EMS Work Session
7-6-93
Handout #3

TANYA COLLIER
Multnomah County Commissioner
District 3

1120 SW Fifth St., Suite 1500
Portland, OR 97204
(503) 248-5217

MEMORANDUM

TO: Acting Chair Hank Miggins
Commissioner Gary Hansen
Commissioner Sharron Kelley
Commissioner Dan Saltzman

FROM: Commissioner Tanya Collier

DATE: July 6, 1993

SUBJECT: EMS Issues and Recommendations

ISSUE: ***Medical Direction***

Recommendation:

- A single Physician Medical Director that focuses on Medical/Clinical issues
- Sets standard of care
- Ensures quality patient care
- Develops medical policies and procedures
- While responsible for medical direction, may use "agents" to insure individual attention and supervision
- The Physician Medical Director should be in the Department of Health and Division of Emergency Management Services which would provide necessary administrative staff to assist the Physician Medical Director
- Job descriptions for Physician Medical Director and System Administration in Ordinance #2

ISSUE: ***Medical Advisory Board***

Recommendation:

- Create Medical Advisory Board in Ordinance #1; explicit powers and duties in Ordinance #2
- The Medical Advisory Board is advisory to the Physician Medical Director on Medical/Clinical issues
- The Medical Advisory Board gives a yearly report to the Board of County Commissioners

ISSUE: ***Provider Design***

GOAL: An EMS System

Recommendation:

1. A Single Ambulance Service Area for first response and transport of critical patients
   A. Portland Fire Bureau
   B. Gresham Fire Bureau

2. Services delivered through performance based contracts administered by Multnomah County

GOAL: Remove redundancy in system

Recommendation:

1. Non-critical patients (through 911 system) assigned to Districts (approx. 1 east district and 1 west district) with a single unified dispatch system directed to send the closest ambulance

2. Services delivered through performance based contracts administered by Multnomah County

ISSUE: ***Rate Regulation***

GOAL: To provide sufficient funding while providing for cost containment

Recommendation:

- Ordinance #1 establish Rate Regulation
- Ordinance #2 establish a Rate Regulation Process for the private and public sector that is based on the cost of providing services with our system design. Start with the lowest possible rate

ISSUE: ***Rural Considerations***

- Urban Growth Boundary dividing line between urban and rural
- Erase jurisdictional lines; meet with all parties and develop a response times and responsibilities (Ord #2)
- Coordinate with Clackamas, Washington, Hood River and Wasco Counties to take full advantage of multi-agency and multi-discipline efforts
- Medical standby
- Life flight when appropriate
- Bolster capabilities of the first responders in the rural areas
  Equipment (Defribulators)
  Training (Defribulators and Airway)

ISSUE: ***Response Times***

- First response goal 4 minutes; 90% of the time
- Eight minute response time; 90% of the time
- Twelve minute response time for non-critical service in the Urban Growth Boundary
- Rural response time of 20 - 25 minutes
- Wilderness region
  - As soon as possible establish dispatch criteria and best effort
  - Establish dispatch
  - Best effort

ISSUE: ***Work Force***

GOAL: Decrease turnover to stabilize work force

<u>Recommendation:</u>

- Handle necessary reduction of private paramedics through attrition to the degree possible
- Address adverse impacts on paramedics

- Establish labor relations goals and objectives in contracts with private providers
- BLS - 1 paramedic, 1 EMT
- Work with schools to provide coordinated training

ISSUE: ***Triage*** (details in Ordinance #2)

GOAL: Rapid and appropriate treatment for those people who call 911

Recommendation:

- Reduce duplication (i.e. Fire trucks going to "every" call)
- Triage at dispatch; may require more sophisticated training
- If in doubt, send too much
- Provide training and equipment to outlying areas

ISSUE: ***Safety***

Ordinance #2

- Address traffic safety concerns
- Establish dispatch criteria for first responders

ISSUE: ***Quality Assurance***

Recommendation:

- Data driven continuous quality management
- Quarterly reviews by treatment team after the fact
- Level of service
- Non-critical and critical patients
- Evaluation - Ongoing performance evaluation in accordance with goals and objectives

ISSUE: ***Sanctions***

Recommendation:

- Establish clear expectations in contract with providers

ISSUE: ***Complaints***

Recommendation:

- Establish a complaint resolution process in Ordinance #2

ISSUE: ***Billing***

Recommendation:

- Establish a single billing system

ISSUE: ***Training***

Recommendation:

- Integrate and coordinate to achieve uniformity and high standards
- Special training programs for rural responders

ISSUE: ***Prevention***

GOAL: Reduce the number of inappropriate calls to 911

Recommendation:

- Cover cost through rates
- Teach appropriate access of the system
- Coordinate though Multnomah County EMS office

ISSUE: ***Regional***

Recommendation:

Keep options open to explore ways in which the system can be regionally coordinated (i.e. protocols, dispatch, medical direction)

ISSUE: ***"Other" Ambulances***

Recommendation:

- Continue to license
- Collect data as part of licensing criteria
- Not subject to 911 regulations
- Establish license requirements in Ordinance #2

MULTNOMAH COUNTY OREGON

OFFICE OF THE BOARD CLERK
SUITE 1510, PORTLAND BUILDING
1120 S.W. FIFTH AVENUE
PORTLAND, OREGON 97204

BOARD OF COUNTY COMMISSIONERS

GLADYS McCOY •	CHAIR	• 248-3308
DAN SALTZMAN •	DISTRICT 1	• 248-5220
GARY HANSEN •	DISTRICT 2	• 248-5219
TANYA COLLIER •	DISTRICT 3	• 248-5217
SHARRON KELLEY •	DISTRICT 4	• 248-5213
CLERK'S OFFICE •	248-3277	• 248-5222

AGENDA

MEETINGS OF THE MULTNOMAH COUNTY BOARD OF COMMISSIONERS

FOR THE WEEK OF

July 5 - 9, 1993

Thursday Meetings of the Multnomah County Board of Commissioners are taped and can be seen at the following times:

Thursday, 10:00 PM, Channel 11 for East and West side subscribers
Thursday, 10:00 PM, Channel 49 for Columbia Cable (Vancouver) subscribers
Friday, 6:00 PM, Channel 22 for Paragon Cable (Multnomah East) subscribers
Saturday 12:00 PM, Channel 21 for East Portland and East County subscribers

INDIVIDUALS WITH DISABILITIES MAY CALL THE OFFICE OF THE BOARD CLERK AT 248-3277 OR 248-5222 OR MULTNOMAH COUNTY TDD PHONE 248-5040 FOR INFORMATION ON AVAILABLE SERVICES AND ACCESSIBILITY.

AN EQUAL OPPORTUNITY EMPLOYER

Tuesday, July 6, 1993 - 9:30 AM

Multnomah County Courthouse, Room 602

BOARD BRIEFINGS

B-1 Briefing on the Status of Tax Title Audit Recommendations and Other Issues. **Presented by Betsy Williams.** 9:30 TIME CERTAIN, 1 HOUR REQUESTED.

B-2 Briefing on Laud Use Appeal Procedure. **Presented by Larry Kressel and Scott Pemble.** 10:30 AM TIME CERTAIN, 1 HOUR REQUESTED.

Tuesday, July 6, 1993 - 2:00 PM

Multnomah County Courthouse, Room 602

WORK SESSION

WS-1 Work Session to Consider Emergency Medical Services Ambulance Service Area Plan Elements and Consider and Modify Draft Plan. Public May Attend, However Invited Testimony Only, No Public Testimony. **Facilities by Bill Collins.** 2:00 TIME CERTAIN, 2 HOURS REQUESTED.

