CLARK COUNTY EMS DISTRICT #2
STAFF REPORT

DEPARTMENT: Clark Regional Emergency Services Agency

DATE: April 29, 2014

REQUEST: Approve the 2013 EMS District #2 Annual Report

BACKGROUND: Based on the EMS Interlocal Cooperation Agreement, EMS District #2 (District) shall present to participating jurisdictions an annual report addressing the ambulance contractor's: economic performance (accounting of user fees and subsidies, if any); 2) clinical capability; and 3) response time reliability.

The accounting of user-fees charged is based on the ambulance contract's Annual Financial Report that is conducted by an independent auditing firm. The evaluation of the systems clinical and response time performance is based on ambulance contract's monthly operations and response time reports.

COMMUNITY OUTREACH: On March 18, 2014, the EMS Administrative Board recommended the District approve the 2013 Clark County EMS District #2 Annual Report. The EMS Administrative Board is composed of citizen volunteers with expertise in health care, business, finance and law, who are appointed by the Board of County Commissioners to oversee the administration of the ambulance contract.

BUDGET AND POLICY IMPLICATIONS
[None]

FISCAL IMPACTS

☐ **Yes (see attached form)** ☑ **No**

ACTION REQUESTED: Approve the 2013 Clark County EMS District #2 Annual Report.

Doug Smith-Lee
EMS Manager

Approved: Tom Mielke
CLARK COUNTY EMS DISTRICT #2
March 13, 2014

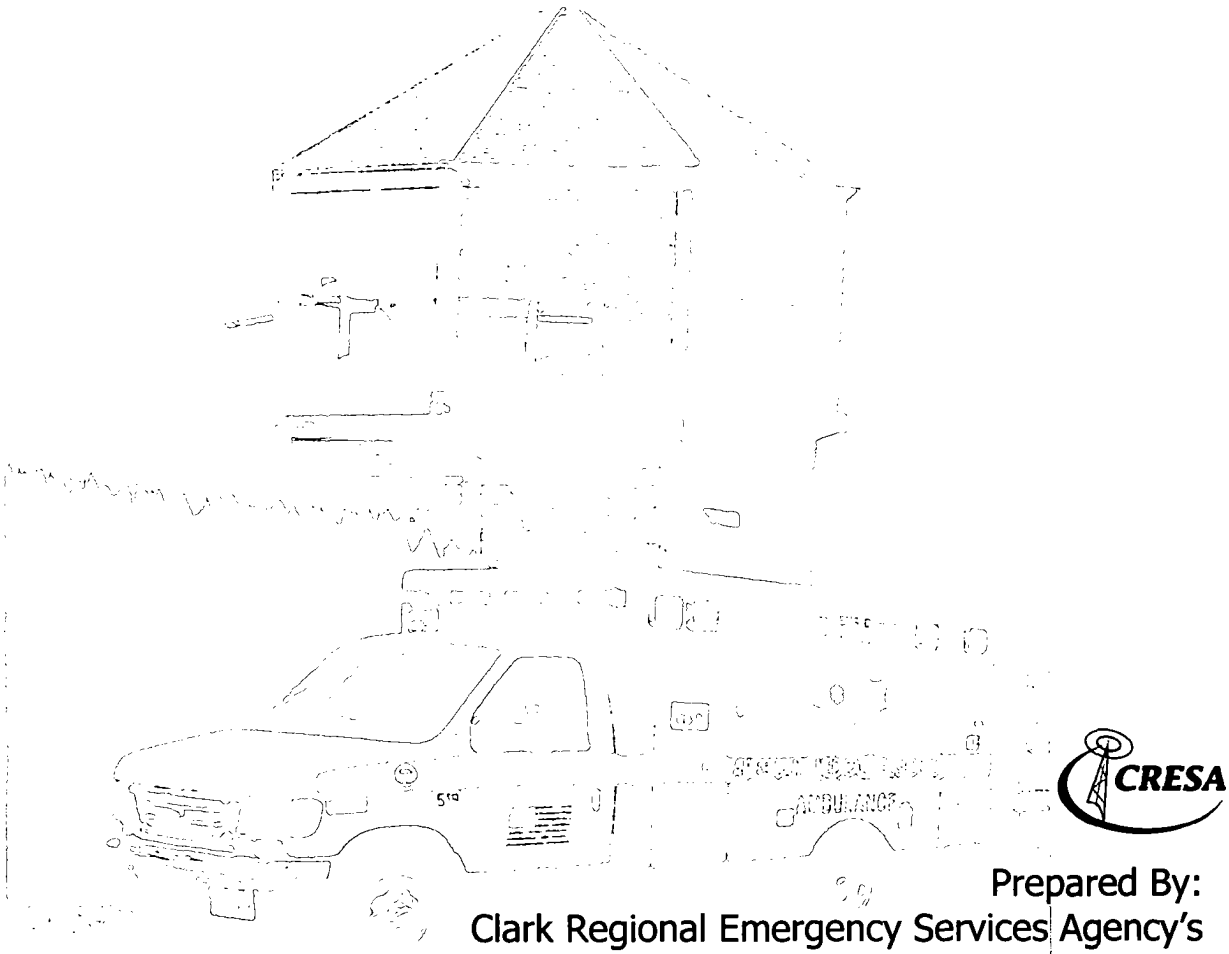
Attachments: 2013 Annual Report Staff Presentation
2013 Annual Report

2013 Annual Report

Serving Clark County and the Cities of Battleground, LaCenter, Ridgefield and Vancouver

EMS District #2

Performance Based EMS: *Patient Focused – Value Demonstrated – Outcome Driven*



CRESA

Prepared By:
Clark Regional Emergency Services Agency's
EMS Program

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List of Exhibits:

A - Contract Response Time Reports. Shows monthly and cumulative year-to-date response time compliance.

B – Ambulance Response Time Zones for Contracted Service Area

C - Annual Financial Report. Independently reviewed report documenting the gross revenues and total number of patients transported.

EMS DISTRICT #2 MISSION STATEMENT

PROVIDE QUALITY OUT-OF-HOSPITAL CARE THAT IS PATIENT FOCUED, VALUE DEMONSTRATED AND OUTCOME DRIVEN

FROM OUR CHAIR AND MEDICAL PROGRAM DIRECTOR

Mike Plymale, Chair EMS Administrative Board

Dr. Lynn Wittwer, Medical Program Director

This marks the 21st year of EMS District #2's partnership with Clark County and the Cities of Battle Ground, LaCenter, Ridgefield and Vancouver. Since 1992, this collaboration has helped create one of the leading high performance EMS systems in the United States.

The EMS Administrative Board is the District's advisory body composed of citizen volunteers with expertise in business, finance, law, health care administration and insurance. This Board was created to oversee the design and administer the District's paramedic ambulance service contract that is consistent with best practices in the industry.

