EMERGENCY MEDICAL SERVICES AUTHORITY – A Public Trust
Board of Trustees Meeting
Wednesday, August 22, 2012
EMSA Corporate Offices
1111 Classen Dr., OKC, OK 73103
1417 N. Lansing Ave., Tulsa, OK 74106

Minutes:

NOTICE AND AGENDA for the meeting of the Board of Trustees of the Emergency Medical Services Authority, a Public Trust, was posted August 21, 2012 in the offices of the City Clerk of Oklahoma City at 9:09 am, and with the City Clerk of the City of Tulsa on August 21, 2012 at 7:40 am, more than 24 hours prior to the time set for the meeting.

A quorum was present. The meeting was called to order at 1:08 p.m. by Mr. Clay Bird.

TRUSTEES PRESENT

Dr. Jim Rodgers
Mr. Gary Marrs
Mr. Clay Bird
Mr. Phil Lakin
Mr. Mark Joslin
Mr. Cet Caldwell
Mr. Larry Stevens
Dr. Ed Shadid
Dr. Jeffrey Goodloe

OTHERS PRESENT

Steve Williamson, EMSA
Kent Torrence, EMSA
Angie Lehman, EMSA
Ann Laur, EMSA
Frank Gresh, EMSA
Kelli Bruer, EMSA
James Davis, EMSA
John Peterson, Paramedics Plus
Lara O'Leary, Paramedics Plus
Jeannie Sacra, Paramedics Plus
Jim Orbison, Riggs/Abney
Michael Brink, Management Review Office
TL Cox, Management Review Office
Kari Culp, Schnake/Turnbo/Frank
Doug Dowler, City of Oklahoma City
Ziva Branstetter, Tulsa World
Kirby Davis, Journal Record
Emory Bryan, KOTV

TRUSTEES ABSENT

Ms. Lillian Perryman
Mr. Joe Hodges

CONSENT AGENDA

1. Approval of Regular Board Minutes of June 27, 2012

Upon motion made by Dr. Rodgers and seconded by Mr. Marrs, the Board of Trustees voted to approve the Regular Board Minutes of June 27, 2012.

AYE: Mr. Gary Marrs, Mr. Larry Stevens, Mr. Phil Lakin, Mr. Caldwell, Mr. Mark Joslin, Dr. Jim Rodgers, Mr. Clay Bird

NAY: None

ABSTENTION: None

ABSENT: Dr. Ed Shadid, Ms. Lillian Perryman, Mr. Joe Hodges

REGULAR AGENDA

1. Chairman's Report

Mr. Clay Bird told the Board that Ms. Lillian Perryman is recovering well from surgery and should be back to work in about three weeks. Mr. Bird is acting Chair for this meeting, and does not have a report.

2. Approval of EMSA Board of Trustees Slate of Officers

Mr. Williamson informed the board that although the Board approved this Slate of Officers in May, the EMSA Bylaws require the approval of the Slate of Officers every year in July. Therefore, the Board needs to approve them now, as the July meeting was canceled.

Upon motion made by Mr. Lakin and seconded by Mr. Joslin, the Board of Trustees voted to approve the EMSA Board of Trustees Slate of Officers.

AYE: Mr. Phil Lakin, Dr. Jim Rodgers, Mr. Cet Caldwell, Mr. Clay Bird, Mr. Mark Joslin, Mr. Gary Marrs, Mr. Larry Stevens

NAY: None

ABSTENTION: None

ABSENT: Mr. Joe Hodges, Dr. Ed Shadid, Ms. Lillian Perryman

3. Approval of Interlocal Subsidy Agreement between the City of Edmond and EMSA

Mr. Williamson explained that an annual agreement for payment of the City of Edmond's subsidy for the next fiscal year is approved each year by the EMSA Board of Trustees.

Upon motion made by Mr. Marrs and seconded by Dr. Rodgers, the Board of Trustees voted to approve the Interlocal Subsidy Agreement between the City of Edmond and EMSA.

AYE: Mr. Phil Lakin, Dr. Jim Rodgers, Mr. Cet Caldwell, Mr. Clay Bird, Mr. Mark Joslin, Mr. Gary Marrs

NAY: None

ABSTENTION: Mr. Larry Stevens

ABSENT: Ms. Lillian Perryman, Dr. Ed Shadid, Mr. Joe Hodges

4. Report from the City of Tulsa Management Review Office

Mr. Bird introduced Mr. Michael Brink and T.L. Cox from the City of Tulsa's Management Review Office (MRO). Mr. Brink worked with a team that looked at EMSA's back office processes for efficiency and effectiveness. He explained that the review dates back to a KPMG study commissioned by Mayor Bartlett to look at all aspects of city government.

