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**GLENN COUNTY BOARD OF SUPERVISORS,
ORLAND CITY COUNCIL & WILLOWS CITY COUNCIL
SPECIAL JOINT MEETING
Monday, June 1, 2026 AT 5:30 PM**

**Willows City Hall
201 N. Lassen St.
Willows, CA 95988**

Call to Order – 5:30 PM

- 1) **PLEDGE OF ALLEGIANCE**
- 2) **ROLL CALL**
- 3) **PUBLIC PARTICIPATION**

Members of the Public will be allowed to address only the items listed on the agenda. The law requires that business not appearing on the agenda may not be discussed at a special meeting.

4) **PRESENTATIONS**

- a. **GLENN COUNTY EMERGENCY MEDICAL SERVICES SYSTEM ASSESSMENT** – Chief Nate Monck, Chief Justin Chaney, and Dr. Jared Garrison
Receive a presentation from Healthcare Strategists Senior Consultant Lou Meyer and Principal Bill Bullard regarding the Glenn County Emergency Medical Services System Assessment, including system findings, operational analysis, and potential recommendations related to EMS service delivery within Glenn County. No action will be taken.

5) **ADJOURNMENT**



**County of Glenn
Emergency Medical Services
System Assessment**

DRAFT

May 28, 2026

***In cooperation with
the County of Glenn EMS Stakeholders
& Sierra – Sacramento Valley EMS Agency***

**Developed by
Healthcare Strategists, Inc.
www.healthcarestrategists.com**

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EXECUTIVE SUMMARY

This report presents an independent assessment of the Glenn County (County) Emergency Medical Services (EMS) system, developed in cooperation with the Sierra-Sacramento Valley (S-SV) EMS Agency and system stakeholders. The assessment examined system governance and coordination, emergency medical dispatch (EMD), continuous quality improvement (CQI), first response integration, ambulance deployment, response performance, data integration and reporting, and overall operational and financial sustainability.

Overall conclusion. The County has a strong EMS foundation, including an Accredited Center of Excellence (ACE) accredited secondary public safety answering point (PSAP) using Medical Priority Dispatch System® (MPDS®). Structural issues require system-level action, including consideration for a single countywide ambulance provider to streamline services and improve efficiency.

Key strengths observed

- Coordinated County EMS system overseen by S-SV EMS
- Broad stakeholder network spanning dispatch, first response, ambulance transport, and receiving facilities
- Access to an ACE-accredited secondary PSAP using MPDS for transferred medical calls, which supports standardized call interrogation and consistent pre-arrival instructions
- EMS direction that aligns well with statewide and national priorities (including EMS Agenda 2050) that emphasize integration, reliability, and patient-centered system design.

Primary challenges requiring action

The assessment also identifies several systemwide challenges that require coordinated action.

- Clinical oversight and clinical quality improvement (CQI) participation and reporting are inconsistent across providers, with limited consistency in quality assurance processes and regional quality-forum participation (e.g., REMAC) and variable responsiveness to required reporting
- Glenn County faces ambulance response performance pressures typical of rural environments
- Emphasize the need to define realistic performance expectations by zone and to reduce preventable response-time outliers through deployment, dispatch, and operational improvements
- Fragmented data limits timely system monitoring, transparency, and shared accountability
- Financial sustainability risks persist, including declining transport volume following the Glenn Medical Center closure and limited availability of consistent, audit-ready financial reporting from one provider, complicating planning and subsidy justification

INTRODUCTION

The County sits in the northern Sacramento Valley, where the flat, fertile agricultural plains meet the rising foothills of the Coast Ranges. The Sacramento River forms its eastern boundary, supporting more than half a million acres of farmland that dominate the county's economy. Rice, almonds, prunes, and livestock operations shape both the landscape and daily life, while portions of the Mendocino National Forest extend into the western side, adding rugged terrain and natural diversity. With roughly 1,314 square miles of land and very little water area, the County is defined by its expansive rural character and strong agricultural identity.

Home to just under 33,000 residents, the County remains a small and largely stable rural community. Its population has grown modestly in some years and dipped slightly in others, reflecting the slow changing nature of many agricultural regions. The median age sits in the mid-30s, with a sizable share of both young residents and older adults, and the County seat of Willows serves as its administrative and cultural hub. Overall, the County's demographic profile mirrors its geography: grounded, steady, and shaped by the rhythms of farming and open space.¹

California law requires each County to establish a local EMS program and to create a local EMS agency (LEMSA) to oversee that program; the County has designated S-SV EMS. California LEMSAs exercise the most direct authority over EMS workplaces by planning, enforcing, and granting exclusive operating contracts with EMS provider organizations.

Throughout 2017 and 2018, EMS professionals, stakeholders, and public members shared ideas through collaborative encounters to update the National EMS Advisory (NEMSA) Council's "EMS Agenda for the Future," initially released in 1996. The new vision, "EMS Agenda 2050," aims to unite everyone with a role in EMS around a singular purpose: a people-centered EMS system.² EMS Agenda 2050 provides a framework and vision for the next generation of EMS Advancement. The EMS system of the future includes the following qualities:

- Adaptable & Innovative
- Inherently Safe & Effective
- Integrated & Seamless
- Reliable & Prepared
- Socially Equitable
- Sustainable & Efficient

In this visionary system, EMS professionals must be ready to take on a broader and more influential role in supporting both individual patient health and the overall wellbeing of the communities they serve. Achieving this vision will require intentional, coordinated action from stakeholders across every level of the EMS landscape—individual providers, agencies of all sizes

¹ [glenn-county-presentation-2026-v2-a11y.pdf](#)

² <https://emsagenda2050.org>

and service models, local and federal officials, and national organizations. It also demands bold collaboration with all partners: communities, local volunteers, payers, healthcare systems, social services, public health, and fellow public safety agencies.

A consortium made up of Glenn County, City of Orland and Willows Fire Department requested a comprehensive EMS system assessment to include:

1. Use of Communication systems including practices and configuration
2. Clinical oversight and performance measures
3. Deployment of ambulance response resources
4. Response Time Compliance
5. EMS system financial analysis, including
 - a. Evaluation of incumbents' audited financials
 - b. Payor mix
 - c. Cost containment strategies
6. EMS Agency Overview

Method of Assessment

EMS stakeholders from throughout the County participated in the assessment. All providers were open and engaging in sharing their agencies' demographics, strengths, and opportunities for improvement.

Interviews Completed

- EMS Medical Director
- Emergency Department Managers
- Enloe Health Leadership
- Orland Fire Department Leadership
- S-SV EMS Agency Leadership
- Westside Ambulance Leadership
- Willows Fire Department Leadership

DISCUSSIONS, FINDINGS, AND RECOMMENDATIONS

1. Use of Communications System, including Practices and Configuration

Using dispatch center with emergency medical dispatch (EMD) is important because it provides verified, continuous quality emergency medical dispatch performance, including standardized call interrogation, accurate determinant coding, and consistent pre-arrival instructions (e.g., CPR and childbirth guidance). This helps reduce variability between PSAPs during call transfers, supports faster and safer resource matching (i.e., advanced vs. basic life support [ALS/BLS] ambulance, first responders, and response mode), and strengthens clinical oversight and accountability through routine case review and measurable compliance. In a rural environment such as this County, where a portion of calls involve longer response intervals, high-quality dispatcher-assisted care and reliable triage during the transfer window can meaningfully improve patient safety, outcomes, and public confidence.

Finding: Enloe Medical Center (part of Enloe Health) is under contract with Glenn County to serve as the medical dispatcher center and uses MPDS protocols when handling transfers from primary PSAPs if medical services are required.

Recommendation: The County and S-SV EMS should formalize and require the use of an ACE-accredited secondary PSAP (e.g., Enloe Medical Center, through a written agreement and operational policy that defines roles, expectations, and performance measures for transferred medical calls. At a minimum, the agreement should require continued use of MPDS with dispatcher pre-arrival instructions, specify target transfer and call-processing timeframes, outline data-sharing and quality assurance processes (including regular case review and compliance reporting), and redundancy/contingency procedures to ensure uninterrupted EMD coverage during high volume events, staffing shortages, or technology failures.

Finding: Assembly Bill 645 mandates that by January 1, 2027, public safety agencies providing “911” call processing must offer prearrival instruction to callers requiring medical assistance.

Recommendation: To prepare for implementation of Assembly Bill 645 (AB 645) by January 1, 2027, all County public safety answering points (PSAPs) and partner EMS agencies should develop a coordinated implementation plan to ensure consistent delivery of prearrival medical instructions to callers requiring medical assistance.

At a minimum, the plan should define who provides prearrival instructions for each call type, adopt or standardize an evidence-based EMD protocol set (e.g., MPDS) under clear medical direction, and establish QA/QI processes for call review, coaching, and continuous improvement. The plan should also confirm staffing, training, and certification/recertification requirements for call takers, update CAD/phone workflows and SOPs to minimize transfer delays so instructions begin as early as possible, and set measurable performance targets (e.g., percentage of eligible calls receiving instructions, time-to-first instruction, protocol compliance) with regular reporting. Finally, agencies should align documentation, public communications, and risk-management/legal review so implementation is consistent across all dispatch centers.

2. Clinical Oversight and Performance

EMS protocols refer to the standardized clinical scope, procedures, and policies for delivering EMS care. These documents are written and promulgated by S-SV EMS under the direct authority of the EMS Medical Director as established by California Health & Safety Code § 1797.202. EMS clinical oversight and performance refer to the processes and systems in place to ensure that EMS providers deliver high-quality patient care and meet established performance standards, as detailed in EMS protocols, procedures, and policies.

Clinical oversight involves monitoring and evaluating EMS providers clinical performance, including adherence to protocols, guidelines, and best practices. This oversight ensures that EMS providers are delivering safe and effective care to patients in emergencies. It may involve reviewing patient care reports, conducting case reviews, and providing feedback and education to EMS providers.

