Health Reform, the Triple Aim, and Ambulance Service

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Spring 2012

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A Publication of the California Ambulance Association

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- Promote effective and fiscally responsible EMS systems and establish standards for system design.

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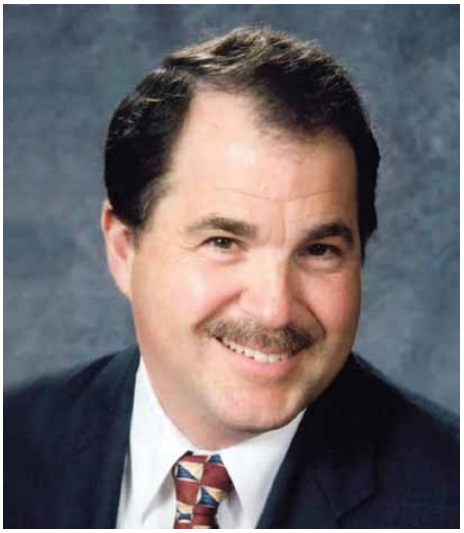
Circulation among California's private ambulance providers, elected officials and EMSA administrators.

Chair's *Message*



Bob Barry | *Chair of the Board*

Be Proactive, Get Involved

"**United we stand, divided we fall**" is a phrase that has been used for centuries to illustrate the need for people or groups that have a common interest, to stick together in order to be successful. In today's environment, this motto can easily be used to describe the CAA and the Ambulance Industry as a whole.

The ambulance industry in California is as diverse as the State we serve. We have large corporate providers, and small "mom & pop's"; we have ALS providers and those that only provide BLS; we have rural providers and those that are primarily urban; we have private providers, public agency providers and even volunteer providers.

Whichever you are, it is safe to say we each have our own unique day-to-day challenges and work hard to make ends meet and either post a profit or meet our budgets. We sometimes partner or compete for business, but all of us focus on delivering quality services to the communities we serve.

It would be nice if we could leave it at that and just focus on our own operations and departments and not be concerned about larger, industry-wide issues that could impact our ability to be successful. Unfortunately, that is not the case.

We have tremendous industry-wide challenges that are affecting all of us. They include reimbursement issues, rate cuts, regulatory changes, tax and fee issues, and the big one looming on the horizon, Health Care Reform.

The CAA has been proactive and is trying to engage and stay in a position to represent the industry as these issues begin to affect our business, but we cannot do it alone.

It is time for all providers to start focusing some time and resources on these state-wide issues and to proactively start making your voices heard. The best way to do that is to join your association and add your voice to the conversation. Start paying attention and get involved in policy discussions or comment on proposed rule and regulatory changes as they are proposed. This is the best way to have an impact on what is happening in Sacramento and to your industry and local business or department.

The other alternative is to continue to do nothing and expect the CAA to take care of all of these issues for you. But we are only as effective as the providers who make up the association. The smaller our ranks, the harder it is to be successful.

At the end of the day, we each have to deal with the changes that come out of Sacramento, and as each of you know, these policies are not always good for our industry. So you have a choice. Be proactive and add your voice to the group and help influence the changes that are coming, or stay on the sidelines and hope that nothing bad is going to happen to you, your business, or your department.

There is an old saying that "Why buy the cow when you get the milk for free?" Well, if you want to make sure the milk is drinkable, owning the cow is a good thing.

Get proactive, get involved. Protect your business or department. Support the one association that looks out for you and your interests.

Brenda Staffan | *Executive Director*

Think Tank Explores EMS System Improvements

Over 50 attendees explored the potential impacts of national health care reform at a unique event on April 16, 2012 called the *EMS Health Care Reform Think Tank: Opportunities and Challenges for California's EMS System*. As host, the CAA's objectives were three-fold: 1) to assure EMS system providers are aware of the opportunities and challenges posed by national health care reform and are motivated to take action to respond; 2) to assure that EMS system regulators are aware of the interconnection between patient care policies and the policies of payers; and 3) to encourage future forums as part of an ongoing dialogue among stakeholders.

Regardless of the outcome of the Supreme Court ruling on the Patient Protection and Accountable Care Act (PPACA), State officials have stated they will adapt their implementation plans and move forward with health care reform implementation. Therefore, change is inevitable. The Supreme Court decision is expected in late June 2012. During an interviewed on the two-year anniversary of the PPACA, former CMS administrator Donald Berwick stated that the new federal law "has profoundly changed the conversation for the good." In recognition of these complex issues and knowing that the stakes are high, the CAA has issued a set of principles regarding the process of integrating the statewide EMS system with health care reform implementation which can be found on the association's website.

