



Santa Clara County Stroke Plan 2019

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California Emergency Medical Services Authority
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Executive Summary

California statute mandates the Emergency Medical Services Authority (EMSA) to adopt necessary regulations to carry out the coordination and integration of all state activities concerning Emergency Medical Services (EMS) (Health and Safety Code §1797.107).

In addition, State statute allows the EMS Authority to establish guidelines for hospital facilities, in cooperation with affected medical organizations, according to critical care capabilities (Health and Safety Code §1798.150).

As a result of these statutes, the EMS Authority established a multidisciplinary stroke taskforce for the development of Stroke System of Care Regulations for California.¹

California's Statewide Stroke Critical Care System is described in the California Code of Regulations; Title 22, Division 9, Chapter 7.2. These regulations outline the requirements of all components of the Stroke Critical Care System including the Local Emergency Medical Services Agency (LEMSA), prehospital providers, and hospitals.

Few things in medicine, certainly in EMS, have been changing as rapidly as the treatment of acute stroke. Of the 11 hospitals in Santa Clara County, 10 are designated stroke centers with four of those 10 designated as comprehensive stroke centers, the remainder being primary stroke centers. 2018 was the first full year following implementation in December 2017 of a stroke severity scale and the selective triage of suspected stroke patients directly to a comprehensive stroke center.

Because data management, quality improvement and the evaluation process all have a vital role in providing high quality care to the stroke patient; these items have also been identified in the regulations. The overall goal of the regulations is to reduce morbidity and mortality from acute stroke disease by improving the delivery of emergency medical care within the communities of California.

The Santa Clara County Emergency Medical Services Agency (SCCEMSA) has been involved with the regulation development process alongside state and hospital system representatives. Santa Clara County already has many of the regulations in place, including prehospital care policies to identify stroke patients, identify designated stroke receiving hospitals, and stroke destination policies.

As a requirement of the California Regulations, this document is to serve as a formal written plan for the SCCEMSA Stroke Critical Care System.

Santa Clara County Emergency Medical Services Agency's Stroke Critical Care System Plan has been written in accordance with Title 22, Division 9, Chapter 7.2 of the California Code of Regulations.

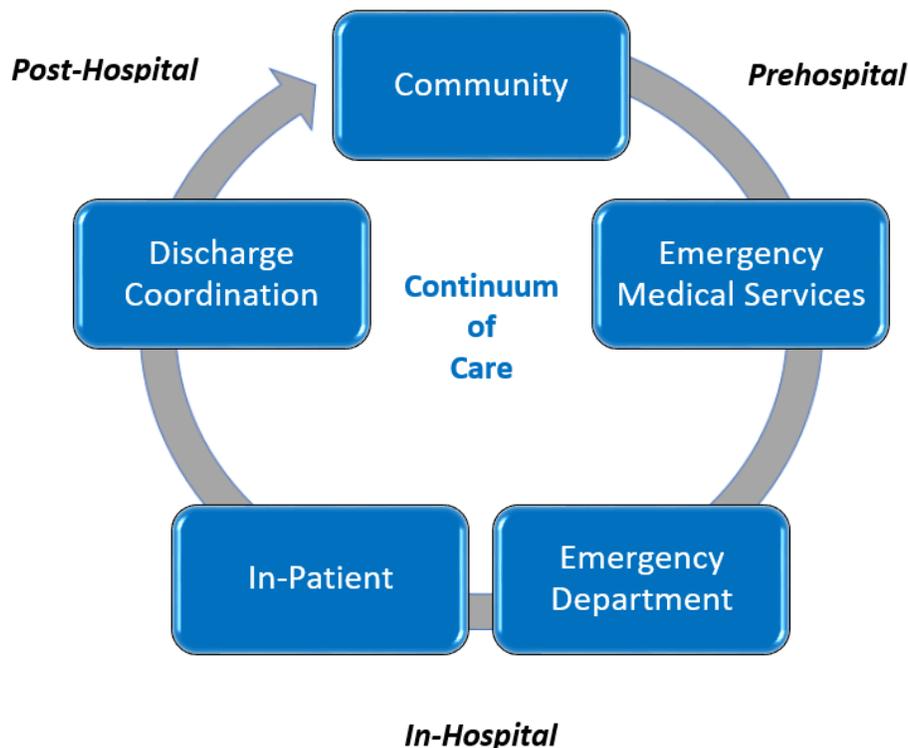
¹ <https://emsa.ca.gov/about-stroke/>

Stroke Critical Care System

Every year approximately 795,000 adult Americans suffer a stroke. Someone dies from stroke every four minutes and is the most common cause of adult long-term disability in the United States. It is a life-changing event that places heavy burden on patients, families, and caregivers. When a patient is suffering an ischemic stroke, timely intervention is critical to reverse the damage, reduce mortality, morbidity, and disability in addition to improving survivor quality of life.

Although there are 172 designated stroke centers in California, there have been no standardized statewide requirements for the development and implementation of a stroke critical care system until now. Hospitals have traditionally been designated as a stroke receiving hospital by their Local EMS Agency because of differing standards from one geographic area to the next. Public safety is best served when patients receive a standard of care based on national standards and best practices. This implementation of standardized statewide requirements for stroke care will provide consistent care across the state.

Santa Clara County's Stroke Critical Care System is a subspecialty care component of the EMS system that was developed by the Santa Clara County EMS Agency. This critical care system links prehospital and in-hospital care to deliver treatment to stroke patients who potentially require immediate medical or surgical intervention.

