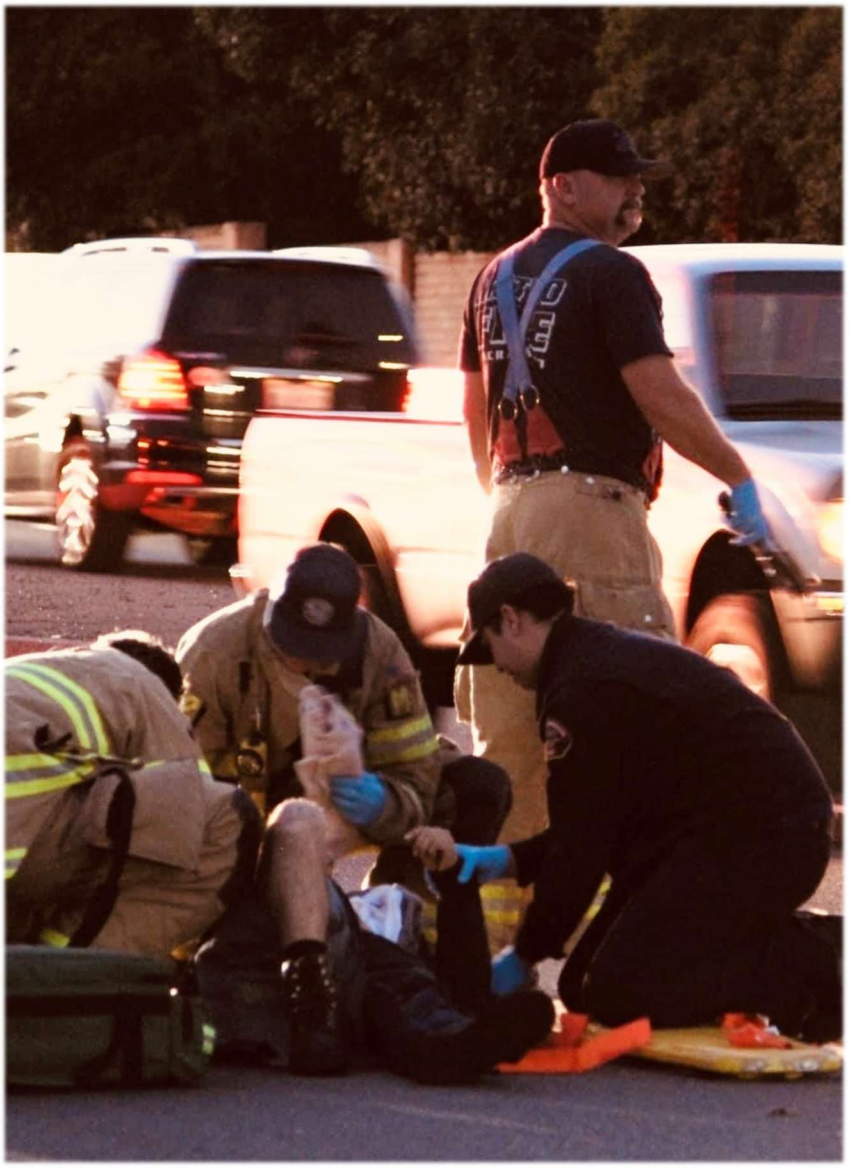
2025

Metro Fire Quality Improvement Plan (QIP) Annual Report



Assistant Chief Jon Rudnicki

CQI Manager Adam Blitz

Metro Fire EMS Division

www.metrofire.ca.gov

2025

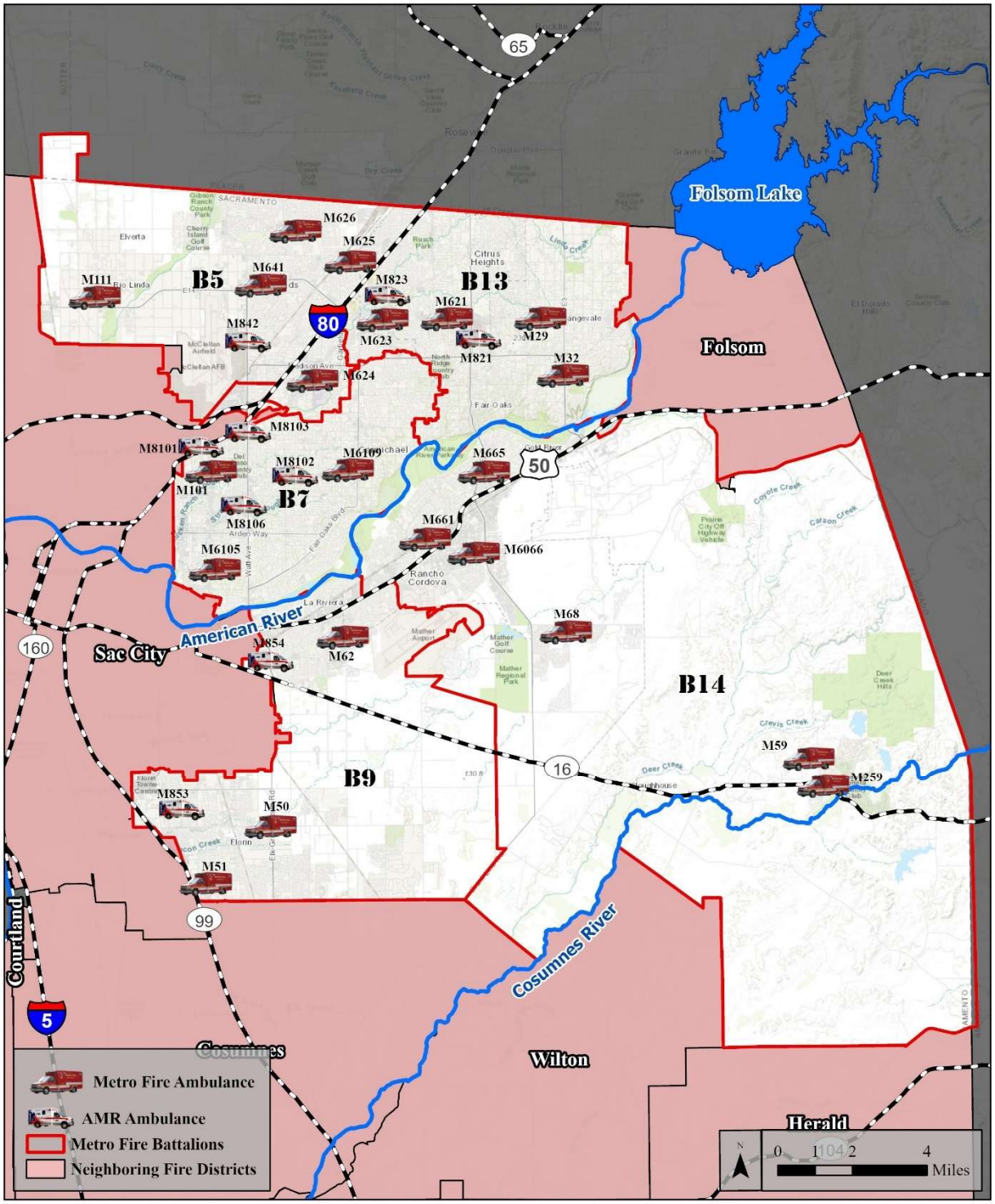
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Core Values

Integrity Professionalism Teamwork Devotion to Duty

Metro Fire Ambulance Coverage



AGENCY OVERVIEW

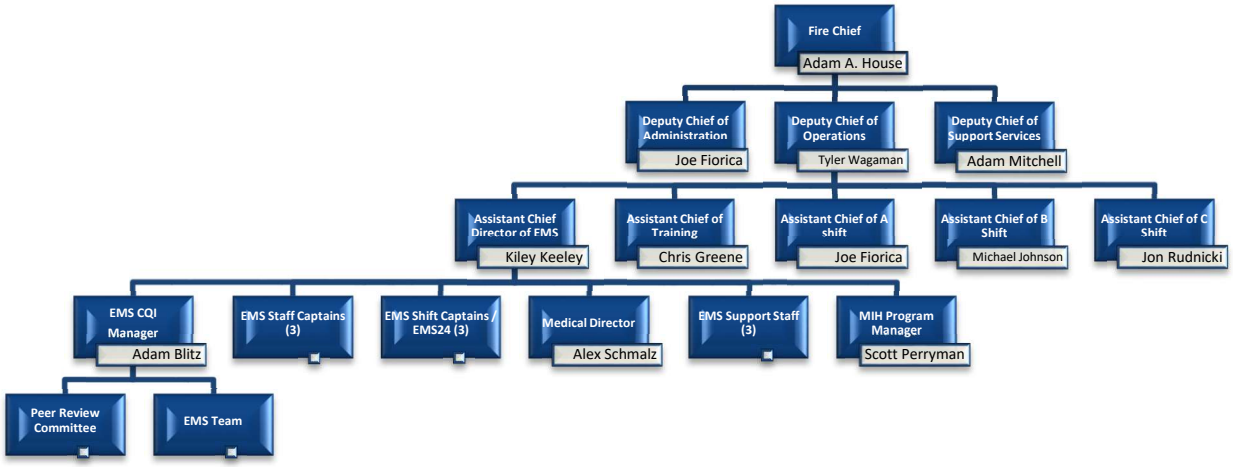
The Sacramento Metropolitan Fire District ("Metro Fire") is a special district that was created in December of 2000 as the result of reorganization of the American River and Sacramento County Fire Protection Districts. The District provides fire suppression, rescue, emergency medical services (EMS), and Mobile Integrated Health (MIH) along with multiple other public safety and specialty hazard mitigation services to a population of over 720,000 people in an area encompassing over 359 square miles.

Metro Fire is governed by a nine-member Board of Directors elected by the voters within specified geographical areas, or divisions, of Metro Fire's operational area. Pursuant to Section 22000(a) of the Election Code, the District's division boundaries were adjusted in 2021 as a result of the 2020 decennial Census so that each division is equal in population, as far as practicable. The Fire Chief oversees the general operations of Metro Fire, guided by the policy direction of the Board of Directors and supported by an executive Staff - consisting of the Board Clerk and the three Deputy Chiefs who manage the Operations, Administration, and Support Services Branches. These three branches work in cooperation to strengthen our organization and further enhance our ability to serve the community with excellence. This collaborative effort encompasses the areas of Fire & Rescue, Emergency Medical Services (including MIH & Telehealth), Training & Safety, Special Operations, Homeland Security, Fire Investigation, and Health & Wellness.

Daily emergency operations are managed by five (5) Battalion Chiefs, and an EMS Officer (EMS24) with oversight by an on-duty Assistant Chief / Shift Commander. Fire suppression crews, including dual role ambulances, work a 48-hour shift, followed by a 96-hour off-duty cycle while the Metro Medic Program (MMP) non-suppression crews work two 24-hour shifts per week on set days, followed by a 96-hour off-duty cycle.

The District is continually monitoring and evaluating crew staffing and unit deployment to ensure resource coverage is appropriate for the needs of the community. Standards of coverage are evaluated with the aid of an apparatus deployment analysis module (ADAM) in Deccan. ADAM is a predictive modeling tool that uses historical CAD data, GIS map data and a rigorous projection algorithm to project the impact of deployment changes on response times and availability. Given the diverse nature of public safety, Metro Fire is committed to being an "All-Hazard" agency, providing the best service possible to the citizens of Sacramento County.

EMS ORGANIZATIONAL CHART



EMS DIVISION - Staff

The EMS Division is supported by the following administrative positions:

1 Assistant Chief / Director of EMS

1 Mobile Integrated Health Program Manager

1 District Medical Director

1 CQI Manager

1 Administrative Specialist

3 EMS Staff Captains

3 EMS Shift Captains (EMS24)

2 Emergency Medical Services Technicians



MISSION, VISION, AND CORE VALUES

Mission

It is the mission of Metro Fire to provide professional and compassionate protection, education and service to the community.

Vision Statement

Forged from a long line of tradition, we are Metro Fire – working together to serve our community with honor, integrity, and selfless devotion to duty.

Core Values

Metro Fire's Core Values define the expectation for the attitudes and behaviors of every member of the organization, and apply to everyone without exception. In the pursuit of excellence, each member commits to embodying these values:

- **Professionalism:** *A personal commitment to exceed expectations in attitude, ability, and appearance*
- **Integrity:** *With honesty as the foundation, always doing what is right*
- **Teamwork:** *A partnership of coordinated effort based on trust, empowerment, support, and communication*
- **Devotion to Duty:** *Recognizing and placing the needs of others before oneself*

EMS DIVISION - Operations



The EMS Division is responsible for the oversight of Metro Fire's emergency medical services, ensuring that its emergency medical technician (EMT) and paramedic personnel are trained, qualified, and equipped to serve the public at the highest level. EMT's are certified to provide Basic Life Support (BLS) care, while paramedics are licensed and accredited to provide Advanced Life Support (ALS).

Metro Fire employs over 545 paramedics who are assigned on resources typed as engines, trucks, medic units, squads, community care response units, helicopters, aircraft rescue and firefighting (ARFF) apparatus, boats, golf carts and bicycles which operate from forty-one (41) fire stations.

This deployment model supports around-the-clock operation of forty-four (44) fully staffed ALS-level first responder companies that answer calls for service in concert with the District's ALS ambulances and those from other 9-1-1 based ALS transporting fire agencies within the region.



The provision of ALS transportation services by Metro Fire is accomplished through the strategic deployment of Fire Department Medic (FDM) ambulances staffed by "dual-role" fire suppression personnel (firefighter/paramedics and firefighter/EMTs), and by additional transporting units staffed with members of the District's Metro Medic (MMP) Program.

Metro Fire deploys a fleet of twenty (20) 24-hour ALS ambulances, with an additional four (4) in-service reserve medics (ISRMs) available to be immediately mobilized and cross-staffed by on-duty fire suppression personnel.

