

First Responders

Selling in the EMS market? Expect ride-alongs, even fly-alongs.

There are a number of differences between selling to EMS agencies and selling to hospitals. “The biggest one is how much more fun it is,” says Dan White, EMT-P. EMS agencies have fewer layers of decisionmakers, and they’re quick to adopt new, innovative technologies, he says. “If they can see patient benefit and they can afford it, they’ll buy it.”



When a person becomes ill or injured and dials 911, the call is answered by an EMS dispatcher, who is trained to obtain key information from the caller about the location and type of emergency, according to the National Association of Emergency Medical Technicians. The dispatcher also may give the caller patient care instructions while sending emergency responders to the scene. Responders include emergency medical technicians (EMTs), advanced emergency

medical technicians, or paramedics. Care may be provided by private ambulance companies, fire or police departments, a public EMS agency, a hospital or by a combination of these. EMS practitioners may be paid workers or community volunteers.

Every state in the United States has a lead EMS agency or state office of EMS that determines requirements of EMS professionals in their state, according to NAEMT. Some state EMS offices issue licenses to EMS practitioners; others do not. All EMS practitioners are required to complete continuing education classes so they can stay current in medical treatment standards and protocols.

The training level needed for EMS practitioners is also a state decision, according to NAEMT. Each level of practitioner is trained to perform different skills to assist patients, and all work under protocols approved by a physician medical director. EMTs can perform cardiopulmonary resuscitation, artificial ventilations, oxygen administration, basic airway management, defibrillation using an automated external defibrillator, spinal immobilization, monitoring

of vital signs and bandaging/splinting. They also may administer nitroglycerin, glucose, epinephrine and albuterol in special circumstances. A paramedic can perform all of the skills performed by an EMT-Basic, plus advanced airway management such as endotracheal intubation, electrocardiographs, insertion of intravenous lines, administration of numerous emergency medications, and assessment of ECG tracings and defibrillation.

The fastest car in town

The emergency medical services market – sometimes called the pre-hospital market – is a multilayered one. A recent news report described it as a “patchwork of ambulance models run by private companies, hospitals and governments.” And in a sense, it is.

The first EMS providers were funeral homes, explains Don Lundy, BHS, NREMT-P, president-elect of the National Association of Emergency Medical Technicians. “They had the fastest car in town, and you could lie somebody down in it.” Eventually, local governments intervened, in an attempt to impose some kind of standards on emergency medical services. “They didn’t even call it EMS,” says Lundy, who is EMS director, Charleston County (S.C.) EMS. “They called it the ambulance service.”

In some locales, government officials decided the fire department should take the lead, others decided the local hospital should do so, and still others decided that the local governmental entity itself, or private enterprise, should be the primary EMS provider. “So there are different delivery models, depending on where you live,” says Lundy.

Is it a patchwork? Maybe, says White, with some qualifications. “The word ‘patchwork’ has a negative connotation,” he says. “In reality, these systems differ from one area to another. The geographies and revenue streams differ.” For example, a rural squad might face funding issues, while a squad in a large urban area may enjoy substantial tax base support. Some squads are staffed by volunteers, while others employ their workers.

White has sales and marketing experience with a medical device manufacturer, and was director of corporate planning and product development for a distributor. He has been continuously certified as an emergency paramedic since 1977, and a certified EMT, paramedic and Advanced Cardiovascular Life Support (ACLS) instructor since 1981. He has designed several emergency medical products.

“We don’t have statewide models, and we don’t have a national ambulance system,” he says. “We have a variety of different models that are tailored to the political and revenue support for the particular region or geography. But I’m not sure I would use the word ‘patchwork’ to describe it.”

“With EMS, you can step into one city and then another, and have two entirely different ambulance or delivery

systems,” says Lundy. “[In one, the responder says], ‘We have to take you to this hospital,’ and in another, they say, ‘We will take you to the hospital of your choice.’ Neither is good or bad. The delivery system is not as important as the commitment of the people who run the system, the people on the street, and the politicians who oversee it.”

