1. The Paul Coverdell program funding to NYS to track and improve stroke care (www.cdc.gov/dhdsp/programs/stroke_registry.htm) gave SEMAC and SEMSCO some preliminary feedback from the AHA Get With The Guidelines (GWTG) Stroke database used by 59 of the 120 NYS designated stroke centers to benchmark themselves. Current EMS opportunities for improvement include more consistent documentation of four stroke performance indicators: last known well time, symptom onset time, results of the Cincinnati Prehospital Stroke Scale (CPSS) and blood glucose. Stroke centers report sporadic EMS stroke notification and are often not getting PCRs. They need more than 15 minutes notice to properly scramble their stroke teams. There also seems to be inconsistency across the state in EMS practices related to the window for administration of tPA (clot busting medication), recently expanded past 3 hours. Soooo…
2. The NYS DOH stroke folks recommended several changes to the NYS BLS stroke protocol. These included adding last known well time, changing the critical window for EMS transport time from 2 hours to 3.5 hours, requiring blood glucose monitoring, pre-hospital notification and hospital collection of EMS data. After considerable wrangling over blood glucose monitoring and oxygen administration parameters, the proposal was tabled. In fact, all BLS Protocols are up for review; a group was assembled to commence that process.
3. The Check & Inject NY (syringe epinephrine kit for BLS providers) demonstration project reports 580 agencies enrolled, 18,900 EMS providers trained and 61 epi administrations to patients with no complications. No word yet on if (or how) this massively cost saving program might be made permanent.
4. On the subject of epi auto injectors, it appears that Congress sufficiently embarrassed EpiPen® manufacturer Mylan over its preposterous price increases (a 2-pack went from $100 in 2007 when Mylan acquired the EpiPen brand to nearly $800 today). In December, Lineage Therapeutics rolled out a generic EpiPen called Impax selling for roughly $100 per 2-pack. It looks remarkably similar (www.epinephrineautoinject.com) to an earlier version of the Mylan EpiPen which, of course it is – Lineage Therapeutics is owned by Mylan (duh). Simultaneously, Amedra Pharmaceuticals jumped on the bandwagon with Adrenaclick® another generic epi auto injector (www.adrenaclick.com) that retails for about $140. At least now, there are choices. Check & Inject, however remains considerably cheaper.
5. As though that's not enough news on epi auto-injectors, Section 3000-C of Public Health Law Article 30 (the section on epinephrine auto-injector devices) was extensively rewritten by the legislature. While the revisions have not yet appeared on the DOH web site, they essentially eliminate the need to file a notice of intent, allow prescribers to write a non-patient specific epi auto-injector prescription, and expand the list of eligible persons and entities who can possess and use them to include just about any public facility including amusement parks, restaurants, stores, day care and sports facilities. The revisions take effect March 28, 2017. Even though a notice of intent is no longer required, the Bureau encourages Regions to continue tracking use by EMS agencies.
6. Medical Standards, SEMAC and SEMSCO approved revised NYC ALS Protocols. Med Standards heard an FDNY proposal for a CFR demonstration project adding nebulized albuterol, aspirin and epi-pens to their CFR program. FDNY officials noted that fire arrives first in 50% of high priority calls and is on scene for an average of 3 minutes and 47 seconds prior to EMS. There was an unusually lengthy banter about this proposal but

it was approved. At SEMAC, the FDNY revised their proposed demonstration project to include only albuterol. Both epi and aspirin are already authorized at the CFR level. This change was approved. At SEMSCO, the whole thing blew up. Literally. Firstly, a FDNY Union spokesperson pointed out that the proposal would generate an additional 384 fire runs per day, likely interfering with the FDNY response to fires. Then, the FDNY Uniformed EMTs, Paramedics and Inspectors Local 2507 SEMSCO rep made an impassioned presentation requesting defeat of the proposal and defeated it was. His points included the excessive length (beyond the statutory hours cap) of the FDNY CFR program, lack of enthusiasm for EMS by FDNY firefighters, and the seeming intent to broaden the scope of FDNY CFR to EMT level in lieu of requiring firefighters to be EMTs. The January 11th SEMSCO meeting video is probably worth a watch at www.health.ny.gov/events/webcasts/archive.

