

Cutting the Fog in Santa Ana

On April 16 of this year, the Santa Ana City Council created an ambulance study committee to decide how Santa Ana could convert its fire department paramedic service to a privately operated system. That committee's preliminary report, presented May 14 to the city council, included a set of findings which I believe may be of great interest to private paramedic providers throughout America, especially in dealing with their own local elected officials.

Few cities approach the problem of understanding today's prehospital care industry as thoroughly and professionally as did Santa Ana. Santa Ana's study committee included city council members, key staff members, local physicians, county EMS officials and representatives of the local business community. The committee was well funded and was provided with good internal staff support as well as outside consulting assistance. Santa Ana Fire Chief Bill Reimer chaired the committee, and I had the pleasure of hosting the committee's tour of some (though certainly not all) of the finest privately operated prehospital care systems.

The committee's work was divided into two phases: Phase 1, during which the committee would develop an understanding of both the pitfalls and opportunities associated with private paramedic service, resulting in selection of a strategic approach to implementation; and Phase 2, during which the committee would develop a detailed system design and implementation

plan. Private paramedic providers throughout the U.S., and the communities they serve, should have access to this committee's Phase 1 findings. This month's "Interface" column provides a slightly condensed reprint of that research. I have omitted nearly all of the committee's strategic recommendations, since they are designed, in part, to accommodate the peculiarities of Santa Ana's local situation and the structure of the entire California prehospital system. But I believe readers will agree that the committee's findings are largely generic—a summary of facts and observations likely to hold true anywhere.

"The committee's findings are largely generic — likely to hold true anywhere."

Background

Santa Ana is a community in Orange County, California. Readers unfamiliar with the California ambulance industry probably deserve a brief overview of ambulance services in the state. California is home to some of the oldest paramedic services. The great majority of these services are fire department based, and many do not provide transport services. As yet there is no statewide standard for paramedic services, and no reciprocity of paramedic certification among the counties. California's relatively new state law depends heavily upon county governments to bring order and logic to the state's heavy proliferation of monojurisdictional minisystems. Few California counties have been willing to accept complete responsibility for restructuring these old and

politically entrenched local ambulance structures.

The status quo is well established throughout California. Many California fire chiefs are protective of their paramedic rescue services. Many private sector ambulance companies, mostly BLS providers, enjoy a profitable business relationship wherein local taxpayers furnish the more expensive and more complex paramedic rescue services, leaving nearly all revenues from fee-for-service billings to the private providers. Some of these private providers even enjoy exclusive transport contracts as well as partial reimbursement for losses from uncollectibles. And because a large part of ambulance system costs are funded by local taxpayers supporting nontransporting paramedic services, third-party reimbursement levels are artificially depressed throughout most of the state, to the clear financial benefit of both governmental and private third-party payers. Thus, a politically powerful combination of fire chiefs, private BLS providers and third-party payers tends to support the status quo.

In Orange County, California, the only transporting paramedic provider is the Santa Ana Fire Department. There are no private paramedic providers licensed in the county, and no other Orange County fire departments provide transporting paramedic services. Thus, Santa Ana is already somewhat of an EMS maverick within Orange County, and the city's move to install unsubsidized, privately operated paramedic services will probably prove controversial.

Preliminary Report

During the course of the committee's intensive work schedule (e.g., extensive reading of current ambulance industry management literature, interviews

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with numerous expert representatives of both the public and private sectors of the industry, and actual site visits of several of the most respected privately operated paramedic level ambulance service systems), the committee recognized the following major findings:

Superb Private Services Do Exist—The committee found several examples of privately operated ambulance service systems that are currently operating at levels of clinical sophistication and response time reliability equal to or in excess of the finest socialized prehospital care systems. The very existence of these superb private systems proves that it is not necessary to socialize prehospital care in order to furnish the public with reliable and clinically sophisticated ambulance services. However, the fact that stable and reliable privately operated ambulance service systems are surprisingly rare, especially when the search is narrowed to systems of excellent clinical and response time performance, indicates that neither the unaided "invisible hand of economics" nor a simplistic regulatory or procurement approach is likely to produce a satisfactory privatization result.

Superb Unsubsidized Services Do Exist—While many cities and counties currently subsidize ambulance services at rates of per capita subsidy as high as \$7 to \$8 (today's average local tax subsidy being around \$4 per capita per year), the committee found that several cities enjoy very high quality ambulance service with little or no local tax subsidy. The committee also found that in some cities the levels of local tax subsidy have been steadily declining on a predetermined schedule, while levels of clinical and response time performance have simultaneously improved. The committee is, therefore, convinced that in the context of an ambulance service system of superior design, the only direct effect of local tax subsidy is the reduction of ambulance fees below actual cost. Furthermore, the committee learned that by setting fees below full cost of service, the subsidizing jurisdiction actually does damage to the financial stability of any neighboring providers whose third-party reimbursement levels are, in part, determined by "prevail-

ing rates"—rates artificially depressed by the effects of local tax subsidy.

