



AMBULANCE INDUSTRY Journal

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2003 Stars of Life Celebration

The American Ambulance Association's 2003 Stars of Life Celebration was an exciting EMS national event that recognized and honored the dedicated professionals in the ambulance service industry. These individuals were nominated by their peers who believed they had displayed extraordinary bravery, commitment, skill and dedication to their life-saving work and to the communities which they serve.

the program featured meetings with Members of Congress on Capitol Hill, where the Stars of Life themselves delivered important information to their U.S Representatives and Senators on the value of quality ambulance service as a key component of an effective and efficient health care delivery system.

This year's celebration was held at the Omni Shoreham Hotel in Washington, D.C., May 4-7, 2003. This three day event involved Stars and their hosts and guests touring Washington, D.C., educational seminars, a barbeque at the National Zoo, congressional meetings on Capitol Hill and an awards banquet honoring all the Stars. The special guest speaker at the banquet was Mr. Thomas Blackwell, MD who spoke about medical response to terrorism. The awards banquet keynote speaker was Chief David Paulson, Preparedness Division Director and U.S. Fire Administrator in the newly created

Department of Homeland Security/Federal Emergency Management Agency.

On the evening of May 6, 2003, during the banquet ceremony the AAA awarded 115 medics from Maine to Hawaii and 32 other states in between. Energy, enthusiasm, dedication, professionalism and sacrifice were words that described many

of the Stars as they were presented with an honorary certificate. We were blessed to recognize the tireless medic who kept operations running smoothly, the unmatched community spirit of the medic always first to volunteer, the compassionate medic with a loyal focus on the needs of each patient, the "humble" medic who literally gave his life to his work, the paramedic whose life was forever changed, and his partner who saved him with an heroic act. The 2003 Stars of Life Celebration was one to remember for years to come. **AJJ**



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AAA's Summer Reimbursement and Professional Education Conference

The AAA's Summer Reimbursement and Professional Education Conference will be held July 23-26, 2003, at the Hyatt Regency Minneapolis at Nicollet Mall in Minneapolis, Minnesota. This essential conference will not only provide you with the most up-to-date reimbursement information, but education on other pressing issues our services are confronting. Items such as Homeland Security, Risk Management Insurance Issues and Emergency Preparedness are some of the additional topics to be discussed.

We invite you and your staff to join us in Minneapolis, MN, to participate in a new and changing educational experience. Through education, interaction and networking we are able to improve our services, improve the communities and most importantly improve your complicated world of providing pre-hospital care to the patients we serve.

For more information on this upcoming conference please visit our Web site at www.the-aaa.org or call AAA's Meetings Manager, Darlene Fredericks at 1-800-523-4447 x345. **AIJ**

Medical Malpractice Challenges for Ambulance Providers

Co-Authors: Ronald W. Thackery, American Medical Response & Lorraine Kehm, Marsh USA

Ambulance companies are under tremendous pressure to come up with cost-effective "cost of risk" solutions that effect change. At the same time, they must also find appropriate vehicles to insure against a wide variety of risks. For many, the answer can be found in traditional insurance coverage's. Others may be more interested in innovative risk financing solutions. While alternative risk financing can be a critical component of any program, the same can be said for fresh thinking about clinical risk management and patient safety initiatives.

With the new millennium has come a major change in the insurance picture. Both the frequency of malpractice claims and the severity of these events have given rise to marked increases in premiums. There is ever increasing concern surrounding the cost of healthcare professional liability insurance. Some malpractice carriers such as Reliance have gone out of business entirely, some have withdrawn from the marketplace, and others have suffered downgrades by the likes of A.M. Best. Failures, withdrawals, and the consolidation of several regional carriers have combined to produce a less competitive marketplace with fewer commercial alternatives.

Consequently, ambulance companies have been compelled to absorb larger retentions of risk while paying more for insurance coverage. Rather than being a buyer's market, it is now a seller's market. Very few insured's with first-dollar coverage still exist. In addition to being forced into higher deductibles or self-insured retentions, ambulance companies are experiencing more stringent collateral requirements for even small retentions at levels close to the aggregate retention amount. Carriers are also reducing limits and declining to offer aggregate deductibles. Coverage terms are also less negotiable as carriers strictly adhere to underwriting guidelines and standard forms and conditions. Some carriers are even requiring a mandatory "risk management fee", depend-

ing on the client's size and risk profile.

Selectivity has increased to the point that those seeking insurance must be able to differentiate themselves to be successful in pursuing traditional malpractice insurance coverage. The current insurance landscape and the demand for patient safety have coalesced, leading to the recognition that the investment in patient safety solutions has a positive return on investment that can be used or leveraged in the insurance marketplace.

A prospective insured should meet directly with insurance company underwriters to discuss its risk management philosophy, patient safety procedures, incident identification procedures, and claims reporting and management procedures. Senior Management of the ambulance company must demonstrate to underwriters their commitment to patient safety and loss control, as well as their ability to manage the overall operations of the organization.

The Myth of Insurance

There is a misnomer concerning insurance that many companies believe, that is, that insurance companies have the desire, and are profitable, even when they must pay claims on behalf of their insured's. In fact, the opposite is true – insurance companies remain profitable when they don't pay claims. Interestingly, many insurance carrier's design their underwriting around groups

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of insured's that are the least likely to have claims or that have management controls in place to minimize the likelihood of claims being filed.

Perhaps the myth stems from experience with our personal lines of insurance. We typically buy homeowners and car insurance. Consequently, we believe that insurance companies exist for the purpose of transferring risk that exceeds an acceptable threshold to each of us (e.g. \$250 or \$500). As a result, we need to merely decide what our appetite for a retention ("deductible") is – then if we have a collision or damage – we pay our \$250 deductible and expect the carrier to pay the rest. We are often surprised when the carrier cancels coverage at our next renewal period – for the mere reason that we had a claim. The next carrier offers a policy with less coverage at an increased price – and coverage becomes more difficult to obtain.

As stated previously, Insurance companies don't make money by paying claims, they make money by not paying claims – and they seek customers who meet the profile of those who won't make claims. Thus, a professionally designed risk management program will involve the analysis of several options for your company – risk transfer, risk sharing or risk retention. If your company is likely to have claims because of size, employee base, etc. – the carrier will help to design a program where claims can be paid through an appropriate financing mechanism. If your company is interested in transferring all of the risk, understand that the carrier will project the anticipated cost of all of your losses and charge that much as a base premium and tack on additional amounts for their profit and administration. Meanwhile, when your company retains the risk, the carrier typically provides a program to get those losses paid through an effective financing vehicle and will assist in the transfer of risk for catastrophic losses so that when that once in a lifetime claim occurs it doesn't put your company out of existence.

Five Tips for an Ambulance Company Seeking Professional Liability Insurance

1. **Submit the Best Application.** Read the insurance carrier's application carefully and make sure that the responses you provide are accurate. Provide details for historical losses that need explanation. Often a third party administrators notes regarding claims are insufficient or can confuse the carrier about what actually happened. Seek to have your completed application positively distinguish you from other companies the carrier may insure.
2. **Value Patient Safety.** Be intimately familiar with every safety initiative in your company that is designed to ensure patient safety. Preventing the incident from occurring in the first place, is the most desirable outcome. Take the time to identify and explain how your company goes above and beyond the call of duty to prevent medical malpractice from occurring in the field. Include examples of preventive programs at your company as an addendum to the application.
3. **Know your Broker.** Work closely with your broker to understand the market and what it offers to your company. Pay attention to the financial position of carriers in the professional liability market and their viability in these difficult times. The exit of The St. Paul from the market significantly reduced capacity for medical malpractice coverage in all of healthcare, including ambulance operations. The outcomes at other carriers have left companies without the benefit of coverage they previously enjoyed. You and your broker should have a common understanding of your companies risk tolerance – i.e. how much risk can your organization afford to retain? Your broker should also provide you with a flurry of options for structuring your program each time it is renewed – what worked best three years ago may not continue to be the best program for your company.
4. **Know the law.** In many states, EMS professionals are afforded immunity for certain medical procedures performed. Also, some states have enacted tort reforms or caps for recovery in medical malpractice litigation. By following medical protocols, EMS professionals and their employer may avoid claims for negligence or gross negligence. You should work closely with your TPA and the EMS attorneys representing your company to make sure that you have any applicable statutes, have reviewed all case law interpreting those statutes and are aware of any legislative processes which impact either. Additionally, you should be knowledgeable of state laws regarding the discoverability of quality assurance reviews of incidents by clinical staff. Explain any of these distinguishing factors to the carrier which serve to improve the insurability of your company.
5. **Seek Long Term Relationships.** In EMS, we are very proud of the service that we've provided to communities – and good service seems to be the backbone for serving communities for long periods of time. Insurance carriers are weary of companies that switch carriers too often. Be willing to commit to a long term relationship that is mutually beneficial to both parties. However, don't be so naïve that you fail to realize the benefits afforded through competitive bidding and how that can aid your negotiation. **AJJ**

Understanding the Disaster Reimbursement Process

By Klark Staffan

Ambulance service providers respond to routine emergencies everyday. We have become quite familiar with the operational aspects and the cost reimbursement requirements associated with these routine emergencies. However, if you ask many ambulance services about their operations and cost recovery success in response to a large disaster, you may hear that it was anything but routine.

Following a rash of large disasters in the early 1990s - which included an increased involvement of private ambulance services, I wrote a number of articles in an attempt to help ambulance providers better understand the unique process involved in preparing for such events. One such article, "Disaster Preparedness for Ambulance Providers," appeared in the March/April 1994 edition of the AAA's Ambulance Industry Journal.

The 1994 article outlined a comprehensive approach to better understand the four phases of Integrated Emergency Management and how ambulance service providers should integrate their operations into the local and regional emergency management process. Most of the discussion in this article addressed planning, response, EOC integration and recovery operations. One section, however, briefly addressed surviving a disaster's financial impact and the cost recovery process.

The recent events of September 11th have once again raised our awareness to future disaster threats including biological, chemical and weapons of mass destruction. As we all know, ambulance services are an essential resource and a vital part of the emergency response system. However, there have been several recent accounts of ambulance service providers who have responded with numerous resources to local and regional disasters, only to find out, after the fact, that the cost recovery process for their services, supplies and other expenses is very complex. The unfortunate reality is that they are often not reimbursed for their services at all.

This article is intended to help you

understand how and why this reimbursement problem exists and what can be done to help mitigate the problem. The emergency management process is complex and involves all levels of government—local, state and federal, and therefore, can be difficult to navigate. Your success at receiving reimbursement is in part based on your understanding of the different stages of a disaster, the powers and capabilities of government during each stage of a disaster and the steps you could take before a disaster strikes.