Performance measurement and improvement are integral components of EMS clinical oversight. Performance metrics, such as response times, patient outcomes, and patient satisfaction, are regularly monitored to assess the effectiveness and efficiency of EMS services. This data is used to identify areas for improvement and implement strategies to enhance overall performance.

EMS clinical oversight and performance also involve CQI initiatives. They aim to enhance the quality and safety of EMS care by continually assessing, analyzing, and improving processes and practices. Quality improvement activities may include regular audits, training and education programs, and the implementation of evidence-based practices.

By implementing effective clinical oversight and performance management strategies, EMS agencies can ensure their providers deliver the highest standard of care to patients in emergencies. Ultimately, this process leads to improved patient outcomes and increased public trust in the EMS system.

Finding: Clinical/quality oversight is inconsistent, with reported weak or reactionary quality improvement processes, limited participation in regional quality forums (e.g., REMAC), and varying responsiveness to required reporting (including multi-casualty incident [MCI] feedback forms), particularly as it relates to Westside Ambulance Service.

Recommendation: Establish and enforce minimum CQI and reporting requirements across providers (including defined CQI roles, participation expectations for regional forums such as REMAC, and timely submission standards for required reports like MCI feedback forms), with monitoring and remedies for non-compliance.

3. Deployment of Ambulance Response and Transport Resources

Deployed ALS Ambulances by Provider Agency		
Provider	Minimum	Maximum
Enloe	1	1
Westside Ambulance	1	2

Ambulance Response Times

Response times are the most visible and considerable influence on EMS system design. How long the ambulance takes to arrive is part of the patient experience and increases the first responder’s on-scene commitment and overall task time. It is also the most substantial factor in the cost of designing an EMS system. Roughly 80% of ambulance expenses are related to field staffing. Shorter response times require more unit (i.e., ambulance) hours and employees.

While response time is a visible and important EMS performance metric, it is not the only measure of patient care quality. Patient outcomes are also influenced by call triage accuracy, dispatcher-assisted instructions, appropriate resource selection, clinical care on scene, transport decision-making, and coordination with receiving facilities. That said, prolonged response times can negatively affect outcomes in time-sensitive emergencies where minutes matter, including cardiac arrest, ST-elevation myocardial infarction (STEMI), and major trauma.

Finding: Prolonged ambulance response times, as seen within the Willows response time compliance data, could create a cascading system impact by delaying availability for other emergencies and degrading overall EMS performance.

Recommendation: Implement system status management practices to reduce outliers and protect coverage: enforce closest-unit dispatch, use predefined move-up/coverage plans when units are committed, and monitor dispatch-to-enroute/response-time performance with routine CQI review and corrective action.

Response Time Compliance Findings

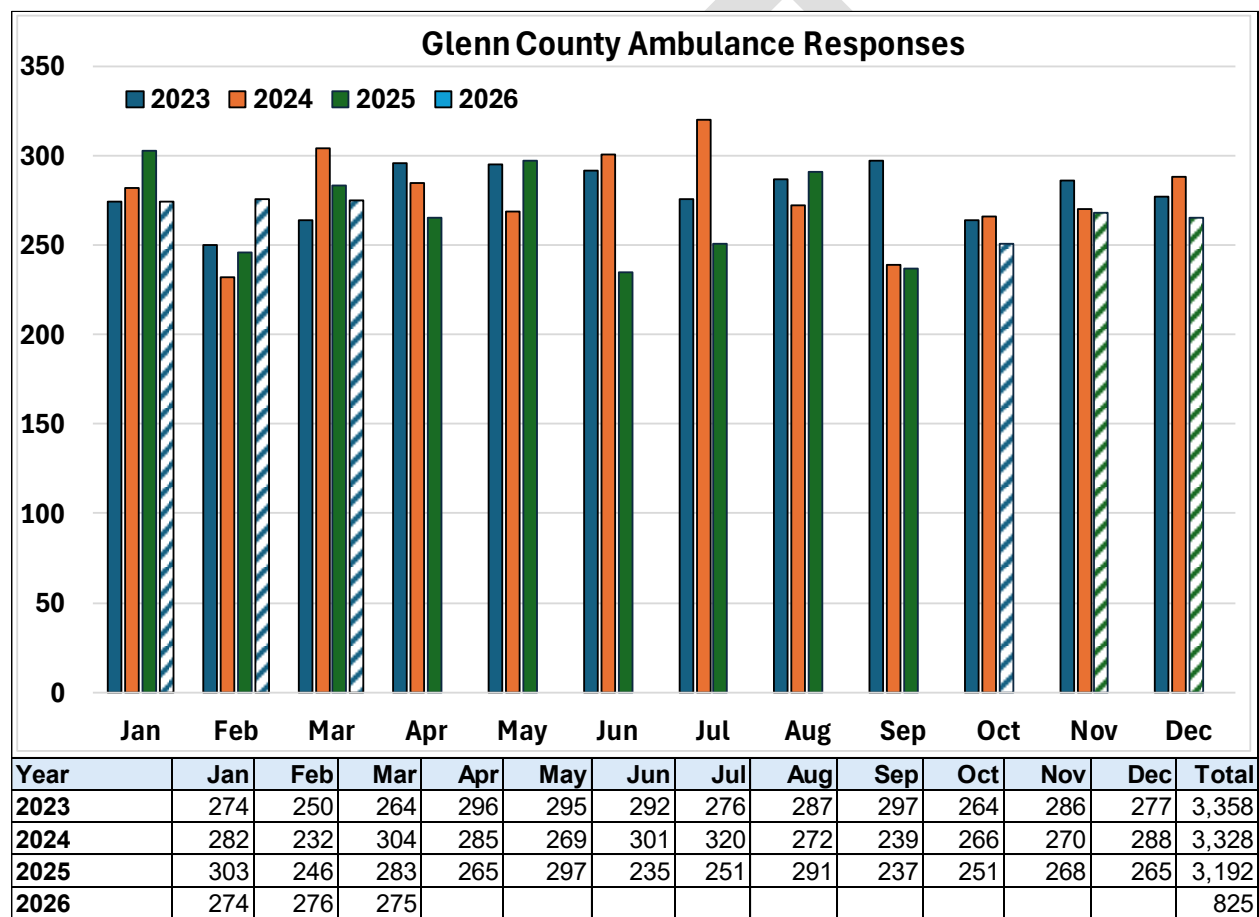
Response Time Compliance (2025 – Feb 2026)														
Zone/ Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Orland/ Westside	87%	91%	90%	97%	92%	100%	79%	97%	91%	95%	100%	97%	91%	100%
Willows/ Enloe	96%	95%	96%	95%	88%	100%	89%	94%	62%	89%	75%	70%	80%	57%
County	100%	100%	100%	92%	98%	100%	100%	100%	100%	100%	97%	100%	100%	100%

Finding: Based on the interviews and reviewing the performance difference gap between zones per month, the declining response time compliance in Willows was likely caused by the improper use of the 12-hour unit, as calls were being rotated rather than using the closest unit.

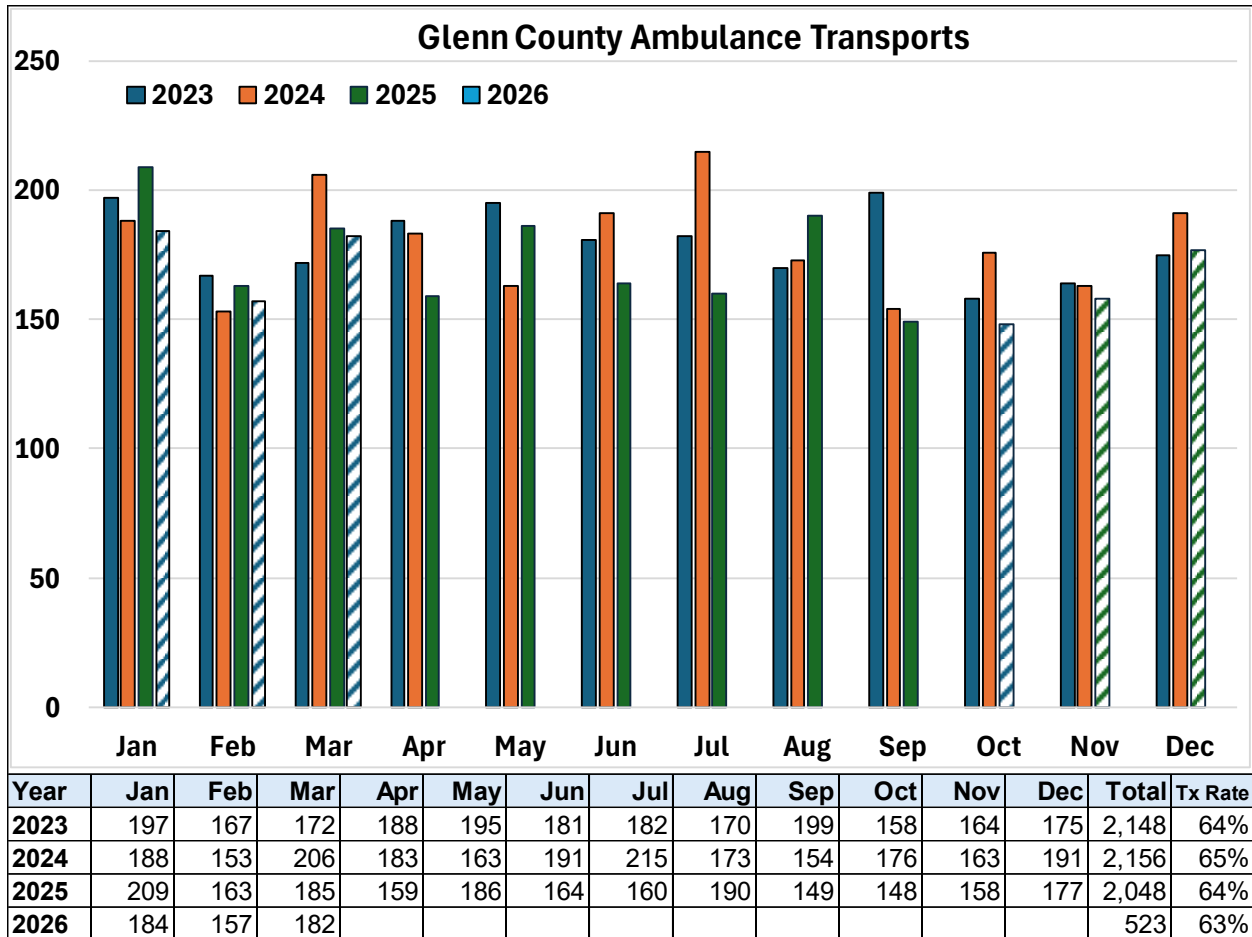
Recommendation: Implement closest-unit dispatch for Willows-zone calls and configure computer-aided dispatch/automatic vehicle location (CAD/AVL) so the 12-hour car is a designated coverage unit (i.e., not on rotation). Establish written posting/coverage rules, limit rotation to documented exceptions (e.g., equidistant units), add an escalation trigger when no unit is enroute within a defined time, and conduct CQI audits of dispatch-to-enroute times and unit selection with monthly reporting to S-SV EMS.