At the Think Tank, the CAA assembled a group of diverse leaders representing multi-disciplinary perspectives. Session facilitator, David M. Williams, PhD, an improvement advisor and faculty member of the Institute for Healthcare Improvement (founded by former CMS Administrator Donald Berwick) led a dynamic discussion that included panel members and attendees. In his opening presentation, Williams described how former CMS Administrator Berwick sought to change healthcare delivery through policy changes which impact payers, starting with Medicare since it is the single largest payer of health care services in the U.S. Williams also identified several opportunities for EMS:

1. **Hot Spotters:** Can systems lower per capita medical costs by giving the highest cost patients access to the most appropriate care and support?
2. **Cost Variation:** Why are there wide provider and regional variations in the cost of nearly identical care or service?
3. **Chronic Conditions:** Can EMS systems lower per capita medical costs by better managing the care of patients with chronic conditions?
4. **Hospital Readmissions:** Can EMS system assets be leveraged to reduce hospital readmissions?
5. **Care Variation & Outcomes:** Why are there wide provider and regional variations in care delivery and patient outcomes?
6. **Systemic Improvement:** How can EMS systems measure and achieve sustained system-wide improvement?
7. **Innovation & Collaboration:** Are there opportunities to innovate and collaborate to achieve the triple aim: enhancing quality and access; improving the health of the community; and reducing per capita cost of care?

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Opportunities and Challenges for California's EMS System

- **Howard Backer, MD –** Director, Emergency Medical Services Authority
- **Bruce Barton –** President, Emergency Medical Services Administrators Assoc. of California
- **Bob Barry –** Chair, California Ambulance Association
- **Art Kellerman, MD, MPH –** RAND Corporation; EMS IOM Committee Member
- **Chief Demetrious N. Shaffer –** President of California Fire Chiefs Association

Executive Director's *Update*

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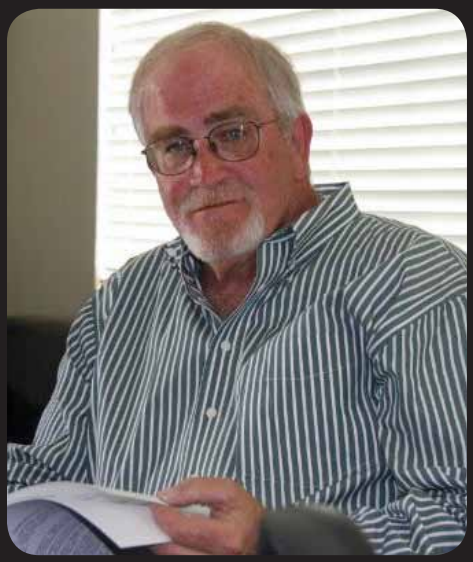
Below are key themes that emerged from the think tank followed by excerpts from key comments of both the panel and attendees:

1. **System Design – Transport Alternatives:** Can EMS systems implement programs to transport patients to alternative destinations other than EDs which also generate downstream savings that are ultimately reinvested into the EMS system?
2. **System Design – Competitive Processes:** EMS systems should separate the development of system design features and structure from the competitive bid process; there are opportunities for EMS systems to partner with the medical community and promote comprehensive patient care protocols that start at dispatch and end at discharge
3. **Public Safety vs. Health Care:** EMS is not uniformly viewed as part of the health care safety net and this omission excludes EMS from many critical policy and funding opportunities; EMS is the bridge from public safety to health care
4. **Change in Payer Mix:** Sometimes there is so much focus by policy makers on reducing the cost of services that policy makers overlook the severe reimbursement system flaws and shortfalls; the potential payer mix changes and Medi-Cal shortfalls pose very serious current and future funding challenges to the statewide EMS system
5. **Limited Community Funding Capacity:** Health care system reforms must include the mental health and social service needs of a growing number of patients; for that subset of patients with complex health needs which generate unusually high costs, can EMS systems lower overall health care costs by contributing EMS assets to achieve better access to appropriate care and to achieve better case management?
6. **Evidenced-based Practice:** EMS systems must become outcome-focused and evidenced-based and must demonstrate their value to payers, patients and regulators
7. **No Measures of Quality/Care Reliability Gap:** EMS systems must redefine EMS quality factors in a manner that meets the objectives of health care reform and focus on outcomes not processes; for example, response times are just one component of a family of measures that contribute to quality outcomes
8. **Proactive vs. Reactive:** While there are various stakeholders, EMS should be viewed from a system perspective and EMS system stakeholders need to begin engaging and preparing immediately; there is value in more collaboration among stakeholders
9. **ACOs Driving Down Costs:** Can EMS systems leverage existing EMS assets to generate value and create downstream savings?