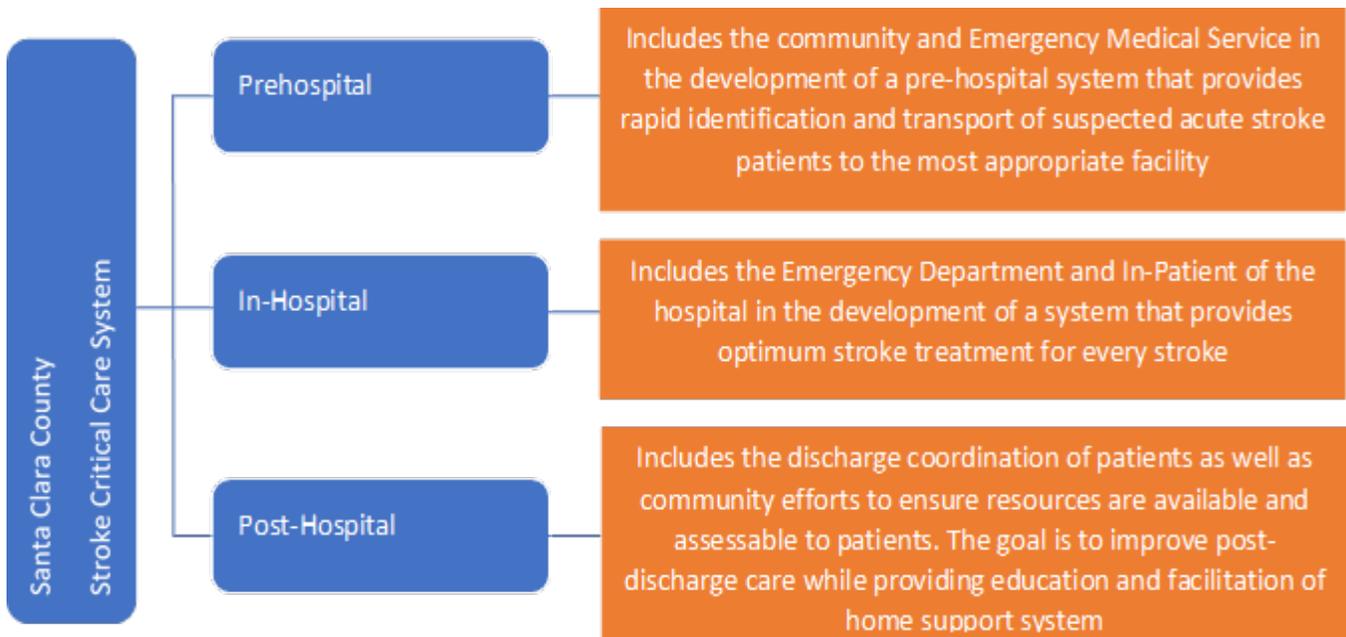


Stroke Continuum of Care

Stroke systems of care improve care and support for stroke patients throughout their health care journey. Over the last several years patient care has improved from the first symptoms of stroke through the transition from EMS to hospital care, throughout rehabilitation and follow up with primary care physicians to prevent complications and second strokes. Together, EMS agencies, hospitals, and health care facilities collect and analyze data about stroke patients and care. When best practices and data are shared, the different disciplines can work together to improve patient care.²

The continuum of care is important to caregivers and patients alike. It leads to an improvement of patient satisfaction levels, reduces costs, and improves health. Keeping up the continuum of care is especially significant for specific patient populations such as those patients who are more dependent on the health services, elderly patients, patients suffering from complex medical conditions, mentally vulnerable patients and patients with chronic diseases. Due to the aforementioned examples, the continuum of care is particularly beneficial to the stroke patient population. Stroke systems of care depend on robust collaboration to ensure that the continuum of care is optimally exercised.

