Annexure

[Date]

Standard Operating Procedure (SOP)

Integrated Patient Transport and Health Helpline Service (Phase-II)

NHM, DoH&FW, Government of Odisha

Mission Director
NHM, ODISHA
H&F.W. Deptt., BBSR

For EMRI Green Health Services

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208

STANDARD OPERATING PROCEDURE(SOP)

1. Table of Contents

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H&F.W. Deptt., BBSR

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STANDARD OPERATING PROCEDURE(SOP)

1 Introduction

1.1 About the Project

1.1.1 The project is titled as **"Integrated Patient Transport and Health Helpline Service (IPTHHS)-Phase-II"**. The project is being managed and operated by the Service Provider[1] selected through a tendering process vide a contract dated 12.09.2024.

1.1.2 The services being offered by the Government of Odisha under the project are:

a) Emergency Medical Ambulance Service (EMAS) (Including both road and boat ambulances).
b) 24x7 Patient Transport Service (PTS) i.e. Janani Express under JSSK
c) Health Helpline Services (including Grievance Redressal Service) being offered by the Government of Odisha.

1.1.3 All these services are managed by a single service provider through a Centralised Call Centre on the 7th Floor, IDCO Tower, Bhubaneswar.

1.1.4 This Standard Operating Procedure (SoP) has been formulated in compliance with the provisions of the Request for Proposal (RFP) and finalized through mutual agreement between the contracting parties. Therefore, both parties commit to adhering to this SoP to ensure the smooth operation and management of the services.

1.2 Purpose of this SoP.

1.2.1 These Standard Operating Procedures delineate the protocols that the service provider must adhere to for the effective implementation, operation, and management of services throughout the State. The SOPs for different services and operations has been developed in conformity with the earlier SOPs with appropriate modification to accommodate the changes in scope of services and other terms and conditions of engagement.

1.2.2. These Standard Operating Procedures are agreed and finalised to be an integral part of the agreement as outlined in the Request for Proposal.

1.2.3 This SOP aims to achieve following objectives:

(a) Quality and consistency of services rendered

[1]Service Provider is the Agency with whom contract has been signed by the Govt of Odisha for operation and management of IPTHHS.

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(b) Adherence to good practices at all times
(c) Determine performance expectations and necessary support.
(d) Optimal utilization of available skills across the services
(e) Provide clarity to the role and responsibilities of the personnel involved in service delivery.
(f) Used as training material to train new project personnel and as a reference material for performance appraisal of project staff.

1.3 Scope of this SOP

1.3.1 The SOP covers the following areas:

(a) Purpose and Scope
(b) Dispatch Centre Protocols
(c) Operational systems, structures, and protocols for emergency response, patient transport, and health helpline services. These include response procedures, ring checks, call codes, vehicle maintenance, management of vehicle breakdowns and accidents, vehicle distribution, health helpline response protocol, grievance redressal and escalation protocol, etc.
(d) Operational protocols for special circumstances (natural calamities, mass casualty events (both manmade and natural), unattended death, transportation of minors, transportation of obstetric cases, pediatric patents, neonate, crime scene operations, fire and accidents relating to hazardous material).
(e) Reporting structures and formats - overall documentation as per Annexure-18 of RFP.
(f) Health and safety protocols for personnel.
(g) Job description, roles and responsibilities of each level of personnel in entire operations.
(h) Training, refresher course and orientation protocols for all levels of personnel (including staff replacement protocols)
(i) Overall Administrative Policies
(j) Inter-facility Transfer Protocols
(k) On-line medical direction and guidance protocols
(l) Transportation refusal policies and protocols
(m) Do Not Resuscitate Policy
(n) Invoicing and Payment process

1.4 Applicability

1.4.1 The Standard Operating Procedure (SoP) is a part of the contract and applies to all parties involved in the contract.

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1.4.2 The SoP applies to everyone involved in the daily operation and management of this project, including personnel engaged directly by the service provider, as well as any other entities or personnel responsible for the project's operation and management.

1.4.3 This Standard Operating Procedure (SOP) will be periodically reviewed and revised as and when required with mutual agreement between the service provider and Authority. Revisions or amendments due to statutory requirements are effective immediately upon notification. Policy statements issued by MD, NHM require Department[2]approval to form part of SOP. The reasonable timeline for implementation of the SOP including any revision, amendment and modification thereto, shall be decided by the Mission Director.Any revision and/or amendment to SoP arising out of any statutory requirement shall be made applicable forthwith from the date of intimation by the Department.

1.4.4 The Authority retains the right to amend the Standard Operating Procedure (SOP) within the framework of the RFP unilaterally, and the Operator shall be bound to implement these changes from the date they are communicated by the Authority. Any revised versions of the Standard Operating Procedure (SOP) will be implemented upon approval by the Authority.

1.4.5 The SOPs apply in all situations unless specifically waived by DoH&FW, GoO.

2 Scope of the Project

2.1 Integrated Patient Transport Service

2.1.1 Under Integrated Patient Transport following services shall be covered:

S. No	Services Covered	Scope & Coverage[3]	Duration of Service
1	**Emergency Medical Ambulance Service. (ALS +BLS)**	In all 30 Districts with a minimum of 411 ALS and 449 BLS	Round the clock (24x7)
2	**24x7 Referral Transport System for JSSK beneficiaries.**	In all 30 Districts with a total of 500 or more vehicles. These vehicles shall be deployed strategically and equitably to ensure most optimal use of the services.	Round the clock (24x7)

[2]Department means DoH&FW, Government of Odisha

[3]Number of ambulances are subject to change from time to time as per requirement

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3	**Boat Ambulances in selected locations.**	Total of 6(six) boat ambulances presently deployed and operational in four riverine districts in Odisha.	Dawn to Dusk. (one shift)

2.2 Grievance Redressal and Health Helpline Service

2.2.1 Grievance registering (24x7 Service)

(a) Receive of complaints and feedback with respect to services being provided by public health facilities and escalation of the same to appropriate authorities for appropriate remedial actions.
(b) Tracking of public grievances regarding the deficiencies in health care delivery, welfare schemes and entitlements on 24x7 basis to ensure timely disposal of the same.
(c) Real-time Grievance Redressal by establishing linkages with the heads of all the health facilities on 24x7 basis.
(d) Citizen's view and suggestions with regards to improving the service delivery with respect to quality of care, safety, Courtesy and other aspects will be received and sent to the concerned department for appropriate action.

2.2.2 Health Advice (24x7 Service):

(a) 24x7 health information for guiding the people on health-related matters like first aid, nutrition, disease prevention and common ailment
(b) Medical advice including emergency medical advice
(c) Information on health care service, health care facilities and diagnostic centres with the help of integrated computerized geographical mapping and database.
(d) Information about blood bank, blood storage centres and availability of blood.
(e) *Support to field health staff like ANM and ASHAs for management of emergency conditions and treatment protocol over the phone.*

2.2.3 Counseling

(a) Counseling regarding general well-being as well as people with psychological problems e.g. adolescent health issue, suicide prevention, Family Welfare, Nutrition HIV/AIDS

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(b) Follow up of sample beneficiaries registered under RCH for availing desired services in time. Special call will be made to High-Risk Pregnant Women on monthly basis and to those defaulters of services as per need.

(c) Follow up of eligible beneficiaries on early childhood development.

2.2.4 Health Information

(a) Information on health programs and health related welfare schemes related schemes implemented in Odisha. (e.g., JSY, JSSK, RMNCHA+, BSKY, ECD, etc.)

(b) Early Childhood Development (ECD) initiative will try to complement reach out to every pregnant mother and parents of every child upto the age of two years through ECD call centre. This ECD call centre would focus on first 1000 days of the child which consists of 270 days during pregnancy and first 730 days or two years after birth.

(c) Under Ayusman Bharat / GJY Scheme eligible beneficiaries can avail of cashless treatment at empaneled hospitals for medical conditions including hospitalization, surgery and pre and post hospitalization expanses.

(d) Ayusman Bharat / GJY inbound calls through 104 Health Helpline usually deals relating to common queries of the beneficiaries such as (i) What are the BSKY facilities and how to avail that? (ii) Ayusman Bharat / GJY empaneled hospital lists, etc. Similarly, Ayusman Bharat / GJY outbound calls through health Helpline are intended to obtain feedback from the patient/beneficiaries on the quality of services that has been provided to then under Ayusman Bharat / GJY.

(e) Health Related information during epidemic and disasters.

2.2.5 Other Responsibilities under Health Helpline Services:

(a) Maintain directory of in charge of all facilities and other stakeholder for emergency referrals, health care service availability and reporting of grievances.

(b) Send SMS of web address, registration number (Complaint ID) and estimated time required to resolve the grievance to complainant.

(c) Forward the complaint to the concerned official through an SMS/email (Call Centre) for redressal within 7 days of the complaint.

(d) Also send reminder SMS (automated) at least 2 days before the end of stipulated time for the redressal of unresolved grievances.

(e) Linkages with ASHA grievance redressal system.

(f) Linkage with Patient Transport Service.

(g) Grievance registration system is to have a scope of integration with other state level grievance redressal portal.

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(h) Agency to carry out necessary modification in the complaint registration system to affect such integration.

2.2.6 Priority Services to be offered round the Clock (24x7):

Following are the priority services, which should be available round the clock:

(a) Redressal of real time emergency grievances
(b) Emergency Medical Advice
(c) Information on Emergency health care service, health care facilities and diagnostic centre **(designated health facility only)**
(d) Information about blood banks, blood storage centres and availability of blood
(e) Emergency counseling services on psychological problems e.g. adolescent health issue, suicide prevention.
(f) Complain regarding female feticide and infanticide
(g) Information on emergency ambulance service
(h) Emergency health related information during epidemic and disasters

2.2.7 Activity Flow (GR Health Advice Helpline Service)

Type of Activity	Actions by Client	Actions by Health Advice Helpline (104) Staff
1.A call to help line.	• Dial the toll-free number (eg.104 or any other number given by the State)	• Once a call relates to a client, assess whether the type of call is related to grievance health query.
2. Registration of grievances	• Explain the type of grievance, name of the facility/person against which grievance has been raised. • Inform/share details of the place / district where the deficiencies were noted / encountered	• Fill the grievance registration form available on web portal. • Then triage the grievances on basis of emergency. a) real time grievances, with focus on those with denial of services b) grievances relating to systemic issues, requiring higher authorities' intervention. • For the real time grievances, resolve the grievances immediately by contacting the concerned authorities. • For the grievances requiring higher authorities' intervention, grievances will be directed to the concerned official through wed portal, and resolution status will be put on the web portal. • Such grievances which are not clear and if operator who receives cannot understand the type of grievance the call

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		should be forwarded to the supervisor who will note down the details and register the grievance. • Registration number and estimated time required to resolve the grievance will be communicated to the complainant. • Also convey the web address to the client so that he may check the status of grievance. • Forward the complaint to the concerned official through a SMS/mail (by call centre/automated through web portal) for redressal of unresolved grievances
3. If the response on the grievance is not communicated within stipulated time	● May ask the status of his/her grievance from toll free number by quoting registration number ● If not satisfied, ask them to forward it to next level and enter details in the web portal	● Irrespective of the clients call back or not to check status of complaints, all such grievances which are pending should be informed to the complainant and details of next level Authority where grievance has been forwarded e.g., district/state responsible for the redressal
4.Grievances forwarded to the Authority	● May enquire the status either through toll free number or through online/checking the web portal ● If not satisfied, write to the State Mission Director, NHM/Secretary Health of the concerned state	● Irrespective of the clients call back or not to check status of complaints, all such grievances which are pending should be put as unresolved grievance on web portal and copy to Mission Director, NHM, Secretary Health and PS to State Minister of Health with information to the client and district
5. Health query	● Explain the health-related issue for which information/facilitation is sought	● Note the caller's details, address, and contact number ● Issue the registration number ● Ask in detail about the health query and triage into a) medical /health query b) health services/facility information c) counselling d) support to field level workers e) and others ● Address the query and if required further support connect the call to medical officer or counselor as per the assessment

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3 Expected Output

3.1 Ambulance Service (Emergency & Patient Transportation)

3.1.1 Provide 24x7 pre-hospital emergency care and transportation services in all 30 districts of the state within agreed timeline.

3.1.2 Operate the centralised call centre (command and control room) uninterruptedly to ensure all emergency calls are responded timely and adequately.

3.1.3 Upkeep, maintain and put to use all project assets including existing ambulances and IT infrastructures handed over under this project or those to be procured in future.

3.1.4 Deploy adequate number of qualified personnel including call centre staff, ambulance crew, field staff, etc., as per requirement for operation of the Project successfully and efficiently.

3.1.5 Develop appropriate training curriculum and modules for the project staff and impart training on regular basis as per the training plan to improve emergency response both in terms of quality and efficiency.

3.1.6 Impart training to the state government employees at the health facilities responsible for emergency response and care as per the request of the department. (Government to bear expenses on such training and workshop).

3.1.7 Submit various reports and information within the stipulated time frame to the State and District Level Management/Monitoring Committees formed exclusively, for the overall supervision of the project.

3.1.8 Operate and manage further scaling up or scaling down of the project.

3.2 Grievance Redressal and Health Advice Helpline (GRHAH):

3.2.1 Increased access to health information for all strata of society through a dedicated call centre (to be housed centrally together with Ambulance Services) for providing desired services as mentioned above. There shall be atleast 40 number of seats in the call centre exclusively for health helpline service and which shall be subject to change as per the actual requirement during the project period at the advice of the department.

3.2.2 Establish the Health Helpline service through the extensive use of proven triage software with algorithms/protocols and appropriate information and communication technologies (ICT). And facilitating the handling of emergency

EMRI Green Health Services

Authorised Signatory

Mission Director
NHM, ODISHA
H&FW Deptt., BBSR

crisis by effectively managing the information dissemination process and directing people to the right place in the least amount of time.

3.2.3 Ensure optimal usages of the resources in the state healthcare system – funds, personnel, facilities, etc.

3.2.4 Deploy adequately trained and qualified manpower for GR & Health Advice Helpline capable of handling the calls appropriately and efficiently.

3.2.5 Ensure availability of timely and appropriate health facility for the citizen and redressal of Grievances.

4. Centralised Call Centre and Control Room

4.1 Infrastructure and Technology

4.1.1 The service provider would be operating entire service from the existing integrated Call Centre facility of the Government situated at IDCO Tower, Bhubaneswar with required modification or augmentation as per the requirement subject to approval of Govt.

4.1.2 The service provider shall make the entire setup ready within the timeline and manner as stipulated in the RFP including procurement of capital assets as required under the project.

4.1.3 The hardware and software in the Control Room would provide for computer telephony integration with ability to log calls with geographical information system. All the ambulances shall be monitored with the help of Geographic Positioning System (GPS).

