City Council Budget Work Session Transcript – 02/01/2017

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>> Mayor Adler: We have a quorum here. First I want to begin, manager, thank you for setting up this process for us. As we have talked about before, there's been a desire I think among myself and colleagues as we go into the budget process to have a little better understanding and a little bit great detail on what's happening in the various departments. When we get into the budget process there's really not much time to do anything other than look at changes year to year. And if we're only looking at changes year to year we can understand those things very well, but there's a whole then 99% of the budget that the budget because it's not represented in the year to year change. And we recognize that over time councils change and priorities change in the city, and what was important to a council 10 or 15 years ago that created a program or a policy may or may not be the priority of the community today, but if we're only looking at changes year to year, that's not going to trick out those kinds of questions. So I greatly appreciate you being responsive to the council and setting up a different kind of look to the budget that might prompt different kinds of questions. And at the very least would lead us to -- individually to greater understanding. The way we've talked about this as a council is we've said these sessions are purely optional, which means people can either come or not come to these, depending

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on what they want to. And no one is obligated to come to these because I know there are some councilmembers that have realistically said that they're swamped with meetings, and yet we're setting more meetings. These are optional. They can look at them later if they wanted to or whatever, but some of us I think will be here for all of them. And then the last thing the context I would put out is that in the budget work that Ed presented to us a year ago in terms of the five-year forecast on where we would be with the cost we had set relative to where we would be on the monies that we would raise, we were getting upside down in that at least for the next two or three years. That's why it was a hard budget and probably going to be a hard budget this coming year as well. That becomes a part of our reality that we need to react to. Should the legislature October to put a cap or not let the citizens enable their -- by electing councilmembers, not letting us as the elected representatives not be able to make decisions, we obviously would add some uncertainty into a budget if we were putting into an election everything that we did. So I can see a lot of cities not wanting to be able to budget predictably, so not exceeding a cap and not creating an expectation with something that would be uncertain. If that happens then the inversion of those lines becomes exacerbated and even greater. So our ability to understand the budget is real important. In past years the two years that we've done this we've

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gotten the budget and then councilmembers have then gone out mining to try and find additional monies in the budget to do the things that they thought reflected current priorities. And that might not be the best way for us to be going about a budget. So this is just, as we evolve and as we iterate and as we try to make the budget process better and better as we go forward, there I think could be a real important element, a new tool that we could look at and see if this helps us. And I just wanted to thank you for stepping in and giving this to us. >> You're welcome. Thank you, mayor. >> Kitchen: I have a question. Should I ask it now? >> Mayor Adler: Go ahead. Let's let the manager give her opening statement and then we'll come back to questions. >> Thank you, mayor and councilmembers. Good morning. We're very excited this morning. Every year during budget we try a little bit different things. This is my 29th budget, and I like to say we never get it right because we keep trying every year, but we do make improvements and changes every year in response to comments that we hear from our councilmembers. Last year I think we heard loud and clear that you did not want to look at just the change from one year to the next. That you wanted to have, if you will, a deeper dive or a better understanding of what our departments do, what their resources are, who they serve, the environment they're working in as well as what they see as issues that they may be facing over the next five years. So we have a series of department review meetings with you. We have restricted those to just the general fund departments this year as that seems to be where our pressure points are during budget or more of our pressure points. The schedule calls for three this month, and I do

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appreciate you setting aside the time. I know that's an extra burden on your offices, but we'll look at the public safety departments, starting with E.M.S. Today, fire next week and police the week after. There are two meetings in March, and those are for public health, animal services, parks and recreation and parks and library and those are folded by two meetings in April for housing, muny court, planning and zoning and development services. So that will be the complement of all our general fund departments. We'll then follow that with our forecast, our five-year forecast showing you a look at our finances over the next five years. And then we've also scheduled on your calendar that you've approved already two policy work sessions. So if there are large policy issues that you identify in some of these department review meetings or questions that we need to do additional analysis, we have those two meetings as kind of a buffer, so there may be a hodgepodge of topics coming back those two days or you may decide that you have some specific topics that you want us to dive into more that you assign to us to bring back on those two days. The design of this is to meet your needs, so if the material that we provide is not meeting your needs, please give us that feedback so we can adjust the process as we move forward. But I know I've met with E.M.S. And with the fire department and I think that you're going to see -- I know you're going to see presentation that is much more operational, it's got some budget, it's got some performance measures in it, but you're going to be able to dig down into more details in these departments to really understand who they are, what they do for our community and our citizens, and where they are financed from. And what their expenditure

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profile is. So with that if you don't have any questions, I think we may be ready to go. >> Mayor Adler: Yes, councilmember kitchen? >> Kitchen: Let me just say first, really, this is a really good opportunity for us, and I'm excited about it also. I think it's-- it has the potential to be a much better way for us to dive into the budget. So I really do appreciate that. I have two questions. The first is more of a comment, and

that perhaps we can address later, but -- and then the second one is a question. So the first one is I think that the enterprise funds would be very helpful for us to understand, the wig ones potentially -- the big ones potentially. Because what happens to us during the budget time is we start to ask questions about the relationship, for example, between Austin energy and us and other funds and us, and we're told no, you can't. That money can't go back and forth. So I just think that we need to have a really better understanding of what are the parameters of those relationships. And so, you know, maybe that's just one session that kind of lays out the basics for us or something, but I think that's really important. And that is a huge amount of our budget, huge amount of our budget. So I don't want to be in the position of only talking about the general fund stuff. So that would be my comment. And then the second thing is more of a question. And this is really just a timeline question because I don't know what the next step is for us after our retreat in terms of moving forward with metrics for our indicators for our outcomes. So I know that's not this meeting obviously, but -- and I don't know yet if you

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know yet, but I would just like to have sort of an understanding of what the thinking is, if we have that yet or if we need to have that conversation next week. >> Sure. The staff is working with the consultants and the performance measurements management staff and the consultants are working with several departments. Staff to work on the framework, they're having some planning meetings to work through that. The plan was to come back to council in the middle of April with more information and the framework built out a little bit more. The staff is looking at those indicators to propose fleshing in performance measures that would roll up to those. So they're actively doing that work. I have talked to them about the possibility of moving that work up a bit. They have not committed to that yet, but they are working towards that end. So it could be that we could bring that back towards the end of March. Rather than mid April. But I'm working with them hand in hand. I've got another meeting with them Friday to see where we are on that work. But they're actively working on that behind the scenes. We have not taken that very valuable workshop and just put it on the shelf -- >> Kitchen: I know you haven't. I'm just trying to get a timeline, that's all. >> So for now it's mid April, but we're working towards moving that up to the extent that we can. >> Kitchen: Okay. >> Mayor Adler: Ms. Garza, did you have something? Your light's on. >> Garza: You mentioned that this was voluntary and I guess I didn't know that. I guess everything is voluntary for us. I just wanted to make sure that we always also make sure that there's a quorum because I would hate for, you know, staff to show up and be present. So with the indication that

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this could be voluntary, I see that that could be an issue. So I don't know if we coordinate with your office or with the management to get a roll call the day before so staff's not sitting here and then we don't end up having a quorum. >> Mayor Adler: Let's talk about that for just a second. Because I know that these are briefings that some of us would want to have whether it happened in our offices or if it happened here, but rather than having these things go to each of the offices, we noticed them and invite all the councilmembers to come so that it can happen. But if only one person wanted to hear the briefing on the fire department, they could either do it in their office or they could do it here with the TV cameras on and it gets record and the public could see it. So if less than a quorum would show up for any one of these, I would think that we would still have the conversation. We're not taking any action at any of these meetings. >> If you don't have a quorum you're not having a council meeting. If you don't have a quorum you're not having a council meeting. So I would suggest if you're going to have these meetings, which we have on the council schedule, that we have a quorum. If there are briefings that you

don't want to have, then -- >> Mayor Adler: Let's talk about it for just a second. If I wanted to have a briefing in my office and these folks were -- would come, and then other councilmembers said they would like to come too in the office, that would be fine, two or three could come. But if six or seven or eight wanted to come, then I would notice it like this. But what we could do if no one came is we wouldn't convene a council meeting. We would just have these folks talking to whatever councilmembers were here. So we wouldn't convene the meeting, but we would still

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have the conversation. Because councilmembers might want to watch it on their TV or it gives the community a chance to see it. Would we be allowed to do that? >> Again, you can certainly talk to any member of the city staff and when you have a quorum you're having a meeting and it has to be posted and all that kind of stuff. If you don't have a quorum show up, you're not having a council meeting. >> Mayor Adler: Correct. >> You can do something else -- >> Mayor Adler: That's how I saw it. It wouldn't be a council meeting because you wouldn't convene it because there wouldn't be a quorum. But whoever wanted to -- rather than doing it privately in their office with two or three councilmembers, they could do it here. >> Kitchen: Mayor? I'm sorry, you go first. >> Troxclair: I was just going to say I plan on attending all of the budget workshops except for next week I have capcog. And I need to attend that on behalf of the city. So this might not be an issue if we all plan on attending. >> Kitchen: Yeah, mayor? It may not be an issue. I plan to come to all of them. It might be good to know. I think it's a good question. So maybe we should just ask folks what they think. >> Houston: Mayor, I'll be at all of them. >> Mayor Adler: Okay. So it's good to see. I would like you to consider that question that I've asked to know that if for whatever reason a quorum -- I understand we might all show up, which is great and I think we all will, but if we didn't it's a kind of broader question. >> Again, you just wouldn't be having a council meeting, you would be having some people visiting with city St. We could just have a videotape of the people doing this presentation and not have you all come. >> Mayor Adler: Or they could come, but we could ask them questions, but it's not a council meeting, it's just group of us asking questions, but it's just a council meeting and it just so happens it's being recorded and broadcast. But it's not a council meeting. Because there's not a quorum present.

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>> Pool: I was just in violent agreement with that because sometimes four of us will meet to talk about something with staff, the difference is it might be in one of the glass-sided conference rooms upstairs or in our offices or it's right here. So it's a discussion that we're having. It doesn't qualify as a meeting if it's not a quorum and it doesn't seem to harm the process if we have posted that there's a meeting but the quorum fails. >> Mayor Adler: And we could take a look both of us at Robert's rules, but Robert's allows for a meeting or two to be convened in the absence of a quorum so long as there's real limited work that's being done, in fact, there's no work being done, only on limited circumstances and for limited purposes. So I'll take a look at that too to see if this kind of meeting would qualify for that. >> Houston: So mayor, I would like to suggest that we get moving and then you attorneys can figure this out after we meet because I think the people who want to have indicated that they will be here and some people have not indicated that they will or will not. So I think you'll have enough. >> Mayor Adler: Point well taken. Let's move forward to the work. Anything else? >> I believe it's my turn now. Thank you very much mayor and council and city manager for allowing us to do this. We were real excited about doing it, several departments got together and put together some sample templates and some models and then we presented those to the councilmember and out of that came what we have today. And I'm excited to be first. I think there's a dual purpose to today's presentation. One is not just to learn about

E.M.S., but also to get some feedback about how the presentation goes and does it contain the right information. So we're looking forward to your feedback. With that I'll jump into the first slide entitled who we are. So there you go. >> Houston: Excuse me. For our new councilmembers, could you introduce yourself? >> I am so sorry.

