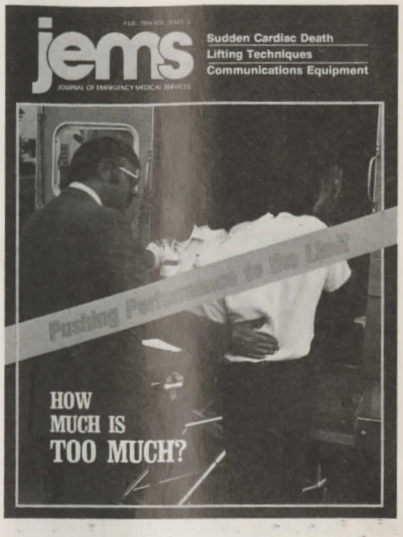
Jack Stout

INTERFACE

Kansas City Revisited



In the February *jems* feature article entitled "How Much Is Too Much?," I presented a crude but important analysis of workloads placed upon field personnel in three high-performance, high-efficiency ambulance service systems. My purpose was, in a small way, to point toward eventual development of industry-wide workload standards, so that both field personnel and managers might eventually have access to more objective and more useful ways of detecting and correcting unreasonable workloads and working conditions.

All three systems subjected to this analysis were all-paramedic, full-service, public utility model systems. All three systems must produce superb clinical and response-time performance and must furnish paramedic-level service for all emergency and nonemergency ambulance patients in their respective service areas.

While two of these three systems were found to employ demanding but certainly not excessive workload requirements, a previously undocumented but potentially serious problem was uncovered in the Kansas City, Missouri, system. While call volumes per crew hour were no greater in Kansas City than in the other systems, time spent running calls and engaging in post-to-post moves combined to reduce at-post time in Kansas City to an average of only 18 minutes per on-duty hour, compared with just over 30 minutes in the other two systems.

The reduced time at post, by itself, didn't tell the whole story. Unlike the other two service systems, Kansas City's night crews were *entirely* made up of persons working 24-hour shifts. Further analysis showed that, on average, these field personnel spent most of their at-post time between 2300 and 0500 hours in uninterrupted time segments of less than 60 minutes. And since these figures were averages, the clear message was that many Kansas City crews must often be maintaining high levels of almost continuous physical activity with little or no useful rest opportunity.

The article concluded that while Kansas City workloads are not inherently excessive, they must be considered excessive in the context of crews working extended shift schedules. To assist in finding solu-

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What Is Enough?

by Mark S. Wozmak

Life presents endless examples of contradictory relationships: life-death, happiness-sadness, love-hate, and yes, unfortunately, management-labor. These are really continuums, not dichotomous entities. As in life, all relationships require balance, including the operation of a business. Management requires much work (labor), and laboring at work requires organizing and planning your activities (management). The two functions cannot be separated.

The EMS segment of the health care industry is still in the dark ages in assuming that labor and management is an adversarial relationship. We have the same boss: the customer. The customer, who regulates and/or pays for services, demands and deserves attentive, high-quality, patient-oriented EMS service at a reasonable price. We must learn to ask what our boss, the customer, wants from us? The answer determines what is enough from both management's needs for productivity and cost effectiveness and labor's needs for fair work schedules and increased compensation. In other words, management and labor must compromise to provide the performance requested by the customer.

The American commercial and industrial landscape is cluttered with the remains of once mighty enterprises and labor unions, that were unable to provide a single focus on the customer. Continued short-term vision and selfishness on the part of both management (profits) and labor (benefits) will guarantee the continued littering of the landscape. The marketplace is ultimately fair and ruthless, and will only reward in direct proportion to service provided.

Kansas City's EMS is confronting this challenge of being able to compromise internal management-labor positions in order to meet the expectation of the "boss." In order to meet the challenge, both management and labor must put aside their respective conditions and adopt the operating mode that meets the expectations of those who pay for services. Removal of entrenched, antiquated doctrines usually associated with management-labor relationships promises an enlightened resolution of the current opposing interests. Change is always a difficult process. Rarely does it proceed in a smooth, orderly fashion. I am confident that Kansas City EMS will recognize and adjust to the changing expectations and demands of the marketplace. The coming of spring is already showing buds of progress.

It would be wise to remember that when the Environmental Protection Agency promulgated new regulations in the mid-1970s, Detroit hired lawyers while Japan hired engineers. □

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tions to this problem, Alan Jameson and I visited Kansas City for a three-day site visit, worked with an ad hoc committee of management and labor and prepared an internal report dubbed the "12,000-Mile Inspection and Tuneup." As outsiders with no official involvement, Alan and I could do little except facilitate communication, document what we heard and make recommendations as we felt appropriate.

