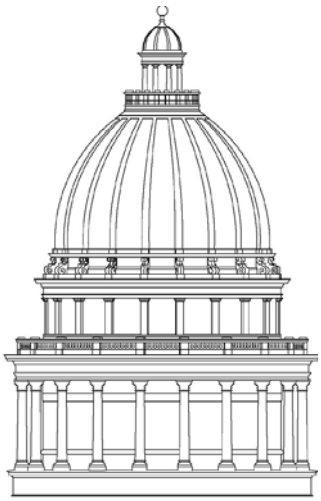
REPORT TO THE

UTAH LEGISLATURE

Number 2014-04



A Performance Audit of the Bureau of Emergency Medical Services and Preparedness

June 2014

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH
Office of the Legislative Auditor General

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June 24, 2014

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of the Bureau of Emergency Medical Services and Preparedness** (Report #2014-04). A digest is found on the blue page located at the front of the report. The audit scope and objectives are explained at the close of the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of a Performance Audit of the Bureau of Emergency Medical Services and Preparedness

The Bureau of Emergency Medical Services and Preparedness (BEMSP) is the organization within the Department of Health charged with regulating the emergency medical services (EMS) market and its providers. The responsibilities of each licensed EMS provider are contingent on the license granted by the bureau. The audit's initial scope consisted of numerous questions, and two themes emerged 1) concerns about the bureau's regulatory practices and 2) whether provider responsibilities have been adequately clarified.

Chapter II
BEMSP Needs to Improve Regulation of Ambulance Providers

BEMSP Needs to Regulate More Effectively. The administrative hearing that removed Dixie Ambulance Service's (DAS) license identified significant deficiencies in DAS's operations. The bureau can regulate more effectively by holding providers to clear minimum standards for EMS service delivery found in Utah statute and administrative rules. In the case of DAS, the bureau should have proactively identified provider deficiencies through monitoring. Instead, provider deficiencies had to be revealed in an administrative hearing initiated by another provider.

Inadequate monitoring failed to identify a provider that violated rules and was not financially viable.

Better Monitoring Procedures Are Needed to Identify Deficiencies. The bureau needs to better monitor its ambulance providers. The following three areas are specific monitoring activities that can improve: 1) Provider goals pertaining to cost, quality, and access for ambulance services need to be established and monitored. 2) More effective financial monitoring is needed, which will require better information and analysis. 3) Equipment reviews need to verify that all minimum standards established in rule are met. Improvement in these and other regulatory areas can facilitate early detection of provider deficiencies and lead to appropriate provider corrections.

Better monitoring and corrective actions allow struggling providers to address their deficiencies.

The Complaint Process Lacks Adequate Documentation and Clear Expectations. Ambulance providers hold negative perceptions

While documentation was missing for 39 percent of complaints, investigation outcomes were missing in 58 percent since 2008.

about the bureau's complaint process, which can be attributed to poor documentation as 39 percent of complaints lack documentation. Since the process has been informal and lacks clear expectations, the bureau needs to: 1) communicate all complaint outcomes in order to avoid the perception of favoritism, 2) document these complaint outcomes, and 3) follow recently updated policies and procedures. While the complaint process needs improvement, it does drive change and can be used to help restore provider confidence in the bureau.

Chapter III
BEMSP Needs to Clarify Provider Responsibilities

BEMSP Has Been Slow to Alleviate Provider Overlaps. Statute discourages multiple ambulance providers unnecessarily responding to calls—a problem that providers felt should have been addressed over a decade ago but still persists. In 2013, the bureau finally removed a statewide overlap that was neither identified nor addressed with other overlaps in 2001. While current provider overlaps in Utah are allowed in statute, the approved overlaps in Utah County remain problematic, as two ambulance providers unnecessarily respond to a single call, which creates provider conflicts.

After being clearly aware of a statewide overlap, BEMSP took 40 months to resolve the overlap.

Inconsistent Licensing Practices Create Confusion among Providers. BEMSP issues two types of ground ambulance transport licenses to providers that grant overlapping rights and responsibilities. Confusion ensued as some providers were issued both licenses, which is completely redundant. Conflicting provider opinions about their service rights and responsibilities have prompted the bureau to initiate an administrative hearing to provide clarification. The outcome from the administrative hearing need to be adopted in Administrative Rule to add needed coordination between the two ground ambulance license types.

Five providers have been awarded redundant licenses which creates confusion about service rights among providers.

Service Areas Should Be More Clearly Defined. BEMSP can improve its management of provider service areas by addressing three areas. 1) BEMSP relies on written descriptions of service areas, which are difficult to use. 2) Ambulance providers have not submitted all mutual aid agreements to BEMSP, which is required in statute. 3) All mutual aid agreements pertaining to ambulance licenses are not cataloged. Mapping these areas and recording all agreements provides greater context that is essential to managing EMS service delivery.

Verbal agreements established during the statewide overlap's removal have not been documented in mutual aid agreements.

REPORT TO THE

UTAH LEGISLATURE

Report No. 2014-04

A Performance Audit of the Bureau of Emergency Medical Services and Preparedness

June 2014

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Chapter I
Introduction

The Bureau of Emergency Medical Services and Preparedness (BEMSP) is the organization within the Department of Health charged with regulating the emergency medical services (EMS) market and its providers. The responsibilities of each licensed EMS provider are contingent on the license granted by the bureau. The audit's initial scope consisted of numerous questions, and two themes emerged: 1) concerns about the bureau's regulatory practices and 2) questions whether provider responsibilities have been adequately clarified.

BEMSP Regulates Utah's EMS Market

Local governments throughout Utah have partnered with fire departments, law enforcement agencies, and private providers to develop a statewide EMS system. The Utah Department of Health has been given statutory authority in ***Utah Code*** 26-8a-401(1) "to ensure emergency medical service quality and minimize unnecessary duplication. . ." by regulating the EMS market. The Department of Health has assigned this responsibility to BEMSP.

The bureau has statutory authority to regulate Utah's EMS market by ensuring ambulance providers are compliant with its standards.

To perform its regulatory function, the bureau has been given statutory authority to:

- License qualified providers
- Develop minimum provider standards
- Monitor provider compliance with established standards
- Take appropriate corrective actions

Performing these functions and regulating the EMS market is critical as it directly impacts the public safety of Utah residents who sometimes require lifesaving medical care. Since Utah's statewide EMS system consists of many different providers, coordinating provider responsibilities and regulating provider performance is essential for quality ambulance service. Chapter II addresses issues related to the four regulatory functions listed above and provides recommendations for improvement. In addition to regulating provider compliance with standards, clearly defining provider responsibilities is an essential role that is also performed by the bureau.

Bureau Licensing Defines Provider Responsibilities

Each EMS license the bureau approves conveys specific responsibilities to its provider. Specific responsibilities include the following three main components of each license:

Provider responsibilities are defined by their license, which includes an exclusive geographic service area, authorized service type, and mutual aid agreements.

- Exclusive geographic service area
- Authorized license type
- Relevant mutual aid agreements with other providers

Since multiple providers can be assigned to serve a single exclusive geographic service area, the license type and mutual agreements among providers add essential detail that clarify provider responsibilities. While an overview of each component is presented in this chapter, deficiencies and areas for improvement are highlighted in Chapter III.

Exclusive Geographic Service Areas Exclude Other Providers

Each license granted by the bureau allows its provider to operate in a specific geographic area. To coordinate providers, each of these geographic service areas is exclusive. Since 1999, ***Utah Code*** 26-8a-402(1) has clarified the exclusive rights granted with each license:

Only providers licensed for an exclusive geographic service area may respond to calls originating there.

> Each ground ambulance provider license issued under this part shall be for an exclusive geographic service area as described in the license. Only the licensed ground ambulance provider may respond to an ambulance request that originates within the provider's exclusive geographic service area, except as provided in Subsection (5) and Section 26-8a-416.

Geographic exclusivity therefore precludes other providers from responding to calls originating in the licensed provider's service area, unless authorized by the provider for that area. However, statute allows some important exceptions.

Applying geographic exclusivity becomes more complex when the two exceptions of ***Utah Code*** 26-8a-402(1) are applied. The first

exception, in ***Utah Code*** 26-8a-402(5), focuses on granting exceptions for occasional assistance. Specifically, the statute allows for a response that is from the exclusive geographic location of another provider:

(a) pursuant to a mutual aid agreement;
(b) to render assistance on a case-by-case basis to that provider; and
(c) as necessary to meet needs in time of disaster or other major emergency.

Statute provides exceptions for occasional assistance in times experiencing unusual demand.

The purpose of these exceptions is to allow for a response protocol when the resident provider does not have available or adequately equipped units to respond to emergencies.

The second set of exceptions, found in ***Utah Code*** 26-8a-416, is more significant, allowing for overlapping providers to concurrently serve a single exclusive geographic area. In 1999, the Department of Health was required in statute to identify and resolve overlaps in provider service areas. Resolving identified overlaps could result in four outcomes, specified in ***Utah Code*** 26-8a-416(6):

(a) a single licensed provider to serve all or part of the overlap area;
(b) more than one licensed provider to serve the overlap area;
(c) licensed providers to provide different types of service in the overlap area; or
(d) licenses that recognize service arrangements that existed on September 30, 1999.

Statute authorizes the possibility that more than one provider can be licensed to serve an exclusive geographic service area.

In seven regions of the state, the bureau identified and approved multiple providers to serve a single area, which is allowed according to options (b) and (c) above. With multiple providers serving a single area, provider configurations throughout the state vary according to provider license types and mutual aid agreements.

Single Exclusive Areas Are Served by Providers with Different License Types

When multiple providers serve the same exclusive geographic service area, their responsibilities are differentiated by the license type assigned to each provider. *Administrative Rule* 426-3-300 specifies two ambulance license types: a ground ambulance transport license and a

separate ground ambulance inter-facility transport license, which is referred to simply as an inter-facility license.

Two types of ambulance licenses have been authorized in *Administrative Rule*.

