Testimony for Public Hearing

For the

House Veterans Affairs and

Emergency Preparedness Committee

April 6, 2016

Chairman Barrar, Chairman Sainato and members of the committee, thank you for this opportunity to come before you today to discuss House Bill 1113 and the concept of "community paramedicine" and "mobile integrated health care".

My name is Tim Hinchcliff and I am the Managing Director for Burholme EMS in Philadelphia and a Board Member of the Ambulance Association of Pennsylvania (AAP). Accompanying me today is Don DeReamus, Legislative Chair and Executive Director Heather Sharar.

Although we come before you today to discuss Representative Bizzarro's legislation, first allow me to reiterate our testimony in March that the ability of EMS System to fulfill its primary mission as emergency responders in this Commonwealth remains in peril. We must not lose sight of the critical issue facing EMS services that were raised less than 30 days ago in this very room. Below cost reimbursement from government and third-party payors for ambulance services is hastening the failure of EMS Agencies across this Commonwealth. This results in decreased deployment of EMS resources yielding longer response times and giving rise to access to care issues.

Now, on the subject of House Bill 1113, the AAP remains fully committed to advancing the practice and securing a reimbursement structure for community paramedicine and mobile integrated health care in this Commonwealth.

During the second term of the Rendell Administration, the AAP assisted in advancing this process by promoting the declaratory language in EMS System Act of 2009 setting the table for future evolution of this field. At that same time, the AAP held early discussions with the American Ambulance Association while

helping introduce the successes of Emed Health to the Office of Healthcare Reform and General Assembly. Today, the innovator of that program Dr. Daniel Swayze, Vice President and COO for the Center for Emergency Medicine of Western Pennsylvania, is the project manager for the CONNECT Community Paramedic Program funded by a large grant from Highmark. Pennsylvania is lucky to have internationally renowned expert like Dr. Swayze driving this effort. He is involved in many of the existing community paramedicine programs underway in this Commonwealth.

While this bill is an excellent starting point, we believe that additional deliberations should be held to include the Administration, General Assembly, insurance industry and all relevant healthcare stakeholders to obtain consensus on any potential legislative or regulatory remedy going forward. We also have a concern that this bill lacks integration with the EMS System Act and may pose conflicts deterring total system inclusion of EMS services and personnel while idle and not actively engaged in providing EMS.

From a statutory construction perspective, the AAP is apprehensive on the thought of codifying a practice or service that is fraught with so many variables. A legislative initiative or language going forward needs to be broad and non restrictive to avoid stifling innovation. The AAP also believes the Department of Health possesses the statutory authority under the current EMS System Act to create provider types, service types and educational standards through the regulatory process.

Questions remain among stakeholders regarding the codified term of "Community Health Worker" in the Patient Protection and Affordable Care Act and how this authorized and grant funded "healthcare navigator" may be integrated into our

"community paramedicine" programs. Should we not place language in any bill referencing this already "funded' job description to increase potential program funding potential? There are also concerns related to the upcoming Presidential election and the fate of the Affordable Care Act. The ACA, along with the Institute of Healthcare Improvement's Triple Aim, were the drivers behind these concepts of improving quality and patient satisfaction, improving the health of populations and reducing the per capita cost of health care.

Expert and model program guidance regarding the development of community paramedicine programs suggests evaluating a community or healthcare population to determine what programs or services may be needed or viable. This is witnessed by the current program diversity and level of training occurring today in Pennsylvania.

For instance, my service Burholme EMS in conjunction with Albert Einstein Medical Center runs a grant supported initiative providing post discharge visits to patients referred to us from hospital care management team. The patient must meet a diagnosis classification of congestive heart failure, diabetes and or hypertension. Most of the referrals in this program are a portion of the most non compliant patients that Einstein Care Management is faced with daily. All our patients are either Medicaid or Medicare Managed Care with a number of referrals in pending status for DHS Medical Assistance approval. We identified a need and developed a program for our primary service area and the North Philadelphia community.

Other ongoing programs in Pennsylvania range from readmission reduction of high risk or chronically ill patients, chronic disease education, mental health ED diversion, reduction of ED visits by super-utilizers, patient navigation/patient

advocate to vulnerable patients, fall and injury prevention, and technical or safety inspections.

These programs aim to address critical problems in local healthcare delivery systems, such as insufficient primary and chronic care resources, overutilization of emergency rooms and community health, safety and social service resource navigation. They will also hope to serve as an additional funding source for already strapped EMS agencies who, through an expanded role, may recoup some revenue during the "cost of readiness" idle times.

Government payors for ambulance service have hinted that the reimbursement models of paying for quality of care and patient satisfaction now deployed in the hospital and physician environment may be applied to EMS in the future. EMS needs to develop levels of healthcare providers and mobile systems directed at population health that respond to emergency situations, redirect less emergent conditions to more cost effective definitive care and reduce over-utilization of emergency and hospital resources.

Again, we thank you for your valuable time and appreciate the opportunity to present our views on this important issue.

The AAP is a member organization that advocates the highest quality patient care through ethical and sound business practices, advancing the interests of our members in important legislative, educational, regulatory and reimbursement issues. Through the development of positive relationships with interested stakeholders, the AAP works for the advancement of emergency and non-emergency medical services delivery and transportation and the development and realization of mobile integrated healthcare in this evolving healthcare delivery environment.

Our nearly 250 members are based throughout the Commonwealth and include all delivery models of EMS including not-for-profit, for-profit, municipal based, fire based, hospital-based, volunteer and air medical. Our members perform a large majority of the patient contacts reported to the Department of Health.