



SKAGIT COUNTY EMS DELIVERY MODEL ADVISORY GROUP

April 25, 2016

HISTORY 1974-2002

- Initially formed in 1974 as the Skagit, Stanwood, Camano EMS Council. The Skagit County Medic One Levy funded the EMS system through a six year levy .25/\$1,000 until 2012, when it was renewed at 37.5/\$1,000 (2013-2018)
- The EMS Council contracted with four providers for ALS ambulance service that included Skagit Valley Hospital, United General, Aero-Skagit and Anacortes FD.

HISTORY 2002-2003

- The ambulance units and their locations were, one ALS unit Skagit Valley Hospital (M-2), one ALS unit at United General (M-1), one ALS unit at Anacortes FD (M-13 and one BLS unit located in Concrete (M-7), which responded with the ALS unit located at United General for ALS.
- In 2002, the hospital based ambulances were no longer going to be operated by Affiliated Health Services (Skagit Valley and United General Hospital).

HISTORY 2003

- 2003 the Skagit EMS Council was formally put under the direction of the Skagit County Board of Commissioners, at the recommendation of the Washington State Auditor, and designated as the Skagit County EMS Commission.
- 2003 the ambulance operations were taken over by the EMS Commission and in addition the EMS Commission contracted with Aero-Skagit and the City of Anacortes for ALS ambulance services countywide.

SKAGIT COUNTY EMS COMMISSION

- The EMS Commission is responsible for strategic planning, the management plan, contracting ALS ambulances, medical oversight through the county MPD, and coordinating all ALS and BLS education countywide.
- The EMS Commission reports to the Skagit County Board of County Commissioners.

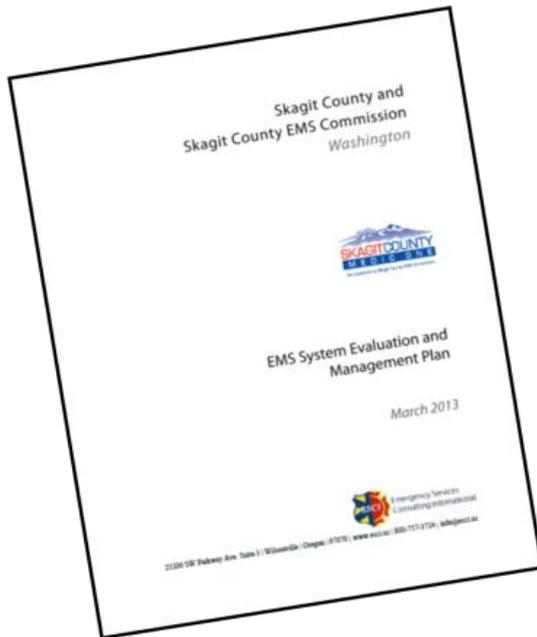
2003-2005

- In 2003 the number of units deployed for ALS ambulance services were; Aero-Skagit one ALS unit, Anacortes FD two ALS units and Central Valley Ambulance three ALS units.
- In 2005 an additional ALS ambulance was added to Central Valley's response area, bringing the total to four.

2005-2013

- Present day coverage is Aero-Skagit one ALS unit (M-7), Anacortes FD two ALS units (M-13, M-14) and Central Valley Ambulance four ALS units (M-1, M-2, M-3 and M-4).

2013 ESCI REPORT



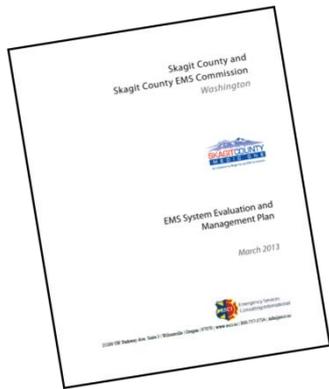
- Three public meetings on November 6, and December 9, 2013, and January 27, 2014.
- Recommendation to form a County EMS Department to replace EMS Commission.
- Recommendations to enhance current system and improve data collection.
- Recommendations on potential changes to service delivery models.

