JOINT ELECTED OFFICIALS AGENDA ITEM SUMMARY

ACTION: AMBULANCE TRANSPORT SYSTEM SUSTAINABILITY

Meeting Date: May 24, 2012
Department: Eugene and Springfield Fire Departments
Lane Rural Fire/Rescue District

Agenda Item Number: 1
Staff Contacts: Randall B. Groves, Chief
Dale Borland, Chief

ISSUE STATEMENT

The Joint Elected Officials Ambulance Transport Task Force (ATTF) recognizes ambulance transport as a core service that is accessible to the residents and visitors of central Lane County regardless of ability to pay. Seen as a regional system, Eugene Fire & EMS Department, Springfield Fire & Life Safety Department, and Lane Rural Fire/Rescue District provide ambulance transport for a majority of Lane County citizens. Rural Metro Ambulance, a private ambulance service providing select non-emergency transports, and LifeFlight, air ambulance transportation for the most critical patients, augment the system. The three governmental providers continue to experience a financial crisis attributed largely to the federal government's decline in Medicare and Medicaid payments and the economic recession resulting in an increase in utilization by those underinsured and uninsured. All three regional providers are projecting annual financial deficits beginning in FY13.

BACKGROUND

Before the implementation of the Ambulance Fee Schedule on April 1, 2002, ambulance suppliers received payment from Medicare on a "Reasonable Charge Basis." Medicare would pay 80 percent of the allowable amount and the remaining balance was the responsibility of the patient. This allowed transport providers broad flexibility in setting rates and assured recovery of costs.

The Balanced Budget Act (BBA) of 1997 added a new section 1834(1) to the Social Security Act, which mandated the implementation of a national fee schedule. This section also required ambulance providers and suppliers to accept the Medicare allowed charge, including patient co-payments as payment in full and eliminated the ability to bill the patient or another insurance provider for the balance of the reasonable charge.

Put simply, the national fee schedule, which covers 60 to 70 percent of all transports, does not allow most ambulance providers to recover the full cost of providing the service. Instead, where we once had the ability to collect the full billable charge (which has risen over the years from $535 to $1,600 per transport), we are now reimbursed between $200 and $400, depending on the type of call. Medicaid, the State of Oregon's health insurance program, reimburses at a similar range.

While Medicare and Medicaid reimbursement reductions are the primary reason that emergency medical transport in our region has become a revenue-negative enterprise, two national trends are also

contributing to the problem. One is the growing percent of population eligible for Medicare. The other is the economy. Regional providers do not refuse transport because of inability to pay and are being forced to write-off more and more bills as uncollectible and the percent of under- and uninsured increases.

TASK FORCE PARTICIPANTS

In October of 2011, the Task Force began meeting on a bi-weekly basis. The Task Force consists of the following elected officials:

Eugene City Councilor Andrea Ortiz
Eugene City Councilor Mike Clark
Springfield City Councilor Sean VanGordon
Springfield City Councilor Marilee Woodrow
Lane County Commissioner Jay Bozievich
Lane Rural Board Vice President Pete Holmes
Lane Rural Board Member Jim Drew

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The attached report from the Task Force provides additional background and a series of options, which are:

1. **Do nothing.** Jurisdictions would remain responsible for providing and funding ambulance transport within its assigned Ambulance Service Areas (ASA). Under this option, jurisdictions recognize stabilizing the fund could require additional fee increases, continued reduction in expenditures, change in service levels, and/or on-going General Fund support for the continued high-quality provision of this core service. The elected bodies could choose to make General Fund support the permanent solution to the problem. However, the Task Force believes that, for the sake of preserving other local government services to the greatest extent possible, General Fund support should be viewed only as a short-term solution.

2. **Privatize.** The Cities of Eugene and Springfield currently contract with a private provider for non-emergency transport. Under this contract, the Cities remain responsible for the service provided within the ASA. Under full privatization, the public would not only relinquish quality control, but also the emergency response versatility afforded by the firefighter/paramedics now staffing local ambulances. The goal would be to find the equilibrium point between these two ends of the public/private partnership spectrum.

3. **Form Ambulance Transport District.** A new limited special-purpose district could be formed in the region, or the region could annex to an existing health district, to provide ambulance service. Alternatively, a county service district could be established. In planning for formation of, or annexation to, a special district, many further, more specific decisions will be needed including boundary issues, revenue requirements, and the possibility of tax rate compression. An election will be required.

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RELATED CITY POLICIES

City of Eugene Value #1: Safe community.
City of Eugene Value #5: Fair, stable, and adequate financial resources.
Springfield City Council 5-Year Goal #1: Provide financially sound, stable city government.
Springfield City Council 5-Year Goal #2: Utilize resources efficiently and effectively to meet citizen needs for core services.
Springfield City Council 5-Year Goal #5: Enhance public safety in Springfield.
Springfield City Council 5-Year Goal #7: Partner with citizens and other public agencies to leverage resources.

ELECTED OFFICIAL OPTIONS

Elected officials are at liberty to adopt any or all of the options presented by the Ambulance Transport System Joint Elected Officials Task Force. Adoption may be by the full JEO group or by the individual governing bodies of affected jurisdictions, as appropriate.

