AMERICAN AMBULANCE ASSOCIATION

2012 Winter Edition

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AMBULANCE SERVICE Journal

Florida Prepayment Review Highlights the Need to Focus on Crew Documentation

By Brian S. Werfel, A.A.A. Medicare Consultant

On December 21, 2011, First Coast Service Options, the Medicare Administrative Contractors for Florida, implemented a statewide prepayment review of hospital discharges by ambulance. The review will focus on BLS non-emergency transports from a hospital to a nursing home. Recent months have also seen the expansion of existing prepayment reviews or the implementation of new reviews in a number of other states.

Individually, these reviews can be seen as an attempt by Medicare contractors to address areas of potential overutilization. Collectively, however, the increased use of prepayment reviews represents a fundamental shift in the federal government's approach towards combating fraud and abuse.

These prepayment reviews highlight the importance of the crew's documentation. If you are in one of the states affected by these reviews, improving your crews' documentation is probably the most effective step you can take to minimize disruption associated with these reviews. However, even if these reviews do not directly affect your service, they highlight the importance of crew documentation. Therefore, it probably makes sense to review your existing policies towards crew documentation, to identify any problem areas, and to implement steps to improve the documentation of medical necessity.

The Florida Review

The Centers for Medicare and Medicaid Services (CMS) conducts an annual study to measure improper payments in the Medicare fee-for-service program. This study, the Comprehensive Error Rate Testing program (CERT), reviews a random selection of approximately 50,000 claims from all industry types, and then uses statistical sampling to estimate an error rate for the claims paid for each industry group. Unfortunately, the CERT program does not separately report the error rate for ambulance claims. Instead, it lumps ambulance services into a larger category, which also includes claims for physician and independent laboratory services.

For 2011, the national error rate for physician, ambulance and lab claims was 9.2%, higher than the overall error rate of 8.6%. This followed on the heels of a 2010 CMS report that determined that four states (CA, FL, NY and TX) account for nearly 40% of all improper Medicare payments. As a result, First Coast is likely facing significant pressure from CMS to reduce its error rate.

This prompted First Coast to look closer at the November 2011 CERT data. That closer look revealed that error rate in Florida for BLS non-emergency discharges from a hospital to a nursing home (i.e., AO428 HN) was greater than 20%. While this represented a substantial reduction from the 60.3% error rate for claims in the November 2010 CERT Report, it was still far higher than the national error rate.

In response, First Coast conducted a probe review of 100 randomly selected claims. First Coast determined that only 35 of these claims met the medical necessity requirements for an ambulance. Among the reasons

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cited for denying claims were trip reports that indicated that patients were ambulatory, were able to sit in a wheelchair, or which otherwise failed to document that the patient could not be safely transported by other means. In one notable example, the documentation indicated that the physician ordered the ambulance solely because there was no public transportation available on weekends. First Coast concluded that hospital discharge planners were routinely requesting ambulance transportation whenever the patient was discharged to a skilled nursing facility or extended care facility, regardless of medical need.

In a conference call with providers to announce the statewide prepayment review, First Coast indicated that the review was not intended to be permanent. Rather, the stated goal was to remove specific providers, once the data demonstrated that the provider's claims were consistently being paid on review. However, First Coast would not commit to a specific time frame for removal, indicating that it needed time to gather information on each provider's compliance with Medicare guidelines. Thus, these prepayment reviews will continue for the foreseeable future.

Focus on Crew Documentation

As a general proposition, EMS crews do an excellent job documenting emergency transports. However, their documentation of non-emergency transports tends to be far more limited. One area of potential concern is vague or ambiguous descriptions of a patient's condition. For example, it is not uncommon for crews to list the reason for the ambulance as "patient was nonambulatory," "patient required maximum assistance to transfer to stretcher" or words to that effect. The problem is that, even if true, these descriptions do not definitely rule out transport by other means. For example, a patient may be unable to walk, but be fully capable of supporting themselves in a wheelchair. Another example would be a simple statement that the patient was "bed confined", without any further documentation as to why. In these situations, the paperwork should be returned to the crew for an addendum that contains a more detailed description of the patient's condition. Ultimately, crews should be required to answer the question: "why could this patient not be transported safely by other means?

Crews should also be reminded to document underlying chronic conditions that might affect the patient's ability to be transported by wheelchair van, even if those conditions do not present any barrier to effective patient care. Common examples include: amputations, contractures, paralysis/paresis, decubitus ulcers (and the location and stage), and the patient's mental status. All of these factors help "paint a picture" of the patient's overall condition, which is

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critical to establishing the need for the ambulance.

Another problem area involves patients that require oxygen. Many states regulate oxygen as a "drug", and, therefore, prohibit its administration in any vehicle other than an ambulance. However, these states may permit a patient to be transported by wheelchair van or private vehicle on their own portable oxygen. Therefore, it is critical that crews document not only that the oxygen was administered, but also the signs and symptoms that indicated the need for the oxygen. The paperwork should also indicate whether the patient had their own portable oxygen, and, if so, whether they were able to self-regulate that oxygen.

Lastly, we would review the patient signature requirement with your crews. Medicare contractors have been instructed to pay closer attention to the signature on trip reports and other medical records, and a prepayment review affords them the opportunity to look at the underlying documentation. In sum, when the patient is physically or mentally incapable of signing, it is important that the crew document the specific reason why the patient could not sign. The crew should then try to obtain an alternative signature on the patient's behalf, either from an authorized representative or a representative of the receiving facility.

Summary

The Obama Administration has made the elimination of Medicare fraud and abuse one of the cornerstones of its health care agenda. In 2009, the President signed an Executive Order that commits CMS to reducing the national CERT error rate to 5.4% by 2012. CMS has also shown a willingness to use the expanded powers granted to it by the Affordable Care Act to combat fraud and abuse. These include a number of demonstration projects, including one expanding the use of prepayment reviews. Although it is unclear whether the use of prepayment reviews will become more widespread, the possibility should not be discounted. As an industry, it is in our best interests to ensure that we are doing everything in our power to improve our crews' documentation of medical necessity.