The Good News and the Bad News

As of this writing, the good news is that many of these suggested improvements have already been completed, and most are well underway. The bad news is that the most important and most complex problem remains unsolved.

That most important and difficult problem is the continued use of extended shifts with insufficient rest opportunities. This problem will be solved because it must be solved. The physicians charged with the responsibility for ensuring quality patient care have mandated that a solution to this problem be found and implemented, and, under a public utility model structure, such a mandate has the force of law.

These responsible physicians cannot allow patients to be served by poorly rested personnel. Furthermore, it is the direct responsibility of Medevac, the operations contractor, to place the interests of patient care above all other concerns. The problem must be solved and solved quickly; so quickly that I am certain change will be implemented by the time this article is in print.

A Choice of Directions

To provide some immediate relief, and to demonstrate good faith toward field personnel, MAST (the Ambulance Authority) and Medevac arranged immediately to effect a substantial increase in unit-hour coverage. Management understood that this move, combined with several other minor adjustments, would fall well short of solving the whole problem, but that a true solution would be difficult to achieve without the understanding and cooperation of field personnel.

For our part, Alan Jameson and I tried to assist by pointing out two alternative solutions, either of which would work. The first alternative involved the complete elimination of all extended shifts, reducing the employee workweek from the current 52.5 hours to approximately 50 hours per week, without reducing monthly take-home pay. To management, this solution involved an effective increase in hourly wages paid and the need to increase the work force slightly to replace the unit hours lost by reducing the average workweek. Under this plan, all employees would work 10-hour shifts, 12-hour shifts, or some other combination of shorter shifts, and all would put in about 50 hours per week.

The other solution was more complex, more flexible and, to me, more appealing. I had the privilege of negotiating a similar work schedule with the Fort Wayne medics. As proposed for Kansas City,

this alternative would involve the creation of a variety of shift schedules, including several high-activity short shifts as well as several types of more extended shifts. In Fort Wayne, we originally established five different shift schedules ranging from 8-hour shifts to 24-hour shifts, and from 40 hours to 56 hours per week — *all paying the same monthly salary.*

Under this section option, the average workweek would be reduced to about 50 hours, but some employees might work 40 hours per week while other worked as many as 56 hours. The rest of the workweeks would fall somewhere in between. I suggested that at least two, and possibly three, 24-hour cars could be maintained in the Kansas City system, provided special dispatching and system status management techniques could be developed to shift some of the activity away from crews working extended shifts and onto the shoulders of those working shorter shifts. Since all shifts would pay the same monthly salary, the effective hourly rate of crews working the 24/48 shifts would be less than the effective hourly rate of crews working the shorter shifts with shorter work weeks. Thus, longer hours at lower levels of productivity would offset shorter shifts with shorter workductivity, allowing monthly take-home pay to remain the same.

More Difficult but Worth It

From the financial perspective, both proposed solutions would have approximately the same impact upon management and labor. In each case, monthly take-home pay would neither increase nor decline. And, in each case, management's labor costs per unit hour would be increased by a few percentage points.

When I proposed these two distinct but equally practical solutions, I indicated that, if I were a field medic in Kansas City (and my son actually is), I would much prefer the variable shift schedules, with periodic opportunities to bid for shifts based upon seniority.

My reasoning is that, given a choice, some of us prefer high-productivity short shifts with daytime hours, some of us prefer medium-productivity short shifts with nighttime hours, and some of us would prefer to work the 24/48 shifts with the longest workweeks at the lowest levels of average productivity.

Our reasons for preferring these various kinds of shifts may be totally different. All of us are individuals, and our personal life-styles, long-term career goals, and family situations differ widely. By treating everyone the same, we eliminate or reduce our own individual choices. I prefer choices.

Impact of Career Development

Eastern Ambulance owner Marty Yenowine visited Kansas City and discussed Eastern's career development program with a group of Kansas City field personnel. Marty believes that field personnel should not be allowed to become vocationally trapped by blind faith that one can realistically expect to make a lifetime career of field ambulance work. In Marty's shop, employees have the opportunity to obtain extensive career counseling, aptitude testing and to tailor for themselves a

realistic and practical career development plan that will provide an honest career option at a later time in life. Marty's case is powerful and persuasive. Eastern's career development program, in my opinion, is the most humane and far-sighted employee benefit program I have come across.

