The impact of health care reform on emergency medical services

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On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. (1) The reforms introduced through PPACA present a paradigm shift in the future delivery model of all health care, including Emergency Medical Services (EMS). Changes embodied in this law offer a variety of opportunities to improve the delivery of care in urgent and emergent medical situations in the out-of-hospital setting. PPACA offers a number of avenues for EMS to engage at a much higher level as professional members of the health care team going forward. Certain components of the law stand to facilitate and further energize innovative programs that have been started in progressive EMS systems.

A monumental shift away from EMS as an emergency-only service with a primary focus on transport to a hospital is already underway. By capitalizing on the opportunities offered by PPACA, EMS stands to mature considerably as a profession in this generation. Further emphasis on modification of EMS scope of practice and a continued transition away from strictly emergency care to greater decision-making capacity, stronger networked linkage to the remainder of the health care continuum, and expanded roles matched to local needs are all tremendous opportunities for EMS.

**Accountable Care Organizations (ACOs)**

A dramatic shift in the mechanism by which physicians and health care organizations will be reimbursed for their services is the element of PPACA that is most likely to drive change in EMS. A number of the greatest opportunities for change in the structure and practice of EMS relate to the formation of accountable care organizations (ACOs) and the opportunities those may offer for EMS to participate in different ways within the continuum of care. ACOs will create new partnerships between local and regional health care stakeholders with the goal of
maintaining or improving the quality of care while reducing the overall cost to the population served. These goals can be accomplished in any of a number of ways based on local and regional needs and available resources. It is expected that one of the core activities of ACOs will be to establish and use long-term relationships between patients and primary care physicians while leveraging new relationships between the “medical home” and a network of support services, including social work, home health, case management, and potentially emergency medical services. The ACO model will be a capitated model, rather than fee for service, thus incentivizing cost effectiveness and containment. Providers will be at risk for all of the health care expenses incurred by the patients for which they are responsible. (2)

As ACOs develop, the hope is that they will discover novel opportunities to improve health and reduce costs through innovative partnerships. EMS organizations will need to proactively engage with their local ACOs as they form, since awareness of the potential roles for EMS may not be obvious to the traditional outpatient and inpatient stakeholder groups. The options for EMS integration into ACOs may take a range of forms, depending on the sophistication and resources available within the local system. This may be simply assuring medical necessity of transport, or may expand to include:

- other options for transport to non-hospital destinations (i.e. physician offices),
- ability to assess and provide simple treatments and non-transport patients with the assurance of prompt physician office follow-up,
- ability to concurrently electronically link to outpatient and inpatient records through health information exchanges (HIE) to provide broader perspective on the patient assessment and treatment plan,
• ability to link patients to other needed members of the health care team through a case management model,
• ability to provide short-term post-discharge follow-up to limit readmissions, and
• ability to provide monitoring of chronic conditions for in-home compliance.

Non-transports
One obvious method by which EMS can reduce health care costs is by taking a direct role in the reduction of unnecessary ambulance transports. Although historically EMS’ ability to accurately identify subgroups of patients who do not require transport has been lacking, with ACOs expected to strengthen HIE integration, the ability to provide timely, quality oversight of this capability while still assuring an appropriate “safety net” is much more robust. Currently, in the vast majority of EMS systems, the only option for a patient who calls 9-1-1 is transport to the emergency department. This is driven by the current payment model, the liability of non-transport, and the lack of established alternative transport destinations and patient selection criteria for same. Linkage of expanded scope, supported by appropriate professional education, validated decision models, and quality oversight could position EMS as a front line in-person triage of patients in need of care to an emergent, urgent, or non-emergent category. This would then allow them to reliably refer and potentially transport patients for care in non-emergency settings when appropriate. (3) The significant cost savings that could be realized by such implementations of EMS capability should incentivize ACOs to engage EMS early in their formation to assure appropriate integration of the EMS resource into the broader local system of care.
Community Paramedicine
PPACA is expected to make health insurance coverage available to 30 million previously
uninsured people by 2014 and will also improve coverage and access to care for many others.
The Association of American Medical Colleges has projected that this increase in the demand for
health care will result in a shortage of more than 90,000 active physicians, including more than
45,000 primary care physicians by 2020.(4) This gap between physician availability and demand
suggests a solution built on ancillary health care personnel working in coordination with
physicians and other innovative means to deliver care. This staged approach could offer the
ability to appropriately match patients to the necessary resource based on acuity and needs. EMS
is well positioned to be an important part of this type of solution. A potential solution to address
this need is found in a small but growing trend in some EMS systems: community paramedicine.
Community paramedics will have special training and an expanded scope of practice. The goal
is to help promote integration and continuity of care, a more reliable transition between inpatient
and outpatient arenas, and better maintenance of health in chronic conditions, with the desired
outcome being improved individual and community health and appropriate reduction of demand
on hospital emergency departments and inpatient resources.
Community paramedicine will require EMS educators and leaders to develop standardized curricula and a validated scope of practice, which is already underway. Because current constructs of community paramedicine are already widely variable, structured to meet local needs, the specific elements of the expanded scope of practice locally will be driven by the new roles EMS engages to fill within the health care partnership. As EMS transitions away from an exclusively “emergency”, on-demand, 911-driven resource the ability to understand and fully integrate within the continuum of care is essential. The future scope of practice for community paramedics may include various elements of:

- Primary care
- Public health
- Disease management
- Prevention and wellness
- Mental health
- Dental care

Within the ACO model, community paramedics may provide early follow-up on patients who have recently been discharged from the hospital, reinforcing and monitoring compliance with discharge instructions and assuring medical stability in the immediate post-discharge period, or modifying therapy, arranging for short-term outpatient follow-up, engaging of additional ancillary health care team members, or adopting other strategies to avoid hospital readmission. This would benefit ACOs by reducing rates of readmission.(5) Community paramedics would be a natural fit to provide home-based services to reduce rates of hospitalization for ambulatory care sensitive conditions, such as asthma, diabetes, hypertension and chronic obstructive pulmonary disease. Using validated assessment and intervention tools, community paramedics
could have a significant role in providing better care, improving health, and reducing the cost to care to this and other medically vulnerable segments of the population. The National Association of Emergency Medical Technicians believes that paramedics can reduce health care costs, but these cost reductions must not be realized through sacrifices in response time or surge capacity.(6)

**Other Programs**

PPACA includes a number of additional opportunities of note for EMS, including creation of the new National Health Care Workforce commission, trauma service availability grants, regionalization initiatives, and support of pediatric research and initiatives through the reauthorization of the EMS for Children program.

Three areas offer the opportunity for ACEP to provide subject matter expertise with regard to emergency medical services. The first is the newly created National Health Care Workforce commission, which is charged with reviewing the entire US health care workforce, and reporting and making annual recommendations to Congress and the presidential administration. The EMS workforce, both career and volunteer, is specifically named as one of the segments they must review. ACEP should support the commission’s efforts with subject matter with respect to the education and training capacity, projected demands, retention and recruitment, and integration within the health care delivery system of the emergency medical service workforce. The recommendations made by the commission have the potential to significantly impact the future of EMS education and the profession as a whole. Another opportunity is with the new trauma service availability grants. These grants will be provided to the states which will then further award them to trauma centers to address trauma service availability by enhancing collaboration
with other hospitals and emergency medical services. ACEP can help support trauma system development by providing expertise and support in best practice development within the framework of these grants. Finally, the creation of Competitive Grants for Regionalized Systems for Emergency Care Response is included in PPACA and offers another opportunity to provide subject matter expertise in support of development of regionalized systems of care through these grants offered to states and Indian tribes.

Pediatric-specific projects are also included within PPACA. There is funding for NIH, AHRQ, HRSA and CDC to support pediatric emergency medical research, which incorporates potential for funding EMS-specific pediatric research. PPACA also provides for the reauthorization of the Wakefield Emergency Medical Services for Children (EMSC) Program. This program has provided key funding to improve emergency medical care for children across the country. As the only federal program of its kind, the EMSC program plays a vital role in enhancing the care provided by emergency physicians to the 31 million children and adolescents who come to the emergency department for treatment each year.\(1\)

**Future**

The future of the law will depend upon the outcome of the 2012 elections. Regardless of the outcome of the elections, the ongoing challenge for governments and health care organizations will still be to provide improved access with lower cost and better quality.\(7\) ACEP is well positioned to provide leadership and subject matter expertise in the evolution and development of many of the initiatives within PPACA as described.
REFERENCES