The Perfect Storm for EMS
Mobile Integrated Healthcare Practice

On behalf of the explorers,

Ed Racht
Eric Beck
Jeff Beeson
Brent Myers
MR. RAWLES’ AFFECTION FOR MONKEYS...
ALL MAKES SENSE NOW...
IT'S FINALLY TIME...
WE DO EMERGENCIES WELL
EMS Makes a Difference:
Improved clinical outcomes and downstream healthcare savings

A Position Statement of the National EMS Advisory Council

December 2009
BUT THE HEALTHCARE LANDSCAPE HAS CHANGED
Current State of “Unscheduled Care”
IS REALLY “PAYMENT” REFORM THAT HAS HEALTHCARE IMPLICATIONS...
Hospital threatened

Kahuku Hospital closing

6 rounds of cuts since 2007! Say no to more healthcare cuts!
“Because you don’t have insurance, all we’re allowed to use to perform your bypass is this stick.”
Tomorrow’s alignment?
(unscheduled care)

911
1st response
“EMS”

E.D.
Hospital
Post Acute Care
HEALTH CARE COSTS ARE THE PRIMARY DRIVER OF THE DEBT

Source: Congressional Budget Office (August 2011)
Governments may be forced to operate like businesses

Hundreds of cities, towns complain that changes will be costly and difficult

BY MELODY PETERSEN
The New York Times

The group that sets the standards for how the nation’s 84,000 state and local governments keep their books is expected to approve a plan this week that would require them to operate more like businesses, providing taxpayers with a more complete picture of what their dollars buy.

The proposal, which has attracted little publicity, has nonetheless prompted hundreds of cities, towns and other local governments to deluge the rule makers with letters predicting how difficult and costly it will be to comply. But citizens groups laud the plan, saying it eventually will arm taxpayers with information that will help them understand when their politicians are spending too little, as well as when their ambitions have grown too large.

The plan would fundamentally change the way government officials look at almost all financial decisions, from spending on infrastructure to borrowing money to selling properties. But most significantly, it would make many money was spent.

To comply, governments say they will have to hire armies of accountants, engineers, consultants and appraisers to come up with the numbers, money that could be spent on worthier causes.

The Governmental Accounting Standards Board, which is at the heart of the firestorm, began setting rules in 1984. The seven-member group, based in Norwalk, Conn., is scheduled to approve Statement No. 34 on Thursday. Its 200 pages of particulars are expected to affect nearly every government in the United States, except the federal government, which writes its own rules.

Unless the board retreats, the largest governments would start using the rules for fiscal years beginning after June 15, 2001. Smaller governments would have one or two more years to comply.

The board cannot legally enforce its rules. But most state and local governments now are required to abide by the board’s standards as a condition of the municipal bonds they issue. And, in some states, lawmakers have passed legislation requiring cities and towns to follow the accounting board’s rules.

Under the proposed system, voters would see the total cost of operating the correctional system, allowing them to weigh the trade-offs between building prisons and, for instance, paying for projects that keep people out of prison.

In yet another significant break with the past, governments no longer would be able to shift a cost to the next year simply by delaying payment.

Until now, governments have been allowed to wait to record an expense until a bill was paid, a financial maneuver that is like allowing consumers to pretend they did not owe money on purchases charged to their credit cards. But the new rules will require governments to accrue costs in the same way businesses do. For example, a cost will be recorded when office supplies are delivered, not when the bill is paid.

The accounting board also is poised to require government managers to answer for themselves, much the way executives of public companies do. Each fiscal year, elected officials would have to give taxpayers “an objective and easily readable analysis” of the government’s financial performance. Government officials will have to explain such things as why they sold a large piece of land or issued millions of dollars in bonds. And for the first time, officials must explain why they spent more than was approved in the budget at the start of the year.
- US health care system most costly in the world
  - Will grow to 20% of GDP ($4.6 trillion) by 2020

- New demands on medical and social services:
  - Aging populations
  - Increased chronic health problems

- One third ($750 billion) in healthcare costs do not improve patient health
You call, we haul, *that’s all*.

