Emergency medical technicians, first responders and paramedics—the backbone of emergency medical services—have worked for decades under a reimbursement system that effectively keeps their pay low and gives them an incentive to not always provide efficient, quality care. That reimbursement model may be in for revision, though, a move that would be welcomed by many in the industry.

At the center of the problem is a 1960s-era reimbursement model that EMS experts say no longer fits with how the EMS community wants to provide care. Under the current model, which was developed when ambulances were used for transportation only, an ambulance service gets paid only if a patient is transported to a hospital. An EMT or paramedic who spends the time and effort to appropriately stabilize a patient in a home or at the scene of an accident gets reimbursed nothing if the patient feels well enough to decline a trip to the emergency room. But if that same patient—who may not need additional care—decides to visit the ER, then not only does the ambulance service get paid, but the hospital ER does too, unleashing a string of bills that possibly could have been avoided.

That kind of reimbursement for a service designed to be ready to go at any time makes it difficult to support the infrastructure and overhead of EMS. It also encourages inefficient use of healthcare resources.

"There's a disincentive to not take people to the hospital," says Skip Kirkwood, president of the National EMS Management Association and chief of the Wake County Emergency Medical Services division, Raleigh, N.C. Kirkwood and others say that EMS professionals do their job to the best of their ability, but EMS providers could do more, saving the healthcare system money by providing additional care upfront. But the current reimbursement model effectively discourages preventive care by not giving agencies the resources to provide it, Kirkwood says.

And while the country has come to expect the use of tax money to pay for the readiness of fire protection, ambulance service is not always subsidized with taxes. There isn't an automatic expectation that the government should back EMS providers. That means ambulance services often may run on a shoestring or may subsidize emergency care with nonemergency care, such as transferring patients between healthcare facilities.

In fact, the trend among public ambulance providers is to pull back, experts say.

"We're actually losing jobs" in the municipal and county arenas, says Connie Meyer, board president of the National Association of Emergency Medical Technicians and EMS captain for Johnson County (Kan.) Med-Act, a public EMS provider. "We're trying to make the case that we're a vital part of the healthcare system," she says. "EMS is a safety net for the healthcare system."

As a result of the current reimbursement model, regions in which emergency medical services don't have well-subsidized funding from the community tax base are more likely to pay their EMS personnel less and struggle to keep personnel in the field for a long time, industry experts say.

Compensation and retention

Recent data from a federally backed 2010-11 survey of members of the National Association of State EMS Officials, or NASEMSO, shows that EMS salaries can be low given their importance in the clinical-care spectrum. That survey found emergency medical technicians earned a median of $25,066 to $28,600 a year, while someone with the more-advanced designation of paramedic earned a median of $38,000, according to the survey, which for this portion received responses from 26 to 29 states.

A separate report from the U.S. Bureau of Labor Statistics, which groups EMTs and paramedics into one classification, estimated their 2010 median pay to be $30,360 a year. EMS workers who do double duty as firefighters generally earn more. The median salary in 2010 for a firefighter was $45,250 a year, according to the BLS. Both fall short of the median salary of registered nurses, which was $69,110 as of May 2011, according to the BLS.

"There is a retention problem because (EMS) is what people consider a low-paying job," says William Brown Jr., executive director of the National Registry of Emergency Medical Technicians, which offers professional EMS certification. The reimbursement needs to include a component that covers the "readiness" required of EMS, Brown says. "How are you supposed to support the delivery of EMS to 300 million Americans when you do not get paid for a lot of the work and readiness that you do?" Brown asks.

While EMS personnel in urban settings generally get paid a salary, there are still a large number of EMS responders who get paid little or nothing as volunteers. That creates some tension in the industry, with some wanting to boost entry-level EMS standards. The U.S.' standards are among the lowest of...
English-speaking countries, Kirkwood says, while communities relying on volunteers often oppose it. Volunteer EMS personnel are already being asked to do a lot, and raising standards would make it even more difficult to attract and retain volunteers, he says.

"People who do it for free want to do it with minimal investment," he says.

Changing certification

The National Registry of Emergency Medical Technicians is in the process of reworking or renaming its certification levels, eliminating some of the categories and introducing a new one. Once all of the changes are in place by the end of 2013, the number of certification levels will stand at four: emergency medical responder, emergency medical technician, advanced emergency medical technician and paramedic.

The emergency medical responder certification, which will replace the first responder designation, allows the holder to provide front-line EMS care though they cannot care for patients in the back of an ambulance, according to the NREMT. EMTs can treat patients in an ambulance using medical equipment such as automatic defibrillators as well as deliver trauma care; EMTs are also educated in simple methods to treat injuries and disease.

An advanced emergency medical technician requires EMT certification plus additional education, allowing the holder to provide more advanced care. The paramedic certification also first requires EMT certification, and they provide the highest level care of the EMS professionals. Not all EMS systems will be affected by the changes because NREMT certification is optional and some states offer their own examinations or recognize only some of the certification levels.

Demographics of the country also may be working against EMS by possibly creating a shortage of these staffers.

"We're going to face increased challenges in the future because of all of the baby boomers growing older," says Gary Ludwig, deputy fire chief for the city of Memphis, Tenn. Memphis is putting a greater amount of emphasis on EMS care and is increasing its workforce and funding for it, Ludwig says.

Some influential groups are taking a look at these core problems with how emergency medical services are provided and paid for, and changes could occur given healthcare's shifting of more focus on a patient's entire continuum of care and rewarding providers for improved quality.

