Evolving EMS Economic Models

Beyond MIH & CP
Asking the *Really Tough* Questions...
Why do supermarkets make the sick walk all the way to the back of the store to get their prescriptions...

...while healthy people can buy cigarettes at the front?
Healthcare Economics Scan

• $10,372 per capita health expenditures (2016)!!
  ○ 18.1% GDP

• Due in large part to *quantity-based* payments

http://content.healthaffairs.org/content/early/2017/02/14/hlthaff.2016.1627.full
Mobile Integrated Healthcare

- 911 Triage
- Alternative Response
- Traditional EMS
- Alternative Destination
- Community Paramedic

Courtesy of Dan Swayze
Healthcare Economics 3.0
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.
Anthem Blue Cross Nears 60% Value-Based Care Spend
By Bruce Japsen
April 27, 2017

Anthem’s top executive says the health insurer is paying out 58% of its reimbursements via value-based care models that are quickly dominating the U.S. medical system.

Anthem, which operates Blue Cross and Blue Shield plans in 14 states, this week opened a window into the health insurance industry’s shift away from the traditional fee-for-service approach that is based on volume of care delivered and can lead to overtreatment and unnecessary medical tests and procedures. Rival insurers, including Aetna and UnitedHealth Group, are also moving aggressively away from fee-for-service medicine.

“Aggregate spend regarding value-based contracts tally up to about 58% of our total medical spend across all lines of business, and over 75% is represented by shared savings agreements, shared risk arrangements [and] population-based payment models,” Anthem CEO Joe Swedish told analysts on the company’s first-quarter earnings call earlier this week.

Value-based pay is tied to health outcomes, performance and quality of care of medical care providers who contract with insurers via alternative payment vehicles like accountable care organizations (ACOs), a delivery system that rewards doctors and hospitals for working together to improve quality and rein in costs.

Starting next month, Anthem Blue Cross Blue Shield of Georgia will no longer cover emergency department services it determines are unnecessary for members with individual plans.

The insurer said the policy aims to steer patients with nonemergent symptoms to see a primary care physician, urgent care provider or use its LiveHealth telehealth app to limit costly ED visits. If a BCBS of Georgia policyholder receives care for nonemergent symptoms, a medical director will use the prudent layperson standard to deem whether the service is necessary.

Jeff Fusile, president of BCBS of Georgia, told WABE, "The cost of care's been going up so much faster than people's earnings. We have got to find a better way to do some of this stuff, taking some of that unnecessary spending out of the system."

The policy does not include referrals from a physician to the ED for nonemergent services, nonemergent services provided to children under age 14, instances when an urgent care clinic is more than 15 miles away and when care is administered on Sundays and major holidays.
By mid-summer, Anthem Blue Cross and Blue Shield (BCBS) plans in at least four states are expected to offer no payment for non-emergent use of the emergency department (ED).

BCBS Georgia individual-market plans on July 1 will become the newest group to implement the policy. Anthem added the policy for its Missouri plans on June 1 and for its Kentucky plans in late 2015. Meanwhile, New York plans have had a “similar program in place for several years,” said Gene Rodriguez, director of public relations for Anthem Inc.

“This is not a new area of focus for Anthem,” Rodriguez said in an email. “Our current effort to decrease inappropriate use of the emergency room [ER] is timely given our work over the past few years to improve access to care for non-emergency conditions and the increase we are seeing in the inappropriate use of the emergency room.”

Other insurers are implementing “similar” plans, said Cathryn Donaldson, a spokeswoman for America’s Health Insurance Plans (AHIP). Specific figures on the extent of such policies were unavailable as of publication of this article.
Healthcare Economics 3.0

• ACOs
  o 923 as of April 2017
  o 32 million covered lives

Healthcare Economics 3.0

• Payment based on **VALUE**
  o Readmissions & VBP Penalties
  o No longer just hospitals

Why do people order double cheeseburgers, large fries... ...and a diet coke?
Healthcare Economics 3.0

• Mergers and Acquisitions
  o Catholic Health Initiatives & Dignity Health
  o UnitedHealth Group & DaVita
  o Ascension Health & Providence St. Joseph Health
    • 191 hospitals in 27 states and annual revenue of $44.8 billion
  o CVS & Aetna
  o Walmart & Humana?
North Carolina treasurer asks UNC Health Care for $1B bond to ensure cost savings from pending merger

Written by Ayla Ellison

February 14, 2018

North Carolina Treasurer Dale Folwell is calling for Chapel Hill, N.C.-based UNC Health Care to issue a $1 billion performance bond to guarantee cost savings from the health system's pending merger with Charlotte, N.C.-based Atrium Health, according to The News & Observer.

