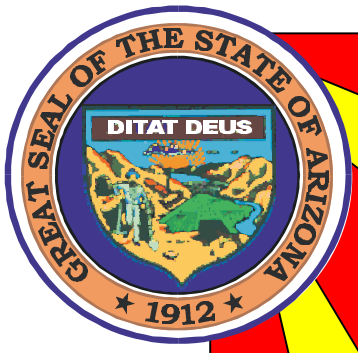

State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES, BUREAU OF EMERGENCY MEDICAL SERVICES

Report to the Arizona Legislature
By Douglas R. Norton
Auditor General

April 1999
Report No. 99-6

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AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

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April 19, 1999

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Dr. James Allen, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Health Services, Bureau of Emergency Medical Services. This report is in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the Sunset review set forth in A.R.S. §§41-2951 through 41-2957. This is the third in a series of reports to be issued on the Department of Health Services.

This report addresses why the State needs to consider changing its current statutory approach to regulating ambulance services, how the Bureau can improve its handling of complaints against various certificate holders, including emergency medical technicians, and how the Department handled the Bureau's former Medical Director's potential conflict of interest. First, Arizona's statutory Certificate of Necessity (CON) system provides more regulation than is necessary for overseeing ambulance service, does not meet its goals, and limits competition. We recommend that the Legislature consider directing the Bureau to form a study group to advise the Legislature on developing a new system for helping to ensure quality service, while increasing the potential for competition within the industry. Second, the Bureau has taken steps since August 1998 to ensure that complaints against certificate holders are resolved more quickly. However, it still needs to improve complaint handling by providing adequate staff training, expediting some complaint resolutions, adequately tracking complaint files, and adopting an appropriate computer-tracking system. Finally, the report also provides information about how the Department handled the Bureau's former Medical Director's potential conflict of interest.

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As outlined in its response, the Department notes that the decision to review the need for the CON system rests with the Legislature. The Department agrees with, and has agreed to implement, all recommendations addressed to it.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on April 20, 1999.

Sincerely,

Douglas R. Norton
Auditor General

Enclosure

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Department of Health Services, Bureau of Emergency Medical Services, pursuant to a May 27, 1997, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by A.R.S. §§41-2951 through 41-2957. This is the third in a series of six audits relating to the Department of Health Services.

The Bureau of Emergency Medical Services (Bureau) is responsible for protecting the health and safety of people requiring emergency medical services. With 34 full-time equivalent positions located in one administrative and four regional offices, the Bureau certifies emergency medical technicians, regulates ambulance service through the statutory Certificate of Necessity (CON), and handles complaints against individuals and ambulance companies. The Bureau also oversees statewide emergency medical services by administering a computerized database of trauma cases and supporting three advisory boards and four regional councils.

The Certificate of Necessity Is An Unnecessary Form of Regulation (See pages 5 through 10)

This audit found that the statutory Certificate of Necessity (CON) provides more regulation than is necessary for overseeing ambulance service and limits competition. Arizona's current system of regulation dates from 1982 and is generally intended to ensure ambulance coverage throughout the State and to provide assurance of quality services. It statutorily requires that companies or local governments obtain a Certificate of Necessity to operate an ambulance service in each geographic area they intend to serve. Arizona is one of only seven states using a CON system for ambulance regulation.

The CON system does not guarantee that all areas of the State have adequate ambulance coverage or that CON holders provide quality service sufficient to meet basic safety requirements. Some locations in the State are not in any provider's service area. Under the CON system, the Bureau has no authority to compel providers to provide service to these locations. Examples include Highway 89 from Flagstaff to Page and Highway 93 from Wickenburg to Wikieup. As a result, unregulated rescue services and costly air ambulances are often used in place of ambulances in those and other areas that have inadequate coverage. Even within CON service areas, the system is ineffective for ensuring quality. The Bureau does not systematically monitor key quality indicators, including ambulance response times. Furthermore, quality can be monitored without a CON system. Arizona has several regulations for controlling the quality of ambulance services that are separate from the CON system.

The Certificate of Necessity system limits competition by creating a barrier to those individuals or companies wishing to enter the ambulance service market. In addition to demonstrating their own qualifications, CON applicants can be required to demonstrate that the existing ambulance service provider does not meet the provisions of its CON. If existing CON holders are meeting the response times specified on their certificates and responding to all calls, the Department may decide there is no need for new service, even if applicants can demonstrate faster response times or other service improvements. The CON system also prevents local governments from finding ambulance service that might better and more affordably meet their communities' needs, including possibly providing services through their own fire departments.

The Legislature could consider directing the Bureau to form a study group to advise it on the need to reevaluate the CON system in light of its limitations in meeting state regulatory goals and its adverse impact on competition. Other forms of regulation used by other states might be effective without the problems that accompany the CON system. For example, the Department could license and regulate the quality of ambulance service without limiting the number of providers, or the Department could establish minimum service standards and allow local governments to determine appropriate levels of service.

If the CON is continued, quality and coverage oversight should be improved. The Bureau could more thoroughly use CON regulatory mechanisms to monitor quality, update and improve response time measures and accountability, and create easily accessible documentation of provider information.

The Bureau Does Not Adequately Handle Complaints (See pages 11 through 17)

Although the Bureau's current complaint-handling process has improved since the Office of the Auditor General's last report in 1988 (see Auditor General Report No. 88-12), the Bureau still needs to improve its handling of complaints against emergency medical technicians, paramedics, ambulance companies, and related entities. Under A.R.S. §36-2204, the Bureau is responsible for investigating and resolving complaints of substandard patient care and unprofessional conduct against emergency medical technicians; and complaints regarding fees, response times, and territorial infringement against ambulance companies. The Department's Office of Special Investigations formally investigates all complaints against emergency medical technicians or paramedics, complaints involving patient care allegations, and appealed informal complaints. Other complaints are handled informally by Bureau staff.

Since August 1998, the Bureau has taken steps to ensure that final resolution decisions are made in a more timely manner. However, Auditor General staff found that 22 complaints from the period prior to August 1998 remained open for more than two-and-a-half years, awaiting a final decision after the investigations had been completed in a timely manner.

The delay compromised the Bureau's ability to resolve complaints and, in some cases, impose appropriate discipline.

Other problems are related to the Bureau's procedures for handling complaints, both informally and formally. Informal complaints are hampered by a lack of monitoring and a lack of complaint investigation training on the part of Bureau staff, who handle all such complaints. Formal complaints continue to be hampered by slow processing, poor tracking of files, an inadequate database, and inadequate notification provided to complainants about the status of their cases.

The Bureau has recognized some of these complaint-handling problems and has begun to make improvements. It plans to implement a new case management plan, which includes policies and procedures for complaint handling. The Bureau has also recognized the need for an improved complaint tracking system for these complaints and is taking steps to address some of the problems. Further changes, however, are still required to correct problems. These changes include better tracking and management of complaints that are handled informally, training for personnel who investigate such complaints, and better communications with complainants.

