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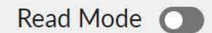
EMS Reimagined:

Health System Integration, MIH, EMS Professionalism

National Association of
State EMS Officials

States Strive to Keep Medicaid Patients Out of the Emergency Department

STATELINE ARTICLE February 24, 2015 By: Michael Ollove Topics: Health Read time: 8 min



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The entrance to the emergency department at North Fulton Hospital in Roswell, Georgia. A new approach to reducing the number of nonemergency visits to emergency departments among Medicaid beneficiaries is showing promise. (AP)

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Health Insurer Goal:
“Keep patients out of ED and hospital”

~~Health Insurer Goal:~~

~~"Keep patients out of ED and hospital"~~

Better Goal:

Keep People Well at Home

Geisinger
Emergency
Medical Services
DANVILLE AREA
AMBULANCE
128
MOBILE HEALTHCARE
Geisinger

You Heard it Here First

"In the future, every EMS provider will be viewed as an MIH provider."

Kupas, 2019

EMS Revenue
CMS History

Transport
Supplier

vs.

Health Care
Provider

NO DOCTOR
NO HOSPITAL
ONE CEMETERY

NBC NEWS
NOW

Access to Emergency Care in the United States

Brendan G. Carr, MD, MA, MS
Charles C. Branas, PhD
Joshua P. Metlay, MD, PhD
Ashley F. Sullivan, MS, MPH
Carlos A. Camargo, Jr., MD, DrPH

From the Department of Emergency Medicine (Carr), and Department of Biostatistics and Epidemiology (Carr, Branas, Metlay), the Robert Wood Johnson Clinical Scholars Program (Carr, Metlay), the Leonard Davis Institute of Health Economics (Carr, Branas, Metlay), and the Center for Clinical Epidemiology and Biostatistics, University of Pennsylvania, Philadelphia, PA (Carr, Branas, Metlay); the VA Medical Center, Philadelphia, PA (Metlay); and the Department of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA (Sullivan, Camargo)

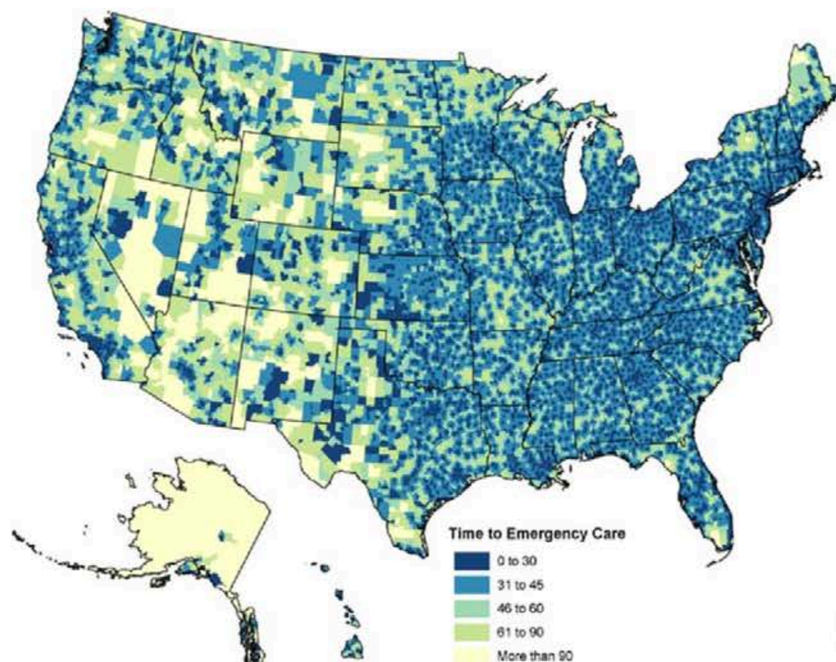


Figure 1. Access to any ED (driving only).*
*All estimates allow vehicles to cross state lines.

