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COMMENTARY: IF WE SHOOT OURSELVES IN THE FOOT, WILL EMS BE THERE TO RESPOND?

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Emergency medical services (EMS) systems have been part and parcel of emergency medicine since their mutual inception in the 1960s. We take pride as emergency physicians in knowing that we are part of the front line of medicine, a line that starts in the alleys, homes, bright rooms, and dark corners of our society and extends, through our professional EMS colleagues, directly to our doors. It's not uncommon for our residents to have started their interest in emergency medicine in the back of an ambulance, and with the new certification of EMS as a subspecialty of emergency medicine, we are better defining and promoting how we as physicians can enhance EMS. As proud as we are of the good work that we do, none of us would presume that the safety net we provide to each member of our communities could withstand the dismantling of out-of-hospital care. Unfortunately, as budget cuts continue to threaten almost every municipality and health care payers fail to keep up with the advances made in out-of-hospital care, we find ourselves in the untenable position of having to face a world in which sick and injured patients have difficulty reaching us because of an overtaxed and underfunded EMS system.

The May 2012 report from the National EMS Advisory Council Finance Committee describes challenges to continued funding of EMS systems and suggestions for addressing the looming shortfalls that threaten to curtail service.[1] Before we address those, however, we should take a look at how we got where we are.

EMS began in the 1960s in response to advances in cardiac resuscitation (such as the invention of defibrillation and the advent of cardiopulmonary resuscitation) and was further pushed forward by the 1966 white paper titled "Accidental Death and Disability: The Neglected Disease of Modern Society."[2] These initial efforts were supported by hospitals and a few forward-looking municipalities that saw the benefit in a more capable system of out-of-hospital care than ambulance attendants who had little equipment and no training beyond first aid. After the 1966 white paper, which corroborated findings from other recent reports, the Highway Safety Act of 1966 was passed, creating the Department of Transportation and granting it oversight of EMS activities. State and regional EMS systems were supported by matching funds from the government, with more than $142 million in investment from 1968 to 1979. The EMS Act of 1973 provided more than $300 million in funding to encourage communities to develop EMS systems, with the idea that they would become capable of supporting themselves financially after being given startup funds from the federal government; these funds were phased out in 1982. Additional funding came from the Robert Wood Johnson Foundation in 1974, which provided a $15 million donation divided among 44 areas to support their EMS system development.

Since that time, federal funding for EMS was consolidated into other programs and eventually ceased. Little progress was made in securing a funding stream for EMS until the Health Care Financing Administration began to develop the National Ambulance Fee Schedule in 1999, which was ultimately published in 2002. Most EMS programs now are supported by municipal funding, with incomplete reimbursement from health care payers and occasional subscription fees.

As the National EMS Advisory Council report illustrates, many changes in EMS have occurred and are occurring, making previous payment models dangerously obsolete. We now know that not every patient needs to be transported to the hospital; for example, a diabetic patient might be unharmed after administration of dextrose, a patient with heroin overdose may require no further treatment after naloxone administration, and a patient with an ankle sprain might do just as well to travel by private vehicle to his or her regular physician. Also common are emergency responses in which no patient is treated either because of the call being canceled after a precautionary dispatch or because treatment was refused by the patient. However, despite each of these calls having at least 1 ambulance with 2 personnel responding—and perhaps 6 personnel on an ambulance and a fire engine—few insurers will pay for this evaluation or treatment because only transportation to a hospital is covered. This leaves patients with a bill they did not expect and likely cannot afford. It also leaves EMS agencies with significant costs for maintaining response readiness and heading out to these calls, despite the general inability to be reimbursed.

Even when EMS services are reimbursed, the compensation often falls short of actual costs (never mind the issues involving

costs versus charges). Medicare averages a little more than $400 in reimbursement for a typical advanced life support transport, regardless of what actually happens on that call; many of these calls are underpaid by hundreds of dollars each. Medicaid can pay as little as approximately $100, and even that funding is in danger of being cut in some states. Overall, the National EMS Advisory Council report estimates that EMS services receive below-cost reimbursement on an amazing 72% of all transports (and of course this percentage doesn't even address nontransport patients), with the total uncompensated care burden in the United States approaching $3 billion annually. For reference, a study conducted about a decade ago found that emergency physicians provided roughly $4.2 billion a year in uncompensated care.