The District also contracts with American Medical Response (AMR) to provide ten (10) ALS ambulances. These units operate in staggered 12-hour shifts, 365 days a year, during times of high call volume. For Fiscal Year 2025/2026, AMR is contracted to provide a minimum of 43,800 unit hours to Metro Fire plus additional surge protection upon request, as needed. This number of contracted hours (and units) not only adds ALS resources for emergent responses – but also accommodates the highly impactful consolidation process – when activated - where patients transported to Mercy-San Juan Medical Center by Metro Fire join other patients to be monitored by contracted AMR staff until they are assigned a hospital room or bed

Air Operations

Air Operations continued to be one of Metro Fire's busiest Special Operations Units, completing 164 helicopter calls related to fire suppression and rescue in 2025. Copters 1 & 2 are a regional resource extending beyond the borders of Sacramento County. They are ALS staffed and have proven to be effective in situations where accessibility by ground units is prohibitive. A decrease in vegetative fires in 2025 reduced call volume significantly. COPTR-3 joined Metro Fire's air operations fleet in 2025.



Tactical EMS



The TEMS team (pictured left) became Metro Fire's busiest Special Operations Unit in 2025 with 189 calls for service. The Metro Fire TEMS team consists of 16 paramedics who engage in quarterly in-house training as well as training opportunities with local LE partners. Each member has completed extensive training in advanced medical procedures, trauma care, canine care, and specialized law enforcement techniques. TEMS works with SSD, CHPD, Sac FBI and Sac HSI to provide ALS Tactical EMS support for every SWAT callout where SSD and CHPD SWAT respond. Team members respond off duty for planned need requests and on duty for immediate need requests. Examples of TEMS deployments include emergent and pre-planned high-risk warrant services, barricaded suspects, and hostage rescues.



STANDARD INDICATORS – Personnel

Academy Training

Newly-hired dual-role and MMP personnel represent a significant area of focus for Metro Fire in the QI process. In 2025, the District ran four (4) recruit academies: two (2) for MMP and two (2) for dual-role firefighters. The two (2) MMP Academies graduated 36 new paramedics and EMTs. The 25-1 Firefighter Academy added 6 paramedics to the front lines of our EMS program, while the 25-2 will complete in early 2026.



Metro MMP Academy 25-2

Accordingly, EMS training comprises a substantial portion of the extended instruction regularly provided by the District within the recruit academies respective to each job classification – 18 weeks for firefighters and 6 weeks for MMPs.

These models incorporate lecture and hands-on teaching including reviews of EMS skills, pathophysiology, documentation, and the legal aspects of EMS. The academies make use of District personnel as instructors, but also include guest speakers drawn from the local medical community. Exposure to instructors with advanced training and experience has been shown to be effective and well-received by the students.

In March of 2025 - with collaboration involving the B-shift commander, the Metro Fire CERT Team, Rescue 21, CSD, EMS24, MSJ, and UCDMC as the control facility (CF) - the academy held another live-action, hands-on MCI drill involving live patient (actors) with real vehicle extrications, patient packaging and radio communication with the control facility. These live-action MCI drills recently replaced our academy table-top drills, and create a much more realistic environment.



Beyond the classroom setting, the academies rely heavily on realistic simulations for training and scored testing in representative situations that require teamwork and time management. These scenarios make use of cutting-edge modalities such as: iSimulate, whose interface converts iPad tablets into realistic fully functioning LIFEPAK 15 trainers – allowing recruits and probationary employees to run 12-lead EKGs, externally pace, initiate synchronized cardioversion, and demonstrate defibrillation; plus, advanced training mannequins

that students can use to perform intubation, pleural decompression and many other invasive procedures in life-like settings. Recruits are required to meet or exceed designated performance standards throughout the academy, as well as subsequent probationary testing.



iSimulate LIFEPAK-15

Initiatives for Probationary Employees

Several methodologies are utilized by Metro Fire in gauging the aptitude of the District's newest ALS and BLS care providers during the year-long probationary phase of employment following successful graduation from the recruit academy.

Probationary Firefighters initially are assigned to a District ambulance as a third-person ride-along (RA) for a minimum of (10) 24-hour shifts under the direct tutelage of an EMS mentor – a tenured paramedic in good standing. During this time, new members undergo an introductory evaluation process that involves demonstrating baseline knowledge and competencies by following a Task Book and earning "sign-offs" relevant to fundamental operational and procedural aspects of the job.

Concurrently, daily and cumulative major appraisals that specify key performance indicators are used as a means to quantify the probationary employee's EMS skills proficiency observed during training and actual incidents. Input from the crew and Company Officer, along with oversight by the operational chain of command and review by the EMS Division are essential components of the process.

Based upon the progress noted, a recommendation to extend the evaluation period or clear the member to count towards staffing (thereby ending RA status) is submitted to the EMS Division at the conclusion of the ten-shift period, along with documentation to support the endorsement, or recommendation for an individual education plan. The EMS Captains gather feedback from the crew and work with the Assistant Chief of EMS, the CQI Manager and Medical Director to develop the Performance Improvement Plan (see Appendix D) when indicated. New MMPs follow a similar format for orientation, but adhere to a more compressed timeline due to a different work schedule and a narrower scope of responsibility, as non-firefighters.

Throughout the remainder of probation, additional measures are applied towards ensuring proficiency with EMS-related disciplines. This includes skills testing at 6-months and 12-months. These periodic performance assessments grade the quality of ALS and BLS-level patient care and often are incorporated into fire suppression-based scenarios (i.e., rescues) to add stress and realism to the event.

In addition to increasingly challenging standards applied in the testing environment, personnel new to Metro Fire receive a thorough assessment of patient care reports by Peer Review Committee members plus ongoing mentorship and evaluation by more experienced members. This collective approach establishes a strong foundation for incoming members to build upon as they begin their careers as EMS professionals with Metro Fire.

STANDARD INDICATORS - Equipment & Supplies

Metro Fire recognizes the importance of deploying the proper tools and equipment to facilitate the delivery of high-quality Emergency Medical Services to the communities that we serve. The District currently utilizes Physio Control LIFEPAK 15 cardiac monitor/defibrillators (pictured right), LUCAS mechanical CPR devices, stair chairs, power loaders and power cots manufactured by Stryker Medical Corporation. All undergo preventative maintenance performed by qualified technicians at intervals prescribed by the manufacturer. Any repair needs that arise are promptly addressed through the terms of a service agreement with Stryker, and faulty equipment is expeditiously replaced in the field by Logistics or EMS24. Maintenance and service records are available upon request.



The annual SCEMSA ALS inspection occurred in November 2025. Just as in prior years, Metro Fire was found to be 100% compliant with SCEMSA's ALS Inventory Policy 2030 (see Appendix F).

In accordance with SCEMSA and District policies, medical device failures are reported to the EMS Division and reported to SCEMSA if patient care is affected. Metro Fire's Medical Equipment Malfunction policy utilizes a reporting tool that streamlines the process of tracking equipment issues for the EMS Division.

In a collaborative effort between the District's EMS and Logistics Divisions, with input from the EMS Team, Metro Fire regularly partners with vendors and completes an annual

business review of supply and equipment needs. This proactive approach allows for the evaluation of new products and supports the identification of new efficiencies and optimal gear configurations.

To maximize cost savings, the District utilized a master cooperative purchasing agreement through a host public agency. The Savvik Buying Group is a non-profit organization that serves the public safety sector by contracting for public safety equipment, supplies, and services through a full and fair competitive bidding or quotation process, ensuring the best pricing on quality products and services. As a member of the Savvik Buying Group, the District is able to utilize contracts that have been competitively bid through this process and obtain the contracted pricing discounts. Utilizing these types of contracts saves the District time and money, while still meeting all competitive bidding requirements.

Stryker Power Cots

The District utilizes Stryker Power Cots along with matching Stryker Power Load systems. This equipment automates the process of loading patients into ambulances and unloading at the hospital – thereby reducing back injuries and extending careers. This aligns well with the Fire Chief's Priority regarding Member Health & Wellness.

The LUCAS Mechanical Chest Compression System

The LUCAS 3 chest compression system improved upon the LUCAS 2 by featuring Bluetooth/Wi-Fi connectivity for wireless data transfer to LIFENET and CODE-STAT analytics, customizable compression rates/depths (v3.1), and enhanced post-incident reporting for quality improvement. It enables better, easier data access and review of CPR performance. Metro Fire began transitioning in 2024 from LUCAS 2 to LUCAS 3 as outlined in the Capital Improvement Plan. As a result, older LUCAS 2 devices have been removed from first-out ambulances and deployed onto engine companies which may have longer waits for an ambulance or squad.

The Metro Fire EMS Team

The EMS Team aids the EMS Division in adhering to the EMS Capital Improvement Plan which focuses on upgrading critical equipment, enhancing controlled substance security, and implementing new medical technologies. Key recommendations by the EMS Team that came to fruition in 2025 (pictured below) included deploying new and safer IV equipment (such as the MicroClave Clear Needle-Free Adaptor), and the selection of the Binder Lift, a non-mechanical

patient-lifting device designed for EMS and firefighters to safely lift or move patients, reducing lifting-related injuries.



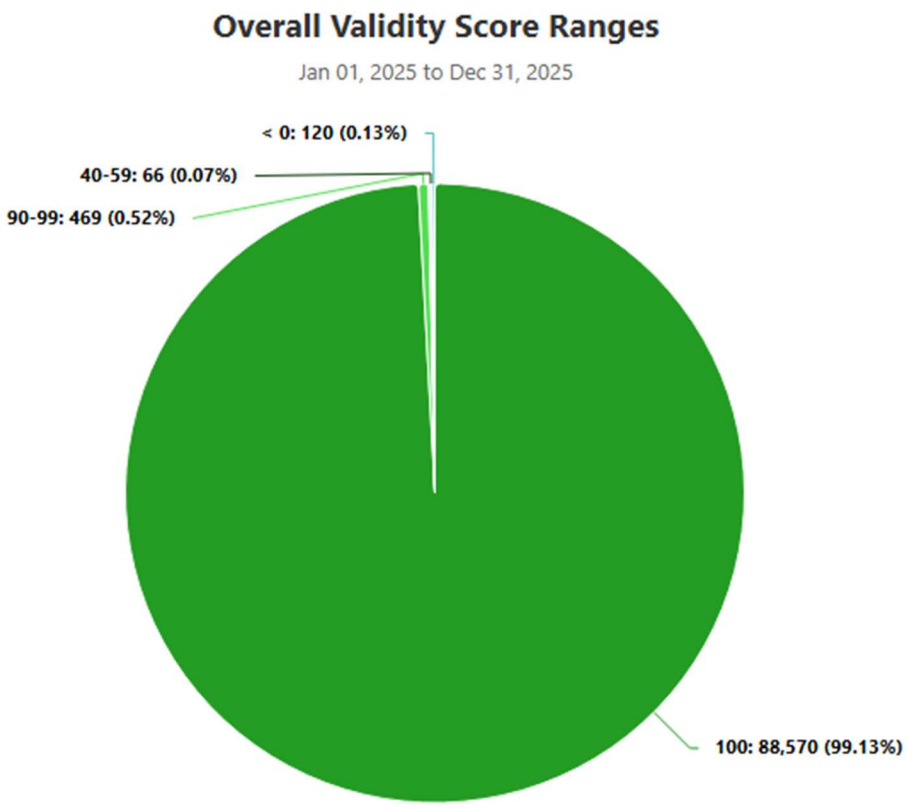


Metro Fire's EMS Team also chose to move forward with permanently selecting the i-View laryngoscope which had been originally selected by the EMS Division to serve only as a bridge to the next iteration of the previously utilized King Vision system. The i-View is very reasonably priced, completely disposable, and with a 5-year shelf life. It utilizes a MAC blade which is more familiar to paramedics than the King blade, as MAC blades are more prevalent in paramedic schools when students first learn to intubate.

STANDARD INDICATORS – Documentation

Quality documentation is an essential yet often overlooked element of patient care. Trends identified during retrospective CQI review of ePCRs reveal a need for continued formalized documentation training for all personnel. Staff develop curriculum on common user errors noted within the ePCR platform. Those trends are then factored into upcoming academies, as well as periodic company level training.

The EMS Technicians review daily auto-exports of ePCRs to CEMSIS as well as to local hospitals, and work to correct export errors to ensure that time-frames for data export are adhered to. Review of quarterly dashboards from SCEMSA allowed for revision of validation rules in the system that provide real-time feedback and detailed guidance to providers completing patient reports. While completing a PCR, personnel can see the current validation score. The higher the score, the more complete the report from a completion, NEMSIS/CEMSIS compliance, and protocol accuracy standpoint. All validation errors have an error message built into the system which instructs the provider on how to correct the error. This has proven to be an effective method of providing crews with documentation instruction on every call as well as decreasing export errors. Metro Fire proudly achieved 100% validation scores on 99.13 % of ePCRs in 2025.



In addition, the EMS Division provides all front-line personnel with Certified Ambulance Documentation Specialist (CADS) certification offered by the National Academy of Ambulance Compliance (NAAC). Documentation is a skill that can be taught, learned, practiced, and improved. The CADS course helps our providers understand the relationship between the clinical narrative and NEMSIS data elements - and their role in providing a complete and accurate record of every patient encounter.

STANDARD INDICATORS – Clinical Care & Patient Outcome

The Assistant Chief of EMS, the SMFD Medical Director, and the CQI Manager work collaboratively to facilitate the review of patient care and monitor indicators. The CQI process maintains confidentiality under Section §1040 and §1157.7 of the Evidence Code of the State of California. The prohibition relating to the discovery of information provided to the District's Quality Improvement committees applies to all proceedings and records of these committees, which are established to monitor, evaluate and report on the quality of pre-hospital care delivered by Metro Fire's providers. Issues meeting the threshold of a Reportable Incident are referred to the SCEMSA Medical Director for review as required by California Health & Safety Code Division 2.5; California Code of Regulations, Title 22, Division 9; and SCEMSA Program Document 7602 Quality Assurance Program.