Other Pertinent Information
(See pages 19 through 20)

The Bureau's former medical director faced a potential conflict of interest because her spouse works for the State's largest for-profit ambulance service provider. The Bureau sought legal direction on the matter and subsequently wrote, but did not consistently follow, an internal policy directing the former medical director to refrain from reviewing any complaints against the spouse's employer or any of its competitors, including complaints against individual employees of such companies. The former medical director participated or made decisions in several complaint cases, although the audit staff found no inappropriately resolved complaints. To avoid this situation in the future, the Department of Health Services reports that it now closely scrutinizes potential conflicts of interest prior to hiring Bureau managers. Auditor General staff reviewed the Statements of Independence of the Bureau's new Chief and Medical Director and found that both should be able to impartially perform their duties.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Department of Health Services, Bureau of Emergency Medical Services, pursuant to a May 27, 1997, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by A.R.S. §§41-2951 through 41-2957. This is the third in a series of six audits relating to the Department of Health Services.

Bureau of Emergency Medical Services' Responsibilities

The Bureau of Emergency Medical Services plans and coordinates the State's emergency medical care system. Federal estimates indicate that the average American will need ambulance service at least twice in his or her lifetime. The Bureau's mission is to protect the health and safety of people requiring emergency medical services through certification, licensure, and promotion of Arizona's emergency medical service systems.

The Bureau has three main areas of responsibility:

- **Emergency Personnel—**The Bureau certifies emergency medical technicians and technician training programs, handles complaints against emergency medical technicians (EMTs), and disciplines violators. There are currently 9,044 certified basic and intermediate emergency medical technicians and 2,360 certified paramedics in Arizona.

- **Ambulance Services—**The Bureau regulates ambulance service by setting ambulance service rates and issuing Certificates of Necessity to ambulance providers. These Certificates establish providers' geographic service areas and required response times. The Bureau also inspects all air and ground ambulances, investigates complaints against ambulance providers, disciplines violators, and certifies hospitals that provide medical direction to ambulance providers and receive emergency patients. Currently, 74 ambulance service providers hold 83 Certificates of Necessity and operate approximately 533 ambulances in Arizona.

- **Statewide Oversight—**The Bureau provides statewide oversight of emergency medical services through several means. It maintains the State Trauma Registry, a computerized database of the incidence of, causes, severity, outcomes, and operation of trauma system cases. In addition, it provides administrative support to several advisory committees including the State Trauma Advisory Board, the State Emergency Medical Services Council, the Medical Direction Commission, and four regional councils. These seven bodies

guide the Bureau in developing policy and programs. The Bureau also administers a grants program for emergency medical service providers to purchase supplies and capital equipment.

Bureau of Emergency Medical Services Organization and Staffing

The Bureau of Emergency Medical Services is a unit within the Department of Health Services, Public Health Division. It has a total of 34 full-time equivalent employees (FTE). Fourteen FTEs staff a Phoenix-based administrative office that regulates ambulance services statewide and oversees a reorganized structure of four regional offices.[1] The regional offices are responsible for certification, ambulance inspection, grant making, informal complaint handling, and some hospital oversight. The Central Region office is in Phoenix and has a staff of 8. The Southeastern Region office, in Tucson, has 5 FTEs. The Northern Region office is in Flagstaff and has 4 FTEs. The Western Region office is housed in Phoenix and is staffed by 3 FTEs. The Department of Health Services supports the Bureau, particularly through the Office of Special Investigations, which investigates formal complaints against emergency medical technicians and ambulance providers.

Budget

The Bureau is financially supported by a portion of a surcharge on fines charged for criminal offenses and traffic violations and by 0.3 percent of the Telecommunications Services Excise Tax. Expenditure of these monies requires legislative authorization. Table 1 (see page 3) illustrates the Bureau's actual and estimated revenues and expenditures for fiscal years 1997-1999.

Audit Scope and Methodology

Audit work was conducted to determine whether the Bureau effectively regulates ambulance services through the Certificate of Necessity program, and whether the Bureau adequately tracks, investigates, and resolves complaints. The audit presents findings and recommendations in two areas:

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[1] Previously, the Bureau had separate sections handling emergency personnel certification, the Certificate of Necessity program, and the statewide trauma system. The sections operated primarily from the Phoenix office. The Tucson and Flagstaff offices employed ambulance inspectors and administrative staff. The Flagstaff office also monitored hospitals who oversee emergency medical personnel.

Table 1

Department of Health Services
Bureau of Emergency Medical Services
Statement of Revenues, Expenditures, and Changes in Fund Balance
Years Ended or Ending June 30, 1997, 1998, and 1999
(Unaudited)

	1997 (Actual)	1998 (Actual)	1999 (Estimated)
Revenues:			
Fines and forfeits [1]	$3,312,692	$3,618,552	$3,908,000
Use taxes [2]	1,584,624	1,815,626	2,035,000
Total revenues	4,897,316	5,434,178	5,943,000
Expenditures:			
Personal services	797,110	823,735	1,015,300
Employee related	186,391	191,227	231,900
Professional and outside services	110,621	326,912	241,200
Travel, in-state	46,609	50,232	51,500
Travel, out-of-state	4,701	6,180	5,600
Aid to organizations [3]	1,874,012	2,020,204	2,028,300
Other operating	495,751	434,758	481,500
Capital outlay	392,588	199,364	166,100
Total expenditures	3,907,783	4,052,612	4,221,400
Excess of revenues over expenditures	989,533	1,381,566	1,721,600
Fund balance, beginning of year	1,844,095	2,833,628	4,215,194
Fund balance, end of year [4]	$2,833,628	$4,215,194	$5,936,794

[1] The Department receives a portion of fines charged for criminal offenses and traffic violations to fund various statewide emergency medical services, including Bureau operations.

[2] The Department receives 0.3 percent of Telecommunication Services Excise Tax revenue to fund the University of Arizona Poison Control Center and poison control services in Maricopa County. This revenue is passed through to other entities and is included in "Aid to organizations."

[3] Includes amounts passed through to other entities for poison control and grants awarded to emergency medical service providers for ambulance purchases and services, emergency receiving facilities, and rescue services.

[4] The Department must receive legislative authorization to spend the Bureau's fund balance.

Source: The Uniform Statewide Accounting System *Revenues and Expenditures by Fund, Program, Organization, and Object* and *Trial Balance by Fund* for the years ended June 30, 1997 and 1998; the *State of Arizona Appropriations Report* for the years ended or ending June 30, 1997, 1998, and 1999; and Division-estimated revenues and expenditures for the year ending June 30, 1999.

- The need for the Bureau to address problems in its regulatory approach to ambulance service provision; and

- The need for the Bureau to improve its complaint-handling process.