Local Emergency Declaration

A "Local Emergency" declaration may be proclaimed by a local governing body for an actual or threatened emergency event posing extreme peril to the safety of persons and property within the territorial limits of a city or county. The actual proclamation of a Local Emergency provides local government several legal authorities, including:

- They may request the Governor to proclaim a "state of emergency," if warranted
- Promulgate orders to provide protection of life and property, including curfews
- Activate local mutual aid plans and emergency plans including the emergency operations center (EOC)
- Require the emergency services of local government officials and employees
- Request or commandeer resources as needed for public safety
- Impose penalties and grant immunity from civil action during emergency operations

As part of the local emergency, your service may be requested to respond with multi-

ple resources for an extended period of time resulting in substantial expenses for your organization. Unless you have a pre-existing agreement with your local government that guarantees payment for your service, the only opportunity to seek reimbursement for the services you provide during a Local Emergency may be through your patient billing efforts. Unfortunately, there are problems with both of these arrangements.

The problem with local agreements, is that local and state government only seem to be willing to sign a disaster response contract that is contingent upon their first receiving federal funds to offset their costs. Unless the emergency reaches a Federal Disaster Declaration level, there are no federal funds for local or state government. In addition, any contingency payment clause in the agreement becomes a problem for the federal government to pay due to federal prohibitions on contingency contracts.

A well-written agreement with local government that does not contain a contingency payment clause (assuming they will sign it) can lay the foundation for you to receive reimbursement for the cost of your services. However, as stated above, the contract must guarantee the payment without federal funding contingencies.

It is otherwise up to you to gather complete and accurate documentation for billing purposes during the disaster response. Good luck billing Medicare! Imagine, during or after the fact, trying to collect all the required billing documentation and then attempting to convince your Medicare Carrier that the evacuation of each nursing home patient was indeed medically necessary. New CMS standards make this even more difficult!

State of Emergency Declaration

A "State of Emergency" declaration may be proclaimed by a Governor when conditions exist that exceed the capabilities of any local

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government, or when a disaster or extreme peril to the safety of persons and property within the state exists or is threatened. A State of Emergency declaration provides state government several legal authorities, including:

- They may request a “Federal Disaster Declaration,” if warranted
- Provide state-wide mutual aid and activate state-wide emergency plans
- Exercise all police powers vested in the state constitution
- Command the aid of citizens as deemed necessary to cope with the emergency
- Suspend the provisions of state statutes or regulations

Though most states have provisions for state disaster relief, in most cases, the “fund” has no money, or, the financial resources can only be allocated as “matching funds” when, and if, the state government receives disaster relief funds from the federal government.

- Commandeer any private property or personnel in carrying out the state’s responsibilities

Though most states have provisions for state disaster relief, in most cases, the “fund” has no money, or, the financial resources can only be allocated as “matching funds” when, and if, the state government receives disaster relief funds from the federal government. Again, federal funds are only available as a result of a “Federal Disaster Declaration.” Once again, unless you have that magic “non-contingent” agreement with local government guaranteeing payment for the services you provide, your only reimbursement option may be through your patient billing, which will be difficult at best.

Federal Disaster Declaration

Upon the request of a State Governor or as otherwise determined by the President of the United States, a “Federal Disaster

Declaration” may be proclaimed to supplement the resources of effected jurisdictions and to provide federal financial assistance. This level of disaster declaration generally occurs during very large man made or natural disasters with enormous damages such as earthquakes, floods, tornadoes and hurricanes. The Federal Emergency Management Agency (FEMA), now under the Department of Homeland Security, is the President’s executive agency for managing the approved disaster relief funds and programs.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act) provides the legislative guidelines for distributing federal disaster funds. This includes: 1) reimbursement of local and state governments, and federal agencies for their losses and expenses on a cost sharing basis; 2) to pay for actual disaster related costs to help

the community recover, and; 3) to provide relief to affected businesses and individuals to assist with rebuilding. It is the Stafford Act that provides guidance on the criteria for federal reimbursement including the types of eligible entities and the types of eligible services to receive funds.

Following a disaster, FEMA (now known as the Office of National Preparedness, ONP) assesses the financial impact of the event and estimates the amount of funds required for response, recovery and rebuilding. Once approved, FEMA forwards the allocated disaster relief funds to the effected states, who in turn manage the distribution of the funds down to the local level. The Governor’s Office of Emergency Preparedness or Emergency Management becomes the state agency responsible for the coordination of disaster relief efforts and the administration of the disaster relief funds.

Although reimbursement of ambulance

service costs during a federally declared disaster is clearly appropriate and appears to be intended in the Stafford Act, unfortunately, some of the language in the Act is vague regarding eligible recipients. Consequently, misinterpretations occur during the financial assistance process, resulting in denied payment of federal funds for otherwise legitimate and requested services provided by private ambulance services.

This problem has occurred even when local ambulance service providers have been requested by local government officials to provide ambulance services as part of a disaster response, and even when ambulance services were issued a claims mission number as evidence of the official request.

The AAA intends to continue to educate its membership on this issue, provide needed tools (such as a model disaster agreement), and to work on efforts to improve the language within the current federal regulations. Look for upcoming educational tracks, articles and additional information on this subject.

In the mean time, I encourage you to meet with you local Emergency Management organization to educate them on this topic. Position your organization to better serve your community during a disaster by working more closely with Local Emergency Preparedness Committees, and begin discussions regarding a non-contingent local agreement to assure you can survive the financial impact on your organization when disaster strikes your community. **AJJ**

Klark Staffan is Vice President of the Regional Emergency Medical Services Authority (REMSA) in Reno, Nevada and is a Certified Emergency Manager. Klark has extensive experience at the local, state and federal level in the field of emergency management including participating in numerous actual responses to major disasters including the Northridge, CA earthquake and Hurricane Hugo, in SC, managing emergency operation centers and staffing recovery field offices. Klark has been a provider, manager and executive in the ambulance industry for over 31 years working in both the public and private sectors.

Beef, Chicken or Pork: What's on The 2003 Congressional Menu for Small Ambulance Providers?

It is often said that the legislative process is like sausage production. While the outcome is sometimes tasty, the ingredients are confusing and the process can be messy.

Small ambulance providers have unique needs. Whether it is private insurance, state or federal payment programs, the payment methodologies for ambulance service have always been geared to urban locales. They are structured to force competition among providers in urban markets in an effort to achieve the best product at the lowest possible cost. These payment methods, whether they be based on average charges (as Medicare was from 1965 to 2002) or one size fits all (as with new ambulance fee schedule, Medicaid and insurance typically) are volume dependent. Competitive market forces work well in our nation's economy in areas where volume supports multiple providers, but are woefully inadequate in markets where a product (like ambulance service) is necessary, but volume only supports one (or less) provider.

While not always true, the typical small ambulance provider (10 ambulances or less):

- serves urban locations that are isolated – serving both urban and rural areas;
- suburban – serving both suburban and rural areas; or,
- completely rural or frontier areas.

Your association, the American Ambulance Association (AAA), supports legislation that has a balanced approach, recognizing the distinctions in market forces. The Dayton/Houghton bills are a prime example of this balanced approach. These bills would pay all providers at the national average cost of providing ambulance service, but go further, and recognize that higher payments are necessary to maintain ambulance service provided in rural areas. The AAA Board reaffirmed this position at their meeting in May.

There are a number of bills in consideration in Congress that have special interest to small ambulance providers. Some are tailored

to specific provider types. Some of the bills in play include:

S171 (Dayton, D-MN)/HR1301 (Houghton, R-NY) Medicare Ambulance Payment Reform Act of 2003

These bills have three provisions and are the bills actively supported by AAA. They:

- Set the Medicare ambulance fee schedule at the national average cost
- Provides higher payments for rural ambulance runs than urban ones
- Requires CMS to adopt condition coding system

S816 (Conrad, D-ND)/HR1675 (Moran, R-KS) Health Care Access and Rural Equity Act of 2003 – H-CARE

These bills provide language important to Critical Access Hospitals (CAH) that own and operate ambulance services. Currently a CAH receives cost-based reimbursement for all the services it provides – except ambulance service, unless the next closest ambulance service is at least 35 miles away. These bills, among a number of other provisions, eliminates the 35 mile “isolation test” and would provide CAHs with cost-based ambulance reimbursement. S172 also contains this provision

HR1475 The Private Firefighter, Ambulance Crew, and Immediate Responder Fairness Act of 2003

Currently the federal government provides a death benefit to the survivors of a police officer, firefighter or medic killed in the line of duty – only if they are employed by a public entity. Those benefits are not available to free-standing, hospital or non-profit police, firefighters or medics. This bill extends “public safety officer death benefits” to medics and certain other ambulance service personnel employed by either public or private police departments, fire departments or ambulance services by changing the definition for eligible employers.

S942 (Brownback, R-KS)/HR937 (Moran, R-KS) Rural Community Hospital Assistance Act of 2003

These bills provide cost-based plus ambulance reimbursement for rural hospitals of 25-50 beds that operate ambulance services.

S315 (Leahy, D-VT) - S466 (Daschle, D-SD) First Responders Partnership Grant Act of 2003

There is currently ambiguity in the definition for agencies eligible to access grant funds controlled by the Department of Homeland Security. These bills would provide \$4B (Leahy) or \$5B (Daschle) in homeland security and terrorism grants and tinker with the definition of eligible entities to include both public and private organizations and to add ambulance services as an eligible grantee. Funds would still flow through state agencies, but any question of availability of the funds for ambulance services would go away. Most states already recognize ambulance services as eligible, but some do not.

Rural EMS Grant Appropriations: Last year the Congress authorized funding for Rural EMS grants, but appropriated no money for the grants. Letters have been sent to both the appropriate Senate and House leadership requesting to fund these grants at \$25 million per year. The letters were coordinated by the two members of Congress who wrote the original bills containing the grant program, Congressman Kennedy (R-MN) and Senator Conrad (D-ND).

Whether it will be beef (Dayton/Houghton), chicken (nothing, or provisions less than a full cost option – with or without additional rural relief) or pork (relief limited to one or a group of states) we won't know until October. The good news is you still have a chance to impact the outcome. If your members of Congress aren't already cosponsors of S.171 or HR.1301, write, e-

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OIG Issues Final Compliance Program Guidance For Ambulance Suppliers

By R. Michael Scarano, Jr., Foley & Lardner

On March 24, 2003, the Office of Inspector General of the Department of Health and Human Services (“OIG”) issued its Final Compliance Program Guidance for Ambulance Suppliers (the “CPG”). Although the CPG uses the term “supplier” both in the title and throughout the text, the OIG makes it clear that it applies to ambulance services provided by both Part B “suppliers” and by Part A “providers.”

The CPG is very similar to the draft CPG issued by the OIG in June 2002, but does include some changes designed to better address issues raised by the Medicare ambulance fee schedule rule that went into effect on April 1, 2002. Changes were also made in the final CPG to address issues raised in the three comment letters submitted in response to the draft.

