

Part II: The Principal Elements

The following article is the second in a three-part series describing the "Public Utility Model" — a specially designed EMS system which operates as a public utility. The concept of this Model was developed four years ago by a team of economists and behavioral scientists after they had undertaken a comprehensive analysis of the factors involved in prehospital care. A practical application of the Model theory was then made in Tulsa and Kansas City, under the direction of Author Stout, who had headed the team, and his partner, Alan Jameson. Last month Stout outlined the "variables" involved in any EMS system and he critiqued the Model with these in mind. Next month he will stress the necessity of building-in certain political safeguards when adopting the Model. Now Stout will lay out the principal elements of the Model structure itself.

The structure itself of the EMS system concept called the Public Utility Model is simple and straightforward. The key to understanding the Model is not so much the structure as the careful — even rigid — separation of authorities and responsibilities. From a legal perspective the mechanism of the Public Utility Model is complex, in that the "organizational glue" which binds the whole system together is a mixture of regulatory authority and contract authority. The principal organizational players in the system, and their linkages, may be seen in Figure 1. But to understand the system, even at a very general level, one must understand the nature of these linkages and the interorganizational "tensions" — the checks and balances — which must be present in any application of the Model, or it's not the Model.

Sponsoring Unit of Local Government

While more than one jurisdiction

may be served by a single public utility system, we recommend that a single unit of local government act as the principal sponsor — preferably the one with the best administrative resources suitable for overseeing the operation. The "public authority" (discussed below) may have a multi-jurisdictional makeup on its controlling board of directors, but one unit of local government should equip itself to handle the day-to-day oversight of the system.

The primary responsibilities of local government under the Model are:

1. Establishing clinical standards of production.
2. Establishing response time standards of production.
3. Rate-setting.
4. Establishing level of subsidy.
5. Enforcing regulations governing these production standards.
6. Establishing a public authority,

by Jack Stout

and selecting the "directors."

There are other responsibilities to be performed by local government under the Model but the above-listed functions are the main ones. While it is necessary that clinical standards must remain the same throughout the service area of the system, it is not necessary for response time standards, rate structures, or per capita annual subsidy levels to be the same for each jurisdiction served by a single public utility system. For example, one community may desire and be willing to pay for a superior response time standard, in which case either the rate structure or the per capital annual subsidy would be higher for services rendered in that community than in the others served by the same system. However, since efficient production demands that every ambulance unit be capable of responding anywhere in the service area, it is impossible to vary the clinical standards within a given system and still maintain real efficiency.

In practice, the local ordinances required to establish and operate the system are relatively complex, and must be "tailored" to the locality.

The Private Emergency Physicians Organization

To assist the local government in enforcing its regulations, a contract is executed between the unit of local government and a private not-for-

profit organization of emergency physicians (EPO) — usually created specifically for this purpose. The EPO is controlled by physicians who regularly practice emergency medicine in the service area, and its articles of incorporation and bylaws must, by contract, admit to voting membership any emergency physician within the service area.

The primary job of the EPO is to perform fact-finding activities on behalf of local government, as part of its regulatory process. The EPO's primary tasks are:

1. Development of emergency care clinical protocols.
2. Performing routine medical audits.
3. Vehicle inspections.
4. Personnel testing for local certification.
5. Investigation of complaints.
6. Providing 24-hour "medical control."

Again, there are other functions to be performed by the EPO. We recommend utilizing a private not-for-profit organization controlled by emergency physicians for several reasons, legal and practical, but our main reason for doing so is our recognition of the fact that the emergency receiving physicians have a monopoly on the most important information in the system — that is, patient care. Emergency physicians receive every patient served by the system. They have almost daily contact with emergency personnel. And they depend upon EMTs in the field to carry out their protocols. Furthermore, using emergency physicians in this way greatly reduces the chances of an EMT's being expected to handle a given clinical condition one way for one physician, and another way for a different physician — a common problem in our industry.