7. Could SEMAC Advisories be facing extinction? Maybe. They are, after all, as old as dinosaurs (www.health.ny.gov/professionals/ems/semac_advisories.htm). Advisory 97-03 on Hyperventilation in Severe TBI might best be moved to BLS Protocol as per discussion at SEMAC. That would leave only one man standing (08-01 on Capnography to confirm ET placement). Questions were raised on whether anyone actually reads these lonely advisories. True dat.
8. Revised NYS Regulations require all ALS services to hold a Controlled Substances (CS) License, effective July 31, 2016. In December, the Bureau wrote to 77 ALS agencies without CS licenses giving them until 2/1/2017 to either begin the CS application process or cease operating at the EMT-CC or Paramedic level. Statewide, five agencies have dropped down to AEMT level and four to BLS. 54 agencies have not declared their intentions. One third of these agencies are in a single county. D'oh.
9. On the subject of new stuff, On November 14th 2016, Governor Cuomo signed into law a bill (A03590-B / S05542) amending Executive Law in relation to qualifications to serve as an Emergency Medical Technician (including all levels of certification as well as persons who may provide care or transportation to patients). This law takes effect March 14, 2017 (120 days from signing). The law requires Chief Officers of agencies operating ambulance services to check the sex offender registry when reviewing applications for membership/employment in the organization. Applicants must be notified that their personally identifying information will be checked against the public records of those individuals required to register under article 6-c of the Correction Law (the NYS Sex Offender Registry maintained by the NYS Division of Criminal Justice Services). The law further requires that agencies must make eligibility for membership determinations consistent with Article 23-A of the Correction Law, and that a copy of Article 23-A be provided to the applicant. Agencies should also consider how they will document and maintain their record of when/who called/checked the registry and the result of the search. Sex Offender Registry www.criminaljustice.ny.gov/SomsSUBDirectory/search_index.jsp. Agencies may want to consider adding a notice like this to their membership/employment application: *Notice: EMS agencies in NYS are required by law (Executive Law, Section 837-s) to check applicants (who may be involved in the care or transportation of patients) personal identifying information against the Sex Offender Registry and make a determination of eligibility to become a member/employee pursuant to Correction Law Article 23-A.*

Not to drag this on ad nauseam, but a couple of pearls: firstly, it may be better to have an investigative firm do these background checks. Many ambulance insurance carriers offer discounts on background check services for their clients. Secondly, the fire service is required to do non-fingerprint arson and sex offender background checks. Their law funnels these checks through County Sheriff's Departments via a process established by DCJS (the State Division of Criminal Justice Services). When contacted, DCJS knew nothing of the new law affecting EMS which seems to imply that there was no intent for DCJS or County Sheriff's to help EMS (as they are required to do for the fire service). Lastly, when implemented several years ago, the fire service quickly ran afoul of 23-A which clearly states that a service cannot discriminate based strictly on a conviction. Policies are needed on how a conviction should be handled. The classic fire service example is an 18 year old male in a relationship with a 16 year old female. He is arrested, charged and convicted of a sex crime involving a minor after the girl's parents file a complaint with the police. Despite being a registered sex offender, the couple have since married and have a family together. It would be difficult to deny membership in an EMS agency based solely on this conviction. Complicated? You betcha.

10. NYS Written Exam pass rates for 2016 (for you number crunchers out there):

Level	2016 # tested	Pass Rate
CFR	3,322	91.31%
EMT	10,780	87.63%
AEMT	80	89.02%
CC	269	87.14%
Paramedic	1,440	86.68%
CLI	94	75%
CIC	170	58%

