

MANAGEMENT FOCUS

— FOR PROVIDERS OF EMERGENCY MEDICAL SERVICES —

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DIVERSIONS:

IS EMS PART OF THE PROBLEM OR SOLUTION?

Hospital overcrowding is one of the largest systemic concerns in Health Care. As this reality spreads, diversions become increasingly common. (see the "Trends" article at page two.) Over time, this has had an effect on patient satisfaction, ambulance turn-around time and productivity levels and on the hospitals' capacity to care for patients.

Guillermo Fuentes, Deputy Director of Operations for Montreal's EMS system provides this insight about how they addressed the problem of diversion. Montreal EMS responds to approximately 265,000 calls annually and provides 197,000 transports. Of these, 160,000 are emergency related and 37,000 are interfacility. They serve 17 emergency rooms and two pediatric hospitals. Both call center and field operations are managed by EMS.

Montreal is different in that one of its initial mandates 20 years ago was to manage hospital overcrowding. Fuentes premise is that "all health care systems are overwhelmed and the diversion system is taking one hospital's misery and shifting it to another hospital forcing that hospital to absorb their misery and someone else's misery which in turn forces that hospital to close."

In its simplest form, hospital diversion occurs when a hospital, by whatever local means available, denies access to patients transported by ambulance. This can take many forms be it full or strict diversion in which case no ambulances are accepted including critically ill patients, to partial diversions which are specialty-specific. While it may seem illogical when taken at face value that the sickest patients are refused access to definitive care, the reality is

that it is founded on sound logic. What Montreal has learned is that every hospital has a finite capacity for care and as such can and will become overwhelmed if not managed appropriately.

A growing number of EMS agencies are *following* the trend by trying to manage in real time a problem that was predictable. Attempts to compensate late in the event are analogous to a parachutist waiting until they are on the ground to open their chute.

According to Fuentes, "We have established that hospitals have a finite capacity for care. We have also admitted that hospitals become overwhelmed. Where the logic becomes weak is in the belief that when one hospital demands a diversion all other hospitals are sitting around waiting for patients. We assume that hospitals become overwhelmed in series, as individual establishments, rather

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EMTALA FINAL RULE

Key provisions of the final rule taking effect November 10 include the redefinition of ED's, clarifications regarding hospital owned ground and air ambulance services and the on-call requirements for backup specialists.

The final rule expands the definition of emergency department to mean any department or facility of the hospital, whether situated on or off the main hospital campus, that: (1) is licensed by the state as an emergency room or emergency department; (2) is held out to the public as providing care for emergency medical conditions without requiring an appointment; or (3) during its previous calendar year, has

provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.

Hospital based EMS services (including air ambulances) can transport to other facilities without violating EMTALA, as long as they are operating as part of a community-wide protocols or protocols mandated by state law. The rule also further clarifies that medical control physicians are not subject to EMTALA when destinations are based upon community-wide protocols. The final rule also changed "closest hospital" to "closest appropriate facility."

Also significant for EMS is the softening of on-call policies for specialists backing up an ED. This may make it more difficult to determine the hospital's true capabilities (appropriateness) in any given instance. Specialists may be "on call" at multiple facilities. The American College of Emergency Physicians (ACEP) indicated that the provision may increase the number of patients requiring transfer to facilities able to provide care.

The final rule also clarifies that EMTALA sanctions would not apply to hospitals in an affected area during a national emergency.

EMS & HOSPITAL TRENDS & NOTES



AAA Launches Internet Based CME. AAA has partnered with EMSED.com to provide CECBEMS approved Continuing Medical Education, monthly management briefings and specialized workshops via the Internet. Contact: www.EMSED.com for more info.

Response Time Validity? Published data from the Ontario Prehospital Ad-

vanced Life Support (OPALS) Study indicate that the response time threshold for many EMS systems may be high. Most urban systems keyed response times to Eisenburg's 1979 study. The data published in the August 03 issue of *Annals*. The OPALS research underscores the validity of the NFPA 1710 standards for First Responders.

More Defib – University of Iowa and University of Michigan researchers evaluated the value of installing defibrillators in various public locations. Published in the *Journal of*

General Internal Medicine, their findings are that the \$3k investment offers good value if the location is expected to have at least one cardiac arrest every seven years. Locations such as retail stores and elementary schools may not be cost effective while defibrillator placements at high-risk locations such as senior centers are. Low risk sites might be better served offering weight loss and smoking cessation classes, according to Iowa's lead researcher.

Zero Tolerance. The International Association of Fire Chiefs (IAFC) has adopted a

policy statement indicating that if someone has consumed alcohol within the previous eight hours they are ineligible to participate in activities and functions of the fire/EMS service including training activities. Alcohol is not permitted in any operational area of the department and for those organizations that raise funds operating or renting social halls must provide a clear separation of facilities. Written policies should be in place to reinforce the policy including blood alcohol testing of any individuals involved in any accident causing measurable damage or injury.

