PennWell®

News & Winning Strategies for EMS Leaders

EMS Insider™

NOVEMBER 2013
VOLUME 40
NUMBER 11

Metrics That Improve Operations

Using evidence-based data to effectively utilize limited resources

Using clinical data to improve patient outcomes has become the new mantra in EMS. The same evidence-based decision-making process should apply to operations, says Todd Stout, founder and president of FirstWatch, a software company that specializes in real-time, public safety data analysis and automated alerting. A longtime EMS practitioner and manager, Stout learned the value of transforming data into operational tactics from his father Jack Stout, an innovative and influential pioneer in the design of high-performance EMS systems.

Improving operational performance requires not only a detailed understanding of several key areas, but their nuances. This information can come from a variety of data sources, including computer-aided dispatch

CONTINUED ON PAGE 10

OIG Report: Utilization of Medicare Ambulance Transports, 2002–2011

Ambulance transports are fastest growing segment of Medicare payments

On September 24, the Office of Inspector General (OIG), U.S. Department of Health and Human Services, released a report regarding the utilization of Medicare ambulance transports. The department reviewed payment requests for transports during the period of 2002 to 2011 and found that the number of Medicare ambulance transports increased 69% (from 8.7 million to 14.8 million). In 2011, payments for ambulance transports totaled $5.7 billion, making it the fastest growing segment of the Medicare Part B program. Payments for ambulance transports from 2002 to 2011 increased 130%, compared to a 74% increase in overall Medicare Part B payments.

The authors of the study concluded that the increase was due in part to inflation, the transition to a national fee schedule for Medicare ambulance transports and the continued growth in utilization of ambulances services.

Although the total number of Medicare fee-for-service beneficiaries increased just 7% from 2002 to 2011, the study found that the number of beneficiaries who received ambulance transports jumped 34%, increasing from 619 to 830 transports per supplier. The number of ambulance providers varied by state, from a decrease of 25% in Mississippi to an increase of 207% in Virginia. Nationally, the average number of transports per beneficiary increased 26%.

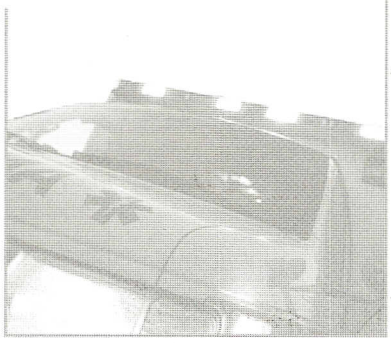
In addition, the number of ambulance suppliers increased 26%, up from 14,087 in 2002 to 17,776 in 2011. The most noteworthy increase was seen in ambulance suppliers that provide BLS nonemergency transports. That number nearly doubled from 2002 to 2011.

Dialysis-related transports increased most significantly, compared with transports to or from other origins

CONTINUED ON PAGE 12

INSIDE

EXPERT ADVICE



Not in My House

Diversion, addiction and EMS

The United States represents 4.9% of the world's population, yet we consume 80% of the world's production of opioids (Jim Avila, *ABC World News*, April 20, 2011).

To many of us in EMS, this statistic is not a surprise. We have directly witnessed the increase of opioid overdose incidents, or we have seen the various healthcare news stories and read articles on the subject. Some of us who may be slightly jaded with years of experience may shrug this statistic off with a laissez faire reaction. But what we need to start to consider is this: How is the volume of opioid prescription availability impacting our own profession? Do we have addiction within our ranks? Do we recognize it or do we turn a blind eye to it? How are our narcotic-medication control and tracking systems working? What is the purpose of all those counting sheets and books? Is our organization compliant with the Federal Drug Free Work Place Act? What do we do if we discover an addicted employee?

Perhaps, it is time to turn on the light, take a look and ask those questions.

What we need to start to consider is this: How is the volume of opioid prescription availability impacting our own profession?

Baselines

Because addiction and diversion may have various definitions or interpretations depending on the reader's background, for the purposes of this article, they are defined as follows:

- *Addiction*: The state of being physically or psychologically dependent or both on a substance.
- *Diversion*: The intentional act of tampering, removing, replacing, stealing or altering a medication, usually a controlled substance.
- *Narcotic-medication control/tracking system*: A program or process to account for medication usage, restocking, to identify expired medications, or loss of medications.

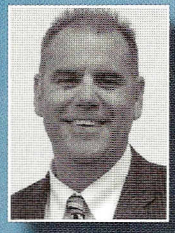
Do we have addiction in our ranks? A quick Google search on the subject "healthcare addiction rates" returns approximately 14,900,000 results. The data seems to show a 10–15% addiction rate among physicians and nurses. Unfortunately, at the current time, the data for specific addiction among EMS professionals is lacking. It's my belief, however, that EMS professionals likely fall within the physician and nurse addiction rates.

Drug counseling for EMS providers

I've directly treated or dealt with addicted EMS staff, nurses, law enforcement and fire service staff from both my career in EMS and as an addiction professional. It didn't start out that way. I began my EMS career in the Army as a medic and when I was discharged, I progressed from practitioner to educator and into leadership. In 1998, I was asked by my medical director to put together a continuing education program on street and designer drugs. We had the usual legal versus not-legal and identification lectures from local law enforcement, but it did not thoroughly address the medical aspect of our professional lives. As a result, I developed a lecture that evolved into a series and unexpectedly found myself making presentations to various audiences, from healthcare providers and law enforcement to education staff and addiction counselors.

