Welcome To EMS 3.0!

Surviving & Thriving

Program

8:00 a.m. — REGISTRATION OPEN
Coffee/Continental breakfast sponsored by Amerian & Strobel

9:30 a.m. — WELCOME AND OPENING REMARKS
“EMT 3.0” — Industry Executive on the J.E. Answer
Matt Zawacki, M.D., M.P.H., Chair, Emergency Medical Services
Office, Medical College of Ohio, Akron, OH

10:30 a.m. — THE MEDICINE
Clinical Care: Prehospital, Hospital-Based, Oversight & Integration of Health Services
- Dr. Jack Mathew, OhioHealth, Columbus, OH
- Dr. Mark Litt, MD, PhD, Clinical Director, University Hospitals, Cleveland, OH
- Dr. David Bayley, MD, University Hospitals, Cleveland, OH

12:00 p.m. — THE EVIDENCE
Program Evaluation, Research & Analytics: Outcome Measures
Cynthia Knox, Research Director, University of California, San Francisco, CA

12:30 p.m. — LUNCH
Sponsors: Medtronic

1:00 p.m. — THE TECHNOLOGY
Operational: Operations & Technology
- Dr. John Kessi, MD, San Diego County, CA
- Dr. John Kessi, MD, San Diego County, CA
- Dr. John Kessi, MD, San Diego County, CA

12:50 p.m. — SUMMIT LUNCH
Sponsored by Medtronic
Marketing Sponsors

Speak up!
or
Text to: 817-991-4487

Shared Vision = Industry Alignment!
Urgent and Emergent Care Remain Core to EMS

But EMS Must Offer Expanded Roles

EMS is Uniquely Positioned to Help
Healthcare 3.0

Demonstrating Value for EMS

Categories:
- Category 1: Redefine the model for quality and value
- Category 2: Implement systems and tools for streamlined, patient-focused care
- Category 3: Improve the system of care and partner for continuous improvement
- Category 4: Improve payment and reimbursement models

The Revolution in EMS Care

Thanks to new technology, new life-saving techniques and new missions, ambulance crews are far from the "horizontal taxicabs" they once were.

By Laura Kakoyiannis
Sept. 25, 2014

There’s a revolution taking place in emergency medical services, and for many, it could be life changing.

From the increasingly sophisticated equipment they carry and the new lifesaving techniques they use, to the changing roles they play in some communities—providing preventive care and monitoring patients at home—ambulance crews today are hardly recognizable from their origins as "horizontal taxicabs."

Covering care: preventive-care teams

In what could amount to a new change for many EMS workers, health-care policy makers are looking at having so-called community paramedic teams provide preventive care—and even make regularly scheduled house calls.

In a concept some are calling “EMS 3.0,” ambulance crews with advanced medical training are more communities already are treating patients in their homes, including frail or elderly patients, helping to manage chronic conditions like diabetes, and are checking on recently discharged hospital patients to ensure they are following their care instructions.

http://w w w .businessinsider.com/think

A healthcare expert explains why you should think twice before taking an ambulance to the hospital

By Dr. Elisabeth Rosenthal
April 25, 2017

Dr. Elisabeth Rosenthal: One of my favorite stories is the time we were with a patient who was in a near-fatal crash. We knew she’d lost something. Hence, someone said, "Oh, let’s call an ambulance." And then, the next chapter, we get a bill from the ambulance company, and it was for $800.

And the ambulance company said, "Oops! We charge, and we’re not in your network. That’s not on us." And she would have taken a cab to the hospital, but the ambulance was there. She used it, and it didn’t think much of it.

We live in an era of ambulances as change agents in health care. And they’re trying to change how they’re billing, and they’re offering out of networks.

In 1976, I was running in New York, and I tripped on the pavement and broke a bone, near Columbus. A bunch of students was there, and we said, "Oh, come help you. Should we call an ambulance?" And one of the students said, "No, I’m walking to the hospital." When people call an ambulance, or think, why don’t we just call an ambulance or get in an ambulance there may be financial repercussions.

http://w w w .w allstreetjournal.com/article/The-revolution-in-EMS-care-EMS-3.0-1288050352
And she could have taken a cab to the hospital, but the ambulance was there.

And I was like, "No! I am walking to the hospital."

Speak up!

or

Text to: 817-991-4487

The Medicine...
THE MEDICINE: The EMS Transformation Summit – Attributes of EMS 3.0

Dr. Brad Lee, MD, JD, MBA, Medical Director, REMSA, Reno, NV
Dr. Conrad Fivaz, MBChB M.MED(FAMMED) IAED; PDC, Salt Lake City, UT
Monday, April 24, 2017

Supply and Demand Mismatch

- How do we break the chain of events?

Calls come into 911 center

Emergency vehicles available for dispatch

EMS back off (time goes by)

More calls not yet assigned to ambulances

Most calls get Ambulance Resource Group (ARG) assignment
delays

Increase in 911 call demand

- An estimated 240 million calls are made to 911 in the U.S. annually
- SPRINGFIELD, Ohio — Emergency medical service runs by the Springfield Fire/Rescue Division have increased nearly 40 percent in a decade
- Boston EMS said it has seen a 26 percent rise in calls over the past decade (2005 to 2014)
- In 2015, the Philadelphia Fire Department’s emergency medical service responded to about 270,000 911 calls. That volume represented an increase of almost 25,000 from the prior year and more than 55,000 from 2007

Priority Solutions, Inc.
Medically Unnecessary Transports
Published Studies

- Cho et al. literature review (2007) cited that medically unnecessary transports comprised at least 31% of all emergency ambulance transports and as high as 92%.

- In their own study (Cho et al., 2007), the authors conducted a random retrospective chart review of one year’s data of patients at a Level 1 Regional Trauma Center in the Bronx, NY (St. Barnabas).

- Even using a very “conservative operational definition of medically necessary transports,” 15% of those patients transported by ambulance to this hospital did not require EMS transportation to an Emergency Department.

- A study by Weaver, Moore, Patterson, and Yealy found that from 1997 to 2007, there was an increase from 13% to 17% in the number of medically unnecessary ambulance transports nationally, as part of all ambulance transports as a whole (2011).

- An English study from 1998 used a panel of emergency room physicians who voted whether or not transports were medically necessary and found that 16%, or approximately 75,000, of transports were medically unnecessary by unanimous vote (Donovan, 2009).

Regional Emergency Medical Services Authority
REMSA

Private non-profit serving Northern Nevada and Northern California
celebrating 35 years of service
TRIPLE AIM

- Improve the quality and experience of care
- Improve the health of populations
- Reduce per capita cost

Hotspotter Demographics

- 953 unique individuals visited an ED 12 or more times in a given 12 month period (Washoe County, 2009-2013). They accounted for:
  - 20,844 ED visits
  - $65 million in total hospital charges
  - Most common diagnoses: headache, abd pain, back pain
  - 46% lived in one of three Washoe County zip codes
  - $46.6 million hosp charges: uninsured, Medicaid, Medicare
  - Insurance: 28% uninsured, 29% Medicaid, 19% Medicare

Community Health Programs

- Transport to Alternative Locations
- Community Paramedics
- Nurse Health Line
Four-Year Program Outcomes

The Patient/Caller Experience

High levels of satisfaction with ECNS

REMBA Program Savings vs. Program Expenditures
Program to Date: July 2012 – June 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Program Savings (Charges)</th>
<th>Program Expenditures</th>
<th>Program Savings (Payments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$27.61M</td>
<td>$9.06M</td>
<td>$9.66M</td>
</tr>
<tr>
<td>2015</td>
<td>$12.75M</td>
<td>$11.00M</td>
<td>$9.06M</td>
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<td>2014</td>
<td>$7.90M</td>
<td>$10.00M</td>
<td>$9.66M</td>
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<tr>
<td>2013</td>
<td>$3.15M</td>
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<td>$9.06M</td>
</tr>
<tr>
<td>2012</td>
<td>$0</td>
<td>$8.00M</td>
<td>$9.06M</td>
</tr>
</tbody>
</table>

Q1 Q2 Q3 Year
Q4 Q5 Q6 Year
Q7 Q8 Q9 Year
Q10 Q11 Q12 Year
Q13 Q14 Q15 Year
Q16 Q17 Q18 Year

Millions

REMSA Program Savings vs. Program Expenditures
Program to Date: July 2012 – June 2016

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<tr>
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Q1 Q2 Q3 Year
Q4 Q5 Q6 Year
Q7 Q8 Q9 Year
Q10 Q11 Q12 Year
Q13 Q14 Q15 Year
Q16 Q17 Q18 Year

Millions
Return on Investment
Award Year Four (July 2015 - June 2016)

Return on Investment: 84%

Notes:
- Program costs include all grant funded expenditures.
- Savings data provided by University of Nevada, Reno, Nevada Center for Health Statistics and Informatics.

