

MANAGEMENT FOCUS

— For Providers of Emergency Medical Services —

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KANSAS CITY LEARNS RESPONSE TIME LESSON

Accountability is essential for any EMS system to maintain credibility. Response times are the single most utilized measure in determining system performance. Response times are frequently misunderstood, often miscalculated and occasionally manipulated.

Kansas City officials and the Metropolitan Ambulance Services Trust (MAST) recently learned that embarrassing lesson. A two-year pattern of response time manipulation was discovered in March. It became a media feeding frenzy and dominated local print and electronic media.

Almost two years ago MAST installed a Tri-Tech Computer aided dispatch (CAD) system. Response times records showed 90 percent compliance but officials became suspicious when the CAD failed to perform as anticipated.

After repeated modifications, Tri-tech personnel discovered discrepancies documenting that the response times were being changed. The communications supervisor immediately resigned during the investigation and may ultimately face charges for altering government records. City officials have called for a full performance audit and the implications for the system are grim.

The discovery could not

have come at a worst time for MAST. Local firefighters are heavily campaigning to move EMS responsibility from the independent regional agency to the fire department. A committee dominated by fire service interests has been appointed to review delivery options.

One of MAST's strongest points was its exemplary clinical and operational performance in nearly 20 communities in the two-state region. The system is now in jeopardy.

January records indicated 90.2% compliance to

MAST's 8 minute and 30 second benchmark, known to be one of the most stringent in America. Response times for February were reported at 82.1% based on more accurate reporting.

In addition to its credibility issues, MAST and its provider must also find a way to fund the additional unit hours required to meet the response time standard. It's believed to be a multimillion dollar issue.

There are several steps that can be taken to ensure response time accountability and avoid a similar quagmire.

They include:

(1) *Use standard reporting increments.* Data should measure key service elements. When does the clock start and stop? Sophisticated systems begin the EMS response time at the point in time key data elements are entered or 30 seconds after the call is transferred from 911, whichever is first.

(2) *Identify fractile measurement.* Averages skew response times. Using a defined time and measuring the percent of compliance against

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"HANGING UP" ON EMS PATHWAYS?

Are payers and providers "hanging up" on EMS pathways? The answer is, not yet. But they are getting a "busy signal"!

The integration between EMS and managing the pathways of a patient's continuum of care has been slower than expected. This, despite broad changes in healthcare that demand innovation, integrated response systems and appropriate access. It seems that neither EMS agencies nor payers fully understand the power of the process, its potential, or the tools currently available to achieve results.

What is pathway man-

agement? In simple terms, it is a process to manage the mechanism individuals use seeking and receiving care in a more cost-effective manner. Appropriately utilized, pathway management can significantly reduce the downstream costs of unscheduled healthcare, enhance the patient's experience and improve effectiveness of transportation entities.

Typically patients call 911 and receive a maximum response including BLS first responders, potentially a medic first responder, and a transport ambulance. Those providers can often make the

decision only to transport or not transport to an emergency department. To avoid liability, transport to an ED often occurs even when there are more cost effective mechanisms available to treat the patient.

Alternatively, an integrated center can impact perceived need for unscheduled care, provide nurse advice, schedule referrals to primary care or other services, and coordinate appropriate transportation.

Factors limiting success include: technology, communications staff expertise,

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EMS & HOSPITAL TRENDS & NOTES



Fraud Alert. Six Pennsylvania municipalities were sued in March for routinely waiving EMS Medicare co-payments for patients. Medicare cases against municipalities have increased in recent years. The largest settlement occurred last year when the City of New York settled an EMS qui tam lawsuit for \$9.5 million. The cities involved include Pittsburgh, Allentown, Bethlehem, Harren Hills, Penn Hills, and Chambersburg.

Spending. Healthcare spending in the US continues to rise faster than in most other nations, according to an article in the May/June issue of Health Affairs. The per capita spending in the US reached \$3,925 or 13.5 percent of the gross domestic product being consumed by healthcare compared to the average of all nations, which was 7.5 percent.