11. Eyebrows were raised at the Training and Education Committee when reviewing pass rates on the CLI and CIC exams. While the exam is brand new, it may need some tweaks.
12. In an ironic twist of fate, the State's current written exam vendor, ProExam was recently acquired by the former contractor, PSI. The transition should not be difficult.
13. The Bureau also announced some (very welcome) changes to the Practical Skills Exams. Station 5A and B (Spinal Immobilization – Seated and Supine) have been removed; Station 1A Medical Assessment is now Station 1 and Station 1B Trauma Assessment is now Station 2. Which, come to think of it, probably means others have been renumbered. Yes, there is a new Practical Skills Exam (PSE) manual and matrix available at www.health.ny.gov/professionals/ems/national_education_standards_transition/index.htm.
14. The 2016, more aptly now 2017 Collaborative Protocol materials were released to Regions on February 1 (with the exception of the new app which will should release closer to March 1). Protocols will go live in March in many regions and for the first month (March), providers can use either the new or their old Protocols. Other regions will likely delay education until the app releases as they intend to use the app as their primary protocol reference. In April the new Protocols will take effect Statewide with the exception of Nassau and New York City (the only two regions not in the Collaborative). Educational materials rolled out to the Regions include podcasts, simulation videos of new skills, a self-study test and a series of didactics (discussion videos) on the changes. Some Regions will test providers on the new protocols, others won't (discretion is left to each Region). A task group formed to look at building (or "borrowing") a pedi dosing

calculator for the Collaborative Protocol app concluded their review and is recommending the Safe Dose/Broselow app as an add in to the Regional Protocol app. The Collaborative intends to seek funding from EMS-C to accomplish this. Discussion will begin at the next meeting on folding the NYS BLS protocols into the Collaborative Protocols.

15. On the subject of meds, SEMAC/SEMSCO will write the NYS Education Commissioner regarding a BON (Board of Nursing) Opinion that RNs cannot administer IV bolus doses of certain conscious sedation/analgesic meds (such as ketamine). "What, what, what?" you say. True it is and this has the ire of many a rural ED and ICU doc who have no other hands than the RN working alongside them. Reasoning that RNs should be able to administer the same meds as paramedics only makes sense. Hence the letter.
16. The New York State EMS Memorial will be held on May 23, 2017 at 11:00 am at the Empire State Plaza. Sadly, three names will be added to the Memorial Tree: Stephanie B. Potter (Moira Volunteer Fire & Rescue), Norman Valle (FDNY*EMS) and Larry Fuller (Hunter Ambulance). See: www.health.ny.gov/professionals/ems/emsmemorial.htm.
17. The CCT TAG presented a preliminary report which (verbatim) is this:

    The CC TAG was tasked with evaluating the future of CC level care in NYS. Years ago when SEMAC/SEMSCO reviewed the revised National EMS Scope of Practice document, the SEMAC voted to continue the CC level of care in NYS. Since that time, several issues have arisen. These include NYS being the only state with a CC level of care (eliminating portability in disasters and reciprocity); a push from the Governor to bring NY into compliance with nationally adopted standards; portability of certification between states; and inability to update CC training curriculum and exams due to costs, administrative burden and lack of any national equivalent. Thus, there has been recent discussion about sun setting the CC level in NYS.

    The TAG is currently exploring CC use in each region, current CC curriculum, ability to sustain CC educational updates, original course participation, refresher course numbers, use of CME refreshers and other training and exam development and maintenance issues. The TAG is also evaluating how a phase out of the CC level or continuation of the CC level might affect the State including barriers to upgrading current CC providers to Paramedic level, establishment of streamlined bridge courses that would optimize costs and time commitment of CC providers, enhancements to the AEMT skill set that might facilitate transition of some CC level agencies to AEMT and timelines with which a transition to either commit to maintaining the CC level or transition to sun setting the CC would be feasible to assure continuity of care to all New Yorkers.

    The TAG will present a complete report with recommendations at the May meeting.

18. Some upcoming conferences offering CE opportunities: Initial Assessment in Lake Placid, May 18-21 (http://initialassessmentconference.com/), Fire 2017 at Turning Stone Casino, June 14-17 (www.nysfirechiefs.com), Pulse Check in Albany, September 21-24 (www.nysvara.org/pulseCheck/index.html), and Vital Signs in Rochester, October 25-29 (www.vitalsignsconference.com).
19. Nominations for State EMS Awards are due a bit earlier this year (May 1st). Consider nominating a peer (or EMS service) for one of the many Regional and State EMS awards. The link to awards info is www.health.ny.gov/professionals/ems/emsawards.htm.

