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CH-CH-CH- CHANGES

Whether by community paramedicine or mobile integrated healthcare, EMS providers nationwide need to deal with the dramatic changes occurring in healthcare—but the question is, how?

By Jenifer Goodwin

On Oct. 16, House GOP efforts to derail the Affordable Care Act failed when Congress, having won almost no concessions from the Democrats, agreed to raise the debt ceiling and reopen government. If there were doubters before, the Republican loss was a clear sign that healthcare reform is here to stay, healthcare experts say.

For EMS, the question is, at what point will the transformative changes occurring in payment and reimbursement policies throughout other healthcare sectors reach ambulance providers? And will EMS-driven innovations such as community paramedicine and mobile integrated healthcare be the vehicles EMS needs to secure its place as a valued partner in the new era?

At the Mobile Integrated Healthcare Summit, more than 300 EMS providers, executives and medical directors sought to answer these questions and more during a



daylong series of panel discussions on community paramedicine and mobile integrated healthcare. Held on Sept. 11 in conjunction with EMS World at the Las Vegas Convention Center, the summit featured presentations by leaders from MedStar Mobile Healthcare in Fort Worth, Texas, and American Medical Response, as well as representatives from organizations in states that have been community paramedicine pioneers, such as Minnesota, Maine, Colorado and Pennsylvania.

“You had a very diverse group at the summit: private EMS, public EMS, fire-based EMS. You also had hospital administrators and payers, such as representatives from Kaiser Permanente,” says Matt Zavadsky, director of public affairs for MedStar Mobile Healthcare, who gave the keynote address. “When you see that level of interest not only from the folks who can provide the service but the folks who can pay for it, that’s pretty cool.”

With interest in partnering with EMS surging among hospitals, private

insurers and the Centers for Medicare & Medicaid, the summit showed that mobile integrated healthcare and community paramedicine have moved beyond the conceptual phase and into the real world, where EMS providers large and small are grappling with the nitty-gritty of getting their programs up and going—including deciding which community health problems to tackle, garnering stakeholder and payer support, dealing with regulatory issues and deciding what training EMS providers need for an enhanced role. “We’ve moved past the discussion phase and into the action phase,” Zavadsky says.

At the summit, J. Brent Myers, M.D., medical director and director of Wake County (N.C.) Department of EMS, discussed his department’s 16 advanced practice paramedics, who can take patients having mental health crises directly to mental health facilities. They are also working with assisted living facilities on connecting elderly people who have fallen but are uninjured with primary care doctors instead of taking them to the ED. “We thought that patients called 911 because they wanted to go to the hospital,” Myers says. “They call 911 because they need help.”

Michael Wilcox, M.D., a family practice and emergency medicine physician in New Prague, Minn., and medical director for the Hennepin Technical College community paramedic program, talked about training community paramedics to do home visits for patients with multiple chronic diseases in rural areas and to help staff a mobile health clinic. The mobile clinic, funded by the Shakopee Mdewakanton Sioux Community (a Native American tribe) and the Scott



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County Department of Public Health, travels to rural communities to provide free health screenings, mammograms, and vision and dental services to underserved, low-income populations.

Jeff Beeson, D.O., medical director of MedStar, talked about the importance of conducting a community needs assessment to pinpoint what healthcare problem or gap in healthcare services EMS wants to address. In Fort Worth, for example, MedStar started with a program in 2009 to help frequent users seek out more appropriate sources of health or social services. More recently, they added a nurse triage line funded by four area hospitals to assist some non-acute callers; a program to help hospice patients having a medical crisis remain in the home per their wishes rather than being transported to the emergency department; and a program in partnership with area hospitals to help congestive heart failure patients manage the disease at home and avoid trips to the ED.

More than 4.5 million Medicare recipients nationwide, or 14%, have CHF, Zavadsky notes, and 43% of Medicare expenditures go toward taking care of them. Fort Worth’s hospitals, which are subject to penalties if those patients are readmitted in a 30-day window, were very open to hearing about a strategy that could help provide more effective, less costly care, he says.

