Joint Committee on Rural Emergency Care
National Association of State EMS Officials
National Organization of State Offices of Rural Health

Policy Brief on Integration of EMS into the Healthcare Delivery System
November 2009

State EMS Offices and State Offices of Rural Health are both committed to the principle that rural EMS systems should be able to respond in a timely, appropriate manner whenever serious injury or illness strikes someone in need. In 2009 the National Association of State EMS Officials (NASEMSO) and National Organization of State Offices of Rural Health (NOSORH) created a Joint Committee on Rural Emergency Care. This Committee is dedicated to advancing policy to ensure access to timely, affordable, and high quality emergency care services in rural America. The committee plans to develop and regularly publish "Policy Briefs" on rural EMS issues. This document is the first of these Policy Briefs.

Statement of Purpose: Emergency medical services (EMS) is a vital component of the nation's healthcare delivery system, but in many ways EMS remains disengaged and separate from that system. In order to attain the highest quality, most efficient health care delivery system possible, the existing system of emergency medical services must be supported and strengthened, and it should also be fully integrated into the larger system of health care delivery.

Background: Anyone can find his or herself in need of emergency medical care, and access to rapid and appropriate health care services in an emergency situation can greatly improve one's chance for survival and recovery. A critical component of the health care system, designed specifically to handle time-sensitive health care emergencies, is the nation's emergency medical services (EMS) system. EMS is a unique discipline at the intersection of health care, public health and public safety. It is also a young discipline, tracing its roots back only a few decades, to the 1960s and 1970s. Congress' passage of the Emergency Medical Services Systems Act of 1973 is cited by many as the birth of EMS as a modern medical discipline. EMS as an industry has matured dramatically since that time, but local EMS services, particularly those in America's rural areas, still face significant challenges.

The Institute of Medicine (IOM), in its recent report *Emergency Medical Services at the Crossroads*, suggested that "a growing crisis in emergency care is brewing." The IOM describes EMS providers in the U.S. as "overburdened, underfunded, and highly fragmented," and expressed concern about the viability of an EMS system that is increasingly the "safety net of the safety net" in underserved areas. Many EMS services routinely lose money and struggle to maintain the services that are expected when someone in need dials 9-1-1.

The fragility of the EMS system is most marked in rural America. At a time when the demand for services is rising, many rural ambulance services report difficulty covering shifts 24 hours a day, 7 days a week due to difficulties recruiting and retaining staff. Many rural EMS providers rely heavily on volunteer personnel, and lack financial resources to build additional system capacity. Thus, in rural areas, where people suffer from poorer health and worse health outcomes (including much higher rates of trauma-related death) than those living in urban areas, much needed advanced emergency care often is simply not available.

Recommendations: Many fundamental reforms are needed to ensure quality health care in rural America. NASEMSO and NOSORH believe the following recommendations deserve critical attention to ensure the availability of quality emergency care for America's rural residents.

EMS and health systems redesign

It is critical that EMS providers be recognized as part of the healthcare system at local, state and federal levels, and that appropriate resources are made available to ensure EMS systems are appropriately integrated into the greater healthcare system.

A. The Centers for Medicare and Medicaid Services (CMS) invests significant resources in efforts to improve the quality of health care services. One such investment is the national network of Quality Improvement Organizations (QIOs) that are funded to provide technical assistance on quality improvement to a variety of health care providers. CMS should authorize and fund the QIOs to provide technical assistance to EMS providers.
B. Critical Access Hospitals (CAHs) nationwide are reimbursed by Medicare through a system of cost-based reimbursement for much of the inpatient and outpatient care they provide. However, CAHs are precluded from receiving cost reimbursement for ambulance services if there are other EMS providers less than 35 miles away from their base of operation. Providing cost-based reimbursement to CAH-based ambulances and community-based ambulance companies that serve CAHs would greatly bolster the EMS industry, improve patient care, and foster greater integration of EMS into the rural health care delivery system.
C. The Department of Health and Human Services should fully involve EMS leadership, including state EMS and state rural health officials, in discussions about design, deployment and financing of the nationwide health information infrastructure. Permanent funding of the National EMS Information System (NEMSIS) should be a priority, and the National Coordinator for Health Information Technology should work with NEMSIS and other stakeholders to ensure EMS integration into interoperable HIT systems. All EMS agencies, regardless of size, should be provided access to NEMSIS compliant software for electronic medical recordkeeping and required to send those data to appropriate state and federal resources for aggregate reporting.
D. Funding for the EMS/Trauma Program (Title XII of the Public Health Service Act) should be restored, and no less than 50% of the funds should be targeted to address rural issues.

EMS and the Healthcare Workforce

Many rural communities have difficulty attracting and retaining health care professionals, and healthcare workforce shortages are becoming more acute in both rural and urban areas. Workforce challenges in rural EMS are even more challenging because of the preponderance of volunteers in rural EMS services.

A. Recruiting and retaining paid and/or volunteer staff requires strong organizational leadership. Too often, those leading rural EMS services lack formal training and education in management and leadership that are critical to their organizations. Universally-recognized guidelines for the education and qualifications of EMS medical directors and service directors should be developed by appropriate experts and adopted by states. These guidelines must be sensitive to the resource constraints of rural EMS services.
B. The Health Resources and Services Administration (HRSA) is the locus for workforce programs in the Department of Health and Human Services. EMS should be included in appropriate HRSA workforce programs.
C. Ensuring the highest quality of health care delivery is a national priority. Accreditation of EMS education programs has been shown to greatly improve practitioners' performance. States should require national accreditation of paramedic education programs to ensure appropriate academic preparation of EMS personnel.

EMS and rural "medical home" models

Ensuring access to preventive and primary health care services through a "medical home" is critical to sustaining an effective, affordable health care system. However, in many rural communities maintaining adequate primary care services is increasingly a challenge. In these rural communities, opportunities for EMS personnel to expand their responsibilities (through expansion of roles and/or scopes) should be explored. Models could be implemented to ensure EMS' availability for emergencies while increasing primary care capacity. Such opportunities might also provide alternative, viable means to compensate EMS providers.

A. While EMS providers are most often used in emergency settings, many are trained to provide services that could be utilized in preventive, patient education and primary care roles. Pilot program(s) utilizing appropriately trained EMS providers (both emergency medical technicians and paramedics) as part of local medical homes should be created and funded. An example of this is the Community Paramedicine model being deployed in a number of locations in the United States and other countries. An evaluation process for these programs also should be supported.
B. EMS reimbursement is based on a "transport model" that provides payment only when transport to an emergency department (ED) is provided. As part of a team-based medical home, EMS systems with appropriate medical protocols and direct medical oversight should be reimbursed for appropriate treatment when called to a scene, including those situations where transport to a hospital ED is unnecessary. This would reduce unnecessary health care costs and help avert ED crowding that is a pressing problem in many communities.
C. A national Rural EMS/Trauma Technical Assistance Center should be reestablished to promote rural EMS programs that support the "medical home" concept and other innovative EMS programs.

Footnote: *Emergency Medical Services or EMS is a broad discipline encompassing ground and air services that provide emergency response, care and transport of patients to hospitals; convalescent transport of non-emergent patients to and from hospitals; and both emergent and non-emergent inter-hospital transport. In this document the term "EMS providers" refers to those "prehospital" or "out-of-hospital" providers, both first responders and ambulance personnel, who provide care as part of these systems.*