Audit of Emergency Medical Services

Report# 2025/26-15 | May 2026

The Fire Department Can Implement Alternative Response Models to Divert Non-Emergency, Low-Acuity Calls Away From Ambulance and EMS Personnel

Although Hospital Delays Have Declined, They Still Create Strains on EMS Resources and Highlight a Need for Further Collaboration With Area Hospitals

Best Practices in Performance Goals Have Not Been Formally Adopted and Are Not Being Met

EMS Policies Are Outdated and the EMS Continuous Quality Improvement Program Could be Strengthened

City of SACRAMENTO

Office of the City Auditor

Performance Audit Division

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City of SACRAMENTO
Office of the City Auditor

AUDIT FACT SHEET

Audit of the Sacramento Fire Department's Emergency Medical Services

May 2026 Report #2025/26-XX

RECOMMENDATIONS

We made several recommendations regarding the Sacramento Fire Department's Emergency Medical Services' goals, operations, strategies. Our Recommendations included:

Alternative Response Models

- Continue to collaborate with the Sacramento Regional Fire/EMS Communications Center to explore programs where non-emergency calls are diverted to an alternative resource response, and discuss opportunities to expand dispatching authority for alternative response units, such as the Mobile Crisis Unit.
- Continue to make progress expanding alternative response units.

Hospital Delays

- Work with the area hospitals to ensure compliance with California Assembly Bill 40 which may result in reductions in patient offload times.

Performance Goals

- Work with the SRFECC to identify ways to reduce call answer times to regularly reach the benchmark of 90 percent of calls answered within 15 seconds.
- Adopt the recommended NFPA 1710 turnout time performance measure of 60 seconds 90 percent of the time and work towards meeting this goal.

Policies and Quality Improvement

- Clarify the roles and responsibilities of its Continuous Quality Improvement committee to ensure that it is providing effective oversight capabilities, as well as to ensure that SFD is satisfying its own internal policies and the guidelines from the State's Emergency Medical Services Authority.
- Incorporate patient surveys into the Department's continuous quality improvement processes.
- Provide copies of patient survey results to the Fire Department's Internal Investigator and the Office of Public Safety Accountability.
- Strengthen their processes by which employee certifications are reviewed to ensure that they are current and strengthen certification tracking processes to prevent certifications from lapsing.
- Perform a gap analysis to identify missing EMS policies that should be added to the Manual of Operations.
- Develop a process to regularly review and update EMS policies.

BACKGROUND

The Sacramento Fire Department's (SFD) Emergency Medical Services (EMS) Division provides paramedic ambulance transport services to the City. 911 calls that require fire and/or medical services are routed from the Police Department's 911 Emergency Communications Center to the Sacramento Regional Fire/EMS Communications Center (SRFECC), who then dispatches fire and/or medical response units. While certain standards are established by State codes, the Sacramento County EMS Agency dictates many of the standards by which the EMS Division needs to operate, and SFD maintains its own set of policies. There are third-party performance standards, set by organizations such as the National Fire Protection Association, that provide guidelines for performance measures such as units' response times to incidents. Industry best practices state that EMS Division should be continuously improving both their policies and their health care delivery processes.

This audit report assessed the types of response models SFD utilizes to respond to medical incidents; data at the 911 call answering, call dispatch, and EMS unit response levels; SFD's performance compared to County EMS and third-party standards; SFD's adherence to continuous improvement processes; and SFD's efforts to update its policies.

FINDINGS

Finding 1: The Fire Department Can Implement Alternative Response Models to Divert Non-Emergency, Low-Acuity Calls Away From Ambulance and EMS Personnel.

- SFD has piloted and is expanding its use of alternative types of units to respond to non-emergency calls. Further collaboration with the SRFECC could potentially make the deployment of alternative response units more efficient and could reduce the overall burden on ambulances and fire engines and trucks.

Finding 2: Although Hospital Delays Have Declined, They Still Create Strains on EMS Resources and Highlight a Need for Further Collaboration with Area Hospitals.

- SFD has made considerable progress in collaboration with area hospitals to reduce the time to offload patients into the care of hospital personnel, but those offload times are not consistently meeting standards set by the County EMS Agency.

Finding 3: Best Practices in Performance Goals Have Not Been Formally Adopted and Are Not Being Met.

- SFD has not formally adopted certain performance standards for EMS operations. Adopting those standards and measuring performance against them could help with process improvements.

Finding 4: EMS Policies Are Outdated and the EMS Continuous Quality Improvement Program Could be Strengthened.

- The majority of EMS Division's policies are several decades old. Renewing policies and strengthening internal quality improvement processes helps to maintain standards and advance the quality of health care delivery.

Introduction

In accordance with the City Auditor's Fiscal Year (FY) 2025/26 Audit Plan, we have completed an *Audit of Emergency Medical Services.* We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The City Auditor's Office would like to thank the Sacramento Fire Department (SFD) for their cooperation during the audit process.

Background

The SFD's Emergency Medical Services (EMS) Division has provided paramedic ambulance transport services since 1994. The EMS Division facilitates the delivery of first responder Basic Life Support (BLS), Advanced Life Support (ALS), and ambulance transport services. The EMS Division is responsible for ensuring all aspects of SFD's Emergency Medical Services System are in compliance with all California Health and Safety Code Division 2.5, Section 1797-1899.207, California Code of Regulations Title 22 and the Sacramento County Emergency Services Medical Authority regulations, codes, standards, policies, procedures and protocols. These areas include: training, certification and licensing, scope of practice, operational standards, medical direction/oversight, data collection/reporting, quality assurance, and quality improvement.[1] Their vision is to "provide the right service to the right patient at the right time." EMS helps share pre-hospital care in the Sacramento region through collaboration with neighboring EMS divisions, local hospitals, and community organizations.

Regulation and Governance of Emergency Medical Services

In 1970, Governor Ronald Reagan signed the Wedsworth-Townsend Paramedic Act which allowed paramedics to legally provide advanced medical care, which was previously restricted to doctors and nurses. President Richard Nixon then signed the Emergency Medical Services Systems Act of 1973 in November 1973, which created a grant program to further the development of regional EMS systems.

[1] California Health and Safety Code Division 2.5, Section 1797-1899.207 primarily establishes the requirements and standards for local EMS systems. California Code of Regulations Title 22 establishes regulations on paramedic and EMT training, practice of care, continuing education and quality improvement, among other items. SCEMSA policies establish standards on hospital transports, accreditation, pediatric treatment, scope of practice, etc.

911 Calls and Dispatch

911 calls made within the City of Sacramento are routed to the Police Department's 911 Emergency Communications Center, which serves as the City's primary Public Safety Access Point (PSAP). Calls that require fire or medical services are then transferred from the Police Department to a secondary PSAP, the Sacramento Regional Fire/EMS Communications Center (SRFECC) where dispatchers answer the calls and route Fire or Medical units, as needed.

The SRFECC was organized through a Joint Powers Agreement (JPA) beginning January 1, 1981, to provide dispatch services for its member agencies. The City of Sacramento Fire Department became a member on May 1, 1994. SRFECC currently has four fire department member agencies that fund their operations. Figure 1 shows the member agencies and their respective budgeted contribution amounts for FY 2023/24 and 2024/25.

Figure 1: SRFECC Member Agency Contribution Budget for Fiscal Years 2023/24 and 2024/25

Member Agency	FY 2023/24 Contribution Budget	FY 2023/24 Contribution Share of Total	FY 2024/25 Contribution Budget	FY 2024/25 Contribution Share of Total
City of Sacramento Fire Department	$5,436,552	44.1%	$5,710,195	44.4%
Sacramento Metropolitan Fire District	$5,351,509	43.4%	$5,517,283	42.9%
Cosumnes Community Services District Fire Department	$1,109,249	9.0%	$1,170,333	9.1%
City of Folsom Fire Department	$427,677	3.5%	$462,989	3.6%
Total	**$12,324,987**	**100%**	**$12,860,800**	**100%**

Source: SRFECC September 12, 2023 and April 22, 2025 board meeting packets.

As dispatchers are often the first point of contact during an emergency, a reliable and robust 911 service is essential to the safety and security of Sacramento's residents and visitors.

Deployment

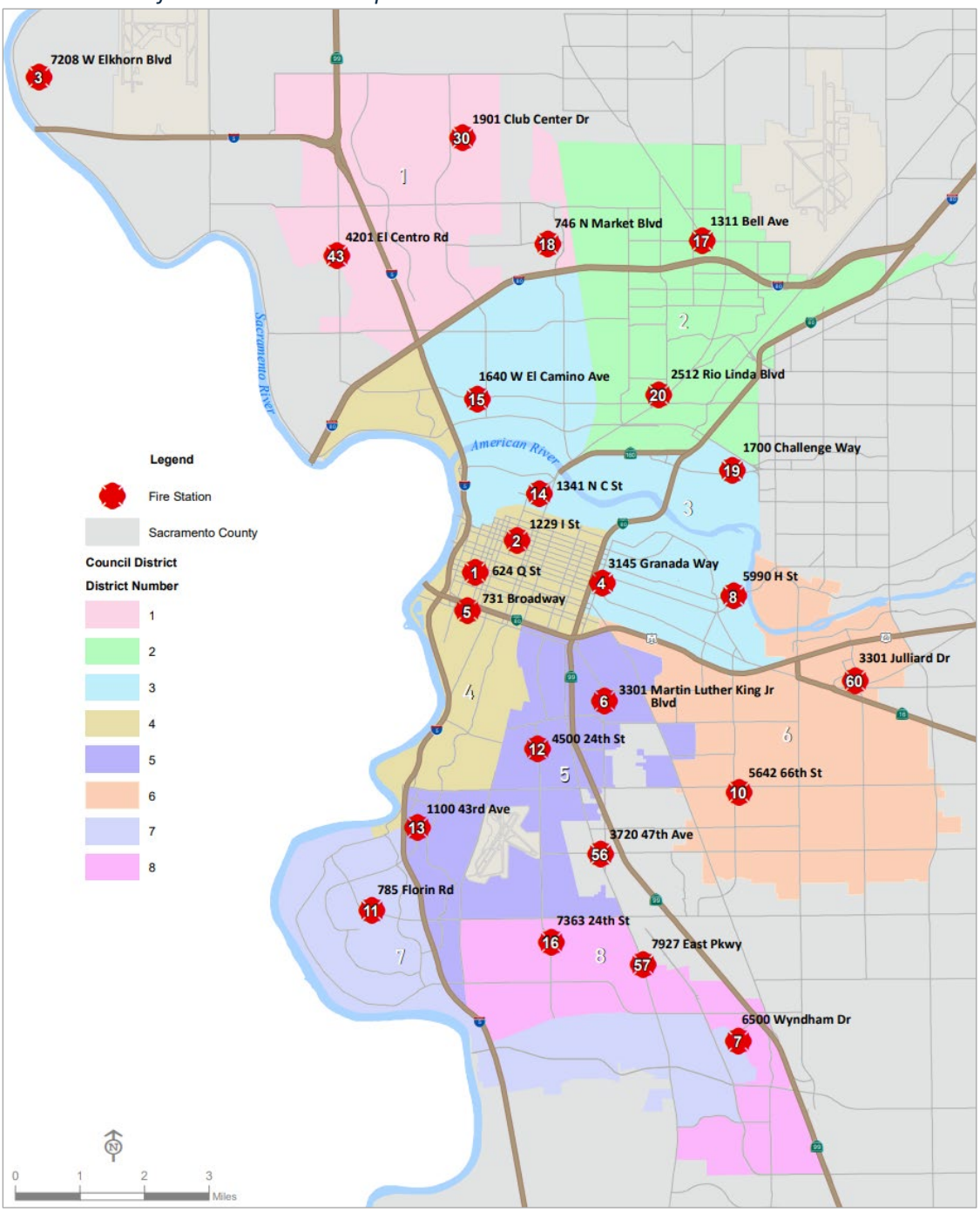
In support of their public safety mission, SFD operates various types of vehicles (apparatus) housed at fire stations located throughout Sacramento. SFD operates 24 fire stations and deploys the following apparatus from those stations:

- 24 Engines
- 9 Trucks
- 16 Dual-Role Ambulances
- 2 24-hour Single Role Ambulances
- 2 12-hour Day Single Role Ambulances
- 4 24-hour BLS Ambulances via Public/Private Partnership
- 2 EMS Command Vehicles

- 1 Shift Commander
- 1 Heavy Rescue
- 2 Type 1 Hazardous Material Units
- 2 Jet Boats
- 2 Jet Skis
- 1 Fire Boat
- 4 Battalion Chiefs
- 1 Bariatric Unit
- 2 Street Overdose Response Teams (SORT)
- 1 Mobile Crisis Unit (MCU)
- 1 Mobile Integrated Health Unit (MIH)

Figure 2 below maps out the location of each of SFD's fire stations. Most of the stations are located within the City of Sacramento. Stations 3, 18 and 56 are located outside of the City's jurisdiction within the County of Sacramento.

Figure 2: Locations of Sacramento Fire Department Stations



Source: City of Sacramento website.

The SFD first responder units—ambulances, engines and trucks—are equipped with firefighter-EMTs and/or firefighter-paramedics to provide Basic Life Support/Advanced Life Support services. SFD has also begun utilizing single-role paramedics and EMTs who only provide medical services. Ambulances can provide patient transport services to local hospitals. In accordance with the City's mutual aid

agreements with other Fire Department agencies, units may be dispatched to calls in areas outside of the borders of the City.

SFD firefighter-EMTs and firefighter-paramedics are required to obtain or possess a license to provide BLS/ALS services by the State of California EMS Authority and accredited with the Sacramento County Emergency Medical Services Agency (SCEMSA)[2] in accordance with Division 2.5 of the California Health and Safety Code regarding emergency medical services.

EMS Performance Measures and Best Practices

There are various measures of performance that can be examined when evaluating the quality of emergency medical services. These range from how quickly 911 calls are answered, to how quickly units respond to an incident, to the accuracy of the patient assessment. Other metrics that can be evaluated include standard measures of ambulance usage, such as unit hour utilization, which tracks time spent delivering emergency medical services against the time the medic units are available.[3]

The National Fire Protection Association (NFPA) is a globally recognized non-profit organization that issues standards on fire, electrical, and related hazards. This includes standards on emergency medical dispatch and response. While compliance with NFPA standards is voluntary, their guidance is widely implemented by OSHA and other regulatory agencies, making them mandatory and providing a benchmark with which to measure performance, and SFD aims to meet the performance standards set by NFPA guidance. NFPA 1710 *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments* was most recently updated in 2020 and provides guidance on turnout time[4], travel time, EMS systems, and quality assurance. NFPA 1221 *Standard for the Installation, Maintenance, and Use of Emergency Services Communications System*[5] was most recently updated in 2019 and provides guidance on 911 dispatch center systems installation, maintenance, and call answer times. We refer to NFPA guidance frequently throughout this report.

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[2] The Sacramento County Emergency Medical Services Agency (SCEMSA) is responsible for "medical oversight for all prehospital care provided by Emergency Medical Technicians (EMTs), Mobile Intensive Care Nurses (MICNs) and Paramedics, and to coordinate the multiple stakeholders involved in the EMS system of care."

[3] Formulas for unit hour utilization (UHU) may vary by EMS system. The California Emergency Medical Services Authority measures UHU by dividing the number of medical transports conducted by the number of hours the medic units were staffed.

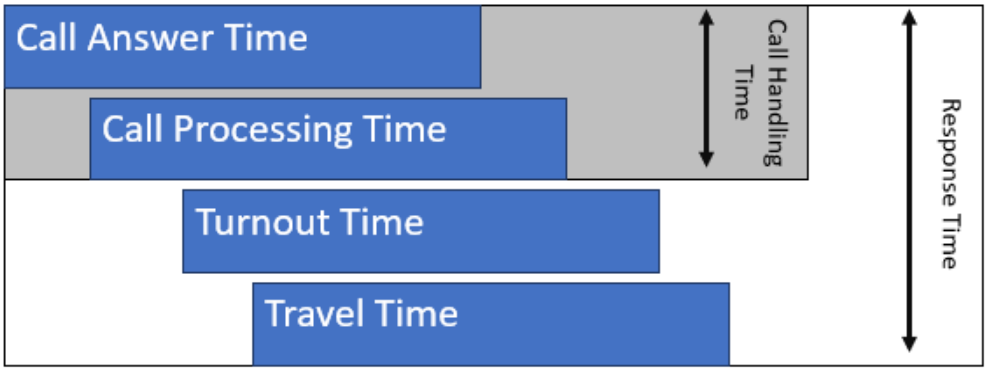
[4] *Turnout Time* is the time interval that begins when the emergency response units notification process begins by either an audible alarm or visual annunciation or both and ends at the beginning point of travel time.

[5] https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=1221

Response Time

A critical factor in EMS response is the amount of time it takes from when a call comes in to when the first unit arrives on scene to begin diagnosis and treatment of the patient. Response time can be separated into its component parts, which includes call handling time, turnout time, and travel time. Figure 3 shows the stages of emergency response.

Figure 3: Response Time Intervals



Source: Auditor generated based on NFPA 1221 and 1710.

