINTER PAPER ROLLS
	✓ SPO2 SENSOR PRESENT INSPECT
	✓ NIBP CUFFS & TUBING INSPECT
	✓ CO2 FILTER LINE PRESENT





DOCUMENT ANY DAMAGE, DINGS, SCRATCHES







A ROCKFORD HEALTH SYSTEM - HEALTHSOUTH Partnership

950 S. Mulford Road • Rockford, IL 61108  
815 381-8500 • Fax 815 484-9035

May 12, 2010

Andy Schultz  
P.O. Box 2549  
Loves Park, IL 61132

Dear Mr. Schultz:

As a hospital, we review our contracts on a yearly basis or more often on an as needed basis. Each contract review goes through a relatively rigorous process that includes comprehensive criteria. These criteria, as they relate to ambulance services, include but are not limited to timeliness, quality patient interaction, ease and accuracy of billing processes, "customer satisfaction", competencies in managing patient needs as they relate to transport and necessary patient interventions, etc.

I wanted to take this opportunity to express my sincere appreciation of your services as they relate to Van Matre HealthSouth Rehabilitation hospital and our patients. All of your staff consistently go "above and beyond" across all of our vendor contract criteria. I have been most impressed with not only the highest level of competency consistently portrayed by you and your staff but also, the level of personal or "human" connectedness with our staff and patients. You and your staff foster an environment of security in the transport and extraordinary care of our patients as well as being an unconditional resource as this relates to your service to Van Matre.

We are all aware that we live in an imperfect world that poses occasional challenges to operations, especially as we work with patients with varying medical conditions and needs. Your company is commended for your receptivity to questions we might have; your responsiveness to any concerns has been superb, and in many cases unprecedented for which I am grateful.

Thank you so very much for being a trusted leader in our community; Van Matre HealthSouth Rehabilitation Hospital is fortunate to have you as a very highly valued vendor! Please extend a THANK YOU to your staff as well.

Respectfully,

A handwritten signature in black ink, appearing to read 'Daniel B. Woloszyn'.

Daniel B. Woloszyn  
Chief Executive Officer



Accredited by the  
Joint Commission



Inpatient rehabilitation program and  
brain injury inpatient rehabilitation program  
accredited by the Commission on  
Accreditation of Rehabilitation Facilities

-----Original Message-----

From: Bird, Michael E SSG MIL USA [<mailto:micheal.bird@amedd.army.mil>]  
Sent: Tuesday, June 01, 2010 1:52 PM  
To: [bbull@atsambulance.com](mailto:bbull@atsambulance.com); [dlonganecker@atsambulance.com](mailto:dlonganecker@atsambulance.com)  
Cc: Duncan, William G CTR US USA  
Subject: Paramedic (UNCLASSIFIED)

Classification: UNCLASSIFIED

Caveats: NONE

Gentlemen,

The week of May 17th through the 22nd was a very busy time for West Point. We had several events going on to include the 2010 West Point Graduation which honored our special guest, The President of The United States.

I am writing to tell you how much your paramedics were appreciated during this demanding time. Because of immediate changes through an After Action Review on a Tuesday, we had to call onto Bill Duncan to bring in an extra paramedic for Thursday and Friday. On such short notice Bill went above and beyond to get us the support that was requested. Because of the quality of paramedics that you have working with us, He was able to fulfill those requests. Clint Davis volunteered to pick up one of these shifts and even though he just came onboard with Keller he was able to jump into our challenging flow immediately.

On Graduation Day, Kathleen Ross was an invaluable asset. As soon as the President started his commemoration speech we started receiving medical assist calls. In a highly visible situation Kat reacted appropriately and professionally during numerous back to back calls. During the United States Military Academy's immediate after action review, a remark was made stating "" the responders that assisted those people in the stadium were right on it"". This comment gave us (Keller) a "Good to Go", and Kat played a major part in that.

Thank you for your Paramedics. With the success that we just had, we would like to incorporate them into every major event that West Point holds.

V/R

SSG Bird, Micheal  
KACH Ambulance NCOIC  
[micheal.bird@us.army.mil](mailto:micheal.bird@us.army.mil)  
[micheal.bird@amedd.army.mil](mailto:micheal.bird@amedd.army.mil)  
1-845-938-4004

Classification: UNCLASSIFIED

Caveats: NONE

# Winnebago County Fire Protection District #1

115 West Howard St., P.O. Box 185  
DURAND, ILLINOIS 61024

Telephone - Emergency 815/248-2100 - Business 815/248-2696  
Fax 815/248-2458

November 3, 2006

To whom it may concern.

This letter is to inform you of our experience with Acute Transport Specialists (ATS). We started our relationship with them in August of 2005 when our EMS system was experiencing some daytime coverage problems. We entered an Auto Aid agreement that included helping us respond to our calls as needed. This worked well but understanding we needed to do something more permanent our Board of Directors decided to look into full time coverage. We gathered a few proposals from area services and chose ATS.

They have been a great asset to our District providing one Paramedic and one Basic EMT on 24 hour shifts. Andy Schutlz and Brad Bull were very involved in the set up and change over to our new Paramedic service. We entered into a full time contract with ATS on February 1, 2006. Since we have received positive service and have a good working relationship, we will be renewing our contract in 2007. Andy and Brad have always been very helpful and reliable in following up on any questions or concerns our department may have.

Regards,



Kim Steward  
WCFPD#1 Chief



DURAND TOWNSHIP - HARRISON TOWNSHIP - LAONA TOWNSHIP - SHIRLAND TOWNSHIP  
(W 01/3RD PM)





201 N. Blackhawk  
Rockton, IL 61072

Telephone: 815-624-6010  
Fax: 815-624-7825

December 11, 2008

To: Whom It May Concern  
From: Ronald E. Weavel, Chief *[Signature]*  
Ref: ATS

This letter is on behalf of ATS ambulance service, owner Andy Schultz and the relationship that is currently in place with the Rockton Fire Protection District.

I've known Andy for many years and have found him to be of the highest quality both personally and professionally.

In December of 2006, ATS was awarded the EMS contact for us to begin on January 21, 2007. ATS has through an excellent working relationship and quality employees have provided an exceptional service to our community. In turn, our customer service reports coming back to me show a 92% rating in terms of services provided. This survey form covers six-questions with a comment section.

ATS structure and the personnel staffing the organization are all of a high caliber and those that function at Rockton actively ensures a great inter-action with our firefighters and EMT's. I contribute this to ATS management and Mr. Schultz's commitment to provide the best service possible.

With this said, I can with confidence recommend ATS as your EMS provider.

Should you desire additional information please feel free to contact me at the above address.

**Win-Bur-Sew Fire Protection District**

110 East Main Street, PO Box 595, Winnebago, IL 61088

Phone 815/335-2651 Fax 815/335-1104

11 December 2008

To Whom It May Concern:

This is a letter of recommendation for A.T. S. Medical Services Inc. We have used A.T.S. since their start up and have had excellent service from them. They provide excellent patient care as well they are prompt. The crews are professional, well educated and work very well with our members.

Like any line of work, issues come up from time to time and Andy Schultz and his staff have worked through them quickly and professionally. I would highly recommend the service of ATS to any and have used the service for my own family.

If you have any questions please don't hesitate to call me at 815/335-2651.

Regards,



Robert M. Martin Jr.  
Fire Chief

**ROCK RIVER REGION E.M.S SYSTEM  
QUALITY IMPROVEMENT PROGRAM  
ALL LEVELS**

**Overview:** The goal of the Rock River Region E.M.S. System is to provide excellent quality patient care and customer service in the pre-hospital care environment. To achieve this goal, a process for review and intervention must be developed and implemented. The program must be a dynamic process so as to respond to the changing needs of the patient, the system, as well as Federal, State, and Local regulatory agencies. The E.M.S. Quality Improvement Plan follows the F.O.C.U.S.- P.D.C.A. Cycle (Find, Organize, Clarify, Understand, Select, Plan, Do, Check, Act) methodology.

**Objective:** To identify areas which may require improvement, organize supportive data, identify key personnel, clarify E.M.S. provider responsibilities, develop an understanding of the response expectations, select the best improvement plan for intervention, plan the best practice program for education / intervention / administrative action, implement the plan, check for plan progress and results, and then act on any changes necessary for completion or conclusion of process.

**Scope:** The Rock River Region E.M.S. System Q.I. program is a combined effort and involves all internal and external stakeholders as well as all aspects of pre-hospital care from access to emergency department admission and / or hospital discharge.