According to the bureau's interpretation of ***Utah Code*** 26-8a-404(3), a ground ambulance license is the default license and as such may provide all services. In contrast, *Administrative Rule* 426-3-400(3) limits inter-facility license holder responses to licensed medical facilities "when arranged by the transferring physician for the particular patient." Throughout the state, provider configurations will vary depending on the license types assigned to providers. Figure 1.1 shows examples of different provider configurations in Salt Lake and Utah counties.

Figure 1.1 Northern Utah Cities Are Served by Various Configurations of Ambulance Providers. Each city has its own history of ambulance provider relationships and corresponding agreements that affect how ambulance services are delivered.

Cities can be served by various configurations of ambulance providers.

Region	Providers & License Types
South Jordan City	*South Jordan Fire Department* • Paramedic Ground Ambulance • Paramedic Inter-facility
Orem City	*Orem Department of Public Safety* • Paramedic Ground Ambulance *Gold Cross Ambulance* • Paramedic Inter-facility

Source: Current Provider Licenses Maintained by BEMSP

As shown in Figure 1.1, South Jordan City's fire department serves as the single provider for ambulance services and has both a ground ambulance license and an inter-facility license. In contrast, Orem City is served by two providers. The Orem Department of Public Safety is the licensed provider to respond to all ambulance requests and may also provide inter-facility transport. In addition, Gold Cross has an inter-facility license that also allows that provider to respond to inter-facility transport requests. Since requests for inter-facility transport in Orem City may be provided by either provider, the potential for confusion and unnecessary duplication exists. Clarifying the responsibilities of providers in these situations is the essential role that mutual aid agreements provide.

Mutual Aid Agreements Provide Essential Detail about Provider Responsibilities

As the prior section illustrated, license types do not adequately detail all of a provider's responsibilities. These essential details are included in mutual aid agreements developed through negotiations among ambulance providers. According to ***Utah Code*** 26-8a-402(4)(c), all of these mutual aid agreements are to be submitted to the Department of Health.

Most of Salt Lake County is served by overlapping ambulance providers. These providers use mutual aid agreements to clarify their responsibilities. In Sandy City, for example, two providers are licensed to respond to ambulance calls. Therefore, to prevent both providers responding to ambulance calls, they established a mutual aid agreement that specifies which provider will respond, based on the patient's condition. These agreements provide valuable coordination among providers by clarifying their responsibilities.

When two ambulance providers serve a single area, mutual aid agreements can coordinate how calls are distributed.

Audit Scope and Objectives

Both topics discussed in this chapter, bureau regulation and provider responsibilities, were areas of concern that were expressed by providers at the beginning of this audit. The audit requestor provided a letter containing 28 questions and concerns from providers about the bureau's role in providing adequate regulation and clarification on provider responsibilities.

Using the 28 questions as a guide, we formulated specific audit objectives that evaluated these questions and concerns during the fieldwork stage of the audit. One of these questions dealt with a concern that two members of the rules revision task force had made unauthorized changes to the rules. Our review confirmed that while changes were made, process controls identified and corrected the unauthorized changes. Since sufficient controls by BEMSP were in place, no audit findings beyond what is reported here needed to be detailed in the remaining chapters. In contrast, other questions produced findings that will be detailed in the following chapters:

While many of the audit's initial 28 questions led to audit findings, one question about an unauthorized *Administrative Rule* change instead confirmed that process controls exist.

Chapters II and III discuss how the bureau can improve its regulation of ambulance providers and clarify provider responsibilities.

- BEMSP Needs to Improve Regulation of Ambulance Providers – Chapter II
- BEMSP Needs to Clarify Provider Responsibilities – Chapter III

Chapter II
BEMSP Needs to Improve Regulation of Ambulance Providers

In 2013, the license of one Utah ambulance provider was removed because of operational deficiencies. This process revealed some concerns with the Bureau of Emergency Medical Services and Preparedness's (BEMSP) regulation of ambulance providers. To facilitate effective regulation, the bureau needs to adopt better monitoring processes, particularly with regard to cost, quality, and access goals, financial solvency, and equipment oversight. Improved monitoring and more effective regulation can give providers opportunities to correct deficiencies and avoid harsher penalties, like license revocation. Since the bureau's complaint process is its primary tool for identifying provider deficiencies, the process needs to be improved as it lacks adequate documentation and clear expectations for providers.

The bureau needs to adopt better monitoring processes.

From May 2011 through January 2013, Dixie Ambulance Services (DAS) was the subject of proceedings that concluded in the removal of its ambulance licenses to serve St. George City. These proceedings, and the subsequent recommended order involving DAS, serve as a case study for identifying ways the bureau can enhance its regulation of all providers.

Proceedings involving Dixie Ambulance Services in St. George serve as a case study for identifying ways the bureau can enhance its regulation of providers.

In February 2013, the mayor and city council of St. George responded to the recommended order by accepting the findings about DAS but raised concern about the bureau's oversight. Specifically, they wrote:

> In summary, the City believes that the Recommended Order brings to light several serious deficiencies on the part of DAS that need to be corrected immediately, but also reveals a lack of oversight and enforcement by the State [BEMSP] in inspecting and informing DAS of these deficiencies and allowing time for DAS to correct them.

Like the St. George City officials, we too were concerned with the bureau's lack of oversight, both because it did not identify DAS

We are concerned with the bureau's lack of oversight.

It is important to clarify that we did not audit the DAS proceedings and do not take a position on the outcome of this proceeding.

deficiencies and because it raised the possibility of an ongoing pattern of insufficient regulation. Therefore, this chapter will discuss actions the bureau can take to address problems with its regulatory practices; these concerns were identified by our review of the DAS license removal case and the bureau's complaint process.

It is important to clarify that we did not audit the DAS proceedings and do not take a position on the outcome of this proceeding. However, we acknowledge that the recommended final order was based on over 100 exhibits and thousands of pages of documents that included statistical information and expert witness reports. Additionally, an outpouring of public testimony in support of DAS was factored into the final order. Notably, the outcome from the DAS proceeding was not appealed by either party despite clear explanation of the statutory right to do so (***Utah Code*** 63G-4-403).

BEMSP Needs to Regulate More Effectively

The bureau can regulate more effectively by holding providers to clear minimum standards in statute and rule.

The administrative hearing that removed DAS's license identified significant deficiencies in DAS's operations. The bureau can regulate more effectively by holding providers to clear minimum standards for EMS service delivery found in Utah statute and administrative rules. In the case of DAS, the bureau should have proactively identified provider deficiencies through monitoring. Instead, provider deficiencies had to be revealed in an administrative hearing initiated by another provider.

Administrative Hearing Identified Significant Provider Deficiencies

The administrative hearing highlighted significant provider deficiencies undetected by the bureau.

The administrative hearing highlighted significant provider deficiencies undetected by the bureau, which should have been monitoring for these deficiencies. In the recommended final order, the presiding hearing officer outlined Dixie Ambulance's operational deficiencies. Specifically, the summary stated "The current licensed ambulance provider of such services, [Dixie Ambulance], is:

a) in violation of Utah administrative rules;

b) does not meet industry operational standards governing EMS staffing requirements and ambulance response times;
c) is not financially viable; and
d) is unlikely able to continue providing quality ambulance services that St. George deserves and requires into the future."

If the Bureau had been actively monitoring providers, then deficiencies such as those found in Dixie Ambulance would likely have been identified. The next section discusses the minimum standards established in statute and rule that the bureau should be using to monitor providers.

Deficiencies Violated Minimum Standards in Statute and Rule

While there are minimum standards in statute and rule, the bureau has not effectively monitored provider compliance with these standards. The Bureau of Emergency Medical Services and Preparedness is assigned the statutory responsibility to regulate Utah's EMS industry by the Department of Health (see ***Utah Code*** 26-8a-401(1)). Statute lists specific areas of provider operations that should be monitored. Specifically, ***Utah Code*** 26-8a-404(2) states the following:

> The department shall make rules establishing minimum qualifications and requirements for:
> a) personnel;
> b) capital reserves;
> c) equipment;
> d) a business plan;
> e) operational procedures;
> f) medical direction agreements;
> g) management and control; and
> h) other matters that may be relevant to an applicant's ability to provide ground ambulance or paramedic service.

Each of DAS's operational deficiencies cited in the recommended final order corresponds to minimum qualifications established in statute and rule.

Each of DAS's operational deficiencies cited in the recommended final order corresponds to one of these areas where minimum qualifications were established. For example, the minimum qualifications for capital reserves was defined by the Department in *Administrative Rule* 426-14-303(1)(j), which states that an application could be denied because

of financial insolvency. This problem occurs when a provider has insufficient assets to cover its liabilities.

The bureau did not identify DAS's operational deficiencies because of its inadequate monitoring of provider compliance.

Our review showed that for each minimum standard developed in statute, there are corresponding minimum standards developed in rule. The bureau did not identify DAS's operational deficiencies occurred because of inadequate monitoring of provider compliance, not because of a lack of defined standards.

Bureau Monitoring Should Have Identified Provider Deficiencies

The bureau's inadequate monitoring was an issue that St. George City officials emphasized in its response to the recommended final order. In February 2013, St. George City officials made a strong point that the bureau failed in its monitoring of providers:

A recommended final order states that DAS is not "financially viable," yet the state has had the authority and duty to have been aware of their financial status.

> It is surprising to us that the Recommended Order states that DAS is not "financially viable" when the state has had the authority and duty to have been aware of the financial status of the City's sole EMS provider. While the City does not dispute the findings regarding the financial status of DAS, the City questions how a state agency, whose job it is ensure that license holders are financially viable to provide this essential and critical service, only became aware of this fact at the same time as the City, and only due to the license application process initiated by Gold Cross.

This statement reiterates that the bureau has the responsibility to monitor providers for deficiencies and did not do so in this case. The question was asked by St. George City officials, "If this lengthy process had not been initiated by the application of Gold Cross, what action would the State have taken of its own accord to discover and address these serious issues and when?"

