# *ANNOTATED MINUTES*

*Tuesday, June 29, 1993 - 9:30 AM*
*Multnomah County Courthouse, Room 602*

## *REGULAR MEETING*

*Acting Chair Henry C. Miggins convened the meeting at 9:35 a.m., with Vice-Chair Gary Hansen, Commissioners Sharron Kelley, Tanya Collier and Dan Saltzman present.*

*REGULAR AGENDA*

*DEPARTMENT OF SOCIAL SERVICES*

*R-1* *Ratification of Amendment No. 1 to Intergovernmental Agreement, Contract #102963, Between the City of Portland and Multnomah County, Housing and Community Services Division, Youth Program Office, Allocating $100,000 Payment in Lieu of Taxes (PILOT) Funds for Emergency Youth Services, for the Period Upon Execution through June 30, 1993*

***COMMISSIONER HANSEN MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF R-1. REY ESPANA EXPLANATION AND RESPONSE TO BOARD QUESTIONS. AGREEMENT UNANIMOUSLY APPROVED.***

*R-2* *Budget Modification DSS #66 Requesting Authorization to Decrease the Mental Health, Youth and Family Services Division Budget by a Total of $231,628 to Reconcile Budget with Actual Funding Levels through State Revenue Amendment #49-R*

***UPON MOTION OF COMMISSIONER HANSEN, SECONDED BY COMMISSIONER COLLIER, R-2 WAS UNANIMOUSLY APPROVED.***

*SHERIFF'S OFFICE*

*R-3* *Budget Modification MCSO #19 Requesting Authorization to Transfer $17,896 from Equipment to Personal Services, within the Corrections Division, Inmate Welfare Budget, to Fund a Temporary Chaplain*

***COMMISSIONER HANSEN MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF R-3. LARRY AAB EXPLANATION. BUDGET MODIFICATION UNANIMOUSLY APPROVED.***

*DEPARTMENT OF ENVIRONMENTAL SERVICES*

*R-4* *ORDER in the Matter of Canceling Uncollectible Personal Property Taxes, 1984-85 through 1989-90*

*COMMISSIONER HANSEN MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF R-4. KATHY TUNEBERG EXPLANATION AND RESPONSE TO BOARD QUESTIONS. ORDER 93-234 UNANIMOUSLY APPROVED.*

R-5 *Budget Modification DES #31 Requesting Authorization to Transfer $130,000 from Road Fund Contingency to Personal Services, within the Transportation Division Budget, for Fiscal Year 1992-93 Wage Settlements*

*UPON MOTION OF COMMISSIONER HANSEN, SECONDED BY COMMISSIONER KELLEY, R-5 WAS UNANIMOUSLY APPROVED.*

R-6 *Budget Modification DES #32 Requesting Authorization to Transfer $38,000 from General Fund Contingency to the Fair and Expo Division Budget, to Cover a Revenue Shortfall in the Fair Fund*

*COMMISSIONER HANSEN MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF R-6. BETSY WILLIAMS EXPLANATION AND RESPONSE TO BOARD QUESTIONS. BUDGET MODIFICATION UNANIMOUSLY APPROVED.*

*NON-DEPARTMENTAL*

R-7 *Budget Modification NOND #38 Requesting Authorization to Transfer Funds from Materials and Supplies to Capital Equipment, within the Commission District No. 1 Budget, to Purchase a Computer for Office Operations*

*COMMISSIONER COLLIER MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF R-7. COMMISSIONER SALTZMAN EXPLANATION. BUDGET MODIFICATION UNANIMOUSLY APPROVED.*

R-8 *Budget Modification NOND #39 Requesting Authorization to Transfer Funds from Materials and Supplies to Capital Equipment, within the Commission District No. 2 Budget, to Purchase Computers for Office Operations*

*COMMISSIONER COLLIER MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF R-8. COMMISSIONER HANSEN EXPLANATION. BUDGET MODIFICATION UNANIMOUSLY APPROVED.*

*SERVICE DISTRICTS*

*(Recess as the Board of County Commissioners and convene as the Governing Body of Mid-County Street Lighting Service District No. 14)*

R-9 *RESOLUTION in the Matter of the Adoption of the 1993-94 Budget for Mid-County Street Lighting Service District No. 14, for the Fiscal Year July 1, 1993 to June 30,*

*1994 and Making Appropriations Thereunder, Pursuant to ORS 294.435*

***COMMISSIONER HANSEN MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF R-9. DAVE WARREN EXPLANATION. RESOLUTION 93-235 UNANIMOUSLY APPROVED.***

*(Recess as the Governing Body of Mid-County Street Lighting Service District No. 14 and convene as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1)*

R-10 *RESOLUTION in the Matter of the Adoption of the 1993-94 Budget for Dunthorpe-Riverdale Sanitary Service District No. 1, for the Fiscal Year July 1, 1993 to June 30, 1994 and Making Appropriations Thereunder, Pursuant to ORS 294.435*

***UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER KELLEY, RESOLUTION 93-236 WAS UNANIMOUSLY APPROVED.***

*(Recess as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1 and reconvene as the Board of County Commissioners)*

*NON-DEPARTMENTAL*

R-11 *RESOLUTION in the Matter of the Adoption of the 1993-94 Budget for Multnomah County, Oregon, for the Fiscal Year July 1, 1993 to June 30, 1994 and Making the Appropriations Thereunder, Pursuant to ORS 294.435*

***COMMISSIONER COLLIER MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF R-11. MR. WARREN EXPLANATION AND RESPONSE TO BOARD QUESTIONS. COMMISSIONER HANSEN MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF THE TECHNICAL AMENDMENTS (AMENDMENT NO. 1). MR. WARREN RESPONSE TO BOARD QUESTIONS. AMENDMENT NO. 1 UNANIMOUSLY APPROVED. UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER COLLIER, APPROVAL OF CARRYOVER AMENDMENT NO. 2 WAS UNANIMOUSLY APPROVED. UPON MOTION OF COMMISSIONER HANSEN, SECONDED BY COMMISSIONER COLLIER, APPROVAL OF REVENUE AMENDMENT NO. 3 WAS UNANIMOUSLY APPROVED. COMMISSIONER SALTZMAN MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF TENTATIVELY APPROVED JUNE 25 AMENDMENTS (AMENDMENT NO. 4). MR. WARREN RESPONSE TO BOARD QUESTIONS AND DISCUSSION. BOARD COMMENTS. COMMISSIONER SALTZMAN MOVED AND COMMISSIONER COLLIER SECONDED, AN AMENDMENT TO PREVIOUS MOTION, DESCRIBING CONTRIBUTION TO THE ASSOCIATION FOR***

*PORTLAND PROGRESS AS A CONTRIBUTION TO ITS ECONOMIC IMPROVEMENT DISTRICT FOR TREATMENT FOR CHRONICALLY MENTALLY ILL (AMENDMENT NO. 4-A). BOARD COMMENTS. AMENDMENT NO. 4-A FAILED, WITH COMMISSIONERS COLLIER AND SALTZMAN VOTING AYE AND COMMISSIONERS KELLEY, HANSEN AND MIGGINS VOTING NO. COMMISSIONER SALTZMAN MOVED AND COMMISSIONER COLLIER SECONDED, AN AMENDMENT TO AMENDMENT NO. 4, APPROVING PAYMENT OF $72,000 ASSESSMENT TO ASSOCIATION FOR PORTLAND PROGRESS (AMENDMENT NO. 4-B). AMENDMENT NO. 4-B APPROVED, WITH COMMISSIONERS COLLIER, SALTZMAN AND MIGGINS VOTING AYE AND COMMISSIONERS KELLEY AND HANSEN VOTING NO. AMENDMENT NO. 4 UNANIMOUSLY APPROVED AS AMENDED. MR. WARREN AND BOARD DISCUSSION. COMMISSIONER SALTZMAN MOVED AND COMMISSIONER COLLIER SECONDED, TO ALLOW DISCUSSION OF ONLY THOSE PROGRAM AMENDMENTS WHICH HAVE NO IMPACT ON THE GENERAL FUND (AMENDMENT NO. 5). BOARD COMMENTS. AMENDMENT NO. 5 FAILED, WITH COMMISSIONERS COLLIER AND SALTZMAN VOTING AYE AND COMMISSIONERS KELLEY, HANSEN AND MIGGINS VOTING NO. COMMISSIONER SALTZMAN MOVED AND COMMISSIONER COLLIER SECONDED, THAT ANY MOTION TO RESTORE AN AMENDMENT WHICH HAS GENERAL FUND MUST HAVE A CORRESPONDING CUT IDENTIFIED. BOARD COMMENTS (AMENDMENT NO. 6). BOARD COMMENTS AND DISCUSSION. AMENDMENT NO. 6 APPROVED, WITH COMMISSIONERS COLLIER, SALTZMAN AND MIGGINS VOTING AYE AND COMMISSIONERS KELLEY AND HANSEN VOTING NO. COMMISSIONER KELLEY DISCUSSION AND EXPLANATION IN RESPONSE TO QUESTIONS OF BILLI ODEGAARD AND MR. WARREN. UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER HANSEN, THE APPROPRIATION OF $21,000 TO HEALTH DEPARTMENT BUDGET TO FUND POSITION AND DEVELOP ILLEGAL DUMPING PROGRAM (HD 6) WAS UNANIMOUSLY APPROVED. BOARD COMMENTS AND DISCUSSION. MS. ODEGAARD AND TOM FRONK RESPONSE TO BOARD QUESTIONS. COMMISSIONER COLLIER MOVED AND COMMISSIONER HANSEN SECONDED, TO RESTORE PATHOLOGY ASSISTANTS POSITIONS WITHIN CURRENT HEALTH DEPARTMENT BUDGET (HD 15). MR. WARREN AND MR. FRONK COMMENTS. BOARD COMMENTS. HD 15 UNANIMOUSLY APPROVED. COMMISSIONER HANSEN MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF DA 6. KELLY BACON EXPLANATION. DA 6 UNANIMOUSLY APPROVED. LAURENCE KRESSEL*

*EXPLANATION IN RESPONSE TO BOARD QUESTIONS. COMMISSIONER SALTZMAN COMMENTS REGARDING SHERIFF'S OFFICE PRIORITIES. UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER HANSEN, MCSO 33 WAS UNANIMOUSLY APPROVED. UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER HANSEN, MCSO 34-R WAS UNANIMOUSLY APPROVED. UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER HANSEN, DES 27, DES 29 AND DES 30 WERE UNANIMOUSLY APPROVED. UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER KELLEY, NOND 8 WAS UNANIMOUSLY APPROVED. MR. WARREN EXPLANATION REGARDING BUDGET AMENDMENT REVENUE NO. 2. COMMISSIONER SALTZMAN EXPLANATION REGARDING CHILD ABUSE MULTI-DISCIPLINARY TEAM. UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER HANSEN, BUDGET AMENDMENT REVENUE NO. 2 WAS UNANIMOUSLY APPROVED. COMMISSIONER COLLIER MOVED AND COMMISSIONER HANSEN SECONDED, APPROVAL OF THE BUDGET AS AMENDED. BOARD COMMENTS. COURTHOUSE SECURITY, NEEDLE EXCHANGE AND HOOPER COLA FUNDS IN CONTINGENCY. RESOLUTION 93-237 ADOPTING BUDGET AS AMENDED UNANIMOUSLY APPROVED.*

R-12 *RESOLUTION in the Matter of Levying Ad Valorem Property Taxes for Multnomah County, Oregon for Fiscal Year 1993-94*

*UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER KELLEY, RESOLUTION 93-238 WAS UNANIMOUSLY APPROVED.*

*UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER COLLIER, CONSIDERATION OF THE FOLLOWING UNANIMOUS CONSENT ITEM WAS UNANIMOUSLY APPROVED.*

*DISTRICT ATTORNEY*

UC-1 *Ratification of Intergovernmental Agreement, Contract #500064, Between the State of Oregon, Department of Human Resources, Children's Services Division and Multnomah County, District Attorney's Office, Providing Legal Consultation and Processing, Filing and Litigating Cases in Multnomah County Juvenile Court Pursuant to State Law, for the Purpose of Terminating Parental Rights to Children who have been Neglected, Abused or Abandoned, for the Period July 1, 1993 through December 31, 1993*

*UPON MOTION OF COMMISSIONER COLLIER, SECONDED*

***BY COMMISSIONER SALTZMAN, AGREEMENT UNANIMOUSLY APPROVED.***

*There being no further business, the meeting was adjourned at 11:03 a.m.*

*OFFICE OF THE BOARD CLERK*
*for MULTNOMAH COUNTY, OREGON*

Deborah C Bogstad

*Deborah L. Bogstad*

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*Tuesday, June 29, 1993 - 1:30 PM*
*Multnomah County Courthouse, Room 602*

***WORK SESSION***

*WS-1* *Work Session to Consider Emergency Medical Services Ambulance Service Area Plan Elements. Public May Intend, However Invited Testimony Only, No Public Testimony. Facilitated by Bill Collins.*

***BILL COLLINS, JOHN PRAGGASTIS, ROY MAGNASON, LOU PARETTA, MARK DRAKE, PHIL MOYER, RANDY LOWRY, NEIL JAMES, DAVID LONG AND GARY OXMAN PRESENTATION AND RESPONSE TO BOARD QUESTIONS.***

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*Wednesday, June 30, 1993 - 9:00 AM*
*Multnomah County Courthouse, Room 602*

***BOARD BRIEFING***

*B-1* *Update on the 1993 Legislative Session. Presented by Multnomah County Intergovernmental Relations Officer Fred Neal.*

***FRED NEAL AND HOWARD KLINK PRESENTATION AND RESPONSE TO BOARD QUESTIONS.***

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*Wednesday, June 30, 1993 - 9:30 AM*
*Multnomah County Courthouse, Room 602*

***WORK SESSION***

*WS-2* *Work Session to Consider Emergency Medical Services Ambulance Service Area Plan Elements. Public May Intend, However Invited Testimony Only, No Public Testimony. Facilitated by Bill Collins.*

***BILL COLLINS, JOHN PRAGGASTIS, SGT. MERLIN JUILFS, BOB YOESLE, DR. JOHN MOREHEAD, LYNN DAVIS, DAVID***

***PHILLIPS, MARK DRAKE, TRACE SKEEN, ALEX JENSEN, DR. GARY OXMAN, RON HEINTZMAN AND RANDY LEONARD PRESENTATION AND RESPONSE TO BOARD QUESTIONS.***

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*Thursday, July 1, 1993 - 9:30 AM*
*Multnomah County Courthouse, Room 602*

*REGULAR MEETING*

*Acting Chair Henry C. Miggins convened the meeting at 9:30 a.m., with Commissioners Sharron Kelley, Tanya Collier and Dan Saltzman present.*

***UPON REQUEST OF COMMISSIONER COLLIER, C-4 WAS REMOVED FROM THE CONSENT CALENDAR.***

*CONSENT CALENDAR*

***UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER SALTZMAN, CONSENT CALENDAR ITEMS C-1 THROUGH C-3 AND C-5 WERE UNANIMOUSLY APPROVED.***

*NON-DEPARTMENTAL*

*C-1* *In the Matter of the Reappointment of Peter McGill to the MULTNOMAH COUNTY AGRICULTURAL REVIEW BOARD*

*C-2* *In the Matter of the Appointments of Rafael Arrellano, Bill Muir, Dan Saltzman, Hank Miggins, Gussie McRobert and Frank Roberts to the MULTNOMAH COUNTY COMMUNITY ACTION COMMISSION*

*DEPARTMENT OF ENVIRONMENTAL SERVICES*

*C-3* *FINAL ORDER Modifying Decision CU 20-92 in the Matter of Review of Condition B of the Hearings Officer's Decision Approving a Non-Resource Related Dwelling in the Multiple Use Forest District*

***ORDER 93-239.***

*DEPARTMENT OF HEALTH*

*C-5* *Ratification of Intergovernmental Agreement, Contract #200524, Between Multnomah County and Multnomah Education Service District, Providing Shared Resources in Order to Comply with ORS 433 Requiring the Establishment of a System to Identify, Test and Track Students Born in Countries with High Rates of Tuberculosis, for the Period July 1, 1993 through June 30, 1994*

*REGULAR AGENDA*

*DISTRICT ATTORNEY*

R-1 *Ratification of Intergovernmental Agreement, Contract #700014, Between the State of Oregon, Department of Human Resources, Adult and Family Services Division and Multnomah County, District Attorney's Office, Providing 75% Reimbursement of Prosecution Costs on Food Stamp Fraud Investigation Cases, for the Period July 1, 1993 through June 30, 1996*

***UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER COLLIER, R-1 WAS UNANIMOUSLY APPROVED.***

R-2 *Ratification of Intergovernmental Agreement, Contract #700024, Between the City of Portland, Police Bureau and Multnomah County, Providing the District Attorney's Office with Three Full-Time Investigators, for the Period July 1, 1993 through June 30, 1994*

***UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER COLLIER, R-2 WAS UNANIMOUSLY APPROVED.***

R-3 *Ratification of Intergovernmental Agreement, Contract #700044, Between the City of Portland, Police Bureau and Multnomah County, District Attorney's Office, to Fund One Detective for Services Related to the Multi-Agency Gaming Law Enforcement Revenue Task Force, for the Period February 22, 1993 through June 30, 1993*

***COMMISSIONER KELLEY MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF R-3.***

*Vice-Chair Gary Hansen arrived at 9:35 a.m.*

***AGREEMENT UNANIMOUSLY APPROVED.***

*NON-DEPARTMENTAL*

R-4 *Ratification of Intergovernmental Agreement, Contract #500463, Between Multnomah County, Multnomah County Sheriff's Office and the City of Portland, Providing the City's Bureau of Emergency Communications an Emergency Back-Up Location at the Multnomah County Sheriff's Office, 12240 NE Glisan, for the Period Upon Execution through June 30, 1999*

***UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER COLLIER, R-4 WAS UNANIMOUSLY APPROVED.***

*DEPARTMENT OF ENVIRONMENTAL SERVICES*

R-5 *First Reading and Possible Adoption of an ORDINANCE Relating to the Establishment, Membership, and Operation of the Multnomah County Citizen*

*Bikeway Advisory Committee, and Declaring an Emergency*

***PROPOSED ORDINANCE READ BY TITLE ONLY. COPIES AVAILABLE. COMMISSIONER SALTZMAN MOVED AND COMMISSIONER COLLIER SECONDED, APPROVAL OF FIRST READING AND ADOPTION. LAURENCE KRESSEL RESPONSE TO BOARD QUESTIONS. COMMISSIONER SALTZMAN MOVED, SECONDED BY COMMISSIONER COLLIER, AMENDMENT TO (B)(1) STATING THE CITIZEN BIKEWAY ADVISORY COMMITTEE SHALL BE APPOINTED BY THE COUNTY CHAIR UPON THE APPROVAL OF THE BOARD OF COUNTY COMMISSIONERS. JOY AL SOFI TESTIMONY. AMENDMENT UNANIMOUSLY APPROVED. MR. KRESSEL RESPONSE TO BOARD QUESTION. UPON MOTION OF COMMISSIONER COLLIER, SECONDED BY COMMISSIONER SALTZMAN, ORDINANCE 770 AS AMENDED UNANIMOUSLY APPROVED.***

R-6 *Ratification of Intergovernmental Agreement, Contract 302613, Between Multnomah County and Powell Valley Water District, Incorporating Needed Water Line Improvements for SE Foster Road Construction Project (SE 122nd - SE 136th)*

***UPON MOTION OF COMMISSIONER KELLEY, SECONDED BY COMMISSIONER HANSEN, R-6 WAS UNANIMOUSLY APPROVED.***

R-7 *RESOLUTION Recommending Approval of the Multnomah County 20 Year 1993-2012 Capital Improvement Plan and Program for Willamette River Bridges*

***COMMISSIONER KELLEY MOVED AND COMMISSIONER HANSEN SECONDED, APPROVAL OF R-7. STAN GHEZZI EXPLANATION AND RESPONSE TO BOARD QUESTIONS. RESOLUTION 93-240 UNANIMOUSLY APPROVED.***

R-8 *ORDER in the Matter of Imposing Gross Weight Restriction on Vehicles Using the Morrison Bridge Over Willamette River*

***COMMISSIONER HANSEN MOVED AND COMMISSIONER KELLEY SECONDED, APPROVAL OF R-8. MR. GHEZZI EXPLANATION AND RESPONSE TO BOARD QUESTIONS. ORDER 93-241 UNANIMOUSLY APPROVED.***

*DEPARTMENT OF HEALTH*

C-4 *Ratification of Intergovernmental Agreement, Contract #200514, Between Multnomah County and Oregon Health Sciences University, Providing a Single Point for Medical Direction, Data Collection and Research as Required by Multnomah County Code and Emergency Medical Services, for the Period July 1, 1993 through June 30, 1994*

***COMMISSIONER COLLIER MOVED AND COMMISSIONER***

***KELLEY SECONDED, APPROVAL OF C-4. BILLI ODEGAARD EXPLANATION AND RESPONSE TO BOARD QUESTIONS. AGREEMENT UNANIMOUSLY APPROVED.***

*PUBLIC COMMENT*

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

*There being no further business, the meeting was adjourned at 10:04 a.m.*

*OFFICE OF THE BOARD CLERK*
*for MULTNOMAH COUNTY, OREGON*

Deborah L Bogstad

*Deborah L. Bogstad*

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*Thursday, July 1, 1993 - 1:30 PM*
*Multnomah County Courthouse, Room 602*

*PUBLIC HEARING*

*Acting Chair Henry C. Miggins convened the meeting at 1:38 p.m., with Vice-Chair Gary Hansen, Commissioners Sharron Kelley, Tanya Collier and Dan Saltzman present.*

*PH-1* *Board Hearing and Public Testimony on Emergency Medical Services Ambulance Service Area Submitted Plans and Plan Elements.*

***CHARLIE HALES, JOHN PRAGGASTIS, MARK DRAKE, LYNN DAVIS, BEN WALTERS, RICHARD LAZAR, FRED CASH, JOHN SHIPLEY, CYNDY FLOCK, RYAN ROY, BOB YOESLE, WARREN ANDREWS, CHARLES SCADDEN, ERIC PEDERSEN, TAMMIE ANDERSON, SEAN RILEY, MARK WEBSTER, COLE THEANDER, EUGENE ZAHARIE, LORIN McPHERSON, RANDY BRUSSE, RON MARIANI, JAMES BEERY, RANDY LAUER, TERRY MARSH, GARY McLEAN, MARY ANN MORRISON, PONTINE ROSTECK, HAROLD STAIGLE, NIKKI JOHNSTON, BETH MURPHY, STEPHEN KAFOURY, JON JUI, FRANK SIMMONS AND KYLE GORMAN TESTIMONY AND RESPONSE TO BOARD QUESTIONS.***

*There being no further business, the meeting was adjourned at 4:40 p.m.*

*OFFICE OF THE BOARD CLERK*
*for MULTNOMAH COUNTY, OREGON*

Deborah L Bogstad

*Deborah L. Bogstad*

# 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*

***JUNE 28 - JULY 2, 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, June 29, 1993 - 9:30 AM*

*Multnomah County Courthouse, Room 602*

***REGULAR MEETING***

*REGULAR AGENDA*

*DEPARTMENT OF SOCIAL SERVICES*

*R-1* *Ratification of Amendment No. 1 to Intergovernmental Agreement, Contract #102963, Between the City of Portland and Multnomah County, Housing and Community Services Division, Youth Program Office, Allocating $100,000 Payment in Lieu of Taxes (PILOT) Funds for Emergency Youth Services, for the Period Upon Execution through June 30, 1993*

*R-2* *Budget Modification DSS #66 Requesting Authorization to Decrease the Mental Health, Youth and Family Services Division Budget by a Total of $231,628 to Reconcile Budget with Actual Funding Levels through State Revenue Amendment #49-R*

*SHERIFF'S OFFICE*

*R-3* *Budget Modification MCSO #19 Requesting Authorization to Transfer $17,896 from Equipment to Personal Services, within the Corrections Division, Inmate Welfare Budget, to Fund a Temporary Chaplain*

*DEPARTMENT OF ENVIRONMENTAL SERVICES*

*R-4* *ORDER in the Matter of Cancelling Uncollectable Personal Property Taxes, 1984-85 through 1989-90*

*R-5* *Budget Modification DES #31 Requesting Authorization to Transfer $130,000 from Road Fund Contingency to Personal Services, within the Transportation Division Budget, for Fiscal Year 1992-93 Wage Settlements*

*R-6* *Budget Modification DES #32 Requesting Authorization to Transfer $38,000 from General Fund Contingency to the Fair and Expo Division Budget, to Cover a Revenue Shortfall in the Fair Fund*

*NON-DEPARTMENTAL*

*R-7* *Budget Modification NOND #38 Requesting Authorization to Transfer Funds from Materials and Supplies to Capital Equipment, within the Commission District No. 1 Budget, to Purchase a Computer for Office Operations*

*R-8* *Budget Modification NOND #39 Requesting Authorization to Transfer Funds from Materials and Supplies to Capital Equipment, within the Commission District No. 2 Budget, to Purchase Computers for Office Operations*

*SERVICE DISTRICTS*

*(Recess as the Board of County Commissioners and convene as the Governing Body of Mid-County Street Lighting Service District No. 14)*

R-9 *RESOLUTION in the Matter of the Adoption of the 1993-94 Budget for Mid-County Street Lighting Service District No. 14, for the Fiscal Year July 1, 1993 to June 30, 1994 and Making Appropriations Thereunder, Pursuant to ORS 294.435*

*(Recess as the Governing Body of Mid-County Street Lighting Service District No. 14 and convene as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1)*

R-10 *RESOLUTION in the Matter of the Adoption of the 1993-94 Budget for Dunthorpe-Riverdale Sanitary Service District No. 1, for the Fiscal Year July 1, 1993 to June 30, 1994 and Making Appropriations Thereunder, Pursuant to ORS 294.435*

*(Recess as the Governing Body of Dunthorpe-Riverdale Sanitary Service District No. 1 and reconvene as the Board of County Commissioners)*

*NON-DEPARTMENTAL*

R-11 *RESOLUTION in the Matter of the Adoption of the 1993-94 Budget for Multnomah County, Oregon, for the Fiscal Year July 1, 1993 to June 30, 1994 and Making the Appropriations Thereunder, Pursuant to ORS 294.435*

R-12 *RESOLUTION in the Matter of Levying Ad Valorem Property Taxes for Multnomah County, Oregon for Fiscal Year 1993-94*

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*Tuesday, June 29, 1993 - 1:30 PM*

*Multnomah County Courthouse, Room 602*

***WORK SESSION***

WS-1 *Work Session to Consider Emergency Medical Services Ambulance Service Area Plan Elements. Public May Intend, However Invited Testimony Only, No Public Testimony. Facilitated by Bill Collins.*

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*Wednesday, June 30, 1993 - 9:00 AM*

*Multnomah County Courthouse, Room 602*

***BOARD BRIEFING***

*B-1 Update on the 1993 Legislative Session. Presented by Multnomah County Intergovernmental Relations Officer Fred Neal.*

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*Wednesday, June 30, 1993 - 9:30 AM*

*Multnomah County Courthouse, Room 602*

***WORK SESSION***

*WS-2 Work Session to Consider Emergency Medical Services Ambulance Service Area Plan Elements. Public May Intend, However Invited Testimony Only, No Public Testimony. Facilitated by Bill Collins.*

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*Thursday, July 1, 1993 - 9:30 AM*

*Multnomah County Courthouse, Room 602*

***REGULAR MEETING***

*CONSENT CALENDAR*

*NON-DEPARTMENTAL*

*C-1 In the Matter of the Reappointment of Peter McGill to the MULTNOMAH COUNTY AGRICULTURAL REVIEW BOARD*

*C-2 In the Matter of the Appointments of Rafael Arrellano, Bill Muir, Dan Saltzman, Hank Miggins, Gussie McRobert and Frank Roberts to the MULTNOMAH COUNTY COMMUNITY ACTION COMMISSION*

*DEPARTMENT OF ENVIRONMENTAL SERVICES*

*C-3 FINAL ORDER Modifying Decision CU 20-92 in the Matter of Review of Condition B of the Hearings Officer's Decision Approving a Non-Resource Related Dwelling in the Multiple Use Forest District*

*DEPARTMENT OF HEALTH*

*C-4 Ratification of Intergovernmental Agreement, Contract #200514, Between Multnomah County and Oregon Health Sciences University, Providing a Single Point for Medical Direction, Data Collection and Research as Required by Multnomah County Code and Emergency Medical Services, for the Period July 1, 1993 through June 30, 1994*

C-5 *Ratification of Intergovernmental Agreement, Contract #200524, Between Multnomah County and Multnomah Education Service District, Providing Shared Resources in Order to Comply with ORS 433 Requiring the Establishment of a System to Identify, Test and Track Students Born in Countries with High Rates of Tuberculosis, for the Period July 1, 1993 through June 30, 1994*

*REGULAR AGENDA*

*DISTRICT ATTORNEY*

R-1 *Ratification of Intergovernmental Agreement, Contract #700014, Between the State of Oregon, Department of Human Resources, Adult and Family Services Division and Multnomah County, District Attorney's Office, Providing 75% Reimbursement of Prosecution Costs on Food Stamp Fraud Investigation Cases, for the Period July 1, 1993 through June 30, 1996*

R-2 *Ratification of Intergovernmental Agreement, Contract #700024, Between the City of Portland, Police Bureau and Multnomah County, Providing the District Attorney's Office with Three Full-Time Investigators, for the Period July 1, 1993 through June 30, 1994*

R-3 *Ratification of Intergovernmental Agreement, Contract #700044, Between the City of Portland, Police Bureau and Multnomah County, District Attorney's Office, to Fund One Detective for Services Related to the Multi-Agency Gaming Law Enforcement Revenue Task Force, for the Period February 22, 1993 through June 30, 1993*

*NON-DEPARTMENTAL*

R-4 *Ratification of Intergovernmental Agreement, Contract #500463, Between Multnomah County, Multnomah County Sheriff's Office and the City of Portland, Providing the City's Bureau of Emergency Communications an Emergency Back-Up Location at the Multnomah County Sheriff's Office, 12240 NE Glisan, for the Period Upon Execution through June 30, 1999*

*DEPARTMENT OF ENVIRONMENTAL SERVICES*

R-5 *First Reading and Possible Adoption of an ORDINANCE Relating to the Establishment, Membership, and Operation of the Multnomah County Citizen Bikeway Advisory Committee, and Declaring an Emergency*

R-6 *Ratification of Intergovernmental Agreement, Contract 302613, Between Multnomah County and Powell Valley Water District, Incorporating Needed Water Line Improvements for SE Foster Road Construction Project (SE 122nd - SE 136th)*

R-7 *RESOLUTION Recommending Approval of the Multnomah County 20 Year 1993-2012 Capital Improvement Plan and Program for Willamette River Bridges*

R-8 *ORDER in the Matter of Imposing Gross Weight Restriction on Vehicles Using the Morrison Bridge Over Willamette River*

*PUBLIC COMMENT*

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

---

*Thursday, July 1, 1993 - 1:30 PM*

*Multnomah County Courthouse, Room 602*

***PUBLIC HEARING***

PH-1 *Board Hearing and Public Testimony on Emergency Medical Services Ambulance Service Area Submitted Plans and Plan Elements.*

*0265C/85-90/db*

# 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 |


## *SUPPLEMENTAL AGENDA*

*Tuesday, June 29, 1993 - 9:30 AM*

*Multnomah County Courthouse, Room 602*

## *UNANIMOUS CONSENT ITEM*

*DISTRICT ATTORNEY*

*UC-1 Ratification of Intergovernmental Agreement, Contract #500064, Between the State of Oregon, Department of Human Resources, Children's Services Division and Multnomah County, District Attorney's Office, Providing Legal Consultation and Processing, Filing and Litigating Cases in Multnomah County Juvenile Court Pursuant to State Law, for the Purpose of Terminating Parental Rights to Children who have been Neglected, Abused or Abandoned, for the Period July 1, 1993 through December 31, 1993*

*0265C/91/db*

SHARRON KELLEY
Multnomah County Commissioner
District 4

Portland Building
1120 S.W. Fifth Avenue, Suite 1500
Portland, Oregon 97204
(503) 248-5213

MEMORANDUM

TO: Board of County Commissioners
Clerk of the Board

FROM: Commissioner Sharron Kelley

DATE: June 10, 1993

SUBJECT: Early Departure from EMS/ASA Work Session

---

I will be departing from the morning EMS/ASA Work Session on June 30th at approximately 10:00 a.m. or shortly after to attend the Open House for Chief Potter's retirement.

1701L-8

BOARD OF
COUNTY COMMISSIONERS
1993 JUN 10 PM 1:35
MULTNOMAH COUNTY
OREGON

Meeting Date: JUN 29 1993

Agenda No.: WS-1

(Above space for Clerk's Office Use)

. . . . . .

AGENDA PLACEMENT FORM
(For Non-Budgetary Items)

SUBJECT: EMERGENCY MEDICAL SERVICES WORK SESSION

BCC Informal JUNE 29, 1993 BEGINNING TIME 1:30 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 TO 2 1/2 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. Invited testimony only, no public testimony.

1993 JUN 22 PM 1:47
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)

# Emergency Medical Services

**Multnomah County**

MEMORANDUM

TO: Hank Miggins, Chair, Board of County Commissioners
Commissioner Tanya Collier
Commissioner Gary Hansen
Commissioner Sharron Kelley
Commissioner Dan Saltzman

FROM: Bill Collins
EMS Director

VIA: Gary Oxman, MD
Health Officer

Bill Odegaard
Director, Health Department

DATE: June 22, 1993

RE: Schedule for Ambulance Planning Work sessions

1993 JUN 28 PM 4:45
MULTNOMAH COUNTY
OREGON

==========

Attached is the proposed schedule of topics for the work sessions on Tuesday, June 29 and Wednesday, June 30, 1993.

Since confirmations are not complete, a list of those invited to testify will be available at the Board meeting.

Also attached is a summary comparison of the various elements of the plans and recommendations.

Our goal for the next two days is to look at each of these elements and determine which your Board feels will best meet the needs of the citizens of the County.

Thank you.

**Health Department**
**426 S.W. Stark Street—9th Floor · Portland, Oregon 97204 · 248-3220 · Fax 248-5453**

AN EQUAL OPPORTUNITY EMPLOYER

# Emergency Medical Services

**Multnomah County**

**AMBULANCE SERVICE PLANNING**

**BOARD OF COUNTY COMMISSIONERS**

**WORK SESSIONS**

**JUNE 29 AND 30, 1993**

TUESDAY, JUNE 29
1:30 PM

ELEMENTS COMMON IN ALL PLANS
DEFINITIONS

MEDICAL DIRECTION AND SUPERVISION

RESPONSE TIMES AND RURAL CONSIDERATIONS

WEDNESDAY, JUNE 30
9:30 AM

PROVIDER (SYSTEM RESPONSE) DESIGN

WORKFORCE ISSUES

OTHER ELEMENTS (IF NECESSARY)

**Health Department**
**426 S.W. Stark Street—9th Floor · Portland, Oregon 97204 · 248-3220 · Fax 248-5453**

AN EQUAL OPPORTUNITY EMPLOYER

# PRIMARY ASA PLANNING ISSUES

| | MEDICAL DIRECTOR | AMBULANCE SERVICE AREAS | FIRST RESPONSE |
|---|---|---|---|
| EMS STAFF | ONE FOR COUNTY, RESPONSIBLE FOR ALL MEDICAL CARE AND EMTs, WORKS IN HEALTH DEPARTMENT. | SINGLE ASA IN THE COUNTY | FIRE DISTRICTS. EMT-BASIC/PARAMEDIC. LEVEL. AUTOMATIC DIFIB. AT EMT-BASIC LEVEL |
| PAPA | ONE FOR COUNTY, RESPONSIBLE FOR ALL MEDICAL CARE AND EMTs AND ADMINISTRATION OF EMS PROGRAM, REPORTS TO THE CHAIR, BOCC. | SINGLE ASA IN THE COUNTY | FIRE, POLICE, OR OTHERS. SERVICE LEVEL NOT DEFINED |
| PROVIDER BOARD | ONE FOR COUNTY, RESPONSIBLE FOR ALL MEDICAL CARE AND EMTs, WORKS IN HEALTH DEPARTMENT. | SINGLE ASA FOR CRITICAL CALLS. TWO ASA FOR NON-CRITICAL CALLS. | FIRE DISTRICTS. EMT-BASIC LEVEL. AUTOMATIC DEFIBRILLATION. |
| BUCK | ONE FOR COUNTY, RESPONSIBLE FOR ALL MEDICAL CARE AND EMTs, WORKS IN HEALTH DEPARTMENT. | SINGLE ASA IN COUNTY. | FIRE DISTRICTS. EMT-BASIC. AUTOMATIC DEFIB. |

| | TRANSPORT PROVIDERS | RESPONSE TIMES | RATES |
|---|---|---|---|
| EMS STAFF | PFB - CRITICAL 911 CALLS<br>SINGLE PVT. - NON-CRITICAL 911 CALLS | FIRST RESPONSE 4 MIN<br>CRITICAL CALLS 8 MIN<br>NON-CRITICAL 12 MIN<br>RURAL -ALL 20 MIN<br>NON-EMERGENCY N/A | RATE BOARD TO SET RATE AND REVIEW CHANGES IN SYSTEM THAT WILL IMPACT RATE. |
| PAPA | SINGLE EMERGENCY AMBULANCE SERVICE.<br>ALL 911 AND CRITICAL TRANSFERS.<br>PUBLIC OR PVT. | FIRST RESPONSE N/A<br>EMERGENCY 911 8 MIN<br>RURAL 15 MIN<br>WILDERNESS 45 MIN<br>NON-EMERGENCY 1 HR | FINANCIAL OVERSIGHT BOARD TO REGULATE RATE. APPROVED BY MAB.<br>SOME CONTROL OVER NON-EMERGENCY RATES.<br>RESERVE HELD BY FOB. |
| PROVIDER BOARD | PFB - CRITICAL 911 CALLS.<br>TWO PVT. - NON-CRITICAL CALLS | FIRST RESPONSE 4 MIN<br>CRITICAL 8 MIN<br>NON-CRITICAL 12 MIN<br>RURAL -ALL 25 MIN | RATE COMMITTEE SET EMERGENCY RATES |
| BUCK | ONE OR TWO PVT. - ALL 911 CALLS.<br>CRITICAL AND NON-CRITICAL LEVELS OF SERVICE | FIRST RESPONSE 4 MIN<br>CRITICAL 8 TO 10 MIN<br>NON-CRITICAL 12 MIN<br>RURAL NOT DEFINED | COUNTY ESTABLISHED RATES TIED TO REGIONAL CONSUMER PRICE INDEX. |

| | WORKFORCE ISSUES | PLAN ADMINISTRATION | QUALITY MANAGEMENT |
|---|---|---|---|
| EMS STAFF | NOT ADDRESSED IN PLAN.<br>DISPLACEMENT OF PARAMEDICS.<br>PFB HIRING PRACTICE | ADMINISTRATION IN HEALTH DEPARTMENT | SYSTEM-WIDE QUALITY MANAGEMENT.<br>DATA DRIVEN PER DEMING.<br>UNDER THE MED. DIR. |
| PAPA | REPLACEMENT PROVIDERS TO HIRE SYSTEM PARAMEDICS.<br>BINDING ARBITRATION. | MEDICAL DIRECTOR IS PLAN ADMINISTRATOR.<br>MEDICAL DIRECTOR REPORTS TO CHAIR. | SYSTEM-WIDE QUALITY MANAGEMENT.<br>DEMING MODEL.<br>UNDER MED. DIR. |
| PROVIDER BOARD | NOT ADDRESSED | ADMINISTRATION IN HEALTH DEPARTMENT. | SYSTEM-WIDE QUALITY MANAGEMENT.<br>DEMING MODEL.<br>UNDER MED. DIR. |
| BUCK | NOT ADDRESSED | ADMINISTRATION IN HEALTH DEPARTMENT. | MED. DIR. SUPERVISE QA PROGRAM |

## SECONDARY ASA PLANNING ISSUES

| | **DISPATCH** | **COMMUNICATIONS** | **HAZ-MAT AND RESCUE** |
|---|---|---|---|
| EMS STAFF | AT BOEC.<br>80 SEC TIME.<br>PROTOCOLS BY MED DIR. | CITY 800 SYSTEM<br>MOBIL DATA TERMINALS | PROVIDED BY FIRE AND OTHER ORGANIZATIONS |
| PAPA | AT BOEC.<br>80 SEC TIME.<br>PROTOCOLS BY MED DIR. | CITY 800 SYSTEM<br>MOBIL DATA TERMINALS | PROVIDED BY FIRE AND OTHER ORGANIZATIONS |
| PROVIDER BOARD | AT BOEC | NO RECOMMENDATION | NO RECOMMENDATION |
| BUCK | AT BOEC | CITY 800 SYSTEM<br>MOBIL DATA TERMINALS<br>VEHICLE LOCATORS | NO RECOMMENDATION |
| | **MEDICAL RESOURCE HOSPITAL** | **EQUIPMENT/ VEHICLES** | **DISASTER/ MASS CASUALTY** |
| EMS STAFF | REMAIN WITH OHSU.<br>MED. DIR. RESPONSIBLE | REQUIRED FOR ALL AMBULANCES PER THE STATE PLUS MED. DIR. REQUIREMENTS | MCI PLAN (REGIONAL).<br>DISASTER PLANNING UNDER WAY |
| PAPA | NO RECOMMENDATION | | MCI PLAN (REGIONAL) |
| PROVIDER BOARD | REMAIN WITH OHSU.<br>MED. DIR RESPONSIBLE | NO RECOMMENDATIONS | NO RECOMMENDATIONS |
| BUCK | NO RECOMMENDATION | NO RECOMMENDATIONS | NO RECOMMENDATIONS |

| | MUTUAL AID | COMPLAINTS |
|---|---|---|
| EMS STAFF | REQUIRED OF ALL PROVIDERS | REVIEWED BY MED. DIR. OR EMS STAFF. RESOLUTION BY MD OR ADMIN. |
| PAPA | REQUIRED OF ALL PROVIDERS. | RESOLVED BY MED. DIR. OR BY MAB. |
| PROVIDER BOARD | NO RECOMMENDATION | NO RECOMMENDATION |
| BUCK | NO RECOMMENDATION | NO RECOMMENDATION |

6/29/93 Submittal
Bill Collins

DRAFT

# EMS MEDICAL DIRECTOR
(Exempt/Unclassified)

## DEFINITION

To provide medical supervision for all emergency medical technicians providing pre-hospital patient care within the County, and to provide medical direction to all components of the emergency medical services system.

## SUPERVISION RECEIVED AND EXERCISED

Receives administrative direction from the Director, Health Department.

Exercises technical supervision over emergency medical technicians.

**EXAMPLES OF DUTIES** - Duties may include, but are not limited to, the following:

Develop uniform standards of emergency care within the County; solicit input regarding standards from physicians, nurses, emergency medical technicians, ambulance providers, first responder providers, hospitals, government agencies, and other interested organizations and individuals.

Accompany emergency medical technicians during the performance of medical duties for the purpose of supervision, education, and system evaluation.

Promulgate and revise, as necessary, medical care standards for: priority dispatch/pre-arrival instructions; ALS and BLS patient care protocols; hospital destination criteria; accreditation requirements for pre-hospital care personnel beyond State standards; staffing, equipment, supplies, and operational criteria for first response vehicles, ground ambulances, air ambulances, specialized critical care and mobile intensive care ambulances, and non-emergency patient transport vehicles for incorporation into licensing requirements; response times for first responders and transporting emergency ambulances; the transferring of patients between hospitals; and the provision of medical services in areas of public assembly.

Set standards for the provision of on-line medical control.

Develop and supervise a quality management program to ensure continuous improvement of all levels of care within the emergency medical services delivery systems.

Set standards and objectives, and participate in the continuing education and training of pre-hospital care personnel.

Approve emergency medical technicians for practice in the County. Establish policies and due process for the limiting of practice of emergency medical technicians, including probation, suspension, or revocation of physician orders.

Perform related duties as assigned.

## QUALIFICATIONS

Knowledge of:

Principles, practices, and procedures of emergency medicine.

Principles, practices, and procedures of pre-hospital patient care.

Principles, practices, and procedures of public health.

**QUALIFICATIONS** (Continued)

Knowledge of: (Continued)

Federal, state, and local laws and regulations governing the practice of emergency medicine and pre-hospital emergency medical services.

Principles of supervision, training, and performance evaluation.

Ability to:

Effectively administer a variety of emergency medical care activities.

Interpret and apply applicable federal, state, and local laws, rules, regulations, and policies governing emergency medical services.

Establish and maintain cooperative working relationships with those contacted in the course of work.

Communicate clearly and concisely, both orally and in writing.

Gain cooperation through discussion and persuasion.

Supervise, train, and evaluate assigned staff.

Experience and Training Guidelines:

Any combination of experience and training that would likely provide the required knowledge and abilities is qualifying. A typical way to obtain the knowledge and abilities would be:

Experience:

Three years of increasingly responsible emergency medical services experience, including system medical direction and emergency medical technician supervision.

AND

Training:

Graduation from an accredited medical school and completion of an emergency medicine residency.

License or Certificate:

Possession of, or ability to obtain, an appropriate and valid license to practice medicine in the State of Oregon.

Board certification in emergency medicine.



DRAFT

Meeting Date: JUN 30 1993

Agenda No.: WS-2

(Above space for Clerk's Office Use)

. . . . . .

AGENDA PLACEMENT FORM
(For Non-Budgetary Items)

SUBJECT: EMERGENCY MEDICAL SERVICES WORK SESSION

BCC Informal JUNE 30, 1993 BEGINNING TIME 9:30 AM
(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 TO 2 1/2 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. Invited testimony only, no public testimony.

(If space is inadequate, please use other side)

SIGNATURES:

ELECTED OFFICIAL _____

Or

DEPARTMENT MANAGER Bill Odegaard

(All accompanying documents must have required signatures)

BOARD OF COUNTY COMMISSIONERS
1993 JUN 22 PM 1:47
MULTNOMAH COUNTY OREGON

Bob Yoesle
Training Coordinator

**SOUTHWEST EMS & TRAUMA SYSTEM**
*SW Region EMS & Trauma Care Council*

112 West Twelfth Street, Suite 210-A
Vancouver, Washington 98660
(206) 737-1888 • FAX 737-1900

The Multnomah County Board of Commissioners has struggled for at least a decade to come up with a countywide ambulance plan as required by Oregon law. Every attempt to reach consensus so far has been buried by legal and political squabbles. The board has narrowed down a wide range of options and received recommendations from the city of Portland and ambulance companies. A final decision is scheduled July 15.

**WHY CHANGE NOW?**

There is general agreement that the current set-up delivers good, fast service. But it could stand improvement. Ambulance bills are high, there are no uniform standards, services are duplicated and patients don't always get the closest ambulance. All of the new proposals have in common a single medical director, uniform quality standards, and some sort of rate regulation and review.

**THE PLAYERS:**

- Portland Fire Bureau/Gresham Fire Department
- AA/Care Ambulance
- Buck Ambulance
- Portland Area Paramedic Alliance

**BOARD'S DECISION SCHEDULE:**
(Room 602, Multnomah County Courthouse)

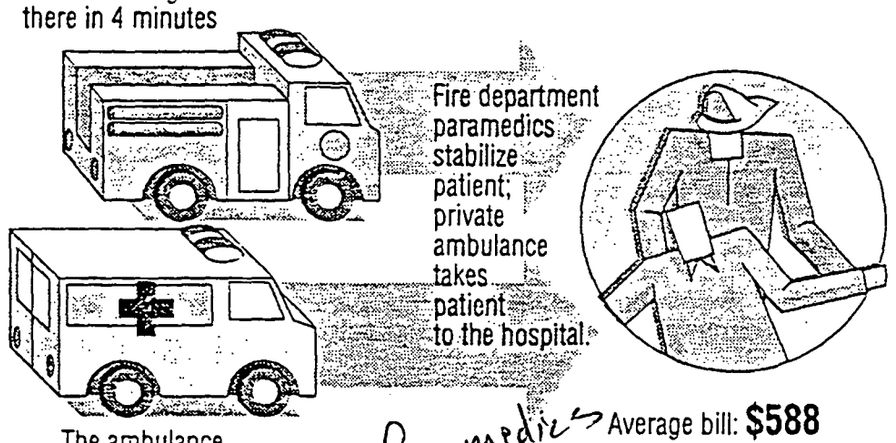
- 1:30 p.m. Tuesday — work session
- 9 a.m. Wednesday — work session
- 1:30 p.m. Thursday — public hearing
- July 6 — work session
- July 8 — first reading of the ordinance
- July 15 — final adoption

## CURRENT SYSTEM

Someone calls 9-1-1 with a medical emergency

Fire departments and private ambulance are dispatched — either Buck or AA/CARE, depending on area.

The firetruck gets there in 4 minutes




The ambulance arrives in 8 minutes

Average bill: **$588**
Rates are unregulated.

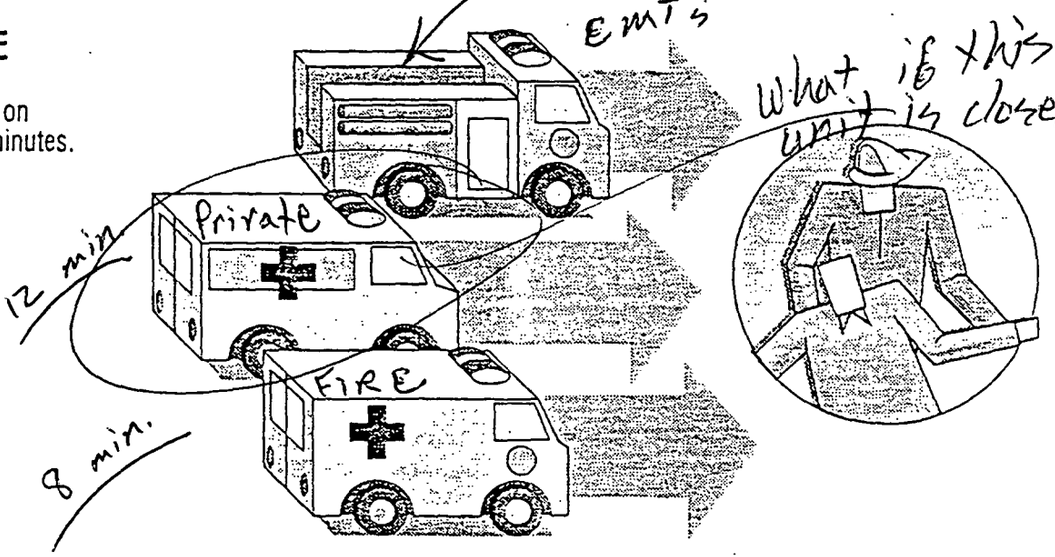
■ Buck Ambulance recommended change: All ambulance calls split between two companies.

## TIERED RESPONSE

Fire department still goes on most calls, arriving in 4 minutes.

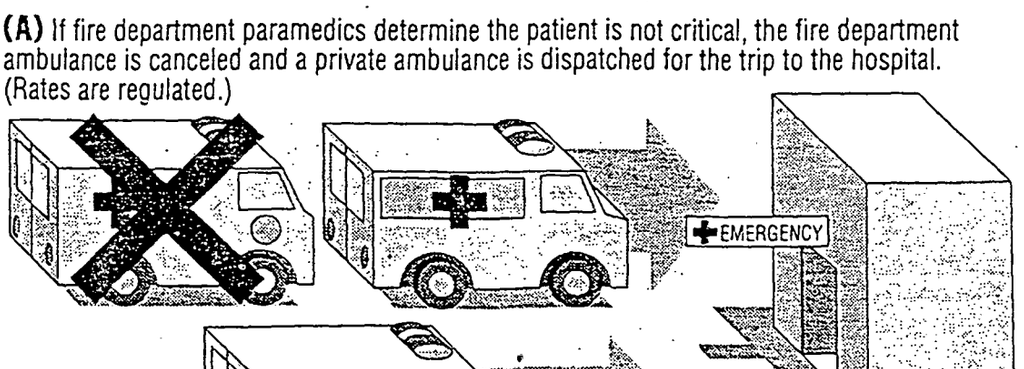
**(A)** If patient is clearly not critical, a private ambulance is dispatched. (One company, under contract to county.)

**(B)** If patient is critical or uncertain, a fire department ambulance is dispatched.




## THE SCENE

**(A)** If fire department paramedics determine the patient is not critical, the fire department ambulance is canceled and a private ambulance is dispatched for the trip to the hospital. (Rates are regulated.)




**(B)** If the patient is critical, a fire department ambulance takes him to the hospital. Estimated bill: **$400**.

■ AA/Care suggestion: Calls are split between two companies.

At this local rate, tax $ subsidize medical insurance.

**SINGLE PROVIDER**

# CRITICAL ASA PLAN ISSUES

## STANDARD OF CARE

- Consistent delivery
- Eliminate decision trees
- Eliminate unnecessary hand-offs

## SYSTEM THAT DOES NOT JEOPARDIZE THE QUALITY IMPROVEMENTS

- Relationships with other agencies
- Special programs in East County
- Special programs in West County
- Special services from Fire Bureaus
- Experienced workforce
- Utilization of existing resources

## HOW CAN YOU IMPROVE THE SYSTEM

- Dispatch the closest ambulance
- Unify Medical Director, training & QA
- Control costs through efficient use of transportation resources
- Solidify first response throughout County

# QUESTIONS THAT MUST BE ASKED

Not Necessarily

| | TIERED SYSTEM | EMS STAFF OPTION #2 |
|---|---|---|
| Will the closest ambulance be dispatched? | Y | Y |
| Will First Response be improved? | N | Y |
| Will the number of paramedics be reduced? | N | Slightly |
| Will the rates be regulated? | Y | Y |
| Does the Plan require the addition of substantially more resources? | Y | N |
| Will experienced paramedics be eliminated from the system? | Y | N |
| Will the County have increased liability? | Y | N |
| Will resources be used efficiently? | N | Y |
| Will all paramedics receive the same level of training & experience? | N | Y |
| Can the process be revised if it becomes too costly or doesn't work? | ? | Y |
| Does the system increasingly rely on tax dollars vs. health care dollars? | Y | N |

# HOW DO WE CONTROL RATES?

- THROUGH THE EFFICIENT AND COMPETITIVE USE OF EXISTING RESOURCES.

A simple equation:

| | | |
|---|---|---|
| | The # of production units required | _____ |
| X | The cost of production units | $ _____ |
| = | Overall System Cost | $ _____ |
| ÷ | Reimbursement Collection Rate | _____ % |
| = | Total revenue required | $ _____ |
| ÷ | # of billable transports | _____ |
| = | Average Patient Charge | $ _____ |

## ESTIMATED PARAMEDIC POSITIONS

| | DEDICATED 911 - SINGLE | TIERED/DEDICATED | TIERED/ALL |
|---|---|---|---|
| HOURS/FTE (12 HR SHIFT) | 2190 | | |
| | 2 FTE/HR | 1 FTE/HR | 1 FTE/HR |
| CURRENT HRS | 125684 | | (MAX) 125684 |
| ESTIMATED HRS | 86476 | (MAX) 86476 | |
| CURRENT FTE | 115 | 115 | 115 |
| ESTIMATED FTE | 79 | 39 | 58 |
| "+/ FTE" | -36 | -76 | -58 |
| FIRE | N/A | 9 | 9 |
| NET | -36 | -67 | -49 |

NOTE: THESE TWO TOTALS DO NOT INCLUDE POSITIONS FOR NON-EMERGENCY CALLS

INCLUDES CURRENT NON-EMERGENCY CALLS

**CITY OF GRESHAM**

Fire Department
1333 N.W. Eastman Parkway
Gresham, OR 97030-3813
(503) 661-3000

June 29, 1993

Commissioner Hank Miggins
Acting-Chairperson
Portland Building, Room 1410
1120 SW Fifth Avenue
Building 106
Portland, OR 97204

Dear Commissioner Miggins:

The Gresham Fire Department has been closely following the activities involved in the development of the County Ambulance Service Area Plan. We have participated in numerous discussions up to this point. We are encouraged that this project appears to be nearing completion after the long and arduous process it has been through.

One of the options you are considering, the Tiered Plan, would have fire service provide transportation of critically ill or injured patients. While the Portland Fire Bureau has been identified as the primary provider of this element of the service, our discussions with them indicate their willingness to explore a partnership between the Portland Fire Bureau and the Gresham Fire Department to provide critical care transport.

Should the Tiered Plan become the selected option, the Gresham Fire Department is prepared to continue exploring this option. If our participation in the transport of critical patients proves to be in the best interest of the Department, emergency medical patients and our citizens, then we would certainly provide that service.

Continued on Page 2 . . .

The Gresham Fire Department is in the beginning phase of a service delivery study which will be completed well before the implementation of whatever option is selected. We will include the Tiered Plan in that study in order to facilitate our decision.

Sincerely,

Bob Yungeberg

Bob Yungeberg
Asst. Fire Chief
Gresham Fire Department

JP/pl

# PORTLAND FIRE FIGHTERS' ASSOCIATION

LOCAL FORTY-THREE OF THE INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS

DEDICATED TO THE TRAINING AND ADVANCEMENT OF PROFESSIONAL FIRE FIGHTERS

4530 S.E. 67th AVENUE • PORTLAND, OREGON 97206-4514 • (503) 774-4302 • FAX (503) 774-5476



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INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS

•

OREGON STATE FIRE FIGHTERS COUNCIL

•

NORTHWEST OREGON LABOR COUNCIL


June 8, 1993

TO: Ron Heintzman, President
Amalgamated Transit Union Division 757

FROM: Randy Leonard, President
Local 43 IAFF

SUBJECT: Displaced Multnomah County Private Sector Paramedics

As we discussed at our meeting on June 1, 1993, the Portland Bureau of Fire, Rescue and Emergency Services is considering entry into the 911 transport business.

Within the next five to six weeks, the Fire Bureau, Portland City Council and Multnomah County Commission will be defining what role the Bureau can expect to play in the Ambulance Service Plan (ASP) for Multnomah County. Other organizations will also have considerable input into the ASP planning process.

Even if the Fire Bureau does not become involved in transport, it is likely that many private sector positions will ultimately be lost within Multnomah County if a single provider is selected or if other streamlining occurs. Local 43 has no control over those reductions. However, I am very sensitive to the issue concerning the <u>additional</u> private positions that would be lost if the Fire Bureau should assume responsibility for a portion of the 911 transports. No hard figures are available yet as to how many private paramedics would be displaced.

The City appears willing to take steps to minimize the impact on the private sector by incorporating displaced paramedics into the Fire Bureau.

Basically, three options appear possible to attain that goal:

1. Hold a "closed" entry exam for the position of

Firefighter/Paramedic. Only Multnomah County private sector paramedics would be allowed to test for the position. Affirmative action objectives would likely play a part in the final selection process. Normal firefighter training, probationary period, etc. would apply.

A review of the literature suggests that the incorporation of paramedics willing to be cross-trained as dual role firefighter/paramedics would have advantages over other options. However, this option would exclude otherwise well qualified paramedics with no desire to become firefighters. It would also postpone involvement in transport pending completion of firefighter training.

2. Hire only paramedics who specifically do <u>not</u> wish to become cross-trained as firefighters. Under this scenario, the ATU would probably have more input into the final selection process, or at least influence which pool of candidates would be considered. There would be no firefighter probationary training involved and thus (perhaps) a greater feeling of job security. The ATU could continue to represent those paramedics.

   Any such positions would be filled with a firefighter/paramedic once a vacancy occurred. Eventually, all positions would revert to firefighter paramedic status.

   One advantage to this proposal would be the immediate availability of the new bureau employees to assume a transport role.

   The major disadvantages would center around the differing pay scales, job descriptions, union representation and similar issues that arise when a firefighter/paramedic works side-by-side with a non-sworn paramedic.

3. Some combination of options 1 & 2 above involving closed exam for the firefighter/paramedic position along with a limited number of non-sworn positions. While this scenario might be attractive to many ATU members, I envision considerable confusion in determining which Multnomah County paramedics would be eligible for the two types of positions.

I trust you have had an opportunity to discuss issues related to these and any other options since our last meeting with your members.

Obviously the City Council and the Bureau of Personnel Services would have considerable influence in formulation of the option ultimately selected. However, Local 43 is interested in working with the ATU to recommend a selection process that would in any case, reserve employment opportunities within the Fire bureau for positions that would otherwise disappear for your members.

We fully intend to keep the lines of communication open concerning these issues.

BCC ✓

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Christopher P. Thomas

Steven A. Moskowitz

June 28, 1993

Multnomah County Board of Commissioners
c/o Board Clerk's Office
1120 SW Fifth Avenue
Portland, OR 97204

**Subject: Emergency Medical Services Planning Process**

Dear Board of Commissioners:

I enclose for your information a set of transcripts of meetings of the EMS Provider Board between April 6, 1993 and June 2, 1993, as part of its EMS planning process. I am formally submitting these transcripts so that they may receive consideration by the Board in its current set of EMS planning meetings.

Very truly yours,

Christopher P. Thomas

cc: Jeffrey M. Kilmer

COMMISSIONERS: THERE ARE 200+ PAGES OF TRANSCRIPTS IN THE BOARD CLERK'S OFFICE - IF YOU WISH YOU MAY CHECK THEM OUT. THANK YOU! (6/30/93 EMS/ASA WORK SESSION FILE)

BOARD OF COUNTY COMMISSIONERS
1993 JUN 30 PM 12:34
MULTNOMAH COUNTY OREGON

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BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Tuesday, April 6, 1993
9:08 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Barry Doherty, CARE Ambulance
Mr. Thomas Steinman, Portland Fire Bureau
Mr. David Phillips, Gresham Fire Department
Ms. Beth Ann Murphy, Community Ambulance

* * *



APPEARANCES

ALSO SPEAKING:

Mr. William Collins
Mr. Jeffrey Kilmer
Mr. Christopher Thomas
Ms. Trudi Scheidelman
Mr. Jerry Andrews
Mr. Randy Lauer
Mr. Cole Theander
Mr. Gary McLean
Mr. John Praggastis

* * *



PROCEEDINGS

MR. ROBEDEAU: Why don't we get started. This is the Provider Board meeting. In case you don't know, I am Pete Robedeau. And I am chair of the Provider Board.

We have two things on the agenda. One thing is, response times have been coming up for the last six or eight months, that according to the staff out at Kelly Butte, all of the providers have been out of compliance with the eight-minute, 90 percent rule.

We had done -- at AA we did a study that shows where the difference between the stats are and between Kelly Butte and between the providers. What we did was, for the month of February we listened to every single, solitary, over-eight-minute response that was on the Kelly Butte printout. And what we found was that there's a 39 percent error rate. And it appears that most of that error rate is assignment of crews has being done sometime



prior to dispatch.

That range -- the average length of time in that was one minute that the assignment of the crew was being done prior to dispatch. And that, for AA, for which -- one of the reasons we used February because of the terrible weather. And the way things went in February, we came out with a 91 percent compliance rate; and applying the same number to January without ever listening to any, we came out with 92 percent, and I think that will probably hold true with most of the providers.

I would certainly think there's no reason to believe that any one particular person is being picked on. But I think it is really important -- I would ask you, Bill, that this be brought up Friday at the MAB. I know the MAB has made a big deal, at least one individual in particular, about how none of the providers are in compliance with the eight-minute 90 percent of the time.

MR. COLLINS: Just to kind of add to this. When Jerry and I -- was it last



month? Last month and a half? -- conducted a series of inservices with all of the dispatchers at BOEC, we put on an eight-meeting series of inservices about EMS and tried to get -- find out what kind of problems the dispatchers felt they had and try to get some information out by EMS.

And one of the things we discovered is exactly the same thing that Pete has identified in this February study. The dispatch rules for EMS at Kelly Butte identified that the response time interval starts when the dispatch is made.

And the definition that we had assumed they were using and, in fact, had been identified, the rule was, the dispatch is counted as started when the unit that's assigned responds to Kelly Butte. And it's not really possible to start a dispatch before that because until they hear that a unit has received the call, they don't know for sure whether -- whether that unit ever heard them or whatever.

What they have been doing, because



of -- I am not sure the reason other than trying to clear their dispatches off their list -- is, in many, many cases, they have started -- they have put the dispatch into the CAD when they assign the unit. So they had a call, they look at whatever information they have, and they decide they are going to send, you know, AA Ambulance, and as soon as they made that decision, they entered it in as a dispatch and contacted the ambulance.

So it's exactly the same problem that you found out, Pete. And this all kind of makes sense, I think, in light of the frequency analysis that we have done in, for, I don't know what -- we did it a couple, three times, and that showed that the 90th percentile, which is, you know, what we are trying to hit for, one period was eight minutes and is seconds to eight minutes and 45 seconds and eight minutes and 45 to nine minutes.

That would indicate that the, quote, noncompliance is not a matter of a large number of long calls but, like I explained



a number of months ago, it's really a number of calls just barely over the line. And this type of dispatch by pushing the button too soon, if it's putting -- well, you have 60 seconds. We didn't go in and do any study. I mean, this is just from talking with the dispatchers. And we went, wait a minute. That's how you are doing the dispatch?

But 60 seconds or even 30 seconds would put a large number of calls over the line. So we have discussed this with BOEC. We are making the correction. One of the things they were concerned about was this would push their dispatch time. And so what we are trying -- make it longer.

So one of the things that we are

looking at is that their CAD, their current CAD will identify when they attempted to contact a unit and when they actually heard from them. The dispatch time would still be when the unit responded, but we want to also look at that interval. Because if what's happening there is, they are trying to contact somebody and nobody answers,

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then that's a status-keeping issue for the unit.

If the unit is in service, they try to dispatch them and nobody responds, then that's a different kind of issue, but that is not a response-time issue.

The response-time issue is that interval between the dispatch and the time that the unit tells Kelly Butte they have arrived. So I think we are all -- hopefully, we have all discovered a big piece of the problem. I don't know what it will take to make sure that all of the dispatchers do this correctly. I mean, they don't work for us. There's a lot of them.

And we have talked to the management up there to get them to change this so that the process would be what is written. You hear from -- when you hear the crew acknowledge, you push the button, and that's when the time starts and the time runs then until that crew reports back to Kelly Butte that they have arrived at the scene. If the crew reports arrived to the

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company at the scene, that doesn't count because you don't know that at Kelly Butte.

MR. DRAKE: Bill, are you going to do any screens or anything to find out if they actually resolved the problem?

MR. COLLINS: Jerry is working with them to see how we can get the data off this interval to make sure that's what's happening. We can do the same type of screen that Pete did where you listen to the tape and then you, you know, you match it up with the time, but there may be a way we can actually get that as part of a report that will just show us when the time was activated.

MR. DRAKE: So the response time records from BOEC are now inaccurate? We don't know what these are because these dispatchers are inaccurately --

MR. COLLINS: Dispatch time on those calls is not accurate.

MR. DRAKE: So the response times are inaccurate?

MR. COLLINS: Right. As I am sure

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that you, the providers, are aware, we have not attempted to try to fine people for noncompliance with the response times because we know we have had various data problems. We are also, as kind of an adjunct to this, we think we are very close to getting Kelly Butte, in the interim before the new CAD goes in, give us a weekly run to show us all the runs plus call the eight-minute runs. This is something requested by the providers at various times. And we are, you know -- the biggest problem we seem to have is, the computer there is very old, and you are never quite sure what it can actually do.

I don't mean to make excuses for Kelly Butte, but that's why they are putting the new computer in. But, yes, I mean, we are aware of this problem now. We found out the same time you did. And we will figure out how to get it straightened out so we get the right times.

MR. DRAKE: You are expecting the new computer to go in September, November?

MR. COLLINS: Well, they haven't

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changed the list, have they?

MR. ANDREWS: Beta test is November 15th, and they are anticipating a January 1 cutover for full operation.

MR. DRAKE: January 1?

MR. ROBEDEAU: That's set back?

MR. COLLINS: That's the same thing. They are going to do side by side.

MR. ANDREWS: Turn-on has always been November 15.

MR. COLLINS: They are going to turn it on and run both systems, test it, make sure there's no bugs.

MR. ROBEDEAU: I thought the system was fully operational by September.

MR. ANDREWS: No.

MR. COLLINS: No. The November, middle of November has been the site, you know, occupying the site with the new equipment in it from the beginning. The new radio system is not until January. And then they are going to run the CAD side by side for some period of time, I guess, you know, a couple months, and make sure it works.

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MR. ROBEDEAU: I have one question. One of the things you were saying, you seem to be in at this meeting that Kelly Butte was assigning calls, assigning crews and starting the dispatch time in order for them to comply with their 80-second rule?

MR. COLLINS: It wasn't their 80-second rule. What they are trying to do is clear the calls fast, move to the next call, and they weren't really paying attention to the fact that they needed to have a response. I mean, it's just, you know, we wouldn't have found out probably until we met with the dispatchers and we said, now, you are doing this, and they said, well, not exactly.

Not everybody is doing it. They are doing slightly different things so we are -- no one has really told them, I guess, in the past to do anything different, so we are telling them to do it different now.

MR. DRAKE: Part of a concern I have is that I think it's good that you can get us weekly reports, but it's kind of not

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economically feasible or whatever for us to sit down and go through our reports when we know they are inaccurate from the start.

MR. COLLINS: Well, there's two issues, though, if you remember that we have talked about in the reports. One is over eight minutes and are we getting accurate data. The other has to do with total number of calls. There are the sort of controversy over who has the right number of calls.

One way to look at the right number of calls is to get them to give us a weekly printout of all the calls, all the EMS calls. Then we can sit down and match them up and see where, because we have had reports where Kelly Butte has had more and the company has less, and we have had the other way around, so we are trying to accomplish two things with that.

One is to see if we can figure out what the call volume question is and then, you know, I don't know how long it takes to fix this. How many? They got a bunch of dispatchers.

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MR. ANDREWS: 87.

MR. COLLINS: We will tell them to fix it, and they will say they are going to fix it, and then we will monitor and figure out what's going on.

MR. DRAKE: How many dispatchers do you have?

MR. ANDREWS: Currently 87.

MR. DRAKE: 87.
MR. ROBEDEAU: All rotate through EMS?
MR. ANDREWS: Actually 70 some are required to rotate through.
MR. ROBEDEAU: Is that going to continue in the new building?
MR. ANDREWS: It's a negotiable issue. It's on the table right now.
MR. COLLINS: The position in -- under the new building, new CAD, the position the fire department and EMS has taken is that we do not want them rotating on a two-hour basis like that; that it needs to be more dedicated. They can bid the job every six months or whatever is negotiated, but that it needs to be a more dedicated system, and



that's essentially what they have agreed to at this point. I can't tell you what's going to happen with, you know, union negotiations.
MR. DRAKE: I would hope they would be able to get some dedicated EMS dispatchers. I can't see how you are going to resolve 70 people rotating through that system and getting accurate data unless we go to the silent dispatch, which we haven't done that yet.
MR. COLLINS: We brought up the same issue. When the new CAD is in is the time that -- that's the time that is proposed for the cutover from FAD. And our proposal is the same dispatch will dispatch EMS and fire on the medical calls, that we will not have split dispatch.
MR. DOHERTY: When was the inservice?
MR. COLLINS: When did we do that? End of February?
Then we discussed this. We will get it straightened out.
MR. SKEEN: How much time is spent determining which provider, which



component?
MR. COLLINS: I don't know. I don't think that's a big issue.
MR. ANDREWS: Part of the problem with the dispatch part of it is once the call has -- the intervals that are marked are call-created and calls for dispatch and then the dispatch time. Currently, the way their CAD is configured, you can dispatch the call before it's sent because of a summary screen that they have. When the call comes up on the screen, there is a built-in unit recommendation based on bases. Since the providers have all changed some of the base assignments and because of the way that the CAD does its expanding circle search, the reliability of the CAD recommendation is probably about 50 percent.
For instance, the entire Sellwood area shows as a base 81 primary dispatch base. Well, it's CARE's, and base 81 doesn't exist anymore. But the cost of changing those tables is kind of what's operating that. So the dispatcher looks at the unit



recommendation and goes, nah, that ain't it, and has to look at the unit available.
MR. SKEEN: So it's tied to preassigned locations as opposed to an actual system status availability?
MR. ANDREWS: Correct.
MR. COLLINS: But they are making their decisions basically on the unit information that they have.
MR. SKEEN: Is that monitored manually?
MR. COLLINS: Yeah. That's why they are putting new CAD in.
MR. SKEEN: Then the other issue you talked about was that the response time, as far as the measurement that you are using for the providers, begins once you know the --
MR. COLLINS: Once a unit responds. You mean currently?
MR. SKEEN: Currently.
MR. ANDREWS: What we have told the dispatchers in inservice is the key strokes for assigning the unit to the call is dispatch-basic-enter; that once they make



the dispatch decision, they tone the car; they get an acknowledgment; they give the car the information on the call; and when they get an acknowledgment from the crew they have the information -- and, generally, that's like "Copy," then they get dispatch-basic-enter. At that point the clock starts.
MR. SKEEN: As much as I hate to admit, that's kind of a deviation from standard methods of measuring response time because you are missing that whole component from the time the three pieces of information are obtained until you dispatch. I hate to bring that up because it changes our response time.
MR. COLLINS: Which?
MR. SKEEN: The component when we identified the three pieces of information which basically comes off the hands-free to the time the unit arrives on the scene. What you are missing from the three pieces you have is until the time that the unit acknowledges.
MR. ANDREWS: No.



MR. SKEEN: That, generally, would run 15, 15 seconds maybe.
MR. ANDREWS: But part of the issue we are trying to resolve in talking with the dispatchers, on that basis, they will say, well, that's AA-55. And what we found was that some of the dispatchers were saying, okay, I am going to give it to AA-55, so they will dispatch-basic-enter, and AA-55 is on a call, whether they have been toned out or not.
Then we have the issue of, okay, I am going to page AA-55, so I set up the board and I hit the page button, and I do his dispatch-basic-enter then. AA-55 may not enter then. AA-55 may answer. Do I hit dispatch-basic-enter then? Or are we requesting to measure the response time from the crew time the crew says, "Oh, I got it. I can go on the call," which is what we said the time you can start the clock for the crew when you know they have got the information and are able to respond.
MR. ROBEDEAU: The first half of the



dispatch problem, for lack of a better term, is Kelly Butte because the County, a long time ago, made the decision they wanted to keep the dispatch function and not have the provider have the dispatch function; where really it works in some other systems where you call 9-1-1: If it's medical, it goes to the ambulance dispatcher.
That doesn't happen here. The County decided back in the late '70s they were going to keep that portion of dispatch function, so that where most systems allow 60 seconds for that call to be taken and dispatched, that's completely out of our control.
So the only fair way to do it is for one of -- when one of our units receives the call -- and that's what they have done -- and those other dispatch functions, your total response time from the time the call is initiated until there is help arriving on the screen stays with the County. And you know the County has some pretty antiquated equipment. Everybody

knows that and I think they are trying to correct that problem.
MR. SKEEN: It's a relative basis, but it's just not consistent with kind of conventional methods to measure response time.
MR. ANDREWS: We are aware of that.
MR. SKEEN: It's not a critique. Then, obviously, Mark brought up the silent dispatching, the use of MBTs and so forth.
MR. COLLINS: Right. That's the plan with the new CAD.
MR. SKEEN: If the computer will stay up, you are in great shape.
MR. COLLINS: That's why you have a radio along with the --
MR. SKEEN: That's right.
MR. ROBEDEAU: You then are going to bring this up at Friday's MAB meeting?
MR. COLLINS: I don't know if we will bring it up Friday's because of the agenda, but we will bring it up to the MAB.
MR. ROBEDEAU: I think this is very important this is brought up. I have been sitting in MAB meetings for the last six



months listening to us be hammered on how lousy our response times are, and, you know, it's really important that the correction be made, and I think it's important the correction be made this Friday.
MR. COLLINS: Okay.
MR. SKEEN: Not that the hammering hasn't brought improved results. It has.
MR. COLLINS: That's good.
MR. ROBEDEAU: It's brought a lot of scratching the head. I will have to say I don't know exactly when this came out, but this is what clued us in to what was going on. This is when we started the study. This is a memo you passed out to the training officers.
MR. COLLINS: Oh, yeah.
MR. ROBEDEAU: About mid-March. When was this done? Do you know?
MR. ANDREWS: That's the inservice notice.
MR. COLLINS: This is the notes from the inservice we did. So we just -- that's kind of the summary of the inservices with



BOEC that we just did the end of February.
MR. ROBEDEAU: So this is done the end of February?
MR. COLLINS: This is the thing we did when we discovered the same problem that you discovered when you looked and listened to the tapes. So I will bring it up in the directors report on Thursday, and we can give a copy of what we have sent to BOEC.
MR. ROBEDEAU: This is what clued us in to start looking.
MR. COLLINS: That's when we just found out about it. So we are on the same wavelength.
MR. ANDREWS: That is one of the reasons we made the decision to distribute that to the training officers and the dispatch meeting we have coming up. We are not trying to hide anything. We are trying to let everyone know what the issues are.
MR. ROBEDEAU: I understand that.
MR. COLLINS: Hopefully, this will, you know, will make the change. We will do the frequency distributions. It will show, you know, the difference.



MR. ROBEDEAU: Okay.
MR. DOHERTY: Do they have the ability now to do the key strokes to initiate a time for when the dispatch is attempted?
MR. ANDREWS: No.
MR. COLLINS: That's an issue -- and we may not be able to resolve that with the current computer. That may have to -- that piece for BOEC may not be able to come in until the new CAD. One of the things that we are trying to do is get some of this stuff solved as we can with BOEC without putting a great deal of money into the CAD. The City doesn't want to put anything into it because they just bought a new one.
So if it's a procedure thing, we can deal with it. If it's the, well, we can deal with it if we did extensive programming, we are not going to deal with it because it's too extensive, and the City is not going to do that as they are developing the new.
So I don't know yet on that. We are still seeing if there's a way to punch another button or something. That's sort



of internal to BOEC. The change for the response time, that's just when they push the button. And we will make -- we are making that change and we will look and see what that does to the response time.
MR. DOHERTY: When should we expect to start receiving weekly reports?
MR. COLLINS: We will have to get back to you. We got a draft on the over eight, and we don't have it to break out all the calls. And I really want to look at that all-call list, even though per week there must be 600 calls. More than that. Almost a thousand calls.
MR. DOHERTY: We would like to give you a little encouragement. We went through all of the calls in February also. And I guess, depending on how you look at numbers, what we found up until the end of February was 100 percent error rate; that virtually every call, they were assigning the call before it was acknowledged; and that listening to the times and timing the actual times of the calls put us at about 91, 92 percent compliance, too.



But at the end of February, around the 26th or so, we started seeing that the two-second dispatch time, i.e., crews that are on the air that are dispatched on the call and acknowledge with "en route," there should be very little rollout time, and there is a marked improvement in that. So, hopefully, your message got across when you talked to them.
MR. ROBEDEAU: Does anybody else have anything else on this before we move on?
For anybody that wants it, I have some copies of a memo that Dave made for me on this. There's a few extras here.
MR. DRAKE: Response times?
MR. ROBEDEAU: Uh-huh. Did you get one?
MR. DRAKE: Yeah, we got one.
MR. ROBEDEAU: Let's see. I am sure nobody came here to listen to response times.
MR. DRAKE: I have never seen so many people at a Provider Board meeting in my life. We generally only have about six people max. In fact, six people is a lot



at a Provider Board meeting. I don't know what drew everybody here. I am sure we will find out. But might be a good idea to go through who the Provider Board is. We have Tom hiding over there in the corner, representing the Portland Fire Bureau. And, Pete, you just might want to say all the people on it.
MR. ROBEDEAU: The Provider Board is just that. It's a board of licensees within Multnomah County. Consists of AA, Buck, CARE, Portland Fire, Gresham Fire. Bill says it consists of Community. I disagree. But, you know, what the hell. It wouldn't be the first time.
MR. DRAKE: Community is considered a member because there is a representative

from Community here today.
MR. COLLINS: Yeah, they are a licensee. The licensees.
MR. DRAKE: She was trying to hide, too. Caught.
MR. COLLINS: The licensees in the County are AA, Buck, CARE, Community Ambulance, the sort of selected rescues at



Portland Fire, Gresham Fire.
MR. ANDREWS: Metro is on the list.
MR. COLLINS: Metro-West does provide service also. And the ambulance that's out at the racetrack.
MR. ANDREWS: Stand By.
MR. ROBEDEAU: They are a licensee?
MR. COLLINS: Yeah. Although they have a very limited role. But, yes, they recently were licensed because the Racing Commission requires that an ambulance be there, so they applied to be licensed as an ambulance, and they are BLS nonemergency responding.
MR. DRAKE: And TVA is also a licensee.
MR. COLLINS: Yeah. If you guys put one name on it, then, it would be easier to keep track.
MR. DRAKE: We are working on it.
MR. COLLINS: So anybody who holds a license, at least in my opinion, is a member of the Provider Board.
MR. DRAKE: And, Pete, it might also be helpful to tell people, the Provider



Board has been run a lot looser than the Medical Advisory Board. We don't have people raise their hands. We have people jump in and discuss issues as they need to. We want to keep the meetings informal, so if the people have comments or questions or issues, please feel free to jump in. And we don't hold people to five minutes. You can talk as long as you want.
MR. ROBEDEAU: Gosh, Mark, you are doing better than I am. I am not much of a chair. I have been chair of the Provider Board for years.
MR. DRAKE: And you're doing a good job, Pete.
MR. ROBEDEAU: It's not exactly my comfort zone, sitting up here in a meeting.
Anyway, there hasn't been a lot of discussion on ASA planning. And one of the things I think is really important at the Provider Board, anyway, is keep this open and up-front discussion and allow everybody to say whatever it is they want to say. With what Mark said, a little interactive



speaking.
I am of the impression that the, by ordinance, the review of the two proposals for the ASA planning has actually gone to the wrong board. I find nothing that allows the MAB to really rule on that. I think the appropriate board to advise would be the Provider Board.
The Provider Board is to advise the director on matters affecting the assignment of calls to emergency vehicles, and I think ASA planning is certainly the assignment of calls to emergency vehicles. The Provider -- or the MAB is there to advise on medical issues. While I don't have the exact quote in front of me, I don't find anything in the ordinance that would make the MAB the appropriate body to be the advisory council on ASA planning.
Is there any comment on that? No comment. Okay.
MR. DRAKE: Everyone needs a little more coffee, apparently.
MR. SKEEN: Well, I am interested in Bill's interpretation of that. That's a



fairly major issue.
MR. COLLINS: Well, I don't know if I have an actual interpretation of it. The ordinance is -- I don't think is all-inclusive in sort of who reviews what. I think that the general direction -- the MAB has both an advisory position or advisory activity to advise the director on issues surrounding -- I mean, medical issues surrounding the EMS system. They also have an approval authority.
I don't have the ordinance, but probably one of our esteemed counsels over there have it and can read it.
MR. KILMER: Want me to read it?
MR. COLLINS: You might as well. There's three things, if I remember. One is approval, and two are advisory. And Pete's comment on the Provider Board is all it says in there.
MR. KILMER: Well, I think it is important to understand the approval limitations on the approval deal. This is Multnomah County code 6.32.057, the powers and duties of the EMS Medical Advisory



Board. And it says, "The EMS Medical Advisory Board shall have the following powers and duties.
A: Approve proposed action by the director relating to protocols for prehospital patient care, emergency equipment, EMT training, and medications required to be carried on vehicles operated by licensees. The Medical Advisory Board shall consult with the physician advisors to the providers of emergency medical services, the Medical Resource Hospital, the Multnomah County Medical Society, the American College of Emergency Physicians, the Emergency Department Nurses Association, organizations representing EMTs, and other affected organizations concerning these actions;
B: Consult with appropriate persons, departments, agencies, and organizations and advise the director on matters concerning the subject matter of this chapter and;
C: periodic reviews of the policies and procedures of the Medical Resource



Hospital and report its recommendations and findings to the director." The Provider Board is 6.32.058. "The role of the Provider Board is to advise the director on policies concerning the assignment of emergency calls to EMS vehicles."
MR. SKEEN: And that's it? The Provider Board?
MR. KILMER: That's it.
MR. COLLINS: That's it.
MR. ROBEDEAU: Were you finished?
MR. COLLINS: Yeah. I mean, I don't know what else I want to say.
MR. ROBEDEAU: Well, I think the Provider Board has some decisions to make. I think one is, we need to decide if we are going to study the issue and perhaps produce a plan; include, I think, medical supervision in the process, meet regularly for the next four to six weeks to produce something.
As I understand it, nothing is going to hang around and wait very long. And I would really like to see the MAB included in the process and see if we can't come up



with something that's going to be consensus for everybody. You know, anyway --
MR. DRAKE: I would just echo that. I think the Provider Board should respond to the plans submitted by both the Portland Area Paramedic Alliance and Bill Collins. Furthermore, I think we should work within the framework of Bill Collins' plan. You

did a wonderful job here. I like your planning.

We have some issues and concerns with your plan, but I think working within that framework that we can develop a good response and possibly come up with a real good system for the County using all available resources that we have in the County, both the private and public resources.

And, Bill, do you know, is there a time line established by the County Commissioners that we have to meet or is that open at this time?

MR. COLLINS: The time lines right now that we are operating under is that the MAB will review plans on Friday. There are --

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my understanding, unless somebody has shown up to the MAB chair with something that I don't have, there are currently three documents.

There's the planning document and plan from our office; there is the plan submitted by PAPA; and there is a document that we have copies here submitted by Buck Medical Services. Those are the three that have been submitted within the current time line that the MAB identified.

Their process is to review the plans at that meeting and make some kind of final statement regarding the plans in the May meeting, which would be May 14th, I think. I will get the dates. Yeah, May 14th is the May MAB meeting. And that -- the results of that will be forwarded to -- the MAB has decided they want to forward that to the board. That's the only time line that is in place right now.

MR. DRAKE: That's a time line from the MAB? That's not a time line from the County Commissioners?

MR. COLLINS: That's a time line from

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the MAB that's also been -- not from the commissioners as a whole, but the liaison commissioner with the Health Department has agreed on that same timing.

MR. DRAKE: If we met once a week for the next four weeks, that would develop a time line? It would take that long to develop a response.

MR. COLLINS: It would meet -- it would be within the framework of the time set out by the MAB. I can't tell you what the MAB is going to do, you know, on Friday, and the subsequent --

MR. DRAKE: Irrespective of the MAB, would that be a time line for the County Commissioners, as far as you are aware?

MR. COLLINS: As far as I am aware, that would meet what is currently in the place, which is the May, yeah, the May meeting.

MR. DRAKE: When are County Commissioners going to hear?

MR. COLLINS: I can't tell you that for sure.

MR. DRAKE: Okay.

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MR. COLLINS: Our department, we have decided that we wanted to have the plan before the County board in June, no later than June. That's the actual date. I mean, there has to be an agenda date.

The process, as far as I am -- unless somebody comes up with something different, is the County Board of Commissioners have to approve a plan. That plan then goes to the State. The State says, yes, you have included everything. No, you didn't.

The State does not, as far as I know, have any process by where they comment on the content of the plan like, we don't like the way you did it. They are just going to review it to see if all the pieces are there.

Then subsequent to the approval by the State, then the County will have to enact an ordinance that would implement the plan. So it's really kind of a two-piece, you know, the plan is a plan. It's not an implementable document. Then you have to take that and then put that into some kind of ordinance that will then allow you to

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implement what the plan told you to do.

I don't have -- I mean, the discussions I have had with the State is that there is no lengthy turnaround time. It does not go before any kind of board at the State. It is reviewed internally by the EMS division of the state Health Division, the EMS section, whatever they call it. So my discussions with them is that is a sort of almost a perfunctory process that they will go through.

MR. DRAKE: Okay.

MR. COLLINS: So I wouldn't expect that would be a delay. But it would seem on the Board of Commissioners' side there's actually two things they need to do. One is, they need to approve a plan to submit to the state, and then, subsequently, they need to approve an implementable ordinance. Those are the two pieces. And then we go from there.

MR. DRAKE: Okay. But I am sure you are going to agree -- you can agree with me we want to keep this a uniform, a fair, and accessible process?

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MR. COLLINS: Yes, we do.

MR. DRAKE: I am sure the County Commissioners will want as well. In fact, reading from Commissioner Collier's memo that she wants to keep it a fair process.

MR. COLLINS: Yes, I am sure she would.

MR. DRAKE: From our standpoint as a provider, as a fair process, we are to need four to five weeks, meeting weekly, to prepare a response to these plans, which would include some financial information, of course, and some real details of getting down to the subject matters that we need to discuss, talking about all areas of the plan themselves. So is that agreeable with you, from the County's standpoint?

MR. COLLINS: That fits into the time frame, as far as I can tell.

MR. DRAKE: What about the other providers?

MR. SKEEN: Well, a couple things, Mark. Just by having the two plans -- and Buck's document was not a plan. It was more commentary on the plans.

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MR. DRAKE: Uh-huh.

MR. SKEEN: -- raised more questions than they answer. Four or five weeks, meeting weekly, I would say would be a significant task to address those issues in that period of time. And I guess that takes me back to the MAB on Friday. Because you talked about a final, final discussion on the plans for them?

MR. COLLINS: No. That's in May. My understanding of what the MAB wishes to accomplish on Friday is review the plans that have been submitted as of the 2nd of April, which was Friday, this last Friday, and to make some decision on what they are going to continue to discuss in May.

MR. SKEEN: Okay.

MR. COLLINS: That's my best summary.

MR. SKEEN: Because I don't think they have enough data in front of them to make the final recommendations.

MR. COLLINS: I can't comment on that.

MR. DRAKE: I would agree with Trace. I don't think there's enough data to make any decision on the vehicle delivery

system.
MR. SKEEN: You talked about involving MAB in the discussions with the Provider Board. Are you talking about asking them to assign a liaison to work in the development?
MR. DRAKE: I think we need to invite all parties, which is the physician supervisors, to participate in that process, and to get the medical input, and certainly invite the members of the Medical Advisory Board -- this is an open, public meeting -- to participate with us if they so desire. Not just be a liaison but anybody that wants to discuss involving here in the issues.
MR. SKEEN: You may want to take that from five weeks to 15 weeks.
MR. DRAKE: Yeah. I am hoping to do it sooner than that, but you are right. It may take longer than that concerning what issues we have.
MR. SKEEN: The other thing, you made some comments about the plan Bill's folks put through. I don't want to discount the



effort that the PAPA group have in their plan. I think they have some very strong components. In fact, I think, Bill, you referred to the issue of response time that needs to be addressed at some later point for the population-density classifications of the County.
And PAPA took initiative to -- went into a little more detail on that. I thought it was good. Concepts of financial oversight board that they submitted I thought were good. I think it's obviously probably gone into a lot of research on various wheels that have already been created in putting their plan together.
MR. COLLINS: I would encourage you to not to pick a plan but to look at the information that's been put forward and see what you recommend out of all the information that's come forward. Because I agree with you. There are some things in each document that should be reviewed, or there may be other stuff, too.
MR. ROBEDEAU: I don't think the proposal is to pick a plan. I think the



proposal is to produce a plan. Most of us have been around long enough. I know you are eminently familiar with other systems in the country. I am familiar with quite a few -- not as many as I used to be, but a lot.
The expertise that we have sitting on the Provider Board is substantial, just out of our heads without even looking up, just for the years we have been here, and I think the Provider Board, if it is desired, the Provider Board can get busy and do a good job fairly rapidly.
We have two plans before us. Both of them have good points; I think both of them have bad points. And I am sure anything we come up with, somebody is going to say it has some good points and some bad points.
And I think that the whole thing -- I think the real question at this point is, do we want to do that? I would like to see us do that. I think it would be the first time the providers really produced something. We have been reactionary for years. I think it would be the first time



we have being proactive than reactive.
MR. SKEEN: Again, I just reiterate the time lines.
MR. DRAKE: We are not held to the times lines. And I am sure, Trace, if we get into this and find there are more issues, it will take more time, we may have to go to the County Commissioners. We will say, here's where we are at and here's the more time we need.
It depends how much audience participation we get. They are pretty quiet out there. So people may get more interested. I think we need to go through the plans and ask some questions. And I would like to work off of Bill Collins' plan as a framework for the Provider Board to response to and to produce a response.
I don't know if, Pete, if we are really looking at producing a plan ourselves but just responding to Bill's plan and making some adjustments.
MR. ROBEDEAU: I think any time you respond to a plan, you respond to PAPA plan or Bill's plan or the Joe Acker plan from



1986, you are producing a plan, and I think we wind up producing a plan here, this says this, I think this would be better that way. You wind up producing a plan.
MR. SKEEN: I would stay away from using one of these as foundation to building blocks to build on and basically look at components you will draw -- you clearly will draw from both of these.
MR. DRAKE: I understand what you are saying. But I would rather work from a framework rather than starting from de novo, new, and going through this process. I think most of the components of an ASA are pretty noncontroversial. You have to distribute the --
(Dr. Gary Oxman left the meeting at 9:55.)
MR. ROBEDEAU: PAPA's plan is copyrighted.
MR. DRAKE: We respond, certainly, I would like to, from CARE's standpoint, we would like to respond within Bill Collins' framework. That's the recommendation to the Provider Board. In fact, furthermore,



CARE-TVA would like to look at option 1, which is the public-private model, as the model that we would like to work off of. That would be our framework that we would essentially like to work with them.
MR. SKEEN: What are your plans for the next meeting, Pete? Do you want to have the providers come with some proposals of components and comments on plans? What's your intent?
MR. ROBEDEAU: No. I have a list of things that -- I went through Bill Collins' plan and picked out things I think we really need to look at. I think the accuracy or inaccuracy or the assumptions in the data are important. I think you need to see what they are, double-check to see if they are correct. I think some of the assumptions, I don't believe, are correct. I could be wrong. I would like to see all the raw data.
MR. SKEEN: You are talking about past performance? Historical performance?
MR. ROBEDEAU: I am talking about projections, I am talking about -- oh, let



me see here. I have a whole -- we have got information on paramedic turnover. We have cost analysis and projected cost savings. Some of that I don't agree with.
I know with paramedic turnover with AA Ambulance, he shows we have 59 paramedics. We only have 28 positions. 26 of those are filled. There's something that has gone awry with some of the -- a lot of assumptions. And I certainly am not going to start throwing any reaction around, but I think we just need to see the raw data where this came from so we can determine what the actual thing is. I don't know.
It shows 181 private paramedics. We have 26. I think CARE has about the same. I am not sure, Trace, I think 181 seems

awfully, awfully high.
MR. SKEEN: I think Bill has been very candid how he's measured that. He can represent himself. When I talked to him, he indicated there's no preassessment other than he used a method of the licensed paramedics with the County. I think there's some holes in some of the

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assumptions there.
MR. ROBEDEAU: I think we have some things we need to get. And if Bill can provide us with the raw data on that, we need to look at it real quick, and I think that's a good foundation for where we are coming from or from where we start and what is correct and what isn't. Then we know better what needs to be fixed and what doesn't, what is working properly, what could work better.
MR. DRAKE: I think there's questions about both plans, too, I have, Trace.
Gary, are you going to be coming to all these meetings if we have them once a week? Are you going to be able to do that or someone from your organization?
MR. McLEAN: We would certainly like to have a representative there, but that's a pretty big chore that you are asking for. And I think our plan is complete. If you have questions about the plan now, I would be more than happy to answer them.
MR. DRAKE: We may have questions as we go through the process, and certainly I

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do have some questions today, but I think we need to ask questions. And certainly Bill will be a resource here, and he can answer questions from his plan.
MR. McLEAN: I can't guarantee someone will be there from MAB. Trace, Mark, you indicated you wanted to work off of Bill Collins' plan, the ASA plan with the selection with the provider selection specified as option 1?
MR. DRAKE: I would like to use that as a framework under options 5.1, the public-private.
MR. SKEEN: I don't even know what your process you are, again, that you want to pursue. You talked about doing more analysis. Again, I would say my comments are, rather than locking on to a particular ASA plan and a particular option -- I think there are six options laid out between the two plans -- that we probably ought to start from assumptions of the ASA components and build from there.
MR. DRAKE: Okay.
MR. SKEEN: Soon as you lock on an

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option, then you are almost agreeing the number of assumptions made there are accurate and validated.
MR. DRAKE: I don't have any problem looking into components of the plan.
Tom, do you have any thoughts?
MR. STEINMAN: Well, we all know the MAB is going to charge ahead with it, so I think it would make more sense to offer the Provider Board's assistance to the MAB, who is obviously going to be looking at all these plans in the next few weeks, and see if we can work together with them, instead of going off on a separate course and banging heads at the County Commissioners' level.
MR. DRAKE: Sure.
MR. STEINMAN: Make that suggestion Friday and see where it goes. If we don't get anything --
MR. ROBEDEAU: It's my understanding the MAB's process is closed.
MR. STEINMAN: We are not going to know it until Friday. It was pretty closed when they had one plan.

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MR. ROBEDEAU: Pretty closed?
MR. STEINMAN: Just because they called Mark a dummy, that's no big deal. I think we need to see what they are up to Friday and then maybe work with them if we can or -- I just don't want to get into any -- a lot of different games in front of commissioners and get this thing stalled for six or seven years.
MR. DRAKE: I agree with that. Tom, you don't have any problem meeting once a week? We can do that and forge ahead with this?
MR. STEINMAN: No.
MR. DRAKE: Any other providers? Jeff is down there hiding. Don't have any problem meeting once a week?
MR. PRAGGASTIS: Mark, I have a question. Am I to understand that you, as agents of the County, are going to write another plan in tandem with the County's plan?
MR. DRAKE: We are not agents.
MR. PRAGGASTIS: This is a County board, as I understand.

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MR. ROBEDEAU: Provider Board, yeah, we are talking about writing a plan.
MR. PRAGGASTIS: As a County board?
MR. ROBEDEAU: As the Provider Board, yes.
MR. SKEEN: I think Pete indicated later there might be a majority and a minority or secondary minority.
UNIDENTIFIED SPEAKER: I was just curious if this was to be done as a County function or if this was to be done as independent providers.
MR. ROBEDEAU: No. This is to be done as the Provider Board, as a group of providers who have been providing EMS in the area. You know, we have not closed the meeting, as with some organizations closed their organization to us, so we could have input into that, which was not allowed. I know with the MAB is not at all receptive to even hearing anything.
I think some of the people on the MAB, if you go back and look, you find there is very, very little room for discussion with the MAB. Their mind has been made up for

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years.
And you look at the minutes of the MAB or you look at the transcripts from the MAB, and every meeting over a period of -- I would dare to say -- the same individuals have said the same things over and over and over and over again, which shows to me that there is no fair process from the MAB, absolutely none. The MAB has made up its mind. The chair of the MAB wrote the white paper. You just go on down the line, and it's not a fair process.
MR. PRAGGASIS: I just was curious, Mr. Chairman, if you were meeting under the shield of the County. That's my only question.
MR. ROBEDEAU: I don't know that we are meeting under the shield.
MR. COLLINS: What is the shield of the county?
MR. DRAKE: I don't know.
MR. PRAGGASTIS: They just --
MR. COLLINS: Both the MAB and the Provider Board are advisory boards in the current EMS ordinance with the County. If

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that's a shield, then, I guess they are a shield. There's no difference in their status. I mean, they are both advisory boards. They are both actually advisory to the director of the EMS office.
There's nothing actually in the ordinances that make them advisory to anyone else. Although in actual operation,

they have taken a different tack, but they are both, whoever set it up however long ago, that's what they set up, two advisory boards, one medical, one provider.

Those are actually the only provider boards -- the only advisory mechanisms that are formal within the ordinance. So I don't know if that answers your question, because I am not sure what shield means. But is that what you are --

MR. PRAGGASTIS: Just was curious. Just thought I would ask.

MR. COLLINS: But I mean, I was asking what you meant.

MR. PRAGGASTIS: If the County is going to run two processes or one, if you were meeting under the -- as a group of



providers or if you were meeting as representatives of the County. That was my only question. Thank you.

MR. COLLINS: Representatives of the County? They are not representatives of the County. They don't work for the County.

MR. SKEEN: You withdraw the question?

MR. COLLINS: I don't understand what you mean.

MR. SKEEN: Probably ought to mention that the opinions expressed by Mr. Robedeau are his own regarding the MAB and does not necessarily represent -- in case there is legal action.

MR. ROBEDEAU: Randy?

MR. LAUER: John raises a question that I think is in a lot of peoples' minds. The fact that the Provider Board is convening now at the 11th hour of this process is a little interesting. I think we ought not bash the MAB because I think their focus has been to get something moving. Whether people overwhelming agree



with that or not is another issue, but I want to ask just one question.

Is it the intent of the Provider Board or the group of providers to reach a consensus on ASA components or is it the intent to forward a majority or minority opinion under the Provider Board umbrella?

MR. ROBEDEAU: I would like to see a consensus reached on a plan that could go in without opposition. However, I think it is -- if there is no consensus that can be reached, I think a majority and a minority report is appropriate, and that the commissioners then make up their mind from there.

I would hope there would be a consensus to send to the commissioners about a plan that meets with Bill Collins' office's approval, and the provider approval and the MAB approval and then the County Commission approval.

MR. LAUER: I think it's pretty important, and I agree with Tom that this group ought not be in conflict with MAB but try to work with them as much as we can.



MR. ROBEDEAU: Intent is not to be in conflict. And there are some strong feelings about some of the things. You know, I have got some strong feelings, and I was speaking, I will tell you, for myself. I am not going to try and apologize for what I said. I think what I said was absolutely true.

You know, I don't think -- I have sat, you know, for years and listened to some of the stuff. But putting that aside, I would like nothing better -- one of my original comments was to see if we could work with the MAB. I would like nothing better than the MAB and Provider Board working together and produce a plan that is agreeable to everybody that can be submitted to the County Commission, you know, something that isn't controversial and something that will work for the citizens of Multnomah County. That is the ideal thing. I don't know that that's possible with some of the agendas that have been out.

I don't know if it's possible with some of the agendas that are still out.



And I expect everyone will have say I have my own agenda. I think that's true. I think everybody alive has their agenda, to some degree.

I think it needs to be fair and open. I think it needs to include all groups, PAPA -- you know, the providers, they are -- in the 27 years that I have been involved in EMS in Multnomah County, I can never remember any plan or any change that has involved all groups. It has always been a group or a couple of groups trying to shove something down the throat of everybody else, you know.

We are never, ever in this County going to get down to having a cohesive system that works well with everybody working and cooperating. I don't think that will ever happen. That's why I made my remarks at the first of this thing. I said, let's get everybody involved. I would invite the MAB, I would invite the physician supervisors. It was an open meeting. PAPA is invited if they wish to come, everybody else. But this has never,



ever, ever, in the history of EMS in Multnomah County, happened. I would certainly like to see it happen, and everybody is invited.

What always has come out of meetings where somebody is trying to shove things down somebody else's throat was, you had a report by the guy who is willing to stand up and holler the loudest. And there was never any disagreement alluded.

I don't think disagreement is a bad thing. I think disagreement is what has gotten the world to what it is now. If everybody was accepting things the way they were in the Middle Ages, we would still be believing things that weren't there, this is the center of the universe. Disagreement is one of the things that helps move things along.

MR. STEINMAN: Good. Then I will disagree with you, Pete.

MR. LAUER: That was a pretty long answer, Pete.

MR. STEINMAN: Can we go off back a second? Part of the confusion, I agree



with Mark, we need to do a report to Bill or County Commission or whatever the process is, and not do another plan. If you throw that in that we are doing another ASA plan, that's confusion.

We need to look at the components of that and come up with what we are recommending. You are talking about minority reports and majority reports, and then you are talking about ASA plans. We need to figure out what we are going to do. I agree with Mark. Get our opinions on the table and let the powers that be make decisions.

MR. ROBEDEAU: I agree. But by doing that, Tom, we are actually producing a plan.

MR. STEINMAN: You think that, but I don't. We disagree.

MR. DRAKE: When you are talking about producing a whole ASA. Some of them are boilerplate, and we are not really going to comment on.

Randy, I think you have been involved in the process out in Washington County for

many, many months.
MR. LAUER: Years.
MR. DRAKE: You know as well as I do discussing those components, we will discuss a component for 20, 30 minutes, for even an hour on just one component of the plan of the process. And so in relationship -- and I am not meaning to be attacking, but giving us five minutes to respond to two minutes, this thing isn't reasonable. We can't even begin to talk about some of these components in five minutes.
So that's part of the process that has led us here is, we need to respond to these. We would like to respond as providers, and it would be nice -- right. You are right. If MAB and PAPA and everybody got together and we could all bring forth a plan to the County Commissioners to respond to a plan, it would be ideal for everyone. I don't know if that's possible.
MR. LAUER: First of all, it's not -- let's not back up and start doing



things the way Washington County is doing.
MR. DRAKE: No, I didn't mean to do that either.
MR. LAUER: We will be well into the next century.
MR. DRAKE: We will still be here in 1995. I think we can do it a lot quicker.
MR. LAUER: I think we can identify the key components from the ASA plan and reach consensus on those.
MR. DRAKE: Right.
MR. LAUER: Rather than get into the details.
MR. DOHERTY: I think we have been spending the last 18 months trying to reach consensus. There were a lot of ASA work-group sessions that that was being done in. And I went to a lot of meetings, and as far as I knew, we were about 80 percent there when all of a sudden there was this other plan pushed forth, which caused, at least in my own opinion -- I can't speak for the other providers -- but that caused the EMS office to put forth a plan right away.



I don't feel we are done. And I don't think that the Provider Board getting together now in the 11th hour is necessarily the case. I know that at least for CARE-TVA, our decision, when Bill came to town and started getting work groups together to build consensus, that was the process we were going to use for ASA planning and be part of that process.
And I think we had a lot of excellent meetings. I don't think we finished that process. And the reason why we are in the 11th hour now is that I believe some plans were brought forth before they were finished.
And so that's why I believe Mark was making the comment that we should use Mr. Collins' plan as the groundwork because that is the result of all the work that we have all been doing for the last year and a half. I just don't think that it was finished.
MR. LAUER: That brings up one additional point. There was never a work group that was targeted to address what's



probably the most volatile part of the ASA plan, and that is the provider selection part. That was never discussed. Never been in any discussion on that at all. If we do nothing else than discuss that, this can substitute as a work group. But that needs more discussion.
MR. DRAKE: I agree, Randy. I think this is a forum for this discussion as long as the other components we have to discuss before we get there. I agree with what Barry is saying; we need to finish what we have started. There were several work groups in process, and I thought we were still meeting, and then this plan came out.
And I think there is some incompleteness, at least what I see in the plan, and I think in the next couple of weeks we can get that wrapped up. We are most of the way there. We just need a little more refinement.
MR. LAUER: Don't you think, then, it would be premature to take the provider options now and use that as a framework? There's a large question that still looms



out there.
MR. DRAKE: I guess that's in part because of the historical background in this process. We have gone through a lot of these occupations, a lot of these discussions before.
But I agree with you, I think we need to just look at all of them, all the options around the table, and that's why I would agree with Trace we need to look at PAPA and Bill Collins' plan. I would like PAPA here to ask them some questions about their plan, and also Mr. Collins, see if we can get down to some nuts and bolts.
Maybe eliminate some of the options that are not feasible in the current economic situation. That might be possible. That it? Pete? You want to take a break? I have some questions of Bill. I think everyone will want to take a quick break?
MR. ROBEDEAU: I don't care.
MR. DRAKE: Let's take a five-minute break. Thanks.
(Recess taken from 10:31 a.m.)



MR. ROBEDEAU: Can we get back to going again, please? Let's reconvene, get going.
I think I need a motion to agree to meet for the next six or seven weeks weekly and review the components of the different plans and advise the director on that. Do I have a motion?
MR. DRAKE: We have a couple of our members out, though. Why don't we wait a minute.
MR. COLLINS: Keep in mind, if you would, the time lines that we are working under so it fits in with that.
MR. ROBEDEAU: Trying to.
MR. COLLINS: We really want to try to stay in that time frame as much as we can.
MR. ROBEDEAU: You were talking June to the commissioners. Right?
MR. COLLINS: June would be -- I mean, if you were going to pick sort of -- a drop-dead date will be whenever the County Commissioners begin the review process and hold their public hearings, and that is -- we don't have the date of the agenda,



but it's in June. And I don't know where what's her name went.
MR. SKEEN: If you were going to take into consideration recommendations from the provider committee into a plan that you put forth, what's the --
MR. COLLINS: We would like to do it in concert with the process that's going on with the MAB, so that would be sort of the middle of May. The date that we -- and I am only speaking for the Health Department, saying when we would do it. I can't speak for the Board of County Commissioners. We said we would bring a plan forward in June.
Now, when in June, obviously, depends on when you can get on the agenda and how

it fits in, but let's assume June. That would be the – that's when the, I would assume, the commissioners would begin whatever public hearings they would have regarding the adoption of the plan.
So there's two dates. There's – we are trying to get the MAB and whatever input we can against that date, and there's

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the June date for the public hearings. I would say once the public hearing date, we are not going to go past that.
MR. ROBEDEAU: What's the MAB date?
MR. COLLINS: The May date is the 14th. We will try – you know, I will talk to the commission and see if we can actually set up a time in June. I mean, there's – that can be done, I think. But we would have to do that with the commission. We can't obligate them to the hearing date.
MR. KILMER: But, Bill, I think it's important for the record here to be that the Provider Board – I think Mr. Doherty made a very good point that the Provider Board is not meeting at the 11th hour. It is because a plan came out faster than the plan without the opportunity to discuss many of its components before recommendations were made, and now they are having to respond to that and they are going – the commitment seems to be they are simply going to do it very quickly.
But there's no guarantee going in that

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they are going to have a fair opportunity to do it within the time frames that you are now talking about. And I don't think anybody wants to waive any claim that any process that is imposed on too short a time frame is unfair by making any commitments today. And I understand that Mark's comments earlier indicated they were reserving the right to request additional time if needed but that there will be a good faith effort to meet what is, all of a sudden, a very accelerated time frame.
MR. COLLINS: I understand that.
MR. KILMER: Today, your comments today were the first notice that anybody was even thinking about such an accelerated time frame. So I just – I think the committee or the board ought to make it very clear that, you know, our fundamental desire is to have a fair, open process that's fully capable of evaluating all these things, and the time frame you are talking about may not be adequate to allow that.
MR. DRAKE: Bill, I have a question

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for you. The next Provider Board meeting, how much notice do we need to put out to people? Is it a ten-day notice?
MR. COLLINS: No. You just need to make a timely notice. There's no time. And there's a lot of people here. Just put it out. Say when you want to do it.
MR. DRAKE: If we schedule meetings on a weekly basis?
MR. COLLINS: If you feel you need to meet on a weekly basis, we will pull it out. If you don't want to meet, then cancel it. We will cancel it. It will help us, us being our office, to know what you want to accomplish in this period of time and what kind of support we are going to need.
If it's a matter of reviewing sort of what has been put together so far, we have got all that, so that's not a big process for us. If it's developing new and different data, that may be something that will be very difficult for us to do.
MR. ROBEDEAU: I don't know that we are going to be able to develop any new

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data. I think we will have to limit to reviewing the components of the existing plans and use the existing data.
MR. COLLINS: Like Barry said, essentially, not – I don't know if all the data has been reviewed because there's been some questions on some of the pieces in the plan that we submitted, but a lot of the data was developed in groups where we know where it came from, so this is not all brand-new stuff. But we can do that. We can put – if you wanted to meet every week, we will just put out a notice you want to meet every week and what time, and you can go ahead and do it.
But I would like to try to, you know, I think on the June date, probably what we should try to do – we, our office, is, contact the board and see if we can set up a date – a reasonably certain date for whatever public hearing process they want to participate in. And that way people will have the date ahead of time as opposed to one week before the agenda. So I would be willing – we will do that.

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MR. DRAKE: Pete, you said you needed a motion. I would so move that the Provider Board develop a response to both plans and forward on a recommendation to the EMS office and Board of County Commissioners and that we meet weekly until that process is done, and hopefully we can do that in five to six weeks, but we may need more time. I think that's recognized by all. And that the meetings be at least two hours in length. I think we will need to do that. I will make that motion.
MR. ROBEDEAU: Do I have a second?
MR. DOHERTY: I second.
MR. ROBEDEAU: We have a second. Discussion?
UNIDENTIFIED SPEAKER: I just like to make a comment. Has the thought occurred to you all that what you might do is determine a process that can fit within a time frame, and if that requires you would meet more than once a week, that you would do that?
MR. DRAKE: That's a good suggestion. Thank you. We can certainly meet more than

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once a week if we have to. It's difficult with our schedules. But –
MR. ROBEDEAU: What would be the notification requirements on that?
MR. COLLINS: Like I said, what we can do, since a multiple meeting type of thing we will – we can send out a notice with as many times as you want to put on them, and that puts everybody on notice when the meetings are. Then we can cancel the times if you don't want to meet them.
That's a – that's better than trying to do each one separately. So if you are going to meet once a week, I can send out a notice on behalf of the Provider Board, like we do with the MAB, and say, the meetings will be on such and such a date, and people know that.
MR. ROBEDEAU: This lady's suggestion of possibly more than once a week, if determined needed – if we meet next week at a time and then decide to meet two days later again, are we legally allowed to do that? That is my question.
MR. COLLINS: What I would suggest you

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do is pick a series of times, like you want to meet on Tuesdays and Thursdays, and you are going to do that over the next four weeks, and we put out a notice. Then if you choose not to meet on one of those times, canceling it is not such a big deal. You can cancel it.
There's no specific time in the public

meeting law that says you have to give ten days or 12 days or four days. It needs to be timely so that people who are interested can attend the meetings. So what you don't want to do is give one-day or two-day notice because then it's not -- people won't get it in time. It would be easier just to put out a whole schedule and then deal with the schedule.

MR. DRAKE: I think we can do that.

MR. ROBEDEAU: I don't know about once a week. That would require an amendment to your motion.

MR. STEINMAN: Mark, why don't you amend a motion to set a date we are going to have this report to the commissioners and then go from there. If they want this



by --

MR. DRAKE: That's what we are trying to get out of Bill. I don't think he can give us a date. I don't have a problem by saying June 1. Is that what you want to do?

MR. STEINMAN: Yes.

MR. SKEEN: Actually, I was very hopeful of having this -- perhaps we can provide those portions that have been completed by May 14th when the MAB -- seems to be the date when they are going to take more definitive action. I think it's important to work towards that. I see June as rather lengthy. By the same token, it's going to be a difficult task to get all that put together by then.

MR. DRAKE: Do you have the time to meet twice a week?

MR. SKEEN: That was the other thing. I think if we talk about individuals who meet twice a week, we will discover real quick there are substantive -- substantial conflicts. Certainly, there ought to be a commitment to have a representative from



the agency that can meet at those meetings. And you will lose some consistency with it. But nevertheless, because of the short time frame we have, there is not a lot of options.

MR. DRAKE: Okay. Does that work with you, Tom?

MR. STEINMAN: Whatever it takes.

MR. ROBEDEAU: If you want twice a week, you amend the motion you are going to --

MR. DRAKE: Just Tuesdays and Thursdays?

MR. ROBEDEAU: Just a second.

MR. DRAKE: Thursday mornings are bad. Only once a week, though, Randy, isn't it? You are just meeting once a month, Washington County policy board?

MR. LAUER: Sometimes two weeks.

UNIDENTIFIED SPEAKER: Bill, what was the intention for MAB for action tomorrow -- or for Friday? The way I understood it, they were going to pick a plan to use as a --

MR. COLLINS: I don't know for sure,



you know, what they will do. The original discussion at the MAB was to pick a plan. But comments -- I mean input has been back to the chair that that may be not enough time to do that. So we will have to see on Friday what they are going to do.

Their commitment to a recommendation is the May meeting, not the April meeting. Whatever they do they are not putting forth any recommendations until May.

UNIDENTIFIED SPEAKER: But they are developing a home plate or base to work on? They thought they were going to pick one of the four, whatever else they came?

MR. COLLINS: That was what they said at the last meeting.

MR. DRAKE: That was my understanding, too, they are going to pick an option on Friday.

MR. THEANDER: Pete, if I say say something since there's so many questions about the actual agenda of the MAB meeting, let me shed some light on it. The discussion was concerning the process. And the process agreed upon was the deadline of



April 2nd; that the April meeting, the plans would be discussed and that public testimony would be heard; if enough public testimony is present but not able to be heard because of time constraints, a secondary meeting will be scheduled. At that time that when public testimony has been finished, a vote will be taken for the template. The MAB will work on that as a template amongst itself, and then in May endorse a single plan.

MR. ROBEDEAU: I am sorry.

MR. THEANDER: In May endorse a single preference for an ASA plan. But the primary vote will be to establish one of the plans as a template and then to amend it, component out, as they will, and then in May endorse the plans to the Commissioners. Now, Tanya has already relayed it to most of us she does not favor any of the plans, one over the other, and is open to discussion on all plans.

So she has also stated that she is in no way bound by the recommendations of the Medical Advisory Board concerning a given



plan. That I believe, Mark, if you have her memo up there, I think that was dated the 30th of March.

MR. DRAKE: Yes.

MR. THEANDER: That she will not be held bound to any recommendation.

MR. ROBEDEAU: Is the MAB interested in working with the Provider Board? Or are you not --

MR. THEANDER: That would be at the pleasure of the chair. I couldn't answer for that.

MR. ROBEDEAU: You are not a representative here as the MAB?

MR. THEANDER: No. I am here as a concerned citizen.

MR. PHILLIPS: I guess my point, they are going to contribute no matter what we do. If we did want to meet, turn this thing into clip-art by sections, bring those in that match that nobody has any problems with, and forward them on, and then, obviously, there's going to be some that we can't agree on.

And give them our majority, minority



opinion as it was put earlier on those issues, and ask that they consider them. Because, basically, that's all we can do, I believe, is ask that they consider what we feel and how we stand on each issue.

MR. DRAKE: Right.

MR. ROBEDEAU: I think that's reasonable. I think a lot of issues are -- there's no argument there are some issues, but I think the issues that there is not complete agreement on deserve review on both sides of the issue. And I think both of those should be forwarded to the County Commissioners. That probably is what we need to do. I can meet twice a week.

MR. STEINMAN: Maybe it would be better to use the May 14th deadline. I know it's really making you guys nervous, but if we set this, we are going to get this information to the MAB, maybe if we do meet jointly and get working on this and more time is needed, they can understand it a little better than if they have a date of May 14th, and we are going two weeks behind them with a report and they don't know what

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it says or what's going on. We can pick that May 14th date -- the MAB is already in -- and do our best to meet those time frames.

MR. ROBEDEAU: Maybe on Friday we can ask the MAB if they would like to move their time frame back from May 14th and move it back to the 1st of June.

MR. STEINMAN: If you do that, Pete, it looks like you are stalling. Why don't you pick their date, and if both can't come up with the stuff, they can't come up with it, and then they will address it at that time. Anything that we do now that says, give us more time, it looks like stalling, give us more, status quo.

MR. DRAKE: We are not stalling.

MR. STEINMAN: I know we are not.

MR. DRAKE: Just wanted that point made.

MR. COLLINS: Want me to record that in the minutes?

MR. PRAGGASTIS: How much is this transcript?

MR. DRAKE: But I hear what you are

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saying. I don't have any problem working towards that goal, Tom. But also I think you will agree that meeting twice a week is going to be real hard for all of us to make that kind of commitment. We all have other counties that we are dealing with.

MR. STEINMAN: No, we don't all have that.

MR. DRAKE: Some of us. We all have other issues and jobs.

MR. STEINMAN: Just need to make a decision, Mark, which county is more important to you.

MR. DRAKE: Oh, gosh. This county is --

MR. STEINMAN: I think, you know, let's try to work with the MAB, Mark.

MR. DRAKE: Okay.

MR. STEINMAN: And go with their date they have already set. They may find out when they try to do it and come up with their idea of the perfect system that they don't have time either, because some of them have other jobs.

MR. DRAKE: Is meeting Tuesdays and

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Thursdays going to have any problems with you?

MR. STEINMAN: No. It will work.

MR. ROBEDEAU: First of all, I think we need to vote. Okay?

MR. DRAKE: We are amending the motion to May 14th, understanding that it may take more.

MR. ROBEDEAU: And amending the motion to once a -- twice a week instead of once a week.

MR. SKEEN: I understood the motion it was to set a time line and meet within that.

MR. DRAKE: With a minimum of twice a week.

MR. ROBEDEAU: It's setting up to meet twice a week.

UNIDENTIFIED SPEAKER: What my suggestion had been -- I didn't mean twice a week. What my suggestion had been, set a time line and, sort of like an election, a vote after or on November 4th doesn't count if it's not cast by November 3rd. Therefore, when you set a system together,

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November 3rd is the date from which you move back, and then you design your activities based on whatever is necessary to meet that particular time frame.

So I only used twice a week as an example of that. Maybe what you all might want to do is set a particular date and then design a process that will fit within that time frame and do whatever is necessary to follow through on that particular perspective. It's just a thought.

MR. DRAKE: I agree. I appreciate those comments. But looking at these documents and how much work we are going to have to do, meeting twice a week by May 14th, I don't even know if that will do it. But we are going to certainly try. There's a lot of information we have to put together here.

UNIDENTIFIED SPEAKER: I think that it's possible that the time and effort would be put forth would be related to the importance of the issue somehow. That's only my perspective.

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MR. LAUER: I think we ought to set a precedent. If it takes an hour to decide how many times we are going to meet, we are not going to make the May 14th deadline. It's an important issue. Let's set twice a week meetings, cancel those we need to, and then let's just move on.

MR. DRAKE: We have all agreed to that. I am just asking, all the providers can do that?

MR. ROBEDEAU: I was going to ask Bill to call the roll, but I guess I am not going to.

MR. STEINMAN: Pete, one clarification here. We go with Trace's suggestion that a representative from each agency so we don't get into any hassles that way, too, in case people --

MR. ROBEDEAU: Right. Okay. AA is going to vote aye. Buck?

MR. SKEEN: Yeah.

MR. ROBEDEAU: Care?

MR. DOHERTY: Yeah.

MR. ROBEDEAU: TVA?

MR. DRAKE: Yes.

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MR. ROBEDEAU: Portland Fire?

MR. STEINMAN: Sure. Can I vote for District 10, too?

MR. ROBEDEAU: Pardon me? Gresham Fire?

MR. PHILLIPS: (Nods head.)

MR. ROBEDEAU: Community?

MR. PHILLIPS: Aye.

MR. DRAKE: That's a yes? I can't hear.

MS. MURPHY: Yes, sir.

MR. ROBEDEAU: Have I missed anybody? I don't think so. Then it's unanimous that we will do that. Let's set Tuesday and Thursdays at nine o'clock. We can cancel if we have to. Is that agreeable?

MR. DRAKE: Trudi, is the place -- is the OMA going to be available? If not --

MS. SCHEIDELMAN: Why -- probably. Why don't you let us determine that, and we will let you know.

MR. DRAKE: Okay. We will start this next week so we can give time to give everybody notification. Next Tuesday? I can't meet Thursday, anyway.

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MR. ROBEDEAU: Beginning the 13th? April 13th?

MR. DRAKE: That's a good date.

MR. ROBEDEAU: At least it's not Friday. I was married on the 13th of October. Friday the 13th of October.

MR. DRAKE: Did you pick that date on purpose?

MR. ROBEDEAU: It was an accident. Didn't last long.

MR. DRAKE: You don't need to record that.

MR. ROBEDEAU: I have -- Bill isn't here. I wish he was. I have a list of things that I had concerns with that I would like to see raw data on from Bill

that we need to look at -- I feel we need to look at. I will wait for him to come back.

I can get these to him in writing. I think it's also important that other members of the board have copies of this. We can get copies from Bill. Are you representing Bill?

MS. SCHEIDELMAN: Why don't you wait



for him. Why don't I tell him you need him.

MR. McLEAN: Question with the May 14th date. That's when you are going to try and have it finished, by your recommendations?

MR. ROBEDEAU: Yes, by May 14th.

MR. McLEAN: Will that give the MAB enough time to review?

MR. ROBEDEAU: I would assume.

(Mr. Collins returned to the room.)

MR. ROBEDEAU: We haven't talked to the MAB yet.

MR. McLEAN: That's the same day they are -- I discussed about voting. Final recommendations.

MR. ROBEDEAU: We haven't discussed with the MAB. What I would like to do is extend an invitation to the MAB and PAPA, if they would like to have a representative at all of the meetings and discuss the thing, the whole proposal as it goes.

I don't know if the MAB is going to be receptive to that. I have no idea until



Friday. I know we have a MAB member who is here as a concerned citizen but Bill, did you notify the MAB we were having this meeting?

MR. COLLINS: We notified everybody. We sent it just like we do every other notice.

MR. ROBEDEAU: So all of the members of the MAB did get notice of this. They were asked about -- the MAB, the May 14th deadline is -- apparently some concern there wouldn't be enough time for them to review it and vote on it. I had said I would hope that Friday we could extend an invitation to the MAB to be part of these meetings.

MR. COLLINS: The notice of this meeting goes out just like the notice for the MAB. Our mailing list is, what, 100 some people.

MR. SKEEN: I think the point, Gary, is probably we need to have that information to the MAB by the 6th, May 6th.

MR. McLEAN: A week.

MR. SKEEN: If we really expect them



to give it any kind of consideration. I think that's what you are addressing more than they had notice of it.

MR. McLEAN: Right.

MR. ROBEDEAU: Some things that I had I would like to review, and I don't know if you want me to read these to you or type them up and get them to you.

MR. COLLINS: If they are real extensive, you might want to send them to us and let us respond and give it to you at the next one of these meetings.

MR. ROBEDEAU: We need to have this information ASAP, before the next meeting.

MR. COLLINS: We get it to you before the next meeting. Go ahead and read them.

MR. ROBEDEAU: You know, the data relied on for the cost analysis of the current system, I would like to see raw data on that.

MR. COLLINS: The data? Sure. The data that was used was the data provided to me by the providers.

MR. ROBEDEAU: You are talking about the --



MR. COLLINS: The cost. And all we did was add it up.

MR. ROBEDEAU: Unit hour cost?

MR. COLLINS: Added it up. We made copies of an agreement that this would not be a process where we were comparing one cost statement by one provider to another. It was not an interprovider. Is that the right word? In-between provider analysis. It was an aggregate.

MR. ROBEDEAU: The analysis on that, too, the information on paramedic touring. I think we discussed that a little bit earlier.

MR. COLLINS: Right.

MR. ROBEDEAU: I have a bit of a problem with that.

MR. COLLINS: We can get you that. Those are all the lists of EMTs provided to our office once a year as required by the administrative rules. Now, we did not differentiate between part-time, full-time, active, on a car, administrative. We just combined the number of people -- is the issue we were trying to look at, was how



many and how it would affect things like training and that sort of thing.

So if you were listed on there, we will give you all the -- give anybody all the detail. It's not -- I will not give the individual costs. I mean, that is, we agreed not to do that. That's a proprietary. I think that --

MR. DRAKE: Right.

MR. COLLINS: We will give you the aggregate of it. The list of paramedics is probably the record. We get one a year.

MR. ROBEDEAU: On the cost, you come down -- well, let me get to that later. Maybe I will just go out of order here. You know, the unit hour utilization findings and cost on unit hour utilization, you put on 75-45. Do we have any stats or anything that shows what, nationally, the average unit hour utilization cost is?

MR. COLLINS: No, I don't.

MR. ROBEDEAU: For a quality system.

MR. COLLINS: I don't know if AA does.

MR. SKEEN: AA doesn't per se.



There's some surveys that have been done.

MR. COLLINS: Right. Again, that data was not data that we developed. That was data from the companies, and we added it up.

MR. ROBEDEAU: So there's nothing that says that's good, bad, or indifferent?

MR. COLLINS: It's as good as the data that was provided to us by the companies during the work-group process by people like Barry and some others involved.

MR. ROBEDEAU: There's nothing that says that's high nationally or low nationally?

MR. COLLINS: No. We did not make any attempt to determine whether it's high or low. We just -- the idea was to use that cost data to get some indication of what a change in unit hours would be. So if it's either, you know --

MR. ROBEDEAU: Then we need to say the data and the analysis on the demand summary, table one, page 14. How did you calculate unit hour savings off of this? Some of these things, I am generally



confused on in the proposal.

MR. COLLINS: We can do that now or however you want to do it. That was done in a work group with representatives from all the companies. There was a representative from PAPA there. We looked at it a couple different ways.

MR. ROBEDEAU: What I really would

like to see, Bill, if you could send this out there, our committee, anybody else that wants it. Is that all right?
MR. COLLINS: We can send it to whoever wants it.
MR. ROBEDEAU: Along with that, in order to get cost savings, is there anything on how many paramedic jobs are going to be eliminated.
MR. COLLINS: No.
MR. ROBEDEAU: Under any of the three options?
MR. COLLINS: No. The only thing that -- I mean, the only thing that we identified as changing in the report was the number of unit hours required to meet the 9-1-1 demand. It doesn't try to say



anything else. How that gets turned into numbers of people, I don't know. I mean, I do.
MR. ROBEDEAU: When that was done, did geographics come into play?
MR. COLLINS: Yeah. We looked to make sure we had the minimum eight-minute coverage geographically. It goes down to like seven or eight, something like that. Units.
MR. ROBEDEAU: Okay. There's some -- the data analysis supporting the dispatch savings is in the single versus multiple provider system.
MR. COLLINS: Yes?
MR. ROBEDEAU: Do you have data on what that's -- you have assumptions made, but is the data in there?
MR. COLLINS: We have the cost provided by each provider of the proportionate amount of the control center that should be allocated to the 9-1-1 calls. And our contention is -- and I know there's disagreement with the providers -- that we already have a dispatch center and



that those costs are not appropriately charged to 9-1-1. That's why the savings --
MR. ROBEDEAU: Does anybody that showed up in dispatch is showing up in -- as a savings to 9-1-1 as an eliminated cost that's currently there?
MR. COLLINS: That's right.
MR. ROBEDEAU: Really?
MR. COLLINS: Well, what we asked for -- I mean, part of my assumption is that the data that we received from the providers regarding the current cost is correct. And if it's correct, the 9-1-1 -- the proportionate amount of the control center that is attributed to 9-1-1 business is what we asked for.
And that if that amount is correct, which I am assuming it is, our contention is we do not need two dispatch centers for 9-1-1's business. And so therefore, I mean, you might have other reasons to have it. I am not here to argue in any way that you don't need something.
I am just making the case, or



hopefully making the case that there is a dispatch center that the taxpayers are currently paying for and we don't need, my feeling is we don't need an additional dispatch center. You might need it for something else, but this is the argument, I think, what belongs in 9-1-1 and what doesn't.
MR. ROBEDEAU: Okay. Well, just -- I want -- you took all of that cost in the proportion to 9-1-1 and said that would be a savings because there would be no provider dispatch center of any kind associated with 9-1-1 calls? Is that correct?
MR. COLLINS: That's what we are saying.
MR. ROBEDEAU: Okay. I just want to know.
MR. COLLINS: Okay.
MR. ROBEDEAU: Wow. That one caught me completely off guard. I would like to see the data analysis that supports the assumptions on page 17 that there would be a reduction in administrative costs of



one-half to two-thirds.
(Ms. Murphy left the meeting at 11:05.)
MR. COLLINS: Okay.
MR. ROBEDEAU: Are there any studies currently existing that show there really will be a reduction of cost due to economies of scale? If we could, we would like to see those.
MR. COLLINS: I will show you everything we have got. It's basically everything we had before. We have no new data.
MR. ROBEDEAU: Do we have any data on raising costs of any --
MR. COLLINS: We do not look at that. I think in the plan, if you read it in there, we tried to make the point that we did not feel that was -- that was by design. And that was kind of discussed with people, that we wouldn't really gain anything from that other than some numbers that may or may not apply to our current system, and therefore what we are looking at ratewise is the rate should reflect what



the cost of the system is, not build the system to meet the rate.
That's our -- you can sort of do either way, I guess. You can pick the rate and make the system fit the rate or you can design the system and the rate would follow. And comparing it would give you -- you know, are you in the ballpark of some of these?
But it's very hard to compare them because of the subsidies and nonsubsidies. I just don't -- that's just the opinion that I put out. And you can look at that. I just don't think as much is accomplished by that.
MR. ROBEDEAU: That's okay.
MR. COLLINS: That's -- go ahead.
MR. ROBEDEAU: I just have a question. Let's see. The data analysis relied on to support conclusions on page 21, top of page 22 --
MR. COLLINS: I will have to look it up.
MR. ROBEDEAU: I wrote down the right page.



MR. DRAKE: The dispatch control center cost?
MR. ROBEDEAU: No. That's up above. That's all taken out.
MR. DRAKE: Is that what you are talking about, though, Pete? You said the bottom of page -- top of 22?
MR. COLLINS: 21 and 22? I have --
MR. ROBEDEAU: Okay. Apply all paramedic costs of $26.83 per unit hour. Determine estimated 39,200 newer unit hours, savings of $1,151,000, i.e. 11 percent reduction of cost. Cost study identified additional savings of up to $1.5 million. And cumulative costs of general administrative overhead, this represents 16 percent of current costs. Ambulance company dispatch control center costs of $594,000 represented another 6 percent cost reduction. These reductions results in a total cost savings of up to 33 percent.
MR. COLLINS: Okay. "The savings represents a change in the unit hours deployed and in the number of providers in the system. All else remain the same."

And then all analysis relied on page 23, part 4.5. However, rates are higher than they could because of the current system design and the portion of rate should be identified for a partial support of first responder program to offset expenses for supplies, equipment, training. This could be accomplished while still achieving the reduction in current ambulance charges." And that's under rates and charges.

And what would the rates and charges and all that come out?

MR. COLLINS: What would the rate be? I can't tell you what the rate would be.

MR. ROBEDEAU: How much is this going to add back into the rate?

MR. COLLINS: I don't know. This was not an analysis of exactly what the rate was or what the proportional part would be for first responders because, trying to recognize that there is a cost that has been brought up by people in the past and then trying to get these things incorporated into the plan, that we need to



discuss recovering some of the cost of the expendables, first responders, if we can.

That was something that we wanted to look at. I can't tell you how much. I mean, this is just a framework – this is a plan framework, not the detail of it. And you know, that would have to be something you would have to do. I didn't try to – you will notice in here there's no attempt to set a rate, just try to set the criteria that should be used in developing the rate. I can't set a rate until you have the thing in place.

MR. ROBEDEAU: It seems you are calling for a 33 percent rate reduction on page 32; and then on page 23, it adds stuff back in but it doesn't say how much. On page –

MR. COLLINS: That's true.

MR. ROBEDEAU: On page 23 it doesn't.

MR. COLLINS: I don't know how much it is.

MR. DRAKE: But it leads the reader to believe there's a 33 percent reduction, but, actually, when you add stuff back in,



it won't be 33 percent.

MR. COLLINS: What we are trying to show in that area is that there were a number of costs identified that should not be allocated to the 9-1-1 rate, that should not be recovered in that manner, like the control center.

You might need the control center for your BLS and interfacility transport work and all kinds of things, but none of that cost, in my mind, should be allocated over to the side that has to be recovered by the 9-1-1 rate because there's another group that's doing that. That's just, you know, you can agree with that or not agree with that, but that's the logic that we are talking about.

MR. ROBEDEAU: Well –

MR. DRAKE: I do disagree with Bill.

MR. COLLINS: That's fine.

MR. DRAKE: The reason is we do use our data from our CAD because you don't have CAD data for a couple things. One, we use the data to develop our system status plan. We have been doing that because the



data is historically inaccurate from BOEC.

MR. COLLINS: I understand.

MR. DRAKE: Secondly, we do it because we have a computerized posting plan the County doesn't have.

MR. COLLINS: I understand.

MR. DRAKE: If the County goes to a computerized posting plan – but you are still going to need to gather data for your own replacement, so that CAD system will not go away. We are still going to need the function of that CAD.

MR. COLLINS: I understand, but I don't agree.

MR. DRAKE: Once we have paid for it, essentially, it's a maintenance cost.

MR. SKEEN: That's irrepresentative. How about we call it department of data retrieval instead of communication center?

MR. COLLINS: I think the issue with the data that's required for the current system, one of the assumptions is that that the City, through BOEC, will install a new CAD. I am making that assumption. If it at all falls apart in the next month, then,



I guess I have to revisit this. But my assumption is CAD will be there, and that you will be able to get the same data out of that CAD that you can get out of any CADs or other methods that you have now, and I see no reason that can't happen.

If it doesn't happen, then, it's a different issue. But I think we have to assume that. They are installing it. I would agree with you that you can't do it now.

MR. DRAKE: Right. But I have a follow-up question. Excuse me, Pete. You are saying you are going to get the same data out of the new CAD system that the County is purchasing. Right?

MR. COLLINS: Yes. There should be no reason why you can't get whatever you need out of that system.

MR. DRAKE: Do you have a copy or sample of all the EIA reports that we might generate?

MR. COLLINS: No.

MR. DRAKE: So you would need a copy of those reports to give to the software



people that you are buying the CAD from and say, "Can you produce these same things?"

MR. COLLINS: Right. Or we can give you the data out of the CAD and let you do whatever report-generating you need to do.

MR. DRAKE: With our CAD?

MR. COLLINS: With our CAD or whatever system.

MR. ROBEDEAU: Well, can I interject something here since I don't have a CAD? Never had a CAD, never intend to buy a CAD?

MR. COLLINS: Then there was no savings on your part.

MR. ROBEDEAU: Could have been. But the dispatch function, at least at AA, is much, much more than dispatch. It is a lot of office function, initial data entry for billing or keeping track of the calls. I don't think BOEC is going to provide us with a daily list of what calls we ran and who they were, and is going to match all of those things up and have them ready to be presented to the office in the morning. That's all a function of the EMS system.



But that is going to have to be done.

Somebody is going to have to do that, and it's going to be a cost, regardless of whether it's a single provider, two dozen providers, or nobody doing it at all. Well, nobody not doing it at all isn't going to work well.

Whatever happens, that function, now, whether you call that a dispatch cost or whether you call that an office cost, but that function must occur.

This is a user-based-driven system and user fee-driven system. And what you are taking and saying, no, this is not going to be a cost because this is a dispatch cost, at least in my – AA's company, a lot of that dispatch cost, quote-unquote, is

administrative, that's going to be there regardless of what kind of system you have.
MR. COLLINS: Okay. I mean --
MR. ROBEDEAU: Our dispatch --
MR. COLLINS: If there's a piece of the cost that shouldn't be in there, you need to identify that so it's not in



there. You should be able to get off the new CAD the same call information you would get off your own CAD.
MR. ROBEDEAU: I don't have a CAD.
MR. COLLINS: Whatever method you use to get the addresses, names, and services provided. That's one of the things that we will provide. It doesn't provide it, then, that's not a cost.
MR. ROBEDEAU: We have prehospital care reports that have been handed in. Those have to be matched with run reports. And it moves through the system. A lot of that function, at least at AA, is done at the dispatch level. Then when we retrieve our data; that is, data entry is put in. And our system is set up, as the data entry is put in for billing, it also retrieves all the stats and everything.
MR. COLLINS: No, I understand that.
MR. ROBEDEAU: I think you have seen how ours works. And that works well. But that is still going to be there regardless because I did the programming so that it didn't make any difference; this stuff



still put in for billing just retrieve it out for the other function.
MR. COLLINS: It may be that the parts of the cost that was allocated into that center when we requested that is billing cost and should be attached to billing.
The point that I was trying to make is that we do not need multiple dispatch centers to dispatch. And we shouldn't need multiple computer systems to gather the same data from the same source. I mean, a run, you know, a 9-1-1 run, the data in the CAD from BOEC should be the same data that you have.
And we know right now -- and I don't want to -- I mean, you need to look at this in the context of a new computer system at BOEC. Do not look at it in the context of what we are currently doing. I know you can't get it out now, and my assumption is that will be go away.
MR. SKEEN: Probably should have used the term "proposed system" other than "current system."
MR. COLLINS: That's a good point,



because it is not the current CAD. That's the one that catches on fire occasionally.
MR. ROBEDEAU: I can't save any money by selling my CAD. It just don't exist.
MR. SKEEN: But Bill's argument is you could save money by eliminating your communication center.
MR. ROBEDEAU: I don't think that's exactly true.
MR. DRAKE: It's not a dollar-for-dollar reduction.
MR. ROBEDEAU: And perhaps what we should do for Tuesday's meeting for the Provider Board, you know, because I think we know that -- I don't know how Buck does theirs and I don't know how CARE does theirs. I know how we do ours. And our dispatch center is not really a dispatch center per se. It has other many, many other functions. Our dispatch center.
MR. COLLINS: I hear what you are saying. In theory, if the figures we requested are correct, they would not have those other functions in there, but I don't know that that's -- I mean, I can only go



by what was provided to me by the providers. So there may be an allocation.
The other thing, I think, in keep in mind when you are looking at these, at the figures that we used in this section is this -- we are not saying that this is going to -- this is a dollar savings to a particular company.
The point that at least I am trying to make in this is that these costs are not appropriately -- if they are currently allocated to 9-1-1, it's inappropriate and it should not be support by the 9-1-1 rate.
Now, I know that that's going to shift a certain amount of cost to other services. But I think that has to be looked at. I mean, why should a 9-1-1 ratepayer be essentially paying to recover costs that are actually being used in other portions of the business? I think that is something that you have to look at. You may need to keep your entire CAD, but you don't need to keep it to dispatch 9-1-1 calls.



MR. DRAKE: Bill, what you are looking at is a system cost, not just a 9-1-1 system. You do have to look at overall system delivery cost. What you are talking about is shifting those costs, but you are not talking about eliminating those costs.
MR. COLLINS: Some of them you eliminate and some you shift.
MR. SKEEN: He is saying it is a real system cost, but somebody else has to pay for it.
MR. COLLINS: For instance, the average 9-1-1 invoice, when we did the invoice study, was $588. Now, I don't believe that the average interfacility transfer is $588 because there's a lot of contracts and bidding, people moving around. And if that cost has been shifted to 9-1-1, then, that's not appropriate.
Now, that doesn't make it cheaper on the other side. I am fully aware of that. But that's not -- we can't design the emergency response to in any way subsidize other parts of the services. I don't think that's appropriate. Why should you do



that?
MR. DRAKE: But also there's a subsidy of the fact that those units respond to nonemergency and interfacility work. At the same time they have to post and do other work for the 9-1-1 system that we get no reimbursement for, and there is a cost associated with that.
MR. COLLINS: Right. But that analysis we did in the work group, we decided that we could not compare the non-9-1-1 portion of this. So what this represents again is the 9-1-1 activity and the some of that is -- those would shift to transfers and some of it wouldn't.
MR. SKEEN: Your point is that the system should stand alone and should not be subsidizing nor be subsidized?
MR. COLLINS: Right, through the rate side.
MR. SKEEN: That's a great, noble mission, and that's really difficult.
MR. COLLINS: I understand. But I think you have to be sensitive to that, or the tendency is to, you know, you are going



to load up the rate side on the 9-1-1 calls because you can't negotiate that with anybody. That's not a piece of business that people are going to negotiate very well.
I know some has been done with HMO. That's kind of another side of the same question. But in trying to look at what

that savings is, that's got – I think it's important to that that is before. People can disagree with it.

MR. DRAKE: I am trying to get down to your base premise. I am having a little difficulty. Is your base premise the 9-1-1 system is supporting the non9-1-1 portion of the business?

MR. COLLINS: In looking at those costs which were provided by the company, there's – there were three areas that we were looking at as how the costs should be appropriately allocated. One had to do with the number of unit hours. And when we did the unit hour, when we did the command study and looked at the offered-up schedule and kind of estimated that, there were a



number of – it was obvious that the staffing was in excess of the demand for 9-1-1 calls.

MR. DRAKE: Right.

MR. COLLINS: Okay. So that was an area that identified. Now, whether that shifts over, maybe it shifts over, but it shouldn't be supported by the 9-1-1 rate.

The second area were the area like the control center, the allocation process. The control center is the example I am thinking of. And the third had to do with potential savings because of the number of organizations involved. And those are just three – I don't know if there's another ones.

I tried to be, on the unit hour stuff, to be very conservative with that and only identify those – only use those costs that were directly associated with the unit hours which were are the costs associated with paramedic salaries.

We didn't put in like changes in vehicle. That was too, you know, that's too gray to put in. There may be more



savings. There may be a little less. But the idea was, if you reduced 38,000 hours on the 9-1-1 system, you ought to be able to reduce a substantial portion of the appropriate salaries. You might use them for something else. But they ought not be supported by the 9-1-1 rate.

MR. ROBEDEAU: Okay. Bill, in your proposal then, are you trying to get to a segregated system where there's no cross-utilization so – you are going to need so many paramedics for so much regardless, and then those people are not going to be then allowed to run any nonemergency calls?

MR. COLLINS: Well, in the plan – the draft that you have that is the potential that – it is not – that it is a dedicated system. And then I think people can make arguments on what it shouldn't be, and we ought to look at that. But in just looking at this cut of it there does not look like – it does not look like that the excess availability is all that's being used.



If it was, we would have the same number of units as required by the 9-1-1 calls. We wouldn't have the extra hours posted so there's – we are doing a combination. And I understand that, and I am, you know, I understand that there are, in theory, potential savings of putting them together, but I don't think they are well demonstrated. And if you think they are, then, we should go back and look at that, but that's an area.

MR. DRAKE: So your feeling is to try and take out – develop a system that responds to the 9-1-1 calls only and private or public model, a private-public model? Is that what you are saying?

MR. COLLINS: Right.

MR. DRAKE: So under the private model, single provider model, they would only respond to 9-1-1 calls, those units would be dedicated to 9-1-1?

MR. COLLINS: At this point. I think if you want to make the argument that the private part of the system should be able to respond to non-9-1-1 calls, then, it



would be incumbent upon you to show that that doesn't increase the cost and therefore the rate to the 9-1-1 payer.

If you can show that, then, I think that that's fine. If you can't, then, I think that's a problem. And at least at this cut in my mind, it did not show that.

MR. LAUER: Bill, is your basic premise – I am not sure I understand. I thought I did, and I am not sure any more. Seemed like the basic premise, when I read your plan, was that consolidation of providers and consolidation of call base, in other words, the single provider running 9-1-1 calls would reduce the cost, the price to the 9-1-1 user? Is that basically it?

MR. COLLINS: Yes. I mean, that's what I think it shows.

MR. SKEEN: Not the price. The cost.

MR. COLLINS: Well, making the assumption if the cost is substantially lower, the –

MR. SKEEN: Cost and rate should be related.



MR. COLLINS: If one assumes the cost has no bearing on the rate, jeez –

MR. LAUER: Is that something you disagree with, Mark?

MR. DRAKE: Well, I think there's some other issues there. Because if you are talking about isolating – the same thing they are trying to do in Clackamas County. If you dedicate units just to 9-1-1, the cost for those units go up dramatically because they can't respond to 9-1-1 calls.

MR. LAUER: I am not arguing with that. I was trying to reduce it to a premise.

MR. DRAKE: That's his premise? What are you asking? Am I agreeing that's his premise?

MR. LAUER: He just is focusing on the 9-1-1 user at this point. And he said we might need to look beyond that.

MR. DRAKE: Right.

MR. LAUER: Basic premise –

MR. DRAKE: That's my understanding of his premise.

MR. SKEEN: Isn't it also, Bill, isn't



it also – that almost sounds like these guys. Isn't it also true –

MR. THOMAS: I haven't said anything.

MR. SKEEN: My sense is, your theory that the 9-1-1 system may be subsiding the nonemergency side, as opposed to vice versa?

MR. COLLINS: It looks like that may be part of it as opposed to the other way. That's part of it. Part of savings have nothing to do with that. They have to do with multiple organizations and whatever infrastructure is required to have more than one company.

MR. SKEEN: Would you be as opposed to the subsidization to the nonemergency to the 9-1-1 as you are to the 9-1-1 subsidizing any other aspects of the operation?

MR. COLLINS: No. You mean, would you like to subsidize the 9-1-1? No. I think if you could – I mean, the reason that that is an issue in my mind is that the 9-1-1 part of the service is the sort of public access side. Public does not have a

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choice of provider. They don't have -- I mean, they call 9-1-1, you get what's sent to them.

And it should not -- the rate that's charged to the provider -- whether the rate is charged in terms of an actual user fee for that -- for that transport or the rate is a tax base, I mean, if you were to do a tax base, I think the same arguments hold. You should not be -- you should not be collecting dollars on that side to in any way subsidize the nonemergency, private business side.

Now, if somebody wants to subsidize the emergency side out of whatever base, I mean, that's sort of fortuitous to the user.

MR. SKEEN: Well, in some ways detrimental.

MR. COLLINS: It's probably going to be the same kind of issue. Because on the other side, then, you are overcharging, in a sense, the nonemergency user. So I mean, I think when you are looking at -- you have got sort of a public service on one hand

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and you have a private business on the other hand.

And they really should not be a cross-tieover in the rate that's charged to people, probably either way. I mean, to be pragmatic, if you want to toss in a bunch of money on the -- to lower the rate, I suppose we would take that.

(Mr. Steinman returned to the room.)

MR. SKEEN: Bill, that's a philosophical approach. The other side of that is there is a medical transportation industry, and your system can be designed to benefit the bulk users of that system.

MR. COLLINS: Yes, it can.

MR. SKEEN: As opposed to segmenting it, without giving up qualitative issues.

MR. COLLINS: I think as long as people understand that's what you are doing, you are doing that. You are going that direction.

MR. ROBEDEAU: Bill, do you have a model, ideal administrative structure for a single provider?

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MR. COLLINS: I am not sure I understand.

MR. ROBEDEAU: Something we could use to compare what savings, if any, may be realized by the elimination of all of this excess overhead that seems to appear in your proposal as savings? 33 percent is a substantial amount. That's the only figure that I have seen in here that really says anything.

And if you take that -- and I think anybody looking at that should say, okay, here shows 33 percent savings. There should be at least a 33 percent reduction in rates. And you know, I want to see all the data. I have asked for the data on that. But just off the top of my head, I don't believe that's --

MR. COLLINS: Do I have an definitive structure for an ambulance company? I don't think it makes --

MR. SKEEN: Could you send a copy?

MR. COLLINS: No, I don't. And actually, I don't think it makes probably a whole lot of difference from a management,

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administrative structure whether it's public or private provider. They are going to have similar requirements.

I mean, you have got to have somebody that does all these tasks. Whether you need three of everybody or four of everybody, I really question. I think that's an issue that needs to be identified.

MR. DRAKE: But, Bill, I guess where I am having a problem with that is, you are going to say you are going to have these administrative costs here today, and you are going to save that administrative cost by going over here tomorrow to side B, if you will, under plan B, and yet you are saying, "But I don't know how many administrators will be under plan B. I just know there would be all this savings," I mean, you would have to sit down and really identify who those people are and those positions.

MR. COLLINS: I don't think we have identified that in the plan. Again, before you can come up with the actual rate that

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would support this, you need to say what the organization is going to look like. But if there are currently three of everything and you go to one of everything, you are going to have some savings. And that's why we just picked -- there isn't a highly scientific structure. But as far as the emergency services, you are not going to need three of everything. I mean, unless you can make an argument, I don't think you need it.

MR. DRAKE: Bill, there is an argument, I think -- there has been an argument that we have. It's been around for years. I mean, there's span of control. When you add more people, you add more supervisory personnel, so the supervisory personnel don't automatically go away. Those administrative people don't automatically go away.

MR. COLLINS: No. I don't think we indicated that.

MR. DRAKE: So there isn't really that administrative cost savings. I think the County looked into it, but combining all

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those departments and decided it wasn't even worth it. And then, secondly, you take that cost savings, whatever that savings is -- I am sure there is some savings divided by the total number of responses, what are you talking? $3 a call? $5 a call?

MR. COLLINS: Depends on what the savings is. We put this out, an estimate, based on the information that we were provided. And I still think it's a reasonable estimate.

MR. DRAKE: Bill, I think, too, we had talked before -- it's been said here before in the meeting --

MR. ROBEDEAU: I think what we need to do is get copies of all of the data and look at it. You know, right now -- at least I am guessing. I haven't seen it. I have read your plan and I am just kind of guessing. Before we go on with this, I think we really need to see the data, Mark.

MR. DRAKE: I agree with you, Pete. Let's get the data first.

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MR. ROBEDEAU: How long you think it will take us to get that? I will type this up and get it to you this afternoon. Is that all right?

MR. COLLINS: I have all the stuff. We will just put it altogether. You got a lot of it. There's not a lot -- there isn't piles of stuff sitting around you haven't seen. And, again, this is -- when you look at this as a plan, it isn't going to tell you, position by position, what you would need in the management of a single provider. It's just looking at sort of magnitudes based on the cost standards that we receive.

MR. SKEEN: Bill, is it reasonable to assume that, in this process, that when

there's requests made for data as it relates to this that you will copy that to the members of the provider committee so we don't have one piece going out here with another piece –

MR. COLLINS: We can give it all out. The only thing I would have to ask you – because this was part of the process we

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have. When we did the cost analysis, the agreement was not to compare companies, so that data has not – I have got it, but nobody else has it. I have fed it – put it together. I can give it to you that way, or you can all tell me that you are willing to put it out piece by piece. And it doesn't matter to me. It's not my data.

MR. SKEEN: No.

MR. COLLINS: Other than that, everything else is what we have got. I will show you what we have got.

MR. SKEEN: For example, if Barry writes you a letter and asks you for a piece of information, make sure all the members of the provider committee have that?

MR. COLLINS: No problem.

MR. ROBEDEAU: I will type a copy of it this afternoon. Probably hand-deliver it.

MR. COLLINS: No problem.

MR. ROBEDEAU: I think the sooner we can get it the better. And we appreciate

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it.

MR. COLLINS: Nothing faxed over two pages, though.

MR. ROBEDEAU: I agree with that. Stand around the stupid fax machine with 40 pages coming over is ridiculous.

MR. COLLINS: We are close enough that we will only fax two-page memos.

MR. ROBEDEAU: That's agreeable.

MR. SKEEN: Also I have one. Is the paramedic alliance willing to give the information, as the County is, how they prepared their plan with background information?

MR. PRAGGASTIS: I wasn't aware there was any data in our plan.

MR. DRAKE: You may not have any data, but did you use any data to put together your plan?

MR. PRAGGASTIS: No.

MR. DRAKE: Do you have any cost studies you have done about your county-wide options or information of where you are going to receive the income to put together your programs?