UNC Health Care and Atrium Health, previously named Carolinas HealthCare, signed a letter of intent to merge in August 2017, but the systems have released few details about the proposed deal.

"With a lack of details on this merger and little evidence that mergers like this have generated savings for the public, I feel I have a fiduciary responsibility to pursue this guarantee that will protect North Carolina taxpayers," Mr. Folwell said in a statement to The News & Observer.

UNC said it will work with the state treasurer to develop ways to meet state employees' healthcare needs at the lowest cost. However, cutting costs is not the system's top priority. "Our No. 1 job is taking care of patients. We do not control inflation or other variables associated with the cost of care," UNC said in a statement to The News & Observer.

Why do banks leave vault doors open... ...but chain the pens to the counters?
EMS Economics 1.0

• You call
• We haul
• That’s all
Question??

• How has “EMS” done in proving value?
EMS Economics 1.0

• Misaligned Incentives
  o Only paid to transport
  o “EMS” is a *transportation* benefit
  o NOT a *medical* benefit

• Downstream healthcare costs
  o ED; admission?
How Can You Demonstrate Value to Healthcare Providers and Payers?

Better patient health

Lowered costs
Demonstrating Value for EMS

VALUE

QUALITY

COST

Outcomes + Patient Experience

Direct Costs + Indirect Costs
Why do we leave cars worth thousands of dollars in our driveways...and put our useless junk in our garage?
131 Million ED Visits (2011)

- The most common reasons for ED visits resulting in discharge were fever and otitis media (infants and patients aged 1–17 years), superficial injury (all age groups except infants), open wounds of the head, neck, and trunk (patients aged 1–17 years and adults aged 85+ years), nonspecific chest pain (adults aged 45 years and older), and abdominal pain and back pain (all adult age groups except those aged 85+ years).
<table>
<thead>
<tr>
<th>YEAR</th>
<th>% OF ED PATIENTS ARRIVING BY EMS</th>
<th>OVERALL ED ADMISSION RATE (%)</th>
<th>% OF EMS ARRIVALS WHO ARE ADMITTED</th>
<th>% OF WALK-IN PATIENTS ADMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>17</td>
<td>16.5</td>
<td>39</td>
<td>12.5</td>
</tr>
<tr>
<td>2012</td>
<td>16</td>
<td>16.5</td>
<td>39</td>
<td>12.2</td>
</tr>
<tr>
<td>2011</td>
<td>17</td>
<td>17.6</td>
<td>42</td>
<td>12.6</td>
</tr>
<tr>
<td>2010</td>
<td>16</td>
<td>18.0</td>
<td>43</td>
<td>13.2</td>
</tr>
<tr>
<td>2009</td>
<td>16</td>
<td>17.3</td>
<td>43</td>
<td>12.4</td>
</tr>
<tr>
<td>2008</td>
<td>17</td>
<td>16.6</td>
<td>43</td>
<td>11.2</td>
</tr>
<tr>
<td>2007–2004</td>
<td>15</td>
<td>16.3</td>
<td>38</td>
<td>12.5</td>
</tr>
</tbody>
</table>
## ED Expenditure Analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ED Visits (2011)</td>
<td>$131,000,000</td>
</tr>
<tr>
<td>Average Expenditure (3)</td>
<td>$969</td>
</tr>
<tr>
<td><strong>ED Expenditure</strong></td>
<td><strong>$126,939,000,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% EMS ED Arrivals Discharged</td>
<td>61%</td>
</tr>
<tr>
<td>Patients Treated &amp; Streeted</td>
<td>13,584,700</td>
</tr>
<tr>
<td>Average Expenditure (3)</td>
<td>$969</td>
</tr>
<tr>
<td><strong>EMS ED Expenditure</strong></td>
<td><strong>$21,579,630,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% EMS ED arrival (1)</td>
<td>17%</td>
</tr>
<tr>
<td>Patient Arrivals</td>
<td>22,270,000</td>
</tr>
<tr>
<td>Average Expenditure (3)</td>
<td>$969</td>
</tr>
<tr>
<td><strong>EMS ED Expenditure</strong></td>
<td><strong>$21,579,630,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of EMS patients Alt. Dest.</td>
<td>15%</td>
</tr>
<tr>
<td>ED Patients Referred</td>
<td>2,037,705</td>
</tr>
<tr>
<td>Average Expenditure (3)</td>
<td>$969</td>
</tr>
<tr>
<td><strong>Potential ED Savings</strong></td>
<td><strong>$1,974,536,145</strong></td>
</tr>
</tbody>
</table>