Response time is a critical measure because a faster response can result in better outcomes for the patient and increases their chance of survival. According to a 2020 study by the American Heart Association, the chances of surviving a cardiac arrest is highest when help arrives in the first six minutes, with decreasing survival rates as more time goes by. The study concluded that shortening EMS response times is likely to be a fast and effective way of increasing survival in those who experience out-of-hospital cardiac arrest.

Figure 4 summarizes the NFPA-recommended EMS call handling and travel time for the first unit to arrive at an incident.

Figure 4: Summary of NFPA Guidance on EMS Response

NFPA Guidance	Stage	Time
NFPA 1221 - 7.4.1	Call Answer Time	15 Seconds
NFPA 1221 - 7.4.3	Call Processing Time	60 Seconds
NFPA 1710 - 4.1.2.1 (2)	Turnout Time	60 Seconds
NFPA 1710 - 4.1.2.1 (7)	Travel Time	240 Seconds
Total Response Time		**375 Seconds (6 Minutes 15 Seconds)**

Source: Auditor generated based on NFPA 1221 and 1710.

The NFPA guidance allows for some variance in these metrics and does not expect that this standard will always be met for 100 percent of calls. The NFPA guidance typically recommends that EMS agencies meet these standards on about 90 percent of their calls.

Call answering and call processing occur at the 911 dispatch centers where trained dispatchers begin the important work of obtaining essential information and sending the responders to the right location. They may also provide initial instructions to the 911 caller, which in many cases is essential to stabilizing or saving a life even before on-scene help arrives.

Firefighters are notified of the dispatch order via station alerting or through their radio to start their response. Their response begins with wearing the appropriate gear and then traveling towards the incident site. If patient transport to a hospital is required, then an ambulance provides this service. Once the patient arrives at the hospital, EMS personnel stay with the patient until their medical information is relayed, and the hospital accepts receipt of the patient. The ambulance then returns to response ready status.

One facet of EMS response is resource allocation. Figure 5 shows that the growth in number of incidents that SFD emergency personnel responded to is more than twice as high as the change in SFD staffing levels for Fire Operations and the EMS Division since 2019. Whereas the number of full-time equivalent staff has risen by 6.1 percent since before the pandemic, the number of incident responses has risen by 15.1 percent.

Figure 5: Number of 911 Calls to SRFECC and Fire Incidents

Year	SRFECC Incoming Call Volume	Total SFD Incidents	SFD Fire Ops/EMS Division Staffing Levels (FTE)
2019	**333,853**	**93,836**	**607**
2020	**320,370**	**94,282**	**617**
2021	**349,784**	**99,201**	**616**
2022	**367,229**	**108,924**	**614**
2023	**353,543**	**110,221**	**615**
2024	**357,111**	**108,665**	**644**
2025	**357,296**	**108,035**	**644**
2019-2025 Change	**+7 percent**	**+15.1 percent**	**+6.1 percent**

Source: SRFECC monthly board meeting packets, City Annual Comprehensive Financial Reports, and City approved budget documents.
Note: SRFECC call volume is calculated on a calendar year basis, and SFD incidents and staffing figures were generated from City documents reported on a fiscal year basis.

Additional considerations that may affect response times are the number of fire stations, which has remained at 24 since Station 15 opened in 2018, that the SRFECC dispatches for 10 member agencies—six in addition to the four contributing member agencies—and that other partner fire agencies in Sacramento County may assist one another in cases of fires, disasters or other emergencies, providing fire prevention, EMS, and water rescue among other types of services.

Transport to Hospital

While there are general standards and guidance for EMS call response and arrival times, there are no broadly accepted standards for how quickly the first responding unit should transport the patient from the scene to the hospital for necessary care. An oft-repeated consideration for trauma patient treatment is the "golden hour," which stresses that the first hour after patient experiences a traumatic injury is an important factor of a patient's chance for survival. However, the importance of the "golden hour" does not appear to be rooted in the evidence.

While studies have shown that reduced call response times and travel times can improve patient survival rates depending on severity of injury, that is not necessarily the case for shorter time frames for emergency personnel to provide medical assistance on-scene or faster transport times to hospitals. In other words, evidence appears to show that getting to the scene of the incident quicker to provide treatment to the patient increases survival rates, but shortening the amount of time that paramedics and EMTs provide treatment on scene and rushing patients to emergency rooms does not generally increase the chance of survival. In fact, a 2010 study found that ambulances travelling at faster speeds to transport patients to hospitals may reduce the quality of care the patient receives in the ambulance and could lead to more dangerous working conditions for the medical staff onboard.

Quality of Care

The State EMSA created a set of core quality indicators for benchmarking processes such as overall EMS system performance and utilization of recommended treatments. EMS providers such as SFD submit data to their local EMS Agency (SCEMSA, for SFD) on the core quality measures, who then provide the data to the State. The measures are based on evidence-based processes and treatments for a condition or illness. Each year, the measures are updated based on data system changes and operational considerations. Core quality measures are intended to help EMS systems improve the quality of patient care by focusing measurement specifications on key processes and results of care. These measures focus on:

- Arrival at the scene in a timely manner
- Accurate patient assessment
- Delivery of time-sensitive pre-hospital therapy
- Transport to a hospital capable of providing necessary care

Figure 6 shows the quality-related performance measures that SFD tracks as part of the California EMS System Core Quality Measures program during August through December of 2024.

Figure 6: SFD Core Quality Measures[6]

Sacramento Fire Department California EMS System Core Quality Measures Service Dates from 08/01/2024 - 12/31/2024				
Set ID	**Numerator Value**	**Denominator Value**	**Reporting Value**	**Performance Measure Name**
TRA-02	9	9	100.00%	Trauma patients transport to a trauma center, Population 1: Patients less than 14 years of age.
TRA-02*	248	259	95.75%	Trauma patients transport to a trauma center, Population 2: Patients greater than or equal to 14 years of age.
HYP-01	2	6	33.33%	Treatment administered for hyperglycemia, Population 1: Patients less than 14 years of age.
HYP-01*	224	351	63.82%	Treatment administered for hyperglycemia, Population 2: Patients greater than or equal to 14 years of age.
STR-01	530	530	100.00%	Prehospital screening for suspected stroke patients.
PED-03	61	61	100.00%	Respiratory assessment for pediatric patients.

Source: Sacramento Fire Department.

SFD also participates in many advisory committees including the Sacramento County Emergency Medical Services Operational Oversight Committee and the Hospital Council's Emergency Services Task Force.[7]

Continuous improvement is not only a best practice, but also directed by State and County regulations, which require local EMS agencies to continuously evaluate their internal practices to ensure the highest level of care and best outcomes for patients. The California Emergency Medical Services Authority

[6] The table numerator values tally the number of patients that identify as meeting a criterion, and the denominator values tally the number of patients that receive treatment for that issue. For example, the numerator for "TRA-02" are the number of patients meeting the trauma triage criteria, and the denominator is the number of patients transported to a trauma center.

[7] The EMS Division of the Sacramento Fire Department also participates in the following committees and working groups: Medical and Operational Advisory Committee (MAC/OAC); ST-Elevation Myocardial Infarction (STEMI) Care Committee; Stroke Care Committee; Trauma Improvement Committee (TIC); Joint Defense Committee; Sacramento Regional Fire/EMS Communications Center Committee; Technical Advisory Group (TAG); Emergency Medical Advisory Group (EMAG); EMS Leadership Group; SFD Image Trend Working Group; Continuous Quality Improvement /Peer Review Group; Medical Quality Assurance Officers Working Group; Sacramento County EMS Chiefs Group; Behavioral Health/Community Wellness Response Team Working Group; Ambulance Patient Off-Load Time Working Group; Cal Chiefs EMS Section North Branch Working Group; Sacramento Incident Management Team Group; SFD Safety Committee Group; SFD Accident Review Working Group; Sacramento Department of Community Response Collaborators Group; Sacramento County Transport to Alternate Destination Working Group; Sacramento County Mobile Medicine Working Group; Sacramento County Image Trend Working Group; and the Sacramento County EMS Coordinator Working Group.

Emergency Medical Services System Quality Improvement Program Model Guidelines[8] recommend that the local EMS Agency quality improvement team should, among other responsibilities, act as the central repository of local EMS system information relating to quality improvement programs, and monitor, collect data on, and evaluate quality improvement indicators, and the SCEMSA *Quality Improvement Program*[9] policy requires continuous monitoring, review, evaluation, and improvement of prehospital, medical, trauma and specialty care services. To that end, SCEMSA policy requires EMS providers to implement a quality improvement program that includes indicators on items such as EMS personnel, equipment, documentation, clinical care, patient outcomes, skills competency, transportation, public education, and risk management. The Fire Department also maintains several positions within their department to assist with medical care and quality assurance: a nurse with duties ranging from reviews of patient care reports, education, and focused audits; a medical director who focuses on medical oversight, quality assurance, EMS training and representing SFD publicly; and two EMS coordinators who review patient care reports, ensure compliance with EMS protocols and participate in Continuous Quality Improvement initiatives. In addition, the Fire Department maintains and supports a peer review group that consists of six to ten SFD firefighter-paramedics. The EMS Division assigned the EMS peer review group to audit a defined percentage of calls meeting the criteria that satisfies the Core Quality Measures identified by the California SMA Authority, the California Code of Regulations, Title 22, Division 9 (Prehospital Emergency Medical Services), and California Health and Safety Code Division 2.5.

Objective, Scope, and Methodology

The objective of this audit was to evaluate the quality of SFD's emergency medical services delivery to the public and to identify opportunities for improvement. This entailed reviewing EMS processes at the levels of both 911 dispatch and health care delivery by City paramedics and EMTs. Additionally, a comprehensive review of the issue requires the perspective of the health care provider and the patient; for example, evaluating ambulance response times.

The scope of our audit primarily included 911 calls that were routed through the Sacramento Regional Fire/EMS Communication Center (SRFECC) during fiscal year 2024 (July 1, 2023, through June 30, 2024). In conducting our audit, we evaluated data reflecting performance of internal controls, interviewed members of SFD and SRFECC management and staff, participated in ambulance ride-alongs, observed SRFECC dispatchers taking calls, reviewed policies and government codes and regulations, studied patient survey results, researched industry best practices, and assessed response data.

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[8] The California Emergency Medical Services Authority. *Emergency Medical Services System Quality Improvement Program Model Guidelines* https://emsa.ca.gov/wp-content/uploads/sites/71/2017/07/emsa166.pdf. 2004.

[9] Sacramento County EMS Authority. *Quality Improvement Program 7600.05*. https://dhs.saccounty.gov/PRI/EMS/Documents/PoliciesProceduresProtocols/7600/PP-7600%20Quality%20Improvement%20Program.pdf. 2020.

For the purposes of data availability, some of the data measures within the report included data outside of the scope of fiscal year 2024. For example, calculations of turnout times for SFD ambulances utilized calendar year 2024 data, and charts of SRFECC call answer times included data from late-calendar year 2024 through early-2026.

Finding 1: The Fire Department Can Implement Alternative Response Models to Divert Non-Emergency, Low-Acuity Calls Away From Ambulance and EMS Personnel

The Sacramento Fire Department (SFD) states that their primary vision for Emergency Medical Services is to "provide the right service to the right patient at the right time." Within that framework, aligning the type of care to the needs of the patient will not only improve quality of care delivered but will reduce strain on EMS resources by limiting the use of emergency vehicles on non-emergency calls.

The Sacramento County EMS Agency (SCEMSA) has a similar strategic goal, as their Medical Director has said that they "want everybody to get the care that they need in the right time and with the right resources." For emergency medicine, this entails understanding not only the medical needs of patients, ranging from mental illness to substance abuse to life-threatening events like cardiac arrest, but also the demographics and socioeconomic statuses of patients. However, despite the name, EMS personnel are often called to respond to incidents that may be considered non-emergencies.

When a patient calls 911 regarding a medical emergency, EMS personnel are required to travel to the scene to provide assistance. This means that paramedics, EMTs and firefighters will still respond to non-emergency or "low-acuity" incidents, which made up two out of every five calls to the City's 911 line in fiscal year 2024. It is estimated that the nationwide figure is even larger; an analysis of 911 calls in 2021 identified 70 percent of calls as non-emergent. Emergency personnel also frequently respond to medical calls from individuals experiencing homelessness, when other, non-EMS related interventions may be more appropriate, and are already being performed by other City departments. Some cities have implemented alternative response units that have homeless outreach or behavioral health specialists accompany paramedics to provide support to their unhoused populations. Based on their performance, units in cities such as Seattle and Albuquerque have expanded to reach a greater portion of their homeless communities.

SFD has taken steps towards adapting health care delivery to the needs of the patient populations by piloting alternative response units, but it has not yet fully incorporated this strategy into its operations. Emergency personnel are still burdened by low-acuity calls. Furthermore, progress still needs to be made to increase coordination between SFD and the emergency dispatch center to develop programs that divert non-emergency calls to telehealth specialists, reducing the need for EMS personnel to respond to such incidents.

In fieldwork for this audit, we reviewed data on the nature and description of the calls and patients that requested EMS and fire intervention services in fiscal year 2024, and found that:

- Low-acuity calls are burdening the EMS health care delivery system;
- Nearly 20 percent of SFD's incidents were flagged as being related to homelessness;
- About 37 percent of the homeless-related medical calls were non-emergencies and could have been treated without an ambulance response;
- 911 calls for individuals experiencing homelessness are concentrated in the downtown urban core;
- SFD should coordinate with dispatch to identify alternative resource responses at the point of call; and,
- SFD should continue to expand alternative response and care units to reduce ambulance demand.

Continued usage of alternative response units for low-acuity calls could prevent unnecessary dispatches of ambulances and fire engines, which would reduce strain on emergency vehicles and personnel. Additionally, it may provide a measure of preventative health, by diverting individuals facing mental health crises or substance abuse to the appropriate care and limiting the number of calls from repeat, low-acuity patients.

Low-Acuity Calls Are Burdening the EMS Health Care Delivery System

According to a 911 industry group[10], individuals are increasingly using 911 and emergency room services for low-acuity issues, which are defined as non-life threatening events or issues that are unlikely to become more serious. The City EMS Division states that it is responsible for providing Advanced Life Support (ALS) and Basic Life Support (BLS) services throughout the City, and as the Red Cross notes, ALS and BLS services are to be performed during emergencies.[11] This indicates a mismatch between the non-life threatening issues that low-acuity patients may have when they call 911 for treatment, and the fact that EMS procedures are targeted towards emergencies, which can result in increasing demand for ambulance services.

In fiscal year 2024, there were 98,157 incidents that required either a medical or fire-related response from the SFD, and about 40 percent of these incidents could be defined as low acuity, which means that the call was for an incident that did not present an immediate danger to life, health, or property.

Medical calls made up about 61,000 of the 98,000 total incidents, and a little over 18,000 of those 61,000 were low-acuity, meaning that callers were asking for treatment for something like minor pain or flu-like symptoms. In other words, about one out of every three times that an ambulance responded to

[10] "*2023 Pulse of 9-1-1*." National Emergency Number Association/Carbyne. www.nena.org/resource/resmgr/docs/2023_Carbyne_and_NENA_The_Pu.pdf.

[11] The two types of EMS care are basic life services (BLS) and advanced life services (ALS). BLS care is designed to maintain life functions of individuals having a medical emergency, and ALS care stabilizes critical patients suffering life-threatening events and prepares them for a hospital transport. Both BLS and ALS treatment would qualify as "high-acuity."

a call for medical assistance, there was no emergency. These figures track trends in other parts of the country, as one estimate puts the number of low-acuity EMS calls to 911 at about 20 percent.

These calls strain the SFD in several ways. First, these calls burden the City's EMS response. When personnel are tied up responding to non-emergency calls, those patients requiring emergency intervention and emergency room transport may be required to wait longer for treatment.

Second, personnel are also impacted by increased workloads, which could add physical and psychological stresses to emergency medicine professionals that may face burnout rates as high as 60 percent. Professional burnout could impact the quality of health care delivery and increase the risk of medical errors, and research shows fatigued EMS personnel face greater odds of injury.

Finally, there is a financial burden to the City and to the SFD department. According to SFD data, the costs of labor to operate fire engines, as well as their fuel, repair and maintenance costs average to $6.22 per minute per unit, for fire trucks that amount is $7.09 per minute per unit, and for ambulances that figure is $2.51 per minute per unit. For a 911 call, EMS may send an ambulance or an engine and ambulance on site to respond, depending on the type of incident. For fiscal year 2024, fire engines, trucks and ambulances spent over 1.2 million minutes combined on low-acuity medical calls, with most of that time coming from ambulance responses.

Figure 7: FY 2024 EMS Unit Costs from Low-Acuity Medical Calls[12]

Apparatus Type	Total Minutes from Low-Acuity Medical Call Responses	Per Minute Labor Costs	Per Minute Maintenance Costs	Total Cost Per Year on Low-Acuity Medical Calls
Engine	271,936	$4.94	$1.28	$1,691,422
Truck	119,676	$4.94	$2.15	$848,503
Ambulance	824,679	$2.29	$0.22	$2,069,944
Grand Total	**1,215,785**			$4,609,869

Source: SFD FY24 dispatch data, payroll data, and fleet maintenance data.