The Management Review office began working with EMSA management about a year ago. At that time (August, 2011), the EMSA Board of Trustees, the Medical Control Board and the Medical Director agreed to provide to the City a list of operational efficiency recommendations based on the OU emergency care study. Mr. Brink indicated that the City of Tulsa and EMSA estimated the recommended efficiencies from an operational review and the OU study are expected to exceed $1 million annually. EMSA also agreed to negotiate with the City a permanent process whereby the City of Tulsa holds fees collected from the EMS Utility Fee Program ("excess of revenues over expenses"), transferring only amounts needed by EMSA to operate. EMSA also agreed to pursue the development of a gain sharing arrangement with the City of Tulsa.

The Review presented today, which focused on administrative and financial processes took place from April 4 – June 29, 2012. Resources used for the team were: Michael Brink (MRO), Ed O'Neill, considered by the Management Review Office as a subject matter expert, having run an emergency billing services company (part of a larger company) for two years; Sean Ratliff and Mark Weathers (both in City of Tulsa Finance); and Vickie Beyer (MRO).

Mr. Brink thanked EMSA executives and employees for being generous with their time. Over 60 documents and data sets were reviewed, resulting in a 50-page written review with 50 separate findings and recommendations.

Subjects reviewed include organizational alignment, use of technology, HR practices, quality, and communications. Processes reviewed were pre-billing, billing, payment entry, scanning, mail, customer care, walk-in payments, accounts receivable, Paramedics Plus data interface, accounts payable and other general business processes and structures.

Mr. Brink stated a number of positive findings were made. EMSA provided the MRO with a list of 18 recent improvements made in back office processes. He believes all of those improvements had been undertaken within the last year. Those items are included as a specific attachment in the MRO Report.

EMSA's management was very cooperative with the MRO. Employees were interviewed without supervisory oversight, and in addition to being very open, expressed commitment to EMSA. Also, a very positive relationship is apparent between EMSA and Paramedics Plus.

Other positive findings were the recent steps taken to improve customer understanding of the City of Tulsa (COT) Utility Fee Program requirements, and steps taken to improve billing data coordination between EMSA and Paramedics Plus.

Mr. Brink then detailed ten major findings and the resulting recommendations brought to the attention of the Mayor from the review.

1. Establishing an EMSA System Chief Operating Officer
   EMSA has grown increasingly complex as it has expanded, and there is no one ensuring all operational functions are working together aside from the CEO, who already has substantial external responsibilities. In addition there is no formal contract manager for Paramedics Plus except the CEO and no evident succession plan.

2. Embracing a Systematic Continuous Improvement Approach
   Mr. Brink said the MRO recommends creating a system whereby monthly or quarterly measurements can be made pertaining to key internal processes to assure consistent quality and control of these areas. Examples of back office processes which could benefit from the continuous improvement approach are:
   - Time to complete key stages of the billing process from date of service
   - Quality assurance and control of processes such as scanning and customer care (measuring defects)
   - Analysis of customer inquiries and complaints to reduce addressing the same issues repeatedly
   - Tracking and reconciliation of "face sheets" to corresponding runs

At this point, Mr. Lakin asked Mr. Brink if there is a department within the City of Tulsa that tracks customer inquiries and complaints. Mr. Brink is not aware of any department within the City of Tulsa that uses a process to track and analyze customer inquiries and complaints. Mr. Williamson indicated the EMSA executive team has been investigating and vetting software for about 8 months. EMSA at one time had a system in place and tried to adapt it for the current needs, but it was not successful. Mr. Williamson stated strides are being made to get a new program installed.

3. Integrating Key Technologies
   The MRO believes there is a great opportunity in this area. Many exciting things are happening in the ambulance service industry that Mr. Brink feels should be evaluated for use at EMSA. Examples are:
   - Integrating into field units point of service identification capture technologies such as card scanners/readers for government issued ID cards and/or health insurance cards
   - Integrating the electronic patient care record and EMSA's billing system to avoid manual input
   - Using scanning technology in back office processes such as mail intake, correspondence management and payment entry
   - Developing an automated "waterfall" process to locate patient information by referencing multiple data sources
   - Creating an automated information exchange with hospitals to secure patient demographic information

Mr. Brink stated EMSA is already pursuing some of these technologies.