Videos of ESCI meetings available at:

<http://www.skagitcounty.net/Departments/TV21/mediaplayer.htm>



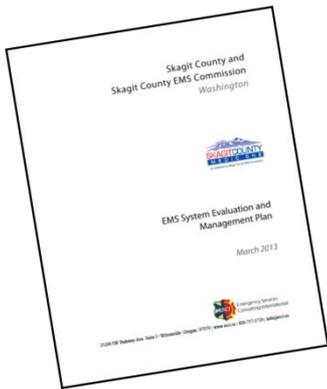
CHARGES



- ✓ **Observation.** The system does not have contractual requirements with transport providers for adherence to an established fee schedule or the ability of the providers to enter into contractual billing arrangements resulting in discounted fees for service.
- ✓ **Observation.** Due to the independence of the agencies in maintaining their own billing systems, there is limited data that reflects uniformity with respect to the billing process. It is unclear if the agencies have the authority or capability to negotiate special pricing or contracts with payors.

All transporting agencies now use the same County Commissioner approved billing rates.

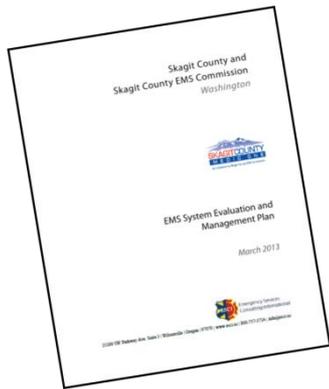
BILLING



- ✓ **Observation.** Each agency maintains independent billing systems. While two of the agencies use the same vendor, there is no systematic process in place to allow system-wide financial review of the revenues generated by patient transports or how those revenues compare amongst the various provider agencies. Furthermore, in the absence of accurate financial reporting, the SCEMSC is limited in its ability to determine the appropriate distribution of levy and revenue for system improvements.
- ✓ **Observation.** The various billing systems utilized by the transport providers do not provide uniform financial data from which accurate financial support decisions can be made. One example is the ability to capture specific elements (payor source) of patient transportation distribution by level of service. This limitation impairs the ability of the SCEMSC system to project revenue, identify revenue trends, and conduct accurate analysis of revenues to support the EMS system. Furthermore, it is difficult to establish trend lines and revenue contribution ratios. This capability becomes more important when demographic changes within the community such as increases in the Medicare population (a capitated payor) can adversely affect revenue generation thereby making it difficult to project pricing and/or service level modifications from a fiscal perspective.
- ✓ **Observation.** The lack of uniformity in financial reporting contributes to discrepancies between actual and reported transport revenues. Additionally, the inability to determine cash receipts by call type is problematic.

All transporting agencies now use the same billing service.

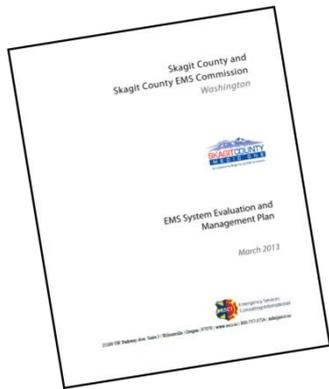
PATIENT CARE REPORTING



- ✓ **Observation.** Data collected to help design the future of the EMS system does not exist. Transport providers utilize proprietary software primarily designed for financial billing. While the system has made efforts at collecting, analyzing, and reporting on data that is critical to analyzing system performance, in many cases the system was not capable of producing complete data for sound analysis. For example, ESCI attempted to evaluate response performance (one of the most basic indicators of quality) in the system. Performance data was difficult to discern from current information systems.
- ✓ **Observation.** Because only the transport agencies report performance, the response performance of the system cannot be determined. In the central valley area (and in other areas where first response agencies provide ALS), it would be useful to know when the first paramedic arrived on the scene as opposed to the first ambulance.
- ✓ **Observation.** Currently, agencies only report their performance at the 90% fractile. This fails to capture inordinately long response times.

Standardized county-wide patient care reporting (ePCR) system is improving quality assurance and system planning abilities.

