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AVIATION TOOLBOX

Saturday, September 1, 2007

Emergency Medical Service: Justifying the Helicopter

IN WEIGHING WHAT HOSPITAL EXECUTIVES should consider in deciding whether investment in a helicopter air ambulance is justified, you are confronted with a fundamental question: why bother?

After all, there hasn't been a new, hospital-based helicopter program launched in the United States in a decade or so, experts in the field note. The trend is heavily toward independent operators setting up community-based programs that work ad hoc with area hospitals or migrate over time to closer and more formal working relationships with them. Neither federal reimbursements or private insurance practices seem likely to increase the margins of health care in general, let alone overhead-laden operations like a flight program.

That is all certainly is true. Yet there are plenty of good reasons to explore whether an air medical program makes sense for a health care facility, a reality highlighted by continual queries from hospital managers on the matter. Consider a few examples.

The high costs of health care force many smaller hospitals to shut down. They are replaced in suburban and rural communities by even smaller, understaffed emergency-care facilities that have little capability or capacity and less appetite for complicated cases, let alone severe ones. Staff at such facilities are quick to call for transport of such patients to higher-level care facilities, by air if available, by lengthy ground-ambulance runs if need be.

Steady advances in the technology of health care make more successful interventions available to wider groups of patients, both acute and chronic. The helicopter emergency medical service industry may have sprung from the lessons of the Vietnam War about trauma care and widespread understanding of the critical "golden hour." But today advances in cardiac, pediatric, and neo-natal care mean the patient in the back may have suffered no trauma at all. With pharmacological advances such as thrombolytics, for instance, that patient may have suffered a stroke, the ill effects of which might be reversed entirely with a speedy transport. The potential of technological advances is nowhere near exhausted.

While hospitals may opt not to have any sort of flight program, they have an abiding interest in the quality of clinical care provided to patients who may arrive at their facilities entirely or in part by air. The best way to assure that quality may be a sound working relationship with the local flight program or programs.

Those factors, combined with regionalization of health care, may mean a large medical center discovers numerous

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reasons for increasing professional links with smaller, outlying facilities that hinge on swift transport of patients among them.

For these and other reasons, experts say, savvy hospital administrators should always have a fresh and detailed grasp of how an air medical program might support their institution's goals.

"There's a matrix of questions you have to address" toward that end, said Ed Marasco, senior vice president of air medical services for CJ Systems Aviation (which is being bought by Air Methods Corp.). He spent 13 years as a hospital administrator and customer of air medical services before joining CJ Systems. The first questions to start off with are: "Does the community need the service of an air medical program? Are we the right entity to provide it?"

He said he is contacted once a month or so by some hospital executive weighing the question of starting or expanding an air medical program or dropping or altering the one in place.

In today's marketplace, there are many different structures of air medical programs to use as models and many entities to assist in doing that.

When the civil air medical business was born in the 1970s, programs were set up by hospitals looking to bring new levels of care to their community. By the end of that decade and into the 1980s, medical facilities were coming to see helicopters as a means of enhancing their revenue. That spurred much growth in air medical programs, said Craig Yale, vice president of business and corporate compliance for Air Methods's LifeNet Div.

Under Medicare payment schemes then, hospitals had an advantage if they were big and could achieve efficiencies of scale. Larger hospitals needed ways to get patients to them, so they were willing to accept helicopter programs as loss leaders.

"They were looking for ways to get a larger catchment area and to bring in more patients," Yale said.

Yale helped on the hospital side to set up one of the United States' first air medical programs, Flight for Life in Colorado Springs, Colo., working with Rocky Mountain Helicopters. He later went to work for Rocky Mountain, joining Air Methods with its acquisition of that company.

In that era, branding became a catch phrase and a helicopter was seen as a flying billboard for a hospital seeking to put its name before the community.

By the 1990s, that all was changing.

Changes in federal health care reimbursements and private health insurance practices limited hospital revenues, forcing them to focus on containing costs. Hospital administrators were less inclined to accept flight programs as loss leaders because they brought more patients requiring extensive treatment to the facility.

"Why are we sponsoring this program when we're losing \$1-2 million to do it?," was a common question, said Ed Eroe, president of the Assn. of Air Medical Services, which this month convenes its annual Air Medical Transport Conference in Tampa, Fla.

Flight programs by their nature are largely fixed-cost operations. Fixed costs include those for the aircraft, maintenance, insurance, staffing, and facilities.

Eroe is a partner and CEO of MedServ Management Services in Overland Park, Kansas. He's familiar with the hospital side of the debate, having started the INOVA Air Care program in the Virginia suburbs of Washington.

