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Ideas
Analysis
Insight

Best Practices
IN EMERGENCY SERVICES

PREPARING FOR THE UNTHINKABLE

EMS and fire develop guidelines for responding to active shooter scenarios.

By Jenifer Goodwin

In 2008, shortly after the Virginia Tech shootings, the Arlington County (Va.) Fire Department participated in an active shooter drill with local law enforcement. In a simulation at Marymount University, police followed the trail of dead and dying in the hunt for the shooter, who had barricaded himself inside the library.

Meanwhile, paramedics and EMTs staged in a parking lot more than 100 yards away and waited. "After about 30 minutes, police had the 'bad guy' and had marked the IEDs and brought out one or two injured people," recalls E. Reed Smith, M.D., Arlington County Fire Department's operational medical director. "Two hours later, we were still staged, and most of the injured were still inside. We could see injured people, but we couldn't go in and get them. Myself and the special operations chief said, 'This is ridiculous. We can't just stand around. Why are we not moving in? The threat has been mitigated.'"

Wanting to be able to do more in real-life situations, Arlington County fire and police soon began to work together to develop a plan for responding to active shooter events that would give firefighters access to victims more quickly. Under the plan, rather than wait for police to declare a scene 100% safe, EMTs and paramedics wearing bullet-resistant vests and helmets would enter the building under police escort as soon as police determined there was no obvious threat, such as if the shooter had moved to another area of the building. Calling it Tactical Emergency Casualty Care (TECC), Smith and his team adapted their plan from the U.S. military's strategy for taking care of the combat wounded, in which responders are trained to quickly assess the wounded, dealing on scene only with specific types of life-threatening yet treatable injuries.

"This is paradigm shifting," Smith says. "We accept a lot of risk in the fire service when you go into a burning building or respond to a hazmat call. You mitigate those risks with proper personal protective equipment, the right tactics and the right SOPs. Why can't we

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Quick Look

REPORT RECOMMENDS MINOR CHANGES IN PINELLAS COUNTY

Pinellas County, Fla., has a "world class" EMS system that should not be "fundamentally altered" to cut costs, concludes a report commissioned by the county and conducted by Fitch & Associates. In recent years county officials have raised concerns that rising costs and falling tax revenues were putting the system in financial jeopardy.

In Pinellas County, first response is handled by 14 city fire departments and four fire districts; Paramedics Plus, a private ambulance company operating under the name Sunstar Paramedics, handles transports. Sunstar supports itself by billing for mileage and transports, while the fire departments receive a combined $40 million from the county, or about one-third of their total annual budget, says Bruce Moeller, executive director for Pinellas County's safety and emergency services.

Two years ago, a consultant, Integrated Performance Solutions, recommended cutting costs by decommissioning 25 fire-based rescue vehicles that respond to medical calls but don't transport and eliminating 150 firefighter positions countywide. Not surprisingly, fire agencies balked, Moeller says, and fired back by calling for fire agencies to take over transports from Sunstar.

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WHERE'S YOUR TEAM SPIRIT?

By Keith Griffiths

The laughter was spontaneous, and maybe a little nervous, as our staff sat around the conference table, reading descriptions of themselves and the people they work with. "That is so true—I am a complete freak about planning things out ahead," one of our staffers said. "And you're the opposite," she noted, speaking to a colleague after reviewing his description. "No wonder you drive me crazy." Then she had a flash of insight. "And you probably think I don't have a spontaneous bone in my body!"

The occasion was a company-wide review of what it means to be a highly functioning team, starting with understanding how each of us is hard-wired to see the world in a certain way. If you've been around long enough, you've likely had a personality index assigned to you at some point in your career. In our case, we were using the Myers-Briggs Type Indicator (MBTI). The last time I'd done this was with a different company 20 years ago and it had the same impact—it's as if people were seeing themselves, and their colleagues, for the first time.

One of the best manuals for interpreting MBTI preferences is *Working Together: A Personality-Centered Approach to Management* (available at amazon.com). You can also find MBTI tests online.

We had some fun with the descriptions, but our facilitator drove home serious points: Our preferences for how we take in information, where we get our energy, how we make decisions and our lifestyle result in 16 different personality types in the MBTI lexicon. However, that doesn't mean we're locked into certain behaviors: Yes, our personality type dictates what is natural for us, our fallback position, but it doesn't predetermine every action. As an INSJ (in MBTI speak), I'm an introvert and I recharge my batteries by being by myself, but I've learned to be comfortable speaking in front of groups and being "on"—extroverted—when the job demands it.

Understanding each others' preferences helps build strong teams in a few ways. It fosters openness and trust. It provides a neutral way to discuss different approaches (there isn't one "right" way; there is only your way). It underscores the importance of diversity in terms of making better decisions, and it allows for alignment of strengths with team tasks.

Back to openness and trust. In his great book *The Five Dysfunctions of a Team*, Pat Lencioni holds out trust as the foundation that makes or breaks a team. By trust, he means not just trusting that someone will do what he says he'll do, but having a willingness to be vulnerable—to admit you've made a mistake or need help, and to be confident in the knowledge that others will be sympathetic and non-judgmental. You can trust the team to "have your back."

According to Lencioni, there are five main ways in which members of a cohesive team behave:

- They trust one another.
- They engage in unfiltered conflict around ideas.
- They commit to decisions and plans of action.
- They hold one another accountable for delivering on those plans.
- They focus on achieving collective results.