CITY MANAGERS' RECOMMENDATION

None; options of the Ambulance Transport System Joint Elected Officials Task Force are presented herewith.

SUGGESTED MOTION

Motion to adopt selected (or all) options.

ATTACHMENT

2011 Task Team Memorandum and Options

FOR MORE INFORMATION

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Eugene Fire & Emergency Medical Services
Springfield Fire & Life Safety
Lane Rural Fire Rescue

City of Eugene
City of Springfield

MEMORANDUM

DATE: May 24, 2012

TO: Mayor Kitty Piercy and Eugene City Council Members
Mayor Christine Lundberg and Springfield City Council Members
Commission Chair Sid Leiken and Lane County Commissioners
President John Baxter and Lane Rural Fire/Rescue Board Members

FROM: Fire Chief Cities of Eugene & Springfield Randy Groves
Fire Chief Lane Rural Fire District Dale Borland

ON BEHALF OF: Ambulance Transport System Joint Elected Officials Task Force: Eugene City Councilor Andrea Ortiz, Eugene City Councilor Mike Clark, Springfield City Councilor Sean VanGordon, Springfield City Councilor Marilee Woodrow, Lane County Commissioner Jay Bozievich, Lane Rural Board Vice President Pete Holmes, Lane Rural Board Member Jim Drew

SUBJECT: REPORT AND RECOMMENDATION

SUMMARY

The Joint Elected Officials Ambulance Transport Task Force (ATTF) recognizes ambulance transport as a core service that is accessible to the residents and visitors of central Lane County regardless of ability to pay. Seen as a regional system, Eugene Fire & EMS Department, Springfield Fire & Life Safety Department, and Lane Rural Fire/Rescue District provide ambulance transport for a majority of Lane County citizens. Rural Metro Ambulance, a private ambulance service providing select non-emergency transports, and LifeFlight, air ambulance transportation for the most critical patients, augment the system. The three governmental providers continue to experience a financial crisis attributed largely to the federal government's decline in Medicare and Medicaid payments and the economic recession resulting in an increase in utilization by those underinsured and uninsured. All three regional providers are projecting annual financial deficits beginning in FY13.

Provider departments and their governing bodies have already expended substantial effort to address this critical public concern by taking steps to reduce expenditures and increase revenues including passing extraordinary increases in user fees, FireMed memberships fees, and implementing initiatives recommended by the 2009 initial Joint Elected Officials ATTF. None of these adjustments individually or in whole has created a sustainable revenue source during any 6-year financial forecast period. The Task Force was re-established in 2011 to continue the discussion of finding a permanent funding source offering stabilization for this vital service.

The 2011 ATTF has developed the following options:

1. **Do nothing.** Jurisdictions would remain responsible for providing and funding ambulance transport within its assigned Ambulance Service Areas (ASA). Under this option, jurisdictions recognize stabilizing the fund could require additional fee increases, continued reduction in expenditures, change in service levels, and/or on-going General Fund support for the continued high-quality provision of this core service. The elected bodies could choose to make General Fund support the permanent solution to the problem. However, the Task Force believes that, for the sake of preserving other local government services to the greatest extent possible, General Fund support should be viewed only as a short-term solution. Further, residents who do not live in the city limits but reside within the ambulance service area will not be contributing to the support of the service under this scenario.

2. **Privatize.** The Cities of Eugene and Springfield currently contract with a private provider for non-emergency transport. Under this contract, the Cities remain responsible for the service provided within the ASA. Under full privatization, the public would not only relinquish quality control, but also the emergency response versatility afforded by the firefighter/paramedics now staffing local ambulances. The goal would be to find the equilibrium point between these two ends of the public/private partnership spectrum. For this option, a feasibility study would be required including a review of costs to each jurisdiction to maintain fire response for medical calls in the event the ambulance transport system is contracted to a private provider in its entirety. For example, jurisdictions would need to maintain contracts for a supervising physician, which are currently funded by individual Ambulance Transport Funds. Additional considerations include payment for first response by the private provider and the financial stability of a private provided to ensure long-term, high quality service.

3. **Form Ambulance Transport District.** A new limited special-purpose district could be formed in central Lane County, or the region could annex to an existing health district to provide ambulance service. These options require governance by an elected board of directors. Alternatively, a county service district could be established. This type of entity would be governed by the Lane County Board of Commissioners. Forming a district requires an affirmative vote of the electorate within the proposed district.

   Attachment B is an overview of district-related options for ambulance service funding, prepared in June 2011 by the Lane Council of Governments (LCOG). The Task Force reviewed a full LCOG report regarding districts that was commissioned by the Lane

County Fire Defense Board. The ATTF also reviewed a high-level presentation on projected costs and estimated rate for the regional service.

In planning for formation of, or annexation to, a special district, a feasibility study highlighting proposed district legal boundaries, changes to the Metro Plan, sustainable tax revenue requirement, and taxing issues such as uncollectible percent and compression, both a reduction to gross tax revenue would need to be completed. Because implementation of district options will take a considerable period of time, we recommend the immediate formation of an intergovernmental staff team to fast track the study of the feasibility of implementing this solution.