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Yes, I'm earn necessary tow Rodriguez, the chief of emergency medical services. I've been here about 11 years. It's been an amazing experience. I'm enjoying it very much. Welcome to the new councilmembers. I look forward to working with you guys. I apologize. I'm really excited to get into this. All right. I know I've got a lot of time, but I know you have a lot of important questions so we'll move on. E.M.S. Is a component of the austin-travis county system so we're a safety net provider. We respond to 911 emergencies. We do it 24/7. We're on all the time. E.M.S. Is also a direct provider of emergency and integrated mobile health care and that's sometimes a little piece of who we are that's often overlooked that we do use professional clinicians, we do provide emergency care, we are very highly trained and skilled and we do some intricate work, albeit in sometimes a hostile environment and a dangerous environment, but we manage that. That's what we do. So we have 46 physical locations throughout our community. Most of those are E.M.S. And fire stations combined. Some of them are standalone stations. And then we have some training facilities and office space that is included in that 46. We have a complement of 520 sworn field personnel. And those are the personnel that fall under the civil service program. And we have 54 additional sworn communication personnel that work in the 911 center and actually talk to persons, the first persons that talk to callers when there's an emergency. We also have 74 and a half civilians. And it's that half thing that always gets me, but we do have 94 and a half and it actually -- 74 and a half and it actually makes sense when you look at how we're divided. We operate 37 full-time ambulance units and six demand units. So the difference between those is the

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full-time ambulance units are 24-hour ambulances. They're on duty 24 hours a day, seven days a week. And then we have what we would call demand units, and those are peak load units. So when you look at the distribution of the calls that we experience on a daily basis, you will see that we have peaks and valleys. And it doesn't make sense to always staff at the highest level all the time, so we use demand units that are 12-hour units to come in and fill in for some of the higher level call volume that we experience throughout the week. We have an emergency fleet of 114 vehicles and it's an assortment of different types of vehicles. It includes ambulances, which is what you see most often. And you will also speak command units, pickup trucks with a special bed on the back to carry equipment and supplies as we need as we respond to various emergencies. Then we have some special response vehicles which you will see during special events where we can get into crowd and take people and move them if we need to out of a crowd towards ambulances that can transport them. We also have bicycles and motorcycles and boats and an assortment of other things that we operate. And it that diversity of equipment and approaches that we take to E.M.S. That makes us quite unique in the emergency medical services arena. But it's enabled us to respond very effectively to an assortment of emergencies, things that we could just not expect. The one example of that was when we had a lot of people that were injured during one of our major events. We had crews on scene, so foot, on bikes, on motorcycling and were able to transport people very effectively. It's so it's that variety that really helps us. We're also always hiring staff. We're always looking for good, talented folks. In 2016 we graduated 73 cadets through our academy. And that academy is a pretty extensive process that people come into

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and that's where they learn how we operate, what our rules, regulations and expectations are. And we fine tune their skills before they actually go out and start practicing in the field. So that's another thing that separates us from E.M.S. Agencies across the nation is that we invest quite a bit of time upfront with our folks to prepare them the best that we can. Some organizations do very, very small academies with their staff. They do orientations and they turn them out very quickly. Sometimes they're just not ready. We don't do that. We invest a significant amount of time and we do it with purpose and very carefully to be sure that we -- when we turn out someone that goes into the field and they're on the ambulance and they come to your home they are ready. So that's an important investment for us. Our population that E.M.S. Responds to is 1.2 million. The reason it's larger than just the city is because we also have an agreement with Travis county to provide emergency medical services throughout the county and the unincorporated areas of our community. So we have a larger population that we respond to. And that's a total of 1,043 square miles. So we have a large area where we distribute ambulances all across our community. On the very back if you've got our handout, the very last slide is a map that shows how we're distributed throughout our community if you would like to get a little bit more detail on that, you can look at that map. We received 143,804,911 calls for service. That's a lot of requests for service and these are emergency calls where people are having a situation that they feel they need assistance with. Sometimes it's medical in nature, sometimes it's different. We sort through all of that and we figure it out and we respond the most appropriate response to them, to their homes. So E.M.S. Is in the business of house calls. We're one of the very few -- if you look at the spectrum of health care that's provided out

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there, we're one of the very few health care providers that gets to see how somebody lives, where they live, who they live with, what they wear, how they cook. Get to see all of of that when we go to their homes and that's really a privilege, but we also utilize that, we leverage that when we get into community health paramedicine and I'll talk more about in a in a second. We responded to 131,835,000 incidents. That's a lot. That's a pretty big call volume. As you compare to other communities throughout the United States, that's a big number. And we do that very effectively. And I'll talk about one of our important measures is response times. Our community feels that they want E.M.S. On time. They want us quickly. When you dial 911 your emergency may have started a few minutes before you got to your phone even so you're in the midst of an emergency, a person is perceiving time very fast and they want E.M.S. There quickly because it could be one of those bad situations where someone could lose their life. So to all of our different priorities, and we have five different priorities, priority one being the greatest, highest level of emergency. Priority five being the lowest. To all of our different priorities, one, two, three, four, five, we're on time 94.84 percent of the time and that's pretty impressive. When I came here in 2006 the best that our agency ever did was 82%. We could never achieve past 82%. What we did is we focused, we did our our analytics. We looked at the call volumes, we adjusted our system, added some staff and we have not been below 90% since then. And I can tell you that as we traveled to that level of performance, that last one-10th of a percent was probably the hardest piece of that climb that we've ever experienced. But we did it. We broke that barrier and we've sustained it ever since.

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One of the things that we do is we process calls. When the call comes into the emergency 911 center, that again has to go fairly quickly. Well, our processing time is 69 seconds. Think about that. That's a

minute and nine seconds. And what we're doing is we're answering a phone call where somebody is calling, their cigarette for help, -- they're desperate for help, they're frightened, there are things in their lives that are not going well, we're asking them questions, giving them information that they need, we're giving them instructions as we go, we're dispatching an ambulance, selecting the closest one and attaching fire if necessary so that we can co-respond to those emergencies. And we do it in 69 seconds 90% of the time. That's pretty huge. That's a major event and hats off to our communications personnel that do that day in and day out. They're doing it this minute. Out of that when we respond, ultimately we transport patients to the hospital. We transported 78,725 patients to the hospital in the last year. And that again is a pretty good number. Compared to 143,000 calls that we received, a lot of folks go to the hospital. And that's important for us. So what happens after that? One of the things that E.M.S. Does that's unique amongst some of our general fund departments is we do billing. The United States of America allows health care providers to seek back some reimbursement for their services. They know that health care happens if you're prepared for it and you can't wait to start health care preparation when a case comes. So there's a cost of readiness that's understood in the health care industry. E.M.S. Has to have trained personnel, equipment, dispatch capabilities and all the things that we provide

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training and everything for our personnel. And so we're allowed to be reimbursed for some of that. And that's through medicare, medicaid, insurance and sometimes people pay themselves. So those are the types of bills that we send. We billed 79,040 patients in 2016. That's quite a few. Now, you will notice that the number of parents that we billed compared to the number of patients that we transported doesn't match. We billed more. And the reason is that there are some things that we do in the field where we do maybe an advanced life support assessment in someone's home and then they decide they don't want to go to the hospital, we can still request reimbursement for the work that we did for an ekg and doing other things that we do with them at their homes. It takes us an average of about 12 days to get a bill out the door. That's longer than it was. In 2006 I was looking at 45 days to get a bill out the door. That's a long time. We did a lot of improvement in how we bill. We worked really well with vendors. We called in consultants. We did all kinds of work to try to fine tune that billing process and we got it down to three and a half days. And we sustained that for quite awhile. But now what's happening is the centers for medicare and medicaid is instituting new requirements and new regulations that are becoming more complex. We're having to slow down to do the extra work so we've now stretched out to 12 days for that. And that's one of the things that's challenging us today is being able to gather all the information that we need to construct a bill and doing it quickly enough to get the bill out the door as effectively as possible. And it matters. Generally in health care the first person that gets the bill out gets paid. So if you're down the list, the chances of you're getting paid for

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everything begins to drop. So our goal is to try to get the bill out as quickly as possible. At the same time we need to be sensitive to citizens in our community. It's a bill. It's a big bill. And they have to deal with that in their households. So we have all kinds of things that we do to work. We set up payment structures, payment plans, and all kinds of things that we work directly with them to help them afford their bill when it happens. We know that in an emergency they don't have a choice. And so we accept that as part of our responsibility. We also had almost will thousand special event hours that we put out throughout the year to cover the special events that we had. Some of those hours are reimbursed by sponsors. And some of those hours are not. And we may have that. I'm not sure if we have the detail on that. But we do provide a significant portion of coverage for special events in our community. We also

have a public education program that we do. E.M.S., as you can imagine, like most public safety agencies, is a reactionary agency. When an emergency happens we go to it. And so one of the things that E.M.S. Is trying to do is to work forward so we try to get ahead of the emergency by doing injury prevention, education, cpr training, all kinds of things we can do to get in front of emergencies, to try to prevent as many as possible. Last year we reached 29,698 people with education programs that span from cpr to lightning education, how to avoid getting hit by lightning. So we have a broad variety of things we do and we make extensive use of social media to distribute some of that. And it's proven to be very effective. One example I can give you about that is several years ago we were experiencing a lot of children and pets being left in cars

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during the summertime. And as you know, that's deadly. That kills. And it only takes seconds. It's a very short amount of time that it takes to take a car and heat it to 120 degrees. So we launched a campaign and the campaign was to prevent people leaving their children in cars. It was somewhat of a reminder thing. We worked with radio stations, TV stations, social media, Facebook, everything that we could and we just sent reminders out, reminders out. And that year zero deaths. So it can be very effective to use social media and the media and other communication techniques to get in front of emergencies. And we do that every year now and it's proven to be very successful. So with that I've got -- I wanted to show you this short video that we did to kind of describe what we do on a daily basis. If we can kick a off. >> They're already on their way. Where is he shot? Stay on the line with me. I'll tell you what exactly to do next. >> Ma'am, I don't know. There's blood everywhere. >> I've got help started on the way there. >> Ejected from a rollover. >> Rescuers descending right now. >> Cpr in progress. >> Requesting a time of death for an approximate 30-year-old male with injuries incompatible with life. >> When an emergency strikes, seconds count. Lives matter. We want to help you know what to do when. >> Austin 911, do you need police, fire or E.M.S.? >> I need an ambulance. >> Ambulance. What's the address of the emergency. >> 4514 James wheat street. >> Okay. Just repeat that address one more time to make sure I have it correct. >> 4514 James wheat street. >> And what is the phone number that you're calling from. >> 512-555-7890.

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>> Repeat that as well. >> 512-555-7890. >> And what is your name? >> Rene. >> O Rene, tell me exactly what happened. >> My friend is here and having severe pain in her chest and she says it's difficult to breathe. >> Medic 28, chest pain 4514 James wheat road. >> Medic 28, page received. >> I have just a couple of quick questions to make sure I'm sending you enough help. Are you with her now? >> Yes. >> How old is she? >> She's 55. >> Okay. Just one moment. Is she awake? >> Yes. >> Is she breathing? >> Yes. >> Is she completely alert? >> Yes. >> Is she breathing normally? >> No. >> Does she have difficulty speaking between breaths? >> Yes. Is she changing color? >> Yeah. >> Okay. Describe the color change? >> She's kind of pale. >> Has she ever had a heart attack or angina? >> No, I don't think so. No, never. >> And did she take any drugs or medications in past 12 hours? >> No. >> Okay. Rene, I'm sending the paramedics to help you. Stay on the line and I'll tell you what to do next. >> We are going on a 55-year-old female with chest pain. >> Okay. (Sirens sounding). >> Do you or anyone there have aspirin or baby aspirin available? >> Yes, I think we have baby aspirin. >> Okay. If you can send someone else to get the aspirin. >> Can you go get the aspirin? Okay. He's getting it. >> Okay. And Rene, is she allergic to aspirin? >> No.

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>> Has she vomited blood or coffee ground material in the last 24 hours? >> No. >> And has she passed black or bloody stools in the last 24 hours? >> No, I don't think so. >> And did they return with the aspirin? >> Yes. He just handed it to me. >> Great. Get one adult aspirin or four baby low dose aspirin and tell me when you have them. >> I've got them. >> Okay. Tell her to chew four baby low dose aspirins right now. >> Okay. Here. Put these in our mouth and chew them. Okay. She's chewing them now. >> It looks like com just directed administration of aspirin. >> Okay, great. Rene if there's a defibrillator available send someone to get it now in case we need it later. >> No, we don't have one. There isn't one here. >> Okay. Reassure her that help is on the way. From now on don't let her have anything to eat or drink. It might make her sick or cause problems. Just have her in a comfortable position and wait for help to arrive. I'll stay on with you as long as I can. Watch her closely and look for changes. If she changes, tell me immediately. And the paramedics should be with you shortly. >> Let's park in the middle of the street. >> Don't leave her alone until paramedics are right there. Is the door unlocked? >> It is. >> I think I can hear them outside. >> Okay. Tell me when they're with her. >> Okay. My husband is answering the door. They're coming in now. They're here. >> Great. I'll let you go then Rene. Thank you. >> Thank you. >> Hello, E.M.S. >> Good morning, council, jasper brown, Travis county E.M.S. This is one of our public service announcements that we

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put together through our public information department. It's designed as a series that's what to do when so the first one is what you do during a 911 call. We'll be putting these out in the future as far as what happens when you're approached by an emergency vehicle and a series of others much this is designed for callers who have also given us feedback that sometimes they feel like all the questions they ask on the phone delay the response. And you can see we try to point out that as soon as we get the address and phone number we start the unit and updates are given while the ambulance is in route and so it's not delaying anything because we're giving that information to the caller. >> Thank you. Mayor, I'd like to also introduce Kerry Lange, she's our assistant director of finance and administration in our department. Chief brown is the chief of staff and works very closely with me everyday. He and I are inseparable. And we do that on purpose. Our department is vital to community. If anything happens to me or otherwise, we're covered. We're like shark teeth. There's always somebody else to replace, but that's on purpose. And so I'm very proud of these folks and they work really hard. I would say that 90% of everything we have in here they did it. And then they trained me to speak it. So if you ever have any questions and you see these folks, grab them. They're very good at what they do. So how we operate: E.M.S. Is a third service provider. And what that means is that we're a department and we standalone. We're not blended with another department. And there's some advantages to that for us. One of the things that I think is -- one of the biggest advantages is that we hire people that are excited about being clinicians and they have a single focus. That's all they want to do. That's what they want their career to be. So there's no confusion about what their role is or anything like that. And that's one of the things that we take pride in, in our community. And many communities look at us and try to reach that, the same goal that we have.

