Health System Market Observations and Go-Forward Strategy

Background. The Hospital Perspective.

Hospitals are experiencing similar issues we are experiencing associated with labor, costs and shifting consumer behaviors. Fortunately, this opens the door for pragmatic discussion regarding shared challenges and how we can assist in resolving.

One of the reoccurring messages we are hearing from our hospital partners is an increase in the **length of stay**. A contributing factor is that accepting facilities (SNFs, Nursing Homes, Rehabs) are facing the same challenges as all of healthcare. As a result, the admission windows to these facilities are eliminating evening admissions. This is particularly impactful since the hospital's discharges involving ambulance typically do not occur until after 3pm. Essentially resulting in discharge to these facilities having a narrow window of 2-3 hours. Missing these discharge windows results in an overnight stay.

Throughput challenges are unresolved. In a recent article by the New England Journal of Medicine, it describes how Emergency Departments are the canary in the coal mine for hospitals. One of the important points made by the article was the issue that discharges of in-patients are not occurring before the late afternoon spike of emergency department traffic. It emphasizes that discharges need to occur prior to the spike to allow patients to transition from the ED to the in-patient room and not wait for room availability. Clearly the current ambulance discharge patterns and the ED spike are occurring simultaneously in the late afternoon. Resulting in longer stays in the ED and creating issues such as "wall-time" for EMS crews.

Regarding satisfaction with ambulance services, we are seeing a substantial levels of **dissatisfaction**. Patient transportation is considered a "barrier to discharge". This is universal to the industry and includes hospital owned, EOA providers and private providers (includes GMR companies). We are seeing hospital currently utilizing private providers evaluating opening their own ambulance operations. We are seeing hospital owned operations exploring private provider contracting. And we are seeing hospitals within EOAs, seeking to break the market's exclusivity. These frustrations will trigger change.

Background. The Ambulance Provider Perspective.

Ambulance providers simply are not meeting the service demands for hospitals. Multiple reasons are contributing but four primary drivers are labor shortages, unrealistic service expectations given the current market conditions, revenue is not keeping up with costs, impacting behaviors of the hospitals, and a misalignment of incentives. The reaction from our Operations teams have been extreme caution regarding growth, retraction for existing contracts, or attempts to renegotiate existing agreements.

Labor Shortages is obvious in its impact. Hospitals are contributing to the problem with their attempts to solve their own staffing crisis and recruiting Paramedics and EMT to serve in lower acuity clinical roles. In response to the issue, our operations are placing lower priority on the Non-emergency Hospital transports to protect 911 agreement. Ultimately, this "domino effect" impacts the hospitals operations. Additionally, we are seeing very little appetite for any substantial growth in general ambulance transport services. In fact, we have seen 41 opportunities that have elected to not pursue due to this issue.

Service Expectations are misaligned to the current market. The traditional model used by GMR non-emergency ambulance operations in contracting with Hospitals/ Hospital Systems has the following components.

- On-demand system - The ambulance industry has for decades taken the approach of "you call / we haul". As a result, the service delivery models attempt to overstaff unit hours with accomplish. Essentially a readiness cost impact.
- Response Time requirements – Ambulance response for non-urgent patients is one (1) hour and thirty (30) minutes for patients in the emergency department.
- No subsidy – Most ambulance transport agreements are fully at risk to the provider.
- Emergency Department (ED) transports prioritized – Hospitals will prioritize ED transports ahead of discharge transports. This has a significant impact on service delivery for the discharge patients.

Revenue is not keeping up with costs. Rising costs are swiftly eroding already thin margins. This make the current model unsustainable.

Misaligned incentives are also creating challenges. The hospitals have an "on-demand" mindset. The current market is restricting resources of the ambulance providers resulting in shortages. Applying more pressure to a shortage, does not resolve the shortage. It exacerbates the dissatisfaction. Additionally, there are occasions when the patients fail to meet medical necessity, yet the hospital is insistent on the patient being transported by ambulance.

Impacting behaviors of the hospitals are contributing to the problem. Below are examples of the behaviors.

- Discharges can be planned just like every other service within the hospital, but they are not.
- Hospitals are notorious for discharging all patients in a narrow late afternoon time window. As a result, the ambulance deployment models must create a stacking, overlap to match the demand patterns. This creates a "bell-curve" in the staffing model. The bell curve creates inefficiency, and we are typically seeing UHU in .30 range for the hospital systems.
- Transports are typically "on-demand". Ambulance resources are treated like they are limitless by the hospital. On-demand models require more staffing. Staffing shortages result in unfilled expectations.
- Multiple providers do not improve service, it makes it worse. When ambulance providers are unable to predict the demand, then the supply becomes mismatched. The hospital does not receive preferred service over hospitals that have commitment to a single provider.
- Patients failing to meet medical necessity are resulting in financial impacts on the ambulance providers.

Hospital's Options to Resolving

A. Hospital entering the non-emergency transport business since the industry is unable to meet their needs.
B. Abandoning Preferred Provider Model and moving to multiple providers contracting strategy.
C. Implementing alternative transport solutions i.e., transporting legitimate BLS patients into lower forms of transportation

Recalibrating the IFT Model

De-risking the financial model is complicated. We have seen examples where we have converted a customer to Leased Unit Hour models. Meaning, the purchase Unit hours for exclusive use of the hospital. They are willing to fund this to improve the service delivery. Unfortunately, this strategy has not been completely successful in the service delivery aspect. While we resolve a revenue issue for us, we are still at-risk due to service issues. The reason, it does not address the fundamental issues of staffing shortages and on-demand service.