Fire departments

Fire department involvement in EMS has been increasing consistently over the past 20 years, says White. One reason is capacity. “There are fewer fires today than 20 years ago. We have better building codes, more smoke detectors. So there are fewer responses for actual fires.” That’s why in many localities, fire trucks are first on the scene of medical emergencies. Firefighters, equipped with defibrillators and trauma equipment, can stabilize patients until a paramedic arrives.

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Some municipalities and counties have trained policemen and policewomen to respond to emergencies, augmenting the efforts of firefighters and other emergency medical personnel, points out Julia Onesto, EMS office manager for MMS-A Medical Supply Company. It’s a more efficient use of personnel, and it improves emergency response times.

Technology

Typical products and equipment carried by EMS professionals include those for airway management, CO₂ screening, vascular access, patient handling and transport, infection control and hemostasis.

EMS-related technologies usually go through an evolutionary path, says White. They are introduced with one application in mind, then EMS practitioners discover more uses for them. Often, these technologies later find their way into the acute-care environment. An example is capnography.

A capnograph measures exhaled carbon dioxide, and lets the responder know that an endotracheal tube has been correctly placed, he explains. (An absence of CO₂ means the tube was incorrectly placed, and the patient is not breathing.) “But we’ve learned that capnography can do a lot more,” he says. For example, wave length capnography is a good indication of perfusion, that is, delivery of blood to the capillaries. And responders have learned that the presence of CO₂ following cardiac resuscitation is a sign that the patient was successfully resuscitated.

Pulse oximetry followed a similar path, says White. “Twenty-five years ago, the pulse oximeter was put on the

come along for the ride. EMS directors meet regularly at state association meetings – another great meeting spot.

“In the hospital market, it’s often hard to get to the decision-maker or talk to someone without getting thrown out or having to register with [a vendor credentialing company],” says White. “But with EMS, you can pull over and talk to the ambulance squad. They don’t mind seeing a new face. They don’t mind talking to you, unless it’s a very busy urban service.”

When White was breaking in a new territory in Pennsylvania 20 years ago, he “followed the blue ‘H’ sign to success,” he says. He’d hang out at hospital emergency rooms

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finger of patients showing signs of respiratory distress. Today, it’s almost the fifth vital sign. Almost everyone has oxygen saturation measured in the ambulance.

“Some of the more innovative diagnostic devices grew in use much more quickly in the EMS world than in the hospital, because paramedics saw the value and got approval to use them from the medical director,” he says. “It almost got to the point where ambulances were coming to the ER with people on pulse oximeters, and the emergency room nurses were asking, ‘Why don’t we have one? Why do we have to call respiratory to come down and measure [oxygen saturation]?’”

Blue ‘H’ sign to success

Sales reps eager to penetrate the EMS market will find it’s relatively easy to meet prospective customers. “You need to go to the local emergency medical services, maybe a volunteer first aid squad that’s having a chicken roast that day,” says Lundy. “Or you might go to an EMS office where the director is rushing out the door to make a call.” More times than not, that director will invite the rep to

and strike up a conversation with EMTs there. “That’s one thing I’d recommend to [sales reps]. Take a minute, go back to the emergency room. Ask if [the EMTs] will show you their ambulance. You’ll find yourself getting a tour.”

Onesto believes that the EMS market is an exciting one, and that sales reps – who often get invited by EMTs for ride-alongs and fly-alongs – are quick to catch on to that fact. “We know that at the end of the day, we’ve helped save lives somewhere,” she adds.

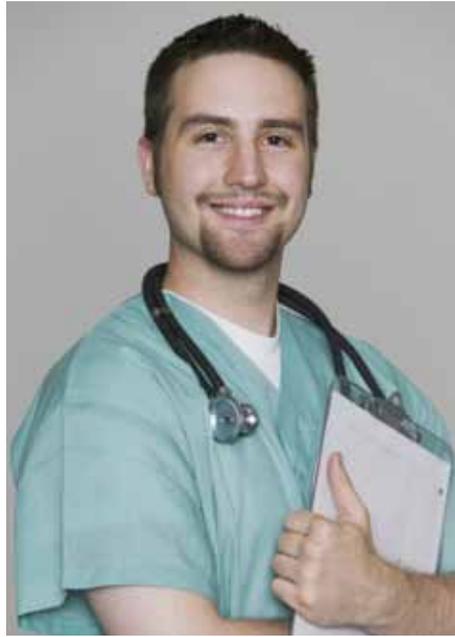
Onesto has been in the business since 1990, when she moved from Chicago to Daytona Beach, Fla., to help her brother-in-law (a paramedic and physician), and another paramedic start an EMS supply company. The company, Advanced Medical and Pharmaceutical Suppliers, was acquired by Tri-anim Health Services (now Sarnova) in 2000. In 2008, Onesto joined MMS-A Medical Supply Company, to help the company launch its EMS supply business.