As Figure 7 illustrates, at an average cost per engine of $6.22 per minute in labor and maintenance combined, $7.09 per minute for fire trucks, and $2.51 per minute for ambulances, the roughly 1.2 million minutes in engine, truck and ambulance responses to low-acuity medical calls requires expenditures of roughly $4,600,000.[13] Additionally, if a patient does not have health insurance, the costs of care may have to be borne by the City: nearly half of uninsured patients have difficulty affording their health care costs. Frequent demand for EMS services by uninsured individuals could create a sizeable financial obligation for the City's coffers.

[12] The higher labor costs for fire engines and trucks compared to ambulances is attributable to the fact that they are staffed with two additional personnel: a fire captain and a fire engineer.

[13] These are just the direct costs of responding to the call, and do not include administrative or dispatch-related costs.

Nearly 20 Percent of SFD's Incidents Were Flagged as Being Related to Homelessness

Medical and fire-related calls for individuals experiencing homelessness have been overrepresented as a share of the total number of emergency calls to the SFD. As shown in Figure 8, there were 19,020 homeless-related incidents in fiscal year 2024, which constituted about 20 percent of the 98,157 total medical and fire incidents, despite individuals experiencing homelessness making up just 1.2 percent of the City's total population. In broad financial terms, if we assume all of the EMS Division's costs are related to emergency response, 19 percent of the EMS Division's approved fiscal year 2024 budget equates to a cost of almost $30 million annually.

Figure 8: Percentage of SFD Incidents in Fiscal Year 2024 Related to Homelessness

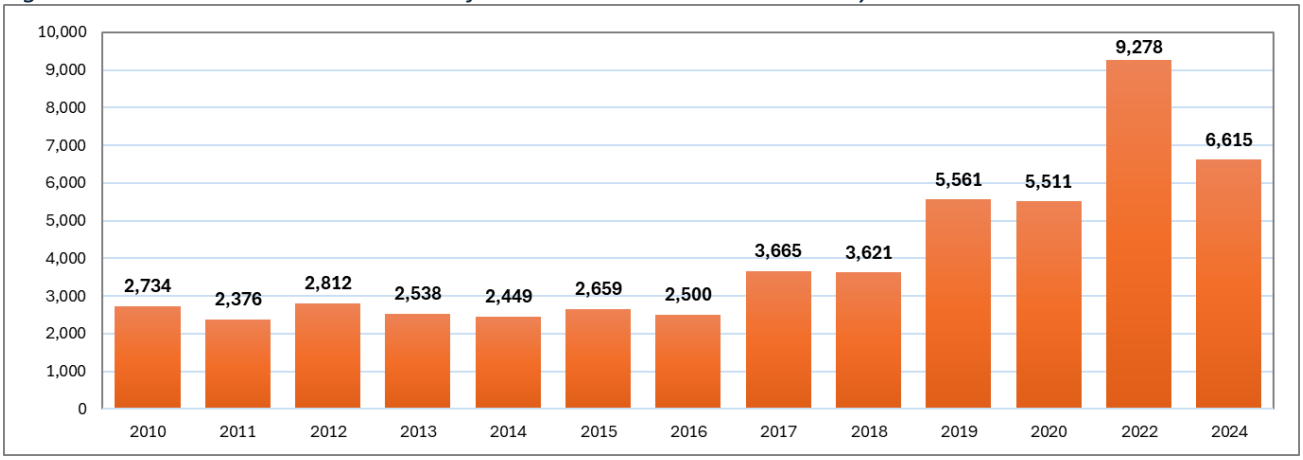
Homeless Related?	Total Incidents	% of Total Incidents	Proportional Amount of FY 2024 SFD Fire Ops/EMS Budget
No	74,783	76.2%	$116,992,271
Yes	19,020	19.4%	$29,755,332
Unknown	4,354	4.4%	$6,811,499
Grand Total	**98,157**	**100%**	**$153,559,102**

Source: SFD FY24 dispatch data and FY24 Approved Budget.

The growth in the City's unhoused population over the past 15 years has put increasing pressure on the City's municipal resources, and has had an outsized impact on the demand for emergency medical services. According to data from Sacramento Steps Forward, there were 6,615 individuals experiencing homelessness in Sacramento County in January 2024, with an estimated 77.4 percent of the unsheltered homeless population living in the City of Sacramento. Extrapolating that percentage to the homeless population of 6,615, that would equate to 5,120 homeless individuals, both sheltered and unsheltered, living in the City of Sacramento.[14] This would mean that, on average, there were almost four SFD responses per homeless individual living in the City in fiscal year 2024, compared with roughly 0.15 responses per non-homeless individual—an incident rate almost 27 times higher. Figure 9 below identifies the growth in the City's unhoused population over time.

[14] Experts have argued that point-in-time counts based on standards from the U.S. Department of Housing and Urban Development significantly undercounts populations of persons experiencing homelessness. See Kofsky, Jared, Maia Rosenfeld, and Jaclyn Lee.
"'You Can't Be Accurate': Annual Count of US Homeless Population Misses Large Numbers of People, Experts Warn." *ABC News*, 3 Feb. 2024, https://abcnews.go.com/US/accurate-annual-count-us-homeless-population-misses-large/story?id=106671876.

Figure 9: Annual Point in Time Counts of Unhoused in Sacramento County



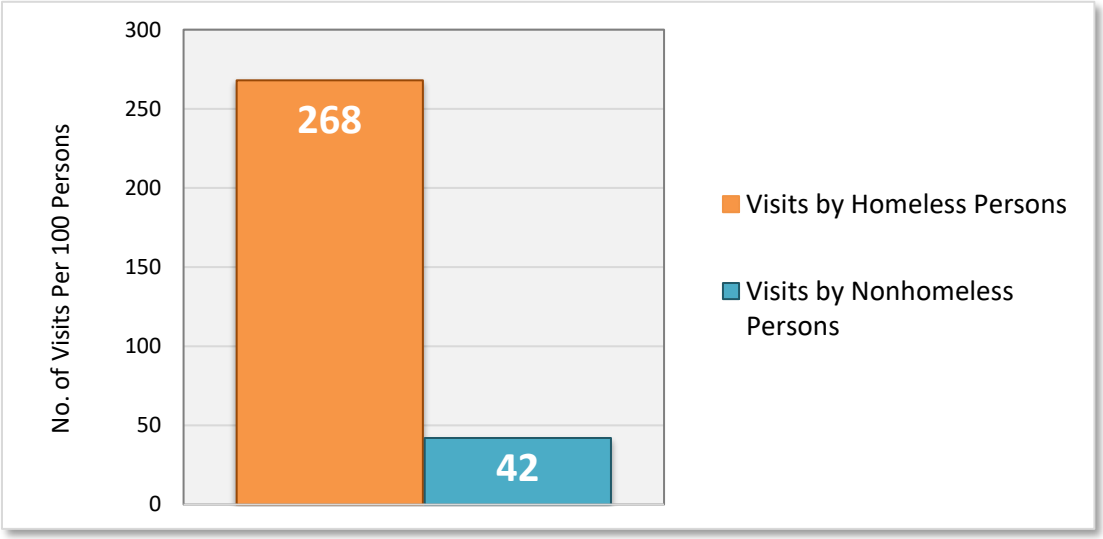
Source: HUD https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ and Sacramento Steps Forward https://sacramentostepsforward.org/continuum-of-care-point-in-time-pit-count/2024-point-in-time-count/.
Due to the COVID-19 pandemic, a point in time count was not conducted in 2021. HUD data for 2021 and 2023 were excluded because they did not include a full count of both sheltered and unsheltered homeless.

Between 2010 and 2024, the unhoused population in Sacramento County grew by about 140 percent, even after accounting for the sharp decline from 2022 levels.[15] For context, the overall population growth in the County of Sacramento between 2010 and 2024 has been about 14 percent. This indicates that, over time, the growth in unhoused population has contributed to an increasing share of EMS resources going towards homeless-related incidents compared with non-homeless related incidents.

According to the U.S. Department of Health and Human Services[16], those experiencing homelessness also visit the emergency room at a significantly higher rate than the housed population. They estimate that in the Western region of the United States, there were 268 emergency room visits per 100 unhoused persons between 2015-2018. In comparison, the housed population visited the emergency room at a rate of 42 visits per 100 persons. Figure 10 shows the frequency of emergency room visits by housing status.

[15] The point in time count process was updated in 2019 to include more volunteers and a more comprehensive statistical model, which likely contributed to a higher total count than in previous years. Direct year-to-year comparisons are cautioned; however, these counts remain the best available data.
[16] QuickStats: Rate of Emergency Department (ED) Visits, by Homeless Status— National Hospital Ambulatory Medical Care Survey, United States, 2010-2021. MMWR Morb Mortal Wkly Rep 2023;72:1153. DOI: http://dx.doi.org/10.15585/mmwr.mm7242a6.

Figure 10: Rate of Emergency Room Visits by Housing Status, 2015-2018 (Western U.S.)



Source: U.S. Department of Health and Human Services https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a8

The graphs show that, as the City's homeless population rises, there is an exponential impact on the demand for EMS responses. Aside from the financial component, growing incidence of calls create additional time, labor and service delivery pressures on EMS personnel. Responding to non-emergency incidents, including those that are homeless-related, with different and more specialized personnel could be mutually beneficial to the City and to the unhoused population.

About 37 Percent of the Homeless-Related Medical Calls Were Non-Emergencies and Could Have Been Treated Without an Ambulance Response

Fire and medical calls from the homeless population not only account for an outsized share of total EMS calls, but medical calls for individuals experiencing homelessness are also more likely to be low-acuity (37.4 percent) than medical calls from non-homeless people (28.9 percent).

About 95 percent of homeless-related EMS calls fall into one of three main categories: fires, medical or good intent.[17] The most common category is medical, which accounts for 46.1 percent of all homeless-related incidents. Figure 11 below identifies the number of homeless-related incidents during fiscal year 2024 by incident type.

[17] A "Good Intent" call refers to an EMS call where treatment or intervention isn't provided because either the call was canceled in route, the wrong location was given, the patient wasn't present on scene, or the caller mistakenly thought they saw smoke.

Figure 11: Description of Homeless-Related EMS Incidents During Fiscal Year 2024

Incident Type	Incident Count	% of Total Homeless Incidents
Medical	8,763	46.1%
Non-Medical	10,257	53.9%
Good Intent	*5,868*	*30.8%*
Fire	*3,371*	*17.7%*
All other	*1,018*	*5.4%*
Total	**19,020**	**100%**

Source: SFD FY24 dispatch data and FY24 Approved Budget.

As the table illustrates, the number of medical calls is roughly equal to the number of good intent and fire incidents combined. Of the 8,763 medical incidents, 37.4 percent were non-emergencies where EMS personnel were dispatched for treatment. In other words, for the largest category of homeless-related incidents, an EMS unit was unnecessarily deployed more than one-third of the time.

A Primary Driver of Low-Acuity EMS Calls for Homeless Individuals Are Related to Mental Health and Substance Abuse

Based on interviews we conducted during fieldwork for this report, SFD stated that mental health and substance abuse were the two largest issues requiring treatment for individuals experiencing homelessness.[18] While we were unable to verify that figure, it is consistent with emergency medicine trends in urban areas for individuals experiencing homelessness; a 2010 CDC report found that unhoused emergency room patients are more likely to arrive by ambulance and experience symptoms of mental illness or substance abuse. Furthermore, evidence shows that people experiencing homelessness generally tend to have higher rates of chronic illness than the housed population, which compounds the use of EMS response for low-acuity homeless incidents given that patients with chronic illnesses frequently and repeatedly call 911 for assistance.

Broadly speaking, issues of mental health, substance use, and homelessness are interrelated. While most people who are homeless are not regularly using illicit drugs, drug abuse has been shown to increase the risk of homelessness, and experiencing homelessness itself can increase the likelihood of drug use. Additionally, certain mental health disorders may be more prevalent in individuals experiencing homelessness than in the general population, and homeless individuals often face barriers to accessing mental health resources. Concerns about the effects of substance use and mental health are not confined to the field of emergency medicine, as results from a nationwide survey showed that

[18] This does not include drug overdoses, which are not considered low-acuity.

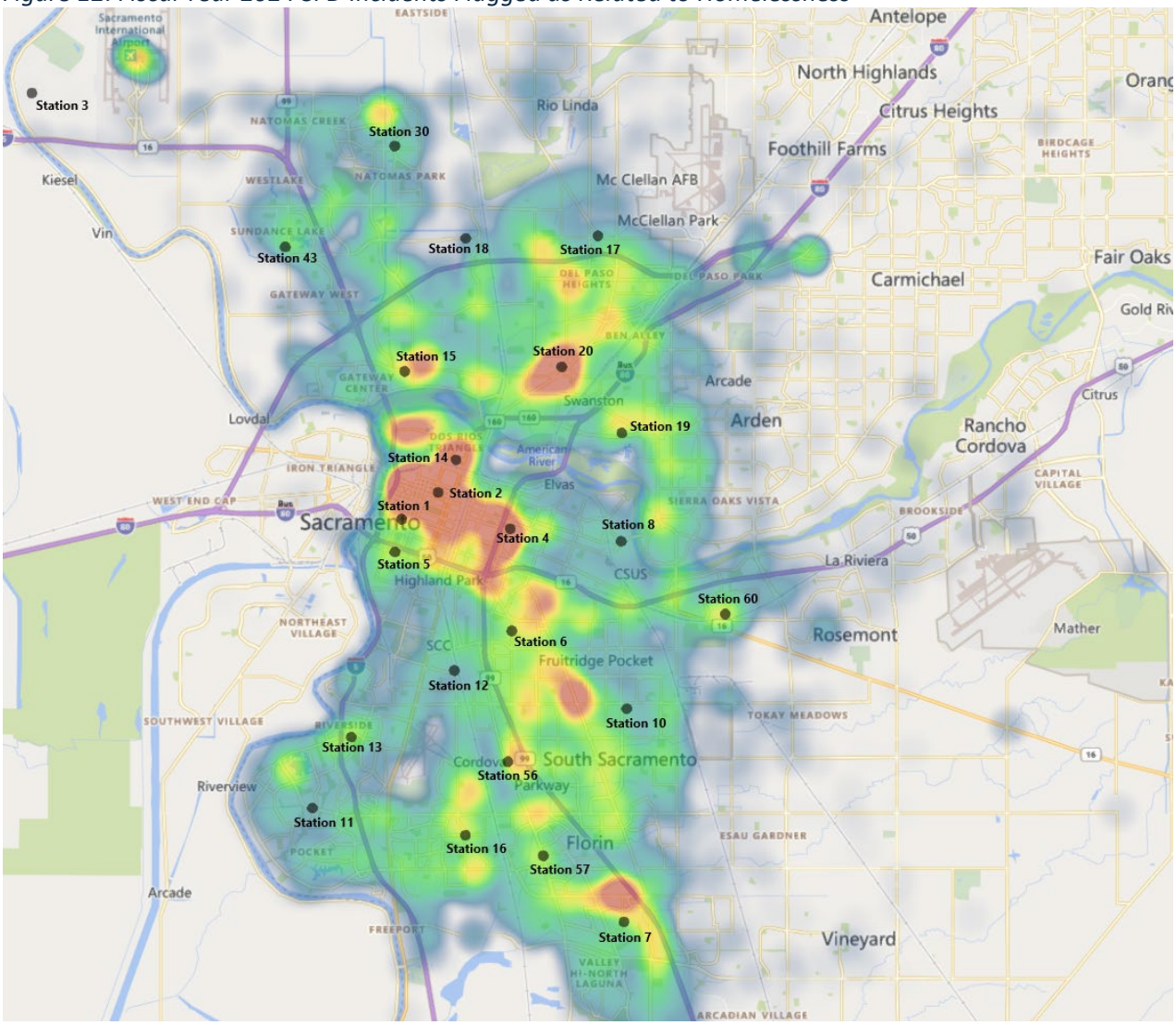
more than 95 percent of mayors[19] are worried about trends in substance use and mental health in their cities.

911 Calls for Individuals Experiencing Homelessness Are Concentrated in the Downtown Urban Core

Using location data of EMS responses for homeless-related incidents, we can identify the areas of the City where these calls are most likely to occur. The highest concentration of incidents occur in the Downtown and Midtown neighborhoods, within the area bounded by Highway 50, Interstate 80, and the Sacramento River and American River. The most frequent occurrences of homeless-related incidents are within the pockets shaded in red in the heat map below.

[19] National League of Cities. *2025 State of the Cities Report*. National League of Cities, 2025. http://nlc.org/wp-content/uploads/2025/07/NLC-2025-State-of-the-Cities-Report.pdf

Figure 12: Fiscal Year 2024 SFD Incidents Flagged as Related to Homelessness



Source: Auditor generated based on SFD FY24 dispatch data.