Call Volume

With the closure of Glenn County Medical Center in October 2025, all transports are required to leave the County. This eliminates the need for inter-facility transports (IFT) from within this EMS system. Providers predicted a drop in monthly call volume to the loss of IFT.



Finding: Reviewing the monthly call volume following the hospital closure did not identify the anticipated decrease in call volume. The six months of available data indicate a negligible change in call volume. Forecasting 2026 data shows 3,300 calls – a 1-2% decrease when compared to 2023 or 2024 and an increase of 3% over 2025.



The transport volume was also reviewed for trends. Like responses, ambulance providers are transporting close to the same number of patients per month. There appears to be a 3% decline since 2023 or 2024, and a 2% increase over 2025 when projecting the first quarter of 2026. The transport rate appears stable at 63% for 2026 year-to-date, down 1-2% from the prior three years. This should be monitored to ensure residents are not using 911 as a triage tool for whether they are having an emergency since the loss of the convenient local hospital.

Recommendation: While response and transport volume do not show a significant or immediate impact, both metrics should be tracked monthly for future impacts. Even without a change in call volume, each transport takes longer to reach the hospital and a reciprocal time to return to the County. This increases the time-on-task for each provider; reducing ambulance availability.

As additional data becomes available (e.g., 12 months since hospital closure), the system may want to study how many times three or more concurrent calls occurred. This analysis would determine the return on investment for the 12-hour unit and whether it is prudent to continue to subsidize it.

4. EMS System Financial Analysis

The following findings and recommendations are intended to support improved financial clarity, operational sustainability, and stakeholder confidence.

Two ambulance providers service the County currently. Enloe and Westside provided financial statements for 2023-2025 (see [Attachments A](#) and [B](#)). Each provider supplied payor mix data for the periods reported (see [Attachment C](#)).

Both organizations generate revenue through fee-for-service billings to Medicare, Medi-Cal, private insurers, and patients. They also offer community membership programs that generate revenue.

Year	2023		2024		2025	
	Westside	Enloe	Westside	Enloe	Westside	Enloe
Transports	1,111	999	1,097	1,012	1,202	862
Net patient revenue	\$1,078,999	\$781,380	\$1,026,145	\$888,514	\$1,222,773	958,934
Net patient revenue per trip	\$ 971	\$ 782	\$ 935	\$ 878	\$ 1,017	\$ 1,112
Expenses	1,191,046	940,921	1,181,149	989,801	1,702,950	944,435
Expenses per trip	\$ 1,072	\$ 942	\$ 1,077	\$ 978	\$ 1,417	\$ 1,096
Deficit	(112,047)	(159,541)	(155,004)	(101,287)	(480,177)	14,499

Enloe (Willows Zone)

Enloe Health provided financial statements for the periods of 2023 through 2025 (see [Attachment A](#)) as well as payor mix data for the same years. Enloe generates revenue through fee-for-service billings to Medicare, Medicaid, private insurers, and patients. It is breaking even currently.

Transport volume began declining in 2025 and dropped further in 2026 after Glenn Medical Center closed in October 2025. Expenses remained flat or increased slightly in the years reported. Enloe projects 2026 revenues will decline 29% and expenses will increase 8%.

Westside (Orland Zone)

In December 2024, Westside was asked to add a 12-hour unit to improve ambulance coverage and decrease response times. The comparison below effectively shows before and after the addition of the new ambulance. 2024 includes one month of the new unit and 2025 reflects a full year. In 2025, Westside transports increased by 99, expenses increased \$470,000, and net revenue increased by \$143,000 compared to 2024. Subsidy in 2025 includes both the 24-hour unit and the 12-hour unit.

Westside Financial Comparison				
Provider	2024	Per Trip	2025	Per Trip
Transports	1,103		1,202	
Net Patient Revenue	\$ 1,079,438	\$ 979	\$ 1,222,773	\$ 1,017
Expenses				
Crew Wages	659,295	598	952,344	792
Other Wages	220,522	200	278,052	231
Employee Benefits and Relations	74,917	68	109,175	91
Professional Services	38,657	35	47,992	40
Supplies	54,680	50	118,174	98
Purchased Services	-		-	
Insurance, Gov. Fees & Licenses	79,902	72	81,257	68
Property and Utilities	41,572	38	51,696	43
Vehicles & Fuel	41,903	38	52,234	43
Bank & Refund	16,832	15	11,681	10
Indirect Support Services	-	-	-	-
Other Expenses	5,122	5	345	0
Total Expenses	1,233,402	1,118	1,702,950	1,417
Patient Revenue less Expense	(153,964)	(140)	(480,177)	(399)
<i>Subsidy</i>	<i>204,000</i>		<i>643,052</i>	
Profit/(Loss)	50,036	45	162,875	136

Notes

1. Subsidy is provided by Glenn County (12-hour unit) and City of Orland (both units)
2. 2024 subsidy for 24-hour unit only (the 12-hour unit was added in December 2024)
3. 2025 subsidy covers 12 and 24-hour units; December subsidy amount estimated based on prior months

Finding: The Westside Manager provided multiple sets of financials stating in the most recent submission that, “Upon further review, we acknowledged that earlier reports did not fully represent our financial position.” The latest financial statements (see Attachment B) were reviewed and it was noted that revenue items did not tie to the summary report. The cost of goods sold section contains items that should be a reduction in revenue (e.g., Medicaid and Medi-Cal write-offs) that must have been deducted in the income section. The detail shows gross and net losses in the multiple millions, which is not accurate.

Recommendation: Since Westside is reliant on government subsidies, it should have an independent governmental audit of its financial statements and underlying accounting records to establish an audit-ready baseline and a reliable financial record for oversight purposes. The audit scope should, at minimum, reconcile reported revenue to billing and deposits, validate contractual adjustments and write-offs, confirm cost of goods sold classifications, and reconcile cash, accounts receivable, and key balance sheet accounts. The audit report should identify material weaknesses and required corrective actions, and produce standardized, complete financial statements and supporting schedules for the Westside Board, City of Orland, and S-SV EMS. Pending completion of the audit, require quarterly submission of system generated financial reports with supporting schedules and source documentation in a format acceptable to the County and City of Orland.

Finding: The Westside Manager is carrying a broad set of responsibilities (i.e., accounts receivable [AR], human resources [HR], logistics, non-profit transition, general operations) and constantly working 10-hour days, with some assistance from a Billing Clerk and Chief Paramedic who is assigned to an ambulance.

Recommendation: Stabilize roles and delegate responsibilities to reduce key-person burnout risk. Define and document core processes (e.g., monthly close, AR, payroll, maintenance tracking, reporting package) with step-by-step procedures and named backups.

Finding: QuickBooks has had “many hands,” causing reconciliation and reporting to be difficult, with key figures requiring manual entry (e.g., revenue inputs). This approach increases error risk and reduces auditability.

Recommendation: Address QuickBooks governance and data integrity by limiting access to trained users, implementing role-based permissions, changing control for posting, editing, and voiding transactions, creating vendors/items. Complete a one-time cleanup and reconciliation (e.g., bank, AR, accounts payable, payroll clearing, revenue accounts) with documented adjustments and approvals and engage a CPA or QuickBooks specialist to support configuration, training, and establishment of a standardized close process.

Finding: Accounts receivable and revenue tracking are fragmented as the separation of billing systems and non-integrated revenue feeds complicate AR and revenue reporting which require manual workarounds.

Recommendation: Integrate or standardize revenue and billing inputs by mapping billing system outputs to a standardized revenue recognition and deposit process, reducing manual entries through import templates or consistent monthly journal entries with supporting reports, and completing a monthly reconciliation of call volume and transport counts to billed runs and cash receipts to identify leakage and timing differences.

Finding: The Westside Board, County, and City of Orland should have clear documentation to support ongoing subsidies from the taxpayers; reviewers expressed difficulty validating data and concerns about the integrity of manual reports.

Recommendation: Formalize board reporting and subsidy documentation. Implement a standardized monthly (or quarterly) reporting package: P&L vs budget, balance sheet, cash summary, AR aging, call volume metrics, and key variances with explanations.

Finding: Current expenditure and staffing levels appear disproportionate to reviewed call volume, indicating potential misalignment between resources deployment and service demand.

Recommendation: Because call volume is low but the area to cover is large, staffing costs remain high. As a result, an ongoing subsidy is necessary to cover the cost gap.