4.1.4 All the ambulances are to be GPS fitted which shall be maintained by the service provider.

4.1.5 Adequate provision shall be made by the service provider to keep back-up of the data generated in the Control Room.

4.1.6 The service provider shall be responsible for maintenance of the hardware and software to ensure uninterrupted operations. In case there is a breakdown due to technical problem, the service provider shall take necessary steps to rectify the same as early as possible. In case of a major breakdown, where incoming calls cannot be taken, information of such breakdown shall be provided to the authority forthwith and the service

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NHM, ODISHA
H&FW Deptt., BBSR

provider shall take all necessary steps as the situation demands to rectify the same at the earliest. . In case of a major break down, where incoming calls cannot be taken, information of such breakdown shall be provided to NHM forthwith and the approved service provider shall take all necessary steps as the situation demands to rectify the same at the earliest. In addition to this Agency shall ensure AMC and insurance of all assets of the projects including Hardware and Software. In case of default in ensuring continuity of insurance and/or AMC any liability for mishap during discontinuation period shall be borne by the approved service provider The Agency shall enter Annual Maintenance Contract with the vendor. However, before completion of the Annual Maintenance Contract/CMC, if the contract was terminated, the Service provider shall take sufficient steps to enter into AMC/CMC with another vendor. But for the intervening period i.e. termination old AMC/CMC and entering of new AMC/CMC, the Agency shall maintain all the assets of the project including Hardware and software. Proper documentation of all the above activities to be ensured by the Agency.

4.1.7 Ambulances without insurance coverage shall be treated as Off Road as defined at Clause 2.14.6, Off Road definition (c) of the RFP.

4.1.8 Authority shall conduct third party audit of IT installation including hardware, software and reporting system to check the accuracy, authenticity, integrity and credibility of the system during the project period.

4.1.9 In case of shifting, scheduled maintenance of hardware and software etc. wherein there can be discontinuance of operations for a specified period of time, the same would be communicated to NHM in advance and the NHM shall ensure that the same is communicated to general public in effective manner.

4.1.10 An application to achieve automation in mapping trips and off road registered in GPS with case details maintained at call centre shall be developed. It is responsibility of the service provider to provide access to data through API for this purpose. In addition to this the Agency shall also provide APIs for dashboard which is to be accessed by public.

4.1.11 Agency to provide access to basic MIS reports on real time basis along with access to voice logs. The MIS data requirements for OPEX processing and regular monitoring are enclosed at Annexure-1 which is subject to change from time to time based on review by authority

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4.2 Access to Service

4.2.1 A victim in emergency would call in the three-digit toll free phone number i.e., 108, which is accessible from all the locations where Emergency Response Services are operational to avail the facility. This number and telephone line shall have toll free access in local area with priority routing through all telephone operators operating in State of Odisha. 108 shall be Category (I) service with unrestricted access from all landlines and mobile phones throughout the State of Odisha.

4.2.2 The existing Toll-Free number "108"allotted by Department of Telecom for the service and presently being used for Emergency Medical Ambulance Serve shall be used for all three patient transport services including Emergency Ambulance Service, 24x7 Referral Transport Service and Boat Ambulance Services. However, for Health Helpline Service, different three-digit toll free number i.e., 104 shall be used.

4.2.3 Further, if there is any disruption in call routing during the tenure of this contract, authority would coordinate with the telecom service provider to ensure routing of calls to 108 is restored at the earliest possible. Similarly, authority would also facilitate availability of optical fiber link, radio link or any other latest links/facilities as and when available with telecom service provider in the Control Room to enhance connectivity.

4.2.4 Authority shall grant permission to service provider to get All Call Report directly from Department of Telecom/BSNL/Private telecom service provider during the tenure of this contract to verify that all calls are landing to the service provider's dialer and share with NHM.

4.2.5 The service provider shall operate the Control Room round the clock on 24x7 modes to respond to medical emergency call. For proper management of the IPTHHS Phase-II the service provider shall equip the Control Room with Geographical Information System, Global Positioning System, Automatic Vehicle Location Track and other necessary hardware and software for computer telephonic integration as specified in the RFP.

4.2.6 On receiving medical emergency call from the victim/beneficiary, the control room shall communicate the caller/or connect ambulances to caller directly and take the patient to the nearest health facility depending on the severity of the patient's condition. The concerned health facility is also to be alerted by the service provider in advance to keep them prepared for immediate emergency care within that critical/ golden hour (Time in between injury become fatal). Authority will provide contact numbers of health officers of

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Mission Director
NHM, ODISHA
H&F.W. Deptt., BBSR

designated hospitals in the vicinity so that the concerned designated hospital is informed in advance to remain prepared to attend the patient or victim without wasting any time. *In case ambulance can't be provided, the same shall be communicated to the caller within 5 minutes and reason for such cancellation of cases must be recoded against the Job ID created.*

4.2.7 In case Health Help Line i.e. "104" the call shall be attended by the team of doctors, Health Advisory Officer or Counsellor seating at the call Centre to address the queries, furnish information and record suggestion and complaint and escalate to appropriate level for consideration and action.

4.3 Functioning of Call Centre

4.3.1 The Control Room shall act as the nerve center of the entire project. The primary objectives of the Control Room or the Centralized Call Centre would be to respond the calls timely and patiently and ensure provisioning of desired services and support to all eligible callers including victims to rescue from crisis.

4.3.2 The objectives of Emergency Response Centre would be:

a) To respond to the emergency caller
b) To quickly collect information related to type of emergency, seriousness, number of persons involved and location of the emergency from the caller. Service request shall be acknowledged by creating a Case ID / Job ID,
c) Dispatch the nearest available ambulance to attend to the emergency
d) Record reasons for cancellation if ambulance could not be provided.
e) Monitor and track the ambulance online till the end of the incident
f) Provide navigational guidance to the ambulance in terms of location
g) MBBS Doctors (Allopathic) will be positioned at the ERC round the clock to provide medical advice to the Emergency Medical Technician in the ambulance.

4.3.3 Steps to be followed by the Service Provider while responding to a call received at the call centre vide toll free number "108" for Ambulance Service.

a) The Junior Executives as call taker shall collect information related to the incidence including nature of incidence and nature of emergency (if any), seriousness of the situation, number of persons involved and location of the incidence, condition of the victim, etc. Based on type of emergency, the call shall be classified into Medical, Police and Fire emergency. In case of Police and Fire emergency, the call shall be

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Mission Director
NHM, ODISHA
H&FW Deptt., BBSR

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transferred to the unit handling Police and Fire emergencies. The executive shall pickup the phone within 10 seconds.

b) Ensure timely dispatch of Ambulance as per the requirement. Dispatch is complete when the nearest available ambulance attends the call that has been assigned *and ambulance starts moving after assignment of job.*

c) The dispatcher shall locate the nearest available ambulance and communicate the message to Ambulance informing the crew about
   i) Pick-up Location (nearest motorable road)
   ii) Nature of injury / illness

d) Provide navigational guidance to the ambulance in terms of location, whenever required.

e) Develop standard scripts for taking the calls for key emergency related processes shall be made readily available to the staff for reference.

f) Depute adequate number of trained personnel in the call center and ensure adequate seating arrangements for call takers for handling calls efficiently.

g) Ensure functioning of the Control Room round the clock with required skilled manpower, equipment and technology.

h) Following minimum information shall be captured at the call centre against each attended call.

   i) Date and time of receipt of call as per the dialer
   ii) Dispatch Time (time when the Ambulance is assigned and started moving)
   iii) Response time (time taken from receiving of the call to when Ambulance reaches the spot (Patient Location) or nearest motorable point to reach the patient, where there is no motorable road up to the point of incidence.
   iv) Where there is no motorable road up to patient location and in such case, caller must be informed beforehand to come to the nearest motorable point prior to dispatch if it can be ascertained at the time of dispatch. Caller shall be asked to come to the motorable point.
   v) Patient Information (Name, contact details, sex)
   vi) Automatically generate a unique ID
   vii) Information related to incident
   viii) Type of emergency as per chief complaint list in Annexure-2
   Information related to location (Town, nearest landmark. etc.)Distance travelled in each trip to be captured as per GPS and Odometer.

i) Maintain a completed and updated list of designated hospitals or health facilities in different locations across the state to attend the emergency victims or the eligible beneficiaries. NHM shall provide

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H&FW. Deptt., BBSR

updated information from time to time as and when its updated. NMH shall also provide all information related to State health infrastructure of public health facilities to ensure smooth 108 service delivery.

j) Develop and implement system specially designed to manage no voice calls, nuisance calls, enquiry calls, non-emergency request calls and other calls which are not of emergency in nature and don't need attention to ensure that the available resources are used for genuine purpose. The service provider shall, as far as possible, shall block nuisance or prank calls to avoid unnecessary jamming the IVRS line. The approved service provider is permitted to design their own strategy to handle these situations which can change based on need and the impact of strategy adopted by the approved service provider. However, every effort should be made to respond to genuine calls.

k) Maintain detailed, updated and accurate information regarding the public safety agencies, evacuation agencies including the Telephone Numbers of all the Police Stations, Fire Stations, Health and Disaster Management units in State of Odisha.

l) *Agency shall have in place required integration with applications of other departments as directed by Govt. from time to time.*

m) Fulfill the response time criteria as specified for different ambulance services. For the purpose of average response time calculation only eligible calls determined as per the set criteria shall be taken into consideration. Similarly, for calculation of "abandoned call" or "ration of non-attended call to total call" only eligible calls shall be taken into consideration. For above purpose hoax calls, no voice, prank call, call disconnected call, repeat calls, crank calls, duplicate calls, call cancelled by the caller shall not be considered. Short abandoned call disconnected within 5 seconds from landing shall not be considered for call centre service level parameter

n) The response time would be calculated from the time the call was received till the ambulance reaches the site of requirement.

o) Service provider can if desired call back all callers which were initially cancelled due to non-availability of Ambulance within 15 minutes, and it is only applicable for home to institution to provide an ambulance if the patient still needs the same. But this is not applicable for IFT Cases.

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H&FW Dept, BBSR

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p) Distance travelled in each trip to be captured as per GPS and Odometer. Further breakup of distance and time as per GPS to be captured as;
   - Time when Ambulance started moving
   - Time when ambulance reached pickup location
   - Time when patient board the ambulance
   - Time when patient reached hospital
   - Time when ambulance reached base location

q) The Call Centre should have a continuous online display of metrics and statistics of number of calls received on that day, unattended call on that day (%), Average call waiting time, longest call waiting time.

5 Field Operation

5.1 Placement of Ambulances

5.1.1 Ambulances under Emergency Medical Ambulances Service (108), Referral Transport Service and Boat Ambulances Service shall be placed at strategic location in order to attain optimal service level performance including response time parameter. The locations for placement of these ambulances shall be finalized in consultation with district administration and NHM.

5.1.2 The Service provider has to be abided by the Performance Parameters prescribed and shall be responsible and maintain average response time of 20 minutes, as key performance parameter. In no case the service provider shall assign ambulance from outside the area of operation exceeding 30 KMs.

5.1.3 The Service Provider will arrange for setting up of parking shed, rest room or any other infrastructure as per the requirement at their cost. Authority may, allow the service provider to park ambulances inside hospital premises and other government office premises, wherever possible, if requested. Agency to ensure cleanliness at parking space provided by Government.

5.1.4 Ambulances would have all equipment for life support as defined under RFP. Service provider shall man these ambulances with trained personnel as defined in RFP.

5.2 Onboard Equipment and Staffing

5.2.1 Service provider shall ensure installation, upkeep and maintenance of all the onboard equipment, instruments and tools of the ambulances by carry out routine preventive and break-down maintenance. The service provider shall ensure zero failure of onboard equipment at the time of emergency. Any loss

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NHM, ODISHA
H&FW Deptt. BBSR

arising during the period of discontinuation of AMC/Insurance is to be borne by the Agency.

5.2.2 The approved service provider, without failure, shall engage requisite number of field and ambulance staff with required qualification and experience as per the terms of the contract or RFP.

5.2.3 Service provider(contracted) shall ensure compliance of labour and other applicable laws with respect to engagement, compensation (including salary, benefits and entitlements) and working hours, etc.

5.3 Screening, Dispatch and Assessment

5.3.1 The call shall be primarily screened at Control Room level to ensure that ambulance is dispatched as per protocol only. The screening will be done at the Control Room level and as approved by NHM. It should be ensured that ambulances are dispatched only against eligible cases. Since PRI line is the only medium to get service request from public due care shall be taken to ensure that calls should not be long in duration.

5.3.2 The emergency response service (108 Service) shall be limited to situation where it is perceived to have a high probability of life-threatening injury or illness and requiring a quick response. The service provider shall develop a clear protocol or triage for proper screening of all the incoming calls to determine if they are emergency in nature.

5.3.3 On receipt of instructions from the Control Room, the ambulance crew shall start rolling immediately and reconfirm the location of the incident and other key information enroute, if necessary, simultaneously. After reaching the location, the ambulance crew shall ensure scene safety before reaching the patient or victim. Also, after attending to the patient or victim, the Emergency Medical Technician would assess the need for emergency service more accurately.

5.3.4 In case the need for ambulance transport is not required, the crew shall inform the Control Room forthwith for further instructions and proceed according to instructions of the Control Room. The service provider shall be responsible to ensure that the non-availed calls are not due to improper assessment at call in the first instance at Call Centre level.

5.3.5 In case of mass casualties and if there is need of additional ambulances, the same shall be communicated by the ambulance crew. If any other resource is needed to attend to the emergency including help from police and fire

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agencies, the same shall also be communicated by the first arriving ambulance crew to the Control Room.

5.3.6 Emergency Medical Technician (EMT) shall assess the type of emergency and seriousness and transport the patient to the nearest appropriate medical facility and pre-hospital care, in addition to onboard treatment and care as per the protocol. If necessary, the EMT shall interact with the doctor in the Control Room for medical advice for guidance. Agency shall be custodian of PCR documents and shall keep such document safely for any legal and statutory requirement in future. In the event of change in operator the incoming Agency should be handed over such document by outgoing Agency.

5.3.7 Patient Care Record (PCR) shall be maintained which shall include patient conditions, vital medical parameters and details of drugs and disposables consumed the time or receipt of call by the Ambulances. Also, PCR would incorporate additional information as provided by NHM through the EMR form.

5.3.8 Time of arrival at the spot (location of incidence), time started towards hospital and time when reached the hospital would be logged in by the driver using GPS devices and paper-based logbook shall also be maintained in the ALS, BLS and RTA Services. The GPS reading would be taken into consideration for all practical purposes, only in exceptional circumstances as defined at clause 10.3.2.