Community Health Programs
Program Savings by Intervention
Program to Date (Jan 2013 - Dec 2015)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Other Gov't</th>
<th>Medicare</th>
<th>Uninsured</th>
<th>Commercial Insurance</th>
<th>Medicaid</th>
<th>Unknown</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Transport</td>
<td>$37,698</td>
<td>$301,797</td>
<td>$518,922</td>
<td>$127,006</td>
<td>$646,646</td>
<td>$0</td>
<td>$1,632,069</td>
</tr>
<tr>
<td>Community Paramedics</td>
<td>($3,367)</td>
<td>$556,181</td>
<td>$75,841</td>
<td>$603,855</td>
<td>$204,508</td>
<td>$265,889</td>
<td>$1,702,907</td>
</tr>
<tr>
<td>Nurse Health Line</td>
<td>$393,920</td>
<td>$351,023</td>
<td>$314,876</td>
<td>$1,065,370</td>
<td>$1,511,303</td>
<td>$854,778</td>
<td>$4,491,270</td>
</tr>
</tbody>
</table>

Savings Generated by Intervention
Program to Date (Jan 2013 - June 2016)

$9,653,154 in Avoided Payments

- Nurse Health Line 60%
- Community Paramedics 27%
- Ambulance Transport Alternatives 13%
Community Health Program

Program Results
Program to Date (Four Years) 7/1/12 – 6/30/16

1. Improved access to quality care
   - 83,866 calls to Nurse Health Line (9/13 – 6/16)
   - 1,324 enrolled Community Paramedic patients (9/13 – 6/16)
   - 1,438 Transports to Alternative Destinations (1/13 – 6/16)

2. Improved patient quality of life & satisfaction

3. Total est. program savings: $9.66 million
   - 6,202 ED Visits Avoided
   - 1,024 Ambulance Transports Avoided
   - 104 Hospital Readmissions Avoided

Note: Estimated program savings calculated based upon average payments.

Community Paramedicine
Specially-trained Community Health Paramedics provide in-home services to improve the transition from hospital to home, including:
- Medical care plan adherence
- Medication reconciliation
- Point of care lab tests
- Personal health literacy
- Protocols: CHF, COPD, MI, Cardiac Surgery
Community Paramedicine

Programs

- Post-hospital Discharge Patient Follow-up
  - Assist patients avoid complications after discharge from hospital
- Episodic Evaluation Visit
  - Provide primary care physicians with a patient care service when an emergency department visit may not be optimal
- Hotspotter Intervention
  - Help frequent emergency dept users to access more appropriate services for unmet primary care, mental health or social needs

Community Paramedicine

Medical Oversight

- Community paramedics function under medical director-approved protocols
  - Existing ground ambulance protocols, PLUS
  - New community paramedic protocols
  - Under the direction of REMSA Medical Director with permission of patient’s primary care physician
- Quality Improvement
  - REMSA Medical Director oversees CQI program and audits

Community Paramedicine

Protocols & Training

- Community Paramedicine Protocol Manual
  - Current: Hotspotter, Congestive Heart Failure, Myocardial Infarction, Evaluate and Refer
  - Future: Diabetes, Pneumonia, Dehydration, Nausea, ER discharge
- Training
  - Initial group (500 hours), CP competency test, refinement, second group (150 hours), incl didactic and clinical rotation
  - Accredited by University of Nevada, Reno
Community Paramedicine

All-Cause Unplanned 30-Day Readmission Rate for Heart Failure Patients
Program to Date (June 2013 - June 2016):

- County Avg: 20.40%
- Nat'l Avg: 22.00%
- Median: 12.90%

Patients Enrolled with REMSA
Community Health Paramedics

Re soprondig our community's healthcare needs.

Community Paramedicine

Patient Satisfaction Survey Results
Program to Date (June 2013 - June 2015)

- n = 230 Surveys Returned

Were our personnel helpful and polite?
How well did our personnel explain your care options?
Was your care provided in a timely manner?
How would you rate the quality of the care you received?
How would you rate your overall patient care experience?

Scale: 0 = Very Poor   1 = Poor    2 = Fair    3 = Good    4 = Very Good    5 = Excellent

Community Paramedicine

Nurse Health Line
ECGS
Key considerations as laid out by the NAEMT

- Best practice
- Science behind Nurse Triage
- Clinical Governance and safety
- Where
- How

The Emergency Communication Nurse (ECN)

How does ECNS work?

ECN determines the patient's Recommended Care Level (RCL):
- Emergency response (911)
- Emergency care as soon as possible
- Seek medical care within 1-4 hours
- Consult medical provider to review symptoms
- Consult regional poison control center
- See medical provider within 12 hours
- See medical provider within 1-3 days
- Routine appointment with provider
- Routine appointment with dentist
- Self-care/Home care instructions
- Others
ECNS recommends the best health care resources to meet the patient’s needs.

What is the best way for this patient to get to the destination?

Who will best meet this patient’s needs?

Clinical governance

As with other disciplines under the IAED, there is a formal process in place for evaluating Proposals for Change and recommendations for improvements to the ECNS. This occurs through evidence-based research and the expertise of the ECNS Council of Standards.

Codes determined to be safe for ECNS are based on research:

- AED Council of Standards
- Evidence from literature
- Clinical governance
- IAED Council of Standards

Priority Solutions, Inc.
Not all secondary medical telephone triage programs are equal

- Clinically sound medical protocols
- Trained Registered Nurse
- Housed within an ECC
- Medical oversight

Stratification Definition:
Consistent or particular way of arranging things according to layers or categories

- ECNS is highly stratified
  - Multiple layers of clinical considerations
  - 212 protocols
  - Multiple recommended care levels
  - Sub-teams of care offered

There is confidence in the ability to determine appropriate alternative dispositions using this system.

Clinically Sound Medical Protocols

Clinical Decision Support Software (CDSS)

- Clinical Decision Support Software system used in ECNS was developed and enhanced over the last 17 years
- First live implementation 2001 South Africa
- Base protocol set: in excess of 80 million triage calls completed internationally
- The protocol set is reviewed and updated continuously based on research and expertise of members of the ECNS Council of Standards

212 Protocols in the set

- Top 5 most frequently used protocols:
  - Falls
  - Abdominal pain
  - Back pain
  - Vomiting
  - Leg pain
ECNS Agencies

ECNS In the USA
- MedStar in Fort Worth, Texas
  - 911 access only
- Las Vegas Fire, Nevada*
  - 911 access only in the initial phase
- REMSA in Reno, Nevada
  - 911 access and direct dial (7-digit) Nurse Health Line
- Northwell Health Services in Long Island, New York
  - Ad

ECNS International
- Canada Nova Scotia*
- United Kingdom ambulance trusts EOEAS, SWAST
- South Africa
  - Johannesburg Netcare 911
- Botswana (Gaborone)
- Australia Queensland Health (Large Nurse Triage call center)
- Austria (3 states)
- Ireland HSE*

* Implementation pending

Survey results:
- 90% of callers indicated that it helped talking with a nurse.
- 88% stated that their condition got better.
- 77% stated they do not believe the call should have been handled any differently.
- Satisfaction scores were 4.6 - 4.7 on a 1-5 point scale for satisfaction with the nurse, care provider recommendation, and transportation recommended.

High satisfaction in Texas

REMSA customers rate ECNS high in Reno
July 2014 - June 2015

REMSA Customer Satisfaction on 1-5 Likert Scale (5 = most satisfied)

REMSA Percentile Satisfied Customers

High satisfaction in Texas

Responding to your community's needs.
High Levels of Customer Satisfaction and Efficacy

National findings in the UK:

- 84% of all respondents said they were treated with kindness and understanding “all of the time.”
- 11% felt they were “some of the time.”
- 5% said they were not treated with kindness and understanding overall.

Similar results were produced for treatment with dignity and respect in this same survey.

Partners and Potential Funding for ECNS

- Grants
- Hospitals
- Physician groups
- Insurance companies
- Other partners

MedStar Data

Expenditure Savings Analysis (11)

<table>
<thead>
<tr>
<th>Category</th>
<th>Reason</th>
<th>Resolved</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding Charge</td>
<td>2,499</td>
<td>521</td>
<td>$492,360</td>
</tr>
<tr>
<td>Outstanding Payment (2)</td>
<td>947</td>
<td>186</td>
<td>$90,267</td>
</tr>
<tr>
<td>C-Charge</td>
<td>296</td>
<td>195</td>
<td>$51,056</td>
</tr>
<tr>
<td>C-Fee</td>
<td>1,718</td>
<td>546</td>
<td>$486,939</td>
</tr>
<tr>
<td>C-Reduced Process (5)</td>
<td>6</td>
<td>566</td>
<td>3,395</td>
</tr>
<tr>
<td>Total Charge Assistance</td>
<td>$948,717</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue Assistance</td>
<td>$880,327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost</td>
<td>$913</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge Inflation</td>
<td>$24,377</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optional Assistance</td>
<td>$13,061</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Presented by MedStar at Navigator Conference 2014*
Northwell Health: PROVIDING ACUTE CARE AT HOME

• This observational study describes a Community Paramedicine (CP) model for treatment of acute medical conditions within an Advanced Illness Management (AIM) program, and compares its effect on emergency department (ED) use and subsequent hospitalization with that of traditional emergency medical services (EMS).
• The CP model was implemented between January 1, 2014, and April 30, 2015 in a suburban–urban AIM program.
• Participants included 1,602 individuals enrolled in the AIM program with high rates of dementia, decubitus ulcers, diabetes mellitus, congestive heart failure, and chronic obstructive pulmonary disease.

Preliminary Results:
Emergency calls were routed to a nursing clinical call center where they are triaged using emergency communication nurse system de-escalation.
The program has had a zero clinical defect rate (that is, zero reported adverse clinical errors or poor outcomes), a very low ED relapse rate post-CP visit, and estimated financial savings of $7,267,081 in avoided payments at an extremely low cost point, with the potential to provide triple-digit returns on investment in a risk-based reimbursement environment.

Nurse Health Line
858-1000
Registered Nurses provide 24/7 medical guidance & triage patients to appropriate health care or community service:
- Protocol-driven Assessment
- Emergency Communication Nurse System
- Access
- Non-emergency number
- Omega Protocol via 9-1-1
- Recommended Level of Care & Recommended Location of Care
- On-line Directory of Services

Nurse Health Line Protocols
Software by Priority Solutions
- LowCode Emergency Communication Nurse System (ECNS)
- Training
  - Emergency Medical Dispatch (EMD) – 1 day
  - Emergency Care Nurse System (ECNS) – 4 days
- Accredited by International Academy of Emergency Dispatch
  - EMD Accredited Center of Excellence (13 years)
  - ECNS Accredited Center of Excellence (2015)
Responding to community healthcare needs.

