

***Critical Access Hospitals - EMS Provider Survey***

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*(Please type or print)*

**EMS Provider Information**

Provider Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

**Program Components**

**A. Level of Care**

1. What level of care is provided: \_\_\_\_\_ Basic \_\_\_\_\_ Defibrillation \_\_\_\_\_ Advanced Airway  
(Check all that apply) \_\_\_\_\_ Epinephrine \_\_\_\_\_ Intermediate \_\_\_\_\_ Enhanced Intermediate  
\_\_\_\_\_ Paramedic \_\_\_\_\_ Other (If Other, Explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Name of Medical Director(s) \_\_\_\_\_

3. Quality Assurance provided by \_\_\_\_\_

**B. Vehicles**

1. How many ambulances does your service staff on a full time/on call basis \_\_\_\_\_

2. Are all of the above vehicles stocked with the same medications & supplies \_\_\_\_\_yes \_\_\_\_\_no

3. Is this number of vehicles and staffing sufficient 90+% of the time \_\_\_\_\_yes \_\_\_\_\_no

**C. Staffing**

1. How many EMT's of each level are licensed to your ambulance service (Number of each in space provided.)?

EMT-Basic	EMT-defibrillation	EMT-intermediate	EMT-paramedic	Other

If other, please explain \_\_\_\_\_  
\_\_\_\_\_

2. How many EMT's of each level respond **on each ambulance** (Number of each in space provided If "other" also indicate type) \*

Ambulance	Basic EMT	EMT-defib.	Intermediate	Paramedic	Other
1					
2					
3					
4					

\* Add additional pages for # of ambulances if necessary.

2. Is the level of care that you provide adequate for your communities needs \_\_\_yes \_\_\_no

D. **Interface with First Responder Groups** (First responder is anyone who responds prior to the ambulance)

1. Does your service use First Responders \_\_\_yes \_\_\_no

2. If yes, provide the names of the F.R. organizations \_\_\_\_\_

3. How many personnel of each level of training generally respond **prior to the ambulance.** (Number of each in the space provided. If "other" also indicate type)

EMT-basic	Intermediate	Paramedic	Certified F.R.	Other

4. How are first responders dispatched \_\_\_\_\_ na

5. Do first responders use fire engines \_\_\_yes \_\_\_no. If no, what vehicle \_\_\_\_\_

6. If more than one type of vehicle is used for first response (simultaneously) please describe.

**E. Response Times**

1. What is the average response time for the **transporting** vehicle (This is the time from receipt of the call from 911 to arriving on the scene) \_\_\_\_\_

2. In the space provided below indicate the average response time for **each** of the personnel dispatched to arrive on the scene of the patient. This includes first responders and/or personnel on the ambulance (If other also indicate type)

Times	Basic EMT	EMT-defib.	Intermediate	Paramedic	Other
Maximum					
Minimum					
Average					

**F. Transport Times**

1. What is the average time it takes to transport patients to your primary hospital(s)

Name of hospital \_\_\_\_\_ Time \_\_\_\_\_

Name of hospital \_\_\_\_\_ Time \_\_\_\_\_

Name of hospital \_\_\_\_\_ Time \_\_\_\_\_

Name of hospital \_\_\_\_\_ Time \_\_\_\_\_

(Add additional pages if necessary)

2. Is air transport readily available to your service \_\_\_\_\_yes \_\_\_\_\_no

**G. Training**

1. Do you feel your personnel should be trained to a higher level \_\_\_\_yes \_\_\_\_no

2. If you answered yes to #1 above, what level \_\_\_\_Intermediate \_\_\_\_Paramedic \_\_\_\_Other  
If other, what level \_\_\_\_\_

3. Who provides training for your EMS personnel? (All levels of EMT) \_\_\_\_\_

4. Does the training provided by the area Training Center meet your needs for **ALS** \_\_\_\_yes \_\_\_\_no for **BLS** \_\_\_\_yes \_\_\_\_no

If no, explain \_\_\_\_\_

5. Would you prefer alternative methods to the way training is provided \_\_\_\_yes \_\_\_\_no

If yes, explain \_\_\_\_\_

6. Is your current training budget adequate to meet your training needs \_\_\_\_\_yes \_\_\_\_no

If no explain \_\_\_\_\_

7. Does your ambulance service own training aids (I.V. arms, intubation heads, etc.)

\_\_\_\_\_yes \_\_\_\_\_no

If yes, describe \_\_\_\_\_

8. Do you feel 911 dispatchers are adequately trained \_\_\_\_yes \_\_\_\_no

If no, explain \_\_\_\_\_

9. Does your service have a computer to enter ambulance call data? \_\_\_\_yes \_\_\_\_no.

If yes, explain how data is kept \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**H. Service Area Description**

1. What is the population of your service area \_\_\_\_\_

2. Do you provide full time coverage to other communities \_\_\_\_yes \_\_\_\_no

If yes, describe how, number of vehicles, staffing, etc. \_\_\_\_\_

\_\_\_\_\_

3. Please include a map of your service area with your survey responses. (Indicate location of ambulances, first responders and hospital(s).

4. Do you have written mutual aid agreements with neighboring ambulance services \_\_\_\_yes \_\_\_\_no

**I. Call Volume**

In the space provided indicate the number of calls your service responded to and the level of treatment provided for the years 1997, 1998 and 1999.

<i>Year</i>	<i>ALS</i>	<i>BLS</i>	<i>Non Emergency</i>	<i>Treat and Release</i>	<i>Other</i>
<i>1997</i>					
<i>1998</i>					
<i>1999</i>					

**J. Communications**

1. On what frequency do you currently communicate with the hospital for BLS \_\_\_\_\_

ALS ambulance to hospital frequency \_\_\_\_\_

2. Do you use cell phones to communicate with the hospital \_\_\_\_\_yes \_\_\_\_\_no
3. Are there places in your service area where you are unable to communicate with the hospital via 2-way radio \_\_\_\_\_yes \_\_\_\_\_no. If yes, explain\_\_\_\_\_
4. Are there places in your service area where you are unable to communicate via cell phone  
\_\_\_\_\_ yes \_\_\_\_\_no \_\_\_\_\_NA If yes, explain\_\_\_\_\_
5. How are EMT's dispatched (i.e. radio pagers, phone, etc.)\_\_\_\_\_
6. Does your service maintain a formal "call roster" \_\_\_\_\_yes \_\_\_\_\_no

***K. Please use the following space for comments or other information you would like to include:*** (Add additional pages if necessary)