5.4 Selection of Health Facility

5.4.1 Accident or other Medical Situation: In the event that the patient is conscious and able to comprehend and communicate clearly or the patient's relative or friend is present, then the operator ambulance shall take the patient to the closet Government Hospital, and (2) in all other cases the operator will take the patient to the nearest appropriate hospital or Trauma center.

5.4.2 Obstetric Emergency: In the event of an Obstetric Emergency where the patient makes a request to be taken to a hospital / healthcare facility where she is registered / referred, the operator shall take the patient to such hospital / healthcare facility, provided that the operator shall ensure coverage on best effort basis, by another Ambulance of the Ambulance operation area of the relevant Ambulance that responds to an Obstetric Emergency in the event the Patient concerned is being taken to a hospital / healthcare facility outside the Ambulance Operation Area of that ambulance.

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5.5 Starting and Closure of Call

5.5.1 When returning to base location after handing over patient to the health facility, the EMT should inform the Control Room about the Ambulance back in service unless a cleaning or reconditioning is required. All cases shall be closed within 48 hrs from completion of cases.

5.5.2 While returning back to the base location and if in between another emergency call is assigned to ambulance, the crew will immediately respond to such calls and close the old case and start the new case from that location only. For the earlier trip the distance (KM run exclusively to attend the call) would be considered till the closure of the call and for the new call the KM reading will start from the time the new call is started. Both of these two calls would be considered as a separate trip. *In such cases utmost care is to be taken by crew in usage of GPS buttons when the ambulance is diverted for another case before reaching base location. At the point of diversion, the earlier trip must be closed by pressing appropriate button. Thereafter the button panel is to be reset for a fresh trip. When the Ambulance is able to take another emergency call, it should be placed back in service.*

5.6 Ambulance Operation:

5.6.1 The ambulance shall be located at Base location unless directions are given by the Control Room regarding dispatch. Dispatches shall be initiated from the Control Room only.

5.6.2 In case any Emergency victim or Patient approaches the ambulance directly, the crew shall inform the person to connect Control Room using 108 toll free number for new case ID generation. *However, in case of Road Traffic Accident cases the EMT can sou moto inform the Call Centre to pick up the case.*

5.6.3 Whenever ambulance is moving out of base station for refueling, cleaning, minor repairs, scheduled repair or any other reasons, the ambulance is to be marked as off road.

5.6.4 Emergency operation shall be limited to any response to a scene where there is perceived to be a high probability of life-threatening injury or illness, and a reduced response time may mitigate the illness or injury.

5.6.5 Multiple calls from different callers from one single location will be handled on a first-come-first-serve basis. Every call would have a unique job IDs and in case of multiple patients transfers during mass casualty or other such events multiple job ID would be created. Job IDs shall *be created against case/trip irrespective of patients carried in the case/trip. Means if at a time more than 1 patient are carried in an ambulance then it will be a single trip.*

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5.7 Equipment Maintenanceand Upkeep

5.7.1 The EMT and the Driver on duty shall maintain inventory of all equipment. At the end of every shift, the EMT and driver shall handover the ambulance to the incoming crew along with a check list to this effect signed by both of them. The concerned EMT shall check functionality of the equipment regularly and report immediately in case any missing, defect or breakdown.

5.7.2 The service provider who receives ambulance equipment (through its employee or representative) must sign for that equipment and must agree to take financial responsibility for such equipment from damage, loss, and/or theft.

5.7.3 It is the responsibility of the crew and the service provider to keep the ambulances and all its equipment (medical equipment, GPS & Biometric device) on working condition before putting them on service. The ambulance shall be treated as out of service unless all the essential equipment as per the Annexure-7 for ALS & BLS vehicles are in functional condition. No case to be assigned if ambulance is marked as off road due to any reason.

5.7.4 The service provider shall conduct regular checks, stocking and cleaning of all medical equipment, tools and instruments and inform about the missing item (if any) to the respective immediate official of the service provider

5.7.5 It is the responsibility of the EMT to ensure that the ambulance is kept clean after each trip. If any items are unavailable, the Cluster Leader and Operations Head should be notified as soon as possible to replenish the stock. Any missing items must be restocked immediately.

5.7.6 In the event of any ambulance under IPTHHS Phase-II being withdrawn by Agency or Authority, the branding shall be removed and Agency who shall provide an undertaking as per **Annexure-3** evidencing that the branding has been removed prior to withdrawal of such ambulance.

5.7.7 The crew shall clean the ambulance regularly and after every trip. When cleaning the Ambulance or equipment, the crew shall assume that all fluids are contaminated and appropriately use gloves and clean all surfaces with appropriate disinfectant

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6 Operation and Management

6.1 Medical Direction and Pre-hospital Care

6.1.1 Medical direction may be provided to initiate stabilization support even before the patient reaches the hospital. The approved service provider is allowed to adopt approved protocol and SOPs for medical dispatch and pre-hospital (on ambulance) care.

6.1.2 There are four components of pre-hospital care

a) Dispatch decision
b) Pre-arrival Instructions
c) Standard Medical Guidelines
d) Destination decision

6.2 Dispatch Decision:

6.2.1 The emergency dispatcher should advice the EMT of the following:

a) Nature of the call (including patient age and sex)
b) Exact location of the call

6.2.2 An Advance Life Support (ALS) Unit is automatically requested whenever the nature of emergency as per the call analysis done at the control room indicates the potential for requirement of ALS.

6.2.3 In cases where a Basic Life Support (BLS) team after reaching the scene realizes the requirement of an ALS for the incident the EMT of the BLS ambulance can call the Control Room and request the dispatcher for the sending one ALS and actual dispatch will happen on the basis of dispatch protocol. In such case, response time will be considered for the first arrival ambulance. In such instance both the cases will considered as separate. The service provider has to provide detail of such incidences where need for an ALS was assessed only after reaching the site. However, the service provider shall ensure that the situation is assessed accurately at the first instance as to whether ALS or BLS is required.

6.2.4 **Pre-arrival Instructions:** Whenever requested and required, Dispatcher in the Control Room(and the Doctor patched in to the call when required) would provide pre-arrival instructions to the bystander of the emergency victim attempting stabilization. Standard guidelines are used if dispatcher provides the instructions.

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6.2.5 **Standard Medical Guidelines:** The EMT must be trained to follow standard medical guidelines which shall be followed by the EMT. In case of any clarity required, the EMT shall seek advice from the ERC and request for the Doctor to be patched into the call for appropriate advice.

6.3 Destination Decision:

6.3.1 The Ambulance will drop the patient to the closest Govt. Hospitals/empanelled Health Facilities and only on urgency as per assessment of EMT may drop the patient to the closest Govt. tertiary care hospital in case the patients requires tertiary care.

6.3.2 The following are criteria which require transport to the nearest Emergency hospital.

a) Cardiac or respiratory arrest
b) Unmanageable or obstructed airway
c) Continuous or recurring seizures
d) Major trauma
e) Amputations
f) Burn patients
g) Imminent birth
h) Suspected myocardial infarction in any patient over age 40 with severe chest pain

6.3.3 The EMT shall have unrestrained freedom to decide to transport a patient / victim if he decides that the patient / victim requires urgent medical care in a medical facility.

6.3.4 In case any victim or the bystander refuses transportation, the same may be recorded by EMT in the patient care record and signature of the victim or attendant id obtained. In case he refuses to sign, the same shall be recorded in the patient care record and the Control Room be intimated about the same.

6.3.5 The ambulance should avoid waiting unreasonably longer time at the time of discharge of the patient from the ambulance, rather prepare itself at the earliest for the next call without wasting time. *However, Referral Transport Ambulance may wait for 30 minutes so that it can transport the same patient in case mother is referred to higher facility immediately.*

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6.4 Do Not Resuscitate (DNR) Policy

6.4.1 The service provider shall develop a policy regarding determination of death, including death at the scene of apparent crimes. When a call is received by Control Room of unresponsive patient with attendants suspecting him/her as dead, on arrival at scene EMT shall collect the following information from the bystanders:

a) When was the patient last found breathing/responsive?
b) How long the patient has been unresponsive?
c) Interventions, if any, attempted by bystanders

6.4.2 The EMT confirms the absence of vital signs. EMT or any staff of the approved service provider including the Doctor in by the Control Room shall not declare or pronounce Death. The bystanders may be clearly informed about the absence of vital signs as the situation warrants. The same shall be recorded in the Patient Care Record which shall be filled with all the observations with record of time when the assessment was completed.

6.4.3 In case of a mob situation, the EMT would act as per the need of the hour and transport the patient / victim to the nearest Government hospital. No death certificate / death intimation shall be issued by the service provider and / or its crew.

6.5 Emotionally Disturbed Patients

6.5.1 If an emotionally disturbed patient refuses treatment or transport, the EMT shall request police to accompany the patient or ask Control Room to do the same.

6.5.2 If a patient displays violent tendencies or violence towards Ambulance personnel, bystanders or other personnel on scene, the crew shall retreat and return to the scene only after the scene is secured by police and relatives.

6.6 Unattended Death

6.6.1 If the patient is not declared Dead on arrival or death has not been pronounced at the scene of the call, resuscitative measures shall be taken in accordance with prevailing medical protocol.

6.6.2 If death is pronounced on scene by a qualified medical practitioner, all actions of the crew prior to the declaration of death shall be recorded on the PCR/EPCR and the same informed to Control Room and follow instructions from Control Room.

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6.6.3 The ambulance personnel shall not disturb the body of a deceased person under any circumstances and pass information to Control Room.

6.7 Patient or Location Not Found

6.7.1 Upon arrival on a scene, it is the responsibility of the EMT to attempt to locate the patient. If the patient/ location is not immediately found, the EMT must contact Control Room dispatcher to determine the exact location. A search of the immediate area should be performed.

6.7.2 If no additional information is available, a Patient Care Report(PCR/EPCR) should be completed, and any significant findings should be documented regarding the efforts made to locate the patient or their location.

6.8 Crime Scene Operations

6.8.1 A scene shall be considered a crime scene if evidence of a crime or suspected crime is found, including but not limited to:

a) Homicide
b) Suicide
c) Rape
d) MVA involving serious injury or death
e) Assault
f) Intake of Drugs and Narcotics

6.8.2 Upon the discovery of a crime scene, the Police shall be informed if not already present, and only personnel necessary to the treatment of the patient shall enter the scene.

6.8.3 On a crime scene, the EMS personnel shall work in close communication with law enforcement while performing up to their standard of care. Care shall be taken to preserve evidence on the scene if possible while providing patient care. The scene and all actions taken by EMS staff shall be thoroughly documented in the PCR. ***Preservation of evidence shall not take priority over patient care.***

6.8.4 Once patient care has been completed or if the scene is deemed unsafe, Police shall be informed and EMT shall intervene as required only after the Police ensure safety.

6.8.5 Ambulance personnel shall not reveal details about a crime scene to any other Ambulance personnel except the authorities permitted under the law.

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6.9 Record Keeping and Documentation

6.9.1 All the forms viz., the Patient Consent Form or Patient Care Record(PCR/EPCR) will be in the custody of the EMT present in the ambulance. All documents shall be handed over to the authorized person of the approved service provider with due acknowledgement.

6.9.2 The Patient Care Record (PCR/EPCR)shall be acknowledged by the Duty Doctors / Nurses at the medical facility / hospital for any patient taken to the medical facility / hospital along with OPD/IPD number.

6.10 Mass Casualty Incidents (MCI)

6.10.1 The Service Provider may in case of severe medical emergency situation or "Mass Casualty Incidence", if situation so demands, take decisions or adopt procedure which is beyond the scope of this SOP, even without a prior approval of the Authority. However, the service provider would inform, with necessary reasoning to the authority (i.e., Mission Director, NHM) within 24 hours time period. In addition to this, the Mission Director, NHM shall have the authority to temporarily suspend these Standard Operating Procedures in case of an emergency and mass casualty situation after due consideration of the gravity of the situation.

6.10.2 For the operational purposes of the Ambulance, a Mass Casualty Incident shall be any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as an accident, hurricane, flood, earthquake, fire, bomb blast, armed attack, vehicle collision that exceeds local logistic support capabilities. In such situation time is considered to be the essence.

6.10.3 A Mass Casualty Incident (often shortened to MCI and sometimes call a multiple-casualty incident or multiple-casualty situation) is any incident in which emergency medical services resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties. For example, an incident where a two-person crew is responding to a motor vehicle collision with three severely injured people could be considered a mass casualty incident. The general public more commonly recognizes events such as building collapses train and bus collisions, earthquakes and other large-scale emergencies as mass casualty incidents.

6.10.4 During MCI, the Ambulances which participates in the rescue operations shall be exempted from all penalties till the time the rescue operation is complete.

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6.10.5 The first arriving EMT is responsible for initial triage and the request of additional resources.

6.10.6 If medical triage establishes that more than one person needs to be transported, then the Ambulance Crew shall immediately call the Control Room appraising the situation for mobilization of additional support to handle the situation successfully.

6.10.7 Each Ambulance shall only allow one person to accompany the patient / victim in the Ambulance.

6.10.8 The Authority may place a written request to the Service provider to deploy required number of ambulances in strategic locations as a preventive measure against any perceived medical emergency situation during a mega public event or an expected natural calamity.

6.11 Fire / Hazardous Materials (HAZMAT) Calls

6.11.1 The duty crew of an ambulance for a Fire or Hazmat stand by, shall remain on the scene, out of service, until released by the Fire personnel.

6.11.2 Upon arrival at any major incident where Command has previously been established, the EMT must report to the command post and advise the Senior Officers (Fire and/or police agencies) of the location of the ambulance in case EMS assistance is needed.

6.11.3 The Driver is responsible for the staging of the ambulance, keeping lanes clear for additional Fire Apparatus and allowing exit for all emergency vehicles.

6.11.4 The EMT shall request First Responders to be on alert or to respond to the scene, as necessary, and must make sure that the Ambulance Supervisor has been notified of the incident.

6.11.5 The Fire Department will automatically be dispatched to all calls for Motor Vehicle Accidents with a confirmation that people are trapped. Additional Fire Department response may be used at the discretion of the EMT/ Nurse/ Doctor (stability of a vehicle involved in MVA, possible Hazmat, CPR assistance, forced entry, etc.).

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6.12 Inter Facility Transfer/Referral Transport within Odisha

6.12.1 Inter-facility transfers would be considered where:

a) Patient is in critical condition and the existing facility doesn't have appropriate treatment facilities.
b) The condition of the patient may be critical if proper treatment is not extended in time, and the treatment facility is not available in existing facility.
c) Existing facility is only a primary care and doesn't have round the clock operations.

