

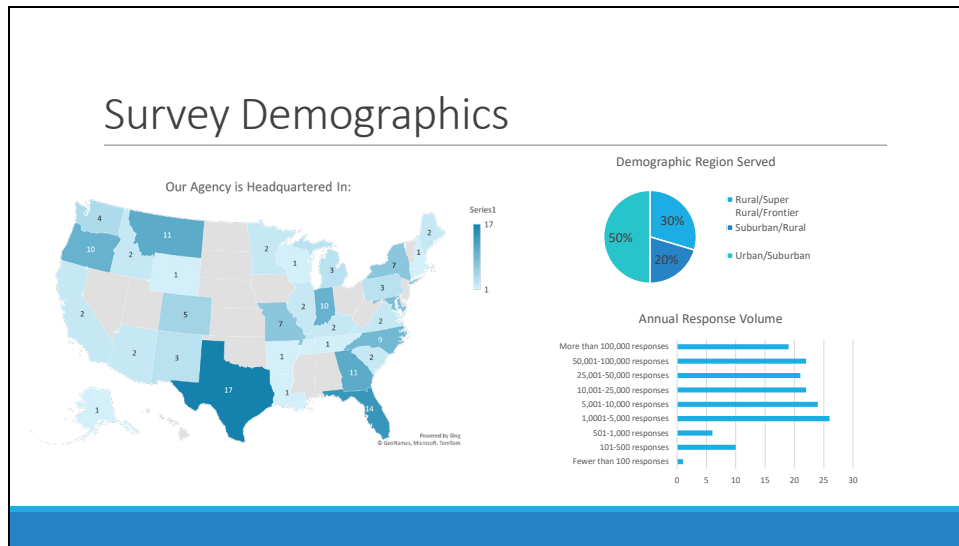


NAEMT has been on the forefront of promoting transformative EMS delivery models, most notably, mobile integrated healthcare and community paramedicine (MIH-CP) programs. The mission of MIH-CP programs is to partner with stakeholders to proactively help patients better manage their healthcare needs to reduce preventable acute care utilization, such as 911 activations, emergency department (ED) visits, and hospital admissions. In rural and super rural areas, community paramedics may serve as primary care physician extenders, providing healthcare services in areas lacking other types of providers.

Numerous studies have proven that EMS-based MIH-CP programs result in improved patient outcomes through reduced acute care utilization, enhanced patient experience, and reduced costs.

Over the past decade, NAEMT has compiled information on approximately 400 EMS agencies nationwide in over 40 states that have launched MIH or CP programs. In February 2023, NAEMT surveyed these agencies to determine the current status of their programs. NAEMT also asked other national associations to share the survey link with their networks of MIH-CP programs. We received 199 unique responses.

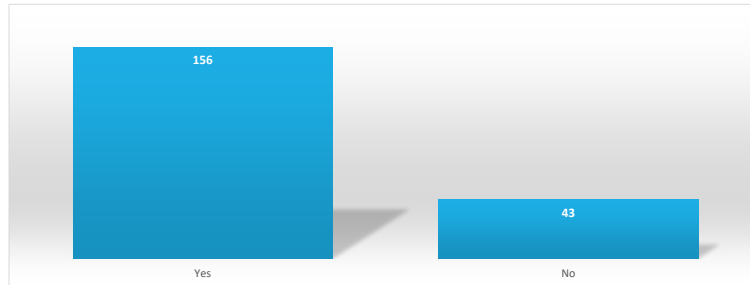
Despite evidence that demonstrates the value of MIH-CP programs, the survey found that EMS agencies continue to face major challenges when trying to enhance the typical EMS delivery model beyond serving as an emergency response and transportation system. Those obstacles include: lack of sustainable funding, regulatory barriers, and workforce challenges.