Medicare Payments 2010

By David M. Werfel, Esq.

CMS has released data for Part B payment of ambulance claims in 2010. Listed below are the national totals for 2010 for allowed services, allowed charges and total Medicare payments:

CODE	DESCRIPTION	ALLOWED SERVICES	ALLOWED CHARGES	TOTAL PAYMENTS	AVERAGE PAYMENT
A0425	Mileage	133,619,172	$1,003,953,186	$801,179,638	$6.00
A0426	ALS, non-emergency	324,939	83,331,855	65,797,165	$202.49
A0427	ALS, emergency	4,664,321	1,900,608,451	1,499,245,227	$321.43
A0428	BLS, non-emergency	6,490,646	1,423,275,566	1,131,100,871	$174.27
A0429	BLS, emergency	2,531,014	888,186,706	699,650,690	$276.43
A0430	Fixed Wing	14,165	35,142,552	27,890,986	$1,969.01
A0431	Helicopter	50,103	224,544,729	178,305,981	$3,558.79
A0432	Paramedic Intercept	3,117	1,132,225	885,435	$284.07
A0433	ALS-2	112,002	65,321,620	51,542,908	$460.20
A0434	SCT	88,373	63,878,927	50,794,952	$574.78
A0435	Mileage, Fixed Wing	1,630,707	18,506,421	14,722,433	$9.03
A0436	Mileage, Helicopter	2,840,722	86,613,815	68,874,673	$24.25
	TOTALS:	152,369,280	$5,794,496,051	$4,589,990,960	

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Based on data obtained from CMS a year ago, I was able to make a comparison to the data for 2010 versus 2009. The first chart below lists the comparison based on the volume of paid claims. The second chart lists the comparison based on the allowed charges.

CODE	DESCRIPTION	2009 ALLOWED	ALLOWED CHARGES	TOTAL PAYMENTS
SERVICES	2010 ALLOWED	133,619,172	$1,003,953,186	$801,179,638
SERVICES	PERCENTAGE	324,939	83,331,855	65,797,165
CHANGE	ALS, emergency	4,664,321	1,900,608,451	1,499,245,227
A0425	Mileage	129,793,177	133,619,172	2.95%
A0426	ALS, non-emergency	326,628	324,939	-0.52%
A0427	ALS, emergency	4,506,533	4,664,321	3.50%
A0428	BLS, non-emergency	6,511,721	6,490,646	-0.32%
A0429	BLS, emergency	2,447,431	2,531,014	3.42%
A0430	Fixed Wing	9,696	14,165	46.09%
A0431	Helicopter	47,331	50,103	5.86%
A0432	Paramedic Intercept	3,126	3,117	-0.29%
A0433	ALS-2	108,368	112,002	3.35%
A0434	SCT	80,535	88,373	9.73%
A0435	Mileage, Fixed Wing	1,578,816	1,630,707	3.29%
A0436	Mileage, Helicopter	2,640,412	2,840,722	7.59%
	TOTALS:	148,053,774	152,369,280	2.91%

CODE	DESCRIPTION	2009 ALLOWED	ALLOWED CHARGES	TOTAL PAYMENTS
CHARGES	2010 ALLOWED	133,619,172	$1,003,953,186	$801,179,638
CHARGES	PERCENTAGE	324,939	83,331,855	65,797,165
CHANGE	ALS, emergency	4,664,321	1,900,608,451	1,499,245,227
A0425	Mileage	$978,755,452	$1,003,953,186	2.57%
A0426	ALS, non-emergency	83,621,919	83,331,855	-0.35%
A0427	ALS, emergency	1,849,098,741	1,900,608,451	2.79%
A0428	BLS, non-emergency	1,426,171,019	1,423,275,566	-0.20%
A0429	BLS, emergency	867,110,884	888,186,706	2.43%
A0430	Fixed Wing	33,715,022	35,142,552	4.23%
A0431	Helicopter	207,086,804	224,544,729	8.43%
A0432	Paramedic Intercept	1,146,354	1,132,225	-1.23%
A0433	ALS-2	63,487,040	65,321,620	2.89%
A0434	SCT	60,128,931	63,878,927	6.24%
A0435	Mileage, Fixed Wing	17,868,312	18,506,421	3.57%
A0436	Mileage, Helicopter	80,577,159	86,613,815	7.49%
	TOTALS:	$5,668,767,639	$5,794,496,051	2.22%

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A few trends, from 2009 to 2010, that are worth noting are as follows:

- Total allowed charges increased by 2.22%.
- Total allowed services increased by 2.91%.

Base (by volume)

- ALS emergencies increased by 3.5%.
- ALS non-emergencies decreased by 0.52% (**Note:** this follows decreases of 6% from 2008 to 2009, 6.52% from 2007 to 2008 and 12.54% from 2006 to 2007). This suggests that many providers that previously billed all-ALS have stopped doing so.
-
- BLS emergency increased by 3.42%.
- BLS non-emergencies decreased 0.32%. This suggests prepayment reviews of BLS non-emergencies are resulting in fewer covered transports.
-
- ALS-2 increased 3.35%.
- SCT increased by 9.73%, which could lead to additional attention from Medicare contractors.

- Fixed wing increased 46.09%, while fixed wing mileage increased by only 3.29%, i.e. while the number of fixed wing transports increased significantly, the average trip was shorter.
- Rotary wing increased by 5.86%, while mileage increased 7.59%.

Mileage

- Total ground miles increased 2.95%.

Saving lives is a community effort

Central Illinois Ambulance provider puts hundreds of free AEDs in the community

By Karen McDonald, Freelance Reporter on behalf of Advanced Medical Transport

What's known is the number of the life saving devices central Illinois' Advanced Medical Transport has placed in the community: 504 as of Jan 15, 2012.

Also known is the number of individuals in the community AMT has trained to use Automated External Defibrillators (AED) since its CardioReviver Program began nearly 10 years ago: 17,028 as of Jan. 15, 2012.

Not known: the number of lives saved.

But there are stories.