All Peer Committee members and attendees sign a confidentiality agreement (see Appendix B) not to disclose information obtained through the district's CQI process. The CQI Manager is responsible for explaining and obtaining a signed confidentiality agreement for guest(s) prior to participation in any committee meeting (see Appendix B). The Chairperson of the Peer Review Committee documents trends identified in meetings and information is distributed to all personnel after each meeting (see Appendix C).

Hospital base coordinators and staff routinely work with paramedics and QIP members during patient contact, run review, and case review in alliance with Metro Fire. The reviews identify outstanding patient care and difficult situations handled well as well as cases that present educational opportunities. This collaboration helps develop quality, trust, professional working relationships, mutual respect, and most of all - the highest-quality patient care.

Utilizing patient outcome information in case reviews enhances the learning and understanding for our medics - and develops slides in their slide deck for future calls. It's not easy being an EMT or paramedic. Responders are exposed to traumatic events on a routine basis and subject to physical and mental stress – all while maintaining compassion and proficiency. Metro Fire's EMS Division strives to provide crews with patient outcome on critical calls to help highlight the positive changes we make in our patients' lives on a daily basis.

QUALITY IMPROVEMENT PLAN OVERVIEW



In 2025, Metro Fire responded to 104,064 incidents, representing a 9% decrease in call volume from 2024. Of those, 82,027 were requests for medical aid, and of those - there were 71,683 patient contacts resulting in 51,222 transports. Approximately 60% of these patients required an ALS level of care. The District utilizes ImageTrend Elite to document patient encounters, and Elite-Cloud for QA/QI reviews completed in the CQI module of the program. Metro Fire is an approved Sacramento County Continuing Education Provider (CE# 34-1010) in good standing (see Appendix G).

Metro Fire's EMS system and its participants require objective feedback about performance that can be used internally to support quality improvement efforts and externally to demonstrate accountability to public governing boards and other stakeholders. The primary purpose and goal of the District's Quality Improvement Plan (QIP) is to ensure continued high quality patient care.

The EMS Division conducts 100% review of cases involving cardiac arrest, transcutaneous cardiac pacing, synchronized cardioversion, chest decompression, childbirth, COPTR-1 transports, patients offloaded to the waiting room, police requests to potentially violent situations, and administrations of both TXA and Ketamine. In addition, the EMS Division conducts focused audits based on system trends and protocol changes, plus random audits in various CQI categories. The vast majority of PCR reviews are peer-driven and processed by the Peer Committee (aka the CQI Team).

Industry standards and regulatory requirements for Continuous Quality Improvement (CQI) in Emergency Medical Services (EMS) typically define what must be reviewed rather than how many cases require review. Each provider has their own unique strengths, challenges, and areas requiring additional focus that often differ from neighboring districts' issues - making

concrete uniform categories or percentages restrictive. As a high-volume EMS provider responding to well over 100,000 cases per year – a usual standard for CQI review falls between 1% - 3% of incidents realistically. That percentage mirrors SCEMSA PP#7600.05 (intended for Emergency Medical Dispatch Centers) because it is the only county protocol that offers percentage goals for review. In 2025, the District met this benchmark by completing 2,022 reviews of 66,497 PCRs - or 3% of all patient contacts cared for by Metro Fire personnel.

This percentage represents the third year in a row that PCR reviews have increased. Some of this marked increase in 2025 can be attributed to the expanded ability of Peer Committee members to earn overtime wages while auditing PCRs from the comfort of their homes, while off-duty. The Peer Committee is an integral part of ensuring we provide superior patient care in our communities by providing timely feedback to our clinicians.

The EMS Division of Metro Fire continues its concerted effort to identify, recognize and commend EMS Excellence. Positive enforcement is an excellent driver of EMS engagement.



To recognize EMS Excellence, individual clinicians (and sometimes entire crews) publicly receive commendation letters and challenge coins to remind them that their commitment to outstanding patient care assisted in saving – or in some cases – birthing a life. In 2025, Metro Fire's EMS Division once again awarded twenty-four (24) challenge coins - and even more commendation letters - for EMS Excellence. These commendations involved several different call types - including a successful resuscitation of 38-year-old male who collapsed at a gas station and a 34-year-old female participant in the California International Marathon (CIM).

Providing outcome information, when shared by hospitals, continues to be well received and shines a light on our clinicians' dedication to patient advocacy. A significant boost in the provision of patient outcomes is expected in 2026 when Sacramento County EMS plans to launch their own Health Information Exchange. This HIE will automatically connect hospital findings and outcome information to the patient care reports generated by EMS.

QUALITY IMPROVEMENT POLICY

The goal of Metro Fire's Policy 04.014.01 "Quality Improvement Program" (see Appendix A) is to ensure the highest quality patient care by providing a comprehensive program to review,

monitor, and evaluate patient care and identify system trends. The QI Structure is responsible for the quality management of the care delivered by Metro Fire and consists of the following positions and committees:

- Assistant Chief/Director of EMS
    - Quality Assurance Officer
    - Responsible for selection of operational indicators and the quality of service
    - Privacy Officer
- Metro Fire Medical Director
    - Provides advice to administrative staff
    - Provides direct instruction to care providers
    - Acts as consultants on policy development
- CQI Manager
    - Coordinates Peer Review meetings
    - Responsible for accessing data for required indicators
    - Responsible for publishing of indicators
    - Liaison to hospitals, allied agencies, and regulators
    - Designated Infection Control Officer
- EMS Division Captains
    - Responsible for identifying opportunities for improvement through communications and outreach
    - Assist in the development and monitoring of indicators and implementation of Performance Improvement Plans (PIPs, Appendix D)
    - Act as Designated Infection Control Officers
- Quality Assurance (EMS Division)
    - Responsible for identifying system trends
    - Responsible for identifying opportunities for improvement
    - Development and monitoring of indicators
    - Implement and monitor Performance Improvement Plans
- Peer Review Committee
    - Performs retrospective analysis of patient care records
    - Identifies opportunities for improvement by applying field experience and providing feedback to individual care providers
    - Identifies system trends and methods of addressing those trends

- Ad-hoc Committees
    - Committees formed for the purpose of addressing specific issue(s)

PERFORMANCE INDICATORS

The Core Quality Measures Project was established in 2012 through a grant from the California Health Care Foundation. The primary purpose of the project is to increase the accessibility and accuracy of prehospital data for public, policy, academic, and research purposes to facilitate EMS system evaluation and improvement. EMS systems across California are measured on their performance in these areas and can compare their results to other Local EMS Agencies.

The project highlights opportunities to improve the quality of patient care delivered in an EMS system. In 2024, the Core Quality Measures Project retired two (2) of the six (6) National EMS Quality Measures previously reported on, and added five (5) new test measures. Furthermore, Core Measures were split into pediatric and adult populations. For 2025, additional criterion has been added to several categories, as well as a sixth Test Measure measuring Successful First Pass Advanced Airway in Cardiac Arrest Patients. Based on analysis of Core Measures in 2025, plus case reviews and CODESTAT reporting – an increased focus on first-pass success rates of intubations (pediatric and adult intubations) with the aid of video laryngoscopy, transcutaneous pacing, cardioversions, and the limiting pauses over 10 seconds during an arrest will be Metro Fire's main areas of focus for quality improvement projects in 2026. Please note that figures in the table below were calculated using select NEMSIS/CEMSIS data points with input from NEMSQA. This means that the percentages reflected in the Core Measure reporting include only the elements counted by NEMSIS/CEMSIS and may not encapsulate each category completely.

The Core Quality Measures Project are currently based on the 2023 National EMS Quality Alliance (NEMSQA) measure specifications. California has adopted and refined nine NEMSQA measures for statewide use, six of which are currently in the testing phase.

The four current California Core Measures are:

- **TRA-2:** Transport of Trauma Patients to a Trauma Center
- **HYP-1:** Treatment Administered for Hypoglycemia
- **STR-1:** Prehospital Screening for Suspected Stroke Patients
- **PED-3:** Respiratory Assessment for Pediatric Patients

The six test measures are:

- **TRA-3:** Documentation of GCS, SBP, and RR for Trauma Patients
- **PED-4:** Documentation of Weight in Kg for Pediatrics Receiving Weight-based Medication
- **AIR-1A:** Successful First Pass Advanced Airway in Non-Cardiac Arrest Patients
- **AIR-1B:** Successful First Pass Advanced Airway in Cardiac Arrest Patients
- **AIR-2:** Waveform Capnography Airway Device
- **AIR-3:** BVM or SGA for Pediatric Patients

California Core Quality Measure Data – CY 2025

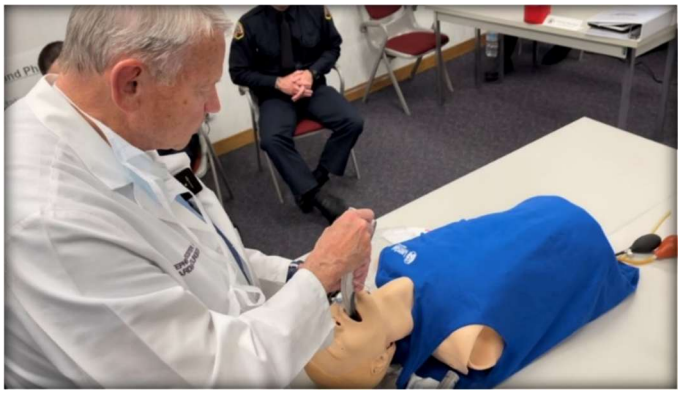
Measure ID	Measure Name	Numerator Value (Subpopulation)	Denominator Value (Population)	Reported Value %
TRA-2-P1	Transport of Trauma Patients to a Trauma Center	85	86	99%
TRA-2-P2	Transport of Trauma Patients to a Trauma Center	1518	1617	94%
TRA-3-P1	Documentation of GCS, SBP, and RR for Trauma Patients	58	70	83%
TRA-3-P2	Documentation of GCS, SBP, and RR for Trauma Patients	922	982	94%
HYP-1-P1	Treatment Administered for Hypoglycemia	10	10	100%
HYP-1-P2	Treatment Administered for Hypoglycemia	531	557	96%
STR-1	Prehospital Screening for Suspected Stroke Patients	1,550	1,654	93%
PED-4	Documentation of Weight in Kg for Pediatrics Receiving Weight-based Medication	707	713	99%
PED-3	Respiratory Assessment for Pediatric Patients	199	209	92%
AIR-1A-P1	Successful First Pass Advanced Airway in Non-Cardiac Arrest Patients	0	0	0%
AIR-1A-P2	Successful First Pass Advanced Airway in Non-Cardiac Arrest Patients	49	53	92%
AIR-1A-P3	Successful First Pass Advanced Airway in Non-Cardiac Arrest Patients	24	33	73%
AIR-1-B-P1	Successful First Pass Advanced Airway in Cardiac Arrest Patients	7	7	100%
AIR-1-B-P2	Successful First Pass Advanced Airway in Cardiac Arrest Patients	386	406	95%
AIR-1-B-P3	Successful First Pass Advanced Airway in Cardiac Arrest Patients	69	108	64%
AIR-2-P1	Waveform Capnography Airway Device	8	16	50%
AIR-2-P2	Waveform Capnography Airway Device	604	662	91%
AIR-3	BVM or SGA for Pediatric Patients	18	18	100%

Source: ImageTrend Report Writer

IMPROVING PERFORMANCE

The correlation between the quality of Cardiopulmonary Resuscitation (CPR) and patient outcome requires that crew members receive pertinent and timely feedback on their performance. It is not enough to simply grade CPR reviews from procedures times gleaned from the patient care report – or by outcome. In close cooperation with local cardiologist Dr. Stephen Rossiter (pictured next page), the District utilizes Physio Control's CODESTAT data gathering program to assess and analyze the proficiency of CPR in an