Major audit methods included:

- An analysis of the electronic complaint database containing information on the 360 formal complaints filed between fiscal years 1993 and 1998;[1]

- An in-depth telephone survey of the emergency medical services agencies of 14 states that are geographically and demographically similar to Arizona or were identified by emergency medical services experts;[2]

- A survey of the remaining 35 states regarding whether or not they have a Certificate of Necessity system;

- A review of relevant Arizona statutes; other states' emergency medical services agency literature, statutes, and rules; recent legal rulings on ambulance service; and current literature on ambulance and public utility regulation and deregulation;

- An analysis of all 15 initial Certificate of Necessity applications filed between 1994-1998; and

- Interviews with emergency medical services experts, legislative staff, a Governor's Office representative, five professional association representatives, Department of Public Safety representatives, five current Certificate of Necessity holders, a rescue service provider, and three emergency medical service providers who do not have a Certificate of Necessity, but are interested in obtaining one. Industry representatives came from rural, urban, and suburban areas.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Department of Health Services Director and the Bureau of Emergency Medical Services' Chief, Medical Director, and staff for their cooperation and assistance throughout the audit.

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1 Database was verified through a statistical sample of 70 complaint files.

2 California, Colorado, Connecticut, Florida, Illinois, Kansas, Missouri, Montana, Nevada, New Mexico, Oregon, Texas, Utah, and Washington.

FINDING I

THE CERTIFICATE OF NECESSITY IS AN UNNECESSARY FORM OF REGULATION

Arizona's Certificate of Necessity (CON) system provides more regulation than is necessary for overseeing ambulance service. CON systems are intended to ensure ambulance coverage throughout the State and to provide quality assurance. Arizona's CON system does not guarantee either of these outcomes, and further, limits competition in the provision of ambulance services. By limiting the ability of new ambulance services to enter a particular geographic area, the CON system may also prevent the introduction of service improvements that would better meet a community's needs. The system should be reevaluated, and other forms of regulation should be considered.

The Certificate of Necessity System

Arizona's current system for regulating ambulance services dates from 1982, when voters approved a Constitutional amendment to reinstate ambulance regulation. The resulting amendment provides for the Legislature's regulatory authority over ambulances in "all matters relating to service provided, routes served, response times and charges."[1] To fulfill this authority, the Legislature enacted statutes establishing the CON system. Only seven states, including Arizona, now use a CON system for ambulance regulation.

Under A.R.S. §36-2233, companies or local governments must apply to the Bureau for a Certificate of Necessity to operate an ambulance service in each geographic area they intend to serve. Applicants must meet criteria demonstrating that they are qualified to offer service. The Department must also find public need for the service, based on demand and the effect upon any existing providers in the geographic area. The application is heard before an administrative law judge if it is an initial application, the Bureau intends to oppose the application, or somebody requests a hearing. The judge makes a recommendation to the Department of Health Services Director, who has ultimate approval authority. If the Director approves the application, the Bureau issues a Certificate of Necessity that delineates locations of the central and sub-operation ambulance stations, the types of service to be provided, average response times, and the geographic area to be covered.

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1 Constitution of the State of Arizona, Article XXVII, *Regulation of Public Health, Safety and Welfare.*

Current Approach Does Not Meet Goals and Is Unnecessary

The CON system as established in statute does not fulfill its intended goals and is not necessary for the fulfillment of these goals. First, the CON system does not ensure all areas of the State are covered by a ground ambulance service. Specifically, it does not oblige ambulance services to cover remote or unprofitable areas outside the area delineated in their CON. In areas with insufficient coverage, unregulated services sometimes substitute for ambulance providers. Second, because the Bureau does not effectively monitor and enforce the quality requirements that are contained within the CON, the current CON system does not adequately ensure quality ambulance service to the public. Additionally, the CON system is unnecessary for meeting such regulatory goals as quality assurance and fee regulation.

CONs do not guarantee coverage—The CON statutes do not provide the Bureau the authority to compel providers to cover remote or unprofitable areas or to improve response times to these regions. Bureau officials indicated that some sections of the State are not included in any provider's CON service area or lack adequate coverage. If the area is uncovered, a CON holder in an adjacent region normally provides service. In these situations, the provider is not required to meet response time standards because these regions are not within its CON. Uncovered and underserved areas include some stretches of state highways, such as Interstate 89 from Flagstaff to Page, and Highway 93 from Wickenburg to Wikieup.

Additionally, the Bureau's method of storing CON information does not ensure that agencies handling emergencies know which service is located closest to the emergency or can respond in the shortest time. Although each CON contains important information about the provider's base of operation, service area, and response times, the Bureau does not delineate this information on a map or other standardized format. As a result, this information cannot be easily shared with other agencies. For example, the Department of Public Safety (DPS) often has the responsibility of placing a call for an ambulance after highway accidents. Because the Bureau does not maintain CON information in a readily accessible format, DPS develops and maintains its own ambulance provider lists and does not cross-reference its lists with information from the Bureau. Providing standardized information could help DPS and other local and state agencies ensure that the ambulance services called are CON holders, and the fastest and closest service to the accident.

Unregulated services and costly air ambulances fill deficiencies—Rescue services and air ambulances are often used in place of ambulances for areas that have inadequate ambulance coverage. While rescue services may represent the only feasible alternative for emergency transport in undercovered areas, the State does not regulate these providers. Under A.R.S. §36-2217(A)(4), rescue vehicles are exempt from CON regulations because they "are primarily used to provide on scene stabilization." However, in uncovered or undercovered areas, where immediate ambulance transport is not possible, rescue services can either transport patients to rendezvous with the nearest ambulance or directly to a hospital.

Moreover, because rescue services are exempt from regulation, they can use this exemption as a way to provide unlicensed ambulance transport and avoid the CON application process. Because they are unregulated, the Bureau cannot directly monitor rescue service quality. Similarly, air ambulances have helped alleviate some of the difficulty covering remote areas, particularly if it is evident that ground transport will result in especially lengthy response times. However, air ambulances are more expensive than ground transports and are unnecessary for some types of inter-facility transports in which the patient is stabilized.

CONs ineffective for ensuring quality—In addition to not guaranteeing ground ambulance coverage, the CON system does not meet its goal of providing an effective method for ensuring quality service. Although providers' certificates contain required response times for their service areas, and although ambulance providers must record this information and submit it to the Bureau, there is no standardized definition of "response times" in Bureau statutes or rules. As a result, CON holders may be calculating response times differently. Further, the Bureau does not consistently conduct analysis of this data. Currently, the Bureau conducts a review of dispatch logs only if complaints have been made against the provider. Moreover, required response times reflected on the CONs are estimates the providers calculate at the time they submit their initial application. Consequently, response times may be out-of-date because they do not reflect population growth or other changes in an area's demographics.

Other quality indicators, such as patient outcomes, are not incorporated in CONs or reviewed in the CON application and renewal processes. In fact, although CON holders are required to renew their certificates every three years, the Bureau does not conduct performance reviews and rarely denies a request for renewal.