TB Problems. TB remains the leading public health threat in the US. According to the Center for Disease Control, between 10-15 million have been infected with airborne TB. Worldwide, there are 8 million new cases of TB annually.

IG Recommendations. The IG has outlined four recom-

mendations for ambulance reimbursement. They include: (1) a simplified structure for the fee schedule, (2) Base the fee schedule of costs not historical charges, (3) Ini-

other institution without stabilization.

ACEP Policy Statements. In the May issue of Annals of Emergency Medicine the

California Response Times. More than half of the Counties in the State of California have adopted response time regulations. Among those counties with full response time standards, 75 percent utilize the fractile rather than average measurement methodology. Unfortunately, "27 percent of those with response time standards are unable to determine the compliance rate to the standard," according to a recent California State University study.

The study's conclusion: "Despite the assumed clinical importance of response times, and despite having the regulatory powers to do so, there is no assurance that Californians receive ambulance service in a timely manner." (See front page article "Kansas City Learns Response Time Lesson" for more on importance of measuring response times.)

CITY FEES LEGAL?

A recent opinion by the Office of the Inspector General (OIG) ruled that fees charged by Cities to ambulance services for municipal dispatch services could violate the anti-kickback statute. According to the IG "Pay to play arrangements, like the proposed arrangement between the ambulance companies and the City enacted by Ordinance, clearly implicate the anti-kickback statute."

In the particular case reviewed however, the OIG determined that it would not sanction the City that requested the opinion. Reasons cited included (1) the

fees were part of a comprehensive regulatory approach. (2) Fees did not exceed the city's costs for dispatching ambulances. And, (3) the fees were not tied directly to the number of referrals.

The opinion created more questions than it answered. It remains unclear whether it is advisable for cities to enact such an approach. Legal experts are coming down on both sides of this issue. Other municipalities will likely seek additional requests for clarification. The opinion can be found at http://www.dhhs.gov/progorg/oig/advopn/1999/ao99_5.htm.

tiative demonstration projects for innovation, and (4) Improve administration of the program and consider centralized claims processing. The full text of the report is posted at <http://www.dhhs.gov/progorg/oig>.

EMTALA. The anti-dumping law applies to other areas of the hospital, not just the emergency department according to a recent ruling by the US Court of Appeals for the first Circuit. The court held the hospital responsible when a newborn with life-threatening respiratory problems was transferred to an-

American College of Emergency Physicians outlined two EMS policies. ACEP believes that "EMS systems should adopt devices, medications, and procedures only after unbiased research has demonstrated their safety and cost-effectiveness in the out-of-hospital setting." This policy may limit individual medical directors' willingness to allow systems to implement unproven methodologies.

The second policy encourages research as an essential element and publication of that research in scientific, peer reviewed publications.

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the standard is a much more accurate approach.

(3) *Ensure CAD integrity.* Software specifications must be explicit. Vendors must have a defined time frame in which they are required to make the system perform. Performance bonds that delay payment until the successful installation can be independently verified should become standard practice.

(4) *Training.* Typically, staff are initially trained by vendor personnel. More at-

tention to system training after the installation (e.g. 3, 6, 12 months) should be specified as part of the performance based contract.

(5) *Internal audit trail.* A foolproof audit trail should be utilized to ensure the integrity of data. Every change should be flagged and a summary of response time changes should be reviewed and signed by a senior executive, outside the communications center.

(6) *Involve multiple*

people. Its hard to keep a secret in EMS. One of the best defenses against response time fraud is to involve multiple personnel in the internal review process.

(7) *Perform random sampling.* Randomly comparing the CAD reports to actual time established by audio tape ensures that individual calls are correctly reported. Regular random review is recommended.

(8) *Annual review & reporting.* Independent review

and verification of response times by an external auditor or EMS consultant can also detect and discourage fraud. This review, when coupled with tuning deployment plans, can be a cost effective mechanism to measure and improve system performance.