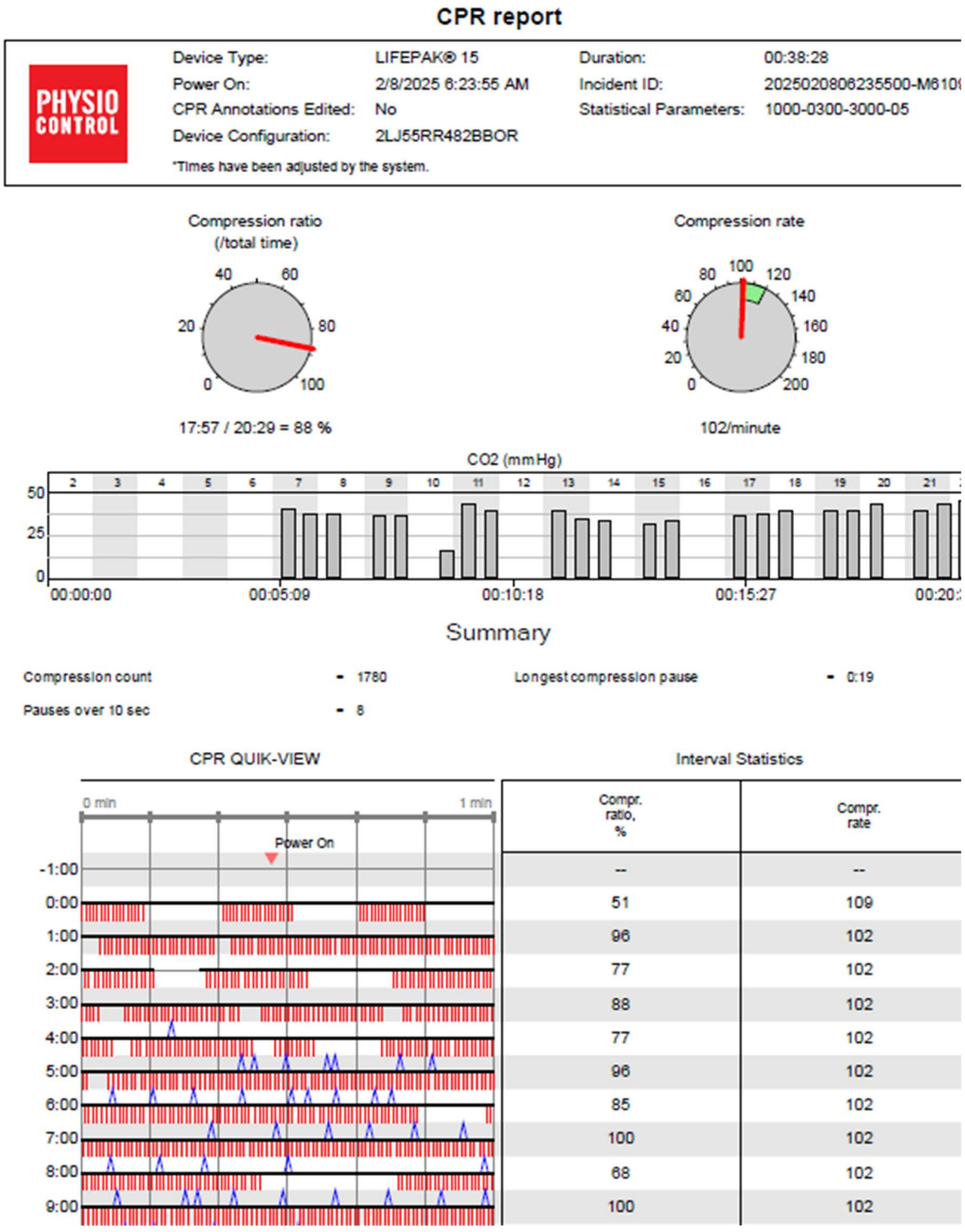
effort to improve the seamless and timely treatment that is critical to the success of field providers. Dr. Rossiter is also a consistent contributor at recruit academies, ongoing training events, and monthly Peer Committee - providing Metro Fire's members the opportunity to learn from a highly regarded and experienced cardiac care specialist. He often shares reperfusion images with the Peer Committee from Metro patients brought to his cardiac catheterization lab to illuminate the impact of their prehospital care.



The EMS Division is committed to utilizing information provided by CODESTAT for purposes of analytics and education. The software provides a comprehensive visualization of critical tasks and events during CPR. Code-Stat can be utilized to provide customized reports and trending data to help track trends, and provide focused areas for further training. The goal is to boost systemic and individual performance and thereby increase patient survival rates.

In 2025, the EMS Division expanded use of this tool's enhanced review of cardiac arrests and STEMIs to include CODESTAT CPR Reports (pictured below). This type of feedback illuminates for crews the efficacy and rate of their chest compressions, their compression fraction (which calculates their cumulative time spent compressing the chest in relation to the total resuscitation time), the rate of ventilations, and most importantly, excessive pauses that can impede positive results.

Some of the valuable information gleaned from the CPR Reports include visualizing a minute-by-minute picture of each compression as a red line, each ventilation as a blue arrow, and each gap between compressions displaying the exact length of the pause. The report begins with easy to comprehend gauges displaying Cardiac Compression Fraction (CCF) and the compression rate which, if kept within 100-120 compressions per minute, lands in the green. Metro Fire plans to upgrade this important tool to CODESTAT 12 in 2026 with an additional investment in their Pro-Analytics module. The LUCAS 3 mechanical compression system feeds even more data via Bluetooth to compile even more actionable reporting.



Example of a Code-Stat CPR report card

AREAS ADDRESSED BY PEER REVIEW

The District's Peer Review Committee is led by the CQI Manager & the Metro Medical Director with support from Dr. Rossiter, and there are 10 members of the committee from all ranks that assist with case reviews.

The Peer Review Committee members are assigned to focus on specific CQI categories created in the CQI module of the ePCR program. The team reviews electronic patient care reports that are drawn from the system based on several designated criteria. In 2025, Metro staff continued to balance sharing as much positive feedback as constructive criticism.

The Peer Review Committee meets during the third week of each month to discuss cases of interest identified in the previous month. When completing reviews, the committee can make one of four findings:

1) Recommendation for commendation for outstanding patient care.
2) Level 1 - Documentation error. Level 1 issues are handled immediately by the peer, and EMS Division staff is notified so we can update the receiving hospital as needed.
3) Level 2 – Protocol violation. Level 2 issues are forwarded to the CQI Manager for review and analysis of system trend or need for individual training.
4) Sentinel Event – These are incidents that meet the SCEMSA definition of a Reportable Incident. Sentinel Events are immediately reported to the Assistant Chief of EMS for review and notification of SCEMSA, as needed.

The following categories were assigned to Peer Review Committee members and EMS Division staff for review in 2025. Categories with an asterisk received 100% review:

ALS to BLS	External Pacing*	Q/A Review
Advanced Airway	Helicopter Transports*	Refusal of Service
Burns / CRW	I.O. and EJ Audits	Restraint Audit
Cardiac Arrest*	Ketamine*	Sepsis
Childbirth*	MCI*	Stroke CVA
Cardioversion Audit*	Needle Decompression	TXA*
Emergent Returns	Police Requests/BAR*	Waiting Room (per #5050)*

2025 CQI STATISTICS & MODALITIES

6721	Total PCRs for July 2025
324	T3 transports
1151	Patients Released at Scene (17%)
918	No Patient Found (13%)
43	Patients Offloaded to the Waiting Room
42	Scene Calls 911 to MIH
36	BAR -Police Requested
28	Cardiac Arrest activations of 59 total Arrests (47%)
29	STEMI activations of 233 suspected cardiac CP patients (12.4%)
112	Stroke activations
217	Trauma activations out of 1140 trauma cases (19%)
0	Metro run MCI
0	Childbirths
5	Burn Patients
830	12-Lead EKGs acquired
36	EZ-IO Placements
1	EJ
28	i-Gels
12	Oral Intubations-manual
6	Oral Intubations-Video OTI
1	Tourniquets placed
0	Needle Decompression
1	Paced Patient
0	Synchronized Cardioversion of 7 SVT and 4 Wide Complex
44	Patients placed in SMR/ Full C-spine
117	Patients placed in SMR/ Cervical Collar
7	Patients placed in Restraints
13	Adenosine
112	Atrovent
173	Pain Control: 58 Fentanyl; 16 Versed; 67 Tylenol; 21 Ketorolac; 11 Ketamine
3	TXA

Documented statistics of the previous month's activations, certain medication administrations and lesser used skills are shared with Metro Fire clinicians on their ImageTrend dashboards upon log-in. This gives crews a better snapshot of the frequency and percentage of these occurrences - which were managed by their peers and themselves.

Metro Fire continued to utilize the National Fire Incident Reporting System (NFIRS) module in ImageTrend through December 14, 2025 to aid in Operational as well as QA/QI activities. Beginning December 15, 2025, Metro Fire completed the upgrade to the next iteration called, NERIS. Within the platform, ePCRs are linked to the corresponding NERIS record allowing staff to transition between the incident and patient care reports for a more complete picture.

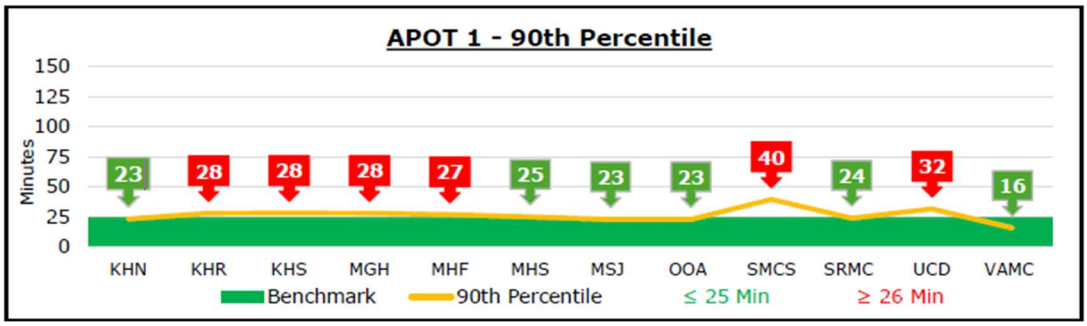
The NERIS dataset is also accessible from the Continuum module which Metro Fire uses for active monitoring and automated delivery of information that provides immediate awareness of specified data points with real-time updates upon posting of ePCRs and NERIS reports. The software is configurable and allows EMS Division staff to determine what is monitored, when the information is received, and how it will be viewed.

Ambulance Patient Offload Times (APOT)

The dilemma of extended wait times and patient delays improved significantly, but not entirely, in 2025 for multiple reasons. In 2024, Assistant Chief Jon Rudnicki addressed the first two local APOT Summits, beginning with an image of a Phoropter to illustrate the different perspectives (and priorities) as viewed by all the entities involved in the chain of patient care.

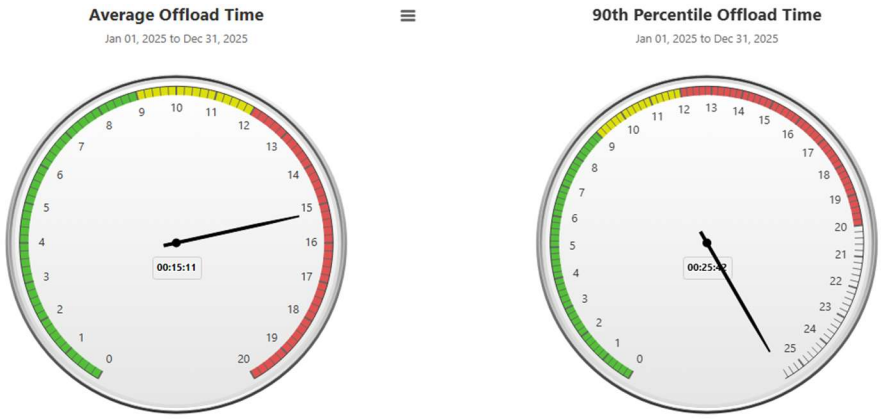
This reference was truly eye-opening for all in attendance - but it was his point regarding the need to "be available for the next patient" that become a rallying cry statewide. Soon after the

APOT Summits, local hospitals began pulling in the same direction as EMS, instituting APOT Alley's and designated patient corrals within their emergency departments. Chief Rudnicki spread this concept by presenting not just in Sacramento County, but across the state – and presented this topic with the SCEMSA Medical Director, Dr. Kann, at the 2025 EMSAAC Conference in San Diego in May. Chief Rudnicki's dedication to reducing APOT and his impactful efforts earned him the California State EMSA ***Medal for Distinguished Service***. Other factors included the impact of additional Squads and the passage of Assembly Bill AB40 - which empowered SCEMSA to set the schedule for hospitals to follow. This schedule initially gave hospitals an increase to 30 minutes (90% of the time) in January 2025 to offload ambulance patients. This increase built a six-month window for hospitals to develop or adjust their ambulance offloading processes - but then included a decrease to 25 minutes in July. Standard offload times are set to reduce more in 2026.



Sacramento Hospital's 2025 4th Quarter Offload Times

The combined efforts described above yielded much success. After owning the state's highest average patient offloading time of 73 minutes in December 2023, Sacramento area hospital wait times finished 2025 among the briefest, averaging 26 minutes overall. Though APOT consolidations continued in 2025, they were at a much-reduced rate of occurrence.



Metro Fire – APOT for the year 2025

NEMSIS & CEMSIS REPORTING

Metro Fire is not a stand-alone entity, and the cooperation and collaboration necessary to provide the community with quality care requires that we operate collegially with the surrounding agencies, and with the County, the State, and the Federal agencies that encompass the whole of Emergency Medical Services.

The District has met the requirements of the federal NEMSIS reporting system through the use of ImageTrend ePCR platform. This system allows secure transmission of patient and system data as required by Law, statute, and policy. The EMS Division monitors updates from CEMSIS and NEMSIS throughout the year, and updates the data elements in the ePCR program as indicated. The EMS Division worked with the SCEMSA Technical Advisory Group to prepare for the subtle but important upgrade to NEMSIS v3.5.1.

CARES

The Cardiac Arrest Registry to Enhance Survival (CARES) was created to provide communities with a means to identify cases of out-of-hospital cardiac arrest, measure how well emergency medical services (EMS) perform key elements of emergency cardiac care, and determine outcomes through hospital discharge. CARES collects data from 3 sources – 9-1-1 dispatch, EMS, and receiving hospitals – and links them to form a single record. Once data entry is completed, individual identifiers are stripped from the record. The anonymity of CARES records allows participating agencies and institutions to compile cases without informed consent. CARES generates standard reports (see Appendix E) utilizing Utstein Scores that can be used to characterize the local epidemiology of cardiac arrest and to help leaders determine how well EMS is delivering out-of-hospital cardiac arrest care. Utstein Scores measure outcomes based on cerebral performance after experiencing non-traumatic cardiac arrest. They utilize a 5-point scale with CPC-1 scoring the best with high cerebral function to CPC-5, the lowest score, indicating a complete loss of cerebral function, or death.

Metro Fire has worked diligently with CARES and ImageTrend to create a method of exporting the pertinent data to CARES. The EMS Technicians regularly monitor exports to CARES and correct data errors if they arise. Metro Fire began participation in the CARES system in 2019 and worked with ImageTrend to ensure proper configuration of our automatic exports; future years have shown actionable data and trends from continued participation in CARES.

STANDARD INDICATORS – Skills Maintenance/Competency

EMS training at Metro Fire utilizes Individualized, Online and Cooperative platforms.

