Introduction

- Who we are
- About this project
  - Contract with current provider ends as of December 31st, 2022.
  - 1 Service: Chickasaw Ambulance Service covers essentially entire county
  - Consider possible models for what an EMS System might look like in Chickasaw County IA going forward
  - 3-Phase project (this is phase II)
  - Scope of work
    - Determine level and quantity of EMS that is need in Chickasaw County IA
    - Suggest models to provide said EMS
    - Estimate revenue and expenses
  - Recomend models that are long-term sustainable/reliable/viable
  - Sources of data
- About this presentation
- The methodology

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14 Key Findings

- The single greatest threat jeopardizing the long-term sustainability, reliability, and viability of EMS in Chickasaw County is the inability of the current parties to govern the current system in a collaborative way.
- EMS is a vital, desirable, and expected element of healthcare and quality of life.
- Chickasaw County is served by a robust infrastructure of emergency services with law enforcement, fire, and separate rescue and EMS services.
- Recruiting and retaining the EMS workforce has been, and likely will continue to be, a major challenge.
- Patient needs are not being met today due to the lack of available resources to meet all interfacility transfers for all patient types and all payor types.
- Communities bordering Chickasaw County with their own ambulance services are courting Chickasaw County Townships for coverage agreements.
- There is little, if any, transparency or oversight for the public dollars going to a private organization.

14 Key Findings

- Adequate coverage for service area is jeopardized when interfacility transports are accepted. At times, the service area is left unprotected when the available resources are used for an interfacility transfer.
- Today, Chickasaw County invests in EMS through a subsidy, the last contract extension is an annualized payment of $294,000.
- Chickasaw County is planning for Essential Service vote to be placed on the ballot this fall, permitting taxation for costs associated with the provision of ambulance services.
- Chickasaw County has created an Ambulance Council – with limited authority, reporting to Board of Supervisors.
- Communities where ambulances were once stationed feel returning ambulances to these communities is necessary (data does not support).
- Public has mixed feelings on government-owned ambulance vs. private
- Many community members question a subsidy being paid to a private for-profit organization.

8 Recommendations

1. **Create a community and county wide shared vision for EMS** (All stakeholders, operational and clinical expectations, number of vehicles and locations, current and future community growth, and assess communities' willingness to pay).
2. **More deeply understand and accept the needs of the current EMS system** (What is desired by the community, what is financially sustainable, how to govern the system and maintain strong partnerships, what the system will cost and how to fund it).
3. **Develop a new model for EMS that meets recommendations 1 and 2** (Whether it's a new contract, new provider, or new ownership model, ensure accountability, transparency, and meet all needs regardless of willingness or ability to pay).
4. **Clearly define scope, authority, and revisit the membership of the Ambulance Council** (Empower the council to lead, manage, and regulate the desired system. Ensure needed voices sit on the council, for example, the hospital).
5. **Maximize current revenues** (Minimize the need for public support).

8 Recommendations

6. **Require any future model or provider that receives public dollars to serve all requests for service** (Regardless of 911 or interfacility, and all payor types).
7. **If a future model includes public dollars there should be full accountability and transparency** (Accountability and transparency on how dollars are used as well as other revenues being maximized to reduce the need for public dollars)**.**
8. **If necessary, use mediation or binding arbitration to develop any contractual tools needed for the new system** (As a condition of a contract, or as part of dispute resolution, require all parties to agree to and enforce non-disclosure agreement and non-compete agreements to the extent allowed by law).

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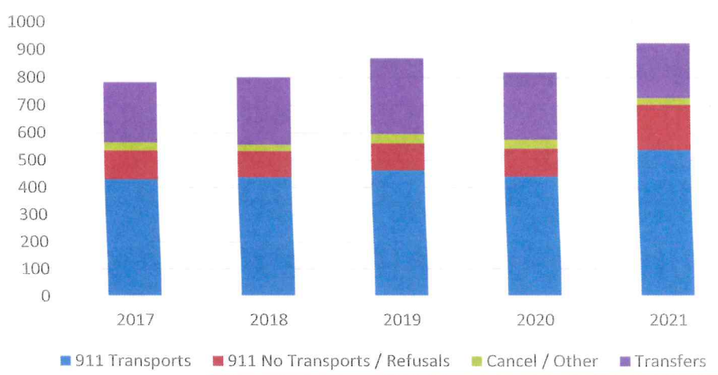
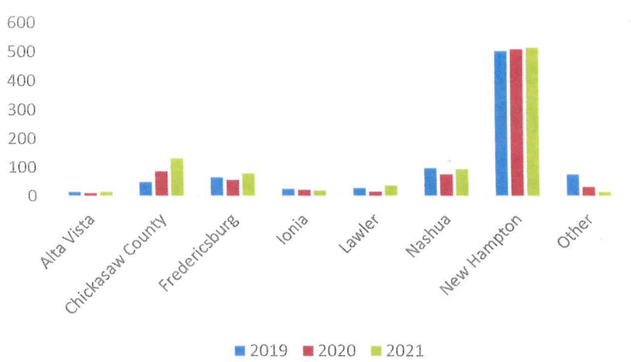
EMS Data