4. Continued Improvements to Revenue Management Efforts
   Mr. Brink acknowledged improvements have been seen from August 2011 to February 2012 in revenue management. MRO recommendations in this area include:
   - Making a concerted effort to recover more demographic information at the point of service
   - Focusing all efforts on getting invoices and claims submitted to payors as quickly as possible
   - Determine best practices, implementing standard processes and automating to locate patient addresses
   - Continue to analyze the value of investing more resources for in-house billing and send fewer accounts to Works & Lentz (EMSA did add an internal position to do this recently)

5. Implementing More Effective Human Resources
   Mr. Brink acknowledged EMSA runs a tight ship when it comes to staffing, with many employees performing a variety of roles. He feels there is still opportunity for further cross training and other strategies.

   - Increase cross training
   - Develop "pay for performance", "gainsharing" compensation plans or, at a minimum, employee recognition programs
   - Identify and build key skill needs into personnel recruitment processes or enter into agreements with contractors to secure scarce skill sets

6. Enhancing Security
   Although Mr. Brink admits members of the MRO are not experts in security, they do have some recommendations.
   - Employee access should be more limited in particular areas of the OKC office
   - Handling of checks and credit card information at various points of the payment process is possibly at variance with PCI requirements
   - EMSA must review PCI compliance standards with its legal and IT departments and outline a plan to eliminate or reduce risk

   MRO concerns with certain areas of security were communicated to EMSA when found, and EMSA immediately took action on those areas.

7. Improving Non-Financial KPI's
   EMSA currently measures about 130 separate performance measures. Most of these are regarding operational measures that affect health outcomes. Others are financial measures. Although health outcomes are the most important aspect of what EMSA does, the MRO feels there is value in focusing on key performance measures in the back office process areas. Recommendations include measuring:
   - Average processing days of key functions
   - Percentage of address matches found through automated means
   - Percent of unidentified patients (i.e. unable to obtain billing info)
   - Trips/accounts sent to Works & Lentz, average days worked prior to sending
   - Customer service metrics such as number/type of complaints and inquiries as well as timing to resolution/closure of same

8. Improving Communications Regarding the EMS Utility Fee Program (TotalCare)
   Mr. Brink acknowledged EMSA is taking steps and making strides in the education of the public regarding the COT EMS Utility Fee Program. The MRO feels EMSA should continue to focus on making the terms of the EMS Utility

Fee Program more understandable, better integrating it into the patient statement and customer care scripts.

9. Improving COT EMS Utility Fee Program Data Usage
   The MRO spoke with people from the City of Tulsa and EMSA regarding customer data. There are opportunities, he feels, for EMSA to better utilize the data that is provided by the City, but also the City could do a better job in providing data to EMSA. Ideas formulated by the MRO include:
   - Using a unique identifier for program participants
   - Automating the process of matching addresses to the program file to eliminate manual lookup
   - Working with City Finance and using database analyst talent to improve the use and structure of the program file
   - Requesting that City Finance provide "look up" rights directly into the City's Utilities billing system to select EMSA employees for purposes of researching an individual's EMS utility fee program status

10. Improving Procurement Practices:
    The MRO looked at various vendors which EMSA had procured and spent over $50,000 with. Mr. Brink believes EMSA could benefit from greater use of competitive procurement.
    - A review of the nine providers with which EMSA spent more than $50K in 2011 indicates at least six, possibly more, were sole source
    - Multiple examples were found of EMSA selecting the vendor before specifying the scope of work
    - Suggest designating a purchasing manager to increase focus on competitive bidding
    - Suggest competitively re-procure the collections contract with Works & Lentz

Mr. Lakin asked Mr. Brink for his recommendation as to who should identify next steps and how to go about making the needed changes. Does Mr. Brink feel the new COO and a Purchasing Director would have more of a say in how contracts are put together and would the Board of Trustees get involved? Mr. Brink responded that the MRO would be involved in identifying next steps, and he feels there are significant recommendations in the review that would likely require action by the Board and EMSA's executive management.