How does your team measure up? BP

WOMEN WITH TRAUMATIC INJURIES LESS LIKELY TO RECEIVE TRAUMA CENTER CARE

Women are less likely than men to receive care in a trauma center after severe injury, according to a recent study. Researchers in Canada analyzed records on 33,000 women and 66,000 men with an injury severity score of greater than 15, or who died of their injuries within 24 hours of hospital arrival. About 50% of women had received care at a trauma center, compared to 63% of men. Among patients 65 or older, 37.5% of women received trauma center care, compared with 50% of men.

After adjusting for clinical, demographic and socioeconomic variables, severely injured women were 21% less likely to be treated in a trauma center. Separate analyses of women with fall-related or motor vehicle-related injuries found that they were also less likely to receive trauma center care.

The study was presented at the American Thoracic Society International Conference in Philadelphia in May.

RATES OF DEPRESSION, ANXIETY LOWER AMONG EMS THAN OTHER HEALTHCARE WORKERS

Researchers from North Carolina's Mecklenburg EMS Agency and colleagues have found that rates of depression, anxiety and high levels of stress are lower among paramedics and EMTs than other healthcare workers, including nurses, physicians and med students.

The researchers analyzed the results of a questionnaire answered by more than 34,000 paramedics and EMTs renewing their national certification in 2009. About 6.8% of EMS workers reported symptoms of depression, 6% reported signs of anxiety and 5.9% reported high levels of stress. Paramedics and those with 16 or more years of experience were more likely to be depressed and stressed-out than other groups. EMS workers who rated their overall health as poor, who did little exercise and who smoked were also more likely to be stressed, anxious or depressed.

Meanwhile, married paramedics and EMTs were less likely to be depressed or anxious than the divorced, widowed or never married; and women were less likely to be depressed than men. The study is in the July–September issue of *Prehospital Emergency Care*.

PAIN MANAGEMENT BOOSTS PATIENT SATISFACTION ... WITH A CAVEAT

Also reported in the July–September issue of *Prehospital Emergency Care*, EMS patients whose pain was managed effectively are 2.7 times more likely to report the overall quality of care they received was excellent—but only if responders explained the medications being used and their side effects.

Researchers from Mecklenburg EMS Agency and colleagues did a retrospective review of more than 2,700 patient satisfaction surveys collected between 2007 and 2010. Of the patients who rated their pain management as excellent, 79% rated the overall quality of care as excellent, whereas only 21% of patients rated their overall quality of care as excellent if pain management was not excellent.

A closer analysis of the data found that neither controlling pain nor explaining medications was independently associated with a statistically significant higher rating for overall care. However, when patients felt their pain was controlled and that EMTs or medics explained the medications to them, they were more likely to rate their care as excellent. Other factors that affected patient ratings included teamwork among EMS staff and the availability of needed technology.

EDUCATING RESPONDERS ABOUT DEATH NOTIFICATION IMPROVES THEIR CONFIDENCE

Training EMS personnel how to deliver news of a death improves both their confidence and their ability to communicate effectively with the bereaved, research shows.

In a study from Indiana University School of Medicine, 30 paramedics participated in a 90-minute workshop that included a lecture and role-playing in simulated death notification scenarios. Responders were taught a structured death notification method known as GRIEV_ING:

G=Gather Gather the family and ensure that all members are present.

R=Resources Call for support resources such as ministers, family and friends.

I=Identify Identify yourself and the deceased patient by name.

E=Educate Briefly explain to the family the events that occurred.

V=Verify Verify that the family member has died. Use clear language, such as "dead" or "died."

_=Space Give the family space and time for an emotional moment and to absorb what has happened.

I=Inquire Ask the family if they have questions; answer them.

N=Nuts and bolts Inquire about organ donation, funeral services and personal belongings. Let the family view the body.

G=Give Give them your card and contact information. Always return their calls.

After the workshop, participants said they felt more confident in their ability to discuss death with grieving families, while a post-workshop evaluation showed marked improvement in responders introducing themselves, making sure all family members were present when delivering the death notification and using clear language. The only area that didn't show improvement was on providing organ donation information.

The study was published online June 27 in *Prehospital Emergency Care*. BP

— Jenifer Goodwin

IMPLEMENTING PATIENT-CENTERED QUALITY MANAGEMENT

Part 2: The missing 'I': Putting improvement back into the quality improvement equation

By Mike Taigman

It's been 25 years since the EMS world started talking about quality improvement as opposed to quality assurance. During that time we've been preaching the importance of focusing on systems rather than individuals, gathering data and using evidence.

Almost every EMS system has something with the word *quality* in it: a quality plan, a peer review QI committee or a quality improvement manager. Yet when you ask most EMS leaders what their "quality whatever" has made better, shoulders shrug and the subject changes. Somewhere along our path we seem to have forgotten the improvement part of quality improvement.

Around the same time EMS started talking about QI, Don Berwick, M.D., and some colleagues founded the Institute for Healthcare Improvement. They engaged a group of rock star statisticians from Associates in Process Improvement in Austin, Texas, and adopted their Model for Improvement as the vehicle for making healthcare better across America and the rest of the world. This simple yet powerful model holds the key to making things better.

HOW THE MODEL FOR IMPROVEMENT WORKS

The first step is to write an AIM statement. Thousands of costly EMS ideas would be derailed if leaders just stopped and asked their team, "What are we trying to accomplish?"

Take my own example. A couple of years ago, some members of my clinical team wanted to change all of our cervical collars to a fancy new brand whose name shall remain anonymous. They excitedly strapped one on me in the day room exclaiming, "See how much better this is!"

When I asked them, "What are you trying to accomplish?" they said, "Better cervical immobilization." That's when I asked the second question in the model: "How will we know that a change is an improvement?" They looked at me as if I'd just asked them to calculate the core temperature of the sun using a nail file, a broken mirror and an out-of-juice C-battery.

