Findings and Recommendations for EMS in Pinellas County

October 25, 2011

Transport

Stay with Current Transport Provider

- Revenues for both 9-1-1 and non-emergency transports = **$40.9 MM**
- Costs to County for both 9-1-1 and non-emergency transports: **$28.6 MM**
  - **County net = $12.3 MM**
- Well established accountability and performance assurances
- Very positive track record

Deployment and Cost Modeling with FD 9-1-1 Transport

- 9-1-1 calls only
- Based on detailed deployment analysis: 53 ambulances
- County-wide averaged personnel costs
- Semi-dynamic deployment (do not have to return to 'home' area for next call)
- Estimated annual cost **$41.3 MM**
    - County net = **loss of $400K + cost of operating non-emergency transport service**
        - Non-emergency revenues are included in calculation of net

Net Cost Impact of FD Transport

- Currently, **$12.3 MM cash positive**
- FD 9-1-1 Transport, **$400 K cash negative plus cost of non-emergency transport program and supports costs for transport**
- **Cost Increase with 9-1-1 FD Transport = $12.7 MM**
  - **Plus $7.7 MM non-emergency transport**
  - **Plus $6.7 MM transport program support**

Fire-Based 9-1-1 Transport Accountability

- Maintaining performance and accountability between multiple ambulance service constantly moving across jurisdictional lines would be extremely problematic
- Needs a consortium or County-wide FD structure as point of contractual accountability
  - Consortium: Participating cities and fire districts would share risk and rewards

Fire-Based 9-1-1 Transport Accountability

- Needs to do their own deployment plan and dispatching in order to be held accountable for performance
  - Not in their budget
- Needs to be ‘at risk’ for under-estimating resources required and other potential reasons for failure to meet requirements
- No prior experience in operating a transport service or a legally and financially accountable consortium

Review of Alternate Proposals
('10-3' and 'Sanford-Millican')

- Similar ideas and concepts
- Decrease MFR volume and apply savings to run FD transport
- If MFR volume *appropriately* reduced as suggested, major step forward

Review of Alternate Proposals

- Transport should be separate issue
  - Reducing MFR costs does not have to increase transport costs
  - Neither demonstrates ability to operate transport for less
    - No deployment analysis support assertions of units needed

Review of Alternate Proposals

- Performance accountability not addressed
  - Single point of accountability needed
    - Consortium of all participating cities and fire districts
    - County-wide FD
  - Their own deployment plan and real-time control of units by their own dispatching
    - Cannot be delegated to County

Review of Alternate Proposals

- Performance accountability not addressed
  - If unsuccessful in meeting standards, unclear who is responsible for spending $ to fix the problem
    - Should be the accountable entity
      - Will impact their taxpayers
  - Needs performance assurances
    - Fines, fail-safe provisions, performance bonds

Review of Alternate Proposals

- Two most significant hurdles
  - Less flexibility in deployment
    - Not using dynamic deployment
    - No experience with dynamic deployment
    - More unit hours, higher costs
    - Peak-load staffing is good step forward
  - Higher personnel costs

Virtual Consolidation of Ambulance Contractor and FDs

- Liberalized FD initiated transport **protocols**
  - While transport units continue to exist
- Contractor requested FD transport – ad hoc
- Option for contractor requested FD transport
- No strong financial advantage
- **Ethical and operational advantages**

Medical First Response

Marginal Engine Funding with Paid Position Option

- 72 County-Funded ALS engines
  - Per deployment analysis
  - Factors in fire call volume
- 1 paid position per unit, 24/7
- Converts 10 locally funded units to County funding

Use County-Wide FD EMS Budget Averages

- Personnel costs
- Vehicle operating costs
  - regardless of vehicle used

Cost Impact

$27.1 MM with 3.6 FTEs

Currently, $38.1 MM

Savings of $11.0 MM

Appropriate Criteria for MFR

- Fire first response
  - Hazards
  - Technical rescue / extrication
- Highly time sensitive
- Manpower
- Scene protection

Reduce # of MFR Calls

- Eliminate MFR on cases that do not meet the criteria
  - Involve EMS Medical Director , fire and ambulance operations managers, 9-1-1 dispatch staff
- Remain available for more serious EMS calls and fires
  - Better response intervals from ‘first due’ unit
- Decrease fuel and vehicle maintenance costs; and extend fire apparatus service life

Operationalization

- Fine tuning of deployment plan
  - New healthcare facilities, roads, etc. not in historical data
  - Constraints on types of vehicles that are appropriate for particular fire stations
    - Ex. – ladder truck should not be moved away from station closest to high rise structures
- Pilot test deployment plan with close monitoring of performance results
  - Adjust and re-test as needed

Fairness

- Same funding for all 72 MFR units
- Fair to low volume / difficult to serve areas

Protects current level of service standards

- MFR in 7 ½ min. (90%)
- Ambulance in 10 min. (90%)

Additional Funding and Cost Adjustments

Low Acuity Care

- Poor design of services to meet the large portion of cases that are not ‘emergencies’
- Develop coalitions; pilot and implement process designs that meet community needs

Set Asides

- Ad valorem funding for:
  - Pilot studies and implementation of new processes
    - Low acuity care
    - Community Life Support program for cardiac arrests
  - Equipment upgrades
  - EMS reserve fund rebuilding
  - Estimated $2.5 MM
  - Add or subtract this to cost, as appropriate, to MFR cost calculations

Funding Equivalence

- Formula that adjusts the ad valorem millage rate year to year
- Property valuations
- Consumer price index
- Set aside fund changes
- **De-politicize the process**

Other Recommendations

Governance

- Better utilization of EMS Advisory Council
- Bi-annual visioning /strategic process
  - Involve system stakeholders
- Bi-annual system assessment process
  - Improve accountability of EMS administration and the providers as a ‘system’

System Evaluation and Improvement

- Electronic medical records as soon as possible
- System-level performance improvement projects
  - Align w/ strategic and operational priorities
- Business intelligence technology
  - System-level performance metrics
  - Performance dashboard technology

Recommendations Based on Community Outreach

Adjust MFR Funding Based on Response Volume

- Fairness issue
- Higher volume MFR units have higher maintenance and fuel costs
- Establish base rate for MFR units (subtract maintenance and fuel costs)
- Allocate maintenance and fuel costs proportionately
- Same net cost to County

Summary

General System Structure and Performance is Sound

Good operational performance and clinical outcomes

Transport issue has hindered system cohesiveness for years

Needs an unambiguous long term decision

System Funding

Needs to be fair, contain costs, and protect current level of service standards

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