MORROW COUNTY HEALTH DISTRICT
Excellence in Healthcare

Working Together to be a Healthier Community Today and TOMORROW

MORROW COUNTY AMBULANCE PROVIDER PRESENTATION FOR SELECTION COMMITTEE

June 21, 2024

How is your organization best positioned to provide ambulance services in the County?

The district's proven track record of exceptional care and excellent response times for 30 years puts us at an advantage to providing the best services. The staff know the cities, the terrain, and many of the residents. Dr. Metzler is already an employed supervising physician that covers the hospital and emergency room in Heppner, and Paramedic Paul Martin is the EMS Director for the district. As you can see from the rosters many staff have chosen to keep their affiliation with the district and respond as QRT's whenever needed. They are current in their training, the ambulances are licensed and ready to be deployed for services at any time, and we have the billing staff in place to submit and collect claims. The entire operation is ready to engage back into providing full services.

How does your plan change if you are awarded one, two or all three Ambulance Service Areas?

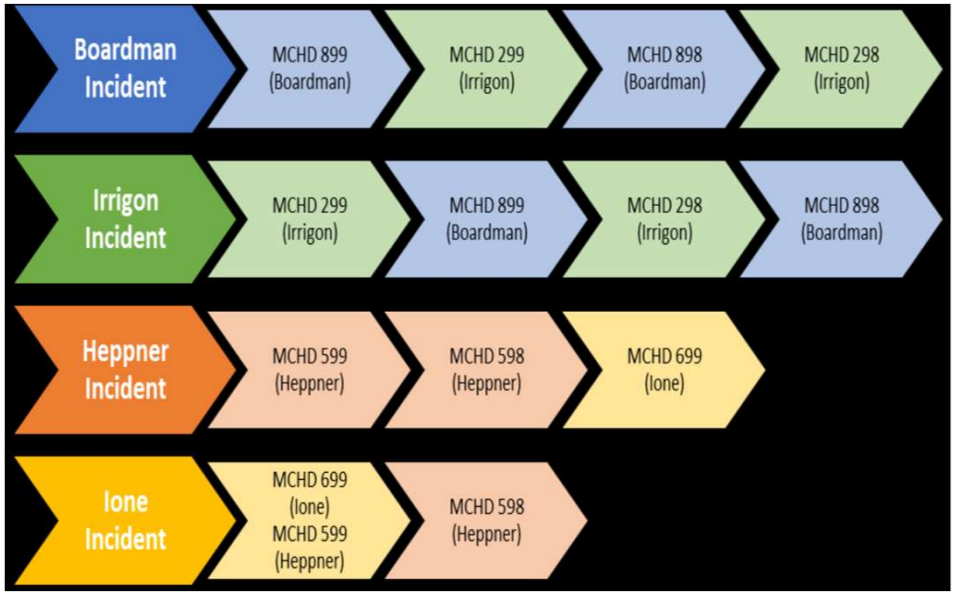
If MCHD is awarded all three areas, each area would need 8 full-time employees (FTE) as opposed to the 12 FTE's with additional staff on-call that are needed to cover a single ASA area. 12 FTE's are also needed in each ASA area if awarded the Southern area and one of the Northern areas because they can't reasonably cross cover due to the geographic distance. The need to ensure a second out ambulance exceeds what any other agency could reasonably provide mutual aid for hence the increased need for staffed positions. All emergency transports in the Northern areas and all hospital to hospital transfers from the Southern area require out of county travel which can take a crew out of rotation for several hours in addition to normal call volumes.

If awarded all three areas there is also a cost reduction due to the cross coverage by the two Northern Areas, so there is a financial savings as a result of that option.

Please explain your approach to second unit staffing in each of the Areas. What level of ambulance service will be provided? (i.e. ALS or BLS)

If one or two areas are awarded, with one of them being Southern, there will be an ALS staffed crew ready to run the second out ambulance located in both areas. Backup is also available beyond that in each area with QRT's that are paramedics and EMT's.

If awarded all three areas, (see chart to the right) North and North East cover each other with their on duty ALS crews. They stage accordingly if one crew is out on a run then at a minimum a BLS QRT crew is queued up through Active 911 so they are aware they may be needed. This is similar for Southern coverage if the first ALS crew is out then at a minimum a BLS QRT crew is queued up for coverage if a second call comes in. This staffing model was successfully used by the District previously and the response times supported this coverage.



Please provide your organization's justification of using your proposed shift schedule for coverage. What positives and negatives are there to your chosen shift schedule?

Staff would be on shift 24/7/365 in Boardman, Irrigon, and Heppner. There is a day shift from 6 a.m. – 6 p.m. and a night shift from 6 p.m. – 6 a.m. MCHD chose the 12-hour shift model after consulting with The Paramedic Foundation. According to The Paramedic Foundation and recent research, 12-hour shifts are safer for staff, patients, and the public than 24-hour shifts because of reduced fatigue, which in turn reduces both medical and driving errors.