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I think the result of that is that we deliver excellent patient care in our community and that is what we do. We do wear uniforms. We do use lights and sirens. We do have badges. We're public safety. We make the scene safe, we make the situation safe first. Once we do that we begin patient care. And we do health assessments and we do incident venges that are clinical and medical in nature so we live in

that dual role. We're recognized in the industry as an industry leader across the nation. There's some things that we've learned. Some of it through hard knocks. Some of it learning the hard way, but there's a lot of things that we do that are partners throughout the nation look at and are constantly querying us about how did you do that? How did you do this? Can we do that? And some of this we became leaders in. We lead in safety, keeping our people safe, trying to reduce injuries. We lead in injury prevention in our community. We train thousands of people in different things that keep them safer as they live everyday. We have excelled at vehicle safety. We've put together employee-based committees that helped us design a safer ambulance. That's where they work. And it has to protect them. We excel at diversification of services. We do what it takes to meet the community needs, whatever that looks like. We're moving forward rapidly with mobile health care integration and that's when you hear about the community health care paramedic program and mental health services. So those are some of the areas that we move forward in. Another one that you just saw a piece of is public education and information. This series that we're doing, this was just the first in a series. We put that out on YouTube and distributed it through Facebook and it has spread across the nation. It took less than an hour before it -- before I was seeing it come

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back at us from different publications that are distributing information online. And there are people using this already to show their communities how E.M.S. Works. There's many communities that can't afford to put programs like this together. We're lucky. We have people in our organization that know how to do this, so we use them and we use their skills to put these kinds of things together. And the agencies that don't have those skills and abilities in their organizations grab our stuff and use it. They often times will present it kind of like the way we've done, but talk about their own organization and how they do their pieces. So we're contributing on a much larger scale than just our local community. We spread out our reach across the nation. A few other things that we're excelling in is performance reporting. We've been recognized as an agency that's doing a best practice in how we report our performance. We actually have a website that anyone can access and look to see how we're doing in our different performance areas. Also an improvement methodology. We have adopted the institute for health care improvement, improvement methodology. And we're owe I've done some training myself and we're training other staff in improvement methods so that we can take quality to the next step. Most organizations measure their performance, and that's where they stop. We measure our performance and then we look to see what we can do to make it better and that's improvement. So we're pretty extensively involved in that. And also in employee wellness. That's been a challenge for us. As you know, we've had some suicides that have occurred. I was at a conference just last week where physicians were talking about the things that are impacting our communities and how suicides are becoming more prevalent amongst public safety providers, police, fire and E.M.S., all of them.

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We're all seeing that grow. They looked at our organization and they talked about this and I was in the room, I didn't know they were going to do this, but they talked about us as an example of how we're addressing that and the steps that we're taking to try to meet the needs of our personnel. Before it becomes becomes a problem that can't be managed. So those are the things again that these are just a few of the things that we're excelling in, that we're showing to be highlights throughout budget information for you. We tried to combine the information that we're presenting to you in two ways. One is that you leave here knowing a little bit more about us and who we are and what we do, but we also give you some information about the budget you can begin to think about us in that balanced way. You

see who we are and what it costs, and then we can talk about that. So in 2017, we approved our budget to be 83.4 billion there are in total. That includes 574 sworn positions and 74.5 civilian positions. So where does our money come from. We're a tax funded organization, obviously. We're a general funded organization. 47.8% of the dollars we use to support ems come right out of the general fund. Fees, 6%. Very few dollars are from grants. Our revenue is 43.5 million. That's a significant portions of funds. Over half of our expenses are paid through revenues in our organization. There's a chart there to see how our dollars are distributed.

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The majority of the dollars we bring in, we use to provide direct services. The remainder of that is support services so that we can continue to do the direct component of that. We respond to emergencies with 497 of the 574 sworn positions. The difference of those are they have assignments. Like our designated medical officers who work in the field alongside with the medics, but their job is to oversee the quality of our clinical services. We have a number of uniform personnel who work in our training division and provide the continuing education to our medics and the academies that we provide and bring in new personnel. We've got a couple of uniform staff that work in injury prevention. They reach out and provide training to members of our community and how to be safe. So we've got an assortment of folks that we have spread out. In our emergency communications area, we provide effective and efficient 911 triage. That includes all the communication centers that you saw in the video. The beginning of that video, you heard some voices speaking. All of that was real. Those were actual calls that you heard. At the point where we started walking through and slowed it down a little, we did that with scripting, but we tried to stay true to time sequence so people can see there's a lot of things happening simultaneously. Just because we're talking with one person on the phone and asking questions doesn't mean we're not dispatching. We're dispatching at the same time. We're doing a lot of things all at the same time. I encourage you to take a moment anytime you like and go visit the communication center. I invite you to plug in to our 911 answering side so you can listen to some of the things

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that we deal with. I can tell you that we make a difference in people's lives every day just out of that communications center alone. >> So some highlights about our data and our budget, we increased our sworn positions by 78 from 2012 to 2016. We do that on purpose to try to keep up with the growth in our community and to keep enough resources available so that we can respond to the growing demand that's increasing. One of the things we've learned in ems over time is that population drives ems. And so the greater the size of our population, the greater volume of emergencies that we're going to have to deal with. And so that's holding true in our community. When you look at the growth and population, and you look at our increase in call volume, it's almost parallel. You can see there's a distinct connection in those things. That's something I provide you as a hint as what to expect as your community grows, as we become more popular and as more people come here, we have more emergencies, and we need more resources to keep up. So that's something to think about as we move forward. So one thing I think that is really key to understand about our budget is how much of it can we actually manage? How much can we actually work with? And how much of it is somewhat flexible? If you look at the pie chart down at the bottom, personnel, fleet, transfers and other requirements are 93% of our budget. Those things are relatively fixed. Now, there's not a whole lot that we can do to vary that amount. When the market pretty much sets those numbers for us. The cost of fuel, the cost of

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fleet services. What we choose to pay our personnel, the increases and the benefits that we provide for them, all of that comes together to produce that 93%. So it leaves a person in my position with about 7% to have to manage very, very carefully to make all the ends meet throughout the year. That's the piece that we work with the most because that's where we can have the influence that we need to have if we ever want to save dollars or if we want to manage our dollars or manage our performance, we have to do that within that 7%. That's a much smaller component. The chart on the right simply shows how we've seen the expense increase over the years from 2012 to 2016. It shows that our sworn fte levels have grown alongside with that. And then the green dotted line is the field sworn fte. So you can see of the sworn ftes that counsels have approved for us, how we stack up in terms of filling those positions. And the lines are following each other. It would be bad if the lines were far apart because that would show we're not effectively filling positions, but we are effectively filling positions, and the line is tracking. We would like to narrow that gap as much as possible. We're working really hard to do that. Mayor, this brings me halfway through. Should I continue, or would you guys like a break? Very good. So the next thing is a quick discussion of our capital budget. We have several stations. Station two, station eight, and station 11 that need improvements, and we have some funds to do that that was approved in 2012. We have renovations and expansion of crew quarters that

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we need to make. We have bay expansions we need to make because our vehicles don't fit. And we've got some compliance with Ada and fire codes that we need to bring the stations up to. Ems actually made a decision to delay some of that construction to give time to the fire department to plan their improvements that they needed to make. The reason that we did that is because some of these stations are shared, and we thought that we would get a better pricing and better construction work if we did it together at the same time. That was a very short delay. And now we're all synced up and moving forward with that. These projects are not managed by our department, so I don't have more information about the status of those. But that's where we are with those particular improvements we're trying to make through capital. We have one new station we plan to bring up in 2018. That's onion creek. We have to bring not just the station, but the ambulance, the equipment, and the personnel to be able to staff that station. Again, that's by February of '18. We have operational factors we wanted to share. As I said before, one of the challenges we're experiencing is the growth in our community. That growth in the community has multiple factors it produces. The obvious one is we have more emergencies with the greater population. As you know, our traffic is also experiencing a lot of congestion. It's very difficult to drive ambulances through that traffic. So it's a challenge for us to try to meet our response times and arrive at locations of emergencies safely while navigating through the traffic. Ambulances are large. They're noisy. They don't maneuver like a small vehicle does.

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Managing that in a way that doesn't injure others and ourselves is a challenge for us. We think the growth is going to continue for the next three to five years at a steady pace. Maybe 3% growth or so over the next three to five years. So we'll see that corresponding increase in call volume and increase in challenges that we experience through that. In the area of recruiting and promotions, there's been a shortage of personnel throughout the nation. This is something we're all facing. It's a very real challenge. Several years ago, part of our approach at trying to get through that was we changed the way that we staff our units to include emts. Emts are basic level trained personnel that work together with

paramedics. Now, there's a variety of levels that you can train emts to, and we train them to an advanced level. So our emts that are called basic emts really are at a higher practice level than the typical emt in the nation. We do this on purpose. We want the best care we can get at bedside when we get it, and we want people that can work together at the highest level of capability all the time. So that helped us, actually, fill a lot of to our vacancies. The challenge was how do we continue to develop emts. Now we instituted a paramedic school. And we put our emts in there. We've started our first class with 16 of our emts. I don't recall when that is supposed to finish. >> September. >> September. So September is our first class that we'll complete in our paramedic program. We did that together with the

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Texas engineering service out of Texas A&M. Texas A&M has an articulation so that when the emt students graduate as paramedics, they can convert some of their education into college credits and continue their education. So that's a very positive thing. We're also using some of our own personnel who are instructors throughout the community to teach in our program as well. So we're excited about that. Another thing that we did is we created an alternative hiring process. When we find paramedics in the community that are looking for work, we go out and recruit them and bring them in. We skip one step per our labor agreement. We're allowed to pay them a little bit more and move them faster through the academy process. We also get them to practice at the als level sooner and faster. We're piloting something that we're really excited about. It's an internship program for our communications staff. One of the things that's been a challenge for us is hiring enough communication staff. As you saw in the video, that's a very multi-task oriented group. They have to be very good at using technology. They have to be comfortable answering questions on a telephone, working and using their imagination many times to picture what is actually happening at the scene they can't see. At the same time, coordinating with another person who's going to dispatch a unit, answering their question, listening to the caller, providing instructions. Where do you get those skills? Our focus was for many years to find people that already did that for a living and recruit them into our organization. That's proven to be very difficult because there's not M. There are probably skilled people in our community that can do this job if they had the opportunity to do it.