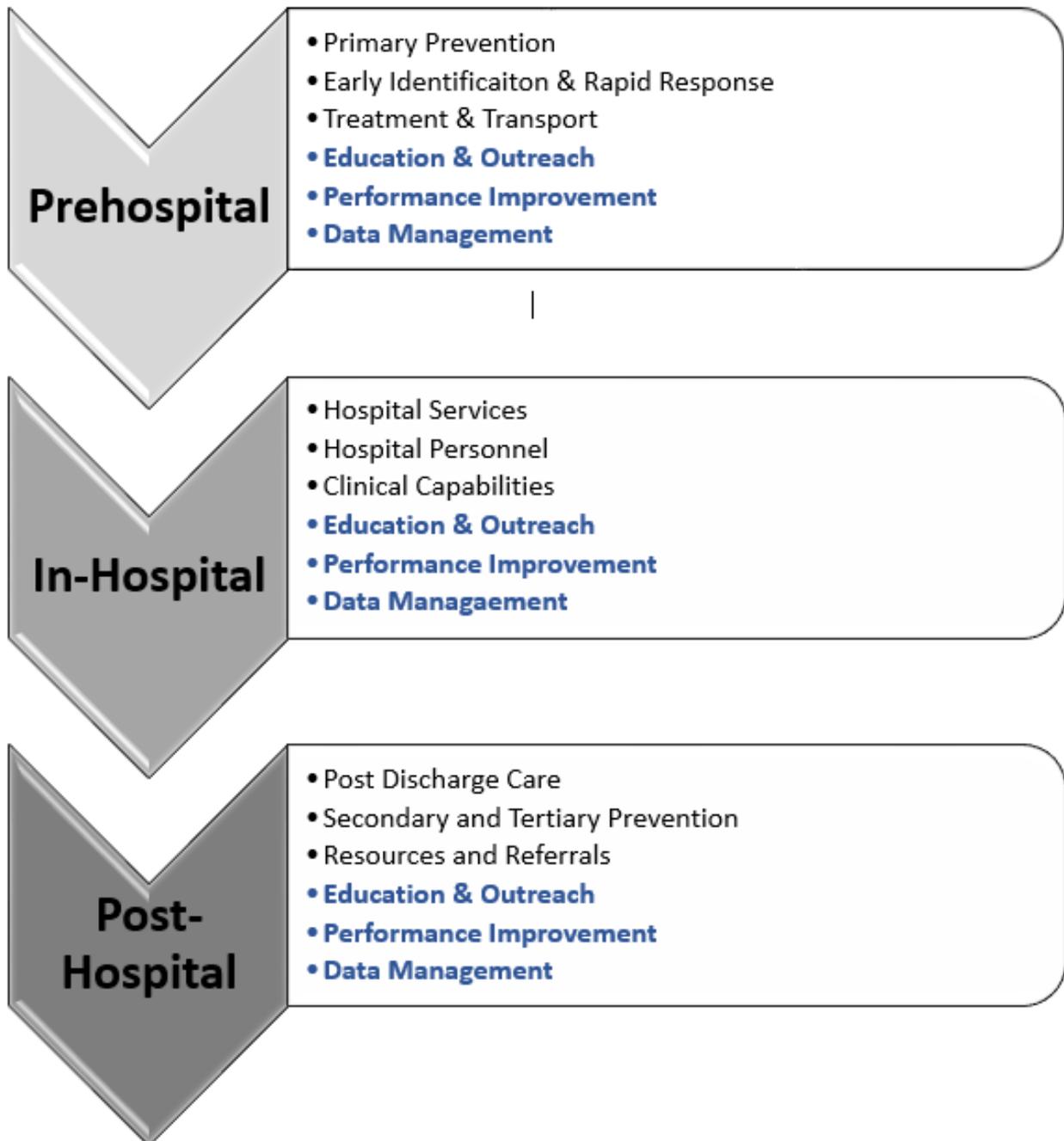
The Santa Clara stroke continuum of care can be broken down and evaluated at three levels:



² https://www.cdc.gov/dhdsp/programs/about_pcnasp.htm

Goals within the Continuum of Care

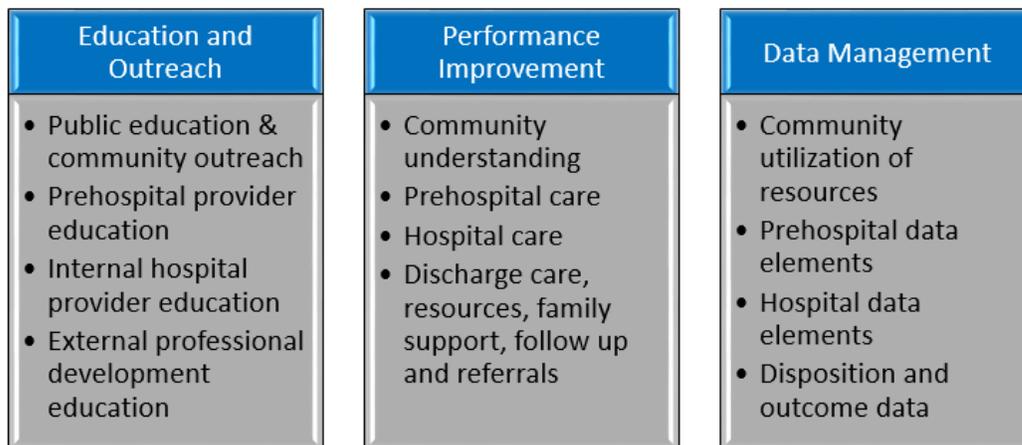
Within each level of the continuum of care, there are identified goals designed to build safety into the stroke system of care, ensuring that patients receive the safest, most reliable care across the continuum.



Three Areas of Collaboration: A Team Approach

Recognizing that patient outcomes are greatly dependent on the quality of care within each level of care on the continuum, it is critical for Santa Clara providers to work in collaboration with a team approach wherever possible. Common themes span across the Prehospital, In-Hospital and Post-Hospital levels that identify opportunities to maximize SCCEMSA's team approach to care of the stroke patient.

- Education of the community, EMS and other healthcare professionals promote and support an integrated system of care. Interprofessional and interdisciplinary education systems prepare care providers to work collaboratively together as a team. When combined with community education and outreach efforts, the patients and their families have an active role in their personal health and well-being.
- Performance Improvement invariably involves work across multiple systems and disciplines within a practice. Within the healthcare practice continuum, this is particularly applicable as patients have various formal and informal care providers throughout their course of illness and into their discharge disposition.
- Good data can help identify, verify and proactively address issues, measure progress and capitalize on opportunities. When data is gathered, tracked, and analyzed in a credible way over time, it becomes possible to measure progress and success. Policies, procedures, services, and interventions can then be evaluated, modified, and improved.



A team approach from a truly integrated healthcare system will go beyond education, outreach, performance improvement and data management /sharing. SCCEMSA's aim is to create a seamless system, which requires EMS professionals and community partners to commit to the same-shared objectives and find ways to achieve them together. This team approach from a people-centered EMS system takes advantages of the strengths and resources brought by each organization and provider to protect the health and wellness of individuals and communities.

Stakeholders

Santa Clara County EMS Agency

Serving 1,938,153 people, the Santa Clara EMS Agency works diligently to ensure that the communities, which are spread over its approximate 1,132 square-miles, have access to stroke treatment and services that provide quality care based off best practices and evidence-based research.