Patients depend upon EMS agencies to be on time. They also expect that the times reported represent actual performance. Doing anything less places the patient and the system at risk.

MANAGEMENT FOCUS ON THE WEB...

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medics' scope of practice, the EMS agency's production capacity, and the MCOs recognition that this can result in significant savings and better service.

MCO and nurse call centers do not understand the 911 environment. While 911 centers desire to enter this market, they may not be well prepared or suited for it. Data systems and other technologies between 911 and MCO call centers have not yet been well bridged.

Medics and EMS leaders have not embraced the changing scope and professional education required to be a full team player in the healthcare game. CommCen-

ter and field roles must change. EMS data deficits and accountability anemia must be dealt with before a successful partnership can occur.

Many EMS agencies offer a single type service rather than preparing to meet healthcare's future demand for multi-mission capable organizations. Non-EMS providers offer services in a frustratingly fragmented quilt of providers that range from federally subsidized medical taxi-service to the most sophisticated critical care transport systems in America.

The operational cost and inconvenience to payers can be likened to a four star res-

taurant offering only appetizers and snobishly telling the patron "we don't provide either entrées or desserts."

Several EMS organizations have tried to put the pieces together. They include AMR Pathways, Rural Metro, Mobile Health Resources International, and CareNOW. Each has EMS call center initiatives underway. Medical Priority Dispatch is trying to increase acceptance of its "Omega" protocol. Other non-EMS medical call center services such as FONEMED and LogistiCare are also trying to integrate the medical transportation component into their operations. To date, none of these efforts has resulted in

a fully integrated approach.

The goal is to reduce mismanaged access and costs associated with it. To accomplish that goal and avoid getting a "busy signal" in the future, providers and payers must fully address issues of data integration, expertise, accountability, value and incentives.

When EMS becomes a meaningful component part of the pathway, significant savings in downstream medical costs can be achieved without compromising care. Even more important, it is likely that objective data will prove that this approach can save lives and improve customer service, too!

-Editorial-

WHAT WENT WRONG?

Throughout healthcare the question, "What went wrong," is being asked.

According to Brian Wong, director of healthcare strategies for Arthur Anderson, LLP, when healthcare organizations worry about margins first, it begins the organization's death spiral.

In a recent article appearing in *AHA News*, Wong was quoted as saying "Starbucks took the lowly coffee bean and elevated it to an experience. Healthcare has taken the most important human experiences and reduced them to the level of a commodity."

The same can be said for EMS/medical transportation profession in recent years. Some claim the fire service

sees EMS only as a mechanism to maintain personal profit margins and life-styles of fire personnel with low utilization. At the same time, private providers - particularly the consolidators - stand accused of focussing only on corporate profit margins.

Both sectors wrap themselves in the flag to support their position. But here is what's true--both public and private providers have reduced EMS to a commodity in selfish pursuit of its own objectives.

The public trust in EMS is at stake. Loss of trust is "an 800 pound gorilla of a problem" that won't get resolved until leaders get clear on priorities.

To find the way forward, the profession must return to its centering point: caring for patients and other customers as *the* top priority. And, this must occur in a cost-effective manner. Those that provide great service will find profit and success. Those that don't will ultimately inherit the whirlwind. This is true despite the fact that public and private providers may define "profit" differently.

There are many reasons. Quality is the biggest one. Fire and EMS entities pride themselves on offering a "high quality" service. Unfortunately, little energy has been spent *proving* that EMS makes a difference or trying radically new ideas to improve the value re-

ceived. Flying in the US is 15 times safer than it was 15 years ago. EMS hasn't had anything close to such a measurable improvement. Part of that trust will be revived only when EMS leaders get absolutely committed to enhancing the day to day performance of the system as perceived by those served.

Throughout healthcare the erosion of trust is like the taste of a sour lemon. The time has come to move beyond the negativity, develop positive options and implement those that will enhance the customers' view of value. To paraphrase an old adage, when given lemons — make lemonade! How sweet or bitter our EMS lemonade becomes, remains to be seen.

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