Individualized Training

Metro Fire's team of skilled first responders is supported by recurrent professional training and continuous quality care improvement. The EMS Division utilizes a training cycle to ensure all personnel are evaluated on key skills each year. To meet the individual needs of Metro Fire's paramedics and EMTs, qualified EMS Staff Members and EMS24 personnel provided direct training for on-duty crew members. This process was used to meet the county requirements for infrequent skills check-offs, and to address remedial issues identified through the Peer Review Committee and focused audits. This is a labor-intensive process designed to address the needs of the employees in a cost-effective and flexible way. One highly impactful improvement involved shifting the entire workforce to the same expiration schedule, making the tracking of upcoming expirations and providing periodic alerts as expiration approaches much more streamlined., For members unable to attend due to leaves of absence, strike teams, and mor – the District provides one-on-one or company-level classes to maintain work eligibility and to bring them back on schedule.

Online Training

The use of Vector Solutions learning management system (LMS) allows Metro Fire to furnish consistent training to the District's workforce. The software was utilized to present educational content to 667 personnel covering a range of EMS-related topics. Additionally, it enabled Metro Fire to track training completions in real time for assignments pertaining to EMS, Fire Suppression, and multiple other essential subject areas.

In 2025, Metro Fire EMTs and paramedics completed mandatory assignments on protocol updates which included the addition of nebulized Epinephrine for croup/stridor. This particular delivery method of Epinephrine for croup is much quicker and more effective than the intramuscular injection previously in protocol. A Metro Fire crew requested a base hospital order for this treatment on a case in 2025. This delivery method was so effective it became SCEMSA protocol for all providers. Other protocol updates included Atrovent for DuoNeb administrations; Magnesium Sulfate for eclamptic seizures, respiratory distress, and polymorphic ventricular tachycardia.

One clear benefit of Vector Solutions is the ability to record, report, and monitor member currency with multiple credentials, such as paramedic licensure and accreditation, EMT

certification, and other specialized courses such as Handtevy, ACLS, and CPR.

While online training is not ideal for the delivery of instruction in every topic, it provides an advantageous means of disseminating information that supports Metro Fire's efforts to ensure that members maintain proficiency and stay up-to-date with training and provider qualifications.

Cooperative Training

Metro Fire's most comprehensive out-of-hospital medical education and training is furnished twice a year through the EMS Division to all Metro Fire Paramedics, EMTs, and first responders. These sessions promote skills maintenance and deliver the competency verification required by SCEMSA. While spring training was shortened in 2025 and reconfigured specifically for CQI trends plus May protocol updates - October's month of training was extended to provide requisite periodic certification trainings like CPR, ACLS and Handtevy.

Because SCEMSA skills verifications must be renewed every two years, Metro Fire's reconfigured fall training development allowed for half the infrequent skills to be verified during CPR & ACLS on odd years - and the remaining skills plus Handtevy or PALS to occur during even years.

There are several skills that don't logically correspond to the certificate classes, such as Duo-Dote administration (2-PAM), childbirth, and patient advocacy. These had been periodically incorporated into other modalities, or provided as needed by members of the EMS Staff to on-duty crew members, but are now a steady component of training in the spring. Realigning the method of delivery has proven effective in not just meeting the requirements - but more importantly, provides a direct, small-group dynamic that elicits greater engagement by the crews and offers opportunities for more personalized, Metro-specific instruction. Having everyone on the same expiration schedule is yet another plus that streamlines certification tracking.

Skills Verified in 2025

Metro Fire	Skill
EMT & Paramedic	Bag-Valve Mask Ventilation
EMT & Paramedic	Cardiac Arrest Management with AED
EMT & Paramedic	Medical Assessment
EMT & Paramedic	Oxygen Administration
Paramedic	Adult Airway Management
Paramedic	External Jugular (EJ) IV Cannulation
Paramedic	Intraosseus Placement and Infusion
Paramedic	Medication Administration: Epinephrine Dilution
Paramedic	Medication Administration: Ketamine
Paramedic	Medication Administration: Nerve Agent Exposure
Paramedic	Transcutaneous Pacing & Cardioversion (Adult and Pediatrics)

Lastly, the EMS Division continued the use of video messages to share important clinical updates delivered by multiple speakers including the EMS Chief, the Medical Director, the CQI Manager, and EMS Captains. The EMS section of the *Training Newsletter*, Metro Fire's internal monthly newsletter, included timely topics with QR codes down the right margin to access the videos or other more in-depth cpontent. Peer Review meetings were held on the third week of each month in 2025 – except the two skills training months of March and October.



Professional Support Staff Training



In 2025, the EMS Division maintained a strong commitment to providing continuing education to its professional support staff. The Administrative Specialist and Emergency Medical Services Technicians received continuing education required to maintain credentials from the National Academy of Ambulance Compliance (NAAC) in Certified Ambulance Privacy Officer (CAPO) and Certified Ambulance Compliance Officer (CACO).

Support staff attended periodic NEMSIS webinars as well as Centers for Medicare & Medicaid Services webinars on cost data analysis. Further, an Emergency Medical Services Technician attended the *ImageTrend Connect* annual conference in Minnesota to network and gain improved proficiency with this now ubiquitous charting and data collecting platform. The CQI Manager along with two EMS Day Captains attended comprehensive 2-day DICO training update for Infection Control Officers, held by Folsom Fire.



Due to retirements and transition back to the line, new EMS Captains joined the EMS Division. These members completed the above referenced Designated Infection Control Officer (DICO) training, plus HIPAA refresher and harassment training for supervisors, among others.

The knowledge gained through the completion of these courses and continuing education aid the EMS Division in handling infection control matters, proactively monitoring HIPAA compliance, and adherence to ambulance billing requirements. Additionally, this education aids staff serving as a resource to our members on the front lines of patient care.

2025 EMS TRAINING CYCLE

Spring 2025 Training

Towards the end of 2024, the Ninth Circuit Court of Appeals ruling in *Scott v. Smith* determined that law enforcement officers can be held liable for using force during non-criminal mental health calls – removing any pre-existing qualified immunity. As a result, instead of enhancing their mental health response training to accommodate the ruling, many California agencies - beginning with Sacramento County Sheriff Deputies - ended police responses to mental health crises altogether, unless crime is in progress. Scenes where EMS traditionally relied on law

enforcement assistance for safety and the provision of 72-hour holds instead left Fire & EMS personnel on their own. With scenes not safe to enter due to a psychotic episode, crews were left with the precarious choice of either abandoning their own safety to enter an unsecure scene, or clearing the call altogether with no patient engagement. This predicament led to SCEMSA creating a memorandum that provided a patient volatility scale, called a Behavioral Activity Rating Scale (BARS) to assess whether to proceed in to assess the patient or to clear the unsafe scene. A score of 6 or higher on the BARS Scale permits EMS providers depart form staging (if no law enforcement responds) and return to service.

Score	Patient Description
1	Difficult or unable to arouse
2	Asleep but responds normally to verbal or physical contact
3	Drowsy, appears sedated
4	Quiet and awake (normal level of activity)
5	Signs of overt (physical or verbal) activity, calms with re-direction/instruction
6	Extremely or continuously active, not requiring restraint
7	Violent, requires restraint

BARS Assessment Scale

This course furnished not only classroom instruction, but also featured a subsequent interactive series of realistic training scenarios (filmed by a 3rd party vendor) that required personnel to work together as a team in their BARS assessment and then react to the results of their decisions.

A second point of emphasis in Spring 2025 focused on patient advocacy. It reminded clinicians to keep the patient's best interests in mind as their "magnetic north" and offered steps to increase patient trust.

Fall 2025 Training

The EMS Division partnered with California Safety Training (CST) to conduct CPR, AED, and ACLS training & renewals in the fall of 2025, along with select infrequent skills verifications.

Paramedic Upgrade Programs

Our nation's EMS System still faces workforce shortages. This is a long-term problem that has been increasing over the last decade. Extraneous issues such as burnout from the covid pandemic followed by what were exorbitant APOT wall times have only worsened the issue.

To improve and maintain the number of licensed paramedics available to Metro Fire, the District continued to sponsor Firefighter/EMTs attending local paramedic programs including American River College, CSUS, UC-Davis and Cal-Jac. Sponsorships include salary, paid tuition and ancillary expenses. These are intense programs, where the students participate in cutting edge instruction.



Cal-Jac Patient Care Scenario

Supporting the region's efforts to improve the number of available paramedics in the workforce, Metro Fire's paramedic preceptors continued to mentor and pass along their knowledge and experience. A field internship provides emergency medical care training and experience to paramedic students under continuous supervision, instruction, and evaluation by an authorized preceptor. The field internship consists of a minimum of four hundred eighty hours (480) of third-person ride time, and represents a significant time commitment from our preceptors. Adding back the ability for interns to complete a portion of their ride time on fire engines instead of only ambulances provides a richer and well-rounded internship experience, guaranteeing more first-responder primary patient assessments with the added ability to continue care on the transporting ambulance for the most critical patients.

Metro Fire requires preceptors to have two (2) years of field experience in prehospital care within the last five (5) years. Ambulance experience within the last twelve (12) months is preferred. In accordance with EMSA requirements, preceptors attend a training course that includes curriculum on adult learning theory and teaching styles which will result in the preceptor being competent to evaluate the paramedic student during the internship phase of the training program. Metro Fire's preceptors are dedicated to paying it forward to develop the next generation of EMS professionals in our community.

STANDARD INDICATORS - Transportation & Facilities

Type III ambulances built by Braun-Northwest have become the adopted standard for patient transportation units purchased by the District. The District's Fleet Division coordinates regular automotive service and routine repairs for our fleet of thirty-nine (39)

ambulances to minimize the likelihood of mechanical failures, and to ensure that an adequate pool of reserve rigs is available at all times. Odometer readings are also tracked, and units with high-mileage are removed from service and replaced with new ones in accordance with the District's apparatus purchase plan. Assigned personnel perform daily apparatus checks and complete weekly preventative maintenance inspections that are documented in the District's pre-trip application. Maintenance records are maintained by the Fleet Division and any service centers that the District contracts with.

The Fleet Division's current objective is to utilize Measure O funding for ordering new vehicles as outlined in the Capital Improvement Plan.

Currently on order are 25 ambulances, 3 squads, 4 Battalion Chief SUVs, a Rescue Unit and a Hazmat Unit.



STANDARD INDICATORS – Public Education & Prevention

Metro Fire devotes considerable resources to initiatives aimed at public education and injury prevention. Members of the District's Community Services Division (CSD) are committed to reducing the incidence of injury and death among every age group in our community.

CSD stayed true to their Community Risk Assessment (CRA) from 2021. The CRA was a comprehensive evaluation to identify and prioritize risks within the communities we serve. The purpose of the CRA is to enhance the safety of the community by reducing fire and other emergency events. The CRA analyzes community demographics & compiles fire and EMS response history, and the data gathered aids in developing a Community Risk Reduction plan to target prevention and enforcement efforts. Entire communities were again provided free smoke detectors in 2025. Specifically, 234 smoke detectors and 71 monoxide detectors, were gladly installed by Metro Fire staff in 110 homes at no cost to the citizen – as well as 68 nightlights.



Community Relations Division

Another valuable contributor in the effort to promote health and safety across all demographic groups within Metro Fire's jurisdictional area and the region at large is the District's Community Relations Division (CRD).

Through the use of social media, partnerships with local news outlets, and public service announcements, Metro Fire is able to disseminate information promoting community risk reduction.

The Community Relations Division at Metro Fire is led by the designated PIO or Public Information Officer. In 2025, Captain Mark Nunez entered the role and has immediately made an impact, raising both community awareness and engagement.

Some 2025 CRD highlights included:

- Launched the Inaugural Citizens' Academy in partnership with the Special Ops Division
- Produced another spectacular Fire Camp
- Held a CPR-a-thon at the California State Capital in October
- Metro Fire's 25th (Silver) Anniversary Celebration



Community AEDs



Data tells a story and one message that's come through loud & clear at Metro Fire is more patients survive when first responders are not the only resuscitators during a cardiac arrest. Without early bystander recognition and intervention – meaning continuous chest compressions, and access to a public Automatic External Defibrillator (AED) - the chance of survival plummets exponentially. That is why Metro Fire made identifying, tracking, registering, and accessing AEDs a District imperative. In 2025, surprisingly there were zero AEDs in Metro Fire's District that were registered with Fire Dispatch (SRFECC) ***and*** accessible to the public 24/7. Most were located inside of businesses that closed at night. Now there are five (5) accessible 24/7 and growing by the day. One of the five was provided by Metro Fire to Hagen Park in Rancho Cordova. But that is just the beginning. It is Metro Fire's goal to not only locate AEDs, but to make sure each AED gets registered - not only with the county and the Pulse Point application (that alerts CPR trained bystanders where patients and AEDs are located) - but linked to Sacramento's 911 call takers, complete with pictures showing what the AED

looks like and where it can be accessed.

Metro Fire's Inaugural Survivors' Social

On May 20, 2025, Metro Fire launched the first of many annual Survivor Socials. The event set the stage for all members of the chain of survival to reunite and celebrate each survivor's new lease on life. From bystanders and family members to first responders, nurses, doctors and surgeons – the shared perspectives humanized each event and provided clinicians the rare opportunity of meeting (and often times, hugging) someone they revived. This event also allowed patients to share their own recollections of those harrowing moments. Each survivor along with their caregivers at every stage received a Metro Fire Survivor's Challenge Coin (pictured right) highlighting the importance of each link in the chain of survival as essential to the outcome – from early recognition, to rapid dispatch, response and care on scene and enroute to the hospital, and finally the stage of receiving definitive care at the hospital. Honoring five survivors filled an entire space with over 100 people, highlighting the impact each cardiac arrest has, not just on the patient themselves but the community around them. It has been said, "to save a life is to save a universe" meaning every life includes an entire network of other impacted lives. One of the more inspiring cases, involving a treacherous auger accident where loss of both life and limb were narrowly averted thanks to timely and proficient care. The case eventually led to Paramedic Chris Barry Lloyd receiving the ***Paramedic of the Year*** award from the California State EMSA.



