

# MANAGEMENT FOCUS

— FOR PROVIDERS OF EMERGENCY MEDICAL SERVICES —

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## ISSUES & OPPORTUNITIES FOR 2003

Here are 10 top issues EMS leaders need to bring into sharp focus in the upcoming year. They include:

### HR ISSUES

**1 Recruitment & Retention.** Staff availability overshadows EMS programs nationwide. Approximately 40 paramedics resign or “retire” each day. Recruiting is seriously lagging as other service industries continue to snap up younger workers. Information technology, not healthcare, comprises 8 of the 10 fastest growing occupations. (*Also see #5*)

**2 Trust & Accountability.** Accountability is a double edged sword. Medics must perform and be accountable for clinical and other actions. Yet, leaders frequently do not accept responsibility for their decisions or actions.

Progressive services are benchmarking these perceptions using 360 degree reviews in which staff also rate leaders’ performance. As more leadership misdeeds are reported in the media (Enron, et al), ethics and trust for EMS leaders is a significantly higher priority.

**3 Employer Liability Issues.** Potential liability surrounding terminations, sexual harassment and other HR issues continue to climb.

A growing number of states are becoming “employer li-

ability states.” In these states, agencies can be held liable for negligent hiring or retention of an employee. For example, a Medic is hired that subsequently is alleged to have sexually assaulted a patient on duty. During the course of the investigation, it is discovered that the Medic was a convicted child abuser in another state, 6 years previously.

In employer liability states there may be a legal cause of action against the service for negligent hiring.

### OPERATIONS ISSUES

**4 Homeland Security.** Response to terrorism,

weapons of mass destruction and homeland security top the operations agendas for many departments.

Readiness has become the issue “de jour” with little mission clarity. Energy is being expended to divvy up the federal pie. If this continues unabated, the outcomes will likely be dismal and results catastrophic.

The best opportunity is to get involved at both state and regional levels.

**5 Training & Development.** There are over 1.2 million EMS providers delivering care in North America.

In the US, changes in curricula have received mixed reviews.

Some areas require paramedic programs be taught only as degree based programs. This effort, designed to improve educational quality, has further exacerbated the limited number of paramedics available. For example, it can take 3 years to become a AA degree medic. Starting pay upon completion ranges from \$10-15 per hour. Alternatively, a diploma RN program at the same institution requires 2 years and starting pay is \$16-20 per hour.

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## STRATEGIC IMPERATIVES

To effectively respond to the issues outlined above, here are four strategic imperatives for 2003.

**Integrating Providers into Cohesive Systems.** Public and private turf wars over the past decade have marginalized innovation. The private sector became mired in mergers and consolidations and adopted a bunker-like mentality about profitability, finances and the Medicare Fee Schedule. The fire service attempted a hostile takeover of EMS transport services in many communities. It turned out to be more about jobs than about quality. Both sectors lost credibility but nei-

ther was mortally wounded.

The dysfunction is not just across sector lines. Within each sector, jealousy and pride keep some agencies from collaborating and fully cooperating. Public agencies that won’t send the closest ambulance and private services holding calls instead of turning them to a competitor are two prime examples.

In 2003, the opportunity rests in discovering pathways for integrating disparate system providers into a cohesive system. Such a system has the hope of returning to the core values upon which EMS was founded: doing good things for patients.

**Integrating Operational, Clinical & Financial Information Systems.** Information is the life-blood of any EMS system. Unfortunately, EMS systems are anemic-at best, and in coma-at worst.

We have not made evidenced based decisions by integrating the operational, clinical and financial data in an efficient manner.

Most ambulance services operate at least 3 different databases. CAD information cannot be integrated with operational scheduling, clinical or billing systems. These cannot share information internally, let alone provide readily

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# EMS HOSPITAL TRENDS & NOTES



**CISD/CISM Questioned.** The World Health Organization (WHO) has added its voice to those opposed to single session debriefings that push persons to share their personal experiences beyond what they would naturally share. Others concerned about efficacy of CISD include the National Institute of Health (US Departments of Justice, Defense, Veterans Affairs and Health & Human Service) and the British Health service that have listed single session debriefing as contraindicated. The full WHO report available on-line at [http://www5.who.int/mental\\_health/download.cfm?id=0000000640](http://www5.who.int/mental_health/download.cfm?id=0000000640)

**Smallpox Issues.** Multiple states are struggling to find funds for healthcare worker vaccination. In Texas, the tab is estimated to exceed \$40 million. In Wisconsin, the \$19.3 million federal bioterrorism funding allocated has been earmarked for other priorities. The cost of vaccinations may negatively impact other health programs. Funding issues, coupled with potential complications and negative labor relations associated with mandatory inoculations are causing some EMS programs to shy away from the shots.