The MIH-CP survey garnered 199 unique responses. The respondents represented most U.S. regions, with a majority of responses concentrated in the South. **The survey captured the following demographics:**

- 50% (76 agencies) reported serving urban/suburban demographics; 30% (45 agencies) reported serving rural and frontier demographics; and 20% (31 agencies) reported serving suburban and rural demographics.
- 68 agencies were fire based; 24 hospital based; 19 public county; 15 private nonprofit; 15 private for profit; 5 public regional; 4 public city; and 1 public utility.
- 83% reported a paid staffing model; 15% combination; and 2% reported a combination of paid/volunteer staff.
- For response types offered, about half reported 911/emergency response only; and about half 911 response with some inter-facility transfer; a small percentage (<5%) offered interfacility transfer only; and a small percentage (<5%) reported mostly inter-facility with some 911 response.
- For type of care offered: 70% (106 agencies) offer both ALS and BLS; 24% (36 agencies) offer ALS only; 4% (6 agencies) offer BLS only; and 2% (3 agencies) offer first response only.
- For response volume – responses were generally equal across all ranges surveyed, with the highest concentration of responses at 1,001 – 5,000 responses annually; and the lowest concentrations of responses under 1,000, under 500, and under 100 responses annually.

Agencies operating an MIH-CP Program



Of these 199 responding agencies, 78% reported that their agencies offered a MIH-CP program; 22% reported that they do not currently offer a MIH-CP program through their agency.



Among those **156** agencies offering MIH-CP programs, we identified nine (9) of the most common non-traditional services being utilized. The most common services offered include: high ED/911 utilizer programs, admission/re-admission prevention, and care management coordination.

Other Non-Traditional Services Offered

Fall assessment and prevention	Lift Assists
Mobile Crisis Response	Appointment Navigation
Homeless navigation and resources	CHF and Diabetes management
Case Management	Adult/Child Protective Services
Testing and immunization	Remote Patient Monitoring
Mental health care navigation	PharmD med reconciliations
Community Risk Reduction	Reverse triage
High risk OB	Primary Care Connect
In-home blood draws	Medicare Partnership
Hospital at Home Program	Insurance Payor Partnership
Medication-Assisted Treatments	Hemophilia clotting factor delivery and administration
Induction	
Telemedicine	



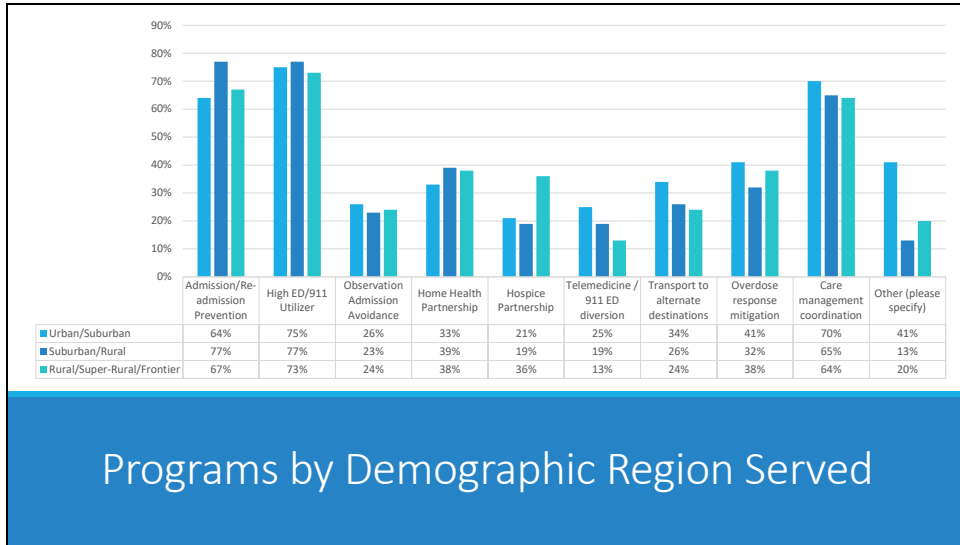
Other services offered that were reported by survey respondents.



Demographic Served

MIH-CP SERVICES DIFFER BY
DEMOGRAPHIC REGION SERVED

We analyzed the non-traditional services by demographic served.



Programs by Demographic Region Served

Some themes emerged.



Urban/suburban providers report offering the greatest variety of non-traditional services overall; and Urban/suburban providers report offering telemedicine facilitated patient navigation, transportation to alternate destinations, overdose response mitigation, and care management coordination at a higher rate than other demographics.



Suburban/rural providers report offering admission/re-admission prevention programs at a higher rate than other demographics.