There was unanimous consensus among participants that stakeholders should continue the process to identify key issues and policy solutions. In addition to the current participants, future panels should include other key stakeholders such as hospitals, social services and mental health professionals, work force experts, payers and the new accountable care organizations. On behalf of the CAA, we thank the panel members and attendees for their dynamic participation in this first event. We sincerely hope this is just the beginning of a focused process to reform our EMS systems to achieve the goals of health care reform.



Tom Williams, Former CAA Board Member Passes Away

Thomas Rhodes Williams, former CAA Board Member, former AMR VP and PRN Ambulance COO passed away peacefully at home on May 15, 2012 after being diagnosed with Stage IV colon cancer in early March. He is survived by his loving wife of 40 years, Marty; his two daughters, Lisa Williams Smith and her husband Brian and Nikki Williams; his three granddaughters, Anna, Sarah and Gracie; his sister, Suzanne W. Griffin and her husband Richard; and his niece and nephew. He was well respected and loved by all who knew him and will be missed. A graveside service was held on Thursday, May 17th 2012 at Sharon Memorial Park. In lieu of flowers, memorials can be made to the American Cancer Society. Condolences may be expressed at *www.HarryandBryantFuneralHome.com.*

State Budget Update Brings Bad News for Health and Human Services Spending

Chris Micheli | *CAA Legislative Advocate*

On May 14, Governor Jerry Brown released his May Budget Revision, which reflects his updated budget proposal designed to take into account updated revenue figures after the April tax receipts. The Governor, in a surprise announcement, estimated the state's shortfall to have grown substantially to $15.7 billion, up from the $9 billion anticipated in the Governor's January budget proposal. The Governor blamed that increase on three factors: his prior revenue estimates were too high; mandated spending to education under Proposition 98 increased; and, courts have blocked some $1.7 billion in cuts included in the FY 2011-12 enacted budget from last June.

These forces have pushed the Governor to propose additional cuts, which he called "more difficult" than initially anticipated, but also necessary to restore the state to fiscal balance by reducing overall spending to a sustainable level. Overall, the May Revise proposal seeks an additional $8.3 billion in cuts and $5.9 billion in revenues. $5.6 billion of the revenues are attributed to passage of the Governor's temporary tax increases that will likely appear before voters on the November ballot.

Included in the May Revise proposal are:

- A 5% across-the-board reduction in State worker pay (achieved through either reduced workweek or pay reduction, but must be done through collective bargaining negotiations);
- Trigger cuts totaling $6.1 billion should the Governor's proposed temporary tax increases fail to reach the ballot or be rejected by voters.

The Governor's budget also includes over $1.2 billion in Medi-Cal cuts alone. His $6 billion in tax revenues resolve 35% of the budget solutions, but are contingent upon voter enactment in November. Health advocates called the budget "a body blow to the health system all Californians depend on." In a YouTube video announcing the new size of the deficit released this weekend, Governor Brown also stated that state spending "is now at its lowest level in decades."

The Governor's 2012-2013 proposed budget already had proposed steep cuts that are retained in the new budget revision – the proposal cuts children's health care in the Healthy Families program by 25% by shifting its 875,000 children into Medi-Cal. The proposal also shifts 1.4 million "dual-eligible" seniors and people with disabilities into managed care. This revised budget also includes hundreds of millions of dollars in new cuts, particularly to hospitals and nursing homes.

Also of interest is that the Governor revised his proposal to impose cost-sharing on Medi-Cal patients which was adopted by the Legislature last year but rejected by the federal government. A new, narrower proposal would seek $15 co-payments on non-emergency ER visits, and $1-3 co-payments on specific prescription drugs, for a $20 million general fund savings.

Tony Myers, Former Paramedics Plus Executive, Passes Away

Anthony Myers, recently retired Vice President of East Texas Medical Center (ETMC) EMS, passed away in Fort Wayne, Indiana, on March 1, 2012 following complications from a long-term illness. Under his leadership for 17 years, ETMC EMS grew throughout the state of Texas and nationally. Tony was responsible for the organization's national EMS outreach, with Paramedics Plus operations in Florida, Oklahoma, Indiana and recently California. Tony had a long career in emergency medical services. The Alameda County operation of Paramedics Plus is a CAA member. Tony is survived by his wife, Linda, and their children.