**Plan Elements:**

The C.Q.I. program consists of four distinct elements and will be the main focus of plan implementation:

**1: Documentation Audits:**

Documentation audits are done monthly on each agency of the R.R.R.E.M.S. System. The minimum sampling size is 10 % of all pre-hospital provider responses. The documentation audits will identify potential problems with documentation, protocol compliance, response time of less than 10 minutes, scene times of less than 20 minutes, and IDPH data collection compliance. Results of the review will be sent to the E.M.S. provider's lead administrator (chief, director, etc.). Identified issues will be addressed following the plan as stated in the overview above.

**2. Procedure / Death Audits:**

100% review of invasive procedures and deaths will be accomplished retrospectively. Interventions that will be reviewed concurrently are: Endotracheal intubations, Combi-tube insertions, Chest Decompressions, Surgical Cricothyrotomies, Needle Cricothyrotomies, Defibrillations, Cardioversions, and External pacing. In addition, any pre-hospital response may be reviewed based on an identified need, change in practice, based upon request by any stakeholder, or as required by applicable regulatory agencies.

**3. Pediatric Response Audits:**

All pediatric response will be audited for compliance as identified in section 1 and 2 above.

**4. Trauma System Review:**

The Trauma Medical Director and Trauma Service Coordinator review a sampling of trauma patients and refer selected issues / aspects of trauma care to EMS System Office on a regular basis. The review will then become a multidisciplinary event and loop closure will be expanded to include all involved stakeholders. The focus of monitoring is on all phases of care from initial resuscitation through rehabilitation

**A. Indicators**

Minimum criteria for review but not limited, to Category I and II trauma patients (Attachment 13), admitted to the hospital or who expire in the E.D., O.R., or patient care services, or all trauma patients transferred to or from Rockford Memorial Hospital. All trauma patients meeting the criteria for review will have their care reviewed both concurrently and retrospectively for all indicators (see Trauma Q.I. Plan). Indicators and audit filters listed have been suggested for review by the American College of Surgeons (ACS COT, 1999, 2002), Illinois Department of Public Health (Joint Committee on Administrative Rules, Administrative Code Section 515) or Rockford Health System institution specific. Indicators and audit filters may be dynamic and change to reflect new technology or evidence based medicine. A calendar of Outcome and Process audits maybe utilized (Attachment 14 & 15).

**B. Types of Indicators**

**1. Patient Safety Outcomes**

- a. Clinical Outcome
- b. Practice Management Guidelines
- c. Patient Satisfaction

## 2. Process / System Indicators

- a. Performance
- b. Focused Audits-time limited
- c. Utilization Management

### C. Levels of Review

The Trauma Service utilizes a three tiered review for Trauma Performance Improvement. The review process is dynamic and may not require all levels of review for action to take place.

### D. Performance Improvement Development and Implementation. The Performance Improvement is developed in cases where a type of process improvement effort is recommended.

Methods for Improvement Opportunities:

- a. Guideline/protocol/pathway
- b. Education/conferences
- c. Resources/Facilities/System Enhancements
- d. Communication Enhancements
- e. Formalized Process Improvement Team (F.O.C.U.S.- P.D.C.A.)
- f. Constructive Counseling
- g. Case Presentation
- h. Change in privileges or credentials
- i. External Review as needed
- j. FMEA

## 5. **Loop Closure:**

Loop closure measures the desired outcome of the Performance Improvement method as well as benchmark tracked indicators (if available) and provides analysis of the data being monitored. Complete loop closure maybe a lengthy process, on going, and at times may never be considered closed. Loop closure is reported in the appropriate plan review file by agency /incident as required.

## 6. **Run Review Request Procedure:**

- a. The E.M.S. office will receive a request to review a run based on a concern by a stakeholder (e.g. RN, MD, MD, Patient, Family, etc.) All requests will be forwarded to the EMS Systems Coordinator.

- b. The requesting party will submit (in writing) the name of the requesting party, requesting party contact number, the agencies or providers involved, the date and time of the incident, and the concern / issue.
- c. The EMS Coordinator will collect all pertinent information (charts, interviews, audio tapes, etc) as need for review.
- d. The EMS Coordinator will review the data and compare to policy, procedure, protocol and all applicable laws, rules, and regulations.
- e. The EMS Coordinator will review all data with the EMS Medical Director. A recommendation of one or more of the following will occur:
  - 1. No further action warranted.
  - 2. Written letter of counseling identifying all pertinent information and actions needed completed and sent to necessary stakeholders.
  - 3. Meeting with EMS Administration and Agency leadership and / or provider. Documentation and plan outcome from said meeting.
  - 4. Meeting with requesting stakeholder. Documentation and plan outcome from said meeting.
  - 5. EMS Administrative action. Appropriate documentation to provider file(s).
  - 6. System suspension
  - 7. License revocation
- f. As a result of items a,b,c,d,e, above, a plan of action may be accomplished as identified in the C.Q.I. plan objective section.
- g. Loop closure measures the desired outcome of the Performance Improvement method as well as benchmark tracked indicators (if available) and provides analysis of the data being monitored. Complete loop closure maybe a lengthy process, on going, and at times may never be considered closed. Loop closure is reported in the appropriate plan review file by agency /incident as required
- h. At any time during the process, the involved stakeholder(s) may meet with the E.M.S. Medical Director upon request. An appointment that is convenient for all parties will be accomplished through the E.M.S. administrative offices.

## RRREMS SYSTEM CQI PROGRAM

**Instructions:**

Each EMS staff member will review run report forms based on the level of care of that agency vs. care provided, (e.g. Protocol Compliance). Indicators will be reviewed 100% of the time. The analysis and CQI form will be attached to the run reviewed. Each run will be filed by agency by month and by medical category, (e.g. cardiac, respiratory, etc.). If immediate action / review is needed, then a copy of the report and letter of recommendation will be forwarded to the EMS Systems Coordinator. Further action will be based on each individual incident and will be followed up with CQI documentation. If trends are identified, the recommendations for a plan of action will be forwarded to the EMS Systems Coordinator for approval and forwarding to the agency involved. Once the plan of action is completed, documentation will be forwarded to the original case file

### PERFORMANCE IMPROVEMENT PROGRAM

**Agency:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Report #** \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_ **Transported to:** \_\_\_\_\_

**EMT Crew** \_\_\_\_\_

**Invasive Proced:** Intub.  C-tube  Decomp.  Crico.  Defib.  IV  Central IV   
Triple 00/ DOA  Cardiac Arrest  Pacing  Other.  (Explain) \_\_\_\_\_

**Response time < 10":** Yes  No  **Scene Time < 20":** Yes  No

**Transport to closest hospital?** Yes  No  Explain: \_\_\_\_\_

**Procedure not done?** Yes  No  Explain: \_\_\_\_\_

**Documentation complete, neat and accurate?** Yes  No  **Discrepancy:** \_\_\_\_\_

**Protocol utilized?** \_\_\_\_\_ **Compliant?** Yes  No

**Protocol Deviation Appropriate?** Yes  No  NA  **Explain:** \_\_\_\_\_

**Immediate Action Required?** Yes  No  **Forwarded to/Date:** \_\_\_\_\_

**Proposed Plan of Action:** \_\_\_\_\_

**Received by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Resolution:** \_\_\_\_\_

**Completion Comments/date:** \_\_\_\_\_

**signature** \_\_\_\_\_ **date:** \_\_\_\_\_

**CC:** \_\_\_\_\_





## Perform QA/QI

The QA Review task allows you to manage and review Responses in the "Complete" state based on criteria that you enter. The QA Review task is accessible from both the [Home Page view](#) and from any [Response/Patient Encounter View](#).

**NOTE** The QA Review Tasks are unavailable in Mobile Disconnected deployed Fusion ePCR clients. However, read the [General Usage section](#) that describes the effect of QA reviews on original authors of a Response, including authors entering Responses on a Mobile Disconnected Fusion ePCR client.

### General Usage

A QA Officer accesses the **Load Parameters** field and selects previously saved QA Parameters, makes any necessary changes to the Parameters and then accesses the **Run** button. The system generates the list of Responses that match the Parameters chosen and changes the view to the [QA Review - List](#).

The QA Officer then selects a Response from the QA Review - List grid and reviews the Response. When the review is complete, the QA Officer accesses the QA - Confirm Review Task Submenu item. The [Confirm Review window appears](#), and the QA Officer enters any comments in the text area provided and accesses the OK button.