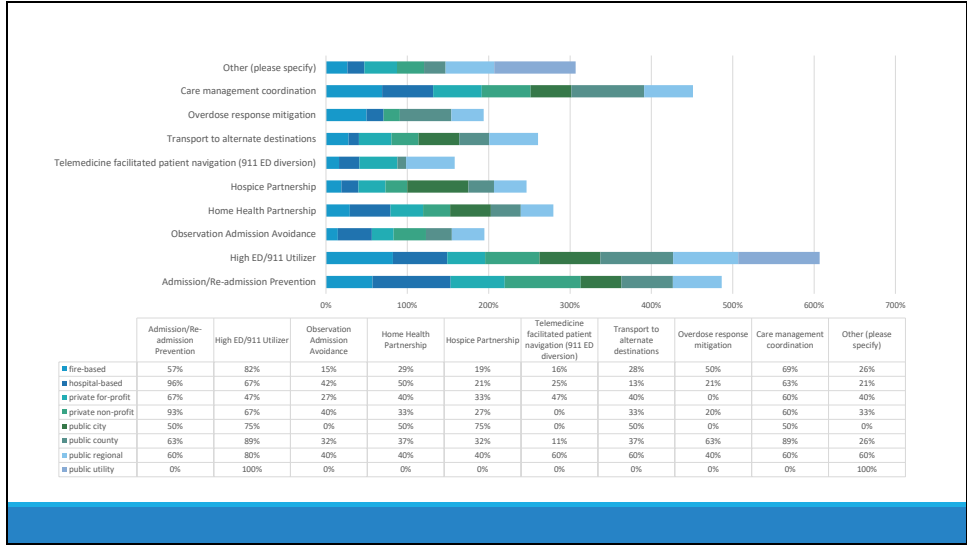
Rural/frontier providers report offering hospice partnership at a higher rate than other demographics.



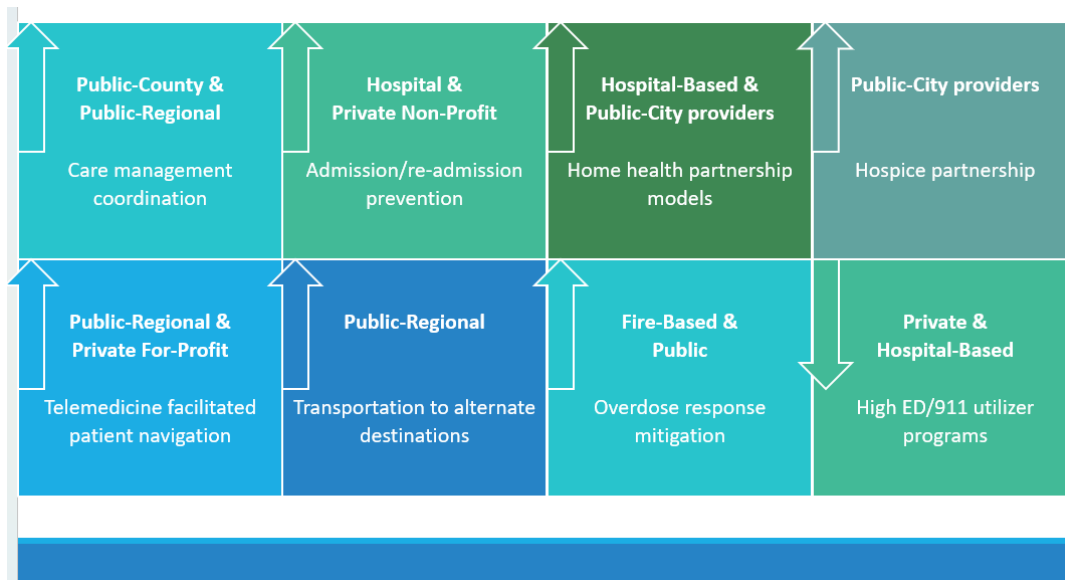
Delivery Model

MIH-CP SERVICES DIFFER BY DELIVERY MODEL

We also analyzed responses by delivery model.



We were able to determine which programs were most or least common among each delivery model.



- Public-county programs report the highest use of care management coordination
- Hospital and private non-profit providers report offering admission/re-admission prevention at a higher rate than other delivery models.
- Hospital-based and public-city providers report utilizing home health partnership models at a higher rate than other delivery models.
- Public-city providers report utilizing hospice partnership at twice the rate of other delivery models.
- Public-regional and private for-profit organizations report utilizing telemedicine facilitated patient navigation at a higher rate than other delivery models.
- Public-regional providers report utilizing transportation to alternate destinations more than other delivery models.
- Fire-based and public providers report utilizing overdose response mitigation significantly more than other delivery models.
- Private and hospital-based providers report offering high ED/911 utilizer programs at a lower rate than other delivery models.