What is the measure of inadequate spinal immobilization? The first one that comes to mind is the number of patients who were able to move their arms and legs before we cared for them who are now paralyzed due to something that happened during care/transportation. So I asked the clinical manager to run a report counting the number of patients each month who had their spinal cord transected during our care for the past two years. There weren't any. In fact, no one could remember that happening in the past 20 years. How many complaints have we had from emergency physicians or nurses about inadequate spinal immobilization? None. How about from patients? None.

Management guru Peter Drucker said, "You can't manage what you can't measure." Dr. Edward Deming, the father of performance improvement methods, used to say, "In God we trust, all others must bring data." If you're not able to measure (qualitatively or quantitatively) what you're trying to improve, it's impossible to know if you've made something better.

I ask this question regularly when visiting with EMS systems that want to add rapid sequence induction (RSI) to their protocols: How many patients per month in your system are unable to have their airway managed and suffer a worse outcome as a result? I've yet to have a single leader show me a graph with this data. If you can't answer this question, then you have no business contemplating RSI.

The third question is where you brainstorm ideas for improvement based on your AIM and measurement criteria—but only after you have completed the first two steps! Too many changes in EMS start with this third step, often after folks return from the exhibit hall at the latest EMS conference.

One clue that an idea has skipped the first two questions is any statement that starts with, "We really need to get [fill in the blank]." Our industry is full of really cool solutions looking for problems, so this is the place to brainstorm improvement ideas. You'll make better progress if you push yourself and your team to come up with at least three, but hopefully more, ideas. Too often we stop after one—or we craft an improvement project around the idea we're most attached to. My favorite is, "If we did everything on the iPad Mini, the world would be perfect."

PUTTING IT INTO PRACTICE

Let's put this model together with a real-world example from AMR's Ventura County, Calif., operation.

Question 1: What are we trying to accomplish?
Answer: Measurably decrease suffering for the patients we serve.

Question 2: How will we know that a change is an improvement?
Answer: A higher percentage of our patient care reports will show a decrease in suffering.

It's important to be specific about how, exactly, measurement will happen, so we will measure this by taking a random sample of 100 patient care reports each month and evaluating them for documentation of the nature and severity of suffering (pain, nausea, shortness of breath, anxiety, etc.); an intervention of some kind designed to decrease the suffering (CPAP, morphine, Zofran, etc.); and a post-intervention reassessment of the suffering. The numerator will be the number of patients in the monthly sample where the PCR demonstrates a reduction or elimination of suffering.

Question 3: What changes can we make that will result in improvement?
Answer: In the case of suffering reduction, improvement ideas might include:

- Adding Ondansetron to the medications carried by crews to treat nausea
- Encouraging non-pharmacologic interventions for orthopedic pain like cold compresses, elevation and splinting
- Changing the morphine dosing protocol from 2–4 mg to a weight-based 0.1 mg/kg
- Expanding the use of CPAP beyond pulmonary edema to asthma, pulmonary infections, CO poisoning, etc.
- Provide myth-busting pain management education that deals with perceived drug seekers, abdominal pain and the limited ability of healthcare providers to assess pain severity using anything other than the patient's own pain rating

MOVING ON TO PDSA

The last part of the Model for Improvement involves a series of Plan, Do, Study, Act (PDSA) tests to learn about the effectiveness of your improvement ideas. For clinical improvements, it is important that only changes supported by the scientific literature be on the list. Improvement ideas that are not supported by science need to be properly researched with full IRB patient protection before they can be considered for use in an EMS system.

The objective of PDSA testing is to learn what really produces beneficial results in your system before anything is implemented. One secret is to start with the smallest, quickest test you can imagine and then do several small, rapid PDSA cycles to quickly learn what works and what does not.

Now, granted, lots of people have written about PDSA cycles over the years and the descriptions can sound a little intimidating. Here's a just-what-you-need-to-know version:

Plan: Briefly describe what you're going to try and how you're going to measure the results, then make a prediction about what will happen. For example, on ambulance 421 B shift, we are going to have them give weight-based morphine to the next patient they have with pain and they will measure the pre-medication and post-medication pain scale. We predict that their 1–10 pain scale will drop at least two points.

Do: Carry out the Plan.

Study: Compare the result with your prediction and capture any ancillary learning. For example: We had a 27-year-old male with a fractured tib-fib from a mountain bike crash. His pain was 7 pre-medication and 2 post-medication. The morphine made him nauseated and the medic thought that it was easy to calculate the dose.

Act: Here you'll do one of three things:

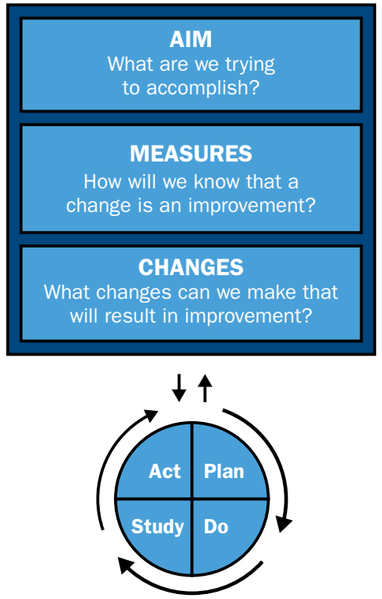
- Adopt the change as successful
- Adapt the change and try another PDSA
- Abandon the change as unsuccessful

In our example we might decide to adapt the weight-based morphine dosing protocol to include the administration of Ondansetron to manage the nausea, provide pain management myth-busting education and encourage non-pharmacologic interventions for pain.