BACKGROUND

Throughout our region, the majority of patients transported are covered by Medicare. Before the implementation of the Ambulance Fee Schedule on April 1, 2002, ambulance suppliers received payment from Medicare on a "Reasonable Charge Basis." Medicare would pay 80 percent of the allowable amount and the remaining balance was the responsibility of the patient. This allowed transport providers broad flexibility in setting rates and assured recovery of costs.

The Balanced Budget Act (BBA) of 1997 added a new section 1834(1) to the Social Security Act, which mandated the implementation of a national fee schedule. This section also required ambulance providers and suppliers to accept the Medicare allowed charge, which includes the patient's co-payment, as payment in full and transport agencies were no longer able to bill the patient or another insurance provider for the balance of the reasonable charge.

The new fee schedule took effect in 2002 and was phased in over a five-year period, with full implementation on January 1, 2006. Year one (4/1/02-12/31/02) provided a blending of 20 percent fee schedule and 80 percent reasonable charge. The reasonable charge portion was then reduced by 20 percent in each of the four subsequent years, so that as of 2006 only the fee schedule amount was payable. Since 2006, jurisdictions have received small, incremental increases in reimbursement. However, current reimbursement levels remain well below the cost of the service.

Put simply, the national fee schedule, which covers 60 to 70 percent of all transports, does not allow ambulance providers to recover the cost of providing the service. Instead, where we once had the ability to collect the full reasonable charge (which has risen over the years from $535 to $1,600 per transport), we are now reimbursed between $200 and $400, depending on the type of call. Medicaid, the state of Oregon's health insurance program, reimburses similarly.

While Medicare and Medicaid reimbursement reductions are the primary reason that emergency medical transport in our region has become a revenue-negative enterprise, two national trends are also contributing to the problem. One is the growing number of individuals eligible for Medicare. The other is the economy. Ambulance transport providers in our region do not refuse transport because of inability to pay and are being forced to write off more and more bills as uncollectible.

The Eugene Fire & EMS Department has taken many steps to try to keep the ambulance service self-sustaining including increasing the transport rates; reducing ambulance coverage during non-peak times; and cutting costs for administrative staff, materials, and supplies. The department has also worked closely with City Finance staff to identify the appropriate cost split between the Ambulance Transport Fund (ATF) and General Fund (GF) to ensure the ATF is not supplementing General Fund services as well as to identify needed GF support on a one-time basis to balance the ATF in 2010 and 2011.

In addition, Eugene's ambulance system capacity is very thin. With inadequate revenues to increase the number of advanced life support ambulances on the street, the department elected to privatize select non-emergency calls for service, which matches a more appropriate level of resource with particular call types to a private provider as a cost avoidance strategy.

Springfield Fire & Life Safety staff has focused on maximizing existing revenue sources for all three providers through the joint FireMed program by increasing the membership fee and by increasing participation in the JobCare program. In FY12, the FireMed program managers focused on decreasing administration and advertising costs of the program. However, it has been noted that even with the recent adjustments go the program, FireMed, in itself, will not garner enough revenues to balance the Ambulance Transport Funds.

Springfield Fire & Life Safety has taken several steps toward keeping the ambulance transport system self-sustaining including increasing transport rates and reducing costs for administration. Springfield Fire & Life Safety also contracts with a private provider for inter-facility, non-emergency transports. In FY11, the Ambulance Transport Fund accumulated reserves totaling $251,605. These reserves are forecasted to be depleted by the end of FY13.

The Lane Rural Fire/Rescue District was granted an Ambulance Service Area (ASA) encompassing the northwest portion of Eugene's ASA in 2001 and in 2002 began providing emergency medical transport in addition to fire and rescue services to that area, resulting in a reduction of ambulance transport revenue as well as FireMed membership revenue for Eugene. As a pre-existing taxing authority, Lane Rural has been able to augment its overall revenue with ambulance fees and FireMed revenue, but not to the extent that the ambulance service is fully self-supported; instead, the district annually levies funds as necessary to provide all of its services, in effect providing some support to the ambulance service with general tax monies. Currently, this requirement is estimated to be at least $400,000 annually.

None of these adjustments individually or in whole has created a sustainable revenue source during any 6-year financial forecast period. All three Ambulance Transport Funds continue to see annual deficits and depleting reserves. Another unobtainable goal is to maintain a reserve equal to two months' operating expenditures. As projected in the current 6-year financial forecasts, no jurisdiction will meet this goal. Additionally, all three jurisdictions have relied on contributions from their general funds to balance in recent fiscal years.