Historical Call Volume

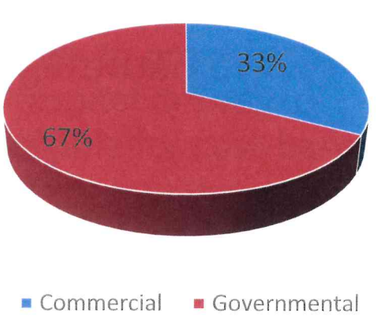


	2017	2018	2019	2020	2021
911 Transports	430	438	463	441	538
911 No Transports / Refusals	106	96	99	102	166
Cancel / Other	29	22	34	32	23
Transfers	218	245	275	245	199
Total	783	801	871	820	926

Historical Call Volume by Location



Blended Pay Mix



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EMS Requirements

- 2 On duty Ambulances
  - 1 Staffed 24 hours a day with fulltime Paramedic/EMT (ALS) staffing model
  - 1 On call 24 hours a day for 911 backup and interfacility requests (ALS) fulltime Paramedic/EMT or RN/EMT
- 3 Physical ambulances fully equipped
- 1 Location to house vehicles along with crew quarters and office space
  - Misc. office and EMS equipment
- 1 Fulltime leader/manager
- Contract for billing services

4 Possible System Models

1. **Develop a new balanced contract with current provider** (Quantitative, qualitative, operations, quality, finance, governance, and transparency and accountability for subsidy dollars.)
2. **Solicit through an RFP for a new provider** (Informal research revealed other interested organizations.)
3. **Create a new provider owned through a joint powers agreement (JPA) or ambulance district** (Entities such as New Hampton and Chickasaw County come together to fund [subsidize through taxes] and provide the service.)
4. **Mercy One New Hampton Medical Center chooses to provide the service** (There has been no indication that the hospital desires to provide the service, the hospital would not be eligible for cost-based reimbursement [35-mile rule]).

Financial Estimates

Assumptions

- Call volume flat
- Expenses based on 1 fulltime ALS ambulances with Paramedic/EMT staffing and 1 on call ALS ambulance with one EMT and one advanced provider (Paramedic or RN)
- Wage of 30.00 /hr with 30% for benefits
- $30.00 used for hourly rate for Paramedic and EMT (blended rate)
- Administrative costs figured at 25% of expenses
- Run volume from current provider
- Financial information projected based on run volume, suggested rates, and blended payer mix
- ALS Emergency rate used to estimate revenue for both 911 and interfacility

Estimated System Costs

Truck 1	Primary	Capital	Start Up		
Salary	$700,795.62		Truck 1	$375,000	
Expenses	$300,000.00		Truck 2	$375,000	
Total Expenses	$1,000,795.62		Truck 3	$375,000	
			Building	$600,000	
Truck 2	Backup / Transfer		Total	$1,725,000	
Salary	$231,262.55				
Expenses	$150,000.00	Personnel			
Total Expenses	$381,262.55		Truck 1	8.3	Fulltime
			Truck 2	4.15	Part time
Truck 3	Spare		Leader	1	Fulltime
Leader	$75,000		$30.08	ALS hourly rate	
Benefits	$24,750		$9.92	Cost of benefits	
Leader total	$99,750		$40.00	Total costs	
Administrative	$370,452.04	Building			
			3,000	Sq ft	
Total	$1,852,260.22		$200.00	Per sq ft	
			$600,000.00	Build Cost	
Capital Costs	Ongoing				
Equipment Depreciation	$100,000				
Capital items	$50,000				
Building Depreciation	$20,000.00				
Total	$170,000				

Estimated System Revenues

Yearly Estimated Revenue

	Base rate	Mileage	Gross	Net
911	$1,345,000	$107,600	$1,452,600	$472,095
Transfers	$575,000	$2,263,200	$2,838,200	$922,415
			Total	$1,394,510

Yearly Expenses

Operations	Personnel	Administrative	Yearly Capital	Total
$450,000.00	$1,031,808.17	$370,452.04	$170,000	$2,022,260.22
			Current Subsidy	$296,000.00
			Gain/Loss with subsidy	($331,750.22)
			Gain/Loss without subsidy	($627,750.22)

$40.00	mileage
$1,500.00	BLS Non-Emergency
$1,500.00	BLS Emergency
$2,500.00	ALS Non-Emergency
$2,500.00	ALS Emergency
$3,500.00	ALS2
$4,500.00	SCT