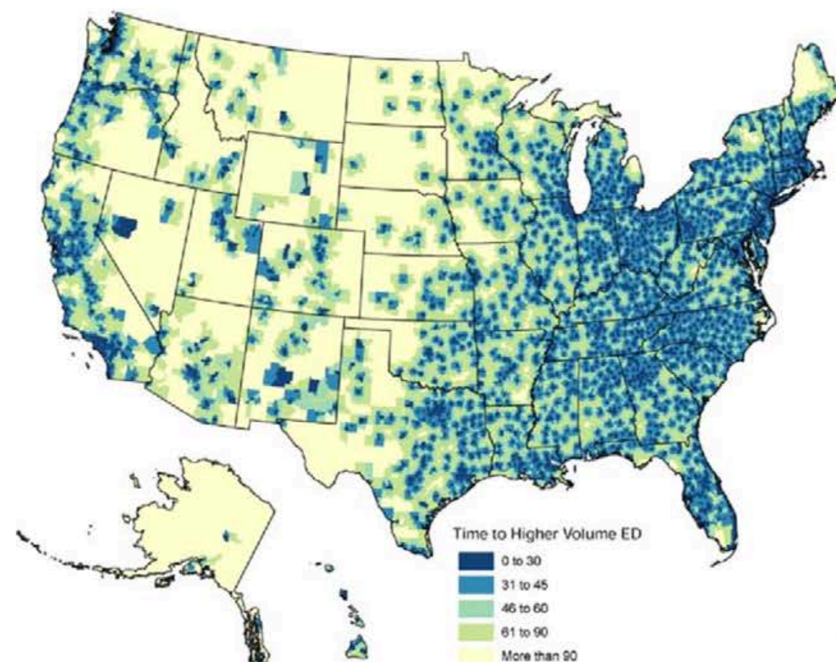
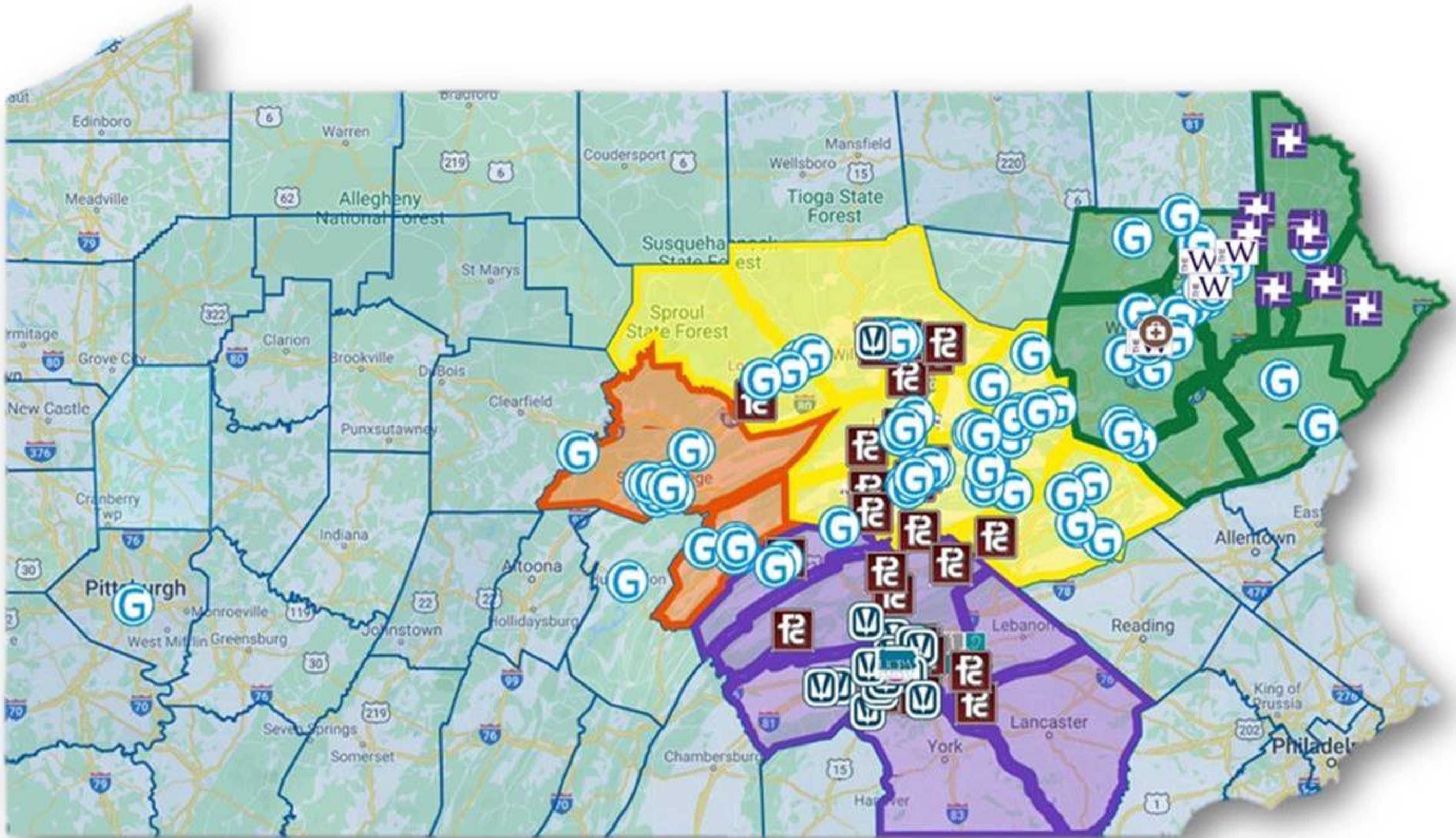