- Current patterns, regulations, educational curricula, and financial incentives lead to the recommendation for transportation of all EMS patients to a hospital ED.
• Improving the patient experience of care (including quality and satisfaction)

• Improving the health of populations

• Reducing the per capita cost of health care
IT'S ALL ABOUT THE OUTCOMES

Quality organizations want hospitals to collect more data that focus on patients and outcomes rather than processes and payments.
National Ambulance Clinical Quality Outcome Indicators
Figure 20
The benefits of managing demand through the call cycle

<table>
<thead>
<tr>
<th>Key areas where the response model can be transformed</th>
<th>See and treat</th>
<th>Alternative destinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage and treat</td>
<td>Resolution of incident at the scene without the need to convey to another provider</td>
<td>Conveyance of patients to an alternative destination such as a minor injuries unit</td>
</tr>
<tr>
<td>Resolving calls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilising telephone clinical assessment without the need to dispatch a vehicle</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TOMORROW’S REALITY

Outcomes will matter more than process
Performance measures will be evidence-based and drive reimbursement
Care provided will be as transparent as delivery model
Cost of service will matter
Hospitals will have a renewed interest in EMS
Many healthcare players are moving their focus OUT of the hospital
The same leadership structure used by most systems today must evolve
We are the key component of the new model...
The Idea

A mobile integrated healthcare practice will incorporate EMS into the larger healthcare community, allowing patients to receive coordinated care - the right care at the right place at the right time.

EMS is the only healthcare entity with an existing infrastructure that is capable of providing the full spectrum of care (high acuity to non-emergent), in an immediately available, unscheduled, in-home, 24/7/365 delivery model.
Pre Event
EMS contacts patient who call 911, uses ED frequently, other need
Post Event
EMS contacts patient for follow up care

Patient Navigation & Care Coordination

Physician
Nurse
Physician Assistant
Advance Practice Nurse
Primary Care Provider
EMS
Pharmacist
Social Worker
Home Health
PT/OT
Community Health Worker

EMS Patient Contact
Event
Better Health: Patient Navigation

Current State

Pt Request

EMS Responds

Transport to an Emergency Department

Mobile Integrated Healthcare Practice

ED

MICP

In-Home Care

Mental Health

Office
Lower Costs

Better Healthcare Experience
- ED $$$
- MICP
- MD Office $
- Mental Health $

Better Individual/Community Health
- Vaccination
- Diabetic Care
- Readmission Prevention
Realigning Reimbursement Policy and Financial Incentives to Support Patient-Centered Out-of-Hospital Care

Kevin Munjal, MD, MPH
Brendan Carr, MD, MS

Innovative models of payment and care delivery are increasingly being used to expand access, improve quality, and reduce medical costs. Although traditional fee-for-service medicine favors doing more than is necessary, newer payment models aim to realign incentives to decrease utilization and increase efficiency. However, little consideration has been given to how fee-for-service reimbursement in out-of-hospital care limits the ability of emergency medical services (EMS) to provide more patient-centered care and reduce downstream health care costs.

Retrospective studies estimate that between 7% and 34% of Medicare patients transported by ambulance to an emergency department could have been safely treated in an alternate environment. However, Medicare and other payers provide no reimbursement for out-of-hospital care, including response, triage, and patient assessment and treatment unless the patient is transported to an emergency department. The Medicare ambulance billing guide states, “The Medicare ambulance benefit is a transportation benefit and without a transport there is no benefit.” With most private insurers mimicking Medicare, this payment policy significantly affects the behavior of EMS agencies contributing to an inefficient use of out-of-hospital care resources.