The original author of the Response now sees the Response that was reviewed in the Comments Tab of the Home Page Response List. The original author accesses the Response. The [Review Comment window appears](#) containing the comments entered by the QA Officer. The original author reads the comments, accesses the OK button and then makes any modifications necessary to the Response and marking the Response complete, ready again for QA review.

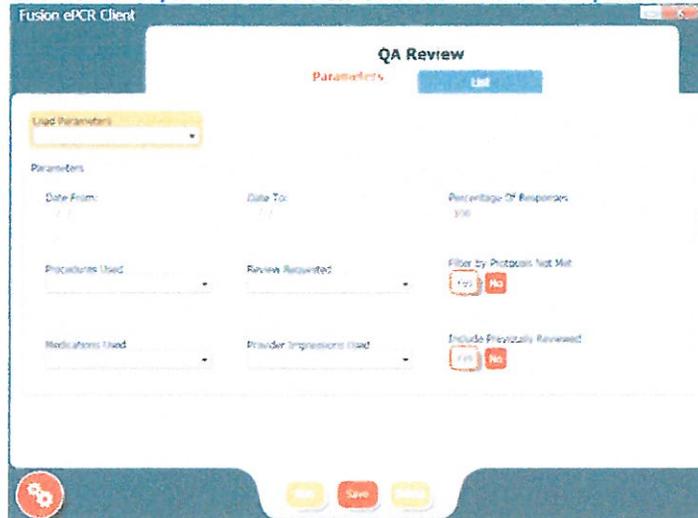


From the Home Page view in Fusion ePCR:

Access the **Task Menu** button.

Access the **QA: Review** Task Menu item. The QA Review View will appear:

[Click for an explanation of a field or button in the example below:](#)



Alternately,

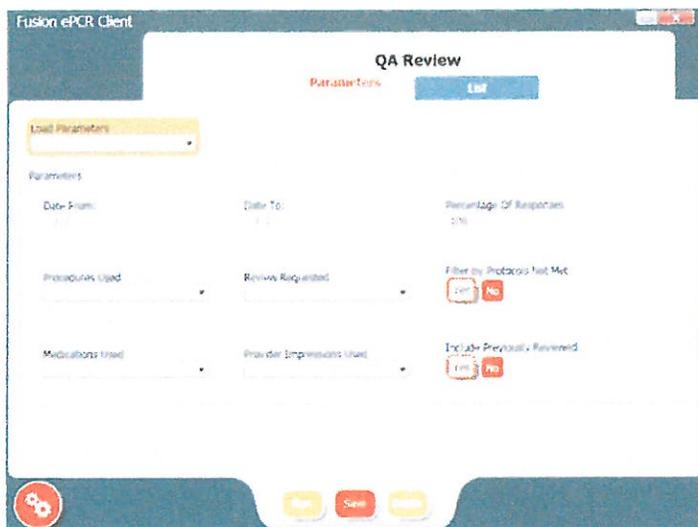


From any Response or Patient Encounter View:

Access the **Task Menu** button.

Access the **QA** Task Menu item and then access the **Review** Sub-Task Menu item. The QA Review View will appear:

[Click for an explanation of a field or button in the example below:](#)



## Managing Parameters

### Load Parameters

The **Load Parameters** field allows you to manage previously saved filters (hereafter, "Saved Parameters"), used to create QA Review Lists. Access the field to select any Saved Parameter. Once selected, the values in the Parameter fields are updated with the saved values. Further modification of any of the Parameter fields are allowed. See the [Parameter Explanation](#) section .

Loaded Parameters may be deleted using the **Delete** button, and modified parameters may be saved as a new set of parameters using the **Save** button.

## Parameter Explanations:

### Date From and Date To

The Responses appearing in the QA Review List will be limited to a date range established by entering values in these fields.

*Example One: Entering **01012009** in the Date From field and leaving the Date To field blank specifies an open-ended date range from 01/01/2009 to the current date.*

*Example Two: Entering **11012009** in the Date To field and leaving the Date From field blank specifies a date range from 01/01/1900 to 11/01/2009.*

*Example Three: Entering **12152009** in the Date From field and entering **12312009** in the Date To field specifies a date range between and including the dates from 12/15/2009 and 12/31/2009.*

### Percentage of Responses

The Responses appearing in the QA Review List will be limited to a percentage of those Responses that meet all other configured parameters.

*For example: If the QA Review List would result in 32 Responses for review based on the values entered in the other parameters, and **50** is entered in this field, only the first 16 Responses (by entered date) will appear in the QA Review List.*

### Procedures Used

The Responses appearing in the QA Review List will be limited to those Responses that contain a TX/RX - Procedure entry in any Patient Encounter associated with a Response matching ANY of the values entered in this field. Multiple Procedures are allowed.

*For example: If **Airway - Intubation** and **Airway - Suction** are selected as the values in the Procedures Used field, the QA Review List will contain only those Responses associated with Patient Encounters where EITHER "Airway - Intubation" or "Airway - Suction" have been selected.*

### Review Requested

The Responses appearing in the QA Review List will be limited to those Responses where the Response View - General Section - Review Requested field value exactly matches the value selected in the **Review Requested** field.

*For example: If **Yes** is selected from the Review Requested field, the QA Review List will contain only those Responses where the Review Requested field has been answered "Yes." The QA Review List will also be limited by any other parameters specified.*

### Filter by Protocols Not Met

When **Filter By Protocols Not Met - No** is selected, no action is taken by the system to limit the Responses in the QA Review List based on Protocols Not Met.

When **Filter By Protocols Not Met - Yes** is selected, the Responses appearing in the QA Review List will be limited to those Responses that have:

- An answered Provider Impression field with a value that has a corresponding Treatment Protocol; and
- one or more Procedures or Medications associated with the Treatment Protocol has not been entered in the Patient Encounter - Treatment - TX/RX section.

*For example: If the "Filter By Protocols Not Met" toggle is **Yes** then a Response with the following Patient Encounter information would be included in the QA Review List: The Primary Provider Impression field was answered **Cardiac Arrest** and the Treatment Protocol for the*

"Cardiac Arrest" provider impression established in Decision Support was "Chest Pain". The Treatment Protocol contains CPR as a procedure, but the Patient Encounter on the Response does not contain a CPR TX/RX entry.

#### Medications Used

The Responses appearing in the QA Review List will be limited to those Responses that contain a TX/RX - Medication entry in any Patient Encounter associated with a Response matching ANY of the values entered in this field. Multiple Medications are allowed.

For example: If **Acetaminophen** is selected as the value in the Medications Used field, the QA Review List will contain only those Responses associated with Patient Encounters where "Acetaminophen" has been selected.

#### Provider Impressions Used

The Responses appearing in the QA Review List will be limited to those Responses that contain a Provider Impression entry in any Provider Impression field in a Patient Encounter associated with a Response matching ANY of the values entered in this field. Multiple Provider Impressions are allowed.

For example: If **Head Injury** and **Concussion** are selected as the values in the Provider Impressions Used field, the QA Review List will contain only those Responses associated with Patient Encounters where EITHER "Head Injury" or "Concussion" have been selected in ANY of the Provider Impression fields (Primary Provider Impression, Secondary Provider Impression, or Other Impressions).

#### Include Previously Reviewed

When **Include Previously Reviewed - No** is selected, only those Responses that meet all other configured parameters AND have not already been "locked" by previously generated QA Review Lists will appear in the List.

When **Include Previously Reviewed - Yes** is selected, all Responses that meet every other configured parameter will appear in the QA Review List, regardless of whether they have been "locked" by previously generated QA Review Lists.

#### The available actions are:

- Run** Access the **Run** button to create the QA Review List of Responses. When the list is finished generating, the view will change to the QA Review - List tab. However, if there are no Responses that qualify for the List, you will be prompted with a "No result" message; in that case after accessing the OK button, the view will return to the QA Review - Parameters Tab View.
- Save** Access the **Save** button to store the values established in the QA Review - Parameters Tab. The "Save" message dialog window will appear, prompting you to enter or select from the **Save Parameters As** drop-down menu. Enter or select a value from the menu and then access the **OK** button to save the parameters.
- Delete** Access the **Delete** button to remove the currently loaded Saved Parameter set. This button is only enabled when a Parameter set has been **Loaded**.

Confirm Review

#### Confirm Review

Once the QA Officer has completed the review of the Response, completion is communicated by accessing the Confirm Review Task. Access the **Task Menu (<CTRL+T>)**, select the **QA** Task Menu Item, and then select the **Confirm Review** Task Submenu Item.

Return to the [Welcome to the Fusion ePCR Help System](#) topic.

Continue to the [How To DataLink Responses](#) topic.