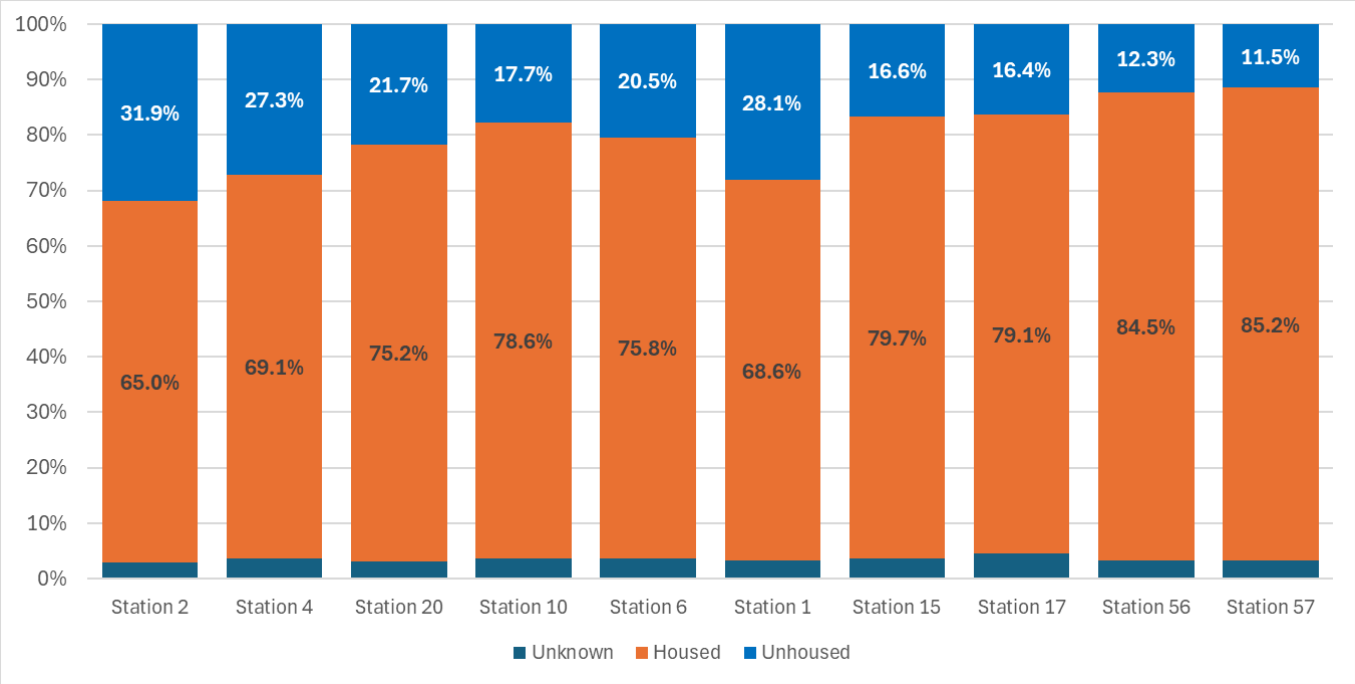
We further analyzed the data to chart which stations respond to the most EMS calls, and what the housing status of their patients were in fiscal year 2024. We found that among the top 10 stations in total unit responses in 2024, three stations had among the highest share of incidents that were related to homelessness.

According to SFD data, Station 2 had the most vehicle responses in fiscal year 2024, at about 11,700.[20] As shown in Figure 13, roughly one-third of those 11,700 dispatches were related to homelessness, which was the second-highest percentage of any of the 24 fire stations. The fifth-highest percentage was

[20] This methodology does not aggregate all unit responses into one incident response. For example, if one fire engine responds to a call, it would count as one response. If a fire engine and ambulance responds to a call, that would count as two responses.

at Station 1, with about 28 percent of its roughly 7,900 responses being related to homelessness, and Station 4 had the sixth-highest percentage of homeless-related responses (roughly 27 percent) and the second-highest number of dispatches overall, at about 10,700. As shown in Figure 12, Stations 1, 2 and 4 are centrally located in the City's Midtown and Downtown neighborhoods, which aligns with the heat map's high concentration zones of homeless-related responses.

Figure 13: Share of Homeless-Related Incidents Among 10 Stations with the Most Total Incidents in FY 2024



Source: Auditor generated based on SFD FY24 dispatch data.

Outside of the top 10 stations in total responses, the highest overall percentage of homeless responses were at the stations with some of the fewest number of total responses. Station 14 had the highest share of homeless-related responses at about 53 percent, but the sixth-fewest total responses. Station 5 had the fourth-highest share of homeless-related incidents, but the seventh-fewest total responses, and Station 60 had the third-highest share of homeless-related calls, but the second-fewest total calls of any station. Station 14 is bordered by the American River to the north, Station 5 is located in Land Park, just south of the Downtown area, and Station 60 is located further out in East Sacramento.

Identifying the areas with the highest number of responses and the greatest percentages of homeless-related incidents can isolate the geographic zones in which alternative response models, described in the section below, could be deployed with the greatest efficacy to reduce unnecessary ambulance responses.

SFD Should Coordinate with Dispatch to Identify Alternative Resource Responses at the Point of Call

County EMS policies establish a tiered response system that varies based on the severity of the incident, but low-acuity, non-emergent calls are still subject to standard medical dispatch protocols. A side effect of this process is that non-emergency and behavioral health calls that may not be best treated by paramedics or EMTs are routed for response in the same fashion as high-acuity calls, potentially creating a bottleneck in response times.

Opportunities exist for SFD, in collaboration with the Sacramento Regional Fire/EMS Communications Center, to consider alternative resource responses at the dispatch level that could mitigate the number of ambulance responses for non-medical emergency incidents. Potential strategies include a nurse triage hotline, where low-acuity medical calls are re-directed to a registered nurse who is able to provide assistance to the caller in real time, utilizing rideshare services for 911 calls regarding hospital transports, and building out dispatch capabilities for behavioral health calls. Cities such as Washington, D.C., San Bernadino, Albuquerque and Baltimore have utilized these services at varying levels.

Nurse Triage Hotline

In July 2024, the Sacramento Regional Fire/EMS Communications Center (SRFECC) was recognized by the International Academies of Emergency Dispatch (IAED) as an Accredited Center of Excellence (ACE). With the accreditation, SRFECC will be able to set up a nurse triage line where calls to the dispatch center may be transferred to a registered nurse that can help determine whether medical personnel need to respond to the call or if there is a more appropriate alternative for treatment. SRFECC stated that they have been reviewing programs where low-acuity incidents would be triaged by emergency medicine physicians via telephone or telehealth for the past few years.

According to SRFECC, San Bernadino is the only California city currently operating an Emergency Communication Nurse System (ECNS), having initiated their program in 2019 as a joint collaboration with the San Bernadino County Joint Powers Authority (“CONFIRE”) and the San Bernadino Council of Governments. The system works whereby dispatchers reroute non-emergent, non-life-threatening calls to a registered nurse at the County 911 center.

The District of Columbia’s (D.C.) Right Care, Right Now program emphasizes the goal of “connect[ing] 911 callers with medical needs to the most appropriate health care,” which mirrors SFD’s EMS “right care-right patient-right time” ethos. According to D.C., “callers to 911 with non-emergency injuries or illnesses are transferred to a nurse either by the 911 call center or by a FEMS [Fire and EMS] first responder. The nurse asks the caller questions and assesses the patient’s symptoms so that the nurse can refer the caller to the most appropriate non-emergency medical care available, most likely a community clinic or urgent care clinic in the caller’s neighborhood.” An experiment that randomized assignment of eligible calls to the nurse triage line found that, over the course of a year, calls assigned to

the nurse resulted in an ambulance dispatch 56 percent of the time, compared with 97 percent without the nurse. Additionally, when there were ambulance dispatches, calls assigned to the nurse resulted in ambulance transport 45 percent of the time, compared with 73 percent in the control group. For reference, a 41 percent reduction in ambulance dispatches for the City would mean 23,000 fewer responses to medical calls, and a 28 percent reduction in hospital transports would be equivalent to about 9,600 transports.

However, there are significant financial and operational concerns regarding ECNS programs, especially in the implementation phase. For example, Santa Clara County implemented a nurse triage hotline in late 2024 in partnership with their ambulance service provider, who also provides Santa Clara County with the medical professionals staffing the hotline. If the City were to build out that infrastructure using the same model and provider that Santa Clara County utilizes, SRFECC estimates that it could cost $1.5 million to $2 million to implement because SRFECC utilizes a different ambulance service provider. According to SRFECC, ECNS programs in other agencies have grappled with funding challenges, such as San Bernadino's ECNS program costing $1.8 million annually, and Las Vegas Fire and Rescue's ECNS program being discontinued due to issues with sustained funding. Furthermore, successful nurse triage programs would require cooperation with hospitals, insurance carriers, and the network of available health care providers.

According to SFD, they have been working with SRFECC to review this option and are finding that it is expensive to implement. However, any program costs would need to be balanced by the effects of potential reductions in unnecessary ambulance responses to low-acuity medical calls, in financial terms and in terms of reduced workload for the EMS Division. While SRFECC estimates that the Sacramento Fire Department's share of implementation costs to establish a nurse-in-triage line could be $500,000 to $750,000 per year, those figures may still be less than the estimated costs from non-emergent ambulance responses. As stated previously, it costs the City about $2.51 per minute for the operation of an ambulance, and in fiscal year 2024, ambulances logged 426,596 call time minutes for incidents that did not result in a hospital transport, for an estimated total cost of about $1,070,000. A 41 percent reduction would be roughly equivalent to $439,000. A 28 percent reduction in hospital transports would be even greater: ambulances logged 2,844,791 minutes in hospital transports at a cost of about $7,140,000, and 28 percent of which is $1,999,000.

SFD's research indicates that a major limitation of nurse triage lines is the lack of sufficient alternative care facilities for redirecting patients away from emergency rooms. According to SFD, the Sacramento area does not have enough urgent care centers, behavioral health services, or rehabilitation facilities to meet demand. Additionally, many patients are covered by Medi-Cal or Medicare, which further restricts the number of facilities willing or able to accept them when attempting to divert patients from emergency departments. However, despite these challenges, there may still be opportunities to further explore nurse triage lines as a strategy to reduce responses to low-acuity calls.

Rideshare Services

Given that 911 calls can be intended purely as hospital transit, a contract with rideshare services such as Uber Health could be a more economical option. Uber Health allows healthcare organizations to arrange rides and services on behalf of others, and rideshare companies like Uber and Lyft are currently subcontracted with Medi-Cal. Our review of rates in Sacramento found Uber rides were typically less than $50 from Northern Sacramento to Southern Sacramento, and that the total call time that an ambulance unit spends on a hospital transport is about 83 minutes; at $2.51 per minute, that comes out to about $208.

The rideshare option could be an affordable alternative for the City, given that SFD receives low-acuity calls where an ambulance is the caller's only way to get to the hospital. For example, during a ride-along we conducted as part of fieldwork for this report with EMS personnel at Station 20, we responded to a call where the caller stated that they called 911 simply to receive a ride to the hospital because they did not have another way to get there on their own. For this call, a four-person engine crew was first dispatched. Upon learning the caller needed transport, a two-person ambulance was called to respond and transport the caller to the hospital. However, patients can still request to be transported to a hospital emergency room under California law, even in non-emergent situations where they would qualify for a transport to an alternate facility.

Implementing this option would require the dispatch center to have a mechanism similar to a nurse triage line to appropriately assess each call and determine when a rideshare response is safe, suitable, and compliant with protocols.

Behavioral Health Crisis Hotline

Since 2025, SRFECC has been operating a program where certain individuals experiencing behavioral health crises will be routed, with their consent, directly to the 988 suicide prevention and crisis services hotline managed by WellSpace Health. These are individuals who are not an immediate danger to themselves or others. This model reflects the practices utilized by the City of Baltimore in its 911 Behavioral Health Diversion program, where crisis calls are diverted to the national 988 helpline. According to SFD, this new program currently works for only a small portion of calls.

Though one key area in where Baltimore's program and the SRFECC program diverge is in the deployment of mobile crisis teams in instances that in-person aid is required. While Baltimore allows for units to be mobilized by dispatchers, the SRFECC does not currently have dispatch authority over SFD units such as the Mobile Crisis Unit—currently in pilot phase—to incidents where callers may need in-person help. Additional collaboration and discussions between SFD and SRFECC would be required to grant dispatching authority.

Albuquerque is another city that coordinated their behavioral health response through their 911 system with the development of their Albuquerque Community Safety department (ACS). ACS can be contacted through the 911 emergency line and Albuquerque's 311 non-emergency line to assist in behavioral

health crises and to provide support services to unsheltered individuals and wellness and welfare checks. When the caller connects with the dispatcher, the dispatcher determines where the call should be diverted for one of four types of ACS response:

- "Behavioral health responders" for behavioral health crises, chronic mental illness, and situations that need de-escalation or mediation
- "Community responders" for low-acuity wellness checks and quality of life concerns, and support services for unsheltered individuals
- "Street outreach responders" for providing services and support to unsheltered individuals and individuals living in encampments
- "Mobile Crisis Team Clinicians" who respond with police to high-risk behavioral health crises (e.g. situations involving a weapon)

Harvard Business School instructors described ACS as "a model for reimagining public safety and community well-being" and a "winning formula of vision and strategy." Other cities, such as Durham, North Carolina, worked with Albuquerque to develop their own Community Services Department. Both Albuquerque and Durham have sharply increased their budgets for their community safety programs; the fiscal year 2025/26 budget for ACS is nearly $24 million, as appropriations have risen with increases in the department's number of calls for service.

Cooperation between the SFD and SRFECC can reduce strain on the City's and County's EMS response resources by potentially expanding dispatch authority, and/or continuing discussions of establishing ECNS programs. Evidence from other cities indicates that triage hotlines from dispatch referral are effective and operable in larger urban areas, and may be adaptable to dispatching operations within the City.

RECOMMENDATION

We recommend the Sacramento Fire Department:

1. **Continue to collaborate with the Sacramento Regional Fire/EMS Communications Center to explore programs where non-emergency calls are diverted to an alternative resource response, and discuss opportunities to expand dispatching authority for alternative response units, such as the Mobile Crisis Unit.**

SFD Should Continue to Expand Alternative Response and Care Units to Reduce Ambulance Demand

The SFD aims to provide the right medical service to the right patient at the right time, and has stated that responding to mental health and substance abuse crises solely with emergency vehicles and personnel may not be the appropriate strategy. In furthering this goal, SFD is in the initial stages of implementing alternative triage teams that could reduce the need for ambulance responses and/or hospital transports: a Street Overdose Response Team which focuses on treating overdose incidents and facilitating access to services; a Mobile Integrated Health team that would respond to low-acuity and high-frequency callers; and a Mobile Crisis Unit that would respond to individuals experiencing mental health crises.

The Street Overdose Response Team (SORT), staffed by a team of two paramedics, currently focuses on assisting individuals experiencing homelessness, especially in encampments. The aim for this intervention unit is to respond in real-time to overdose emergencies, perform follow-up visits, and facilitate access to services such as harm-reduction kits and long-term care.

The Mobile Crisis Unit (MCU) team, which began its pilot phase in mid-July 2025, will focus on stabilizing patients experiencing behavioral health[21] and/or substance use[22] crises without the need for hospital transports, and connecting them to long-term support services, where appropriate. The MCU team is staffed by a SFD paramedic and a licensed behavioral health clinician from the Sacramento County Behavioral Health Services department, and is responsible for conducting rapid mental health and medical assessments, determining disposition (i.e. identifying if the patient can be stabilized on scene or if they need a hospital transport), and initiating referrals to follow-up care through County Behavioral Health Services. The MCU team will be dispatched either by a requesting EMS team already on scene, or by self-attaching to calls from high-frequency EMS patients or calls indicating a behavioral health crisis.

The Mobile Integrated Health (MIH) team is slated for implementation in May 2026, and is targeted towards individuals impacted by the opioid crisis, those who have high emergency department utilization, and who face systemic barriers to health care access. The SCEMSA's *Mobile Integrated Health (MIH) Pilot Program* policy drafted in August 2022 allows for low-acuity patients who decline a hospital transport to be seen by a physician assistant or nurse practitioner, and frees up an ambulance to return to service. By providing on-scene care with either a physician assistant or nurse practitioner, low-acuity incidents may be able to be diverted from what would otherwise be a hospital transport. SFD also utilizes other policies that provide options for non-emergency room transports. As long as certain criteria are met, the triage to alternate destination program allows for patients, with their consent, to be

[21] According to the Substance Abuse and Mental Health Services Administration, a "behavioral health crisis" is defined as "A disruption in a person's thoughts, emotions, behaviors, or functioning that leads to an urgent need for assessment and treatment to prevent the condition from worsening or becoming dangerous." Whether an incident qualifies as a crisis is based on the judgment of the call taker and responding personnel.
[22] Treatment for drug overdoses remain under the purview of 911 first responders and ambulances.

transported to other locations such as mental health facilities or sobering centers, and SCEMSA policy allows for patients that meet certain vital sign parameters to be offloaded to hospital waiting rooms.

The goals of the alternative response units and the high percentage of homeless-related incidents indicate opportunities for continued discussions of efforts between the SFD and the Department of Community Response (DCR). DCR was established in July 2020 to provide responses to 911 calls that do not require a police officer assistance, and has operated an Incident Management Team (IMT) since August 2023 to better coordinate the response to the ongoing homelessness crises. It is important to note that the objectives for the two departments may not necessarily align on a given incident response, though DCR may have relationships with other agencies that could connect the individual to the appropriate support network.