The flying billboard also became less relevant as patients began coming to hospitals through regional alliances or

agreements with insurance programs.

Those trends led to the development of so-called community-based programs, set up independent of a medical institution. Eroe said AAMS' membership today is split evenly among traditional hospital-based services and community-based programs. As recently as the early 1990s, community-based programs were almost unheard of.

In traditional, hospital-based services, an aircraft operator provides aviation services under contract to a hospital, which typically provides the medical crews.

In community-based programs, the aircraft operator provides the aviation and medical services, earning revenue from insurance payments for patient transports or a combination of that and subscriptions for their services from community residents.

The community-based operator develops the service area, focusing on finding operational efficiencies such as using regional management structures and communications centers and hiring local medical crewmembers rather than those in what may be the hospital's higher-priced metropolitan area. Such programs also may avoid the burdensome labor rules of a big medical facility.

A third model of a flight program is the interim program, in which the operator provides the aircraft, but the hospital chooses to provide oversight of the medical aircrew and the care they provide. In some cases, the operator contracts with the hospital for that oversight.

The quality of patient care is a real concern for many medical facilities, whose staffs feel it must be consistent with the institution's mission and standards.

"This is a very big issue," said Eroe. "They want to have that influence and control. It is still a very big thing."

The institution sponsoring an air medical program is pushing that the flight care is an extension of the clinical care provided in the hospital. "That's how they initially justify the program."

But with the changing nature of health care, the question becomes how do you continue to justify it.

"Why do I have to do this program?" Eroe framed the question. "It still gets down to the pushback from the clinical staff, the receiving physicians," who ask whether an independent program will have the same standards as the hospital. "That's a big part of a hospital-based program."

But hospital executives have to figure out how to provide that level of care in a fiscally responsible way.

This is not a question isolated to helicopter operations.

"These days hospitals are faced with such questions in many areas: security, food service, plant maintenance," said CJ's Marasco. Nearly every health care institution is searching for means of becoming more efficient and focusing on core businesses.

Despite the fiscal pressures, some hospitals with traditional programs are choosing to remain in business and expand their operations, said Air Methods' Yale. That is due in part to the fact that the hospitals are now charging much more consistently with what the service costs them. He cited Tennessee's Vanderbilt University Hospital as an example.

Hospitals particularly stick with an air medical program if they perceive a strong niche for that service.

"Helicopters make sense if the flight program is tightly tied to a hospital's image and mission," Yale said. "They may get their volume up to cover costs. They may subsidize the flight program to fulfill mission the hospital's mission."

Survival Flight at the University of Michigan Health Systems in Ann Arbor, Mich. is one example of that.

"Survival Flight is truly an extension of the health system," said Denise Landis, a registered nurse and manager of critical care transport at the operation.

Survival Flight does a high volume of pediatric, cardiac, and neo-natal transports. It does 1,400 transports are year.

"We do a lot of the newest technology," she said. The program just started doing nitric-oxide transports of severe pulmonary cases. "We have a lot of niches. We're not here to compete with ground ambulances. Only 10 percent of our transports are scene calls. Everybody we transport is going to our acute care — 99 percent go to ICU or the ER." Some transports are low-volume, but high-risk cases

"Nobody can do these transports" in Michigan but Survival Flight, she said.

The program flies with teams of two nurses and has invested heavily in their education. All 20 flight nurses are dual licensed as paramedics.

Another example is the CareFlight program at St. Mary's Regional Medical Center in Grand Junction, Colo. Dustin Duncan, a registered nurse, is its program manager and chief flight nurse. The program flies a Bell Helicopter 412EP, which Duncan described as "the most expensive rotorcraft to operate. But it's the only aircraft for our mission," which is to cover an area that he called "rural meets frontier. Grand Junction is the largest city between Denver and Salt Lake City. We truly are a regional resource."

That, he said, is how hospital management views the program. The 412EP is fitted with performance-enhancing Boundary Layer Research strakes. The program in February 2006 upgraded to night-vision goggles, and has bought helmets and four flight suits for all its crewmembers. It also put Outerlink's flight tracking and communications system on, and since then has figured out a way to bill off Outerlink. "For 20 years, we were billing as crow flies," Duncan said, "and underbilling as much as 10-12 mi for a flight."

St. Mary's owns the Bell but farms out its operation. "Long-haul, we don't feel leasing an aircraft through the traditional model made sense," Duncan said. As for not having its own operating certificate, "the hospital's in the health care business not aviation business."

The program also benefit

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