Thursday, July 8, 1993 - 9:30 AM

Multnomah County Courthouse, Room 602

REGULAR MEETING

CONSENT CALENDAR

SHERIFF'S OFFICE

C-1 In the Matter of Transfer of Found/Unclaimed or Unidentified Property to the Department of Environmental Services

DEPARTMENT OF ENVIRONMENTAL SERVICES

C-2 ORDER in the Matter of the Execution of Correction Deed D930777 to Correct an Historical Error in Title Precipitated by Tax Foreclosure

C-3 ORDER in the Matter of Contract 15757 for the Sale of Certain Real Property to Raymond Tindell

C-4 ORDER in the Matter of Cancellation of Land Sale Contract 15606 between Multnomah County, Oregon and ROBERT HALES upon Default of Payments and Performance of Covenants

REGULAR AGENDA

DEPARTMENT OF HEALTH

R-1 First Reading of an ORDINANCE to Adopt an Ambulance Service Area (ASA) Plan for Multnomah County

PUBLIC CONTRACT REVIEW BOARD

(Recess as the Board of County Commissioners and convene as the Public Contract Review Board)

R-2 ORDER in the Matter of an Exemption from Public Bidding, Contracts with Safeway, Fred Meyer, Albertsons, McDonalds, Burger King, Ray's Grocery & Payless Grocery for the Purchase of Food Vouchers

(Recess as the Public Contract Review Board and reconvene as the Board of County Commissioners)

NON-DEPARTMENTAL

R-3 In the Matter of Ratification of the Collective Bargaining Agreement between Multnomah County and Local #88, AFSCME (Juvenile Groupworker)

R-4 First Reading and Possible Adoption of an ORDINANCE Amending Ordinance 720 to Provide Changes in the Bylaws of the Metropolitan Human Rights Commission and Declaring an Emergency

MANAGEMENT SUPPORT

R-5 RESOLUTION in the Matter of the Cancellation of Certain Checks Heretofore Issued by Multnomah County More than Seven (7) Years Prior to July 1, 1993, and Not Heretofore Presented for Payment

R-6 RESOLUTION in the Matter of Accepting the Recommendation of the Employee Suggestion Committee Regarding Employee Suggestion Number DHS-14

R-7 RESOLUTION in the Matter of Accepting the Recommendation of the Employee Suggestion Committee Regarding Employee Suggestion Number DHS-15

R-8 In the Matter of the Review, Discussion, and Adoption of the Budget Notes to the 1993-94 Multnomah County Adopted Budget

PUBLIC COMMENT

R-9 Opportunity for Public Comment on Non-Agenda Matters. Testimony Limited to Three Minutes Per Person.

Thursday, July 8, 1993 - 1:30 PM

Multnomah County Courthouse, Room 602

WORK SESSION

WS-2 Discussion and Further Review of the Tax Title Audit Report Recommendations. **Presented by Betsy Williams.** 2 HOURS REQUESTED.

0266C/1-3
cap

GARY HANSEN
Multnomah County Commissioner
District 2

1120 S.W. Fifth Avenue, Suite 1500
Portland, Oregon 97204
(503) 248-5219

MEMORANDUM

TO: Chair: Miggins
Commissioners: Saltzman
Collier
Kelley

FROM: Gary Hansen

DATE: June 22, 1993

SUBJECT: Vacation

I will be on vacation July 5 through July 9, therefore, I will miss the Board meetings July 6 and 8th.

BOARD OF
COUNTY COMMISSIONERS
1993 JUN 22 PM 4:15
MULTNOMAH COUNTY
OREGON

Meeting Date: JUL 06 1993

Agenda No.: W8-1

(Above space for Clerk's Office Use)

. . . . . .

AGENDA PLACEMENT FORM
(For Non-Budgetary Items)

SUBJECT: EMERGENCY MEDICAL SERVICES WORK SESSION

BCC Informal JULY 6, 1993 BEGINNING TIME 2:00 PM
(date)

DEPARTMENT: HEALTH DIVISION: REGULATORY HEALTH

CONTACT: BILL COLLINS TELEPHONE: 248-3220

PERSON(S) MAKING PRESENTATION BILL COLLINS AND INVITED GUESTS

ACTION REQUESTED:

[X] INFORMATION ONLY [ ] POLICY DIRECTION [ ] APPROVAL

ESTIMATED TIME NEEDED ON BOARD AGENDA: 2 HOURS

CHECK IF YOU REQUIRE OFFICIAL WRITTEN NOTICE OF ACTION TAKEN: _____

BRIEF SUMMARY (Include statement of rationale for action requested, as well as personnel and fiscal /budgetary impacts, if applicable):

Work session to consider Emergency Medical Services Ambulance Service Area plan elements and consider and modify draft plan. Invited testimony only, no public testimony.

1993 JUN 29 PM 12:14
MULTNOMAH COUNTY
OREGON
BOARD OF
COUNTY COMMISSIONERS

(If space is inadequate, please use other side)

SIGNATURES:

ELECTED OFFICIAL _____

Or

DEPARTMENT MANAGER Bill Odegaard

(All accompanying documents must have required signatures)

MEETING DATE: JUL 08 1993

AGENDA NO: R-1

(Above Space for Board Clerk's Use ONLY)

AGENDA PLACEMENT FORM

SUBJECT: Emergency Medical Services Ambulance Service Area Plan

BOARD BRIEFING *Date Requested:* _____

Amount of Time Needed: _____

REGULAR MEETING: *Date Requested:* July 8, 1993

Amount of Time Needed: 15 Minutes

DEPARTMENT: Health *DIVISION:* Regulatory Health

CONTACT: Bill Collins *TELEPHONE #:* 248-3220

BLDG/ROOM #: 160/9th Floor

PERSON(S) MAKING PRESENTATION: Bill Collins

ACTION REQUESTED:

[ ] INFORMATIONAL ONLY [ ] POLICY DIRECTION [X] APPROVAL [ ] OTHER

***SUMMARY** (Statement of rationale for action requested, personnel and fiscal/budgetary impacts, if applicable):*

First reading of an ordinance to adopt an Ambulance Service Area (ASA) Plan for Multnomah COunty.

The Ambulance Service Area Plan establishes a system to provide efficient and effective ambulance services in the County.

SIGNATURES REQUIRED:

ELECTED OFFICIAL: _____

OR

DEPARTMENT MANAGER: _____

1993 JUN 30 PM 12:51
MULTNOMAH COUNTY OREGON

ALL ACCOMPANYING DOCUMENTS MUST HAVE REQUIRED SIGNATURES

Any Questions: Call the Office of the Board Clerk 248-3277/248-5222

0516C/63

6/93

Orig

ORDINANCE FACT SHEET

Ordinance Title: Adoption of Ambulance Service Area Plan

Give a brief statement of the purpose of the ordinance (include the rationale for adoption of ordinance, description of persons benefited, other alternatives explored):

Pursuant to Oregon Administrative Rules 333-28-095 through 333-28-130, each county must have an Ambulance Service Area Plan in effect and filed with the State of Oregon.

What other local jurisdictions in the metropolitan area have enacted similar legislation?

All other counties in the state have in place or are in the process of doing an Ambulance Service Area Plan.

What has been the experience in other areas with this type of legislation?

The Ambulance Service Area establishes a plan to provide efficient and effective provision of ambulance services in the county.

What is the fiscal impact, if any?

none

(If space is inadequate, please use other side)

SIGNATURES:

Person Filling Out Form: Bill Collier (BMC)

Planning & Budget Division (if fiscal impact): _____

Department Manager/Elected Official: Billi Odegaard (BO)

1/90

BEFORE THE BOARD OF COUNTY COMMISSIONERS

FOR MULTNOMAH COUNTY, OREGON

ORDINANCE NO. _____

An ordinance adopting an ambulance service plan for Multnomah County pursuant to ORS 823.180.