The Clark County Medical Program Director is appointed by State Department of Health and is under contract with the county for oversight of training, certification and patient care provided by all EMS personnel, including the District's paramedics and Emergency Medical Technicians (EMTs) and Emergency Medical Dispatchers (EMDs)

Remarkable improvements to ambulance service performance and the EMS system are evident throughout these past 21 years. Some of the key achievements as a result of District's performance based ambulance contract include:

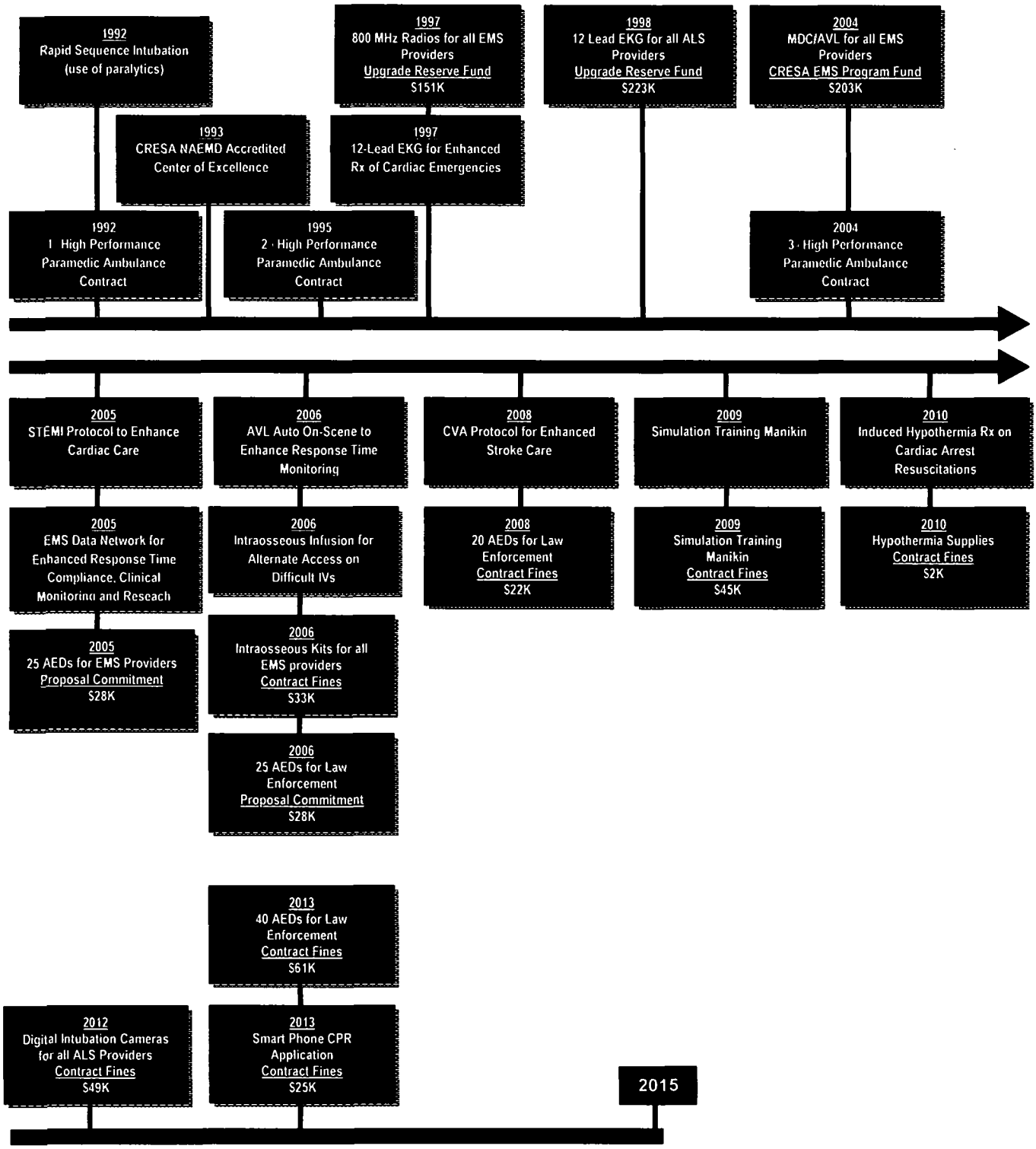
- ✓ CRESA becoming the 4th Accredited Center of Excellence in the world for Emergency Medical Dispatch by the International Academy of Dispatch, and maintaining that status since 1994.
- ✓ Some of the best response times and reliability in the nation.
- ✓ Leading innovations in patient care and high cardiac arrest survival rates.
- ✓ The ambulance contractor, American Medical Response (AMR) making significant contributions to the community in over $3 million in fire first responder enhancements.
- ✓ Ambulance rates (public and private) 14% below the average in the metro area.

Vancouver decided to withdraw from the District at the end of 2014. This will result in the District on longer administering the ambulance contact for the participating jurisdictions starting in 2015. With this in mind, it is imperative that we continue to focus on innovative ways to improve efficiency and effectiveness despite the myriad of challenges that come with this change.

On behalf of everyone in the District, we have been fortunate to have had such outstanding performance, community partnerships and citizens who've entrusted us to deliver quality service for the past 21 years.

A HISTORY OF PROGRESS

Since implementation of the high performance paramedic ambulance contract in 1992, the District has implemented a number of innovations along with funding to assist all EMS providers in the community. The following timeline illustrates significant milestones and contributions in the delivery of EMS over the past 21 years:



DESIGNED FOR HIGH PERFORMANCE

The historic performance of this ambulance contact has not been based on chance, or luck. Rather, the key to the District's high performance over the past 21 years is due to the 32 *EMS System Design Policy Decisions* that are approved by Clark County and the Cities of Battle Ground, Ridgefield, LaCenter and Vancouver. These Policy Decisions are designed to meet the *Five Hallmarks of High Performance Ambulance Service*[1] that include:

1. **Holds the service accountable** to clinical excellence, response time reliability, economic efficiency and customer satisfaction;
2. Has **an independent oversight entity** that provides ongoing performance monitoring and independent outside audits;
3. **Accounts for all service costs** for true benchmarking and transparency;
4. Establishes **system features that create economic efficiency** and maximize economies of scale[2]; and
5. Ensures long-term high performance through **benchmarking and/or competitive procurement.**

The 2013 Annual Report will show how these EMS System Design Policy Decisions have continued the high performance ambulance contract with AMR for the October 2012 – September 2013 contract year. Based on the EMS Interlocal Agreement, the District and Medical Program Director are to provide Clark County and the Cities of Battleground, LaCenter, Ridgefield and Vancouver an annual report on:

1. The ambulance contactor's response time and clinical performance;
2. The ambulance contractor's economic performance; and
3. Any problems and improvements encountered; as well as any anticipated problems and improvements for the next contract year.

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1 Krumperman K, et.al., *EMS Structured for Quality: Best Practices in Designing, Managing and Contracting for Emergency Ambulance Service*, American Ambulance Association; 2008. p 11, 12.

2 System features that create economic efficiency: Exclusive market rights, All-ALS and large multi-jurisdictional contract services area.