Dia Gainor, executive director of the NASEMSO, says there are a number of issues that industry stakeholders are working to solve, including a workforce count; creating national definitions for what constitutes an EMS worker--paid or volunteer; and the industry's approach to reimbursement, which generally is below the cost of providing the service.

Work to review the EMS model is under way at organizations such as the U.S. Department of Transportation's National Highway Traffic Safety Administration, the National EMS Advisory Council and the Medicare Payment Advisory Commission as well as the NASEMSO.

The NHTSA, which has primary oversight of EMS as a result of its history as a transporter of patients, commissioned a series of major reports on the EMS workforce. The most recent of which, released last year, aims to highlight the issues facing the industry. Called The Emergency Medical Services Workforce Agenda for the Future, the report outlines goals regarding EMS workforce: health and safety; education and certification; planning and development; and data and research.

The dearth of data on the EMS workforce was previously addressed in a 2008 NHTSA report, and was summarized in the more recent report. "The most basic workforce statistics, such as workforce size, cannot be accurately estimated using available data," the report authors wrote. The BLS doesn't distinguish between EMTs and paramedics, does not identify EMTs cross-trained as firefighters, and does not capture volunteer EMS workers, according to the report. Others note that many EMS workers have more than one job, which also complicates the calculation of an industry workforce total.

"It's very hard to count this workforce," Susan Chapman, one of the authors of both reports, says in an interview. There have been different attempts to calculate workforce totals, but the studies' results produce divergent numbers, says Chapman, director of allied health workforce studies at the University of California at San Francisco's Center for the Health Professions and an assistant adjunct professor at the UCSF School of Nursing.

Effects of reform

Another effort by the NHTSA-affiliated National EMS Advisory Council is studying the ways the EMS segment could participate in the kind of initiatives being implemented as a result of healthcare reform, such as pay-for-performance and shared-savings programs, says Marc Goldstone, a member of the council and vice president and associate general counsel for a regional division of Community Health Systems Professional Services Corp., Franklin, Tenn., the management services unit of for-profit hospital chain Community Health Systems.

"The council has been very active," and is addressing a number of issues, including attracting and retaining good employees, Goldstone says.

MedPAC's interest in EMS is driven by an order from Congress that was part of the Middle Class Tax Relief and Job Creation Act of 2012, which calls for the advisory group to recommend whether the Medicare ambulance fee schedule—which produced fees of $5.2 billion in 2010—should be reformed in the long term and for shorter-term issues related to rural Medicare add-on fees that were implemented in 2008 to try to alleviate some reimbursement problems.

MedPAC members expect to get at least an initial draft of a report from staff members before the add-on fees expire at year-end, though the final report isn't due until June 15, 2013, according to a transcript of an April MedPAC meeting.

And just last week, a group of industry stakeholders convened by the NASEMSO was set to meet to move forward with the NHTSA-funded project titled EMS Workforce Planning and Development Guidelines for State Adoption.

The goal is to produce "an informative document to prepare state EMS offices to properly collect and aggregate EMS-specific workforce data in a manner considered appropriate by the workforce development planning industry, and provide the state EMS officials with enough depth and literacy to be enabled to engage their state department of labor, state workforce development commission, or others to initiate a sector-based strategy for workforce planning and development," according to the meeting invitation.

Already being tested in urban and rural settings is the concept of community paramedicine. The concept is based on giving specially trained paramedics the ability to work as primary caregivers in selected situations and settings. The movement aims to draw on existing skills and apply them in new ways, providing wellness care or performing follow-up visits for patients who could benefit from assistance in the home but may not require a traditional home health visit (Aug. 22, 2011, p. 28).

The approach requires a more extreme reworking of reimbursement. Minnesota has approved a form of that type of care for rural Medicaid participants and test projects are in place in several other parts of the country.

Some providers have taken it into their own hands to boost EMS care. In parts of Kentucky and Tennessee, an Ascension Health-owned chest-pain network has trained EMS personnel to try to improve outcomes in the regions it serves, says Ranee Curtis, director of regional network services for Nashville-based St. Thomas Health, which runs the St. Thomas Chest Pain Network.

In developing the network, St. Thomas found that there were a variety of protocols and procedures in place among various EMS providers, while resources and education were lacking. As a result, the network created training programs for EMS workers and other caregivers to try to standardize care within the network, Curtis says.

St. Thomas networks have trained about 1,200 EMTs and paramedics in critical care, ventilation transport and other types of pre-hospital care, a spokeswoman says. The network also has developed the first state-approved critical-care paramedic course, according to St. Thomas. EMS played an integral role, Curtis says. "We want EMS to be a value to the community."

Copyright 2012 Crain Communications Inc. All Rights Reserved.
Trauma in EMS: Emergency medical services system faces myriad challenges, including overhaul of reimbursement structure

Author: Barr, Paul
Publication title: Modern Healthcare
Volume: 42
Issue: 20
Pages: n/a
Publication year: 2012
Publication date: May 14, 2012
Year: 2012
Publisher: Crain Communications, Incorporated
Place of publication: Chicago
Country of publication: United States
Journal subject: Medical Sciences, Health Facilities And Administration
ISSN: 01607480
CODEN: MOHEDA
Source type: Trade Journals
Language of publication: English
Document type: Feature
Document feature: Photographs;Charts;Graphs
ProQuest document ID: 1014001900
Copyright: Copyright 2012 Crain Communications Inc. All Rights Reserved.
Last updated: 2012-05-25
Database: 3 databases
AB/INFORM Complete
ProQuest Central
ProQuest Research Library