### References:
Why don't you ever see the headline ‘Psychic Wins Lottery’?
Anthem supports EMS transformation!

• Decouple payment from transport
  o Allow EMS to make patient-centric, clinical decisions
    • VS. Economic decisions for the EMS agency

• HCPCS Code A0998
  o Ambulance Response and Treatment, without Transport
  o Historically not funded, a non-covered benefit

• Anthem will pay at...
  o 75% of the state average of allowed payment for all ambulance trips
  o Missouri example:
    • $688 average allowed x 75% = allowed amount of $516.08
Measures of Success

• Use of the code
• Repatriation within 6 hours of the original contact
• Reduction of expenditures
• Balancing measures
  o Impact on providers and other healthcare stakeholders
• ED visits vs. Other (Urgent Care, MD, etc.)
Legislative/Regulatory Issues

• Likely will not require legislative or regulatory changes
  o Patients always have the right to refuse transport

• WE “convince” them to go
  o Based on clinical need?
  o Based on economics?

• If alternate destinations used
  o Agreements with alternate locations
  o Patient outcome feedback for QA
States are increasingly turning to community paramedicine to help fill the gap in the health care workforce. States have been experimenting with community paramedicine programs for the last five years or more. Expanding the role of licensed or certified emergency medical technicians—or EMTs—and paramedics to provide non-emergency preventive health care services directly to patients in their communities can be cost-effective and make up for health care workforce shortages.

“Community paramedics offer extensive background experience and will provide for better access to health care,” Oscarson said. “Nevada now has an opportunity to fill unmet or unrealized community primary care and health needs. Using EMS providers in an expanded role will increase patient access to primary and preventive care, save health care dollars and improve patient outcomes.”

In late August, Nevada received approval of a state plan amendment from the Centers for Medicare and Medicaid to provide Medicaid reimbursement for medically necessary community paramedicine.

Janet Haebler, senior associate director of state government affairs for the American Nurses Association, said community paramedicine “strives to fill in gaps in services that previously had been provided by public health and home care nurses but were lost with funding cuts.”

http://knowledgecenter.csg.org/kc/content/states-using-emergency-medical-techs-expand-health-care-services
A New Kind of Paramedic for Less Urgent 911 Calls

Community paramedicine, which can drastically reduce unnecessary ER visits, could be the future of emergency care.

by Mattie Quinn

September 2016

If there is one issue confronting our health-care system on which just about everyone agrees, it’s this:

Unnecessary emergency room visits are a significant driver of costs. But getting the people who most abuse emergency services under control has been an uphill battle.

Some of the big insurance players involved with government health-care programs are starting to get in on the action as well. Blue Cross and Blue Shield of New Mexico has begun pilot programs for its Medicaid patients in a few of the state’s more urban areas. The company says a group of patients identified in one of the programs has cut its ER use by 60 percent. One former super-utilizer hasn’t been to the ER in the 11 months he’s been enrolled in the program, says Kerry Clear, the company’s manager of community social services.
HealthCraft Center at the University of California at San Francisco — looked at data from the first year of the California pilot’s operations and found they were improving health care and cutting costs. For example, a pilot in San Diego reduced 911 calls by 10 percent and cost savings of $40,000 a month, according to the center’s report. Paramedics referred patients to services such as mental health clinics, drug/alcohol treatment, food assistance, housing assistance and domestic violence resources. In several cases, the paramedics transported the patients to those service providers. Another pilot looked specifically at alternative destinations for behavioral health. One-third of participating patients were transported to a mental health crisis center instead of the emergency department for a net savings of about $631 a month. Despite the potential for savings, one of the biggest setbacks for CP is, of course, funding. As Zavalea’s “you can, we can!” comment implies, traditionally Medicaid and private payers only reimburse for EMS if the patient is taken to an emergency department. If the CP-CP concept is to be widely adopted, that has to change.