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So what we did was create an internship program. We hire them on. Put them in the internship program and they go through all the training processes. At the end of the internship, if they've been able to complete everything as they've been trained to do and pass all of our competency tests, they're hired on staff. We went from receiving 10 or 12 applications for a vacancy to 120 applications. I think the last batch we did was over 200 applications for the internship program. What we find is we have a lot of members of our community, people who live in Austin, who are wanting to switch careers and get into public safety, but they have family. They have bills. They have rent. How do you go to school and still work? So this gives them the opportunity to come in to a new career, get paid while you do it. Get trained while you do it. And learn a new career on the fly. So that's a really good process that we're doing. It's proving to be very positive at this stage. So that's the thing we're excited about. Affordable care act, as you know, that's a big part of diussion in our nation right now. It's hard to tell exactly what is going to happen, but here's our kind of little piece of our crystal ball, I guess, so to speak. We think that the care reforms that have been initiated by the affordable care act -- in other words, how we care for patients, how we provide clinical services most effectively and most efficiently, focusing on outcomes. We think that's going to stay. That's a good idea. That's a good way to practice medicine. So we think those things are going to continue on. What is going to change is the reimbursement mechanism. We

just don't know what that's going to look like. We can expect that is going to have an impact on ems. About 52% of our funds come from

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billing, from medicare, medicaid, insurance, other payers. So when that structure of reimbursement changes, we're going to see the impact. And hopefully it will be positive for us. As we learn more, we'll share that with you. I think we're all going to see that develop as it goes. We're anxiously awaiting to see what that's going to look like. One of the challenges we're experiencing that I've said over and over, I guess, is the growth in our population. We've grown by 26494 from 2012 to 2016. So, again, that drives the work that we do. That increases our volume and increases the challenge of what we do. So you can anticipate we coming at some point with updates on that information and explaining what the challenges actually are and how that translates into emergency vehicles, personnel, and all the resources that we need to do to keep up with that. Unfortunately I don't have that yet. With moving the time line forward, we're in the process of doing our analytics right now to get that information, but we haven't completed it yet. So we're working on that as quickly as we can. So we have a few other service challenges that we're looking at. One of them, I've already mentioned it, the bill processing time. That is increasing. And that's increasing because of the complexity of the billing process. That's being driven by regulators outside of our organization. So the other thing that we're seeing is with population and with the increase in the call volume and transports, we're generating more bills. So we're having to do more work in our billing office. And as a billing office, it has to face more processes and slows us down. So that's one of the things we're continuing to work on. One of the challenges that we're looking at is our medical record system that we're using is becoming outdated. Our billing system is completely

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reliant on our medical records. So that's one of the things that we're going to be evaluating this year, I hope, to determine whether or not it's time to look for a new product that serves us better and can make us more efficient and effective in that domain. >> We also are looking for a tool that better supports the health work we're doing. Our current billing system and medical records system, rather, doesn't support that. So it's a challenge for us to keep track of all of the patient contacts that we have outside of the 911. So the percent of calls answered by ems communications in less than ten seconds has dropped from 99.6 to 99.2. Now, our goal is 90%, but we have way overperformed that for many years. We do that on purpose. To give you an idea of what that ten seconds is, it's four telephone rings. If your telephone rings about four times, that's about 10 seconds. Our goal is to answer every 911 call in less than four rings 90% of the time. Now, think about everything that's going on in the communication center. Think about everything that's happening and somebody's life, when they're dialling 911. That's why it's so important to answer the phones so quickly because you need help. You need help now. You don't need to be on hold. You don't need to be transferred. You need help now. And so we've made it one of our hallmarks to try to answer that phone as quickly as possible. The reason I mention that, when we're still way above goal from 99 to 92 is a 7% drop in performance. Why is that happening? Because the call volume is increasing. One of the things that we're looking at is to see what we can do to become more effective and efficient in our communications center to be able to answer the telephone as much as possible, as quickly as possible. Now, there's a balance that we keep. One of the things that we do, we'll engage with the caller and

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providing instructions for them and the 911 phone is ringing and ringing and ringing. One of the things, when you visit, you will notice that every now and then we have these lights that start flashing. They're strobe lights. They're flashing because it's a 911 call that has not been answered. What we'll do is call it e-ruling. We'll take that caller that we're currently working with, disconnect by them by giving them rapid instructions and asking them to call back if anything changes, and we'll answer the next call. That's a delicate balance. We have to be very, very careful when we're disconnecting with callers who might continue to need help to answer the next caller who we know needs help. That's a very tough balance. So that's one of the thins that we look at constantly is the level of e-rules that we have to the level of 911 answering effectiveness. We call it the goose. That's our time of ability to answer our phone in less than ten seconds. So grade of service is what we call it. That's where that comes from. That's a balance that's extremely important to us. So when you go in and visit the communications center, watch for that. Watch for the flashing light. Listen to how we're managing the callers at that point. We have trained extensively our personnel on when they can release a caller to answer the next 911 call. I will tell you that there are times we have to let the phone ring. We have to just let it ring because we cannot release that caller. It wouldn't be safe to do so. That's where it gets dangerous. That's where we work really hard to keep up with that. One of the things, as a predictor of where we're headed, is evaluating our staff levels and the communications center, evaluating how we manage our calls and looking for ways that we can improve ourself. Now, we always look for what can we do first before we actually have to add staff. We know that staffing is probably the most expensive

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solution. So we always look for other efficiencies and ways to manage calls differently or better so we can better utilize the staff that we have. Before we go to the point of coming here and asking you for more. So that's something that is coming towards us. It comes with population growth. It's just a challenge that we're facing as we go. So let's talk about some key indicators. We've selected four key indicators to share with you the first on top, the red and the blue bar charts on top, are about response time. The first one is the response time to all priorities. That's the one I've already mentioned earlier. That's at 95.7% in 2016. We have maintained a relatively high response time to all of our emergencies. Now, the way that we do that is every different response time level has a different response time requirement. So we don't respond in the same amount of time to every level of emergency. The shortest amount of time, 9:59, we aim at our highest level of priority. And then it's 2 minutes more as we go to the highest level -- to the lowest level of priority fives. So that's how we manage those. In our system, what we do is if you have a low priority call and a high priority call and they're near to each other, we'll reassign the balance that's assigned to the lower priority call and send it to the high priority call and send another ambulance to the low priority call. That's called call substitution. That's one of the high-performance methods that's used in medical services across the nation. Distribute your units in the most effective way. Do it all the time so we're constantly moving units, and then we send the highest priority calls first. So we're always moving units around to achieve that.

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That's how we do that. The other result of that is that we meet the highest level of emergency calls consistently. And that's the blue bars. So you can see that it's been 92, 91, 92, 91. And it stays at that level. Our goal is to keep it there. One of the things that I set out for our performance levels is I want at least a 2% buffer for the highest level priority. So that 92%, that would be considered high for priority one emergency. But we think that's what we need to do in our community to keep it safe and to be on time. If you run it a little bit too close, if your goal is only to be 90% of the time, I guarantee you you will

be at 88, 89, 87%. You won't meet that goal. So we aim for 92. We produce 91 and 90 and 92. So we stay in that safe range. That's a very difficult process to do. When you consider the nature of what ems does, we're a live nerve all the time. 24/7, holidays, nights, whatever. Super bowl, we're on duty. We don't know when the next caller is going to call. We don't know where they're going to be. We don't know what their emergency is going to be. Imagine what it takes to prepare for that. That's exactly what we do. So we think constantly about what we do. Now, one of the things that I want to point out in the blue bars, the 92 is happening less now. We're moving to the 91s. Right? So that's a very, very small shift in our performance level. As a chief of ems, that's an important shift for me. A 1% shift in response time at the highest level of emergencies is a big deal for me. That's one of the things that we're going to be focusing on, is trying to push that back up

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toward 92 to keep that safety margin in place where it needs to be. That, again, is being driven by our population growth. The expanding growth of our community. We have further area to reach. And these changes that are happening, not only in the city but in the county as well. As I said before, that's one of the things that for us is unique. We cover all the emergencies in Travis county. If you've ever taken the opportunity to drive out, just next time you're driving out of the city, look for that Travis county sign. It's a long way out. That's where we go. There's some areas where we actually have to leave the county and come back in to get back in the county to reach. So there's some challenges there. There's areas up in the west that if you're not already there, you're just not going to get there. If you start looking at the bodies of water that we have, you can't cross those. So we have to be on both sides all the time. Those volumes change seasonally as well. You will see on the west side of the lake, the call volume increases in the summertime. We have more instance where the emergencies are. If you're on one side -- and I just took a bath. Thank you. >> Speaking of the lake. >> Speaking of the lake. I now have a personal lake. [Spilled water] >> So we end up shifting there. We did say this is kind of informal, right? [Laughing] >> So we'll see those shifts happen. We have to physically move our system towards that end. And those are things that we do on the fly every day. One of the masters of that -- I'm proud to sit next to jasper because he's one of the masters of that. A lot of the design of the system movement and the system flexibility that we have today was masterfully designed by

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chief brown who constantly looks at maps and does constantly analysis. I'm always driving him crazy because I'm asking him how with -- how are we doing with this. It's like artwork. It's a true skill and talent. We wanted to share with you the cardiac arrest measures that we have. Cardiac arrest is probably one of the most severe of all emergencies that we go to in emergency medical services. It only takes three or four minutes before brain damage happens after your heart stops. So we have a response time of 9:59 to most of our emergencies. Now, how do we do it? How do we actually get their quickly enough to prevent brain damage as much as possible? This is one of those examples of it really does take a village. It takes a community. We invest a huge amount of time training as many people as possible in cpr, teaching them how to use ads. Many times, when somebody calls and they have a situation where it's a cardiac arrest, we can use them to be the first responders. We call that zero response time. So with a zero response time and we walk someone through with cpr, we can save a life. We've done it day in and day out. Now, our goal is for 30% of the persons who we come in contact with who have a cardiac arrest, to arrive at the hospital with a pulse. That gives them the best opportunity to survive. We have about five or 600 people ayear that experience cardiac arrest. It's a relatively small number. That's a good thing. We would like to make that even smaller, if possible. As that number gets

smaller, the measure becomes more sensitive. So you will see that sometimes we're right at 30. Sometimes we're at 33%, last year. That's a lot of hard work. We do a lot of unique and smart

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things to do the best care we can. Not only do we engage the community as early as possible, we organize the way we respond. We call it a pit crew response. If you've ever seen a car race and the car pulls into the pit, everybody has a job. There's very little communication actually happening at that time. Some folks are doing tires, some folks are doing fuel. Someone is getting water to the driver. They're all doing different things, and they do it very quickly because they have to get back in the race and they can't lose any time. Cardiac arrest is the same thing for us. We instituted a program called the pit crew. We've trained all the fire service and medics, and even I'm trained in it, which is probably the hardest piece of their training, to get me trained in that. We all have a job. Any of us can walk into a cardiac arrest situation and take a position and know what we're supposed to do. That has taken cardiac arrest response from a very highly escalated and chaotic scene, if you can imagine -- a lot of people trying to do a lot of things very quickly and in time and keeping time all while performing at the same time. It's taken it to a very quiet and organized and effective process. We're actually seeing our cardiac arrest numbers resuscitations increase. That's what we wanted to see. We're still pushing that. We want to see that number continue to climb. How does that translate into survival? Ultimately, what we want is as many people as possible who have a cardiac arrest experience to survive and leave the hospital. We call that hug time. They have a cardiac arrest. They die. We work on them, resuscitate them. Take them to the hospital. They go into the data lab. They go through rehabilitation, and they walk out the other end to go out and hug their family. That's the goal. That's what it is that we want to do.

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So currently, our community is experiencing 13% survival because we get people to the hospital alive. We've done a good job in the field from the time the phone rings to the time we get them there. That compares to 10% in the nation. So we're 3% higher than other areas of our nation. And that's something to be proud of. We're not stopping. We're continuing to work on that. We're constantly looking for ways that we can provide even better care. So, for example, one of the things that is difficult for us to manage during a cardiac arrest is to help somebody breathe. That sounds like a simple thing. We take it for granted. We're all breathing. We do it every day. When someone goes into cardiac arrest, they can't help us. They can't open their airway or move their muscles. They can't do anything. We have to do that for them. So the airway passage into their lungs is hidden from us. It's inside your neck. There's things in the way, teeth, dentures, et cetera. We can actually look in the throat and see the trachea and pass a tube through it. Presently way we're using is a manual device. You have to get down and try to see with your eyes, and it's very difficult. The new device we're implementing now has a camera. You put it in. It has a screen on it. And you can see the anatomy and intervene in ways that we may not be able to before that. So that's an example of the things we continuously do to try to look for ways to improve that even more. So another thing that we look at is we have a triple aim

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organization. The triple aim was an initiative established by the institute for health care improvement. It looks at three different angles of patient care. One of them, the initiative requires a triple aim organization to focus on a population that needs particular type of health care to try to improve it. The other is that we look at the patient's experience. They should have a positive experience when they're

cared for. People should feel good about receiving good, high-quality care. Finally, if you do these things well, and you work on your effectiveness, you can improve your efficiency and ultimately drive the value of the care you provide and impact the cost of that care that you're providing across the nation. Now, imagine, what would happen if every health care provider in the United States of America was a triple aim organization focused on the population, focused on the quality of care, the experience of care, and the cost of that care? That's how you drive the cost of health care. That's how you reduce it. We joined that bandwagon several year ago. One of the things we look at, besides the other quality of care and all that, we also look at how satisfied are patients with our care. So we call them within 48 hours of the time we discharge them to the hospital, and we ask them how we did. We use a person who is non-clinical who we trained as a surveyor. She sits on the phone and talks to people about the care we provide. We have a 96.5% satisfaction rate. We use a scale of 1-5. 4 and 5 are our goals. So we're doing very well with that. So we have some horizon issues we thought were key -- >> Mayor? Can I ask a couple of questions before we go to the horizon