Provider Financial Comparison, 2025					
Provider	Westside	Per Trip	Enloe	Per Trip	Combined
Transports	1,202		862		2,064
Net Patient Revenue	\$1,222,773	\$1,017	\$ 958,934	\$1,112	\$2,181,707
Expenses					
Wages	1,230,396	1,024	526,107	610	1,756,503
Employee Benefits and Relations	109,175	91	266,050	309	375,225
Professional Services	47,992	40	41,154	48	89,146
Supplies	118,174	98	22,585	26	140,759
Purchased Services			28,025		28,025
Insurance, Gov. Fees & Licenses	81,257	68	11,970	14	93,227
Property and Utilities	51,696	43	-	-	51,696
Vehicles & Fuel	52,234	43	-	-	52,234
Bank & Refund	11,681	10	-	-	11,681
Indirect Support Services			48,419	56	48,419
Other Expenses	345	0	125	0	470
Total Expenses	1,702,950	1,417	944,435	1,096	2,647,385
Revenue less Expense	(480,177)	(399)	14,499	17	(465,678)

Finding: When comparing the 2025 financial data for the two providers, there are some definite differences. The Westside supply costs are five times greater than Enloe, with only 40 percent more calls. During the interviews, Westside shared that Enloe had offered to provide supplies using their buying power but has not taken advantage of it. Due to the size of Enloe Health, its insurance expense is significantly less than Westside. The latter also has substantial bank expenses for the organization’s size. All these factors combine to produce expenses per trip of \$1,417 for Westside versus \$1,096 with Enloe; a difference of \$379 (29%) per trip.

Recommendation: There are immediate steps Westside can implement to reduce costs. It should consider accepting Enloe Health’s offer to reduce supply costs. Westside could also benefit by researching new insurance carriers. Bank fees should be minimal, close to zero. Any expense savings is a direct benefit to the taxpayers in the County and the City of Orland.

Finding: The current two-provider model in the County is inefficient and not cost effective. It creates duplicative costs that are currently being funded by significant taxpayer subsidy. Moving to a single provider would reduce overhead expenses and possibly lead to cost savings in other areas. A rough estimate is a reduction of \$220,000 in subsidy needs. If the ambulance service was provided by a public provider, it could increase net revenue and potentially eliminate the need for a subsidy.

Recommendation: Consider a single private provider or public provider(s). The proforma using 2025 data demonstrates that it would be less expensive with a single private provider. Should there be interest in a public provider, there is a significant increase in revenue.

Proforma Models using 2025 Data			
	Current Providers	Single Provider	Public Provider(s)
Transports (2025)	2,064	2,064	2,064
Net Patient Revenue	\$ 2,041,342	\$ 1,961,342	\$ 1,961,342
Other Revenue			
Private GEMT (QAF)	\$ 140,365	\$ 140,365	\$ -
Public GEMT2	-	-	820,667
Other Revenue (Standby, etc)		30,000	30,000
Membership Fees		50,000	50,000
Total Revenue	\$ 2,181,707	\$ 2,181,707	\$ 2,862,010
Direct Expenses			
Crew Wages	\$ 1,478,451	\$ 1,478,451	\$ 1,478,451
Non-Crew Wages	278,052	178,052	103,052
Employee Benefits ³	375,225	353,863	337,841
Professional/Purchased Services	117,171	117,171	117,171
Indirect Support Services	48,419	48,419	48,419
Supplies	140,759	54,078	54,078
Vehicle Operating Expense	52,234	52,234	52,234
Insurance, Gov. Fees & Licenses	32,562	20,000	15,000
QAF and GEMT Fees	60,665	60,665	385,714
Property and Utilities	51,696	51,696	51,696
Other (uniforms, licenses, training, etc.)	12,151	12,151	12,151
Total Direct Expense	\$ 2,647,385	\$ 2,426,780	\$ 2,655,807
Revenue Less Expenses	\$ (465,678)	\$ (245,073)	\$ 206,202

Notes

1 uses actual 2025 financial statements

2 GEMT is not a guaranteed, long-term revenue stream, NO EMS system should be built assuming it is permanent

3 Employee Benefits would be greater for a public provider, unless part of an alliance model with a private provider

5. EMS Agency Overview

S-SV EMS is responsible to “plan, implement, and evaluate” the EMS system under Division 2.5 of the California H&SC. S-SV EMS administers agreements, operating permits, and designations. A large part of fulfilling this role consists of collecting and evaluating data for system improvement.

Finding: S-SV EMS is well positioned to sustain that momentum by setting clear performance expectations, consistent quality oversight, and transparent reporting.

Recommendation: S-SV EMS should continue its work in strengthening systemwide integration through standardized communications, joint training, and data-driven CQI. It should prioritize cross-agency coordination (e.g., dispatch, field providers, base hospitals, receiving facilities) and modernize data systems to enable routine multidisciplinary case review, timely feedback, and consistent protocol adherence.

DRAFT

6. Next Steps

The County should strongly consider a single provider to reduce expenses, eliminate duplication, and create a more efficient EMS system. The estimated cost savings are \$100,000. If the County were to consider a public provider, it could take advantage of the Medi-Cal Public Ground Emergency Medical Transport (GEMT) Program supplemental funding. Based on estimates provided by EMS-MC, a leading billing company, the private to public GEMT increase is \$446,520 (net increase). This could create a slightly profitable EMS system at the current operations staffing level.

However, there is a substantial caveat related to GEMT funding. The federal government has been investigating and auditing GEMT programs in other states; Texas saw a decrease in its funding last year. GEMT is likely to decline in future years. The County (and cities) should plan to subsidize the long-term needs of the EMS system or adjust the future ambulance staffing level based on available funding.

While GEMT exists, it can defer using local dollars to pay for ambulance service.

It is possible through a public-private partnership (often referred to as an Alliance Model) to have a public agency as the provider of record for billing that contracts with a private ambulance company to provide the ambulance service. This model exists in Contra Costa, Sonoma, and San Joaquin counties.

Projected Proforma Models for 2026			
	Current Providers	Single Provider	Public Provider(s)
Transports, Estimated (2026)	1,900	1,900	1,900
Net Patient Revenue	\$ 1,915,200	\$ 1,835,200	\$ 1,930,200
Other Revenue			
Private GEMT (QAF)	\$ 129,000	\$ 129,000	\$ -
Public GEMT ¹	\$ -	\$ -	\$ 842,490
Other Revenue (Standby, etc)		\$ 30,000	\$ 30,000
Membership Fees		50,000	50,000
Total Revenue	\$ 2,044,200	\$ 2,044,200	\$ 2,852,690
Direct Expenses			
Crew Wages	\$ 1,522,805	\$ 1,522,805	\$ 1,522,805
Non Crew Wages	106,144	\$ 106,144	\$ 106,144
Employee Benefits ²	347,977	347,977	347,977
Professional/Purchased Services	117,171	117,171	117,171
Indirect Support Services	48,419	48,419	48,419
Supplies	129,575	49,781	49,781
Vehicle Operating Expense	48,084	48,084	48,084
Insurance, Gov. Fees & Licenses	37,382	20,000	15,000
QAF and GEMT Fees	55,845	55,845	395,970
Property and Utilities	51,696	51,696	51,696
Other (uniforms, licenses, training, etc.)	12,151	12,151	12,151
Total Direct Expense	\$ 2,477,247	\$ 2,380,071	\$ 2,715,197
Revenue Less Expenses	\$ (433,047)	\$ (335,871)	\$ 137,493

Notes

¹ GEMT is not a guaranteed, long-term revenue stream, NO EMS system should be built assuming it is permanent. 2026 program has not been approved as of 4/7/2026

² Employee Benefits would be greater for a public provider, unless part of an alliance model with a private provider
Reduced 2025 patient revenue, GEMT revenue, supplies, vehicle operating expenses by 8.9% due to drop in call volume

CONCLUSION

This EMS system assessment finds that Glenn County has a dedicated EMS workforce and strong foundational capabilities, including an accredited dispatch center. These strengths create a solid base to build a more integrated, resilient, and patient-centered EMS system.

However, the assessment also identified systemwide issues with response-time performance, labor-intensive CQI, fragmented data, and limited contractual accountability that require coordinated action, including the use of a single ambulance provider. If not addressed, these issues increase risk to patient outcomes, provider safety, financial sustainability, and public trust.

The recommendations in this report provide an actionable roadmap:

1. Move to a single ambulance provider
2. Consider a public provider or Alliance Model to access GEMT funding
3. Modernize data and CQI infrastructure
4. Optimize deployment and tiered response
5. Integrate behavioral health crisis response
6. Prepare for emerging models (e.g., community paramedicine, alternate destinations)

Implemented together, these steps will improve care, strengthen accountability, and support long-term system sustainability.

ATTACHMENTS

DRAFT

Attachment A: Enloe Health Financial Statements

ENLOE HEALTH			
WILLOWS AMBULANCE ANALYSIS			
For The Twelve (12) Months Ending June 30, 2024.			
Year	2022	2023	2024
Transports	1,041	999	1,012
Avg. Daily Transports	2.9	2.7	2.8
Worked FTE	8.5	8.5	8.3
Total FTE	9.2	9.1	9.2

Net Patient Revenue¹	\$ 832,052	\$ 781,380	\$ 888,514
EXPENSES			
Salaries and Wages	\$ 502,779	\$ 467,999	\$ 527,844
Employee Benefits	246,362	231,660	262,866
Dispatch Services	107,483	96,896	55,201
Supplies	44,713	48,323	41,600
Purchased Services	19,901	35,948	33,503
Vehicle Insurance & Registration	10,193	6,917	41,600
Other Expenses ²	125	280	253
Total Direct Expense	\$ 931,555	\$ 888,023	\$ 932,888
Contribution Margin	\$ (99,503)	\$ (106,643)	\$ (44,374)
Contribution Margin Percentage	-12.0%	-13.6%	-5.0%
Indirect Support Services ³	\$ 51,311	\$ 52,898	\$ 56,913
Net Contribution Margin	\$ (150,814)	\$ (159,527)	\$ (101,287)
Net Contribution Margin Percentage	-18.1%	-20.4%	-11.4%
CASE MIX⁴			
Medicare	55.9%	52.3%	55.6%
Medi-Cal Trad	4.6%	2.8%	3.0%
Medi-Cal Mgd	21.3%	21.2%	21.5%
Blue Cross	4.4%	5.9%	4.4%
Blue Shield	2.8%	2.6%	2.3%
Self-Pay	7.1%	11.7%	8.5%
Other	4.0%	3.6%	4.7%
TOTAL	100%	100%	100%

ENLOE HEALTH

WILLOWS AMBULANCE ANALYSIS

For The Twelve (12) Months Ending June 30, 2025.