RESPONSE TIME RELIABILTY

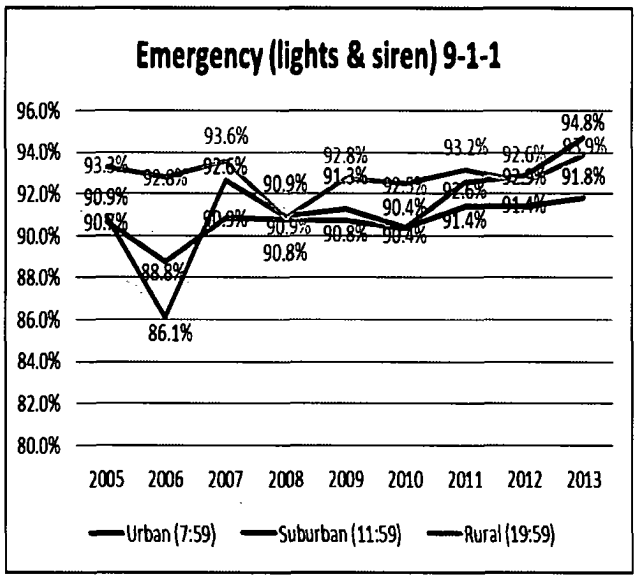
The District's response time standards are some of the best in the nation and are cited as a best practice and used at the example in the *National Association of EMS Physicians Medical Director's Handbook*. Under the current contract that began in 2004, the ambulance contractor has provided high compliance to these standards.

Goal: 90%

2013 Performance: Urban **94.8%**; Suburban **91.8%**; Rural **94.8%** Goal Outcome: **Met**

Standards:

	Urban	Suburban	Rural
1st ALS	7:59	11:59	19:59
Ambulance	9:59	13:59	21:50

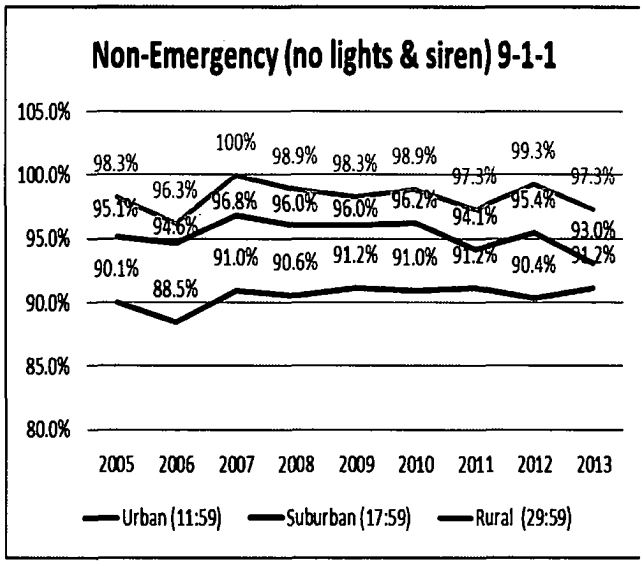


Goal: 90%

2013 Performance: Urban **91.2%**; Suburban **93.0%**; Rural **97.3%** Goal Outcome: **Met**

Standards:

	Urban	Suburban	Rural
1st ALS	11:59	17:59	29:59
Ambulance	13:59	19:59	31:50



CLINICAL EXCELLENCE

Advanced Medical Priority Dispatch System (AMPDS)

AMPDS provides a safe and effective method to: determine the severity of the patient; assist in determining the correct EMS response to send; and provide life-saving instructions over the phone. To ensure each patient receives the correct help when calling 9-1-1, CRESA maintains accreditation by the International Academy of Emergency Dispatch. This accreditation in critically important not only to the patient receiving the care, but also EMS providers as they look at ways to efficiently send appropriate response.

Goal: 90%

2013 Performance: **99.9%** Goal Outcome: **Met**

	Case Entry	Key Questions	PAIs	PDIs	Chief Complaint	Code	Score
IAED Standard	95	90	95	90	95	90	90
CRESA	97.72	98.11	99.11	97.24	98.51	99.80	99.89

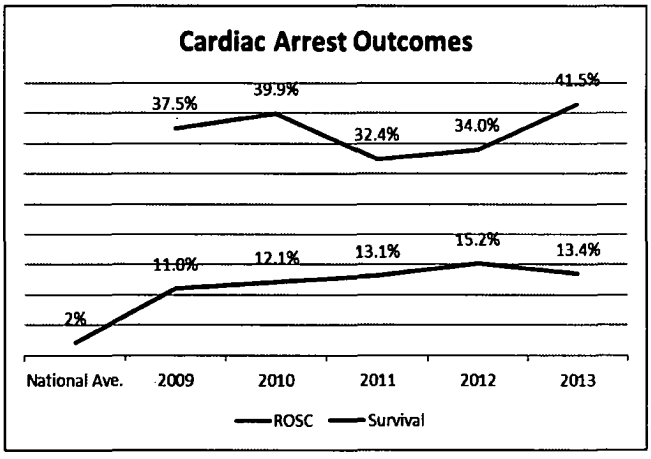
Sudden Cardiac Arrest

Sudden Cardiac Arrest (SCA) calls are among the most challenging EMS personnel face. That's why the Medical Program Director and EMS providers have implemented a number of enhancements over the years to improve a patient's chance of surviving. All of the fire first responders and AMR's crews are trained and equipped to provide an evidence based approach in caring for these critical patients. As a result, the District has some of the highest SCA survival rates in the nation.

Goal: > 9%

2013 Performance: **13.4%** Goal Outcome: **Met**

Return of Spontaneous Circulation (ROSC) is defined as the patient's pulse and heart rhythm being restored along with significant respiratory effort at time of arrival at the hospital. Survival is defined as the patient being discharged from the hospital with preserved neurologic function. Of note is the survival rate of **41%** for patients with a shockable rhythm (Ventricular Fibrillation & Ventricular Tachycardia).



Cardiac Triage Composite for Percutaneous Coronary Intervention (PCI)

Another key measure in cardiac care is making sure the time to cardiac reperfusion is kept at a minimum for certain patients suffering from blocked coronary arteries. Paramedics work closely with area hospitals by activating cardiac teams at the hosptial so the cath lab is open and the interventional cardiaologist is ready for the patient with a miniumum delay in the hospital emergency department.

Goal: 90 mins.

2013 Performance: ## **mins.** Goal Outcome: **(information is pending)**

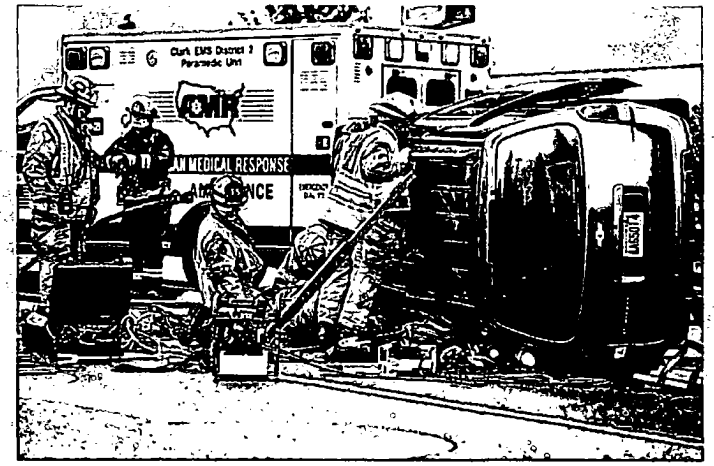
	National Standard	Field STEMI (+) EKG in ED	Field STEMI (+) EKG in ED
Hospital Arrival to Perfusion	90 Mins.		