60-Day Repayment Requirement: A Landmine For Providers

R. Michael Scarano, Jr.

One of the provisions in the Patient Protection and Affordable Care Act ("PPACA") which has had the greatest *practical* impact on ambulance providers is the so-called "60-Day Rule," which requires all health care providers who receive reimbursement from Medicare and other government programs to report and return any "overpayment" within the later of: (a) 60 days after the overpayment is "identified," or (b) the date any corresponding cost report is due, if applicable. (The later deadline will only apply to Part A (hospital-based) ambulance providers.)

Although this requirement became effective on March 23, 2010, when many other provisions of PPACA became effective, CMS recently promulgated a proposed regulation (the "Proposed Regulation"), which, once finalized, will give providers very specific guidance on how to comply with the Rule. For example, the Proposed Regulation would require providers to include significant information at the time of repayment and disclosure, including: how the error was discovered; a description of the corrective action the provider intends to take to ensure the error does not occur again; the reason for the refund; and, if a statistical sample is used, a description of the methodology utilized by the provider in determining the amount of the repayment.

Providers should take the new 60-Day Rule very seriously, since failure to comply can result in Draconian penalties. Due to corresponding changes in the False Claims Act made last year, the "knowing" retention of an overpayment is deemed to be a "false claim" punishable by penalties equal three times the amount of the overpayment, plus $11,500 per overpayment. In addition, the False Claims Act's *qui tam* (whistleblower) provisions are applicable, meaning that private parties can bring an action in the name of the government against a provider for failure to report and return an overpayment.

To constitute a violation, the retention of the overpayment must be "knowing." However, this term is defined as either actual knowledge of the overpayment; or acting with deliberate ignorance or reckless disregard of the fact that an overpayment has been received. In other words, no specific knowledge or affirmative intent to defraud is required. Basically, a provider can be liable for failing to report and repay an overpayment if it knew or should have known of the overpayment. This places an affirmative obligation on providers to remain vigilant in discovering and repaying overpayments.

One of the difficult challenges posed by the statute is determining when an overpayment is deemed to have been "identified," since identification of the overpayment starts the 60-day clock ticking. The Proposed Regulation gives providers some latitude to conduct an investigation before the 60-day clock starts ticking; it states that an overpayment is not deemed "identified" until after a provider has had an opportunity to undertake a "reasonable inquiry" into the basis of the alleged overpayment. However, it further states that providers have a duty to conduct a reasonable inquiry "with all deliberate speed" upon receipt of credible information that a potential overpayment has occurred. If a provider fails to promptly make such an inquiry, it may be found to have acted in reckless disregard or deliberate ignorance, thereby triggering the penalties described above.

The Proposed Regulation provides the following examples of when an overpayment may be deemed to have been identified:

- An internal audit indicates that the billing office incorrectly up coded certain services;
- A provider learns through a hotline call that services were provided by an unlicensed or excluded individual;
- A Medicare contractor sends a letter identifying a pattern of using incorrect codes or modifiers.

Another difficult issue posed by the Rule is the question of whether an overpayment must be quantified before it is deemed identified. Frequently, when an overpayment is discovered, the provider requires a significant amount of time to ascertain the precise amount of the overpayment. Both the statute and the Proposed Regulation are silent on whether the clock starts to tick when the overpayment is first ascertained, or whether a provider must first quantify the amount before that occurs. The safest approach is to deem the payment "identified" when it is initially discovered, even if it has not been quantified, and to use the 60-day period to do so. Logic suggests that CMS included a 60-day period precisely for that purpose.

Another question the statute and the Proposed Regulation leave unanswered is whether providers may continue to use the existing adjustment bills/claims correction process to resolve innocent overpayments within the one year claims correction window. Use

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of that process gives an easy and convenient way to refund routine overpayments.

Perhaps the most criticized provision in the Proposed Rule is the section stating that overpayments which occurred as long as ten years ago must be reported and refunded if "identified." This means that if a provider discovers an issue which may have been around for a long time, it may have an obligation to trace that problem back as long as ten years prior to the date of discovery. Historically, providers refunding overpayments have limited their investigation and repayment to the Medicare administrative claim re-opening period, which is four years.

One problem many providers will face under the Rule is that, if the overpayment is large, they may lack the financial resources to make repayment within sixty days. Fortunately, the Proposed Regulation would permit them to request an extended repayment schedule ("ERS"), pursuant to an existing CMS procedure. ERSs are not automatically granted, however, and providers must submit significant documentation allowing CMS to verify that timely payment would be a hardship on the provider.