Any model that we offer to the market must contain increased revenue either through reimbursement of subsidies, decrease cost (less labor), and reduction of risk to the ambulance provider.

Over the past year, we have been developing of such a model. There are three distinct aspects: On-demand for ED and Freestanding ER, Concierge for discharges, and on-demand for Specialty transports (Neo-natal, CCT, Behavioral Health).

On-demand for ED and Freestanding ER (FSER): OPAP builds a demand analysis the returns a 15% to 20% margin. All ambulance resources for these transports are dedicated to the hospitals(s). Essentially this is what they are resourced without a subsidy. If the hospital desires better service than can be delivered with the assigned ambulance resources, the hospital can purchase additional unit hours to augment the capability. Essentially, we shift performance risk to the hospital while maintaining our margins. The ambulances assets for this service are exclusive to the transports designated in the model and not used for other discharges.

Concierge for discharges: Create a more efficient model that improves UHU by 60% and thus reduce the labor require to produce the same transport volume by 40%. This model relies on improved efficiency as the driver. Improve Throughput, Patient Satisfaction and Service Reliability is the objectives of this program.

GMR's **Concierge Discharge Model** will deliver near 100% service reliability for non-emergency discharges, while adapting to the evolving challenges of medical staffing shortages. It is exclusive for discharges and not utilized for ED or FSER transports.

HOW CONCIERGE WORKS

Distribution of Discharges:

- Congregation of discharges to the afternoon, impacts the hospitals efficiency and throughput. With the Concierge model, hospitals will have the ability to schedule discharges several hours or as soon as a day in advance, improving patient throughput
- Improved hospital throughput will occur as bed availability improves throughout the day, while not overly burdening nursing staff with discharges compressed over a few afternoon hours

Financial Cost of service delivery is exceeding realized revenue:

- Our model can reduce or eliminate the need to fully subsidize the ambulance service delivery by the hospital and rely substantially on a fee-for-service arrangement due to cost improvement provided they utilize the Concierge Model.
- Providing ambulance resources that efficiently match supply of ambulance resources to the demand of each day. As an ambulance provider this will impact costs and efficiency of services.

- On-demand transports will have additional fees assessed due to the increased costs related to on-demand. On-demand is subject to availability and has no response compliance metrics. The intention is to align incentives between parties.
- Cancelations which create delays unused Concierge Slots will be assessed fees. The intention is to align incentives between parties.

Discharges from Hospital Floor and ER / FSER are managed independently:

- Ambulance assets for ER & FSER discharges are separately resourced from floor discharges and pledged to service the ER and FSER transports only.
- Ambulance operations have established profitability that is tied to the Unit Hour Utilization (UHU). The ambulance provider will supply ambulance resources to achieve a profitable UHU. If the hospital desires improved response performance greater than the Unit Hours (UH) supplied, the ambulance provider will sell UHs to augment the staffing to achieve the desire response performance. This approach essentially eliminates the responsibility of response time standards imposed in current agreements.
- Ambulance resources committed to the emergency aspect of the model, are matched to the expected volume of discharges per day to always ensure availability for on-demand services.

Technology enables Model:

- The hospital will be able to identify available time slots to schedule discharges based on the preset schedule using our Online Ordering Tool
- Our technology paired with this model improves efficiency, routing the ambulance crew from discharge transport to discharge transport, utilizing our CAD system

Summary of the Key Financial Drivers of the Concierge Model:

- Decrease of the ambulance labor of 40% for in-patient discharges. This typically represents ~65% of all ambulance transports for a hospital. (Impacts labor shortages of ambulance provider)
- Scheduling will increase the efficiency of the ambulances by 40% over current on-demand model (achieving more with less)
- Non-utilized or canceled transports slots are assessed fees.
- Additional Fees for On-Demand responses (not to ED/FSER)
- ED/FSER are staffed to maximum at profitability threshold. Additional Unit Hours are contracted on a Leased Unit Hour methodology. If Client wants better service, then it is purchased via Unit Hours.

Specialty transports (Neo-natal, CCT, Behavioral Health): The traditional models for Specialty transports have worked well and are properly resourced and revenue generated achieves profitability expectations.

Summary

Market conditions have been radically altered since the start of Covid. We are at a crossroads of either adaptation or exit of the underperforming IFT markets. And with the current economics, how long before we experience erosion of the currently performing business units. We know that the customers

are looking for answers and there is a willingness to pay for something that works. But any change must be a major disrupter to how service is currently delivered, improvement in service delivery, and a meaningful improvement in the economics for the ambulance provider. We are at the cusp of launching the technology that will support such a radical transformation. I would hope that the first step before we implement closures, is an evaluation of a different Model. We obviously have nothing to lose if our first option was closure.

Comparative Models

	Traditional IFT Model	Concierge Plus Model
Patient Scheduling		
Emergency Department	On-Demand	On-Demand
Discharge Patient	On-Demand	Scheduled
Specialty Patient	On-Demand	On-Demand
Funding Source		
Emergency Department	FFS	FFS + On-demand Fee + LUH
Discharge Patient	FFS	FFS
On-Demand Fees	N/A	FFS + On-demand Fee
Cancelation / Unused Fees	N/A	Cancel Fee
Specialty Patient	FFS + Subsidy	FFS + LUH
Provider	Preferred Provider	Preferred Provider
Response Requirements		
Emergency Department	20-30 minutes	Based on Client Contracted Unit Hours
Discharge Patient	1 Hour	Level of Effort
On-Demand	1 Hour	Level of Effort
Specialty Patient	20-30 minutes	Based on Client Contracted Unit Hours
Incentives Aligned	No	Yes