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issues? Thank you so much for sharing. I can tell you're passionate about this. I hope that if I ever need to call ems, you're on the wagon, on the apparatus. >> We'll show up. >> A couple of things before we go to the horizon issues. The special event hours, who pays for that? Does that special event pay for you to be on standby? >> We have some sponsors that pay for us. When we do standbys at the raceway, most of those are sponsored events. So we charge the overtime coverage -- we have a set-up fee that we charge if we have to take equipment and set up any kind of stations, and they pay our costs. >> So would that be captured in revenue? >> Yes. >> Is that just for billing? >> It would be captured in revenue. We have some -- I think council waived some of those. >> I have that information. There's only six that were waived by council last year. I can go through them real quick. It's the Austin new year's, the 2016 Texas run and parade, the pride parade, the fourth of July and auditorium shores, and south by southwest, there's only a portion that was waived because there was a cap put by how much could be waived. That was spread amongst departments. So it wasn't all fee waived but some of it was. And the kite festival. Everything else, we bill for those and the sponsors pay for those. Generate about $783,000 in revenue for that. >> The special events? >> Yeah. >> I know you can't give me a specific, but is there an average cost to transport someone from home to the hospital? >> So we have two billing fees

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that are set forth by council in our fee schedule. There's a vls -- bls fee and als. It's $800 for bls and 900 for the als. But it's in the fee schedule. We can use those exact numbers for you. >> So it's $900 to get me from my house to the hospital? >> If it's advanced life support, that means different interventions need to be done, and we charge per mile. All of that is billed to medicaid, medicare, or one of the private payers. >> So how much per mile, do you know? >> It's $13.50 per mile. >> Oh my goodness, I thought -- okay. $13.50 a mile. So it's beneficial for us to stay healthy, is what you're saying. That could cost a lot of money. One of the other things is that the motorcycles, I think, are great when you guys are on your motorcycles or ladies or on your motorcycles and bicycles because they can get in between. I've seen them on I-35 trying to get to a crash while waiting for the large apparatus to get there. Are other cities doing that? >> There's a few other cities that have adopted the motorcycle program. We were probably one of the first to initiate it. The first set of motorcycles we got were actually donated to us from the Austin crime commission. So that's how we started the program. You mentioned on I-35 -- we ran a pilot where we were running during traffic hours -- we know I-35 is all day traffic hours, but to do that, we were using personnel that were on units to pull them off to put them on the motorcycles to get

to those accidents because a large number of those are refusals. They don't really need a transport there. We're hopeful that as our

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staffing numbers come up, we can pull personnel that are motorcycle qualified and put them on the program so they can access patients quicker on the I-35 corridor, cancel units or continue units as needed. As you stated, they can get to the accidents quicker versus the large apparatus. >> People ask me all the time when you're doing the tee and at the -- triage. Is there any way to roll fire department and police? >> We don't roll the fire department on all calls. That only go on the high priority calls. Respiratory arrest. Priority two would be the calls could become problematic. In other words, it's a chest pain that somebody is having difficulty breathing and so we roll a fire department as first response to that because it could turn into a cardiac arrest situation. About a year ago we transitioned some of our priority 3 calls that Austin fire department was responding to and actually took them off the call and we recused their Cal volume by 10,000 calls. It's not just to reduce call volume but to keep them ready for their emergencies in their area. If they're on a low priority call, they could have -- we want to keep them available for the highest priority calls. They don't go to every call. They do go to a large number of their calls. I think the ems volume is 70,000. Don't quote me on that. I'm sure they have the numbers. We don't send them on every call. >> And are we keeping metrics on that to see how that is being reduced? >> Yes, ma'am, we were. In fact, through that triage system we utilize, for every call there's a determinant.

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We look at those to see if when we got on scene, what was needed. Was advanced life support needed? Can we not send fire to those? It's very, very specific and down in the weeds to somebody who has chest pain who may have been had taken cocaine. We can look over time and we have four years of data to see are those calls predictors of needing als services on scene. If it's als, we may want to send fire on those. That's how we were not able to send fire on priority 3s and we're looking to see if we need to be sending fire on those. The next step is look at the accidents to see if we need to be coming on some of those da call in and they're not on scene. They say, we just saw an accident. Right now we send police, fire, ems. Fire has a dual role and a hazard mitigation role. Even if they're not needed medically, they're needed for hazard reason. We're looking at not sending an ambulance on some of those unless a patient is identified. Where we can, we're trying to reduce the number of vehicles going to things. Anytime we run code 3, it's the most dangerous time for us, our providers, and the public. If we hit them or they hit us, it's not good for either one. It also keeps them available for higher priority calls. >> Thank you. >> Yes, ma'am. >> Jasper, would you give us some examples besides cardiac arrests, what priority one and priority two calls are? Just so the public has a better idea of what they are. >> So, again, the priority 1 calls, somebody's -- childbirth, choking, cpr, cardiac arrest. Anytime we're going to be giving prearrival instructions falls into a priority one call. Priority two calls are severe. They just -- there may be a chest pain, respiratory, but they're just having difficulty breathing, but their airway is

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still open. They're able to talk and pass air. That's a high priority call for us because some of those calls could degrade. Somebody is having an asthma attack. As their airway is closing, it may be priority two because they can breathe and talk but then it turns into a priority one call because they can't breathe at all. There's so many different levels. The chest pains, respiratories, strokes, somebody who has had a

stroke, it's a priority two call. And that's the call phiers. >> The als fees are 901 or 966. >> Thank you. >> Just a few follow-up calls on the billing. And the reason I'm asking these calls, I'm just wanting to explore -- my higher-level question is the extent to which we can increase the amount of reimbursement that we're getting. So I will send you some questions that are more of a drill down, but some higher-level questions right now because if I'm seeing it right. 47.8%, we're covering that cost and we're not getting reimbursement for it. So my question is, then, I'm trying to think about what the barriers are to moving that needle. Now, obviously there's a certain percentage of folks that just don't have a payer source because they're uninsured, but I'm curious whether that hole 47% or so, whatever it is, is all people without a payer source because they're uninsured or are we getting paid for map, the medical assistance program? Do we have a bad debt component? What is in that percentage that

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we're having to cover the cost for? Are they all uninsured folks? That's what I'm trying to understand. >> We do have a significant portion of people that are self-insured and they can't afford to pay. >> Right >> We do try to set up payment plans for them and things like that. Also, medicare and medicaid don't pay the full costs. They maybe pay 80%. Medicaid pays less than that. We do have an agreement with central health to pay for map patients. >> Does map pay the full cost? >> They do not. They pay a reduced rate. It's a capitated plan. One of the things we're working with them on is to go back and look at the entire population of map patients. When we sign an agreement with them, we're responsible for 100% of their population. >> Right. >> And that population is growing, but the payment is not growing. So that's one of the things we want to go back and review with them and maybe revise the way we're paid by them. >> Okay. So when we say that they're not paying the full cost, the cost is what -- I'm using that term -- I think we're using it the same way. The cost is what it costs you to provide the service. We've got a capitated agreement with map where we're not covering the full cost. I'm glad to hear you're revisiting that with them. Map is central health because -- and that's something that we can't control medicaid and medicare as readily in terms of what their payment level is, but, you know, this is a community benefit that we're providing. Particularly when we get to the community paramedic program, I will talk more with you about that, but this is a benefit that we're providing to folks that are uninsured and the map program is designed to cover. Having the city eat some of the cost is, I'm not sure, the appropriate way to handle that. That's one of my questions going forward. So medicaid, are most of these medicaid folks on managed care?

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Or are you paying some fee for service or do you know? In other words, are you billing the insurance companies for this? >> Yes, we do. We bill insurance companies, and we bill -- if someone has medicare or medicaid and has another insurance, a supplement, we bill them as well. So we go at every source that we can identify. >> The reason I ask that -- and I will stop getting into detail, we can talk about it more. But to some extent, the managed care organizations have more control over how much they're paying you. So if they're not paying you your costs, that concerns me. Let's see. So it sounds like some of the barriers, just to recap, is that, of course we have uninsured people. I'm not suggesting -- obviously they need to be served. So I'm not talking about that category. I'm talk about the category that has some payer source, and there's a disconnect between how much it costs us and how much we're getting back, it sounds like. Okay. Is there any other barrier that's causing us only to have to pay for about 47%? Is there anything I'm not seeing? >> For a while, it was our own fault. >> For a while, some of the methods that we were using on our billing department was not actually hitting every source that we needed to have. >> Okay. >> What we did is we -- through working with consultants, we had an

evaluation done of our system. We actually hired a person that used to own and operate their own billing program, so now that person is on board. We fine-tuned quite a bit. So we've picked up a lot of that. Other thing we've done is because medicare/medicaid do not pay full costs -- they pay a portion of it -- we found that for hospitals there were cost adjustment opportunities for

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them where they could go back and justify receiving more funds to adjust how much they received because of their cost that was greater than what was paid for. What we did is we hired a consultant to work with them to come up with a cost adjustment for ems. We were the first in the nation to do that. >> Okay. >> We have since received several million dollars in cost adjustments, so we have tried to make up for it >> Okay. >> The problem is the dollars available for those cost adjustments, as soon as other ems agencies got on board, our cost adjustments started to drop. Now they're having to spread that across the entire population of ems agencies. And so that was beneficial for us. That did help, but that's not a long-term solution. We're looking for ways to improve that. One of the things we're doing is participating in a national movement. One of the things that is a limitation for us is ems only gets paid when we transport a person. What we want to do is to be paid as a provider. Very much like a doctor's office bills for the different levels and types of services they provide. That allows you to bill for the work that you're doing. Ems is not allowed to do that right now. So we're trying to cross that and close that gap so that we're able to bill for the things that we do and for transport as well. So that would give us an opportunity to reach in and become qualified to bill for more things. We think that will help. I really don't know how far that's going to move. Again, we're working at the national level. That's going to take a lot of work. >> Okay. Does the map program pay us for transport or the other services. >> They pay us for transport. >> Every transport. >> Every time we transport a person, yes. >> Okay. I will send you more. Last question, the electronic medical record system and the

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patient management system you mentioned, the improvements you need in that, I'm thinking that perhaps those kind of improvements would help you with billing? Or do you think it will make a difference? >> Yes. One of the thing that's happening is the IC10 (phonetic) Has been implemented. That have's made the amount of information that we need to develop a bill, it's probably doubled or tripled. The data that we're capturing right now in our medical record is insufficient. So we have to do a lot of back-end work to try to gather the information. >> So it's not all electronic at the moment. >> It is, but it doesn't document it well. We have to go back and talk to medics and manually enter stuff so we can generate the bill. >> Okay. >> We want a software that's better at that, more up to date, and that's more flexible. The other thing that's a challenge for us, in ems, the medical records, each medical record is an instance. So each time that we go to the same person, it's a new instance for that same person. We can't see everything that we've done for a personal -- >> That's got to be fixed. >> That's very clumsy for us. >> You don't actually have an electronic medical record for the person. >> Correct. >> Okay. Thank you. >> Okay. Yes? >> Can you tell me how y'all handle the -- like the k2 overdose that's been going on? Do y'all recover any of that cost? >> Do we what? >> Recover any of that cost? >> I would guess that almost none of it is recovered. What we're seeing is an expanding use of k2 amongst our most disadvantaged population. I actually think that there are people that are preying on them to get them to use this and take what few dollars they do have. Unfortunately they can't afford ems. >> Is there any way that you can give us the information of how much it has cost your department

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to transport these people that don't have insurance or the ones that have been od'd on k2? >> We can do that. >> Okay. Thank you. >> Mayor protem? >> I have a couple of questions. I was able to hear a couple of my colleagues question. I hope I'm not repeating. I apologize if I am. First, I just wanted to say I had the need to call 911 recently a couple months ago to report an accident that had happened that I wasn't involved with, but there were several cars involved. One of the things that I was struck by -- because I've called them before -- just what you said earlier, several times they reminded me that the questions were not impeding the response time. And so I just wanted you to be aware that -- and you probably are -- that 911 operators are making that very clear. The dispatcher I talked to said that a couple of times in the course of our conversation. It's my understanding that our 311051 dispatchers -- 311 dispatchers are contract compliers >> They are all certified as emergency medical technicians. And we do that on purpose. That gives us the ability to provide medical care over the phone, which would be more difficult to do if we didn't have persons that meet that criteria. So I don't know if any other portions of our communication centers -- >> Tovo: You covered that piece before but I didn't make all of those connections. I appreciate your reminding us about that, that level of training for the 9-1-1 E.M.S. Dispatch. >> Yeah, the 9-1-1 that answers the phone first is usually Austin police department and some of the 311. They are managed all by them. I know they have some part-time and contract employees that are with the department. >> Tovo: I hope as a council that sometime during the budget process we can talk about that.