CONs unnecessary for ensuring quality and regulating fees—Ambulance service quality and charges could be regulated without the CON system. Many emergency medical service agencies, in states without a CON system, monitor response times and suspend provider services. Furthermore, the Bureau has quality control regulations that do not depend on the CON system. For example, it has regulations regarding how hospitals oversee emergency medical personnel, ambulance design requirements, inspections of EMT/paramedic certifications, and vehicle inspections. Additionally, the fees ambulance providers charge can be regulated without the CON system. Currently, the Bureau sets ambulance provider fees based on the CON service area. However, this is not required by statutes or rules.

CON System Limits Competition

While the CON system does not meet its intended goals, it also limits competition in the ambulance industry. The Certificate of Necessity system creates a barrier to other service providers wishing to enter the market, and the application process upon which it is based is

perceived as favoring current CON holders. Moreover, because the Bureau administers the CON at the statewide level, local governments are denied a role in choosing ambulance service.

CON system creates a barrier to entering the market—Companies and local governments that wish to provide ambulance services in Arizona face substantial barriers. In addition to demonstrating their own qualifications for providing services, applicants can be required to demonstrate that the existing ambulance service provider does not meet the provisions of its Certificate. After the applicant submits all required information, the Department of Health Services establishes a public hearing date and notifies all existing ambulance services in the proposed service area. If existing services or other interested parties file an intervention, the applicant may need to demonstrate at the hearing that the current CON holder is not adequately meeting demands for service in the area.

Because the Bureau can require the applicant to demonstrate that current ambulance services are not meeting public need, the system tends to work in favor of existing CON holders. If existing CON holders are meeting the response times specified on their certificates, and responding to all calls, the Department Director may decide there is no need for new service, even if applicants can demonstrate faster response times or other service improvements. For example, Yuma's fire department applied to the Bureau for a CON. After a long and controversial process, the fire department eventually withdrew its application, citing as reasons the existing provider's opposition, the lengthy and legally expensive application process, and overall lack of support from the Bureau. Several other city fire departments are also interested in applying for a CON but are reluctant to do so, because they expect to face strong opposition from the current CON holders in their areas.

In addition to limitations imposed by the CON system, competition within the ambulance industry may decrease even further because of industry changes. Specifically, the State's two largest private ambulance providers have merged. This merger will significantly concentrate the number of providers owned by one company. Currently, the merged company holds CONs for Maricopa, Pima, and Yuma Counties as well as for other areas of the State, and controls approximately 41 percent of the State's registered ground ambulances. Combined with the CON system, these industry changes could make it even more difficult for new providers to enter the market.

Denies local governments a role—At the local (county or municipal) level, limiting competition through the CON system denies local governments a role in selecting ambulance providers. Local governments may be in a better position to find ambulance services that are suitable to their communities' needs, including the possibility of providing services through their own fire departments.

CON System Should Be Reevaluated

Given that the CON system does not meet its goals, but limits competition, other methods of protecting public health and safety should be considered. Specifically, the Legislature should consider whether other types of statewide or local ambulance regulation might be more effective. Regardless of whether the Legislature maintains or eliminates the CON system, the Bureau could improve efforts to ensure quality.

Legislative guidelines for regulation suggest that state governments consider whether the "benefits to the public outweigh" the effects of reduced availability of services. These guidelines also recommend that governments provide minimum levels of regulation to meet public need. The Legislature could consider these factors when deciding the future of the CON system.[1]

The Legislature should consider other forms of regulation—A 50-state survey revealed that only 7 states, including Arizona, use the CON system. It is more common for states to license ambulance providers. Additionally, some states supplement statewide regulation with local regulation, allowing the county or municipality to determine the amount of service that is appropriate for their area. These regulatory approaches allow for more competition and / or local control. For example:

- **Strictly licensure—**Providers are licensed by the state to offer ambulance service. The state does not limit competition by controlling the number of ambulance providers. Quality of services is still regulated by the state or local EMS agencies through inspections of EMT / paramedic certifications, inspections of ambulances, collection and monitoring of response time data, and other quality controls. States that use a similar model include Illinois, Kansas, Montana, and Texas.

- **Licensure combined with local control—**The state licenses the ambulance service. Counties determine appropriate levels of service and issue request for proposals to establish exclusive operating areas for providers through a competitive process. Quality control measures are contained within state regulations and local plans or they are contained entirely in the local plans, but are based on state guidelines. Alternatively, regional councils can administer local plans. States that use a similar model include California, Colorado, Oregon, and Washington.

Arizona's Bureau of Emergency Medical Services has already implemented steps that enhance the duties of regional offices. If the Legislature were to remove the CON system, this regionalization effort could be used as the first step toward increasing the regulatory authority of local agencies over ambulance services.

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1 Shimberg, Benjamin and Doug Roederer. *Questions a Legislator Should Ask.* The Council on Licensure, Enforcement, and Regulation / Council of State Governments. Lexington KY, 1994.

Given the variety of regulatory approaches available, the Legislature may want to direct the Bureau to form a study group to advise it on the future of Arizona's ambulance regulatory system. Any study group should be composed of a wide variety of stakeholders, including regulators and governmental ambulance and rescue service providers, as well as representatives of the for-profit ambulance industry.

If the CON is continued, quality and coverage oversight could be improved—Regardless of whether the Legislature continues the CON system, the Bureau should improve its efforts to monitor quality by:

- More thoroughly using the regulatory mechanisms that are part of the CON, such as the power to revoke or suspend a CON or deny a CON renewal, to monitor quality.

- Updating and improving response time measures, and holding providers accountable for these response times. The Bureau may also develop and systematically monitor other quality measures.

- Creating easily accessible documentation that lists or maps information contained in the CON about provider service areas and response times. Other emergency agencies can use this information to verify that they dispatch the appropriate and/or nearest ambulance service.

Recommendations

1. The Legislature should consider directing the Bureau to form a study group to evaluate possible changes in the manner in which Arizona regulates ambulance services. This group should study various options, including the following:

    a. Licensing providers to ensure quality, without limiting competition by controlling the number of providers; or

    b. Licensing providers and allowing local governments to establish operating areas through a competitive process.

2. Whether or not the CON system is continued, the Bureau should use its regulatory authority to enforce quality controls such as response times.

3. The Bureau should assemble the information it has regarding providers and their service areas into easily accessible lists or maps so that this information can be used by other agencies.

FINDING II

THE BUREAU DOES NOT ADEQUATELY HANDLE COMPLAINTS

The Bureau's system for investigating and resolving complaints against EMTs, paramedics, ambulance companies, and related entities needs further improvements. Since August 1998, the Bureau has taken steps to ensure final resolution decisions are made in a more timely manner. However, the Bureau continues to have systematic problems in how it handles informal and formal complaints, including a lack of appropriate staff training, long delays, inadequate file tracking, and an inappropriate computer tracking system. The Bureau recognizes many of these problems and is beginning to make further improvements in some areas.

Current Complaint-Handling Process

Under A.R.S. §36-2204 and §36-2245, the Bureau is responsible for investigating and resolving complaints against EMTs, paramedics, ambulance companies, emergency personnel training programs, and hospitals that oversee the work performed by EMTs and paramedics. Complaints against individuals include such matters as substandard patient care and unprofessional conduct, while complaints against ambulance companies include billing disputes, response times, and territorial infringement.