Subsidization Hides True Costs, Prevents Fair Comparisons, and Supports Continued Fragmentation of Service Delivery Systems—The committee found that local tax support of ambulance services tends to mask the true cost of services in the subsidizing jurisdictions. An unsubsidized provider's prices may appear unreasonably high to a public accustomed to artificially depressed fee structures. A more efficient provider or service delivery system may be unfairly compared with a far less efficient operation whose poor financial performance is hidden by below-cost rate structures. Local tax financing tends to inhibit the evolution of more regional service delivery systems covering natural medical trade areas, and important economies of scale are lost.

"A more efficient provider may be compared unfairly with a far less efficient operation."

Fire Department First Responders Are Essential—It was determined that, regardless of system type, a fully integrated program of fire department first responder services is necessary to life-saving system performance. However, where a reliable paramedic ambulance service system exists, such fire department first responder services need not operate at the paramedic level, but need only maintain basic life support (BLS) capability, with brief paramedic-assist training and regular in-service training furnished by the private paramedic provider as a contractual obligation. Additionally, the committee found that Santa Ana's current frequency of responding fire apparatus on ambulance calls could be safely reduced to approximately one-third present levels, if fully centralized, paramedic-level dispatching and system status management were in place.

Fire Department First Responder Services Should Be Reimbursed—The committee learned that the marginal cost per run of non-transporting BLS fire department first responder

services, using fire apparatus, is approximately \$22 to \$25, including all marginal costs of fuel, medical supplies, extra vehicle maintenance, additional training, and allocated capital equipment depreciation costs. Many industry experts are of the opinion that such per-run costs can and should be fully incorporated into the ambulance fee-for-service billing systems, with the proceeds paid to the participating fire department on a subcontractual basis. (The committee understands that most third-party payers currently have no provision for reimbursing first responder services. On the other hand, few first responder programs have even sought such reimbursement, and no well-organized attempt to secure a policy change has been initiated. Even so, many private paying patients would happily pay for first responder services, and many insurance claims are paid as invoiced.)

Call Screening Found Dangerous and Unnecessary—The committee found that the widespread practice of call screening (i.e., the practice of screening telephone requests to limit the dispatching of paramedic units) is both dangerous and unnecessary. In fact, the committee found that some of the most efficient paramedic ambulance systems have completely eliminated call screening, dispatching a transporting paramedic ambulance on every request for service, emergency and non-emergency. This practice, combined with a sound medical billing system, allows fee-for-service financing of additional production capacity, thereby improving peak-load emergency coverage and disaster readiness, while simultaneously improving economies of scale and eliminating 9-1-1 call screening as a serious source of municipal exposure to tort liability.

Many Non-emergency Patients Need Paramedic Care—This finding was perhaps the most startling and instructive of all. Most if not all California ambulance systems were originally designed around the untested assumption that patients can and do categorize themselves (i.e., "diagnose their own conditions") as needing either emergency or non-emergency services, and that those needing less clinically sophisticated non-emergency transport will call a non-emergency provider. It was also assumed that a portion of those patients requesting emergency service are not actually in need of

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emergency service, and that such requests can often be detected and "screened" by way of telephone interview. . . . The committee learned that when paramedic units routinely respond to non-emergency requests (i.e., not broken arms or other non-life-threatening emergency calls, but calls properly coded as non-emergency calls), paramedic-level assessment skills are required on nearly 10 percent of non-emergency calls. *Where paramedics are routinely present on non-emergency calls, one or more invasive paramedic procedure is appropriately employed on approximately 3 percent of all non-emergency calls.* (The committee notes that these facts are likely to go unnoticed in any system which does not routinely send paramedics on non-emergency requests, since BLS personnel may not possess the assessment skills necessary to determine the need for more advanced procedures

EMS Concepts, Terminology Often Confused—The committee noted that both within the ambulance industry and among consumers there exists a great deal of confusion regarding the use of the specialized concepts and terminology of the ambulance service industry. For example, in Santa Ana a consumer's telephone request for an "ambulance" may be interpreted by a dispatcher as a request for a private BLS unit, unless the caller specifically requests a paramedic unit or MICU. Throughout California an ordinary paramedic ambulance is regularly referred to as an MICU (i.e., mobile intensive care unit), yet a privately operated MICU inspected by the committee during its out-of-state site visits was a much larger vehicle costing approximately \$250,000, staffed and equipped to a level of clinical capability far in excess of the most advanced paramedic rescue unit. (Outside California a transporting paramedic rescue unit is simply called an "ambulance.") While a basic EMT may have only about 100 hours of training, and a paramedic about 10 times that training investment, the general public may consider both as "health care professionals" or "paraprofessionals," not realizing the vast difference in clinical capability. In contrast, a licensed *beautician* in California must complete 1600

hours of training, plus testing. Consumers familiar with licensing requirements of beauticians, barbers, electricians, nurses, respiratory therapists, able seamen, and other skilled trades and para-professions may understandably be confused by the impressive designation of the "licensed" or "certified emergency medical technician." In some places, this official designation can be obtained following a two-week course.

Santa Ana's Current Coverage Found Lacking—The committee found that current paramedic staffing fails to fluctuate to provide peak-load coverage, and that paramedic production capacity is routinely depleted during peak-load periods. Control center operations, dispatch protocols, and system status management techniques currently in use are rudimentary at best when compared with those of the best privately operated systems.

Safe and Effective Privatization Requires Complex Business Structure—The committee found that, while several cities and counties enjoy excellent ambulance services furnished with little or no subsidy by loosely regulated private providers, such situations are extremely rare and appear to lack public safeguards and long-term stability. Where local government has deliberately designed and implemented a stable and clinically sound, privately operated ambulance system, the resulting business structure is highly complex, incorporating a carefully designed restructuring of financial incentives and numerous public safeguards. Clearly the alternative to socialized prehospital care is *not* a simplistic return to street-level competition by multiple firms. Nor does the answer lie in tighter regulation alone. Safe and successful privatization of EMS requires fully informed and expert intervention by the public sector. It can be done; it has been done. But not by way of simplicity.

Some System Structures Attract Talent—In several of its site visits, the committee was struck by the caliber of personnel that seemed to have gravitated into the local ambulance system. Managers on both the public and private sides of these systems were found to be unusually professional, articulate, and knowledgeable of the financial, operational, legal, technological, even political aspects of their

business. But more interestingly, the committee was exposed to middle managers, maintenance personnel, billing personnel, field supervisors, and training personnel whose professionalism, intelligence, and enthusiasm were extraordinary. Apparently, some types of system structures have the inherent feature of being able to attract, retain, and motivate persons of unusual talent and ability. The direct results of this concentration of talent were readily apparent to the committee—surprisingly sophisticated, even elegant approaches to everything from vehicle maintenance to scheduling, dispatching, subscription sales, inventory control, public relations, medical audit, response time control and analysis, data processing, system status management, even marketing. In every case, this observed concentration of talent appeared to be the *indirect* result of the system's very structure—not the result of any specific attempt on the part of local government to recruit and motivate such talented people. Over time, such systems seem to be self correcting . . . capable of evolving toward increasingly higher levels of performance and efficiency. This, the committee feels, is the acid test of any system structure.

Public Utility Model Not Recommended At This Time—The committee had the opportunity to inspect closely both established and newly implemented versions of the Public Utility Model, an elaborate and sophisticated means of restructuring the form of private competition in the ambulance industry to improve the quality of competition and to create a powerful incentive network for safe and reliable production of some of America's highest levels of prehospital care. The Public Utility Model does seem to offer the most successful and thorough approach to date. Unfortunately, representatives of the Fourth Party, Inc., the model's developer, have advised the committee, after consultation with the Santa Ana City Attorney, that California statutes governing ambulance service delivery may not furnish sufficient authority to support implementation of that model. Therefore, although the Public Utility Model appears to hold the greatest promise for a safe return from socialized prehospital care, upon the advice of our consultants the committee is unable

to recommend its adoption at this time.

Elected Officials, Public, and Even Press Often Confused Regarding Cost of Service—Many ambulance service systems, by their very structure, evade true financial accountability. For example, Santa Ana's own ambulance service system costs the residents of Santa Ana well over a million dollars annually in local tax dollars, plus the fees paid to support at least three private firms holding

transport agreements with the fire department, as well as such fees as may be paid by residents to other private firms. However, the *total* cost of Santa Ana's present ambulance system is unknown. Fort Wayne, Indiana, officials estimate that the total cost of their previous system, a multiple provider, two-tiered system similar to Santa Ana's current system, was well over \$2.5 million annually in 1980 dollars. Fort Wayne's current all-paramedic

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full service system performs at far more sophisticated levels, while its total annual cost in 1984 dollars is under \$2 million. But since Fort Wayne's annual subsidy has declined by over \$500,000, the fee structure has risen substantially. Now, with nearly the full cost of service incorporated in rates, the dramatically improved service *appears* to cost more. Such misunderstandings may prove even more difficult to deal with in California, where some of the most expensive ambulance services pass as bargains, the costs obscured by token fee structures.

Recommendations

The study committee was asked to determine the best and safest method whereby Santa Ana's paramedic services might be converted to a privately operated ambulance service system. But although we were not asked to consider the desirability of such a conversion, the committee feels that an informed comment on that subject is in order.

The committee has seen several examples of privately operated ambulance service systems performing reliably at the highest levels of clinical, technological, and response time performance. Several of these private operations work in close coordination with fire department first responder programs, sharing training resources, facilities, even medical record-keeping systems. Given the levels of service being delivered, even the economic performance of these privately operated systems must be admired.

Even so, reviewers of this report are cautioned to avoid unwarranted and oversimplified generalized praise of "privatized" ambulance service systems. The remarkable success of a handful of privately operated systems seems to owe less to the fact that they are privatized than to certain structural aspects of the systems within which the private providers are allowed to perform.

The committee has seen enough to conclude that, *in the context of well-designed overall system structure*—a structure capable of safely and effectively harnessing and directing the powerful incentives of private financial motivation—a privately operated system has greater potential for superior clinical and financial performance than does any form of socialized system. ☐



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