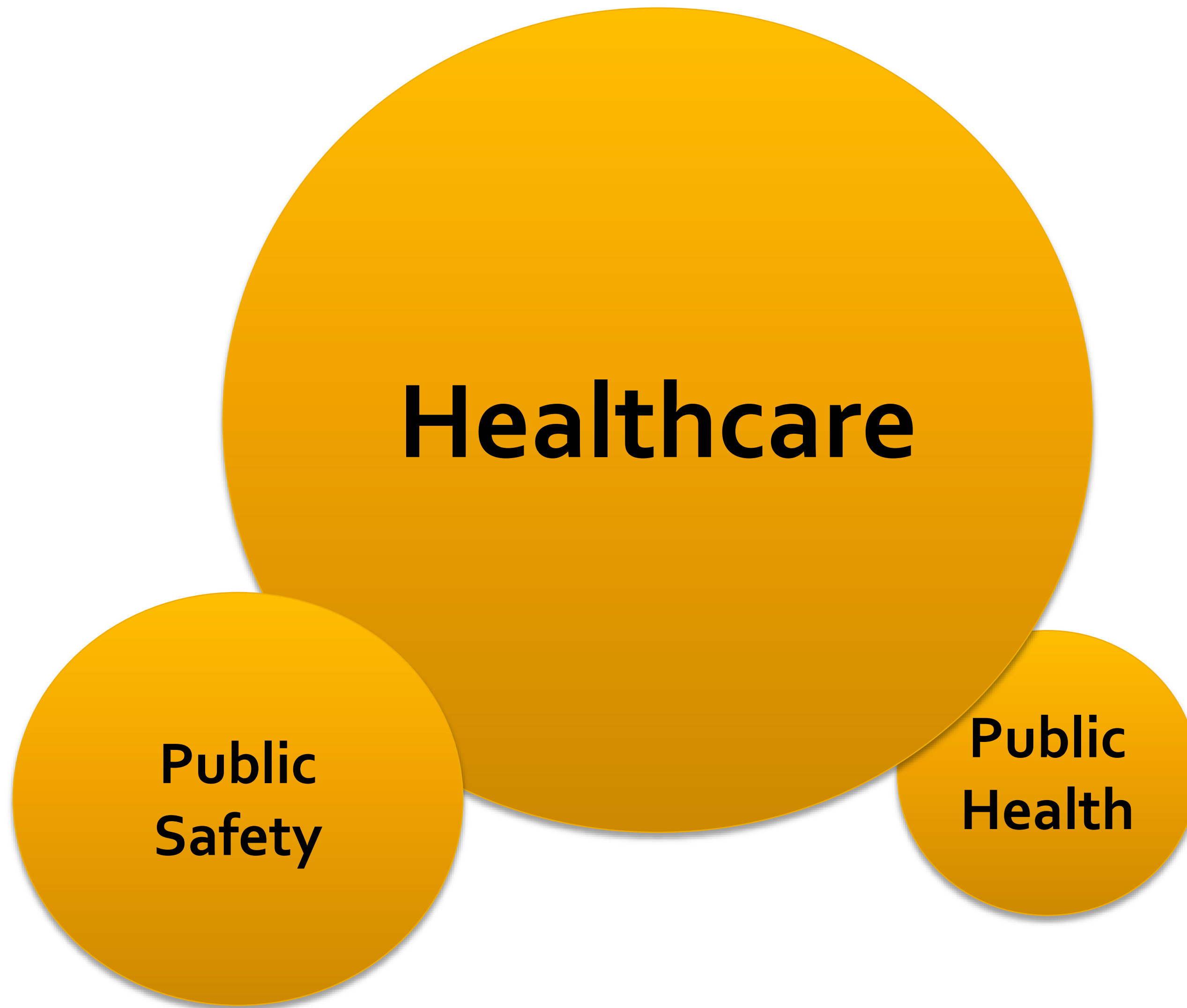