There are several major sources of funding, says Zavalea. A public agency such as a fire department may be willing and able to develop and pay for programs from its own budget. But more commonly, pilot programs are funded through grants from the government, private foundations or insurers. CMMI, for example, has granted nearly $63 million to EMS agencies over the past six years for these programs, according to Zavalea. In addition, states can get a waiver to allow their Medicaid programs to reimburse for community paramedicine services. The problem with great money, however, is that it runs out. A more permanent and stable funding model would be for those that benefit from the program, like health care systems, pay for it. “The critical stakeholder who is financially at risk for the patient’s health care utilization — whether it be a hospital, a physican practice, home health agency or insurer — should provide the funding,” says Zavalea. But some of the stakeholders have been taking back their stitches, sending mixed evidence of the effectiveness of community paramedicine. While individual pilots seem to be producing good results, they are small and limited to particular geographic areas, like the pilot in San Diego. And California’s funding situation is complicated by the fact that community paramedicine is not currently allowed under state law. (The pilot is operating under a waiver.) Large insurers are interested but reluctant to participate until the law changes and such programs can be implemented statewide, says Lou Meyer, manager of the pilot project. “They say that once this is approved so it can happen everywhere in the state, then we’ll talk.” Meanwhile, MedStat’s program in Texas is on the cusp of a funding breakthrough. “We are currently negotiating with three large national third-party payers,” says Zavalea. The ideal outcome would be an agreement under which they would pay MedStat a certain amount per insured patient per month to perform CP-CP services. If that happens, it could lead to a broader shift from the traditional model to one that empowers and incentivizes EMS to offer the best care for the patient rather than a one-size-fits-all ride to the emergency room.

"Third-party payers are finally getting enough information and feeling comfortable enough to give this a try," he adds.
ALBUQUERQUE, N.M. — Getting the people who overuse emergency services under control has been an uphill battle, but one major health insurer has been teaming with metro area emergency medical services agencies for over a year to put a dent in the numbers of ER visits by some of its Medicaid members.

During that time, a handful of Albuquerque paramedics have been making house calls through a program designed to reduce hospital readmission rates while helping discharged patients stay on the road to good health.

It seems to be working.

The insurer saw an almost 62 percent drop in emergency room visits and a 63 percent decrease in ambulance use by frequent flyers, many of whom live alone, have a limited support network, lack transportation or have a housing situation that’s in flux.

The insurer is in contract talks with ambulance and fire agencies to expand the program to other New Mexico communities.
New Riders of the Purple Sage: Community Paramedicine

Say the word “paramedic” and most people think of the men and women who respond with flashing lights and screaming sirens when someone suffers a medical crisis. But what if there were a way to provide help before the crisis happens?

Across the country, health care companies are implementing a new strategy to deliver help to the people who need it most, and in some cases prevent needless and costly trips to the emergency room. And it’s paramedics who are providing the help – without the drama of a speeding ambulance.

Providing a Solution
Realizing that prevention and education are critical to reversing costly, inappropriate ER usage and hospital readmission, the team at BCBSNM had a hunch. In a pilot program, it contracted with two state-based emergency medical service companies to assign a paramedic to each of the 15 members. It was one of New Mexico’s first ventures into community paramedicine, and it was a perfect match. Since they had frequently relied on paramedics to get to the hospital, these members trusted their new medical guardians.

https://connect.bcbsnm.com/making-it-work/b/weblog/posts/community-paramedicine
The clients saw paramedics as healers rather than paper pushers, Clear said. The results were impressive. We were able to reduce ER visits for all 15 members from 686 visits to an average of 115 visits per month within the first couple of months.

BCBSNM has seen similar success. Since January, contracted paramedics have visited more than 1,100 high-ER users and Medicaid recipients recently discharged from the hospital. Of those visited, repeat visits to the ER have dropped 61 percent while hospital readmission rates have dropped to where just 9.7 percent of the members are readmitted. The company is hoping soon to expand community paramedicine to San Juan County and the cities of Santa Fe and Taos.

To serve its Medicaid members, BCBSNM has contracted with three ambulance companies – Albuquerque Ambulance, American Medical Response and Rio Rancho Fire Department. Currently 18 full- and part-time paramedics serve Medicaid recipients in areas most in need: Bernalillo County, which includes Albuquerque and the nearby East Mountains; parts of Sandoval County, which includes Rio Rancho, Corrales and Bernalillo; Valencia County to the southwest; and Doña Ana and Otero counties to the south, home to Las Cruces and Alamogordo.

https://connect.bcbsnm.com/making-it-work/b/weblog/posts/community-paramedicine
Why is 'abbreviated' such a long word?

abbrev. n. Short for “abbreviation.”
abbr. n. Short for “abbrev.”
ab. n. Sh-t - “abbr”
A. n. “ab”
Future EMS Economic Model

- Per Member/Per Month (Capitation)
  - No FFS billing
- Shared Savings
  - Total cost of care reduction
  - Case-rate reduction
Happening Now...
Good morning Matt,

Thank you for the documents, XXXXXXXX is working with the internal team to move the contracting forward. At this time I believe we can leverage the information you currently track and report for inclusion into the contract language, we need to confirm what is covered in our standard contract language and then add any remaining specific metrics. *The following is my suggested metrics for inclusion.*

**MIH Metrics - Mobile Integrated Healthcare Program – Measurement Strategy**
- Q5 – Unplanned Acute Care utilization (e.g.: emergency ambulance response, urgent ED visit)
- Q6 – Adverse Outcomes
- E1 – Patient Satisfaction
- U2 – Hospital ED Visits
- U3 – All-cause Hospital Admission
- U4 – Unplanned 30-day Hospital Readmission
- C1 – Ambulance Transport Savings
- C2 – Hospital ED Visit Savings
- C3 – All-cause Hospital Admission Savings
- C6 – Total Expenditure Savings

**MIH Metrics – 911 Nurse Triage – Measurement Strategy**
- S5 – Organizational Readiness Assessment – Medical Oversight
- S9 – Specialized Training and Education
- Q3 – Call Processing Safety
- Q9 - Adverse Outcomes

Once we have confirmed the time lines with IT and Network, we can schedule the follow meetings with Clinical Analytics and the IT team discuss any outstanding issues or deliverables.

Thanks, Mark
Morning Matt – so, I finally have upper leadership’s attention. They are wanting me to put together a business use-case based on this new 3.0 EMS model.

Couple questions for you:
• What if we are dealing with multiple ambulance agencies?
• I believe Rebecca and Larry indicated you were interested in being a third-party administrator, correct? How would that work?
Why do they sterilize the needle used for lethal injections?
<table>
<thead>
<tr>
<th>Enhanced Services</th>
<th>Possible CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-1-1 Nurse Triage Services</td>
<td><strong>98967</strong>: Telephone assessment and management service provided by a qualified non-physician healthcare practitioner.</td>
</tr>
</tbody>
</table>
| Mobile Healthcare Paramedic Visit – Routine | **99349**: Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:  
  - A detailed interval history;  
  - A detailed examination;  
  - Medical decision making of moderate complexity.  
  Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. |
| Mobile Healthcare Paramedic Visit – Episodic/Emergent | **99341**: Home visit for the evaluation and management of a new patient, which requires these 3 key components:
- A detailed history;
- A detailed examination; and
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. |
<table>
<thead>
<tr>
<th>Enhanced Services</th>
<th>Possible CPT Codes</th>
</tr>
</thead>
</table>
| Ambulance Transport, Emergency, Alternate Destination | A0429 (modifier)  
- D: Diagnostic or therapeutic site other than P or H when these are used as origin codes  
- E: Residential, domiciliary, custodial facility  
- H: Hospital  
- N: Skilled nursing facility  
- P: Physician’s office  
- R: Residence  
- S: Scene of accident or acute event                   |

<table>
<thead>
<tr>
<th>Examples:</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-1-1 Ambulance, Scene, Transport to Urgent Care</td>
<td>A0429 SD</td>
</tr>
<tr>
<td>9-1-1 Ambulance, Scene, Transport to Primary Care Clinic</td>
<td>A0429 SP</td>
</tr>
<tr>
<td>9-1-1 Ambulance, Home, Transport to Urgent Care</td>
<td>A0429 RD</td>
</tr>
<tr>
<td>9-1-1 Ambulance, Home, Refer to PCP, scheduled App’t</td>
<td>A0998 RP</td>
</tr>
</tbody>
</table>
Who’s Paying?

• Hospitals \{Reduced penalties and uncompensated care\}
  o Readmission prevention
  o Super Utilizers
  o BPCI programs

• Home Health \{More referrals; narrow network contracts\}
  o Preventable ED and admission reduction
    • 9-1-1 Notification and care coordination
    • After hours back-up support
Who’s Paying?

• IPAs {Shared risk contracts}
  o Readmission prevention
  o Super Utilizers
  o BPCI programs

• Hospice {Cost of care; reduce revocations}
  o Revocation prevention
  o Care coordination
    • 9-1-1 Notification and care coordination
    • After hours back-up support
Who’s Paying?

• Post Acute Care agencies \textit{(Shared risk contracts)}
  o Admission/readmission prevention
  o Super Utilizers
  o BPCI programs
Who’s Paying?

• 3rd Party Payers \{Expenditure savings\}
  o 9-1-1 Nurse Triage
  o Ambulance Transport Alternatives
  o Readmission prevention
  o Super Utilizers

• Medicaid
  o FFS
    • MN, NV, AZ, NM
  o DSRIP/1115a
    • ID, TX
Who’s Paying?

• Managed Care \textit{\{Expenditure savings\}}
  o Medicare
  o Medicaid
    • Medical Expense Issues
      ▪ 15\% vs. 85\%

• ACOs
  o Medicare/Commercial
Future EMS Economic Models

• Supplier to Provider status
• Part of a bundled payment
• Shift to outcome-based payments
  o Like the rest of healthcare
• Shared risk contracting
  o Payers, other providers
  o Part of an ACO (for real)
  o Capitated fees (happening now)
• Pay for performance
  o Adherence to clinical bundles
  o Proven to make a ‘clinical’ difference
    • STEMI, Stroke, Trauma, COPD clinical bundles
Why don't sheep shrink when it rains?
Rural EMS Connection

- Primary care access point
- CAH/Rural hospital closures
- EMS becomes the default primary care
  - Only care?
- Expanded role in the community
- Physician extender models
  - Telemedicine?
- Value: Economic Models still apply
  - Prevent long trips to medical care
  - Prevent SNF admissions
    - “Safe at Home” projects
What is EMS 3.0?

EMS 3.0 is an EMS Industry Initiative to help EMS agencies and practitioners understand the changes that are needed in EMS to fully support the transformation of our nation’s healthcare system, and to provide tools and resources to help them implement these changes.

- America’s healthcare system is broken and needs fixing. The best way we can fix our healthcare system is by changing the way care is delivered and coordinated across the spectrum of healthcare providers and facilities. EMS must be a part of the solution.

- Today, EMS operates in communities across the country as a trusted and expected medical provider. EMS providers administer care in homes and throughout the community, delivering rapid and reliable medical assessment, care and transportation.

- Many of the patients to whom EMS provides care are not in need of emergent medical interventions, but rather have medical needs that can be better addressed through actions other than transporting these patients to an emergency department. Some examples of these actions can include care coordination, community resource acquisition, and facilitation of transportation to appropriate healthcare facilities.
**EMS 3.0: Explaining the Value to Payers.** This document has been created to provide talking points for EMS agencies to explain to payers the value of EMS 3.0 services.

**Infographic for EMS stakeholders** is intended for payers and other EMS stakeholders to help them learn how EMS can help transform our nation’s healthcare system.

**EMS Transformation:** moving our profession to "EMS 3.0" is an informational presentation to help better understand the move to EMS 3.0.
EMS3.
Explaining the Value to Payers

NAEMT
Advancing the EMS profession
Explaining the Value to Payers

This document has been created to provide talking points for EMS agencies to explain to payers the value of EMS 3.0 services.

Please review and download as needed the following talking points:

PAYER
City Council/Tax Payers .................................................. 3
Hospitals ......................................................................... 4
Home Care Services ......................................................... 5
Hospices .......................................................................... 6
Commercial Insurers ........................................................ 7
Post-Acute Care Services .................................................. 8
Medicare ......................................................................... 9
State Medicaid Offices ..................................................... 10
Foundations .................................................................... 11
Labor Unions ................................................................... 12
Accountable Care Organizations (ACOs) ......................... 13

EMS 3.0 INFOGRAPHIC

City Council/Tax Payers

Cost Savings
- Achieves more efficient use of city/tax payer resources by decreasing the cost of EMS and law enforcement resources required for non-emergent medical calls.
- Helps coordinate and streamline system responses and resources during a 911 call by facilitating alignment between patients' needs and appropriate community and health system resources, thereby reducing emergent responses for preventable 911 calls.
- Leads to additional downstream savings by reducing tax payer expenditures for tax-funded indigent care.

Care Coordination and Population Health
- Identifies patterns and trends in utilization of social, mental health, and community resources.
- Provides a unique perspective working with residents in crisis, often identifying potential crises before they occur.
- Generates and shares data that significantly impacts population health initiatives.
- Proactively works with identified high utilizers of these services, assisting them in learning how to navigate the local health system and established community resources.

Revenue Generation
- Increases revenue for the community.
- Payers are increasingly willing to pay for enhanced services provided by EMS, such as programs that improve patient outcomes and reduce expenditures for preventable ED visits and hospital admissions.
- Diversifies the revenue stream from solely ambulance transportation to revenues from other value-added services.
  - Ambulance Transport Alternatives
  - Community Paramedicine
  - 911 Nurse Triage
Cost Savings
- Reduces the impact of readmission and value-based purchasing penalties.
- Reduces the consequences of under-reimbursed care.
  - Appropriately navigating patients through the healthcare system based on medical need and payer source.
- Reduces readmissions and repeat ED visits from patients covered under a bundled payment.

Revenue Generation
- Reduces the length of stay for Inpatient admissions.
  - Reduces length of stay for Diagnostic Related Groups (DRG) payment to maximize bed utilization.
- Reduces cost of care to Accountable Care Organization (ACO) or other shared-risk populations.
- Promotes additional payer network contracts based on perceived value of effective care coordination for members.

Patient Satisfaction and HCAHPS
- Enhances patient experience scores for value-based purchasing measures.
  - Enhances the patient’s perception of the hospital’s concern for their wellbeing through post-acute care follow-up on behalf of the hospital.
  - Improves HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores for understanding of discharge instructions by having EMS providers review instructions in the home with patient and their family.

Revenue Generation
- Enhances Referrals:
  - Hospitals today want to partner with home care agencies who can help assure patients have safe transitions to avoid preventable ED visits and readmissions.
  - A home health/EMS partnership helps reduce these occurrences and has resulted in increased referrals to the high performance home care agency.

Cost Savings
- Reduces Penalties:
  - Partnering with EMS on care coordination for patients on service with the home care agency helps avoid preventable ED visits and hospital admissions.
  - Care coordination with the home care agency can occur on scene through medical interventions and care transition to the home care personnel to avoid a preventable ambulance transport to the ED.

Enhances Efficiency:
- The EMS agency can notify the home care agency if they are transporting a patient on service to the hospital, avoiding a no show visit and enhancing schedule efficiency.
- An EMS agency can also serve as a reliable and readily available back-up provider at the request of the home care agency for patient visits if a patient requests an episodic visit after hours, or during peak demand times.

Care Coordination
- Notification of Patient Transport:
  - The EMS agency can notify the home care agency in the event of a patient transport to allow the home care agency to contact the hospital and/or the patient and help assure the patient returns to service by the home care agency when discharged.
Cost Savings
- Reduces expenditures for preventable ED visits.
  - Identification and proactive management of super utilizers.
  - Effective navigation of patients accessing 911 with low acuity medical condition through the in-network healthcare resources.
- Reduces expenditures of preventable hospital readmissions through safe transitions.
  - Improves understanding of discharge instructions by having EMS providers review instructions in the home with patient and their family.
  - Enhanced access to 24-hour episodic care through the EMS provider.
- Enhances Health Effectiveness Data and Information Set (HEDIS) measures.
  - Improves proper Emergency Department Utilization by allowing non-emergent patients to be scheduled and taken to proper in-network treatment centers, such as primary care offices or urgent care centers.
  - Decreases rate of readmission through post-discharge follow-up visits by EMS.

Revenue Generation
- Enhances promotion of insurer's health plan by partnering with a trusted community provider.
  - Utilizes enhanced 24/7 medical services available through the local EMS agency.

Enzymes Care Experience for the Patient
- Aligns Incentives.
  - Many patients who call 9-1-1 can have their medical need met at an alternate destination, which may be more patient-centered for the patient and be able to provide follow-up care.
  - Safely navigating patients to the most appropriate medical resource, including 9-1-1 Nurse Triage at call intake or transport to alternate destinations, can enhance the patient's experience of care and improve outcomes through effective care coordination.

Cost Savings
- Reduces Acute Care Expense.
  - EMS agencies are paid by Medicare to transport patients to an ED.
  - An ambulance trip to the ED often results in significant additional expense to Medicare.
  - Medicare payment for things like 9-1-1 Nurse Triage, or transport locations other than ambulance transport to an ED, could reduce expenditures of preventable, high cost ED visits.
  - Medicare coverage for preventive services provided by EMS agencies could reduce the expenditures for both ambulance and high-cost ED visits.

Care Coordination
- Enhances Care Across the Continuum.
  - An EMS agency can provide timely post-acute care transition safety by conducting a post-discharge in-home safety, risk and medical assessment for sharing with the patient's medical care team.
  - On a 9-1-1 call, an EMS agency can assess a patient, and if a low acuity medical event, contact the patient's PCMH for assistance with determining the most appropriate care transition for the episode.
Achievement of Community Benefit Mission

- Enhances Community Health.
  - EMS 3.0 has demonstrated the ability to enhance access of medical care in the community by using existing EMS resources in new roles such as prevention, patient navigation and primary care services.
  - Foundation funding of these programs can reflect favorably on the mission of the foundation in the community and allow the foundation to address the problem with effective solutions.
- Demonstrates Enhanced Patient Outcomes.
  - EMS 3.0 programs effectively reduce the frequency of ED visits and hospital admission by high utilizers of the emergency care system and people with complex medical conditions.
  - Often, these patients receive uncoordinated, episodic care.
  - The use of EMS as a trusted and reliable community care partner, for the prevention of acute care services and the appropriate and safe navigation of patients through the healthcare system has demonstrated improved patient outcomes.
- Reduces Healthcare Expenditures.
  - Effectively using EMS to help prevent acute care utilization, navigate patients who access 9-1-1 services to the most appropriate care setting, and provide timely post-acute care follow-up has demonstrated savings to the healthcare system.
  - The Foundation will generate perceived value in the community by funding the EMS initiatives and demonstrating a return on the foundation’s investment.

Enhances Wages and Benefits

- Creates new sources of revenue to support livable wages.
- Enhances the professional value of EMS and its compensation.

Enhances Working Conditions and Job Satisfaction

- Lowers stress as patient interactions shift from crisis management to preventative and coordinated episodic care in a familiar environment.
- Reduces stress and strain on the workforce due to lower transport rates of patients, decreasing lifting demands.
- Greater emphasis on adaptation skills by Paramedics and EMTs.
- Instant gratification by viewing first-hand patient care results.

Provides Job Security and Longevity

- Offers new career opportunities within EMS.
- Positions EMS as a valuable provider in the continuum of care.
- Creates additional value to EMS work unit by creating additional functions to be performed.
- Adapts to changing healthcare market and patient expectations.
Accountable Care Organizations (ACOs)

Cost Savings
- Reduces expenditures for avoidable care.
- Working with high utilizers decreases the cost associated with ED visits.
- Decreasing payments for Emergency Service including the ambulance transport.
- Decreasing unnecessary hospital admissions by community paramedic interventions for the patient after the ED visit.
- Finding alternate sources for care in the community.
- Utilizing community resources.
- Connecting patients with community resources that are in existence and are currently funded, socialize the members and access for support.
- Alignment with alternative care sites.
- EMS works to find alternative care sites for needs that are more scheduled.
- Connection.
- 24/7 ability to connect with care provider.
- Access to dispatching system to alert the care provider of the 9-1-1 call.

Care Coordination
- Care directed to patient.
  - EMS provider will connect with patients during their enrollment to understand their behavior and patterns.
  - CP will arrive at ED, skilled facility, hospital of choice changing current practice but providing alternatives.
  - Connect with pharmacies to understand medication practice and ensure adherence.
  - Connect with home health to develop comprehensive plan for patient.
  - Provide alternate connection points such as telemedicine on non-emergent phone number.
  - Many projects and innovative concepts being researched currently.
  - Partnership and introduction of community resources that are available and some not utilized.

Alignment to the ACO Attributed
- Referral management.
  - Develop plan and outline of care community for patient to ensure continuity of care. The EMS/COP will work with the PCP to direct care in the most appropriate place and setting to ensure communication portals are aligned.
  - Consistent follow-up by completing brief ‘pop-ins’ to assess compliance and health status.

State Medicaid Offices

Enhances Care Experience for the Patient
- Aligns Incentives.
  - Many patients who call 9-1-1 can have their medical need met at an alternate destination, allowing for patient-centered care and follow-up.
  - Safety navigating patients to the most appropriate medical resource, including 9-1-1 Nurse Triage at call intake or transport to alternate destinations, can enhance the patient's experience of care and improve outcomes through effective care coordination.

Cost Savings
- Reduces Acute Care Expense.
  - EMS agencies are paid by Medicaid to transport patients to an ED.
  - An ambulance trip to the ED often results in significant additional expense to Medicaid.
  - Medicaid payment for things like 9-1-1 Nurse Triage, or transport locations other than ambulance transport to an ED could reduce expenditures of preventable, high cost ED visits.
  - Medicaid coverage for preventive services provided by EMS agencies could reduce the expenditures for both ambulance and high-cost ED visits.

Care Coordination
- Enhances Care Across the Continuum.
  - An EMS agency can provide timely post-acute care transition safety by conducting a post-discharge in-home safety, risk and medical assessment for sharing with the patient's medical care team.
  - On a 9-1-1 call, an EMS agency can assess a patient, and if a low-acuity medical event, contact the patient's PCMH for assistance with determining the most appropriate care transition for the episode.
Follow the $$

- Who’s at risk for the cost/spend
- Who makes the **VALUE** decision
- Don’t talk to mid-level managers
  - Perceive this ‘work’ without reward
  - CFO buy in key
Takeaways...

• Our external environment is changing
• WE have to prepare
• Know your cost of delivery
• Know your \textit{VALUE}
• Try new models
• Follow the money!!
  \begin{itemize}
  \item \textit{Who is at risk for the expenditure?}
  \end{itemize}
EMS
Metamorphosis
thank you!