Trauma Scene Times

It is crucial that severe trauma patients receive rapid surgical intervention at a trauma hospital. Fire first responders and AMR's crews work together to rapidly access, package and treat trauma patients while rapidly transporting them to hospitals specifically designed to treat major multisstem trauma. This type of intervention provides the greatest chance of survial for the patient.

Goal: 10 mins.

2013 Performance: **6 mins.** Goal Outcome: **Met**



ECONOMIC EFFICIENY

Ambulance Rates

The ambulance contractor is funded 100% by user fees. It receives $0 in subsidy, which is a significant accomplishment considering AMR collected 41% of the amount it billed to insurance plans and private payers. Despite the challenges of reduced federal funding from Medicare and Medicaid, and a growing uninsured and underinsured population, the District has been able to keep the average annual rate of inflation at 3.2% compared to overall healthcare inflation rates at 6.5%[3]. In fact, AMR's 2013 ALS base rate was 14% below the average charged from both private and public ambulance services in the 5 surrounding counties.

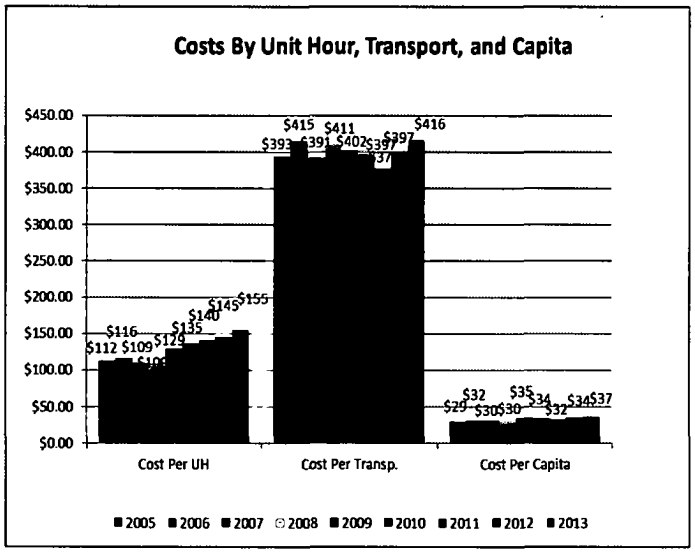
The District regulates ambulance rates through an Average Patient Charge (APC), Maximum Patient Charge (MPC) and Maximum Mileage Charge (MMC). The APC is based on the Unit Hour Cost (cost of staffing and equipping a paramedic ambulance per hour) for services offering similar service levels and market conditions. The MPC protects against extraordinary cost shifting caused by elective discounts that are not due to higher collections, or higher non-emergency transport ratios.

Goal:		2013 Performance:	
APC	$844.97	APC	**$843.12**
MPC	$1,136.80	MPC	**$1,055.96**
MMC	$12.25	MMC	**$12.25**

Goal Outcomes: **Met**

Ambulance Costs

This is a performance based and not level of effort contact. As a result, there are no cost standards established. AMR determines what factors of production it needs to use to meet the performance obligations. Even though there are no cost standards, the District monitors AMR's costs to track the financial stability of the ambulance contact.



While the cost of operations continues to rise at 4.3% annually (see "Cost per UH", AMR has kept the "Cost per Transport" relatively flat at .7% annually due to the system design features that maximize economic efficiency including: an exclusive 9-1-1 and non-emergency contact; an all-ALS ambulance system; and a large multi-jurisdictional contract services area.

[3] Estimated healthcare inflation rate for 2014. Prior to 2005 it was at 8.0%. Health Research Institute of PricewaterhouseCoopers, June 2013.

COMMUNITY OUTREACH & SUPPORT

EMS District #2's ambulance contract and American Medical Response have made significant contributions to the community's health and safety; as well as enhancing the first responders ability to provide care when help is needed. Over the past 21 years, the District and American Medical Response have contributed over 3 million dollars to improve our EMS response (See "A History of Progress" for details). Some of the key contributions include:

- ✓ $151,000 to purchase 800 MHz radios for all EMS providers when the county upgrades from UHF radios in 1997 (clinical upgrade reserve fund);
- ✓ $223,000 to purchase the 12-lead EKGs for all first response paramedic services when initially required in 1998 (clinical upgrade reserve fund);
- ✓ $203,000 to purchase mobile computing devices in 2004 for EMS providers when the county began providing 9-1-1 data to emergency responders (CRESA EMS Program Fund Balance); and
- ✓ Over $130,000 to purchase AEDs for fire and law enforcement units (Contractor proposal commitments and response time fines)

In addition to financial support, American Medical Response participates in public safety fairs, child safety seat inspections and community CPR training.

A summary of Community Outreach and Support efforts in 2013 are as follows:

Goal:	2013 Performance:
Public CPR Training –	Public CPR Training –
✓ 5 courses per yr.	✓ 3 courses per yr. and 1,153 persons
Public Access of Defibrillation –	Public Access of Defibrillation –
✓ 50 AEDs at beginning of 2004 contract.	✓ 110 AEDs at beginning of 2004 contract ✓ $25,000 to Purchase PulsePoint[4] in 2013
Child Safety Seat Inspections –	Child Safety Seat Inspections –
✓ 12 clinics per yr.	✓ 12 clinics per yr.
First Responder ALS Medical Supplies –	First Responder ALS Medical Supplies –
✓ Purchase or exchange	✓ Purchase or exchange at $32,494[5]. ✓ ALS First Response Agreements $117,476 ✓ ALS 1st Response Slowing Response Clock $114,000

Goal Outcomes: **Met**

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4 PulsePoint is a smart phone application that lets subscribers know the location of public cardiac arrests and locations of AEDs

5 Vancouver stopped requesting reimbursement for supplies May 2013

Vancouver Withdraws from the District

The current contract between EMS District #2 and American Medical Response is due to expire December 31, 2014. At that time City of Vancouver and Fire District #5 will implement their own contract for ambulance service.

Over the course of the last few months EMS District#2 and City of Vancouver staff have been working with EMS industry consultants to develop a single RFP that could meet the needs of the two separate contract areas. Recently the industry consultants have recommended that we consider changing that approach and develop a single system that the City of Vancouver would oversee and administrate. In addition, they have suggested that EMS District #2 consider contracting for ambulance service through an Interlocal agreement with the City.

While the District understood and recognized the merits of the Consultant's recommendations, District staff worked diligently with the fire chiefs within the District to explore and vet the pros and cons of contracting separately, or having Vancouver administer the contract on behalf of the District. It's become clear that based on the current revenues that come from the District it would be unable to contract for ambulance service apart from Vancouver.

At the time of this report, staff has drafted a Letter of Intent for the District Board to advise Vancouver of its intent to have the City contract for ambulance service on behalf of the District and the Cities of Battle Ground, Ridgefield, LaCenter and Woodland.