HEALTHCARE TRENDS & EMS STRATEGIES

Noted futurist Russ Coile recently outlined 10 broad healthcare industry trends. Six of these have direct implications for EMS and non-emergency providers. Organizational strategies can be built if one understands the trend, the implication or customer problem that needs to be solved.

1. *Expanding inpatient demand will overtax capacity.* Hospitals will be stretched as inpatient service demand increases. Diversions will continue to be an issue for emergency services. Developing innovative ways to monitor capacity is a priority. Non-emergency services positioned to seamlessly transport patients between out-patient and in-patient facilities can achieve a competitive advantage.

2. *Consumers becoming the centerpiece of health-*

care. According to Coile, hospitals are getting a consumer centered make-over from parking lots to critical care units. For ambulance services, strategies should be focused on making it easier for customers to do business with your organization. These efforts have a positive impact at call reception/dispatch, during patient interactions and particularly by using high levels of personalized service when collecting accounts.

3. *Costs are rising.* The story of rising costs and decreasing reimbursement is quickly forgotten. It must be told and retold if the public and local regulatory officials are to understand this is occurring throughout the nation, not just within your service.

4. *Safety remains paramount.* Implications for EMS include using the media to tell

your side of the story. From investment in driving safety and technology (e.g. CAD & GPS) improving safe response times to explaining your involvement in homeland security and ongoing community educational efforts. Since 9-11, safety and security is a higher priority.

5. *Workforce shortages continuing.* Ambulance services need to be innovative with methods to attract and retain staff. Efforts include alternative initial training models and broader acceptance of Internet based distance learning for medical and management CE.

6. *Damaged public confidence.* The recent USA Today articles about EMS, reports of Medicare fraud and news accounts of poor service have undermined confidence and suggest the need

for focused communications programs to address issues of public trust.

Trends provide perspective. Implications of the trends and addressing the underlying issues can be challenging. However, trends also create opportunities for those whose vision, strategy and tactics are tightly linked.

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than as a system. We also assume that ambulance diversions can correct a problem punctually that took hours, days or weeks to create.”

In Montreal, EMS represents 10 to 15% of all patients seen in an emergency room but will represent an average of 50% of all admissions. See Figure 1.

Simply put, the older the patient, the higher the probability that when he or she is admitted to a hospital, they will have been transported by ambulance. See Figure 2.

It is easy to observe that the older the patient the longer the patient may stay when he or she is hospitalized. See Figure 3.

Montreal’s conclusion is that the single largest controllable consumer of hospital services is EMS. Fuentes believes that this is valid for other North American cities.

If this premise is correct, the importance of managing incoming hospital volume correctly from EMS becomes critical. While it may be impossible to control the volume, it is possible to make sure distribution is equitable and more importantly predictable. This allows hospitals to adjust to a predictable reality (getting the cute open earlier) and avoids trying to manage at the end of the freefall event.

To achieve a different outcome EMS must stop looking at hospitals through the emergency room and to start looking at hospitals as a whole, according to Fuentes. Quotas, or a maximum capacity to absorb patients, exist in all systems be it a shared quota in which all parties are aware

Figure 1.

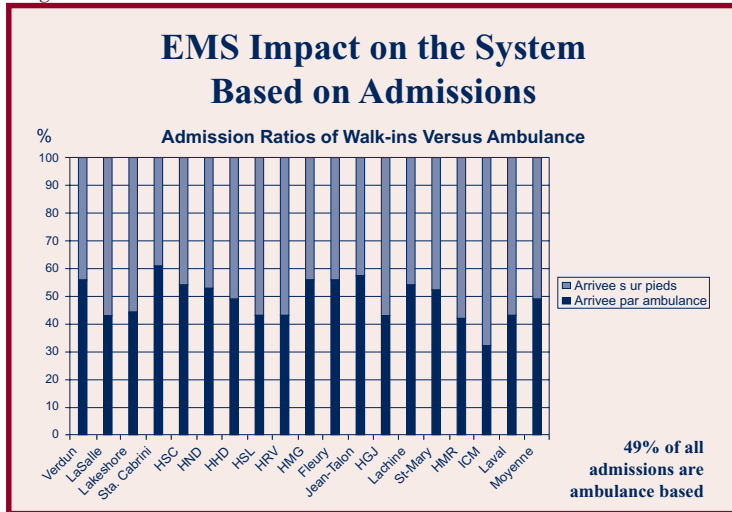


Figure 2.