Since the bureau did not take action on DAS's deficiencies, it was ultimately beneficial that another provider, Gold Cross Ambulance, exercised the statutory authority to take action against a deficient provider. While this process may have resolved the ambulance service issue for St. George, a timely bureau-initiated process would have

notified the provider of its deficiencies and likely allowed adequate opportunity to address the issue. This process should be the preferred regulatory model moving forward for the state. In the next section, we list some key areas wherein we believe the bureau can begin to exercise greater regulatory oversight.

Notifying providers about deficiencies and allowing adequate opportunity to address issues is a preferred regulatory model for BEMSP.

Better Monitoring Procedures Are Needed to Identify Deficiencies

The bureau needs to provide better monitoring of its ambulance providers. Three areas where we focused our audit review illustrate how monitoring activities can improve.

- Provider goals pertaining to cost, quality, and access for ambulance services need to be established and monitored.
- More effective financial monitoring is needed, which will require better information and analysis.
- Equipment reviews need to verify that all minimum standards established in rule are met.

We believe that improvement in these and other regulatory areas can facilitate early detection of provider deficiencies and lead to correction.

Cost, Quality, and Access Goals Are Not Documented or Monitored

An important performance measure discussed at length in the Dixie Ambulance case was response times. The bureau director told us that they do not monitor response times, because local governments are encouraged to develop standards and monitor ambulance providers' performance. ***Utah Code*** 26-8a-408(7) states, "the Legislature strongly encourages local governments to establish cost, quality, and access goals for the ground ambulance and paramedic services that serve their areas." As a regulator, the bureau still needs to ensure that local governments are holding providers accountable for meeting these goals because, without such standards, providers have no metric to evaluate themselves and no authoritative body to hold them accountable.

As a regulator, the bureau needs to ensure that local governments are holding providers accountable.

Our limited sample of eight cities in counties of the first and second class found that seven cities have adopted response time goals for their providers. We believe that response times, as well as other standards, are needed to effectively regulate provider performance. As outlined in our office's *Best Practices for Good Management*, the three stages of the management cycle include planning, implementation, and evaluation. Evaluation, of course, requires information such as provider standards and actual performance.

Provider accountability for cost, quality, and access goals was an important feedback mechanism missing in St. George, but is now being implemented for its new provider. To help ensure a high level of ambulance service in all areas of the state, we recommend that the Legislature consider amending ***Utah Code*** 26-8a-408(7) to make the establishment of cost, quality, and access goals mandatory for all local governments. In addition, the bureau should promote the development of these goals by documenting which of their providers have goals established and whether local governments are holding them accountable.

We recommend that the Legislature consider making the establishment of cost, quality, and access goals mandatory for all local governments.

Effective Financial Monitoring Requires Better Information and Analysis

Bureau staff relies on the financial information submitted for ambulance rate setting to evaluate provider financial viability. The problem with this practice is that the information focuses on revenue and expense data. No balance sheet data showing assets and liabilities is collected. The relationship between assets and liabilities was used in the Dixie Ambulance case to evaluate financial solvency, highlighting the need for bureau review of balance sheet data. Therefore, it is problematic that balance sheet information is not collected by the bureau.

Balance sheet data, needed to evaluate financial solvency, is not being collected by the bureau.

Staff also expressed concerns about the quality of data they currently receive. For example, some municipalities may include only EMS personnel data, while other municipalities that provide both EMS and firefighting services include data for all of these staff. These differences in accounting for personnel make cost comparisons difficult. Since no methodology has been developed to consistently report costs and revenues among providers, comparability is limited. Therefore, the bureau needs to evaluate quality and relevancy of the financial data it collects from providers and develop a methodology

whereby providers can submit data that is more consistent among providers.

Equipment Reviews Do Not Verify Maintenance of Critical Devices

One inspection area where the bureau actually does fairly well is the annual equipment reviews performed by its contractors. *Administrative Rule* 426-4-900 lists all equipment required to be carried by various ambulance types; we verified that bureau contractors check for the required equipment. However, inspections of critical devices, such as defibrillators, could be more thorough.

Inspections of critical devices, such as defibrillators, could be more thorough.

For example, *Administrative Rule* 426-4-900(5)(a) requires the provider to "document all equipment inspections, testing, and maintenance." Subsection (b) elaborates that applicable equipment, such as defibrillators, must be inspected monthly. However, the checklist used by bureau contractors does not include an inspection of maintenance logs for this critical equipment. Consequently, the bureau has no assurance that proper maintenance of critical equipment is occurring. Therefore, we recommend that the bureau be more comprehensive in reviewing provider compliance with all equipment requirements specified in *Administrative Rule* 426-4-900.

Because we only reviewed three of the compliance processes the bureau should use to hold providers accountable for meeting minimum performance standards, we believe review of additional regulatory areas is warranted. The bureau should review all standards required in ***Utah Code*** 26-8a-404(2) to ensure that its monitoring processes support early detection of possible provider deficiencies.

The bureau should review the additional regulatory areas beyond the three we commented on.

Inadequate Early Detection Allowed Deficiencies to Persist

The removal of DAS's licenses because of operational deficiencies did not follow the expected process of escalating penalties, including restrictions, probation, and suspension. Since the bureau was not aware of DAS's deficiencies, it did not exercise its statutory authority to apply the lesser penalties. These lesser corrective actions serve as early detection of issues and allow a penalized provider adequate opportunity to correct its deficiencies.

License removal should be used as an action of last resort, after other measures have been taken to correct provider deficiencies.

Removal of Dixie Ambulance Proceeded More Favorable Actions. Removing a license should be used as an action of last resort, after other measures have been taken to correct provider deficiencies. However, in the case of Dixie Ambulance, rather than using other, less serious penalties, license removal was used first despite warning signs that DAS was noncompliant. According to the bureau complaint log, three valid complaints had been filed against Dixie Ambulance, including one complaint that resulted in a written warning. This written warning was the result of a validated complaint about inadequate staff training filed in November 2009. These complaints should have provided sufficient evidence to prompt the bureau to follow up with additional review of DAS, but this further review did not occur.

In addition to the authority to revoke a provider's license, the bureau also has authority to suspend, restrict, or place a license holder on probation, according to ***Utah Code*** 26-8a-504(1). Because the bureau had performed insufficient monitoring to be aware of DAS's deficiencies, the bureau did not pursue these other corrective actions.

Corrective actions, such as suspension, restriction, or probation, serve an important function as they make a provider aware of the severity of their deficiencies.

Corrective Action Serves An Important Function. We are concerned with the bureau's inaction in cases like Dixie Ambulance, because it does not offer providers opportunities for correction. Corrective actions, such as suspension, restriction or probation, serve an important function as they make providers aware of the severity of their deficiencies. Perhaps more importantly, they provide specific guidance and a time frame for providers to address those deficiencies.

The absence of this opportunity for DAS was a significant concern for St. George City officials, who were seeking an opportunity for their ambulance provider to correct its deficiencies. The process appears harsh when the only formal corrective actions the provider received were a written warning in November 2009 and license removal about three years later in May 2013.

We do not question the statutory authority and legitimacy of the action Gold Cross took to petition for the removal of DAS's license and to become the licensed provider for St. George City. However, the lack of formal corrective actions, in this case and more generally, is a concern that needs to be addressed by the bureau. Another way the

bureau can improve its regulatory oversight is by bolstering the complaint process, discussed in the next section.

The Complaint Process Lacks Adequate Documentation and Clear Expectations

Ambulance providers hold negative perceptions about the bureau's complaint process. Poor documentation largely accounts for these perceptions as 39 percent of complaints had no documentation. In addition, the process has been informal and lacks clear expectations, which the bureau needs to correct by:

- Communicating complaint outcomes in order to avoid the perception of favoritism
- Documenting complaint outcomes
- Following recently updated policies and procedures

We found that submitted complaints about providers were valid about one-third of the time. While the complaint process requires improvement, it does drive change and can be used to help restore provider confidence in the bureau.

Some Providers Have Negative Perceptions of Complaint Process

Bureau management told us that the complaint process is one tool they use to regulate the EMS industry. The process relies on ambulance providers voluntarily policing each other, which requires provider confidence in the process to be effective. Unfortunately, some providers are not confident that the process will yield results and thus do not use it. As one EMS provider stated, "I have real lack of confidence in the complaint process. The lack of follow-through by BEMS is very disheartening."

The complaint process relies on ambulance providers voluntarily policing each other, which requires provider confidence to be effective.

Provider concerns about the process varied widely. During a rules task force meeting, the Department of Health's attorney suggested to one provider that a solution to the provider's concern was to file a complaint about an alleged violation. In response, the provider stated that filing a complaint "never makes any difference anyway."

Discussions with a sample group of individual providers showed more tempered, but still concerning, perceptions. Specifically, some stated that they were not aware of the complaint process, others raised concerns about how findings were disseminated, and another felt the core issue was simply poor communication between the state and EMS agencies. All of these perceptions illustrate that providers are not confident in the process. Low confidence reduces the likelihood that a provider will engage the process, which makes the process less effective. Based on our review, problems with the complaint process can be largely attributed to the bureau's poor documentation practices.

Complaints Are Poorly Documented

Our review of complaint documentation revealed that 39 percent of complaints had no documentation related to the complaint.

From 2008 through 2013, the bureau received and tracked 66 complaints (about 11 complaints a year) filed against licensed EMS providers. Our review of complaint documentation revealed that 26 of the 66 complaints (39 percent) had no documentation related to the complaint. When we requested the missing complaint documentation, bureau management stated that the documents could not be located and were not available electronically.

Maintaining adequate records is a basic tenet of regulation and needs to improve at the bureau. The bureau's initial step should be to ensure staff activities related to complaints are documented. During our review of other records kept by the bureau, finding documentation was difficult because some information was scanned while other documents were retained as physical copies. We recognize that the bureau is in the process of digitizing the immense amounts of documentation it has received. However, we believe that well-organized documentation will better serve all stakeholders in the ambulance licensing process. Therefore, we recommend that the bureau assess and improve its documentation practices for all processes related to ambulance regulation.