“We’re a young division, and we continue to add personnel,” she says. MMS uses a combination of field reps and telesales to reach current and prospective customers. The company stocks EMS products in its hospital

warehouses as well as several EMS-specific facilities. Larger EMS agencies can handle shipments of boxes and cases, but smaller ones cannot. “We have customers who will replace two ET tubes and one box of bandages, so we have to be prepared to ship in small quantities,” she says.

Checks and balances

In smaller ambulance squads, the task of ordering supplies usually falls to a volunteer, that is, someone who has taken an interest in the task, or has simply stepped up to the plate. “You



one medical director might describe the circumstances and procedure whereby a patient receives a cervical collar, while another might prescribe what brand of cervical collar should be used. “Paramedics who order supplies will fall back to whatever the medical director says,” says Onesto. “If their protocol says they have to use this manufacturer’s product, that’s what they’ll use.”

“We do call on medical directors,” says Onesto. “If it’s a bandage, no. But if it’s a product that will change patient care in some fashion, it has to go to the medical director for approval and then written into the protocols.”

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can find out who that is just by asking,” says White. But larger agencies, such as urban fire departments, are more likely to have a dedicated, paid supply officer. “For capital equipment sales, that individual often has to lean back on a committee or working group to evaluate new devices, sometimes seeing that they’re tested in the ambulance.”

An important call point in the EMS world is the medical director. Every agency – be it a fire department, hospital, private ambulance service or other – works under the direction of a medical director, explains Onesto.

The medical director is an M.D., often an emergency room physician, who writes the protocols that emergency personnel must follow when caring for patients, she says. Depending on the individual, those protocols can be extremely detailed, or relatively loose. For example,

“The medical director is the guy who steps out at the edge of the cliff and looks at what’s out there” in terms of new products and technologies,” says Lundy. He or she attends shows looking for new products, which paramedics then test out in the field.

Government involvement means bids

Bids play an important role in product selection and hence, sales. That’s not surprising, given the heavy influence of local and state governments in EMS. Many bids are for a year, with renewal clauses. The ubiquity of bids influences the approach sales reps must take on sales calls, explains Onesto. Reps must either attempt to sell products – such as new technologies – not included in the bid, or they must lay the groundwork for the distributor to have a crack at the bid next time around.

Budget constraints represent another challenge for EMS agencies and, hence, for the sales reps calling on them. “Like any other industry, because of the recession, fewer funds are available [for EMS agencies],” says Onesto. Personnel are being changed, some captains are being demoted, and overtime hours are being cut. “But as far as patient care goes, they may be keeping their inventory a little tighter, but I haven’t seen agencies not get the equipment they need to save lives. They still make sure they have the best products available for patient care.”

Public entities are always trying to save money, points out Lundy. Problems usually arise when “the political dog gets into the middle of the fight,” and efforts are made to change the culture of an agency, he says. “But there are really excellent systems, top notch systems, where the patient comes first, and they don’t have a dollar; they’re volunteer or rural services. And then there are other services that have millions of dollars but give poor care. It’s not the money. It’s the focus and passion of the people who develop it and who look over it.”

hand, some patients can benefit from the warmth generated by IV fluids or warming blankets. It’s a technique called “normothermia,” and it can lead to less damage to vital systems.

Telemedicine – that is, the ability to transmit medical information from the ambulance to the hospital ER staff – is an improvement over current methods of communication, namely, cell phone and radios, says White. By being able to visualize the EKG of the patient while he or she is still in the emergency vehicle, the emergency room staff can tell if the patient is having a major heart attack, and make necessary arrangements.

