CHALLENGES OF OPERATING A HOSPITAL-BASED AMBULANCE SERVICE

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DOES OPERATING AN IN-HOUSE EMS DEPARTMENT CONTINUE TO MAKE SENSE?

The number of hospital-based ambulance services continues to decline. In a 2010 study, hospitals that closed ambulance services outnumbered hospitals that started ambulance services by a three to one margin.[1] The reasons are numerous, and include the following:

- **REIMBURSEMENT** — One of the most significant challenges for hospital-based providers is mastering the specific nuances of ambulance service reimbursement. The majority of hospitals use in-house resources for EMS billing and collection. These systems often report significantly reduced reimbursement and lower net cash per transport relative to comparable private or government-operated ambulance providers with EMS-specific billing operations. Hospitals operating their own ambulance service can also encounter challenges when billing multiple service lines with a common Medicare provider number, including running the risk of absorbing ambulance costs into bridged diagnosis-related group (DRG) reimbursement. In addition, discounts afforded to major health plans for hospital services often get applied to hospital ambulance services, resulting in lower cash per transport compared to other provider types.

- **AMBULANCE-SPECIFIC OPERATIONS** — Another challenge facing hospital-based ambulance programs is the lack of cross-departmental applicability with a majority of the necessary support services. For example, it is rare that a hospital will have a need for fleet maintenance services for diesel engines outside of the ambulance service. Additionally, emergency medical dispatching, with specific training requirements for 9-1-1 dispatchers and a need for specialized IT and communications infrastructure is also not generally used elsewhere within the hospital. As a result, the variable overhead and fixed costs related to these services must be absorbed completely by the EMS department, even if a hospital only has a small handful of ambulances generating revenue.

- **PURCHASING** — In theory, a hospital should be able to take advantage of the discounts provided by the bulk purchasing of medical equipment and disposables. However, many hospital purchasing administrators recognize that there are relatively few items that are truly interchangeable between the ambulance and the hospital environment. For example, the majority of the durable equipment required for ambulance operations – from back boards to monitor-defibrillators – are designed for the specific rigors of EMS use and do not function effectively in a hospital. Even the medications used in a pre-hospital environment require different, more durable packaging and cannot be refrigerated easily.

- **RECRUITMENT AND RETENTION** — The EMS labor pool is generally smaller and often lacks the ability to pull from outside a specific geographic area – especially in rural communities. In addition, job conditions, including operating in stressful and occasionally hazardous environments, often lead to higher turnover. For hospital HR departments that need to manage a spectrum of healthcare providers and support staff, the particular nuances of hiring EMTs and paramedics can be challenging.[2]

- **LIMITED ABILITY FOR INTEGRATION** — In many states, the ability of EMTs and paramedics to perform patient care activities is restricted to the out-of-hospital setting. This greatly restricts a hospital's ability to use EMS staff to backfill other hospital departments or re-purpose EMS crews during periods of system downtime.[3]

- **TRAINING** — EMS providers require specific, state-mandated training for licensure/certification and continuing education. Opportunities for EMS-specific training can be limited or very costly for a hospital to provide.[4]

- **MANAGEMENT CHALLENGES** — Ambulance operations are fundamentally different from those that occur within the hospital's walls, and have given rise to a unique culture of EMS providers that does not always mesh well with the hospital's overall goals. Furthermore, management and "oversight of [ambulance] operations carry a disproportionate amount of problems and issues relative to other hospital services."[5] This may be a result of the functional limits of hospital administrators' abilities to be present at the site of ambulance operations, as opposed to a medical unit or surgical suite at the hospital.

SUMMARY

The last five years have been difficult for many hospital-based ambulance programs. The increased number of EMS regulations has led to additional overhead and capital expenditures for a service that already had thin operating margins. Furthermore, reimbursement cuts and changes in payer mix have exacerbated the problem.

A devastating recession led many hospitals to make difficult decisions about staffing and service lines. With an emphasis on strengthening essential services, hospitals looked to shed non-core services and reduce labor costs to regain economic stability. For many systems, hospital-operated ambulances were one of the easiest to drop due to the perceived "different nature" of the services provided and because of the availability of private and government operated ambulance services to take their place.

As rollout of the ACA continues, hospitals will be challenged to operate efficiently and effectively. The present trend of hospitals closing and/or restructuring ambulance systems will continue for the foreseeable future.

ONLY 7 PERCENT OF THE NATION'S 15,000 AMBULANCE SERVICES ARE HOSPITAL-BASED, MEANING LESS THAN 20% OF US HOSPITALS ARE IN THE AMBULANCE BUSINESS.

1. *Freeman, V. A., Howard, H. A., & Lavergne, R. (2010). Rural Hospital Support for Emergency Medical Services. The University of North Carolina at Chapel Hill. Chapel Hill: Rural Health Research and Policy Centers. Retrieved September 17, 2014, from http://www.shepscenter.unc.edu/rural/pubs/report/FR100.pdf*

2. *Ibid.*

3. *Ibid.*

4. *Ibid.*

5. *Ibid.*

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