EMS Community Healthcare Program

In the last 20 years, EMS providers have seen a significant increase in the number of individuals who utilize 9-1-1 services for routine and episodic healthcare. Transferring these patients from the emergency system into a structured healthcare plan is challenging.

Emergency Medical Service (EMS) organizations (emergency medical call-takers, fire first responders and ambulance service providers) throughout the Portland-Vancouver metro area strive to provide state of-the-art services to the citizens we serve in an efficient manner. Despite these efforts, we have identified three distinct gaps in the patient care continuum:

- ✓ Lack of access to appropriate care systems;
- ✓ A need for a wider variety of response and destination options; and
- ✓ A need for additional methods to deal with frequent users of emergency medical resources.

An additional challenge for EMS in effectively responding to these gaps is ambulance insurance reimbursement requires transport to the hospital Emergency Department (ED) which perpetuates a costly healthcare system.

EMS providers in the Portland-Vancouver area are forming a coalition so that multiple agencies and organizations can come together to better coordinate and maximize response in addressing the healthcare challenges our community is facing. The proposed Community Healthcare Programs outlined below encompass distinct strategies designed to address these challenges and

are based on the specific needs of the community and reduce healthcare costs. A Community Healthcare Summit with local health plans, insurance carriers and hospitals is planned in April 2014 to explore how partnerships can be formed to offer the kinds of programs offered below.

911 - Nurse Triage Program (Proposed Pilot in Clark County)

A trained nurse dispatcher manages low-acuity 9-1-1 calls and provides secondary triage designed to identify the most appropriate resource and destination. This simple, yet effective system provides an alternative option to emergency response. A substantial number of 9-1-1 calls do not require an EMS response, and many patients do not require a visit to a hospital ED. Some callers simply need help connecting with appropriate healthcare resources. The nurse dispatcher can field these calls to provide and find the appropriate services. Such services may include: scheduling appointments with a primary care provider, making arrangements for transportation, or dispatching a community paramedic unit to respond for further assessment or hands-on help. The nurse dispatcher may help direct the patient to an in-network provider for continuity of care, or help find available alternate care resources for patients who are not assigned a primary care provider.

With the decline of fee-for-service based medicine and the transition to accountable care organizations, it's more important than ever to ensure patients are receiving the services most appropriate resulting in the best outcomes. A 9-1-1 nurse triage program alleviates some of the burden on the healthcare system by better allocating resources for non-emergent situations.

EMS Low Acuity Triage (Proposed in All Counties with Current Pilots in Clackamas and Multnomah Counties)

Approximately 22% of EMS calls to 9-1-1 are for low acuity complaints that usually don't require a rapid emergency response,[6] the EMS resources typically sent on 9-1-1 medical calls, or transport to an emergency department. Some low acuity patients may be appropriate for alternate care options[7] such as: ambulance transport to urgent care; clinic appointment; physician consult; and home care.

During the assessment for alternate care services the paramedic can use the nurse dispatcher to help the patient access services for appropriate care.

6 Based on Clark County EMS District #2's 2012 patient acuity data and corresponding response priorities.

7 Based on OHSU's 2012 CMS Innovation Grant application estimating 6.3% of total EMS responses.

Mobile Integrated Healthcare Practice (Proposed in All Counties)

Fire departments and ambulance services provide non-emergent care in daily operations all across the country. When a patient dials 9-1-1 and receives an emergency response for a low acuity or non-urgent situation, the level of care provided is not only unnecessary but adds significant costs to the healthcare system.

An alternative response is the Mobile Integrated Healthcare Practice Program that utilizes more efficient vehicles and fewer EMS personnel, for example Community Paramedics, specially trained for pre-scheduled assessment/prevention (e.g., BP and BGL monitoring, prescription drug compliance, fall risk-assessment, 12-lead ECG tracing, specimen collection, immunizations/vaccinations and social interaction) and intervention services (e.g., breathing treatments, medication administration and IV monitoring). Eligible patients for the Mobile Integrated Healthcare Practice would be pre-identified as either frequent users of 9-1-1 services, or high likelihood to be re-admitted to the hospital.

CONCLUSION

The participating jurisdictions within EMS District #2 have established a carefully structured EMS system and ambulance contract to ensure the standards of clinical excellence, response time reliability, and economic efficiency are met. This system was designed so that it can be responsive to changes in economic conditions and advancements in clinical care. As a result, the EMS system has a proven track record to be self-correcting, providing stability, and meeting the performance standards established.

Through periodic managed competition for the right to provide ambulance service, along with independent performance based monitoring, the community is assured that service is delivered by an ambulance contractor who meets 134 different performance obligations. Financial penalties and default takeover provisions are in place should the provider fail to meet these standards. The design of the system and the standards established are developed by medical and business authorities who have the necessary expertise to be informed EMS consumer advocates.

Big challenges still lie ahead with Vancouver's withdrawal from the District, the slow recovery from the economic recession and health care funding challenges. Our EMS system needs to be looked at as a whole, especially as traditional sources of public and private funds continue to shrink. The EMS community and elected officials need to critically look at these challenges and work together through proven and sound EMS system design to solve them.

EXHIBIT A

American Medical Response
Priority Hot YTD Response Time Compliance

AMR w/FRA

	Urban <= 7m 59s 1st ALS*				Suburban <= 11m 59s 1st ALS*				Rural <= 19m 59s 1st ALS*			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	1455	1336	91.82%	91.82%	213	193	90.61%	90.61%	35	33	94.29%	94.29%
2012-11	1492	1420	95.17%	93.52%	185	169	91.35%	90.95%	27	25	92.59%	93.55%
2012-12	1479	1411	95.40%	94.15%	202	181	89.60%	90.50%	32	28	87.50%	91.49%
2013-1	1544	1468	95.08%	94.39%	249	225	90.36%	90.46%	44	39	88.64%	90.58%
2013-2	1344	1303	96.95%	94.86%	182	169	92.86%	90.88%	35	33	94.29%	91.33%
2013-3	1502	1461	97.27%	95.27%	219	204	93.15%	91.28%	46	45	97.83%	92.69%
2013-4	1380	1314	95.22%	95.26%	179	171	95.53%	91.81%	28	28	100.00%	93.52%
2013-5	1504	1463	97.27%	95.52%	180	171	95.00%	92.17%	32	31	96.88%	93.91%
2013-6	1522	1451	95.34%	95.50%	195	176	90.26%	91.96%	48	45	93.75%	93.88%
2013-7	1534	1486	96.87%	95.64%	199	188	94.47%	92.21%	48	45	93.75%	93.87%
2013-8	1524	1465	96.13%	95.69%	183	166	90.71%	92.09%	49	46	93.88%	93.87%
2013-9	1469	1402	95.44%	95.67%	194	174	89.69%	91.89%	43	41	95.35%	94.00%