Figure 2. Access to a higher-volume* ED (driving only).
*Higher-volume EDs are defined as treating at least 1 patient/hour, 24 hours/day, 7 days/week (ie, at least 8,760 visits/year).

Keystone ACO (Accountable Care Organization)



What is Our Value? TactiCOOL or MediCOOL



Healthcare System

Chronic Care

&

Wellness

"EMS of the future will be community-based health management which is fully integrated with the overall healthcare system"

Acute/

Episodic

Care

Palliative Care

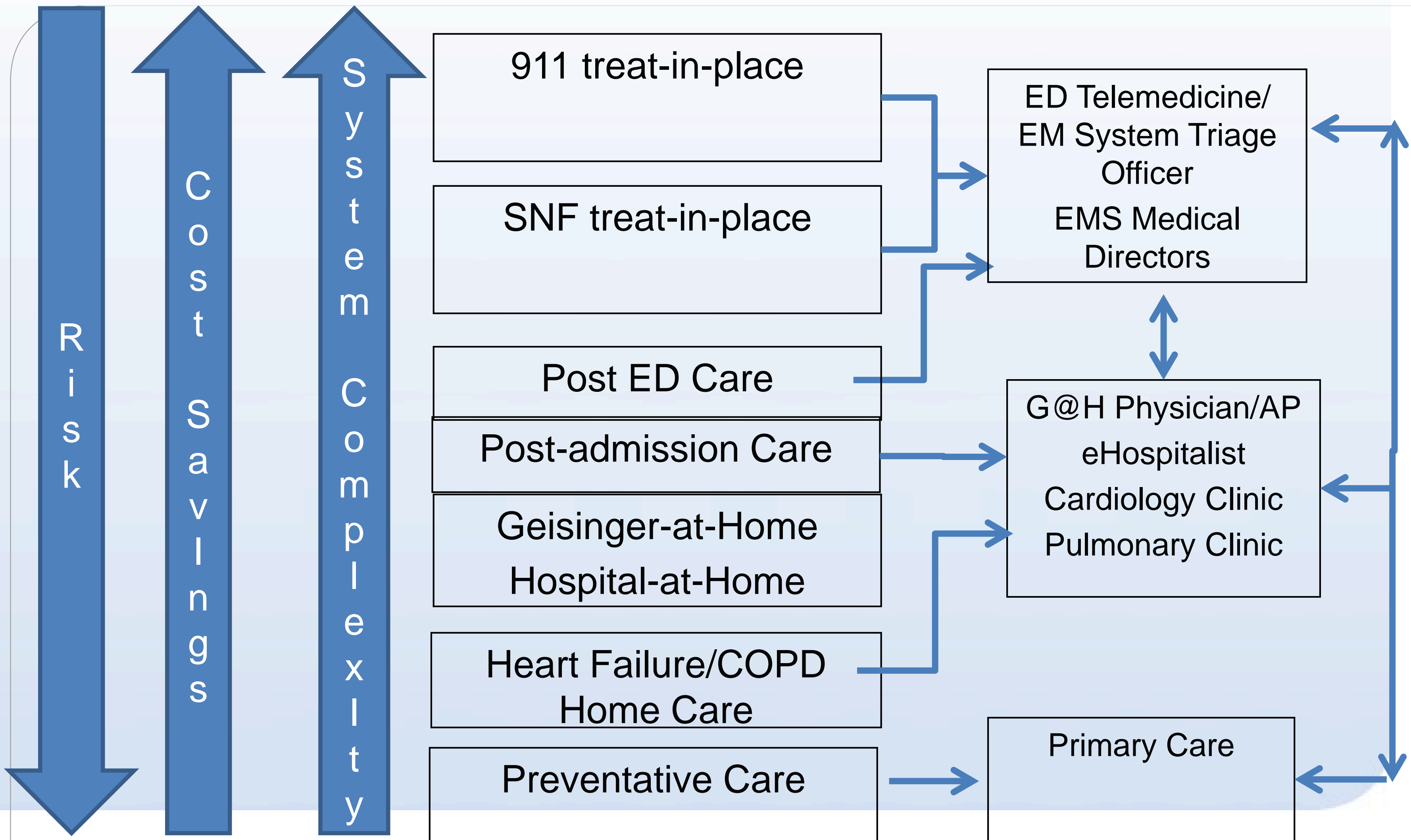
&

End-of-Life

"EMS of the future will be community-based health management which is fully integrated with the overall healthcare system"

EMS Agenda for the Future (NHTSA, 1996)