The concept is to continue doing PDSA cycles until your "degree of belief," as shown by the results you're able to produce, indicate that it is time to implement one or more of the changes systemwide. Too often, EMS systems implement interesting ideas without these testing cycles, which is how we got MAST pants, esophageal gastric tube airways and high-dose epinephrine. BP

Mike Taigman is the general manager for AMR's Ventura County and Gold Coast operations. He's also part of the national leadership team for Caring for Maria, AMR's national performance improvement collaborative.

The Model for Improvement



Adapted with permission from *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, by Gerald J. Langley, Ronald D. Moen, Kevin M. Nolan, Thomas W. Nolan, Clifford L. Norman and Lloyd P. Provost.

Q&A
WITH BOO HEFFNER
President and CEO of Falck USA

A former longtime executive with Rural/Metro, Robert "Boo" Heffner made headlines in 2010 when he accused the company of cheating the city of San Diego out of revenues generated by San Diego Medical Services Enterprise (SDMSE). For years, SDMSE was cheered as an example of a public-private partnership done right, benefiting the city, the company and patients. But soon after Heffner's charges were made public, the city auditor issued a report claiming the ambulance company had withheld millions between 1997 and 2007.

After months of investigations, negotiations and media coverage, an independent accounting firm found "no evidence" that Rural/Metro had fraudulently withheld revenue. Rural/Metro agreed in mediation to pay a $1.4 million settlement to cover the city's costs, while the city announced that it would put the contract out to bid. (As of June that had not been done.)

Shortly before bringing his whistleblower suit, Heffner had been fired from his job for allegedly violating the company's expense reimbursement rules. Shocked by what he viewed as a wrongful termination and knowing the city was preparing to audit SDMSE, he says he had to speak out to protect himself. "There were a lot of things I just blatantly and categorically disagreed with. I felt under no circumstance was I going to have any of that laid upon me," Heffner says. "I had been let go by the company, obviously as a complete surprise. From a defensive perspective, I had stayed hush long enough and I felt it was time for the story to be known."

Heffner was out of a job only briefly before being hired by Falck, a company based in Copenhagen, Denmark, that operates EMS, fire suppression and other services in 37 countries worldwide. During the time Heffner was with Rural/Metro, Falck held a 15% stake in that firm but sold its shares when a private equity firm bought Rural/Metro in March 2011. Of Falck, Heffner says, "Our values were 100% completely aligned. I had a close relationship with them over 10 years, and I made the decision very quickly that Falck was the company I wanted to go with."

As the youngest of seven children growing up in Idaho, Heffner became an EMT and paramedic while in college at Boise State. "I fell in love with the career," he says. After graduating with a bachelor's of science in sports medicine, he went to work for Ada County EMS as a paramedic supervisor before leaving for Mercy Ambulance/MedTrans in Reno, where he was promoted to director of operations. In 1996, after Laidlaw purchased MedTrans, he moved to Houston to become divisional CEO of the ambulance companies acquired by Laidlaw along the Texas Gulf Coast. In 1998, he was hired by Rural/Metro as chief operating officer and later became president of the company's West Emergency Services Group.

Having experienced the wave of acquisitions of the mid-'90s, Heffner says Falck is determined not to repeat the mistakes of the past. Then, the big companies snapped up ambulance services, immediately repainted ambulances with their new logo and fired long-time owners and senior staff, he says. That's not Falck's M.O.—the company respects local culture and believes in acquiring companies that are already well run, keeping staff and managers in place, he says.

"I was working for those companies during the roll-ups. I have a saying: I will never teach as I was taught and I would never manage as I was managed," Heffner says. "I finally have been given the opportunity to build an ambulance company on a grand scale using the culture and values of this international company that are so much aligned with me personally."

Heffner spoke with Best Practices *about his EMS career and Falck's plans for the U.S. market.*

Q How did you get the nickname "Boo"?

When I was a kid, *To Kill a Mockingbird* was the biggest movie. Robert Duvall was Boo, and my sister started calling me that. The only time I was ever called Robert was when I was in trouble with my mom. I always know when someone knows me or doesn't know me—they call me Robert if they don't know me.

Q Why did Falck choose to enter the U.S. EMS market now?

Falck has been in the U.S. market for a while through its investments in Rural/Metro. Three years ago, we made the decision to go out on our own because we saw this potential. It finally materialized what the Affordable Care Act would be, and what it would look like, and it was going to change how prehospital care is delivered and reimbursed in the U.S. We've done this in other countries, and done it very well, and we know how to do it. Through our call centers, established transportation networks and resources, we are beginning to implement it here.

Q Falck operates fire services in other countries. Does it have plans to take on that role here?

It never has been Falck's intent to get into the fire suppression business in the U.S. We do different services in every country—if you go to Scandinavia, Falck does roadside assistance sold on a membership basis, like AAA is here. In other countries, Falck's healthcare division provides occupational and preventive healthcare services for companies and individuals. We also have a very large training division, including providing safety training for workers on offshore oil platforms throughout the world.

But you don't come to the U.S., which has, hands-down, the best, most well-established fire suppression service in the world, and say, *We can do it better.*

We do have a very strong intention of building a strong EMS transportation network in the U.S. both on the interfacility side as well as the prehospital 911 side. We feel that we have a great deal to offer in today's economy, in these stressful times for getting reimbursed, on how to partner with different entities to work together to provide the best service.

Q What can Falck bring to the U.S. from its European experience?

If you look at the reimbursement models here vs. Europe, they are completely different. In Europe, Falck has learned to be highly efficient. It's a fixed-fee reimbursement model—you receive X dollars to run the service for a geographic area.