AMR wo/FRA

	Urban <= 9m 59s AMR Only				Suburban <= 13m 59s AMR Only				Rural <= 21m 59s AMR Only			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	1455	1319	90.65%	90.65%	213	199	93.43%	93.43%	35	33	94.29%	94.29%
2012-11	1492	1383	92.69%	91.69%	185	170	91.89%	92.71%	27	25	92.59%	93.55%
2012-12	1479	1362	92.09%	91.82%	202	181	89.60%	91.67%	32	29	90.63%	92.55%
2013-1	1544	1426	92.36%	91.96%	249	219	87.95%	90.58%	44	41	93.18%	92.75%
2013-2	1344	1282	95.39%	92.59%	182	173	95.05%	91.37%	35	32	91.43%	92.49%
2013-3	1502	1438	95.74%	93.13%	219	202	92.24%	91.52%	46	43	93.48%	92.69%
2013-4	1380	1313	95.14%	93.40%	179	171	95.53%	92.02%	28	27	96.43%	93.12%
2013-5	1504	1430	95.08%	93.62%	180	168	93.33%	92.17%	32	31	96.88%	93.55%
2013-6	1522	1441	94.68%	93.74%	195	177	90.77%	92.02%	48	46	95.83%	93.88%
2013-7	1534	1452	94.65%	93.83%	199	187	93.97%	92.21%	48	44	91.67%	93.60%
2013-8	1524	1441	94.55%	93.90%	183	164	89.62%	91.99%	49	47	95.92%	93.87%
2013-9	1469	1371	93.33%	93.85%	194	177	91.24%	91.93%	43	40	93.02%	93.79%

Doug Smith-Lee, EMS Manager

Anna Pendergrass, Director

*VFD (Effective February 28th, 2012); FD3, VD6 and CCFR (Effective January 11th, 2012)

EXHIBIT A

American Medical Response
Priority Cold YTD Response Time Compliance

AMR w/FRA

	Urban <= 11m 59s 1st ALS*				Suburban <= 17m 59s 1st ALS*				Rural <= 29m 59s 1st ALS*			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	757	689	91.02%	91.02%	111	105	94.59%	94.59%	11	11	100.00%	100.00%
2012-11	748	682	91.18%	91.10%	81	78	96.30%	95.31%	9	9	100.00%	100.00%
2012-12	776	701	90.34%	90.84%	114	101	88.60%	92.81%	9	9	100.00%	100.00%
2013-1	736	670	91.03%	90.88%	96	87	90.63%	92.29%	16	15	93.75%	97.78%
2013-2	718	664	92.48%	91.19%	95	91	95.79%	92.96%	7	7	100.00%	98.08%
2013-3	759	702	92.49%	91.41%	107	103	96.26%	93.54%	24	24	100.00%	98.68%
2013-4	802	746	93.02%	91.65%	92	86	93.48%	93.53%	14	13	92.86%	97.78%
2013-5	792	732	92.42%	91.75%	69	67	97.10%	93.86%	18	15	83.33%	95.37%
2013-6	803	716	89.17%	91.45%	87	82	94.25%	93.90%	13	13	100.00%	95.87%
2013-7	852	771	90.49%	91.35%	113	104	92.04%	93.68%	25	25	100.00%	96.58%
2013-8	849	752	88.57%	91.07%	114	105	92.11%	93.51%	15	15	100.00%	96.89%
2013-9	866	780	90.07%	90.98%	98	87	88.78%	93.12%	18	18	100.00%	97.21%

AMR wo/FRA

	Urban <= 13m 59s AMR Only				Suburban <= 19m 59s AMR Only				Rural <= 31m 59s AMR Only			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	757	702	92.73%	92.73%	111	105	94.59%	94.59%	11	11	100.00%	100.00%
2012-11	748	687	91.84%	92.29%	81	76	93.83%	94.27%	9	9	100.00%	100.00%
2012-12	776	706	90.98%	91.85%	114	99	86.84%	91.50%	9	9	100.00%	100.00%
2013-1	736	672	91.30%	91.71%	96	90	93.75%	92.04%	16	15	93.75%	97.78%
2013-2	718	666	92.76%	91.91%	95	92	96.84%	92.96%	7	7	100.00%	98.08%
2013-3	759	698	91.96%	91.92%	107	98	91.59%	92.72%	24	24	100.00%	98.68%
2013-4	802	759	94.64%	92.33%	92	86	93.48%	92.82%	14	14	100.00%	98.89%
2013-5	792	745	94.07%	92.56%	69	67	97.10%	93.20%	18	16	88.89%	97.22%
2013-6	803	738	91.91%	92.48%	87	82	94.25%	93.31%	13	13	100.00%	97.52%
2013-7	852	799	93.78%	92.63%	113	105	92.92%	93.26%	25	25	100.00%	97.95%
2013-8	849	781	91.99%	92.56%	114	106	92.98%	93.23%	15	14	93.33%	97.52%
2013-9	866	802	92.61%	92.57%	98	88	89.80%	92.95%	18	18	100.00%	97.77%

Doug Smith-Lee, EMS Manager

Anna Pendergrass, Director

*VFD (Effective February 28th, 2012); FD3, VD6 and CCFR (Effective January 11th, 2012)

EXHIBIT A

American Medical Response
Priority Scheduled YTD Response Time Compliance

AMR wo/FRA

	Urban <= 10m				Suburban <= 10m				Rural <= 15m			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	99	93	93.94%	93.94%	8	8	100.00%	100.00%	1	1	100.00%	100.00%
2012-11	80	68	85.00%	89.94%	4	4	100.00%	100.00%			0.00%	100.00%
2012-12	116	107	92.24%	90.85%	5	5	100.00%	100.00%			0.00%	100.00%
2013-1	127	113	88.98%	90.28%	9	8	88.89%	96.15%			0.00%	100.00%
2013-2	106	103	97.17%	91.67%	5	5	100.00%	96.77%			0.00%	100.00%
2013-3	117	116	99.15%	93.02%	3	3	100.00%	97.06%			0.00%	100.00%
2013-4	110	105	95.45%	93.38%	6	6	100.00%	97.50%			0.00%	100.00%
2013-5	169	166	98.22%	94.26%	13	13	100.00%	98.11%			0.00%	100.00%
2013-6	201	192	95.52%	94.49%	7	7	100.00%	98.33%	1	1	100.00%	100.00%
2013-7	107	104	97.20%	94.72%	9	8	88.89%	97.10%			0.00%	100.00%
2013-8	98	95	96.94%	94.89%	5	5	100.00%	97.30%			0.00%	100.00%
2013-9	114	105	92.11%	94.67%	5	4	80.00%	96.20%			0.00%	100.00%