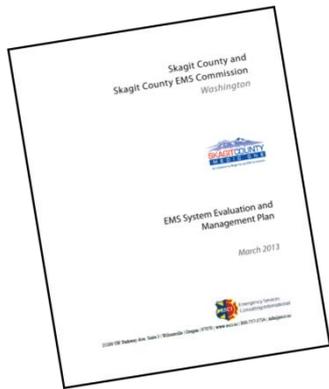
OVERSIGHT



- ✓ **Observation.** The inability of the system to verify call data with agency data creates the potential for transports not being entered into the system and subsequently not billed, resulting in loss of revenue.
- ✓ **Observation.** The system is not capable of generating valid, reliable call volume data nor does it have the ability to verify data for analysis efforts. Significant variations were found in individual agency data and system data. However, we note that during the course of this study, the EMS system participants are making strides in ensuring that these data can be verified.
- ✓ **Observation.** The system is unable to produce quality statistical driven data from which to adequately analyze call volume or call distribution for deployment analysis. The data that is available from the Spillman CAD is wholly inadequate to monitor the performance of the EMS system or of the responses of the respective agencies. One of the critical deficiencies in the current EMS system is that the SCEMSC administrative authority does not have essential call data necessary from which system improvements can be generated.

EMS department now has direct access to both patient care and financial record systems.

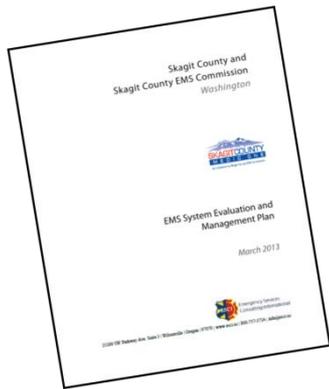
STANDARDIZATION



- ✓ **Observation.** SCEMESC maintains minimum equipment standards for ambulance equipment (but not first response equipment).
- ✓ **Observation.** Portable EMS equipment should be standardized throughout the EMS system. In addition, plans should be established to inspect, maintain, and replace critical equipment. The State has established minimum inspection requirements for annual inspections to ensure that the capability of the personnel is maximized.

Online BLS disposable supply ordering system is creating uniformity in supplies and streamlining payment process.

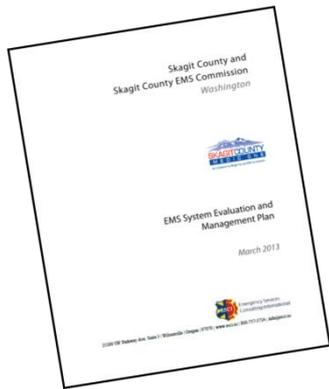
INTER-FACILITY TRANSPORTS



- ✓ **Observation.** The participating providers are not engaged in providing scheduled non-emergency patient transports or BLS inter-facility transfers. The system should review the loss of potential revenue associated with these transports and the opportunities to improve total system revenue with existing transport resources.

CVAA is working with United General and Skagit Valley Hospitals to increase IFTs.

EMS QUALITY ASSURANCE



- ✓ **Observation.** The lack of performance requirements other than merely response time is a concern. There are no quality requirements, no customer service requirements; no fatigue limitations, and no other beneficial outputs.
- ✓ **Observation:** The medical authority oversees the ambulance service with a much higher level of attention paid to transport agencies rather than first response agencies or other system participants.
- ✓ **Observation.** Customer service reports which will help design the future of the system are not readily available. When the data is available, it is reviewed on an agency basis rather than on a system-wide basis.

New Medical Program Director (MPD) and new EMS Training & Quality Assurance Manager are building a more robust ALS and BLS Quality Assurance Program.

CALL VOLUME CHANGES SINCE ESCI REPORT

Annual Transports	7/1/11 - 6/30/12				2015			
Agency	BLS	ALS	Total	BLS %	BLS	ALS	Total	BLS %
Aero-Skagit	107	253	360	29.7%	153	160	313	48.9%
Anacortes	291	1304	1595	18.2%	573	1273	1846	31.0%
CVAA	996	4530	5526	18.0%	1795	4816	6611	27.2%
Sedro-Woolley	0	0	0	n/a	39	0	39	100.0%
Total	1394	6087	<u>7481</u>	18.6%	2560	6249	<u>8809</u>	29.1%

Total transport volume has increased 17.8%.
 84.2% of the total increase has been BLS transports.