In light of the harsh penalties for violating the Rule, providers are advised to establish and carefully implement an effective policy for determining when overpayments have occurred; investigating and quantifying the amount; and making timely repayment and disclosure. Specifically, the policy should:

Define when an overpayment is deemed to have been identified, e.g., "an overpayment will be deemed to have occurred when the organization has credible evidence that it is probable it has received an overpayment."

Define when the organization has a duty of inquiry to investigate whether an overpayment has occurred, e.g., "when credible information is received indicating a material possibility that the organization has received an overpayment, it shall conduct an internal inquiry/investigation to determine whether the overpayment did, in fact, occur."

Require the creation of a work plan for determining when an overpayment exists, including a timeline and deadlines, as well as the assignment of responsibility for specific tasks to specific individuals.

Include a process for reaching a conclusion, e.g., "the ultimate determination regarding whether an overpayment has occurred shall be made by a specific individual such as the Compliance Officer, the compliance committee or a special ad hoc committee."

In light of the serious consequences of failing to report and return government overpayments, Providers should be vigilant in monitoring overpayments and make sure that they report and refund them within sixty days. ✱

R. Michael Scarano, Jr., is a Partner and Vice Chair of the Health Care Industry Team of Foley & Lardner LLP, a national law firm with 20 offices coast to coast, including four in California (San Diego, Los Angeles, San Francisco and Sacramento). Mike specializes in representing ambulance service providers in a wide range of matters, including compliance, reimbursement and government investigations; health facility, health plan and 911 system contracting; HIPAA and privacy; and general business transactions and regulatory matters.

Feature *Article*

Health Care Reform, the Triple Aim, and Ambulance Service

David M. Williams, Ph.D.

On May 8th, Health and Human Services (HHS) announced the award of the first round of the health care reform law's Health Care Innovation awards. $122.6 million was awarded to 26 projects around the country. Up to $1 billion in grant dollars is expected to be awarded in total. The program is part of the newly fashioned CMS Innovation Center; a program introduced by Donald Berwick, former CMS director and founder of the Institute for Healthcare improvement (IHI).

The innovation grants are a reflection of a key element of health care reform modeled after an initiative called the Triple Aim, which focuses on achieving three critical objectives:

- *Enhancing the experience of patient care* – including quality, access, and reliability
- *Improving the health of the population* – working with communities and organizations to focus on prevention, wellness, and managing chronic conditions
- *Reducing, or at least, sustaining, the per capita cost.*

Over the last five years, health care organizations participating deeply in this work has grown to more than 50 across eight nations. It's predicted that this same framing will trickle down to other sectors of healthcare, including EMS.

So, why is this important to you? While cable "news" networks have presented health care reform through a limited lens that may influence the uninformed to the left or right, the facts on the state of health care quality and cost are very clear. The Organization for Economic Co-Operation and Development (OECD), in its most recent health indicators report, found the U.S. spends 2.5 times more than the average of all 40 nations – 17.4% of our GDP – which is almost double the average of 9.6%. With that much investment in health care, you'd expect the best outcomes, but the U.S. does not lead in patient outcomes or access.

In addition, health care costs are limiting our global competitive advantage. For example, today, more than $1500 of a new GM car built in Detroit goes to cover worker health costs. GM spends more on healthcare for workers than on steel. This is not an issue in countries with single payor, government health care systems (e.g. Canada).

While it's not known when the affects of health care reform will reach EMS, you can begin today to plan for testing and implementing changes that achieve the Triple Aim. For example:

Enhancing the experience of patient care – Align clinical care guidelines with the available evidence and measure indicators to aid in improving reliability and reducing variation. Transition from trying to filter only the acute patients to supporting all patients; facilitate access to the most appropriate care to meet their needs including transporting to alternative destinations or partnering with other health care providers.

Improving the health of the population – Prevention evolves to a new level, including adopting chronic patients in your service area, working with "hot spotters" or patients that generate more than normal utilization, and partnering to reduce hospital readmissions for key clinical conditions.

Reducing per capita cost – After reading the two previous action items, reducing costs may seem unattainable. However, organizations must focus services, improve quality, reduce variation, cut out waste, rework, and continually ask: How does this directly help the patient or community? There are a lot of opportunities in every organization.