The Complaint Process Has Been Informal and Lacks Clear Expectations

Maintaining documentation and formalizing the complaint process should improve provider perceptions.

Poor provider perceptions of the complaint process are the product of an informal complaint process that is not adequately accountable to participants. Maintaining documentation and formalizing the process should improve provider perceptions by establishing clear

expectations, beginning with the following three areas for improvement.

- Communication of outcomes needs to be formalized to ensure all providers perceive process fairness.
- The process needs to formalize how outcomes are documented.
- The process should adhere to the formal set of policies and procedures that the bureau has recently adopted.

Once these improvements are implemented, the process can be used to more effectively promote bureau action.

Communicating Complaint Outcomes Should Be More Formal. During the audit, providers raised concerns about the questionable approach the bureau sometimes uses to communicate information. In one particular instance, a complaint outcome was disclosed to a member of the Orem City Fire Department, which was neither the alleged offender nor the complainant, before the complaint outcome became public. The following message was sent from the bureau director to the battalion chief: "Since you and I had previously talked about this I am sending you our final order but it won't go out until Monday so please don't distribute it."

This communication is problematic as some providers may be granted inequitable access to information. The EMS provider who filed the complaint reported being frustrated "that they were the last to know about the information." Consequently, part of formalizing the complaint process should include communicating complaint outcomes only to the complainant and alleged violator.

Formalizing the complaint process should include communicating complaint outcomes to just the complainant and alleged violator.

Complaint Outcomes Should Be Formally Documented. As previously mentioned, the bureau had no documentation for 26 of the 66 filed complaints. Using a limited sample of 12 complaints that were documented, outcomes were missing or not clearly stated in 7 instances (58 percent), which is very concerning.

For example, the investigator for one complaint noted, "issues resolved and discussed," but supporting documentation and a letter to the involved providers were missing. When asked why so many complaints were missing clearly stated outcomes, staff stated that they

"only issue letters in cases where a corrective action was necessary," and complaints were often resolved informally.

Administrative Rule 426-4-500, which became effective in August 2013, now requires that the department provide written notification even if the complaint is not deemed meritorious. This requirement is reinforced in the bureau's complaint policies and procedures, which should address the issue in the future.

The bureau recently documented and formalized its complaint process.

The Bureau Needs to Adhere to Its Recently Adopted Policies and Procedures. An update to *Administrative Rule* 426-4-500(1), which became effective August 2013, states that "complaints will follow Department's Policy and will be investigated by the appropriate Department's staff." According to the bureau director, the recently documented and formalized complaint policy will help resolve issues due to lack of documentation.

Prior to drafting its complaint policy, there was no authoritative source where providers could go to understand the process, which significantly contributed to the ambiguity about the process worked. In contrast to Utah, Idaho's complaint form is posted on their state EMS website and the process is documented electronically. We recommend that the bureau consider enhancing its transparency by posting both its complaint process policies and the form on its website. This step is very important as it addresses concerns from providers who stated they did not know a complaint process existed.

The Complaint Process Does Drive Changes

While the majority of complaint cases have a finding of no fault, some cases involved violations of statute or rule, which resulted in bureau action.

Because supporting documentation was missing for many of the complaints filed, we used staff comments about complaints to evaluate complaint outcomes. While the majority of complaint cases had no finding of fault, a number of violations of statute or rule resulted in bureau action. Providers perceive that the bureau is not being responsive to the complaints they file, but this is likely due to the infrequency with which complaints are substantiated and the way these outcomes are communicated. The following is our breakdown of staff comments about the action taken for the 66 complaints:

- 35 indicated no finding of fault (53 percent)
- 23 indicated fault and some action was taken (35 percent)

- 5 did not clearly describe bureau actions (8 percent)
- 3 were still being investigated (4 percent)

While staff frequently specified the corrective actions taken or the reasoning why a violation did not occur, the 5 instances (8 percent) did not state a clear resolution. For example, one resolution stated that information was requested from the Department of Homeland Security, and another vaguely stated that a staff member "resolved [the] issue." As these percentages nonetheless illustrate, about one third of all complaints result in agency action. These actions can promote change, as illustrated by the following two complaints.

The first complaint involved an allegation that a non-resident provider responded to a call in Tooele County. After the bureau validated the allegation, the violator was issued a letter documenting the bureau's findings. In response, the provider changed its dispatch protocols, and data shows corresponding changes in the provider's behavior.

In response to a meritorious complaint, the provider changed its dispatch protocols, and data shows corresponding changes in the provider's behavior.

The second complaint is still pending and involves allegations of an inter-facility transfer without proper medical control authorization. Because of the nature of this allegation, the bureau initiated an administrative hearing to clarify providers' service rights in Utah County. While the complaint has not been resolved, the bureau-initiated administrative hearing should promote significant change.

In both of these cases, complaints have resulted in bureau action. This is contrary to some providers' belief that filing a complaint will not yield results. This contradiction highlights the importance of documenting and communicating results from complaint investigations to providers, regardless of outcome.

Recommendations

1. We recommend that BEMSP utilize its statutory authority to take formal corrective actions, such as restrictions, probation, and suspension, when provider deficiencies warrant.

2. We recommend that the Legislature consider amending ***Utah Code*** 26-8a-408(7) to make the establishment of cost, quality, and access goals mandatory for all local governments.

3. We recommend that BEMSP promote the adoption of cost, quality, and access goals by documenting which providers have goals established and whether their local governments are holding them accountable.

4. We recommend that BEMSP require that providers submit financial data that is consistent among providers and indicative of their financial solvency.

5. We recommend that BEMSP comprehensively review provider compliance with all equipment requirements specified in *Administrative Rule* 426-4-900.

6. We recommend BEMSP review all standards required in ***Utah Code*** 26-8a-404 (2) to ensure that bureau processes support early detection of provider deficiencies.

7. We recommend that BEMSP assess and improve its documentation for the complaint process and for all other processes related to ambulance regulation.

8. We recommend that BEMSP avoid communication about complaint outcomes with unassociated providers until outcomes are made public.

9. We recommend that BEMSP follow its complaint policies and procedures and document the outcomes of all complaint investigations.

10. We recommend that BEMSP post its complaint process policies and complaint form on its website.

Chapter III
BEMSP Needs to Clarify Provider Responsibilities

An effective emergency medical services (EMS) system in Utah requires the Bureau of Emergency Medical Services and Preparedness (BEMSP) to provide better coordination of responsibilities among providers and minimize unnecessary duplication. Over the years, BEMSP has been slow to eliminate service overlaps statewide. Some service overlaps have been allowed to exist without regulatory actions for years and some still exist. The overlap in St. George City existed for more than three years without BEMSP taking action to resolve numerous complaints. A current approved overlap in Utah County is still causing questions among licensed providers. Inconsistent licensing practices by the bureau have created confusion about provider rights and responsibilities. The bureau needs to more clearly define service areas and consolidate licenses to eliminate redundancy.

To minimize unnecessary duplication, provider responsibilities need to be clarified where overlaps exist.

Chapter I established that multiple ambulance providers can serve a single geographic service area. *Administrative Rule* 426-3-300 establishes two ambulance licenses that are both authorized to provide inter-facility transportation, in which a patient is transferred between two licensed medical facilities. Since both license types allow for inter-facility transport, these types of patient transports are the largest source of service duplication and confusion among ambulance providers. The remainder of this chapter describes the extent that duplication remains a problem and specifies recommendations to coordinate and clarify provider responsibilities.

BEMSP Has Been Slow to Alleviate Provider Overlaps

Statute discourages multiple ambulance providers unnecessarily responding to calls—a problem that providers felt should have been addressed over a decade ago but still persists. In 2013, the bureau finally removed a statewide overlap that had not been identified or addressed with other overlaps in 2001. While current provider overlaps in Utah are allowed in statute, the overlaps in Utah County

While most overlap issues have been addressed, conflicts among providers persist in Utah County.

remain problematic, as two ambulance providers may unnecessarily respond to a single call, which creates provider conflicts.

Provider Duplication Is Problematic

Statute assigns the Department of Health responsibility to minimize unnecessary duplication.

Utah's EMS system has been intentionally designed to minimize duplication. Specifically, ***Utah Code*** 26-8a-401(1) states that "to ensure [EMS] quality and minimize unnecessary duplication, the department shall regulate the [EMS] market." To accomplish this objective, statute prescribes that the system consist of exclusive geographic service areas. These areas are often served by a single ground ambulance provider, frequently the city fire department, and less frequently by two providers.

The negative effects of duplication can be observed when two providers are allowed to compete for ambulance service calls, and occasionally, both providers respond to a call. In these situations, conflict ensues as providers have no agreed-upon way to distribute calls between them. In written correspondence between two conflicted providers, one stated:

Duplication creates conflicts among responding providers and delays critical care to patients.

> Such conflicts between ambulance service providers are a disservice to the public. They impair the ability of the licensed service provider to do its job. They delay critical care to patients.

These situations are an inefficient use of EMS resources as units from both providers unnecessarily respond and utilize resources that could respond to other calls.

The audit request for this audit included 13 letters from various EMS providers who expressed concerns about whether their exclusive geographical areas are being promoted and preserved. ***Utah Code*** 26-8a-402 requires the bureau to issue ground ambulance licenses for exclusive geographic areas, which minimizes unnecessary duplication. Based on the concerns expressed by these providers, the bureau should be more proactively addressing issues related to provider rights and responsibilities rather than following the prolonged process experienced thus far.

During the 1999 General Session, the Legislature passed SB 54 that specified an initial schedule where overlaps should be addressed.

According to ***Utah Code*** 26-8a-416(1), "By May 30, 2000, the department shall review all licenses in effect on October 2, 1999, to identify overlap, *as defined in department rule,* in the service areas of two or more licensed providers." After the bureau's initial review, seven overlaps were identified and resolved, but the bureau did not identify the statewide overlap discussed in the next section, which has been a big concern for many providers.