6.12.2 Inter-facility transfers have to be through Control Room only. The physician at the transferring facility should provide detailed instructions to be followed for safe transport. The physician at the transferring facility should enter on the PCR form the reason and justification for transferring and with sign and seal. The detailed protocol for interfacility transfer is given in **Annexure-4.**

PROTOCOL FOR INTER-FACILITY TRANSFER OF PATIENTS

1. Inter Facility Transfers would be considered only on the request of the Medical Officer (on duty) of the facility in special cases, where Patient is in critical condition and the existing facility doesn't have appropriate treatment facilities.
2. The condition of the patient may be critical if proper treatment is not extended in time and the treatment facility is not available in existing facility
3. Existing facility is only a primary care provider and doesn't have round the clock operations.
4. Inter facility transfer has to be through ERC. Preferably, the staff of the transferring hospital should accompany the ambulance. The physician at the transferring facility should provide detailed instructions to be followed for safe transport. The physician at the transferring facility should enter on the PCR form the reason for transferring and the sign & seal.
5. Where the patient is transferred before being admitted to the facility due to absence of the doctor or health staff then this shall not be considered as inter-facility transfer/referral transport and the patience shall be moved to the next nearest appropriate health facility. However the service provider is required to maintain record of such instances.
6. **Critical or unstable patients** must be transported to the closest designated Government / empanelled facility based on levels of care provided.
7. The following are criteria which require transport to the closest Emergency hospital unless otherwise ascertained by the EMT on the ambulance in consultation with the advising doctor:
   I. Cardiac or respiratory arrest

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II. Unmanageable or obstructed airway
III. Continuous or recurring seizures
IV. Major trauma
V. Amputations
VI. Burn patients
VII. Imminent birth
VIII. Suspected myocardial infarction in any patient over age 40 with severe chest pain.
IX. Patients in ICU irrespective of the disease suffering from.
X. Patients in SNCU

8. The EMT shall have unrestrained freedom to decide transport a patient / victim if he decides that the patient / victim requires urgent medical care in a medical facility.
9. Ambulance is under no obligation to transport any patient to a facility, which does not have appropriate medical facilities or enlisted under the scheme.
10. In case any victim or their by stander refuses transportation, the same may be recorded by EMT in the patient care record and obtain signature of the victim or attendant. In case he refuses to sign, the same shall be recorded in the patient care record.
11. The Emergency MO of the CHC is authorized to transfer an emergency case directly to next higher(Tertiary) health care facility side stepping the DHH (Secondary health care facility) during odd hours, with a proper Emergency Form (Format at Annexure-4) giving complete details as regards to the clinical condition and management of the patient. A patient can only be transferred from a Tertiary level health care facility, on the recommendation of the Medical Superintendent of the concerned hospital or any officer authorized on his behalf. Without signature on the referral form the service provider shall not transfer the patient.
12. Under no circumstances inter-facility transfer of a patient is permissible from a higher to lower health care facility.
13. The Govt. Medical Officers are not authorized to refer patient to any private hospitals, no patient from a Govt. health facility can be referred to any private hospital by Govt. Medical Officer.
14. While carrying a patient on board, if the EMT of the ambulance suspects that the patient is not likely to be alive, he will take the patient to a nearest Govt. health care facility instead to the health care facility to which the patient has been referred, for check up. If the patient is declared dead by the Medical Officer there, the EMT shall leave the dead body at the hospital and inform the attendant/ relation of the patient to make their alternative arrangement for carrying the dead body and return to the base location of ambulance. The ambulance of OEMAS project is not permitted to transfer any dead body, as per the provision under Clause-6. (I) of the SOP. If the patient's relations

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insist to take the suspected dead body home instead of a Govt. health facility to confirm death, the EMT may do so with information lodged with the local / nearest police station and inform 108 control room

15. The protocol on inter-facility transfer should be prominently displayed in every Govt. Health Care Facility and inside the ambulances of OEMAS.
16. **Advance Life Support Ambulance:** As per the patient Assessment Protocol for pre-hospital care, the Agency follows the guidelines compiled by Life supporters for ZIQITZA Health Care Ltd. According to the guide lines patients with following conditions can be transported by ALS ambulance after initial assessment for management.
    - i. Chest Pain- when the patient requires application of Nitroglycerine patch/ requires monitoring with Cardiac Monitor/ having dysrhythmias.
    - ii. In Anaphylaxis
    - iii. Acute Myocardial infarction (Heart attack)
    - iv. Cerebro-vascular Accident (Stroke).
    - v. Abnormal Delivery (breech/limb presentation/prolapsed cord/multiple birth)
    - vi. Post-partum Hemorrhage.
    - vii. Miscarriage.
    - viii. Diabetic Emergencies; Hypo/Hyperglycemic conditions.
    - ix. Severe Dyspnea.
    - x. Poisonings: severe cases of Ingested/ inhaled/ poison on skin/ in eye/ insect bite/snake bite.
    - xi. Seizures (in Diabetic emergency cases only).
    - xii. Severe cases of Chest Injuries/ Abdominal injuries/ severe Extremity injuries/Spinal injuries/ Crush injuries.
    - xiii. Severe Hemorrhage.
    - xiv. Severe Burn cases (including thermal, chemical and electrical burns)
    - xv. Shock (Hypoperfusion)
    - xvi. Head/ Neck/ Spinal Injuries

The above protocol for transport of patients in ALS ambulance being followed by the service provider to be continued as such.

Where the patient is transferred before being admitted to the facility due to absence of the doctor or health staff then this shall not be considered as inter-facility transfer/referral transport and the patience shall be moved to the next nearest appropriate health facility. However the service provider is required to maintain record of such instances.

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6.13 Request for "Dead Body" Transfers

6.13.1 Ambulance won't transfer any person declared dead by a doctor.

6.13.2 Victim shall be considered dead only when it is declared officially by a qualified doctor as dead.

7 Human Resource Management

7.1 Manpower Recruitment

7.1.1 The Service Provider would recruit, train and engage adequate number of personnel both at field level and at call centre level to run the project smoothly as envisaged under contract.

7.1.2 The Service Provider shall ensure that all the staff members are having the requisite qualification and experience for the position they are hired as per Clause No. 2.5.15 of RFP.

7.1.3 The Service Provider can employee any one suitable for the job in compliance with the laws of the land (Labour Act/ Minimum Wages Act, etc.). The service provider being the Principal Employer shall comply with the provisions of MTWA, EPF, ESI, Payment of wages, Bonus, Gratuity, etc. as applicable and would indemnify the Authority from liability (whatsoever) on account of its failure or negligence. There will be no Employee- Employer relationship between the staff deployed for the project by the approved service provider. Whereas there is a principal-to-principal contract between service provider and NHM.

7.1.4 The Service Provider will be solely responsible for staff related expenditure including salary, compensation and other statutory payables and timely payment of all such expenditure. The Service Provider shall open a dedicated bank account for salary disbursement to all the project staff engaged by it within the prescribed timeline. The authority may seek documentary proof of such payments with respect to salary and other statutory dues from the service provider. No provisioning of such documentary evidence by the Service Provider shall be considered as breach of contractual obligations and accordingly liable for corrective/penal action.

7.1.5 The Service Provider will take prior approval from the authority (MD,NHM) for any change in the composition of key personnel or replacement of any key personnel proposed by it in the technical proposal before its deployment. In case of replacement, the authority shall accept the replacement only if it is

equivalent or better than the original candidate with respect to education and experience.

7.1.6 The Service Provider shall submit with the authority (MD, NHM) the detail curriculum for the training, or the courses designed for EMTs, Pilot and other personnel to be engaged in the project from a recognized institution.

7.1.7 It is not obligatory in the part of the authority (MD, NHM)to redress or attend the grievances, if any, raised before it by the project staff. The approved service provider is primarily and solely responsible to attend the grievances and resentments made by the staff and provide appropriate and timely remedy, wherever required. However, authority shall take appropriate actions to ensure uninterrupted provisioning of the services and held the approved service provider primarily responsible for all such act and abstinence affecting the operation. Under no circumstances any of the crew member or vendor shall approach NHM on resolution of payment and HR related issues.

7.1.8 Service provider being the Principal Employer of all the staff deployed for this project, shall be responsible for due compliance of all obligations under any statute or laws as applicable in India.

7.1.9 Service Provider shall ensure that all the dues and entitlements of the staff members including the field staff are meet on time. Any interruption in the service due to any act or abstinence of the approved service provider shall be treated as breach of contract.

7.1.10 Details of the proposed manpower deployed and disengaged shall be shared with the authority as and when sought.

7.1.11 The recruitment and training manual for the project (IPTHHS) and the policy of the Service Provider with respect to the recruitment, replacement, training and other matters specific to this project should be compliant to the terms of the contract and other documents including RFP, SOP and applicable statutes.

7.1.12 The Service Provider shall deploy required number of ambulance staff and other staffs with required qualification as stipulated at clause 2.5.15 of the RFP & corrigendum to the RFP IPTHHS Phase-II for smooth operations..

7.1.13 While recruiting existing field staff the incoming Service Provider shall ensure that their performance and conduct in the earlier project is clean and satisfactory.

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7.1.14 Agency (Service Provider) shall ensure that the working hours of ambulance and call centre staff are within the permissible limit as prescribed under relevant laws in India. The Agency shall also ensure that no staff is allowed to work for more than 12 hours in a day. Service provider shall also carry out medical fitness test on yearly basis of all ambulance staff from the designated government health facility to ensure they have the required level of medical fitness to carry out their job responsibility efficiently and effectively.

7.1.15 Service Provider shall ensure that monthly salary of the project staff, directly involved in the operation of different services under this project (including call centre, ambulance, and other field staff) are paid directly through their bank account without any delay latest by 5th of the following month. The service provider is required to submit along with the monthly invoice proof of payment of salary for the previous month as a mandatory requirement in the manner and format as sought by the Authority.

7.2. Staff Uniform and Identity

7.2.1 All ambulance crew who works for the approved service provider are, at all times whilst performing their duties should wear proper uniform.

7.2.2 Uniform dress code and minimum standards of appearance shall be ensured by the approved service provider to inspire confidence in service, through a professional image.

7.2.3 Uniform when worn must at all times be clean and pressed and individual's overall appearance should be of a smart, professional person.

7.2.4 No ambulance crew is allowed to perform his/her duty without wearing uniform. Non-adherence to this provision shall amount to breach of service code.

7.2.5 Uniforms provided by the approved service provider should not be worn by the crew member when not in duty. The staff/crew member shall ensure that the uniforms given to him are not used by any other person.

7.2.6 The staff shall report loss of uniform forthwith to the service provider and make every effort to trace the same.

7.2.7 The staff member must return the uniforms and badges to the immediate line manager on the event of termination or resignation from the service, failing which appropriate amount of deduction shall be made from the payables by the service provider.

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7.2.8 Crew members while on duty are not allowed to wear open toe shoes, sandals or chappals.

7.2.9 Crew members shall wear the ID or badge issued by the service provider during the duty hour. The id or badge should be clearly visible to others.

7.2.10 If the crew member found working either without the uniform or ID the Badge/ID shall be marked absent for that day.

7.3 Code of Conduct for Crew Members

7.3.1 The crew members should not:

a) Be drunk intoxicated or under the influence of narcotic substances on duty.
b) Indulge rash driving or deliberately causing damage to the vehicle.
c) Using ambulance for personal work (includes taking unauthorized halt or taking unauthorized / longer route).
d) Damage or misuse any property or assets belongs to the project.
e) Misuse the medicine on the ambulance. (Like selling it).
f) Giving false details in report or not maintaining proper reports or creating job ids for not eligible patient or even if there is no patient.
g) Demand/receive any gifts/tips or other inducement, cash or in kind from the public.
h) Allowing entry of anybody other than patients/ victims or bystanders in the ambulance.
i) Indulge in any practice that is unethical or fraudulent or involving in unlawful strike or indulge in fuel theft and any other theft.
j) EMT should not be seated in the driver cabin when patient is on board. Drop patients in private hospital or collect money from hospital authorities.
k) The crew members are not allowed to use mobile for personal purpose while on duty.
l) The crew members are required to remain alert while on duty and not allowed to sleep during duty.
m) The crew members are required to behave professionally with utmost decency. They should restrain themselves from abusing patient or attendant in general and elderly and child in specific.
n) No post on social media should be made while on duty, on uniform or in ambulance.

7.3.2 All the crew members shall strictly adhere to the above code of conduct. The Service Provider shall be primarily responsible for complete implementation of the code of conduct and shall be held primarily responsible for its non-compliance by any crew member.

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7.3.3 The approved service provider shall be primarily held responsible for non-compliance of code of conduct by the staff as the principal employer and to initiate appropriate disciplinary action.

7.3.4 The crew members should abstain from any kind or form of elder or child abuse. Abuse shall include:

a) Not providing proper healthcare.
b) Charging for free medical care and service
c) Receiving or asking for kickbacks for referring to a particular health facility or for showing any other undue favour contradictory to the protocol.
d) Over or under-medicating to the victim.
e) Recommend fraudulent remedies for illnesses or other medical conditions.
f) Inadequate responses to question about care.

7.3.5. Physical Behaviors and Restrictions:

a) Ambulance crew needs to be aware of different behaviour displayed by patients.
b) Awareness of these behaviour helps them to take the first steps towards better care to the patient needs.

7.3.6. Types of Patient Behaviors could be one or more of the followings:

a) Some patients are difficult, nasty, obnoxious or disruptive.
b) Some patients file lawsuits
c) Some patients place unrealistic responsibilities on the EMT.
d) Sometime patients are just frustrated.
e) Some patients demand treatments which is contradicting to the prevailing medical conditions and treatment protocol.
f) A belief that a disease doesn't exist.
g) Sometimes patient gets violent due to stress.
h) Female patient might resist a male EMT to proceed with the necessary treatment.

7.3.7. The EMT is expected to understand behaviour of the patient and treat him/her with utmost professionalism and courtesy.

7.4 Training

7.4.1 The service provider shall enhance the capacity of staff employed for the operation management of the project through qualitative and ongoing training programs within the scope of this project.

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7.4.2. Continued training should be provided to Ambulance Personnel (EMT, Pilot, Helper) and Control Room staff to perform their duty with required efficiency and quality standard.

7.4.3 The Service Provider shall ensure training to staff keeping in mind the provisions as defined in clause- 2.5.15 of the RFP document.

7.4.4 The training module shall aim at to enhance the capacity of the personnel involved in service provisioning in terms of knowledge and skills through induction and periodic refresher trainings.

7.4.5 Develop curriculum and training modules as required for State health staff to improve emergency response at health facilities at the request of the Government. (Government to bear expenses on such training and workshop).

8 Repair, Maintenance and Management of Ambulances

8.1 Ambulance Upkeep and Maintenance

8.1.1 Ambulances shall be procured, fabricated, equipped and registered in the name of National Health Mission,Odisha or any other authority as proposed by the governmentfollowing the prescribed procurement procedure and other relevant statutory provisions including registration and fitness clearances.