## Overview of Billing Practices for Patients with Private Insurance:

1. All commercial or private insurance is billed before any balance or bill is submitted to the insured.
2. A.T.S. will accept the primary insurance maximum allowable and bill any secondary insurance for the remainder of the balance.
  1. Due to constraints of the Medicaid system, A.T.S. cannot bill Medicaid if it is a secondary or tertiary payer for patient.
  2. Any balance remaining on the account after billing the primary, secondary, and tertiary payers have made their adjustments and payments will be submitted to the patient for payment.
3. In the event a patient has Medicaid as their primary insurance, all bills will be submitted to Medicaid, and the remaining balance after Medicaid payment is written-off by A.T.S. in good faith.
4. In the event that insurance information is not submitted at the time of service, A.T.S. will in good faith attempt any and all means necessary to obtain said information before submitting a bill to a patient, up to and including communicating with hospitals or other facilities to acquire payer information.
5. If a patient is uninsured and is forwarded to collections, a patient will become responsible for any collections fees associated with the account.
  1. A.T.S. makes every effort to work with private-pay patients to settle their accounts reasonably.
  2. A.T.S. Offers payment plans and a financial hardship plans for patients and makes every reasonable effort to avoid sending a patient to collections.
6. In the event a patient refuses to sign a standard HIPAA release of information form, A.T.S. cannot legally bill the patients insurance and the patient will become responsible for the entirety of their bill.
  1. Every effort is made to work with patients to ensure their private insurance is billed.
7. If a client is Medicaid Pending at time of service, their account is frozen for 90 days pending approval of their Medicaid ID. Once granted, A.T.S. will proceed billing Medicaid for the transport.
8. All clients are sent four (4) monthly bills (covering 120 days) and can contact our billing department at any time within this grace period to settle their account, set up a payment plan, or apply for financial hardship before being sent to collections.

A.T.S. Medical Services, Inc

“Evaluation of Cardiac Arrest Outcome Utilizing the Utstein Criteria”

April, 2011

CJ Scaminaci, NREMT-P

Abstract: Cardiac arrest outcome evaluation utilizing the standard Utstein Criteria. Although impractical to apply to the out-of-hospital environment the Utstein criteria provides a comprehensive evaluation of cardiac arrest variables. The sample size for this study was ten (10) patients from 2009-2010 who were all either discovered in cardiac arrest or witnessed going into cardiac arrest.

Subsection 1: Cardiac Arrest with No Resuscitation Attempted

Of the sample group, one patient was excluded with a valid DNAR (Do Not Attempt Resuscitation) order. Although this patient met criteria for inclusion in this study, they were excluded due to code status and had no intervention performed.

Subsection 2: Attempted Out-Of-Hospital Resuscitations

Of the sample group, nine (9) patients had Advanced Life Support interventions performed outside of the hospital environment by licensed Emergency Medical Services personnel. Of these nine, no patients were only defibrillated, no patients had only CPR performed, and no patients had only airway procedures performed. Of the nine patient sample group, all patients had an extensive combination of interventions performed.

Subsection 3: False Arrests

During the sample period (2009-2010), A.T.S. Medical Services answered twenty six (26) calls for a false cardiac arrest. A call is determined to be false if the patient has either been resuscitated by time of arrival and required no stabilizing treatment, or if the patient was never actually in cardiac arrest.

Subsection 4: Non-VF/VT Arrests

Of the nine patient sample group, seven (7) patients were in an Asystolic heart rhythm on initial assessment.

#### Subsection 5: VF/VT Arrests

Of the nine patient sample group, two (2) patients were in a rhythm denoted as Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT).

#### Subsection 6: No ROSC

Of the nine patient sample group, four (4) patients did not achieve return of spontaneous circulation (ROSC). Regardless of Advanced Life Support interventions performed, all four patients were found Asystolic and arrived to the receiving hospital Asystolic.

#### Subsection 7: Any ROSC

Of the nine patient sample group, five (5) patients did achieve return of spontaneous circulation (ROSC). Of the five patients, four had an initial rhythm of Asystole and one had an initial rhythm of Ventricular Fibrillation. Of the five patients, all five arrived at the receiving facility with a perfusing, life sustaining rhythm.

#### Conclusion

Due to the nature of EMS, patient outcomes and functional outcomes are not available to this study. A.T.S. Medical Services has analyzed current data available and data gathered to accurately depict a cardiac arrest survivability trend. A.T.S. has concluded that statistically, A.T.S. Medical Services has a ROSC rate of 45% in out-of-hospital cardiac arrest situations.



The Technology of ATS  
*“To Serve and Connect”*

## ATS Information Technology: Mission Statement and Goals

ATS Information Technology (IT) strives to provide a seamless fusion of data processing, data entry, and communication to all nodes under its jurisdiction. IT provides reliable and sustainable technology services to ATS in a timely, efficient and cost effective manner. IT is committed to meeting the needs of Field Crews, Billers, Administrators, Dispatchers, and other staff by equipping and supporting them with quality resources in technology. IT constantly seeks to improve and implement appropriate hardware and software for the benefit of ATS and its partners.

***Mission Statement: "To Serve and Connect" - Information Technology will provide the highest quality technology based services, in the most cost effective manner, to facilitate the mission of ATS as it applies to the management, teaching, learning, and security of information; and to facilitate quality patient care.***

To meet this mission IT will:

- Provide effective technology support for audio/visual, computer, multimedia, voice, video, and web based applications and services to all areas of the company.
- Promote and facilitate the effective integration of technology into the basic mission of the company through planning, programming, training, consulting, and other support activities.
- Develop, enhance, and manage the company's enterprise networks to provide high speed, transparent, and highly functional connectivity among all information resources.
- Develop and maintain highly effective, reliable, secure, and innovative information systems to support patient care, administrative, dispatch, and billing functions.
- Facilitate the collection, storage, security and integrity of electronic data while ensuring compliance with all applicable HIPAA and PHI regulations.
- Provide capabilities including the ability to develop and manage the distribution (and marketing) through broadcast, narrowcast, broadband, software, the Web and other telecommunications technologies, products and services both within and beyond the company scope.
- Promote new uses of information technology within the company through the support for exploratory and innovative applications.
- Provide leadership for effective strategic and tactical planning in the use of technology.
- Provide fast and reliable access to all information systems.
- Provide easily accessible and readily available support for all employees.
- Provide and maintain a network uptime of at least 99% annually (excluding planned maintenance).
- Provide evidence-based decision support to management regarding pertinent technologies.

## Overview of Field Technologies

### **In Motion onBoard Mobile Gateway (oMG)**

In Motion Technology's flagship product - the onBoard Mobile Gateway - delivers high performance, high security, wireless broadband networking for mobile applications by turning vehicles into communications hotspots. The Gateway extends the enterprise network to the fleet, including security layers to ensure the reliable flow of information to and from any device or application. ATS uses oMG's on every Ambulance. The oMG provides Internet (Via 3G Cellular Technology), GPS, AVL, and 12 Lead EKG Transmission. ATS' oMG's constantly broadcast GPS data to the ATS home servers which are directly translated to Automatic Vehicle Location (AVL) arrays. This allows dispatchers to see in real time where the fleet resides. Internet allows dispatch criteria and voiceless dispatch to take place via MobiCAD, as well as live GPS navigation and 12 Lead Transmission to receiving hospitals. ATS remains the first and only EMS provider in Northern Illinois to adapt this cutting edge technology.

### **Utility Rocket On Board Mobile Gateway (oMG)**

The second generation of On Board Mobile Gateways, the Rocket by Utility Inc, is the future of mobile communications. Employed by Indianapolis crews and future ATS locations, the Rocket provides speed, efficiency, and power that demanding EMS services require. High performance, high security wireless broadband networking for mobile applications are at the center of this breakthrough technology. Equipping ATS field crews with powerful 4G cellular technology, the Rocket is the most technologically advanced mobile gateway in the world. Transmitting GPS and AVL data to up to 5 simultaneous servers, the Rocket allows seamless interoperability for mutual aid. The Rocket also couples vehicle diagnostics and asset tracking that instantly alerts dispatchers when a vehicle requires maintenance or when a crew has left a crucial piece of equipment (i.e. a Cardiac Monitor) on a scene.