Multnomah County ordains as follows:

Section I. Findings.

1. ORS 823.180 requires that the County develop a plan relating to the coordination of ambulance services within the County.

2. In conformance with ORS 823.180, the Board of County Commissioners has consulted with and sought advice from interested persons, cities, and districts with regard to ambulance service planning.

3. The Board of County Commissioners has considered all proposals for providing ambulance services that have been submitted for consideration, and has considered existing boundaries of cities and rural fire protection districts in establishing the ambulance service area under the plan.

4. The Board of County Commissioners heard presentations of proposed ambulance service area plans on June 23, 1993; conducted

work sessions on June 29, 1993, June 30, 1993 and July 6, 1993 to consider plan elements; and held a public hearing on July 1, 1993 to hear public testimony on submitted plans and plan elements.

5. After extensive discussion and consideration of various policy options, the Board of County Commissioners has determined that the ambulance service plan attached hereto as Exhibit A best serves the public interest.

6. The ambulance service plan attached hereto as Exhibit A meets the criteria set forth in OAR 333-28-100 thru 333-28-130 (Oregon State Health Division Administrative Rules).

7. The Board of County Commissioners recognizes that amendments to the current EMS Code, or other actions, will be necessary to fully implement the plan adopted by this ordinance.

Section II. Adoption of Plan.

The Ambulance Service Plan attached hereto as Exhibit A is adopted. The Director of Emergency Medical Services shall promptly

submit the adopted plan to the State Health Division as required by ORS 823.180.

ADOPTED this _____ day of _____, 1993.

(SEAL)

By_____
H. C. Miggins, Chair
Multnomah County, Oregon

REVIEWED:

LAURENCE KRESSEL, COUNTY COUNSEL
FOR MULTNOMAH COUNTY, OREGON

By_____
Jacqueline A. Weber
Assistant County Counsel

D:\WPDATA\SEVEN\819JAW.ORD\mw

06/30/93:1

EMS Work Session
7-6-93
Handout #5

ESTIMATED RATES FOR REQUIRED REVENUE
PRIVATE PROVIDER

UNIT HRS. FOR 911		86476			
TRANSPORTS PER YEAR		21700			
UNIT HR COST		NET REVENUE	GROSS REVENUE REQUIRED		
			56%	60%	65%
@	$60.00	$5,188,560	$9,265,286	$8,647,600	$7,982,400
@	$70.00	$6,053,320	$10,809,500	$10,088,867	$9,312,800
@	$75.00	$6,485,700	$11,581,607	$10,809,500	$9,978,000
ESTIMATED AVERAGE BILL					
@	$60.00		$427	$399	$368
@	$70.00		$498	$465	$429
@	$75.00		$534	$498	$460
CURRENT AVERAGE BILL				GROSS REVENUE-ACTUAL	
	$588.00			$12,759,600	
REVENUE DIFFERENCE FOR REQUIRED REVENUE					
@	$60.00		($3,494,314)	($4,112,000)	($4,777,200)
@	$70.00		($1,950,100)	($2,670,733)	($3,446,800)
@	$75.00		($1,177,993)	($1,950,100)	($2,781,600)

EMS Work Session
7-6-93
Handout #4

DAN SALTZMAN, Multnomah County Commissioner, District One

1120 S.W. Fifth Avenue, Suite 1500 • Portland, Oregon 97204 • (503) 248-5220 • FAX (503) 248-5440

July 6, 1993

TO: Board of County Commissioners

FROM: Dan Saltzman

RE: EMS

After a great deal of study and thought, I firmly believe that a single provider system for 911 transport represents the best public policy decision available to the BCC today. I want to share with you some of my reasons for this position.

From the outset, I have tried to limit the criteria by which to measure the various proposals to what best serves patient needs, the public interest, and controls the cost of service. I have purposely excluded considerations such as preserving a market share for companies currently providing service, providing the Fire Bureau with a secure new role or avoiding litigation from disappointed parties. As compelling as those issues might be to some of the "players," I feel that they are simply not appropriate to the task before us - to create good public policy in the design of an EMS system.

I must confess that it has always seemed to me that the tiered plan is a creature of "political realities." That is in no way a criticism of the excellent work that Bill Collins and his staff has done: I have confidence in their ability to make things work under either scenario. He has done a good job in presenting us with alternatives, and clearly delineating features that should be present in whatever system we adopt. It is my belief that the single provider model best serves patient needs, the public interest, and controls the cost of service:

- It's simple and clean. It allows for the broadest number of players to compete for the right to provide 911 transport. The Fire Bureau, Buck, Care/AA, plus any other companies interested in the Portland market can submit proposals in response to a County prepared RFP. The RFP process, with all players welcome, provides the County with a uniform set of evaluation criteria. It truly allows us to design the best system in terms of patient care and rate control -- rather than piecing together a system that attempts to keep the current set of players appeased and allow the Fire Bureau in to patient transport.

- It ensures the closest ambulance responds to a 911 call.

- It preserves the high quality paramedic workforce in the Portland area. It does

not set up a two-tiered level of professionalism. The two-tiered approach also sets up a two-tiered level of interaction among equally qualified paramedics. Fire Bureau paramedics will have the say over whether a case is "critical" or "non-critical". In addition to what would seem to be an inherent conflict of interest, this arrangement relegates private sector paramedics to a second class both in terms of their work on-scene with fire paramedics, and in their exposure to advanced life support experience. Will highly trained and dedicated paramedics want to work for a private firm that no longer transports "critical" calls?

- It does not necessarily put one private company out of business. In fact, nothing prevents Care/AA and Buck from forming a joint venture to bid for the system as a single provider.

- The single provider plan has a much clearer vision of rural care/response issues.

I continue to have serious concerns about the tiered system. One is conceptual: given a choice between two models that can work, it seems to me that we should choose one that is simple, straightforward and accountable over one that is complicated and fraught with unanswered questions. Other concerns include:

- The "hand off" for 911 non-critical transports still seems unclear. In comparing the single provider versus the two-tiered 911 transport, a football analogy comes to mind. A single provider is like a running play: the first responder hands the patient off once, who is then taken straight to the hospital. The tiered system looks more like a "flea flicker" where the ball (patient) can be handed off a number of times. "Flea flicker" plays can work, but they are inherently more risky: a coach only chooses it when he is backed into a corner. We are not backed into a corner as we design our EMS system. I think we want a 911 transport system that minimizes the chances of "fumbling" the patient's care and well being en route to a hospital.

- The two-tiered approach puts the county in a potentially awkward position of regulating a city of Portland service. It is a situation that could lead to a deterioration of relations between the city and county -- clearly a direction we do not wish to go. For example, if the Fire Bureau were not performing up to county EMS standards, what remedies are available to the county to compel compliance? Remedies include fines, penalties, or ultimately declaring the 911 transport contract with the Fire Bureau to be null and void. Fines and penalties are in essence having the county impose financial obligations on the city council and city of Portland taxpayers. Pulling the contract altogether could expose the city (and its taxpayers) to carry salary and disability/retirement fund expenses for personnel not needed for firefighting and no longer paid for out of 911 transport fees.

- Under the two-tiered system, we are replacing private sector jobs with public sector jobs. I think this is clearly the opposite direction the public expects from us in the Measure 5 era. It would also displace minorities and women paramedics in the private sector with absolutely no firm commitment or guarantee that the Fire Bureau workforce would become as diverse as the private sector. The Fire Bureau's commitments to hold a closed entry exam to only hire displaced Multnomah County private sector paramedics is simply not doable. Any attempt to do so would almost certainly invite a lawsuit from those people (including paramedics) who have been on the Fire Bureau's hiring list for at least three years.