Services by Delivery Model



Public-county and public-regional providers offer the greatest variety of non-traditional services overall.



Almost all delivery models report high percentages of use of care management coordination.

- Public-county and public-regional providers report offering the greatest variety of non-traditional services overall.
- Almost all delivery models report high percentages of use of care management coordination; with public-county accounting for the highest reported use of this type of alternative service.



Call Volume

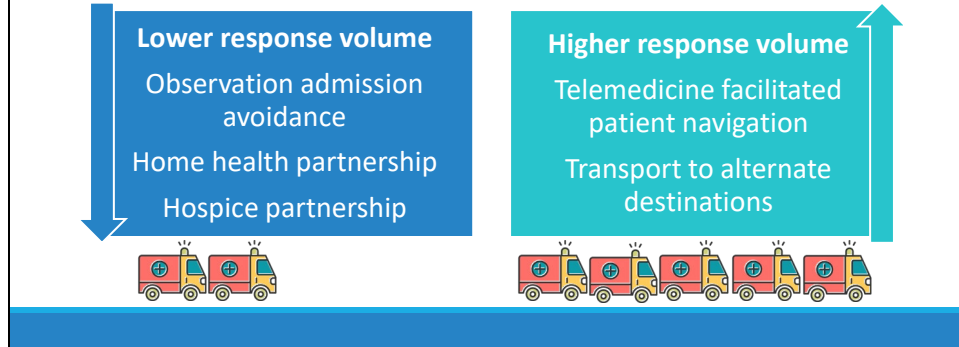
MIH-CP SERVICES DIFFER BY CALL
VOLUME

Finally, we analyzed programs offered by call volume.



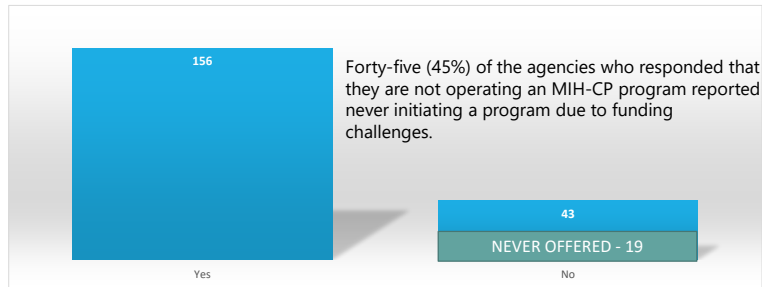
Here we were able to determine which services were most or least commonly offered based on the volume of calls received by responding agencies.

Services by Call Volume



- Lower response volume providers report higher use of: observation admission avoidance, home health partnership, and hospice partnership than higher response volume providers.
- Higher response volume providers report higher use of: telemedicine facilitated patient navigation and transport to alternate destinations than lower volume providers.

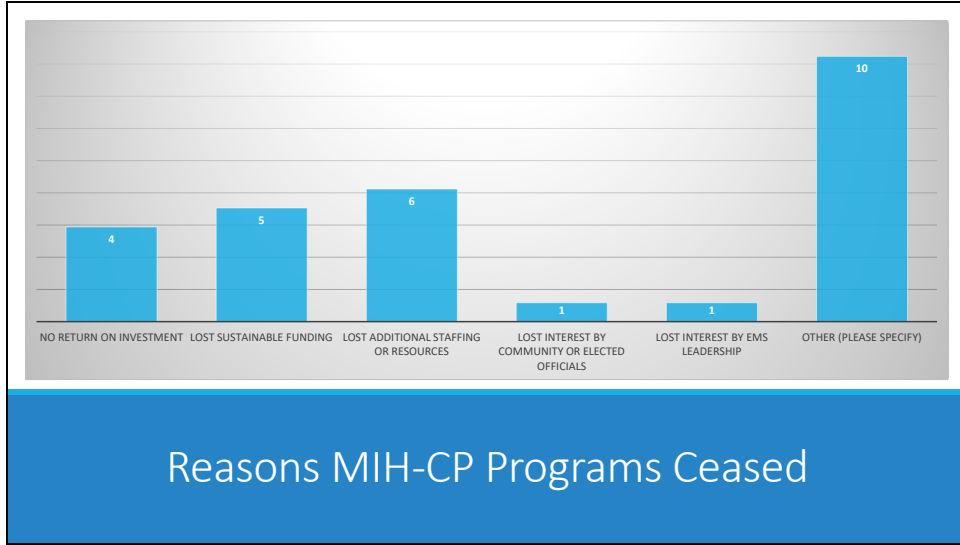
Agencies Never Operating an MIH-CP Program



