Vermont EMS District 6
The Test Tone
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Ethics in EMS Care
By Jim Baraw

EMS ethics is the discipline of evaluating the merits, risks, and social concerns of activities in the field of EMS. There are many defined codes of ethics for EMT's. EMS ethics shares many principles with other branches of health care ethics, such as Beneficence, *The act of doing good, helping others*, and Non-Malfeasance*, a Latin phrase that means "First, do no harm."*

Ethics has been an integral part of EMS practice from the earliest foundations of modern EMS in this century. This has always entailed a respect for human rights of the persons in their care. However, early attempts to define ethics in EMS were focused more on the virtues of nurses, rather than looking at how the rights of the patient or client might be promoted in particular. In the modern era, the ethics of EMS has shifted more toward the promotion of these rights and the duties of the EMT

More so, the EMT's role is one of advocate for the interests of the people in their care. In terms of ethical theory, this means having a respect for the autonomy of the person to make decisions about their own treatment and be provided with information available in order to do this. So the principle of informed consent, where a person understands fully the implications of having or refusing a treatment, is one which is held in the EMT's mind when suggesting treatment options. This principle is not absolute as people are sometimes unable to make choices about their own treatment due to being incapacitated or having a mental illness that affects their judgment. This means that the EMT has to weigh their duty of care against the autonomy of the person in care.

I have listened to many EMS personnel comment, "next time I get him in the ambulance, I'm going to put a 14 gauge line in, and shove a nasal airway up his nose, that'll bring his ass around." Although this seems like an appropriate intervention to give to the "Saturday Night Drunk" or the "Seizer Faking" person, we need to think first against any unnecessary harm that may be caused by our feelings of anger toward this situation, remember, Non-Malfeasance *"First, do no harm."*

Other common themes are that of truth telling in interactions with the person in care. This, however, also has to be weighed against any harm that may be caused by divulging the information. Confidentiality is also an important principle in many EMS ethical codes. This is where information about the person is only shared with others after permission of the person, unless it is felt that the information must be shared to comply with a higher duty such as preserving life.

EMS personnel are interested in the quality of life of the people in their care. Treating a patient in an inappropriate manner as to cause harm is viewed as assault, a crime punishable with fines and jail time. Remember, ALL patients deserve the right to quality, friendly, and competent treatment for their medical issue, we all need to provide that in all cases, regardless of our personal feelings.

Looking at Ourselves
By EMS Liaison Mike Morgan

Most of us who have been in the EMS business for a while get pretty comfortable in our roles. We know our jobs, our equipment, and our colleagues. We know most of the current goings-on in our own service and around the district and the state, and not too much surprises us anymore. If we need something, we know where to get it. If we have questions, we know where to find the answers. We're comfortable in our roles as problem solvers – people who can get things done. We're doing a pretty good job and we know it.

It's easy after a few years to become a little complacent. The pace at which we're learning new things slows down, and our learning curve starts to flatten out. This isn't all bad; most of us like being comfortable

Training Corner

Well it is finally here-that short-lived season we call summer. We wait for 11 months for, what seems like, 2 weeks of warm weather. Enjoy it while you can!

But, just because it is summer does not mean things slow down in the training area. There are a bunch of things going on. The I-03 class is moving along, we just completed district training #3 for 2007, there is a B refresher coming up soon, as well as an I –03 and B re-cert exam on 22 July.

Speaking of the B refresher what is the difference between “continuing education” and a “refresher class”? This question came up recently when I was doing a course review. The course was marketed as “continuing education” but the content was what I learned in the Basic class. How could this be “continuing education” when it covered stuff I already knew?

The fact of the matter is even though we use these terms interchangeably, they have vastly different meanings.

A refresher class is just that- aimed to “refresh” the knowledge you already have. Remind you of things which you may not use every day in your work on the streets.

Continuing education takes a subject, which you have already been exposed to and goes deeper. Maybe you learned just enough of a particular subject to pass the Basic course for example – now you want to delve deeper into that subject and find out

District 6 Exam: **B Re-cert and I-03 Sunday July 22 0800 at Webb Hall on the Norwich University Campus.**

What is Medical Necessity?

By Jim Baraw

On Many occasions people here have listened to me harp on the need to improve documentation, especially in the correlation of the Run Report and the Medical Necessity Form. Many runs we deal with gets billed for service at one level or another. Every insurance company we deal with looks at the run on a case by case basis, but none of them are as picky as the (CMS) Medicare program.

A physician, healthcare facility, or EMS agency that bills Medicare for services which he/she should know are not medically necessary can be prosecuted for fraud by the Office of Inspector General (OIG). Now, does that mean we don’t transport a patient because he/she can walk and really does not need an ambulance for a sore thought, no. We always need to transport, the determination of transport is never ruled by the ability to bill or pay for the service. What does it mean; it means subjectively and objectively write up what you have for a patient condition. Document, document, and document your patients need or lack of need for medical transport and/or care, be honesty in what you see, hear, and do for the patient.