The IMT specifically operates by responding to 311 calls regarding encampments of homeless individuals by referring individuals to sheltering and supportive services, behavioral health support, substance abuse treatment, and wellness and recovery services such as showers, laundry and activities. DCR data showed that the IMT helped reduce the number of SPD calls related to homelessness by eight percent, and nearly 20 percent in certain parts of the City, during the year ending in August 2024.

The implementation of the MIH team in coordination with the continued work of the IMT could help to reduce the number of medical calls for ambulance response, which could reduce demands on emergency personnel. The coordinated response may provide more appropriate care, while also bridging any communication gaps that might occur when two City departments provide services to the same groups of individuals.

Other cities and municipalities have studied various approaches to alternative response units, and some of those studies have resulted in the implementation of non-emergency programs. In 2021, the City of Berkeley commissioned a study which noted that, "just as a physical health crisis requires treatment from a medical professional, a mental health crisis requires response from a mental health professional. Unfortunately, across the country and in Berkeley, police are typically deployed to respond to mental health and substance use crises. Without the proper infrastructure and resources in place, cities are unable to adequately meet the needs of people experiencing a mental health and/or substance use crisis." [23] This largely echoes what still occurs in the City of Sacramento, where firefighters and paramedics/EMTs are often dispatched to calls where an individual is experiencing a mental health crisis.

The City of Berkeley's Crisis Response study further noted that "Mental health and physical health needs often co-present, with physical needs ranging from basic first aid (e.g., wound care, dehydration) to reactions to substances, such as overdoses or drug interactions. A medical professional, such as a Psych-

[23] https://berkeleyca.gov/sites/default/files/documents/Attachment%2003_Berkeley-MH-SCU_Final-Recommendations_FINAL_0.pdf

NP[24], brings the clinical expertise to understand how physical ailments, chronic medical conditions, and psychiatric conditions affect a service utilizer (e.g., someone with hypertension and schizophrenia using methamphetamines). Other medical professionals, such as NPs, may also have sufficient training to meet the mental health and substance use needs of service utilizers." Again, this is reinforced by the City EMS principle of "right service-right patient-right time."[25]

The City of Anaheim and the City of Seattle have both implemented MIH programs within the past 15 years, after they experienced changing trends in service demands from callers. Anaheim started California's first MIH program in 2015, called the Community Care Response Unit (CCRU), with the aim of the program is to reduce costs to the health care system by delivering services on scene with a certified nurse-practitioner and a Fire Captain/Paramedic and preventing unnecessary transports. The program was launched as a public-private partnership, with a significant contribution from Kaiser Permanente. Anaheim had found that, over the decades, fire service delivery has changed where the overwhelming majority of 911 calls are no longer fire and rescue-related but instead calls for medical services. Within the first few months of program implementation, 40 percent of the low-acuity patients that the CCRU responded to were able to be treated without a hospital transport.

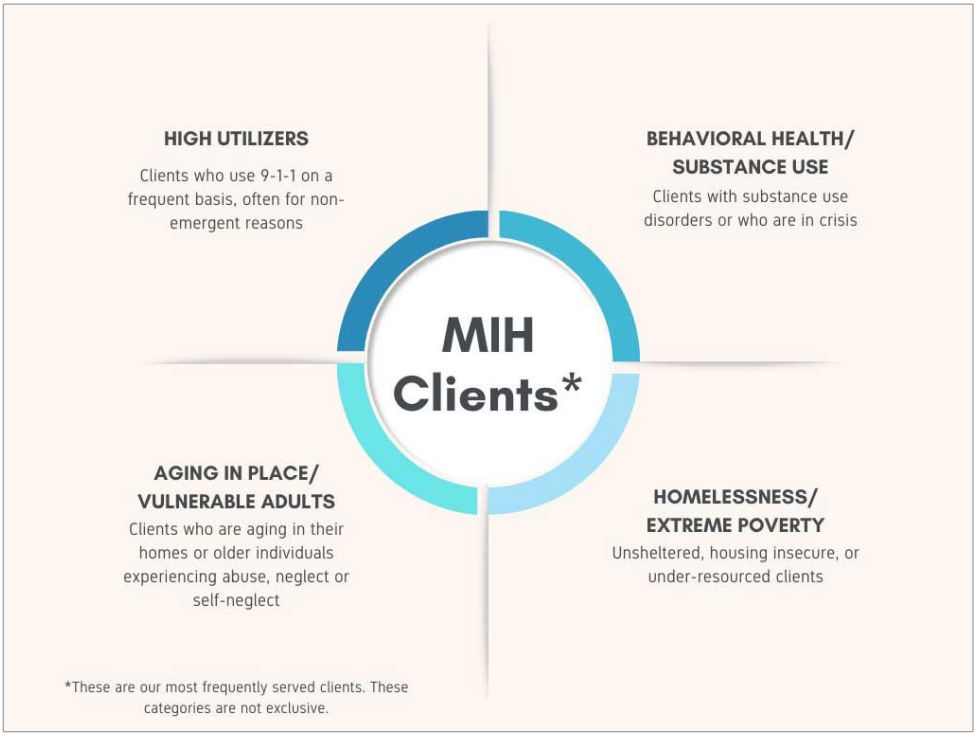
The City of Seattle established what would become known as a MIH program in 2016 to reduce the growing burden of low-acuity responses from the Seattle Fire Department. Their MIH program encompasses the following divisions, in partnership with Seattle's Human Services Department:

- Health One response team, which provides medical care, mental health care, shelter or other social services on site with a team of firefighters and case managers.
- Post Overdose Response Team, which draws on Health One staff, and responds specifically to opioid overdoses.
- Client Case Management, which provides short-term case management services to connect clients with long-term care, such as primary care, behavioral health, and/or substance use treatment, as well as homeless outreach and in-home care.
- Vulnerable Adult reporting program, which reports on abuse, neglect, self-neglect, or exploitation of adults above the age of 60, or those found incapacitated or with developmental disabilities.

[24] Psychiatric Nurse Practitioner (Psych-NP)

[25] Operations of Berkeley's Specialized Care Unit would later be handed off to Alameda County's Behavioral Health Care Services, after the program was plagued by what the Berkeley City Manager stated were staffing shortages, funding challenges, long response times, and unmet community expectations.

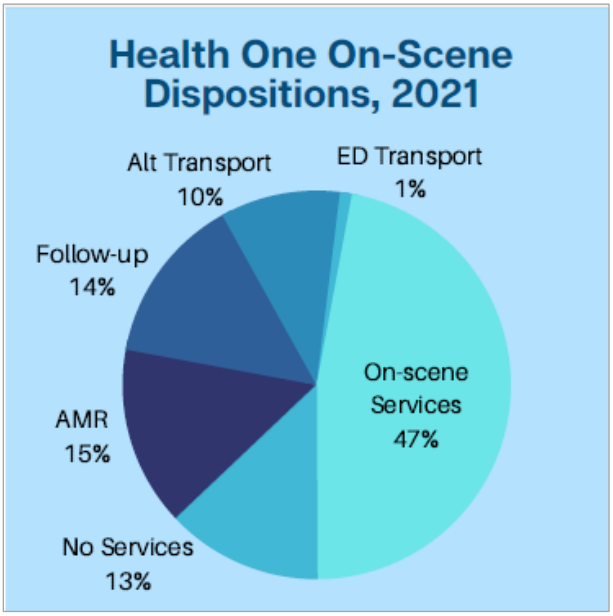
Figure 14: Clients Served by Seattle's MIH Case Management Program



Source: City of Seattle.

In addition to these services, their MIH program provides education and training for high-utilizing locations such as shelters, clinics, and long-term care facilities, and its work is supported by a network of partners in Seattle, King County, healthcare and nonprofit groups, neighboring fire departments and others. In September 2020, Seattle's MIH program received a national award, noting that the program has "resulted in significant reductions in 911 calls as well as unnecessary trips to emergency rooms. With these resources our community can receive the care and service they need while ensuring our first responders are available for true emergencies." Figure 15 shows an excerpt from Seattle's 2021 Mobile Integrated Health Program that shows the disposition of on-scene calls. They were able to provide "on-scene services" for 47 percent of their calls. Their team responded to over 1,000 calls in 2021, with just over half of those calls for individuals experiencing homelessness.

Figure 15: Seattle's Health One Mobile Integrated Health Program Dispositions



Source: City of Seattle.

The Mobile Integrated Health program provides the wraparound services and longer-term care that Seattle Fire Department units are not necessarily able to provide. According to the United States' Department of Transportation, National Highway Traffic Safety Administration's *EMS Agenda 2050*, a challenge to many EMS systems is that "many systems remain designed to treat every incident as a life-threatening emergency, despite the majority of 911 medical responses not requiring lifesaving interventions." As these other examples have shown, when more specific and non life-threatening interventions are required, other cities have found more utility in branching out treatment services to non-emergency personnel with targeted expertise. This is especially applicable to frequent users of emergency medical services, as a study found that individuals who have between four and six EMS transports per year generally call for assistance with reoccurring conditions, which the researchers argued could be reduced with better care management. The primary reason that the highest frequency EMS patients, those with seven or more transports per year, tend to call for assistance is for issues surrounding substance abuse.

It is important to note that there are potential obstacles with alternate response units like Mobile Integrated Health teams. According to SFD officials, other fire departments have raised financial concerns about cost recovery from MIH responses to incidents, especially from federal agencies. Whereas patients are billed for ambulance services, the current logistical framework through the Centers for Medicare and Medicaid Services and the City's contractor for EMS billing limits the City's ability to recoup costs from MIH treatment. A full implementation of an MIH team may benefit working with the State legislature on some method of cost recovery.

SFD should continue to work with DCR and expand treatment services to target the common, specific needs of callers, such as mental illness and substance abuse. The departments may want to determine

how best to coordinate response, as they have experienced a mismatch of goals during previous efforts, which led to the reformation of Street Overdose Response Team from a collaboration between SFD and DCR to only being staffed by paramedics. Paramedics and EMTs would have more flexibility to focus on emergency incidents if the alternative response units could utilize efforts by mental health professionals, case managers, and medical professionals. Furthermore, it would make progress towards ensuring that patients receive a targeted type of care to help their specific circumstances, rather than a less efficient strategy where emergency personnel respond to any and all calls, regardless of the nature of their training.

RECOMMENDATION

We recommend the Sacramento Fire Department:

2. **Continue to make progress expanding alternative response units.**

Finding 2: Although Hospital Delays Have Declined, They Still Create Strains on EMS Resources and Highlight a Need for Further Collaboration With Area Hospitals

Both emergency medical services providers and hospitals follow time-based guidelines that are intended to shorten the periods in which EMS personnel respond to calls and patients are treated in emergency rooms. However, increasing call volumes and demand for ER treatment can lengthen these response times.

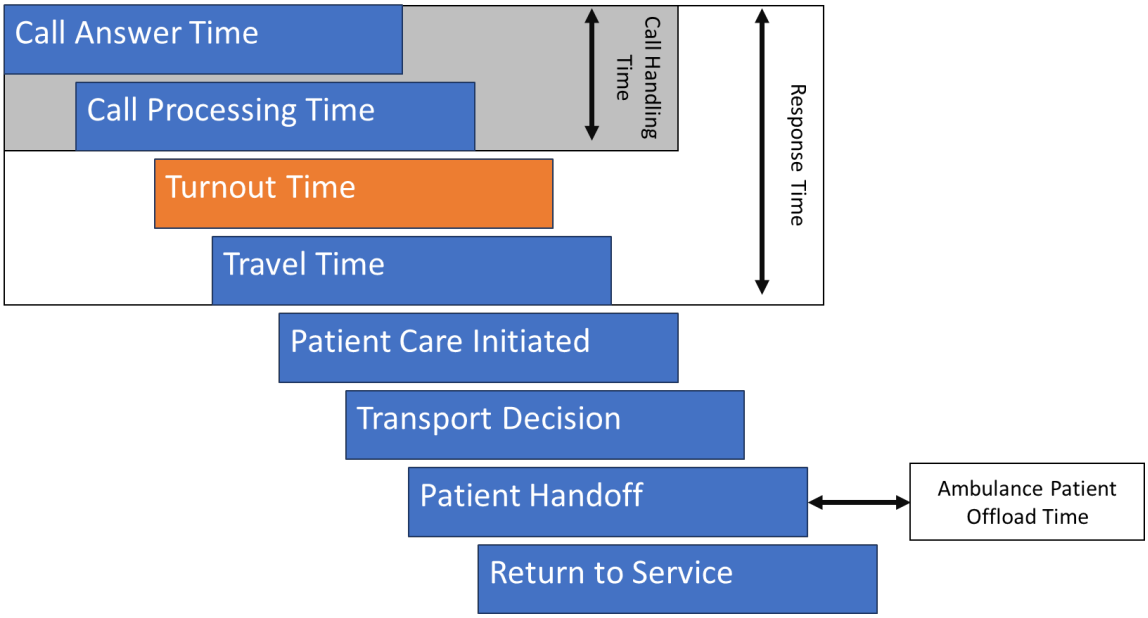
Nationwide data have shown that staffing trends and the demand for health care services are placing growing pressures on the capacity of the current hospital system, and hospitals across the country utilized practices to keep up with patient arrivals that may be in violation of federal law.

The hospital delays create a noticeable trickle-down effect on the City EMS system. Reports from recent years have shown that ambulances faced substantial wait times at Sacramento-area hospitals. As EMS personnel are required to wait at the hospital before the patient can be offloaded into the care of the ER, the lost time is an opportunity cost for other patients who could otherwise be attended to. As noted in Finding 1, any non-productive wait times for EMS personnel create a financial cost on the City.

According to news articles and reports, the County EMS system and area hospitals are not currently meeting standards set for ambulance patient offload times (APOTs), even though they have made significant progress in reducing these wait times. An April 2025 article from EMS1 stated that patients transported by EMS providers within the County were being transferred to hospital care in an average of 33 minutes, just above the 30-minute standard dictated in County EMS policies. When hospitals face delays in admitting patients who arrive by ambulance, it causes residual effects on the broader EMS system, as ambulances are unable to quickly return to service.

APOT is the time it takes for paramedics to transfer care to emergency room staff once they arrive at the hospital. Transfer of care occurs when the receiving emergency department accepts responsibility for the patient. Figure 16 shows where the patient offload time is located in the emergency response workflow.

Figure 16: Stages of Emergency Response



Source: Auditor generated based on NFPA 1221 and 1710.

Back in 2006—and reiterated in a 2019 draft of their State Operations Manual—the U.S. Department of Health & Human Services Centers for Medicare & Medicaid (CMS) issued a memo[26] recognizing that hospitals were intentionally delaying transfer of care by "parking" patients in hospitals and refusing to accept patients until they had a bed available. The memo states that:

> "CMS recognizes the enormous strain and crowding many hospital emergency departments face every day. However, this practice is not a solution. "Parking" patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of the EMS personnel to provide emergency services to the rest of the community…
>
> This practice [delaying ambulance emergency department offload] may result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community.
>
> Additionally, this practice may also result in a violation of 42 CFR 482.55, the Conditions of Participation for Hospitals for Emergency Services…"

[26] U.S. Department of Health & Human Services Centers for Medicare & Medicaid. S&C-06-21 *EMTALA - "Parking" of Emergency Medical Service Patients in Hospitals*. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter06-21.pdf. July 13, 2006.

According to the memo, hospitals were routinely preventing EMS staff from transferring patients from their stretchers to a hospital bed with the belief that if they did not "take responsibility" for the patient that the hospital was not obligated to care for the patient. In areas like San Francisco, patients are still experiencing long wait times for offloading into hospital care.

More recently, in January 2022, a local media outlet reported on first responders feeling frustrated at having to wait at hospitals in Sacramento for more than 8 hours for a bed to open up. The article noted that "When an ambulance arrives at an emergency department without capacity to take on more patients, paramedics and EMTs wait "on the wall," sometimes in the hallway with the patient laying on a gurney awaiting transfer."[27] This means that EMS first responders are unable to go back into service and must wait with the patient at the hospital.

According to the Sacramento County Department of Health Services' 2019 Emergency Medical Services Report, the most recent version:

> "In the past ten years, Emergency Department (ED) visits nationally and in Sacramento have increased by approximately 15-18%. With no similar increase in ED beds, this has worsened ED overcrowding in Sacramento. In turn, this has resulted in extended periods between EMS arrival to an ED and the time it takes to transfer care to hospital staff. This period of time is commonly referred to as "wall time," or Ambulance Patient Offload Time (APOT). When large numbers of ambulances are being held at hospitals, unable to transfer care to hospital staff, and not able to respond to new calls, EMS operations are adversely affected in the community."[28]

This issue is not just affecting the County, but the State as a whole. According to the California Hospital Association, "delays are not an isolated issue but are often symptoms of a larger problem. Research and expert opinion connect patient offload delay with obstructions in hospital throughput. Including decreased inpatient capacity, nurse patient ratios, hospital regulations limiting areas of care, and inability to rapidly turn over hospital beds." If hospitals are not keeping up with the demand for emergency medical services, then that delay has a domino effect that impacts the City's EMS transport capabilities.