What has a career development program to do with this issue? It should be obvious. A variety of shift schedules, made available annually by a seniority bid process, will provide both the company and individual workers with the best possible means of pursuing the wide range of career development programs that may be selected and pursued by work force members—more variety, more opportunity.

Recognizing Reality

The debate has already gone on too long in Kansas City. While management and labor have discussed these issues, however diligently, medics without adequate rest have continued to respond to calls. The patients and the community deserve better. Some members of the labor force have expressed a preference for universally short shifts and 40-hour workweeks, with no reduction in take-home pay. Unless the labor force could be greatly expanded, such a plan would destroy response-time performance, while drastically increasing workload volumes per unit hour. And if everyone works a 40 hour week, the cost of expanding the work force to maintain present unit hour coverage would be something in the neighborhood of one million dollars annually.

At first, some medics thought Medevac could simply pull the extra money from its "profits." A look at the books by union officials dissolved this myth. Others have suggested going en masse to city hall to demand a doubling of the declining city subsidy. One may as well propose reversing the direction of the earth's rotation.

No, with *present financial resources*, and that's the key to understanding, reality limits both management and labor to dealing within the general parameters of the two options outlined above. There are, of course, a thousand variations on these themes, but the system's total labor bill cannot be increased significantly, unit-

hour coverage cannot be decreased significantly, and therefore the labor cost per unit hour cannot be increased significantly. That's not policy—it's simply fact. Reality constrains us all.

The Issue of Fairness

Most Kansas City medics have come to recognize that extended shifts with inadequate rest opportunities must and will end. But even though the issues and alternatives were presented nearly three months prior to this writing, the work force has been unable to recommend to management the solution it would prefer. Jeff Royer's thoughtful contribution to this article helps to explain the difficulty of securing a clear majority recommendation from a work force of such diverse backgrounds, interests and expectations.

But the question of fairness remains, and it is a valid question. Some medics have recently compared their wages, working conditions and shift schedules to those of nurses, respiratory therapists and other allied health care professions. Is it fair that persons in related professions often make a higher salary working shorter hours and under less adverse working conditions? And if it isn't fair, what can be done about it?

The first and most obvious answer is that if you would like to enjoy the salary, working conditions, work schedules and fringe benefits of a respiratory therapist, the easiest way to do that is to become a respiratory therapist, not an EMT or paramedic. There is nothing in America that guarantees or even hints at equality of compensation among the various professions. In fact, our economic theory depends, in part, upon differences in compensation to guide the flow of manpower among our competing industries.

It may be interesting to compare EMT and paramedic compensation with that of other allied health professionals, firefighters, even police officers. But it won't be useful. The "boss," to use Mark Wozmak's term for our industry's sources of regulation and finance, will compare medics' workloads, compensation and fringe benefits locally with those provided elsewhere throughout the ambulance industry. The standard of the industry—this industry—is what the city councils and rate payers will be looking at.

The present Kansas City system evolved out of one of America's most expensive low-performance systems. Before the public utility model was installed in Kansas City, wages were high while productivity was low by any reasonable standard. Everyone worked 24/48, nearly everyone got plenty of rest, response times were terrible, equipment was terrible and clinical performance was variable at best.

Coming from that background, it may be difficult to assess the question of fairness objectively, as performance expectations are elevated to become consistent with pre-existing compensation levels. But rather than argue the question of fairness myself, I will simply provide the facts, and I specifically invite comments and reactions regarding this important question of fairness from field personnel throughout America.

The February *jems* feature article pretty clearly identifies the workload. A mixture of emergency and

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nonemergency calls are employed deliberately, in part to relieve the continuous stress of nonstop emergency work. On average, Kansas City crews run .26 patient transports per hour on duty and .37 total calls per hour on duty. Crews average about one post-to-post move per on-duty hour. On average, 18 minutes per on-duty hour are spent at an ambulance post, and 12 minutes per hour are spent on miscellaneous activities such as shift changes, meals and other activities reported to the dispatch center. In short, about 30 minutes out of every on-duty hour are spent either running calls or actively providing coverage in the system. The other 30 minutes are spent in miscellaneous activities or at post.

Crews in the Kansas City system enjoy the use of some of the finest equipment in the industry. Superb equipment, one of the best maintenance programs in the industry, reportedly good and improving in-service training combined with medical control by physicians knowledgeable of the system should make for good, if not perfect, working conditions.

