Indianapolis EMS
A New Model for Pre-Hospital Care in Indianapolis

“Hoosier Daddy?”

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409 Square Mile

Population
1.3 Million Day
.89 Million Night

9 Townships and
Elected Twnshp Govts
The Situation

- Marion County, IN served by 8 fire-based (suburban) and 1 hospital-based (inner city) EMS agencies plus 3 intercalated cities
- 5 medical directors
- 12 administrations, fire depts, EMS Systems and budgets
- One Common set Marion County EMS Protocols since 1992
- One Medical Director for IEMS (IFD + Wishard Ambulance Service) since 2000
The Problem

- Wishard Ambulance Service is a division of Wishard Hospital
  - The Ambulance Service Director reports to the Chief of Nursing
  - All Ambulance Service revenue goes to the hospital general fund
  - Hospital Collections is not aggressive in going after relative low ambulance bills
  - Hospital budget cuts have significantly cut EMS Supervisory and CQI staffing
Confounding Factor

• In 2005 IFD begins to consolidate Township Fire Departments (along with their intrinsic fire based EMS Systems) into itself
The Problem

• By 2009 the City is running two separate EMS transport systems: one through the IFD and one through the county’s Health and Hospital Corporation

• The City-County govt. is losing over $13M on IFD civilian staffed EMS Transport
  – Disparate EMS administration, budgets, quality programs, education, etc.
  – Civilian EMS staffing pattern is 24 on 48 off with Kelly day.
  – IFD U/UH = 0.18 - 0.24
A Plan Is Made
The Process

• A committee is formed consisting of IFD chiefs; Wishard Ambulance Director; IUSM; HHC CFO; Mayor’s DPS, and lots of lawyers

• 18 month effort to develop the best single-agency EMS delivery model for the county
  – $$$$$
  – Quality Care
  – Efficiency
  – Fairness
The Process

- 6 months reviewing variety of fire-based, third service, hospital-based, and public-private partnerships
- Public-Private partnerships provided highest performance through efficiency and revenue & consistent quality of care
- The HHC provided a solid financial backer without sacrificing revenue to Wall St.
The Solution: Indianapolis EMS

- A public-public-public partnership between IUSM, City DPS, and the HHC (Inter-local Agreement)
  - Single agency under DPS for day to day operations
  - Transport owned and funded through HHC
  - Directed by IUSM EM physician
New Division of Public Safety

Department of Public Safety

- Indianapolis EMS
- Indianapolis Metropolitan Police Dept.
- Indianapolis Fire Dept.
- Division of Homeland Security
- Animal Care and Control
New Division of Health and Hospital Corp.

Health and Hospital Corporation

- Marion County Department of Health
- Wishard Health Services
- Indianapolis EMS
The Solution: Indianapolis EMS

- Fully integrated into DPS daily operations, emergency management, and cross agency services (ie. TEMS)
- Provider-based status provides higher revenue ($2-3M difference)
- IUSM direction ensures quality patient care and EMS education, university supported research, and access to a quality EMS System for education of medical students, residents and fellows.
Architecture

- Fire-based first response & technical rescue
- Third service 911 transport
- Physician Chief of EMS: Reports to DPS Director for daily operations
- Physician Chief of EMS: Reports through HHC Board’s EMS subcommittee for executive issues and finance
  - DPS director or appointee
  - HHC CEO or appointee
  - IUSOM DEM Chair or appointee
Advantages

• Protected revenue
  – no general fund
  – Guaranteed reinvestment
• Insulation from changing metro politics
• Distinct identity and culture for providers
• Own and implement quality improvement, EMS education, training, and system efficiency
• Integrate academic agendas
Challenges

• Marry two contentious, disparate, and ingrained cultures
  – 12 hour shift hospital-based
    • Efficient, cavalier, low morale
  – 24 hour shift fire-based
    • Structured, inefficient, and unionized

• Academic MD Chief-WTF?
  – Multiple reporting chains
  – Complex checks and balances
Process

• Strict adherence to the 4 Pillars
  – Patient Care, Education and Research, Investment and Sustainment, CQI and Accountability

• Third party chief with mixed general staff

• Phased implementation

• Focus on metrics, accountability, and reporting

• Focus on street level management
Current Challenges

• Culture: gut everything & create a new culture and history
• Payroll/Staffing:
  – 24 and 12 hour shifts
  – IAFF representation
  – transition to single fair strategy
• Financial reporting: removed the hospital
• Optimizing efficiencies in deployment
Current Challenges

- Quality improvement
  - develop resources, metrics and technology
- Building accountability
  - Implement discipline and HR policies that invest in, remediate, and incentivize the employee
- Integrating academics
- Leadership/mentorship development
3 Year Goals

• Consistent high quality provider
  – High moral
  – Highest caliber
• Dedicated leadership/mentorship track
• EMS academy
• Industry leading quality program
• Financial independence
• Dedicated research program