Mobile Integrated Healthcare Summit

North Carolina Association
Office of EMS

North Carolina Association
Emergency Medical Services
ADMNISTRATORS
November 22, 2013
Wake Forest Medical Center
Biotech Place

Mobile Integrated Healthcare

Summit
Welcome and Introductions

Graham Pervier, NC EMS Advisory Council Chairman, Dr. J. Wayne Meredith, Director of General Surgery, Executive Director–CIPT Childress Institute, Wake Forest Baptist Health
A rundown of the new healthcare landscape and how mobile medicine fits (and differs from another popular new notion, community paramedicine); how to build relationships with stakeholders; how to recognize and communicate value; and why EMS is well positioned to be at the vanguard of this change.
Laying the Foundation:
Emergency Medical Services?
“EMS?”

Reasons people use emergency services

- *To see if they needed to*
- *It’s what we’ve taught them to do*
- *Because their doctors tell them to*
- *It’s the only option*

37 million house calls/year

- 30% of these patients don’t go with us to the hospital
<table>
<thead>
<tr>
<th>DISPATCH COMPLAINT</th>
<th>2012 COUNT</th>
<th>2008 COUNT</th>
<th>% INCREASE</th>
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<td>38,891</td>
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<td>Sick Person</td>
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<td>Traffic Accident</td>
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<td>Traumatic Injury</td>
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<td>Unconscious/Fainting</td>
<td>66,579</td>
<td>35,294</td>
<td>46.99</td>
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A FEW MORE FRIVOLOUS TRIPS TO THE E.R.
AND I'LL EARN A FREE CAT SCAN

9-1-1
BREAKING NEWS

Scientists have discovered that ambulances and taxis are in fact, not the same thing.
Unscheduled Medical Services!
Conundrum...

Misaligned Incentives

• Only paid to transport
• “EMS” is a transportation benefit
• NOT a medical benefit
“If you think **change** is uncomfortable...

Imagine what **extinction** feels like”
Health Reform Basics

Affordable Care Acts (ACA) Basics

- Coverage expansion – this is a basic first step (major leap) toward bringing all Americans into a health system
- Insurance reform – assures that people will have coverage when they need it
- Payment reform and experimentation – attempts to incentivize efficiencies and quality improvement
- Prevention and community health – public health in all health
- Primary care capacity and infrastructure – addresses demand from newly insured
How many are uninsured?

- 2010: 16.3%, 49.9 million uninsured
  - 10%, 7.5 million children < 18 years old
  - Decrease in employer-sponsored insurance
  - Increase in public insurance
- Churning
  - 85 million uninsured between 1996-1999
  - Public program eligibility
  - Life events
- Consistently 12%-16% of population
- 10%-25% are underinsured
ACA and Medicare

- No expansions in coverage anticipated in Medicare
- Cuts in provider payments – Part C Medicare Advantage, hospitals, clinical labs, EDs, EMS other services
- Lots of experimentation to incentivize better, more efficient care: Accountable Care Organizations, global payment initiatives, reducing readmissions
- $10 billion now being spent over the next 10 years for Centers for Medicare and Medicaid Innovation
Wellness and Prevention

- Recommended preventive care fully covered with no co-pays and deductibles
  - Includes contraception: Ongoing issue with respect to religiously-affiliated employers
- Annual wellness exam in Medicare
- Employer wellness programs incentivized
- Sustained funding for prevention and public health – Public Health Trust Fund and Community Transformation Grants
- Calorie information posted on chain restaurant menus
Preparing for the Future of Emergency Care
OPPORTUNITY!!
The Future of Emergency Care
Here is what we know:

- EMS responses to grow organically
- ED visits to grow organically
- Trauma center patients to grow organically
By 2019:

- 39 million newly insured
- 43% Medicaid
- 57% Insurance exchange
Vast Culture of “Waste” & “Overuse”
Think EMS “waste”:

- “sending everything!”
- To “everything”
- regardless of need/outcomes
Think ED “waste”:

- High cost structure
- No lower acuity model
- Tremendous variation of care givers (aka = over ordering, etc.)
- Episodic care
Think Trauma Center “waste”:

- Excessive triage (think “MOI”)
- The “Welcoming Committee” aka “trauma team”
- Freezing hospital activities (i.e., CT)
- Low yield ancillary testing
Moving from: Fee Based