The CPG is divided into five sections with four appendices. Section I provides a brief introduction regarding the CPG; Section II provides information about the basic elements of a compliance program; Section III focuses on specific Medicare fraud and abuse and compliance risks for ambulance suppliers; Section IV briefly summarizes compliance risks related to Medicaid coverage for medical transportation services; and Section V discusses various risks ambulance suppliers face under the anti-kick-back statute. The appendices address a number of additional potential risk areas, which are not covered in the body of the CPG and provide information regarding additional compliance resources.

The following summarizes each section of the CPG.

Section I. Introduction

In the Introduction, the OIG observes that “the ambulance industry is made up of entities of enormous variation,” including organizations that are large and small, non-profit and for profit, hospital-based and inde-

pendent, and governmental and private. Consequently, the OIG notes that “this guidance is not intended to be a one-size-fits-all guide on ambulance supplier compliance programs,” nor does it establish mandatory obligations for any type of ambulance organization. Rather, like the previous CPGs it has issued for other segments of the health care industry, it is intended as a helpful tool for entities that wish to establish a voluntary compliance program or have already done so.

Section II. Components of a Compliance Program for Ambulance Suppliers

Section II of the CPG discusses the building blocks of an effective compliance program, which include: (1) developing compliance policies and procedures; (2) designating a compliance officer or contact person(s); (3) conducting appropriate training and education; (4) conducting internal monitoring and reviews; (5) responding appropriately to detected offenses and developing corrective actions; (6) developing open lines of communication (e.g., through a hotline or other mechanism); and (7) enforcing disciplinary standards through well publicized guidelines.

With respect to training and education, the OIG suggests that suppliers consider offering two types of training: general compliance program training and job-specific training. The OIG recommends that employees complete a post-compliance training test or questionnaire to verify comprehension of the material presented, and that additional training be provided on at least an annual basis in order to keep employees current on applicable requirements.

The OIG recommends that ambulance suppliers conduct a risk analysis which includes an evaluation of their internal operations and whether they comply with federal program requirements. The OIG states that

the evaluation process should furnish ambulance suppliers with a snapshot of their strengths and weaknesses and thus assist them in recognizing areas of potential risk.

This evaluation can also result either in the creation and adoption of written policies and procedures or the revision of these for organizations, which already have them in place. With respect to suppliers in the latter category, the OIG suggests that existing policies and procedures be reviewed to ensure they are representative of actual practices. As an example, the OIG notes that “an ambulance supplier’s policy for reviewing ambulance call reports (ACRs) should not state that it will review 100 percent of its ACRs unless the ambulance supplier is capable of performing and enforcing such comprehensive reviews.” This is excellent advice because failing to adhere to existing policies can sometimes be worse than having no policies at all.

The OIG devotes considerable attention to the performance of periodic claims reviews as part of a compliance program. The CPG does not prescribe or endorse any specific claim review process, but describes some general procedures to be followed and issues to be reviewed. The OIG emphasizes the importance of documenting how often reviews are conducted and the information reviewed in each instance. The CPG states that ambulance suppliers should review claims on a pre-billing basis to identify errors before claims are submitted, but notes that a review of paid claims may be necessary to determine error rates and quantify overpayments and/or underpayments. In addition, the OIG recommends a periodic review of claims denials to see if patterns can be identified.

Section II of the CPG also addresses the need to periodically review and test the sup-

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Innovations: Positively Shaping the Future of EMS

By Jay Fitch, PhD

Introduction

Since the birth of modern EMS in the late 1960s, steady progress has been made. Research-driven improvements in pre-hospital care delivery — such as EMT defibrillation and now public access defibrillation, improved non-invasive monitoring devices, new drugs, and better protocols coupled with enhanced quality processes — all improve patient care.

Less known are technological improvements that impact or have the potential to impact the way we manage our EMS organizations. Technology is beginning to address several areas that have been sources of frustration to EMS managers for many years. In this article, five of these issues are highlighted, as are new tools to help managers address them.

Patient Care Reporting Systems

Identifying a patient care reporting system that meets the needs of all its customers has been a challenge faced by EMS managers since the EMS Systems Act of 1973 included “evaluation” as a component of an EMS system. Getting information recorded by medics on scratch paper and gloves transcribed in to a format that meets the needs of receiving hospitals, QI and research staff, billing departments, and myriad other users who need this information is an ongoing problem. The needs of receiving hospitals are typically met by having medics complete hard-copy forms.

For many years, the only option for creating data was to have data entry extract that data from handwritten PCRs and enter it in to a database. This was inefficient, costly and could be less than fully accurate. Next, scannable “optical mark recognition” forms (“bubble forms” to takers of standardized tests) attempted to fill the gap. These forms collected only limited data sets, and were difficult both in the field and to handle afterwards. A number of states required these type forms and have subsequently abandoned them.

Throughout the 90s, direct data entry computer systems, ranging from desktop computers and laptops to slate computers, hand-helds, and PDAs were seen at every EMS trade shows. Although quick, accurate, reliable data entry was promised, often these beta systems delivered less than advertised, and at a greater price. Some products with promise are emerging but many have expressed the opinion that direct data entry will not be fully functional EMS until voice recognition technology improves, and until reliable interfaces between monitoring devices (ECG monitors, capnographs, non-invasive pulse and blood pressure monitors, etc.) are a reality. Moreover, direct data entry systems have high initial costs, and agencies must deal with the relatively short useful lives and high acquisition and maintenance costs of computer devices.

A new product on the scene, called HealthEMS™ threatens to eliminate this problem. HealthEMS™ is both a product and a service from a company called ScanHealth, of Duluth, Minnesota. ScanHealth has a long history of success in the home-health records industry. Some two years ago, having turned its focus to EMS, ScanHealth released HealthEMS™, a comprehensive web-enabled EMS data management solution that consistently and accurately collects critical point-of-care patient data using pen and paper, gives providers instant management information and reports via the Internet, and automates much of the claim generation process to help increase agency cash flow.

At HealthEMS agencies, medics prepare their PCRs on multi-part carbonless forms that are very similar to the forms prescribed by many states for the last twenty years. In addition to the data usually entered, medics include 3-digit codes for the various drugs administered, treatments performed, supplies used, and diagnostic tests performed. The reports can be completed at the hospital, and a copy left with the receiving physician or



nurse.

Back at the EMS agency, the forms are scanned using ordinary (and inexpensive optical scanners just like those you'd use at home to scan a photograph). The scanner and its host PC use powerful HealthEMS RD3+(P) technology to read the written PCR and turn the writing in to data. The system displays any areas where it has any difficulty in cleanly interpreting the handwriting. An operator validates the computer's interpretation, usually taking 30-90 seconds per report. The data is then uploaded over a HIPAA-compliant, encrypted Internet connection to the HealthEMS host computers in Duluth. Just minutes later, data is available for downloading and use. A “billing review form” is produced, which classifies the call according Medicare guidelines using data from the form (to identify BLS, ALS-1, or ALS-2 calls, for example). This data can be fed directly in to ScanHealth's own billing system, or can be printed for use by an agency's own billing department. At the same time, data is available for QI purposes, training, or any other reason.

Once uploaded, the system becomes entirely paperless. The PCR is stored in two formats — as “data”, having been interpreted, and as an optical image that cannot be altered. Paper forms can be archived or destroyed immediately. If needed, months or years later, true and correct copies of the original form can be printed (in color, even) to respond to subpoenas or to respond to requests for records.

This system sounds too good to be true. It is not. It is just good. If you're convinced you can't live without an entirely paperless system, HealthEMS recently introduced the same powerful software that runs on a tablet computer for an entirely paperless approach. Find out more at <http://www.scanhealth.com/healthems.asp>

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Deployment Planning and Crew Scheduling

If your ambulance service has all the resources it will ever need, or your deployment plan and staff schedules are set in stone, you may not be interested. But if you're a high-performance EMS agency that reviews its deployment plan on a regular basis, and you have a workforce that wants some flexibility in shifts and hours, the duo of Quick Response Deployment Planner (ORDP) and Quick Response Crew Scheduler (QRCS) from the Isera Group may be very useful to you. Using industry standard data formats, ISERA software analyzes and displays data from your CAD or records management system, and allows managers to "test-drive" various staffing patterns. Its simulation capabilities allow you to evaluate deployment performance, including call coverage and unit workloads, prior to your making a change in your deployment plan. QRDP has the capacity to handle zone-based limits (like EMS equity zones) and allow you to examine the impact of multiple shift schedules on field operations.

QRCS takes this a step further, and takes the output from QRDP down to the level of the individual field associate. It allows managers to establish rules and parameters, including individual associate skill levels, qualifications, availability and preferences. It then makes recommendations for staffing assignments. It allows managers to perform "what if?" scenarios and to test drive new scheduling options. Once schedules are established, individual shift calendars can be printed. Schedule changes can be automatically e-mailed to those who are affected by the change.

If you've been stymied by the assignment of "re-doing the schedule", or hunted through files to find that "HazMat certified paramedic who's not already assigned on Monday from 0800-1900", these programs may be for you. You can find more information at <http://www.isera.com/private.htm>.

Just...MARVLIS!

Another issue that is a perennial headache for

EMS managers is keeping map books current and available to crews. Since the Minnesota Supreme Court allowed a \$11 million verdict to stand against an EMS agency whose crews drove past a cardiac arrest call,¹ awareness of mapping and correct response routing is at an all-time high.

Over the last year, MEDIC – the Mecklenburg (NC) EMS Agency – has worked with Bradshaw Consulting Services of Aiken, North Carolina, a geographic information systems firm, to develop a system called MARVLIS – the acronym stands for Mobile Area Routing and Vehicle Location System. This system sits between the agency's CAD system and mobile computers located in each ambulance. It combines automatic vehicle location (AVL) capabilities, status reporting capabilities, along with mobile mapping and navigation.

This system is truly amazing. It takes the location of the ambulance from the AVL system, the location of the call from the CAD system, examines a geographic data base, and in just a few seconds, over wireless data radio, serves up the appropriate maps, recommend-

ed routes of travel, and other information to the cab of the ambulance. A push of a button notifies that CAD system that the ambulance is en route. As the crew travels, the map turns with the vehicle, pans, zooms, and otherwise does a good bit to keep the vehicle on the best track to the call.

Map books now become a backup system, rather than the critical and difficult potential point of failure of the past. MEDIC reports that their response times improved significantly after implementation of the MARVLIS system. See <http://www.bcs-gis.com/pg000012.htm> for more information.

Providing "24/7" Education

Providing high quality continuing education has been a long term problem for ambulance services. Consistently delivering orientation, protocol review and other specialized training such as HIPAA and reimbursement documentation has also been thorny issues. Work schedules, instructor availability, course costs and the overtime pay associated with sending staff to mandatory sessions have made this particularly difficult.