Rates

Billing Levels	National Averages
Mileage	$30 - $40
ALS non-emergency	
ALS emergency	$2,500 - $3,500
BLS non-emergency	
BLS emergency	$1,000 - $2,000
ALS2 emergency	$3,000 - $4,000
Specialized Critical Transport (SCT)	$3,500 - $4,500

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Develop a New Balanced Contract

Pros

- Address and resolve current challenges between parties
- Greater accountability of the provider
- Limits costs and responsibilities of government
- Clarify expectations of provider for use and accountability of public funds
- Increased transparency

Cons

- May require larger subsidies from public sources
- Structure may require more from the Ambulance Council
- Provider may not accept terms
- Legal support, mediation, or arbitration may be required

Contract Recommendations

- 6 Major Sections
  - Operations
  - Quality
  - Accountability
  - Governance
  - Transparency
  - Finances

Contract Recommendations

- 6 Major Sections
  - Operations (examples)
    - Service level required (ALS)
    - Chute time (notified by 911 to enroute)
    - System capacity (resources for multiple calls)
    - Provide service to all 911 and interfacility transfers regardless of payor type or payment method
    - Always at least one staffed and on duty ambulance in the response area (cannot take last ambulance out of area for a transfer)

Contract Recommendations

- 6 Major Sections
  - Quality (examples)
    - Clinical care key performance indicators (KPIs)
    - Patient outcomes
    - Participation in systems of care
    - Customer service
    - Employee engagement
    - Equipment maintenance
    - Equipment age
    - Collaboration with receiving facilities

Contract Recommendations

- 6 Major Sections
  - Accountability (examples)
    - Documentation and public reporting of how subsidy dollars are spent
    - Regular public reporting of:
      - Performance data
      - Customer survey and customer satisfaction
      - Clinical KPIs
      - Employee engagement

Contract Recommendations

- 6 Major Sections
  - Governance (examples)
    - Agreement and acceptance of reporting and authority of designated body (Ambulance Council)
    - Constructive and cooperative partnership
    - As allowed law
      - Non-disclosure agreement
      - Non-compete agreement
      - Mediation and arbitration agreements
    - Financial penalties for non-performance (both parties)

Contract Recommendations

- 6 Major Sections
  - Transparency
    - Regular and complete reporting of all uses of public subsidy dollars
  - Finances
    - Must accept all payor types
    - Must respond to all 911 and interfacility requests for service regardless of any contracts and any payor types
    - Require the use of an outside independent billing agency to ensure revenues are maximized

Request for Proposal

Pros

- Seeks provider who knows risks and gains before becoming the provider
- Limits costs and responsibilities of government
- RFP can clarify expectations for the provider
- Increased transparency

Cons

- While others have expressed an interest, unsure if providers will respond
- If there are limited responses, will the community be forced to accept less than desirable terms?
- What is plan B if no responses?
- Will a provider begin service *by or before Jan 1, 2023*

Not For Profit

Pros

- Independent
- Starting from scratch
- Potential for expanded role for EMS
- Easy to grow and expand
- Usually not affected by elections
- Easily accepted by grants and programs
- Tax exempt status

Cons

- Independent
- Starting from scratch
- EMS management / leadership experience risk
- No current EMS infrastructure
- Startup costs could be large and difficult to recover
- Finding the right board
- May be difficult to ensure public subsidy (as needed)

Joint Powers Board / EMS District

Pros

- Starting from scratch
- Potential for expanded role for EMS
- Easily accepted by grants and funding programs
- Often have taxing authority
- Many of the benefits of a governmental organization

Cons

- May not be independent
- Starting from scratch
- May be difficult to grow and expand
- Can be affected by elections
- EMS management / leadership experience risk
- No current EMS infrastructure
- Startup costs could be large and difficult to recover
- Limited control of board membership
- Duplication of taxation
- *The public would likely need to vote*

Hospital Based

Pros

- Non-EMS Infrastructure
- Strong community relationships
- Potential for expanded role for EMS
- Proven non-EMS track record (operations, clinical, community)
- Part of an established healthcare system

Cons

- EMS / Hospital paradox
- EMS management / leadership experience risk
- No current EMS infrastructure
- Startup costs could be large and difficult to recover
- Unsure of long-term affect on organization
- No clear exit strategy
- Unsure of desire to take on EMS

Keys to sustainability

- Call volume or subsidy
- Rates that maximize revenues
- Unproductive time
- Leading as a business
  - Transfers as important as 911
  - Finding and keeping the right people
  - The right governance model

Observations

- Hard choices will be required.
- Parties may choose to do nothing, likely deepening the distrust that seems to exists between the parties.
- Issues around trust and transparency have resulted in jeopardizing EMS in Chickasaw County.
- Unclear philosophy around pay for use vs public good.
- A different model/contract will need investments, transparency, accountability, and trust.