**Pediatric Resources.** EMSC has created a resource kit for providers. It has an array of information to improve pediatric injury and illness prevention, treatment and rehabilitation. Protocols, training courses, guidelines and con-

tact information are in the kit. Downloadable free from <http://www.ems-c.org/search/framesearch.htm>

**Rural AEDs.** \$11.9 million in grants, part of the Rural Access to Emergency Devices Grant program, will go to states to buy automatic external defibrillators and train emergency personnel in rural areas in their proper use. Contact the state EMS office for grant info.

**EMS & Heart Attacks.** Half call an ambulance. However, a recent study of 772,586 heart attack patients who were treated at acute-care hospitals around the country found that ambulance-transported patients received fibrinolytic therapy an average 12 minutes sooner than patients arriving by other means. And they received angioplasty

an average 31 minutes sooner than the self-transported group. <http://circ.ahajournals.org/cgi/content/short/01.CIR.0000041246.20352.03v1>

**NFPA.** Standards (1710 & 1720) caused quite a stir. Now, NFPA is developing EMS system guidelines. Known as NFPA 450, these are to be guidelines without specific performance standards. Comments will be accepted until later this year with an approval vote scheduled for the 2004 NFPA annual meeting.

**Rural Metro.** CBS Marketwatch included R/M among its top performers of 2002. The firm's stock rose nearly 500% after restructuring its debt and selling money losing operations in South America. R/M posted an 8% gain in domestic revenue over prior years.

## EMS FATALITIES

A frightening study by Brian Maguire, et al, published December 2002 in *Annals of Emergency Medicine*, quantified that EMS personnel suffer occupational fatalities at a much higher rate than suspected.

A fact Maguire could not conclude, but one that EMS leaders have known for years, is that many of these deaths are preventable. There are a number of reasons: Ambulance vehicle designs are inadequate and are exempt from regulations under the Federal Motor Vehicle Safety Standards; Training is less than effective; Equipment can be-

come a deadly projectile upon impact. Current occupant/patient restraint systems are ineffective.

In fact, less than 50% of on duty medics wear seatbelts while in the patient compartment. Dr. Nadine Levick's tireless research and video evidence graphically shows how unbelted occupants can be seriously injured and injure others in a crash.

In a related *Annals* editorial, Dr. Herbert Garrison described it as a "rescue first, my safety later" mentality that is worsening safety in some agencies. Garrison outlines 3 trends including (1) sparse

safety training, sometimes an afterthought, (2) disparate availability and use of personal protective equipment, and (3) limited understanding of work processes and the appropriate role of safety.

The profession needs vehicle manufacturers to improve crashworthiness through design and construction enhancements.

Leadership needs to become more proactive in analysis, worker selection/education, and prevention.

Finally, crew members need to improve the likelihood of their own survival by facing these statistics and changing

attitudes about the importance of safety, everyday on the job.

### MANAGEMENT FOCUS

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## ISSUES AND OPPORTUNITIES FOR 2003

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Healthcare career enhancement, e.g. Medic to RN bridge programs, remain limited. Forty-three states currently require National Registry.

While training is typically an HR issue, finding qualified staff is rapidly becoming a significant operational issue.

### 6 Improving Communications & Data Throughput.

EMS data is frequently disconnected. CAD systems that don't talk with one another; billing, training, QI, scheduling, and vehicle maintenance applications are typically independent software that make real time exchange of data difficult. Those leaders desiring to make evidence based decisions are often buried in separate mountains of reports.

### 7 Employee & Vehicle Safety.

Fatality rates for

EMS are slightly less than fire and police at 12.7 per 100,000. Over half the fatalities involve vehicular crashes. Coupled with Dr. Nadine Levick's research indicating <50% wear seat belts in the patient compartment, the need for better equipment and restraint systems, training and vehicle construction requires careful attention in 2003.

Increasing EMS assaults, homicides and suicides need leadership attention to be prevented.

#### COMMUNITY ISSUES

### 8 EMS Entity Entitlement Attitudes.

Throughout the profession, an "entitlement" attitude is taking hold. This negative thought pattern facilitates both public and private entities belief that it is their right to provide EMS in a particular community regardless of measurable response

times, other quality measures or cost.

Entitlement is a dangerous EMS attitude. Leaders and workers become passionate and uncompromising about the wrong issues. In the end, communities and patients become victims.

#### FINANCE

### 9 Adjusting to MFS & HIPAA.

There have been Medicare Fee Schedule winners and losers but services are adjusting. The complexity of the change process is what's exasperating. There are new procedures, codes, and carriers that don't understand. This has led to cash flow issues and further tightening of EMS budgets.

HIPAA remains either a mystery or maze for most providers. Privacy rule compliance is required by 4/14/03, which among other things,

requires training for all EMS employees.