20. Some Systems Committee members were red in the face over an about face in the Bureau's position on CON (Certificate of Need) policies and practices. I'll summarize a very lengthy and heated discussion here: for about two years now, a TAG has worked to refine the CON process in hopes of reducing senseless, ridiculous and time consuming appeals. They first worked to refine a definition of "need" and then set out to revise, clarify and update Policy Statement # 06-06 on the CON process. That's where the legal eagles apparently flocked in, advising the Bureau that Article 30 of Public Health Law empowers Regional EMS Councils (REMSCOs) – not the Bureau or SEMSCO to make initial determinations of need and take action on CON applications. Policy 06-06 was intended as a guidance document for REMSCOs to adopt as their own process. For whatever reason, that has not happened. Many CON appeals (that tie up hours of DOH and Administrative Law Judge time and waste hundreds of thousands of buckaroos) cite Policy 06-06 which, in fact, has nothing but imaginary authority. Hence, a revision of 06-06 is not in the cards. It may be possible to create a so called, "guidance document" for REMSCOs to facilitate their CON processing, but the days of Policy Statements being interpreted as though they were Regulation are done. Yup, you read that correctly. Some Policy Statements recommend equipment – these are recommendations only, not enforceable policies. Whodathunkit?
21. SEMSCO Chair Steve Kroll hosted a series of statewide conference calls last year under the theme, "The Changing Face of Emergency Medical Services in New York State." Topics included financial sustainability of EMS agencies, EMS workforce issues, integration with the health care system, rural EMS concerns, Delivery System Reform Incentive Program (DSRIP), regulatory barriers, EMS leadership, agency consolidation and more. A summary from the calls is attached to these minutes.
22. Along similar lines, SEMSCO will distribute a workforce shortage survey to agencies in early 2017, the results of which may shed some light on current issues and concerns.
23. In what's clearly déjà vu all over again, the Finance Committee presented (and SEMSCO approved) a $24,180,127 budget for F/Y 2017-2018. Currently, the actual EMS budget (for training, Program Agencies, Councils, the Bureau, SEMSCO/SEMAC/STAC and EMSC) sits at $16 million despite a $19.3 million request (uh huh). Program agencies have not seen an increase since 1997. As usual, this budget will probably fall on deaf ears. Whatever.
24. In the same blah, blah, blah vein, the Safety Committee continues to review the three ambulance standards (NFPA 1917, CAAS GVS and KKK-A-1822) with an eye towards revising Part 800.22. On the brighter side, it looks like the cat fight between NFPA and CAAS may be winding down – the two are actually speaking to each other. Meanwhile, several national organizations are pressuring the feds to sunset KKK. Yawn…
25. The Center for Public Safety released a sweet booklet outlining the top 10 EMS Safety priorities. Download a copy from www.centerforpatientsafety.org/emsforward/wp-content/uploads/sites/4/2017/01/EMSForward.pdf.
26. Folks interested in resuscitation might find a new list server operated by McMaster University exciting: https://plus.mcmaster.ca/ResusPlus/. The site allows you to sign up for notices of newly published resuscitation research.
27. Results of a study many local EMSers took part in have released. The National Institute for Occupational Safety and Health (NIOSH) just published a comprehensive database of EMT worker body measurements: www.cdc.gov/niosh/data/datasets/rd-1008-2016-

0/default.html?s_cid=3ni7d2_JGEmail. The data were collected as part of a nationwide survey, and can aid ambulance manufacturers in improving the design of the ambulance patient compartment for safe and effective use. Yippee!