8.1.2 The ambulances once before being deployed shall be subject to inspection by the representative of the Government.

8.1.3 The responsibility of maintenance and upkeep of the ambulances throughout the contract period shall solely rest with the approved service provider.

8.1.4 The service provider would renew the insurance policy, AMC and fitness and any other statutory compliance as per Odisha Boat rule and Motor vehicle Act annually to maintain continuity until the end of the contract. The service provider shall bear all the expenditure relating to vehicle insurance and road tax for the entire contract period.

8.1.5 The flow chart for complaint escalation shall be as below:

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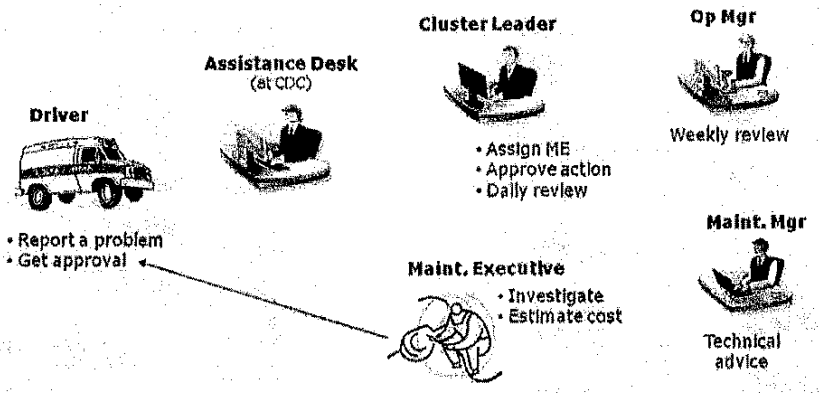

8.1.6 The service provider will check the vehicle as per the maintenance schedule *prescribed by the manufacturer* in order to maintain the health of the vehicle.

8.1.7 The exterior design (branding) shall be finalised by Government. First year branding (stickering) of newly introduced ambulances owned by Government shall be part of CAPEX. Branding of ambulances shall be done afresh in 31st month post initial deployment, and such cost shall be part of the OPEX and borne by the Agency.

8.1.8 The Service Provider is solely responsible for the branding of 24x7 RTS Ambulance as per the design and specification to be provided by the Government. In case of 24x7 RTS Ambulance fresh branding is required within one month after 30th month of initial deployment of the vehicles.

8.2 Mechanical Break Down of Ambulance Vehicles

8.2.1 If the breakdown occurs while responding to a call or with a patient on board, next nearest ambulance at that point of time must be requested through the EMS dispatcher in the Control Room.

8.2.2 It is the responsibility of the EMT to ensure that the Control Room isinformed immediately after such breakdown. *Thereafter the Cluster leader is to be informed.*

8.3 Accidents Involving Ambulance Vehicles

8.3.1 Whenever an accident occurs, no matter how minor, the Ambulance shall stop and the EMT shall survey the scene.

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8.3.2 If a critical patient is being transported, the Driver shall quickly survey the scene, and request Control Room necessary resources if an alternative ambulance is required to transfer the patient.

8.3.3 A Complaint shall be filed at the nearest police station by the cluster leader. Accident Information Report (AIR) will be emailed to the NHM within 48 hours of incident.

8.3.4 NHM will provide against written request by the Service Provider all necessary authorization to the service provider as nodal agency for Integrated Patience Transport and Health helpline Services for the State to deal with insurance authorities for matter involving accident of ambulances and other project assets.

8.3.5 It is the sole responsibility of the Service Provider to take adequate and appropriate insurance coverage for the project assets belonging to Government including Ambulances (EMAS & Boat) owned by the State Government. It shall be the responsibility of the Service Provider to take necessary action for insurance claim settlement and repairing of ambulances to put then back to service. In case any ambulance vehicle is damaged due to accident, it would be the sole responsibility of the Service Provider to repair or restore those ambulances on its own cost. State Government in no circumstances shall compensate for the amount to the extent not covered under the insurance policy.

8.3.6 If the vehicle (EMAS or Boat Ambulance) owned by the Government is declared as **"Total Loss"** then the same shall be replaced by the Department/NHM at their own cost. However, it would be responsibility of the Service Provider to keep such vehicle at its designated base location until its formal condemnation and disposal. Any amount due from Insurer on account of final settlement of claim of total loss should be immediately transferred to NHM account.

8.3.7 To carry repair minor / major and accidental repairs the vehicle will be mapped to the service provider workshop, if any, or the nearest authorized workshop.

8.3.8 Service Provider may set up own workshop duly authorised by the manufacturer for timely repair and maintenance if required and ambulances would be mapped to this workshop depending upon its location.

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8.3.9 In case for any reason, insurance claim for ambulance or other assets could not settled due to deficiency in compliance of Agency, then such ambulance or assets shall be repaired / replaced by the Agency out of its own cost.

8.4 Scheduled and Preventive Maintenance

8.4.1 The schedule of maintenance would be primarily as per manufacturer's recommended schedule to avail the warranty benefit Service provider will strive to maximize uptime of the ambulance so as to ensure that in any given point of time in a district a minimum no of ambulances is operational.

8.4.2 The scheduled maintenance activity would be carried out in such a way that services are not delayed beyond the point where the warranty coverage would be decayed. In order to ensure that ambulance remain in perfect running condition and at the same time to ensure maximum life of each component of the ambulances, the service provider can plan preventive maintenance.

8.4.3 Each Ambulance shall be allowed a maximum of 18 days of off roading for preventive and breakdown maintenance per each completed year of service, calculated @1.5 days per each completed month. The unutilized off-road days for the vehicle in a year shall not be carried forward to next year. No ambulance (ALS/BLS) shall be allowed to be off roadbeyond 18 days in a year.Allowed off-road days of 18 days per year do not include force majeure cases accident and mob violence. However, it covers all other maintenance including routine or preventive. For accident or mob violence cases a maximum of 15 additional days shall be allowed to the Service provider to repair or replace the vehicle and beyond that off-road penalty shall be applicable.

8.4.4 The off-road days per ambulance are to be calculated for each ambulance separately. No case to be assigned if ambulance is marked as off road for more than 12 working hours continuously due to any reason including non-functional essential equipment as defined at **Annexure-7.**

8.4.5 An ambulance does not have an operational status in a sequence like Off-road->On-road-> Off-road unless a minimum of one case is successfully attended in between two Off-road condition. That means there can't be an On-road condition between two Off-road conditions of an ambulance unless a call is attended successfully in between. Such On-Road condition shall be treated as Off-road condition for all practical purpose where not even a single call has been attended successfully.

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8.5 General Maintenance

8.5.1 The Service Provider shall be responsible for both general and preventive maintenance of EMAS ambulances. General maintenance shall include breakdown repair and maintenance. No additional off-road days shall be allowed for general breakdown maintenance.

8.5.2 Ambulances under repair and maintenance for damage due to force majeure events including accidents and mob violence shall be allowed 15(fifteen) days extra off-road days over and above 18(eighteen) off-road days in a year.

8.6 Sanitation and Privacy in the Ambulance

8.6.1 The sanitation inside the ambulance is of utmost importance. It's the responsibility for the crew members to strictly follow sanitation norms as below:

a) An ambulance should be well maintained to ensure proper sanitized condition for safety of patients and ambulance crew themselves.
b) The interior of the ambulance, including all storage areas, must be kept clean so as to be free from dirt, grease, and other offensive matter.
c) If an ambulance has been used to transport a patient who is known or should be known by the attendant or driver to have a transmissible infection or contagious disease, other than a common cold, liable to be transmitted from person to person through exposure or contact, surfaces in the interior of the ambulance and surfaces of equipment and materials that come in contact with such patient must, immediately after each use, be cleaned so as to be free from dirt, grease, and other offensive matter and be disinfected or disposed in a secure container so as to prevent the presence of a level of microbiologic agents injurious to health.
d) Smoking in any portion of the ambulance is prohibited.
e) Bio medical waste to be segregated as per Government norms.
f) Bio medical waste to be disposed as per BMW Management Rules.

8.6.2 The crew members are obliged to maintain the protocol with respect to the privacy of the patient or victim as explained below:

a) Ambulance team need to maintain patient confidentiality to allow the patient to feel free to make a full and frank disclosure of information to the EMT with the knowledge that he will protect the confidential nature of the information disclosed.

b) EMTs duty is to keep their patients' confidences. In essence, their duty to maintain confidentiality means that they may not disclose any

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medical information revealed by a patient or discovered by an EMT in connection with the treatment of a patient.

c) Full and frank disclosure of patient's condition enables the EMT to diagnose conditions properly and to treat the patient appropriately.

d) In return for the patient's honesty, the EMT generally should not reveal confidential communications or information without the patient's express consent unless required to disclose the information to any hospital or medical care center or doctor where the patient needs further treatment.

e) Each ambulance must be maintained in full operating condition and documentations of maintenance must be kept in the file.

8.7 Breach of Confidentiality:

8.7.1 A breach of confidentiality is a disclosure to a third party, without patient consent, of private information that the EMT has learned within the patient-EMT relationship.

8.7.2 Disclosure can be oral or written, by telephone or fax, or electronically, for example, via e-mail or health information networks. The medium is irrelevant.

8.7.3 Breach of confidentiality in any manner will be treated seriously and can result in termination of the employee's services in addition to other legal recourses available under relevant law.

8.8 Continuous Quality Improvement

8.8.1 The service provider shall have quality initiatives to support continuous improvement of emergency management.

8.8.2 Feedback should be collected by various methods with appropriate sample to ensure the desired quality of services is maintained.

8.8.3 The service provider should have a proper complaint redressal mechanism in place wherein the complaints from the patients who availed service are captured and remedy is provided within specified time period. In addition, there shall be a facility of automated mechanism to measure the satisfaction level of the user of ambulance service by sending a text massage to the users availed the service to grade the level of service numerically. The ratings are to

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be compiled periodically to evaluate user response rate, service quality and take possible corrective measures.

8.8.4 In processes and areas where there are frequent complaints, the service provider would initiate special projects in quality improvement to resolve the same.

8.8.5 The service provider would set up a quality department to monitor quality initiatives of the program.

8.8.6 Any inputs from the feedback of patients using the service which would require amendments of terms and conditions of the agreement with best interest of the intended user would be brought to the notice of NHM and NHM would consider the amendment after detailed study. Any amendment for which the service provider would be incurring additional costs, the additional costs would be reimbursed by NHM, Such initiatives would be taken up in the best interest of the improvement of Emergency Management.

9 Monitoring, Evaluation and Implementation

9.1. Monitoring Structures

9.1.1 There shall be following committees with defined role and responsibility to ensure smooth implementation, operation and monitoring of the project.

a) State Steering Committee
b) State Procurement Committee
c) State Management Committee
d) District Level Management Committee

9.1.2 Service Provider shall provide access to online data to facilitate online monitoring on a continuous basis. Service Provider shall also give login rights to the designated officials of NHM and Department for online monitoring and evaluation. Service Provider shall also provide hardware and software, if required, at the office of MD, NHM for online monitoring of the services.

9.1.3 The services and records of the service shall be subject to inspection by designated officer(s) of Department or NHM.

9.1.4 Government reserves the right to evaluate the performance of the Service Provider as well as the project periodically by a third party. After rolling out of IT Solutions system audit as detailed at Clause 2.16.5 shall be carried out by the Agency.

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9.1.5 The approved service provider shall develop and implement a fool proof monitoring and evaluation system to ensure efficiency in capacity utilization. Key indicators need to be put in place for looking at equity of access, quality of care, volume of utilization and wasteful consumption.

9.1.6 An online monitoring system having access to data is to be provided at the office of Mission Director, NHM, Bhubaneswar by the Agency. The Agency shall also provide all necessary information in the manner, form and frequency as required by the Authority from time to time.

9.1.7 The Department of Health and Family Welfare, GoO, would be conducting regular monitoring and evaluation of the program based on quantifiable indicators and set parameters. Based on results of evaluation, inputs could be provided to Service Provider for improvement.

9.1.8 The MD, NHM would review the performance of the program quarterly basis. Whereas the senior most Secretary of the Department of Health and Family Welfare, Govt of Odisha would review the program as and when required.

9.1.9 The Chief District Medical & Public Health Officers will review the activities in the district under this project And the findings shall be shared and discussed at the District Health Society meeting for necessary action and support.. The review at the district level shall focus on but not be limited to following areas.

a) Review of the action Points
b) Updates on functions of different services under the project including EMAS, RTS, Health Helpline Service.
c) Off-road status of the Ambulances vehicle-wise
d) Service quality Issue
e) Empanelment of Additional Facilities, IEC Activities, Training Activities, etc.
f) Compliance to SoPs and other protocols
g) Vehicle & Crew preparedness & Conduct of the crew members
h) Status of public health institution used as designated drop in points under EMAS. Committee may recommend addition of new functional Govt Medical College & Hospital as new drop in point.
i) Any other items.

9.2 Project Monitoring Cell (PMC)

9.2.1 Project Monitoring Cell established and empowered to be the dedicated Cell for monitoring of this Project on day-to-day basis, which shall work under the overall supervision and control of the Mission Director, NHM, Odisha. This Cell will act as an interface between the department and the approved service providers and perform the following functions:

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a) Ensuring seamless coordination between the Government and the Service Provider in effective and efficient implementation of the project as per the agreement.

b) Proactive role in strategic and operational planning of activities that would enhance the value of the services, both existing and potential, and effective monitoring of the outputs and outcomes of the project activities.

c) Protecting the interests of the Government in consultation with the Service Provider duly ensuring that all major policy and operational decisions relating to the human resources, procurement, financial management, management information system, etc. (limited to Odisha operations) of the Service Provider are shared with MD, NHM, Odisha.

d) Ensuring timely release of funds to the Service Provider and their utilisation in accordance with the agreement and follow-up action thereof.

e) Ensuring proper upkeep and maintenance of project assets that are purchased with the Government funds that are under the control of the Service Provider for delivery of services.

f) Anticipate and alert the Government of any problems that might have a direct impact on the quality of services.

g) Supervise the fleet management, data management, HR management etc. periodically and keep the Government informed.

h) Any other task assigned by the Government from time to time based on the circumstances

i) Ensuring all the Government expenditures under the project are within and as per the provisions of the Agreement.

j) Ensuring implementation of all provisions of the Agreement before recommending the release of monthly payment.

k) Monitoring the implementation of all clauses in the Agreement.

l) Ensuring optimum utilization of ambulance services by rational deployment of ambulances and organization of segments;

m) Submission of specified periodical reports to department on Physical and operational performance.

n) Co-ordination with department and other authorities at district/institution or state level for smooth functioning and appropriate grievance redressal.