The Bureau's complaint-handling process differs according to the nature of the complaint. Bureau staff informally handle some complaints, including non-patient care complaints against ambulance companies, hospitals that oversee emergency medical personnel, and training programs. The Bureau does not maintain a log or written reports regarding complaints handled informally. In contrast, all complaints against EMTs or paramedics, complaints involving patient care allegations, and appealed informal complaints are handled formally, under the following steps:

- Bureau staff refer the complaint to the Department of Health Services' Office of Special Investigations.

- The Office of Special Investigations logs the complaint and investigation information into its Complaint Tracking System database.

- The Office of Special Investigations conducts interviews and other investigative activities and prepares a report containing all pertinent information.

- The complaint and investigative report are submitted to the Bureau's Medical Director or Bureau Chief for a hearing, if necessary, and resolution.

The Bureau has a wide range of options for formal complaint resolution, including no action, censure, civil penalties, probation, requiring additional training, and suspending or revoking licenses.

Some improvement since 1988 audit report—Although problems remain, the Bureau's current complaint-handling process includes some improvements since the Office of the Auditor General's last report in 1988 (Auditor General Report No. 88-12). That report noted severe problems, including the lack of any system for tracking complaints and the failure to investigate or take action on even serious patient care complaints. The current audit found that although timeliness remains a problem and other improvements are still needed, progress has resulted from the Bureau's current practice of referring certain types of complaints to the Office of Special Investigations, and the Office's consistent, formal approach to complaint tracking, investigation, and reporting. Furthermore, in contrast to the 1988 findings showing that few actions were taken, the Bureau took action to revoke, suspend, or otherwise decertify 26 licensees between fiscal years 1993 and 1998. Likewise, it placed 18 licensees on probation during the same period.

Final Resolution Decisions Delayed in the Past

Although since August 1998 the Bureau has taken steps to ensure final resolutions are not unnecessarily delayed, previous delays compromised the Bureau's ability to resolve complaints and in some cases impose appropriate discipline.

The Bureau was slow to make final resolution decisions on a significant number of complaints prior to August 1998. For example, Auditor General staff found 22 complaints that were open for more than two-and-one-half years, and in which the complaint investigations were completed in a timely manner. However, the files were held awaiting a final decision for an average of more than two years. These cases were finally closed when a new interim Bureau Chief reviewed the case backlog and took action.

These delays negatively impacted the Bureau's handling of complaints. For example, the Bureau did not resolve 8 complaints that included a total of 21 separate allegations. These allegations included failure to dispatch ambulances closest to the scene, and that substandard care resulted in patient deaths. By the time the cases were discovered, up to four years had elapsed since the investigations were completed. The interim Bureau Chief closed the complaints without taking punitive action. In at least one of the cases, this lack of action was directly attributed to "the considerable period of time that has passed."

Other Complaint-Handling Problems Still Exist

The Bureau's handling of complaints continues to be hampered by other factors. Informal complaints are hampered by the lack of monitoring and by the lack of training for staff who handle these complaints. Formal complaints are hampered by long delays, inadequate file tracking, an inadequate computer system, and insufficient communication with complainants.

Informal complaints not tracked and most staff not trained—The Bureau's handling of informal complaints has been hampered by a lack of tracking. The Bureau does not note the complaint or resolution in a centralized database or log. As a result, management cannot determine whether these complaints are resolved in a timely manner and cannot monitor the quality of investigations or ensure that problematic providers are easily identified. While informal resolution is appropriate for some complaints, and in fact is required by statute A.R.S. §36-2245(E) for complaints involving ambulance company rates and charges, the Bureau's failure to track such complaints prevents it from ensuring that such complaints are handled appropriately or from discerning repeated problems or industry-wide trends.

Lack of tracking is also a problem because the Bureau cannot assess its compliance with timeliness standards established in statutes for some of these complaints. A.R.S. §36-2245 contains specific processing deadlines for complaints against ambulance companies. For example, the Bureau must respond to a complainant within 15 days after receiving a written complaint, determine if the complaint has merit within 45 days of receiving ambulance company records, and notify all parties within 5 days if a complaint is resolved. However, when informal complaints are investigated and resolved by Bureau staff, they are not entered into the Bureau's complaint tracking system or tracked otherwise, so that the Bureau's compliance with the statutory deadlines cannot be monitored.

A second problem is that informally handled complaints may not receive the same level of investigative expertise as formal complaints. Bureau staff who handle informal complaints have not received formal training in complaint investigation. As a result, they may not be optimally knowledgeable about interviewing complainants, identifying potential evidence, and drawing legally defensible conclusions. In contrast, formal complaints are investigated by the DHS Office of Special Investigations, whose certified investigator has received nationally recognized training in investigating complaints.[1]

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[1] The Council on Licensure, Enforcement, and Regulation (CLEAR) provides investigators/inspectors training specifically for licensing and regulatory boards. CLEAR's National Certified Investigator/Inspector Training curriculum offers training in interviewing techniques, evidence development, administrative law, and report writing.

Formal system also contains problems—The Bureau also continues to have problems handling formal complaints. Specifically, formal complaint-handling problems include:

- **Slow complaint handling—**While the Bureau has made progress since the 1988 Auditor General's report, this audit found that many complaints were still not resolved in a timely manner. The Bureau has not established target time frames for complaint resolution, but like other medical regulatory boards in Arizona, it should be able to resolve complaints within 180 days. However, the Bureau does not meet this standard. The analysis covered complaints received during fiscal years 1992-93 through 1997-98. During the six-year period reviewed, the Office of Special Investigations investigated 152 complaints against ambulance companies and 135 other complaints, and conducted 73 recertification background checks.[1] As shown in Table 2 (see page 15), about 40 percent of all complaints required more than 180 days to resolve. Additionally, although Bureau officials regard patient care complaints as the most important, 33 complaints required more than 180 days to complete. Four of these complaints took more than 720 days, or almost two years, to complete.

- **Complaint file custody not adequately tracked—**Once the Office of Special Investigations returns complaint files to the Bureau, the locations of the files are not adequately tracked. For example, during the course of the audit, Bureau staff were initially unable to provide six complaint files to auditors because the files were in the custody of different staff than those originally thought to have them. Some of these complaints included serious allegations, including patient care problems and impersonation of an EMT. Although all files were eventually located and provided to audit staff, even a temporary loss can cause problems.

  Complaint files need to be consistently tracked and their location known. They serve as the sole repository for investigation reports, interview results, and supporting documentation, so loss of a file can seriously compromise the Bureau's ability to appropriately resolve complaints in a timely manner. Despite the importance of complaint files, the Bureau still lacks practices to track them. It does not have a formal process for transferring custody of files among Bureau staff, and its tracking system does not flag complaints when they reach an excessive age to alert staff that files may be misplaced or languishing in the process.