One Model Geisinger EMS



All non-911 care documented in health system EHR

You Heard it Here First

"In the near future, EMS agencies that embrace patient-centered healthcare that is integrated with regional health systems will provide
20% traditional 911 transport and
80% home-centered care."

Kupas, 2019

COST & PAYMENT

By Abby Alpert, Kristy G. Morganti, Gregg S. Margolis, Jeffrey Wasserman, and Arthur L. Kellermann

Giving EMS Flexibility In Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings

$560 million

Saved

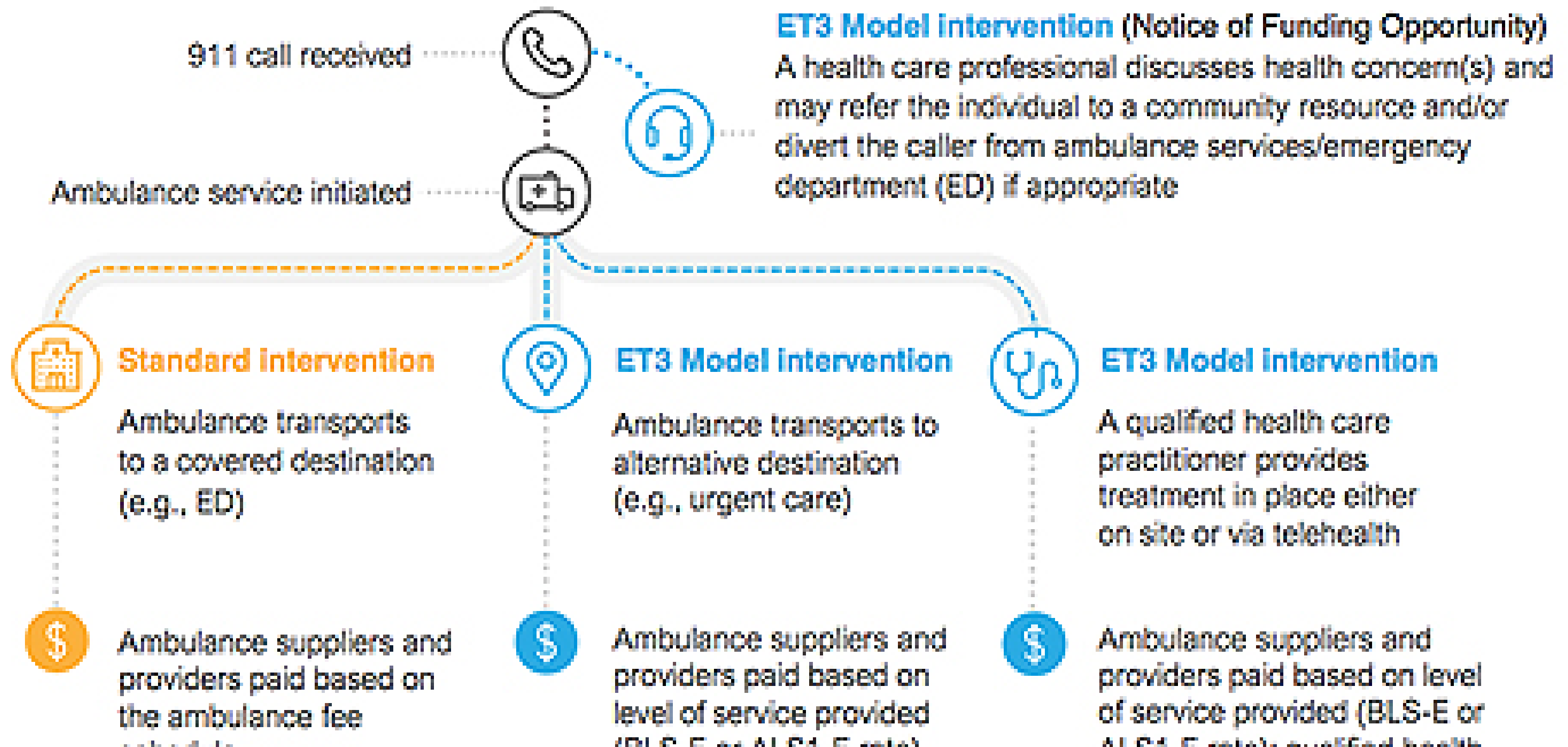
If low-acuity cases were managed in less expensive settings, Medicare could save roughly $560 million per year.