Moving to: Value Based

Value = cost / outcome
I've secured the impedance threshold, e-tidal volume, dead space, vesicular excursion, rate/depth, tic-tack dispenser, ketone akalotic/acidotic, alveolar elastic, and blood alcohol automatic analyzer detectors.... **but now I can't remember the patent's chief complaint.**
Think:

- Cost effective
- Appropriate utilization
- Data driven outcomes
Are you at the table?
Innovative Partnerships
Better Care – Reduced Cost

• Right Resource
• Right Time
• Right Patient
• Right Outcome
• Right Cost
... NO... IT'S YOUR JOB TO CLOSE THE DOORS...

ROLE CLARITY
Patient Navigation

- Community Health Program
- System Abusers
- CHF/High Risk Dx Readmissions
- Observational Admission Avoidance
- Hospice Revocation Avoidance

“Mobile Integrated Healthcare Practice”
Community Health Programs

- “EMS Loyalty Program”
  - Proactive home visits
  - Educated on health care and alternate resources
  - Enrolled in available programs = PCMH
  - Flagged in computer-aided dispatch system
    - Co-response on 9-1-1 calls
    - Ambulance and CHP medic
- Non-Compliant enrollees moved to “system abuser” status
  - No home visits
  - Transport may be denied by Medical Director in consult with on-scene CHP medic
CHF Readmission Reduction

• At-Risk for readmission
  • Referred by cardiac case managers
  • Routine home visits
    • *In-home education!*
  • Overall assessment, vital signs, weights, ‘environment’ check, baseline 12L ECG, diet compliance, med compliance
  • *Feedback to primary care physician (PCP)*
  • Non-emergency access number for episodic care
  • Decompensating?
    • Refer to PCP early
    • In-home diuresis
Observation Admission Avoidance

- Partnership with ACO
  - ED Physician (*Case Manager*) identifies eligible patient
    - Refer to Community Health Program.
    - Non-emergency contact number for episodic care given to patient.
  - In-home care coordination with referring physician.
  - Assure attendance at PCP follow-up next business day.
Hospice Revocation Avoidance

- Enroll patients “at risk” for revocation
- Visit at home
  - Counsel – instruct – 10 digit access
- “Register” patient in CAD
  - Co-respond with a “9-1-1” call
- Help family through process
  - While awaiting hospice RN
Additional Partnerships...

- **Delivery System Reform Incentive Payments**
  - 1115a waiver - Regional Health Partnership
    - IGT Based
  - New process for **Disproportionate Share Hospitals**
  - Paid for programs that meet:

- How can EMS change the landscape of healthcare?
Catalyst for Payment Reform

- Coalition of employers (Wal-Mart, Walt Disney, Intel, GE, Boeing, Delta Airlines, FedEx, 3M, )
- Pushing for *value oriented payments* to providers (20% by 2020)
  Aetna – Now paying the same for c-section or vaginal birth – eliminate incentive for c-section (H&HN)
  $1,250 for screening colonoscopies – regardless of in or out of the hospital (H&HN)
Opportunities in Your Community?
The Medicine in What We’re Doing

A panel of top EMS medical directors will examine the new requirements of their job; expanded roles vs. expanded scopes for providers; developing new protocols; and the differences between urban and rural models.

James “Tripp” Winslow, MD, NC State Medical Director; Brent Myers, MD, MPH, Medical Director, Wake County Department of EMS, Raleigh, NC; Adjunct Assistant Professor; Emergency Medicine, UNC School of Medicine; Michael Ghim, MD, Wake Forest School of Medicine, Moses Cone Hospital; Darrell Nelson, MD, Davie & Stokes County EMS Medical Director, Chairman of the NCCEP Protocol Committee
What do we need to accomplish our goals?
Scope of practice

- Do we need expansion of the scope of practice?
What do we need to accomplish our goals?

- Are additional protocols needed or adjustment to current ones?
What do we need to accomplish our goals?

- Do urban versus rural programs require a different paradigm?
What do we need to accomplish our goals?

- How will the role of the medical director change?
What do we need to accomplish our goals?

- Will the traditional training officer centered method of training suffice?
What do we need to accomplish our goals?