Dr. Shadid asked Mr. Brink if he has a list of the six vendors that are sole source. Between the attendees at the meeting a list was provided. It included (1) Physio Control, (2)Medusa, (3)Zoll, (4)TriTech, (5)Total Radio and (6)GIS Data Systems. Mr. Williamson explained that four of these (Medusa, Tri Tech, Zoll, and Physio Control) are maintenance agreements. Total Radio is the vendor the City of Tulsa has contracted with to handle the 800 MHz State radio systems. GIS Data Systems is the mapping software that goes with the TriTech dispatch system.

Mr. Marrs asked Mr. Brink if the recommendations of adding personnel, purchasing programs, etc. have been factored in to the projected $1 million savings stated at the beginning of the presentation. Mr. Brink replied the $1 million was identified as a target between the City of Tulsa and EMSA in August, 2011. The MRO proposed working with EMSA to identify if the changes made to date begin to affect the projected savings amount. Mr. Brink stated the only personnel position proposed by the MRO was that of a COO. A cost benefit analysis should be run to make sure it makes good financial sense, but he believes the benefits to the effectiveness of the billing process and the coordination of operations would justify the cost of that position. The recommendations discussed were items they propose EMSA look at in order to begin to achieve the $1 million in savings. Each recommendation should be analyzed on the basis of whether it makes sense, and this is beyond the scope of the initial study.

Mr. Marrs then told Mr. Brink that identifying best business practices typically indicates the business being reviewed is a private business, not a governmental entity. Yet in some areas of the review, Mr. Marrs feels the MRO is encouraging EMSA to be run like a private business. In other areas, it seems as though they are encouraging EMSA to be run like a City of Tulsa department.

Mr. Brink stated the MRO is not advocating EMSA be run like a City of Tulsa department. The MRO believes many private business practices can be adopted and used in a public sector environment.

Dr. Shadid asked for clarification as to the delineation of responsibilities between a CEO, COO and CFO. Mr. Brink explained the CEO is often the person who deals with elected officials, a board of trustees and legislative bodies. At EMSA, he would, of course, be responsible to some extent for internal operations, but also have a significant amount of responsibility externally. The COO, in EMSA's case, he envisions as someone who is 100% dedicated to the interface between the emergency services provider and all of the different operations with EMSA. He/she would be focused exclusively on the process from the point of service through the ultimate billing, making sure every aspect is integrated and connected to generate the most appropriate financial outcome. The CFO is responsible for ultimately all of the reporting requirements and financial performance of the organization.

Mr. Brink told the board that prior, working drafts of the MRO findings had been reviewed with EMSA executives on June 28 and July 18. The interaction has been generally positive, with limited disagreement on particular findings. As of August 20, EMSA was in complete agreement with 27 of the 50 findings and recommendations as assessed by the MRO. EMSA agreed partially with 11, and disagreed with 12 of the findings. At this point they have conveyed to the MRO that they are involved in implementing about 18 of the recommendations to this point, and have made some type of tangible progress on those.

Mr. Brink then reviewed some next steps with the Board. The MRO proposes continued, active involvement in the following:

- Assistance in calculating all savings from steps taken since 8/2011
- Monitoring key competitive procurements and procurement process improvements
- Confirming improvements in payor identification technologies and efforts
- Developing employee incentive plans
- Developing KPI's to better capture process timeliness and quality
- Improving the use of the City's EMS Utility Fee Program data file

Mr. Williamson informed the Board that EMSA has responded to the review. EMSA management looked at the experience positively, and although EMSA disagreed on some things, there was more agreement than disagreement. The response indicates how EMSA is addressing each of the recommendations and Mr. Williamson will report progress being made at each board meeting. Copies of EMSA's responses were sent out to the Board via email the previous day along with the report itself, and Mr. Williamson asked the Board to review them for discussion at the next meeting.

Dr. Shadid requested Mr. Brink return to the Board meeting on September 26 after the Board has had time to review the documents thoroughly. Mr. Brink agreed.

Mr. Lakin asked Mr. Bird if a timeline could be sketched out for implementing the changes. Mr. Bird agreed a timeline would be helpful. He feels a lack of succession plan is a serious issue that needs to be addressed.

Mr. Williamson agreed to work with the Board in forming a timeline and discussing issues brought forth in the MRO report in detail.

5. President's Report

Mr. Williamson directed the Board's attention to the compliance and exclusion reports for the months of June and July, 2012. Response times were very good for both June and July. Mr. Williamson stated the industry is starting to get a better feel on volumes regarding baby boomers. Paramedics Plus has done a wonderful job of trying to second guess demand and EMSA's growth, and tools are being developed in the industry to help services understand how to cope with 10,000 people a day turning 65.