Electronic medical records promises to be another frontier for EMS. In fact, it already is. “Most EMS systems with five trucks or more are probably using some type of EMR,” says White. “There’s not a lot of hard paper being written, except in small rural squads.” Data is routinely shared electronically with the receiving hospital and regional medical director. “And we look to see that sharing grow in the years to come,” perhaps to include the patient’s family physician.

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Future

Exciting times lie ahead for EMS providers. White is enthusiastic about some of the technologies that are just around the corner. Non-invasive diagnostic devices are one. Such devices are laid on the patient’s chest, allowing the emergency responder to get a reading on the electrical current generated with each breath or heartbeat. “We’re looking to see more measurement of minute electrical currents even without the need to apply an electrode,” he says.

Therapeutic hypothermia, in which the patient is rapidly cooled down, has been shown to reduce brain damage and improve recovery dramatically for cardiac arrest victims, he says. Rapid cooling of patients with spinal cord injuries may help minimize spinal damage. On the other

Time spent on non-emergency calls

Financial, political and technological challenges aside, EMS agencies face a bigger challenge – the growth in the number of non-emergency 911 calls. “Maybe they’re sick with who knows what,” says Lundy. “Maybe they’re unable to get into the healthcare system. A lot of us might say, ‘Just call a doctor.’ But to a lot of people, that’s way out of their circle.” The result is that emergency responders spend time on non-emergency calls, and end up bringing patients to the hospital who might better be served by a primary care provider.

Historically, responders get reimbursed for bringing patients to the hospital, but not for successfully handling a situation at home and leaving the patient there. Stabilizing

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a diabetic patient who has suffered an insulin reaction, for example, would go un-reimbursed.

But Lundy and others envision a different future. “Imagine this,” he says. “The paramedic goes to the house, treats the patient, then takes a moment, sits down and asks, ‘How many times has this happened to you this month? Let me get my iPad and set up an appointment at a clinic for you.’” Several states are hosting pilot projects in what is called “community paramedicine,” which would allow paramedics to do just that, and get reimbursed for it. (See related article.) Pilot project organizers hope that paramedics can help get certain patients out of the habit of going to the ER rather than a primary care provider. No doubt hospitals would benefit from such programs, as they face financial penalties for readmitting patients beginning in 2018, says Lundy.

In fact, he is optimistic that such plans may come to fruition following discussions with individuals from the

Medicare Payment Advisory Committee, or MedPAC, about the potential role EMS can play in improving care and reducing healthcare costs. MedPAC is an independent Congressional agency that advises Congress on issues affecting the Medicare program.

But EMS agencies and hospitals don’t have to wait for legislation to be enacted before they address the “frequent flyer” issue. In Charleston County, for example, area hospitals are working to get the most frequent “transports” – that is, patients who are frequently transported to the ER by emergency vehicles – into the primary care system. “The hope is to get them into some kind of social system, where the \$400-an-hour ambulance isn’t taking care of you, but maybe a nurse practitioner or home health nurse is,” says Lundy.

Such systems call for collaboration between the EMS agency and local hospitals. “Here [in Charleston County], I know all the ER managers; we eat dinner together,” says Lundy. “I know most of the CEOs. I know the physicians; we meet quarterly, sometimes more often. We have huge collaboration here. I’m sure this happens in other areas of the country.

But then there are probably other areas where [hospitals and EMS agencies] don’t want anything to do with one another. That’s when CMS should step in and say to the hospitals, ‘You’re going to have to sit at the table with EMS.’ That would start the process of bringing EMS into the healthcare arena.

“I’m not a proponent of not sending EMS when somebody calls 911,” he says. “But there are lots of things that can be done.” For example, the emergency medical dispatcher can ask the caller questions that might lead to a discussion with or visit by a nurse rather than an emergency vehicle.

“It’s as hard for us in the business to change as it is for patients,” says Lundy. “We’ve always heard the bell ring and, like Pavlov’s dog, we go on the call. But eventually, we have to look at the patient who’s dying and the patient who [has a minor injury] and figure out, ‘How can we make sure both get the right care they need?’” ■