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Regionalization of Emergency Medical Services: The Experience of Michigan's Upper Peninsula

How Can Regionalization Help?

The emergency medical services (EMS) systems of most rural areas are characterized by small, volunteer squads that provide medical first response and basic life support services and by a shortage of advanced life support (ALS) capabilities. These squads may be located, almost by happenstance, in communities that have the volunteer base and financial resources to sustain them, and these locations may not reflect rational decisions regarding the optimal use of scarce area resources. Moreover, in some regions, neighboring squads may duplicate efforts, resulting in higher total system costs.

By regionalizing EMS systems—sharing resources across geopolitical boundaries—it may be possible to increase provider coordination and make better use of scarce resources.

Several states have used a portion of their Rural Hospital Flexibility Program (Flex Program) funds to support EMS regionalization projects. This Finding reports on one such project in Michigan's Upper Peninsula (UP).

The Michigan Experience

In the eastern half of Michigan's UP, Flex Program funds are being combined with substantial financing from other sources to advance an ongoing regionalization effort. Although the accomplishments of this effort are far from uniquely attributable to the Flex grant, the Michigan project has important lessons that may help other areas seeking to establish regional systems using Flex Program funds.

This area of the UP relies on small, volunteer corps of medical first response and basic life support providers scattered throughout the area. The only ALS providers are located in the far eastern and western edges of the region. The area is facing difficulty recruiting and retaining volunteer providers and is having trouble meeting higher national and state standards for EMS training.

EMS oversight in Michigan is provided by county (or multi-county) entities called Medical Control Authorities (MCAs). MCAs are organized by an area's hospital(s), and the MCA's principal responsibility is to develop protocols for pre-hospital care. Participants are volunteers and include a medical director, hospital representatives, and representatives from area EMS squads.

The regional EMS system envisioned by area planners has five components:

1. standardization of EMS protocols across MCA boundaries;
2. centralized collection and analysis of pre-hospital data;
3. provision of EMS training at local sites throughout the area;
4. strategic placement of ALS providers throughout the region; and
5. continued planning and funding for future EMS improvements.

Three MCAs serving four eastern counties of the UP are currently collaborating to create a more coordinated, regional EMS system. This process was initiated several years ago when a large area hospital began working with the three MCAs to standardize EMS protocols across counties. Participants recognized that the joint development of protocols could reduce the burden on MCA volunteers and improve care for patients crossing county lines. Standardization of protocols is nearly complete, and the resulting collaboration is helping to further remaining regionalization goals.

Area planners are now working to implement a computerized system to collect pre-hospital data. These data will be analyzed to pinpoint quality problems, which could then trigger revisions to protocols, new training initiatives, and/or new prevention programs. Some volunteer EMS providers have resisted this initiative due to concerns about confidentiality and the burden of data entry, as well as skepticism about the value of centralized data collection. Thus, regional proponents are implementing the system slowly and investigating the feasibility of having area hospitals perform data entry, at least initially. Flex Program funds have been targeted to help pay for the necessary software and hardware.

Regional leaders have also been quite active in EMS training, recognizing that sharing resources will make it easier for all area providers to meet the higher national and state standards and to receive needed continuing education. This training component also focuses on increasing the area's supply of EMS providers, rather than simply trying to share the over-extended existing supply across geopolitical boundaries.

The hospital that spearheaded the standardization of EMS protocols has obtained a large grant (unrelated to the Flex Program) to build several trailers and outfit them with all equipment required to teach up to the paramedic level. These trailers move throughout the region as needed, so training can be offered in students' home communities. Local school boards have granted permission to hold EMS classes in schools on nights and weekends, thus fulfilling the state's requirement that training take place in approved facilities. (That requirement had tended to centralize training in community colleges, reducing local training opportunities.) There have also been discussions between a local community college and an area high school regarding a college-credit EMS class for high school students. This approach is seen as a way to attract a new generation of EMS volunteers. Several other entities in the region have received non-Flex Program grants from the state to support additional EMS training programs, including teleconference-based training and scholarships.

In the longer term—as more paramedics are trained—area planners hope to create additional ALS “hubs” at strategic points throughout the region. A “blended” system that combines the existing mix of volunteers with carefully located, paid ALS units is viewed as a rational way to improve EMS services in a region where the supply of volunteers is waning, yet call volumes cannot support an all-paid, paramedic system.

The region offers several examples of creative financing methods used to facilitate the move toward the partially paid system that will likely be needed if additional paramedics are to be recruited to these hubs. One existing ALS provider contracts with the state to provide ambulance services for the state prisons in the area. It also charges a flat rate for each paramedic intercept provided and contracts with the hospital that receives these patients to handle all related billing and collections. A second area provider, which hopes to become an ALS hub as additional paramedics are trained, has been able to move to a paid staff by contracting with the local Native American tribe to provide safety and risk management services for its two casinos. Area leaders hope these staff members can eventually assume additional public health duties at area clinics and schools. In both cases, the providers noted that the move to a paid staff has alleviated their long-standing staffing difficulties.

In a final example, three area critical access hospitals are planning to open a new clinic in the territory between their facilities. This area currently has no ALS providers. The hospitals are considering a staffing model that includes paramedics—to be implemented as additional paramedics are trained. The clinic would become another of the region’s ALS hubs, and paramedics based at the clinic would supplement clinic staff when not needed for emergency runs. Use of EMS personnel to provide non-emergency services (whether in clinics, hospital emergency rooms, or other community settings) can generate revenue to sustain the EMS system, help keep clinical skills current, alleviate shortages of other personnel, and enhance local access to care in areas with provider shortages. Movement in this direction may face several obstacles, however, including state restrictions on scope of practice and resistance from other provider groups. Thus, the ability to replicate a model such as the one envisioned in Michigan’s UP will depend on state laws and local conditions.

Factors Related to Successes in the UP

Some features of the UP appear to be facilitating these regionalization efforts and may make this type of initiative more difficult to replicate in other areas. In particular, the UP has a strong history of regional cooperation, perhaps due to the unique “island-like” geography. Many of the key players have worked together for years. A non-profit EMS foundation (UP-EMS Corporation) has operated in the region for several decades and is a strong proponent for EMS development. The two largest area hospitals have demonstrated a clear interest in strengthening the local health care system and have worked closely with smaller hospitals and EMS providers. Both hospitals have also been successful at obtaining large grants from other sources to support their efforts.

However, another key ingredient for success appears to be the enthusiastic core group of people who represent diverse interests and have been involved since the early stages of project planning. These people are committed to improving their EMS system, are working patiently to build the necessary partnerships, have a clear and unified vision of the direction in which they want to move, and have delineated the steps needed to move in that direction over the coming years. These features need not be unique to the UP.

Factors Related to Successes in the UP

- A strong history of regional cooperation in the UP.
- Key players who have worked together for years.
- A non-profit EMS foundation that has operated in the region for several decades.
- Two large area hospitals that have demonstrated an interest in strengthening the local health care system.
- An enthusiastic core group of people who represent diverse interests and have been involved since the beginning.

Where Can I Get More Information?

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About this project:

Check our website: <http://www.rupri.org/rhfp-track/>

Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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