The Perfect Storm for EMS

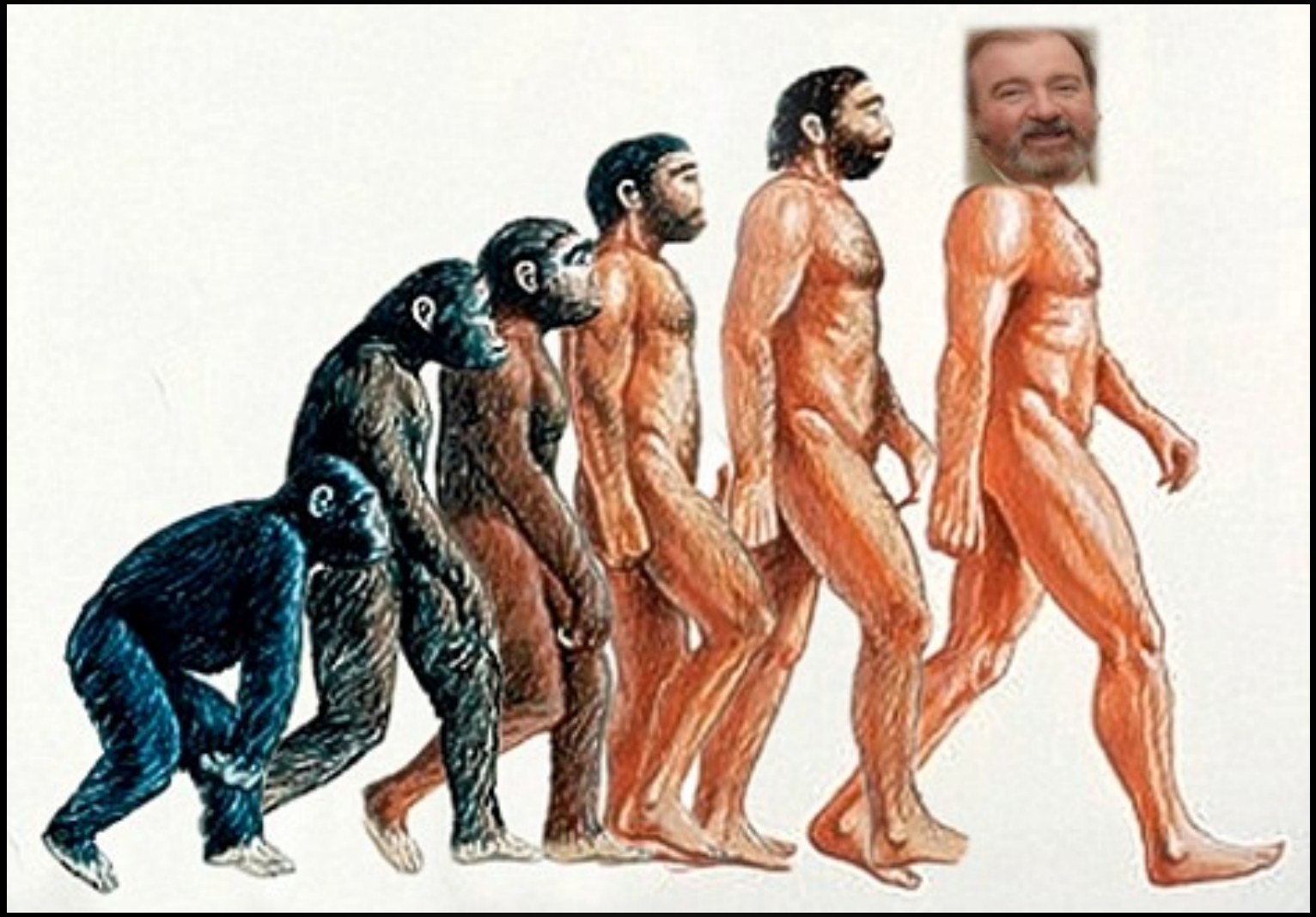
obile Integrated Healthcare Practice

On behalf of the explorer

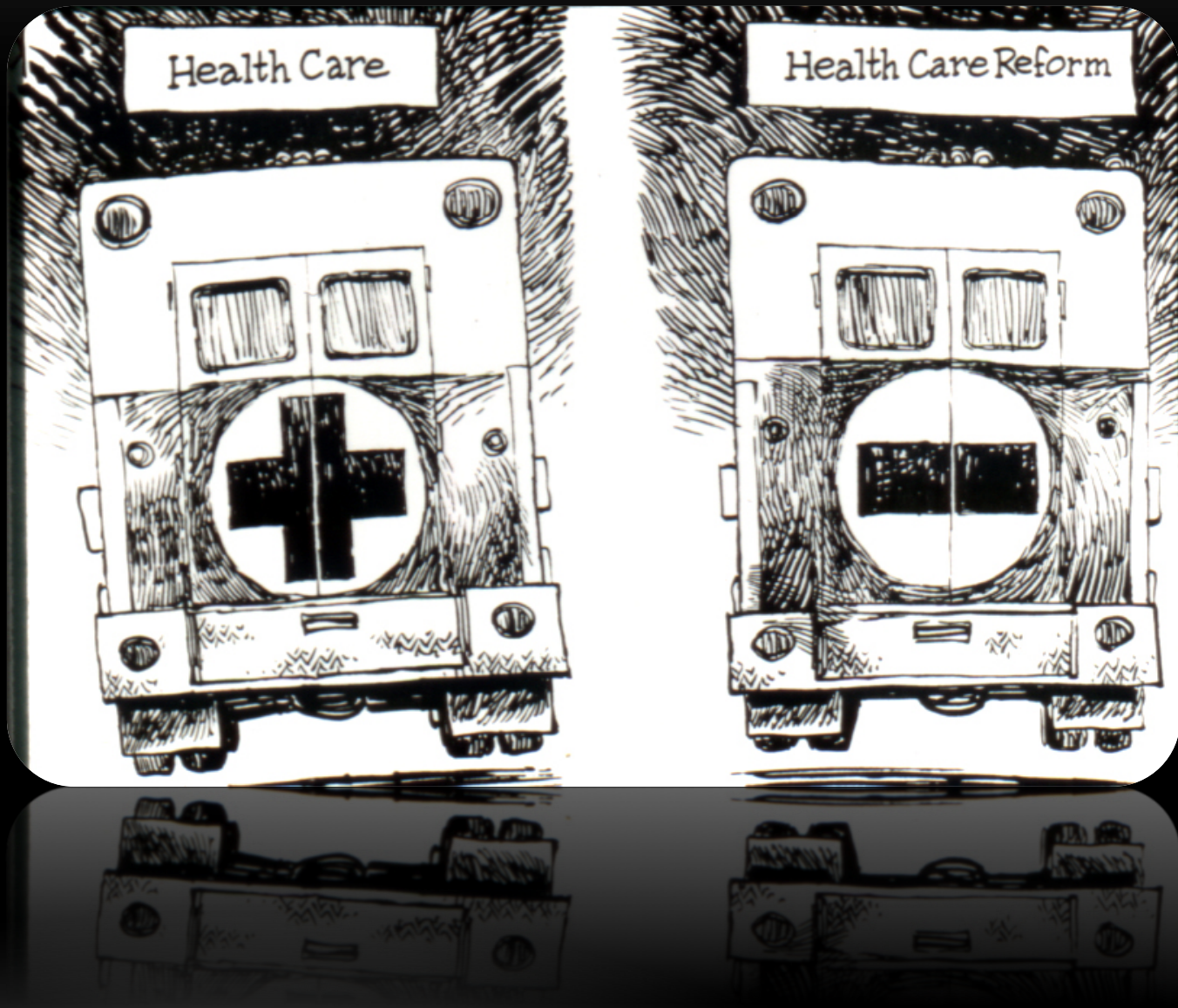
Ed Racht
Eric Beck
Jeff Beeson
Brent Myers

R. RAWLES' AFFECTION FOR MONKEYS...

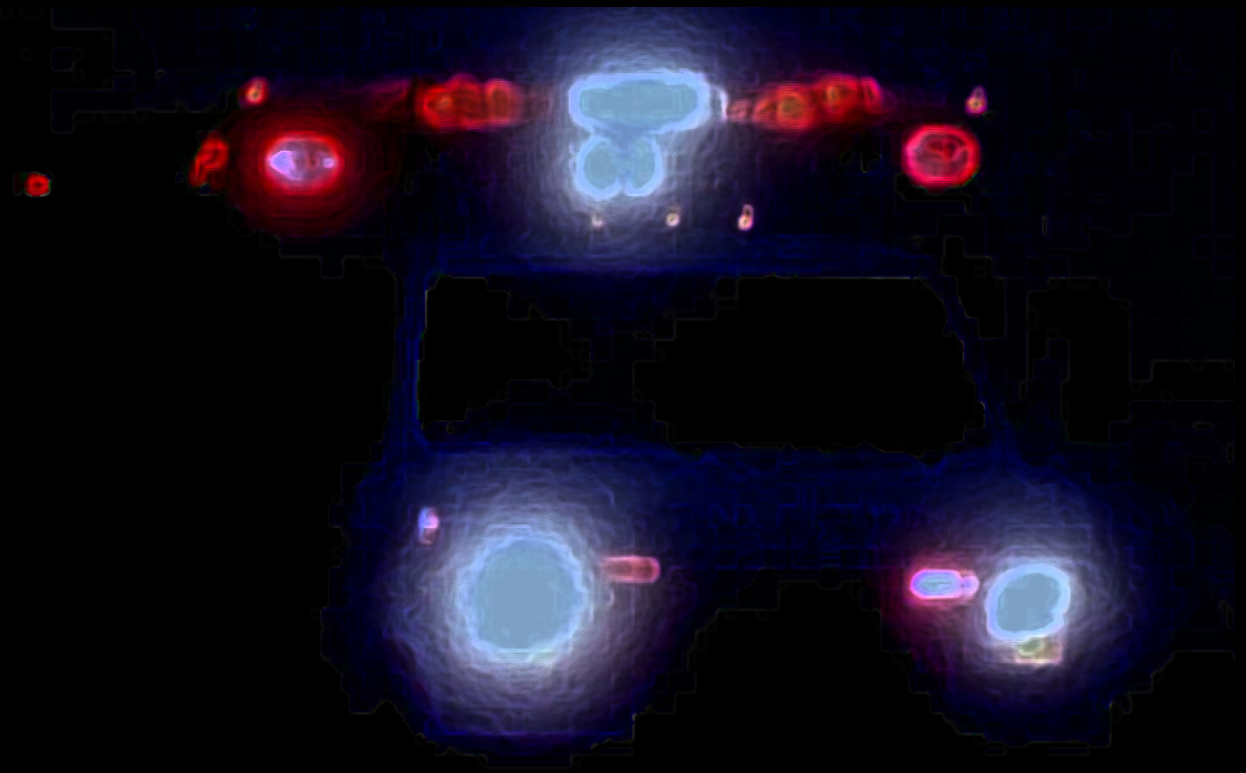
ALL MAKES SENSE NOW…



FINALLY TIME…



E DO EMERGENCIES WELL



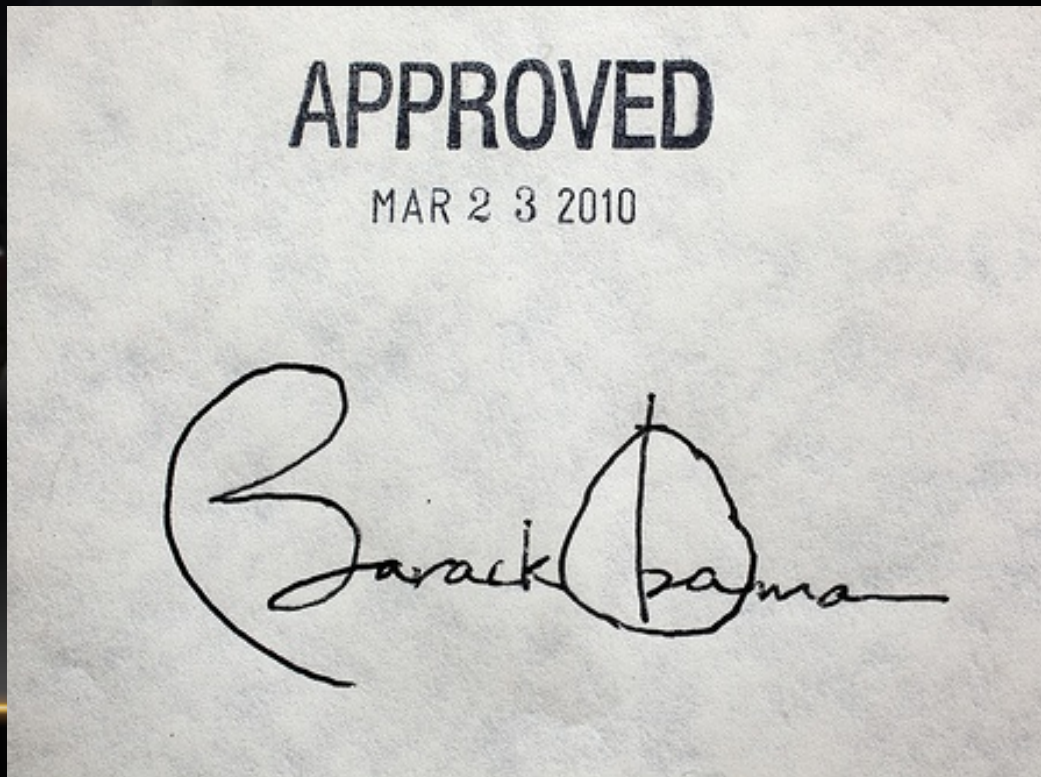
EMS Makes a Difference:

Improved clinical outcomes and downstream healthcare savings

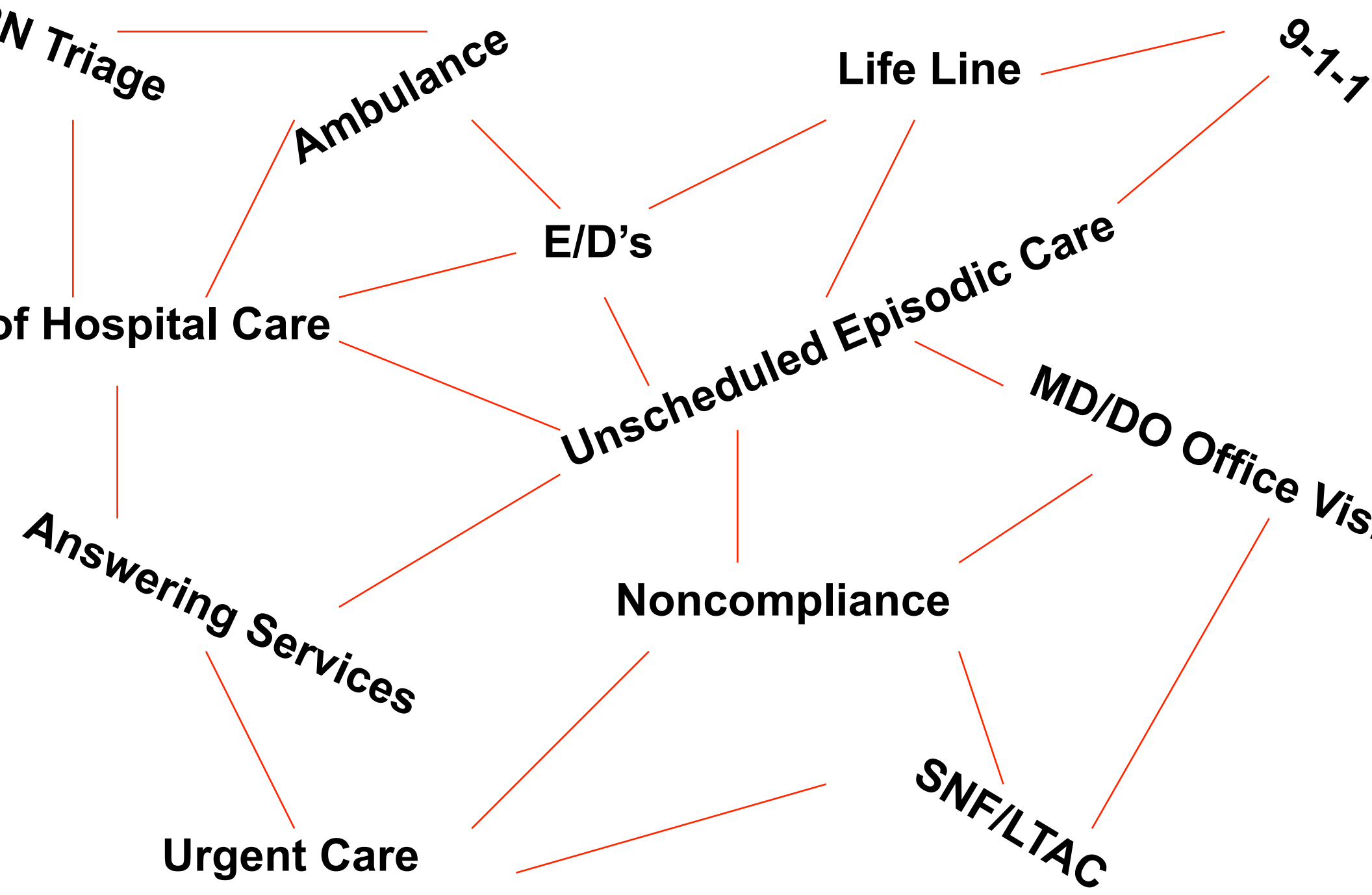
A Position Statement of the
National EMS Advisory Council

December 2009

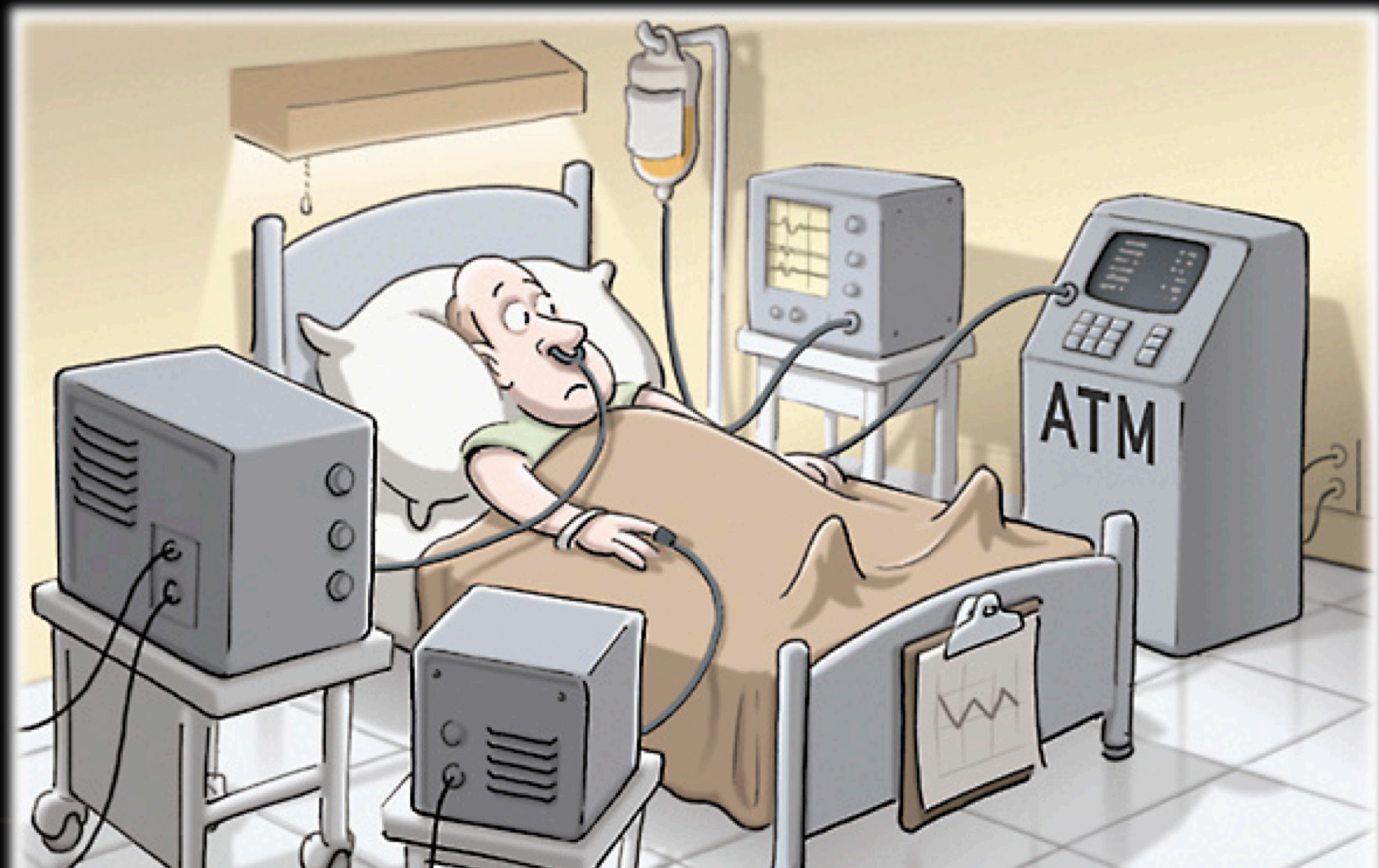
UT THE HEALTHCARE LANDSCAPE HAS CHANGED



urrent State of "Unscheduled Care"



IS REALLY “PAYMENT” REFORM THAT HAS HEALTHCARE
ICATIONS…




SOLEMN CEREMONIES

Tom Brokaw to keynote poignant Pearl Harbor events on Dec. 7. A12

GOBBLE UP

Pumpkin pie, turkey, stuffing, beans... It's Thanksgiving. Need we say more? D1

Dick Tomey Hawaii tie

Good Morning!

Star ★ Bulletin

starbulletin.com

WEDNESDAY, NOVEMBER 15, 2006

Kahuku Hospital closin

The loss leaves the rural community an hour away from any emergency care

SHARK FEEDING FRENZY CAUSES COMMOTION

HMSA weighs another rate hike

The health insurer warns its costs are beginning to rocket

go! ch receiv offens T-shirt

Blocked-heart belief questioned

Hanabusa takes over as Senate president

Isle stores starting up Christmas tree sales

Learn the Financial Secrets of the Wealthy

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... MESA has no aloha

IY “REFORM”?


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MCPHERSON
12-29
“Because you don’t have insurance, all we’re allowed to use to perform your bypass is this stick.”

Tomorrow's alignment? (unscheduled care)

911

E.D.

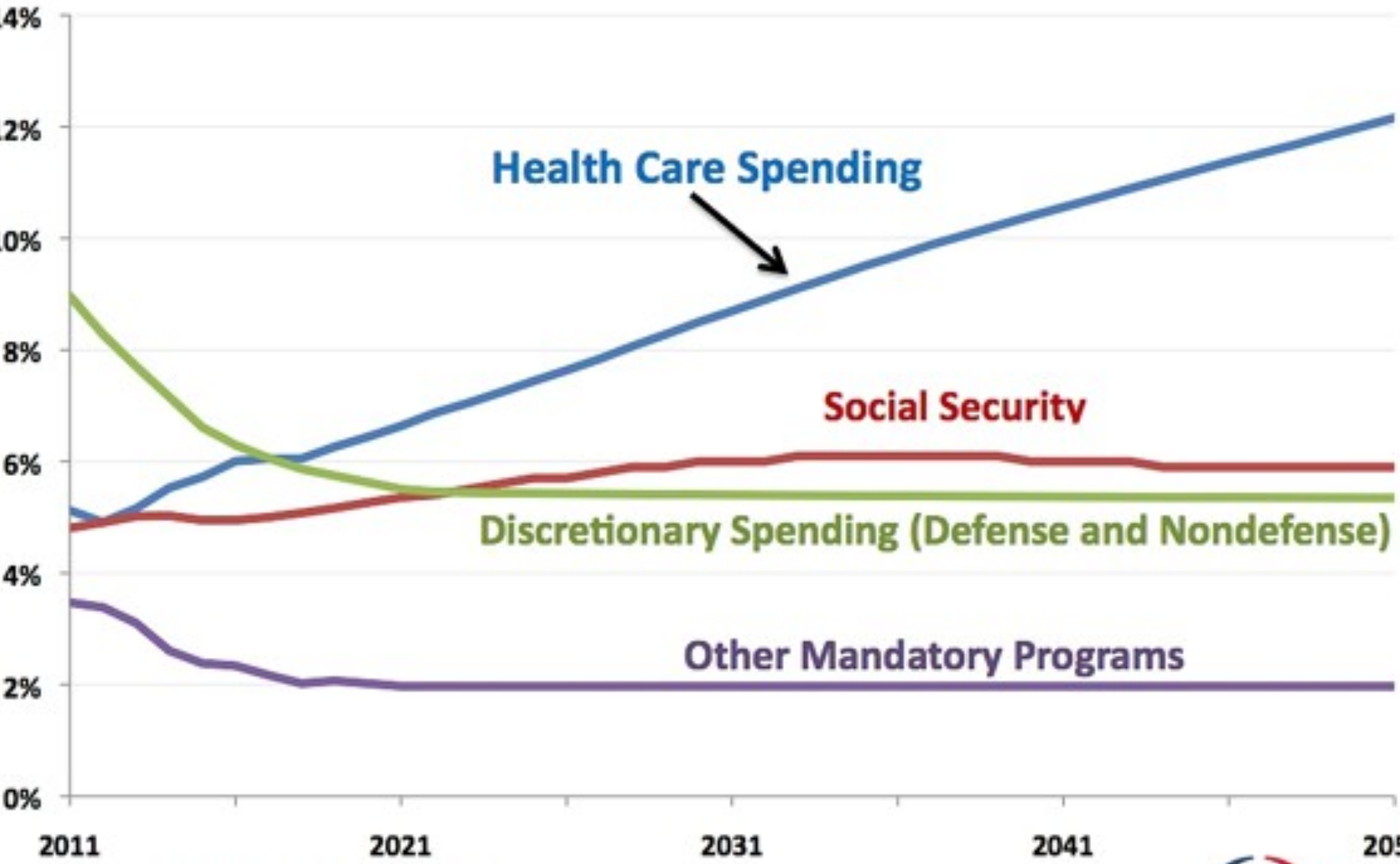
1st response

Hospital

"EMS"

Post Acute Care

HEALTH CARE COSTS ARE THE PRIMARY DRIVER OF THE DEBT



Source: Congressional Budget Office (August 2011)

Governments may be forced to operate like businesses

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

By Melody Petersen
The New York Times

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

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

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

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

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

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

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

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

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

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

The accounting board also is poised to require government managers to answer for themselves, much the way executives of public companies do. Each fiscal year, elected officials would have to give taxpayers "an objective and easily readable analysis" of the government's financial performance. Government officials will have to explain such things as why they sold a large piece of land or issued millions of dollars in bonds. And for the first time, officials must explain why they spent more than was approved in the budget at the start of the year.

HE CHALLENGES

- US health care system most costly in the world
    - Will grow to 20% of GDP ($4.6 trillion) by 2020

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

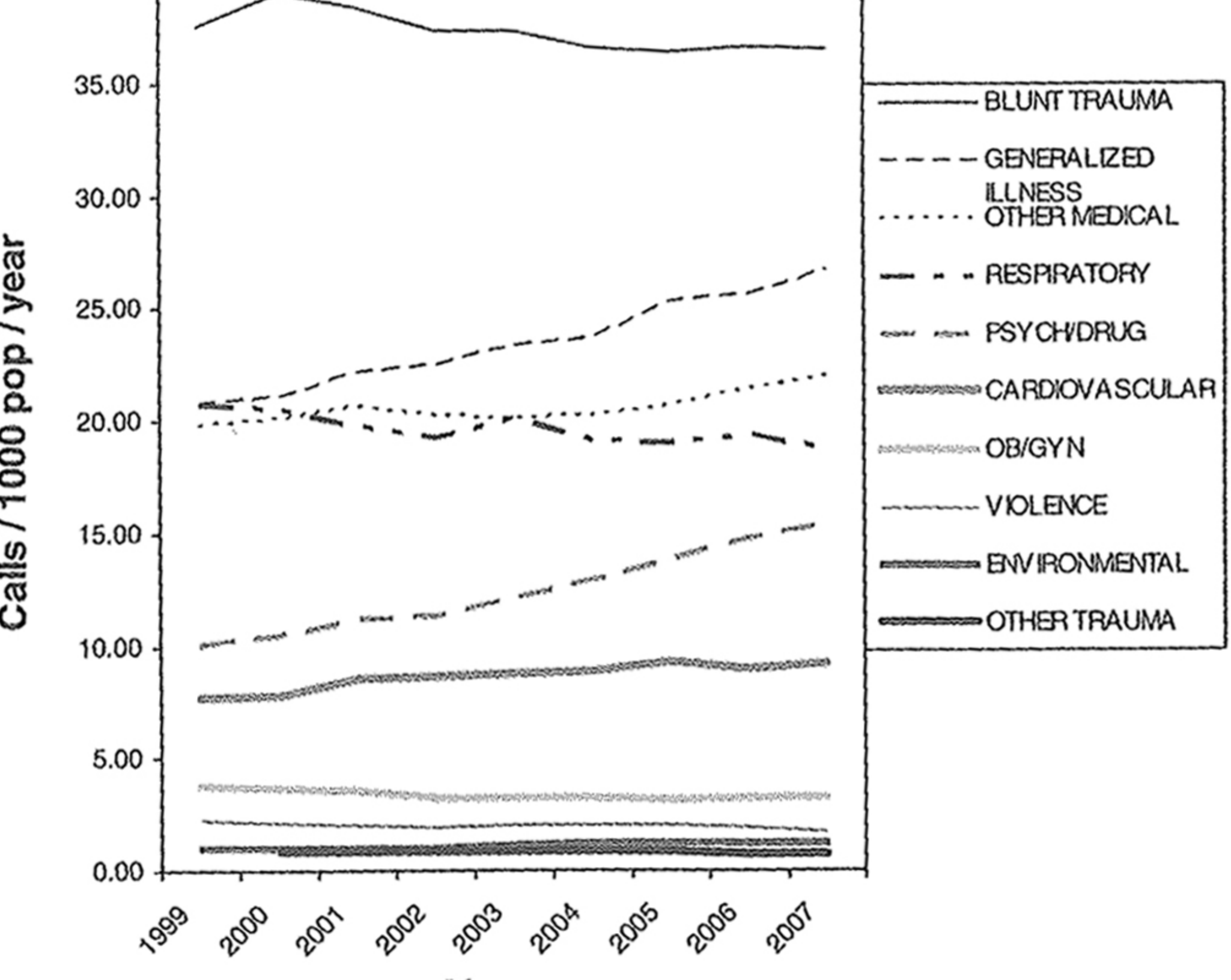
- One third ($750 billion) in healthcare costs do not improve patient health

HE CHALLENGES

- 5 - 10% of population will access EMS via the 911 system each year
  - 11 - 52% of these may not require ambulance transportation to an emergency department

You call, we haul, *that's all*.

- Current patterns, regulations, educational curricula, and financial incentives lead to the recommendation for transportation of all EMS patients to a hospital ED


Calls / 1000 pop / year
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
1999
2000
2001
2002
2003
2004
2005
2006
2007
BLUNT TRAUMA
GENERALIZED ILLNESS
OTHER MEDICAL
RESPIRATORY
PSYCH/DRUG
CARDIOVASCULAR
OB/GYN
VIOLENCE
ENVIRONMENTAL
OTHER TRAUMA

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

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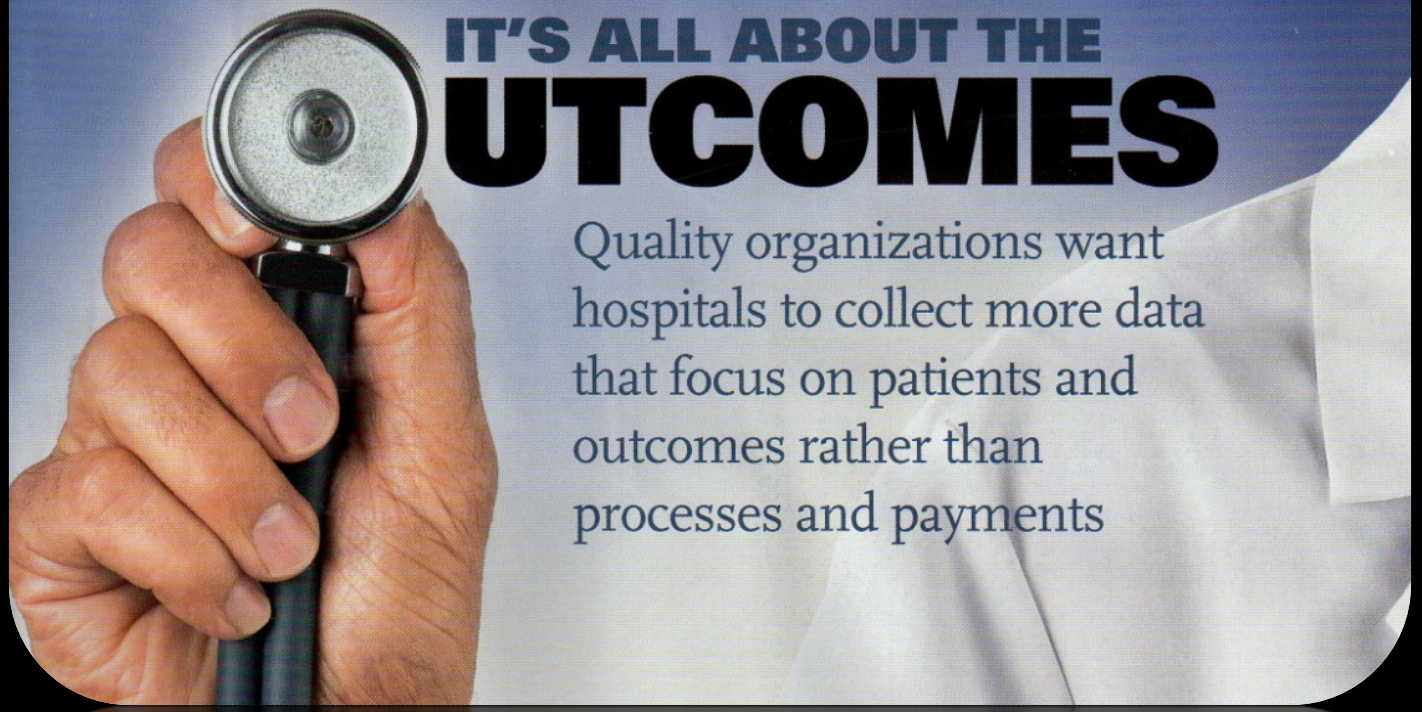


IT'S ALL ABOUT THE OUTCOMES

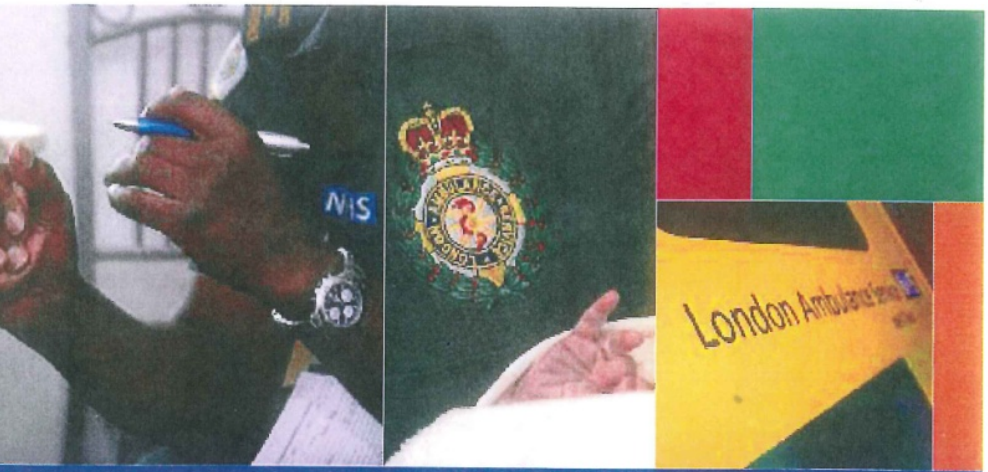
Quality organizations want hospitals to collect more data that focus on patients and outcomes rather than processes and payments

ef Executive
up

London Ambulance Service NHS
NHS Trust

New Ways of Working

Transforming Clinical Leadership



e objective is a simple one: to create on each ambulance station the perfect
vironment for clinical leadership to grow and flourish, improving not only the
ient's experience, but also the job satisfaction of all the staff.

National Ambulance Clinical Quali Outcome Indicators

"Transforming"

gure 20

he benefits of managing demand through the call cycle

ey areas where the response model can be transformed		
ear and treat	**See and treat**	**Alternative destinations**
esolution of calls sing telephone clinical sessment without the eed to dispatch a vehicle	Resolution of incident at the scene without the need to convey to another provider	Conveyance of patients to an alternative destination such as a minor injuries unit
ey benefits		

OMORROW'S REALITY

- utcomes will matter more than process
- erformance measures will be evidence-based and drive reimbursement
- are provided will be as transparent as delivery model
- ost of service will matter
- ospitals will have a renewed interest in EMS
- *lany* healthcare players are moving their focus OUT of the hospital
- he same leadership structure used by most systems today must evolve

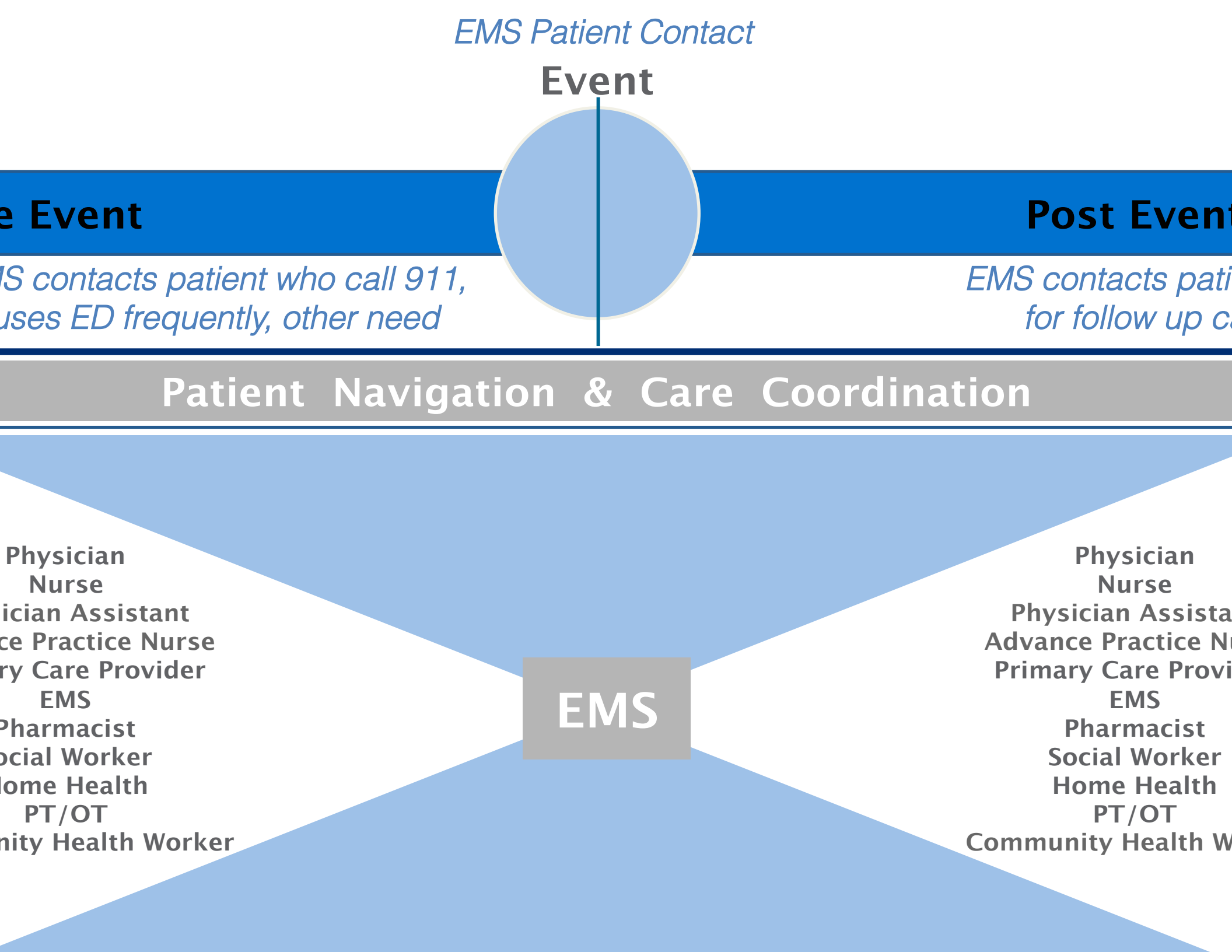
OMORROW'S REALITY

We are the key component of the new model…

The Idea

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

EMS is the only healthcare entity with an existing infrastructure that is capable of providing *the full spectrum of care (high acuity to non-emergent), in an immediately available, unscheduled, in-home, 24/7/365 delivery model*


EMS Patient Contact
Event
e Event
Post Event
IS contacts patient who call 911,
uses ED frequently, other need
EMS contacts pati
for follow up c
Patient Navigation & Care Coordination
Physician
Nurse
ician Assistant
ce Practice Nurse
ry Care Provider
EMS
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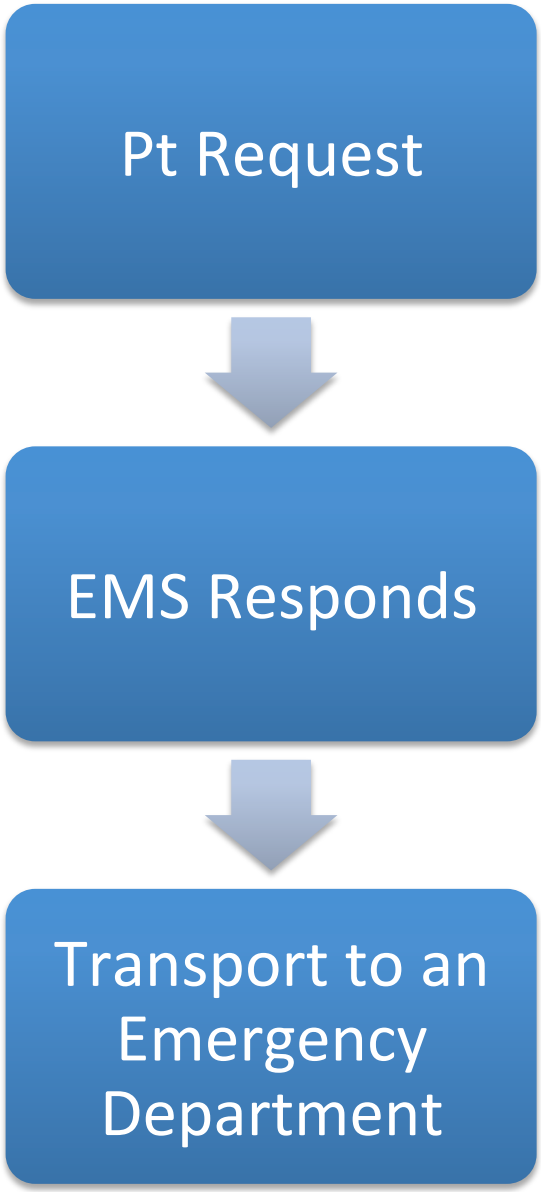
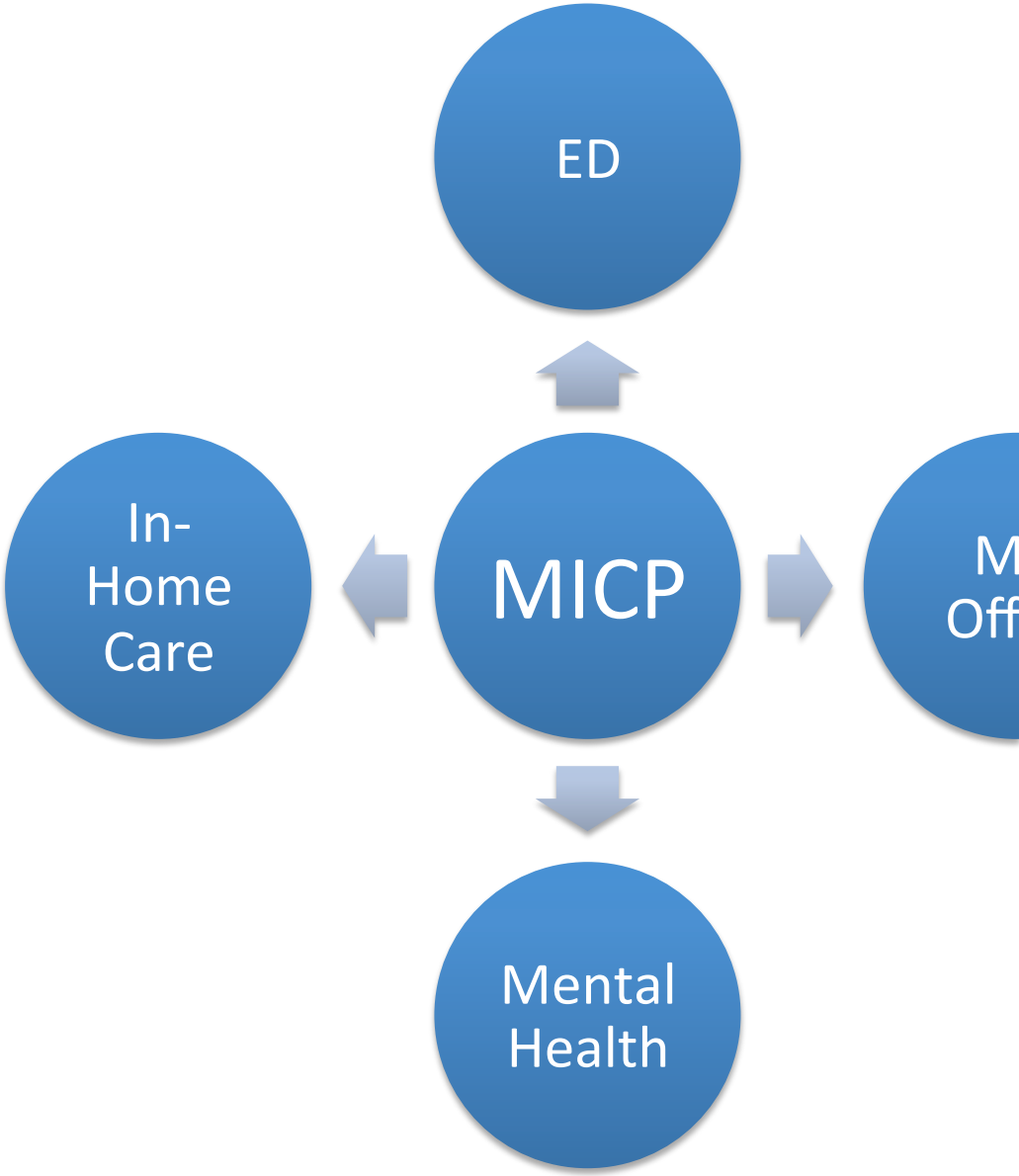
etter Health: Patient Navigatio

Current State

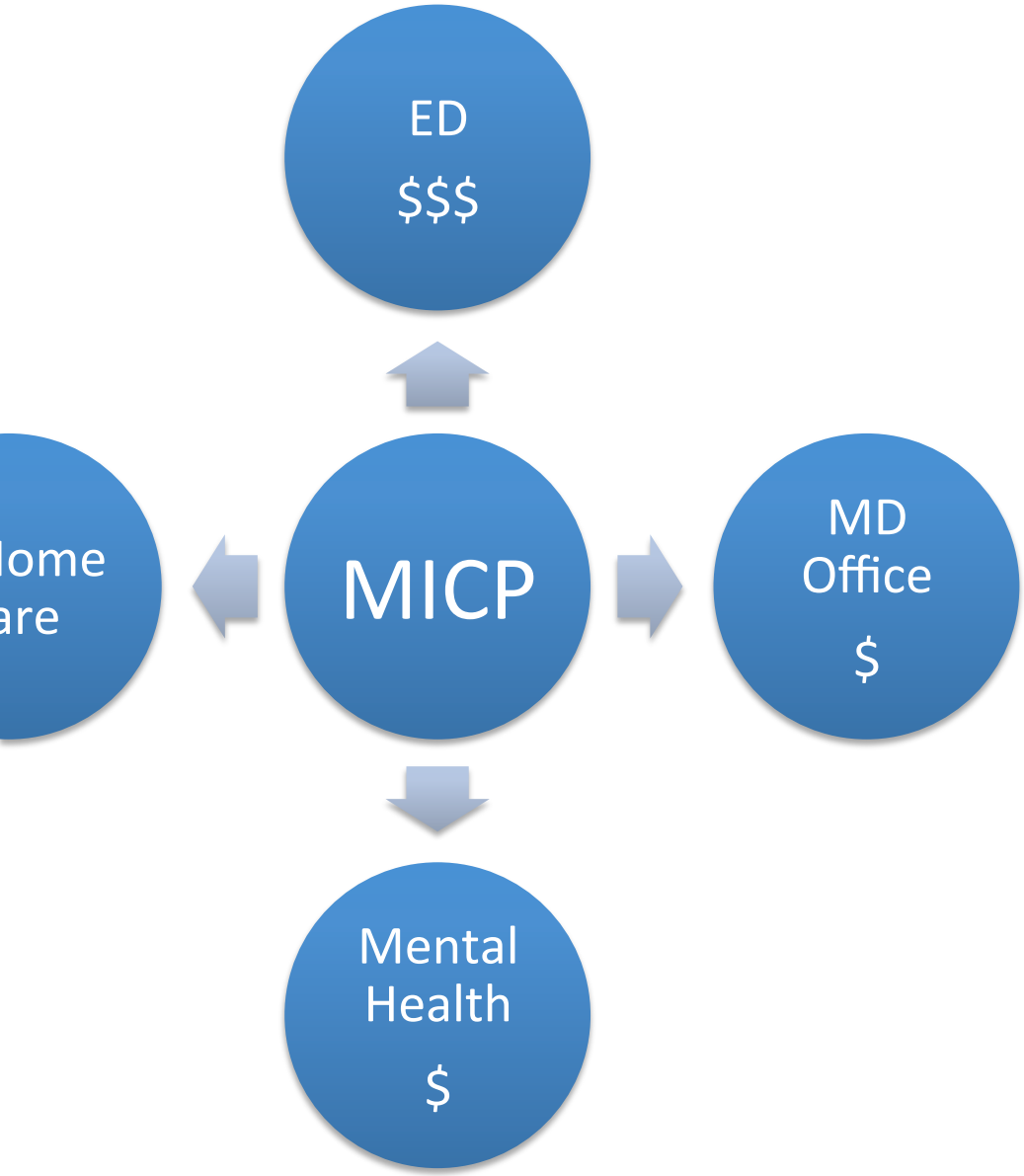


Mobile Integrated Healthca Practice



Lower Costs

tter Healthcare Experience



Better Individual/Commun Health

Vaccination

Diabetic Care

Readmission Prevention

Realigning Reimbursement Policy and Financial Incentives to Support Patient-Centered Out-of-Hospital Care

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

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

Retrospective studies estimate that between 7% and 34% of Medicare patients transported by ambulance to an emergency department could have been safely treated in an alternate environment.[1,2] However, Medicare and other payers provide no reimbursement for out-of-hospital care including response, triage, and patient assessment and treatment unless the patient is transported to an emergency department. The Medicare ambulance billing guide states, "The Medicare ambulance benefit is a transportation benefit and without a transport there is no benefit."[3] With most private insurers mimicking Medicare,[2] this payment policy significantly affects the behavior of EMS agencies contributing to an inefficient use of out-of-hospital care resources.

Financing Out-of-Hospital Care

National EMS expenditures from Medicare are approximately $5.2 billion per year.[4] Although this is less than 1% of total Medicare expenditures, there are considerable downstream health care costs associated with patients transported to emergency departments.[2] An average EMS agency receives 42% of its operating budget from Medicare fees, 19% from commercial insurers, 12% from Medicaid, and 4% from private pay; it requires approximately 23% in additional subsidization, most often provided by local taxes.[2] Thus, more than three-fourths of EMS revenue is generated from fee-for-service reimbursement, the service being transportation, not necessarily medical care.

However, approximately 26% of EMS responses do not result in a transport,[5] including situations in which patients refuse because their condition was effectively treated by EMS prior to transport (such as resolution of hypoglycemia or treatment of asthma). In 2010, median Medicare reimbursement was $464, slightly above the median cost per transport of $429 after adjusting for nontransported patients.[4] This slim margin must cross-subsidize Medicaid and uninsured patients whose care provides little or no reimbursement and would be quickly eroded by any change in transport rates. This creates a perverse incentive for agencies to transport patients to the hospital emergency department, even if transport is not what a patient needs or wants, and even if other alternatives might be better, less expensive, or more patient centered.

Patient-Centered Out-of-Hospital Care

Out-of-hospital care agencies that are reliant on transportation-based fee-for-service reimbursement are limited in the role they can play within the continuum of health care. Consider a patient with uncomplicated asthma who is without β-agonists or a patient with end-stage renal disease who becomes short of breath secondary to fluid overload on the day of dialysis. In either case, a patient-centered approach might be something other than transport to an emergency department. The patient with asthma might benefit from nebulized albuterol treatments and coordination of care with a primary care physician. The patient with renal disease might benefit from stabilization and transportation to the dialysis center. Neither of these alternative approaches would be reimbursed under existing rules. Instead, for EMS to collect $464 in reimbursement, the EMS agency triggers an extra emergency department visit at an average societal expense of $969.[6] The goal of reimbursement reform should be to realign incentives so that EMS agencies are not financially penalized for offering the patient the most medically appropriate option and offering society the highest value intervention.

Options for the EMS system might include a standard ambulance response, a multipatient transport vehicle, a

Author Affiliations: Department of Emergency Medicine, Mount Sinai Medical Center, New York, New York (Dr Munjal); Department of Emergency Medicine and Epidemiology, The Center for Emergency Care Policy and Research, Perelman School of Medicine, University of Pennsylvania, Philadelphia, and Office of the Assistant Secretary for Preparedness and Response, US Department of Health and Human Services, Washington, DC (Dr Carr).
Corresponding Author: Kevin Munjal, MD, MPH, Department of Emergency Medicine, Mount Sinai Medical Center, One Gustave L. Levy Place, New York, NY 10029 (kevin.munjal@mountsinai.org).

Here’s our storm…

Focused areas of practice

ost acute care

- Readmission prevention
- Transitional care

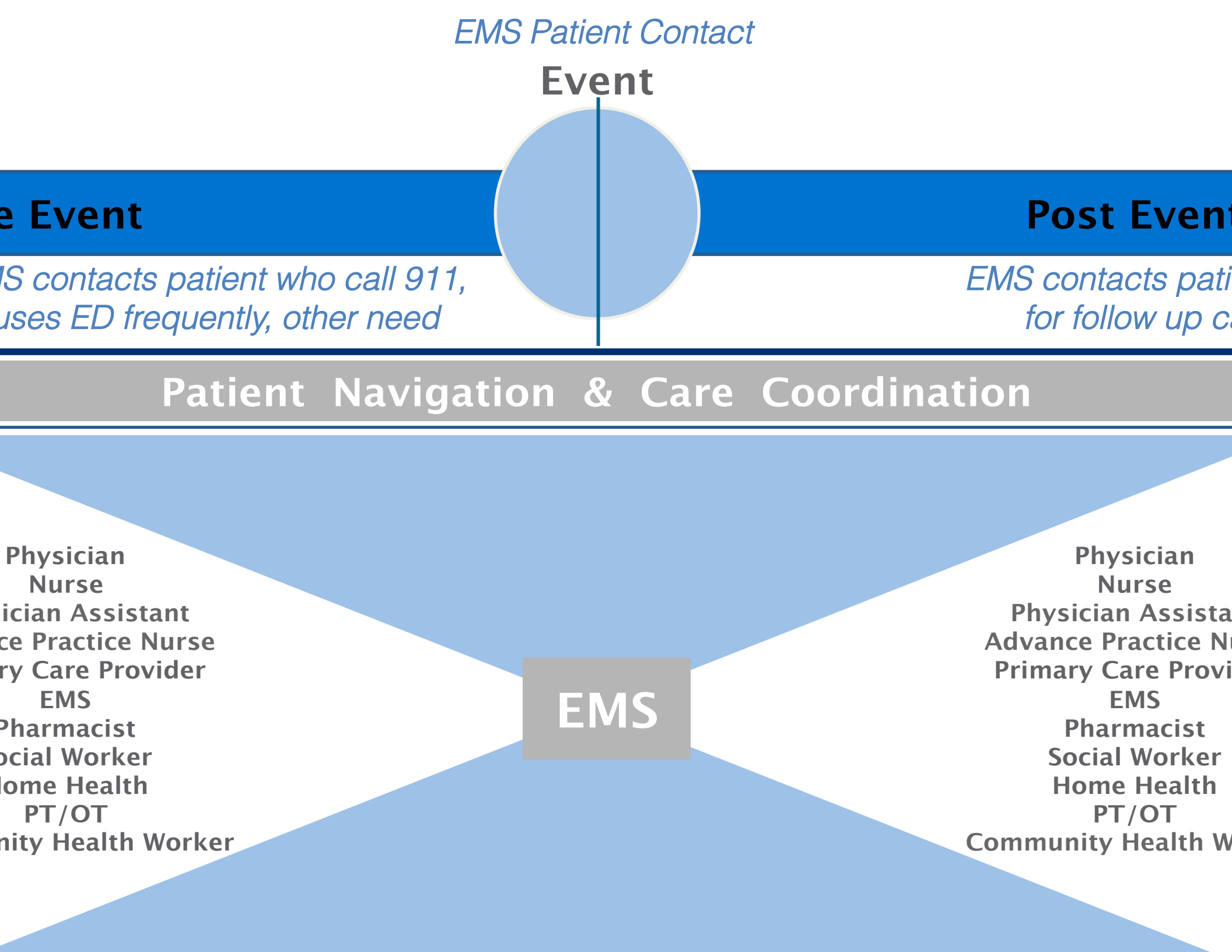
ong term chronic care

ost-ED care

requent system users

lome-bound, impaired mobility

lealth screening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EMS
Physician
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Physician Assista
Advance Practice Nu
Primary Care Provi
EMS
Pharmacist
Social Worker
Home Health
PT/OT
Community Health W

Core Components

- medical direction
- ommunity assessment
- trategic partnerships
- patient centered access
- oordination/communications
- elepresence
- apacity of navigation
- ealthcare providers
- ransportation
- ntegrated health record (HIE/HPE)
- ustainable funding
- erformance measurement/evaluation – safety

how Me the Money!!

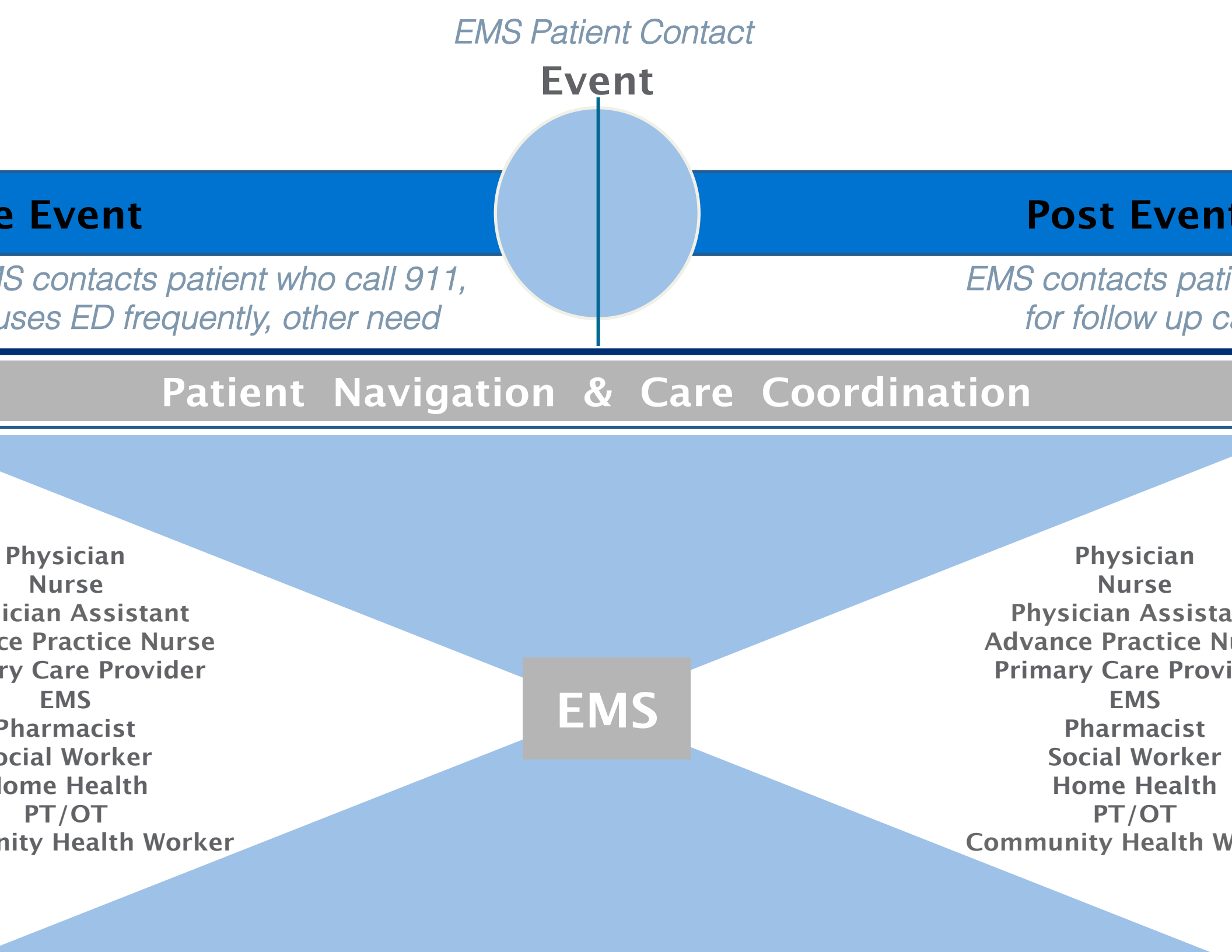
“Mobile Integrated Healthcare”


MEDSTAR
MOBILE HEALTHCARE

EY CONCEPTS

- EMS has the opportunity to drive a new practice of medicine
- EMS will not own this space, but is the most qualified
- This is not expanded scope, it is expanded practice
- We can integrate the skill sets of our clinical colleagues with our expertise in mobile health logistics
- Community Paramedics, like our emergency paramedics, are an integral part of the healthcare team.


IN CASE OF AN
EMERGENCY, PLEASE GO
TO THE NEAREST
EMERGENCY ROOM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