### **TriTech MobiCAD**

MobiCAD runs on a mobile computer in the vehicle, and is a mobile extension of Sweet-CAD. The mobile user is provided with a seamless data path to the dispatch center, with the ability to send and receive call specific information. MobiCAD provides real-time position and status meaning Dispatchers have precise information to make the best and most informed decisions. MobiCAD also provides real-time mapping and navigation to crews via GPS. Also included is voiceless dispatch, time tracking, and voiceless status. A complete failure in radio communication cannot impede ATS dispatchers. Because MobiCAD operates via the internet and oMG, dispatch criteria always makes it to a crew, and status can be tracked in real time with a push of a button. Text messaging between vehicles or vehicle-to-dispatch is a standard feature of MobiCAD.

### **TriTech Fusion ePCR**

The crown jewel of ATS' IT infrastructure, Fusion is the newest and most comprehensive PCR software available. Beyond the standard functions of PCR software, Fusion incorporates touch-screen navigation, decision support (the ability for the software to populate a majority of a report based on certain criteria), the ability to attach photos and documents, customizable layouts, encrypted patient data, and the ability to save a report and finish it on another workstation. Coupled with MobiCAD and the oMG, ATS crews can complete a run, finish a report, fax a report to a location, and transmit the run data and billing information to ATS' billing department without ever leaving their ambulance.

Transmission and data linking can happen absolutely anywhere cellular service is available. Fusion is NEMESIS Gold compliant and automatically tracks State Required data for transmission by billing. Coupled with a powerful QA/QI module, it is clear why Fusion is the industry leader. ATS was the first agency in Northern Illinois to adopt in-vehicle computers with PCR capabilities and one of the first 10 adopters of Fusion in the world.

### **iDrive X1 System**

The iDrive system is a small camera mounted in the cab of an Ambulance that provides a real time recording loop. With lenses pointing both inside the cab of the Ambulance and outside the windshield offering a driver's view, the iDrive camera provides retroactive capture of driving incidents. The X1 system incorporates a G-Force sensor, when a certain inertial force is obtained the camera "trips" saving a loop of the event. The X1 saves data 15 seconds before the incident occurred and 15 seconds after the incident, providing agencies with the ability to see events leading up to a collision or trip. Saved events are stored on a flash chip in the device, when the vehicle returns to its home station and turns off the ignition, the camera automatically begins uploading the event video via Wifi to a workstation to be reviewed. The camera is tamper-proof and also provides capture of sound upon event trigger. Additionally, because of the mounting location, the camera does not capture sensitive data involving patients. The camera can also be triggered manually by crews if they wish to document an incident (i.e. witnessing a car accident).

## **TriTech Sweet-CAD**

*Sweet-CAD* is a comprehensive computer-aided dispatching (CAD) program designed to serve the demanding call-taking and dispatching needs of Emergency Medical Service (EMS) organizations.

*Sweet-CAD* was developed to simplify and provide ease-of-mind for call taking, tracking and dispatching. The following design and functionality elements of this EMS CAD software product provides communicators with fast, flexible call taking for emergencies and prescheduled transports, thus increasing productivity and reducing response times:

### **Hot key functionality**

- Drop and drag dispatching
- User-defined colors for tracking unit status
- Respective maps for each incident card, simplifying incident and vehicle viewing
- Common patient database for scheduling recurring reservations
- System recommendations for dispatching
- Flashing alerts to notify dispatchers of response time issues
- Multiple vehicles assigned quickly and easily to an incident

### **Mapping**

*Sweet-CAD* is a map-centric EMS CAD software application with:

- Automatic geo-coding of locations to ensure accurate address information and best possible unit recommendations
- Ability to view landmarks, such as facilities and bases
- Real-time tracking of vehicles
- GIS industry standard ESRI shape files for map layer flexibility

### **Integration**

*Sweet-CAD* offers a dynamic group of interfaces and industry standard system architecture to advance your system's efficiency. Existing interfaces and imports include:

- Web Reservations
- Alpha-Numeric Paging and MobiCAD
- ANI/ALI (Primary PSAP and Remote)
- AVL/GPS
- ProQA™

### **Panasonic Toughbook CF-52**

ATS employs the Panasonic Toughbook CF-52 Scarab line of rugged laptop. Military grade shock and drop protection as well as an 1100NIT sunlight viewable touch screen are standard features of this line. The CF-52 Scarab is the fastest line of Toughbooks on the market. With a 15 inch footprint (13.1inch viewable touch screen), the CF-52 Scarab sports an Intel Core 2 Duo (Dual Core) processor at 2.63Ghz, 4GB DDR3 RAM, and a 160GB Solid State Hard Drive.

### **Microsoft Windows 7**

ATS operates exclusively on the Windows 7 operating system. All field terminals and administrative computers operate on Windows 7 Professional. Windows 7 is the latest and most advanced operating system from Microsoft offering the most advanced security and greatest stability and reliability. All of ATS' back end servers operate on Windows Server 2008 R2, which is based on Windows 7 technology.

### **Radio Infrastructure and Alerting**

ATS communicates on the standard VHF Wide Band at 154.54 Mhz with a DPL (Digital Private Line) tone of 131.8. Licensed by the FCC as WQEA813, ATS is fully compliant with existing radio communications regulations and laws. ATS is narrow-band ready.

ATS owns and operates its own radio infrastructure. ATS broadcasts and receives from its communications center located on Material Avenue in Loves Park, IL. ATS is fully capable of implementing Radio over IP to tie in to any existing radio trunk/system that exists on any frequency band.

### **TriTech Sweet-Billing**

The "Home Base" for Data residing on the ATS network, Sweet-Billing is the end destination for CAD data, MobiCAD data, Fusion Reports and Field Data reports. Sweet-Billing is a state of the art Ambulance billing suite that supports multiple sites (i.e. allows one service to bill for multiple companies or agencies). Sweet-Billing couples with Fusion ePCR to electronically import attached documents such as electronic signatures obtained by field crews, and integrates with Fusion's powerful QA/QI module offering nearly endless reporting features.

### **Altigen and VoIP**

Altigen is a network based telephone server. Currently, ATS obtains phone service via the internet and Voice Over Internet Protocol (VoIP). A triple trunked T1 line services ATS divided into many phone lines. The Altigen server then communicates with these phone lines providing ATS with vast feature-rich capabilities including call recording, conference calling, forwarding, voicemail, etc. In its current incarnation, ATS is able to function as a Primary Public Safety Answering Point (PSAP) and is capable of directly answering 911 calls. Integration with ANI/ALI data is supported by our CAD.

## Conclusion

Combining hardware, software, education, and the very best support possible is not only the mission of ATS IT, but a primary reason ATS continues to thrive. We are in the boom of the true technology age. Healthcare as a whole is passing us by. EMS – even as a relatively new industry – rejects technology and change for “the ways things have always been.” Information Technology, when done right, will not only return your investment.

ATS has seen a consistent increase in efficiency of crews, efficiency of billing, and a general increase in productivity. Crews should not be out of service for an hour at the hospital doing reports; nor should they be unable to transmit potentially life-saving data to a receiving hospital. You should not have billing delays because you can't read crew handwriting. When properly implemented, Information Technology is the foundation on which efficient business is built.

Bringing technology to the field is what we do at ATS IT. We have proven time and time again to be the pioneers for not only our region, but also for the industry. ATS' technologies are built by a Paramedic, for Paramedics, because only a Paramedic can know what is needed in the field.

It's no secret ambulances bill by the call. With our technology, we see our crews doing more runs, faster. Better response times thanks to MobiCAD, better PCR's thanks to Fusion, better in service times thanks to online fax capabilities, faster returns due to reports being transmitted to billing within seconds of being completed in the field. Hard work, determination, and ingenuity are what drive successful businesses, and those values are what drive Information Technology at ATS.

# The Rocket.™

## The fastest route to real-time situational awareness.

Transform your vehicles into integrated mobile communications hubs with direct, reliable, real-time access to all the info your personnel need. The Rocket™ makes it easy, affordable, and fast.



*It's not just how fast you respond, it's what you know when you get there. The Rocket mobile communications gateway makes first responders faster, smarter, safer, and more efficient. Right out of the gate.*



### Real-time situational awareness. Made easy.

The Rocket™. A single device leveraging one off-the-shelf USB cellular data card from any nationwide cellular carrier. Its future-proof design allows you to change cellular carriers or upgrade from 3G to 4G with just a key. Can it get any simpler?

### It just works. So your people can, too.

First responders need to focus on work, not fiddle with technology. That's why The Rocket automatically powers on when the vehicle is started. The Rocket Locker protects the antenna connections from idle hands. The Rocket's 20-channel GPS chipset provides accurate location reporting even in Manhattan urban canyons and densely wooded areas. The Rocket is loaded with smart features that keep it, and your people, always ready.