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MR. PRAGGASTIS: Actually, with all respect to the chair and the board, the majority of the people in the room have left, and this has really boiled down to a small discussion. Our president has left. Some of the provider representatives have left. Perhaps if you just give us the questions in writing, we would be happy to give you an answer to whatever you have.

MR. DRAKE: Sure.

MR. PRAGGASTIS: I think in the essence of time – it's nearly noon. We have been here a long time.

MR. ROBEDEAU: Also in the essence of time, is there an address we could send the questions to for a response prior to next meeting? The next meeting is not until the 13th.

MR. PRAGGASTIS: That's a letterhead on the front page of the plan with an address. That would be just fine.

MR. DRAKE: I didn't get that with mine.

MR. PRAGGASTIS: Bill should have put.

MR. DRAKE: I am sure.

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MR. SKEEN: P.O. Box 42095?

MR. PRAGGASTIS: Uh-huh.

MR. DRAKE: Thank you.

MR. ROBEDEAU: Sending out copies of that. Will you provide us all with a list of Provider Board people who are interested persons so we can copy everybody, save a step there, so you don't have to?

MR. COLLINS: It's easier, I think, if you want to send stuff out, to let us do it. We have got it all set up to do it. Notices of meetings go out to the entire group. We usually do not send like the detailed data and stuff to just everybody because it's such a huge list, but anybody – of course, this is all public record information, so anybody who wants it, anything, can ask for it and we get it.

MR. THEANDER: I might ask, on behalf of the Medical Advisory Board members, to assist in their decisions, that the information be mailed to each of those members as well.

MR. COLLINS: Okay.

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MR. THEANDER: That is important.

MR. SKEEN: Cole, the only thing I would offer with that is, you are going to get an awful lot of raw data with it and a lot of room for assumptions, and that I think they would be better served by having some analysis to some of that, to some of that data.

MR. THEANDER: At least I would prefer the data.

MR. SKEEN: Obviously, you have every right to it. I am just saying –

MR. THEANDER: I understand your point. But I also understand there's going to be a lot of questions, and any kind of data that may be helpful in making decisions is important, especially with an endorsement such as this. Members of the MAB are big boys, and the fact they may get snowed in paperwork is something they should be expecting.

MR. SKEEN: Boys and girls.

MR. THEANDER: Boys and women.

MR. COLLINS: If you will send it to me, I will let you know whether there's

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anything different than what's in the plan, and I will send it out. Some of it's just what's in here.

MR. DRAKE: Is that everything, Pete?

MR. ROBEDEAU: Everything I have. Anybody else? We are adjourned.

(PROCEEDINGS ADJOURNED)

* * *

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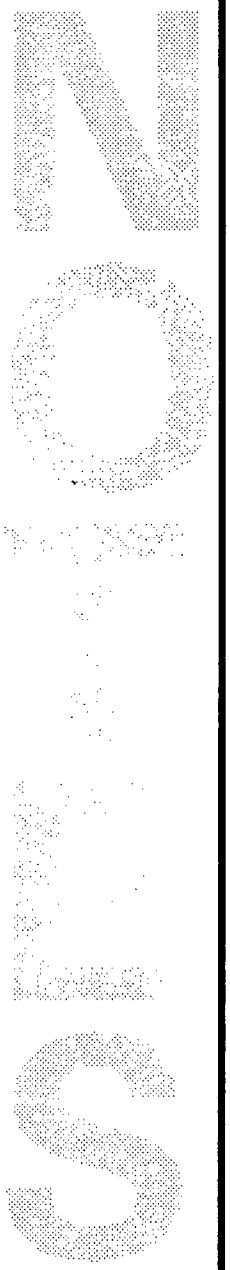
CERTIFICATE

I, CAROL STUDENMUND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the testimony and proceedings had upon the hearing of this matter, previously captioned herein, before the Multnomah

County Provider Board; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 8th day of April, 1993.



BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Tuesday, April 13, 1993
9:20 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Barry Doherty, CARE Ambulance
Mr. Thomas Steinman, Portland Fire Bureau
Mr. David Phillips, Gresham Fire Department

* * *



APPEARANCES

ALSO SPEAKING:

Mr. William Collins
Mr. Jeffrey Kilmer
Mr. Christopher Thomas
Mr. Steven Moskowitz
Ms. Trudy Schidleman
Mr. Randy Lauer
Mr. John Praggastis



PROCEEDINGS

MR. ROBEDEAU: Why don't we call the meeting to order.

First on the agenda, I would like to ask everybody if they would like to do a moment of silence to remember Gladys McCoy. Or, you can use the time as you wish.

(Pause.)

MR. ROBEDEAU: Thank you.

Are we going to do a roster? Why don't we do that, for attendance, who is here. And one thing, perhaps because there are going to have to be some mailings going out, because of my time frame, we are going to have to be doing it pretty fast. So if you could get addresses. Does PAPA still want everything going to their P.O. box?

MR. PRAGGASTIS: M-hm.

MR. ROBEDEAU: No matter what?

MR. PRAGGASTIS: Well –

MR. COLLINS: Why don't you put your name, the organization, whatever, and if you have a fax number, the fax number. We



have addresses, unless anything has changed.

MR. ROBEDEAU: Okay. I'm the only one I think with a change of address. That's the P.O. box. When it goes to the P.O. box, it's quick.

Let's see. I have done an agenda that is tentative. We sat down and drew it up because we didn't have a lot of time. We don't have to stick with this.

The first agenda item is review of the minutes, and I do have – I think the minutes are a bit too short in regard to response times that we talked about at the last meeting, you know. One of the things I think really needs to be in the minutes is the fact that we did go through and do February, and that 39 percent of the over eight minutes for AA were in fact not over eight minutes. I think that's very significant due to the fact that February was probably the worst-weather month we have had in five years, and there are no exceptions allowed in this system. We still came in in February at 91 percent.



From what I listened to for the last six or eight months at the MAB, other places, I know that response times are going to become an issue as we go on with this system, as we go on with the discussions on what kind of systems we're going to have at the end of this.

Along that line, Bill, I'd like to ask if Steve Moskowitz can do the minutes. I think he's very capable.

MR. COLLINS: Okay with me.

MR. ROBEDEAU: Okay. The reason for the addresses and the mailings is we need to be issuing periodic reports. We're on a real, real short, fast time frame. We need to keep things moving and have reports come out.

There will be a final report issued by the Provider Board with possibly a minority report, if that is what is agreed upon by the board.

Again, we're going to get back to the same thing we're trying to talk about last time, about the process and all interested persons being invited to attend and



participate. I notice there's no representative from the MAB. I'd like to again extend an invitation to the MAB, if they wish to come.

I notice PAPA is represented, and I appreciate that.

Any other providers, fire – Tom, do you know if Gresham Fire is going to participate?

MS. SCHIDLEMAN: David Phillips called yesterday about four o'clock in the afternoon and said he would be here. So, I don't know.

MR. ROBEDEAU: Rain keeps everybody in, stops riots.

MR. LAUER: We hope.

MR. ROBEDEAU: I think it's what we need to do.

I know the physician supervisors were invited. I don't see anyone here. Does anyone know if they are going to come?

MR. LAUER: I haven't heard anything from them.

MR. KILMER: My understanding with respect to the physician supervisors is



that they do intend to participate in this process. They may not be at every meeting because of time constraints.

MR. ROBEDEAU: The EMS community is here. Okay.

As everybody knows, we are transcribing – our court reporter is here. Copies of transcripts from all of these meetings will be available for anybody who wants at 20 cents a page, paid in advance, if you want a copy from these meetings. The meetings are going to be approximately two hours, and we will try and I will try to keep everybody on task.

I think one of the first things that we have discussed in the past, exactly what we're going to look at, and I have asked

Jeff Kilmer to make a short presentation on how we should be looking at all of the different proposals.

MR. KILMER: As you know, Mr. Robedeau, we have for years asked for a process to be engaged in an EMS planning that truly took the time to explore the myriad of very complex issues that are

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involved in this process. I had made a suggestion about the process that we're going to engage in for the next five weeks, as I understand it, or that you are, and frankly I commend the Provider Board for instituting a process that even allows this.

As you know, a letter has gone off to Mr. Collins saying the Provider Board will do its best to meet the deadline that has been imposed on us sort of at the last minute by the county commission, but that, you know, it may be this process can't occur adequately in that time.

But with that in mind, we had talked about the way in which this process ought to work, and you asked my thoughts on that. And I understand that what you're going to tentatively propose today is that an agenda be announced at the next meeting which will identify the various topics that ought to be addressed in this process and that each meeting will be devoted to one or two or three of those.

I had suggested to you that today the

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subject be the PAPA plan and that several of the questions that ought to be addressed in this process are the following:

The first is, which part of the PAPA plan did the MAB adopt? I don't think anyone was clear from that process on that.

The second is: What changes are being considered by the MAB for the template? And I don't think anybody knows that. We had hoped that the MAB would be here to participate in this.

Another question is: What are the concerns of the paramedics that the plan, the PAPA plan, supposedly uniquely addressed? Somebody made a representation that that occurred, but nobody identified those concerns.

Another question is: Can those concerns, once articulated, be addressed in other ways? That was never considered.

Another issue that ought to be addressed is: What are the costs of addressing the various concerns that they believe ought to be addressed? No one has

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articulated that or studied that or asked for information or input on that. A process that doesn't do that is difficult to accept as fair or complete, from my perspective. And I think the Provider Board process ought to explore this in detail.

The related question is: What will these costs do to rates? In other words, if you're going to increase costs to create additional system features, what is going to be the effect on rates and what's going to be the ability of the system to pay for that and where is the money going to come from if it's decided that that addition to rates is justified?

The next question that ought to be asked is: What else does the system want? Because I think it wants more. Everybody seems to want more, and some of those things are things that the paramedics necessarily don't want.

And the next is with respect to each of those, what will those cost? What will each of those do to the rates?

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And then there has to be a question about, is there competition where you can have some but not all of these things? And what is the process to weigh the relative merits of this? And one of those ought to be the cost and another ought to be the medical benefit that you are obtaining for that additional cost.

And so one of the questions ought to be, what will be the medical benefit in the sense of effect on patient outcomes of each of the proposed changes? And someone ought to be asked to address that specifically, because without addressing those issues specifically, no one can really have enough data or information to make any credible decision in this very complicated area.

And in order to answer those questions, I think someone has to address, how do you know what the medical benefit will be? Are you relying on data? Are you relying on studies? Are you relying on analyses? Are you going to require that that actually be put forward where it can be evaluated? Or is this just guesswork,

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conjecture? Is it self-serving hopes that without any analysis have been arrived at and then are being fought for without further analysis?

Another question ought to be, are there risks to the changes? In other words, it's not just, hey, can you get a benefit? The question is, if you make a change, are there potential problems?

It seems to me at least one way you would take a look at that is to ask yourself whether there is any other system in the country that has the features people claim to want in this system. And they ought to be asking what in the system ought to be identified, and then somebody ought to find out what is the cost of that system compared to what we have here, and what additional features does that have that we don't have here.

And, then, is the additional cost, if there is an additional cost, worth the additional features that it has compared with what we have now?

And then somebody else ought – or

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some other thing that ought to be asked, are there systems that have less, even though they're single-provider systems, regulated by a single medical control and all that, that has less than what Multnomah County now has?

I think someone ought to look at the cost of those systems and look at their histories, because my understanding is that systems came in promising a whole bunch of stuff and have not been able to fulfill it and have resulted in systems that at least are more costly and have lower quality than what was promised and higher costs and lower quality than what we have here now. And that ought to be evaluated in any process.

And another thing that has to be looked at is, what is the upcoming revenue changes from health-care reform, from tax effects of Measure 5 and other things going to do on the revenue streams now supporting this system? And what is going to be the effect of those on ambulance rates?

I think everybody knows that a

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significant percentage of ambulance rates are paid by Medicare and that if Medicare allowances are frozen or go down, system costs continue to increase, and those costs are going to have to be recovered from someplace, and there is a question about how that is going to occur. Now, that may mean that our system has to be leaned up.

And the question is, if that's true, where should it be leaned up? In other words, what we now have is going to have to give way to have the most cost benefit with the least medical impact? And that should be studied before decisions are made.

Now, it seems to me that this really is a cost benefit analysis, and yet there's been tremendous resistance to approach ambulance planning based on a cost benefit analysis. We ought to explore what the basis for that is and whether that is still a valid, analytical process in light of the current realities facing the health care industry generally, facing county and budgets generally.

Another related question is, what is



value that's put into the cost benefit analysis? There are certain aspects of this that have intangible value, that have a cost associated with them. One is system stability. One is avoiding delay. One is, is there a benefit to competition from keeping, you know, one provider honest because another is available to step in if there's unavailability?

Seems to me that all of these questions must be asked in any rational process with respect to both medical and cost effects of issues, and that this would apply to the issue of paramedic concerns, but it also ought to be applied to all of the other issues and changes proposed by various proponents of change, and that this process ought to occur in a context in which those issues are faced head-on rather than avoided in order to give the planning process any validity and ultimately minimize the chance that well-intentioned but superficially arrived at proposals don't adversely affect the citizens of Multnomah County.



Another issue that I think ought to be explored in the context of the PAPA proposal is where the PAPA proposal differs from the Collins proposal in terms of philosophy, in terms of choice between options, issues of provider selection. These are specifics that were alluded to in the MAB discussion but were never specifically articulated. And the problem with the process like this is that without those being articulated, no one can participate by submission of additional written materials, comments on the statements that were made at the MAB meeting, or anything else which should be relied on and reviewed and analyzed and considered by the MAB in its process of fine-tuning its template.

So it seems to me that at a minimum this process ought to consider these kinds of concerns in this sort of an analytical way.

MR. ROBEDEAU: Okay. Thank you.

MR. SKEEN: Do you have a list of all those questions, Jeff?



MR. KILMER: We're going to provide it.

MR. PRAGGASTIS: 20 cents a page.

MR. ROBEDEAU: We will provide that. That's one of the things that -- one of the reasons I want to address this, speed up the process, get them out probably right to the board members, I'll mail them out myself so everybody has all of the same questions and the same information. I know I'd asked Bill for some information. He has brought some or perhaps all. I don't know. I'm going to have to let him speak on that. I think we're going to need copies of that for everybody too that's on the board.

I do have -- my question on this, it's not on the agenda, is, does anybody know exactly what the MAB did adopt? Because I don't. Nobody --

MR. SKEEN: Well, my impression is that they adopted the PAPA template as a basis to start making modifications on it. That was my impression.

MR. LAUER: That document is a draft,



I think. I think they're planning on changing it based on a lot of the questions that Jeff put out.

MR. ROBEDEAU: As a template -- you know, I'm not trying to seem dense here. Maybe I am. The PAPA plan, I've read it. Quite frankly, to me it doesn't seem to say much other than it's a philosophical idea.

Well, anyway, I am not sure what the MAB adopted. Did they adopt the idea that they'll use the plan and redo everything that's in it, or were there specific things in it that they adopted, or --

MR. SKEEN: Pete, I think the root of the problem is that both plans came forward with options as to who the provider should be to fulfill the plans. And I think that's convoluted the process somewhat rather than working on the ASA and the basis for how the system should operate as opposed to who should operate it. And it may very well be that MAB accepted PAPA's template because they liked the options perhaps better there than they did the one Bill put forward. But it would have been



nice to have --

MR. ROBEDEAU: Bill, what's your understanding?

MR. COLLINS: We didn't put forth any options. We put forward the options we looked at and made the recommendation for a tiered system. We didn't make any recommendation for options.

MR. SKEEN: It listed options. PAPA's listed options.

MR. COLLINS: In reading that in the plan that came from our office, you should be clear that we did not put that out as, choose one of those options.

MR. SKEEN: Suggestions on the table basically then?

MR. COLLINS: No, we did not suggest. We just said we viewed three options in making our recommendation.

MR. LAUER: I thought it specifically said that you recommended option one.

MR. COLLINS: We did. We did.

MR. KILMER: Was it your understanding, Bill, that the MAB read the PAPA proposal that way and that it



recommended its option one?

MR. COLLINS: No.

MR. ROBEDEAU: What's your understanding of what the MAB did?

MR. COLLINS: Just what they said. As far as I know, they adopted the plan put forward by PAPA as a template, whatever that means, for further discussion. I mean, that's what they said, and that's all that I could -- that's all that I can say. I don't know what else -- I don't think there's anything to read into that. They just chose one of the two plans.

MR. KILMER: The PAPA plan was really three options, three different plans. Do you know which of the three that they adopted?

MR. COLLINS: I don't think they adopted any of the three. I think they just adopted the document that you saw. And then, according to their time plan, they meet in the middle of May and fine-tune the template.

MR. DRAKE: I think there's --

MR. KILMER: That's all you understand

about it?
MR. COLLINS: It is. I don't understand anything else about it.
MR. ROBEDEAU: They adopted it as a template. They really know nothing about it, and now they're going to meet in a month and fine-tune it and adopt it. Is that right?
MR. COLLINS: I don't know that I could say they don't know anything about it. Their motion, if I remember correctly, was to adopt the plan as a template and to fine-tune it, I think it is. Weren't those the words, John?
They were going to fine-tune it. I don't have the minutes, so I can't say exactly what their words were.
MR. DRAKE: I guess the problem I have, when you say fine-tune the plan, under what basis are they going to fine-tune it? And what components are they going to look at to fine-tune?
MR. STEINMAN: I think the point is, we all know what's going to happen with the MAB and the PAPA plan, so why are we



spending a lot of time on it?
I thought we were here to look at the county plan and see what the providers wanted to do with that. I think everybody here knows what's going to happen with the PAPA plan.
MR. ROBEDEAU: I think it's important to understand what they did. I don't think anybody understands.
MR. STEINMAN: I don't think anybody knows. I think you've got everything on the record that you need to get on the record. Let's get on with that, because I don't have a lot of time to spend on PAPA without the MAB here and telling us what they want to do.
MR. KILMER: Tom, can I ask one question? You understand they will ultimately adopt plan No. 1?
MR. STEINMAN: I didn't understand that. In my opinion, they adopted strong medical control, and I don't think they care on the provider, on the four votes that were there. So I don't know what they're going to do. I think they're going



to put it through as written because I don't think they have a concept of what an ASA plan is. I think this was mentioned at the MAB, an interhospital battle that is still going on. And I'd like to look at Bill's plan and the county plan and see what we can do with that. I think that more addresses our needs on an ambulance service area plan.
MR. ROBEDEAU: The MAB said this was an interhospital battle –
MR. STEINMAN: No. People said. You know what's going on, Pete.
MR. ROBEDEAU: I was just curious. I didn't hear that, but I was just curious that maybe that got on the record after 15, 20 years.
MR. STEINMAN: I don't know if it got on the record there. I've seen Jeff's letters.
MR. LAUER: Somebody said it.
MR. KILMER: Mr. Brusse said it.
MR. DRAKE: We are going to look at the proponents plan, we're going to look at the PAPA plan. I think, Randy, you or



Trace said there were some positive things in the PAPA plan you liked. Is that fair to say?
MR. LAUER: Mark, I don't know that I'm in agreement that we should adopt a plan, take the same course that MAB did. I think we're really setting ourselves up for never coming to a conclusion. If the MAB goes to the county commissioner saying, we want this plan, if we go there saying, we want that plan, then the commissioners are going to be really confused because their input is in conflict.
MR. DRAKE: I guess what I'm trying to do in a sense, Randy, is narrow some of the wide range of options that we have. I think in talking to other providers, the ones in agreement, a third type of service from the county is not reasonable in today's market. So if you eliminate that out of the options, what you're looking at under the PAPA proposal is a single provider by competitive bid as a vehicle is one of the options for vehicle delivery, there are several other components in the



PAPA plan that people may find positive that they want to pursue.
MR. KILMER: Mark, can I make a suggestion here? You have made the statement that everybody agrees that the third service is not any good because of time constraints and things like that.
MR. DRAKE: And financial –
MR. KILMER: We have a PAPA guy here.
MR. PRAGGASTIS: Wait. I'm a guy here.
MR. KILMER: You're not here for PAPA?
MR. PRAGGASTIS: No. I'm here as a citizen to see how my tax dollars are being paid today.
MR. KILMER: We have somebody that participated in the PAPA plan, regardless of his role here. I think our process here ought to be what we wanted from the MAB and never got, and that is for somebody to make a statement like a question, not an assertion that is not subject to debate, and allow people the opportunity to say, I disagree with that, and here's why I think



that option one of the PAPA plan makes sense.
And in deciding the other plans, I know everybody wants to get to the bottom line real quick. The problem is, you don't have a process in that situation, and one of the concerns that the MAB expressed concern about were the interests of the providers – of the paramedics. Those have never been expressed. And I think at least if you're going to look at the Collins plan, you have to understand those concerns, among others, and then look to see whether they can also be realized in the Collins plan as part of any rational decision by this board eventually to recommend that, if that's our tentative direction. But always leave it clear that our tentative direction is subject to modification based on what we hear here because this is going to be an open-minded process.
MR. DRAKE: Okay.
MR. PHILLIPS: Bill, will the county council see both plans?



MR. COLLINS: Yes, they see anything anybody wants to give them.
MR. SKEEN: I think Connie indicated – she indicated an open process.
MR. COLLINS: Right. She's handed out some tentative public hearing times. It's the obligation of our office to make a recommendation to the board, and I am not approaching this from "These are the two plans and you've got to pick one" kind of thing. We're going to make every effort to reach a situation that will be able to go through the county commission process.
It isn't going to do any good to come up with options that nobody can vote on in the commission, so we're going to look at

what's been presented by PAPA, but what's been put together out of our planning process and any other information that we can to make that recommendation.

Now, other people will also make recommendations to the board. The MAB has chosen to make a recommendation, the Provider Board. Anybody can make a

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recommendation. They're not bound by anything that happens until they vote. So there could be other -- I haven't heard of any other plans, but they could certainly pop up.

MR. PHILLIPS: I guess my point is, in light of the county council looking at both plans, the Provider Board, there are some things we're not going to agree on as a group, but maybe we ought to start with the things we can agree on and make the decisions based on the facts and back that up, and if it comes down to something we can agree on, provide the council with how the vote went on that issue, and we agreed, disagreed on some things, and put it in their hands and go with that.

MR. ROBEDEAU: That was the idea behind the minority report, rather than just one report. In order to do a lot of that, we have to have the information in front of us first. And some of the things that we looked at, what exactly did the MAB adopt out of the template? Which nobody seems to know. What are the paramedic

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concerns that were addressed at the MAB meeting that were never articulated. And I don't know what those are.

Does anybody here know what those are?

John, I know you've worked with PAPA. Maybe you're not a member of PAPA. Do you know what those are?

MR. PRAGGASTIS: Well, to be honest with you, I'm just here as a citizen to watch the process. You all employ all of us. Certainly you must know our concerns. You meet with us every day. You employ us.

MR. KILMER: But why don't you state them again, John, for the record, so that they will be articulated and everybody will understand them the same way. To sit silently requires people to speculate about those.

MR. PRAGGASTIS: I'm not really familiar with the county process where the county board asks citizens specifically to comment when it's trying to do its own work. I'd just as soon sit quietly here

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for just a moment and listen to your concerns.

MR. KILMER: Okay.

MR. SKEEN: John, I'm trying to do some comparison between the two plans to get to the guts of it. I'm looking on page of the PAPA -- I'm sorry. You are probably more familiar with this than anyone else. It appears that page 10 through 23 is essentially the plan per se?

MR. PRAGGASTIS: I don't even have a copy of the plan in front of me. Frankly, gentlemen, if I'm here to be deposed, that's one thing.

MR. SKEEN: I'm just asking -- I'm not taking anything to task. I'm just trying to get down to the roots of it so we can compare.

It talks about system elements, and it goes through division of service types, response times for each ASA provider, level of care, and personnel. I assume that's kind of the guts of the ASA plan?

Has anybody else studied that?

MR. COLLINS: Keep in mind, both

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documents that you received have more in them than the actual plan. The plan itself, the format and content of the plan is completely controlled by the state. You might read the -- when I read the format, I will have to comment, I read the format, and it's a bit bizarre, but that's the format.

So when you look at the plan, it's sort of like you can't really complete the plan if you just filled out the plan.

MR. DRAKE: PAPA included a copy of an actual plan in the back. Right? They followed --

MR. COLLINS: No. It's the same plan. It's got all the --

MR. DRAKE: That's what I mean. They followed the state plan in the back.

MR. PHILLIPS: It follows the same.

MR. DRAKE: Right. That's the last document, which is pages 1 through 30 on the back, this part of it.

MR. PRAGGASTIS: 31.

MR. DRAKE: This is all PAPA proposal here. And it's after -- it's the last

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section. That's an actual plan that follows the state guideline. That's right, that's essentially what it is, that you've seen, that PAPA proposed?

MR. SKEEN: So it begins after you get past the definitions.

MR. COLLINS: The definitions are part of the plan. There's a page that starts there that says, proposed ambulance service plan. It doesn't have a number on it. Okay?

And it's followed by page 1 of their last tab. If you look at the format of the plan and the format of the plan submitted by our office, those are exactly the same format. We should go down piece by piece. I looked through, and I didn't see any difference.

MR. ROBEDEAU: You have proposed ordinance and --

MR. COLLINS: Ordinance is different.

MR. ROBEDEAU: Because I've got proposed ordinance.

MR. COLLINS: That's not the plan. The plan has to be adopted by the county in

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a nonemergency ordinance. But that could be as detailed as the ordinance proposed by PAPA, or it could be as simple as the county board of commissioners adopt the plan, period.

MR. ROBEDEAU: You're talking about just the second half of the proposal.

MR. COLLINS: Right. That's the plan. That's in the same format as the plan that was submitted by our office.

MR. ROBEDEAU: I think this really illustrates the problem. Nobody really knows quite what's been adopted by anybody, but we're going to go to the county commission with it. I think that hits the nail right on the head.

MR. STEINMAN: At our last meeting, I didn't think it mattered what had been adopted by anybody. We were going to come up with a process here.

MR. COLLINS: I would suggest we look at both these things.

MR. PHILLIPS: First, maybe we ought to formally invite PAPA to provide testimony as we work through this.

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MR. ROBEDEAU: We did.

MR. COLLINS: We invited everybody. We sent out the same mailing list.

MR. ROBEDEAU: And I sent a letter to PAPA asking for information, the same letter that was sent to Bill. I have not got copies of those out, but I have them with me here. And the memo with it was a

copy, it was a copy of the request for information that I had sent to Bill, and it's just identical. It's even addressed to Bill.

I will supply everybody with copies of that so you know what they got. I have received no return, no comment, no nothing from PAPA.

MR. PRAGGASTIS: I will tell you that we have not received your letter, sir. I will go and check the post office box today. But as of this morning, I have not received your letter, nor has Gary, nor has anyone. And no phone call.

MR. ROBEDEAU: We sent it --

MR. PRAGGASTIS: I'm just putting it on the record that it's interesting, but we



have not received it.

MR. DRAKE: That's fine. No one's --

MR. PHILLIPS: I'd just like to say, there's good in both of these plans, and I guess my point is, if we'd like to hear from Bill and get the information out on the table, good, or maybe we ought to just start at the first area, do we agree on it? Do we not? What data do we need to support it?

And let's just start putting these to bids piece by piece, and if Bill can comment or PAPA can be here each day to comment on that section. If we don't agree -- it's two to one or five to zero or whatever -- this is a vote. We submit that information to the county and let them make the decision.

MR. ROBEDEAU: That's on the agenda to start with. We're going to take each, address each section of the plans.

Some of the agenda, part of it says, questions from Bill and conclusions on his data. But nobody had the data in time. We need to have a chance to study it. It's a



matter of getting that passed out.

We've got about one day before we meet again to read over the data and any questions on it and make any recommendations. It's going to be fast. We're not going to have the PAPA data, although I understand from the last meeting that there is very little, if any. So we'll just have to wait and see.

MR. DRAKE: What kind of information do we need, Pete? We have a list of memoranda, the number of paramedics in the system now, paramedic turnover. We have demand summary table one, which is from Bill.

That's the information you put together in the demand analysis?

MR. COLLINS: (Nods head.)

MR. DRAKE: And the current unit hours in the system and unit hour savings under the different scenarios. We can start out with those pieces of information and at least get that -- a lot of that stuff we get from the company.

MR. ROBEDEAU: Well, what Bill has on



his data, and the 29 points -- some of it he says he doesn't have, and we need it. We'll mark it and say we don't have it on the list. Some of it he's brought with him. We can run it out this afternoon.

MR. COLLINS: I've got copies with me.

MR. ROBEDEAU: You've got copies for everybody. Can we pass that out?

MR. COLLINS: Yes. Do you want to pass it all out, or do you want to talk about it, or what do you want to do?

MR. SKEEN: I guess my question, Pete, is how relevant a lot of the data is to this process.

MR. ROBEDEAU: I think the data is very relevant in that the data -- a lot of what the recommendations come out of here are things that need to be fixed, and the data is going to say what needs to be fixed.

MR. SKEEN: Well, it seems to me the issues I know, that everybody took exception with, were response time, which you've probably brought that issue up,



response-time compliance.

MR. COLLINS: Although that's not an issue in the plan. In fact, it's not an issue in either plan. The goal is reiterated.

MR. SKEEN: That's my point. Turnover was -- I think everybody took -- most people took exception to the conclusions with that, but I'm not sure how relative that is to setting up the plan. That becomes almost more characteristic of the provider selection process, what's put forth. Certainly the rate-setting methodologies become critical to this process.

I just would hate to see us get bogged down with a lot of documentation or analysis that Bill has that may not be pertinent to what we're trying to accomplish here.

MR. ROBEDEAU: Mark?

MR. DRAKE: I think part of the problem, Trace, historically what has occurred here is people make assumptions and based on those assumptions they design



a vehicle delivery system for Multnomah County. And I think part of the problem we've had in the past is those assumptions are based on false information or information that's not accurate.

We need to make sure we're dealing with accurate information in order to base our assumptions, make sure all the information is accurate, we're all talking about the same sheet of music. We need to know how many paramedics are currently in the system, current FTDs there are, rather than how many paramedics, say, a company has on their list.

Buck has a lot of paramedics on their list, 120, 130, whatever the number is, maybe more, but not all of those paramedics work in Multnomah County. And the same way with CARE, we have other paramedics listed. We have part time. They don't all work in Multnomah County at the same time. These are some of the numbers we have to agree on.

MR. LAUER: Well, this is real confusing for me, what we're really doing



right now, because on one hand, in the last meeting, there were statements made that we ought to adopt Bill's plan, and the meat of that, most important part of that is provider selection model, the tiered system.

But now, and then the last meeting too, we are saying that the data that was used to reach those assumptions that led to the recommendation of that tiered system is inaccurate. So --

MR. ROBEDEAU: I don't think we said it was inaccurate. I think what we said was we need to look at it so we know what it is. It's the same deal with asking the question that started the meeting on, what was it exactly that the MAB adopted? They adopted a template. Bill says they adopted a template based on the PAPA plan, the template, and followed by whatever that is.

I'll have to admit, Randy, I'm not real sure what that is either. If we're adopting a template based on the PAPA plan, apparently the MAB has made a bunch of

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assumptions based on some kind of information, and if I read the PAPA plan right, you have one of two options. And if it's the template, only one of those two options will be considered. One is a municipal system, and the other one is a single-bid model.

MR. LAUER: I think it's broader than that, Pete. The state statute calls for I think four main points to be addressed, but two of those are the system elements, describe your system, things like what are the response times going to be, what's the medical supervision going to be like, things like that. We really need to talk about those. One of the other four things is what sort of provider-selection process are you going to use.

But we tend to I think walk around and conclude that the ASA plan is just that one element, what kind of a provider-selection process is there going to be. We need to not forget the rest of the planning process. And I think that's where we've got some common ground rather than talking

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about a majority and a minority vote at this point. We ought to talk about things we've already I think reached some consensus on.

For example, a single physician supervisor, as described in the PAPA plan, is a job that no human being can probably do. It's much too large. We need to talk about that. Response time, what kind of response time should this county have? And things like that. I think we've got some areas there where we can make some progress and put those behind us, and then later on we can work on what kind of provider-selection model we want to see.

MR. DRAKE: Pete, if I can comment for a minute -- sorry to interrupt you -- I think that's true. We need to do both of those things. But I also have to agree with a comment made earlier. We did last time vote and adopt Bill Collins' plan as the kind of methodology we want to follow, based on the components of his plan. Everybody voted and that's what we decided. To go back on that --

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MR. LAUER: Did I miss that part of the meeting?

MR. DRAKE: We didn't? I thought we did.

MR. ROBEDEAU: No. We voted. The only vote that was taken was we voted to look at the plans, spend the time and review everything and make a recommendation.

MR. COLLINS: I would really suggest that you try to look at both plans. To say that --

MR. DRAKE: That's fine.

MR. COLLINS: To adopt a plan as a template, that the MAB did, at least in my mind, doesn't make a lot of sense since the template of the plan is already set by the state. It's got big blanks, but it is a fill-in-the-blanks plan.

MR. DRAKE: Okay. The second part, let's not do that, let's look at the components, let's look forward, look at the components, agree what the components are. Is that fair to say?

MR. LAUER: M-hm.

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MR. DRAKE: Everybody agree with that?

MR. ROBEDEAU: I think it's also fair to say the most important aspect is provider selection. That's the thing. Since 1977, I know that there has been no opposition to a single physician supervisor, but we have listened countless times to MAB members refuse to recommend a single physician supervisor because they were afraid by recommending a single physician supervisor, that would lessen the desire to have a single provider. There's a lot of things on that, Randy, I don't think there's really a lot of controversy on.

A single physician supervisor has been agreed on by all the providers for the last 16 years, that I know of; it's just never been adopted because the single physician supervisor indeed is not an EMS problem, it's a hospital problem that's been a fight for 16 years.

MR. LAUER: Exactly.

MR. ROBEDEAU: But we're the ones that

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are getting the heat for it. That's one of the things that's been being used for years and years and years and years, to say we have to have a single provider so we can have a single physician supervisor. So I think, unless I'm wrong, we can do away with the single physician supervisor issue here by, if we have to, do a vote on whether or not we should have a single physician supervisor or a single medical system, if you would prefer that, rather than adopting the actual PAPA plan where you have a single individual who is going to be Lord God Almighty of everything and have duties and assignments that he can't possibly fulfill, so you set it up to fail.

If I remember right, reading the PAPA proposal, it says this person cannot delegate to anybody anything. I have to agree with you, that with a hundred, 120 private EMTs, paramedics, 200 -- Tom, what is it, 850 Portland Fire people?

MR. STEINMAN: No.

MR. ROBEDEAU: What is it?

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MR. STEINMAN: Under 700.

MR. ROBEDEAU: And Gresham has about?

MR. PHILLIPS: About 75.

MR. ROBEDEAU: So we're dealing with a thousand people, give or take. We have Corbett, Skyline, a few other fire departments.

MR. PHILLIPS: Probably 150.

MR. ROBEDEAU: So I think a thousand is fair. I have to agree with you, it's physically impossible for one single human being to follow state guidelines and state law and be able to adequately supervise, ride with, observe, and in other ways do everything that's required by state law and have only one person doing it.

MR. LAUER: I think we're in agreement. I think that's one key element of the PAPA plan. We asked the question earlier, what exactly did the MAB approve?

The thing that kept recurring throughout the discussions we had about the medical direction months ago was that they wanted to have a single person accountable for the medical care that's provided in the

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county. And where the discussion ensued was, how do you do that?

We had a group of physicians who were the physician supervisors group who wanted to continue to act as a group. The MAB and others wanted one specific person to have the final order. There's some merit to that, because we discussed how slow the process is now. For example, it takes roughly a year to implement a new protocol, and that's because you've got to go through this committee, group process to do that, and it was felt that one physician could do that.

And they used the Clark County system as an example. Granted, that's a smaller system, has a condensed group of

paramedics, but you have one doc who says what kind of care is provided and things move rapidly. Multnomah County wants to do something like that.

MR. ROBEDEAU: I don't think –

MR. THOMAS: Pete, let me make a suggestion here. You guys have nine meetings, and if we do a

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stream-of-consciousness approach, where you jump from topic to topic, you're not going to get through the nine meetings and have a product that will have the impact whichever ones of you want to have.

We started into the medical supervisor issue, but I don't know if everybody's ready to discuss that as a main topic agenda. That in itself is probably a whole meeting to discuss and go through and analyze and figure out what your conclusions are. That may be one of the easier ones. There's topics like that that you can go through. And I don't know what they all are. Okay?

And it seems to me you can map those out so that on this meeting, you can hit that topic, that meeting we're going to hit that one. That's one set of issues. That probably orients – well, it can orient both towards responding to existing proposals that are on the table and potentially arriving at a proposal that this group might want to recommend. That's one approach which I think needs to be

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taken.

And maybe I think it's really important to pin down what those topics are and when they're going to be discussed. I think the other thing is there are proposals on the table, and at least some of the members here are hopeful that this group will, in addition to whatever it proposes affirmatively, also have some critiques or suggestions for revisions, whatever, for the proposals that are on the table. Major aspects of those are based on conclusions as they're argued. I think Bill's is the example of that. Some of his conclusions are argued based on the data he had in his analysis of it.

Seems to me it is appropriate for members here to want to get the total package of data he arrived at and have a discussion with him I guess after they reviewed the data, do you have a common understanding of the data and how did he arrive at his conclusions and did he agree or disagree with that? I think that's the relevance of the data. I think those are

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the two things that need to be done.

I am really concerned that unless you have a road map of when you're going to consider each thing and go through each thing in depth, you're not really going to produce anything that's going to be useful to yourselves or anybody else. I guess I'd rather see you map that out right now than go into a topic now for a surface discussion that you're going to have to come back to and discuss in depth at some point later. I know a lot of stuff that's on today's agenda has been discussed already, and you're not ready to have a dialogue with Bill about his data because nobody's seen it.

I sort of think that time's running here. You will be well oriented to deal with items five and six, figure out what the system elements are, and set your agenda for the next meeting, which might have to do, say, with one system element and a beginning of a dialogue with Bill about whatever his conclusions were, and PAPA may have gotten their letter by then

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and have a chance to respond to it.

I think you will get frustrated if you don't do it that way ultimately.

MR. ROBEDEAU: I think you're right.

MR. LAUER: That's the rational approach.

MR. COLLINS: The elements that need to be considered, they're actually laid out in the plan. We can start from the top and go down. The only plans that are not explicit in the plan – and I'm talking about the actual plan, not the rest of the documents – but the only parts that are not explicit in there are things that are not discussed in the state plan.

For instance, there is no real discussion of first response as part of the system. So you've got to kind of put that in where you want to put it. There is very little in the plans about the organizational elements within any jurisdiction. But it lays it out. You can just start at the top and decide if – item two is speaking about, item two, item three, get through the whole plan.

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MR. DRAKE: I think that's the method we should use. Both plans, both PAPA and Multnomah County, follow that outline essentially, and we ought to go through that outline.

MR. PHILLIPS: What do we like, what don't we like.

MR. DRAKE: Right. Take both plans, put them together, take elements from both plans, maybe come up with other options.

MR. ROBEDEAU: But what we're going to talk about at the individual meetings I think is important so when we come Thursday, we know we're going to be talking about X topic and maybe start the next topic F.

MR. THOMAS: Maybe you can look at the list here. There may be some things you figure we don't need to discuss.

MR. COLLINS: If you look in the county document, at the beginning of the plan portion of it is the table of contents, which will be page 1 of the plan. It's in the second section, just like in PAPA's. There is a table of

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contents, which essentially is the outline of the state requirements.

MR. DRAKE: And PAPA I think has the same thing.

MR. COLLINS: You can start at the top. We probably don't have to spend a lot of time on the language of the certification document. The chair of the county commission will probably leap ahead to the next item.

MR. KILMER: I'd like to suggest that that is not the best way to approach this thing because it's too unfocused. It does seem to me that Randy is right and Mark is right and Tom is right, that there are several elements to the Collins plan built on that, that there is relative consensus on. Because there's relative consensus on those doesn't mean there's total consensus on all of it.

It seems to me if you went through and identified the way these things were handled as proposed by the Collins plan, which everybody seemed to think would be a more fruitful starting point for

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discussion, that that would be go. Around this table today, you could identify those portions of the Collins proposal about which there seems to be general agreement, single medical control, maintenance of eight minutes 90 percent of the time, first response, all that stuff.

And if there's any discussion on any

of that, people can have it. But that reserves the issues then for later discussion about the methodology that Mr. Collins used to arrive at some of the recommendations he made in his plan. With respect to a single provider of the public -- or the private component of the tiered response, option one is one big example. With respect to that, you don't have to worry too much about provider selection if you decide that the current providers will be left basically in place doing what they do.

Buck may have a different view on that point, in which case on that point there may be a minority report. That's what's lacking here today, is a focused response



which I think starts from areas of general agreement but invites people to discuss each one of these.

The second part that I still think you ought to talk about is the paramedics have concerns that are not articulated, and private providers have their concerns that are not articulated. The medical community has their concerns that are not articulated. The fire department has their concerns that are not articulated. Those concerns ought to be invited here.

We run the great risk, if this thing goes the way it is, we're going to be conceived as somebody with a preconceived agenda that is doing the superficial stuff to create a record to support that. That's dangerous. You need to go into these things in detail and on at least every single point give people a chance to respond.

MR. PHILLIPS: We would do that, wouldn't we, by going, 2-1 geography, does anybody have anything to complain about the way the geography is written in the plan?



Is there some disagreement?

MR. DRAKE: I think, Jeff, going through this, we will hit all the areas. We can talk about all the areas we agree or disagree with, and those areas of concern, we should invite people -- obviously we have a lot of the information from PAPA. I agree there are some secondary paramedic concerns that were articulated at the MAB. It would be nice to get a list of those paramedic concerns.

We can certainly go back to our companies, from individual companies, what those concerns have been articulated and go to the PAPA group, representative of some of the paramedics and get their concerns certainly listed out so we can put all those on the table. Certainly the medical community has concerns, and we should contact those medical people, again invite them to the meetings and tell us what medical concerns do they have, what part of this plan are they concerned about, and address those issues. And the same way with the fire bureaus.



I mean, certainly if we're going to write up a plan and do this right, for example, hazardous materials, are the fire bureau and districts happy with the way the hazardous materials -- happy with the integration of private service with hazardous materials? Is there something else we can write to strengthen that to make it better? I don't know. You guys can let us know how you want to deal with that.

On the first responders, we can talk about the response times, response time zones, staffing levels. I think, personally, there's going to be a lot of discussion just on definitions. That's going to kind of set everything else out from there.

Does that seem like a reasonable plan, process to proceed? Anybody have any issues?

MR. ROBEDEAU: Mark, if you're going to use that, I'd prefer to go through and mark off the points in complete agreement. We don't need to take this step by step in



the subsequent meetings.

MR. DRAKE: Right.

MR. ROBEDEAU: Because all of one I think is agreed on. Ambulance service area boundaries are agreed on. System elements --

MR. DRAKE: I don't think ambulance service area boundaries are agreed upon. We agree it's Multnomah County. We don't agree with what the ASA should be.

MR. ROBEDEAU: I stand corrected.

MR. DRAKE: About the only one we can agree on possibly is the overview of the county.

MR. LAUER: We can agree on the certification part.

MR. DRAKE: Okay.

MR. ROBEDEAU: What certification?

MR. LAUER: That's the letter from the county commissioner.

MR. SKEEN: Pete, it seems like sections three, four, five, six, and seven are the ones that really need discussion on. My suggestion is -- this is a pretty good task for somebody -- that something



that would be helpful for me is to see kind of a side-by-side comparison of the two plans and how they compare and then allow us to give opportunity -- opportunity or input from the Provider Board as it relates to that.

I like Mark's idea setting up and perhaps in a particular day to invite testimony from the work force and then maybe go to the ATU, a representative from your group.

MR. ROBEDEAU: We need to do an agenda today for the remainder -- I didn't mean to interrupt you; sorry about that -- for the remainder of the Provider Board meetings so that each agenda item is known today, the remainder.

MR. DRAKE: Okay.

MR. SKEEN: Okay. I think in doing a side-by-side comparison, like I said, it's a pretty good task, but I think it will allow us to look at the two options that are on the table and see if we as a group reach consensus on other considerations for that and, like you said, there may be a



minority opinion as to how that might interface.

MR. ROBEDEAU: Those minority opinions be allowed to be expressed.

MR. SKEEN: Right.

MR. DRAKE: I don't know, Trace. I think the side-by-side comparison is something we need to do as we go through this process. I don't know if someone can sit down and say what those things are. We need to hear from both groups. We need to hear from PAPA and from the county maybe some reasons as to why they came to that conclusion.

MR. SKEEN: My thought was to do that, provide a copy of that to PAPA and obviously to Bill and make sure that the assumptions are drawn up there -- I'm talking about bullets -- make sure the assumptions are accurate, we're not misrepresenting their position, and use that as a basis. I think that would help us get through what Chris is talking about, because we're bouncing all over the place here without getting into any substance.

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MR. DRAKE: Possibly could I suggest to the chair that maybe a subcommittee, not just one person, do that; that maybe a representative from each one of the providers just sit down quickly and do that.

I think it's a good idea, Trace. There are people that are interested that want to participate could do that quickly.

MR. ROBEDEAU: We can do that. It's going to have to be ready by the next meeting. We need to definitely decide on an agenda item before the next meeting.

MR. THOMAS: You can do it by piece for each meeting.

MR. DRAKE: That would make it easier.

MR. LAUER: My question, do we have here today the road map that Chris talked about?

Bill, in your section headed, Multnomah County ambulance service plan index, is that by state statute?

MR. COLLINS: With the exception of the first response to be added in. I don't

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know. PAPA's got the same thing -- don't you guys have something in here someplace?

MR. PRAGGASTIS: I'm sorry?

MR. LAUER: We need to look at what the atlas looks like.

MR. COLLINS: You can get it out of the state statute.

MR. ROBEDEAU: If you have to move South America a couple of the feet to the left, it doesn't make any difference.

MR. COLLINS: This is the state format.

MR. SKEEN: The only comments I would make, Bill, you talked about the first response being in there. I think somebody was remiss in setting this up on a statewide because it's a major --

MR. COLLINS: It is not required. If you look at the actual state statutes and administrative rules, it is not required. They don't require you to say that. When we put this together, we did not feel that that described the system sufficiently, so we just added the first-response stuff.

Now, there is not a great deal of

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stuff about first response, but it's in it at appropriate places. But the one, two, three, four, five, those are the titles. It's the same. It's the state statute. We can get you a copy of the statute if anybody brought it.

MR. DRAKE: It's in the PAPA plan.

MR. PHILLIPS: It's in the PAPA plan. John was just telling me that these definitions have to be, as far as what the -- if we don't want to believe him, that's fine. Let me state what he's told me.

These definitions need to be stated as they are stated in the Oregon administrative rule verbatim, and if we wanted to add any, we could have them added. We can use the definitions or the ones that are in here.

MR. DRAKE: There are plans that have been submitted to the state that have been approved that don't follow them verbatim, and they have approved them. I think most counties are better off to at least include the verbatim portions of the state

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definitions.

MR. COLLINS: The thing you have to look at the definitions, and actually on any of the state statutes, is we can't propose and adopt a standard less than the state standard. The state says, the minimum standard for X is whatever it is. We can add to it, we can make it more, but we can't make it less.

MR. DRAKE: Most of the counties, though, ad definitions that the state doesn't have. They adopt the definitions the state does have and then add in addition to first responders, or whatever they want to do, quick response team. That's certainly a good place to start.

MR. LAUER: I would suggest for the purpose of starting to form an agenda that we look at the broad topic of system elements first and then break them out as agenda items. I'll make that as a motion, if necessary.

MR. DRAKE: I would second that motion if you would add, why don't we start with definitions, look at that first.

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MR. LAUER: I'm not so sure we can change the definitions.

MR. KILMER: Mark, I think it's better to start with the issue, and if you have a problem that makes that difficult --

MR. DRAKE: Okay. I'll second that.

MR. COLLINS: What you can do is look at the definitions as a piece you're looking at and make sure they support each other.

MR. DRAKE: I'll second his motion to look at system elements to start. So, we can move on.

MR. COLLINS: That's a fairly good one to start.

MR. ROBEDEAU: We've had a motion. I'll move discussion.

MR. THOMAS: Why don't you -- I'll be quiet until you vote on that.

MR. SKEEN: The motion is to look at that first. Do you want to break that down?

MR. LAUER: Yes. The motion is essentially, take system elements out of the ASA process to look at first and then

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to create an agenda, which would be the road map that has the subtopics of the system elements to discuss as an item-by-item agenda topic.

MR. DRAKE: Okay.

MR. ROBEDEAU: For how many meetings? Provider selection, which is No. 7, you know, I would not want to just do system elements for the whole road map for the nine meetings that we have and miss provider selection, which comes out as No. 7.

MR. KILMER: Pete, I'm going to think you can handle most system elements in a meeting or two because most are going to be uncontroversial, and there will be two or three that will be controversial, and those can be anticipated, and those can be scheduled in for time at subsequent meetings. But what Randy is suggesting is a starting point.

MR. ROBEDEAU: Okay. I understand. Is there any more discussion?

MR. SKEEN: Pete, we had talked last time about -- I think just in closing it

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would be good to get these recommendations to MAB, that there was a desire to get them to MAB by the 7th so that they would have them the week prior to the 14th. If that's the desire of this group, then really on the Tuesday-Thursday format we're looking at about seven meetings left. And just discussion on Randy's motion, if we start with system five, I don't think -- item five, I don't think there's any way we'll get through that on Thursday.

But if we can set that up and do side-by-side comparisons prior to that meeting and start through with a goal of really trying to get through that by the third session, anyway, and then that should give us adequate time to move ahead.

MR. DRAKE: Sounds reasonable.
MR. SKEEN: I do like the idea, too, of inviting comment, at the appropriate time inviting comment, both comment from paramedics, fire medics, private sector medics, union medics, particularly physician supervisors. And, to be honest with you, I've found that difficult at



times to pin them down on what it is they're after.
MR. KILMER: All you can do is give them the chance.
MR. LAUER: That's true. You can lead them to the water.
MR. KILMER: Exactly. The big problem has been that no one's even led us to water in the past, at least some of us.
MR. THOMAS: If I can make a suggestion on specifically what you do, I'm just looking through this, under system elements, under 5.1, two, and three, response times of personnel -- I'm using Bill's model at this point -- he has tiered response. The proposed shift of some of the emergency calls that would not be part of what would be transported by the fire under his concept to 12-minute response time, and he has his proposal on the changing personing, rather than manning, personing of the plans. That's sort of part of a total single concept that he has.
It seems to me that that's one topic.



It's sort of hard to break those out and discuss those separately. I could see, for example, setting that as a meeting agenda maybe. I'm looking at how do you break this down. That's sort of one set of topics.
Then when we go into the system elements. There's medical supervision, training, and components. Those are a separate category. Then you have patient care equipment and vehicles, which probably is not a topic at all or something you can dispense of pretty quickly. At least I haven't heard there's going to be a lot of discussion about that. Those two things are at least two meetings worth of discussion. So I could see those. Then you've got --
MR. STEINMAN: Could we stick on that for a second? If we took the medical supervision and the patient care and equipment and lumped them together, then we could hopefully attract the docs to come to that meeting and keep those together in case they have something they want to say



about equipment.
MR. DRAKE: I agree.
MR. THOMAS: I'm trying to give you a feel for how the meetings might go. Those would be two different meetings.
Under "coordination," 6.1, probably the main thing he's got there which you guys would want to discuss is rates. Seems to me that's a major topic.
Mutual aid agreements, disaster response, personnel and equipment resources, which has to do with haz. mat.'s, and special response team, those probably aren't major topics. Maybe you want to discuss those provisions at some point.
Emergency communications and system access, I'm not sure about that one. And then provider selection obviously is a major topic. It seems like the super major topics are medical control, tiered response and what goes with that, rates and provider selection. And you ought to specifically figure out when you're going to do those and maybe do the balance of the plan,



unless somebody has another major issue that's in there that I haven't recognized, maybe all in a single meeting just to polish off.
If those are the topics, you've got maybe two meetings for each of those four major topics, because there were four that I listed, which would cover eight meetings and polish off everything else. I'm trying to give you a feel for how it might go and an approach.
I think people said, the medical people, you can invite them in and invite them into the other meetings, and say, "If you have something to say about this issue, please come to this one," that these people know when to come and you know when you want to urge people to come.
MR. LAUER: That's a good point. I guess we have a consensus that we're going to look at system elements.
MR. ROBEDEAU: Do we need to vote on that?
MR. DRAKE: Does anyone disagree?
No one's in disagreement.



MR. LAUER: As we proceed, I agree with you, Chris. We need to get the horses in the right order in front of the cart.
One thing, I don't know if you mentioned or not, is level of care. In my mind, defining what the level of care is should precede a lot of the other discussion points because you will outline your response-time requirements, standards based on your level of care. For example, if you have an ALS first response, BLS ambulance, you've got different response times than you would have if you had it the other way around.
MR. COLLINS: That's what Chris said, putting response time, level of care all in one chunk, one meeting.
MR. THOMAS: They all interact with each other, the way he's proposed it.
MR. SKEEN: Go through this one other time and adopt this. You're talking about 5.1, .2, .3 for Thursday?
MR. DRAKE: Right. For this Thursday. Okay?
MR. KILMER: Is that going to involve



the doctors?
MR. ROBEDEAU: I thought we were going to do that Tuesday so we could invite the doctors and invite them to be here.
MR. THOMAS: There's a number of places the doctors might want to show up. That's one of them because it involves, do you have two EMTs and do you want to change the response time for some emergency calls? There's a lot there.
MR. LAUER: That's a full meeting.
MR. THOMAS: Frankly, I would suggest that you pass the data out and use Thursday's meeting, since it's going to be hard to get people to think about something substantive ahead of time, for people who have reviewed that, have a dialogue with Bill here about any questions they want to ask him about the data or the conclusions he arrived at from it. That's something you all can do internally. It doesn't involve people who aren't here today.
Then you have your meeting maybe next Tuesday on 5.1, two, and three, and let the medical community know you're going to be



discussing those because they do have interest in those.
MR. DRAKE: I might suggest we look at Bill Collins' data and any other data that's presented to us as we come to it in this process.
MR. STEINMAN: I think if we take his data now and use the next meeting to figure

out whether we want to hammer Bill quietly without inviting other people or --

MR. COLLINS: I would like to strongly recommend that you all take this data now so I don't have to haul this back, regardless of when it's going to be considered.

MR. KILMER: How many copies do you have of your data?

MR. COLLINS: I don't know. There must be 15 or so here. There's enough for everybody.

MR. KILMER: Bill, is that all your data?

MR. COLLINS: This is pretty much it. Any other data is in the plan. This is not a -- I don't think there's anything else.



You can look through it if there's a question.

MR. KILMER: What you're giving us is the data that you initially obtained and all your notes and analysis of that data?

MR. COLLINS: I've given you all the summary stuff. I haven't given you all the sheets, the yellow sheets I have. I tried to go through and find anything that was pertinent, that would fit into that, the data that is not specific in here, and I will be happy to hand it out to people as long as all three companies agree, is that when we did the -- when we looked at the cost data of the current system, we agreed that we would not make this an issue between companies but we would aggregate it and say, this is what the cost of the system was. So I did not bring each of those.

If you want me to, I can hand it out. If not, that's up to you.

MR. SKEEN: I think we ought to go through this data first.

MR. COLLINS: You can look at it if



it's a question. That was one of the concerns, if we sat there and started looking at the cost, say, well, Buck's is this, CARE's is that.

MR. SKEEN: As it relates to the data, the only thing I'd offer again, I think we need to be careful we don't look at such a historical perspective on this, that we create a box that we have to fit. I guess that's my point. I'm not sure how relative --

MR. ROBEDEAU: I'm sorry. I couldn't hear you.

MR. SKEEN: I'm not sure how relative all of this data is, if we want to talk about ASA plans and setting standards.

MR. ROBEDEAU: I'm not sure how relative it is, either, Trace, but too many years.

MR. SKEEN: I know.

MR. ROBEDEAU: I think we need to look at it. Then if we decide it's not relevant, then we decide it's not relevant. That makes it easy.

I would like to ask Chris to go on



with his deal and finish itemizing this out because I think he's on the right track.

MR. THOMAS: 5.1, two, and three could be one meeting or two. I don't know. You'll have to decide that. The next topic I would see would be 5.4 -- actually, Tom, were you suggesting we do 5.4 through 5.8 as a single group? That includes patients care equipment and vehicles. They might be sort of throw-aways. Essentially, that is medical supervision and all of the things that have been encompassed in all of the different proposals about medical supervision that have floated around over the last two years.

The key parts are the supervision and then 5.7 and eight, training and quality assurance. So that's a topic which is also either one or two meetings.

The next one that I think is -- by leaving things out it indicates, I don't think they're major discussion issues, would be 6.1.2, which is rates, and I think that's a major discussion issue and is at least a one-meeting discussion. That's



sort of got lots of things that could be talked about. It has to do with how the system will deal with rates.

And then the other major one that I saw was provider selection, which I think also connects back to -- that's topic seven, and that also relates to topic four, which is ambulance service area boundaries. So it seems to me that's the place where single, multiple, where that discussion would take place, and also a discussion about whichever the conclusion is with what the selection process is, and that's either one or two meetings.

MR. DRAKE: Did you go over 6.4, 6.5, and 6.6?

MR. ROBEDEAU: Seven and four were put together.

MR. THOMAS: I left those out because I'm not aware of those being major issues, but if they are --

MR. DRAKE: I think there are some issues we need to at least discuss and put into the plan, emergency medical services, dispatcher training, hospital availability,



radio communications network, going to the 800 trunk, what is the impact going to be. We talked about multiple data terminals in the system. Do we need those. We talked about ASL necessity. I think we ought to discuss those.

MR. THOMAS: That should be -- that catchall bunch maybe ought to be in its own meeting.

MR. DRAKE: Right. I don't think it will take a whole meeting, something we should get past because that is something we have to make a recommendation to the county.

MR. ROBEDEAU: May I make a suggestion that we review the data, take that category Thursday, along with any questions of Bill on the data and any questions on anything that might be provided by PAPA, if they wish to participate, and then a week from today start with 5.1, two, and three.

MR. DRAKE: Okay.

MR. ROBEDEAU: Because those, the ones you just discussed, are pretty easy. Disaster response I think is going to be



primarily exactly as it is now.

MR. DRAKE: So for the meeting on Tuesday, we're going to talk about personnel. Is that the meeting we want to invite the respective paramedics to as well and the union, too, to talk about paramedic concerns, talking about personnel?

MR. KILMER: Who does Mr. McLean work for?

MR. SKEEN: He works part time for us. He's going to school, working as --

MR. LAUER: Nursing school.

MR. SKEEN: Nursing school.

MR. KILMER: I think it's pretty important that invitation be extended to him personally by somebody at Buck, today if possible, so he'll have a chance to be here on Thursday. Apparently there wasn't any formal notice.

MR. DRAKE: On Tuesday, a week from today.

MR. ROBEDEAU: Bill, did you send this to him? You said you sent --

MR. COLLINS: Isn't that the one we sent to everybody?

MR. ROBEDEAU: You said you had 120 people on your mailing list.
MR. COLLINS: Yes.
MR. THOMAS: I think at the next meeting, somebody could come with a proposed agenda for all the rest of the meetings that identifies at this point the proposed topics for them. And, Bill, maybe you can send out, I know it's a lot of mailings, but another list so people know specifically when that is.
MR. COLLINS: Didn't we do that now?
MR. THOMAS: No. They have that. But they don't know the topics.
MR. COLLINS: No. We just went through identifying groups of topics. Why don't we come up with dates and send them out. There's no sense of waiting, is there?
MR. THOMAS: No.
MR. COLLINS: I didn't hear anybody suggesting doing it in a different manner.
MR. THOMAS: All right.
MR. STEINMAN: What about Trace's suggestion about doing a side-by-side



comparison?
MR. COLLINS: I think people should do that, they need to look at this, for each of these topics, know what's in at least the two proposed plans and whatever else is in their mind that they think needs to be looked at in that. Otherwise, if both of the plans have left something out and you recognize it, then that needs to be added in there for consideration.
MR. STEINMAN: Do we want to do the subcommittee approach like Mark said or everybody do it themselves? Or let Trace do it, since it's his suggestion.
MR. DRAKE: I vote for Trace doing it since it was his suggestion.
MR. COLLINS: Sounds like a unanimous acclamation.
MR. LAUER: I vote he not be allowed to delegate that.
MR. SKEEN: I'll tell you what, between Mark and I -- and he whispered to me a minute ago, he really hoped he would be appointed to this -- between the two of us --



MR. DRAKE: I did not, for the record.
MR. SKEEN: My suggestion, since we have a week, to get that faxed out in advance, to make sure the conclusions that are drawn from that and the bullets are consistent with what you had intended and also to Gary, to make sure they're consistent there, so we're not misrepresenting the position.
MR. COLLINS: I think you'll have to look at the plan document, then you'll have to look at both documents' preceding information around that area, both the proposed ordinance and planning report, to see if there's anything in there that adds to it.
MR. SKEEN: I would suggest -- and I thought actually John did a very good job Friday in stating up front the reason they didn't talk about first responders in there is because it doesn't call for it in the state plan.
My suggestion, I think the state screwed up by not including that because



it's a very key, integral component, and I would suggest we keep that in here for the discussion part of this.
MR. THOMAS: As I understand it, if next Tuesday you're going to be discussing whatever is 5.1, two, and three, the three groups that you want to be sure know about that are PAPA, the MAB, and the physician supervisor group, because they involve both paramedic and medical issues.
MR. DRAKE: Well, also and the paramedics' groups, either PAPA and/or the unions.
MR. THOMAS: The unions.
MR. DRAKE: Right. The ATU, they have representatives at the MAB, and I think they should be invited to speak here as well and list out the concerns and issues they feel as part of this process goes and the impact on the paramedics from their standpoint.
MR. ROBEDEAU: So that's 4-20. Right?
MR. THOMAS: Yes.
MR. ROBEDEAU: And then 5.4 through



eight is 4-22? Is that correct?
MR. COLLINS: Okay.
MR. SKEEN: That again would have -- we're talking about having them come back for that, the physician supervisors come back on 4-22?
MR. LAUER: You'd think they'd want to be there.
MR. KILMER: Inviting them back.
MR. LAUER: It's a pretty ambitious plan here because it took the MAB about eight months to discuss that one item.
MR. THOMAS: But a lot of the discussion --
MR. ROBEDEAU: The consensus was last time, we don't have eight months, Randy.
MR. COLLINS: The medical supervision issue?
MR. ROBEDEAU: We have eight meetings, period.
MR. THOMAS: You could do that, or if you don't want to have them come twice in one week, you could do that one the following Tuesday and put, say, rates in next Thursday.



MR. DRAKE: Why don't we invite them to the meeting on medical supervision, and of course invite them to the other meetings as they are, tell them what it's about.
MR. THOMAS: That's a good idea.
MR. COLLINS: What's the dates now?
MR. ROBEDEAU: 4-20 for 5.1, two, and three.
MR. COLLINS: Rates are going to be 4 what?
MR. SKEEN: 27.
MR. ROBEDEAU: 4-27 would then be 6.1, .2.
MR. COLLINS: 4-29.
MR. THOMAS: Provider selection.
MR. SKEEN: I wonder if rates needs to come behind provider selection.
MR. THOMAS: That would be fine.
MR. SKEEN: I think that might be more appropriate.
MR. COLLINS: I think you guys may want to discuss more about rates than in the plan. If you've read the plan, you'll notice there is very little in the plan about rates.



MR. KILMER: Rates, you'll talk about costs and rates together, and that should come before provider selection, I think, because the issue of rates and costs and duplication and effect on costs and rates that Mr. Collins is suggesting may exist, you know, to the extent that they exist, influences other provider-selection issues.
MR. THOMAS: I think that's right. It's a smaller piece of the larger issue.
MR. SKEEN: So hit that on the 27th and then have to come back to it, get rates on the 27th? Pete?
MR. COLLINS: Wait. Cost of rates on the 27th?

MR. ROBEDEAU: Rates on the 27th, provider selection on the 29th. That leaves us two open meetings that we can push things to if we have to.
MR. KILMER: You can use to fine-tune, because other issues will come up.
MR. ROBEDEAU: May 4th and May 6th and that's it.
MR. THOMAS: Mark has some issues on



6.4, five, and six he wants to discuss.
MR. COLLINS: We're going to do that Tuesday.
MR. KILMER: I would suggest you not give up on the May 11th and May 13th meetings, because even though you may not be able to get information from those meetings to the MAB with the one-week deadline that Trace talked about, the fact is that there can be fine-tuning, that can be presented on very short notice, and those two extra meetings are likely to be the one where a whole bunch of things come together and the bigger picture is seen and its complexity and the interrelationships is going to be addressed.
MR. THOMAS: I agree. You're going to need those, plus some of these topics you cannot finish. So you have those meetings open to finish them up.
MR. ROBEDEAU: They can be carried over.
MR. COLLINS: We'll call that follow-up, prior topics.
MR. ROBEDEAU: Can be followed up at



any meeting.
MR. KILMER: I think it's pretty clear that this is a tentative agenda; that, you know, we're not locked into this thing in some legal sense that we can't move it around.
MR. COLLINS: Some of this is stuff out of the plan. It's what you asked for. Some of it has supporting documents, some of it does not.
MR. LAUER: This isn't in the plan now.
MR. COLLINS: I was asked to produce what I had.
MR. SKEEN: Pete, you're going to issue the invitations for people?
MR. KILMER: Pete's going to do that.
MR. ROBEDEAU: I can, yes.
MR. KILMER: Pete is the chairman.
(Discussion off the record.)
MR. THOMAS: We're off the record.
(Discussion off the record.)
MR. KILMER: On the record here. I want to pin this down.
I think the board needs to know that



this is the information that you have submitted in response to the board's inquiry for all your data and analysis contained in Pete Robedeau's letter to you.
MR. COLLINS: Right. Most of what Pete asked me for in the letter doesn't exist.
MR. KILMER: Are you going to return something that identifies it doesn't exist?
MR. COLLINS: Yes.
MR. KILMER: What I'd like to have, then, is have this lady mark these two documents. The Exhibit 1 will be draft 3/18/93 at the top, and the other one will be the tables, beginning table4.XLS, and put a couple of exhibit numbers on those. And those are the two documents that Mr. Collins has produced.
(EXHIBITS NOS. 1-2
were marked for identification.)
MR. COLLINS: I did mention earlier, the detail of the cost by company I did not bring because we had said we would not look



at that. That is the only thing that I guess could have been asked for that is not here.
MR. KILMER: Thanks.
MR. ROBEDEAU: Okay. Trace and Mark going to do a side-by-side comparison and get it out this afternoon?
MR. SKEEN: Of 5.1, two, and three.
MR. KILMER: This afternoon. Right?
MR. SKEEN: I would think we could have that actually before Thursday.
MR. DRAKE: No problem.
MR. KILMER: That he will delegate.
MR. DRAKE: We'll talk about it, Trace.
MR. ROBEDEAU: Is there anything else? Okay. Then we're adjourned.
(Discussion off the record.)
MR. KILMER: Let's go on the record.
There is one additional document that will be Exhibit 3, and that is at the top, demand summary.
(EXHIBIT NO. 3
was marked for identification.)
(PROCEEDINGS ADJOURNED)



EXHIBIT INDEX



(Original exhibit attached to original transcript.)



CERTIFICATE

I, ROBIN L. NODLAND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.
Witness my hand at Portland, Oregon, this 15th day of April, 1993.

Oregon CSR No. 90-0056

BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS
Thursday, April 15, 1993
9:05 o'clock a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Barry Doherty, CARE Ambulance
Mr. Thomas Steinman, Portland Fire Bureau
Mr. David Phillips, Gresham Fire Department

* * *



APPEARANCES

ALSO PRESENT:

Mr. William Collins
Mr. Jeffrey Kilmer
Mr. Christopher Thomas
Ms. Trude Scheidleman
Mr. Randy Lauer
Ms. Lynn Bonner
Mr. Steven Moskowitz
Mr. Knute Eie

* * *



PROCEEDINGS

MR. ROBEDEAU: Before we do anything else, up here we have four handouts. One is the minutes that were done -- and speaking of that, Chris is going to do the minutes until Steve gets here, Chris Thomas.

One is the minutes, one is the statements that Jeff made at the last meeting. I had been asked for a copy of the request for documents and the letter to Gary McLean, and there's the last handout. There's a letter to Bill Collins. There's the request for documents, the letter to Gary McLean. The thing that Bill may not have is a memo to me from my dispatch supervisors about how the EMP plan was prepared and what was going to happen with it. So if anybody didn't get these, they're up here and you need to get them.

Has everybody had a chance to read the minutes? Are there any corrections or additions or anything?

(Pause.)

MR. ROBEDEAU: Okay, the minutes then stand. Do I get a motion for approval of the minutes? Somebody?



MR. SKEEN: So moved.

MR. LAUER: Second.

MR. ROBEDEAU: In favor? Opposed? Okay. We have a lot to go through in a very short period of time. The one thing we have done is put together a list of questions. We faxed these over to Bill yesterday so that there are no surprises.

MR. SKEEN: Which list are you looking at?

MR. ROBEDEAU: This is the list of the agenda, proposed agenda, for the provider board. Did you get that, Trace?

MR. SKEEN: April 15th?

MR. ROBEDEAU: Right, okay. Well, this includes more than April 15th, and anybody who has any additions or changes or anything you want to do -- it has April 15th, it has April 20th, on page five is April 22nd. On page six is April 29th, and there's May 4th, May 6th, May 11th and May 13th which finishes the process.

So this runs us straight through to the end of the process. We included all of the remainder of May in here. If everybody is finished prior to that, those last couple



meetings don't need to take place, but I thought it was best to include them because there is an awful lot of ground we need to cover, and I think those meetings will probably have to be. Do you want a minute to review these?

MR. DRAKE: If we could, Pete, just take a minute.

MR. ROBEDEAU: Why don't we take a minute and everybody just review the --

MR. DRAKE: This was faxed over to Bill?

MR. ROBEDEAU: Yesterday.

MR. DRAKE: Yesterday? Okay.

You might want to take some sort of attendance to know who is here and who is not here.

MR. ROBEDEAU: It doesn't appear there's any representation from the commissioner's office or from PAPA here, MAB or the physicians supervisors group.

MR. DRAKE: Are you going to start an attendance list, Pete?

MR. KILMER: I have one started here.

(Pause.)

MR. ROBEDEAU: Is everybody finished or do you need some more time? Are you okay? Why



don't we get started here?

One thing I wondered about, Trace Skeen and Mark Drake were going to do a side-by-side comparison with the PAPA plan and --

MR. SKEEN: That's just dang near finished.

MR. ROBEDEAU: It's just dang near finished?

MR. SKEEN: Dang near finished.

MR. ROBEDEAU: I won't say we're not going to do that today.

MR. COLLINS: Can we enter that in the minutes?

MR. SKEEN: I think there was some discussion that was going to be a Tuesday topic rather than a Thursday topic. I committed to PAPA that we'd run it past them before we made a formal submission here to make sure we represented them appropriately.

MR. ROBEDEAU: Where is PAPA?

MR. SKEEN: I don't know. They don't work for us.

MR. PHILLIPS: For today it should be pretty easy to do. We can do it ourselves. There's about a paragraph each for each topic.



MR. ROBEDEAU: Today we should get more of an understanding of what the county's proposal is.

MR. COLLINS: We sent the letter out on Tuesday to all the interested parties with the topics that were identified in the minutes, so that's already gone out to everybody.

MR. KILMER: Do you have a fax number for PAPA?

MR. COLLINS: No.

MR. ROBEDEAU: Their list was blank. The fax numbers for everybody that was here last time are on the -- they were in the back of the minutes, but --

MR. DRAKE: Are the minutes here?

MR. ROBEDEAU: No. This isn't the minutes.

MR. PHILLIPS: They're in the back of the minutes.
MR. ROBEDEAU: They are?
MR. DRAKE: Yeah, they are.
MR. ROBEDEAU: All the fax numbers are in the back of the minutes.
MR. SKEEN: As it relates to that side-by-side, I'll give my best shot at that to

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get that out tomorrow afternoon. Then everybody can put their input into that for the changes prior to the meeting on Tuesday.
MR. ROBEDEAU: I'd appreciate your getting it out as early as you can to everybody so there's no surprises. It's an open process, and I really don't want anybody to feel like they've been ambushed.
MR. DRAKE: And I think, too, though, Trace, wouldn't you agree, that PAPA has a chance to come to the provider committee and protest or comment on anything that is raised on the side-by-side assessment. Anybody does.
MR. SKEEN: All I'd like to do is make sure we're working with accurate information. I'd rather deal with it up front than have it contested in a formal presentation to the commission that you might make on behalf of the provider.
MR. ROBEDEAU: Okay, that's fine. For today, the first portion is an hour and 45 minutes on the schedule and it's mostly asking for some questions. We can go past 11:00 o'clock, or at least I can if anybody else is able to. 9:00 to 11:00 is the schedule, but I am

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committed to taking whatever time we need to. It's just a matter of what everybody else's schedules look like.
MR. LAUER: Before we get started, I'd like to comment on the detailed agenda that you proposed. I think it's real useful. You worked it out real well. And for this meeting I think it's pretty much what we discussed, that we're going to look at the data and discuss that in some depth.
For the subsequent meetings beginning April 20th, however, it's my understanding that we were going to use as a road map the different parts of the state statutes as a planning process and discuss them, discuss the application of both plans as it relates to those specific parts of the statute and to discuss anything that may not be in either plan that we think should apply. Your agenda, however, indicates specific review of Bill's plan, and I think that wasn't the way I understood it.
MR. DRAKE: It probably should say Collins' plan slash PAPA plan.
MR. LAUER: Or actually anything that's not either plan. It's more of a general review.

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MR. KILMER: Can I comment on this? I was the one that drafted this up. We met with Steve afterwards and went through carefully his minutes, his notes of what was finally agreed upon. There was discussion, Randy, that you talked about about looking at the state plan. Bill made reference to his own plan in the outline and scheduled his own outline. And ultimately when we broke them out into topics pursuant to what Chris Thomas recommended, he specifically mentioned these sections, and that was what had ultimately been agreed upon.
Now, I think that what that reflected was the initial decision that was made by this board to use the Collins plan as the outline against which everything was going to be compared. This was never an intent to suggest that because the Collins plan happened to identify all of the discussion that nothing else would be discussed, and the PAPA plan and this man's and everybody else's ideas can't be commented upon in the context of the level of care.
So nobody -- there's no effort on our part to exclude the concerns you're suggesting

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ought to be covered. This just was the agreed outline that I thought had emerged, and I think Chris and Steve did, as well.
MR. LAUER: I think we had agreed that Bill's -- the outline in Bill's plan mirrored the outline of the state statute.
MR. DRAKE: Right.
MR. COLLINS: We're just using the numbering scheme off of this plan.
MR. KILMER: So everybody was looking at the same spot on the same page at the start of the discussion.
MR. LAUER: I wanted to bring that up because I think there are things that neither plan administers this and that we need to talk about it.
MR. ROBEDEAU: Maybe we could put that in the agenda.
MR. LAUER: Sure, sure.
MR. ROBEDEAU: This is one of the reasons that we had included -- even though we had kind of assumed we would be done prior to May 13th, we included May 11th and 13th to cover everything and that was all we had. I think Trace wanted to do an initial rough draft on our

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report handed in on the 6th, which was fine.
But then we have the 11th and 13th to finish everything. We're on a real fast time track. And my notes show 5-1, 5-2 and 5-3 for the 20th. That was what we agreed to be discussing. That's using the Collins plan.
MR. LAUER: Okay.
MR. DRAKE: I think it's important to note, Pete, that there are -- the state just simply requires that you address these system elements, and that other counties have gone beyond that. And you ask what they feel are EMS system elements, and I think that's what we kind of as a consensus group agree needs to occur.
I don't think everyone has disagreed with that, so we need to look at these other system elements that we put in there, and now is the time to do the things that need to be addressed.
MR. PHILLIPS: Your concern is that people just don't feel like the door is slammed in their face, because it reads our agenda is to look at section 5.4 of Collins plan.
MR. LAUER: I wanted to make sure that it was --

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MR. PHILLIPS: Maybe we should say what the issue of 5.4 covers. We're going to discuss that topic, which is basically what you need, but it doesn't say that.
MR. KILMER: In every case I meant to include that it discussed 5.2 level of care.
MR. ROBEDEAU: Let's go on. We're already 20 minutes into the meeting. Is it all ready, Bill? I just read the questions into the record and you can respond.
MR. COLLINS: You want to read all of these questions?
MR. ROBEDEAU: One at a time.
What kind of system do you envision? Can that be accomplished with the current system? With multiple providers of any part of the system?
MR. COLLINS: How do you want to do this? A lot of this is in the plan. I can just reiterate it. I mean --
MR. DRAKE: You can refer to the plan, however you want to do it.
MR. COLLINS: The system that we're recommending, which we think is supported by the data analysis that was done and the conclusions

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we reached, is a tiered system and a single fire medic provider and a single contract ambulance provider.
The reason that basically we reached and tried to answer the question that has been -- seems to be foremost in this process from as long as I can remember, even when I worked up at OHSU, is anything to support or not support a multiple

provider system, a multiple ASA versus a single ASA.

And in meeting with people around -- we had some groups that met to look at work load and to look at cost and try to see how we should approach that. And in reviewing that it was -- we chose the methodology of trying to put together a model of a single ASA and look and see what the demand analysis would be for that, how did that match with what we have now, look at the cost as reported by the providers and see what portions of those costs variables according to the model could be put up, and see if there was a major reason financially to do it and to identify any other reasons that anybody brought up.

And what we gathered and what we looked at indicate there's probably a substantial



financial difference in running a single ASA versus a multiple ASA. That doesn't really speak to how many entities are involved in the ASA, but right now in theory we operate sort of a three ASA system, even though we have quite a bit of crossover because of the response time requirements of the county. But that's in general.

What we're running is a three ASA system, so we're looking at it to see what would happen if we just kind of put it altogether. That's kind of what the findings in the report show.

I guess the second part of this, can this be accomplished with the current system, I'm not sure what that means. If the question we're answering is should you have one ASA or more than one ASA, and we're saying it looks like from our data that you should only have one ASA, that sort of precludes then can you accomplish it in another way.

I'm not quite sure what you mean by that. How many providers you have within the ASA structure that's finally developed I think is still open for people to discuss. It's a matter



of showing that that's not going to be detrimental to however the system design is. So there's kind of two levels to that ASA.

I mean, in my mind an ASA is the area served by the plan. If you're going to have two of them then you draw a line and you have two of them. If you have one of them you go out in the county and have a single ASA.

MR. PHILLIPS: Under a tiered system, how many ALS transporting units do you foresee that we would need and how many BLS do you foresee we would need?

MR. COLLINS: The numbers of units will depend on the protocols that are described to say who transports -- we don't have any protocols to the plan. This is a plan, not an implementation document, and a medical director or medical input would really have to be the determinant on how many would be transporting. You can -- there are tiered systems.

For instance, when I talked to the people at King County -- that's not Seattle; those two are different systems. They all call them Medic 1, but those are two totally separate systems. The King County side of it, the Medic 1



units transport about 16 percent of the population. Now, in Seattle they do more, but Seattle couldn't tell me how many.

MR. KILMER: Their data is just as good as ours.

MR. PHILLIPS: Is this something we would be willing to discuss? These are the kind of recommendations that this board has to make, I think.

MR. COLLINS: In order to determine how many -- I mean, you can look at the total demand. The total demand isn't going to change. Then you have to decide on how you're going to split it up and therefore how many units you would need.

King County and Seattle, if you put them altogether, I think the last time I counted there were ten Medic 1 units. There could be more. They are a tax supported system and they go before their county boards to get permission to put on or take off units, so they don't operate like we do here where the companies --

MR. LAUER: Do you know how many private ALS ambulances they have on their system, as well?

MR. COLLINS: No, I don't.



MR. ROBEDEAU: Bill, I have an observation. The plan that you've produced makes financial assumptions which now, if I understand what you're saying, is you really don't have any basis for those financial assumptions because you don't know how many units you're going to require. I've seen savings of something like $3 million a year in the plan.

MR. COLLINS: We looked first at the question, that is, of one ASA versus multiple ASA's. The assumptions I made -- first of all, the financial data they used for the financial part of this was the data that I got from the providers. There's no data in here that was generated by our office out of independent means. We said -- the group that met said this looks like what we ought to collect, and that's what we collected. Then we just looked at, okay, if you're having one instead of three, we looked at demand analysis and the cost identified -- I'd have to look at the page that's got that.

But there's paramedic salaries and billing and collecting and all the different categories, and we just looked at that just to answer that one question. And I think, you know,



we can look at the data and you can decide whether you like it or not, but I think it answers that question.

The number of -- the split of the number of units you have is another aspect of this that you'd have to do after you've decided what the protocols are going to be. And we were proposing a tiered system because we believe it makes better use of the existing resources. It gives a more stable long-range funding, and it matches the resource requirements to the patient.

I mean, right now we send everybody the same thing, you know. A twisted ankle gets exactly the same response as a cardiac arrest. Now, by the time you get there, then things change. But they send everybody, and the assumption is every call, with the exception of the ones that are obviously triage, out in the front. But we pretty much send everything to every call. The idea is to try to, you know, match up resources better than what we're doing now.

MR. KILMER: Bill, in the savings that you are calculating then, what of those savings come from reduction of three providers to one



provider, and what of those savings come from your assumptions about the changes that will influence your system that will diminish the cost of the private component of this because you're better able to avoid sending everyone to everything?

MR. COLLINS: There's two -- let me find the right page. There's kind of two categories in that -- if you'll look at that first. The savings that are identified on the demand side going from our current deployment to a single deployment are identified actually only as the paramedic unit hour savings. I have to find the right part of it here.

MR. SKEEN: While you're turning to that, it seems like there's another issue that would come into this calculation individually. That would be the assumption that you're still working on, an independent 90 percent liability response and --

MR. COLLINS: We are for part of it.

MR. SKEEN: That would be county wide as it is now?

MR. COLLINS: No. Actually the response time, if you look in here, there are two

different response times. The fire medic response times are eight minutes. The contract times are -- what are they -- ten, twelve minutes.

MR. SKEEN: So your system data is based solely on the option one that you put forward?

MR. COLLINS: The system findings plan is based on the one we're currently doing.

MR. LAUER: I was part of that group and I remember it pretty clearly. It had nothing to do with multiple providers.

MR. COLLINS: No, no, no.

MR. LAUER: We didn't look at that at all. How the fire medic system would play into this was really not even on the table.

MR. SKEEN: So it was strictly an eight minute, 90 percent response for the number of units?

MR. LAUER: If you raised the ASA lines, those boundaries, and you had a single provider, could you service that system with more or less or the same amount of unit hours we currently deploy? The difficulty that came into play was an apples and oranges comparison because we were looking at a 9-1-1 system; whereas with our



current system, it was impossible to break out which of the currently deployed unit hours were deployed only for 9-1-1 calls. So the data is not going to be based on conclusions. It led to some assumptions. That's about it.

MR. KILMER: Are you saying that assumption was a dedicated system? You made your analysis in the group based on a dedicated system?

MR. LAUER: Yes, right.

MR. ROBEDEAU: That assumption did not take geographic fix into consideration. The assumption only took raw calls and raw unit hours.

MR. DRAKE: That's right.

MR. LAUER: The program you then run --

MR. COLLINS: We sort of tried to validate that to some extent at this point to see. But when we looked at the demand, the current demand, unit hour demand was --

MR. ROBEDEAU: I think I'm going to interject a little bit here. I think that comes in later on, so why don't we finish here and move on, because I know question 22 is actually asking for that starburst study that you had talked



about.

MR. COLLINS: Okay. What do you want me to do? I mean --

MR. ROBEDEAU: Do you want to take question 22 now, take it out of order?

MR. COLLINS: No, no. Let's go down your list.

MR. LAUER: Just with question one though, is this a fair statement that the data that you prepared looked at the existing systems in terms of what kind of providers, looked at a single private provider, didn't look at a multiple provider within a single ASA?

MR. KILMER: You're talking about his plan?

MR. LAUER: Yes.

MR. COLLINS: Which part of it?

MR. LAUER: The option that you included as your option number one as a tiered system was not -- the data didn't take that into consideration?

MR. COLLINS: No, no.

MR. LAUER: Okay.

MR. COLLINS: The bulk of the data that was applied to this was to look at the current



system versus -- the current three ASA versus the one ASA to see if there was any reason to move. I mean, that was kind of the whole issue that had been before us for years. People would say that there needs to be one ASA, and then you'd say why, and then they go, "Why? Well, God spoke to me," or whatever. Nobody will give any reason one way or the other. So that is the question that we were trying to look at at the beginning of the process, so that would be fair to say.

MR. KILMER: So the bottom line is you did not study the relative cost of one ASA with multiple providers as opposed to one ASA with one provider?

MR. COLLINS: I don't know if that's true. Let's go through the data and see if that -- because we looked at -- we currently have a -- well, we have a multiple ASA with multiple providers, so I don't know. You'd have to -- we did not -- we didn't create a model that was a single ASA with multiple providers. I don't think we did that.

MR. KILMER: So you didn't study whether you could accomplish all of the purposes of a



single ASA with multiple providers with them simply providing fewer ambulances and coordinating the response in a single dispatch system?

MR. COLLINS: Well, yeah, I think we did to some extent. I mean, the demand analysis does not -- it's not going to identify what you need, whether you need one or two or three or ten providers. It's just looking at the number of calls you have and the response time and trying to make sure you met the geographic fix. And then you apply a schedule to that, and that gives you the number of unit hours you need. It doesn't say who applies the unit hours.

MR. KILMER: Right, right.

MR. COLLINS: The only other things we looked at was some of the costs that had been identified by the providers being more than one provider and looking -- and making some very broad assumptions, not detailed assumptions but some general assumptions of the -- of having more than one organization versus less than one.

MR. KILMER: And where is that analysis? Did you write that down or did you reflect it in your report?



MR. COLLINS: We just identified it in the plan. When we get to that question I'll show you. This is not a step by -- we do not try to do a step by step of how many people will you actually need to do the billing, this sort of thing.

MR. KILMER: Except for what's in the plan, you have no other data identifying your analysis of that point?

MR. COLLINS: No.

MR. LAUER: In our analysis we did look just at 9-1-1 calls and how many unit hours you would need to deploy to that. I think it was a very good exercise as an exercise this county would have to do to develop their system. The status plan was done by representatives from all of the companies who do that all of the time.

MR. COLLINS: Right.

MR. LAUER: And we concluded that that system would need "X" number of unit hours by hours of the day, days of the week, etc., and I personally think that data is valid. It's good data, and we ought to keep that in mind.

MR. DRAKE: But that was just for 9-1-1 calls. It doesn't take into account those units



are used for nonemergency and interfacility --

MR. LAUER: From a comparison standpoint, Mark, it may be a little bit vague, but you're just looking at this as a system we want or we wanted to study and how many unit hours you'd need to deploy to that system. And you're not comparing it to what's out there now, but I think if you're just comparing it to that aspect I think that's a very good analysis.

MR. DOHERTY: Did I miss some meetings?

MR. LAUER: I don't know.

MR. DOHERTY: Because I think we realize as we're going through that it is important to supply the data and then analyze what that was and what it meant, and I don't remember any meeting where we analyzed the geography data.

MR. COLLINS: No. We didn't bring back

-- what I did was use the program we have, which I can't give you a printout because we can't make it print, to see if when we did the scheduling we used your schedule and applied it and said, "Okay, here is the units. We'll need to see if those met the geographical requirements. Is there enough in there." And by just doing each one of them on whatever the level was, whatever

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the lowest level was, eight, nine, it covers the county. It's kind of like our level eight.

I think after doing this people wonder why we're at level eight. That seems to be the number with the county, also. Maybe that's why it showed up back wherever.

MR. LAUER: We looked at the volume and how many unit hours would need to be produced to cover the volume.

MR. DRAKE: But, Randy, to sit down and discuss and analyze that to see if it was accurate, you're going to kind of be making an assumption to say this is accurate. I don't recall that we sat down and poured through the data and said, "That is accurate and it does meet the demand." I've never done that.

MR. LAUER: We did, I think, agree this would be a unit hour production plan we would put into place if we were tasked with stacking that kind of system. We also had a lot of discussion centered around the fact of that as being the start-up point, to get into any system would then be further fine-tuned because you can't really validate it until you try it.

MR. DOHERTY: I think also what we ended

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up doing was assuming that this was a system that already had some fine-tuning and that we were comparing, you know, the work load and the time associated with the work load compared to other systems that we learned about in school to try to develop these plans.

And I don't think that the Multnomah County system and the time it takes to run a call or the average time our units are on assignment or the amount of time that they're at the hospital before they're available to run another call and those type of things are comparable. I think it's higher, and that kind of skews the numbers.

So I thought as the work group was going that that particular work group, the data from it, you know, I figured we had another four or five meetings to go before we were really able to say how many units we needed in Multnomah County by hour of day, day of week to start the plan, to ensure we were going to be able to meet those response times.

MR. DRAKE: Randy, there were other issues raised that we've never answered in that process.

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MR. ROBEDEAU: What Mark and Barry are saying is exactly what Dave Higginbotham told me. I don't know if you know, but yesterday was Dave's last day. He took a job with a service on the coast.

But that's what he told me. He said all of sudden this just stopped. He said we were still scheduled for meetings, and all of a sudden there were no more meetings, and here is data coming out and no one was ready to make any assumptions. Nobody knew what was happening, that all of a sudden the process just ended for no apparent reason.

MR. LAUER: I think we arrived at that kind of data --

MR. DOHERTY: Based on some assumptions we did, and I --

MR. SKEEN: Without geographical considerations.

MR. DOHERTY: One without geographical considerations. And at least it's my opinion that the numbers we were coming up with did not take into recognition what the difference in Multnomah County may be on an average length of call versus other systems.

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MR. DRAKE: And the third thing we didn't take into consideration -- my understanding is we didn't take into consideration the actual scheduling of the units. Because it's one thing to say you could meet the unit demand with "X" number of unit hours, but then you have to plug it back into a schedule and then --

MR. LAUER: We did that.

MR. COLLINS: We did not look at purported differences between length of time, say, in this system and another system, because we started off the process and we made the assumption up front the calls for an hour. We did that purposely because there's no way to do it if you don't make some assumptions to start with.

Also, this is not intended to be the actual deployment schedule to be used by any one company. That was to look to see if the magnitude of the differences was worth paying any attention to or not. I mean, that was -- it was not to come up with, "Here is an implementation system status plan, take this and plug it in and go hire the people."

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And I kind of reiterate what I was saying. The idea of this exercise was to look to see if there was any basis to move ahead with answering the question of one ASA versus multiple ASA's.

Now we did have an issue that the only way that -- and correct me if I'm wrong, Randy -- the only way we felt we could deal with it was to set it aside, does the current deployment schedule include hours for non 9-1-1 service. However, it does not include all the hours for 9-1-1 service. I mean, we could have done it if we had 100 percent of it, but we didn't. We had sort of an unknown amount. We knew the deployment was greater than 9-1-1 calls but less than all the calls.

So we made that assumption also at the beginning that we would only look at 9-1-1. You know, I'd certainly be the first to admit that the unit hour savings are moving from a kind of semi-dedicated, undedicated, semi -- whatever you wanted to call it -- to a system looking at only 9-1-1, because there was no way to look at the other one.

MR. ROBEDEAU: Bill, did your analysis

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identify where any of the extra unit hours might be?

MR. COLLINS: No. If you look at the unit hours, I mean, you can make -- I guess you could draw two assumptions from -- since we're into that, the number of hours that we identified as being saved was 39,000 hours. So we went from 125,000 to 86,000. Some of those -- in fact, I can't even say which one it is, but some of those are because there are three ambulance companies and there are more hours deployed because of the additional boundaries. And some of those are because there are more hours deployed in order to run the nonemergency calls.

Now, we don't -- this did not -- there was no way to say how many fit into what. But those two things would have to comprise the difference because we're using the same 9-1-1 base, and I don't think -- you know, I guess the third thing is -- well, no. That's before we did the scheduling, so that that was the number, like when you did the schedule that you worked off the wrong number.

So it's those two things, unless I'm missing something, unless there's some other

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reason you would show that number of savings.

MR. ROBEDEAU: Did you do anything in your analysis to determine which provider may be providing too many hours and which providers --

MR. COLLINS: No.

MR. ROBEDEAU: In other words, which provider was efficient and which --

MR. LAUER: That was impossible to do,

Pete. I think for the sake of comparing the current system as opposed to the 9-1-1 system, we can't do that with the current data we have. The point I was moving to, I think it would be very interesting and very revealing if we looked at the initial system status plan. The unit hour deployment that we arrived at from the 9-1-1 only system has "X" number of hours in it, compare the provider options, whether you have a single provider versus a tiered system, and how many hours would be necessary in each of those systems to match the system status plan. That would be a very interesting exercise.

MR. SKEEN: Essentially you're coming up with three different system status plans. One is for time critical transports, the fire medic units. The other is for secondary stretcher

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carriers, and the third one is for the nonemergency market that appears to have been totally segmented in this process.

MR. PHILLIPS: Didn't they decide not to make that -- it's not in the plan, the nontransfers and the --

MR. SKEEN: Well, it's not in the plan.

MR. PHILLIPS: It's a factor for you.

MR. SKEEN: It's a factor for the public.

MR. LAUER: When you look at the overall cost, you've got to factor that in.

MR. SKEEN: Somebody has to be responsible for that, the whole issue with managed care. It's just the opposite.

MR. DRAKE: I think there is one other issue here, too. You mentioned two conditions. There's more hours for additional boundaries, more hours for additional calls that aren't in the system. There's also more hours that we have to put on the street to meet the levels required by the county, so we can't pull our units out to run code one calls --

MR. SKEEN: Under the option one you're talking about?

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MR. DRAKE: Right. Well, under his supervising we're doing an apples to orange comparison when you try and take the current system and try and fit it into this narrow scope here.

MR. SKEEN: What's the third one here?

MR. DRAKE: We have to put on more additional street hours because of the levels required within the county.

MR. ROBEDEAU: The county ordinance, you had to have the 50 percent rule which required two ambulances for every one needed. The county did away with that but kept an eight --

MR. COLLINS: You're right. There is some because the current system artificially stops at eight, and so even though the demand and the scheduling could be at seven or six, although that --

MR. KILMER: That would be provider number neutral, regardless of the number of providers, if you had to keep that number in the system.

MR. DRAKE: Right. But Jeff, the point is, when we make this assumption for that exercise to draft up the number of units you'd

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need for just 9-1-1 calls, we didn't base it on any minimum number of units or any of that stuff. Of course, any additional calls -- and if you wanted to look at a true cost comparison to say you as the provider now take all the provider's unit hours, and say if you were a provider you had to run all your calls under a single ASA, how many unit hours would you put on the street, that's your difference between three providers and one provider.

MR. SKEEN: You're saying complications in scheduling?

MR. DRAKE: Right. No. I mean, if you want to just do that, if you wanted to make an apples and oragnes comparison between two providers and three providers and --

MR. KILMER: We didn't do that.

MR. ROBEDEAU: Under your system we can run out of ambulances, and that's the way most single provider systems I've seen -- the longer they're out of ambulances and have nobody to respond more efficiently to the system, that's what we go for.

MR. SKEEN: You're talking about the --

MR. ROBEDEAU: Yeah.

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MR. KILMER: Which has medical consequences. I wish there was a medical person here to address this.

MR. ROBEDEAU: With the comparison we have here that Mark is getting at, he's absolutely right, and I completely missed it. This system by ordinance has built-in deficiencies I guess that are beyond the control of the provider. And what Mark I think is getting at -- and it's a good point -- is how many of the 39,000 unit hours that you're talking about are mandated by county law.

MR. DRAKE: Of the current --

MR. ROBEDEAU: Yes. The 39,000 unit hours that are excess within the system at the current time --

MR. COLLINS: It's probably very few, but I don't really have a number because the geographic fix is going to come into play when you get down to minimum units.

MR. DRAKE: To a certain degree.

MR. COLLINS: I don't want people to raise their hands and agree. If you were to pick eight and say that level eight actually represents the geographic minimum, that you just

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can't get to the rest of the county -- I mean, if that's what it is, then anything below an eight, even though that's a unit, potential unit hour savings, you're not going to realize it because you can't actually get there, you know.

Because we showed -- I think at one part in here on the demand study there's some days where the demand is like three hours. It's real low. But you can't get down that demand because that would leave two-thirds of the county totally uncovered.

MR. ROBEDEAU: Well, then the other thing that's not taken into consideration here, Bill, is a lot of unit hours that are on the street also depend on what the deployment pattern is. If you're using a 24-hour car where you take time to get out of your quarters and into your car and you're going with an eight minute response, you need actually more unit hours even though the cost of those unit hours is cheaper than if you were using a twelve-hour or eight-hour car sitting on the street corner.

MR. COLLINS: That's true.

MR. ROBEDEAU: But unit hours are more expensive.

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MR. COLLINS: Actually, the schedule we used since it was the only one that was offered up, Barry, I think it did hold on a twelve hour shift basis.

MR. DOHERTY: There were some 15.

MR. COLLINS: There were a few that were a little bit longer, but there were no 24's.

MR. LAUER: We said for this exercise we did set a maximum shift length of 15 hours.

MR. COLLINS: Something like that. The idea was to try to use 12 as kind of the rule of thumb, and then when Barry did it there were some times when we bumped it up to 13 and 14 hour shifts. But that's it. There's no 24's. We didn't look at that.

MR. ROBEDEAU: See, Bill, what I'm getting at with that, you have done all 12 hours there. We currently run two 24 cars in unit hours, but they come up double. What you've got -- you know, the system has historically done 24's. I think most everybody but us has done away with 24's. The reason I stay with two 24's is because of the way the ASA is, but it also skews the picture.

If you had to go to a single ASA and had

to do with those 24's, you would have to eliminate some of the unit hours. But you're going to put more unit hours in, especially at the north end. The north end is very difficult to change, and going to a single provider is not going to change the geographic layout of North Portland. It isn't going to change.

MR. COLLINS: When we put together the demand model we essentially did what you're saying. Because the current unit hours are just whatever was on the schedules, 24, 12, 8, whatever anybody had. And the model went to the single ASA basically on a 12 hour schedule model. So it showed -- I mean, that difference is in there, whatever it is, both coming off on one side and adding it on the other.

But we didn't -- you know, there was no way to go through and say each one of these pieces, what happened to them.

MR. KILMER: Can I ask whether, aside from what you gave us at the last meeting there, there are any other notes of the work group meetings that Randy and Barry and Mark are talking about, an analysis of that data that you used to finally arrive at the model that you just



said you used?

MR. COLLINS: Oh, there's no other analysis. I guess there's the sheets, the individual company's data that we put together like we did with the cost, although the cost stuff people asked not to see it. I don't know if anybody asked that on the other, because this was really --

MR. KILMER: Did you provide that with the --

MR. COLLINS: That's not in here. I can give you those sheets.

MR. KILMER: I wish you'd make a note to get that. The other part then is, did you take that and play games with various --

MR. COLLINS: No. I just put it together.

MR. KILMER: But you have raw notes of the various options you considered before putting the one in that you elected?

MR. COLLINS: No, no. This was not an option process. This was -- you just collect up the number of calls and then you go through -- there's different statistical inferences on each one of these, and we actually did -- which it



states in the plan -- we actually did two things. We used the current ambulance system status planning methodology, and then at one of the meetings -- when was that somebody said -- that was Praggastis who brought up that this didn't really meet the percentile analysis, so we did the same thing which was also on here.

So there really isn't -- this wasn't like a whole bunch of different guys put this together. You just sort of added them up, applied the statistics and printed them out, and then it gives a certain number of units required per hour, per day of the week.

And then one of the members of the group said he would take a shot at doing a 12 hour schedule, so he did a 12 hour schedule, and we put that in, and that identified what the total number is.

MR. DRAKE: But that was for 9-1-1 calls only.

MR. COLLINS: Hopefully I was clear in the plan. We made no attempt in here to try to figure out the non 9-1-1 part of this because we could not take the current amount and do it because we didn't have all the calls, plus the



9-1-1 calls are seen -- though I understand, you know, your comments about the larger health care system, this plan is what to do with the emergency calls. This plan is not what to do with the private business and nonemergency calls.

MR. KILMER: Here is the problem I have with the methodology you've just adopted. Number one, you have in your plan at least made it

appear that every ounce of the savings that you would get would come from the reduction of providers. The distinction between reduction of providers and reduction of ASA's is not clear in that report.

The second is that you have not identified or apparently made any effort to identify what really are the differences between reduction of providers and reduction of ASA's so that you can dispatch as a single system.

But the third is a large amount of this cost reduction really results from a cost shift from the emergency side to the nonemergency side. What you have ignored is that you are going to administer the cost of the emergency component, because many cost shifts are going to occur away from emergency and toward private that are going



to require an increase in the rates for emergency calls only because these units are going to be used less often to generate revenue.

And so your methodology ignores the efficiency and the cost benefit on the emergency side. You have assumed that that cost will remain the same and will only be deducted from the changes that you're proposing and, in fact, that doesn't work. You're going to increase the cost of the system if you have a dedicated system. And Pete tells me there are studies on this, and I'm wondering whether you considered that in your cost savings analysis because that's a provider number neutral.

MR. COLLINS: I hear what you're saying because of the difference of the number of units. That's one of the parts that we have problems with about the nonemergency part of it. If the current plan -- if the current deployment plans were in place based on the 9-1-1 business and any other business that was run was sort of using excess availability and you could really -- you felt that was sound, then I might be able to, you know, might follow what you're saying.

But that doesn't seem to be the case



when you look at the difference in the number of hours. There's no hours on the street. They're all there for 9-1-1. If they are, then the utilization is very, very low.

MR. LAUER: We didn't take it to the end. What we did -- and Mark, you can relate to this because you developed the number of system status plans in questions for proposals. You're given a geographic area, "X" number of calls identified by day of the week and hour of the day, how many unit hours would you have to pay to deploy, what would your staffing schedule be. And that's information that you use to arrive at what it's going to cost you to service that system. That's what we did using Multnomah County as a whole.

9-1-1 calls were the base of those calls. If you wanted to make an accurate comparison you would do the same thing taking the three existing ASA's and doing that same exercise for each of those three ASA's, adding all those hours together, and compare it to the single ASA model. We didn't want do that because we ran out of time.

MR. KILMER: Well, you should have a



third analysis and that is: Can you do what Bill wants to do, which is to reduce the whole number of units in the system and maintain multiple providers of the optimum number of units?

MR. ROBEDEAU: I think the other thing that should be put in here is -- my question, Bill, is: Did you do any analysis to find out from the providers how many non 9-1-1 calls each ALS unit does a month or week?

MR. DOHERTY: We provided that information and that was -- I'm sorry to interrupt you, Pete, but I want to know the difference between that data and the savings in unit hours. Is it a similar percentage?

MR. COLLINS: No. If you remember the beginning of this when we first laid out the unit hours, we had that included -- we were trying to

look at BOEC data, total provider data, and we decided we couldn't make that analysis, that that was not going to work.

MR. DOHERTY: Well, that's given what our project was.

MR. COLLINS: Right. So all we did is what -- all that this represents is exactly what Randy said. This would be like if you were --



you know, if we were a group and some of us were going to bid on a proposal and somebody said there are 39,000 9-1-1 calls and here's the geography and we got as far as we could without actually putting the plan on the street. I mean, the next piece of this -- if this was, you know, completed this would be to put this on the street and fine-tune where the units are and maybe move some hours around, because we can't go that far. I mean, we can't actually deploy it.

MR. DOHERTY: We could have done the geography distribution. But what I'm wondering is: Is that information in the data the total number of calls that the ALS units ran compared to the 9-1-1 calls?

MR. COLLINS: That's in the first set of data that we used that we decided not to -- I think those numbers are around there. I could -- I'd have to go back and see if I still have that. We decided we weren't going to use them.

MR. DOHERTY: For that first part of what we were working on, if we were going to then take the information and compare it to the next step, then it would be important to do that. That was my assumption all along, that we weren't



going to use those calls in that process because we were just starting. That was like the first phase. Am I --

MR. COLLINS: I didn't know we were going to do any other phase. The idea was just to see what would it take to run a single 9-1-1 system.

MR. DOHERTY: If we were going to take a look at if you would do a single ASA with multiple providers providing service, and I think you would have to do the next step.

MR. THOMAS: Could I ask Bill a number of questions?

MR. ROBEDEAU: Dave has some.

MR. PHILLIPS: Did your analysis tell you the maximum amount of ambulances you would need, transporting ambulances?

MR. COLLINS: Yes.

MR. PHILLIPS: Do you know what that number was?

MR. COLLINS: I have to go through and see which day is which.

MR. LAUER: We got up to 13 or 14, didn't we?

MR. DRAKE: I think 14 was the maximum.



MR. COLLINS: There's a 15.

MR. DRAKE: Based on that, there's another -- there's a couple of hours that have 15. I'd have to look at the schedule. If you -- if you just dropped those off -- 9, 10, 11, 12 -- 14, 15, 16 -- 16 ambulances at one point.

MR. PHILLIPS: So to determine how many ALS and how many secondary BLS transports with the one paramedic under your system, you would need -- you would have to decide how many of those calls were true ALS and how many were BLS and how many hours you would have to add to be able to adequately staff so that you could have 16 ambulances. But 12 or 10 would be ALS or 6 would be BLS, run ALS for BLS transport.

MR. LAUER: My point was: If you were to do a tiered system to do that 16 ambulances at that particular time of day, if you had private ambulances, my argument is you're going to need a lot more than 16 units on the street. You're going to probably need 30 units.

MR. ROBEDEAU: Not necessarily. I think the problem -- I want to get my question answered. I guess you've got 39,000 hours. If I remember reading it right, that's about a 50



percent decrease in the number of unit hours. Was there anything -- you dropped it from 120 to 80 something?

MR. COLLINS: From 125 to 86.

MR. ROBEDEAU: You dropped it a lot. Was there anything ever done --

MR. KILMER: One-third.

MR. ROBEDEAU: Was there anything ever done to try and figure out if that's really an accurate number, or are those 39,000 hours being taken up with private nonemergency business, or are those 39,000 hours being used because of mandated inefficiencies in the system? Why are those 39,000 hours there? When you have that big of a discrepancy --

See, Bill, that to me clues off that something is drastically wrong, either with the data or with something else. And I think I -- see, the assumption here says, well, then it's the providers that are drastically wrong and that's all I wanted to know.

Was there ever any follow-up to try and figure out exactly where that 39,000 hours came up?

MR. COLLINS: First of all, I don't



think it implies there's anything wrong. It's just if you look at the current staffing, the current number of unit hours -- we just talked about this. I mean, some of it's due to having three ASA sets of lines. Some of it is due to the running of nonemergency calls. I don't know what the difference is, but you --

MR. ROBEDEAU: There's where I am. How many --

MR. DRAKE: We never did that.

MR. ROBEDEAU: Why?

MR. COLLINS: Because we don't know.

MR. ROBEDEAU: Why don't we do that?

MR. KILMER: You could have found that out, though.

MR. COLLINS: I don't think we could have.

MR. LAUER: We decided not to take it that much farther, Bill.

Your argument, Pete, if I can try to paraphrase, is that the current system cannot be compared to what the proposed system would be.

MR. DRAKE: Right.

MR. LAUER: Yes, that's true.

MR. ROBEDEAU: In either a tiered



response system or a single bid system, this system can't be compared to that, I don't think, because of the way everything is changing. You know, one time in a system -- I don't know if we were hammered for all these unit hours, but we were required by law to have two cars on for every call we ran.

And then we were hammered on the unit hours, and I kind of see the same thing coming up here. It's the same type of a deal where we are required to make response times now that -- I'm not sure if they're still required within the system or required in this. That we don't know.

There's nothing -- I know how many calls, non 9-1-1, calls A.A.'s ALS unit runs. Some of them run none, some of them run very few. The difference in unit hours that are required to staff A.A.'s ASA as a dedicated 9-1-1 system and the difference in the number of unit hours required to staff A.A.'s district as it currently is are virtually zero. Now that's my experience, Bill.

MR. COLLINS: But you cannot -- you really can't compare -- I mean, we're not trying -- this is not trying to compare the details of



the current system based on -- put it this way --

MR. ROBEDEAU: I only have information on a third of the system.

MR. COLLINS: We do not dictate to any of the companies how they should deploy their ambulances. We only require that if you run the calls you -- in fact, we don't even require -- if you look at the ordinance there's no requirement

that any one of the ambulance companies run any calls, only that calls run in your area you're responsible for, and you have to meet the eight minutes 90 percent of the time.

MR. ROBEDEAU: But there is a requirement that you can't take a unit out --

MR. COLLINS: We have an overall level eight requirement, and we've already talked about that. I agree that at times it may be greater, but it may also meet the requirement for the geographical distances that have to be covered in eight minutes.

But I think you're trying to read more into this than is here. The idea was to look at what would a model of a single ASA 9-1-1 look like, period, and so we did that. Now --

MR. LAUER: But you can't then say



because we deploy more hours than that, now this is more efficient. That wasn't the conclusion.

MR. DRAKE: Right.

MR. COLLINS: The only thing you can conclude -- and I think you can conclude this. If I'm trying to put together a 9-1-1 response system, you do not need 125,000 hours on the street to run the calls that are available in the 9-1-1 system now. You don't need them. You may need them for something else or you might not need them at all or just some portion of it, but you don't need them for 9-1-1.

MR. KILMER: Don't you now then have to look at the cost implications for dedicating them exclusively for 9-1-1? The ones that are left are going to cost you more money.

MR. COLLINS: That's something we need to look at.

MR. KILMER: So a study wouldn't be required to look at that to say there would be savings to the system from doing what you're talking about?

MR. COLLINS: The savings were showing for the unit hours deployment -- I mean, that's what you'd save, or something very close to it.



MR. ROBEDEAU: My question, Bill, still comes back to: With that number of hours, a third, was there anything done to double-check it to make sure that number was right? Because I quite frankly think something has gone desperately wrong, and I don't believe that number is right, unless my understanding of what the other two providers are doing is --

MR. COLLINS: If everybody --

MR. SKEEN: It sounds to me like you're all saying basically the same thing. This is the number of hours that would be required to run a single ASA, to run 9-1-1 calls on it, and you did a reduction of force over what is being used currently.

MR. ROBEDEAU: That's not what I'm saying. I'm saying the number, the 39,000 hour reduction, it's my understanding that if what the other two providers are doing is the same it's very, very wrong. But when you take from what I have firsthand knowledge of -- and I know that there's virtually no unit hours that that request be eliminated within A.A.'s ASA, so that takes and dumps virtually that whole 39,000 hours on to Buck and CARE.



Are Buck and CARE so inefficient that they're wasting 39,000 unit hours? I don't think so. Buck's system says they're not inefficient, so then it's all on CARE.

MR. COLLINS: This is not a comparison between ambulance companies. We took all the demand, put it into one pool and did a demand analysis.

MR. ROBEDEAU: I understand that. I want to explain to you where I'm coming from.

MR. COLLINS: That's what you did when you went to bid for it.

MR. THOMAS: Let me make sure I understand.

MR. KILMER: We're covering a lot of assumptions in here.

MR. THOMAS: The 39,000 hours, whether it's right or wrong, the assumption that it relies on those units are going to carry any BLS calls, so something is going to have to carry the calls. So some study will be done to determine whether there's more BLS calls and what the cost of that would be.

I think it is true, Bill, it sounds like you're saying by going to this you're going to



save 39,000 hours in the total system, and I understand you're saying that's not what you're saying.

You're saying some of the hours may be transferred and have to go on the BLS side. We don't know how many those are. We don't know what the cost is associated with that, etc., etc., because you haven't looked at that. Am I right so far?

MR. COLLINS: Yes, that's true.

MR. THOMAS: Then in terms of your option one, I want to make sure you don't deal anything in there with tiered response, and what portion of the 39,000 hours or whatever the number is would be credited or picked up through the fire bureau having part of the tiered response and handling that stuff. We don't know how much.

MR. COLLINS: How much would be picked up?

MR. THOMAS: How many would be picked up there?

MR. COLLINS: You really have to do the protocols to figure out what that is.

MR. THOMAS: And you don't figure out



any portion of the savings that might come from shifting the non fire bureau calls to a nine minute response time.

MR. COLLINS: Say that again.

MR. THOMAS: Presumably on the other side that lets them have less numbers of units out there, so you're reducing numbers of units and how that relates.

MR. COLLINS: No.

MR. KILMER: And there's nothing in there that doesn't equate to your option one. You shifted the manning of the ambulances that aren't handling the fire bureau calls. Obviously there's some savings there, and that changes the multiplier, I suppose, that you would multiply --

MR. COLLINS: Say that again, Chris.

MR. THOMAS: Well, if you change -- I think you've recommended not changing the manning of the ambulances that are not carrying the time critical calls.

MR. COLLINS: Of the staffing?

MR. THOMAS: Right. That's the word I'm searching for. I don't like to use "manning." Staffing is better.

So if you change that, that changes the



cost per unit hour of those vehicles, and that would be a lower cost per unit hour. What I'm trying to get at is the 39,000 hours and the savings associated with that doesn't equate really at all with your option one.

MR. COLLINS: The savings, the unit hour savings, of that exercise was done to look at a change from -- look at what the effect would be of going from three ASA's to one ASA and look to see if that's it for purposes of -- is that a big number or a small number.

MR. SKEEN: Well, it wasn't only from three to one. It was from segmenting it.

MR. COLLINS: Actually, originally that was not what we tried to do.

MR. THOMAS: What I'm thinking about is the issue that -- maybe it's not obviously in your option one of one provider for the private side or two providers or three providers or however many for the private side.

And at least as I understand the discussion so far, the analysis that you came up with, the 39,000 hours and the dollars associated with that really doesn't bear much, if any, relevance to the decision in your option one as

to how many providers you have on the private side. Is that --

MR. COLLINS: Well, yes and no. The number of providers on the private side, the private side in that option, is more tied to what looked like duplicated costs. The unit hours -- I mean, in theory we could put in a 9-1-1 single ASA and buy unit hours.

I mean, that's what the PUC models do. We could just buy them from the ambulance companies. They'd give us the cost and we'd buy them and run the system.

MR. SKEEN: Same day delivery?

MR. COLLINS: Close to same day. You could look at it in that -- like that number of hours doesn't presuppose one provider, two providers, three providers, four providers. It just presupposes a single ASA system operated as a single system status plan. So it does not divide it up.

MR. DRAKE: That's the problem.

MR. THOMAS: Let me put it to you this way: If you say -- if somebody said to you, Bill, you've done this thing that shows 39,000 hours going through this process and this amount



of dollars associated with that. Does that mean if we have one provider rather than two, in your option one on the private side, we're going to save that amount of money from that change? Your answer to that, I assume, is no, it doesn't mean that at all?

MR. COLLINS: I would assume if we were to put the whole system out to bid that we would come somewhere close to this demand. If we didn't, then I would -- then the data we've received from people has been wrong.

MR. DRAKE: Maybe you're making an assumption, and you're trying to go -- as an example, there's 18 ALS units now within three providers on the street. And for your system you'd have nine ALS units. The problem is you're taking the current system and saying we're going to respond just to 9-1-1 calls. You'd reduce the number of units. The question you need to ask them, to go back to providers and say, "If you as a provider responded to just 9-1-1 calls, how many unit hours would you have in your district," and then take that number of unit hours.

And then say, "If you had a single system, how many total units would you need on



the street responding to just 9-1-1 calls?" In other words, compare 9-1-1 calls to 9-1-1 calls. That would then tell you how many unit hours you could go from these providers to a single provider, and that hasn't been done here.

MR. COLLINS: Although, you know, when we were discussing that that was -- basically the provider said they couldn't do that.

MR. DRAKE: We can do that. That wasn't the question that was asked.

MR. COLLINS: We did ask about can you separate the 9-1-1 response from the rest of your deployments, and he said, "Well, we can't do that."

MR. DOHERTY: We were talking under the current system.

MR. DRAKE: Right. Yeah, you can do that. If you asked me to do that we could sit down and say how many units we need to provide to just 9-1-1 calls. The answer that you got, I think at least from the conveyer ambulance is that, but that doesn't make any sense because that's not what our units do. That's not what our units would do under a single provider system. They would respond to 9-1-1 calls,



nonemergency and interfacility transport, because that's the most efficient use of that unit.

MR. LAUER: If we had been asked would you submit a system status plan that responded to ALS single system we could have done that, and we decided not to do that because there was -- for a variety of reasons.

MR. KILMER: And if asked, you could have said, "For us to continue to respond to the same value of private calls we would have to make these adjustments, and those adjustments would cost this amount of money. So it would be possible to compare between a dedicated 9-1-1 component to your company and a 9-1-1 component of your company to continue to deliver emergency, nonemergency, interfacility transports, which is the real system that everybody ought to be concerned about.

And that probably would have led Bill to the determination that the 9-1-1 system you're talking about would have increased in price and that the other side would have increased in price. Now you're shaking your head.

MR. COLLINS: I don't think so.

MR. KILMER: But you haven't done any



studies on that. It seems to me it's important.

MR. COLLINS: We haven't looked to see if that's it.

MR. ROBEDEAU: If I can interject something. I've got a feeling that a lot of those hours are Clackamas County hours. That's just my opinion off the top of my head, that there's --

MR. COLLINS: I'd be happy to give you -- you've got the data. You can do your own system status plan. I'm not going to do another one. The data I got is from the companies, and if you gave me the wrong data that's your problem. You've given me data that is not correct.

MR. DRAKE: Bill, what table one says is the current system of 125,684 unit hours is our unit hours of our units responding to 9-1-1 calls, nonemergency and interfacility transport, and then proposed 86,476 as those unit hours dedicated to just 9-1-1.

MR. COLLINS: That's correct.

MR. DRAKE: So you're comparing apples to oranges. What you need --

MR. COLLINS: We said that.



MR. THOMAS: He's agreed with that.

MR. DRAKE: So you can't say the unit hour savings and then -- okay, okay.

MR. THOMAS: I think the problem and part of the reason for these questions, I wanted to say what I said before, is that the impression -- and maybe I'm wrong, but I think the impression people would get from reading this -- I don't think they would understand what Mark just said.

I think what they think all this says is it's 39,000 hours inefficient. And I think it would be important for people to understand that that's not from you, that that's not what you're saying here, that you really haven't addressed the issue of the interhospital transfers and the BLS calls of these units.

What I'm saying is: I don't think that's, to most people reading this, that that's apparent, because I actually didn't understand that, and at least I know something about this stuff.

MR. COLLINS: We're not proposing in this plan what is in effect in, you know, some communities, which is a top to bottom franchise.



I mean, we could say, okay, we want a franchise. Nobody can operate an ambulance unless you're part of the franchise. We've separated out the nonemergency care, and I think that's the appropriate way to go. I don't think you should try to franchise that. That's another piece of business that, for the most part, is competitive. The 9-1-1 stuff is not competitive by definition.

MR. THOMAS: I want to be sure you hear what I'm saying.

MR. KILMER: The issue is when you have a dedicated system, Bill, where the emergency provider of services is precluded from using those ambulances to also compete in the private market as opposed to being able to compete in the market that you're not regulating in order, if possible, to reduce costs.

My understanding is that most dedicated – most single provider 9-1-1 systems allow their providers to also deliver nonemergency care and do that with their emergency units.
MR. COLLINS: Most do.
MR. DRAKE: Which ones don't?
MR. ROBEDEAU: As a practical matter, Bill, the fact that you're leaving really



anything without 9-1-1 for private business is just not there, especially with what's coming down the pike, and everyone knows that HMO's are the future.
It's going to be – it's going to take 10 years for everybody to decide that's not a good idea before we go back to doing other things. As a practical matter, an HMO gives to the provider who is going to give them a cut in his business. It's just the way it is. So when everyone is on HMO it will be only the emergency providers who will be able to do nonemergency business. That's just the way it is.
MR. DOHERTY: That's a change in the syndication laws which is going to affect the cost of doing the transfers and the level of personnel that you'll need to do the transfers.
MR. THOMAS: Don't we move on there?
MR. ROBEDEAU: Let's take a five-minute break.
MR. DRAKE: I think there's one more comment that needs to be made here. To me it's obvious we haven't finished what we started out to do with that committee on studying the unit hours. That's never been done by the discussion



today. We need to complete this because there's several other things we need to look at.
One of them is can we get more efficiencies out of response time zones. We started to talk about that and never completed that discussion.
MR. SKEEN: There's so many components here.
MR. LAUER: It could take two years.
MR. DRAKE: If you had a response time of 20 minutes on the other side of 220th going east and Sauvie Island was a 25 minutes response time zone, how would that affect your response time coverage?
I know you could figure that out, Randy.
MR. LAUER: But you'd be doing so many different analyses that are still theoretical until you try them.
MR. SKEEN: I think you could get closer.
(Discussion off the record.)
MR. KILMER: Let's stay on the record. There is still some conversation going on.
MR. ROBEDEAU: We never – I won't say never. There have been a couple of accidents



where we had a car on Sauvie Island and – you know, you do one call a month and it's a – every one of them is over eight minutes. I believe that.
Let's take a five-minute break.
(Recess taken.)
MR. ROBEDEAU: I would state staying on the unit hours and the number of hours there are double cost savings associated with that. One was the cost of the paramedics and the other was the cost of administration. And as long as we're here, why don't we go ahead and cover that? There's a couple of questions on those in here. Skip down to number seven.
MR. DRAKE: Number seven?
MR. COLLINS: Let me find that.
MR. ROBEDEAU: Then you go to number nine. Seven and nine are both cost, and then I think we can just go through real fast.
MR. DRAKE: It's quarter to 11:00 now.
MR. ROBEDEAU: I know. I'm looking at my watch now. I think a lot of them have already been covered.
The supposed cost savings are elimination of providers and the elimination of



supposedly duplicated administrators are addressed all the way down to 16. This whole sequence of question deals with various aspects of the statements in the plan about how a reduction from three providers to one could theoretically save from one-half to two-thirds of the administrative costs that he took from the provider plan.
MR. LAUER: So you're saying we've already discussed through number 16?
MR. KILMER: No. That is what ought to be discussed in this component. What Bill said earlier, he believes his data with respect to reduction of ASA's from three to one involves some cost shift to private. It involves some efficiency by reduction in the number of crews and things like that, and to some extent there would be a savings by the elimination of three providers and having one provider do it.
He has not quantified any of those differences. And what I thought Pete's question was going to be now is what information, if any, do you have on the administrative cost savings components of this in the plan that's broken down to dispatch savings, which is sort of a separate



issue.
And then there is also his discussion on pages 17, 16 and 17, regarding duplicated costs. That's 3.4.2 of his comments planning report which says that there would be up to $1,525,000 in administrative and overhead savings.
MR. LAUER: I don't know if we're ever going to quantify that.
MR. KILMER: I think it ought to be pinned down, though, to the extent of what Mr. Collins relied upon to arrive at that number. That's what I thought Pete was going to ask about.
And then there's an additional indication in here of 594,000, almost $600,000, in private control centers to emergency calls he feels is inappropriately applied and is now an additional savings.
MR. PHILLIPS: You're on 17? Well, 13 deals with the management costs which might be available from the proposed changes. And 14 deals with the assumption that there are economics of scale, and 15 deals with how would you define administrative and overhead costs as he uses them in his analysis on page 17. And



then 16 has to do with, you know, did he do an analysis of the likelihood these savings that he hypothysizes might be there would really be realized.
MR. COLLINS: Which one do you want to start with? Should I just go through what we did?
MR. ROBEDEAU: Yes, that's fine.
MR. COLLINS: So we're done talking about the demand summary for right now?
MR. DRAKE: I thought number six, basis for determining savings –
MR. ROBEDEAU: Maybe we should just start with two, and should we just read them into the record and go straight through, Bill?
MR. COLLINS: Two has to do with number of paramedics. It has nothing to do with costs. Analyzing, let's start with six. I don't care, whoever wants to do that.
MR. ROBEDEAU: I can go. "Basis for determining savings alleged to be made from reduction of number of providers: From reduction of overhead, from changes in the system which would occur whether or not providers were reduced, from cost transfers which would be



realized regardless of number of providers."
Do you want to take number six, Bill?
MR. COLLINS: Sure. Anyway, when you're looking on page 14 –
MR. KILMER: That's 16 and 17.
MR. COLLINS: When we were trying to look at the cost associated with the potential change, there were three areas of cost that we

looked at. One we just talked about, which is unit hour reduction, and the cost applied to the unit hour reduction was only the -- if you look on table three over on unit hour there's a figure of $26.83 which represents paramedic salary and benefits.

And the unit hour reduction, that's all we applied, and I think it describes that someplace in here, that that's -- I mean, there could be other savings having to do with vehicles and things, but that is not -- we did not apply that number. We were trying to follow the logic of this through and be as conservative as we can be. So we're not making -- I wasn't making statements that were greater than what we could be. So the first savings is based on that.

Now, the other two areas, that



identified what essentially either duplicated costs or costs that I felt should not be associated with the 9-1-1 service at all. The two duplicated costs that seemed to make a reasonable amount of sense are the administrative costs and the general overhead costs that were provided to me by the providers.

If you only have one organization versus three organizations in which that cost has to be associated with 9-1-1, the process you're going to be able to reduce that is someplace between probably half to a third. I mean two-thirds. I mean, in theory you could do it in two-thirds. I don't know if that's good or not.

You don't need three sets of overheads, three sets of owners, three sets managers, three sets of everybody. What the exact amount would be would be dependent on how you organized whatever the single entity was. But it isn't going to take triple of each of those areas.

Now, we didn't look at any of the other costs that were on table three because that is -- you know, to say what you're actually going to say to billing, I don't know. You're going to have the same number of invoices. You probably



won't need the same number of supervisors or whatever, but we made no attempt to try to do that.

We were just trying to pick out those areas that seemed to be very obvious on the face of it. The third area was in the control center, and we've had a discussion someplace about that already.

But my contention is that even though the control center activity may be necessary for some other aspect of the ambulance company, it is not necessary for the 9-1-1 service. It already is a control center. It's already been paid for by tax payers. Whether you don't like it or like it or it gives you what you want or doesn't give you exactly what you want, I don't think that's the issue.

The issue is: Do you need to have duplicated control centers for the same vehicles, and again you need to read this plan in the context of this 9-1-1 system. If you need them for other things I can understand that, but you cannot tell me that the cost of that should be allocated to the 9-1-1 system, which is what we ask for in developing the cost. The rate for



9-1-1 should not support that.

That's basically what we did. There's no other magic little things. We didn't get into any other of these other categories because these are just too dependent on the number of runs of which ambulance does which.

MR. ROBEDEAU: Bill, that theory was applied in San Mateo County in California back in the late '70s. Did you do any checking into what happened to that system?

MR. COLLINS: To San Mateo County?

MR. ROBEDEAU: Yes.

MR. COLLINS: No.

MR. ROBEDEAU: Okay.

MR. DRAKE: I have a couple of questions to make sure I'm hearing you correctly. You said your first area of cost savings was based on unit hour of reduction. Was that based on the fact you go from 125,000 to 86,000 unit hours?

MR. COLLINS: Right.

MR. DRAKE: As we discussed earlier, that really is an associated cost savings because you're comparing apples and oranges.

MR. COLLINS: I heard what you said. You asked me if that's the way we did it. This



is the demand analysis and staffing plan for a dedicated 9-1-1 system, and there are -- if you take the number of paramedic hours or number of unit hours, now you have less unit hours that should be allocated to 9-1-1.

What you do with the other unit hours, the cost may go up or it may go down. I guess it wouldn't go up real high because you have to negotiate it.

MR. DRAKE: Negotiate with who?

MR. COLLINS: With whoever you provide the service for.

MR. DRAKE: You can't negotiate with -- you don't negotiate with each private patient you go pick up?

MR. COLLINS: No, not the 9-1-1, the other --

MR. DRAKE: We have other private that are not 9-1-1.

MR. COLLINS: Whatever. There's no attempt to try to determine that.

MR. PHILLIPS: Bill, do you have any figures on what a one or two-minute reduction in response time would do?

MR. COLLINS: No, I don't. To do that I



think you'd have to -- you'd have to do a demand analysis, a geographic distribution again, because each --

MR. PHILLIPS: To start all over, basically?

MR. COLLINS: Yeah. You're making a different set of assumptions on what the criteria are for the response and then you kind of feed it into this. In theory, the longer the response time to some point, the less number of unit hours are -- at some point you're going do -- it's more on the geography than it is on the -- there's still the same number of calls.

MR. PHILLIPS: Right.

MR. COLLINS: But you have to meet the demand. Let's say the demand is down at the five and six call level and you now have to meet an eight minute response time. You have to have a number of unit hours to meet the eight minute response time.

If you had the same number of calls, you could do it in 12 minutes, and there would be some savings in there. I can't tell you what it is. I have to think it to do it.

MR. DRAKE: You have a computer that can



do that?

MR. COLLINS: The computer program that I have, which is working at about half right now because there's a problem with the memory -- but the computer program will tell you any given unit location, what area it will cover in any set time frame. But it will also tell you how many units you need and where to put them based on the time parameters you want to feed into it.

MR. DRAKE: So if you fed in different time parameters --

MR. COLLINS: Right. It has a work load -- if it has the geography in it, if you said we want a response time of 12 minutes and you set it at -- it's got a top and bottom, so you'd set it on 10 to 12 or something like that, and it will tell you what you need.

MR. DRAKE: Okay.

MR. ROBEDEAU: It tells you -- well, never mind. I want to come back to that.

MR. COLLINS: Because that's -- we have not used all that. All I did was use the geographic placement part of it. Actually the program is too big for the computer, for a P.C., so I'm cutting the program down. I'll explain

that later.
MR. ROBEDEAU: I have a couple of questions.
MR. COLLINS: On the question you asked about number six, that's all the level of the financial analysis. This was not -- there was no attempt to compare one company to another company; you know, one is good, one is bad. I didn't do that. Again, I just added up the costs that were provided. And those areas where it seemed evident that you have less organizations involved in the 9-1-1, there's going to be some savings again to the 9-1-1 system which should be reflected to some extent in the rate.
MR. ROBEDEAU: But did you do any analysis on what additional personnel would be required, both at Kelly Butte and at the individual providers or provider, depending on what you come up with, what additional cost would be incurred by the provider, not having a control center to be able to keep track of things that their cars were doing? What kind of -- how much is going to be added back into, quote-unquote, the control center costs in order to carry on functions of a business that the control centers



now do?
MR. COLLINS: Add it back into whose control?
MR. ROBEDEAU: The 9-1-1 cost, whether it be through public or private.
MR. COLLINS: There shouldn't be anything added to Kelly Butte.
MR. ROBEDEAU: Well, if there's no control center and the provider or providers have no idea what their car is doing, as in the case of San Mateo County, I think when they were doing that twice a day, San Mateo County provided a list of calls that the particular providers' cars had run, you know, all of that stuff.
San Mateo County provided a supervisor who went out and met with each car to pick up patient care information. The county guaranteed information to the provider in San Mateo County, and the county guaranteed that their call volume and call stats were absolutely accurate and that they were all included.
There was quite a bit that went on down there, that if you were to do that kind of a system here somebody is going to have to make up those costs. Those are all costs that are there



that are never going to go away. That is stuff that currently is being done by our control center, and you could call that an office function or a billing office function or something on that order.
But you're looking at at least computer software. You're looking at at least one full-time additional person, and you're looking at at least one additional full-time supervisor on 24 hours a day, seven days a week, who is going to go around and meet with each one of these vehicles.
That would be off the top of my head a plan, that if we take and kind of compare this as to what they had done in San Mateo County in the '70s, I know the only contact that Medivac had with their cars at the time is that they had a scanner in their business office, and that was all they knew what went on. That was all that was provided by the county.
But that function being listed as control center has a great deal more than just sitting there dispatching cars. There's a lot more to it that isn't taken into account here, or at least that I don't see as taken into account.



MR. COLLINS: Well, I don't think there's any increase in personnel to do the dispatch and system status control. I will agree that if we would try to do this right now that there would be a problem getting new data from BOEC. I think everybody is aware of that. The change in CAD system will allow you to get the call data essentially on line if you want it.
So as far as I know, the incident dispatch data or you can get it in batches, that's not available right now.
MR. LAUER: What Pete is saying is that's currently a function of the private dispatch center.
MR. COLLINS: I understand that. I'm making an assumption here also that the CAD is in place and that the city's data is functional. Now, if that does not occur, then I understand that we'd have to figure out what else it's worth.
But as far as the dispatch function, the system status controlling function and the data that's available through the dispatch activity, that's -- I mean, that's all available --
MR. LAUER: Right.



MR. COLLINS: -- From the city.
MR. LAUER: I guess the main point is that the communication center does more than dispatch and maintain a system status plan. It has a lot to do with recovery cost. BOEC Kelly Butte has never done that function. It's been totally supported from other sources, and they've never had to worry about how to cover their cost from the computer. A private dispatch service, a component of it, is doing exactly that. That has to still be there.
MR. COLLINS: You need to get that information.
MR. LAUER: Right. That's the first step in the cost recovery process.
MR. COLLINS: That should be the same information. You shouldn't have a different set of information.
MR. DRAKE: Can BOEC give us the information to format what we need? Secondly, can BOEC give us the information in a timely manner, which is daily; third, can BOEC be able to provide us on late responses information instantaneously?
MR. COLLINS: What I just said, my



understanding at this point is that the CAD management information system can provide it to you on line. I mean, you can just get it right off the machine.
MR. ROBEDEAU: The other part, you know, still is -- I don't know. Again, I can only go by my experience with A.A. Our, quote-unquote, control center is also all of our data entry. All of our stats, all of our billing, everything is done in our control center. Whether Buck does that or CARE does that, I don't know, but that's where ours occurs.
You're dealing with any savings, at least on our part, with at least one full-time person in the billing office. All you're doing is just changing a bunch of what you call a lot of this in order to do that. The savings that show by the elimination of the control center, Bill, I'm afraid just plain don't exist.
Who is going to get the patient care reports to make sure they're completed on a daily basis? Is that going to become a function of EMS? If that's done like we do it, every time a crew goes off duty -- or more often, if we could come in, then the supervisor picks up those



patient care reports to match them to the calls to make sure everything is there. And those reports are completed and signed.
And then Kelly Butte, almost four or five or six times a day, is going to have to make sure somebody, a runner, takes that to the provider, whoever that provider may be, in order to match this paperwork. The paperwork as you've sent it out is absolutely mandatory for hospitals and stuff.
MR. SKEEN: You know, just from a pure system design I understand where Bill is coming from. If the three of us took our tasks on the communication centers, control centers, and upon the cut we reduced our unit hour cost by $4.98, or whatever it was, and thereby reduced rates, and then said to BOEC -- took them some nice cake

and said, "Congratulations, we're now in business together, here are the tasks we want you to perform."

If you took that approach, BOEC would clearly have to add staff in spite of the 60 people they have. They'd have to add staff. So it -- the other thing is for BOEC to say, "We're not going to do that. That's not part of our



mission. We would do the dispatching."

So then the 4.98, or whatever it is, per unit hour then goes to the control center into administrative tasks that will have to be provided either by multiple providers or -- the other side is to say, "Could we perhaps save BOEC numbers by havign them into 9-1-1 dispatch, by having them transferring the screens to the ambulance control centers that's already working with those additional tasks, and that control center from ambulance provider.

MR. ROBEDEAU: Multnomah County, from what I understand, said that's just not going do happen.

MR. COLLINS: That's not true, not from my perspective. That is certainly another option, but that is not an option -- that's not an option that will work with multiple providers, but it is an option if you have a single provider.

MR. ROBEDEAU: That's brand new.

MR. COLLINS: I didn't put it in there, because I don't think we ought to do it that way.

MR. ROBEDEAU: But, see, the fact that Multnomah County is not opposed to that as of



this minute is brand new information for me, because this has been coming up periodically for over, God, I'd hate to say how many years. And each time this has come up in the past there's this, "This will never happen, don't do anything."

MR. COLLINS: I'm not in favor of doing it under the current multiple provider system. I don't think it could possibly work. If you have only one -- if you have only one dispatch center, it doesn't matter probably where it is.

And, in fact, if you have one provider with one dispatch center, there might be an argument of why you move it to one provider, because then you can hold the prior responsibility for the time the call is created.

But there are some other issues. One of the things we're looking at currently in the change to BOEC changes is that the fire alarm dispatch, as you well know, is not going to exist. It's going to go away, and many dispatchers are going to dispatch fire.

The proposal is the same people are going to have to dispatch both fire and EMS, instead of what we're doing now, which is -- the



city maintenance is a five or six person fire alarm dispatch, and they maintain a two person EMS dispatch and they have a supervisor.

That's all going together to being reduced to either three or four people, depending on who wins the argument in the city. I'm not in that argument. I'm standing back. But the option of having the dispatch in the control room being done away from BOEC is certainly an option if the plan that's put in would support that. Now, that has not been proffered in this plan because there isn't any reason to do it right now.

That's the same kind of thing. If a company did it -- let's say we had a company. I would expect the cost to go away from BOEC and the tax payers shouldn't have to support that portion of it, although that's kind of a basic question that's a little more complicated.

MR. DRAKE: I have to leave, but I do have one question. I'd like to see what you have on page 17. There could be savings overhead up to $1,005.80.

MR. COLLINS: That's off the sheet, table three.



MR. DRAKE: That's off table three.

MR. COLLINS: Add up general overhead, general administration. I think I cut it in half.

MR. COLLINS: You cut it in half?

MR. DRAKE: So you didn't take into consideration any -- if you had a single provider building, the administration building, in the system they would have to have building in the infrastructure for both management --

MR. COLLINS: I took that into consideration because I eliminated it all.

MR. DRAKE: But you didn't actually try to build the system?

MR. COLLINS: Right. We currently have three organizations with aggregate costs. Again, these are aggregate costs and nothing to say whose costs these are. If you add up those two according to the information I got from the providers, it's two-million-four and, you know, what is it? 600,000 or --

MR. THOMAS: Let me say something about that. And say what you think about this, Bill. Let's make an assumption which may or may not be true, but at least for purposes of discussion,



that each of the current providers has maximized, optimized its efficiency so that you know for each lower level of employee you've got a span of control determination you have to reach about how many supervisors they'd need, and they set themselves up so they go right up like a pyramid, and the top person has just the appropriate number of people under him or her.

It seems to me if that were the case for each of them -- and let's forget about total number of paramedics, that side of the equation. And if you combine the three of those, you wouldn't change any of the personnel at the administrative level because each of them has the appropriate number of people under them for span of control purposes.

And possibly you would need one more person on top so that you don't have three people at the top of each of those pyramids. That seems like a correct analysis to me, but it doesn't to you?

MR. COLLINS: Well, no, not from the definitions that we had identified. Supervisors, training officers, incremental costs for like training people are not included. That's in



another category we didn't touch.

MR. THOMAS: I'm talking about the personnel who are in the administration.

MR. COLLINS: Let me give you an example. If you have three organizations currently and if each one of those had a personnel officer, if you only had one organization would you have three personnel officers?

MR. THOMAS: That's what I wanted to talk about. Well, wait. Let's talk about that here. Wait, wait. Just let me tell you what I was saying, and that's what I wanted to talk about, because I want to see where our thinking differs.

If each of the personnel officers has the appropriate number of people on a span of control approach that they are training, you can't have one officer then triple the number of people. You actually do need three people training more people. There's a point at which you have to add more people.

MR. COLLINS: I understand what you're saying, and that I think holds probably quite well at the line, at the line of supervision



level. If you've got one -- if you have one field supervisor and 20 paramedics and you combine three organizations and have 60 paramedics, you're probably going to need more than one. You're going to need two or three field supervisors. I would grant that. That's why it's separated.

But I would not agree that you would

need three or two of what is considered to be management level positions, personnel officers, CEO's, financial officers, any of those kind of levels, because their jobs are not span of control oriented. Only in the very broadest aspect of it.

I mean, if you are the CEO of a small company and you ended up as the CEO of a gigantic company, you might have to have some other little management in there. But for a lot of these functions that fall into -- and again, I didn't try to go through here.

We just asked each company to say how much was in that area of it. There may be things where you have to have more of it. I don't agree with you at that level that would hold.

MR. THOMAS: That's part of your



assumption, is at that level actually span of control is not an issue.

MR. COLLINS: My experience is that that does not hold once you get to that level. It definitely does at the line of supervision.

MR. THOMAS: I understand that.

MR. COLLINS: We left that, and you might even -- might have to add more.

MR. SKEEN: Generally you're always in a range where -- the smaller the organization, you're always in the range generally. There are going to be incrimental increases in your administrative tasks to a certain point. You wouldn't think that it would be duplicated in total.

MR. COLLINS: That's why I did not make the assumption what it should be like. There's now three. If you go to one it ought to go two-thirds less because there's some -- you know, it's well taken it's not going to be even. You could pick a third or you could pick two-fifths or -- I mean, I just picked half because that was what I picked. That is not a detailed --

MR. THOMAS: It is sort of interesting. What's implicit in what you're saying is small



organizations are almost inherently less efficient, at least less than middle size to large organizations. And actually, I think -- at least I think most people's experience is the most efficient businesses are small businesses, maybe because they get their administration to do more stuff than somebody in a large organization might not do.

Anyway, I understand where you're coming from. That's what I wanted to understand, what was the assumption you made at that level.

MR. SKEEN: I think there's kind of a template for that structure in the requirement for them to respond to all 9-1-1 calls. And I'd have to go back and look at it, but it seemed like --

MR. THOMAS: In terms of the hierarchy and how high the pyramid has to go.

MR. SKEEN: It is usually impressive.

MR. COLLINS: The infrastructure necessary to do the operation of the ambulance company, which is what they're saying to add to it, isn't there at all. What is there is the general organizational infrastructure which you would not change. And this implies that at least



you know that the stuff is already there, that it's a duplication and not an add-on. I mean --

MR. PHILLIPS: Realistically, nobody is going to go away out of this system. It's just that it won't all be involved in the EMS, the 9-1-1 section of it.

MR. COLLINS: Well, I didn't try to make any analysis of what goes away or doesn't go away, only what should be allocated and identified as 9-1-1 calls. And the logic that I think prevails in this is that if all these costs are in the 9-1-1 system, then in theory the rate has to support these costs. And if these costs either go away or belong someplace else, then they should not be supported with the rate. They can be supported by contract providers or some other rate or -- I'm fully aware that you move costs and you pump them up on the other side and there are going to be some problems.

But we're not proposing a top to bottom franchise, and I haven't heard really anyone support that. These aren't all my ideas. I'm trying to get a compilation of what people say, and I have not heard anybody yet really support that kind of a system.



I suppose somebody can raise their hand and we could add it in. I don't think that that's appropriate for a public service system to really be providing services that can be well provided by the private sector in that manner.

MR. THOMAS: You didn't do any -- I know you didn't, I guess.

Another thing that somebody might consider in doing your kind of analysis of what happens when you put three into one -- I mean, I'm guessing that -- well, I don't know. Conceivably there could be pay level differences as somebody is responsible in a larger organization.

MR. COLLINS: I didn't look at that.

MR. THOMAS: I know you didn't.

MR. COLLINS: I think we made the statement somewhere in here -- I can't remember what page -- that the actual dollars would have to do without being reallocated once you were in whatever organizational framework. It's true. You could put a bunch of stuff together, and you could pay the top guy -- you know, greater responsibilities might increase, but those would not be substantial.



MR. THOMAS: A lot of people who are reading your report are thinking you're saying all these things are absolute cost savings that go away. I was even talking to Lynn out in the hall, and she was saying the $39,000, she thought it went away, whether they may be BLS transports or interhospital transports or something else.

I think it will help people if you make sure what it is you're saying in there and what it is you're not saying, because there's a lot of misinterpretation out there about what it means. I know you had to write it fairly rapidly, so it's not your fault.

MR. SKEEN: Just for the record, so I don't remain quiet on your comment about anyone who believes it should all be on an integrated system.

MR. COLLINS: You'd like to --

MR. SKEEN: I think it clearly should be on an integrated system.

MR. KILMER: Are you talking integrated, exclusive public, exclusive private? You're saying at the very least the franchisee of the public part of it should be able to compete in the private part of it, or are you saying they



should have exclusive private as well?

MR. SKEEN: They should at least be able to compete. By arbitrarily segmenting you drive the cost up on both --

MR. KILMER: I think every provider agrees with what you said. They drive it up on both sides, segmented between emergency and nonemergency.

MR. PHILLIPS: And I think the problem that you're trying to get away with in the system is someone coming in and out of the system, floating in and out of the system?

MR. COLLINS: I'm sorry. I don't follow you.

MR. PHILLIPS: With a BLS or transfer and also 9-1-1 generated system, you are trying to separate them. Aren't you also trying to experience whether or not a car is 9-1-1 dedicated or can float in and out of the system?

MR. COLLINS: Actually, we didn't really propose it's a dedicated system. We just did the analysis of the demand on a dedicated system because there was no way to do it realistically on a combined system. Now, I still hold that's the demand that ought to drive the rates, and

that if you add to that in order to do what we're doing now, that that should not affect in any way the rates for the franchise part of the system.

And I don't think you can say -- I mean, you can say it, but you know the cost is the cost that was reported. If you're going to have units that can go in and out and you're saying it's going to be more efficient, you have to be able to make that argument when looking at the rates that you are not adding unit hours that have to be somehow supported by the rates.

So I don't even know -- I know in theory it should be more efficient, and I suppose that's something we could probably do. We could look at what's going on now on a unit hour production ratio and look and see what you'd do on this.

MR. SKEEN: Barry and Randy, when you guys met in looking at the demand model, did you look at a reasonable utilization ratio that could be expected in a single provider system?

MR. LAUER: I don't know.

MR. SKEEN: If you took an estimation at .3 on, is that a reasonable county wide --

MR. LAUER: I don't know if it's an assumption we reached individually, I don't know



if we agreed to it by virtue of setting a maximum shift length. At least what I thought we were saying is that this demand, unit hour production would be a highly utilized one.

MR. SKEEN: Would be?

MR. LAUER: Would be, and would have a high utilization ratio, and therefore we were going to limit shift lengths to 24, recognizing that would be kind of busy for them.

MR. COLLINS: You mean they would die soon after?

MR. ROBEDEAU: I'd like to go off the agenda here for just a little bit.

MR. SKEEN: Pete, let me follow that just for a minute. .5 is going to be stuff to do at eight minutes, 90 percent county wide. And, you know, I don't know what you guys are doing, but I would think county wide .30 or even .32 would be considered reasonable for eight minute; 90 percent county wide if you look at the volume of calls you're looking at, which I think is around 38,000, 40,000 9-1-1 calls.

MR. COLLINS: 40,000 calls?

MR. SKEEN: Roughly 40,000, at 60 percent transport ratio, it takes you --



MR. COLLINS: 70 percent.

MR. SKEEN: Well, you're not counting disregards. You're counting 70 percent -- 60 percent, which is even somewhat liberal, of all calls and a transport per unit hour -- transport per unit hour utilization. Go through that calculation. It takes you back to unit hours, to about 140,000 unit hours, a .32 in an eight minute, 90 percent, which goes back to what you started with the utilization ratios.

Now, that was quick and dirty using your calculator, and I assume the batteries are up. There's various ways of backing into it, and that's a single provider system. I guess my greater concern is, even if I'm way off on that, even if you can do it .4 or .4 to .5, when you mitigate that with kind of two system status plans with that 9-1-1 system you're getting -- your unit hour requirements are going to go well beyond that.

MR. ROBEDEAU: You're saying rather than 89,000 your calculation said 140,000?

MR. SKEEN: Backing into a different direction at roughly a .32 -- I figured a .30 backing into it -- it comes back in at around



130,000 based on the number of calls.

MR. DOHERTY: That's one of the things, though, I had in my mind, we'd used to verify the applicability, if you will, of the data we generated in additional meetings in that work group and see whether or not it was realistic.

MR. ROBEDEAU: That just backs up my deal that when you come up with 39,000, that large a savings, that should have set up a red flag that something is wrong, and apparently --

MR. SKEEN: That's only one aspect. It doesn't mean there aren't some other positive reasons to modify this whole system. I'm concerned about the unit hour reductions that have been calculated to this point. I don't want to go back and beat that horse.

MR. ROBEDEAU: I wanted to go off -- it's not quite in the agenda. But one thing I keep hearing, and I've heard for years and years and years, is that the two remaining or the two unlucky or two providers that don't win the bid, if there is a bid, will be left, and we'll have plenty of business to do in nonemergency.

And I would really like to know, Bill, since I've heard that several times, has the



county ever really done any analysis -- and I don't mean just you. I mean the county, the county commissioners, John Acker, anybody else along the line as to how true that assumption is. You know, will there really be a --

MR. COLLINS: I have not done that, nor have I made that statement.

MR. SKEEN: I don't know if I've heard that statement.

MR. KILMER: It's been made by many people, though.

MR. ROBEDEAU: That is an underlying assumption that remains because it's been made so many times. And I have heard that in these meetings. I have heard that at the MAB. I think I heard it here.

MR. COLLINS: Not from me.

MR. ROBEDEAU: And I would have -- I would like to see something --

MR. COLLINS: That assumption is made in the PAPA plan.

MR. STEINMAN: You heard it from that dumb kid from Gresham.

MR. PHILLIPS: The dumb kid from Gresham was asking you about it.



MR. COLLINS: I have not made any statements in this plan at all about anything except the 9-1-1 business.

MR. SKEEN: It depends on whether it's a dedicated 9-1-1 response or integrated.

MR. COLLINS: Of what?

MR. SKEEN: How much business there will be left and how competitive it will be.

MR. ROBEDEAU: As a practical matter, I think I would like to say that there is no way that the loser could survive, absolutely not.

MR. COLLINS: I do not have any reasonable information on the number of nonemergency ambulance transports or calls. We don't collect that. It's not a requirement. The only thing we have to do with nonemergency anything is that we license nonemergency ambulances, make sure they've got what they're supposed to have on them. We don't look -- the rates that follow, the general rates, people aren't supposed to follow rates on discounts or --

MR. ROBEDEAU: The discounts on the MAB level, county level, any other level I'm aware of is that there will be plenty of business left,



and that the only difference between a losing provider and a winning provider will be the losing provider will be requiring fewer calls, but will have ample income to maintain their status. I don't believe that's --

MR. LAUER: Part of that belief was based on early 1980's thought that 9-1-1 was only a little part of the total call line. People thought that just up to a few years ago. Private companies, 90 percent of their calls are nonemergency, and that's not right.

MR. ROBEDEAU: In the late '70s, up until 1980 when this ordinance passed and the county took away 70 percent of our business and then gave it back to us and is now calling the public business, 90 percent -- in fact, in A.A.'s case, more than 90 percent of what we did was

private business. That was emergency and nonemergency, and you had police districts then, and then the county passed an ordinance requiring us to give them most of our business.

And in passing that ordinance they stated before the county commissioner and before the city council that as long as we followed the rules there would be no problem. We could



continue to do bills for as long as we were willing to follow the rules.

Now, we have followed the rules right along the line. You know, as far as I can see, you know, there has been a contract. Now, what happens is that we have -- 70 percent of our business is given to us by the county in 9-1-1 business, and now I am hearing all of this -- they come out and say this is public business, it doesn't belong to you. What this really is is this is business that is our business and was taken away from us.

MR. KILMER: For the record, Mr. Robedeau, I want to say what you're saying is not really what we have ever talked about. They never took your business back in the '80s. They did impose certain regulations on you as a condition of continuing your business which you have assiduously followed since that time.

MR. ROBEDEAU: That's correct.

MR. KILMER: You have used in a colloquial sense "take away," but I think about that as being any interference, that that is never really what happened, and I don't think you really mean to suggest that that was what



happened.

MR. ROBEDEAU: No.

MR. KILMER: Am I correct on that?

MR. ROBEDEAU: You're correct on that Mr. Kilmer.

MR. ROBEDEAU: I'm not an attorney. Maybe my terminology is wrong. I do know what happened. I was an eyewitness to it.

MR. LAUER: We'd talk them all out of going to the hospital.

MR. COLLINS: We are not going to try to do "B" in this? Are we on disaster responses? Are there any real issues that anybody has?

MR. ROBEDEAU: No.

MR. COLLINS: Mark was the one who brought up something about communication. I mean, the disaster response I can tell you right now, there is no plan. I mean, what you saw in today's paper is probably as good as we've got, not MCI's.

MR. ROBEDEAU: There's an MCI which --

MR. COLLINS: We have an MCI plan, but response to disasters that destroy the infrastructure, the county has no plan, nor does the city. The earthquake woke us up again, and



so there will be a flurry of activity around that.

MR. ROBEDEAU: According to Bill Stafford we're going to have another one here in a couple of months.

MR. COLLINS: Do you know what Mark's concern was about communication?

MR. ROBEDEAU: I don't.

MR. SKEEN: Probably about the items we were talking about a few minutes ago.

MR. DOHERTY: That was my assumption. The costs associated with savings, costs with --

MR. SKEEN: The whole method of BOEC.

MR. COLLINS: Okay.

MR. LAUER: Did we talk about turnover?

MR. ROBEDEAU: Well, I think we need to get back up -- it's 11:30. We really need to move it along. I think we need to go ahead and finish the --

MR. KILMER: Can I make a suggestion, Mr. Chairman? The issue of paramedic turnover and the analysis that he did involves PAPA. No one from PAPA is here today. I'd like to suggest that you defer this portion of this until one of the meetings that we have saved for additional



discussion in the hope they would take the opportunity to show up at that time.

This invitation can be reflected in the minutes, and they'll certainly be getting copies of the minutes, and the record will be clear they've been offered an opportunity in this process to participate in that discussion and make their comments on it. So I'd like to suggest you defer it until another time.

MR. ROBEDEAU: Randy?

MR. LAUER: Can you just encapsulate the conclusions you reached in your ASA plan about turnover as it applies to the direction your --

MR. COLLINS: Oh, okay. Well, yeah, we can go through what we did. I mean, I gave you guys -- you all have a copy of the information. It wasn't too tricky. I think all we were trying to do -- let me get to the part that -- I don't want to tell you something we didn't do.

What we tried to do was to look at turnover as a function of two issues that had been identified. One issue was, I guess for lack of a better word, the stability of an organization that had been brought up in the past.



And the other had to do more with the training that would be necessary, like the number of paramedics and how that might affect patient care, but not -- we didn't do any real analysis of patient care. This was kind of a -- this question had come up enough that I felt we needed to look at it from the data we had.