Yet even as astounding as those Medicare CHF figures are, EMS organizations trying to establish their own mobile healthcare programs may find that hospitals or insurers have other priorities. In Lafayette, La., for example,

the hospital system wanted to target diabetic readmissions, so MedStar is working with Acadian Ambulance on developing a program to help diabetics better manage the condition at home.

A QUESTION NOT OF IF, BUT WHEN

In the healthcare reform movement, EMS has, per usual, flown under the radar. Even as hospitals faced penalties for failing to meet certain quality criteria and worked to prove that interventions improve outcomes, EMS has escaped scrutiny in part because ambulance transport accounts for only about 1% of Medicare costs, according to an October 2012 report by the Medicare Payment Advisory Commission (MedPAC).

But many believe it’s only a matter of time before insurers and CMS realize that decisions made in the field have a larger impact than that 1% would indicate. A Feb. 20, 2013, editorial in the *Journal of the American Medical Association* said EMS impacts “downstream” medical costs.

“While much of health reform emphasizes avoiding emergency department visits, EMS remains paradoxically incentivized to transport any and all patients who call 9-1-1 to the emergency department,” wrote authors Kevin Munjal, M.D., M.P.H., of Mount Sinai Medical Center in New York City, and Brendan Carr, M.D., M.S., of the University of Pennsylvania’s Perelman School of Medicine in Philadelphia. They cited examples such as a patient with asthma who could benefit from nebulizer treatment at home instead of ED transport, or a patient short of breath due to renal disease better off stabilized

at home and taken to a dialysis center.

They went on to call for changes in reimbursement policies that would discourage unnecessary trips to the ED. “The goal of reimbursement reform should be to realign incentives so that EMS agencies are not financially penalized by offering the patient the most medically appropriate option and offering society the highest value intervention,” they wrote.

The time for reimbursement reform may come sooner than some might believe. On Sept. 25, 2013, the U.S. Department of Health and Human Services Office of Inspector General released a report, “Utilization of Medicare Ambulance Transports, 2002–2011,” which was critical of rising costs for Part B Medicare ambulance transports. The report noted that ambulance transports have grown at a faster rate than total Medicare Part B payments. While the number of beneficiaries who received ambulance transports increased 34%, total Medicare beneficiaries increased just 7%. Payments for ambulance transports also increased 130%, compared to the 74% increase in overall Medicare Part B payments.

The report, Zavadsky believes, may be a prelude to changes that EMS may not like. “CMS is about to start reviewing the ambulance fee schedule,” he says. “Our experience in the ambulance industry has been that whenever that step gets taken, get ready for a rate cut. When Medicare wants to review the fee schedule, the message is, *It’s happened to physicians, to hospitals, and it’s going to happen to us.*”

GAINING SUPPORT AND NEGOTIATING AGREEMENTS

Sensing—and, for some, anticipating—the winds of change, many EMS leaders are working to develop and implement new delivery models that would use EMS’s unique attributes—their workforce of EMTs and paramedics, their fleet of vehicles, their emergency dispatch capabilities and their mobile,

24/7 availability—to solidify and expand the role of EMS in a changed healthcare environment.



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With so much money at stake, hospitals and insurers are more and more interested in hearing about programs that help achieve the Institute for Healthcare Improvement's Triple Aim: Improve the patient experience, improve health and lower costs.

Yet even though the aim is to reduce costs, Zavadsky warns EMS agencies to avoid under-pricing their services in these new arrangements. EMS has traditionally priced its services based on the cost to provide the service, he says. In today's market, EMS needs to consider what the service is worth to the customer—that is, the hospital or the insurer. "It's value-based pricing," Zavadsky says. "Say we're helping a hospital avoid a 30-day readmission. We may have to make five home visits to prevent it. Do we get paid based on the home visit or on preventing the readmission? I would argue we get paid for preventing the readmission, not for the activity of going to the patient's house."

When hashing out mobile healthcare agreements, EMS should follow a simple rule of negotiation: Ask the payer to name their price first. "We learned the hard way: Don't under-price yourselves," he says. "The value proposition to them may be more than you think it is."

