

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 35(20)

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SUBJECT: Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care

PURPOSE: Take a leadership role to ensure inclusion of prehospital care as a seamless component of health care delivery, rather than a transport mechanism; advocate for bidirectional data integration between hospital and EMS; advocate for appropriate payment of EMS services to include clinical services separate from transport; advocate for payment structure for EMS medical direction and oversight; advocate for support to NHTSA Office of EMS; and collaborate with other stakeholders to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of health care delivery.

FISCAL IMPACT: Budgeted staff resources to convey ACEP’s position to federal Executive and Legislative branch officials.

1 WHEREAS, In 2016, The National Academy of Sciences published “A National Trauma Care System:
2 Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury” Recommendation
3 10: Congress, in consultation with the U.S. Department of Health and Human Services, should identify, evaluate, and
4 implement mechanisms that ensure the inclusion of prehospital care (e.g., emergency medical services) as a seamless
5 component of health care delivery rather than merely a transport mechanism; and
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7 WHEREAS, EMS operates at the intersection of healthcare, public health, and public safety and integration
8 across the continuum of care delivery is essential to optimizing patient outcomes and to managing costs effectively; and
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10 WHEREAS, Through an estimated nearly 26 million transport calls annually, prehospital EMS care is delivered
11 directly to patients, in the locations where help is needed, providing a measurable effect on mortality to certain life-
12 threatening medical emergencies; and
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14 WHEREAS, EMS agencies are forced to limit services because of poor reimbursement, which leads to extended
15 delays for interfacility transports particularly in rural areas; and
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17 WHEREAS, The groundbreaking work of innovative EMS clinicians to deliver healthcare as Mobile Integrated
18 Health or Community Paramedicine programs has demonstrated the benefit of these mobile providers of healthcare to
19 improve health and decrease cost of more conventional healthcare delivery models; and
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21 WHEREAS, Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year trial payment model, in
22 which the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and clinicians to:
23 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations; 2)
24 transport to an alternative destination partner; or 3) provide treatment in place with a qualified health care partner, either
25 on the scene or connected using telehealth, and as a result, the ET3 model aims to improve quality and lower costs by
26 reducing avoidable transports to the ED and unnecessary hospitalizations following those transports; and

27 WHEREAS, EMS has demonstrated during the COVID-19 pandemic their ability to respond in new and
28 innovative ways to deliver medical care to include telehealth platforms, assisting with disease screening and testing, treat
29 and non-transport protocols, and providing immunizations; and
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31 WHEREAS, EMS has stood with our emergency department partners on the front lines to provide care in this
32 pandemic and countless other disasters and EMS should be reimbursed for these services both within and outside of
33 pandemic response; and
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35 WHEREAS, The Department of Transportation National Highway Traffic Safety Administration (NHTSA)
36 Office of EMS (and its precursor entities) has been the only federal agency to provide continuous support to the national
37 EMS systems development since the publication of the paper, “Accidental Death and Disability: the Neglected Disease of
38 Modern Society” by the National Academies of Sciences in 1966; and
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40 WHEREAS, The NHTSA Office of EMS has led the development and maintenance of the National EMS
41 Information System (NEMSIS), the standardized repository for all EMS clinical care records; and
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43 WHEREAS, The evolution of the healthcare system in the United States, to include the integration of prehospital
44 care as an outcomes-driven, appropriately remunerated, patient-centered element, will require the shared efforts of all
45 relevant stakeholders, including professional organizations (ACEP, NAEMSP, ACS-COT, NAEMT, AAA, NASEMSO,
46 etc.) and governmental agencies (NHTSA, DHS, DHHS, DOD, FCC, CMS, HRSA, etc.); and
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48 WHEREAS, Emergency physicians are leaders in prehospital care, serving as medical directors, systems
49 directors, educators, and as care providers and they should play an integral role in evolution of the healthcare system as it
50 seeks to integrate prehospital care as a seamless component; and therefore be it
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52 RESOLVED, That ACEP take a leadership role to ensure the inclusion of prehospital care (e.g., emergency
53 medical services) as a seamless component of health care delivery rather than merely a transport mechanism; and be it
54 further
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56 RESOLVED, That ACEP advocate for bidirectional data integration between hospitals and EMS; and be it
57 further
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59 RESOLVED, That ACEP advocate for appropriate payment of EMS services to include all clinical services
60 separate from transport; and be it further
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62 RESOLVED, That ACEP advocate for the development of a payment structure for EMS medical direction and
63 oversight including physician field response; and be it further
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65 RESOLVED, That ACEP advocate for additional support to the National Highway Traffic Safety Administration
66 Office of EMS to allow for further federal leadership of EMS systems development and evolution and expansion of the
67 National EMS Information System; and be it further
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69 RESOLVED, That ACEP collaborate with other stakeholder organizations to promote legislation that will allow
70 for the integration of reimbursed prehospital care into a seamless patient-centered system of healthcare delivery.