NOTES OF FINANCIAL DATA

¹Net Revenue is the total payments Enloe

²Other Expenses include Education and T

³Indirect Support Services include an alloc coding, and IT.

⁴The Case Mix is the percent of transport Supplies expense restocking is being done

	2023 (12 months)	2024 (12 months)	2025 (12 months)
Transports	999	1,012	862
Avg. Daily Transports	2.7	2.8	2.4
Worked FTE	8.5	8.3	8.2
Total FTE	9.1	9.2	8.8
Net Patient Revenue¹	\$ 781,380	\$ 888,514	\$ 958,934
EXPENSES			
Salaries and Wages	\$ 467,999	\$ 527,844	\$ 526,107
Employee Benefits	231,660	262,866	266,050
Dispatch Services	96,896	55,201	41,154
Supplies	48,323	41,600	22,585
Purchased Services	35,948	33,503	28,025
Vehicle Insurance & Registration	6,917	11,621	11,970
Other Expenses ²	280	253	125
Total Direct Expense	\$ 888,023	\$ 932,888	\$ 896,015
Contribution Margin	\$ (106,643)	\$ (44,374)	\$ 62,919
Contribution Margin Percentage	-13.6%	-5.0%	6.6%
Indirect Support Services ³	\$ 52,898	\$ 56,913	\$ 48,419
Net Contribution Margin	\$ (159,527)	\$ (101,287)	\$ 14,501
Net Contribution Margin Percentage	-20.4%	-11.4%	1.5%

CASE MIX ⁴	2023	2024	2025
Medicare	52.3%	55.6%	51.5%
Medi-Cal Trad	2.8%	3.0%	1.9%
Medi-Cal Mgd	21.2%	21.5%	28.9%
Blue Cross	5.9%	4.4%	3.5%
Blue Shield	2.6%	2.3%	4.1%
Self-Pay	11.7%	8.5%	5.6%
Other	3.6%	4.7%	4.6%
TOTAL	100%	100%	100%

Attachment B: Westside Ambulance Financial Statements

1:17PM	Westside Ambulance				
03/25/26	Profit & Loss by Class				
Accrual Basis	January through December 2024				
	12H Ambulance	24H Ambulance	Clerical	Unclassified	TOTAL
Ordinary Income/Expense					
Income					
11500 • Account Receivable 12-HR	0.00	0.00	0.00	0.00	0.00
31500 • Reimbursement	34,416.38	0.00	0.00	0.00	34,416.38
40000 • M.e.dJca T.ransport Inc.o.me	3,500.99	1,075,937.25	0.00	0.00	1,079,438.43
40200 • Membership dues	0.00	6,215.00	0.00	0.00	6,215.00
40300 • Other Income	0.00	13,377.25	0.00	0.00	13,377.25
40400 • Collections Income	0.00	3,871.67	0.00	0.00	3,871.67
41000 • Interest income	0.00	3,924.54	0.00	0.00	3,924.54
Total Income	37,917.37	1,103,325.90	0.00	0.00	1,141,243.27
Cost of Goods Sold					
50000 • Hardship Write-Off	0.00	9,469.07	0.00	0.00	9,469.07
50002 • Insurance Adjustment	0.00	13,706.56	0.00	0.00	13,706.56
50003 • Medicare Write-off	27,269.08	2,684,802.32	0.00	0.00	2,712,071.40
50004 • Medi.Cal Write-off	597.51	1,909,660.14	0.00	0.00	1,910,257.65
50005 • Member Discounts	0.00	552.37	0.00	0.00	552.37
50006 • Write-offs-Workfeps Comp	0.00	29,470.35	0.00	0.00	29,470.35
50007 • Refunds	0.00	-9,905.51	0.00	0.00	-9,905.51
50008 • Bad Debt Write-off	0.00	86,370.00	0.00	0.00	86,370.00
50009 • Write Off Military	187.77	25,559.83	0.00	0.00	25,747.60
50010 • Write Off • Collection Expense	0.00	136,011.81	0.00	0.00	136,011.81
50011 • Write Off • Deceased	0.00	455.90	0.00	0.00	455.90
50012 • Returned Checks	0.00	802.25	0.00	0.00	802.25
50016 • AB 7 • 6 Adjutment	0.00	21,380.98	0.00	0.00	21,380.98
Total COGS	28,054.36	4,908,336.07	0.00	0.00	4,936,390.43
Gross Profit	9,863.01	-3,805,010.17	0.00	0.00	-3,795,147.16
Expense					
50098 • Employee Relations	0.00	2,587.65	0.00	0.00	2,587.65
56201 • Purchases. Medical supplies	104.51	40,504.24	0.00	0.00	40,608.75
60000 • Accrued Payroll Taxes	2,488.02	56,264.05	11,889.02	0.00	70,641.09
60010 • Advertising	0.00	876.23	0.00	0.00	876.23
60099 • Meals & Entertainment	0.00	1,688.54	0.00	0.00	1,688.54
60100 • Charitable Contributions	0.00	30.00	0.00	0.00	30.00
60200 • Payroll Expenses	0.00	-1,280.52	0.00	0.00	-1,280.52
60300 • Miscellaneous Expense	0.00	4,994.74	0.00	0.00	4,994.74
60600 • Computer Expenses	1,089.24	6,467.88	0.00	0.00	7,557.12
61000 • Dispatch Svs	0.00	18,000.00	0.00	0.00	18,000.00
61111 • Bank Service Charge	0.00	4,061.98	0.00	0.00	4,061.98
61300 • Dues & Subscriptions	0.00	3,793.85	0.00	0.00	3,793.85
61400 • Fuel	114.22	27,732.42	0.00	0.00	27,846.64
61510 • Refund Expense	0.00	12,770.19	0.00	0.00	12,770.19
61600 • Vehicle Licenses • Prog Srv	0.00	2,200.00	0.00	0.00	2,200.00
61601 • Govt Fees & Licenses	0.00	41,649.53	0.00	0.00	41,649.53
61900 • Insurance	0.00	38,252.04	0.00	0.00	38,252.04
62100 • Insurance. Health • Mgmt	0.00	81,289.12	-2,269.41	0.00	79,019.71
62200 • Legal and Accounting	0.00	1,525.00	0.00	0.00	1,525.00
62600 • Office Supplies	45.03	4,460.78	0.00	0.00	4,505.81
62610 • Rent 612 4th Street	9,600.00	0.00	0.00	0.00	9,600.00
63000 • Postage	0.00	1,534.66	0.00	0.00	1,534.66
63200 • Property Taxes	0.00	2,276.70	0.00	0.00	2,276.70
63601 • Repair & Main/Crew Qtrs	848.76	4,823.18	0.00	0.00	5,671.94
63602 • Repair & Main/Equip, Furn	1,366.01	1,450.11	0.00	0.00	2,816.12
63603 • Repair & Main/Med Equip	0.00	2,551.21	0.00	0.00	2,551.21
63604 • Repair & Main/Office Bldg	0.00	171.25	0.00	0.00	171.25
63606 • Repair & MainVehicle	0.00	6,970.62	0.00	0.00	6,970.62
63607 • WS 1 (2016) Vehicle Maintenance	0.00	2,934.85	0.00	0.00	2,934.85
63608 • WS 2 (2019) Vehicle Maintenance	0.00	0.00	0.00	0.00	0.00
63609 • WS 3 Vehicle Maintenance	1,950.70	0.00	0.00	0.00	1,950.70
Total 63606 • Repair & MainVehicle	1,950.70	9,905.47	0.00	0.00	11,856.17
61000 • Telephone	1,189.98	10,546.38	0.00	0.00	11,696.32
64100 • Small Equipment	3,001.24	1,691.96	0.00	0.00	4,693.20
64200 • Training Expense	0.00	1,366.75	0.00	0.00	1,366.75
64400 • Uniforms	1,560.45	1,778.38	0.00	0.00	3,338.83
64800 • Utilities	0.00	12,327.12	0.00	0.00	12,327.12
65000 • Wages-Ambulance	3,567.80	632,351.74	0.00	0.00	635,919.34
65001 • 12-Hour Ambulance Wages	17,184.05	1,192.43	0.00	0.00	23,376.48
65100 • Wages-Office	0.00	0.00	142,784.37	0.00	142,784.37
65110 • Mileage for Reimbursement	0.00	0.00	93.60	0.00	93.60
67000 • Depreciation Expense	0.00	35,867.00	0.00	0.00	35,867.00
Total Expense	44,069.81	1,072,702.02	152,497.58	0.00	1,269,269.41
Net Ordinary Income	-34,206.80	-4,877,712.19	-152,497.58	0.00	-5,064,416.57
Net Income	-34,206.80	-4,877,712.19	-152,497.58	0.00	-5,064,416.57