MR. LAUER: So did you conclude that turnover was high amongst the private providers, and therefore the system --

MR. COLLINS: We concluded the system -- turnover was higher among the private providers than the --

MR. LAUER: Is that part of the ratio that supports having a tiered system?

MR. COLLINS: Yes. Well, supports using the fire department as part of -- as a part of the system, because you're looking for the stability of the -- now, again, the date that we used to do this is exactly the date that that was reported by the companies.

MR. LAUER: Kind of collated differently?

MR. COLLINS: It's --

MR. LAUER: When I read that the



assumption was the fire department was going to build better paramedics because they're going to be around longer, I take exception to that. If you want to address that issue you can, but I think we first ought to look at the turnover, because the data that I have that was put together to address specifically this question was different. I mean, I show our 1992 paramedic turnover as being eight percent.

MR. COLLINS: I don't think we included your 1992 turnover, if I can remember.

MR. KILMER: What was his methodology in determining turnover? I understand there's a question about whether he determined turnover as a turnover, even though a paramedic went from one system to another system, and there was no skill degradation that's normally associated with turnover, assuming the paramedic goes out of the system.

And I think it's appropriate at least to pin down the methodology to determine if the turnover rate is really as low as his numbers suggest, and then to ask whether the fire department's turnover includes those that come into the EMT system for a period of time and then



pass out, and to compare the skill degradation that's applied to that.

Those are methodology questions that have to be pinned down before you can draw any conclusions about the validity of the results.

MR. LAUER: I'd like to end that with revised data, revised statistics. I think they will be dramatically revised.

MR. KILMER: I think you ought to pin down Mr. Collins on how he did that and what he did do and what he didn't do.

MR. LAUER: I guess we could do that.

MR. KILMER: If you're going to do this in this process, it probably does help to have it done for the record.

MR. COLLINS: We did nothing real tricky. If you look at these, what we did is we used the reports provided to our office for 1987, '88, '89, '90, '91 and '92 that are required by the ordinance that each licensee has to report to us, the EMT's in their employ, and the level of training of the EMT went through from year to year. And we looked at who was working for each provider in 1987. And then we went to 1988 and said who was added and who was deleted,



numberwise, I mean.

If you look at the sheets, they actually have people's names on them. They just went across. We did not try to differentiate those paramedics who are on the schedule working in the car versus those paramedics who are in some other position in the company. Because that was not -- these are all people who ostensibly are certified paramedics. So therefore, they need the same training, they need the same whatever it is to keep them certified.

So there's no assumption as to what they do in the company. But we can certainly go and look and see what the effect is of seeing if somebody left one company, did they show up in another company. I tried to do that to some extent, but it was very difficult on the pages to try and figure that out. And that's all we did.

Now, we did have -- we got to Buck in '92. We did not do a comparison for '92 because there was sort of a gigantic change. It looks like the whole methodology of reporting changes, so I didn't do it. There was no way to compare.

But everybody else was pretty much the same. We did the exact same thing with the fire



departments. They report to us the same way, so this is whatever was sent in. That's all we did.

And you can look and actually see the sheet for whatever company. You can see who the person's name was and did they work. The little X's means they were on the list for that year. If they were on the list for '87 and they were not on the list for '88, then they were one of the people who left. And actually, some people did come back to the same company after a number of years. We identified those.

MR. KILMER: Did you count every person on that list as a whole year employee?

MR. COLLINS: We got the list once a year, so I made the assumption that whoever was -- we were going in theory from the same time period to the same time period. Now, you could have somebody who came to work and left within the year, but we would not catch that turnover.

But if you had somebody who came to work in the last month of the year they would show up as being on that list. We have no data to show who started on what date. That just isn't reported.

MR. KILMER: Did you ever report -- ask



A.A. Or CARE or Buck how many full-time equivalent paramedic positions they had?

MR. COLLINS: No, because we were not interested in looking at full-time equivalent. We were looking at people.

MR. KILMER: But by your failing to do that -- let's say A.A. Has always had 25 paramedics. You've shown them as having 45 in a particular year. And then you have taken the 45 and drawn your conclusion about the number of paramedics in the system. In effect, you have double-counted a whole bunch of people.

MR. COLLINS: No, I don't agree with that. Attachment "A" gave me a list in 1987 that had 43 names on it listed as paramedics and they had 43 people that were paramedics, unless they gave me a list that wasn't true.

MR. KILMER: The fact is they weren't all employed by A.A. During that year.

MR. SKEEN: I think what he's saying is at a given time there were 43 people on the list.

MR. KILMER: No. At any given time there wasn't 43 people on -- actually employed by A.A. At the end of the year they may have had 43 different names that occupied a position for a



particular period of time.

MR. COLLINS: We're looking at people not FTE's.

MR. KILMER: What I'm saying is: You took this list, totaled them up, and arrived at the number of private paramedics in the system. It overstates that. That may show up in Buck, A.A. And CARE over the course of a single year.

MR. COLLINS: There could have been that -- like I said, I don't know how many crossed over. But if you look at the numbers that are listed, whether the person worked for one month or twelve months, that was an individual who was employed as a paramedic in the system. And if you are looking at the effect of the number of people on issues like training and availability or experience, it's all there.

I mean, you still have that number of people, even if everybody was part time. In fact, if you had everybody part time you'd have a whole lot of people. You'd have a big problem. You'd have more people. You don't give different training to anybody who works part time as opposed to full time.

MR. LAUER: In the police bureau, for



example, if an officer went from working the traffic in the streets to the detective division, by your methodology it would be turnover?

MR. KILMER: No, it wouldn't be turnover.

MR. LAUER: My point was --

MR. KILMER: It should be turnover.

MR. LAUER: If we had an employee who went from Clackamas County to Multnomah County, he's our employee. It's not company turnover. That would be viewed in your methodology as a new employee in Multnomah County. If the opposite were true, if somebody went from Multnomah County to Clackamas County, that would be turnover?

MR. COLLINS: Yes.

MR. LAUER: Then, in fact, there is kind of a different way of defining turnover.

MR. SKEEN: Jeff's point about paramedics with air fire service, that goes from a first responding apparatus to a Sauvie Island or engine apparatus. And it's probably --

MR. COLLINS: The fire service would be the same way, though, Trace. If they list them on the report as being a certified paramedic in the fire service, we did not try to figure out



what all these people were doing. If they got ten people, they got ten people.

If we're going to do -- the issue came up, I think, with training officers in the MAB in the past of wanting to use paralytic agents and how are you going to get all these people trained. You could, but the position people are taking is you need to train everybody. So if training was an issue, you'd have to train all these people. It doesn't matter if they're working on an engine now.

Now, if they gave up their certification and do not list themselves anymore as a paramedic, then they would not be on this list, and they would be listed as somebody who left, even though they left as a paramedic.

MR. KILMER: Are you troubled at all by the fact that while the fire department licenses 106 paramedics, only maybe 30 or 40 of them are working as paramedics in the system at any particular time; that when you list all 106 of them as paramedics, that others might draw the conclusion that we have way too many paramedics in our system, as Dr. Trunkey I think did in one of his missals to the fire board; and that all

statistics based on total number of paramedics which seemed to be involved in your unit hour characterization and your numbers of turnover misstate the real picture of this system? Are you concerned about that?

MR. COLLINS: I don't think they misstate the real picture of the system from what we're trying to look at. If you have all those paramedics, one of the schedules would have -- if you have 100 paramedics wherever in the system and 75 of those paramedics were assigned on a regular basis to staff ambulances in the street and the other 55 aren't, but they're still trying to be certified paramedics and they're still in the system, that to me is an issue.

MR. KILMER: Isn't the object to concentrate the number of paramedics into a smaller number so they serve as paramedics full time; in other words, put caps on the number of paramedics that can be certified?

MR. COLLINS: That's an issue. That is done in some places.

MR. KILMER: I know it. Did you think about that as an option to realize the savings that your statistics suggest might otherwise be



available?

MR. COLLINS: Well, the turnover doesn't identify any savings. There was no attempt to show any savings in this. We were just trying to look at the -- seemingly whatever the number of turnover is.

MR. KILMER: Don't you divide the number of calls by the number of paramedics?

MR. COLLINS: I did not look at the statistical -- it would be the mean of whatever we used to try to look at this as part of the number of paramedic questions, is if you have all of these paramedics, are there enough options for experience to keep their skills up?

And I think we said also in the plan referenced that I know some paramedics, you know, who -- you know, one group is seeing the bulk of the patients and one is not seeing very much.

But if you look at the number, it is a responsibility to have enough continuous exposure to patient care to be able to say you can still do it. It identifies a potential problem, that there aren't very many exposures.

MR. KILMER: It identifies a potential problem, but does it identify a problem that



really exists in this system based on the way paramedics are actually used?

MR. COLLINS: I think it's a real problem in that we don't differentiate, you know, paramedics that are working as paramedics and paramedics that aren't. And in theory, any one of them could go to work tomorrow and have maybe not seen a patient in a long -- you know, I don't know whatever the requirements are. There aren't any actual requirements for certification for having a certain number of actual patient contacts.

Some other jurisdictions who have a medical director model will impose that over and above the certification, and they'll say yes, you could be certified with the state or whoever certifies you.

But in order to be qualified to work in the system you have to have a certain level of continuing experience with patients. We don't do that now. That's something we'll, you know, get into, the medical director and what they want to do and what they might want to discuss. That's brought up mainly in the plant because people -- that was the question that kept being



thrown out.

(Interruption in the proceedings.)

MR. COLLINS: You know, that came up in discussion, that with some paramedics that were seeing more of whatever our number was, 1.6 per week or --

MR. DOHERTY: Right, a lot more.

MR. COLLINS: Paramedics on the street on a daily basis on the schedule are going to see more.

MR. DORERTHY: But, Bill, when you end up having three or four paramedics on one call with one patient, then you can't take the number of patients and then divide, you know, responses and divide paramedics into it and do that. I mean, clearly when you do it that way that assumes that three of the four paramedics on the call have their eyes closed.

MR. COLLINS: We didn't do that. We did just opposite. For every patient there were two paramedics and they both counted them twice.

MR. KILMER: That could be to derive your low number of contacts per week.

MR. COLLINS: That's what we did.

MR. KILMER: What you've come up with in



a statistical approach bears absolutely no relationship to the real world of EMS delivery in this county. And now the question is: When planners are making their decisions, do they do it based on the real world or do they do it based on statistics which bear no relationship to that real world? The process ought to at least identify between the statistics and the real world and then see which is the more valid basis for making proposed changes or evaluating proposed changes.

MR. COLLINS: How would you argue that's not the real world?

MR. KILMER: Because these guys are seeing more than 1.2 patient contacts a day.

MR. DOHERTY: Some of the people on my list are working full time for the fire bureau. There's some people on my list that work full time for the Portland unit.

MR. LAUER: The last complete year's data you have, you have listed 337 paramedics that you've construed as being -- 337 paramedics that work in Multnomah County. That's not true. That's probably how many work in four counties around here.



MR. KILMER: Not all of them are working at PAPA at any given time.

MR. ROBEDEAU: Some of this is not accurate on our part. It may be my fault. I'm looking at wheelchair drivers, EMT-1's. Apparently somebody just sent in a list of everybody on this stuff. I know people on this list that are working for you people who have left us and are working for people that are working at CARE. And I have ten here that are wheelchair drivers. I have one that got divorced so she changed her name back to what it was. And there's three on my list, Bill.

We kind of work with some rural areas, and we bring them back to work for a while and then when they go back to their rural area they've got experience in this system. The state is trying to fix up what they especially want to have in North Portland, stuff people will never see again in their lives.

MR. LAUER: That gives us a list of all the names of people so we can match their certification numbers and be sure they're certified and can be working in Multnomah County this year. We gave you a list of paramedics we



employed that could potentially work in Multnomah County. If I thought you were going to use this for turnover figures, I would have given you a different list for sure.

MR. ROBEDEAU: You know, system turnover figures need to be compared. We have a couple of part-time people who aren't Portland firemen or fire fighters, whatever you guys are called nowadays.

MR. DOHERTY: Let's pretend for a second the figures are accurate. Then what -- another question I have is: Do we compare -- borrow ratios between public and private or between the two year paramedics and the six year paramedics?

MR. COLLINS: There is nothing in this plan, and I don't think there's anything in the other plan, that speaks to quality of care

specifically. There's nothing in the system to indicate quality of care is good or bad or indifferent. Nobody has ever done anything to look at that. So I'm not making any statements that this currently is bad quality, that this is good quality.

MR. ROBEDEAU: So we're doing all of this just strictly for rates? Is that what I

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hear you saying?

MR. SKEEN: Bill said earlier this is not related to cost.

MR. COLLINS: The turnover study?

MR. ROBEDEAU: I'm talking about the ASA plan and desire to change. We're not doing it for quality care, so we're just doing it for cost; is that right?

MR. COLLINS: We're required by the state to come up with a plan as to how we're going to run the system. We're looking at as many components as people identify and trying to incorporated them in the plan. But the major component that seems to come out in looking at multiple ASA versus single ASA is a cost issue.

MR. ROBEDEAU: So the cost is the total justification for changing the system. The state says we have to come up with an ASA plan, so we have to come up with an ASA plan. That's why we're doing this, to come up with an ASA plan? The proposal to change the system then is totally based on nothing more than cost?

MR. COLLINS: The data in my plan is predominantly based on the efficiencies of the system. It's not based on patient outcomes of

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the system.

MR. ROBEDEAU: But the reason for the change is cost and rates, and the whole basis of this change of either single private or a tiered response is to lower cost?

MR. COLLINS: That's a major factor. You'll hear from other people like the MAB and some other positions who will tell you there are quality of care issues, but I was not able to articulate those in the planning process. I mean, we don't have -- there's no data to support that one thing or another. There are some studies that people are looking at from the MAB, but not anything I'm aware of.

MR. KILMER: Did the MAB people say their quality of care issues identified those issues or did they identify those for you?

MR. COLLINS: You've heard the same thing I've heard. No.

MR. KILMER: I have heard no identification.

MR. COLLINS: You just hear people say -- one of the things we tried to do at the very beginning of this was get a bunch of people together and identify the issues that needed to

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be addressed.

MR. KILMER: Did that process identify what issues needed to be addressed?

MR. COLLINS: I did in -- let me --

MR. KILMER: And those are to do with organizational and administrative, not with medical?

MR. COLLINS: Let me find this. They're on page seven, 2.2.1.

MR. SKEEN: Pete, back to your question you asked Bill. I thought he was pretty clear. In the introduction on page two he talked about five goals for the ASA and EMS planning process. Personally I don't have any argument with any of those.

MR. ROBEDEAU: Well --

MR. SKEEN: Personal interpretation of them might vary but --

MR. ROBEDEAU: I don't -- you know, the only thing I see really addressed is rates and costs. System status dispatches isn't really addressed other than a plan that, by your own quick calculations, is probably highly inaccurate; 86,000 hours as opposed to 140,000 hours.

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And what I heard Bill say was we're talking about costs here, and that's all there is. There's nothing else that is really pushing the system. And I think we have to get it down to -- what is it? What is the impetus behind changing things? Is it the continued prejudice that has been going on here for some time that just said single provider, single provider, damned with the facts? You know, I don't think Bill is trying to skew anything here or trying to skew any of the numbers. But I have listened from, you know, the beginning, and he keeps going back. I've listened for years and years, and even the MAB refused to do anything to the system, stating that any change in the system might deter the need for a single provider system.

And regardless of the fact that the single provider system has never been proven to be needed to accomplish anything of the stated desires of the county, there is a preconceived notion on some people's part, and it seems to have gotten to the point where it is nothing more than a demand by certain individuals because their egos have been hurt that they haven't been

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able to push their will on everybody else, that the single provider system is the only answer to this system.

And there are countless times that the MAB has rejected suggestions for system improvement because -- their stated reason was that it might detract from the perceived desire and need for a single provider system, and I think that's just plain wrong.

And part of this is to try to get to the basis for the exact reasons why it is impractical or impossible to come up with something besides a single provider system. Granted, this time we've got a tiered response system, but we still have a single provider system. What is it that makes a single provider system so attractive other than ego by certain individuals? And I don't think you were even involved in that, quite frankly. This was going on long before you ever arrived.

MR. SKEEN: The issues that I hear are duplicated costs.

MR. ROBEDEAU: Redundant response. What was the term that Dr. Trunkey used? It had to do with the organizational aspect, demand structure. A single demand structure was the terminology

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used.

MR. SKEEN: A single demand structure.

MR. LAUER: Accountability. That's thrown out there all the time. Whether or not you advocate any of those positions, those are some that have already been thrown out by single provider. Joe Acker used to say he preferred a single provider because he -- those are all reasons.

MR. SKEEN: I think Skip Kirkwood mentioned that again in a letter, as well.

MR. KILMER: Where is any data to support the idea that it's easier to administrate one more than several? I submit there is none. Second is that once you have only one, the ease of administration in the sense that you can only call one person to tell them what you want is counterbalanced by the fact that you have lost enormous leverage in the ability to obtain compliance from that one because of the hostage factor.

That is, once there's only one, the cost of punishing someone for disagreeing rises exponentially. That has never been discussed, addressed or factored into this ease of

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administration issue. Any politian will tell you that particularly a very highly popular government body is almost immune from political regulation because of its indispensability.

MR. ROBEDEAU: But the fact of ease of administration is not listed here. It's not here. If that's something that is on the agenda that's not listed in the plan, then I think it

needs to get listed in the plan.
MR. KILMER: And discussed, right.
MR. ROBEDEAU: What I heard here was the reason we were doing the plan the way the plan was, regardless of which plan it was, was all of a sudden because of costs that there were no medical implications. There was nothing else. We're talking about costs. That's when I asked Bill, if that's what we're talking about is cost.
I'm trying to nail this down to exactly, you know, when this came up, what we're talking about. We have prejudices that have been thrown out over many, many years in the system. We have lots of people on record stating that they have absolutely no desire to do anything but have a single provider system.
But we really have no data. We have



some system things here, rates and costs. We have system status and dispatch. All of these things that are listed here have had options proposed for taking care of them. People in authority have repeatedly said no, no, no, no, no, no, no, no, we don't want to do this because it will detract from the perceived need or our desire to have a single provider system.
And what I was getting at is, you know, why, if it's just raising costs here, if that's all we need to look at for looking at whether this system really goes -- maybe I'm starting to lose you. I guess I'm starting to ramble a little bit.
MR. LAUER: I understand exactly what you're saying. What the issue has been, people say we need a single provider because it's not all these economics, and Jeff says where is the data to support that? They say prove it won't. So you've got -- you prove it does and you prove it won't and you never really get --
MR. SKEEN: We go through cycles and you have gone through cycles, and I'm now in one where you have to justify yourself, and lots of industries that are public services are asked to



do that.
MR. KILMER: What Pete has articulated without saying it, he's complaining about the process that has been followed in the past, because many aspects of it seem to point to the idea that no one was open-minded. But instead, the process was defined to facilitate the adoption of a preconceived agenda.
And those process issues have been repeatedly -- our concerns about them have been expressed and will be expressed again. But the fact is that if anybody is saying it's our obligation to prove it doesn't work, otherwise you're going to go with something they haven't proved might work better, that's a highly fluid process.
It seems to me the burden ought to be on those suggesting changes, that the changes will cause a reduction of cost and greater efficiency. Any study of any other systems outside of Multnomah County will find perhaps one or two that someone might argue delivers better care and higher levels and standards than ours at a comparable or lower price.
What it will also find is many, many,



many other systems that don't provide as good of care at higher prices, and that ought to be looked at. And the people that are proposing change ought to be at least required to address the issue of why don't they expect that will happen here. That has not happened.
Now, it seems to me it is not a fair process to tell us that we have an obligation to justify our current system beyond the level that we have done before. The burden shifts then to the other side to say, despite everything that you have said, we think you're still wrong, without them having to come forward and saying why they think that; that the proponents have never really listened to anything we have said, and they have never been asked or taken the initiative to put any data on the table or even specify the basis for their belief that a change would work.
Am I reflecting some of the other process concerns you have, Pete?
MR. ROBEDEAU: I would say so.
MR. KILMER: And this is why I think that this current process is based on everything that happened before. The idea that we have some



segregated record from the moment that Mr. Collins walked in here I don't think will ever apply. It is so vulnerable to litigation.
And I don't want that to sound like a threat, because this whole process here is an effort to try and demonstrate that, if you really do look at these issues and look at the data for proposals for change and then take a look based on that data, change is desirable.
And based on that, you would find that it wouldn't be -- any process that relies on that data is one that is already anxious to arrive at a result that that data happens to support, even though it itself doesn't withstand analysis. That's our concern about this current process.
And nothing about the MAB process or anything that's promised by the county commissioners promises any opportunity to go into the flaws in the data underlying the recommendation in any detail, and that is another concern about our process, particularly when this is such a highly complicated issue.
And all of that seems circumstantial evidence that this process is not really intended to be fair, but instead is structured to advance



a preconceived agenda.
MR. ROBEDEAU: Anyway, you know, you had made the statement, as I understood it, that rates and costs were what we're really primarily dealing with.
MR. COLLINS: That's a big issue. You saw on the first page or second page of what we think the goals are to put it together, and it's obviously a big issue. And you can argue about the data or not argue about the data. The data does not support the status quo.
MR. KILMER: The data doesn't support changes from the status quo as it stands.
MR. COLLINS: I hear what you're saying.
MR. ROBEDEAU: Well, Bill, is there any contingency if this were to go through and the cost didn't change? Then what? Has there been given any thought as to that or how you're going to know if the desired cost reductions are going to actually occur prior to a change?
MR. COLLINS: Well, we would know -- I'm trying to think of how you'd know. You'd know if people were submitting information that was different. Most of the argument has been the data doesn't apply somehow. And, I mean, you can



argue that and I understand most of what people are talking about. But I still think most of it still applies. So I'm not sure what you mean if it wouldn't happen.
MR. ROBEDEAU: Suppose you're going to go to a single provider and you got -- the rates I think are marked in here at, what, 560, 580, somewhere in there.
MR. COLLINS: Or the average rate, the average current rate.
MR. ROBEDEAU: Right.
MR. COLLINS: That's not the rate. That's the average invoice, rates and mileage.
MR. ROBEDEAU: Well, that's rate -- okay, the average bill.
Somewhere in that range you're talking about, what, 20 percent reduction by overhead. You're talking, I think, more than that. You're talking about several millions of dollars, probably a 45 percent reduction. I'm just trying to figure it off the top of my head. I haven't exactly figured it out.
Is there any contingency for a bid if that reduction doesn't materialize? What do you do then?

MR. COLLINS: Well, I don't know because we didn't propose that option. We proposed the tiered system option which would most likely have a negotiated rate rather than a dead rate.

MR. ROBEDEAU: Negotiated rate with a single provider?

MR. COLLINS: Well, that's what's in there now.

MR. KILMER: Who would the negotiation be between?

MR. COLLINS: It would have to be between the county and whoever the providers are. The reason I'm saying negotiated is that one of the issues I think you'd want to avoid in a tiered system is having different rate structures depending on who is transporting or ones where people would try to make the decision based on the rate.

I mean, we have a bit of that now; not from a transport standpoint, but we have people who call 9-1-1 and do not want the ambulance company to come. They say, "Do not send the ambulance company, just send us the fire department." They don't wanted to pay the rate. It's not based on care, it's financial. You



don't want to set up a tiered system that's based on rates that has a rate structure that will cause those problems.

Now, that's not an issue in some places because some places it's all tax supported. At least in my mind, anything that involves taxes, that's not something that's going to fly.

MR. ROBEDEAU: I think I understand your proposal then. You're saying a tiered response, which I think that's the fire department doing time. You also said a single provider, is that correct, for the balance of the --

MR. COLLINS: Right.

MR. ROBEDEAU: How are you going to chose who you negotiate with?

MR. COLLINS: We have not specified that in here at all. That's another step. I mean, if somebody wants to -- if this plan went forward there is a number of things you'd have to do. You'd have to figure out the details of how you're going to deal with the contracts, how you're going to choose a contractor.

There's no detail in here. This is a contract for a proposal, whether you had one or two or, you know, however you did it.



MR. KILMER: So under this system the fire department, if it wanted to, could contract with two providers and --

MR. COLLINS: Under this system the fire department can't contract with anybody except Multnomah County. There's no provision for the fire department to contract with the other providers.

MR. KILMER: How did the selection of the private provider occur?

MR. COLLINS: We'd have to go through some kind of bid process. There's no specification in here of exactly what that is, but my -- and the reason I didn't do that one, that's a tremendous amount of work to put together in a proposal. The only reason I put a bid in is my discussions -- not written opinions, but my discussion with our counsel was for the county to have to use some kind of public bid process. They're still looking to see what other options there are. Right now when the county contracts for this kind of service, it's got to be a public bid.

MR. KILMER: Have you considered that the county could contract with the fire



department to be the fire's first responder in the ASA in Multnomah County, single ASA, and the fire department would then subcontract for the private component of the system?

MR. COLLINS: Why would we do that?

MR. KILMER: Have you considered that?

MR. COLLINS: I don't know why we would do that. See, the fire department technically does only the City of Portland. We would either have them in a tiered system or we'd have to work out some intergovernmental agreement that's going to include the county. I don't know we'd want them to contract. I wouldn't want to have to go through a subcontract process in order to regulate the system. That to me would be kind of awkward.

MR. LAUER: Could the fire department compete for the remainder of the balance of the 9-1-1 calls?

MR. COLLINS: In a tiered system?

MR. LAUER: Yes.

MR. COLLINS: No.

MR. LAUER: Why not?

MR. COLLINS: I wouldn't think so.

MR. MOSKOWITZ: Why not?



MR. COLLINS: I suppose they could. That was not in anybody else's discussion.

MR. SKEEN: In the issue of the two fire departments and the county, you said the county had two contracts for the time critical calls with Gresham and Portland?

MR. COLLINS: The discussions to date with Gresham were that they didn't want to do transports. In the discussions to see if this is even feasible for Portland Fire, it was clear to them if we would proceed in this matter they'd have to provide the transport capability throughout the county.

MR. SKEEN: So Portland Fire Bureau would come to Gresham as well?

MR. COLLINS: No, the transport. Half of Skyline and Sauvie Island and -- what's the other one? And Corbett.

MR. PHILLIPS: And Orient and all the way down to Bluff Road.

MR. SKEEN: That will be interesting.

MR. KILMER: And you wouldn't let some of those outlying calls be contracted, subcontracted?

MR. COLLINS: Some of the calls?



MR. KILMER: In other words, in those outlying areas the fire bureau might want to subcontract even the critical transports.

MR. LAUER: Anything out of the Portland city limits, they could say, "We don't want to do it."

MR. COLLINS: I can't answer that. One of the things that happens, with the exception of -- when you're out by Gresham, when you get out of the City of Portland and the rest of the county, the population drops off awfully quick. Now, when you get out of the east side there are other cities and stuff but, you know, you get out to Sauvie Island and there aren't a lot of people out there.

MR. LAUER: Do you anticipate that the fire bureau's rates for what you chose to transport would be identical to the rates that the private company would discharge for the balance of its ALS transports?

MR. COLLINS: That would be something we would try to make happen, either equal to or greater than.

MR. DOHERTY: What if Gresham wanted to transport?



MR. COLLINS: Then we'd have to -- if they did, we would have to work it out so it operated as a single system between the two fire departments.

MR. DOHERTY: So you would still have --

MR. COLLINS: That's like -- King County, Washington is like that. The Medic 1 program actually resides in three or four different fire departments.

MR. DOHERTY: It's a matter of choice as to whether they'd want it?

MR. COLLINS: It isn't spoken about here because the information to date is that they don't want to. They did a study last February or something and that was the result of it.

MR. KILMER: The result was what?

MR. COLLINS: They did not want to enter

into transport.
MR. KILMER: Gresham?
MR. COLLINS: Gresham. So that's reflected in the plan. That's what I've heard.
MR. KILMER: When you studied Medic 1 or Medic 4 in Seattle and you said that the medic responses, Medic 1 response was provided by more than one fire department particularly out in the



King County area, did you find any evidence that that did not work well?
MR. COLLINS: When I went up to talk to them they did not comment one way or the other.
MR. KILMER: If that's not an issue of concern about coordinating first response among multiple providers, why is there a concern about coordinating private response?
MR. COLLINS: First response is still run by other aspects of the fire department.
MR. KILMER: Were they able to coordinate the transport component of Medic 1 1's response even though --
MR. COLLINS: Yes.
MR. KILMER: Is there any reason that couldn't happen down here with multiple providers?
MR. COLLINS: Probably not. I don't know why -- I don't think it's a coordination issue.
MR. KILMER: It's a cost issue?
MR. COLLINS: I can't speak to why they're set up like that. I know the Medic 1 program started in the City of Seattle. And because they liked it, it got expanded out into



King County. And King County, the non-Seattle piece of King County, is where most of the growth has been, so the program has sort of been done piecemeal.
They also operate strictly on a tax base. There's no fee associated with that. You know, I don't have, you know, tons of depth into their system. The only place I looked really closely is on Vashon Island because my parents live there.
MR. KILMER: Bill, in your starburst study did you submit data, going into their data base, to do the work with the department of civil engineering up there?
MR. COLLINS: No. What we did up there to date on that is we contracted with them to create a program for us. We did not give them data to run. We've only been able to do part of what the program will do. I was able to assign ambulance locations and look at the magnitude of the response.
Otherwise, the say five to eight minutes -- they call them isochromes on their program. Other parts of the program which match will give you the best fit. I have to -- I kept trying to



run it, and we were having a lot of problems and couldn't figure out what was going on. We had the professor come down, and it turned out the data is too large for the program and we have to cut it down. I'd have to show you what I'm talking about.
But, in essence, we used Metro's traffic analysis zones to put the data into. Metro's size is the Portland Metro area which includes Clark County and Washington County and a big chunk of Clackamas County. We don't have work load out there because we're only talking about Multnomah County. But it has too many calculations to one run. We're changing that. That's just to give us, what, the placement of the ambulance. The eight minutes you can still do.
MR. KILMER: When you talk about the placement, though, that placement depends upon the response time. Did you do that on eight minute responses or twelve minute responses?
MR. COLLINS: Eight minute. All that was to do at this point was to see if when we did the demand analysis and the schedule, the draft schedule, if you went through that schedule --



and I can't remember what the minimum number was. It was seven or eight, whatever the schedule was. So was that enough to meet the geographic requirements? Otherwise -- for instance, I know that five will not -- no matter where you put them, you can't cover eight minutes with five ambulances.
MR. KILMER: Did you have data correspondence between your office and that office that identifies the parameters and identifies exactly what the assumptions were and identifies what they did with that in terms of drafting the program and then the results of these various studies as you --
MR. COLLINS: They didn't do any studies for us.
MR. KILMER: You gave them some data that they then used to build a program?
MR. COLLINS: They have a program called EMS IMS. I can't remember what the IMS stands for. That's all they did for us, was put some data into the files. We didn't have anybody to do that, nor had we used the program before.
So what we did was ship them -- actually, we sent data to Metro and Metro used



their program, which is called a Point in Polygon program, to take the data and put it in squares, shipped it to Seattle. They put it into the file format we needed.
The program is all done. It's not standard because they don't sell it. It's an academic program, I guess you'd say. And they shipped that back to me, and then we were running parts of it and we found out that the links and nodes are too great to do this one part of it, so then I had to go call the guy back up, and he's trying to figure out how to get it smaller so it will run.
MR. KILMER: Can we get copy of that so we can play these games, too?
MR. COLLINS: Copies of the program?
MR. KILMER: Yes.
MR. COLLINS: You'd better wait until I get one that will do all the pieces. The '92 data we have not gotten into that format.
MR. KILMER: The data that you submitted in order for them to even develop this program and give it to you so you could play games with it, is that data documented someplace so that we can get it?



MR. COLLINS: That's the -- which data?
MR. KILMER: Whatever data you used to do this supposed study.
MR. COLLINS: The work load is the '91 work load data.
MR. KILMER: Multnomah County data?
MR. COLLINS: The rest of it is Metro time analysis data. It's not our data.
MR. KILMER: How much of it comes out of the data used to build a program initially, which I assume is Seattle data?
MR. COLLINS: None of it is Seattle data. I mean, I'd have to break -- you'd have to look at the program, Jeff, to see all the --
MR. KILMER: Obviously that's what we want to do.
MR. COLLINS: I can't explain it real clear exactly, the data.
MR. KILMER: I'm trying to find it in here. You made a reference in here to a study that you had done. You made reference to identifying the eight minute response pattern, which is only a piece of -- I mean, it doesn't print it out because -- your statement here suggests that you have run a rather full scale



simulation of what you're proposing?
MR. COLLINS: What page?
MR. KILMER: Page 13 and 14.
And was that significant in your arriving at the 38,000 unit hour savings?
MR. COLLINS: It was to the extent that did the demand analysis that we do to cover the geographic fix of the county.

MR. LAUER: If the level was eight, all that's doing is saying that if you have eight different positions in the county covered, you can respond to every place in the county?
MR. COLLINS: That's all addressed.
MR. LAUER: And that's based on the traffic analysis and all that different --
MR. COLLINS: Right. We did not run the part of this that --
MR. LAUER: They compiled that using time of day, using street patterns and all sorts of things like that.
MR. COLLINS: Everything except the work load numbers is all from -- it's really all from Metro. Metro has a traffic analysis system. And actually what we did was -- in Seattle they made up their own and they didn't have a Metro to do



it. So the civil engineering department made a grid and essentially made a traffic analysis program.
Instead of doing that again for us for Portland, we said, "Can't we just use what Metro has?" So they looked at that and said, "Sure, that will fit."
So Metro sent them that piece of it, and we sent them the work load, like which one of these little zones is the work load in.
MR. ROBEDEAU: So your analysis is driving time, and assumes that the unit is actually there all the time? So if you have --
MR. COLLINS: We have to assume it someplace.
MR. ROBEDEAU: So if you're down to four units or even down to seven units, you're not going to make it?
MR. LAUER: No.
MR. COLLINS: But you don't necessarily make it now.
MR. LAUER: All this is based on if you have an ambulance in this spot on the map?
MR. ROBEDEAU: It has to be there all the time.



MR. LAUER: Where can that make it in eight minutes?
MR. KILMER: The point you're making and Pete's making is this is another study that doesn't replicate the real world of delivery of ambulance services.
MR. COLLINS: Yes, it does replicate it. That's what we do right now.
MR. PHILLIPS: It could tell you where you need to have eight ambulances.
MR. KILMER: What we now have, it would take 16 to guarantee that we've got eight at any particular point in time?
MR. COLLINS: That's not true.
MR. LAUER: Being able to respond to all of the calls is one thing, Jeff, but being able to respond everywhere in eight minutes is a different thing.
MR. KILMER: I understand that, too, and that's another deviation from the real world in terms of having a cost efficient ambulance company, system.
MR. COLLINS: That's what we do right now. Buck and A.A. And CARE had a system plan that says how many ambulances they have on and



where they're located to provide the coverage and the response time. As calls come in you're constantly moving them off there, but hopefully you've used the right statistical data to indicate that at this time of night when we've got this number of ambulances on you expect to have a certain number of calls.
So you don't put on twice as many ambulances as calls just to do that. Sixteen doesn't guarantee you eight.
MR. KILMER: Maybe I missed what Randy said. Basically what Randy is saying is that the study you're doing is going to station ambulances so you can respond within eight minutes to, say, the furthest reaches of Sauvie Island and the furthest reaches of Corbett within eight minutes, and that is not really the way we do it.
What we do is staff them differently so we're going to respond in the county in eight minutes 90 percent of the time, but the 10 percent that we miss is going to be concentrated out in the fringes, and staffing patterns that are going to result are going to be significantly different.
MR. LAUER: Didn't you drop boundaries,



like you say, some line in East Multnomah County, or are we looking at something inside the urban area?
MR. COLLINS: PAPA's suggestion makes a lot of sense using a different time zone. You do the time requirement within the urban zone. What you're trying to match up is not only the number of calls but where the calls occur.
So if you've got -- like we have lots of calls downtown and kind of near Northwest and Northeast.
MR. LAUER: Jeff says the analysis you did doesn't try to get an ambulance to Sauvie Island or to Bonneville in eight minutes. It looks at the primary response area in terms of volume, right?
MR. COLLINS: Actually where level eight positions are, the ones that had been used by the county for quite a while does cover pretty much almost all the county. It does not get you to Bonneville.
MR. PHILLIPS: It barely gets you on to the freeway.
MR. LAUER: You didn't look at that part.



MR. SKEEN: Before we adjourn, I'd like to go back to what we were discussing a few minutes ago, and that's on clinical issues. And Bill, if you have anything from your office or from MAB or whatever on clinical issues, I agree it's been real difficult, as I said last time, to pin those things down, and I think it's going to be a necessary ingredient for us to continue once we get into the meat of things next time.
MR. ROBEDEAU: Let's call it adjourned.
(Proceedings adjourned at 12:30 o'clock p.m.)



CERTIFICATE

I, Pamela Beeson Frazier, a certified shorthand reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.
Witness my hand at Portland, Oregon, this 16th day of April, 1993.

Certificate No. 90-0061

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BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS
Tuesday, April 20, 1993
9:10 o'clock a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Barry Doherty, CARE Ambulance
Mr. Thomas Steinman, Portland Fire Bureau
Mr. David Phillips, Gresham Fire Department

* * *

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APPEARANCES

ALSO PRESENT:

Mr. William Collins
Mr. Jeffrey Kilmer
Mr. Christopher Thomas
Ms. Trudi Scheidleman
Mr. Randy Lauer
Ms. Lynn Bonner
Mr. Steven Moskowitz
Robert Norton, M.D.
Jon Jui, M.D.

* * *

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PROCEEDINGS

MR. ROBEDEAU: Has everybody had a chance to review the minutes? Then let's call the meeting to order.

MR. COLLINS: I have two corrections at page three at the top of the page when we're talking about unit hour savings. I don't know if I said it or not, but the part on billing and collections, that wouldn't be a savings.

MR. ROBEDEAU: Where are you, Bill?

MR. COLLINS: Top of page three, first paragraph. It says, the sentence starts at the previous page at the bottom. It said there would be savings from paramedic salaries and billing and collections, and I'm not sure how that got in there. But billing and collecting I don't think ever came up.

And on page ten under discussion of the role of the Portland Fire Bureau, in the first sentence there it said his preferred option would require a negotiated rate with the private provider. That option would require negotiated rates with all providers.

MR. ROBEDEAU: Bill, that's what I

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recall you saying. Maybe you can clarify that on what the negotiated rate was.

MR. COLLINS: Well, if we were going to negotiate rates as opposed to bid rates, we'd have to negotiate them with whoever was charging rates. So the fire department and fire provider would have to do the same thing. If I said that, I didn't mean that.

MR. ROBEDEAU: I can understand that. I have a couple of things. On page four, third paragraph, last sentence where it says, "Robedeau said that this company ran two 24-hour cars and that going to a single ASA would eliminate those cars." I didn't say -- going to a single ASA wouldn't make any difference whether or not you had 24-hour cars. That's a correction if --

MR. SKEEN: Which paragraph?

MR. ROBEDEAU: Third paragraph, last two lines.

MR. SKEEN: That it wouldn't make any difference; is that what you're saying?

MR. ROBEDEAU: I don't think it would make a difference. If I said what's there, I didn't mean to. I'm kind of like, Bill. I don't

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recall saying it, but what the hell.

Then on page nine, if I remember correctly, Bill, we were talking about the paramedic turnover. You said you had not looked at whether or not people went from company to company, just that they left or --

MR. COLLINS: That's right. Does it say something different there?

MR. ROBEDEAU: Yes, it does.

MR. COLLINS: Where?

MR. ROBEDEAU: One, two, three, four, five, six lines down which says he said that he had looked to see if an employee went --

MR. MOSKOWITZ: It should be a "not."

MR. COLLINS: It should be "not."

MR. MOSKOWITZ: I think that was a typo. I think I remember that.

MR. ROBEDEAU: That's all I have.

MR. SKEEN: Pete, on page seven, first paragraph, three lines up from the bottom it says, "Mr. Skeen suggests that a private provider could screen calls to be dispatched by BOEC." I have no idea what that even means. I question the context in which that was stated.

MR. ROBEDEAU: We were talking at that

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time about calls coming into a private dispatch with a CAD system.

MR. SKEEN: And they could monitor?

MR. ROBEDEAU: No. Well, I'm not sure that this is exactly accurate, but what it was talking about was the private dispatch center screening the calls and therefore having a value within the system. I'm not quite sure off the top of my head. I don't quite remember the context of that right now, either, but there was something on that.

MR. COLLINS: I think you were talking about the dispatching, not call screening. Because, you know, if you wanted to exercise that kind of an option, a private provider or somebody other than BOEC could dispatch calls, but nobody other than BOEC would be the piece out. They can't be the answering point, even if you wanted it.

MR. ROBEDEAU: I think this was in connection with a transfer.

MR. SKEEN: Transferring the screen could receive a secondary screen from BOEC?

MR. COLLINS: You could be the secondary but -- weren't we talking about

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dispatching?

MR. ROBEDEAU: We were talking about dispatching. If I remember right now, what it was was we were talking about BOEC's interest which was transferred directly. When they said medical it went straight to --

MR. COLLINS: Is that what we were talking about?

MR. SKEEN: Well, the following statement here where it says, "Mr. Collins said that could be a possibility" on the discussion that the private contractor could do the dispatching of the units, and you said that could be a possibility.

MR. COLLINS: Right, but not the call taking.

MR. DRAKE: If it came in as a medical

call, isn't that what you were talking about, Trace, that it would be automatically handed over to the dispatcher?

MR. SKEEN: I don't think we ever got to that point in the discussion.

MR. COLLINS: We never got it that fine-tuned.

MR. THOMAS: Bill said you could have



dispatch if there was one provider, not if there were multiples. And Pete said, "Gosh, that's the first I ever heard you could do that."

And Bill said, "I wanted to make it clear I don't agree with that concept but you could do it."

MR. ROBEDEAU: What should that read?

MR. THOMAS: It really should say that Mr. Skeen suggests a private provider could dispatch calls. I don't think he talked about --

MR. COLLINS: We just talked about the dispatching.

MR. THOMAS: It had something to do with the question of whether Bill had properly eliminated dispatch calls from the ALS -- your dispatch center calls from the ALS rate and that was when you got into, well, we could actually dispatch.

MR. ROBEDEAU: Anything else? Does anybody have a motion to approve the minutes as corrected?

MR. DRAKE: So moved.

MR. ROBEDEAU: Second?

MR. STEINMAN: Second.

MR. ROBEDEAU: In favor? Opposed?



Carried.

Okay, two things today. We have Dr. Norton here.

Are you here representing the Medical Advisory Board, or are you here as a physician?

DR. NORTON: Both. I'm primarily here as a medical advisory board representative.

MR. PHILLIPS: A concerned citizen.

MR. ROBEDEAU: I'm sure everybody knows Dr. Norton.

Let's take a five-minute recess.

(Discussion off the record.)

MR. SKEEN: I think there's about 12 copies here.

MR. KILMER: Why don't you give one to the reporter and have the record reflect this was passed out at this meeting as the draft that Mr. Skeen prepared, the side by side comparison between the PAPA proposal and the Collins' proposal.

Did you have anything to do with that, Mark? Is this a final document or is this just the first draft?

MR. DRAKE: First draft.

MR. COLLINS: We just faxed out what



you sent us as fast as we could put it in the fax machine.

(Discussion off the record.)

MR. ROBEDEAU: I think everybody here knows Dr. Norton. If anybody doesn't know Jon Jui, Dr. Jon Jui is a supervisor. They're two new ones that haven't been here before.

I would like to go on with the agenda. This first portion of agenda this morning was to cover physician supervisors and MAB concerns on the current system. Mainly we're talking about level of care here this morning.

Do you have a copy of the agenda?

DR. NORTON: I don't, no.

MR. ROBEDEAU: I don't know if I have an extra one. Does anybody have an extra copy of the agenda?

MR. KILMER: Do you have one in front of you?

MR. ROBEDEAU: I have one in front of me. Here is one. I don't think I've marked on it.

DR. JUI: I have -- yeah, I have the agenda.

MR. KILMER: Yes, that's it.



MR. ROBEDEAU: There's some notes on that.

For your information, what we did is we went through it at the first meeting and did a tentative agenda that we got out to everybody that's pretty explicit so we could stay on task and get this -- get this finished by and into the county commission by May 14th.

So what we have as the first item -- and these are suggested questions and we would certainly hope anybody would add anything that they had to say or any concerns they may have that are not here or anything that's addressed in either one of the plans that we did not put on our list.

But one of the things we had asked and asked PAPA to attend, and they have apparently refused, is what would be of concern to the paramedics, and their answer was pretty much "find out for yourself." But let's move on with our agenda for today.

Dr. Norton is a representative of the Medical Advisory Board. I know the Medical Advisory Board has some concerns. Could you articulate those for us?



DR. NORTON: Boy, I don't think I want to be the spokesperson for the Medical Advisory Board at this time because I think my opinion is different from some of the others on the board. I guess the question is the level of care in the current system and how the ASA plans should be designed to address those issues. Is that the question under review?

MR. ROBEDEAU: The concerns expressed over the past or the concerns expressed by the MAB at their last meeting and what are the concerns the MAB has with level of care, if any. And I'm not trying to put you on the spot. If you want us to back off that and let you off the spot, that's fine.

DR. NORTON: Well, I can express some of my own personal opinions about it, I guess. One of the issues, I think, in this system is it's my belief that there are probably too many paramedics in the system, so that the experience of an individual paramedic is limited; and that experience is measured by the number of critical care patients that they take care of and of the number of skills that they do. And in particular, the one area that I have major



concern about is the airway management skills, and I don't have hard data to prove that.

I have anecdotal experience and that, of course, is subject to a lot of bias. But I think one of the problems in the current system is that we don't have a good way to monitor that kind of experience. We don't have the data base to look at that. So I think that is an issue.

That, I guess, would be my main area of concern. I think there's issues still about training, and the physician supervisors are meeting regularly to address that and try to come up with a cohesive, comprehensive, organized training program which includes continuing education; so that the paramedics are hearing a more unified voice from the physician supervisors rather than each individual physician interpreting protocols individually, which may disagree with some of the other supervisors.

So I think we've made good progress along those lines. And it's hard to measure the effect of that. I don't have any way to say whether that's improved the system. It's my belief it has.

So I think that my major concern, I



guess, for the system as it is is that I'm concerned that the paramedics aren't individually seeing enough critical patients and maintaining their skills and procedures.

MR. ROBEDEAU: Okay.

DR. NORTON: I'd like to hear Jon's view of that, also. He offers another perspective on that.

MR. ROBEDEAU: Are you representing physician supervisors?
DR. JUI: I guess I could.
MR. ROBEDEAU: Why don't we hear from you?
DR. JUI: We share the same concerns, although it's hard for us to determine whether these concerns are in total valid, because we have no data showing comparisons between outcomes of highly trained paramedics versus outcomes of people with not as much critical experience.
In other words, I couldn't say -- it would be nice to do a study between the Seattle two-tiered system where you have, quote-unquote, highly trained paramedics who have a delayed response or paramedics who are not as highly trained with critical patients. Does that make a



difference or not? And I really don't know.
I can't tell you any studies that has shown that kind of outcome. Although it's logical to assume that if you deliver, given all the parameters are equal, the highly trained medical people you get a better outcome; parameters being arrival at the scene, same equipment, same time, same dispatch, same level of care in the emergency department and final care.
That's addressing Bob's -- I have a lot of other concerns, as well, if you want me to go into that now.
MR. ROBEDEAU: I think Trace wanted to say something here.
MR. SKEEN: I just had some questions.
When you talk about training and high performance, is the training -- are you looking at training as a component of having more experience because of having more incidents, that they are --
DR. JUI: Yeah. I'm looking at patient encounters. The axiom is usually assuming you're the same intelligent person, the more experience you have the better because you've been through



that scenario before and you know how to react and you've thought about it before.
The more experience with medical leadership the better, because at least you know what you're doing sometimes. Sometimes the blind can lead the blind. But given the contextual situation of an equally qualified medic, the more experienced medic, from a medical point of view, is going to probably have a better outcome.
And there is a corollary in medicine for that, and the corollary is it's obvious you need to do an internship and residency before you really, quote-unquote, know what you're doing.
MR. SKEEN: I think clearly there is an issue of the number of incidents. I guess my question is: Are you insinuating that there is a higher level of training that's available to current paramedics within the system that they're not receiving, or are you just talking about experience?
DR. JUI: No. I think experience -- I think the level of training is actually quite good within the system. It could be better, and some of the areas where it could be better is obviously airway. Some of that we're trying to



work on right now, and that's access to airway areas of training, specifically O.R.'s or operating rooms.
So that facility has not been made available to us, and that's a political as well as an operational issue within the community. But as far as the other areas of training, I think we do a pretty good job. There is --
DR. NORTON: I would support that, too, except that I think there are still some -- I mean, for instance, the paramedic program that we're associated with up on the hill, we send our interns, our students, for internships at other systems because we don't feel that in this system that they get enough of the intensive experience and exposure to patients that they need during the concentrated time during their internship.
And I know that other programs in the area still intern here. We do occasionally; I'm not saying we never do. But I'm saying the majority of the students that come out of our program take their internship in other EMS systems, because we feel the intensity of exposure during internship is not there in this system.



DR. JUI: There's some element of that, although if you take a look at our current internship site location, that's not a huge variable. We're sending people up to Tacoma and some of the other places and the volume is, quote, fairly similar. You can get experience here.
Most of the reasons for sending people away have been to see another system. They have a different outlook, a broader outlook on how the systems are arranged. The other would be do not burden one system with the educational body of paramedic education. So there's more variables in that.
MR. LAUER: I might point out also there's a lot of competition for internships. There's a lot of paramedic training programs. We certainly feel that we're inundated by requests for internships, and there's only so many that any provider can reasonably accommodate to provide a good experience.
DR. JUI: I think there is a dichotomy. The dichotomy is that essentially EMS systems by comparison -- everybody knows about it more than I do -- is that the public must have easy access.



They must have someone to answer the phone, and they must have someone to respond as quickly as they can to the scene if it's a critical incident. And they need to make an assessment at the scene and, if necessary, take that person as quickly as possible to the hospital.
And basically that's sort of our emergency response from an operational point of view. There's a lot involved in that, where if you take a look at our system right now where we are weak is not ALS response. In part, our BLS response is only meeting it 75 percent of the time. ALS is 90 percent or 85 percent or 95 percent, depending on how you draw your times. We're not doing CPR. We're having some problem with 911 dispatch. Our BLS responders are not getting there. Some parts of our area are not having defibrillation, and in certain cases airways is not being controlled, and I'm having a problem from medical directors training my BLS providers. There's only so many hours and so many trainers that --
MR. KILMER: Jon, how are you using the term BLS provider? I thought we had an all ALS system.



DR. JUI: First responders.
MR. KILMER: Is BLS response --
DR. JUI: Yes.
MR. KILMER: Thanks.
DR. JUI: As you know, Jeff, there is a combination of BLS and ALS first responders, but the majority of my problems right now is with BLS first responders. I'm having a hard time as a medical director getting to them and training them. Not because there's not a desire, it's just that there's 600 or so bodies. In order to get efficient quality you have to be everywhere, and that's what the major problem is that I have.
Getting back to paramedics, the top dichotomy is having enough to cover time response but having a small enough number to maintain a critical experience, and there is a magic number, whatever that is.
MR. ROBEDEAU: I just wanted to interject something here. You're talking about having a problem with your training of BLS first responders. Under either one of the plans or the current system is anything on that going to change?
DR. JUI: Without -- without getting

into -- depending upon what -- let's assume that the support of the plan is -- the example Mr. Collins pointed out, and I thought we publicly said this, any support of the fire service which is essentially BLS and ALS depending on first responders would enhance fire's ability to train BLS first responders.

And my point here, in putting my fire hat on, is that the system needs to support each other, and there is need within the fire service to develop an EMS operation that would support BLS training first responders.

MR. KILMER: Isn't it fair to say that if the fire service was to do the first response in the tiered situation that Mr. Collins is talking about that it would greatly accelerate the number of early ALS response and at least to that extent address your concern?

DR. JUI: Partially. If you take Mr. Collins' plan, plan B, which some of you are in favor of here, and say that there's money allocation to first responders, that would also address it as well. So we're looking at resources that are finite within the system.

MR. STEINMAN: If we're comparing these



two plans, I think the biggest problem with BLS training is physician time. I think PAPA's plan would be disastrous if we go with that single medical czar. That person would be busy enough just taking care of the paramedics in the system and never touch the first response.

MR. LAUER: I guess I have a broad question. We're talking about level of care, and we seem to be focusing on first response right now. What do we as a group want to accomplish with first response? That first four minutes, if that's the standard we ask for, what do we want to have done between four minutes and when the ALS unit arrives?

DR. JUI: I think that's pretty clear. The major interventions that have been proved to be of efficacy have been -- actually three interventions. Number one would be determination of criticality of illness, proper mobilization. That's been a hidden agenda that most outcomes have not really studied.

The second one obviously is paramedic intervention, and third one is early defibrillation. Outside those interventions, I don't think you could be a sound medical model



for saying anything else. It's my bias that certain other ALS interventions -- of particular interest is heart failure, dysrhythmias can be of benefit, but I don't have the data to prove that right now.

MR. DRAKE: So if you wanted to, your model for first responder service would be that the paramedic engine companies, paramedic first response with early defibrillation --

DR. JUI: Yeah. There are two major advantages to the ALS engine first response system. The primary advantage for me is I have noticed within the last 18 to 24 months that there is a dichotomy between our engines, BLS engines and ALS engines.

I go to an ALS engine. The people on the crew know they're EMS. Why? There is a role model, continuous feedback, there's 24-hour training, there's questions and answers. So I have representatives. My agents are my medics who actually pass that information down to my other 600 EMT-1's.

MR. DOHERTY: I was going to ask you that question, if you can tell the difference between --



DR. JUI: Absolutely. It's like night and day. It's not even -- you have a hard time believing you're in the same system. I go around and I go around to -- I do ride-alongs all the time and there's a night and day difference.

I can't get to that system and that kind of level of training without putting a medic in the house, and that's -- that's sort of my hidden agenda with ALS and first response. You could make a case for early EEG's and good BLS training, but I still have a training problem.

So essentially the ALS engine process fulfills my primary need and then it's EMS training for EMT-1's and BLS responders, and that's the real need that I have.

MR. LAUER: So to accomplish that, the optimum would be to put a paramedic in every fire station?

DR. JUI: Yes, that's correct.

MR. DOHERTY: Does it make a difference, have you been able to look at whether or not you have a paramedic in any of your stations versus a paramedic actually on the engine; i.e., the paramedic goes out on the rescue?



DR. JUI: There's a difference and that's dynamics, the difference between dynamics in station houses. And the paramedic on the engine is part of the crew. When they're a part the crew, the crew responds when they're given responsibility. When they're isolated to a rescue, it is those guys that do EMS. We just do fire, okay?

MR. PHILLIPS: The worst trained or experienced EMT's that we have are the ones on the engine that are stationed in the station with the rescue because the rescue handles all the first response in that station. They don't have any patient contact unless the rescue is somewhere else and another call happens in their station.

MR. LAUER: How many fires stations are there in Multnomah County?

DR. JUI: Thirty-three, plus Corbett Fire, plus Sauvie Island --

MR. ROBEDEAU: Bill, does your plan call for a paramedic in Corbett and Sauvie Island and Skyline and that?

MR. COLLINS: No. In fact, I think there was a mistake in what we said. But on the



personnel part of this, we proposed that the EMT basic list of the minimum requirement for anybody engaged in any EMS response, and that was more to set a standard for the smaller departments so they could work towards it.

I mean, I know that Sauvie Island isn't going to scoop everybody up and round them out and get them trained all of a sudden, but that was kind of -- you know, being a predominantly urban area that that was the minimum requirement. That's all that we said. We didn't say anybody had to do anything with that. Now we have other training.

MR. LAUER: I wanted to kind of follow along on the map of the desired outcome. A desired outcome would be to put a paramedic in every fire station.

DR. JUI: Let me finish this point.

MR. ROBEDEAU: We need to determine which fire stations you're going to put them in in order to -- I think I know where you're going.

MR. LAUER: If you put one in every one of them, you'd need over 200 paramedics.

MR. KILMER: Can I just suggest that to address what Randy is talking about, Jon said he



has additional concerns early on, and Trace asked a question, and we never got all of the concerns on the table. It seems to me as we go to desired outcomes, we ought to be talking about that in terms of all of the concerns that Jon has and Bob has and the MAB has if we can state them and talk about it as a system.

Because we're focusing on the first responder's ability to address a large number of these things, and that's independent of the privates or the numbers of privates, and that needs to be segregated, at least from the medical point of view it seems to me as we discuss this around this table.

MR. ROBEDEAU: Well, I think that is part of at least Bill's plan -- and correct me, Bill, if I'm wrong -- and what Randy is getting

at is how many paramedics under Bill's plan as opposed to the number of paramedics under the current system or the PAPA plan.
MR. KILMER: I'm saying that you have to discuss that in terms of all of the concerns, and those concerns are not on the table. So you ought to get the concerns on the table and then talk about that. Because one without the other



is only going to leave you having answered one problem but not addressing four or five others.
MR. LAUER: Well, Bob Norton and Jon both brought up that they think there's too many paramedics in the system, and I tend to agree with that.
MR. KILMER: Those are on the list, but he hasn't completed the list.
DR. NORTON: Well, if you want another item, I think the turnover is an issue, so maybe we can talk about that.
DR. JUI: Let's talk about the process for a second. The process that I'm envisioning right now this very minute is to establish needs, physician and EMS needs, and then we can go and decide which system would best fit those items.
I agree with you, Randy; for quality ALS we have a problem with too many medics. I'm not saying it isn't a problem. I'm telling you there's a need from BLS first response to maintain EMS expertise. I'm not sure if I have the answer as far as that, but there is a need. I'm just saying that. I know what you are --
MR. LAUER: I think you misunderstood me. You're talking in a context of level of



care, and I think it's important to talk about what level you want and what that means in terms of meeting your total needs, the --
DR. JUI: The other need, before I forget, is that EMS is not static. It is dynamic. By that, I mean there are certain advances that come along down the pike, as you all know. It's not unique to EMT-4's or 3's or 2's or 1's or even first responders.
So, you know, 1994 may come to a point for something ridiculous that -- like we find that magnesium would be efficacious at the first response level. How am I going to do that for BLS without having someone that knows what to do from an ALS point of view? Again, the training needs are not static. Today it's AED. It may be the PTL or -- tomorrow might be early I.V. Drug, a wonder drug, or whatever it is. So that's the other need.
We're seeing creep -- creep up of national BLS standards, are going to come up with AED's and potentially intermediate airway. How are you going to maintain that airway? There's 600 people you've got to pass through every year to maintain that airway. So there's continuous



education need and the need to incorporate newer technologies and newer medical advances when they're deemed to be appropriate for the system.
MR. DRAKE: So to clarify what you're saying, what I hear you saying -- part of what you're asking for to put that paramedic on an engine, they would be the medical leader for that engine company?
DR. JUI: Absolutely.
MR. DRAKE: So you don't need to train necessarily all the BLS technicians to do PTL and to do all of that stuff because you have a paramedic that knows how to do all of that?
DR. JUI: That's right.
MR. DRAKE: So it simplifies your training needs and your access to the people?
DR. JUI: Absolutely.
MR. SKEEN: Well, I thought I had it until you agreed to that. If I understand what Mark just said, is that you don't need to turn the BLS people to the AED and those other issues because you have the paramedic. My sense was that that paramedic assists you with teaching the rest of that engine crew or the BLS people on the crew --



MR. STEINMAN: Why do we need an AED if we have a defibrillator there with a paramedic on it?
DR. JUI: You don't need an AED. What we need is an assessment and the skills of knowledge and assessment of the EMT-1's and BLS people to know what to do, how to do it, how to fill out the forms and the proper approaches. The actual technical skills of operating an AED are real technical. They're almost -- there's a certain amount of finite hours you can learn, and either you know it or you don't know it. With a medic there you don't need that amount of skills.
On the other hand, what you do need is good EMT-1's that can work as a team to identify as a resource and deliver better patient care. And I actually think there's a question of are two medics better than an engine medic? In some ways an engine medic, an EMT-1 and a medic is a bit superior in some ways to a combination of two EMT-4's, are superior. So I don't really have a solid answer as far as that's concerned
MR. SKEEN: Just to backtrack, so I understand this, very quickly. You talked about the interventions of the first response being the



determination of predictability and immobilization and stability. Secondly was airway, and I guess my question on that is: It basic airway management or advanced airway management?
DR. JUI: Basic airway management right now.
MR. SKEEN: And third was early defibrillation?
DR. JUI: That's right.
MR. SKEEN: Okay. And then your comments were that there is a marked difference between a group of BLS people that has a paramedic in their midst versus those that have paramedics that they rely on to run the rescue, to run all the EMS stuff.
DR. JUI: That's correct.
MR. SKEEN: What you're saying is that you saw a real advantage with a paramedic being a facilitator to help with the training process with these BLS people to accomplish these tasks as first responders?
DR. JUI: Exactly. It's much more than training. It's attitude, and the attitude permeates the whole house. And those are



primarily the BLS needs. On certain of the primary ALS, BLS airways are not being met either because they can't do it. Their jaws are clenched or they can't maintain protection because they don't have any PTL tubes. Maybe the PTL tube is an answer, but I don't know how --
MR. ROBEDEAU: One clarification that needs to be made. If there's 33 total fire stations between two departments, I think we're talking about closer to 100 paramedics, assuming that there's a paramedic in every fire station on every shift rather than 200. That would be 99 plus --
MR. KILMER: Jon, have you articulated all of your concerns?
DR. JUI: I haven't had the opportunity. There hasn't been the opportunity to do this at the Medical Advisory Board.
MR. KILMER: Right. But here you do have the opportunity to articulate all of your concerns.
DR. JUI: That's what I'm saying.
MR. KILMER: And have you articulated them here?
DR. JUI: Oh, I have more.



MR. KILMER: Why don't you get those on the table?
MR. DRAKE: Dr. Norton had one, too, here.
DR. JUI: The two primary ALS skills obviously is, as we said before, paramedic skills and knowledge. Some of those are numbers and some critical encounters. I think our system

needs an effective quality management program. We're trying to integrate that right now. It's not being put on hold, but this process has superseded that process.

We need better community input and feedback from our people that we deliver patients to, both patients as well as other providers. We hear a lot of bitching, and there's no mechanism to hear that bitching. I would prefer to get before all the directors, nursing and medical directors, of the emergency department and say, "Okay, this is the forum. You're going to yell at me, okay, and I'm going to hear all your bitches. If you don't bring them up now, don't say you never told me or didn't have an opportunity." That needs to be done, and we need to work on solutions as a system to iron out



those problems.

There are other special needs, and those include disaster management, hazardous materials management, urban rescues as well. And EMS needs to be integral to that. You don't have to be part of the same operation, but it needs to be incorporated within those special operations teams.

There needs to be more prevention, and specifically injury prevention. EMS, in order to survive in the 1990's, is going to have to make its case before the health care providers. And as we're going through this MPH stuff you're going to need to talk their language and do their analysis in a way that they want to hear and that the system needs to go to that.

From a user point of view, cost is a huge problem. Stability, system stability being low turnover of EMS dispatchers, BLS providers and ALS providers and BP providers in all of the systems. Finally, research is a need, continued research and analysis of our system. Those are my big needs of what I think or consider this system needs.

MR. ROBEDEAU: Bob?



DR. NORTON: Well, I can just basically echo all of those. I think the quality management issue should assume a priority. I think one of the advances that we've seen in the last couple of years is the physician supervisors are working more closely together, but they're still stymied somewhat by access to the information from the different companies and not being able to share that and look at a problem from a system perspective rather than from an individual agency's perspective. And I think that clearly needs to be changed and coordinated and make it more comprehensive, I think.

MR. KILMER: On that point, have you made an effort to articulate those problems to the various providers and seek to smooth those out? In other words --

DR. NORTON: I personally have not, no. But in the different forums that we have, different quality assurance activity, it always seems to come up. Now, I'm not saying you can't get any information, but there's always the question, "Well, can we release this, can we share this," that kind of thing. Just some of -- it's just the cumbersomeness of going through all



of the agencies and trying to ask for it and get that information. It's improved. I have to admit that.

MR. KILMER: One of the issues that has always been one that has been supported by the single provider components is the idea that it would be easier to administer a single versus a multiple group of ambulance companies from the physician supervisor perspective.

And I had had some conversations with your department now that all of these are the -- all of the major groups in this area except for Metro West, as I understand it, are concentrated now in your department.

And I've heard that that problem has diminished a great deal, and I'm wondering whether you can tell us in the complex of all of the things the physician supervisors have to deal with how large a factor is the one you're articulating now? Is it still a major factor in allowing adequate physician supervision? Does it take significant additional amounts of time? Does it slow down your process of bring uniformity to the system to any significant extent, and has there been resistance to your



efforts to try and cure that problem?

Those are the kinds of things that I think we need as a provider board here to decide how big a problem that is and whether it can be solved in a multiple provider situation to the satisfaction of the reasonable physician supervisor.

DR. NORTON: I think the answer to most of your questions was yes, but there has been improvement, and I want to make that clear. Because we just have completed a study on contacting medical resource hospitals before using certain drugs for presumed congestive heart failure, and all of the agencies cooperated very well with that.

But it takes something like that project to get people to work more together, I think. And what we need is a system designed to do that on regular basis rather than going through a research project to get it done. But clearly over the last couple of years it's much better than it was before. And I am not discouraged. I think that it can improve even more, but I think there still is a need.

MR. KILMER: Jon, you've had experience



supervising both the first responder and one or more privates. Have you found it -- have you found you've been able to do your job in a uniform fashion that way?

DR. JUI: I think, yes. Multiple providers can work, assuming that they're all on the same thinking as we are. I would rather have two multiple providers that are pro EMS than one single provider that really is anti EMS.

A good example would be Philadelphia Fire where it's really anti EMS and that seems to be stagnated. You could be sitting here with a list of good single providers and bad single providers and good multiple providers, as well. It is easier from a single operations point of view to have a single provider.

Essentially, a single provider will automatically do single operations. So I want to reiterate, if you have BLS first response and ALS you already have two providers, and you need to integrate the two systems, assuming you're only on one system.

And so if you design a multiple provider system, you need to have single operations and a single way of quality assurance,



medical direction and unified operations.

MR. KILMER: Based on your experience, you see that as a reasonable possibility in a multiple system?

DR. JUI: It can be if you design the system correctly. It's more difficult.

MR. LAUER: So system design would be really figuring out how to coordinate --

DR. JUI: Yes.

MR. KILMER: I think the thing has to start with making that a high priority rather than it's something you have to do and a drudgery. Quality management has to be elevated to almost number one in priority for everyone, and then the organization comes from that and operations from it will go smoothly.

DR. JUI: I think it would be helpful, Jeff, to go through a process -- let's assume that we wanted to go for congestive heart failure. For us to do this right now, I would have to go through each of the providers education officer and operations manager and okay that with him or her.

And so right now -- before it was three, so I would go to all three and that's

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duplicity of work. If there was one provider, I would sit down with one or two meetings and you'd be done with it.

One of my biggest frustrations as a medical supervisor is essentially the system, although controlled by the super doc, is controlled by legislative action. Legislative action is the MAB -- that's good, but it's not near as responsive as the dictator system.

An example, with Seattle, if you say something is going to happen, it's going to happen throughout the whole system. The danger from the dictator system, if the dictator is not knowledgeable, he or she will take that system down the wrong pathway for awhile. There's no checks and balances to that system.

As a physician supervisor I think there needs to be checks and balances to the system but not burdensome to quick medical direction and changes and quick implementation of resources and knowledge and equipment.

MR. KILMER: In the whole context of physician supervision though this difficulty of multiple contacts for a new program, does that represent one percent, five percent, ten percent

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or fifty percent of your duties? That's really what I'm trying to do is quantify this problem, because everybody focuses on the problems, it seems, and no one focuses on how much would be the same whether you had single versus multiple.

DR. JUI: It's not an insignificant problem. It's moderate.

DR. NORTON: As an example, Jon has the system of monitoring the skills and procedures per paramedic instituted in his agency. But when we talked about trying to do this as a system-wide, it was like it's a huge project and it would be very difficult to implement.

But that should be something that the whole system is doing now. And it's something that I think we should still work for, but it will be a lot of work trying to get that coordinated through all the different agencies. Yet it should be something that everybody is doing routinely.

MR. STEINMAN: I have a question for Bill, I guess.

It gets kind of confusing when we're talking about single providers and quality management with everybody involved. Is it

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possible to ever see a single provider EMS in this system? My way of thinking, you'd have to have 9-1-1 for every fire first response agency plus the ambulance. I mean, there is no such thing as the possibility of a single provider system in Multnomah County, is there?

MR. COLLINS: If you are looking at a single agency to do all of it, it would be pretty hard. Because even if you wanted fire, you'd have to have one of the fire departments assume all the rest of them.

MR. STEINMAN: You know, I don't know what the single provider system is that we keep talking about. I don't think it's a possibility. There's always going to be multiple providers in the system.

MR. KILMER: I think the point that Tom is making is so important from this, because people tend to assume if you reduce three providers to one you've eliminated all the problems. The fact is: A number of agencies involved in this are dispatch, police, fire, the hospitals. And reducing from three to one is really not going to solve very much at all of the kind of problem that you were talking about.

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And in that sense, this needs to be quantified and put into perspective, as well. And it's that depth of thinking that I think everyone in the system needs to engage in when they really talk about the relative benefits of system change and where the burden ought to lie in light of some of the risks that Jon has identified about going to a single system and having it not work well or become extremely expensive, as the Seattle system is.

MR. STEINMAN: I'd like to point out for the record that was not a safe way for Mr. Kilmer, that I was pointing out -- I was just getting confused, especially the Q.I. Process when we get on that. I mean, it's a horrendous problem to try to bring everybody together now, and I think it will continue to be a problem. Because I think that's the biggest problem we're faced with.

The State of Oregon decided that the only thing they could address on EMS was ambulances, and that's what they've pawned off on the county to do. And then we've got you over there getting confused as to what is first response, are we going to do AED's, are we going

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to do ALS, your questions about paramedics. And we're all sitting here and looking at ambulance service area plans, not ALS planning, and it's really confusing.

MR. LAUER: I think the state must describe first response in the statute.

MR. STEINMAN: It describes it, but tells you to mention it. It doesn't tell you to use it in your planning process, to make it part of your system. It just says, "Tell us what you do."

DR. JUI: The other major problem is a regional problem. No matter what you do -- let's assume there's a disaster hazardous materia'. Those clouds are going to cross the Multnomah County, Washington County, Clackamas County line. It doesn't care. We have multiple providers in those counties. They're going to be milling around four or five countries in this area. There needs to be an interaction between all EMS providers and health care providers that deal with EMS, and right now there's no forum for that.

A good example is a disaster management plan. We have no area regional wide disaster

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management planning effectively going on. Why? There's no forum. There's no dictator. We have essentially nothing that would be equivalent to an A ten one or regional EMS authority. There's no structure hanging on. Citizens are confused. They say, "Well, why can't everybody work together?"

It's not that simple. You have no structure to work together in. There's no mandate from the state, etc. That hole is going to continue to occur unless one or two things happen: All the EMS providers get together and say, "It's going to kill us, we better work together," or "There's going to be a dictate from the state saying you need to work together," one of the two.

MR. STEINMAN: But in this process I'd like maybe if the providers could figure out what are we looking at, just the ambulance end of it, or are we looking at first response that Randy wanted to point out would burden the system with more paramedics? It's two separate issues, and I'm not sure -- I'm starting to get concerned myself.

MR. ROBEDEAU: I think what we're here

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for, Tom, is to look at two separate plans. We have the EMS plan and PAPA plan, and part of what today is is to look at the medical aspects of both plans. And part of the medical aspects, as I understand it, as articulated by both Dr. Norton and Dr. Jui, are the coordination. I think what we need to do now is address how Dr. Norton and Dr. Jui representing physician supervisors in the MAB see both plans fitting in, addressing the issues that we've just articulated.

Does the PAPA plan and the EMS plan, do they or do they not address the issues, or do they address parts of them and not other parts of them? I think we need to keep this on -- what we're here to do is to evaluate the plans and make a report to Bill Collins.

MR. LAUER: We also, Pete, we talked about addressing issues --

MR. ROBEDEAU: We did do that, but right now we've come along with a lot of concerns addressed by the medical community, and I think to keep this on task the way, you know, I think we need to do it is to now determine off the two plans if any of these are addressed or if they

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are not addressed or if they could be addressed, and then address the things that are not in either plan.

MR. LAUER: Tom's question was: Do we look just at ambulance providers or do we look at the whole system?

MR. COLLINS: I don't think you can do that. I can't possibly see -- and hopefully it was somewhat reflected in our plan that we put together. I do not see how you can look at transporting ambulance services for 9-1-1 systems and not look at a first response. I just don't know how you -- even if you say we're going to keep the first response exactly like it is and that's going to then drive these decisions. I mean, you just can't do it.

MR. SKEEN: You can't look at it in a vacuum, and I think Dr. Jui specified that in looking -- forget about who is going to be the provider of services. What's the outcome, or what are the outcomes you're trying to reach, and what's the reasonable methodology for reaching those outcomes?

And you went through and enumerated that. And I'm disappointed you didn't have the

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venue to provide that before, because we talked last time about the difficulty of getting input on the clinical performance of the system heretofore. I'm fairly new to the system, but what you've offered today is probably more than I received in the --

MR. KILMER: Last two years.

MR. SKEEN: Two years for me.

MR. ROBEDEAU: That's what I was saying. Does the PAPA plan address the EMS system? No. That's my opinion.

DR. JUI: To be honest, neither plan does.

MR. ROBEDEAU: Does the Collins' plan, or this county plan, for lack of a better term, address it? I think it tries. I think it could be added.

DR. JUI: There's more body in the Collins plan that would support a system wide operations issue than the PAPA plan.

MR. COLLINS: You need to identify if there are pieces missing because they need to get into the -- whatever the final document is going to be.

MR. ROBEDEAU: Are we past that or do

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we need to --

DR. NORTON: I would like to just add that one piece that I think needs more discussion and review is the integration of air transport in the system. I think the paramedical transport is an ambulance system, and I'm surprised that there's not a representative from Life Flight on this board. Because I think they provide ALS response, and they should be included within the --

MR. COLLINS: They are included. They're just not here.

MR. ROBEDEAU: Dave Long, as far as I know, is Life Flight's representative, but they have not come to a provider board meeting, and I can't tell you when the last one was.

MR. LAUER: Because they don't provide first response.

DR. NORTON: But we're not just talking about response.

MR. SKEEN: Air transport, yes.

MR. ROBEDEAU: Are you talking also about fixed wings out of the airports?

DR. NORTON: No. I think that we can deal with the problem on a manageable basis I

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think just within scene response.

MR. COLLINS: Well, plus, there are no fixed wing carriers in this area that provide the patient care component, that I'm aware of.

MR. LAUER: Well, I hope the fixed wing people don't start doing scene response.

MR. COLLINS: No, no. They just have a big hook and they fly very low.

MR. KILMER: Swoop and scoop.

MR. STEINMAN: I think that's a good point, though, because one of our members of the citizens' group did recommend we do all first response using helicopters just like Emanuel, so maybe we should get them involved.

MR. ROBEDEAU: All first response?

MR. DRAKE: Have we completed your list?

DR. NORTON: I think the research part of it is a very important component of the system design, and I think we're going to have to justify what we do more and more. And we're going to have to do outcomes research, and we're going to have to look at the technology that we're using. I think we need to look at the ALS first response, whether or not that really does

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improve the system. I think that's open to some question.

So I think more and more that that should be designed as like with quality management, one of the high priorities within the system, to continually analyze what we're doing and ask the question is it effective.

MR. KILMER: Should that be done before you come up with a plan to change the system?

DR. NORTON: No. Well, ideally, yes. But, I mean, it's just the logistics of trying to get all the questions answered is just so overwhelming. I think that we need to take small parts of what we do in EMS and look at them on an ongoing basis and say does this make sense? Is it really an improvement in care, and is it cost effective?

And I think those are the measures by which we're going to have to justify our being in the next few years. We might as well incorporate that in any system design.

MR. KILMER: Can I then ask this question which was raised, it seems to me, by your first concern, which is, there are too many providers in the system to allow the level of

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contact with critical patients that will maintain the skills, the paramedic contacts. And considered in isolation, you can obviously increase that level of skill by reducing the number of people that are allowed to respond to a finite number of critical care experiences in this system.

The major problem is that our people are telling me that the number of critical incident occurrences in the system is quite low. It is probably 10, maybe 15 percent that might be considered. When you actually arrive at the scene it's 5, maybe 10 percent of the kinds of things that are really going to respond to experience where you have the unique situation, a very severe injury and that kind of thing. There is an enormous cost associated with concentrating that group of paramedics.

Number one, you have to dedicate the system and, number two, you probably have to concentrate that in the first responder. And if you're going to do it that way, the tax cost or the cost of the EMS component alone of the system is very high. And at some point is the cost so high that you can't increase, you know, this

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patient contact ratio in a cost effective manner?

DR. NORTON: Well, I think those are good points. I think, though, the 10 to 15 percent is something that has been looked at in other systems and probably it applies to almost all EMS systems. It may be even lower than that.

But the issue is not only just having those paramedics see those patients. I think

having a smaller group of paramedics allows you to do other training than just patient care and patient contact, although I still believe that's a very important part of their experience and their maintenance of the skills. But ongoing training, continuing education will be a lot more effective with a smaller group of paramedics.

MR. KILMER: See, the reality of this is that you have 40,000 responses a year. You have something like 60 to 70 percent that you actually involve transports. Of those, that's the only group that is 10 to 15 percent. If you divide that out, what you have is a couple thousand of these things, maybe 3,000 a year.

Well, then you divide that by days and you've got maybe 10 a day scattered all over this county and scattered through all shifts and two



paramedics on the private ambulance that responds, plus an additional two on the fire department that responds.

And you start taking these numbers and looking even in a system where the response is concentrated in a small number of people, and you're only getting one contact a week maybe or two weeks per paramedic. And so now maybe that contact is one every three weeks. Does the increase in contact from three to two accomplish anything medically that justifies the cost of accomplishing that?

MR. LAUER: I think that the point that's being missed is that whatever that percentage of time sensitivity to critical patients is is not immediately known when you roll up on the scene. The true experience is needed to figure out who needs treatment real quick, what treatment they need, and it could be provided by somebody who has done it before. But that's a lot more than whatever that group ends up being, because there's a real gray area that's a lot bigger than --

MR. KILMER: How big do you think the gray area is? If we had even the most remote



group triage, what group might represent that kind of injury?

MR. LAUER: It's hard to tell. Nobody knows that, really.

MR. KILMER: It seems to me these kinds of questions ought to have been addressed a long time ago in the process. When you look at the cost benefit aspect of --

DR. NORTON: I agree. But I'd also say that I don't think we should agree there should be four paramedics on the scene for these critical patients. To me, it should be open for review and discussion.

MR. KILMER: My clients have been proposing for years that you can change that. We have been proposing single dispatch. We have been proposing cutting back on people and training, some of the other stuff, and none of this has really been addressed.

And we have suggested this ought to all be done as a cost benefit basis, and part of our concern has been that the system has resisted this sort of an evaluation.

DR. JUI: I'd like to make three statements. Number one, we don't know what



amount of training and what type of training is necessary for retention, and there is a huge dichotomy of abilities.

Some people in my service right now, I can have one code every other year and they would remember everything. Some people can't remember anything after five codes in one week. So there's a huge variability of retention of knowledge.

There is not enough science right now from an educational model to indicate which people need what and what they need. I have -- you think you can run manikins. You can run simulators. Some of them may be okay for certain people, but maybe not. So I think there's a whole science of literature and knowledge that's out there that's really needed to answer your question. Until we do have that knowledge, we're going to assume the logical things that they need to see, the interactions and have good medical leadership and guidance on that.

The other hidden agenda here is that the doctor-paramedic interaction is a treasured one in this system. That one is -- for some reason we have a very high doctor to paramedic



ratio, and that's something that I think my medics like. For all good systems there usually is a very high doctor to medic ratio. If you have some problem, you call the doc on the phone and you'll have immediate interaction with that problem.

MR. KILMER: Do you think the PAPA proposal threatens that?

DR. JUI: Well, I can't answer to PAPA. It depends on whether PAPA uses agents or not. In the current context without the agents it does threaten it, but Bill's only calls for one as well, but Bill uses agents that will work.

MR. KILMER: What would have to be the qualifications of the agents?

DR. JUI: Same as the medical director.

MR. DRAKE: Dr. Norton, you had some other concerns. I'd like to have them out on the table.

MR. SKEEN: Let me ask some questions of Dr. Jui before we go on to Dr. Norton.

You talked about the high doctor to medic ratio. Are you talking about accessibility?

DR. JUI: Yes, accessibility and



interaction between quality of medical care and what you should have done and what you should have not done.

MR. SKEEN: Earlier I believe you indicated when we talked about the quality management process, quality management as well as research, do you include cost benefit analysis in that?

DR. JUI: Absolutely. Absolutely.

MR. SKEEN: Also, I think you used the term access when you talked about quality management. I guess it was Dr. Norton that talked about access being stymied by individual organizations. My question is whether there is a orchestrated resistance or whether it's just a difficult task.

DR. JUI: No orchestrated resistance from my perception. It's just difficult within the current structure as outlined. There is no structure of a unifying quality management body in this area right now.

MR. THOMAS: That's where you were talking a little bit about you sort of liked the czar concept, the checks and balances, that somebody could answer your question that this is



what's going to happen and everybody knows it.

DR. JUI: That's correct.

DR. NORTON: But I think with the quality management you need input from more than just the czar. I'll restate. I think there's been great progress in the last couple of years, but I think we've also come late to this and maybe somewhat reluctantly on some people's part.

So I think as long as it's placed at a high priority it's feasible to do in a multi-provider system, but it is more difficult just because of the different agencies involved. It's not impossible but more difficult.

MR. PHILLIPS: Can I respond to his comments earlier?

MR. COLLINS: No.

MR. PHILLIPS: Thanks, Bill.

MR. LAUER: Thanks for asking.

MR. PHILLIPS: In the current system with the multi-county system that we basically have, right now we're talking about what happens in Multnomah County. In Multnomah County when an experienced paramedic fire fighter becomes burned out and asks for a transfer, he goes to a different station in Multnomah County, whereas

with the other ambulance companies, when they -- the potential exists that they do not get transferred to somewhere else in the Multnomah County system. They get put somewhere in a different county, and they may or may not come back into our system until later or move up into our county. But under a one-county system we may never see them again if they're to be excluded from the county under a single provider.

MR. LAUER: That's sort of a regional approach.

MR. PHILLIPS: I mean, eventually we probably need to look at a regional approach, but we're here talking about Multnomah County. And when a paramedic goes down to a busy fire station and gets the experience and becomes a good paramedic and decides he doesn't want to be an experienced paramedic anymore and wants to work at another station, he's still a benefit. He's still a benefit in Multnomah County. We don't send him to Tualatin Valley Fire to work.

I have to go here, but if I could just make a couple comments.

We like the county's approach in the areas of levels of care. We like the county's



approach. We're resistant to anything that says we shall provide first response. By all means our goal is to provide the first response. But we have an MAB that is like a fire board that recommends what we should do, and that recommendation is that we provide ALS first response. So our goal is to do that. We also have a city council and a budget committee who says what are we getting for our dollar.

So in light of that, our goal is to provide ALS first response but we don't want anything to say we shall. We're happy to negotiate that, and we're happy to do that. As far as cost savings and level of care, by having paramedics out there we can do two things. We can either lower the cost to the system, i.e., the costs of the transport, or get more improved service for that cost, leave the cost the same.

And what we're looking at is by putting a paramedic on every engine for that same transport cost, hopefully we can get some of that transport money back to improve his training and also maybe improve the system by if we could provide a paramedic there on every call, maybe eight minutes is too soon to have a transporting



ambulance come. Maybe we can get by in ten. I would put that up to talk about. That would be less units, less paramedics in the system. It would be transporting paramedics, not first responding paramedics.

MR. KILMER: That's in your plan, isn't it, Bill, to reduce the response time for the private and tiered response?

MR. COLLINS: In the tiered response. I think his statement, though, is another aspect of this, that while we didn't exclude it we didn't expand the discussion to that. And that is, if you actually have a guaranteed ALS first response throughout the county, you might have a different configuration on all of your transports. But I think --

MR. KILMER: Even without fire transport?

MR. COLLINS: With or without. But I think that the key word in there is you've got to guarantee the response. You can't have a first responder system that sort of says, "We'll try to get somebody out there." But if we don't then you run into staffing problems. And we're not to that point yet, and we did not try to push that



in the plan. We just didn't.

MR. PHILLIPS: Our only concern about a tiered response would be getting out there after a four minute response, taking two to three to four minutes to recognize the call; and then eight minutes into the call after receiving the call, calling for an ambulance that only has to be there in 12 minutes, and therefore us sitting on the scene for 20 minutes. That would be our only concern. We're happy to stay another two minutes to get that transporting, add another two minutes, but maybe not the full additional 12.

MR. DRAKE: The ambulance is dual dispatch, so it would be arriving there within 12 minutes.

MR. PHILLIPS: But under the tiered response it sounds like a code, but they're up and walking around. They don't need this critical transport. Right now let's call a BLS ambulance.

MR. DRAKE: That needs to be worked out.

Dr. Norton, do you have any other concerns? We are trying to list those out and keep getting sidetracked.



DR. NORTON: The stability and turnover issue I think is a concern. And again, it's not something that you can point to a study saying that high turnover leads to poor care. I think it's more intuitive that high turnover leads to more training and continuing education problems and not effective use of either the physician's time or the training officer's times and those kinds of things. So I think it's an issue how it directly impacts patient care. I can't tell you -- I can't measure it, but intuitively I think it does.

MR. KILMER: What do you understand the real incidence of turnover here is? Bill's, we believe, artificially inflates that because it counts as a turnover. An experienced paramedic that goes from A.A. To CARE, from Buck to A.A., that's turnover. Do we have any good statistics in the real turnover rate here among active paramedics?

DR. NORTON: I don't, but I have my own observations within the system doing the monthly paramedic conferences, and it's rare that you see all of the same faces twice at these conferences. I think just observation-wise I think it's an



issue, and I don't have the statistics to support it.

MR. KILMER: The second question -- and I wish the PAPA people were here for this one -- but is there a turnover? Is it money or is it working conditions or is it something else?

DR. JUI: Yes.

DR. NORTON: I'd have to defer to the paramedics on that. I don't know.

MR. KILMER: What's your understanding, though?

DR. NORTON: From what I've heard in talking to them, it's the working conditions and the pay issues. There's no sense of pride in working for whatever agency they happen to be working for, and so they don't feel any commitment to staying. They don't see any chance of professional advancement, long-term career stability. I think those are issues.

MR. KILMER: How do any of these plans address that, though? Because the issue seems to be if it's primarily money, that money is going to have to come from an increase in rates which will then impact the ability of the system to do some of the other medical things that you want.



And has anybody --

DR. NORTON: Those are probably the two major issues. I think still the frustrations that the paramedics are feeling about all of the anxiety of what the system is going to be, whether they're going to have a job, those kinds of things are very important to them, as well.

MR. ROBEDEAU: Those things -- I would like to just kind of follow up on a couple of things here. Those things you're talking about are out of control as far as whether or not they're going to have a job, stability, all of that.

The other thing I would like to suggest that the paramedics who were saying there's no career opportunities, there's nothing like that for them in the system, they're shortsighted.

They want to see career opportunities in two or three months. I know I've seen that, and I've had people tell me there's no way for a paramedic to advance in the system and become anything but lower echelon management. And I think, at least for some of us, that that's not true.

MR. DRAKE: Do you hear the same things that Dr. Norton is hearing from the paramedics,



Dr. Jui?

DR. JUI: A couple of things. There are some very dedicated medics that have stayed within the system. Some of them are sitting in this room. I've noticed when I go outside Multnomah County, all the good medics I've seen, the older medics I've seen in Clackamas County that are older, and I've known many for a long period of time. There's a higher turnover seemingly within the core of the Multnomah County area. I'm not sure if that perception is true or not, but that's my perception.

So from a regional point of view there is retention, but from our point of view, sitting downtown, we're seeing new medics every day. So there is a problem with that. Within the county we're not retaining the medics. The medics are somehow staying in the system but not in the county.

There is a high turnover, I think, within the private for many different reasons. There might be a different bunch than public, different career advancement, obviously different pay and different working conditions.

MR. KILMER: Do you consider it as a



turnover when a fire paramedic comes into the fire, does paramedic work on a rescue unit, and even though he retains his paramedic status, moves back and becomes principally a fireman as opposed to principally an EMS guy?

DR. JUI: If I can call on that medic to work as a medic, that's not a turnover. If I cannot call on that medic to work as a medic, that's turnover.

MR. STEINMAN: Questions came up last time about our turnover. We've got the same thing that happened to you with people going between the companies. When we move people up for promotion reasons or whatever it appears as turnovers in Bill's data, so we're all in the same boat.

DR. JUI: If I can't get ahold of that person, that person is gone, that's a turnover. If I can use them, him or her, as a paramedic, that's a rare thing, whether he or she is within the system.

MR. STEINMAN: One question, Jon, since the court reporter is here and you have a lot of paramedics that worked for you, you say the best paramedics you know are in the outlying areas?



MR. LAUER: That's what he said.

MR. KILMER: Are you saying the best are out there or some of the best are out there?

DR. JUI: I'm saying some of my best, favorite medics are sitting outside the county.

MR. STEINMAN: Which type of paramedics is that?

DR. JUI: All types. This is the truth. There are some friends I know out there that I've known for a real long time.

MR. LAUER: Multnomah County is a busy place.

MR. ROBEDEAU: One of the things, too, that needs to be looked at with paramedic turnover, and I know to a degree A.A. Has done that, has brought in rural paramedics, put them with an FTO, brought their skill levels up, and then they went back to the rural area. And I know the state is trying to do that on a regular basis with rural paramedics. Especially they seem to really like the district A.A. Has because we see stuff that real paramedics never see in a thousand years.

And I know we have done that with some of the coastal communities and a couple of



Eastern Oregon communities, and I realize in looking at that that those paramedics that we had brought in and done training with in order to benefit the rest of the State of Oregon were counted against us as turnover.

MR. SKEEN: Dr. Jui, there's a real paradox with this, because most large urban settings run into the problem of high intensity, high utilization and some eventual burnout. I think that's going away industry-wise perhaps because we're getting a little smarter about it. But you have the issue of wanting, on the one hand, to have a highly experienced -- I think intensity is what Bob used -- highly experienced medic, and on the other hand you have the issue of turnover that results often times as a result of that, whether it be being transferred to another company or to an outlying -- within the same company to an outlying area.

DR. JUI: Right.

MR. SKEEN: It's just a difficult issue.

DR. JUI: I can guarantee with the fire turnover I personally have less -- I mean, you can build advancement of increasing knowledge



with decreased turnover, see the same bodies, same faces, same thing we talked about over and over again. You can build on that advancement.

With agencies -- fire I believe has a lesser turnover than the private, and it's easier for me to do my job as a medical director of fire because I don't have to teach the same things over and over again.

And it's inherently one of the demands of the job that's -- it's a hidden agenda, until you decrease the turnover as medical director and his or her agents are going to be saddled with continuing in servicing and not advancing the system.

MR. SKEEN: Are you basing that on an intuitive perception of turnover, or do you have hard data that shows that the --

DR. NORTON: We don't have hard data, but I think our experience is probably the same, is that we keep talking about the same thing with new faces.

DR. JUI: The numbers don't make -- I would say that the fire turnover is smaller than the public -- I mean the private turnover. What



quantity, I don't know. I don't really know.

MR. SKEEN: But you're basing that on observations of what you're seeing as far as people you're dealing with?

DR. JUI: Yes.

MR. ROBEDEAU: I would agree with that to a degree, and I'm not -- I would like to make one more observation. We didn't have, prior to the ordinance that is currently in effect, the turnover rate that we have now in paramedics. We have experienced paramedics fully trained coming into the system with their EMT-4 who suddenly are there for a very short period of time and realize this is not for them.

And by virtue of two EMT-4's being required on every ALS unit, we have no way to allow paramedics or potential paramedics to decide if they want to be a paramedic. The fire bureau has that ability, and they're responding to these things, and many of the firemen I believe as EMT-1's learn whether or not they want to go on and whether or not they can handle this. And that's one of the things that's been built into the system, as I see it, as an inefficiency that has created problems.



Quite frankly, I can remember one case where we had a young lady who came to us fully trained as a paramedic, came out of the U, worked for three shifts, went on a rape-murder and walked off the job after that, and she has never gotten back into it. It was something she was not prepared to see. That's happened more than once.

MR. SKEEN: That's what you, Dr. Jul, said about the internship that you have in the physician community, is that opportunity to be able to evaluate their career.

DR. JUI: That's right.

MR. STEINMAN: Trace, I have a question. You seem to be uneasy with the turnover rate figures. Do you believe that there's a big discrepancy between our retention and yours?

MR. SKEEN: My sense is also without a lot of hard data that no one seems to have -- my sense is if you really get down and looked at the experience factor between private and public paramedics and what happens to those paramedics as you track them through the system, that you probably wouldn't see a lot of difference



probably between public and private. My sense is that the public sector probably has a bit less turnover, but probably not a lot.

DR. NORTON: Can I ask a question? If there's so many questions about Mr. Collins' data about turnover, why don't the agencies provide that information?

MR. KILMER: We're going to --

MR. SKEEN: That's a great question.

MR. KILMER: We're in the process of trying to work that out. We didn't know until Mr. Collins' data came out that it was going to look the way it did. That's part of our concern.

We wish that he would have preliminarily published his view and said, "That is what it looks like to me. What do you guys have to say about it before I make any plans based on it?" A.A. Has 26 paramedic slots. It is counted as having 40, 41, 42 paramedics every year. The reason for that is that some of those are part-time people in there. Some have been promoted, some have left. But there really aren't more than that number of paramedics on a staff at any given time. You take 40. You do the same thing with CARE and do the same thing



with Buck, and all of a sudden you have a much larger group of people that are listed as paramedics working in the system that actually aren't working at any given time as paramedics in the system. And then you divide this much larger number by patient contact, and it skews dramatically the contact figures that you fellows are now basing your concerns on.

DR. NORTON: But it just goes back to, I think, one of the points we've made over and over. We've got to have that information.

MR. KILMER: Exactly. And we gave him the information that we thought he wanted, and then he took more from that information and what was legitimately available in it without asking any more questions. That's our criticism. We talked about that last time.

We will be in the process of giving more accurate data of how many paramedics really are in the system at any particular time. Now, we can't do that for the fire bureau. We don't know how many of them are on rescues, back off on the engines doing paramedic work, how many of them go into areas where they're not --

MR. STEINMAN: Trust me. It's public



record, and I know you have access to anything.

MR. KILMER: I don't mean that as criticism, Tom.

MR. STEINMAN: I'm saying you could get that data. If you want it, it's yours.

MR. DRAKE: We can also ask Tom.

MR. THOMAS: Dr. Norton is right. The system as a whole does not gather data well. I view that as completely independent from things having to do with numbers and providers. The system hasn't made that a priority. That's another area to actually decide exactly what data it wants to collect and collect it and make everybody provide it and all that. And that is a significant issue. It would help a lot of things, I think, over time.

MR. SKEEN: The other thing, Bill has never represented his data to be anything other than the process that he used. He said, "This is the process I took." And other people probably formed assumptions that he didn't necessarily form.

MR. THOMAS: Something I've wondered about, because we've hit both edges of it now, one of which is experience and paramedics having



the chances, at least a number of them, to handle the critical cases. And the other is the potential for overload and its relationship to turnover.

And I have always been interested in knowing what is -- I guess we talked about unit hour utilization ratio is the way you measure in that area what the right range is for paramedics to fall in. It would seem that is really a critical number to know. There's a number that's too high and there's a number that's too low.

MR. LAUER: There's too many variables, Chris. It depends upon the length of your shift. For example, if you're working 24 consecutive hours, you can't have near the observation --

MR. THOMAS: I'm trying to have Pete get away from how you manage that and accomplish something more from strictly a physician's point of view apart from the economics of it where Dr. Norton would like the paramedics he's thinking about in terms of experience to fall.

MR. LAUER: The danger though, Chris, is to use unit hour utilization as a measure of work load. There's some correlations that it really doesn't do that well.



MR. COLLINS: There are no particular standards that have been put forth, that I'm aware of, that says what the level of experience should be.

DR. NORTON: I can just give you a range, I guess. Keith Neeley, who many of you know as a paramedic who works with us, came from Denver, and he basically I think would admit he became burned out with that system. And they were seeing patients, doing at least one every hour. It mean, it was continuous in a 12 hour shift. So I think clearly that's the extreme.

I mean, Keith is an excellent paramedic and very knowledgeable, and it's a shame that that kind of thing happens. I think for his own good he has advanced, but -- so that's too many. Seeing one a shift is too few.

So it's going to be around, you know, five or six at least. But again, that's sort of my own opinion and it's not based on a scientific study. It's something we need to look at, though. And also it depends on the types of patients that you're seeing. If you're seeing six straight cardiac arrests, that's different from seeing minor injuries that you don't



transport.

DR. JUI: You have a corollary with the doctors, as well, here. The doctors burn out. I can tell you from experience it's harder working constantly at Kaiser because you're on the go all the time, and the same thing applies to our paramedics. So that kind of -- there's the fatigue factor and there's more burnout in the systems that are continuously under stress.

MR. THOMAS: Randy, part of your point was if you're doing a 24-hour shift, one per hour is different than if you're doing an eight-hour shift. I mean, there's a lot of variables on that.

MR. LAUER: Yeah, right.

MR. STEINMAN: It's real hard, though. I mean, we've been trying to figure out for a long time -- in fact, Jon and I had lunch the other day and I got into a discussion with him. I wanted to know why all of the E.R. Docs are so qualified, because some of them see one patient a shift and some of them see 50. It's the same thing there. He contends they're all qualified because they retest every two years.

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MR. THOMAS: It would seem like in system design, however you're going to design your system, you want to figure out what you want to accomplish there. It is awfully hard to do that in that area, at least until we sort of hone in on what the range is that we want.

MR. KILMER: It seems to me also with a system design that you want to compare what you've got now with what you want, and you want to take a look at what you've got in other cities compared with what we have here now. And then you take a look at what's medically good about the system, what is not medically good, and the criticisms you've made of this system are issues that are basically highly subjective in terms of judgments.

And the more you stop and look at them, the more tenuous some of the underlying assumptions become. And in the meantime, we have an excellent system here in many respects. We are all ALS, two paramedics on every ambulance, all of these paramedics are reasonably well-trained.

There's no indication that we are having bad outcomes. The number of complaints

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that come out of the hospitals, the number of complaints that come from citizens to EMS, the number of those complaints that ever result in a citation or further investigation is very, very low.

And so the question is: Do you want to give up what we've got and risk the current level of performance for accomplishing a couple of marginal additional improvements that may or may not be needed and take the risk that you'll end up with a system like many single provider systems that are now around the country that are more costly and less effective than ours?

MR. STEINMAN: Is that the question, or is the question if the county wants to know whether they can continue to afford this system, the citizens can continue to afford this system?

MR. KILMER: I think that question involves two things: What will the new system cost, and what are the risks that it will be more costly than this one? You know, there's assumption around here that you can reduce the quality -- cost of this system significantly by a change. And I don't think that that would bear analysis, but certainly it ought to be analyzed

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before you make the change.

MR. ROBEDEAU: What I heard Tom kind of say was there was a confusion between cost and rates.

MR. STEINMAN: No. What you heard Tom say was he wanted to take a shot at the Jeff to see if he could get him to shut up.

MR. DRAKE: Is there anything else from either doctor, any other issues?

DR. NORTON: One last thing, and that's the role of on-line medical control. And I speak now as a medical director for a medical resource hospital rather than an MAB representative. And I think in terms of the system design, just making that fully integrated into the system, I think we do a pretty good job of that from an operations point of view but we don't from a funding point of view. So I just want to introduce that topic. It needs to be discussed.

MR. LAUER: For the record?

DR. NORTON: For the record.

We provide that service. We're essentially a $10,000 contract from the EMS office. It costs at least 175,000 to provide a 24-hour communications clerk, and that doesn't

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even begin to address physician time for staffing that. Comparable California systems with medical nurses answering the call run anywhere from 300 to $350,000. So that's part of the system that is not addressed or funded, and I think it needs to be discussed at some point.

MR. SKEEN: How were those California models funded, do you know?

DR. NORTON: Bill can speak to that. I think hospitals bear some of the costs.

MR. COLLINS: Most of them are funded pretty much like our MRH's here, little or no funding to the hospital, although I think that's changing. It's the same -- you know, the concerns that Bob has. As it becomes more expensive as dollars become tighter for the hospitals, we have to start looking at whether they can provide that service or not. I don't know any that are fully funded. Well, that's not true.

In the areas of California that I'm familiar with, those areas that have EMS service districts do fund out of their tax base. Most tax supported or substantially tax supported EMS systems tend to fund these things out of the tax

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base.

DR. JUI: I've got two other issues. One of them is rural EMS. There are rural aspects in Multnomah County, and from a medical director's point they need to be addressed. I don't know quite what their needs are besides a slowness of response, perhaps maintenance of EMS skills in the community. Those are the primary ones, particularly the Corbett, Multnomah Falls area and Sauvie Island.

The other one is there is no current system data handling within our county. I would like to have numbers, and some of the numbers we're talking about today had a comprehensive data management system within the county that would look at system performance. We don't have all those numbers. We don't have access to the numbers.

MR. SKEEN: Well, system performance relating to response time?

DR. JUI: Outcomes in process performance, performance times, outcome measurements, how good we are doing.

MR. SKEEN: Patient outcomes?

DR. JUI: Patient outcomes. Those are

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roughly -- whether we're accurate in dispatch. I mean, I have a lot more questions.

MR. SKEEN: On the patient outcomes, is it because the health care facilities don't participate?

DR. JUI: No. I have no idea how our system performs except for anecdotal studies, one of them which we'll present at the physician supervisors meeting. So the only two ones we can potentially compare right now are the trauma system performance compared to other comparable cities with equivalent injury scores, as well as cardiac arrest data compared to other cities with similar response times and similar capabilities.

MR. ROBEDEAU: Have you done any comparisons on that?

DR. JUI: The cardiac arrest study is probably going to be presented, and we're doing actually pretty good. Ventricular fibrillation witnessed, we're running about 45 percent safe. Unwitnessed, around 20 percent, around 20 percent. And there's a great big delta between with CPR and without CPR, as well.

MR. MOSKOWITZ: Those numbers, could you go over them again?

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DR. JUI: Well, actually, those numbers will be presented formally at the physician supervisors meeting.

MR. MOSKOWITZ: Can you go over them informally again then?

DR. JUI: Roughly 40 percent by standard witness with CPR. That's all the new variables. And 20 percent unwitnessed with CPR, and no CPR, no witness, about 15 percent.

MR. DOHERTY: That's really exciting.

DR. JUI: This is defib only.

MR. DOHERTY: Was there a comparison in response times between first responders and transporting --

DR. JUI: ALS response time in the 1991 study was roughly 5.5 minutes or even less.

MR. DOHERTY: In comparison with the

survivors and --

DR. JUI: Time of dispatch through time of arrival.

MR. DOHERTY: Was there a comparison of successful cases and what those responses were compared to unsuccessful?

DR. JUI: I don't have that information right now. I just have the information I gave.



But that's the first -- the real reason for me bringing that up is that's the kind of information that we need to evaluate the system.

MR. THOMAS: One thing that you have eluded to but haven't specifically talked about is portions of Bill's plan proposal, not for the tiered response but for changing the staffing of the ambulances that are not handling the ones that the fire bureau would be handling, and the change in response time from eight minutes to twelve.

I'd be interested if it would be worth the group's hearing, whether you guys feel that's appropriate medically, not appropriate, what you think the implications of that might be.

DR. NORTON: I think the key to that is working out the protocols for what would involve a critical patient that fire would be transporting. And I think as long as those are well thought out, that having a single paramedic on the -- transporting noncritical patients would be acceptable.

DR. JUI: There are two demands. One of them is a scene assessment, scene intervention demand. That usually is cardiac or airway. The



second demand is to get the patient that's traumatized to the hospital as soon as they can, and that's usually transport, obviously with a ten-minimum model of trauma system.

So you need both. You need early arrival, as well as early enough arrival to get the traumatized patient to the hospital.

MR. KILMER: Is that your definition of time critical transport?

DR. JUI: It's one of the examples of time critical transport.

MR. THOMAS: What I was thinking of was for -- not for the ones that the fire bureau is carrying under, or however you would define it, but for the balance do you see a problem with shifting to -- for the other carrying vehicles, one for the paramedic and the staffing that Bill has proposed the change in response time from eight to twelve minutes?

DR. JUI: That's one answer. Bill's need is real. He needs to be able to guarantee that person is there within a certain period of time.

DR. NORTON: To answer the second part of your question, I don't think there's a problem



with extending the time with the privates. I think the eight minute is based on the Seattle study for ALS arriving at the scene and it's for cardiac only, and I think it does make sense. But when you have fire or ALS first response then the time when you actually transport becomes perhaps less important for those noncritical patients.

DR. JUI: We do know, Chris, the following scenario: You have a cardiac arrest patient. That person does not have CPR. The eight minutes really doesn't make that much difference. The outcomes between six and eight and ten are about the same. If you put CPR involved, then it does make a difference.

So one of the variables is citizen CPR, and the training of that issue. It turns out in this study that I just mentioned, the CPR, about 50 percent of the patients actually had an arrest inside their own house, which implies that a relative would be doing CPR, which usually is not a problem from an HIV, social disease standpoint.

MR. LAUER: The other part of that, too, is that the four minute and eight minute time came out of the Seattle study addressed --



DR. JUI: That's correct.

MR. LAUER: The other thing that we need to keep into consideration, the penetrating trauma patient that needs rapid transportation. I don't know if there's any independent studies, but a lot of people would agree that's the only way to treat someone in the field.

MR. MOSKOWITZ: Should we take a break?

MR. SKEEN: One quick question, Dr. Jui. How would you characterize either currently or the need in a plan for expanding the feedback groups from the medical -- the medical oversight arena, the physician supervisors, the on-line medical control with the administration of the provider, whoever that administration might be?

DR. JUI: Are you asking me to comment on the value in the plan, of each plan in administering that?

MR. SKEEN: Not of each plan. If you were going to be the author or architect of a plan, is that a component that you use?

DR. JUI: Absolutely.

MR. SKEEN: And I guess the other question is: How would you characterize that



current status?

DR. JUI: There are some people that are left out of the planning, the community feedback. We're not doing a good job of getting the AED managers, both medical and nursing managers involved.

The Medical Advisory Board does that in part. Certain critical components are kept out; namely, one critical component is Kaiser. Kaiser has one-third of the population in this town. I don't know if anybody represents Kaiser.

MS. BONNER: (Inaudible)

DR. JUI: From a Medical Advisory Board?

MS. BONNER: No.

DR. JUI: That's one component left out. Other health systems are represented from medical directors. What's also missing is the nursing. The nursing managers are not represented, as well. They actually control a lot of the operations in the emergency department.

MR. SKEEN: Seems to me there's really two paths. One is the clinical training people and clinical Q.A. People of an organization. The



other is perhaps even the administrative arena to make sure that you're carrying out the agendas that are proposed.

DR. JUI: Part of my problem is there's so many hours in a day. I totaled my amount meeting hours and it's over 70 or 80 hours a month. That's not including the super doc model that is in the current plan. That's incredible. You can't train the medics, be at the meetings, go out to the providers, go to the paramedics and meet with operations people. You're not -- there's not enough hours in the day.

MR. KILMER: This will be talked about next time in detail.

Are you going to break or are you going to recess at this point?

MR. ROBEDEAU: I actually think we've covered the whole agenda.

MR. KILMER: I was going to suggest maybe you take a five-minute break, let Bob and Jon and anybody else look at the agenda of issues and see if they want to comment on anything else, or have any of the people ask them any questions on any other issue here.

MR. ROBEDEAU: We can do that.



I do have one question of Dr. Norton. You were the first person to really articulate anything here regarding paramedic desires, and you brought up working conditions and wages and advancement.

Other than my -- I guess for lack of a better term I should say self-centered response, has anybody ever really articulated anything --

do you have anything written down that says what the paramedics really want?
MR. LAUER: I have several volumes of it right now.
MR. ROBEDEAU: I'm not talking so much about union negotiations. The thing I hear is there's no advancement. Well, I know if you work at it there is advancement. The chances of becoming an owner are probably pretty slim, but it is possible.
MR. LAUER: It happens.
MR. ROBEDEAU: It happens once in a while. You talk about wages. Wages as opposed to what, and working conditions as opposed to what?
DR. NORTON: Well, I don't want to be represented as a spokesperson for the paramedics'



attitudes and current beliefs because I think you need to talk to them about it. All I was commenting on is what I've heard in discussions with them.
MR. ROBEDEAU: What I was wondering is if you were ever supplied with any documentation that shows anything that would really lend anybody to believe that there was a problem, other than the problem perceived within the individuals?
MR. LAUER: I don't know if there's any documentation, Pete. I think what Bob said is that -- I've heard the same kind of stuff. There's a real concern or fear factor of paramedics in the system because of the instability of the system. They don't know if the system is going to be here as they know it five years from now or ten years from now. That's been going on for ten years.
MR. ROBEDEAU: We don't know if the world is going to be here.
MR. THOMAS: He's talking about the anxiety over the new plans.
MR. LAUER: Wages and benefits, those are important issues with paramedics. Most



private paramedics believe they're undercompensated, and I think they have some valid points there. And then our side of that is we have to be able to fund that compensation somehow.
MR. ROBEDEAU: That's right.
MR. LAUER: That gets into the funding of the whole system, and -- but I think those concerns are there, and I think they'd be shared by the majority of the people that work in the field.
MR. ROBEDEAU: But that's a perception. That's what I was trying to get at. I was hoping maybe somebody had submitted something to the MAB that perhaps could be shared with us. That has apparently not been the case, but maybe Bob had something that --
MR. LAUER: We do that in our company through exit interviews. That's a real common thing, lack of stability, unpredictability in your future.
MR. DRAKE: We're trying to correct that here.
DR. NORTON: I just wanted to expand on that once. I think it's a very important part of



what's driving the paramedics' concern, at least from the discussions that I hear, and there's the perception, whether you think it's accurate or not, that the private agencies are not very understanding or receptive to their concerns, the paramedics' concerns.
And that's why there's -- I think there's so much emphasis on having a third municipal provider or some kind of single provider that would be more responsive to their concerns, their problems and their issues, and that's a very real problem, I think.
MR. THOMAS: So, for example, I would take it you're saying what you're picking up is the companies may not be doing that good of a job of translating to the paramedics the relationship between the gun that the providers have been under on rates and the compensation levels of the paramedics. I mean, if they don't want to deal with it or else they're not hearing it unless to understand at least the larger dynamics. That's just an example.
DR. NORTON: Right. But also I think Pete needs to be careful, because when you present it as an issue and say, where's the data,



that's not the response they want to hear. They want to have more understanding and dialog, rather than let's look at the science of it. Because it's an attitude and personal satisfaction issue.
MR. DRAKE: I appreciate that. We need to hear that from other sources. We need to hear what paramedics tell you. Some of the things they tell you they don't tell us.
MR. LAUER: Some things they've been telling us all for years.
MR. DRAKE: But I would like to thank the docs for coming here today. I think this is a real important part of this process. Every component of this system essentially has three parts: An operational part, medical part and cost part. We have to look at all three of those, and we need your input on all of these components of the system.
You brought up about response time, you brought up about air transport. That's a real critical issue we need to look at when you start talking about dividing this county into response time zones, maybe 25-minute zone, 45-minute zone for Sauvie Island or rural areas. Do we need to



involve Life Flight? Do we need to be first on the scene? I don't know. We want to talk about that and see if it's an issue. What should your response time be? Is 12 minutes adequate in Bill Collins' plan? I think it is, but we need to hear from the physicians how they want to set those response times up, what they feel is adequate, talking staffing levels, what do you feel is adequate. That gets us into training, quality assurance, performance.
DR. JUI: I would personally like to see a regional EMS plan, EMS service area that looks at all aspects of the EMS, and ALS is one component of that. The other point I would like to make is the medical director in both plans is fairly centralized, if I can politically say that.
The PAPA plan gives him czarist power -- him or her czarist power. I don't have all knowledge, especially with EMS operation right now, so the idea of having all that kind of knowledge of operations and is not feasible from a doctor's point of view. I don't think that's going to work.
MR. KILMER: I'm a little confused. I



think what the PAPA plan did is took what the MAB plan has been saying they wanted for some time and just adopted it. Is the MAB going to reconsider?
DR. JUI: I want to go on record saying that the doctor can't be the big kahuna.
MR. ROBEDEAU: I'm not arguing with that. I'm just curious -- never mind.
MR. COLLINS: One of the things that happened in the medical director discussion that's gone on is that the plan that PAPA put forth has actually kind of come all the way around in that they have a very centralized medical director. Then if you look at the requirements of the plan, everything the medical director does has to be approved by the MAB, and I think what they've done is shifted to the -- I mean, the way I read it, the responsible medical party is the MAB, not as an advisory group but as an actual responsible group.
But, you know, your statement is well taken. You can't get one physician to do all this, I mean, unless you want to stay awake. I think 70 hours of meeting is okay. What do you do with the rest of your time?

DR. JUI: It's what we're good at. It's a combination of training and knowledge, and at least I hope we're good at medicine.

MR. ROBEDEAU: I remember your last proposal to the MAB. It called for more than one --

MR. COLLINS: Whether you have an identified medical director or not, just the components that are in anybody's plan or even in the current system, you can't physically have one person do all that.

MR. ROBEDEAU: That's my point.

MR. COLLINS: I think you can have one person who is the responsible physician.

MR. DRAKE: Right.

MR. COLLINS: You can look at lots of medical --

DR. NORTON: I would support that, too. I think it's important to have the one person identified as the last accountable individual, but you need more than one to do all the duties. I don't think having the Medical Advisory Board be that final individual authority or final authority is really a workable situation. I think it needs to be invested in a single person.



MR. DRAKE: Pete, it's after 11:00 o'clock so we need to close. But can the physicians come to our next meeting?

DR. NORTON: That's Thursday?

DR. JUI: I'll be half asleep.

(Proceedings adjourned at 11:20 a.m.)



CERTIFICATE

I, Pamela Beeson Frazier, a certified shorthand reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 26th day of April, 1993.

Certificate No. 90-0061

NOTES

BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Thursday, April 22, 1993
9:20 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Barry Doherty, CARE Ambulance
Mr. Thomas Steinman, Portland Fire Bureau

* * *



APPEARANCES

ALSO PRESENT:

Mr. William Collins
Ms. Trudy Schidleman
Mr. Jeffrey Kilmer
Mr. Christopher Thomas
Mr. Steven Moskowitz
Dr. Jon Jui
Ms. Lynn Bonner



PROCEEDINGS

MR. ROBEDEAU: Why don't we call the meeting to order.

Has everybody read the minutes? I know they were faxed out in two different sections.

MR. SKEEN: When were they faxed?

MR. COLLINS: I didn't get a fax.

MR. ROBEDEAU: You didn't get a fax? I got a fax, and then I spilled grease on it so a lot of paragraphs are gone.

MR. MOSKOWITZ: You got faxed a draft. I don't know if you've got the final ones, the final version there, which I already know there's some typos in that.

MR. ROBEDEAU: On page 2, the fourth paragraph, where Dr. Jui is discussing BLS and the training problem with BLS, I believe that was in regard to fire first responder, wasn't it?

DR. JUI: Yes, it was.

MR. ROBEDEAU: I think that should be clarified.

MR. STEINMAN: And the next paragraph,



I'm not sure what --

MR. ROBEDEAU: Since 37 fire stations. I think you said 27.

DR. JUI: 28.

MR. STEINMAN: Above that. The 24-hour training, the advantage to an ALS engine response system is that the engine crews know EMS because of 24-hour training? I'm not sure what that means.

MR. ROBEDEAU: I'm not sure.

MR. SKEEN: I think what he meant is 24-hour exposure, all the paramedics in the station.

MR. DOHERTY: Specifically on the unit with them.

MR. ROBEDEAU: I think the fire stations should be, what did you say, 28?

MR. STEINMAN: We have 28, but I think he added in Gresham, all countywide.

DR. JUI: On page 3, there's a word, Dr. Jui said he had been able to do so, with regards to concerns of the MAB. I think I said I have not.

MR. MOSKOWITZ: Not. Right. That was left out. It's about the middle of the



first paragraph, page 3. The sentence begins, Dr. Jui said that he had -- it says he had been able to do so. It should say, he has not been able to do so.

DR. JUI: The statement on that, also on page 3, Dr. Jui also listed the stability of dispatchers and providers. I think I meant -- that's not quite clear -- ALS providers, the last sentence on the first paragraph -- the second to the last sentence doesn't make sense to me.

MR. MOSKOWITZ: You want it to say ALS providers?

DR. JUI: Just EMS providers.

MR. DOHERTY: What page are you on?

DR. JUI: Page 3. The first paragraph, second to the last sentence.

MR. MOSKOWITZ: Would you feel more comfortable if we said, organizational stability, as opposed to, any other forms of stability?

DR. JUI: Yeah. I'm not quite sure.

MR. SKEEN: EMS providers I think is what he said.

DR. JUI: I think EMS providers, it



should be.

I think on page 5, under the first paragraph, it says, Mr. Kilmer asked if the PAPA plan threatened that goal. I said, yes, it did.

I think I also said if Mr. Collins's plan also had one single person, it would also threaten that goal. Mr. Collins' plan has the ability to have agents.

MR. DOHERTY: On page 5, third paragraph? He was talking about they kind of have their own MAB.

MR. ROBEDEAU: Where are you talking about?

MR. DOHERTY: On the third paragraph down on page 5, second sentence of the third paragraph, "He stated that MAB said one thing and the city council gave other directions." What I recall him talking about is, he said there was kind of two groups in Gresham. One was kind of their own MAB.

MR. STEINMAN: He said that, but he meant their council.

MR. KILMER: It's the fiscal versus



the physical conflict that he was trying to talk about there.

MR. DOHERTY: I heard of that.

MR. STEINMAN: He did say MAB instead of council, but I'm sure that's not what he meant.

MR. KILMER: He did say the MAB wants one kind of service and we've got the council and budget committee telling us how to allocate our resources and their inconsistencies. There's no way the resources they can bring to EMS would allow them to fulfill the MAB requirements, is what he was trying to say.

MR. SKEEN: And he said that on a couple of occasions.

MR. KILMER: Yeah.

DR. JUI: Page 7, I think it would be clearer, third paragraph on the CPR data, the last sentence in the third paragraph, it should be probably just simplified to eliminate the -- everything to the semicolon. It starts from, it shows 45 percent saved; and cardiac arrest 40 percent witnessed with CPR, 20 percent

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saved and unwitnessed cardiac arrest with CPR; and 15 percent cardiac arrest with no witness, no CPR. We're talking about the same thing. Some of this is redundant.

Does that make sense to everybody?

MR. ROBEDEAU: No.

MR. SKEEN: You're saying you eliminate the first two percentages?

DR. JUI: Everything up to the first semicolon is redundant. The last portion of the sentence has everything in it.

MR. MOSKOWITZ: Okay.

MR. KILMER: Are you saying, Jon, that the 45 and 20 are not right numbers or --

DR. JUI: We're talking about roughly the same numbers. Okay?

MR. KILMER: All right.

DR. JUI: So the sentence should read, specifically, it shows cardiac arrest saves are 40 percent witnessed with CPR, 20 percent witnessed with no CPR and 40 percent no witness, no CPR. Is that clear?

MR. MOSKOWITZ: M-hm.

MR. SKEEN: And that was with defib?

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DR. JUI: With defib, right. Cardiac arrest -- should say ventricular -- you can make it specific to ventricular fibrillation?

(Discussion off the record.)

MR. KILMER: What I asked him was whether he is actually going back and physically revising last week's minutes -- last session's minutes with these changes that are being made here as opposed to simply reflecting the changes in the new minutes.

MR. MOSKOWITZ: No. I've been reflecting in the new minutes the changes that should be made to the old ones.

MR. KILMER: But no revised old minutes will be issued?

MR. MOSKOWITZ: If the chair directs me to do that, I can do that. I think --

MR. KILMER: You don't think it's necessary?

MR. MOSKOWITZ: I don't think so.

MR. ROBEDEAU: I don't believe it's necessary, unless we want to give the minutes specifically to the county

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commissioners, and then it might be a good idea, if we put that in as attachments to a report. That would be my only --

MR. KILMER: Even if we reflect the changes in the next minutes, that would satisfy that.

MR. ROBEDEAU: Okay. Is everybody done with the minutes? Anybody not done?

Okay. Can we have a motion to approve the minutes as corrected.

MR. SKEEN: So moved.

MR. ROBEDEAU: Second?

MR. STEINMAN: Sure.

MR. DOHERTY: Second.

MR. ROBEDEAU: In favor?

(Vote taken.)

MR. ROBEDEAU: Opposed?

(Silence.)

MR. ROBEDEAU: Okay. We're talking about medical control today, and Dr. Jui is here, and we need to kind of move it along. He's been up all night and would really kind of like to get out of here and go to bed, which I don't blame him.

I really appreciate you coming. Thank

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you.

One thing I thought might be helpful, I think will be helpful, is to get an exact number or a very close number of what we're really talking about as far as paramedics and BLS people. What is this physician supervisor or physician supervisor group really going to have to do? And I don't think there's anything that I have ever seen that really nails down that number.

And so I was kind of hoping Gresham would be here this morning. I was thinking about this last night, how many positions, and I think is what we should be looking at will be filled or not, because I think that has the potential of the physician supervisor having to manage those people, how many does each organization have, ALS and BLS.

And I think with the ambulance services that should exclude wheelchair cars, even though I believe that most wheelchair providers, or at least the three ambulance companies have EMTs on their ambulance vehicles and by law they do

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require a physician supervisor but they do absolutely nothing for patient care. So I know AA has 28 paramedic positions and eight BLS positions.

Trace, do you know the exact number on Buck?

MR. SKEEN: Multnomah County?

MR. ROBEDEAU: Multnomah County only.

MR. SKEEN: No. I'd have to get you that to get you an accurate number, separate it out.

MR. ROBEDEAU: Barry, Multnomah County only, how many paramedic positions, filled or unfilled, and how many BLS positions, excluding wheelchair, does CARE have?

MR. DOHERTY: 28 and six.

MR. ROBEDEAU: 28 and six.

Tom, do you know off the top of your head about Portland Fire?

MR. STEINMAN: No. I'll have to get it for you.

MR. SKEEN: Pete, wouldn't we want to generate these numbers based on current status and then the various different delivery models also?

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MR. ROBEDEAU: Well, you're talking about current status. We're talking about delivery models. Today what we're talking about is a physician supervisor or a single medical authority that is realistically going to be able to control just the medical aspect. That's all we're on this morning. And I think it's really important that the numbers of people actually being supervised, regardless of the plan, if you take the Collins' plan and the Collins' plan calls for -- I'm not exactly sure.

How many paramedic transportable fire rescues are you calling for?

MR. COLLINS: It doesn't specify because it would depend on the protocols.

MR. ROBEDEAU: See, and a lot of that's my problem with doing this. The PAPA plan, I've read it. It doesn't specify anything, that I can find, really. So we don't know what they're doing.

And I think maybe what we need to do is kind of set a standard of what's the maximum that anybody -- any one person or any group of people can do, and maybe using

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Dr. Jui and his experience, can help us do that.

DR. JUI: It depends on what's the goal of the physician supervisor. Obviously if you're talking about -- assuming that you want to know the skills and the ability of the paramedics on a one-to-one basis with a relationship

similar to Seattle, King County, which is a very intimate relationship, the maximum I would suggest that a physician could probably handle is 100 minutes on that relationship. It's a very time-intensive relationship.

MR. ROBEDEAU: You think one person could do a hundred?

DR. JUI: Maximum. I think probably 60 comfortably. I can tell you 60, for me, from a personal point of view, is stretching even me, and that's not even devoting my BLS work as well. And I devote approximately .5 or more of my time to supervision of medics. So that's approximately what I would say.

MR. SKEEN: Dr. Jui, what all are you



including in those duties, then? Are you talking about the day-to-day oversight of the paramedics?

DR. JUI: The day-to-day oversight of the paramedics. Some of those duties are administrative in nature.

MR. SKEEN: Continuing education?

DR. JUI: Yes. If you want the list of duties, simply it is all the committees that the physician supervisor attends. That's a good start. The committees include the protocol subcommittee, the scientific review committee, the quality assurance committee, the dispatch committee, the MRH QA committee.

MR. SKEEN: What was the last one?

DR. JUI: MRH physician quality assurance committee. The physician's committee.

Did I miss anything, Trudy?

MS. SCHIDLEMAN: No.

DR. JUI: Those committees are about four hours apiece. Those are the upfront committees. There's usually within each agency two to three two- to four-hour



sessions a month. One's a quality assurance meeting, which is a two-hour meeting a month; one operational meeting, which is a two- to four-hour meeting a month.

How many hours are we up to?

MR. ROBEDEAU: It's a lot.

DR. JUI: Yeah. This is all I would consider administrative, besides the teaching. And then the teaching would go on -- where we consider ride-along, ride-along times and interaction with the paramedics and special sessions, teaching sessions, like ACLS, PHDLS, and one-on-one evaluation of the medics' abilities on the ride-alongs.

MR. KILMER: Jon, I'm curious. In -- have you ever been contacted by anybody from MAB to ask you what your load was as a physician supervisor?

DR. JUI: No.

MR. KILMER: To your knowledge, was anybody at your department contacted to get that information?

DR. JUI: No.



MR. KILMER: How about Mr. Collins? Did he contact you about all that?

DR. JUI: No, but I have had conversations, and he knows my -- I think he knows roughly my load.

MR. KILMER: How about the PAPA people? Did they call you?

DR. JUI: No.

MR. KILMER: Or anybody in your department?

DR. JUI: No.

MR. KILMER: Thanks.

MR. SKEEN: Jon, in the context of those few small items that you just outlined, where does what would you classify as research fit into there?

DR. JUI: Research is not even in this area. I would classify the EMS -- we are activating EMS research, and I would say, if I can get time, eight hours a month minimum.

MR. SKEEN: But it's not necessary within the context of these responsibilities, it's something you're doing --



DR. JUI: It is required, but frankly, research -- no one watches research, and that's sort of an internal driving force within our group.

MR. ROBEDEAU: Nobody watches -- are you referring to the system as a whole, there's nobody set up to actually do the research?

DR. JUI: Yes. The excellence in research does not -- if you don't do research, it's not as readily apparent as if you don't do quality assurance or some of the other operational duties. That tends to be put on the back burner when other duties call, and that's what happens.

MR. ROBEDEAU: How many medics do you supervise right now?

DR. JUI: Active, 70. Plus or minus five. Probably minus 5.

MR. SKEEN: Have you done any National Association of EMS physicians -- have they put in any guidelines of parameters and scope of control and ratios?

DR. JUI: As you know, Trace, there is



a handout published I think by the American College of Emergency Physicians on the duties of a medical director, but I do not believe I have seen any guidelines from any EMSP on the exact workload of the medical director.

MR. ROBEDEAU: That was going to be my next question. Does anybody know of anything nationally -- has anybody else heard of anything?

Bill, do you know?

MR. COLLINS: No, I don't. One of the problems you want to -- when you try to look nationally, different systems, different states have different requirements, and this state has a very specific requirement for each paramedic to be directly connected to a physician supervisor. In other states, you go to California, that's not the law. So it's a totally different system.

The ACEP thing does identify kind of the general parameters of the medical direction.

MR. SKEEN: Doesn't go in depth.



MR. COLLINS: No. That may be why it gets confusing to people when not only reading these plans but discussing them. We're really talking about two different things. We're talking about the medical direction necessary for the system, and then we're talking about meeting the supervision requirements for the individual paramedics. And right now we have a number of physician supervisors who are involved in -- they supervise the paramedics and the EMTs, and they also are involved in the medical direction.

But for our system in Multnomah County, the medical director, quote, is the Medical Advisory Board. That's who approves and sets forth the medical criteria.

MR. KILMER: To your knowledge, has the Medical Advisory Board ever attempted to initiate any working relationship with the physician supervisor community?

MR. COLLINS: I don't know. I can't -- since I've been here, we've gone through some discussions prior to this

point in the planning about physician supervision and medical direction, and I don't know what they've done with or without the medical directors.

MR. KILMER: The thing people talk about, integrating the medical direction here with physician supervision and say this has always been separated, but nobody's ever tried to have the MAB incorporate the physician supervisors into its process, into its protocol making, into anything, in any formal way where you could acquire all the benefits of supervision through cooperative interaction. At least to my knowledge have not done that.

Have they ever done that, to your knowledge, Jon?

DR. JUI: No. I think there is a confusion -- and frankly I don't know the answer to this -- of the real role of the Medical Advisory Board. What I understand -- and correct -- you're the attorney -- but it is an advisory role with legislative authority for medical protocols. I think they have taken it upon



themselves, and there's no judgment to speak on other matters. There is a confusion between the physician supervisors and the Medical Advisory Board, and confusion is very simple, that the physician supervisors are ultimately responsible with my license and our licenses for the practice and conduct of the EMTs and paramedics.

On the other hand, within the county -- and I agree with Bill -- the Medical Advisory Board has been the medical director of the county, and therefore you have a system with two groups of authority: one from a state authority, and one from a county authority. And that has been a source of confusion.

MR. KILMER: I think you are -- there's nothing in the state statute that identifies the Medical Advisory Board or anybody else as the medical authority in this county, the medical director in this county. There's nothing in the county ordinance that identifies the MAB in that role either. The MAB is an advisor to



Mr. Collins, and that is all. Has no direct administrative rights and responsibilities, and, until very recently, it never -- in fact this is the first time I every heard that it even thought of itself as the medical director in Multnomah County.

MR. COLLINS: I don't know if they think of themselves as that. I'm trying to put it in the context of this planning process. However, I don't agree with you on the county ordinance. The county code does require that the Medical Advisory Board approve certain medical protocols, equipment.

I mean, I can write certain kinds of rules, but if I'm going to write a rule having to do with medical-care protocols, equipment to be carried on ambulances and -- I didn't bring the code with me, but whatever else it is, they do have that little piece of actual approval authority.

MR. KILMER: They have oversight authority; they do not have director authority. They do not have direction



authority. There's really nothing in there that authorizes them to take any initiatives on that. All there is, is to review the initiatives you take. Has to go through them on medical issues.

MR. COLLINS: Right. I think in actual application, you know, regardless of what you call them, whatever medical direction the system gets, it gets via the Medical Advisory Board. Whether they should be doing that or shouldn't be doing that, that is my opinion on what they're doing.

I think both these plans, and tons of discussion prior to everyone putting these plans together, are identifying the need for a medical director for the system. Then how it gets implemented and what they're responsible for kind of goes in two different directions.

MR. KILMER: I think that the appropriate way to view what's happened in the system is that the day-to-day medical direction in the system has come from the physician supervisors on virtually all



issues that are important. What the MAB has done is taken the initiative in the area of protocol development to create uniform of protocols that the physician supervisors are then responsible for imposing.

Until recently, you had basically two groups of physician supervisors. You had Buck and the fire bureau at the OHSU through Dr. McNeil or through somebody else, and then you had for a long time AA and CARE with Dr. Siqueira as its physician supervisor. And then CARE went up to the hill and AA had a different physician supervisor, but it's now up there too.

So there's really been physician supervision from two different groups, neither one of whom has been active in the MAB process, mostly because the MAB has not wanted that involvement. That's my understanding of what has actually happened here. To the extent there's been direction, most of it has come from the supervisors.

DR. JUI: I'm not sure -- this is



clouded beyond my history. I think there was history of the Medical Advisory Board when Mr. Acker was here and that clouded some of the responsibilities of who had -- who was responsible for what. And there was clearly many different voices in the community trying to provide input to the EMS agencies.

MR. THOMAS: What do you think the relationship -- we're talking about supervision, medical supervision such as you do, and then the broader issue of medical direction. How do you think those two things ought to work in relation to each other?

DR. JUI: And this is my opinion. I think the medical director and his or her agent probably is the most knowledgeable EMS operation, but they cannot operate in a vacuum. And there needs to be a feedback or advisory panel to the medical director and the EMS director on EMS operations, and that should be responsive to citizens and the community's needs.

MR. KILMER: Don't you think the



director ought to be the physician supervisor, or do you think they should be separate?

DR. JUI: I think they should be one in the same. I think the medical director should have the power not to be intimidated by his advisors when there happens to be a correctly -- medical correct response. On the other hand, I think the advisory board should have significant influence when there is a pressing community need as well. Some systems don't have that advisory board. I know for a fact King County -- I mean city of Seattle doesn't.

MR. THOMAS: You say does or does not?

DR. JUI: Does not.

MR. COLLINS: Does not.
MR. ROBEDEAU: One thing, Trace, I assigned you eight FTEs. Is that okay? Eight full-time equivalents. So call you 48 paramedics for Multnomah County.
MR. SKEEN: Eight FTEs?
MR. ROBEDEAU: Yes.
MR. SKEEN: I can adjust our



schedules.
MR. KILMER: Is that close, approximately?
MR. SKEEN: That's quite close. We're in the neighborhood -- the number I wanted to throw out was 52 paramedics for Multnomah County, and that puts it real close.
MR. ROBEDEAU: I assigned you 48.
MR. KILMER: Why don't you give him 52.
MR. SKEEN: That's qualified until I can research it.
MR. ROBEDEAU: All I wanted to look at here, under the current system I gave the fire bureau 70, I gave Gresham Fire five. If I remember from talking to David, they don't have a lot of paramedics, as I recall.
DR. JUI: They have two active units, ALS units.
MR. ROBEDEAU: Do they have that many?
DR. JUI: They have two, engine paramedics. Engine paramedics.



MR. ROBEDEAU: That would be six, then. I'm going to leave it for my numbers. I show 179 paramedics in the system. And under Collins' plan, the best case scenario would lower that to 157. That would be cutting the privates in half, 14, 24, 14, returning the Portland Fire Bureau up to a hundred in order to have an ALS first response, and I left Gresham Fire at five. My understanding was that they were not going to gear up; that the Portland Fire, from what David was saying here, was going to be covering transport for time critical in Gresham. Is that correct?
MR. STEINMAN: (Nods head.)
MR. ROBEDEAU: You still wind up with 157 paramedics, regardless of which one you look at. If you take the PAPA plan, which to me is sketchy, and trying to make a dedicated unit, I just come up with an educated guess, which may be very uneducated, at 209.
MR. KILMER: What's the basis for that guess, Pete?



MR. ROBEDEAU: Was adding paramedics and paramedic units. In order to be a dedicated system where the paramedics did nothing, you're going to have to add units in order to make the same coverage you have now, provided -- now, a lot depends on how much of the response-time standard is lowered and what the protocols are going to be. But if you maintain two paramedics on an ambulance, I think you're going to have to add ambulances.
MR. KILMER: But the assumption you've come up with of 209 rests on a certain amount of ambulances, the certain number on the fire of first responses.
MR. ROBEDEAU: Right.
MR. KILMER: You should articulate those for the record.
MR. ROBEDEAU: I'm sitting here trying to remember what I did on that, and I know this is really stupid, but I can't remember.
MR. SKEEN: The problem is there's about five different scenarios.
MR. COLLINS: I need to at least make



a comment on this. I don't think this is the right methodology. If you want to try to look, see what the workload is for physician supervisor, you need to count people. It doesn't matter to John at the fire department whether the person works half time, quarter time, or full time. It's still an EMT or paramedic that needs to be supervised.
So counting the number of units, A, it's going to understate the number of people, whatever that number is, and to try to -- we can look at the current system. There's no question about that. We can look and see how many people you employ at Buck that work in Multnomah County, regardless of how much they work, but I don't think you can really do it on units. With all the scenarios, I don't think you can guess what it's going to be. I mean, if you look at either the plan that we submitted or PAPA's plan, there's no finite numbers of how many people you need in there. You can look at demand analysis we did. That would give you part of it. But



like, for instance, in PAPA's plan they're talking about transporting all the 9-1-1 calls and, at least my reading of it is all the other transports that need paramedics.
MR. SKEEN: ALS interfacility.
MR. COLLINS: So you can look at demand analysis, that will give you an idea for 9-1-1, but it won't give you an idea for the rest of it.
MR. KILMER: Except there is a number with respect to interfacility ALS transports that could be pinned down to at least a relatively approximate number, and your assumption it needs to be supervised the same whether or not these are active paramedics, I'm not sure that's correct.
MR. COLLINS: If you have 28 FTEs, you might have so many of those be part time and filled with two people for every one of those. So 28 FTEs could represent anywhere from 28 people to God knows how many.
MR. KILMER: In doing an analysis, it could do that. You have expertise around this table that will tell you what are the numbers, the raw numbers in the system.



How many part-timers do you have, Pete?
MR. COLLINS: That's what I want to know, whether we should collect that from the providers. I don't think that's -- I understand you want to kind of get a ballpark of number of paramedics, but the question is, if you're looking at these two plans, one plan proposes that one single individual supervise all the paramedics, all the EMTs, and do all the medical direction.
MR. KILMER: Right.
MR. COLLINS: And the other plan says, one individual would be the medical director, and that, based on whatever the established need is, you'd have other agents. Those are the -- both of them speak to a single medical director, both of them speak to that medical director being the supervisor of record for all the EMTs. I mean, you're talking about the fire department paramedics. You also have hundreds of EMT-Is or II's or whatever they are. There's just a lot of people.



MR. THOMAS: I think where the discussion needs to go is for Dr. Jui to be able to talk about how it works with one person doing it all and how it works with one person with an agent, sort of what we're talking about. Unless you get some feel for what ballpark for the numbers of people they're having to supervise, it's

your word against somebody else's word. I don't think that's an adequate basis for discussion of that issue.

We need to be in the ballpark. We don't need to be right. It's 100, 150, 200, 250, 300. And then you can really talk about which – how are you going to structure it, if you're going to have one person of record be the physician, how are you going to structure it to make it work.

MR. KILMER: I think you add to that – I would add to that –

MR. STEINMAN: I think if we're going to do this for the record, I'm going to go home.

MR. KILMER: Tom, just a minute. We're all on the same side here.



The big issue, it seems to me, is if one person can do it all, then the PAPA plan has some merit in terms of coordinating that in one place, but if the PAPA plan can't do it because it's going to, as a practical matter, take several people, then the option a lot of people are thinking about, which is to contract with some agency like the health – the emergency department of OHSU, as an alternative to the Health Division, makes it – hiring somebody directly, makes a great deal more sense. And that's part of the reason an analysis based on numbers is important. And then you have to get into the ballpark that Pete's talking about.

MR. STEINMAN: Mr. Chairman, I'd like to say, I agree with Mr. Collins' concept. What you need to do is look at the total number of employees that are certified at some level of EMT with each agency. It doesn't matter how many paramedics I've got on rescues or whatever. Jon's responsible for me when I work a call shift, for me when I drive up on an accident. Jon's



responsible for our guy that's issuing clothing. Even though he's got a bad back, he's an EMT-I. He's ultimately responsible for every employee at our organization that's certified at any level of EMT. That's the numbers you need to look at.

MR. ROBEDEAU: That's to a degree partly what we're doing. You're right. Okay? But in comparing the plans, what I put down was 700 BLS people, just as a ballpark, and to answer the question what I do was – to come up with the PAPA plan was added 30 firemen to bring the fire bureau up to full ALS first response to the current number in the system. You're right on that.

But I think the thing with the exercise, or I know the thing with the exercise on what I wanted to accomplish by doing this was to get a consensus on whether or not one individual person can do it, as is called for in at least one of the plans, or whether or not we need to actually come up – what we need to do here is to come up with a workable method that's



going to work. I think we can get a consensus that, with nearly a thousand people, one individual person cannot do the job.

MR. STEINMAN: Wouldn't it be easier for you to go around and poll the providers and ask them if one person can do it instead of all this bickering and bantering back and forth? I know one person can't do the job, period.

MR. ROBEDEAU: I don't think it's bickering and bantering back and forth. I think one of the problems, we have gone around or some groups have gone around and polled some people and said, what do you think, and this is it. So they produced a plan that, as far as I can see, is based on a lot of hypotheticals and a wish list. And it calls for one single person to be a czar who is going to handle 900 to a thousand people and do a good job, because we haven't even counted any of the outlying fire bureaus that are going to have to be included in a plan somehow.

So is it fair to say, would I get



consensus from the whole board that one person can't do it?

MR. DOHERTY: I think that's very fair to say. I believe the people who were supporting or are supporting a plan that says one person can do it have never been physician supervisors. When that was raised by the MAB, I don't believe there was any members of the MAB that had ever been a physician supervisor.

MR. ROBEDEAU: Okay. Then the second half of the question is, what can we do that will really work?

That's why Dr. Jui is here. He has experience. What is a realistic medical supervision plan that will do all of the things that are needed that Dr. Jui has articulated yesterday and some of it today and not kill whoever is doing it?

MR. STEINMAN: Mr. Chair, I believe, contrary to what Mr. Kilmer had asked Dr. Jui and he said no, the county has that. The county had a subcommittee looking at medical supervision. We spent months in meetings on that, meeting with



the docs and everybody else. We made recommendations to the MAB that were totally ignored. So the county has that document, and that work's been done already, by all the providers, and physicians at all of those meetings.

So we know that stuff's there. We know the recommendations were made. And I would like to get that stuff out and get on with comparing these two plans and coming up with some document instead of sitting here and spewing out stuff for the record. It's getting real frustrating here that we're not making any progress at all.

MR. ROBEDEAU: I think we've made a lot of progress.

MR. THOMAS: Tom, I think there is something that needs to be done, which has nothing to do with the record. It has to do with how you're going to present whatever – say it's what the group came up with or whatever, any revision that this group comes up with to the County Commission. You all can sit around the table and say, we all think – say it won't



work, and the MAB can sit at the table and say, yes, it will work. And there's very little basis on that for the County Commission, which ultimately has to make the decision, to pick between those two positions. That's my concern.

I think there's a level of numbers that you don't have to work out today but this committee ought to come to some sort of agreement on that will make it very clear to the County Commission what won't work anyway, and I think that's the thing you're going to need to identify to present to them at some point.

MR. STEINMAN: And I agree with that, and I say the county probably has that because we all have to send in that list every year to the county, and we should use the numbers that are in the county's hands.

I take offense at coming to this meeting and having my physician supervisor, who I asked to come here after being up all night long working on patients, be questioned in such a way I can see he's

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going to spend a lot of time in court when this thing comes out. Have you ever been asked by the county, or Bill Collins and that stuff, I find offensive.

We know the plan's there. We've worked with the county. All the providers have worked with the county. PAPA hasn't. We know that. So let's get on with this thing, and let's get on with comparing the two plans and coming up with some recommendations.

Don't we have some stuff from that committee, Bill?

MR. COLLINS: Yeah, we do. We also have the stuff from -- we have whatever the earlier positions were.

The end result of that process kind of prior to this planning, even though there was some differences of opinion I think between the MAB and the earlier group, was that there should be a medical director, there should be a single physician who is responsible for the medical direction and supervision. Where it parted ways with PAPA and other people -- in fact really

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with PAPA and pretty much everybody else -- was that as that medical director supervisor, that person couldn't do all the work. And whether the number is 700 or 600 or 500, if you even look at what Jon said earlier today, with kind of a hundred people the absolute outside max, we know there's more than a hundred people no matter how you count it.

I don't disagree with you at some point you need to count up all these so that people can understand. I think from looking at the options, it isn't like we're on a fine line like we could do 600 but we couldn't do 610. It seems to me, from my perspective, this is at sort of opposite ends of the dumbbell.

And I don't think there was any disagreement prior to the plan being presented again at the MAB that there shouldn't be a medical director. Everybody I talked to, which was all the providers, PAPA, and the MAB, pretty much everybody said, yeah. And then the only issue that came up was one group says they can't do

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anything else, it has to be the sole person, and other people say no.

Correct me if I'm wrong. That was at least my understanding, that everybody pretty much agreed on that, including the physician supervisor.

MR. SKEEN: My interpretation of that is the PAPA plan said, it shall be the medical director, and they went through to specify what they perceived many of their responsibilities were and said they could not delegate to anyone else without the MAB's approval.

So I don't think they contemplate that one medical director doing it at all, but for some reason they had the Medical Advisory Board approving who the agents were going to be, as opposed to your plan, which talks about a medical director and very obviously having to rely upon some agents. I'm not sure how those agents are specified.

It seems to me one way or the other, there are too many people in whatever plan comes up, there would be too many people

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for one person to do this all, under either plan. I guess the question is whether that medical director should control the agents or whether the agents working for various agencies should serve as an advisory board back to that medical director.

It gets -- to me it gets into all of that feedback group and the control factor.

MR. ROBEDEAU: What you get into, too, Trace, is state law. The agents that are actually working for the agency cannot -- as my understanding of the state law, they are the ones then that become responsible, and if the medical director comes down and gives a direction that they believe is wrong, by state law, it's their responsibility not to follow that direction. Somehow or another that needs to be blended in.

That's been what I have heard has been articulated as the reason why that the MAB and some other groups feel that the system that has individual agencies having an individual physician supervisor is a bad

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system that will never accomplish anything, and then I have heard docs articulate that any doctor who is working for a private agency and receiving a salary will sell out to that agency because they're getting money for it. I don't believe that's true. And I haven't had that as my experience.

But whatever plan Multnomah County does or whatever physician supervisor role anybody plays, it has to fit in with the state law.

MR. THOMAS: Since we've got Dr. Jui here, I think Tom's right, we ought to make his time useful.

You have some thoughts about how you would like it organized -- I'm guessing. I'm not sure -- but, with, say, a medical director and then agents, who ought to have authority over whom.

DR. JUI: I'm not quite sure if the organization -- all I can say, speak to the medical issues right now. Let's assume that my -- the people I have talked about are paramedics for assumption and that I

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want to guarantee the quality. Guaranteeing the quality is one of my medics working on my own relative. Okay? And having that ability for the medic to do the right thing.

I think within that context, and having that medic save one of my relative's lives, I think between 50 to 75 is a comfortable number for a medical director to personally supervise and be assured of the competency of that person. Much above that, you lose the intimacy and closeness of association and know which way the medic is going to decide one way or the other and make sure that decision process is accurate.

Above that number, it becomes an administrative number where you are delegating that responsibility to another person. And it can be done, it can be delegated, but you have to be very careful how that delegation is done, because sometimes there are differences in tolerance of some medical physicians.

Amongst us physicians at OHSU, we

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happen to have a very similar standard and we have a very organized way of arguing out our differences, and we practice very similar medicine. Obviously, we cross-cover each other and we have the same patients. I think that's one of the reasons why OHSU's program works with multiple physicians: because we're comfortable with one another, we work with each other all the time, we know how we decide, and we're comfortable with the decision-making process of the agents.

So what I'm trying to describe is when the medical director has his or her agents, that agent cannot be on a superficial basis; it should be on a very close personal relationship basis.

MR. SKEEN: So what you're suggesting with the Multnomah County system, depending on the plan, at 50 to 75 paramedics per physician –

DR. JUI: If you desire the closeness.

MR. SKEEN: The optimum.

DR. JUI: Yes.

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MR. SKEEN: So if you're looking at that – and the various models appear to me to be requiring anywhere from 100 to 150 to 250 paramedics in the system, depending on how it's set up – obviously, you're going to need anywhere from three to five physicians. So what I'm hearing is what you're advocating, is similar to what you have up at OHSU right now, with a preexisting network of the physician supervisors that are working with those different agencies.

DR. JUI: That's a system I know will work. Whether it's an optimal system or not, that's another question. There are many different ways of operating.

MR. SKEEN: How would you see the medical director – if we assume that the current people remain involved with the agencies with physician supervision, then how would you see the medical director interacting with those physicians? Them being subject to the medical director, under the control of the medical director, or in an advisory capacity to the medical

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director?

DR. JUI: It depends on what Bill wants of the medical director. If the medical director is going to be responsible for the medical care of everybody in the system, then they would have to be subservient to the medical director. If the medical director is an administrative medical director and the agents are, quote-unquote, independent of the clinical responsibility, then they don't have to be under and they can be agents of the agencies or the other – do you sort of understand?

MR. SKEEN: Yes.

So under the administrative concept, would those supervisor physicians be an administrator?

DR. JUI: Exactly.

MR. SKEEN: You feel that's the optimum from what you see?

DR. JUI: The community has told us that they want one single medical director, and I think they are implying within the lines that they want one voice and one

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point of contact. And we won't argue with that need. And there's a logic to that need as, again, we're flexible, and I think we can work with the other system if the communities all want.

But I think Bill is correct, that there is – there has been a consistent voice within the community of that single concept. So in spite of what might work, the community I think has said fairly straightforwardly that they would like the former model, where the medical director would be responsible for all the agents from a patient-care standpoint.

MR. SKEEN: So a clinical medical director?

DR. JUI: That's correct.

MR. SKEEN: As opposed to administrative?

DR. JUI: Yes.

MR. THOMAS: So that person would be, if I understand, integrated with the total group, but in charge?

DR. JUI: That's correct.

MR. THOMAS: And I'm assuming from

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what you said that that person, if that were the way it were set up, you would think it would work best to get that integrated group if the medical director had the control over who were going to be agents and select them?

DR. JUI: That's correct.

MR. SKEEN: Do you see that being a workable situation, to have those various agents from other groups?

We've talked earlier about how everything's kind of merged up to the university currently.

DR. JUI: I think it could be workable. I'm actually scared of the intrahospital rivalry or intra – the medical care facilities are divided into three camps now: Legacy, Sisters of Providence, and Kaiser Sunnyside. And, unfortunately, prehospital care is heavily politicked as well, and so there will be influence. And obviously I don't need to tell people in this room about that. And that's the danger of that.

One of the dangers right now is that

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one small group who actually doesn't have the dominant force in the market is over-represented in the medical supervision, and perhaps there's been some criticism of that. I'm not sure where that –

MR. THOMAS: As I understand where you're coming from, to really make it work right, some group is going to be the dominant – some hospital is going to be the dominant hospital, because you need that close team where they have the same ethic and concept?

DR. JUI: Most likely, yes.

MR. THOMAS: And approach.

DR. JUI: Yes.

MR. THOMAS: At least from a medical perspective. That's interesting.

DR. JUI: There's no question, one of the things about our group, we don't go to a meeting and have hidden agendas of the systems you represent. You can concentrate, hopefully, on the medical issues of the care providers and leave your interrivalry systems out of the medical

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transfer, whichever system it is.

MR. DOHERTY: Dr. Jui, would you say that MRH physicians are also providing medical direction?

DR. JUI: Absolutely. It's on-line medical control.

MR. DOHERTY: Would it help – do you think it's necessary for consistency that MRH also be at the same location as the agents?

DR. JUI: It doesn't have to be. It would be helpful to have it at the same location. I think on-line medical control should be confined to a small group of people that know the protocols and know the hospital care providers, especially the paramedics, so when they get interaction over the radio, there's a huge element of trust and knowledge of who's at the other end of communications, and that requires good knowledge of the system and the paramedics.

Ideally, the people that would be – one of the reasons it may have worked with MRH is we know who is calling us, and it is

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a definite value being on the on-line medical control receiving end to know who is calling me and why and how they – he or she thinks. No question about it.

Right now we have approximately 15 faculty, five of which are very heavily involved in the EMS and know the medics very well.

MR. DOHERTY: Do you depend, in your duties as an MRH physician, to assist in -- lack of a better of term, the intimate knowledge or understanding of paramedics in the system?

DR. JUI: Yes. It's invaluable. I think it's a necessary portion of the understanding of medical supervision. There's on-line and off-line. I think they go hand in hand. They're not necessarily completely integral. They work better from a single -- from a unified, operational point of view.

MR. THOMAS: Is there any argument on the other side of that from a medical perspective that people have made?

DR. JUI: The only argument, you can



work from another way.

MR. THOMAS: Any argument there's a negative from a medical perspective linking on-line and off-line?

DR. JUI: I can tell you the history. Everybody knows that the medical supervision prior to 1986 or '87, I believe, when we developed associations with prehospital care providers, was done by non-MRH physicians, and there was difficulties in understanding by the prehospital care providers of the differences in opinions and orders between their on-line and off-line.

There is always some differences. But those differences have been minimized having the on-line and off-line at the same institution with the same people telling the orders.

MR. SKEEN: What would you characterize as the unifying influence for physicians within the same institution?

I would think there's a lot of independence by physicians that are involved in emergency medicine. What is it



about having the same institution that brings about a unification? Is it internal research that's being done?

DR. JUI: I think it's we have spent a lot of time within our group discussing the objectives and where we would like the standard of medical care to be at. There's a huge time commitment and communications. And based upon those communications, I think we agree, I think with 98 to 99 percent, to certain standards of care, and we continuously do this at physician supervisor meetings every month.

And based upon that, based on a common goal of hospital care and community, you have obviously your mission statement, which would be equivalent to an organizational statement of excellence for the physician supervisors. Does that make sense?

MR. SKEEN: I understand what you're saying. What's the application of that or practicality of that if you move out of that host organization into multiple hospital facilities?



DR. JUI: You could do that, but from personal experience you would be involved in intra-health-care-provider issues, and the politics would be heavily involved. I can't really walk into a room right now in this community and say, "This is Jon Jui, Portland Fire physician supervisor." They'll say, "OHSU at the other end." So you'll be branded with the organization that you're associated with. No matter if you agree with OHSU, you'll be associated with that.

There's no question the influence of health care agencies have tremendously made their impact on this decision-making.

MR. SKEEN: And is it, just your opinion, that the physician supervisors for the various EMS disciplines should be appointed to them by this oversight group, or that the agencies should be able to select their physician supervisor who then would fall into this restriction?

DR. JUI: Have to be careful about that.

MR. SKEEN: I'm not trying to be



cute.

DR. JUI: There are the county's needs and there are the agencies' needs. The agencies need to have a responsible person that they can interact and have an intimate relationship with. The county, on the other hand, needs a responsible person that is not influenced by other things besides the county influence. And I think there are two needs. I'm not sure there's a happy answer between the two needs.