**Nurse Health Line**

**Incoming Calls by Month**

Program to Date (Oct 2013 - June 2015)

<table>
<thead>
<tr>
<th>Month</th>
<th>Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
<td>1,046</td>
</tr>
<tr>
<td>Nov</td>
<td>1,675</td>
</tr>
<tr>
<td>Dec</td>
<td>3,167</td>
</tr>
<tr>
<td>Jan</td>
<td>2,451</td>
</tr>
<tr>
<td>Feb</td>
<td>2,534</td>
</tr>
<tr>
<td>Mar</td>
<td>2,382</td>
</tr>
<tr>
<td>Apr</td>
<td>1,899</td>
</tr>
<tr>
<td>May</td>
<td>1,991</td>
</tr>
<tr>
<td>Jun</td>
<td>2,115</td>
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<tr>
<td>Jul</td>
<td>1,910</td>
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<tr>
<td>Aug</td>
<td>1,964</td>
</tr>
<tr>
<td>Sep</td>
<td>2,118</td>
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<tr>
<td>Oct</td>
<td>1,895</td>
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<tr>
<td>Nov</td>
<td>2,025</td>
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<tr>
<td>Dec</td>
<td>2,089</td>
</tr>
<tr>
<td>Jan</td>
<td>2,095</td>
</tr>
<tr>
<td>Feb</td>
<td>2,011</td>
</tr>
<tr>
<td>Mar</td>
<td>1,885</td>
</tr>
</tbody>
</table>

**Nurse Health Line Calls by County**

Program to Date: October 2013 – June 2015

<table>
<thead>
<tr>
<th>County</th>
<th>Calls</th>
<th>% of Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Nevada – Total</td>
<td>13,497</td>
<td>95.51%</td>
</tr>
<tr>
<td>Washoe County pop. 440,078 (15.5%)</td>
<td>10,860</td>
<td>76.85%</td>
</tr>
<tr>
<td>Carson City pop. 54,522 (1.9%)</td>
<td>1,042</td>
<td>7.37%</td>
</tr>
<tr>
<td>Elko County pop. 52,766 (1.9%)</td>
<td>7</td>
<td>0.05%</td>
</tr>
<tr>
<td>Lyon County pop. 51,789 (1.8%)</td>
<td>853</td>
<td>6.04%</td>
</tr>
<tr>
<td>Douglas County pop. 47,536 (1.7%)</td>
<td>385</td>
<td>2.72%</td>
</tr>
<tr>
<td>Churchill County pop. 23,989 (0.8%)</td>
<td>160</td>
<td>1.13%</td>
</tr>
<tr>
<td>Humboldt County pop. 17,279 (0.6%)</td>
<td>116</td>
<td>0.82%</td>
</tr>
<tr>
<td>White Pine County pop. 10,034 (0.4%)</td>
<td>8</td>
<td>0.06%</td>
</tr>
<tr>
<td>Pershing County pop. 6,698 (0.2%)</td>
<td>24</td>
<td>0.17%</td>
</tr>
<tr>
<td>Lander County pop. 6,009 (0.2%)</td>
<td>11</td>
<td>0.08%</td>
</tr>
<tr>
<td>Mineral County pop. 4,500 (0.2%)</td>
<td>15</td>
<td>0.11%</td>
</tr>
<tr>
<td>Storey County pop. 3,912 (0.1%)</td>
<td>13</td>
<td>0.09%</td>
</tr>
<tr>
<td>Eureka County pop. 2,018 (0.1%)</td>
<td>3</td>
<td>0.02%</td>
</tr>
<tr>
<td>Southern Nevada - Total</td>
<td>157</td>
<td>1.11%</td>
</tr>
<tr>
<td>Clark County pop. 2,069,681 (72.9%)</td>
<td>149</td>
<td>1.05%</td>
</tr>
<tr>
<td>Nye County pop. 42,282 (1.5%)</td>
<td>7</td>
<td>0.05%</td>
</tr>
<tr>
<td>Lincoln County pop. 5,184 (0.2%)</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Esmeralda County pop. 822 (0.0%)</td>
<td>1</td>
<td>0.01%</td>
</tr>
</tbody>
</table>

**Nurse Health Line**

**Lessons Learned**

- Extraordinary community demand across broad spectrum (50%+ provider referral rate)
- Independent call review results high protocol compliance
- No adverse outcomes
- Protocol-driven triage (NOT ADVICE) outperforms alternatives
- Advertising campaign effective
- Generates greatest share of program savings
“Why won’t the 911 system listen to its own nurses?”

I fell and twisted my ankle. I couldn’t drive with the pain and swelling, and I didn’t know what to do. I called 911.

After talking to two people, they put me through to a nurse who talked me through my fall and suggested taking a taxi to an urgent care. She was looking up nearby clinics with X-ray when the EMTs started arriving.

I told the EMTs that the phone nurse was helping me and didn’t need an ambulance. They didn’t listen, weren’t interested in hearing anything the nurse had to say, ordered me to hang up and instructed me to go to a hospital via ambulance.

Well, I did as I was told and dutifully got into the ambulance where some different EMTs took over. In the ER, the doctor diagnosed a sprained ankle. I asked why I had to go to the ER; he replied that taking a cab to an urgent care would have been just fine.

To the 911 EMTs: Thank you for your responses, but please listen to your dispatchers, nurses, and patients. The ER is crowded enough without my ankle injuries.

- Alice Peterson Reno

Reno Gazette-Journal
Letter to the Editor – 09/12/2015

ECNS Quality Improvement Program

Priority Solutions, Inc.

- Key component
- QA/QI Reports in AQUA
- Additional Two-Day training course for ECN-Q auditors
- Accreditation for ECNS

Quality Assurance and Improvement
Alternative Destination Transports

Ambulance Transport Alternatives

- Advanced assessment by field personnel of 9-1-1 patients facilitating Alternative Pathways of Care including transport to:
  - Urgent Care Centers
  - Clinics/Medical Groups
  - Community Triage Center
  - Mental Health Hospitals

Protocols

- Protocol-driven advanced assessment
- To determine eligibility for alternative destination
- Current ground ambulance protocols, PLUS
- Additional protocols: Intoxicated, psychiatric, low acuity
- Documentation via Ambulance EPCHR
- Advanced assessment completed on every patient
- Flex-field added to ground ambulance EPCHR
Ambulance Transport Alternatives

Training

- Training
  - 4 hours of in-service for all ground ambulance personnel
  - Determine and document eligibility for alternative destination

- Quality Improvement
  - 100% review of repatriation transports by medical director

Ambulance Transport Alternatives

January 2013 – June 2016

Preliminary Results

- 1,509 alt transports
- 1,438 ED visits avoided
- 131 ambulance transports avoided
- 4.7% repatriation rate

Estimated Savings

- $1,841,689 (avg. payments)

Lessons Learned

January 2015 – June 2015

- Safe, reliable way for patients to receive right care at lower cost
- Factors: facility open, patient consent, facility accept insurance
- No adverse outcomes
- Volumes lower than projected
- EMS role in healthcare safety net
- Tool to intercept hotspotters
Challenging the Healthcare Status Quo

Creating & Sustaining System-wide Change

Taking Aim & Building the Evidence Base

Converting Stakeholders in Partners

Targeted Utilization by Zip Code

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Baseline Baseline Baseline Baseline Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
</tr>
<tr>
<td></td>
<td>ED (n)</td>
</tr>
<tr>
<td>89501</td>
<td>4252</td>
</tr>
<tr>
<td>89512</td>
<td>25574</td>
</tr>
<tr>
<td>89502</td>
<td>43566</td>
</tr>
<tr>
<td>89431</td>
<td>1685</td>
</tr>
<tr>
<td>89433</td>
<td>20188</td>
</tr>
<tr>
<td></td>
<td>Average Rate for Washoe County is 320 visits/1000 persons/year</td>
</tr>
</tbody>
</table>

New Model of EMS Care and Payment

**Principles**

- Balanced triage: Subjective, layperson definition of emergency
- Patient-centered: Patient choice and consent
- Integrated: Emergency care, primary care, mental health, social needs
- Stakeholder-engaged: Tailored strategies for clinical partners
- Payor-aligned: Referral to in-network care
- New health information technologies: Exchange of patient records and data
- Evidence-based: Use of new data analytics across all domains
References

*1 http://www.nena.org/?page=911
*4 http://www.northeasttimes.com/2016/jul/5/fire-department-911-calls-should-be-emergencies/#.WNRVZ3nfOdI


*10 Data presented by MedStar at Navigator Conference in 2014.


*12 National findings from the 2013/2014 Ambulance survey of ‘Hear and Treat’ callers in UK. Summary document.

EMS 3.0 Data Analytics

San Diego Resource Access Program (RAP)
- Originally a frequent user management program
- Primary functions:
  - Surveillance
  - Crisis intervention
  - Coordination
- Requests
  - Missing persons
  - Drug patterns
  - Trafficking
  - Others
Our Mission

“We address the needs of vulnerable EMS patients and preserve safety net resources.”

