

POSITION PAPER

NATIONAL ASSOCIATION OF EMS PHYSICIANS

EMS SYSTEMS AND MANAGED CARE INTEGRATION

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Managed care organizations (MCOs) and EMS systems share the common goal of providing health care that is appropriate and timely. Despite this common thread, each has distinct priorities and incentives. Cooperation between EMS and MCO systems is required to preserve the emergency health care safety net.

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Managed care organizations operate under the evolving paradigm of health care financing: capitation.¹ In this manner, a set fee is paid prospectively to providers; any expense incurred in excess of the plan's capitated rate represents a loss to the provider. The provider is given an incentive to provide cost-effective medical care to the health plan's members. This is largely accomplished by emphasizing preventive health maintenance and attempting to accurately match resources to medical need.

On the other hand, EMS systems were established to provide rapid episodic emergency health care access, regardless of the patient's location or financial status. EMS system design emphasizes preparedness, which is extremely difficult to quantify. This paper is intended to guide those involved with EMS systems and MCOs to make sound decisions that preserve access, quality, and integrity in emergency health care.

POSITION

The National Association of EMS Physicians (NAEMSP) believes in the following principles:

1. The highest priority of EMS systems is to provide immediate medical care and transportation to persons with a perceived medical emergency.
2. Current EMS practice is based on the best available information. Any EMS service changes must be evidence-based to the greatest possible extent. Quality improvement and validation studies are necessary to ensure the safety of nontraditional triage, response, and destination algorithms.
3. The integrity of current 911 systems must be maintained and system fragmentation discouraged. The public should be encouraged to utilize 911 systems whenever a perceived medical emergency exists, as determined by a prudent layperson.
4. Calls received by EMS that involve nonemergency health care advice may be directed to appropriate alternative resources. These resources may involve an MCO or other health service resource.
5. Mandatory preapproval for accessing EMS via 911, and retrospective denial of payment based on the final diagnosis, is medically unsound, and therefore unacceptable.
6. A collaborative effort between MCOs, physicians, and EMS systems is essential to educate the public on the appropriate use of 911. Such a collaborative approach should provide a

cost-effective, medically appropriate service that will meet the patient's and community's emergency health care needs.

7. Coordination between EMS systems and MCOs should be accomplished with the participation of the entire community, including physicians, out-of-hospital care personnel, out-of-hospital provider agencies, local EMS agencies, hospitals, educational institutions, public health agencies, patients, consumers, and MCOs.
8. EMS systems must continue to have independent and qualified medical oversight of all medical and operational policies and procedures, including triage, dispatch, patient care, and destination protocols.²
9. EMS systems must provide prompt quality patient care and, when medically indicated, rapid transport to the closest appropriate facility. While the patient's MCO affiliation is one of several valid factors that helps to determine the appropriate destination, the emergency health care needs of the patient are paramount.
10. Complying with the needs of an MCO need not result in differing standards of care within the community, based on insurance status. A single standard of care within the community is imperative.
11. A clearly designated physician must have oversight authority and responsibility for each interfacility transfer. EMS systems should establish interfacility transfer protocols that define the responsible agency or agencies. All transfers must be made in accordance with patient care needs, preestablished medical standards, and local, state, and federal laws.

12. Strategies to develop funding mechanisms for EMS systems should acknowledge that MCO subscribers represent only a fraction of the lives covered by EMS. Innovative funding approaches should facilitate alignment of the incentives of MCOs, other third-party payers, and EMS systems.

13. Managed care may create changes in the workplace for EMS. Employers must take necessary steps to meet the operational, educational, and fiscal duties that are attendant to such change.

DISCUSSION

Out-of-hospital resource management has become an important issue because of the influence of MCOs and the increasing focus on the global cost of medical care.³ There is little question that dispatching a fully-equipped paramedic-staffed ambulance to every 911 call, with subsequent obligatory ambulance transportation to the nearest emergency department, is not always justified.

Provided that patient care is not compromised, resource management and cost containment in EMS are laudable goals. Increased efficiency may reduce the overall cost of emergency health care delivery. Examples of programs to reduce emergency health care costs might include: transport of patients to urgent care centers or physicians' offices, on-scene treat and refer protocols, and interfacility transfers to hospitals affiliated with the patient's health care network.⁴

Managed care plans should not develop alternate access numbers for patients with emergencies.⁴⁻⁶ System fragmentation would undermine medical quality and operational efficiency. It has been a long struggle to implement 911 systems through much of the country; such systems have improved access and outcome. Statutory changes may be

necessary in order to protect access to emergency health care.

The assertion that patients should call their physicians prior to or rather than 911 assumes that the EMS system no longer has a role in determining whether or not the patient has an emergency necessitating the dispatch of an ambulance. It is incumbent on the dispatch service to develop a system of caller questioning to ensure that appropriate resources are sent. However, even a prudent layperson cannot reliably determine whether or not to call 911.⁷ Whenever possible, EMS dispatch centers should establish links with health care network referral and advice lines in order to facilitate appropriate disposition of nonemergency calls.

The current funding structure tends to reimburse emergency care on a fee-for-service basis only for patients who are transported. This encourages limited service-delivery options and treatments that may have no medically proven benefit, and provides no motivation for the development of a less costly but medically appropriate resource.⁸ Funding mechanisms that align the incentives of EMS systems, MCOs, and traditional insurers should be developed. EMS providers are a valuable resource. Changes in their role need to be explored with a focus on training, education, and adaptation.

Finally, EMS systems research is crucial. Current models deliver excessive responses with minimum triggers and have multiple built-in redundancies. Evaluation of patient outcome and its relationship to cost needs emphasis. Response configurations need to be validated against need.⁹ Research findings will serve the interests of patients, EMS systems, and MCOs.

SUMMARY

Emergency medical services systems and MCOs must cooperate and educate each other in order to effect delivery of reliable, high-

quality emergency health care to the entire community. Shared goals are rapid access, medically appropriate care, and operational efficiency. An integrated approach is necessary in order to maintain the integrity of EMS systems. EMS systems serve as a safety net for patients with perceived emergencies. Changes in form and function should be guided by outcome studies that ensure the continued delivery of quality emergency health care services.

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