The EPO is only a fact-finding organization. It does not have authority to enforce provisions of the ordinance. However, if the EPO "finds" that an EMT does not perform well under pressure, then that finding will most always result in the revocation or suspension of that EMT's certification by the regulating unit of local government. In a sense, the EPO acts almost as a "binding arbitrator" in settling disputes related to quality of care — disputes involving the local government, the public authority, or the private contractor.

The Public Physician Advisory Board

The public physician advisory board is created nearly parallel to the EPO, and, in fact, we recommend that a majority of the board of both groups be made up of the same individuals. The reasons for having two separate organizations are primarily legal, and the public physician advisory board is, in effect, an arm of local government. Its primary function is to advise the local government concerning issuance, suspension, or revocation of vehicle permits, personnel certifications, and ambulance operators' licenses.

To take an extreme example, let us say that, from medical audit findings and other information documented by the EPO under contract to the regulating unit of local government, the physician advisory board recommends that a private contractor in the system be shut down. Let us further assume that the unit of local government concurs with the recommendations of the physician advisory board. The contract between the public authority and the contractor in question will reference this decision-making process and, if the unit of local government does shut down the contractor, such an event is contractually defined as a "major breach" of the contract, and a variety of performance security and liquidated damages provisions of the contract will go into effect.

Less dramatic would be the case of an EMT employed by the contractor whose certification is recommended for revocation or suspension by the physician advisory board acting on facts presented to the board by the EPO. Early in the operation of the Tulsa system, for example, a crew was taken off the streets by precisely this action, and the contractor was, of course, forced to temporarily replace the crew with more acceptable personnel, while that crew was given intensive refresher training acceptable to the physicians before being returned to the streets.

These mechanisms are designed to separate, as much as possible, the clinical control of the system from the political and business aspects of the system. Thus, if the doctors aren't satisfied with the system's clinical performance, the whole system must react.

In both Kansas City and Tulsa, we found the best legal structure for

constituting the "public authority" to be in the form of a "public trust" with the city serving as "beneficiary." Oklahoma statute specifically provided for this type of trust and, under Missouri law, it was the "home rule" provision of the state constitution which enabled us to use a similar mechanism.

The closest analogy we can think of to the public authority in our Model is the board of a municipally owned hospital. In fact, the responsibilities of the public authority are almost identical to those of a municipally owned hospital board, including:

1. Assumption of top level management responsibility for the financial affairs of the service system.
2. Cost-containment.
3. Proposing rate structures and subsidy arrangements, and recommending trade-offs between these two revenue sources.
4. Acquiring the use of appropriate facilities and capital equipment necessary to system operations.
5. Conducting procurements and managing subcontractors in the interests of the public.

In carrying out these responsibilities, however, the public authority is constrained by its indenture (or other legal instrument creating the authority) in that it *must* contract with a private for-profit firm (or firms in certain cases) for the day-to-day management of the delivery system. Public agencies historically grow faster and experience greater rates of inflation than do private firms, and a key feature of the Public Utility Model is the prohibition against bringing a service delivery system "in-house," except for short-term emergency situations. The public authority has little incentive to "build an empire" since that empire would not be its own.

Another constraint placed upon the authority is that it *may not* allow its ambulance operator to perform billing and collection functions. The public authority must either operate the revenue side of its business in-house or may at its option contract with a private firm other than its ambulance services contractor for these and other financial management services.

There are many reasons for the organizational separation of service

production vs. accounts-receivable management, but only two will be discussed here. First, contractor compensation for production should be structured in a manner which neutralizes all fee-for-service incentives to either overserve or underserve any individual or neighborhood, and if the contractor responsible for service delivery is also contracted to perform accounts-receivable management services, and if compensation for managing accounts-receivable services is somehow linked to collection performance (and it should be), then an indirect, though very powerful, linkage will be created between the production side of the system and the revenue side of the system that will inevitably make certain patients and certain services more "profitable" to the contractor than other patients or services. Second, minimizing the use of local tax dollars at any given level of production requires that both the production side of the system and the revenue side of the system be man-

aged extremely well. In the Public Utility Model, the *only* way the ambulance service contractor can increase his profits is to find ways of meeting his production standards at lower costs. There is no other way. Since there is no other way, we find a tremendous amount of contractor energy and creativity being devoted to cost-containment — not to improving collection, justifying a larger subsidy, or any of the other "revenue side" considerations with which most fee-for-service ambulance operations concern themselves.