The American Ambulance Association recently partnered with *EMSED.com* to facilitate continuing education and information management. EMSED provides BLS and ALS continuing education accepted by the CEBEAMS and the National Registry via the internet. It can be accessed 24/7 from any high speed or dial up modem. Developed by long time EMS Educator Jim Eastham, the EMSED approach uses some of the most sophisticated (and secure) learning management software on the market.

Members of the recent Ambulance Service Manager's (ASM) program pilot tested the EMSED system for AAA and used it for obtaining reading assignments, completing group projects between sessions and taking quizzes. The EMSED system can be fully customized for individual organizations or can be obtained through the AAA. For more information contact <http://www.emsed.com>

Watching for Terrorists – FirstWatch™

One of the greatest challenges facing our nation as we come to grips with the reality of terrorism in the homeland is the identifi-



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TOO MUCH STRESS?

What to Know, What to Do

By: Richard W. Patrick, VFIS - Director of EMS Programs & Services

It's no secret that emergency service providers have very high-stress jobs. Administrative hassles, threat of injury or exposure to infectious disease, the added hours involved in volunteering, traffic, weather extremes, and the consuming nature of the work itself are all contributors.

But too much stress can hinder your performance. It can affect your memory, spark interpersonal conflict, ruin morale and increase accidents. It can also make you sick. High stress is a contributing factor in heart disease, hypertension, ulcers, cancer, diabetes, depression and other problems.

Signs and Symptoms

Knowing about stress – how to recognize it and what to do about it – is an important safety issue. The nearly universal signs of being over-stressed include:

- **Persistent fatigue** – When you don't feel refreshed even after many hours of sleep.
- **Negativity and cynicism** – Worsens where it already exists and starts where it didn't exist before.
- **Diminished job motivation** – If an activity starts to hurt, it's natural to become less motivated to do it.

There are other signs and symptoms as well. *Physically*, stress can promote general muscular tension, headache and a stiff neck, pain between your shoulder blades or in your lower back, respiratory illness and gastrointestinal upset. You may feel like a "coiled spring" or find yourself clenching your jaws or fist.

Emotionally, you may feel overwhelmed, helpless or hopeless, isolated or relentlessly pressured. After a while, it may feel as if everyone is making demands for your help. You may also cry easily, sleep and eat too much or too little, become irritable or begin to overuse alcohol, caffeine, nicotine or

other "comforting" substances.

Action Steps

What do you do if you experience these symptoms? Basically, there are three ways to attack stress: 1) change or eliminate things that stress you, 2) change your attitude toward them, 3) minimize your physical/emotional response by using various stress-management techniques.

Here are a few suggestions for the third option:

- **Exercise** – Among the many benefits are improved fitness and a general sense of



- well being and self-control.
- **Try Progressive Muscle Relaxation or Yoga** – Local adult education programs may offer training in some of these methods.
- **Learn Deep Breathing** – This is done with the diaphragm, not the upper chest, and is inherent to many martial arts, yoga and meditation.
- **Take Time Off** – Take a break: a vacation, a few days off, maybe just less overtime.
- **Expand Your Social Circle** – Find non-EMS/emergency friends who may not be interested in talking "shop."
- **Rekindle an Old Hobby** – Or develop a new one.
- **Unwind Appropriately** – Don't go right home and to sleep after a call or shift. Try exercising a few hours before sleeping and

avoid heavy meals before bedtime.

Critical Incident Stress

Fire, rescue and EMS personnel are expected to tolerate a certain level of crisis. But some events are unusually powerful emotionally, even by emergency service standards. These are known as *critical incidents*, and they can generate often-debilitating stress responses. Unfortunately, many providers hide their emotions after such an event because of peer pressure and the fear they will make fools of themselves if they vent or express their feelings. Externally, they may appear callous – giving the false impression that nothing affects them. Internally, the results can be devastating both emotionally and physically.

But there is no shame in asking for help. In Chinese, the character for crisis has two meanings: "danger" and "opportunity." In the wake of a critical incident, emergency service providers have a golden opportunity to take the effects of stress seriously and develop a proactive approach towards addressing an otherwise debilitating situation.

This is where the intervention of a Critical Incident Stress Management Team is vital. Often volunteering their services, these formally trained mental health professionals and peer supporters provide stress debriefing and group and individual counseling. Confidentiality is guaranteed. No blame is placed. And the meetings they conduct become safe places to talk about feelings. Placing a call begins the process.*

Stress and Your Family

The stress you experience can touch everyone from your spouse and children to your parents and siblings. Being a "Fire/Rescue/EMS family" often means try-

Too Much Stress • continued on page 12

Bio-Terrorism Response

The launch of the 21st century has brought with it a new series of potential scenarios affecting our communities that include the threat of biological, chemical, and radiological emergencies. In virtually every such incident, EMS, fire, and law enforcement personnel would be among the first responders. In light of this new reality, the need for readiness is critical, and emergency service leaders, officers, and responders must be keenly aware of the unthinkable.

Prevention, preparedness, response, and recovery are considered the four phases of contingency planning in terms of dealing with any potential scenario. While we may not be able to prevent every one of these threats from occurring, we can be prepared. This article focuses on dealing with the threat of bioterrorism.

What are Biological Agents?

The Federal Emergency Management Agency (FEMA) defines biological agents as organisms or toxins that have illness-producing effects on people, livestock, or crops. They can be dispersed as aerosols or air-borne particles. Terrorists may use biological agents to contaminate food or water because they are extremely difficult to detect. And because they can't be easily detected and may take time to show their effects, it is almost impossible to know that an attack has occurred.

The Centers for Disease Control and Prevention (CDC) lists three categories of biological agents. These are the diseases and agents, both old and new that could confront our nation and its allies. Take a look at the following lists. Do any of these sound familiar?

Category A

The U.S. public health system and primary healthcare providers must be prepared to address various biological agents, including pathogens that are rarely seen in the United States. High-priority agents include organisms that pose a risk to national security because they:

A wide range of information on bio-terrorism and bio-terrorism response already exists on the internet. For additional information, check out these sites:

www.CDC.gov (Center for Disease Control and Prevention)

www.FEMA.gov (Federal Emergency Management Agency)

www.FBI.gov (Federal Bureau of Investigation)

www.oep-ndms.dhs.gov (Office of Emergency Preparedness)

www.dhhs.gov (U.S. Department of Health and Human Services)

- can be easily disseminated or transmitted from person to person;
- result in high mortality rates and have the potential for major public health impact;
- might cause public panic and social disruption; and
- require special action for public health preparedness.

These include:

- Anthrax (*Bacillus anthracis*)
- Botulism (*Clostridium botulinum* toxin)
- Plague (*Yersinia pestis*)
- Smallpox (variola major)
- Tularemia (*Francisella tularensis*)
- Viral hemorrhagic fevers (filoviruses [e.g., Ebola, Marburg]
- Arenaviruses [e.g., Lassa, Machupo])

Category B

Second highest priority agents include those that:

- are moderately easy to disseminate;
- result in moderate morbidity rates and low mortality rates; and
- require specific enhancements of CDC's diagnostic capacity and enhanced disease surveillance.

These include:

- Brucellosis (*Brucella* species)
- Epsilon toxin of *Clostridium perfringens*
- Food safety threats (e.g., *Salmonella* species,

- Escherichia coli* O157:H7, *Shigella*)
- Glanders (*Burkholderia mallei*)
- Melioidosis (*Burkholderia pseudomallei*)
- Psittacosis (*Chlamydia psittaci*)
- Q fever (*Coxiella burnetii*)
- Ricin toxin from *Ricinus communis* (castor beans)
- Staphylococcal enterotoxin B
- Typhus fever (*Rickettsia prowazekii*)
- Viral encephalitis (alphaviruses [e.g., Venezuelan equine encephalitis, eastern equine encephalitis, western equine encephalitis])
- Water safety threats (e.g., *Vibrio cholerae*, *Cryptosporidium parvum*)

Category C

Third highest priority agents include emerging pathogens that could be engineered for mass dissemination in the future because of

- availability;
- ease of production and dissemination; and
- potential for high morbidity and mortality rates and major health impact.

These include emerging infectious disease threats such as Nipah virus and hantavirus.

Response Issues

An individual affected by a biological agent requires immediate medical attention, yet

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The Commission on Accreditation of Ambulance Services (CAAS) Accredits Seven New Agencies in March

At their March 2003 meeting, the CAAS Panel of Commissioners granted accreditation to seven ambulance agencies. The Medical Center Emergency Medical Services of Bowling Green, Kentucky; Pride Care Ambulance of Kalamazoo, Michigan; American Medical Response—Riverside, California; American Medical Response—San Bernardino, California; American Medical Response—Orange County, California; American Medical Response—Ventura, California; and Emergency Ambulance Service, Inc., of Brea, California, all received three-year accreditations.

CAAS accreditation is open to all private, public, fire-based, volunteer, and hospital-based ambulance services. The number of communities in America touched by CAAS-accredited agencies continues to grow. Located in 26 states across the country, CAAS-accredited agencies provide high-

quality emergency medical services to a combined population of well over 60,000,000 people. CAAS-accredited agencies recognize that once accredited, they have a responsibility to continue growth and improvement as knowledge and experience are gained.

To learn more about the Commission on Accreditation of Ambulance Services, its accreditation program, standards, and upcoming accreditation seminars, visit the web site at www.caas.org. **AJJ**

The Commission on Accreditation of Ambulance Services (CAAS) Elected to 2003 Associations Advance America Honor Roll

The Commission on Accreditation of Ambulance Services has been elected to the 2003 Associations Advance America Honor Roll, a national awards competition sponsored by the American Society of Association Executives (ASAE) in Washington, DC.

CAAS received this award in the ethical, technical or professional standards category for its outstanding ambulance accreditation program, which has resulted in significant benefit to American society.

Now in its 13th year, the prestigious Associations Advance America Awards program recognizes associations that propel America forward—with innovative projects in education, skills training, standards setting, business and social innovation, knowledge creation, citizenship, and community service. Although such activities have a powerful impact on everyday life, they often go unnoticed by the general public.

“The CAAS program truly embodies the spirit of the Associations Advance America campaign. It is an honor and an inspiration to showcase this activity as an example of the many contributions associations are making to advance American society,” remarked ASAE President, Michael S. Olson, CAE. **AJJ**

Too Much Stress

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ing to appear invulnerable to the outside world, able to “take the heat” when a personal emergency (such as a line of duty injury or death) happens. Your family must understand that it is okay to react humanly and to seek the kind of support that other families would normally expect. It would be wise for you to build in group stress-management time and maintain good interpersonal communication. In addition, there are many spouse support groups that have cropped up informally; others are part of a national support network.

The Bottom Line

Managing stress is essential to your overall

good health, which, in turn, helps assure your safety, as well as the safety of your colleagues and family. Recognizing the symptoms and dealing with them will also ensure you and your organization continue to provide outstanding public safety services without the hindrance of this often-hidden and destructive disease.