- **Computer tracking system inadequate—**The computerized complaint tracking system database used for tracking the Bureau's formal complaints is inadequate for the Bureau's needs. This complaint tracking system was developed for use by another DHS division and has not been modified to fit the requirements of the Bureau's complaints.

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[1] Background checks are initiated when the Bureau receives information suggesting it may not be appropriate to renew an individual's certification. According to Bureau staff, these allegations typically come from coworkers who believe the individual to be incompetent or unreliable.

Some critical fields are either missing or do not apply to Bureau complaints.For example, the complaint tracking system does not track statutory processing deadlines for complaints against ambulance companies.

The complaint tracking system also makes it difficult to monitor different types of investigations. It does not distinguish among the different types of investigations (initial certification and recertification background investigations, complaints against EMTs and paramedics, and complaints against ambulance companies). Therefore, users cannot easily query it for basic certification, recertification, or complaint-handling trends or statistics.

Table 2

Department of Health Services
Bureau of Emergency Medical Services
Days Needed to Resolve Complaints
Years Ended June 30, 1993 through 1998

Days to Resolve [1]	Type of Complaint			Total Complaints	Percentage of Resolutions by Number of Days
	Recertification	Ambulance	All Other		
0-180	52	93	70	215	60%
181-360	16	19	31	66	18
361-720	5	19	27	51	14
Over 720	0	21	7	28	8
Total	73	152	135	360	100%

1 Resolution calculated from the date the complaint is received to its closure.

Source: Auditor General staff analysis of Department of Health Services, Bureau of Emergency Medical Services' Complaint Tracking System data for years ended June 30, 1993 through 1998.

Complainants dissatisfied with process—The Bureau's complaint-handling process and untimely complaint resolution has caused complainant dissatisfaction, according to complainant letters and interviews. For example, one complainant wrote a letter to DHS investigators stating the following about the amount of time needed to address the complaint:

"It appears…you did little actual investigation into the incident despite the extensive time you took….I would have presumed that, given the amount of time you had to conduct your investigation it would have been more thorough. I am disappointed and believe that if this simple matter took this long (and produced this little) then someone needs to take a closer look at this agency."

Further, although the Bureau complies with A.R.S. §36-2245, which requires it to notify complainants that their written complaints have been received and are being investigated, it does not adequately keep consumers informed throughout the complaint process. In some cases, complainants do not receive any further information until the Bureau notifies them that their complaint has been closed.

Bureau Beginning to Make Some Improvements

The Bureau has recognized some of these complaint-handling problems and is beginning to make improvements, although additional work is needed. The Bureau plans to implement a new case management plan, which includes policies and procedures for complaint handling. Further, the Bureau and the Office of Special Investigations have recognized the need for an improved complaint-tracking system and are taking steps to resolve some of these problems. However, additional changes are required to correct problems.

Bureau plans to implement new case management plan for formal complaints—In order to address problems with complaint handling, the Bureau is currently drafting a new case management plan. This plan covers all aspects of complaint handling, including receiving and processing complaints, complaint tracking, and file location. As part of this new approach, the Bureau has hired an ombudsman. This position's duties will include receiving, routing, and tracking complaints from receipt to resolution. Bureau management believes this position will help the Bureau route complaints to the appropriate investigator or staff person, track complaint progress, and ensure complaints are resolved in a timely manner. The plan also establishes a standard of 180 days to resolve complaints.

Need for improved complaint-tracking system identified—Both the Bureau and the DHS Office of Special Investigations recognize the need for an improved complaint-tracking system. For example, an improved system could capture processing deadlines mandated by A.R.S. §36-2245 for informal complaints against ambulance companies, "flag" complaints that are not progressing, and allow staff to easily obtain critical information and trends through data queries.

The Office of Special Investigations is currently considering its needs and investigating both commercially available software and complaint-tracking systems used by other Arizona investigative agencies. Until a new computerized tracking system is identified and purchased, the Bureau and Office of Special Investigations are conducting bi-weekly meetings to manually track complaints and ensure they are resolved in a timely manner.

Although the Bureau's plans to improve complaint handling represent an improvement, DHS should make it a priority to follow through on these plans, and monitor the effect of these changes. Also, in addition to the improvements covered by the plan, the Bureau

should require that informal complaints be entered into the complaint tracking system for monitoring purposes and address staff training needs.

Recommendations

1. The Bureau should continue to develop and eventually adopt its case management plan, including the standard of resolving complaints within 180 days.

2. The Bureau should continue efforts to identify and eventually obtain the type of complaint-tracking database needed and available. Specifically, this database should include key fields to handle complaints unique to the emergency medical service industry, track statutory time frame processing requirements, identify the current location of complaint files, and differentiate between types of investigations.

3. The Bureau should develop a mechanism to note information on informally handled complaints. At a minimum, this information should be used to ensure that the Bureau meets statutory processing deadlines for ambulance company complaints, handles informal complaints appropriately, and identifies industry-wide problems.

4. The Bureau should provide investigative training for staff who handle informal complaints.

5. The Bureau should develop procedures for transferring and tracking complaint files, to ensure that their location is always known and the cases do not languish.

6. The Bureau should provide complainants an explanation of the complaint-handling process and periodically update the status of their complaints.

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OTHER PERTINENT INFORMATION

During the audit questions arose as to whether the Bureau's former Medical Director had a potential conflict of interest and, if so, whether it affected the Bureau's handling of regulatory matters.

Questions were raised regarding whether the former Medical Director had a potential conflict of interest as a result of her husband's employment with an ambulance company. Because statutes require the Medical Director to be an active emergency physician, all Bureau Medical Directors face conflict situations when their decisions would affect the hospitals they work in, and as a result they must recuse themselves from such decisions. The official in question had a wider range of potential conflicts, since her husband's company and its competitors provide much of the ambulance service in the State. Although the Bureau did not consistently follow its own policies regarding this official's participation in decisions, the Auditor General staff's review of available files revealed no inappropriately resolved complaints.

Former Medical Director faced potential conflict of interest—Industry representatives, Department personnel, and legislative staff raised questions during the audit regarding whether the Bureau's former Medical Director had a potential conflict of interest. The official in question served from November 1, 1993, until her resignation effective October 30, 1998. Questions arose because beginning in 1994, her spouse worked for the State's largest for-profit ambulance service provider.

Under state statutes and Bureau procedures, the Medical Director is responsible for many aspects of regulating the emergency services industry, such as reviewing complaints against ambulance companies, emergency medical technicians, and paramedics. Additionally, the Medical Director consults on virtually every aspect of the Bureau's activities. These responsibilities placed the former Medical Director in the position of making decisions that could potentially impact or be impacted by her spouse's employer.

Bureau did not consistently follow its policy—In response to this potential conflict, the Bureau obtained legal advice in 1995. The Bureau's Attorney General representative advised that the former Medical Director did not have a legal conflict of interest because her husband did not hold a financial interest in his employer's company. However, the attorney recommended exercising caution because there could be an appearance of conflict of interest, which could expose her to scrutiny and criticism. As a result, the Bureau wrote an internal policy directing the former Medical Director to refrain from reviewing any complaints against her husband's employer or any of its competitors, including complaints against individual employees of such companies. According to the policy, "None of these items should be routed to" the former medical director, and she should review copies of public records on matters covered by the policy only after the record became public.