28. Remember Ebola, H1N1, Bird Flu, and SARS? Our preparedness was not so hot (some would say it outright sucked). Well, the InterAgency Board (IAB) published a new document, "A Proposed Model for Bioterrorism Response: Initial Operations and Characterization," which may be of interest to your organization. The IAB proposes a model for a biothreat response capability that brings together public safety jurisdictions, federal resources, processes, standards, and doctrine to support the creation of a network of locally owned and operated validated bioterrorism response teams. See the report at www.interagencyboard.org/sites/default/files/publications/IAB%20Bioterrorism%20Preparedness%20and%20Response_A%20Proposed%20Model%20for%20BT%20Respo....pdf
29. February 27 through March 8, 2017 will see a statewide DOH exercise called Outbreak Unchecked Response Exercise (OUREx) involving County Health Departments, hospitals, emergency managers, EMS and some at-risk people. It involves as worldwide pandemic flu requiring activation of PODs (Points Of Dispensing) to mass distribute meds to people who have been exposed in NYS. It is primarily a paper/pencil/telephone/computer drill with no actual response. EMS will be polled for availability using the Statewide MA Plan. Now you already know too much. Just pretend you never read this.
30. A slate of officers was presented and (some) elections were held. Steven Kroll was reelected Chair and Patty Bashaw reelected 1st Vice Chair. The Nominating Committee advanced two names for 2nd Vice Chair: Stephen Cady and Mark Philippy. Their biographies will be distributed to SEMSCO members and an election will take place at the May 2017 meeting. Of note, Mike Reid, a long-serving SEMSCO member representing FASNY resigned to accept a position with the NYS Legislature.
31. Curious about National Registry computer based exams? Rob Wagoner, the Chief Operating Officer of the National Registry of EMTs spent the last 30 years intimately involved in the Registry's cognitive and psychomotor testing development and administration. Rob took time to describe the computer adaptive testing (CAT) used by the National Registry EMR, EMT and Paramedic exams including how the exams are developed, validated, scored, administered and updated. This interview is on my Firemedically Speaking Blog Talk Radio program at www.blogtalkradio.com/fireengineeringtalkradio/2017/01/21/episode-1466-firemedically-speaking-inside-the-nremt-exams.
32. SEMSCO will meet again May 9-10, September 26-27 in 2017 and January 9-10, 2018 at the Hilton Garden Inn in Troy.

These notes respectfully prepared by Mike McEvoy who previously represented the NYS Association of Fire Chiefs on SEMSCO before being replaced by Mike Murphy. Contact Mike at mmcevoy@saratogacountyny.gov or visit www.mikemcevoy.com. If you want a personal copy of these "unofficial" SEMSCO minutes delivered directly to your email account, go to http://eepurl.com/iaXHY to put yourself on the list (or adjust your delivery settings). Also, past copies of NYS EMS News are parked at the bottom of the EMS News page at www.saratogaems.org. Feel free to download any notes you missed. Tell your friends. The more, the merrier.

The Changing Face of Emergency Medical Services in New York State

Statewide SEMSCO Conference Call Summary

Steven Kroll

January 2017

EMS agencies of all types are struggling across New York State in the face of tremendous change. EMS leaders are facing serious challenges and the pathway to success is yet to be defined. Some are beginning to doubt the sustainability of EMS services and those fears are beginning to play out as the cracks in the system are becoming more evident in some communities. The citizens of the State of New York State are largely unaware of this struggle. New Yorkers that need emergency medical assistance have always expected, and continue to expect, that EMS will arrive when needed, 24-7-365. However, there are already circumstances under which this expectation is at risk or not being met.

Topics Discussed

- The Business Model of EMS and Financial Sustainability off EMS Agencies
- EMS Workforce Recruitment and Retention
- Integration of EMS into the Health Care System
- Rural EMS
- Patient-Centered EMS
- Delivery System Reform Incentive Program (DSRIP)
- Quality, Value, and Outcomes
- Regulatory Barriers
- EMS Leadership and Agency Consolidation

CHANGING DEMOGRAPHICS: UNDERLYING CHALLENGES FOR NYS

- Aging Population
  - Chronic Illness
  - End of Life Care
  - Alzheimer's and Dementia in the Elderly
- Public Health Crisis
  - Obesity
- Health System Restructuring
  - Greater Travel Distance for Hospital Care in Many Communities
- Tremendous lack of public awareness of EMS

The Business Model of EMS and Financial Sustainability of EMS Agencies

- Medicaid rates do not pay the cost of providing service
  - Especially severe for agencies with high Medicaid volume
  - DOH studying the cost of Medicaid transportation
- Medicare rates are not generous, non-governmental payers scrutinizing rates
- Payer mix shifts
- Growth in high deductible insurance products; often equivalent to self-pay
- Need for increased business skills in EMS environment
- Growing insurance denials
  - Lack of denials management experience

The Business Model of EMS and Financial Sustainability of EMS Agencies

- Wage increase and expense pressure not supported by revenue increases; low wage levels impact recruitment and retention
- How will capitation and global budget models impact EMS?
- Tax cap pressuring local jurisdictions to pull tax funds out of EMS, eliminate inflation adjustments, and increase reliance on revenue recovery
- Reserve funds being depleted, capital cycle lengthening, larger capital needs being delayed or beyond reach
- Public does not understand how EMS is funded
- Municipalities shocked when EMS comes looking for new funding

