

2009 Wyoming Ambulance Survey

Please complete all questions. The survey integrity and results relies heavily on the completeness of this form.
 Incomplete surveys will be returned and counted as not submitted.
 Please call Jay Ostby at the EMS Office with questions or help completing this survey.
 Use calendar year beginning January 1, 2009 through December 31, 2009
 Return the completed form to the EMS Office by Friday January 22, 2010 Thank You!

N a m e	Name of EMS Agency:		City:	County:
	Supervisor	Day Phone	Business Phone:	
	Email Address:		Website Address: WWW. _____ May we link to your website from the EMS Office Website? <input type="checkbox"/> Yes <input type="checkbox"/> No	

S y s t e m	<u>Financial Information is Confidential</u>		Check One:		
	What is this services total operating budget? \$ _____		For: <input type="checkbox"/> EMS only <input type="checkbox"/> EMS & other services		
	Who dispatches this agency ? <input type="checkbox"/> In house <input type="checkbox"/> Fire <input type="checkbox"/> 911 Center <input type="checkbox"/> 911 transferred to your dispatch <input type="checkbox"/> Other				
	Does this Service use Emergency Medical Trained Dispatchers? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes <input type="checkbox"/> Commercial <input type="checkbox"/> Local Developed Are Dispatcher(s) Involved in Performance Improvement?: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Dispatch Center: _____ Supervisor: _____ Dispatch Center Mailing Address: _____ City: _____ State: _____				
Organizational Type from which EMS Services are delivered and staffed by check 1 only : <input type="checkbox"/> Governmental, non fire <input type="checkbox"/> Community, Non Profit <input type="checkbox"/> Fire Department <input type="checkbox"/> Hospital/Health District <input type="checkbox"/> Private, Non Hospital					

V e h i c l e I n f o	(Make copies to add more vehicles)	Vehicle	Vehicle	Vehicle	Vehicle	Vehicle	Vehicle	Do you have a vehicle replacement fund? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you contemplating the purchase of a new vehicle in 2009? <input type="checkbox"/> Yes <input type="checkbox"/> No est. cost: \$ _____ (Thousands)
	Permit #							
	MS #							
	Vehicle Year							
	Make (Ford, Chevrolet, etc.)							
	What Type: I, II, III, or Suburban							
	Total Mileage on odometer as of 12/31							
	Odometer last survey (Call if needed)							
	How many miles in 2009?							
Was this vehicle acquired in 2009? :	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		

A c t i v i t i e s	Total number of EMS runs calendar year 2009: _____		Total number of standby's for public events: _____		
	Total number of billable calls per year 2009: _____				
	Approximate population served by this ambulance service: _____		Square miles served: _____		
	As a result of the actions of this agency in 2009 (use your best judgement in providing the following answers): Estimated number of lives that were saved: _____ (Example: successful resuscitation, unconscious diabetics revived, multi-system trauma stabilization, etc. - estimated as less than 3% of total call volume) Estimated number of persons that were saved from permanent disability: _____ (Example: spinal fractures immobilized, severe fractures splinted, etc. - Estimated at less than 5% of total call volume)				
	Does this service participate with the sponsor hospital Performance Improvement Committee?: <input type="checkbox"/> Yes <input type="checkbox"/> No Does this service have an internal Performance Improvement Committee?: <input type="checkbox"/> Yes <input type="checkbox"/> No Does this service participate on hospital trauma review committee?: <input type="checkbox"/> Yes <input type="checkbox"/> No Does this service receive feedback on patients that fit within the Trauma activation protocol?: <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Number of times your physician medical director reviewed charts with staff at general meetings in 2009: _____				
	Percentage of continuing education hours acquired by this service in 2009 (Totaling 100%): Practical(s) _____% Monthly In services _____% Videos _____% CD-Rom _____% Internet _____% Conferences _____% Other _____%				
	Check course(s) personnel attended: <input type="checkbox"/> ABLS <input type="checkbox"/> ACLS <input type="checkbox"/> PALS <input type="checkbox"/> PEPP <input type="checkbox"/> BTLS <input type="checkbox"/> PHTLS <input type="checkbox"/> ATLS Hazmat Training to what level in 2009: <input type="checkbox"/> None <input type="checkbox"/> Awareness Level <input type="checkbox"/> Operations <input type="checkbox"/> Technician <input type="checkbox"/> Other: _____ NIMS Training: <input type="checkbox"/> Yes <input type="checkbox"/> No Bio-terrorism Training: <input type="checkbox"/> Yes <input type="checkbox"/> No Did this service participate in a disaster drill(s) in 2009?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes how many drills? ____ What was the highest number of patients used in a drill?: _____ Did this service have any EMS/Law Enforcement Tactical Events?: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How Many?: _____ Did this service receive funding for training or equipment from the local Emergency Management Agency?: <input type="checkbox"/> Yes <input type="checkbox"/> No Did this service receive funding from the Homeland Security?: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, List Amount \$ _____ Is this service involved with the Local Emergency Planning Committee (LEPC's) in the community?: <input type="checkbox"/> Yes <input type="checkbox"/> No Did this service receive an educational grant fund from the EMS Office: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how many?: _____ Please describe how the educational grant funds were expended for each grant received:				
	Briefly describe what you are doing to help educate the public: <input type="checkbox"/> Blood drive <input type="checkbox"/> BP events <input type="checkbox"/> CPR <input type="checkbox"/> EMS Week <input type="checkbox"/> First Aid <input type="checkbox"/> Health Fairs <input type="checkbox"/> Open houses <input type="checkbox"/> Public displays <input type="checkbox"/> Safety programs <input type="checkbox"/> Car Seat Safety				
	Estimated number of people attending this services public programs throughout 2009: _____				