***EDITOR'S NOTE:** For more information on stress and stress management, contact *VFIS Education and Training Services*, at 1-800-233-1957. Information on *Critical Incident Stress Management* is also available through the *International Critical Incident Stress Foundation (ICISF)*. To contact ICISF, call 410-750-9600 or, in an emergency, call 410-313-2473. You can also check their web site at www.icisf.org.

Beef, Chicken or Pork

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mail and meet with them as soon as possible and ask them to become cosponsors. The best place to start is by using a tool provided by your American Ambulance Association. Go to www.the-aaa.org today, type in your zip code, and send your message. And, encourage your neighboring ambulance services (whether AAA members or not) and employees to do so also. **AJJ**

Gary Wingrove is manager of government affairs for Gold Cross Ambulance in Minnesota, a member of the AAA Small Providers Committee and vice-chair of AAA's Government Affairs Committee.

HAZMAT For The Modern Day EMS Provider

By Trevor Hale, CCEMT-P, I/C, EMS Education Coordinator, Taney County Ambulance District

You and your partner are paged to respond emergency to a local hotel for several patients complaining of food poisoning-like symptoms. While responding, dispatch reports that these patients are part of a tour bus, and they ate at a restaurant about three hours ago. All the patients are complaining of nausea, vomiting, severe abdominal cramps, fever and chills? The first question that comes to my mind is: Where did they eat, so I don't go there for dinner. However, this call poses a more serious question: Is the scene safe for my partner and I to enter? In the very first day of your EMS training and beyond, your instructors stressed personal safety. This call, even as routine as it seems, can involve serious safety concerns for you.

Pre September 11, 2001, when you heard there was a HAZMAT response, chances are your first thought was an industrial accident or spill. Now, when you hear the word HAZMAT, what is the first thought that comes to mind? Is it still that industrial accident, or is it the "new" threat - terrorism? Terrorism has been thrust into the spotlight over the last 18 months or so. It seems every time you turn on the news, there is a new threat, or someone has been arrested in possession of a biological or chemical substance. So, what does this mean to us as EMS providers? How will a terrorist attack change what we do as EMS providers? Are you ready to handle the influx of patients that will be generated from a biological, chemical or weapon of mass destruction (WMD) event?

In the early 90's when I was a firefighter, we did a lot of HAZMAT training, such as the Awareness and Operations level programs. In 1995, I became a HAZMAT Technician, and at that time I often wondered if these skills would be necessary. Now, when I think about the present state of our nation, and the threat that we live with every day, I'm afraid that these skills will be necessary. As an EMS provider, I'm painfully aware of how unprepared EMS services are for incidents of this nature. Not necessarily because we don't know what to do, but because we don't have the equipment to protect ourselves. With the

new Healthcare Finance Administration fee schedules, some services are just trying to survive, never the less, buy expensive HAZMAT equipment and PPE.

So why should this matter to me, we are in a low-risk area right? Well, chances are that a terrorist is not going to go to rural Missouri, and detonate a "dirty bomb". However, if the moons were all aligned just right, and something did happen, do you have the equipment and training to protect yourself, partner, and the public? If you are the first on the scene, (which most or you will be) what are the people who have been affected by this going to do when they see you pull up in an ambulance? They are going to come to you for help, and they expect you to know what to do, and to have the equipment that is necessary. Remember, if they are covered with contaminate, what kind of risk is it going to pose to you, your partner, your ambulance, bystanders, etc. These are the issues that we as EMS providers need to consider to stay safe in this new world.

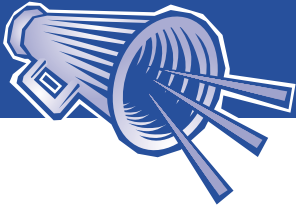
If you have ever completed any HAZMAT training, you probably left the program feeling that the class has very little use in the EMS arena, and for the most part, that's true. Very little of the common HAZMAT programs offer the kind of information that we as EMS providers need to know, such as how high water solubility will affect your patients, or what the most common route of contamination is, and how will it affect my patient. When it comes to HAZMAT, the same properties that the HAZMAT team uses to mitigate the incident are the same properties that we will use to determine how it will affect our patient. Fortunately, there is a new program for EMS providers that deal with these types of issues. We recently developed a program specifically for EMS providers that addresses hazardous materials issues. The program is three days long, and meets all the didactic and practical standards of NFPA 473. This program looks at all aspects of a HAZMAT response, and identifies how will affect your patients, and your treatments. We are in the process of training all of our staff in this

new program, and we have had very positive comments from the front-line providers. They all have indicated that this is new information to them, and it puts a new spin on their previous HAZMAT training.

It's clear that HAZMAT is going to be an ever-present part of EMS. Now is the time to be proactive, and look at the policies/procedures, training, equipment, that are in place to respond to such calls. When the call happens, it's too late to try and determine how you are going to handle the incident. It's a fact that in most areas of the state, that EMS is going to be the first on the scene, and the patients are going to migrate to the ambulance for help. We harp about personal safety from the first day that you enter into the EMS field, however, a true HAZMAT incident will put your safety and life on the line, and it's an area that we do very little to prepare for. We as professionals need to recognize our weakness in this area, and take steps immediately to protect ourselves.

This particular scenario was a real event that happened in our county, and our crews approached it as a food borne illness. However, it was not that simple. This tour bus was infected with the Norwalk virus. This is the same virus that has affected so many of the cruise ships over the past year. Unfortunately, our crews did become ill with the same symptoms as the patients they were treating. This emphasizes the need for further training in this area to prevent future exposures to our crews. EMS personnel need to evaluate all information available to ensure their safety. This call could have turned out much worse if there was a biological, chemical or WMD exposure. So, the next time you respond to a call of multiple patients with the same complaint, such as food poisoning, you should think twice about your initial patient contact. The next one could be the difference between life and death.

If you would like more information about our HAZMAT training program, or would like to attend our next program, contact me by phone at 417-334-6462 or e-mail medicthale@aol.com. **AIJ**



HIPAA and Wheelchair Van Operations: Does the Privacy Rule Apply to Paratransit Services?

By Doug Wolfberg, Esquire and Steve Wirth, Esquire • Copyright 2003, Page, Wolfberg & Wirth, LLC

Most ambulance services are “covered entities” under the HIPAA Privacy Rule and have taken steps to comply with this complex regulation. However, many are unsure how HIPAA affects their wheelchair van or paratransit operations. For instance, do you have to give a Notice of Privacy Practices (NPP) to your wheelchair van patients? Must you make a good faith effort to obtain a signed acknowledgment of receipt of the NPP? This article is intended to help those ambulance companies with wheelchair van or paratransit services in understanding how HIPAA applies to these operations.

Covered Entity or Not?

The first question that you must answer in deciding how HIPAA affects your wheelchair van operation is whether or not your organization is a covered entity under the Privacy Rule. As a refresher, a “covered entity” is (1) a health plan; (2) a health care clearinghouse; or (3) a health care provider that transmits health information electronically in connection with certain covered administrative transactions, such as claim filing, remittance advice, health plan enrollment or eligibility, claim status and certain other transactions. An ambulance service that bills electronically would be an example of a covered entity.

Next, you must next examine whether your wheelchair van operation is part of the same corporate entity as your ambulance service or whether it is a separate legal entity. Many, if not most, ambulance services operate wheelchair vans through the same corporate entity as their ambulance operation. Let’s take the example of a typical private ambulance service. Let’s assume that

the “XYZ Ambulance Service, Inc.” is a corporation owned by one individual, and that the corporation has ambulances and wheelchair vans in its fleet. In this instance, the corporation as a whole is a covered entity for HIPAA purposes. (However, read the rest of the article before concluding that the HIPAA rules apply to your wheelchair van operations – we have another possible way out for you later in this article!)

Some ambulance services may have organized a separate corporation or other legal entity for their wheelchair van or paratransit operations. In this case, you have to determine whether or not that corporation or entity meets the definition of “covered entity” on its own. Let’s consider that scenario a little further. Earlier we defined “covered entity,” so let’s see if a stand-alone wheelchair van operation meets the test.

Are Wheelchair Van Transports “Health Care?”

If your wheelchair van or paratransit operations are provided through a separate, stand-alone company, or if you are solely a wheelchair/paratransit company, it would be necessary to determine if that stand-alone wheelchair van business meets the “covered entity” definition as a “health care provider.” (We are going to assume that a stand-alone wheelchair van or paratransit company doesn’t meet the “health plan” or “health care clearinghouse” covered entity test, as most would not.)

To be a covered entity as a health care provider, it is necessary, first and foremost, that you provide “health care.” The Privacy Rule broadly defines “health care” as “care, services, or supplies related to the health of

an individual,” including “preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition . . . of an individual.” Whether or not wheelchair van services constitute “health care” is a close question. In many states, wheelchair van/paratransit operations are regulated by public utility commissions or other such agencies as “transportation” or “common carrier” services and are not regulated by a health department or other health care agency. In other states, wheelchair van transportation benefits may be covered under Medicaid to transport beneficiaries to and from medical appointments. However, some state Medicaid programs cover these services in the context of “transportation” benefits as opposed to health care benefits.

Many wheelchair van operations are staffed with one driver and no medically trained attendants. Many do not carry EMS or medical equipment on their vans or paratransit vehicles. While the van operator may provide “bed-to-bed” lifting and moving (as opposed to the “curb-to-curb” service of a taxi operator or bus, for instance), most are not trained or qualified to perform patient care-type services in connection with the transportation. However, even if your wheelchair vans carry medical equipment and are operated by EMTs or other medically trained staff, this doesn’t necessarily mean that you are providing “health care” when performing a wheelchair van transport.

On the other side of the coin, if a particular state or jurisdiction regulates your wheel-

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chair van service as a health care entity, that might tip the scales more toward a conclusion that your wheelchair van operation constitutes “health care” services.

These factors are not dispositive, but they do address some of the pros and cons as to whether wheelchair van operations qualify as a “health care provider” under HIPAA’s covered entity test. You should consult with qualified legal counsel to make this determination in connection with your own organization. In our view, however, a wheelchair van operation that does not utilize medically trained van operators or carry medical equipment is a “transportation” service and not a “health care” provider.

Does Your Wheelchair Van Service Engage in Covered Transactions?

Let’s assume, for the sake of argument, that your wheelchair van operation does constitute “health care” (which in most cases, we think is a stretch). But bear with us for the sake of argument. There is still one more issue to determine if a stand-alone wheelchair van company is a covered entity: you must determine whether or not you engage in one of the covered electronic transactions under HIPAA, such as claim filing or remittance advice.

