

Addressing EMS issues for federal EMS agency heads, state EMS directors, EMS chiefs, EMS department heads, agency owners, leading manufacturers and national EMS association leaders

WHAT'S IT TO YOU?

What could healthcare reform mean to the ambulance industry? It's hard to tell, but here are some possibilities

With so much still up in the air (and more than 20 states suing over its constitutionality), all we can really do at this point is look at what could happen under the Patient Protection and Affordable Care Act.

Here are some of the changes healthcare providers and suppliers may see over the next few years.

- **More insured:** The bill's main objective is to provide access to insurance coverage for all Americans and legal citizens. Generally, reimbursement for ambulance services is higher for insured individuals than for uninsured; therefore this should have a positive financial impact on ambulance providers.

- **Required coverage:** Employers with 50 or more employees must offer healthcare coverage or face penalties. If you are a private service with more than 50 employees not currently offering health insurance to your employees, now might be a good time to begin shopping for policies.

- **Expanded Medicaid:** Medicaid coverage is expanded to individuals with incomes up to 133% of federal poverty guidelines. Medicaid may be an exception to the rule about insured individuals having higher claims payments than the uninsured. Depending on your state, having more people covered by Medicaid may not have much impact on your overall reimbursement.

- **Medicare bumps:** The bill extends the 2% urban and 3% rural and super-rural bonuses for ground ambulance providers. Increases are retroactive to January 1.

- **Bundling pilot:** The bill establishes a Medicare pilot program to develop and

evaluate bundled payments between different providers for episodes that begin three days before hospitalization to 30 days following discharge. This does not sound promising to me—it smacks of Part A PPS payments to skilled nursing facilities, where the money goes to the SNF and we have to beg to get paid after we finally figure out the claim should not go to Part B.

- **Medicare Advantage:** The bill restructures payments to Medicare Advantage plans by setting them to different percentages of Medicare fee-for-service (FFS) rates: higher payments to areas with low FFS rates, and lower payments for areas with high FFS rates. This could potentially raise ambulance rates in some geographic areas while reducing them in others.

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- **Productivity adjustments:** For Medicare providers, these adjust annual reimbursements downward with a presumption that providers become more efficient over time. EMS is a difficult provider group to apply any type of "productivity" assessment to. Hopefully this will be taken into account.

- **Preventable readmissions:** Medicare payments to hospitals are reduced for preventable readmissions. Given the difficulties same-day readmissions can have on payment of multiple ambulance claims (one set is often denied as a duplicate or Part A claim), this could be beneficial to us.

- **Prevention and wellness:** This bill emphasizes prevention and wellness activities. As employers in a physically

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demanding profession, I'd think we would benefit from a focus on healthy employees.

- **Pinching pennies:** The bill increases programs and incentives to prevent waste, fraud and abuse. At a time when ambulance providers have experienced a significant increase in audits, the promise of even more scrutiny for overpayments (i.e., "abuse") is not welcome. Ambulance services caught up in these reviews often find themselves in extreme financial difficulty even if they are eventually vindicated.

These are some high points. I wish I had a clearer view of the future, but much of the final analysis will have to wait until we see how the provisions are handled by HHS. As this happens, we'll talk again soon! ◀

—G. Christopher Kelly, JD

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HERE TO SEE THE BABY

Colorado service taking proactive care to the people with community medic program

Numbers are never the whole story, but chew for a moment on these: In Colorado, 80% of emergency department visits in 2008 were for things other than true medical emergencies. Some of those folks may not have had a choice; 52 of the state's 64 counties are fully or partially designated as "health professional shortage" areas. In 2007, nearly 14% of Coloradans couldn't see a physician due to cost.

What can EMS do about that? In Eagle County, they're embracing the concept of community paramedicine. That means sending EMS providers out to proactively help citizens with routine care so they don't have to call 9-1-1 or see a physician for it.

The county is a good place to test such a premise. While home to Vail and numerous high-end ski resorts, Eagle's western end—the 1,100 square miles west of Wolcott served by the Western Eagle County Ambulance District (WECAD)—is more medically underserved than you might suspect from a look at a map.

"We don't currently have a hospital in our area, so we have to drive about 32 miles, on average, to our hospitals," says WECAD Chief Chris Montera. "The average price of a house here is \$720,000, and the median is \$1.4 million, but our area has a 46% uninsured rate. We're kind of a bedroom community to the ski resorts, and we have people who make too much to qualify for federal programs, but not enough to get health insurance."

In such a setting it makes sense to help people with their most manageable issues before they seek ED trips for them. That can prevent problems from occurring and worsening, thus helping

control demand; it makes good use of talented medics, so often capable of more than they're utilized to do; and it's been associated elsewhere with better health outcomes and cost savings.

Needs and Goals

WECAD is the second system to use a community paramedic curriculum developed by the North Central EMS Institute. Based on best practices from similar programs in places like Canada and Australia, it's a flexible model that can be customized to state or local requirements.

The curriculum consists of two phases. The first covers foundational skills, with didactic instruction in advocacy, outreach and public health, performing community assessments and developing strategies for care and prevention. The second phase is training in clinical skills. WECAD added extra lab hours.

Since Eagle County recently completed a community health assessment, county officials have a pretty good idea of its needs, and that public-health perspective informs the WECAD program. Priority areas include infant and child wellness (community medics will do things like immunizations and well-child checkups); chronic diseases and their management (medication compliance checks, equipment maintenance, etc.); and oral and dental health (no dentistry, but basic education and assistance). Everything is within the state's paramedic scope of practice. Other anticipated activities include things like posthospital follow-up, blood draws, wound care, suture removal, fall prevention and other efforts for vulnerable populations.