Ambulance services have a lot on their plate. Waiting to act may put your organization at risk in the future. How health care reform will affect EMS remains unclear, but the Triple Aim approach is deeply rooted in the national health care reform vision and you can begin today to transform your organization to meet the challenge of tomorrow. ✱

David M. Williams, PhD, is Chief Improvement Advisor at www.truesimple.com. He advises EMS and health care organizations in the US and Europe on measurement and process improvement to improve care reliability, patient safety, and operations. He is an improvement advisor and on the faculty of the Institute for Healthcare Improvement founded by former CMS Administrator Donald Berwick. Dr. Williams previously served as an expert EMS systems consultant and as the Commander over Quality for Austin-Travis County EMS. He earned undergraduate and graduate degrees in EMS Management and a PhD in Organizational Systems where his research focused on the obstacles to patient-centric EMS system design.

National Focus on EMS Safety Strategies

NATIONAL EMS CULTURE OF SAFETY STRATEGY ANNOUNCED

EMS has been identified as a high-risk industry and safety impacts more than just EMS personnel. Safety in EMS affects patients, EMS responders, and the public and includes factors such as vehicle operations, medical errors, infectious diseases, scene safety and responder health and fitness, just to name a few.

A new cooperative agreement will bring together representatives from national EMS and fire organizations to develop a national EMS "Culture of Safety" Strategy. The three-year cooperative agreement has been reached between the National Highway Traffic Safety Administration (NHTSA), with support from the Health Resources and Services Administration's (HRSA) EMS for Children (EMSC) Program, and the American College of Emergency Physicians (ACEP). The NHTSA/EMSC/ACEP culture of safety project will synthesize literature and research of non-EMS systems and describe components of leadership that have a positive or negative impact on EMS safety culture. There is an opportunity for the EMS community to participate in this groundbreaking initiative, to share ideas and make concerns known. For more information about the Culture of Safety Project, go to: *www.emscultureofsafety.org.*

NEMSAC ADVISORY: THE ROLE OF LEADERSHIP IN EMS WORKPLACE SAFETY CULTURE

In a related effort, the NEMSAC Safety Committee has issued an advisory which analyzes the role of leadership in EMS workplace safety culture. The advisory states, "EMS leadership plays an important role in promoting safety culture, and we believe the current research suggests that leadership that is accountable, engaged, motivated, adaptable, and persistent is required to instill and sustain a positive EMS safety culture." According to the committee, the core elements of leadership as regards safety culture include:

- Setting and regularly promoting the expectation for safe operations;
- Communicating a vision of a safe workplace, develop a process for achieving that vision, stimulate and arm co-workers with the resources needed to achieve that vision;
- Adopting safety and a positive safety culture as a value rather than a priority because the latter are susceptible to change over time;
- Developing and sustaining processes for regular internal and external evaluations of safety conditions in the workplace and disseminate findings to create an 'informed culture;
- Providing an avenue for management and front-line workers to recognize the need or availability of innovations that improve the workplace safety; and
- Facilitating a variety of processes and interventions in and out of the workplace that promote the safety of workers and their families.

For the NEMSAC Advisory titled, "The Role of Leadership in EMS Workplace Safety Culture," go to: *www.ems.gov/pdf/nemsac/dec11/Advisory_on_Leadership-Safety_12142011.pdf.*

Pending Members

Bell's Ambulance Service, Inc.
Active Member
Pamela Bell Simmons
Healdsburg, CA

Commercial Trade, Inc.
Commercial Member
Hal Ennis
Bakersfield, CA

San Bernardino County Fire Protection District
Associate Member
Mark A. Hartwig
San Bernardino, CA

Comments or questions about membership applications should be directed to: Kim Ingersoll: *kingersoll@the-caa.org.*

CAA *Feature*

CAA Celebrates Stars of Life – Class of 2012

Forty-three paramedics, emergency medical technicians (EMTs) and emergency medical dispatchers from across the State of California were recognized as *Stars of Life* on April 17, 2012. Their stories demonstrate the courage, discipline and skill needed to remain calm under pressure while delivering basic and advanced life support care in the field. Aside from their core responsibilities of caring for those who fall victim to sudden illness or injury, some of this year's Stars of Life recipients were also honored for their community service.

The Stars began the day with a morning briefing followed by the presentation of the *Star of Life Medal.* Afterwards, they met individually at the State Capitol with members of the State Senate and Assembly to tell their life-saving stories and deliver important first-hand information regarding the essential service provided by California's ambulance providers.

The awards banquet was a time to reflect and to celebrate. The evening began with the presentation of the CAA's 2012 *Legislator of the Year Award* to Senator Ed Hernandez, Chair of the Senate Health Committee for his support of the health care safety net. The Stars of Life presentation was kicked-off with a keynote address by Dr. Howard Backer, Director of California's Emergency Medical Services Authority (EMSA). As their accomplishments were read, each *Star* received a special lapel pin and legislative certificate honoring their service.