Some state Medicaid programs and commercial insurers do pay for wheelchair van service for their beneficiaries or enrollees. In some areas, wheelchair van operators do bill these programs electronically for these services, which are included in the list of covered transactions. However, in some cases these benefits are included in a list of “transportation” services, like taxi or bus fares. If, for example, a taxi company would transport someone to a doctor’s office for a medical appointment, and bill the Medicaid program for it, the taxi company would not be a covered entity under HIPAA merely because it took a person to a doctor’s office for an appointment. So, even though your wheelchair van operation may bill electronically for its services, that doesn’t mean it is covered if it does not provide “health care” as we discussed above.

IF a stand-alone wheelchair van company provides health care, and IF the company bills electronically or engages in the other covered electronic transactions, the entity would be a covered entity for purposes of the HIPAA Privacy Rule.

Covered Entity: Now What?

If your wheelchair van operation is a covered entity, your organization must fulfill numerous requirements under the Privacy Rule. These include: (1) furnishing a detailed Notice of Privacy Practices (NPP) to your patients; (2) making a good faith effort to obtain the patient’s signed acknowledgment of receipt of the NPP (except in an “emergency treatment situation”); (3) providing patients with the rights of access, amendment and accounting with regard to their Protected Health Information (PHI); (4) appointing a privacy officer; (5) providing mandatory privacy training to all members of your workforce; (6) implementing reasonable technical, physical and administrative safeguards to protect the privacy of PHI; and (7) implementing numerous forms, policies and procedures to achieve compliance with the Privacy Rule.

A Possible “Final Escape” – Making a “Hybrid Entity” Designation

If you operate an ambulance service and wheelchair van operation in the same organization (i.e., in the same corporation, partnership, etc.) you may qualify as a “hybrid entity.” A hybrid entity is a covered entity that performs both covered and non-covered functions. Therefore, while your ambulance operation may indeed be a covered function, your wheelchair van operation may qualify as a non-covered function if it does not provide “health care” (as outlined in our discussion above). If this is the case, your organization can declare itself to be a hybrid entity and essentially “wall off” its covered functions (i.e., ambulance) from its non-covered functions (i.e., wheelchair).

If your ambulance service makes a hybrid entity designation and declares its wheelchair van operation to be a non-covered function, it would not be necessary to furnish an NPP or obtain acknowledgment signatures from your wheelchair van passengers, provide HIPAA training to the wheelchair van staff,

safeguard your wheelchair van records as PHI, provide rights of access, amendment or accounting with regard to the wheelchair van documentation, or fulfill the other HIPAA requirements. However, there are certain restrictions on what type of information covered component (i.e., the ambulance operation) may share with the non-covered component (i.e., the wheelchair van operation), and there are also guidelines with respect to the use of PHI by individuals that are employed to perform both functions (for instance, a medic who takes shifts both on the ambulance and the wheelchair van).

Finally, if your organization desires to make a hybrid entity designation, it is not necessary that you file any documents with any agency or have this designation “approved.” You simply draft and implement the appropriate documents, and maintain this documentation in your files in the event you ever undergo a compliance inspection or investigation and are asked to produce such documentation. You should consult qualified legal counsel to assist you in properly executing your hybrid entity designation.

Conclusion

Ambulance services with wheelchair van operations can certainly choose to comply with the HIPAA Privacy Rule in all respects in their wheelchair van operations. However, with a little bit HIPAA strategy, many ambulance services may be able to “carve out” their wheelchair van operations from their HIPAA compliance obligations, which might make the lives of your owners, managers and staff a little easier. In any event, make sure you don’t neglect this part of your operation, because, chances are, some steps are required in order to achieve HIPAA compliance with respect to your wheelchair van or paratransit operation.

Doug Wolfberg and Steve Wirth are attorneys with Page, Wolfberg & Wirth, LLC. The firm is an AAA Affiliate Member, and both Doug and Steve are frequent speakers and attendees at AAA conferences and events. They are also the co-authors of “The Ambulance Service Guide to HIPAA Compliance” and co-producers of “The HIPAA Privacy Training Video for EMS.” More HIPAA information is available on their web site, www.pwwemslaw.com. AIJ

AEDs - Why are they so important?

The automated external defibrillator or AED is the most exciting development for saving the lives of victims of sudden death since CPR. Now anyone with just a little training can deliver a lifesaving shock to a dying heart. Experience with AEDs has shown that each minute of delay getting an AED to the side of a sudden death victim decreases the chance of survival by approximately 10%. The American Heart Association estimates that “public access to

defibrillation” could save 100,000 of the 350,000 people who simply fall dead of heart failure each year.

Do you have a large number of employees or an at-risk customer base? Then you should begin considering the placement of an AED on your premises. You should also consider an AED to ensure defibrillation within five minutes. An AED should be placed where there is a reasonable possibility of one sudden car-

diac death happening every five years. About four hours of training will prepare your workforce to prevent sudden death with both CPR and early defibrillation using an automatic defibrillator.

If you are interested in learning more about AEDs or adding them to your life-saving equipment, contact Acadian Education Coordinator, Scott Saunier at 1-800-259-3333 or 337-291-1571. **AIJ**

Donations of AEDs in Louisiana High Schools

Acadiana Heart Institute at Our Lady of Lourdes Regional Medical Center and Acadian Ambulance Service have joined forces in an initiative designed to immediately promote greater safety on school campuses and, in the long term, enhance the safety of the entire community.

The immediate aspect of the program, announced at a news conference at Lourdes, involves the donation of an automatic external defibrillator (AED) to the nine public and private high schools in Lafayette Parish, LA. Richard Zuschlag, chairman and CEO of Acadian Ambulance, said the advanced medical devices have the potential for saving lives of students, faculty and staff, as well as people attending school functions who suffer Sudden Cardiac Arrest.

As a component of the program, the schools are being asked to permit representatives of Acadian Ambulance, Acadiana Heart Institute at Our Lady of Lourdes, and the Louisiana Technical College to meet with senior students who have not chosen a career path to discuss health care careers as nurses, paramedics, and other allied health professionals.

The placement of automatic external defibrillators in the schools coincides with the American Heart Association’s public access defibrillation program that seeks to make the devices immediately accessible at

sports arenas and other public areas. At each of the local schools, personnel from the Heart Institute and Acadian Ambulance personnel will train a designated person on the procedures for using an AED. “It is very basic and very simple,” said Zuschlag. “Many airports now have them and any lay person can use one by reading the instructions on the side of the machine. The device is so technically advanced that it requires little human intervention. When it is placed on the chest of a cardiac victim, a computerized diagnostic program is activated, and the machine provides directions to the user. In one instance, a group of sixth graders were able to use an AED properly after a single lesson.”

Despite the simplicity of use, training on the AEDs is essential because an operator must know how to recognize the signs of Sudden Cardiac Arrest, when to activate the EMS system, and how to do CPR. Training also teaches the operator how to avoid potentially hazardous situations, according to Zuschlag.

Zuschlag said there are 250,000 to 350,000 deaths annually in the United States due to Sudden Cardiac Arrest. “Responding to such an emergency with CPR alone offers 6 to 10 percent chance of survival,” he said. “CPR with defibrillation within three minutes of collapse increases chances of sur-

vival to 74 percent. Immediate access to the AEDs is crucial since, with each minute that elapses, a patient’s chance of survival decreases by 10 percent.”

The AEDs being donated to the schools have a value of approximately \$3,500 each.

“The long-term component of the program — meeting with students who might be encouraged to enter the health care field — can make the community safer by relieving the severe shortage of paramedics and nurses,” said Ron Webb, Our Lady of Lourdes Regional Medical Center President & CEO. “The shortage of nurses is a nationwide problem, and we deal with it daily at Lourdes. I know that Acadian Ambulance faces the same problem in regard to paramedics.”

Faye LeBlanc, president of the Acadiana Heart Institute at Our Lady of Lourdes Regional Medical Center, said access to the students to discuss careers in the health care field could lead to rewarding opportunities for students while addressing the shortage. “Those who choose such a path will find that it is a career with multi-faceted rewards, both in terms of earnings and the personal satisfaction of helping to ease suffering and save lives. The AED program is a win-win situation for the schools, the community and Lafayette’s health care providers.”

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OIG Compliance Guidance

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plier's overall coding and billing systems (e.g., to detect any deficiencies in the supplier's automated system, such as improper "hard coding"); the need to check the OIG and General Services Administration exclusion lists (available on their websites) prior to employing or contracting with new individuals, and to re-check existing employees and contractors on at least an annual basis; and the importance of developing reasonable responses to address and correct any identified problems. With regard to the last point, the OIG recommends that suppliers develop written protocols that explain how certain situations will be addressed, including the internal reporting obligations and involvement, if appropriate, of legal counsel.

Section III. Specific Medicare Fraud and Abuse Risks

Section III of the CPG focuses on certain risks associated with Medicare requirements applicable to ambulance suppliers. Specifically, the OIG identifies the following as areas in which suppliers should focus their compliance efforts:

Medical Necessity: The CPG describes a number of medical necessity issues that should be addressed in an ambulance supplier's compliance program. Upcoding, where a supplier bills for a level of service above what was actually provided or warranted, is identified as a concern. As an example, the OIG describes a 1999 case involving a supplier, which billed for advanced life support (ALS) services when only basic life support (BLS) services were provided. The supplier involved did not even employ ALS personnel.

The CPG also identifies non-emergency transports as a special area of concern, noting that there have been several fraud cases involving non-emergency transports to non-covered destinations, as well as transports that were not medically necessary. Also in connection with non-emergency transports, the CPG discusses the requirement for physician certification statements ("PCSs").

Documentation, billing and reporting

risks: The OIG identifies inadequate or faulty documentation as a "key risk area for ambulance suppliers," stating that the compilation of correct and accurate information is the responsibility of all ambulance personnel, including the dispatcher. The OIG warns against making assumptions or inferences during the billing process to compensate for lack of information or contradictory information on a trip sheet or other medical source documents. The CPG contains a catalog of 11 types of information that should be gathered in order to fully support a claim. The inclusion of "dispatch instructions" on this list is particularly noteworthy, since the fee schedule rule places new importance on the condition of the patient as reported at the time of dispatch. For example, the fee schedule rule permits suppliers to bill at the ALS1 level even if the patient does not receive any ALS interventions, so long as the patient's condition as reported at the time of dispatch warrants (and the patient receives) an ALS assessment. Documenting dispatch instructions will provide essential support for claims at the ALS1 level in such cases.

The OIG also identifies the appropriate use of HCPCS and diagnosis codes in preparing claims as an important documentation area. The CPG states that diagnosis code information should not be based on past medical history or prior conditions unless this information also specifically relates to the patient's condition at the time of transport.

As a last documentation area, the CPG states that suppliers should carefully document transport origins (including the "point of pickup zip code"), destinations and "loaded" mileage. If a beneficiary requests transport to a facility other than the nearest appropriate facility, the OIG recommends that the supplier inform the patient and he or she may be responsible for payment of the additional mileage.