Background

This resolution directs ACEP to take a leadership role to ensure inclusion of prehospital care as a seamless component of health care delivery, rather than a transport mechanism; advocate for bidirectional data integration between hospital and EMS; advocate for appropriate payment of EMS services to include clinical services separate from transport; advocate for payment structure for EMS medical direction and oversight; advocate for support to NHTSA Office of EMS; and collaborate with other stakeholders to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of health care delivery.

The essence of this resolution revolves around the role ACEP should play in the development and support of the Mobile Integrated Healthcare/Community Paramedicine (MIH/CP) model of patient care. ACEP's legislative and regulatory priorities currently include working to promote appropriate guidelines and procedures for community paramedicine.

In June 2016, the ACEP MIH/PC Task Force developed an [information paper](#) on these issues. As stated in the primer: "Mobile integrated healthcare and community paramedicine (MIH/CP) is a term applied to a new model of community-based health care service delivery that often primarily uses emergency medical services (EMS) personnel and systems to provide acute medical care, coordination of services, healthcare maintenance, post-acute care, and prevention services to patients outside of routine EMS transport service to hospital destination care." While each community may have unique needs that may benefit from various aspects of this health care delivery model, there are several core services this model is designed to address – chronic disease management and injury prevention, reduced 911 requests and transports for non-urgent patients, and the ability to provide appropriate follow-up care for high-risk patients without hospital readmission. Since EMS services in the United States are essentially reimbursed only when an appropriate transport to a hospital, skilled nursing facility (SNF), or for renal dialysis treatments are provided, the MIH/PC model also seeks to derive reimbursement for these alternative services.

Proponents of the MIH/PC model suggest patients' health would be improved by helping them manage their chronic diseases, such as diabetes, high blood pressure, and high cholesterol, as well as reducing common injuries. This would be achieved through home visits/wellness checks to verify compliance with prescription medications and simple home improvements to prevent accidents. The MIH/PC model would also decrease "down time" between EMS calls and improve access to primary care services, especially in rural communities where many patients lack access to primary care and use 911 and EMS to receive health care services in non-emergency situations. Additional benefits of an MIH/PC model would be improved patient satisfaction with their overall health care experience and improved access to timely early warning signs of worsening conditions. Finally, by reducing non-emergency transports, it is argued that the system is keeping those resources available for true emergencies.

The Center for Medicare and Medicaid Innovation (CMMI) within the HHS' Center for Medicare & Medicaid Services (CMS) has established a demonstration program, the "Emergency Triage, Treat, and Transport (ET3) Model," to test the MIH/PC system and its potential benefits to Medicare beneficiaries and the Medicare program overall. ET3 is a voluntary, five-year payment model designed to "provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call." Under this model, CMS will reimburse Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers to either: (1) transport the patient to a hospital ED or other covered destination (see above), (2) transport to an alternative destination partner (primary care/urgent care), or (3) provide treatment in place with a qualified health care partner (either on the scene or connected using telehealth). These determinations would be made by establishing a medical triage line for low-acuity calls within an existing 911 dispatch operation.

As a result, the ET3 model "aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports." Any individual who calls 911 and is connected to a dispatch system that has incorporated a medical triage line under the model would be screened for eligibility for medical triage services prior to ambulance initiation. Upon arriving on scene, participating ambulance suppliers and providers may triage Medicare FFS beneficiaries to one of the model's interventions upon ambulance dispatch following a 911 call.

During the development of ET3, ACEP submitted comments to CMMI about important patient safeguards that should be incorporated into the model. Specifically, ACEP stated "all triage, treatment, transport, and destination decisions should be through direct oversight with EMS medical director physicians." While acknowledging the health care providers delivering these services should be credentialed by their participating EMS system's clinical oversight body, ACEP urged the model to "require the highest level of consult available, ideally with the EMS physician who is substantively familiar with resources available to the EMS system in the area it serves." ACEP further urged CMMI to require all EMS system applicants "to attest in their application that they will commit, attain, and maintain contemporaneous direct medical oversight by physicians board-certified in EMS Medicine." Finally, understanding that aspects of the demonstration project will likely change over time, ACEP highlighted one essential aspect that must remain – "proper safeguards for patient safety and responsible triage, treatment, transportation, and destination decisions obtained with continuous EMS medical director physician oversight."

The ET3 model was supposed to begin on May 1, 2020 but has been delayed until the fall because of COVID-19.

