

EXECUTIVE OVERVIEW

Purpose

The purpose of this study is to identify the hospital and pre hospital emergency medical services (EMS) capabilities of each of the participating Critical Access Hospitals (CAHs) or CAH applicants.

Background

Funding for the study is provided by the federal Health Research Service Administration's Rural Hospital Flexibility Program through a grant to the Bureau of Quality Assurance (BQA) of the Wisconsin Division of Health and Family Services. The funding allowed the Rural Wisconsin Health Cooperative to contract for consulting service to assess and make recommendations for upgrade of the emergency medical services for the eight participating rural CAHs or CAH applicants during the 1999-2000 grant period.

Initially nine hospitals applied for Critical Access status but one (St. Mary's - Kewaunee) postponed their application. The hospitals participating in the EMS survey include: Eagle River Memorial Hospital, Oconto Memorial Hospital, Wild Rose Community Memorial Hospital, Franciscan Skemp Health Care - Sparta Campus, Franciscan Skemp Health Care - Arcadia Campus, St. Joseph's Community Health Services Inc. - Hillsboro, Memorial Hospital of Lafayette County - Darlington, and Osseo Area Hospital and Nursing Home Inc.

This project is a collaboration of the eight CAHs or CAH applicants and the following organizations: Bureau of Quality Assurance (BQA), Bureau of Emergency Medical Services and Injury Prevention (BEMS & IP), Wisconsin Health and Hospital Association (WHA), Wisconsin Office of Rural Health (WORH) and Rural Wisconsin Health Cooperative (RWHC).

Methodology

The consultant developed two questionnaires to be used to establish baseline data regarding how the EMS system of each CAH or CAH applicant is currently operated. One questionnaire was designed to obtain information relevant to the ambulance service providers while the second questionnaire was specific to the hospital.

The ambulance provider survey questions targeted the areas of:

- Level of Care
- Medical Direction
- Number and licensure level of EMT personnel
- Number of Ambulances
- Staffing
- Training
- Service Area
- Dispatching
- Communications
- Data Collection
- Call Volume
- Response Times
- First Responders
- Transport Times

- Mutual Aid
- Primary Receiving Hospital(s)
- Financing
- Billing
- Interfacility Patient Transfers*

*(Although it was not initially intended that the survey include study of interfacility patient transfers or use of helicopters, it was clear early on the significant role that interfacility patient transfers play in Critical Access Hospitals.)

The hospital EMS survey addressed many of these same issues from a hospital perspective and also included questions regarding the effectiveness of prehospital care provided to patients. It was recommended that the questions regarding medical care be addressed by the physician medical director or other qualified hospital medical personnel.

After review of the completed surveys, the consultant site visited each ambulance service provider followed by a meeting with hospital personnel. The meetings with ambulance providers ranged from 1 to 2 hours in length while hospital meetings lasted from 2 to 4 hours. During the meetings the answers to the survey questions were reviewed and time was allowed for the participants to voice their feelings regarding the current EMS system.

A report of the findings of each survey was developed, which included recommendations for EMS system improvement. The recommendations were ranked according to degree of difficulty to achieve (high, medium, low) and anticipated benefit to the community (high, medium, low). The CAH Emergency Medical Services report was presented in draft form to the hospital for review and comment prior to issuance of a final report. The final report was provided to the hospital including copies for each of the ambulance service providers. Copies of the final reports for each hospital, including recommendations, can be found in "tabs" 3 - 10 of this document.

GENERAL FINDINGS

Most of the hospitals had issues and concerns that were unique to their system. The following issues, however, were common to all or most of the hospitals. The fact that the majority of hospitals share these issues does not necessarily mean to imply that they rank in difference of importance to those issues that are unique to individual hospitals. A summary of all findings can be found in "tab" 2 of this document. Additionally, findings for each hospital along with recommendations can be found in "tabs" 3 -10

1. Hospital interface with the prehospital EMS system. A significant number (5) of the hospitals have little or no interface with the ambulance service providers in their area. In many of these systems, the hospital has no involvement with EMS training, continuing education, data collection, EMT recognition or formal communication with the providers. There is generally no person designated as liaison between the hospital and EMS personnel. This lack of communication has, in some cases, lead to misinformation between the hospital and providers resulting in poor relations between the hospital, ambulance personnel and/or the general public.

2. Medical Direction. Nearly half of the hospitals indicated that their physician medical director was either totally inactive with EMS personnel or needed to be more involved with EMS issues. Two surveys revealed that their medical directors needed time and/or funding to provide this service.

3. Interfacility Patient Transports. All participating hospitals indicated a need for developing or improving the way patients are transferred from the CAR to hospitals that are capable of providing more extensive care or services beyond the scope of the community hospital. The ability to transfer patients in a timely and cost efficient manner is of key importance to a Critical Access Hospital.

4. Data Collection. Most of the systems surveyed do not participate in EMS (prehospital) data collection. It is difficult, if not impossible, to determine the effectiveness of an EMS system or provide Continued Quality Improvement (CQI) without this information.

5. 911-Dispatcher Training. Nearly all systems indicated a desire to have better trained 911- dispatchers. Training should qualify dispatchers to better assess the patient's condition and to provide pre-arrival instructions to the bystanders.

6. Dedicated phone line in the emergency department. While all ambulance providers communicate with the emergency department via cell phone at least some of the time, most of the hospitals do not have a phone line in the emergency department that is dedicated to communicating with ambulance personnel.