Secondary payers—coordination of benefits: One risk area identified by the OIG which presents particular challenges for ambulance suppliers is the need to determine whether Medicare, Medicaid or other federal health care programs should be billed as the primary or as the secondary insurance. The

OIG recognizes that ambulance suppliers frequently have incomplete insurance information and may not be aware of a secondary payer. However, the CPG states that "an entity that knowingly, willfully and repeatedly fails to provide accurate information relating to the availability of other health benefit plans shall be subject to a civil monetary penalty." Thus, it is incumbent upon suppliers to have policies and procedures in place designed to elicit information from patients regarding secondary coverage whenever possible. In addition, if it is determined that an inappropriate or duplicate payment is received, the payment should be refunded to the appropriate payer in a timely manner. Further, "ambulance suppliers should develop a system to track and quantify credit balances to return overpayments when they occur."

Medicare Part A Payments: Finally, the OIG reminds ambulance suppliers they should not submit a claim to Medicare for transports that are covered under a hospital's DRG or nursing home's PPS payment. The OIG has included duplicate payments to both a Part A provider and to a Part B supplier for the same services as an area to be addressed in its prior annual Work Plans.

Section IV. Medicaid Ambulance Coverage

The CPG addresses Medicaid issues only briefly, noting that Medicaid requirements vary based on applicable state regulations. The CPG states that Medicaid covers medical transportation services that are not covered by Medicare, such as transports in wheelchairs vans, ambulettes, and cabs in appropriate circumstances. The OIG notes that state Medicaid Fraud Control Units and federal authorities have prosecuted numerous fraud cases in this area.

Section V. Kickbacks and Inducements

It is noteworthy that the CPG includes an entire detailed section regarding issues raised by the anti-kickback statute in the ambulance industry. This section starts out with an overview of the anti-kickback statute, stating that "the key inquiry under the statute is whether the parties intend to pay,

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or to be paid, for referrals.” Because of the gravity of the penalties under the anti-kickback statute, the OIG states that “ambulance suppliers are strongly encouraged to consult experienced legal counsel about any financial relationships with potential referral sources.”

The OIG offers some general guidelines for compliance with the anti-kickback statute:

- All arrangements for items or services between potential referral sources should be fair market value in an arm’s length transaction not taking into account the volume or value of existing or potential referrals. For each arrangement, ambulance suppliers should carefully and accurately document how it has determined fair market value.
- Suppliers should exercise caution when selling services to purchasers who are also in a position to generate federal program business, such as hospitals and skilled nursing facilities. Any link or connection, whether explicit or implicit, between the price offered the seller for transports paid out of the buyer’s pockets and referrals of federal program business will implicate the anti-kickback statute. This echoes advice that has been provided previously by the OIG in Advisory Opinion 99-2 and in other published statements, in which the OIG has warned against what it sometimes refers to as “swapping” discounts on DRG and PPS transports for referrals of Medicare fee for service business. (See *Law Watch* 99-13, March 10, 1999, and *Law Watch* 00-16, May 23, 2000.)
- “An ambulance supplier should not offer or provide gifts, free items or services, or other incentives of greater than nominal value to referral sources. . . . In general, token gifts used on an occasional basis to demonstrate good will or appreciation (e.g., logo key chains, mugs or pins) will be considered to be nominal in value.”

The CPG also identifies certain specific

arrangements that ambulance suppliers should review with particular care. These include the following:

Arrangements for emergency medical services: The OIG states that “ambulance suppliers should not offer anything of value to cities or other EMS sponsors in order to secure an EMS contract.” While cities and other EMS sponsors may charge ambulance suppliers amounts to cover the costs of services provided to the suppliers, they should not solicit inflated payments for access to EMS patients, including access to dispatch services under “911” or comparable systems. The OIG notes that “in general, ambulance suppliers may offer cities or other municipal entities free or reduced cost services for uninsured, indigent patients.”

The CPG discusses ambulance restocking, and summarizes the provisions of the anti-kickback safe harbor addressing such arrangements.

Arrangements with other responders: The OIG is aware that “it is common practice for a paramedic intercept or other first responder to treat a patient in the field, with a second responder transporting the patient to the hospital. In some cases, the first responder is in a position to influence the selection of the transporting entity. While fair market value payments for services actually provided by the first responder are appropriate, inflated payments by ambulance suppliers to generate business are prohibited, and the government will scrutinize such payments to ensure they are not disguised payments to generate calls to the transporting entity.”

Arrangements with hospitals and nursing facilities: Because health facilities “are key sources of non-emergency ambulance business, ambulance suppliers need to take particular care when entering into arrangements with such institutions.” (See the second guideline described above.)

Arrangements with patients: The CPG states that arrangements offering patients incentives to select particular ambulance suppliers may violate the anti-kickback statute, as well as the prohibition under the civil monetary penalties law against giving inducements to Medicare and Medicaid beneficiaries.

The OIG notes that programs providing

for the routine waiver of co-payments violate the anti-kickback statute. The OIG also identifies “subscription or membership programs offering patients purported coverage for the ambulance supplier’s services only” as “problematic” to the extent that they can be used to disguise improper routine waivers. To reduce the risk of these programs under the anti-kickback statute, the OIG recommends that ambulance suppliers carefully review such programs to ensure that the subscription or membership fees collected from subscribers or members, in the aggregate, reasonably approximate—from an actuarial perspective—the amounts that members or subscribers would expect to spend for cost sharing amounts over the period covered by the subscription or membership agreement. In a recent OIG advisory opinion, the OIG further clarifies that this actuarial determination can be made either with reference to all members (i.e., both Medicare and other payor categories), or solely with reference to Medicare members.

The OIG also states that suppliers may waive co-payments based on good faith individual assessments of financial need, so long as the availability of financial hardship waivers is not advertised.

Appendices: Additional Risk Areas and Resources

The CPG includes four appendices, which set forth additional risk areas not identified in the body of the CPG, and also provide helpful information about other compliance resources.

Four additional risk areas are found in Appendix A. The first such area involves “no transport” situations where an ambulance supplier responds to an emergency call, but no transportation is required due to the patient’s death or refusal of transport. The OIG recites the rules that apply in this situation under the new fee schedule, and reminds suppliers to accurately represent the time of death in situations where that is the reason for non-transport.

The second additional risk area involves situations where an ambulance transports multiple patients concurrently. The OIG recites the new fee schedule rule providing

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for a percentage of the base rate in such situations (e.g., if two patients are transported simultaneously, 75 percent of the applicable base rate).

A third identified area involves situations where more than one ambulance supplier responds to an emergency call, which the OIG refers to as “dual transports.” In such cases, only the transporting supplier may bill Medicare for the service provided, and the non-transporting ambulance service must receive payment directly from the transporting supplier. The OIG states that if a BLS supplier is billing at the ALS level because of the services furnished by another organization’s ALS personnel, “appropriate documentation should accompany the claim to indicate to the carrier that dual trans-

portation was provided.”

As the last additional risk area, Appendix A identifies “billing Medicare substantially in excess of usual charges.” The CPG states that “ambulance suppliers generally may not charge Medicare or Medicaid patients substantially more than they usually charge everyone else,” and violation of this rule is grounds for exclusion. “This exclusion authority is not implicated unless the supplier’s charge for Medicare or Medicaid patients is substantially more than its median non-Medicare/Medicaid charge.” Thus, this constitutes a risk area if a supplier “is discounting close to half of its non-Medicare/Medicaid business” below the Medicare allowable rate.

In addition to Appendix A, the CPG includes an Appendix B, which provides contact information for the OIG; Appendix C, which provides contact information for Part A fiscal intermediaries, Part B carriers and state Medicaid directors; and Appendix D, which lists a number of internet resources

pertinent to compliance.

Conclusion

The CPG provides useful guidance to ambulance organizations of all kinds, which either wish to establish compliance programs or have already done so. It sets forth important information both as to the general structure of compliance programs and the specific ambulance risk areas, which should be addressed. A copy of the CPG can be obtained on the OIG’s website at <http://oig.hhs.gov>. **AIJ**

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Innovations

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cation of clandestine bio-terror events. How will a community know if there has been a release of a toxic agent that does not immediately manifest itself? Traditional public health reporting mechanisms are often slow and unreliable, possibly taking days to realize that something unusual has taken place.

A few around the nation have realized that EMS systems, particularly those that use computer-based emergency medical dispatch systems, could serve as early warning points for bio-terrorism. Long before a definitive diagnosis of smallpox or brucellosis could be made, EMS systems will see an upswing in calls related to “syndromes” that might signal an unusual event – calls for patients with “fever and chills” or “nausea and vomiting.” Watching for trends like this is called “syndromic surveillance”, a hot topic among homeland security and public health

officials these days. Many authorities realize that recognition might first occur in the EMS dispatch center, but until now that recognition would be based on the sudden realization by dispatch personnel that a particular type of call had increased.

Enter FirstWatch™, a product of Stout Solutions of Encinitas, California, that monitors volume of particular call indicators captured by the ProQA system from Priority Dispatch Systems. The agency using FirstWatch, in cooperation with its public health and emergency preparedness officials, selects the parameters to be monitored. When FirstWatch detects a statistically significant “spike” in those parameters, within defined geographic areas, alarms are triggered – sending pager notification and e-mail to designated officials.

FirstWatch was first implemented as a custom product in 1999 in Kansas City. Since that time, it has undergone substantial refinement. The first commercial implementation occurred in September 2002 at the

Richmond Ambulance Authority in Richmond, Virginia. In addition to identification of bioterrorism, the system can alert authorities to accidental mass poisonings (for example, carbon monoxide or food poisoning) or to environmental emergencies (for example, widespread illnesses caused by heat or cold).

If your EMS organization wants to make sure that you notice a trend as it happens, FirstWatch may be one for you. See <http://www.stoutsolutions.com/firstwatch> and <http://www.raaems.org> for more information. **AIJ**

ⁱ See *Blatz v. Allina Health System*, No. C9-00-826 (Minn. Ct. App Feb 6, 2001).

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2003 AAA Calendar of Events

July 23-26, 2003

- Summer Reimbursement and Professional Education Conference
- Hyatt Regency, Minneapolis, MN

This essential conference will not only provide you with the most up-to-date reimbursement information, but education on other pressing issues our services are confronting.

September 21-25, 2003

- Annual Conference and Tradeshow planned in conjunction with EMS Expo and NAEMT
- Las Vegas Hilton, Las Vegas, NV

EMS Expo, the National Association of Emergency Medical Technicians and the American Ambulance Association have now come together in one international event that offers educational opportunities for all EMS providers.

Visit www.the-aaa.org for more information.



Bio-Terrorism Response

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many first responders will probably be unaware that a biological substance is involved. Adding to an already complex situation is the fact that some agents are contagious and victims may need to be quarantined. In fact, some medical facilities may not wish to receive victims for fear of contaminating the hospital population. This puts first responders at even greater risk.