The system has fallen much more towards the governmental needs, and those are the ones with the, quote-unquote, strong medical director, and the needs of the agencies have fallen secondary.

MR. SKEEN: Secondary.

MR. STEINMAN: I think most of that was covered -- and, Barry, correct me if I'm wrong. Didn't we cover almost all of that in that subcommittee on physician supervisor stuff, interagencies and committee type deal? I'm not sure what yo·· still have available for that.

MR. COLLINS: I can look and see. I



think one of the forces that needs to be looked at, if you go to a medical director or agent kind of thing, is whether there's any validity to it or not. The perception of providers, whether they're public providers or private providers, hiring their own medical direction can cause problems in the system. That's not that it's actually causing any problems, but people perceive that as an issue. And I think that's something that has to be addressed as we're going through this.

MR. THOMAS: Maybe one thing the committee ought to do is get a recommendation that was developed before, maybe at one of the future meetings look at that. Tom may be right. It may cover everything that we're talking about. And I think there's more discussion of the philosophy of it here than I've seen before.

MR. ROBEDEAU: The recommendation that was made to the Medical Advisory Board before from the discussion that came out of this committee, was there be a single



medical authority and that the physician supervisors had made the recommendation that there be a chair elected from the existing physician supervisors from the agencies, the chair serve for at least one year, and that any contact between the MAB or anybody else and this group would go through the chair so they'd have a single person to report to.

And as I recall, the MAB was so angry at that that they would not even vote on whether or not they wanted it; they just threw it out.

MR. THOMAS: Well, it seems to me you could get that in front of you and see if there's some little different changes that you would make based on the history that's gone on and see where that is. There were actually two of them, weren't there? The physician supervisor group had a proposal, as I recall.

MR. ROBEDEAU: Yes. That's the one I was talking about.

MR. THOMAS: Wasn't there another group which sort of took that and refined

it some more?
MR. COLLINS: There was a committee to look at medical supervision. It went through a number of iterations. But what was presented out of that committee originally for consideration to the MAB was basically what Pete was identifying. Then there was much discussion, gnashing of teeth. And sort of what came out of that I think was the concept of the county-employed medical director and the necessary hours of medical supervision that needed to be put in place. But that didn't -- that's kind of from our perspective.
When the MAB, you know, made their statement, we did not agree with that. We went to the Board of Commissioners and said, we do not agree with that, and got some informal -- I guess that's what you'd call it -- informal direction from the board to move toward what we were talking about. And then the board changed.
MR. THOMAS: Seems to me, we could get -- it would be good to get that earlier



proposal back in front of us and at least see what it looks like. It was quite detailed, as I recall.
MR. STEINMAN: I think, you know, if we get that, we're going to find out, and Trace had a good point about PAPA's plan, it really boils down to PAPA's plan saying the MAB will decide who the agents are and Bill's not really specifying, and maybe we need to look at that plan, and it might be as simple as bringing that thing up again.
MR. THOMAS: That's what I was thinking. From what Dr. Jui was saying -- personally, I'm not a physician; sounds right to me -- that's a critical distinction because the MAB's approach probably is to try to distribute the physician supervisors, the agents around among the different hospitals, to be blunt, and at least Dr. Jui's argument is, regardless of which is the hospital or facility, it actually makes sense to have on-line medical control and off-line medical control housed among a group of people who work together on a regular



basis.
I think that's a key issue for somebody to decide, and it's a major policy decision, which probably the commission is going to make ultimately.
MR. ROBEDEAU: Without some kind of I think strong direction that the County Commission can hang their hat on, going against the MAB, I can guarantee you that, you know, spreading this thing out into different hospitals and different groups is going to tie this thing up for another 20 years just like it's been tied up for the last 20 years. Nothing is ever going to move as far as medical direction until there's an edict out of the County Commission.
And this will -- medical direction has never been an EMS issue. Since 1974, for 20 years it's been a hospital issue. And I say we've got to make a recommendation out of the Provider Board that's strong and allow them to hang their hat on something.
MR. SKEEN: Both plans currently leave it hanging.



MR. ROBEDEAU: I know. I'm aware of that.
MR. COLLINS: Leave which part hanging?
MR. SKEEN: The definition as to how the medical control be facilitated, who the agents will be. Both --
MR. COLLINS: Did we leave ours hanging?
MR. SKEEN: The PAPA plan says that the medical director can't delegate this to anybody without permission from the MAB. Your plan says basically, this is going to need more people than just the one.
MR. COLLINS: I better read my plan.
MR. SKEEN: Then it never goes into any detail about whether that should be housed within the same institution, whether on-line and off-line should be consolidated within the same group, who reports to who.
MR. COLLINS: We didn't talk about on-line/off-line consolidation, but I think we did talk about the other part.
MR. SKEEN: Dr. Jui, I think there are some markets where there can be some



research to see what they've done.
DR. JUI: Absolutely.
MR. SKEEN: I'm not the most well-traveled person, but I've worked in other states. The other observation I have is Oregon and probably Washington as well have much more advanced controlled environments for the paramedic-physician relationship than any that I'm familiar with.
DR. JUI: I would tend to agree with that. There's something special. I've been to a lot of cities, and there's something special about this, and only a few cities that I know have those kinds of relationships. But that's probably biased, from my point of view.
There's one area I really would like to plead. The area is the following: It depends on what you want as a medical director. If you want the medical director to be the medical clinical director, i.e., the standard of care, we believe, and the physician supervisors of OHSU I'm speaking for, that that person needs to be a practicing emergency physician. It cannot



be a full-time administrator. We believe that you would lose credibility with your EMTs and paramedics if that happens.
Obviously, some systems do do that, but we believe it's important and vital to your position to have that continuing experience. And, unfortunately, in order to maintain -- speaking very personally now -- that experience, the standard of workload for emergency physicians in this community is anywhere from 12 to 14 shifts per month, 12-hour shifts. Dividing that by three, that's three weeks, three shifts a week, for 36 hours, and we believe a minimum of anywhere from four to six shifts a month are required to maintain skill. We don't go much below four.
MR. SKEEN: Four 12-hour shifts?
DR. JUI: Yes. So what I'm trying to tell you is the medical director automatically is going to have four -- minimum of four, probably five or six 12-hour shifts out of his or her's life to maintain his medical -- their medical schools.



MR. MOSKOWITZ: I'm sorry. That's four 12-hour shifts a month?
DR. JUI: Yes. Out of four weeks, not a month. And we would prefer to have it six. You lose their edge to a certain point.
MR. THOMAS: That's good.
MR. MOSKOWITZ: Could we possibly get actually brought to the meeting, maybe next week, the subcommittee's report that was presented?
MR. COLLINS: Yes. I'll see what we can --
DR. JUI: The other medical issue that I would like to bring up is a hidden issue. Both plans, neither plan addresses the expertise of EMS. Specifically, EMS is

a new subspecialty in emergency medicine and has a completely different set of knowledge and skills. Being board certified in emergency medicine does not necessarily make you an expert in EMS. Speaking as a person that learned by doing it, there's a lot to this job, and I think I could do this another 20 years and learn



more.

It's very difficult for someone, especially just getting out of residency, to be effective in this organization. I think Multnomah County, being the more densely populated in the state of Oregon, should have much higher standards of the medical director than just being board certified in emergency medicine. I think one of them should be expertise in EMS and perhaps expertise in other administrative skills -- public health or health administration or some other comparable training. I'm not just saying this because we've had it, but I think it's really valuable.

The other one is having access to research methodology for further improvements in the system. None of those are specified in either system plan.

MR. COLLINS: Although I think those are specified in the last document that went to the board on medical supervision. It didn't -- we didn't put -- the job description is left out of here, but in the



last proposal for medical supervision, the requirements were -- I'm trying to remember exactly -- they were board certification in emergency medicine, X years -- the county had some numbers -- three years experience in EMS system management or medical supervision of paramedics, research was I don't think a requirement but a desirable. So when that group had looked at that before, that had been addressed.

DR. JUI: Some of this content is in the American College of Emergency Physicians.

MR. SKEEN: Gentlemen, when you go back to the 75 to 50 paramedics optimal, we can think of the paramedics in the system. Back to the EMTs, is there a relationship? Can you handle 75 paramedics and another hundred EMTs? How do you see that?

DR. JUI: I'm having difficulty getting that kind of quantity because I'm learning how to be a medical director for EMTs, and there's a less -- I won't say less. I can't state. There is a different -- slightly different



interaction, although not to say it's less important.

MR. STEINMAN: A lot of that kind of depends on what you talked about on Tuesday about the paramedic individual. If he can have --

MR. DOHERTY: Paramedics or agents.

MR. STEINMAN: -- then he can get over quite a few people. Without those, I think he's probably talking about the same numbers, if you want quality care.

DR. JUI: I must be clear with you. An EMT-I doesn't clear an airway, and they fail to perform that critical but stupid -- not stupid but elementary step. That is just as important as the paramedic not recognizing a seriously ill patient, because you're going to lose the patient both ways. I don't think you can shortchange the EMT-I's training.

MR. COLLINS: I looked up to see what we said about that, because I should -- I'm here with one plan, and I can't really speak for what PAPA is doing on medical direction. But I want to make sure it's



clear. What we proposed is a county-hired medical director who then can figure out what they need to support the duties that are assigned to the medical director. We did not specify there should be three agents and these agents should be paid this way. We hire the expert medical person who then says, okay, for me to do this job, I'm going to need, you know, three other docs working so many days to do this or to do that. We didn't specify any of the details.

But it should be clear in our plan, there is no -- there's nothing in here that speaks to any of the providers, public or private, hiring medical directors of any kind, that that all gets incorporated into one medical direction supervision system.

MR. MOSKOWITZ: And there's nothing in your plan, apart from some other documents that were submitted at some other point, regarding whether this medical director ought to be the clinical director, someone who continues to practice in the emergency room.



MR. COLLINS: Yeah. Part of that -- I think we're talking about -- the medical direction is in the plan, but it was also discussed in great detail prior. Those documents do have, from different people, requirements. We have the requirement I think in the one that we presented that they be a practicing physician. I'm certainly -- if I'm the responsible person for making sure we have medical direction, I wouldn't in a million years consider a physician that was not practicing. It wouldn't make any sense.

MR. MOSKOWITZ: So when the county board looks at your plan here, that's also what they will -- they will know that's part of what they are --

MR. COLLINS: Yeah. It isn't in the copy that went out. There's an appendix that's got the job description and what you would hire. We'll have to make that clear if there's any different issue in that. But our position is that the medical director should be a clinical director responsible for the clinical care in the



system and should not be, as I think in the other plan, should not be the administrator for all aspects of the system. That's even more work piled on it.

You hire the physician because they are the clinically competent people and that's who you want.

MR. THOMAS: Bill, I think it would be helpful to the other people here to know about the conversation we had after the last meeting about the county, when they were talking about this one person and designating an individual, they have reached the conclusion that essentially this person is an employee of the county and that that's how you would have to do it, which I agree with from a lawyer's perspective.

But that did not mean that rather than contracting with an individual, the county couldn't contract with a facility and then set the work tasks in a way that there would be a director and there could be agents designated by the director. So I think that's important for people to



understand, they had ruled out this option.

(Mr. Drake entered the room.)

MR. COLLINS: Right. But again, before this plan, going back to the other medical-direction discussions, we had asked the county counsel whether we could make -- whether we could contract with the person

as an independent contractor, and the county counsel's opinion was, no, that this would not meet the test for independent contractor because of the amount of support the county would provide.

And the county doesn't happen to have in their current employment process a contract employee. Some places have employees who can be contracted. They are employees, but they're paid a lump sum. And benefits and stuff don't come in to play. They just don't have it right now. That isn't that they couldn't invent it at some point. So the advice we got was make the person an employee, which is -- we could make them an employee.

Now, that doesn't preclude us from



contracting with some organization to provide that. We just can't contract with an individual. So if we found the ABC EMS Director's, Inc., then we could probably develop a contract. What we're not interested in at this point, at least at this point in the planning, is contracting with a whole bunch of different physicians or employing a whole bunch of different physicians. That's more complicated than we would be involved in. That's why we want to hire a medical director and have them tell us how they want to do it and then we can support that.

DR. JUI: Bill, do you have any idea of other systems of I guess comparable size and coverage and the amount of medical director, I guess I would prefer to say FTEs, that they allocate?

MR. COLLINS: My only other experience really specific is in California, and in Santa Clara County we were systemwise about twice the size of this system as far as number of transports. It was a dedicated system, so we probably didn't have quite as



many paramedics.

But that system, it's a different kind of system. We had a half-time medical director, and there, in California, the medical directors are not only responsible for supervising EMTs and paramedics, but they are the certified authority, unlike the state here. They certify. And that's what we had.

Then there were other people working for both the companies and the fire departments who were involved in training and quality assurance.

DR. JUI: The agents, however they were, base station agents or --

MR. COLLINS: The base stations, like MRH, had some, I don't think you call it supervisory authority, but they had sort of an oversight authority. They were the ones that did the -- reviewed runs. They made recommendations to the medical director regarding any particular issues that came up regarding an EMT or -- so it's kind of like the agent thing, but not exactly.

DR. JUI: How many hospitals had those



kind of arrangements?

MR. COLLINS: There were three when I got there, and there were two when I left because it was a money issue on one hospital. So there were two hospitals that were like MRH. There were two MRHs. That's the only one that I know of where I can give you detail on it.

MR. STEINMAN: Pete, what are we going to do on this? Are we going to continue to talk, or are we going to start to try to come to some consensus on which points we support or which points we don't and start putting together some kind of document?

MR. ROBEDEAU: I believe -- is it next week we start on the document?

MR. KILMER: Week after that.

MR. ROBEDEAU: Week after that. We have a couple more things to go through, and there are four meetings reserved for the preparation of the majority and minority report.

MR. STEINMAN: Can I get another copy of that? Some physician stole my copy.

Thanks, Jon.



MR. COLLINS: They're wont to do that.

MR. ROBEDEAU: Today we're talking -- I apologize. I missed some of it -- but we were talking about the physician supervisor plus patient care equipment and vehicles, which I don't think is a problem; then system cost and rates, 27th; provider selection on the 29th; and the 4th and the 6th to write the draft plan; and the 11th and 13th if it needs to be revised.

And I believe Trace had asked that we get the draft plan to the County Commission on the 6th, if we can, or right after, so we can get some action from them.

MR. COLLINS: To the MAB --

MR. SKEEN: It was to the MAB, because of that meeting on the 14th.

MR. DRAKE: I've got a couple issues with that, Pete. I think there are some issues as far as equipment and vehicles go. There have been at least issues in the past.

MR. ROBEDEAU: What we're trying to do here is to finish up the medical direction



so Dr. Jui can leave. He's been up all night. Those are the other two agenda items.

MR. DRAKE: Right. I am saying there are some things with those.

MR. ROBEDEAU: Right. Right.

MR. STEINMAN: One thing I'd like to point out, too, Chris talked about earlier, about all these agencies that may want to get involved in the physician supervisor. Four or five years ago now we went out with an RFP to -- because we were contracting with two agencies that could not come up with the malpractice insurance to cover our EMT 800 ones. We had one respondent; that was the university.

I think some of the stuff that's gone on in the not too far past, MRH -- not MRH but regional hospital -- nobody's ever wanted to do that. They want to pawn it off on the one facility. Everybody gives it a lot of talk like they all want to be involved and they want their facility involved, but when push comes to shove, they never show up.



It would be interesting to see what happens if this does go out to bid and Bill sends it out to groups or whatever, if anybody plays the game.

MR. ROBEDEAU: The involvement they want, Tom, they want to be able to tell the group that's doing it what to do.

MR. COLLINS: Having been involved in bidding out -- "bidding out" -- putting out requests for proposals in hiring the medical director, the other aspect I think is not identified in at least one of the plans, when I did that in Santa Clara County, I couldn't find anybody who was interested in pursuing the job who did not also want to be connected with the academic institutions, of which there were two.

It wasn't they cared which one, and they were certainly not coming from that direction, but that was part and parcel the kind of people that were interested in doing the job. The research aspects that Jon was relating to was of a lot of interest to them.

It, unfortunately, took the same

position it takes here, which is sort of on the back burner because people get busy. That was one of the recruiting efforts, was focused on that.

But I think that's a good point, Tom. MRH, there's nobody beating my door down to be the other MRH.

MR. STEINMAN: But they like to take shots at it.

MR. COLLINS: Regional hospital has basically told us, Greg has, that this is a real hardship for him because he lost some funding. He's willing to keep doing it, but he wants it someplace else.

And again, we don't need to open up a big file to put all the letters of the people who are interested in the file. So a lot of this stuff is being done essentially for free, and that's -- the people that are interested are the ones that are doing it.

MR. SKEEN: It seems an RFP would put a lot of the issues to rest, ask them to put it on the line. And I think you could use some guidelines from ACEP and NEMSP to



establish what you are after and embodies what we are after here, and the subcommittees that you talked about, Tom, that was discussed.

MR. STEINMAN: The other question I have, question No. 1, have you done the job description for that physician yet? Did that ever come back from personnel or whatever?

MR. COLLINS: Yeah. I've got a draft of it. It's pretty much what was in that report from the committee, the one that the MAB finally agreed to. I'll bring a copy of that with the other -- the piece that's not done that has to be done is what the compensation is and how you do it.

One of the things I've found, as I started to look around, to see who had done a few surveys so we could use their information and we can't find any.

MR. ROBEDEAU: Bill, could you mail that out today?

MR. COLLINS: I will mail it out, if I can find all the subcommittee report, today.



MR. ROBEDEAU: Okay. And wait for the next meeting.

I think I heard consensus that everybody's pretty much interested in going back and revisiting everything that had been done in the committee before and recommending in part of our plan, as part of that or maybe a slightly revised version of Bill's committee. Is that correct?

MR. STEINMAN: Clarify that. If you mean go back and revisit it all, are we going to have multiple meetings on that?

MR. ROBEDEAU: No. We're not going to have multiple meetings. We have had our meeting on it. We're going to get it from Bill, everybody re-get all the information from Bill, everybody read it.

MR. STEINMAN: Okay. Good.

MR. ROBEDEAU: Pretty much the consensus of the committee, as I understand it, is to represent the same or essentially the same proposal that we had through a different committee that Bill had set up, presented to the MAB prior to this on medical direction, which would have a



strong single medical authority but not necessarily only one physician.

MR. DRAKE: Isn't now what we're looking at, is a single medical physician with agents? That's what the plans are?

MR. ROBEDEAU: No.

MR. THOMAS: That could be a refinement of what comes over. I think you want to see how it's written.

MR. SKEEN: Pete, I would suggest a letter to PAPA again, even though they're not responding, ask these specific questions, because they left this hanging.

MR. KILMER: Frankly, I think you have enough by sending them the minutes to let them know what's being discussed here. They have had repeated opportunity to come and specific invitation to come to this meeting. If they want to respond here, if they want to respond to the MAB directly without participating in this process because they are afraid of it or for some other reason, let them do it. I don't see any reason for us to hold up anymore.

MR. SKEEN: I'm not suggesting that we



hold up, Jeff. I think it would be prudent to send a letter out to them asking them for clarification of it. I don't have a lot of hope that it will be responded to, but at least the request is there.

MR. ROBEDEAU: If that's the will of the committee, I'd be happy to do that, ask them for clarification on their medical supervision. A clarification by next Monday, I think, is appropriate because we're really working on a short time frame.

MR. STEINMAN: And, Trace, just for your information, I did talk to Dr. Dugoni when he called me last week, and I encouraged him to have his group attend, and they just flat won't. They really have nothing to say.

MR. THOMAS: One issue I heard here, which I don't think shows up in the work that was done before -- I'm a little bit apprehensive, but I think that has nothing to do with the merits of it -- is the question of whether you want to look at whether MRH and the medical supervisor,



director, whatever we call it, thing ought to actually be in one place and whether that's a recommendation we wanted to make.

MR. STEINMAN: You might find that in the report because I think we may have either had that physician on the subcommittee or on the physician --

MR. COLLINS: Yeah. Something was discussed about that. I'll look back and see --

MR. THOMAS: I remember there was something discussed about saying it couldn't be that way.

MR. STEINMAN: That was the MAB.

MR. ROBEDEAU: That's the MAB.

MR. THOMAS: I think that's an issue for you guys to decide when you come to making a decision about what you want to recommend.

MR. ROBEDEAU: I agree with Tom, that was part of the recommendation, that MAB and the physician supervisor group be at least in the same physical location.

MR. THOMAS: MRH.

MR. ROBEDEAU: Or MRH. And the



physician supervisor group, if I remember correctly, also had QA authority over MRH. Was that correct?

DR. JUI: That's correct. The one issue that continues to plague that last consensus statement by, I guess, that committee was accountability, whatever that magic word "accountability" means.

I guess the way I interpret accountability is the public's ability to influence the medical supervisor or the medical director. In other words, is it responsible to the county, or is it responsible to the agencies that hire it?

So that magic word, which is a little bit cloudy in my mind, was a major stumbling block from some of the advisory

boards.
MR. THOMAS: As I recall, apart from -- I'm going to leave the providers out of this at this point, but my understanding is the consensus that's developed so far is, what I've heard, is a fairly strong direction so far has been to have the accountability be on the medical

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side. I think that's what -- most of what I heard.
The arguments haven't been made very strongly in any form that I've heard by the providers otherwise, although I think that's also a decision that obviously this group has to arrive at a decision on, whether they want to give that up.
MR. COLLINS: I think also you might want to look at both the plans in light of -- it's tied I think to the accountability and responsibility, is all through the process of the medical direction, at least that I've been involved in since I've been here, the move has been or I think the consensus is that you need a medical authority, however you describe that, that has authority to act regarding clinical care.
And one of the things that I -- I'm concerned about the way that it's structured in the plan that PAPA presented, is that that was -- everyone, including PAPA, had all been kind of talking the same way. Now there's a new overlay that I

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think I mentioned earlier, where, at least the way I read it, the authority rests with the MAB. And I think that's a big difference that could -- in my mind, that could affect who and how you would recruit for medical director.
You know, does somebody really want to work under that kind of a setting, that kind of an 11th hour thing that came in? And I think we need to look at that.
MR. DOHERTY: Bill, I remember the MAB members were all interested parties and therefore invited to be involved in the work group on medical direction. Isn't PAPA?
MR. COLLINS: There were some involved.
MR. DOHERTY: Dr. Norton is the only one I remember.
MR. COLLINS: PAPA wasn't around. That was before PAPA was organized. So it had some -- there were some paramedics involved, but not from a focused group like that.
MR. KILMER: The thing that has struck

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me that's new from this discussion today is in the other discussion about single medical authority versus single medical supervisor, and all of the process that I'm aware of that Tom was talking about, it was assumed that whatever you came up with would be effective. What you want to have is effective medical control that is not bound up with its own bureaucracy, that slows down its ability to act.
What Jon Jui has raised today and what Pete raised today is the very important reality, that under the PAPA proposal, it is apparently assumed by its proponents that the agents would be selected from various hospitals. That process is doomed to create the situation where those people will be in conflict because of political agendas, medical agendas and other things, so that the director, even though he has the power to make the decision, will be hampered from making it.
What Jon Jui is talking about, as a practical matter, as a single medical director or not, you're going to have a

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group of agents that can work together effectively with the director. And that to me is the single biggest problem with the PAPA plan and the reason why the medical authority concentrated in a collegial group, like the one Jon represents, is as an alternative that ought to be revisited.
The alternative is you have single medical control to avoid the problems that used to exist with multiple medical supervisors that weren't in contact with each other. You're going to have the same problem underneath because you're going to have multiple agents fighting with each other, that will create the same problem of lack of immediate opportunity to respond because of political and nonmedical concerns.
MR. COLLINS: Well, if you look at the PAPA plan -- we're making a big assumption about the PAPA plan. If you listen to the discussions prior, that the way the medical direction was proposed by the MAB following PAPA's plan for medical direction, there was really no discussion of any agents.

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There was really no intent, that I was aware of, that there's anybody else involved other than the medical director.
Now, they were not -- in the plan they proposed, I think it leaves it open to discussion at this point, but there's nothing in there that says one way or the other. I've asked that question in a letter I've written to them because part of my responsibility as the director is to make a recommendation to the Board of County Commissioners. So I had a number of questions in that plan, and that was one of the questions, because it wasn't real specific.
MR. ROBEDEAU: In reading the PAPA plan, I got the impression that the agents were paramedics.
MR. COLLINS: I don't know. It doesn't really talk about it.
MR. THOMAS: That's his point. You don't know if they were contemplating physician agents or whether they were really thinking just one.
MR. COLLINS: I'm trying to go back to

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that discussion that we had before, and the main difference in the discussions at the MAB was one faction wanted a full-time medical director who didn't practice anyplace, who did all of everything, medical, clinical, administrative, even down to determining which radio frequencies ought to be used on the radio. It went on and on. And the faction was supporting a clinical medical director to handle all of the medical input with whatever he or she needed to do it with, but not this other.
I mean, this business of agents didn't really kind of come up as much. It was sort of a single versus more. But no one got into any detail. You were involved in that. I don't think we ever got into any kind of detail as to how you would hire agents and who they would be, where they would come from. It was more, one person can do it all or one person can't do it all.
MR. STEINMAN: I think it came up in that committee that MAB would have some type of input, along with the providers,

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along with the county, on who those agents would be. It wouldn't be the agency hiring them, that sort of thing. I remember that discussion.
Question, did you get a response from PAPA?
MR. COLLINS: No. I sent it out. I didn't request one yet. I can't remember

what date I gave. Not yet.
MR. KILMER: Seems to me that this process has made it very clear that the idea of a single person to do everything that the PAPA proposal suggests is impossible and that anybody looking at this will recognize that. My assumption is that PAPA will now modify its proposal to say, oh, yes, this person can now retain agents, because that's the only way it can work, and that their view will be that agents, because of the interhospital aspect of rivalry here that is driving some of the people behind the PAPA proposal, will be those people come from various hospitals to avoid the domination of OHSU.
That was the two assumptions



underlying this. If they won't even admit that they need agents or if the agents are going to have to be somebody less than board certified emergency physicians, which Jon had testified last time would be the minimum qualification for an effective agent -- did I understand you correctly?
DR. JUI: That's correct.
MR. KILMER: -- then the PAPA plan is doomed. It's only with the modifications we're talking about to control this under the county that that program is going to go forward. I think that's the MAB's real agenda, because the MAB feels it can control that process, whereas they don't feel like they can control OHSU, and that's a political agenda that has no medical component to it.
MR. COLLINS: That's an agenda I can't even figure out anymore why that's an agenda. If you look at EMS --
MR. THOMAS: That's Tom's point.
MR. COLLINS: If you look at EMS years ago, back in not just this community but any community, back to the time it started,



oftentimes the connection to the hospital was very beneficial to the hospital. If you look in California where base hospitals were all over the place -- years ago I worked for UCLA, and I can tell you the only reason we were a base hospital was because people perceived that was going to get patients in the door, and actually there was a great deal of influence. That's pretty much gone.
MR. KILMER: Right.
MR. COLLINS: Unless now you guys figure you're getting a lot of patients. It's evident in the fact the hospitals have backed off what they're willing to participate in, if they saw that as a rival. I don't think that that is a hospital issue anymore; I think it is a personal issue of people involved, regarding different physicians that are involved in these aspects.
I just don't think that there's anything that you can show that would indicate that the hospitals or the -- maybe more like Jon was saying, the associations



of medical providers in Portland are really -- that that's a real high priority, that they try to control the medical supervision of paramedics. It's still real -- the Portland area is highly competitive still in medical care.
But that faction of it which drove, I think, a lot of decisions really is not as big a deal as it is -- as it was.
MR. DOHERTY: It was a really big deal. I can make a couple of historical observations. In 1978, I believe, the university wanted to do a study on utilizing one spot to get your orders instead of always calling in the receiving hospital, and they got a grant somehow, somehow got some radios, and it was just like sudden hysteria with the hospitals. And they had to be very, very careful about how they wrote up, making sure the procedures did not have anything to do with giving any advice whatsoever about patient destination.
And the second historical observation I would like to make is five or six years



ago medical direction in this community wasn't working. Every agency was doing things based on some interpretations quite differently. In those days, we had multiple physicians doing multiple systems. Presently, I think the medical direction has improved dramatically, and what we have now is multiple physicians doing the single system, and it works.
And sometimes I get -- maybe I'm a little paranoid, but I'm concerned that some members of the MAB are kind of keeping something from happening that works because of their own agendas.
MR. ROBEDEAU: There have been numerous times that certain individuals on the MAB have openly pronounced they wanted nothing to happen, least the drive to have a single provider might be waylaid by the fact that the system was actually working. I don't think that's a secret. It's been pronounced often enough that it's in the record a hundred times.
MR. THOMAS: I'm aware of the time. I think, unless Dr. Jui has more, maybe -- we



want to be sure you've sort of gotten out of everything you want to, and then we ought to let Mark hit his issues.
DR. JUI: There's only one other issue. On the medical supervision, in order to improve you need dissent.
MR. KILMER: You need what?
DR. JUI: Dissent and interchange of ideas. Dissent maybe. There is a proper way to do that.
At an academic institution, we often argue or discuss, which can be perceived as argue. There needs to be a forum of, I guess, discussion where you can improve upon the system, and that needs to be a collegial one where you all have the same mind, but you can have differences of opinion.
I think where I'm very comfortable, especially from my institution, among the physician supervisors, there can be major disagreement. On the other hand, we all know you need to come up with a single, common goal and perhaps a single, common statement, and we end up coming down to an



agreement. Some of us may feel more strongly about that agreement than others.
What I'm trying to say is the environment of a physician supervisor and agents need to be a proactive -- help me with some words, Chris -- conducive environment for doing that.
MR. THOMAS: I think your description is good, as opposed to an environment that acts by dissent and by undiscussed victim. That's a good point.
MR. DRAKE: Pete, where are we at here? I came in late. We had a model that was made up before about --
MR. ROBEDEAU: We talked about that.
MR. COLLINS: You were too late for that.
Trace.
MR. SKEEN: Dr. Jui, I have three brief questions, clarifications from the minutes from the last meeting.
DR. JUI: Yes.
MR. SKEEN: These should be very brief. You indicated on page 2 in the first paragraph, the minutes reflected, you

indicated you thought progress was being made in the paramedics hearing a more unified voice from the medical community. Do you have a reason why you think that's the case?

DR. JUI: I need a copy of the minutes.

MR. SKEEN: You got yours there, Tom?

MR. STEINMAN: Yes.

DR. JUI: Which page?

MR. SKEEN: Page 2, the top paragraph, very last sentence. I assume that's the discussion we're having today. In other words, if you're saying the things are improving, I want to be clear what's causing them to improve.

DR. JUI: From a medical supervision point of view?

MR. SKEEN: You said the paramedics are hearing a more unified voice from the medical community.

DR. JUI: Yes. Probably what's happening, the last statement I made, the atmosphere of disagreement and decision-making is a proactive, conducive



environment for a single stance. The second thing is, No. 2, there is an innate reason for us to have to come to an agreement. If we don't come to an agreement, we find the system not to work.

And so there is a need by physician supervisors to work together, and that need is -- surpasses all other needs.

MR. SKEEN: Okay. I'm sorry. That was Dr. Norton's comment.

The other one, I'll just ask you maybe to comment on it. Again he said there's improvement within the system, that the system needed to be designed so as to incorporate cooperation. I guess that goes to my third one, which was from you, that there was -- you indicated there was no unified quality management forum in the system.

I wondered if you have a model for a quality management forum that's kind of irrespective of who the providers are or how to provide it.

DR. JUI: Bill and I were talking about this later. There is in draft stage,



I believe -- Randy or one of your people has that document -- a copy of what I consider the first document of a unified CQM forum. And that's available -- I have it on my desk. It's available from Bill. It's a very early conceptual paper. Trudy has seen it.

MR. SKEEN: That's one you developed here?

DR. JUI: It's very simple. It's four pages long. It has the fundamental concepts that the continuous quality management group has met for four or five times and has come to a consensus of some important issues that we would like to develop, and inside that document has a rough structure of how all these committees are -- groups need to work together from a single source.

MR. DRAKE: Can we get a copy of that?

DR. JUI: Absolutely. It's been circulated fairly widely.

MR. COLLINS: I'll send it out.

DR. JUI: I guess needs to be



circulated more widely. Keep in mind as a group, it's a draft document and is not a final product.

MR. THOMAS: Is that one of those -- something that one of those subcommittees that you had involvement in?

MR. COLLINS: No. It kind of came from some different directions. We did some educational work on CQM a number of months ago in the planning process, sort of subsumed everybody's time, and then the university had put on a couple of meetings with --

DR. JUI: -- Bev Ringerberg.

MR. COLLINS: -- Bev Ringerberg, who is the quality management physician at the university, and this grew out of that with people discussing the concepts of it. And Jon put together just a draft. This is just like this is not coming from a formal committee charged with anything. But it does give you good initial concept of what people are talking about, I think.

DR. JUI: Many people, many agencies, including all regions, did attend many of



these meetings, so we had widespread attendance and interaction.

MR. STEINMAN: Are you guys done with Jon?

MR. SKEEN: Yes.

MR. STEINMAN: Does everybody know Jon works with the Forest Service and us and everybody else in the world? I suppose the attorneys don't.

Jon works for the Forest Service as their physician advisor for this district. Right?

DR. JUI: Yes. I don't get any money from it, but --

MR. STEINMAN: He works with us. Are you still director of the training program up there?

DR. JUI: No. Modie (phonetic) is.

MR. STEINMAN: Some other one I was going to pop in there.

DR. JUI: I'm on the board of directors of the American College of Emergency Physicians and also currently hold the chair of the state EMS committee and on the academic -- I'm sorry -- public



health committee of Society of Academic Emergency Medicine, amongst --

MR. KILMER: Aren't you AA's physician supervisor, too?

DR. JUI: Yeah.

MR. STEINMAN: Just had to get that into the record.

MR. KILMER: Well, I think -- he's not solely for the fire department.

MR. STEINMAN: He's also probably the one that's the chair of the state EMS committee to come up with these new OARs that pretty much eliminates all us paramedics because under "unprofessional conduct," we have to have wings and halos to be certified, or state certified.

MR. THOMAS: Well, fire people have the wings and halos.

MR. KILMER: Right. That mandates the public system.

MR. DRAKE: That hasn't gone through the committee.

DR. JUI: This was made by a lawyer.

MR. DRAKE: It was, as a matter of fact. I haven't had a chance to talk to



Jon yet, Tom, but we probably need to discuss that at a committee level. I'm getting phone calls from all over the state on that, and I'm getting phone calls -- let me tell you, I can't repeat what the people say in a public forum, but it's not very pleasant.

DR. JUI: I've been getting feedback.

MR. KILMER: They have an opening for a smoke jumper?

MR. ROBEDEAU: Without a parachute.

MR. DRAKE: It's getting quite a bit of feedback. We're going to address it at the Oregon Ambulance Association. We're having a meeting there, and Skip's going to be there. I told him to wear more than one flak jacket.

MR. STEINMAN: It may absolve PAPA if we let it go through. There won't be paramedics.
MR. DRAKE: If you belong to a monastery, you might qualify.
MR. ROBEDEAU: We have two more items on the agenda, if we want to cover them.
DR. JUI: I'm here for good. I'm



asleep now.
MR. ROBEDEAU: Patient care equipment. Is there anybody who has anything to say? Mark?
MR. DRAKE: Yeah. We have talked in the past about standardization of patient care equipment, and we've always as providers agreed with that. I think that's been an issue as well with the supervising physicians, if they want standardization, and with the EMS office.
So are we going to address that as a group and make a recommendation that the equipment all be standardized within Multnomah County for the advanced life support units? I will.
MR. KILMER: When you're talking about equipment, you're talking about the ambulance, the basic ambulance?
MR. DRAKE: I'm going to talk about that separate, as a separate issue. I'm talking about the equipment on board the ambulance, both disposable and nondisposable equipment.
That's been a problem in the past.



Medications, one drug from one manufacturer comes in a purple box, and it's a different drug from a different manufacturer in a purple box. Somebody says, hand me the purple box. There's been discussion about standardizing the medications.
MR. ROBEDEAU: Mark, stuff like that, quite frankly, I would rather refer to a single physician supervisor or a group after the proposal. I don't think this is going to accomplish any of that.
MR. DRAKE: I think we need to make recommendations, Pete. I agree with that. But we recommend that it go to the supervising physician, and they have the authority to standardize the equipment.
MR. KILMER: That's a good idea.
MR. ROBEDEAU: We can do that with -- I think it should be said, you know, over a period of time.
MR. DRAKE: Yes. It's not going to happen tomorrow. But they have the authority to do that.
MR. ROBEDEAU: I don't know if you can afford to go out and buy a bunch of 10s. I



think we're the only company running 10s.
MR. COLLINS: All planning aside, we're moving in that direction anyway. One of the things the county through the rule-making process has not done is specify a brand name. Drugs are -- some drugs are specified by how they're packaged, doses. So it's kind of moving along in that way.
MR. DRAKE: I think it's an important statement from providers: We believe in standardization.
MR. STEINMAN: You won't get it from us. I've never figured out how we're going to hook the trailers on behind those engines to carry this standard equipment that some physicians want us to all carry. You know, we put a lot of that -- a lot of stuff on a fire engine, and when we start adding ALS capabilities, it's a real problem. If you come up with every provider will carry blah, blah, blah equipment, the rigs will have to be built around that. That will take a long time to do.
MR. SKEEN: That's why the importance



of the cost benefit analysis that we talked about on Tuesday, is so that those decisions aren't made in a vacuum.
MR. ROBEDEAU: Exactly.
DR. JUI: From a medical point of view, as close to a standardization, the better it is, and within the limits of operations and budgets.
MR. DRAKE: It does get to a point, and Tom makes a kind of almost humor, but it's true. When they're starting to talk about the amount of equipment we need to carry, we're looking at finding bigger rigs or a trailer. So we need to agree on how much equipment we have to carry.
I want to know what that process -- I just think we should spell out that process.
MR. THOMAS: Tom, you wouldn't disagree there's some merit to the concept of standardization; your disagreement would be over how far it's carried, I assume?
MR. STEINMAN: I think we should work towards that, and I think we are, and I think if we go to a single medical



authority, that would be a lot easier. I don't think it should be spelled out in the state plan; it maybe should be spelled out in a physician's job description.
MR. DRAKE: Okay.
MR. THOMAS: Right. You could identify sort of where the authority lies in that area and how it should work versus what the end result is.
MR. DRAKE: Okay.
MR. ROBEDEAU: Anything else on that?
MR. DRAKE: No. That will meet both. I think what Tom is saying is true: As long as we identify the equipment and the amount is carried, that will identify the kind of vehicle we all will need.
We're up to the limit on type 2s. We've got stuff in boxes, and I don't think we can carry any more in a type 2 unless we make them taller.
MR. ROBEDEAU: I think realistically, working with physician supervisors, I think we can take a lot of equipment off the ambulances, you know. 150 angio cast is just not needed.



DR. JUI: Absolutely. I think we've made a plea to the board of medical examiners, when you look at the equipment, you need to look at the intervention you want, and the intervention, it should have some scientific and medical basis for that and can't be piecemealed out. You need to have the whole big picture, and that needs to be incorporated in what you carry. I agree with Pete.
MR. DRAKE: And there needs to be, like Trace is saying, a cost benefit analysis done. We're not carrying everything in the world, stair chairs, plus clamshells, plus four back boards, that kind of stuff.
MR. ROBEDEAU: All right. Is there anything else before we adjourn?
Hearing nothing else, we stand adjourned.
(PROCEEDINGS ADJOURNED)
* * *



CERTIFICATE

I, ROBIN L. NODLAND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein, before Mr. Peter Robedeau; that I transcribed my

said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 26th day of April, 1993.

Certificate No. 90-0056

NOTICE

BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Tuesday, April 27, 1993
9:06 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Thomas Steinman, Portland Fire Bureau

* * *



APPEARANCES

ALSO SPEAKING:

Mr. Mike Anderson
Ms. Lynn Bonner
Mr. William Collins
Mr. Randy Lauer
Mr. Steven Moskowitz
Mr. Cole Theander
Mr. Christopher Thomas



PROCEEDINGS

MR. ROBEDEAU: Why don't we call the meeting to order. Shall we review the minutes and get any corrections we may have?

(Pause.)

MR. ROBEDEAU: Has everybody finished or do you need more time?

MR. SKEEN: Fine.

MR. DRAKE: No.

MR. ROBEDEAU: Okay. Everybody's finished? Are there any corrections?

I didn't have any this time.

MR. STEINMAN: On John Jui on the last page, I think it needs to say that he's the chair of the state EMS committee instead of a member. That's the only thing.

MR. DRAKE: I missed that.

MR. ROBEDEAU: Okay. Including chair of the state EMS committee rather than a member?

MR. STEINMAN: Yeah.

MR. ROBEDEAU: Okay.

Anything else?



Nothing. Can I have a motion for the approval of the minutes?

MR. DRAKE: So moved.

MR. ROBEDEAU: Second?

MR. STEINMAN: Second.

MR. ROBEDEAU: Favor?

Aye.

Opposed? None.

They carry.

First order of business, Cole Theander's with us. Hi.

MR. THEANDER: Good morning.

MR. ROBEDEAU: Just have a question of clarification. Are you here representing MAB, PAPA, or Cole Theander?

MR. THEANDER: I'm here on my own account.

MR. ROBEDEAU: You're here with Cole Theander, okay.

Two hand-outs, if you haven't received them yet. One is a reply from the original PAPA letter -- or letter we sent to PAPA. Do you guys -- you guys don't have one, okay. And the other one is a copy of the letter I sent to PAPA after the last



meeting requesting clarification on their position for physician supervisor. One for each of you.

MR. SKEEN: Thanks.

MR. ROBEDEAU: Does everybody else have copies of those?

Okay. Today's agenda, system costs and rates. I think -- I hope this one's fairly short. I understand from reading the PAPA proposal there is nothing in the PAPA proposal that addresses rates or costs that I determined that was any kind of specifics.

Oh, wait a minute. Can I back up on one thing?

MR. DRAKE: Sure.

MR. ROBEDEAU: Just as we were ending last meeting Mark passed out -- Mark Drake -- this to me. Is this part of the meeting? I don't understand what it is.

MR. DRAKE: No, no. That's something that I'll get copies out to everybody. We're redoing them in color because you can't tell much from that. That's a cost of the number of providers in the EMS



system. It just shows all the people that provide service in the EMS system including the hospitals, fire departments, everybody.

MR. ROBEDEAU: Is this part of today or is this part of last week or is this even --

MR. DRAKE: No, no. I'll introduce it next week. I need to get copies out to everybody in advance.

MR. ROBEDEAU: Okay.

MR. STEINMAN: I've got one question before we get going, Pete.

MR. ROBEDEAU: Sure.

MR. STEINMAN: Bill, have you heard anything on the time process on this with everybody in the world announcing for --

MR. COLLINS: No. I mean, we never actually -- I don't think we've ever gotten anything back on the original time proposal that the commissioner made at the MAB. I mean, that was a memo to other commissioners, and then we've never received anything back officially. And then everybody's, you know -- everybody's



running for everything, so, you know, who knows.

MR. MOSKOWITZ: Are you jumping in?

MR. COLLINS: Who knows. Every day there's somebody new. I figure by the time the ballot comes out it'll take more than a 29 cent stamp, so I don't know. We're trying to find out what -- time-wise what that all means.

MR. ROBEDEAU: Who's new?

MR. COLLINS: Some guy that runs a grocery store in southeast.

MR. MOSKOWITZ: And Paul McCoy.

MR. COLLINS: Paul McCoy was in the paper the other day.

MR. ROBEDEAU: The last I saw it, he didn't list as a candidate, so I don't know

what gives with him. I don't know. It doesn't make any difference.
MR. THOMAS: I did talk to Carol Kelsey to ask her what she thought was going to happen. And what she said was basically that the other commissioner members, the remaining commission members, would be deciding at some point what their

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schedule is going to be. And she said she thought everybody ought to move forward on the basis the schedule was going to be what Tanya proposed, but that it might not actually be that. That was as much as she could say at this point.
MR. ROBEDEAU: Well, as I understand the schedule Tanya proposed, that would put it before the board of county commission with her not on the commission, and I don't think she'd allow that to happen.
MR. THOMAS: Would put at least the June hearings, that certainly would be the case.
MR. DRAKE: Did she give any sense of when they would let us know if there was a change?
MR. THOMAS: No.
MR. COLLINS: No. We're talking to the chair's office now to see what they're going to do. But it's difficult to get an answer because everybody's getting into the political running mode, and it's hard to get them to talk about stuff.
MR. DRAKE: Pete, I have one other

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question. On the minutes it says Mr. Collins said he had a draft job description for the medical director. Have you passed that out?
MR. COLLINS: No, I haven't. In fact, it's still over at the personnel office, but I'll get a copy of that as soon as we get it back. They're still hanging onto it because the -- we tried to get some data on a study that was done on emergency room physician salaries, and we haven't been able to get that yet. And I don't want to personally go out and conduct another study if we don't have to.
MR. ROBEDEAU: I have one question, too. Did you ever check into anything in San Mateo County and what happened to their system, or do you want me to do that?
MR. COLLINS: No, why don't you. I don't know who's down there. Who's down there now?
MR. ROBEDEAU: Oh, I know half a dozen people in that area.
MR. COLLINS: Yeah.
MR. DRAKE: San Mateo?

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MR. ROBEDEAU: Well, see, they did exactly what was being proposed here, and it lasted for a couple years, and then bottomed out. They did that I believe in '76 or '77.
MR. COLLINS: They did which?
MR. ROBEDEAU: Took all dispatch away from the provider and tried to run it out of a county dispatch where the provider had no contact with the vehicles at all with dedicated units. And it was a -- I know that it didn't last long and it was quite a fiasco, but I don't remember all of the exact details on it.
And 15 years ago it didn't -- it's kind of hard to remember. I know it was quite the deal. In fact, a lot of -- a lot of the idea of dedicated units and eight units for Multnomah County I know came from the San Mateo system as they kicked it off as what should be done. That's a lot of why dispatch is done out of Kelly Butte.
Okay. Anything else before we get going?
MR. THOMAS: I'm trying to remember if

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the board asked -- was going to get ahold of a copy of the recommendation of that subcommittee. As I recall, that was something that --
MR. COLLINS: We mailed that out, so you should get it.
MR. THOMAS: That'll be arriving. Great.
MR. ROBEDEAU: Now I've forgotten. Recommendation of subcommittee?
MR. COLLINS: On physician supervisor position.
MR. THOMAS: This was the original subcommittee on how the physician supervisor, whether or not it was set up.
MR. COLLINS: You asked for a report.
MR. ROBEDEAU: Right.
Okay. We're back to system cost and rates. Does anybody have -- I had said I see nothing in the PAPA proposal about system costs or rates.
MR. DRAKE: Well, actually, I do, Pete. I think there are several areas that they pointed some stuff out. They do mention they have a fee structure that they

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talk about, which is the thousand dollar fees plus $365 a year.
MR. ROBEDEAU: That's licensing fees.
MR. DRAKE: Licensing fees. They also talk about a penalty over on page 18, the beginning, first section. Notice of civil violation, notice to correct, so they're talking about monetary stuff. They talk about the financial oversight board on page 20. So they address the issue I believe of rates.
In reading what they talk about on page 20 and 21, I didn't get from that a description of what they would look at. Maybe I'm missing something from this. And it's the authority to charge fees, and that's for the medical director. But I didn't get anything about actually how they determine cost. If --
You know this document better than I do. Did you notice anything, Cole, or --
MR. THEANDER: None more than you've just said.
MR. DRAKE: Okay. That's -- so I mean, they have a board set up to

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address -- I couldn't pull out of that exactly what they were. It just says here -- it doesn't exactly say what they address.
MR. SKEEN: Well, on page 22 it talks about establishing the maximum rate.
MR. DRAKE: Yeah, that's right.
MR. SKEEN: But I don't think they went into any detail about the methodology.
MR. DRAKE: Right. That's what I was looking for.
MR. ROBEDEAU: You're establishing the maximum rate as compared to what, you know? I think that, quite frankly, in my opinion, is a flaw with both plans.
It doesn't really say what benefit cost-wise or rate-wise is going to come out of any system being proposed, other than as I read the Collins plan and he refers to $3.1 million in savings approximately with a -- I know that there's -- $588 is the average emergency rate, with $3.1 million in savings comes out at approximately $80 a call, when in fact during the noncollection

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rate on that it comes up you should be able to reduce rates with that cost savings of $147 which would come out with a rate of -- an average rate of four forty-one. I quite frankly, knowing the cost of running an ambulance service, find it difficult to believe that a rate of four forty-one would support this system on an average rate of

four forty-one.
I know Vancouver bid an average rate of five twenty-two and Vancouver doesn't have the indigent population that Oregon does, and Washington Medicaid, as I know it, pays significantly better than Oregon Medicaid. And I don't have any stats at all on Vancouver other than the fact that the demographics over there are better than Portland and that's what I've --
MR. SKEEN: We've been successful in finding the transients over there, those that exist. They are there.
MR. COLLINS: If I'm correct, the rate in Vancouver was not a bid rate, that was averaged out at the current billings and established prior to the selection process.



MR. SKEEN: That's right. It was a fixed rate.
MR. DRAKE: That was the methodology.
MR. COLLINS: It'd be just like if we said five eighty-eight and went through the same methodology, took a number of invoices and figured out what the average was. Right.
MR. SKEEN: Yeah. And I think the rationale for that, for whatever value this is to this discussion, was that the rates were not a particular -- they didn't perceive that the rates were a particular issue over there, and so they established the customary rate and used that as a base line and threshold.
It would appear here, and I think Bill started to get into that in the county plan as it relates to the costs and that the variabilities on this again goes back to the things that we've been talking about the last several weeks, and that has to do with the resources that are going to be used within the system, whether you're going to run dual systems with fire medic



units at eight minutes and another system at 12 minutes 90 percent, and what the staffing level is going to be on those ambulances that respond, how much of it is going to be offset with tax monies, if any, the fees that come back to the medical program -- or to the medical director to help support that.
MR. ROBEDEAU: But I think the point, Trace, is that anybody reading the proposal with the numbers given is going to say that if we take this plan, we're going to save this much money. And I think we need to take a look and see how realistic the idea of saving three and a half million dollars is.
MR. SKEEN: Well, yeah. And I think Bill went through that discussion a couple weeks ago about the removal of the communications aspect from it and the reduction in the number of unit hours and made some assumptions.
So I guess the key is, is whether we want to follow on that line and determine whether those assumptions that you made in



the savings are realistic, or take a different approach to try and determine what the cost for the system should be.
MR. DRAKE: Or certainly a methodology to determine that cost accurately, because I think --
MR. SKEEN: That's what I'm saying, yeah.
MR. ROBEDEAU: And part of that is, I had assumed, and that's probably my fault for assuming, that Bill was going to do some checking on what happened in San Mateo County. I should have done that myself.
Part of that is how realistic is it that the county can take over dispatch without the provider having any knowledge of what his cars are doing or where they are and still expect the provider to be able to function and accurately get information and do billing and the core tasks that a provider is required to do in order to keep the system financially viable.
MR. SKEEN: And I think on that individual point, Bill can speak for



himself, but what I understood you to say, that may have to be a phase-in at such point that the county has the data processing capability to generate.
MR. COLLINS: When we were talking about the dispatch, my assumption in that is that at whatever point the system is in place in the county, that it will be able to provide the same level of information on those calls to whoever's doing the billing. Now -- and I think that at that same time I agreed that currently today, with the computer that catches on fire, that's probably not a reliable source of data for billing. You can't get it in a timely manner.
MR. SKEEN: And then there was some discussion also, Pete, I think that indicated that a number of functions that are currently being performed by the communications centers would have to be transferred to other administrative functions in the absence of that.
MR. ROBEDEAU: I understand that. But I think our task here today is to determine



what, if any, system there is in the system and what methodology we use for determining that.
You know, I don't -- I personally, from what I remember of San Mateo County, don't believe that a system that has no coordination from the provider is going to work. I know San Mateo has been tried once. There were other systems I know of -- I cannot find my data on which they are, it's been 15 years ago, that's a long time -- that tried similar things the same way. And to the best of my knowledge, there is no system in this country left doing what is being proposed here. Now, am I wrong or am I right or --
MR. DRAKE: Which proposal are you talking about?
MR. ROBEDEAU: I'm talking about the Collins proposal where the dispatch is completely out of the hands of the provider and the provider has no idea where his cars are, what they're doing.
MR. DRAKE: I don't.
MR. ROBEDEAU: And then you get down



to the issue on that and you get into some accountability, who's responsible for response times then.
MR. DRAKE: But I think we have to decide, like Trace is saying, I mean, do we want to first look at the analogies Bill Collins went through in the EMS office in determining the figures or do we rather -- and/or do we want to just simply say, okay, here's the various proposals, options, models in front of us -- the tier, the single provider, and there's two different kind of options on the single provider, and then the county-run system -- and determine -- how would we determine the cost of setting those systems up and what costs savings would there be, if any, in --
MR. ROBEDEAU: I think we have to determine methodology for what the cost savings really is.
MR. DRAKE: Right.
MR. ROBEDEAU: Anybody can stand up and say, here, if we go with the Collins plan we're going to save three million bucks, if we go with the single provider

we're going to save six million, if we go with multiple provider we're going to save ten million. It doesn't make any right.

MR. DRAKE: I know, Pete. I know we need to determine the methodology to determine those costs to make those comparisons. Isn't that what you were saying, Trace?

MR. SKEEN: Yeah. I think we need to look at that. I guess the question is whether we want to address specifically the issues that Bill has brought up or whether we want to do more of an independent approach. Because we may come up with some potential cost savings that Bill didn't contemplate and we may want to refute some that were suggested in his document.

MR. ROBEDEAU: I think it's a little bit of both.

MR. SKEEN: Probably is. The other thing that I'd like to throw in, and I know Bill has indicated that this is not his charge, but I think that it really is incumbent upon us to provide an analysis of the overall system cost, whereas the issue



– the charge that his office has, in looking at the 9-1-1 system, has repeatedly said they are not responsible for the other medical transportation that occurs in the county.

I think there needs to be some very careful consideration of those issues. Because one of the approaches that one undoubtedly takes is to remove unnecessary redundancy. We need to be careful not to create redundancy in that process.

MR. ROBEDEAU: What do you propose?

MR. DRAKE: One thing I would propose right off the bat, Pete, instead of looking at system cost and rates, could we look at system cost and revenues? Because we need to know what kind of revenues we're going to generate from this system. We all have a handle on that in our various areas of expertise. Rather than looking at rates – rates is kind of the end product of all of this.

MR. ROBEDEAU: Rates is the end product, but rates is the end product that is looked at by everybody. You know, costs



are seldom looked at, you know, write-off numbers are seldom looked at, but when you go and talk to a commissioner and you say five eighty-eight, they don't look at the fact that $280 of that, and don't quote me on that number, is cost shifted to medically indigent.

MR. DRAKE: But I think what we can start out with first off is the assumption is we're going to look at the current system cost. That's what you were saying, Trace. And also the other assumption is that we will then compare the costing of the various models that have been presented in both PAPA and Multnomah County. Is that right?

MR. ROBEDEAU: That's fine with me.

MR. SKEEN: It still seems to me that we've got to get back to the various options that are sitting out there.

MR. DRAKE: Yes.

MR. SKEEN: Because if you're going to look at a unit-hour cost, then there's the determination of what the incremental increases in costs are for excess capacity



that one model might have over another, and the staffing levels, the cost of a dual paramedic unit versus a one-on-one paramedic unit.

MR. DRAKE: M-hm.

MR. SKEEN: I am sure that Tom has some interest in the cost of – if he was mandated to provide ALS first response throughout the city of Portland, what his costs would be. So I guess what my point is, it's difficult to find a starting point until we really have identified what the various plans and the components are.

MR. ROBEDEAU: I think we have our starting point. It's what we have now. That has to be the starting point. I don't see how it could be anything else.

And see, what I see you're – what you're saying is you're talking about designing a new system, and that has its benefits, essentially if we had more time to do it, but we have constraints within our system that create costs so we have to stay with those constraints.

You know, most systems that I am aware



of run out of cars more often than we do. We seldom run out of cars. Once in awhile during the day. But we are never really allowed to cut down to running out of cars.

Everybody goes absolutely nuts when we're down to level one and level two within the system. And a lot of your single provider systems out, as I understand it, is really quite common. It's one of the things that creates the high volume patient contacts for the paramedics.

Other than Tulsa, Oklahoma, I don't know of another system that is going with two paramedics in the rigs. You know, some of these – you guys may have information that I don't have.

There's a lot of things that we have in this system. In order to compare apples to apples, we have to compare this system to this system. We can't compare this system to another system that is operating differently than we are.

We're stopped from pulling cars at



level eight unless it's a specialty transport. And I don't know of other systems that do that. The other systems that have that capacity built in also are talked about in the system, and they run all the nonemergencies and the nonemergencies then are just put on hold and, you know, they do the best they can. But if they get there, fine; if they don't, that's – you know, the person who needs the ambulance transport can just go fish. They control the cream skimmers, as it's called.

And there's none of that here. You know, we've got several fairly different qualified transport – gurney car transport facilities, which that adds to the cost of your system. That changes everything. All of those things change what the perception of cost is.

MR. THOMAS: But at some point somebody's got to make an intelligent I suppose choice, has to do the best they can to isolate costs that are associated with different ways of doing things. I mean,



presumably one of the things you want to end up with or the decision-maker should have would – you've got bunches – a bunch of changes, I mean, that have to do with different regulations that are going to be adopted for the system.

Having a single medical supervisor has some cost component to it; shifting the personnel on the vehicles, if you change the criteria for what they have to meet, that has a cost associated with it. Those are independent of other structural changes that might be made.

And you've got to be able to figure out what costs are associated with what so you can sort of analyze each of the changes and figure out what its implications are,

and not confuse changes that are associated with a shift to a 12-minute response time for some calls, if that's what they want to do, with -- you don't want to confuse those costs with costs that are associated with how many providers there are in the system. And I suppose -- I mean, ideally, those -- you would have each of the



different sort of variables costed out in a way that you can then put together the puzzle and see what's impacting costs and, ultimately, rates.

My impression is that a lot of that hasn't been done at this point. Bill's projected what he thinks are some savings associated with aspects of the system which, you know, this group probably debates and wouldn't agree with him on. But as I understand it, Bill has not taken his total preferred option and come out with a -- what that would cost the total system, what the cost of that would be. I mean, it seems to me that's something you'd want to know.

PAPA's got their proposal. And I don't know to what extent you're able to derive costs for that or they have or they could, but it seems somebody ought to know that.

And then if this group were to make a proposal that's a variation of one of the those two proposals, it seems like you'd want to know what the cost difference was



between that and the proposal it's a variation of. I mean, there's got to be a way to come up with some numbers or, you know, get yourselves within a range. I mean, that's sort of what -- sounds like what Mark and Trace are talking about conceptually.

MR. DRAKE: M-hm. There's a whole bunch of cost factors in the EMS system. There's the cost of first responders, if we have helicopter service, which we do in this community, there's a cost associated with that, with the ambulance service, with -- Pete is saying with the cream-skimming operations, community and assist transportation, transporting people on a stretcher car basis.

You have the cost of the dispatch center BOEC, you have the MS office, the regulatory authority. All of these are costs involved in the EMS system. You have the cost of the other outside providers. They add a certain cost to the system.

So all those cost components, I think, need to be identified and what cost



changes would change as a result of these different models. As an example, BOEC costs may not change at all, the regulatory costs may not change at all across the board on all these models, or it might change significantly, depending upon how much work you have to do.

We may make this system so easy under a tiered response that we're going to make Bill's job a whole lot easier.

MR. LAUER: Or a whole lot harder.

MR. DRAKE: I mean, that's where I think we should start, is identifying those cost issues.

MR. THOMAS: I do agree, by the way, that you've got to look at total system cost. I agree that Bill can't regulate nonemergency. On the other hand, I do think that he has some responsibility to -- if he's shifting costs from the way it's currently working out of emergency into nonemergency, that at least his decision-makers ought to know what that is going to be.

MR. DRAKE: But I think, although he



cannot currently regulate that nonemergency inter-facility work, stretcher cars, there is a couple ways that they can possibly -- counties have passed stretcher car legislation, No. 1. No. 2, the state of Oregon is passing -- hopefully will pass Senate Bill 95 which would regulate stretcher cars and ambulance services, what they can and can't do.

So there is a couple different ways that we may look at it and say, here's this cost of the system and we can regulate that cost. We can regulate either those providers out of the system or we can say, that's fine, we're going to recognize that as a cost in the system, and that's all it's going to be.

MR. THOMAS: I think at least you've got to identify if there's costs shifted from ALS calls to BLS calls. I don't think it's adequate to say, well, we're only responsible for ALS calls. At least we gotta tell people here's what the shift's going to be.

MR. COLLINS: But I think you have



to -- regulating them I don't think is the right terminology.

(Mr. Robedeau left the room.)

MR. COLLINS: We can certainly put -- you know, between the state and county ordinances, we could regulate nonemergency ambulances just like the city regulates cabs. I mean, we can do that. I think the -- when you're looking at this, you're looking at the difference between a -- a noncompetitive portion of the system and a competitive portion.

And while we might regulate nonemergency ambulances as far as the standards of care, I don't think it's appropriate for the county to regulate the business portion of that. I mean, there might be ten people out there now. When we shuffle it around it may be all that can be supported is one or two, I mean, from a business standpoint on the nonemergency side. And that -- I think the marketplace should drive that.

MR. THOMAS: I'm distinguishing, at this point, rates from cost, at this



point. And I'm saying, for example, if for BLS transports you gotta have a dispatch center, it's actually the same number of personnel and people that you have if you have some involvement in ALS and you're saying they don't really need the ALS dispatch function because BOEC can perform it, but there's no saving to them, you need to know that that is not a cost saving to anybody who rides in an ambulance.

What you're talking about is saying, that cost shouldn't be charged to ALS calls which means a hundred percent of it now is going to be charged to BLS calls. Now that's something you can analyze whether that's actually the way it works, but that's something that should be identified. Because you are going to recover the costs, whatever the competitive system is and model is, and you can actually -- that's something you can deal with.

MR. DRAKE: Because I don't think we're talking about actually lowering -- well, we are. We're talking about lowering



the cost in the system, but also we're talking about shifting cost.

MR. THOMAS: Right. And you need to identify which is which.

MR. DRAKE: Right. Where are we actually going to lower the cost and where are we going to shift the cost? Because in a couple of the models that have been

presented they're just shifting costs across the spectrum.
MR. SKEEN: You may very well discover also that the nonemergency portion the county does not want to regulate may very well be subsidizing the 9-1-1 system as well.
MR. THOMAS: Those are the things you have to figure out.
MR. DRAKE: I believe to some degree that's true.
MR. THOMAS: Am I just -- I want to be sure. I'm assuming, Bill, from the first meeting I think we had, that you haven't actually costed out the -- your preferred proposal in terms of what either the ALS side of that would be in terms of the cost

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of the total system.
MR. COLLINS: No. We didn't do that. All we looked at was the current system, the unit-hour cost and to see if there were any pieces of the current system where the cost was not appropriate and just identified a couple of areas. One was the number of unit-hours in the system and the other was what I termed to be redundant or repetitive costs because of the number of providers. We did not go in and figure out what is it going to cost and, therefore, you know, what the rate should be of any particular system regardless of whose it is.
MR. THOMAS: Do you know, Cole, did PAPA do that kind of an analysis sort of?
MR. THEANDER: I wasn't the author. I'm not the author on that portion of the plan, but I honestly can't tell you just how in depth any cost analysis was performed.
MR. DRAKE: So where do we want to start, just identifying the costs, factors in the system current, and trying to come

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up with a unit-hour cost or system cost?
MR. LAUER: I think you can do that. I think you can broadly identify the things in the system that you can attach a cost to, but I don't think we're ever going to get as definitive as a lot of people would like to get. Because no matter what data you have, kind of an analysis you do, somebody's going to be able to shoot holes in it.
MR. ANDERSON: Didn't you already identify the criteria and what the costs would be identified as? I thought you had already done that.
MS. BONNER: In the work groups.
MR. COLLINS: Well, we did for what we were doing. I don't know if you're talking about --
MR. ANDERSON: It sounds like you're trying to reinvent the wheel, if I can be blunt.
MR. DRAKE: He took a look at a narrow scope of what a provider does, transportation providers did on page 15, and simply looked at what the unit-hour

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cost is and tried to pull that out of the system for 9-1-1 responses. I have a problem with the particular methodology that was used for that, but we're talking about system cost. We're talking about the cost of first responders, which has not been identified.
MR. ANDERSON: But couldn't you use the same methodology, identify the criteria that you agree on that would constitute the cost?
MR. DRAKE: That'll get into a lot more discussion, but, yeah, I think we can, sure.
MR. THOMAS: Maybe you could approach it -- I mean, Bill has data from the three companies and from that he got total system cost.
MR. COLLINS: Not the system cost, the 9-1-1 cost.
MR. DRAKE: For the transportation.
MR. COLLINS: See, part of this was like -- for instance, with the first responders, the assumption at least that I made in this plan on the first response was

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that there isn't going to be a radical change in the first response as it is currently financed. Whether people agree that it ought to be financed out of tax base or it ought to be paid for in some other way, nevertheless it's currently financed, so that didn't enter into any of this.
And I don't know what we gained by going through and detailing out the cost of first response unless you can somehow try to incorporate that in the rate structure.
Now, we did mention -- I think we mentioned in here, at least we've had many discussions about recovering some of the cost of first response, the supplies and equipment costs. I don't think we identified how much it was, but said that that was a factor that we wanted to put in there.
But I don't really know what you're going to gain other than trying to figure out what the whole system costs. I mean, what are you going to do with that once you get the whole system cost?

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MR. DRAKE: I don't know that we're going to actually find out whether we agree and care that the first responder cost out of the fire bureau is two million, three million, four million. That's not really going to tell us a lot, because, like you said, it may not change. If it doesn't change under any of these models, what difference does it make?
But identifying that it is a cost factor that we have to consider when you're looking at the overall cost of the system -- because if you do start playing with it and saying we're going to either eliminate it or significantly add to it or change it in some way, then it is a cost factor you're going to have to consider, depending upon whatever model you finally come up with.
The same way with the BOEC. We're saying they're a cost factor in the system. It is. I mean, it's there. There is a cost associated with the system. They do a function with the system. They dispatch 9-1-1 units.

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Now, what you're saying I think under one of the models is BOEC is going to do a different function. It may have more of a function than they do currently as far as regulating the control of ambulances than they currently do.
And that is if they're going to totally manage the system status plan and they're not currently totally managing the system status plan, is that going to add to the cost of the BOEC? Is that a cost that we have to consider?
Now BOEC may come back to us and say, no, we don't have to add any personnel, there's no increase in time. Fine, then we don't have to worry about that. I personally think if they're going to take on more of an active role, they're going to have to add some costs.
And where is that money going to come from? Is that going to be charged back to us, the providers, to -- which is passed on to the patient, or is this cost --
MR. COLLINS: I agree with you. Any variables that are going to affect the

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price need to be considered. I just don't know how much will be accomplished looking at variables that do not affect the 9-1-1 price. It's like the whole nonemergency side of the business.

I mean, the cost could change, people could restructure how they're doing. I mean, there's a whole bunch of changes that could be made, none of which will specifically impact the price on the emergency side, if you identify what costs are going to be allowed into that side.

MR. DRAKE: Bill, I tend to disagree. And the reason is that depends on how you structure the system. If you automatically said there is going to be one provider top-to-bottom franchise and decide that's the most cost effective methodology to use it for, say the backup ambulance service could be fire bureau under a tiered response, there's certainly going to be a cost change if you're going to say they can do top to bottom as compared to just this small segment of the market and we're going to allow the -- this other part of the market

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to be unregulated. There is a cost impact.

MR. MOSKOWITZ: Can I ask Bill a question? Let's say the county adopted your plan and then somewheres down the road the nonEMS regulated portion of the ambulance business went up in cost and citizens were upset, would your response be, well, that wasn't our job to regulate that and what the providers do in that portion of their business is their business?

MR. COLLINS: Yeah, pretty much I would. Because I think it's inappropriate to tie the two cost bases together, especially if it affects the rate on the emergency side. So if it went up, then the implication is, is it was -- the shift was to the emergency side. If it went down, then you could imply that the shift was the other way.

MR. MOSKOWITZ: And I think you're speaking from what your sense of your mission is in terms of the job that you've been given. These folks here feel a responsibility to at least prepare or make

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knowledge available to the public, if not the county board, about some of the implications for that part of the business.

MR. COLLINS: No, I understand that. I've got no problem with that. And again, separating the regulation of patient care standards from the actual, you know, what's the best bid you can put together to get Kaiser's business. That's a good example. Kaiser's a huge provider and has a big chunk of business.

MR. THOMPSON: Well, there's something I don't understand. You got data from the three companies, and based on that you went through your analysis and you said by doing X, Y, and Z you can save this amount of money. The data you got was for costs of emergency calls only.

MR. COLLINS: That's what we asked for. There seems to be some concern about they gave us something else, but when we sat in the room --

MR. THOMAS: Certainly the administrative costs could have been emergency only.

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MR. COLLINS: Yes. We asked prorated out.

MR. DRAKE: Right.

MR. COLLINS: For instance, if you have a large company that has -- well, CARE is a good example. I won't pick on you. I mean, I'm just using him as an example. I mean, they make -- as far as I can tell, make wheelchairs and make van conversions and do all kinds of things. So obviously if you're costing out the compensation that goes to the owner of the company, that comes from a bunch of different places, and if you want to cost that out, you can't put it all into one side or the other.

MR. THOMAS: Well, let's take Mark Drake. And were you a hundred percent in his -- in the data that he got?

MR. DRAKE: No, no.

MR. THOMAS: So you did allocations?

MR. DRAKE: Yeah. Because I'm allocated -- corporate people are allocated to cross all the properties that we have, ambulance properties. And in addition to that, though, for my salary we took out

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that section which is applied by Portland, and then again we took out a percentage which applied only to 9-1-1 calls.

MR. THOMAS: Okay.

MR. DRAKE: And that is the flaw I believe in the methodology that was used, but we won't get into that.

MR. COLLINS: I'm not drawing any more of those lines.

MR. SKEEN: I want to go back to your statement, though, Bill, about if in fact a non -- cost of nonemergency business increased, that that would be evidence that it had been shifted previously to the 9-1-1 side. And I don't think that's a correct assumption, because essentially what you are doing is creating a redundancy. And it doesn't necessarily mean it was shared by the 9-1-1.

MR. COLLINS: What redundancy would be created?

MR. SKEEN: Oh, duplicated infrastructures, for one. If you segment the business. It's just like if you go to BOEC and indicate to them that the

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dispatching is now going to be done by the private contractor or contractors, can you reduce your staffing now by 22 people? Their response is likely to be no, there's no way we can do that and still maintain the bulk of the other business that we're doing up there.

MR. COLLINS: Well, that would be a good example. BOEC has and they do departmentalize cost-wise. They have two major functions; they answer telephones and they dispatch units. If you were to shift the dispatch, if you said they don't want any dispatch of BOEC, we want to go with a single provider because that's going to give us better control over the response time, then that portion of their -- they'd have no reason to keep those people because there would be no function for them.

Now, if they kept them, then one would want to go to the city and say, maybe you're not budgeting this right, but they're -- I know that those are dedicated FTEs that do that job. Now, they cannot shift out call taking because that's a

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different function and they do that.

But should they charge you, for instance, for the call taking? I mean, should they try to shift the call taking and keep their same budget? But I think that's a prime example, because we do have a choice there. We could do it at BOEC or we could do it someplace else.

MR. DRAKE: That's right.

MR. COLLINS: But we can only do part of it and we know what BOEC -- how much it costs or at least what they say it costs to do the dispatch as opposed to everything else. So if you were to move it out of there, one would expect that the city budget for BOEC would go down. It'd have to go down. Well, it wouldn't have to. I

suppose they could ignore it, you know.
MR. SKEEN: What percentage -- do you have any idea what percentage that is, that represents of BOEC?
MR. COLLINS: No, I don't.
MR. SKEEN: Would you guess 15 percent, 20 percent?
MR. COLLINS: I don't know. I mean,

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it's -- I know that EMS out of the total BOEC is not a big number because the big number is the police. So when you look at their total activity, EMS is this chunk here and the police is this.
MR. LAUER: It's not insignificant.
MR. SKEEN: The $64,000 question is if that represents 25 percent of BOEC and that part was removed, that function was removed and transferred to someone else, would BOEC's overhead be reduced by 25 percent as well? And I'm willing to put money on that one.
MR. COLLINS: I don't know what percentage of the business it is. I mean, I can't --
MR. STEINMAN: What do you pay for BOEC out --
MR. COLLINS: I don't pay anything.
MR. SKEEN: So I'm trying to figure out why we're spending so much time, since the county or EMS pay nothing for the dispatch center.
MR. COLLINS: That's why I brought that up, you know. Like first responder,

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BOEC is not a -- it's not a price in what we're talking about.
(Mr. Anderson left the room.)
MR. COLLINS: I mean, it could be the city could decide to make it an issue. But at this point, there's no indication that they're going to change that. So the cost of -- essentially the cost of dispatching ambulances has been spread out over the tax base. That's how it's paid.
(Mr. Robedeau entered the room.)
MR. STEINMAN: It's a system cost, but it's not a cost in the ambulance rates or anything else.
MR. COLLINS: It would only be of concern if we got a letter from the city of Portland that says, we're not going to pay this anymore.
MR. STEINMAN: And I haven't been able to get them to do that for years. I've been trying.
MR. DRAKE: I think we could kind of --
MR. COLLINS: So, I mean, I agree it's a system cost, but I don't know what is

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gained by spending a lot of time trying to figure out what it is.
MR. DRAKE: No, I'm not.
MR. STEINMAN: We're looking at the ambulance rate. And he's right. We had the committee put together the information, and Bill's got a lot of it in here. Are we here today to look at ambulance rates or change this over to system costs? I sat here for an hour and am totally confused now. What the hell are we looking at?
MR. LAUER: I think there's some use in looking at whether or not any of the existing system cost can be decreased, but I don't know that we want to spend a major amount of our time on that.
MR. DRAKE: No. I think we just need to identify what factors go into a system cost, those elements, and move on. And quickly we can decide just like he's saying. And we talked about first responders, I mean, we just simply ask Tom, are you going to increase your costs on the tiered response, he says no, so we have no increased cost on the current tiered

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response model.
MR. LAUER: Did you say no, Tom?
MR. DRAKE: I mean, I don't know if he's saying no or not.
MR. STEINMAN: Why are we looking at system cost though? I mean, if this is a ambulance service area plan that's just looking at just the ambulance industry.
(Mr. Anderson entered the room and Mr. Collins left the room.)
MR. STEINMAN: I'm not sure where we're going with this.
MR. THOMAS: Well, I mean, I think where you want to get -- I mean, if I'm the county commissioner sitting there, I want to know two things.
(Mr. Collins entered the room.)
MR. THOMAS: And I think it's correct. I want to know what the variable costs are, not the things that are uniform no matter what we're talking about. BOEC is uniform no matter what. I don't give a damn.
But I want to know for this particular configuration we're talking about, what is

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the cost of the government, that the government absorbs, and what's the cost that is going to ultimately have to be passed on to rate payers one way or another?
And I don't want to know just on the emergency side, I want to know the total package, because I'm going to take a hit from the nonemergency patients potentially, too. And so I want to know, you know, what the constituencies are.
And I'm going to want to know for each of the things that's presented to me what's the -- in the variable area what's the difference in terms of what the government's going to pay for and what's the difference in terms of what the total patient population is going to pay for. That's the beginning point it seems to me.
Then you get into saying, well, we're going to strictly only charge the emergency patient for the emergency side of that, that's a policy decision. If you make that, that's fine. But I'm going to want to know, if I'm on the county commission,

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what does that mean for the BLS riders who happen to be more in numbers than the emergency patients as I recall. Is that right?
MR. COLLINS: I don't have any numbers.
MR. THOMAS: Well, depends on where you draw the line I suppose. Those are the kinds of things I want. So that's what you want to know. So if it's going to cost you more to do the transports you would be doing, I think that's something somebody needs to know. I think the assumption is it's probably not going to cost a lot more, but --
MR. STEINMAN: There isn't a plan on the table here that will not cost the city more to provide first response or first response and transport. I mean, when you start moving everybody going to AED's or all ALS first response, yeah, there's a cost.
MR. THOMAS: But then the other side of it is there may be a revenue associated with that, which side there's not a net

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cost, and that's what they want to know. And they want to know, but how is that all going to work?
So seems to me it's not that difficult -- well, maybe it is -- to identify. I mean, the way I think about it is you've got you and you've got the private providers.

I mean, you can identify whatever you assign your costs as, I don't know, or maybe nothing or whatever. But, I mean, they can say, okay, here's for an ALS and BLS patient, here's what our cost is, and you've got the allocation to the ALS side. And you can say, here's how we do it and allocate to the BLS side, that's the total. And then you can say, if we make shifts to A, B, C, D, E, F, G, in those areas here's how those numbers change. And just do that by the -- you know, what the different elements are.

And I know it's not exact. I mean, you've got to be able to approximate, because that's how you make a business plan. If there were a shift, you'd come up



with some kind of pro forma.

And then you say, you know, so for this one it ends up with this kind of cost and this one ends up with that one. If Bill Collins wants to allocate costs differently within the system so that none of our dispatch is charged to the ALS patient, well, fine, we can do that. We just -- we've allocated some costs on the ALS side from dispatch, what we'll do is we'll put all the costs on the BLS side from dispatch. So at least you can compare -- you know, show what happens when you do that.

I mean, that's not -- is it that hard? Is it -- I mean, how difficult -- now when you get into talking about we're going to shift to 12-minute response times for some of the calls and we're going to change the personnel on the ambulances, it may become more. But you can still do your best guess as to what those are going to be, can't you?

MR. DRAKE: M-hm.

MR. THOMAS: I mean, you gotta do



that.

MR. DRAKE: We can come real close.

MR. STEINMAN: But why are we trying to do that today? I mean, I agree.

MR. THOMAS: The reason you want to do that is because one of the issues here is what the rates are going to be. In other words, if I'm making a presentation to the county commission, at least this is what I want to do, and I'm Bill Collins, I would feel like I've got some obligation to give them predicted rates both for ALS and BLS, I think, what the predicted rates are going to be. So that --

MR. COLLINS: You can't predict -- I mean, I couldn't predict the nonemergency rate, because what we -- I mean, when you're looking at --

MR. THOMAS: What you can do, though, is you can say -- you can --

MR. COLLINS: I can't do it.

MR. THOMAS: Well, they can do it.

MR. MOSKOWITZ: They can do that.

MR. THOMAS: They can do that for you.

MR. COLLINS: Well, they can do it



under, again, a number of series of models. But if you're looking at the ALS cost of the emergency cost, we've identified what the requirements are, we've also identified exactly or as close as we can what the revenue is based on the number of calls. We know the number of calls, we have all that, so you've got a very finite package.

On the nonemergency side, one, we don't have all the business everybody has. Their nonemergency business may be tied to services in other counties. Not to pick on Kaiser, but Kaiser's got a big pool of transports, nonemergency transports.

And whoever wants that is going to try to give them a price that is most favorable to them, so it isn't going to be driven by a third-party rate set.

MR. THOMAS: Whoever's going to do that at least has to recover their cost or they won't do it. They'll go out of business. So at least you gotta recover costs.

MR. COLLINS: But they can spread



their costs over all kinds of other things that have nothing to do --

MR. THOMAS: Let me tell me what it sounds like you're saying to me.

MR. COLLINS: Well, for --

MR. THOMAS: Let me tell you, because I'm the county commissioner, and I'm going to sit here and say --

MR. LAUER: Are you running?

MR. THOMAS: No. I don't have time.

You're saying, we're going to isolate costs for the ALS system and we're going to only charge those costs to the ALS patients. The ambulance companies are saying that means that there's going to be some -- that's not all cost savings, there's going to be some costs shifts.

Then you're telling us to account differently for how we're going to charge our calls and we're going to charge to BLS patients. And you're saying, well, that's okay, because nobody can ever tell you, Mr. Commissioner or Mrs. Commissioner, what the impact of that is going to be on the BLS rate payer, and you should just forget



about that, don't worry about it.

That's not -- that's not a satisfactory explanation of the total picture to the county commissioner. Because there is going to be an impact on BLS rates and they need to know that.

MR. COLLINS: Well, I think you can discuss how much or what kinds of things are shifted. But, I mean, a good example is your control center also dispatches or talks to people that -- units that are out of this county that have nothing to do with the cost base in this county.

MR. DRAKE: That's correct.

MR. COLLINS: And you can try to figure out what that's worth, but that's going to be very hard to come up with a rate. It's hard to come up with a rate for a piece of business that is --

MR. THOMAS: Well, but somebody is going to up come with a rate.

MR. COLLINS: What are you going to come up with?

MR. LAUER: We don't know.

MR. COLLINS: They're going to say BLS



cost, the rate's going to be $400, except we have this big contract over here, that rate will be 210, and we have this other contract over here, and that one will have to do 312.

MR. THOMAS: All you're saying is it's complicated, but it's complicated, therefore, I throw up my hands.

MR. LAUER: It's complicated, Chris, because I couldn't right now begin to tell you what our rates would be under a tiered system because I have no idea what the market base is, the revenue base is. We don't know how many calls we're going to be responding or transporting. We do now today from a historical perspective.

MR. THOMAS: I understand that. But I'm the decision-maker. For me to make a responsible decision I gotta have some concept of what the rates -- what the costs and, therefore, what the rates are going to be.

MR. LAUER: Well, you're never going to get to that point unless you answer the basic questions. How many calls are going

to be run? Which you have to look at that first and then figure out what your cost for doing that is.

MR. STEINMAN: And that's what I thought we were doing here, is coming up with what the system design is, not the nitpicky details of how many things.

MR. LAUER: You can't even do that until you establish protocols -- if you're looking at the tier system, until you establish protocols and dispatch guidelines to say fire medic unit's going to end up transporting 10,000 patients a year and private ambulance companies are going to have -- one or three or four are going to each transport X number.

But until I, with Buck, look at what the X is, I can't begin to tell you how many units I have to deploy and, therefore, what my costs are going to be to determine what the rate's going to be.

MR. THOMAS: Well, make the assumption that they're ten, 20, and 30 percent, that's going to be it, and run a scenario for each one.



I'm sitting on the county commission. I wouldn't let you get away with this. I wouldn't let Bill get away with what he's saying here. I'd say, come on, tell me -- I don't want to know -- what I want to know ultimately is, what are the rates going to be? What, Bill, is your projection as to what the rates are going to be for ALS calls and BLS calls in the county?

MR. STEINMAN: 9-1-1 or the whole county? What are you talking about?

MR. THOMAS: Not just 9-1-1.

MR. DRAKE: Everything.

MR. THOMAS: I want to know that. Because they're all going to be affected. And my constituents, some of them are going to be mad and some happy, and I want to know which ones and how many. Plus, apart from constituents, it's important to know that information so I can decide as a part of policy what's the best design.

MR. SKEEN: 72 minutes ago when I said we've got to figure out, make sure we've got the cart behind the horse on this, that's exactly what I'm getting at, is that



we've got to determine what those costs are. Chris, we need to know what the scenarios are, what the resources are going to be required for that. And there's a whole -- I think back to Bill, if I recall, what he was talking about in the cost reduction in his model was the communication center.

(Mr. Lauer left the room.)

MR. SKEEN: And he indicated he thought there could be a two-thirds reduction in administration and overhead, but he said even on the 50 percent reduction we can save this much money. And then the third component was reduction in unit-hours I believe.

MR. THOMAS: Right.

MR. SKEEN: Well, I think there's some flaws in all three of those.

MR. DRAKE: Right.

MR. SKEEN: But that's kind of an aside to get to the plans that talks about the number of unit-hours that are going to be required in these different models so that we can -- so that we can determine



what our costs are going to be.

MR. THOMAS: Okay. I'm for that. So if you could have that ready by the next meeting.

MR. ROBEDEAU: How about a subcommittee?

MR. THOMAS: So, I mean, you're actually -- that was a proposal. You identified the unit-hours that would be needed, say, for Bill's proposal, which means you have to make an assumption about what the protocol's going to be.

MR. DRAKE: First off, you have to start off with the number of calls that we're going to run, then you have to figure out what your range of unit-hour utilization is for each one of those units, which then tells you how many units you're going to have in the system, okay. That's how you get to that figure.

(Mr. Anderson and Ms. Bonner left the room.)

MR. SKEEN: Yeah, utilization. But that's also going to be factored by response time requirements.



MR. DRAKE: But you figure that with -- yeah, you have to figure your response time area, include that with this amount of unit-hour utilization to meet the response requirements takes this many units, and you have to do some working with the numbers, make sure that they'll work out.

MR. SKEEN: This is really the key to the whole process, though, because this goes back to the staffing levels we talked about in previous sessions, medical control issues. None of these are really free-standing and independent concepts.

MR. MOSKOWITZ: But is it possible to take each of those variables and plug in different assumptions and come out with different conclusions? I mean, it may be a very long or multiple-page set of scenarios, but is it possible to do that?

MR. DRAKE: Yeah.

MR. SKEEN: I think that's what you'd have to do.

MR. DRAKE: But I think also it's important to note here that we do have to



consider the impact of control agencies on the system, such as Kaiser and the VA.

MR. ROBEDEAU: Well, first of all, you have to determine -- VA is kind of out of it. But I have heard both ways. Bill has said he's not going to be allowing any contract agencies to get special rates.

MR. COLLINS: No. The only thing we said about that was, is that the discounting of the rate charge for 9-1-1 calls is not appropriate. I still don't think it's appropriate.

MR. DRAKE: Okay.

MR. COLLINS: Because you have another contract, you ought to be allowing a lower rate on 9-1-1.

MR. DRAKE: Is there anybody doing that now?

MR. COLLINS: As far as I know, there is.

MR. DRAKE: Who? Because we're not doing that for VA that I know of.

MR. SKEEN: Contract rates?

MR. ROBEDEAU: You're talking about Kaiser. I've got a couple contracts.



MR. SKEEN: There's contract rates across the board.

MR. DRAKE: For 9-1-1?

MR. ROBEDEAU: Yes. I've got a couple contracts on 9-1-1, and Buck's got Kaiser. I'm assuming others. You know, it's just an assumption. I'm assuming that you've got a couple, too, Mark.

MR. DRAKE: I didn't think we made a break on the 9-1-1. I'll have to check.

MR. ROBEDEAU: For VA, their contract isn't for emergencies.

MR. DRAKE: Right. So we don't have a special rate for 9-1-1 is what I'm saying.

MR. ROBEDEAU: But there are other outfits out there. And my assumption is you said you're not -- the new system was

not going to allow any contracts for special rates off 9-1-1.
MR. COLLINS: Right.
MR. DRAKE: So what --
MR. COLLINS: For 9-1-1 calls, right. Because even if you have a contract, you have no way of fulfilling the contract on a 9-1-1 call because you have no control over



who goes.
(Mr. Skeen left the room.)
MR. ROBEDEAU: So --
MR. DRAKE: To get to the models -- we want to go to where we started out awhile back, is we have to say we have several assumptions. Those assumptions are, A, there is a cost associated with first response in the system, there's associated cost with BOEC, we're going to assume that the contract -- there will be no breaks for 9-1-1 calls on the contracts.
(Messrs. Anderson and Lauer entered the room.)
MR. DRAKE: Right. We can all make that assumption.
MR. LAUER: What assumption are we going to make?
MR. DRAKE: Just agree.
MR. LAUER: I'm not agreeing to anything without hearing it.
MR. COLLINS: If you're trying to do this, the first thing you have to do is what we did in the plan. You've got to decide what costs you're talking about, I



mean, what that's going to be.
(Mr. Skeen entered the room.)
MR. COLLINS: No matter how you work this out, you're coming out to some kind of unit-hour costs you can plug in and say, this is what it cost us to put this many units on the street. Because that's your basic variable.
I mean, you have variables that go into the unit-hour cost, but the thing that you provide is hours of ambulance service. That's the product. And whether they're productive or not is -- changes the rate. But that's what you provide, and so you need to talk about what costs go into that.
And then you can apply it to the models to the extent you have data, but it's going to be pretty hard to apply -- then you'll have to make some assumptions about the various models and say, well, this model is X and these are the assumptions for this, but we've already -- I mean, unless you disagree with the costs, not the dollar figures but the categories, we've already done that.



I mean, we spent a great deal of time with a number of people going through all that stuff. Now, you could say, I think you should add this and I think you should delete that or something. I mean, we could go through that again, but -- I'd do that first.
I think that gives you what's, you know -- to use an example of the absurd, should the cost of converting vans at CARE be in the cost accounting for a rate for 9-1-1, and you'd say no. So you don't put that in there.
MR. DRAKE: Right.
MR. COLLINS: But there's a whole bunch of -- we listed them all out. There are a page of them.
MR. DRAKE: Page 15. The problem is -- I didn't like the basis of putting that together.
MR. ROBEDEAU: 15 in the Collins plan?
MR. DRAKE: Yes, at the beginning.
Because you tried to pull out a specific number, and I think that we should



use the total unit-hour cost currently that we're using to provide service.
MR. COLLINS: I hear what you're saying. But I think you'd have -- to do that, you'd have to go through each of the categories -- I mean, if these are the categories -- decide whether the cost is equal. I mean, this is a long -- this will take a long time to do.
For instance, if you're going to say that the paramedics, the staffing costs for unit-hour on ALS cars is going to be different than on a BLS car so why would you use the same rate? I mean, if you use the same rate, it sort of averages everything out, but it tends to discount the --
MR. ANDERSON: Yes.
MR. SKEEN: Is there a disagreement on the assumption made on the unit-hour cost; seventy-five forty-five?
MR. DRAKE: Yes, I agree with the methodology that he used to get there. And then by using that comparison and using that as --



MR. COLLINS: You disagree with the methodology on the figures that were provided? Because I think those are two different.
MR. DRAKE: I don't disagree with the figures you provided, because you base those figures on the information that the companies gave you. I don't disagree with that. You took the figures and you put them together.
I disagree with the methodology that you used to arrive at those figures in making that conclusion. That's what we went over. That's what we were drawing all those lines for.
(Ms. Bonner entered the room.)
MR. STEINMAN: Have you got another methodology you want to throw out here or --
MR. DRAKE: Yes. The methodology is to take the total unit-hour cost we use for ALS and BLS units and not try to pull the 9-1-1 out of that and try to apply the unit cost, because we don't normally do that. Maybe you do, but we don't apply a 9-1-1



unit-hour cost just for 9-1-1 calls. We have a unit-hour cost to put an ALS unit on the street. And that unit responds to 9-1-1 calls, facility transports, nonemergency calls, everything.
MR. SKEEN: Multiple county?
MR. DRAKE: We do break it down by county.
MR. STEINMAN: But Bill's charge is to only worry about the 9-1-1 calls here, so how -- and I think that's what -- I know the county commissioners want to know every vote they may lose or may gain in this. But the charge in this thing is to provide a 9-1-1 ambulance system. And Bill's methodology I think is correct.
And you've gotta break out those things that you said you included in your unit-hour stuff, you know, the other business that you do. You can't subsidize or either side of that equation with the other, so --
MR. THOMAS: Well, I think you can do it that way, and then what you do is then compute a unit-hour cost for the other



calls.
MR. DRAKE: No.
MR. ANDERSON: Can I make a suggestion? I think you could be talking about this problem for hours and hours, and there's been lots of discussions about this for hours and hours and hours. You might be worth -- it might be worthwhile to have

some independent third party come in who knows financial analysis and cost based analysis and look at this and discuss this issue with you, because I don't think -- you go around the room and somebody who doesn't agree with you and another person doesn't agree.

You need to get some sort of a consensus about the direction you're going to go, because otherwise you're going to be here until the cows come home arguing about which methodology makes the right sense. And without somebody that has some really grounding and basis in financial management and economics, you're not going to get anywhere.

MR. STEINMAN: I think I heard that at

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one of our other meetings.

MR. ANDERSON: I've said it before. This is sort of a recap of what I said a year ago.

MR. DRAKE: Well, the only problem with that is we're unfortunately under a time gun that's being held to our head by the county.

I agree with you. That would be a preferred method to do this, is to go out and get some other financial people involved. We have an in-house CPA that does this.

MR. ANDERSON: You could certainly get somebody on fairly short notice to come in here and at least be part of the discussion who wouldn't have an interest in the outcome, who could steer you in the right direction or say, this doesn't make sense or this does make sense. I don't know. That's just -- I mean, I'm invested in this just as much as everybody else so I can't begin to say which makes the best sense.

MR. SKEEN: Well, I think you're exactly right. And we'd indicated that --

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in the letter to the MAB some time ago, is we thought there's a number of issues that deserve better analysis than what we can provide. And as pure and righteous as we all tend to be, we still have interests that we're looking after.

MR. DRAKE: M-hm.

MR. SKEEN: I guess in the meantime, because of the time considerations, I feel like we need to have some of this together, is that there needs to be probably some discussion on how much controversy there is over -- disagreement there is over the unit-hour cost that Bill has applied here on table three, and then be able to use that to go back to the various models that are being proposed out there.

MR. DRAKE: See, what you're doing is you're comparing, in my opinion, apples and oranges. You're trying to pull out a separate unit-hour cost for 9-1-1 calls only. You don't need to do that. You just need to pull out for ALS and apply the unit-hours for each model and that gets you where you want to go.

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My problem with Bill's analogy is he tried to pull out a specific 9-1-1 unit-hour out of the air here somewhere and say, this is the cost for 9-1-1 unit hour. And I don't believe you can pull that out of the information that we have, at least not in the time that we have.

MR. LAUER: That's a portion of that total, though, too. One thing that would be constant is the personnel cost wouldn't matter if it was a 9-1-1 or what kind of call they ran.

MR. DRAKE: No. But see, there's an obvious difference of how we did this then. Because what we did is we took the personnel cost and pulled the percentage of 9-1-1 calls that they ran on for that unit and applied that to the personnel cost. That's what we thought --

MR. LAUER: That doesn't make any sense.

MR. DRAKE: That's what we thought he needed to have.

MR. LAUER: Why does that cost more than the same two paramedics? Did you

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think --

MR. DRAKE: I agree.

MR. COLLINS: This is not an attempt to pull out a current unit-hour cost. It was an attempt to identify the cost -- this is like a cost accounting process. And one of our problems obviously is none of the ambulance companies do cost accounting so that made it difficult to get it.

But the idea was not to determine what is a portion of your current unit-hour but to identify the cost, and then look at the number of unit-hours and, by definition, if that's the cost and this is the unit-hours, that's the unit-hour cost. I mean, there isn't anything else to put in there. The reason that the number's high is because there's a lot of cost against a limited number of unit-hours.

MR. DRAKE: Right. That you're applying, saying -- and we disagree with units-hours.

MR. COLLINS: If you wanted a lower unit-hour cost, if you said this is not appropriate, then according to the

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methodology we used, there's too much cost in it, not too many unit-hours. And that's the cost accounting problem. And I agree, you could have somebody come in and kind of look at the methodology. I don't know that you could do in any kind of reasonable time frame, do the cost accounting.

MR. ANDERSON: Couldn't --

MR. DRAKE: We're talking a couple months.

MR. ANDERSON: Right.

MR. COLLINS: Health care is still going through that process. This is more like Medicare step down where you say these are the costs.

MR. ANDERSON: I think what I was driving at was that at least you could have somebody look at the two arguments and say which argument -- you know, which is logical here, which is going to get you the number that you want to get to or which direction should you go. I mean, is Mark's point valid or not valid in the context of the overall cost that you're trying to arrive at?

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MR. STEINMAN: More facilitated to get us focused and moving. I hate to say this, for the record, but this has been a real frustrating meeting and we've gotten off track. And I hope it's not because Kilmer's not here, I hope.

(Laughter.)

MR. DRAKE: Don't put that on the record.

MR. STEINMAN: I'd hate to have to admit that.

MR. ROBEDEAU: Well, you know, the meeting is getting old, and I don't think we're going to accomplish much except maybe a consensus on what we're really looking at, at cost. You know --

MR. STEINMAN: I think one thing I'd like to see is, I know that the information that all the agencies gave to Bill is kept in strictest of confidence, but listening to the way you guys broke things out, you know, if we could take Bill's costing deal from each of the providers and say we thought he meant this and we did this, and had that on -- in front of us at the next

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meeting, maybe we could see where the big problem is here.
Because, you know, it sounds like Mark broke out personnel different than you did, and don't know what Pete did. Maybe if we had that in front of us without any of the dollar figures or something we could figure out where the problem is with Bill's methodology.
Because I'm sitting here going, I don't know what the heck you guys are talking about. We bounced from 9-1-1 calls to all calls to, you know, some system in Chicago. None of it's relevant. And I'd like to get back to what Bill did here and is it right or wrong and do we have anything to suggest to make it better before it goes up to the county?
MR. DRAKE: I think in the interest of time, I have some problems with the methodology used by Bill, and I think we should just take -- put that aside, as we talked earlier, and just say, here's the costing methodology we want to use and go forward with it.

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MR. LAUER: One thing you can do, too, is say, what we do know is that personnel is a constant part of unit-hour cost. That's based on the level -- what you actually have to pay to put people on an ambulance for an hour. And that's -- you can apply that to whether you have two paramedic ambulances, a paramedic and EMT ambulance, two EMTs.
And you can make a comparison that would be just personnel cost. When you start allocating costs, it gets very confusing, overhead and et cetera. When you start allocating that in, it's going to be difficult to compare.
MR. DRAKE: We have some fixed and variable costs, but I think we can come up with a cost of two paramedics in a unit and one paramedic and an EMT in the unit and agree -- with the three of us, come up with an average cost.
That would be a simple thing to do. We can put the average cost on these for a unit not trying to pull out 9-1-1, just saying that's the cost for that portion.

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Right?
MR. LAUER: M-hm.
MR. DRAKE: Okay. We can come prepared to do that at the next meeting on Thursday?
MR. ROBEDEAU: Say that again.
MR. DRAKE: We can come up with an FTE cost per paramedic and for an EMT so we'd know what the FTE cost is for two paramedics for now.
MR. COLLINS: Well, you know what it is for two. It's --
MR. LAUER: We don't know.
MR. DRAKE: Based on your methodology, not on ours.
MR. COLLINS: This is yours.
MR. DRAKE: No.
MR. COLLINS: I mean, this is like pogo, you know.
MR. DRAKE: You've pulled out something different.
MR. COLLINS: There's the cost, there's the FTEs.
MR. DRAKE: Which table are you looking at?

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MR. SKEEN: Three.
MR. LAUER: Only cost of an FTE.
MR. COLLINS: Right. This is based on your -- on the figures provided by each of the three providers, and then averaged out on a weighted average.
MR. STEINMAN: But Mark's concerned because he screwed up and misinterpreted what you said, Bill, and gave you the wrong numbers.
MR. DRAKE: Don't put that on the record.
(Laughter.)
MR. COLLINS: That's the cost. Now, you'd have to figure out what the difference is if you had a paramedic and an EMT, just figure out what the difference in salary and benefits are between the two, and subtract that or one of them and you got it.
MR. DRAKE: Right.
MR. COLLINS: I'd like to follow up, though, in figuring out how we might have somebody look at the methodology even without even looking at the figures. But

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for me to ask anybody to do that or find somebody, I need to know more what methodology -- other methodology you want to look at.
MR. THOMAS: I think that -- I mean, this is -- I'm not sure why this discussion is so difficult, other than maybe it gets real close to home or something. But I think somebody needs to put in writing a proposed methodology so people have something to react to, because the discussion is so vague and general.
MR. COLLINS: It's hard for me.
MR. THOMAS: Not you. Maybe Mark could do one and maybe Randy or Trace could propose what the methodology is. I mean, to me the proposal ought to be how are you going to get -- what's the methodology to use, so that at the end you can say, this system costs this much, this system costs this much, this system costs this much.
MR. DRAKE: Right.
MR. THOMAS: And maybe you can do it for the fire side, because they can't do it for the fire side, and you can come up with

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whatever you come up with.
MR. STEINMAN: You haven't seen the new book on costing the city put out, huh? We'll never understand that one.
MR. THOMAS: It seems to me if people bring in written proposals, then it's going to be easier to talk about something. I mean, this is sort of all so theoretical.
MR. COLLINS: I think if you're going to do that it needs to be done in our "would you develop the costs," not what the cost is. Because you need to put those components in there. This ought to be included and this is how it should be included. This should not be -- that's kind of the basis of it.
Because out of all this you'll still come down to a cost per unit-hour or cost per something. I mean, it'll be some kind of a unit cost that you're going to look at. Then you apply it to all these different --
MR. STEINMAN: That would really help to have something, because I'm -- this hearing is confusing.

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MR. THOMAS: And our discussion so far would not be adequate to communicate to the county commission what we think about cost and rates. I can assure you of that.
MR. DRAKE: Well, I think part of the discussion has been, though, all along is that there is a disagreement in what we're including in the cost, because I disagree with the analogy of using 9-1-1 cost only.
MR. THOMAS: Well, fine. That should be part of your proposal. I happen to agree with that. Others may not. But I think you can put that in your proposal. So you say you gotta do the total package and here's the way you do this part and here's the way you do that part.
MR. ROBEDEAU: If I understand what

Chris is saying, we end the meeting, prepare methodologies putting in no numbers, and then use the next meeting -- the first part of the next meeting to put a single methodology together.
MR. THOMAS: If you can.
MR. ROBEDEAU: If we can.
MR. THOMAS: Or identify what the



different ones are and just agree that there's a dispute. But, you know, I mean, I suppose the committee -- there's been talk about a majority and minority report. Maybe there will be several.
MR. MOSKOWITZ: Would it appropriate then to have some independent person come to that meeting to hear these different methodologies?
MR. ROBEDEAU: Who could we get?
MR. DRAKE: Who are you going to get by Thursday? We can bring our CPA. Is everyone going to use that?
MR. COLLINS: They may not even have to come to the meeting. I mean, if you can write this out, you can --
MR. THOMAS: I'd say why don't you see where you are when people come in with their proposals. I'm not sure there's going to be that much difference. I have no idea.
MR. COLLINS: We could find a disinterested cost accountant.
MR. ANDERSON: Maybe you could go back to Portland State and see if there's



somebody there or some financial person. I wouldn't use a CPA. I don't think a CPA has the insight that you need for that.
MR. COLLINS: You need somebody that's pretty versed in cost accounting and how best to apply that.
MR. STEINMAN: As much as I hate to suggest the university, but there's a rumor up there that they set up some health reform office to study all this health care reform.
MR. ANDERSON: That's right. Mitch Greenlick chairs the department up there, yeah.
MR. STEINMAN: Maybe it would be good to contact him and see --
MR. ANDERSON: That would be an excellent idea.
MR. COLLINS: Who's that?
MR. ANDERSON: Mitch Greenlick just formed a new department that looks at health care reform -- is looking at health care reform. He chairs the department of -- I can't think of the name of the department now.



MS. BONNER: OHSU, he has several hats, but one of the them is associated with the Portland State sort of health research entity.
MR. ANDERSON: Right. We could ask him and see, or maybe you could ask him.
MR. STEINMAN: Are you going to ask him, Bill? That might be the way.
MR. COLLINS: I'll try to get ahold of him and see if this is something that --
MR. ANDERSON: Or at least he might be able to give us some resources or lead us into some resources that might be able to help us with this problem.
MR. THOMAS: One thing the committee hasn't talked about is rates and the rate control side of things. That is a topic -- I mean, that's an additional topic to the one we've been fumbling around with.
MR. COLLINS: You mean the process that you would --
MR. THOMAS: Well, there's several proposals that have been around over time. I think Bill's and I believe PAPA's is for rates to be set through bid processes.



MR. COLLINS: I think in the PAPA one they have -- the financial oversight board is the responsible rate setter. I mean, with some approval process.
MR. THOMAS: Okay.
MR. COLLINS: But yeah. I mean, you can set them -- I think we've talked in the past about if there's a bid process. You can set them through the bid process or you can set them through some independent panel that looks at the costs that we're all talking about and comes up with a rate, kind of a PUC idea. And actually either one of those is fine with me.
MR. THOMAS: You recommended the bid process, as I recall.
MR. COLLINS: Well, yeah. If you're going to go through a bid, then if you can set the rates in the contract -- what I would prefer to see on a rate basis is that the rate is part of the contract or the agreement, and then there is some, you know, automatic review of that vis-a-vis the CPI or some adjusted index, so that you're not going back every year to try to



justify minimal changes in the rate, and then anything else would have to be outside the contract, it's a renegotiate, if you've got a big change in the system so that you -- so the rates just become part of the contract. I mean, that's --
MR. THOMAS: I don't know if the group wants to discuss this now or later. I mean, I have -- since I have actually done some research in the past on some bid systems at least I have my own thoughts on it. I think that's a very risky approach personally.
MR. LAUER: Which approach?
MR. SKEEN: To tie to CPI?
MR. THOMAS: No. I don't know if risky approach is the right phrase. I think there's substantial experience that bid systems promise you that this is what the rate is going to be, but are not able to hold to the promise.
MR. COLLINS: That's true.
MR. THOMAS: So that -- and I think -- I suppose the thing that is more secure in terms of getting you what you predict



you're going to get is more of a traditional rate regulated system. Not traditional, but I mean traditional for some businesses.
(Mr. Steinman left the room.)
MR. COLLINS: Both those work. I think either one of those could be used to establish a rate. And then once it's established, you put it into whatever contractual agreement you have.
MR. THOMAS: I've never seen any kind of study, and I'm assuming you haven't either. Maybe -- I don't know if anybody else has, that indicates in bid systems whether in fact the rates that are bid -- where rates are bid or the rates that are specified where services are bid are actually the rates that are maintained throughout the term of the contract according to what the contract provisions are. I mean, is there any --
MR. COLLINS: The only experience I have is when I was in California and the rates in the contract were the rates that were charged. There were no changes. And



that was -- that was a five-year contract, although it did have some built-in like rates go up two percent. It wasn't CPI-driven. It's just whoever -- I didn't do the contract, but whoever wrote the contract actually specified what the annual change in the rate would be.
MR. THOMAS: Are there any --

MR. COLLINS: And that's what the rates were.

(Mr. Drake left the room.)

MR. THOMAS: They would specify what the rate was?

MR. COLLINS: Yes. Year one the rate will be and year two the rate will be.

MR. THOMAS: I'm just aware of cases with contracts like that where the contract didn't work that way actually. And has anybody seen any kind of, you know, systematic study of all the places where this has been done around the country and where the rates stayed what they were?

(Mr. Steinman entered the room.)

MR. SKEEN: Yeah. I think what Bill's talking about is actually pretty common in



the ambulance industry, where a bid -- where a rate is set. In fact, that's -- seems to be more recently in terms of the rates are regulated upfront, and then there are --

MR. THOMAS: I understand that. What I'm saying is I know the contracts say that's what's going to happen. The question I have is, I know there are cases where that is not actually the way it's worked out because the companies couldn't do it and got bankrupt.

And what I want to know, has anybody actually done a systematic review around the country which tells how many times they've been able to hold to the contract and how many times they've had to deviate from it?

MR. SKEEN: Yeah. I understand what you're saying.

MR. LAUER: Probably not.

MR. SKEEN: I don't know of any study, but I know there have been some deviations.

MR. THOMAS: Yeah.

MR. SKEEN: Actually both public and



private sector.

MR. THOMAS: M-hm. Both types of contracts.

Or the alternate is they keep the rates the same but they change what the services are that are required. I mean, it would be important, if you're going for that approach, to know whether it really works in a -- you have a high degree of security that it's going to work and that it's going to be the way the contract says it's going to be, or whether you really don't have much security. I know there have been some very major systems where it hasn't worked.

MR. ROBEDEAU: I've never seen a study, but I know what we did, and I think what you're alluding to is, I don't know of a system that has come in at the bid rates, you know, and stayed with everything that was guaranteed in the original bid. And I don't know of one.

And we've looked into a lot of stuff over the years and different systems, and every one have been changed after the bid



was left, either the rates weren't up or the quality of service being provided went down.

MR. ANDERSON: How do they establish rates on succeeding years? They fix them or do they inflate them?

MR. SKEEN: Generally it's a combination of CPI components, combination of medical transportation.

(Mr. Drake entered the room.)

MR. COLLINS: Either CPI -- it's kind of a modified CPI index. Or like the one we had in Santa Clara actually was just fixed. I mean, I couldn't even tell you why they were in that way, because when I got down there the contract was in place. But it just said this is what it was.

And I believe the only variable -- it's kind of interesting, they must have been written when they had the big gas shortage, because the only variable in there was fuel. There was a special, you know, contract provision that if fuel costs went up more than so many percent, they could adjust the rate, but I'm sure that



that was on the heels of when everyone was lining up, you know, to get gas.

MR. SKEEN: If it was 1985, it would have been insurance then.

MR. ROBEDEAU: One other thing that I know has changed in bid systems where they've bid it out is, in systems where they bid out the emergency only, within about a year of that time, because of purported problems, the nonemergency has been included and was just awarded without a bid to the winning provider. There have been some systems like that.

MR. SKEEN: Pete, there are a number of bids I'm aware of that have maintained the pricing as well as the performance. I know there's some like you're referring to that I can think of that have been the other way around.

MR. COLLINS: But your point's well taken. I think there is some risk when you're going on a low bid or reasonable bid basis, that you have to sort of verify that what is bid actually has some relationship to what's being provided.



MR. THOMAS: It would be nice to know what the level of risk is.

MR. COLLINS: Well, actually, you know, if we were to have a tiered system like we proposed, we probably could not bid the rate because of public -- the fire department would probably have to go through a rate-setting process. Can't bid sort of half the rate.

There would be no reason to bid the rate from the fire department who isn't competitive. That same would be if you followed any of the -- in PAPA's plan the non -- the publicly run components. You wouldn't bid any rate there. You'd have to go through some rate-setting process.

MR. ROBEDEAU: Okay. Bill, then what are you going to bid?

MR. COLLINS: You have to bid service. I mean, if you bid, you have to -- I mean, that's -- that's -- there's only two ways that I know of. I suppose you could bid both, but I've never heard of anybody doing that. Has anybody bid both?

MR. ROBEDEAU: Oh, yeah.



MR. COLLINS: Well, they tried it.

MR. SKEEN: Seems like I've heard these arguments before.

MR. COLLINS: I don't think that makes a whole lot of sense.

MR. DRAKE: I agree with that.

MR. ROBEDEAU: So then you're setting the rate, you're doing a rate -- you're talking about a rate constant bid rather -- I had assumed that you were talking about a no rate.

MR. COLLINS: If you set the rate --

MR. ROBEDEAU: You're going to give us and we'll negotiate the rate with you later.

MR. LAUER: Clark County set a price.

MR. DRAKE: Sort of.

MR. COLLINS: Price fixed.

MR. DRAKE: Price fixed with a variable aspect to it.

MR. THOMAS: That still has the same element of risks to it, price fixed bid. It doesn't really matter. Well, okay. So you're assuming you'd set the rates, and if you bid anything, you'd bid the services.

MR. COLLINS: We're still talking to the county council about what we can do and what we can't do under all these different variables. And the more I talk to them, the more confusing it gets, so --

MR. ROBEDEAU: That's kind of one of my problems, Bill. You know, as I've articulated before, we don't even know what we're doing, but we're within 30 days of going to a county commission to adopt a plan and nobody knows what the plan is.

MR. LAUER: I don't think we're going to the county commission that soon, Pete.

MR. ROBEDEAU: Don't confuse the issue with any facts here, you know.

MR. STEINMAN: Like the approach, there's no data in it, so there's nothing to dispute, then you don't sit in these meetings all day.

MR. ROBEDEAU: Are we coming back with methodology next meeting?

MR. DRAKE: Yes.

MR. ROBEDEAU: Okay. One other thing on the next meeting. Next meeting is the last regularly scheduled meeting and then



there are four open dates. I think one thing that we should have is, for the next meeting also, any additional agenda items we want in the four open dates so everybody has a chance to see those in advance like we've had in the current agenda items. Is that agreeable?

MR. SKEEN: Is provider selection, is that next week? Thursday?

MR. ROBEDEAU: Provider selection and ASA description. Thursday.

MR. LAUER: Day after tomorrow.

MR. SKEEN: I just want to go back so I'm really clear on this. When we talk about coming with methodology next week, it still appears to me that we have an issue of costs in having -- that there's a need here somewhere to define what the demands for resources are going to be.

MR. ROBEDEAU: That I think is in the methodology, Trace.

MR. SKEEN: Well, so what you're talking about is the number of unit-hours going to be required under the various option plans?



MR. THOMAS: You can propose it however you would like, what do you think is the right way to.

MR. ROBEDEAU: I was thinking more the methodology on how to determine the number of unit-hours that are going to be needed under the various plans rather than -- you can, and put down what you think the numbers are, but put down how you arrived at that number.

MR. LAUER: Right. Do whatever the formula is.

MR. DRAKE: Right. Whatever formulas you want.

MR. ROBEDEAU: Use the formulas on whatever you think should be done. And if it's at all possible, we can get them out tomorrow, which I know is a joke, but -- I'm not planning on that. But, yeah, put in everything you think, but give the formula that you used to come up with that number.

MR. DRAKE: So we'll bring in our dartboard.

MR. ROBEDEAU: Whatever turns you on.



MR. DRAKE: All right.

MR. ROBEDEAU: Is that it?

MR. DRAKE: That's it.

MR. ROBEDEAU: Okay. We're adjourned.

(PROCEEDINGS ADJOURNED)

* * *

(NOTE: Untranscribed steno notes archived permanently; transcribed paper notes archived 2 years; computerized English text files archived 3 years.)

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CERTIFICATE

I, SHANNON K. KRSKA, a Certified Shorthand Reporter for Oregon, do hereby certify that I reported in stenotype the testimony and proceedings had upon the hearing of this matter, previously captioned herein, before the Multnomah County Provider Board; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 28th day of April, 1993.

Certificate No. 90-0216

COPY



BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Thursday, April 29, 1993
9:10 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Pete Robedeau, Chairman, AA Ambulance;
Mr. Trace Skeen, Buck Ambulance;
Mr. Randy Lauer, Buck Ambulance;
Mr. Mark Drake, CARE Ambulance/TVA;
Mr. Tom Steinman, Portland Fire.

* * *



APPEARANCES:

Ms. Lynn Bonner, Kaiser Permanente;
Mr. Bill Collins, EMS;
Ms. Trudy Schidleman, EMS;
Dr. Gary Oxman, Mult. County Health Dept.;
Mr. Jeffrey Kilmer, AA/CARE Attorney;
Mr. Chris Thomas, AA/CARE Attorney;
Mr. Steven Moskowitz, AA/CARE Attorney.

* * *



PROCEEDINGS

MR. ROBEDEAU: Why don't we take a minute to review the minutes, and also, as we're reviewing the minutes, there's two handouts. One is from Randy Lauer. And I haven't read it yet, but it's an explanation how to figure unit-hour cost. And the other one is from me. It says, Provider Board evaluation questions.

And this is a partial list of things I thought we should be looking at and comparing each plan to and making recommendations off that, and at the same time as we discussed earlier, things that were not on the – in the current plans that are before the board and other options that we wanted to discuss.

I think this is where these should be brought up. I know this list is not complete, and I think we need to add some.

MR. KILMER: Randy, can I ask you a question on your handout?

MR. LAUER: Sure.

MR. KILMER: What is this number



8,760?

MR. LAUER: Number of hours in a year.

MR. DRAKE: On a 24-hour basis?

MR. COLLINS: Total number of hours.

MR. KILMER: When you say number of unit hours in a year, you're talking about number of hours in a year?

MR. LAUER: Hours. You're right.

MR. KILMER: This assumes 24 hours a day, every day of the week, it would be –

MR. SKEEN: To staff one unit 24 hours a day, seven days a week.

MR. KILMER: All right. And the times eight is in effect three eight-hour crews plus two reserves?

MR. LAUER: Well, I can just run through this real quick, if you'd like.

If you go down to the example, just take 40,000 – somewhat of an arbitrary figure. You can plug any figure in there – that's potential full-time-equivalent cost for wages and benefits to staff a unit 24 hours a day, 365 days a year, suggesting it would take



eight personnel to do that. They run, for example, 12-hour shifts, 12 on, 12 off, all the time. It takes eight people to do that.

MR. KILMER: Right.

MR. LAUER: And the reason I did that is because if you have 24/48-hour shift, it would take six people to do that, the unit hour cost would be less, but the volume would be higher.

At least in my mind, we need to assume this is going to be a very busy system. 24-hour shifts are probably not going to be a very feasible thing to do.

And then divided by – it takes 40,000 times eight. So the personnel cost of staffing that unit for a year, 24 hours a day, would be $320,000. Divided by the number of hours in a year, you get personnel, payroll related cost at $36.53.

MR. KILMER: I guess the question I have, the way you've done this, this assumes the same eight people would be available all the time and excludes vacation and other costs associated with



this?

MR. LAUER: Except for the cost of paying for the vacation is included in the FTE cost. It does not assume additional staffing.

For example, there's been discussion that I've heard in the past that related to pay for six people. You're really paying for seven people. I didn't do that. It would be important, I think, when we look at one kind of a model versus another that we don't include that additional cost in either one.

MR. SKEEN: This assumption was FTEs only.

MR. KILMER: I understand. The reason I'm asking these questions only is I think any analysis that comes out of this committee has to reflect the real world. We have been critical of Mr. Collins for not doing that. We don't want to open anything, the board does, to the same criticism.

So the question I have is, does this reflect the real-world ambulance costs?



And if it really is higher because, as a practical matter, you have to have an additional half person or full-time person over the course of the year to adequately staff these things to account for vacations, sick leave, you know, other leave that you grant and that kind of thing, then that ought to be factored in here.

MR. LAUER: I purposely didn't include that because then it gets difficult to compare when you start adding in allocated costs, different kinds of providers or different providers in the same kind of an organization could allocate costs different.

For example, Mark described that his

salary was allocated on a percentage of time he spent dealing specifically with Multnomah County, recognizing he deals with a lot more than that. So when you start making allocations, they get to be somewhat subjective. And we need to keep that subjectivity out of there.

You can base it on a simple formula.



We can compare one kind of a staffing model to another one, one system model to another, recognizing that it doesn't reflect a true, actual cost of the unit hour. But for comparative sense, it gives a good basis.

MR. KILMER: The problem is, you're coming at this from the front end. You're making certain assumptions and coming up with cumulative-hour costs. Mr. Collins is purporting to come at this from the back end, which is taking all the costs you've incurred and coming up with what actual unit costs are. There's a substantial difference between his calculations and yours. I think there are substantial costs than these you have put in your formula.

MR. LAUER: I agree.

MR. KILMER: And in order to get a better sense of which more accurately reflects the real system cost so that it can be compared with Mr. Collins's cost -- I thought there were ambulance, industry agreed upon add-ons for at least for the additional personnel cost, like one person



out of five. Am I wrong?

MR. LAUER: You're not going to find consensus on that.

MR. COLLINS: Isn't FTE about 2,000 hours a year?

DR. OXMAN: It's 2,080.

MR. COLLINS: What you need to staff this is 8,760 hours.

MR. ROBEDEAU: You couldn't do that. What you're talking about with a 2,080-hour year is essentially nine to five, five days a week. You would have to do a minimum of 2,080 times six. That would be an absolute minimum, not counting any vacation, sick time.

MR. COLLINS: This is 12-hour staffing, not 24 hours. Right?

MR. ROBEDEAU: You have to account for the 24 hours or have a system outline to show what you have.

MR. COLLINS: Aside from that, if you have an employee, full-time employee, they're going to work a certain number of hours a year based on their shift and how much vacation, sick time they have for an



eight-hour, standard eight-hour employee, the numbers are a little over 2,000. I don't know what it is for 12-hour employees. Probably slightly different.

MR. ROBEDEAU: It depends again on what your 12-hour shift is.

MR. COLLINS: It shouldn't.

MR. ROBEDEAU: Sure. Are you four on/three off, or three on/four off?

MR. COLLINS: There's going to be a little bit of difference. A 24-hour shift, you're assuming they are working and not working at the same time essentially. In other words, you work 24 hours, not on all the time. So you end up with a different number there.

MR. ROBEDEAU: But you still have a cost for that hour whether they're sleeping or on a call.

MR. COLLINS: I was looking at the eight-hour, 2,000 hours. The number is pretty close.

MR. LAUER: The purpose for this is to use a model for different kinds of deployment plans. It's not to get into any



more of a cost analysis other than it's comparing A to B.

MR. KILMER: I think it's useful for that purpose. No question about it. And any process ought to agree on this.

MR. DRAKE: There is a couple things here -- and I think you're on the right track here, Randy -- but I think there's a couple things we need to look at: One, your annual FTE cost. You're assuming that's an annual average FTE cost for employees.

MR. LAUER: Actually, I assumed it as a top.

MR. SKEEN: That's an arbitrary figure. Please don't take that as any representation other than it's --

MR. LAUER: You could easily turn it into 50,000.

MR. DRAKE: I understand. If we did assume the annual FTE cost is the cost for the ambulance services for the three companies, we could each come up with an average cost for paramedic services. We average those out, those would be the



average cost in the system for a paramedic FTE. We could do that?

MR. COLLINS: We already did that, unless the figures you gave us are not right.

MR. KILMER: No, Bill. We gave you, and you took artificially high numbers in the system.

MR. COLLINS: You're wrong, Jeff. We did the cost thing. We have an average FTE paramedic cost of 30,000-some-odd dollars. That has nothing to do with where they're deployed, where they are, anything.

MR. KILMER: In other words, the number you're working on is not 40,000, it's 30 --

MR. COLLINS: He said we could come up with an average number, and I said we did that.

MR. ROBEDEAU: Trace just said don't believe the 40,000.

MR. DRAKE: I understand it's an arbitrary figure. I understand that. I'm saying to come closer to the actual cost of the current system, we could average the



paramedic FTE cost currently in the system. We could all three -- Pete comes up with a number, I come up with a number, you come up with a number. We average it out. Okay? We can do that.

That would be the same number we all use to plug into all the models.

MR. LAUER: Could, but it gives you more variables. I think if you look, everybody has pay scales that are established, whether they're contractual or not contractual. They have a pay scale. Just look at that pay scale and take a top-of-the-scale paramedic, I think you're comparing the same kind of thing from one provider or staffing configuration to another.

MR. SKEEN: I think the concern from Jeff and probably from Mark, too, is that this number -- make sure everybody understands -- this number is not the full cost of staffing that unit. It is the lowest common denominator we could get to without variables. It is clearly not the full cost, unless you don't give any of



your people any time off.

MR. DRAKE: Right.

DR. OXMAN: Randy, is the goal here just to -- I guess I'm reading into this a goal of getting an index of how systems compare to each other and cost. This one will save about a million, this one will save about a half a million, given this set

of assumptions. So whatever number you choose, it doesn't matter.
I think the issue is you want it close enough to reality so that when you talk about that ballpark figure, what you're going to save and what the cost difference is, it has some reasonable relationship to reality, plus or minus, 30 percent, 50 percent, whatever. Is that the goal?
MR. LAUER: Yeah. An index, that's exactly what it is.
MR. DRAKE: Right. I'm trying to get to that, but I'm trying to get as close to the real number we're currently using as possible. I think it's simple to get to that one number by simply averaging the FTE cost by the three providers. I take our



average FTE cost, his, you, we put it into the system. That's the number we use from now on. It would be the same unit cost number.
MR. KILMER: It seems to me that's the more efficient way to do it, because that's the real number. You take that number, say, what happens if you increase wages from what they are now to by five percent? What if you change ambulance staffing so you have one EMT instead of two? You can talk unit hour, cost per hour of exposure or experience or something like that. So once you get this one number, then you can test all different assumptions on that formula.
I tend to agree with Mark, that his approach would give you a number that would be more meaningful throughout this game plan than this artificial one.
MR. LAUER: Except if you look from provider A to provider B -- say, provider A, all their EMT-I's are brand-new. That average EMT-I cost is real low. Provider B's EMTs have been around. That cost is



higher. Provider B has a higher pay scale but similar to provider A.
You have to look at potentials, I think, especially if that's a goal in here somewhere, to reduce turnover. You're recognizing eventually you want to get people up to that level.
MR. KILMER: But any system that comes out of this will hopefully be one to come up to that. You take system averages now. You take a provider now. You're going to get a fair look at what this is going to look like. You're always going to have turnover.
MR. ROBEDEAU: I think what Jeff is saying, if you apply the same numbers to evaluation, if everybody has the same evaluation, we can choose a buck an hour if you want to, as long as everybody has the same numbers. What Mark is saying, trying to make it realistic to what is currently happening in the world today and apply all those exact same numbers to any system as evaluated or any proposed system as evaluated, and Jeff is more going to



sticking with the same numbers.
I think they're both saying the same thing. I think you all three are saying the same thing.
MR. KILMER: It's just a question what number you use.
MR. ROBEDEAU: Which number you use. I think that's irrelevant. It's probably better to go with something that's pretty close to current-day cost just so that it can be compared. But I think the thing that's really important is to make sure the number remain the exactly the same, the formula remain the same, the formula remain the same throughout any figuring for evaluation purposes.
MR. DRAKE: Right. That's why I wanted to bring up two points.
MR. ROBEDEAU: You said the FTE for come up with taxes and benefits. You're also including the taxes?
MR. LAUER: Yes.
MR. ROBEDEAU: I'm going to finish on this. We've gotten off here a little bit. We need to get back to starting the



meeting.
MR. KILMER: That's all been on the record, I hope.
THE COURT REPORTER: Yes.
MR. DRAKE: We have started the meeting.
MR. DRAKE: The other point I wanted to make, when you're talking about unit hours in the year, we're talking about total unit hours, that's what I'm referring to. You used this as an example. Is that right?
MR. LAUER: (Nods head.)
MR. DRAKE: Same with number required to staff a unit, you're talking about the total number required, total staffing requirements, not to staff a particular unit?
MR. LAUER: Yes.
MR. DRAKE: So you're talking about total staffing requirements, to get to the final number.
MR. LAUER: With the staffing pattern that utilized eight people to accomplish it, and accomplishing 8,760 unit hours per



year, for example, 12-hour shifts back to back would take eight people. Eight people that ran 12 hours a day would take 48 hours still, divide the annual number of hours in it, the personnel hours would be lower, so therefore the unit hours would be lower.
It's a mathematical process. We can't look at it as being true and actual costs of your system because we know it's a portion of it, but it's not the whole thing for sure.
MR. DRAKE: I assume you would determine unit-hour costs for FTE now. That's one the formulas that you pull out of your analysis?
MR. LAUER: M-hm.
MR. DRAKE: That is essentially the same formula you're using, take the FTE cost and divide them by the number of unit hours to find your total costs. Right?
MR. LAUER: Right. That's an internal thing. Other people could question how we arrive at that, how you allocate your costs to get unit-hour costs. We could question each other's methodology of doing that.



You keep that out of the formula, you don't have all these questions and variables hanging around.
MR. KILMER: Mr. Chairman, can I say that I think what this demonstrates is the whole problem with the process that we have had, and it was revealed even in the discussion last week, and I wasn't here but I've read the minutes. In order to do any adequate study of system costs, particularly when you are going to recommend changes in the system because of alleged cost changes and cost savings, you have to have an agreed upon measure for those costs.
And on the simplest issue, which is unit-hour costs, there is no such agreement, because in this whole process, until last week, no part of the process ever asked that question. That's one of the criticisms we have had with the past process. And when Mr. Collins did his work, he never gave us a chance to evaluate that before he announced it. So that we are reduced to the situation of trying to

come up with comments about it.
But last week's whole meeting seemed to suggest that there was no even consensus in the system, even the most sophisticated components on it, on how costs are to be defined. There's no consensus on the adequacy of the data with respect to costs. Very few of those have been identified with any specificity.
There are no questions about the adequacy of Mr. Collins' data collection efforts, in the sense he didn't collect on the public side of the system, he didn't collect on the nonemergency side of the system, and he didn't collect on the nonambulance transport components of the system. There are real questions about the way in which Mr. Collins used the data he had. But there's a real question about the adequacy of the methodology that he used in limiting his inquiry to the private-company EMS transport costs and rates, without measuring them against the public -- the nonemergency component of this.
And all of us at the table were



communicating it various ways. We didn't feel this led to a realistic explanation or analysis or picture of what was in this system.
And it seems to me that the agenda for today ought to be, first, what costs ought to be evaluated when you are doing ambulance planning?
And it seems to me that those must include at least the ambulance response and transportation costs for emergency services. They ought to also include the balances and rates for private services, particularly if that's going to be separated out, because the costs have to be recovered from that system someplace. If you're going to transfer from public to private, you have to look at the increase in rates there, and you also have to look at whether you're really going to suffer a decreased system cost.
This requires you to define, what is the system? Is the system just private ambulance transport? Is the system first response plus emergency transport? Is the



system emergency response plus public and private transport? Is the system BOEC? Is the system EMS administration? Does the system include medical supervision?
None of those costs have been determined or put into this system, and, therefore, different systems can't be compared in terms of the effect on those other system costs to determine whether there's real system change.
Once those costs have been defined, then you have to take a look at the role of rates. What are the rates supposed to recover? Clearly, there is tax support for this. That tax support is now in the fire department first response and it's in BOEC, it is in EMS, it's in medical supervision, and it's in -- but there's none for transportation.
Under these new plans, you're going to transfer some costs to the public side. Some of those may be recovered in rates, some may not. But there will be increased responsibilities under BOEC under Mr. Collins's plan. There will be



increased administration expenses under Mr. Collins plan which doesn't exist now, and all of which has to be measured, the increase, against the supposed decreases you're going to get from his changes. That has not occurred.
Once you've defined what the rates are supposed to recover, then you have to look at the impact of increased costs in the rate structure in terms of what that's going to do to the rates.
What that's going to do is, for every dollar increase in rate-allocated system costs, you have to raise your rates twice that dollar because of the reduced collection fee. And the fact is that because we have reached the limit of our ability to collect from private ratepayers, the marginal increase in recovery will begin to go down from that 50 percent, independent of Medicare, Medicaid, and other health reforms that are going on. And that has to be factored into this as well when you decide what you want in the system and whether the system can bear that



cost.
And then to the extent the cost is not recovered in the rates, is it a subsidy? Are there different ways of taking that subsidy and buying the biggest bang for the buck for that? And that's the kind of analysis that has to be done, and they all interrelate to everything else, just like the environment.
And any discussion that tries to break that down is ultimately not going to lead to something that is not useful in this debate. That's been the problem with this process, I think, to date.
MR. SKEEN: So are you suggesting, Jeff, that we do that as a committee, or we go back to the discussion last Tuesday and talk about bringing a financial wizard in?
MR. KILMER: As you know, Trace, we have recommended from day one that any planning be done in a committee that has sophisticated people on it, financial people, business people, ambulance people. We've always felt that should be done rather than have the MAB or County



Commission or somebody else that has none of that expertise do it. And the process ought to be one in which all of these issues are evaluated together and finally balanced out. I think that's what ought to happen.
Obviously, this committee cannot do what an eight-year process should have done and has never touched in four more weeks. And I think that this makes it quite clear, just the fact you can't even agree on the basic numbers that for this system to be adequate we have to -- this process to be adequate, it requires more time.
And I'd like to propose to the chairman, you know, the letter go out that we said we might have to send, that we can't adequately do this in the time period established by the County Commission. I assume that's also going to be set back because of Gladys McCoy's untimely death and the new election and everything.
My suggestion is that it can't be as simple, even as you said, of having a financial wizard do this. It ought to have



more than just a financial wizard, but it ought to at least have a financial wizard in the process.
MR. ROBEDEAU: I think what Bill is referring to, Jeff, is table three in his plan. Do you have his plan?
MR. COLLINS: I'm referring to what?
MR. ROBEDEAU: When you started to --
MR. COLLINS: But that was based on what Mark was saying. He said you wanted the average FTE cost. That has the average FTE cost.
MR. KILMER: That has the average FTE cost by your calculation.
MR. COLLINS: Has the average FTE cost as reported to me by the companies in answering the question, what is your

average FTE cost. You can argue they gave me the wrong figures.
MR. KILMER: No. We argue you didn't do the right thing with those figures, Bill.
MR. COLLINS: There isn't anything to do with it. If I ask you how old are you and you tell me 53, and I go, 53, I didn't



really do much, you know. This is the average FTE cost that you provided.
MR. LAUER: If we're -- I'm sorry.
MR. COLLINS: And it's a weighted cost based on how many relative pieces of the unit hours are provided, basically half and a quarter and a quarter.
MR. KILMER: You include --
MR. DRAKE: Wait a minute. I have a question on that. Let's not lose that.
You said weighted average. How did you assign that weight?
MR. COLLINS: Just on the general percentage of the business so that --
MR. DRAKE: General percentage of the business. What is that general percentage that you used? General percentage of 9-1-1?
MR. COLLINS: 50, 25, and 25.
MR. DRAKE: So you assigned 50 to Buck?
MR. COLLINS: Right. And 25 and 25, for purposes of averaging out the FTE.
MR. ROBEDEAU: Wait a minute. You weighted -- I don't understand.



MR. COLLINS: If your average FTE cost for paramedics was $20,000 and Buck's average was $22,000, I took your 20,000 times a quarter of the business and their 22,000 times half the business when I was averaging out the number. I could have averaged out the same, and it would just have been a slightly different number. If you're roughly a quarter of the business and he's roughly a half of the business, there's a difference in the two costs. I give you a quarter's worth of the cost and him half the cost.
Now, it might be 27 percent and 51 percent, but that isn't going to make a big difference in the average --
MR. LAUER: Mr. Kilmer made a good point --
MR. COLLINS: -- plus they're all real close.
MR. LAUER: -- earlier when he said we can't agree on methodology. That's pretty clear. What I try to do is make it as simple as possible. We can't even seem to agree to that.



I think when Bill came into this system, what he came in with a mind to do was to build a consensus about what the system should be, excluding any past processes occurred, and realizes now that a consensus, agreement among all the people who had input into the EMS system is not possible.
MR. KILMER: I don't think he gave it a chance. I think we moved very close to a consensus, and it's unfortunate that was interrupted by some precipitous action.
MR. LAUER: Jeff, we've been discussing this for millenniums.
MR. ROBEDEAU: That's exactly the point. This thing, you know, didn't all of a sudden jump out for some reason. I don't know what it is. I'm sure somebody was told to put something on the table. But the fact is, that it was produced, given to the MAB, and said, rule on it, and that's what it was. And there is nothing about the MAB's hearing process or the MAB that says that there was any chance of ever having a fair hearing on this.



All you have to do is look at the makeup of the MAB. You've got the chair of the MAB is the author of the white paper that came out ten or 15 years ago. You've got Dugoni on the MAB who has been saying since day one -- and he doesn't even want to listen to facts -- that single provider is the only way to go. You've got Cole Theander, who is a member of PAPA and author of the PAPA proposal. You just go right down the MAB and you can see what the process is.
And the process says, there's absolutely nothing here that is a fair hearing.
MR. KILMER: Randy, you say we have talked for millennium. That is not true. There has been nothing in this process that has allowed everyone the quality of discussion that we have had today, in all of the eight years. We have tried and tried to have such a process. We have submitted data that, if ever reviewed, might have led to something. But the talk that we have done has been entirely sterile



for the reasons that I talked about here.
The issues that are really important with respect to costs and understanding the system have never been addressed in any substance. Now, Mr. Collins did start to do that with his work group, but then they stopped. We thought they were going to continue, and they did, and instead out comes this.
This process, from my prospective, is sort of a Rosemary's baby. We're stuck with it. What we need to do now is try, in the last minute, to have a process that goes into this in a little more depth.
MR. LAUER: What you're suggesting, though, if the process doesn't result in total agreement, the process is flawed. I suggest there is no such process.
MR. KILMER: I don't think it can result in total consensus agreement. What is resulting is much more consensus on basic issues. You don't happen to be part of that consensus on that issue, but there is a lot of consensus that you have heard about, about a tiered response with two



private providers, medical control at OHSU in a situation where that contracts with the county and has many of the -- provides everything that everybody ever wanted from a single-provider system.
That sort of consensus is beginning to develop and was before Mr. Collins' plan.
MR. LAUER: I don't know that that's much of a consensus than a compromise.
MR. KILMER: What is a consensus but a compromise? There is no such thing as an consensus but the ideal situation. It's an oxymoron.
MR. DRAKE: Pete, can we get this meeting back on track?
MR. ROBEDEAU: I was going to let the discussion on this thing continue until it finished. There's no point in stopping it.
MR. DRAKE: I think we need to get back on track, if we can. I think there's some points to discuss on this. I agree.
MR. STEINMAN: Has the meeting been called to order?
MR. ROBEDEAU: It was called to order



a long time ago. Or disorder?
MR. KILMER: Come on, guys. This has been what is the track. You keep saying you want to get on the track. What is the track?
MR. DRAKE: We wanted to approve the minutes and get back to the discussion.
MR. LAUER: We ought to at least

approve the minutes.
MR. STEINMAN: I like the minutes. Good job, Steve.
MR. MOSKOWITZ: They keep getting shorter and shorter. I don't know if that's because you guys are talking less or my arm is getting tired.
MR. LAUER: Jeff wasn't here.
MR. STEINMAN: Jeff was gone.
MR. ROBEDEAU: If you're doing corrections, on page 2, second paragraph below "Discussion on how to measure," you've got 1.3 million. It should be 3.1.
MR. COLLINS: On page 3, at the last paragraph, it says the county should not regulate noncompetitive, i.e. the nonemergency. It should be the competitive



or the -- the nonemergency is right, but the nonemergency is the competitive side, not the nonemergency noncompetitive.
(Mr. Chris Thomas entered the room.)
MR. ROBEDEAU: Are there any additional corrections?
Can we get a motion, then, to approve the minutes?
MR. DRAKE: Randy made the motion to approve the minutes.
MR. ROBEDEAU: I was out getting food. Sorry about that. Anybody second?
MR. DRAKE: I'll second.
MR. ROBEDEAU: In favor?
(Vote taken.)
MR. ROBEDEAU: Opposed?
None. All right. Carried.
MR. STEINMAN: Pete, before we get into this other stuff, I have a question to ask of the providers, provider business.
We're getting a lot of tension on the street with our providers. We need to not take this battle down to that level. I'm getting a lot of complaints in about



uncooperative paramedics who will stand back and not do patient care, make comments either about our wages or PAPA's plan.
And I did receive a letter in my mailbox -- I don't know if Buck was nice enough to send it over or an employee -- a letter you sent out on the labor stuff. And we're taking this battle down to a level it should not be, and I would hope you would encourage your people to let us fight it out here and at the levels we get paid to fight it out at and not in front of the patients and not jeopardize patient care out there.
I did send out a memo today asking for anybody to report any instances, and I will forward those to the county when they come in. But one of our division chiefs stopped by one of the stations yesterday and got an earful. And he was very concerned, as I am. And I know we can't do anything about PAPA cranking them up, but if we could keep it at this level, I would appreciate it.
MR. SKEEN: Your point is well taken, Tom. But it's probably a bit naive to



think, as evidenced by the testimony at the MAB meeting, that employees aren't concerned about this. And there's a lot that we can do to try to curtail that, but to think that employees' jobs aren't threatened by this in this environment is a bit naive.
I'm anxious to get this resolved as soon as possible.
MR. STEINMAN: Trace, you may think it's naive. I've been in this business for eight years. We've been successful in keeping it off the streets. You sent out a letter that I think stirred that up quite a bit. I don't think that's called for. I think we get paid big bucks to come in here and fight with each other. They get paid what they get paid to deal with patients, not get involved with that system.
We have been successful in this system, and I think all the providers should be thanked for what they have done in this, because I think everybody has in the last eight, ten years worked hard to keep it here, and it can be done and should



be done throughout this process.
MR. LAUER: Can I respond to that?
I agree. I think it is naive to think that we can somehow keep paramedics in a bubble and isolate them from the process that has been building consensus, that Mr. Kilmer described, that would change the whole nature of their jobs, eliminate the part of the job for which most of us, myself included, got into this line of work in the first place.
That's a paramount concern to our employees. Those are the people I'm responsible to, and they've got a right to know what's going on.
Now, I agree it shouldn't interfere with patient care. I don't necessarily think that people know what the issues are automatically --
MR. STEINMAN: An information letter I have no problem with, but when you don't somewhere in that letter ask them to let us do the stuff, come to us with the problems, not discuss it on the street, when you call it a fight that they're involved with and



we need your support in this fight, I think you're asking for it to drop down onto the level citizens see it and citizens see patient care is potentially jeopardized. And I think that's insane.
MR. LAUER: I don't think it gives people much credit to assume they're not going to take that to the street.
Paramedics -- and I hope this goes on the record. I think paramedics are mature people who know where to keep the politics, where to keep the patient care.
MR. DRAKE: Randy, he is saying he's gotten complaints from the people, it has gotten down to the street level and is involved in the street paramedics.
MR. LAUER: Let us see the complaints, and we can deal with it. I don't want to respond to anything else.
MR. DRAKE: I agree.
MR. SKEEN: That point is well taken. I don't think there's any encouragement to employees to take that to the street. By the same token, it's our responsibility to communicate to employees about what's going



on.
Tom, if that's how it was perceived, we'll take some action to try to reverse that because there was no intent --
MR. STEINMAN: I'd appreciate that.
MR. SKEEN: -- that patient care should be compromised in this process. But obviously there's a lot of anxiety involved, probably from all of us. And it probably deserves a conversation between you and I independent of this setting to talk about some of those things.
MR. STEINMAN: Now, slightly off the subject, in reading that letter, it is more -- your wording -- a tiered system is, from a purely economic standpoint as it relates to Buck Medical Service, a tiered model system is probably superior to the model we have currently.
Is that true?
MR. SKEEN: Depends how you spell it out. There are scenarios that could be argued. Until we figure out what our unit costs are going to be -- that's why I kept suggesting for the last couple of weeks

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that I think we need to get down to the various options, the various plans, and talk about what types of resources, what kind of protocols are going to be involved in a tiered response system. Until we get that, it just seems like all of this other discussion and dialogue is kind of meaningless.

MR. DRAKE: But I think it's important to point out, Trace, if the paramedics are concerned, that any correspondence to the employees as groups would encourage them to participate in this process, not at the street level, but the process we're engaged in on a weekly basis. Encourage the employees to come to this meeting forum and express their views or frustrations. That's what the meeting forum is.

MR. ROBEDEAU: The dog and pony show, I understand, at the last MAB meeting I think is totally uncalled for, especially when I know one person who is very much involved in PAPA, he's an employee of AA, quite frankly, stood up there and started bad-mouthing the fire department about how

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lousy they were. I think that's inappropriate. No. 1, I don't think he knows what he's talking about; and, No. 2, that's what's being -- by some people, and I don't believe it's management of any of the companies, but some of the paramedics are encouraging to happen. And I think that's what Tom is talking about.

I would really prefer if -- Tom, if you want to turn the complaints in to EMS, that's up to you. But I would like to see a phone call directly to me as soon as you find out about it, because the faster we can get looking at them, the better off we're going to be.

MR. STEINMAN: Anything that jeopardizes patient care I will turn in to the county and talk to you about it, which is also a personality conflict for providers.

MR. ROBEDEAU: In the county that's fine, but I'd like to get it as quickly as possible.

MR. KILMER: I think it's important to note here that to some extent PAPA and the

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paramedics are sowing the wind and reaping the whirlwind, which is a process likely to hurt them than help them, and they are upset about that that the provider management has done or has any control over.

It is irresponsible for people to whip that up and appeal to that for company agendas. I think that's where people have to be careful.

MR. STEINMAN: I'm not saying that's what Buck did. The letter could be interpreted many ways. I really blame PAPA for the major stir on that, because once they were at our tri-data meeting, it took less than four hours for them to convince AA and CARE's paramedics they were sold out, and we had a nightmare with people not wanting to bring in that gurneys or anything else. They're the major stirrers in this.

MR. ROBEDEAU: You listen to the street, and what's happening is real obvious. You know, they have convinced themselves, through whatever process they

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used, that once they decided that they were going to do this, there was nothing anybody could do and that they would completely be in control. And I believe, from listening to some of the things I've gotten fed back, that certain people running for office, political office, contributed to that feeling. And now they all of a sudden find out that somebody else has a voice. They feel betrayed by a whole bunch of people, and they don't know which way to jump.

Right now I think they're taking it out on MAB, and they don't take it to the people who whipped up this frenzy.

MR. SKEEN: Who are you referring to when you say "they"? PAPA?

MR. ROBEDEAU: The paramedics, not necessarily PAPA.

MR. SKEEN: Paramedics in general.

MR. ROBEDEAU: Paramedics in general. PAPA fed this thing. There were certain people that attended meetings that helped, I think, whip up this frenzy six or eight months ago, a year ago, whatever it was that -- I'd have to go back to the PAPA

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meetings, before PAPA closed their meetings and wouldn't allow anybody else to come to them. And you had -- one was -- one of the members of the MAB stood up and told PAPA how lousy all the ambulance companies, the owners, and managers were. I mean, you had certain political individuals involved in this stuff too.

And I think the paramedics generally feel -- they went through this period where they were very convinced that they controlled the whole world, and all of a sudden they realized they don't, and they have a very -- they have a feeling of being betrayed.

MR. DRAKE: I think we all recognize the paramedics are frustrated and that we as providers back our paramedics and consult with them and explain to them. We expect them to act professionally at all times.

Tom, you're going to get to us any complaints which we hear, any comments. I appreciate that.

MR. ROBEDEAU: Well, let's move on. I

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took a stab, I passed it out to everybody -- Chris, I don't know if you have one.

MR. THOMAS: I do.

MR. ROBEDEAU: -- the handout I gave, Provider Board evaluation questions, this I think goes along with what Trace was trying to get at. This I'm sure is an incomplete list, but I tried to sit down yesterday, with what little bit of time I had, to write down the things that I felt had been articulated, not only in this process but over the years, on how the plan should compare. And when Randy and Trace had both talked about, they want to talk about other plans or other components of a plan that are not as they currently exist in the other plans, and I think this is the place to do it.

On the medical issues, I think we need to sit down and evaluate, fairly quickly because we don't have a lot of time line -- and we've never gotten any indication from any of the powers that be that are going to be interested in extending any time line --

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just go through it. Medical issues, usual issues, and one of those is the number of paramedics in the system, and under the PAPA plan how many paramedics there are going to be, under the Collins plan how many paramedics there are going to be, under the current plan how many paramedics are there, and is there a way to reduce the number of paramedics and still maintain the level of care.

It gets down to level of care. Are we even going to maintain a level of care?

But those -- I've got the four headings. I'm sure there are more. I would like to add to those now before we do anything. Or, if you think this is a bad idea, I'd like to hear that too.

MR. DRAKE: I don't think it's a bad idea, Pete. I think when you're looking at the number of model options that you talked about, you mentioned PAPA -- and we don't want to say Collins -- but the EMS plan and then the other models that we're talking about, the CARE, fire department models, there's the two provider options --

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MR. ROBEDEAU: There are lots of options.

MR. DRAKE: We need to put those all out, across the top. That's what I thought you were saying.

MR. ROBEDEAU: We can do that too. I think each one of these things has to sit down, in an outline form, evaluate as best we can and make our recommendation, showing what will happen with each one of the proposals.

MR. DRAKE: That's what I'm saying. Each one of those proposals has options. The PAPA proposal has single provider by bid, and than the county provided bid.

MR. LAUER: That's one option.

MR. ROBEDEAU: We can do that.

MR. DRAKE: Instead of saying PAPA, how about PAPA-1, 2, and 3, EMS-1, 2, and 3.

MR. LAUER: Basically, the delivery options, system delivery models.

MR. DRAKE: System delivery models.

MR. ROBEDEAU: That's fine.

MR. DRAKE: The number of paramedics,

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you wouldn't have paramedic turnover under those. One of the things I thought was peak units employed, we should add that in somewhere. I added it in under cost. We can add it under medical issues. I think it's better under cost.

MR. ROBEDEAU: Actually, that would be a heading of its own.

MR. DRAKE: We could find out --

MR. ROBEDEAU: -- our number of paramedics in the system -- number of units, number of paramedics are all interrelated, and that's one of the things we have been hearing for years. Ever since the county said you need to have two paramedics on a car, we've been hearing there's too many paramedics in the system.

MR. LAUER: Before we get to the number of paramedics in the system, we need to agree on something.

MR. DRAKE: We do.

MR. LAUER: It could take years, but we need to agree on the number of unit hours that are needed in the system.

MR. KILMER: You can't do that until

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you know how many units you're going to need.

MR. ROBEDEAU: No.

MR. LAUER: How many calls occur and how many unit hours are necessary to service these calls.

MR. DRAKE: Randy is right. I was going to get into another issue, and that's called unit-hour utilization.

MR. LAUER: Don't you think we need to start with a demand, systems demand?

MR. ROBEDEAU: I think what this is, perhaps if we're designing the ideal system, which would be the third part of this component, which would be a new system, but under the current PAPA proposal, the EMS plan, and then other plans, I think we need -- I think this needs to sit down and say, under the current system there are so many cars, 1, 2, and 3; under the PAPA proposal, there are so many cars, 1, 2, and 3; EMS-1, 2, and 3 there are so many cars.

MR. LAUER: We need to arrive at that. Until you find out what the demand

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is, you can't determine how many unit of cars are needed. You can say how many are in the current system because that's actually happening. But if you want to compare that to some theoretical systems, you need to have the demand to base it.

MR. DRAKE: Randy, I think we're getting ahead of ourselves here. I think all we're talking about is the different categories we want. He has number of private hours and public hours. He's got the number of hours under the cost. We're talking about that.

I think the number of paramedics in the system, what you're talking about, Pete, is the current number of scheduled FTE slots for paramedics.

MR. ROBEDEAU: The current number of scheduled FTE slots for paramedics. The number proposed under PAPA-1, 2, and 3; the number proposed under EMS-1, 2, and 3; and number proposed under other plan, Randy-1, 2, and 3.

MR. LAUER: I don't have a plan.

MR. THOMAS: In order to come up with

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a number of paramedics, you've got to know what the demand is under any existing or proposed system. That's included in that.

MR. DRAKE: We understand that. We're talking about the number of categories.

MR. LAUER: We need a big white board.

MR. ROBEDEAU: I don't think I'm being understood very well, unless I'm not understanding what you guys are saying.

What my idea was, here are the issues that have been articulated. Here is an issue. How does PAPA-1, 2, and 3 address that issue? Does it address the issue? Is it silent on the issue? There may be none.

MR. DRAKE: I see what you're saying.

MR. ROBEDEAU: It may say nothing. Then you take EMS-1, 2, and 3. Does EMS address that issue? If it does, what does it say?

MR. SKEEN: A side-by-side comparison?

MR. ROBEDEAU: Yes. It may say nothing. Then you get over to Randy-1, 2,

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and 3, which is the ideal plan, the perfect plan, and we'll be able to put down what we have there.

If you guys think my idea is bad, then say so. I think a side-by-side comparison, so the commissioners can look at that and say, okay, here are the problems articulated, here are the solutions articulated in each one of the plans, is that reasonable?

MR. DRAKE: That's reasonable.

DR. OXMAN: You're not talking about this group developing the quantitative answers to those questions, but a checklist of whether the proposals have addressed that question?

MR. ROBEDEAU: Yes. If they have come up with an answer.

MR. KILMER: And then you're going to add your own thoughts on this.

MR. ROBEDEAU: Then we'll add our own thoughts. That's Randy-1, 2, and 3.

MR. LAUER: Wait. I think my point was if you look at, say, the PAPA option one, delivery model, that we need to be

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able to say, it appears that it's going to take X number of paramedics to do that.

MR. ROBEDEAU: I think you take PAPA option one delivery model, and it doesn't address delivery issues.

MR. LAUER: Right. It doesn't say how many responses are going to be formed, but how many responses are going to happen. We

need to look at how many units responding to each call.
MR. ROBEDEAU: We put that over in Randy-1, 2, and 3. You have to look at the plan and say, okay, the commissioners have been told they're going to have two plans to look at. They're going to have PAPA and EMS. And I think part of what our agreement to do at the beginning was to compare these plans.
And obviously the number of paramedics has been an issue in this system since '81 or '82. As soon as the rule passed for two paramedics on every rig, within a very short time it came out, there were too many paramedics in the system.
Number of paramedics: Does the PAPA



plan actually address of number of paramedics in the system? You look at PAPA plan one; no, it does not. It's completely silent on the issue, which means you could wind up with fewer paramedics, you could wind up with just as many paramedics, you could wind up with more paramedics.
MR. LAUER: It's silent.
MR. KILMER: Right. Whoever is going to rule on the PAPA proposal one, two, or three, or any of these, has to sit down and pencil this out. Any process that is going to be worth a damn has to have that component to it.
What we've got here, the MAB is going to come in, tinkle with a couple plans in two hours, and vote. What this discussion is demonstrating is that that process is not that simple. Any process that purports to be that simple is ridiculous. And it's a sad commentary on eight years that we've gotten to this point and nobody knows the proper starting point.
MR. LAUER: I guess what I'm suggesting is it may be incumbent on this



group to do that now.
MR. KILMER: We should do it, but we should have enough time to do it. That's why whether there's consensus or not, Mr. Chairman, I suggest you authorize the sending of the letter requesting additional time.
MR. DRAKE: I agree with Jeff. We're going to need more time.
I agree with you, Pete.
I agree with you, Randy.
This is a two-step process. Step one is, do this analysis. I agree. That should be done. Step two is do what Randy says and try to go through and plug in those numbers.
MR. ROBEDEAU: I don't disagree with that. I don't disagree with that at all. That's what I'm saying. I think it's really important for us to take each step, to take the issue -- number of paramedics, was it addressed? In order for it to be a viable plan that's going to fix these things, it must address those things.
If it doesn't address them, how can



you consider it a plan? That's my point. Or if it does address them and it addresses them absolutely incorrectly, how can it be a plan?
MR. DRAKE: I agree.
MR. SKEEN: Just for comparisons, you say the PAPA plan doesn't address number of paramedics.
MR. ROBEDEAU: I can't find where it does.
MR. SKEEN: Okay. Is your sense that the option one of the EMS plan addresses the number of paramedics?
MR. ROBEDEAU: Not really, because I'm not convinced.
MR. SKEEN: I didn't think it did either, but I wanted to make sure we're on the same wavelength.
MR. KILMER: It tries to do a better job than the PAPA plan, but it doesn't do a very good job.
MR. ROBEDEAU: I think it tries to address the issue. It addresses the issue of private paramedics. But I find, unless I missed something in there, it's silent on



the number of fire rescue transporting units there will be.
MR. COLLINS: When you're looking at both these plans, I think if you use this as an example -- because I think your idea of going through and setting these up side by side and seeing where the holes are that need to be filled in makes a lot of sense -- but you need to comment on, for instance, the number of paramedics. I don't think any of the plans have a number like 123.
But if you read the PAPA plan and you look at what they're proposing in option one, that's going to give you the framework for how many paramedics are there going to be in the system, because they say where they're going to be.
MR. SKEEN: To make some assumptions for analysis.
MR. COLLINS: Right. I think just because there isn't a number, it doesn't get crossed off. In any of the plans, you say how much was done. Then you need to think -- in order to reevaluate these, you



need to run the number out, say that. A lot of these have things like that.
It's not the way the plans are dictated. They're not going to be exactly the same way as we think about a lot of stuff.
MR. ROBEDEAU: Part of the discussion, is going back and picking it up. I think it was the meeting before last where I sat and did a quick analysis on the number of paramedics, and the PAPA plan actually increased the number if we took that kind of evaluation and applied those numbers. And I'll grant you, it was very quick, very unscientific.
MR. COLLINS: Maybe that is as far as you go with describing what is in the plan. The PAPA option definitely identifies a type of ambulance and what the staffing is going to be and the types of runs they're going to take.
So if you did the demand analysis and got the number of runs that fit into that category, you can infer, then, how many paramedics that that's going to actually



take to staff.
MR. KILMER: What assumptions go into that inference?
MR. ROBEDEAU: Because you're going to have to assume unit-hour-utilization figures on that, and I don't see anywhere -- you can have 16,000 paramedics requiring no more than one call a year. That's a little absurd. But unless the plan --
MR. COLLINS: If there's holes in the assumptions, then that should be what this group identifies: What are the holes that are there that do not allow for whatever analysis you need to take place?
DR. OXMAN: I think you can make some qualitative statements about what the group feels the effect would be. I think if you look at, just as an example, a dedicated single-provider emergency-only system and compare that with a combined nonemergency system that requires two paramedics per car, I think you can say something about the number of paramedics required in each of those systems relative to each other.