Of course, EMS has a role to play in reducing health care costs, along with every other field of medicine. Payment models that allow for alternative destinations (such as private offices or dialysis centers) would help conserve resources by getting patients to the most appropriate destination, which could also help reduce the amount of downtime experienced by some ambulance teams that find themselves waiting hours to offload patients at crowded emergency departments (EDs). If EMS services could be paid for treating and releasing patients at the scene, it's not hard to imagine that not only would reimbursements improve but also some patients who don't really need a trip to the ED might not be transported anymore.

The potential for improved resource use goes even further, however, when combined with the potential to radically improve public health. EMS has long been considered to be at the intersection of public health, public safety, and medicine, and proper funding and use of the already existing infrastructure, along with new training, could lead to effective, widespread use of community paramedics. Our EMS colleagues meet our patients in their homes and places of business; they have the best ability to truly understand the social, financial, and other barriers that conspire to keep our patients from doing their best to keep themselves healthy. Hospital-based programs to reduce readmissions for congestive heart failure are good, but a community paramedicine program can provide early detection and intervention, along with linkage to vital community support services to help keep the congestive heart failure patient out of the department in the first place; in other words, this is an upstream approach, near and dear to every public health expert's heart. In the future, we could very well see 911 call centers expand to include space for medical command and control, overseeing not just urgent EMS responses, but also visits to patients with chronic health needs, direction of advanced practice paramedics providing alternate treatment and destination programs, coordination with private physicians about their patients, and more rational patient distribution.

In fact, the recent Health Care Innovation Challenge sponsored by the Centers for Medicare & Medicaid Services includes 4 funded grants to improve EMS system capability. By providing community paramedicine, telemedicine, and care coordination services, these 4 pilot programs hope to save tens of millions of dollars during the next 3 years.

Of course, not every EMS system can rely on a research grant. So where does the money for this come from? Nobody expects us to return to the federal funding stream of 4 decades ago. Although government still has an important role to play in EMS funding, it's also important that insurers and other health care payers update their payment models to incorporate modern EMS system capabilities, along with flexibility, to support innovative programs that will ultimately reduce resource use. Furthermore, as the National EMS Advisory Council report observed, when EMS helps the rest of the health care system save money, it makes sense to share those savings with EMS to support these gains and allow further progress. Working with public health agencies to support their mutual missions would also provide an avenue for increased EMS funding, giving public health departments opportunities to take advantage of EMS infrastructure and experience. Other changes would be helpful as well, including implementing regulatory changes to facilitate the sharing of billing information from hospitals to EMS agencies, ensuring that the prudent layperson standard is enforced at the EMS level while taking into account local protocols and standards, and allowing and encouraging EMS agencies to implement better regionalization to allow for economies of scale.

This won't be easy, but it's a fight worth fighting for emergency physicians. During every shift, when we're in the trenches, we see the results of a health care system that makes no sense. We have patients who can't get their medicines, others who can't properly store them because they have no place to live, others who would rather go to their regular physician but can't get a ride, others who wait far too long for care because even our hallways are filled to capacity. . . The list goes on and on. Improved funding of EMS systems won't be the panacea for all of our departments' ills, but it will help make significant inroads into tackling these problems. Naturally, this isn't primarily an issue for us, or even for EMS providers; it's for our mutual patients. Ensuring uninterrupted access to quality emergency medical care and improving community health while conserving resources is a policy platform that everybody can agree on.

As initiatives sprout in our communities to help secure stable funding streams for EMS, develop community paramedicine services, and coordinate medical response across multiple fire, EMS, law enforcement, public health, and public safety services, I hope to see emergency physicians lending their respected voices in support. This is more than a pipe dream for the few of us who plan to become certified in EMS: It's a chance to make a real change for our patients.

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