ET3 Model | CMS

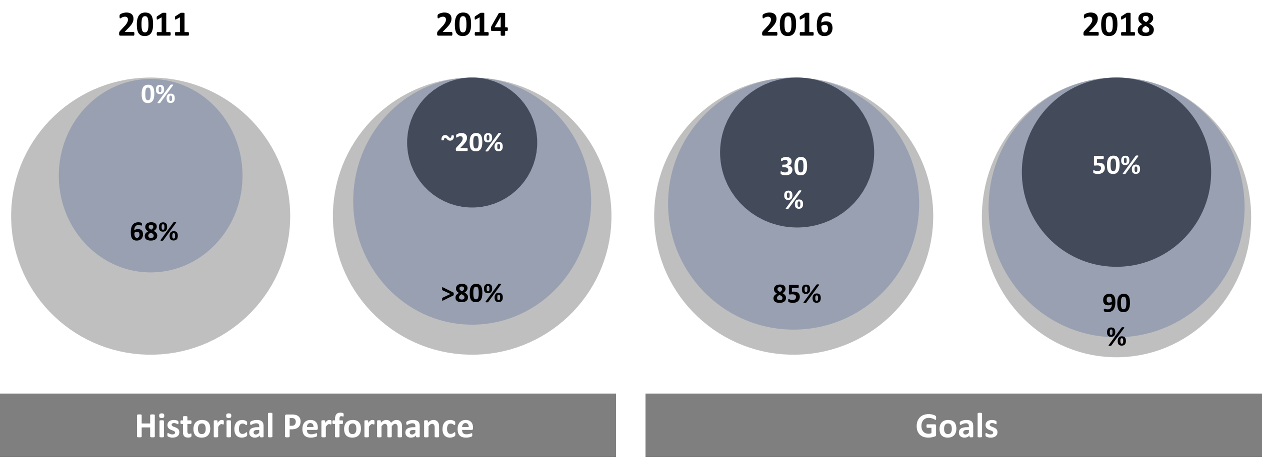
The Emergency Triage, Treat, and Transport (ET3) Model is a **voluntary** 5-year CMS payment model that provides **greater flexibility** and new **payments** to ambulance care teams for Medicare beneficiaries.