OVERCOMING REGULATORY BARRIERS

If there is one hurdle EMS representatives cited again and again in their efforts to get community paramedicine or mobile integrated healthcare programs up and running, it's regulatory barriers. With EMS governed by a patchwork of regulations that vary from state to state, it's not always clear to individual EMS agencies what they can and cannot do under the community paramedicine or mobile integrated healthcare banners.

Texas has the luxury of being a delegated practice state, meaning there is no statewide scope of practice. Instead, medical directors determine what EMS can do, which means that a supportive medical director such as Beeson has a lot of latitude in determining the roles EMS providers can take on, Zavadsky says. Likewise, primary care physicians in the state can authorize paramedics to provide certain services that they would ordinarily do.

When faced with regulatory obstacles, Minnesota took a different tact: It changed the law. In 2011, it became the first state to pass legislation recognizing community paramedics as distinct providers. In 2012, the state legislature authorized community paramedic programs to bill Medicaid.

Short of changing the law, another method may simply be finding a way forward within current regulations—even those that initially look prohibitive, EMS experts advised. In Colorado, the state EMS office (officially, the Health Facilities and EMS Division of the State Department of Public Health and Environment) is in charge of certifying EMS providers but otherwise doesn't regulate EMS ground transport. It does, however, regulate home health agencies, which are defined as providing services in the home on a scheduled basis, explains Randy Kuykendall, Health Facilities and EMS Division director. EMS agencies that want to provide in-home post-discharge follow-up in the home, for example, have had to apply for home healthcare licenses.

But EMS encroachment into their

work raised concerns among homecare providers, he says. So Kuykendall and his team held four meetings in 2012 and 2013 to bring stakeholders from EMS, public health and homecare together. "From the homecare perspective, if you're doing the same kind of work, it should be a level playing field. And I don't think anyone would argue with that," he says. "The debate is whether community paramedicine is a homecare model or should EMS agencies be exempted? I don't know the answer to that."


Another state trying to figure out a way forward while dealing with a varying set of regulations is California—which, like Colorado, is also regulated at the local EMS agency level. Among the first to embrace managed care in the 1990s and healthcare reform in the 2000s, California has traditionally been a leader in healthcare innovation. Yet even as other states have forged ahead with community paramedicine and mobile integrated healthcare, California has largely been left behind. The reason, says Howard Backer, M.D., director of California's Emergency Medical Services Authority (EMSA), is language in state law that says EMS must respond "at the scene of an emergency" and that EMS providers must transport patients to the hospital. That, combined with strong opposition from powerful interest groups such as the nurse's union, contributed to delaying community paramedicine programs in the state despite strong interest from EMS and fire departments, Backer adds.

More recently, EMSA and community paramedicine supporters found a way around the statute. Another state law permits pilot programs that use healthcare personnel in new roles to show that they improve patient outcomes or reduce costs. This summer, EMSA and the Office of Statewide Health Planning and Development recently put out a request for proposals for community paramedicine-style programs and has received numerous proposals. Up to 12 California sites will be selected to take part in these programs starting as early as this summer.

All will have strong requirements for data collection. Data will be analyzed by an independent data analyst, so that if the programs are effective, the evidence can be presented to the state legislature, which would ultimately need to re-write the law to make the programs permanent.

Still, that's two to three years away, Backer admits. After the proposals are authorized by EMSA, the state must hold two public hearings. If the pilots are approved, then comes training providers and implementation. The pilots then have to run for at least a year or two to gather enough data for the analysis to prove effectiveness. Only then would EMSA seek changes in the law to

accommodate the new role. And along the way, the expanded role vs. expanded scope question will need to be hashed out: that is, will community paramedics use their current skills in different situations, such as in post-discharge home visits to check vital signs, or will they need additional training and be able to do more procedures or administer different medications?

On one point most everyone agrees: With change happening rapidly, EMS needs to act quickly to make sure hospitals and insurers are aware of what EMS can provide. "Our profession has a very narrow window of opportunity to show these programs work," Zavadsky says. 



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