Sacramento County Emergency Medical Services Agency (SCEMSA) staff monitor patient offload times for the entire County-wide system to identify issues and trends. According to SCEMSA's *Extended*

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[27] "Ambulances, patients waiting more than 8 hours for beds at Sacramento emergency departments." *ABC10*. https://www.abc10.com/article/news/local/sacramento/ambulances-waiting-emergency-departments/103-da97c1f9-de72-4189-a40c-298b7ae2824e

[28]Sacramento County Department of Health Services Primary Health Division. *Emergency Medical Services Report 2019*. https://dhs.saccounty.net/PRI/EMS/Documents/SCEMSA%20EMS%20Plans/Sacramento%20County_EMS%20Annual%20Report%202019%20Ver2%20October%208%202019.pdf. October 2019.

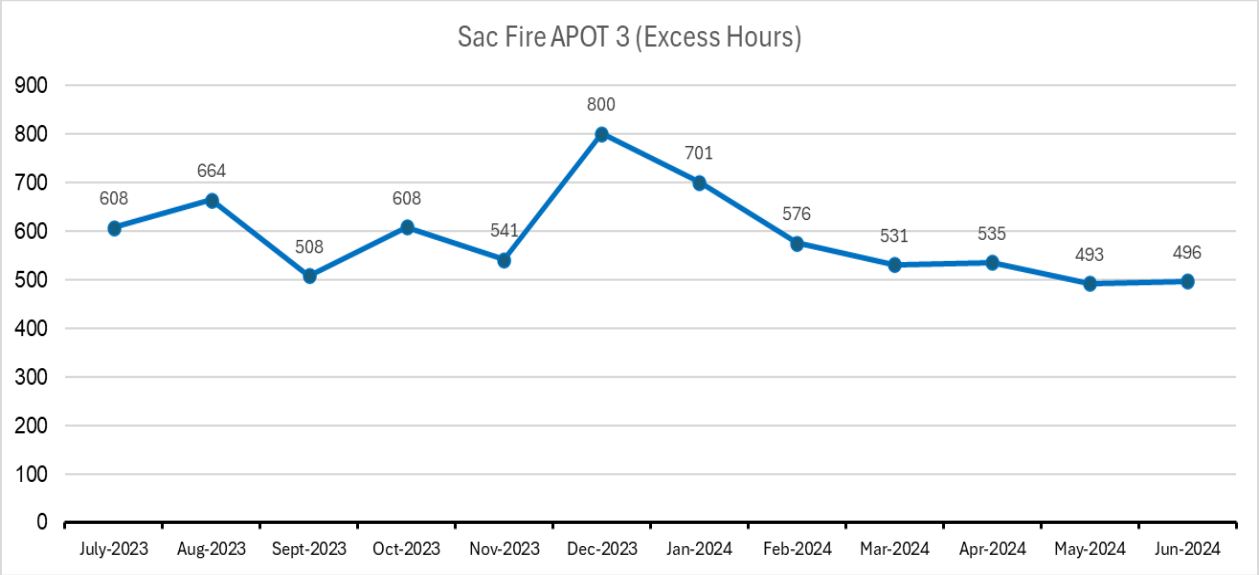
Ambulance Patient Off-Load Times (APOT) Policy[29], "emergency room surge and overcrowding has resulted in circumstances of extended wait periods for EMS personnel before transfer of care and patient off-load onto emergency room gurneys can be accomplished. These situations delay the prompt return to service for EMS staff and are a potential health risk for patients who are waiting for definitive assessment and care by hospital staff."

Sacramento County recently increased its APOT standard from the 20 minute standard established in 2016 to 30 minutes in January 2025. This means that the current expectation is that ambulances will transfer patient care to emergency department staff within 30 minutes of arrival at the hospital. However, this change is temporary, and the standard will gradually revert to the 20-minute offload time as of January 1, 2027. According to their 2024-2025 annual report, SCEMSA is currently close to meeting the 30-minute APOT standard. The County EMS Agency already made substantial progress between December 2023 and April 2025 in reducing patient offload times from 73 minutes to 33 minutes—a 55 percent reduction—according to a 2025 article. SCEMSA's 2024-2025 annual report showed a patient offload time of 29 minutes for a period in late 2024, which was below the County's 30-minute benchmark.

Failure to accept the patient at the emergency room transfers staffing costs from the hospital to the City, whereby SFD employees must wait with the patient instead of going back into service. To more closely examine how this affects SFD's staffing model, Figure 17 shows the excess number of hours SFD had to wait to drop off patients at hospital emergency rooms during fiscal year 2024. SFD had over 7,000 hours of excess "wall time" waiting more than 30 minutes at the hospital to drop off emergency room patients during fiscal year 2024.

[29] Sacramento County Emergency Medical Services. *Extended Ambulance Patient Off-Load Times (APOT) Policy* 2524.04. https://dhs.saccounty.gov/PUB/EMS/Documents/PoliciesProceduresProtocols/2000/PP-2524%20Extended%20Ambulance%20Patient%20Off-Load%20Times%20(APOT).pdf. July 2022.

Figure 17: FY 2024 Sacramento Fire Department APOT by Month[30]



Source: Sacramento County Emergency Medical Services Agency.

Based on data provided by SFD, the average excess time for SFD apparatus to return to service after arriving at the hospital in FY24 was roughly 21 minutes per patient. Wall time cost the City approximately $970,000 in fiscal year 2024 just in non-productive labor costs. It also delays ambulances from returning to service, potentially resulting in increased response times for ambulances when multiple units are impacted. There is also a lost revenue opportunity cost; when ambulances are stuck at the hospital they are not earning transport revenue. Even more concerning is that when patients must wait to be transferred to the care of hospital staff, they are not receiving the level of medical care the hospital is intended to provide, which could result in poorer outcomes for the patients.

It is important to note that APOT delays are not necessarily the fault of hospitals, which are facing overcrowding in emergency departments and resource constraints hospital-wide. Structural changes to how EMS providers and hospitals interface are broad and multifaceted and are outside of the scope of this audit. This report's recommendations focus on pointed changes achievable in the near term. Stronger coordination between EMS providers and area hospitals can potentially reduce wall times further through the adoption of standards from Assembly Bill 40.

To increase efficiency in the ambulance transport process and to streamline the transfer of patient care between ambulances and hospitals, California Assembly Bill 40 was passed in October 2023. AB 40 required that all local EMS agencies "develop a standard not to exceed 30 minutes, 90% of the time, for ambulance patient offload time and report the standardized time to the [Emergency Medical Services Authority]" by July 1, 2024. Emergency Medical Services Authority (EMSA) will oversee and collect data

[30] APOT-3 represents the excess time (in hours) over 30 minutes aggregate of patient transferred from EMS to hospital per month. Example: if APOT in minutes is 184 minutes then 184-30 (APOT benchmark) = 154 minutes. Then 164/60 = 2.57 hours.

on APOT trends, and "report ambulance patient offload time exceedance to the relevant local EMS Agency and the Commission on Emergency Medical Services if…[the] hospital with an emergency department has an ambulance patient offload time that exceeds the local EMS agency standard, as specified, for the preceding month."

Additionally, the law instructed EMSA to "develop and implement a California Emergency Medical Information System required for an electronic signature for use" between the receiving hospital and the EMS agency "that captures the points in time when the ambulance arrives at the hospital emergency department bay and when transfer of care is executed for documentation of ambulance patient offload time" by December 31, 2024. Furthermore, hospitals with an emergency department must have developed protocols to reduce ambulance patient offload times by September 1, 2024. According to SFD, hospitals have implemented some changes through coordination in monthly APOT strategy meetings, though there is still room for progress on more substantive reforms through further coordination and communication.

We recommend the Fire Department work with the area hospitals to ensure compliance with California Assembly Bill 40 to reduce offload time for EMS staff.

RECOMMENDATION

We recommend the Sacramento Fire Department:

3. **Work with the area hospitals to ensure compliance with California Assembly Bill 40 which may result in reductions in patient offload times.**

Finding 3: Best Practices in Performance Goals Have Not Been Formally Adopted and Are Not Being Met

As mentioned in Finding 2, EMS providers follow guidelines to ensure a consistent level of care provided to patients. In California, local EMS Authorities (LEMSAs) are generally responsible for the standards of EMS operations within a given area, such as carrying out regulations set at the State-level, setting medical treatment protocols, and determining ambulance patient destinations. While service delivery is a coordinated effort between LEMSAs and cities, the National Fire Protection Agency (NFPA) issues standards, guidance and recommended practices, allowing for local EMS agencies and EMS providers to evaluate performance.

Research suggests that as ambulance response times increase, patient survival rates decrease for emergencies like cardiac arrest. EMS providers should strive to achieve their response time standards, as well as to continuously look for opportunities to reduce response times and the amount of time it takes to return to service after completing a call.

There are several factors that can impact response times, including: call volume, call answer time, call processing time, turnout time, travel time, and ambulance coverage. Each of these steps can be tracked and measured, and measuring each step in the process allows the SFD to pinpoint specific areas for improvement. The NFPA provides recommendations on turnout time performance measures, and as previously stated, while their guidance is not mandatory, it is widely accepted.

We evaluated several of these metrics along with emerging EMS practices to determine if there were areas for improvement with SFD's deployment model. We found the following:

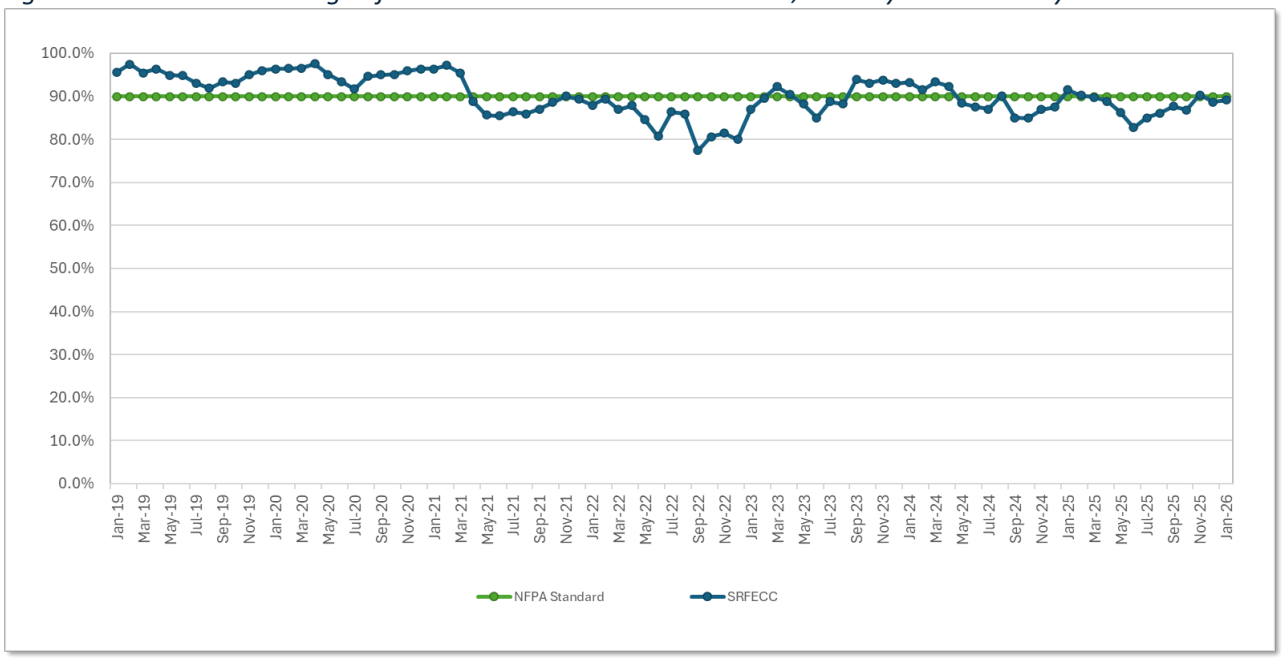
- The SRFECC Dispatch Center's call answer times do not consistently meet best practices; and,
- SFD has not adopted the NFPA-recommended turnout standards for EMS calls and is not currently meeting that standard.

Meeting guidelines for performance measures ensures a consistent standard of care and the best results for health care delivery. SFD stated that they do not have a formal turnout time policy, and adopting a standard for performance is a first step towards maintaining a standard of care. SFD should consider adopting a turnout time standard against which they can measure and evaluate performance.

The SRFECC Dispatch Center is Not Consistently Meeting Call Answer Time Goals

The SRFECC was organized through a Joint Powers Agreement (JPA) in January 1, 1981 to provide dispatch services for its member fire department agencies which include SFD, Sac Metro, Folsom Fire, and Consumnes Community Services District Fire, among others.[31] To evaluate the SRFECC's call metrics against recognized NFPA standards and best practices, we aggregated publicly available data from monthly board meeting reports.[32] Figure 18 shows the percentage of calls answered within 15 seconds as reported in their board packets in comparison to the recognized NFPA standard.

Figure 18: SRFECC Percentage of Calls Answered within 15 Seconds, January 2019-January 2026



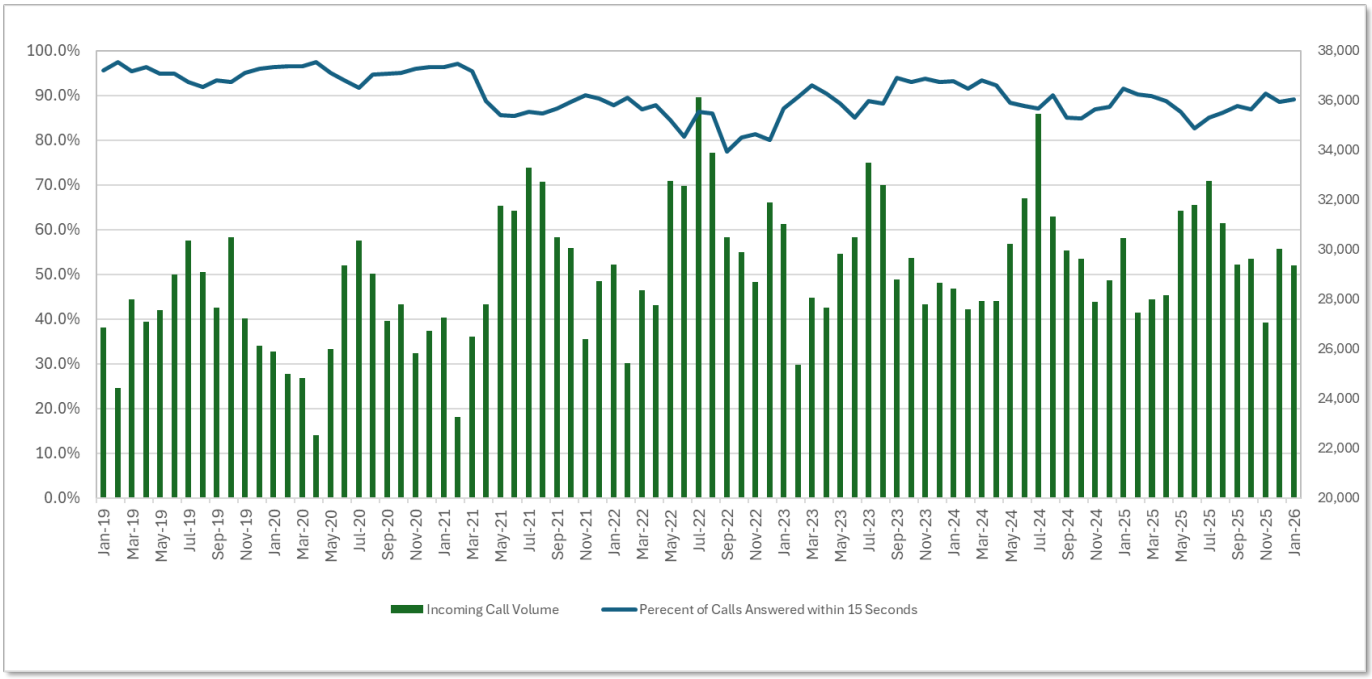
Source: SRFECC Board Packets

Based on the available data, the SRFECC consistently exceeded the NFPA standard of answering 90 percent of calls within 15 seconds between January 2019 and March 2021. In the two and a half years after that, response time percentages drop below the 90 percent benchmark for all but three months, and then fluctuate through January 2026, for which the most recent data were available at the time this report was written. When plotted with incoming call volumes, call answering time percentages appear to decrease with increases in monthly call volumes. Longer answer times means callers have to wait longer to reach a dispatcher, which has an adverse effect on the City's overall response time.

[31] The SRFECC also dispatches for the following non-member agencies: Courtland Fire Protection; Herald Fire Protection; Isleton Fire; River Delta Fire Protection; Walnut Grove Fire Protection; and Wilton Fire Protection.

[32] For the months in which data were missing from board meeting reports, SRFECC provided the data as requested.

Figure 19: Percentage of SRFECC Calls Answered within 15 Seconds Compared with Incoming Call Volumes



Source: SRFECC Board Packets.

As previously stated, patient survival rates can be positively impacted when EMS response intervals are shortened: from when dispatch answers calls, to calls being dispatched to EMS units, to EMS units mobilizing, to EMS units responding to the call. Increased efficiencies in call dispatch procedures can directly impact patient mortality in certain circumstances. Currently, the SRFECC plans to add personnel to accommodate and respond to the rising call volumes by training staff on dispatch software and radio usage, and maintaining dispatch software operations and radio communication quality. The additional planned staff may help to expedite call answering and processing times.