Brenda Staffan, Executive Directory, addresses the attendees during the morning briefing.

Chris Micheli, Legislative Advocate, provides a legislative update.

EMSA Director, Dr. Howard Back discuss the current state of Health Care Reform in California with CAA Chair, Bob Barry.

2012 CAA Legislator of the Year, Senator Ed Hernandez receiving award from CAA Chair, Bob Barry.

Members of the Class of 2012 Stars of Life and their guests enjoy their copies of *Siren* at the Stars of Life Celebration Dinner.

Carol Meyer of McCormick Ambulance and Steve Grau of Royal Ambulance conducts the prize drawing.

"As our State and local communities grapple with great challenges, it is inspiring to focus on the personal character of the outstanding men and women we honor tonight. Despite often encountering roadblocks, they persevere to deliver the services our patients and communities need. Our local EMS systems are a critical component of the statewide health care safety net, even though we are often under recognized for the significant role we play. In these tough times, we have seen an increase in the charity care we provide. And, we know we will continue to respond and treat without exception, because our services, and our people, are unique."

— Bob Barry | *Chair of the Board*

Congratulations Class of 2012 Stars of Life!

Gordon Anderson
American Medical Response
San Diego

Nicole Bonn
Medic Ambulance
Solano County

James Bradbury
Hall Ambulance Service, Inc.
Bakersfield

Jeronimo Carlos
ProTransport-1
Berkeley

Lisa DeMetz
American Medical Response
Riverside

Miguel Diaz
Riggs Ambulance Service
Merced

Matt Drake
McCormick Ambulance
Hawthorne

Curtis Dunn
American Ambulance
Fresno

Tim Emling
Royal Ambulance
Castro Valley

Bryan Frey
Care Ambulance Service, Inc.
Orange

Matthew Godby
McCormick Ambulance
Hawthorne

Harvey L. Hall
Hall Ambulance Service, Inc.
Bakersfield

Colleen Heinrich
ProTransport-1
Santa Rosa

Mike Hilliard
Hall Ambulance Service, Inc.
Bakersfield

Jessica Hopkins
Care Ambulance Service, Inc.
Orange

Hiroshi Ikeda
Royal Ambulance
Hayward

Tanya Johnson
Hall Ambulance Service, Inc.
Bakersfield

Remy Jordan
Royal Ambulance
Stockton

Craig Kelly
Riggs Ambulance Service
Merced

Timothy Kunstman
Medic Ambulance
Solano County

Steven Lewis
Hall Ambulance Service, Inc.
Bakersfield

Alison "Belinda" Lowder
Paramedics Plus
Santa Rosa

Zack Martinez
American Ambulance
Kings County

Kerry Monk
Hall Ambulance Service, Inc.
Bakersfield

Ryan Moynihan
Royal Ambulance
San Ramon

Hanna Nash
Pro-Transport-1
Richmond

Eileen Navarro
Hall Ambulance Service, Inc.
Bakersfield

Jeff Perkins
Hall Ambulance Service, Inc.
Bakersfield

Shawn Perryman
Hall Ambulance Service, Inc.
Bakersfield

Anthony Reyes
Royal Ambulance
Berkeley

Julie Senter
San Luis Ambulance
San Luis Obispo

Chad Smart
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Member *Profile*

LifeLine Medical Transport

Stephen Frank talks about his Ventura-based ambulance company **LifeLine Medical Transport** with the experienced knowhow of an owner who understands his small business from the ground up and what it takes to keep the 77-year-old company thriving in the 21st century.

"This business is about two things: It's about relationships, and it's about service," said the 54-year-old president and CEO of the eight-ambulance company that services Ventura County and its 850,000 residents.

It's a simple philosophy that has served the longtime Ojai resident well during his 18 years as head of the company he began with in 1979 as both an EMT and director of operations for what was then Ojai Ambulance.

ROOM TO GROW

At the time Frank started, Ojai Ambulance was just that – a single ambulance serving the Ojai Valley, a picturesque rural community that lies at the edge of the Los Padres National Forest in northern Ventura County.

Frank took ownership of the company in 1991 and sought ways to grow the two-ambulance outfit's customer base. Frank said the company held the Ojai Valley's exclusive emergency service contract – and continues to do so – but that the valley's small population meant his company's growth would require he seek other markets.