ET3 Model Goals

• Encourage appropriate utilization of emergency medical services • Increase efficiency in the EMS system •
• Provide person-centered care at the most appropriate care level •



EMS Revenue
HHS & Delivery System Reform



What about:

Value?

Pay for Measurement?

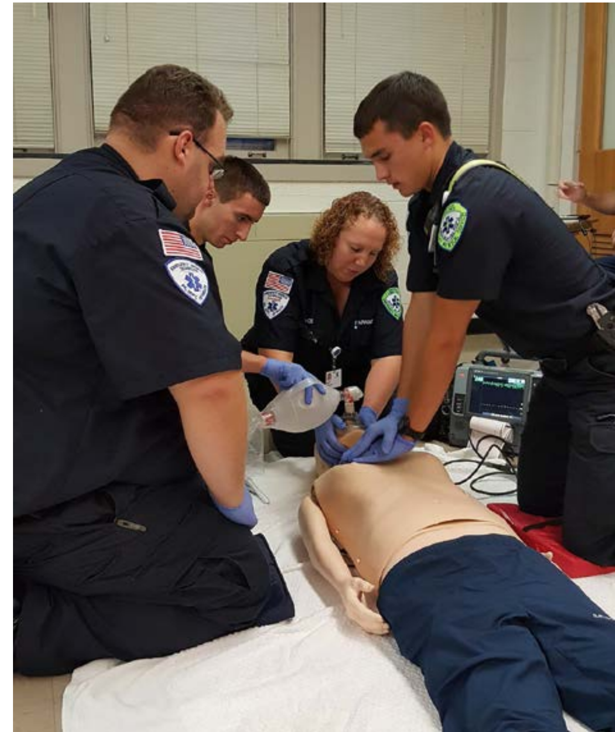
Pay for Performance?

BACKGROUND

OOHCA Care Paradigms

Scoop and Run

Vs.



Treat on the "X"

Results

After adjusting for significant confounding variables, the following significant differences emerged when comparing patient outcomes between LFTA and HFTA.

	LFTA	HFTA	Adjusted OR
ROSC	26.4%	35.4%	1.20
Survival to Discharge	8.5%	12.5%	1.95
Favorable Neurologic	77.9%	86.7%	1.60

Funding Cardiac Arrest Care

CURRENT STATE

- Pay ALS fee if treated/transported
  - >$4,000 ED fee
- Pay BLS fee if treat and field termination

PROPOSAL

- Fund CARES data
- Pay ALS fee (possibly x2) if treated and FTOR
- Pay BLS fee for DOA

WHAT DO WE NEED FOR THIS VISION?

WHAT DO WE NEED FOR THIS VISION?

- Nomenclature
- EMS Profession

AUGUST 2019
CPR LifeLinks Toolkit
Nomenclature of EMS
Naloxone EBG
Draft EMS Education Standards
« Return to Newsletter

WHAT'S IN A NAME? EMS STAKEHOLDERS DISCUSS THE PROFESSION'S NOMENCLATURE

NEMSAC recommendation for a change in nomenclature brings more than 20 EMS stakeholder groups together for a conversation about EMS terminology

The term "emergency medical services" and the associated titles of EMS providers is the topic of an ongoing discussion in the profession. In 2017, the National EMS Advisory Council (NEMSAC) approved an advisory entitled "Changing the Nomenclature of Emergency Medical Services is Necessary." In this advisory, NEMSAC outlined its concerns about the number of terms used to describe EMS and its practitioners over the years, and how this can be extremely confusing for the general public, elected officials and members of the media, as well as within healthcare and public safety. The council also recommended specific terminology to describe the practice of EMS clinicians and recommended the creation of a single term to describe all certified EMS practitioners

The Profession of Paramedicine (EMS)

Credit for Education (degree)

Commensurate Pay as a Health Care Practitioner

We Make House Calls

EMS Reimagined

- Paid for services, not transport
- Integrated with health systems
- All EMS practitioners have a role in MIH
- Engaged medical direction is critical
- This is paramedicine (or whatever nomenclature is best)
- Paramedicine practitioners must be on par with similar healthcare professionals
- Paramedicine can improve increasing healthcare gaps in rural areas
- We make house calls and can keep people well at home