Mr. Lakin asked if EMSA has the numbers on TotalCare regarding how many opted out by the end of June. Mr. Williamson indicated eastern division opt out numbers increased 1% over what they were in the previous year, but reminded the board that the method had been changed in which people opt out. Citizens were able to opt out permanently this year, rather than just opting out for one year at a time. The opt out rate last year was 10% and this year was 11%.

Dr. Shadid asked why it appears exclusions were significantly more in the last five months than the first five months. Mr. Williamson stated that the volume of transports is very difficult to predict. The majority of the variability in the exclusions is due to changes in volume.

6. Approval of RFP for Ambulance Services

Mr. Williamson told the board he placed the RFP on the agenda today, which is one month before it actually needs to be approved. He will make a presentation and allow plenty of time for discussion and questions. In addition, he is happy to meet individually with board members before the September meeting to discuss any concerns or questions they may have before the RFP must be approved. He emphasized how important it is to have a quorum for the September meeting in order to keep to the schedule needed for the RFP process.

Dr. Rodgers asked Mr. Williamson if he could provide a brief synopsis of why each change (redlined) was made to the previous RFP. Mr. Williamson agreed.

Mr. Williamson began his presentation by stating all decisions made regarding the RFP were made by the Medical Control Board (MCB). The MCB and Dr. Goodloe worked with the OU School of Emergency Medicine to write a white paper on all aspects of the RFP. Dr. Goodloe was able to get leading experts in the field to respond to the white paper. Clinical issues in the Request for Proposal are based on evidence-based medicine vetted for the standard of care in this area of Oklahoma.

Dr. Goodloe, speaking on behalf of the Medical Control Board and the University of Oklahoma School of Emergency Medicine, stated his appreciation to the Authority for commissioning the work. It was an opportunity for each author to simply reflect what the medical science says about system-based design variables in an EMS System in the United States for 2011, 2012 and in the short term beyond.

Mr. Williamson explained that with this approach, a model to protect citizens, the Board is buying services for the community. The quality and delivery of care must be determined prior to use, and that is why this model has been accepted so widely, and why it is an important process to go through. EMSA is trying to purchase high quality care for the least possible cost. A single contract will be awarded for the provision of emergency and non-emergency services. Under this procurement, the contractor chosen will provide both divisions with efficient and reliable EMS services at a reasonable cost to consumers. Under the contract, the relationship between EMSA and the contractor should be one of cooperation, not conflict, achieving the best possible marriage of the public interest with the contractor's expertise.

Mr. Williamson reviewed EMSA's functional responsibilities in the performance-based approach to contracting. Those are:

- Conduct periodic competition to select and contract with an ambulance service provider
- Monitor compliance with contractual terms
- Supply the infrastructure necessary for the operation of an ambulance service system in accordance with the standards called for by the Uniform Code for Emergency Medical Services and other regulations
- Handle all patient billings and collections
- Pay the contractor monthly for services performed
- Facilitate provision of qualified twenty-four (24) hour physician radio coverage at no charge to the contractor

Mr. Williamson reviewed the contractor's functional responsibilities, noting that the contractor shall furnish and manage ambulance dispatch services and field operations including, but not limited to:

- Employment of dispatch and field personnel
- Equipment maintenance
- In-service training
- Quality improvement monitoring
- Purchasing and inventory control
- Support services

Mr. Williamson further explained that since EMSA is supplying all of the equipment to be utilized in the performance of the contract, there is no requirement for large-scale investment in capital equipment – another substantial reduction in risk for the proposer.

It is EMSA's intention to eliminate or reduce risk from uncertainties beyond the control of the contractor to such an extent that the principal uncertainties and risks remaining are largely within the control of the contractor – namely, the ability to recruit and manage personnel efficiently and effectively.

Companies proposing bids must establish minimum qualifications in three key areas: previous experience in managing emergency services; financial depth and capability; and regulatory compliance.

EMSA is providing ambulance services utilizing a regional approach. The region served has approximately 1,200,000 citizens in 16 cities covering 1,000 square miles.

Dr. Shadid questioned Mr. Williamson regarding how a provider can qualify to bid if they haven't had experience providing service for communities with a population of more than 1 million citizens. Mr. Williamson explained there are two ways to qualify explained in the RFP – one being a simplified method for accredited organizations and the other a standard method. The Board will have a chance to review those who pre-qualify. The proposal itself

will be reviewed by a nine member group of which staff is not a part of. The group will consist of councilors, medical representatives, Board members and one person who is knowledgeable in the industry.