As a practical matter, the nature of the expertise required to professionally and efficiently manage the actual production of advanced life support EMS services is almost entirely unrelated to the expertise required for good accounts-receivable management. Thus, we can see several reasons to separate these two functions, and we can see no good reason for linking them.

It is occasionally argued that production and accounts-receivable

management should be linked with the private contractor as a means of making him more accountable to the consumer. However, in the Public Utility Model, contractor selection is conducted by the public authority — not by the patient. Thus, the proper route for consumer feedback should be through the authority. If that important source of information rests in the hands of the contractor himself, it is likely that much negative consumer feedback will be "dead upon arrival."

The makeup of the board of directors, or board of trustees, of the public authority is absolutely critical to overall system performance — particularly long-range performance.

Unless the public authority is controlled by a board of appropriately expert individuals, a gradual degradation of performance and efficiency should be anticipated. Membership on the board of directors of the authority should, therefore, be based — not upon political representation

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— but upon the need for specific kinds of expertise necessary to the day-to-day management of a multi-million dollar health care organization. More specifically:

- Physicians should be on the board because they are expert in the clinical issues at hand, namely emergency medicine, and because they are intimately familiar with the system and its day-to-day operations. They should *not* be selected because of their contribution to the Mayor's campaign, or because the local medical society recommended them.
- One or more hospital administrators should be appointed to the board for their reputation as quality professional health care administrators. They should *not* be appointed because of their involvement with other civic projects, or because they are in charge of the municipal hospital.
- Representatives of the local business community should be selected because of their demonstrated ability to understand and manage complex business structures. We

know of no industry that is more complex than the prehospital EMS industry.

- In addition to expertise in emergency medicine, health care administration, and business management in general, the board should also include expertise in city finance, both administrative and corporate law, and at least one member of the sponsoring city council should serve to provide informed linkage between the public authority and the sponsoring unit of local government.

Other Participating Units of Local Government

The public authority's trust indenture, or other legal instrument creating the authority, should empower the authority to accept contractual responsibility for rendering ambulance services in neighboring communities, but should require the authority to manage its financial involvement with other communities in a manner which avoids subsidizing services in one community with the tax dollars of another community.

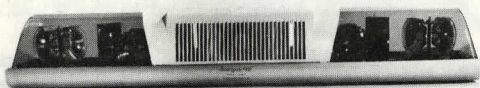
For example, if contracted services to a contiguous unit of local government are exactly the same in quality and response reliability as everywhere else in the service system, and if the collection rate in the neighboring city is greater than in the rest of the service area, then under the Public Utility Model the rates charged in the neighboring city (or the required per capita annual subsidy in that city) would be lower than in other areas. To achieve this equity, the public authority must, of course, possess the administrative sophistication to analyze these financial issues and to provide differential billings throughout its service area.

Private For-Profit Contractor(s)

The job of the private for-profit contractor is to operate the production end of the system. The business relationship between the public authority and the private contractor must be such that financial risk from events beyond the control of the contract are largely eliminated. Similarly, it should be impossible for

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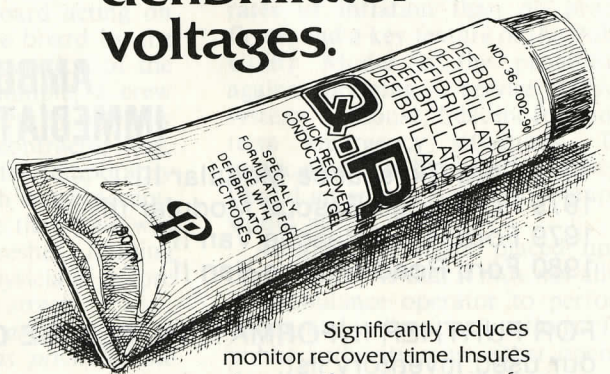
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the contractor to make money without doing the job properly.