SCCMSA's specialty care programs are further refined by the agency's commitment to excellence as defined in the Vision, Mission, and Values:

Vision

Assuring an EMS system in Santa Clara County that provides safe, quality, and effective prehospital care.

Mission Statement

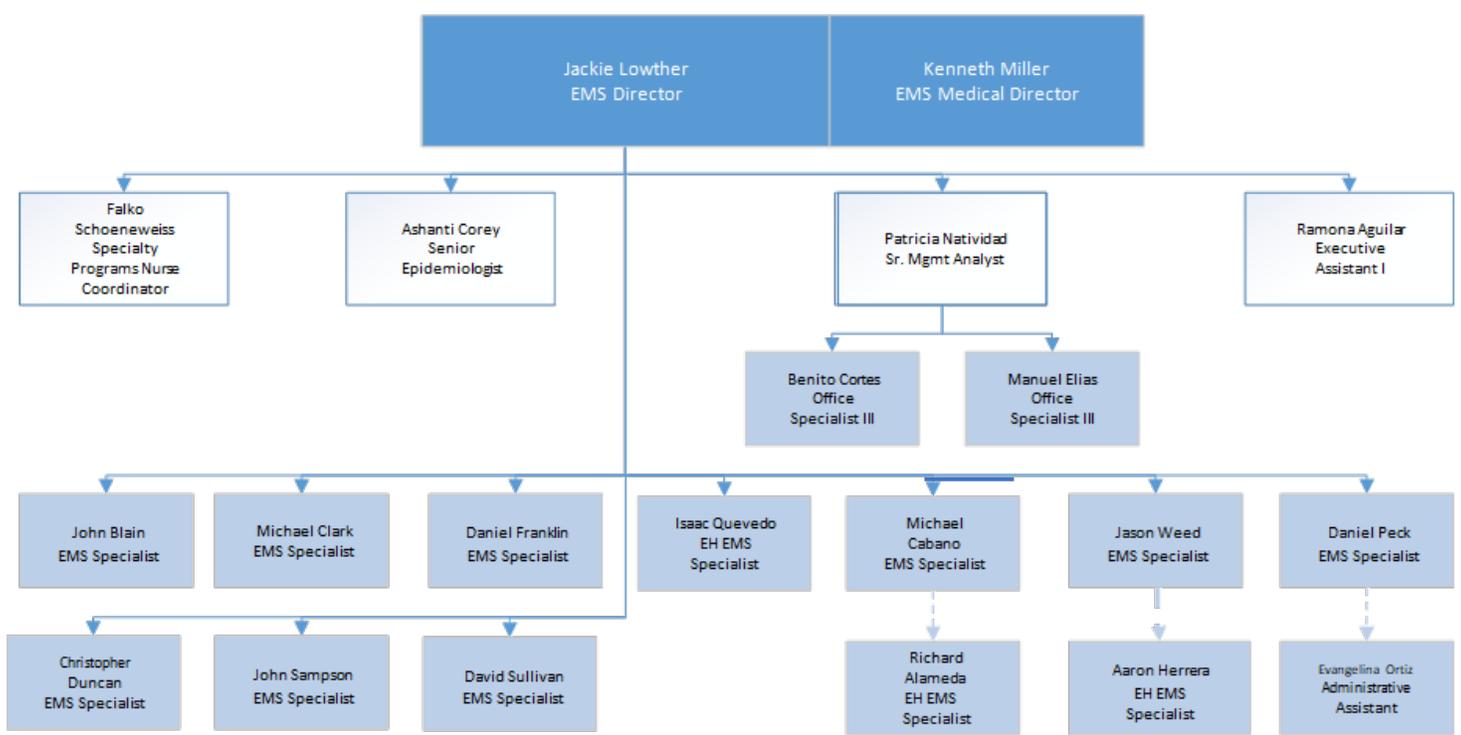
The Santa Clara County Emergency Medical Services Agency is an essential service dedicated to ensuring the provision of quality patient care to the people of Santa Clara County through collaboration, facilitated regulation, and system management.

Values

- **Dignity and Respect:** We treat people with dignity and respect.
- **Progressive Innovation:** We are dedicated to the continuous improvement of our processes and systems, based on science, data, and best practices.
- **Professionalism and Objectivity:** We treat all individuals and organizations professionally, fairly, and without prejudice.
- **Leadership:** We lead through collaboration and facilitation to ensure accountability, the provision of quality patient care, while ensuring fiscal and operational stability.
- **Participation:** We value the contributions of the public, other agencies, and organizations in the development, implementation, and evaluation of the Santa Clara County EMS System.

The Santa Clara County Emergency Medical Services Agency is comprised of an EMS Director, EMS Medical Director, Specialty Programs Nurse Coordinator, ten EMS Specialists, one Senior Epidemiologist, one Senior Management Analyst, one Executive Assistant, one Administrative Assistant, two Office Specialists III's and two Extra Help EMS Specialists. Although each staff member has a different role in the Stroke Critical Care System, it is through the work that is managed collectively as a group that the Stroke System exhibits optimal performance.

Santa Clara County EMS Agency Organization Chart



Santa Clara County Stroke Centers

Santa Clara County has ten (10) prehospital receiving centers. The Joint Commission currently certifies all ten of the receiving centers as Primary Stroke, two Comprehensive and one Thrombectomy Capable Stroke Centers.