In 2009, the initial Joint Elected Officials Ambulance Transport Task Force was formed because a solution to this crisis was determined beyond the capacity and authority of any one provider agency acting unilaterally. After studying this issues and the range of available options, having

engaged the public at a series of community forums and online, and having worked in concert with stakeholders including local fire and ambulance service professionals, hospitals, and firefighters' unions, the taskforce recommended the following:

1. That all three jurisdictions remain prepared to allocate a level of General Fund support as necessary for the continued high-quality provision of this core service.
2. That the Eugene and Springfield City Councils authorize initial steps toward merger of their fire departments.
3. That exploration begin immediately of more sustainable public funding options.
4. That marketing of FireMed subscriptions be enhanced and expanded in an effort to generate additional revenues to lessen reliance on general fund tax support.
5. That the City of Eugene and Lane Rural Fire/Rescue analyze the possibility of reconfiguring the boundaries of the county's Ambulance Service Areas so as to provide for an urban-rural split between Eugene and Lane Rural Fire/Rescue; and, if conditions appear favorable, that the Lane County Board of Commissioners be asked to enact such reconfiguration.
6. That work proceed as rapidly as possible regarding provision of a regional mobile health care system, featuring tiered levels of response (and cost) available to patients depending on the nature of the emergency with a report to elected officials by the end of calendar year 2010.
7. That public ambulance service provider agencies continue to lobby the Oregon legislature and U.S. Congress for larger-scale, long-term solutions.

Several of these recommendations have been implemented including continued General Fund support as needed per jurisdiction to keep programs viable. All three providers recognize General Fund support is considered one-time and, at this time, is not a sustainable solution. The merger initiative continues to make positive steps toward a fire district, which could ultimately provide needed funding for ambulance transport. However, it is projected that forming a district is a long-term goal and will not address the immediate funding need of the ambulance transport service. As previously stated, increased revenues for the enhanced FireMed program have been determined that the program cannot in itself, garner enough funding to stabilize the system. The City of Eugene has moved forward with recommendation #5 by contracting with Lane Rural Fire/Rescue District to provide rural ambulance transport services west of the urban growth boundary. This agreement has resulted in decreased response times for the constituents being served. This recommendation has had minimal impact on the Eugene workload issue but does not address the financial stability of either ambulance transport system. Finally, regional providers continue to actively work with the United Front at the State and Federal levels for developing larger-scale, long-term solutions.

CONCLUSION

With the political will already expressed to continue emergency medical transport as a core public service, and with the existing revenue streams no longer adequate, there is little question that additional tax support will be required. The only questions are as to the form and magnitude of that additional tax support.

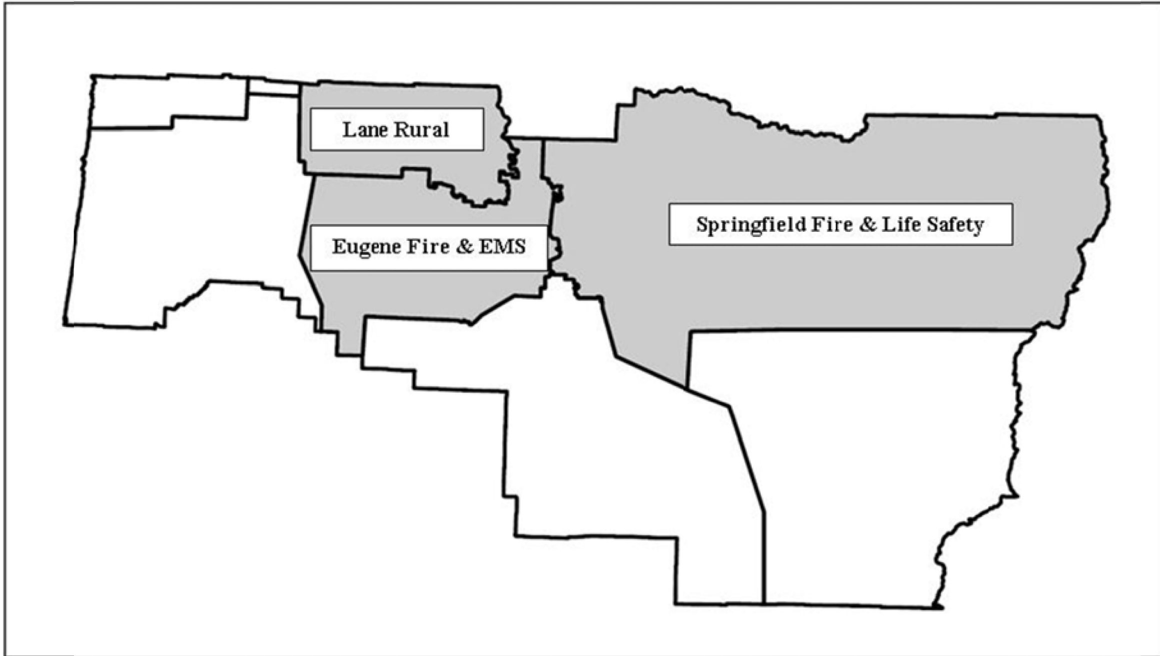
As shown, some of the measures recommended provided a degree of financial relief and/or service improvement. However, to address the larger and more critical central issue, General Fund support will probably be required to bridge the gap over the short to mid-term, and we conclude further that some new form of general tax support is the best solution for the long term, both from a fiscal and service standpoint.

Please contact any member of the Task Force, or staff in the respective fire service agencies, if you have questions or would like additional information.

