McBee High School
Learning Packet

Dates:	3/23/20 – 4/3/20
Thematic Topic:	The COVID-19 Pandemic
Subject:	EMS
Teacher Contact Info:	Nita Coleman mcoleman@chesterfieldschools.org
Essential Concepts:	To understand the impact COVID-19 has on the healthcare system and EMS.
Materials Needed:	Pen and Paper
Online Links:	http://www.naemt.org/WhatsNewALLNEWS/2020/03/22/the-gatekeepers-how-ems-will-save-the-u.s.-healthcare-system dictionary.com
Assignment Steps:	Week 1 -Read the Article -Define the following words and abbreviations 1. Community Paramedicine 2. Medical Directive 3. Healthcare System 4. PPE 5. CMS Week 2 -Write a 2-paragraph summary of the article. First paragraph should be about the article. Second paragraph should be your opinions on how community paramedicine could prevent unnecessary trips to the emergency room. For those of you able to log on to the internet you can send me your work via email in a word document. I hope everyone is safe and well. I miss you all so much!!!

The Gatekeepers: How EMS Will Save the U.S. Healthcare System

Mar 22, 2020 *Matt Zavadsky, MS-HSA, outlines the path ahead for EMS in the new normal, community paramedicine's role, and his talks with CMS about treat-no-transport reimbursement*

As COVID-19 continues its spread in the U.S., infectious disease and public health experts are modeling the future impact on the American healthcare system. Even mid-level projections illustrate a stark reality of not enough – not enough resources, not enough healthcare personnel and not enough hospital beds.
I spoke with Matt Zavadsky, MS-HSA, EMT, chief strategic integration officer for MedStar Mobile Healthcare in Fort Worth, Texas; chair of the NAEMT EMS Transformation Committee; and the president of NAEMT, about the future of EMS.

According to Zavadsky, the reality is there are two paths ahead for the role of EMS in our "new normal." The first is utilizing specially trained, expanded-role personnel – community paramedics – to keep people safe at home. "That's been the goals of many of these [community paramedic] programs since they started, and the involvement in the COVID-19 crisis is no different," he said.

What does that look like?

Some systems, like the Renfrew County, Ontario, Canada EMS system, are using their community paramedic program to conduct in-home specimen collection for COVID-19 testing, after initial screening by a nurse at the Renfrew County and District Health Unit. This prevents potentially sick patients from traveling to other locations for testing, providing a much safer process.

MedStar, and many EMS systems across the country, are receiving an increasing number of calls from people who think they have COVID-19 but don't have priority symptoms. "We probably don't need to send an ambulance to those people, and they certainly don't need to go to the emergency room," Zavadsky said.

A community paramedicine response can rule out high-acuity concerns with an assessment within an hour or two. While not historically prevalent in the U.S., it's common practice in many other countries, Zavadsky noted.

Once people are diagnosed with COVID-19, and they are quarantined, community paramedics can also perform home checks once a day, allowing them to be monitored from their homes.

"This could be a very good time to show the value of specially trained paramedics in the community, managing patients to help keep them out of the hospital. Mobile, trusted resources in the community could fill that role very appropriately," Zavadsky related. This is an incredible opportunity for the EMS profession. We can show the public health officials, the hospitals, the payers, what we've been trying to drive home for the past 20 years, which is that we have a standing army of medical providers in the community, who just happen to be on fire trucks or ambulances, who can relatively easily navigate these patients."

The economic impact of EMS as the gatekeepers

That's all one path. The second path involves the larger EMS system.

MedStar's COVID-19 response procedures starts with a pandemic medical directive from the medical director. The 911 call is managed, just like all 911 calls, with the emergency medical dispatch being derived from the call taker, then, some are directed to a nurse, some might get a community paramedic response, and some might get an ambulance response, depending on the patient's needs. Once the resource arrives, the providers assess the patient, and, if by protocol, there is no need for a hospital transport, they can refer the patient back to their doctor, their patient-centered medical home, or a website where they can get secondary screening to see if they need a COVID-19 test, and schedule it. If, after the assessment, the EMS provider feels an ambulance transport to and ED is required, they can request it.

"Our responsibility today, literally in today's environment, is preserving hospital capacity for people who are really sick," Zavadsky said. "When you look at presidential actions that bring floating hospitals to California and New York, we are the gatekeepers. At Medstar, we are the gatekeepers for about 500 patients a day who call 911." Many of those patients don't need to go to the hospital, and EMS could help make that determination.