Financing Out-of-Hospital Care

National EMS expenditures from Medicare are approximately $5.2 billion per year. Although this is less than 1% of total Medicare expenditures, there are considerable downstream health care costs associated with patients transported to emergency departments. An average EMS agency receives 42% of its operating budget from Medicare fees, 19% from commercial insurers, 12% from Medicaid, and 4% from private pay; it requires approximately 23% in additional subsidization, most often provided by local taxes. Thus, more than three-fourths of EMS revenue is generated from fee-for-service reimbursement, the service being transported, not necessarily medical care.

However, approximately 26% of EMS responses do not result in a transport, including situations in which patients refuse because their condition was effectively treated by EMS prior to transport (such as resolution of hypoglycemia or treatment of asthma). In 2010, median Medicare reimbursement was $464, slightly above the median cost per transport of $429 after adjusting for nontransported patients. This slim margin must cross-subsidize Medicaid and uninsured patients whose care provides little or no reimbursement and would be quickly eroded by any change in transport rates. This creates a perverse incentive for agencies to transport patients to the hospital emergency department, even if transport is not what a patient needs or wants, and even if other alternatives might be better, less expensive, or more patient centered.

Patient-Centered Out-of-Hospital Care

Out-of-hospital care agencies that are reliant on transportation-based fee-for-service reimbursement are limited in the role they can play within the continuum of health care. Consider a patient with uncomplicated asthma who is without β-agonists or a patient with end-stage renal disease who becomes short of breath secondary to fluid overload on the day of dialysis. In either case, a patient-centered approach might be something other than transport to an emergency department. The patient with asthma might benefit from nebulized albuterol treatments and coordination of care with a primary care physician. The patient with renal disease might benefit from stabilization and transportation to the dialysis center. Neither of these alternative approaches would be reimbursed under existing rules. Instead, for EMS to collect $464 in reimbursement, the EMS agency triggers an extra emergency department visit at an average societal expense of $969. The goal of reimbursement reform should be to realign incentives so that EMS agencies are not financially penalized for offering the patient the most medically appropriate option and offering society the highest value intervention.

Options for the EMS system might include a standard ambulance response, a multipatient transport vehicle, a
Here’s our storm...
Focused areas of practice

- Post acute care
  - Readmission prevention
  - Transitional care
- Long term chronic care
- Post-ED care
- Frequent system users
- Home-bound, impaired mobility
- Health screening
EMS Patient Contact

Event

Pre Event
EMS contacts patient who call 911, uses ED frequently, other need

Post Event
EMS contacts patient for follow up care

Patient Navigation & Care Coordination

Physician
Nurse
Physician Assistant
Advance Practice Nurse
Primary Care Provider
EMS
Pharmacist
Social Worker
Home Health
PT/OT
Community Health Worker

Physician
Nurse
Physician Assistant
Advance Practice Nurse
Primary Care Provider
EMS
Pharmacist
Social Worker
Home Health
PT/OT
Community Health Worker
Core Components

- Medical direction
- Community assessment
- Strategic partnerships
- Patient centered access
- Coordination/communications
- Telepresence
- Capacity of navigation
- Healthcare providers
- Transportation
- Integrated health record (HIE/HPE)
- Sustainable funding
- Performance measurement/evaluation — safety
Show Me the Money!!
“Mobile Integrated Healthcare”
KEY CONCEPTS

EMS has the opportunity to drive a new practice of medicine

EMS will not own this space, but is the most qualified

This is not expanded scope, it is expanded practice

We can integrate the skill sets of our clinical colleagues with our expertise in mobile health logistics

Community Paramedics, like our emergency paramedics, are an integral part of the healthcare team.
IN CASE OF AN
EMERGENCY, PLEASE GO
TO THE NEAREST
EMERGENCY ROOM
EMS Patient Contact

Event

Pre Event
EMS contacts patient who call 911, uses ED frequently, other need

Post Event
EMS contacts patient for follow up care

Patient Navigation & Care Coordination

Physician
Nurse
Physician Assistant
Advance Practice Nurse
Primary Care Provider
EMS
Pharmacist
Social Worker
Home Health
PT/OT
Community Health Worker

EMS