### Blazing-fast video uploads with Rocket Access Point.

Transfer gigs of in-car video or digital data in minutes instead of hours. With Rocket Access Point in your parking lot, your high value personnel can deploy quickly to the scene, doing the work they were hired to do.

### Start small, scale big, with ease.

With Remote Configuration Management, configuration changes and firmware updates can easily be pushed to 10 or 10,000 vehicles at the same time - without ever touching a Rocket™. Count on seamless performance regardless of the number of vehicles, laptops and workstations across your agency.



*Rocket Access Point. Upload gigs of data in minutes.*



[utility.com](http://utility.com)



## THE ROCKET™

### Multiple Frequency Bands and Protocols

- Supports all cellular carriers and technologies through standard USB data modems
  - AT&T, Sprint, T-Mobile, US Cellular, Verizon
  - GSM, 3G CDMA, HSDA, 4G LTE
- Automatic switching between authorized wireless access points and your cellular carrier data network
- GPS, RFID tag and vehicle diagnostic data uploaded automatically
- Remote Configuration Management and firmware updates for the Rocket appliance—even if the Rocket is not powered up
- Optional cellular booster provides connectivity to cell towers up to 30 miles away, filling in coverage gaps and increasing communications reliability

### Environmental

- Operating temperatures: -30C to +60C
- Operating humidity: 0%~95%
- MIL STD 810F temperature and vibration certification

### Physical Characteristics

- USB Type A/RJ-45 100MB PoE/ serial port connections
- Carbon fiber frame
- Rocket Locker vehicle lockbox mount with key control
- Protective/locking USB modem cover
- Dimensions: 12"(L) x 8" (H) x 2"(W)

### Vehicle Telematics, Diagnostics, and active RFID tag reading

- OBDII/CAN/J-BUS vehicle diagnostics with the optional vehicle engine computer interface cable
- Report trouble codes and engine operating parameters
- Report electronic odometer and PTO operating hour readings
- RFID tag reading for optional active WiFi RFID ID badges, key fobs with panic buttons, and asset tags
- Supervisors and Dispatchers have real-time vehicle operating data and alerts, know what people and assets are in and around a vehicle, and know where an asset was located when IT last reported

### Wireless Communications / GPS

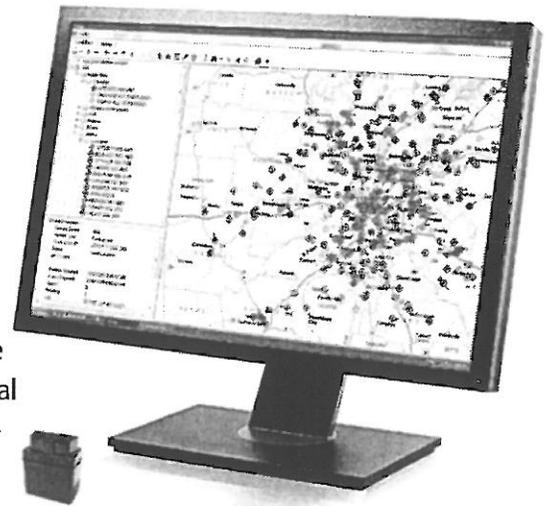
- 2.4GHz 802.11 b/g WiFi hotspot
- Optional High Frequency communications for ultra high speed data upload
- Optional 802.11 protocols for ultra high speed data upload
- SiRFstar III GPS chipset
- GPS multicast over WiFi for local virtual COM port reporting
- Event-based GPS reporting provides an actual route of vehicle travel



Take the Utility Solution for a test drive.  
 Contact us or visit our web site to learn more.  
 404.816.0300 · email: [info@utility.com](mailto:info@utility.com)

# The Tracker. Plug it in. Log on. And there's your fleet.

Get current info and breadcrumb trail reporting of vehicle location history. Share vehicle location data with other Mutual Aid partners. The Tracker is a discreet, easily installed, cost-effective mobile resource management tool.



*Easy as a USB stick to plug in—the Tracker is a cost-effective mobile appliance that provides event-based location reporting for field operations.*



## Wireless mobility.

Discreet and easily installed, the wireless Tracker appliance is one of the most cost-effective tools for mobile resource management. Simply plug the Tracker Y cable into a standard vehicle OBDII port, tuck the Tracker out of sight, and have event-based location reporting for field operations immediately. No separate antenna installation or power connection required—it just works.

## Leverage GPS data to the max.

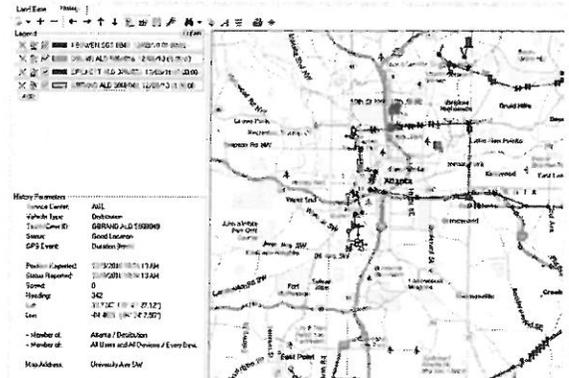
With a highly sensitive GPS chipset along with an integrated GPS antenna, get comprehensive event-based reporting of current location, and the data for accurate breadcrumb trail reporting of vehicle location history.

## Create a dynamic view of fleet operations.

Combine the Rocket and the Tracker appliance data into one dynamic, scalable, map-based view of all vehicles in your fleet. Monitor location status and provide comprehensive vehicle location history.

## Enable mutual aid.

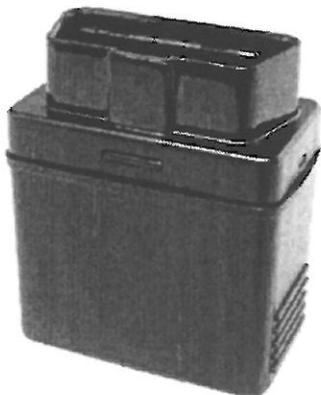
Responding to major emergencies and service outages often involves multiple organizations and agencies. Your front-line teams can easily share vehicle location data with other Mutual Aid partners. See your Mutual Aid partner vehicles on the map-based view along with your own vehicles. Each customer has full control over when and how much fleet information they share with their Mutual Aid partners.



*The Tracker tells you not only where they're going but where they've been.*



## THE TRACKER



With a highly sensitive GPS engine along with an integrated GPS antenna, the Tracker can be installed in the majority of vehicles available in North America.

### Physical Characteristics

- Dimension 1.8" (L) x 1.5" (H) x 1" (W)
- Weight < 2oz.
- Case Material ABS Plastic
- Operating Temp -30°C to +75°C

### Status Indicators

- Network Registration/GPRS
- GPS Position Acquisition Status

### Frequency Band

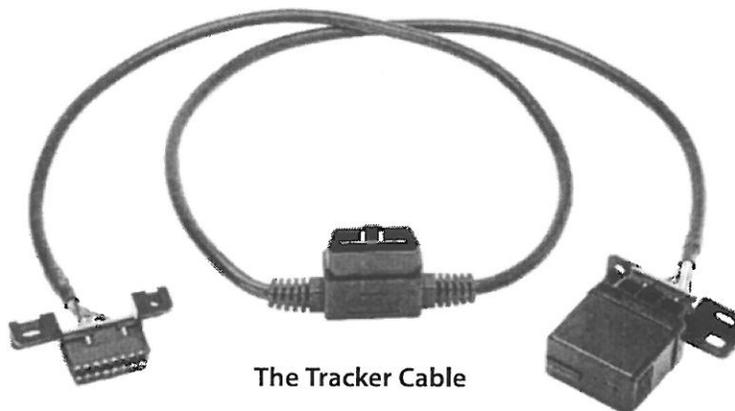
- 850/1900 MHz

### Easy Upgrade From the Tracker to the Rocket™

Upgrading from the Tracker to the full capabilities of the Rocket—full vehicle engine diagnostics reporting, RFID tag reading, and broadband WiFi access—is easy. Simply unplug the Tracker from the OBD II port and install the Rocket.

### Physical Connection

- OBD Connector J1962
  - GPS Antenna Integrated
  - Cellular Antenna
  - Integrated dual-band (850-1900 MHz)
- The Tracker comes with a Y cable so it can be easily hidden under the dash, with the other end of the Y cable left open and available to the vehicle maintenance shop technician to connect their diagnostics computer to the vehicle in the shop.
  - With a Y cable, the Tracker never has to be unplugged from the OBD II port. The Y cable stays attached, with the Tracker on one end, and the other end free for the maintenance shop to connect to.
  - The Y cable is a splitter—so both the Tracker AND a vehicle maintenance shop diagnostic computer can be connected to the vehicle OBD II port at the same time.