They are also performance-based contracts. In Europe, utilization is watched closely. You have to have enough units to meet the response time standards, although maybe not everybody goes to the hospital. Instead, paramedics determine if they can go out on a preventive basis to check on frequent users and check their blood pressure, etc., and make sure they are doing what their doctor tells them to do. There is a great deal of emphasis placed on preventive medicine rather than reactive medicine. This is what Falck does in Europe that they can bring to the U.S.

Q Some EMS operations are embracing community paramedicine and mobile integrated healthcare, even removing "EMS" from the name on their ambulances. What is Falck's take on this?

There is no doubt the Affordable Care Act is going to change the landscape of reimbursement in the U.S. We are already working on a preventive medicine model in some of our East and West Coast operations. Either via phone or via a physical visit, we're taking high system utilizers and implementing preventive measures to ensure these people are OK. We are working with insurance companies as well as certain healthcare organizations and other entities that will reimburse for such services. The challenge in the U.S. is to prove to the payers that this is the way to go.

As the system sits today, two of our largest payers, Medicaid and Medicare, do not reimburse providers for such services. That's a challenge all providers face. We're putting our emphasis on insurance companies and other payers that have responsibility for these patients and showing them the benefits of preventive healthcare to reduce unnecessary transports to the hospital.

We have non-transport vehicles that are not ambulances that are making some home visits to high system utilizers. But we haven't gone so far as to take "emergency" off of our ambulances, and we're not going to do that. An ambulance is an ambulance, and it's going to be used as an ambulance. And when it's not warranted, we'll use another mode of patient interaction.

Q When Falck purchased Care Ambulance in Southern California in 2010, there was much speculation about whether it signaled the start of another round of acquisitions. Can we expect a repeat?

When we first looked at the U.S., we asked, *Do we go in and purchase one of the big companies and put Falck on it?* But culturally, that wouldn't be the right thing to do. What Falck wants to do is to take the best of the best of EMS management in the U.S. and put together a great company using the Falck core values and business model that has been successful throughout the world.

If you had to take an ambulance company that mirrors the values and service delivery of Falck, it would be Care Ambulance. It is clean, professional and top grade. But most unique is the partnership with fire departments: Fire is the first responder and we work together in a public-private partnership.

When we acquired it, Care was not a company for sale. It was founded in 1961 and run by two brothers who are two of the most honest people you would find in EMS.

The roll-ups of the '90s was a desecration of longtime, family-owned companies that the local communities knew well. If there is one thing that differentiates us from the other roll-ups and the two other large ambulance companies, it's that we've always felt it is imperative that you keep the identity, the culture and the name of the company you acquired. Why come in and get rid of a name like Care and slap a Falck name on it? We don't want to do that. We're going to pick a target that is a lot like we are. We are going to instill our values. But it's not going to be a humungous cultural change, because we did our homework ahead of time.

When we bought Care, I was the single employee of Falck USA. I've never believed in a big corporate structure—I don't believe it's healthy. Falck is a $2 billion company, but Falck USA is a very small corporate entity. I have nine people in our corporate office, and their average tenure with me is 14 years. My entire team worked for me at Rural/Metro; some have been with me since my MedTrans days.

Q Falck has become the third largest ambulance company in the U.S. in a few short years. How did that come about?

After buying Care, we wanted a platform on the East Coast. We acquired Lifestar Response, which operates in seven mid-Atlantic states. With those two platforms, we began our organic growth. The word got out: Falck is in town. People started asking, *What's Falck? What are their intentions?* We had a lot of people who wrote articles who never picked up the phone to ask. They drew their own conclusions.

On both of the early acquisitions, we kept the owners in place and the

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> "Under no circumstances is it our objective to be the largest ambulance company in the U.S. It is our objective to be the best and prove to the EMS community that a large private ambulance provider can be successful in the U.S. for a long period of time."
>
> *— Boo Heffner*

management in place. We then acquired Cape Cod Ambulance, a company that's been around for a very long time. We took a career firefighter in Cape Cod and made him the general manager. We then acquired American Ambulance in Florida. Over the next two years, we acquired five companies. We are now operating in 14 states.

Q It sounds like you have some bad memories of the wave of acquisitions.

It was cultural genocide. The new bosses would come in and say, *Guess what? We're in charge now.* We saw a lot of great people from the industry who were basically gone. What I observed was that a lot of vendettas were settled. If you were the acquirer, you got rid of some people, downsized and settled some old scores. That happened from management all the way down to the field level.

The people who work in Orange County, Cape Cod and elsewhere are the fabric of the community. You don't come in and do that to the fabric of the community.

Q What is Falck's long-term objective?

I mean this from the deepest of our hearts: Under no circumstances is it our objective to be the largest ambulance company in the U.S. It is our objective to be the best and prove to the EMS community that a large private ambulance provider can be successful in the U.S. for a long period of time.

When we acquire an ambulance company, we retain the owners, the management and the culture. We allow them to prosper and grow with the resources that an international company brings. We also allow the owners of these companies to make an investment in the company they sold for the betterment of the company down the road.

Falck funds 100% of our acquisitions and capital expenditures out of our own operating cash flows. We don't rely on private investment. The majority of our company is owned by two Nordic-based nonprofit foundations that take their proceeds and distribute them in the form of grants to healthcare and research entities. That's significant because traditionally in the U.S., roll-ups have been held by private equity or publicly traded firms. We are a 107-year-old company. We're not flipping the company. We are long-term players.

Q What's next for Falck?

We are in play against our regional and national competitors. We consider ourselves to clearly be a very formidable competitor in municipal contracting and large institutional contracting. The only caveat is we will not bid against a municipal fire department that is providing transport services themselves. Communities are stretched right now, and we're not going to go in and undercut them. However, if the fire department and the fire union said, 'How could we build a public-private partnership?' we'd do it.