- High utilizers
- Vulnerable patients
- Provider safety and wellness

Data In

- ePCR
- Health information Exchange
  - Medications
  - Medical History
  - Past encounters at hospitals and clinics
- Community Information Exchange (RAP)
  - Social services usage
  - Homeless Management Information System
- Reverse 211 (RAP)
  - Health Navigator communication
- Community Information Exchange
- EMS encounters
- 211 Referrals
- Field referrals for social issues like nutrition, in-home care, etc.
- RAP to Field transmissions
- Safety information
- RAP care plans

**RAP16-0000051**

**PRE-HOSPITAL CARE INSTRUCTIONS**

Community Care Plans:

- Early AK-09 release with no assigned medical alert.
- Currently does not meet the criteria.
- AK-09 release is not recommended.

**COMMUNITY CARE PLAN**

- Early AK-09 release with no assigned medical alert.
- Currently does not meet the criteria.
- AK-09 release is not recommended.

- Contact 911 or RAP if you encounter this individual in an emergency. For emergency concerns, all medical personnel to release information from this page.
- Call the 911 operator for an AK-09 release with no assigned medical alert.

- For information on this page, contact the nearest medical affiliate.
Insight-driven patient care

- Protocols are built for the masses
- Patients can be complex
- 360-degree view

Case Example

- 30 y/o male
- 7 calls this year
- 1. Asthma
- 2. Anxiety
- 3. Terrorist threats
- 4. Assault
- 5. Jaw Pain
- 6. CPR – Fentanyl OD
- 7. Prescription refill

The many faces of healthcare
- Housing, nutrition, crime

Thesis Statement

Integrated health needs data management methods, processes, and systems designed to address an individual’s complex needs.

Do our systems fit the purpose?

Integrated health requires integrated insight

<table>
<thead>
<tr>
<th>Sector</th>
<th>Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law Enforcement</td>
<td>Intelligence</td>
</tr>
<tr>
<td>Business</td>
<td>Business Intelligence</td>
</tr>
<tr>
<td>Market</td>
<td>Market Intelligence</td>
</tr>
<tr>
<td>Healthcare</td>
<td>??</td>
</tr>
</tbody>
</table>

"...we waste energy in angrily accusing people of intellectual dishonesty or abuse of words, when their only sin is that they use words in ways unlike our own, as they can hardly help doing especially if their background has been widely different from ours." - Hayakawa and Hayakawa
The full picture is held by a broad range of individuals (and disciplines)

"...end up responding to the immediate crisis and not implementing preventative and longer-term problem solving approaches." (1)

"In an integrated intelligence approach, the expectation is that each and every member of staff understands what intelligence is, their responsibilities in collecting it, and how it can benefit them. An integrated intelligence approach assumes that the agency will be proactive in gathering intelligence, not merely relying on information that comes to them..."
• Data storage
• Sources
  • EMS ePCR (NEMSIS)
  • Incident details
  • Referral notes
• Partner data
  • HIE
  • CIE
  • Human insight
Processing

- Manipulates data to produce information
- Methods
  - Reports
  - Transformation
  - Incident – Patient – Provider – Procedure – Location
- Aggregation
- Classification

Analytics

- Extract insights, knowledge, or intelligence from information
- Methods
  - Rule-based query
  - Statistics
  - Machine Learning
  - Deep Learning
  - Artificial intelligence
  - Neural Networks
  - Predictive analytics
- Data Mining
  - Uses all methods above
  - Classification
  - Clustering
  - Association
  - Regression
Dissemination

Ethics

- Privacy
- Need-to-know vs stalking
- Bias
- Data Equity
- Safety Threat redefined
- Verbal aggression
- Aggression toward property
- Aggression toward people
- Drug seeking
- Others
Our quest as integrated providers

- Help our patients achieve their best possible health
- It will require innovation to help us
- Grasp their complex stories
- Collaborate with other systems of care
- Find solutions for our patients

References

- ajensen@sandiage.gov
- Photos used with permission from The San Diego Union-Tribune. Copyright 2015 The San Diego Union-Tribune, LLC. All rights reserved.
- Citation and Recommended Text:
How Do We Integrate

- Goals
  - Establish bi-directional data exchange
  - Improve the accuracy of data
  - Decrease redundancies and improve efficiency
  - Partnership for patient care
- Challenges
  - Perceived to have low return / value
  - One-to-many or many-to-many relationships
  - Integration solution variety
  - Cybersecurity

Value

<table>
<thead>
<tr>
<th>Hospital</th>
<th>EMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct integration to registries</td>
<td>• Patient lookup</td>
</tr>
<tr>
<td>• Pre-admit – decrease door-treatment times if registration is a barrier</td>
<td>• Outcome data</td>
</tr>
<tr>
<td>• Healthcare Information and Management Systems Society (HIMSS) stage 7 certification</td>
<td>• Improved demographic info</td>
</tr>
</tbody>
</table>

Getting Connected

- What we want
Real World Complexity

Integration Solutions

• HIE
• Integration engine
• Direct integration
• NEMSIS and HL7
  • Clinical Data Architecture (CDA)
  • Continuity of Care Document (CCD)
  • Admit, Discharge, and Transfer message (ADT)
• Phased approach

Integration Analysis

• Establish the integration goals
• Assess information security
  • Internal and external
• Establish the use case or model
• Define the dataset
• Define and understand the dataflow
• Design system for integration
• Implement, test, improve
Cybersecurity in EMS vs Other Healthcare

- EMS trusts partners
- Hospitals and payors verify the trust

Cybersecurity and Integration

- Reactive agencies pay 4.1 times more than proactive agencies for an incident
- Compliance is not enough
  - Prepare for partner’s due diligence process
  - Create a cybersecurity due diligence process
  - Cybersecurity is basically a quality improvement process

What’s at Risk?

- Medical identity theft
- Mother in New York vs CPS
- Adverse outcomes from inaccurate meds, history, and allergies
- On average costs patients $13,000
- Identity theft
- Money
Third Party Risk

- 63% of breaches in 2016 attributed to third party according to Soha Systems survey
- Anatomy of a common breach
  - Compromise a weak link
  - Use the weak link to gain access
  - Search for the goldmine
  - Extract the gold

HHS Breach Data

Summary

- Integrations provide enhancements and improvements
- Hurdles can include perceived value, cybersecurity, number of integration points, complexity
- Integration solutions help resolve challenges
- EMS will need to step up cybersecurity to match partner efforts
Questions?

Speak up!
or
Text to: 817-991-4487

The Evidence…
The Evidence

“Do you see, then, that the important prediction is not the automobile, but the parking problem; not radio, but the soap-opera; not the income tax but the expense account; not the Bomb but the nuclear stalemate? Not the action, in short, but the reaction?”

Isaac Asimov

The Phoenician Tablets

Apple

Android
The Rosetta Stone

Found in 1799. Thought to be written in 196 BC.
The key to deciphering.

Journals

JEMS

EMS World Expo
Overview of how to do studies

Abraham Maslow 1966, "...if the only tool you have is a hammer, to treat everything as if it were a nail."

The Blind Men and the Elephant
This is why we need our version of the Rosetta Stone.

AN ASSESSMENT OF EMS AS AN "ESSENTIAL SERVICE"
A PUBLIC GOODS ANALYSIS OF EMS SYSTEMS
POLICY IMPLICATIONS OF EMS SYSTEMS AS COMMON GOODS

Beyond EMS Data Collection: Envisioning an Information-Oriented Future for Emergency Medical Services

2013

2014

2016
Renewed Emphasis and Clarity

An Information Culture

Information System Development and Improvement

An Information-Driven Future

Do we share the same problem?

I expect we do

Where We've Been: The History and Background of Data in EMS

Chief among the earliest concerns was responding to highway trauma

Followed by:
- early intervention in cardiac arrest
- "Golden Hour,"
- 8-minute response time
- military anti-shock trousers

All were based on limited clinical data and research
EMS Education

“The absence of a national EMS database has been a significant impediment to the structuring of a coherent national EMS education system,” Mears, Ornato, and Dawson wrote in Prehospital Emergency Care.

Epiphany in Pittsburgh, Pa

For years we said there was a problem with the NRP test (paramedic). Many blaming the format of testing.

18 programs - 24% - 6 students or fewer; 70% & 82%

The greater discovery was the issues concerning the EMT level instruction. Resulting in the need to assist more so in that level of programming.

83 EMT centers 51 doing programs - 65%. 76%

If we are casual in what we do, there will be casualties …
Patient Outcomes
EMS leaders argued that data could help providers improve patient outcomes by measuring the impact of EMS intervention on “something other than death.”

1991 American Heart Association report Recommended Guidelines for Uniform Reporting of Data from Out-of-Hospital Cardiac Arrest: The Utstein Style

EMS Research
Academics agreed with clinicians and government officials that data are essential to EMS improvement

“EMS professionals of all levels should hold themselves to higher standards of requiring evidence before implementing new procedures, devices, or drugs.”

“There should be standardized data collection methods at local, regional, State, and national levels.” 2001

“Having access to a national EMS database could facilitate research efforts considerably, providing a large sample of standardized data from which to draw. Such a database would be invaluable in the generation of research hypotheses, evaluation of cost-effectiveness, and standardization of data used by researchers.” 2002

EMARN Emergency Medical Services Agency Research Network

Reimbursement
As the concept of pay-for-performance took shape in healthcare, EMS leaders believed that data also had the potential to play a significant role in EMS reimbursement decisions, including the national Medicare ambulance fee schedule that was being developed in the late 1990s.
Be sure to go to EMS.GOV
Find the various documents
Become more informed

What do Baby Boomers want from you:
- Evidence Based Medicine
- Best Practice
- Outcomes
- Metrics
- Evaluation

"If A is a success in life, then A equals x plus y plus z. Work is x; y is play; and z is keeping your mouth shut." - Albert Einstein

Dying is not a technical glitch of the human operating system; it's a feature.

Belinda Luscombe

At its core, health care is a profoundly human endeavor – one person and one family at a time.