As to pay and benefits, average pay for a KCMO paramedic working a 52.5 hour week is slightly under $20,000 per year, not counting benefits. The average EMT working the same schedule makes just under $15,000 per year, excluding benefits. Benefits include a 5 percent retirement program, workers comp, a modest life insurance program, full hospitalization and a comprehensive major medical plan, including optical and dental coverage at no expense to the employee, plus partial payment of dependant coverage. There are six paid holidays, salary interruption insurance paid by the company covering approximately two-thirds of an individual's weekly salary when the employee is unable to work due to a non-job-related illness or injury. Vacation pay is 1/52 of the employee's approximate annual salary for each week of earned vacation with one week of vacation available after one year of employment, two weeks after two years of employment and three weeks after eight years of employment. In addition to regular pay and benefits, employees average around $400 per year in bonus pay.

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Prognosis for Kansas City

When I was much younger, someone advised me, quite correctly, that I could benefit from learning to practice "the art of the possible." If it is true that this entire industry is underfinanced, and that this industry's employee salaries and benefits are substandard when compared with those of comparable industries, we must recognize that neither problem will be solved by the actions of one company or one labor force or one ambulance service system.

I believe our industry is underfinanced, and that it is partially our own fault. Both Alan Jameson and I have harped on the stupidity of our industry's pursuit of federal grants while ignoring our fair share of third-party reimbursements. For the most part, the government-operated segments of our industry continue to make a similar mistake by persistently relying upon diminishing local tax dollars, while failing to assist the rest of the industry, represented by the American Ambulance Association, in its quest for a much-belated fair share of America's health care dollar.

The trend is away from—not toward—local tax financing of health care service. This industry is on the move. Every piece of the industry that can't perform, by our industry's own rapidly advancing standards of performance and efficiency, will surely be replaced.

Think about it. Kansas City replaced an entire ambulance service system when the previous system couldn't perform. As long as there are systems, companies and personnel that can demonstrate higher levels of performance at greater levels of efficiency, all the other system designs, companies and personnel remain at risk. Again, that's not a policy, but simply a fact.

Will the more mature and career-oriented members of the Kansas City labor force lead the way? Will both management and labor settle for some compromise solution that, first of all, protects the patient? Will the constraints of reality be recognized and accepted, or battled to the death?

The field personnel in Kansas City are represented by a local of the International Association of Firefighters(IAFF). The EMS system

depends heavily upon the continued cooperation of the city's fire department and its personnel for essential first responder services, ambulance post locations and, as the Hyatt Regency disaster response proved, superb cooperation and leadership during disaster events. I suppose it is not impossible that the viability of the entire Kansas City ambulance system could be destroyed by the system's failure to secure the understanding and cooperation of field personnel. A lot is at stake.

The consequences of failure to resolve these issues cooperatively are, at best, dramatic. The entire system could be replaced by another. Just as Kalamazoo, Michigan, has recently decided to close its city-operated paramedic service in favor of laissez-faire prehospital care, it is unlikely but not impossible that Kansas City might withdraw its support of the public utility model, should the present system become paralyzed. What would the new system be like? How would it be financed? How would it be controlled? What would the wages be? How many paramedic jobs would it support? The possibilities are endless. Just look around at the nation's big-city systems and make your predictions.

For myself, I have learned one thing in recent weeks. At this early stage in our industry's development, it is unreasonable to ask a heterogeneous labor force, such as that in Kansas City, to propose specific solutions to complex problems of this type. In an attempt to obtain input from the work force, things went too far. Improved communications and understanding are essential. And it is equally essential that management gain from workers a clear understanding of their interests, expectations and how any decision may affect their lives. But the work force cannot and should not be asked or expected to make a decision that is, in essence, a management responsibility. This is especially true when, in the case of a difficult question, almost any option is likely to be unpopular to some important extent.

I do not believe that Medevac intentionally burdened its work force with such a difficult decision-making responsibility merely to avoid the consequences of making an unpopular but necessary decision. In the course of our "12,000-Mile Inspection and Tuneup," we discovered deficiencies in labor-management communications and it is possible that Medevac overcompensated for these past deficiencies. It is even possible, perhaps likely, that the idea of asking labor to pick the desired direction originated with me.

It no longer matters. The Kansas City physicians have mandated an end to extended shifts without adequate rest opportunities. There isn't any more money, and, for the foreseeable future, there won't be any more money. Medevac recognizes its primary responsibility to the patients and can no longer delay the implementation of some practical solution, however unpopular it may be.

I don't know now what will happen, but I believe it will happen before this article is in print. In a future edition of "Interface" I will report what happened and invite comments and evaluations from Medevac's management. □