I think it's tough to put numbers on it without a whole lot more analysis, but I think you can say one will likely have a whole lot more than the other.

MR. DRAKE: Right. We can do that. But I think it's important to note that if some of the plans have not done that, then they may be making assumptions or there is another group obviously the Medical Advisory Board is going to pass off.

They have already approved the PAPA model. I assume they're going to approve, I assume, one of the options under the PAPA model. They have not done these analyses, these costs, these numbers.

One of the things we could add under "medical issues" is staffing levels.

MR. ROBEDEAU: The PAPA model, I think one of the things is -- under either one of the models, if you take both the current model -- in their purest form, both models call for the elimination of at least two of the current ambulance providers. Two of them are gone, out of business. That's a big step.



And to come out and call for that, saying, "Gee, trust me," I think that's an awful reach, an awful long reach to say it's going to be better because I say so. In the meantime, put two businesses out of business and let's see what happens.

MR. KILMER: Especially with this amount of superficiality.

MR. ROBEDEAU: And maybe put all three businesses out of business and bring somebody else in. That's an awful long reach for something that doesn't say anything.

MR. SKEEN: Are you saying the economy will be turned around in a hundred days?

MR. KILMER: Cut taxes, increase defense spending, and we'll all get rich.

MR. ROBEDEAU: We have the impression.

MR. THOMAS: As I understand the approach being raised by this, and that we're talking about, No. 1, against these different sort of issue areas, look at each of the proposals that are out there, and I suppose any other proposal that somebody



wants to have out there, if there is one.

MR. LAUER: I don't have one.

MR. COLLINS: Come on, Randy. We know you have a plan. We've heard it talked about.

(Laughter.)

MR. THOMAS: But identify where the gaps are in the proposal, where they don't address, and I suppose in the broadest possible context, maybe inferences that this group might draw from them about what the impact of that particular proposal will be: This will increase the paramedics in the system; this will decrease, whatever. That's one step. Maybe the first step is to do that.

I think the second step, then, is to decide whether you can and whether, if you can, you are going to spend the time trying to fill the gaps yourselves based on whatever analysis you can do or whatever assumptions you want to build into filling the gaps.

And I think part of the question I heard somebody mention earlier was, the



first step is the easier step: identifying the gaps. Filling in the gaps is the more difficult one.

And there's some question, maybe a substantial question, whether it is reasonable, within two weeks from today, to fill in the gaps. But it seems to me you want to get rolling, at least starting down the road on that approach. It seems everybody is in agreement with the basic concept.

MR. ROBEDEAU: We agreed to have a draft, first draft, out by a week from today.

MR. KILMER: I don't know if we're going to be able to do that.

MR. ROBEDEAU: I'm coming up with real fears myself we're not.

MR. KILMER: It's turned out to be even more complex than we had assumed going in.

The thing I'd like to suggest now is we have spent now 25 or 30 minutes, quote, getting back on track, which has ended up talking about how are we going to write a



report. We haven't done one thing about cost and rates and the interrelationship of those two things, nor what really ought to be factored into costs, the things I was talking about before that you were all chuckling about.

Mark and I had sat down beforehand and talked about what had been the agenda here, and I thought I was reading off that agenda and the reason why it was important. I really suggest it is important, particularly with Dr. Oxman here, to talk about the impact of the cost transfers on other costs in the system and whether it is appropriate in the methodology that's been adopted by Mr. Collins to ignore the impact on the nonemergency care, just for instance, and to talk about what's it going to cost to add features to this plan.

MR. ROBEDEAU: Both plans have ignored the cost to nonemergency care. In fact, I think both plans have actually encouraged nonemergency care to go up, which, by the fact that neither plan is willing to do anything about nonemergency care providers,



is automatically going to drive up the cost of emergency care because once the cost of nonemergency care gets to the point where the emergency providers cannot compete in that market, they'll be out of that market, we will definitely have a dedicated system, and dedicated systems all over the country have proven to be more expensive than nondedicated systems.

MR. KILMER: The other point is, do you really achieve a cost savings when you artificially say and arbitrarily say we won't allow dispatch cost to be spread over all the systems? Because BOEC is going to take over that without allocating the BOEC function now done by the private dispatchers. And without recognizing that the private dispatcher, private companies are still going to need dispatch to do the private side of their calls and what it does to the private rates when all of those costs now have to be recovered from that smaller rate structure.

Many of the same people that are the beneficiaries of the emergency system are



also beneficiaries of the nonemergency system. The higher those costs go, the more those calls, just like the emergency room system. The more people can't afford it, the more they are going to be calling 9-1-1 to get what is really nonemergency care. And you are going to warp this system.

Mr. Collins totally ignored the implications of that. And any cost savings he identified from these cost shifts are going to be blown up astronomically in other places. That has to be evaluated in some detail.

MR. DRAKE: I think what we're trying to do here, we've all agreed in the past we do want to look in the EMS system at a

total system. Therefore, we need to look at the total system cost involved in this.
There is an impact on emergency rates, depending upon what you do with the nonemergency providers in the system. Other systems, counties in this state have done something about the nonemergency providers. They've taken that step. I



think we need to know what those steps are and to look at those areas because that is going to happen.
MR. ROBEDEAU: Why don't we take about a five-minute break.
MR. KILMER: Let me make this one other comment, because there is a flip side to the BOEC issue. That is this: To the greater extent, the BOEC has increased costs because it's going to take over what has traditionally been recovered in rates. The tax cost of that is going up. So what you've done is transfer what is now recovered in rates to a tax subsidy.
The implications of that ought to be studied and specifically set out on the table, because one of the going-in processes that was made is, we are not going to have a tax-subsidized system. To have hidden tax subsidies is not honest.
That's all been ignored. That ought to all be looked at. It's not going to be looked at by the MAB. It's never been looked at in eight years. It was never looked at in Mr. Collins's interrupted



group meetings, no notes from any of those meetings that we've been able to find. We are all flying real blind on issues that any honest process should have evaluated before any conclusions were drawn.
MR. DRAKE: We're going to take a five-minute break?
MR. ROBEDEAU: Yes.
(Recess.)
(Mr. Kilmer, Ms. Schidleman, and Mr. Steinman left the room.)
MR. ROBEDEAU: What I want to do is get consensus on either what I passed out here as the Provider Board evaluation questions or not to do it.
MR. DRAKE: Pete, I think we should do it. No question.
MR. ROBEDEAU: Randy, seeing as you -- Randy or Trace, the only other Provider Board member here -- the question is, should we or should we not do an evaluation as I outlined?
Mark says yes. I think we should. What do you guys want to do?
MR. SKEEN: It probably ought to be



done. My sense is that the second step of that, filling in the blanks that are accentuated by doing that analysis, is clearly the most important charge.
MR. ROBEDEAU: We have to do this first to show what needs to be done.
MR. DRAKE: I agree, Pete. So you're going to do that?
MR. ROBEDEAU: It's pretty obvious we're not going to get this done today. I had hoped to get it done today.
MR. DRAKE: We can't.
MR. SKEEN: In paramedic turnover, I don't know what you're addressing in there. You're saying, do the plans address paramedic turnover?
MR. ROBEDEAU: The problem, Trace, nobody's sure what we're measuring. The next time you listen to somebody, it's ten percent versus the next time 70 percent.
All I did here was, the things we discussed and everything I can remember being articulated over the last few years, what's wrong with this system, I sat down and wrote it down. If a plan is going to



fix the system, to my way of thinking, it must address all these things that have been articulated what's wrong with the system.
MR. SKEEN: It's a prospective view and not reflective view of turnover.
MR. ROBEDEAU: Right.
MR. SKEEN: Does the plan eliminate it?
MR. ROBEDEAU: Does it address it? I'm more liberal than, "Does it eliminate it?"
Did it even mention it? Neither plan -- Collins' addresses paramedic turnover -- Collins-1 addresses turnover, saying the fire department has less paramedic turnover, but it doesn't say what "less" is. It makes assumptions.
MR. SKEEN: Exactly. It doesn't say what "less" is. It also is addressing paramedic turnover in a certain venue, and that venue will change, and if you look at comparative systems -- Dallas, Houston, San Antonio, any number of systems -- say, now that they're in this other venue which



includes the day-in/day-out transport, what happens to the --
MR. ROBEDEAU: I understand. The other half of that, Tracy -- or Trace -- sorry -- the other half of that is, is it a valid assumption to say because a paramedic goes from a rescue or an ambulance in the public sector to a fire truck, that that's not turnover.
My belief on that is, no, that's not a valid assumption because that person is no longer doing the job because what we have is --
MR. SKEEN: Dr. Jui is on the record in opposition to that.
MR. ROBEDEAU: I understand that.
MR. SKEEN: Because he said that paramedic is still available. It goes back to the whole issue he's talking about anyway, are the paramedics experienced.
MR. THOMAS: Guys. Stop. Stop. Stop. Stop. Part of the problem you have is everybody jumps ahead to the discussion you're anticipating you're going to have before you've agreed to have it.



MR. ROBEDEAU: You're right.
MR. THOMAS: If we're going to do this, you're going to do this. Trace is saying the second step is to look at the gaps and figure out, what would you have to do to fill them in, and then you can decide what that is and whether you want to do it. I think the question is, is that the road you want to start down?
MR. MOSKOWITZ: Actually, I think there's even -- that's a third step. I think a second step might be some kind of analytical comments by the board on how each of these plans talks about turnover. For example, you might have a comment saying, when the Collins plan refers to turnover, it uses these definitions as turnover, and we're not sure that those are valid. So you might have some comment on the form of analysis, then go on to trying to plug in to it.
MR. DRAKE: Pete, I assume by what you're saying that you want us to do for the next meeting by looking at this, since we are going to be into the next meeting,



is to come back at the next meeting with our figures from each of our respective companies.
MR. ROBEDEAU: We don't need figures at all.
MR. DRAKE: You need to know the number of paramedics in the system currently.

MR. ROBEDEAU: We need to – I think what we need to do on that is agree what we're dealing with, and I think what we're dealing with are FTEs of street paramedics.

MR. DRAKE: Right. But the other part of that is people. If we're going to do that, I think that's an important step, is to know what the current system, because we've got to be able to measure against the current system. We've got to go through these one by one and make the definitions so we're all clear this is what the definition is.

We just talked about that, paramedic turnover. What are we defining as paramedic turnover? Are we talking about a



paramedic that goes from a paramedic to an administrative position, that's turnover, because they're no longer working in the street full time? Are we talking about paramedics that leave the organization totally?

MR. LAUER: Why don't we talk about it when we get to it.

MR. DRAKE: We already talked about that.

MR. LAUER: I know. But I think Pete's point is, look at this whole thing as a road map essentially. Is this a good map?

MR. DRAKE: We discussed that.

MR. ROBEDEAU: I've added things to it. Under No. 3, dispatch system in each plan, I've put cost of dispatch, and added a No. 5, is billing office.

MR. LAUER: In which one?

MR. ROBEDEAU: Provider Board evaluation questions, under No. 3 I added cost of dispatch, and I added a No. 5, billing office.

I don't know what other providers'



methodology is, but I know our dispatch office is also our first – our entry for billing. All of our status and all of our billing entry and everything comes out of dispatch. So the fact you eliminate AA's dispatch office does not mean that that cost goes away; it just means that cost goes into a different department.

MR. THOMAS: So that's a topic to discuss.

MR. LAUER: Backing up to No. 1, D-1, number of critical patients seen by paramedics, to use that as the measurement of skill degradation, I don't know we'll be able to do that.

MR. ROBEDEAU: Pardon me?

MR. LAUER: I'm not sure we'll be able to do that because I'm not sure we have a number, how many critical patients in the system.

MR. THOMAS: That might show up as a blank.

MR. ROBEDEAU: That's one of the problems. When I did this, Randy – I'll go back to this – I sat down and said,



okay, what are all the problems that have been articulated? Skill degradation is one of the problems that have been articulated as a problem in this system.

I'll grant you, in getting into Chris's deal a little bit, a little bit of discussion, there's no proof, there's no numbers, there's no nothing. But if one of these plans is going to solve that problem, then how? Or did the plan even address the problem? That's what we're looking at.

MR. LAUER: I guess in the discussion I always thought of that as a component of the number of paramedics.

MR. DRAKE: Right. Let's back up, though. We're getting ahead of ourselves.

MR. LAUER: I'm on No. 1.

MR. DRAKE: So was I. I was on 1-B. You said we're not there yet. Now we're down to 1-D.

We're all in agreement we're going to establish current numbers with these slots. We're in agreement with that.

MR. THOMAS: If we can.

MR. DRAKE: If we can.



MR. COLLINS: Is that for 1-A?

MR. DRAKE: No. We go through each one of these and determine how we're going to determine that and bring it back to the next meeting and –

MR. ROBEDEAU: Get it out before that. We're so far behind now, we should be at this meeting or next meeting really talking about reviewing the first draft if we're going to get this stuff in.

MR. DRAKE: Pete, when do you want this information? We'll send it in to you, and you'll put it in a format?

MR. ROBEDEAU: I'll try to do it Monday. You guys get it faxed to me by Monday?

MR. DRAKE: By Monday.

MR. ROBEDEAU: Or Bill can do it.

MR. COLLINS: Bill won't do it. Bill's done 1-A. I'm not going to do that again. If you're going to do that, then you need to tell me the information in 1-A you provided to me is not correct.

MR. DRAKE: It may be the same.

MR. COLLINS: But I'm not going to do



it. I'll help where I can, but I'm not going to replicate stuff.

MR. DRAKE: That's fine.

MR. LAUER: I want to clarify. The comparisons we're making to evaluate one of the delivery models, comparing it to the existing system?

MR. DRAKE: We're doing a couple different things here. Let's just keep going through this. Okay? Because that's the second step we're going to go through.

So we've got number of FTE paramedics in the system. Right?

MR. ROBEDEAU: Are we doing FTE or actual paramedics?

MR. DRAKE: FTEs. You may have 26 scheduled positions and only 24 paramedics currently.

MR. ROBEDEAU: All right.

MR. DRAKE: All right? Okay.

Paramedic turnover. How do we want to measure paramedic turnover?

MR. ROBEDEAU: The only question on that is, do you count people that come in and wash out in the first 60, 90 days? I



don't count that as paramedic turnover, and we have that happen.

MR. LAUER: We count it as a turnover because it gets back to your hiring process.

MR. DRAKE: We do.

MR. LAUER: We count everything other than promotions, death, or retirement, I think.

MR. THOMAS: It seems to me that both concepts have some merit to them, and what you really want to identify, if you could, would be which are the ones that actually become established paramedics in the system and how they're turning over. That tells you one piece of information. The other one is, who are the ones who are coming for 60, 90 days? Because they're the ones who actually never arrive.

It seems to me for informational purposes, for evaluating the impact of paramedic turnover, it is correct to discount to some extent the ones who come and leave quite rapidly. Give somebody a little better sense of what's going on, if

you can do that.
MR. DRAKE: We're going to do over 90 days and under 90 days? Is that agreed?
MR. SKEEN: Using 90 days as a probationary period?
MR. DRAKE: That's what Pete said. I'm throwing the number out there. Doesn't matter what the number is. Make it 120, 60.
DR. OXMAN: Can I ask a question? It seems to me with each of these elements -- this is a good one to talk about -- you're trying to develop a piece of information to pass on to the MAB and ultimately to the county board for them to use in making a decision. And to me the question is, what does paramedic turnover mean?
I think there's a bunch of assumptions imbedded in there. When I look at it, I would say, gee, what we really want is a relatively stable work force that has enough experience in our system to have good skills in terms of knowing where to drive and knowing what the protocols are, so we don't want a lot of new people coming



into the system all the time, we don't want a high rate of exit from the system because we want to have this basic mass. But on the other hand, we probably do want some turnover to promote some level of intellectual diversity and the positives that turnover brings.
So it seems like your measure needs to be confined in terms of what sort of policy goal you as a group are trying to promote.
MR. ROBEDEAU: We're not under a policy goal at the moment. What we're doing, I get back to it again, what I took was all of the problems that I recalled being articulated and said, okay, if this is a problem and these plans are going to fix it, did they even address it. Mark wants to get to at least a zero mark --
MR. DRAKE: Base line.
MR. ROBEDEAU: -- base line so you can tell what kind of base line it's addressed, if it's addressed.
My question on these plans, reading the plans -- I'm not going to get into that. Look at it and say, did this plan --



did EMS-1, 2, and 3, and did PAPA-1, 2, and 3 address this issue?
The problem is, Gary, I think as we look at it -- gee, I really hope you can come next Tuesday, you'll find out -- no, they're not addressed. It may make a statement about it; it'll be an offhand statement. That doesn't say this, it doesn't say it's going to fix it; it just makes an assumption because there's a line through it that says, gee, there's high paramedic turnover, and all of a sudden this is going to fix it. That's not what it says.
And what is the probability that plan one through six or one through nine -- if you want to put Randy-1, 2, and 3 in there -- is going to adequately address the issues that have been being raised over the all the years. And I think that's the only fair, objective way you can evaluate the plan and make a recommendation.
DR. OXMAN: Do you need a numeric standard, though?
MR. ROBEDEAU: That's what we're



trying to come up with right now.
MR. DRAKE: And I think part of our problem, Gary, is I dispute some of the figures in the EMS proposal that is presented, and I also dispute some of the ways they're presented. So I'm trying to get to a base line, come to agreement between all three providers, fourth provider here as well, this is how we're going to measure turnover. Everybody measures turnover the same, and we'll come back with the figures.
MR. THOMAS: And everybody knows how they measured it.
MR. DRAKE: Right.
MR. THOMAS: I don't know what the probationary period is. I think that would be useful to have a cutoff there.
MR. ROBEDEAU: I don't care as long as we're all doing it the same way.
MR. THOMAS: 90 days is the standard?
MR. LAUER: Chris, I guess we don't use it. Even if that's a probationary period, that's a paramedic that's working in the system and delivering patient care.



And if they leave, that is a turnover from that kind of person doing that.
MR. THOMAS: What I'm saying, though, if you punch the totals, you could create a deceptive situation. You could have 90 percent of your paramedics stable and extremely high rate of paramedics coming in, and it would look like you have a lot of people turning over if you give a gross statistic, when in fact you have a very few number of spots turning over. There is a high rate of turnover in those spots. And I think you want to give people a number, a feel how those numbers are turning over.
MR. ROBEDEAU: That's a good point. Rather than doing bodies, positions, turnover of positions.
MR. DRAKE: I think what he's saying is how we measure bodies. If we can agree over 90 and less than 90 days, we can get there.
MR. THOMAS: The best you can.
MR. DRAKE: You can.
MR. ROBEDEAU: I think the other thing, if you have one open position and



every 90 days you turn somebody over in that position because you haven't picked somebody good, all of a sudden for that one car you have an 80 percent turnover.
MR. THOMAS: That's true, Pete. What it will tell you is you may have a high rate of turnover grossly because in your intake system you're not doing that good of job, or it could be because it goes throughout the system and you're just turning people everywhere. Partly helps you defining what the problem is.
DR. OXMAN: The way to display it is if you show periods of longevity and a percentage of work force that fails in that period. So, for example, if you show a zero to one year period and one to two, two to three, and you show the percentage of work force that's in those experience periods, looking at that shape gives you a good feeling about who's been around and how long.
MR. ROBEDEAU: One of the problems -- maybe I'm missing this whole thing. We have 28 FTEs. 26 have been filled for some



time. But in Bill's plan, showing turnover, he shows us with 56 paramedics. I don't have 56 paramedics. It's either something -- there's something wrong in there.
MR. THOMAS: Pete, you've got to come to a definition of what you're going to -- you've got to break yourselves away from critiquing other plans and all that stuff and figure out what the definitions are. That's sort of an abstraction.
MR. DRAKE: That's what we've got to do. And the other definition, under paramedic turnover, we're talking about the people that leave the organization. That should be the definition, not the people that step up into an administrative

position, because they're still in the organization. All we're talking about is people that leave the organizations for the purpose of this definition. Is that agreeable?

MR. SKEEN: You can do that. If you do that, then just on a comparative basis you're going to have to concede to the fire

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service that when people move out of an active unit out to Sauvie Island that it's not turnover either.

MR. DRAKE: Right. Let's not get into that argument now.

MR. SKEEN: Talking about remaining in the organization?

MR. DRAKE: Right. We're talking about turnover is the people that leave the organization.

MR. ROBEDEAU: I don't think you can. We're talking about street paramedics. We're not talking about managers or anything else. We're talking about street paramedics.

MR. DRAKE: I know.

MR. ROBEDEAU: We're talking about people out actually running the call. And once people within the street organization go into a supervisory role, you do very little of running calls.

MR. THOMAS: There is a contrary argument to that, which is one of the people have advanced for the claim -- at least remember Dr. Jui even mentioned this,

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then there's a high level of turnover, and one of the reasons they assign for it is there's no opportunity for advancement or not much opportunity. So there's some reason -- I think as long as you explain what you've done -- I guess you could go either way, as long as everybody understands which way you've gone.

MR. DRAKE: The problem is, in our organization, Pete, if you talk about someone who moves into an administrative role, we take them out of scheduled FTE slots, but they still fill in those FTE slots.

MR. ROBEDEAU: I understand.

MR. THOMAS: They're not lost to the system.

MR. DRAKE: To get rid of the gray stuff, so it's clean, it's simple to say, this person is with our organization, they're no longer with our organization.

MR. ROBEDEAU: Field sups, training officers, and that stuff, are required to work a certain number of shifts.

MR. COLLINS: Part of it is like Gary

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said, what you want to show. If training is an issue, then you need to know that these people are still certified paramedics because, regardless of what their job is, you're going to have to include them in the training process.

If that's not what you're looking at, if you're looking at stability of street paramedics, then you want to look at the longevity of the people that are in those positions. In fact, you want to look, then, specifically at who got moved up because you want them out of there now because they're not part of it. And so it's --

MR. THOMAS: What you might want to do is do what Pete was saying and say, however, a number of these are people who went up in the organizations.

MR. ROBEDEAU: The reason for paramedic turnover, every time I've heard it articulated is a problem, is, No. 1, because you have green people working on these patients, and the other reason it's used as an example of the instability of

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the system, the system is not stable and God only knows, you know, it's going to collapse any minute. That's the inference that's drawn when they talk about paramedic turnover.

So I think we need to show what the paramedic turnover really is, and maybe we should show the number of paramedics that are promoted into management positions, would be a very good idea, because that was one of the things that was brought up here earlier, was that the paramedics feel they have no career ladder.

And I strongly disagree with the fact paramedics have no career ladder. But it gets down to the point of people who -- it depends on what they want to have. Somebody who wants to work there 40 hours a week, period, and that's all they ever do probably doesn't have much of a future in anything as far as a career ladder goes.

MR. THOMAS: Why don't you do that as a separate number.

MR. DRAKE: Let's do both. Paramedics that move up in the organization, and the

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number of paramedics that leave the organization.

DR. OXMAN: To address the stability -- people are talking it's instable and there's a million green paramedics -- how I would evaluate it is I would look at the current street paramedic staff and I would question, either through verbally or through administrative-record review, how long have you worked in the Multnomah County system, in my company or any other company?

Because, from a physician's perspective, what I want to know is how experienced is this clinician, this paramedic clinician?

MR. LAUER: That doesn't answer the question, Gary, because what if they worked in a different system doing the same job?

DR. OXMAN: That's a different issue.

MR. DRAKE: I see what you're saying. How long have they worked in Multnomah County?

DR. OXMAN: Right. If you're talking about turnover.

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You're right, Randy, you can float in with a crew of special paramedics, and in three to six months they'll know the streets and protocols, and in six months you'll have a crew of special paramedics. It's probably an artificial way to look at it.

You can look at surrogates of that: How long have you been a paramedic, and how long have you worked in the system? But if you're trying to get that image and if it's a quality-of-care problem, you want people who are experienced in their career, and you want them experienced in the specific system. Those are two different measures.

But who leaves and the rate of leaving, that may be relatively less important. One is also a mirror image of the other. If 90 percent of the people are here for six years, by any count, only ten percent have left.

MR. DRAKE: I think that's a good point. We can add a No. 5, the average tenure of each company. We'll do it for our company today and average for all

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paramedics in the system.

MR. THOMAS: In the system. Are you guys able to do that?

MR. LAUER: In Multnomah County?

MR. DRAKE: Yes. How long have they worked for you in Multnomah County?

MR. ROBEDEAU: You're saying how long at Multnomah County. We hired all of

Buck's people last year.
DR. OXMAN: The legitimate criticism of our study was we did not look at what was between company and we acknowledged that in our report.
MR. LAUER: We can't focus on Multnomah County. We have people that operate in Clackamas County. Identical protocols. They operate through Multnomah County. Most of the hospitals are in Multnomah County. That needs to not be thought of as New York City.
MR. ROBEDEAU: But what we're talking about is Multnomah County, that's all. You have to separate it out and do the best you can with Multnomah County.
MR. DRAKE: It's a simple thing to



do. As of April 1st --
MR. LAUER: You'll get an artificial picture of what you're looking for.
DR. OXMAN: I think Randy is right. You don't get a street knowledge of Multnomah County as Clackamas County, but you get the clinic -- I guess in your system you get the same supervision.
MR. LAUER: Everything's the same except the streets.
MR. DRAKE: We've got to come up with a number and pick a date, because as of April 1, take all of your employees in Multnomah County, what is their average tenure. You can do it for your company and how long for Multnomah County. That's a question we have to ask the employees, one by one.
MR. LAUER: I think it's a distorted view of what you're looking for.
MR. THOMAS: What would be an undistorted view?
MR. LAUER: I would say within your company, not confine it to Multnomah County. I know we're talking about



Multnomah County EMS system here.
MR. THOMAS: I think as long as you articulate what it is that you're measuring, I think for our purposes that's okay. I think if everybody --
DR. OXMAN: If you're talking about the tri-county area, you'll have a similar thing. I would also ask the question about Multnomah County specifically, just because there's that street-knowledge issue. And that becomes --
MR. THOMAS: Or they could acknowledge, if we haven't broken it down by Multnomah County, because of the way some of the companies are organized, therefore it does not take this factor into consideration. Everybody knows what you're talking about.
MR. LAUER: It's an exercise that would be very time consuming, among other things. Are you talking about this time? What if they've been in Multnomah County now for six months but they've previously been in Multnomah County five different times for a cumulative of five years? Do



you have to go back and reconstruct that?
MR. THOMAS: I think Pete is correct. This has been an area of extremely high criticism, and it's talked about all the time, and the truth is that -- even the discussion here reveals the level of discussion about this has been extremely unsophisticated and hasn't really taken into account the kinds of issues you've been raising, about what really is experience in the system. And until a task like this is gone through and is done, nobody really knows what they're talking about.
The assumption is that this system is bad because of high paramedic turnover. It seems to me, you know, if it's something people are going to keep talking about, it really needs to be done at some point. I'm not the one who's sitting there thinking, how am I going to do it.
MR. LAUER: I can't do it. I just can't.
MR. DRAKE: You can, but it takes a long time.



MR. ROBEDEAU: One of the things, if you go back and look at it, one of the criticisms in this system has been there's high paramedic turnover and they go from Buck to AA. Buck fires them because they're bad medically, and AA hires them and then fires them because they're bad medically, and CARE hires them and then fires them. That's been the assumption in this turnover: Everybody was passing the bad paramedics around.
Then we came up with a system that we didn't hire anybody until the physician supervisors talked to each other to make sure that problem was taken care of, and that articulates that the problem has gone away, and now it's just high paramedic turnover.
That's where we have to stop and take a look at it and try -- I don't think you're talking about a lot. Buck has 48.
MR. SKEEN: 52.
MR. ROBEDEAU: We discussed that --
MR. LAUER: 46.
MR. ROBEDEAU: 46 Multnomah County. I



assigned 48. You said 52. We'll assign 46.
You have 46 people in Multnomah County. Somebody in your organization knows this person or this person, this gal or guy. One of your field people really knows all of your people, I would assume, that can sit down and say, okay, Randy's been here and been here, and his personnel record will real quickly say he graduated from paramedic school in 1981 and he has been doing this ever since. So I think that should be fairly easy to come up with.
MR. THOMAS: If you can't do it, come back and say you can't do it.
MR. LAUER: I think what you're going to come up with, you're going to get a number that's going to look like turnover is more than it really is.
What's the bad thing about turnover? The bad thing is inexperienced people or people who have been deemed medically incompetent in some process are taking care of patients. That's what would be bad



about turnover. But if we come up with using this formula, I think we're going to have a number that's inflated and doesn't really get to that. And that's why I guess I don't like that idea.
MR. ROBEDEAU: Again, I'll go back to what I did here, in order to try to make a fair evaluation, something we can take to the County Commissioners, say, this is what you're looking at, is to evaluate the plans, and along with what we had discussed earlier is we wanted to fill in holes in the plans and come up with or our own recommendations on that. I don't want to see us wind up doing what I see has happened in the past and is just coming off the wall with nothing.
What are the problems? That's the first thing we have to address, is what is the problem? Is it accurate or inaccurate, is really irrelevant, is what has been articulated.
Paramedic turnover has been articulated in this system for the last three or four or five years, whatever it

is, as a problem. We need to address the problem. Then we need to stop, keep this thing in focus on what we're looking at.

We take a look at EMS-1, 2, and 3, and did it address the problem? Yes or no. And if yes, how? If no, no.

We take PAPA-1, 2, and 3. Did it address the problem? Yes or no. You take Randy-1, 2, or 3. What is the problem? How are we going to address the problem?

These I think are the things that we have to address, that have never really been articulated and addressed.

MR. LAUER: I agree with that. I guess it's just the methodology. Because it's similar to an EMS system plan, there are statements in there that there's an exception taken to that there's going to be X amount of cost production, and the argument is, people are going to look at that number and focus on it.

It's the same thing with turnover. Say our turnover is 20 percent. People are going to focus in on that number and intuitively view the 20 percent as bad



without really knowing what that figure reflects.

MR. ROBEDEAU: It doesn't make any difference. We may know a 90 percent turnover rate. The question is, okay, we have a 90 percent turnover rate. Did EMS-1, 2, and 3 address that problem? Yes or no? Did PAPA-1, 2, and 3 address the problem? And did Randy-1, 2, and 3 address the problem?

We have to keep it focused on what that is. This may actually be a problem. We may have a 90 percent turnover rate.

MR. LAUER: Why say turnover of 90 percent? Why don't you say there's a perception of a high turnover rate.

MR. DRAKE: We need a base line. What is the current system giving us today?

MR. MOSKOWITZ: You end up with a geographic definition for looking at turnover.

MR. DRAKE: We've looked at --

MR. ROBEDEAU: I'd like to see us -- throw one thing in here. Take the calendar year of 1992.



MR. DRAKE: 1992.

MR. ROBEDEAU: Is that okay?

MR. SKEEN: Yes.

MR. DRAKE: 1992. Define a time. What we've defined so far is paramedic turnover greater than 90 days, less than 90 days, paramedics that leave the organization, and paramedics that move up in the organization. Those are the four things we talked about.

MR. ROBEDEAU: The other thing Dr. Oxman wanted is, how long have they been in the system? Do we know they've come from Buck or CARE or fire?

MR. DRAKE: Two things: one is average tenure with the company, we can get easily; and the second thing from Dr. Oxman, how long have they been in the Multnomah County system. To get that figure we have to go back and poll all the employees that are currently working with us.

MR. ROBEDEAU: You should have it right there in your personnel files. Flip open your personnel files, on the back it



says, previous job history and says Buck and CARE. Three months in each one, three months in ours, got nine months in the system. Not bad.

MR. LAUER: But if they worked in Clackamas County for six months.

MR. DRAKE: We can't do that with Buck because they may have been in Clackamas County or somewhere else.

MR. ROBEDEAU: Let's give it a try.

MR. THOMAS: My feeling is, if they're in Clackamas or Washington County and you want to count that time, you count it. You footnote it and say, this is how we did it. I think that's good enough for the purposes here, and I think you've got legitimate points on that, and not knowing the streets is probably not the most significant issue. The more significant issue is, are they used to the protocols and the way the system works.

MR. DRAKE: Actually, it is, do they know the streets. That is a significant issue, response time.

MR. THOMAS: Okay. Note that.



Somebody will note that.

MR. SKEEN: Response time is measured by another criteria.

MR. DRAKE: I know.

MR. SKEEN: Is there any objection, Gary, to you or Bill on measuring the way Chris talked about?

DR. OXMAN: Two comments. One, no; and, two, I don't think I have any business objecting. I'm here just as an observer and to throw my two cents into the group. It's the group's process.

MS. BONNER: If you decide to use 1992 and you're asking people that work there now, does that skew it some?

MR. DRAKE: The turnover is for paramedics that left the organization and moved up in the organization in 1992. The average turnover of employees is current employees, go back to employees --

MR. ROBEDEAU: Let's confine the whole thing to 1992. You can't do an average tenure --

MR. DRAKE: You're doing average tenure of current employees.



MR. THOMAS: As long as you state what you've done, then to the extent there's not a whole bunch of people, they'll know that and determine if that's relevant. For these two things it won't make much difference.

MR. LAUER: Average tenure needs further definition. Average tenure as paramedic or average tenure with the company?

MR. DRAKE: Average tenure with the company. Make that assumption. All the employees you had working there as of whatever, April 29th.

MS. BONNER: If you're looking at paramedic turnover --

DR. OXMAN: If you're talking about paramedic turnover --

MR. DRAKE: We're asking about tenure.

MR. THOMAS: They're only talking about paramedics, not people who are working as paramedics in the system.

MR. DRAKE: When you're looking at turnover, paramedics left the organization,



paramedics that left the organization, not EMT-I's. We're clear on that.

When you talk about average turnover, you go to a paramedic. "How long have you been with CARE Ambulance?" "Five years."

DR. OXMAN: As a paramedic.

MR. DRAKE: He may have been one year as an EMT and four years as a paramedic.

DR. OXMAN: If we're looking at the system that uses paramedics to deliver care, the way I would phrase the question is, how long have you been with CARE as an EMT, and how long have you been with other provide -- as a paramedic, rather, and how long have you been with other providers in Multnomah County or the tri-county area as a paramedic?

MR. DRAKE: Okay.
DR. OXMAN: That's just mine. You could do however you want.
MR. LAUER: You could do both. Average with the company or average tenure as a paramedic.
I don't know. We could probably make this much more confusing.



MR. DRAKE: Average tenure as paramedic is fine.
MR. THOMAS: It's important you define and articulate what you've done. You're not going to get every little nuance and cut of the way to organize the data. It's too much.
DR. OXMAN: What you're going to come out with -- Bill, your number was, what, 30 percent?
MR. COLLINS: On the average, we did over six years. Something like that.
DR. OXMAN: You're either going to come out with a number that says, you know, the turnover is ten percent or it's 70 percent, and that's kind of your answer.
MR. LAUER: We need to do average tenure with the company because the paramedic has been around since '75, and you could try to figure out whether they're a paramedic, and it would be impossible.
MR. THOMAS: What I would suggest is Mark go back to his office and write up what he thinks you've all agreed to and fax it to you guys.



MR. SKEEN: See if it looks familiar.
MR. THOMAS: I think it's helpful. You're talking it through, but I think there's six different pieces of the criteria he's talking about.
MR. DRAKE: I'll do that.
MR. ROBEDEAU: Actually, I agree with that, and I want to move on. I think we've been long on this one.
Going back and looking at this, I would like an agreement that this is what we're going to do next meeting. I don't care if we sit down next Tuesday. We can sit down and get it out to everybody, everybody can go through it.
Keep in mind what we're comparing is the six proposals on the table and see if they address the problems. That's all we're doing. If you have something you want to put in the remaining proposals, the three Randy proposals, we'll discuss them next Tuesday at the meeting.
But this is strictly, for next Tuesday, we're going to sit down and sit there and go through it without too much



comment on the first two, the EMS plan, the PAPA plan, EMS-1, 2, and 3, and PAPA-1, 2, and 3, did it address the issue raised. If it did address the issue, how did it address the issue, or if it did not address the issue, the answer is just no and we move on. Is that fair?
MR. DRAKE: M-hm.
MR. ROBEDEAU: So within the next hour of the next meeting we cover all six proposed plans, all five of these articulated items.
MR. DRAKE: Okay.
MR. ROBEDEAU: You didn't write down additions?
MR. SKEEN: I've written down some additions.
MR. ROBEDEAU: I put cost of dispatch, and I had it on billing add-ons No. 5, which was billing office.
MR. DRAKE: Where did you put number of peak units deployed? I had that under cost under No. 4.
MR. ROBEDEAU: I don't have that. Are we adding that? Where are we adding that?



MR. DRAKE: I added it as F to No. 4.
MR. SKEEN: Is what?
MR. DRAKE: Number of peak units deployed.
MR. THOMAS: I believe you also under -- that's okay. That's what your answer would be.
MR. ROBEDEAU: I don't understand the peak units deployed. What you're asking for is the system status plan?
MR. DRAKE: I'm saying how many units you deploy at peak, whether that's seven, 12, 14, and do the plans address them.
MR. THOMAS: I think there's one other thing you should have in there -- you may think it's implicit in the others -- is under skill degradation of paramedics, 1-D, you should have unit-hour utilization. You have number of critical patients seen by paramedics, but they may be more or less the same thing, but I think unit hour utilization is how people talked about it.
MR. SKEEN: You're talking about under the existing system?
MR. THOMAS: And under the six options



that have been proposed, do they address it somehow.
MR. LAUER: Do they set maximums or minimums?
MR. THOMAS: No. Do they do anything about it? Do they address the issue, No. 1? And if they address it, how do they address it?
MR. ROBEDEAU: Those are the only two questions, when you're going through this and looking at these, on the six proposals, is: One, do they address the issue? If the answer is no, you're done. You just move on. The other one is, if the answer is yes, how do they address the issue, and does that really address the issue?
If it's a sentence that says, unit-hour utilization is too low, that's no, to me, that's not addressing the issue. You can say, yes, they address it by saying that. That's up to you.
As we go through these different things at the next meeting, it's just -- these are all the things that we see that have been articulated as being seen as



wrong with this system and why does it need a change. And you come down to the fact if these are the things that are wrong with it, do the plans address what has been articulated as needing changing? Yes or no. And if yes, how?
Is that making any sense? You look confused.
MR. LAUER: No.
MR. THOMAS: Something you might say, Randy, for example, there's an assumption on unit-hour utilization. You may say, yes, it addresses it, it assumes this may result in a higher unit-hour utilization ratio, but it doesn't say why that might happen. That might be something that gets filled in.
MR. LAUER: I guess I'm one step before that. What we're starting is with the assumption these are the issues that are addressed.
MR. DRAKE: No.
MR. LAUER: These are the issues that are identified as problems.
MR. ROBEDEAU: No. These are the



issues that I've heard articulated over the last few years.
MR. LAUER: As being areas of concerned?
MR. ROBEDEAU: As being problems. That's what I said, are there more?
MR. LAUER: I don't know. I think what we've opened ourselves up to is debate

whether or not these are concerns ultimately. We're going to go through a comparison and say, wait a minute, that wasn't a problem. What about this?

MR. DRAKE: Randy, it's not whether it is a concern or isn't a concern; it's a concern that Pete has heard. So any concerns that you've heard or any concerns that I've heard, we'll all put them down and see how the plans address them.

MR. ROBEDEAU: Randy, do you see something here that is not a concern?

MR. LAUER: Like the dispatch system. Has that been really said that's a problem with the current system? Everything I've heard about that was that it's an external component to the system, it's going to be



done by BOEC, and it's always going to be done by BOEC.

MR. ROBEDEAU: Bill's plan says the dispatch system is a problem, but as far as costs are concerned, as far as the county is concerned, they have a dispatch system that does everything that a dispatch system needs to do, and that all of the private providers' dispatches, dispatch offices are redundant and a duplication of cost, which shouldn't be there. That's what's been articulated.

MR. LAUER: That's part of the cost, though. It's not a separate -- the dispatch system in itself is not something somebody said, this is something we have to fix.

MR. MOSKOWITZ: It was a cost issue.

MR. COLLINS: It's a cost.

MR. THOMAS: That's what that means on the list, is what he said. Regardless of where you put it, as long as you all know what that means on there, it's talking about a certain problem that those costs are being charged to ALS.



MR. DRAKE: There is a performance issue as well. It's been articulated in the past. Buck has articulated it in the past.

MR. LAUER: Everybody has. It's not something a system design, the ASA plan affects -- it affects it as being done through a tax levy and it's in the dispatch center.

MR. DRAKE: No. You in the past -- not you in the past, Buck in the past --

MR. LAUER: Trace.

MR. SKEEN: It hasn't been Trace. Way in the past -- Alek --

MR. SKEEN: Who's not here.

MR. DRAKE: -- who's not here, said the BOEC should not be dispatching, they should turn it over to a private system, because if you're going to hold us responsible for response times, we should have a say in how we deploy our systems.

It's been an issue. We should bring it up, talk about it.

MR. ROBEDEAU: That wasn't what I was talking about. We can add that to the list



if you wish.

MR. DRAKE: It's a subcomponent of the dispatch system in each plan.

MR. ROBEDEAU: Actually, we can put that under response times.

MR. DRAKE: Okay. Is that no longer a concern of Buck?

MR. LAUER: It's a concern. When you talk about it being a system concern, it's kind of gone away.

MR. DRAKE: I don't have anything else. Are we done?

MR. ROBEDEAU: Unless somebody has something else, I think we're done.

Meeting adjourned.

(PROCEEDINGS ADJOURNED)

* * *

(NOTE: Untranscribed steno notes archived permanently; transcribed paper notes archived 2 years; computerized English text files archived 3 years.)

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CERTIFICATE

I, ROBIN L. NODLAND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 6th day of May, 1993.

/s/ ROBIN L. NODLAND

Certificate No. 90-0056

COPY



BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Tuesday, May 4, 1993
9:20 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Barry Doherty, CARE Ambulance
Mr. David Phillips, Gresham Fire Department
Mr. Randy Lauer, Buck Ambulance

* * *



APPEARANCES

ALSO SPEAKING:

Mr. William Collins
Mr. Jeffrey Kilmer
Mr. Christopher Thomas
Mr. Steven Moskowitz
Ms. Lynn Bonner

* * *



PROCEEDINGS

MR. ROBEDEAU: Let's call the meeting to order, then. We're 20 minutes late.

Has everybody read the minutes? Any corrections, additions, deletions?

MR. DRAKE: I have a couple things, Pete. First, as we stated before, although we're making additions, deletions to the minutes now, I would like to hold the passing of the minutes open so the fire bureau has a chance to respond to the minutes.

MR. ROBEDEAU: That's fine.

MR. DRAKE: At page 4, at the top, where it states, I feel the paramedics needed to remind them to act professionally, my intent was certainly that the providers need to remind them to maintain their professionalism during this process, not to act professionally. I believe they are acting professionally. I just wanted to maintain their professionalism.

And on page 6, the last paragraph,



first sentence, confirm that at the next meeting members will bring the information described.

It was the information that we agreed to, if possible. I think there was consensus, Pete, that not all the information would be possible to bring to this meeting. There was just too short of a time line.

MR. ROBEDEAU: Yeah. I'm way behind and, quite frankly, I don't know if I'm ever going to get caught up, but we'll get most of the stuff.

MR. DRAKE: That's the only two corrections I had.

MR. ROBEDEAU: Trace, Randy, anybody?

MR. SKEEN: Another good job, Steve.

MR. MOSKOWITZ: Thanks.

MR. ROBEDEAU: Motion for tentative approval pending Steinman's review?

MR. KILMER: Did anybody say there was intended to be an action by you requesting a request for extension?

MR. ROBEDEAU: No, we didn't.

MR. LAUER: I don't think we discussed



it. You raised it.

MR. KILMER: I raised it. Pete said he thought it was a good idea. Mark said he thought it was a good idea. There are several head nods. If that's an issue, that ought to be raised today.

MR. SKEEN: That ought to be one of the formal things we do, is to make a motion that there be a request for an extension.

MR. ROBEDEAU: Let's finish the minutes and then make a motion as the first item on the agenda. Can we get tentative approval?

MR. DRAKE: Move they be approved tentatively.

MR. ROBEDEAU: Second?

MR. SKEEN: Second.

MR. ROBEDEAU: In favor? Aye?

(Vote taken.)

MR. ROBEDEAU: Approved, tentative.

I think, quite frankly, we need more time. I'm so far behind I don't think I'm ever going to get caught up with this stuff.



Trace did -- that's third on the agenda -- an itemized list that's going to be passed out, which I think will be a big help. We're going to need more time. I think we should write to the board and ask them. I'm talking County Commission, not MAB.

MR. THOMAS: I was talking to Bill beforehand. So that everybody understands, Tanya Collier originally wrote the schedule that everybody received, and that actually was in a form of a proposal to the commission as to what the commission's time line ought to be, the County Commission actually. The County Commission has never acted on that, and so that, as far as the commission side has been concerned, has never been carved in stone.

Since then, obviously, Commissioner McCoy has obviously died and there's a campaign going on. In two weeks Tanya will be resigning her seat to formally run. Nobody knows at this point what the time line is going to be.

In talking with Bill, Bill said



Dr. Oxman is trying to schedule some time with Hank Wiggins to talk about that, but is caught with the fact they're under the budget. What I was going to ask them, rather than advising them to reform the schedule, since there isn't a formal schedule established yet, you might want to urge them not to follow the schedule as has been proposed to them, but to allow some additional time whenever they get around to deciding what the schedule should be.

MR. ROBEDEAU: I think we should ask for 90 days.

MR. LAUER: Chris, having worked with the city, you probably know how this works. Is it likely they've agendaed any of these things yet?

MR. COLLINS: No.
MR. THOMAS: They haven't yet.
MR. COLLINS: They for sure haven't. Not that far ahead.
MR. LAUER: It wouldn't be a matter of changing the agenda.
MR. THOMAS: My proposal was that hadn't been acted upon. That was a

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significant chunk of time they were going to use. I think there's a major internal dialogue they have to have.
I should mention, I spoke to Carol Kelsey last week and asked her if the change in events had changed the schedule, and what she said to me, what the schedule was going to be was going to be up to the remaining commission members. So I understood from that that she was saying she wasn't sure what the schedule was going to be as of then.
MR. ROBEDEAU: My question is, do we –
MR. THOMAS: I think you should decide how much time you want them to grant you, I suppose, if we want to have them push the time back some.
MR. ROBEDEAU: Do we even know if Tanya Collier is really going to resign and run for that office?
MR. THOMAS: I think we can be pretty confident. Things always can change.
MR. COLLINS: I'll know for sure at the end of May, whatever the filing date

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is.
MR. DRAKE: 26th.
MR. ROBEDEAU: I've gotten ideas both ways. I don't know that they're worth anything.
MR. THOMAS: Until she formally files, you won't know for sure.
MR. DRAKE: Does anyone have a problem with Chris Thomas, since he has a handle on this, drafting a letter and faxing it around to each other?
MR. KILMER: For what?
MR. DRAKE: Asking for an extension.
MR. KILMER: Such a letter has already been drafted.
MR. LAUER: My only problem with such an extension, it at least continues the perception that this board is going to attempt to slow things down.
MR. KILMER: The letter addresses that. Look, the fact is that this process has revealed that there isn't even any agreement on some basic issues of how a plan ought to be developed, and what it ought to address, and what the county

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wants, other interested people want out of the system. None of that stuff has ever come in.
This thing has been imposed from the top pursuant to somebody's agenda. That agenda has never been identified and never been subjected to the scrutiny of independent analysis. This board started off to try and do that, and we have never been able to get off of first base on some issues because no one can even agree on the starting point. How can you in six weeks begin to address plans when the foundation is based on such amorphous, unidentifiable objective data, objective concerns. And that's why we need more time.
You know, there's the computer action, garbage in/garbage out. If we're responding to the garbage that came out of a garbage process, we run the risk of having more garbage. And it clearly is going to take more time to develop a foundation from which to build appropriate comments to these – to the proposals in either the PAPA plan or the EMS office

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plan.
MR. DRAKE: I think what we originally looked at, Randy – I hear what you're saying – but I think what we have done is said, instead of just responding to the ASA plans, that we feel this is the time also to put in our comments about the development of the entire EMS system. We've all agreed to that. And that kind of input necessary to do that is going to take us a long time. And I think that we've seen that as we've gotten involved in this process.
We've made a lot of progress to date, but there's a lot of work still to do. Asking for 90 days' extension is not, in my opinion, out of line, especially since 90 days from today you're talking basically the end of July, beginning of August. Commissioners don't even have it on their agenda yet. We don't know if they can put it on their agenda until August or September.
MR. LAUER: My point is this process has been extended and extended and extended

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for a long time, and we come out with this recommendation, there will definitely be a perception the Provider Board is trying to stall it longer. That's my perception.
MR. KILMER: You are correct that perception will be there. Those who have said for eight years that AA and CARE Ambulance Company have been responsible for all these delays will use this to advance that view and will try to create a wrong picture. The fact is that this process has revealed all sorts of deficiencies in the past process, that it's taken eight years but virtually nothing was done in that eight-year period. The issues weren't defined, different points of view were never invited or addressed or considered and allowed to modify the additional stuff. No data was collected.
In the whole period of time that Joe Acker was here, not one stick of useful data, useful in this process, was ever developed.
We are not asking to delay still further a process that has been egregiously

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delayed by improper procedures in the past. During that whole period of time we asked to have a process like this and claimed that it would accelerate the process and lead to a good plan under circumstances where there wouldn't be much litigation, much threat of litigation. We were always deflected on that.
MR. LAUER: Wait a minute, Jeff. This board – there's never ever been anything that prevented this board from convening. Pete's the chair. He could have called it any time during his chairmanship.
MR. KILMER: True enough.
MR. DRAKE: Just a minute. Randy, what we have been working on over the past year and a half or year is under a planning process with the county, under the county's direction. We have been doing that. We have been meeting at different times to talk about – we met to talk about the single physician supervisor issue. We met to talk about this issue, about cost, rates, system status plan. We've been involved in that process.

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MR. LAUER: Jeff just said we never had access to that process.
MR. DRAKE: Just a minute. We've been doing this process. Then all of a sudden this process – a gun was held to our head and said, you're going to accelerate this process and have it done in five weeks.
In the very first meeting we met, we

all said there's no way we can do this kind of planning in five weeks. We didn't think we could get the process done.

MR. LAUER: That's because the Provider Board convened in a reactive setting, to react to another action.

MR. DRAKE: However we got here --

MR. SKEEN: I don't think we're disagreeing on this. Randy has a valid point and question. Pete, if we have four or five parties, us being one, MAB being another, I think we very realistically can ask for a delay to do more analysis on this, especially if it's time specific you have addressed.

My concern is, if there's five parties, the other four are charging



forward and we're the only ones asking for a delay, we might not get that. It may be the garbage in/garbage out process you talked about.

MR. ROBEDEAU: That's one of the reasons we have to ask for a delay.

MR. DRAKE: Not a delay.

MR. ROBEDEAU: This is the first time -- pardon me?

MR. DRAKE: For the record, it's not a delay.

MR. KILMER: Asking for an adequate amount of time to do what needs to be done.

MR. ROBEDEAU: This is the first time anybody has ever been allowed -- I think if you notice the way I've run the meeting, has not been to control things the way the MAB has constantly tried to control and nobody's allowed to say anything with meaningful input. I've allowed everybody, anything they want to say so we can look at the real issues.

I think case in point -- maybe you want to just hold off there because I



wanted to go on to the next item. I think that will show what I'm talking about and why I think we need to really go into this more in depth, if that's okay with you guys. I sent, Bill --

MR. THOMAS: Wait, Pete. One of the problems the group has is it has trouble finishing things when they're not real comfortable for everybody. I think Randy's right. There will be some perception problems, and Jeff's right, some people will use that.

I think the real question is -- and they may say, no, they won't delay it. If they do, so be it. I really do think, practically, you write a decent report to them, we're not going to be able to meet their schedule and we need to tell them that and tell them how much time we will need, and they can say yes or no.

MR. SKEEN: That's a good point, Chris. Perhaps this report structure that I gave to Pete, we can talk about a little bit, would be something we could provide to MAB that indicates that there are a lot of



holes in the assumptions that need to be addressed.

But, actually, even if this group reached a consensus on that, because you have three ambulance providers, two first-responding agencies, the EMS office, can't forget Kaiser in this process, a consensus from those are major players in this.

I guess my concern is whether MAB, on the issue of the medical direction, may want to charge forward at 90 miles an hour in spite of these other pieces coming together in an orchestrated manner.

MR. THOMAS: Let me say, frankly, MAB will want to charge ahead because they feel like they have the momentum and the initiative, and they'll perceive anything that invites any other players in or gives them more of an opportunity to say something in depth as a threat. I think that's realistic.

MR. SKEEN: Well, then in the letter, maybe what we need to do is provide -- this is probably a legal term that you're more



familiar with -- but provide a basis for -- that at least puts something in their record that shows we think there's some issues that we think need to be addressed.

MR. KILMER: The letter does that. I had thought, and I think Pete thought, the consensus had been reached.

Did the letter go out yesterday? We drafted a letter to go out yesterday.

MR. ROBEDEAU: It didn't go.

MR. KILMER: It didn't go.

What I suggest is you make copies of that draft and fax it around to everybody. But, you know, you're correct that it ought to identify the reasons. And it's a two-page letter, which purports to do that, to explain what's necessary.

Now, with respect to the MAB process, I think it has become increasingly clear in this process that the medical issues, that the MAB has any knowledge of at all, are not really going to be affected by whatever plan comes up. They are, in other words, medically neutral.

These things all involve a whole bunch



of policy, financial, tax, cost, that kind of thing that PAPA did not evaluate, Mr. Collins evaluated, to some extent, and in some respects we quarrel with. And the Medical Advisory Board has no ability to measure those, never heard any input on any of them, has no basis at all to come to any conclusions on those aspects.

With respect to the physician supervisor issue, I think it has become very clear to everybody involved in this process that that's medically neutral. Regardless of the form of medical supervision, everybody agrees it ought to be there, everybody agrees it ought to be consolidated so there's uniformity throughout the system.

The question is how to accomplish that, whether that's done through OHSU or whether it's done through some other independent mechanism. And the driving force behind that dispute is not medical advantage or even system control. It is an interhospital dispute.

And again, the Medical Advisory Board



should not -- is not the place to resolve that. That is a health issue. That's a financial issue that ought to be going on in some other environment.

Thirdly, the Medical Advisory Board is here to advance agendas having to do with their expertise and the conflict-of-interest issues that they face but have not addressed and refuse to put on their agenda, you know, only undermines that approach. I don't think that we need to be concerned about the MAB. Nobody looking at this process later, in a fair process, is going to give what happened there any weight. Only if this has already been greased is it going to be given any weight, and then it's just a convenient fig leaf to justify a preconceived agenda.

I do think we might do this: We have Dr. Jui's testimony and Dr. Norton's testimony here in two sessions, and I suggest that this board send a copy of the transcript, of both of those meetings, to the MAB with a proposal that -- with respect to single medical control, suggests

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that single medical control occur through a contract between the county and OHSU, where one doctor is defined as the single medical control, but all the agents of that doctor will come there, and that will maximize the chance that you will have a group of doctors that will work together.

The thing that is so interesting about the PAPA plan is that that's clearly an effort to remove medical control from OHSU, create one county-operated director. Dr. McNeil is already being touted by some people and pushed for that. Then that guy is going to go out to different hospitals apparently and select his agents there. You are going to have the same problems of interhospital dispute and medical disputes under the single medical control it used to have when you had different medical supervisors.

Dr. Jui very carefully -- very clearly pointed that out. That's something no one has thought about. The process PAPA is talking about carries with it the significant risk that will recreate that

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the single-medical-control advocates wanted to get rid of, and that was rivalry among supervisors that used to exist in the old system.

We ought to prepare a report, it seems to me, that points that out to the MAB. It isn't going to do a hill-of-beans good. We all know what they're going to do. But this process can enter into the one issue that the MAB has any expertise in, in the way I've just described.

In the meantime, we go ahead and do the other things we have to do, whether or not they grant us the delay. We'll do it as fast as we can; we'll do it right. That's the proposal I would suggest to the board.

MR. DRAKE: I was going to say something.

MR. PHILLIPS: Go ahead.

MR. DRAKE: I was just going to say, Trace, I understand you and Randy too, people are going to perceive this as an attempt to delay, that other groups may proceed ahead. I think as professionals we

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have to act responsibly in this EMS system, and because the MAB has chosen to act irresponsibly should not deter us from our task. We need to proceed ahead as we feel is better.

MR. SKEEN: You're preaching to the choir. I'm not arguing the delay. I'm saying it needs to be structured in such a way that it has some time-specific points that we will come forth with information, but I think we also need to point out why we're suggesting there needs to be an extension right now.

MR. DRAKE: I agree.

MR. THOMAS: We should circulate their letter and everybody comment on it.

MR. SKEEN: I think we should all make a party with that. I love arguing with Jeff under these conditions.

MR. DRAKE: For the record, Jeff is not sitting here.

MR. SKEEN: One of the exceptions, I guess, I take to much of what he said is that when it relates to physician supervising, supervision and medical

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control being a neutral issue, you know, I don't think that's the case. I think there are certain advocates of a particular medical-control system out there who have indicated that there is a particular format in which they can operate, and that has to do with whether it's a single provider, a multiple provider, a tiered provider, whatever. So I don't think it's necessarily a neutral position, because I think they very clearly would have a preference for that single issue when, in fact, they may be ignoring 15 other issues in the process.

MR. ROBEDEAU: I think what Jeff was saying on medical supervision being a neutral position is that nobody has had a problem with single medical authority or single physician supervisor. What has happened is that certain individuals with preconceived agendas have taken that issue and tried to bootstrap it on to other issues that they wanted.

The idea of single medical authority has for years been an agreed-upon issue

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within this system, and like I've said before at these meetings, there are numerous times that certain members of the MAB have articulated very clearly they are absolutely opposed to any change in the medical supervision, lest it might diminish their chances for their particular idea of what an ideal system would be, which specifically is single provider.

I think that's what Jeff is saying, is this is something that could have been taken care of, and that's why it's neutral, is because there is no objection by any of the providers, that I am aware of, to having single medical authority.

MR. LAUER: I think it is objection -- I don't know if it necessarily comes from any provider, but the objection to having single medical authority, that doesn't have some neutrality, is that one hospital or one hospital group is going to gain some sort of control over the EMS system, and whether or not they would stand to gain from that remains unknown. But that's the perception there.

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There's one hospital that's pursued that agenda aggressively over a long period of time and almost has single medical authority under their roof. There are other hospital groups who are taking exception to that. That's where the real battle lies. That won't go away either under the -- under the OHSU plan, but a single medical director that doesn't have that direct affiliation with any one particular hospital group.

MR. ROBEDEAU: I would disagree with that. This single medical -- this whole EMS issue has been a fight between hospitals since day one. The ambulance providers, the prehospital care providers, even the fire bureau first responders don't really have a lot to do with this. This is a patient-driven --

MR. LAUER: That part, yeah.

MR. ROBEDEAU: Almost all of it's economic and it's hospitals. It has nothing to do with Portland Fire or Gresham Fire or AA or CARE or Buck Ambulance. We're the whipping boys who are

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being pushed on.

MR. LAUER: I heard Jeff's testimony -- and I like arguing with him under these circumstances --

MR. DRAKE: Jeff is still out of the room.

MR. ROBEDEAU: I'm not Jeff --

MR. LAUER: -- transferring authority to OHSU, I have some real problems with that specifically because OHSU has endorsed a system that I think is medically irresponsible. What they want to do is, they want to create -- they've endorsed a system that will create a core group, small core group of paramedics and operate under their umbrella and has essentially discounted the rest of the system that will

be compromised.
MR. DRAKE: I think we should stick to the fact we've all agreed by consensus, or do we need a motion, Mr. Chair, that we want to send out a draft of the letter to all the parties?
MR. SKEEN: I think the intent was to circulate the letter and get everybody's



comment on it.
MR. DRAKE: Right.
MR. PHILLIPS: I'm interested to look at it and comment on it. I feel like this group -- when the MAB starts talking nuts and bolts, they're going to bog themselves down. We may not have to ask for anything because come May 14th, they're going to do it themselves.
MR. DRAKE: The path is pretty much greased.
MR. ROBEDEAU: The MAB is not going to talk anything. The MAB has already made up its mind. The votes are in. It's four to two. No matter what happens, it's four to two. No matter what, they're going to do like that, three minutes, say your piece, sit down, shut up, that's it.
MR. PHILLIPS: That wasn't my impression. My impression was they were going to go through and talk about each individual issue, and I think when that discussion comes they're going to get bogged down.
MR. LAUER: I think Dave is right.



MR. ROBEDEAU: The thing is -- can I respond to that?
MR. THOMAS: Let's not try to predict the issue.
MR. ROBEDEAU: It's never been defined.
MR. PHILLIPS: What we can do, those issues we feel they should have some input on, maybe provide our opinion of that issue to them for consideration on the 14th. Let's work to do that.
MR. LAUER: Actually, I think that's what this process is useful for. The MAB -- my understanding, they adopted the PAPA plan as a template, but there's still a large process, really the one we're going through, where they go through and build an ASA plan from that template.
MR. PHILLIPS: They're going to give the PAPA plan to Bill, and Bill is going to have to fill in the blanks, and the answers are going to come from this group.
MR. ROBEDEAU: Yeah.
MR. LAUER: I guess my question is -- maybe you guys can help me out -- the



process to build an ASA plan, in what form is that going to occur through the MAB? That's obviously not a week-long process. That's this process.
MR. THOMAS: I don't think anybody knows and nobody knows what final action the MAB, Dr. Chipman, Dr. Dugoni, who are probably the driving forces at this point, what they think their product is going to be. I would not make any assumptions about what they're doing having a high level of sophistication or involving a lot of detailed dialogue because that's something the MAB has not been successful at doing because of the level of polarization there.
My view is that this committee needs to produce its own product, which will stand on its own, and provide it to the County Commission at the appropriate time, whatever that turns out to be, as a product that we believe is of equal stature with whatever the MAB comes out with, and just do it that way, because they're not going to be interested in what we have to say



because they view us as the enemy. I feel quite confident that they are not going to be interested, as a majority, in having our input, and I think experience proves that.
MR. ROBEDEAU: My understanding of what is -- to address what you had to say a little bit, my understanding of what's going on is on the 14th, between 9:00 and 11:00, the MAB is going to do everything that's necessary to formulate a plan. It will be voted on at 11 o'clock, and it goes to the County Commissioners on what it is. They're going to take two hours to do what we've been doing here for over a month.
MR. LAUER: That's my point.
MR. ROBEDEAU: It is just not possible for the MAB to have any meaningful discussion in two hours. A lot of these meetings have run a lot more than two hours. We have been -- people have been doing a lot of stuff on the side. Just this thing that Trace came up with, that he's going to pass out later, I know took him more than two hours.
MR. PHILLIPS: That's why I say if we



can throw a couple tacks out there to get them talking about, maybe we can delay that -- not delay that.
MR. DRAKE: I think that's a good idea. I agree with you. The MAB simply lacks any necessary expertise to put together the system, and I don't believe they're interested in getting the input from any of the professionals in this room that have that knowledge or background.
MR. PHILLIPS: Then they're going to send a system to the county, and the county will have a lot of questions they won't be able to answer.
MR. DRAKE: Or a system that won't work, we know won't work. That's what's happening.
MR. LAUER: A lot of the problems in the system, there are a lot of different opinions of what some key components of the ASA plan should have, and there's no consensus on that. The number of providers, the kind of provider, the medical authority versus a single medical director, there's no consensus on that.



And people are going to use one process or another to end up with something in writing that this is what the ASA plan is going to be formed around.
The difficulty is that those key issues -- it's probably not possible to prove that one is better than the other with definitive data. And if we proceed in this process trying to prove things that will withstand any questions or withstand any attack, it's not going to happen. It's not there. It's not that type.
MR. THOMAS: I agree with a lot of that. I think the committee can do two things, though:
One, it can put what data is available and what hard information is available in a format that somebody who's not into this stuff at least can begin to deal with -- I'm talking about the County Commissioners -- in a way that, to some extent, they can use it to reach their own conclusion;
I think the other thing this group can do is to make their recommendation, either



as a whole or with one group recommending one thing and one something else, based on that as to what, you know, the group thinks ought to happen. I think that's one of the main services this body can perform, which I don't think anybody else has really done for them.
And I think that's why some of this

information you guys are developing becomes important in the process: because it allows them at least to get some of the stuff in a realistic proportion in terms of, you know, how much difference there is between one thing and the other, whatever judgments they want to make. Obviously there are judgment calls.

But I think it sounds like everybody's agreed that the draft of this letter will be circulated, and people will provide comments to?

MR. DRAKE: To Pete.

MR. THOMAS: To Pete. Okay.

MR. ROBEDEAU: I think going right along with what you were saying about consensus on things brings us into the



second part. As I was sitting down and making out the list that I made out on things I had heard about over the years on what might be problems with this system, it also dawned on me that Multnomah County has, as far as I can remember, has never really articulated what's wrong with the system.

So I sent Bill a letter and asked him to address -- to articulate the shortcomings of the current system. And the response came back today, and I think maybe Bill may have misunderstood what I was actually asking for. It says, the ASA plan developed by the EMS office proposes the following major changes in the current system, and says, one, single ambulance service area.

What is the problem -- we need a clearly articulated problem that this single ambulance service area is meant to address, not just the fact a single ambulance service area. How is anybody going to make a reasonable decision if this is going to fix the problem if only the



solution is articulated and the problem never is?

MR. LAUER: I think, to comment on that, I don't think there's a crisis in our EMS system. What I think is, that people have made some statements over the course of years where we can take our current system and make it better, but recognizing people have repeatedly said that this system provides good patient care, delivers good response times, but we think we can make it yet better.

And people have made a judgment, a long time ago, the County Commissioners and lots of others, that one way to do that would be a single ambulance service area. Now, that's a judgment.

MR. KILMER: Pete's point is, do you know what ways specifically that it would be better and needed to be better?

MR. ROBEDEAU: Do you know what the problem is?

MR. KILMER: Do you know what the problem is they want to cure?

MR. ROBEDEAU: You're saying people



have said the response times are good, the patient care is good, all of this. That isn't quite accurate. Back when the judgments were made for single provider, people had said everything is bad. We need this to change it. And Multnomah County set out on a process to develop ordinances to regulate the ambulance services, and their first ordinance, they said, everybody has to be EMTs. So we said, fine.

They looked at it and said, aren't you going to object?

We said, no. Everybody is EMTs.

They said, you have to have one paramedic on every ambulance.

Fine.

Aren't you going to object?

No, we're not going to object. Everybody has one paramedic.

The only thing Multnomah County could get us on that we weren't doing was two paramedics on every ambulance.

MR. KILMER: We did that how quick?

MR. ROBEDEAU: The only thing that has been articulated, when I went to talk at



the last meeting before ordinance 229 was adopted by the policy board, when I stood up, Don Clark looked at me, and I never even got to the mike, and he looked at me and said, "Sit down and shut up. We've heard from you too often. We're going to have the best system there is, and we don't care what it costs."

So what the county said is, you go make the best system there is, charge whatever you want, whatever cost, we don't care, and as soon as that was done they came back and said, it's too costly.

That led up to the Fitch report. The Fitch report came out saying all sorts of things was wrong, and over a period of time the providers in Multnomah County were able to disprove the Fitch report. It got down to the point where the Multnomah County commission said, yes, we understand the Fitch report is fatally flawed, but we don't care. We think single provider, and everybody has done all this work, so we can't throw this out now.

MR. THOMAS: But let's stay focused



here. What you were -- I don't know anything about this, but what you were hoping to get from Bill would be a list of criticisms made of the system, or what he feels the criticisms of the system are, to cure what the problems were, or to put it differently, rather than criticisms, things in the system that could stand to be improved that his proposal would improve. Those were the things you were interested in versus what was the fix, what are the improvements that are going to be made, what's not as you would like it.

MR. ROBEDEAU: What is it that the county started to do with this plan, the problem they were trying to fix? What is the problem? Then if we can identify the problem, we can identify whether it's been fixed. But there are no problems listed. There are only fixes.

And to be real honest with you, other than just guessing from everything over the years I've heard, I'm not sure what the problems are we're fixing. We know the single medical supervisor is a problem that



has been articulated.

MR. THOMAS: Why don't you ask -- just ask again and maybe you'll get a different response. We can't sit here and keep guessing.

MR. ROBEDEAU: That's exactly what I'm saying. And I guess that's it, is what are the problems that articulate the shortcomings of the current system that are being fixed by a single ASA?

MR. COLLINS: Well, I think, if you look at the document we wrote, the question was, should there be a multiple ASA system or a single ASA system? And we looked at it from the standpoint of the demand analysis and the cost that that would incur. And whether you agree on the numbers or not is another question. But what we showed was that a multiple -- that the system that we currently had was considerably more expensive than what could be formulated in a single ASA.

MR. KILMER: Bill, can I interrupt, because what you're saying is an after-the-fact analysis. What Pete is

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trying to get here is what concerns have been articulated that has driven the desire to change the system at all? What you have answered is, in doing an analysis to change the system, we were able to justify change based on high cost of a multiple provider system. That has never been an articulated factor, to our knowledge, anytime in this process.

MR. THOMAS: Wait a minute, Jeff. That's not true. Cost has been a criticism, at least ever since I've been around.

MR. KILMER: Cost has been a criticism, and there has been intuitive thought that three administrative systems are worse than one. There has never been any study of that, and we have submitted in response to that a couple of things, several years ago. Nothing ever happened with that.

Always the view was, cost is not really a problem in this system. We agree that the rates here at least are average for the work done. Not until you take a

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look at our cost versus an ideal system as opposed to our cost versus cost in other cities has cost re-arisen as a driving force for any change.

Now, in the meantime, though, the quest for a change in the system has continued, and to this day nobody knows what other reasons were driving this, what concerns about the current system existed. That's what Pete is trying to get.

MR. LAUER: I think what came out of that original discussion, that did come up because of cost primarily, was that a single provider versus multiple provider would gain some efficiencies because of reductions in the number of paramedics, duplication of service, you have more standardization of equipment, you'd have more standard delivery of the level of patient care, you'd have more accountability. Now, those are all judgments.

MR. KILMER: That's not true. None of that ever came up.

MR. LAUER: Yes, it has. It's come up

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many times. That's carrying this argument forward to this day.

MR. KILMER: No, Randy. Those assertions were made. What you just said, assertions were made. They were responded to by showing that virtually everything that you say they want from a single provider could be obtained from a multiple provider, and the difference in cost of two administrations was only at the top management layer. In other words, you had three presidents rather than one. But when you take three presidents and turn it into one, you have a much bigger system, and he's going to have an intermediate level of management right below him that is basically as costly as three presidents.

We analyzed that, and there was never any follow-up after that at all. I submit to you to this day the reason there was no follow-up was because, as those assertions were made, they could not be demonstrated.

In the meantime, however, those comments have not been part of this system or the debate on this for a long time. But

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there has been this continued effort to change the system supposedly to gain other advantages. But those advantages have never been defined or articulated. And that's what the problem is.

MR. THOMAS: But I've understood Bill to say -- and, Bill, I suppose you at least -- what people want to find out from you, at least to some extent -- I've understood that your basis for recommending a single rather than multiple is strictly an economic basis, and that you, yourself, would not indicate that there are other reasons why you would make that shift. Now, I don't know if that's right or not, but that is what I've understood.

MR. COLLINS: I think that's essentially true. There is some question about the number of paramedics, that being tied to training and maintenance of skill. But all that we really showed was there are a lot of paramedics and there could be fewer. There was never really shown what any skill degradation actually was.

MR. LAUER: Ease of administration.

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MR. SKEEN: Ease of administration from a regulatory standpoint.

MR. COLLINS: We did identify to some extent that we felt there would be less regulatory time and, therefore, allow us more time to look at other aspects of the system, such as quality assurance, that sort of thing. But that was just based on our time and effort that is currently involved.

MR. KILMER: What percentage of your time, Bill, is dealing with ambulance companies as opposed to all of the other people that are involved in the EMS system. the commissioners, the hospitals, the MRH.

MR. COLLINS: For our office time, we do spend a lot of time. I have essentially one person that spends a great deal of time sort of sorting out what's going on with the number of providers we have, just following the dispatch and who's going to the right call.

MR. KILMER: That's dealing with BOEC and this dispute between BOEC and the companies about the issues.

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Now, the point I want to make is, if you reduce the number of providers from two to one -- and with the AA-CARE merger that's what we're dealing with, a two versus one deal -- you're still having a conflict between the BOEC and that one provider. You're sitting between the one provider and the first responder. You're still going to have to deal with the first responders, the hospitals, the other people in the system.

What needs to be quantified is -- maybe you can argue that there will be some decreased administration. How big is that in terms of your whole administrative load?

MR. COLLINS: I don't think that was a big issue in the plan. That was a factor that we identified. We predominantly looked at the cost and how that would affect the price. That was -- when I came here, that was still a big issue that people were yelling about. You can argue that it's evened to other communities or you can argue not. I think in the plan

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-- one of the things I proposed was that we do not look at other communities because of the myriad of ways that financing is done.

You try to look at -- well, we're like Sacramento. Then you can go to Sacramento, and they've got a subsidy, they have this and that. You're not gaining anything. It's much more focused on what do you want the system to do than to figure out what it's going to cost for you to do it.

MR. DRAKE: Can I ask a question here, Bill? You said when you came here, people were still concerned about the cost and the price. Who were those people that were concerned?

MR. COLLINS: That was still a concern

when we held that meeting with -- back in, what was that, a year ago December.
MR. DRAKE: Whose concern was it?
MR. COLLINS: I don't have a list of people there. That was one of the issues that was still in the forefront. I could go back and tally up, I suppose.
MR. DRAKE: Is that a county issue or

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a county concern? Because we had raised at the time that there were very, very -- you have told us there were very, very few rate complaints compared to the number of transports in the system.
MR. COLLINS: I'm saying when I came here, people were feeling that price was expensive. Even if the price was equal across the board, if you can do it for less, then you ought to do it for less. This is not a "Get as much as you can out of the public." I don't believe that's a direction to go.
MR. ROBEDEAU: When I did the analysis and came up with the fact -- with using your figures that, by what you were saying, the rate should be no more than 441, you said, no, that wasn't right.
MR. COLLINS: I said what?
MR. ROBEDEAU: You said, no, that wasn't correct. You didn't know what the rate was going to be. The rate might be 441 or 641.
MR. COLLINS: Did you ask me what I thought the rate was?

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MR. ROBEDEAU: When I did the figuring, there should have been a substantial reduction in the cost and the rate should be no more than 441.
You said, no, that wasn't right. You didn't know what the rate was going to be.
What I'm saying, Bill, I guess the problem, if there is a problem with rate and rate is a driving force behind this, then EMS, or the county or whomever you want to call it, must have some kind of an idea of what the rate should be when we finish. We know what the rate is now. It was 558. You said there was $3.1 million in savings that could be accomplished in this system. If there's $3.1 million in savings and there's 50,000 calls, that should reduce the rate to 441.
MR. KILMER: Is that assuming collection rates, or is that assuming hundred percent collection?
MR. ROBEDEAU: That's assuming collection rates. I think we dropped it -- I dropped it down to 441. But when I asked you that question, you said, no, you didn't

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know what the rate was going to be, and you weren't going to make any judgments on that. There has to be at least some kind of a bench mark that says if we're getting somewhere.
MR. COLLINS: I didn't do any rate computation because we don't have the exact setup. If there is -- my thought process is if there is three million bucks in savings, then there ought to be a substantial change in the price. If there was not a change in the price, then one would ask, what the hell is going on?
MR. ROBEDEAU: The other thing that needs to be --
MR. COLLINS: You can argue you don't like the figures and therefore you come to a different conclusion.
MR. ROBEDEAU: No. No. No. I'm not arguing I don't like the figures. What I'm arguing is, no matter what figures you use, there should be a bench mark.
If the single ASA is meant to address the problem as perceived of cost, then it should -- the plan should state what the

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savings is going to be and the plan should also say, okay, the rates now are going to be no more than, because we have determined there's $3.1 million, almost $3.2 million. And my figures are not accurate to the penny because I was using just a ballpark figure on the number of calls, the number of transports that are going to take place.
What I am saying is, the plan should then say, should articulate what the savings is going to be, not just that we hope there will be a savings, and I think that's the problem.
What the plan says is, we identified $3.1 million worth of savings and we really hope there should be that savings. The plan should say, when we do this bid, the single ASA, the plan is going to be no more than 400 bucks. That's it. That's all you're going to charge.
MR. COLLINS: What do you want me to say?
MR. KILMER: Wait.
MR. COLLINS: You could follow that

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logic if you take the cost study we did and the demand tables, you said, we're changing no other variables other than making that -- those changes, then you could say, fine, the rate's going to be 441, whatever you figure it out to be.
MR. KILMER: Here is what Pete is talking about is your methodology. Whether there's a different methodology that might have worked better, now, one thing that you could have done is go up north to Clark County.
Clark County took a look at the average bills for the last couple years up there between CARE and Buck, two local companies also delivering care here. They found the average billing up there was $522 and some odd cents.
MR. SKEEN: 76.
MR. DRAKE: $522.76.
MR. COLLINS: 66 dollars and change less than here.
MR. KILMER: What is it Multnomah County came up with?
MR. COLLINS: 588.

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MR. KILMER: So you have a difference of $60, $68. That is a system that has a higher collection rate. It is a system with response-time zones so you can manage it much more easily. The costs are lower to the company because of that, and it only has one paramedic on every ambulance.
MR. LAUER: Two.
MR. DRAKE: One required currently.
MR. KILMER: The point that I'm making is that that difference, when you look at the fact that you had basically a single provider up there, and it was basically a Portland company, suggests that the savings inherent in joint administration are not nearly as great as you're hypothesizing.
You can go to other cities and at least do comparisons like that, that will be more solid than your analytical method, which is to take your ideal system based on really very little knowledge of what the system is going to come out from the other end and then work backwards from that from the data you got from us, which was only approximate anyway.

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MR. LAUER: Are you suggesting the difference between a single and multiple provider, using that rationale, is $60?
MR. KILMER: No. What I'm suggesting is with all those differences, the difference is only $60. The probability, looking at Portland and its lower collection rate and its higher staffing

requirements and greater response-time requirements in the outlying areas, you're not going to have any difference at all with a single provider. That's what I'm suggesting.

MR. DRAKE: Also, I'd like to bring up one point before we get into that.

MR. SKEEN: Into what?

MR. DRAKE: I was intimately involved in that process. That 522.76 is being disputed by American Ambulance as not an accurate reflection of the rates up there. Those rates are higher.

What he did was compare a provider that did about ten percent of the business at the time to a provider that did 90 percent of the business, and that 90



percent provider served the rural and suburban zones while that ten percent provider only served in urban zones. So the rate could be much higher.

MR. SKEEN: Your statements may have validity, but I don't think it applies.

MR. COLLINS: You can argue about the methodology we used to collect the data if you want. I took 15 days' worth of invoices. If your invoices are wrong, let me know.

MR. SKEEN: Let me make a comment.

First of all, you talk about what's wrong with the system, coming from the outside and listening to the rhetoric over the past couple of years. First of all, I tend to be pretty defensive because I think this is an excellent system, the response time, performance, staffing levels.

But, you know, people don't judge you by what's going on nationwide. They judge you by perceptions. If something's broken here, it's probably perceptions. And it appears to me all this process Bill has gone through and the MAB and others are



going through is an effort to try to change the perception of what's wrong, which is a cost issue.

Now, what Bill has said, if we want to change a perception, let's try a different delivery system and see if, in fact, that can lower some costs. And by his own admission, neither the tiered system or any of the other models that have ever come forward have been costed-out to determine whether, in fact, there are savings, whether our rates are unrealistic or not.

The two other methods you can do is take what you proposed should be savings to the system and say, okay, we're going to reduce rates to reflect those savings.

Second one is, this is a different delivery system. Let's look at this and price it out and cost it out and see if, in fact, it has any beneficial effect on the rates. But my sense is, you really don't have enough perceptions.

MR. ROBEDEAU: You are dealing with perceptions.

MR. SKEEN: And you can't ignore



perceptions.

MR. ROBEDEAU: The point is --

MR. KILMER: It's a political process, a public policy thing that really talks about what's in the best interest of the county, and county citizens ought to make that decision on hard data and hard analysis, not perceptions. Do you agree with that?

MR. SKEEN: I agree that they should. What degree of public policy anywhere is based on data, Jeff?

MR. KILMER: That is a very significant process not only with this process, but this process happens to have people in it that are less willing to tolerate the abuses that comes from the public policy-making process that we've evolved in this country than most people are.

MR. DRAKE: Go ahead, Pete.

MR. ROBEDEAU: I still think -- and when we send a plan to the County Commission, our own plan or our own perception of a plan or however you guys



want to put it, that that plan has to say what is being addressed. And I think that's the problem, one of the major problems with both plans, and I think because it doesn't say what is addressed, that neither plan is legal.

You know, there has to be something that you're addressing. That's just off the top of my head as a non-attorney, and I've never even talked to my attorneys about this or anything else. But one of the things that is stated as part of the rules is that a plan must address and consider different issues.

The thing that this discussion, I think, has shown very clearly is that there are no articulated issues. The issues really aren't there. If an issue is there and an issue is addressed and considered by a government body to comply with the plan, the issue has to be addressed. It has to say, this is the issue that we're addressing with this section.

If it's rates and that our rates are too high, then that -- I think that needs



to be stated. And here's the reason our rates are too high, because there's $3.1 million. Therefore, the rates at the end of this process will be no more than 400 bucks. Just, you know, don't quote any of the exact numbers.

And that's not only a flaw that I see with the current EMS plan, it's a flaw with the PAPA plan and with other plans I've seen put in. It's a general flaw.

I think the citizens of Multnomah County have a right to know what the issues are. I think the providers in Multnomah County have a right to know what the issues are. And when I sat down and wrote out what I felt the issues might be, it was strictly guessing.

MR. THOMAS: I think Bill has -- Bill has said that his primary issue is he thinks that the system could be more efficient and therefore less costly. You may agree or disagree with that. That's what he said. That's the concern he would raise. I think he hasn't really honed in on concerns that other people might raise.



That's the one that he lends credence to. So that's one that --

MR. ROBEDEAU: Okay. That's an issue that he has put in.

MR. THOMAS: The Provider Board needs to address that and figure out what its response is.

MR. ROBEDEAU: Along with it, and the proposal put in with the EMS office, and increases response times by 50 percent. How much is that worth?

MR. COLLINS: Hm?

MR. ROBEDEAU: Goes from eight to 12.

MR. THOMAS: I'm saying that's what he -- there's all sorts of ways to deal with what Bill has recommended and to criticize it or agree with it, whatever. It's significant that's the real concern that he is addressing with the single provider proposal.

I agree with you that you need to somehow separate out other changes from the single/multiple provider issue and deal with the rationale for his recommendation and how the Provider Board agrees or

disagrees with that.
And I do agree actually that it is good to require the proposer of a system to tell you what the rates are going to be, because I think that actually is a test when you start pinning somebody down to that extent of how secure they feel about the result being what they've predicted, because it gives them something to be held accountable for in the future, and I feel that that's really important.
I suppose the answer to that would be, if Bill can't do that, somebody else can do it for him and say, we did the calculations, here's what's the rates are going to be in your system. If your basic assumptions are right, are you willing to stand by those? That's sort of the way I deal with that, if he doesn't want to do it himself, or if PAPA doesn't want to do it themselves.
I know you and your list tried to guess other things that people have raised as issues, and actually I think the things you've listed are things people have said



over time. I don't think they've talked about how what they're proposing is going to respond to those.
MR. ROBEDEAU: That's exactly my point. When I was looking at this -- I'm not really trying to get after Bill.
I hope you really don't think I am.
But, when I sat down, I said, you know, all I'm doing here is guessing.
MR. THOMAS: He's not raising those other issues, though, really. I think he alluded to --
MR. ROBEDEAU: That was the point of this, that says, what are the corrections or the criticisms that have been raised about Multnomah County's system, so we could have it today to compare to what I had. And maybe possibly Bill misunderstood what I was saying. What we got back were proposed changes rather than articulated shortcomings of the current system.
MR. THOMAS: I agree with that. That's why we've had this dialogue with him.
MR. SKEEN: Pete, can we jump to this,



because I think it fills in some blanks.
MR. ROBEDEAU: It has to because this isn't going anywhere. I think Mark has some things.
MR. DRAKE: Let's jump to that.
MR. ROBEDEAU: Can we take a five-minute break, please.
(Recess.)
MR. ROBEDEAU: Why don't we call the meeting back to order. It's 10:30.
Trace did an ASA plan components comparative analysis. Trace, why don't you explain everything you did. Looks like a good job.
MR. SKEEN: I gave most of you, might have been a little bit short, but I gave most of you a copy I had filled in the yeses and nos and one copy that's blanks for future reference.
What I did is go through and pick up -- I used Pete as an outline and picked up all of those. Under the "current," the premises I've taken there is, do we currently have data on those issues or can we reasonably produce data on those



issues. The next, EMS-1, tiered; PAPA-1, single dedicated; EMS-2, single-provider system, one two and three, and you see my indications whether I thought those issues were decreased in either of those.
Now, what you'll see in Bill's prelude to his plan was I think some comments about there being too many paramedics in the system. It's mentioned but it's not addressed in spelling the plan out as to how many paramedics are going to be there.
Second one is paramedic negative turnover. Yes, I think we can come up with those. Bill addressed those as an issue; PAPA did not. You can go down through there and look at the various issues.
Now, I'll tell you, my yeses and nos, certainly a number of those could be argued and I also probably could be easily swayed on a position. But it was just a quick-and-dirty indication of whether I thought they had been addressed.
My sense is that this, with some additions here probably, provides a good template for us as a Provider Board to



address in looking at these various plans and be able to make recommendations, either a majority or a majority and minority or whatever.
But I think that this also needs to be -- something similar to this needs to be presented to the Board of County Commissioners, to MAB, or to whomever, saying that we think there's still some pretty big holes in this process.
I tend to be a little bit defensive where Bill came from because I think he got cut short in being able to spell out how his various options -- what they would look like, numbers of paramedics, numbers of unit hours, utilization, costs associated with them, so forth. Because of being cut off short, he's had to make some assumptions.
So that's basically where I'm coming from with this.
MR. DRAKE: I think it looks good, Trace. I think as we go through this, we may want to add some things to this.
MR. SKEEN: I already picked up one as



the county QA process and second is a cost-benefit process.
MR. DRAKE: Also, under "staffing," you have a staffing as a general category. I think that's what we talked about last time. We should look at staffing on transport units, first responders, and so forth, because there's several different optional models of what that staffing will be and what it would look like.
MR. SKEEN: Yeah. That comes back again, Mark, under "cost," I suppose, because under six, staffing, was it addressed under the plans? Yes. We know what we're doing currently. When you go down to cost with staffing, were the costs of staffing addressed? No, they weren't, based on what you're saying, the various configurations.
MR. DRAKE: You have costing -- staffing is addressed in all the plans, but I don't believe the PAPA proposal addressed the staffing of the first responders at all, to my knowledge.
MR. SKEEN: That's true.



MR. DRAKE: So we separate that out between first responder emergency providers and nonemergency providers, then that would be helpful to us.
And also on response times, you did break that out here, but do we want to look at response-time zones, because we've discussed that, ran that around the block several times? I think it should be in here.
MR. LAUER: I agree.
MR. ROBEDEAU: By response-time zones, you're referring to new ones that have been developed?
MR. DRAKE: New ones being proposed, Pete. Some propose, some don't, and how do they propose them. I think both the plans

actually propose some response-time zones.
MR. SKEEN: Bill has indicated he intended to do that as well, but it was not addressed in the plan.
MR. DRAKE: We understand this is a draft, Trace, so please don't take these comments --
MR. SKEEN: No.



MR. DRAKE: Under "communications," I think all those as well, we haven't talked about how the calls are to be turned over to the emergency provider. There's a proposal by Bill that they be directly dispatched, but in addition I think we've also talked before about the electronic transfer, some of those other options that may be available and how they're addressed.
MR. SKEEN: But once you start dissecting that, you come up with two pages in and of itself on the process.
MR. DRAKE: I don't want to get into that. I think that is important, that we look at that, how the units are dispatched.
MR. ROBEDEAU: I honestly don't believe that is going to make any difference.
MR. DRAKE: It does make a difference in the cost, Pete.
MR. THOMAS: Whether it will or won't make a difference is something to discuss, I suppose.



MR. DRAKE: I think there is some cost differences though. Number of primary providers, can we add an F for air?
MR. ROBEDEAU: Mark, why don't you stop -- I only have one correction on this.
MR. SKEEN: I'll take this back and modify that and send it back out to you, if you like.
MR. DRAKE: Also, under "cost," can we put other system cost, that we may have some other options that we come up -- I think there's some other costs. I can't think of any off the top of my head.
MR. PHILLIPS: Supplies.
MR. DRAKE: They may be covered under unit-hour cost, but I'd like to put another system cost because I think costs -- for example, mutual aid provider, there's a cost to administer those people. May want to put those under "other."
MR. SKEEN: Mutual aid?
MR. DRAKE: M-hm. Disaster, haz. mat., those are all costs of the system.
MR. SKEEN: Is it something that's



going to change substantially between system design?
MR. DRAKE: There may be some differences, Trace, when you talk about tiered response versus private provider. I think there may be some differences.
MR. KILMER: I'd like to suggest that many of these issues involve -- many of these categories involve issues that are not really in dispute, or that are beyond the province of the Provider Board to comment on. Haz. mat. and all that stuff, it's not something we need to get involved with, it shouldn't waste a minute of time dealing with. We want to avoid being subjected to the same criticisms we have of the MAB: going way beyond their area of expertise.
MR. ROBEDEAU: Is that a requirement, though, to be addressed by the state in an ASA plan, Bill?
MR. COLLINS: What's that?
MR. ROBEDEAU: The haz. mat. and --
MR. COLLINS: Yeah. But all that's being addressed in those areas -- first of



all, the state requirement, they talk about disaster is really mass-casualty planning. That's all they've told us. And all the plans require is to give some definition as to what you mean by these things.
I agree with Mark. If you really want to get down into it, spend a lot of time, you want to find out all the costs, billing mutual aid and stuff. That's not going to matter what gets put in place, I don't think. I don't see how the system design would alter that very much.
MR. SKEEN: The mutual-aid issue, Mark, I think my intent was under No. 9, system overload capabilities, that's where I was trying to pick that up, is to what resources do we have available, our cost associated with them, who will it be with, level of service, so forth.
MR. PHILLIPS: Trace, can you state again your definition of "current."
MR. SKEEN: It's really pretty loose. It's, one, are we currently addressing it? Do we have data that we can make a determination of what that is? Or can we



reasonably obtain that data?
For example, the negative turnover employment, as of -- unfortunately, you missed last week, but as of last Thursday, I don't think there was an agreement about what that figure was, but there was an agreement that it could be certainly obtained more accurately. Bill addressed it in his plan, although it was argued.
MR. PHILLIPS: No. 10, Bill on his EMS No. 1 addresses ALS dedication, wouldn't you say?
MR. SKEEN: It does. Actually, both No. 1 and No. 2 were ALS dedicated systems, weren't they?
MR. COLLINS: All ALS or dedicated units?
MR. SKEEN: Dedicated units to the 9-1-1 system.
MR. COLLINS: No, we didn't address that. When we did the demand analysis, that was based on a dedicated -- we took out the nonemergency calls. But in the planning about this is what -- we didn't say whether the contract ambulances would



be dedicated or not.
MR. SKEEN: Under option two, the single provider, it says, the emergency response will be dedicated to that service.
MR. COLLINS: What page is that?
MR. SKEEN: 29.
MR. COLLINS: Of which side?
MR. SKEEN: The first section.
While he's looking that up, the other thing I ought to mention is item 14 on the cost-shifting impact, I purposefully made that into a large box because I think there's a lot depending on the scenario. I think there's a lot of impact and there's currently cost shifting. Currently the people who can pay, pay, the people who can't, don't.
Then we've talked a lot about the cost shifting of moving administrative functions within our current control centers to some other functions if BOEC does the whole thing and shifting costs to the nonemergency venue for dedicated systems and some of those type of things.



MR. DRAKE: So you just need some categories under that? Do you think --
MR. SKEEN: I don't know about categories. I think you probably go over into the different plans and probably try and list -- try and identify where some cost shifting would likely take place. And it may be good, it may be bad.

MR. DRAKE: Okay.
MR. PHILLIPS: Right above that on H, first response, I would go back to what your definition of "current" is. What does that mean?
MR. SKEEN: Whatever Gresham is doing as far as first responder, do you know what your costs are for doing that? I don't. You may. I don't think any of the plans identified what the costs would be.
MR. DRAKE: But I think, Trace, under "current," because you're saying currently can we identify that, I believe we can identify that cost.
MR. SKEEN: May be able to.
MR. DRAKE: I don't know if we can identify -- let me back up -- all of the



costs. We may be able to do it in the urban growth area. When you're talking about Corbett and Skyline and district 20, I don't know if we can pull all of those out unless we tried to contact each one of those departments and tried to find out what their cost is.
MR. PHILLIPS: That goes back to the last time I was here, got on my soap box and left, not intentionally but that's how it occurred, by looking at fire's cost, I'm certainly willing to discuss that, and if we can provide you with a paramedic on every incident, what's that going to do to your cost? So if we explore that and look at that, what's that going to provide to you?
MR. SKEEN: Exactly.
MR. DRAKE: Part of that is a cost shift.
MR. PHILLIPS: Right. People are paying for -- the supervision of that paramedic is already paid for because he's also a firefighter on that engine, so that's covered. We typically have less



costs because that's only a portion of that paramedic's job and that structure is already there. So for us, if we add nine new paramedics, there's already the supervisors there to manage that. The system's already there. So there's not a need for nine plus one additional supervisor.
MR. ROBEDEAU: But in an EMS system, those paramedics are going to have to be dedicated because in the event of a major fire plus a major -- a mass casualty incident, possibly from that same fire, those individuals are going to have to either be firemen or paramedics, and in a system where the fire bureau took over response to the criticals and time-critical transports, those individuals are going to have to be dedicated to EMS. Therefore, there is a great deal of additional cost, I think, in that dedication.
MR. PHILLIPS: You're talking tiered response and I'm talking first response. I'm talking first response, have the first responder have a paramedic there to help



you.
MR. ROBEDEAU: I'm talking tiered response and transport.
MR. PHILLIPS: The engine is going to be their first response. Having the paramedic there, isn't three or four thousand dollars to have that paramedic be there; it's the additional amount of his pay, which is $300, probably, around that.
MR. ROBEDEAU: Okay. That's fine.
MR. PHILLIPS: If that allows you to only come out with one paramedic on your ambulance, there's a system savings.
MR. ROBEDEAU: There would be a system savings, but we have several plans to look at. EMS No. 1, which is a tiered response with a paramedic transport, would have to put in some additional public cost, and exactly what that formula would be for figuring that out, I don't know, but it would have to be there.
MR. COLLINS: That's not first response. That's another cost.
MR. ROBEDEAU: That's your plan one.
MR. COLLINS: Right, but that cost is



not down under first response. First response is a different issue.
MR. LAUER: But the differences in first response would be paramedic, first response would cost more than nonparamedic first response, and you can identify that.
MR. PHILLIPS: Right. Basically, what it boils down to, my taxpayer pays an extra 20 cents per thousand, if that, or if anything, to enjoy a $100 reduction in his transport bill, whoever provides the service, tiered, single provider, whatever. That's when you get down to looking at the system and merging the system together.
MR. ROBEDEAU: Is there any additional?
MR. COLLINS: You did add QA or something down there?
MR. SKEEN: I added countywide QA and cost-benefit analysis, which I guess I would say is questionable as to whether that's the place for it.
MR. ROBEDEAU: Where did you have that?



MR. SKEEN: I wrote it in just a few seconds ago.
MR. ROBEDEAU: As 19?
MR. SKEEN: Yeah, 19, 20.
MR. DRAKE: You adding QA under cost?
MR. SKEEN: I added it as a separate item.
MR. LAUER: That's a significant -- including quality improvement?
MR. DRAKE: Yeah. I think there should be a category under cost for QA, QI.
MR. THOMAS: Trace, I know you have paramedic skills proficiency. Is that an issue where unit-hour utilization ratios would compute?
MR. SKEEN: No. Unit-hour utilization is actually transport utilization.
MR. THOMAS: No. 5. Okay.
MR. SKEEN: It's interesting, we can come up with critical-patient frequency. That's pretty easy to come up with if you look at the number of emergency transports to the hospital. The paramedic-skills proficiencies is probably a little more



difficult to come up with.
I don't know how you track yours, Barry, but we can -- we're kind of halfway between automated and manual at this point and actually charting the number of IVs and fibrillations and intubations per person, per individual. I think if we wanted to do a lot of research, we could probably go back and pick that up.
Then the ones you see where there are blanks where I didn't put yes or no, those are ones where I chickened out.
MR. PHILLIPS: Caved in to your own pressure.
MR. SKEEN: That's right.
(Laughter.)
MR. THOMAS: So would you suggest you do the revised thing and get it out and people fill them in the way they see it and then the group discuss any differences they have and how to report this?
MR. SKEEN: We could do that at the pleasure of the chair. I'd be happy to do that. I think that's probably a start, to see how much agreement there is with this.

I think this also in some form, perhaps not this one but in some form, I think this provides a basis for saying, these are the items that need to be looked at under any system design, including current, single provider, multiple provider, tiered.

MR. ROBEDEAU: I think it's a good idea to go ahead with this the way it is, only have the providers start putting in Provider Board recommendations, the members of the board.

Under number of paramedics in the system where it says current, we know what they are. That's what you're saying, we know how many currently are here?

MR. SKEEN: Reasonably so, yeah.

MR. ROBEDEAU: Under EMS No. 1, we don't know how many they're asking for, PAPA-1 we don't and EMS-2 we don't. I think to come down to the end, in an ideal system, how many should there be. That's kind of a shot in the dark.

MR. SKEEN: But I guess on that, Pete, what we probably need to do, rather than have the whole group do it, we probably



need to make some assignments to people to flesh out how a tiered system should look and to flesh out the PAPA single dedicated system, which actually I don't think there's a lot of difference between your option two, Bill, and PAPA-1.

MR. COLLINS: From an operational -- that's not true. The major difference is their single dedicated system also will be transporting all ALS transfers. That's a major difference.

MR. DRAKE: Right. They do all ALS.

MR. SKEEN: But until we can flesh out a tiered system or even a single-provider system, I think some of the committee work that Mark and Barry, Randy were involved in, probably has done a lot of that work.

We're still -- at least I'm still groping to determine how many unit hours there are going to be, what the efficiency of that utilization is going to be, how many paramedics are going to be involved, whether it should be a one-and-one staffing versus two-paramedic staffing? Are we going to have to defer cost that we



currently can incorporate across a broad transport scheme to push some of those down into the private business arena?

MR. COLLINS: Actually, in the single-provider option in our plan, you can count the paramedics. We've got unit hours. You can count them, you know, off the schedule.

MR. ROBEDEAU: I think what Trace is saying --

MR. COLLINS: A tiered one you can't. You'd have to figure out what the tier is going to be.

MR. ROBEDEAU: You call for a 39,000 reduction, 39,000 unit-hour reduction. I think what Trace is saying is, is that really correct?

MR. COLLINS: Huh? You're asking -- you're looking at -- I'm just saying, you're looking at a plan option. In that particular plan option, you can take the number of deployed unit hours according to the schedule, and if you've got two paramedics on every rig, you can count them up, you can figure out what that number



is.

MR. SKEEN: That's that 89,000 unit hours, which you have in there.

MR. COLLINS: Whatever. You can count that one out. That's one where you can -- whether you agree to it or not is a different issue. You can count that way. You can't really count the PAPA plan, unless you know how many transfers they're talking about, because you have to figure out what the staffing requirements are for the transfers, and you can't really do the tiered system unless you know what the tier numbers are and what the deployment requirements are for 12-minute response for the other half. You'd have to do all of that work in order to come up with a number of paramedics.

MR. SKEEN: To your knowledge, has Portland Fire Bureau conducted any kind of planning that fleshes that out?

MR. COLLINS: Well, that's -- they have that tri-data plan, but I don't know whether that's fairly sound or not. I can't comment on whether it's any good or



not.

MR. LAUER: It's not.

(Laughter.)

MR. SKEEN: There's some assumptions there --

MR. COLLINS: Right. You ask if they have done anything. They have done something.

MR. THOMAS: The last discussion reminded me of a question. I thought the group had asked Bill -- maybe it wasn't clear -- if it could get from you -- this has to do with the 89,000 hours and the Starburst program or whatever it was you did.

The assumptions that are built into the sort of computer program, you ran that through to arrive at that number and any assumptions that you pumped in to that, because I know the group feels like that number is wrong and they want to try to analyze how a program could kick out that kind of a number.

MR. COLLINS: That program didn't do that. All we did with that program to date



is to look at the geographical coverage on a unit-by-unit basis. I'm having to take some extraneous out of the program. I don't mean extraneous from Multnomah County. There are too many links to do that, and to do the best fit, it won't run very well. We're fiddling around with that.

For what we did in the plan, that was just saying, you know, if you put a unit here, it covers this area; put one here, it covers that area. It had nothing to do --

MR. THOMAS: Let me put it this way: You started with data which I think was by and large agreed on, a set of data, and there was some manipulation done to the data that produced the 89,000 hours at the end. And I think the group wanted to understand how it got from the original data to the end figure and to be able to see exactly what the process was it went through so you could decide whether you agreed with it or not or whether there was a flaw, where it was.

And somehow I think there needs to be



a way for the group to find out what the manipulation was that the data went through and arrive at the conclusion. Is there some way to do that?

MR. COLLINS: It didn't go through any manipulation.

MR. DRAKE: It did. It went through a set of assumptions. You went from a system currently to a 9-1-1 only use.

MR. COLLINS: We did that in the work group.

MR. DRAKE: No, we didn't.

MR. COLLINS: Yes, we did. That's where all the figures came from.

MR. DRAKE: No, Bill. Sorry. No. What you asked the group, when I left that meeting, unless I alone left earlier than

everybody else did, clearly you asked us, you said, give us an idea of going from a single-provider system to a 9-1-1 dedicated system. Is that correct?
MR. SKEEN: From single provider to dedicated multiple?
MR. DRAKE: From multiple provider to single-provider system only dealing with



the 9-1-1 calls.
MR. COLLINS: Right. We decided we couldn't deal with the 9-1-1 in doing the analysis because the units were split. You did not have one homogeneous group of units that were providing both sets of calls. So we looked at the data on the calls and did the demand analysis on the 9-1-1 calls. Right?
MR. DRAKE: Tried to pull out just those 9-1-1 calls only.
MR. COLLINS: It's not a matter of just those 9-1-1 calls only. They're listed.
MR. DRAKE: We currently staff our ALS units -- to respond to 9-1-1 calls, we staff those unit hours for response to nonemergency, emergency, and interfacility transport. Right?
MR. COLLINS: Right. Okay. So?
MR. DRAKE: So what you did, took those figures, the three providers, and said if you go to a 9-1-1 dedicated system only under a single provider, that you're going to save 39,000 unit hours. Is that



correct? Is that right?
MR. COLLINS: That's right.
MR. DRAKE: Okay. What I have said from the beginning is, you are comparing apples to oranges. You haven't asked us to go from a current three -- now two providers and comparing just the number of 9-1-1 unit hours that we would put on the road between the two providers to the single provider going to 9-1-1 -- responding to 9-1-1 calls.
That's the problem. You took a system, and then you kind of created a system over here that doesn't exist, and you took numbers from a current system and current set of assumptions to a new set of assumptions, and you're comparing apples to oranges there.
MR. COLLINS: The numbers are the same. I don't agree with you at all. 9-1-1 is running --
MR. DRAKE: You're making an assumption you're going to save 39,000 unit hours from the current system to the system of just responding to 9-1-1 calls. That's



an unfair assumption.
MR. THOMAS: What I hear Mark saying is, you could take a multiple provider system with dedicated units and say, okay, if you had only dedicated units could you put on 9-1-1 calls.
MR. COLLINS: You could do that.
MR. SKEEN: If you want to look at the overall system, assuming these numbers, Mark, you provide to him, unit hours, is that your existing operation unit hours that covers all of those calls?
MR. DRAKE: Wait a minute. I don't know what figures you're looking at, Trace. We were asked to provide -- first off, we took the total number of unit hours in the system. Okay?
MR. KILMER: Emergency or nonemergency?
MR. DRAKE: Emergency or nonemergency and interfacility. The problem is he says you're going to save these unit hours and therefore you're going to save this cost.
MR. SKEEN: I think this is an important analysis. What you show,



essentially you're going to do all the nonemergency work with 39,000 hours, and I don't know if you can do that or not. Drake's right.
And, No. 2, he's making an assumption you're going to save that cost. What I'm saying, you're not going to save that cost. You're going to shift it to another place. Actually, as to whether you have cost savings, you may not have cost savings; you may have cost increases because you're dedicating units. You have to do that, Bill.
MR. THOMAS: I think what we need, this helps me, is a write-up of what it was that was done so that -- because you guys sat in on the meeting, but there's a lot of people. That 39,000 hours is a very important piece of something, especially in Bill's recommendation and what people might understand it to mean or not to mean.
I think people need to know what was done to arrive at that figure and what that figure represents and what it doesn't represent. And I think that needs to



really -- that's really important because that's where the big money is in his proposal, so people can then evaluate, you know, exactly whether it's a saving or a transfer or what is it.
MR. LAUER: We've had this discussion before. I think there's a way to proceed from here, though, and the way is, you asked the individual providers to send to you, during the period we identified, which had a number of weeks --
MR. COLLINS: 30.
MR. LAUER: 30 weeks. -- number of 9-1-1 calls we responded to. Correct?
MR. COLLINS: Right. The data we got was calls by hour, hour of day, day of week.
MR. LAUER: We submitted a number of 9-1-1 only calls we responded to. This doesn't have anything to do with unit hours. Then Bill took that information and combined it to arrive at the number of 9-1-1 calls in the EMS system, in Multnomah County, by hour of the day and day of the week, and did a demand analysis. That was



done.
Barry, you were there. You agree that was done right?
MR. DRAKE: Just a minute. That was based on a demand analysis based on numbers only. It had nothing to do with geographical demand. We did not agree that was done right.
MR. LAUER: Okay. Let me continue. That volume demand analysis should be accurate, and Bill's got that information together. What we did then was we prepared -- we each took a shot at preparing staffing configuration that would cover those requested hours and then you get the number of hours you need to produce to run those calls by hour of the day, day of the week. Right?
MR. DRAKE: Right.
MR. LAUER: We did that systemwide. What I suggest we could do now is look at the individual numbers we sent to Bill, the same exercise, prepare a staffing configuration for each of the three ASAs we have now.



MR. DRAKE: Two ASAs. We're going to two.
MR. THOMAS: Do it with both.
MR. LAUER: Either way. That will give us a comparison of our current system, which currently has three ASAs, a system that's on the horizon that's going to have two ASAs, and a single-provider system, and

the number of hours that will need to be staffed to respond to those calls, and you can compare those systems to other.

MR. KILMER: You're ignoring the fact, while you may have two providers, you also are going to have a system dispatched as a single system. Now, the only reason there would be any difference between the outcome of what you're proposing with two providers and the outcome of your study, the two providers, and what you'd have with a single provider would be that the artificial district boundary that would remain would somehow increase its number of units.

Once you get rid of that assumption, you're going to have dispatch as single



system, and you're looking at emergency systems only, you're going to have the same number, one or two.

MR. LAUER: It would appear that way, but it's not. The reason it's not is the size, the volume of calls. You have to staff in excess of the requested hours.

MR. KILMER: To do what? To do the private work?

MR. LAUER: To cover the hours. This has nothing to do with the private.

MR. DRAKE: He's right. To do the staffing correctly --

MR. KILMER: You'd have to do that whether you have one or two.

MR. LAUER: That's right. My point is, two providers have to staff excess hours to cover that demand. One provider would have to provide excess hours to cover that, also. It has to do with size and volume of calls. The excess created by two providers individually, the sum of that excess typically exceeds the excess of a single provider.

MR. THOMAS: Let's find that out.



MR. KILMER: How would you prove that?

MR. LAUER: You can prove it by the process I just proposed.

MR. THOMAS: Let's find it out that way, and then you can find out, if there is a difference, then is there something you can do with dispatch to correct that difference. But let's find out what the size of the difference is first because I don't think we really know that.

MR. COLLINS: You're going to have two differences that are going to come up. Aside from the geography, you're going to have -- well, one is the geography because you're going to have whatever the difference in staffing requirements to meet the demand on a volume basis, and in theory the larger the volume, the more you have ability to move units around, the less that overstaffing would be. The other, then, would be the fact that if you have two areas or three areas or four areas, what it takes to meet the response times given the lines.



MR. LAUER: Right.

MR. COLLINS: That's always a factor no matter where the line is. If you have a single unit in Multnomah County and if you only had part of Clackamas County, you'd be able to get some more -- it keeps going. You're going to have some economies.

MR. THOMAS: Theoretically, if the United States was one ASA, I suppose you'd be at maximum efficiency. I don't actually believe that's true.

I think what Randy has proposed is a good idea, to get in mind the scale of the problem, and then you can look at if there is a significant difference or when -- No. 1, is the only way to eliminate that difference to have one ASA? Or are there

things that can be done and how dispatching is handled and how permeable the boundaries are between the ASAs as a way to handle that?

And I think that begins to hone in on that question of how many are you actually saving and, if so, how many unit hours between configuration A and configuration



B?

I think it's just, do the same thing -- I think he's right -- do the same thing within the multiple ASAs that Bill did for his single ASA using that as a concept.

MR. SKEEN: Are we going to have each of the providers go through an exercise to come up with those assumptions?

MR. LAUER: Bill's already got that data.

MR. SKEEN: You guys did that on a single ASA, the number of unit hours to be required? You've already gone through that?

MR. DRAKE: For 9-1-1 dedicated calls only.

MR. SKEEN: Excluding ASA facilities --

MR. DRAKE: We're not.

MR. LAUER: -- for this analysis.

MR. DRAKE: For this analysis, that's right. I think overall we have to look at the system as a whole.

MR. SKEEN: At some point, you have to look at how many units hours it would take



to do a single ASA 9-1-1 system, apparently looking at a newly dedicated system for 9-1-1 system. You also have to look -- if you're going to dedicate it, you have to look at the private side, because the costs he doesn't care about, but they are costs that affect --

MR. COLLINS: The reason we do not look at it is because the units we were looking at don't provide all the service on the private side. So if you're really going to look at that, then every company is going to have to come up with their total nonemergency volume from all the places they have it, and you're going to have to do it as a whole system. You can't chop off a chunk of it right like you do now.

MR. DOHERTY: We did look at the nonemergency calls that the emergency units ran. So we knew that.

MR. SKEEN: There's an additional.

MR. THOMAS: You'll reconfigure --

MR. KILMER: We did that at your request.



MR. DRAKE: You asked us to do that.

MR. KILMER: Our whole criticism -- your methodology, Bill, is this: that you have taken a whole system, emergency and nonemergency, you ask these guys to carve out the emergency and to estimate, to some extent, the costs associated with only that part, even though they don't keep their books or anything like that. Then you took that data, you defined that there are certain unit-hour savings without recognizing that the method that Randy described applied only to -- ignores the amount of time those unit hours are applied to private work. That always understood that in addition to those 39,000 hours, other hours were also devoted to private work that weren't in the initial study.

In order for the analysis Randy is talking about to really be any good, you have to do it not only with respect to the emergency calls, you also have to do it with the nonemergency calls, and then you have to take a look at the unit hours of nonemergency, unit hours of emergency, run

separately, and then take a look at what those unit hours are total compared to what it is today.

Only then will you know whether there are efficiencies from running emergency and nonemergency, and only then will you know the tradeoff that is inherent in that, in terms of any reduction in utilization ratio, in terms of patient contact ratios with emergency patients only.

MR. THOMAS: I think what Randy and Trace together are suggesting, we actually ought to go through that drill so you can actually figure that out as best you can.

MR. LAUER: There's two things you can do. You can compare the current system to another set of systems, or you can compare these proposed new systems and compare them to each other and exclude the current system. That was what I was advocating.

MR. THOMAS: Propose new systems where you have multiple providers but dedicated ALS.

MR. KILMER: You've got to compare both with the current system in order to



know whether all the trauma of change is worth the benefits.

MR. LAUER: That's a broader comparison. We can also do that too. This is extremely time-consuming, and if we're going to do it, we should take it a piece at a time.

MR. KILMER: Our bitch is this all should have been done years ago before we got up to debating plans. This should have been done before anybody came up with it, instead of having to be done in the context of demonstrating why the planning process is flawed.

MR. ROBEDEAU: I think part of what we're doing here -- I'm going to interject --

MR. KILMER: That's why we need an extension.

MR. ROBEDEAU: -- we're missing the point of what economics of scale are, what it is. No. 1, it's a manufacturing term that's been tried to be applied to a service industry, but everything I have read, every study I have seen done,



everything that has to do with economics of scale in the ambulance industry involves the same unit, the same unit hours being used for emergency and nonemergency transport in order to fill up that time that's needed, you know, where you are getting -- Trace kind of took a breath.

If you have something else, I'd sure like to see it.

MR. SKEEN: I'm taking a collective breath for the whole process.

MR. ROBEDEAU: We've missed the whole thing with what economics of scale really are. Everybody knows that this is a hit-and-miss industry, and on the days that we aren't doing anything with the emergency units, they're filling up their time and therefore creating savings by doing the nonemergency business. On the days they are busy, the nonemergency business is set back. The appointments are changed by the dispatcher. All of this is being done in order to create the economies that come with a whole system.

And that's the thing that's been



missed here, and that's the thing that needs to really be looked at, is what, if any, savings. And I think this is what Mark has been saying, but we need to keep in context how economics of scale are applied to the ambulance industry.

MR. SKEEN: But, Pete, you can't do that unless you spell some of these plans out.

MR. ROBEDEAU: I understand that. That's what we need to look at, is the fact that some of these plans -- the PAPA plan, the EMS plan, that and the different proposals are touted in economics of scale and that's something that's been tossed around for years and years and years and years on how good this is going to be, and all of a sudden they come out and say, here you're going to get all these savings; however, we're going to exclude everything that gives you the savings.

MR. DRAKE: Every analysis I've ever looked at in the system looks at the cost-benefit analysis, if you will, and the benefits of having those units run all



types of calls, Tulsa, Oklahoma City, all of them.

MR. SKEEN: If American Airlines said, we're going to run certain flights for business travelers only, we're going to run other flights for leisure travelers, what's going to happen to cost of doing that?

MR. DRAKE: It's going to go up.

MR. SKEEN: Same concept. Still goes back, who's going to do that? Is everybody going to take their shot at -- I've got to tell you, if I'm Portland Fire Bureau and I've seen a plan like this come out, what, six weeks ago, when these unfolded, and I saw someone committing me in a proposed option to a certain plan, I would expect that they have done some work.

Tom's not here to comment on it. I hate to go in and do the work that Tom should be doing on what it's going to take to do an eight-minute response, 90 percent liability, with 11s, 223 L-24 transports. That's got to be done before we can continue on and really do the analysis on all this.



MR. DRAKE: I agree with you, Trace. All these analyses need to be done. We need to analyze the costs, because we have done this out in Clackamas County. That's what Clackamas County, John Hildner, promised. He said you're going to take units that run just 9-1-1 calls, and you've got to recover the entire cost of 9-1-1 units just off the 9-1-1 costs. We all told him, all the providers said, you're crazy, you're going to raise the cost of providing calls to 12, 1400 dollars a call.

MR. KILMER: Requiring bills of over 2,000 a call.

MR. THOMAS: Maybe you've done the calculations, but you sound guilty of what you accuse people of other -- proponents of other plans of being guilty of, which is you're making the statements but we haven't done the derivation to demonstrate its truth.

MR. KILMER: We're pointing out issues that need to be studied because there are -- so much of our experience suggests that those studies will demonstrate the



problems of unrealistic assumptions underlying these plans.

MR. THOMAS: I'm saying, let's do that. Is there a reason why we don't want do that?

MR. DRAKE: That's what we need to do.

MR. SKEEN: My fear in this process, lacking that information, people will make decisions to proceed.

MR. KILMER: That's my fear. That's the reason we've pled for years to have a process where this information is developed before decisions are made.

MR. SKEEN: So we're going to flip a coin to see who does this orchestrating?

MR. KILMER: Everybody is going to have to take stab at the first analytical

plan.
I tell you, people are going to come to this, get together, all three different people will start from different assumptions, different data. We'll have to figure out how three people who don't know about this stuff can come to a common measuring point that will demonstrate the



problem that permeates this whole process. We haven't defined, measuring points.
MR. COLLINS: Looking at what you're proposing to do. I agree with Randy. You need to bite off pieces of this. If you want to look at the economies of scale, then you should look at your current total deployment and then you should do this for a single service, top to bottom, franchise.
MR. DRAKE: That's right.
MR. COLLINS: And see if that is cheaper -- if you can show the economies of scale. And if you're following what you're saying, if your presumption is right, then a top-to-bottom single-provider franchise is going to be cheaper than multiple providers. It's just -- that's what you've said.
MR. KILMER: It doesn't follow.
MR. COLLINS: Sure it follows. It follows exactly. If what you're saying, economies of scale is based on volume and that you need to run your units to take both emergency and nonemergency --



MR. KILMER: It means a nondedicated system will be cheaper, but that nondedicated system will be a single- or multiple-provider system.
MR. COLLINS: Why would that not follow? I think you need --
MR. THOMAS: I don't think the information is there to know the answer to that question.
MR. COLLINS: Sure it is. Why isn't it?
MR. KILMER: You're make assumptions here what you should have studied.
MR. THOMAS: Here's why. I think I can tell you why. There's a level of calls that you need to have in order to not have units sitting there doing nothing longer than they need to and still meet the response time requirements.
There's a number -- I don't know if it's 1,000, 2,000, 3,000, 4,000, 5,000 calls -- spread over time. There's a point at which you reach a sufficient number that you are about as efficient as you're going to get. It's sort of like then you can



have an area next door and when you reach that number, that's also efficient. And combining the two doesn't necessarily increase your efficiency. That's what I was saying.
I don't think it's correct that the most efficient ASA in terms of even unit hours is the largest. There's a point at which you haven't improved things by adding more, you've -- it's sort of the efficiency goes like this and then it levels off.
The thing we don't know is, where does it level off? Because it may be that it levels off in a smaller ASA than the total county. And I think by doing this, breaking it down for the smaller ASAs, what you'll find out is, how close are we to the point where it would level off, or are we there where it really doesn't make a difference?
MR. ROBEDEAU: That's one of my questions. Bill had mentioned earlier, at some point economics of scale begin to diminish. I have never seen anything that says where that is. I know there is a



point, but I don't know where it is. Do you?
MR. COLLINS: No.
MR. THOMAS: I think if they do the breakdown the way Randy suggested, we'll begin to get at that.
MR. LAUER: The problem, Chris, we may not get to it because the end result is going to be whoever does this will make an argument that it was done correctly because the bottom number is going to be how many unit hours do you have to deploy to do two things: to respond to all of the calls and respond to them within eight minutes, or whatever the response time criteria is going to be.
It's going to be based on assumptions, on guesswork because you're going to have to create the system status plan that's ultimately going to determine how many unit hours you have to deploy. That's going to be subject to all sorts of debate. I don't think we'll ever have an answer.
MR. KILMER: No projections can ever be made without making some assumptions.



Any analytical process is adopted to reduce the number of assumptions and maximize the number of hard data. To the extent you're making assumptions, you narrow the range to which those assumptions can be shaky. You can't write off this process for an alternative to another process because both have assumptions to them.
The process you're talking about and Chris is talking about will result in a program that is based on much less than assumptions, and those assumptions leave a much larger margin of error than the one we're devoted to now.
MR. LAUER: My only point is we won't completely erase --
MR. KILMER: You will never do that. That's not a criticism. That's something that explains why you have to have a study, the very thing we've been crying for.
MR. LAUER: I agree. We can narrow it.
MR. THOMAS: How is this going to happen?
MR. ROBEDEAU: That's just exactly



where I'm coming back to. What are we doing for the next meeting?
MR. DRAKE: Pete, for the meeting on Thursday, we are not going to be able to do this analysis by the next meeting on Thursday. There's no way.
MR. ROBEDEAU: Exactly what is the analysis? We have kicked this around so much that I am now confused as to what we're going to be analyzing.
MR. LAUER: What I'm proposing is that Bill has the raw data that is -- the information -- the data the providers submitted individually and that he combined, simply added it up, and we use that as the basis for the volume of determinations.
MR. KILMER: For emergency.
MR. LAUER: Just for 9-1-1 calls. I think it needs to be done probably, and bring it back to the subcommittee that looked at it the first time, that never got to that analysis, Mark. We actually talk about that, that will be the next step there. So maybe go back and do that step.



MR. DRAKE: We do need to go through that process of taking -- I'd say two or three ASAs, let's say two ASAs, and developing the number of unit hours dedicated to 9-1-1 calls under each provider.
MR. ROBEDEAU: What I'm hearing here, without an extension, there's no way this

is ever going to get done. Unless we get an extension, I don't see any point in even moving on with this unless somebody else has --

MR. THOMAS: I do, because I think the process, whatever they go through, extension or no extension, is a several-month process in any event. In other words, they're not talking about getting somewhere until July. And I think if we can do this at whatever point it is done -- the only possibility is they've taken the final action before we're done, and I don't think we want to take that long to do it.

I think whatever point that is done, that is information that can be made



available and will be useful to the County Commission.

I think, Bill, you know what we're talking about doing at this point. I would assume that you would be helpful in having them at least take a look at the comparison so they understand what your 39,000 compares to in a reconfiguration of the current system going to dedicated ALS.

I think you also ought to -- you ought to do that first. After you've done that, you, then, also ought to do, what would you have to do with BLS in that kind of a system? Sort of do the same kind of approach so that then you've got the whole picture Trace was talking about, which takes into account you're now having unit hours over here too, so you get the total picture of what are shifted unit hours and, if any, what are saved unit hours.

MR. LAUER: Right. We need to decide which ones to do first. It's a different analysis. Each will take a couple weeks to do.

MR. THOMAS: I'd do the dedicated ALS



first because I am very concerned the most prominent thing people are going to see in Bill's plan is 39,000 hours, and people need to understand what that is and what it isn't and how that -- they think you save all that because you go to a single provider. And what we've got to do is try to get that back in the correct proportion and say, actually, with multiple providers, if you do it this way, here's what the number would be.

I also think you need -- unless everyone accepts -- I thought Trace was saying before, he did his own calculation -- there's no way you could run even those calls with a 39,000-hour saving.

Remember you sat here and you came up with the calculation and came up with 140,000.

MR. SKEEN: Those are rough, but at some point in time we have to bite the bullet and do that.

MR. DOHERTY: Look at the schedule. I have serious doubts you can make response times in this country with seven units.



I have a question. We did provide information on our 9-1-1 units, the emergency calls they ran and the nonemergency calls they ran. My memory of that is that they were doing about 15 percent nonemergency.

Is that right? Do you remember, Randy?

MR. LAUER: I can't recall that.

MR. COLLINS: I can't remember off the top of my head. We've got the data, the files.

MR. DOHERTY: What I'm wondering, if we add that percentage to that rough schedule, what number do we come up with?

MR. ROBEDEAU: That would still be 20,000 hours under.

MR. DRAKE: We know what our current unit hours is for each company. All right?

So one test that we can do is take current number of unit hours that we both operate and, say, we ran a system, just like we do now, on the same number of calls by the same number of units, how many unit



hours would you have under a single provider, comparing apples to apples?

The true exercise is to take number of calls that Bill pulled out just for 9-1-1 dedicated and take current providers and say, if you had to run just 9-1-1 calls, how many units hours would you have?

MR. LAUER: I would say we do that.

MR. DRAKE: That's exercise one. The other is exercise two. Everybody agreeable?

MR. SKEEN: Mark, in Bill's plan, current hour deployment, it's on page 16 -- follows page 16 -- it lists the three companies, and it gives unit hours by day of week.

MR. DRAKE: Table three?

MR. SKEEN: Table two.

MR. COLLINS: That would only be accurate to the point we wrote the plan. If you've changed them now, they could be off. There's always a movement around.

MR. DRAKE: Ours is a little less now.

MR. SKEEN: Okay. Does this



represent -- is this a manipulation of what you would staff if you were doing 9-1-1 only, or is this what you're doing your emergency and nonemergency?

MR. DRAKE: This is current. This is what we're doing.

MR. SKEEN: Everybody's total?

MR. DRAKE: Yeah. That's been my complaint.

MR. THOMAS: Let me --

MR. COLLINS: Your complaint is what? These are not the right numbers?

MR. DRAKE: No, Bill, these are the right numbers for the current deployment. The complaint is, then, you compare that to a different type of system and say you're going to save this number of unit hours is wrong. You can't say that.

MR. SKEEN: What you're saying --

MR. COLLINS: I hear what you're saying. I don't agree with you.

MR. LAUER: The other thing you look at, too, you say this doesn't include other than ALS units. This is strictly ALS unit deployment hours now.



MR. DRAKE: M-hm.

MR. COLLINS: If you gave us the right numbers, these are the units that are deployed to answer 9-1-1 calls as well as do whatever else they're doing. It does not include an ALS unit that is used for transfer and it's not in the system.

MR. LAUER: That's correct.

MR. COLLINS: I have no idea what number. We didn't look.

MR. LAUER: That number probably -- it sounds pretty close to me. What Barry said, of those unit hours, 125,000, that possibly it may be somewhat valid to say that 15 percent of those hours are responding to the 9-1-1 calls.

MR. DRAKE: You can't use those hours, though, and then make a schedule out of that.

MR. LAUER: No. There might be a simpler analysis. It might be based on assumptions that are just as valid.

MR. SKEEN: Mark, are you running -- Pete, do you run -- we run BLS units above our Multnomah County 9-1-1 units. Do you

do those as well?
MR. ROBEDEAU: (Nods head.)
MR. SKEEN: We need those numbers somewhere employed to do these various analyses we're talking about.
MR. LAUER: For an example, on our table, our unit hour deployment was 55,016. What I can't find out is of all the calls that those units ran, which percentage was 9-1-1 calls and which percentage was non-9-1-1 calls.
MR. ROBEDEAU: I can tell you that.
MR. DRAKE: That's not going to get you anywhere because what you've got to do is take a demand for just the 9-1-1 calls and then build a schedule to meet that demand. It's not going to be a direct correlation.
MR. ROBEDEAU: Part of my problem -- can I get in a question I've been trying to get in for the last hour?
MR. SKEEN: You're the chair. Committee recognizes the chair.
MR. ROBEDEAU: On your Starburst study, I come back to this and I'm still



confused, and what you had here earlier gets me back to where I was -- Mark, don't go anywhere --
MR. COLLINS: Let me tell you what I did.
MR. DRAKE: Go ahead, Pete.
MR. ROBEDEAU: You took and put a unit at X spot and drew a circle around it and said, within eight minutes it can hit anyplace within this circle. Is that correct?
MR. COLLINS: Right.
MR. ROBEDEAU: Then you covered the whole county with those circles and said, that's the number of units we need, eight, ten, whatever it is, because these units can get from point X to any one up to Z within eight minutes.
MR. COLLINS: Right.
MR. ROBEDEAU: What did you do -- all of your assumptions here, then, are based on the fact that those units are always available when a call comes in within that circle.
MR. COLLINS: No, they won't always be



available because the workload will change. All I did was take the staffing pattern where it says -- I can't remember what the smallest number was, but it was seven or eight, and -- which is very comparable to sort of what our minimum is at this point, what the minimum where you can't take out units again, and looked to see if that number generally covered the county. Are we close? Are we off?
MR. DRAKE: We need to see. We need to see the geographical demand.
MR. THOMAS: Pete's question, I assume, if the unit in the middle of the circle is on a call, how does that circle get covered?
MR. DRAKE: Or that unit is not in that location.
MR. ROBEDEAU: Which is more important. If you have three or four of those units out, I don't understand what you've done, I guess, is my biggest problem. I think what you've done is to say, at point X and point X-1 and X-2 and X-3, all over the county, if you have a



unit there, it can make all of this area within eight minutes and then the assumption is that that --
MR. KILMER: That they will always be there.
MR. ROBEDEAU: Always be there and, therefore, you've cut the number of unit hours because you've made no allowances for that unit not being there and still making response time.
MR. COLLINS: No, I don't think the units were cut at all like that.
MR. KILMER: How were they?
MR. COLLINS: We did the demand analysis, and the schedule gave the number of units to run the calls, just like we have now. Now we have three -- I've got in my office now three system status plans that show, you know, what your deployment is over time, where you move the units to as the numbers fall down. All I did was to try to take what we did in that exercise and see if it matched up reasonably well with what we're doing now.
In other words, if we got down to



where the demand was two units, we don't have anything now where the deployment schedule is two units. We've stopped it at about seven or eight countywide. So it's not -- that's all it was, just to see if there was a reasonable match to verify, that, yes, the demand is reasonable given what we're doing now.
MR. DRAKE: Let me ask this question: Eight o'clock in the morning, the demand analysis shows seven units. You put seven units on the map. Is that correct?
MR. COLLINS: I didn't do it piece to piece. I looked at the low number. Right now, you can look at what we're doing right now, just count the units, and you can say -- I don't know what our lowest number is. I'd have to look. Whatever the number was in the current --
MR. DRAKE: You put the lowest number into the system.
MR. COLLINS: Right. To see if that lowest number matched, some reasonable way, what the lowest number is now. We're meeting the response times now -- right?



-- or reasonably so.
MR. KILMER: Yes, we are.
MR. COLLINS: So the number we have, it should be verified by the fact we meet the response times. If you can match the numbers up and look to see whether they cover the county, then that's a reasonable assumption, I think, that that low number is valid.
MR. KILMER: But that low number is valid as long as all those people are there, all those numbers are there. The minute one disappears, unless something else --
MR. COLLINS: That's not exactly true. It sounds like it should be. The response time is a matter of distance. It's also a matter of workload. And it's a statistical analysis.
So you've got periods during the day when the demand is very, very low, and you just need to figure out what the bottom is going to be to meet, otherwise the geography then overlays.
We've got periods of time in our



current system where the demand is probably down to five or four. We don't have five or four ambulances on because, at least based on -- whatever factor in the past, eight is sort of our magic number.
MR. KILMER: You're willing to accept a 12- or 15-minute response in that situation because it meets ultimately the statistical and is balanced off with, in the middle of the day, you get a whole bunch of two-, three-, four-minute responses.
MR. COLLINS: Right. Same demand.
MR. KILMER: Same demand?
MR. COLLINS: Same process.
MR. KILMER: Yeah.
MR. COLLINS: If you have a

response-time requirement of eight minutes 90 percent of the time, that – implicit in that system that ten percent of the time you're not going to meet the demand.

MR. KILMER: Exactly. What you're ignoring, Bill, is the denser the number of systems in the peak times, the denser the number of plans in the peak times, the more

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you reduce the average response times in the two, three, four, five minute, which outbalance that eight. Your approach here, by – outbalance the 15.

The minute you start cutting units, the number of three-, four- or five-minute responses goes down, and your whole statistical basis goes to beyond eight-minute response because you don't have enough real short responses to balance off the real long ones. Yes.

MR. SKEEN: I guess the question is, what percentage of response times are beating eight minutes.

MR. COLLINS: We can't do it because the level changes constantly. We can't say, in theory – if it worked exactly right, you wouldn't need more ambulances than the demand shows. But it isn't going to work that way.

MR. KILMER: The thing you're missing is the availability of these three or four or five extra ambulances in the system that are doing private as well as public calls allows the replenishment of dedicated units

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otherwise pulled out for transport in a way –

MR. COLLINS: I understand.

MR. KILMER: I don't think you do understand.

MR. COLLINS: I understand exactly what you're saying. However, if you do the demand analysis in the scheduling and if you're saying that process is reasonable, a reasonable way to staff an ambulance system, then the number you need for the 9-1-1 calls is the number that comes out of that process. Otherwise what you're saying is, we'll do this process and then we'll add more ambulances in because we really don't believe the statistics that we get in the process.

MR. KILMER: No. The minute you dedicate all those ambulances to that process, you've got more ambulances doing just 9-1-1 calls than you would have if you had them split up. There's no way you can achieve the same result when you limit the number of sales, in effect, that generate the revenue to support the system.

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Every transport you bill is a sale. And when you say, "Sears, I'm not going to let you sell to anybody other than 9-1-1 patients, where before you had sold to both 9-1-1 and non-9-1-1, but I don't want you to raise the price," you can imagine the gesture that would come back at you.

That's basically the same analysis you have tried to impose on the system without recognizing it, and that's what's been so troublesome to me.

MR. COLLINS: We're talking about demand analysis now.

MR. KILMER: Demand analysis in the concept of savings. If you take the demand for products, dresses, and say, I'm going to allow you to sell those dresses to a smaller number of people, they're going to have to close half their stores and their price is going to go up.

MR. COLLINS: You're talking economies of scale, not demand.

MR. KILMER: This is another problem. We're not using the words, I guess, in the same way. The problem is, Bill, there's a

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big hole in your analysis that somehow we aren't able to communicate what we all intuitively feel. This would have been so much easier had these discussions occurred before you came out with your plan.

MR. THOMAS: I still want to know, who's going to do what to give us this? What's going to happen in the area we've been talking about? People are going to figure out how many unit hours they would be deploying in an ALS dedicated system in their service area, and presumably CARE and AA in their service area, and then in a joint service area in order to meet the ALS demand. That's the first step of the process. We'll take the next step after we do that.

MR. LAUER: Right. That's the only thing I'm agreeing to so far.

MR. ROBEDEAU: I think it needs to be understood nothing is going to be ready by the 14th.

MR. SKEEN: Are the four models we're talking about current, using the current status, the tiered, single provider, and

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multiple provider, multiple being two providers?

MR. THOMAS: Here's what I'm thinking – Bill didn't do that. Bill didn't worry about any of that when he came up – I'm interested in something that compares to the 39,000 hours so it's a realistic comparison of what we have now if we went to an ALS dedicated system.

MR. SKEEN: Chris, we can kill two birds with one stone if we do this.

MR. KILMER: He's right. The four he came up with would be a good one.

MR. SKEEN: Then if you go down –

MR. THOMAS: What were the four again?

MR. SKEEN: Current, tiered, single, and dual, I guess.

MR. KILMER: Being two as opposed to three.

MR. SKEEN: The categories you look at is what the total unit hours are – by "total," being emergency and nonemergency – then what it would be for 9-1-1 only dedicated system.

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MR. KILMER: And?

MR. SKEEN: And critical care only and noncritical care only.

MR. KILMER: And private.

MR. SKEEN: And private.

MR. LAUER: I don't think it will work that way because even –

MR. SKEEN: You're not going to have numbers in all of those blocks. Some of those don't apply.

MR. LAUER: The critical care versus noncritical care, all of those calls still have to get a unit at the scene.

MR. SKEEN: Somebody's got to make some assumptions somewhere. If somebody gave me a plan and said, put this together, this is what I would come up with to get that, and somebody can shoot holes where they want. Somewhere we have to get a base line.

MR. KILMER: That's right. What everybody has to keep in mind, we have focused on the two versus one provider and whether there will be savings. I don't think anybody should ignore, in a program

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where you have fire department do the tiered response, several responses that will reduce the response. One of those is going to be one EMT instead of two; the second is the response time will lengthen, so you reduce the number of staffing to some amount, 12 minutes instead of eight minutes. The fire department will be able

to cancel a large number of the initial dispatches, which will further reduce costs for the private companies.

And I don't know whether it's possible to factor those in with certain assumptions into the analysis of Collins' system.

Then you have to take whatever assumptions you use, and you have to apply them to a single system and a two system -- a two-provider private component of the system when you're evaluating the tiered response in order to get to one of the issues we're concerned about, and that is in the tiered system, is there any significant advantages to also going to the one provider as opposed to just leaving it with the two?



MR. SKEEN: Where it gets complicated, where you have to be careful is on the tiered system to reducing the cost to the private provider with the 12-minute response time and you can be canceled, you have to be careful to that because we don't know whether that's 50 percent of the calls, whether the screening is going to take place at BOEC, whether it's going to take place on the scene.

MR. THOMAS: In order to do what you outlined, we have to make an assumption about what the percentage of calls is going to be. So what's the assumption going to be?

MR. KILMER: I'd like to propose this assumption: My understanding is the fire bureau wants to get into this with a minimal, if any, increase in budgetary costs. And I think that we can all calculate that their ability to transport a significant number of patients, somewhere between ten and 20 percent is probably the maximum they can do without adding considerable resources and that all the



rest of them are going to be first responses. And that that -- let's take a figure of 15 percent. I think that ought to be used in this analysis.

MR. LAUER: I think using -- comparing the different system designs against each other is good. But, for example, the fire medic units as proposed to the tiered system are going to have to respond to every 9-1-1 call.

MR. KILMER: That's true. They're going to have to add at least one unit, as I understand it.

MR. LAUER: There are peaks in here, Jeff, that go up to 17. They're going to be tied --

MR. KILMER: There's no dedicated system that's going to have 17 units on the street at one time.

MR. LAUER: To respond to all those calls. To send somebody to all those calls and those hours, they're going to have to have 17 units deployed, otherwise they're going to put calls on hold.

MR. KILMER: Is that right? That you



have certain periods of time in a dedicated system, you're going to have to have 17 on the street?

MR. COLLINS: You have to look and see what the time is because the assumption is, all the demand analysis is an hour, and that's not the assumption of the tiered system. It's considerably less.

MR. ROBEDEAU: What is the assumption in the tiered system?

MR. COLLINS: You start with the calls and you don't get there.

MR. LAUER: That's where we have to get to.

MR. KILMER: You can again make some calculations because if the fire department is only going to transport 20 percent, it's going to have two options.

No. 1, it will say, we'll transport this guy, and it's a time critical deal you can't get here before the guy needs to go. There'll be a cancellation. The other part of this I think is desirable for the ambulance if you have an all-ALS response system --



MR. ROBEDEAU: Wait a minute, Jeff. I think what Randy was saying, was the fire bureau, in order to get there, if there's 17 calls within that hour, the fire bureau is going to have 17 manned units. We're not talking about the cancellation of the private company under the tiered system.

MR. KILMER: You're assuming one ambulance will be available to respond to only one call in that hour.

MR. LAUER: That's one of the assumptions that are made in the whole methodology, Jeff, is that a unit hour -- that it takes an hour to run a call. What you're saying, there is no methodology available.

MR. KILMER: That's right. I think you're raising some very good questions. All my response is, every time I hear this, is, this shows another problem with the way this process has gone that leaves enormous gaps between reality and some idealized system that's built on a foundation of sand.

MR. LAUER: You need to make some



assumptions. If you seek reality, you're going to put something in place, and if it doesn't work, you'll have some big problems, not be able to go back.

MR. KILMER: Let's assume we have compacted sand. If there are times in the day when you have to have 17 units -- 17 responses in that time, the probability is, based on our current evaluation, that many of those will be the response, "Nothing's the matter," it will be back into service. I don't know how many those are.

MR. ROBEDEAU: About 30 percent of our current call volume is "no patient." Is that correct?

MR. LAUER: That's based on an average peak call, which is one methodology. If you go to a maximum, there are times of the calls when -- there's 27 that -- during that 30-week period we analyzed, there was at least one hour in there, there were 27 calls that came in.

MR. KILMER: The reality is there ought to be a far higher number of duplicate response calls because the fact



of the matter, the fire department will not be able to get to all of these with the staffing that is required. So the backup of the tiered response, the private response, they're going to be -- in order to meet the eight-minute, 90 percent response to all emergencies, you're going to have to have the fire-apparatus first response there within four minutes, but no guarantee of a rescue unless it's an all-rescue first response, which no one could possibly pay for. The cost of that would be unbelievable.

Then you're going to have a situation, Bill, where the private companies are going to have to be available at least at certain periods of time to back up the fire bureau in order to get an ALS unit to all these emergencies. To not do that is going to carry with it considerable medical detriment to the current system, which is one of the policies, is whatever is adopted is not going to evolve to a decline in medical care.

And if that's true, what he is

pointing out is at least during significant periods of time during this system, you are going to have to have ambulances, private ambulances staffed by two EMT-IVs. If you're going to have that part of the time, you save nothing by making a system change because you might as well have that all the time.

MR. SKEEN: If you get into a system overload, then you're probably going to say, private contractor, "We need you to move now to an eight-minute response versus the 12."

MR. KILMER: Yeah. You're going to have to add it up. All of the system cost that supposedly is going to be saved will be right back there. Here's another indication of another wart on the side of Rosemary's baby.

MR. THOMAS: Is there an assumption that you need to make about how many -- when you do your critical care-only thing, how many -- there is an assumption you need to make about what percentage of the 9-1-1 calls --



MR. LAUER: The basic assumption to the whole demand unit analysis, Chris, if you have X number of calls occur in one hour, because they occur in a huge geographic area, you have to deploy a unit to respond to those calls, they're going from point A to point B.

MR. THOMAS: I was following up Trace's outline what needs to be done. To do the critical care components of that, you have to make an assumption about how many calls that is.

MR. SKEEN: You have to make assumptions.

MR. THOMAS: Jeff has proposed 15 percent. Why don't we use that and say that's the assumption.

MR. SKEEN: I'm using 15 percent. What I'd like to do, Jeff, is contact a couple systems and see if they're doing this.

MR. KILMER: I think that's a good idea. Here's the problem: If you contacted Seattle or some places, they have an unlimited fire budget. Those places are



not comparable with ours because here you do have a limited fire budget.

As a practical matter, the tiered-response option is not going to be saleable for economic and tax-policy purposes if it requires a substantial increase in the number of fire personnel, and 15 percent is basically the maximum that the fire bureau can do with its current resource, perhaps augmented by two more rescues with the staff to go with them.

There's still going to be a hell of a lot of calls left for the privates in that system, independent of the medical necessity of that, because economics are going to dictate some undermining of ideal medical outcomes. And just as they do on the MAB, they don't have two paramedics and a gold-plated ambulance on every corner of the city. Economics make that ridiculous, even though it would be more ideal from a medical point of view.

And so -- but the other assumption that Randy's comments have made is that the



numbers of private ambulances that are going to have to be in this system, at any particular time, to provide the private component within the current medical guidelines is going to be a hell of a lot higher than I had assumed when I walked in here today.

And in your analysis of unit hours for privates on both the emergency side -- at least on the emergency side, I think you need to factor that in. You're going to increase the number of emergency staffed ambulances under this system if you're going to dedicate the private component of this thing.

MR. LAUER: Even if you don't dedicate, collectively the number of paramedic ambulances regardless of what the responders do is going to increase.

MR. KILMER: I can see ways it would increase. It's not going to increase as much as we thought. The thing that strikes me too, from the paramedics' point of view, everybody bows to the paramedics, and you want to be realistic to them. You dedicate



a system that's going to have the least number of private paramedics in them, whether you have two or one in the ambulance.

You have a public-private system, you're going to have to have more paramedics on the increased number of ambulances that you have in the system doing both. And the private paramedics ought to like that, and, frankly, there are a few occasions on interhospital transfers and nursing home transfers, and something like that, where you do have something where that extra training would be helpful.

MR. LAUER: It would. But try and sell that.

MR. KILMER: I know. We're talking here about what's medically desirable, fiscally desirable, we're also talking about politically. This is trying to incorporate, one, the paramedics, and that is that as many of them as possible be kept in the system.

MR. LAUER: The split will create two



levels of paramedics.

MR. KILMER: No question about it.

MR. LAUER: I think that's -- what I have heard, that's a paramedic's biggest concern.

MR. ROBEDEAU: Any system will create two levels of paramedics. Currently we have two levels of paramedics. You've got a bunch of -- you've got a group of paramedics called PAPA, who think they're better than everybody else and better than the whole world. In fact, Jesus Christ himself is probably not as good. I think Tom Steinman articulated it very well at the last meeting, where you got people going out on the scene now --

MR. LAUER: That wasn't the classic paramedics or level of paramedics they talk about. That you can talk about in terms of what kind of skills they practice.

MR. ROBEDEAU: Do you go with a single-provider system? You are going to have a group of people with a single provider, whether it's single-provider tiered system, with the fire department



being essentially in charge, or whether a single provider private, the private paramedic being essentially in charge, you're going to create two classes of paramedics.

The only thing we're arguing about now is which class is going to be deemed to be better, whether it's going to be the private component or the public component.

MR. SKEEN: What Randy is talking about is what Jon Jui addressed when he was here, that is they want to work with a group of 50, 75 paramedics that have the skills and, yes, there is a need for all paramedics, but they don't want to deal with that. There is a problem with that.

MR. KILMER: I respond to him, we got

way too many licensed paramedics in the system that, under the state guidelines, require training. The way to deal with that is not to limit the number of private providers. The way to limit -- you're still going to need a certain number of paramedics in the system. The way to do that is to limit the number of paramedic



licenses that you grant that require training.
And if people pass out of immediate interaction in the trauma system, then they ought to lose their paramedic license, and when they come back, they ought to be required to go back and get a refresher course. That's the way to solve that problem.
MR. ROBEDEAU: Already done.
MR. KILMER: The second part that comes back to Randy's point is, the two classes of paramedics is based on the assumption the fire department will be able -- will take over from what is now being done by the privates, and that is the primary responsibilities for all critical traumas, which is -- it's like the murder case and the law. That's what everybody comes in to be a paramedic to do.
MR. LAUER: That's a good analogy.
MR. KILMER: Now the private paramedics are the chief trial counsel. Some of that's going to transfer to the fire department paramedic. And the other



guy is going to be a second chair.
But if you're correct, that a substantial understaffing at the fire level is going to exist at several points during the demand day, I'm going to guess that in the high demand periods of time, that's the time where you're also seeing the most critical injuries, in other words, Friday night from 10:00 p.m. to 3:00 a.m. And there's going to be a lot of private paramedics that are going to have to respond to those calls because the fire department's resources will be stretched to the end.
MR. LAUER: This tiered system makes less sense to do.
MR. KILMER: Right. These are all implications, again, that should have been studied before we got to this point, because the more you talk about this, the more inefficient this system looks like it may become as we introduce more players into it.
MR. LAUER: According to what you're saying, you're going to ask a paramedic who



hasn't had an opportunity to routinely practice those skills to suddenly be thrust into an environment where he or she needs to have those skills.
MR. KILMER: The fact is, A, Jon Jui and Norton sat here and said, there's no studies that any medical skill is parallel to experience over a particular period of time. That's an intuitive judgment that makes some sense, but not a lot.
MR. LAUER: They both said they believed that was the case.
MR. KILMER: The second is, the fire people are not going to have any greater skills in that area if they take this over than our people have now, and supposedly everybody doesn't have enough now. This whole idea that you're going to increase significantly the utilization ratios in the most critical types of trauma, that's really not accurate. The fact is critical types of trauma really only reflect ten percent of the types of responses. They're spread among a huge base.
MR. LAUER: It's not just trauma.



MR. THOMAS: So 15 percent is the assumption you're going to use and you're going to check some other systems.
MR. COLLINS: Why don't you use 20 percent instead of 15, because when we talked to King County, their number, I think, was 18 percent or something like that.
MR. SKEEN: But King County is dealing with a BLS contract provider. Probably ought to deal with Tacoma, Tucson.
MR. ROBEDEAU: Who are you going to check with?
MR. SKEEN: Tacoma and Tucson come immediately to mind, where they have a tiered system.
MR. COLLINS: But Tacoma is pretty weird. Tacoma's got a system, from when I talked -- when I came down from Tacoma, they put a call out, whoever gets there first gets the patient.
MR. KILMER: Check that out.
MR. THOMAS: What's the assumption going to be?
MR. SKEEN: I'll use 20 percent and



barring any other --
MR. THOMAS: Everybody needs to use the same assumptions.
MR. SKEEN: Is 20 percent acceptable?
MR. THOMAS: Fine. Twenty percent.
MR. SKEEN: Just a comment, though. When you talk about the clinical performance of the system, Dr. Jui laid out his findings on the cardiac. That's really too good to be true, to be honest with you. I can't believe there's those kind of success ratios. I hope it is. If it is, Portland will go on the map as the medical preference arena.
MR. ROBEDEAU: We've gone through that before on the system, and I know other providers around the country have, and before you can believe anything like that, you have to document what they're calling a save. Is that somebody who's not declared dead at a scene?
MR. SKEEN: Or if it was somebody who was talking to you before you defibrillated?
MR. ROBEDEAU: I've had very good



success rates --
MR. SKEEN: Witnessed and nonwitnessed. I tell you, you're going to be hard pressed to find any system in the country that can replicate those numbers.
MR. KILMER: I think that's good for us because when you've got that sort of medical outcome based on the best studies available, however weak they may be, that certainly undermines the view that there's any significant medical quality-of-care problem in this system.
MR. ROBEDEAU: I know Seattle did a study on what their success rate was, and their criteria for determining the save was anybody that the fire medics did not declare dead on the scene.
MR. LAUER: If they transported them to a hospital, it was a save.
MR. KILMER: What's the difference in the bill?
MR. THOMAS: Let's stop the meeting so she can stop writing. She's going to lose it in a minute.
MR. ROBEDEAU: It is after noon.



MR. SKEEN: Are we adjourned?
MR. ROBEDEAU: Yes.
(PROCEEDINGS ADJOURNED)
* * *
(NOTE: Untranscribed steno notes archived permanently on computer; transcribed English files archived three years on computer.)

* * *



CERTIFICATE

I, ROBIN L. NODLAND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein, that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 17th day of May, 1993.

/s/ ROBIN L. NODLAND

Certificate No. 90-0056

NOTES

ORIGINAL



BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Thursday, May 6, 1993
9:27 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Thomas Steinman, Portland Fire Bureau

* * *



APPEARANCES

ALSO SPEAKING:

Mr. William Collins
Mr. Christopher Thomas
Mr. Randy Lauer
Ms. Lynn Bonner
Mr. Steven Moskowitz



PROCEEDINGS

MR. ROBEDEAU: Are there any corrections? Randy.

MR. LAUER: Bottom of page 2. Single medical authority. I think there might be a word that was different.

The third sentence that said -- he said that he thought system of a small group of -- core group of supervisors was not reasonable. What I said was a small group of paramedics was not reasonable. And I further describe that as saying, because it creates specifically two classes of paramedics and that wouldn't promote good, consistent patient care throughout the County.

MR. DRAKE: I know you said that before, Randy, but did you say that the other day? We were talking about single medical authority.

MR. LAUER: Right. It was prefaced by saying OHSU could act as the single medic authority, and my response to that was I didn't think -- I had problems with that



because their goal was to establish a small core group of paramedics, of which they would have --

MR. COLLINS: I am understanding that.

MR. LAUER: The rest of the paramedics would be sort of left along the wayside.

MR. DRAKE: I see what you are saying.

MR. ROBEDEAU: And you said -- I remember the conversation, too. I didn't quite remember it that way. But you did mention -- I do remember the small core group, and I think it's six of one, half dozen of the other on either proposal, that I had added in there that I see a core group, a small core group, and no matter what proposal is adopted, the author of the proposals sees themselves as a first-class paramedic and everybody else is a second class.

The PAPA proposal and the way, from experience on the scene, Randy, and the experience we have had for years with the private/public-paramedic fight shows each group believing themselves to be better



than the other group. That's been a problem in this system since the -- back -- christ, since the first PAPA was formed in '74, which was the coalition for paramedic advancement.

(Mr. Moskowitz entered the room.)

MR. ROBEDEAU: The argument that the physicians supervisor group or a physician supervisor who's goal is, or perceived goal is, to be a small core group of first-class paramedics when compared to one proposal as compared to another is not -- I don't see that as being a valid argument because each proposal proposes that.

And each group that authored each proposal had that very thing in mind, to set themselves up as a special core group. PAPA sees themselves telling the fire bureau what to do. The fire bureau sees themselves telling the priority paramedics what to do. To me that's happening right now.

MR. LAUER: It was my perception it would shift. But when Jon Jui was here,



and what I based my comments on was, Jon said that his support or OHSU support of the tiered system was that the fire medics would be the core group that they could be most responsible for, and he made statements, I think, that optimally -- I may be wrong in this number, but 50 paramedics was the maximum.