Whether it's the police department in a tiny village that calls AMT to request replacement pads for their AED because they had a "save" the previous night …

Or the police officer with an AED in his trunk who hears the report of an elderly gentleman at a golf course with a heart problem who collapsed and rushes to the scene beating emergency personnel …

CPR Instructor Jeff Edwards explains the benefits and the use of an AED as part of American Heart Associations Heart Saver CPR AED class. Edwards is one of 25 instructors employed by AMT to instruct more than a dozen classes per month as part of AMTs public access defibrillation program known as CardioReviver.

Or even the primary school teacher who collapsed in front of her class and ultimately was saved by CPR and an AED whose life savers were recognized at a banquet for heroes.

AMT boasts a total workforce of nearly 300 and an estimated 30 ambulances on the streets and technology including Computer Aided Dispatch (CAD), cutting edge cardiac and medical equipment, vehicle location systems, advanced telecommunications and computer documentation systems. The company provides emergency and scheduled ambulance service and critical care.

The motto? AMT saves lives. It's what we do.

AMT also recognizes that from a consumer point of view, faster than any fire truck, police or ambulance, is a trained citizen with an AED, said Executive Director and CEO Andrew Rand.

"We here at AMT are not going to save as many lives as we can save together with the entire community and that's why it's called public access defibrillation," Rand said. "It's zero response time."

In 2002, AMT's Board of Directors agreed to invest in a CardioReviver program. The goal was to get AED's placed in a variety of venues where large numbers of people gather – from athletic facilities, schools, parks and community centers to business offices, airports and churches, said AMT's Community Relations Coordinator Sharon Kennedy.

And just as operations have grown -- in the first year of operation in Peoria, Illinois AMT logged 7,500 calls and today, 40,000 service requests are reported annually in Illinois and Iowa – so too the Cardio Reviver Program has grown.

Training to save lives

Theresa Wehrli knows both the personal and professional benefits of AEDs. She's an EMT and instructor for AMT's CardioReviver Program.

A few years ago, a friend collapsed in a local gymnasium while playing basketball. Coaches grabbed a nearby AED and shocked him within minutes ultimately saving his life.

Professionally, Wehrli recognizes "People having more access can mean a matter of life or death."

Training to use the devices and ongoing maintenance goes hand in hand with donating the devices for community organizations and groups.

"It's not just providing the equipment, it's also about providing the training and monitoring the equipment, and making sure everything is functioning," said Cardio Reviver Coordinator Sandy Randall.

Traditionally, the ability to defibrillate was only available for emergency medical personnel. Non-medical personnel such as police, fire service, security guards, teachers, and other properly trained lay rescuers now can use AEDs.

"Early CPR and early defibrillation is what makes our jobs easier and more effective," Wehrli said. "It's not a matter of who does the job, it's a matter of what the patient outcome is."

AMT includes defibrillator training with its free four-hour CPR classes that provides two-year certification through the American Heart Association. The organization underwrites instructor fees, class supplies, AED trainers, educational materials and other associated costs.

AMT has about two dozen instructors, many of whom are nurses, nursing students or paramedics.

Denise Durrell gave up her career crunching numbers as an accountant about six years ago to save lives as a nurse. Part of that change up included her getting involved as an instructor for AMT's CardioReviver Program.

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Her previous employer and church both benefitted from AMT's AED grant program. She decided to become an instructor to help train others on how to use the devices.

While not every individual in every class will use CPR or an AED during their lifetime, Durrell tells her classes at least one person in every class will.

The demand for classes is high because AMT offers them to anyone who purchases or receives a donated AED through the organization. More than a dozen classes typically are offered in a month to accommodate requests, but also for re-certifications.

"This class gives you the ability to help save someone," Kennedy said. "Not everyone lives within five minutes of emergency medical personnel. Hopefully, none of them will have to use it, but if they do they will have the knowledge and confidence to do it."

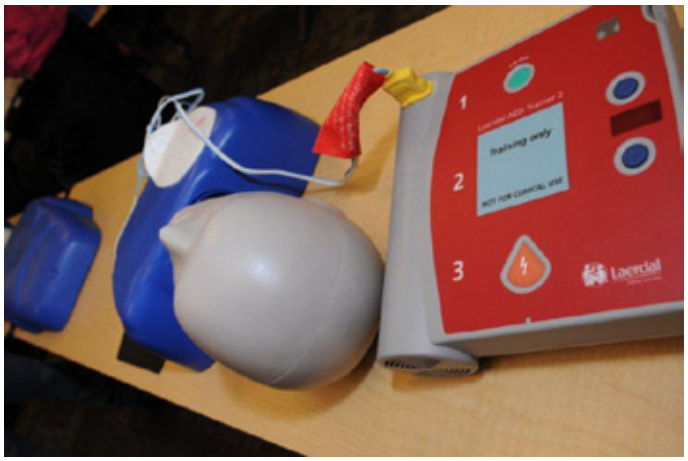
The mechanics behind AEDs

It's about the size of a small laptop computer or desk phone yet it packs a live-saving punch.

The American Heart Association estimates widespread use of AEDs can save tens of thousands of lives each year in the U.S. alone.

Nearly 300,000 out-of-hospital sudden cardiac arrests occur annually, and 80 percent of cardiac arrests occur at home, according to the AHA.

Typically, CPR is not enough to resuscitate the victim and defibrillation is the only way to restore the heart to a normal rhythm and save a person's life. For every minute that passes without defibrillation, a victim's chances of survival decrease by up to 10 percent and after 10 minutes, very few resuscitation attempts are successful, according to the AHA.



AMTs Cardio Reviver program success has been attributed to the widespread distribution of AEDs such as the one pictured here.

The AHA estimates widespread use of AEDs can save tens of thousands of lives each year in the U.S. alone.

The portable, battery-powered devices automatically diagnose life threatening heart rhythms and then treat the irregular heart rhythm by defibrillating the heart. It will only deliver a shock if one is needed.

"AED's are simple enough to use even for untrained individuals," Randall said. "The machine is very user friendly for the lay person."

Instructor Wehrli said ease of use and portability of the AED has proven key to saving lives. She's taught individuals as young as 12 years old up to those in their 80s and 90s.