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10 Procurement, Financing, Payment and Reimbursements

10.1 Procurement

10.1.1 Procurement all the assets under the project shall be undertaken by the Agency in the manner specified below.

a) For the purpose of the procurement a Purchase Committee shall be formed by the Agency and the State Steering Committee (PTS) shall nominate four Government officials with approval of the Govt. of Odisha to represent in the Purchase Committee. It would be the responsibility of the committee to ensure that all the procurements are done on a transparent, competitive and fair manner through open tender.

b) Prior approval of the State Procurement Committee (PTS) formed by the Government of Odisha to be obtained in each occasion with respect to the procurement terms and conditions including evaluation criteria, eligibility criterion, mode of procurement, performance security, specifications, designed other special conditions included in the bid document.

c) Approved specifications of the Ambulances, healthcare equipment is given in **Annexure-6 of RFP**. The specification of IT equipment and other items of capital in nature required for up gradation and expansion of the existing Control Room and Call Centre facility shall be finalised as per the requirement.

d) All non-consumable procurements shall become assets of the project, which will have to be handed over to the Government on termination/completion of the project. Proper records of such assets will be maintained in the project accounts.

e) Inspection will be made by an inspection team constituted by the NHM for Ambulances (fabricated/prefabricated) and other capital assets for its satisfactory work and operational readiness.

f) All the bills or invoices for capital items procured, insurances, licenses, should be procured in the name of the NHM.

g) Inventory record of Drugs and Consumables shall be maintained by the approved service provider.

h) The medical and non-medical consumables used inside the ambulance are to be procured by the approved service provider independently and is

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responsibility of the approved service provider to adhere to the standard quality parameter with respect to those products.

i) All other capital assets (excluding ambulances) shall be replaced as and when required taking in to condition its standard usable life and current operational status.

j) All capital assets procured for the project would be handed over to Government after termination of the agreement.

k) The service provider shall maintain a record of assets in the project held on behalf of Government and those records shall be made available to department officials or its representatives for inspection and review periodically.

l) In normal cases, no ambulance shall be due for replacement before 5(five) years of its induction.

10.2 Financing

10.2.1 **Capital Expenditure**: Government shall finance for all capital expenditure relating procurement, designing, refurbishing, and installation of assets including civil infrastructure, IT infrastructure (hardware), ambulances[4] (ALS & BLS), machineries, equipment, accessories, office furniture & fittings. However, the Service Provider shall invest from its own fund for the procurement/development of software required to be installed to run the IPTHHS including Call Centre, Computer Aided Dispatch system, Vehicle Tracking System and Monitoring System, etc. The payment shall become due once ambulances or other capital assets, as the case may be, are ready to operate in all respect and put to use.

10.2.2 **Operational Expenditure:** Government shall bear the operational cost for running the ambulance service on actual kilometer run (i.e. trip kilometer) or on fixed cost[5] basis as the case may be. The rate per Km or per month per ambulance shall be paid as per the contracted rate.

10.2.3 In case of **24x7 RTS (JE Ambulance)** the cost of vehicle and equipment as per the specification shall be borne by the Service Provider and Government shall not incur any capital expenditure. The Service Provider is free to either procure these assets or have them on rent/lease. No vehicles under 24x7 RTS

[4]Vehicles and equipment cost under Referral Medical Transport Service (RTS) (i.e. Janani Express) shall be borne by the Agency.
[5] In case of Boat Ambulance only

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should be older than 6 years (from the date of first registration with RTO) anytime during operation. **The vehicles should be registered as commercial vehicle and as ambulance.**

10.2.4 In case of GR & Health Advice Helpline Services, Government shall pay per seat/shift/month basis (separate rate for doctors and non-doctors) at the end of the month on satisfactory completion of services.

10.2.5 **Advance financing towards procurement of capital asset:** The Service Provider, shall be provided advance, if required, only towards procurement of capital asset (i.e. CAPEX) under the project against 100% Bank Guarantee separately (other than performance security).Advance financing towards CAPEX shall be limited to of Rs 15.00 crores at any given point time. This advance shall be adjusted against claim for CAPEX. While requesting for advance financing, service provider shall produce sufficient evidence justifying the CAPEX requirement.

10.3 Claims and Reimbursements

10.3.1 Claims or reimbursements towards operational expenditure shall be payable on monthly basis on submission of statement of claim and invoice along with supporting documents by the Service Provider. The supporting and details as required to be provided along with the monthly invoice towards operating expenses is given in **Annexure-5A & 5B.**At the time of submission of the invoice the approved service provider shall ensure that the invoice is complete in all respect. Submission of invoice with incomplete information and supporting shall not be considered and shall be returned back by the Project Monitoring Cell within seven working days after scrutiny along with a deficiency note, if any. Government shall release 75% of the monthly invoice value as part payment immediately on submission of invoice and other documents and remaining 25% after due verification.

10.3.2 Monthly payment towards road Ambulance Services under EMAS (108) and 24x7 RTS shall be based on actual kilometers run exclusively to attend the call as supported by GPS tracking reports or based on Odometer reading from EDS, whichever is lesser. Odometer reading from EDS shall be considered only in exceptional circumstances where the variation in distance covered (kilometer run) in a trip between odometer reading and GPS tracking report is more than 10% due to defunct GPS device during the course of the trip and which shall be limited to maximum 2% of the total cases completed in a month across the fleet, to be calculated separately for 102 and 108 ambulance services.

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Calculation for 2% Cases:

1) *First calculate billing KM for all Cases by choosing minimum of GPS and EDS KM*
2) *Select cases where variation between GPS and Odometer reading is more than 10% and GPS reading is less than Odometer.*
3) *Find out average variation i.e. EDS-GPS distance per case from cases obtained above.*
4) *Find out excess KM to be added for 2% of cases by multiplying 2% of all cases by average variation per cases.*

10.3.3 The Service Provider shall submit the GPS reports (as customized by the Authority from time to time) along with monthly claim to validate the same. Service Provider shall go to the destination by following shortest possible route and shall avoid detouring the vehicle to gain kilometers. If found, payment of additional Kilometers run during the trip(s) could be deducted. In case, detouring is done due to reasons beyond the control of the Service Provider, the same shall be reasoned out in the monthly claim. The agency shall submit the job details captured at the call centre properly mapped to trips registered in the GPS.

10.3.4 Price increment on contracted price shall be applicable as per provision 1.4.4.3 (7) of RFP, IPTHHS Phase-II

10.3.5 Payment towards 104-Health Helpline Service shall be on per seat/shift basis at the contracted rate.

10.3.6 Any penalties imposed against non-compliance shall be recovered from the bills/performance security deposited by the Service Provider. If penalties or any other payment recovered from Performance Security, then the Service Provider is required to replenish the Performance Security to make it to its original amount within 15 days from such deductions.

10.3.7 The payment against all ***capital expenditure*** incurred by Service Provider (Where it is to be borne by the Government) shall be released upon the procurement and satisfactory commissioning of assets and upon declaration of such capital assets as the properties of the State Government. Prior to the approval for reimbursement the Agency shall furnish acknowledgements received from the venders/suppliers conforming that the payment has been made to them by the Agency (Service Provider) against such capital assets. The Government shall within two months from the date of submission of the invoice and other necessary documents with respect to procurement of the capital asset reimburse all eligible capital expenditure incurred by the Service

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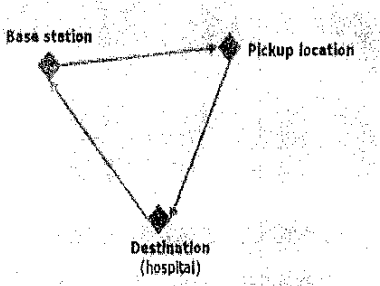
Provider. A compliance checklist for reimbursement of Capital Expenditure is given in **Annexure-6.**

10.3.8 The billing period and due date for submission of monthly Invoice or different services under the project shall be as fellow:

Sl. No.	Project Components	Billing Period	Due Date of Claim Submission
1	ALS, BLS Ambulances	Calendar Month	By 10th of ensuing month
2	Referral Transport Ambulance (RTS)	Calander Month	By 10th of ensuing month
3	Boat Ambulances	Calendar Month	By 10th of ensuing month
4	GR & Health Help Services	Calendar Month	By 10th of ensuing month

10.4 Trip Distance

10.4.1 In case of ALS, BLS and RTS, the approved service provider shall be paid on the basis of total distance (Kilometre) covered exclusively to attend the calls(i.e. trip distances) by the ambulance during that billing period. The word 'Trip distance' shall mean anyone one of the following distance.



a) When the ambulance dispatched from the base station: Journey from the base point to the site of emergency and onwards to the hospital/CHC with the patient and back to the base location or the location from where the vehicle is dispatched by the Control Room before reaching the base station to attend another case.

b) When the vehicle is dispatched before it reaches to the base station: Journey from the point of dispatch to the site of emergency and onwards to the hospital/CHC with the patient and back to the base location or the location from where the vehicle is dispatched by the Control Room before reaching the base station to attend another case.

c) Journey from the base point to the site of emergency, where the patient is stabilized on the spot and patient is not required to be taken to health facilities and back to the base location.

d) Journey from the base point to the site of emergency where the patient

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is not found /or has moved from the site by using some other transportation means and back to the base location. In cases where more than one patient is transported in the same Ambulance at the same time (Multiple Patient Trip), different patient ids will be generated; however, the same will be counted as 1 trip only.

e) If Ambulances are deployed for Specific Event / Festivals /Mela etc., in such cases the ambulance would be considered as having completed the minimum number of trips and the minimum number of kms per day. Further the said ambulances would not be considered for response time penalty and any other penalty parameters.

f) If on reaching the hospital the patient is referred to a higher hospital on immediate basis as inter facility transfer, then the said transfer would be a new case and trip. The GPS reading would be broken into two separate trips and all the kms logged would be considered for billing purpose.

11 Response to Communication

11.1 Any communication from the employer (i.e. Government of Odisha) through its representatives to the Service provider shall be responded within following specified time limits.

S.No	Particulars	Response Time
1	Questions raised in the Legislative Assembly	Within 1(one) working days or as per the rule of the legislative assembly.
2	Details Requested under RTI	Within 3 to 5(three to five) working days
3	General letters & Queries	Within 7(seven) working days
4	Urgent letter & Queries	2(two) working days
5	Reply to NHRC, OHRC, MACT& Writ Petitions	Within 3(three) working days/as per the urgency

12 11.2 The Agency shall comply any queries/clarifications related to services provided under old contract periods, in response to RTI/any other Legal matter.

Settlement of Dispute

12.1. In case the Service Provider (Agency) fails in comply with the provisions under as applicable laws and thereby any financial or other liability arises on the Government by Court orders or otherwise, the Agency shall be fully responsible to compensate/indemnify to Government for such liability. For realization of such damages, Government may even resort to provisions of

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Odisha Public Demand Recovery Act 1962 or other laws as applicable on the occurrence of such situation.

13 Penalties & Deductions

13.1. Service provider shall be liable to penalty for non-performance or non-adherences to performance or quality parameters in the manner described in **Annexure-10.**

14 Transition Phase and Handing over- Taking over Process

14.1 The Incoming Agency (different than the existing Agency) , who would be awarded the contract through the selection process has to take over the operation &management of the entire project (all districts) from the existing service provider within 3 months (maximum) from signing the Agreement. (without disruption of services).

14.2 For smooth handing over and taking over (HOTO) of Ambulances (Roadworthy condition), Equipment, IT Infrastructure including related Hardware/Software, PRI lines, Call Center, Records etc. to be done within the stipulated time period, between both the Outgoing & Incoming Service Providing Agency, both need to have a comprehensive plan (with timeline) in advance for Inspection of Ambulance & Equipment, where Officials from NHM/Govt. will witness and facilitate the process.

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ANNEXURE

Annexure-1: Details of Cases Dispatched or Cancelled

Sl No	Name of field	Description	Whether Applicable for cancelled Call
1	JOB NO	Unique Identifer	Yes
2	FLEET	108 for 108 Ambulances & 102 for 102 Ambulances	Yes
3	CALLER NAME	Name of the Caller who made call	Yes
4	CALLER CONTACT NO	contact number Mobile / landline	Yes
5	ALTERNATE CALLER CONTACT NO	Alternate number if available	Yes
6	TYPE OF EMERGENCY	Emergency (to be defined)	Yes
7	CHIEF COMPLAINT	As per Annexure	Yes
8	IS IFT	Yes or No	Yes
9	REFFRED BY	Name of medical staff who referred (applicable only for IFT Cases)	Yes
10	ASHA	Applicable for JSY Cases	
11	ASHA MOBILE	Applicable for JSY Cases	
12	NO OF PATIENT	Total no of patients carried in the trip	
13	STATUS OF CALL	AVAILED/ Not Availed / Cancelled	
14	AMBULANCE NO	Tracking ID of Ambulance	
15	BASE LOCATION	Base Location of Ambulance	
16	CALL DATE AND TIME	Date & Time of Call landing on dialer	
17	CALL END TIME	End time as per Dialer for Calculation of Handling Time	
18	DISPATCHED DATE AND TIME	Time when ambulance was assigned and ambulance started moving	
19	ONSCENE DATE AND TIME	Time when ambulance reached site of emergency	
20	TOTAL DISPATCH TIME	dispatch time	
21	TOTAL RESPONSE TIME	Call to Site Time	

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Sl No	Name of field	Description	Whether Applicable for cancelled Call
22	PICKUP ADDRESS	To be divided into separate components: Rural: District, Block, GP, Village, location, landmark , PS Urban: District, MC/M/NAC/CensusTown, location, landmark, PS For IFT Cases, pickup address should be District, Block, Hospital Name	Yes
23	DROPOFF ADDRESS	Only Hospital Name to be given	Yes
24	TYPE OF HOSPITAL	Government Hospital MCH,DHH,SDH, CHC, PHCN,SC, Non Designated, Private	Yes
25	PCR ACKNOWLEDGED	Whether PCR Acknowledged	
26	REASON FOR NON ACKNOWLEDGEMENT	If PCR is not aknowledged then reason	
27	PCR ACKNOWLEDGEMENT DATE AND TIME	Date & Time of acknowledgeing PCR	
28	OPD NO	OPD No	
29	IPD NO	IPD No	
30	OPENING KM AS PER ODOMETER	start value as per Odometer	
31	CLOSING KM AS PER ODOMETER	end value as per Odometer	
32	COMPLETION OF TRIP	Date time of completion of Trip when case is dispatched, for cancelled calls completion means closure of cancelled case	Yes
33	TOTAL KM AS PER GPS	Trip distance as per GPS	
34	PATIENT NAME	Name of the patinet, name is not known then "unknown", if infant or neonate then "baby of XXX"	
35	AGE	for less that 1 year the value should be .1 to .11	
36	SEX	Sex of patient	
37	PATIENT CONTACT NO	Patient contact No if available	