Priority Un-Scheduled YTD Response Time Compliance

AMR wo/FRA

	Urban <= 60m				Suburban <= 60m				Rural <= 60m			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	503	476	94.63%	94.66%	8	8	100.00%	96.55%	1	1	100.00%	100.00%
2012-11	478	450	94.14%	94.56%	6	5	83.33%	95.70%	3	3	100.00%	100.00%
2012-12	542	526	97.05%	95.01%	10	10	100.00%	96.12%			0.00%	100.00%
2013-1	576	564	97.92%	95.48%	9	9	100.00%	96.43%	1	1	100.00%	100.00%
2013-2	553	544	98.37%	95.87%	3	3	100.00%	96.52%	1	1	100.00%	100.00%
2013-3	573	557	97.21%	96.04%	11	11	100.00%	96.83%	1	1	100.00%	100.00%
2013-4	538	523	97.21%	96.16%	7	7	100.00%	96.99%			0.00%	100.00%
2013-5	583	575	98.63%	96.41%	7	7	100.00%	97.14%	2	2	100.00%	100.00%
2013-6	591	582	98.48%	96.60%	6	6	100.00%	97.26%			0.00%	100.00%
2013-7	576	565	98.09%	96.72%	12	12	100.00%	97.47%	1	1	100.00%	100.00%
2013-8	581	565	97.25%	96.76%	10	9	90.00%	97.02%	1	1	100.00%	100.00%
2013-9	534	512	97.71%	96.82%	5	5	100.00%	97.11%			0.00%	100.00%

Doug Smith-Lee, EMS Manager

Anna Pendergrass, Director

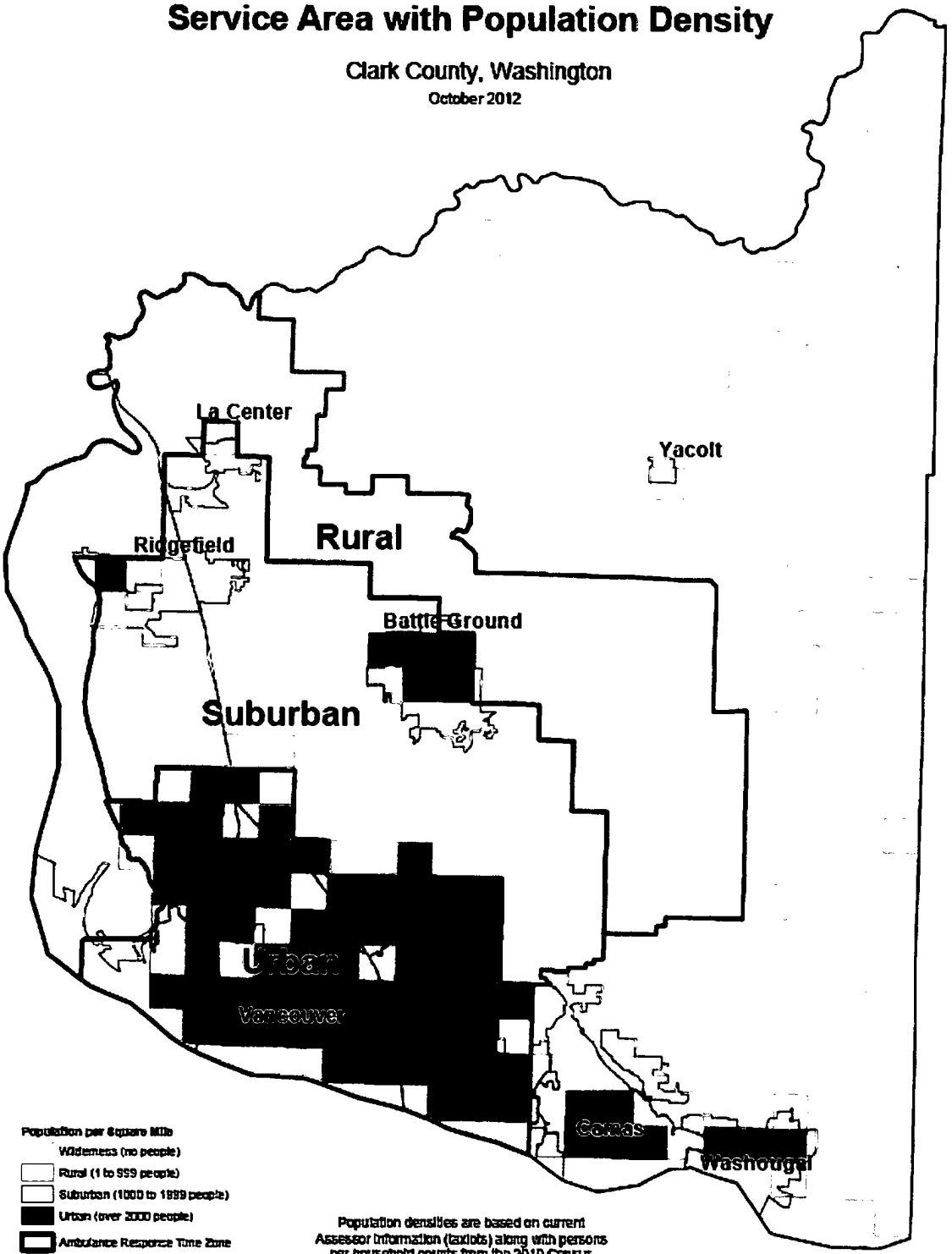
*VFD (Effective February 28th, 2012); FD3, VD6 and CCFR (Effective January 11th, 2012)

EXHIBIT B

Ambulance Response Time Zones for Contracted Service Area with Population Density

Clark County, Washington

October 2012



Population densities are based on current Assessor information (taxlots) along with persons per household counts from the 2010 Census.

EXHIBIT C

Van Beek Co., llc
CERTIFIED PUBLIC ACCOUNTANTS

Thinking outside the box since 1974

INDEPENDENT ACCOUNTANT'S REVIEW REPORT

American Medical Response Northwest, Inc.
Portland, Oregon

We have reviewed management's assertion that the accompanying Schedule of Clark County Average Patient Charges of American Medical Response Northwest, Inc. (the "Company," a wholly-owned subsidiary of American Medical Response, Inc.) for the year ended September 30, 2013 is presented in accordance with the provisions of the Master Contract for Paramedic Ambulance Services dated October 1, 2004, including Addendums 1 through 8. Management of American Medical Response Northwest, Inc. is responsible for the assertion. The Contract gives the Company exclusive rights to all "911" and "routine transfer" ambulance services originating in Clark County, Washington. As part of the Contract, the Company must meet or exceed certain performance standards set forth in the Contract. However, our review was not conducted to ascertain whether or not the Company met any of these performance standards.

Our review was conducted in accordance with *Statements on Standards for Attestation Engagements* established by the American Institute of Certified Public Accountants. A review is substantially less in scope than an examination, the objective of which is the expression of an opinion on management's assertion. Accordingly, we do not express such an opinion.

Based on our review, nothing came to our attention that caused us to believe that management's assertion that the Schedule of Clark County Average Patient Charges for the year ended September 30, 2013 is not presented, in all material respects, in conformity with the provisions of the Master Contract for Paramedic Ambulance Services dated October 1, 2004, including Addendums 1 through 8.