Fraud is a big deal, violators face penalties of up to $10,000 for each service, an assessment of up to three times the amount claimed, and exclusion from federal and state health care programs. The problem is that determining medical necessity is not always easy.

The dilemma is due to several factors, the first of which is definitional. There are almost as many definitions of medical necessity as there are payers, laws and courts to interpret them. Generally speaking, though, most definitions incorporate the principle of providing services which are "reasonable and necessary" or "appropriate" in light of clinical standards of practice. The lack of objectivity inherent in these terms often leads to widely varying interpretations by

CTERT– Corinth/Topsham Emergency Response Team

The Corinth/Topsham Emergency Response Team was established in 1982 with one goal in mind: " to give emergency medical help to those in need ". We are an all volunteer squad and serve the towns of Corinth, Topsham and the sections of Orange & Washington that lie on the east side of Orange Heights. All of the towns we serve have some very remote areas and there is minimum wait of 20 minutes for an ambulance for most of our coverage area.

CTERT started with 5 original members: Lillian Olsen, John Knoll, Connie Thurston, Sandra Clark & Larry Eastman. These members were trained in Advanced First Aid along with CPR. By 1984 there were 17 volunteer members.

Originally the squad members were "dispatched' by telephone. The residents were given a list of the member's telephone numbers and since it was a "neighbor helping neighbor" system , the person who needed help called the squad member that lived the closest to them. The squad then graduated to a CB radio system where the members were "toned" on Channel 9 with a homemade system utilizing an old plectron donated by the Middlesex Fire Department. The squad then started working on setting up a radio system with a repeater in the Pike Hill area. By 1986 the CTERT members had a radio link set up and were waiting for their FCC license.

In 1986 the members were also given a van for their equipment but due to insurance costs this was never put into operation.

While we do not have our own ambulance all of our members carry as much equipment as possible in their personal vehicles. This equipment includes everything from backboards to AED's and one donated cardiac monitor. CTERT also has a "Rescu-Boggin" and Polaris snow machine to be able to respond to the many miles of the VAST system in our service area.

CTERT is currently an Intermediate service with 8 members. We have 2 EMT-I's, 4 EMT-B's and 2 FR/ECA's.

We are dispatched by Barre City and own an up to date radio link system. The Tri-Village FD and the Corinth VFD are also dispatched from our radio system.

The town of Topsham uses Barre Town Emergency Medical Services for their transporting service and the Corinth uses Upper Valley Ambulance. Our call volume is usually around 150 to a high of 200 calls a year. The majority of our calls are medical as we have an extensive elderly population. We also cover a large section of Route 302 and average 3-4 moose vs. car collisions every year. In recent years we have responded to an average of 5 ATV accidents a year.

CTERT, like most all volunteer squads, is always looking for new members. We try to sponsor a First Responder class every other year to hopefully add to our roster .

Trustworthy
by Dr. Phil Brown Medical Advisor

Trustworthy. ***Webster's dictionary defines trustworthy as something or somebody "worthy of confidence, dependable." Do you believe Vermont EMS District 6 to be trustworthy in providing pre-hospital care? That is, is Vermont EMS District 6 worthy of confidence, dependable? I imagine your answer would depend upon your perspective. If you're a dispatcher in our district you might conclude "yes"; when a patient calls 911 that patient can with confidence know that somebody will answer the call and that somebody will dispatch an ambulance to the caller's address. From this perspective Vermont EMS District 6 is trustworthy. If you're a select board member in a given town where ambulance transport is available, you might conclude "yes"; every time a need arises for transport in that town, you can conclude that with confidence an ambulance (or backup) rolls out to meet that need. However, what if you're the medical control physician in the CVMC ER listening to the day's EMS radio reports, some well done, some not so well done. You might conclude that as it relates to radio communication with the ER physician Vermont EMS District 6 is "somewhat trustworthy". How about the perspective of the patient who is involved in an MVA who has sustained significant intra-abdominal bleeding injuries, is hypotensive and in desperate need of IV fluid resuscitation and is being transported by BLS EMTs because its 3am on a Sunday morning. That patient would conclude that Vermont EMS District 6 is not providing "trustworthy" care. How about the perspective of the spouse of a patient with severe asthma whose last 2 trips to the hospital resulted in near death due to respiratory failure and who lives in an area not served by EMT's able to perform endotracheal intubation (ie paramedics). I would venture that this spouse might conclude that Vermont EMS District 6 is not trustworthy as it relates to her husband's probable future need for definitive airway management in the field.***

Over the next few issues of the Test Tone I want to devote my "corner" to looking at a few discreet goals which will make Vermont EMS District 6 a more "trustworthy" entity. Stay tuned…Phil

Looking at Ourselves cont'd

with who we are and what we do. On the other hand, EMS people like challenges. We like learning new things. One of the ongoing challenges for emergency services personnel, especially leaders, (and most EMS folks are leader types) is to avoid becoming a prisoner of your own perspective. Try looking at yourself and your service from another perspective. There are lots to choose from. The challenge is to remove your own preferences, predilections, likes and dislikes from the picture and look at things in the cold clear light of day. If you don't see things that need improvement, you're not paying attention.