While the bureau identified seven county-specific overlaps in 2000, the bureau missed identifying a statewide overlap.

BEMSP Was Slow to Eliminate Overlap of Statewide License

Gold Cross Services, Inc. (Gold Cross) received statewide authority from the bureau in 1984 to provide inter-facility transport services. After the bureau was clearly aware of the overlap in March 2010, the process to address the overlap did not conclude until three years later with the removal of the statewide language in July 2013. For 20 months after sending its letter in March 2010, the bureau took no action to address the statewide language.

We received no documentation from providers indicating that the statewide language was a problem until March 2010. On March 22, 2010, the bureau sent a letter to Gold Cross that confirmed they "have authority to respond to a request from local medical control authority for an inter-facility transport anywhere in the State of Utah." Subsequently, Gold Cross began using its Salt Lake County license to provide inter-facility transfer services for Dixie Regional Medical Center in St. George City.

Gold Cross Services, Inc.'s statewide license created conflict with the incumbent provider for St. George City.

This action by Gold Cross created conflicts with the incumbent provider, Dixie Ambulance Service (DAS) that required two administrative hearings and, ultimately, the removal of DAS's license. Concurrently from November 2011 to December 2012, the bureau began conducting 13 months of overlap hearings with providers throughout the state to discuss concerns with Gold Cross's statewide authority. While issues raised at most hearings were quickly resolved, Washington County and Weber County providers requested a formal administrative hearing to resolve their concerns.

The bureau addressed the statewide overlap three years after the bureau clearly knew the overlap existed.

Gold Cross relinquished the language when its license was renewed on July 31, 2013. According to bureau management, this was the result of a negotiated verbal agreement between the bureau and Gold Cross that resolved the overlap and avoided any legal proceedings.

We do not oppose the bureau director's negotiated verbal agreement but also recognize that delaying action prolonged a process that was already unacceptable to some providers. While the exact cause for not identifying a statewide overlap is not certain because key staff retired, it is clear that the department did not adequately define the scope of its initial overlap review. ***Utah Code*** 26-8a-416(1) required that overlaps be "defined in department rule," but no definition of overlaps was added to rule as required in statute. Therefore, resolving the statewide overlap should have been addressed earlier than it was.

Coordinating Providers in Utah County Is a Lingering Problem

Overlapping providers in Utah County have not coordinated when each provider will respond to EMS requests.

While ambulance providers in Utah County are part of an approved overlap, the lack of coordinated services among overlapping providers is problematic. Inadequate coordination creates situations where two providers respond to a critical patient and claim they are the appropriate responder. As discussed earlier in this chapter, these conflicts have the potential to adversely affect patient care.

In Utah County, attempts thus far to minimize unnecessary duplication by coordinating provider activities have been unproductive. Mutual aid agreements, which specify the criteria that would be used to allocate services among overlapping providers, have been proposed by one provider only to be rejected by the other.

Salt Lake County providers have developed a matrix that specifies which provider responds based on patient condition.

While Salt Lake County has the same situation with approved overlapping providers, potential conflicts have been avoided through the negotiation of mutual aid agreements. For Salt Lake County providers, a matrix has been developed where the severity of patient symptoms will dictate which provider responds.

Bureau management likened the condition in Utah County to that of Salt Lake County over a decade ago. Therefore they anticipate that, over time, agreements will ultimately be developed. We believe that this is a weak regulatory response to a situation that deserves a more timely resolution because of possible negative effects to public safety that providers attribute to current conflicts. During the audit, however, the bureau came to a similar conclusion and initiated an administrative hearing to clarify provider rights and responsibilities in Utah County. The following section details the proceeding's objective and includes recommendations for making its outcome effective.

Inconsistent Licensing Practices Create Confusion among Providers

BEMSP issues two types of ground ambulance transport licenses to providers that grant overlapping rights and responsibilities. Confusion about service areas ensued as some providers were issued both licenses, which is considered redundant. Conflicting provider opinions about their service rights and responsibilities have prompted the bureau to initiate an administrative hearing to provide clarification. The outcome from the administrative hearing should be adopted in administrative rule to add needed coordination between the two ground ambulance license types.

Redundant Licenses Issued by BEMSP Creates Confusion about Rights and Responsibilities

The bureau issues two types of ground ambulance transport licenses, according to *Administrative Rule* 426-3-300. The first type is specified in section (1) and is considered a multipurpose license. This license type is considered the default, and according to ***Utah Code*** 26-8a-404(3), this license "shall be for all ground ambulance services . . . arising within the geographic service area," allowing the provider to respond to ambulance calls and requests for inter-facility transport. The other license, which is specified in section (2), is considered a limited license specifically for inter-facility transport. According to *Administrative Rule* 426-3-400(3):

> A ground ambulance inter-facility transfer licensee may only transport patients from a hospital, nursing facility, emergency patient receiving facility, mental health facility, or other licensed medical facility when arranged by the transferring physician for the particular patient.

Both ambulance licenses allow providers to offer inter-facility transport services.

An inter-facility transport license is more limited because it grants only a portion of the same rights and responsibilities associated with the all-purpose license.

Awarding Both Licenses to a Provider Is Redundant. Since the rights and responsibilities to provide inter-facility transport services are conferred with both license types, allowing a provider to possess both licenses is redundant. Our review of current licenses revealed five

The bureau has awarded both license types to five providers, which is unnecessary and creates confusion among providers.

providers that possess both licenses at the same service level. The most recent occurrence was an inter-facility transport license issued to Park City Fire Service District in September 2012. Since the provider already had an all-purpose license, the addition of an inter-facility transport license was redundant.

Issuing both license types to a single provider raises questions about what provider rights each license conveys.

As the bureau awards these redundant licenses, providers are questioning what service rights and responsibilities their license actually confers. Wanting to ensure they have rights to provide inter-facility transport services, providers with a multipurpose license have applied for their own redundant inter-facility license.

License Applications Created Confusion about the Need for Both Licenses. Prior license applications contributed to provider confusion by allowing a single provider to apply for both licenses. For example, Figure 3.1 illustrates the different treatment of inter-facility licenses between 2005 and 2007.

Figure 3.1 Inter-Facility Transport License Has Been Treated Differently on Prior Applications. License application in 2005 (left) and 2007 (right) illustrate how the relationship between inter-facility and multipurpose licenses has not been consistent, because applicants are given different instructions over time.

2005 License Application	2007 License Application
Licensure Type and Service Level (*choose one*)	Licensure Type and Service Level
o Ground Ambulance, EMT Basic o Ground Ambulance, EMT Intermediate o Ground Ambulance, EMT Intermediate Advanced o Paramedic Rescue o Paramedic Tactical Rescue o Paramedic Ground Ambulance	o Ground Ambulance, EMT-Basic o Ground Ambulance, EMT-Intermediate o Ground Ambulance, EMT-Intermediate Advanced o Paramedic Rescue o Paramedic Tactical Rescue o Paramedic Ground Ambulance o Interfacility Transfer Ground Ambulance (Basic, Intermediate, Intermediate IA or Paramedic)
Inter-Facility Licensure Type and Service Level (*choose one*)	
o Inter-facility Transfer Ground Ambulance, EMT –Basic o Inter-facility Transfer Ground Ambulance, EMT –Intermediate o Inter-facility Transfer Ground Ambulance, EMT –Intermediate Advanced o Paramedic Ground Ambulance Inter-facility Transfer Service	

Source: BEMSP Scanned Document Repository

Inconsistent license applications added to the confusion rather than providing clarification.

In the 2005 application, on the left in Figure 3.1, providers were instructed to select a multipurpose license as well as an inter-facility

transport license. By 2007, the application changed, and the example on the right in Figure 3.1 shows all license types are grouped together.

While statute and rule established a basic framework for the two-license system, the bureau's deviation from this framework has raised uncertainty about provider rights and responsibilities. This uncertainty has subsequently promoted additional questions defining the limits on an inter-facility transport license, which are discussed in the next section.

Administrative Hearing Was Convened to Clarify Provider Rights and Responsibilities

To address provider questions and concerns about the rights and responsibilities conferred by the two ground ambulance license types, the bureau convened an administrative hearing to clarify the relationship between the two license types. Specifically, the notice of agency action on February 26, 2014 stated that the objective of the hearing was to review "the rights and responsibilities of ground ambulance providers pursuant to ground ambulance licenses issued by the bureau to serve any areas in Utah County."

The bureau convened an administrative hearing to clarify the rights and responsibilities of ground ambulance providers.

Based on the outcomes of the hearing, the bureau has stated that it "intends to clarify licenses as may be necessary. It also intends, as appropriate, to consolidate licenses held by the same entity." We recommend that the bureau follow through on this intent to consolidate licenses as appropriate to clarify provider rights and responsibilities. The consolidation proposed by the bureau should address the redundant licenses that were discussed in the previous section. We believe that this proposed action by the bureau is a prudent approach, considering the confusion that exists regarding provider rights in Utah County. Statewide consolidation efforts are also important as they convey consistent practices among all providers.

Administrative Hearing Outcome Should Be Adopted in Rule

In addition to the bureau's efforts to consolidate licenses, we recommend that the relationship between the all-purpose license and the inter-facility transport license be clarified in administrative rule. As discussed earlier, the current rule only limits the scope of services offered by an inter-facility transport license. Rules could provide

additional value by clarifying the extent to which duplicate providers should compete for inter-facility transport services.

Administrative rule has not coordinated how providers with the two licenses should interact in potentially overlapping situations.

For example, one Utah County provider raised concern that an inter-facility transport provider was responding with "lights and sirens" to a licensed medical facility to transport a patient. The provider's concern was that "lights and sirens" would suggest the patient's condition was an emergency, which the Utah County provider believes should direct the call to the ambulance provider rather than the inter-facility transport provider. Clarifying provider rights in situations like this where no guidance in rule is provided seems to be the purpose of the administrative hearing convened by the bureau.