EMS cannot and must not lose its fundamental compassion and humanity, even as pressure mounts as the industry radically transforms.
Evaluation of California’s Community Paramedicine Pilot Program

Dr. Janet Coffman, MPP, PhD
Cynthia Wides, MA (presenter)
Matthew Niedzwiecki, PhD
Igor Geyn

April 24, 2017

Outline

• Overview of project and evaluation
• Findings
  • Safety
  • Effectiveness
  • Cost and savings
• Conclusion
Overview of Project and Evaluation

Community Paramedicine Concepts

In June, 2015, 10 EMS agencies in California began testing 6 concepts in Community Paramedicine under the Health Workforce Pilot Projects program:

- Post-hospital discharge 30 day follow-up
- Frequent EMS user
- Directly Observed Therapy for Tuberculosis
- Home hospice support
- Alternate destination - mental health crisis center
- Alternate destination – medical care

Evaluation

- Data reported by pilot sites on:
  - Numbers of patients enrolled and their characteristics
  - Provision of CP services/patient outcomes
  - Cost of providing CP services and ambulance transports
  - Existing sources of data on cost of ED visits and hospital admissions and historical readmission rates
  - Interviews and conference calls with EMS project manager, pilot project leaders, CPs, and partners to provide context for quantitative data
Findings – Patient Enrollment

Cumulative Patients Enrolled by Concept Through September 2016

<table>
<thead>
<tr>
<th>Concept</th>
<th># enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Discharge 30 day Follow-Up</td>
<td>922</td>
</tr>
<tr>
<td>Frequent EMS Users</td>
<td>77</td>
</tr>
<tr>
<td>Directly Observed Therapy for Tuberculosis</td>
<td>29</td>
</tr>
<tr>
<td>Hospice</td>
<td>226</td>
</tr>
<tr>
<td>Alternate Destination – Mental Health</td>
<td>169</td>
</tr>
<tr>
<td>Alternate Destination – Medical Care</td>
<td>39</td>
</tr>
<tr>
<td>All Projects</td>
<td>1,462</td>
</tr>
</tbody>
</table>

Enrolled Patients’ Payer Types – Through September 2016

- Medicare: 43%
- Medi-Cal: 15%
- Uninsured: 14%
- Private Insurance: 28%
Findings - Safety

No Adverse Outcomes

- No enrolled patients enrolled experienced adverse health outcomes
- Improved patient safety:
  - Medication reconciliation and home safety inspections
  - Referrals to housing, social services, and behavioral health care
  - Improved patients’ well-being
  - In the alternate destination – mental health project, having paramedics transport directly to mental health crisis center enabled law enforcement officers to focus on law enforcement duties
- Rerouting and secondary transports due to non-life threatening condition – 9 pts in Alt. Dest.-Behavior & 11 pts in Alt. Dest.-Medical

Effectiveness

...
Post-Discharge Reduced Inpatient Readmissions

Post-discharge projects achieved statistically significant reductions in 30-day readmission rates.

- 4 (of 5) projects reduced readmissions for heart failure. The exception is due to less intensive services in HF intervention.
- 3 (of 3) reduced readmissions for acute myocardial infarction (i.e., heart attack)
- 2 (of 2) reduced readmissions for chronic obstructive pulmonary disease
- 1 (of 1) reduced readmissions for pneumonia

Evidence of Efficacy in Other Projects

Projects reduced ambulance transports and ED visits for:

- Frequent EMS users (focus on high volume callers)
- Hospice patients (pre-pilot 80%/post-pilot 36%)
- Persons with mental health needs (pre-pilot 100%/post-pilot 5%)
- TB project increased medication adherence (6% missed DOTs by CHWs/0.1% missed DOTs by CPs)

Cost and Savings
Cost

• Monthly expenses were highly variable by:
  • program type,
  • provider type (public vs. private), and
  • full-time vs part-time use of CPs.

Savings

• Reductions in ambulance transports, ED visits, and inpatient admissions yielded savings for health plans & hospitals
  • Savings ranged from $188 to $1,754 per patient per month
  • Medicare & Medi-Cal realized savings based on project enrollment
  • Post-discharge projects reduced risk of readmission penalties hospital with Medicare patients
  • Frequent EMS user projects reduced uncompensated care provided by hospitals to uninsured persons

Conclusion
Conclusion

- Specially-trained paramedics can provide services beyond their traditional and current statutory scope of practice in California
- Projects have improved patients’ well-being
- No adverse outcomes for patients
- No other health professionals displaced
- In most cases, yielded savings for health plans and hospitals

Conclusion (cont’d.)

- Post-discharge, frequent EMS user, Tuberculosis, hospice, and alternate destination – mental health projects are safe and effective.
- More data are needed to make conclusions about the alternate destination – medical care projects despite paramedics’ ability to triage patients accurately due to
  - The limited number of patients enrolled
  - The number of patients rerouted or transferred to an ED.

Through its singular focus on health, UCSF is leading revolutions in health.

Thanks are extended to the pilot sites, project participants, the California Health Care Foundation, the California Emergency Medical Services Authority, and the California Office of Statewide Health Planning and Development.
It’s All About the Money $$$
Funding Mobile Integrated Healthcare Pilots and Programs: A Payers Perspective

Stacy Elmer, MA, MPA, EMT
Director, Medical Device Integration and Special Programs
Kaiser Permanente
Why Mobile Integrated Healthcare?

- Growing aging population
- Pressure to reduce healthcare costs
- Increase in covered care
- Nursing shortages
- Physician shortages
- Misaligned financial incentives

Cost of Care

Avoided ambulance rides & ED visits
Individual Care
Prevention & most appropriate care received
Population Health
Connecting to primary care & social services

Why Mobile Integrated Healthcare?

Triple Aim Impact

Cost of Care
Reduced ambulance rides & ED visits
Prevention
More appropriate care received
Population Health
Connecting to primary care & social services

Why Systems Matter
Value in Non-Integrated Systems

1. Decreases overcrowding
2. Revenue loss

Value in Integrated Systems

1. Increases opportunities for improved patient care
2. Creates cost savings to the system
3. Diminishes overcrowding in EDs & urgent care

Kaiser and Mobile Integrated Healthcare

1. Alternative Destination Transport
2. Treat & Release/Refer
3. Pre-scheduled visits
Kaiser and Mobile Integrated Healthcare

Kaiser Based EMS Models
- Post-discharge follow-up
- Management of chronic conditions
- Mental & behavioral health

The First Value Proposition

- Kaiser + other payers
- Kaiser only

The Second Value Proposition

Know the problem you are trying to solve
The Second Value Proposition

High utilizers of 911

ED high utilizers

ED high cost utilizers

Outside medical expenses

Data as We Typically Know It

Excel...YAY!

KP MIH Pilot Process

Visualized the data

Field hospital leadership meeting

Leadership formed ED High Utilizer Workgroup

Pulled Pan City ED data

Chart review super high utilizers
1. ED High Utilizers Workgroup – Meeting 1
   - Identified the problem
   - Socialized the data analysis process – introduced Tableau

2. ED High Utilizers Workgroup – Meeting 2
   - Reviewed data analysis
   - Narrowed down subgroups to target

3. Chart Review Party!!!!

4. ED High Utilizers Workgroup – Meeting 3
   - Review chart review outcomes
   - Finalize subgroups to target
   - Map current KP assets and interventions available to address subgroups
   - Identify gaps in the continuum for these members

5. Utilize video ethnography capability to talk with members in the identified subgroups about their ED utilization.

6. ED High Utilizers Workgroup – Meeting 4
   - Review video ethnography
   - Empathy map members in targeted subgroups
   - Identify quality improvement needs in existing assets
   - Develop options for solutions to address gaps

7. Validate proposed solutions with members

8. Convene ED High Utilizers Workgroup – Meeting 5
   - Review member input
   - Design plan for operationalizing solutions

9. Present proposal to hospital
10. Present proposal to regional leadership
11. Implement pilot program
Data as We Typically Know It

We started with all ED encounters that occurred at the Panorama City Medical Center from July 2014 – June 2015 (one calendar year).
62,152 encounters
Kept only the ED encounters attributable to patients who live in the Panorama City Service Area.
Before 62,152 encounters
After 51,348 encounters

Understanding ED High Utilizers

Kept only the ED encounters attributable to patients who live in the San Fernando Valley subregion of the Panorama City Service Area.
Before 51,348 encounters
After 45,613 encounters
Kept only the ED encounters attributable to patients who live in the San Fernando Valley subregion of the Panorama City Service Area who are age 18 or older.

Before 45,613 encounters
After 35,987 encounters

Kept only the ED encounters attributable to patients who live in the San Fernando Valley subregion of the Panorama City Service Area who are age 18 or older and are KP members.

Before 35,987 encounters
After 26,102 encounters

Kept only the ED encounters attributable to patients who live in the San Fernando Valley subregion of the Panorama City Service Area who are age 18 or older, are KP members, and were either discharged to home or otherwise left without being admitted.

Before 26,102 encounters
After 20,501 encounters
Among these 20,501 encounters, these are the top discharge diagnosis categories, stratified by whether or not the individual arrived in an ambulance.

Among these 20,501 encounters, these are the top discharge diagnosis categories, stratified by whether or not the encounter is from a "high utilizer".