Finally, I believe forwarding a straightforward, single provider plan will not only be good public policy, but will be well received by the public, who look to us to give them government that is effective, efficient and accountable. The single provider option does that.

EMS Work Session
7-6-93
Handout #2

CITY OF

PORTLAND, OREGON

OFFICE OF CITY ATTORNEY

Jeffrey L. Rogers, City Attorney
1220 S.W. 5th Avenue
Portland, Oregon 97204
(503) 823-4047

July 6, 1993

INTEROFFICE MEMORANDUM

TO: Commissioner Sharron Kelley
Commissioner Dan Saltzmann
Commissioner Tanya Collier
Commissioner Gary Hansen
Board of County Commissioners B106/R1500

FROM: Liana Colombo
Deputy City Attorney

SUBJ: Paramedic Displacement

As a result of recent testimony on the ASA Planning process, questions were raised regarding "closed examinations" for potentially displaced paramedics. I understand that this question was prompted by Randy Leonard's testimony before the Commission on June 30, 1993.

In Chief Lynn Davis's testimony on July 1, 1993, he stated that the Portland Fire Bureau is committed to accommodating displaced paramedics. Chief Davis indicated that a possible option would be to offer a special examination open only to displaced paramedics. Given City Charter civil service provisions, the City may not limit recruitment processes this way. However, there are several other approaches that achieve similar results while complying with City Charter and other legal constraints.

The Bureau of Fire, Rescue and Emergency Services is exploring several possible approaches. Some are:

1. Once a new classification of Paramedic is established and wages have been established, have an expedited open recruitment process. (Recruitment open for a limited time with focused recruitment efforts targeted at Portland-area displaced paramedics). Establish minimum qualifications that match existing community standards for this type of work. Current private sector paramedics would probably be very competitive in such an exam process. An unranked eligible list or banding of test scores would enable the Bureau of Fire, Rescue and Emergency Services maximum flexibility in interviewing and hiring the best qualified candidates while being sensitive to paramedics on the list who have been targeted for layoff by the private companies.

2. Consider giving applicants points on their exam for relevant experience.

3. Review the current Fire Fighter eligibility list for currently employed paramedics (approximately eleven employees) and appoint the employees to Fire Fighter positions, if available, or review the Fire Fighter exam for possible exam comparability to make appointments to a newly created classification of paramedic.

The City Attorney's Office is committed to working with the Bureau of Fire, Rescue and Emergency Services and the City's Personnel Bureau to develop a viable, legal response to the problem of paramedic displacement.

If you have any further questions regarding this matter, please feel free to contact me.

LC/bf
pers\fire\comm.mem

EMS Work Session
7-6-93
Handout #1

MULTNOMAH COUNTY OREGON

OFFICE OF COUNTY COUNSEL
1120 S.W. FIFTH AVENUE, SUITE 1530
P.O. BOX 849
PORTLAND, OREGON 97207-0849
(503) 248-3138
FAX 248-3377

BOARD OF COUNTY COMMISSIONERS
GLADYS McCOY, CHAIR
PAULINE ANDERSON
RICK BAUMAN
GARY HANSEN
SHARRON KELLEY

COUNTY COUNSEL
LAURENCE KRESSEL
CHIEF ASSISTANT
JOHN L. DU BAY
ASSISTANTS
J. MICHAEL DOYLE
SANDRA N. DUFFY
GERALD H. ITKIN
H.H. LAZENBY, JR.
STEVEN J. NEMIROW
MATTHEW O. RYAN
JACQUELINE A. WEBER

M E M O R A N D U M

TO: Commissioner Collier
Commissioner Saltzman

FROM: Jacqueline A. Weber (106/1530) JW
Assistant County Counsel

DATE: July 6, 1993

SUBJECT: Ambulance Service Planning

QUESTION: Does ORS Chapter 279 (public contracting) require that the county award ambulance service contract(s) thru a competitive bid process?

ANSWER: No.
Given the types of options the Board has under consideration, the question must be analysed both in the context of a public provider (Portland Fire Bureau), and a private provider.

PRIVATE PROVIDER
ORS 279.011 to 279.111 controls public contracts and purchasing. ORS 279.015 requires that all "public contracts" be based upon competitive bids, with certain enumerated exceptions. "Public contract" is defined by statute as : "...any purchase, lease or sale by a public agency of personal property, public improvements or services other than agreements which are for personal service." In awarding an ambulance service contract, the County is not entering into the purchase or sale of services. Rather, the county is exercising the regulatory authority given by ORS 823.180 to 823.320. ORS 823.180 requires the county to regulate the provision of ambulance services to the public. The public purchase the service, not the county. Therefore, the public contracting laws requiring competitive bidding do not apply in this instance.

PUBLIC PROVIDER
ORS 279.015(1) specifically excepts contracts made with other public agencies from the competitive bid process. Therefore, if the county were to award an ambulance service contract to the Portland Fire Bureau, either under the tiered system, or for the

complete provision of emergency ambulance servies within the county, PFB would not be required to participate in a competitive bid process.

SUMMARY

The competitive bidding laws (ORS Chapter 279) do not apply to the award of an ambulance service contract within the ambulance service planning process. The Board may choose a competitive bid process for policy reasons.

D:\WPDATA\SEVEN\COMPBID\jaw

MOSKOWITZ & THOMAS
Attorneys at Law
2000 S.W. 1ST Avenue
Suite 400
Portland, Oregon 97201
Telephone (503) 227-1116
FAX (503) 227-3015

Christopher P. Thomas

Steven A. Moskowitz

July 6, 1993

BOARD OF
COUNTY COMMISSIONERS
1993 JUL -6 AM 11: 14
MULTNOMAH COUNTY
OREGON

Multnomah County Commission
1120 SW Fifth Avenue
14th and 15th Floors
Portland, OR 97204

Subject: Emergency Medical Services Plan

Dear Commissioners:

Care/AA provides the following information, to supplement the previously submitted report of the Multnomah County EMS Provider Board on Ambulance Service Area Planning, June 18, 1993. This information is in response to issues raised during the Commission's recent proceedings on EMS planning.

1. **Rate Setting**. Some Commission members have asked how rates should be regulated in the EMS system. Care/AA proposes the following:

a. **Initial Rate Making**. There should be an initial PUC-type rate making proceeding. The proceeding will be conducted by an experienced, unbiased hearings officer. The purpose of the proceeding will be to determine reasonable system costs and a reasonable return to the providers, together with a uniform emergency rate that will provide sufficient revenues to cover the costs and return. The proceeding will be formal, with detailed submissions from the providers; an analysis by County EMS staff; an opportunity for participants to intervene as parties; advance exchange of testimony and documents as in PUC-type hearings; cross-examination of witnesses; and all of the other procedural safeguards of this type of proceeding. The type of information considered in the hearing will include actual cost information provided by the providers; comparable cost information from other systems; and other information the parties consider relevant. The hearings officer will prepare recommended findings and conclusions, including a recommended uniform emergency rate, for submission to the County Commission. The Commission then will review the recommended findings and conclusions and make a final decision.