This report is intended solely for the information and use of the Board of Directors of Clark County Emergency Medical Services District #2 and the management of American Medical Response Northwest, Inc., and is not intended to be and should not be used by anyone other than these specified parties. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

Van Beek & Co

Tigard, Oregon
January 20, 2014

16045 SW Upper Boones Ferry Rd., Tigard, Oregon 97224-7733
503-639-4700 • FAX 503-639-4747

EXHIBIT A

American Medical Response
Priority Hot YTD Response Time Compliance

AMR w/FRA

	Urban <= 7m 59s 1st ALS*				Suburban <= 11m 59s 1st ALS*				Rural <= 19m 59s 1st ALS*			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	1455	1336	91.82%	91.82%	213	193	90.61%	90.61%	35	33	94.29%	94.29%
2012-11	1492	1420	95.17%	93.52%	185	169	91.35%	90.95%	27	25	92.59%	93.55%
2012-12	1479	1411	95.40%	94.15%	202	181	89.60%	90.50%	32	28	87.50%	91.49%
2013-1	1544	1468	95.08%	94.39%	249	225	90.36%	90.46%	44	39	88.64%	90.58%
2013-2	1344	1303	96.95%	94.86%	182	169	92.86%	90.88%	35	33	94.29%	91.33%
2013-3	1502	1461	97.27%	95.27%	219	204	93.15%	91.28%	46	45	97.83%	92.69%
2013-4	1380	1314	95.22%	95.26%	179	171	95.53%	91.81%	28	28	100.00%	93.52%
2013-5	1504	1463	97.27%	95.52%	180	171	95.00%	92.17%	32	31	96.88%	93.91%
2013-6	1522	1451	95.34%	95.50%	195	176	90.26%	91.96%	48	45	93.75%	93.88%
2013-7	1534	1486	96.87%	95.64%	199	188	94.47%	92.21%	48	45	93.75%	93.87%
2013-8	1524	1465	96.13%	95.69%	183	166	90.71%	92.09%	49	46	93.88%	93.87%
2013-9	1469	1402	95.44%	95.67%	194	174	89.69%	91.89%	43	41	95.35%	94.00%

AMR wo/FRA

	Urban <= 9m 59s AMR Only				Suburban <= 13m 59s AMR Only				Rural <= 21m 59s AMR Only			
	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %	Total Calls	Compliant Calls	Monthly %	YTD %
2012-10	1455	1319	90.65%	90.65%	213	199	93.43%	93.43%	35	33	94.29%	94.29%
2012-11	1492	1383	92.69%	91.69%	185	170	91.89%	92.71%	27	25	92.59%	93.55%
2012-12	1479	1362	92.09%	91.82%	202	181	89.60%	91.67%	32	29	90.63%	92.55%
2013-1	1544	1426	92.36%	91.96%	249	219	87.95%	90.58%	44	41	93.18%	92.75%
2013-2	1344	1282	95.39%	92.59%	182	173	95.05%	91.37%	35	32	91.43%	92.49%
2013-3	1502	1438	95.74%	93.13%	219	202	92.24%	91.52%	46	43	93.48%	92.69%
2013-4	1380	1313	95.14%	93.40%	179	171	95.53%	92.02%	28	27	96.43%	93.12%
2013-5	1504	1430	95.08%	93.62%	180	168	93.33%	92.17%	32	31	96.88%	93.55%
2013-6	1522	1441	94.68%	93.74%	195	177	90.77%	92.02%	48	46	95.83%	93.88%
2013-7	1534	1452	94.65%	93.83%	199	187	93.97%	92.21%	48	44	91.67%	93.60%
2013-8	1524	1441	94.55%	93.90%	183	164	89.62%	91.99%	49	47	95.92%	93.87%
2013-9	1469	1371	93.33%	93.85%	194	177	91.24%	91.93%	43	40	93.02%	93.79%

Doug Smith-Lee, EMS Manager

Anna Pendergrass, Director

*VFD (Effective February 28th, 2012); FD3, VD6 and CCFR (Effective January 11th, 2012)

EXHIBIT C

AMERICAN MEDICAL RESPONSE NORTHWEST, INC.
(a wholly-owned subsidiary of American Medical Response, Inc.)
SCHEDULE OF CLARK COUNTY AVERAGE PATIENT CHARGES
for the year ended September 30, 2013
(See Independent Accountant's Review Report)

All Service Levels:

Payor Group	Number of Patients Transported	Distribution	Amount Billed	Average Patient Charge (APC)	Maximum Patient Charge (MPC)
Private pay	4,339	13.0%	$ 3,928,028	$905.28	$1,055.96
Medicaid	5,579	16.8%	4,861,862	$871.46	$1,055.96
Medicare	13,851	41.7%	11,412,868	$823.97	$1,055.96
Kaiser	5,377	16.2%	4,390,954	$816.62	$1,055.96
Other HMO	533	1.6%	448,176	$840.86	$1,055.96
Contracts	375	1.1%	177,200	$472.53	$1,055.96
Private insurance	2,661	8.0%	2,321,291	$872.34	$1,055.96
Veterans Administration	535	1.6%	493,248	$921.96	$1,013.96
	33,250	100.0%	$28,033,627	$843.12	$1,055.96

The accompanying note is an integral part of this schedule.

EXHIBIT C

AMERICAN MEDICAL RESPONSE NORTHWEST, INC.
(a wholly-owned subsidiary of American Medical Response, Inc.)
NOTE TO SCHEDULE OF CLARK COUNTY AVERAGE PATIENT CHARGES
for the year ended September 30, 2013
(See Independent Accountant's Review Report)

1. **BACKGROUND AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES:**

Background:

American Medical Response Northwest, Inc. (the "Company") is a wholly-owned subsidiary of American Medical Response, Inc. and provides ambulance services in Clark County, Washington under a Master Contract for Paramedic Ambulance Services dated October 1, 2004, including Addendums 1 through 8 (the "Contract") with Clark County Emergency Medical Services District No. 2 ("Clark County"). Under the Contract, the Company's total Average Patient Charge ("APC"), including all base rate and add-on charges but excluding mileage and other charges (see below), shall not exceed $844.97. The Company's Maximum Patient Charge ("MPC"), including all base rate and add-on charges but excluding mileage and other charges (see below), shall not exceed $1,136.80.

Contract Negotiations:

The Contract, including extensions, was scheduled to expire September 30, 2014. In 2013, the City of Vancouver announced plans to withdraw from the contract upon expiration. In response, Clark County extended the contract through December 31, 2014 to allow time to develop a new joint Request for Proposal ("RFP"). The Company intends to respond to the RFP when it becomes available in 2014.

Summary of Significant Accounting Policies:

Basis of Presentation

The information in the accompanying Schedule of Clark County Average Patient Charges is presented in accordance with the Contract with Clark County.

Payor Groupings

The Company initially identifies the "payor group" based on the information available at the time of the transport. Subsequent to that time, additional information may become available that indicates the actual payor group is different from the initial categorization. For purposes of this report, the Company has not reclassified the payor group after its initial categorization.

Service Level Groupings

The Company identifies the "service level" based on the initial type of life support services that are provided during each transport. There are no service level reclassifications after the initial coding, except in the case of a billing error where a patient was billed for a higher level of service than was actually provided.

Revenue Exclusions from "APC" and "MPC" Calculation

Mileage charges, revenue from transports originating outside Clark County and other non-transport revenue totaling approximately $4.7 million for the year ended September 30, 2013 have been excluded from the accompanying APC calculation in accordance with the Contract.