ACEP has long acknowledged the critical role EMS, and EMS physician medical directors, play as an integral component in the continuum of acute medical care. According to ACEP's "[Emergency Medical Services Interfaces with Health Care Systems](#)" policy statement: "EMS plays an essential role in the clinically effective, fiscally responsible regionalization of healthcare, providing acute medical assessment and interventional care contemporaneous with navigation of patients. Patients, particularly those with time-critical conditions, are best served in geographically appropriate health care facilities having the specialized capabilities and services, either on site or via appropriate communications modalities, required for their evidence-based, optimal clinical outcomes. Appropriate funding of coordinated continuum of care systems (e.g., trauma systems) is essential to promoting the availability of regionalization of healthcare. EMS systems must have significant involvement, funding, and leadership decision-making authority in any regionalized system of healthcare to best provide necessary out-of-hospital acute assessment and care to patients, including safe, timely navigation of patients. EMS destination protocols must be constructed with the substantive leadership of the EMS system's physician medical director(s), always based primarily upon evidence-based clinical rationale, factoring geographical operational realities."

While appropriate physician oversight/supervision remains a core concept for ACEP, other factors that may be relevant for consideration by the ACEP Council regarding the long-term viability of these programs are financing, liability, the Prudent Layperson Standard (PLS), and the Emergency Medical Treatment and Labor Act (EMTALA).

Generally, where MIH/PC models currently exist, they are funded by grants or subsidized by hospital or other health care entities as cost saving vehicles, particularly in response to bundled payments and formation of Accountable Care Organizations (ACOs). As mentioned previously, CMS/CMMI is about to undertake the ET3 demonstration and while the administration of the program will be funded through normal federal appropriations, reimbursement for the services provided for either alternate transportation or on-site treatment will come from the Medicare Trust Fund. There is no current long-term model for financing these programs and no standardized reimbursement for MIH/PC activities at the federal level.

Since paramedics and EMTs provide health care services under the EMS physician medical director's license, the expanded practice roles for EMS physician medical directors involved with MIH/PC likely will require different malpractice coverage. The expanded services addressing wellness, prevention, care for the chronically ill, post-discharge care, social support networks, and increasing compliance for a local population. In addition to the potential added liability these services may create, the actual role of providing medical direction for an MIH/PC program may not be covered under the EMS medical director's traditional insurance plan.

Regarding PLS and EMTALA, ACEP has stressed that patient safety must always be the primary defining element when considering alternatives to ambulance response, ambulance transportation, and/or non-emergency department destinations. Per ACEP's "[Patient Autonomy and Destination Factors in Emergency Medical Services \(EMS\) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs](#)" policy statement: "Patients utilizing a prudent layperson standard of a medical emergency accessing emergency care via 911 (or equivalent) public safety answering points with acute, unscheduled, and undifferentiated medical conditions should be transported to an emergency department with clinical capabilities consistent with emergency care needs. Similar patients, but with stable, differentiated medical conditions that may be suitable for transportation to a destination other than an emergency department (e.g., mental health facility, sobering center, physician's clinical office) must be afforded at that alternative destination a medical screening exam (MSE) and stabilizing treatment by a qualified medical professional in accordance with [EMTALA]."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted staff resources to convey ACEP's position to federal Executive and Legislative branch officials.

Prior Council Action

Resolution 34(13) Community Paramedicine adopted. Directed ACEP to develop a policy statements on the definition of community paramedicine and the role of the pre-hospital provider in community paramedicine; develop guidelines and standards and a clinical model.

Prior Board Action

June 2018, approved the policy statement "[Patient Autonomy and Destination Factors in Emergency Medical Services \(EMS\) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs](#);" replacing the following rescinded/sunsetted policy statements: Alternate Ambulance Transportation and Destination (2001-2018); Medical Direction of Mobile Integrated Healthcare and Community Paramedicine Programs (2014-2018); and Refusal of Medical Aid (2000-2018).

June 2018, approved the policy statement "[Relationship Between Clinical Capabilities and Medical Equipment in the Practice of Emergency Medical Services Medicine](#)."

February 2018, approved the policy statement "[Emergency Medical Services Interfaces with Health Care Systems](#);" replacing the following rescinded policy statements: Ambulance Diversion (1991-2018); Emergency Ambulance Destination (1983-2018); EMS Regionalization of Care (2013-2018); and Interfacility Transportation of the Critical Care Patient and Its Medical Direction (1999-2018).

October 2017, approved the policy statement "[The Role of the Physician Medical Director in Emergency Medical Services Leadership](#);" replacing the following rescinded/sunsetted policy statements: Leadership in Emergency Medical Services (1995-2017); Medical Direction for Staffing of Ambulances (1999-2017); Medical Direction of Emergency Medical Services (1984-2017); Physician Medical Direction of Emergency Medical Services Dispatch Programs (1998-2017); and Professional Liability Insurance for EMS Medical Control Activities (1985-2017).

June 2016, reviewed the information paper "[Mobile Integrated Healthcare/Community Paramedicine \(MIH/CP\) Primer](#)."

Resolution 34(13) Community Paramedicine adopted.

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