As I continued my EMS career—and kept my hands in the addiction world—I eventually secured my certification as an addiction interventionist. I have learned that factors contributing to addiction are no different for the healthcare provider or public safety worker than someone outside these worlds. The primary factors include poor stress-coping skills, self-medicating for undiagnosed or under-treated mental health issues, experimentation and genetics.

What may be slightly different for healthcare professionals, compared to the general



Jeffrey M. Stewart has been in EMS since 1986 as a practitioner, educator and leader. He is the owner of Dragon Shield Consulting, LLC and is the director of Clinical Services & Education for a private ambulance service in Massachusetts.

public, is ease of access to prescription drugs. In EMS, we have immediate access to benzodiazepines and opiates. We also have relationships with other prescribing healthcare professionals who may have a more compassionate pen when it comes to prescribing for "one of our own."

Many of us also "grew up" in EMS with the uninformed attitude that says: "Bad calls are part of the job and you gotta get over it or get out of the business." We learned that "getting over it" often included commiserating with our colleagues over drinks after a shift. Then, because we were in EMS, we had plenty of access to "post-consumption recovery treatments" when we arrived to work for the next shift. Unfortunately, for many, this process becomes a repeated ritual that can easily transition to outright addiction.

Control and compliance

The narcotic-medication control/tracking system establishes a retrospective analysis-monitoring system. An effective system provides data for cost containment, quality assurance improvement, and discovery when a loss has occurred. True, the majority of loss is usually mitigated quickly, with identification of a counting error or breakage—in essence, no harm, no foul. But what happens if a diversion is identified? This identification can be several hours or days after the event, which makes it more challenging to identify the person(s) who committed the diversion.

Some systems have various levels of drug-testing procedures—"for cause" or randomized—that may assist in identification of person(s) who are diverting. The problem is that this identification always occurs post diversion.

Two other compliance concerns arise when we look at this issue. They are the Drug-Free Workplace Act of 1988 and the Americans with Disabilities Act. The Drug-Free Workplace Act establishes criteria for employers to craft and implement policies, awareness programs and notification of employees of such policies and programs. It requires the employer to uphold a "good faith" effort to maintain a drug-free workplace.

If we can identify the person who committed the diversion, the easy answer is we fire them because they stole from us. But does that address the issue or just pass it along for the next agency?

The Americans with Disabilities Act adds layers of complexity to this issue when establishing policies and practices for dealing with employees who, pre- or post-incident, disclose addiction diagnoses.

Creating a culture of compliance

So what do we do when we discover someone has committed a diversion? Assuming we can definitely identify the person, the easy answer is we fire them because they stole from the company. But does that address the issue or just pass it along for the next agency? By the way, if you terminated someone for theft, did you report it to the local authorities, and if it was theft of narcotics, did you also report it to the DEA? Do your local news agencies have a crime reporter? Would they pick up on the fact that Paramedic John Doe was arrested on narcotic theft charges from a local EMS agency? How will this impact your public trust capital at the next budget cycle or contract renewal?

Case in point: The U.S. vs. Kwiatkowski. David Kwiatkowski, a traveling cardiac technologist, diverted narcotics by taking the medications and replacing them with saline-filled syringes while working at Exeter (N.H.) Hospital. Kwiatkowski also had Hepatitis C and the syringes were tinged with his blood. In August, Kwiatkowski pleaded guilty to 16 federal drug charges. The case involves 18 hospitals in seven states, resulting in 46 patients contracting the same strain of Hepatitis C as Kwiatkowski. The guilty plea only addresses the New Hampshire issues of drug charges. The U.S. Attorney's office is still investigating other aspects of the case.

Creating a "culture of compliance" is a phrase or process that, if you are not already aware of, you will hear or see more of as the Affordable Care Act is pushed forward. Remember, since we take federal dollars as part of our business practices the quid pro quo is that we will comply with all applicable federal regulations. From an addiction-in-EMS perspective, here are some specific recommendations to address the issue:

- Review, adjust and create policies and procedures that address overall compliance and specifically include matters of post-accident/incident testing, reasonable suspicion, medication usage while on duty and post-investigation reporting to regulatory agencies.
- Internally publicize and educate staff and supervisors on the policies and programs.
- Educate staff on signs and symptoms, assistance options and self-referral options. This could be included as part of your CME offerings as it would fall under the "Well-being of the EMT" category.
- Seek your local experts for assistance—Employee Assistance Programs (EAPs), Critical Incident Stress Management (CISM) teams, local addiction treatment practitioners or treatment facilities.

Shining a little light on this historically dark, taboo subject and creating this compliance culture requires a top-down approach. A full, open acknowledgement of the potential problem and leadership buy-in is needed to mitigate the issue of addiction among our colleagues. The risk of turning a blind eye to addiction in EMS is far too costly to our employees, our agencies, our profession and the public. □