The Business Model of EMS and Financial Sustainability of EMS Agencies

- EMS is not an essential service in NYS
- EMS finances driven by socio-economic forces
  - Drives high Medicaid volume
- ACA has increased Medicaid volume and lowered self-pay; What happens in ACA repeal scenario? Will high-utilization patients end up with high-deductible insurance?
- Will donations dry up when agencies start billing?
- Transporting agency must bill and fire-based EMS can not bill
  - Difficult to solve issue between volunteer fire-based EMS and ALSFRS

EMS Workforce Recruitment and Retention

- Aging EMS providers – both volunteer and paid – average age is over 40
  - Number of EMT students relatively stable
  - Next generation has different work ethic
  - Concept of volunteerism has changed with generation
    - NYS has a low volunteerism rate when compared to other states
- Not enough providers – both volunteer and paid
  - Data collection could establish breadth of vacancy challenge

EMS Workforce Recruitment and Retention

- Pressure of competitive employers
  - Similar pay can be earned in less challenging careers
    - Equivalent salary for an EMT and big box store worker
- Providers working multiple jobs to earn a living
  - Exhausted providers
  - “loyalty” demanded by primary agency
- Lack of EMS career path in many EMS systems, with notable exceptions
- EMS becoming stepping stone to other careers
- Question: More than 80% of calls are BLS; is ALS conversion to BLS a viable strategy for some communities?

EMS Workforce Recruitment and Retention

- As the number of paid agencies expands, they are all competing for the same pool of responders, resulting in unaffordable salary inflation
- Small ambulance services hiring paid staff that revenue does not support and are running themselves into insolvency
- Communities want EMS service, don't want to pay for it
- Bureau of EMS training and support activities severely limited by cash ceiling budget constraints

EMS Workforce Recruitment and Retention

- Ideas discussed *(not necessarily endorsed)*:
  - Should EMS providers be licensed?
  - Development of county-wide ambulance initiatives; there are several successful models
  - Bunk in programs
  - Decrease hours worked by EMS providers
  - Can EMS providers pool together to improve benefits

Integration of EMS into the Health Care System/Patient-Centered EMS

- Integration of EMS into the health care system and patient-centered EMS is in its infancy; EMS is too isolated
- Hospitals in many areas still do not act as if what happens in the pre-hospital care encounter is an important influence on the hospital stay
- Opportunity for EMS to work with health care to develop safety net at transitions of care
- EMS not well integrated with niche providers – behavioral health, hospice, disability awareness and special-needs populations
- What can EMS bring to the table with health care?

Integration of EMS into the Health Care System/Patient-Centered EMS

- Data integration with hospital electronic medical record?
  - Getting pre-hospital care data directly into the RHIO
  - Allowing EMS to pull data on the patient from the RHIO
  - Using integrated chart for quality and outcomes improvement
- EMS is expanding its safety-net role as home care is reduced
- Challenge: lack of behavioral health capacity throughout the emergency care system
- Challenge: There are people that should use EMS that don't and those that shouldn't be using EMS are filling up the capacity
- Good Examples:
  - STEMI and stroke care integration
  - Fall prevention programs

Integration of EMS into the Health Care System/Patient-Centered EMS

- Lack of ability to implement community paramedicine/mobile integrated health care in NY
- Potential for *EMS Compass*
- Potential for customer satisfaction surveys – several good examples in use

Quality, Value, and Outcomes

- EMS quality, value, and outcomes is in its infancy
- Development of metric measurement is also in the early generations
  - Challenge of differentiating data that measures value and outcomes
  - Establishing correlation between data and outcomes
    - Example: are response times and patient outcomes linked? What about provider skill level and outcomes?
- How do we prepare for the value-based systems evolving in the health insurance and hospital realm? When will we start to see value-based metrics in contracts?