We've also done greenfield startups in communities that haven't met our criteria for acquisitions. ['Greenfield' is a term for starting a business from the ground up. It's believed to come from the construction industry, referring to buildings constructed on what were green fields.] We did it in the Seattle-Tacoma area with Falck Northwest, where we're currently doing critical care and BLS interfacility work and 911 work. We've also done that with Falck Northern California and Falck San Diego, where we're currently doing interfacility and critical care work in and around San Diego. We're waiting for the city of San Diego to put the city 911 contract out to bid.

Q You played a critical role in both the creation of the San Diego model and its unwinding. What are the lessons learned?

It's very sad. We currently have some excellent public/private partnerships that are unequivocally transparent, but what happened in San Diego gave the perception that it can't work.

You can't be as financially tied to the hip as SDMSE was. You have to be careful who you go into business with. You have to have excellent controls in place to ensure that everybody knows what's happening, and you have to be able to account for every cent that comes into the system. In San Diego, the patient care was second to none. But the further you can distance yourself from financial intertwining, the safer and better it is.

Q How has this affected you personally?

I look back on it now and realize that as difficult as it was to go through, it was the best thing that ever happened to me. With Falck, I was given what I always wanted, which was the ability to prove that a large nationwide ambulance provider can be a great company and it can work. And I don't have the day-to-day interference of outside parties. There is a great deal of autonomy but a great deal of responsibility. When you have a large number of shareholders and people who are financially incentivized to make decisions, sometimes wires can get crossed. The values at Falck are different. BP

— Jenifer Goodwin

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bring that concept to an active shooter incident and use law enforcement for law enforcement and us for the medical stuff, and have the fire department assume some risk and use the skills that save lives?"

Though Arlington County is at the vanguard of planning for active shooter events, they're not alone. Fueled by a seemingly endless string of deadly shootings in schools, universities and movie theaters—as well as a growing urgency in law enforcement and the federal government to do more to thwart these tragedies—some individual agencies and large fire and EMS organizations are beginning to ask hard questions about how EMTs and medics can better respond to active shooters.

The U.S. Fire Administration is preparing a detailed operational guide for responding to active shooters. And in April, the International Association of Fire Chiefs (IAFC), the International Association of Chiefs of Police (IACP), the FBI and the Department of Homeland Security (DHS) held a summit at the IACP's Washington, D.C., headquarters to discuss improving active shooter response.

"One thing we hear from physicians is that a lot of patients in active shooter situations can be saved," says IAFC CEO and executive director Mark Light, whose organization is preparing a position statement on the importance of developing active shooter response plans. "It's critical we know how to do that."

Yet significant gaps remain. In February and March, the IAFC conducted an online survey about how fire departments prepare for active shooter events. The survey found:

- 75% of respondents didn't have specific response protocols in place for active shooter incidents.
- About 44% of those that didn't were working on protocols or had plans to start developing them soon.

"We were surprised by the large number that didn't have operational plans to address this, given the high visibility of the shootings," Light says.

The National EMS Management Association is watching the fire service's efforts closely, says Ryan Greenberg, a NEMSMA board member who attended the meeting and is heading up an initiative to develop active shooter response best practices. "In many of the situations we respond to, our jobs and our roles are independent of each other," he says. "Now we are getting into situations where our jobs are dependent on each other. We need law enforcement to secure an area. Law enforcement needs us to care for patients. We need law enforcement to get patients to us or get us access to patients. And we need law enforcement to ensure our safety while we're caring for those patients."

Interest in EMS's role in active shooter response extends to the White House. President Obama's plan to reduce gun violence, issued after the shootings at Sandy Hook Elementary in Newtown, Conn., directs DHS to seek the input of first responders on best practices for improving preparation and response to mass casualty shootings. Also this spring, Greenberg was one of more than 100 fire, EMS and law enforcement representatives invited to attend a conference led by Vice President Biden on reducing gun violence, during which guidelines to help schools, universities and houses of worship respond to active shooters were released.

"The release of these documents brings tremendous opportunity for EMS systems across the country to become more involved and better prepared in the event we have to respond to such an event in our own community," Greenberg says.

It's about time that fire and EMS get prepared, Smith says. "We spend millions upon millions of dollars for WMD preparation, which more than likely isn't going to happen," he says. "Bombs and bullets kill the most people. Acquiring them is easy, it's inexpensive and anybody can do it. That's why you see it happening all the time—and yet there is very little training for fire and EMS to deal with it."

FOLLOWING LAW ENFORCEMENT'S LEAD

Years before the term became known to fire, EMS and the community at large, police were already well acquainted with the term "active shooter." Law enforcement defines an active shooter as an individual actively engaged in killing or attempting to kill people in a confined, populated area using a firearm and sometimes other weapons.

Traditionally, police response was based on experiences with hostage situations. The assumption was that the perpetrator was after something specific, like money, or the release of political prisoners. "The thinking was the bad guy didn't want to kill people," Smith says. So police would seek to control the scene, call for the specialists—SWAT—and try to communicate or negotiate with the suspect.

But the 1999 shootings at Columbine High School changed all that. On a spring morning, two students armed with rifles, shotguns and homemade bombs gunned down 13 people and wounded 24 before committing suicide. Officers responding to Columbine did what they were trained to do: set up a perimeter to contain the shooters and wait outside for SWAT.

Read more about Arlington County's Tactical Emergency Casualty Care at c-tecc.org.