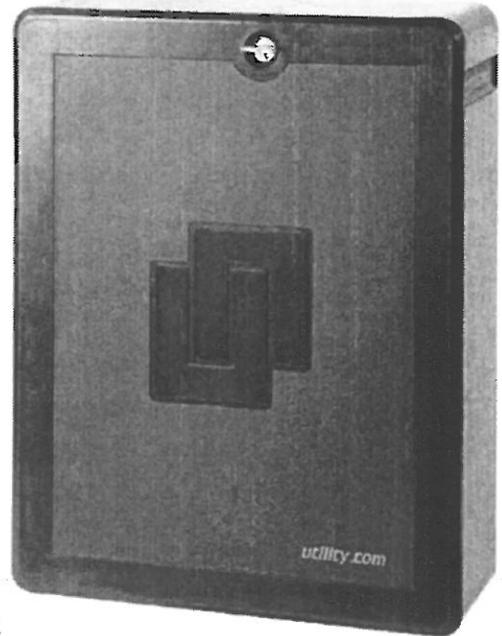


Take the Utility Solution for a test drive.  
 Contact us or visit our web site to learn more.  
 404.816.0300 • email: [info@utility.com](mailto:info@utility.com)

# The Rocket Locker. Increased Security and Performance.

**Fast and Rugged.** The Rocket Locker is an enhanced security solution for the Rocket™ and its peripherals. A built-in quick release dock provides secure mounting within the carbon fiber composite case while maintaining ease of access with a standardized lock.

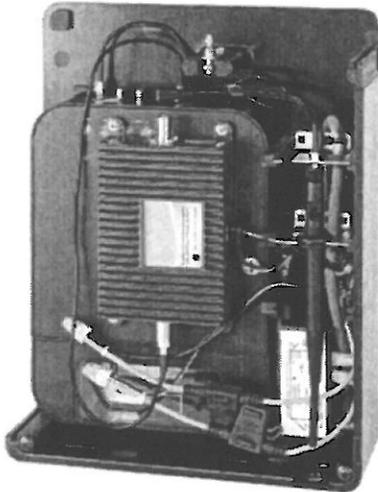
*"Locked" Rocket Locker: single unit to install, protecting the hardware from all angles.*



**Fully Secure.** The Locker seamlessly encloses a Rocket™, Booster, and Power Timer, with three compression fittings for antennas and power cables.

**Peace of Mind.** Tampering is greatly reduced - no cable connection or hardware can be reached without a key.

**Single Item Install.** The Rocket Locker reduces the overall footprint of the Rocket™ solution. The Rocket™, Booster, and Power Timer are mounted within the Locker itself, requiring only a 13"x10"x3.75" space.



**Power Timer.** Prevents momentary voltage sags that can cause peripherals to reboot. Protects vehicle batteries by shutting the Rocket™ and Booster off after a configurable time period (15 mins – 8 hours), or when vehicle battery voltage drops to 10.5v.

**Single Connection for Power.** Only one connection to ground, power, and ignition is needed for both the Rocket™ and Booster. The Locker can also power a vehicle laptop.

**Optional Cellular Booster.** Provides additional transmit power for the cellular datacard, increasing range from 3 miles up to 30.

*"Open" Locker with Booster, Rocket™ and Power Timer. When ordered together, the complete solution comes pre-wired and mounted at the factory (as shown here).*





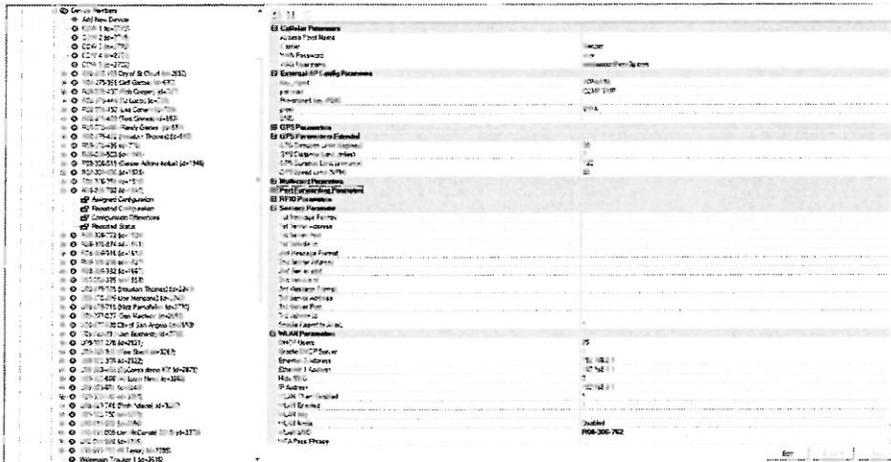
# Remote Configuration Management. (RCM)

Complete Hands Free Management.

RCM enables "over the air" management of your entire fleet from your desk.

## Efficient Over-the-Air Management of Your Entire Fleet of Rockets.

- Maximize Rocket Support functionality
- Customize icons, reporting settings and fleet preferences
- Configure advanced networking and application parameters
- Maintain GPS reporting parameters
- Immediately change security credentials for individual or multiple Rockets in your fleet



### Ongoing Support.

RCM gives users access to Utility Support whenever needed.

### Hardware Maintenance.

The RCM subscription includes replacement hardware maintenance, firmware maintenance and a 2% hot spares pool.



# Fleet Command and Control with AVaiL OBD

**Move beyond vehicle tracking and keep your fleet in top shape.**

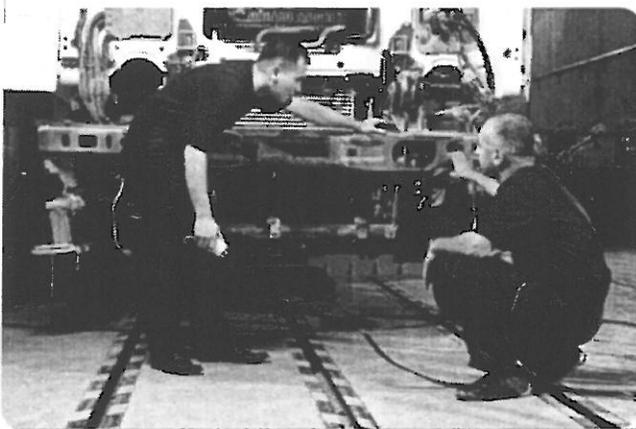
AVaiL OBD connects the Rocket directly to your engine computer via the OBDII or JBUS port for greater situational awareness of your vehicle fleet's health.



**Instant Control.** Gain peace of mind knowing exactly how your vehicles are performing. With constant updates on parameters like engine status, PTO run time, oil pressure and temperature, RPMs, coolant levels and more, you always know exactly where you stand.

**Preventative Maintenance.** Protect your vehicles by knowing exactly when they're having a problem and what that issue is. Engine trouble codes are read and reported to the system to minimize the time the Check Engine light stays on.

**Status Reports in Two Clicks.** Engine diagnostic data is easy to access. Simply log on to AVaiL, select a vehicle, and click for the most recent data. Vehicle status displays right there in the same window so you can see where each vehicle is, where it's headed, and its engine status.



**Intelligent Reporting with Datasync.** AVaiL OBD coupled with the Datasync reporting module allows you to run and create reports to make the most of your fleet data. Speed, idle time, PTO run time, coolant levels and more are standard reports for the at a glance information you need most. The optional Datasync module also gives you access to historical and current fleet data so you can create any custom report you need.