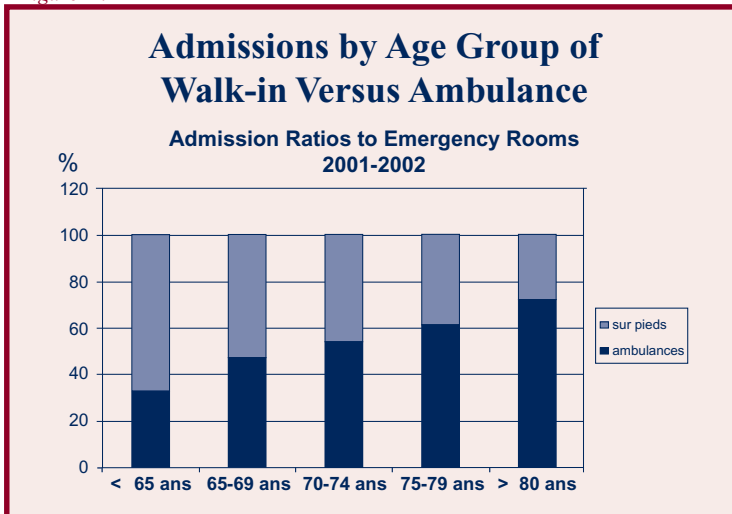
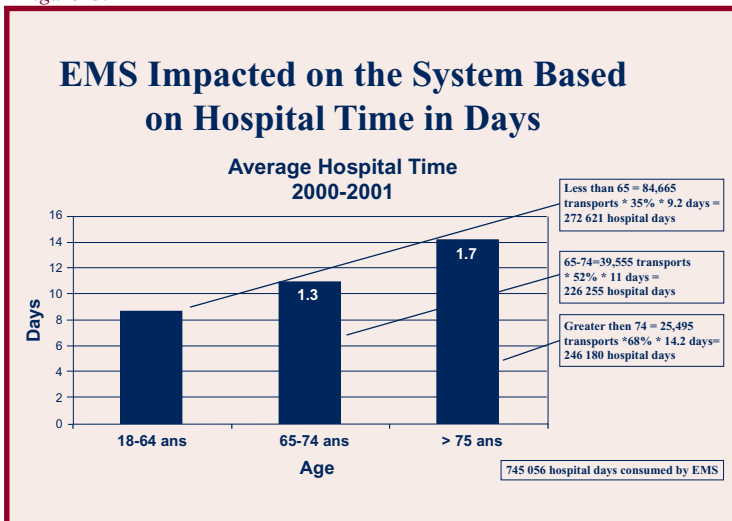


Figure 3.



of it or be it a perceived quota. For example, “We know that XYZ Hospital never takes more than 10 ambulances.” There is a point at which a hospital must divert because it is no longer able to absorb patients. A maximum limit that is easily understandable is the physical capacity that hospitals have.

In Montreal, they take the system as a whole, count all hospital beds then attribute a quota of ambulances at the equivalent ratio of beds that the hospital has. (e.g. if the hospital has 10 percent of all beds in the city then it cannot receive more than 10 percent of all ambulance patients in the city. Obviously with more data, the equation becomes more precise. In Montreal, “we take into consideration, walk-in patients versus patients that arrive by ambulance; age factors, specialty programs etc. Once the amount of patients are established (amount is equivalent to a percentage of ambulance transports and not absolute numbers) EMS then manages to attain those numbers.”

Since the elimination of the diversion system we went from respecting the hospitals’ capacities to absorb patients at the 40th percentile to respecting the capacity at the 90th percentile, according to Fuentes.

This approach leads to reducing the impact of delaying care which correspondingly increased satisfaction for both patients and crewmembers.

Focus appreciates Montreal EMS sharing this information with our readers.

CREATING SUCCESSFUL ALLIANCES

The future of EMS lies in the cooperation of stakeholders in developing community based alliances that provide good value to respective constituent groups. Instead of drawing lines in the sand, individuals and organizations must recognize the forces at work in our society and economy that are driving these changes.

Public safety and healthcare organizations are beginning to work together with increasing frequency. Here are seven steps to be considered when developing a community alliance:

Recognize everyone must give up some power to gain power. Compromises have to be made, and everyone has to approach the situ-

ation willing to give something up.

Reach agreement early on assumptions about the future. This step is time intensive, but without these fundamental agreements, goals and future directions can be difficult to achieve.

Make sure the process has integrity. Don't game it. There must be respect and trust at all levels within the respective organizations for this process to be successful. Consensus building doesn't just happen; it is the result of a deliberate process.

Establish a strong "case for cooperation." Identify the risks for each organization if they continue independently, as well as the benefits

to each if they collaborate. But most important, focus on the benefits to the community.

Recognize each entity has its own culture and operating style. Regardless of the level of collaborative effort, potential gulfs caused by past history and differing philosophies must be bridged.

Create a compelling shared vision. Too many leaders dismiss this as unnecessary and have a failed joint planning effort to show for it. When people are faced with new paradigms, such as creating partnerships and collaboration, instead of competition, they need time to let go of the old ideas and embrace the new. The powerful force of a

shared vision may be the only thing that keeps everyone on track when the going gets rough.

Provide financial disincentives for disruptive partners. The "rules" need to remain constant remain for the life of the agreement. This can be addressed contractually regardless of changes in fire chiefs and administrators, company ownership and local elected officials.

Producing higher-quality EMS and medical transportation services with fewer resources is an economic fact of life. Creating alliances and partnerships that emphasize collaboration instead of competition is a creative way to improve outcomes.

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