Administrative rule should coordinate the two licenses based on the suggestions from the administrative hearing.

A Rules Task Force is currently reviewing the rules governing emergency medical service. The assistant attorney general assigned to work with the Rules Task Force agreed that more clarity is needed, stating that "I believe that part of that task force's work will be to insert some type of coordinating clause, even if the statute does not have one, or to otherwise clarify the rules in their treatment of inter-facility ground ambulance licenses." The State Emergency Medical Services Committee is given statutory authority to promulgate rules regarding Utah's EMS. We recommend that the committee consider adopting the outcome provided from the hearing and define in rule the relationship between a ground ambulance and an inter-facility license. This solution coordinates services provided within a service area, which can be clarified with the recommendations in the following section.

Service Areas Should Be More Clearly Defined

Minimizing duplication requires a comprehensive understanding of service areas and readily accessible documentation. BEMSP can improve its management of provider service areas by addressing three issues. First, BEMSP relies on written descriptions of service areas, which are difficult to use. Second, ambulance providers have not submitted all mutual aid agreements to BEMSP, which is required in statute. Third, all mutual aid agreements pertaining to ambulance licenses are not cataloged. While the written descriptions of service

areas used by BEMSP are accurate, their usefulness is limited. Mapping these areas and recording all mutual aid agreements provides greater context of neighboring service areas that is essential to effectively manage how EMS services throughout Utah are provided.

Provider service areas could be more clearly defined with maps, all corresponding service agreements, and by cataloging applicable agreements.

Considering the extent of provider concerns about service overlaps, it is essential that the bureau ascertain the absence or presence of provider overlaps throughout the state. While the bureau director assured us during the audit that all overlaps have been addressed, we could not independently validate his assertion. The issues identified in this section regarding the way service areas are defined would have required additional staff time beyond what was prudent for this audit. Therefore, the recommendations in this section are intended to make service area data a more useful tool for future users.

While the bureau director assured us during the audit that all overlaps have been addressed, we could not independently validate his assertion.

Written Service Area Descriptions Are Cumbersome and Should Be Mapped

Provider service areas are described in lengthy descriptions rather than using a map that identifies the geographic service area of a provider. Figure 3.2 shows one of these lengthy descriptions.

Figure 3.2 Service Areas Rely on Written Descriptions Rather Than a Map. The written descriptions used by BEMSP are accurate but do not provide the valuable insight that a map showing neighboring service areas can provide.

Service Area:
Utah and Juab Counties excluding the following area licensed to the town of Eagle Mountain and Eagle Mountain Fire Department. Beginning at the intersection of Utah, Tooele and Salt Lake Counties; then East along the Utah/Salt Lake County boundary until the boundary line intersects the eastern boundary line of Section 5 of Township 5 South, Range 1 West; then South along the eastern boundary lines of Sections 5, 8 and 17 of Township 5 South, Range 1 West to the intersection of State Road 73 and the eastern boundary of the Town of Eagle Mountain; then South along the eastern boundary of the Town of Eagle Mountain including the western half of the southeast quarter section of Section 20 and all of Section 28 of Township 7 South, Range 1 West and continuing southward along eastern Eagle Mountain Town boundary to the southeast corner of Section 6 of Township 7 South, Range 1 West; then South along the eastern boundary line of Sections 6, 7, 18, and 19 of Township 7 South, Range 1 West to the intersection of Soldiers Pass Road; then east along and including all of Soldiers Pass Road to the intersection of Lake Mountain Communications Road; then due South to the intersection of the northern boundary line of Section 29 of Township 7 South, Range 1 West to the northeast corner of Section 29 of Township 7 South, Range 1 West; then South along the eastern boundary lines of Sections 29 and 32 of Township 7 South, Range 1 West to the southern boundary line of Township 7 South Range 1 West; then West along the southern boundary lines of Township 7 South Range 1 West, 2 West and 3 West until the Utah/Tooele County boundary; then North along the Utah/Tooele County Boundary until the point of beginning.

Source: Current Provider Licenses Maintained by BEMSP

Provider service areas use written descriptions rather than maps.

As Figure 3.2 shows, the written descriptions of these service areas cannot be readily used to identify areas of overlap without a map. We

Arizona has mapped the service areas for its providers, and the maps are accessible online.

contacted surrounding states, and Arizona stood out as an example of how mapping service areas could be done. The Arizona Department of Health Services website contains a statewide map of service providers (see Appendix A) as well as service area maps for specific providers (see Appendices B & C).

Creating a mapping system that mimics Arizona's would not be overly difficult because, in prior years, BEMSP already laid the groundwork for such a system. Utah's Automated Geographic Resource Center (AGRC) website shows that emergency medical service area mapping was started but has not been updated. According to the bureau director, the project was abandoned as involved staff left the bureau and AGRC. We recommend that the bureau resume its incomplete project of mapping emergency medical service areas.

The bureau could partner with dispatch centers to develop initial service area maps.

The greatest hurdle to mapping service areas is converting the lengthy descriptions into geographic information system (GIS) data. During our visit with the Valley Emergency Communications Center, staff reported that they have an up-to-date GIS-based map that enables them to identify and route calls to appropriate providers. Follow-up discussions revealed that this map information is possibly exportable, but the bureau would need to negotiate with dispatch centers for access. Since this opportunity could eliminate unnecessary re-creation of service areas and thereby reduce start-up costs, we recommend that the bureau work with Utah AGRC and various dispatch centers to determine whether sharing these resources is feasible.

We recommend the bureau resume efforts to map service areas with its own staff or outsourced the project to AGRC staff.

Once a map is adopted, updates of map-related data could be performed by trained bureau staff or outsourced to AGRC staff. In a recent discussion, the BEMSP director indicated he has an existing position that will soon be freed up that could be made available to resume work on mapping. To assist the bureau with considering alternatives, we obtained a maintenance estimate from AGRC staff. Their estimate suggested 5 to 10 hours of monthly maintenance at $73 per hour. Therefore, maintaining the data could cost between $4,000 and $9,000 per year.

All Service Agreements Have Not Been Submitted to BEMSP

While service area maps establish the foundation of a provider's rights and responsibilities, the details are contained in the various

mutual aid agreements established with other providers. We are concerned that all mutual aid agreements have not been documented and submitted to the bureau.

For example, during the removal of Gold Cross's statewide authority, specialty team transport services were identified as a particular statewide service that should continue being provided because of its efficiencies. These specialty team transport services originate at Salt Lake City hospitals with specialty teams that are sometimes required when transporting extremely critical patients, such as premature babies that need specialty neonatal care. Rather than have the local ambulance provider make two trips to Salt Lake City (once to pick up the specialty team and once to transport the patient), Gold Cross could make a single trip since it is in the same location as the specialists.

Mutual aid agreements detail how and when a provider will receive assistance from another provider.

During the proceedings to remove Gold Cross's statewide authority, providers throughout the state acknowledged the efficiencies of this particular service. Transcripts from these meetings show that providers committed to creating agreements with Gold Cross specifying the mutual aid that would be provided. However, no agreements have been documented and submitted to the bureau.

Providers have not documented their mutual aid agreements for specialty team transport.

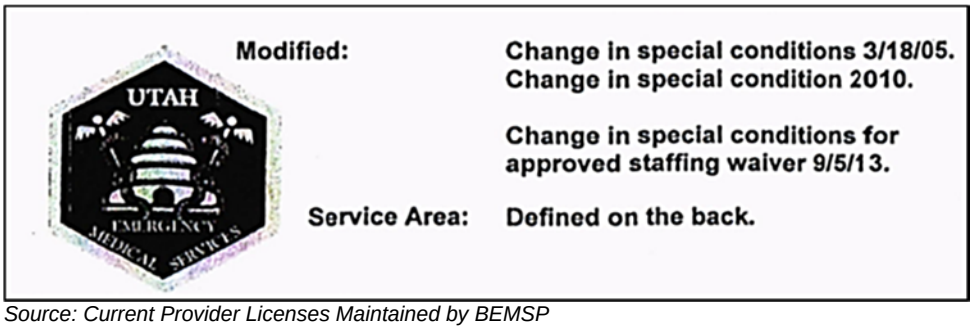
According to ***Utah Code*** 26-8a-402(4)(c), "the parties to a mutual aid agreement shall submit a copy of the agreement to the department." Based on the example of missing agreements for specialty team transport, we recommend that the bureau enforce the requirement that providers submit copies of all mutual aid agreements that pertain to them. Without this essential detail, the EMS response procedures for a particular service area cannot be fully understood.

Statute requires that these agreements be submitted to the Department of Health.

Cataloging Service Agreements Is Essential and Should Be Expanded

The final component that the bureau should continue implementing is cataloging mutual aid agreements with service area maps. As mentioned earlier, cataloging ensures that detailed response protocols are connected to affected service areas. To the bureau's credit, staff have begun logging some details on provider licenses. For example, Figure 3.3 shows an example where special conditions and a staffing waiver applicable to a particular license are cataloged.

Figure 3.3 Adjustments to Service Areas Are Being Cataloged on Provider Licenses. The bureau has been cataloging applicable mutual aid agreements and other pertinent changes by marking them on provider licenses.



Source: Current Provider Licenses Maintained by BEMSP

The bureau has started cataloging pertinent information pertaining to provider licenses.

With annotations such as those in Figure 3.3, pertinent details regarding a particular license are all identified.

Without a catalog, no assurance exists that all pertinent details about a provider's service area are available.

To illustrate the problem that not cataloging agreements presents, we requested all of the mutual aid agreements associated with a Salt Lake County provider, and bureau staff provided seven mutual aid agreements. However, there was no master list to verify that we received all applicable agreements. We believe that adopting the practice of cataloging applicable mutual aid agreements will help ensure that the bureau has all details associated with the licenses it issues.

