

**Question:**

Mr. Driscoll asked about REMSA's system performance related to 90% compliance to 8:59 seconds as required in the Franchise Agreement and the potential impact on the 10% of calls that are cared for after 8:59.

**Summary answer and supporting documentation:**

**REMSA's average response times are 5:30 (minutes:seconds), 6:08, and 8:50 in the City of Reno, City of Sparks, and Washoe County, respectively.**

Regarding the 10% of responses where REMSA arrives after the 8:59 EMS standard, REMSA arrives:

- Under 3 minutes, 71% of the time
- 3:01 to 5 minutes, 15% of the time
- 5:01 to 10 minutes, 10% of the time
- Over 10 minutes, 4% of time

**The basis for the EMS 8:59 response time standard:** The 8 minutes, 59 seconds (8:59) response time benchmark for high-priority (Priority 1) EMS calls is a widely used performance standard in the United States. It represents a policy-driven proxy for clinical survivability, rather than a strict physiological cutoff. The 8:59 benchmark is closely tied to cardiac arrest survival science promoted by the American Heart Association.

Chief complaints and acuity are determined by Emergency Medical Dispatch protocol and triage upon receipt of the call and resources are assigned based on the patient's condition.

**Quality of care:** Studies and current professional research show that quality of care matters more than speed. In Northern Nevada, our system of patient care begins with call triage handled by clinically trained technicians who begin life-saving care such as CPR, tourniquet guidance, child-birthing coaching, clinical decision making, and assignment of appropriate resources including integrated health solutions. Patients receive care before the ambulance arrives on scene.

**Co-response by fire agencies on the highest-priority calls:** In Northern Nevada, calls flow through one of three primary public safety answering points who capture details about the caller and chief complaint. Upon first identification of the high-priority chief complaint, calls known as ECHO determinants such as choking, drowning, cardiac arrests, airway compromise, severe trauma, for example, trigger both fire and EMS responses to the caller because first hands on the patient matter. In these cases, fire and EMS resources are deployed before EMD is completed.

Response time is an important operational indicator, but it is not a complete measure of patient care or system effectiveness based on current studies and research. REMSA continuously monitors

performance, evaluates the factors behind delays, and adjusts deployment, staffing, and clinical practices to protect patient outcomes. REMSA has continued to add equipment and resources to comply with its Franchise Agreement and the needs of a growing community.

The EMS industry continues to adapt to changing requirements of the communities served. Organizations such as the [National Academies of Sciences, Engineering, and Medicine](#) have recommended moving beyond sole reliance on response time metrics. We will continue to see additional branches available to treat residents based on studies of chief complaints and clinical outcomes.

#### **Further details about REMSA's response time standards and system design:**

- The NNPH District Board of Health establishes EMS response time benchmarks. REMSA designs and manages a system to meet and exceed those standards.
- Medical research has proven that patient outcome is optimized when care begins with medically trained technicians applying Emergency Medical Dispatch protocol upon receipt of the call and aligning the patient with the appropriate solution.
- The traditional rule was derived from United States EMS protocol for high-priority calls based on early studies.

#### **Ongoing performance review and continuous adjustment:**

- REMSA maintains a continuous improvement philosophy which includes the following steps to ensure compliance to high priority calls.
  - After-Action Review Group (AARG): Conducted daily to review the previous day's performance and anticipate the upcoming week, allowing for real-time operational adjustments.
  - Specific elements included in our daily reviews:
    - Call processing time
    - Chute time
    - Routing efficiency
    - Hospital offload delays
    - Excessive or overlapping call volume
- REMSA's Clinical Director completes extensive reviews of critical care provided:
  - 100% of cardiopulmonary arrests
  - 100% of pediatric patient treat (both patients who are transported and patients treated with no transport required)
  - 100% of advanced airways (excluding cardiopulmonary arrests)
  - 100% of STEMI alerts
  - 100% of deliveries and neonatal resuscitation
  - 100% advanced airway success rates

- Deployment strategies are continuously updated, including:
  - Dynamic deployment of resources
  - Temporary or event-based deployment (e.g., Rib Cook-Off)
  - Shift bids and peak-demand staffing adjustments
- Ensuring appropriate resource allocation—sending the right resource to the right call (ALS vs. BLS vs. other paths of care such as integrated health)

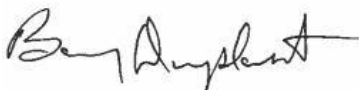
**Additional factors that can impact response times include:**

- Simultaneous high-priority calls in the same area
- Weather conditions
- Traffic congestion
- Hospital offload delays
- Special events
- Ambulances are often near major hospitals, which often results in faster response times in those areas compared to outlying zones.

**Summary conclusion:**

REMSA staffs the organization to beat response time obligations. Our community's emergency response system includes complementary components of care to augment and supplement REMSA ambulances responses to ensure safe patient care.

Kind regards,

A handwritten signature in black ink, appearing to read "Barry Duplantis".

Barry Duplantis, President and CEO  
REMSA Health

#### Footnotes / Sources

1. [American Heart Association](#). 2020 Guidelines for CPR and ECC.
  - Establishes Chain of Survival and time sensitivity of defibrillation.
2. Larsen MP et al. "Predicting survival from out-of-hospital cardiac arrest." *Annals of Emergency Medicine*, 1993.
  - Quantifies decline in survival per minute without intervention.
3. [National Highway Traffic Safety Administration](#). EMS Agenda for the Future (1996) and subsequent guidance.
  - Influenced system design and performance benchmarking.
4. Fitch JP. "Response times: Myths, measurement and management." *Journal of Emergency Medical Services (JEMS)*, various publications.
  - Explains origins and limitations of response time standards.
5. [National Academies of Sciences, Engineering, and Medicine](#). *Emergency Medical Services: At the Crossroads* (2007).
  - Recommends moving toward outcome-based EMS performance metrics.
6. Pons PT & Markovchick VJ. "Eight minutes or less: Does the ambulance response time guideline impact trauma patient outcome?" *Journal of Emergency Medicine*, 2002.
  - Finds limited correlation between strict response times and outcomes in trauma.