ATTACHMENTS

A. ASA map
B. LCOG overview of district alternatives
C. Media clippings

Attachment A
Ambulance Service Area



Attachment B

OVERVIEW OF SELECTED ALTERNATIVES FOR FUNDING AMBULANCE SERVICES

Type of Entity	Applicable Statutes	Creates New Revenues	Governing Body	Election	Impact on Existing Districts	Statutory Limitations	Comprehensive Plan Impacts
Intergovernmental Agreement	ORS 190	No	Existing Elected Bodies	No	No		No
Formation of a new fire district	ORS 198 and ORS 478	Yes	New Elected Board	Yes, primary or general election	Yes	Cannot have overlapping district formed under same principal Act	Perhaps (Metro Plan has specific language about special districts)
Formation of a new health district	ORS 198 and ORS 440	Yes	New Elected Board	Yes, primary or general election	Yes	Cannot have overlapping district formed under same principal Act	Perhaps (Metro Plan has specific language about special districts)
Formation of a county service district	ORS 198 and ORS 451	Yes	County Board of Commissioners	Yes, primary or general election	Yes		Perhaps (Metro Plan has specific language about special districts)
Annexation to an existing district	ORS 198 and principal Act	Yes, at established permanent tax rate	Existing Elected Board	Optional	Yes	Cannot have overlapping district formed under same principal Act	Perhaps (Metro Plan has specific language about special districts)
Merger of like districts by cessation of district(s) being absorbed into surviving district	ORS 198 and principal Act	No	New Configured Elected Board	Yes, next available election	No		Perhaps (Metro Plan has specific language about special districts)
Consolidation of 2 or more like districts into a new successor district	ORS 198 and principal Act	Yes	New Configured Elected Board	Yes, next available election	Yes		Perhaps (Metro Plan has specific language about special districts)

Attachment C

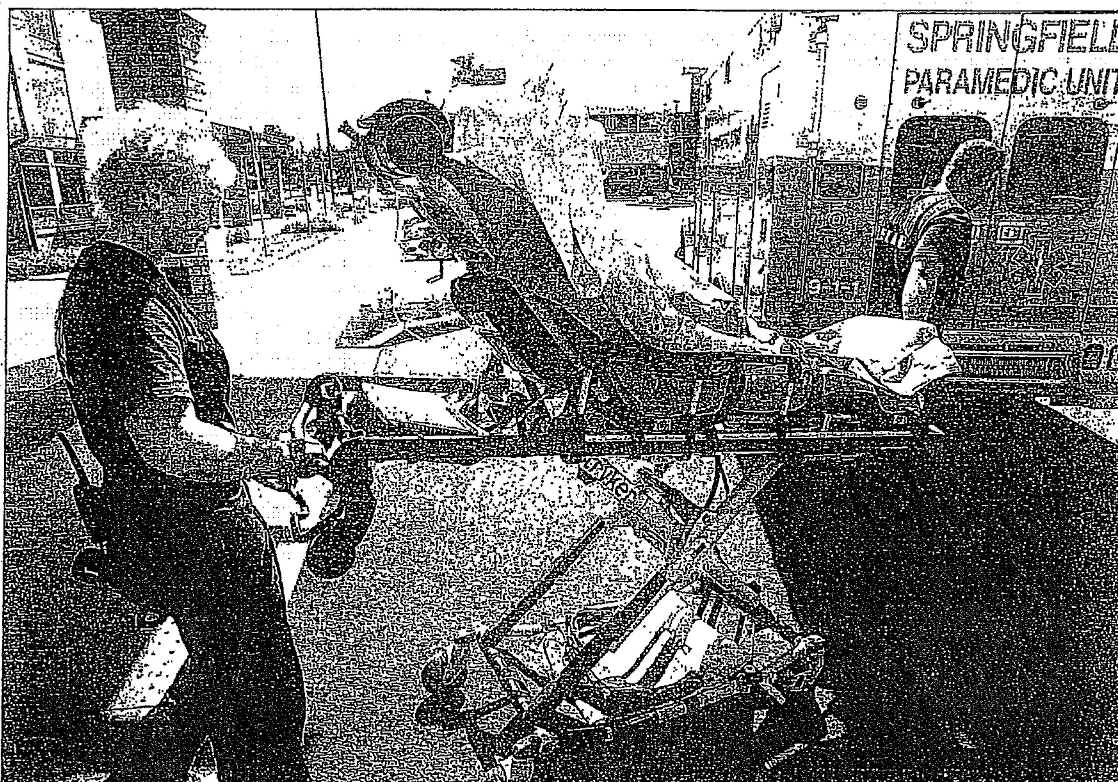
The Register-Guard

ON TUESDAY, SEPTEMBER 15, 2009 50 CENTS

AMBULANCE SERVICE

CASH EMERGENCY

Fees aren't covering the costs, so local officials float options



BRIAN DAVIES/The Register-Guard

Paramedics *Betty Lou Hansen and Bryon Harvey prepare to take a patient to the hospital. Urban and rural ambulance services in Lane County are in the red because of low federal reimbursements and nonpayment by uninsured people.*

BY SUSAN PALMER
The Register-Guard

Ambulance services in Eugene, Springfield and rural Lane County are in financial trouble, and government officials want community feedback before proposing fixes, which might include new special taxing districts.

A task force meeting this year to seek a solution has crafted options and scheduled nine public meetings in coming weeks to discuss them.

