Where Have All the Patients Gone?

This column is written in turn by attorneys Mark Flaherty, Michael Scarano and Richard Lazar.

By Richard A. Lazar, Esq., an attorney in Portland, Ore., who specializes in EMS law. Lazar, a former EMS director, EMT and emergency department trauma technician, provides a wide variety of legal and consulting services to EMS professionals nationwide. He was recently elected chairman of the National EMS Alliance.

Where have all the patients gone? The EMS world may soon be asking this question on a fairly frequent basis. Public re-education and market-driven health care system reform are causing changes in EMS patient flow patterns. Diminished patient volumes will undoubtedly impact the structure and function of EMS system economics.

Over the past 2½ decades, the EMS industry has expended millions of dollars and thousands of personnel hours teaching the public to call an easily memorized three-digit number when in emergency need of police, fire or EMS. This public education campaign was extremely successful—perhaps too successful. 9-1-1 systems are deluged daily with thousands of nonemergency calls.

Now as a result of what some term 9-1-1 "abuse," a public re-education campaign has begun. For example, the federal government recently developed a media campaign designed to teach members of the public to "Make the Right Call." Many local 9-1-1 agencies are undertaking similar strategies. The goal: Prevent those without emergency needs from calling 9-1-1, thus reducing the unwarranted use of costly public resources.

Managed care organizations approach health care economics in a manner sharply contrasting with the fee-for-service approach. MCOs earn greater profit by providing fewer services and by tightly controlling costs associated with the services provided.

It is too soon yet to predict EMS system impacts resulting from the "call 9-1-1 only if you need it" strategy. Theoretically, only contacts that would not have otherwise generated an emergency resource response will be eliminated from the prospective pool of 9-1-1 callers. Thus, overall EMS call volumes ought not be affected. However, it is likely that a small number of callers with a legitimate medical need will be discouraged from dialing 9-1-1, which would result in a small reduction in the number of EMS responses. A pebble in the ocean, as it were.

Of greater import to EMS patient flow patterns are recently evolving market-driven health care system changes. Principal among these is the transition to a managed care environment. Millions of Americans are acquiring managed care insurance instead of traditional third-party indemnity insurance. The impact this change in health care economics will have on the EMS system already shows signs of being profound.

Historically, individuals and health care insurers paid for health care services on a fee-for-service basis. The more services health care providers rendered, the greater the service fees that were generated. For example, a chest pain 9-1-1 call might generate fees for an ambulance service, an ED physician, a variety of hospital-related services, and one or more specialists. For both economic and risk management reasons, patients with traditional third-party indemnity insurance received the full scope of services available regardless of whether those services were always medically necessary. Health care system costs thus rose at rates alarmingly disproportionate to the rise in the cost of living.

Managed care organizations (MCOs) approach health care economics in a manner sharply contrasting with the fee-for-service approach. Managed care insurers seek to reduce both the scope and cost of

[illegible] services rendered their members. MCOs earn greater profit by providing fewer services and by tightly controlling costs associated with the services provided.

MCOs seek to control the cost of each and every component of their health care delivery network. To accomplish this goal, MCOs generally own or contract for all services offered to [illegible] members. This includes services provided by hospitals, doctors, laboratories, allied health technicians—and even ambulance services [illegible]

MCOs also seek to control access to health care services through, among other means, the use of primary care physician gatekeepers and [illegible] tion requirements, which [illegible] before the MCO will pay for the requested services. The goal is to ensure that only costs associated with "medically necessary" health care are incurred by managed care members.

A secondary issue associated with both cost and access relates to the source of services rendered. A goal of MCOs is to ensure, to the extent feasible, that members receive all services from the managed care network rather than from "out-of-plan" providers. Unaffiliated health care providers simply charge higher fees than those captured within the MCO's network.

In sum, the fiscally successful managed care approach requires absolute control over health care service and cost access. In its present form, managed care might better be termed *managed economies.*

The explosion in the number of individuals insured by managed care organizations will impact EMS systems in interesting ways. For example, MCOs have, to a large degree, found it difficult to control costs associated with the "out-of-plan" use of both medical transportation and ED services. To gain a higher degree of cost control over medical transportation services, MCOs are educating members not to call 9-1-1. Instead, members are told to call an 800 number before calling 9-1-1. Following telephone triage, patients may be referred to the MCO's capitated medical transport company rather than to the local 9-1-1 provider. The coinciding reduction in the number of 9-1-1 transports will directly impact the economics of the EMS system.

In many markets, the EMS delivery [illegible] is funded by fee-for-service rev[illegible] [illegible] to build an [illegible] project, [illegible] ed system [illegible] and governmentally established performance requirements. While performance requirements are unlikely to be induced, the managed care movement will reduce the fee-for-service customer base available to financially support a provider infrastructure.

Under most circumstances, any reduction in EMS customer base revenues would result in [illegible] to the non-emergency environment. However, MCOs, with their careful attention to such financial matters, are unlikely to allow this. Rather, increasing pressure to raise EMS rates is likely. In addition, absent a reduction in system performance standards, the transfer of managed care members out of the 9-1-1 environment will result in an underutilization of EMS system resources.

The rapid evolution of market-driven health care systems has impacted and will continue to impact EMS systems. Meanwhile, EMS economics and system design will be affected by federal and state legislative health care reform efforts.

EMT Transition *from page 1*

assessment-based format—which may not be new to them, since they may have learned it from their practice—and the changes in terminology, skills such as [automatic external defibrillation], and the differences between the [old and the revised EMT-Basic] curricula."

The task force has not yet determined how many hours will be needed to teach EMTs the new skills, but Smith said it will probably require between 12 and 20 hours, since the AED segment alone is seven hours long. "This may be tacked onto or integrated into refresher courses," he said.

Communications Equipment Disrupts Medical Devices

Cellular phones, radio and TV transmissions, citizen band radios, and police, fire and ambulance mobile communications equipment may be endangering the lives of patients by causing equipment malfunctions and false alarms in electronic medical devices such as defibrillators and electrocardiogram equipment.

The Food and Drug Administration has been investigating reports of electronic medical equipment problems caused by electromagnetic interference (EMI). In July, the FDA released guidelines for manufacturers of powered wheelchairs after investigating reports of erratic, unintentional wheelchair movement. Now the agency is soliciting information about problems with any electronic medical devices that may be associated with EMI.

Although EMI is not new, the increased use of devices such as cellular phones has made EMI problems more apparent and given medical manufacturers another factor to consider when designing portable equipment.

"The signals we monitor are very small

CERTIFICATE OF SERVICE

I, Glenda Sumpter, a secretary in the law firm of Joyce & Jacobs, do hereby certify that on this 23rd day of September, 1994, copies of the foregoing Reply Comments of Acadian Ambulance Service, Inc. were mailed, postage prepaid, to the following:

Chairman Reed Hundt*
Federal Communications Comm.
Washington, D.C. 20554

Commissioner James H. Quello*
Federal Communications Comm.
Washington, D.C. 20554

Commissioner Andrew C. Barrett*
Federal Communications Comm.
Washington, D.C. 20554

Commissioner Susan Ness*
Federal Communications Comm.
Washington, D.C. 20554

Commissioner Rachelle Chong*
Federal Communications Comm.
Washington, D.C. 20554

Martha Carter, 9-1-1 Administrator
Caddo Parish Communications District Number One
1144 Texas Avenue
Shreveport, LA 71101

Glenda Sumpter

* denotes hand delivery