### 10 Litigation, Liability & Healthcare Insurance.

Increased litigation and costs of both liability and healthcare insurance continue to be front burner issues. The only thing increasing faster than EMS claims and settlements are insurance rates. (See related story on page 4). Liability and vehicle insurance is difficult to obtain at any price. Healthcare insurance costs are expected to climb 13-15%, each of the next 5 years.

There are numerous other issues. And, constantly struggling with issues can be exasperating! EMS leaders have the responsibility to ask themselves: "What else needs to be done; How can value be created in this community; and, How can my leadership encourage others?"

## STRATEGIC IMPERATIVES

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benchmarkable data across system boundaries to facilitate research and accountability.

In 2003, the opportunity can be found in advances in networking and application interactivity, increases in reliability and ease of use that facilitate improvements in productivity.

**Accountability & Transparency.** Transparency is at the center of every well managed organization. Transparency is accountability for performance and quality based upon independently observed

metrics and standards.

According to Jeff Goldsmith, PhD, "it's the ability to see through the organization to the end product." A transparent system lets everyone know how everyone else is doing. Standard achievement, not politics, determine how people are rewarded. When there is a variation, someone is held accountable. People behave more responsibly when performance is made public.

Both public and private sectors are slowly embracing this imperative. NFPA guidelines

and standards and the AAA's revised community contracting guide are excellent tools to improve transparency in EMS.

**Developing Widespread Acceptance of E-learning for EMS.** In 1988, the National Registry first approved up to 10 hours of distance learning for CE. In the 15 years since, technology has improved significantly but compared to other professions and four year degree granting institutions, EMS remains "in Kindergarten."

Most states today will accept limited CE via the web.

Given the tremendous pressures facing EMS with recruiting and retention there should be significant efforts to teach large portions of the basic EMT and EMT-P programs and CE electronically. Students can be brought together for skill sessions and testing.

If the non-clinical components of bachelors and masters degrees in nursing can be taught on-line by fully accredited universities, why can't EMS?

## \$10 MILLION SETTLEMENT SHOWS SYSTEM DEFICITS

A recent *Boston Magazine* article titled "Emergency" highlighted a number of system deficiencies in the case of Ashley Leveillee. The blue eyed seven year old continues to suffer six years following her parent's desperate call for help when the child stopped breathing. The ambulance arrived 22 minutes after the initial 911 call.

First responders on the scene were frustrated at the long response time but were amazed, according to police, that paramedics took their time walking up the driveway. The patient, apparently suffering a febrile seizure, was hypoxic.

With no veins obvious, the medic requested and received permission for an Intraosseous infusion. After inserting the catheter, the medic realized that he *did not* have the key to the drug box and couldn't give the valium intended. Ten minutes passed and it was now 32 minutes after the initial 911 call.

The crew was met enroute to the hospital by another unit

and three doses of valium were administered. When the ambulance reached its destination Ashley had been without sufficient oxygen for nearly an hour.

The medic's written patient care report failed to disclose the difficulty finding the house, the lost key nor the additional unit providing the narcotics.

The ambulance supervisor who was at the hospital when the unit arrived didn't ask for an incident report to be completed. No action was ever taken by the company against the employee.

The settlement was the largest known personal injury settlement against an ambulance company in Massachusetts. The State Office of EMS would have never known about the case had it not been for a lawyer reporting the base information to *Lawyers Weekly* in accordance with the settlement agreement. The newspaper asked: If physicians are required to report medical errors, why aren't ambulance companies? The

state office had no report of the case but decided to investigate, five years after the incident.

The OEMS investigation, focused on 3 questions, according to *Boston Magazine*: Did the ambulance get lost? Did forgetting the key delay administration of the medication? Did the medics falsify information to hide mistakes?

The state's answer to each question was: We don't know. OEMS subsequently determined the patient care report contained inaccuracies and sent a letter of reprimand to the medic.

New regulations requiring services to report errors were approved in December. Ashley Leveillee can't comprehend that fact. At 25 pounds, the seven year old is unable to speak, use her extremities and must take nourishment through a feeding tube.

Michael Blanding's full article is at [www.bostonmagazine.com/ArticleDisplay.php?id=170](http://www.bostonmagazine.com/ArticleDisplay.php?id=170)

### EMS MANAGEMENT TODAY CONFERENCE

"Dreaming to be Great & Strategies for Making it Happen" is the theme of the new *EMS Management Today* Conference.

Three well-known seminars have combined to provide optimal value. Fitch & Associates' annual Leadership Conference has joined forces with the EMS Insider and the EMS Technology Conference. *EMS Management Today* will be held in Washington DC, June 28-29, 2003 at the historic Mayflower Hotel.

Specific tracks will include EMS Law & Policy Issues, Reimbursement & Technology and EMS Leadership & Human Resources.

In addition to great learning, it's an ideal time to visit the nation's capital. Mark your calendar and watch for the brochure in the mail or on-line at [www.fitchassoc.com](http://www.fitchassoc.com).

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