This initial rate making proceeding will assure the public that the costs incurred by the providers are reasonable and that the rates charged are only as much as is needed to provide a financially stable, healthy system.

b. **Rate Adjustments**. The County also will establish a rate adjustment process. This will be before a Rate Commission (although as an alternative it could be before the hearings officer). Either a provider or the EMS Office, on its own initiative or on the request of a member of the public, will be able to initiate a rate adjustment proceeding. Rate adjustment proceedings will be to adjust the initial rate either upward or downward based on changed costs due either to unanticipated events or changed regulatory requirements. (It is recommended that the initial rates have built in periodic adjustments based on changes in an appropriate economic index related to system costs.) In these proceedings, the only questions will be whether there have been unanticipated cost changes or cost changes due to regulatory changes; the extent of those cost changes; and the extent of any rate changes needed to match the cost changes.

This rate adjustment procedure will assure the public that upward or downward shifts in system costs are matched by rate changes so that the rates charged always are as much, but only as much, as is needed to provide a financially stable, healthy system. This procedure also will assure that changes in system regulatory requirements undergo a cost/benefit analysis.

2. **Provider Selection**. Commissioners have asked how providers initially should be selected; and under what circumstances, and how, replacement providers should be selected. Care/AA proposes the following:

a. **Initial Providers**. For Life Threatening Emergencies, the Portland Fire Bureau will be designated as the initial transporting provider. If the Commission so desires, Gresham Fire can be the transporting provider for the area where it presently provides fire service. This can be accomplished in either of two ways: (1) Portland Fire and Gresham Fire can serve separate ambulance service areas; or (2) Portland Fire can be the designated provider for a single ambulance service area, subject to a requirement that it subcontract with Gresham Fire to provide service and that the substance and form of the subcontract be approved by the County. For Life Threatening Emergencies, the provider(s)

will be licensed by County EMS to provide transport service, with the license being in the form of a contract between the County and the provider.

For Non-Life Threatening Emergencies, Buck and Care/AA each will continue to serve a district based on its current service area, although the boundaries may be adjusted as appropriate to make better geographic sense. (As indicated in the Provider Board proposal, notwithstanding the districts, the closest ambulance always will be dispatched to a call, and vehicle staging will be subject to ultimate County control.) The private providers will continue to be licensed by the County, but the form of license will change to a contract between the County and the provider.

b. Provider Replacement. If for any reason an existing provider is unable to provide service in conformance with its license, or if the County determines that the provider is failing to meet substantial requirements of its license, then the County will use the following procedure:

(1) The County will notify the provider and take appropriate legal steps to terminate the provider's license;

(2) If the provider can continue to provide service without endangering the public's health or safety, the provider will continue operations pending selection of a replacement provider;

(3) If the provider cannot or will not provide appropriate service pending selection of a replacement provider, then the other County providers will provide service pending selection of a replacement provider.

In selecting a replacement provider, interested providers will be offered an opportunity to be selected as the provider for the transport work that has opened up. Selection will be through a competitive procurement process in which providers will be evaluated to determine which provider can best meet the County's license requirements within the rate structure established by the County. The new provider, as well as the other remaining providers, thereafter will serve the County so long as it meets all substantial requirements of its license.

3. Impact on Paramedic Jobs. Various groups have raised questions about the impact on paramedic jobs of the proposals submitted to the County. The following portion of this letter describes the impact on paramedic jobs of the various proposals.

Proposers have submitted four basic models of system delivery:

(1) Public/private partnership, or tiered model. This is a single provider system for Life Threatening Emergency calls, with the Fire Bureau transporting these patients and the private providers transporting all other patients. Supported by the EMS Office, Portland Fire Bureau, and Care/AA.

(2) EMS Office option 2. This calls for a single private provider selected by competitive bid, for a dedicated 911 system. This is not the EMS Office's preferred option.

(3) Various PAPA proposals of a single provider for transport of all Advanced Life Support patients. Supported by PAPA and a majority of the Medical Advisory Board.

(4) Buck Ambulance proposal, leaving the two private providers in place, but dispatching the system as a single system.

In comparing the models and their impacts on paramedic jobs, we have made several assumptions and calculations:

(1) The first assumption is that the medical community continues to have the objective of decreasing the number of paramedics in the system that are treating critical patients.

(2) The second assumption is that the figures for unit hours in the County EMS plan are fairly accurate. Therefore, all single provider system models use the same figure of 86,476 unit hours for handling emergency calls. (The Provider Board believes that the required number of unit hours actually may be higher than this number.)

(3) The third assumption is that all shifts are 12 hours. In practice, paramedic shifts vary from 8 hours to 24 hours, but 12 hour shifts are used for comparison purposes. Further, the 12 hour shifts are assumed to be 4 days on and 4 days off.

(4) The fourth assumption is that all paramedics will have full time equivalent (FTE) positions, and that all paramedics will work exclusively in Multnomah County.

(5) The total number of hours scheduled for a 12 hour shift for one year is 2190. The calculations used to derive that figure are:

365/2 = 182.5 days per year

182.5 days x 12 hour shift = 2190 unit hours per year

(6) The calculations used to derive the number of shifts currently scheduled in a year are:

total unit hours (emergency units transporting emergency and non-emergency calls) 125,684 / 2190 unit hour per shift = 57 shifts

Since there currently are two paramedics per shift, 2 x 57 = 114 FTE paramedics.

(7) Note that although the public/private partnership model requires 1 paramedic and 1 EMT on each private transporting unit, nevertheless some of those units will have two paramedics on board. This is due to training needs, EMTs upgrading their skills to paramedic level, and other reasons. This factor is not considered in the following comparisons. Also, Care/AA has committed to not lay off any paramedics as a result of the public/private model being adopted. They will accomplish the staffing transition through attrition rather than layoffs. Since Care/AA respond to 60% of all 911 calls in the County, the short term loss of paramedic jobs following adoption of the public/private model will be significantly less than has been indicated by various groups. This factor also is not considered in the following comparisons.

(8) Since no Portland Fire Bureau paramedic positions will be lost, Portland Fire Bureau paramedic positions are excluded from the following numbers, except as noted.

(9) In the proposals that will result in lost paramedic positions, the lost positions will be replaced in most cases with EMT Basic positions. This is not reflected in the comparisons.

Model	Unit Hours	Shifts	Paramedic FTEs
Current system	125,684 (1)	57	114
Public/private	125,684 (1)	57	66 (48) (2)
EMS Option 2	86,476 (3)	40	80 (34)
PAPA	85,476 (3)	40	80 (34)
Buck	125,684 (1)	57	114

The numbers in parenthesis are the numbers by which paramedic FTEs are reduced.

(1) Includes emergency and non-emergency transports.

(2) These numbers recognize that some of the lost paramedic FTEs are made up by the Fire Bureau, which estimates that it will need 9 additional paramedic FTEs.

(3) Does not include any non-emergency transports.

4. **Diseconomies of Scale**. County EMS, in its tiered response public/private partnership proposal, indicated that one private provider handling Non-Life Threatening Emergencies would be preferable to two providers, based on County EMS's belief that one large provider would be more efficient, in administrative expenses, than two smaller providers. County EMS appears to agree that (1) this is its only basis for preferring one private provider, and (2) it has not done an actual study to determine whether there are economies or diseconomies of scale in the ambulance business.

The Provider Board, in its June 18, 1993 Report, provided data from a 1989/90 Financial Survey of the American Ambulance Association. The data indicate that there are not economies of scale in administrative expenses in the ambulance industry. Rather, there are diseconomies of scale. Thus one provider will be less efficient, administratively, than two. (Specifically, the Survey indicated that for private providers in the $500,000

to $1 million range, administrative and marketing costs were 3% of revenues; in the $1 to $5 million range, 18 % of revenues; and in the $5 to $10 million range, 20%.)