Quality, Value, and Outcomes

- Lack of quality activity at local squads
  - Lack of direction, limited bandwidth, and limited interest
- Regional QI committee meetings suffer from lack of interest
- Providers do not yet realize that payment will start to be based-on performance
- We have to start thinking like health care providers

IHI Triple Aim

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations, and
- Reducing the per capita cost of health care

- Numerous publications suggest that the list be expanded to a ‘Quadruple Aim’ to include: Improving the Care of and Experience of The Provider

Quality, Value, and Outcomes

- STEMI and Stroke initiatives more common opportunities for hospital collaboration
- What percentage of calls are being turned over?
  - Is there an obligation to make the public aware at the local level?
- Does EMS Quality = Hospital Quality?
- Potential for EMS Compass – Improving Systems of Care through Meaningful Measures

Quality, Value, and Outcomes

- THE RIGHT METRICS
- THE RIGHT ANALYSIS
- USING THE ANALYSIS TO AFFECT CHANGE

DSRIP

- EMS as valuable partner to reduce avoidable admissions, reduce readmissions, reduce inappropriate ER utilization
- Most DSRIP collaboratives have yet to define the full value that EMS brings to the table; EMS has the opportunity to define their role
- EMS is at the initial patient contact for many avoidable health care encounters:
  - Chronic illness, Long-term care, elderly and special needs populations
- Examples: North County DSRIP, fall reduction programs, Northwell Health programs

Rural EMS

- Agencies shutting down at an alarming rate
- Many small agencies that cover large geographic areas are individually unsustainable
  - Are mergers the answer?
- May not be enough call volume for paid EMS to be sustainable if volunteer EMS fails
- Should we have the equivalent of the “Critical Access Hospital” for EMS?
  - Reimbursement would be increased to cover costs
- Rural agencies have responsibility for facility to facility transfers; which are increasing in number and resource intensive

Rural EMS

- Many challenges are intensified in the rural environment
  - Local government budget pressure
  - Aging of volunteers and population
  - Declining young population base to recruit as volunteers
  - Economic realities of earning a living impacting volunteerism
  - Non-emergent use of EMS has more dire consequences in rural
  - “Small town pride”
  - Local governments shocked by the potential cost of needing to replace volunteers with paid and don’t have the bandwidth to develop solutions
- What about moving to county-based systems with a broader reach?

Rural EMS

- Rural solutions are years in the making, but the problems have been kept in the shadows – visibility is needed
- Should hospital system be tasked with responsibility for rural EMS?
- Controversial debate: the increasing demands of certification – disincentive for people to become EMTs or raising the acceptable standard of care?
- Telemedicine is a potential solution that is in the early stages of development
- Community paramedicine could be particularly beneficial in rural communities
- Ban on subscription fees is a barrier to rural EMS

Regulatory Barriers

- Legislative framework for EMS that sets the NYS regulatory context is in desperate need of modernization, however, achieving a comprehensive modernization is likely beyond the capacity of the collective stakeholders
- Barriers to achieving Community Paramedicine

Regulatory Barriers

- Inability of EMS to transport non-emergent 911 calls to alternate destinations
  - Potential pilot – transport to article 28 hospital affiliated urgent care
  - Can be double negative – lose money and unnecessary transport
- Inability to shift low acuity patients away from EMS
  - Example: cab vouchers for routine and inappropriate EMS use
- No Medicaid copay = no incentive to be prudent in calling EMS

NYS EMS Leadership Themes

- The public does not recognize what we do; they assume that we are there and always will be
- EMS community can be to resistant to change
- Mergers are not a dirty word
- How can agencies assess their strengths and weaknesses to help make decisions about sustainability and mergers; desire for an assessment tool
- There are several models of successful unifications
  - Agency to agency
  - Area-wide collaborative models
  - Examples: Jefferson County, Greene County, Wayne County, Albany County

NYS EMS Leadership Themes

- EMS needs a new generation of innovative leaders
- Founding generation aging into retirement
- Much of EMS management and leadership training is on the job
- Formal management and leadership structures relatively undeveloped; how do we train future LEADERS?
- Both volunteer and paid agencies have similar leadership demands
- Do we identify with health care, public safety, or both?

NYS EMS Leadership Themes

- The EMS Community in NYS needs to develop the motivation to engage the broader communities in understanding EMS, expressing our vulnerabilities and potential, engaging others in solutions, and making sure broader constituencies see the value in what we have to offer and the risk of not taking a piece of the responsibility for our future success