Frank looked to the neighboring city of Ventura and the Santa Clara Valley and saw an opportunity to serve the two markets – both booming in the 1990s – as an ambulance company offering the very best in non-emergency services.

"That's where our growth really took off, seeing a niche where there was a need for an increased level of service," said Frank, who renamed the company LifeLine Medical Transport. "That caught on, and we've been able to expand that service over the past few years pretty aggressively."

To be sure, Frank expanded the company over the ensuing years to include a staff of 50 and a fleet of eight ambulances. He said the growth was due in no small part to his personal promise to provide first-class customer service and his dedication to building positive relationships.

MEETING CUSTOMERS' NEEDS

Frank said the key to outstanding customer service is the daily commitment by his team not to take a one-size-fits-all approach with the patients they transport.

"With us, you are going to get tailored service for your particular situation," Frank said.

Each of his employees' ability to problem solve on the job is an important aspect of LifeLine's company culture, he said.

Frank recalled a customer a few years ago who was being moved back home for his final days of life. The man told LifeLine's ambulance crew about his love for the ocean, prompting the paramedics to make a short detour to the beach before taking the man home.

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Member *Profile*

Continued from page 12

"The crew pulled over and opened the doors right there on the beach," Frank said. "He could feel the sun on his face and saw the ocean, which probably was for the last time. And while there were no news crews out there and that's not terribly exciting to anybody, it meant a lot to him. I think that's why we do what we do."

Frank also noted the time one of his crews stopped to pick up a tuxedo for a very sick man who had been cleared by doctors to temporarily leave ICU so he could attend his daughter's wedding.

"The interesting thing about ambulance service is that most of the time our interaction is based on some sort of negative situation," Frank said. "Our goal is to take that negative and make it a positive in terms of their interaction with us."

That commitment to top-notch service, Frank said, certainly extends to LifeLine's emergency calls.

Frank said LifeLine – 98 percent of the time – meets or exceeds the 8-minute response time required for emergency calls by the Ventura County Emergency Medical Services, the county agencies which regulates ambulance providers.

THE RIGHT EMPLOYEES

Frank is quick to point out, however, quality customer service at LifeLine starts with each employee – whether it's the paramedics on call or the office staff taking calls.

"We ask more of our people than we've ever asked before," he said.

Because of the importance of hiring good people, Frank said he strives to find those who not only show they have an absolute command of their training but those who also posses "positive and uplifting" attitudes.

BUILDING RELATIONSHIPS

Positive attitudes – despite the tremendous stress paramedics and EMTs face on a daily basis – go a long way in cementing positive relationships in the community LifeLine serves, Frank said.

"The local ambulance service is all about relationships," he said.

Relationships, he said, are built with each interaction his EMTs and paramedics have with the patients they transport and the doctors, nurses and medical professionals at either end of the transport.

LifeLine's office staff also understands that each time they schedule an appointment – whether it's with a patient or through a hospital, a hospice care provider or a retirement community – it's important to listen to the needs of the customer and ensure a smooth transport.

"No matter what the transportation issue is, we're going to look at how to solve it," he said.

What truly makes his company unique, Frank said, is the fact that he makes himself readily available to his staff and his customers.

"It's very easy to get a hold of me," he said. "They have my cell number. They have my office number. They can get the guy that is going to take care of the problem. Those we deal with know that, and I think that's extremely important to them."

A BENEFICIAL SERVICE

What does Frank love most about what he does?

"It's that I'm part of an organization that, on a day-to-day basis, is providing a service that is beneficial to a lot of people," he said. "I think I can go to sleep at night knowing that we've got in place a great service that if something happens to someone tonight, we're going to be there for them. That's what makes LifeLine great." ✱

To learn more about LifeLine Medical Transport, visit *http://lifelineems.net* or call (805) 653-9111.

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Schedule-at-Glance

Tuesday, September 25
- Annual Ray Lim Memorial Golf Tournament

Wednesday, September 26
- Committee Meetings
- Board of Directors Meeting
- Welcome Dinner & Golf Awards

Thursday, September 27
- Executive & Reimbursement Track Educational Sessions
- CAA MarketPlace
- General Membership Meeting
- Chairs Banquet & Awards

Friday, September 28
- Executive & Reimbursement Track Educational Sessions
- CAAPAC Prize Drawing

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The CAA has reserved rooms for attendees at two hotels:

- Disney Paradise Pier® Hotel: $139.00
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For room reservations, please call (714) 520-5005. The guest room reservation deadline is September 4, 2012. For more information, go to: *www.disneymeetings.com/disneyland/paradise-pier.*