The Bureau did not consistently follow its own policy for handling the potential conflict of interest. First, the Bureau continued to route some complaints to the former Medical Director that involved companies or employees affected by the policy. For example, she resolved some complaints against individual emergency medical technicians and paramedics employed by the affected companies. According to the former Medical Director, the Attorney General representative verbally approved her participation in each of these cases (current and former attorneys recall these conversations). In addition, in all such cases reviewed by Auditor General staff, another Bureau or Department official also reviewed the case and came to the same conclusion as the former Medical Director. However, according to the policy, these cases should not have been submitted to the former Medical Director at all. Second, although the policy required the Bureau to compile a list of affected ambulance companies every quarter, the Bureau compiled only two such lists. According to the former Medical Director, the list would not have changed so there was no need to follow the policy and create new lists.

Department reports attempts to avoid similar situations—To avoid this situation in the future, the Department of Health Services reports that it now closely scrutinizes potential conflicts of interest prior to hiring Bureau managers. For example, both the Bureau's new Medical Director and Bureau Chief's potential conflicts of interest were reportedly reviewed prior to their hiring. Additionally, Auditor General staff reviewed their conflict-of-interest statements. The new Bureau Chief relocated to Arizona and, therefore, has no potential conflicts. The new Medical Director has only a limited potential conflict because he is a licensed, practicing emergency medicine physician. This is consistent with statutory requirements placed on the part-time, Medical Director's position. As a result, both Bureau managers should be able to impartially perform their duties.

Agency Response

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Office of the Director

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Mr. Douglas R. Norton, CPA
Auditor General
Office of the Auditor General
2910 North 44th St., Suite 410
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Dear Mr. Norton:

Thank you for the opportunity to review the report of the Performance Audit, conducted as part of the Sunset Review set forth in A.R.S. §41-2951 through 41-2957, of the Arizona Department of Health Services (ADHS), Bureau of Emergency Medical Services.

The findings and recommendations contained in your report have been carefully reviewed by the staff of ADHS, and in accordance with the instructions contained in your letter of April 2, 1999, the enclosed response is provided.

ADHS greatly appreciates the hard work and professionalism shown by your staff during the conduct of their audit. We also appreciate the insights provided by your staff during the audit process and through the audit's findings and recommendations. From the knowledge gained as a result of your efforts, we will be able to significantly improve the work processes that relate to the certification and regulation of emergency medical services. As a result, we will be able to better serve both the regulated community and consumers of emergency medical services within the State of Arizona.

Sincerely,

James R. Allen, M.D., M.P.H.
Director

JRA:SPH:df

Enclosure

ADHS Response to the Performance Audit on
the Bureau of Emergency Medical Services

Overview:

The Arizona Department of Health Services (ADHS) agrees in general with the recommendations and conclusions of the audit team.

We feel it is important to point out that Finding I relates to a legislatively mandated activity. We recognize there are other ways used in other states to regulate ambulance services; the CON process has been prescribed by state lawmakers as the method for use in Arizona.

With respect to Finding II, ADHS management had recognized the need for improvement, and had undertaken major steps toward overall improvement as well as developing specific strategies for the issues identified within the report. Already, significant changes had been made in the leadership, structure and operations of the Bureau:

- The Bureau has been changed from a centralized organization of specialists to a regionalized organization of generalists. This change allows for improved relations and communication with our regulated clients.

- A new Medical Director, Bureau Chief, and Paralegal Investigator have been hired.

These changes should be seen as a major and ongoing commitment on the part of ADHS to address the findings cited in the report and to improve upon the Bureau's ability to serve and protect the public.

Finding I - The Certificate of Necessity is an Unnecessary Form of Regulation

(A) Current Approach Does Not Meet Goals and Is Unnecessary

This section of the report comments upon the existing Certificate of Necessity approach to approving ambulance operations. Specifically:

CONs do not guarantee coverage - The report finds that some areas of the state are not covered, and that ADHS cannot compel providers to offer service in remote or unprofitable areas. While we are aware this is true, we do not know of a system that is able to accomplish this. In any system there are some areas that simply cannot support ambulance services. These reasons may be economic in part, but it is also difficult to attract and retain qualified personnel for an ambulance service with a paucity of calls. In order to address some of the problems faced by certain areas within Arizona, ADHS is supporting legislation to allocate funding for the improvement of rural emergency medical services.

This section also raises a concern about whether ADHS has assured that the Department of Public Safety (DPS) has correct and current information on the location and capabilities of ambulance

providers. While we can provide DPS with such information, ambulance dispatching is conducted under the color of local authority, not through DPS.

Unregulated services and costly air ambulances fill the gap - The report finds that rescue and air services are often used in place of ambulances for areas that have inadequate ambulance coverage. ADHS shares the concern of the auditors that rescue vehicles occasionally and perhaps improperly cross the line into the provision of ambulance service. While this may be symptomatic of unmet need, there are also local political issues at play. ADHS will consider approaches to integrate rescue services and personnel into the emergency medical services system.

Upon completion of the new ground ambulance rules, the Bureau will begin working on drafting new regulations for air ambulance services. Opportunities exist within that context for developing air ambulance utilization criteria.

CONs ineffective for ensuring quality - The observation is made that the CON system does not meet its goal of assuring quality services because the Bureau does not routinely conduct analyses of response time data. We recognize opportunities exist to improve upon this. Response time is not uniformly calculated nor reported. It is important to note the Bureau is taking measures now, in concert with the EMS community, to establish a regulatory definition of response time. A second critical step is the establishment of electronic reporting of this data to facilitate its analysis. We are considering all options in regard to electronic reporting.

It is also important to recognize that response time alone is an inadequate expression of quality. The total amount of time between the event and the administration of definitive care at a hospital may be meaningful to patient outcome, but the ambulance response time is a single parameter within this timeframe (See table 1. below.) ADHS is committed to finding more effective and reliable ways to evaluate quality.

Table 1.

System Reaction Time		**Total Run Time**			**Care Time**
Access Time	Processing Time	Response Time	Scene Time	Transport Time	Definitive Care Time

Access Time is the amount of time between the event and the call for help.
Processing Time is the amount of time between the call for help and when the ambulance is dispatched.
Response Time is the amount of time between when the ambulance is dispatched and when the ambulance arrives on the scene.
Scene Time is the amount of time between when the ambulance arrives on the scene and when the ambulance departs the scene.
Transport Time is the amount of time between when the ambulance departs the scene and when the ambulance arrives at its destination.
Definitive Care Time is the amount of time between when the ambulance arrives at the facility, and definitive care is rendered.

