

The EMS Transformation – Moving to “EMS 3.0”

ACROSS THE NATION, more EMS agencies are offering mobile integrated healthcare and community paramedicine, while state legislatures are amending laws to clear the way for EMS to go beyond reacting to 911 calls to *preventing* them. At the same time, a growing number of healthcare entities are contracting with EMS to conduct frequent user interventions, readmission avoidance programs and other services to improve patient health while reducing costs.

In January 2015, in response to questions about what differentiates MIH from CP, leaders from NAEMT and four national EMS organizations met in New Orleans to hash out clearer definitions for each term. The goal, participants agreed, was to make it easier for EMS to explain the value of MIH-CP to stakeholders, including other healthcare providers, elected officials and payers.

But during the discussions, it became obvious that what was needed wasn't just a definition of MIH and CP, but an articulation of EMS's role in our nation's healthcare transformation – a new EMS value proposition. The group realized that the changes necessary to survive – or even thrive – transcend MIH-CP. Market forces will dictate that EMS re-evaluate every aspect of EMS delivery through the lens of value.

The wider healthcare transformation, called “Healthcare 3.0,” represents the understanding that the healthcare system is in its third phase of evolutionary transformation, and that there is likely to be more change to come (4.0, etc.).

With Healthcare 3.0, economic value is central. Things like pay-for-performance, outcome-based payments, bundled payments, accountable care organizations, shared-risk contracting, penalties for adverse outcomes such as readmissions or healthcare-acquired infections, financial bonuses for reporting outcome data (and penalties for not reporting it), and patient satisfaction scores have all had a significant impact on hospitals, home health agencies, skilled nursing facilities and physicians.

“How all these changes will impact EMS is relatively predictable – all we have to do is look at what's happened to our fellow healthcare providers and begin preparing ourselves



for the third evolutionary transformation for EMS, or what we could refer to as ‘EMS 3.0.’ And, like Healthcare 3.0, we need to base EMS 3.0 on the value proposition we bring to our stakeholders,” said Matt Zavadsky, NAEMT's representative at the meeting, and chair of NAEMT's MIH-CP and EMS Data Committees.

DETERMINING EMS VALUE

While EMS is present in almost every community in this country, EMS has often struggled to clearly define and articulate the value of its services, noted Kevin McGinnis, program manager for the National Association of State EMS Officials (NASEMSO).

In the 60s, the primary *service* provided by EMS was transportation, while the value was swift response and delivery to a hospital.

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In the '70s and '80s, the concept of EMS as part of a system of care took hold, as did the idea that EMS could bring value by preventing injuries and emergencies. Yet state laws written at the time locked EMS into its emergency response/transportation function, he noted.

1996's "EMS Agenda for the Future" and 2004's "Rural and Frontier EMS Agenda for the Future" again called on EMS to bring value by integrating with the healthcare system to offer community-based health management, treatment for chronic conditions and injury care follow-up. In the early 2000s, the establishment of the first community paramedicine programs began to see that vision realized.

Out of community paramedicine grew mobile integrated healthcare. According to an NAEMT national survey published in 2015, more than 100 EMS agencies reported offering MIH-CP. And since then, dozens more EMS agencies have launched these new service lines.

Yet with strong connections to both public safety and healthcare, EMS has sometimes described itself as "floating" between spaces, McGinnis notes.

"Traditionally we have always defined EMS being on the crossroads of public health, public safety, medicine...When in reality EMS has a professional space, and a service space, that is a very real offering of value to the public, and it's time to claim that space, name the space, define the space and continue to shout that from the mountaintop," McGinnis said.

DISRUPTIVE CHANGE IN HEALTHCARE DELIVERY IMMINENT

To Jonathan Washko, assistant vice president at Northwell Health's Center for EMS in Syosset, N.Y., defining EMS's space and articulating its value comes not a moment too soon.

The types of insurance patients have are changing, with many EMS agencies seeing more patients with Medicaid or high deductible plans that don't cover the cost of ambulance transport, Washko said. Some commercial insurers have applied pressure to EMS to reduce rates by sending reimbursement checks directly to patients, much of it money that EMS is unlikely to ever see.

To survive, many healthcare entities and payers are turning to mergers and joint ventures with their former competitors to enhance efficiency and gain negotiating leverage. EMS also needs to seek out joint ventures that can help demonstrate value, he said.

"There are opportunities for EMS in this space. EMS needs to be aggressive in looking for the right partners in the marketplace," Washko said.