Mr. Williamson then briefly reviewed:

Operations Management Provisions detail:

- Scope of Service
- Response Time Performance, Reliability and Measurement Methods
- Equipment Furnished and Provisions for Maintenance
- Supplies for Basic and Advanced Life Support
- Performance vs Level of Effort
- Integration of First Responders
- Communications System Management
- Data and Reporting Requirements
- Internal Risk Management/Loss Control Program Required
- Stand-By and Special Events Coverage
- Community Education Requirements
- Disaster Assistance and Response
- Deployment Planning and Initial Plan

Mr. Williamson then explained for the Board some of the changes made to this RFP which make it different than the current contract now in place. One major change is that call determinates will be based in accordance with the then current Medical Priority Dispatch System (MPDS) protocols approved by the Medical Director. Not all responders will respond to every type of call and not all types of calls will be running hot (lights and sirens).

Another change he noted is on page 12 of the RFP. The response time standard for Priority 1 calls will change from 8 minutes and 59 seconds to 10 minutes and 59 seconds. Response times for Priority 2 calls will change from 12 minutes and 59 seconds to 14 minutes and 59 seconds. EMSA has not changed their response times in 35 years. Many studies have taken place to indicate those time requirements are not necessary, especially in a system where first responders are in each community. EMSA wants to give the best possible care, but it should be in conjunction with the best possible cost. The savings from this change are debatable, but clinical outcomes were studied carefully, as EMSA will not sacrifice quality of care and clinical outcomes.

Mr. Bird asked Mr. Williamson if EMSA could ask proposers to include a cost for providing the service at the current response times of 8:59 and 12:59 for Priority 1 and 2 calls, respectively, and for providing service at the proposed new response times of 10:59 and 14:59. Mr. Williamson agreed. Mr. Bird clarified that he believes the Board could get some idea of the cost savings, if two sets of response times are quoted.

Another change Mr. Williamson reviewed with the board is on page 16 of the RFP, and has to do with exclusions. Regarding weather exclusions, a third party forensic weather specialist will be used to look at all the readings in the cities when weather exclusions are requested. It doesn't take much moisture on the streets to cause hazards for the vehicles. The other change regards exclusions to volume. Currently, the average is taken for a certain time and day of the week and compared to the same time and day of the previous year, looking at the 90th percentile of the average. In the new RFP, 200% of the average demand for the hour and day of the current week, and the same hour and day of the previous year, will be used as a basis to determine volume exclusions. Volume predictions are determined more accurately now, and using the 200% number will keep the contractor from adding more cost to the contract. It is now the number typically used in many bids. The number in the RFP draft shows 130%, but Mr. Williamson has changed it 200%.

Dr. Shadid then asked Dr. Goodloe about Priority 1 calls. Dr. Shadid has read literature that states for non-life threatening emergencies, outcomes are not really affected by one, two, three and even four minute differences in response times. But he would like Dr. Goodloe's opinion about responding to Priority 1 life-threatening emergencies with a response time of 11 minutes.

Dr. Goodloe responded he is completely, clinically comfortable with the response time of 11 minutes. He agrees Dr. Shadid is correct in discerning presumed life threatening conditions from presumed non-life threatening conditions, and agrees the literature is very clear that one, two, three, four, even a five minute difference in response times has no bearing on non-life threatening emergencies. However, the literature is surprisingly non-conclusive to the importance of low response times on life threatening conditions, as well. We might think a minute has a dramatic impact on survival from trauma or respiratory difficulty, but the reality is the only clinical entity where time has been proven to have some correlation is in the setting of cardiac arrest, which is less than 1% of calls. What the medical evidence now shows clearly and unequivocally makes the difference, is prompt recognition and prompt initiation of CPR, which can be successfully guided over the phone in an increasing number of cases.

These response time standards also have to be taken in the consideration of the utilization of fire department resources in these life-threatening cases. It is the reason why we are advocating for the fire department not to respond on every medical service request. In many of the lower medical priority calls, that service has no clinical bearing, but it can definitely have a clinical bearing on the higher acuity calls. If a fire engine is responding to a lower medical priority call when a high priority call comes in, and therefore is not available for that high priority call, an engine from a further distance would respond, resulting in a longer response time.