"It's amazing to go into a class at the start and have people nervous about using the machine with lots of questions and after the class, because they've made the use of it so easy, they're completely comfortable because the AEDs themselves walk you step by step through the process," Wehrli said.

Laws and liability of AEDs

Illinois has been a leader nationwide in promoting public AED use. Making the public comfortable with the devices and getting them in public places has required a very deliberate and consistent educational campaign in the past ten years in conjunction with the approval of laws to address liability concerns, Kennedy said.

Since 1999, when Chicago-area airports became the first high-

AMTs CardioReviver campaign focuses on getting AEDs in the hands of properly trained individuals. Proper training equates to a "zero minute response time" for victims of cardiac arrest.

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profile public spaces in the nation outfitted with the devices, lawmakers have drafted and approved legislation requiring the life-saving devices in some public locations and protecting users from civil liability.

"Since the technology became available and these devices became more user friendly and the laws and cultures regarding both public and private buildings have evolved, people believe they have a role in this and accept it has made it easy to sell this idea," said AMT CEO Rand.

The first of its kind, the 2003 Colleen O'Sullivan Law required AEDs at all private and public indoor fitness facilities serving over 100 individuals including schools and parks.

In late 2007 the Rashidi A. Wheeler law was signed, which required AEDs at outdoor fitness and sports facilities including football stadiums, soccer and baseball fields.

All 50 states provide immunity to laypeople under Good Samartian laws so volunteer responders cannot be held civilly liable for the harm or death of a victim by providing improper or inadequate care, according to the National Conference of state legislators.

Additionally, the Cardiac Arrest Survival Act, which was passed by Congress and signed in 2000, provides AED users with Federal Good Samartian protection from liability in addition to recommending the placement of AEDs in all federal buildings.

The culture of community

The CardioReviver Program began just about a decade after AMT Inc. was formed in 1991 by three Peoria hospitals, OSF Saint Francis Medical Center, Proctor Hospital and Methodist Medical Center.

Following a vision of establishing a modern, high-performance emergency ambulance service, AMT is committed to high quality, non-tax subsidized programs & services.

It is a not-for-profit community organization governed by a local board of healthcare, business and community leaders that values being prepared, community-centered and customer-focused.

Everything AMT does revolves around a culture of caring. The AED program is a $1.2 million investment.

"Our CardioReviver Program is the pinnacle of our community involvement effort," said Rex Comerford , AMT's Administrative Director.

"In today's market and today's economy, you have to figure out how to do things and collaborate with entities you never would have thought you had to do in order to be successful."

By the Numbers

# of AED Units donated:	Over 500
# of individuals trained on AEDs:	Over 17,000
Hours of required training:	Between 3.5 and 4
Total community investment:	$1.2 million

(Source: Advanced Medical Transport)

Nearly 300,000 sudden cardiac arrests occur annually Typically, CPR is not enough to resuscitate the victim and defibrillation is the only way to restore the heart to a normal rhythm and save a person's life.
For every minute that passes without defibrillation, a victim's chances of survival decrease by up to 10 percent and after 10 minutes, very few resuscitation attempts are successful.
(American Heart Association)

Response Time Realities – Do They Really Matter?

By Matt Zavadsky, MS-HSA, EMT, Public Affairs Director MedStar EMS

Ask any EMS system in the United States about the quality of their performance and almost invariably one of the first benchmarks discussed is response time. But is that truly a measure of system quality? More importantly, does response time even matter in patient outcomes? How did response times become the predominant measure of system quality? What does really matter? How do we change our community's understanding of what really matters and ultimately transform from being evaluated based on the effectiveness of a process – to the impact we have on patient outcomes?

How did we get here?

The closest thing we have to a "national standard" for response time is the "8 minute" standard (or 8:59) for ALS ambulances. How did this standard come about? Here are some hints… It was the year that the Ford Pinto was the best-selling car, Jimmy Carter was President, John McEnroe won the U.S. Open, and the band Chic topped the Billboard charts with the song "Good Times"… Yep, 1979!

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In 1979, the Journal of the American Medical Association published a study by the research team of Eisenberg, Bergner and Hallstrom called *Cardiac Resuscitation in the Community - Importance of Rapid Provision and Implications for Program Planning* (JAMA. 1979;241(18):1905-1907). In the study, the authors found "If CPR was initiated within four minutes and if definitive care was provided within eight minutes, 43% of patients survived. If either time was exceeded, the chances of survival fell dramatically." In the study, 'definitive care' was defined as defibrillation. At that time (1979) only paramedics could defibrillate. So voilà, the 8 minute standard for ALS was born!

To make matters worse, we as an industry then used the concept of response time as a competitive determinate of success – even vowing to meet or exceed response time standards in an effort to win the right to serve communities. So in a way, the use of response times to measure a quality EMS system is a monster of our own making.

Scientific Reality Check:

EMS has a history of implementing new systems or products based on perceived value. It has not been until recently that we started to focus on the science of service delivery. The same should apply to response times. Thankfully, there have been several published studies that seem to demystify the impact of response times to patient outcomes.

Here are some highlights:

Paramedic Response Time: Does it affect patient survival (Acad Emerg Med. 2005 Jul;12(7):594-600)

This study evaluated 9,555 patients in Denver to see if there was any correlation to patient outcomes based on response times. The final study conclusion was: "A paramedic response time within 8 minutes was not associated with improved survival to hospital discharge after controlling for several important confounders, including level of illness severity. However, a survival benefit was identified when the response time was within 4 minutes for patients with intermediate or high risk of mortality. Adherence to the 8-minute response time guideline in most patients who access out-of-hospital emergency services is not supported by these results."