2013 – 2015 EMS LEVY FUNDING FOR AMBULANCES



\$183,899



\$190,794



\$190,794



\$190,794



\$190,794



\$118,091

One remounted and five new ambulances = \$1,065,166

2013 EMS LEVY FUNDING FOR ALS CARDIAC MONITOR / DEFIBRILLATORS



12 ALS Monitors added to the EMS System - \$372,490

2013 EMS LEVY FUNDING FOR AUTOMATIC EXTERNAL DEFIBRILLATORS (AEDS)



117 AEDs added to the EMS System - \$302,179

11 to ALS providers (\$28,410)

106 to BLS providers (\$273,769)

2015 EMS LEVY FUNDING FOR BLS GLUCOMETERS



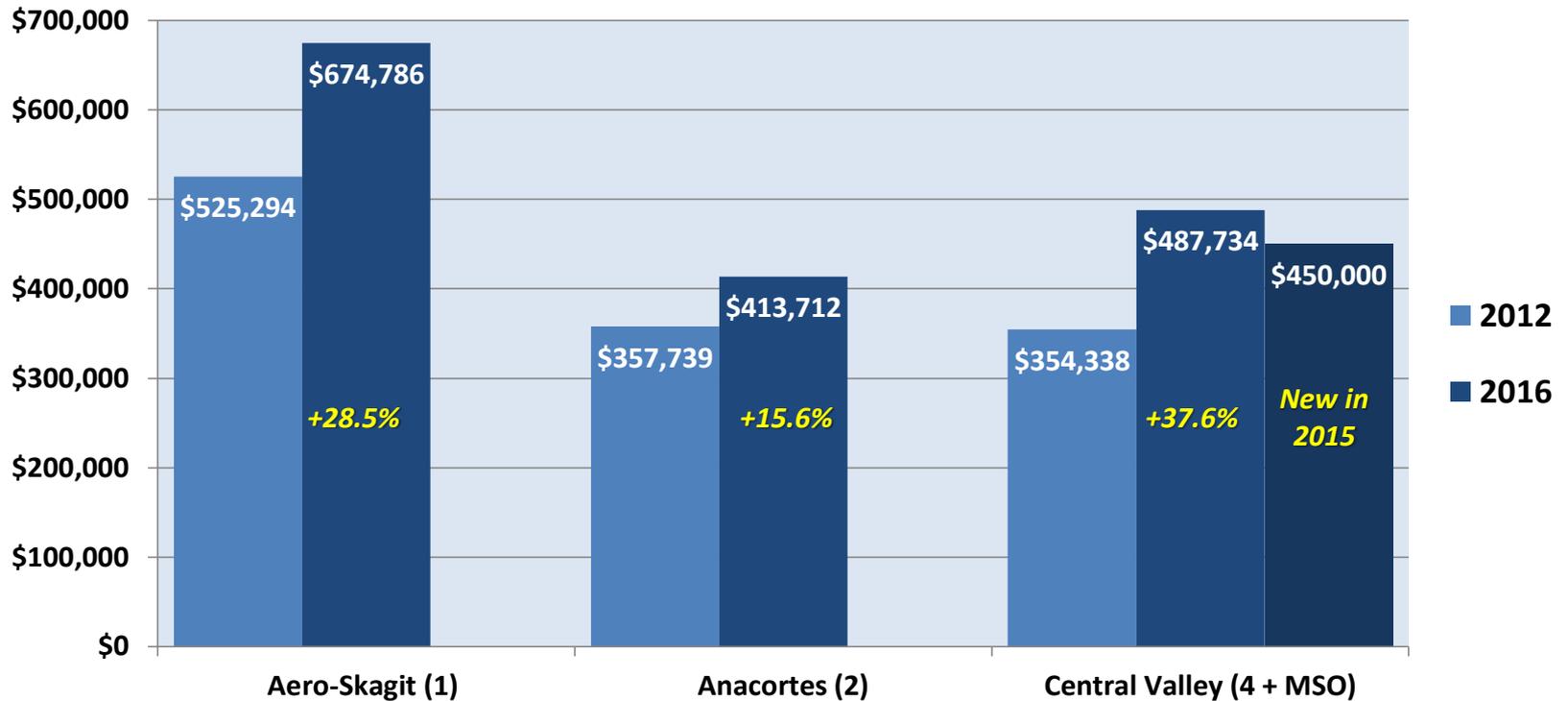
67 Glucometers added to the EMS System - \$1,882