MR. SKEEN: 50 to 75.

MR. ROBEDEAU: 50 to 75 was the maximum a single physician supervisor could supervise. If I remember correctly, we talked about that -- that was part of the discussion that said a single physician supervisor was not ever going to be able to do this system.

MR. LAUER: With the current number of paramedics, you have paramedic first response and paramedic transport. That's a lot of paramedics.

MR. ROBEDEAU: Or that arose from -- that came out of the discussion where I sat down and quickly tried to figure out what the proposals were and came up with something like 100, oh -- without going



back through the minutes and looking it up, the PAPA proposal showed 209 paramedics under columns plan one. I think I figured 157 paramedics, and, currently, there were like 160 paramedics. So any way you wanted to look at it, we weren't going to change the system much. That's in the context, as I remember it, that that thing was.

MR. LAUER: Those numbers probably are subject to debate. And that's going to be the key issue is, the number of paramedics each with a different system model would have. But just -- and that may be a whole -- we are sort of getting off into a whole different discussion or revising a previous discussion.

For the sake of correcting the

minutes, is that my discussion was -- had to do with -- I didn't think a small core group of paramedics was reasonable, not of supervisors.

MR. DRAKE: Right.

MR. ROBEDEAU: Okay. You want something else in that paragraph? "Mr. Phillips thought the MAB might bog



itself down if there was discussion."

MR. LAUER: No. The rest looks good.

MR. ROBEDEAU: So all you want changed is paramedics, supervisors to paramedics?

MR. LAUER: Right.

MR. ROBEDEAU: Okay.

MR. DRAKE: Page 4, Pete, the bottom of the first paragraph, where I said I added American Ambulance, was American Ambulance was -- I am stating here where it says that American Ambulance was arguing that $522 was not an accurate figure, of the average rates were actually much higher because -- I want it reflected in the minutes -- that he compared two companies, American and Buck. Buck was serving small, core urban area while American was serving urban, suburban and rural areas, so the rates were different.

Our rates were higher because we had more mileage into them and we explained that at the time. That's why the $2, $5, $522 figure was higher. It's not an accurate average.

Also on page 5, second paragraph down,



about the middle, it says, when Mr. Collins figured the 39,000 excess hours was correct, in the next sentence it goes down and says, Mr. Thomas told Mr. Collins and the group, et cetera, used to arrive at the figure of 89,000 hours. I was wondering if that was a typo and whether that should be 39,000.

MR. MOSKOWITZ: That's what I wrote down. When I went back over, I wasn't sure whether that was what I heard correctly.

MR. ROBEDEAU: The figure 39,000 hours is in Bill Collins' one? Says that's the number of unit hours necessary under your proposal. Is that correct, Bill?

MR. COLLINS: Say that again. I was reading this paragraph. Where's the 89,000?

MR. ROBEDEAU: It's --

MR. COLLINS: I am reading the paragraph below it.

MR. ROBEDEAU: Seven lines down. That 89,000 figure is the number that you say, the number of unit hours that are needed?

MR. COLLINS: That's right. Whatever



the number in there --

MR. ROBEDEAU: I think it's 89.

MR. COLLINS: That's right.

MR. ROBEDEAU: If I understood it, Chris's question was, how did you arrive at that number. That's when we went into discussing Starburst's. Is that right?

MR. COLLINS: Yeah.

MR. DRAKE: And I have got one more.

MR. ROBEDEAU: Okay.

MR. DRAKE: The second-to-the-last sentence and the last sentence.

MR. ROBEDEAU: Same paragraph?

MR. DRAKE: Same paragraph. You said that Mr. Collins had asked for data on how many 9-1-1 calls each provider responded to, and then took that total and created a system which providers responded only to 9-1-1 calls.

If I did say that, that was not what I meant to say. What I meant to say was how many 9-1-1 unit hours each provider had, and then he took that number of how many total unit hours or 9-1-1 cars that we schedule, and then we break that down; and



then the system he creates is where those same ALS units responded only to 9-1-1 calls. So there's a disparity in unit hours. Does that make sense?

MR. COLLINS: No.

MR. MOSKOWITZ: It doesn't need to make sense. It needs to be what you meant to say.

MR. ROBEDEAU: In order for the minutes to reflect accurately.

MR. LAUER: Did you mean not to make sense?

MR. DRAKE: Did I mean not to make sense? Well, no. I did.

MR. ROBEDEAU: Did you mean not to make sense?

MR. DRAKE: I meant to make sense.

MR. COLLINS: Actually, what's in the minutes makes sense.

MR. DRAKE: No. That isn't what I meant to say. Don't confuse me, Bill. It's early in the morning and I confuse easily. Don't record that.

What I am saying there is, what Bill Collins did with the EMS plans, he took the



total number of units hours our ALS units responded to, and then he took the different system --

MR. ROBEDEAU: Not the total number that we responded to. Total number that we have on the street.

MR. DRAKE: Total unit hours scheduled.

MR. ROBEDEAU: Right.

MR. DRAKE: Which includes the 9-1-1 calls and all other calls we respond to. That's right. And then he took that system and made a different system where they respond only to 9-1-1 calls.

MR. COLLINS: Right.

MR. DRAKE: Said he reduced the unit hours by 39,000.

MR. ROBEDEAU: Right.

MR. DRAKE: Right.

MR. LAUER: Is that what you meant to say?

MR. DRAKE: That's what I meant to say.

MR. COLLINS: Does it make sense?

MR. DRAKE: Yes.



MR. LAUER: Are you awake now?

MR. DRAKE: I am getting there.

MR. STEINMAN: Can you define unit hours and system status management in two minutes?

MR. DRAKE: Yeah.

MR. ROBEDEAU: Are there any other corrections or changes?

Can I have a motion to approve the minutes as amended?

MR. DRAKE: So moved.

MR. SKEEN: Second.

MR. ROBEDEAU: Approved?

(Chorus of ayes.)

MR. ROBEDEAU: Approved.

MR. ROBEDEAU: I went through last night -- just a couple things real quick here -- went through some of the minutes. And some of the things that I did not get done, I will -- I have a list of four of them for sure. And I kind of apologize.

I went out of here after the last meeting, broke a tooth and spent a day and a half in a dentist office. I have to go back for another day.



But I have not contacted San Mateo County. I wanted to ask Trace about Tacoma and Tucson.

MR. SKEEN: I contacted people in Tacoma. And I was unable to reach anyone in Tucson. I made an attempt and was unable to reach them.

MR. ROBEDEAU: So we will be hearing on that. I am glad. There's a "Trace didn't" and four "Pete didn't." I did not fax out the letter to everybody for additional time. But that will be tomorrow. Hopefully, I will mail it Friday. And the other deal we have passed, which is the subcommittee -- you suggested a subcommittee for determining unit hours?

MR. SKEEN: Yeah. Probably did.

MR. ROBEDEAU: It's in the minutes.

MR. SKEEN: Sounds familiar.

MR. ROBEDEAU: I sat up all night last night reviewing the minutes, trying to figure out what I was supposed to be doing, because this has gone so fast I don't know where I am at.

Mark had asked for some time at the



beginning of the meeting, if that's all right.

MR. DRAKE: If you will all indulge me for a few minutes. One thing I want to bring up, Pete, before we get started, the additional time -- have we heard back from the County, Bill, on what kind of time lines are they looking at? You were going to look into that.

MR. COLLINS: Yes. We are still trying to look into it. One of the problems is the County Commissioners are involved in trying to finish up their budget, so they are not looking at anything else right now.

We are still assuming the same time line that was put out by Commissioner Collier, until we hear something different. And we are meeting with the commissioners. And actually the time line would come out of the chair's office in a formal time line. So as soon as we know, you will know.

MR. SKEEN: I just got the tail end of something on Tanya today. Did anybody hear



that? As it relates to her running for the chair?

MR. ROBEDEAU: On the news?

MR. MOSKOWITZ: There was just an article in the paper about whether it's appropriate for her to be campaigning before she is fully resigned. But there should be some legal determination about that.

MR. DRAKE: I think the timing is crucial to this issue. We have been meeting twice a week, which is just wearing all of us out. We can't get stuff done between Tuesday and Thursday's meeting. We don't have time. We all have other jobs, moreover.

I would like to see us move to once a week or once every two weeks and extend this thing out a little bit, so we can get some of these projects done, a lot of information we are going to have to gather.

MR. ROBEDEAU: I might go for once a week, Mark, but once every two weeks isn't going to happen.



MR. DRAKE: Once a week is fine. Does everybody agree with that? Tuesdays?

MR. SKEEN: Tuesdays is fine. Tuesday or Thursday. Tuesday is better. Because Washington County has their Provider Board meeting on Thursdays. Policy board meeting.

MR. MOSKOWITZ: Maybe I should bring up at this point -- did you get my memo?

MR. ROBEDEAU: Yes.

MR. MOSKOWITZ: About a phone call from one of Hank Miggins' staff?

MR. ROBEDEAU: That's another "Pete didn't." I was going to make copies.

MR. COLLINS: Who from? From Joy?

MR. MOSKOWITZ: Joy. I got a phone call from Joy Al-Sofi, who is one of acting Chairman Miggins' staff people, and she said she had been reading the minutes and was interested in what was going on.

MR. COLLINS: She asked our office for a copy of the minutes, and we sent them over.

MR. MOSKOWITZ: She said she would like to attend but that our meeting



schedule conflicts with the meeting schedule of the County board, because the County board meets every Tuesday morning for an informal briefing and every Thursday morning for their formal sessions.

So I just faxed that message over to Pete, and said -- and told her I would bring it up here to see what this board's pleasure was in terms of facilitating her attendance at either one or more sessions.

MR. DRAKE: I don't mind moving to Wednesday.

MR. ROBEDEAU: I don't mind moving either. I think the more knowledgeable -- the more people become knowledgeable about what's happening, the better off we are.

MR. STEINMAN: So we are going to say we are moving to Wednesday at once a week, at the request of Acting Chair Miggins' office?

MR. ROBEDEAU: That's a good idea.

MR. COLLINS: So you want to try to move to Wednesday?

MR. DRAKE: Will that work for you,



Bill?

MR. COLLINS: That's not a problem for me. We just have to get a room for it. I can't commit the rooms here until we talk to them. If we can't get them here, we have to find someplace else.

MR. ROBEDEAU: We can move to Wednesday, but on the 19th of May, if we are still going there, I am not sure that I will be here. And if I did -- well, I won't get here if it's in the morning. If I did get here somewhere around noon, I wouldn't be able to talk anyway, which might make you guys really happy.

MR. LAUER: I have the same problem on the 12th. For certain I can't be here on the 12th.

MR. DRAKE: It would be the following week.

MR. LAUER: Next week we could stick with Tuesday-Thursday?

MR. DRAKE: Right.

MR. COLLINS: So you want to change it on the 19th?

MR. LAUER: We won't schedule anything



after the 14th.

MR. COLLINS: The last we have scheduled is the 13th of May.

MR. DRAKE: Right.

MR. STEINMAN: So we decided this isn't going to be finished for the MAB and it's going to be a continual process? Is that what we are saying?

MR. ROBEDEAU: It is not going to be a continual process. Everything is not going to be finished. One of the things, you know, I have -- and maybe kind of getting off, too -- I want everybody to really have all the input they wanted. Even though we agreed on some things, we haven't really come to any resolution on things. And that's something that we have to stop doing and really come to resolution.

MR. DRAKE: That's what I wanted to talk about.

MR. COLLINS: Before you do that, let's finish up this, when you are going to meet next, because we need the lead time to get the rooms.

MR. SKEEN: If we are going to extend

a request to --
MR. ROBEDEAU: Invitation.
MR. SKEEN: A request to extend, I would suggest we start the weekly meetings next week then. I don't see any purpose of rushing that through.
MR. DRAKE: In other words, meeting next Tuesday only.
MR. SKEEN: Meet Tuesday and then --
MR. COLLINS: Meet next Tuesday and then change to Wednesday?
MR. SKEEN: Although it sounds like there's a conflict with that next 19th.
MR. COLLINS: The week after that. The 19th.
MR. ROBEDEAU: Let's do Wednesday next week and within invitation with --
MR. DRAKE: I can't do. Let's do Tuesday the 11th, and then after the week of the 17th, switch to Wednesday.
MR. LAUER: Back up a second. What about Thursday the 13th? Cancel that meeting?
MR. SKEEN: Yeah.
MR. COLLINS: Scratch that.



MR. DRAKE: We have Washington County policy board meeting.
MR. ROBEDEAU: If we can accommodate Commissioner Miggins' assistant, I think that would be a very good move on our part.
MR. MOSKOWITZ: I would suggest that if you are going to do that, that you might also send a letter of invitation to all the other commissioners' offices, inviting them to send a staff person, too.
MR. LAUER: I would agree with that.
MR. ROBEDEAU: I would be happy to. Can we do Wednesday afternoon?
MR. DRAKE: On the 19th? Yes. I can.
MR. LAUER: 19th?
MR. ROBEDEAU: How about the 12th?
MR. DRAKE: No.
MR. SKEEN: I think we need to keep it Tuesday next week.
MR. STEINMAN: You will need the lead time, anyway. For getting room?
MR. LAUER: Afternoon on the 19th is fine with me.
MR. COLLINS: 19th p.m.?



MR. ROBEDEAU: Can I ask for a different chair? I will be out of the dentist office by ten or 11:30.
MR. SKEEN: Can you sign?
MR. ROBEDEAU: I can sign.
MR. STEINMAN: Will Jeff be there? Maybe we don't need you.
MR. DRAKE: We can get an easel.
MR. ROBEDEAU: If somebody else can run the meeting, that will be fine.
MR. LAUER: One o'clock?
MR. COLLINS: We will get back to you for sure, because we don't -- I would like to try to meet here. This is a lot better than trying to meet someplace else. So let me find -- we will go for the afternoon of the 19th and --
MR. STEINMAN: Are you going to check on other doctors' meetings so we do get the doughnuts?
MR. COLLINS: You would like to have this coordinate?
MR. STEINMAN: See what the menus are.
MR. COLLINS: We really don't care



when we meet; we would like to see the menus? Yeah. We will do that.
MR. ROBEDEAU: How about the afternoon of the 11th instead of the morning, which might accommodate the commissioners?
MR. SKEEN: I would prefer to do it in the morning. The afternoon -- I have got the afternoon committed.
MR. DRAKE: There's a meeting in the afternoon that I have you scheduled for, Pete.
MR. ROBEDEAU: You do?
MR. DRAKE: Yeah.
MR. ROBEDEAU: Thanks for telling me.
MR. DRAKE: Two o'clock.
MR. COLLINS: 11th stays. The 19th we go for the afternoon. We will also, then, ask them to schedule out on the Wednesday. You want to keep doing it in the afternoon?
MR. DRAKE: I would rather do it in the morning.
MR. ROBEDEAU: I would rather do it in the morning, but whatever is convenient for the commissioners. We get a letter out.



Do I just have permission to send a letter out to all five commissioners from the board? You guys want to see it first?
MR. LAUER: Just inviting them?
MR. ROBEDEAU: Yes.
MR. LAUER: Maybe them asking their input on a good meeting time?
MR. COLLINS: I wouldn't do that. You will never meet.
MR. STEINMAN: Will you also send it to Commissioner Hales' office in case somebody from there wants to?
MR. ROBEDEAU: You want City Commissioners?
MR. STEINMAN: I think Hales' office because he's the bureau's commissioner. They have set up their committee to look at it.
MR. MOSKOWITZ: To cover yourselves, I would suggest sending it to all, and then they can decide. I mean --
MR. DRAKE: Politically.
MR. MOSKOWITZ: Suggesting sending a representative from their office. Otherwise you wind up with a quorum of



elected officials here. You will have to go through this whole public meeting notification process and everything.
MR. COLLINS: We actually go through that anyway. This meeting has been -- is a public meeting, and this has been scheduled out, and the notices have gone out to interested parties. We mail out 100 notices to interested parties. The only thing is, we don't put it in the paper.
MR. DRAKE: For the record, though, if we are going to have commissioners' aides here, we are definitely going to need doughnuts.
MR. COLLINS: We don't buy doughnuts.
MR. ROBEDEAU: I make a motion that Tom supply the doughnuts for the rest of the meetings.
MR. DRAKE: Fire Bureau has a lot of big budgets.
MR. STEINMAN: I will talk to Chief Wilson.
MR. DRAKE: Talk to Randy Leonard. Tell him we want doughnuts.
MR. STEINMAN: I will say, like Bill



did earlier, when you ask if this meeting's user fees will have to go up for doughnuts. Right, Bill?
MR. COLLINS: That's right. All our funding.
MR. SKEEN: With those aides here, just as far as content and format of the meetings, I think the subcommittee work probably becomes more important, so when we have them here we are -- I don't feel uncomfortable with the process that we use right now, but I probably would feel uncomfortable if we had some aides here.
It doesn't perhaps look the most organized and structured. So I would just suggest we try and do more work in the

committee work here, and when we bring it here, it's more of a presentation format.
MR. MOSKOWITZ: I think, because they will be coming in completely ignorant, you have to assume, about all these issues and so, if they are listening to you reviewing some work that you have already done, that will help them and better educate their bosses.

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MR. DRAKE: I am concerned, though, somewhat about subcommittees going off and coming up with things. I mean, kind of one of the complaints we have had about the process is that it's not been an open process. And we want to ensure that this will be an open process as well, and it has been. Everybody has been free to talk, say what they want to, bring out any issue.
MR. SKEEN: Sure. I think, Mark, if the subcommittee comes back, for example, on the unit hour utilization study -- the subcommittee comes back and explains the methodology and assumptions, all that's clearly spelled out, if people want to argue a point or don't understand or seek clarification, it does that, instead of trying to determine what the methodologies are going to be here in kind of a group discussion. I think it just gives you a little better base line to start from.
MR. DRAKE: I agree with that. I just don't want the subcommittees to get out of hand where they are more subcommittee meeting time than actual meeting time.

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MR. SKEEN: I suggest any subcommittee will be duly challenged in its assumptions and positions it brings forward.
MR. ROBEDEAU: So let's bring this to a conclusion.
MR. DRAKE: Yes.
MR. ROBEDEAU: Nine o'clock on the 11th is still on. We are going to cancel Thursday the 13th. And we will be meeting, after we talk to Bill, one o'clock on the 19th, tentatively.
MR. DRAKE: Right. And they will be meeting in the mornings on Wednesday for the 26th, and then we are to June 2nd.
MR. SKEEN: Pending availability of the room and so forth.
MR. DRAKE: Tentatively. We wore out one court reporter.
MR. ROBEDEAU: We do a lot of work.
MR. DRAKE: Need to take more frequent breaks.
MR. ROBEDEAU: Mark, you had some things you wanted to say?
MR. DRAKE: Yeah, if I could.
MR. ROBEDEAU: One more thing. Bill,

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can you get back to me tomorrow on the availability of rooms so we can send out a letter?
MR. COLLINS: No problem. We'll get back to you today.
MR. ROBEDEAU: That's fine. The sooner the better. And just to be sure, too, we are going to invite staff or commissioners again from the County, all of the commissioners, and from all of the City Commissioners. Is that -- okay. Then I won't.
MS. BONNER: Does that mean you have to invite people from Gresham also?
MR. ROBEDEAU: No, I don't think so.
MR. DRAKE: It's a public meeting. If they want to show up, we are going to need a bigger room.
MR. ROBEDEAU: Go ahead.
MR. DRAKE: What I wanted to take a few minutes to talk about was, bring us up to date on where we are and where we are going. We started out this process saying we would be responding to Collins' plan and PAPA's plan, and then in the first meeting

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we said we needed to really develop an EMS system for Multnomah County as well as respond to PAPA and to Collins' plan.
And I just want to make sure we are all working off the same sheet of music, that's the same ideals and goals everybody has, we are still working towards those goals.
And a couple other things. We are making a record here for a couple reasons, but the major reason I believe we are making a record with the court reporters is to add integrity into this planning process. Because in the past, our complaint has been that there hasn't been integrity in the process.
I believe that the MAB has acted grossly irresponsibly in trying to pass through a plan, giving us only five minutes to respond to a plan that we couldn't hope to respond to in 30 minutes.
We have been meeting every single week for four hours. We are not even halfway done with this process. I don't think we are a quarter of the way done. That's a

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big process and it takes a lot of time and effort on all of our parts.
But I also believe that we need to proceed forward and actually, in my mind, starting to get some things generated out of this, all this expertise and energy, and putting something out.
I would like to see the Provider Board put out some position statements on things that we have agreed to, and, continually, as part of this process, put out position statements on things that we agree to -- we may have position statements on things we don't agree to -- and those position statements would then become the basis of our plan we are going to submit.
Agree with that or disagree?
MR. ROBEDEAU: I think that's pretty much what we agreed to before, and it's just kind of gotten out of hand, like I said.
MR. SKEEN: I don't think we have done a check along the way to see what it is we have reached consensus on.
MR. DRAKE: Right.

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MR. SKEEN: Just kind of continued to plod along.
MR. DRAKE: Part of this came from the statement that someone made the other day, at the last meeting was, we have already talked about that and agreed to it. And when I thought about it and looked back through the minutes, the person was right, we had all talked about it, we had all agreed to it, and here we are talking about it all over again.
We need to come out with these position statements where we agree on something so we are all clear: We do agree on this. We don't agree on this. We agree that we need to gather data on this. And continually do that so we are actually starting to produce some paper out of these meetings; we are starting to show some things.
I think we are pretty much in agreement we have been on single medical authority. We may not agree on the exact format. We are in agreement that we have some problems with some of the data in the

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EMS plan. We agree we have some problems with portions of the PAPA proposal and so forth. And we just simply need to put out position statements so we have agreement. We have problems with the proposals; we have problems with the data, whatever those positions are.
So that other people that ask, what

has this Provider Board been accomplishing? What have you done? We have all these things we have agreed to and we can show them something. This we have agreed to so far.

Is that agreeable to everybody? Do we have a problem with that? No?

MR. ROBEDEAU: Yes, I think that's what we should be doing.

Randy, you look like you want to say something?

MR. LAUER: No. I think that's fine.

MR. ROBEDEAU: Okay.

MR. SKEEN: I think that's, yeah, I think that's accurate, Mark. I guess I thought we were getting close to it with this particular document we have, provider



recommendations, Provider Board recommendations, that someone suggested last Tuesday, is that we start -- I think it was you, Pete -- that said we need to start reducing those to writing as to what our recommendations are. Some of these will be easy to do. Some will not be so easy.

You probably need to talk about or need to have discussion on the process of how we start reducing that, and I don't know that it all has to be done here. I would think people could do some work, bring it in here, and then let's go through it and see how far apart we are.

MR. DRAKE: I agree. We are not going to use this as a working group. We don't want to take this kind of time here, write all these position statements out here. We do agree on some things.

I think we need to start writing those down as position statements, submitting them to the group, everyone agrees. Change the word, what have you, and let's move on, rather than sitting there and sometimes



regurgitating up -- I feel that we are dredging up the same old stuff we talked about three meetings ago and we agreed and we are discussing it all over again.

MR. LAUER: I suggest we use this as a format to do that.

MR. ROBEDEAU: Just a minute, Randy. That hasn't even been brought up yet.

MR. LAUER: I mean, in terms of, you know, I agree with what Mark said he wants to accomplish. I think we need probably a way to do that, something to enable that. And as we go through and discuss each consensus -- I think maybe this is a good time to bring this up.

But I think the document that Trace put together, that was revised from last meeting, identifies those system elements, does two things: It will address whether or not the current system and any of the proposed systems speak to those issues; and it can also allow space for the Provider Board to recommend what it would like to see as it pertains to each of those issues, if we can reach agreement.



Now, we might only have four Provider Board recommendations filled in, but it would give you a way to do it.

MR. ROBEDEAU: Some type of format, yes, I agree is necessary. And to take them one at a time and either reach consensus or not reach consensus, but we need to report consensus and nonconsensus, the majority and minority reports that we had discussed in the beginning. And we are probably going to need to have a majority and minority report on several things that we need to take it and go. This is a good format.

I had understood this, more myself, to be more of something on how we are going to look at the overall system and to see that everything was addressed as far as a complete EMS system rather than just an ambulance system. But you know, I can change on that.

I think the one thing that's really important is that for the MAB meeting that we have at least a majority and possibly a minority report saying to the MAB on



medical supervision. That, in fact, is the MAB's point of expertise. And if I read the ordinance, that is where the MAB really has authority to recommend, you know.

I still do not believe the MAB had any other authority. They are a medical board. The other authority for recommendation rests with this board. We have -- we recommend -- I think we have the authority to recommend to the MAB what they adopt for medical supervision.

MR. LAUER: That gets to be kind of muddy, Pete, because in an EMS system, virtually all aspects of it can be related to medical care because that's what we do. That's what EMS does. So I think that the MAB's position is that things that might not be quite as direct as medical supervision is also within their purview.

MR. ROBEDEAU: Well, then, if you take and accept that approach, then, by reading the ordinance and what the charge of the Provider Board is, we have every bit as equal authority to evaluate and recommend everything else, including medical, because



that has to do with assigning of emergency calls to a licensee's vehicles.

MR. DRAKE: Without getting into that, though, I think to put this thing in more -- a little more focus -- and I agree with what Pete is saying, that I think we need to send some stuff on to the MAB --

MR. ROBEDEAU: And the County Commissioners.

MR. DRAKE: And the County Commissioners.

MR. ROBEDEAU: I am not convinced that anything we ever send to the MAB at all will see the light of day. So I think we need to send it on to the appropriate body.

MR. DRAKE: To develop this EMS system, we have all spent about -- in the past we have taken -- there has been agreement that we take into account first responders and that this EMS system has to function at a reasonable cost to the consumers.

And that is where I have a real trouble with the PAPA proposal is that they



ignore cost entirely. And we cannot, as a responsible group of providers, ignore cost. You have to look at the cost of the system, and we are.

MR. LAUER: I agree with part of that, but I don't know that we are in agreement that we simply accept what a current system costs as what we want to continue. I think we are at --

MR. DRAKE: No, I didn't say that.

MR. LAUER: That's what I understood you to say.

MR. DRAKE: If you understood that, no, I am not saying their costs are reasonable or unreasonable. I am saying any system we develop has to look at the cost; that the cost should be reasonable to the consumers. Okay?

MR. SKEEN: Yeah. And in the process of doing that, obviously, a number of components may represent some cost savings, but when you put it together with all of the pieces -- in other words, you need to look at the global picture --

MR. DRAKE: Right.

MR. SKEEN: -- of the overall cost. It's really easy to go out and solve individual problems. Solving the big picture becomes a little more complicated.

MR. DRAKE: That's when we start talking about cost of the first responders in Corbett and what kind of those costs are contributed, cost of the trauma systems, cost to providing supervising functions, the cost of the BLS. Those are all costs of the system. I think we need to look at all of them, not just the one small one which is the transportation delivery.

MR. ROBEDEAU: That's what we discussed was an EMS system, not an ambulance system.

MR. DRAKE: Right. So we are all clear on that? Everyone is in agreement? Tom, you are in agreement?

MR. STEINMAN: With what? You know, I am in agreement -- I hate this -- with Trace. I think we need to use a format like this. I don't want to see us coming out with single pieces of paper and see us influencing everything with single pieces



of paper.

MR. DRAKE: I don't say either.

MR. STEINMAN: Some format that is easily understood.

MR. SKEEN: You rotten guy.

MR. STEINMAN: I can't agree with anybody here today. I'm getting in trouble.

MR. LAUER: Now you just have to agree with everyone else. We are everyone.

MR. STEINMAN: I am not sure we need to do anything for the MAB. I think we all know where the MAB is going to go and what we are going to do. I talked to Jim Dugoni a week or so ago and I don't think there's going to be any changes at all. They fully intend to put PAPA's plan through as written and not even make a recommendation on a system. So -- or on an option.

So I think we need to get this done as rapidly as possible, and I agree that we need to start digging in and putting stuff down and yes or no.

(Mr. Thomas entered the room.)

MR. STEINMAN: Maybe some format.



Maybe not what Trace has here, but real clear and easily understood by those people that don't understand EMS.

MR. ROBEDEAU: I couldn't disagree more that it's not important that we put something into the MAB. I think it's absolutely essential that we do that, and to the County Commission and apparently to the City Commissioners. The fact that the MAB went into this with their minds made up, the fact the MAB had people who helped write the PAPA proposal and lobbied for it behind the scene, and the fact they have not conducted any kind of a fair process is really irrelevant whether or not we recommend anything to them.

I think we agreed at the beginning that we were going to write proposals, come up with position papers, submit it to the MAB and to the County Commissioners, and I think that we still need to do that. You know, there's no doubt in my mind the MAB is not going to read a thing. They are just going to put it in the circular file.

MR. STEINMAN: I won't disagree with



that, Pete. It's the same deal that we are dealing with the MAB we have dealt with in other processes here.

MR. ROBEDEAU: We have got, you know, a little bit of eyewash to make it look like there was some kind of public hearing and a proposal and the preconceived agendas were put there. That's one of the reasons why these meetings have been conducted the way they are, as open as I can possibly get them. But we do meet to submit to the MAB. They will not read it. I have no doubt in my mind that you are absolutely correct, but it makes no difference.

MR. LAUER: I would frame it as we need a copy to MAB on information we submit to the County Commissioners as a courtesy, but I think the MAB and Provider Board both look at the system from a different perspective: MAB primarily from a medical perspective; we look at it from an operational, administratively cost perspective. But we are both looking at the same thing. We are just giving different angles of input.



MR. ROBEDEAU: I don't agree with that. At least from my perspective, I look at it from medical also, as well as the rest of which completes the system. You know, I look at it as medical, I look at it as administrative, and I look at costs and what really -- we are really able to deliver. You know, we could put an ambulance on every corner and have a 30-second response time. That is an option. And you know the MAB.

MR. LAUER: Not very viable one.

MR. ROBEDEAU: I understand that. The MAB can and if they want to say they would give the best medical care, they could do that. But we have listened to problems with medical care for years and years and years and costs, and the Oregon health plan has come out to ration health care, you know. The Canadian system rations health care. And I think that is quite frankly going to be the wave of the future.

What's the cost benefit analysis? How many times, you know, have we run code three out on terminal CA patient whose



family is saying, don't do anything, and the patient is essentially saying, don't do anything.

This system and other systems, it's not just here, it's -- well, this is off the point. But it's a cost I don't think should be there and, you know, I think as our society changes its attitude toward dying and death, and I think they have changed their attitude on what is affordable for a society and medical care and what isn't.

MR. LAUER: I don't disagree with that, Pete. Just for procedurally saying that essentially we need to report something to the board and copy to MAB. That would be my recommendation.

MR. ROBEDEAU: Okay. So we will copy -- I think we need to copy MAB.

Are you done, Mark?

MR. DRAKE: Yeah. That's all I had for now. Thank you.

MR. ROBEDEAU: I prepared a proposal paper. I think it's one that we have to have out before the meeting. I think we



can give the court reporter a chance to take a five-minute break.

MR. DRAKE: While we read it and we can discuss it.

(Recess.)

MR. ROBEDEAU: Is everybody ready? That is a proposed position paper on medical supervision. Can we have discussion? Does anybody disagree with it or agree with it?

MR. LAUER: I can say that I, without any reservation at all, I disagree with it. I think this actually might provide a preview of what might be produced by this board, however. This could be looked upon as one of the myriad of majority of opinions that might come out of the board.

I think it's pretty inflammatory, Pete. And to send it to the MAB is -- there's only one way they can read it and that's as an insult. And I think that in that regard, it will have very little positive effect.

One of the key points in here is that the recommendation to have OHSU provide

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medical direction, control of Multnomah County EMS system, Buck has previously gone on record as being opposed to that, and I have to reiterate that at this point. I don't believe that that is a healthy outcome.

So that is the key component of this, in particular, I am opposed to. But I think sending this whole thing, sending it to the MAB would be counterproductive.

MR. ROBEDEAU: Is there anything good about it?

MR. LAUER: I have looked real hard. If I find anything, I will let you know.

MR. SKEEN: I think there are some things. I think that one, the issue of conflict of interest, I think the way this is reading is that Randy Busse brought the conflict of interest up.

MR. ROBEDEAU: Yes. He did.

MR. SKEEN: And suggested that there was a conflict of interest between Dugoni and Chipman and Theander. I am not familiar enough. I have heard various comments from people. I am not familiar

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enough to know whether there's a conflict of interest with Dugoni and Chipman. I don't think there's any more conflict of interest with Cole Theander with his past involvement with the plans than there is with Randy Busse.

MR. LAUER: Brusse.

MR. SKEEN: There is an R? With Randy Brusse or than there would be for this group to put forth a plan endorsing OHSU and so forth. So I just don't understand that whole conflict of interest. I don't know how you cannot have on that basis -- I don't know how you cannot have broad-based conflict of interest with everybody.

MR. COLLINS: There were two issues that were brought up on the conflict of interest. One had to do with Dr. Dugoni and Cole and the fact that they were authors of one of the plans that they were considering, and that probably is a pretty gray area.

The other issue was the fact that the chairman of the current MAB would be voting to recommend a plan that had a specific

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employment opportunity and compensation for him.

MR. SKEEN: For him. Wasn't that on an interim basis?

MR. COLLINS: Interim or not, that was a question that came up, that the chairman was considering a plan that had -- that purported to have the job for him.

MR. DRAKE: He is voting for a plan that gives him money.

MR. COLLINS: We have asked the County counsel --

MR. LAUER: However, he didn't vote.

MR. COLLINS: Yeah, he doesn't vote unless it works out that way. We have asked him to look at that. I don't know what constitutes it or not.

MR. THOMAS: There's an issue as to whether or not voting is adequate or whether or not you have to step out of the process completely. It's an unknown. That's probably what we are looking at.

MR. LAUER: I think Trace's point is key, though, that whatever is produced is going to be produced by people who are

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within the system. And in that there is potential conflict of interest.

MR. ROBEDEAU: There's a difference between producing something in secret, putting it out, slamming it through, and participating in a process that's open where everybody knows and everybody has been invited to these meetings. Anything that we produce comes from an open process.

Both -- well, the PAPA proposal was produced by a secret society in a closed process. In fact, after the first couple of PAPA meetings, Randy, all of their invitations to meetings were closed with the fact that it was only PAPA members and invited guests that were allowed at any meetings. Yet they are sitting there writing a proposal that's going to affect things.

And we know that part of this secret society from the first couple of meetings we were allowed to go to was Duane Dugoni. He was there. And he was bad-mouthing the private providers and the fire bureau. He

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was bad-mouthing everybody.

MR. LAUER: I don't know that the secret meeting thing has a lot of weight. You know, for example, this issue that the conflict of interest would be raised at the MAB came out of a meeting that was called at OHSU on the eve of this MAB meeting. One could look at that as a secret meeting. I don't think it is.

MR. STEINMAN: Randy Brusse was not at that meeting, and I have not talked -- Randy raised that, and nobody at that meeting raised that issue.

MR. LAUER: It's highly coincidental.

MR. COLLINS: This seems to be kind of a separate issue for a proposal for medical supervision. This is a technical issue for the Medical Advisory Board.

MR. DRAKE: I think it's important, too. I think we should look at it. There is a conflict of interest here. There is a big difference in the process we are going through than they went through. They kind of purported to people, we are going to look at Collins' plan and we are going to

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look at PAPA's proposal and then we are going to make this decision as a Medical Advisory Board.

The truth is that members of the Medical Advisory Board had already made the decision and, in fact, helped write the PAPA proposal. They weren't just looking at this de novo, look at it anew and going, which one should we choose. They knew that; we knew that.

MR. LAUER: Did you know which one you would choose prior to that meeting?

MR. DRAKE: They don't write it. People draw conclusions.

MR. LAUER: This is a real technical point. We have no place making a statement.

MR. MOSKOWITZ: Maybe I could suggest another way to raise a similar issue, rather than trying to attribute all kinds of motivations and so forth expressed like that, is to look at what the result is of the proposal.

And as I understand it, one of the results of that proposal would be to,

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rather than concentrate medical supervision and control in one place, would be ostensibly to spread it around a number of places.

And I think it's not inappropriate to draw the conclusion from that clear statement of their plan to say, this would seem to benefit, you know, all these people

that are on this board rather than benefiting just one institution. And you can draw some conclusions from that about why -- whether that choice is made for purely medical reasons or for some other reasons.

MR. DRAKE: Right. Because there's a political outcome. They won't want it to go to the University because the people that voted against it are from Emanuel and Providence.

MR. MOSKOWITZ: If, in their finding, they can give good reasons why that should be done, they can argue that. If Randy wants to argue that he has got good reasons, you know, he can put that into his findings and draw that conclusion why it



should be spread out rather than concentrated.

But I am not aware that that was done at the MAB, with the MAB proposal or PAPA proposal. And you had presented at least some medical justification for why it should be concentrated. Whether there are other reasons as well is open to conjecture.

MR. LAUER: But the notion that the chair of the MAB, by supporting, the PAPA plan, presented a conflict of interest because one of the components of the PAPA plan made the chair of the MAB the interim medical director, until one could be recruited and hired, could be turned around and say that a member of the MAB, who represented the fire bureau and voted for a plan that expanded the role of the fire bureau, would present a similar conflict of interest. And I think they are both ludicrous.

MR. ROBEDEAU: Randy, I will guarantee you one thing. That once -- well, I will guarantee one thing that under the current



hassle and under the PAPA proposal, there will never be a physician supervisor other than the chair of the MAB.

You know, this physician supervisor thing was put out years ago. This thing was put out 15 years ago for people to become a single physician supervisor for Multnomah County. They couldn't get anybody in this country to take it because of the hospital politics that existed in this system, so to solve the problem with the ordinance until they changed the ordinance -- and that's only been a few years ago -- the County -- Dr. Oxman's position, was it County medical director?

MR. LAUER: County Health Officer.

MR. ROBEDEAU: Was appointed to be the single physician supervisor. And as we went through the first wave of all of this stuff about how there was no single medical director, Dr. Shade was the single medical director by ordinance, because there was no way that any doctor in this whole country was stupid enough to take on the job here and go against every hospital.



So the fact you are talking about an interim position as the chair of the MAB, you aren't talking about an interim position. You are talking about a permanent position as chair of the MAB will be single medical director because there is, you know, Bill -- and it's nothing against Bill or anyone else -- with the politicians that exist in this town, he can put out RFPs for medical directors until hell freezes over and he is not going to get anybody to take them.

They interviewed people. They had people come to town who were really interested in the job. They flew them in. They went around and interviewed them and went around and talked to other people and got back on their plane and went home, the hell with this place. Not now; not ever.

MR. SKEEN: Let me ask a question. How does Bill's proposal -- how do you perceive that it compares with the recommendation from Gary Oxman and Gladys McCoy, the November 9th recommendation for medical control?



MR. COLLINS: I don't have it -- you mean that we presented?

MR. SKEEN: Right. From Gary Oxman, Bill Collins. Subject: EMS medical director.

MR. COLLINS: We didn't specify who would do it. What we put forth back in November. And which actually we were making the changes in the ordinance until the commissioners kind of sucked it all back together again, was to hire a single medical director and then, based on the workload and the funding, they would be able to have as many helpers or agents or whatever term.

I don't like agents. That's a state term. Sounds like they got FBI guys out there. But whatever, you know, whatever other people were needed, other physicians that were needed to carry out the list of responsibilities for the medical director.

Our major difference between -- the major difference between what we proposed then and what the MAB had proposed back then via their PAPA plan is that we didn't



feel that it was necessary to hire a medical director to also be responsible for all the administrative aspects. We were very much opposed to setting up another County department just to be setting up another department. That was the issue reporting to the chair. Because all we could figure out that would do would be to increase the support costs.

And that was pretty much it. There wasn't really -- we did not look at who should do it or look at the University or any of that. And our instructions from the board at that time was that it should not report to the chair -- of course, now there's all new people -- and to go ahead and prepare the ordinance to put it in place.

MR. SKEEN: I think, Pete, the testimony that Jon, particularly Jon Jui gave when he was here a couple weeks ago was very good, very valid. Talked about consolidating that. My concern is, by edict, essentially doing the same thing here, making a recommendation here, doing



the same thing that some have accused the MAB of, and that's kind of slam-dunking the chair of the MAB into the position, we kind of do the same thing.

I think there's a lot of advantage to the University being involved with that in a way that Jon might not, but I mentioned to Bill after the meeting -- I doubt it's on the record anywhere -- that it would seem to me that the program -- and it was the same as the testimony that I had before the MAB on their last hearing, is rather than try and determine who is going to do it, first determine what it is that you need.

MR. ROBEDEAU: Okay, Trace, and how it should be structured and then look at who the providers of that should be. The U of O may -- University may very well come through as the only entity that can do that. I just have concerns about us coming through and saying we have all done the due process here. They should be it.

MR. DRAKE: We actually went through a subcommittee -- in direct relationship to

that, Pete, we went through a subcommittee that did that for a long time. Talked about medical direction and all, came up with the plan that it should be a single medical authority. They would have agents and, essentially, what you are talking about. And it was that that hospital should be affiliated with a trauma center and should be the medical resource hospital, the same hospital. Now – go ahead, Pete.

MR. ROBEDEAU: I don't want to interrupt you but I am going to.

MR. DRAKE: Okay.

MR. ROBEDEAU: I think we need an agreement on this today. It's 10:35. You know, I have just made some points here, agreements and disagreements. What is it we can agree on?

MR. COLLINS: Let me make some comments on the second page. I am doing this in my role as the director that has to make a recommendation to the board.

The points that are listed out here as being deficiencies in the PAPA plan I think



are for the most part not true. The PAPA plan is extremely specific on the duties of the medical director. It permeates their entire plan. I mean, I think that's just flat out wrong.

I don't understand – I understand the amount of time necessarily. I don't think anybody has gone through and tried to figure out exactly how much physician time is needed to accomplish all these tasks. And I would agree neither the PAPA plan nor our plan nor anybody's plan nor the group that met before the plans came out got down to any specificity on that.

There is a provision in the PAPA proposal for hiring agents. They are not called agents. But it's called, the medical director shall not do this without the approval of the Medical Advisory Board. It doesn't say he can't do it. It just lists.

They did not establish criteria for qualifications of those people. They didn't carry it past that. I don't understand it anyway. But both plans have



that in it. The other thing is, if we are going to – if you are going to put out something that comments on the lack of specificity in a proposal as a proposal, then you have to be real specific in your proposal what it is that you want to have done.

I would think that both – you know, being involved in one plan more than the other – but they both have a lot of detail about what the physician medical director should do. In fact, if anything, we probably have too much in the plans about the medical director. But that's all right.

MR. ROBEDEAU: My interpretation, to be real honest with you, Bill, was – it was, the plan was deliberately vague in what the physician medical director's job was because they were trying to bootstrap the physician medical director –

MR. COLLINS: The PAPA plan?

MR. ROBEDEAU: Yes. They were trying to bootstrap the physician medical director and EMS director who was going to report



directly to the paramedics committee.

MR. COLLINS: What?

MR. ROBEDEAU: That was my impression in reading the thing.

MR. COLLINS: We must be reading a different plan.

MR. STEINMAN: Pete, there's no way that –

MR. ROBEDEAU: The peer review committee. But I think what we need to do here is – let's say that this is not even a good template. Okay? Let's sit down, and what can we agree on? All of us have been here. What are the components that are needed that we agree on with some specificity for the medical director?

MR. THOMAS: I have a question because of what Trace said, which was if – let's forget the procedural stuff and all that stuff. If you are just looking at the medical direction components, if OHSU were not identified as the likely – as the one, and instead defined generically, this is the way it ought to work – is that close? In fact, I tend to agree it's a little – I



mean, you select a provider after you define the criteria, I suppose.

MR. SKEEN: Define that criteria, Mark?

MR. DRAKE: Yeah. Or Bill does. We can pull that out. Because we went through that subcommittee or committee.

MR. SKEEN: Is it in the side by side from Oldegard to Gladys? This is what you sent out the other day.

MR. THOMAS: Pete has in here an A through C, and it identifies OHSU. How does that sound?

MR. COLLINS: That's it.

MR. THOMAS: What I was talking about, Trace, was in three A through C here. What it is really talking about is an integrated on-line medical control and medical supervision at one institution or in one regularly functioning group. So apart from whether that's OHSU, is that a good idea that everybody agrees to or is that an idea everybody doesn't actually agree with?

MR. SKEEN: I don't think we should be in a position here of determining that some



other group can't mirror what OHSU is kind of currently doing.

MR. THOMAS: I tend to do that.

MR. SKEEN: Put the burden back on them.

MR. THOMAS: Apart from all that, should it be integrated in one group? That's the more fun question here, regardless of who it is, and do you want to recommend that? I suppose that's the question.

MR. DRAKE: We all agreed to that before, that it should be a single medical authority with a group of people, they had to be at a trauma center.

MR. SKEEN: With MRH.

MR. DRAKE: MRH had to be there, it is contracted with the County, and the County can contract that out to a different hospital.

MR. SKEEN: There's nothing that precludes Emanuel, if they want to bite the bullet on all these issues, there's nothing that would preclude them from competing for this.



MR. STEINMAN: Why do we want to specify trauma center?

MR. DRAKE: We did –

MR. STEINMAN: I know because that cuts it down to two. That precludes Providence if they want to participate or anybody else.

MR. LAUER: I agree.

MR. DRAKE: The reason for doing it – I don't agree that, Tom, because the reason we did the trauma center originally was for the training of EMS; that we wanted the teaching hospital, whichever it was then, to provide training for the paramedics in the system so they could spend time in the trauma unit, those kinds of issues. And so we wanted that medical group to assist in

the training of the paramedics, and you can't do that at a nontrauma center. I thought that was an important component.
MR. STEINMAN: Well, I think we can accomplish the same thing by just saying that medical group will provide access and training in different arenas and not limit it. One thing I think we need to do, if we



are looking A through C, is not specify gender in what we want as medical director.
MR. THOMAS: Him? Absolutely.
MR. COLLINS: Where?
MR. THOMAS: Second line. Him. His agents to help him. Or at least let's specify a different gender.
MR. LAUER: I agree with Tom. And I think that that's a positive and constructive way to go forward to the MAB if we are going to present something to them that we --
MR. DRAKE: Delete those words.
MR. LAUER: I agree we shouldn't specify a trauma center because you may not need it. I also agree that the medical director and his or her agents should either provide on-line medical control or oversee on-line medical control. And those are broad concepts, and I think it would be perfectly appropriate to take to the MAB and ask them to look at it when they consider this further.
MR. DRAKE: So going through this document, though, using that as a



template -- I agree with what you are saying, Randy -- everybody agreed we want to take out No. 1, that that was inappropriate for this paper. Is that clear? General consensus?
And then with respect to No. 3, that we broaden it to include -- take out gender-specific language. Make it gender neutral. And that we delete any reference to the Oregon Health Sciences University.
MR. ROBEDEAU: What are we putting in?
MR. LAUER: I would go through and edit it. Paragraph 2 starts -- I would delete "Only." I think it's appropriate to say "Expertise of the Medical Advisory Board" instead of "The only." That's kind of limiting.
MR. SKEEN: I don't see any need to put in the inflammatory stuff.
MR. DRAKE: That's what we are here for. What do you want to take out?
MR. LAUER: Take out "Only".
MR. THOMAS: Where?
MR. ROBEDEAU: No. 2, it says "Only"



and "Expertise."
MR. DRAKE: What else?
MR. SKEEN: Probably "precipitously."
MR. DRAKE: Where?
MR. SKEEN: About a third of the way. "The PAPA plan precipitously adopted."
MR. THOMAS: Should be adopted.
MR. SKEEN: And then that next sentence, "The EMS office plan does contain features in areas such as" -- it names them. The PAPA plan also contains many of those. You can't ignore that -- can't pretend it doesn't because it does specify that.
I guess the underlying message would be that there are -- that there's a lot more to this. And we have certainly uncovered it in the past five weeks in going through this -- and I will go back again. I would like to see us at least present something like this partially completed, or maybe not even completed at all, that says, folks, there's a lot of other issues here that you have to deal with besides who is going to be your



medical control director.
MR. DRAKE: I wouldn't be opposed at all to submitting this as blank and saying there's the things we are looking at.
MR. SKEEN: These have been identified and evaluated.
MR. DRAKE: Sure. Along with the second one, EMS design unit hour requirements. I have some questions on this, but I think a blank form.
MR. ROBEDEAU: I really think this has to be in by the 14th.
MR. STEINMAN: If you are going to stick with a lot of this stuff, I think you need really just to point out that MAB or somebody needs to find the common ground between the two plans. You are saying County does this and the -- PAPA does that.
MR. ROBEDEAU: I think what we need to do is submit our plan, which is the common ground. If we tell them to find the common ground, they will say it's already adopted.
MR. STEINMAN: But you are not going to be able to do that by the 14th, so you need to point out that that needs to be



done and hasn't been done by the MAB, if you want to.
MR. THOMAS: I have a question for Pete. In terms of wanting to submit something to the MAB, are you more concerned about making -- submitting this group's recommendation as to what the medical control ought to be? Or are you more concerned about the sort of critiques that are built into this about the PAPA plan or Bill's plan?
MR. ROBEDEAU: I think what we need to do is concentrate on what our recommendation to the MAB is.
MR. THOMAS: I agree with that. I think if you can do that and forget a lot of other stuff, you will be better off.
MR. COLLINS: Why don't you look at the two proposals for medical control and either decide that these -- this component is okay or this one is not. I mean, if you look at the medical control aspect of the two plans -- and, actually, what we presented to the board in November is pretty much what we have in our plan, there



really is not a lot of difference. There's a few key elements. Now, there may be something missing and that you should fill in, but there's not a lot of difference in those two plans.
The major difference that I have seen between the two proposals for medical direction is that the plan that's been adopted by the MAB expands the role of the medical director to essentially be the responsible person for the whole system, so there's a big administrative component.
The other key thing, which is kind of a turnaround from where they were at the MAB, was that the initial concept was a very strong, independent medical director. The plan that has been adopted by the MAB has a medical director but has a very expanded and different role for the MAB. You need to look at that. Other than a couple of those things, the rest of it is, at least in my mind, is pretty much the same. It's like more semantics than anything else.
MR. ROBEDEAU: That is just exactly



what I was saying about A through E here were the PAPA plan was so vague that it was setting the EMS -- the physician medical director up to be the administrator of the system.
MR. COLLINS: No. No. That's not what I am saying. When the medical direction was considered previously, before

the plans came up --
MR. ROBEDEAU: What you just said, the PAPA proposal makes the medical director the administrator of the system.
MR. COLLINS: Yes, it does that. But it also, one of the other things it does -- right now, if you take it right now the way the system is, we have a bunch of physician supervisors and an EMS director. The physician supervisors are obligated within the ordinance to follow certain medical protocols. And the director of EMS is obligated, when putting into the rule, to get the MAB approval on certain things.
One proposal for medical direction, and actually the one that went to the board for informal consideration, establishes a



medical director position who was the responsible person and did not -- they report administratively to people through some other body that sort of redoes their thing. They write the process policies; they put them into place.
When this finally got into the plan situation-- and that was pretty much what both -- what everybody was agreeing on.
When this got into the plan, one of the major changes that, at least, I found in the PAPA plan over the plan that we put out, is that the medical director, who is hired by the County, has to have all his or her actions approved by the Medical Advisory Board. So it actually changes dramatically the independent authority of the physician.
I mean, that's one big difference. And the other difference is the administrative stuff, which is, you know, you can argue whether it has anything to do with medical plan. So those are -- I mean, I don't know if there's any other big difference. Agents or agents, there's



slightly different ways to put them in place.
MR. MOSKOWITZ: Except that issue was significant at least in terms of what Dr. Perretta and Norton were saying, how they thought those people that were doing the supervision ought to all be part of the same group, which is what these folks here were saying.
MR. COLLINS: Right. Right. I understand that. And that actually didn't get into the plan but --
MR. MOSKOWITZ: So that may be something added to.
MR. COLLINS: I don't think there was anything in either plan that precluded having that done. It just -- no one said you will do it this way.
MR. LAUER: It didn't require it.
MR. MOSKOWITZ: But it would allow the other to happen. Those plans would allow something other than to an integrated group to occur.
MR. SKEEN: I suppose there's a subjective element to that in that the MAB



had to approve any of those -- did we come up with another word for agents?
MR. COLLINS: Agents. That's the State term for it.
MR. SKEEN: That may be a consideration.
MR. COLLINS: That's kind of the general tenor of the difference, I think, in the medical direction part. The administrative part we said, you know, our plan said split it out, there are two different functions. But in the medical direction part the approval process by the MAB is a very different way of doing it than was originally approved, and actually different than what we are doing now.
MR. LAUER: Right. And actually, we discussed this previously and agreed, at least the private providers agreed it shouldn't happen. The reporting relationship shouldn't be to the MAB; it should be directly to the chair.
MR. ROBEDEAU: No, we didn't agree it should be directly to the chair. We agreed it should not be to the MAB.



MR. LAUER: Okay.
MR. ROBEDEAU: Perhaps there was quite a bit of discussion but --
MR. LAUER: The EMS board shouldn't be -- this is my and Pete's signature on it. It says, direct reporting to chair of County Commissioners.
MR. COLLINS: On that one thing you came out with? Right.
MR. LAUER: EMS system should report to the County chair, should chair the MAB, rather than have MAB chair be the director. The director should be the chair. And I think that's an interesting --
MR. ROBEDEAU: We had recommended that, that in order to create -- that is correct. I remember that. That was the requirement between the MAB and the physician medical director that we had agreed on was that they be the chair, but not that the MAB have really anything to do with the hiring of this physician medical director. He was the person who was injected into their process.



MR. LAUER: Right. Essentially became the chair and, as a result -- and this comes right out of here -- as a result the MAB would have direct advisory input to the physician medical director.
MR. ROBEDEAU: Right.
MR. LAUER: Would be an advisory board and not an oversight board.
MR. ROBEDEAU: I don't remember us saying directly to the chair. I thought we had agreed the physician medical director was going to report directly to the health officer.
MR. DRAKE: That's what I thought. It wasn't directly to the chair.
MR. MOSKOWITZ: Can I suggest, maybe just take -- the description of medical supervision piece by piece and see if you agree or disagree with each piece? Because the conversation is kind of covering all these areas.
MR. ROBEDEAU: I think Steve is right. We need to get this down because we have to have something out.
MR. MOSKOWITZ: I mean, for example,



do you agree or disagree that medical supervision should be integrated in one group rather than spread out among several individuals who are independent of one another?
MR. ROBEDEAU: Yes.
MR. DRAKE: What was that again?
MR. MOSKOWITZ: Maybe there's a better way to say it. But integrated medical supervision, a core group of medical supervisors who are part of the same medical group, rather than who work for a variety of different organizations or institutions.
MR. DRAKE: Right.
MR. ROBEDEAU: Two yeses. Tom, do you agree or disagree with that?
MR. STEINMAN: I don't know if I can do this. I will agree.
MR. MOSKOWITZ: Maybe you are not allowed to take any positions.
MR. STEINMAN: I am not sure. Which companies agreed? I am not sure.
MR. ROBEDEAU: Trace?
MR. SKEEN: You know, in going back to

the testimony, that's probably optimum, but I think even Dr. Perretta said it possibly could work distributed, but that optimum, it's easier for them to work within the same group.
MR. ROBEDEAU: What we are agreeing on is that would be the best way to do it.
MR. SKEEN: If I were doing it, I would say, while it may work by different agencies, the optimum would be to have it within the same group.
MR. STEINMAN: Have you filed --
MR. ROBEDEAU: Is that a yes or a no?
MR. SKEEN: You know, are we willing to litigate this thing if it's not all within one agency? Certainly not.
MR. ROBEDEAU: No.
MR. SKEEN: But from an optimum standpoint, it probably is.
MR. DRAKE: We are making a recommendation saying this is what we recommend, we think it should be.
MR. SKEEN: I just don't want to lose sight of the fact that Jon Jui made the recommendation, also indicated it could



probably work in another venue.
MR. STEINMAN: And it has.
MR. LAUER: That is not required. It is desired.
MR. ROBEDEAU: Then I do hear a unanimous yes on that one point? Okay.
MR. DRAKE: One point down.
MR. ROBEDEAU: The other one.
MR. COLLINS: Put a big star by that.
MR. ROBEDEAU: The original committee had recommended a report to the County Health Officer, not to the chair.
MR. LAUER: Actually, it's pretty, I guess, quickly described in a flowchart we came up with where the chair of the County Commission would have ultimate authority; reporting to the chair would be the director of the health department, who was not the County Health Officer.
MR. COLLINS: Right.
MR. THOMAS: Right.
MR. LAUER: That was the difference.
MR. ROBEDEAU: That was right.
MR. LAUER: Directly reporting to the direct -- either health department. And



the reason we did that, we did not think it was a doable thing to establish a different department within the County.
MR. COLLINS: I mean, that's kind of a basic premise.
MR. LAUER: Obviously, to the physician medical director then is the Medical Advisory Board of which the physician medical director chairs. Under that EMS system administrator reports to the medical director advisory to the system administrator is the Provider Board, and it is staff below that.
MR. THOMAS: So you have the EMS system administrator reporting to the medical director?
MR. LAUER: Right. Well, when we talked about that we looked -- how would it work if they were parallel? Because medical issues and nonmedical tends to be gray, what overlaps and what doesn't, so Buck had to stop somewhere, essentially. CARE.
MR. ROBEDEAU: The biggest part of the conversation was whether or not --



MR. THOMAS: I am just raising my eyebrows because none of the hospitals work that way and none of you guys work that way. You don't put the physician as the person who is the top totem pole because you don't want a physician being the dominating factor. It doesn't -- to me that's not actually a right way to do it.
MR. LAUER: You would reverse that? Or keep it parallel?
MR. THOMAS: I think I would. Or I would have them both report to somebody. But I mean, I agree there's a problem with two reporting. But I really don't think it's right to have the doctor at the top of everything because you lose your cost-containment side largely.
MR. LAUER: And there's a whole bunch of discussion about that very issue, about that reporting structure.
MR. THOMAS: Other than that, other than that, though, I don't know. What would be the alternative, Bill? Reporting doctor works for the administrator, I assume.



MR. COLLINS: It doesn't really work like that. I mean, that's always -- you know, hospitals are a good example. The physician in the hospital, the medical director of a hospital doesn't report to the administrator of the hospital.
MR. THOMAS: Who does the director report to? The board?
MR. COLLINS: The director of the hospital usually reports to the board, and the medical director is an autonomous figure. And that's worked like that ever since they gave up having physicians be administrators of a hospital.
MR. THOMAS: So who selects the medical director, ultimately?
MR. COLLINS: The medical staff. Now, in this case, the County is employing it, there would have to be a selection process. But the way, you know, the way it actually happens in medical direction in a system is that you hire the medical director for their medical expertise, and that is independent of their reporting, for purposes of maintaining their contract or



their employment. In other words --
MR. THOMAS: I understand.
MR. COLLINS: -- nobody comes in and says -- let's say you have the medical director reporting to the head of the health department, who is not a physician. The head of the health department would not go to the medical director and say, I don't like the medical decision you made so I am changing it. That just doesn't happen.
MR. THOMAS: Under your system, actually, the way it would work would be the County Health Officer -- in a way the County Health Officer would be the one that would be responsible for the health side.
MR. COLLINS: The County Health Officer wouldn't be doing that either. What you would do if you didn't like the medical direction that was being provided, then you would terminate the employment. You would not -- it's not a reporting relationship on a superior-subordinate basis of making decisions.
MR. THOMAS: I understand.
MR. COLLINS: It's just where are they



in the organization from the standpoint of, you know, who is evaluating the general process?
MR. THOMAS: Okay.
MR. LAUER: EMS was sort of a little brother to the health officer's department a long time ago when it was first conceived, and I think the statement is that it's become a different thing now.
MR. THOMAS: The main concern I had was, actually, the EMS administrator reporting to the medical director. I think that person ought to report to whoever Bill reports to now. That's the department head. Right?
MR. COLLINS: I report to the health officer.

MR. THOMAS: The health officer?
MR. LAUER: This would replace the health officer with the department director.
MR. COLLINS: You can make those decisions, but in the report, but I think those are really minor issues. And I think they are focused mainly around what people



perceive is going to happen. It's sort of like they think that you are going to hire a medical director, and then the medical director says do A, and if the health department doesn't like it, they are going to change it and do B or C.
I mean, that really isn't going to happen. That isn't how it works. I mean, it's like your physician supervisor. You can disagree with them and you can fire them. But you can't make them change their medical decision.
You can't say, well, to the paramedics, well, I know the physician supervisor said do A, but forget that. You have to do B or C. You can say that, but that doesn't hold any weight at all. You can fire them. You can say I don't like your medical direction. I will get somebody else.
MR. MOSKOWITZ: Can I just list a couple others and see if -- what about integrating medical supervision with MRH?
MR. ROBEDEAU: I think it should be at the same location. We agreed on that



before.
MR. MOSKOWITZ: Okay. What about what Tom and Randy were saying, that the medical supervisory personnel are responsible for making sure paramedics are trained through some trauma center?
MR. THOMAS: Trauma experience.
MR. MOSKOWITZ: Trauma experience?
MR. THOMAS: Not trauma center necessarily.
MR. DRAKE: Right.
MR. ROBEDEAU: No. Wait a minute.
MR. SKEEN: I don't understand.
MR. ROBEDEAU: I am a little confused.
MR. SKEEN: We are slow over here in this corner.
MR. DRAKE: They have to provide training for the paramedics in a hospital or clinical setting.
MR. COLLINS: But they have to do that for a number of things. Right?
MR. STEINMAN: Yeah. Not just trauma.
MR. SKEEN: All right.
MR. ROBEDEAU: Leave the word trauma



out.
MR. DRAKE: Just put critical setting.
MR. ROBEDEAU: Covers all aspects of their job medically.
MR. MOSKOWITZ: Did you want to specify anything about the qualifications of the medical supervisor? Dr. Perretta had a whole list, as I recall. Did you want to get that specific about being more than just certified as an emergency physician?
MR. THOMAS: His main thing was, they have experience in EMS.
MR. LAUER: We had recommended in this document qualifications, duties, responsibilities, and authority should be consistent with ASAP guidelines, and they actually promulgated a whole document about medical director qualifications. What stuff?
You don't know what I am reading.
MR. SKEEN: I wanted to see what you are working off.
MR. COLLINS: That's a fairly good document.



MR. LAUER: And that's what we previously recommended. Let's not reinvent the wheel. There's a good thing out there. Let's plagiarize it. Let's adopt it essentially.
MR. DRAKE: And also their agents should meet the ASAP guidelines. I think that's the point Dr. Perretta made.
MR. ROBEDEAU: I think some other points Dr. Perretta made that perhaps should be adopted is if the optimum any one physician can supervise is 75, then 50 to 75. Then I think the physician medical director should be precluded from supervising, directly supervising more than 50 to 75 paramedics. In other words, saying you have to have agents.
MR. THOMAS: There's two ways to go on that. One is to try and lock down on your supervisor. One is to say the person has to be from an institution that can do certain things, whatever that institution is. But let the supervisor figure out themselves how they are going to allocate that out.



That was what I wanted to advocate, and he thought of things like, obviously, you have to have enough personnel available to meet whatever the need was going to be. One was, he said there would be a collegial atmosphere.
The thing we haven't talked about that he mentioned was that there needed to be a research facility. I will look at my notes of the things he said. That was it. I don't know if that's -- he may have defined something which locks it into one institution, and I think that's maybe a problem if he did.
MR. STEINMAN: Yeah. I mean, his numbers were just off the top of his head. There's nothing to back those up. There's nothing to support it.
MR. SKEEN: That 50 to 75?
MR. STEINMAN: Yeah. I think Chris is right. It needs to be a little broader that says, the institution that is interested in providing this needs to have a system.
MR. ROBEDEAU: Or individual.



MR. STEINMAN: Individual or system has to provide a system to cover X number of EMS, paramedics, first responders, transport agencies. We can come up with an approximate number on that number on that. I think we need to point out somewhere in this -- and maybe if they are going to be an employee of the County, it's not going to be a problem -- but that malpractice insurance is going to be a big headache for somebody.
MR. ROBEDEAU: To the best of my knowledge, Tom, an individual physician supervisor has never been sued. It's always been the company or the fire department, the municipality or the private company.
MR. STEINMAN: To the best of my knowledge, Molalla never had an earthquake.
MR. ROBEDEAU: Oh, yeah, they have had lots of them.
MR. STEINMAN: That's irrelevant. It's going to happen.
MR. ROBEDEAU: We discussed that. If



the physician supervisor is an employee of the County and is protected by tort, and the maximum exposure he is going to have is going to be $100,000.
MR. STEINMAN: That's fine if they are an employee of the County. You know, then it -- are those agents employees of the County? I think we need to be kind of

specific on that.
MR. THOMAS: Tom is just saying at some point people need to -- whoever is going to be a potential applicant for doing this needs to think about the liability issues.
MR. STEINMAN: We are talking about two things here. We are talking institutions and employees of the County. You know --
MR. THOMAS: If they contract with an institution, they are not going to be employees.
MR. ROBEDEAU: I think Bill had already come out and said, and the County attorney --
MR. COLLINS: We can contract with an

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institution. We can't contract with an independent contractor.
MR. THOMAS: If it was an individual they can't.
MR. COLLINS: If it's an independent contractor who is essentially going to work as a County employer. But if it looks like a contractor, that isn't going to work. If this was to go through an institution --
MR. ROBEDEAU: Then it will work?
MR. COLLINS: See, if we were to do this, we would contract with the University. We would not contract with the individual physician. Those physicians are employed by the University. That's not -- that's not a free --
MR. THOMAS: Then we have to start talking about contracting with Providence hospital and maybe it will fly.
MR. ROBEDEAU: Well, that's an error, I had thought.
MR. COLLINS: That's even more complicated because those physicians are contractors.
MR. LAUER: If we are going to -- we

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are sort of redoing things we have done before. If we are going to put something forward to the Medical Advisory Board and we want to do it constructively, I think we should revisit what we have previously done.
As you recall, the medical authority proposal, the PAPA made a medical authority proposal. What we did as providers was looked at that, said there's some good points, got some points we would like to change, and presented a document to --
MR. COLLINS: Us.
MR. LAUER: To Bill. The problem is and the reason we are back discussing is the PAPA plan did not consider any of the changes we asked them to make for our endorsement.
MR. COLLINS: Right. In fact they went a little further.
MR. LAUER: I think what we need is to reiterate our original plan, which is now part of the bigger ASA plan.
MR. SKEEN: Bill, how does your recommendations here on this side by side

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compared to the one that Randy is quoting from there, the Provider Board recommendations? Were they pretty consistent?
MR. COLLINS: I can't remember exactly. There were a couple minor things. We took the position before the board that, A, the medical director should not report to the chair; and that, B, the medical direction should be part of the EMS program of the health department. We did not specify who reported to whom.
MR. SKEEN: Was there any big divergence between your office plan and the Provider Board recommendations?
MR. COLLINS: No.
MR. SKEEN: I think Randy is right, that ought should be used as a template. Steve has addressed a couple other items there. And they ought to be incorporated.
MR. STEINMAN: I think they may be in that. I still haven't received that, Bill.
MR. COLLINS: Why aren't you getting --

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MR. STEINMAN: Some of the stuff Steve has got in here is already in there, isn't it?
MR. LAUER: Probably. There's a lot of things that are common.
MR. DRAKE: Dr. Norton participated with us when we drafted that, participated in committee meetings.
MR. STEINMAN: I don't think we are going to be able to come to consensus today. I would suggest we take a look at that as a template and be ready to come in and come up with a --
MR. COLLINS: Did everybody get that? I can't remember if I sent that out.
MR. ROBEDEAU: It's not in this packet.
MR. STEINMAN: I didn't get one either.
MR. SKEEN: This.
MR. COLLINS: People are trying to tell you something.
MR. SKEEN: This already has agreemen by the Provider Board.
MR. COLLINS: No, it's not.

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MR. LAUER: It's not actually the Provider Board because it wasn't a real public meeting.
MR. COLLINS: It didn't have agreement of everybody there. There were only three people.
MR. LAUER: It has the signatures -- this is the document that has the signatures of Pete, me, and Mark.
MR. MOSKOWITZ: Someone should take responsibility for taking -- sending it out for the next meeting and people come in and say what should be added, and if there's anything in there that the whole board as a majority disagrees with.
MR. SKEEN: Do you feel comfortable with him taking that and Pete's letter here and trying to incorporate that and to come up with a draft for next Tuesday?
MR. STEINMAN: Let's take that, Pete's letter and the side-by-side stuff, and everybody be prepared to come in Tuesday with the understanding we are going to pump something out Tuesday to get to the MAB by Friday.

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MR. ROBEDEAU: I would agree with that. We have to pump something out Tuesday. Nobody leaves Tuesday until it's complete.
MR. COLLINS: It would be helpful for -- you are getting some statement from the Provider Board on the current PAPA proposal vis-a-vis the Medical Advisory Board role because that is kind of the new twist, and I don't really have any input from anybody on that.
MR. STEINMAN: You will get input from me on that it.
MR. COLLINS: If you look at the past documents, that was not sort of in the consideration. Nobody had talked about that. Now it's kind of a new piece where the MAB sort of selects the medical director and everything gets approved by them. And I need to get some feedback on that also.
MR. THOMAS: I guess that's a good idea. I wouldn't -- just in terms of strategy, I would not want to get diverted from the main task, which is to make an

affirmative proposal.
MR. COLLINS: I think that's a major part of it. Maybe I am the only one that sees that. I don't think I could hire a physician under those conditions. If I hired a physician and said, you have all the responsibility but everything you propose is going to have to be approved, I don't think I would find anybody. That's my concern. So I just want to hear if that's other peoples' concerns and, if it's not, they should say so.
MR. MOSKOWITZ: That can be sort of an affirmative proposal, that the medical supervisor has the authority to issue the protocols that will be followed.
MR. COLLINS: Whatever.
MR. THOMAS: I understand.
MR. SKEEN: My sense, like Chris said, from a strategy, we ought to come forward with recommendations without reference of how it relates to PAPA and how it relates to others.
MR. COLLINS: That's fine.
MR. SKEEN: It doesn't establish our



own credibility. Put it in a positive statement.
MR. MOSKOWITZ: Looking at some of these other proposals may lead people to insert something as an affirmative statement.
MR. ROBEDEAU: Bill, is there a copier here? Could we get some copies run off right now before we leave?
MR. LAUER: Only problem with this, Pete, you recall that PAPA proposal, the document on medical authority? This is in response to that. You are going to need to have it.
MR. ROBEDEAU: It's here.
MR. COLLINS: I sent that out.
MR. ROBEDEAU: A proposal for medical supervision written by Portland Area Paramedic Alliance, September '92.
MR. STEINMAN: Randy can handle that. He has lots of time.
MR. LAUER: I will bring it back by two.
MR. ROBEDEAU: Perhaps since you never get it, Tom, I thought we could do it now.



MR. LAUER: Where is your office, Tom?
MR. STEINMAN: I have been gone two hours. I can't remember. Can we look at this -- can we all look at this for the next meeting and make our changes so we can also potentially submit that to the MAB that says, here is our intent in going through this? Just so they know. I think we need something like this that's real clearcut.
MR. ROBEDEAU: There's a second portion. That's the single paper.
MR. STEINMAN: I don't believe in unit hour utilization stuff.
MR. DRAKE: What we talked about, single dedicated, there is a single provider model, other than the single dedicated to 9-1-1. Because PAPA and Collins' plan were different, and then you have added a dual integrated, which is a new one.
MR. SKEEN: The dual integrated has been referred to a lot.
MR. DRAKE: But not in the past



document.
MR. SKEEN: No, it was not. And I took out reference to PAPA or EMS policy and just basically tried to look at the whole a little more purely.
MR. THOMAS: What does dual provider mean?
MR. SKEEN: That's, basically, you said there are now three integrated providers under this; it would be two integrated providers. Most of the discussion mainly from Jeff has been the merger, and CARE and AA has been reduced from three to two.
MR. COLLINS: What's this other thing? Looks like it's in code.
MR. STEINMAN: Actually figured it out while I was sitting here.
MR. ROBEDEAU: You are doing better than I am.
MR. SKEEN: I can give you the numbers that I came up with using these assumptions. And this is simply one model, and this is using reasonable unit hour, even though Tom doesn't believe in it, unit



hour utilization. The other model would be what this committee that -- I don't know if you were part of that or not, but certainly Randy and Mark and Barry participated in -- which was a demand model, that specifies unit hours, but I can give you the numbers that I came up with here on these assumptions, or you can go back and do your own math with it.
MR. ROBEDEAU: One thing here real quick. You are putting in -- on No. 3 on your assumptions, assumes non-life threatening response of 12 minutes with 90 percent reliability. You have got current system, tiered system, single provider integrated, then single integrated, dual integrated and single integrated. Are you assuming the current system with eight minutes and putting that in or are you assuming the current system with 12 minutes? That I am confused on.
MR. SKEEN: The only one that would apply to would be the tiered system where it called for a 12 minute response time with 90 percent reliability for the



non-life threatening calls.
MR. ROBEDEAU: Somehow that needs to be separated out. What we need to do, I think, with this is, we need to show what it would take or what we believe it would take using the eight minutes, so you can compare current to this and take the 12 minute, so we can get a current to compare to the balance. Otherwise --
MR. SKEEN: I think that's there. I know that this is confusing. For example, if you looked at the tiered system --
MR. ROBEDEAU: You have to remember, I am an owner.
MR. SKEEN: If you looked at the tiered system, my numbers -- we came up with with life threatening response, this is essentially the fire medic units under Bill's plan that require 94,000 unit hours per year. That's based on the fact we could to a .40 calls -- calls not transport -- .40 calls per unit hours.
MR. DRAKE: Okay.
MR. SKEEN: The question is -- Mark, you have done a lot of this work. The



question is, do you think that's a reasonable number to respond for all calls, all 24,400-37,600 9-1-1 requests within eight minutes 90 percent? And I will tell you that I am probably low on that. So that would be 94,000.
Then for the contracted provider that responds to the non-life threatening, and we use the term -- you guys said 20 percent and I mistakenly did it at 18 percent -- so in other words, they are responding to 88 percent, or, excuse me, 82 percent of those calls at 12 minutes. On that basis you would make the assumption that you could do that with a .35 transports per units hour based on a 12-minute response time but that's also with the code three response.

Now, if you compare that to what we are doing today, Mark, I have made the assumption we are doing a .25 today. And I don't know how that compares to you but it's -- we don't vary a whole lot off of that.
MR. STEINMAN: Trace, you are saying on the 12 minute you are basing it on a



code three response?
MR. SKEEN: Yeah. And I don't know what the policy on that -- whether it was intended for this to be a code three response.
MR. COLLINS: Why would it be code three? By definition they are not life threatening.
MR. SKEEN: If it's not code three, the ability to respond in 12 minutes, it's going to take more units.
MR. ROBEDEAU: You are going to be talking about more than units hours than you are dealing with now.
MR. THOMAS: You may want, for economic reasons, to have code three response.
MR. ROBEDEAU: The other response you are probably dealing with twice -- well --
MR. THOMAS: Recommendation would be that you keep it as a code three response for that even -- not for health reasons but for economic reasons.
MR. SKEEN: And also --
MR. ROBEDEAU: Complying with state



law to be an emergency vehicle, it has to be for health reasons.
MR. SKEEN: But keep in mind the emergency is in the mind of the patient, too.
MR. THOMAS: That's right.
MR. COLLINS: I want to make sure we understood the assumptions. In assumption No. 2 in the box, that's half an hour call, a little less than half an hour a call. Right?
MR. SKEEN: Yeah. Well, what it is --
MR. COLLINS: 9-1-1 calls.
MR. SKEEN: All calls. That's based on 37,600 requests, which was, I think, a figure.
MR. ROBEDEAU: And you have .40.
MR. SKEEN: .40 is calls, not transports, because we are talking about really not transporting.
MR. ROBEDEAU: So that means, ultimately, fire units are going to respond to a little more than two calls an hour?
MR. COLLINS: You figure that's 94,000



hours? We did demand analysis and that was 89,000 for hour. How does that fit?
MR. SKEEN: But calling for two hours.
MR. COLLINS: Not transport. Just calls. Down at the bottom you have call assumptions, 37,600 for 9-1-1, 6,000 for private. Does 6,000 represent all of the ambulance transports in the County that are not 9-1-1? Because that's the rest of the business.
MR. SKEEN: No. It represents -- I believe it represents, from the discussions we had last time, it sounded like about 75 percent of the work that the current 9-1-1 units are doing are 9-1-1 calls and 25 percent are private calls. So the 6110, 6110 is essentially saying 25 percent of the current business would equal 6110.
MR. COLLINS: 25 percent of the what business?
MR. SKEEN: Current business 9-1-1 calls do as part of the integration. And this is probably the least -- this is probably more guesswork in that 6110 than



anything else because I didn't have a chance to poll you guys.
MR. DRAKE: I think it's a real good start. I think this diagram works real well. The only thing I would like to see is to add a line under life threatening/non-life threatening there, and private units hours and have a line total units hours. So you just total them up.
MR. SKEEN: Right.
MR. COLLINS: Let me go back to the 6,000 again. What I heard you say is the 6,000 represents 25 percent of the workload of the units now deployed on 9-1-1 system?
MR. SKEEN: Yeah. 6110 is 25 percent -- or is one-third --
MR. THOMAS: The way you calculated it was roughly 25 percent of the 9-1-1 transports. What they were trying to do was say the 9-1-1 vehicles, what they do is 85 percent 9-1-1 calls and 15 percent other calls, and he is trying to account for those because you have to figure out what you are going to do with them. Right?
MR. SKEEN: Bill did a study based on



how many 9-1-1 transports are. The missing piece, X, equals -- is the private calls, and this is an assumption.
MR. COLLINS: So let me state it again. The 6,000 represents the additional calls over 24,000 run by the units that are currently deployed to run 9-1-1 calls?
MR. SKEEN: That's the assumption.
MR. COLLINS: So the total number of calls that those units are running, that is like 30,500? Is that right?
MR. SKEEN: That's the assumption. Now, does that represent all transports? No.
MR. THOMAS: There's others.
MR. SKEEN: Because there are additional BLS units out there.
MR. ROBEDEAU: If you are using that as a constant assumption, we do 32 percent of the 9-1-1 calls by your numbers. When this stuff first came up, about how badly beat up the paramedics were being because they had to run all these nonemergency calls, I did a very thorough study and the average, each one of our units does an



average of two non-9-1 -- each one of our ALS does an average of two non 9-1-1 calls per week.
MR. LAUER: Do you know what a percentage of those ALS units? Is it 75-25?
MR. ROBEDEAU: Ours, our ALS units do almost nothing for non-9-1-1 business.
MR. LAUER: That would be an interesting figure to arrive.
MR. ROBEDEAU: Only time is for critical care transport, and those fall when the BLS units were not available, and then we will pull a non-9-1-1 or 9-1-1 car, an ALS car out to do a critical care transport. That's almost all they ever did. Everything else is 9-1-1.
MR. SKEEN: In that case, your unit hour utilization is much less than .25.
MR. ROBEDEAU: No. We are pretty tight. I would -- we have been criticized as having too high a unit hour utilization.
MR. SKEEN: So their complaints were valid then?



MR. ROBEDEAU: No. They are all doing 9-1-1 calls. So the complaints aren't valid.
MR. STEINMAN: Did we decide on this code three response? Are you guys going to figure this code three for non-life threatening?
MR. ROBEDEAU: There's really no way

to figure it non-code three because without sitting down and doing a real tough study to determine traffic patterns and where the calls are coming from, if we are going to figure it out of code ones, you know, in this system we are adopting the fire department practice on standing by for as much as an hour at every scene.
MR. STEINMAN: Well, because I think that's going to be a real sticky point. There's been a million studies done about how much time you save with those lights and sirens, and it's sure not 48 minutes. Everybody is saying, are these things really --
MR. ROBEDEAU: What we are talking about is reducing the vehicles, the



noncritical care transport units, adding four minutes, saying that makes up for it, and saying everything is going to be code one.
MR. STEINMAN: I am just saying --
MR. SKEEN: You are saying it's sticky?
MR. STEINMAN: If you are saying it's non-life threatening and running people code three, I think the politicians are really going to question some of the safety factors.
MR. ROBEDEAU: Then take a look at the current ordinance. It defines emergency as any nonhospital injury delay in transport may -- you know I mean.
MR. THOMAS: He's raising the issue. I mean, there's obviously a big economic component to that question.
MR. STEINMAN: I know there is.
MR. SKEEN: I thought about that.
MR. STEINMAN: It would be nice if we could do it both ways and say it can't be done, but I think you all know we have all been out there running code three enough to



know you don't save a lot of time, especially after one or two wrecks in an intersection -- that you have a policy you have to stop at them anyway.
MR. COLLINS: Time between eight and 12 minutes on the getting the speeds? What method --
MR. SKEEN: Between eight and 12?
MR. COLLINS: We have it now set up on eight-minute response time. Set it to 12 minute response time. What method would you use to calculate the difference?
MR. COLLINS: Other than Ouija board.
MR. LAUER: Guess.
MR. SKEEN: 20 years. Nothing scientific. 20 years.
MR. DRAKE: If you take the average response times they are doing now and average distance and mileages.
MR. ROBEDEAU: A lot of what we are going to have to look at, if you are not going to allow code three running what time, you have to look at what time of day.



MR. COLLINS: I am talking about --
MR. ROBEDEAU: If you are running code one rush hour, Bill, sometimes you have to wait two or three times to get through a light. Code one at three o'clock in the morning --
MR. COLLINS: I understand that. I am not talking about changing from code three to code one. I am talking about now there's a deployment pattern for ambulances that is ostensibly based on eight minute response times. Somebody says to you, I am changing the response time to 12 minutes. What method are you going to use to determine the deployment pattern for the ambulances for 12 minutes versus eight minutes?
MR. SKEEN: One response to that is from the historical standpoint, in just looking from a utilization model -- and that's all this purports to be -- is that all persons are consistent with what we have here where there was an eight-minute response time, where we were running about .30, .31.



So if you assume that there's a 12 minute response time, it worked one, say, roughly .25 or .26. You see that increment go up to ten minutes, you can assume that it's another four or five points to 12 minutes.
MR. DRAKE: Couple different ways you could look at it.
MR. LAUER: If you compare it to a different part of the business, which is BLS calls, our response times for BLS calls are 30 minutes, and we get unit hour utilization of almost up to .6 with those units. So you know it's -- that gives you a range of eight minutes equals .28 or whatever and 30 minutes equals .6. So it gives you an outside edge.
MR. SKEEN: The other issue that I make sure is the demand analysis, that you guys did go back and look at this as well. It gives you a different method to look at it.
MR. COLLINS: You mean changing the number of calls? You do two things. You change the number of calls, you change



the time factor. You change the time factor.
MR. SKEEN: This is generic as the demand model is time specific to the hour of the day. Mark, you did some studies on that, I think.
MR. COLLINS: That was one of my -- in looking at the assumptions, although I haven't run any numbers out on this, if you were looking at the time to run a call being either four-tenths of an hour, is that right? Is that 40?
MR. SKEEN: .4. It means you run .4 calls per hour. So it would take you -- so you would run a call every two hours and --
MR. COLLINS: No. No. Go the other way. Isn't that what you are saying?
MR. SKEEN: A .10, assuming a call, equals an hour.
MR. COLLINS: I am not talking about utilization. So many calls per hour you have for the fire medic units. Our assumption in the command analysis is one



hour, one call. That was the assumption we used. Right?
MR. DRAKE: Uh-huh.
MR. COLLINS: Then you are saying --
MR. SKEEN: This is assuming, if that unit worked ten hours, they would run four calls. On a .40.
MR. COLLINS: I don't understand that assumption at all.
MR. DRAKE: What don't you understand? You are talking about the No. 2 he has down here?
MR. COLLINS: Yeah.
MR. DRAKE: He is assuming .40 unit hour utilization.
MR. SKEEN: Calls, no transports.
MR. DRAKE: Right. You are saying responses.
MR. COLLINS: I will play around --
MR. SKEEN: You are saying it could be twice that high.
MR. COLLINS: I am looking at it from demand analysis standpoint.
MR. SKEEN: This is not the demand analysis report. This is utilization. And

it's cumulative -- cumulation report.
MR. DRAKE: The only question -- he brought this up -- your total 9-1-1 and private unit hours, that includes -- the total includes -- the next four lines down -- 9-1-1 dedicated life threatening, non-life and private? Is that correct?
MR. SKEEN: Under which model, Mark?
MR. LAUER: Under any of the models.
MR. DRAKE: The first line --
MR. SKEEN: For example, under the current system, total 9-1-1 and private unit hours, that's the only one you have in there.
MR. DRAKE: Okay.
MR. SKEEN: Everything fits into that blank. Well, let me just show you.
MR. LAUER: It would be a sum.
MR. DRAKE: That's what I am asking.
MR. COLLINS: So that would be -- I don't know exactly, but that would be 125,000 hours. Right?
MR. MOSKOWITZ: Would it be appropriate to maybe adjourn for the court



reporter's sake?
MR. DRAKE: We are adjourned.
(PROCEEDING ADJOURNED)
* * *
(NOTE: Untranscribed steno notes archived permanently on computer; transcribed English files archived three years on computer.)
* * *



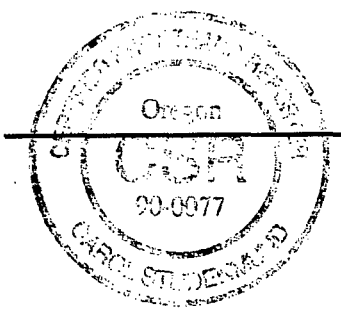
CERTIFICATE

I, CAROL STUDENMUND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype proceedings had upon the hearing of this matter, previously captioned herein, that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 18th day of May, 1993.

/s/ Carol Studenmund

Certificate No. 90-0077



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**In The Matter Of:**

*Before the Multnomah County*
*Provider Board*

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*Transcript of Proceedings*
*May 11, 1993*

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BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD
TRANSCRIPT OF PROCEEDINGS
Tuesday, April 27, 1993
9:06 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Randy Lauer, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Thomas Steinman, Portland Fire Bureau

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APPEARANCES
ALSO SPEAKING:
Ms. Lynn Bonner
Mr. William Collins
Mr. Jeffrey Kilmer
Mr. Steven Moskowitz
Mr. Christopher Thomas

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[1] **PROCEEDINGS**

[3] **MR. ROBEDEAU:** Has everybody read the [4] minutes?

[5] Okay. Has everybody finished? [6]Tom, are you done?

[7] **MR. STEINMAN:** (Nods head.)

[8] **MR. ROBEDEAU:** Let's, I guess, call [9] the meeting to order and review the minutes [10] from last meeting. Any corrections, [11] additions, deletions?

[12] Well, I have one. Page 3, last [13] paragraph, where it says, only PAPA and [14] invited guests have been at the MAB [15] meetings where the plan was developed. [16] When I was talking about PAPA becoming a [17] secret society, I was talking about — I [18] don't know that MAB was having secret [19] meetings. It was —

[20] **MR. SKEEN:** The PAPA meetings.

[21] **MR. ROBEDEAU:** The PAPA meetings had [22] become a closed meeting and weren't [23] allowing anybody to be there.

[24] **MR. SKEEN:** Yeah.

[25] **MR. ROBEDEAU:** And what I don't — I

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[1] don't know that they had any — that it was [2] official MAB meetings. I do know that the [3] first two meetings that were open to the [4] public, that there were MAB members [5] present.

[6] **MR. DRAKE:** So your only concern is [7] with sentence No. 2 then, Pete, not [8] sentence No. 1 of the last paragraph of [9] page 3?

[10] **MR. ROBEDEAU:** Sentence No. 2, right.

[11] **MR. DRAKE:** Right, okay.

[12] **MR. KILMER:** Well, Pete, do you mean [13] to say that the MAB's process —

[14] **MR. ROBEDEAU:** Secrecy of the MAB [15] process. I was referring to PAPA in that [16] whole thing. The MAB — well —

[17] **MR. DRAKE:** No, I think —

[18] **MR. ROBEDEAU:** I was talking about the [19] secrecy of the MAB process in that they've [20] had one meeting with this thing and adopted [21] it.

[22] **MR. KILMER:** Well, I agree.

[23] **MR. ROBEDEAU:** There was never any [24] real discussion, but the PAPA proposal was [25] written by PAPA in secret, and I don't —

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[1] that was not, that I know of, a secret MAB [2] process.

[3] **MR. DRAKE:** Right. So the second [4] sentence should read, only PAPA and invited [5] guests had been at the PAPA meetings where [6] the plan had been developed.

[7] **MR. ROBEDEAU:** Right.

[8] **MR. DRAKE:** So just take out MAB and [9] insert PAPA, and that would correct that.

[10] **MR. ROBEDEAU:** Okay. Does anybody [11] have anything else?

[12] **MR. DRAKE:** No.

[13] **MR. ROBEDEAU:** Can I have a motion to [14] approve the minutes?

[15] **MR. SKEEN:** So moved.

[16] **MR. DRAKE:** Second.

[17] **MR. ROBEDEAU:** Favor? Aye. [18] Opposed? [19] No. [20] Carries, all that good stuff.

[21] **MR. DRAKE:** Let the record reflect it [22] did carry.

[23] **MR. ROBEDEAU:** I have two handouts. [24] One is a copy of letters I just included, [25] the one to the county chair and the one to

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[1] Mayor Vera Katz. I had sent — you had [2] asked me to send, last time, to everybody [3] inviting them to the meeting on the 19th, [4] and Collins' office called back and changed [5] that from one to 1:30.

[6] **MR. SKEEN:** On Wednesday.

[7] **MR. ROBEDEAU:** On Wednesday the 19th. [8] Where is Bill Collins this morning?

[9] **MR. MOSKOWITZ:** Tom knows.

[10] **MR. SKEEN:** Tom knows, but he ain't [11] saying.

[12] **MR. DRAKE:** Tom knows.

[13] **MR. THOMAS:** You have to ask him what [14] he knows.

[15] **MR. STEINMAN:** He'll be here a little [16] late.

[17] **MR. ROBEDEAU:** Will he still be with [18] us —

[19] **MR. STEINMAN:** He said he'll be with [20] us a little late.

[21] **MR. ROBEDEAU:** — or will he be [22] deceased?

[23] The second handout I have is a copy of [24] the letter from PAPA that they sent back [25] via Collins at the last meeting. The two

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[1] letters are identical.

[2] **MR. LAUER:** Is this the same letter [3] that was circulated at the last meeting?

[4] **MR. ROBEDEAU:** Right. I just ran [5] copies off of here.

[6] **MR. LAUER:** I read it then.

[7] **MR. ROBEDEAU:** It's just copies for [8] your file so everybody has everything.

[9] Okay. Today — I think what we need [10] to do today, and I think what we agreed on [11] last meeting, was we need to come up today [12] with a proposal for medical supervision.

[13] Randy did fax everybody copies of our [14] original agreement. Did everybody get [15] that, that the Provider Board did last [16] October?

[17] **MR. DRAKE:** Yes.

[18] **MR. LAUER:** As you see from that [19] letter, what it did was responded to the [20] PAPA proposal. It recommended changes so [21] it referenced a different document. It's [22] kind of hard to read by itself.

[23] I didn't get any discussion feedback [24] back from anyone, so what I did was I [25] rewrote — rewrote that to some degree to

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[1] be a letter that's readable on its own. [2] And I'll pass that around. And I would [3] propose that we could look at this and [4] discuss this today.

[5] **MR. DRAKE:** Do you have copies?

[6] **MR. LAUER:** Yes, I have copies.

[7] **MR. DRAKE:** Okay.

[8] **MR. KILMER:** Randy, this was a [9] response formally adopted and sent in on [10] behalf of the Provider Board?

[11] **MR. LAUER:** It was a response.

[12] **MR. SKEEN:** Not — this letter has not [13] gone.

[14] **MR. KILMER:** No, no. But did a letter [15] go as a formal act of the Provider Board?

[16] **MR. LAUER:** As a formal act of the [17] three private providers. It was signed by [18] Mark, myself, and Pete.

[19] **MR. DRAKE:** That letter was simply [20] generated out of that subcommittee or that [21] committee on medical supervision that Bill [22] Collins formed. It was not an act of the [23] Provider Board.

[24] **MR. KILMER:** Okay. That's what I [25] wanted to know.

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MR. ROBEDEAU: No, it wasn't of-ficially an act of the Provider Board. But what PAPA had proposed was a physician's supervisor who took over everything. You know, the companies are responsible for paying the employees, but the physician supervisor sets all terms and conditions of employment. And I think that's it — from reading the PAPA proposal, that's pretty much the same thing, only it's just worded a little differently.

MR. LAUER: This is significantly different than the PAPA proposal. It embodies the changes that we wanted to have made to that proposal. It incorporates a lot of the ACEP guidelines for medical direction, and a lot of the information from the Multnomah County ASA plan. And it also incorporates information from PAPA's ASA plan.

It takes a lot of different pieces and fits them together and customizes somewhat for Multnomah County. And I began it with a background with an eye to recognize that

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advancements had been made and that whatever changes are made in the medical direction of prehospital EMS needs to not undo progress that has been made to date.

MR. DRAKE: Pete, can we take a few minutes to go over this?

MR. ROBEDEAU: Sure.

(Pause in proceedings.)

MR. KILMER: This was originally sent when, Randy?

MR. LAUER: October something 92.

MR. KILMER: '92?

MR. STEINMAN: 14th.

MR. LAUER: 14th.

MR. ROBEDEAU: Jeff, here's the original.

MR. KILMER: Thanks. Well, this does say on it Provider Board.

MR. ROBEDEAU: Yeah, it does.

MR. KILMER: Well, so the question is whether — see, it's signed by the three of you guys, but it's — there are many members of the Provider Board that aren't — didn't sign it. Nobody signed it

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as an officer of the Provider Board, and I don't know whether there was Provider Board meeting.

In light of Mark's comments that it didn't sound like this was an action of the Provider Board in any formal sense, it's a little hazardous to put something out under that rubric when, you know, the fire departments and some of the other departments and agencies weren't involved. I wonder whether this really was an action of the Provider Board.

MR. SKEEN: Were you invited or did you attend?

MR. STEINMAN: Yeah. I attended.

MR. ROBEDEAU: Everybody was invited.

MR. STEINMAN: It's questionable whether it was a legal Provider Board because of the way Bill Collins interprets how we now have to announce meetings. But everybody was advised and attended, and I just didn't agree with them so I didn't see it.

MR. KILMER: Okay. The reason that this is important is that if this is not a

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action of the Provider Board, then any changes that you might make now don't need to be justified and referenced in whatever we're going to put out today.

MR. ROBEDEAU: Jeff, we invited everybody who was on the Provider Board to come to the meeting. We had the meeting over in Buck's basement over there on Hawthorne — not Hawthorne, Belmont. What is it? Equipment store. They've got a conference room down there.

MR. LAUER: It's not our basement room.

MR. THOMAS: Nobody's trying to reference that document in this one. Randy's proposal is this is a standalone document.

MR. KILMER: The reason I'm bringing this up is, I'm not certain that this document is the one that the consensus of this board today wants to articulate. And if what we ultimately put out here today is different than was put out before and what we put out before was also an action of the Provider Board, you want to have an

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explanation for why the Provider Board has changed its mind.

MR. DRAKE: Okay. That was not an action of the Provider Board. If it said Provider Board, that was in error.

MR. ROBEDEAU: We had a meeting and the people were invited. Most of the people didn't come. And the announcement time was not sufficient, according to Bill Collins, to actually constitute a Provider Board meeting. And as the three private providers, with compromise, we were able to agree basically on what's there.

MR. SKEEN: Well, Jeff, I guess first we ought to see if there is a departure from what Randy's articulated here based on the previous findings from what went into the Medical Advisory Board, whether it was a legal or official document or not.

MR. KILMER: Okay.

MR. SKEEN: I understand what you're saying about —

MR. KILMER: And at some point, this has to be disavowed as a Provider Board action in the record we're making here for

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the public officials that are going to be looking at this, or we need to adopt it and, as a Provider Board action, recognize it may have some procedural deficiencies, and make that in the record. And then if there's going to be any changes in position, they will be explained.

MR. DRAKE: Okay.

MR. KILMER: That's probably the safer course.

MR. LAUER: And this document does reflect some changes to that original direction. And it came from our last meeting. For example, in the algorithm, the reporting structure, the discussion last week I believe was that the physician and the EMS system administrator could in fact act essentially on a parallel level, so that's different.

MR. DRAKE: Now, Randy, before we had the physician medical director I find you have director of the health department. Is that who they're responding? Because I don't think Gary Oxman's a director of the health department.

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MR. LAUER: That's correct.

MR. DRAKE: He is the health officer.

MR. LAUER: He also reports to the director of the health department.

MR. DRAKE: So before in our discussion, correct me if I'm wrong, that we didn't necessarily specify the physician medical director/EMS system administrator report directly to the director of the health department. That's a line of responsibility. They may actually report to Gary Oxman directly.

I mean, the director of the health department's ultimately responsible for anything in his department. Do you remember that discussion?

MR. LAUER: Well, I think the intent was, was to break EMS off of the health officer's responsibility, because you're going to have another

physician in there [21] that's specific to EMS. So you have two [22] physicians in the health department now, [23] they both worked under the director.

[24] That was one of the key points. That [25] was one of the points of discussion, was

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[1] that they didn't want the physician [2] reporting directly to the health officer.

[3] **MR. DRAKE:** Okay. I think we need to [4] review that with Bill Collins when he gets [5] here and make sure there's no problem with [6] that.

[7] Pete, I have a couple questions with [8] this report that Randy put out.

[9] Randy, I appreciate you doing this [10] work. I think that's good. I think that's [11] great that you did all this. I only have a [12] couple concerns. Under qualifications, No. [13] 10, it says, knowledge of local mass [14] casualty and disaster plans. I think we [15] should delete the word local and use [16] national, and disaster plans rather than [17] plans.

[18] **MR. LAUER:** That's fine. A lot of [19] these qualifications/responsibilities are [20] straight out of the ASA draft.

[21] **MR. DRAKE:** The reason is, if you want [22] to use somebody from the outside, they may [23] not have knowledge of local issues.

[24] And the second issue was over under [25] authority, under the state of Oregon the

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[1] only person that can suspend or revoke a [2] certification. We're not dealing with [3] licenses here at all. Certifications is [4] the — well, I guess we deal with licenses [5] of vehicles, but the only one that can [6] revoke or suspend a certification of the [7] EMT is the state health division.

[8] The only thing a supervising physician [9] can do is restrict it. They can pull their [10] orders, but they can't revoke someone's [11] certification.

[12] **MR. SKEEN:** Is it common for them to [13] recommend that action by the health [14] division?

[15] **MR. DRAKE:** Not really, Trace. I [16] mean, it's — to my knowledge, no. They [17] sometimes do, but more than likely that [18] they — yeah, they actually get a lot of [19] complaints through other sources. And [20] that's where the health division actually [21] ends up restricting or revoking their [22] certification.

[23] **MR. KILMER:** But, you know, I think [24] that you're correct that you can't delegate [25] authority to this guy that the state —

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[1] that would contradict the state policy. [2] But I do think Trace raises a good point, [3] that one of the powers and authorities [4] ought to be to be able to recommend that to [5] the state independently.

[6] **MR. DRAKE:** They have now under the [7] board of medical examiners. And I think we [8] need to just reword No. 3 to reflect the [9] state law and how the process works.

[10] **MR. LAUER:** Okay. Do you have any [11] suggested wording?

[12] **MR. DRAKE:** I would take [13] certifications for EMTs out and put it [14] under a separate number. Because actually [15] we're saying that they can restrict the [16] licenses supposedly of the providers and [17] permits maybe, I think is that what you're [18] talking about.

[19] **MR. ROBEDEAU:** Mark, where are we?

[20] **MR. DRAKE:** Page No. 3, authority. [21] And I think that's what you're [22] referring to. In other words, you have a [23] licensed ambulance, and a medical director [24] should be able to come in and say, you [25] don't have this equipment, I'm taking this

Page 19

[1] car off line, or something like that.

[2] **MR. LAUER:** Would you want to start [3] that sentence with restrict?

[4] **MR. DRAKE:** I think it would say, EMT [5] certifications out. And do that as a [6] separate line item, Randy, that would [7] resolve it. Just leave the sentence as is [8] and take out — and then just have a [9] separate No. 5 that says, they can't issue [10] — they can — they can't even suspend. [11] They can restrict EMT certifications [12] required by Multnomah County for first [13] responders, ambulance personnel, and that's [14] it.

[15] **MR. LAUER:** So back up to 3. It would [16] read: Issue, renew, suspend, revoke, [17] restrict the licenses and permits —

[18] **MR. DRAKE:** Required by Multnomah [19] County.

[20] **MR. ROBEDEAU:** No, no. Wait a [21] minute. Wait a minute. You're getting up [22] with issue, renew, suspend, revoke.

[23] Revoke, what you're doing is creating [24] a whole brand-new county department and a [25] whole brand-new something, a whole new

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[1] bureaucracy, an agency. I think the whole [2] thing just needs to be thrown out. Leave [3] it the way it is, you know.

[4] **MR. LAUER:** The intent was to say that [5] the medical director can essentially [6] restrict a certification or license within [7] Multnomah County. And they can do that.

[8] **MR. ROBEDEAU:** They can do that now [9] with the state law. But what you're doing [10] — to issue, renew, suspend, and revoke [11] licenses and certifications means that [12] you're going to create a whole new [13] bureaucracy in Multnomah County to license.

[14] **MR. DRAKE:** Pete, we can resolve it [15] this way. Just say restrict and make [16] recommendation for issue, renewal, [17] suspension, or revocation of license, [18] certifications, and permits. They can [19] restrict, they can do that.

[20] **MR. ROBEDEAU:** I think we just need to [21] leave it with the state. Just put it in to [22] comply with the state law, and put it in [23] that way. And as the state law changes, it [24] changes.

[25] **MR. DRAKE:** I think the county does

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[1] want that authority. In other words, what [2] we're saying is, we want this person to — [3] either that, or take it out of the [4] authority and just put it under job [5] description.

[6] (Discussion off the record.)

[7] **MR. ROBEDEAU:** I don't want to spend a [8] lot of time on this, but I think we're [9] recreating the wheel here.

[10] **MR. DRAKE:** Do you just want to delete [11] it?

[12] **MR. ROBEDEAU:** The state law is pretty [13] clear. The physician supervisor, no matter [14] who that physician supervisor is, has the [15] authority to withdraw standing orders. [16] Without standing orders, a paramedic is — [17] or an EMT, as far as that goes, is out of [18] business.

[19] **MR. DRAKE:** Right.

[20] **MR. ROBEDEAU:** They have to have a [21] physician who issues them standing orders. [22] Just leave it they have the authority to [23] withdraw the standing orders, and then [24] whoever the person is must comply with [25] state law in order to get reinstated.

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[1] **MR. THOMAS:** The distinction that that [2] is trying to draw is — I mean that item 3 [3] is in relationship to item 4 as I recall [4] historically. And I'm guessing that item 3 [5] was intended to respond to the question [6] about who is it who withdraws standing [7] orders. And it's the supervisor, physician [8] supervisor, of record.

[9] **MR. LAUER:** Right.

[10] **MR. THOMAS:** And that's really what [11] three was trying to say, is this person [12] would be the physician supervisor of [13] record.

14] **MR. LAUER:** Yes, I think you're ight.

15] **MR. DRAKE:** In other words —

16] **MR. THOMAS:** And it could just say 17] that specifically, if that's what you vant [18] to do.

19] **MR. DRAKE:** Another way is just efer [20] to the state statute, supervising hysician [21] has all the authority ranted under ORS [22] whatever it is.

23] **MR. THOMAS:** Sure.

24] **MR. LAUER:** So as the physician of 25] record for personnel practicing in

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1] Multnomah County, physician super- isor has [2] the authority delineated nder Oregon State [3] law.

4] **MR. THOMAS:** Sure.

5] **MR. DRAKE:** Or you would want to ite [6] ORS whatever the number is. I an't [7] remember offhand.

8] **MR. LAUER:** There's probably a cou- le [9] of them.

10] **MR. DRAKE:** Well, no, I had under —

11] **MR. LAUER:** 8.3 —

12] **MR. DRAKE:** Might be under eight 13] twenty-three six hundred.

14] **MR. THOMAS:** Just say under Ore- on [15] state law.

16] **MR. KILMER:** Mr. Chairman, it's an 17] important issue and technical issue. ut [18] the big issues that requires dis- ussion [19] from this board, it seems to ne, are in [20] paragraph 4, should the gents be required [21] to be board certi- ied emergency physicians.

22] **MR. SKEEN:** Paragraph?

23] **MR. KILMER:** 4 of authority. Seems o [24] me that that's important in light of vhat [25] Dr. Jui said to this committee bout the

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1] nature of the physician supervision hat is [2] given, and the importance of aving that [3] given at an intensity that llows good [4] interaction with no more han like 50 or [5] whatever the number f paramedics he said a [6] physician upervisor could reasonably deal [7] vith.

8] **MR. DRAKE:** Are you talking about he [9] qualifications for physician gents, Jeff?

10] **MR. KILMER:** Yes, I am.

11] **MR. DRAKE:** That should be spelled ut [12] in here somewhere. That's what ou're [13] saying.

14] **MR. KILMER:** Yes. And I would — ut [15] the second is that this document ollows on [16] the heels of the October locument at which [17] time AA was not upervised at OHSU. Since [18] that time, A has become supervised and [19] that has worked out, my understanding, [20] better than anybody had anticipated.

21] All physician supervision is now [22] concentrated at OHSU. The system is [23] getting a single medical control in the way [24] that it's always wanted it.

25] And what I think Dr. Jui was strongly

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1] suggesting, if he didn't say this, and what [2] I had understood consensus of some of the [3] others were, that rather than change that [4] to realize a luxury possible benefits and [5] take the risk of considerable detriment, [6] that instead of using the word in the very [7] first sentence on page 2 of medical [8] director, Multnomah County should employ a [9] medical director, perhaps this board wants [10] to consider the idea of should contract [11] with OHSU to become the medical director [12] and to appoint one of its members as the [13] medical director.

14] **MR. LAUER:** Jeff, that's never going 15] to get a consensus with the MAB. There's [16] nothing in this document that precludes [17] that from happening.

18] **MR. KILMER:** The reason that I think 19] this board should not be driven by what is [20] likely to get a consensus with the MAB is [21] that there is not going to be a consensus [22] to anything on the MAB that hasn't already [23] been arrived at before the MAB ever holds a [24] hearing. Everybody in this room knows what 25] the MAB is going to do. And however we

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1] word our document, it isn't going to make a [2] hill of beans difference to what the MAB [3] does.

4] So it seems to me that our [5] responsibility should be to draft something [6] that is in the best interest, from this [7] board's perspective, of the citizens of [8] Multnomah County in a properly functioning [9] plan. And state that directly and clearly [10] with no modification because of the remote [11] possible benefit that it's going to — a [12] different wording is going to influence the [13] MAB. It's not. And in the meantime, [14] you're going to sell your credibility.

15] **MR. LAUER:** Well, the only difficulty 16] is that for you to pursue your agenda of [17] implanting OHSU as medical control for [18] Multnomah County is going to receive an [19] awful lot of opposition that may preclude [20] getting any kind of effective medical [21] direction model in place in Multnomah [22] County. You may end up with one that [23] doesn't work.

24] **MR. KILMER:** This board ought to make [25] this decision. I'm not pursuing any

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1] particular agenda. I'm representing a [2] couple of clients here that I understand [3] have an agenda. But the board should be [4] talking about it.

5] **MR. ROBEDEAU:** Just a minute here.

6] **MR. DRAKE:** Trace wanted to make a 7] statement. He's been raising his hand. 8] And then I have something to say.

9] **MR. SKEEN:** I think our position is [10] that we should include in this document the [11] characteristics of the medical control that [12] have been discussed. And there may be [13] consensus on that, there may not be. But [14] what we should try and articulate, though, [15] is —

16] I'm opposed to the Provider Board 17] conducting this selection process of who [18] the medical director should be. It may [19] very well be that the — by the time we [20] spell it all out as to what it should be, [21] that the options are limited as to who can [22] do that, but I don't think it's in the best [23] interest of the Provider Board to have our [24] other issues taken seriously by making the [25] selection process with that.

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1] **MR. ROBEDEAU:** Let me say something in [2] here. You know, over the years, Trace, you [3] know, there's always been this cry for [4] single medical authority. And everybody's [5] come up with this and everybody's [6] essentially agreed to it, but nobody's been [7] willing to go out on a limb and say who [8] it's going to be.

9] You know, we have submitted countless [10] documents that detail what a physician [11] supervisor should do and what a single [12] medical authority should be. The white [13] paper has gone through it. The medical [14] society. Every committee, every [15] organization you can possibly think of has [16] detailed what the criteria should be. You [17] know, absolutely nothing has been done on [18] it.

19] I think that we, as the Provider [20] Board, need to pick a rock and stand on it [21] and then have the Medical Advisory Board [22] tell us why that OHSU or Emanuel or [23] Providence or Woodland Park or Seaside [24] Community is not a good place to have that. [25] You know, somebody has to get this process

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1] off its dime and moving. And I think [2] that's up to us.

3] **MR. SKEEN:** And actually I agree with [4] you. But I think whoever's going to make [5] that selection process, be it the county or [6] whoever, should have an option to look at [7] various people

who propose to do that to determine whether they have the capabilities.

And the other thing, and just in a discussion with people from OHSU yesterday, one of the physician supervisors indicated that there's becoming less consensus with them over the way they think this should unfold, so —

**MR. ROBEDEAU:** I'm not sure there is consensus there. What I am sure is, is we need to make a recommendation. We need to be specific enough that we force — perhaps using force is the wrong word, but for — we need to make it so if they reject what we say, which they're going to, that at least we stand some kind of a chance of getting a clearly articulated reason for the rejection.

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Because this has been going on, Trace, for 20 years. You know, we've been talking about a single physician supervisor in this system since 1974. And I can't tell you how many times the duties of a single physician supervisor have been outlined and submitted in documents.

**MR. DRAKE:** So many.

**MR. THOMAS:** I don't know if you two are talking about the same thing.

**MR. DRAKE:** Well, I think we are.

**MR. SKEEN:** Let me just say I appreciate the position on it. I just think that the — that strategically the integrity of this group to make recommendations is better served by not naming that. And that's just a philosophical difference we all have.

**MR. DRAKE:** I think we should make a recommendation. I think we have stood on this ground so long and we've thrown it up in the air and said, here's what the qualifications should be. And then everybody talks about it for years and years and years and nothing gets done. I

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think it is time that we make a recommendation of what we want to do based on the information that we have here, based on a lot of the criteria we put here.

But I want to go back to something that Jeff said before it gets lost, because he said two or three things. One is the qualifications of the supervising physician agent. We do need to put that in here. That is an important part of this process.

And we talked about that physicians — talked about that the physician agent should be an emergency room physician, should be associated with the medical director. Those kinds of issues, qualification should be down there.

**MR. LAUER:** Well, that's the whole — that's the key point, Mark, is that the medical director has to essentially be the boss of any physician agents.

**MR. DRAKE:** That's right. And we need to spell that out.

**MR. LAUER:** The biggest problem with the current medical direction model is you've got a group of people who sort of

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get together and talk about stuff but nobody's in charge. There's no one person in charge. And that is the hurdle that we have to jump, Pete. The one that we've not yet dealt with.

**MR. ROBEDEAU:** Okay. Then we need to name specifically. Because when our proposal is rejected, which it's going to be, you know that —

**MR. LAUER:** Not necessarily.

**MR. DRAKE:** Come on, Randy.

**MR. ROBEDEAU:** Then maybe they'll tell us why.

**MR. LAUER:** If you recommend OHSU, it will be rejected.

**MR. DRAKE:** Listen, Randy, excuse me just a second. They already made — the MAB has already decided on a different model, already made their decision. So they're not going to accept this model no matter what we attach to it.

**MR. LAUER:** Well, I think what our — we have an opportunity here to get a consensus from the Provider Board by not going through a selection process, by

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defining the model that we would recommend. And I think it's a good model.

Absent — if we don't succeed in that consensus, what we'll end up putting out of this group are two separate differing opinions. And now you're going to have three different models. You're going to have an MAB one and two Provider Board models and they're all going to have some similarities and some differences. And the County Commissioners will simply pick one. We've diluted our ability to make a recommendation.

**MR. STEINMAN:** Can we go through this model and get off the selection process and see what problems we've got with this model and then come back to who should maybe be the provider or not be the provider?

You know, I mean, we've got a format here I think we need to get through. And that may lead us to recommend or not recommend.

I got a question, since Bill's here, on page 2. Why do we want — under your algorithm here, why do we want to name the

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county chair? That seems to be a real sticky point with the County Commissioners now.

**MR. COLLINS:** That's how it is.

**MR. STEINMAN:** It is right now this way?

**MR. COLLINS:** Yes. The director of the health department reports to the chair. The director of every department reports to the chair. The chair's the exec, and so that's why they do that. But only department heads report to the chair.

**MR. STEINMAN:** So this would have to be the director. If somehow they put in Gary here he goes off into a different commissioner, is that what you're saying?

**MR. COLLINS:** No, no. Gary reports to the director of the health department. Gary's the health officer. He's got kind of two functions that don't quite report the same. For all the administrative stuff that he does, he reports to the director of the health department.

There are certain statutory authorities that the health officer of a

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county has. And he has those independent of — actually of anybody. I mean, he has them unless somebody fires him.

**MR. KILMER:** Who do you report to? Do you report to the director of the health department or Oxman?

**MR. COLLINS:** I report to Oxman.

**MR. KILMER:** It seems to me maybe what you're raising is that the physician medical director ought to report to the same person as the EMS director reports to.

**MR. DRAKE:** And earlier what Randy was saying was — and I think that's the question we had, and we were waiting for you to arrive, Bill, is that either of these two people here, physician medical director and EMS system administrator, report to Gary or the public health officer, or they report directly to the director of the health department? In other words, do we want to remove EMS out from underneath Gary Oxman?

And then there was discussion — I recall now, from what Randy said, that we

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had this discussion before. And I can't remember. I thought we decided we did want to, you're right, remove it from underneath Gary Oxman and have you and the physician medical director report directly to the director.

**MR. COLLINS:** The reason we report to Oxman is that administratively he's responsible for all the regulatory health activities. So he has the ME, he's got the sanitarians who inspect restaurants, he has the regulatory EMS activity, he's got a couple other things that I can't remember what they are. But they're all kind of regulatory oriented as opposed to the public health clinics who report to somebody who runs the clinics.

**MR. KILMER:** Is that statutorily mandated by state or just in the local?

**MR. COLLINS:** No. None of this is — there are no organizational mandates. The only statutory things are the powers of the health officer. You know, he can condemn things and that kind of stuff.

**MR. KILMER:** Thanks.

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**MR. DRAKE:** Because I don't have any problem, I don't have any energy personally that he report to Gary Oxman. I don't have a problem with that, if these two people report to Gary Oxman who reports to the health department.

I think why don't we — Randy, if you don't disagree, why don't we just put that in there? Because that's the way it currently reports.

**MR. LAUER:** Let me ask Bill, though, does this algorithm, as it's draw out there, does that work? Would that work?

**MR. COLLINS:** Would it work? I don't think any of this — anything you draw will work. The only issue that we've brought up in the past, and we did this back last November, was, when you had the medical director reporting to the chair, it created another county department. And we could find no reason to do that other than people just wanting it that way.

**MR. KILMER:** Right.

**MR. COLLINS:** You would incur more cost and all that kind of stuff. But, as

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far as, you know, say whoever you want it reported, it'll work — it works fine.

**MR. LAUER:** I think, Mark, a lot of — I understand what you're saying, but a lot of discussion that's occurred over probably a couple years now has been that EMS should not fall under the health officer's responsibilities but should lie parallel to it; that EMS is not —

EMS was put into the health officer's domain when it was new, when it was infantile. And now it's grown, and it's a big system. It's a very important system. And it ought to — it's risen essentially.

**MR. DRAKE:** I agree with that. But I think, even though it's risen, it's still under the public health officer. He's saying that's just the way that department functions.

Those kind of things from under the public health officer, there's no reason for us to try and create a separate department or a separate entity. Let's just keep him under the public health officer. I mean, I don't see how that

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creates any problem.

**MR. COLLINS:** You could do either one. I mean, it's just our preference when we spoke to this, again, not to create a separate county department. Otherwise it's a public health service and we want it in public health because that's where we get our support from.

**MR. KILMER:** Let's say directly what everyone I think knows but no one wants to say, and that is that the whole reason that some people, Dr. Dugoni in particular, wants to remove EMS from reporting to the health officer is that Dr. Dugoni believes that the health officer is the one that interfered with Joe Acker imposing the agenda that Acker wanted to impose.

And Dugoni has never forgiven Oxman for that, and removed — changing this line of command is only a mechanism for avoiding Gary Oxman's influence on the process that Dr. Dugoni feels is inconsistent with Dugoni's. That's why they're doing that. There is no other reason.

And given the way that the county

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health department is organized, it makes perfect sense for EMS to be under Oxman, along with the myriad of other regulatory issues he handles, regardless of size. And EMS today is not the biggest of the things that Oxman has to deal with.

**MR. ROBEDEAU:** Part of the other problem that had been articulated is that Oxman should be inserted in there, because there was quite a discussion on how a physician would feel reporting to a nonphysician. And —

**MR. COLLINS:** That is not going to be an issue. I mean, I do not think — I mean, you might see it as an issue, but that — my experience, that is not an issue. The physician medical director is going to have to, quote, report to somebody because he's going to have a contract. But that medical director is not going to be reporting to any physician or nonphysician who is going to interfere with their medical decisions. I mean, that just isn't going to happen.

You can write this any way you want.

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And you hire somebody to be the medical director, they're going to be the medical director. It doesn't really matter. You know, Oxman is not going to override them medically.

**MR. THOMAS:** You know, in terms of the —

**MR. COLLINS:** I've never seen —

**MR. THOMAS:** Well, that relates to what I was thinking, which is, in terms of the medical difference between — or the impact on the system, I mean, if we get away from the personalities that are there at the time — I don't even know who the director of the health department is right now. I know who it used to be.

Probably — it probably doesn't make a lot of difference over the long term who it is. I think, to me, there's a question of internal county organization and how they would like to organize the working divisions that they have. I don't think there's a reason actually for this body to particularly recommend whether it be the health department or the county health

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officer.

It's more a matter of how they would like to — at least to me it's a neutral thing. And it might be appropriate to indicate it could be either one, depending on how the county would like to organize itself, but to indicate that we don't think it's an issue, a medical issue, for the system.

**MR. DRAKE:** Right.

**MR. LAUER:** If we depict an organizational tree like this, it may allay some of the concerns that have been expressed.

**MR. THOMAS:** Well, you know, I tend to be skeptical about — I suppose I'm sort of like some of the others. Actually, I'm not concerned about making the Medical Advisory Board respond to something we submit,

[20] because I don't think they're going to [21] respond anyway, but — my main concern is, [22] I suppose, that you recommend what you [23] think is good and what will work, and that [24] you not worry about — too much about it as [25] a sort — as part of a negotiation.

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[1] Because I think those who you might think [2] we're negotiating with don't see themselves [3] as in negotiations with us.

[4] **MR. KILMER:** The problem is that, in [5] the process of negotiating, you're selling [6] the citizens and the system down the drain.

[7] **MR. LAUER:** In your opinion.

[8] **MR. KILMER:** You have to decide which [9] is more important.

[10] **MR. THOMAS:** My thought would be [11] somehow to indicate that it could be either [12] the director of the health department or [13] the county health officer, and that's — [14] that's a choice that we feel is a county- [15] organizational choice.

[16] **MR. LAUER:** I think we should get off [17] of that, because that's not the key [18] difference. The key difference is the [19] relationship of the Medical Advisory Board [20] to the physician medical director, which in [21] this draft is in stark opposition to the [22] PAPA draft.

[23] **MR. KILMER:** Right.

[24] **MR. LAUER:** Which I think, Jeff, this [25] plan needs to go forward, because this is

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[1] in the best interest.

[2] **MR. KILMER:** On that point I [3] absolutely agree with you.

[4] **MR. DRAKE:** But that's a whole [5] different —

[6] **MR. KILMER:** No, no. But that's a [7] whole different issue, that who the [8] physician medical director in turn reports [9] to, Oxman versus the other guy. It's a [10] completely separate issue.

[11] **MR. THOMAS:** Actually the way you [12] could do this, if we wanted to reach [13] something we might all be able to agree to [14] on the county health officer issue, is [15] indicate that the director of the health [16] department could assign this subfunction [17] that you've got under him to the county [18] health officer, which actually is the way [19] it is now I think.

[20] **MR. LAUER:** Could do it anyway.

[21] **MR. COLLINS:** Right.

[22] **MR. THOMAS:** Just clarify that, and [23] that these —

[24] **MR. COLLINS:** The director of the [25] health department tomorrow could say, EMS

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[1] is going to report to clinical services or [2] it's going to be its own division or it's [3] going to — whatever. They don't have to [4] go to anybody to do that.

[5] **MR. DRAKE:** I think we should put a [6] sentence in.

[7] **MR. COLLINS:** Why don't you take out [8] the word director and have these people [9] recording to being in the health [10] department. Then you don't specify.

[11] **MR. LAUER:** Would that work?

[12] **MR. THOMAS:** Actually what you do is [13] say health department. And probably the [14] proper thing at the top would be county [15] executive, wouldn't it?

[16] **MR. COLLINS:** Well, actually, the [17] title is chair of the County Board of [18] Commissioners, even though they're the [19] county exec.

[20] **MR. THOMAS:** That works.

[21] **MR. LAUER:** Is that something that [22] would work for everybody, just get rid of [23] director?

[24] **MR. STEINMAN:** Yeah.

[25] **MR. DRAKE:** That does it. We're

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[1] moving.

[2] **MR. THOMAS:** Brilliant, Bill. Plus we [3] got rid of a word.

[4] **MR. COLLINS:** We got rid of a word.

[5] **MR. KILMER:** A whole line of authority [6] in our management tree.

[7] **MR. ROBEDEAU:** And then that let's the [8] county structure it however they want to.

[9] **MR. THOMAS:** Right.

[10] **MR. LAUER:** So then on page 1, last [11] paragraph, we need to delete director there [12] also.

[13] **MR. DRAKE:** Right.

[14] **MR. THOMAS:** It would say, report to [15] the health department.

[16] **MR. DRAKE:** M-hm.

[17] **MR. COLLINS:** Since we're talking [18] about employing this person, why don't you [19] just say the medical director will be [20] employed by the health department?

[21] **MR. KILMER:** Well, the issue of [22] employment is, I think, still up in the [23] air.

[24] **MR. COLLINS:** Oh.

[25] **MR. KILMER:** That's —

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[1] **MR. COLLINS:** You mean for what you [2] want to recommend?

[3] **MR. KILMER:** Exactly.

[4] **MR. COLLINS:** Okay. But I mean, I can [5] tell you, unless county counsel comes up [6] with something totally different, it's [7] an — oh, you mean —

[8] **MR. THOMAS:** He's holding open the [9] contract.

[10] **MR. COLLINS:** The contract with a [11] group as opposed —

[12] **MR. KILMER:** Exactly.

[13] **MR. LAUER:** Are there any other [14] changes to page 2?

[15] **MR. ROBEDEAU:** There's to director. [16] Go ahead.

[17] **MR. THOMAS:** Some of this may have to [18] do with the change since the fall. On the [19] third line down where it says, has been [20] standardized to some degree, it seems to me [21] that's gone farther now, at least if it's [22] correct, I would say to a substantial [23] degree rather than to some degree.

[24] **MR. KILMER:** Why say substantial?

[25] **MR. DRAKE:** I'd just say has been

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[1] standardized.

[2] **MR. KILMER:** Has been standardized, [3] period.

[4] **MR. LAUER:** No. Gresham and all the [5] other agencies — the private providers and [6] Portland Fire is at OHSU. Gresham is not, [7] Sauvie's Island, Corbett.

[8] **MR. KILMER:** Where are they?

[9] **MR. LAUER:** They have their own [10] physician.

[11] **MR. STEINMAN:** Gresham and Sauvie's [12] Island has Mark Smith.

[13] **MR. THOMAS:** What I would say is [14] something like this — I'd do it so it just [15] more conveys more information. You could [16] say something like, has been standardized [17] to a substantial degree by consolidation of [18] the private provider and Portland Fire [19] Bureau, if that's who we're talking about, [20] physician supervisors under the auspices of [21] Oregon Health Sciences University. That is [22] I think — that's accurate.

[23] **MR. LAUER:** Okay. Has been [24] standardized —

[25] **MR. THOMAS:** To a substantial degree

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[1] by consolidation of the private provider [2] and Portland Fire Bureau physician [3] supervisors.

[4] **MR. DRAKE:** M-hm.

[5] **MR. ROBEDEAU:** To the consolidation of [6] what?

[7] **MR. THOMAS:** The private provider, the [8] private provider and Portland Fire Bureau. [9] It is a majority, but I think it conveys [10] more information.

[11] **MR. LAUER:** That's fine.

MR. THOMAS: Then I had one other question, really, which is: The last sentence of that paragraph refers to critiques because of the extended time necessary for protocol implementation and the fact that medical accountability is spread over a large group. I'm not — the question in my mind is: I suppose it's true on protocol implementation, although I've never actually heard that actual criticism in the public forum. I guess in private ones there have been. I'm wondering if that criticism is as current as it was back then. I mean, is that —

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MR. LAUER: I think it is.

MR. THOMAS: You know what I'm saying. I don't want to overstate a criticism of the current system.

MR. KILMER: This whole last sentence ought to just be taken out.

MR. LAUER: I think it's important to leave that in, because I think that is the criticism of the system we have now. It's that you have it spread out over a large group of docs.

MR. KILMER: That's not true, that it's spread out over a large group of docs, unless you're going to talk about a large number of docs at OHSU.

MR. LAUER: Let's list the supervision. Jon Jui, Terri Schmidt, Carol Fredrick —

MR. KILMER: All at OHSU.

MR. LAUER: — Mohamud Daya. Who else?

MR. ROBEDEAU: Daya is officially not. It's going to be Daya, but as soon as he gets certified by the state.

MR. LAUER: Who is it now?

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MR. ROBEDEAU: Jui.

MR. LAUER: Okay. So it's going to be Daya essentially. Mike Murray. Greg Lords.

MR. KILMER: Who's Greg Lords of?

MR. LAUER: Port of Portland. You have seven physicians. Nobody is in charge.

MR. KILMER: But who's the other guy? Who's the other guy that you mentioned? Who's the supervisor of —

MR. LAUER: Who?

MR. KILMER: Mike Murray.

MR. COLLINS: Gresham Fire and Corbett Fire.

MR. KILMER: And where is he located?

MR. LAUER: Mt. Hood Medical Center.

MR. ROBEDEAU: But see, this is another one of the things that keeps coming up. You've got all these splinter groups that don't come to any meetings, and they're off there by themself. And we're the ones riding the heat for it.

MR. DRAKE: We're all consolidated.

MR. ROBEDEAU: You've got Corbett,

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Gresham Fire, Port of Portland, Sauvie's Island. You've got District One up there I don't think even has a — or, yeah, District One. I don't think they even have the physician supervisor they're supposed to have.

You know, the truth is that the physician supervisors are at U of O for everybody who does the majority of the system.

MR. LAUER: But, Pete, even at OHSU the argument is that nobody's in charge, unless you talk about John Moorhead as the director of the emergency room.

MR. KILMER: Who's making that argument?

MR. LAUER: I'll make the argument.

MR. KILMER: And what is the basis of the — what's the factual basis for your making the argument that no one is in charge?

MR. LAUER: Well, let me just ask you a question. Who has ultimate accountability for medical direction in Multnomah County?

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MR. KILMER: We had testimony here — and I'm going to take your question in response to my question as an indication that you have no evidence to support the statement that you made. If you do, then the public officials that are going to be reviewing this record have a right to know what that evidence is. And Mr. Collins does, too. That is an assumption that's been permeating this process that has no analysis or factual basis to report it.

Now, Dr. Jui's testimony here, which was not questioned by anybody at the time, was that what they have up there is a department, all of whom work together, all of whom share a view of the overriding system of medical control for this county, all of whom have subordinated their individual agency associations to this overriding view, and that that is developed pursuant, A, to the congenial relationship they have, and, B, the departmental policy.

Now, what that means is that the director of the department, Dr. Moorhead,

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in the process that he's developed up there, has evolved a single medical control. There's no evidence to contradict any of that. And what that says is —

Now, there's two issues here. No. 1, is the idea that seven or five physicians at OHSU means that there's a whole bunch of physicians, or are they all working in concert as a medical director with agents would be expected to work? That's question No. 1. Question No. 2 is: What percentage of our system is now being administered in that small group working together like that? I don't know what percentage of first responses are done by Gresham Fire.

Tom, do you?

MR. STEINMAN: No.

MR. KILMER: Is it less than ten percent?

MR. DRAKE: Of the 9-1-1 calls in town?

MR. KILMER: Of the 9-1-1 first response.

MR. DRAKE: It's got to be less than ten percent. Isn't it, Bill? I'm just

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clarifying.

MR. COLLINS: I haven't the foggiest idea.

MR. LAUER: There's no data to show that.

MR. KILMER: I'm sure there's data, but no one's bothered to collect it. That's another thing that's important.

Now the second issue is: What percentage of the responses come from Corbett? Virtually zero, as I understand it.

MR. DRAKE: Not zero, but very few.

MR. KILMER: The third is: How about Sauvie's Island? How about Sauvie's Island? Very few percentage.

So what you have now is virtually 100 — you have 100 percent of the private companies being at OHSU now and you have over 90 percent of the first responses at OHSU now.

MR. LAUER: You drew those numbers out of the air, though.

MR. KILMER: There's no data to contradict it. In all of our experience,

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knowing the system shows that that data is very close to the mark, and is probably conservative in the sense that Gresham is probably less than ten percent.

MR. LAUER: You based it on call volume when it really should be based

on [7] the number of paramedics and EMTs.

[8] But to respond to our original [9] question where you said I have no data to [10] support — or no evidence to support [11] there's nobody in charge of Multnomah [12] County, the fact that you couldn't answer [13] the question of who is the medical [14] director, who has control of the medical [15] supervision of medical county, there isn't [16] an answer to that. You inferred —

[17] **MR. KILMER:** You are very close —

[18] **MR. LAUER:** You inferred that [19] Dr. Moorhead was.

[20] **MR. KILMER:** And Dr. Moorhead can be [21] designated that and make explicit what is [22] now basically implicit. And the fact that [23] I've just painted is a far more factually [24] accurate representation of what we are [25] working on now than the assumptions

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[1] underlying your view that you've [2] articulated here, that we have seven [3] doctors and no coordination. That's really [4] not true. We have a great deal of [5] coordination.

[6] **MR. LAUER:** And I don't disagree with [7] that. I don't disagree with you. We have [8] a lot of coordination. However, there's [9] nothing in this document that could [10] preclude John Moorhead from becoming the [11] medical director but bringing all the other [12] provider agencies into that umbrella.

[13] **MR. ROBEDEAU:** Let's — can I [14] interject something here?

[15] **MR. DRAKE:** Let's take a break. We [16] promised the court reporters that we'd [17] break every hour. We need to take a break, [18] and then we need to discuss this and get on [19] with the issues. I think there's some [20] important issues that have been raised [21] here.

[22] **MR. ROBEDEAU:** But one thing I want to [23] get on the record here first, before we [24] take a break. And I do want to take a [25] break.

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[1] What we're dealing with here — and [2] the same game is being played now as was [3] being played back in the '70s where you had [4] a bunch of bureaucrats open up the score [5] book and say, see — they counted up all [6] the different telephone numbers, even [7] though repeated over and over, in the [8] yellow pages and said, see, we've got 19 [9] ambulance companies here, and we need to [10] change things because we've got 19 [11] ambulance companies and, oh, my god, the [12] whole world's going to come to an end. The [13] same game is being played here.

[14] There are nine different agencies that [15] I sat here right now and just looked at. [16] The three major players are all in one [17] place. You know, there are six players who [18] are out in the other places that don't [19] attend any of the meetings. And the only [20] way that can be controlled is for the [21] county to say this is what it is.

[22] The county controls EMS. The reason [23] there is no single physician supervisor is [24] because the county hasn't done anything [25] about it. These six people have to be

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[1] told, you know, what — six agencies have [2] to be told what they're going to be able to [3] do. It's not our problem.

[4] But the same game is being played with [5] us as was being played back then. Look at [6] all these different agencies, look at all [7] these different physician supervisors, and, [8] gee, it's all the private ambulance [9] companies' fault.

[10] **MR. DRAKE:** The point does need to be [11] made, Pete, that has been made here, [12] Randy. Randy, I do think this is important [13] the point Jeff was making in reality.

[14] And you talk about the number of [15] paramedics and EMTs. Over 90 percent of [16] the paramedics are being served by the [17] University of Oregon Health Sciences Center [18] today. Vast majority. In fact, the guy [19] from Gresham said I think they only have [20] seven paramedics out there. So — and [21] you're talking about 150 paramedics in the [22] system and seven of them aren't at OHSU.

[23] **MR. LAUER:** I think we're talking [24] about — the goal is to have a single [25] person in charge of medical supervision

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[1] throughout the county. And I'm not saying [2] that we're not on the road to that through [3] OHSU. That — and we stated in this letter [4] that there have been a substantial — [5] there's been a substantial degree by [6] consolidation. We just want to finish it.

[7] **MR. MOSKOWITZ:** Although functional [8] advances have occurred in this system, the [9] system in the past has been criticized. [10] Just add those words, in the past we have [11] been criticized.

[12] **MR. THOMAS:** Well, why don't you take [13] a break and think about some words.

[14] (Recess.)

[15] **MR. THOMAS:** I have a suggestion on [16] that last sentence we've been debating. [17] And what I suggest is that instead of what [18] was there, we put something which is maybe [19] a little more positive that would say [20] something like this: Although functional [21] advances have occurred, it would be [22] desirable, one, to bring the remaining [23] small area EMS providers, and I've written [24] Gresham Fire, Sauvie's Island Fire, and [25] Corbett Fire, I don't know who they are and

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[1] their right names, but under a common [2] medical supervision umbrella; and, two, to [3] clarify that the common position umbrella [4] group should have a single physician [5] ultimately responsible to the county for [6] medical commission with commensurate [7] authority. I think that's a little more [8] specific and gets what I think were the two [9] things you were talking about.

[10] **MR. KILMER:** I think you should [11] certainly say, although significant [12] functional advances have occurred.

[13] **MR. LAUER:** Well, this is —

[14] **MR. KILMER:** If you're going to leave [15] that sentence in.

[16] **MR. THOMAS:** That's okay with me. I [17] was looking at we sort of led into that, [18] but —

[19] **MR. KILMER:** Or you can say, despite [20] the significant functional advances.

[21] **MR. LAUER:** This is under the heading [22] background, so I think we need not rewrite [23] what has been background. And I think the [24] system has been criticized. And I think [25] you can substitute "has been" for "is," but

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[1] I think changing it further than that is [2] trying to change history.

[3] **MR. THOMAS:** I'm sorry, say that [4] again.

[5] **MR. LAUER:** This paragraph, this one [6] paragraph, attempts to encapsulate the [7] history of the issue. And the system has [8] been criticized, Chris.

[9] **MR. THOMAS:** It has. But that [10] doesn't — what I'm concerned about is this [11] doesn't say — it doesn't reflect the — [12] what the process has been. And there were [13] criticisms. There was a quite significant [14] change in the system, which finished itself [15] this past fall when you ended up with, I [16] don't know whether it was 80, 85, 90, it [17] probably is about 90 percent of the system [18] all being under one group of physicians who [19] worked out of a single place. And the [20] extent to which anybody still even makes [21] those criticisms or would apply them to the [22] current situation is really in question I [23] think.

[24] And the impression — what I was [25] concerned about and the reason I brought

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[1] this up originally was I felt like there [2] was an esoteric criticism that you

vere [3] trying to describe there but was being [4] expressed as a current criticism with [5] regard to the fact there had been a lot of [6] change. And there needs to be a way to [7] clarify that I think, because otherwise it [8] actually I think overstates, for somebody [9] who's reading this, the current criticisms [10] of the system and actually creates a false [11] impression.

[12] **MR. KILMER:** That's right.

[13] **MR. THOMAS:** I'm not saying you [14] intended to do that. But, I mean, just [15] reading it through, that was my immediate [16] reaction, was, well, wait a minute, there's [17] been a whole lot of change.

[18] **MR. MOSKOWITZ:** Why not remove the [19] first clause that says, although functional [20] events have occurred, and say, in the past, [21] the system has been criticized because of, [22] and then state what the current situation [23] is, currently the three private providers [24] and the first responders representing 90 [25] percent of the 9-1-1 calls are all under

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[1] one unified medical supervisory structure, [2] and the ones that aren't, and name them, [3] represent this many.

[4] **MR. LAUER:** Well, I think that the [5] criticism has been about how the group [6] functions, so it's —

[7] **MR. KILMER:** Which group?

[8] **MR. LAUER:** OHSU physicians. Because [9] they function by — they make decisions by [10] a group process. And the criticism that [11] I've heard is that we want one person to be [12] in charge of medical supervision.

[13] **MR. STEINMAN:** I'm getting confused [14] here, because the criticism I hear about [15] the system and that I can agree with you on [16] here is that if you go up a couple lines to [17] the treatment protocol committee, that [18] takes a year to get anything through the [19] system. That's a criticism that we've had, [20] is if you want to change a protocol, you [21] better plan on a year, year and a half down [22] the road you actually get that to hit the [23] street. That's been the criticism.

[24] I don't see the criticism against the [25] physician supervisors for extended time in

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[1] this whole process. It's just the [2] bureaucracy of the protocol committee going [3] to the MAB and getting everything approved [4] and back down to where we can actually buy [5] the drug or take the drug off the rig.

[6] You know, I think it sounds to me like [7] we have consensus here with everybody but [8] you. We have a majority that say that [9] sentence is a little strong. And it's not [10] really — you're saying it's background and [11] it's history. This is pointing out that [12] there are problems. It's not historical [13] stuff. I think we just need to remove the [14] whole sentence.

[15] **MR. LAUER:** Well, without that [16] sentence, though, Tom, this really — this [17] whole document says leave everything as it [18] is.

[19] **MR. DRAKE:** No, it doesn't.

[20] **MR. STEINMAN:** I think if we remove [21] that sentence and put in a sentence that [22] describes MRH and that form of medical [23] control, and then you can kind of end it [24] down here with the whole system can be [25] streamlined and system improvements can

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[1] occur by going to a more centralized [2] medical control.

[3] **MR. LAUER:** How about — I guess the [4] point we need to make — that I want to see [5] made in here is that the current system has [6] been criticized because, one, single [7] physician has not been identified as a [8] medical director.

[9] **MR. STEINMAN:** I think we could — [10] well, you could also start that off at the [11] top of this thing.

[12] **MR. DRAKE:** That's the purpose.

[13] **MR. STEINMAN:** Yes, the purpose. [14] Because, like Pete says, it has been for 20 [15] years.

[16] **MR. DRAKE:** I mean, you could even say [17] a different section and say the purpose [18] of — the purpose of this whole document [19] here is because we have not had a single [20] medical authority in the county, and that's [21] what everybody wants and everybody has [22] wanted. But I think what the —

[23] **MR. STEINMAN:** That'd be into your [24] history.

[25] **MR. LAUER:** I think you need to get

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[1] away from the word authority. Do you want [2] a — what I'd like —

[3] **MR. DRAKE:** Director.

[4] **MR. LAUER:** One person director.

[5] **MR. DRAKE:** That's fine. What I'm [6] hearing here, Randy, is that everyone kind [7] of has a problem with what the criticisms [8] have been in the past, No. 1; and, No. 2, [9] whether those criticisms were actually [10] valid criticisms of the system. And so I [11] think that we need to stay away from that. [12] That's what I'm hearing people say.

[13] And I don't think it's going to add or [14] detract from this paper if we actually go [15] into those or don't go into those. Really [16] what this paper is, is a recommendation of [17] how we feel it should be in the future. [18] And everybody kind of knows, in their own [19] mind, what a criticism has been, but we're [20] here making a recommendation of what we [21] feel the system should be.

[22] **MR. LAUER:** How about if we just [23] substitute — and I think I probably just [24] said this, but lead me read it again. For [25] that last sentence, to substitute the

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[1] system has been criticized because a single [2] medical director has not been identified as [3] being overall — with overall [4] accountability for medical direction EMS.

[5] **MR. ROBEDEAU:** And then add Chris's [6] sentence.

[7] **MR. DRAKE:** Yes.

[8] **MR. LAUER:** You'll have to tell me [9] what it was again.

[10] **MR. ROBEDEAU:** It was the private [11] provider/Portland Fire Bureau are all [12] at University of Oregon, that is the [13] outlying —

[14] **MR. LAUER:** We've already said that, [15] though, above.

[16] **MR. DRAKE:** No. But I think he's [17] saying that.

[18] **MR. STEINMAN:** Put in the percentages [19] of how many people are under.

[20] **MR. LAUER:** Without measuring that, we [21] can't list — state percentages.

[22] **MR. STEINMAN:** I'm not sure we need [23] Chris'. I mean, it's — I don't know. We [24] just need to move on on this.

[25] **MR. DRAKE:** We need to move on. We've

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[1] been spending a lot more time. We were [2] going to work on this for an hour and we've [3] been —

[4] **MR. LAUER:** Isn't it fair to say the [5] criticism is because there's not a single [6] person identified as being accountable?

[7] **MR. STEINMAN:** I agree with Mark that [8] should probably be the purpose of this. [9] The purpose of this paper is that there is [10] no single physician and —

[11] **MR. DRAKE:** And we all — all the [12] providers —

[13] **MR. LAUER:** That's objected to, [14] though.

[15] **MR. DRAKE:** I think —

[16] **MR. ROBEDEAU:** No. Actually, you [17] know, the criticism changes as the [18] situation changes. You know, people had [19] asked for a single group. At one time that [20] was going to be okay. It was all agreed [21] upon. And that all went you know where. [22] They'd come up with one single doc and it [23] was — and then

everybody agreed, including [24] most of the MAB, that that was impossible. [25] Doc wouldn't do it.

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[1] So now you're down to something else. [2] You know, it's a preconceived agenda that [3] certain people have to want to accomplish [4] something, and they're using this to do it.

[5] **MR. DRAKE:** How about this: Why don't [6] we just say there have been various [7] criticisms in the past in the medical [8] system. There have been various criticisms [9] in the past for whatever reasons, and to [10] resolve those issues the Provider Board is [11] making these recommendations.

[12] **MR. LAUER:** Well —

[13] **MR. DRAKE:** Okay?

[14] **MR. LAUER:** What's wrong with saying [15] the system has been criticized because it [16] doesn't have a single medical director [17] who's accountable for the system?

[18] **MR. DRAKE:** Because of what Pete was [19] exactly saying.

[20] **MR. LAUER:** Isn't that the truth, [21] though?

[22] **MR. DRAKE:** No. Because in the past, [23] we've also criticized because of single [24] medical authority, single medical director.

[25] **MR. ROBEDEAU:** There have been a lot

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[1] of different proposals.

[2] **MR. COLLINS:** The two things that seem [3] to be the focal points of medical direction [4] are the time it takes to develop the [5] protocols, not to implement them. Because [6] once you develop them, they can be [7] implemented the next day.

[8] But there's a long process, like Tom [9] said, to develop the protocols, and that [10] there — and I think this is more in the [11] past than now, but there has been criticism [12] that there has not been a single medical [13] accountability like you said.

[14] I mean, historically the docs didn't [15] work together very well. Now, whether [16] they're working better now or not, that — [17] those are the two things that I have heard [18] consistently put out of what the problems [19] of medical direction were.

[20] **MR. DRAKE:** Right.

[21] **MR. COLLINS:** Maybe there are some [22] other ones, but those —

[23] **MR. LAUER:** I thought that's what I [24] said.

[25] **MR. COLLINS:** Well, it is kind of what

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[1] you said. There's been a lot of proffered [2] solutions for it. And pretty much [3] everybody, for whatever reason, seems to [4] have come to the need for a single — a [5] medical director plus whatever else you [6] need to run the system. But, you know, [7] I've heard — I'm considering that there is [8] reasonable consensus that you need a [9] medical director. And then you need some [10] other stuff, too.

[11] **MR. DRAKE:** Right.

[12] **MR. COLLINS:** I don't think you need [13] to go too much more into it. I'm not sure [14] why you need to fiddle around with this too [15] much. You're looking at the background. [16] That's the background that I've seen. I [17] mean —

[18] **MR. LAUER:** As it's written you mean?

[19] **MR. DRAKE:** Not entirely.

[20] **MR. COLLINS:** I mean, aside from — if [21] you're looking at the background and [22] saying, what have people been concerned [23] about in the last X number of years? I [24] mean, that's what — the two things that [25] came to.

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[1] **MR. STEINMAN:** Are you saying your [2] statement is the background, or are you [3] saying that written document is what you [4] say could be looked at?

[5] **MR. COLLINS:** I'm saying if you want [6] to say in the background what the concerns [7] have been over time, those are the two [8] issues that I've heard that are the [9] concerns over whatever period of time you [10] want to do it. Whether it's improved or [11] not improved, that's not written in the [12] background. That's kind of another [13] statement.

[14] **MR. STEINMAN:** So he didn't agree with [15] you, Randy.

[16] **MR. COLLINS:** I do agree with you.

[17] **MR. KILMER:** Everybody's learned how [18] to be a lawyer here.

[19] **MR. ROBEDEAU:** We're going to get off [20] this one here.

[21] **MR. DRAKE:** I think that — Pete, I [22] think we need to resolve this and move on [23] quickly.

[24] **MR. ROBEDEAU:** That's what I just [25] said. We're going to get off it right

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[1] now.

[2] **MR. DRAKE:** Okay. How do you want to [3] get off of it?

[4] **MR. ROBEDEAU:** I think —

[5] **MR. LAUER:** The system has been [6] criticized in the past because of the long [7] time needed for protocol development and [8] the fact that medical accountability is not [9] in the hands of a single medical director. [10] Isn't that true? Isn't that?

[11] **MR. DRAKE:** Sure.

[12] **MR. LAUER:** Isn't that what you and [13] Bill said?

[14] **MR. DRAKE:** That is true. [15] Can you agree with that, Tom?

[16] **MR. LAUER:** What it does is put it in [17] the past tense.

[18] **MR. ROBEDEAU:** We're scratching out [19] that last sentence in its entirety and [20] replacing it with — what'd you have again, [21] Randy?

[22] **MR. LAUER:** Well, I need to think [23] through the grammar a little bit.

[24] **MR. KILMER:** She can read it back. [25] That's one nice thing about having a

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[1] reporter, some of these inspired sentences [2] that you immediately lose can be brought [3] back.

[4] **MR. ROBEDEAU:** Okay.

[5] **MR. MOSKOWITZ:** Can I read back what I [6] have?

[7] **MR. ROBEDEAU:** Okay.

[8] **MR. MOSKOWITZ:** The sentence begins, [9] system has been criticized in the past [10] because of the extended time necessary for [11] protocol implementation and the absence of [12] a single medical director responsible for [13] the entire system.

[14] **MR. LAUER:** I like that. That works.

[15] **MR. DRAKE:** Fine. [16] Do you agree?

[17] **MR. STEINMAN:** Hey, good job, Steve.

[18] **MR. DRAKE:** Okay. We're in [19] agreement. That's in.

[20] Let's move on.

[21] **MR. LAUER:** Can you write that down [22] for me? Then I won't have to write it down [23] again.

[24] **MR. ROBEDEAU:** I didn't get it all [25] either. I'm going to snatch it.

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[1] **MR. DRAKE:** That's fine.

[2] **MR. KILMER:** Let the record reflect [3] that that's what gets bought with three [4] lawyers rather than two.

[5] **MR. STEINMAN:** Expensive sentence.

[6] **MR. KILMER:** That's an inside joke, [7] folks.

[8] **MR. DRAKE:** Okay. The objectives are [9] fine. Does anybody have a problem?

[10] **MR. STEINMAN:** I'm still in the [11] background, I think.

[12] **MR. LAUER:** Tom, knock it off.

[13] **MR. STEINMAN:** No. In the background [14] I think we also need to mention on-line [15] medical control someplace, because I — I [16] mean, the ulti-

iate system, to me, you need [17] to tie iat physician in with on- and [18] off-line iedical control.

9] **MR. KILMER:** Very good point.

0] **MR. DRAKE:** In your second sen-ence [21] you could say, on-line and off-ne medical [22] direction through writ-en protocols has [23] been standardized ) a substantial degree. [24] Add it there?

5] **MR. STEINMAN:** No. Because then ou

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l got consolidation there. I think, you l know, maybe just a simple sentence iat, [3] over the years on-line medical ontrol has [4] developed and been con-acted through — by [5] the county irough MRH, and that the [6] physician uthority needs to be over both [7] on-nd off-line medical control.

·] **MR. LAUER:** It does say that later I [9] iink.

0] **MR. STEINMAN:** Does it? I haven't 1] read the document.

.2] **MR. COLLINS:** You could put a sen-ence [13] in the background that says iat.

4] **MR. DRAKE:** Yes. Under that second 5] paragraph, just add that. Or before iat [16] second paragraph actually, yeah.

7] **MR. LAUER:** Okay. I'll put something 8] in there about on-line medical con-ol.

9] **MR. DRAKE:** Just like Tom said, like 0] Jeff was saying, she can read that ack so [21] you can have it exact.

2] **MR. ROBEDEAU:** Okay. Let's move n to [23] objectives.

4] I like objectives as they are. Are [25] here any objections to it?

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1] **MR. DRAKE:** No.

2] **MR. ROBEDEAU:** Okay. Consensus hat [3] we move on then to reporting tructure and [4] advisory positions?

5] **MR. DRAKE:** M-hm.

·] **MR. ROBEDEAU:** God. I don't believe ] that.

5] **MR. KILMER:** You already agreed on 9] that.

10] **MR. DRAKE:** We already agreed to et [11] rid of the director.

12] **MR. COLLINS:** Let me ask a ques-ion, [13] since you've already done it. Vhy do you [14] want the medical direc-or to chair the [15] MAB?

16] **MR. DRAKE:** Let's not get into that 17] discussion, but we agreed to that efore. [18] We're all in agreement to it.

19] **MR. THOMAS:** Well, for his help —

20] **MR. COLLINS:** I just wondered why.

21] **MR. LAUER:** The background on hat [22] discussion was —

[23] **MR. KILMER:** That's a perfectly [24] appropriate thing to ask and have [25] information on in our record for the public

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[1] officials.

[2] **MR. LAUER:** The background was, what [3] is the role of the Medical Advisory Board [4] as it relates to the medical director, how [5] do they interact? There's — the PAPA plan [6] calls for it to be in an oversight [7] position. And we didn't like that. We [8] agreed here that it should be an advisory [9] role. And then if that's the case, why not [10] have the physician chair the committee? So [11] his advice is coming within the committee [12] rather than outside.

[13] **MR. COLLINS:** Okay.

[14] **MR. ROBEDEAU:** That was it. And it [15] was also because of the Medical Advisory [16] Board is advisory and the chair of the [17] Medical Advisory Board only votes to break [18] a tie. And we felt that the Medical [19] Advisory Board and the physician supervisor [20] would have a greater contact if he was [21] chair.

[22] **MR. COLLINS:** Okay.

[23] **MR. ROBEDEAU:** And it would create [24] better communications.

[25] **MR. DRAKE:** And it also would

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[1] streamline the process for protocol [2] implementation because of having the MAB [3] vote and pass something and then take it to [4] the medical director. The medical director [5] is the chair of the MAB and so he's [6] involved in the whole process as it [7] develops. It would just smooth it and make [8] it quicker.

[9] **MR. STEINMAN:** And then down the road [10] we're going to make your position chair of [11] the Provider Board, so watch that.

[12] (Laughter.)

[13] **MR. ROBEDEAU:** That sounds good to me.

[14] **MR. COLLINS:** That probably won't make [15] it through our recommendation, but you can [16] try.

[17] **MR. DRAKE:** That's actually a good [18] idea. I like that.

[19] **MR. KILMER:** Yeah.

[20] **MR. ROBEDEAU:** Okay. The medical [21] director will report directly to the health [22] department and EMS system administrator [23] will have parallel authority to the medical [24] director and will also report directly to [25] the health department. Leave "the

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[1] director" out there?

[2] **MR. LAUER:** I already scratched it.

[3] **MR. ROBEDEAU:** All right.

[4] **MR. THOMAS:** You can remove "directly" [5] also.

[6] **MR. DRAKE:** All right.

[7] **MR. ROBEDEAU:** And report to the [8] health department.

[9] **MR. LAUER:** You don't like those [10] "directs" or any variation thereof.

[11] **MR. THOMAS:** They only apply if you're [12] talking about a specific individual, [13] somebody reports to.

[14] **MR. ROBEDEAU:** The medical director [15] will chair the Medical Advisory Board. As [16] a result, the EMS director will chair the [17] Provider Board. Is that supposed to be [18] inserted there?

[19] **MR. KILMER:** You know, when you think [20] about it, though, Bill, that really does [21] make a lot of sense, for the same reason [22] that Mark is talking about. And you have [23] to look at the system past the planning [24] stage it seems to me.

[25] EMS has been put really in a position

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[1] of antagonism toward at least several of [2] the providers. But when this system goes [3] into place, if we do it right, that will [4] end.

[5] And the providers have quite an [6] important role to play in advising the [7] director on the day-to-day realities of the [8] operation of the system that, unless they [9] have regular contact with the providers, [10] will not be understood and will lead to [11] more indirect understanding, [12] misunderstanding about day-to-day street [13] realities, enforcement actions that are [14] going to be handled formally that would [15] otherwise be involved informally.

[16] And if you had a regular meeting of [17] the Provider Board that you or your [18] successor chaired, you're going to have a [19] lot more collegiality there the same way [20] the director will have with the advisory [21] board. There's a lot to be said for that [22] concept in the post — the post-war period.

[23] **MR. LAUER:** After the cold war is [24] over?

[25] **MR. KILMER:** That's right.

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[1] **MR. LAUER:** I agree with that, and I [2] would agree to incorporate that, but to do [3] it in a different forum, since this one [4] speaks specifically to medical direction.

[5] **MR. DRAKE:** Let's move on.

[6] **MR. ROBEDEAU:** I meant it as a joke. [7] I didn't mean to get us of on a ten-minute [8] discussion.