Lack of association between pre-hospital response times and patient outcomes (Prehosp Emerg Care. 2009 Oct-Dec;13(4):444-50)

The authors of this study looked at the current 10:59 response time standard in an urban system and evaluated the patient outcomes of 746 patients experiencing life threatening conditions. The authors

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concluded "Compared with patients who wait 10:59 minutes or less for ALS response, *Priority 1 patients who wait longer than 10:59 minutes could experience between a 6% increase and a 4% decrease in mortality, and do not have an increase in critical procedures performed in the field. Our data are most consistent with the inference that neither the mortality nor the frequency of critical procedural interventions varies substantially based on this pre-specified ALS RT."*

As part of the famous OPALS study (Ann of Emerg Med Volume 42, Issue 2 , Pages 242-250, August 2003), the authors published the following conclusion with regard to response times: "The 8-minute target established in many communities is not supported by our data as the optimal EMS defibrillation response interval for cardiac arrest. EMS system leaders should consider the effect of decreasing the 90th percentile defibrillation response interval to less than 8 minutes."

Response time effectiveness: comparison of response time and survival in an urban emergency medical services system (Acad Emerg Med. 2002 Apr;9(4):288-95)
This study reviewed 5,424 patient transports in an urban EMS system with a 10:59 response time standard and evaluated 71 patient encounters that resulted in death. The conclusion they reached was:"emergency calls where RTs were less than 5 minutes were associated with improved survival when compared with calls where RTs exceeded 5 minutes. While variables other than time may be associated with this improved survival, there is little evidence in these data to suggest that changing this system's response time specifications to times less than current, but greater than 5 minutes, would have any beneficial effect on survival.

What About Trauma?

We have often held that the "Golden Hour" was paramount in significant trauma cases. So one would presume that the "need for speed" would clearly be required in trauma cases – right?
Eight minutes or less: does the ambulance response time guideline impact trauma patient outcome (J Emerg Med. 2002 Jul;23(1):43-8).
This was another study in Denver that looked at 3,940 trauma cases, all of which were transported to a Level 1 trauma center. The results from this study were "After controlling for other significant predictors, there was no difference in survival after traumatic injury when the 8 min ambulance RT criteria was exceeded (mortality odds ratio 0.81, 95% CI 0.43-1.52). There was also no significant difference in survival when patients were stratified by injury severity score group". The authors concluded "Exceeding the ambulance industry response time criterion of 8 min does not affect patient survival after traumatic injury".

In 2007, the *U.S. METROPOLITAN MUNICIPALITIES' EMS MEDICAL DIRECTORS (a.k.a. the "Eagles Consortium") promulgated a position paper published in Prehospital Emergency Care on the whole issue of response times measures and the evaluation of the quality EMS system* (PREHOSPITAL EMERGENCY CARE 2008;12:141–151). Among the most notable quotes from their position paper are the following:

- "In many jurisdictions, response-time intervals for advanced life support units and resuscitation rates for victims of cardiac arrest are the primary measures of EMS system performance."
    - "The association of the former with patient outcomes is not

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supported explicitly by the medical literature, while the latter focuses on a very small proportion of the EMS patient population and thus does not represent a sufficiently broad selection of patients."

- "Over-emphasis upon response-time interval metrics may lead to unintended, but harmful, consequences (e.g., emergency vehicle crashes) and an undeserved confidence in quality and performance…"
- "…much of the clinical research utilized to establish an acceptable "advanced life support (ALS) response time interval" was conducted in a period when only paramedics could operate a defibrillator, and the compression component of basic cardiopulmonary resuscitation (CPR) received much less emphasis."
    - "Now that basic life support (BLS) providers and lay rescuers can provide rapid automated defibrillation as well as basic CPR, the relative importance of the ALS response-time interval has been challenged, both for cardiac arrest as well as for other clinical conditions."
- "Many communities are still not measuring the intervals for the most important predictive elements for optimal outcome: time elapsed until initiation of basic chest compressions and time elapsed until defibrillation attempts."

What's the Harm?

Aside from the obvious risks of driving lights and siren to calls in which we will have minimal patient outcome impact, providing an 8 minute ambulance response time standard results in two major drawbacks. First, the community invests significant dollars for the cost of readiness to assure the ambulance can get there in 8 minutes. Second, we need many more paramedics in the system staffing those ambulances. Is it better to have an experienced paramedic in 15 minutes, or an inexperienced one in 8 (or less)? During his Keynote address at the 2011 EMS Today Conference, Dr. Brent Myers, the Medical Director for the Wake County (NC) EMS system, expressed his opinion it is clinically beneficial to have fewer paramedics with more experience caring for patients.

Further, the Eagles Consortium published in their previously mentioned position paper "Pragmatically, considering that ALS cases constitute a small minority of all EMS 9-1-1 responses, adding more paramedics into the system may actually reduce an individual paramedic's exposure to critical decision-making and clinical skill competencies."

What to do Now?

As a profession, we need to unwind the clock and focus on the things that truly make a difference in patient outcomes. Imagine what we could do with a few million dollars saved by not having as many ambulances in our EMS systems. We could fund more BLS 1st Response to get hands on the chest more reliably within 5 minutes. We could invest in public education campaigns for CCCR, or even campaigns teaching chest pain or stoke patients not to wait hours to call 9-1-1 when their symptoms start rendering interventions futile. Perhaps even invest in community health initiatives to PREVENT the 9-1-1 call by helping patients navigate our healthcare system and keep themselves healthy enough to not need our services!

Understanding the Birth of Best Practices in EMS

By Jonathan D. Washko, BS-EMSA, NREMT-P, AEMD

For the past two years, I have had the privilege to get to present about Best Practices in EMS to my peers at the AAA annual convention in Las Vegas, NV. These sessions have covered a variety of topics from EMS operations to communications, finance, fleet maintenance, safety and risk, EMS system design, use of technology to improve efficiency and effectiveness and the list goes on and on…

Typically I am approached after these sessions and asked where did these Best Practices come from, how were they conceived, what catalyst helped springboard these ideas and concepts into reality?

Over my 25+ year career in EMS, I have had the unbelievable opportunity (and luck) to both see and work in many different EMS systems and organizations, literally working with or for every type of EMS system design known to man (Hospital, 3rd Service, Fire, Private, For-Profit, Not-For-Profit, Volunteer, PUM, Government, etc). Because of these experiences, I get exposed to really cool concepts and ideas from these agencies that have had many of these Best Practices in place for years.

When I ask these agencies about a particular practice or approach that I have never seen before, that I consider to be in a class of a Best Practice, I always ask how and why did they get to where they are today….and the answer is almost always the same…out of necessity….