STANDARD INDICATORS – Risk Management

Metro Fire understands the importance of risk management. The District investigates all issues and complaints related to patient care and professional conduct or associated concerns. Reviews and fact-finding are conducted for the purposes of remediation and appropriate follow-up with the reporting party. When the issue has been resolved, a record is kept on file and is protected from disclosure by California Evidence Code §1157 and §1157.7.

Metro Fire participates in the Client Connect program offered by Paige, Wolfberg, & Worth LLC (PWW). PWW is a national EMS industry law firm with over two decades of experience providing legal and education resources for EMS agencies, billing companies, public safety agencies, and others related to the provision of EMS and

prehospital care. The attorneys and consultants have years of hands-on experience as EMS field providers, billers, managers and administrators, and expertise in a full range of legal matters affecting the ambulance industry, EMS and Mobile Integrated Healthcare.

Client Connect offers the District a flat fee program that provides the EMS Division with unlimited access to the EMS attorneys and consultants at PWW by phone, email, or Zoom to answer everyday questions on issues such as HIPAA, reimbursement, billing, coding, compliance, liability, documentation and other issues. The arrangement also provides discounts on continuing education courses for professional staff. The partnership has been a tremendous asset to staff and was utilized frequently throughout the year.

In addition to participating in the Client Connect program, the EMS Division utilizes PWW for ambulance claims reviews. These reviews are performed from a strict compliance perspective to identify deficiencies and risk areas, as opposed to whether claims may be "defensible" in an appeal situation. The goal of these reviews is to identify compliance risks (no matter how minor) to allow the EMS Division to explore and correct the crew documentation or billing risks identified.

PWW performs reviews of randomly-selected paid Medicare claims. Using the Office of the Inspector General's RAT-STATS 2019, Version 1.9.0.0, Random Number Generator Program, they select a pool of Medicare claims, from a universe of transports provided by Metro Fire. The review included documentation and claims submission analysis consistent with applicable Medicare ground ambulance regulations, 42 CFR Parts 410 and 414, Medicare Manuals (e.g., Medicare Benefit Policy Manual (100-02), Chapter 10, and Medicare Claims Processing Manual (100-04), Chapter 15) and related guidelines (e.g., CMS Program Memoranda, Transmittals, and Medlearn Matters articles).

In addition to verifying correct payment from the primary payer, PWW also reviews whether patient cost-sharing obligations (i.e., co-payment and deductible) were collected. The EMS Division received the results of the audit in the first quarter of 2022 and worked with our third-party claims administrator, Wittman Enterprises LLC to address any identified risks or deficiencies from the claims review.

The District maintains a comprehensive program for security of controlled substances, which includes a written policy and training for all personnel who are entrusted with controlled substances. The system includes engineering controls that limit access to narcotics and track access to secure Knox Med-Vault safes. In 2025, the EMS Division continued to utilize the electronic narcotics tracking module within the Operative IQ system.

Section 1128 of the Social Security Act entitles the Office of Inspector General (OIG) to

preclude entities and individuals from federally-funded health care programs. The List of Excluded Individuals/Entities (LEIE) is kept up to date and maintained by the OIG[1]. Metro Fire compares the district's roster to the OIG list on a monthly basis to ensure compliance with federal regulations. This process is accomplished through the use of "Fuzzy Logic" to compare similar names on both lists and to avoid missing personnel whose names are typically abbreviated, or where a nickname is used (i.e. Bill vs. William).

EMS DIVISION – Special Programs

Sacramento Mobile Integrated Health (MIH)

The Sacramento Metropolitan Fire District pioneered Mobile Integrated Health (MIH) in Sacramento County beginning in November 2021. The program combines advanced-level providers (Nurse Practitioners or Physician Assistants) with paramedics to address patient health needs in the prehospital setting. MIH reduces non-emergent emergency department (ED) visits, lowers healthcare costs, increases healthcare accessibility, improves care coordination, and enhances outcomes.

The objectives of the program are to:

- Reduce unnecessary EMS transports and emergency department visits;
- Reduce hospital readmissions;
- Reduce healthcare expenditures;
- Expedite appropriate care for patients calling 9-1-1; and
- Provide appropriate care and navigation for the most at-risk patients dealing with crises such as opioid addiction and behavioral health problems

911 Referrals/High Utilizer



High utilizer outcomes improved substantially in Year Four. When comparing six months before and six months after initial MIH engagement, 911 calls decreased from 779 to 472, representing a 39.4% reduction. This improvement marked a strong increase from Year Three and more closely aligned with the program's early successes. Contributing factors included earlier identification of high utilizers and the addition of a dedicated part-time case management professional, which strengthened follow-up, care coordination, and

connections to community-based resources. Suppression and EMS crews played a critical role by making 340 direct referrals to MIH, identifying high utilizers in the field and accelerating access to services. This earlier engagement allows MIH to intervene, leading to more effective care coordination and sustained reductions in 911 utilization. By addressing underlying medical, behavioral health, and social needs, MIH continues to reduce unnecessary 911 utilization while improving stability and outcomes for some of the system's most vulnerable patients.

Direct 911 Referrals

Within the direct 911 system, MIH provides on-scene evaluations and treatment for a wide range of medical and behavioral health concerns. While many encounters involve common medical issues, two of the most system impacting services are behavioral health and jail clearances, which historically required ambulance transport and ED evaluation.

Case Management and Social Work Integration

MIH continued to advance case management and social work integration to better address social determinants of health. In 2025, MIH hired a part-time case management worker to better coordinate follow-up care, care coordination, and connection to community resources.

Advocacy, Education, Community Collaboration, and Statewide Leadership

Throughout 2025, MIH expanded its impact at the local, state, and national levels. Metro Fire representatives attended the California MIH Summit in Beverly Hills and met with California Surgeon General Dr. Diana Ramos, who expressed support for MIH initiatives and community-based care models.

MIH team members also presented at the EMS World Expo through the National Association of Mobile Integrated Health Providers (NAMIHP) and at the ImageTrend Connect Conference, highlighting MIH documentation practices, data-driven decision-making, and measurable outcomes.



Locally, Metro Fire partnered with Arrive Alive to bring fentanyl awareness education to schools across Sacramento County, expanding prevention efforts and reinforcing Metro Fire's commitment to community collaboration and public

health engagement.

But local community collaboration doesn't stop there. Metro Fire has been instrumental in sharing our blueprint to help our neighboring fire departments stand up their own MIH Programs to mirror this success.

MIH Incidents					
	2022	2023	2024	**2025**	Grand Totals
Total Incidents	193	486	940	**1,142**	2,761
911 Calls Directly Dispatched	20	253	679	**834**	1,786
911 Calls Treated/Released on Scene	17	152	501	**619**	1,289
911 Calls Treated/Released Percentage	85.00%	60.10%	73.80%	**74.20%**	73.28% avg.
Jail Clearances	n/a	7	45	**43**	95
Behavioral Health Clearances	3	33	96	**134**	266
High Utilizer 911 Calls Pre/Post MIH	652/368	634/369	729/552	**779/472**	
High Utilizer 911 Call Reduction Percentage	43.60%	41.80%	24.30%	**39.40%**	37.28% avg.
Health System Cost Savings	$1,103,290	$2,404,422	$3,920,162	**$5,424,102**	$12,851,976

*Grand totals percentage (treat and release and high utilizer reduction) is an average of all four years

Through innovation, collaboration, and compassionate care, MIH has reduced high utilizer demand, preserved Emergency Department capacity, improved behavioral health outcomes, and addressed opioid use disorder in meaningful ways.

With a skilled team of 16 part-time advanced providers, amazing paramedics, dedicated case management, and strong community partnerships, Metro Fire's MIH program continues to enhance system efficiency and patient outcomes, serving as a sustainable and scalable model for integrated prehospital healthcare.



Infection Control

Though coronavirus has been reclassified, categorized and processed like any other Aerosolized Transmittable Disease (ATD) since mid-2023, providers are still notified when transported patients are discovered to be COVID-19 positive. The EMS Division continued to receive and track close proximity exposures from hospitals who became aware of positive coronavirus EMS patients under their care – often days or weeks after the fact - but the need



to report or trace covid exposures has ceased.
The remaining tracked exposures in 2025 involved saliva, mucous or blood to the eyes, proximity to TB patients, unexpected positive TB results revealed by annual check-ups, scabies infestations, and an uptick in needlesticks (which causes have been addressed).

SUMMARY

Throughout 2025, the men and women of the Metro Fire District continued to demonstrate exceptional resiliency and professionalism in the face of varying local challenges. As APOT delays improved and call volume decreased, mandatory overtime, and newer issues like no law enforcement presence on behavioral health calls leave responders in uncharted waters, stuck between the tug of war between a duty to act and scene safety.
The outlook for 2026 appears both exciting and promising – especially with Metro Fire's goal to double the number of survivors from out of hospital cardiac arrest (OHCA).

Through the modalities discussed in this QIP, Metro Fire has maintained an ongoing commitment to measuring performance and providing education based on that performance. EMS is ever changing. Every initiative, program and process that Metro Fire implements is aimed at improving the overall health of our patients; at all times, as they are our main focus.

To that end, a few of the many things we look forward to in 2026 include:

- **2026 Heart Safe Community Initiative:** Continued collaboration with SCEMSA, SRFECC (Fire Dispatch) and Pulse-Point to establish a much more robust and complete directory of AED locations within the Sacramento Metropolitan Fire District
- **2026 Heart Safe Community Initiative:** teaching the public Bystander CPR & AED
- Training for Sacramento County's new 2026 MCI plan, including SALT Triage
- Upgrading to a more superior and efficient CPAP delivery system
- Orienting field paramedics to the **Clinical Opiate Withdrawal Scale (COWS)** in preparation for the administration of Buprenorphine
- Adapting to, and monitoring Behavioral Crisis situations without Law Enforcement present - keeping member safety as priority number one
- SCEMSA launching its own **Health Information Exchange (HIE)** for patient outcomes
- Sending EMS Team members to conferences pertinent to their duties, such as The Resuscitation Academy, EMS World, and more

- Continued focus Fire Chief House's Priorities, as well as Metro Fire's Board of Directors' Priorities - which include Member Health & Wellness; External Engagement; Service Delivery; Additional Revenue Resources; and Culture – in all we do.

APPENDICES

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APPENDIX A

QI PROGRAM POLICY

Sacramento Metropolitan Fire District

OPERATIONS POLICY

POLICY TITLE: Quality Improvement Program OVERSIGHT: EMS
POLICY NUMBER: 04.014.01 EFFECTIVE DATE: 02/20/19 REVIEW DATE: 02/20/19

Background

The Sacramento Metropolitan Fire District (District) Emergency Medical Services (EMS) system and its participants require objective feedback about performance that can be used internally to support quality improvement efforts and externally to demonstrate accountability to public governing boards and other stakeholders.

Purpose

The primary purpose and goal of the District's Quality Improvement Plan (QIP) is to ensure a continued high quality of patient care.

Scope

This policy is applicable to all District first responders, emergency medical technicians, and paramedics.

Definitions

1. **Prospective:** Prevent potential problems.
2. **Concurrent:** Identify problems or potential problems during patient care.
3. **Retrospective:** Identify trends and potential or known problems, and prevent their reoccurrence.
4. **Reporting/Feedback:** QIP activities that are reported to Sacramento County EMS Agency (SCEMSA) and may result in system design changes.
5. **Reportable Incident:** Issues that contributed to a negative patient outcome and/or issues involving grossly inappropriate behavior by any involved personnel. Additionally, issues that may potentially be a threat to public health and safety, but did not necessarily contribute to a negative patient outcome.

The District has established a system-wide QIP to continuously monitor, review, evaluate and improve the delivery of prehospital patient care services. QIP is comprised of participants from all ranks and includes the following activities:

a. Prospective
b. Concurrent
c. Retrospective
d. Reporting/Feedback

2. The District shall submit an Annual Update to SCEMSA by March 31. SCEMSA evaluates the District's QIP and requests revisions as needed.

3. All proceedings, documents, and discussions of the QIP are confidential and covered under Section 1040 and 1157.7 of the Evidence Code of the State of California. The prohibition relating to discovery of information provided to the District's QIP committees shall be applicable to all proceedings and records of these committees which are established to monitor, evaluate, and report on the quality of pre-hospital medical and trauma care. Issues requiring system input may be sent in totality to SCEMSA for review and input.

   All QIP members will sign a confidentiality agreement not to divulge or discuss information that would have been obtained solely through the District's QIP process. The EMS Battalion Chief is responsible for explaining, and obtaining, a signed confidentiality agreement for invited guest(s) prior to their participating in any committee meeting.

4. All Reportable Incidents will be referred to the District's designated Quality Assurance Officer.

Procedures

1. Prospective Review
   a. Participate on committee(s) as requested by SCEMSA.
   b. Provide and/or participate in education:
      I. Orientation to the EMS System
      II. Peer Review Audits
      III. Participate in continuing education courses and training of pre-hospital care providers
      IV. Offer educational opportunities based on problem identification and trend analysis
      V. Establish procedures for informing all field personnel of system changes
   c. Engage in evaluation of individual paramedics including:
      I. Review of electronic patient care reports (ePCR), audio tape or other documentation as available.
      II. Direct observations.
      III. Evaluation of new employees.
      IV. Routine evaluation of patient care.
      V. Develop Performance Improvement Plans as needed.

VI. Design educational plans for individual paramedic deficiencies.

d. Accreditation- establish policies and procedures based on SCEMSA policies.