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Sl No	Name of field	Description	Whether Applicable for cancelled Call
38	NO OF PATIENT	if More than 1 then name and age to be mentioned as comma separated list	
39	PATIENT CONDITION	Description of patient/ patients condition after boarding	
40	CLOSING REMARK	Closing remarks to include for availed case, reason for unavailed & Cancelled case	
41	ONBOARD DELIVERY	Applicable for pregnency cases, if yes indicate Y else nothing	
42	ONBOARD DEATH	Applicable for all cases, if yes indicate Y else nothing	
43	START_MANUAL	Time recorded by Crew when START Button of GPS is pressed	
44	START_MANUAL_ODOMETER	Odometer reading recorded by Crew when START Button of GPS is pressed	
45	ONSCENE_MANUAL	Time recorded by Crew when ONSCENE Button of GPS is pressed	
46	ONSCENE_MANUAL_ODOMETER	Odometer reading recorded by Crew when ONSCENE Button of GPS is pressed	
47	BOARD_MANUAL	Time recorded by Crew when BOARD Button of GPS is pressed	
48	BOARD_MANUAL_ODOMETER	Odometer reading recorded by Crew when BOARD Button of GPS is pressed	
49	HOSPITAL IN_MANUAL	Time recorded by Crew when Hospital IN Button of GPS is pressed	
50	HOSPITAL IN_MANUAL_ODOMETER	Odometer reading recorded by Crew when Hospital IN Button of GPS is pressed	
51	HOSPITAL OUT_MANUAL	Time recorded by Crew when Hospital Out Button of GPS is pressed	
52	HOSPITAL OUT_MANUAL_ODOMETER	Odometer reading recorded by Crew when Hospital Out Button of GPS is pressed	

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Sl No	Name of field	Description	Whether Applicable for cancelled Call
53	CLEAR_MANUAL	Time recorded by Crew when Clear Button of GPS is pressed	
54	CLEAR_MANUAL_ODOMETER	Odometer reading recorded by Crew when Clear Button of GPS is pressed	
55	START_GPS	Time as per START Button of GPS	
56	ONSCENE_GPS	Time as per ONSCENE Button of GPS	
57	ONSCENE_GPS_DISTANCE	distance from START to ONSCENE as per GPS	
58	BOARD_GPS	Time as per BOARD Button of GPS	
59	BOARD_GPS_DISTANCE	distance from ONSCENE to BOARD as per GPS	
60	HOSPITAL IN_GPS	Time as per Hospital IN Button of GPS	
61	HOSPITAL IN_GPS_DISTANCE	distance from ONSCENE to Hospital IN as per GPS	
62	HOSPITAL OUT_GPS	Time as per Hospital Out Button of GPS	
63	HOSPITAL OUT_GPS_DISTANCE	distance from Hospital In to Hospital Out as per GPS	
64	CLEAR_GPS	Time as per Clear Button of GPS	
65	CLEAR_GPS_DISTANCE	distance from Hospital Out to Clear as per GPS	
66	CREATION TIME	Time stamp when row containing job is created in database	Yes
67	LAST UPDATE TIME	Time stamp when row containing job is updated	Yes
68	UPDATE COUNTER	Total no of updates applied on the row	Yes
69	NAME OF PILOT	Applicable for both EMAS & Referral Transport	
70	NAME OF EMT	Applicable for both EMAS	
71	NAME OF HELPER	Applicable for both EMAS	

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Annexure-2:List of Chief Complaints for use of in Emergency Medical Dispatcher

Sl No.	Chief Complaints
1	Abdominal Pain/Problems
2	Allergies (Reactions) / Envenomations (Stings, Bites)
3	Animal Bites / Attacks
4	Assault / Sexual Assault / Stun Gun
5	Back Pain (Non-Traumatic / Non-Recent)
6	Breathing Problems
7	Burns (Scalds) / Explosions
8	Carbon Monoxide / Inhalation / HAZMAT / CBRN
9	Cardiac or Respiratory Arrest / Death
10	Chest Pain
11	Choking
12	Convulsions / Seizures
13	Diabetic Problems
14	Drowning / Diving / SCUBA Accident
15	Electrocution / Lightning
16	Eye Problems / Injuries
17	Falls
18	Headache
19	Heart Problems / A.I.C.D.
20	Heat / Cold Exposure
21	Hemorrhage / Lacerations
22	Inaccessible Incident / Entrapments
23	Overdose / Poisoning (Ingestion)
24	Pregnancy / Childbirth / Miscarriage
25	Psychiatric / Suicide Attempt
26	Sick Person
27	Stab / Gunshot / Penetrating Trauma
28	Stroke (CVA) / Transient Ischemic Attack (TIA)
29	Traffic / Transportation Incidents
30	Traumatic Injuries
31	Unconscious / Fainting(Near)
32	Unknown Problem (Collapse 3rd Party)
33	Inter-Facility Transfer / Palliative Care
34	Automatic Crash Notification (A.C.N.)
35	HCP (Health-Care Practitioner) Referral (United Kingdom only)
36	Flu-Like Symptoms (Possible H1N1)
37	Inter-Facility Transfer specific to medically trained callers

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Annexure-3: Undertaking for Removal of Branding post withdrawal of Ambulances

It is hereby confirmed and certified that the Branding of Referral Transport Ambulance (insert the registration number of Ambulance) which is to be withdrawn on (insert the date of withdrawal) has been removed completely in the presence of our authorized representative. We are aware that in the event of the said vehicle being used in patient transport in future, we shall never claim the operational expenditure for the ambulance as it will not be part of the of fleet of ambulance under IPTHHS.

Dated this _____ Day of _____, 20____

For _____

(Name)
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Annexure-4: Emergency Transfer Form (Protocol for Inter facility Transfer)

EMERGENCY TRANSFER FORM	
Cause of Referral:	
The Patient may be transferred with Risk: Yes/No	
Details of the Referring Doctor: Name:_____ Designation:_____ Contact No:_____ Name of Hospital:_____ Signature of Doctor:_____	Details of the Referred Hospital: Name:_____ Address:_____ _____ _____ _____

ଅନୁମତି ପତ୍ର

ଶ୍ରୀମାନ୍ ଦ୍ୱାରା ପରିଚାଳିତ .ଜିକିସା ହେଲଥ କେୟାର ଲିଃ ,ସ୍ତ୍ରୀ / ପୁରୁଷ ...ବୟସ ..... ଶ୍ରୀମତୀ / ଆମ୍ବୁଲାନ୍ସ ସହାୟତା ରେ ନିମନ୍ତେ ଆବଶ୍ୟକ କରୁଅଛି କୁ ସ୍ଥାନାନ୍ତରିତ ହେବା ..... ଠାରୁ ..... । ମୁଁ ଭଲ ରୂପରେ ବୁଝି ପାରୁଥିବା ଭାଷାରେ ସମସ୍ତ ବିପଦ ବା କଷ୍ଟର ସମ୍ଭାବନା ଓ ପରିଣାସ ସମ୍ବନ୍ଧରେ ମୋତେ ଅବଗତ କରାଯାଇଅଛି । ମୋର ଜ୍ଞାତସାରରେ ସ୍ଥାନନ୍ତରିତ ହେବା ନିମନ୍ତେ ମୁଁ ଅନୁମତି ପ୍ରଦାନ କରିଛି ।

ଯଦି ମୁଁ ଆମ୍ବୁଲାନ୍ସ କର୍ମଚାରୀଙ୍କ ବିନା ଅନୁମତିରେ ଆମ୍ବୁଲାନ୍ସ ପରିହାର କରେତେବେ ଏହା ମୋର ଅନୁମତିରେ , ହୋଇଛି ବୋଲି ବିବେଚନା କରାଯିବ । ଯଦି ଏଥି ନିମନ୍ତେ କିଛି ଅଘଟଣ ଘଟେ ତେବେ ମୁଁ ସେଥି ନିମନ୍ତେ ଦାୟୀ ରହିବି ।

କ ମୁଁ ହେଉଛି ରୋଗୀ ଯାହାକୁ ସ୍ଥାନାନ୍ତରିତ କରାଯିବ (।

ଖମୁଁ ହେଉଛି ରୋଗୀର ସର୍ମ (କୀୟ ସାଥୀ ଯାହାକୁ ସ୍ଥାନାନ୍ତରିତ କରାଯାଉଛି (ରୋଗୀର ସର୍ମକୀୟ)

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ସ୍ୱାକ୍ଷର ପାରାମେଡିକ ଡାକ୍ତର ଆଟେଡାଣ୍ଟଙ୍କ

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Annexure-5A: Checklist for Reimbursement of Operational Expenses towards EMAS

Sl No	Item	Submitted (Y/N)	Number of Pages
1	Proof of payment of salary to staffs engaged in project: The proof should preferably be bank statement		
2	List of manpower engaged in project for the concerned billing period.		
3	EPF ESIC payment details for the preceding month along with payment challans		
4	District wise list of Ambulance Crew , Maintenance Executive and CL		
5	List of MBBS Doctors		
6	Fitness and Insurance Renewal document		
7	Undertaking for payment of Special allowance to Ambulance crew on monthly basis		
8	Any other document as required by the authority.		

Annexure-5B: Checklist for Reimbursement of Operational Expenses for 24x7 RTS.

Sl No	Item	Submitted (Y/N)	Number of Pages
1	Proof of payment of dues to RTS Vendors: The proof should preferably be bank statement along with undertaking .		
2	Inspection Report and Handing over document in respect of Ambulances introduced in the fleet along with copy of RC, Insurance(comprehensive coverage 5 persons as occupant), Fitness		
3	Handing over document for the Ambulances interchanged base location		
4	Copy of Renewed Fitness and Insurance in respect of Ambulances operational under the project.		
5	List of Ambulance crew engaged for the concerned billing period		
6	Any other document as required by the authority.		
7.	Proof of payment of salary to AMBULANCE CREW in 24X7XRTS project: The proof should preferably be bank statement		

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Annexure-6: Checklist for Reimbursement of Capital Expenditures incurred on behalf of Govt by the Agency

Sl No	Item	Submitted (Y/N)	Number of Pages
1	Original Invoice (certifying payment made to the supplier on face of the bill, stock entry on back side of the bill)		
2	Copy of extracts from the Asset Register		
3.	Actual Payees Receipt from the Supplier/vendor indicating quantity of materials.		
4	Inspection Report		
5	Copy of Minutes of the meeting of Purchase Committee for selection of supplier		
6	Copy of Finance bid of the supplier		
7	Any other document as required by the authority.		

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Annexure-7: List of most Essential Equipment in ALS & BLS

Sl No	Equipment	Condition	Type	Action
1	Defibrillator / Monitor	Manual Defibrillator – not working ECG – Absolute no display (No downgrade if printer is not working) ECG Pads / Cable not available / Not working Pulse Oxy Meter not working (No downgrade if handheld pulse oxy meter is provided as back up) Fully discharged and Charging facility not working	ALS	Off Road
2	Transport Ventilator	Transport Ventilator not working (only If alternate provision for Mechanical ventilation with ambu-bag set not provided)	ALS	Off Road
3.	Syringe Pump	Syringe pump not working (Machine not getting on), Battery pack expire, syringe not recognised	ALS	Off Road
4.	AED	AED not working (AED not getting on) AED Pad expire. Display showing battery low (voice message coming "Maintenance require")	BLS	Off Road
5	Suction Pump Electrical	Only if both the suction pumps are not working	ALS & BLS	Off Road
6	Suction Pump Manual	Only if both the suction pumps are not working	ALS & BLS	Off Road
7	Laryngoscope with Blades	Laryngoscope non-functional	ALS	Off Road
8	Oxygen cylinder "B" Type	Oxygen Cylinder empty (only if all other Oxygen cylinders in ambulance are empty)	ALS & BLS	Off Road
9	Oxygen Cylinder "D" Type	Oxygen Cylinder empty (Only if all other Oxygen Cylinders are empty)	ALS	Off Road
10	Collapsible Chair cum Trolley Stretcher	Stretcher fully not functional (doesn't include minor issues which don't effect the transportation of patient from one place to ambulance including failure of auto loading facility)	ALS & BLS	Off Road
11	Pulse Oxymeter	Pulse Oxymeter not working	ALS & BLS	Off Road
12	GPS Equipment	GPS equipment in non operational condition for more than 12 working hours	ALS & BLS	Off Road
13	Fire Extinguisher	Available in the Ambulance (Valid)	ALS & BLS	Off Road
14	AC	Functional	ALS & BLS	Off Road

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Annexure8: Penalty & Deduction for Non-performance

S. No.	Performance Parameter	Description & Incidence of Default	Penalty
A	**"EMAS-108": Emergency Medical Ambulance Service**		
A1	Taking over and operationalization of all the services under the project within 3 months of signing of the Contract.	For each day of delay in deployment beyond 3 months' time.	Rs 12,00,000.00 (Rupees Twelve Lakhs only) per each day of delay.
A2	Average Response Time (ART[6]) for State: Less than or equal to **20 Minutes.** *(For response time calculation Interfacility transfer cases to be excluded)*	For each minute of delay in average response time: *(To be calculated as monthly average over the entire fleet of vehicles (ALS & BLS) i.e., State Average.)*	0.5% of the total monthly charges/fee payable towards EMAS service for the entire State, per each minute of such delay.
A3	Eligible Call Attended: More than 95% *(More than 95% of the calls as eligible for response is attended by dispatching ambulance)*	Penalty shall be levied if attendance level falls below 95% in a month.	Rs 1,00,000/- for each completed month for each percentage of shortfalls from 95% level.
A4	i) Each Ambulance shall be allowed a maximum of 18 days of off roading for preventive and breakdown maintenance per each completed year of service, calculated @1.5 days per each completed month. The unutilized off-road days for the vehicle in a year shall not be carried forward to next year. No ambulance (ALS/BLS) shall be allowed to be off road* beyond 18 days in a year.	i) Allowed off-road days of 18 days per year do not include force majeure cases accident and mob violence. However, it covers all other maintenance including routine or preventive. For accident or mob violence cases a maximum of 15 additional days shall be allowed to the Service provider to repair or replace the vehicle and beyond that off-road penalty shall be applicable. For "95% on-road condition" only those	(i) ***Rs 2,000.00 per day/vehicle more than allowed days.*** (ii)Rs 200.00 per ambulance hour more than 5% limit (district-wise). *Above penalties with respect to off*

[6]Average Response Time (ART) is the time lag between the landing of call at the call centre and arrival of Ambulance on the site.