Look at your service from the point of view of a member of the community who has had no personal experience with your service. How do you think you're perceived? Community awareness is important every day, and especially on Town Meeting day.

How about the view from the newbie's spot – the person who has just joined up as a new member. How about the potential new member - someone who has some spare time and energy and is looking for something to get involved in? How does your outfit look to them? Does it seem like a friendly and welcoming organization or a closed little club? Is your new member introduced around, given an orientation, provided with equipment, and set on a path to becoming a valuable member? Or is he just kind of ignored and left to figure out who people are and how things work on his own?

How do we look to the patients we serve and to their families? How about to our colleagues in the ER, the PD, and the FD? Are we perceived as capable, competent and caring? More importantly, are we perceived as *consistently* capable, competent, and caring?

Consistency is an important goal in emergency medicine. Our patients have the right to expect excellent care *all* the time, not just some of the time. Consistent excellence is a goal for each of us individually as well as for our services and our district. None of us are always at our best, but we can strive to always give our best. As an old partner of mine used to say: "If you're having a bad day, have it on your own time. When you're at work, your patients and your co-workers don't care what kind of a day you're having. They expect you to do your job, do it well, and be pleasant while you're doing it. If you want to be crabby, save it for your day off!" Do we *always* do our best? I know I don't, and I'd guess most of us could say the same. Most of the time, yes, but "*always*" remains a goal to strive for.

Our services need to be consistent, too. How successful are we at consistently providing excellent care? If our service is licensed as an ALS provider, do we provide that level of care 24/7/365, or only when certain personnel are available? Is there always somebody on the crew who knows the service area thoroughly? Do we always have enough people to respond, or a good backup plan for when we don't?

It's useful to look at a service's capabilities in a "worst case" situation. What do things look like on the day when lots of people are out of town or on vacation, and the ambulance is responding with the fewest and least experienced personnel possible? The goal should be for the "worst case" scenario to be almost as good as the "best case" scenario when the most capable and experienced people are available. If it's not, are there policy changes or crew reshufflings that would make the service's response more consistent?

On a larger scale, how are we working in the district, the state, and the country to improve the quality of EMS? It's easy to think in terms of yourself, your crew, or your squad. It's harder to see the big picture and ask the big questions about how we provide EMS as a district and as a state or even as a nation.

Being credentialed to provide medical care is a privilege. We are entrusted by society with the ability to do things that other people cannot. Our patients and their families trust us to do the right thing. We prove that we are worthy of this privilege and trust by subjecting ourselves to evaluation of our abilities. Initially this takes the form of a state examination. Later on in our careers, we need to start examining ourselves, and evaluating what we're doing, how we're doing it, and how we might do it better. Being willing to do this honestly is key to improvement.

A flight nurse friend told me about transporting a 7 year old girl who had been struck by a car and critically injured. The parents were at the scene and understandably very upset. He said, "All they knew was that their little girl might die, and that they were letting people they didn't know load her into a helicopter and take her away. All I could do was look them in the eye and tell them we would do our best. They trusted us to take good care of her – we always need to be worthy of that trust." Willingness to be evaluated, both by others and by ourselves, is an essential part of deserving that trust.

Socrates said that the unexamined life is not worth living. I would say that the unexamined EMS system in one that is missing some opportunities to improve!

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THE TEST TONE

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This publication is for anyone in the District to contribute to and enjoy. We are currently producing the TEST TONE on a quarterly basis. If there is anything that you would like to see in the future please feel free to contact the editor or one of the members , so that we can know how to better serve you.

What is Medical Necessity? Cont'd
By Jim Baraw

. . .physicians and payers, which, in turn, can result in the care provided not meeting the definition. And last, but not least, the decision as to whether the services were medically necessary is typically made by a payer reviewer who didn't even see the patient.

For example, Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. While that sounds like a hard and fast rule, consider that CMS (formerly HCFA) has the power under the Social Security Act to determine if the method of treating a patient in the particular case is reasonable and necessary on a case-by-case basis. Even if a service is reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a national coverage policy, a local medical policy or a clinically accepted standard of practice.

Take a close look at the from next time, ask yourself, is this patient a patient that can go to the hospital by means of personal transportation (personal car) ?

Look at the Medical Necessity Form, and consider what you need to write on your State Run Report. . .

Is the patient confined to bed? Yes/No

Does the patient have other means of transportation available? Yes/No

Does the patient require continuous oxygen? Yes/No

Is the patient ventilator dependant? Yes/No

These are just a few examples of the many things that need to be taken into consideration when reviewing the Medicare reimbursements policies.

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The deadline for the next edition is September 15th for the October issue