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You know, we require extensive training for our 311 operators and I was a little surprised to hear that a large number of those are contract employees and they are making a pretty low wage. And that's a very high-stress, high need for knowledge base job. And I hope that as a city we can look at that more carefully in our budget process. I think I heard you say earlier that you have a public information video coming on what to do when an ambulance is driving. Did I understand that to mean like if you're a driver -- so that would be when people see an ambulance how they should respond. >> When approached by an emergency vehicle, knowing we encounter a lot of activities drivers are doing and try to give them the best advice possible. We're also going to get with the other departments, fire and police, just to make sure that the information we put out also coincides with what their expectations are and their department does. We don't want to say something, well we do it this way but somebody else does it different. >> Tovo: That's great. There's a need for that. I see people all the time not pulling over. >> We do low impact. So if we come to an intersection and there's just a lot of traffic and there's no places to move, we shut down, rather than to push a vehicle out into cross traffic that can't hear our lights and sirens. We do have some delays. But it's safer to do that than it is to try to push a car out into an intersection that oncoming traffic or cross traffic can't hear our warning signs. To avoid collisions, we kind of back off a little bit on some of those responses. It doesn't cause a huge delay but we do understand in traffic it's a little bit different. Sometimes there is no place to go. >> Tovo: How are you publicizing those videos? Online, on YouTube, channel 6? What's the distribution?

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>> We put them out through our Facebook and Twitter accounts. I know it was picked up in the spectrum and also through the new 6 -- or our own internal communications. >> Tovo: Like atxm and city watch. >> And other agencies are picking up on it and feeding it back out. >> Tovo: What's the possibility of getting some of those videos aired on some of the local channels as public information? >> We pushed them to all the media and, you know, we have encouraged them to utilize them when and

where they could. That's the extent of they have it, they can use them. It's then just if they are going to use them. >> Some of them do teasers on their television broadcast and send people to their websites. >> Tovo: To your websites? >> Correct. >> Tovo: And I think my last question, and if you have already answered it, you can tell me you have answered it and I'll go back and watch the tape I missed, but you referenced earlier there are unreimbursed civil costs associated with some of your event work and you had existing data on that. What would be the best way for us to access that data? >> I can send it to you. There are six events. >> Tovo: Perfect. >> I went over each one of those and I can send you -- >> Tovo: That would be great. Thank you. >> Mayor Adler: Mr. Flannigan. >> Flannigan: On one slide you talk about population increase and you have it in parenthesis. How do these numbers compare to what we are providing in the extraterritorial areas and unincorporated areas? Are we talking about numbers that are just provided to city of Austin residents? >> I believe so. >> So the increase in population is under the city of Austin. >> Flannigan: The budget numbers. When we talk about 90 or $84.3 million budget, that's to serve the whole county plus the

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Austin part? >> Yes. Do we have -- how do we track how much of that gets paid for by Travis county? >> Within our revenue we return back to the interlocal agreement. >> Flannigan: 43.5 includes the reimbursement? >> From Travis county. >> Flannigan: Is this like a per call? If a call originates in? >> We have an agreement. We have been through a process where we calculated all of that and then we totaled the amount that it would cost. And then they pay us monthly for the total cost. So if they send us a monthly payment, I think it's about $16 million that they contribute into the system. And we receive monthly payments. We provide summaries of the calls that we make and we provide performance data for them. You could actually see that county data specifically on our website, the city website. And you can see our performance and the population and the call volume and our response times all specific to the county. All of that is rolled up into our budget as one item. >> Flannigan: It's a prenegotiated amount. It's not based on call volume or where service calls come from or anything like that? >> The number that we derive comes from all of that. So it is included. We -- what we do is we answer the question what does it take to cover the county at this level of service. And then we use that to determine the cost. And then we take that cost, analyze it. >> Can you help me understand when I see private ambulances driving around. >> We have two companies we have given franchises to to operate in the city. They move patients between hospitals. They interinterfacility transports and nonemergency. >> Flannigan: You referenced earlier that on these -- the hours that you list in your presentation, which is 7900,

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almost 8,000 hours. All of those are reimbursed short of council per fee waivers. Every hour is paid for by the special event? >> Correct. >> Flannigan: Do you find yourself providing service to events that are occurring, like the non-sanctioned south by events, specifically, but I imagine there are others. >> There's a collateral impact that occurs. >> Flannigan: Yes. Thank you. That's a much better phrase than I was thinking. >> When we have a big major event in the city we also have a company in car accidents and things that happen outside of the event that increases our call volume. That is not covered by contracts. >> Flannigan: But that's being tracked. You track the service level you have to provide as relation to -- >> We could actually look at the call volume that occurred during the event, but we don't specifically -- we don't target any particular event related to an accident or something like that. There's no direct correlation. But we can see changes and fluctuations in call volume that happen during the event. >> Flannigan: The numbers during your presentation, 131,000 incidents, 78,000 transports.

79,000 patients billed. The difference between the incidents and transport is services provided on site? >> Correct. We have several cases that occur where we go and do an assessment and the person declines to be transported. >> Flannigan: This would be almost 50%. It's not several. >> It's a large number. >> Flannigan: From what I understand is we only get reimbursed for transport. >> Correct. >> Flannigan: Half of the calls there's no reimbursement. >> We do send a bill for some of the services we provide. We do assessments on scene. Many times those are not covered by payers and we don't recover those costs. >> Flannigan: So on-site medical assistance isn't covered by insurance? >> Correct. >> Flannigan: Wow.

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Speaking about insurance, I know that you referenced affordable care act impacts, what ratio, if you know off the top of your head, I'm pulling the numbers up, the fees we collect. That 43.5 minus the Travis county number. It's much less than that in terms of reimbursement for services provided. What ratio of that is coming from federal insurance programs? >> I don't know if we have our payer distribution with us, but we have the information. I can get it for you. >> Flannigan: That's something I would like to see. I would also, chief brown, would love a chance to sit with you and look at the mapping and how you design the system. That's fascinating to me. And really understand how you go about that process. I really would love an opportunity to do that at some point. Council member kitchen talked about about that program that comes through central health. Is there a program that comes willco? >> Not with us. >> Flannigan: Over 5% of the city is in willco, including if you would come to my house. Not that I would be on map, but I'm curious. >> I think they have a similar program but I don't know very much about it. >> They do. It probably -- it may not cover as high a level of income, but they have a county engine health care program. So it's worth checking. Some counties it's pretty low in terms of the income level that they cover, but it's worth checking. >> Within my district, more of my lower income residents are on the willco side than the Travis county side so that becomes an important datapoint for me. That's enough for now. Thank you. >> Mayor Adler: Before we go back, I have to leave here in ten minutes, so I'm going to leave you as a group.

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One observation I would make -- this has been really helpful and really good. But it doesn't look like we're going to have a lot of time at all to get actually into the individual programs, which was one of the real goals of this as well as the horizon issues that you're facing as well as the questions that we have. So maybe as we learn and we go through this process we could come into the room with the assumption that everybody has read the materials that were given to us ahead of time and start, perhaps, just with questions rather than having a presentation, so that we can actually use the time that way. That might be something to consider. While I have you, before I leave, the budget in E.M.S. Over the last several years has gone up more rapidly than population increase because there are needs and back needs and staffing needs associated with trying to increase the standards and the level of service. It would be really helpful -- and I don't know if there is such a thing, is kind of a five-year projection so we could anticipate over a longer period of time. Usually we look at the horizon in a shorter period of time than that, to be able to gauge what the anticipated movement is over a period of time. So we have contacts for the other priority decisions that we make. When you talk about the horizon issues, one of them is the affordable care act issue. You mentioned that real briefly. And that's a concern that I hope you talk about so I can watch the video later to be able to address. Also I was going to ask questions on a larger area in terms of cost and function so that I could learn about the issues related to merging fire and E.M.S.

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I know that's come up periodically over time and I need to understand that better, whether there are any efficiencies associated with that kind of thing or whether that kind of operation works. I'm excited too to see the motorcycle program that we led with that. And I don't know and would like to know if there are within the community of emergency service providers. As you look out front at the conventions or the workshops, whether there are discussions about future business models, or performance models that are changed than the ones we have now where there's a greater reliance on things like the motorcycles. Where there's taking a look at, you know, the number of incidents where we have both the fire department and E.M.S. Responding. Whether there's differences on the horizon on business model changes that people are looking at. We have some big capital expenditures that we are being asked to put money against, most notably fire station increases. So being to better able understand the relationship where we have E.M.S. And fire. You mentioned you were waiting for them because they are combined. But just trying to find, you know, as many of those kind of efficiencies as we can. You know, in the transportation, the big issue now is having a model that is just in case versus just in time. And I don't know if there's a corresponding debate within this industry as well. The statistics I have seen seem to indicate that over a period of time that the fire department is doing, because of all the great practices that are happening, are responding to less fires and responding to

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more medical calls. And I don't know if so at some point we look at the cost expenditures, the capital expenditures for the return and risk of events that are occurring. And I don't know what the long-term arc of that is and whether that's something that would impact decisions that we're making. Obviously another area of interest is the wellness issues that we have. You talked about the challenges associated with staffing. You talked about what I thought you said was the internships for the communications side. I don't know that we have talked in terms of in the diversity context and fire. We talked about trying to do more programs at the high school level. And I don't know if there's a similar opportunity for us to be doing that kind of work in order to get folks that live here that might not have gone and had direction to really see how much more we can do. I know the workforce solutions folks are going to be looking at doing more and more internships and apprenticeships and skill trades, whether there's an opportunity for us in that area. But on the turnover and wellness issue, we're spending a significant sum of money on that and we are -- for the employees, and I want to make sure we are doing everything we should do and that what we're doing is right. I just need to understand that better because it's a concern that has come up. And then later when we have the discussions -- I think we're going to get a briefing on esd4-12, kind of the longer term look on that that Ms. Houston raised yesterday. We're dealing with these but are we going to deal with ten of these over the next two or three

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years. And if we are, what's the longer term policies that should guide us as we're making these initial decisions, both in terms of how we spend, where we spend, and what is the ultimate governmental or business model function with that as we get to more and more people in the region. So I ask those questions. I'm going to go to somebody else now. But I have those questions. >> I have a question. I thought the -- with staffing. Is it one paramedic and one emt on every ambulance? >> Correct. >> I thought the reason that changed is because it's more expensive to staff with two paramedics. So wasn't that part of reason? >> Our primary drive was it would fill all the vacancies we have. We expanded our

hiring pool by looking at emts and there was a savings that resulted from that. >> I'm wondering, and you know because of the constraints we have as a budget, we have to look for ways where we can save. I understood you to say -- so aside from when paramedics came in they were already certified paramedics. The training consisted of getting them up to speed on sops or standard operating procedures. It wasn't training them to be paramedics. >> Correct. >> So now it seems that we've -- so now we're hiring emts and we have added a training component now, because now the emt is trained, does the city pay for that training? >> Yes, we spend about $3,000 a person for the entire program. >> Okay. And I'm just wondering if that

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is affecting recruiting already trained paramedics? Because if I know that -- my experience in the fire department is that some people would get certified as a firefighter on their own and pay for it and then there were those who came in -- because Austin has an academy, so you can get certified through the academy. If I know that the city will pay for my paramedic training, I'm wondering if that's hurting us in a way that you're going to come in as an emt and you know the city will pay for me to become a paramedic. I want to know how that helpeddous cost savings. If it was one paramedic and one emt to save money, but now we have added a training component, what is the net savings now because of that? >> Those are numbers I would have to calculate for you, but we are doing both. We are still recruiting paramedics and we recruit emts. The price we have for the training for the paramedic program is significantly less than it would be if you went out and did it on your own. And less than what's provided in general in the market out there. We are able to negotiate a really good price with the school. We have driven the cost of that training down as much as possible. We also instituted the alternative hiring process. When we recruit people who are already paramedics, we are seeing that number of applicants climb. I don't think it is diverting people. I think it is actually helping. >> Who funds stargh >> Star flight funded by the county. It's entirely paid for by the county. >> And so I thought, you know, we were going to try and really drill down on numbers. And so the pie chart here, what percentage of that -- I mean, where would training be in this pie chart? >> Which chart are you looking