You may have heard me say in my lectures and other writings that "necessity is the mother of invention but it also drives acceptance of the previously unacceptable". I coined this phrase (yes I believe it to be a Washko original), after many years of these experiences and watching and participating in transforming failing, mediocre and good EMS systems into superior, high quality, financially sustainable organizations that people want to work for.

In almost every case, a Best Practice was born through necessity. "Necessity" can be financial, political, clinical or altruistic in nature. Most of the time, the financial definition applies, where an EMS organization has to either develop best practices from scratch or embrace a practice shared by another agency, in order to effect internal change.

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It is also common to see organizations in crisis (financial, clinical and/or political) before they will change Bad Practices, and only though a complete organizational transformation that embraces the incorporation of numerous Best Practices into every aspect of the organization, can the system survive to see another day (acceptance of the previously unacceptable).

So what makes up a Best Practice? I believe that it is rooted in finding a great recipe, just like that favorite family recipe we all have (my Mom's meatloaf for example – YUM!), organizations have developed their own mix of processes, practices, technologies, logistics and cultures that when mixed together in proper proportions and under great leadership, have become EMS's version of the "Big Mac", "Original Recipe KFC", "the Number 9 at Jimmy Johns" or "the Double/Double Animal Style at In-N-Out" (yes all my favorite successful fast food chain recipes – can you tell I work in EMS ;-). Some of the coolest Best Practice recipes are used to improve patient care, employee well-being and organizational sustainability (what I call the EMS success Triad).

So what makes up a Best Practice? I believe that it is rooted in finding a great recipe,

Just like in cooking, when organizations try to reproduce or first create that great recipe, sometimes they just can't quite get it right, are able to pull it off perfectly or they improve upon greatness. Where organizations end up in this continuum is usually driven by necessity, the intensity of necessity and leadership's ability to get the right team on board and in-sync all rowing in the same direction. Where the organization lies in terms of developmental maturity also plays a significant role.

What do I mean by developmental maturity? Well, the best way to describe it is that I believe that organizations are like human beings (and this makes sense as human beings make up organizations). And like human beings where developmental psychology gives us insights on human behavior and the stages of psychological growth in humans (e.g. Maslow's hierarchy of needs), I believe the same holds true in all types of organizations.

To help better understand this, let's quickly recap Maslow's theory. Maslow's hierarchy of needs is typically represented by a pyramid, with the basic essentials of food water and shelter at the foundation of the pyramid, followed by safety, love/belonging, esteem and finally the pinnacle of self-actualization. Human psychological development and maturity moves between these stages as these needs are met or lost. I believe organizations follow the exact same continuum, and where your organization lies in this continuum, drive your necessities and willingness to develop new, embrace existing or reject Best Practices.

Moving between these developmental stages occurs in a hierarchy like fashion where the basics must be met before safety which must be met before the next stage and so on. Organizations can move up and down this continuum (just like humans) based on internal and external forces and ability and willingness to adapt and change. The most successful organizations and those at the top of the pyramid are highly adaptive, learn from their mistakes, are willing to take risks, are transparent and are values based organizations. Those that stagnate at the middle or bottom of the continuum have the opposite traits and are "steeped in tradition unencumbered by progress."

Organizations that one day find themselves in trouble and at the bottom of the pyramid (survival mode) either don't know what they don't know or do know what they don't know but never did anything to alter this or are unwilling to take the risks associated with change, because the warmth of safety and comfort overshadow the need or desire to change course. Eventually, the lack of course change plows these organizations into an iceberg they didn't see coming because they were not looking for them or were not capable of mitigating the ensuing breech in the hull (healthcare reform is one of those metaphoric icebergs for many of us by the way, if you're not currently watching). Usually, these organizations are driven by substantial financial necessity, which brings about significant organizational changes.

Those in the middle of the continuum can fall into the other stages of organizational development with politics or patient care frequently driving changes, although always staying "safe" (the middle of the pyramid) often stagnates organizations into the "doldrums". These types of organizations are typically destined to eventually end up on the bottom or top of the pyramid as remaining in the middle stages of the continuum is typically not sustainable nor evergreen.

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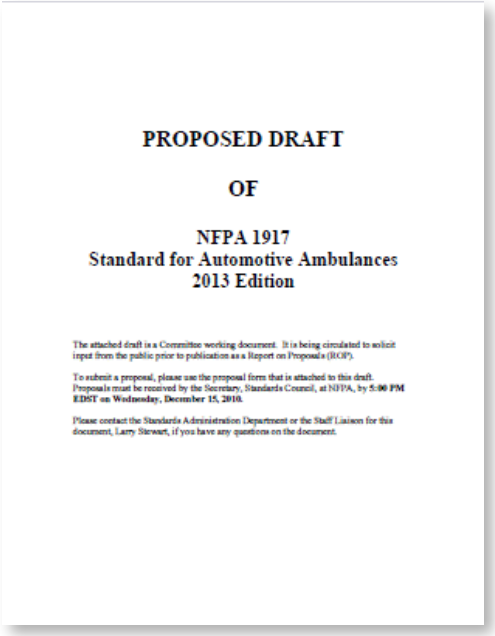
Some of the most amazing organizations and leaders are those that can move themselves from the middle of this continuum to the top without necessity driving the need for change (altruistic missions). These organizations typically have visionary governance steering the ship and have 20/10 insightful vision beyond their peers. These types of organizations are farer and fewer between but do exist in EMS, and are at the forefront of developing new and innovative Best Practices that we may someday embrace in our own organizations.

I hope that this deeper dive into the birth of Best Practices was useful and helps you stratify your organization in the developmental continuum. Understanding where you are is the first step in course navigation, and having and embracing the right tools (Best Practices) to get you to your organization's next destination can shorten your road traveled and make the journey so much more enjoyable!