During the last week, Care/AA also surveyed some private providers to determine their percentage of administrative staff out of total personnel. Although the percentage of administrative staff is affected by a number of factors (e.g., wheelchair services, subscription services), the survey confirms generally that larger ambulance providers have a higher percentage of administrative staff than smaller providers. Ranging from smaller to larger, the five providers reported percentages as follows:

National Ambulance Rochester, NY (716)346-2525 (George T. Heisel)	17% administrative staff
Ambulance Service Co. Denver, CO (303)292-4434 (Carl Unrein)	24%
Physicians & Surgeons Ambulance Akron, OH (216)733-4034 (Ron Myers)	29%
Myers Ambulance Service, Inc. Indianapolis, IN (317) 781-3422 (Carole Myers)	32%
Mercy Medical Services Las Vegas, NV (703)386-9985 (Robert Forbuss)	38%

By comparison, Care Ambulance presently has administrative staff that is approximately 24% of total personnel. It is at the more efficient end of the spectrum, and AA Ambulance's percentage is even lower. It therefore is likely that a single private provider will be less efficient administratively than Care/AA and Buck as separate providers.

5. Single Provider Problems. Finally, in late 1990, AA Ambulance provided the County with detailed information on single provider systems in the United States that had encountered significant financial and quality of care problems. The information demonstrated the gap between the promise and the reality of single provider systems and also the impotence of regulators when single provider monopoly systems go bad. For

their value as case studies, we have attached an excerpt from the information provided in 1990, describing the problems encountered in six single provider systems that "went bad." For more detail, the Commission may refer to the full 1990 report.

Care/AA will be happy to answer any questions you may have about the information contained in this letter.

Very truly yours,

Christopher P. Thomas
Attorney for Care/AA

cc. County Commission Clerk
Bill Collins
Jeff Kilmer

CPT/ms
multcc7.6

SEVERE PROBLEMS: OTHER U.S. SYSTEMS

Across the United States, many EMS ambulance systems are experiencing severe financial problems. These problems most frequently are accompanied by degradation in quality of care.

Systems experiencing severe problems include Kansas City and Oklahoma City, single provider systems created by eliminating multiple provider systems, as is proposed in Multnomah County. These systems were used as "comparables" in evaluating the Multnomah County system, and their supposed "success" was a good part of the original basis for the single provider bid system now proposed by ASA Plan Draft II. As demonstrated below, those restructurings now have proved to be failures, and to be examples of what is happening in many other systems around the United States. Indeed, the Oklahoma City system's failure has been attributed by one expert to "system structure" design defects that are identical to the system design proposed by ASA Plan Draft II.

Examples of systems in total or partial failure follow. These are documented by clippings attached as Exhibit B to these comments.

Kansas City, Missouri
(Population 450,000)

This city has been considered to be the area demographically most similar to Multnomah County for EMS ambulance purposes.

In 1982 Kansas City forcibly created a single provider system from what had been a multiple provider system. After extensive litigation, Kansas City did this by "buying out" the multiple private systems. Kansas City then replaced the multiple providers with the Metropolitan Ambulance Services Trust (MAST), giving MAST a monopoly over all City ambulance services, emergency and non-emergency. The purpose for the monopoly over non-emergency service was to allow MAST to use non-emergency revenues to offset the cost of emergency services. The City also provided an annual subsidy to MAST, which was supposed to decline over the years to a low of $200,000 in 1987-88.

MAST was a quasi-public non-profit corporation. It received the City subsidy and billed and collected revenues from ambulance users. It also owned the capital equipment -- ambulances and so on -- used in the system. It provided for system operation, however, by contracting with a single operator using a bid process. The operator through most of the 1980s was Medevac MidAmerica, Inc. The total system structure thus was a sole provider bid system variant that has been called a "public utility model." At the outset, according to one observer, it "rapidly gained a national reputation as an industry trendsetter."

Response time requirements for MAST were 9 minutes 90% of the time for Life Threatening Emergencies (LTEs) and 13 minutes 90% of the time for non-LTEs. MAST had to meet these requirements Citywide, but not for subdistricts within the City (unlike Multnomah County, where presently each ASA must meet County response time requirements. This results in shorter response times County-wide than would a response time requirement such as Kansas City's, that would not apply by ASA). It is important to note that MAST was responsible for EMS dispatch, so that the longer MAST response time requirement included additional time needed for dispatching, where the shorter Multnomah County time does not.

By 1987, it became apparent that MAST was experiencing major problems. The bloom was off the rose. Response times to some areas of the City were poor; system employees were overworked, underpaid, and exhausted; and MAST complained that the City subsidy was not adequate. In late 1987 and early 1988, these problems were aired publicly, highlighted by the fact that Medevac's contract with MAST was to expire in June 1988.

With Medevac's contract due to expire, MAST began the bid process for a new contract in the summer and fall of 1987. There initially were 5 bidders, including Medevac. However, 1 bidder withdrew early in the process, 2 were found not qualified, and 1 withdrew late in the process. Thus by December 1987, as the ambulance system problems were being aired, MAST was left "stuck" with Medevac as the only interested provider. This created problems because Medevac, in its bid, was demanding higher employee salaries and shorter hours; and more ambulances. Medevac's bid would have doubled the cost of the MAST contract from $3.4 million for 1987-1988 to $7 million for 1988-1989. Medevac proposed that MAST cover this increase through increased government subsidies and through expanding a subscription program -- where a person "subscribes" for a fee to the right to ambulance service for a year with no charge beyond that covered by health insurance.

MAST, finding itself stuck with Medevac and not wanting to accept Medevac's terms, attempted to negotiate with Medevac. At the same time the City auditor completed a performance audit that severely criticized Medevac's response times in some districts of the City; and that criticized Medevac's high employee turnover and excessive employee work hours. These problems degraded quality of care not only due to delays in response, but also due to employee fatigue. The audit also observed that MAST collections had dropped to less than 65% of billings. The audit at the same recognized that solving these and many other problems would cost money and that Kansas City might have to increase its subsidy from $200,000 per year to $2 million per year. At the same time, others characterized the one-time "industry trendsetter" as "sick," "Mediocre and Slipping," and verging on collapse, and cited "the chasm between promise and action." (Ironically, in a sense Kansas City's financial problems have been the indicator of an industry trend.) In February 1988, MAST's executive director since the beginning resigned.

In March 1988, Medevac revealed it was going to pull out of Kansas City at the end of its contract and that it was negotiating to sell out to Hartson Medical Service of San Diego. (Hartson at the time had services in San Diego, Las Vegas, and Forth Worth, two of which now are experiencing problems.) Hartson entered into negotiations with Medevac's union over future pay levels. The negotiations were difficult because Hartson wanted to increase the number of employees in the system, which would drain potential funds Medevac had been promising for pay raises. Finally, Hartson agreed on a wage package, but it was contingent on receiving an acceptable level of subsidy for MAST from the City. Ultimately, the three parties -- Hartson, the union, and the City -- were not able to agree and Hartson withdrew.

On June 30, 1988, the Medevac contract terminated and MAST itself began operation of the ambulance system through Emergency Providers, Inc., which was established and owned by MAST. MAST gave EPI a 5-year contract without any bid process.

In the following months, system employees developed the concept of and a proposal for an employee-owned system. The employees began negotiations with MAST, and in January 1989 the employees and MAST reached an agreement. The employees formed American Ambulance Providers, Inc., which bought out EPI and EPI's 5 year exclusive ambulance service contract with MAST. The buyout was not bid. The employees financed the new corporation by using their pension funds (80% of the employees put up over $300,000 in pension funds); by obtaining an equity loan from the Missouri Public Employees Retirement System; by obtaining bank accounts receivable financing; and by recruiting some outside investment. AAPI is approximately 70% employee owned.