1:16 PM

03/25/26

Accrual Basis

Westside Ambulance Profit & Loss by Class January through December 2025

	12H Ambulance	24H Ambulance	Clerical	Unclassified	TOTAL
Ordinary Income/Expense Income					
11500 • Account Receivable 12-HR	0.00	0.00	0.00	0.00	0.00
31500 • Reimbursement	403,987.60	204,000.00	0.00	0.00	607,987.60
40000 • Medical Transport Income	450,455.59	818,785.52	0.00	0.00	1,269,241.11
40200 • Membership dues	0.00	5,994.81	0.00	0.00	5,994.81
40300 • Other income	0.00	8,213.03	0.00	0.00	8,213.03
40400 • Collections income	0.00	3,422.54	0.00	0.00	3,422.54
41000 • Interest income	0.00	2,955.91	0.00	0.00	2,955.91
Total Income	854,443.19	1,043,371.81	0.00	0.00	1,897,815.00
Cost of Goods Sold					
50000 • Hardship Write-Off	0.00	4,572.66	0.00	0.00	4,572.66
50002 • Insurance Adjustment	-327.02	4,096.14	0.00	0.00	3,769.12
50003 • Medicare Write-off	1,446,317.62	2,069,672.89	0.00	0.00	3,515,990.51
50004 • Medi-Cal Write-off	667,462.21	1,233,749.18	0.00	0.00	1,901,211.39
50005 • Member Discounts	42.75	66.60	0.00	0.00	109.35
50006 • Write-offs-Worker's Comp	0.00	9,491.92	0.00	0.00	9,491.92
50007 • Refunds	-875.18	-916.18	0.00	0.00	-1,791.36
50008 • Bad Debt Write-off	134.14	8,826.61	0.00	0.00	8,960.75
50009 • Write Off Military	979.80	14,073.84	0.00	0.00	15,053.64
50010 • Write Off - Collection Expense	3,648.89	63,340.95	0.00	0.00	66,989.84
50011 • Write Off - Deceased	407.47	4,283.83	0.00	0.00	4,691.30
50016 • AB 716 Adjustment	21,251.38	102,532.21	0.00	0.00	123,783.59
50017 • Write Off - Public Assisi	21,360.00	33,468.50	0.00	0.00	54,848.50
Total COGS	2,160,402.06	3,547,279.15	0.00	0.00	5,707,681.21
Gross Profit	-1,305,958.87	-2,503,907.34	0.00	0.00	-3,809,866.21
Expense					
50098 • Employee Relations	0.00	3,300.17	0.00	0.00	3,300.17
56201 • Purchases - Medical supplies	41,180.15	44,191.96	0.00	0.00	85,372.11
60000 • Accrued Payroll Taxes	25,436.56	51,977.52	13,587.19	0.00	91,001.27
60099 • Meals & Entertainment	726.60	3,303.89	0.00	0.00	4,030.69
60100 • Charitable Contributions	0.00	92.83	0.00	0.00	92.83
60200 • Payroll Expenses	2,969.50	4,053.03	0.00	0.00	7,022.53
60600 • Computer Expenses	7,674.07	7,475.15	0.00	0.00	15,149.22
61000 • Dispatch Svcs	5,999.55	12,000.45	0.00	0.00	18,000.00
61111 • Bank Service Charge	1,142.49	5,925.67	0.00	0.00	7,068.16
61300 • Dues & Subscriptions	0.00	9,747.47	0.00	0.00	9,747.47
61400 • Fuel	9,158.60	19,107.25	0.00	0.00	28,265.85
61510 • Refund Expense	875.18	3,737.39	0.00	0.00	4,612.57
61600 • Vehicle Licenses - Prog Srv	0.00	2,055.00	0.00	0.00	2,055.00
61501 • Govt Fees & Licenses	1,342.54	37,785.81	0.00	0.00	39,128.35
61900 • Insurance	10,547.18	31,581.48	0.00	0.00	42,128.66
62100 • Insurance - Health - Mgmt	7,576.72	85,727.27	-2,235.12	0.00	91,068.87
62200 • Legal and Accounting	0.00	1,625.00	0.00	0.00	1,625.00
62600 • Office Supplies	436.21	5,636.90	0.00	0.00	6,073.11
62610 • Rent 612 4th Street	19,200.00	0.00	0.00	0.00	19,200.00
63000 • Postage	793.08	1,782.96	0.00	0.00	2,576.04
63200 • Property Taxes	0.00	2,682.38	0.00	0.00	2,682.38
63601 • Repair & Main/Crew Qtrs	1,549.63	9,669.79	0.00	0.00	11,219.42
63603 • Repair & Main/Med Equip	600.00	2,870.17	0.00	0.00	3,470.17
63606 • Repair & Main/Vehicle					
63607 • VVS-1 (2016) Vehicle Maintenance	0.00	10,992.91	0.00	0.00	10,992.91
63608 • WS 2 (2019) Vehicle Maintenance	0.00	9,548.79	0.00	0.00	9,548.79
63609 • WS 3 Vehicle Maintenance	1,371.31	0.00	0.00	0.00	1,371.31
Total 63606 • Repair & Main/Vehicle	1,371.31	20,541.70	0.00	0.00	21,913.01
64000 • Telephone	2,591.29	10,135.91	0.00	0.00	12,727.20
64100 • Small Equipment	6,497.06	6,436.59	0.00	0.00	12,933.65
64200 • Training Expense	0.00	1,575.00	0.00	0.00	1,575.00
64400 • Uniforms	3,537.64	5,663.04	0.00	0.00	9,200.68
64800 • Utilities	5,453.53	11,633.06	0.00	0.00	17,086.59
65000 • Wages-Ambulance	19,490.56	11,026.66	0.00	0.00	30,517.22
65001 • 12-Hour Ambulance Wages	285,839.83	5,987.19	0.00	0.00	291,827.02
65100 • Wages-Office	7,506.38	0.00	172,521.71	0.00	180,028.09
65110 • Mileage for Reimbursement	0.00	0.00	252.59	0.00	252.59
Total Expense	469,495.86	1,049,328.69	184,126.37	0.00	1,702,950.92
Net Ordinary Income	-1,775,454.73	-3,553,236.03	-184,126.37	0.00	-5,512,817.13
Net Income	-1,775,454.73	-3,553,236.03	-184,126.37	0.00	-5,512,817.13

Attachment C: Payor Mix

Enloe Health

Enloe Payor Mix				
Payor	2023	2024	2025	2026YTD
Medicare	52.3%	55.6%	51.5%	49.4%
Medi-Cal Traditional	2.8%	3.0%	1.9%	2.2%
Medi-Cal Managed	21.2%	21.5%	28.9%	29.1%
Blue Cross	5.9%	4.4%	3.5%	5.3%
Blue Shield	2.6%	2.3%	4.1%	2.2%
Self-Pay	11.7%	8.5%	5.6%	3.4%
Other	3.6%	4.7%	4.6%	8.4%
TOTAL	100%	100%	100%	100%

Westside

Westside Payor Mix			
Payor	2023	2024	Jan-Jun 2025
Medicare	58.9%	57.4%	58.8%
Medi-Cal Traditional	3.6%	1.7%	0.5%
Medi-Cal Managed	24.3%	28.2%	28.0%
Blue Cross	3.1%	3.6%	4.9%
Blue Shield	2.9%	2.6%	3.0%
Self-Pay	4.7%	3.0%	4.3%
Other	2.6%	3.6%	0.6%
TOTAL	100%	100%	100%

Attachment D: Acronyms

AB	Assembly Bill
ACE	Accredited Center of Excellence
ALS	Advanced Life Support
BLS	Basic Life Support
CAD	Computer-Aided Dispatch
CPR	Cardiopulmonary Resuscitation
CQI	Continuous Quality Improvement
ED	Emergency Department
EMD	Emergency Medical Dispatch
EMS	Emergency Medical Services
H&SC	Health and Safety Code
IFT	Inter-Facility Transports
LEMSA	Local EMS Agency
MPDS	Medical Priority Dispatch System®
NEMSA	National EMS Advisory Council
PCR	Patient Care Report
PSAP	Public Safety Answering Point

DRAFT

GLENN COUNTY EMERGENCY MEDICAL SERVICES FISCAL ASSESSMENT

*Presented by
Healthcare Strategists
June 2026*

**HEALTHCARE
STRATEGISTS**

Introduction

- **Goal:** A comprehensive financial EMS system assessment of the County EMS system.
- **Healthcare Strategists:** Consultants represent EMS, fire, fiscal, and clinical experts, each with at least 40 years of industry experience.

Assessment Process

- **Interviews:** Ambulance provider, EMS agency, and fire department leadership.
- **Data Analysis:** Historical financial statements, call volume, performance, agreements, and other materials reviewed.
- **Support:** The stakeholders were open and engaged in sharing their agencies' information; however, one ambulance provider shared multiple financial statements for the same fiscal year.

EMS System Highlights

- **A coordinated EMS system overseen by the EMS Agency (S-SV EMS).**
- **Broad stakeholder network spanning dispatch, first response, ambulance transport, and receiving facilities.**
- **Access to an emergency medical dispatch (i.e., MPDS) communications center for transferred medical calls, which supports standardized call interrogation and consistent pre-arrival instructions.**
- **EMS direction that aligns well with statewide and national priorities (including EMS Agenda 2050) that emphasize integration, reliability, and patient-centered system design.**

EMS System Challenges

- **Clinical oversight and clinical quality improvement (CQI) participation and reporting are inconsistent across providers, with limited consistency in quality assurance processes and regional quality-forum participation (e.g., REMAC) and variable responsiveness to required reporting.**
- **Glenn County faces ambulance response performance pressures typical of rural environments.**
- **Emphasize the need to define realistic performance expectations by zone and to reduce preventable response-time outliers through deployment, dispatch, and operational improvements.**
- **Fragmented data limits timely system monitoring, transparency, and shared accountability.**
- **Longer transport times following the Glenn Medical Center closure and possible decline in transport volume and revenue.**
- **Financial sustainability risks persist with limited availability of consistent, audit-ready financial reporting from one provider, complicating planning and subsidy justification.**

DISCUSSIONS, FINDINGS, AND RECOMMENDATIONS

***HEALTHCARE
STRATEGISTS***

Preface

- Findings and recommendations are based on best practices, industry trends, and service innovation.
- Recommendations may need to be part of an EOA bid, new provider contract(s), or other process.
- Recommendations do not consider external factors such as financial resources, provider interest, or political support to implement.
- **Key Findings/Recommendations are indicated in red.**

1.

Use of Medical Priority Dispatch System (MPDS®)

Finding: Enloe is under contract with Glenn County to serve as the medical communications center using MPDS protocols when handling transfers from primary PSAPs if medical services are required.

Recommendation: The County and S-SV EMS should formalize and require the use of a secondary PSAP. This will be mandatory by 2027 (AB645). Consider ACE-accreditation as a future goal.