Here's what's wrong: The vast majority of the patients who use ambulance services are Medicaid or Medicare subscribers — elderly, low-income or disabled people — with the federal government paying the fee. But the government doesn't pay enough to cover what it costs to run the service, and hiking ambulance fees for those with private insurance isn't closing the financial gap, officials said.

Turn to **AMBULANCE,** *Page A5*

Ambulance: Federal reimbursement pays fraction of fee

Continued from Page A1

While the ambulance services and their paramedics are part of their respective fire departments, they don't receive any of the general funds — money raised from property taxes — that pays for fire protection. Rather, the ambulance services are supposed to be paid for entirely by user fees — from federal programs or from private insurance.

This year, both Eugene and Springfield have raised the basic charge for ambulance service to $1,600 per trip, Springfield Fire Chief Dennis Murphy said. But only 17 percent of their patients have private insurance to cover the bill, Murphy said.

About 70 percent of them are Medicare and Medicaid patients, and the federal reimbursement for those trips ranges from $300 to $450.

The rest have no insurance and often can't pay any of the bill.

Eugene and Springfield have well-equipped vehicles and well-trained staff, Murphy said.

The vehicles and crews stand ready to go, 24 hours a day, 365 days a year, he said.

"Whether I run one call or 10,001, the ability to respond around the clock, the overhead cost of that is there all the time," he said.

"I don't have different types of people for different types of care. If I have an ambulance, it's full of paramedics, and every firefighter is also a trained paramedic. ... You call, we come, no questions asked. You get first-class treatment," he said.

The system could be maintained if the department received $565 per trip, Murphy said. But that's much more than the federal government pays.

Eugene and Springfield both offer a membership program, a $52 annual payment that guarantees a household its members won't face a $1,600 bill if they need the service.

The 32,000 local households that last year bought into Fire Med, as the program is known, provide enough money to cover the 10 percent of them who needed transport, Murphy said, with a small amount left over.

"The user fee plus Fire Med memberships are no longer totally enough to fund the system," he said. Springfield exhausted its reserves in March and is now operating in the red, he said.

Both Eugene and Lane Rural Fire are in similar straits as are ambulance services all over the country, he said.

At the public meetings, several options that have been under consideration by elected officials will be explained.

Ideas include taking general fund money from other programs to help pay for ambulance service, creating a special taxing district, and merging separate fire departments into one new taxing district that would also cover ambulance service.

PUBLIC MEETINGS ON AMBULANCE SERVICES

Today: 7 p.m., Hilyard Community Center, 2580 Hilyard St., Eugene
Wednesday: 7:30 p.m., Fire Station 51, 29999 Hallett St., Eugene
Thursday: 7:30 p.m., Fire Station 11-1, 88050 Territorial Highway, Veneta
Sept. 22: 7:30 p.m., Eugene Emergency Services Center, 1705 W. Second Ave.
Sept. 23: 7 p.m., Churchill Estates, 1919 Bailey Hill Road, Eugene
Sept. 24: 7:30 p.m., Springfield Library Meeting Room, 225 Fifth St.
Sept. 29: 7:30 p.m., Fire Station 3, 1225 28th St., Springfield
Sept. 30: 7:30 p.m., Petersen Barn, 870 Berntzen Road, Eugene
Oct 1: 7:30 p.m., Fire Station 6, 2435 Willakenzie Road, Eugene
Online: To read about options and weigh in electronically, go to www.eugene-or.gov/fire

Attachment C

The Register-Guard

GON TUESDAY, SEPTEMBER 15, 2009 50 CENTS

EDITORIALS

Unsustainable ambulances

Current funding system needs changes

It costs $565 to send an ambulance and a crew of paramedics to the scene of an accident or medical emergency. Seventy percent of ambulance calls come from Medicare or Medicaid patients, and those programs pay only $300 to $450 per response. Another 13 percent have no insurance and usually pay nothing at all. That leaves the 17 percent of patients who have private insurance to pay a rate that will make ambulance service a break-even proposition for Eugene, Springfield and the Lane Rural Fire/Rescue District. The rate works out to $1,600, and still the service is losing money.

Something has to change. In a way that mirrors the problems of the health care system nationwide, the status quo for local ambulance service is unsustainable.

Elected officials from Eugene, Springfield, Lane County and the rural fire district board have formed a task force to explore the options. The task force is seeking ideas from the public in forums that began Tuesday and continue through Oct. 1.

The discussion should begin with a commitment to two principles. First, the Eugene-Springfield area should not retreat from a high standard of care — every call should be answered quickly by people trained to provide life-saving assistance. Such assistance is often the most important medical care a patient will receive. It saves lives and reduces the need for other medical services later on. Second, ambulance service should continue to be a public service available to all, not a private service providing different levels of response depending on a caller's ability to pay.

One promising financing concept is demonstrated by the successful Fire Med program. The program works on the insurance principle: If many people pay a small amount for a service they use only occasionally, the pooled funds can cover the full cost of the service for those who need it. About 32,000 people are enrolled in Fire Med, paying $50 a year for assurance that they can call an ambulance any time at no further cost. Most enrollees are people who are somewhat more likely than average to need emergency medical services, but even so, only about 10 percent of them call an ambulance each year. The ambulance service breaks even on Fire Med calls.

Broadening the pool still further would probably require public funds, either through an appropriation by the jurisdictions receiving ambulance service or by forming some type of special taxing district. A general fund appropriation would put ambulance service in budgetary competition with other government programs, ranging from police to libraries. Thorny questions of financial equity among the various jurisdictions could also arise. A taxing district could exist for the sole purpose of providing ambulance service, but its formation would be complicated and time-consuming.

Ending the ambulance service's exclusive reliance on fees, however, would bring advantages. Above all, the increasingly disproportionate fees charged to people with private insurance could be reduced. Everyone could be charged the same rate, perhaps pegged to the rates of Medicare and Medicaid reimbursements. The gap between the rate and the cost of the service could be covered with public funds collected from all taxpayers, on grounds that anyone might need ambulance service at any time and nearly everyone is likely to need it eventually. Because the cost would be spread widely, the expense for each household would be low.

In the long run, a separate district is most promising — and it might be designed to provide other public safety services in addition to ambulance response. If creating such a district would take a period of years, general government appropriations may be needed in the interim.

The current arrangement, however, can't continue indefinitely. Without a broader system of finance, people needing an ambulance will one day be told to call back later, or asked for a credit card number.

Thinking big Cities should seriously consider merging fire agencies

Appeared in print: **Thursday,** *Jul 30, 2009* RG Editorial

The idea of merging municipal emergency services is hardly a new one in the Eugene-Springfield area. Proposals to combine fire and ambulance services, as well as law enforcement agencies, have been considered several times in recent decades, usually when constricting budgets make the prospect of saving money attractive.

But the proposals have never gone beyond the discussion stage. Invariably they're dismissed by officials who cite logistical difficulties or "cultural differences" between the cities and their fire and police departments.

Now, municipal budgets are being squeezed by the Great Recession, and a new merger plan is emerging. Eugene and Springfield officials should find a way to make it reality.

Eugene Fire Chief Randy Groves and Springfield Fire and Life Safety Chief Dennis Murphy are jointly proposing that their cities combine departments. The departments would operate under an intergovernmental agreement similar to the one that formed the Metropolitan Wastewater Commission 25 years ago. If the agreement proved successful, the plan calls for an eventual full merger of the two departments.

Mergers of fire departments and districts should be judged on a case-by-case basis. But as a rule there often is much to be gained in terms of efficiency, reduced administrative costs, the elimination of duplication and an end to jurisdictional disputes.

That appears to be the case with the proposed merger of the Eugene and Springfield fire departments. A study commissioned by the cities and released this month indicates the move would save the two cities $850,000 a year. And the two chiefs say it could be accomplished without compromising the current levels of service.

That makes sense in a recession — and it should make sense in a booming economy, as well. Hopefully, a merger would provide opportunities to save significantly more than $850,000, which is a small percentage of the departments' combined budgets. And a merger could eventually improve the levels of service to the two cities rather than merely preserving current levels.

Later this year Eugene and Springfield council members plan to discuss blending fire departments, and they should start by acknowledging the many ways in which the agencies have worked together for years. For example, the departments routinely cross boundaries to reduce response times and provide mutual assistance.

They should also avoid the treadworn arguments that have halted merger discussions in the past. The "cultural differences" argument cited by a Eugene councilor this week is a case in point. If your house is burning or you are suffering from a heart attack, you want professional help from a fully funded, equipped and trained fire department. "Cultural differences" are the last thing on your mind.

That's not to say there aren't serious issues, ranging from oversight to response times to the possibility of merging with other regional departments, that need to be discussed.

But Eugene and Springfield officials should look for ways to resolve these issues — and not for justifications to walk away from yet another merger idea.

As a rule there often is much to be gained in terms of efficiency, reduced administrative costs, the elimination of duplication and an end to jurisdictional disputes.

Attachment C

latimes.com

L.A. County's 911 system burdened by non-emergency calls

Patients who summon paramedics for rides to clinics or to refill prescriptions are taking time and resources from patients with dire needs. Officials consider changes to make the system more adaptable.

By Anna Gorman, Los Angeles Times

8:13 PM PDT, May 14, 2012

Just before 10:45 a.m., Keith Marks called 911 and the Los Angeles County emergency response system sprang into action. A fire engine, a paramedic squad and a private ambulance — eight men in total — rushed to the Martin Luther King Jr. urgent-care center in Willowbrook.

When they arrived, Marks, 56, was sitting calmly in a wheelchair just outside the entrance. His complaint: he was having joint pain from gout and wanted his medication refilled.

"I can't walk," he said. "I need to go to the closest emergency room."

The paramedics checked his vital signs. Marks told them he called 911 after the county clinic wouldn't see him for free because he had other insurance. Then the paramedics did what Marks wanted — sent him by ambulance to St. Francis Medical Center.

PHOTOS: 911 calls

During an eight-hour period at L.A. County Fire Station 41 last week, paramedics responded to a handful of calls but only one actual emergency — a man who reportedly had a seizure while driving on the 105 Freeway. Several other calls, they said, could have been handled differently if there were other options. The call from Marks was one.