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Do you have computer(s) at this service?: Yes No
 Is there a state supplied computer at this service?: Yes No
 If computer is state supplied: Computer Serial #: _____ Monitor Serial #: _____
 Check what version(s) of Windows?: 95 98 2000 XP Vista Windows 7
 Do EMTs have access to a computer for their use at the ambulance service?: Yes No
 Does this service have Internet Access?: Yes No **If Yes** where? Office Home Office & Home
 What speed of Internet Access?: Low Speed "Dial Up through modem" High Speed "DSL, Satellite, Cable"
 Has this service heard of the EMS Office's WebBoard communication technology? Yes No
If Yes on WebBoard communication technology, Have you used the WebBoard? Yes No

What percentage of time is a patient care report left or provided to the patient's receiving facility:
 before the crew departs the facility? _____%
 within 24 hours of the patient being left there? _____%
 Does this service use the Wyoming Pre Hospital Care written Report?: Yes No
 Has this services initiated the use of electronic patient care reporting?: Yes No
 Is this service interested in obtaining electronic patient care reporting?: Yes No
 Does this service need a computer for entering electronic patient care reports when it becomes available?: Yes No

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Number of persons that provided prehospital response during 2009 as of December 31 st 2009:	BEC	EMT-B	EMT Int.	EMT-P	RN	Other (driver)	Total
Number of Full Time Salaried (primarily Employed Full Time for EMS)							
Number of Part Time Compensated (Less than 20% salary of full time staff)							
Number of Volunteer Non-compensated							

Number of staff (or desired number) on the ambulance for 911 responses: _____
 Has your staff been the victim of an threat/assault while on duty?: Yes No **If Yes**, how many events? _____
 Did this service have an infectious exposure (excluding needle sticks) in 2009? Yes No Number of events? _____
 Did this service have a needle stick exposure in 2009? Yes No Number of events? _____

Does any staff pay out of pocket for personal liability insurance working in EMS?: Yes No **If yes** number of staff: _____
 Does any staff pay out of pocket for personal liability insurance to teach? Yes No **If yes** number of staff: _____

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Charge for services provided? Yes No **If Yes**, complete the following (fees charged per patient):
 Estimated percentage received from fees billed verses actual fees received (billable runs): _____%

BLS	\$.	Mileage BLS	\$.		\$.
BLS Emergency	\$.	Mileage ALS	\$.		\$.
ALS	\$.	Standby (per 1/2 hour)	\$.		\$.
ALS Emergency	\$.	Wait Fee (per 1/2 hour)	\$.		\$.
ALS Level 2	\$.		\$.	Percentage of write offs (bad debt)	%
Specialty Car Trans	\$.		\$.		

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Please check equipment for this service:

<input type="checkbox"/> AED, How many? _____	<input type="checkbox"/> GPS	Children (0 to 8 years)
<input type="checkbox"/> Defib/Monitor Manual, How many? _____	<input type="checkbox"/> Tyvek Suits if checked, How many? _____	<input type="checkbox"/> Broselow Tape
<input type="checkbox"/> Glasgow Coma Score Chart	<input type="checkbox"/> Helmets if checked, How many? _____	<input type="checkbox"/> Pediatric BP Cuffs
<input type="checkbox"/> Gluco meter	<input type="checkbox"/> Turnouts/Bunker Gear, How many? _____	<input type="checkbox"/> Infant Chair
<input type="checkbox"/> Pulse Oximeter	<input type="checkbox"/> Fire Retardant coveralls, How many? _____	<input type="checkbox"/> Meconium Aspirator
<input type="checkbox"/> I V Fluid Warmer	<input type="checkbox"/> Chemical Resistant Gloves	<input type="checkbox"/> Non-Rebreather Mask
<input type="checkbox"/> Pelvic Binders	<input type="checkbox"/> Warm Water to Decontaminate Patients	<input type="checkbox"/> Pediatric Chair
<input type="checkbox"/> Triage tags for patients, How many? _____	<input type="checkbox"/> Prehospital Decontamination Showers	<input type="checkbox"/> Pedi Board
<input type="checkbox"/> Traffic Safety Vest(s), How many? _____	<input type="checkbox"/> HEPA Masks	<input type="checkbox"/> Pediatric Wheel
<input type="checkbox"/> Air/Ground Intercept Protocol/Chart	<input type="checkbox"/> Filtered Masks	<input type="checkbox"/> Pulse Oximeter
<input type="checkbox"/> Emergency Response Guidebook Hazmat	<input type="checkbox"/> SCBA	<input type="checkbox"/> Pediatric Stethoscope
<input type="checkbox"/> Heated/Warm blankets	<input type="checkbox"/> Binoculars	<input type="checkbox"/> Stuffed Animal
		<input type="checkbox"/> Traction Splint

In this services response area, Is there a means readily available to rinse contaminated patients prior to the ambulance transporting the patient? Yes No **If Yes** Is Warm Water available?: Yes No

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How can we improve this survey? _____
 Do you have a "Public Access Defibrillation" program in your response area? Yes No **If Yes** # of: _____
 Was this service or staff involved with "Public Access Defibrillation" program? Yes No
 Any operational problems (personnel, rates, etc.): _____
 How can the EMS Office help you better? _____