Among the target subset (San Fernando Valley, Panorama City Members, Age 18+)

<table>
<thead>
<tr>
<th>Utilizer Category</th>
<th>Unique Patients</th>
<th>Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-time utilizers</td>
<td>9,759</td>
<td>9,759</td>
</tr>
<tr>
<td>Low Utilizers (2-5 times)</td>
<td>4,355</td>
<td>8,524</td>
</tr>
<tr>
<td>Moderate-to-High Utilizers (6-21 times)</td>
<td>382</td>
<td>2,993</td>
</tr>
<tr>
<td>Super High Utilizers (22+ times)</td>
<td>10</td>
<td>225</td>
</tr>
</tbody>
</table>

Understanding ED High Utilizers
Dead ends: older patients would have longer ED stays since they were more complex, but that didn’t turn out to be a huge effect. Younger adult patients had much shorter lengths of stays. What conclusion to draw of this? It was uncertain.

Nice to know: we looked at race/ethnicity of ED utilisers by age, and noted that it reflects the changing demographic of Panorama City’s membership – younger patients are more likely to be Hispanic, older patients are more likely to be White.

Cost Analysis – Predicted High Utilizers

8.9% of ED encounters were due to Predicted High Utilizers.

1 out of every 20 of this subgroup is predicted to be a member who might spend close to $60,200 per year (compared to the average member yearly cost of $5,300).
Closing Thought

THANK YOU!

If a dog wore pants would he wear them like this or like this?

Stacy.Elmer@kp.org

Attention Please!

- $10,372 per capita health expenditures (2016)!!
  - 18.1% GDP
- Due in large part to \textit{quantity-based} payments
131 Million ED Visits (2011)

- In 2011, there were about 4.2 ED visits for every 1,000 individuals in the population.
- More than five times as many individuals who visited an ED were discharged as were admitted to the same hospital.

ED Expenditure Analysis

- % of ED Patients Admitted: 17%
- Overall ED Admission Rate (%): 18.5
- % of EMS Patients Who Are Admitted: 39%

Patient Arrivals: 22,270,000
Average Expenditure: $969
Total: $22,035,940,000

Alternative Destinations: 15%
ED Patients Referred: 2,037,705
Average Expenditure: $969
Potential ED Savings: $1,974,536,145

ED Visits (2011): 131,000,000
Average Expenditure: $969
Total: $126,438,000,000

References:
EMS Economics 1.0

- You call
- We haul
- That's all

EMS Economics 1.0

- Misaligned Incentives
  - Only paid to transport
  - "EMS" is a transportation benefit
  - NOT a medical benefit
EMS Economics 2.0

- Movement toward alternate payment models
  - Mobile Integrated Healthcare
  - Enrollment fees
  - Patient contact fees
  - Limited capitation

EMS Economics 3.0

- $ for response vs. transport
- Population based payments
  - PM/PM
- Shared savings models
  - Downstream savings for patient navigation
Poll: What is your _____ cost....
- Ambulance
  - Annual
  - Unit Hour
  - Response
- Engine
  - Annual
  - Unit Hour
  - Response

Cost of Service - EMS
- If you were to STOP providing EMS, what costs would you eliminate?
  - Personnel
  - Ambulances
    - w/equipment
  - Ambulance supervision
  - EMT/Paramedic stipends
  - EMS Training costs
  - 1st Response costs
    - Fuel, medical supplies, wear and tear

Revenue Analysis
- Poll –
  - What is your average patient charge?
  - What is your amount collected per transport?
  - What is your collection rate?
  - Who is your largest payer
    - Billed?
    - Collected?
<table>
<thead>
<tr>
<th>Service/Item</th>
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</tr>
</thead>
<tbody>
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<td>1.1</td>
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</tr>
<tr>
<td>Fully Allocated Hourly Expense (1)</td>
<td>$170.93</td>
<td>$170.93</td>
<td></td>
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<tr>
<td>Trip Expense</td>
<td>$27,932</td>
<td>$55,865</td>
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<tr>
<td>Admin Monthly Expense (2)</td>
<td>$8,880</td>
<td>$17,760</td>
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<tr>
<td>2nd Total Monthly Expense</td>
<td>$36,642</td>
<td>$73,685</td>
<td></td>
</tr>
<tr>
<td>Risk Adjustment %</td>
<td>15.0%</td>
<td>15.0%</td>
<td></td>
</tr>
<tr>
<td>MIH Factor</td>
<td>15%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>MIH $</td>
<td>$5,466</td>
<td>$10,933</td>
<td></td>
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<tr>
<td>Total Expense</td>
<td>$42,178</td>
<td>$94,750</td>
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</tr>
<tr>
<td>Per Patient/Per Month</td>
<td>$47,375</td>
<td>$94,750</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
(1) Includes pay/pay related, vehicle, equipment, supplies, IT, etc.
(2) Includes patient record entry, CAD entry, reconciliation, billing
Takeaway…

• Our external environment is changing
• WE have to prepare
• Know your cost of delivery
• Know your VALUE
• Try new models

Speak up!

or

Text to: 817-991-4487
The Importance of Credentialing

John R. Clark, JD, MBA, NRP, FP-C, CCP-C, CMTE
Chief Operating Officer
International Board of Specialty Certification (USA)
WHY SPECIALTY CERTIFICATION?

▸ SPECIALTY CERTIFICATION allows PATIENTS to confidently place their TRUST in their healthcare providers.
▸ Demonstrates a MASTERY LEVEL OF PARAMEDIC PRACTICE coupled with entry-level competency over the knowledge, skills and abilities contained within a SPECIALIZED AREA OF PRACTICE.
▸ Exhibits a PROFESSIONAL commitment to the PUBLIC, EMPLOYERS and PEERS.

WHAT IS SPECIALTY CERTIFICATION

▸ The process of validating KNOWLEDGE and SKILLS of a provider.
▸ Follows a STANDARDIZED PROCESS involving data collection, primary source verification and committee review.
▸ Assurance of a professional’s MERIT and EXPERIENCE.
▸ EXAMINATIONS are not meant to test entry-level knowledge, but rather to VALIDATE the EXPERIENCED PARAMEDICS’ skills and knowledge.

MAJOR CREDENTIALING PHASES

▸ Qualification
▸ Application
▸ Examination eligibility
▸ Examination
▸ Certification
PRACTICE ANALYSIS

▸ SURVEY practicing professionals regarding the COMPONENTS of their PRACTICE.

▸ CONTENT VALIDATION studies are conducted for each exam EVERY 3–5 YEARS.

DETAILED CONTENT OUTLINE or BLUEPRINT

▸ Based on the results of these studies, examination BLUEPRINTS are created that capture the PRACTICE AREAS that make up the specialty.

▸ QUESTIONS are written for the examinations to MATCH the blueprint.

▸ This process insures that the exams reflect the STATE OF PRACTICE.

GUIDELINES

▸ There is NOT a prescribed education program tied to any examination.

▸ Examinations measure a UNIQUE DOMAIN BEYOND ENTRY-LEVEL CERTIFICATION or licensure.
MITIGATING THE LEGAL RISK

▸ The LEGAL RISK to the employer and the medical director INCREASES EXPONENTIALLY without validation of clinical competency.

▸ The exam development processes and the exam evaluation procedures are PSYCHOMETRICALLY SOUND and LEGALLY DEFENSIBLE

▸ This INSURES that the examinations are a TRUE and ACCURATE measure of knowledge, skills and abilities.

HISTORICAL STATE

The US EMS system started with regional schemes and moved towards a national model.

▸ TECHNICIANS functioning under a physician license.

▸ In the shadow of NURSING.

▸ FRAGMENTED regulatory schemes from state to state.

▸ Multiple designations and ALPHABET SOUP.

VERSION 3.0

Standardization of EMS nomenclature.

The creation of the US COLLEGE OF PARAMEDICS as the independent professional body for EMS providers in the United States.

▸ Must be an INDEPENDENT professional body and comes FROM THE COMMUNITY.

▸ For SPECIALIZED AREAS OF PRACTICE, candidates need more than certificate education.
VERSION 3.0 – SELF GOVERNANCE

As an occupational group evolves over time and comes to develop a specialized body of knowledge; members of the group become experts. Due to this knowledge being so specialized, the Government is presented with the difficult and expensive task of determining and monitoring standards of practice for the profession in question. The thought is therefore that, members of a profession are in the best position to set standards and to evaluate whether they have been met.


The best PARAMEDICS in the world are board certified.

jclark@bcctpc.org
@clarkjrc

The Education – Education Systems, Certification & Credentialing, Continuing Education

Dr. Walt Alan Stray
Professor – Emergency Medicine
University of Pittsburgh
Director of the Office of Education
Center for Emergency Medicine

The University of Pittsburgh
School of Health and Rehabilitation Sciences
The Education – Education Systems, Certification & Credentialing, Continuing Education

Dr. Walt Alan Stray
Professor – Emergency Medicine
University of Pittsburgh
Director of the Office of Education
Center for Emergency Medicine

The EMS Transformation Summit – Attributes of EMS 3.0
Monday, April 24, 2017
“In times of rapid change, experience could be your worst enemy.”

J. Paul Getty

The Greatest Threat To Future Success… Is Prior Success

Jeffrey Romoff

Major Marketplace Changes Underway

Health Care Spending On Unsustainable Path

Science Will Radically Transform Patient Care

Consumerization of Health Care

Health Care Spending On Unsustainable Path

Approaching 20% of U. S. economy

Government/subsidized care (Medicare, Medicaid, Health Exchange) majority of provider revenue

Growth in high deductible plans – shifting cost

Industry consolidation
Factors Affecting EMS Education

Continued escalation of cost of the education in the EMS domain is a concern. Cost of products, services and personnel required to provide instruction pushes up cost that must be transferred to the student.