2.

Clinical Oversight and Performance

Finding: Clinical/quality oversight is inconsistent, with reported weak or reactionary quality improvement processes, limited participation in regional quality forums (e.g., REMAC), and varying responsiveness to required reporting (including MCI feedback forms), particularly as it relates to Westside Ambulance.

Recommendation: Establish and enforce minimum CQI and reporting requirements across providers (including defined CQI roles, participation expectations for regional forums such as REMAC, and timely submission standards for required reports like MCI feedback forms), with monitoring and remedies for non-compliance.

3.

Deployment of Ambulance Resources

AMBULANCE RESPONSE TIMES

Deployed ALS Ambulances by Provider Agency		
Provider	Minimum	Maximum
Enloe	1	1
Westside Ambulance	1	2

Finding: Prolonged ambulance response times, as seen within the response time compliance data, could create a cascading system impact by delaying availability for other emergencies and degrading overall EMS performance.

Recommendation: Implement system status management practices to reduce outliers and protect coverage: enforce closest-unit dispatch, use predefined move-up/coverage plans when units are committed, and monitor dispatch-to-enroute/response-time performance with routine CQI review and corrective action.

3.

Deployment of Ambulance Resources

RESPONSE TIME COMPLIANCE FINDINGS

Response Time Compliance (2025 – Feb 2026)														
Zone/ Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Orland/ Westside	87%	91%	90%	97%	92%	100%	79%	97%	91%	95%	100%	97%	91%	100%
Willows/ Enloe	96%	95%	96%	95%	88%	100%	89%	94%	62%	89%	75%	70%	80%	57%
County	100%	100%	100%	92%	98%	100%	100%	100%	100%	100%	97%	100%	100%	100%

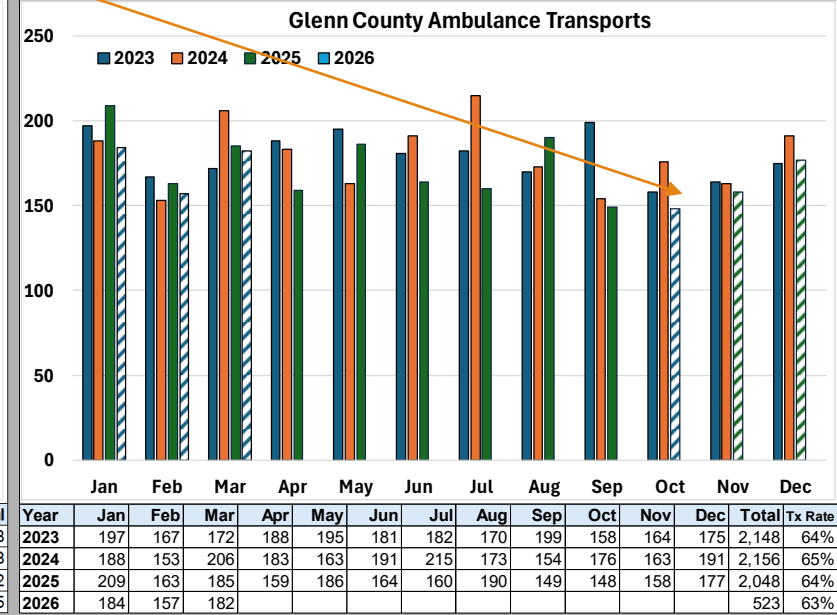
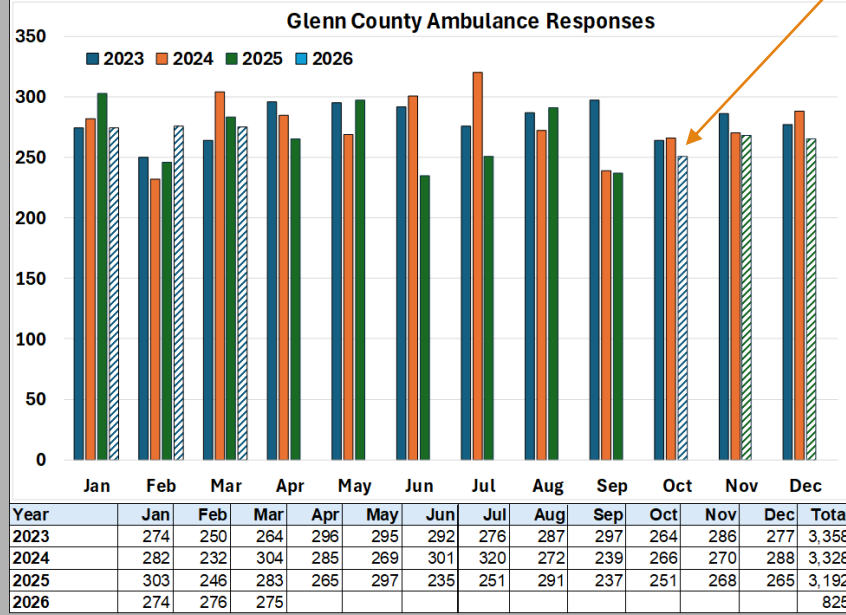
Finding: Based on the interviews and a review of the monthly performance gap between zones, the declining response-time compliance in Willows was likely caused by improper use of the 12-hour unit, as calls were being rotated rather than routed to the closest unit.

Recommendation: Implement closest-unit dispatch for Willows-zone calls by configuring dispatch software and utilizing the automatic vehicle location system to use the 12-hour car as a cover unit (i.e., not on rotation).

4.

Call Volume Trends

Hospital Closure



Finding: Reviewing the monthly call volume following the hospital closure did not identify the anticipated decrease in call volume.

Recommendation: While response and transport volume do not show a significant or immediate impact, both metrics should be tracked monthly for future impacts.

5.

EMS System Financial Analysis

FINANCIAL HISTORY

Year	2023		2024		2025	
	Westside	Enloe	Westside	Enloe	Westside	Enloe
Transports	1,111	999	1,097	1,012	1,202	862
Net patient revenue	\$1,078,999	\$781,380	\$1,026,145	\$888,514	\$1,222,773	958,934
Net patient revenue per trip	\$ 971	\$ 782	\$ 935	\$ 878	\$ 1,017	\$ 1,112
Expenses	1,191,046	940,921	1,181,149	989,801	1,702,950	944,435
Expenses per trip	\$ 1,072	\$ 942	\$ 1,077	\$ 978	\$ 1,417	\$ 1,096
Deficit	(112,047)	(159,541)	(155,004)	(101,287)	(480,177)	14,499

Finding: Neither service is breaking even.

Recommendation: Consider other EMS system designs to improve the financial position.

5.

EMS System Financial Analysis (Enloe)

ENLOE HEALTH AMBULANCE SERVICE

Finding: Financials and payor mix data were formal and professionally produced. This enabled an effective and confident evaluation of its financials.

Recommendation: Continue to require annual reporting for the County to track fiscal viability long-term.

5. EMS System Financial Analysis (Westside)

WESTSIDE AMBULANCE SERVICE

Westside Financial Comparison				
Provider	2024	Per Trip	2025	Per Trip
Transports	1,103		1,202	
Net Patient Revenue	\$ 1,079,438	\$ 979	\$ 1,222,773	\$ 1,017
Expenses				
Crew Wages	659,295	598	952,344	792
Other Wages	220,522	200	278,052	231
Employee Benefits and Relations	74,917	68	109,175	91
Professional Services	38,657	35	47,992	40
Supplies	54,680	50	118,174	98
Purchased Services	-	-	-	-
Insurance, Gov. Fees & Licenses	79,902	72	81,257	68
Property and Utilities	41,572	38	51,696	43
Vehicles & Fuel	41,903	38	52,234	43
Bank & Refund	16,832	15	11,681	10
Indirect Support Services	-	-	-	-
Other Expenses	5,122	5	345	0
Total Expenses	1,233,402	1,118	1,702,950	1,417
Patient Revenue less Expense	(153,964)	(140)	(480,177)	(399)
<i>Subsidy</i>	<i>204,000</i>		<i>643,052</i>	
Profit/(Loss)	50,036	45	162,875	136

Notes

1. Subsidy is provided by Glenn County (12-hour unit) and City of Orland (both units)
2. 2024 subsidy for 24-hour unit only (the 12-hour unit was added in December 2024)
3. 2025 subsidy covers 12 and 24-hour units; December subsidy amount estimated based on prior months

Finding: Multiple sets of financials; the latest noted revenue items that did not tie to the summary report. The cost of goods sold section includes items that should be deducted from revenue (e.g., Medicaid and Medi-Cal write-offs) and must have been removed in the income section. The detail shows gross and net losses in the millions, which is inaccurate.

Recommendation: Since Westside is reliant on government subsidies, it should have an independent governmental audit of its financial statements and underlying accounting records to establish an audit-ready baseline and a reliable financial record for oversight purposes.

5.

EMS System Financial Analysis (Westside)

WESTSIDE AMBULANCE SERVICE

Finding: The Westside Manager is carrying a broad set of responsibilities (i.e., accounts receivable, human resources, logistics, non-profit transition, general operations).

Recommendation: Stabilize roles and delegate responsibilities to reduce key-person burnout risk. Define and document core processes with step-by-step procedures and named backups.

Finding: QuickBooks has had “many hands,” making reconciliation and reporting difficult.

Recommendation: Address QuickBooks governance and data integrity by limiting access to trained users, implementing role-based permissions.

Finding: Accounts receivable (AR) and revenue tracking are fragmented, as the separation of billing systems and non-integrated revenue feeds complicates reporting and requires manual workarounds.

Recommendation: Integrate or standardize revenue and billing inputs by mapping billing system outputs to a standardized revenue recognition and deposit process.

Finding: The Westside Board, County, and City of Orland should have clear documentation to support ongoing subsidies from the taxpayers.

Recommendation: Formalize board reporting and subsidy documentation; implement a standardized monthly (or quarterly) reporting package.

Finding: Current expenditure and staffing levels appear disproportionate to the reviewed call volume, indicating potential misalignment between resource deployment and service demand.