The Medical Control Board, although they strive to be good financial stewards of the system, keep their focus primarily on the clinical piece, making sure medical advice is based on sound medical principals, not financial reasons.

Dr. Shadid then asked Dr. Goodloe if he believes all Priority 1 calls should be lumped together or if a separate category should be used for those calls in which the literature clearly shows a correlation between response times. Dr. Goodloe replied that it would be difficult as a system to carve out and say that cardiac arrest calls must be responded to in 8:59, but in all other Priority 1 calls, responders can respond in 10:59 or less. Cardiac arrests aren't proven to be cardiac arrests until responders are actually on scene. The call might actually have been for something that appeared it could be cardiac arrest, yet turn out to be something entirely different. Dr. Goodloe feels that in this particular system, 10 minutes and 59 seconds as a Priority 1 standard for the transport component of it would not be unreasonable, including cardiac arrest. For other systems without the developed layer of fire department first response, it would be unacceptable.

Dr. Shadid then asked how the CAD2CAD interface upgrade is running. Mr. Williamson replied it is running well.

Mr. Williamson then directed the Board's attention to page 17 of the RFP draft. In the last contract, the contractor was given a two minute time period as a leeway on response times before the penalty started being assessed. That two minute leeway has been removed. Also, non-performance deductions for Priority 1 transports made from the contractor's payment will be made monthly instead of quarterly, as before.

The most important thing about this contract, differing from many others, is the fact it is performance based.

Mr. Williamson then informed the board of an item beginning on page 21 regarding the possibility of consolidation of municipal dispatch. It is possible that during this contract period one or both Beneficiaries will choose to consolidate their municipal dispatch. Should this happen, all requirements requested under this RFP shall be provided by the consolidated dispatch. A sample contract regarding this issue will be attached to the RFP.

Regarding clinical and employee provisions, Mr. Williamson stated there is little change, except for the addition of the new compliance requirements necessary for federal, state and local requirements for contracts with Medicare and Medicaid (detailed on page 31 and 32 of the RFP).

Another change is the updating of insurance language to today's environment.

On page 37, the performance letter of credit would change from the current amount of a $3 million cash escrow or letter of credit to an amount of $5 million.

The topic of gain sharing was added to this RFP, and can be reviewed on page 43. EMSA anticipates gain sharing with the contractor during the life of this contract, and extension, if so granted. The design of this gain sharing shall constitute all profits above the profit margin as stipulated by the bidder in their response.

There is a proposal for deposit. Instead of a bid bond, we ask for $200,000 in the form of a certified or cashier's check made payable to EMSA. This proposal deposit will be returned to any unsuccessful proposers by EMSA within ten business days after the award of the contract, unless it is determined the proposer has misrepresented itself or provided false or inaccurate information in the qualification or RFP response.

Format requirements for the actual proposals are outlined on page 46 – 48, and the evaluation of the proposals is detailed on page 51 – 55.

The RFP draft needs to be approved at the next Board meeting. It is scheduled to be published in JEMS magazine on October 1. If any of the Trustees have questions or concerns regarding any issue in this RFP draft, Mr. Williamson will be happy to meet with individuals to discuss.

Mr. Caldwell asked Mr. Williamson to better explain the relationship between the incentives and the penalties discussed on page 17 and 18, as he is new to the Board and wants to be sure he understands. Mr. Williamson did so and answered his question.

Dr. Shadid expressed concern that in the future, contractors applying should be discouraged from making campaign donations to elected officials. A brief discussion was held by the Trustees, and the general consensus was that donations would not be offered.

Mr. Lakin asked about the possibility of a municipality deciding not to renew their contract with EMSA during the period of this upcoming contract for service. Mr. Williamson explained that both beneficiary cities are now tied to this upcoming contract period, due to their decisions to continue to use EMSA at the last Window of Opportunity.

7. Medical Director's Report

A. Bed Delays

Dr. Goodloe first brought the topic of bed delays to the Board's attention at the June 27 board meeting, where factors contributing to bed delays and the clinical impact they have on the system were discussed. He thanked the Board for their sincere interest shown in the subject, and detailed a chain of events that resulted in where the situation stands today.