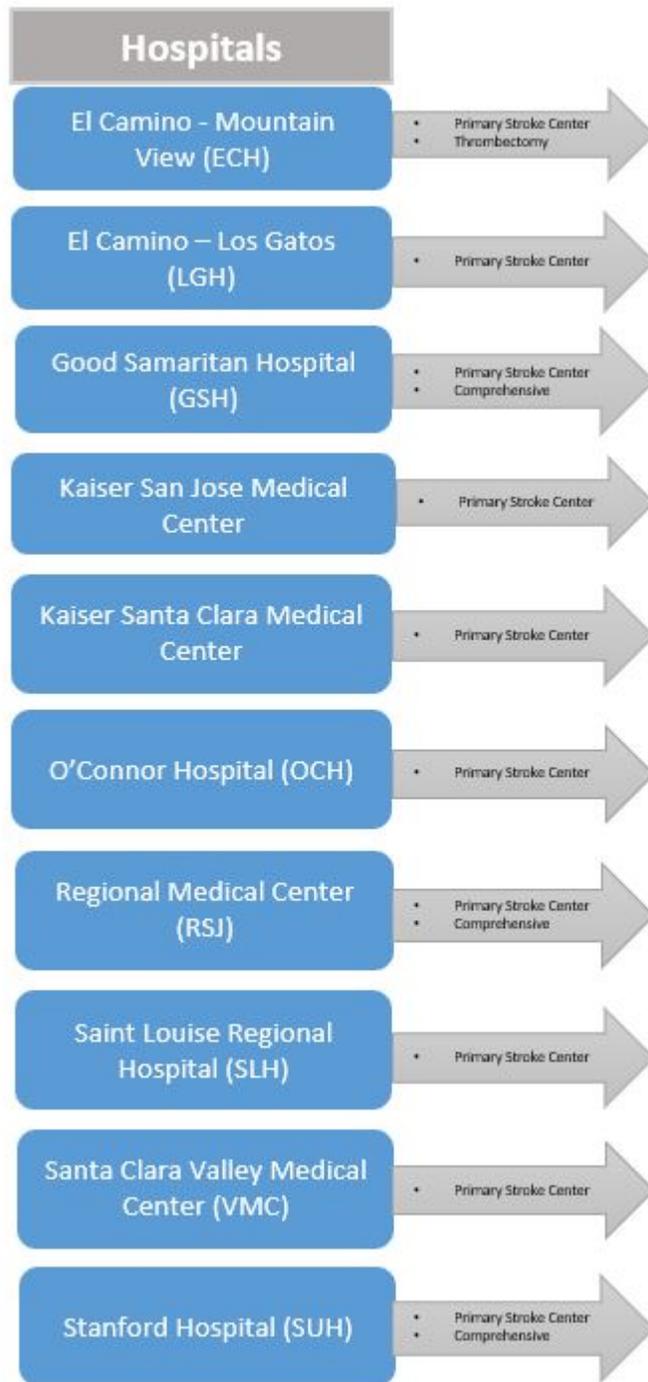
The California State Regulations define a Primary Stroke Center as a hospital that “...stabilizes and treats acute stroke patients, providing initial acute care, and may transfer to one or more higher level of care centers when clinically warranted”.

The California State Regulations define a Comprehensive Stroke Center as a hospital that “...diagnose and treat all stroke cases and provide the highest level of care for stroke patients”.

Santa Clara County Emergency Medical Services Agency has written agreements with hospitals that are designated stroke receiving hospitals. To be considered for stroke receiving center designation, hospitals must hold current certification as a Primary Stroke Center by The Joint Commission and will begin filling out a SCCEMSA Stroke Center Designation Application packet starting on January 1, 2021. The application packet will contain an evaluation tool that SCCEMSA will use to ensure that the facility meets the requirements to receive Stroke Center Designation.

Stroke Centers must also maintain compliance with Santa Clara County EMS Agency designation criteria outlined in Policy document #409 and #412.

Stroke Center Standards & Stroke Center Designation.



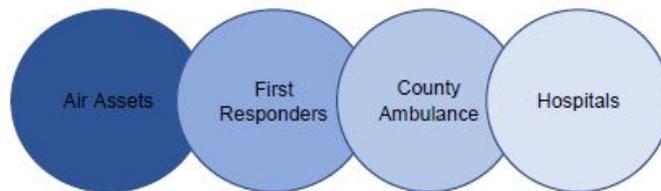
SCC Stroke Center Designation Application Packets will be available in January 2021.

Santa Clara County Prehospital Providers

The County of Santa Clara currently has a non-exclusive EMS Advanced Life Support (ALS) First Response and Advanced Life Support Emergency Ambulance Services. The county has a contract with Rural/Metro of California providing 911 transport services. A combination of ground, air and specialty CCT transport are all offered within the county. The community can access emergency services through the 9-1-1 system.

Once on scene, the first responder and ambulance transport crews coordinate their efforts to rapidly identify, treat, and transport stroke patients to a Stroke Receiving Center. When needed, prehospital providers can contact base hospital personnel for medical support. Field crews notify the Stroke Receiving Center of the incoming patient with a “*Stroke Alert*” radio report to allow hospital staff to prepare for expeditious triage and treatment upon patient arrival.

Prehospital providers work closely with the hospital staff to ensure that all pertinent information is relayed for a seamless transition within the continuum of care.



The Stroke Patient

SCCEMSA believes that early identification of stroke symptoms by emergency medical personnel is a valuable part of optimal care for the victims of stroke. EMS professionals should attempt to determine the time of onset of the patient’s neurological symptoms and the time the patient was last known to be symptom free. Time of onset is an essential component of prehospital stroke screening instruments and may be a factor in determining triage and transport modality decisions.

It is imperative that both field and hospital clinicians are well trained and educated on stroke assessments including the utilization of a stroke screening tool that is used universally within the Santa Clara Stroke System.