Over the course of 45 minutes, the teens stalked the hallways of the school. It was nearly an hour after the first shots were fired that SWAT entered the school and four hours before all students and teachers were evacuated. One of them, a teacher, bled to death 3.5 hours after he'd been shot, still inside the building. His students, hiding in a science classroom, held signs up to the window telling police he was dying.

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Fueled by a seemingly endless string of deadly shootings in schools, universities and movie theaters—as well as a growing urgency in law enforcement and the federal government to do more to thwart these tragedies—some individual agencies and large fire and EMS organizations are beginning to ask hard questions about how EMTs and medics can better respond to active shooters.

"Because of Columbine, the police community realized the tactics and the concepts were flawed," Smith says.

Police response to active shooters underwent a fundamental change. Instead of waiting for SWAT, the first patrol officers to arrive on scene are taught to enter immediately, usually in teams of four. They're trained to step over the dead and wounded, follow the sound of gunshots and pursue one objective: stop the shooter any way they can to prevent further mayhem.

The shift in police tactics took hold quickly. In the 2001 Santana High School shootings in Santee, Calif., officers were inside the school within moments. According to news reports at the time, they captured the 15-year-old shooter within six minutes of the first shots being fired.

Yet even as police response changed, Smith says, fire and EMS largely didn't, and continued to stage on the perimeter of such incidents. One reason EMS hasn't changed is that no one has demanded it, he adds. "The police were faulted for what they did in Columbine. We have never been faulted for it," Smith says, "although you are starting to hear some discourse on the EMS response, particularly involving Aurora."

On July 20, 2012, 12 people were killed and 58 wounded when a lone gunman opened fire during a midnight screening of the film *The Dark Knight Rises*. According to a fire department internal review released in May, fire engines attempting to get to the injured were stuck in gridlock by parked cars, police vehicles and 1,400 fleeing moviegoers, while other engines and ambulances sat idle in a staging area. The review found that it took 17 minutes for fire dispatchers to tell EMS that there were victims inside the theater who needed medical attention, even though police officers had been telling police dispatchers they needed medical help for seven minutes before that.

ROOM FOR IMPROVEMENT

In Arlington, the basic plan for firefighter response to active shooters goes like this: During an active shooter incident, the first team of four police officers enters the building to hunt for the shooter. As additional officers arrive on scene, they, too, enter the building in teams of four, going room by room and hallway by hallway looking for additional shooters or explosive devices.

Under TECC, a third wave—teams of two medics or EMTs partnered with two police officers—enters after an area has been declared cleared—meaning there is no obvious threat—but before police conduct the methodical search that can take hours to declare a scene safe and secure. Called a rescue task force, additional teams of police and EMTs or medics would enter depending on conditions and the number of victims.

"It can't be a specialized team—it takes too long to get them there," Smith says. "The people who are dying are going to be dead."

Among the injuries responders treat immediately on scene: stopping bleeding using tourniquets, closing open chest wounds and treating tension pneumothorax. "It's doing quick things to save the ones who are savable," Smith says, citing research from the Vietnam era that estimates about 15% of battlefield mortalities could have been avoided by relatively simple steps such as stopping hemorrhaging with tourniquets.

Precisely what would be done on scene depends on the level of threat, according to the TECC guidelines. But generally speaking, responders move on to the next patient as soon as one is stabilized. Likewise, any injury that isn't immediately life-threatening waits until the victim can be evacuated outside to additional EMS personnel.

In developing the plan, Smith borrowed heavily from the military's Tactical Combat Casualty Care (TCCC) while adapting it to reflect civilian constraints such as liability, scope of practice and medical protocols.

The IAFC's position statement will outline other key considerations for fire and EMS, including the need for joint training and using consistent terminology when developing plans so that the various responders are speaking the same language on scene. "In the fire service, when you say, 'All clear,' it means they have searched the floor and there are no victims," Light says. "When police say, 'All clear,' does that mean no victims or no shooter? There needs to be integrated planning and practical exercises across all disciplines."

Another key point is getting support and cooperation from police. With one fire and one police department serving an area spanning 26 square miles, Arlington was able to get law enforcement buy-in quickly. But in areas where various jurisdictions overlap, that can be more complicated. In Prince George's County, Md., for example, the fire department covers an area that's served by 21 police departments, Light says, meaning there will be lots of legwork to get everyone on the same page of an active shooter response plan.

Another consideration is making sure firefighters or EMS responders don't get mistaken for a shooter. To alleviate those worries, Smith and his team worked out a system of communications in which police would use one channel to relay information about the scene and the shooter to the command center, while fire would use a second channel to communicate medical information, making sure that everyone is using the same terminology and that command knows exactly where everyone is in the building at all times.

PREPARING FOR THE UNTHINKABLE

As fire and EMS grapple with how best to respond to active shooter incidents, one central question is just how much risk responders should be expected to take on. While many Arlington firefighters eagerly embraced the active shooter guidelines, some were afraid they would be put in harm's way, according to Smith.

But by entering only "warm" zones, going in with police and wearing proper protective gear, Smith believes the risk is minimal—especially when compared to other risks that EMS and firefighters take on as part and parcel of their job. "What kills more firefighters every year? Fighting fires," he says. "What kills EMS? Turning on lights and sirens."