We recognize the bureau's efforts to begin implementing a solution that will enable its staff to better track all applicable documentation to provider service areas. Therefore, we recommend that the bureau continue the practice of cataloging all pertinent documents that affect provider service areas.

Recommendations

1. We recommend that BEMSP consolidate redundant licenses into a single license that indicates all rights and responsibilities conveyed to ambulance providers within their exclusive geographic service area.

2. We recommend that the EMS Committee adopt the Utah County hearing's outcome and define in rule the relationship between ground ambulance and inter-facility transport licenses.

3. We recommend that BEMSP work with ambulance providers to document and verify documentation of all mutual aid agreements among providers, including those agreements involving specialty team transport.

4. We recommend that BEMSP work with Utah AGRC and various EMS dispatch centers to develop a mapping solution for geographic service areas that is within the bureau's current financial resources.

5. We recommend that BEMSP continue the practice of cataloging all pertinent documents that affect provider service areas.

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Appendices

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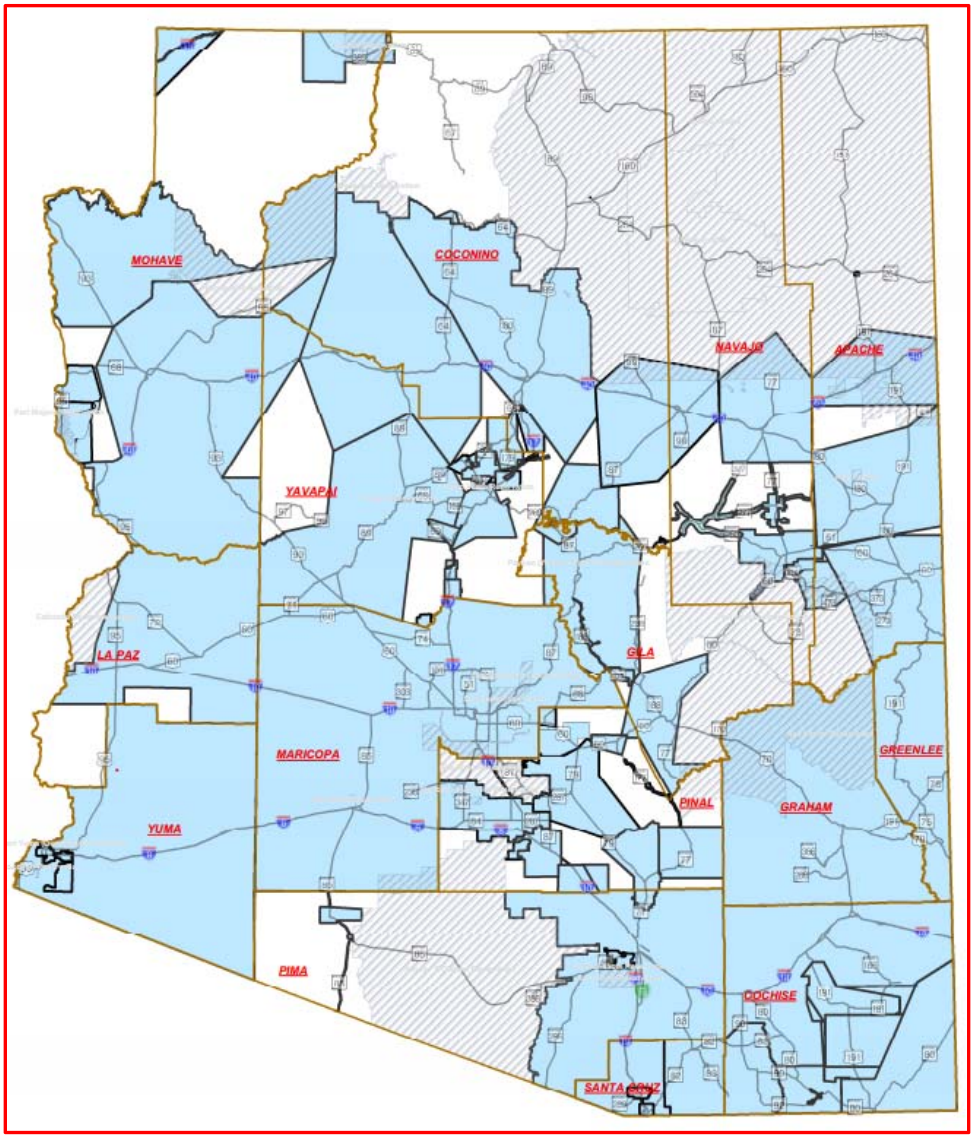
Appendix A
Statewide Map of EMS Providers in Arizona

This map illustrates how regions of Arizona are served by its licensed ambulance providers. A similar map should be created that outlines Utah providers' geographic service areas.



Source: Arizona Department of Health Services Website (http://www.azdhs.gov/bems/ambulance/maps/index.php)

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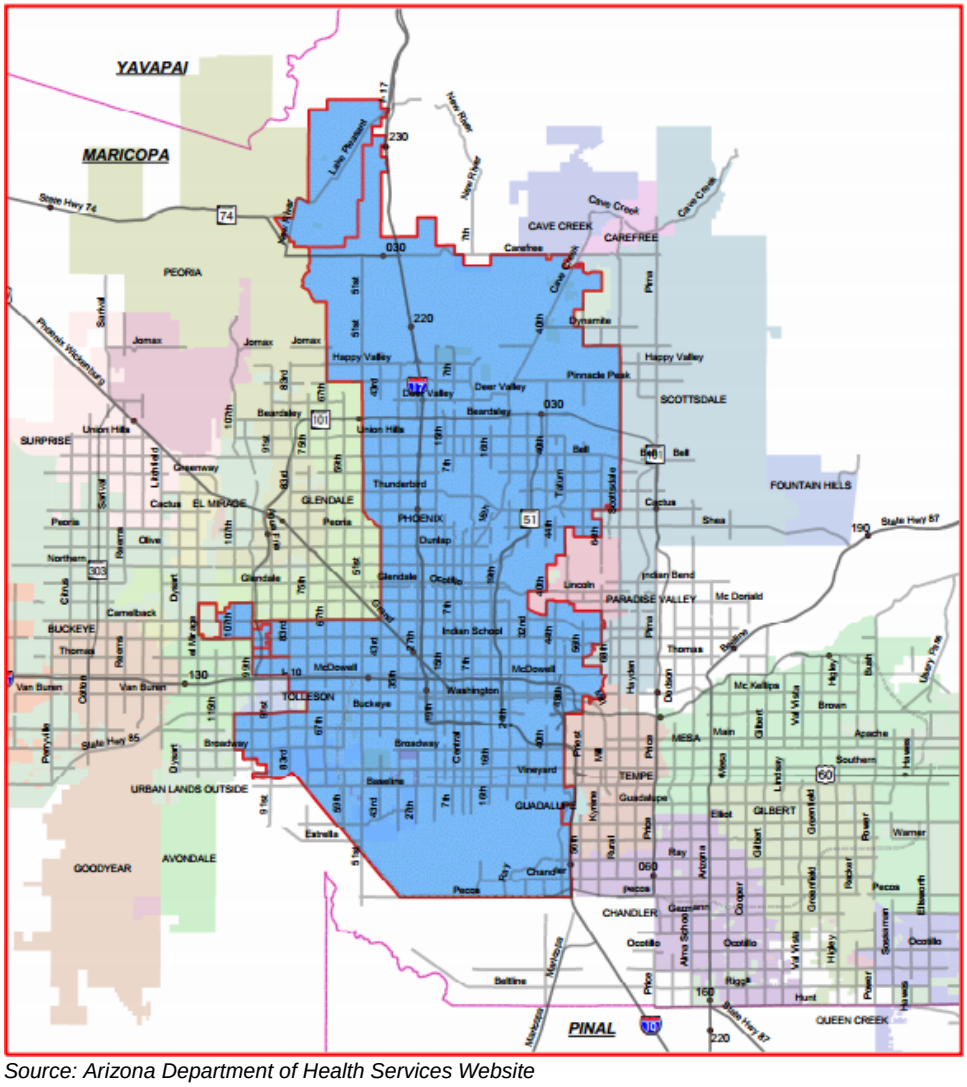
Appendix B
Service Area Maps for
Individual Arizona EMS Providers

City of Phoenix Fire Department

The Arizona's Department of Health has created maps for each provider's service area. Utah providers receive a written service area descriptions with their license.