Recommendation: Because call volume is low but the area to cover is large, staffing costs remain high. As a result, an ongoing subsidy is necessary to cover the cost gap using the current model.

5.

EMS System Financial Analysis (Enloe & Westside)

Provider Financial Comparison, 2025					
Provider	Westside	Per Trip	Enloe	Per Trip	Combined
Transports	1,202		862		2,064
Net Patient Revenue	\$1,222,773	\$1,017	\$ 958,934	\$1,112	\$2,181,707
Expenses					
Wages	1,230,396	1,024	526,107	610	1,756,503
Employee Benefits and Relations	109,175	91	266,050	309	375,225
Professional Services	47,992	40	41,154	48	89,146
Supplies	118,174	98	22,585	26	140,759
Purchased Services			28,025		28,025
Insurance, Gov. Fees & Licenses	81,257	68	11,970	14	93,227
Property and Utilities	51,696	43		-	51,696
Vehicles & Fuel	52,234	43		-	52,234
Bank & Refund	11,681	10		-	11,681
Indirect Support Services			48,419	56	48,419
Other Expenses	345	0	125	0	470
Total Expenses	1,702,950	1,417	944,435	1,096	2,647,385
Revenue less Expense	(480,177)	(399)	14,499	17	(465,678)

Finding: Westside supply costs are five times greater than Enloe, higher insurance expense, and substantial bank expenses.

Recommendation: Westside should consider ordering supplies through Enloe to reduce supply costs, research new insurance carriers, and minimize bank fees.

5.

EMS System Financial Analysis (2025 Proforma)

Proforma Models using 2025 Data			
	Current Providers	Single Provider	Public Provider(s)
Transports (2025)	2,064	2,064	2,064
Net Patient Revenue	\$ 2,041,342	\$ 1,961,342	\$ 1,961,342
Other Revenue			
Private GEMT (QAF)	\$ 140,365	\$ 140,365	\$ -
Public GEMT2	-	-	820,667
Other Revenue (Standby, etc)		30,000	30,000
Membership Fees		50,000	50,000
Total Revenue	\$ 2,181,707	\$ 2,181,707	\$ 2,862,010
Direct Expenses			
Crew Wages	\$ 1,478,451	\$ 1,478,451	\$ 1,478,451
Non-Crew Wages	278,052	178,052	103,052
Employee Benefits ³	375,225	353,863	337,841
Professional/Purchased Services	117,171	117,171	117,171
Indirect Support Services	48,419	48,419	48,419
Supplies	140,759	54,078	54,078
Vehicle Operating Expense	52,234	52,234	52,234
Insurance, Gov. Fees & Licenses	32,562	20,000	15,000
QAF and GEMT Fees	60,665	60,665	385,714
Property and Utilities	51,696	51,696	51,696
Other (uniforms, licenses, training, etc.)	12,151	12,151	12,151
Total Direct Expense	\$ 2,647,385	\$ 2,426,780	\$ 2,655,807
Revenue Less Expenses	\$ (465,678)	\$ (245,073)	\$ 206,202

Notes

1 uses actual 2025 financial statements

2 GEMT is not a guaranteed, long-term revenue stream, NO EMS system should be built assuming it is permanent

3 Employee Benefits would be greater for a public provider, unless part of an alliance model with a private provider

Finding: The current two-provider model in the County is inefficient and not cost effective.

Recommendation: Consider a single private provider or public provider(s).

6. Next Steps

Projected Proforma Models for 2026			
	Current Providers	Single Provider	Public Provider(s)
Transports, Estimated (2026)	1,900	1,900	1,900
Net Patient Revenue	\$ 1,915,200	\$ 1,835,200	\$ 1,930,200
Other Revenue			
Private GEMT (QAF)	\$ 129,000	\$ 129,000	\$ -
Public GEMT ¹	\$ -	\$ -	\$ 842,490
Other Revenue (Standby, etc)		\$ 30,000	\$ 30,000
Membership Fees		50,000	50,000
Total Revenue	\$ 2,044,200	\$ 2,044,200	\$ 2,852,690
Direct Expenses			
Crew Wages	\$ 1,522,805	\$ 1,522,805	\$ 1,522,805
Non Crew Wages	106,144	\$ 106,144	\$ 106,144
Employee Benefits ²	347,977	347,977	347,977
Professional/Purchased Services	117,171	117,171	117,171
Indirect Support Services	48,419	48,419	48,419
Supplies	129,575	49,781	49,781
Vehicle Operating Expense	48,084	48,084	48,084
Insurance, Gov. Fees & Licenses	37,382	20,000	15,000
QAF and GEMT Fees	55,845	55,845	395,970
Property and Utilities	51,696	51,696	51,696
Other (uniforms, licenses, training, etc.)	12,151	12,151	12,151
Total Direct Expense	\$ 2,477,247	\$ 2,380,071	\$ 2,715,197
Revenue Less Expenses	\$ (433,047)	\$ (335,871)	\$ 137,493
Notes			
¹ GEMT is not a guaranteed, long-term revenue stream, NO EMS system should be built assuming it is permanent. 2026 program has not been approved as of 4/7/2026			
² Employee Benefits would be greater for a public provider, unless part of an alliance model with a private provider			
Reduced 2025 patient revenue, GEMT revenue, supplies, vehicle operating expenses by 8.9% due to drop in call volume			

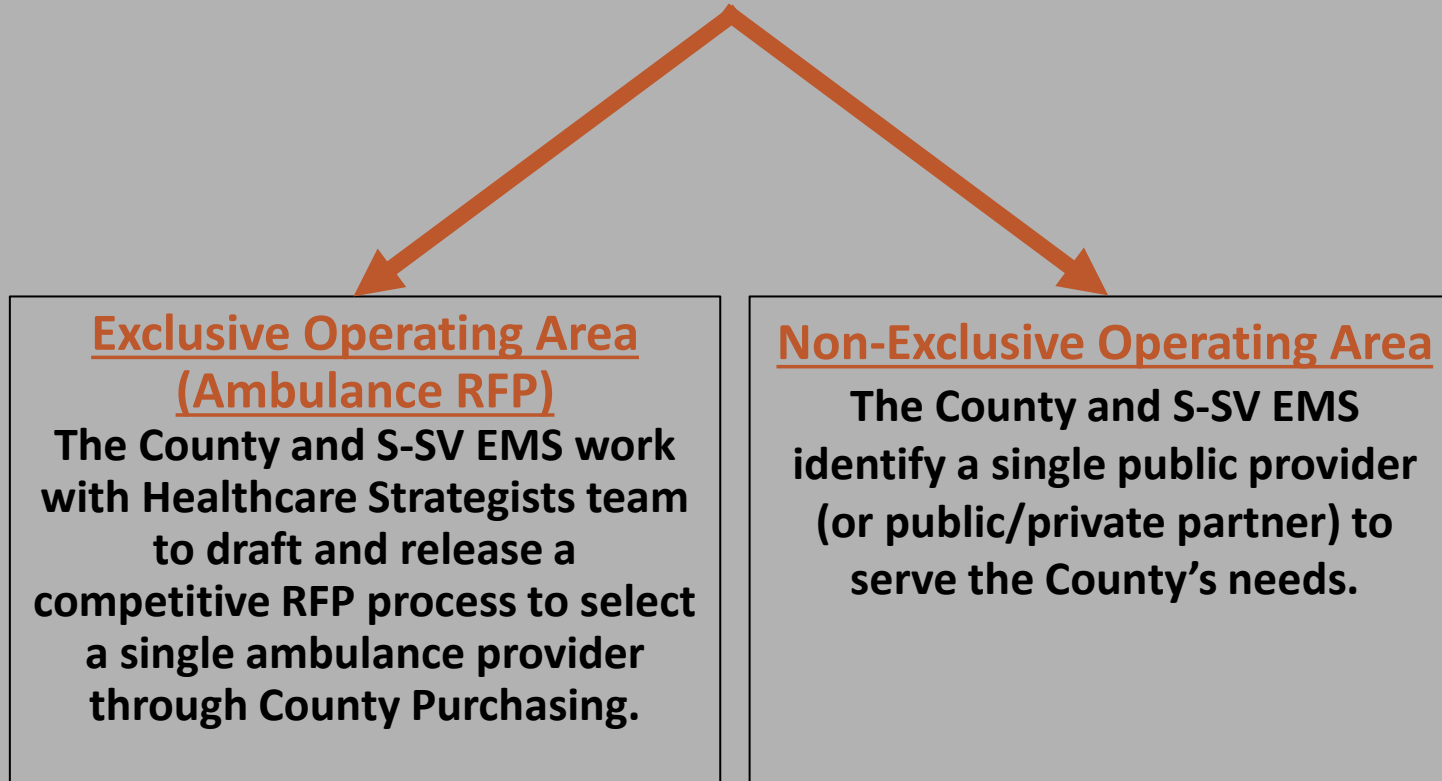
- 1) A single provider EMS system will reduce expenses, eliminate duplication, and improve efficiency.
- 2) Consider a public provider (or public/private partnership) to improve revenue.

7.

Conclusion

- **Dedicated EMS workforce and strong foundational capabilities, including an accredited dispatch center. Solid base to build a more integrated, resilient, and patient-centered EMS system.**
- **Systemwide issues with response-time performance, labor-intensive CQI, fragmented data, and limited contractual accountability that can increase risk to patient outcomes, provider safety, financial sustainability, and public trust.**
- **Recommendations**
 1. **Move to a single ambulance provider**
 2. **Consider a public provider or Alliance Model to access GEMT funding**
 3. **Modernize data and CQI infrastructure**
 4. **Optimize deployment and tiered response**
 5. **Integrate behavioral health crisis response**
 6. **Prepare for emerging models (e.g., community paramedicine, alternate destinations)**

Next Steps



**GLENN COUNTY
EMERGENCY MEDICAL SERVICES
ASSESSMENT**

Questions & Answers

***HEALTHCARE
STRATEGISTS***