One thing is unfortunately clear: Active shooter killing sprees will likely continue. Between 2006 and 2012, there was an average of 15 incidents in the U.S. annually in which two or three people were killed, according to a study by the New York City Police Department. And although these incidents are relatively rare, they can happen anywhere, anytime, in big communities and small, Light says. He likens preparing for active shooters to the firefighters who responded to the recent 777 crash at San Francisco Airport. "That will hopefully be the only large-body jet they will ever see crash," he says. "But some of them trained their entire career, 20 or 25 years, for that." BP

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The Fitch report, a draft of which was released May 28, recommended against the earlier consultant's proposal and the fire departments' proposal. Cutting 25 rescue vehicles and laying off firefighters is too extreme, the Fitch report says. "Pinellas County fire and EMS are not in a state of disrepair that would require such a drastic cut," the report reads. Nor would the fire agencies' proposal work, according to Fitch, as that plan would lead to "unrealistically high and dangerous" crew workloads and unit hour utilizations on fire agencies' transport units.

Instead, Fitch recommends a third plan, called "CARES," or Community-wide Alignment of Resources for Efficiency and Service, which suggests minor tweaks to put a lid on costs. Under the Fitch plan, 19 fire-based rescue vehicles would have their shifts cut from 24 to 14 hours, eliminating excess capacity in the middle of the night, Moeller says.

A second part of the Fitch plan suggests trimming costs by changing who responds to the 24,000 annual low-acuity Alpha and Omega calls. Last year, county staff had proposed having only Sunstar respond to low-acuity calls, the rationale being that it was overkill to send both a fire truck and an ambulance to minor medical issues.

But in something of a surprise, the Fitch analysis says that fire agencies are better positioned to serve as first responders for Alpha and Omega calls and should call for Sunstar only if the patient needs transport. "Here in Pinellas County, we all agree that fire and EMS don't both need to go to those calls—we just didn't agree on who should," Moeller says. "The county said Sunstar should go. Intuitively that made a lot of sense, but when Fitch did its study, they had a surprising finding. They said that Paramedics Plus is very, very efficient, and they don't have much excess capacity, but the fire departments do. Fitch said the fire department should go because they have excess capacity."

Fitch, which was paid about $300,000 for its analysis, estimates its plan would save a modest $6.3 million annually, or about 5.5% of the overall $112 million EMS budget, without jeopardizing clinical excellence. The plan was approved by the county board of commissioners, which also serves as the county EMS authority, at the beginning of August.

NAME CHANGE FOR EMSC, NEW CEO FOR AMR

Emergency Medical Services Corporation, the parent company of American Medical Response (AMR) and other health-related services, recently changed its name to Envision Healthcare Corporation.

"The new name better represents our service lines and offerings," says Ron Cunningham, director of marketing communications for Envision Healthcare Corp., which is based in Greenwood Village, Colo. "Emergency care is still a very important part of our service offerings, but it is no longer the only service we offer."

Also in June, Edward "Ted" Van Horne became AMR's new president, replacing Mark Bruning, who left in January. Van Horne began his career in EMS 24 years ago and has served in senior management positions at AMR since 2003. He holds a bachelor's of science degree from Rochester Institute of Technology and an MBA from the University of Phoenix. BP

— Jenifer Goodwin

SOME CLARITY ABOUT LEADERSHIP DEVELOPMENT

By John Becknell

Last month I wrote about a smart and talented young EMS supervisor named Jason who has little interest in leadership. He sees little he wants to emulate in the bosses running his agency and the so-called leaders at the forefront of the industry. I concluded that we need to do a better job of guiding a new generation of young people into leadership. Getting clear about what leadership is—and is not—and reflecting on our own leadership may illuminate some needed changes.

The term *leadership* gets thrown around a lot these days. From NEMSMA to NAEMT, IAFC, NASEMSO and the AAA, there is much talk about the need for leadership development in EMS. But here is where the confusion starts: If you listen closely, there is wide variation in what's being talked about. Some are talking about the knowledge and skills needed to manage an EMS operation such as budgeting, deployment strategies and human resource management. Some are talking about mastering a set of officer competencies. Others are talking about creating a ladder where field providers can move from the field to supervision to management and so on. But there is little clarity about what leadership is—and, consequently, little clarity about how to develop leadership in others.

To stir the pot around this topic, consider the following questions: Does calling someone a leader make them a leader? Can someone manage an EMS agency without providing leadership? Does the title of director, administrator, manager, supervisor, executive or chief guarantee leadership? Are most EMS agencies truly led or simply managed? Is your state EMS director providing leadership of EMS in your state? Are the people tasked with leading EMS in the federal government exercising leadership? Is the head of your association actually leading the members somewhere? Is that charismatic speaker at the national conference a model of leadership?

Many are called leaders, but there is often a wide gap between the title and the actual practice of leadership.

The need for leadership shows up when there is a need for a group of people to collectively move toward a goal or destination. The acute need for leadership is often most visible in crisis. But the need for leadership shows up daily when something impacting a group needs group action to change, be different, be improved, be created or be stopped. Leadership then is a process of identifying a goal or destination coupled with a process of influencing others to action toward the achievement of the goal or destination. At its most basic level, leadership is about seeing ahead; it's also about social influence.

Most of us would agree that EMS would benefit from having more people who actually see ahead, describe a compelling vision of the future and inspire others to put their best efforts toward achieving that vision. We especially need leadership that is not self-serving and has more than a personal career at its center. We need leadership that serves the basic missions of the organizations and groups being led and leadership that is benevolent and fully engaging to followers.

The development of leadership requires learning, but it also requires modeling and mentoring—which means those of us who would develop leaders need to reflect on how we personally show up as leaders.

So I end this with some personal questions. If a young EMS millennial came to you wanting to learn more about leadership, could you adequately define leadership for him or her? Could you help them clearly distinguish leadership from management? Is your own practice of leadership a model worthy of followership? If you were to mentor someone in leadership, could you point to your own successes in influencing others toward a destination?

In answering these questions we will discover how we might better lead a new generation into a positive and compelling view of leadership. BP

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