RECOMMENDATION

We recommend that the Sacramento Fire Department:

4. **Work with the SRFECC to identify ways to reduce call answer times to regularly reach the benchmark of 90 percent of calls answered within 15 seconds.**

SFD Has Not Adopted the NFPA-Recommended Turnout Standards for EMS Calls and Is Not Currently Meeting That Standard

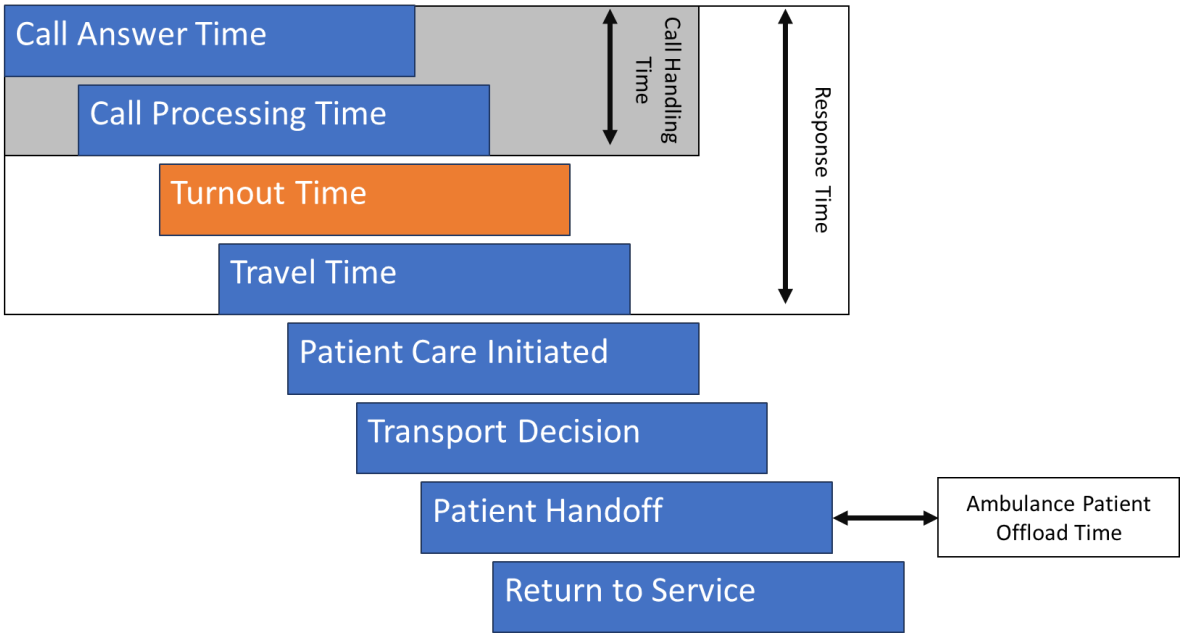
"Turnout Time" is defined by the National Fire Protection Association (NFPA) 1710[33] as "the time interval that begins when the emergency response facilities (ERFs) and emergency response units (ERUs) notification process begins by either an audible alarm or visual annunciation or both and ends at the beginning point of travel time." Turnout time essentially measures the amount of time it takes from when the fire station or vehicle is notified of the incident to when they start to travel towards the incident. Turnout time is largely driven by the staff's response but can also be impacted by station logistics and time of day.

Earlier sections of this report stated that evidence favors neither the commonly held "golden hour" principle nor an emphasis on transporting patients to the hospital as quickly as possible. However, that is not necessarily the case with EMS response time, which refers to how quickly the EMS unit arrives on scene. A rapid mobilization and response from EMS units has shown to affect patient survival rates for certain types of incidents, with some studies highlighting a response window as short as just four to five minutes. In that regard, turnout time can be a significant indicator of patient survival, as the quicker that EMS unit is prepared to drive to the emergency, the quicker they are able to arrive. Within the field of emergency medicine, response time has been considered an important performance measure for years.

Figure 20 shows where turnout time fits into the overall EMS response model.

[33] National Fire Protection Association. *NFPA 1710 Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments*. 2020.

Figure 20: Stages of Emergency Response

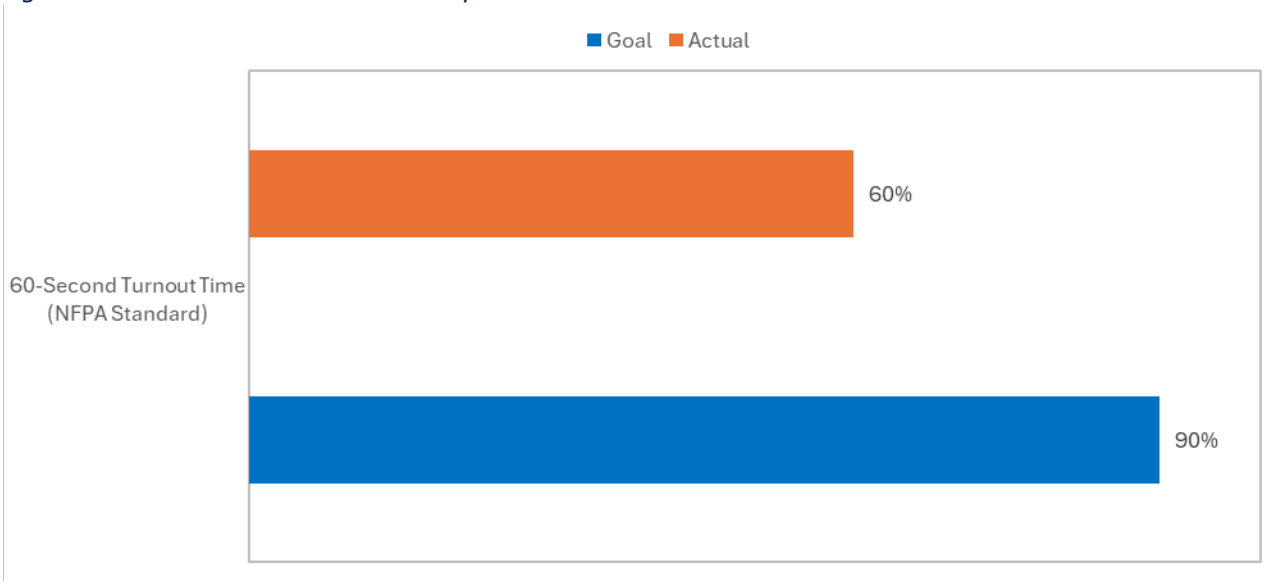


Source: Auditor generated based on NFPA 1221 and 1710.

The NFPA-recommended standard for EMS turnout time is to have emergency response units begin to travel within 60 seconds of alarm notification, 90 percent of the time. While the NFPA standard is considered best practice to which SFD adheres to unofficially, SFD does not currently have an internal policy that establishes a turnout time goal. As of time of writing this report, SFD is not measuring their turnout time performance against the NFPA standard.

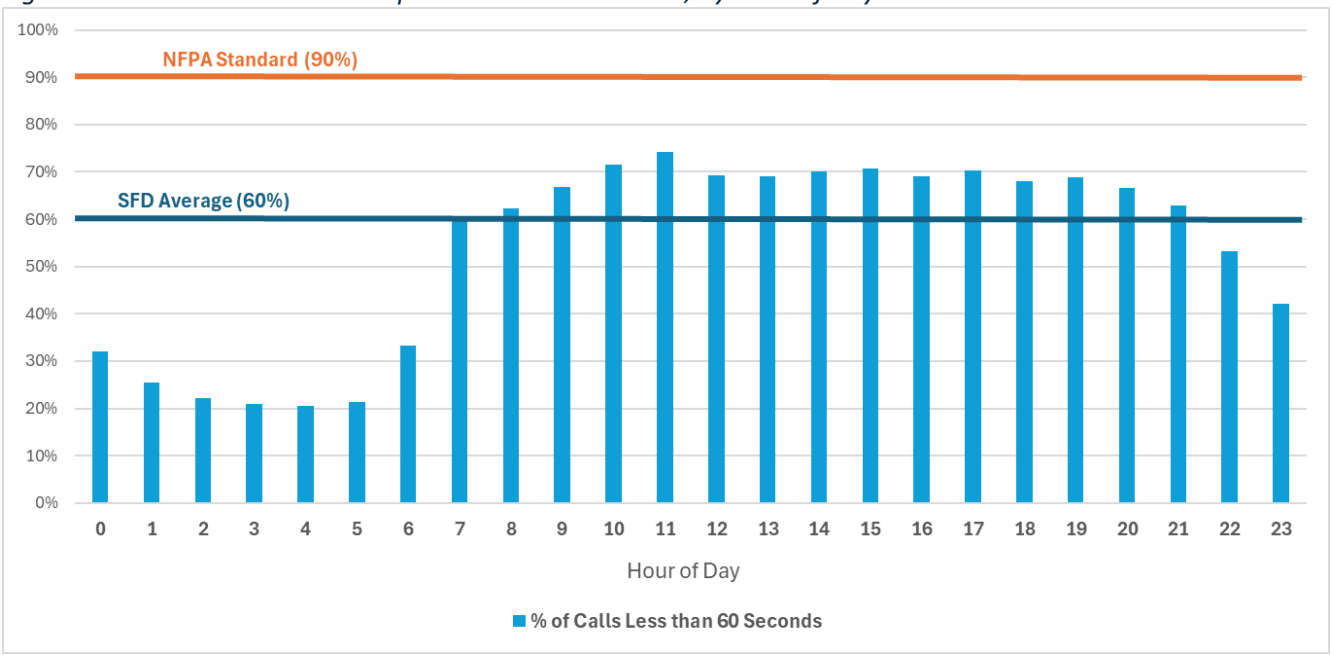
If it were an established policy, SFD performance for EMS calls would currently fall short of the 60 second, 90 percent NFPA standard, according to their calendar year 2024 dispatch data. Figure 21 shows that, for EMS calls in 2024, SFD units are achieving a turnout time of 60 seconds 60 percent of the time.

Figure 21: 2024 SFD Turnout Time Compared to 60-Second NFPA Guidance



We further analyzed the SFD's calendar year 2024 EMS dispatch data to evaluate performance against the NFPA-recommended standard by hour of the day, shown in Figure 22. During early morning hours, presumably when the firefighters are attempting to sleep, the percentage of dispatches that had a 60-second turnout time drops to around 20 percent, but rises above 70 percent during the midday hours.

Figure 22: SFD Turnout Time Compared to NFPA Standard, By Hour of Day



Source: Auditor generated based on Sacramento Fire Department dispatch data and NFPA guidance.

This may indicate that turnout time is adversely affected by SFD's 24-hour staffing model, as firefighters working on the ambulances must also find time to sleep.

Notably, the inaugural graduating class of the City's Emergency Medical Service (EMS) Academy would be the first group of single-role EMTs and single-role Paramedics with a modified shift schedule, in a departure from EMS personnel previously needing to perform both medical and fire mitigation roles. EMS academy graduates serve 12-hour shifts on a three days-on, three days-off schedule, rather than the 24-hour schedule served by the fire suppression personnel. SFD is also in the process of hiring dedicated EMTs and Paramedics—in addition to graduates from the EMS academy—that will not provide fire suppression services. In addition to any potential benefits to EMS personnel from the switch to a 12-hour shift from a 24-hour shift, the addition of single-role paramedics and EMTs is anticipated to generate revenue by increasing EMS response capabilities. It may also be worth evaluating the performance of the single-role paramedics to determine if the change in shift model has an effect on unit turnout times and response times, compared with those units staffed by dual-role firefighter-EMTs and firefighter-paramedics.

Evidence shows that reducing ambulance response times affect patient survival rates in emergencies such as cardiac arrest, and a key component of responding to a call is in the time in which EMS units are notified of the emergency and begin their travel time. In an effort to minimize that mobilization period, we recommend the SFD codify the 60-second NFPA turnout time standard as policy and begin measuring their progress towards achieving this goal.

RECOMMENDATION

We recommend the Sacramento Fire Department:

5. **Adopt the recommended NFPA 1710 turnout time performance measure of 60 seconds 90 percent of the time and work towards meeting this goal.**

Finding 4: EMS Policies Are Outdated and the EMS Continuous Quality Improvement Program Could be Strengthened

A quality improvement program involves systematic activities that monitor, assess, and make recommendations to optimize and improve the quality of health care. Organizations that implement quality improvement programs typically experience a range of benefits which include improved patient health outcomes, improved efficiency of managerial and clinical processes, avoided costs associated with process failures, and proactive processes that recognize and solve problems before they occur.

The EMS Division already engages in several internal quality assurance practices and they have made progress in building up their quality improvement practices, though there are opportunities to build them up. The State EMS Authority develops guidelines on implementing quality improvement programs, and those guidelines recommend EMS providers provide their quality improvement programs to the LEMSA for review. Based on our review of SFD's EMS continuous quality improvement program, we found the following areas could be strengthened:

- While the Sacramento Fire Department has reinstated the EMS Continuous Quality Improvement Committee, the Committee's roles and responsibilities should be clarified to strengthen oversight;
- EMS Patient Survey responses are not being used to inform the SFD's quality improvement processes;
- Paramedic certification data should be regularly reviewed to prevent lapses in accreditation; and
- EMS policies should be continuously reviewed and updated.

We recommend the SFD's EMS Division clarify and strengthen the staffing roles in its Continuous Quality Improvement Committee, update EMS policies, make better use of patient survey data, and regularly verify that accreditation records are complete and accurate.

While the Sacramento Fire Department Has Reinstated the EMS Continuous Quality Improvement Committee, the Committee's Roles and Responsibilities Should Be Clarified to Strengthen Oversight

While the State EMS Authority provides coordination for the planning, development and implementation of local EMS systems, the day-to-day operations of EMS programs are managed at the local government level. Local EMS agencies, or LEMSAs, provide essential functions such as developing treatment protocols and policies, designating trauma centers, identifying ambulance patient destinations, and collecting, analyzing and reporting EMS data, and more. This includes one of the core functions of a LEMSA, which is to provide oversight for quality improvement. Quality improvement differs from quality assurance, as the Centers for Disease Control and Prevention define quality improvement in health care as "a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community." Quality assurance, on the other hand, looks to prevent adverse events by correcting existing system flaws. Quality improvement is a more proactive approach, where quality assurance is a more reactive approach.

Most EMS agencies—71 percent, based on a nationwide survey from 2015—have personnel on staff working solely on quality improvement. However, because of funding constraints, the responsibilities of the City's CQI Committee are performed by volunteer staff through the use of overtime, and the Committee does not have a dedicated EMS coordinator at its lead. The staff of the CQI committee could benefit from additional clarification of their roles and responsibilities, which would help to strengthen efforts to continuously improve policies and operations based on patient data and surveys.

The *EMS System Quality Improvement Program Model Guidelines*[34] established by the State's Emergency Medical Services Authority promotes certain standards for CQI committees, such as that the QI team is supplemented by an internal Quality Improvement Program Technical Advisory Group to coordinate with the LEMSA, collect data, evaluate indicators, conduct meetings, develop improvement plans, and assure access to training.

The SFD Manual of Operations *Section XI – Subject 6 Continuous Quality Improvement Program* (CQI) establishes the requirements for the department to maintain a continuous quality improvement program and the general procedures to follow.

[34] EMSA #166 Emergency Medical Services System Quality Improvement Program Model Guidelines https://emsa.ca.gov/wp-content/uploads/sites/71/2017/07/emsa166.pdf. 2004

"OBJECTIVE
To provide a system whereby pre-hospital care, rendered by the Sacramento Fire Department personnel can be continuously monitored and evaluated, in accordance with specific indicators and thresholds, as identified by the County of Sacramento Office of Emergency Services, Department of Medical Systems. This system shall be peer driven. Also, this system shall seek to continuously improve the quality of patient care through the review of collected data for trends and to identify education and training needs.

PROCEDURE

- Establish a CQI Committee to monitor, evaluate, and report on the quality of pre-hospital care and potential improvement opportunities in the quality of that care.
- Identify potential system problems that may compromise patient care and develop appropriate corrective action strategies.
- Identify potential medical control problems involving patient care and develop appropriate corrective action strategies.
- Identify potential treatment discrepancies involving patient care and develop appropriate corrective action strategies.
- Monitor effectiveness of corrective action strategies through continuous audits.
- Identify exemplary cases of patient care, by individual and company actions.

All documents used or developed during the committee meetings shall be collected by the chairperson and filed in a secure location."

Data provided by SFD shows that operations of their CQI Committee exceed the standards that the SCEMSA sets, but that those operations are not currently being used to improve policies. For example, the number of patient care reports reviewed to look for gaps in EMS service delivery or to identify potential violations in conduct from EMS personnel exceeds the minimum standards set by the County EMS Agency, but data from CQI Committee operations do not affect change in SFD policy. SFD officials added that these functions of the Continuous Quality Improvement Committee are performed by SFD staff volunteers because of funding constraints. Those funding constraints also affect the quality of data reviews performed by SFD, as SFD officials stated that they are limited in their efforts to review survey responses from previous patients because of the time required to perform a comprehensive review of incidents. This means that feedback from the public might not be utilized to the fullest extent to address potential issues.