As part of the employee-owned AAPI takeover, response times were to be improved to 9 minutes 90% of the time for Life Threatening Emergencies (but not non-LTEs), by district. More paramedics and EMTs were to be hired. The ambulance fleet was to be increased from 22 vehicles to 28. And the City subsidy to MAST was to increase to $1.5 million per year, approximately $3 per resident.

A month later, in February 1989, MAST announced it was going to increase its base rate for all emergency calls by 5% to $391 -- to which a charge for oxygen is added -- and for mileage to $3.75 per mile. (Note that whereas MAST has one base rate for all emergency calls, to which charges for oxygen and mileage are added, AA Ambulance has one flat rate for ALS emergencies and a lower flat rate for BLS emergencies, to which only mileage charges are added.) MAST also announced a 16% rate increase for all non-emergency calls. In justifying this, MAST revealed that from 1986 through 1988, MAST had drawn down a $2 million reserve fund by $1.8 million; and that MAST had operated at a loss every year from 1984 through 1988. This was true even though the City had adjusted its subsidy to MAST and had provided $1.7 million in FY 1988. MAST further justified the rate increase by pointing out that the average subsidy for US urban EMS ambulance systems is over $6 per person, whereas Kansas City was going to provide only $3 to MAST. (Multnomah County provides no subsidy.)

What the future of the Kansas City system will be is unknown. The City now appears locked into a private, employee-owned ambulance system, in which the employees have invested their retirement savings and in which substantial state employee retirement funds are invested. It is politically inconceivable that it will be possible in the future, whatever the circumstances, to terminate the present provider and install a new one. How this will impact quality of care is unknown, but

one key form of leverage to assure high quality of care -- the ability to terminate the provider -- is lost.

Oklahoma City, Oklahoma
(Population: 800,000)

Oklahoma City, like Kansas City, is an example of a "public utility model" single provider system, created in the late 1970's. It, like Kansas City, was one of the systems cited as an example to be followed when a single provider system for Multnomah County was recommended in 1986. Oklahoma City set up the Central Oklahoma Ambulance Trust, which was to provide equipment and perform billing and collection functions, while contracting on a bid basis with an operator. The operator was to provide paramedics, EMTs, maintenance personnel, and management. COAT received a start-up loan of $1.4 million from the City, which it eventually repaid. Although COAT was to select an operator through an independent contracting process, by the mid-1980s, for unknown reasons, COAT had created its own operator, AmCare, which operated the system without bidding.

In 1989, the City had a response time requirement of 8 minutes 90% of the time for Life Threatening Emergencies (unlike Multnomah County's 8-minute/90% requirement for all emergencies). Earlier, the requirement had been 10 minutes 90% of the time.

In late 1988, AmCare began to reveal it was having financial difficulties. At that time, it obtained a 15% average rate hike, saying it was experiencing significant cash flow problems due to a 5-year freeze in Medicare reimbursement rates and increasingly restrictive Medicare payment practices. AmCare also had had only minimal rate increases during the preceding 5 years.

During 1989, greater concerns about AmCare began to surface. The City hired a consultant, who investigated the system and reported back to the City that AmCare's financial problems were "acute" and were about to become "critical." AmCare had a "bleak financial future." He pointed out that most cities either provide a significant tax subsidy or give the EMS ambulance provider the exclusive right to all ambulance service (emergency and non-emergency), and asserted that absent either a subsidy or an exclusive right to all ambulance service, an EMS system cannot succeed in porviding high quality care. (Since ASA Plan Draft II for Multnomah County provides neither a subsidy nor the exclusive right to non-emergency service, the consultant presumably would characterize the proposed Plan as inherently defective.) The consultant found that there was overall system service deterioration in the form of poor and declining response times (8 minutes or less only 46% of the time), poor morale and substandard wages, aging equipment, and discord. In addition, COAT's ownership of AmCare meant that there was no external

system-wide medical quality control. He found that COAT would need an immediate capital infusion in excess of $1 million and either a substantial longterm subsidy or emergency and non-emergency market exclusivity.

Following release of the consultant's report AmCare's top three administrators and all 9 trustees of COAT resigned. The City was forced to take over responsibility for AmCare, while seeking a longterm solution to the EMS ambulance service problem. The projected need for immediate capital was increased from $1 million to $1.6 million.

In mid-October 1989, the City concluded that, "We have a business that is broke and cannot meet its obligations." The City decided to pay the consultant $400,000 to manage AmCare for 6 months and to develop options for complete restructuring. The City also paid $900,000 to COAT to cover $400,00 in overdue August and September bills and $500,000 in COAT equipment purchase obligations. It projected the need to pay another $225,000 to cover COAT October losses, and assessed overall COAT operations as losing $250,000 per month. In addition, there was a need for $2.4 million in new equipment due to neglect. Subsequently, it was determined that COAT was $1.4 million in debt -- "essentially bankrupt."

In November 1989, the City had to provide another $285,000 to cover October operating losses plus newly discovered overdue customer refunds.

In December 1989, the City approved the concept of a merger with the Emergency Medical Services Authority of Tulsa, some 75 miles away, to take place in April 1990. The projected cost to the City of the merger was $600,000, whereas the projected cost to reconstruct an Oklahoma City stand alone system was $8 million. The merger would not reduce the number of employees -- 95-98% would be employed by EMSA. The City Council begrudgingly went along with the merger. One member commented about the prior history, "We've been duped, we've been fooled, we've been lied to, we've been had." The December subsidy from the City was $153,000.

By February 1990, the City had passed an ordinance giving AmCare the exclusive right to provide non-emergency ambulance service to the City.

The merger into EMSA of Tulsa was finally approved, with AmCare to be transferred fully to EMSA as of April 15, 1990. AmCare had no net worth. The merger created an additional management tier, in order to "facilitate" the two-system operation. The EMSA contract operator, Medic One, was required to hire all AmCare employees who could pass a drug test and meet Medic One's employment standards.

The merger actually occurred on April 15, 1990. At that time the City had subsidized AmCare, over the prior 6 months, in the amount of $3 million, and the City retained a final $100,000 further obligation.

Immediately following the merger, Oklahoma City transport base rates were increased by 9% to $456 per transport, to which mileage and oxygen charges apparently are added.

It is not known how the merged system will work out over the long run.

Tulsa, Oklahoma
(Population: 400,000)

Tulsa, like Kansas City and Oklahoma City, is a single provider "public utility model" EMS ambulance system, set up in the late 1970's. It bids an operator contract on a three-year basis, while providing the equipment and billing and collection services. It, like Multnomah County, is one of the few unsubsidized systems in the nation. It is discussed briefly here because of the merger of Oklahoma City's system with Tulsa's and because the Tulsa system, together with Kansas City, Oklahoma City, and Wichita, was one of the primary comparison systems for Multnomah County when the single provider bid system decision was made in 1986.

Tulsa's service is provided through the Emergency Medical Services Authority, a non-profit trust. EMSA has contracted for operation with Metro Ambulance Service, which sold out to American Medical Transport (Medic One) in late 1989.

There are no overt indications of quality of care problems in Tulsa. However, the Tulsa system recently has experienced financial pressure.

For example, in January 1988, EMSA ended a 5-year rate freeze by increasing its emergency transport base rate by 24% to $397 -- to which mileage and oxygen use charges are added. (Note that Tulsa charges one rate for all emergency transports, as distinguished from AA Ambulance's split rates for ALS and BLS emergency transports.) EMSA also increased its non-emergency transport charge, by 64%; and its mileage charge, by 33%. EMSA stated that it needed to increase rates in order to comply with shortened response time requirements; and to obtain adequate Medicare reimbursements, which had become inadequate due to rapidly increasing ambulance system costs.