In early July, Dr. Goodloe attended a Medical Control Board meeting, and the topic of bed delays was discussed at length there, as well. The Medical Control Board, like the Board of Trustees, is interested in advocating for the reduction of occurrences both in frequency and

in length of bed delays. Dr. Goodloe continued to work with Mr. Jason Likens, the Director of Clinical Services of Paramedics Plus, regarding bed delay data. Mr. Likens spent many, many hours studying the frequency of the delays, the length of each individual delay, overall system occurrences, occurrences by division (east and west), and down to the level of occurrences at individual hospitals.

Once Mr. Likens felt comfortable with the data analysis conclusion and the individual institutional occurrences, he prepared a letter explaining how to read the data, and Dr. Goodloe drafted a cover letter to accompany Mr. Likens letter and the attached data. Dr. Goodloe's letter emphasized the great respect EMSA has for each institution and shared his intent to continue to build upon positive, collaborative relationships between EMSA and each hospital. He asked each institution to reflect upon the data, instructed them how to read the data letter, the division report and the individual institution report. The letters and reports were mailed to each hospital's CEO, Emergency Department, Nursing Director and Emergency Department Physician Medical Director.

Within a few days after the mailing, Mr. Likens received some email inquiries and a subsequent telephone inquiry from one institution in particular, stating a concern about the data, as their numbers of bed delays were, in fact, very low and they had never experienced any that were over an hour.

Due to the fact this institution was one that did, indeed, have very few bed delays, the data for this hospital was pulled to be looked at on a case by case basis to see if there could be an issue.

Once the data was individually pulled and studied, Mr. Likens and others from Paramedics Plus and EMSA did indeed find there was some inaccuracy in the data. The inaccuracy was not only in the frequency of events, but in the length of events, as well. Further research showed the reasons for the inaccuracies.

In the instance of frequency issues, erroneous data was occurring in cases where more than one patient was transported form the same accident. For example, in the case of two patients involved in a single accident and each being transported to a different facility, it was found that both institutions were being counted in the data as having bed delays; when in fact, only one of the facilities was actually delaying the examination/treatment of patients.

To understand the problem with the data regarding bed delay length issues, one must first understand how the standard practice works for notifying dispatch regarding beginning and ending times of bed delays:

> When the crew is told by the hospital that a room is not available and the patient must be kept in the hallway, bed delay is considered to have begun, and the crew then calls to

notify dispatch they are on bed delay. When the hospital frees up a room for the patient, the crew should then call dispatch again to notify them they no longer on bed delay.

However, there is a fair percentage of the data that resulted from situations which occurred when the crews did not call dispatch to report they were no longer on bed delay. In that instance, the system scanned for the next available timestamp, which occurred when that ambulance went back into service after leaving the hospital. Perhaps the medics needed to finish up a report and clean the unit - there is some time involved in making a unit ready again for service, but it is unfair to count that time as part of a bed delay.

Dr. Goodloe then drafted a second letter to let the institutions know of the inaccuracies. He assured the notified individuals that trust in this medical practice of emergency medical service is important, and that trust in the physicians overseeing this medical practice is important. He assured them they had his firm commitment that he and the Medical Control Board would not make a decision based on data they are not comfortable with. They are considering the current data as "vaporized" in terms of being used for decision making.

Dr. Goodloe explained, however, that just because there is inaccuracy in the data collected, it doesn't mean bed delay issues don't exist, because they clearly do. They exist in some degree at nearly every hospital in the system. And the busier a hospital is, the more likely it is to have bed delays occur.

Dr. Goodloe than informed the board there is another Medical Control Board (MCB) meeting on September 5th. He anticipates the MCB will voice their concerns to EMSA and to Paramedics Plus, and say they cannot comfortably, scientifically work with this data. Dr. Goodloe feels a way must be found to correct the issues that resulted in the data inaccuracies.

He would like to continue to follow the bed delays anecdotally. He acknowledges anecdotes are not strong data indicators, but anecdotally, the bed delay issue seems to have improved a bit in the last few weeks.

The divert reports and QI summary reports for the months of June and July, 2012, are on the website for the Board's review.

Mr. Bird thanked Dr. Goodloe for his report.

8. New Business

None.

9. Trustees' Reports

None.

10. Next Meeting – Wednesday, September 26, 2012 – 1:00 PM via video conference – EMSA Administrative Offices, 1111 Classen Drive, Oklahoma City, OK 73103 (Western Division) and 1417 N. Lansing Ave., Tulsa, OK 74106 (Eastern Division)

11. Adjourn.

The meeting was adjourned at 3:15 pm.

Ann C. Laur, Assistant Secretary

Date: