by Jack Stout

Accreditation For What?

by Jack L. Stout

Dawn crept toward Podunk at a snail's pace, or so it seemed to Podunk city manager Fred Swartz as he finally abandoned his last hope of sleep. Podunk's government-operated EMS program had been a constant headache for years . . . ever-increasing costs with no end in sight, chronic vehicle maintenance problems, three EMS directors and four medical directors in only two years, several lawsuits and a smart local reporter hot on the trail.

The telephone call-screening program that was supposed to solve the response time problem was squashed by risk management when Podunk was forced to become self-insured. Then there was the attempt to implement peak load staffing and the union's successful political defense of their 24/48 shifts, including permanent post assignments. But these problems were not the cause of Fred's relentless insomnia.

The decision to privatize Podunk's EMS system had been fairly easy as these things go. The privately contracted advanced life support (ALS) service in neighboring Metropolis, while not trouble-free, seemed to be working well and wasn't costing Metropolis a dime. What's more, Metropolis' contractor furnished its own insurance and indemnified the city. After a study of Metropolis' EMS system, the Podunk city council had voted unanimously (two weeks after the last election) to "go to bid" for an EMS contractor.

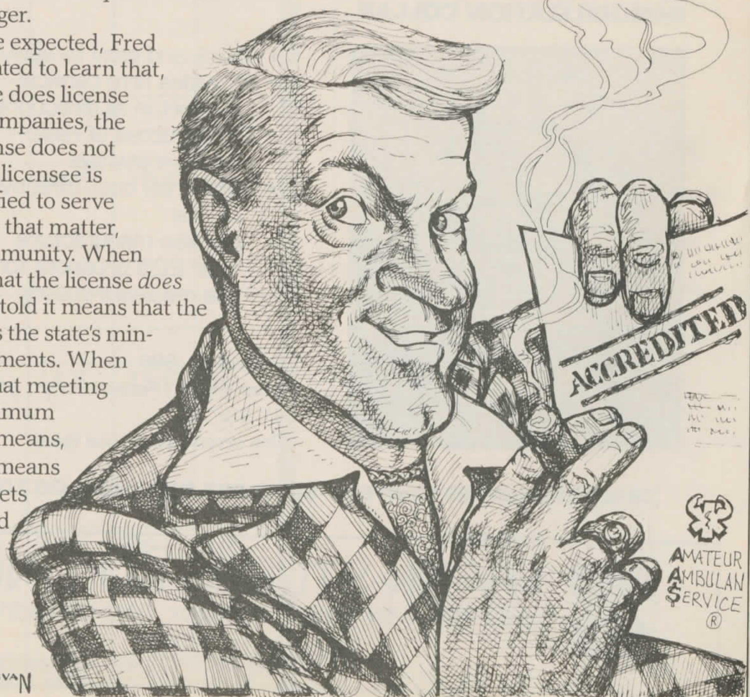
The bid process had been conducted, bids received and a contract awarded. What was keeping Fred awake was a nagging suspicion that the winning firm, Amateur Ambulance Service, might be less than fully qualified to safeguard the lives of the citizens of Podunk. It was nothing that Fred could put his finger on. Amateur was licensed by the state as an ALS provider, met all of the city's requirements for financial strength, and had supplied a performance bond in standard form, written by Mafia Mutual. Even so, Fred was uneasy.

In designing the procurement process, Fred had tried to locate some sort of industry standard (e.g., licensing, certification, or accreditation program) suitable for use in establishing minimum bidder qualifications. He telephoned the state's EMS director, explaining that Podunk, a community of 250,000 people, needed a list of private firms approved by the state to serve as primary provider of emergency ALS services for a community the size of Podunk or larger.

As might be expected, Fred was disappointed to learn that, while the state does license ambulance companies, the grant of a license does not mean that the licensee is actually qualified to serve Podunk or, for that matter, any other community. When Fred asked what the license *does* mean, he was told it means that the licensee meets the state's minimum requirements. When Fred asked what meeting the state's minimum requirements means, he was told it means that the firm gets a license. Fred understood.

Next Fred telephoned the offices of the American Ambulance Association (AAA). He had heard about their accreditation program, and he asked for a listing of association members "accredited" to serve as the primary provider of emergency ALS services to communities with populations of 250,000 or more. He was disappointed to learn that the AAA accreditation program was not yet ready for implementation, and that it was by no means certain that AAA's accreditation program would ever serve the sort of purpose Fred had in mind. When Fred asked what sort of purpose AAA's accreditation program *would* serve, he was told at length about leadership and credibility and industry image.

Fred was frustrated. "What good are standards," asked Fred, "if meeting them doesn't mean you are qualified to do anything in particular?" Fred answered



*Jack Stout has been at the forefront of innovations in the design and implementation of EMS systems for the past dozen years. If you have a question, a problem, or a solution related to the public/private interface in prehospital care, address your letter to "Interface," **JEMS**, P.O. Box 1026, Solana Beach, CA 92075.*

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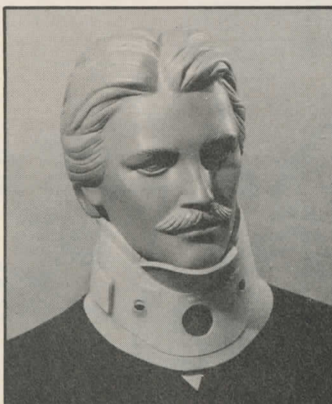

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the question himself: meeting standards makes everyone feel better – providers, consumers, and government officials – even if the standards themselves indicate nothing in particular.

Our industry's best and worst providers meet minimum standards. That's why we call them *minimum*"– it's the worst you can be and still lawfully remain in business. What Fred needed was a system of standards capable of establishing that a given provider can be safely entrusted to carry out a given service responsibility. Since no system of standards exists in the EMS industry, communities like Podunk are forced to develop and apply their own standards. In many cases, the results are dangerous or unfair, or both. So far, our industry has offered local officials no practical alternative.

To be of practical use to anyone (other than making us all feel better), accreditation standards must be related to specified service responsibilities. For example, consider the task of writing a single set of standards which could reasonably be applied, both to a firm providing non-emergency basic life support (BLS) services within a large, multiple-provider urban system, *and* to the sole provider of ALS emergency services to the same community.

Whether we discuss financial strength, collection practices, equipment, in-service training, equipment replacement policies, control-center operations, maintenance practices, qualifications of managers, communications system requirements, or any other sensible topic of accreditation requirements, we will soon discover that the service responsibilities of these two hypothetical firms are so vastly different that any standard that is suitable (and meaningful) for one firm must be either impractical or irrelevant when applied to the other.

Even if we were to focus upon accreditation standards for two small non-emergency providers – one operating in an urban setting with short trip times, the other in a rural setting with extended trip times – we would quickly discover that, while many of the standards would be identical, the added risk of extended trip times through rural areas would probably call for certain differences in onboard equipment and supplies, communications capabilities, personnel qualifications and in-service training.

Similarly, consider how standards might differ for a BLS provider who occasionally transports emergency

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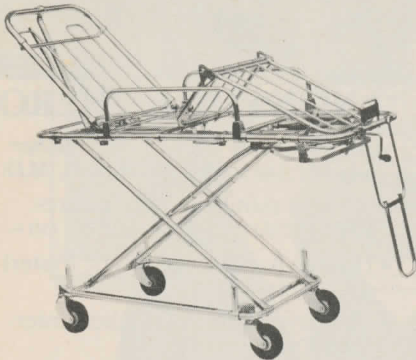

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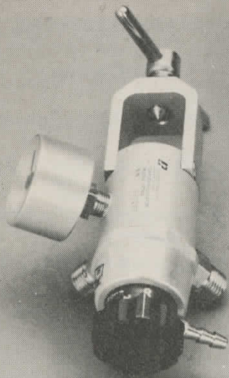

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patients handed off by an ALS provider after on-scene assessment by paramedic crews, versus one whose crews are sometimes accompanied by an onboard firefighter/paramedic while en route to the hospital. Again, the appropriate standards might, in several respects, be different.