[9] As a result, the MAB will have direct [10] advisory input to the medical director. No [11] problems.

[12] EMS providers will have the same [13] direct advisory relationship with the

EMS [14] system administrator. The following [15] algorithm depicts the recommended reporting [16] structure. That might be the place where [17] we need to put in the fact that the EMS [18] director should chair the Provider Board. [19] You know, you brought it up here and you [20] get to it.

[21] **MR. STEINMAN:** Like you said, it was a [22] joke. I agree with you.

[23] **MR. ROBEDEAU:** Well, either that or we [24] should take the EMS providers.

[25] **MR. STEINMAN:** Right now I don't think

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[1] we can, because we need to look at the [2] ordinance of the makeup of the Provider [3] Board, and Bill's not a provider.

[4] **MR. KILMER:** I think that's correct. [5] But this is something that ought to be [6] considered later.

[7] **MR. DRAKE:** Let's move on.

[8] **MR. ROBEDEAU:** Okay. Anybody have a [9] problem with the algorithms?

[10] **MR. COLLINS:** I've got one question. [11] That isn't really an algorithm. It's just [12] an organizational chart.

[13] **MR. DRAKE:** Yes.

[14] **MR. COLLINS:** But there's no decision [15] point, so it isn't really an algorithm.

[16] **MR. DRAKE:** The following chart.

[17] **MR. ROBEDEAU:** The following [18] organizational chart.

[19] **MR. LAUER:** Good point, organizational [20] chart.

[21] **MR. DRAKE:** We're just going to chair [22] County Board of Commissioners?

[23] **MR. ROBEDEAU:** That's just County [24] Commissioners, isn't it?

[25] **MR. THOMAS:** You're just going to take

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[1] the word director out from health [2] department.

[3] **MR. ROBEDEAU:** And everything else [4] remains the same?

[5] **MR. THOMAS:** Right.

[6] **MR. ROBEDEAU:** Okay. And then we get [7] down to medical director. Multnomah County [8] should employ a medical director that has [9] authority over all clinical and patient [10] care aspects of the EMS system with a job [11] description that has the following [12] qualifications and responsibilities as [13] recommended by the American College of [14] Emergency Physicians.

[15] Anybody have a problem with that [16] paragraph?

[17] **MR. KILMER:** I would like to suggest [18] that you not use the word employ. Or at [19] least if you're going to use the word [20] employ, that the word employ creates the [21] option of either a direct employment or an [22] independent contractual relationship.

[23] **MR. ROBEDEAU:** Employ or contract [24] with.

[25] **MR. LAUER:** Employ the services of.

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[1] **MR. KILMER:** Well, employ or contract [2] with, Pete, that's good.

[3] **MR. DRAKE:** Okay.

[4] **MR. ROBEDEAU:** I don't have a problem [5] with that.

[6] **MR. KILMER:** Now, I also think that [7] you ought to seriously consider putting in [8] there, Multnomah County should contract [9] with OHSU to provide medical direction, and [10] that a member of that department be [11] appointed as medical director having the [12] following qualifications, duties, and [13] responsibilities.

[14] **MR. DRAKE:** That sentence should come [15] under recommendation that goes at the end, [16] okay. We have another section that says [17] recommendation, we recommend the following.

[18] **MR. KILMER:** Okay.

[19] **MR. LAUER:** Maybe you could even do [20] that under separate cover.

[21] **MR. DRAKE:** Let's move on, because I [22] want to get through this. But I agree that [23] that should be a recommendation.

[24] **MR. ROBEDEAU:** Right.

[25] **MR. DRAKE:** Let's put that at the end,

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[1] though.

[2] **MR. ROBEDEAU:** The qualifications [3] you've got listed, Randy, are directly from [4] College of Emergency Physicians. Right?

[5] **MR. DRAKE:** M-hm.

[6] **MR. LAUER:** Pretty much, pretty close.

[7] **MR. KILMER:** I think that you ought to [8] say, as recommended by the American College [9] of Emergency Physicians as modified by [10] additional local needs and experience. [11] Something like that. In other words, you [12] don't want to lock yourselves into that.

[13] **MR. DRAKE:** We could just add that up [14] at the front where he says, as recommended [15] by the American College of Emergency [16] Physicians, as modified —

[17] **MR. KILMER:** By local needs and [18] experience, something like that.

[19] **MR. LAUER:** The only difference is in [20] qualifications between ACEP, they split [21] them out as essential and desirable. And [22] No. 11 they said was just desirable. They [23] also added it could be an active member of [24] ACEP, which I thought was self-serving in [25] their document.

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[1] **MR. COLLINS:** They put board [2] certification as being desirable.

[3] **MR. KILMER:** Yes. And I think in this [4] city we ought to demand it.

[5] **MR. STEINMAN:** We did on this.

[6] **MR. KILMER:** And the other thing that [7] I think you ought to put in here is that he [8] has affiliation with a teaching institution [9] that offers courses in emergency medicine [10] so that he is in an — he's in an academic [11] capacity in the area in which he's to [12] administer. That ought to be a [13] qualification.

[14] **MR. ROBEDEAU:** That was put in by the [15] MAB I believe.

[16] **MR. COLLINS:** No, that was put in —

[17] **MR. ROBEDEAU:** Was that put in by us [18] and taken out by them?

[19] **MR. KILMER:** Yes.

[20] **MR. COLLINS:** It was put in by the EMS [21] plan. Not the PAPA plan, but it was in the [22] last discussion that went to the board in [23] November.

[24] **MR. DRAKE:** Okay. So let's add —

[25] **MR. COLLINS:** But I don't think we put

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[1] in — I know we put it more as an interest [2] in EMS research and teaching, not must be [3] affiliated.

[4] **MR. DRAKE:** I think we should put [5] association or affiliation with a teaching [6] institution, because they've got to be able [7] to do that.

[8] **MR. STEINMAN:** Do you agree, Randy?

[9] **MR. ROBEDEAU:** That would be all [10] right. That pretty much qualifies I guess [11] most of the hospitals.

[12] Is Kaiser considered a teaching [13] institution?

[14] **MR. DRAKE:** No.

[15] **MR. STEINMAN:** But most of the docs [16] that would be interested in this probably [17] have faculty appointments at the University [18] already. I mean, I've got a faculty [19] appointment. You probably do. I mean, [20] it's —

[21] **MR. LAUER:** I don't. How do you get [22] those?

[23] **MR. ROBEDEAU:** You have a faculty [24] appointment to the U of O?

[25] **MR. STEINMAN:** They're 39 cents in the

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[1] bookstore.

MS. BONNER: I don't know what a teaching institution is. We have residents, and some of our doctors have teaching appointments, but I assumed that was a way to get OHSU as the only one. I thought it was the only one.

MR. COLLINS: No. There are more —

MR. DRAKE: Emanuel has.

MR. COLLINS: It depends on what you're asking. If you want them associated with a teaching institution, then it's got — the institution has to have its own teaching process.

MS. BONNER: And which institutions qualify?

MR. ROBEDEAU: That's my question.

MR. COLLINS: OHSU and Emanuel Hospital. I don't know who else has it. It's usually tied to a residency. If you're at this level, it's not — it's not tied to graduate medical education.

MR. ROBEDEAU: Do most — my understanding is that most hospitals have intern residency programs. Am out of —



MR. LAUER: I understood it that way.

MR. KILMER: Well, they have them through OHSU.

MR. COLLINS: There's two ways to have them. They can have — I don't know how many hospitals in town have their own residency program. I know that Emanuel has a residency program. I'm sure that a couple other hospitals do.

Most of the subspecialty residency activity that goes on all comes out from OHSU, because you can't put together that kind of a residency in a community hospital very well. But it is not — this should not be an issue, because there's — there's no problem with the physician regardless where they work. If they have an interest in education and research, they can get an appointment at the teaching institution.

MR. KILMER: That's right. And an affiliation. I mean, they have all sorts of clinical appointments.

MR. ROBEDEAU: So are we agreed to put in, must have affiliation with a teaching institution?



MR. DRAKE: Yes.

MR. STEINMAN: And what Bill had put in, academic research experience preferred, in your proposal before.

MR. COLLINS: We were specific to research.

MR. DRAKE: So let's add that.

MR. KILMER: That's important.

MR. DRAKE: I think we also — and I've said this before, but I believe they should be associated with a trauma center. I think that is important. We've agreed on that in the past.

MR. LAUER: When you talk about associated, what's that mean?

MR. KILMER: On the staff of. You've got to be on the staff of a trauma center to do this job right.

MR. COLLINS: What was that, he wanted the research thing, interest in or —

MR. STEINMAN: Academic research experience preferred.

MR. ROBEDEAU: Okay. That wouldn't be a qualification, that would be, A, under —

MR. DRAKE: No. That would be a



qualification.

MR. ROBEDEAU: When you say preferred —

MR. DRAKE: It's a preferred qualification.

MR. KILMER: It's a conditional qualification as the other are mandatory.

MR. DRAKE: M-hm.

MR. STEINMAN: You know, I really don't think we want to limit it to trauma centers. You know, I've never had a physician that didn't have an academic appointment with the University from Portland Adventist or Providence or anyplace else, but I think we're — I'm not sure why we'd want to limit it to just trauma centers, especially being on staff at trauma centers. Because you're just going to set everybody off, and probably rightfully so.

MR. KILMER: Do you want this person to be doing, on a periodic basis, clinical work in the emergency department?

MR. LAUER: Yes. That's in here someplace.



MR. STEINMAN: There are more emergency departments than just trauma centers.

MR. KILMER: That's correct. But the principal beneficiaries of the 9-1-1 system and the requirement for ALS calls is to make sure that the heavily traumatized get the immediate care that they want. And it seems to me that for an EMS physician supervisor to be adequate in that job, he's got to be associated with a trauma center and dealing with those trauma patients.

MR. THOMAS: What's No. 5 say on the qualification? Active participation in the emergency department management of the acutely ill or injured patient?

MR. ROBEDEAU: Right.

MR. COLLINS: Means he's got to be working an emergency department.

MR. DRAKE: Let me clarify. There are four categories of trauma centers in the state, level four, three, two, and one. And I didn't say a level one trauma center. I just said they have to be associated with a trauma center, so that's



a hospital that says we are accepting trauma patients.

MR. ROBEDEAU: But in the Portland metropolitan area there are only two trauma centers, and they're both level ones. As I know it, there are no other trauma centers. There's no —

MR. COLLINS: The other thing you need to think of is —

MR. DRAKE: I thought there was.

MR. COLLINS: I mean, we're looking for — in these qualifications —

No. There's just two in Multnomah County. We're looking for qualifications focused on emergency medicine physicians. And while they have a role in a trauma center, the trauma center is there because of the surgical capability of the hospital, not the emergency department.

MR. KILMER: Right.

MR. COLLINS: So saying an emergency physician must be associated with the trauma center isn't going to make a lot of difference in their participation in the trauma side of it, because it's — I mean,



when you put a trauma center together, emergency medicine is a — it's part of it, but it's not the focal point. The focal point is the surgical capabilities.

And, you know, you can — you could say they need to be — you know, you have a lot of knowledge and familiarity of, and you could say they need to be knowledgeable of trauma systems just like EMS systems so you don't get somebody that — you know, that you don't think has any sensitivity to the trauma protocol.

But I don't think you — I hear what you want to have happen work-wise, but that isn't going to necessarily — I'll give you an example. If you were an emergency physician at Emanuel Hospital, you would have almost no participation in the trauma system.

MR. KILMER: That's right.

MR. COLLINS: Because they just don't use the emergency room. You'd

have a [23] little bit more at OHSU. But the people [24] that actually show up to take care of the [25] trauma patients, especially the major ones,

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[1] are the surgeons, not the — the ER doc [2] kind of goes and takes care of the other [3] people.

[4] **MR. DRAKE:** My reasoning for this is [5] what we're dealing with in the state is [6] trying to get education for paramedics. [7] And it's not just any kind of education, [8] it's education that's — that they can [9] utilize that's significant to them.

[10] And part of that has been — the [11] problem is that some people have [12] supervising physicians that aren't [13] connected with the hospital that will allow [14] any kind of teaching. And part of that [15] also is that if you have a supervising [16] physician from, and I'll use a smaller [17] hospital in Portland, even though that [18] doctor may be able to get the paramedics to [19] the ER or OR, it's such a small operation [20] they're not going to get any experience or [21] value out of that.

[22] And so the idea is that if this [23] person's associated with a trauma center, [24] hopefully they can get the paramedics in to [25] participate in that system. They can get

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[1] more valuable experience by being in a [2] trauma system if the supervising physician [3] is not associated with a trauma center.

[4] Then they're going to have to work to [5] try and get the paramedics into that [6] program, they're not associated with that [7] hospital. I think that's going to be a [8] barrier. And we can eliminate that barrier [9] by simply saying they've got to be [10] associated with a trauma center. There's [11] no reason why not to be.

[12] **MR. LAUER:** I don't think it's going [13] to be a barrier.

[14] **MR. DRAKE:** It has been.

[15] **MR. STEINMAN:** They're associated [16] already with the MRH association. If [17] they're going to be over MRH or associated [18] with MRH, they're going to be actively [19] involved in the trauma system more than any [20] ER doc you could ever find probably. So I [21] think we already have that link if we —

[22] **MR. KILMER:** If you have that link, I [23] think that's correct.

[24] **MR. DRAKE:** Then qualifications is [25] they have to have association with a

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[1] Medical Resource Hospital.

[2] **MR. KILMER:** Affiliation, yeah.

[3] **MR. LAUER:** They're in charge of it.

[4] **MR. STEINMAN:** We already put that [5] in. So you've got the link.

[6] **MR. COLLINS:** Now, if you want — I [7] think it would be reasonable, though, where [8] you have this knowledge of types of things, [9] that you specify trauma, since we have a [10] trauma program.

[11] **MR. KILMER:** That's a good idea.

[12] **MR. COLLINS:** And there are many [13] communities that have no trauma program.

[14] **MR. STEINMAN:** Probably needs to [15] say trauma system and, you know, off-line [16] medical control system. What do you [17] call them in California? They've got all [18] their —

[19] **MR. COLLINS:** Base hospitals. We [20] don't have that here. But I think [21] knowledge or experience in trauma.

[22] **MR. LAUER:** Do you want to just put [23] that in there like under qualification?

[24] **MR. COLLINS:** Just put it under [25] experience in or knowledge of.

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[1] **MR. STEINMAN:** That gets us to 13 [2] qualifications. That'll be good.

[3] **MR. LAUER:** 13 or 12?

[4] **MR. KILMER:** That's a lucky number.

[5] **MR. ROBEDEAU:** That will be 14.

[6] **MR. LAUER:** I missed the other ones [7] then.

[8] **MR. ROBEDEAU:** Must be affiliated with [9] a teaching institution, academic experience [10] preferred is No. 13, and 14 would be [11] knowledge of trauma systems.

[12] **MR. DRAKE:** No. 13 was research as [13] well, wasn't it, Pete?

[14] **MR. ROBEDEAU:** Academic and research I [15] guess. I didn't get all of it. I'm going [16] to corner Steve when this is over and try [17] and get all of it.

[18] **MR. DRAKE:** Because we were reading [19] from the Multnomah County qualifications. [20] Pete, I was going to do the same thing.

[21] **MR. ROBEDEAU:** Right. And then 14 [22] then is knowledge of trauma systems. And I [23] just left — is it okay just to leave it [24] that generic?

[25] **MR. STEINMAN:** That's fine with me.

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[1] **MR. DRAKE:** Okay.

[2] **MR. ROBEDEAU:** Okay. So [3] qualifications we are agreed on. Right?

[4] **MR. DRAKE:** M-hm.

[5] **MR. ROBEDEAU:** Thanks. [6] Responsibilities. One, to set and [7] ensure compliance with patient care [8] standards including communication [9] standards, dispatch, and medical [10] protocols.

[11] **MR. DRAKE:** Yeah.

[12] **MR. COLLINS:** What do you mean by [13] communication standards as opposed to [14] dispatch?

[15] **MR. ROBEDEAU:** That's a good [16] question.

[17] **MR. KILMER:** What is the role of the [18] physician medical director in BOEC? Are [19] they entirely separate?

[20] **MR. ROBEDEAU:** Nothing.

[21] **MR. COLLINS:** No. I mean, they [22] wouldn't — they wouldn't — BOEC needs [23] medical direction having to do with their [24] triage activities. Now, they don't need a [25] medical director to tell them how to design

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[1] their radio console, but — and that's — [2] the MAB has sort of served that function. [3] In other words, the protocols that are used [4] — what are they called? Standard [5] operating procedures that are used in the [6] triage guide has been approved by the MAB.

[7] **MR. KILMER:** How about putting — [8] including medically-related communication [9] standards in —

[10] **MR. COLLINS:** Is that what you're [11] referring to, BOEC?

[12] **MR. KILMER:** Well, yeah. I mean, [13] nobody knew — somebody asked what does [14] communications mean. I think you did.

[15] **MR. COLLINS:** I did. Because it says [16] communications and dispatch, and I want to [17] know, are those different things or the [18] same thing?

[19] **MR. DRAKE:** They are different. ACEP [20] looks at communication standards as the [21] dispatch standards. In other words, how do [22] they dispatch calls, what kinds of radio [23] communication systems do they use, do they [24] use mobile data terminals, those kinds of [25] things.

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[1] **MR. KILMER:** Why don't you put in [2] medically-related dispatch standards and [3] medical protocols, and that leaves them out [4] of all the nondispatch-related standards [5] that Bill said they don't need medical [6] direction for.

[7] **MR. LAUER:** Why don't we just scratch [8] communication standards.

[9] **MR. DRAKE:** Let's do that.

[10] **MR. LAUER:** So it would read, [11] including dispatch and medical protocols.

[12] **MR. DRAKE:** Right.

[13] **MR. COLLINS:** Okay.

[14] **MR. DRAKE:** That does it.

[15] **MR. ROBEDEAU:** Yeah.

[16] **MR. COLLINS:** Few more words.

[17] **MR. ROBEDEAU:** No. 2, approve and [18] implement protocols and standing

orders [19] under which the prehospital are provider [20] functions.

[21] **MR. DRAKE:** Should be providers [22] function.

[23] **MR. ROBEDEAU:** Okay.

[24] **MR. STEINMAN:** Nice try, Randy.

[25] **MR. LAUER:** Wait a minute. I want to

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[1] see if I took that just verbatim off this.

[2] **MR. DRAKE:** Probably a Freudian [3] lip.

[4] **MR. ROBEDEAU:** Any problem with [5] wo?

[6] **MR. COLLINS:** Well, I would take out [7] approve, because the medical direc- [8] or [9] doesn't need to approve the pro- [10] cols they [11] write.

[12] **MR. ROBEDEAU:** Right. He's going to [13] be writing the protocols.

[14] **MR. COLLINS:** Just say implement [15] protocols.

[16] **MR. DRAKE:** That's fine.

[17] **MR. LAUER:** Where are you at?

[18] **MR. ROBEDEAU:** No. 2, scratch the [19] first two words.

[20] **MR. COLLINS:** Just trying to take [21] more [22] words out.

[23] **MR. LAUER:** Implement protocols, [24] okay.

[25] **MR. DRAKE:** Yeah.

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[1] **MR. ROBEDEAU:** Okay. No. 3, ap- [2] prove [3] and implement the process for [4] the provision [5] of on-line medical di- [6] rection. Implement [7] again?

[8] **MR. COLLINS:** I'm not sure what [9] that

[1] means. The process — I don't know [2] what — [3] are you just talking about the [4] process [5] which is a contract, or are you [6] talking [7] about it's the same thing, it's [8] the [9] standards and protocols?

[10] **MR. DRAKE:** Why don't we just put [11] standards and protocols.

[12] **MR. ROBEDEAU:** Oversee the [13] op- [14] ration —

[15] **MR. COLLINS:** I'd do it the same way [16] as above. It's the protocols or proce- [17] lures [18] and whatever words for the [19] provision of [20] on-line medical direc- [21] tion.

[22] **MR. STEINMAN:** On-line and off-line [23] medical direction. Right?

[24] **MR. COLLINS:** That's true.

[25] **MR. DRAKE:** Standing orders is [1] off-line.

[2] **MR. ROBEDEAU:** Okay. Implement [3] protocols for the provision, is that [4] what [5] we're talking about?

[6] **MR. DRAKE:** M-hm. Protocols and [7] standards for the provision of on-line, [8] we [9] can just add, and off-line medical [10] direction.

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[1] **MR. THOMAS:** This one is —

[2] **MR. ROBEDEAU:** Protocols and standing [3] order are off-line direction, that's in No. [4] 2.

[5] **MR. THOMAS:** This one is intended, [6] though, just looking at the list, not just [7] to cover the protocols for on-line medical [8] direction, but also I think is intended to [9] say that responsibility for contracting for [10] on-line medical control resides with this [11] person.

[12] **MR. COLLINS:** Could be protocol [13] standards and process. I just didn't want [14] to leave it just process, because I didn't [15] know what that meant. So you could add [16] that, too. You could leave process and [17] just add the other one.

[18] **MR. DRAKE:** Process, comma, protocols [19] for the standard of on-line medical [20] director. And I'd like to put in [21] parentheses, MRH for Medical Resource [22] Hospital, because that is our on-line [23] medical direction in this community.

[24] **MR. LAUER:** Back up. Process comma [25] what?

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[1] **MR. ROBEDEAU:** Back up to beginning. [2] Read the whole thing over again, will you?

[3] **MR. DRAKE:** Implement the process, [4] comma, protocols and standards for the [5] provision of on-line medical direction, [6] paren, Medical Resource Hospital, close [7] paren.

[8] **MR. LAUER:** Okay.

[9] **MR. ROBEDEAU:** Process, protocols, and [10] standards?

[11] **MR. DRAKE:** M-hm.

[12] **MR. ROBEDEAU:** For the provision of [13] on-line medical direction, parentheses, [14] MRH?

[15] **MR. DRAKE:** Right.

[16] **MR. ROBEDEAU:** All right. [17] Okay. Are we all agreed on that?

[18] **MR. DRAKE:** M-hm.

[19] **MR. ROBEDEAU:** All right. No. 4, [20] ensure the appropriateness of initial [21] qualifications of prehospital personnel [22] involved in patient care and dispatch.

[23] **MR. DRAKE:** Yes. We got one down.

[24] **MR. ROBEDEAU:** Anybody have a problem [25] with that one?

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[1] Okay.

[2] **MR. LAUER:** No. That one's good.

[3] **MR. DRAKE:** We're rolling.

[4] **MR. ROBEDEAU:** Let's see. Ensure the [5] qualifications of prehospital personnel [6] involved in patient care and dispatch are [7] maintained on ongoing basis through [8] education, testing, and credentialing.

[9] **MR. STEINMAN:** Next.

[10] **MR. ROBEDEAU:** I don't have a problem [11] with it, except is it — except the [12] testing. Is that —

[13] **MR. DRAKE:** That's fine.

[14] **MR. ROBEDEAU:** Is that legal?

[15] **MR. DRAKE:** Yes, it is.

[16] **MR. ROBEDEAU:** Six, develop and [17] implement an effective quality improvement [18] program for continuous system and patient [19] care improvement.

[20] **MR. LAUER:** Good. Has to be.

[21] **MR. ROBEDEAU:** Promote EMS research.

[22] **MR. DRAKE:** Good.

[23] **MR. ROBEDEAU:** Serve as chair of the [24] Medical Advisory Board, yes. Move on.

[25] Nine, maintain a regionalized approach

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[1] to the delivery of prehospital care through [2] participation with emergency departments, [3] physicians, paramedics, and adjacent [4] jurisdiction.

[5] I'd like to add provider in there, [6] providers. Emergency department, [7] physicians, paramedics, providers, and [8] adjacent jurisdictions.

[9] **MR. DRAKE:** I would like to delete the [10] word paramedics. Add EMT, because [11] emergency medical technicians includes all [12] levels of EMT.

[13] **MR. LAUER:** EMTs, providers, okay, I [14] got it. Next.

[15] **MR. DRAKE:** Okay. We're ripping now.

[16] **MR. ROBEDEAU:** Okay. Arrange for [17] coordination of activities such as mutual [18] aid, disaster planning and management, and [19] hazardous materials response.

[20] **MR. DRAKE:** M-hm.

[21] **MR. STEINMAN:** Do they arrange for [22] this — will this position arrange for or [23] just —

[24] **MR. LAUER:** Arrange for.

[25] **MR. DRAKE:** Arrange for coordination.

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[1] **MR. ROBEDEAU:** The actual coordination [2] on some of that's going to have to be [3] provider coordination. If he arranges for [4] it as a mediator, I think that's a good [5] point.

[6] **MR. LAUER:** Okay. Anybody have any [7] problems with 11?

MR. ROBEDEAU: Promulgate public education and information on the prevention of emergencies.

MR. DRAKE: Off the record.

MR. LAUER: You can't do that.

MR. DRAKE: Okay.

MR. COLLINS: On No. 10, I think in order — I mean, I don't think this would be a big issue, but I can see a few people pointing at it. You need to talk about medical mutual aid and medical disaster plan, or you're going to get sidewards with the emergency management people.

MR. MOSKOWITZ: I agree.

MR. LAUER: Okay. Medical mutual aid.

MR. COLLINS: Right. And medical disaster planning and management.

MR. LAUER: Okay.

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MR. DRAKE: Yes.

MR. COLLINS: Or FEMA will be at your front door.

MR. LAUER: Bruce Binder's going to be showing up.

MR. STEINMAN: Does anybody want me to put on the record what Mark wanted to say off the record?

MR. DRAKE: No.

MR. STEINMAN: I'd love it on the record.

MR. DRAKE: No.

MR. STEINMAN: Next one.

MR. DRAKE: Yeah, authority.

MR. ROBEDEAU: Authority. Okay. Approve dispatch protocols and prearrival instructions, medical protocols for ALS and BLS providers, communications protocols, and system procedures.

What's the difference between communications protocols and dispatch protocols?

MR. LAUER: Well, commun —

MR. COLLINS: There's radio communication protocols, that would be

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different. But again, I wouldn't use the word approved. I mean, if you want this person to have the authority, I'd say promulgate.

MR. THOMAS: Establish.

MR. LAUER: Promulgate, okay.

MR. THOMAS: How about establish? That's a more common word.

MR. COLLINS: You don't like promulgate. Doesn't that mean put out?

MR. LAUER: I'll let you guys arm wrestle.

MR. KILMER: It's a legally appropriate word, who would confuse most people.

MR. COLLINS: I want to use —

MR. LAUER: What do we want to use?

MR. COLLINS: Promulgate.

MR. ROBEDEAU: I don't care. Do you want to leave in dispatch protocols and communication protocols?

MR. COLLINS: Yes.

MR. DRAKE: Yeah.

MR. ROBEDEAU: I think it's redundant, but I'm not going to argue about it.

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MR. DRAKE: Okay.

MR. ROBEDEAU: Okay. Two, set standards for certification of prehospital care personnel including medical call-takers, first responders, ambulance personnel, on-line medical direction physicians and others.

MR. KILMER: Should have a comma in here.

MR. DRAKE: We can't set standards for certification. That's a state function. But you can delete the word "for certification" and just say — or delete the word "certification." Set standards for prehospital care personnel and delete the word "certification of."

MR. COLLINS: Right.

MR. ROBEDEAU: I think it would be better to say, ensure compliance with certification standards of.

MR. STEINMAN: Let's do that as No. 5. Let's assure compliance with all state laws.

MR. KILMER: That's it.

MR. ROBEDEAU: Well, I think No. 2 is

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allowing the physician medical director to set his own standards. And the physician medical director standards have to be the same as the state.

MR. KILMER: They can be greater, Pete.

MR. ROBEDEAU: They can be greater, but they can't be less.

MR. KILMER: And nobody's suggesting that he would have the right to make them any less.

MR. LAUER: Set standards.

MR. KILMER: It's a given that he could not go below the floor.

MR. DRAKE: Right. Pete, they do that now. They do now set standards. And all we're saying is that's what they're going to do.

MR. ROBEDEAU: All right. So we're leaving No. 2 alone?

MR. KILMER: Taking out "certification of."

MR. DRAKE: Right.

MR. ROBEDEAU: Set standards for.

MR. LAUER: No. 3 we've already

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written.

MR. COLLINS: What does "and others" mean?

MR. LAUER: Anybody else that comes along.

MR. KILMER: Don't you want a comma after on-line?

MR. COLLINS: Medical direction physicians, and others.

MR. KILMER: Wait, wait. On-line medical direction physicians, is that all intended to be one comment, or is it —

MR. COLLINS: That's one comment.

MR. KILMER: No comma. What is on-line medical direction physicians?

MR. COLLINS: Those are the physicians who talk on the radio at MRH. And they need to meet certain requirements to talk on the radio.

MR. KILMER: Wouldn't you want to use the word directing or something like that?

MR. DRAKE: No. Medical direction physician.

MR. ROBEDEAU: No. It's on-line

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medical direction. And that's coming from the physicians who are talking on the radio. And that's what it — it's identifying a group of people. It's kind of like saying trial lawyers and nice lawyers.

MR. DRAKE: Jeff, this is medical language.

MR. KILMER: Remember, trial lawyers are only plaintiff lawyers. Defense attorneys are a different breed.

MR. DRAKE: This is medical language, Jeff, not legal language.

MR. STEINMAN: We already did No. 3. Right?

MR. ROBEDEAU: What about others? What others are we talking about?

MR. COLLINS: There could are others, I can understand that.

MR. ROBEDEAU: Okay. No. 3, issue, renew —

MR. DRAKE: We already did this.

MR. ROBEDEAU: — suspend, revoke —

MR. COLLINS: Well, my input is not to do that.

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MR. ROBEDEAU: — and restrict the licenses.

Yeah, I don't believe we can do that.

MR. COLLINS: I think that the physician medical director should provide the medical input into that process. But there are other things involved in that besides medical requirements.

MR. DRAKE: So just why can't we say make recommendations for the issuance, renewal, suspension?

MR. LAUER: We did.

MR. COLLINS: Or provide into the issuance of. The reason I say that is, for instance, if the state took your license because you didn't keep your insurance current, we'd revoke your license. It's got nothing to do with the doc.

MR. DRAKE: Right.

MR. LAUER: We had the discussion earlier.

MR. COLLINS: I missed that.

MR. LAUER: From that I scratched all of No. 3, and we're going to replace it with — I don't have the definitive

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language here, but something to the effect that it acts as the physician of record or as a physician of record, restrict.

MR. MOSKOWITZ: That was on No. 5. Right?

MR. DRAKE: We added another number. Does anyone have a problem with saying what Bill just said, provide medical input into the issuance, renewal, suspension, revocation, and restriction of licenses, certifications, and permits required by Multnomah County?

MR. KILMER: That's really good.

MR. STEINMAN: Good job, Bill.

MR. COLLINS: Thank you.

MR. DRAKE: Good job, Bill.

MR. LAUER: So you just added two words in the beginning.

MR. COLLINS: What'd I add?

MR. KILMER: Provide medical input into the issuance, renewal, suspension, turning all these — I don't know what they are — into something else. Adverbs into pronouns or something.

MR. DRAKE: Restriction of the

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licenses, certifications, and permits.

MR. ROBEDEAU: Add medical — do that again, will you, please?

MR. LAUER: Provide medical input —

MR. DRAKE: Into the issuance.

MR. LAUER: — into the, and then I'll change all those words.

MR. DRAKE: Okay.

MR. STEINMAN: No. 4. Can we all talk at once, see if we drive the court reporter nuts?

MR. THOMAS: Wait a second on No. 3. I think we need to think through what this was trying to do in the first place, because I'm wondering if we're misinterpeting something.

Item 2 allows — gives the director the authority to set additional standards. And it's not just talking about EMTs and who's the physician of record, but it also is talking about — well, ambulance — it is mostly actually first responders, but then when you get to the next one, No. 3, it's also talking about — forget it, strike it all. Never mind.

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MR. STEINMAN: Okay.

MR. ROBEDEAU: God, I'm glad I'm not the only one that does that.

MR. LAUER: Okay.

MR. THOMAS: I won't even tell you what I was thinking. It was wrong.

MR. COLLINS: You might be right on what you were thinking.

MR. DRAKE: No. 4. Let's move on.

MR. ROBEDEAU: Bill, what are you —

MR. COLLINS: I may have read this wrong, too. There are two different things going on: One is the licensure requirements or permit requirements of the providers and the ambulances and stuff; the other has to do with the practice requirements of the people. And the medical director should have the authority to restrict the practice of any EMTs or EMDs based on some kind of due process.

MR. DRAKE: Yes. That is a separate line item, though.

MR. COLLINS: Okay. Add that. It needs to be in there someplace.

MR. DRAKE: Yes, it does.

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MR. ROBEDEAU: That goes in as No. 5. As a physician of record, for he has the authority. If your physician of record pulls standing orders, you're out of a job.

MR. COLLINS: Right.

MR. KILMER: What if you left this sentence exactly the way it is and just add, at the end, as otherwise authorized by law? And what that does is, in the areas where the state law preempts him, he only can make recommendation.

MR. DRAKE: Are you talking about No. 3?

MR. KILMER: On No. 3.

MR. DRAKE: We already fixed that.

MR. COLLINS: Those are two different things. I hear what you're saying.

MR. KILMER: I thought that would clarify the issue you brought up.

MR. COLLINS: But they're going to put in another place and try not to meld the two together.

MR. STEINMAN: Are we leaving revoked in No. 3, the licenses? Because we talked

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about that pre-Bill, that physician doesn't have the right to revoke certification.

MR. COLLINS: We changed that to provide medical input into. In other words, the EMS — the county can revoke the license based on whatever criteria in the code.

MR. STEINMAN: Okay.

MR. ROBEDEAU: Okay. No. 4, appoint and approve physician agents to act as an adjunct for the purposes of inservice education, field supervision, quality improvement, and provider interface.

I would say appoint and scratch and approve.

MR. THOMAS: Just appoint?

MR. DRAKE: Yes. And I would add to the end of that. It says, and provider interface. I'd have comma, and other duties as described by statute. Because the statute is specific under what physician agents are responsible for.

MR. THOMAS: What are you thinking?

MR. DRAKE: Well, the state statute says, in the absence of the physician of

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record, the agent acts in their place.

MR. THOMAS: Okay.

MR. KILMER: Okay. And don't you want to add there, board certified emergency physicians?

MR. DRAKE: Well, I think what we want to do is we need to have qualifications, Jeff, for the physician agents. And we need to list out three or four qualifications for them.

MR. THOMAS: So just say, physician agents should meet the following requirements colon.

MR. COLLINS: I think we talked about the medical — I think you should have the same qualifications for the agents.

MR. DRAKE: Right.

MR. COLLINS: Otherwise you're going to get into, why are you allowing this different?

MR. DRAKE: So what you're saying under medical director, you would have all agents must — or agents must meet the following qualifications, something to that effect, under medical director?

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MR. COLLINS: Yes. Just add another sentence.

MR. KILMER: What you'd said is appoint physician agents having the same qualifications as the medical director.

MR. DRAKE: Right, good.

MR. STEINMAN: Now, if this person can appoint, can they also terminate? Do we need to put that down? I mean, are we just going to continue to appoint and keep them?

MR. KILMER: You can put in — I would say you should have a separate one you can hire and fire and make all appropriate management decisions.

MR. DRAKE: But I think that's a good point that Tom's making. Just say appointed and terminate physician agents.

MR. THOMAS: Sure.

MR. ROBEDEAU: Appoint and replace.

MR. DRAKE: Replace is probably better. Terminate kind of sounds kind of final.

MR. STEINMAN: Not now that they're out of the trauma hospital.

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MR. LAUER: So instead of appoint and remove, it's appoint and replace. Do we put "and" back in there?

MR. ROBEDEAU: Yes.

MR. STEINMAN: Put any word.

MR. LAUER: We got rid of approve, didn't we?

MR. STEINMAN: No. We replaced it.

MR. THOMAS: Appoint and replace.

MR. ROBEDEAU: So we have appoint and replace physician agents to act as an adjunct for the purposes of inservice education, field supervision, quality improvement, and provider interface — and I missed the last part.

MR. COLLINS: And other duties described by statute.

MR. ROBEDEAU: And other duties. Okay. Is that it?

MR. LAUER: What about the No. 5? How do we want to — the physician of record and the authority under ORS.

MR. ROBEDEAU: No. 5's going to have to be added.

Okay.

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MR. THOMAS: So you want to say, serve as a physician of record with the authority and responsibility set out in Oregon law.

MR. STEINMAN: Good job. Got that, Randy?

MR. LAUER: Okay. I got it.

MR. ROBEDEAU: Serve as the physician of record?

MR. THOMAS: With the authority — let's just say authority and responsibility set out in Oregon law. That's good enough.

MR. LAUER: Okay. That was it. Right?

MR. ROBEDEAU: That was it with the exception of recommendations. We still —

MR. DRAKE: We need to put a recommendation down.

MR. LAUER: I would recommend that any recommendations as to who should provide what we just described should come out under separate cover.

MR. ROBEDEAU: Well, first of all, before we get into that, I think it's probably appropriate on this point, can —

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and I don't even know if that's legal, but can we have a vote on whether or not we approve everything up to recommendations as far as unanimous? Is that —

MR. KILMER: That's perfectly legal.

MR. LAUER: Approving this document?

MR. ROBEDEAU: Can I get a motion on that then from somebody?

MR. LAUER: I'll make a motion that we approve this document as amended.

MR. DRAKE: M-hm. I'd second.

MR. ROBEDEAU: Okay. It's been moved and seconded. Any discussion?

Make it legal here. In favor? Aye.

MR. DRAKE: Aye.

MR. LAUER: Aye.

MR. DRAKE: He said aye.

MR. STEINMAN: I mumbled.

MR. ROBEDEAU: Opposed? So it is approved unanimously by the Provider Board, at least up to recommendations.

Okay. I think we need to make a recommendation. You know, nobody —

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everybody's been afraid to make a recommendation. I think most of the medical supervision right now is coming out of U of O. In order for this to move on, at least with this phase of the EMS system, to recommend that the U of O be allowed to take over medical supervision, I would say immediately, and act as the single medical authority for the EMS system, subject to an — interim subject to an RFP.

Didn't the EMS do an RFP?

MR. COLLINS: We've never done — I mean, I don't know if they've done it in the past.

MR. ROBEDEAU: I think they did.

MR. DRAKE: They did a long time ago?

MR. THOMAS: Yes. Five years ago.

MR. LAUER: There are more issues.

MR. KILMER: I think you ought to separate the interim issue from the system design issue. I'd like to suggest that you remove that part from your recommendation.

MR. DRAKE: What?

MR. LAUER: Leave what's in place in place until the new system can be put in.

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MR. KILMER: In other words, don't talk about interim, Pete. Talk about making your recommendation. I think that'll make a —

MR. DRAKE: Pete, I just think we should make the recommendation and just — to get off this point. And the reason is, in the past we all come up with an idea or a model, if you will, and everybody sits down around and discusses it and no one knows what to do with it.

And we need, as the Provider Board, to make a recommendation. We've come up with a model. Who should do the model? And if the county wants to make changes later on, they certainly have that ability. But for now we just need to move off this dime and recommend it be the University of Oregon.

MR. ROBEDEAU: I agree with you we need to make a recommendation. We've written protocol. We need to make a recommendation. But — well, I'm just not sure how to word it.

You know, U of O is doing it. I think U of O ought to continue to do it subject

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to whatever guidelines the county comes up with, renewal of their con-

ract or setting [3] the ASA or — god, I lon't know what I'm [4] trying to say.

5] **MR. THOMAS:** You don't have to do hat [6] all now.

7] **MR. KILMER:** That's right. You don't 8] have to say all that now.

9] **MR. DRAKE:** Right. The recommendation [10] is that the University's doing t now. One [11] of the things we've ooked at through this [12] whole process is to make recommendations [13] based on available resources. University 14] is the available resource. They've got 15] everything in place; the resource IRH, [16] their trauma center, their eaching [17] institution.

18] They meet all the standards we want. 19] Simply say, we recommend the University of [20] Oregon Health Sciences Center be contracted [21] with the ounty or employed by the county, [22] however the relationship should be, for he [23] purposes of providing medical lirection in [24] Multnomah County.

25] **MR. STEINMAN:** I think we just need —

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1] if you're going to recommend anything, you [2] should recommend that he county move [3] forward with a process of contracting with [4] a person or group to do this. You're [5] just asking or trouble if you do OHSU.

6] **MR. LAUER:** I agree.

7] **MR. ROBEDEAU:** The trouble is, you 8] know, we've been through this before nd, [9] you know, I have to agree with Mark, and [10] that's where I'm coming rom, is we've gone [11] through this. We've turned it in. [12] Everybody, for 20 ears, has been in [13] agreement that here should be a single [14] medical uthority in the system.

15] Everybody puts it out trying not to 16] hurt anybody's feelings. And what appens [17] is they say, yeah, we need ingle medical [18] authority, and it's hose damn ambulance [19] companies hat are holding this up.

20] **MR. STEINMAN:** Well, all I can say is 21] I'm a little sensitive to the political 22] arena this week. And recommendations that [23] are made need to be real benign, neutral.

24] **MR. THOMAS:** You know, let me say 25] something about this, because I had huge

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1] internal debate within myself about his. [2] And I think what I'm going to say s true, [3] which is everybody here I hink thinks it [4] ought to be at OHSU. Maybe I'm wrong, but [5] I think that's what everybody thinks.

6] If that's the — and if you read this, [7] hat's what it looks like. And I suppose [8] there's a plus to being straight — there [9] is a plus to being straightforward and not [10] writing something which directs something [11] someplace and trying to act like it [12] doesn't. I mean, I think that's really [13] true.

[14] I mean, somebody can reject this and [15] they can put it out for bid and everything [16] else. But I suppose the truth of it is, if [17] it doesn't — if the group doesn't say, we [18] believe the appropriate place for this to [19] be is OHSU —

[20] **MR. KILMER:** Directly.

[21] **MR. THOMAS:** — it's creating one of [22] those situations where you're setting [23] something up to end up someplace, but [24] you're not willing to say what you're [25] trying to do.

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[1] And I mean, if that is what everybody [2] thinks is best for the community, I really [3] think it ought to say that. And I have to [4] say I sort of revolutionized my view on [5] this because I can think of all sorts of [6] strategic and other reasons to do it the [7] other way. But it doesn't look totally [8] clean to not say if that's what we think.

[9] **MR. DRAKE:** And we have all discussed [10] this, I mean, in many different arenas. [11] We've all agreed the University's the one [12] doing it now. They should continue to do [13] it.

[14] The only way we can get medical [15] direction in this community tomorrow is to [16] have the University do it, because they're [17] the only ones that are doing it and have [18] the qualifications for doing it. I'm not [19] opposed to a different institution doing [20] it, as long as they can meet all the [21] qualifications. None can today.

[22] **MR. KILMER:** I would like to make this [23] one modification to the way the University [24] has done things. It addresses the concern [25] that Randy raises, which remains something

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[1] of a concern, even though the consolidation [2] of doctors in one place minimizes [3] considerably the problem of lack of [4] accountability among several physicians.

[5] The county wants one person that is [6] the medical director and is accountable and [7] has the authority to dominate and control [8] its agents. Now, that's going to be a lot [9] easier in the environment of the OHSU [10] department of emergency medicine because [11] they're already in this collegial [12] environment.

[13] But I do think OHSU ought to do it, [14] but they ought to appoint somebody that is [15] the medical director who has the right to [16] appoint the agents and has some power over [17] defining the agents' response of things in [18] a way that maximally ensures a uniform [19] team. So you're not buying into the OHSU [20] as is, you're buying into OHSU as the only [21] place that can give everybody what you [22] want, but you're asking OHSU to do one [23] thing, and that is appoint a boss.

[24] **MR. LAUER:** That's partially true. I [25] disagree that OHSU is the only institution

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[1] that can do it, however.

[2] And I don't think it's a given that we [3] all think it ought to be at OHSU. I think [4] several hospitals or institutions around [5] this area are quite capable of providing [6] medical direction under this model.

[7] **MR. THOMAS:** And serving as MRH also?

[8] **MR. LAUER:** Yes.

[9] **MR. ROBEDEAU:** MRH is simply a matter [10] of moving radios. That's no big deal.

[11] **MR. KILMER:** I would like to address [12] this, that, Randy, you say that —

[13] **MR. COLLINS:** MRH is more an issue of [14] how to fund it if you want anybody else to [15] do it.

[16] **MR. KILMER:** You say what you just [17] said. You said what you just said about [18] any number of emergency rooms being able to [19] do this. I don't think there's any [20] evidence to support that at all.

[21] None of them have. None of them have [22] expressed any interest in doing that. To [23] my knowledge, none of them have the team of [24] internal emergency physicians that would [25] want to undertake this responsibility or

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[1] would have the expertise to do it well, [2] even if they did. I think it is wrong that [3] there's any other group in town that can do [4] it, except possibly Emanuel. And Emanuel [5] has expressed no interest in the past in [6] doing it.

[7] And in the meantime, OHSU has stepped [8] to the plate. It's got the group already [9] in place. And it is the biggest emergency [10] department in town, to my understanding. [11] And it is already affiliated with the [12] medical control, the MRH hospital [13] responsibilities that it's paying for. And [14] it deserves to have some payback for that [15] subsidy to the system that is essential.

[16] And I think if you have information [17] that contradicts what I just said, then I [18] think you ought to put that in this [19] record.

[20] **MR. LAUER:** I don't think the cost of [21] MRH is all that large. It's provided by

staff that has to otherwise be there except for one operator. The equipment was purchased by a grant so that the cost of the equipment is maintenance. The

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equipment's going to have to be replaced anyway eventually, because the UHF Med-Net system is outdated. I mean, it is, for the most part, a matter of moving equipment from one place to another.

**MR. KILMER:** That's the MRH issue. What about the other issues? Are other departments qualified?

**MR. LAUER:** I think other departments are clearly qualified.

**MR. KILMER:** Can you name them? And what's the basis for your view they're clearly qualified?

**MR. LAUER:** I think Emanuel would be qualified, because they have a group of physicians in their emergency room, one of which could be a medical director. They have access to clinical — I don't know. We have to ask them.

My whole point is that we have to go through a process that does two things: It solicits interest from those out there; and it selects the one who is most qualified.

**MR. KILMER:** Is that all the evidence you have on the availability of the

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alternatives to OHSU?

**MR. LAUER:** Providence, why couldn't Providence do it? Why couldn't Portland Adventist do it?

**MR. KILMER:** How big are their emergency departments?

**MR. LAUER:** You mean in terms of patient flow or staff?

**MR. KILMER:** Staff.

**MR. LAUER:** I can't give you any numbers. They're fairly large.

**MR. STEINMAN:** You know, I'm fairly comfortable with — I know if the county goes out to bid and, you know, we still got this tort stuff hanging and malpractice insurance stuff hanging, it's going to have to be a county employee I guess however you contract. Can you contract and still keep under the tort stuff?

**MR. KILMER:** County can. The county will have exactly the same amount of protection. And if you go to OHSU, OHSU has that protection. OHSU is a state agency.

**MR. STEINMAN:** Jeff, I totally agree

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that OHSU is in place, they're doing a great job. And I think they're the only ones that will come out of this, if it went to RFP, that would even be interested in bidding. There's no doubt in my mind. Because I've been through RFP's on this process, and I got one responder. And that's what the county would get, is one responder.

But if we don't put that out there to the other people, that one responder will have the next ten years of 13 hospitals shooting at them and so will we. And that's my concern. I'd like to see the county move to a selection process and maybe give some consideration to in-place providers of physician supervisor services, whatever.

But the University — you know, I mean, we were the first to go up there. I couldn't ask for any better. And I would hope that they would pick up the contract. But, you know, if we put something like this through or the county did, they'd just have years of everybody shooting constantly

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that it was, you know, a phoney deal, blah, blah, blah. We want it. They didn't want it when we went out to bid.

**MR. KILMER:** Seems to me, Tom, is what you're doing here is, the Provider Board is making a recommendation for what would be best for the system. The odds of this being adopted at the OHS — at the MAB level are zero. The big issue is, we are taking a position about a system design.

If the County Commissioners are concerned about what you're talking about and the people that want to oppose this recommendation are going to shoot at it, their time to shoot at it is at the time it goes before the County Commission. If they don't shoot then, they're not going to shoot later. And if they don't shoot then, then they have — you know, what's happened is that you have short-circuited an enormous RFP process.

Now, the concerns that you've raised are some that our policy-makers are going to have to evaluate at some point. But that doesn't have to be us. We ought to

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make a recommendation, as we are with everything else, about what this ought to look like. And we have come to this with a much more thoughtful process than has ever existed in this system before. There's a lot more solid stuff in the hearing process that we've developed to support this.

And for us not to stand on that for fear of giving political offense, in my view, is buying back into the very problem that has plagued this process from the beginning. People have been unwilling to stand up, get the facts, and then make the most reasonable decision on those facts because it might offend some faction.

**MR. STEINMAN:** I'm not talking about the political arena. I'm talking about system stability. If we do get this thing finally moving forward and we do contract, I do not want the system to be constantly shooted at. I don't want to see any more ridiculous MAB meetings like we've had for the last year. I want it to be as fair and open a process as we can, to steal somebody's words. You know, that's my only

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point.

I totally agree it should be the University. I'm thrilled with the service they've given us. But, you know, I would support somehow wording in there that the University has provided good service and maybe should be given some special considerations if they can, but I think the county needs to go out on a nice clean RFP and get one response back, just like the city did, and then everybody's quiet.

**MR. COLLINS:** I would suggest that you, in your recommendation — in looking at this again, you've outlined all the criteria you want for medical director, but you have not described at all in here why it would be advantageous or disadvantageous to have it in some kind of a medical group, whether it's at the University or not. It's just not in here.

**MR. KILMER:** That was the other comment that I wanted to make, are that there was this draft that was prepared that some people said is going to offend the Medical Advisory Board. To me that's a

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nonissue. They're already offended. I mean, we couldn't do anything to offend them any more. And anything we do is not going to make any difference to what they're going to say. But in this, it was recited, in paragraph F, and in paragraph G —

**MR. THOMAS:** They don't know what you're referring to.

**MR. KILMER:** Well, this is the proposal of the Provider Board on medical control that was passed out last time I thought.

**MR. COLLINS:** What I was referring to is, you know, based on the document here that you all agreed to, when you're looking at the recommendation, you might speak to why you feel this set of criteria best fits in whatever place you want it to fit in.

[20] **MR. LAUER:** What we've done —

[21] **MR. KILMER:** What I started to say is [22] that that is done in the other thing hat [23] you —

[24] **MR. COLLINS:** That might be a bet-er [25] recommendation than just saying lo it at

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1] the University.

2] **MR. KILMER:** Well, I'm agreeing with 3] you, that this ought to be supple-nented [4] with the recommendation. \nd I was going [5] to recommend that 'ou put in the [6] recommendation, this )ught to be contracted [7] to the Univer-ity right now. That ought to [8] be the ecommendation. But the University [9] nust appoint a single medical director vho [10] has supervisory control over his .gents, [11] who will be selected from hat department. [12] I can fine tune that. The reason for this [13] recommendation s, and now you go back to [14] this locument that we started off with at [15] he last meeting, or something like that, 16] if you want to take out some inflam-natory [17] words or something.

18] **MR. LAUER:** I think the thing that 19] confuses — what we've done is ve've [20] approved a model for medical lirection by [21] vote. Now what you vant to do is recommend [22] that that )e given to OHSU.

23] **MR. KILMER:** Correct.

24] **MR. LAUER:** And I think if that's the 25] way you want to proceed, with a separate

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1] recommendation as to who should do his, [2] then proceed that way. But you need — [3] we'll probably need to do it n a minority [4] and a majority opinion. \nd that's fine. [5] But I think what we )ught to do is stop [6] dancing around ind just do that.

7] **MR. KILMER:** Well, that's — that's [8] right. What we're doing now is that I [9] hink Pete and Mark agree with what 'ou [10] said. Tom is having misgivings )ecause of, [11] you know, his concern hat we not do [12] something that ends ip getting enacted that [13] will then eave a whole lot of turmoil.

14] My guess is a lot of what Tom's [15] concerns are will actually be resolved 16] between our recommendation and he [17] implementation of whatever pol-cy this [18] process ultimately yields up. Hopefully it [19] will be something more han the Rosemary's [20] babies that ve've had in the past.

21] But I think your concerns are too [22] early, Tom, for the recommendation here. [23] But they are very important concerns that [24] must be addressed and resolved in the [25] balance of this process. And one way to

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[1] encourage that is to express your concern [2] that all others who are opposed to this, [3] the other hospitals that are afraid of the [4] University of Oregon's control in this [5] area, come forward with feasibility [6] alternatives that will not result in a [7] situation where the agents are fighting [8] among themselves.

[9] One of the points that was made in [10] this approach that was drafted up and made [11] last time is you're going to have a [12] director hired by the county under the PAPA [13] plan. In light of the antipathy that those [14] people have for the University, their [15] agents are not going to be hired by the [16] University, or there may be one token [17] agent.

[18] The agent's going to come from various [19] other emergency rooms. And in order to be [20] ecumenical, they're going to come one from [21] each, and they're all going to start [22] fighting among themselves. And the medical [23] director is going to be so bogged down in [24] resolving disputes from his agents that [25] what we have now is paradise and what we

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[1] had 15 years ago and ten years ago when we [2] had different medical supervisors will be [3] paradise compared to what they are risking [4] with this new system.

[5] Those things ought to be pointed out. [6] And they are pointed out, to some extent, [7] in the thing I said last time. But I think [8] if we make this recommendation, Tom, we [9] actually take some responsibility for [10] guiding the direction of the future [11] debate. And that's something we, as a [12] board, ought to be willing to do — you, as [13] a board, ought to be willing to do.

[14] **MR. STEINMAN:** Or we lose all [15] credibility.

[16] **MR. DRAKE:** Let's take five.

[17] **MR. COLLINS:** But still, there's a — [18] I'm looking at not part of the Provider [19] Board but something coming to our office.

[20] It says here is a document. And the [21] piece that is missing for me in this [22] document is there is nothing in here that [23] explains in any way why these criteria can [24] best be met in a group practice. It just [25] isn't in here.

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[1] I mean, I got this. I could follow [2] all these things. You could go out RFP and [3] hire a medical director. That's what it [4] says to do. And that's it.

[5] It doesn't make any mention in here of [6] why it should be in any kind of group [7] practice with or any connections like [8] that. It doesn't say. So to go from here [9] to any recommendation of any hospital would [10] — to me would not make sense.

[11] I would look at this and go, why [12] should I do that? I mean, I know [13] historically what's going on, but if I was [14] looking at this from that perspective, [15] that's not here. It just doesn't say that.

[16] **MR. LAUER:** It doesn't have to be [17] there.

[18] **MR. STEINMAN:** It does if you're going [19] to make the recommendation, though. That's [20] right.

[21] **MR. COLLINS:** No. But everybody has [22] been talking about — has been saying there [23] are positive things to have this in a — [24] you're talking about the University. But [25] if you did it in a more general framework,

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[1] you're talking about having medical [2] direction in an emergency medicine group [3] practice. That's what you're talking [4] about, as opposed to hiring an individual [5] and having them going out independently [6] finding people.

[7] So there needs to be some — you need [8] to make that next step in this process of [9] why you think that that's a good idea. [10] Because it's not referenced in here at [11] all.

[12] **MR. DRAKE:** You need to make that [13] bridge.

[14] **MR. LAUER:** That's in the [15] recommendation, though.

[16] **MR. COLLINS:** Yes.

[17] **MR. DRAKE:** You need to make that [18] bridge. I agree with you.

[19] (Discussion off the record.)

[20] **MR. KILMER:** You gotta move till you [21] act on this.

[22] **MR. ROBEDEAU:** We have to act.

[23] **MR. DRAKE:** That's going to involve [24] some more discussion. So let's take a [25] five-minute break real quick, two-minute

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[1] break.

[2] (Recess.)

[3] **MR. DRAKE:** Pete, are we back?

[4] **MR. ROBEDEAU:** Yes. Let's get back. [5] We've got to finish this up.

[6] **MR. DRAKE:** Let's go.

[7] **MR. ROBEDEAU:** Okay. I think Chris [8] had written something up.

[9] **MR. THOMAS:** Let's get what we can. [10] Here is what I was writing up what I [11] thought people were saying.

[12] This I think is different than what [13] you were saying, but what I thought the [14] others were saying.

[15] **MR. COLLINS:** Except for you.

[16] **MR. THOMAS:** The medical director [17] physician agents and MRH should be at a [18] single institution in order to provide a [19] fully collegial atmosphere for medical [20] intervention, and could avoid the [21] inappropriate interjection of [22] inter-hospital competitive issues into [23] medical supervision of the EMS system. [24] OHSU has demonstrated its ability to meet [25] this requirement and has done an

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[1] outstanding job in providing these [2] services. The Provider Board, therefore, [3] recommends that OHSU be the organization to [4] fill this role.

[5] **MR. LAUER:** Could you substitute the [6] word "promote" for "avoid" between the [7] inter-hospital interjection part there?

[8] **MR. DRAKE:** To avoid the [9] inter-hospital rivalry rather than — is [10] that what you're saying?

[11] **MR. KILMER:** It doesn't make any sense [12] when you change that.

[13] **MR. THOMAS:** That's a joke I think.

[14] **MR. LAUER:** Sort of.

[15] **MR. KILMER:** Now, what I would like to [16] do — Chris' language, as far as it goes, [17] is great. I think that we ought to add to [18] this an additional sentence, in order to [19] minimize the concern attendant to a [20] group — a multiple-doctor delivery of [21] medical control, one member of the [22] department ought to be appointed medical [23] director with supervisory authority over [24] others in his department he selects — he [25] or she selects as agents.

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[1] That solves the problem that you [2] articulated is the one thing that people [3] point to about the OHSU process, and it [4] gives you the label medical director that [5] everybody has said they wanted.

[6] **MR. DRAKE:** Okay. Randy, do you have [7] any problems with the way that's worded as [8] worded right now? I mean, you said you [9] wanted to add something but —

[10] **MR. LAUER:** No, I was just kidding. [11] No. I'm not going to support [12] essentially naming OHSU as this — as [13] carrying out this model. What I would [14] support would be to go — to proceed with [15] the process that is fair and open, to [16] paraphrase Jeff, that fairly selects a [17] provider of this medical direction model, [18] period. And in the interim, why — you [19] know, what exists today will continue, [20] which is essentially what you just [21] described.

[22] **MR. DRAKE:** The reason that I [23] wouldn't — I can't support that position, [24] Randy, is that we've been doing that for [25] four years. We've been trying to go

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[1] through a process. And by naming the [2] Health Sciences University — and all they [3] have to do is, the county has to say one of [4] those docs up there is the medical [5] director, the system is in place now.

[6] And then the county can say, we're [7] going to do this for a year or two years, [8] and then go through an RFP process and then [9] other hospitals can get up to speed and do [10] it, if they want to, and apply.

[11] **MR. ROBEDEAU:** I don't —

[12] **MR. LAUER:** That needs to be done in [13] the front end rather than give that [14] incumbent advantage to the OHSU.

[15] **MR. ROBEDEAU:** I don't agree with what [16] you said, Mark. You know, I think one [17] thing that we'd find out just — if this [18] process would even work is to, at this [19] point, you know, name U of O and see if [20] they can even come up with somebody to be [21] the physician supervisor. That would sure [22] tell us a whole lot, you know. Because I [23] have questions whether or not any hospital [24] will really do that.

[25] **MR. DRAKE:** Oh, I think they will,

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[1] Pete. I don't think they have any problem [2] doing that. They can name Jon Jui or [3] Moorhead.

[4] **MR. KILMER:** One or the other of those [5] will almost certainly be named as the [6] medical director. And the important thing [7] is that that guy have the ability to, in [8] situations where collegiality does not, in [9] a reasonable time frame, lead to consensus, [10] impose his view. The system needs that. [11] And any direction needs that.

[12] And it will disrupt, in some small [13] respects on some issues perhaps, the way [14] that department currently functions. But [15] that small modification in their [16] functioning gives everybody everything they [17] want. It gives them single medical [18] direction, gives them accountability to the [19] county, accountability through one person, [20] gives everybody the collegiality [21] environment.

[22] It keeps this place where it is now [23] where we know it will work, and where the [24] chance of the inter-hospital rivalries and [25] the rivalries between people as agents that

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[1] have never worked together before is [2] eliminated. An elimination of risk of [3] unknown or untested alternatives is a very [4] important factor in any decision-making [5] process. So it gives everybody everything [6] they want.

[7] **MR. LAUER:** Haven't — let me ask you [8] a question, Jeff. One problem we've had [9] with everything that's occurred in the past [10] is you questioned the process.

[11] **MR. KILMER:** Pardon me?

[12] **MR. LAUER:** You've questioned the [13] process that's occurred to date, the whole [14] system design. What I'm hearing you say [15] now is that the process you would employ [16] for selecting the medical director for [17] Multnomah County would be to have OHSU [18] appoint one.

[19] **MR. KILMER:** Correct.

[20] **MR. LAUER:** And that process is [21] flawed. On what basis will they appoint a [22] medical director?

[23] **MR. KILMER:** If you want to define — [24] first of all, it would be the same basis as [25] anybody else would appoint them. And that

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[1] is, they'd have to meet all these [2] criteria.

[3] The big issue you ought to be raising [4] is how about the selection by appointment [5] of OHSU rather than open it up in the way [6] that you've been talking about and Tom [7] talked about to some extent. And there you [8] have a tradeoff.

[9] But this process in the Provider Board [10] has brought forth all kinds of evidence to [11] support this recommendation. No evidence, [12] despite repeated requests from MAB, PAPA, [13] and others to come here and provide other [14] evidence has been forthcoming.

[15] You're leery of what we're doing, but [16] you have no information that contradicts [17] the approach here. And so when you have a [18] process that leads you inexorably to a [19] particular conclusion that makes sense to [20] everybody and the only issue is whether to [21] follow that immediately to its conclusion [22] and say it ought to be OHSU or the [23] alternative is we all believe it's OHSU but [24] we don't want to say it's OHSU, instead [25] let's have this formalistic approach in

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[1] which we have RFPs and all that stuff after [2] which only one person responds, our view is [3] it makes more sense to look at the [4] realities and say it ought to be OHSU.

[5] Once you say it's OHSU, the selection [6] in its department of the medical director [7] by OHSU, if you want to make that in [8] consultation with Gary Oxman so that you [9] know the two can work

gether, something like that, that ould be an appropriate additional omponent. But, Randy, everything lse about this makes a lot of sense.

And the second is, this is only a recommendation. This recommendation, in any fair process that I would ke to have, will be tested at the MAB vel — should be, it won't be — and the county commission level, opefully.

So you are putting the cart way ahead of the horse. We're not making a ecision binding on the county. We re making a recommendation as eople that have more experience this system than anybody else, and ave had more intensive hearings

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that have explored the issues in more epth than anybody else in the history of EMS planning in Multnomah ounty.

**MR. DRAKE:** And I think —

**MR. LAUER:** I just wanted to respond. You've just described a process, Jeff, that will lead you to a conclusion, will lead you to the process.

**MR. KILMER:** Every process should o that.

**MR. LAUER:** But I'm going to say what I think that conclusion's going be. You've described a process that vill lead you to the selection of a edical director as we've defined in his medical direction model. You've lready said it's a given that that will ither be John Moorhead or Jon Jui. o what you've done just now is ou've endorsed the process that is ompletely contrary to processes that ou allege have been improperly pplied for the other EMS system ssues. In other words, you know the nswer so develop the process that ets you the answer you want.

**MR. KILMER:** It's easy to structure

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this that way if you want to. What ou're again omitting is this is going o be a recommendation to the MAB.

Now, in a fair process in front of the MAB, you have every right to raise our concerns, A, about the process o which we got to this recommendation, and, B, about the recommendation. And you can argue what you ave just argued and we can argue the alternative.

And in the process of resolving this argument, hopefully the MAB will ay, you know, that there are substantive differences between these two, nd in order to decide them we need o have more facts. One of those facts vould be, who else is really interested in bidding? B, what is the capability of any other interested bidder in actually being able to provide the service here? And there's a whole host of other things that would come up.

Once they explored them, I have high confidence that they would come to the same recommendation that we have come to. Why play all these games when the outcome is

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already predetermined?

**MR. LAUER:** You don't know that's true.

**MR. KILMER:** I don't know that's true. But, Randy, you never know the sun is going to come up tomorrow morning. What we have done is narrow the range of permissible problems.

**MR. DRAKE:** Jeff, hold —

**MR. KILMER:** And this board ought to make its — ought to make a proposal. It shouldn't mealymouth around.

**MR. DRAKE:** Just a minute. Just a minute. Randy, I think where we're getting off on here is I believe that the purpose of the Provider Board is to make recommendations to the EMS and the medical community about what we feel should happen.

**MR. LAUER:** I agree.

**MR. DRAKE:** And I think that's what we're doing here. We're not violating a provision. There is a process to go through that we all recognize.

And in fact, we could add in the recommendation there that they follow the

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normal county process of review by letter. MAB and County Commissioners and EMS director and everybody else is going to have input into this. We're not necessarily saying the University's going to get it. We just recommend that they're the ones that should get it now because they're the ones doing it.

**MR. LAUER:** Then why make a recommendation?

**MR. DRAKE:** Because we should make a recommendation about all issues, Randy. I think we should make recommendations on everything. And that's all we're doing here.

**MR. LAUER:** We've done something I probably predicted couldn't be done. We've agreed on a model for medical direction. That's distinguished. That's progress. This is the most progress we've made in these Provider Board meetings today.

Now we're talking about a separate issue. Now we're talking about recommending who is going to be that medical director.

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**MR. DRAKE:** That's right.

**MR. LAUER:** The only thing is, and I think we probably discussed it to death, is I don't think we're going to get a consensus on that recommendation.

**MR. DRAKE:** Right.

**MR. LAUER:** Maybe we ought to call it.

**MR. DRAKE:** But I think the issue, though, Randy, is because one of the issues you raised in your conversation with Jeff is — the point I'm trying to make is, the Provider Board should be making recommendations of specific entities, organizations, et cetera.

**MR. LAUER:** You're talking about selection recommendations?

**MR. DRAKE:** Yes. We recommend the University.

**MR. LAUER:** Be selected for this?

**MR. DRAKE:** Be selected for this.

**MR. LAUER:** Well, then we ought to proceed rather than debate I think on whether or not we agree with the recommendations.

**MR. DRAKE:** Right.

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**MR. ROBEDEAU:** I want to — you're saying this is the first recommendation or the first proposal the Provider Board has made. And I just want to say, Randy, that the Provider Board has, numerous times, made recommendations on single medical authority, but we've never recommended — we haven't made recommendations. We've never recommended who it be.

And the proposals are handed in. They're looked at and they just kind of evaporate. Something has to get this stuff off the dime. And, you know, I don't today know who would be interested in being the medical director. But, you know, nobody except U of O has ever come out and said they were interested that I know of. Maybe this will flush some people out of the woodwork. I don't know.

Is Kaiser interested, Bonnie?

**MS. BONNER:** I don't know.

**MR. ROBEDEAU:** I don't know if Providence is. I don't know if Emanuel is.

I do know that two years ago — two

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years ago I believe it was, maybe three years ago, I approached Emanuel about making the same arrangement with them with us, as Buck and CARE

had with U of O, and they were not interested, absolutely wanted nothing to do with it.

**MR. THOMAS:** I think Randy's saying — feels like we debated enough and let's just vote on it.

I wanted to — based on what Jeff said, I wanted to — would suggest on what you're voting on you add one sentence, which would say this, after everything else that I read before: Under this — this is really clarifying how this would work. Under this arrangement, one OHSU physician would be designated, by contract, as the medical director for the system and would have the authority to designate other OHSU physicians to work as the medical director's agents under the medical director's control.

**MR. DRAKE:** Right.

**MR. KILMER:** Beautiful.

**MR. THOMAS:** That just locks it into

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the broader proposal.

**MR. DRAKE:** Right. So I move that we make that recommendation.

**MR. ROBEDEAU:** Okay. We have a motion.

**MR. COLLINS:** That whole paragraph?

**MR. THOMAS:** Yes. There were three sentences before it that I read before.

**MR. KILMER:** You're going to have to second.

**MR. ROBEDEAU:** Can the chair second?

**MR. THOMAS:** M-hm.

**MR. ROBEDEAU:** Well, I'll second it then.

Call the question. In favor?

**MR. LAUER:** Do we have a quorum?

**MR. ROBEDEAU:** Yes. We've never had a quorum before.

**MR. COLLINS:** There's no quorum requirements.

**MR. ROBEDEAU:** In favor? Aye.

**MR. DRAKE:** Aye.

**MR. ROBEDEAU:** Opposed?

**MR. LAUER:** Nay.

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**MR. ROBEDEAU:** Okay.

**MR. KILMER:** Well done, gentlemen.

**MR. ROBEDEAU:** And I will get this redone, fax it out to make sure that everything is right, and get it down to Bill hopefully this afternoon, maybe tomorrow morning, to get to the MAB.

Is that agreeable?

**MR. COLLINS:** Sure.

**MR. LAUER:** Could I ask a question, just back it up here on the vote? Can it be specified how the vote was? I mean that it was —

**MR. KILMER:** Sure. The minutes will reflect that.

**MR. LAUER:** It was two to one with everybody else essentially abstaining or missing.

**MR. MOSKOWITZ:** Well, it will say by name who voted which way.

**MR. DRAKE:** But I think the record should also reflect I talked to Tom Steinman and showed him that document from Chris Thomas, and he had no problems with that documents as written. He did not see

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the addition that we made here during this discussion.

**MR. LAUER:** However, he is not here to vote.

**MR. DRAKE:** That's correct.

**MR. THOMAS:** Okay.

**MR. KILMER:** But, Mark, you're voting in behalf of CARE and TVA; is that correct?

**MR. DRAKE:** That's correct.

**MR. KILMER:** And do you have any proxies you're voting?

**MR. DRAKE:** Not right now.

**MR. LAUER:** So it's still two to one. Right?

**MR. DRAKE:** Three to one.

**MR. COLLINS:** How is it three to one?

**MR. DRAKE:** CARE and Tualatin Valley Ambulance are two separate.

**MR. COLLINS:** So you want us to make sure we separate the ASA operations. Right?

**MR. DRAKE:** No.

**MR. KILMER:** We have not yet. We have not, but as long as you won't, we want.

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**MR. COLLINS:** Choose one or the other, Mark. Choose one or the other.

**MR. KILMER:** Can I give you advise of counsel? Tell him that if he will separate it, you'll be glad to accept. If he'll consolidate, you'll be glad to accept the consolidation.

**MR. LAUER:** Did we get off on a tangent?

**MR. ROBEDEAU:** I think we should just adjourn.

**MR. LAUER:** Before we do that, we're going to give this to the MAB, but it's really essentially to the County Commission. Correct?

**MR. ROBEDEAU:** We're going to see it —

**MR. COLLINS:** Depends how you want to do it. Ordinarily you're advisory to the director, if you want to give it to me. If you don't, don't. If I don't get it officially, we won't consider it till it gets to the board.

**MR. LAUER:** The other thing I wanted to —

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**MR. COLLINS:** The MAB has taken the position, for whatever reason, that they are recommending to the chair and not to our office.

**MR. KILMER:** We are submitting this into the MAB process.

**MR. COLLINS:** I'm not talking about that. He's aside from the — I'll send it to MAB as soon as you give it to me.

**MR. THOMAS:** Wait. His question is should we also make a recommendation to Bill Collins and to the County Commission?

**MR. COLLINS:** Do you want us to consider this separate from the MAB, or are you submitting it only to the MAB?

**MR. KILMER:** Submitting it into the process, and it should be to both.

But listen, guys —

**MR. ROBEDEAU:** No. Wait a minute. It is going to Bill Collins to be submitted to the MAB, as well as the County Commission, as I understand it. It's part of the record of the County.

Okay. That's what I said. I will try and get this faxed out to everybody this

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afternoon to relook at it to make sure everything's straight.

**MR. LAUER:** You're talking about the —

**MR. THOMAS:** It also should be submitted to Bill Collins as the EMS director.

**MR. ROBEDEAU:** That's what I'm saying.

**MR. THOMAS:** All three. All three. Bill Collins as the EMS director to submit to Bill to submit to the County Commission.

**MR. LAUER:** Right, exactly.

**MR. ROBEDEAU:** That's what I thought I was saying.

**MR. KILMER:** But listen, guys, there are some other wrinkles here that aren't in this draft. And I still think that you ought to strongly consider taking the draft that was sent around last time. Pete, I sent it down to you and I didn't get it back.

Oh, that has in it this paragraph. Without waiving any of the objections to the Medical Advisory Board's purported process for evaluation of the EMS plans,

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] down to the end of that paragraph, ]at [2] should be at the beginning of this, [3] we're going to submit it into the [AB [4] process. Because we do not 'ant, by [5] participating in it without ]ying [6] something about not waiving nything, to [7] somehow be considered ) have waived all [8] our objections. And ]at could happen, [9] legally.

0] The second is that I do think Bill [11] ollins' comment about putting into the 2] record reasons why the board has ome to [13] this conclusion is a good ne, and the [14] recommendation that 'as made in this [15] proposal.

6] **MR. COLLINS:** I thought you put it ].

7] **MR. LAUER:** Wait a minute. Jeff, [18] ou're confusing the whole thing.

9] **MR. KILMER:** No, I'm not. Now just a 0] minute. Let me finish.

.1] The fact is that there is a lot more [22] ]at should be in here, including Dr. Jui's 3] testimony in here upon which this 4] recommendation and Dr. Norton's omments [25] are, in large part, based. .nd I strongly

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] recommend that with this submission oes [2] the transcript of those two hear- ]gs where [3] Norton was here for one f them and Jui was [4] here for both of hem which contains the [5] more spe- ific information upon which this [6] is one. That ought to be part of your [7] ubmission, I respectfully suggest to the 8] chair.

9] **MR. LAUER:** Well, they won't be able 10] to read all that stuff.

11] **MR. KILMER:** Who cares.

12] **MR. LAUER:** This is the Provider [13] Board's — it's my understanding we're 14] forwarding two things. We're pre- enting [15] two things to the EMS direc- or, and that [16] is: A, a model for medical lirection; and, [17] B — which had a nanimous vote in favor [18] of; and, B, a ecommendation for the [19] selection of hat medical director which [20] did not ]ave a unanimous vote.

21] **MR. KILMER:** That's right.

22] **MR. LAUER:** Bill then, as the [23] di- ector, will distribute that to MAB for [24] heir process on the 14th as being [25] nformation from the Provider Board.

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1] The only thing I wanted to bring up 2] was that I thought — and we had liscussed [3] this before. What I'd really ike to take [4] to MAB on the 14th is to ay, look you [5] guys, we've met X num- )er of times, give [6] them this as an xample of the issues we're [7] looking t and the depth to which we're [8] look- ng at the various models that have [9] been presented, and among other things say, [10] we've already agreed, I think, by [11] discussion that we're going to need more [12] time to finish to bring this up to process.

13] **MR. KILMER:** I think supposedly a [14] letter to that effect has already gone out [15] to Bill Collins that we need more time. I [16] don't think we need to ask.

17] **MR. ROBEDEAU:** I have not gotten it [18] out yet.

19] **MR. KILMER:** We need to get that out [20] today, Pete.

21] **MR. COLLINS:** When I was asking about [22] this particular document, I just need to [23] know from the Provider Board, in my role as [24] staff, do you want me to take this document [25] as written and send it to the MAB for their

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[1] consideration? Do you want me to take it [2] as written and send it to or incorporate it [3] into the process with the county board? [4] And do you want me, as the director who is [5] going to also make a recommendation to the [6] board, to consider this as part of the [7] information that I have to use to make a [8] recommendation?

[9] **MR. KILMER:** Don't leave yet. [10] But if it's going to go to the MAB [11] through you in this formal process, then [12] this nonwaiver language needs to be in it.

[13] Now, and I also would like to suggest [14] to you, and it ought to be incorpo- rated [15] into the document, and the reasons why we [16] think it. And the — and the transcripts [17] ought to go with it as part of the record.

[18] And the third thing that ought to [19] happen is that either in this document or [20] by separate letter I believe and recommend [21] that this board take po- sitions, A, on the [22] conflict of interest that was set forth in [23] paragraph 1 of this other proposal, and, B, [24] the lim- ited expertise and right to rule [25] that the MAB has. This board ought to take

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[1] a formal position on that point regard- ing [2] the MAB process.

[3] **MR. LAUER:** I don't think we ought to [4] stir the beans.

[5] **MR. ROBEDEAU:** Well, Randy, will you [6] agree to add the conditional lan- guage?

[7] **MR. LAUER:** No. I think we're [8] con- fusing it. I think we've got something [9] that's pretty simple right now. We're [10] taking two things that Bill is going to [11] take to the MAB as being representative of [12] something that's being —

[13] **MR. ROBEDEAU:** I mean the non- waiver [14] language.

[15] **MR. LAUER:** I don't know. I mean, [16] it's — I guess I'm not clear enough about [17] what you want to put in there. I'm a [18] little suspect.

[19] **MR. KILMER:** Here, you can read it.

[20] **MR. ROBEDEAU:** What it says is we're [21] not waiving any of our rights, you know. [22] We have talked about and everybody's been [23] in agreement this board, at the MAB [24] process, is a sham, that it's just been [25] shoved through.

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[1] **MR. KILMER:** By participating in the [2] process we don't want to waive that [3] position. And I can tell you there's some [4] risk that that will happen.

[5] **MR. LAUER:** Well, I don't know. [6] That's a bit inflammatory.

[7] **MR. KILMER:** Oh, god. Who — you [8] know, what — that's like saying, hey, I'm [9] afraid to inflame Hitler.

[10] **MR. COLLINS:** Oh, jeez.

[11] **MR. KILMER:** Who cares about it being [12] too inflammatory to somebody that's already [13] got the gun pointed at your head and is [14] going to pull the trigger whether you say [15] yes, sir or (indicating).

[16] The second issue you ought to be [17] thinking about is, in a separate letter — [18] people were talking about making the formal [19] objections to the failure of the MAB to [20] consider the conflict of interest issues [21] and the limited scope of the MAB's [22] expertise and what it can legitimately [23] consider. I strongly recommend that the [24] second letter be sent as a cover letter on [25] the submission to the MAB with this

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[1] recommendation. And it may be that the [2] language you don't like in the preliminary [3] nonwaiver language could be put in that [4] second letter as well.

[5] **MR. MOSKOWITZ:** Is there any rea- son [6] why, since the staff from commissioners' [7] offices are going to be coming to the next [8] meeting supposedly, it might not be helpful [9] to raise a lot of this stuff about kind of [10] reviewing concerns about the MAB pro- cess, [11] the advisibility of supplying the [12] transcripts to commissioners offices, as [13] well as the MAB kind of ought to be gone [14] over at the next meeting? That might be an [15] education for some of those people.

[16] **MR. DRAKE:** I would make that [17] recommendation. Let's talk about that at [18] the next meeting.

[19] We do need to add that paragraph that [20] Jeff talked about, that first para- graph of [21] his — that other letter sub- mission that we [22] had last time about we do not waive the [23] right so we don't lose anything there. We [24] need to put that in there.

[25] **MR. ROBEDEAU:** Will you agree to that,

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[1] Randy?

[2] **MR. LAUER:** You're going to put it [3] exactly where, though?

[4] **MR. DRAKE:** At the beginning.

[5] **MR. ROBEDEAU:** It would be at the [6] beginning. All it does, it's a waiver of [7] any rights. It'd be at the beginning.

[8] **MR. THOMAS:** Put it at the end if you [9] want.

[10] **MR. DRAKE:** Or we can put it at the [11] end. Just put it at the end, then.

[12] **MR. ROBEDEAU:** Which is better? It's [13] just a matter of saying we're not waiving [14] any rights in the process to continue our [15] input or to object to the way it's being [16] handled at the MAB.

[17] **MR. LAUER:** But I guess — maybe I'm [18] just missing this whole point here. You [19] want to insert that language at the [20] beginning of what document?

[21] **MR. ROBEDEAU:** The medical —

[22] **MR. DRAKE:** The document we approved.

[23] **MR. LAUER:** I don't think that has any [24] place there.

[25] **MR. KILMER:** You could do it in a

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[1] separate letter. If you want to do it in a [2] separate cover letter, that's okay.

[3] **MR. DRAKE:** We'll do it in a separate [4] cover letter.

[5] **MR. LAUER:** If you want to put it with [6] your recommendation without waiving any [7] other rights, et cetera.

[8] **MR. KILMER:** The recommendation's [9] going to go in this document. I'll prepare [10] a cover letter for it.

[11] **MR. ROBEDEAU:** Is a separate cover [12] letter all right with you? Leave this the [13] way it is.

[14] **MR. LAUER:** Well, as amended, leave it [15] intact.

[16] **MR. ROBEDEAU:** And then do this in a [17] separate cover letter that will go with [18] this? Is that —

[19] **MR. KILMER:** He's not going to agree [20] to anything, Pete. You should make your [21] motion and we'll get out of here.

[22] **MR. ROBEDEAU:** Is that okay with you?

[23] **MR. DRAKE:** We'll send you a copy of [24] the cover letter and you can take a look at [25] it.

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[1] **MR. LAUER:** Okay.

[2] **MR. ROBEDEAU:** Okay. But in the [3] meantime, we need a motion to do that, [4] because we're not going to reconvene before [5] I have to get this out, to send it in [6] separate cover letter.

[7] **MR. DRAKE:** You're going to send out a [8] separate cover letter that we're all going [9] to have a chance to look at and approve.

[10] **MR. ROBEDEAU:** But we need a motion to [11] do that.

[12] **MR. LAUER:** I make a motion that you [13] send out a cover letter for everybody to [14] read and approve.

[15] **MR. DRAKE:** Yes, there's consensus to [16] do that. I agree.

[17] **MR. KILMER:** Well, is there a [18] consensus to send it after it's approved?

[19] **MR. LAUER:** We can't approve it till [20] we read it.

[21] **MR. ROBEDEAU:** And it will accompany [22] Randy's May 11th draft for prehospital [23] emergency medical services and medical [24] director.

[25] **MR. KILMER:** Mark, as long as we're

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[1] playing this game, you need to make a [2] motion to send that letter in substantially [3] that form as a cover letter. Randy can [4] read it, but whether he approves or not, [5] it's going to be sent.

[6] **MR. DRAKE:** Which letter?

[7] **MR. KILMER:** A separate cover letter [8] raising the nonwaiver issue to the MAB.

[9] **MR. DRAKE:** I agree. I make the [10] motion.

[11] **MR. ROBEDEAU:** I second. [12] In favor? [13] Aye.

[14] **MR. DRAKE:** Aye.

[15] **MR. ROBEDEAU:** Randy, opposed?

[16] **MR. LAUER:** I didn't hear it. I have [17] to be leaving. I have to leave.

[18] **MR. KILMER:** Put down as a no.

[19] **MR. ROBEDEAU:** The motion was to [20] include that first paragraph in a second [21] cover letter to go with your document as [22] rewritten for medical advice — or medical [23] supervision, excuse me, and be sent with [24] that document to Bill Collins and MAB and [25] the County Commission.

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[1] **MR. LAUER:** I'm not comfortable to [2] vote yes, but what I will do is abstain.

[3] **MR. ROBEDEAU:** Abstains. [4] Then we're adjourned.

[5] **(PROCEEDINGS ADJOURNED)**

[7] **(NOTE:** Untranscribed steno notes [8] archived permanently; transcribed [9] paper notes archived 2 years; [10] computerized English text files [11] archived 3 years.)

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CERTIFICATE

I, SHANNON K. KRSKA, a Certified Shorthand Reporter for Oregon, do hereby certify that I reported in stenotype the testimony and proceedings had upon the hearing of this matter, previously captioned herein; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 24th day of May, 1993.

Certificate No. 90-0216
LORD, NODLAND, STUDENMUND
(503) 299-6200

/s/ Shannon K. Krska

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# *Travelling Transcript*

*Before the Multnomah County Provider Board*

*TRANSCRIPT OF PROCEEDINGS*

*Wednesday, May 19, 1993*

BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD

TRANSCRIPT OF PROCEEDINGS

Wednesday, May 19, 1993
1:41 p.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon

THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Randy Lauer, Buck Ambulance
Mr. Thomas Steinman, Portland Fire Bureau

* * *



APPEARANCES

ALSO SPEAKING:
Commissioner Tanya Collier
Mr. William Collins
Mr. Christopher Thomas
Mr. Jerry Andrews
Mr. John Praggastis
Mr. Steven Moskowitz
Ms. Lynn Bonner
Mr. Bill Farver
Mr. Ramsey Weit
Ms. Joy Al-Sofi
Ms. Carolyn Marks Bax



PROCEEDINGS

MR. ROBEDEAU: Has everybody finished the minutes? Everybody has finished the minutes. Why don't we call the meeting to order.

I think before we review the minutes, it might be appropriate to go around the room and for everybody to introduce themselves. There are a couple people I don't know. I am Pete Robedeau with AA Ambulance and I am also chair of the Provider Board.

MR. SKEEN: Trace Skeen with Buck Medical Services.

MR. MOSKOWITZ: Steve Moskowitz, an attorney for AA and CARE Ambulance companies.

MR. WEIT: I am Ramsey Weit. I have been retained by a very large East Coast ambulance company, who is interested in taking over this whole operation. No, actually, I work for the mayor's office. But I used to do ambulances.

MR. FARVER: Bill Farver. I work with



Gretchen Kafoury for the City.

MR. PRAGGASTIS: I am John Praggastis.

MR. STEINMAN: Tom Steinman, Portland Fire.

MR. THOMAS: Chris Thomas, AA and CARE.

MS. AL-SOFI: Joy Al-Sofi, Multnomah County chair's office.

MR. DRAKE: Mark Drake with CARE Ambulance and AA.

MR. ANDREWS: Jerry Andrews, Multnomah County EMS.

MR. COLLINS: I am Bill Collins, EMS director for the County.

MR. LAUER: I am Randy Lauer, Buck Medical Services.

MR. ROBEDEAU: And we have one addition.

MS. MARKS BAX: Carolyn Marks Bax, County Commissioners, Sharon Kelly's office.

MR. ROBEDEAU: Thank you. Review of the minutes. I didn't find any corrections. Anybody have any corrections?



MR. DRAKE: No.

MR. ROBEDEAU: Okay. Do we have a motion to approve the minutes?

MR. DRAKE: So moved.

MR. SKEEN: Second. Although I wasn't here for the entire meeting so what do I know?

MR. DRAKE: In favor?

(Chorus of ayes.)

MR. ROBEDEAU: Opposed? Minutes carry.

Maybe we should go back a little bit and explain what we had been doing here for some of our guests. One of the things that we had decided to do several meetings ago, was to do a side-by-side comparison of the current system and the proposed systems. The two that are currently on the table -- and make recommendations from the Provider Board.

I was smart enough before I left the office to run off some copies of our comparisons, and Trace and I have both gone through and started this process, anyway, to be passed out. We both took different



approaches, which shows that we did not exactly --

MR. SKEEN: Collaborate.

MR. ROBEDEAU: -- collaborate. I have some copies of those, too. For people that don't have them, here is what we are looking at, copies of that.

MR. DRAKE: I gave her one.

MS. AL-SOFI: The blank?

MR. PRAGGASTIS: Pete? I have got one. I think I have got one. I can get it. Okay.

MR. ROBEDEAU: And I have ten copies. Trace has some copies of what he had done. How many do you have?

MR. SKEEN: I think I have got about five or six.

MR. ROBEDEAU: I have ten copies of what I did. And I did it in two sections. When you look at it, it goes one through nine and ten, 11, and 12, and I haven't completed it. So they go together. They have side-by-side comparisons, and I don't have enough to go around for everybody.

(Discussion off the record.)



MR. ROBEDEAU: I want to emphasize that mine is not complete, and Trace said his wasn't complete either.

MR. MOSKOWITZ: Could you repeat again who did which?

MR. ROBEDEAU: The one that is marked -- just typed in, looks neat and all that kind of stuff, that's Trace's. The one that is two sheets that only goes through 12 and refers to pages in the different proposals, is mine.

(Discussion off the record.)

MR. ROBEDEAU: We will wait a minute. Bill Collins is getting some more copies made.

(Recess.)

MR. SKEEN: That's 70 for current fire

ORIGINAL

and 100 for private sector.
MR. ROBEDEAU: Part of the problem that Bill had talked about when he went with numbers to paramedics was, he was talking about the management people as well.
MR. THOMAS: So that the guests who are here understand what is happening, you

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might explain what you are talking about, what the debate is. I don't know myself so I am sure they don't.
MR. DRAKE: The debate is kind of over the number of paramedics, whether they are working with FTEs. That's what you pulled out for your figures?
MR. SKEEN: Mine basically takes an FTE approach. The 70 from fire is kind of a loose figure because it's -- it doesn't give you full staffing for full ALS first response component.
MR. DRAKE: You are just going on 70 as current?
MR. SKEEN: I think that came out of Bill's study as 70.
MR. DRAKE: Are you using that as an assumption all the way through?
MR. SKEEN: No. The other options are FTEs.
MR. THOMAS: Why don't you, before you get into that, explain to the people what I think -- you were the one who created this sort of grid format. Why don't you explain what it is and what it is attempting to

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do. Then they will know when you are talking about FTEs.
MR. SKEEN: Sure. Pete started out with the first effort of trying to identify all the issues that have been brought up in the MAB, issues that he has recognized that have been brought up as concerns, incidents, issues over the past few years, actually, and, then, in testimony that we have received here at the Provider Board meetings.
And so we started identifying all of those in this system, everything from the number of paramedics in the system to the number of production units, as a pretty generic term, that would be required under the different plans, the communications aspect, who does the dispatching, what type of staffing on the ambulances, the numbers of paramedics versus EMTs, response time compliance figures, the number of providers that would be involved, how the service would be funded, whether the rates would be regulated or not, medical authority, whether there is a cost benefit analysis

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provision.
And then what we looked at is the different plans. I have got across to determine whether they were addressed in the various plans that have come forward so far. And I think what we found is that for the most part, probably less than 50 percent of these issues have yet to be addressed specifically. Probably the structure is there to address them, but they have not addressed them specifically.
So the Provider Board -- my sense is the Provider Board wants to come forward with recommendations.
MR. ROBEDEAU: That's what we said we were going to do.
MR. SKEEN: On each of these issues that essentially can formulate into a plan.
MR. ROBEDEAU: One of the things that we determined is that we wanted to be specific. And the thing we realized early on in the process is that we were trying to respond to things that had not been clearly articulated by anybody, including

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ourselves. And that's why we did this process.
(Discussion off the record.)
MR. DRAKE: You may want to back up one more step. One of the reasons why we are doing this, the State requires that every County come up with an ASA plan, ambulance service area plans, but ambulance area service plans are very limited in their scope. They are not really an EMS plan. They only could do things by statute which is limited to ambulance, very little to do with first responders, first responder requirements, et cetera.
All the Counties that I know of that have gone throughout ASA planning process recognize the need to do EMS planning to widen the scope, to take in everything you need in an EMS system, and address those issues. And so that's what early on the Provider Board decided, we have to address EMS system issues, not just ASA plan. And, of course, in resolving the EMS system issues, we will resolve the ASA plan as part of this process. That's why this is

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more involved.
Of course, as we go through this with what Pete has brought, is that some of the proposals do not address the issues because some of them were limited in scope, and they said we were just going to address the ASA planning process and not all the EMS planning, which is what we need to look at.
MS. MARKS BAX: You address them geographically? County? Regional?
MR. DRAKE: It's done at a County level.
MR. ROBEDEAU: For state law it's done on a County level. Washington County, Multnomah County, and Clackamas County, over the last few years, have made a lot of strides with protocols.
For example, protocol, here, will be ready to be put in place, but before we put it in place -- a medical protocol, before we put it in place, we have tried to get Clackamas County and Washington County to do it so that all the protocols are essentially the same in all three Counties. That has been regionalized.

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There's been a lot of effort put into it.
One of the criticisms about this system is that it takes so long to get protocol put in place, and if we wanted to isolate ourselves just to Multnomah County, and pretend like nobody else exists, I imagine it would be faster to get protocols put in place. But I think that the regionalization approach that's been going on here for several years is really the best way to do it.
MR. DRAKE: We are looking at a regional impact. Everything we do has an impact on the towns around us in the first respond requirements, the paramedic requirements, mutual-aid requirements.
We are not served just by the providers you see sitting here. There are mutual-aid providers that also serve the County that could be part of the Provider Board but choose not to attend. There's a lot of fire departments. Metro-West covers Northwest Multnomah County and actually part of Southwest Multnomah County.
MS. MARKS BAX: Thank you.

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MR. DRAKE: Sure.
MR. THOMAS: So is this yours, Trace, this one that's here? Are you going to explain -- sort of walk us through it?
MR. SKEEN: And that's a first draft. And I reserve the right -- once again, what's an appropriate disclaimer? Reserve the right to change opinion on some of

these positions.
And I can do that, Pete, if you would like to go through it, or whatever your pleasure is.
MR. DRAKE: Trace, I would like you to address current dual integrated, where those come into the plans that have been submitted.
MR. ROBEDEAU: Can I say something real quick?
MR. DRAKE: Sure.
MR. ROBEDEAU: I did on mine, you will notice, I left out dual integrated because I wasn't sure what he was talking about. But I put in PAPA proposal and compared -- or went through the PAPA proposal to see what I could find on particular



issues. And go ahead.
MR. SKEEN: Sure. The current system is -- current system as it stands. Obviously, the tiered response is primarily the No. 1 option that was put forward by the County EMS office, with some assumptions there that the fire bureau would employ fire medic transport units to transport anywhere from 20 percent to 50 percent of the critical -- of the 9-1-1 calls that the -- that a private contractor or contractors would be staffed not quite as intensely.
In other words, with one paramedic and one EMS, would respond 12 minutes, 90 percent of the time for the balance of the 9-1-1 calls. That's the tiered response.
The single dedicated 9-1-1 system more closely resembles the PAPA option one proposal that was put forward. The dual integrated simply refers to two providers, two ambulance providers throughout the County indicating either of two things.
One is that they operate very much like a single provider with a



centralization of a number of components, but, secondly, that it includes that those providers would respond to both emergency and nonemergency calls as well, so that the entire medical transportation system falls under an existing infrastructure as opposed to segment.
So that's kind of the basis for those four plans. Now, if there's some others that have been discussed, I am not aware of them. But those are the four that I have heard come up in various discussions.
MR. DRAKE: So the dual integrated is just the two ASA, taking Buck as one and CARE and AA as --
MR. SKEEN: It could be that. I suppose it also could be one ASA with two providers within that ASA, and it depends on how you would probably interpret that. But essentially it would be two providers.
MR. DRAKE: And you looked at FTE from your tiered response across and used current staffing for under the current, rather than FTEs?
MR. SKEEN: No. I used FTE and what



is based on 12 hour staffing by using 12 hour incremental staffing by the ambulance contractors, 24 hour staffing by fire as it relates to first response and so forth.
In other words, the assumption, so that you will know under the others, if you said that fire was going to provide ALS first response out of every station, that the calculation was that there were 33 stations including Gresham. Is that close, Tom?
MR. STEINMAN: Real close.
MR. SKEEN: So thereby it would be 99 on a 24 -- 48 -- 99 paramedics for the first response component. Obviously, it takes more than that to cover vacations and time off and so forth, but those were not calculated into it. It was for full-time positions, equivalent positions only.
MR. DRAKE: Did you use that same number all the way across for fire? Before you said you didn't.
MR. SKEEN: I believe so. With the exception under current, I took a 70 that was in Bill's plan that they currently have



in the fire bureau.
And I might say, on any of these that call for factual statistical statement, this is simply a start. And certainly, someone can refute that and plug in a more accurate number. I am not claiming to have total accuracy on any of these at this point. So --
MR. DRAKE: I think you have adequately disclaimed everything.
MR. THOMAS: Trace, one question I have is, when you get over to single dedicated and dual integrated, is that -- are what you list as paramedics there -- let's see. How do I want to say this? Under the current system, they are carrying both ALS and BLS patients, 9-1-1 and non-9-1-1, at least under some circumstances.
And I am wondering if under single dedicated and dual integrated, those would include the people that would be carrying non 9-1-1 calls. Do you understand my question?
MR. SKEEN: Let me explain it this



way. Because under each of these, there's really three scenarios. If you looked at the single provider system, my calculations show that with the ambulances -- with an ALS first response 100 percent of the time for four minutes, 90 percent on all units, with an ALS first response, which calculates to the 99 paramedics and then staffing the ambulances with one paramedic and one EMT, that I calculate that at 137 paramedics.
Now, if we change that configuration, we say, yes, we want ALS first respond but two paramedics on the ambulance, which we currently have, that number goes up to 175. If we go with two paramedics on the unit but BLS, the number goes down to 76.
MR. THOMAS: Say that last thing again.
MR. SKEEN: Goes down to 76, two paramedics on the ambulance, BLS first response. So within every one of these plans, depending on how you want to configure your responding units, the numbers change.



MR. STEINMAN: Trace, on your single dedicated, you said it's PAPA's No. 1. How much different is that than the County No. 2? I mean, is there --
MR. SKEEN: I would assume that it's about the same. Neither one of them really made a representation as to how many units would be involved in that, but I think the County two and PAPA one are, I think, are identical.
MR. DRAKE: As far as what you are saying, they are identical?
MR. SKEEN: County's No. 2 option and PAPA's No. 1 option.
MR. DRAKE: PAPA's No. 1, the ALS units respond all emergency calls, including all 9-1-1 calls, and do all ALS transfers. It's my understanding of it. So that's different than Collins' idea of his plan, or the EMS plan is, that the ALS units respond only 9-1-1 emergencies.
MR. SKEEN: That's true. PAPA's would include the ALS transfer components.
MR. DRAKE: Right.
Is that right, John?

MR. PRAGGASTIS: No, it's not, but close.
MR. DRAKE: Correct us.
MR. PRAGGASTIS: We made the distinction not in the level of the ALS-BLS care but made the distinction in a stable or unstable patient. We anticipate that if there's an ALS transfer, that ALS transfer, depending on why there's the transfer involved, could go either in the competition market, in the nonemergency market, or if that patient was unstable, he would go or she would go in the emergency ambulance.
And a perfect example is a patient who is on a nitro drip, being transferred from a hospital to a hospital, is inherently an unstable patient. That's a person with a heart problem.
A person going from a hospital to a care facility who is on an antibiotic drip is not a person whose health is unstable. They are just going from place to place. We would like to see the unstable patients come into the emergency system and the



stable patients, whether they are ALS or BLS, can be put out to competition in the open market.
MR. DRAKE: So you are differentiating the ALS to stable and unstable?
MR. PRAGGASTIS: Break is not ALS or BLS but stable or unstable patients.
MR. DRAKE: That would be based on whatever protocols are developed to establish --
MR. PRAGGASTIS: That's right. That's right.
MR. LAUER: Do you find it largely what kind of facility they are being transported to, whether they are going to equal or higher level of care versus a lower level of care?
MR. PRAGGASTIS: That was a consideration that came up. Also a question came up when we were over talking about Kaiser, what about the transfer from a Kaiser facility to a Kaiser facility that crosses a state line or county line that also has an unstable patient in it. Could that patient go in a contracted ambulance



as compared to the emergency ambulance?
And those are not a large percentage of the calls. And I imagine that could easily be worked out with the physician medical director to make sure those patients receive the most satisfactory level of care and still meet the transfer guidelines.
Does that answer your question?
MR. LAUER: I think so.
MR. PRAGGASTIS: See, what we would like, we would like the emergency system to have -- to -- those patients who are inherently unstable be seen by people who see emergency patients the most. And those patients that are on sophisticated equipment but aren't in a very unstable or life threatening condition can very easily go in a nonemergency ambulance across the County line, in the County, any place they would like to go.
MR. SKEEN: For purposes of the numbers I have listed, it didn't take that into consideration, John.
MR. PRAGGASTIS: Okay.



MR. SKEEN: Just so you understand. So they are very similar.
MR. THOMAS: Just to clarify a little more, it sounds like, for tiered response, single dedicated 9-1-1, dual integrated, I am guessing you could do three calculations for each of those, depending on what the configuration is, for first responder as distinguished from transporter.
MR. SKEEN: Right.
MR. THOMAS: Did you actually do those?
MR. SKEEN: Yes, I did.
MR. THOMAS: It would be interesting for all of us to hear the array.
MR. SKEEN: I will tell you my calculations. So I can tell you those three configurations are -- keep in mind, this gets a little complicated, because you have to assume how many units there are going to be that -- the critical units versus the noncritical units versus the private ambulance business units.
In calculating that again, using one paramedic and one EMT on the ambulance with



an all ALS first response it's -- I came up with 162 paramedics under the tiered system. With two paramedics on the ambulance and an all ALS first response, came up with 200 paramedics. With two paramedics with BLS --
MR. THOMAS: How many was that last one?
MR. SKEEN: 200 with two paramedics. With BLS first response, it's 101.
MR. DRAKE: Did you do any unit hour calculations to add into those?
MR. SKEEN: Yes. That's on the assumption that the -- and this is based on the fire medic units transporting -- I think the figure we used was transporting 18 percent of the 9-1-1 transports -- that we had agreed that was the arbitrary figure we would use -- that their utilization would be .05, that the contracted ambulance that responds 12 minutes 90 percent would be .35.
MR. DRAKE: Is that .05 for transport utilization?
MR. SKEEN: Not transport.



MR. THOMAS: .05 would be -- for those -- that would be one transport for every 20 hours? Yes?
MR. LAUER: Right.
MR. THOMAS: .30 would be .30 transports for every hour?
MR. DRAKE: One every three hours, two and a half. Somewhere in that range.
MR. SKEEN: And I know that may sound a little bit confusing to some people here the first time. It's a standard method of measuring, in the ambulance industry, that we think we have got figured out.
MR. THOMAS: Has to do with how busy the paramedics are.
MR. DRAKE: The number of units hours is important because it reflects cost. The most you add -- our unit-hour cost can range from $65 to $75 to $85 a unit hour, so you add a thousand units hours, you are adding a lot of cost to the system. How many do we have in the system now? 90?
MR. SKEEN: There's some debate on that, but I think it's 122,000, I think is what Bill had calculated.



MR. DRAKE: So we are talking a lot of unit hours.
MR. THOMAS: So you have the numbers for single dedicated? He has a question.
MR. PRAGGASTIS: I was just going to make a comment to follow up.
MR. THOMAS: I was going to say, why don't you go through the rest of your numbers.
MR. SKEEN: What you are looking at, the number of total unit hours per system?
MR. THOMAS: I was going over the number of paramedics.
MR. SKEEN: For the single provider?
MR. THOMAS: Yes. You gave us tiered.
MR. SKEEN: One paramedic and one EMT

with ALS first response, it calculated at 137 paramedics, with two paramedics on the ambulance and all ALS first response, 175 paramedics, and where two paramedics on the ambulance and a BLS first response, 76 paramedics.

MR. THOMAS: That you gave us. And how about dual integrated?



MR. SKEEN: Dual integrated, one and one with ALS first response is 143. Two paramedics with ALS first respond is 187. And two paramedics with BLS first response is 88.

MR. DRAKE: But are you adjusting the unit hours? Because you have to on each one of these plans.

MR. SKEEN: Yes. Right.

MR. DRAKE: Do you have those calculations somewhere, those figures? The 9-1-1 hours?

MR. SKEEN: I distributed this meeting before last, this work sheet with those kind of unit hours. This is simply unit hour reasonable utilization model. Randy and you guys have worked on more of a demand model that can be measured against each other to make sure that we have some reasonable assumptions.

I am sorry, now, Mark. What did you ask for?

MR. DRAKE: That's fine.

MR. ROBEDEAU: John is sitting over here with his hand up.



MR. PRAGGASTIS: I would like to make another comment. When people talk about unit hours, there's an important consideration to -- that's not only a good medical decision that needs to be made but also a political decision that needs to be made. And the question is, do you want the same amount of ambulances available at four in the morning as you want at four in the afternoon?

Now, currently in this system there are less ambulances in the evening later into the hours, less units than there are more in the daytime. It has to do with two things: The fact that more people are up driving around, walking around, doing things that people do that get them into trouble and they have to call the ambulance, and also it has to do with economics. There's not a lot of call volume. People would like to close down ambulances so that those crews can go home.

It's a financial consideration. And so one of the things that's important as



you develop policy, someone is going to have to say, do they want the same amount of ambulances available or how many do you want available around the clock? From my point of view, emergency services, fires and disasters and all kinds of things happen just as likely and sometimes more dramatically late in the evening. It's just one of those things. Right now it's different staffing at different times.

But as you take these unit hour calculations and considerations, that's something that you need to ask, which is, as a political body and which is as a vendor, how many hours do you want? How many units do you want?

MR. DRAKE: The reason we put those units on the way we do is to meet demands of the system and demand of the system includes disasters, historical demand.

MR. PRAGGASTIS: Sure. But when we had the earthquake, how many units were on?

MR. DRAKE: There are certain things that we can't predict.



MR. PRAGGASTIS: So in emergency services, there's excess capacity because you never know what's going to happen.

MR. LAUER: This isn't a new concept. Restaurants do the same thing. They staff more personnel at lunch hour than they do at one o'clock in the morning, if they happen to be open. That's pretty normal in any kind of business.

MR. SKEEN: And the key to all of this is analyzing the data to know when your demand peaks are. And I think Bill will agree that we are getting closer to that, but we are -- I mean, every community in the country is still struggling a little bit with the technology that seems to be there now that's writing the correct programs to be able to pull that data out to analyze it appropriately. And it becomes almost an art, along with a science, in building your system status plan to get the efficiencies.

You know, the reason I had a .35 on there, John, is that that's -- people nationally will argue with me, but I



believe that when you get above .35, that you are probably taxing the system too much and personnel within the system.

MR. PRAGGASTIS: I have worked in systems where it was one-point something, and the crews went crazy. It can be that busy. That's more than a call an hour every hour. So it can go all over the board. That's not an unreasonable number.

MR. SKEEN: If you go below .25, then there's a question about whether you are being inefficient or not. So it becomes a measurable item.

MR. ROBEDEAU: I think what paramedic skill proficiency, John, I think is the one thing that has hung around in this system, and we have been criticized about forever, and that is all of the docs are saying there's more paramedics than are needed and the paramedics aren't seeing enough critical patients and therefore we must reduce the number of paramedics.

Now, to just throw money to the wind and everything else and have paramedics on as many four o'clock in the morning as you



do at four o'clock in the afternoon is going to further denigrate any skills or not any skills. That's poor. But the skills the paramedics have, especially those who are working -- if you are working non 12-hour shifts, that are working at four o'clock in the morning, you aren't going to see any patients who -- when the whole system is only doing three or four patients in the morning, it doesn't make sense to have 30 paramedics on. That's the balance we have to do.

MR. PRAGGASTIS: But I disagree with that. I don't think that's necessarily true. Because you can rotate your day people to night people and you can rotate your night people to day people so that your workload is varied and your people don't burn out, for just one example. I don't necessarily agree with you.

MR. ROBEDEAU: Well, I think in the police circles we could go on to look at how the police departments have worked and what they have done with shifts in order to stabilize police forces. I know there have



been a lot of studies out that have talked rotating people from nights to days, and the fact the biological clock never has a chance to get set, and therefore you have policemen who are very, very irritable all the time.

MR. LAUER: Which is not a good thing.

MR. PRAGGASTIS: But your company hires people running 24 hours, and then the next day they will work a short shift. All your 24 hour people don't exclusively work 24 hours. Or am I wrong?

MR. ROBEDEAU: Usually, they may pick up an overtime shift here and there that's non-24, but if they are working 24-hour shift, that's what they are working. They also have an opportunity to sleep in the evening, where if you have 12 hour or eight hour or 20 hour or some other type of system, you don't have that opportunity.

MR. SKEEN: The argument is and it is -- it is a contested issue. There's no data that supports how many intubations a paramedic should have in a 60-day period in



order to maintain the skill. And we had some very good testimony, I think, from the medical community, the direct emergency physician supervisors who came in and indicated that they would prefer to see -- admitted they didn't have the data -- but they would prefer to see paramedics practice their skills more frequently than they are currently doing.

The other argument to that or the other issue of that also came from the same group, and they indicated that the task of supervising the number of paramedics in the system right now is just very difficult.

Now, we could say that's their problem, but nevertheless that was their testimony. They felt like there were too many.

MR. DRAKE: And the issue that the doctors brought up as well, which I think is important to know, although they don't have any exact data on paramedic skills, they do say that it's standard in the medical community. That's why they have intensive care units, pediatric intensive



care units. A small group of people treating a lot of specialized patients get very good at what they do. And that's somewhat of the basis of the Seattle-type paramedics, a very few number of paramedics treating a lot of patients. They supposedly get very, very good here. That's to reduce the number of paramedics seeing the critical care patients. Supposedly they get very, very good at what they do or better than what they do today. Admittedly, they don't have the data that says they are doing poorly or what skills they need to do.

MR. SKEEN: In fact, Dr. Jui indicated -- I don't think he's released -- he indicated the cardiac saves that are in here -- I think it was higher performing than is the Seattle system, which kind of has this national reputation because they were the first ones to proclaim themselves --

MR. DRAKE: To publish the data.

MR. THOMAS: Just a piece of information here. I dug through my notes



from several years ago, and at one point the MAB did adopt, through one of the early RFPs they did, was what they felt was an acceptable utilization ratio. They indicated for a 24-hour ambulance, it ought to be between .17 and .40; for 12 hours it ought to be between .33 and .60; ten hours, .40 to .65; and eight hours, .50 to .75. I don't know if those are realistic or how they work, but that was when they did their scoring. You got top score if you fell within that range and penalized if you fell outside on either side.

MR. DRAKE: I think data has come up since then that would shoot that down. That's too busy for the crews. That just runs them ragged.

MR. STEINMAN: I wish you would date those so we would know what group this came out of.

MR. THOMAS: This is about four years old. There weren't any studies that went into that. That was just what they came up with.

MR. DRAKE: Okay, Trace.



MR. THOMAS: So continue.

MR. SKEEN: Do you want to go through -- it's actually not a number that's in here. Do you want to go through the calculations I came up with, each of the total unit hours for all of the systems?

MR. THOMAS: Maybe he could provide that.

MR. SKEEN: Current, I came up with 120,040. That was off of Bill Collins's.

MR. LAUER: Maybe we should just describe what a unit hour is real quickly.

MR. SKEEN: If a unit is on -- well, a unit that is on 24 hours a day, seven days a week is 24 unit hours. 168 unit hours per week times, four per month.

MR. DRAKE: All a unit hour is is a crew and their vehicle for one hour. That's a unit hour.

MR. SKEEN: All right. 122,040 off the current system. And the source for that is Bill's plan.

The tiered system, keeping in mind, there's three different levels here, the fire medic critical response level, the



contracted entity noncritical response level, and then the current calls that are being run by the nonemergency calls that are being run by the current 9-1-1 calls is the third level. That comes to 166,000.

MR. THOMAS: Which is that? Tiered?

MR. SKEEN: Tiered.

MR. COLLINS: That's all three?

MR. SKEEN: That's the total of all three. The single provider, dedicated provider is 107,577. And there are two tiers to that, really. It's the one tier that responds to all the 9-1-1 calls and the other tier that responds to those calls that are currently being responded to by 9-1-1 calls that are nonemergency.

MR. COLLINS: Then that's not dedicated.

MR. SKEEN: Single provider, yeah, right. Those would be two different functions.

MR. COLLINS: What's the number of hours single dedicated system for the cars and the 9-1-1 --

MR. SKEEN: 94,000.



MR. ROBEDEAU: That's in addition to the 107?

MR. SKEEN: No. 94,000 and then 13,000 to pick up the balance for a total of 107.

And then the dual integrated, I show at 108,964.

MR. STEINMAN: Trace, what was the difference on the tiered response on your page 3, 1515?

MR. MOSKOWITZ: He just added those two together to get you that total number.

MR. DRAKE: On 155,499, are you including all the ALS engine companies in that calculation? How did you arrive at that?

MR. SKEEN: Including --

MR. LAUER: Actually, that was, I believe, paramedics on a transport capable vehicle. Wasn't it?

MR. SKEEN: Yes. It was paramedics on a transport capable unit that respond to .40 calls per unit hour, Mark. Not transports, because we understand they are not going to be transporting people. But

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in order to get the response -- I will tell you I think I was conservative on the number of units to do that and still have eight minutes, 90 percent. But it was based on .40 calls per unit.

MR. DRAKE: How many fire medic units did you have in that calculation? Because if you look at seven 24-hour units, seven times eight is 6,000 units hours.

MR. SKEEN: I don't think they have seven units that can do eight minutes 90 percent. You could divide that out and see what it is. I don't have a calculator with me.

MR. DRAKE: The 155,449 is all fire?

MR. SKEEN: I am sorry?

MR. DRAKE: The 155,449 is all fire?

MR. SKEEN: 155,449 is fire plus 61,409 for the private contractor. I am sorry. 94,000 for fire, 61,449 for the private contractor and 15,567 for the provider.

MR. SKEEN: 13,577.

MR. DRAKE: I think your assumption for the fire was too high.

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MR. LAUER: What do you think that would be in terms of unit hours, Mark?

MR. DRAKE: I think we are -- in some discussions we have talked about, the fire would yield seven units 24 hours a day, 8,700 units a year, for a unit receive, times eight is 56,000 units.

MR. LAUER: 8,000 -- 24 hours in a day times 365 is 8,760.

MR. DRAKE: I am sorry. You are right.

MR. LAUER: I think Trace started from the assumption it would take a minimum of eight, because in the program that Bill ran, with UW --

MR. COLLINS: On the geographics. And also looking at without calculating it out, looking at if you look up north at King County, for the size of the population is like ten or 11.

MR. LAUER: The conclusion for geographic deployment, you have to take these units and spread them around the county to respond eight minutes 90 percent of the time. That's the lower possible

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level for that response time. It doesn't take into account volume.

MR. SKEEN: I think the demand analysis that you guys worked on to produce an eight minute 90 percent response, wasn't that a minimum of 14 units?

MR. COLLINS: That's all predicated on --

MR. SKEEN: On transporting everything.

MR. COLLINS: And all demand hours being an hour as opposed to being a smaller increment.

MR. SKEEN: And the variable there is the difference.

MR. ROBEDEAU: John?

MR. PRAGGASTIS: I would like to ask a question I have never been very clear. In the proposal where it talks about eight transport ambulances for the time critical patients, then we talk about that being for the County, and then I also see references to that being within the City of Portland, are we talking about eight transport emergency fire medic ambulances for the

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County or just within the city limits of Portland?

MR. COLLINS: Where do you see any reference to the City of Portland?

MR. PRAGGASTIS: In the Tri Data study, the eight locations only given in the City of Portland. Are we talking eight units for the County or eight units just for the City? This has never really been clear to me.

MR. STEINMAN: Tri Data study was for the City. That was commissioned by the City of Portland. That's all they looked at. I don't think there's anything in the County plan.

MR. PRAGGASTIS: This is what I wasn't clear about. If Tri Data feels it's eight for the City of Portland, it must obviously be higher for Gresham and the surrounding parts of the County. So when we figure unit hour utilization, what are we using here?

MR. COLLINS: All of our demand and all of the analysis for the plans are all based on the County. So you can go back

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-- you know, we can look at Tri Data and take that or not take their data, however you want to look at it, but we have looked at nothing that is not County-wide.

MR. PRAGGASTIS: Have you reached a conclusion how many of the specialized transport time critical ambulances you would need for the County?

MR. COLLINS: No. We don't know exactly because we don't know what percentage of the transports is, but the best estimates without doing that are around eight, something like that.

MR. PRAGGASTIS: So eight is the real number we are looking at here for both the City of Portland and the County?

MR. COLLINS: No. There's no number of eight for the City of Portland.

MR. STEINMAN: I can't comment on the Tri Data stuff.

MR. PRAGGASTIS: Didn't I just hear you say eight?

MR. LAUER: The point is that's -- that information has never really been studied in depth. We don't know under the

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tiered system. The protocols haven't even been developed for what patients the paramedics would transport, whether or not the dispatch triage criteria would need to be changed.

MR. PRAGGASTIS: So we really don't know how many ambulances the fire bureau will respond to outside the city limits of Portland yet? Is that right? Is that fair to tell the County, "County, what do you mean, outside the City limits of Portland?"

MR. SKEEN: I think that's pretty fair. Maybe I am wrong.

MR. SKEEN: Let me be very clear. The assumptions I have made on here -- in fairness to Tom and the fire, they have not come forward with the plan. The assumptions I have made on here that we have discussed are simply our assumptions of what we think their plan would be.

MR. PRAGGASTIS: Okay. That's fair.

MR. SKEEN: I would say the providers are a pretty reliable source to go to, having done this for years to figure it

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out.

MR. STEINMAN: It seems like the number eight just comes up in everything. That's the minimum level before we panic at BOEC, and it keeps popping up that that's the minimum we can cover the County geographically. It just seems to always come back to that. Maybe that's why Tri Data picked that up. I am not sure, but that is still a draft. It has not gone to council.

MR. PRAGGASTIS: I was curious what the number was, how many estimated units we are talking about for the whole county.

MR. STEINMAN: I think we all are.

MR. SKEEN: My sense is when we go to level eight, which is this magical number

when we get real careful about what we send ambulances on, my sense is -- and Jerry would have a good feel for this -- is that the County would not be able to be operated efficiently at a level eight 24 hours a day. Essentially, we are saying it's a minimum level versus the maximum level.

MR. ANDREWS: That's correct.

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MR. LAUER: Actually, level eight is sort of invalidated in lots of different ways. Currently, I think our lowest staffing level is level eight at nine. Is that correct?

MR. ANDREWS: With --

MR. COLLINS: The demand is below that.

MR. LAUER: But everybody is in service. That's the lowest.

MR. ANDREWS: I think the lowest we go calculated is nine right now.

MR. LAUER: Whatever the lowest level is now, in those wee hours of the morning there are very few, very few nonemergency calls that come in.

MR. COLLINS: It's primarily emergency calls.

MR. LAUER: Median response times, now we are meeting response times. To go along with that, we don't have a lot of time to -- slack time to play with. If we go below that, we are probably in trouble. That's just the minimum. The other hours, the higher demand hours of the day, it's

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just logical that you are going to need to staff more unit hours, as we do today.

MR. DRAKE: Randy, you would have to look at the response time percentage of those hours to do that calculation. And you would have to know, because if we are in a 96 percent at eight minutes, we have too many unit hours. We would have to cut back. We don't know that. There's a lot of reasons why we have that extra staffing on. It is not to maintain staff response but it's to maintain level eight.

MR. SKEEN: What I have heard, that may not be a valid level during certain hours of the day.

MR. DRAKE: Right.

MR. SKEEN: That's another study.

MR. DRAKE: That's another issue.

MR. LAUER: Right now our system is dedicated to level nine.

MR. SKEEN: In just referring that first item -- and this was -- this was my recommendation, although I thought that I have heard this pretty consistently -- is that there probably is room to reduce the

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number of paramedics in the system to be more efficient with the skills --

MR. DRAKE: Currently.

MR. SKEEN: -- under the current system.

MR. DRAKE: That goes back to the issue that we have to have extra units on, because it gets below level eight, we can't run them out for priority calls, so we staff extra in order to have those units available.

MR. SKEEN: It all becomes a number of units you will put on the street, the staffing considerations. There have been -- I believe that there have been some studies -- I think Buck conducted a study, AA conducted a study -- that showed that the more paramedics you get -- three paramedics on the scene, it actually delays the time on the scene versus two paramedics.

MR. DRAKE: We have done the same thing. If you have four paramedics on the scene with fire and paramedics, your scene time expands.

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MR. SKEEN: Like having too many generals at a war or something.

MR. LAUER: Like the larger the committee, the longer it takes to reach a conclusion.

MR. SKEEN: One of the issues that's come up frequently is concerns about paramedic turnover. And Bill had represented in his -- and I think he addressed it very honestly and openly in his plan. He said, based on the materials he looked at that the private sector turnover ratio was 26 percent or 30 percent, something like that. A lot of discussion here ensued, and I think determined that the measurements probably weren't valid.

The eight percent that you see there in the representation, we went back to the beginning, January of 1992, we had 100 paramedics on staff in the region, the area, that three-County area. At the end of 1992, 92 of those paramedics were still on staff.

And using that philosophy or that

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formula, that represents an eight percent negative turnover. The 12 percent I put over there, that should be a standard. To retain turnover under ten percent tends to be -- I would simply represent that as an industry standard. It really shouldn't exceed that.

MR. DRAKE: There's nothing in the commission records or any other records that you are aware of that set a standard for turnover?

MR. SKEEN: I am not aware of really any contracts or any models anywhere other than, obviously, if you run 50 and 60 percent turnover, that's not good. It's very costly for the training and reorientation.

MR. THOMAS: What does NTE stand for?

MR. SKEEN: Simply negative turnover of employment.

MR. ANDREWS: Thanks.

MR. SKEEN: The formula for that is the termination of any employee for any reason other than death, retirement, or promotion.

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MR. SKEEN: We talked about the under three months and the over three months.

MR. COLLINS: Did you break that figure out?

MR. SKEEN: No. So this is even probably a more expansive interpretation.

MR. COLLINS: This was one year. Right?

MR. SKEEN: This was 1992. Our eight percent represents 1992.

Paramedics skills proficiency, I believe the only way we can measure that is manually. I don't know anybody that is gathering automated data to measure that.

Do you know, Jerry?

MR. COLLINS: There's no apparent standard. I have looked every place to look to see if there's a number like a number of patient contacts or anything, and I was unable to find anything, anything.

MR. SKEEN: Probably the closest thing that even comes to that is a number of states have requirements paramedics must have so many intubations during a two-year period, and that's pretty broad -- or IVs,

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IVs intubations, defibrillations.

MR. THOMAS: Let me say something. I am realizing what the relationship is between the sheets that Pete prepared, which are these ones that are typed this way, and this one. He has addressed the issue in terms of whether the plans that are on the table address them and, if so,

how.
And what you have done is, you have taken those things and you have filled in what you think the answers are as to how those things relate, so you can actually read these three together if you want to.
MR. SKEEN: Right. Right.
MR. ROBEDEAU: I was going to say, why don't we back up a little bit on that.
MR. SKEEN: Sure.
MR. ROBEDEAU: I thought that's what we agreed to, as a committee, we were going to first see what -- if the plan addressed the issue, and then we were going to make a recommendation.
Is that correct?
MR. DRAKE: Yeah.



MR. ROBEDEAU: Is that your understanding, Randy?
MR. DRAKE: So, Trace, by the blank spots here means those plans do not address those issues, or you made no assumptions?
MR. SKEEN: I made no assumptions. I figured that I didn't have enough data to put something forward.
MR. ROBEDEAU: See, as I was going through this and look at mine, I only got as far as, I think, 12. I haven't been all the way through this. And I just looked at the plans to see how they address the issues that we at least perceive are the issues that are driving the system change.
And I found that in most cases, the issues were not addressed in any of the plans. And what we are doing here is sitting here talking about just that fact that the issues are not addressed, but we are also sitting here talking about the fact that nobody knows how to address the issue.
And that, I think, is pretty important as to what's going on with EMS planning in



probably the United States is that, you know, we are about a 30-year-old industry as we exist today, and we are still an infant in a lot of assumed -- 1970s and 1980s assumptions are in the 1990s proving to be incorrect.
MR. SKEEN: And the approach on my document is basically filling that in with the most accurate information we think we have available, and then it can certainly be contested to try and verify it to get to that answer that we need in there in order to come up with a plan.
MR. ROBEDEAU: But if we have an issue, we need to have at least an answer that is measurable. And we weren't -- paramedic negative turnover -- and I went through and looked. I did AA's, and the thing we talked about was paramedics that were in the system a very short time and washed out, or paramedics that transferred to or moved over to other providers within the system.
And we had 26 percent turnover, with 42 percent of those people lasting in the



system less than 90 days or moving to other system providers, which puts us down in the 13, 14 percent rate. This was just for 1992. And we figured that out. According to Collins' plan, fire bureaus has 13 percent turnover, which puts us about the same place.
MR. STEINMAN: But, Pete, we can do the same thing on that. Where it comes up in Bill's is when we promote a paramedic to Lieutenant or Captain. They are still out there saving patients. They are just not assigned to rescue. I don't think we will see 13 percent unless they change the retirement system.
MR. ROBEDEAU: What we took was the proposal as it was here.
MR. STEINMAN: I understand. You know, to me, I think we need to start coming up with recommendations. I mean, we have been weeks and weeks hashing over what numbers are right or wrong, and I don't want to go -- continue on weeks and weeks.
I like Trace's on the turnover. It should be less than 12 percent. I think



that's something the Provider Board needs to provide to the County Commissioners is a recommendation, whether they agree with it or not. We are never going to agree on all these numbers.
MR. ROBEDEAU: No. And I understand that.
MR. DRAKE: We have to get real close. Because if you look at the different plans, just the difference in the number of unit hours times 87 per unit hours, it's a $2 million difference in the system. You are talking about 22,000 hours of unit hours difference. That's really big numbers here.
It's very important the plans address how many unit hours you are going to put on the street. We can put a system in place there that's going to cost us more money. We don't want to do that. We have to put in a system that either costs the same or less. That's still the issues we have to deal with. We are going to have to come down with some real stringent recommendations and identify how many unit



hours we can put on the street to run this system.
MR. SKEEN: Let me just suggest that our industry, and particularly here, has never been very good at doing cost benefit analysis. Over the years we went through the '70s when people said you cannot put a dollar amount on the health of a life. And the health care forms indicated that --
MR. DRAKE: Yes, we can.
MR. ROBEDEAU: They have to.
MR. SKEEN: And I think that it's really the responsibility of all of us -- be it County, City, providers, regulators -- to go back and start doing some cost benefit analysis, the issue of three paramedics on the scene versus two, response times. And we pick eight minutes 90 percent, and there's nobody in the country that can tell you that's an imaginary number except, some other communities do it, so it must be the standard.
MR. DRAKE: But there are some standards that we do know. We have



looked. There is no data that says the two paramedics on one unit are better than one paramedic. There's no data that says they save more patients, two paramedics system, one paramedic. None that I am aware.
The only data we do know about is that early defibrillation, early conversion of dangerous arrhythmias saves more lives. Most of that data comes out of the Seattle system.
MR. COLLINS: That's starting to come out in other places.
MR. SKEEN: That's coming out on a lot of national standards. That's the one issue the American Medical Association has determined is a valid procedure.
MR. DRAKE: So that's when we are talking about automatic defibrillator program for the first responders.
MR. ROBEDEAU: But that's also a BLS, not ALS, for automatic defibrillator program. That's a lot of things. That essentially is a hardware-buying thing rather than a manpower --
MR. DRAKE: That's correct. That's a

hardware cost. Automatic defibrillators is something anybody in this room can learn how to use in an hour or two. You put them on.

MR. STEINMAN: How many? This committee says I have to train my people for six months.

MR. SKEEN: Don't touch that. Don't.

MR. ROBEDEAU: We need to go off the record on that one.

MR. COLLINS: It takes longer for the fire bureau.

MR. STEINMAN: Pete, a little confused. We are under some time constraints here to come up with an ASA plan, not a system design. And we have got to get moving if we are going to make any recommendations to the commissioners on the plans that are on the table. And we can debate all of this back and forth.

Under No. 3, I think we need to make a recommendation this system needs to start gathering data to see what's going on and move on to the next one. We know we don't have it, so it's not doing anybody good to



sit here and come up with all the different ways we could do it.

MR. SKEEN: Basically, what we have there is medical community testimony. That's what we have to work off of. I agree that we ought to move on.

MR. ROBEDEAU: We should --

MR. STEINMAN: We all agree the State should design an EMS system if they are only talking ambulance service plans on it. Let's focus on that and get through it.

MR. SKEEN: Then it takes us to really what I think is the key issue, and it's not addressed by ASA planning either, and it's real difficult to separate it, and that is, what are the components of the first response versus how you want to design your response time standards and your staffing configurations on the ambulances?

I will tell you that my sense is -- and I think that it would be supported broadly -- is that if you are going to use BLS EMT first response four minutes 90 percent of the time, and that's a validated



benefit to cardiac patients, then, you need to have two paramedics on an ambulance eight minutes 90 percent.

If you are going to use an ALS first response four minutes 90 percent, then you should go to a one and one staffing on the ambulance, and maybe you ought to look at eight minutes versus nine minutes on the response time. The longer response time allowances, the fewer unit hours you are going to need in production.

MR. STEINMAN: I agree with you totally, Trace, but what we are faced with, this is May 19th. We have until June 2nd to get our recommendations in. We have a Medical Advisory Board that's so out of control that they wouldn't even listen to anybody recommend something that logically makes sense, so let's focus on what we have got.

MR. SKEEN: This will be real easy. What can you represent from Portland Fire Bureau -- Dave is not here from Gresham -- what did you represent today that the City is prepared to provide in a first response



component, so that we can move ahead with the other issues as it relates to ambulance?

MR. DRAKE: Trace, we have to look at all other outlying areas. If we design an area, we have to recognize that the smaller fire departments in the outlying areas, most of which are volunteer, are not going to be able to afford to put paramedics on their units.

MR. SKEEN: Right. In fact, Dave Phillips from Gresham Fire said, please don't form mandates for my City that we perhaps don't have the ability to fill. That's part of the dilemma that we have here is getting the cart and the horse lined up so we can have a plan.

MR. ROBEDEAU: Just one second here. We need to take a break for about five minutes and formulate that. But before we take a break, just let me put in one thing here. I think the first thing that we have to decide when we come back from the break is, what are the response times going to be. And it may be varied. And then, what



are the personnel going to be? And then design the system off that.

What are the response times? What do we want to deliver? What do we want to deliver how fast? Then you have to design your system off that because everything else flows from that. Is that fair?

MR. SKEEN: Yeah. Tom, are you prepared to answer the City's position on that?

MR. STEINMAN: It's already decided. The County has a four-minute first response request -- it's not a requirement on our part -- and an eight minute 90 percent of the time. I still don't think we can sit here and reinvent the wheel or say what the system should be. We have to work off the things that are in front of us, and that's what's in front of us.

MR. LAUER: What we want to know, what kinds of people are going to the scene. There's a big difference. In a lot of forums people have agreed two paramedics are useful on the scene of a call but of little use in transport.



MR. STEINMAN: You will not hear me say today that the City is taking a stance on ALS first response or anything else. We are just not at that point. You know that we are working towards that. You know that we have been trying to work with you in putting our ALS stations in areas that it is hard for you to get to in eight minutes.

But to go to all ALS first response is very spendy. To go to an EMT-D program is very spendy. I can't tell you right now if the City would be willing. I could not get life pack ten replacements approved in this budget. I know I couldn't get 29 AEDs approved. What we have got is what we have got today, and that's what AEDs cost, about 7,000.

MS. MARKS BAX: Thank you.

MR. PRAGGASTIS: Get them for a lot less than that. If you will buy them at seven, I will sell them to you.

MR. DRAKE: We buy certain units.

MR. ROBEDEAU: Let's take a five-minute break.

(Recess.)



MR. ROBEDEAU: Let's reconvene. At the break I had mentioned the two things I think we need to do, before we put a system together, is decide what we are going to have for response times and what we are going to have for personnel. And I don't see anywhere -- I don't see anywhere in the system where it's clearly refined.

And I would like to suggest the Provider Board recommend the double response time standard, which would change the dispatch triage system at the same time, which is an eight-minute response time for life threatening emergencies and a 12 minute response time for non-life threatening emergencies.

That would create dispatch triage to

determine what it was. It would take rewriting all of the dispatch protocols and probably -- I don't know how the Medical Advisory Board would go for that, but I don't think they will go for anything anyway.
MR. DRAKE: Actually, Pete, that job isn't that difficult, because they would



simply go through -- the triage guidelines currently determines what's life threatening. We know most of those. And the ones that are non-life threatening, there's just a few of them, and the supervising physician or the Medical Advisory Board, whichever medical board wants to do that, can be involved in that since they are currently involved in the triage guidelines. I don't see it as a real big job.
MR. ANDREWS: The process right now is, there is a dispatch subcommittee, and they are charged with the responsibility of maintaining the triage guide because they are -- because emergency medical dispatch is, in fact, a medical process that occurs -- the MAB has established the dispatch subcommittee, so everything they do does go through Medical Advisory Board. So that would be the avenue to change those.
And I would point out that we have made significant changes in the triage guide over the five years I have been involved in the system, but I can tell you



that the vast majority of those changes coming from the medical side of this have been to tighten the standards and to increase the response. I can't think off the top of my head of any situation where we have altered -- where we have decreased the level of response. So it's just some information to chew on.
MR. SKEEN: Are you inferring that that would decrease the level of response?
MR. ANDREWS: No. No. I am saying that has been the historical perspective of that group. As an example, when I went onto the committee just over five years ago, the medical-professional-on-scene issue was one that was bandied about at every single meeting ad nauseam. And it was, an MD, a DO, an RN, an LPN, et cetera, could alter the emergency response, particularly the nursing homes.
Because of countless problems that were referred to the quality assurance committee and subsequently on to dispatch subcommittee, a decision was made that the only medical professional that can alter a



response is an MD or DO who is either on scene or, in the case of a nursing home, has seen the patient in the preceding two hours. Taking the RN option out, taking the LPN option out, again, an example of how our system has increased the response to the patient.
MR. COLLINS: I think you can look at it. It's going to be a matter of how comfortable the providers are with the up-front triage. That's always been the issue with the triage.
MR. ROBEDEAU: I think we can get comfortable with that, Bill. Other systems all over the country do just that. Eight minute. They triage life threatening and non-life threatening calls. It's done all over the country. You are making your system more economical and you get a better utilization, and I don't believe that you are going to compromise any patient care anywhere along the line by coming up with that kind of standard.
MR. ANDREWS: Right. Please don't misunderstand me. I am not implying that



would happen. I am just trying to give you a perspective on what the track record has been with regard to the triage guide.
MR. ROBEDEAU: Oh, yeah. I have been here 27 years.
MR. THOMAS: There is one thing. In terms of allowing greater response times, since the MAB did endorse those who voted to endorse the PAPA proposal, as I understand it, John, it does provide for three levels of response times.
MR. COLLINS: But that, Chris, is a different issue. That's not based on the acuity of the patient. That's based on location of the call.
MR. PRAGGASTIS: Geographically.
MR. THOMAS: I am just making the point they are showing flexibility.
MR. COLLINS: We agree with that. I think everybody agrees we currently have a county-wide standard, geography-wide, that we say is there, but we don't do it. We don't get out to Bonneville in eight minutes ever.
MR. PRAGGASTIS: It never happens. It



just won't ever happen.
MR. COLLINS: It could if somebody would like to put lots and lots of money into the system and buy Bonneville its own ambulance.
MR. PRAGGASTIS: It's a reasonable reflection of what happens now and that it covers the largest percentage of the population in the shortest period of time. And then as you go out into the more suburban and rural areas, the time increases.
MR. COLLINS: You guys don't have a problem with that, do you?
MR. ROBEDEAU: No.
MR. COLLINS: You are talking about in the urban area.
MR. ROBEDEAU: I am talking about also changing the response time in the core area to create more of a dispatch triage, and the life threatening emergency -- and has life threatening remaining the same as 12 minutes and/or at eight minutes, excuse me, and non-life threatening emergencies be changed to 12 minutes within the core



area.
MR. THOMAS: How different is that in actuality? I am wondering, Bill, or anybody else, how different that would be from what you have proposed in the tiered response? In actual practice? What happens? Would it be very different, do you think?
MR. COLLINS: Under that kind of triage, you are making the decision earlier in the process. It's not that you can't do it. As long as you -- in fact, if you do that, then, a tiered response works even better. But you have to set up that kind of triage. And like Jerry was saying, this particular community has just been very conservative on how they deal with the triage. I mean, we basically triage everything as an emergency and we send almost everybody code three everywhere.
MR. ANDREWS: Part of that, going back, part of that, when the triage guide was initially conceived, that we had response levels of zero through nine. And we had a category, which was a level eight



response, and that was a fire first response code three and the transport capable ambulance nonemergency. And that was based on a presumption that you need to get your first responder there and that, if there was no life threatening emergency, transport could come along.
The medical community said, that's

crazy. And I am paraphrasing, liberally, but paraphrasing nonetheless.

MR. PRAGGASTIS: Crazy with a K.

MR. ANDREWS: Well, at any rate, if we are going to send the first responder code three, then, we need to send the ambulance code three as well. So they did away with the level eight response.

Today, from nine levels with a response, we are down to essentially four. We are down to the zero, which is nonemergency referral, and not just to the private ambulance companies, but we also refer, of course, to City Cab, we refer, of course, to the CHIERS unit. We have a number of varieties. We have the one response, the three response, and the nine



response in addition.

The one and the three are going to get you the same response. When the fire bureau -- Tom, two years ago you had the significant budget impact and were looking at laying off several firefighters?

MR. STEINMAN: Uh-huh.

MR. ANDREWS: We suggested we do away with the levels and the paramedics on the committee, and the dispatch committee said, hold it, we want to keep the one and the three differentiation because a UN-1 is unconscious, not breathing, which gives the paramedics something else to think about as opposed to UN-3 which is conscious -- unconscious but breathing.

So right now the difference between a one and a three, for our system, is a very cursory description of how severe the patient is, a TA-1 versus a TA-3.

The nine is still and forever has been the fire to check. You don't get an emergency ambulance response. Fire goes out, checks on this seizure patient and then makes a determination, whether the



response ends at that point or whether they need an ambulance.

So we have gone from nine categories of EMS response down to four and one bizarre one nobody wants to talk about, and that's the BLSU-4, which is fire code three on a structure fire and an ambulance goes along. Then we have the whole issue of police responses.

MR. THOMAS: It is interesting, because one of the things which I remember from the comparative -- comparisons of our systems to others was, we did have a very high level of emergency responses with no transports relative to other systems.

MR. COLLINS: We do.

MR. THOMAS: That's a function of what you have been talking about, is the way in which we have decided to do it.

MR. COLLINS: That's an indicator that your dispatch triage is overcompensating.

MR. ROBEDEAU: If anybody is like me, there's a thunderstorm outside. It's raining very hard.

MR. ANDREWS: The other thing is, we



have made dramatic changes in our system evidenced by MN-99, the man-down category. Fire bureau did -- I don't know -- six-month study of what happened, what the disposition was on the MN nines that they were going on. And three percent of those required a subsequent ambulance transport.

We don't -- nobody -- no medical response goes on MN-9s or MN-0s any more except the police or the CHIERS unit, so we have made some changes, but it was only with the fire bureau's documentation of what they experienced on MN-9s that we were able to make that change. And we are still reviewing how exact that was as evidenced by occupational referrals Randy gets from our office. We want to review all the referrals from CHIERS to an ambulance and see what happened.

MR. ROBEDEAU: Well, we are going to have to, as Tom Steinman has pointed out, we have to make some recommendations. And I think for this system on -- I will get to them in just a minute -- but I think the



system should change our dispatch triage into becoming more what the national standard is, and that's what our recommendation should be. Between an eight and a 12. John wants to --

MR. PRAGGASTIS: Just two things. One, I don't know that your comment just a second ago that national standard is eight and 12. I don't know if that's, in fact, a national standard.

I think that we are missing another important piece here. The important piece is, let's assume you know the call very well and that the call is a person who has fallen and sprained their ankle. You know exactly how it happened. No chance of cardiac history. It's very clearly done. A lot of people say this is exactly how it happened. Are you going to send a first responder code three to that call or not? Are you going to send the ambulance code three to that call or not?

MR. ANDREWS: John, even in our system, even in our current system with the inherent overresponse, that particular call



should be triaged out as a nonemergency even to one of two choices. Either to the fire department to go out and put a bandaid -- bandage on this guy's ankle and help him into his car or, alternative, a nonemergency ambulance referral of what he needs is a ride to the hospital and has no alternative.

MR. PRAGGASTIS: This happened just the other day at Kelly Butte. Someone twisted their ankle. Fire code three and ambulance code three. And I am willing to tell you I think the danger to the public in emergency vehicles running code three to things that you are willing to allow as a longer response time -- and that may be appropriate -- I think there's really more danger involved -- the units involved are going to hurt somebody or get hurt than saving the patient life or limb. And if we are going to talk about slowing things down, I think it's also important to talk about level of first response and what you expect that if that is supposed to cover some of the extra four minutes or not.



MR. ROBEDEAU: Right now we are not talking about first response. We are talking about ambulance response time but --

MR. PRAGGASTIS: But they are linked, Pete.

MR. ROBEDEAU: And we are talking number of responders. But I would like to see some data on what the incidence -- I don't know if you are going to get out of here.

COMMISSIONER COLLIER: Really?

MR. ROBEDEAU: My windows are open and I decided not to try it.

(Discussion off the record.)

MR. ROBEDEAU: God, now I forgot where I was.

The incidence on what danger to the public there is from running code three. I know I have been hearing that kicked around.

MR. PRAGGASTIS: God, Pete, you don't think that's a little more dangerous for us to be out there, driving around code three? I do.

MR. ROBEDEAU: A lot of it depends on the particular person. Now, maybe you are dangerous. Maybe you are not. I don't know.

MR. LAUER: If you are going to look at it from that perspective, if you are going to talk about changing the dispatch codes and triage criteria and limiting the number of responders to a response, you don't have to reinvent the wheel to do that. That's a matter of changing the current system, so I think we need to keep that in its proper place, is that, you know, we don't want to change the bath water necessarily.

MR. ANDREWS: You don't.

MR. ROBEDEAU: Is my recommendation going to die for lack of a motion?

MR. DRAKE: I think what John is saying over there, Pete, the response times of the first responders and transported agency go hand in hand. You can't adjust one without the other. I mean, you have to know what they both are, and that's, I think, valid. And we have to make the



recommendation that the fire -- if we are going to make the recommendation fire bureau get there in four minutes or less, we need to do that -- and what kind of response that's going to be.

MR. ROBEDEAU: Is it ALS or BLS first response? We know that's No. 1. I think we need to -- one of the criticisms of this system is the cost.

MR. DRAKE: That's right.

MR. ROBEDEAU: Most of the cost in this system is personnel. And we are responding to fractured ankles in eight minutes where a perfectly appropriate response would be 12. So, I think, first, we need to make the recommendation to change the ambulance response to an eight-minute life threatening and a 12-minute non-life threatening. That's the same response times that are in most of the, quote-unquote, high performance systems.

That's the response time in Kansas City. You said it's the response time in Tulsa. It's the response time that we were



compared to in the 1986 Fitch study that was not exactly articulated well in the Fitch study, but came out later and diminished in cost and, I think, reduced the unit hours that are needed in the system. And I think it's -- I think we need to look at it as a viable option.

MR. DRAKE: I don't have any problem with that.

MR. SKEEN: I don't have a problem with it, but I see that as a goal, that like -- it's kind of like Randy said. It's something we could modify right now, I assume, Jerry. It should be a goal that we move towards. I think you would probably be a little bit hesitant to say, oh, yeah, we can turn that switch tomorrow.

MR. ROBEDEAU: No.

MR. ANDREWS: But what I would be willing to say is, on a recommendation from this committee, we will ask the dispatch committee to revisit it and to look at a -- developing a criteria for potentially life-threatening problems. We can identify four or five of them off the top.



MR. THOMAS: But I think as I understand what Bill had proposed in the tiered response and that conceptually in terms of creating a distribution of acuity -- is that what you called it? -- the acuity.

MR. COLLINS: It's a legal term.

MR. THOMAS: They didn't have a problem with one set being transported on a 12-minute response time basis and one set being transported on an eight-minute response time basis. The real question we are dealing with is how you do the triage. You do it through telephone triage at BOEC or you do it through on-the-scene triage by the fire bureau. It may be that the definitions, one is talking about life threatening and non-life threatening, and maybe he is talking about something different. It sounds like, at least conceptually, they didn't have a problem with this concept in terms of transport times. It's more to do with where the triage is.

MR. SKEEN: I see that really as a



fine-tuning of the system.

MR. THOMAS: Yeah.

MR. SKEEN: With that, what you are trying to do is get more efficiencies out of your resources; but with that, you will undoubtedly encounter the famous Poff case in Dallas where, I mean, they undertriaged, and the whole system takes a hit.

MR. THOMAS: That's the decision you have to make: How much tradeoff?

MR. ROBEDEAU: That was refusal to send an ambulance.

MR. SKEEN: That's true.

MR. ROBEDEAU: If they had sent an ambulance with at least one paramedic on it, that case would not have come up.

MR. SKEEN: I think you would have if they had sent a 12-minute unit as opposed to eight-minute units on that case.

MR. DRAKE: I would have to disagree on that case. It was a problem with some telephone triage and a mistake and an error on that one person's part on that particular case. And I would hate to see us not move forward on triage guidelines



out of the hundreds of the thousands of cases that are dispatched every year.

MR. SKEEN: Don't misunderstand. All I am saying is understand -- and I agree. I think that we can't -- we can't be everything to everybody and always stage for the absolute worst case scenario. That you have to make some determinations.

But I don't want us to be so naive that we won't have some occasional incidents, whether BLS is doing it or a contractor or whoever is doing the dispatching, that you won't have incidents that will call that policy into question.

MR. ROBEDEAU: We have had some incidents -- I remember there have been some questions about current policy. I don't remember the instance off the top of my head, but in the past there have been incidents where people have questioned the response they are getting with the current system. And I think that's going to happen no matter what happens.

MR. DRAKE: I think the bigger issue of people being put on hold by 9-1-1.



MR. THOMAS: The other issue this relates to -- I say this because Lynn is here and this relates to Kaiser -- Kaiser is doing after-the-fact triaging. I am involved in a lawsuit about that -- where regardless of how 9-1-1 triages, they go back and look at the incidents afterwards and say, we don't care if they triaged it and said it was an emergency. They didn't triage it. They said it was an emergency.

We say it wasn't. And we might alleviate -- and therefore they are not willing to absorb it under a state payment contract. We might alleviate that problem somewhat if you had a more rigorous triage process, I suppose. That is no -- maybe not a driving factor, but it does relate to

system cost because that call is now going to be paid for by somebody else.

MR. LAUER: When our dispatch criteria was set up quite a while ago, and even the two paramedic system on the ambulance and the move toward paramedic first response, that's all set up with an eye toward ultraconservative. That was a conscious

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direction that this system took a long time ago.

Now things are a bit different. And if you want to take a different direction, you want to look at a cost benefit and changing some of those things, then, there's a lot -- you can take the system we have got right now and change it and save a whole lot of money.

MR. ROBEDEAU: We have to do a cost benefit, you know. The '70s are gone. They are over ten years ago. And the idea there's money, you know, falling out of everybody's pockets just isn't there. And we have to lower the cost of the system, period, no matter what we do.

MR. LAUER: Maybe that's the direction we ought to take then.

MR. ROBEDEAU: We have to take a realistic look at the Oregon health plan. Ten years ago do you think something called rationing would have made it even as far as the State Senate, Statehouse?

MR. DRAKE: It wouldn't have made it past the lounge they talked about it in.

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No one would discuss it outside of a small group of people.

MR. ROBEDEAU: Now we have got it approved.

MR. DRAKE: We need to bring this to a close. I would like to make a recommendation on a couple of things. One thing, I would like to have some time to go through the information that Trace put together here.

And also, Trace, could you fax around the assumptions that brought out the numbers here?

MR. THOMAS: The unit hour chart that you had?

MR. DRAKE: The whole chart on ASA planning components, comparative analysis. Because there's assumptions made.

MR. SKEEN: Sure.

MR. DRAKE: If you can send those out. And also I would like to see for next time that -- Pete, I would be willing to help you out -- we need to go through the rest of these about which plans contain information and which ones don't. You got

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up to No. 12 you said. You need to continue that and go through the rest of them. This is also a good analysis. It says whether a plan has it in it or doesn't have it in it, addresses it or doesn't address it. We need to look at those as well.

MR. ROBEDEAU: Going through this, what I did, in just looking to see if it addresses the issues we are talking about, the plans don't address any issues.

MR. DRAKE: A lot of them.

MR. ROBEDEAU: Very few. I won't say any. Very few as far as I could see. I would certainly be willing to talk to anybody who wanted to discuss this with them.

MR. DRAKE: Okay.

MR. ROBEDEAU: I am assuming by watching everybody here they want to adjourn at 3:30.

MR. DRAKE: Yeah.

MR. THOMAS: When is the next meeting?

MR. ROBEDEAU: We need to set probably

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two more, and that's all we are going to have. We are going to have to have a proposal in after that.

MR. THOMAS: Better beat that June 1 deadline.

(Discussion off the record.)

MR. STEINMAN: June 1 is two Tuesdays from last Tuesday.

MR. ROBEDEAU: Two next week and finalize it and have it in by -- is it June 1st?

MR. SKEEN: Wednesday, Friday of next week and Tuesday, June 1st?

MR. ROBEDEAU: I think we have to have it in by June 1st.

MR. DRAKE: The Provider Board is Wednesday, June 2nd. Right?

MR. SKEEN: The hearing is June 2nd.

MR. COLLINS: There is not going to be a hearing on the 2nd. There is going to be -- most likely what will occur on the 2nd will be an informal tutorial, for the lack of a better word, by our staff to the board about kind of what the system is now, what the terms are, what the requirements are of

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the plan. I doubt very much it will be any public testimony or anything.

The next meeting after that is being proposed when plans and recommendations will be presented.

MR. ROBEDEAU: Which would be the 9th.

MR. COLLINS: The 9th or the 16th. This is still being looked at by the board offices.

MS. BONNER: What time on the 2nd?

MR. COLLINS: I don't know.

MR. SKEEN: 9:30 and 11:30. That's briefing from MAB and County staff.

MR. COLLINS: The recommendation part, we are proposing not to do that. There was expressed a need by a number of board members to just get some information as to what the system is now currently, what are the requirements for this planning process. I mean, some of them do --

MR. THOMAS: As I understand it, what do the words mean?

MR. COLLINS: That kind of thing.

MR. THOMAS: What is ALS, what is BLS.

MR. DRAKE: So the meeting on the 2nd,

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if we have the Provider Board, will be the afternoon? We will have -- the next one is the 26th, nine to 11. The one on Wednesday the 2nd, we will schedule for the afternoon again? 1:30 to 3:30 again?

MR. COLLINS: What are these dates?

MR. DRAKE: The 26th, nine to 11. And the second, I am just saying from 1:30 to 3:30, but I am throwing that out there.

MR. ROBEDEAU: Bill has an informal briefing on the 2nd.

MR. DRAKE: In the morning.

MR. LAUER: Is that open or closed?

MR. COLLINS: Everything before the board is open. Just can't talk. You can whisper.

MR. DRAKE: You can sign.

MR. SKEEN: Wednesday is the 26th?

MR. LAUER: At nine o'clock?

MR. ROBEDEAU: Nine to 11. Is that all right, Bill?

MR. COLLINS: You give me the dates, and we will call and see if we have the room.

MR. ROBEDEAU: 26th, nine to 11. See

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what you can get and we will send out a notice. And the 2nd in the afternoon? Is that all right?

Okay. We have to finish on the 2nd. Is that agreed?

MS. BONNER: When is the meeting that is not the 26th?

MR. ROBEDEAU: One on the 26th and the 2nd before we adjourn. Can we at least go with the eight and 12?
MR. DRAKE: Yes. So moved.
MR. ROBEDEAU: Motion. Do we have a second?
MR. SKEEN: Well, I mean, is the motion that that be implemented? That it be phased?
MR. ROBEDEAU: That that be the recommendation that we submit.
MR. SKEEN: Pete, I would just throw out that -- I am sorry. You need to vote on that.
MR. ROBEDEAU: I need a second.
MR. SKEEN: Second.
MR. ROBEDEAU: Now we have discussion.



MR. LAUER: I don't understand the whole motion, I guess.
MR. ROBEDEAU: The motion is, when we put in our recommendation, the recommendation be that we start more triage at Kelly Butte, and there would be an eight-minute response for life-threatening emergencies and 12-minute response for non-life threatening emergencies.
MR. PRAGGASTIS: I don't know that you have a quorum here. Do you? For a vote? I think your quorum member just left.
MR. ROBEDEAU: Our quorum member?
MR. DRAKE: Not required.
MR. LAUER: We have one, two, three.
MR. THOMAS: Is there not a quorum requirement.
MR. DRAKE: For the Provider Board.
MR. ANDREWS: Can I make a comment with regard to the motion?
MR. LAUER: Sure.
MR. ANDREWS: Would you read the motion back. I want to be sure.
(The reporter read the record as follows:



"MR. ROBEDEAU: The motion is, when we put in our recommendation, the recommendation be that we start more triage at Kelly Butte, and there would be an eight-minute response for life-threatening emergencies and 12-minute response for non-life threatening emergencies.")
MR. ANDREWS: The comment I have is that the motion says more triage at Kelly Butte. It's not an issue of more triage. It's an issue of more specific triage for life-threatening emergencies.
MR. DRAKE: Right.
MR. ROBEDEAU: All right. Change the motion to more specific triage. Any more discussion? Call the question? Oh.
MR. SKEEN: Let me just state that I think that's one component out of the master picture that still has to be evaluated.
MR. ROBEDEAU: One tiny component.
MR. SKEEN: Maybe I am hung up on it,



but I am still interested in the whole concept of the eight minute versus the nine minute and what this does to life -- I think it ought to be part of an integrated package as opposed to pulling it out singly.
MR. DRAKE: I think as part of the idea, we are trying to get some recommendations out on the table. There's still going to be further discussion, further fine-tuning.
I would not be opposed to amending the motion, Pete, that says we are going to have two response time requirements, life threatening and non-life threatening. Whether it's eight and 12 and nine and 13 or we can decide that later.
I think that is a component that's something John said, we would have to look at the level of first response and response time in the car first response before we actually make a response time requirement. But I agree there should be two requirements for life threatening and non-life threatening.