- Who will EMS need to bring to the table to put together these programs?
What do we need to accomplish our goals?

- Information technology
How Do I Do This?
Program Development & Implementation

Change starts with determining your community’s needs. What’s missing in your area, and what could fix it? Who are the right providers to do so, and what knowledge, skills and abilities do they need? This session also covers licensure, developing curricula, and clinical documentation/patient tracking.

William Kehler, McDowell County EMS Director, Brent Myers, MD, MPH, Medical Director, Wake County Department of EMS, Raleigh, NC Adjunct Assistant Professor, Emergency Medicine, UNC School of Medicine; Rick O’Donnell, New Hanover EMS Director; New Hanover Regional Medical Center, Wilmington, NC; David Glendenning, Education Coordinator, New Hanover Regional Medical Center, Wilmington, NC
Community Paramedicine

“In the Rural Setting”

William Kehler, NREMT-P, CCEMT-P

Director, McDowell County EMS
EMS recognizes the need for pre-hospital case management due to:

- High Utilizers
- Uninsured patients with no primary care home accessing ER services for every illness
- Patients being readmitted on a continuous basis due to critical disease processes
- Importance of preventative medicine
Current Drivers

- Unemployment
- Uninsured
- Lack of Coordination Between Providers
- Lack of Awareness Related to Resources
**Financial Impact**

- MCDEMS currently has 15 patients classified as high utilizers that have a combined balance of $260,791 = 580 EMS transports
  - Most are uninsured
- Severe impact on resources

- “Each agency has their own story”
Program Designs

- Address High Utilizers
- Prevent 30 day re-admissions to hospitals
- Tele-Med to link directly to PCP
- Community Wellness
- Hybrid Models
Building a Program

- Understand Your Community
  - www.countyhealthrankings.org
  - Unemployment rate
  - Chronic disease rates
  - Uninsured
  - Rate of governmental assistance
  - Get input from the community
  - Compile data
Identify Core Objectives for Program

- Construct plan based upon community findings

- How will plan be executed

- Identify community partners
  - Have ICE Breaker Conversations
  - Judge Interest
## Potential Partners

<table>
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<tr>
<th>Hospitals</th>
<th>Nursing Facilities</th>
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<tbody>
<tr>
<td>Public Health</td>
<td>Home Health</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Faith Based Community</td>
</tr>
<tr>
<td>DSS</td>
<td>School System</td>
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<tr>
<td>Care Coalitions</td>
<td>Primary Care Physician Offices</td>
</tr>
<tr>
<td>Community College / University</td>
<td>Non-Profits</td>
</tr>
<tr>
<td>Fire / Rescue Departments</td>
<td>Corporations</td>
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</table>
Evaluation of Funding Sources

- Foundations
  - Healthcare
  - Private Sector
  - Explore corporations within your community

- Partnerships
  - Hospitals
  - Mental Health / Public Health

- Legislative Changes
  - Fee for service / wellness visit charge
  - Non traditional transports to locations other than ER’s
Foundations

- DO YOUR HOMEWORK
  - Most information is available on-line

- VISION

- FUNDING OBJECTIVES

- CRITERIA FOR APPLYING
EXECUTE

- Construct the grant based upon information collected and program design.

- Have clarity
  - Target population
  - Objectives
  - Vision of Success

- WRITE THE GRANT WITH EMPHASIS ON YOUR VISION AND NOT ON LACK OF FUNDING
Interview

- Often used to screen applicants
- Important to talk to proposed partners prior to submitting your grant application
Avoid the Pitfalls

- Rushing the application process
  - Errors
  - Incomplete application
  - Lack of specific data
  - Short turn around for letters of support

- Failure to adequately budget for program
Evaluate Program Design

- Requires constant evaluation of program
- Collecting and interpreting data
- Making changes based upon trends and identified areas needing improvement
**Contact Information**

- McDowell County EMS
  - 828–652–3241

- William Kehler
  Director
  wkeehler@mcdowellems.com

- Lt. Chad Robinson
  Community Care Paramedic
  crobinson@mcdowellems.com
New Hanover Regional EMS

Wilmington, NC

Our Journey to provide Mobile Integrated Healthcare-Community Paramedicine

Rick O’Donnell
Director/Chief

David Glendenning
Education Coordinator
• 9-1-1 Volume increasing
• Continually Adding Ambulances
Non-emergency Medical Services