NFPA 1917 Document Still Seeking Input

Posted by Justin on November 18, 2011; http://www.penncare.net/blog/index.php/2011/11/nfpa1917/

The National Fire Protection Agency (NFPA) recently released a document that is open to public comment with regard to ambulance construction standards. The document itself, entitled NFPA 1917, will essentially replace the Triple K specification which has long guided the direction of ambulance construction. Whether or not the document will fulfill its purpose of creating safer ambulances, however, depends upon the creative insight and input from EMS professionals on the document itself.



PROPOSED DRAFT

OF

NFPA 1917
Standard for Automotive Ambulances
2013 Edition

The attached draft is a Committee working document. It is being circulated to solicit input from the public prior to publication as a Report on Proposals (ROP).

To submit a proposal, please use the proposal form that is attached to this draft. Proposals must be received by the Secretary, Standards Council, at NFPA, by 5:00 PM EDST on Wednesday, December 15, 2010.

Please contact the Standards Administration Department or the Staff Liaison for this document, Larry Stewart, if you have any questions on the document.

NFPA 1917 Ambulance Standards Document

Stakeholders in the ambulance manufacturing sector will be paying especially close attention to what the final draft of this document will hold with regard to new specifications. As it stands now, the average price of an ambulance will be expected to rise if the standards are more stringent. More safety enhancements will come at a greater cost to the department. By opening the document up to public comment, however, the cost and safety of future ambulances will ultimately be affected by ambulance manufacturers and city managers alike.

EMTs want a safer vehicle and rightly so. A separate document from September 2011 created by the NFPA containing ambulance crash statistics is essential for anyone looking to weigh in on the proposed NFPA 1917 standard. The report contains data that was collected over a nineteen year period (1990-2009) about ambulance crashes and related fatalities.

Table 3-1: Summary of Ambulance Crash Data from NHTSA FARS and NASS GES, 1990-2009

	Single Vehicle Ambulance Crash				Multi Vehicle Ambulance Crash				TOTAL			
Use Type	Fatal	Injury *	$ Loss Only*	Total	Fatal	Injury *	$ Loss Only*	Total	Fatal	Injury *	$ Loss Only*	Total
Not in Emergency Use	70	794	2,638	3,502	195	8,560	15,614	24,269	265	9,355	18,252	27,871
In Emergency Use	51	1,653	3,265	4,970	273	16,235	27,915	44,423	324	17,889	31,180	49,393
Unknown	---	471	2,299	2,770	1	1,255	3,520	4,776	1	1,726	5,819	7,546
TOTAL	121	2,919	8,202	11,242	469	26,051	47,049	73,568	590	28,969	55,251	84,810

* Note: "Injury" and "$ Loss Only" are estimates.

Source: September 2011 Fire Protection Research Foundation

One of the biggest omissions in the NFPA 1917 standards is the lack of ambulance crash testing requirements. This might come as a surprise to those in the EMT community looking for safer ambulances. The main reason being given for the omission is that a "pulse" cannot yet be identified for what makes an ambulance worthy of passing a crash test.

Have a question or comment about what you think makes an ambulance suitable for the road? The document will be reviewed by the NFPA this upcoming February 2012 so now is the time to voice your opinions. We'd love to hear what you have to think!

Once final review is complete, the NFPA 1917 document will be adopted on January 1, 2013.

Our Future Leaders

Randy Strozyk, CEO, AMR Air Ambulance, Secretary at Large of the AAA

Last December I had the honor of attending the Army-Navy game held for the first time in our nation's capital. I say honor not because that I am a big football fan, I'm not, but because I had the honor of experiencing 8000 Cadets and Midshipmen in one place. These young women and men represent the best of the best, and are not only our future military leaders, but many will later lead our nation both in government and business.

As I watched this amazing group of young American's I reflected upon the future leaders of our service and what are we doing to both recruit and train our next generation leaders. That is not to say that I am feeling old and looking to retire, and as I like to remind anyone who wants to listen that my hair began turning gray when I was in my early 20's. But the challenge is upon us to pass the baton in the not so distant future

For the American Ambulance Association and its members the future is not far away. Since the formation of the AAA in 1979 we have been gifted to have amazing leaders that have guided us through the challenges and evolutions of EMS. I remember well the sense of awe I experienced attending my first Annual Conference in 1984 and listening to folks like Bob Forbus and others speak about the complexities of business, and express a vision for what the future may hold. Since that first meeting the baton has been passed on to others like Trace Skeen, Mark Meijer, Jerry Overton and Steve Williamson, to name a few members of a honored fraternity, who have dedicated countless hours to ensure that Private Ambulance Service made the transition into the 21st Century.

The leadership of the AAA in the course of looking to future of our association determined that we need to ensure that we have a pathway to balance experienced leadership with instilling an influx of new leaders. With the change of our association's bylaws laws in 2010, term limits have been established for board positions. 2012 will be our first year where seats will open in response to change. Equally important for our members is the desire to encourage new members to the various committees and projects that the AAA sponsors.

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Photo by Heidi Willis

For me becoming active in the AAA provided me with access to industry leaders that are on the cutting edge of this industry. I've always thought of the AAA as my other family.

Jim McPartlon, President Mohawk Ambulance Service Region1 board member, Past President of the AAA

Clearly a challenge that is upon us today is our ability to ensure that we as a provider of EMS and patient transportation services will be viable in the next decade. A significant mission of the AAA is to work to ensure a sufficient level funding for services. This mission consumes a significant portion of our leadership's time and efforts. The phrase of "no margin, no mission" has never been more true.

But let me propose that the next generation of AAA members and leaders will also need to be knowledgeable in all facits associated with being a healthcare provider. And in terms of our associations continued position of being the representive of private ambulance Service it is time to ensure the next group great leaders like Gene Moffit, Mark Meijer and Bob Garner are ready to take reins of leadership.

Many times when I approach members of our association about becoming involved in the various committees and programs I hear a number of reasons given for not participating. " I don't have time to spare", " I don't know anything about the issue", "It is too expensive to participate in the all the meetings" are many of the excuses I hear. And I many times I get the impression there is a degree of resistance because of real or imagined barriers that the same people have controlled certain projects forever and new people may not be needed.

I don't think that any of the reasons are unique to our association or any other national association. The reality is that we are an association that welcomes new members and clearly understand the importance of growing our base of representation.