Factors Affecting EMS Education

Trying to keep up with the others…
Simulation Center
Accreditation Cost

Science Will Radically Transform Patient Care

Unlocking insights:
Aging
Immunology
Genetics

We are living longer, but for some, not necessarily healthier lives.
**Consumerization of Health Care**

Consumers make choices based upon price, service and convenience

Need to ensure connectedness with “stickiness”

Affordable Care Act – 20+ million newly insured

---

**We Need to Stop Talking and Thinking ONLY in the EMS Domain**

Retailers Thought Their Competition Was Other Retail Entities – They Were Wrong

---

**Deconstructing the Present to Create the Future of EMS Education**

If We Are NOT Initiating and Embracing Innovative Disruption, We Will Be Its Victim

We Must Deconstruct and Reconstruct To Create The Future
Always Seeking Breakthroughs and Innovation

Emergency Medical Service Education Trust (EMSET)

Consortium of Academic Program in Emergency Medical Services (CAPEMS)

Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions

CoAEMSP

Commission on Accreditation of Allied Health Education Programs

CoAEMSP is here – not the future of MIH/CP
Curricula Alteration

EM 1250 – Introduction to Community Health
2 credits

EM 1251 – Mobile Integrated Health Care
2 credits
Nursing Alternative
Students positioned to take 24 of their senior credits in Nursing or other areas

One year or three terms to complete
Accelerated BSN

Can move from this to Doctorate of Nurse Practitioner Program

Community Engagement Center (CEC)
EMT Students
Paramedic Students
Senior EM Students

A school-wide effort
Alumni and others
Moving Health Care to the Under Served

Operation Safety Net
Decades of effort by Dr. Jim Withers
David Gloss EM Graduate of 2015
Internships with our senior students

Protocols
Medication List
Nation Curricula
Conference
As of January 20, 2017, the Republican Party Has:

1) The Presidency.
2) A majority of the House of Representatives.
3) A majority of the Senate.
4) Almost two-thirds of all governorships.
5) Total control of the statehouses in almost two-thirds of all the states.

And, as of April 7, Republicans added:
6) A majority of the Supreme Court (5-4)

The above has never happened before in American history.
A Historic Victory

Trump won 306 electoral votes, the most for a Republican since George H.W. Bush in 1988

Trump won over 2,600 counties nationwide, the most since Reagan in 1984

Trump won over 62 million votes in the popular vote, the highest all-time for a Republican nominee

Trump won over 200 counties nationwide that Obama won in 2012

A Changing Portrait of Red and Blue

Hillary Clinton drew heavy support from urban areas and some Hispanic parts of the country, but was overpowered by Donald Trump's stronger showing in small and rural communities. She was also hurt by declining vote totals among African Americans.

Republicans Maintain Majority of U.S. House

Democrats 194 (+6)  Republicans 241 (-4)
Republicans Win Big at the State Level

Republicans now control 69 of 99 state legislative chambers and the governor’s mansion in 33 states.

25 states have both a Republican governor and Republican state legislature
20 states have some form of Republican control (either one or both chambers, or governor)

Source: The Washington Post

America is Seeing Red

State & Federal Breakdown of Legislators and Executives by Party

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2017</th>
<th>Dem Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>State House</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Republicans</td>
<td>2,334</td>
<td>3,062</td>
<td>-735</td>
</tr>
<tr>
<td>Democrats</td>
<td>3,058</td>
<td>2,323</td>
<td>-218</td>
</tr>
<tr>
<td>State Senate</td>
<td></td>
<td></td>
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<tr>
<td>Republicans</td>
<td>889</td>
<td>1,151</td>
<td>-218</td>
</tr>
<tr>
<td>Democrats</td>
<td>1,024</td>
<td>806</td>
<td>-218</td>
</tr>
<tr>
<td>Governors</td>
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<td></td>
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</tr>
<tr>
<td>Republicans</td>
<td>22</td>
<td>33</td>
<td>-11</td>
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<tr>
<td>Democrats</td>
<td>28</td>
<td>16</td>
<td>-12</td>
</tr>
<tr>
<td>Attorneys General</td>
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<td></td>
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</tr>
<tr>
<td>Republicans</td>
<td>18</td>
<td>20</td>
<td>-12</td>
</tr>
<tr>
<td>Democrats</td>
<td>32</td>
<td>17</td>
<td>-15</td>
</tr>
<tr>
<td>U.S. House</td>
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<td></td>
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</tr>
<tr>
<td>Republicans</td>
<td>178</td>
<td>241</td>
<td>-63</td>
</tr>
<tr>
<td>Democrats</td>
<td>257</td>
<td>194</td>
<td>-63</td>
</tr>
<tr>
<td>U.S. Senate</td>
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<td></td>
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</tr>
<tr>
<td>Republicans</td>
<td>41</td>
<td>52</td>
<td>-11</td>
</tr>
<tr>
<td>Democrats</td>
<td>59</td>
<td>48</td>
<td>-11</td>
</tr>
</tbody>
</table>

U.S. Senate Elections 2018

8 Republicans up for re-election

- Chris Murphy (CT)
- Mark Warner (VA)
- Jeff Flake (AZ)
- Ted Cruz (TX)
- Ben Sasse (NE)
- Dean Heller (NV)
- Roger Wicker (MS)
- John Barrasso, MD (WY)

25 Democrats up for re-election (includes 2 Independents)

- Claire McCaskill (MO)
- Heidi Heitkamp (ND)
- Mazie Hirono (HI)
- Joe Manchin (WV)
- Kirsten Gillibrand (NY)
- Sherrod Brown (OH)
- Amy Klobuchar (MN)
- Jon Tester (MT)
- Debbie Stabenow (MI)
- Joe Donnelly (IN)
- Maria Cantwell (WA)
- Bob Casey (PA)
- Sheldon Whitehouse (RI)
- Bill Nelson (FL)
- Dean Heller (NV)
- Roger Wicker (MS)
- John Barrasso, MD (WY)
- Bob Casey (OK)

Dem/GOP Lean

- Trump +19
- Trump +36
- Trump +42
- Clinton +5

Most Likely to Flip

- Trump +19
- Trump +1
- Trump +2
- Clinton +1

Trump’s Current Cabinet

Key White House Officials

Reince Priebus - Chief of Staff
Former head of the Republican National Committee

Stephen Bannon - Chief Strategist and Senior Counselor to the President
Former Executive Chairman of Breitbart News Network

Jared Kushner - Senior White House Adviser
Trump son-in-law; CEO of Kushner Companies and publisher of the New York Observer

Rick Dearborn - Deputy Chief of Staff for Policy
Former top aide to Sen. Jeff Sessions (R-AL) and nominee for Attorney General

Sean Caine - Deputy Assistant to the President and Senior Advisor to the Chief of Staff
Republican National Committee Chair Operating Officer and Deputy Executive Director and General Counsel to the National Republican Senatorial Committee for two cycles (2009-2012)

NAEMT

Serving our nation’s EMS professionals

Key White House Officials

Sallieann Conway - Counselor to the President
Founder and owner of The Poling Company, an informal think tank and research firm; has counseled leading political figures, nonprofits and companies.

Moni Sprint - Assistant to the President and Director of Legislative Affairs
Previously worked as a top operative during the administrative efforts of the Bush brothers; also a longtime advisor to the White House. During the 2016 campaign, worked as an advisor to Sen. Marco Rubio during the primaries, later as a senior advisor for Pence during the general election.

Andrew Brenneman - Director of the White House Domestic Policy Council
Worked at the U.S. Department of Health and Human Services from 2001 to 2009, including serving as Chief of Staff to the Office of Public Health and Science. Nominated as a Policy Adviser and Counselor to the President, and currently serves as Deputy Director. Also served as the Policy Director for the 2008 Republican Party Platform.

Katy Talento - Domestic Policy Council Adviser for Healthcare Policy
Vice President of a federal policy, research and government oversight and investigations and program evaluation, served on the campaign since 2009. Talento spent 6 years in the U.S. Senate, working for two Senators and two committees.

Donald McIvor - Assistant to the President and White House Counsel
Partner at Jones Day in Washington, DC, and has specialized in political law, including government ethics, served as a member of the ERC for two years, during which he served as both chairman and vice chairman.

Trump’s Current Cabinet

Ben Carson - Secretary of Housing
Health care entrepreneur; former neurosurgeon and candidate for the 2016 Republican nomination for President.

Loretta Eitzman - Secretary of Education
Formerly a federal government lawyer and legislative aide to former Rep. Bob Dole.

Ryan Zinke - Secretary of the Interior
Former U.S. Marine Corps officer; served four years in the Reagan administration; one of President Trump’s early supporters.

Nikole Bacewicz - Secretary of the Treasury
Former counsel for the House Financial Services Committee.

William Barr - Attorney General
Former U.S. Attorney General; served in the Reagan administration.

Sonya Kowalkosky Pichler - Secretary of Agriculture
Former Senior Policy Director of the National Corn Association.

Dennis Ross - Special Advisor to the President
Former U.S. Ambassador to Israel; served in the Reagan administration.

Love Morrison - Assistant to the President
Former aide to Sen. Richard Shelby (R-AL).

Marc Short - Deputy Chief of Staff for Operations
Previous Chief of Staff to Sen. Kay Bailey Hutchison (R-TX) and Pence, when he was in the Senate.

Ellen L. Kuehlmann - Acting General Counsel
Former Counselor to the President.