## Log Report

### RKFD Response Times

History ID : 8400294

Call Number Leg Call Date --Level Of Care	Patient Name Doctor Attendants Current Payor	Age Day Charges Credits	Caller Primary Reason Second Reason Dispatch Urgency	Unit Description Pick-up Location Drop-off Location Transport Urgency	Time 1 Time 2 Time 3 Time 4	Time 5 Time 6 Time 7 Time 8
112487 1 03/01/2011 --ALS LEVEL 1, E	PARTEE, DAPHINA NELD DLON MEDICAID	44 Year(s) Tue 615.60	ROCKFORD FIRE DEPARTME SUICIDAL/PSYCHIATRIC DIS SUICIDAL IDEATION V62.84 Emergent - Code 3	CHARLIE 71 Residence ROCKFORD MEMORIAL H Non-emergent Code 2	10:10 10:10 10:11 10:21	10:21 10:44 10:51 11:09
112527 1 03/01/2011 --ALS LEVEL 1, E	LASTER, ANGEL M RGUN APRI PRIVATE (SELF PAY)	20 Year(s) Tue 595.20	ROCKFORD FIRE DEPARTME PAIN, NECK 723.1 PAIN, BACK UNSPECIFIED 72 Emergent - Code 3	CHARLIE 75 Scene of Accident/Incident ROCKFORD MEMORIAL H Non-emergent Code 2	19:43 19:43 19:43 19:53	19:53 20:03 20:07 20:27
112612 1 03/03/2011 --ALS LEVEL 1, E	JAMES, HAGER JLAN JSEL BLUE CROSS/BLUE	52 Year(s) Thu 601.20	ROCKFORD FIRE DEPARTME PAIN, GENERALIZED 780.96 FALL - UNSPECIFIED E888.9 Emergent - Code 3	CHARLIE 76 Residence SWEDISH AMERICAN HO Non-emergent Code 2	08:50 08:50 08:50 09:03	09:03 09:14 09:27 09:45
112663 1 03/04/2011 --BLS, EMERGEN	JOHNSON, HELEN J EQUI CMCM MEDICARE	83 Year(s) Fri 384.40	ROCKFORD FIRE DEPARTME WEAKNESS 728.87 CONFUSION / DELIRIUM 293. Emergent - Code 3	CHARLIE 75 Residence SWEDISH AMERICAN HO Non-emergent Code 2	11:58 11:58 11:58 12:05	12:05 12:14 12:19 12:53
112700 1 03/05/2011 --BLS, EMERGEN	RAY, KELLIE CMCM APRI PRIVATE (SELF PAY)	47 Year(s) Sat 386.80 319.34	ROCKFORD FIRE DEPARTME ABRASIONS 919.0 FALL - UNSPECIFIED E888.9 Emergent - Code 3	CHARLIE 79 Scene of Accident/Incident ROCKFORD MEMORIAL H Non-emergent Code 2	13:51 13:51 13:51 13:57	13:57 14:07 14:11 14:32
112880 1 03/09/2011 --ALS LEVEL 1, E	BENNETT, YOLANDA CMCM EQUI SBRA PRIVATE (SELF PAY)	42 Year(s) Wed 606.00	ROCKFORD FIRE DEPARTME HEADACHE, HEAD/FACE PAI WEAKNESS 728.87 Emergent - Code 3	CHARLIE 78 Residence SWEDISH AMERICAN HO Non-emergent Code 2	17:07 17:07 17:07 17:21	17:21 17:25 17:38 18:13
113042 1 03/13/2011 --DENIAL OF CAR	DEBROCK, LORRAIN CMUL RGUN	80 Year(s) Sun 0.00	ROCKFORD FIRE DEPARTME WEAKNESS 728.87 ----- Emergent - Code 3	CHARLIE 79 Residence ----- Emergent - Code 3	19:16 19:16 19:17 19:26	19:29 ----- ----- 19:37
113081 1 03/14/2011 --ALS LEVEL 1, E	BANKES, MICHAEL CSCA EQUI CMCM PRIVATE (SELF PAY)	50 Year(s) Mon 615.60	ROCKFORD FIRE DEPARTME ALTERED MENTAL STATUS 7 OD, MEDICINAL SUBSTANCE Emergent - Code 3	CHARLIE 78 Residence SWEDISH AMERICAN HO Emergent - Code 3	10:08 10:08 10:08 10:12	10:12 10:18 10:26 10:42
113100 1 03/14/2011 --BLS, EMERGEN	PAKULA, MARK A CMCM EQUI CSCA PRIVATE (SELF PAY)	47 Year(s) Mon 395.20	ROCKFORD FIRE DEPARTME ABNORMAL LABS 796.9 ETOH INTOXICATION 303.00 Emergent - Code 3	CHARLIE 78 Residence SWEDISH AMERICAN HO Non-emergent Code 2	17:08 17:08 17:08 17:20	17:20 17:22 17:30 17:47
113269 1 03/17/2011 --BLS, EMERGEN	JONES, DAHANI A GBRO DSHE MEDICAID	1 Year(s) Thu 391.60	ROCKFORD FIRE DEPARTME SEIZURE, FEBRILE, NOS 780. ----- Emergent - Code 3	CHARLIE 78 Residence ROCKFORD MEMORIAL H Non-emergent Code 2	09:27 09:27 09:27 09:37	09:37 09:40 09:45 09:56

## Log Report

### RKFD Response Times

History ID : 8400294

Call Number Leg Call Date --Level Of Care	Patient Name Doctor Attendants Current Payor	Age Day Charges Credits	Caller Primary Reason Second Reason Dispatch Urgency	Unit Description Pick-up Location Drop-off Location Transport Urgency	Time 1 Time 2 Time 3 Time 4	Time 5 Time 6 Time 7 Time 8
113434 1 03/21/2011 --ALS LEVEL 1, E	WASHINGTON, TER NELD JSEL PRIVATE (SELF PAY)	48 Year(s) Mon 582.00	ROCKFORD FIRE DEPARTME SEIZURE/CONVULSION 780.3 HYPOGLYCEMIA W/HX DIABE Emergent - Code 3	CHARLIE 76 Residence SWEDISH AMERICAN HO Emergent - Code 3	11:01 11:01 11:01 11:06	11:06 11:23 11:26 12:03
113637 1 03/24/2011 --BLS, EMERGEN	WAINWRIGHT, DENI TPIT ABRA PRIVATE (SELF PAY)	53 Year(s) Thu 394.00	ROCKFORD FIRE DEPARTME BLEEDING, MOUTH 528.9 NOSE BLEED, EPISTAXIS 784 Emergent - Code 3	CHARLIE 79 Residence SWEDISH AMERICAN HO Non-emergent Code 2	13:26 13:26 13:26 13:35	13:41 13:41 13:48 14:15
113838 1 03/29/2011 --ALS LEVEL 1, E	BOWEN, GEORGE H RNEB APRI MEDICARE	85 Year(s) Tue 571.20	ROCKFORD FIRE DEPARTME ABDOMINAL PAIN 789.00 ABDOMINAL TENDERNESS 7 Emergent - Code 3	CHARLIE 79 Physician Office SWEDISH AMERICAN HO Non-emergent Code 2	09:34 09:34 09:35 09:42	09:42 10:01 10:11 10:19
113967 1 03/31/2011 --ALS LEVEL 1, E	TRAMMELL, SHAWN RGUN CMUL PRIVATE (SELF PAY)	21 Year(s) Thu 621.60	ROCKFORD FIRE DEPARTME ABDOMINAL PAIN 789.00 ----- Emergent - Code 3	CHARLIE 79 Residence ROCKFORD MEMORIAL H Emergent - Code 3	11:24 11:24 11:24 11:35	11:35 11:44 11:52 12:13
1139968 1 03/31/2011 --ALS LEVEL 1, E	OLSEN, DORIS NELD JSEL PRIVATE (SELF PAY)	74 Year(s) Thu 584.40	ROCKFORD FIRE DEPARTME WEAKNESS 728.87 INJURY, FACE/NECK 959.09 Emergent - Code 3	CHARLIE 76 Scene of Accident/Incident ST ANTHONY MEDICAL C Non-emergent Code 2	11:25 11:25 11:25 11:25	11:25 11:25 11:36 12:04
113755-1 1 03/27/2011 --ALS LEVEL 1, E	MORRIS, ORIL E CMCM JCOM MEDICARE	97 Year(s) Sun 606.00	ROCKFORD FIRE DEPARTME CONFUSION / DELIRIUM 293. WEAKNESS 728.87 Emergent - Code 3	CHARLIE 79 Scene of Accident/Incident SWEDISH AMERICAN HO Non-emergent Code 2	12:22 12:22 12:23 12:33	12:33 12:43 12:51 13:16
113914-1 1 03/30/2011 --ALS LEVEL 1, E	BARR, AMY CMCM DLON MEDICAID	29 Year(s) Wed 644.40	ROCKFORD FIRE DEPARTME VOMITING W/O NAUSEA 787. WHEEZING (EXCLUDING AST Emergent - Code 3	CHARLIE 78 Residence ST ANTHONY MEDICAL C Non-emergent Code 2	14:18 14:18 14:18 14:30	14:30 14:38 14:56 15:14

**Total For All**

**Total Calls: 17**

**Total Charges Total Credits Total Balance**

**8595.20 319.34 8275.86**