Our association management company team lead by Maria Bianchi, EVP, give 150% effort to ensure new members are welcome and encouraged to become active members. The leaders of the various committees are always looking for new active members to help with the work and bring their skills to the table. That leaves the challenge to all of us to look around and find our future leaders and

Photo by Heidi Willis

begin the process of training them to lead us into the next evolution of healthcare.

In the February edition of the Harvard Business Journal there is a column by Nitin Nohria, Dean of the Harvard School of Business " What business schools can learn for Medical Schools". In his column he speaks of the methodology where new Physicians are trained by working closely with senior medical personnel, and thus are given the opportunity to have hands on experience, yet are closely mentored and guided. Those of us who came from the field remember our days of being new Paramedics and EMT's and learning from the old guys on how not to screw-up. And equally important we challenged the seasoned caregivers to ensure that they were up-to date with the latest teachings. But the key, as is pointed out in the article, is that the training is guided. The author suggests, and I fully agree, that applying the same concept to training our new leaders in the business world will provide for a better leader who has been given the opportunity to stretch their leadership horizon.

Once you start going to committee meetings you will notice first of all the information you learn is invaluable. The thoughtful process of large and small services sharing thoughts, and developing industry policy through consensus is obvious. Once you start to participate you will find out that your thoughts and ideas are welcome and it doesn't matter if you come from a small, medium or large service we all work together to learn from each other.

Jim Finger, CEA, Vermont Regional Ambulance Service
Immediate Past President of the AAA

When I talk with other managers around the Country about what they are doing to bring folks into leadership roles many times I hear a common story about the challenges making that transition from the field to the office. Those of us who may have a few more gray hairs will attest to learning our skills from managers and owners who would exemplify the description of "old school". And over time we have learned to balance strong values from the past with new and very defined business rules that are all functioning under today.

Today a large number of new managers are making the transition from field care to leadership roles with a greater level of education than we saw 20 years ago. Business degrees are no longer the exception and many are working on advanced levels of education.

So where does making the commitment to being an active member of the AAA translate into being a better leader? Excluding the opportunity to attend meetings in some great locations like Washington DC and Las Vegas, the real opportunity lies in the networking. As I reflect back to 30 plus years in management and where I gained my knowledge base, one of the most important sources of information and guidance came from the people I have met across the Country who became both colleagues and friends. Not all these contacts came from AAA meetings and I do not propose that attending the annual conference will fill you cardex with every possible contact you may need. But What I do know is that the opportunity to attend meetings and participate in projects will allow new management personnel to be exposed to concepts and ideas that may be happening across the Country.

Nothing could be more exciting than for us than, to meet that new member who will be tomorrow's leader of our association. See you at the next conference.

Photo by Heidi Willis

THE AMERICAN ASSOCIATION
2012 EVENT CALENDAR

Stars of Life

April 29-May 2: Washington Court Hotel, Washington, DC

Board of Directors Meeting, April 29

The most beloved event on the AAA calendar, Stars of Life truly is the heart and soul of our organization. This one of a kind event honors EMS professionals for their contribution to their communities, companies and colleagues. Nominate your "Star" and the join us as we recognize our industry's unsung heroes in a series of celebratory events in our Nation's Capital.

Learn more and Register Now

National Reimbursement Workshops

Two Dates:

- **May 22, 2012 - Doubletree New Orleans, New Orleans, LA**
- **September 10, 2012 - Hyatt Regency Cambridge, Cambridge, MA**

Each workshop is an information packed one day session designed to give you actionable knowledge and skills in a small groups format. Our experienced panels of presenters and industry experts will take you through real life examples of everyday reimbursement challenges with hands on exercises and takeaway materials. *AAA will issues a certificate of 8.5 CEU's upon completion of a workshop. Successful completion of the program will meet CAAS accreditation standard education requirements for billing personnel (8.5 CEU's).

Summer Summit

August 9-10: Hyatt Rosemont, Rosemont, IL

Board of Directors Meeting and 2013 Strategic Planning, August 8

The AAA is pleased to be adding the Summer Summit as a unique event for the 2012 calendar. The Summer Summit will be a day and a half meeting with dynamic education, industry discussion and networking opportunities. This event is a hybrid of our National Reimbursement Workshops and preview of our Annual Convention with content suitable for all operations regardless of size.

Annual Convention & Tradeshow

November 27-29: Annual Convention & Tradeshow, Caesar's Palace, Las Vegas, NV

***Board of Directors Meeting November 26**

This premier event is one of the largest inclusive gatherings of ambulance and pre-hospital care leaders, and features three distinct tracks for Administration, Leadership and Operations. Our primary focus continues to be providing critical information that both new and established ambulance services may utilize to better serve their communities.

AAA Online Knowledge Center

New Webinar Series

February 27, 2012 11:00am EST -60 minutes

Selecting and Implementing an ePCR System Part I

Presented by: Jonathan D. Washko, BS-EMSA, NREMT-P, EMD, Assistant Vice President for CEMS Operations, North Shore - LIJ Health System & Jerry Zapolnik, MBA, BSBA-IT, EMT-P I/C, Chief Operating Officer for Huron Valley Ambulance

The first in a two part series, Selecting and Implementing an ePCR System is a valuable primer for identifying the best ePCR solution for your organization's needs. This 60 minute session will cover the benefits and practical applications, technology and equipment requirements, vendor selection, administration and maintenance. A must for any provider looking to invest in or upgrade their ePCR system.

March 26, 2012 11:00am EST-60 minutes Selecting and Implementing an ePCR System Part II

Presented by: Jonathan D. Washko, BS-EMSA, NREMT-P, EMD, Assistant Vice President for CEMS Operations, North Shore- LIJ Health System & Jerry Zapolinik, MBA, BSBA-IT, EMT-P I/C, Chief Operating Officer for Huron Valley Ambulance

Part II will provide additional information on ePCR implementation best practices followed by a panel discussion with small providers. The panel will share their ePCR experiences and the impact it has had on their organization's existing processes. Guest Panelist Brian Werfel will address the financial benefits.

Register Now