State Board of Emergency Medical, Fire, and Transportation Services
Mobile Integrated Healthcare
EXECUTIVE SUMMARY

Problem: The healthcare landscape needs to evolve to better address how people access and utilize healthcare resources. The identified concerns include, but are not limited to:

- Some patients' access 9-1-1 and emergency medical services (EMS) frequently for non-emergency issues.
- Many calls for assistance do not require the high acuity resources of an emergency department. There are patients who require medical care that can be adequately delivered or initiated at the site to which the response is dispatched and followed by engagement with an outpatient care resource or transport to a more appropriate destination (e.g. dialysis center, physician's office).
- A growing segment of the population who lack primary medical care resources rely on EMS and emergency departments to access the healthcare system.
- Emergency department utilization for non-emergency medical issues contributes to longer wait times, decreased patient satisfaction, and emergency department overcrowding.
- Hospitals can be penalized financially for patients being readmitted to their system within 30 days from discharge.
- Accountable Care Organizations (ACOs) seek avenues to deliver healthcare in more patient-friendly and fiscally responsible ways.
- The lack of primary care physician resources in Ohio may result in episodic care for many patients rather than continuous monitoring and support for those with chronic illnesses.

What does Mobile Integrated Healthcare solve: Mobile integrated healthcare is a coordinated model of healthcare delivery that utilizes resources that are already well known and trusted in the community; specifically, paramedics, EMS providers, and dispatch centers paired with established outpatient medical service providers and the community's primary care physicians. The inclusion of EMS providers, particularly Paramedics, in this model does not displace visiting nurses, hospice, public health or other professionals and healthcare agencies. Supported by community assessment, mobile integrated healthcare has the capacity to fill the gaps and voids in healthcare needs throughout our state, both in rural and urban landscapes. Mobile integrated healthcare works in collaboration with many agencies and professionals to optimize an individual's health primarily through, but not limited to, the management of chronic disease states. It is also recognized that EMS providers, due to their primary visualization of the residence and interaction with family members, have access to critical information about the status of a patient's home and social environment that hospitals may not have or that a patient may not want to admit is negatively affecting their health status.
The Mobile Integrated Healthcare Committee (hereafter referred to as the Committee), an ad hoc committee of the Ohio Emergency Medical, Fire, and Transportation Services Board, has explored what other states' have implemented with this model of healthcare delivery. States from which we have sought expertise are Minnesota, Texas, Missouri, Pennsylvania, Indiana, and North Carolina. Of these states, Texas and Minnesota currently have the most developed mobile integrated healthcare systems.

What Ohio needs to enable Mobile Integrated Healthcare: EMS in Ohio is regulated by the Ohio Revised Code (ORC) 4765 and the Ohio Administrative Code (OAC) 4765. The definition of EMS in Ohio per ORC 4765.01(G) and ORC 4765.01(H) limits EMS to the delivery of care within the realm of emergency response

care. To enable the creation of mobile integrated healthcare in Ohio, a law change in ORC 4765 is required in order to broaden this definition and incorporate non-emergency care that may not require patient transport and to allow transport to appropriate non-hospital destinations.

The committee views this proposed law change as an avenue to enable, and not mandate, those communities who wish to implement mobile integrated healthcare as a gap-filling or supportive element for their local medical systems. If a community or agency doesn't believe their community will benefit from this type of care delivery model, they do not have to participate.

Finance: The committee recognizes that financial issues are a hurdle. Currently, the reimbursement of EMS by the Centers for Medicare and Medicaid Services (CMS) is linked to patient transport. However, there are multiple initiatives ongoing at the federal level to eliminate this requirement and to potentially create funding support for mobile integrated healthcare systems. It is anticipated that implementing mobile integrated healthcare in Ohio may be a two-step process. First, legislative change will need to be enacted, followed by the identification of viable funding resources. The website CMS.gov contains statistical data and funding information, especially the areas of chronic conditions that may be useful to reduce the existing reimbursement hurdles until amendments in federal policy have been made (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html). In addition, the pending Field EMS Bill (H.R. 809), if passed, will provide support of mobile integrated healthcare at the federal level. Analogous to what has occurred in other states, there may also be ways to partner with hospitals for support of mobile integrated healthcare systems since the 30-day readmission penalties that they soon will face may exceed the costs of including EMS participation. The committee acknowledges that funding is a critical component of this healthcare delivery system; however these challenges are not insurmountable.

Risks of not implementing Mobile Integrated Healthcare: There are many risks associated with not enabling this collaborative model for healthcare delivery. Foremost, EMS providers feel an obligation and a responsibility to the communities they serve and have a sincere desire that all residents and visitors remain as healthy as possible. Without a change in legislation, Ohio will be lagging behind other states in the nation and incongruent with the initiatives at the federal level to facilitate the creation of mobile integrated healthcare systems. The patients in Ohio will continue to receive episodic care instead of cost-effective patient-centered continuous preventative care. The overall cost of healthcare in Ohio will increase while EMS providers, a valuable and untapped resource, will be forced to remain on the sidelines except when they are dispatched for patient transport to an overburdened emergency department. The Patient Protection and Affordable Care Act is emboldening our entire healthcare system to develop innovative ways to deliver quality-driven medical care that is cost-effective. Mobile integrated healthcare is an excellent avenue to achieve this goal and to create a healthier status to the citizens and visitors of Ohio.