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at? >> That's another thing I was going to ask. If we could have the departments number the slides. Oh, it is. 6. >> If you look at slide 5, the royal blue, bright blue bar is for employee development and wellness. And that would be where your education program is. So it's about 2.9% of the total budget. We can provide you the exact numbers if you would like them. >> So I guess all these different charts is -- so expenditure budget by category, there is no line item of training -- not line item. No wedge? >> There's no piece of the pie for that. That was trying to get at showing you what portion of their budget was for personnel, what portion was for contracts and for commodities. If you wanted to cut 25% of their budget, typically you could see where you might be able to cut that from. And for the departments to show, give a representation of what portion of their budget was really more discretionary. That was just to give you a sense of how much of their budget was in that category. >> I don't have a suggestion on how to better do this, but I don't think it was anyone's -- I don't think anyone's going to say where can we cut 25%. It was more to understand every single little thing in that 25%, maybe, and see maybe there's a $200,000 program. And so that's what I thought we

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were, how we were drilling down in the budget. And you guys did a great job and I know you're kind of the Guinea pigs because this is the first one. But what this felt like was an extended version of what we get during budget anyway. >> Council member, in these other ones, there's more details about the specific programs and their costs. So if you look at those and there's more information you need, we'll be happy to look for you. >> I guess if there was a way, when I do budgeting at home there's a list with groceries and mortgage payment. And so I'm a visual person and it's one thing to flip through and see the numbers on a different page and it's another thing to have it all on one page and know that's what training cost and that's what this cost. I know that's moving toward zero-based budgeting but I thought that's what we were trying to achieve and get a good visual of the dollars and cents for each department. >> So for example on the one that's called employee development and wellness. On the second page it details a little bit more. There's 12 sworn civilian personnel and six civilian personnel assigned to that group. And then it lists the services that they provide and gives some further descriptions about the type of work that they do. So if you look at those and you have more specific questions, we'll be happy to drill down as much information as possible. >> What I'm saying is there a way to do a one page. These are the education, wellness, training, these are the training things. Instead of having to flip back and forth to do that. I just feel like that would be a little bit easier. >> You know, so the mayor also made some comments about kind of

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how we might move forward with this. And I wonder if we could all submit some ideas, maybe to city manager heart about how we want to see those presentations. This has been a really valuable presentation, and I have heard your presentations for the last several years, of course, but I certainly learned a lot today. But I think if we're trying to really look in a more detailed way at the different line items that comprise a particular department's budget, it sounds like a lot of people need different kind of information to have that conversation. >> We'll try and address that before next week. I think what we need is to take the activity sheet and give you a summary of all those activities. And they add up to the total budget. Give you a summary sheet and then provide you more detail on each of the activity so you can peel the onion layers back and see how they connect to each other. We'll try and do that and do less discussion of powerpoint pages on the front-end. >> Council member kitchen, you're next. But council member Garza, I think you want not just a summary but actually lots of detail within those different program categories. Was I understanding your point correctly? >> I think the detail is here. I just think it's not all together. So, I mean, I feel like it would be -- it's just putting the entire budget on one page in an excel spreadsheet. >> I think I have an idea. We may do a prototype and bring it to you and see if that addresses your need. There's some pages in the actual budget document that do just that that we may be able to use. But I'll work with Ed and see if we can't address that need before next week for fire. And we'll provide the

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information for E.M.S. For your notebook. >> Council member kitchen and troxclair. >> I think I would support that. You know, it's almost like giving us the line item budget, you know. So that's really what we're interested in. So okay. So it's just some quick things. I just want to say that just for purposes -- I think one of the things that we're trying to do here, in addition to understanding the budget, is also start to surface some policies and some issues that we may be looking at as we get into the budget. I just want to share mine real quickly. What I will be focusing on is increasing our ability to cover our cost, understanding that there's already been a whole lot done in that regard and there may not be much left to be done, but that is one area -- that's one area I want to further explore. So that's one area. The

second thing is I think that one of the ways that can be done is by increasing efficiencies for the whole community. Because what the services you provide is for the whole community. So your programs like the community paramedic program, which have a very positive return on investment for the entire community, not just for the city, I'm going to want to explore expanding that program. And the third thing that I'll be looking at is getting you the technology that you need. Because you cannot be efficient without the up to date technology. So just for the city manager and the staff and for my colleagues, those are the three things that I will probably focus on in terms of looking at this budget. >> What was the second one? >> The second one was the return on investment for the entire community. >> Okay. Thank you. >> The community paramedic, for example, saves money, saves a lot of money. But some of the money it saves

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is for hospitals. Some of the money it saves is for the county or for central health. And not so much us, you know. So when we look at that kind of program and we look at who's covering the cost for people that are not insured and who is covering the much higher cost when someone goes to the emergency room that could have been prevented, that's a community cost. And it's a conversation we need to have as a community. Because we've got a program that can cut that cost and is already doing a lot to cut that cost. >> The thank you for that additional explanation. I appreciate it. That sounds like a really important area to pursue. Council member troxclair. >> I just want to echo the comments that were made about the presentations overall. I would love to spend our time really drilling down into the individual programs rather than just on the overview, but great job for the first department who is coming before us this year. I wanted to ask on slide 6 you have the expense and fte history. And you made a comment about how you were working to close the gap between ftes and filling those positions. And I understand the challenges that you have faced there. But it doesn't seem like that was the case for at least 2015 to 2016. It looked like the -- that we lost -- we lost someone who had been in a position, and we didn't make much progress in filling the position. >> One of the challenges we are facing is our turnover rate. When you compare our turnover rate to the turnover rate of other E.M.S. Agencies, we're actually pretty healthy. But when we look at ourselves we think we can do better. We are approaching about 10.6% turnover rate. Compared to my partners out in other communities, they are approaching the 20%, which we're

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way better than that. But right now what we're experiencing is we're losing our highest area of turnover is within the first year of the time that someone comes here. And so we talk to each person that leaves. We try to figure out what it is that they're leaving for. And there's a whole broad assortment of reasons. We've got everything from they've decided to go back to school, to go to pa school or something, to they are homesick and want to move back to California and things like that. We have had a number of them. And I say this cautiously, we have had a number of them that come and get their training. They have now on their resume that they worked at Austin and Travis county E.M.S. And they go looking for organizations that are not as busy and have shorter retirement periods. And so we lose them. That's one of our competition points that we're trying to figure out how to get past. >> And those are people that the city has invested money to train them? >> Yes. >> Is there a way to do, you know -- because I think like you said, they can be trained somewhere else if they want to. If the city is going to do it, there is a two-year commitment. >> We do that for the medics that go into the paramedic program. >> I know we made a significant investment during the budget and to E.M.S. -- Last year or the year before? Both years to try to address -- I'm not remembering all the details, but I guess it was to reduce the work day,

right? To reduce the number of hours in the workweek to try to reduce stress. There have been some suicides and things like that. So help me understand how that investment has led to tangible positive change within the department. >> We have had a pretty positive change in our organization. Our morale has really taken a boost when we started

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implementing the 42-hour workweek. We retooled the schedule. We went to a 24-hour schedule. We have always had them but we added more of them, and we varied the start times. Sometimes we have start times that are in the morning and we have some evening start times. We tried to increase the variety of schedule availability that we have and meet the rest period that's needed. So when we went to a 24-hour schedule, we put together the number of days off to be more. So they have three days off, for example. That gives them time to recover and rest and actually be ready for their next shift. So we have seen a real improvement when we did that. And I described it like flipping a light switch. The day that we did that we felt a collective sigh. It made a huge difference. And we're still continuing to move in that direction. But we've also added some support features. We have entirely shifted the way that we look at our organization from how busy we are to how rested we are. So we -- one example is we went to work with a vendor and we literally invented a tool that monitors our system and tells us when an employee needs a break because they have had too many calls in a row. So that's something that in a busy system can happen and you'll never know. Now it doesn't. We know when crews are responding to the number of calls in a row and haven't had a meal break or a break, so we check in on them and give them breaks to be sure they have a break. We also have -- we instituted safe sleep rooms. So several years ago we had one of our employees who got off duty and drove home. He was tired and ended up in a collision and was killed. And that was a very tragic thing that happened to us. And so what we've instituted now is, number one, change the culture. It's not okay to do that. If you're tired and you had a

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difficult shift you don't need to drive home. We can get you home if you need to go home right then. But we have created safe sleep stations now where a person can go and sleep for a few hours before they try to drive home. Another thing that we're doing is called 24-hour strong. 24-hour strong is a cultural shift. So what that means is how do you work in E.M.S. In the types of shifts that we have and survive? So in there we talk about how to eat, how to rest, how to sleep, how to live your life in a way that's conducive to a good, healthy lifestyle working shifts. Shift work is difficult, period, in any industry. It's even more difficult when you have all the mental trauma and psychological trauma and emotional stuff that hits us when we do our work. We've also -- we've got a contract now with a psychologist who specifically works on PTSD and also on suicide prevention. So we have that in the mechanism. We've added a chaplain to our cadre of resources that we provide. We have done a lot of things to try to improve all of that. >> But that hasn't resulted -- I don't see -- I guess I don't see it resulting, at least thus far, in retaining, being able to retain employees for longer. That's great to hear that you think that there has been, you know, a shift in people's attitudes and mindsets and things. But why hasn't that translated into, I guess something that we're measuring here? >> One of the things we're looking at is we ask the question are we hiring the right folks. So we're retooling our recruiting process. We increased the amount of experience that's required to apply. We also noticed that in the people that were departing in that first year of experience, these were the people that had no E.M.S. Experience.

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So that led us to think that, well, maybe we're hiring people that don't know what they're getting into. And when they get into it they don't like it. I'll give you an example. I had one employee that resigned because it all of a sudden became real that they have to work nights, weekends, and holidays and the individual didn't want to work nights, weekends, or holidays. Yet we told them that at the very beginning. It just wasn't real and then all of a sudden they realized I do have to work those and quit because of that. >> Let me ask the question in a different way. Do you expect those investments to make a tangible difference in the number of employees that you're retaining or the number of calls that are answered? I mean, any of these metrics. It's hard -- I'm just looking at we have invests millions and millions and millions of dollars into our budget and E.M.S. Recently to try to help you with the workload and with the stress and all that. I'm just not seeing the result. >> I think we will see the result. I think it's not an immediate sort of thing. I think there's going to be a little delay as we catch up and move the whole organization forward. But, yeah, I do think you're going to see that. And I'm very confident that we'll see that. Now one thing we are seeing is that people that have the greater amount of tenure, those aren't leaving anymore. Who is leaving is the brand new folks, an we have already changed some of those hiring parameters and search parameters that we have been using. So we expect that we're going to see some changes soon. >> One thing I wanted to add is over the two fiscal years, the first we at 15 captains. The bulk came in October. We transitioned those shifts in mid October, so we're really only about four months into this

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new way of doing things, so we expect those results to show fruit here soon as our retentions will continue to improve. And then some of the positions aren't even funded until April of this year that we can't hire into. So all that is still to come. So it's a little early to really show that fruits of the labor so far. >> Even from the investment from two years ago? >> It's been allowed us to transition about 44% of our work staff to that 42-hour workweek, so that's been a big help on that. But when the full implementation happens and we have everybody on board that's when I think we'll see that. >> If it's possible to put down in writing what you hope to achieve over the next -- when you hope to see results and what you think that those results will be, that would be helpful for me. And my last question is just kind of a general one. The events that are having their fees waived by the city, are those events -- how are those events chosen? Is that city council -- are those city-sponsored events and that's why we're not recovering fees from the organizations who host the events? >> A few of them are city sponsored, like the Austin new year's eve thing is a city-sponsored event. Others are brought forward by the provider and their sponsor to the city council in various ways. The number of city waived have dropped over the many years. But that's the only way it comes forward is through them to the council, or brought forward by a council member, usually. >> Do the same events roll over every year or is a council member bringing them forward? >> They have to be brought forward every year. There's nothing that I know of on a continual basis. It has to be every year that

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it's brought forward. >> Council member alter had some questions and it is my understanding we have some additional presentation. >> We only have two slides to go through. >> We have a hard stop at new. >> Thank you. As a new person on the dais here I do appreciate the additional background, but it may be more appropriate at other times, but it's very helpful to me to have the wider perspective, so thank you. City manager, this may be an observation by you that I would like to see, it seems to me there are going to be a number of times when we are doing workforce development-type training in order to meet our own employment needs. And I think it would be good to have some sort of snapshot

of what's going on across the departments. Because I believe we have some areas that are making investments in workforce development that kind of broader and not necessarily targeted at helping the city. But I'm wondering if there are ways to improve how we're doing that that also help us to meet our own staffing needs while also meeting our desire for a diverse workforce, a living wage, and providing training opportunities for the young people or other people who are making transitions in our community, and somehow seeing that across the departments in some format. I don't know what that looks like. I think that could be helpful. One question I had for E.M.S. Was how do the numbers break down across the priorities. So you have talked about what is a priority one, what is a priority two, but what percentage of the calls that you're getting, you know, in relation to the numbers that you have fall into priority one, et cetera. >> We can get you those numbers. I don't have them off the top of my head. But it is a curve. There's not a lot of priority one calls and then it increases to prior two and prior three is the higher. And then it starts to drop down to prior four and five.