Should government officials become aware of a biological attack, either through an informant or a warning by terrorists, they will most likely instruct the public to seek shelter and seal the premises or evacuate immediately. However, it is more likely that first responders will already have treated and perhaps transported victims to applicable facilities before information or confirmation of biological agent use is made. *In fact, fire, EMS, or law enforcement personnel may not even be the first responders to an incident.* It is just as likely that members of the public will already have sought medical treatment from their respective family physicians. This means that first responders in many biological scenarios could well be nurses, doctors, hospital and private physicians, animal control work-

ers, and veterinarians instead of traditional emergency response personnel.

Target Areas and Precautions

First responders need to understand that terrorists look for visible targets where they can avoid detection before or after an attack. Targets such as international airports, large cities, major international events, resorts, and high-profile landmarks are common. This does not rule out other venues. FEMA suggests that everyone – including first responders, take the following precautions:

- Be alert and aware of the surrounding area. The very nature of terrorism suggests that there may be little or no warning.
- Take precautions when traveling. Be aware of conspicuous or unusual behavior. Do not accept packages from strangers. Do not leave luggage unattended.
- Learn where emergency exits are located. Think ahead about how to evacuate a building, subway or congested public area in a hurry. Learn where staircases are located.
- Notice your immediate surroundings. Be aware of heavy or breakable objects that could move, fall, or break in an explosion

Staying Informed

Of course, in terms of the issues and information surrounding bio terrorism, this arti-

cle can only reflect the tip of the iceberg. At the forefront of the Bush Administration's efforts to confront bio-terrorism and other threats is the Homeland Security Administration. Other government agencies are also involved; for example, the Department of Health and Human Services alone has issued one billion dollars in grant monies to assist states in developing plans for bio-terrorism response and preparedness. According to the American Ambulance Association, many states have already formed Bio-terrorism Commissions.

Do you know whether your state has set up a Bio-terrorism Commission and, if so, what its directives are? First responders must be aware of the resources that are already in place as well as changing guidelines and regular alerts issued by the CDC, FEMA, and other organizations. They must also enhance their training and their knowledge of bio-terrorism issues and maintain a keen sense of awareness as they move forward in this rapidly changing world.

It is important to understand that the issues surrounding bio-terrorism are complex. Prevention, preparation, response, and recovery are essential to the safe mitigation of all incidents. Plan now for a safer tomorrow. Your personnel and communities depend on you. **AJJ**

Call for Candidates as Officers, Directors, and Members of the Ethics Committee;

also, Call for Nominations of Individuals for “Honorary Membership”

In accordance with the By Laws of the American Ambulance Association, it is time to call for members in good standing that wish to serve as a Regional Director, or a member of the Ethics Committee. We are now seeking candidates for the following positions:

Regional Director

(all regions) – two-year term

Member, Ethics Committee

two-year term

Anyone who wishes to be considered for an elected position as an Officer or as a Regional Director must:

1. Be a member of the AAA in good standing;
2. Commit to attend at least five meetings per year, be ready to devote time and effort to matters which concern the Board of Directors and to actively participate in all Board activities;
3. Be prepared to assist other AAA members with concerns and problems which relate

to the ambulance industry and the workings of the AAA; and,

4. Understand that these positions provide no compensation for time or reimbursement for expenses. All travel-related expenses, including transportation, lodging and food are the responsibility of the individual and/or their sponsoring organization.

There are no restrictions against an individual running for more than one position in the same election cycle, though no person shall hold more than one position simultaneously.

All those who wish to stand for election and believe they are qualified are requested to prepare a statement which describes both their qualifications and reasons for wanting to participate either in the leadership of the AAA or as a member of the Ethics Committee. This statement should be accompanied by a recent photograph which may be distributed, along with your statement, in the package containing official ballots sent to all AAA members who are eligible to vote in this election. **AJJ**

Honorary Membership Nominations

We are also accepting written nominations for worthy AAA members who have significantly contributed to the accomplishments of the AAA and should therefore be recognized through the granting of Honorary Membership. The name(s) of anyone nominated for this category of membership, as well as the text of the nomination will be included in the election ballot as described above, and will provide a place for a vote of “YES”. If the vote(s) of “YES” is expressed by at least seventy-five (75) percent of those voting, the individual(s) will be granted Honorary Membership.

All nominations, forms and accompanying materials are due to the AAA attention Maria Bianchi on or before, July 14, 2003. AAA, 8201 Greensboro Drive, Suite 300, McLean, Virginia 22102 or fax to 703-610-9005.

Donations of AEDs

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Principals attending the news conference were urged to move quickly on setting up meetings for presentations to students. “Paramedic classes will begin July 7 at the new National EMS Academy in Lafayette,”

Zuschlag said. “While the focus of the classes will be on paramedic training and certification, participants can branch out into other areas of health care, such as nursing. Because the academy will operate in conjunction with South Louisiana Community College, participants will be able to earn an associate degree in Allied Health Sciences.”

Zuschlag noted that 28 people who began

a health care career as Acadian Ambulance Service medics have gone on to earn medical degrees and become practicing physicians.

Information on classes at the National EMS Academy can be obtained by contacting Jay Pierret, education manager for Acadian Ambulance Service, at 337-291-3372. **AJJ**

AAA HONORARY MEMBER NOMINATION FORM

FOR 2003 AAA Elections

Form is Due on or before July 14, 2003

By completing and submitting this form to the AAA Nominating Committee, I hereby place in nomination the person whose name appears below, for consideration as an Honorary Member of the AAA. I include a written statement, which attests to the good character and accomplishments, which have been performed by this individual for the benefit of the AAA and its members.

Therefore, I would like the AAA Nominating Committee to consider the following person for the process, which may lead to their being chosen by the membership of the AAA as an HONORARY MEMBER.

NOMINEE'S NAME: _____

NOMINATOR'S INFORMATION

(Please PRINT)

Name: _____

Company: _____

Street Address: _____

City, State and ZIP Code: _____

Phone: _____ Fax: _____

E-Mail Address: _____

Signature: _____

**PLEASE COMPLETE AND SEND THIS FORM, ALONG WITH YOUR WRITTEN STATEMENT
DESCRIBING THE NOMINEE AND THEIR CONTRIBUTIONS ON OR BEFORE JULY 14, 2003.**

Attn: Maria Bianchi, AAA
8201 Greensboro Drive, Suite 300
McLean, VA 22102

AAA OFFICIAL NOMINATION FORM

FOR 2003 AAA Elections

Form is Due on or before July 14, 2003

By completing and submitting this AAA Official Nomination Form to the AAA, I hereby express my consent and willingness to serve the AAA in the capacity indicated below, and offer my name to the 2003 AAA Nominating Committee. I understand there is no reimbursement by the AAA for any expenses I may incur if I am elected to a position.

I also acknowledge that I have read the relevant sections of the By-Laws of the American Ambulance Association, as well as its Policies and Procedures (available on the AAA Website: <http://www.the-aaa.org>), particularly Article XI – Officers, Sections 2 & 5; Article VIII – Board of Directors, and Article XII – Committees, Section 3.4, as they relate to the positions of Officers, Directors and Ethics Committee.

Therefore, I would like the 2003 AAA Nominating Committee to consider me for the following position:

- Director Ethics Committee

(Please check the appropriate position; only one position per form, please.)

CANDIDATE'S INFORMATION

(Please PRINT or type on another sheet of paper)

Name: _____

Company: _____

Street Address: _____

City: _____

State: _____ ZIP Code: _____

Phone: _____

Fax: _____

E-Mail Address: _____

Signature: _____

DIRECTOR

Qualifications: Must be an Active AAA Member in Good Standing.

Note: The Eligible Regional Director Candidate receiving the second highest number of votes in each Region shall be the Alternate Director for that Region for a one-year term.

- Director - Region I (CT, MA, ME, NH, NJ, NY, RI & VT) Director - Region IV (AL, AR, IA, KS, LA, MN, MO, OK, ND, NE, SD & TX)
 Director - Region II (DE, DC, FL, GA, MD, NC, PA, SC, VA & WV) Director - Region V (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA & WY)
 Director - Region III (IL, IN, KY, MI, OH, TN, TN & WI)

ETHICS COMMITTEE (Positions are Open for a Two-Year Term)

Qualifications: Must be an Active AAA Member in good standing.

- Ethics Committee

PLEASE SEND THE COMPLETED OFFICIAL NOMINATION FORM, YOUR CANDIDATE STATEMENT AND PHOTO TO THE AAA ON OR BEFORE JULY 14, 2003.

Attn: Maria Bianchi, AAA
8201 Greensboro Drive, Suite 300
McLean, VA 22102

Profit verses Non-Profit: The Debate Rages On

By: Michael Freeman, Compliance Officer, NREMT-1, Pendleton EMS

There have been many articles written over the years about the conflicts that sometimes arise between for profit and not for profit ambulance services, community based services, such as rescue squads and volunteer ambulance companies. In South Carolina there are several instances where this type system holds true. Most EMS providers in the state are county agencies with a focus on providing a service and not a business. But in Anderson County the system is made up of seven independent, not for profit services and one large for profit service that covers the metro area of the City of Anderson. Large-scale conflicts arise from time to time between these agencies with the patients getting caught in the middle. Our experience in the current system has been that you have a multi million-dollar operation that puts the profit margin ahead of proper care decisions.

Then you have seven small not for profit providers covering the rural and small town

areas in the county. These services provide the same, and in some cases better, patient care and advocacy than the larger service. Yet the larger service, who is owned by the county coroner, continues to infringe on the smaller services call districts in an attempt to cut down there call volumes and choke them out so that they, the for profit provider, can eventually take over their call areas. When this happens, the citizens of the rural communities will be exposed to higher cost, very aggressive billing collections regardless of financial status, and a monopoly of the system, which would allow them to demand more tax dollars due to them being the only option for coverage available.

- The smaller not for profit services are the remnants of what used to be an all volunteer EMS system up until 1994 when the county realized the need for 24 hour paid ALS service to the citizens. Currently the not for profits get funding that covers only

payroll expenses. This leaves the services responsible for revenue from billing of 911 calls and non-emergent transports. Due to the size and stature of the larger service, they, the for profit, tends to keep all the non-emergent business to themselves.

- All in all, my point is this. EMS is a service to the communities of America much like Fire and Law Enforcement. No one, regardless of their situation, should be exposed to the business attitudes of a for profit EMS service. I understand that not all for profits are like this, but most appear to present themselves that way. All this does is continue to alienate EMS in the public view and it makes it harder for community based services to provide a low cost, unilateral EMS system that puts only the patient at the fore front. I hope that other EMS professionals could see this and push for more community based services. We are a part of public service, not private enterprise. **AlJ**



American Ambulance Association
8201 Greensboro Drive, Suite 300
McLean, VA 22102

AMBULANCE INDUSTRY
JOURNAL