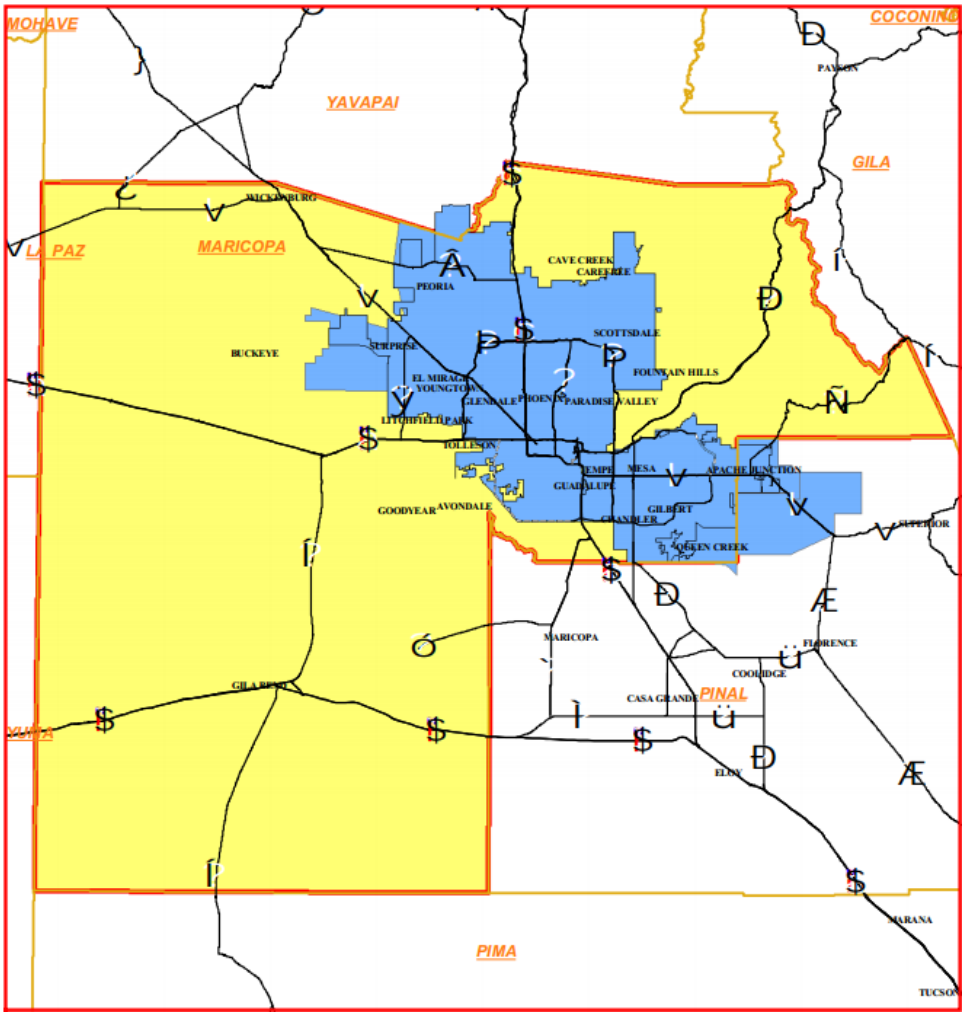


Source: Arizona Department of Health Services Website (http://www.azdhs.gov/bems/ambulance/maps/index.php)

Appendix B - Continued

Southwest Ambulance – Maricopa

The Arizona's Department of Health has created maps for each provider's service area. Utah providers receive a written service area descriptions with their license.



Source: Arizona Department of Health Services Website (http://www.azdhs.gov/bems/ambulance/maps/index.php)

Agency Response

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State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health
W. David Patton, Ph.D.
Executive Director

Division of Family Health and Preparedness
Marc E. Babitz, MD
Division Director

Bureau of Emergency Medical Services and Preparedness
Paul R. Patrick
Bureau Director

June 14, 2014

Mr. John M. Schaff, CIA
Legislative Auditor General
315 House Building
P. O. Box 145315
Salt Lake City, Utah 84114-5315

Dear Mr. Schaff:

I appreciate the opportunity to review and respond to the legislative report "A Performance Audit of the Bureau of Emergency Medical Services and Preparedness" (Report No. 2014-04).

I realize the work done by you and your staff in this review was in depth and covered a large number of accusations made by a small percentage of the EMS providers in the State of Utah. Your staff conducted themselves in a professional and cooperative manner as they interacted with staff and EMS stakeholders. I commend their efforts as this performance audit resulted in fifteen recommendations designed to improve our processes and ultimately the EMS system.

I accept all the recommendations and a response to each is included with this letter. I look forward to working with your office to ensure that implementation strategies are consistent with the intent of the recommendations.

Sincerely,

Paul R. Patrick
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UTAH DEPARTMENT OF HEALTH

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Chapter II
BEMSP Needs to Improve Regulation of Ambulance Providers

1. **We recommend that BEMSP utilize its statutory authority to take formal corrective actions, such as restrictions, probation, and suspension, when provider deficiencies warrant.**

   We agrees with the recommendation and will utilize our statutory authority to take action against providers when warranted and apply restrictions, fines, probation, and suspensions to when deficiencies in meeting the minimum licensing standards are discovered through an inspection and investigative process. To help with this process, we will organize a new Compliance, Investigation, and Enforcement (CIE) Program reporting directly to the Bureau Director. All complaints will be sent to the CIE for investigation, and the CIE will also take a prospective look at all EMS providers performing reviews and agency audits.

2. **We recommend that the Legislature consider amending *Utah Code* 26-8a-408(7) to make the establishment of cost, quality and access goals mandatory for all local governments.**

   We agree with this recommendation. Since the EMS providers cover such diverse areas of the state ranging from urban to rural to frontier this situation necessitates cost, quality, and access goals be established by local governments. We will work with the Utah State Legislature to approve legislative changes to *Utah Code* 26-8a-408(7) mandating local governments establish EMS cost, quality, and access goals.

3. **We recommend that BEMSP promote the adoption of cost, quality and access goals by documenting which providers have goals established and whether their local governments are holding them accountable.**

   We agree with this recommendation and will reorganize our existing staff by assigning a full-time Licensing Officer who will have the responsibility to document which providers have established local cost, quality, and access goals. We will also work with local governments to help them see the benefit of establishing these goals, and once the legislation is changed, holding them accountable.

4. **We recommend that BEMSP require that providers submit financial data that is consistent among providers and indicative of their financial solvency.**

   BEMSP agrees with the recommendation. We will institute a better mechanism to monitor financial solvency among all providers. We will reassign a current staff member to be our Financial Officer directly responsible for monitoring provider financial solvency. BEMSP will also contract with financial and accounting experts to review the fiscal operations of private ground ambulance services on a regular basis.

5. **We recommend that BEMSP comprehensively review provider compliance with all equipment requirements specified in *Administrative Rule* 426-4-900.**

We agree with this recommendation and will augment the current agency inspectors by changing their supervisory management and include process improvement with additional oversight of the inspections. We will make certain that the reviews are more comprehensive and include all the equipment requirements specified in *Administrative Rule* R426-4-900. We will also look at implementing a process to reward high achieving providers who have a record of superior compliance.

6. **We recommend BEMSP review all standards required in *Utah Code* 26-8a-404 (2) to ensure that bureau processes support early detection of provider deficiencies.**

BEMSP agrees with the recommendation. We are in the process of identifying internal compliance procedures and have drafted standard operating procedures (SOP) to guide staff in efforts to ensure provider compliance. As mentioned in our response to recommendation number one above, "We will organize a new Compliance, Investigation, and Enforcement (CIE) Program reporting directly to the bureau director. All complaints will be sent to the CIE for investigation, and the CIE will also take a prospective look at all EMS providers performing reviews and agency audits." This process will ensure early detection and identification of provider deficiencies.

7. **We recommend that BEMSP assess and improve its documentation for the complaint process and for all other processes related to ambulance regulation.**

We agree with the recommendation. As part of the CIE, we will hire a clerical professional to focus on improving the documentation process for complaints and all investigations. Working closely with the attorney assigned to BEMSP from the Attorney Generals Office will occur to improve all of the our documentation processes.

8. **We recommend that BEMSP avoid communication about complaint outcomes with unassociated providers until outcomes are made public.**

BEMSP agrees with the recommendation. By hiring a new clerical professional whose principal focus will be on the CIE practices, we will improve the process to make certain notification is not sent our prematurely. Once an investigation is completed, and the parties involved in the complaint have been notified, the outcomes will be posted on the bureau website.

9. **We recommend that BEMSP follow its complaint policies and procedures and document the outcomes of all complaint investigations.**

We agree with the recommendation and will comply with the new rules and updated internal complaint policy. As mentioned above, all outcomes of complaint investigations will be posted on the bureau website. Documentation will be improved and all records will be maintained according to state records management schedules.

10. **We recommend that BEMSP post its complaint process policies and complaint form on its website.**

BEMSP agrees with the recommendation and will assign the newly formed CIE program to develop a complaint form that will be posted on the Bureau website. Along with the complaint form policies, will be posted on the bureau website as well.

Chapter III
BEMSP Needs to Clarify Provider Responsibilities

1. **We recommend that BEMSP consolidate redundant licenses into a single license that indicates all rights and responsibilities conveyed to ambulance providers within their exclusive geographic service area.**

BEMSP agrees with the recommendation. As mentioned in our response to finding three in Chapter II, the newly reassigned Licensing Officer will be tasked with eliminating all redundant licenses for ambulance services. This will also include combining of redundant licenses into one license. This process will be standard and all licenses will become a comprehensive document.

2. **We recommend that the EMS Committee adopt the Utah County hearing's outcome and define in rule the relationship between ground ambulance and inter-facility transport licenses.**

We agree with the recommendation. We will work with the Rules Task Force to develop a rule that clarifies the relationship between ground ambulance licenses and inter-facility transport licenses. That information will then be presented to the EMS Committee for their approval. This work has already begun with the Rules Task Force. We will also utilize the hearing officer recommendation from the Utah County proceeding in development of the rule.

3. **We recommend that BEMSP work with ambulance providers to document and verify documentation of all mutual aid agreements among providers, including those agreements involving specialty team transport.**

BEMSP agrees with the recommendation. As mentioned in our response to recommendation number one above and recommendation number three in Chapter II, the newly reassigned Licensing Officer will be tasked with verifying documentation of all mutual aid agreements among providers and including them on each provider's license. If they are not found, the Licensing Officer will make certain that they are in place, validated, and signed or the CIE program will initiate corrective actions against the providers. The EMS Committee has already developed a mutual aid template that can be used by any EMS providers.

4. **We recommend that BEMSP work with Utah AGRC and various EMS dispatch centers to develop a mapping solution for geographic service areas that is within the bureau's current financial resources.**

We agree with the recommendation. We initiated a project with AGRC a few years ago to start mapping the geographic service areas. Though work was initiated, the AGRC stated they needed additional funds to continue the project. BEMSP recently entered into discussions with AGRC. They are now able to collaborate with us to continue mapping geographic service areas. Funds have been identified through the 911 grants so the project may continue without further interruption due to funding. We will integrate these efforts with emergency medical dispatch centers.

5. **We recommend that BEMSP continue the practice of cataloging all pertinent documents that affect provider service areas.**

BEMSP agrees with the recommendation and have designated a Records Management Officer. She has developed a manual for records retention and schedules for all programs within the BEMSP. Pertinent documents, including those affecting provider service areas, will be classified and maintained according to state standards and the developed schedules.