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	ii) At any given point of time more than 95%[7] of the vehicles (ALS/BLS) shall be on-road condition[8].	ambulances which are off road for more than 1(one) hour at a stretch, shall be considered and calculation shall be done for each district separately. However, in case of small districts where 5% of the vehicles in a district is less than 2 (two) then in lieu of 5% of vehicles, 2 vehicles shall be taken.	*roading are concurrent in nature. (i.e., both penalties shall be levied simultaneously in case of default)*
A5	Minimum average of 4(four) cases per Day/Ambulance at State level and minimum average of 3(three) cases per Day/ Ambulance at District level. Average (State) running of 170 KM /Day/ Ambulance.	Penalty shall be imposed if any of these performance indicators is not complied. ***This penalty clause shall not be applicable in case more than 95% eligible calls are attended by the service provider.***	@ Rs 2,000/- per each 0.1 cases shortfall from expected level of 4 cases (State Level)/3 (District Level) Cases/Day/Ambulance in each month of operation. Penalty shall be imposed @Rs. 400/- per each 1.00 KM shortfall in average daily running of Ambulance). And *If all three performance parameters are not complied than all three penalties will be applied simultaneously.*
A6	Any shortfall/ default found on inspection by Authorised representatives or officials of the Authority.	1. Poor General cleanliness /Ambulance body Hygienic storage of Medical/ non- medical consumables/staff uniform and availability. 2. Non-availability of Medical/ non- medical consumables as per the enclosed list at **Annexure-6 of RFP.** 3. Non-functioning of major equipment. 4. Improper maintenance/non-updating of logbook, stock register, PCR record, vehicle maintenance record as prescribed by Authority.	Penalty of Rs 2,500/- per ambulance 1st time for every shortfall/ default and subsequently Rs. 5000/- per Ambulance (Individually for every shortfall/ default)

[7] Vehicles damaged due to accident and mob violence shall only be excluded.
[8] Ready to attend the emergency call with all major equipment functional including the GPS device in functional condition.

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		5. Non-functioning of Air-conditioning of Ambulance.	
A7	Delay in 2nd time branding (stickering) of ambulances	1. It is the responsibility of the Service Provider to rebrand the Ambulances after two and half years i.e., in 31st month as part of OPEX from its own source.	Penalty of Rs 2500/- per Ambulance for each month of delay.
A8	Operational Expenditure towards "Not Availed Cases" over and above 10% of entire cases shall not be paid.	Not availed cases beyond 10% of total cases shall not be paid.	"Not Availed Cases" totaling upto 10% of entire cases during the billing period shall only be paid. For this average trip size of not availed cases is to be found out by formula (i.e., Total billing KM of all not availed cases / Total not availed cases) thereafter the deduction is to be calculated by multiplying average trip size of not availed case with number of not availed cases over and above 10% of total cases.
A9	In no case the service provider shall assign ambulance from outside the area of operation of 30 KMs distance. (i.e., no ambulance should travel more than 30 KMs to reach the site).	Cases assigned beyond 30KMs distance shall not be paid	Total K.M. covered in such cases where the Ambulances have travelled more than 30 KMs to attend the patient shall not be paid.
A10	Multiple Dispatch of Ambulances resulting in "Not Availed Cases".	More than one Ambulance assigned to pick up a single case, resulting to "Not Availed Case".	No payment shall be made for "Not Availed Cases" resulting due to multiple dispatch of Ambulances to attend a single case. Such Not Availed Cases shall not also be considered for calculation of 10% limit set under provision at A8.
A11	Non-IFT cases with trip size of more than 150 km where the Service provider fails to justify.	The Agency to capture justification/reason for all such cases.	In such case, where the Service Provide fails to provide reasonable justification, payment shall be made on the basis of average trip size of Non-IFT cases instead of actual KM run.
B	**Referral Transport Ambulance (JE)**		
B1	Complete rolling out of all vehicles (Ambulances) within 3	Each day of delay per vehicle	Rs. 1,000 per vehicle for each day of delay in deployment.

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	months of signing the contract.		
B2	i) The off-road days for preventive and breakdown maintenance would be accumulated @1.5 days per vehicle for each completed month. No ambulance shall be allowed to be off road* for more than the accumulated (allowed) off-road days. ii) At any given point of time more than 95%[9] of the vehicles (Ambulance) shall be on road. iii) Accumulated unutilized off-road days shall not be carried forward to the next year.	(i) Allowed off-road days of 1.5 days per month do not include accident and mob violence cases for which additional up to **30 days(maximum)** in each year of operation is allowed for repair, restoration, or replacement of vehicle. (ii) For 95% on-road condition only those ambulances, which are off road for more than 1 hour at a stretch, shall be considered and calculation shall be done for each district separately. However, in case of small districts where 5% of the vehicles in a district is less than 2 (two) then in lieu of 5% vehicles 2 vehicles shall be taken.	i) ***Rs 1,500.00 per day/vehicle more than allowed off-road days.*** *(No penalty shall be levied for additional allowed off-roads days i.e., 30 days.)* ii) Rs 120.00 per ambulance hour more than 5% limit (district-wise calculation to be done).
B3	Average Response Time (Call to Site): 25 minutes *(For response time calculation drop-back cases to be excluded)*	Per each minute of such delay in avg. response time (call to Site). *Average response time to be calculated on monthly basis for all the vehicles in the State.*	0.5% of the monthly charges/fee payable towards Referral Transport Service for the entire State, per each minute of such delay
B4	Eligible Call Attended: 95% or more. (More than 95% of the calls as eligible for response is attended by dispatching ambulance)	Penalty shall be levied if attendance level falls below 95% in a month.	Rs 40,000/- for each completed month for each percentage of shortfalls from 95% level.
B5	Minimum numbers of cases/ambulance /day	Multiple patients in a single trip will be considered as a	Penalty shall be imposed in case of any shortfall in average

[9] Shall exclude vehicles under repair in accident or mob violence cases (maximum up to 30 days in each year of operation).

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H&FW Deptt., BBSR

	(Average 3 (three) cases per day.)	single trip. No penalty shall be imposed if less then 5% of the total eligible calls are cancelled during that month. Average Cases per ambulance per day to be calculated each month considering total number of vehicles (Ambulances) deployed in the State.	cases/ambulance/ day in each month of operation @ Rs. 2,000/- for each shortfall of 0.1 cases per ambulance. (Short fall in cases per ambulance/day = Minimum Expected Average Cases per Ambulance/Day (i.e., 3 trips) – Actual Average Cases per Ambulance/Day) ***Example: If service provider does 2.8 cases/day/ ambulance for 100 vehicles then penalty shall be = 100x2000 x 2 = Rs. 4,00,000/-***
B6	Operational Expenditure towards "Not Availed Cases" over and above 10% of entire cases shall not be paid.	Not availed cases beyond 10% of total cases shall not be paid.	Only not availed cases totaling upto 10% of entire cases during the billing period shall be paid. For this average trip size of not availed cases is to be found out by formula (Total billing KM of all not availed cases / Total not availed cases) thereafter the deduction is to be calculated by multiplying average trip size of not availed case with number of not availed cases over and above 10% of total cases.
B7	In no case the service provider shall assign ambulance from outside the area of operation of 30 KMs distance. (i.e., in circumstances the ambulance shall travel more than 10 KM to attend the case)	Cases assigned beyond 30 KMs distance shall not be paid	Total K.M. covered in such cases where the Ambulances have travelled more than 30 KMs to attend the patient shall not be paid.
B8	"Not Availed Cases" resulting from multiple dispatch of vehicle against single case.	More than one Ambulance assigned to pick up a single case, resulting in "Not Availed Case"	No payment shall be made for "Not Availed Cases" resulting due to multiple dispatch of Ambulances to attend a single case. Such Not Availed Cases shall not also be considered for calculation of 10% limit set under provision at B6.
B9	Non-IFT cases with trip size of more than 150 km where the Service provider fails to justify.	The Agency to capture justification/reason for all such cases.	In such case, where the Service Provide fails to provide reasonable justification, payment shall be made on the basis of average tripsize of Non-IFT cases instead of actual KM run.
B10	Cases attended by Referral Transport,	Rendering services to ineligible cases including	Payment shall not be made

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NHM, ODISHA
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	Ambulances other than the purpose it is meant for.	attending to emergency cases or cases beyond the scope of the service.	
C	**Boat Ambulance**		
C1	Response Time (Call to Site) of 45 minutes.	Penalty shall be levied if the average response time is more than 45 minutes.	No Penalty
C2	Cancellation of job without any valid reason.	Penalty shall be levied if the job cancelled without any valid reason.	Rs 1000/- for each job cancelled without any valid reason.
C3	Minimum 6(six) cases per Boat Ambulance in each month.	Penalty shall be applicable if the average cases for Boat Ambulance is less than 6(six).	Penalty will be **Rs.4000/- per each 0.1 cases of shortfall** from expected level of **6 cases /month.** *(No penalty shall be levied in the cancelled call is less than 5%)*
C4	"Off-water" of Boat Ambulances *(Failure in the part of the Service Provider to keep Boat Ambulances ready for use)*	If the Boat Ambulances remains out of order continuously for more than 8 hours, then it shall be considered as "Off Water" and liable for penalty. It is responsibility of the Service Provider to keep the Boat Ambulances ready for service all the time.	**The penalty shall be @ Rs.4,000/- per day per Boat Ambulance beyond the permissible limit of 18 day in a year.** Proportionate deduction shall be made from the monthly fees for the off-road days more than allowed off-road days of 18 days.
C5	Statutory Compliance **(Orissa Boat Rules 2004)**	It is the responsibility of the Service Provider to ensure required Statutory Compliance.	**Noncompliance, the Boat Ambulance to be treated as "out-of-service" and off-water penalty as applicable will be imposed.**
C6	Delay in 2nd time branding (stickering) of ambulances	It is the responsibility of the Service Provider to rebrand the Ambulances after two and half year's operation i.e., in 31st month as part of OPEX from its own source.	Penalty of Rs 2500/- per Boat Ambulance for each month of delay.
D	**Centralised Call Centre Based Health Helpline Service (104):**		
D1	Average calls to be attended by each call takers in a day: • Health Helpline Service including ECD: 20 calls/seat per shift. • BSKY: 100 outgoing calls/seat per shift.	If number of calls are less than the targeted call, then penalty shall be deducted from monthly contracted rate.	Penalty shall be proportionate to the shortfall in number of targeted calls.
D2	Availability of call takers during working hour	Absent for more than an hour during the working hours.	150% of the proportionate charges
D3	Percentage of abundant	Penalty shall be imposed if	Penalty shall be at the rate of Rs

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	call shall not be more than 1%	the percentage of abundant call goes above 1%	2000/- per each additional 1% of abandon call.
E	**Call Centre Service Level Efficiency**		
E1	Service level target of 90% of the calls is to be attended within threshold limit of 10 seconds. *(Short, abandoned calls within 5 seconds are to be excluded)*	Penalty shall be imposed if the rate goes below 90%.	Penalty shall be @ 50,000 per each completed month for each 1% of Shortfall from 90%.
E2	Call Centre Down Time beyond permissible limit of 0.5%, calculated over a month. (Mechanical or Operational). This is non-cumulative.	Average down time each month beyond allowed limit of 0.5%. Average down time to be calculated separately for Health Helpline Service & Ambulances Services.	Rs.5000/- per each hour of downtime exceeding 0.5% in case of Health Helpline. Rs 10,000/- per each hour of downtime exceeding 0.5% in case of Ambulance Services.

OFF-ROAD CONDITION (FOR THE PURPOSE OF PENALTY CALCULATION):

a) An ambulance shall be counted as'Off-road condition" in any one of the following instances:

   (i) GPS is not working for more than 12 hours at a stretch.
   (ii) Key equipment not functional/available for more than 12 hours at a stretch.
   (iii) Ambulance is not working (breakdown condition) for more than 12 hrs. at a stretch.

b) In case of EMAS (108) vehicles (which are government owned) "Off-road" does not include force majeure cases including accident and mob violence vehicle under repair (maximum up to **15 days**). However, it covers/includes all other maintenance including routine or preventive.

c) No ambulances (108-EMAS, Boat & 108-JE) are allowed to operate without insurance coverage and valid fitness certificate. Ambulances shall be treated as off-road (off-water in case of Boat Ambulance) in absence of comprehensive insurance coverage and fitness. However, in case of renewal of fitness certificate where application for renewal is made within stipulated timeline (i.e., 30 days before date of expiry of validity) but fresh certificate has not been issued by the Authority then it will not be treated as off-road/off-water.

d) In case of Referral Transport (108-JE) maximum 30 days in each year of operation shall be allowed for each vehicle for repair in case of damage due to mob violence or accident in addition to 18 days for routine and preventive maintenance.

e) For 24x7Referral Transport Service (108-JE), "Off-road" days more than 30 days (which is allowed for repair in case of mob violence and accident) shall be treated as off road. Service Provider is required to replace accidental vehicles within 30 days.

f) An ambulance cannot have an operational status in a sequence like Off-road → On-road →Off Road unless a minimum of one case is successfully attended in between two Off-road conditions. That means there can't be an On-road condition between two Off-road conditions of an ambulance unless a call is attended successfully in between. Such On-road condition shall be treated as Off-road condition for all practical purpose where not even a single call is attended successfully.

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g) In case the ambulance does not attend the call when the vehicle is showing on-road status then it shall be treated as off-road.

h) For EMAS Ambulances damaged in case of accident or any other force majeure event, the agency must repair Ambulances or deploy back-up Ambulances in their place with 15 days, failing which Off-road penalty shall be applicable.

i) Proportionate deduction shall be made from the monthly contracted rate in case of off-road/off-water beyond allowed days for an ambulance in addition to applicable penalty deductions.

j) The Penalty, which is in absolute value, shall be increased proportionately with the annual increment in monthly fee.

k) In case of Helpline Service, the seats in the call-centre should be earmarked to respective Program/Scheme. *Similarly, separate seats to be allocated for incoming and outgoing calls.*

l) Boat Ambulances must have Comprehensive Insurance for both initial and subsequent years, which shall be part of OPEX and borne by the Agency. It shall be a comprehensive insurance covering at least 6 (six) persons for each Boat Ambulances. In absence of comprehensive insurance coverage, the Boat Ambulance shall be treated as off-water and accordingly OPEX pertaining to that period shall not be paid, in addition to applicable penalty for off-water beyond allowed days.

m) As per clause 2.15.5 of RFP, Service Providor is allowed to maintain upto 5% of the total RTS ambulances of identical specifications and technical condition as backup ambulance and that are to be used as replacements for ambulances that are out of service due to reasons such as accidents, damage, or delays in repairs beyond the allowed off-road period, to avaoid offroad penalties.

n) Offroad and SOR penalty shall not be levied for maintenance and breakdown period of EMAS ambulances which have run for more than 2,50,000 KM and more than 5 years of age.

o) The Agency has to submit following documents for claiming accidental ambulance off road exemption I) Copy of FIR/Station Diary ii) Photo of the affected ambulance iii) Copy of repair invoice iv) Copy of insurance claim settlement

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