Agencies Terminating an MIH-CP Program



The other 55% of agencies not currently offering an MIH-CP program reported a variety of reasons for terminating their MIH-CP Programs.



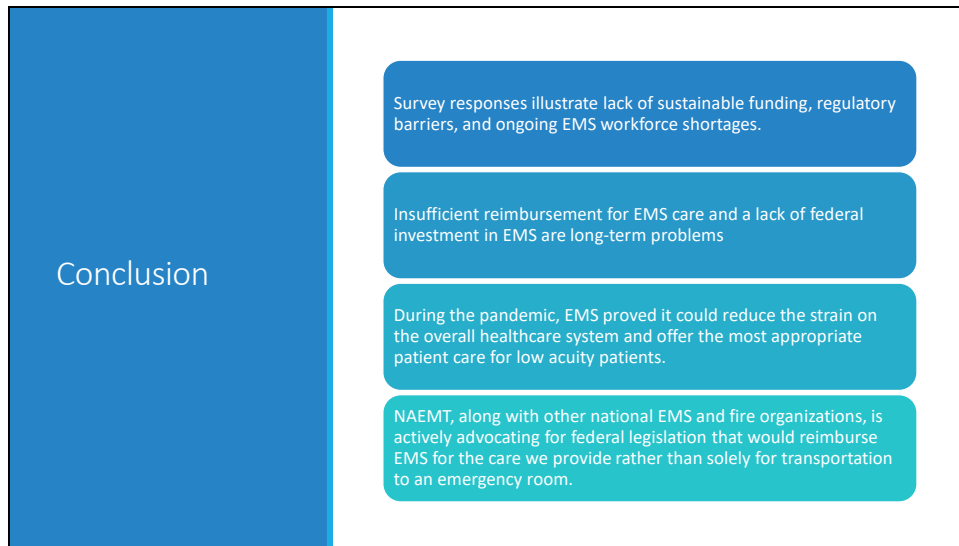
Agencies faced a lack of ROI, loss of sustainable funding, loss of additional staffing or resources, loss of interest by community or elected officials, loss of interest by EMS leadership, and a variety of other obstacles.



Notably, 38% reported that they terminated nontraditional services due to loss of funding, staffing, or resources.



42% reported a variety of other reasons for terminating non-traditional services. These reasons included poor internet availability, licensing issues (operational partner agreements restricting MIH-CP offering), lack of training, and size of service area (too much territory or distance to cover).



The responses to the survey illustrate that the lack of sustainable funding, regulatory barriers, and ongoing EMS workforce shortages are the primary reasons MIH-CP programs have not been sustainable, and why many agencies do not even pursue this valuable service delivery model.

Insufficient reimbursement for EMS care and a lack of federal investment in EMS are long-term problems that have been building for decades. The additional burdens placed on EMS systems and personnel during the pandemic exacerbated the challenge, pushing many EMS systems in our country to the brink.

During the pandemic, CMS waived regulations that reimburse EMS for only transportation to hospitals, and instead allowed reimbursement for EMS to transport patients to alternative healthcare facilities or for providing treatment in place. EMS proved it could reduce the strain on the overall healthcare system and offer the most appropriate patient care for low acuity patients. EMS reimbursement for treatment in place, facilitating telehealth consultations, transport to alternate destinations, and MIH-CP services relieve the stress on hospital emergency rooms, support the ability of hospitals to increase their surge capacity when needed, and most importantly, provide quality patient-centered care to patients.

NAEMT, along with other national EMS and fire organizations, is actively advocating for federal legislation that would reimburse EMS for the care we provide rather than solely for transportation to an emergency room. We call on Congress, state and local officials and commercial insurers to implement sustainable revenue for MIH-CP services and other non-traditional EMS care, and state regulators to assure a regulatory framework that facilitates more patient centered care through EMS-based MIH-CP programs.