Regarding response time requirements, from 1977 through June of 1988, EMSA had to meet a seven minute <u>average</u> response time

requirement for Life Threatening Emergencies, and ten minute average for non-LTEs. As of July 1, 1988, this was changed to 8 minutes 90% of the time for all emergencies, which produces an average response time of about 4.5 minutes. (This is the Multnomah County standard.) EMSA stated that this would require a 40% increase in ambulance-in-service hours, with resultant system cost increases.

A further factor indicating financial pressure is that in late 1989 EMSA indicated it needed a further rate increase. Although we have no further information, we assume that rates again have been increased.

Finally, it should be remembered that the longterm result of the Oklahoma City/Tulsa ambulance system merger is not known.

Fort Worth, Texas
(Population: 590,000)

The Fort Worth system is cited here because it is a relatively new, "designed" EMS ambulance system, much like the one proposed for Multnomah County.

In 1985, Fort Worth established the MedStar system. The City was to provide building and dispatch facilities. Through a bid process, the City was to select an EMS ambulance operator, who was to provide paramedics and EMTs, billing and collection personnel, maintenance personnel, and management. We have not been able to determine who provided the vehicles. The operator also was to have the exclusive right to all non-emergency business, so it could use non-emergency profits to subsidize emergency rates. The operator was to meet a response time requirement of 8 minutes 90% of the time for all emergencies in incorporated areas and 15 minutes 70% of the time for any unincorporated areas served. (The Fort Worth contract was to be exclusively for the City, but the system also served some unincorporated areas.)

Following a bid process, Texas Lifeline Corp. was selected as the winning bidder. In 1986, its first year of operation, TLC was to receive an $840,000 subsidy and to charge average rates of $230 for emergencies and $110 for non-emergencies. Over the 5-year contract term, the subsidy was to gradually decline and rates were to gradually increase to a ceiling of $330/emergency and $153/non-emergency.

In April 1987, TLC announced it had lost $1 million in 1986. The City had to increase its subsidy above $840,000, instead of decreasing it; had to allow an immediate rate increase (30%) to the $300 emergency ceiling that was not supposed to be reached until 1990; and had to allow an immediate rate increase (63%) to

$180 for non-emergency service, well above the ceiling that was not to be reached until 1990.

Problems continued, and in April 1988, the region agreed to change the Fort Worth authority to a regional Area Metropolitan Ambulance Authority. AMAA also took over the billing and collection responsibility from TLC, thus becoming more like the Kansas City/Tulsa/Oklahoma City "public utility model."

In November 1988, AMAA decided it would need a further rate increase to $385 for the average emergency -- to which mileage and oxygen charges apparently were added. The 1988 subsidy was $1.18 million. To balance the rate increase, AMAA modified its method for billing Medicare patients.

By August 1989, AMAA realized that its November 1988 adjustments in rates and Medicare billing methods had not worked. It returned to its earlier average emergency rate of $312, reversed the Medicare billing procedure, and received a $500,000 loan from Fort Worth to cover losses between November and August, supposedly to be paid back in 1 year.

A year later, however, in July and August 1990, AMAA revealed that it had suffered a further loss for the year of $3.4 million. Fort Worth faced the need to increase its subsidy to $3 million. It was hoped that other cities and the surrounding county would make up the $400,000 difference. The average emergency rate in the meantime had risen to $450 -- to which mileage and oxygen charges apparently were added; and for areas not providing a subsidy, the average emergency rate was likely to increase to $600.

It is not known what will happen in Fort Worth over the longterm, or what the financial problems will mean in terms of quality of care, though certainly quality of care will diminish if the system's financial needs are not met.

Allen County (Fort Wayne Suburbs), Indiana
(Fort Wayne Population: 320,000)

The Allen County EMS ambulance service is cited here because it involves the Fort Wayne system. The Fort Wayne system is a "designed" system set up in 1982, to replace a City owned and operated system. It is designated the Three Rivers Ambulance Authority and operates independently of the City as a "public utility model" system. It is a fee-for-service system that receives no subsidy.

Prior to 1989, TRAA served the Allen County suburbs of Fort Wayne on a fee-for-service basis, for the transport of Life Threatening

Emergencies. TRAA had the only paramedics in the County certified to provide LTE care.

In early 1989, TRAA informed the County that it was losing $265,000 per year in the suburban area and would have to cut off service July 1, 1989 unless the loss was covered. TRAA indicated that possible ways to cover the loss were a grant of exclusive rights to all ambulance business, emergency and non-emergency; government subsidies; and rate increases. TRAA's average emergency rate at that time was $474 -- to which mileage and oxygen charges apparently were added. The County representatives did not like any of the options.

We do not know how this problem was resolved, although TRAA made it clear it would end LTE service on July 1, 1989, leaving the Fort Wayne suburbs uncovered, absent additional funding.

Arlington, Texas

Arlington is cited because it is a single provider bid system. Life Star Ambulance won the bid in 1986 and proceeded to lose money, losing $940,000 during its first fiscal year of operation. Life Star had received a subsidy, in accord with the bid, of $450,000. In addition, it had to meet service requirements that included numbers of vehicles and response times. In the fall of 1988, when the first year's losses were disclosed, the Arlington City Council was forced to lower its quality of care standards by allowing less ambulances and longer response times. The City Council also was forced to allow Life Star to increase its rates above those it had bid. This has not proved sufficient, and for 1990-91, the City has had to increase Life Star's subsidy from $450,000 to $660,000. It still is not known if this will solve Life Star's financial problems.

The Arlington situation illustrates a major problem with the single provider bid concept. Bidding reinforces an already existing dangerous tendency to underestimate emergency ambulance system costs, by encouraging further underestimates of costs and over commitments on services in order to win the bid process. Once the provider is installed, the underestimates and over commitments come to the surface and the municipality, with only one provider, is forced to allow rate increases, or subsidy increases, or reductions in quality of care commitments, or some combination of all of them.

Community Ambulance

241-7701 • P.O. Box 69128
Portland, OR 97201

BOARD OF
COUNTY COMMISSIONERS
1993 JUL -6 PM 1:17
MULTNOMAH COUNTY
OREGON

July 06, 1993

Chair Hank Miggins
Commissioner Tanya Collier
Commissioner Gary Hansen
Commissioner Sharron Kelley
Commissioner Dan Saltzman

Dear Honorable Chair and Commissioners:

Community Ambulance is Multnomah County's only licensed and dedicated Basic Life Support ambulance company. We have been following the move to select a single 911 provider in Multnomah County. We have always felt that the intent was to contract only for those critical care patient calls. Lately, however, we have seen some proposals that would involve all levels of care.

We want you to know that actual 911 Advanced Life Support calls make up only a minimal percentage of the total ambulance service (testimony given to you recently estimated 10% or less.) If you are considering any plan that involves the other estimated 90%, please consider the future of Basic Life Support. We know that you have received very little testimony or figures regarding what is the bulk of the transports. We would be happy to supply you with whatever you might require, should you be considering a plan beyond the Advanced Life Support 911 calls.

We believe that all calls below 911 should remain in the current free enterprise system. It is the Basic Life Support industry (Community Ambulance in particular) that gives medics their first chance to obtain real ambulance experience and skill building. It is possible for paramedics to become paramedics without ever holding a job at any lower level, without any experience beyond the clinical requirement.

We will be present in today's work session, should you have any questions on Basic Life Support. We continue to hope that you are considering a plan strictly for the 911 Advanced Life Support transports. Again, we will be happy to assist in providing you with whatever assistance is needed in obtaining all the information you may need to make those difficult decisions.

Thank you for taking the time to read this material.

Junita Kauble
President

Beth Murphy
Client Relations