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It's kind of a curve that way. >> I'm guessing you have done this because it sounds like you are into the performance metrics and learning and improving, but when we look at the homeless population we had a focus on, you know, what do our targets need to be to minimize the cost we have to pay as a city later on, while we're still able to transition people into another environment. And I'm wondering, as you look at the environment that you're facing as E.M.S., have you identified where those high priorities are where the lowest hanging fruit is, where you can make the biggest buck, both for serving people's health but also in terms of cost drivers? >> Yes. That's a great question, by the way. Yeah. In the area -- if you look at our department and look at the things that we do, one of the areas that has the greatest potential to address those low-hanging fruit sort of things, to get more proactive and intervene before there's an emergency, which is very costly, is our community health paramedic program. That also has a component called the host program. And that's a specific area that focuses on the homeless population. One of the problems that we have there is a three-fold issue that we experience amongst that population. One is they don't have a home. They don't have a place to call home. %-@It's very difficult to be healthy and strong when you don't have a home. The other is they have chronic illness. The third is they have some or of substance abuse issue combined with mental health. Using a host approach and the community health approach you can identify them and connect them to the type of service that they need, try to move them out of homelessness and try to get them the care that they need. And in these specific documents, the more detailed ones, there's a story that we provide there of one encounter that we had where we actually moved a person from

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homelessness and a poor health condition to a better condition. So it explains how that would work and how we're moving in that direction. >> I guess I was using the homelessness as an example of that kind of target and was wondering if there are other areas where you get a significant bang for your buck emphasizing a problem. >> That would be the community help program. One of my goals is I would like every person that works in our organization to have a background and training in health care. The reason that is important is because we're going into people's homes. We get to see and can predict oftentimes what their situations are going to be downstream. What I want is for all of our medics to be able to do environmental assessments. If they are going to your home they can observe your lifestyle and what needs you might have. Do you have a good diet? Do you have a safe home? Who do you live with? Is it a healthy environment? And use that information to connect you to the resources that could help you, health care, social, and other types of services. Because that would eliminate emergencies

downstream. And it sounds kind of weird trying to eliminate my job but I think that's the approach we need to take. >> Thank you. You mentioned that growth was a challenge. We are asked every week to approve new developments that add -- potentially add population. How do we currently account for the ams cost of that additional population through the process and are there things we could be learning from elsewhere in the country that would be useful to help meet some of those needs as we move forward, as we're thinking about our land use policies and how they interact with E.M.S. >> Any time there's going to be an annexation, one of the things chief brown does is look at that area and tries to determine what the needs are going to be. Can you talk about that? >> I don't mean only an

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annexation. >> Through the other -- as developments come forward, we are also working with the departments to, if there's a need possibly for a station that maybe that the pud or whoever that might be, would create a station there as part of the development. That's what we're going to be doing, hopefully, with the new campus when it gets redeveloped. And some of the others do we need a station there as part of the improvements they need to make. I know that's done with the fire department in conjunction. I know the mayor talked about different fire stations that the fire departments needed. We have worked with them and identified those same stations and same areas. And some of them are in areas that have been annexed. And hopefully the developer will either donate land, maybe build the facility itself, and then turn it over to the city as a much lower cost. >> Okay. Thank you. And then I just want to say that I'll be particularly interested in the recovery issues that council member kitchen raised but also the sort of retention and training question and just kind of flagging the rest of the presentation the question of the repeat uses of ambulance service. I understand there's a wider framework in which you are required by law to take them anywhere they want to go and that creates cost drivers. And that may be one area where we could look at seeing if we could make any change. >> Council member Houston. >> Thank you. I appreciate the detailed information. I appreciated the overview, but I noticed that you really tried to do a good job about aligning what your services are to some of the things we talked about. And you have some policy issues in here. On E.M.S. A-3, break down of billing service budget. What I'm hearing most of us saying under the policy issues

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that you have identified would be that we could somehow identify if there are ways to assist you to be able to get reimbursed for the services that you give in the home when people say we don't want transfer. That, to me, would be a policy issue that I would be interested in helping you do. So you have some policy issues here that you have identified. And I just didn't have time to review all of those to see where it was that we could tweak that a little bit and bring more revenue in and also provide more opportunities for people. The other thing that I would like to have is -- and I have asked this before, in parts of our city we have boarding homes that up until October have not been regulated or licensed. And so many of those 200 and some homes are in district 1. And it's helpful to see the fiscal impact of when one of those homes call and everybody goes. Because we know who those homes are. We have a record of and how many times. One house last year had 72 calls, all three public safety entities. If we could keep some kind of metrics on those homes. And hopefully we'll be registering them so we won't have as many of them. But that's something I think the community health program paramedics could help with to go to those homes that we have multiple calls on to say what's going on here, how can we help? Because there may be some overlap between what the community health paramedic program does and Austin health department. I'm just not sure. Because they are out and they have case managers that go out. So have we looked to see if there's duplication or overlapping of those two? I

know they have some specific things that they do, but there may be some things that we need to combine or coordinate so that

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we're not duplicating. That's really all I needed to say. >> Other questions before we finish the presentation? Okay. >> May I approach? I have covered most of this information, so I can be fairly brief on this. I was reading over my notes and I've covered everything except one item. And that's the emergency medical services workload. I don't think I mentioned that with the growth that we're experiencing and the growth of the organization in field medics and field operations. That presents a challenge to us to provide all of the support that those individuals need to keep doing their jobs. Areas like having sufficient numbers of instructors in our academy and our continuing education program. Having enough people in our billing program for the number of growing bills that we're having. Providing human resource personnel. We have one need that's something that the city is driving, and that's better compliance with contracts, contract management. We don't have a contract compliance person. And so we have persons doing double and triple duty trying to keep up with that. So those are some of the areas there that we would like to see improved. And a note on the special events is that right now the way that we cover the special events, it's all overtime cost. So that has two impacts. It's the most expensive price that we would pay for covering something. And it also affects fatigue. The more time off that a person has, and we call them back to work to work a special event, the less rest time they have. So that's a challenge for us there. The aging and outgrowth facilities, which is the last item I had is another one I hadn't mentioned. More specifically we're working right now to try to find a new

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warehouse so we can move all our supplies and equipment. That is in an opportune location so we can serve the whole city and county from. We have several stations that we're rapidly outgrowing and really need a lot of repair, but it's really hard to go in and fix an old station. You can only do that so much and then it costs you too much after a while. And we are very crowded, administratively. We have training facilities, and my facilities where I office and have a lot of admin staff, we converted balcony space and things like that. But we're trying our best to keep up with that. Those are things that we see on the horizon. And I'm sure you're going to hear something like that from everyone. There's a couple of areas that I wanted to highlight. Because I think it goes a long way in addressing several of the comments that I have heard. And that's in the slide 11, that last one that's up now. The community health paramedic program has probably been one of the most innovative programs that we have tried. We started developing that program in 2006. We started with one medic looking at five patients who were frequent callers. And we saw a significant impact that when we worked with them more closely their utilization of E.M.S. Dropped. And what it does was it was a hallmark movement for the E.M.S. Organization. Because up until that point I think the outlook of E.M.S. Towards people that were calling a lot was that they were being labeled as abusers of the system. What we did was took a step back from that and said maybe they are not abusers. Maybe they have issues we are not fulfilling and that's why they keep calling us back. They are calling us a lot to give us more chances to get it right. So what we have done now, by building the community health program, we have connected with

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every type of social, medical, and health care resource that we can find in our community. So when we go to somebody and we connect them with a community health paramedic, we need two things. One is we take care of their medical needs and assess them where they are. But the other thing is, we provide advocacy for them. Many of the folks we are dealing with are lacking in a couple of things. One of them is ready access to health care that is equitable. That would be the same as everybody else. We find there is inequities there. And the other is they don't have social capital. They don't have people they can rely on. They don't have people that can back them up, that will advocate or speak for them in some cases, and that have knowledge about how to connect in a health care system. So the community health program now is beginning to spread across the nation. It is what is beginning to be called in the E.M.S. Industry as E.M.S. 3.0. It's a restart for E.M.S. And we're looking at that from a variety of factors. One of them, clearly that we want to provide better health care for our communities. We realize that emergency medical services in most communities is an army waiting to happen. We have people everywhere throughout the community. They are highly skilled, highly trained. They understand health care. And they go to emergencies every day. So we rapidly respond to emergencies. We do very little to proactively visit and get ahead of emergencies. So that's the change that's happening right now. And you're seeing that in our community health paramedic program. I can tell you story after story about how we have connected people to the right resource at the right time so they can get better care than what they would get in an ambulance and emergency department. That's requiring us to rethink what we do. So, for example, right now we're

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testing an alternative transport option. So currently everybody that gets transported by E.M.S. Goes in an ambulance, the most expensive tool we have for health care in the street right now is an ambulance with medical personnel on it. The question we asked was does everyone need to go that way or are there other options? We are testing alternative models for that and we're finding that it's not as easy as we thought it would be. We had to sort through a lot of challenges. And we're getting ready to launch phase two of that right now. But that's the kind of stuff that's going to redesign how we address health care. And we've combined navigation of the very complex health care system with advocacy for our folks, our community. One of the terms that's coming out of this is navcacy, and that's a combination of navigation and advocacy. You put that together and that creates a new social environment that we have never had in the industry before. One of the things that we saw that came out of that that's a significant thing for us is the way we have connected with mental health care into emergency medical services. Many of our calls have psychological or mental health challenges that we need to address. So we connected with mcot. Mcot had been working with the police department for quite a few years and we connected them to them and we hugely increased their ability to respond to cases. We actually housed them in one of our stations. We issued them radios so we could communicate with them. I think beginning today we're going to simultaneously dispatch them when we have a mental health case so that we can reduce their response time to those incidents. What difference it makes? 85% of the people now that we go to for mental health cases are treated and placed and don't

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need to be transported anywhere. That's huge. When you think about the challenge that's presented to a person who is already struggling with their mental health and you displace them to a clinic, they have to adapt there. They get their treatment and then you take them back home and they have to adapt again. This way they get care in place. We think that's a very positive way we're reaching out and touching our community in a different way. And as council member kitchen said, that presents and

opens a whole series of doors for us to look for reimbursement in a different way. Right now we charge the users. We bill individuals. It could be in the future we're working with payers in hospitals and other organizations to close that gap. So that's where our area of greatest opportunity is. At the same time, I don't want to make it seem like E.M.S. Should give up its roots. We have a primary duty, and that's to go to emergencies and save people's lives. We have to keep doing that. At the same time, if we don't grow in these other ways economically, we're going to go extinct. We can't continue to do the business without paying attention of both of those things. I know it's difficult as the leaders in our community for the E.M.S. Chief to say I need more and more and more. But the channels -- challenges are growing and they're not stopping. What we're trying to do is find what are the smart solutions, what are the innovative solutions. What can we do that's different and better than the thing we have done over an over all the time? That requires a huge amount of thought. It requires a willingness to challenge ourselves. I call it disruptive technology. It's when you do things that actually begin to defeat your own purpose but yet improve the total situation. So that's kind of where we're living now. And along with that, the more community education and outreach that we can do, the stronger the community will become.

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We want our community, so does the health department and central health and different providers that do this, we want our community to be strong and healthy. They become less reliant on safety net organizations when that happens. Those are the things that we're working on. And that pretty much wraps it up. >> I would just say thank you so much and I'm really excited. I've known you for a while and I've known that you have that innovative, Progressive approach. And it's really nice to hear you articulate it. Because that is the name of the game and it fits perfectly with your mission. And you're uniquely situated to really help the community with, as you aptly named it earlier, the triple aim. So I look forward to working with you more on that. >> Seeing no further questions, we will -- >> I want ting-- I want to thank you guys. I'm very excited and I know the other directors are too. We want to do a good job for you and I'm happy to go first and appreciate the feedback. >> We appreciate your patience in hearing our discussions about how we want to move forward with regard to the budget sessions. But thank you so very much for putting together this presentation. It was very informative. >> I just want to make a comment. We have had staff upstairs scribing your questions. The budget q&a is open, so we'll do the standard pushout, the written q&a to the extent we can. And we'll look at changes we can make for next week to streamline the process to get you the information that you have asked for and the changes. And we're keeping track of the policy issues that you would like to talk about. And we'll bring those back. Not clear when, but we're

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tracking those and we'll be researching those a little bit more. >> Thank you, city manager. Anybody else? We stand adjourned at 11:57. Thank you so much.