CONs unnecessary for ensuring quality and regulating fees - The report finds that ambulance service quality and charges could be regulated without the CON system. Certainly other methods for evaluating service quality or establishing rates could be used with or instead of the CON process. The regulation of fees has been coupled with the CON process because the CON describes a population base within a distinct geographic area. This facilitates the ability to accurately project costs and revenues and to determine appropriate rate structures.

(B) CON System Limits Competition

This section of the report comments upon the effect of CON on the market. Specifically:

CON System creates a barrier to entering the market - The observation is made that CON makes it difficult for new services to enter the market and discourages competition. The CON process is built, in part, on the premise that entities will be willing to provide services in otherwise economically unattractive areas, if they are guaranteed that there will be limited or no competition in the particular market as a result of (1) limitations in the awarding of CONs and (2) service restrictions on those entities not awarded a CON (for the particular area) who would otherwise have been competitors. The concept is that guaranteed market control over a service area can create sufficient economic incentive for a private entity to be willing to furnish services. Obviously, the incentive would be even stronger if market control involved the independent setting of fees by the CON holder as opposed to the rate regulation done by the Bureau (and, in effect, by third party payors).

Denies local governments a role - The report states the CON process denies local governments a role in selecting ambulance providers, when they may be in a better position to determine their community's needs. Local governments can choose to pursue a CON, but the decision-making authority rests exclusively with the state in the CON model for the ostensible reason that the state is in the best position to assure the complete integration of the provider community into a statewide EMS system.

(C) CON System Should Be Reevaluated

This section of the report suggests a more effective means of regulation should be considered. Specifically:

The Legislature should consider other forms of regulation - Should the legislature choose to pursue this we will assist in any way possible.

If the CON is continued, quality and coverage oversight could be improved - The report finds that quality could be improved through increased use of the authority to revoke or suspend, holding providers accountable to response time, and creating documentation that lists or maps information about provider service areas and response times. We agree that quality should be continually improved, but as previously mentioned, response time is only one aspect of that. ADHS is considering all options

in developing improved quality and outcome monitoring.

Finding I Recommendations

1. The Legislature should consider directing the Bureau to form a study group to evaluate possible changes in the manner in which Arizona regulates ambulance services. This group should consider various options, including the following:

    a. Licensing providers to ensure quality, without limiting competition by controlling the number of providers; or
    b. Licensing providers and allowing local governments to establish operating areas through a competitive process.

    The finding of the Auditor General is agreed to, and the audit recommendations will be implemented pending approval from the Governor and/or the Legislature before proceeding.

2. Whether or not the CON system is continued, the Bureau should use its regulatory authority to enforce quality controls such as response times.

    The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

3. The Bureau should assemble the information it has regarding providers and their service areas into easily accessible lists or maps so that this information can be used by other agencies.

    The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

Finding II - The Bureau Does Not Adequately Handle Complaints

(A) Final Resolution Decisions Delayed In the Past

This section of the report comments upon the Bureau's ability to resolve complaints and in some cases impose appropriate discipline. Specifically, the observation is made that some complaints were open for an extended period of time even though the investigations had been concluded. The report also mentions that the majority of cases have been handled promptly, and that the Bureau has made significant improvements since the last audit.

The new Bureau Chief is certified by the Council on Licensure, Enforcement and Regulation as an investigator. The new Bureau Chief's background and certification will prove valuable as the Bureau seeks to improve its training and investigative procedures. In addition, a Paralegal Investigator has now been hired by the Bureau to manage and track complaint investigations.

(B) Other Complaint-Handling Problems Still Exist

This section of the report finds the Bureau to be hampered by other problems. Specifically:

Informal complaints not tracked and most staff not trained - The auditors observe that lack of an effective tracking methodology may prevent it from ensuring complaints are handled appropriately or discovering industry-wide trends. A further observation is made that the staff handling informal complaints have no formal investigative training. A new complaint-tracking procedure is under development, planning for a computer-based complaint tracking program is under way, and the new Paralegal Investigator works directly with the Bureau Chief and the Medical Director in conducting investigations.

Formal system also contains problems - Four observations are made: slow complaint handling, complaint files custody inadequately tracked, inadequate computer tracking system, and complainants are dissatisfied with the process.

The report finds that the majority of complaints were handled in a timely fashion. Up to 22% of the investigations may have taken more than one year to complete, and 8% took considerably longer. It must be recognized that while ADHS agrees improvement is needed, some cases are extremely complicated, necessitating interagency coordination, interviews with uncooperative or hard to locate witnesses, or a need to await the outcome of related legal proceedings. In some instances, because of pending legal action or other considerations, a rapidly concluded investigation does not guarantee timely resolution and *closure* of a case.

The report indicated six complaint files were initially difficult to locate. On November 19th, a request was made that these six files be located by November 25th. The location of these files was determined and made known to the audit team on November 20th.

The report finds that the current computer complaint-tracking system makes it difficult to monitor different types of complaints, and does not track statutory deadlines. We are aware of this and are actively engaged in replacing this system.

Complainants have expressed dissatisfaction with complaint-handling, and are not informed throughout the complaint process. The new case-management system will address this need.

We expect that the new Paralegal Investigator will significantly reduce the workload of investigations being handled by OSI, and the development of appropriate software will significantly improve operations.

(C) Bureau Beginning to Make Some Improvements

This section of the report recognizes some of the Bureau's efforts to improve. Specifically, the development of the new case management plan, the semimonthly status meetings, the addition of the

Paralegal Investigator (ombudsman) and the identification of the need for improved computerized complaint tracking are recognized.

Finding II Recommendations

1. The Bureau should continue to develop and eventually adopt its case management plan, including the standard of resolving complaints within 180 days.

   The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

2. The Bureau should continue efforts to identify and eventually obtain the type of complaint-tracking database needed and available. Specifically, this database should include key fields to handle complaints unique to the emergency medical service industry, track statutory timeframe processing requirements, identify the current location of complaint files, and differentiate between types of investigations.

   The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

3. The Bureau should develop a mechanism to note information on informally handled complaints. At a minimum, this information should be used to ensure that the Bureau meets statutory processing deadlines for ambulance company complaints, handles informal complaints appropriately, and identifies industry-wide problems.

   The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

4. The Bureau should provide investigative training for staff who handle informal complaints.

   The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

5. The Bureau should develop procedures for transferring and tracking complaint files, to ensure their location is always known and the cases do not languish.

   The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

6. The Bureau should provide complainants an explanation of the complaint-handling process and periodically update the status of their complaints.

   The finding of the Auditor General is agreed to, and the audit recommendations will be implemented.

Other Pertinent Information

This section of the report contains no findings, but comments upon an alleged conflict of interest on the part of the past Medical Director of the Bureau. It is observed that the previous Medical Director was placed by her work responsibilities in the position of making decisions that could potentially impact or be impacted by her spouse's employer.

ADHS is pleased that the Auditor General recognizes the fact that no actual conflict ever arose as a result of the former Medical Director's ties with the provider community. The facts demonstrate that in practice, the Bureau adopted a self-policing approach to the problem.