Rural, International Conferences This Summer

Who goes to Vail in the summer?

Maybe not skiers, but in August there will be plenty of reason for certain representatives of the EMS community: The city will host consecutive educational gatherings for those with rural and underserved populations.

From August 9–11, the sixth International Roundtable on Community Paramedicine (IRCP) will be held at the Manor Vail Resort. Then, from August 11–13, the Critical Illness & Trauma Foundation (CIT) will host its Summit at the Divide examining rural and frontier EMS and trauma issues.

Community paramedicine was born in places like Canada and Australia, but is

beginning to trickle into the States—in particular at the far end of Eagle County, where Vail is located. Western Eagle County Ambulance District Chief Chris Montera talked about his service's new program at last year's IRCP in New Zealand, and now, with its community medics nearing street-ready, WECAD has home field honors for this year's event.

"I got to meet people last year who were really interested in community paramedicine and learn from their experiences," says Montera. "They're all very interested in our program because of all the community paramedic programs that have been started internationally, none have really been able to tap into that

public health piece. That's a goal for us: making sure our outcomes have kind of a public health flavor to them."

The Summit at the Divide is geared for a diverse audience from federal and state policy makers to local EMS managers, hospital administrators and individual providers. The fourth in the CIT's Summit Series, its theme this year is "Beyond Old Boundaries—Exploring New Frontiers."

The agenda includes areas like prehospital ultrasound, STEMI systems, pediatric trauma, communications and long-distance learning. CIT Research Director Teri Sanddal will discuss the findings of a study of preventable mortality

SURVIVING REGIONALIZATION

What's the blueprint for small, rural community systems?

The program is 100% physician-led and -driven. "When a community paramedic goes into a home," says Montera, "it will be physician ordered, much like a consult. We can come in for some kind of follow-up care and see the patient in their environment, which physicians don't get to do. Then we'll send our notes back and make sure there's continued care."

The Eagle County effort is a five-year project with five distinct goals: 1) to reduce rehospitalizations by 50% for patients seen post-discharge; 2) to ensure all patients in the program have medical homes; 3) to calculate cost savings and compare them to the cost of ongoing/hospital care; 4) to promote injury prevention and try to determine its financial benefit; and 5) to deliver vaccinations and public health visits.

"We were part of the flu vaccination program this past year, and our paramedics worked shoulder-to-shoulder with public-health nurses," notes Montera. "We thought, *This is a great idea! Why aren't paramedics giving vaccinations all the time?* It's in our scope, and it's something very easy paramedics can be doing in homes."

For more on the program, see www.wecadems.com/cp.html. ◀

within the Utah emergency trauma care system.

"While Utah has shown outstanding leadership in supporting the development of an inclusive and integrated trauma system," says CIT chief Nels Sanddal, "we found there is really a long way to go in terms of actualizing the infrastructure for that system. There are opportunities for improvement that impact the prehospital phase, the early phases at local community hospitals, and on up the chain. Even in the Level 1 and 2 trauma centers, there are ways we can better care for injured patients."

For more: www.ircp.info, <http://eu.montana.edu/summit>. ◀

Regionalization has been a hot concept in emergency care in recent years, but it's not always an idea that's appealing to everyone.

"From a rural perspective, regionalization has historically meant losing something—a post office, a school, whatever it may be," says Nels Sanddal, MS, REMT-P, CEO of the Montana-based Critical Illness & Trauma Foundation (CIT), which works to research and reduce injury and illness among rural Americans. "There's a lot of resistance to the idea. We need to help our rural constituents understand it doesn't mean centralization, but it means access to additional resources and the better organization of resources within rural communities to meet the needs of emergent patients."

Achieving the right blend of rural and urban capabilities,

and sufficient connectivity between them, is an ongoing challenge. States wrestle continuously with integrating prehospital, hospital and specialist care in their rural areas and creating systems to get patients the right care in the right place at the right time.

Such systems typically involve moving patients upstream, from smaller community resources to higher-level trauma centers or specialty care. But just as important is movement the other way—particularly to the ends of financial responsibility (which precludes needless transfers and interventions) and the survival of smaller rural institutions.

"In some cases, it's even more important to get that expertise downstream, through televideo and telehealth kinds of applications, to help make decisions about whether patients can be treated within local facilities," says Sanddal. "A good example is small head bumps. If you don't have a neurosurgeon or neurologist available within a local hospital—and 99.9% of those small critical access

hospitals don't—but you can do a CAT scan and send it to be evaluated, I think over time we can reduce unnecessary transfers, keep patients closer to their homes and families and friends, and still have great outcomes. It's about integration, and the two-way sharing of resources and communications."

The CIT conducts a lot of work toward ends like that, and has current efforts focused on related areas. On one project, the foundation is working with a multi-facility healthcare system in a western state to develop a "trauma system within a trauma system." The goal is that patients who enter the stream at any of the system's 17 facilities—which range from maximally capable Level 1

trauma centers to modest Level 5 clinics—can be evaluated and moved, smoothly

and quickly, to whatever level of care is most appropriate for them.

"They want to ensure that patients, regardless of where they enter that system, receive optimal care," says Sanddal, "and that the requirements for transfer and all the barriers and impediments have been dealt with, so patients can flow easily between and among those facilities."

The CIT's also working on a decision-making schema to help guide destination decisions for critically injured patients. There are a lot of factors to consider.

"It depends on the patient's acuity, the level of training of the prehospital care providers, the level of expertise available at the local facility, what the next nearest facility's level of expertise is, and what the options for critical care transport are," says Sanddal. "We're excited about creating something to help local facilities and EMS providers make decisions that allow for the best utilization of resources for those most critically injured patients."

For more, see www.citmt.org. ◀

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