9-1-1 USER FEES PER EMS CALL



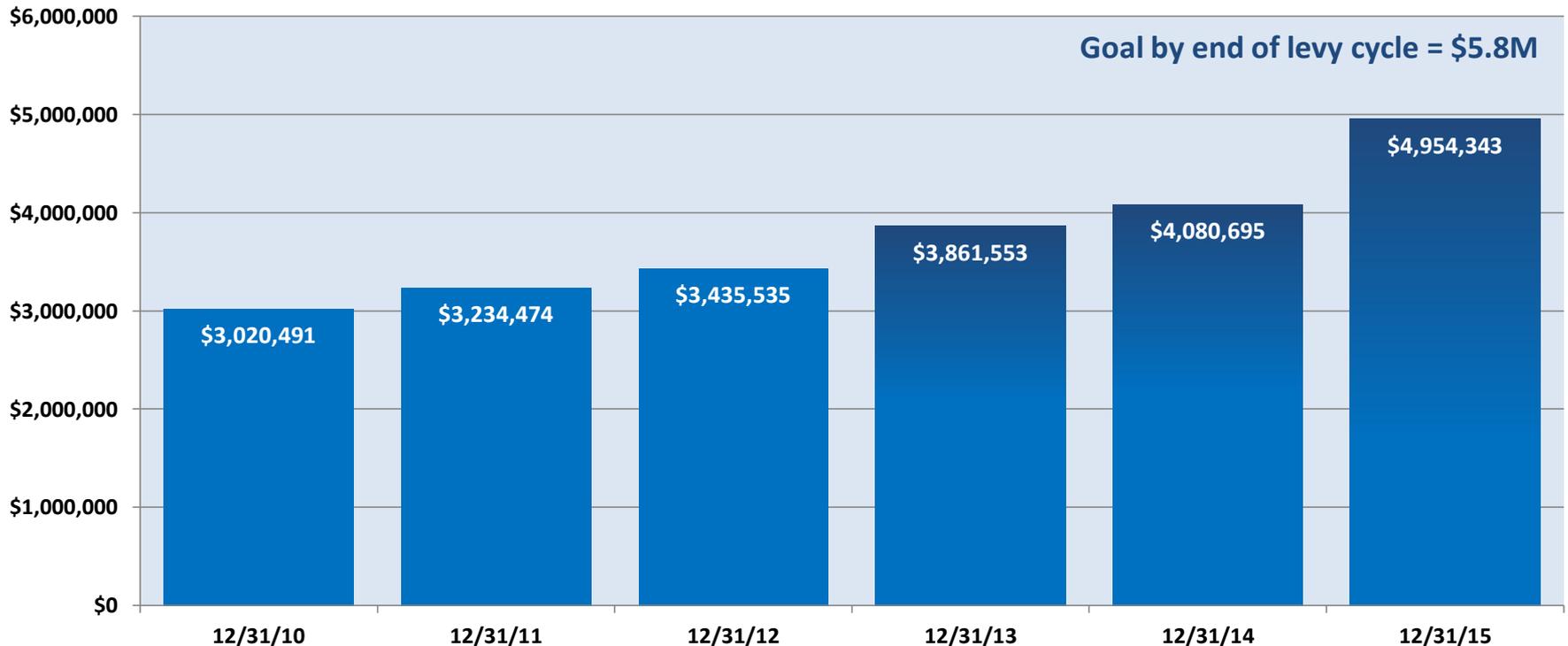
Per call fees have increased by 104% in since 2012.

EMS LEVY FUNDING PER ALS AMBULANCE



\$1,245,022 (+ 46.8%) annual increase to ALS providers

YEAR END EMS LEVY RESERVES



Cash and Investments have increased by 44% since the end of the last levy cycle.

QUESTIONS?