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EMS, FIRE
RESCUE
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BEST PRACTICES

IN EMERGENCY SERVICES

Richmond Offers More Than a Ride to the Hospital

By Daniel Casciato

Like all EMS systems, the Richmond Ambulance Authority (RAA) in Richmond, Virginia, receives many 911 calls from patients who do not need transportation to an emergency department. Instead of dispatching an ambulance to many of these callers, RAA uses its 911 center to identify low-acuity callers and connect them to a nurse, who then offers self-care advice and/or matches them with another, more appropriate community healthcare resource.

"We're providing them with true healthcare," said RAA Executive Director Jerry Overton.

In the last year (March 2006 to March 2007), RAA processed more than 400 calls through this program, known as the Community Health Access Program (CHAP), which went live last March after an 18-month pilot period. Two other EMS systems — East Anglia Ambulance Services Trust in England and the Ambulance Service of New South Wales Sydney Operation in Australia – successfully tested and implemented their own versions of the CHAP program during the same time frame. There are now 25 sites with CHAP systems in place worldwide.

Identifying CHAP Callers

CHAP relies on prioritization software called Priority Solutions Integrated Access Management (PSIAM), which was developed jointly by Priority Dispatch Corporation, makers of the widely used Medical Priority Dispatch System (MPDS), and Clinical Solutions, which provides Teleguides algorithms for nurse advice systems. PSIAM software links these two programs to provide a computerized path to safely identify and refer patients who may qualify for CHAP referral.

"The world needed a solution to the problems of increasing utilization of ambulance services and decreasing availability of resources for ambulance providers," said Bill Boehly, president of the Utah-based Priority Solutions Corporation. "We foresaw that there would be a time where we would need to take patients out of the emergency queue and refer them out of the system."

When a 911 call comes in to the dispatch center in Richmond, an emergency

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Medicare Fees Insufficient

Average Medicare payments within 36 months will not be sufficient to cover the cost of ambulance transport for as many as 61 percent of EMS services. The shortfall will be an average of 6 percent and as high as 35 percent in "super-rural" areas.

These are among the frightening findings of a report on the costs and expected Medicare margins for ambulance providers, published in May by the Government Accountability Office (GAO).

The report examined financial information from 215 EMS services that do not share the cost of EMS with any other institution, such as a fire department, a hospital or a government agency. Independent EMS services account for about one-third of the EMS industry, according to the GAO.

The ambulance industry was quick to respond to the GAO report. The American Ambulance Association (AAA) released its own cost report, based on a survey of 108 EMS services. Like the GAO, the AAA expressed concern that Medicare reimbursement is not sufficient to cover the cost of ambulance transport. However, the AAA said that it already has evidence that the problem is worse than the GAO estimates.

"We estimate that Medicare payments, excluding the MMA provisions, were 8 percent below average cost per transport in 2004...," the AAA stated in a document released May 23. "Only the largest providers broke even on their Medicare business. Smaller providers made proportionally larger losses, and the smallest class of providers (under 5,000 Medicare transports annually) had

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Richmond

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medical dispatcher goes through the MPDS algorithm to determine if the call is for a low-acuity situation, dubbed an Omega-level call. Calls that meet the criteria are transferred to a nurse stationed in the communications center.

The nurse evaluates the patient using the PSIAM software. The software provides a series of questions that helps the nurse gather information from the caller, so the patient can be provided with self-help direction or connected with appropriate community healthcare providers.

If the caller needs a ride to a facility other than an ED, such as a health clinic, RAA provides alternative transportation to the facility and back. Of the 400 callers last year, about 100 used the alternative transportation. However, Overton said, "At any time, the caller can still request an ambulance and we'll go."

Software-based quality assurance tools are built into PSIAM to assess the performance of nurses and emergency dispatchers and to measure compliance to both protocols and algorithms. It can also randomly select calls for review. RAA follows up on all the calls, whether or not an ambulance is dispatched.

Results Thus Far

Nearly 40 percent of the 400 calls processed by CHAP last year were for sickness, while 15 percent were for falls. The average initial processing time per call was about 8 1/2 minutes.

With more than 46,000 patients transported annually in Richmond, RAA is the only EMS provider in the United States running this program; however, Boehly expects to see more systems come on line within the next year. "The one thing that we heard from EMS managers is that patients are getting older, the need for emergency services is increasing and utilization is growing at a rapid rate," said Boehly. "Conversely, access to resources is being restrained. There have been cuts in budgets, people have been asked to consolidate and to do more with less."

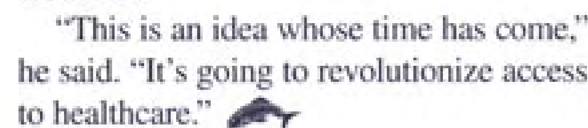
While it costs RAA about $365 per EMS transport, the cost of using a medical van is only $25 per trip, thus RAA saves money with CHAP. "The cost savings occurred because the acuity of the call was less likely to get reimbursed for the transport anyway," said RAA Clinical and Research Coordinator Derek Andresen. "If we can provide an alternate treatment at a lesser cost that was superior to what they would have gotten, it's good for all parties involved."

CHAP refers callers to one of three free clinics, a poison control center, a behavioral health system and an urgent care center; however, RAA hopes to add to its healthcare options in the future.

"We're working with them more intimately to identify more resources," said Overton. "It's very time-intensive to match the resources with the patients, but as we further develop the resources, the program will really grow."

According to Boehly, the 25 PSIAM sites have determined that an average of close to 20 percent of the primary requests for emergency calls coming through the MPDS system could theoretically be referred to alternate community healthcare resources.

"This is an idea whose time has come," he said. "It's going to revolutionize access to healthcare."



Reimbursement

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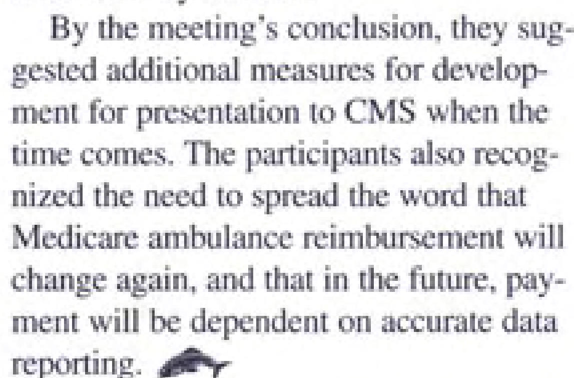
compliance rate may be reflective of agency data entry practices.

The culprit, they said, is likely to be the practice of clinging to paper patient care reports (PCRs) as the primary run record. Field personnel document treatments on paper, and then, at a later time, they or other staffers enter data from those records into a computer-based reporting system to satisfy state data system requirements.

It appears that the people with the data-entry responsibility are short-cutting the process by entering the minimum information required to satisfy the state data system elements. Apparently, recording oxygen use for respiratory patients under these circumstances requires a step that is being avoided.

During the April meeting, participants heard reviews of CMS and state quality improvement organization developments and discussed the final draft of the NHTSA Performance Measures Project benchmarks document, now under internal review by NHTSA.

By the meeting's conclusion, they suggested additional measures for development for presentation to CMS when the time comes. The participants also recognized the need to spread the word that Medicare ambulance reimbursement will change again, and that in the future, payment will be dependent on accurate data reporting.



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