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302 Wilson Lane
Boardman, OR 97818

899 Type 1
898 Type 1

705 N Main Ave NE
Irrigon, OR 97844

299 Type 1
298 Type 3

564 E Pioneer Drive
Heppner, OR 97836

599 Type 1
598 Type 1

160 West Main Street
Ione, OR 97843

699 Type 3

OHV Park Medical Station
Heppner, OR

Quick Response Team **Boardman**

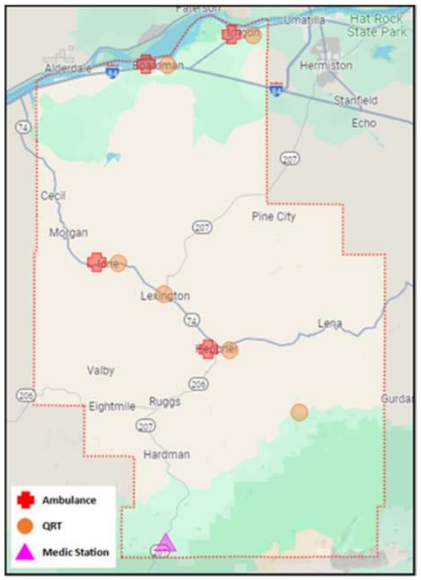
Quick Response Team **Heppner**

Quick Response Team **Blake's Ranch**, Heppner

Quick Response Team **Ione**

Quick Response Team **Irrigon**

Quick Response Team **Lexington**



What is your approach to the use of QRTs?

MCHD has many QRT's located across the county and uses the Active 911 communication software application to alert of the need for their assistance and queue up additional staffing. The QRT's are also available to be dispatched whenever needed, provide coverage at special events, and are often first on scene because they are spread out across all the communities. The QRT's are employees of the district and are paid for their time worked and on call.

The staffing list provided with the application does not break down staffing by ASA. Is it truly universal? Will all those personnel be available if your organization is awarded only one or two ASAs?

Everyone on the roster is willing to work in some capacity whether it's QRT, fill-in scheduled shifts, inter-facility transfers or full-time scheduled shifts. Additional staff will need to be hired if the District is awarded one or more areas.

When could your organization start as a provider? Outside of contract finalization, what needs to happen before that start date?

From the date of contract finalization, MCHD could start providing services in the Southern area in 2-3 weeks because there are currently several full-time ambulance staff working at the hospital and North and North East areas would take 4-6 weeks for recruitment of new staff, converting part-time staff back to full-time and time to provide orientation.

The Intergovernmental Agreement is a challenge for the County as it introduces other parties to the ASA determination and doesn't stop residents from initiating a petition for withdrawal from the special district. Would MCHD consider being an ambulance provider without the IGA in place?

In order to make the investment in providing ambulance services again, the District needs support and cooperation from the county and cities to keep all essential health services viable for our rural communities. All of Morrow County needs to encourage and engage in development of the health partnerships across the entire county. A withdrawal by any area from the health district would lower the tax revenue to a level that would not sustain operations and many services across the county could be lost. All services provided need subsidized in order to operate, even with cost-based reimbursement, which is not unusual for a large county that is sparsely populated with diverse needs. The Board is trying to preserve care delivery in four clinics, home health, hospice, swing bed rehabilitation and extended care services, acute care, emergency care and full diagnostic services such as laboratory and imaging. The ability to rely on tax revenue is needed to make investments in staff & capital for expanded services and to promote long-term strategic healthcare initiatives. The District cannot jeopardize other services over ambulance services and will need to have the IGA's in place to become a provider.

Has MCHD considered using the 24/48-hour shift model instead of the 12-hour shift model? What would the impact be?

The District fully researched all shift options prior to the conversion to an all paid staff model. The 12-hour shifts that we are proposing are the recommended staffing model by The Paramedic Foundation in that it's safer for EMS personnel and patients, sleeping quarters are not needed which the district does not have, and the opportunity for recruitment is greater because staff can travel in from outside areas to work the 12-hour shift and return home, promoting a better work-life balance. The District experienced firsthand the benefit of the 12-hour shift model.

Is the roster provided an accurate listing of personnel? It appears that this was the roster from before MCHD ceased ambulance operation. Will all these individuals be available if MCHD is a successful applicant?

The listing of personnel is accurate as many staff stayed on with the district and just changed from full-time status to occasional part-time status and are available to fill shifts currently or to take inter-facility transfers and respond as QRT's, which the district compensates them for. They will be available but may change their status if they return to full-time positions. Fourteen employees have confirmed they would return to full-time positions if the district provides services again.

MCHD has experienced intense levels of turnover in the past few years in staff and the board. Please explain how MCHD can assure stability for providing ambulance services.

The District's rolling three month turnover rate as of April 30th was 5.5%. This is lower than the Oregon turnover rates and much lower than national health care sector rates. The Board turnover is mostly related to the expiration of position terms and no one has left the board for reasons other than personal circumstances. The board members are elected positions and serve without compensation.

The District has proven their stability in the last 30 years of providing ambulance service successfully and it's not any different today. The staff are dedicated to rapid response times, delivery of quality care and serving their communities. The biggest risk of instability for the district is not ambulance staff turnover, its lack of stable funding with increasing expenses. Its the risk of losing tax revenues, federal and state cost-based reimbursement programs, and loss of patients to more modern care delivery systems & competitors. The instability is in the rising cost of implementing regulatory staffing mandates, soaring costs of technology and supplies. The District has implemented many cost saving measures over the past year and have prepared a balanced budget for FY 2024-2025.

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Questions?

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