Santa Clara County Emergency Medical Services Agency has a policy in place to assist field providers in the rapid identification of a patient who may be suffering a stroke. Policy document # 700-A13: *Stroke*; describes signs and symptoms of a suspected stroke and gives direction for treatment therapies including the application of G.F.A.S.T. (Gaze, Facial Droop, Arm Drift, Speech, Time).

G Gaze Deviation	(0-1)
F Facial Droop	(0-1)
A Arm Drift	(0-1)
S Speech Abnormalities	(0-1)
T Time Last Seen Normal	(No points)

The GFAST stroke severity scale correlates well with the National Institutes of Health Stroke Severity Scale (NIHSS). The NIHSS is a 15-item scale with a score of 0-42. Values of 16 or greater indicate moderate to severe stroke symptoms. When all four findings of the GFAST stroke severity scale are present, the median NIHSS score is 14 with a range of 8-22. When one, two or three of the GFAST findings are present, but not all four, the median NIHSS score is 3 with a range of 1-8. Of patients presenting with all four GFAST findings 63% are found to have a stroke due to small or large blood vessel occlusion. The remainder have one of several forms of intracranial bleeding, transient ischemic attack, or occasionally an encephalopathy, unwitnessed seizure, complex migraine or sepsis. In contrast, of patients presenting with one, two or three, but not all four, GFAST findings 35% are found to have a stroke due to small or large blood vessel occlusion.

The reason for introducing a field expedient stroke severity scale is to identify suspected stroke patients with more severe blood vessel occlusion and transport them to a hospital with resources to provide both intravenous clot lysis as well as evaluate the patient for potential endovascular clot retrieval thereby avoiding the need for an inter-hospital transfer between a primary and comprehensive stroke center. Many factors go into the decision to offer endovascular clot retrieval to a patient with a large blood vessel occlusion stroke. Across all diagnosed strokes approximately 5-11% go on to endovascular clot retrieval. That proportion increases in patients who present early in the development of their stroke symptoms.

The median door-to-intervention interval for clot lysis across all primary and comprehensive stroke centers is 43 minutes. The American Heart Association/American Stroke Association (AHA) guideline is 60 minutes in at least 50% of patients. In patients arriving directly to a comprehensive stroke center and going on to receive endovascular clot retrieval, 52% of patients received that intervention within 120 minutes. The AHA guideline is 120 minutes (with a preferred 90 minutes) in at least 50% of patients. However, when a stroke patient was transferred from a primary to a comprehensive stroke center for endovascular clot retrieval only 9% of patients had a 'first door-to-intervention' interval (arrival at primary stroke center to intervention at comprehensive stroke center) of 120 minutes or less.

Destination

In stroke systems of care, stroke patients should be transported to the most appropriate facility staffed and equipped to manage an acute stroke patient. This determination will include assessments of local resources and transport times.³

In the rare situation that the closest, most appropriate stroke center is not available to accept a stroke patient due to an internal disaster or a failure of all Computerized Axial Tomography (CT) scanners, field providers will transport the patient to the next closest, most appropriate stroke center.

Santa Clara County Emergency Medical Services Agency has a policy in place to assist field providers in determining destination for a potential stroke patient. Policy document 602; *Destination Policy*; outlines the destination facilities for patient populations requiring specialty systems of care.

Communication

Emergency Medical Service personnel should provide pre-hospital notification to the stroke-receiving center that a suspected stroke patient is en route so that the appropriate hospital resources may be mobilized before patient arrival.⁴

Santa Clara County prehospital providers have two ways to make pre-hospital notification. In addition to the 800 MHz radio system available to transporting units in Santa Clara, providers have a phone number that is assigned to each receiving hospital for the purposes of receiving radio reports. Either method of communication is reliable and is utilized frequently amongst field crews.

Santa Clara County Emergency Medical Services Agency has a policy in place to give direction on administering a notification report to receiving hospitals. Policy document #501; *Hospital Radio Reports*; addresses the minimum acceptable information to be communicated and provides a standardized and consistent approach to prehospital notifications.

Inter-Facility Transfers

Fortunately, in Santa Clara County, 10 out of 11 receiving hospitals are currently certified by The Joint Commission at a minimum as a Primary Stroke Center. Although infrequent, there may be times when a stroke patient needs to be transferred from one acute care facility to another. For this reason, Santa Clara County Stroke Centers have plans developed that include:

- Pre-arranged agreements with stroke receiving hospitals (primary or comprehensive) for transfer of patients

³ [Recommendations for The Establishment of an Optimal System of Acute Stroke Care for Adults pp 26](#)

⁴ [2018 Guidelines for Management of Acute Ischemic Stroke pp 7](#)

- Pre-arranged agreements with EMS providers for rapid transport of patients who are eligible for time-sensitive treatments

Inter-facility transfers may apply to patients who would benefit from being transferred from a stroke-receiving hospital with primary stroke center capabilities to a comprehensive stroke center or equivalent.⁵ In either case, emergency transfer protocols are pre-arranged, and it is understood that transport should be provided with the urgency of a 911 response.

Santa Clara County Emergency Medical Services Agency has a policy in place to provide guidelines for ambulance transport of patients between acute care hospitals. Policy document #808; *Prehospital Care Interfacility Transportation*; outlines transfer agreements, medical control and levels of care to ensure that patient needs are being met while providing quality rapid transport to definitive treatment.

Data Collection

The primary aim of Santa Clara County's Stroke Critical Care System is to develop a comprehensive system in Santa Clara County that provides timely access to proven treatments necessary to reduce morbidity and mortality. It is through continuous quality improvement efforts that stroke patients receive care based on best practices. Implementation of quality improvement programs and clinical best practices reduces morbidity and mortality, hence improves patient outcomes.

Retrospective data collection and analysis lie at the heart of quality improvement. Data aids in understanding how well the systems work, identifying potential areas for improvement, setting measurable goals, and monitoring the effectiveness of change. Robust data systems, with the ability to report clinical indicators and performance measures, are a key tool to accomplish Quality Improvement (QI) activities. The goal is to connect data from across the continuum of care from pre-hospital to in-hospital to post-hospital disposition to optimally evaluate patient outcomes.⁶

Currently, SCSEMSA collects stroke pre-hospital care data elements through Patient Care Record (PCR) extraction. Data elements that are specific to Stroke centers will be extracted through a common software registry platform shared with the hospitals called *Get with the Guidelines* in 2020.

Santa Clara County Emergency Medical Services Agency has a policy in place to standardize data elements collected from designated Stroke Centers and EMS providers to monitor, review, evaluate, and improve the delivery of pre-hospital advanced life support and hospital stroke care services. Policy document #413; *Stroke Registry Standards*; outlines the data elements that are requested from both prehospital and hospital providers on a monthly basis.

Stroke Quality Improvement

Reaching for excellence in any system requires a functional decision-making process among the team of workers and users within that system. Inherent to this process is the need to know how the system is

⁵ <https://emsa.ca.gov/wp-content/uploads/sites/47/2017/12/CDPH-Stroke-Document-2010-Published.pdf>

⁶ <https://emsa.ca.gov/wp-content/uploads/sites/47/2017/12/Core-Measure-Report-for-2016-Data.pdf>

functioning and what to do to fix or improve it. The concept of continuous quality improvement (CQI) particularly in the field of health care relies mainly upon the following fundamental components:

- The availability of reliable and trusted information
- The ability to effectively communicate that information in easy to understand ways
- A standardized approach to reaching decisions and acting on those decisions

It is through SCCEMSA's Continuous Quality Improvement that the gap between performance and expectations narrows. It pushes the standards upward which results in better outcomes. Quality Improvement stresses understanding complex processes, measuring performance using reliable statistical methods, and using that information to build quality into the process.⁷

Santa Clara County Emergency Medical Services Agency has a policy in place to ensure continued high quality of patient care in emergency medical services provided within the community. Policy document #111; *EMS Quality Assurance and Improvement Program*; establishes a system-wide Quality Improvement Program to continuously monitor, review, evaluate and improve the delivery of Prehospital, In-Hospital and Post-Hospital care of the stroke patient. The program has active members from all system partners and includes prospective / concurrent / retrospective reviews as well as a feedback system.

Stroke Care Committee

As the delivery of stroke care evolves to become more interconnected, coordinating care between prehospital providers, nurses, physicians, and other disciplines has become increasingly important. In its simplest form, interprofessional collaboration is the practice of approaching patient care from a team-based perspective.

When implementing interprofessional collaboration, learning to work together, and respecting one another's perspectives in healthcare, multiple disciplines can work more effectively as a team to help improve patient outcomes. In addition, it improves the coordination and communication between healthcare professionals and thus in turn, improves the quality and safety of patient care.

Santa Clara County Emergency Medical Services Agency has a Stroke Care Committee that has representation from each of the Stroke Centers as well as members that represent the prehospital providers in our area. The Stroke Care Committee meets regularly and is tasked at reviewing performance data, identifying areas in need of improvement, carrying out, and monitoring improvement efforts. For these activities, the committee uses a variety of QI approaches and tools, including Plan, Do, Study, Act (PDSA) cycles, assessments, audits and feedback, benchmarking and best practices research. The Stroke Care Committee provides expertise to address potential quality improvement initiatives within the stroke system, which contributes, to the development or revision of stroke related policies, procedures and treatment protocols.

Santa Clara County EMS Agency has a policy in place that describes the scope of the role in membership on the Stroke Review Committee. Policy document #411; *Stroke Care System Quality Improvement*; provides the context in which the interprofessional collaboration across the continuum of care meets quality improvement.

⁷ Stroup, Craig, *Fundamentals of Emergency Medical Services System Evaluation and Quality Improvement* (Pinecrest Publishing House, 2015), 5.

Education and Outreach

According to the Robert Wood Johnson Foundation (RWJF), enhancing interdisciplinary collaboration and coordination in healthcare is imperative. As the delivery of care becomes more complex across a wide range of settings, and the need to coordinate care among multiple providers becomes ever more important, developing well-functioning teams becomes a crucial objective throughout the health care system. Health professionals have traditionally operated in separate spheres. Studies show that if they “breakdown the walls of hierarchical silos” and come together as a team, they will improve the safety and quality of patient care.

Collaboration between professions starts with interdisciplinary education. To break down those walls, health professionals must begin training together before they start working together. Interdisciplinary education will lead to more effective communication across disciplines and, ultimately, safer, more affordable, and higher quality care.⁸

In addition to interdisciplinary education, there is a vital component of public education and outreach that contributes to the health and wellness of a community. One of the goals identified in Healthy People 2020 is to increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life. Educational and community-based programs play a key role in:

- Preventing disease and injury
- Improving health
- Enhancing quality of life

Health status and related health behaviors are determined by influence at multiple levels. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.⁹

Public education and outreach will continue to contribute to the improvement of health outcomes in the United States and is a major component of the Santa Clara County Stroke Critical Care System.

Understanding the critical role that stroke education and outreach has in healthcare, SCCEMSA is developing a reporting process for Stroke Centers as well as pre-hospital providers to identify education and outreach efforts within the community. The reporting matrix includes four elements of education and outreach.