Confidential

96
Trump’s Current Cabinet

- John Kelly – Secretary of Homeland Security
  - Former Marine General, head of the Trump Administration’s anti-terrorism efforts.
  - Recessed confirmation vote.
- Rick Perron – Administrator of the Environmental Protection Agency
  - Former head of the Environmental Protection Agency.
- Donald Trump
  - President of the United States.
- Reince Priebus – White House Chief of Staff
  - Former Chairman of the Republican National Committee.
- Scott Pruitt – Administrator of the Environmental Protection Agency
  - Former head of the Environmental Protection Agency.
- Jezebel West
  - Deputy White House Chief of Staff.
- Betsy DeVos – Secretary of Education
  - Former Charter School Executive.
- Jeff Sessions – Attorney General
  - Former US Senator from Alabama.
- Robert Wilkie – Assistant Secretary for Veterans Affairs
  - Former head of the Veterans Administration.
- Ron Klain – Chief of Staff
  - Former chief of staff to Vice President Joe Biden.
- Mick Mulvaney – Director of the Office of Management and Budget
  - Former Small Business Administrator.
- John Kelly
  - Former Marine General, head of the Trump Administration’s anti-terrorism efforts.
  - Recessed confirmation vote.

Trump’s First 200 Days

- Fill Cabinet
  - Supreme Court Confirmation
  - Repeal/Replace ACA
  - Tax Reform
  - Renegotiate trade deals
  - Immigration reform/Mexico border wall
  - “Drain the Swamp”
  - Infrastructure
  - Government-wide regulatory review

Trump’s 4,100 Presidential Appointees

- Positions range from high-profile advisers and Cabinet posts to ambassadors, small agency directors and special assistants.
- These are all of the politically appointed positions listed in the Office of Personnel Management’s newly released Plum Book. Some may not be filled in this Trump Administration.

<table>
<thead>
<tr>
<th>Position Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presidential appointees who do need Senate confirmation</td>
<td>1,242</td>
</tr>
<tr>
<td>Presidential appointments who do not need Senate confirmation</td>
<td>472</td>
</tr>
<tr>
<td>Non-career Senior Executive Service positions</td>
<td>761</td>
</tr>
<tr>
<td>Schedule E Appointees</td>
<td>1,538</td>
</tr>
</tbody>
</table>

*Note: ACA is the Affordable Care Act.*
Make-Up of the 115th Congress (2017-2018)

While the 115th Congress will include a record number of minority women, Congress will remain overwhelmingly white, male, and middle-aged.

- 60 Freshman members of the House and Senate (includes 1 non-voting member)
- 104 Women who will serve in the 115th Congress.
- 49 The same number as the 114th Congress, and 18.6% of the total number of Senators.
- 49 African Americans who will serve in the 115th Congress, including 46 in the House (+2).
- 38 The record number of Hispanic who will serve in the 115th Congress, including 35 in the House (+3).
- 15 Asian Americans who will serve in Congress, including 12 in the House (+5).
- 3 Former House Democrats who won their old seats back: Colleen Hanabusa (HI), Brad Schneider (IL), and Carol Shea-Porter (NH).

Senate Health Jurisdiction

House Health Jurisdiction

Source: The Hill
Physicians in Congress

<table>
<thead>
<tr>
<th>House of Representatives</th>
<th>Senate (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Thomas Price</td>
<td>Dr. Ron Johnson</td>
</tr>
<tr>
<td>Rep. Mike Pompeo</td>
<td>Sen. John Barrasso</td>
</tr>
<tr>
<td>Rep. Michael Burgess</td>
<td>Sen. Dean Heller</td>
</tr>
</tbody>
</table>

United States Senate

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Tom Price</td>
<td>AZ</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Sen. John Cornyn</td>
<td>TX</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Sen. John Barrasso</td>
<td>WY</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Sen. Ted Cruz</td>
<td>TX</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Sen. John McCain</td>
<td>AZ</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Sen. Marco Rubio</td>
<td>FL</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Sen. Dean Heller</td>
<td>NV</td>
<td>Surgeon</td>
</tr>
</tbody>
</table>

Legislative Vehicles 2017

Department of Health & Human Services (HHS)
Other Key HHS Officials

- Eric Hargen – Deputy Secretary Nominee
  - Previously Acting Deputy Secretary of HHS and Regulatory Policy Officer in the George W. Bush Administration
  - Formerly a shareholder in Greenberg Traurig’s Health & FDA Practice
- Paul Starnes – Senior Advisor to the Secretary
  - Former Deputy General Counsel and Acting General Counsel at HHS
  - Formerly worked for Alston & Bird LLP
- John Brooks – Counselor for Health Policy
  - Former Senior Principal and Department Head, Health Policy and Economics, the MITRE Corporation
- Mary Sampier Loginiski – Counselor for Public Health and Science
  - Served as Health Policy Director on the Senate HELP Committee
- Sarah Atkeson – Principal Deputy Assistant Secretary for Legislation
  - Former Vice President of Business Roundtable
  - Served as Health Policy Director on the Senate HELP Committee
  - Former Legislative Assistant for Senator Mitch McConnell (R-KY)
- Laura Knapper – Deputy Assistant Secretary for Legislation
  - Served as Counsel for Senator John Cornyn (R-TX) and as a Health Policy Advisor to Tom Price during his time in the House
  - Former Associate at Alston & Bird
- Courtney Lawrence – Deputy Assistant Secretary for Legislation
  - Served as Intern Vice President of Federal and External Affairs at America’s Health Insurance Plans (AHIP)
Appointments at HHS

SAMPLE POSITIONS

19 • Presidential Appointees who DO need Senate confirmation

2 • Presidential appointees who do NOT need Senate confirmation

80 • Non-career Senior Executive Service positions

80 • Schedule C appointments

HHS Positions Requiring Senate Confirmation

Position Title
Secretary, Health and Human Services (Confirmed)
Deputy Secretary, Health and Human Services
Assistant Secretary for Financial Resources
Assistant Secretary for Preparedness and Response
General Counsel
Assistant Secretary for Aging and Administration, Administration for Community Living
Assistant Secretary for Planning and Evaluation
Assistant Secretary for Health
Surgeon General
Assistant Secretary for Legislation
Assistant Secretary for Children and Families
Commissioner, Administration for Children, Youth, and Families
Commissioner, Administration for Native Americans
Administrator, Centers for Medicare and Medicaid Services (Confirmed)
Commissioner of Food and Drugs
Director, Indian Health Service
Director, National Institutes of Health
Administrator, Substance Abuse and Mental Health Services
Inspector General

Democratic Leadership is Aging...

Age
70s
Bernie Sanders: 75
Steny Hoyer: 77
Nancy Pelosi: 76
Jim Clyburn: 76
Dick Durbin: 72

60s
Charles Schumer: 66
Patty Murray: 66
Elizabeth Warren: 67

50s
Chris Van Hollen: 58
Tom Perez: 55
Keith Ellison: 53

Next Generation
Chuck Schumer: 56
Patty Murray: 56
Elizabeth Warren: 57
### Republican Leadership

<table>
<thead>
<tr>
<th>Age</th>
<th>70s</th>
<th>60s</th>
<th>50s</th>
<th>40s</th>
<th>30s</th>
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</tr>
</tbody>
</table>

### Key Players for 2020: Democrats

- Hillary Clinton (69)
- New York Governor Andrew Cuomo (59)
- Starbucks CEO Howard Schultz (56)
- U.S. Senator Elizabeth Warren (D-MA) (67)
- U.S. Senator Cory Booker (D-NJ) (47)
- U.S. Senator Kristen Gillibrand (D-NY) (50)
- Former Mayor of NYC Michael Bloomberg (75)
- Cathy McMorris Rodgers (R-WA) (47)
- Ronna Romney McDaniel (R-MI) (43)

Jeffrey J. Kimbell & Associates
601 13th Street NW, Ste 650 North
Washington, DC 20005
(202) 735-2590
www.kimbell-associates.com
JKimbell@kimbell-associates.com
SNAPSHOT OF TODAY

Ambulance Medicare Payment System

CORE COMPONENTS OF OTHER MEDICARE PAYMENT SYSTEMS

PAYMENT REFORM
## PAYMENT REFORM FUTURE

<table>
<thead>
<tr>
<th>Intermediate</th>
<th>Long-term</th>
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<tbody>
<tr>
<td>• ADT</td>
<td>• MIH Services</td>
</tr>
<tr>
<td>• Treat &amp; Refer</td>
<td>• Alignment of clinical &amp; reimbursement</td>
</tr>
<tr>
<td>• Expansion of emergency services</td>
<td></td>
</tr>
<tr>
<td>• Non-emergency</td>
<td></td>
</tr>
</tbody>
</table>

## WRAP UP

1. Short-term (first 100 days of 2017)
   - A. Cost Data Collection System
   - B. Supplier to Provider
   - C. Permanent Extenders

2. 2017 and beyond
   - A. Industry alignment imperative
   - B. Solution-oriented reforms
CONTACT INFORMATION

Asbel Montes
VP of Governmental Relations & Reimbursement
Acadian Ambulance Service
Asbel.Montes@acadian.com

Speak up!
or
Text to: 817-991-4487

2017 EMS 3.0 Transformation Summit
Hosted by NAEMT
April 24, 2017 • Arlington, Virginia
Holiday Inn Residence at Key Bridge

Next Steps...
Action #1
Strengthen competencies in all professional levels to ensure ability effectively provide the services that the community needs.

ListServ Subscriptions & Assistance
- NAEMT
- AIMHI
- NASEMSO
- NEMSMA

Action #2
Embrace continuous quality improvement and strive to adopt "pay for performance/value based purchasing" reimbursement linked to clinical outcomes.

Action #3
Utilize all opportunities to advocate how EMS 3.0 supports the healthcare transformation.
Action #4

Clearly articulate the types of services that EMS 3.0 can offer to improve patient outcomes and lower costs.

Action #5

Integrate all services into a well-coordinated, medically directed and performance-measured EMS 3.0 package of services provided by professionals at basic and advanced levels.

Act NOW...
Speak up!
or
Text to: 817-991-4487
Thank YOU NAEMT Staff!!

Thank You For Joining Us!