There must be financial penalties for defined forms of "minor breach," and there must, of course, be severe financial consequences resulting from "major breach." Conditions constituting major breach must be specifically defined; we rely heavily upon the physician advisory board to "call the shots" where issues so volatile as "major breach" are involved.

Provision for compensation must be designed to neutralize the fee-for-service incentives which plague the rest of the health care industry, or cumbersome "utilization review" types of mechanisms must be installed.

The private contractor must be given a job to do and, for the most part, he must be allowed to do it his own way. Performance standards should be extremely specific, and mutually agreed-upon measures of performance must be thoroughly defined in the contract. There must be no dispute after-the-fact concerning what performance is required

and how it shall be measured for purposes of contract management.

The bid process used to solicit offers from contractors is at least as important to system performance as is the contract itself. An attractive and realistic business opportunity must be presented in order to attract truly qualified bidders and, at the same time, all the "holes" must be plugged in advance so as to discourage bidding by unqualified or unscrupulous companies. *The idealistic goal of the bidding process is to: Make the "deal" look so good that several qualified firms will bid at competitive prices; simultaneously make the "price of entry" too high for a company with insufficient financial resources to do the job; and while accomplishing both of those objectives, also close every possible avenue to a rip-off opportunity so as to discourage well-financed, but not well-intentioned, companies from bidding.*

Management Services Contractor (Optional)

It is recommended that, once base-

line revenue side performance data has been obtained by the system, accounts-receivable management services should be contracted "outside" to further reduce the tendency toward "empire building" in the system, and to institute additional financial incentives for superior performance. However, performance contracting for accounts-receivable management requires a solid understanding of baseline performance variables upon which financial incentives can be built. This type of procurement is extremely complex, and should not be attempted until the production side of the system is working smoothly.

Any performance-based contract for accounts-receivable management should properly vary compensation with the financial classification of the account. Collection effectiveness in dealing with Medicare accounts should be measured differently from that for Medicaid accounts or combination Medicare/Medicaid accounts, private paying patients, etc. Mechanisms should exist for

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allowing certain debts to be "forgiven" in hardship cases, without necessarily penalizing the collection contractor in the process. For these and other reasons, we strongly recommend that accounts-receivable management be conducted "in-house" by the public authority, possibly with outside help employed on a "level of effort," rather than on a "performance," basis.

Finally, a number of private charity hospitals, municipally owned hospitals, and even private proprietary hospitals have achieved greater financial stability and superior service capability by full-scale contracting of all management services to a professional private health care management organization. Such contracting for what amounts to "chief executive and staff services" may have the advantage of adding tremendous depth to "in-house" staff capabilities. This type of contracting is certainly worthy of consideration due to its widespread success

throughout the hospital industry.

Training Services Provider (Optional)

If the private ambulance contractor is to be held entirely accountable for the clinical quality of service produced as well as for the response reliability of his system, then that contractor must remain in complete control of personnel. Thus, even though EMT training may be available in the area, the contract between the public authority and the private operator should clearly state that responsibility for initial training as well as for in-service and refresher training rests entirely with the contractor.

If the contractor is satisfied with training already available in the area, then, of course, the contractor will probably take advantage of that training. But, if that training is inadequate as evidenced by chronically poor medical audit results or by chronic failure of his employees to pass local tests prerequisite to local certification, then the contractor must be free to develop in-house

training or to contract elsewhere for training assistance.

(We see no objections to a training link between the private contractor and the not-for-profit emergency physicians organization, if both parties desire such a relationship.)

We have now presented the principal elements in the structure of the Public Utility Model, with some of the "design constraints" critical to the system's smooth implementation and successful long-range operation. As we said in part I of this discussion of the Model, it offers more opportunity for serious error than any other EMS management strategy on the scene today. Once a mistake has been made in implementation, chances are corrective action will be expensive, time-consuming and probably much more difficult than under another management structure.

Next month two very important constraints will be discussed in some depth, because cognizance of the potential for "driver error" in such a high performance vehicle as the Model is advisable. □

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