"Really, what are we going to do for gout?" Capt. Ernie Clayton asked.

The incident illustrates a chronic problem — unnecessary 911 calls that result in costly trips to already crowded ERs, which divert resources from true emergencies. Increasingly, uninsured patients rely on 911 as their only way into the healthcare system.

Now, four decades after public safety agencies began launching fast-response paramedics, counties

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around the nation are overhauling the 911 system to save money, improve care and reduce ER overcrowding, an especially acute problem in the Los Angeles area. Federal health reform is driving the changes, as hospitals try to reduce readmissions and the healthcare system prepares for more patients.

In San Francisco and San Diego, paramedics have worked with law enforcement to reduce the burden of alcoholics on the 911 system. Paramedics in Maine, Minnesota and Colorado are beginning to treat patients in their homes, doing preventive and follow-up care and helping manage chronic illnesses.

"The emergency room is expensive and not always a pleasant experience for patients," said Maine's community paramedicine coordinator, Kevin McGinnis. "It is much better to treat them where they are."

Although the discussions in Los Angeles County are just beginning, officials said they hoped to make changes to the 911 system in the next few years. This is the perfect time, they said, because there is federal money available for new efforts to deliver better care in a more cost-effective way.

"People are calling 911 not because they are really, really sick or really, really injured. It's because they have no other option," said L.A. County Fire Department Chief Deputy Mike Metro. Fire departments cannot continue to add engines and paramedics to meet the need, he said. "We have to have the ability to make different decisions."

Paramedics in L.A. County responded to 543,715 calls in 2010 — a little more than one call every minute. About one in five patients taken to the ER might have been better served elsewhere, according to Cathy Chidester, director of the county's Emergency Medical Services Agency.

Under current emergency response rules, there is little flexibility. After receiving initial aid, 911 patients have only two choices — either go to the emergency room or stay behind. In L.A. County, more than three-quarters take the ambulance ride, which can cost up to $1,500, even when their complaints are as minor as a cough or a headache. By law, emergency rooms must take patients regardless of insurance status.

Officials are exploring whether ambulances could take certain 911 cases to clinics rather than hospitals. They are also exploring whether paramedics could treat some people at their homes and refer others to primary care doctors or advice lines. And they are considering mobile health vans in some cases.

"This is a skilled workforce," said Mitch Katz, director of the county Department of Health Services. "Their basic choice is to transport a person to the emergency room or not. That is not a very nuanced choice."

Katz said the goal is that all patients "go to the right place and the right time to see the right person."

California officials also are looking for ways to make the process more efficient and expand the role of paramedics, said Howard Backer, director of the California Emergency Medical Services Authority. Paramedic teams — staffed to provide service 24 hours a day — are qualified to do several medical procedures, such as insert breathing tubes and conduct electrocardiograms.

With additional training, Backer said they could help fill the primary care gap in California. "There are EMS personnel everywhere," he said. "It's natural to look at how we can do the most with the resources we have."

Changes won't be easy. California law restricts where ambulances can take 911 patients, and insurance, private and public, reimburses only when they are transported to hospitals. Clinics also would need to

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have the right hours, staffing and expertise to take the patients.

Then there is the concern about errors in judgment. What happens if a patient is taken to a clinic but really needed to go to an ER? What if a 911 patient is treated at home but really needed to see a doctor?

"It all comes down to liability," said Patrick Hanrahan, an L.A. County firefighter-paramedic. "We don't want to be left on the hook."

Hospital personnel already talk with paramedics in the field, so under a new system, nurses and doctors could help quickly determine the best place for a 911 patient to be treated, said Jim Lott, executive vice president of the Hospital Assn. of Southern California.

"This is long overdue," Lott said. "The communication is there, the technology is there, the expertise is there. There is no reason why this kind of triaging can't be done effectively."

Another problem is that paramedics and ambulances often get stuck with their patients waiting for ER beds to open; creating new protocols could make the process work more smoothly. "If you have ambulances waiting at the emergency room ... the people who need the care are not getting it," said Brian Bledsoe, who teaches emergency medicine in Nevada and has written several EMS textbooks.

At Station 41 in Willowbrook, paramedics said they have responded — with lights and sirens — to babies who wouldn't stop crying, people who couldn't sleep and alcoholics who drank too much. "In their eyes it's an emergency," Clayton said. "We know better. But once the call is made, we have to care for them."

On the day Marks called from the urgent-care center, paramedics from a nearby station headed to a Watts motel for a call about a man with a gunshot wound. But the victim, Terrance Montgomery, said he was shot and had been treated nine days earlier. The motel owner said she called 911 because Montgomery owed her money and she wanted him off the property.

As he was loaded into the ambulance, Montgomery, who is uninsured, said he hadn't seen a doctor since leaving the hospital the previous week. "This is going to be my follow-up," he said.

Later in the afternoon, paramedics went to the home of 90-year-old Nathan Shands, who had been vomiting for a few days. His granddaughter said she couldn't get him into the car, so she called 911 to take him to the hospital. She hadn't expected so many people to show up.

"She just wanted transport to the hospital," Clayton said. "She didn't understand 911 response."

PHOTOS: 911 calls

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