2. Concurrent Review

a. Evaluate EMTs and Paramedics utilizing performance standards through direct observation.

b. Provide field supervisors and/or quality assessment personnel for consultation/assistance.

c. Review low frequency, high risk skills at least on an annual basis.

3. Retrospective Review

a. Conduct analysis of field care, utilizing ePCRs, audio tapes, or other applicable documentation to include:

I. High risk.

II. Trend analysis of high volume calls, unusual occurrences and problem oriented events.

III. Incidents requested for review by SCEMSA or another system provider (e.g. receiving hospital or response partner agency).

IV. Specific audit topics requested by SCEMSA or any quality improvement committee.

b. Develop District specific indicators for reporting to SCEMSA in the annual report.

c. Abide by SCEMSA specific indicators and develop benchmarks.

d. Participate in the incident review process, prehospital research, and studies as requested by SCEMSA or other quality recommendations as specified by SCEMSA.

4. Reporting/Feedback

a. Comply with reporting and other quality recommendations as specified by SCEMSA.

b. Develop a process for identifying trends in the quality of field care.

I. Submit reports as specified by SCEMSA.

II. Design and participate in educational offerings based on problem identification and trend analysis.

III. Make changes in internal policies and procedures based on trend analysis to reflect SCEMSA policies and procedures.

APPENDIX B

CQI CONFIDENTIALITY AGREEMENT

SACRAMENTO METROPOLITAN FIRE DISTRICT

CQI Meeting Attendance Roster

Confidentiality Statement

I understand and agree as follows:

That confidentiality is vital to the free and candid communication necessary to the effective Continuous Quality Improvement activities,

That I shall respect and maintain confidentiality of all discussions, deliberations, records, and any other information generated in connection with this meeting,

That I shall make no voluntary disclosures of such discussions, deliberations, records, or information,

That I shall only diseminate or act on information obtained from this meeting based on written direction of the CQI Manager or directed action items recorded in the minutes,

That all printed and written material associated with this meeting (including notes taken during the meeting) shall be submitted to the recorder prior to the end of the meeting, unless associated with action directed by the CQI manager.

The undersigned have agreed to the above for the the meeting held on: March 18, 2020

Start Time:_____ End Time:_____

Name	Employee Number	Paramedic Number	Signature	Initial for Overtime

APPENDIX C

SAMPLE CQI NOTES FROM PEER REVIEW MEETING

Airway Management

1) *Trend*: ETCO2 is not being used on all advanced airways.
    a. ETCO2 is required for all advanced airway placement (iGel or ET)

2) *Trend*: Unable to capture ETCO2 waveform on monitor, or waveform only present for brief time period.
    a. Esophageal tube can cause an initial waveform, so it is important to verify capnography waveform periodically throughout the code.
    b. Proper calibration was not allowed for prior to hooking capnography up to the ET
    c. If ETCO2 reading not registering, reconfirm & ***document*** good tube placement
        i. Check for breath sounds with ventilation
        ii. Verify absence of epigastric sounds with ventilations
        iii. Consider the need to suction the tube to clear secretions inhibiting waveform
        iv. Re-visualize the airway using video laryngoscope
    d. If you can't confirm the tube is in the correct place, and there is no ETCO2 waveform, pull the tube and insert the iGel.

3) *Trend***:** Documenting ETCO2 sensor failure on PCR, but not reporting to EMS Division.
    a. All perceived failure of the monitor's ETCO2 sensor must be reported to EMS24 immediately and documented in a Report of Occurrence.
        i. SCEMSA protocol Biomedical Maintenance 5550 requires us to report malfunctioning biomedical device that may have effected patient care to SCEMSA on the next working day.

4) *Trend*: Incomplete documentation of advanced airway confirmation.
    a. PCRs consistently have no documentation of lung sounds with ventilation before or after advanced airway placement.
    b. Consistently lacking documentation that epigastric sounds were checked and absent with ventilation after advanced airway placement.
    c. Consistently lacking documentation that tube placement was checked throughout transport and after each patient move.

Vascular Access

1) *Trend*: Not attempting (or documenting) peripheral IV or EJ before IO for vascular access
    a. Vascular Access protocol 8808 states "*peripheral IV is preferred choice for all patients requiring vascular access*" & new ACLS 2020 guidelines state "*Intravenous IV access is the preferred route of medication administration during ACLS resuscitation*".
        i. Comparing IV versus IO drug administration during cardiac arrest found that IV route was associated with better clinical outcomes in 5 retrospective studies.
    b. Vascular access protocol lists EJ as the 2nd option if peripheral access in not obtained for patients in extremis with immediate need for fluids and medication.
    c. IO is indicated for adult and pediatric patients weighing ≥ 3kg who are *unable to be successfully IV cannulated* and who need fluids and/or medication.
        i. When indicated, the humeral head is the preferred site for an adult patient over the tibia

2) *Trend:* Unsuccessful IV attempts not documented and/or no rationale documented for bypassing IV and going to IO.
    a. Protocol update coming July 01, 2021 requires providers to document the rationale for forgoing IV and going straight to IO & will require documentation of why humeral head wasn't used for an adult patient.

3) Additional considerations
    i. IO carries risk of osteomyelitis, compartment syndrome, fractures, and incompatibility with MRI scanners
    ii. Significant cost difference between IV catheter ($1.83/catheter) vs. IO needle ($110/needle)
    iii. IO insertion automatically results in ALS2 billing which is the highest charge for the patient.
4) Bottom line, we are over using IO in the cardiac arrest setting unnecessarily without benefit for the patient.

Routine Use of D50% and Narcan in Cardiac Arrest Setting

1) *Trend*: Medics checking blood glucose level during cardiac arrest event & administering D50% if result is <60 mg/dl
    a. Point-of-care glucometers are calibrated for use with capillary blood (finger stick). Point-of-care glucose testing in patients suffering cardiac arrest results in inaccurate reading most of the time, which may prompt us to administer D50% when it is truly not indicated.
    b. Retrospective analysis of Cardiac Arrest Registry data found that patients who receive D50% during the prehospital phase of cardiac arrest have a decreased chance of survival to hospital discharge. For those who do survive, administration of D50% appears to decrease the chances of good neurological recovery.
    c. SCEMSA memo to all providers in September 2019 states the following:
        i. Only use D50 to treat hypoglycemia which was documented by the patient or caregiver BEFORE cardiac arrest occurred, if it has not been yet been treated.
        ii. Do not check capillary blood sugar during cardiac arrest (also don't use venous blood from IV start. Point-of-care glucometer isn't calibrated for this use).
        iii. If resuscitation efforts result in ROSC, check blood glucose and treat according to hypoglycemia protocol.
2) *Trend*: Administering Narcan during cardiac arrest AFTER advanced airway has been established
    a. SCEMSA memo to all providers in September 2019 states the following: use Narcan during cardiac arrest only with suspected opiate overdose (presence of drug paraphernalia on scene, suggestive history from bystander, unexplained arrest in young person, etc.).
    b. Narcan is not indicated if an advanced airway has already been secured. If Narcan is going to be given due to high suspicion for opiate OD, give it prior to advanced airway attempt.

Medical vs. Trauma Cardiac Arrest

1) ***Trend*:** Remaining on scene with traumatic cardiac arrest and running the code for 20 minutes before making a transport determination.
    a. Patients in traumatic cardiac arrest have issues that will not be fixed with standard ACLS & need a trauma center.
    b. Decision point on traumatic cardiac arrest:
        i. Does patient meet criteria to declare death (absence of pulses & asystole in 2 leads or PEA at a rate ≤ 40 beats per minute)?
        ii. If patient doesn't meet criteria to declare death transport is indicated, and the provision in the Trauma protocol applies: "time on scene for critical trauma should not exceed 12 minutes under normal circumstance. Conditions requiring extended scene times shall be documented".

APPENDIX D

PERFORMANCE IMPROVEMENT PLAN (PIP)

SACRAMENTO METRO FIRE DISTRICT
Performance Improvement Plan

Probationary Firefighter Information:		
Date:	**Start Date**:	**Name**:
Class:	**FTO:**	**Company Officer:**
# of ride along shifts to date:		

Evaluation Factors: (Highlight areas needing improvement)

Patient Assessment

Scene Size-up

Initial Assessment

Focused History

Physical Exam

Scene Activities/Management

Transfer of Care

Scene Safety

Use of Resources

Critical Thinking

Treatment

Protocol Knowledge

Treatment Skills

Decisiveness

Appropriateness of Treatment

Communications

On-Scene Communications

Communications with Patient, Family, Bystanders

Hospital Communications

Other:

SACRAMENTO METRO FIRE DISTRICT
Performance Improvement Plan

Areas in need of improvement

Patient Assessment
Probationary FF/P_____has not demonstrated competency in performing a prompt, complete, and appropriate patient assessment. He does not consistently identify the primary chief complaint or sift through multiple complaints to find the most critical and relevant. Probationary FF/P_____sometimes forgets to ask assessment questions that would assist with differential diagnosis, such as determining pertinent negatives and relevant past medical history.

Treatment
Probationary FF/P_____inconsistently applies the Sacramento County EMS Protocols which adversely affects his ability to develop and implement an appropriate treatment plan. Other ALS crew members occasionally have to step in to guide treatment of patients.

Scene Activities/Management
Probationary FF/P_____has needed prompting to direct crew members to perform diagnostics or interventions, especially on critical patients. Probationary FF/P_____looks to the crew for approval and direction. Probationary FF/P_____does not consistently assume a leadership role relevant to medical management of patients.

Communications
Probationary FF/P_____ inconsistently communicates clear and concise orders to the crew during incidents. Although verbal communications are respectful and professional, he does not instill confidence in his patients, bystanders, or crew.

Other
Probationary FF/P__has showed improvement in all aspects of EMS performance, however he requires additional time as a 3rd person ride along to become a safe, competent and consistent paramedic for the District.

SACRAMENTO METRO FIRE DISTRICT
Performance Improvement Plan

Recommended Training:

Probationary FF/P_____is being assigned to work with FTO FF/P XXX for 6 shifts during which he will ride on Medic XXX and will consistently demonstrate improvement in the following areas:

Patient Assessment
Utilize a thorough and systematic assessment to competently identify the treatment needs of patients in a timely manner in the drill setting and on incidents. If receiving a transfer of care report from first arriving paramedic, process the information received and continue down that treatment path if appropriate or recognize additional needs and formulate your own treatment plan.

Treatment
Memorize Sacramento County EMS Protocols. Practice developing treatment plans in a timely manner in a scenario setting as well as actual incidents with feedback from the crew. Utilize the full body CPR mannequin and cardiac rhythm generator available through Logistics to practice realistic, real-time patient assessments that incorporate the necessity to provide rapid intervention (i.e. CPR, active bleeding, cspine precautions).

Scene Activities/Management
Practice scene control and delegation in the drill setting in addition to actual emergency incidents. Practice giving clear and concise direction to crew members while assuming a leadership role in relation to patient management.

Communications
After completing drill scenarios and actually performing on emergency scenes, deliver a radio report which clearly and accurately reflects the patient's condition to the receiving hospital. Practice and perform transferring care to hospital staff in the same manner as mentioned above.

Other
All of Probationary FF/P_____ePCRs will be reviewed by a Peer Review member for the duration of this PIP.

SACRAMENTO METRO FIRE DISTRICT
Performance Improvement Plan

Required Outcomes

At the completion of this Performance Improvement Plan on the morning of XXXXX XXth, XXXX @ 0800, Probationary FF/P _____shall have consistently and competently demonstrate the following:

Patient Assessment

Probationary FF/P_____must have demonstrate the ability to perform complete physical examinations that were appropriate for the chief complaint promptly without direction from the crew, identify any imminent life threatening needs, and initiated appropriate interventions immediately.

Treatment

Probationary FF/P_____must have demonstrated consistent knowledge of the Sacramento County EMS protocols and utilized them without hesitation or direction from the crew on all incidents. Probationary FF/P_____must have consistently demonstrated knowledge of the indications, contraindications, adverse effects, and dosage of all medications used in the Sacramento County EMS Protocols. Probationary FF/P_____must have passed a written protocol knowledge and cardiac rhythm interpretation examination to be administered by the EMS Division on XXX XXth, 20XX with a minimum score of 80%.

Scene Activities/Management

Probationary FF/P_____must have immediately assumed a leadership role related to medical management and scene control as appropriate. He must have demonstrated competency in directing crew members to assume medical duties within their scope of practice to facilitate completing the patient assessment without direction from other crew members on all incidents.

Communications

Probationary FF/P_____must have consistently provided clear and concise direction to crew members on scene. Probationary FF/P _____ must have delivered radio and transfer of care reports which clearly and accurately reflects the patient's condition to the receiving hospital.

Other

All ePCRs should have been completed in compliance with SCEMS protocols and District documentation policies 04.001.01, 04.003.01, 903.00, & 923.01

.