Internal Education will be driven towards “in-house” educational efforts on stroke care. This would include mandatory staff training, in-service training, and any other educational opportunities that are offered only to the staff members within that stroke center system or within the pre-hospital agency.

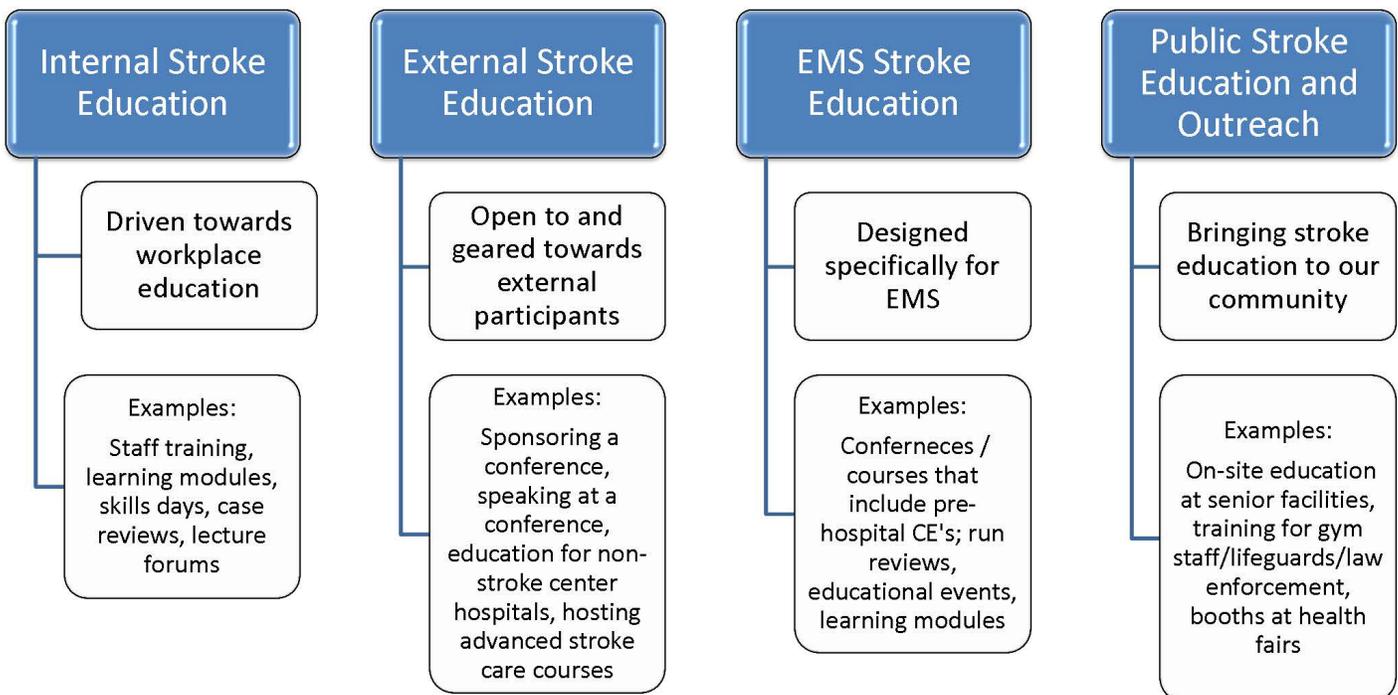
External Education will be geared towards “external” participants that may include sponsoring a conference or speaking at a conference, stroke education for non-stroke center hospitals.

⁸ <https://www.rwjf.org/en/library/articles-and-news/2010/11/interdisciplinary-collaboration-improves-safety-quality-of-care-.html>

⁹ <https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs>

Emergency Medical Services Education will be education that is designed specifically for the EMS providers. This may include station visits by stroke teams to review stroke care assessment scales or on-line learning management systems created to give lectures with pre and post quizzes to evaluate learning. In addition, it may include run reviews or protocol updates.

Public Education and Outreach will be specific to bringing stroke education to the community members. This area of education provides the greatest opportunity for the EMS Agency to partner with both prehospital providers and the stroke centers to deliver a comprehensive message of heart and vascular health to the members of the community.



Neighboring EMS Agencies

Due to the complex nature of an EMS System that provides care to close to 2 million persons with additional local operational oversight, it is imperative to have processes in place in which patients' care is uninterrupted despite crossing county lines. The stroke system functions through collaboration with countywide and regional care providers in the pre-hospital, hospital, and rehabilitation phases of care.

Summary

In summary, the boundaries of prehospital EMS are evolving to meet the needs of our communities based on local data and science from around the globe. The ideal is for all communities to be served by well-planned and highly coordinated emergency medical systems that are accountable for performance and serve the needs of stroke patients within the system and improve the health of the entire community.

As in previous years, EMS expanded along with the needs of our stroke system, and we are confident in our sustainability and ability to adapt to the dynamic communities we serve. Maintaining our current capabilities and striving toward future success depends on the outstanding support we receive from the local system stakeholders and the leadership of the Santa Clara County Board of Supervisors and County Executive Office.

Our primary goal is to provide the highest quality care for those in need of emergency medical services in the county. Through our exceptionally coordinated network of paramedics, EMTs, nurses, physicians, and other emergency professionals who work together with a strong commitment to excellence in all aspects of patient care, we will continue to achieve, and exceed, this goal.

We are confident that 2020 will bring many challenges and opportunities to grow. With the collaboration of our partners, we look forward to another year of providing the best care, anywhere.