By thinking in terms of specific categories of service responsibility, the job of developing standards becomes not only easier but also more meaningful. It is my own opinion that the "missions" of all ambulance companies can be grouped into 15 to 20 categories of service responsibility, and that every ambulance company currently in operation already meets or is capable of meeting reasonable standards of accreditation for at least one of these categories.

With only one exception (i.e., accreditation for provision of long-distance mobile intensive care transport services), being accredited at a higher level would imply that the firm is also qualified to provide lower (i.e., less demanding) levels of services. For example, being accredited to serve as an exclusive provider of 9-1-1 ALS ambulance services to populations up to 250,000 would automatically imply qualifications to provide all types of non-emergency services, as well as emergency services to smaller communities.

The point is that, for an accreditation program to be anything more than symbolic, firms must be accredited to handle a defined range of service responsibilities. Table 1 shows a type of matrix that could serve to identify the various accreditation levels, and to relate specific types of standards to each defined level. Because my purpose is to present a concept, a perspective – rather than to advocate any specific content – I have listed only a few sample "accreditation levels" and only a few categories of standards.

In general, moving down the table involves decreasing levels of service responsibility and therefore decreasingly stringent standards (except for the special standard at the end of the table). In many cases, standards applicable to lower levels of service would be incorporated by reference within the higher levels and added to as appropriate. Thus, firms accredited at lower levels of service responsibility could follow a clear path to higher levels of accreditation by building upon their existing strengths in incremental fashion.

Purposes of Accreditation

The best use of an accreditation program, or of any other program of self-regulation by an industry, is to protect the public from unscrupulous and unqualified providers. The worst use is to promote unwarranted public confidence in existing providers by the award of a meaningless but "official" stamp of approval. In general, the public can tell the difference.

Properly designed and conducted, an accreditation program can also provide additional advantages. If the program actually *does* protect the public interest, it can and often will be adopted by reference in regulatory statutes and ordinances, saving considerable cost to the taxpayer and limiting opportunity for adoption and enforcement of worthless (or worse) "rules and regulations." The National Registry program, now recognized by numerous state and local regulatory agencies, is a superb example of privately developed national standards gradually replacing a hodgepodge of state-by-state regulation.

A properly structured accreditation program can also furnish third-party payers essential information for reimbursement purposes. For example, the reasonable cost per transport of ambulance services rendered by a primary emergency provider is considerably higher than that of a secondary provider who does not incur the costs of maintaining the surplus production capacity (i.e., geographic coverage) required for reliable response time performance. A well-designed accreditation program can distinguish providers' differing service responsibilities, justifying higher reimbursement for primary providers of emergency services.

A sound accreditation program can also assure local communities that their current providers, public and private, are qualified to provide the services for which they are responsible, or, in some cases, prove that they are not. (Any accreditation program that places its stamp of approval upon every applicant without exception cannot be taken seriously by anyone.)

Where a current provider is deficient, specific accreditation standards and an independent assessment can provide a blueprint for correcting problems and perhaps saving the company, not to mention the lives of its patients. And where chronic deficiencies persist and a bid must be conducted to select a new provider, meaningful accreditation standards can provide safe, fair, and objective criteria for establishing eligibility of firms wishing to participate in bid competition (e.g., "the City of

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INTERFACE

Podunk hereby requires that bidders must hold current or pro forma AAA-6 accreditation or higher . . . ").

Pro Forma Accreditation

One of the most interesting aspects of accreditation should be a process of granting pro forma accreditation at a higher level than that already held by the applicant. For example, assume a given firm has successfully operated at a given accreditation level for a reasonable period of time and now wishes to advance to the next level, perhaps in order to participate in bid competition to serve a larger neighboring market. By examining the increased standards required for accreditation at a higher level, the firm can prepare a detailed business plan and implementation schedule designed to meet the higher standard.

The upgrade plan and schedule would then be submitted to the accreditation board for review and approval. Almost certainly the applicant's track record of operations at its current accreditation level would weigh heavily in the board's decision to grant or deny pro forma approval. A grant of pro forma approval would indicate that, in the opinion of the Accreditation Board, the firm is ready to be entrusted with a higher level of service responsibility, and that the approved business plan and implementation schedule constitute a prudent approach to advancement which, when implemented, will result in the award of full advanced accreditation.

Such a pro forma accreditation process would resolve a major question now plaguing our industry—i.e., how can well-managed smaller companies safely advance to compete in major procurements, and how can public officials justify the award of a major service contract to a firm whose experience is confined to smaller-scale operations?

Independent Processing of Applications

While the collective expertise of the American Ambulance Association membership is by far the best source of accreditation standards, the process of reviewing applications, verifying applicants' claims, and determining the accreditation levels for which the applicants are actually qualified must be conducted by an independent body having no business or financial ties to the ambulance service industry or to the applicants for accreditation.

Some observers feel that such an organization should be governed by persons with expertise in related healthcare fields (e.g., hospital administrators, emergency nurses, emergency physicians, etc.). I disagree. The process of reviewing applications, verifying claims and issuing or denying certificates of accreditation is not a policymaking activity. Ideally, this should be a straightforward process of comparing the applicant's current operation with accreditation standards developed and periodically revised by the ambulance industry as represented by the American Ambulance Association.

Such a process can, in my opinion, best be carried out by the professional staff of a small accreditation board (e.g., five members) consisting of persons whose main qualifications are their integrity and lack of direct or indirect personal financial interest in the EMS industry. The required expertise can be hired. Accreditation board members should be appointed for limited, staggered, non-cancelable and non-renewable terms by the AAA, and paid reasonable directors fees. The costs of funding the activities of the accreditation board should be recovered from non-refundable processing fees charged applicants for certification.

A Word of Warning

Creating standards also creates standardization. Whether standardization is good depends upon what is being standardized. If what is being standardized (and periodically upgraded) is a high level of *performance*, standardization can benefit both the public and the industry. On the other hand, if standards merely lock in currently accepted production *methods*, the effect of standardization is to inhibit innovation and to arrest the development of an industry which is, comparatively, still in its infancy. This distinction is critical.

For example, consider the impact of the following hypothetical standards, the first based upon performance, the second upon production method:

Sample A. In urban areas the primary provider of emergency services shall place a fully equipped and staffed paramedic unit on the scene of not less than 90 percent of presumptively classified life-threatening requests within eight minutes or less after receipt of the request by the 9-1-1 center.

Sample B. In urban areas the primary provider of emergency services shall maintain on duty at all times not less than one paramedic unit per 40,000 population, such units to be geographically deployed throughout the service area by assignment to designated post locations, and dispatched only in response to presumptively classified life-threatening requests.

It is easy to see that the Sample A standard does nothing to inhibit development and use of innovative ways of achieving the required performance results. The standard could be met using ALS-capable fire engines or ALS rescue units, single-tiered or multi-tiered systems, telephone call-screening or priority dispatch techniques, fixed post locations or aggressive system status management, peak-load staffing or constant staffing levels; in short, *any method that works.*

In stark contrast, the Sample B standard would mandate the use of constant staffing levels, telephone call-screening, and fixed post location *without* necessarily achieving the desired result—i.e., reliable response time performance. Moreover, the Sample B standard would elimintate both incentive and opportunity to develop more reliable or more efficient production methods.

Standardizing performance at reasonably high levels is good public policy, and for innovative and well-managed firms it is also good for business. Standardizing the means whereby performance is achieved only insulates less capable organizations from the threatening forces of progress.

Apology in Advance

Now I've gone and irritated some of you, especially those readers who have spent more than a few hours over the past two years working faithfully to develop either the AAA accreditation program or on the ASTM standard-setting process. The problem is that neither process has maintained a focus upon the specific service responsibilities to which the standards should theoretically relate. There is no such thing as a generic ambulance service, just as there is no such thing as a generic ambulance patient. An ambulance service can either meet the clinical and response time needs of each individual patient, or it cannot. Similarly, an EMS provider is either qualified to be entrusted with specific responsibilities, or it is not.

At the risk (and probably dead certainty) of offending a great many people, many of whom have earned my personal respect, I recommend abandonment of the generic standards approach in favor of a focus upon specific service responsibilities and development of appropriate standards for each. My reason is simple: Generic standards can only relate to generic responsibilities, of which there are none. □

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