Would you agree to amend the motion, Pete?
MR. ROBEDEAU: I didn't make it. You did.
MR. SKEEN: Actually, I seconded it.
MR. ROBEDEAU: You withdraw. You withdraw. All in favor?
(Chorus of ayes.)
MR. ROBEDEAU: Opposed?
(No response.)
MR. ROBEDEAU: Okay. It carries.
MR. SKEEN: The only thing, I suggest we consider meeting the 28th.
MR. ROBEDEAU: I actually think you are right. 28th is Friday.
MR. LAUER: Bill is calling to see if the room is available.
MR. ANDREWS: I will pass it on.
MR. DRAKE: We can do that in the morning, Pete?
MR. SKEEN: Morning, afternoon.
MR. DRAKE: Nine to 11 again?
MR. SKEEN: I know that's Friday before the holidays.
MR. DRAKE: There's no holidays in the



ambulance business.
MR. THOMAS: It means right before your very busy period.
MR. ROBEDEAU: The 26th, the 28th, and the 2nd. Okay? We are adjourned.
(PROCEEDINGS ADJOURNED)
* * *
(NOTE: Untranscribed steno notes archived permanently on computer; transcribed English files archived three years on computer.)
* * *



CERTIFICATE

I, CAROL STUDENMUND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein; that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.
Witness my hand at Portland, Oregon, this 2nd day of June, 1993.

Certificate No. 90-0077

CSR 90-0077 CAROL STUDENMUND

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**In The Matter Of:**

*Before the Multnomah County*
*Provider Board*

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*Proceedings*
*May 26, 1993*

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BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD
TRANSCRIPT OF PROCEEDINGS
Wednesday, May 26, 1993
9:15 a.m.
Oregon Medical Association
5210 S.W. Corbett Avenue
Portland, Oregon
THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance
Mr. Randy Lauer, Buck Ambulance

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APPEARANCES
ALSO SPEAKING:
Mr. Christopher Thomas
Mr. Steve Moskowitz
Ms. Lynn Bonner

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PROCEEDINGS

**MR. ROBEDEAU:** Second paragraph, page 4. Something was wrong there. I remember Steinman stating that —

**MR. MOSKOWITZ:** And Mr. Skeen's recommendation.

**MR. ROBEDEAU:** Do you remember what that was?

**MR. MOSKOWITZ:** The recommendation is on the second-to-last paragraph on page 3.

**MR. DRAKE:** 12 percent is maximum acceptable level.

**MR. ROBEDEAU:** I think that's a little low. But we need to do that stuff.

**MR. DRAKE:** I've got a few things, too, Pete.

**MR. ROBEDEAU:** On page 3, second-to-last paragraph, fourth line up, it says, Mr. Collins pointed out that, here, too, there were no apparent standards. Mr. Skeen said the closest standards would be to measure the number of IVs or fibrillations. I think that should have been probably intubations, page 3,

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next-to-last paragraph.

**MR. DRAKE:** You sure this is page 3?

**MR. ROBEDEAU:** Yes. Says page 3 there. It says fibrillations.

**MR. LAUER:** Should be defibrillations.

**MR. ROBEDEAU:** I'm thinking that should be intubations. Intubations was talked about and intubations fits in there well.

**MR. DRAKE:** Instead of IVs?

**MR. ROBEDEAU:** No. It says IVs applied and fibrillations. I think it should be intubations.

**MR. DRAKE:** Okay.

**MR. ROBEDEAU:** Okay?

**MR. DRAKE:** Okay with me.

**MR. LAUER:** Works for me. Got a nod factor on that one.

**MR. ROBEDEAU:** Let's have a motion — wait a minute.

**MR. DRAKE:** It's Randy's turn to make the motion.

**MR. LAUER:** I move to approve the minutes.

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**MR. DRAKE:** Second.

**MR. ROBEDEAU:** Approved. Everybody approved?

(Vote taken.)

**MR. DRAKE:** Good minutes again.

**MR. ROBEDEAU:** I think what I'd like to do is go through this stuff, make some recommendations, and try to have a rough draft out by Friday.

**MR. LAUER:** Rough draft of an ASA plan?

**MR. ROBEDEAU:** Of the recommendations. I don't think we're going to do the ASA plan.

**MR. DRAKE:** Let's talk about that. I don't think it's necessary we duplicate an ASA plan. An actual ASA plan follows the format in the OARs. This whole outline, you have to put this information, the 9-1-1 district boundaries and all that stuff. We don't need to do that. What we're coming up with is an EMS plan that will contain all the ASA plan that's necessary. A lot of the ASA plan is information submitted. And Bill Collins has already done that in

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his ASA plan. That we don't have a problem with.

**MR. ROBEDEAU:** I think we —

**MR. DRAKE:** Describing the radio system, that's what the —

**MR. LAUER:** I agree with that, Mark. We ought to focus on — if we're using this document as a guide, this Provider Board recommendation column, to have the firm recommendations incorporated into the plan.

**MR. ROBEDEAU:** And making sure these are firm recommendations, I want a strong, from the Provider Board — this is what we've been kicking around for 15 years. These are the ones everybody has been dodging, keep coming back to. These are the ones that need fixing.

**MR. DRAKE:** I agree with that, Pete. I think we need to make some assumptions here, based on this. We're talking about these ASA plans, components, comparative analysis. I went through this the other day —

**MR. ROBEDEAU:** Certain things we're

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going to have to put down — everybody talks about clinical proficiency. Paramedics, nobody has once said what that proficiency should be. Before they can do an ASA plan, they need to define it, because that's been an issue for 15 years, but nobody has defined clinical proficiency of paramedics. They just say there's a lot of skill degradation. They never say how. It has to be defined.

**MR. DRAKE:** Pete, I think we have to make a recommendation from the Provider Board how to measure proficiency skills of paramedics. If we can come up with that, I agree with you. There's no data I'm aware of or any report that talks about it.

**MR. ROBEDEAU:** I think the burden — Steve, you've been with city government.

**MR. DRAKE:** Yeah.

**MR. MOSKOWITZ:** Okay. I'll admit it.

**MR. ROBEDEAU:** When the government comes up to make a change, because of a perceived problem, is there any requirement of them to prove the problem or prove the correction?

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**MR. MOSKOWITZ:** Well, when you're talking about their legislative capacity, they are supposed to come up with findings that substantiate the reasons for why they're doing what they're doing. It's not scrutinized in the same way as when they're acting in their quasi-judicial capacity and making some ruling that directly affects someone's legal rights. But they are supposed to have some kind of reasonable basis for whatever regulations they're adopting, and those are supposed to be founded in some kind of findings that they should adopt.

If I could just back up for a minute, because I had some thoughts after the last meeting, when there were a number of staff people who were there, all of whom I know from my background, and I think that they were looking for some kind of general education on this issue. And I think that a comment I got from one of them afterwards was the people around the table were talking about the wattage of the light bulbs, and we're trying to figure out what

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needs to be lighted up rather than what the wattage ought to be.

And so I think if you're going to come up with recommendations on all these specific points, which I think would be helpful to the county, and obviously is missing in terms of a whole systemwide plan, you should at least have some kind of introductory summary that gives some kind of big picture about, you know, why —

/hat [11] the big issue is, because I think t the [12] big-policy level, they're not oing to [13] spend a whole lot of time n a lot of these [14] small details.

5] The big issues obviously are, should 6] we allow fire to do what — some-hing [17] different than what they've een doing? [18] And what should we do bout the private [19] providers gener-lly? Those are the [20] big-scope issues hat they're going to be [21] dealing with.

22] I think you would want to have some 23] kind of — some kind of introductory 24] executive summary that explains hat this [25] new plan that's being pro-noted by EMS is

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1] based — says it's based on cost sav-ngs, [2] and that's in part what motivated his [3] board to look at it, to see if that vas [4] substantiated, and state what heir [5] conclusions were.

6] You can state what your conclusions 7] are about how there's so many miss-ng [8] details to such a plan, and then I hink [9] you ought to state what your osition is on [10] the big issues, if you an agree on what [11] that position ought to be in terms of the [12] role of he fire bureau and what the role [13] of he private providers ought to be. [14] Because otherwise I think they will kind of [15] dismiss all the level of detail that ou've [16] gotten into because it's just oo hard for [17] them.

18] And they'll just listen to what Bill [19] Collins will say, which will be a much [20] more, I think — maybe we'll find out [21] Tuesday from the briefing, but my guess is [22] it will be much more of a broad-brush [23] approach to the issue as will, my guess, [24] PAPA and the Medical Ad-visory Board. I [25] don't think they'll get into the level of

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1] detail that you have, which is part of the [2] problem, that they haven't paid attention [3] to those details.

[4] But on the other hand, in terms of [5] staff people to the commissioners' of-fices [6] trying to brief their commission-ers, [7] they're not going to have two hours to go [8] over with their bosses all these level of [9] details about what par-amedic skill [10] proficiency criteria ought to be. The [11] politicians are going to say, just tell me, [12] what's the hot stuff here that I need to [13] address.

[14] **MR. ROBEDEAU:** I guess part of that's [15] what I'm talking about. Maybe you're [16] talking about doing the bigger picture, the [17] whole picture, that this has been going on [18] for years. These are the things that are [19] always identi-fied, but none of them have [20] been articulated. They're identified as [21] problems, but nobody's ever come up with a [22] standard to measure them by. They just [23] continue to be problems.

[24] **MR. LAUER:** I think those are — you [25] really get into the details that Steve was

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[1] talking about, most of the commis-sioners [2] and the staff, and are they going to have [3] the time to learn or the time to discuss. [4] I agree with Steve.

[5] I think what we should do is approach [6] this from a real broad perspective and to [7] say, to look at system designs and to say [8] just in general terms what we think the [9] system will do as opposed to what our [10] system does now. And is it moving in the [11] direction we per-ceived, the desire to move [12] in the opposite direction.

[13] (Mr. Thomas and Ms. Bonner [14] en-tered the room.)

[15] **MR. DRAKE:** What we're talking about, [16] Chris and Lynn, is how we should make the [17] presentations to the County Commissioners. [18] Steve was filling us in on making sure we [19] talk about the key issues and [20] recommen-dations and how we presented those [21] to the commissioners so they can under-stand [22] them, rather than talking — he was saying [23] at the last meeting, we talked quite a bit [24] about detail and we kind of lost the people [25] over there at the commissioners' office.

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[1] Is that a fair summation? [2] And I agree with what you're saying. [3] I think part of what our frustration has [4] been in the past years has been that people [5] come out and say things without any [6] sup-porting data, without any supporting [7] information, without any clear-cut [8] in-formation that really would lead them to [9] that conclusion.

[10] And part of the process which I have [11] enjoyed here is, it gives us an oppor-tunity [12] to question other people and talk to people [13] and say, where did you get those numbers? [14] How did you get those numbers? What are [15] you basing those numbers on?

[16] And that discussion needs to take [17] place among the Provider Board. And then [18] when we make the recommen-dation to the [19] County Commissioners, we say, here's the [20] recommendation, here's some reasons why, [21] and if someone questions it and says, where [22] did you get that reason, we say, we've got [23] supporting data back here.

[24] **MR. MOSKOWITZ:** As someone who is [25] newer to this process than anyone else here

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[1] and also spent some years in a politi-cal [2] office, the issue that struck me most was [3] the whole issue about the number of hours [4] that would be saved and the point that the [5] Provider Board raised in terms of, those [6] are not hours that are going to be saved; [7] they're going to be shifted to somewhere [8] else inside the system.

[9] And that's something that the county [10] board should understand so that they can [11] make a decision and say, "Well, okay. We [12] understand that those are going to be hours [13] that are shifted, but we don't care. We're [14] making this decision anyway," rather than [15] acting under the assumption that someone [16] could make from just reading the EMS [17] reports, oh, look, if we do this, we can [18] save our constit-uents this number of hours [19] from ambulance services —

[20] **MR. ROBEDEAU:** And how do you put [21] that? Part of the problem with the EMS [22] report, it assumes you'll save 39,000 [23] hours, but it also changes the [24] response-time standards. When you change [25] response-time standards in the current

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[1] system, how many hours are you going to [2] save?

[3] **MR. DRAKE:** That is something we need [4] to look at, the assumptions, what we can [5] change, what we can't change, and if you do [6] change some-thing, what does that mean. [7] There are several assumptions I think we [8] have to make as we go through these [9] com-parisons, what we talked about last [10] time. We started getting off — I asked, [11] Trace, where did you get these 9-1-1 unit [12] hours, where did you get that number, where [13] did you pull that number from?

[14] One of the assumptions we have to make [15] is the number of unit hours for the fire [16] service remains the same, under any model. [17] They have fire units, and they're going to [18] be there under any model as a fire first [19] re-sponder. In other words, they have 33 [20] engine companies. They're going to have 33 [21] engine companies under any model. That's [22] not going to change.

[23] The role of the fire bureau between [24] automatic defibrillator service they [25] provide to ALS and engine service they

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[1] provide doesn't make any difference under [2] any models because they can do that [3] irrespective of a model.

[4] The first response is something [5] totally separate. It's something we need [6] to look at. We need to point out there's a [7] cost associated with that. If they upgrade [8] all the ALS engines, there's a cost. [9] There's a cost to the system. But

that's not something we can use in the comparisons to the different models, because they can go to the ALS engine company today, or they can go to an all-defibrillator company today.

**MR. LAUER:** I think we ought to make a statement today about what we think as a provider the optimum first response system ought to be.

**MR. DRAKE:** I agree with that. I think we ought — if we make it auto defibrillators, you can go to the ALS engines, here's what it's going to cost. Here's what's going to be added into the system.

**MR. LAUER:** I don't think, Mark, we

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can assume what that cost is going to be. We can assume it's going to be additional cost to the city primarily to assume that additional cost.

**MR. DRAKE:** All right. That's what I'm saying. There is a cost associated with it. We can estimate what the cost is for auto defibs. If they own none today, we know they went out and purchased three auto defibs, approximately $5,000 apiece, let's say, here's what the estimated cost will be for the auto defibs.

The second thing we have to assume for all models, the total call model for the county is not a variable we can affect. That's the same no matter what you do. There's so many patients transported every year. There's so many responses we go on every year. We can't change that. So what are the variables we can control or change?

We can control the unit-hour utilization. Agreed? We can do that. We can try to make the system more efficient or less efficient. And that is a variable

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that affects the cost a lot. If you have unit-hour utilization of .3 as opposed to .2, at .3 you're a lot more efficient and you're going to have less cost, takes you less unit hours.

But for a comparison between the models, we must assume that the unit-hour utilization figure is the same for each model. Use that as a constant. Say, let's pick a number. .3 unit-hour utilization for transport, or .2, .25, whatever that is. That will be a constant that we use as a comparison between the models.

**MR. LAUER:** I don't think you can make that assumption, though, because I don't think unit-hour utilization would be constant.

**MR. DRAKE:** For the privates, not for the fire. The fire is another variable. The fire — there's a couple other assumptions. Let me finish with the assumptions and maybe that will help out.

We can assume that the staffing levels will vary among the plans two-fours or one-fours. That's a variable. Agreed?

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Everyone, depending what plan you look at, they call for different staffing levels.

Response-time requirements are a constant. There is a variance in the plan, but the response-time zones are constant. We must assume there will be response time zones in the plans because that's what it wants to do. We have to assume there are 12-hour shifts for privates, like Trace did, and 24-hour shifts for fire bureau. That's why the unit-hour utilization is a variable under the fire department, because their unit-hour production is the same. We're not going to vary that. If they put out six units and six units in 24 hours, if they put out seven units, it's seven units in 24 hours. If they put out eight units, it's eight units in 24 hours a day. There's no variable. We vary it on what the demand is.

So, obviously, the more units the fire bureau puts on, assuming the number of patients they transport will be a constant somewhere, no matter whatever that constant is, that X number, then the unit-hour

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utilization will change.

**MR. LAUER:** You're talking a tiered system?

**MR. DRAKE:** Right. So we have to set a number under the tiered response system, and say, this is the number of units that they have. Therefore, this is the number of unit hours they have. This is the estimated number of patients they'll transport. Therefore, that's their unit-hour utilization. But for the privates doing a comparison —

**MR. LAUER:** Wait a minute, Mark. I don't know we can do that because no one has come forward with a plan and said, this is what the operation model of a tiered system will look like. We have no idea.

**MR. DRAKE:** We need to do that as part of the process. We need to do that as part of the process, Randy. I'm saying, to do a comparison — what you've got here under No. 5, under current system you've got .25, you've got .35 under tiered response, and .28 under dual integrated. I'm assuming that's for the private. I think

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that number needs to be a constant across there for comparison purposes because by varying that number, you can vary the number of total unit hours in the system and thereby vary the cost.

**MR. ROBEDEAU:** I don't think so. I think we're getting off the picture on what Steve was saying to do this morning, stay on the broader picture. You're trying to get into specifics. We need to make the statement and give the specifics as backup. But what you have is, you have to compare to what is, I think, currently existing, Mark.

**MR. DRAKE:** No.

**MR. ROBEDEAU:** Wait. Let me finish. Okay?

You have Collins coming out and saying you can save 39,000 unit hours. That's a crock of horse. You know that; Collins knows that. What we have to do is say, no, you're not going to do that. Collins has taken and changed the entire system and then come out and said, you're going to have this big savings. Collins knows it's

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a bunch of crap. I don't think the County Commissioners know it's a bunch of crap.

**MR. THOMAS:** That's only half of a response. I don't think the providers, the position any of them have, can simply say, no, he's wrong. Then you have to say, what is right?

**MR. ROBEDEAU:** We're going to have to say, no, he's wrong, here is what is going to happen. You're going to have two deals. Collins has come out with a different response time, Chris, and you add 50 percent to your response time, that extra four minutes, you can cut a lot of hours out of this system by doing telephone triage at Kelly Butte. The problem is how do you —

**MR. THOMAS:** What I'm saying, we can take apart his saying, which I think we have to do. But I'm saying, I think just opposing something won't fly. There's got to be an affirmative thing for which you have to supply the same kind of —

**MR. ROBEDEAU:** I understand that. Then you have to show he's added 50

Page 23

percent. You show under the current system, No. 1, if you eliminate 50 percent of the paramedics, which the Collins plan calls to do, right off the

at, and you [5] eliminate about 40 per-ent of your actual [6] response time, ou're probably going to [7] come up vith somewhere around 20,000 or [8] 0,000 unit hours that are savable, and 9] you're going to come up with that [10] quivalence in salaries saved.

11] That's what has to be pointed out: [12] ny savings he's deriving is being de-ived [13] from changing the system that ould have [14] been changed in its cur-ent form a year ago [15] to see how it vould come out. If we could [16] go to ne paramedic and 12-minute response 17] times on non-life-threatening calls, vhich [18] is going to be somewhere round 90 percent [19] of the calls that re run out there, you're [20] saving an wful lot. You know, I think you [21] ould go through and eliminate one car ut [22] of every company right off the at.

23] **MR. LAUER:** I think the issue is [24] eally much simpler. I think that — this 25] is my opinion, but I think that

Page 24

1] efficiencies are gained when you rase [2] lines. What I mean by that, lines, vhen [3] there's a line, whether it be lrawn on a [4] map, or the line between vhat kind of calls [5] a unit can respond o, I think what that [6] line does is it estricts a unit from being [7] able to espond. What that does is, it [8] means here's more units necessary to [9] re-pond to all the calls.

10] I would like to see the Provider oard [11] come out with a very simple tatement that [12] anybody can under-tand, is that we ought to [13] design the ystem that has no lines. That [14] doesn't nean a single provider; that means [15] o restrictions on response.

16] So if it means one ASA, doesn't matter 17] how many providers are responding, s long [18] as they all respond to all the alls. [19] That's been one of the biggest ssues, one [20] of the biggest criticisms f this system, [21] is that the closest unit s not allowed to [22] respond. And that's vhere some of the [23] inefficiencies in he system come from.

24] I would like to approach it from that 25] perspective. I think that's very sim-le.

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1] I think that any — the layperson can 2] understand that because it's not spe-ific [3] to EMS. That would be logic that an be [4] applied to almost any industry.

5] **MR. THOMAS:** I think everybody grees [6] that the closest unit should be 7] dispatched. There may be issues bout how [8] you — what your system tatus magnum plan [9] is and where the nits are placed in [10] varying situations, vhich could be worked [11] out, but I think everybody agrees with the [12] idea that there are at least — there needs [13] to be enough permeability flow around, that [14] the closest unit is responding. I think [15] everybody has figured that's a must. Then [16] it becomes a question of where you stage [17] your units.

[18] **MR. LAUER:** We look at different [19] system models and forget to compare it to [20] that, something that's easily [21] understandable and a goal most people can [22] agree on. You might end up creating a [23] monster that moves in the other direction. [24] And we need to be real careful about that.

[25] **MR. ROBEDEAU:** We've created a

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[1] monster. I won't say we haven't taken any [2] credit for this thing here, but the monster [3] is here. The question is, how do you get [4] the monster put back in its bottle?

[5] You know, all of this stuff — I kind [6] of agree with what Steve said about [7] painting a broad picture, but I also think [8] part of that broad picture needs to itemize [9] all of these things that have been [10] articulated. One of the things that got me [11] a little riled last time is you have — [12] what's his name? Warren Andrews?

[13] **MR. MOSKOWITZ:** Jerry Andrews?

[14] **MR. ROBEDEAU:** Jerry Andrews, that's [15] it. — sitting here, and when I suggested [16] telephone triage be at Kelly Butte to [17] determine life-threatening and [18] non-life-threatening emergencies, he got [19] all jacked out of shape. He said, we've [20] got committees for that.

[21] Christ, we've got more committees than [22] Carter's got pills.

[23] **MR. LAUER:** I think we get hung up [24] when we talk about system changes. [25] Telephone triage is a change within the

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[1] system. What I'd really like to do is to [2] say, this is what a system should look [3] like. Should be a complete, integrated [4] system throughout the county, one ASA, [5] whoever responds, and then look at the [6] current system that says — and analyze [7] it. It doesn't accomplish that goal [8] because, and look at the tiered system and [9] say, it doesn't accomplish that goal [10] because, and look at all the different [11] models, and then come back — because we [12] have to provide a solution and say, this [13] would hold true to that goal.

[14] **MR. THOMAS:** Here's the problem, [15] though, I think you're dealing with, [16] because I think you have to think about the [17] fire bureau and how it relates to this. [18] Some of this I think is impacted by the [19] added scrutiny that Ballot Measure 5 has [20] gone to the city spending money. The city [21] is spending money on the fire bureau.

[22] There has been strong suggestions in [23] the past that the city ought to look at [24] downsizing the fire bureau. I think [25] there's a political reality related to

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[1] that, which is that's extremely unlikely to [2] occur, just as a practical, pragmatic [3] matter. So the city's got the fire bureau [4] sitting there now, and apparently apart [5] from equipment, with little or no [6] additional personnel cost, can produce some [7] level of transport.

[8] So the incremental cost to doing the [9] transport is — some transport is low. [10] There's a point at which if they didn't, it [11] would start becoming high. But the [12] incremental cost is low. If you wanted to [13] do a cost center accounting purpose where [14] you're allocating cost across all the [15] things equally to everything else, you can [16] say, the cost of doing that is high.

[17] But if that were the first thing you [18] were doing as opposed to the increment you [19] were adding, the reality is, they're [20] probably not adding a lot of cost for some [21] level of transport. At least I think [22] that's the case. And, if they charge for [23] that, there's a potential to generate some [24] revenue.

[25] And so for them, it's a low-cost,

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[1] relatively high-revenue operation to get [2] into some level of transport. And I think [3] it's going to be very difficult to ignore [4] that or to convince somebody else they [5] ought to.

[6] Now, you could say, if you allocate [7] cost properly in their system and not do an [8] incremental costing or an average costing [9] basis, whatever you call it, for accounting [10] purposes and maybe budgeting purposes, the [11] way they would budget their cost centers, [12] you would say that is resulting in a system [13] that is more costly exactly because what [14] you're talking about, you've drawn a line [15] between what they're going to carry and [16] what the privates are going to carry.

[17] But from their perspective, the costs [18] we say they're adding to the system because [19] of fire are costs they wouldn't even count [20] according to one approach. And I think [21] that's the difficult part of dealing with [22] this issue with the fire bureau. And I [23] think there's — whereas — it's the same [24] argument that came up, wherever it was, [25] five or ten years ago when fire was trying

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to get into this and they were convinced that it wasn't fair to do it on an incremental cost basis. At least that was a part of it. I don't know what else all was involved.

I think now with Ballot Measure 5 having come in, it is much harder to get them to swallow that argument when they can see additional revenues. I just don't know how — to me, that's the tricky part of this, is you may say it's more costly. To them, they look at it and say, it's not, actually. Even if it's more inert, it's not more costly.

**MR. LAUER:** Fire department's costing methodology is ultimately going to be resolved in the courts I'm sure. Until that happens, it's very clear: They have seven rescue units. If those seven rescue units, whatever they do now, if they're going to be transport units, that's what they're going to do. That's all they're going to do. And they're going to — on 24-hour shifts, they are not going to survive in that model very long.

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Anybody that's worked in the system can tell you right now that seven units responding to the critical calls throughout the county on 24-hour shifts, you are going to have some very upset firemen who are not going to want to do that. And the fire bureau — let's face facts, the fire bureau is either going to add more 24-hour units, which is what I would say they're going to do, because taking people off the 24-hour shifts is not going to be a very palatable option, or they're going to 12-hour shifts, which I don't see as happening.

So we're going to put something in place that can not change. Once it's in place, it will be there unless there's a major crisis. We'll start heading toward that crisis from day one. They will be full-costed because that is all they will be doing. They will not be responding to fire. They will not be doing any attack on fire. They will be EMS-dedicated 100 percent, period.

We've also drawn lines. We've got these other ambulances out there that are

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going to be all around them that are not going to be able to respond to calls. The bottom line is that the people out there, the people we ought to be thinking about, who call 9-1-1, are not getting a good deal. And that's a fact.

**MR. ROBEDEAU:** Well, that's — you get Steinman in here and argue that, and he would say it's a fact the other way.

**MR. LAUER:** Someone is getting a good deal. It's the fire bureau.

**MR. DRAKE:** Also the citizens, if their rates are lower.

I want to address one thing you said, Randy. You said we're headed towards a crisis for this and the crews won't stand it. One thing we do know, because we know — we can assume the number of calls they're going to run. We'll pick a number, whatever that number is, based on information that we can get on the number of critical calls running the county, the number of promises, the number of cardiac arrests around the county. We'll come up with some number they'll run on.

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You can address that whatever way you want to. We can come up with the unit-hour utilization figure. The unit Trace came up with is .05.

**MR. LAUER:** Transport utilization. That's because we're going to be off responding to another call. Their workload, Mark — and you know "unit" is not an accurate workload. Their workload is going to be extremely high.

**MR. DRAKE:** But there is some number we can come up with for response utilization. There is a number we can come up with.

The second thing I'd like to respond to is, you say we're headed towards a crisis. Seattle has been doing this for 15 years. They haven't reached a crisis. They have people that love working the 24-hour shifts, working the fire and medic units. So it's not —

**MR. LAUER:** This is not Seattle.

**MR. DRAKE:** No, it's not Seattle.

**MR. LAUER:** It's not everybody in the same structure. They're a tax-supported

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system. Their citizenry — the argument — here's a good argument. People in Seattle are upset because the fire department there wants to start charging for ambulance service. In Portland, the attitude is completely different. Portland people have a different — Oregonians have a different view on taxation than the people living in Seattle and King County do. They're not the same. You can't look at them and say, they do it in Seattle, so we can do it in Portland. That's not a valid conclusion.

**MR. DRAKE:** No. The issue, Randy, has nothing to do with taxes, nothing to do with rates charged. The issue you said was the techs, the paramedics and fire units. They'll get tired. They'll get burned out. We're heading towards a crisis. I assume you meant because these paramedics are going to be working on 24-hour shifts, they're transporting, going to have to go to 12-hour shifts. That's what you said.

What I was relating, the fire system in Seattle was working 24-hour shifts.

**MR. LAUER:** Let me ask you a

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question. They get ten calls in a period of time. When they use up their units, what happens?

**MR. DRAKE:** They call in backup units to transport patients from the private service.

**MR. LAUER:** How often? Seattle is a leveled system. They run until they can't run it anymore and then someone else does it. That focus is different than Portland. Portland has a response-time standard with a reliability component to it. That's a completely different deal. If the Seattle fire bureau is expected to respond to all of the calls eight minutes 90 percent of the time, they couldn't do that.

**MR. DRAKE:** Do you know that?

**MR. LAUER:** Yes. Their system is a level-of-effort system. They respond with their units until they're gone. When they're gone, someone else responds. It's basically no different than taking the phone off the hook.

**MR. DRAKE:** What we're talking about,

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you're not talking about an exact Seattle model —

**MR. LAUER:** All I'm saying, when you compare Portland to Seattle, you need to understand the difference. There are some very key differences.

**MR. DRAKE:** There is. One of the key differences is they have BLS units. We'll have paramedic units as backup to the fire department. A big difference. When they run out of units, a paramedic unit is going to respond to back them up, not a BLS unit. That's a big difference. We will have private units responding. I think part —

**MR. LAUER:** You think we'll run out of units, at seven?

**MR. DRAKE:** Possibly.

**MR. LAUER:** How often a day do you think that will happen?

**MR. DRAKE:** I don't know, Randy.

**MR. LAUER:** Does it make sense to create a system where you know

ou're going [24] to run out of units and ave to have that [25] contingency ackup? That makes no sense.

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[1] Let's not talk about the peripherals.

[2] **MR. ROBEDEAU:** Properly utilized, I [3] don't think you will of run out if you alk [4] about tiered response and proper riage. [5] When you get right down to even [6] life-threatening emergencies re happening [7] any one time in Multnomah County, that's [8] not true. It's not rue now. And it's [9] never happened. hat's one of the reasons [10] that we're ere right now, we've been here [11] for 0 years. This whole system was set up [12] to be a gold-plated system, and, you now, [13] damn the torpedoes, full peed ahead. Who [14] cares what it costs. hat's the direction [15] we were given.

[16] And everything all along the way has [17] gone along with this gold-plated system. [18] There aren't seven life-threatening [19] emergencies. You're going to be 9 percent [20] on the phone in determining the life [21] threatening versus a on-life-threatening [22] emergency. And f it's a 12-minute [23] response with a elephone triage [24] life-threatening mergency that's triaged [25] out as a on-life-threatening emergency,

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[1] you're still going to have a paramedic [2] response.

[3] **MR. LAUER:** Who's going to have nore [4] response, private or public?

[5] **MR. ROBEDEAU:** Private.

[6] **MR. LAUER:** If you have more private [7] units than fire units, wouldn't it make [8] sense that the odds are the private is nore [9] available than the fire medic is going to [10] be? And how do you defend not sending that [11] ambulance?

[12] **MR. DRAKE:** I'm not.

[13] **MR. LAUER:** It's a bad system.

[14] **MR. DRAKE:** Randy, you're making [15] assumptions about a system that lon't [16] exist. You're making assumptions that this [17] is how the system will perate. What we [18] are here to do is to make recommendations [19] of how it should work. You're saying, we [20] don't end a private ambulance. I never [21] said we weren't going to do that. Why not [22] say as a recommendation, if ou're going to [23] do the tiered response, this is how you [24] should dispatch the units, whatever that [25] is.

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[1] **MR. ROBEDEAU:** The other half of [2] hat —

[3] **MR. DRAKE:** I think that's what our [4] role is.

[5] **MR. ROBEDEAU:** If you're going to alk [6] about a system that is going to work right [7] and is going to be responsible — Steve is [8] getting —

[9] **MR. MOSKOWITZ:** It's okay.

[10] **MR. ROBEDEAU:** — is going to be [11] fiscally responsible to the people it's [12] serving, you're not going to send that [13] crew; you're going to send the first [14] responder just like you do, and you're [15] going to send, for lack of a better term, [16] medic unit, and the first responder is [17] going to tell you if they even need to [18] continue.

[19] How many cancels could we have now if [20] the first responders were being sent two [21] minutes ahead and allowed two minutes to [22] just triage the scene? We're doing 35 [23] percent no patients in this system.

[24] How many unit hours, Randy, does it [25] take in this system just to respond to

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[1] phony calls? 39,000 a year?

[2] I wouldn't doubt that we spend 39,000 [3] a year in unit hours just to respond [4] because this system says that we'll respond [5] to everything regardless and who cares what [6] it costs, because, after all, the insurance [7] companies are paying it anyway. That's how [8] this — that's how this system is still [9] operating with that kind of 1970's [10] mentality that was no good in the '70s and [11] it sure as hell is no good in the '90s.

[12] **MR. LAUER:** I don't disagree with [13] that, Pete.

[14] **MR. ROBEDEAU:** My god.

[15] **MR. LAUER:** If you're saying we're [16] going to have to change the way calls are [17] dispatched and manage whether or not it is [18] telephone triage or on-scene triage, let's [19] look at that and then look at the different [20] models in the ASA plan and measure those [21] against that. The assumptions we're making [22] is the tiered system, if we make these [23] other changes it will fly. But what we're [24] not doing is saying, what would our current [25] system look like if we made these other

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[1] changes? We can do better.

[2] **MR. ROBEDEAU:** It would be [3] dramatically different and probably a lot [4] less expensive.

[5] **MR. THOMAS:** I think you need to do a [6] couple of things because, No. 1, you need [7] to do your projections. And I think [8] Steve's right, at least the unit-hour thing [9] is something they can grasp because it's a [10] fairly gross concept. But maybe basically [11] based on that. But you need to do a review [12] of a number of different alternatives and [13] what the cost of them is, to whatever.

[14] I think that's correct, and I think [15] one of them is maybe the exact current [16] setup of these modifications to it, and [17] here's what it would cost. One would be [18] tiered response. Here's what it would [19] cost. Another would be single tiered [20] response, single provider, single tiered [21] response dual provider, single provider [22] integrated, whatever those are. Here's [23] what they look like.

[24] As I understood Mark earlier, you've [25] got to make some common assumptions to all

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[1] of them so you're comparing apples to [2] apples, as best you can. So I think that's [3] one set of functions this board can perform [4] for the commissioners, and we have to be — [5] I think we have to have something in [6] writing which gives a fair amount of [7] detail, but we have to be careful the oral [8] presentation is not so overwhelming they're [9] lost in the first two or three minutes.

[10] Then I think the second issue is what [11] the Provider Board wants to recommend, and [12] it, if anything, has been made clear to me [13] over the course of all of the meetings, I [14] suppose something we all sort of knew ahead [15] of time, was that there are at least two [16] different positions on that. And I think [17] you can have one set of — the people on [18] the board can recommend one and people on [19] the board can recommend another.

[20] I don't think you're going to have a [21] very satisfying time yourselves if you try [22] to convince each other that they ought to [23] support your position or that you ought to [24] support theirs because I don't see that [25] happening, frankly, and I sort of hate to

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[1] see you trying to sit here trying to [2] convince each other, trying to support the [3] other side's position.

[4] **MR. ROBEDEAU:** That was one of the [5] reasons why we decided early on to have a [6] minority and majority report.

[7] **MR. THOMAS:** At least have the [8] opportunity. I do think something the [9] board could do is provide them a report on [10] the array and what the implications are. [11] And I think the kind of thing that Trace [12] did, and I know Mark's working on something [13] like that, begins to give some feel for, [14] you know, this one puts you here, this one [15] puts you here. You begin to see that some [16] of them, there's not very much difference; [17] some of them there's quite a bit of [18] difference. And I think that's where you [19] get into them being able to make [20] judgments.

[21] I suppose my comments about the fire [22] bureau more were along the line

of trying [23] to analyze where — what they're likely to [24] look at and they're likely to say, unless [25] there's a huge difference in some area,

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[1] that's something they might be interested [2] in wanting to do for their own reasons. [3] That's more of a political observation. I [4] think you guys don't have to persuade each [5] other on that as much as I think, what [6] would be nice, if the board were in [7] agreement on, were sort of the numbers that [8] are assigned to the different options, or [9] at least you're as close as you can be on [10] those.

[11] **MR. LAUER:** What you're saying, Chris, [12] is we really ought to — we're really [13] wasting our time when we talk about the [14] different provider options, because I think [15] you're right, we're not going to reach a [16] consensus position.

[17] **MR. THOMAS:** You shouldn't argue back [18] and forth, that's right, about reaching the [19] best one. You've each decided what's the [20] best one, and they're reasonable [21] positions.

[22] **MR. LAUER:** In my mind, there are two [23] components to an ASA plan. One is how the [24] system works, and the second one is who [25] provides the response. And if we focus how

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[1] the system is set up, things like dispatch, [2] scene cancellations and et cetera, I think [3] we probably have some common ground. But I [4] think we need to not touch the provider [5] part of that as we do that or we're never [6] going to, I think, progress.

[7] **MR. THOMAS:** I think you could analyze [8] what the different provider options, what [9] you think the costs are going to be of [10] those different ones. But I do think it's [11] productive for you to say, these are the [12] things that ought to be in whatever the [13] system is —

[14] **MR. DRAKE:** Right. I think we [15] really —

[16] **MR. THOMAS:** — as a first step [17] maybe.

[18] **MR. DRAKE:** It really gets down to [19] real basic level too, because what we're [20] really looking at in front of the [21] commissioners is, there's service levels [22] and there's cost. And the motivating [23] factor behind the commissioners is to [24] somehow reduce the cost to the consumer. [25] That's what their motivating factor is.

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[1] It's not to reduce the service levels [2] because people think the service levels are [3] pretty good, although the medical community [4] is saying, they want improvement in the [5] services in the medical care. They see [6] room for improvement.

[7] **MR. ROBEDEAU:** But they don't have any [8] way to measure that improvement.

[9] **MR. DRAKE:** I'm not saying.

[10] **MR. ROBEDEAU:** I think that needs to [11] be pointed out.

[12] **MR. DRAKE:** What I'm talking about is, [13] what's driving this process? It's driving [14] the process from the political scene, the [15] County Commissioners are, reduce the cost [16] to the consumer. The driving force in the [17] medical community is somehow increasing [18] that level of care, whatever that level of [19] care is, whatever much they can increase [20] it. Is there any other things that are [21] driving this?

[22] **MR. LAUER:** Yes.

[23] **MR. THOMAS:** The desire to get it [24] done.

[25] **MR. DRAKE:** What else is driving it

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[1] besides those two factors?

[2] **MR. LAUER:** Provider competition. And [3] that's what's driving this thing more than [4] anything, is who is going to be the players [5] in the system.

[6] **MR. MOSKOWITZ:** That's not what's [7] driving the county to make its decision.

[8] **MR. DRAKE:** No. That's what I'm [9] asking. What is driving the county to [10] change? What is motivating the county to [11] make a exchange? It's to reduce the cost [12] to the consumer. They're being told they [13] can reduce the cost by changing the system [14] to X, Y, or Z. Is that a fair assumption?

[15] **MR. MOSKOWITZ:** That's certainly the [16] rationale behind the EMS report.

[17] **MR. DRAKE:** Right. In the medical [18] community, the rationale they want to see [19] change is to increase the level of service [20] they see is being delivered in the field. [21] Whether it's bad or good, they're saying [22] it's okay, but we can do better. That was [23] the assumption I got from here. Is that [24] it?

[25] **MR. THOMAS:** From them, I think that's

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[1] the case. I'd say there's a lot of [2] personal history, and it's driving people, [3] too.

[4] **MR. DRAKE:** Right. Individually, [5] people —

[6] **MR. THOMAS:** Has nothing to do with [7] any of the merits. It's power plays.

[8] **MR. LAUER:** I think the commissioners [9] are primarily driven by the conflict that's [10] existed in this system for so long and they [11] want to come up with a system —

[12] **MR. THOMAS:** Right. That's why I was [13] saying, getting it over with is also a [14] driving factor.

[15] **MR. LAUER:** If it ends up costing [16] less, it's a bonus.

[17] **MR. DRAKE:** So there are ways we can [18] do that. When we focus on making this [19] message to the County Commissioners, we're [20] going to have to focus on the fact, this is [21] what we're trying to do, reduce cost, and [22] this is how we can reduce costs in the [23] system, and this is how we can either [24] maintain the service level we're providing [25] to reduce that cost or we can increase that

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[1] service level.

[2] That is the chief kind of tension [3] here, is that you can drive costs down a [4] lot and decrease your level of service. [5] Right? We all know that. So what we're [6] trying to do is lower the cost and keep the [7] level of service the same or increase it.

[8] **MR. LAUER:** I need you to clarify [9] cost.

[10] **MR. DRAKE:** Cost to the consumer.

[11] **MR. LAUER:** So you're talking about [12] price, not actual cost.

[13] **MR. DRAKE:** We're talking about the [14] price, that they pay. That's what's [15] motivating the commissioners.

[16] **MR. ROBEDEAU:** You're talking about [17] rates, not cost.

[18] **MR. DRAKE:** Right.

[19] **MR. LAUER:** I would disagree. I don't [20] think that's the primary issue. I think [21] that's the whole other side of the issue, [22] and it's the cost.

[23] **MR. DRAKE:** It's not my issue. It may [24] not be your issue. What I'm saying, it's [25] the commissioners' issue. The

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[1] commissioners are concerned about the rates [2] that their constituency is paying for the [3] service that they're getting. That's the [4] complaints they hear. You don't want to [5] have a constituent calling up and saying, [6] gosh, the cost per capita went up from [7] $12.13 to 14 dollars —

[8] **MR. LAUER:** I don't think that's [9] accurate anymore. I think the Fitch report [10] may have kicked this thing off at least at [11] one time because of the rate study. I [12] think in Bill's plan it says there are not [13] a lot of complaints about the rates. I [14] think you've said that, that those — the [15] complaints have gone away.

[16] **MR. DRAKE:** I agree. I don't think [17] rate complaints are a big issue. I'm [18]

saying, what are motivating the County [19] Commissioners.

[20] **MR. LAUER:** You said they're getting [21] calls complaining the rates are too high.

[22] **MR. DRAKE:** That's right.

[23] **MR. LAUER:** If they're getting calls [24] complaining the rates are too high and yet [25] the rates are not the issues —

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[1] **MR. THOMAS:** I think it's a little [2] more sophisticated than getting calls. I [3] think — I know Gary Oxman feels this way, [4] and I am sure this is part of his [5] conditioning the minds of the County [6] Commissioners, is that cost control — [7] let's forget about rates for the moment — [8] cost control in the health care area is an [9] issue which is upon us and he perceives is [10] going to be with us for the long-term [11] future, and I think he recognizes that we [12] cannot constantly be increasing the cost of [13] the system that we have by adding this [14] thing and that thing and the other thing.

[15] So I think that is — in that sense, [16] cost is probably correct. Now, the way it [17] comes back in to them, one way is through [18] people who complain about rates.

[19] **MR. DRAKE:** Right.

[20] **MR. THOMAS:** I think the other place [21] it comes back to him, and maybe more [22] severely really, is the realization that as [23] you move to more Kaiser-like health care [24] plans, that the pressure is going to become [25] more and more intense to contain costs in

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[1] that sense.

[2] The reason I was talking about the [3] fire bureau at the beginning is, I don't [4] actually think they think about the current [5] budget of the fire bureau to the extent it [6] can absorb cost as being costs in that [7] sense. And I was saying, I think that's [8] something to be aware of. But I think in [9] that sense you're right. It's sort of — [10] the cost and how the cost is going to be [11] reimbursed to the providers and the [12] question of whether they — the system is [13] going to be able to keep reimbursing that [14] cost is a real concern Gary has. I think [15] Mark and I had a discussion with him, and [16] he almost said it was an article of [17] religious faith for him that that was [18] something that really had to be tended to.

[19] **MR. DRAKE:** It's the cost, and the [20] costs do affect the rates charged to the [21] consumers.

[22] What I was relating, I agree we're not [23] receiving very many rates complaints. And [24] that's been one of our complaints for [25] years, is the EMS office hasn't actually

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[1] been receiving any rates complaints. The [2] commissioners, however, are telling me they [3] do receive rate complaints. How many, I [4] don't know. There's no way to quantify it [5] probably.

[6] How many people live in their district [7] and how many people get transported as to [8] how many people complain, I don't think [9] they care about that either. I think they [10] do care if the costs are rising. I do [11] think they want to contain costs. I think [12] they're concerned about the rates charged [13] to their consumers, whatever those rates [14] are.

[15] Maybe it's not motivated generally by [16] complaints, but certainly it's motivated by [17] they want to make sure their people are [18] paying a fair price for the service they're [19] getting, for lack of a better term.

[20] With that, do we need to take a [21] break?

[22] **MR. ROBEDEAU:** I do.

[23] (Recess.)

[24] **MR. THOMAS:** Can I make a suggestion [25] here?

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[1] It seems to me, a good first thing to [2] do right now would be to identify those [3] things you all can agree on which you think [4] all to be a part of any provider system. [5] Whoever is doing the work, these are [6] elements that ought to be any of them, if [7] there are changes that you want to [8] recommend from what we have now. I mean, [9] that's sort of an area I think you can [10] agree on. And then you can sort of go from [11] there after that, because it seems to me [12] that would be a good first step.

[13] **MR. ROBEDEAU:** I would tend to agree. [14] I've written some things down as we've been [15] talking this morning.

[16] **MR. LAUER:** Well, one thing, I don't [17] know if you guys are with me or not, but [18] one of the problems with the system they [19] have now is there are too many responders [20] going to a scene. Is that fair statement?

[21] **MR. DRAKE:** I think that's fair, [22] Randy.

[23] **MR. LAUER:** Is it fair to say, the [24] reason there are too many responders going [25] to a scene is that there are too many kinds

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[1] of responders?

[2] **MR. DRAKE:** I think that's a fair [3] assumption. I think we need to look at — [4] what about doing this, as a suggestion: [5] You're aware — the federal government came [6] out with all the system components in an [7] EMS system, and ACEP has taken another look [8] at that and rearranged that. I think as a [9] simplified version we can look at the [10] system components of system access, triage, [11] through the telephone system or 9-1-1 [12] system, the system response, is what you're [13] talking about, is broad based, how the [14] system responds; the subsequent treatment [15] and transportation and/or transportation of [16] the patient; and then the facility [17] interface, where they transport the patient [18] to and how that patient is dealt with in [19] the system after they reach the facility. [20] And then, of course, we're going back to [21] make it a complete loop, is the patient [22] outcome. And that gets into research and [23] quality assurance.

[24] **MR. LAUER:** Feeds back into the first [25] part of the system.

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[1] **MR. DRAKE:** Right, feeds back to [2] system access, how the system responds. Is [3] that as a broad base? Does that include [4] everything we've talked about? Comes under [5] patient outcome, research, QA, training, [6] because training is part of the QA loop.

[7] Does anyone disagree with that?

[8] **MR. LAUER:** You can almost — quality [9] improvement is a very popular term, you can [10] probably substitute that.

[11] **MR. DRAKE:** QI instead of QA.

[12] **MR. LAUER:** You can substitute that [13] for patient outcome. Determining patient [14] outcome is part of the quality-improvement [15] process. Therefore, it's the [16] quality-improvement process that feeds back [17] into the first part, the system access.

[18] **MR. DRAKE:** Okay. I agree with that. [19] That's better than patient outcome. You're [20] right, part of the quality-improvement [21] process is what is the outcome of the [22] patient. Okay.

[23] All the other systems that we talk [24] about are elements or subsets of those [25] broad categories. The concern that I have

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[1] that has come out in the past — we're [2] going to prepare obviously a majority and a [3] minority report, I think. I don't think [4] there's been any question about that from [5] the beginning. The information we provide [6] to the commissioners should be as accurate [7] as possible between all of us.

[8] We'll all know what the assumptions [9] are. There are some assumptions.

Where [10] the assumptions are made, we should tell [11] them, "This is an assumption. We're [12] assuming this number and based on this." [13] We don't want to be telling the [14] Commissioners which number is accurate when [15] we don't know this number is accurate.

[16] Part of the problem in the past, what [17] Pete has been saying, there's a problem [18] with paramedic skills. There's a big [19] problem in the system, say something to [20] that effect. There's no supporting data to [21] support that. Rather than standing up and [22] saying, "I am concerned about patient and [23] paramedic skills, here are nine reasons I [24] am concerned. We have no data to support [25] this," I think that's our responsibility as

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[1] responsible providers, is to provide [2] accurate information. Do you agree?

[3] **MR. LAUER:** I think we need to [4] acknowledge that for most of the components [5] there is no definitive data and it's based [6] on an opinion drawn from experience.

[7] **MR. DRAKE:** Right.

[8] **MR. ROBEDEAU:** In some cases I would [9] say just based on opinion, a bias —

[10] **MR. LAUER:** Maybe not drawn from [11] experience?

[12] **MR. ROBEDEAU:** Maybe not drawn from [13] experience.

[14] **MR. DRAKE:** That's fine too.

[15] **MR. ROBEDEAU:** I think most of the [16] time not drawn from experience.

[17] **MR. DRAKE:** However these reports come [18] out, that they come out — I think we have [19] an ethical responsibility to the [20] commissioners as providers, and I'm talking [21] about EMS systems. We're the experts. We [22] should be as accurate as we can be with the [23] information we provide them, and any [24] assumptions are so stated as such, or [25] opinions.

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[1] **MR. ROBEDEAU:** I think Chris has a [2] pretty good idea of how to write this [3] properly.

[4] **MR. DRAKE:** Right.

[5] **MR. ROBEDEAU:** I would like to suggest [6] that we actually get out of here a little [7] early. If Chris has the time to sit down [8] with me and kind of do a rough draft to get [9] these facts out to everybody to start, skip [10] Friday's meeting, because we're not going [11] to have it by then, and have a rough draft [12] ready by the June 2nd meeting.

[13] Can we do that, Chris?

[14] **MR. THOMAS:** That's Wednesday?

[15] **MR. DRAKE:** I've started a rough [16] draft.

[17] **MR. THOMAS:** What we can do, we can do [18] an outline. I don't think we're going to [19] have the full thing written. I think we [20] can do —

[21] **MR. ROBEDEAU:** A good rough draft so [22] we see where we're going?

[23] **MR. THOMAS:** Let's do the best we [24] can.

[25] **MR. ROBEDEAU:** Lynn, do we have your

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[1] fax number?

[2] **MS. BONNER:** I don't know. I'll give [3] it to you.

[4] **MR. THOMAS:** I was describing [5] something for Pete in the bathroom. I [6] guess that's not fair because it's a male [7] enclave in it. This is why the men's clubs [8] are bad. Right?

[9] **MS. BONNER:** I missed it.

[10] **MR. THOMAS:** Among other things — I'm [11] more interested in, what's the affirmative [12] recommendation going to be, although I know [13] we have to do it. But on the affirmative [14] side, saying, there are certain things [15] that, No. 1, acknowledging that there are [16] some differences among those on the [17] Provider Board about what the system design [18] ought to look like. But there are a number [19] of things we can agree on that ought to be [20] part of any system, are these. You list [21] those.

[22] Say, some providers think the system [23] structure with the elements ought to be [24] this, which will add some; say, in [25] addition, this ought to be done. I can see

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[1] it saying, other providers — I think we've [2] identified who everybody is — feels it [3] ought to be done this way. And then lay [4] out the rationales for the different ways [5] of doing it.

[6] In a sense, maybe it's a minority and [7] minority report, or maybe it's a document [8] that everybody can agree on, but lays out [9] the different positions that those that [10] advocate them are happy about. I don't [11] think that matters so much, just that [12] everything be portrayed accurately.

[13] **MR. ROBEDEAU:** I think that's [14] important.

[15] **MR. THOMAS:** I think that will be real [16] useful. Then there will be a detailed part [17] that will address at least Bill Collins' [18] proposal and some of the detail in it and [19] says, here are some either things that he's [20] said or concluded in his report we don't [21] agree with, or here's some things we feel [22] are not expressed properly and could lead [23] you to the wrong conclusion, although that [24] may not be what he intended to. And I'm [25] thinking about the fact 39,000 hours, and

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[1] most people will think that's an absolute [2] savings, versus, well, there's going to be [3] other transports he hasn't even talked [4] about.

[5] So, that's sort of the broad concept. [6] And I think it will be up — obviously [7] there's one ultimate conclusion that I'm [8] going to be more able to deal with, and I [9] think you'll probably need to spend time [10] working on sort of what your system [11] structure is, although I'd be interested in [12] having the whole report written so that [13] it's all something that they will be able [14] to understand as much as you can reasonably [15] expect them to.

[16] I think that would be really good for [17] the providers in the sense that it will [18] show, No. 1, we're able to have [19] disagreements among ourselves and we're [20] willing to have the other side's position [21] fully heard, which is not the case I think [22] in some of the other proposals that are out [23] there. I think that itself will give our [24] work some credibility.

[25] I think actually that Gary Oxman and

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[1] Bill Collins will appreciate that, too, [2] because I think they feel at this point — [3] and I think — I think this is true, they [4] feel they have a fair amount of credibility [5] with the commission, and I want them to, [6] regardless how they feel about our [7] conclusions, to feel happy with what we [8] submit. They may not agree with us, but I [9] want them to be able to say, this is a [10] credible piece of work.

[11] I partly went through that so you [12] would get a feel, Randy, of at least [13] — I've been trying to think about how to [14] do this in a way we haven't wasted our time [15] completely. I think either group would be [16] free to embellish however they want.

[17] **MR. DRAKE:** I agree with what you're [18] saying, Chris. I think we should come up [19] with a report that has an introduction, [20] opening remarks that hopefully we can all [21] agree on, and also some background we can [22] bring them up to date, hopefully, the EMS [23] system, and a simple description of the EMS [24] system in Multnomah County today that we [25] can all agree on. I think we all agree the

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[1] quality of care here is not that bad. I [2] think it's pretty darn good, and hopefully [3] we can agree to that.

**MR. THOMAS:** I think probably we all agree. Because of the regulations we have here, the regulations have created a quite expensive system.

**MR. DRAKE:** Right.

**MR. LAUER:** I think that's an okay approach, Chris, and I would take Mark's description of — the general description of the system design, the major components of the system, I would work that into the introduction, say, this is what we're going to talk about. And then talk about the individual aspects of an EMS system separately because I think we will have — we will have some agreement on access. Access is almost a moot point. We've got a 9-1-1 system, and that's access. Then there's triage.

**MR. DRAKE:** Access also comes into — part of access is public education.

**MR. LAUER:** Good point. We can do better there.

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**MR. DRAKE:** Right. There are components we all agree on we can do better.

**MR. ROBEDEAU:** I think you need to recognize, and I think it needs to be put in there, that in this system you're reeducating because the 9-1-1 system originally put in, it was deliberately put in the way it was and disconnected all other phone numbers in order to force the public to call 9-1-1 for everything, from what time is it, to my wife just had a heart attack and is dead on the floor. And they did that deliberately.

Now they are going back to try to redo it. And I think that's one — perhaps the fact that 9-1-1 is as — encountered such problems because it was part of the same thing that was designed with the 9-1-1 system back in the '70s and it's just another — I think another example of how it was poorly conceived in the first place, was that you just can't have a center that's going to answer every call for every government agency, and you can't have a

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center that's going to respond for nothing to every call that everybody has a cut finger on.

**MR. DRAKE:** Right. That's part of the —

**MR. LAUER:** We probably are in agreement in that component of it.

**MR. DRAKE:** The other section of components that we need to agree on that the County Commissioners need to understand is those cost components we can measure in the system. In other words, we can measure unit-hour cost. I'm talking real basic things. And service components, what are important service components that you measure. You measure response times. That's an important service component that we measure. Response time exceptions, we can measure that. We can measure, for example, hours of training that people get. We know that.

Those are the different services components that we can measure in a system. You can then gather information about that and make assumptions about how

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well your system is doing and how much your system costs.

**MR. LAUER:** Is that part of quality improvement?

**MR. DRAKE:** Yeah. It's all part of it — it's the part of the way we look at a system. In other words, we have to teach the commissioners the way you look at an EMS system is to look at these things. These are the basic parts, components of a system. How we looked at a system, what we look at, is how we measure, how you measure anything, how you measure an EMS system is: You have cost components, things that cost you money, how you measure those, how do we measure those things; and service components, what do we look at that affects the actual service delivery. We look at first responder response times, transport response times, those things we look at. Here are some other things you may not look at.

In other words, in my opinion, the number of units as a service component, the number of units on the street is not a

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service component. Doesn't matter if there's 20 units or five units. Doesn't make a difference as far as service component. It's a cost component, not a service component. The service you measure is the response time. I don't care if you have 500 cars on the street.

**MR. LAUER:** There's a correlation. There's a certain number you need for response times.

**MR. DRAKE:** Right. I understand that. There is a certain number to meet demand and to meet geographical need. Those are how you measure it. Those are the parts we look at. But that is what I believe we need to explain to the commissioners so they understand how we, as providers, look at a system, how we do the measurement. Agreed?

This is such an agreeable group today. I can't believe it.

**MR. ROBEDEAU:** Response times I think is the most important element to system cost. We've always recognized that. One thing I'm just sitting here wondering,

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maybe Lynn can help us with, are there any statistics or anything collected hospitalwide on how many patients seen in emergency rooms are really emergencies, life threatening, non-life threatening, and how many are doctors' office calls that should have waited until next week?

**MS. BONNER:** I'm not sure. I can find out about our system. Maybe the ER docs know about the rest of the hospitals. There's probably some data on the number, percent that go to the doctor next week.

But life threatening is probably another issue. I'll see what I can find out.

**MR. DRAKE:** I would assume that the emergency service departments would have how many patients are admitted from ER as to how many are seen? They see 300,000 patients a year and 50,000 are admitted. Of those, how many are admitted to specialty care units? They should have that information. From that, we can extrapolate that.

**MR. ROBEDEAU:** That would give us

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status. That would give us the basis for changing the response times.

**MR. DRAKE:** Also, how many patients come in by ambulance. Not all the patients that are admitted to specialty care units come in by ambulance. Some come in by walk-ins. At least it gives us an idea of how many critical patients are in the system as opposed to how many patients overall.

**MR. LAUER:** Also, a morbid thought, but you need to include those not admitted who didn't survive.

**MR. DRAKE:** Yeah.

**MR. ROBEDEAU:** I think those are life-threatening emergencies.

**MR. LAUER:** If you only capture admissions, they aren't admissions.

**MR. DRAKE:** They're admitted into the morgue.

**MR. ROBEDEAU:** I don't think that's an admission.

**MR. DRAKE:** Something I wouldn't admit. When I worked on a car I said nobody died in an ambulance, they died in

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the emergency room. Have a perfect record.

**MR. ROBEDEAU:** Either before or after. Never during transit.

**MR. DRAKE:** That's right. Never during my car did they die.

Okay. Since we're talking about assumptions here today, can we assume, Randy, that Buck is still going to back the single-provider-by-competitive-bid model? Is that an assumption we can do here today?

**MR. LAUER:** I don't think so. I think what we're going to back is a provider model that functions as a single provider.

**MR. DRAKE:** Okay.

**MR. LAUER:** It gets back to erasing restrictive boundaries.

**MR. DRAKE:** Would it be possible for you to write that up?

**MR. LAUER:** We're already working on it.

**MR. DRAKE:** Okay. But I would like to see that the two thoughts or ideals here are both presented together — we present

Page 72

them together at the same time and, obviously, in front of the County Commissioners, but they come in under one package, report, side by side or something.

**MR. LAUER:** That's June 2nd. Correct?

**MR. THOMAS:** No. June 23rd — you apparently — why don't you take a look at this schedule.

**MR. LAUER:** I saw that.

**MR. THOMAS:** June 23rd, they're doing the primer on the 2nd. I think the other thing which actually, if we get both concepts developed more fully, will be to help us see what the common elements are, because I think that's going to be —

**MR. ROBEDEAU:** Going to be a rough draft by June 2nd.

**MR. LAUER:** That's what our goal is, produce a rough draft by the 2nd. I don't know if we'll make the goal.

**MR. DRAKE:** I know. That's the same goal, time gun we're under.

**MS. BONNER:** Memorial Day weekend.

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**MR. THOMAS:** If you count Memorial Day weekend, that's two days from now — no, it's not. It's three. Doesn't matter.

**MR. DRAKE:** I know where I'm going to be Memorial Day weekend.

**MR. LAUER:** Where?

**MR. DRAKE:** In the office, working.

**MR. THOMAS:** I have a question for — I suppose I want to know what you guys' thoughts are. To what extent — I'm imagining what section of what comes out in terms of a report analyzing others', none of ours, recommended changes or recommendations, one of which would be whatever's come out of the EMS office and the other would be the PAPA proposal. And I suppose I'm wondering to what extent — I feel we need to deal pretty seriously with the EMS proposal, and I'm wondering to what extent we need to deal with the PAPA proposal. I guess we need to do it thoroughly.

**MR. DRAKE:** I think we need to say the PAPA proposal — it's pretty easy to talk about it. It's a shell. It doesn't really

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have any substance to it. We need to outline all the things it lacks. I think things like, ASA plan components comparative analysis, something either in this format or something similar needs to be done, because they don't address a lot of issues.

**MR. ROBEDEAU:** What we said about PAPA before was it was a philosophical plan.

**MR. THOMAS:** It is. I happen to be one of the people that tends to think there's more detail in what they submitted than others think. I think what I'm thinking, maybe we describe — I'm thinking of an introduction, we describe the current system design by element, maybe using that format you guys were talking about, of the six elements. Then maybe we talk about — we say, we're going to have some recommended changes, some of which we all or none agree on, some of which some of us agree on.

And I think part of this ought to say, we want to describe those changes and tell you their impacts on the system, and here's

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the methodology that we're going to use in doing that, and here's sort of the assumptions that will be built into that. So we sort of tell them how we're going to sort of explain to them what we think the impacts of the changes are.

Then we describe agreed changes, and then we describe changes that aren't agreed on, how that would work, ideally we do this. I was thinking we do an analysis of recommended changes by others and try to apply the same methodology we do to our own changes to them. And probably what that will reveal in some cases is, we can't do a full analysis of this one because the data don't exist or it's not specific enough or whatever.

It seems to me that kind of a total report attempts to give them enough information that they can, No. 1, evaluate whether they think that what — the way we've approached the stuff is a good way to approach it; No. 2, lets them make their own judgments and see what we've done, which I always think is important. You

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want them to see exactly how you got to where you got so they can agree or disagree with your method, instead of saying, you say it's this and I say it's this, and they just got to choose.

**MR. DRAKE:** Right.

**MR. THOMAS:** So that's where I hope we can go.

Are we done?

**MR. DRAKE:** I think so. I think we need to go off from here and work on drafting them up.

**MR. ROBEDEAU:** I think so.

**MR. DRAKE:** And exchanging the drafts, Randy. We should do that.

**MR. ROBEDEAU:** We should get them faxed out before. It's 1:30 on the 2nd.

**MS. BONNER:** There's a Provider Board meeting at 1:30 on the 2nd?

**MR. DRAKE:** Yes. I have a question, because one of the questions brought up by Bill Collins when I talked to him was, he has a big issue with nonemergency subsidizing emergency or emergency subsidizing nonemergency.

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**MR. ROBEDEAU:** He's saying emergency is subsidizing nonemergency.

**MR. DRAKE:** I have a question to ask you or Randy, because I don't have the answer to this. Under Buck's contract or arrangement or whatever with Kaiser, does Kaiser get a break on the 9-1-1 calls that Buck transports or do they not? Do you give them any break?

**MR. LAUER:** I don't think so.

**MR. DRAKE:** Okay. Because that would make a difference under what the assumption of Bill Collins — I think Bill Collins is under the assumption you do. I told him I wasn't sure. I thought at one point that you did and at one point you didn't, where you had in the past or you don't anymore. I don't know.

But I think we need to have an answer to that because that's going to

nswer some [21] questions for Bill, because he believes [22] that, yes, the emergency business is [23] subsidizing the nonemergency.

[24] **MS. BONNER:** Overall he thinks hat? [25] Over certain segments?

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[1] **MR. THOMAS:** Overall he thinks that, [2] and he thinks that's a specific component [3] of —

[4] **MR. DRAKE:** Kaiser.

[5] **MR. THOMAS:** — that kind of [6] contract. He's concerned it will become [7] he specific kind of component of more f [8] those contracts.

[9] **MR. DRAKE:** Right. I told him, the [10] VA, we do not give them a break on the [11] 9-1-1 calls. I will go back and verify [12] that.

[13] **MR. ROBEDEAU:** It's never been hat [14] way in the past.

[15] **MR. DRAKE:** I don't think we do. The [16] reason we don't, the 9-1-1 calls, he VA [17] agreed several years ago to se 9-1-1 for [18] 9-1-1 calls, not to go hrough the [19] contracted providers. They don't get a [20] break on 9-1-1 calls, hat I'm aware of. I [21] will verify that nformation and let you [22] know.

[23] I think that's an important [24] cost-evenue component that we have to ook [25] at. That is the other two broad-ased

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[1] components that we looked at. We alked [2] about the system access. Those kinds of [3] components.

[4] We have to have a seven and eight, nd [5] that would be system cost and ystem [6] revenues. We need to understand where the [7] revenues come from nd where the costs come [8] from. Okay?

[9] **MR. ROBEDEAU:** I think we need to ave [10] another one, rates, what makes p a rate, [11] because I don't think they nderstand that [12] when you've got a 6 percent write-off what [13] your cost hift is.

[14] **MR. DRAKE:** That's a good point. [15] No. 9, rates.

[16] **MR. LAUER:** That's probably a subet [17] of costs, isn't it, Pete? Because ates [18] are higher to recover the costs, ve will [19] describe as being higher ecause of the [20] various system elements.

[21] **MR. ROBEDEAU:** You could put it in [22] there, but I think cost and rates are ery [23] different, and I think the problem is that [24] they intermingle the two erms, cost and [25] rates, as being synonmous, and they're

Page 80

[1] not.

[2] **MR. DRAKE:** Rates is actually a subset [3] of revenue and cost because both revenue [4] and cost affect the rate that is charged, [5] and what factors affect revenues, what [6] factors affect costs, and both those [7] together determine the rate that you [8] charge. Use that as a separate subset, [9] separate area.

[10] Okay. I'm ready to break. Are we [11] done?

[12] **MR. LAUER:** I will move that we [13] adjourn.

[14] **MR. ROBEDEAU:** I second.

[15] **MR. DRAKE:** All in favor?

[16] (Vote taken.)

[17] **(PROCEEDINGS ADJOURNED)**

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CERTIFICATE

I, ROBIN L. NODLAND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein, that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 11th day of June, 1993.

Certificate No. 90-0056
LORD, NODLAND, STUDENMUND
(503) 299-6200

/s/ ROBIN L. NODLAND

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**In The Matter Of:**

*Before the Multnomah County Provider Board*

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*Transcript of Proceedings*
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BEFORE THE MULTNOMAH COUNTY
PROVIDER BOARD
TRANSCRIPT OF PROCEEDINGS
Wednesday, June 2, 1993
2:27 p.m.
CARE Ambulance
519 N.E. Hancock Street
Portland, Oregon
THE MULTNOMAH COUNTY PROVIDER BOARD:
Mr. Peter Robedeau, Chairman, AA Ambulance
Mr. Trace Skeen, Buck Ambulance
Mr. Mark Drake, Tualatin Valley Ambulance

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APPEARANCES
ALSO SPEAKING:
Mr. William Collins
Mr. Christopher Thomas
Ms. Lynn Bonner
Mr. Steven Moskowitz

Page 3

[1] **PROCEEDINGS**

[3] **MR. THOMAS:** Let's start.

[4] **MR. ROBEDEAU:** Are we calling to order [5] now an hour late? Has everybody read the [6] minutes?

[7] **MR. DRAKE:** Yes.

[8] **MR. ROBEDEAU:** Everybody have a copy [9] of the minutes? Any corrections? I found [10] one. I don't think I marked it.

[11] Everybody read the minutes? Trace, [12] you done?

[13] **MR. SKEEN:** Yeah. Yeah.

[14] **MR. ROBEDEAU:** I had found a [15] correction last night but now I can't find [16] it. So I don't know where it is. I'll [17] loc it over later. I am late as can be. [18] Can I get a motion for approval and I will [19] bring it up at the next meeting if I have [20] to?

[21] **MR. SKEEN:** So moved.

[22] **MR. DRAKE:** Second.

[23] **MR. ROBEDEAU:** In favor?

[24] (Chorus of ayes.)

[25] **MR. ROBEDEAU:** Opposed?

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[1] (No opposition.)

[2] **MR. ROBEDEAU:** Passed. As everybody [3] knows, we are coming up on the time line. [4] The County informal presentation, they said [5] the 23rd. Right?

[6] **MR. COLLINS:** Right.

[7] **MR. ROBEDEAU:** Anything we want to [8] submit has to be there by the 23rd. How [9] much in advance, do you know, Bill, do we [10] have to have it there?

[11] **MR. COLLINS:** We are probably not [12] going to set a time in advance because we [13] don't know if somebody is going to pop out [14] of the woodwork. But we'd like to have it [15] a few days ahead of time so we can be sure [16] there's enough copies and that sort of [17] thing.

[18] **MR. ROBEDEAU:** So at least by the [19] 20th?

[20] **MR. SKEEN:** That's a Sunday.

[21] **MR. ROBEDEAU:** 23rd is Wednesday. So, [22] what, Monday the 21st, the absolute [23] drop-dead date?

[24] **MR. COLLINS:** If you want us to — I [25] mean, I suppose you could show up with the

Page 5

[1] copies.

[2] **MR. DRAKE:** We can make copies for all [3] the commissioners.

[4] **MR. COLLINS:** We like to get the stuff [5] beforehand. They actually like to get it a [6] long time beforehand. But they may not. [7] So the sooner that you can, the sooner we [8] will see that it is distributed [9] appropriately.

[10] **MR. SKEEN:** Is it unrealistic to have [11] it for the 18th so they have it for the [12] weekend?

[13] **MR. ROBEDEAU:** I don't think so. I [14] don't think it's unrealistic.

[15] **MR. THOMAS:** I think that's a good [16] target. That would be real desirable to [17] have it by then. And they and their staffs [18] have read it over the weekend, or at least [19] they know they had it.

[20] **MR. ROBEDEAU:** So we will shoot for [21] the 18th. I need to get my pad out.

[22] Don't have it with me. Okay. [23] So we will write our two reports or [24] majority and minority, depends on how much [25] it was, by the 18th, and have it to the

Page 6

[1] commissioners.

[2] What I did was, I went through the [3] minutes and sat down with Mark, and I [4] already had a couple conversations with [5] Trace, and we had kind of outlined [6] everything that we had talked about in the [7] different meetings on what we think should [8] be done, what should not be done, [9] essentially setting up the components of a [10] plan.

[11] I gave everybody a copy of this this [12] morning at the Provider Board — or at the [13] Board of County Commissioners meeting. I [14] didn't give Bonnie one.

[15] **MS. BONNER:** I have one.

[16] **MR. ROBEDEAU:** I just thought about [17] it. I saw you there and I was going to [18] catch you.

[19] **MR. THOMAS:** Lynn Bonner.

[20] **MS. BONNER:** Right.

[21] **MR. DRAKE:** What did you call her?

[22] **MR. ROBEDEAU:** Bonnie.

[23] **MR. SKEEN:** I didn't catch that.

[24] **MR. ROBEDEAU:** It was close. Sorry.

[25] **MS. BONNER:** That's okay.

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[1] **MR. THOMAS:** It's okay, Robbie.

[2] **MR. ROBEDEAU:** Yeah. I have been [3] called a lot worse than that. When I was a [4] kid everybody called me Rob-a-dog-do. You [5] don't need that on the record.

[6] **MR. COLLINS:** We want that on the [7] record. In capitals.

[8] **MR. ROBEDEAU:** You could have skipped [9] that.

[10] But I thought what we would do today [11] is, take each item and each subitem, or [12] each subitem under each agreement, and see [13] if there's agreement or not agreement, and [14] then we will know more where we are going [15] to write the report.

[16] I would like to — we need to meet [17] next week with a rough draft and we need to [18] set a time and then we need to meet, I [19] think, the week after that with a final and [20] have that ready to turn in by the 18th. So [21] next week would be the 9th and then the [22] 16th. Is that agreeable?

[23] **MR. DRAKE:** The 9th? What time?

[24] **MR. ROBEDEAU:** That's what we need to [25] decide.

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[1] **MR. DRAKE:** Nine o'clock?

[2] **MR. ROBEDEAU:** Bill, can you get OMA?

[3] **MR. COLLINS:** What time do you want to [4] meet?

[5] **MR. DRAKE:** Nine?

[6] **MR. ROBEDEAU:** Nine on the 9th?

[7] **MR. SKEEN:** Nine or one, either one.

[8] **MR. COLLINS:** I will make a note on [9] that.

[10] **MR. ROBEDEAU:** Nine on the 9th is not [11] going to work. It will have to be one. I [12] will be at the dentist.

[13] **MR. SKEEN:** One o'clock is actually [14] better for me.

[15] **MR. COLLINS:** What was the other one?

[16] **MR. ROBEDEAU:** The 16th. And I will [17] be here on the 16th.

[18] **MR. COLLINS:** So what do you want on [19] the 16th?

[20] **MR. ROBEDEAU:** I don't care. That was [21] vacation. I will be here. I have nothing [22] scheduled.

[23] **MR. DRAKE:** Nine o'clock. Let's do it [24] in the morning. Give us more time to get [25] stuff out.

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[1] **MR. COLLINS:** Okay.

[2] **MR. SKEEN:** Did you say nine?

[3] **MR. DRAKE:** Nine. That way if we are [4] going to make some corrections, we can do [5] those.

[6] **MR. ROBEDEAU:** And one o'clock on the [7] 9th.

[8] **MR. COLLINS:** Are you planning — are [9] you going to write a plan? Are you

going [10] to write components of the plan? What are [11] you — since I missed a couple meetings [12] here.

[13] **MR. SKEEN:** These minutes said we [14] didn't want to write a plan.

[15] **MR. DRAKE:** Right.

[16] **MR. ROBEDEAU:** We weren't actually [17] going to write a plan but write [18] recommendations for what should be in the [19] plan. I think the EMS office has done the [20] plan. We can start in at No. 1 with system [21] access, and we were recommending, which [22] needs to be a vote, we recommend that all [23] emergencies that — well, the only access [24] number for emergencies be 9-1-

[25] **MR. DRAKE:** That's the way it is

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[1] currently.

[2] **MR. ROBEDEAU:** That's the way it [3] currently is. And what I want to do today [4] is just go through each of these one at a [5] time and see where we are, and we will [6] submit a rough draft of a plan of [7] everything we are unanimous on, plus those [8] that there's a majority or minority [9] opinion, will also be in the plan.

[10] And the other question is, if there's [11] a majority and a minority, do we want to [12] name the majority and the minority or do we [13] want to leave that blank?

[14] **MR. DRAKE:** I think we should name the [15] majority and minority. Minority could be [16] two and one.

[17] **MR. ROBEDEAU:** What do you think, [18] Trace?

[19] **MR. SKEEN:** Probably should. [20] Otherwise it can get a little confusing in [21] trying to figure out what direction any [22] particular party is headed.

[23] **MR. THOMAS:** People will ask anyway.

[24] **MR. ROBEDEAU:** Then we will plan on [25] putting in the name.

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[1] **MR. DRAKE:** On this list, Pete, just [2] as a process, I don't think we need to take [3] motions on these. You just need to go down [4] through the list, and if there's any [5] discussion on them, we can discuss them. [6] Anybody wants any language changes, we can [7] do that. Otherwise we just vote as we go [8] through. And do agreement.

[9] **MR. ROBEDEAU:** Okay.

[10] **MR. DRAKE:** If there's any nays.

[11] **MR. ROBEDEAU:** It's all yeas unless [12] the nays speak up? Is that what we are [13] saying?

[14] **MR. SKEEN:** Yeah. What do we have? [15] Three out of four?

[16] **MR. ROBEDEAU:** Mark is TVA.

[17] **MR. DRAKE:** Actually.

[18] **MR. SKEEN:** Four out of five?

[19] **MR. DRAKE:** Tom said he would be here.

[20] **MR. COLLINS:** No. I talked to Tom. [21] He couldn't come.

[22] **MR. SKEEN:** I talked to him just as he [23] was leaving the building. He said, I will [24] see you at 1:30.

[25] **MR. COLLINS:** Maybe he changed his

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[1] mind.

[2] **MR. SKEEN:** He said, fat chance, so [3] maybe —

[4] **MR. ROBEDEAU:** That could have meant [5] something.

[6] **MR. DRAKE:** Let's just go through [7] them. I don't have any problems with A or [8] B.

[9] **MR. SKEEN:** A, recommend 9-1-1 for all [10] emergencies, I assume that's excluding your [11] facility? Emergencies?

[12] **MR. ROBEDEAU:** Yeah.

[13] **MR. SKEEN:** Like your contract with [14] Emanuel and so forth?

[15] **MR. ROBEDEAU:** Yes.

[16] **MR. SKEEN:** So for all prehospital [17] emergencies? Is that consistent?

[18] **MR. ROBEDEAU:** For all non-hospital.

[19] **MR. COLLINS:** The others have to be [20] called nonemergencies. You can't publish [21] an emergency medical number.

[22] **MR. SKEEN:** You don't want to get into [23] a point where Emanuel has to get to the [24] 9-1-1 system because they have an emergency [25] transport.

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[1] **MR. THOMAS:** I think Bill is saying, [2] in the County, they defined emergency as [3] nonhospital.

[4] **MR. COLLINS:** That is a statute. You [5] couldn't put in the phone book any more [6] emergency number for CARE Ambulance in the [7] phone book. They won't let you do that. [8] If you do, they will come and jump up and [9] down.

[10] **MR. THOMAS:** We mean to exclude [11] interhospital transfers.

[12] **MR. SKEEN:** But if he is going to [13] respond emergency with his critical care [14] unit, that doesn't have to go through the [15] 9-1-1 system. You don't have language [16] that —

[17] **MR. ROBEDEAU:** Right. He is correct. [18] I put recommend 9-1-1 for all nonhospital [19] emergencies.

[20] **MR. DRAKE:** Okay.

[21] **MR. ROBEDEAU:** Is that acceptable?

[22] **MR. DRAKE:** Uh-huh.

[23] **MR. ROBEDEAU:** There's also an SOP up [24] at Kelly Butte that allows going to homes [25] on neonates. We have in the past — we

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[1] haven't done that for years, but in the [2] past, especially during the big midwife [3] craze, University would send a team out to [4] homes to pick up babies who really should [5] have been born in a hospital. I don't know [6] if we want to cover that, seeings how it's [7] been a nonproblem for several years. Leave [8] it out? Okay.

[9] **MR. DRAKE:** If it becomes a problem [10] again, it can be addressed.

[11] **MR. ROBEDEAU:** Being nonemergency [12] seven-digit phone numbers, that's B, for [13] nonemergency calls. And I added a C, calls [14] received, seven-digit phone numbers are to [15] use a triage guide. Approved by EMS?

[16] **MR. DRAKE:** Uh-huh.

[17] **MR. DRAKE:** Are to use the [18] EMS-approved triage guidelines.

[19] **MR. ROBEDEAU:** Okay. [20] That works for you?

[21] **MR. COLLINS:** Yeah. This is the same [22] thing we are doing. The only issue that's [23] ever come up since I have been around is [24] sending ambulances code three to [25] hospitals. We will deal with that at some

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[1] point. Whether in this plan or later, [2] anyway. That's a philosophical [3] discussion. It's very hard to say that the [4] person is going to die if they don't get [5] there.

[6] **MR. ROBEDEAU:** Generally, you go code [7] three to the hospital; you pick up a [8] specialized hospital; you go code three to [9] the patient. And it's the time-critical [10] factor. It's all part of the same [11] response.

[12] **MR. COLLINS:** I don't think you should [13] do that in the plan.

[14] **MR. THOMAS:** That's too much detail.

[15] **MR. COLLINS:** It's the discussion of [16] how many code three calls should be run. [17] But this is basically what we are doing [18] now.

[19] **MR. DRAKE:** Let's move on.

[20] **MR. ROBEDEAU:** Okay. So No. 1 is [21] unanimous approval?

[22] **MR. DRAKE:** Yeah.

[23] **MR. ROBEDEAU:** UA. Okay. No. 2, [24] triage, emergency medical dispatcher, 9-1-1 [25] center, with triage all requests for

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[1] emergency medical services and dispatch [2] them as either life-threatening [3] emergencies, non-life threatening [4]

emergencies, or non-life threatening nonemergencies. The new one in there is non-life threatening emergencies. That breaks ground when we get to response times down at C for what we had already approved as eight- and 12-minute response times.

**MR. DRAKE:** There needs to be an understanding here. Dispatch for non-life threatening nonemergencies doesn't mean they necessarily dispatch the units. They will turn it over to a private ambulance service, what have you.

**MR. SKEEN:** I was just going to ask about that.

**MR. DRAKE:** In other words, they will hand off the call or dispatch.

**MR. COLLINS:** That's what we do now.

**MR. DRAKE:** Right.

**MR. ROBEDEAU:** What we have done with two is create telephone triage.

**MR. DRAKE:** For non-life threatening emergencies.

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**MR. ROBEDEAU:** To determine the difference between non-life threatening emergencies and non-life threatening emergencies. That's the difference in what we are currently doing. What we are currently doing is just saying, anything other than a stubbed toe is a life-threatening emergency and they get full response.

**MR. SKEEN:** So the last one there is really, refer non-life threatening nonemergencies.

**MR. THOMAS:** It might be less confusing if you call them nonemergencies.

**MR. ROBEDEAU:** So we are saying either life-threatening, non-life threatening emergencies or nonemergencies?

**MR. THOMAS:** Yeah. People will understand that better.

**MR. ROBEDEAU:** This makes us seem so brilliant because we understand all this garbage.

**MR. SKEEN:** I think you ought to add "refer" in front of "nonemergencies."

**MR. DRAKE:** Or refer nonemergencies,

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yeah, to private.

**MR. THOMAS:** You can say, "refer the calls to private providers as nonemergencies."

**MR. DRAKE:** "Refer nonemergency calls to private transport services"? Does that work for you?

**MR. THOMAS:** Sure.

**MR. DRAKE:** And I will add "as per ordinance" or "per rule"? What would be better there?

**MR. THOMAS:** I wouldn't say that at this point. Otherwise we would say that everywhere.

**MR. DRAKE:** Okay. Everything will be organized according to the rule. All right.

**MR. ROBEDEAU:** How do we wind up with that?

**MR. THOMAS:** Or refer nonemergency calls to private transport services.

**MR. DRAKE:** The reason I use that terminology, Pete, is that includes the CHIERS unit that's still operating that's still funded.

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**MR. ROBEDEAU:** That's fine.

**MR. COLLINS:** For what?

**MR. DRAKE:** I mean, if they get a call, referral to 9-1-1 for the CHIERS wagon.

**MR. COLLINS:** That's a different — that's even a different thing.

**MR. DRAKE:** It comes under nonemergency.

**MR. ROBEDEAU:** This is an ambulance plan. So I don't think that's part of — that's not actually part of the ambulance plan. That's part of the overall EMS system.

**MR. COLLINS:** CHIERS? CHIERS isn't even part of EMS any more.

**MR. DRAKE:** It isn't?

**MR. COLLINS:** No. After we took away man-down, they are not considered EMS provider. They are an alternative to police. We dispatch them by the EMS dispatcher but that's only because that's — that's what they want a cop on the radio to do. So they are —

**MR. DRAKE:** All right.

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**MR. ROBEDEAU:** Shut up. Never mind.

**MR. DRAKE:** Sorry I mentioned it.

**MR. ROBEDEAU:** Let's just get out of that one.

**MR. DRAKE:** Okay. That's good information.

**MR. ROBEDEAU:** Any problems with two? Unanimous approval?

Okay. Three, system response. Under system response, A, tiered response under protocols to be developed per No. 2 above to function as a single system. Okay?

**MR. SKEEN:** Well, I guess the question is, what are you referring to as a tiered response?

**MR. ROBEDEAU:** Tiered response is —

**MR. DRAKE:** Private response. Public response to some calls, private response to other calls.

**MR. SKEEN:** That's your first introduction to the segmentation of public versus private?

**MR. DRAKE:** Under the tiered response comes — under the county plan — is calling for County option 1 — or

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recommendation, I should say.

**MR. SKEEN:** So this in response to County's option 1, then? Is that all this is responding to? As opposed to everything else we have discussed?

**MR. DRAKE:** No. This is responding — you mean what will be derived from this document?

**MR. SKEEN:** I assume that what we are doing is going through and saying this is all the things we agree to or disagree to.

**MR. DRAKE:** Or disagree.

**MR. THOMAS:** So A and B would be actually read together and B-1, you really mean to say, fire medic unit staffed by two EMT paramedics. B is actually explaining what A is, so they go as a concept. This is probably the area where Trace doesn't agree with.

**MR. SKEEN:** I would take exception to that. Surprise.

**MR. DRAKE:** We agree, we being CARE and TVA.

**MR. ROBEDEAU:** We want to change anything? Let's take A and B together. I

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think Chris is right. Tiered response under protocols to be developed to do No. 2 above, which is the life threatening-non-life threatening and nonemergencies. And it goes with that as staffing. Under staffing is, medic units should be staffed by two EMT paramedics, and, No. 2, private ambulance is one EMT basic and one EMT paramedic. So we have three to one? You are voting — assume —

**MR. SKEEN:** That's all kind of together.

**MR. THOMAS:** Right.

**MR. ROBEDEAU:** Right. I just took those together, so on that part, anyway, we have three-one. Then response times?

**MR. SKEEN:** I think part of the response times, Pete, ought to be the measurement defined. And the reason I say that, there is substantial discussion in the Tri-Data document that indicates fire measures only from the

ime the unit leaves [23] the station until t arrives at the scene.

24] And further went on to say that the 25] component that's missing from this could be

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1] as much as 60 to 90 seconds. So really 2] what you are talking about is anywhere from [3] four to five and a half minutes, and that's [4] quite a disparity. So I think we ought to [5] spell out — and we are all familiar, I [6] think, with the normal language — that [7] would be used for measuring response time.

8] And on that basis, then, Buck concurs 9] with the first response of four minutes or [10] less with 90 percent reliability.

11] **MR. ROBEDEAU:** If we do that on 12] response times, we have to define response [13] times.

14] **MR. THOMAS:** So it's measured from —

15] **MR. SKEEN:** — from the time the three [16] variable pieces of information are [17] received. Actually, with B it is from the [18] time the entity is identified.

19] **MR. COLLINS:** No. It is the time they 20] respond.

21] **MR. ROBEDEAU:** We can do it from he [22] time you notify them, but that puts you in [23] a somewhat precarious position.

24] **MR. DRAKE:** Let's do it then from he [25] time B notifies the unit.

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1] **MR. SKEEN:** No.

2] **MR. ROBEDEAU:** Wait. What happens to [3] that time, Bill, from the time they notify [4] and the time they respond? It's a black [5] hole. That could be two minutes.

6] **MR. THOMAS:** No. I don't think that's 7] what Bill means. Why don't you — because [8] you have just been through this, and [9] there's an acknowledgment he has to receive [10] so he knows the unit has actually gotten a [11] call.

12] **MR. COLLINS:** If B is dispatching and [13] therefore does not have direct control of [14] the front part of that unit time, it really [15] has to be from the time he unit responds [16] that they have received the information.

17] **MR. SKEEN:** Acknowledges. Don't use [18] respond.

19] **MR. DRAKE:** Acknowledges receipt of [20] the call.

21] **MR. COLLINS:** Now, there is a time 22] period when BOEC may be attempting to [23] contact the unit and not getting a [24] response. But at least in my mind, that's [25] a different issue. That's a status-keeping

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1] issue with the ambulance. If they say they [2] are available and they don't respond, then [3] that is a non-responsive status-keeping [4] issue, not a —

5] **MR. DRAKE:** We can agree when the unit [6] acknowledges receipt of the call from BOEC.

7] **MR. ROBEDEAU:** Response time begins [8] with the receiving unit acknowledging the [9] receipt of the request for service or the [10] request for response and ends with the unit [11] arriving at the scene.

12] **MR. DRAKE:** Right.

13] **MR. COLLINS:** Right.

14] **MR. ROBEDEAU:** Of the response or the [15] emergency.

16] **MR. SKEEN:** Yeah.

17] **MR. DRAKE:** Arrives at the incident [18] scene. Right?

19] **MR. COLLINS:** That's good. That's [20] good.

21] **MR. DRAKE:** Do you agree with that, [22] Trace?

23] **MR. SKEEN:** Yeah. Yeah. Where do [24] you — should we actually go up above, if [25] you want to talk about the clinical

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1] capabilities of the first response units? [2] Should that go up under staffing? I don't [3] see anything down below.

4] **MR. DRAKE:** Yeah, you are right. It [5] should.

6] **MR. ROBEDEAU:** Can I jump in here just [7] a second on the definition again? I [8] believe the way it's currently worded is [9] dispatch order. Is that correct?

10] **MR. COLLINS:** Probably. I can't [11] remember. Something like that.

12] **MR. ROBEDEAU:** So response time begins [13] when the unit acknowledges receipt of a [14] dispatch order and ends with the arrival at [15] the scene?

16] **MR. DRAKE:** Uh-huh.

17] **MR. COLLINS:** It actually ends with [18] them reporting their arrival at the scene. [19] If they don't report it, it doesn't end.

20] **MR. DRAKE:** That's right.

21] **MR. COLLINS:** Even though they are [22] there.

23] **MR. ROBEDEAU:** Okay.

24] **MR. DRAKE:** Okay. That's good.

25] **MR. ROBEDEAU:** I am sorry. I didn't

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1] mean to interrupt, but I want to finish 2] this.

3] **MR. SKEEN:** Yeah. So I go back to the 4] staffing for the first response. And our 5] proposal would be that it be a minimum of 6] the EMT-D.

7] **MR. DRAKE:** I agree.

8] **MS. BONNER:** What's EMT-D.

9] **MR. SKEEN:** Rapid defibrillation.

10] **MR. COLLINS:** On the state change, 11] there is no more D, whenever they get that 12] in.

13] **MR. SKEEN:** So what would we do? EMT 14] with rapid defibrillation?

15] **MR. COLLINS:** That's part of it.

16] **MR. SKEEN:** How do you want to put it 17] in this?

18] **MR. COLLINS:** You can put it EMT-D. 19] It will just change to basic.

20] **MR. ROBEDEAU:** You want to add a three 21] to staffing above?

22] **MR. SKEEN:** That's what I would do, 23] and just do, first response is EMT-D. 24] Which puts us in the position of opposing 25] A, B-1 and two and supporting B-3.

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1] **MR. ROBEDEAU:** Okay.

2] **MR. THOMAS:** So first response staffed 3] by one EMT-D?

4] **MR. SKEEN:** At least one EMT capable 5] of rapid defibrillation. As a minimum at 6] least. Over a hundred lives a year can be 7] saved with that. I read that in Tri-Data's 8] report.

9] **MR. ROBEDEAU:** Now, Trace, you are 10] getting catty.

11] **MR. THOMAS:** So that would be a three 12] that says, first response staffed by at 13] least one EMT capable of rapid 14] defibrillation, and that would have 15] unanimous approval, as I understand it.

16] **MR. DRAKE:** That's good.

17] **MR. SKEEN:** I am not so sure Tom 18] supports that in a discussion I had.

19] **MR. ROBEDEAU:** Tom didn't show up.

20] **MR. COLLINS:** Actually, the areas that 21] would have the biggest effect or the 22] biggest problem are not going to be 23] Portland or Gresham Fire but Corbett and 24] Sauvie Island. They have a hard time 25] coming up with EMTs, let alone a

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1] defibrillator, but it should be in there as 2] a standard if that's what you think. You 3] think you ought to put it in there.

4] **MR. SKEEN:** He and I were discussing 5] this morning part — somewhere that's part 6] of the risk of living in the country. You 7] don't breathe all the bad air but you also 8] don't get rapid response.

9] **MR. COLLINS:** Actually, they do get 10] pretty rapid response.

[11] **MR. ROBEDEAU:** They do get pretty [12] darned good response, but the problem is [13] this whole — you know it's another one of [14] the things we are going to cover here later [15] — well, we are at it right now — is [16] response times and what it's going to be is [17] the system is sold to everybody saying [18] everybody could have everything, no matter [19] if they had one occupant for 100 square [20] miles.

[21] **MR. THOMAS:** Okay. So No. 2, C-2.

[22] **MR. ROBEDEAU:** Okay. So everybody [23] approved first response, four minutes or [24] less with 90 percent reliability? So we [25] are C-2.

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[1] **MS. BONNER:** Is that the right term? [2] Reliability?

[3] **MR. THOMAS:** Uh-huh.

[4] **MR. ROBEDEAU:** C-2, life-threatening [5] emergencies, eight minutes or less with 90 [6] percent reliability?

[7] **MR. SKEEN:** What's your consideration [8] for that response time if you have all ALS [9] response?

[10] **MR. ROBEDEAU:** The life-threatening [11] emergency doesn't change. All ALS or you [12] will get BLS.

[13] **MR. SKEEN:** Whether you have all ALS [14] response or not?

[15] **MR. ROBEDEAU:** The eight-minute [16] reliability for life-threatening [17] emergencies remains.

[18] **MR. COLLINS:** You are asking if you [19] had all ALS first response, would you stop [20] the clock to four minutes?

[21] **MR. SKEEN:** Move 24 to ten minutes.

[22] **MR. DRAKE:** We can look at that as an [23] option, but this has to follow in line. If [24] we are saying right now the first responder [25] is EMT-I-D.

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[1] **MR. SKEEN:** You need an algorithm to [2] work down. If this then this?

[3] **MR. DRAKE:** Right now we are looking [4] at EMT-I-D; then ALS transportation should [5] be eight minutes. I agree with you, [6] though, Trace, if you go to an ALS first [7] response, then, definitely the [8] transportation can be ten minutes.

[9] **MR. SKEEN:** Certainly argument in [10] favor of reducing the time.

[11] **MR. DRAKE:** We can even put a comment [12] in there that if such time that the first [13] responders go to all paramedic first [14] response, you would look at reducing or [15] extending that time.

[16] **MR. ROBEDEAU:** I think that's [17] something that's just going to confuse the [18] issue. I think it ought to be left — it's [19] easy to understand. Life-threatening [20] emergencies gets a better response than [21] non-life threatening. I think that's [22] really easier to understand.

[23] **MR. COLLINS:** I understand it's [24] something that you — it's hard to put in [25] the plan, but as you move along, if that

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[1] happens, or that direction, then you go [2] back and look at it.

[3] **MR. SKEEN:** It probably represents the [4] most substantial cost recovery that you [5] will have.

[6] **MR. COLLINS:** But to do it —

[7] **MR. SKEEN:** The staffing level as well [8] as the response time.

[9] **MR. COLLINS:** The biggest problem I [10] think in that is actually accomplishing an [11] all ALS first response on a guaranteed [12] level. That's the hardest piece of that. [13] But I agree with you. Once you have got [14] it, you ought to be looking at the other [15] response times.

[16] **MR. ROBEDEAU:** Then you go to three, [17] the non-life threatening emergencies at 12 [18] minutes or less with 90 percent [19] reliability. And let me finish the other [20] two because they all fit in together. Four [21] is the, establish response times zones for [22] urban, suburban and rural areas; and No. 5 [23] is, establish response time exceptions for [24] inclement weather and et cetera.

[25] There are a bunch of different things,

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[1] unusual system demand, a lot of different [2] things that other systems use for response [3] times exceptions, and this system does not [4] allow you any, no matter what happens. [5] Every bridge in town could be blown up and [6] we could still be required to meet the same [7] response times.

[8] **MR. COLLINS:** Seems fair to me.

[9] **MR. ROBEDEAU:** And we do it, too.

[10] **MR. DRAKE:** Most systems have [11] exceptions.

[12] **MR. SKEEN:** And we are quick and [13] inexpensive.

[14] **MR. DRAKE:** I thought we were good and [15] quick.

[16] **MR. THOMAS:** I think with the response [17] time zones, we ought to suggest that, for [18] outlying areas, there be a preference [19] for — what do you want to say? — [20] automatic defibrillation units when they [21] become available. In other words, that [22] would be the first place they would go to [23] help alleviate the zone problem. Does that [24] make sense or does it not?

[25] **MR. SKEEN:** I am not following you.

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[1] **MR. THOMAS:** Well, there's been [2] discussion about stocking — at least under [3] the tiered response concept, I suppose, [4] stocking fire medic units with automatic [5] defibrillation units. And one of the big [6] questions is, what's going to happen in the [7] rural areas if the response — if there are [8] response time zones? And one way to at [9] least help alleviate concern about having [10] response time zones would be if they have [11] the first preference for the defib units.

[12] **MR. ROBEDEAU:** You are talking about [13] fire first responders, not the medics?

[14] **MR. THOMAS:** That's true.

[15] **MR. DRAKE:** We should put a note in [16] there because that's what we recommend. If [17] they are going to purchase automatic [18] defibrillator units that they should go [19] first to the outlying areas, whatever those [20] outlying areas are.

[21] **MR. COLLINS:** But you realize the [22] providers in the outlying areas are not the [23] people that can afford the defibrillators.

[24] **MR. DRAKE:** We are going to fund them [25] through your budget.

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[1] **MR. COLLINS:** That's fine.

[2] **MR. ROBEDEAU:** One easy payroll [3] deduction for you, Bill.

[4] **MR. SKEEN:** Is it the equipment or the [5] manpower?

[6] **MR. COLLINS:** It's both. I went out [7] and spent some time talking with the fire [8] guys on Sauvie's Island. Equipment is a [9] big issue. They don't have the money. [10] Training is an issue because they are all [11] volunteers. If they are not EMTs, to go [12] through the EMT program when you are [13] working a full-time job, they have real [14] issues about how they get trained. It's [15] not that they want to do it.

[16] **MR. SKEEN:** It's your service area. [17] Right?

[18] Pete will do it.

[19] **MR. COLLINS:** There wasn't any [20] discussion, "We shouldn't be doing this." [21] Just the logistics of trying to do it.

[22] **MR. THOMAS:** If we can go to response [23] time zones, there's probably some fairly [24] significant savings to the system there, [25] but what it's going to take to get the

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[1] response time zones — and one thing that [2] may help —

[3] **MR. COLLINS:** Fibrillators might be a [4] good thing.

5] **MR. THOMAS:** It might be a good [6] nvestment for the whole system to pay or [7] the units for those areas rather han the [8] whole system having to pay or a higher [9] number of ambulances ecause we have to [10] meet the other esponse time requirements [11] out here. It would be a good trade.

12] **MR. ROBEDEAU:** I think it's a [13] ecommendation we need to make. I hink [14] you are absolutely right. At this oint, [15] it's really up in the air on how nuch of [16] anything that will be ac-epted, anyway.

17] **MR. COLLINS:** I would also suggest 18] that you want to, to establish two esponse [19] time zones, not try to do hree. It's hard [20] to tell in Multnomah ounty the [21] urban/suburban line very vell. I mean, [22] it's more urban than — you are out in [23] Washington County, ou can probably do that [24] easier.

25] One of the things we look at, I got

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1] the map of the urban growth bound-ry just [2] to see what that would estab-sh. And it [3] looks like you could prob-bly establish [4] kind of the urban-other. mean, it would [5] have to be rural. You ould call it one of [6] the two.

7] **MR. DRAKE:** Since it fits —

8] **MR. COLLINS:** Instead of doing three 9] gradations. It looks real difficult to put 10] three gradations but two —

11] **MR. ROBEDEAU:** What would you all [12] Sauvie's Island?

13] **MR. DRAKE:** We will call it subur-an. [14] The rest of Multnomah County uburban.

15] **MR. COLLINS:** Urban and suburban nd [16] rural or whatever you wanted to.

17] **MR. ROBEDEAU:** What I was half-vay [18] thinking, you have got Sauvie's sland area [19] in Northwest Portland is uburban, but you [20] get out into East ounty, essentially east [21] of Troutdale, nd you are rural. You have [22] a couple f small pockets.

23] **MR. COLLINS:** There is a third area 24] that is sort of the unpopulated area.

25] **MR. SKEEN:** Frontier?

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1] **MR. COLLINS:** Kind of frontier. If [2] ou look at what we are doing now and ry [3] to see what the logical break vould be, it [4] looks like having kind of — one response [5] for the predomi-antly urban area and one [6] response utside that. And then if you [7] want to ut any exceptions in, like Bull [8] Run, ou just write it in and say, you [9] know, n areas where there is no [10] popula-ion, if there are any calls, [11] response imes don't apply, whatever.

12] **MR. DRAKE:** Then you could call hose [13] areas rural, because Pete does have a [14] point. You go beyond — be-cause Multnomah [15] County goes all the way out to Multnomah [16] Falls, a little beyond.

17] **MR. ROBEDEAU:** It goes all the way to [18] Bonneville Dam.

19] **MR. DRAKE:** I said beyond.

20] **MR. ROBEDEAU:** More than a little bit [21] beyond. Quite a bit beyond.

22] **MR. DRAKE:** That area out there, there [23] is no population.

24] **MR. ROBEDEAU:** Maybe we need to make [25] an exception once you past Troutdale.

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1] **MR. DRAKE:** It is rural.

2] **MR. ROBEDEAU:** So Sauvie's Island, [3] Northwest Portland, that area is [4] reasonable. But 25 minutes to Bonne-ville [5] Dam is not reasonable. You can write off [6] $300,000 a year in bad debt on an ambulance [7] stuck out there to make a 25-minute [8] response time. You know where, where if [9] you make a 45-minute response time, they [10] are going to make it, and that should be a [11] 45-minute response time rather than a [12] 25-minute response time. It's 38 miles to [13] Bonneville Dam. So you are going to be [14] pushing to do it in 45 minutes. Anything [15] off I-84 in 45 minutes is going to be a [16] hard run. But it might be reasonable.

17] **MR. DRAKE:** We should say out there, [18] the trail head, because they have had [19] calls, when I worked up there, up off some [20] trail, the person is 600 feet up that way.

21] **MR. ROBEDEAU:** And it winds up six [22] miles.

23] **MR. DRAKE:** 600 feet up.

24] **MR. SKEEN:** Sounds like we ought to [25] have three rather than four. Clackamas has

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1] urban, suburban, rural, and frontier. [2] Maybe what we need to have is urban, [3] suburban, frontier.

4] **MR. DRAKE:** Why don't we just say [5] urban.

6] **MR. THOMAS:** Urban, rural, frontier. [7] That's language most of these people are [8] used to dealing with, because the area [9] inside the urban growth bound-ary is [10] urbanizable, I suppose, and area outside is [11] called rural in land use terminology, which [12] the commission-ers at least are familiar [13] with. And then you could have frontier if [14] that's what you are talking about.

15] **MR. DRAKE:** Frontier, though, is a [16] specific — we also have specific [17] definitions under state statute and the [18] trauma guidelines — and I would have to [19] look those up — based on population [20] density. And let me tell you, frontier is [21] like no people.

22] **MR. THOMAS:** Okay.

23] **MR. DRAKE:** Like seasonal popula-tions.

24] **MR. THOMAS:** What we are talking about [25] then is three zones. What you really want

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1] to do is draw on a map where they are. I [2] am wondering how Troutdale — Troutdale [3] would be not urban?

4] **MR. ROBEDEAU:** Troutdale —

5] **MR. COLLINS:** It is in the urban [6] growth boundary.

7] **MR. ROBEDEAU:** Under this, Troutdale [8] would still be suburban. Everything except [9] the far East County, once you get past [10] Troutdale would be suburban. And maybe [11] just a little tiny corner of West County. [12] But not much more than that.

13] **MR. DRAKE:** Most of it would fit under [14] definition of suburban or urban except, [15] like Pete is saying, the far end you could [16] define as rural.

17] **MR. ROBEDEAU:** It's just not [18] rea-sonable — if you set up a standard [19] where you are going to have a 12-minute [20] response time, or even 25-minute response [21] time to that area out there by Bonneville [22] Dam, you know, it's setting up for failure [23] because it's not going to happen unless the [24] system is willing to waste an enormous [25] amount of money to keep a car out there.

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1] **MR. DRAKE:** But, you know, you are [2] going to have, for each of those zones, you [3] will have a minimum of two response times. [4] You will have a re-sponse time for [5] life-threatening emer-gencies and response [6] time for non-life threatening emergencies.

7] **MR. SKEEN:** Exactly.

8] **MR. ROBEDEAU:** Once you get out there, [9] you can't do that.

10] **MR. DRAKE:** Yeah.

11] **MR. SKEEN:** Like life-threatening, we [12] have here, eight minutes. Actually what it [13] would probably be is some-thing like eight, [14] 12, and 30.

15] **MR. DRAKE:** And for non-life [16] threatening, it would be 12, 20, and 60. [17] 45 or 60. Because non-life threaten-ing [18] emergency, if they are respond-ing code one, [19] they may not get there in 30 minutes.

20] **MR. SKEEN:** Incidentally —

21] **MR. ROBEDEAU:** I still disagree with [22] code one response on non-life threatening.

23] **MR. DRAKE:** Even if it's code three. [24] There's different requirements in the

urban zone. Then it behooves you to have them —

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MR. ROBEDEAU: Then we need to define what the responses are going to be. Maybe what we need to do is go one, two, and four, and do we agree on those for urban? And then we need to sit back and redo a one, two, and three for suburban and one, two, and three for rural. I think that's what we are going to have to do.

MR. DRAKE: One, two, and three?

MR. COLLINS: First response, life-threatening, non-life threatening.

MR. ROBEDEAU: Each response time zone, then, we need to do a one, two, and three for each one.

MR. DRAKE: Okay. I don't have any problem with that.

MR. ROBEDEAU: Then for — does anybody have a problem with urban, approving one, two, and three as written?

MR. SKEEN: Four, eight, and 12? That's fine.

MR. DRAKE: That's fine.

MR. ROBEDEAU: Then we better do suburban.

MR. SKEEN: Now, I ought to

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— probably ought to say that we did some measuring response times, because Tom brought up the non-life threatening responses. He thought they would have a problem responding emergency. And we haven't gotten to that yet, I know, how to respond to. We discovered it is an 80 percent longer response time nonemergency than it is emergency. And we measured specific emergency calls. We went back and measured them on a nonemergency response, and it's 80 percent. So just keep that in mind as you are —

MR. ROBEDEAU: All of your staffing savings by going to a different response time standard for non-life threatening emergencies is loss of code response.

MR. COLLINS: 80 percent?

MR. SKEEN: 80 percent longer, yeah. Measured ten responses in the Portland area.

MR. ROBEDEAU: I haven't measured them.

MR. COLLINS: What did you do? Ran two?

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MR. SKEEN: No. Well, we ran the call. We went back and looked at actual specific calls of what their point of dispatch was and the scene, and we went back and measured that as if it had been an ambulance that was responding nonemergency and measured the time. We already had the code three times measured. What — I mean do you have strong opinions on that, Bill, as far as the code three versus code one?

MR. COLLINS: I think the only issue that comes — well, there's a couple of things. There's starting to be more data coming out of different systems as to the efficacy of lights and sirens in responding, are you — the difference between saving time and causing wrecks.

I think, though, there is kind of a — set it up when you talk about, if it's a non-life threatening call, then how can you justify using lights and sirens, which are only to be used if you are saving a life? I mean, it's almost by definition you have taken it out. I understand that it may take you longer but —

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MR. SKEEN: You may not be saving a life but you may be saving extent of injury.

MR. ROBEDEAU: Life or limb.

MR. COLLINS: Whatever it is you are saving, but what you have certainly said, this doesn't require that.

MR. SKEEN: Your point is valid. All I am — it's like Pete said, though. If you are knocking that to nonemergency response, you have lost any advantage. Obviously, you would have to staff as heavy for 12 minute as you would for eight minute.

MR. ROBEDEAU: I think probably heavier, if you want to know the honest to god truth. Without doing the stats that you have done —

MR. SKEEN: That's 50 percent longer and that would be 80 percent longer.

MR. ROBEDEAU: You will need more people, and it's going to cost the system more money, and we are going to wind up — the way the system is set up is to make sure the system doesn't get sued, and this

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system doesn't get sued because it responds to everything.

No. 1, the argument has been made, Bill, about traffic accidents and how the ambulances get into traffic accidents. And the fact is, it just doesn't happen running code three. Periodically.

MR. COLLINS: This isn't my opinion. I am just quoting the stuff that's coming out in the journals. It's not necessarily that the ambulance gets in an accident. Somebody else. And it wasn't just ambulances. They are talking about fire trucks.

MR. SKEEN: In fact, it's a whole argument in favor of priority dispatch protocols.

MR. COLLINS: I think you just need to speak to that. When you say it's a non-life threatening event, but you say, we have to go code three, if you are saying, we have to go code three because it saves us money, it's going to make it harder.

MR. ROBEDEAU: We are also talking about telephone triage. I don't think it's

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a bad thing to sit here and say we are trying to save some money. I really don't. I think we need to say that we need to save some money.

MR. SKEEN: But if you are saying responding emergency to save money —

MR. ROBEDEAU: That's not the entire reason.

MR. THOMAS: I think there's two issues. One is, as long as you have a response time requirement, say, 12 minutes for the ones we are talking about, that suggests that there's some reason to want to get there —

MR. DRAKE: Quickly.

MR. THOMAS: — at some deadline. And so I think that partly addresses that question. And the question is, what does it take to get there at that deadline in a way that's efficient and economical? There is, obviously, I suppose you could say, well, we are — if we can't go with the lights flashing and the siren going, then, ordinarily it's going to take us 80 percent longer, which is, instead of 12 minutes,

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it's going to take us 20 minutes, but we still got to meet a 12-minute requirement there, therefore, we have to have that much units out there. I think that's a reasonable argument.

MR. SKEEN: Actually, probably the most reasonable one is the emergency exists in the mind of the patient, not the responder.

MR. ROBEDEAU: We are talking here about telephone triage, which, by definition, carries some risk. And we don't know what —

MR. SKEEN: That's true.

MR. ROBEDEAU: — what is really wrong with that patient. We have a reasonable idea that it's non-life threatening, but we don't know that for sure, so we are putting somebody

on the scene as soon as possible to find out.

**MR. COLLINS:** Maybe you need to use different words or something.

**MR. ROBEDEAU:** What do we need to use?

**MR. DRAKE:** Let's assume for now that

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the units are responding code three.

**MR. THOMAS:** That's what I would do.

**MR. DRAKE:** Let's base our response time requirements on that. So we have got suburban. How fast do we want the first responders to get there? Do we have any data, any reports that would give us any information on that?

**MR. SKEEN:** Well, so, by our definition here, suburban still falls within the two major fire districts? Is that right?

**MR. DRAKE:** Well, part of it would. Part of it wouldn't.

**MR. ROBEDEAU:** Gresham and Portland wouldn't fall in. Suburban.

**MR. DRAKE:** Gresham covers part of Troutdale, don't they?

**MR. ROBEDEAU:** Unless they have an intergovernmental agreement they don't.

**MR. COLLINS:** They cover it.

**MR. DRAKE:** They cover Troutdale. I think they cover Fairview as well.

**MR. ROBEDEAU:** Sauvie's Island fire bureau which is, quote-unquote, first

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response, it might be four or five days they get there after a call.

**MR. DRAKE:** These are recommendations, Pete. They can be adjusted.

**MR. ROBEDEAU:** To put them on a leal throughout that says they have to respond at all is kind of ridiculous.

**MR. DRAKE:** Well, we can make exceptions for areas as well. What I am saying is, what do we want to put down for first responders? We need to get back and talk to Tom Steinman to get information from Tom Steinman and Gresham Fire and first responders.

**MR. SKEEN:** Just to throw it out, what if we went with ten, 12, and 20 or that next category of calls?

**MR. DRAKE:** Ten minutes for first responders, 12 minutes for life threatening.

**MR. COLLINS:** You might want to hold off on first responders because you have a different mix than you do with the ambulances. Like you don't have an ambulance out in the Gorge but you do have

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a fire department. They actually respond rather quickly. Corbett is out there. They have two or three stations. There's just no ambulance out there.

So you may not want to change substantially the first responder part of it. Just put — I think on the first response, you have to be putting out a goal for them. If you want them to get there in four minutes, that's what we ought to say. Then they are going to — kind of come up with what they want. Because it really is not consistent with the ambulance response activity.

**MR. DRAKE:** So for first response under suburban, can we put ten minutes, as Trace suggested, and in parens, goal?

**MR. THOMAS:** This is not what Bill's suggesting.

**MR. COLLINS:** First respond, just say four minutes, 90 percent. Just leave it. Don't even talk about it. And rural and suburban, because it's a whole different thing.

**MR. DRAKE:** Okay.

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**MR. COLLINS:** Like Pete said, you got a fire department on Sauvie Island, but it's all volunteer. It might take them forever to get there.

**MR. ROBEDEAU:** Skyline is the same. Sometimes they don't get there at all.

**MR. COLLINS:** Nobody is going to do anything to change that. We are not going to put another first response program in there.

**MR. DRAKE:** Life-threatening emergencies, you are suggesting under suburban, it be 12 and 20?

**MR. SKEEN:** I am just throwing that out.

**MR. DRAKE:** That's fine. And rural, what do you want to go? 20 minutes?

**MR. ROBEDEAU:** You have to do more than that. We are going to have to do more than 12, too. I think 20 and 25 on rural. Puts it way out.

**MR. SKEEN:** Clark County rural, what was that? 30?

**MR. DRAKE:** 30. They had four zones.

**MR. SKEEN:** They had no frontier,

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though. Clackamas County I think is 60.

**MR. COLLINS:** Frontier is two hours.

**MR. ROBEDEAU:** Four hours and a half is the national — four and a half is the national recommendation for frontier.

**MR. SKEEN:** That wasn't in the RFP.

**MR. COLLINS:** Actually, most places now that I am aware of don't bother to put a time in for frontier. They just say, as quickly as possible.

**MR. ROBEDEAU:** Clackamas County did — after you passed Molalla and Estacada, everything out there, it's four and a half hours.

**MR. COLLINS:** It's easier to say, as quickly as possible.

**MR. DRAKE:** Four hours to trail head.

**MR. SKEEN:** Then the hiking pace of three miles per hour.

**MR. DRAKE:** So let's do, rural is 35 and 45? 35 for life-threatening and 45 for non-life threatening? I'm just throwing numbers out there.

**MR. ROBEDEAU:** Well, I think we need to do — well, I think once you get into

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rural and suburban, go to one response time for four emergencies, period. Change that. 25 and 45 minutes.

**MR. SKEEN:** Actually, on rural, because you have so much disparity there, it's almost like you could cover if said to be dispatched immediately, without putting response time in. Just that there's no delay of dispatch.

**MR. ROBEDEAU:** I think we cover — most of East County can be hit in 25 minutes. The only part that you are going to have trouble is once you pass Troutdale.

**MR. SKEEN:** Bonneville.

**MR. ROBEDEAU:** And the only part we have trouble with is the small sliver of west end of Sauvie Island, which is actually in Columbia County.

**MR. DRAKE:** The question remains, because you have to meet response times 90 percent, is the County going to measure them by zone or as an aggregate?

**MR. SKEEN:** That's the problem. If you set that rural up and you are measured on that 90 percent — right now all of

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our — well, at least us, the ten percent that we are not making in eight minutes are clearly all of our rural calls. If you create that — the bulk are. Then you create that into its own zone, and you really — then you really run the risk of never being able to meet those response times.

MR. DRAKE: If you make them 35 or 45 minutes for non-life threatening, you ought to make —

MR. ROBEDEAU: You call non-emergencies 25 and 45, would be my recommendation for.

MR. COLLINS: If you set up the zones, you have to have zone — if you set this up on a zone basis, we will look at each zone by itself. And you would look at the urban zone and you would have to meet 90 percent of the calls in eight minutes. Or, in fact, on the urban zone, you might want to shrink it and say you have to meet eight minutes, 95 percent of the time, and shrink it down. But each zone is independent. You can't blur them together. There's no way to measure that way.

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MR. ROBEDEAU: I still think they need to be separated.

MR. SKEEN: Is 30 and 60 unrealistic?

MR. DRAKE: For rural area?

MR. ROBEDEAU: No. 30 for suburban.

MR. DRAKE: Life-threatening?

MR. SKEEN: I thought we already passed suburban.

MR. ROBEDEAU: I was back on the deal not separating life threatening and non-life threatening and urban and rural.

MR. DRAKE: I think you have to, Pete. Because we set up those definitions, I think you have to do that and you have to continue that through. And I think also you are going to want to, if you serve those areas, you are going to want that response time difference. Trust me on this one.

MR. ROBEDEAU: I don't think so. But —

MR. DRAKE: Yeah.

MR. ROBEDEAU: You got all that nice area right in the middle of town with nothing out of town.

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MR. DRAKE: We have Southwest and Northwest.

MR. ROBEDEAU: You don't go anywhere in Northwest. We pick it up and go on out. You have the easy part.

MR. DRAKE: Let me tell you —

MR. ROBEDEAU: Can we agree to disagree on this and move on?

MR. DRAKE: Any recommendation from CARE-TVA will have Southwest in as a suburban zone.

MR. COLLINS: I can tell you right now that no consideration will be given to that particular —

MR. ROBEDEAU: We are only to No. 3. It's 3:30. Can we —

MR. THOMAS: If I could make a suggestion, why doesn't everybody think about No. 4 and what they ought to be — you are sort of inventing out of thought now — and take that up next week, after everybody has had a chance to think about how you want to handle that.

Bill has also suggested that you not have suburban and rural and be treated as

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one, and I think you ought to think about that whole concept.

MR. SKEEN: If you have some real strong feelings about that, you ought to maybe outline that for us to work within.

MR. COLLINS: The only reason I said that is, when you look at the County where the calls come and kind of where the line is, it doesn't seem to be a good break in Multnomah County for what you call suburban area. And we are now serving sort of — within the growth boundary, if you use that just as an indicator, we are doing fine with eight minutes. We just need to separate, at least in my mind, the urban area, or the predominantly urban area from the pieces of the County where we know the response time currently is a problem.

And when you get out kind of past the Sandy River and when you get out kind of on the Sauvie Island and up in the hills, we sometimes make the response times now, but that's where, you know, most of them occur. And those are the kind of break I think that we need.

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We may still want to put in something for areas where no people live and just — in my mind, you don't put a response time there. I can't — you know, you get way out in Bonneville off the highway, and you are up, you know, above the highway, I don't have a problem with just not having response time. Just pick the zone and say, for this area, you move in an expedient manner. Because there just —

MR. ROBEDEAU: Or best effort.

MR. COLLINS: Best effort type of thing. On the highway out there, there is a lot — that's where anything that happens happens and we need to have a way of identifying that.

MR. DRAKE: I think the State requires, though, you have a response time for each part of the County. Whatever it is, you can make it six hours or eight hours, but you have a response time.

MR. ROBEDEAU: It can be best effort, too. That's a response time.

MR. DRAKE: Okay. We can talk about that.

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MR. COLLINS: If there's a problem, we can always put in some very long time.

MR. DRAKE: 12 hours.

MR. ROBEDEAU: The State doesn't review these things anyway. They just go through and remove all of them.

MR. DRAKE: Multnomah County could have a model for the system. Same-day service.

MR. THOMAS: Why don't you think about No. 4 and maybe talk with each other during the week. I think you will get a better conclusion that way.

MR. DRAKE: Okay. Let's move on. Because we agreed with the urban. We agreed with No. 5, there should be exceptions.

MR. ROBEDEAU: Yes.

MR. COLLINS: Are you proposing it be actual response times identified for inclement weather?

MR. ROBEDEAU: No. No. I am saying that during increment weather and the response times be suspended.

MR. COLLINS: Okay. Why don't you say

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that.

MR. DRAKE: Well, they are not necessarily suspended, Pete. It's just they are going to take into consideration any response time exceptions due to inclement weather.

MR. COLLINS: The way I read this, I would have to say, if there's six inches of snow on the ground, the response time is — instead of being eight minutes is 14 minutes or something, as opposed —

MR. ROBEDEAU: No. It's suspended. It becomes, then, what you said, a best effort.

MR. COLLINS: I think you should be more specific about that.

MR. DRAKE: We will.

MR. COLLINS: Write it up that way.

MR. DRAKE: We all agree there should be response time exception language in the plan.

MR. ROBEDEAU: Yes. Wait a minute. Yes, I do. Trace?

MR. SKEEN: Yeah, I agree.

MR. COLLINS: A lot of snow storms,

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you drive quicker because people are colder.

MR. SKEEN: Really drive fast.

MR. ROBEDEAU: Get stuck in the ice, you drive and use your red lights and sirens.

Treatment and transport — and I just realized something sitting here reading this the first time, we mentioned system medical director, and I don't know if we want to put that in the record or not.

MR. THOMAS: You actually have that in here somewhere. It's 10-A. You say, "We reaffirm our commitment to that proposal," which was the detailed medical direction proposal.

MR. COLLINS: Right. You have already given that one.

MR. DRAKE: Right.

MR. ROBEDEAU: Treatment and transport under A, treatment to be provided in accordance with medical protocols adapted by the system medical director, and, C, transport to be either — to be by either public or private conveyance in accordance

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with protocols promulgated by the system medical director. Is there a problem with either one of those? There is?

MR. SKEEN: Well, yeah. I mean, our exception to that is that that's not nearly detailed enough to outline the intent or the scope of the treatment of transport protocols. Don't take exception to the fact that the system medical director ought to develop the protocols.

MR. DRAKE: You don't have any problem with A? But you have a problem with —

MR. SKEEN: I don't have any problem with A other than I would like to see what they are before approving them.

MR. DRAKE: Currently now, there is medical protocols. All we are saying is, the system medical director has medical treatment protocols.

MR. SKEEN: Restricted to treatment here. Right.

MR. DRAKE: The only change, instead of them being approved through the process they are currently, that then they will have a system medical director that will do

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the approval.

MR. ROBEDEAU: Currently, what it does is, all it does is bypass the MAB, get something moving.

MR. DRAKE: And B is just, those have to be outlined, and they are not outlined. So the concept is, there would be a public transport service. I assume you take exception to that.

MR. SKEEN: You know, and I will be real clear here, too. Is that — and I think we have made it pretty clear of the type of system that we think ought to — components that ought to be involved with this. And it puts us in a position of having to say, this is our preference. If nobody in the world buys off on that, then, we move to option two, which we think is an inferior model but nevertheless requires our support of it.

So what I am talking about going through here, I am talking about our first option. I don't disagree with that. And we will spell all that out in whatever we do.

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MR. DRAKE: Okay.

MR. THOMAS: Great.

MR. ROBEDEAU: Well —

MR. DRAKE: So CARE agrees with B. Pete, do you agree with B?

MR. ROBEDEAU: So we are three to one on B.

MR. SKEEN: And the only thing I would say there, Mark, again on that is that even in support of the tiered system, which is what this speaks to, is we would want to see protocols written out. This is a pretty broad brush with this.

MR. DRAKE: Right.

MR. ROBEDEAU: It is but there are no protocols I know of.

MR. SKEEN: There are. There are some around the country. You are talking about locally?

MR. ROBEDEAU: Right.

MR. THOMAS: But it does indicate that the distinction between what is a life-threatening emergency and non-life threatening emergency would be defined by protocols developed by the system medical

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director or not. That's pretty vague at this point.

MR. SKEEN: And it speaks — it has impact on a lot of things. It makes a difference whether your first tier is going to transport 50 percent of the patients or 13 percent of the patients.

MR. DRAKE: That needs to be outlined — kind of chicken and egg situation.

Is there a difference you would support, Trace? Would you support 13 percent as opposed to 50 percent? Are you not going to support it at all at this point as your option one or option A?

MR. SKEEN: We will address it in option B.

MR. DRAKE: Okay.

MR. SKEEN: If the — I guess it really boils down to, what is the purpose of the tiered system, what you are trying to accomplish. And if you are trying to provide minimal utilization of existing resources within the fire service, then, the lower percentage of the transport has a greater facilitation of that.

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If you are trying to accomplish massive revenues for the first tiered system, then, obviously, they need higher percentages. But you hate to kind of deal in ratios and percentages either as opposed to actually probably the definition of life-threatening and non-life threatening.

MR. DRAKE: Excuse me.

MR. ROBEDEAU: We are done with that? It is broad brush. I understand that. Quite honestly, don't know what the protocols are going to be.

MR. SKEEN: I think that's something we ought to try to do in the next few days because there are a lot of systems around that use the life-threatening versus non-life threatening protocols, even for the same provider. They use those differences. And we probably could get —

MR. DRAKE: Tulsa.

MR. SKEEN: Pinellas. There's a number of them.

MR. DRAKE: Kansas City.

MR. ROBEDEAU: Do we have a volunteer to get them?

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MR. COLLINS: Actually, we can get them for you if you give me a list where you think they are.

MR. SKEEN: I think virtually all of the —

MR. DRAKE: Tulsa, Oklahoma City, Kansas City, Pinellas County.

MR. ROBEDEAU: Almost everybody in the country uses dual system except us.

MR. SKEEN: Clark County is going to that, but I doubt they have theirs developed yet. It's something they promised to do a year ago.

Jeff Clausen could probably tell you. In fact, he probably has copies of those because that's part of his.

MR. COLLINS: Oh, Jeff has that —

MR. SKEEN: That's part of his whole priority dispatching.

MR. COLLINS: He probably charged $10,000.

[22] **MR. ROBEDEAU:** You will get off that [23] cheap?

[24] **MR. COLLINS:** That's only to look. [25] Can't copy them. You have to memorize what

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[1] you can.

[2] **MR. ROBEDEAU:** Let's go to five. What [3] five was, just essentially, made a very [4] short list of the facilities available and [5] said the patients will be transported to [6] the appropriate facility. And I realize [7] that is also very broad brush.

[8] **MR. DRAKE:** But that's what they are [9] doing now.

[10] **MR. COLLINS:** What is mental health [11] now?

[12] **MR. SKEEN:** Good state of mind.

[13] **MR. COLLINS:** Thank you.

[14] **MR. SKEEN:** But that's not important.

[15] **MR. DRAKE:** It's not something we [16] have.

[17] **MR. THOMAS:** It means what none of us [18] have.

[19] **MR. COLLINS:** Why is it in here?

[20] **MR. ROBEDEAU:** Portland Adventist does [21] some mental health admissions.

[22] **MR. DRAKE:** Just an identification of [23] the system.

[24] **MR. COLLINS:** But are these resources [25] to which emergency ambulances transport?

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[1] **MR. ROBEDEAU:** Yes.

[2] **MR. DRAKE:** Uh-huh.

[3] **MR. COLLINS:** We only transport the [4] top three.

[5] **MR. ROBEDEAU:** No. We have taken for [6] admission for mental health on police holds [7] at Portland Adventist.

[8] **MR. DRAKE:** And at University.

[9] **MR. COLLINS:** Only emergency.

[10] **MR. DRAKE:** No. We bypass the [11] emergency department. We don't drop off [12] mental patients in the emergency.

[13] **MR. COLLINS:** If they do, they are in [14] violation of the County code. Emergency [15] ambulance can only transport to a hospital [16] that has an emergency hospital.

[17] **MR. ROBEDEAU:** You are going through [18] the emergency department, and they tell [19] them to take them to the mental department.

[20] **MR. COLLINS:** The emergency department [21] is telling them — the reason I bring this [22] up, we still have security psychiatric [23] patients at Holladay Park.

[24] **MR. ROBEDEAU:** Only if you go from [25] Portland Adventist after they have been

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[1] evaluated, and then you transfer them over [2] to Holladay Park.

[3] **MR. COLLINS:** To Emanuel Hospital. [4] Right?

[5] **MR. ROBEDEAU:** They will come from [6] Emanuel, too, and Good Sam. But those all [7] have to be seen first. But for the ones [8] that will take admissions off the street, [9] when you take a mental case in, and on an [10] emergency, and if you try and leave that [11] patient in the ER, you are in big trouble.

[12] **MR. SKEEN:** This is all captured on [13] your following sentence, though. So the [14] top A, B, C, D, and E are kind of [15] irrelevant. Because you are saying the [16] medical director will develop —

[17] **MR. DRAKE:** You should describe an EMS [18] plan, the facility resources that are [19] available, which is part of the plan.

[20] **MR. SKEEN:** Do we need to make comment [21] on that?

[22] **MR. COLLINS:** Only if you want to [23] transport to someplace that isn't in the [24] current plan.

[25] **MR. ROBEDEAU:** I don't really care

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[1] whether you scratch off the bottom two, [2] too.

[3] **MR. THOMAS:** Why don't you scratch [4] them off. Make Bill happy.

[5] **MR. COLLINS:** Well, we just had an [6] issue with this about Holladay Park when [7] they closed. At first, well, we will be [8] okay. Bring them there. No. You don't [9] have an emergency room. You don't get to [10] do it both ways.

[11] **MR. MOSKOWITZ:** I see.

[12] **MR. COLLINS:** So I was just hoping you [13] wouldn't open that up again by putting that [14] back in.

[15] **MR. ROBEDEAU:** We scratched it off. [16] We don't take them directly to Holladay [17] Hospital. We go to Emanuel, Good Sam, or [18] Gresham General. You do go to Portland [19] Adventist or the University.

[20] **MR. DRAKE:** Do we need to take a [21] break?

[22] (Recess during which Mr. Thomas [23] left the meeting.)

[24] **MR. ROBEDEAU:** Why don't we get [25] going. I think there's a few things here

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[1] that are going to be pretty easy. No. 6, [2] quality improvement, "The Provider Board [3] recommends that Multnomah County establish [4] a quality improvement committee consisting [5] of a representative of each provider [6] including: MRH, BOEC and law enforcement."

[7] **MR. SKEEN:** Our only comment on that, [8] I think, is the — are you suggesting that [9] the County be responsible for the oversight [10] of the QI?

[11] **MR. ROBEDEAU:** Yes.

[12] **MR. SKEEN:** As opposed to the medical [13] director?

[14] **MR. ROBEDEAU:** Well, no. It would be [15] the medical director. The medical director [16] will be contracted, as I understand it, [17] with the County. And it would be —

[18] **MR. COLLINS:** I think wherever you [19] read County, you can say medical director. [20] That just says who in the County.

[21] **MR. SKEEN:** Okay.

[22] **MR. ROBEDEAU:** "The committee will be [23] charged with the responsibility of [24] establishing a database and retrieval [25] system for total quality management."

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[1] So we can get some data. Is that [2] agreeable to everybody? No. 6 that you [3] wrote, Mark, is agreeable to everybody. [4] Vote on it.

[5] **MR. SKEEN:** I would expand it to talk [6] about patient — be very specific about [7] patient outcomes.

[8] **MR. ROBEDEAU:** We can. I envision [9] that as part of the database for retrieval [10] of system information.

[11] **MR. SKEEN:** Okay.

[12] **MR. DRAKE:** You are saying to look at [13] outcome studies?

[14] **MR. SKEEN:** I agree with that. [15] Probably ought to be developed because some [16] of this is new concepts to people, TQM. [17] Spell it out a little bit.

[18] **MR. DRAKE:** This whole thing has to be [19] written out. This is just the concept. [20] Okay. So that's a yes?

[21] **MR. SKEEN:** Yes.

[22] **MR. ROBEDEAU:** Okay.

[23] **MR. DRAKE:** Good. We are moving.

[24] **MR. ROBEDEAU:** Seven, system revenue [25] sources: "User fees will remain the

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[1] primary source of income to fund the [2] Multnomah County EMS system, as is being [3] done currently."

[4] That's just plain statement. That's [5] our recommendation that this not become a [6] tax-supported or tax-subsidized system.

[7] **MR. SKEEN:** Of course, if you talk [8] about Multnomah County's EMS system, right [9] now the first responders, whatever [10] component of that is, is subsidized.

[11] **MR. ROBEDEAU:** You go down to No. 8, [12] which is system cost, we can go put them [13] together. No. 8, system cost, is, A, "All [14] system costs currently supported by user [15] fees (rates) will continue to be supported [16] by user fees"; and, B, "All system costs [17] currently supported by tax revenues will [18] continue to be supported by tax revenues," [19] which is essentially what we are saying [20] with No. 7 and 8, is that there will be no [21] change in the funding mechanism of [22] Multnomah County EMS.

[23] **MR. DRAKE:** Pete, if we could just [24] change — right now what the user fees are [25] doing is funding Multnomah County EMS

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[1] office, not the system.

[2] **MR. ROBEDEAU:** Maybe my terminology is [3] bad on user fee. Fee for service?

[4] **MR. SKEEN:** That's —

[5] **MR. MOSKOWITZ:** I think that's an [6] issue that Mark says, when you use the word [7] system there, it means something beyond the [8] EMS office. Is that —

[9] **MR. DRAKE:** Yeah. User fee.

[10] **MR. ROBEDEAU:** User fees, we are [11] talking about two totally different things [12] here. The user fee that we are paying [13] EMS. The $240,000 that EMS gets is not [14] what I am talking about user fees here. [15] The user fees I am talking about are the [16] rates that are charged for services [17] rendered that support at least the private [18] aspect of the system.

[19] **MR. SKEEN:** So what it should have [20] been, "User fees remain the primary source [21] of income to fund the emergency transport [22] system."

[23] **MR. DRAKE:** In Multnomah County.

[24] **MR. SKEEN:** Just so it's clear.

[25] **MS. BONNER:** That leaves out fire

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[1] bureau. Right?

[2] **MR. SKEEN:** Well, not necessarily.

[3] **MR. ROBEDEAU:** No.

[4] **MR. SKEEN:** It would.

[5] **MS. BONNER:** Currently. It leaves out [6] the current fire response?

[7] **MR. SKEEN:** Right. Which is funded [8] by tax dollars.

[9] **MR. DRAKE:** Is that okay, Pete? [10] Because that works.

[11] **MR. ROBEDEAU:** Now, wait a minute. I [12] am confused.

[13] **MR. MOSKOWITZ:** Read No. 7 again. [14] User fees —

[15] **MR. SKEEN:** "Users fees will remain [16] the primary source of income to fund the [17] Multnomah County EMS system, as is being [18] done currently."

[19] **MR. ROBEDEAU:** Okay.

[20] **MR. SKEEN:** I think you are saying the [21] same thing, but there's room for [22] misinterpetation of Multnomah County EMS [23] system. Then seven and eight, are they all [24] right as changed? Elaborate on them so we [25] know what we are talking about.

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[1] **MR. SKEEN:** 8-A, a question I have, [2] "All system costs currently supported by [3] user fees will continue to be supported by [4] user fees." Under the tiered system you [5] guys are talking about, that would then [6] indicate that all of the costs associated [7] with fire department transport would be [8] funded by user fees.

[9] **MR. ROBEDEAU:** The fire department [10] proportion of that would have to be.

[11] **MR. SKEEN:** For the fire medic units, [12] would have to come from user fees and [13] cannot come from tax subsidies.

[14] **MR. DRAKE:** It's a little confusing [15] but —

[16] **MR. ROBEDEAU:** Not — any additional [17] cost the fire bureau is talking about doing [18] would have to be a user fee-based system, [19] is what I am saying.

[20] **MR. DRAKE:** Why don't we, instead of [21] saying "All," because that's a finite [22] number system — under A and B instead of [23] deleting the word "All" —

[24] **MR. SKEEN:** What you have is, if fire [25] medic units are required only to charge

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[1] user fees for their incremental costs, [2] according to Tri-Data study, you will have [3] a rate of $139.

[4] **MR. DRAKE:** Trace, right.

[5] **MR. SKEEN:** That's what I am saying.

[6] **MR. DRAKE:** I don't agree with the [7] Tri-Data figures.

[8] **MR. SKEEN:** But if you understand what [9] I am saying, though —

[10] **MR. DRAKE:** Yes.

[11] **MR. SKEEN:** If they are only going to [12] fund incremental costs with user fees, [13] those user fees are going to be [14] substantially low. And then if you have [15] the secondary provider, you have a [16] situation with a patient lying in the [17] street saying, I am really, really hurt [18] because I want to take the $139 trip as [19] opposed to the $673 trip.

[20] **MR. MOSKOWITZ:** Well, has it been [21] decided that it's only going to be the [22] incremental costs that will be charged?

[23] **MR. SKEEN:** Well, it hasn't, but I [24] think that's what this statement gives rise [25] to if we are not careful with what we are

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[1] recommending here.

[2] **MR. DRAKE:** Where we are trying to go [3] here, I think — and, Trace, you kind of [4] hit the nail on the head — is that we [5] don't want that to occur. We want to say [6] that if the user fees — if there's a user [7] fee rate, it should be the same. Not [8] necessarily the same.

[9] **MR. ROBEDEAU:** Not necessarily the [10] same.

[11] **MR. DRAKE:** But similar.

[12] **MR. ROBEDEAU:** The fire department — [13] we are not currently subsidized by — with [14] tax money now.

[15] **MR. DRAKE:** Right.

[16] **MR. ROBEDEAU:** We are currently [17] subsidizing taxes. I actually think we [18] ought to make a recommendation it goes [19] away. But that's something I am not going [20] to get into right now.

[21] **MR. SKEEN:** That what go away?

[22] **MR. ROBEDEAU:** The user fee we pay to [23] Multnomah County.

[24] **MR. DRAKE:** The horizontal head tax.

[25] **MR. MOSKOWITZ:** Are you trying to say

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[1] that those functions that are currently [2] supported entirely by user fees should [3] remain entirely supported by user fees, so [4] that if the fire bureau gets into [5] transport, the full cost of that transport [6] ought to be covered by a user fee?

[7] **MR. SKEEN:** That's the position we [8] would take. Determine what the full cost [9] of service is for the fire bureau, and [10] that's what should be taken into [11] consideration for establishing rates rather [12] than incremental costing.

[13] **MR. MOSKOWITZ:** And, of course, you [14] will get into a wonderful debate about what [15] constitutes the full cost of that, I [16] suppose.

[17] **MR. DRAKE:** Can I make a suggestion [18] here?

[19] **MR. COLLINS:** We are not proposing [20] either one of those.

[21] **MR. DRAKE:** If I can make a [22] suggestion, it's four o'clock. Why don't [23] we go on to nine and ten. People have to [24] get out of here. Leave system cost for [25] next week.

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[1] **MR. ROBEDEAU:** We are going to have to [2] write something on system cost. We have to [3] get a draft out before next week's meeting [4] so everybody

can review it and talk about it at next week's meeting.

**MR. DRAKE:** Pete, I am saying, this is a such a broad pen, we need to explain it a little better and then vote on it next week.

**MR. SKEEN:** That's fine. But you ought to hear Bill's comment when he said we are not supporting either one of those.

**MR. COLLINS:** Well, what I am really supporting on the fee structure is that there be no difference in the fee structure.

**MR. SKEEN:** That they be uniform rates.

**MR. COLLINS:** So there is never a question of, a transport was done because the rate was thus or so. So that is not really — that's not, the fire department needs to base it on full costing or incremental costing. It means that the rate in the system will have to be a rate

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that meets the various cost requirements in order to do that.

**MR. SKEEN:** So that rate would be no less than the full costing of service?

**MR. ROBEDEAU:** Let's go on to nine. We are covering that here. Nine, rates charged, A, "The County should establish a rate committee to set uniform rates for ambulance service"; and, B, "Rates established by the committee must be sufficient to allow the provider to recover the full costs of providing the service."

**MR. DRAKE:** Right. And so this committee would do that, however that committees goes.

**MR. COLLINS:** If you are looking at the tiered system, you can say this, but it may not be true. You may need to recover — the private ambulance company may need to have a rate X in order to recover the necessary cost.

**MR. DRAKE:** Right.

**MR. COLLINS:** The fire department's cost may be in excess of that, but they may not want to recover their cost.

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**MR. DRAKE:** Well, it just must be sufficient to allow the provider to recover the full cost.

**MR. COLLINS:** That's what I am saying. If you do full costing, if you took the position in a tiered system that you set the rate to recover the full cost of the fire department, whether they wanted to or not —

**MR. DRAKE:** That's not what it says. It just says, "The rates established by the committee must be sufficient to allow the provider."

**MR. COLLINS:** That's an option?

**MR. SKEEN:** Bill is exactly right. The Tri-Data study has said that the tiered system would cost — they indicated it would cost them $1,008 per transport.

**MR. ROBEDEAU:** $1,008.

**MR. SKEEN:** 1008 per transport.

**MR. DRAKE:** But B should be saying it's to allow the provider to recover the full cost.

**MR. SKEEN:** You could allow fire to charge that amount if they wanted to?

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**MR. DRAKE:** The rate committee is going to set the rates.

**MR. SKEEN:** If they set the rates to allow them to, then, they are going to set the rates at $1,008.

**MR. COLLINS:** If you have it, it must be. The way I read this statement, you must set a rate that allows them to recover full cost whether they wanted to or not.

**MR. DRAKE:** No.

**MR. ROBEDEAU:** That's right. That's what I intend. I wrote it.

**MR. SKEEN:** Well, I do. I agree with Pete.

**MR. DRAKE:** I can't agree that it should be —

**MR. ROBEDEAU:** Eight says —

**MR. DRAKE:** 8-A I agree with.

**MR. ROBEDEAU:** What's currently will remain user fee and what's tax will remain tax. And nine says that you have to have full — recover full cost.

**MR. DRAKE:** No. The discussion is that, and has been, the committee should allow — the rates should be sufficient to

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recover the cost but they don't have to be that. I mean, they can be whatever they are, but they must be —

**MR. ROBEDEAU:** I don't think so.

**MR. DRAKE:** — able to.

**MR. ROBEDEAU:** What Bill has been saying, I think from day one here, is that he believes that emergency services or emergency transports are subsidizing nonemergency transports.

**MR. DRAKE:** That's a different issue, though.

**MR. ROBEDEAU:** But how are you going to set a rate, then, if you don't know the cost of an emergency transport?

**MR. COLLINS:** In the tiered system.

**MR. ROBEDEAU:** On nonemergency transport?

**MR. COLLINS:** If the rate committee or whoever is setting the rate agreed that the appropriate rate for the system ought to be $500 —

**MR. DRAKE:** Then that's what it would be.

**MR. COLLINS:** — that's what it would

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be. If the fire department, it cost them a thousand bucks, if the police set in a tiered system with the fire department's use of the subsidy that the City already has if the City says, we are not going to provide a subsidy, then, we would say there isn't any reason — I mean, there's no advantage of using current resources. You have taken those away.

**MR. DRAKE:** Right.

**MR. COLLINS:** It's implicit in that.

**MR. DRAKE:** Then the rates —

**MR. COLLINS:** What I want to do is make sure the fire department doesn't charge $150 and the ambulance companies charges $350 or a thousand bucks.

**MR. ROBEDEAU:** Then this rate comes out and says, because Lynn gets to chair the rate committee, and she says these are only worth 30 bucks a pop and that's all we are going to give you, the City is going to do fine.

**MR. COLLINS:** Well, the rate committee, you set rates. Right now we don't set rates.

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**MR. ROBEDEAU:** I understand.

**MR. COLLINS:** You set rates. You are going to have to do some kind of an audit under some kind of a controlled basis to decide what's going to be allowable cost for whoever is getting the rate and the rate gets set. It's like Medicare, you know, or Medicaid. Not Medicaid. Maybe Medicare.

**MR. DRAKE:** There are two separate issues on uniform rates. Bill is bringing up one. There's another one that's been a complaint in the system. Complaint in the system has been that AA, CARE, and Buck all charge different rates for the same service. And so one of the ideas to establish uniform rates for set services is the two providers in the system — we are hoping there will be two providers — private providers.

**MR. COLLINS:** That an editorial comment.

23] **MR. DRAKE:** Yes. — will set — the
24] rate committee will set the same
ates for [25] each service. And all we are
aying is

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1] those rates they set must be able to
llow [2] the provider to recover the full
ost.

3] **MR. ROBEDEAU:** Okay. We are not
oing [4] to get very far on this.

5] **MR. MOSKOWITZ:** What if you said,
] private provider full cost.

7] **MR. ROBEDEAU:** No. I just can't
gree [8] with that. I have to agree with
race. [9] And I realize that's bad form
ere but —

0] **MR. COLLINS:** I will make a note of
1] that.

12] **MR. SKEEN:** I happen to agree with
13] Pete.

14] **MR. ROBEDEAU:** It should be uni-
orm.

15] **MR. MOSKOWITZ:** No. The rate
hould [16] be uniform. But what if the
ommittee [17] deciding the rate only
ooked at the [18] private providers in
erms of allow —

19] **MR. ROBEDEAU:** No. Then you are
20] allowing the fire department to
ome out [21] and say, gee, what we are
oing here is, [22] for $139, we are taking
ll these really [23] serious patients; all
ou are doing is [24] creating more prob-
ems. We are taking all [25] these serious,
ife-threatening emergencies

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1] for $139, and here's the private out
here [2] charging $500 bucks.

3] **MR. DRAKE:** No. No. No. We are not
] going to let them do that. They are
oing [5] to establish uniform rates. That
s No. 1.

] **MR. SKEEN:** What you are doing —

7] **MR. ROBEDEAU:** When you do that,
ou [8] are doing exactly the same thing.
ou have [9] the fire bureau over here
andling all [10] these, the most seriously
ll patients, and [11] you have got the
rivates over here [12] handling just ordi-
ary kind of routine [13] stuff. They are
harging 700 bucks; they [14] are charg-
ng 700 bucks. It's the same kind [15] of
problem.

16] **MR. SKEEN:** There will be — as I [17]
hink everybody is in agreement that the
18] rates should be uniform, whatever
ve arrive [19] at, they should all be uni-
orm so it [20] doesn't put the patient in
position of [21] having to determine
vhat it is.

22] **MR. DRAKE:** So we agree to 9-A. [23]
verybody agrees.

24] **MR. SKEEN:** Yes.

25] **MR. DRAKE:** Okay.

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[1] **MR. ROBEDEAU:** Okay.

[2] **MR. SKEEN:** What we have a [3] philosophical problem with is —

[4] **MR. DRAKE:** B.

[5] **MR. SKEEN:** — is an entity that — [6] whose cost is $1,000 and essentially — and [7] the rate being $500, and essentially tax [8] dollars subsidizing insurance companies and [9] HMOs.

[10] **MR. DRAKE:** Let's rewrite B. Let's [11] move on. We have to rewrite that.

[12] **MR. ROBEDEAU:** Let's, just for the [13] minute here, I don't think there's any [14] argument with ten. Can we finish off ten?

[15] **MR. DRAKE:** Yeah. That's what I want [16] to do.

[17] **MR. ROBEDEAU:** Maybe there is an [18] argument with ten. Just a minute. I will [19] just read it again.

[20] **MR. MOSKOWITZ:** You are arguing with [21] yourself?

[22] **MR. ROBEDEAU:** No.

[23] **MR. SKEEN:** When you said the proposal [24] submitted to the MAB on May 14th, Buck [25] agrees with everything except the naming of

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[1] the University, is that the document you [2] are referring to?

[3] **MR. ROBEDEAU:** Yes.

[4] **MR. DRAKE:** Uh-huh.

[5] **MR. SKEEN:** That's already been [6] submitted?

[7] **MR. DRAKE:** Right.

[8] **MR. ROBEDEAU:** That went to the MAB on [9] the May 14th meeting. That was the medical [10] director proposal.

[11] **MR. COLLINS:** Right. That should be [12] presented, whoever is presenting for you.

[13] **MR. ROBEDEAU:** That was given to MAB. [14] They unanimously rejected it without —

[15] **MR. SKEEN:** They never discussed it.

[16] **MR. COLLINS:** They agreed to bring it [17] up again on the 23rd.

[18] **MR. SKEEN:** I understand the [19] University wasn't exactly thrilled with [20] that recommendation.

[21] **MR. COLLINS:** We have looked at it. [22] We will comment on the thing. We actually [23] can't take a recommendation, I don't [24] believe, naming anybody. But that's beside [25] the point, Trace, that the components are

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[1] all there.

[2] **MR. ROBEDEAU:** My attitude on that is [3] still the same. We have been bringing it [4] for years. It's never been a problem.

[5] **MR. DRAKE:** So we agree with A except [6] with the naming of the University. And [7] then, obviously, there is a disagreement [8] that — there will be disagreement with B [9] and C.

[10] **MR. ROBEDEAU:** Let's go back up and [11] see if we can resolve the rest of them when [12] we get back to this. You out of here?

[13] **MR. COLLINS:** Yeah. I have to go. I [14] just have to take off. You guys can stay [15] for as long as you like.

[16] **MR. ROBEDEAU:** We have all got to get [17] going.

[18] (Mr. Collins left the room.)

[19] **MR. DRAKE:** We have accomplished most [20] of what — I think we just need to rewrite, [21] Pete, 8-A, B, and 9-B. Those need to be [22] rewritten a little bit or fleshed out a [23] little bit more so that people have a [24] better understanding what they are so we [25] can vote on them.

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[1] **MR. ROBEDEAU:** I don't know what you [2] want to do with A and B.

[3] **MR. DRAKE:** I think we need to explain [4] it a little bit better.

[5] **MR. ROBEDEAU:** Okay. Can we do this? [6] Why don't you — you seem to have a handle [7] on what you want it to be. Can you sit [8] down, kind of write it out, fax it out to [9] us tomorrow? And let us look at it and get [10] it on over to Steve?

[11] **MR. DRAKE:** I will try and do that [12] tomorrow. We are off the record now.

[13] (Discussion off the record.)

[14] **MR. ROBEDEAU:** So 10-A was agreed to. [15] We are back on the record to do 10-B, the [16] County establish a single ambulance service [17] area for the life-threatening emergencies, [18] with the single provider to the Portland [19] Fire Bureau. And C, two ambulance [20] districts for non-life threatening [21] emergencies, with one private provider for [22] each district.

[23] That's the two recommendations. I [24] think we need to vote on those. I don't [25] think you are going to agree to them.

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[1] **MR. SKEEN:** Huh-uh.

[2] **MR. ROBEDEAU:** Yeah.

[3] **MR. DRAKE:** So we agree. You should [4] write the things — I mean, if you don't [5] agree with these, some of these things, [6] write what your position is going to be [7] because we need to submit that as part of [8] the report.

[9] **MR. ROBEDEAU:** One thing I would like [10] to see — those will go as a three

to one [11] — is that the majority and the minority [12] report will go together.

[13] **MR. SKEEN:** That's fine.

[14] **MR. ROBEDEAU:** Write it up as a single [15] package.

[16] **MR. SKEEN:** I don't have any problem [17] with that.

[18] **MR. ROBEDEAU:** And present it to them.

[19] **MR. DRAKE:** As a matter of form, each [20] — you know, the majority report here, and [21] if there is a minority report, that it be [22] for that section rather than at the end or [23] something. That each section, it goes that [24] way so they can see them together.

[25] **MR. MOSKOWITZ:** For each element.

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[1] **MR. DRAKE:** Each element. Thank you.

[2] **MR. ROBEDEAU:** That's a better idea. [3] Is that okay with you?

[4] **MR. SKEEN:** That's fine. I probably [5] ought to read a couple things in there for [6] the record. Whenever you are ready.

[7] **MR. ROBEDEAU:** Sure.

[8] **MR. SKEEN:** One is, we believe that [9] the testimony before the Provider Board has [10] indicated a substantial lack of data to [11] support broad base system modifications. [12] There ought to be a time-definite period [13] for gathering data before making system [14] modifications.

[15] Secondly, as it relates to high [16] performance systems, that Multnomah County [17] currently meets all of the high performance [18] standards established on an industry-wide [19] basis with the exception of the first [20] response component, which in a high [21] performance system calls for EMT-D four [22] minute 90 percent response time, which is [23] not currently being met.

[24] Nor does it have a single associate [25] medical director. And essentially, we have

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[1] kind of merged towards that, but it's not [2] an official component.

[3] And thirdly, that the clinical [4] training should be centralized and [5] coordinated under a single entity, and that [6] component is missing currently. Other than [7] that, high performance system standards are [8] all consistent, including the comparative [9] rates and charges on a national basis with [10] the system of these capabilities.

[11] Thirdly, that there needs to be [12] established, before the acceptance of a [13] specific ASA plan, there needs to be [14] established a system status plan for both [15] the tiered system as well as a nontiered [16] system. Transport protocols need to be at [17] least roughed out; dispatch protocols need [18] to be roughed out. The plan needs to [19] indicate whether there is an increase or [20] reduction in the number of paramedics. And [21] I can't read what my next note reads.

[22] That there be rate regulation that's [23] established and then tied to automatic [24] inflationary adjustments tied to economic [25] index. That the full — we just got

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[1] through discussing, but the full cost of [2] services are generated from user fees for [3] ambulance transport. And the agencies be [4] specified as to fire service, secondary [5] provider, and the dispatch agency.

[6] And that's actually what my other one [7] that was up there I couldn't remember. I [8] think our recommendation would be that the [9] dispatching be performed by the provider [10] itself as a secondary PSAP.

[11] **MR. DRAKE:** I would like to respond to [12] just a couple things you said, Trace. [13] First, I agree that we have not had enough [14] time to respond — gather the data [15] necessary. We are being held by response [16] — or a gun to our head by the County. We [17] don't have a choice in this. If we had a [18] choice of doing this in three to six [19] months, I would agree with you, and I think [20] we do need three to six months for the [21] record to put this system together [22] correctly. We don't have that kind of [23] time. That's not a fault of the providers [24] here. I mean —

[25] **MR. SKEEN:** I will tell you, I think

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[1] the data retrieval that needs to be created [2] is more than a three- to six-month [3] process. It's probably a four to eight [4] months.

[5] **MR. DRAKE:** Secondly, you said we have [6] all the high performance standards [7] currently in this system. I would [8] disagree. The one component we don't have [9] is the dispatching.

[10] **MR. SKEEN:** You are right. [11] Accountable dispatching. I will add that.

[12] **MR. DRAKE:** And I agree with that. We [13] do need to somehow redo the dispatch [14] system. Either they need to be totally in [15] charge, including posting units all the [16] time, dispatching all the units and the [17] closest unit to an emergency, or they need [18] to do something different. Okay?

[19] **MR. SKEEN:** I prefer the latter.

[20] **MR. DRAKE:** Well, something needs to [21] be done. That's all I got.

[22] **MR. ROBEDEAU:** We will have the [23] rewrite to everybody by Friday morning?

[24] **MR. DRAKE:** I will try and do that.

[25] **MR. ROBEDEAU:** No try, no try. If we

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[1] are going to have a Wednesday meeting, we [2] have to get this —

[3] **MR. DRAKE:** Friday morning.

[4] **MR. ROBEDEAU:** — at least out by [5] Tuesday so everybody has a chance to read [6] it.

[7] **(PROCEEDINGS ADJOURNED)**

[9] **(NOTE:** Untranscribed steno notes [10] archived permanently on computer; [11] transcribed English files archived [12] three years on computer.)

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CERTIFICATE

I, CAROL STUDENMUND, a Certified Shorthand Reporter for Oregon and a Registered Professional Reporter, do hereby certify that I reported in stenotype the proceedings had upon the hearing of this matter, previously captioned herein, that I transcribed my said stenotype notes through computer-aided transcription; and, that the foregoing transcript constitutes a full, true and accurate record of all proceedings had upon the hearing of said matter, and of the whole thereof.

Witness my hand at Portland, Oregon, this 15th day of June, 1993.

Certificate No. 90-0077
LORD, NODLAND, STUDENMUND
(503) 299-6200

/s/ Carol Studenmund

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