Please Sign Below:

Company Officer:_____ Date:_____

FF/P FTO: _____ Date:_____

EMS Captain: _____ Date:_____

Probationary FF/P:_____ Date:_____

This Performance Improvement Plan (PIP) has a duration of 6 shifts and will be completed and reviewed by the following date:

XX/XX/XX

(Signed original PIP stays in probation binder; signed copy to EMS Captain)

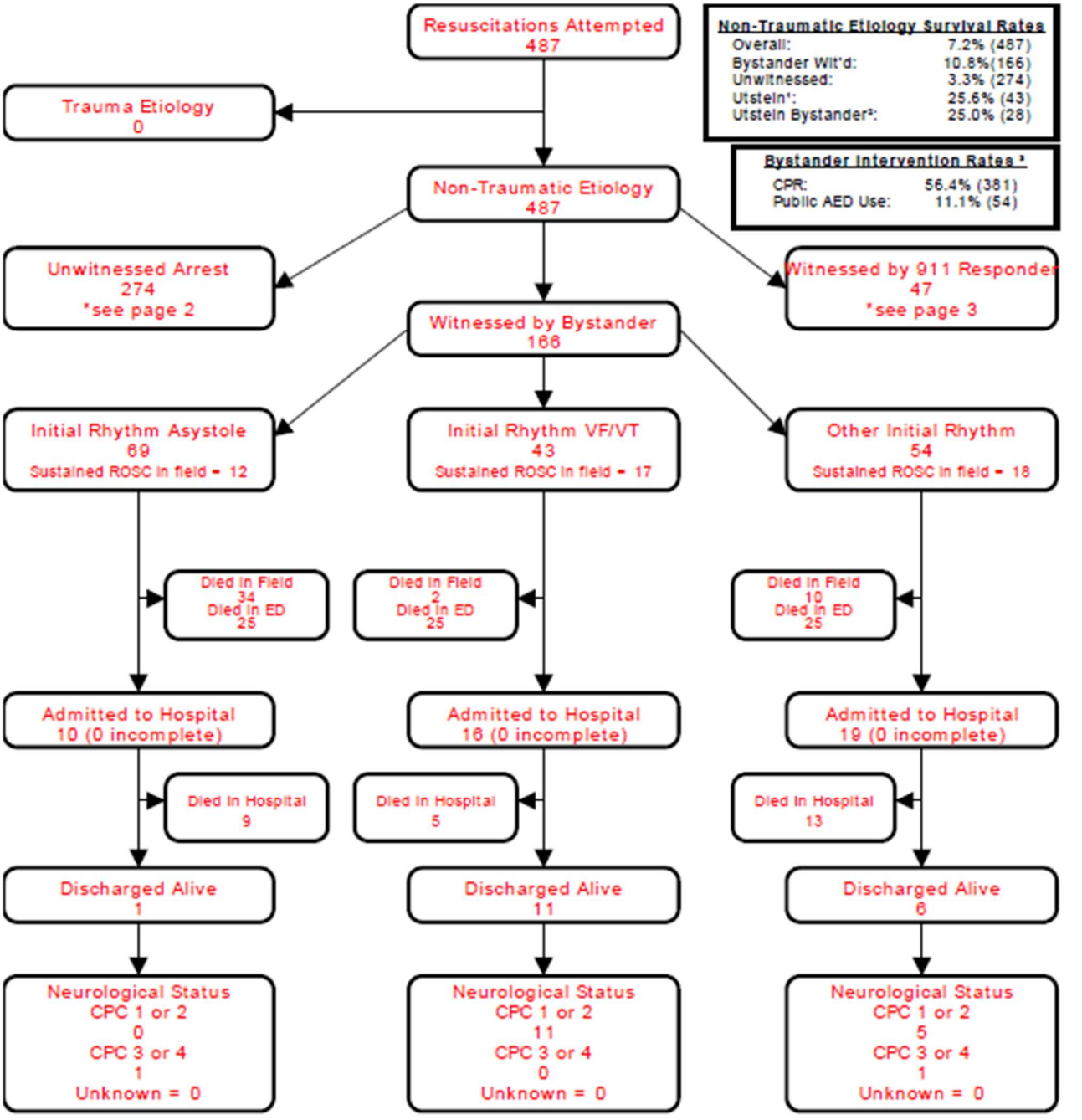
APPENDIX E

2024 UTSTEIN SURVIVAL REPORT

Utstein Survival Report

Sacramento Metropolitan Fire District

First Responder: Sacramento Metropolitan Fire District | Date of Arrest: From 01/01/2025 Through 12/31/2025



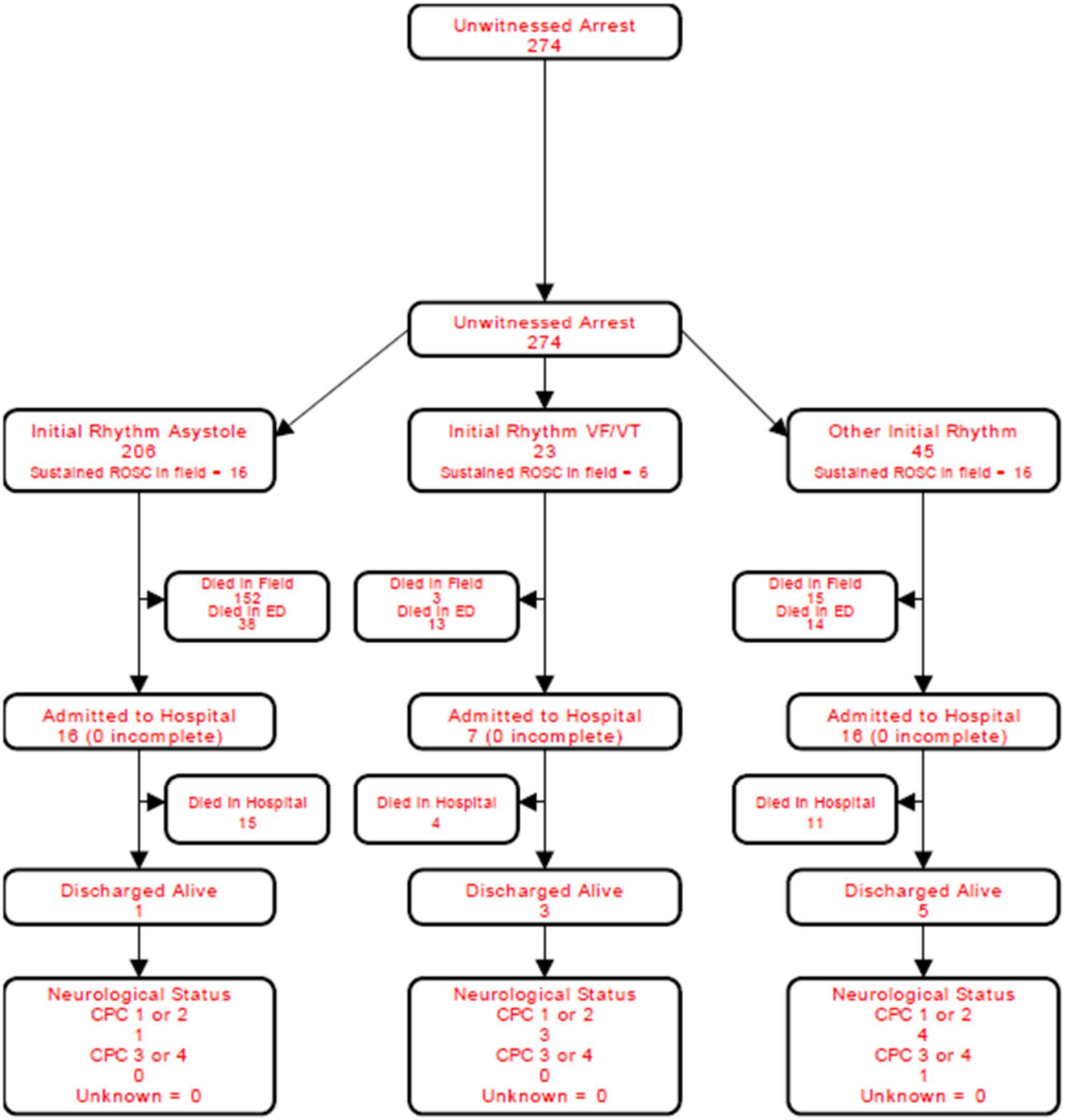
¹Utstein: Witnessed by bystander and found in shockable rhythm.
²Utstein Bystander: Witnessed by bystander, found in shockable rhythm, and received some bystander intervention (CPR and/or AED application).
³Bystander CPR rate excludes 911 Responder Witnessed, Nursing Home, and Healthcare Facility arrests. Public AED Use rate excludes 911 Responder Witnessed, Home/Residence, Nursing Home, and Healthcare Facility arrests.

**Only data from the previous calendar year is fully audited. Data from the current calendar year is dynamic.*

Utstein Survival Report

Sacramento Metropolitan Fire District

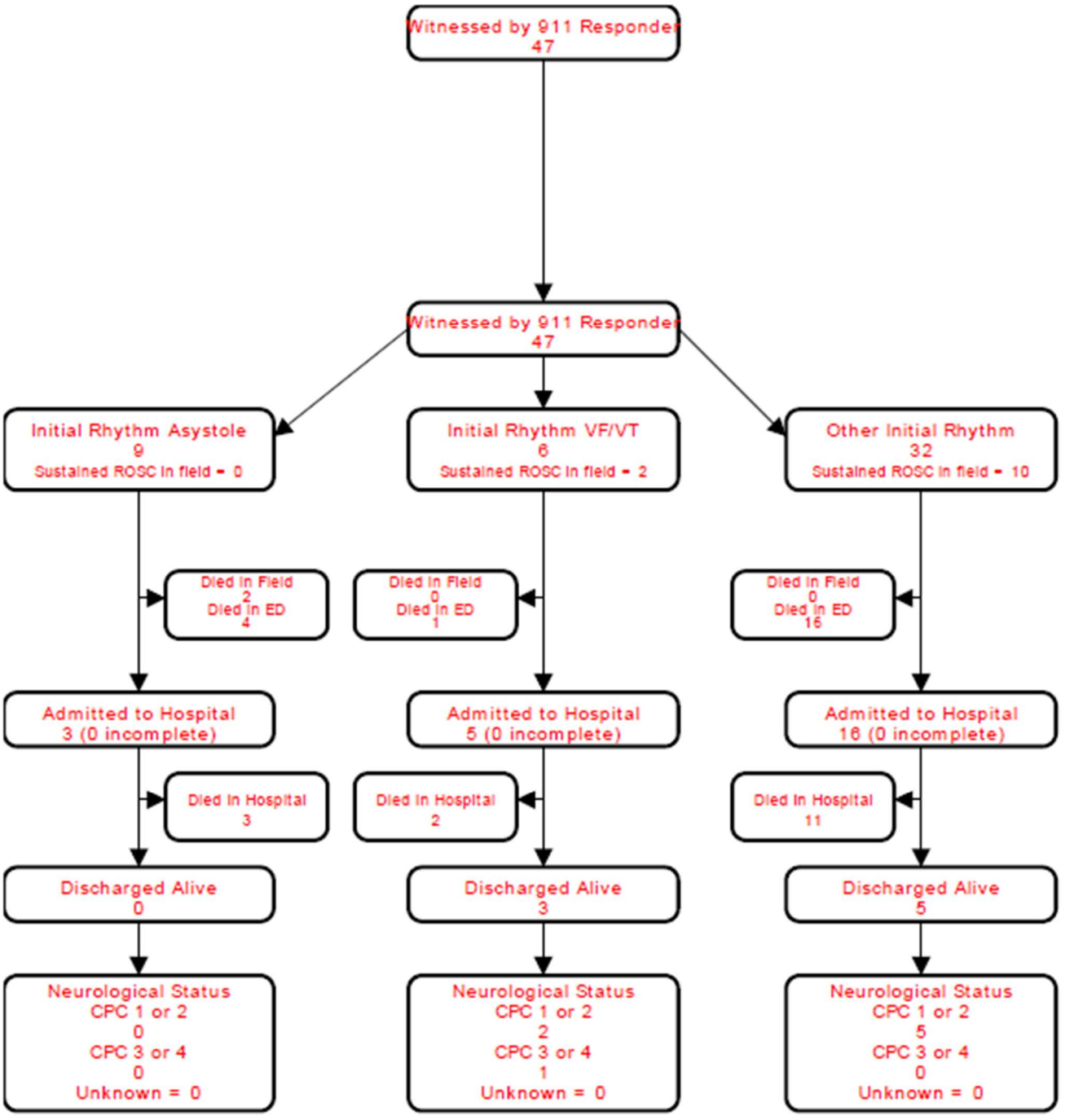
First Responder: Sacramento Metropolitan Fire District | Date of Arrest: From 01/01/2025 Through 12/31/2025



Utstein Survival Report

Sacramento Metropolitan Fire District

First Responder: Sacramento Metropolitan Fire District | Date of Arrest: From 01/01/2025 Through 12/31/2025



March 31, 2026 3 of 3

APPENDIX F

SCEMSA Inspection Letter

Department of Health Services
Timothy W. Lutz
Director

Divisions
Administration
Behavioral Health
Primary Health
Public Health

County of Sacramento

Sacramento Emergency Medical Services Agency

Inspection Findings For:

Sacramento Metropolitan Fire District

Critical items resulting in Out of Service status for unit:

ALS Ambulances, Engines, Trucks, and Helicopters were inspected between November 12 – 25th of 2025. During the course of the inspections, there were no critical items missing that would cause an Out of Service status. All ALS units inspected were in compliance with Policy# 2030.

General Observations:

The inspections went very well.
Thank You!

Overall Compliance with Policy 2030:

100%

Inspections and report completed by:

Jenna Alexander

Date of Report:

March 24, 2026 (Created by Kristin Bianco at the request of Jason Butler on March 23, 2026)

9616 Micron Ave Suite 940 · Sacramento, California 95827 · phone (916) 875-9753 · fax (916) 854-9211 ·
www.dhs.saccounty.net/pri/ems

APPENDIX G

SCEMSA CE Training Program Provider Certificate

Sacramento County
Emergency Medical Services Agency

In accordance with the provisions of California Code of Regulations, Title 22, Division 9, Chapter 11 and Sacramento County Emergency Medical Services Agency Policy 4302

Sacramento Metropolitan Fire Department
10545 Armstrong Ave, Suite 200
Mather, CA. 95655

Has been approved as a
Continuing Education (CE) Training Program
by Sacramento County Emergency Medical Services Agency

Effective Date: 07/02/2024
Expiration Date: 06/30/2028
CE # 34-1010

David Magnino, EMS Administrator
County of Sacramento