Part of the reason why a lot of agencies don't perform this patient assessment screening is because of the economic impact. Ambulance agencies are generally only paid if they transport a patient to the hospital from a 911 call. If an

agency that transports 20, 30, 40 people a day to the hospital and bills for those transports, now, under a new process to help with enhancing healthcare system capacity, only takes one-half, or two-thirds that number to the hospital, that's a significant revenue hit, Zavadsky explained. "But, if they got paid to *not* transport, like Anthem has been trying to do, like ET3 is going to do, then we can do all sorts of things, because we won't have to go back to the taxpayers and ask for more money because of lost transport revenue because we're doing the right thing for the patient and the healthcare system by not taking people to the hospital that don't need to be there."

Lobbying CMS for an urgent change to EMS reimbursement

Wearing his NAEMT president hat, Zavadsky, along with the American Ambulance Association, the Academy of International Mobile Healthcare Integration, the International Association of Fire Chiefs and the International Association of Fire Fighters, has been speaking with CMS and the National Highway Traffic Safety Administration, which have reached out to ask: In a perfect world, what would EMS be able to do to help maintain hospital capacity with COVID-19? How can we leverage EMS to help the healthcare system during this crisis?

There is already a Medicare approved HCPCS code for ambulance response treatment and no transport, it's just never been paid by CMS before, Zavadsky noted: "Flip the switch, turn that payment code on, now we can [provide that patient navigation approach] across the board for any ambulance agency in the country, because we're not going to take a financial hit for that."

On the community paramedicine side, EMS can demonstrate value in this crisis by keeping people out of the hospital and checking on them to make sure they are safe at home, Zavadsky said. "And then, on the larger EMS side, it's time for us to step up, and say, 'You know what, we are healthcare providers; we have medical training; we have assessment, diagnostic skills and tools; let's us use them to help keep the healthcare system from collapsing."

"With the way that our healthcare system has transformed in the last week, with CDC making significant recommendation and policy changes, CMS making significant policy changes and payment model changes, (such as paying for expanded telemedicine services), we, right now, along with the other national stakeholders, have to really message this information both to Congress and the CMS. 'Hey, the latest COVID relief bill is working its way through Congress. Put some funding in that helps us do better for our patients, saves healthcare capacity for the truly sick people – and oh, by the way, can you also write some language in there that makes sure that we get PPE,' so we're really doing that sort of joint collaboration with various national associations that quite frankly is unprecedented."

Changing the CMS payment policy does not require legislation. The Affordable Care Act gives HHS the ability to change payment policy without Congressional approval, which is how CMS is making these changes. So fire/EMS agency leaders need to convince the policymakers at CMS to turn the payment code on. One sign that CMS "gets it," Zavadsky pointed out, is ET3, which may provide an avenue for rollout. "One of our comments to CMS is, at the very least, take the 205 agencies that you've already vetted, that could do this ET3 project – they've given you their alternate destination partners, they've given you their qualified healthcare practitioner/telemedicine partners, they've given you outlines of their implementation plans – approve them now for a 'soft start'. Instead of having to go through all of the contracting and everything, just send them an email and say, 'Hey, whenever you want to start, let us know.'"

Zavadsky credits this progress to the leaders of the organizations who have worked together to lobby CMS – the AAA, AIMHI, IAFC, IAFF and NAEMT. "We really have had the best communication and best joint strategy approach to this issue that we've had in a really long time," he said. "We've got these large national EMS associations that have pretty quickly come under alignment with a lot of things that we're all pushing for together because we've got a common challenge. So, I think it may work."

"This is an unprecedented moment for EMS in our country," Zavadsky noted. And the speed at which some of these developments have unfolded is also unprecedented. He hopes to see the change in CMS billing for non-transport EMS occur in the next week or two. "A month or two from now, it's not going to matter," he said. "If we're going to get what everybody thinks is going to happen over the course of next few weeks, we need to get this implemented pretty fast."

For many organizations, it wouldn't be that difficult to change how providers assess and navigate patients, he noted. Many agencies, like MedStar, are already implementing these measures without the funding in place. "We're doing it, a lot of agencies are doing it," he pointed out, "but we know we're going to take the revenue hit." And, that revenue hit will come at a time when fire and EMS agencies are already facing dramatically increased expenses, as personnel are quarantined or are out sick. "It's a tough swallow when you're trying to do the right thing sometimes, and we're just hoping that the payers will agree that this seems to make sense, and include us in the revolutionary change that is happening in our healthcare system