EMS 3.0 will also be heavily data-driven, said Nick Nudell, chief data officer for the Paramedic Foundation and a member of NAEMT's EMS Data Committee. "Data provides information that EMS professionals use to create knowledge that can, in turn, be used to demonstrate their value to their community through measurement," Nudell said. "The most important measures look at patient outcomes."

Finally, EMS 3.0 is raising questions about how EMS can best educate its workforce and develop new leaders who have the qualities and the skills to adapt and thrive in a changing role, said Brian LaCroix, president of Allina Health EMS, who represented the National EMS Management Association (NEMSMA) at the meetings.

"As our profession matures and evolves, we will always have a role for EMTs and paramedics who are interested in responding to heart attacks and car crashes," LaCroix said. "However, a

growing segment of what we do will be in the non-urgent space, working with the chronically ill and frail elderly. We need people who want to provide those services and who are educated to do that."

REACHING CONSENSUS ON A VISION FOR A NEW EMS

In January, EMS leaders again met at the 2016 National Association of EMS Physicians' (NAEMSP) meeting in San Diego to discuss EMS 3.0.

"Healthcare is changing and the value propositions that EMS can offer need to be well articulated," said Dr. Kevin Munjal, an assistant professor and associate medical director of prehospital care at Mt. Sinai Medical Center who represented NAEMSP at the meeting.

The group agreed that to succeed as a profession in redefining EMS and cementing its role as a valued participant in the new healthcare environment, EMS associations and the EMS workforce must work together to drive change.

"EMS has grown up and recognized we have a role in the Triple Aim. As our society has grappled with the fact we need to reinvent healthcare, EMS has discovered we have a place in that process," LaCroix said. "If we can demonstrate that we are more than just that ambulance racing around town, we can educate people about our place in healthcare and get the attention of payers."

EMS has a professional space, and a service space, that is a very real offering of value to the public, and it's time to claim that space, name the space, define the space and continue to shout that from the mountaintop.

Kevin McGinnis, program manager for the National Association of State EMS Officials (NASEMSO)

THE NEW EMS VALUE PROPOSITION

SERVICE LINES

To remain relevant and valued...EMS agencies need to offer service lines including a menu of emergency and preventive medical services that meet the particular needs of their communities...

- Emergency medical dispatch
- Rapid response, emergency and critical care (ground and air) transport
- Interfacility and other medical transportation
- Emergency medical assessment and intervention
- Logistical, operational, or clinical support of mobile integrated healthcare (MIH)
- Community paramedicine services, as part of an MIH system or stand-alone.

VALUE

EMS provides essential value to the transforming healthcare system because:

- EMS is already in virtually every community.
- EMS is fully mobile and able to address patient needs 24/7.
- EMS is an expected, respected, and welcomed source of medical assessment and care in people's homes and elsewhere in the community.
- EMS provides highly reliable patient assessment and intervention during calls to 911 and in response to emergency, urgent or unscheduled episodes of illness or injury.
- EMS, through its multiple service lines, can effectively navigate patients needing urgent or unscheduled care through the healthcare system to ensure they receive the right care, in the right place, at the right time.
- EMS' CP services fill gaps in patient care identified by its providers and by others in the community's healthcare network. EMS can prevent new or recurrent medical episodes through these services. This reduces the incidence of ambulance transports, emergency department visits, hospital admissions and readmissions, preserving medical resources and reducing costs.
- Mobile Integrated Healthcare is a model in which a variety of community healthcare providers/agencies organize to deliver a broad spectrum of patient-centered preventive, primary, specialty, and/or rehabilitative care outside of medical facilities. EMS can support this model by operating an MIH system or by providing CP services for it.

EMS ASSOCIATIONS PARTICIPATING IN THE NEW EMS VALUE PROPOSITION

National Association of Emergency Medical Technicians (NAEMT)
National Association of State EMS Officials (NASEMSO)
National Association of EMS Physicians (NAEMSP)
National EMS Management Association (NEMSMA)
National Association of EMS Educators (NAEMSE)



WHAT'S THE DIFFERENCE BETWEEN MIH AND CP?

Community paramedicine and mobile integrated healthcare are both patient-centered, mobile services offered outside of medical facilities. CP is an extension of EMS paramedicine practice and services to cover healthcare gaps in communities. MIH is an administrative organization of multi-disciplinary medical, nursing, and other practices which may or may not involve EMS paramedicine providers.