Having an active and effective EMS quality improvement committee demonstrates the City's commitment to excellence and the wellbeing of its residents, in addition to following best practices in EMS operations and operating in accordance with State regulations. Having staff dedicated to leading

the CQI Committee and reviewing patient care reports and patient surveys can help to better incorporate and address patient feedback, and potentially expand and grow the CQI committee as needed without relying on volunteer staff utilizing overtime.

RECOMMENDATION

We recommend the Sacramento Fire Department:

6. **Clarify the roles and responsibilities of its Continuous Quality Improvement committee to ensure that it is providing effective oversight capabilities, as well as to ensure that SFD is satisfying its own internal policies and the guidelines from the State's Emergency Medical Services Authority.**

EMS Patient Survey Responses Were Not Being Used to Inform the Fire Department's Quality Improvement Processes

Patient satisfaction surveys are a commonly used tool for evaluating the quality of health care delivery, and organizations may use them to dictate certain personnel behaviors or identify operational issues. Customer service surveys are a vital source of information the EMS Division can leverage to find out how the City's residents feel about the quality of medical services being provided. SFD currently utilizes a third-party vendor, Wittman Enterprises, to provide ambulance billing and accounts receivable services for the City's ambulance transport services since 2017, which also includes distributing surveys to 10 percent of the City's ambulance transport patients. SFD confirmed that, in the past, these survey results were not being utilized to inform process improvements for patient care, and SFD's Internal Investigator stated previously that they had not received complaints that were delivered through the Wittman surveys.

Between the dates of January 1, 2024 and December 31, 2024, Wittman received 819 completed surveys from former patients treated by the SFD regarding how the patients felt about the level of service they experienced. Ninety-seven percent of respondents rated their satisfaction with SFD's response to the incident as either "Excellent" or "Good," and only two percent was rated as either "Poor" or "Very Poor." Of the six survey questions, SFD scored the highest on "The Fire Department personnel were professional and courteous." [35]

Among a sample of survey responses from May 2024, there were positive reviews that included write-in comments showing appreciation for the care that EMS personnel showed in a time of crisis or the

[35] The other four questions were: "The Fire Department took time to explain their actions"; "If present, my pain was relieved"; "The Fire Department met my needs, even though I was not transported to the hospital"; and "My overall satisfaction with the Fire Department regarding this incident is:".

efforts to save the respondent's life or the life of a loved one. For example, one respondent wrote: "The team was very professional and treated my dad very well. I appreciate everything they did which saved my dad's life."

However, within that sample, there were surveys that shared criticisms or complaints about the conduct of SFD personnel. This includes complaints regarding billing, the inability of family members to ride in the ambulance, impatient dispatchers and EMS personnel, disagreements with patients about the severity of the incident, and indiscreet discussions of personal information. While the negative responses were a small percentage of the overall feedback, they provide a valuable resource for identifying employees that may require additional training.

If an individual wants to submit a complaint about SFD, in person, via mail, online or over the phone, there is a standard policy that SFD follows: the complaint is either directed to SFD's internal Professional Standards Unit for further investigation, or forwarded to the personnel's supervisor for review. In each complaint, the Fire Chief will make a determination on the outcome of the case based on the evidence and investigation. The Office of Public Safety Accountability (OPSA) provides civilian oversight of SFD's complaint process, audits departmental investigation results, and investigates misconduct complaints against SFD employees. OPSA, in its annual reports, stated that it fully reviewed 100% of the complaints against the SFD filed with them from 2021 through 2024. Of the 243 complaints in those four years, 59 complaints or 24% of the sum total were flagged by OPSA as needing additional scrutiny or oversight.

While SFD confirmed that Wittman survey results that identify complaints are submitted to the Professional Standards Unit, they added that those survey results are not currently being used to make operational adjustments or to foster an environment of continuous improvement. If survey results are not being used to inform practices, that feedback may end up being underutilized. Well-executed surveys of patient feedback can grant a better understanding of the views and needs of the patient populations. We recommend SFD incorporate the survey results into their continuous improvement processes.

RECOMMENDATION

We recommend the Sacramento Fire Department:

7. **Incorporate patient surveys into the Department's continuous quality improvement processes.**
8. **Provide copies of patient survey results to the Fire Department's Internal Investigator and the Office of Public Safety Accountability.**

Paramedic Certification Data Should be Regularly Reviewed to Prevent Lapses in Accreditation

EMT's and Paramedics are healthcare professionals whose responsibilities include assessing injuries and illnesses, providing emergency medical care, and transporting patients to medical facilities. EMTs are educated in patient assessment and providing treatments such as epinephrine for allergic reactions, administering oxygen and administering CPR for cardiac arrests; Paramedics go through additional training and therefore have more advanced life support knowledge and skills. The State of California requires all persons that provide EMT or Paramedic scope of practice emergency medical services to obtain a license. An EMT or Paramedic license is the legal right to practice as an EMS professional within a set scope of practice. As part of the licensing process, EMT's and Paramedics are required to regularly attend training and recertify their skills, to make sure they are aware of new protocols and to keep their skills up-to-date.

In addition to the Paramedic and EMT licenses, there are other certifications and trainings that are required to be completed and/or maintained, either by regulation or City policy. SFD tracks approximately 11,000 certifications and certification expiration dates for active employees. We reviewed the data to determine if any employees had expired licenses. Figure 23 shows the number of active user licenses that were listed as "expired" in SFD's tracking system.

Figure 23: Count of Expired Credentials from SFD's Tracking System as of September 2025

Credential Name	Count of Expired
Advanced Cardiovascular Life Support	2
CPR Card	3
EMT-Basic	1
EMT-Basic for Reserves Only	13
EMT Sac County Accreditation	2
First Responder	1
Paramedic Infrequent Skills Verification Form	9
International and Prehospital Trauma Life Support	1
Pediatric ALS/Handtevy Pediatric Resuscitation	4
Paramedic	2
Paramedic for Reserves Only	4
Sacramento County Paramedic Accreditation	2
Grand Total	**44**

Source: Auditor generated based on Target Solutions training data.

We found 44 certifications that were listed as expired in SFD's internal tracking system. It is important to note that this data is from SFD's internal system and does not reflect the actual status of a certification with Sacramento County. For the two individuals with expired paramedic licenses, their credentials also show as having lapsed in the Emergency Medical Services Personnel Registry maintained by the State

EMS Authority. We also found that one of the two employees with an expired paramedic certification was receiving a paramedic pay incentive at the time of writing.

If the City doesn't identify lapsed certifications, personnel may end up performing their duties without the required licensing and potentially lead to increased risk and liability for the City. We recommend SFD strengthen their processes for reviewing employee certifications and tracking expired certifications.

RECOMMENDATION

We recommend the Sacramento Fire Department:

9. **Strengthen their processes by which employee certifications are reviewed to ensure that they are current and strengthen certification tracking processes to prevent certifications from lapsing.**

EMS Policies Should Be Continuously Reviewed and Updated

The GAO's *Standards for Internal Control in the Federal Government*[36] states that "management should implement control activities through policies and procedures" and that "management reviews policies, procedures, and related control activities on a periodic and ongoing basis for continued relevance and effectiveness in achieving the entity's objectives or mitigating related risks." The *Manual of Operations* stores SFD's policies that encompasses most areas of their operations, including but not limited to: Fire Operations, Apparatus Maintenance, Safety, Training, Communications, Fire Prevention, and EMS. SFD has 73 policies in the EMS section, with many of the policies consisting of only a few pages. When we reviewed these policies, we found that 62, or 85 percent, had not been updated in over 25 years. Figure 24 shows a sample of the SFD's EMS policies with their most recent revision date.

[36] U.S. Government Accountability Office. *Standards for Internal Control in the Federal Government*. https://www.gao.gov/assets/gao-25-107721.pdf. Page 56. May 2025.

Figure 24: Sample of Fire Department Manual of Operations Most Recent Policy Revision Dates as of August 2025

Policy Section	Policy Title	Revision Date
SECTION XI – Subject 10	Assisting Medic Unit Personnel During Transport	1996
SECTION XI – Subject 47	Backboards	1996
SECTION XI – Subject 64	Bio-Hazard Waste Containers	2011
SECTION XI – Subject 20	BLS Patient Evaluation Report Form (SFD-28) - Completion and Dispersal	1996
SECTION XI – Subject 17	BLS Release at Scene (R.A.S.)	2002
SECTION XI– Subject 42	Cardiac Monitor/Defibrillator Operation, Inspection, and Maintenance (ALS)	2006
SECTION XI – Subject 27	Child Abuse, Mandatory Reporting of Suspected	1996
SECTION XI – Subject 25	Code 2 Response on Violent Crimes	1996
SECTION XI – Subject 62	Communicable Disease Exposure Procedure	2011
SECTION XI – Subject 31	Contacting the Disaster Control Facility (DCF) at the scene of an EMS incident	1996
SECTION XI – Subject 6	Continuous Quality Improvement Program (CQI)	1996
SECTION XI – Subject 51	Controlled Medications Security and Procurement	2014
SECTION XI – Subject 8	CPR/Determination of Death	1996
SECTION XI – Subject 16	Daily Vehicle Inspections (Medic Units)	1996
SECTION XI – Subject 63	Disinfecting Equipment, Uniform Contamination & Disposing of Contaminated Waste	2011
SECTION XI – Subject 4	Duties and Responsibilities of the EMS Shift Captains	2010
SECTION XI – Subject 56	Emergency Medical Services Incident Report (SFD-165)	1996
SECTION XI – Subject 65	Emergency Response Employee Report (ERE) – Communicable Disease	2011

Source: Auditor generated based on Sacramento Fire Department Manual of Operations.

Based on the revision dates, most of SFD's policies for EMS have not been updated since 1996. SFD does occasionally issue "Directives" in the form of an email or PDF document that provides direction to staff. However, these directives have not been incorporated into their formal policy documents.

For example, Section XI – Subject 27 *Child Abuse, Mandatory Reporting of Suspected* lists three phone numbers to call depending on the circumstance. However, when we tried to call these numbers, we found the Child Protective Services number and the County Sheriff's number were no longer in service, and that the Sacramento Police Department has an alternative non-emergency number listed on their website.

Figure 25: Excerpt from the Fire Department Manual of Operations

II. Suspected child abuse must be reported immediately by telephone:

A. In cases of child abuse by a family member, call Child Protective Services (CPS) at 366-2386.

B. In cases of child abuse by an unrelated person, call the Sacramento Police Department at 264-5471, if the incident is within the City limits.

C. In cases of child abuse by an unrelated person, call the Sacramento County Sheriff's Department at 440-5115, if the incident occurred outside of the City limits.

Source: Sacramento Fire Department Manual of Operations.

Another example of an outdated policy is *Section XI Subject 46 Zoll Battery Testing*, which describes the importance of maintaining charged batteries to prevent monitor/defibrillator failures. Monitor/defibrillators are a critical component in performing CPR and treating cardiac arrest. SFD stated that they transitioned from using the Zoll brand monitor/defibrillator to the Stryker LIFEPAK 15 in 2019. This policy is very specific to the Zoll lead-acid battery model which states that batteries should be tested every two months, which is no longer relevant given the newer model the department uses now comes with a battery indicator light.

Figure 26: Manual of Operations Section XI Subject 46 Zoll Battery Testing

MANUAL OF OPERATIONS

DATE : July 30, 1996
SECTION: XI
SUBJECT: 46
PAGE : 1 of 2

SUBJECT: ZOLL BATTERY TESTING

OBJECTIVE:

To have a standardized program to maintain and test the Zoll lead-acid monitor/defibrillator batteries and to prevent monitor/defibrillator failures from bad batteries.

PROCEDURE:

A. All Zoll batteries must be tested at least every four (4) months. The Zoll batteries should be tested every two (2) months. Testing the Zoll monitor/defibrillator batteries helps prevent a monitor/defibrillator failure and increases the batteries life.

B. At a minimum, test the least recently tested battery on the first of the month.

C. Before you test a battery it must be fully charged. Fully charge the battery you want to test in any charge well. After the battery is fully charged, the ready light at the base of the charger will be fully lit.

D. Move the battery you want to test into the test well and press test.

Source: Sacramento Fire Department Manual of Operations.

We also noted there were no policies that address unhoused patients or treatment of the mentally ill. SFD may also want to perform a gap analysis and determine if there are any additional areas where a policy should be created to address the changing needs of the City.

The benefit of regularly revisiting policies is it ensures that processes are consistently improving. The risk of not actively updating policies is that the information contained in the policies may no longer reflect current standards or in some cases, may contain inaccurate information. Regular policy evaluation helps to maintain standards of compliance, and limits employee confusion by keeping messaging consistent and cohesive. According to SFD, they attempted to implement a policy update in 2015, but were unable to have the process finalized. They have made several attempts to update their policies, but were unable to garner approval in discussions with the Labor Relations division. We recommend that, as part of the Department's continuous improvement program, policies should be reviewed on a regular basis, as should attempts at policy revisions.

RECOMMENDATION

We recommend the Sacramento Fire Department:

10. **Perform a gap analysis to identify missing EMS policies that should be added to the Manual of Operations.**
11. **Develop a process to regularly review and update EMS policies.**

City of Sacramento Fire Department
Chris Costamagna, Chief

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Sacramento, CA 95822
Phone: 916-808-1300

Memorandum

Date: May 13, 2026
To: Farishta Ahrary, Auditor, City of Sacramento
From: Tilden Billiter, Deputy Fire Chief
Ref No: 26-2
Subject: The Audit of Sacramento Fire Department EMS Division

The Sacramento Fire Department appreciates the opportunity to review this report and respond to the recommendations proposed by the Office of the City Auditor. These recommendations are listed below, as well as the fire department's response for each:

Recommendation 1: Collaborate with the Sacramento Regional Fire/EMS Communications Center to continue to explore programs where non-emergency calls are diverted to an alternative resource response and discuss opportunities to expand dispatching authority for alternative response units, such as the Mobile Crisis Unit.
Response 1: The Sacramento Fire Department (SFD) supports the ongoing implementation of alternative response models. This approach aligns with the EMS vision of delivering the appropriate service to each patient in a timely manner, ensuring equitable care for all members of the community. Furthermore, adopting these strategies enhances the availability of both first responder and ambulance resources for emergency situations.

Recommendation 2: Continue to make progress expanding alternative response units.
Response 2*:* Agreed. SFD has implemented alternative response resources; expanding this model will help EMS deliver the right service to the right patient at the right time.

Recommendation 3: Continue to work with the area hospitals to ensure compliance with California Assembly Bill 40 and continue monthly Ambulance Patient Offload Time committee meetings with stakeholders, which may result in reductions in patient offload times.
Response 3: Agree. Persistent delays at hospitals profoundly affect the SFD's ability to fulfill its mission. Extended wait times limit the availability of ambulances for emergency responses, increase overall response times, and ultimately diminish the quality of care provided to the community. The SFD remains steadfast in its commitment to actively participate in the County-Wide Ambulance Patient Offload Time (APOT) Working Group, which is dedicated to reducing APOT throughout the county.

Recommendation 4: Work with the SRFECC to identify ways to reduce call answer times to regularly reach the benchmark of 90 percent of calls answered within 15 seconds.
Response 4: The SFD acknowledges the challenges faced by SRFECC in consistently achieving call answer time benchmarks, given the current staffing levels and increasing call volume. We fully support SRFECC's initiative to increase personnel in order to better accommodate and respond to the growing demands.

Recommendation 5: Adopt the recommended NFPA 1710 turnout time performance measure of 60 seconds 90 percent of the time and work towards meeting this goal.
Response 5: Agree. Additionally, the SFD would support the City of Sacramento adopting the entirety of NFPA's, Stages of Emergency Response Standard.

Recommendation 6: Clarify the roles and responsibilities of its Continuous Quality Improvement committee to ensure that it is providing effective oversight capabilities, as well as to ensure that SFD is satisfying its own internal policies and the guidelines from the State's Emergency Medical Services Authority.
Response 6: Agree. At present, the SFD surpasses SCEMSA standards in CQI incident review. Moreover, the SFD has utilized its existing CQI committee to establish clearer roles and responsibilities, along with ensuring adherence to both internal and external policies.

Recommendation 7: Use patient survey results to inform the department's Continuous Quality Improvement Program and develop a process to address complaints of poor service.
Response 7: Agree. The SFD has developed and implemented an internal process to address complaints of poor service.

Recommendation 8: Provide copies of patient survey results to the Fire Department's Internal Investigator and to the Office of Public Safety Accountability.
Response 8: Agree. The SFD now forwards complaints to the Professional Standards Unit (PSU), which then shares with OPSA post investigation with OPSA.

Recommendation 9: Strengthen their processes by which employee certifications are reviewed to ensure that they are current and strengthen certification tracking processes to prevent certifications from lapsing.
Response 9: Agree. Our internal process has already been updated to address this issue. The new approach uses technology and places a deliberate emphasis on all SFD certifications.

Recommendation 10: Perform a gap analysis to identify missing EMS policies that should be added to the Manual of Operations.
Response 10: Agree. This has been completed and is currently with Labor Relations.

Recommendation 11: Develop a process to regularly review and update EMS policies.
Response 11: Agree. The SFD regularly reviews and updates EMS policies, but faces challenges with City of Sacramento approval process.