The reality:
• 9-1-1 has become the safety net for non-emergent healthcare
• 29% of 9-1-1 requests are non-emergency (alpha or omega responses)
• Top 10 users of our 9-1-1 system accounted for 702 EMS responses
• ED turn-around-times increasing

The question:
• Are we providing the right level of services and are we delivering these patients to the most appropriate facilities?
Affordable Care Act has become a reality
-U.S. per capita health expenditures are not sustainable
Healthcare Spending per capita vs. Average Life Expectancy Among OECD Countries

2009 Data

OECD
Healthcare Reform

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

So as pre-hospital providers, what role can we play?
- **Fill unmet needs with untapped resources**

- Use our existing scope of practice and expand role
- Assess and identify gaps between community needs and services
- Improve quality of life/health
Our Community Needs

Reduce unnecessary 9-1-1 utilization and ED visits for our familiar faces/familiar places
   Proactively manage care and serve as a trained navigator of community resources (Code Outreach)

Improve NHRMC’s readmission rates
   -Caring for high risk patients

Partner in Healthcare System Integration & Care Coordination
   -Working in cooperation with other stakeholders/medical providers
Potential Funding

CoastalCare

THE DUKE ENDOWMENT

Elderhaus, Inc.
PACE services for Seniors
Providing a safe, supervised and therapeutic environment for seniors for over 30 years.

Lower Cape Fear Hospice & LifeCareCenter
Live well. Every moment matters.

BlueCross BlueShield of North Carolina

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

U.S. Department of Veterans Affairs

New Hanover Regional Medical Center
Provider Selection

Three Part Interview Process (multidisciplinary evaluators)
- Panel Interview
- Presentation
- Written clinical exam/inbox exercise

Three Providers selected: Matt, Sarah & Michael
- Avg. 21 yrs. EMS experience (Avg. 15 yrs. as Paramedics)
- 2 were FTO’s & the other was an SOP
- Great personalities & big hearts
Total: 308 hours of didactic and clinical training
- 64 hours classroom (via interactive TV)
- 48 hours online
- 196+ hours clinical training

Retooling a new kind of clinician
Program Keys

• Develop Program Guidelines

• Build a CP documentation module within Epic
  - Electronic Medical Record

• Hold Weekly Quality Assurance Meetings
  - Ensure we are delivering quality/cost effective care

• Measure Client Satisfaction

• Cultivate partnerships with other community stakeholders
PATIENT SATISFACTION WITH COMMUNITY PARAMEDICINE PROGRAM
(1 to 5 scale used, 1=poor / 5=excellent)

“I’m just having a bad day, Dave. I’m happy you came by” - CP Beta patient
Early Results

INPATIENT STAYS PRE & POST COMMUNITY PARAMEDICINE PROGRAM

“They helped me when asthma was getting bad and I stayed out of the hospital.” - CP Beta patient
Early Results

ANNUALIZED HOSPITAL CHARGES PRE & POST COMMUNITY PARAMEDICINE PROGRAM

Pre: $511,019
Post: $118,454
LESSONS LEARNED

• Community Paramedic students don’t know as much as they thought they did.
• Community Paramedic has great opportunities for impact under existing ALS scope where other levels may not.
• Start small and collaborate with other stakeholders.
• These concepts can be applied in any county/EMS setting.
• Go with the brand name that the public, healthcare providers, and payers can already understand.
QUESTIONS?

Rick O’Donnell, Director/Chief
rick.odonnell@nhrmc.org

David Glendenning, Education Coordinator
david.glendenning@nhrmc.org
Collaboration is Key:

Why is the concept of “mobile integrated healthcare practice” receiving so much attention?

How does this relate to community paramedicine?
Why does this idea have the potential to transform and literally redefine

Jim Albright, Interim Director of Guilford County EMS; Brent Myers, MD, MPH, Medical Director, Wake County Department of EMS, Raleigh, NC; Adjunct Assistant Professor; Emergency Medicine, UNC School of Medicine
Integration and Collaboration with Other Healthcare Practitioners

We’re gaining many new friends and partners under changing delivery models. Learn to work with hospitals, primary-care physicians, ACOs, SNFs, home health, case managers, nonprofit groups and other key players who will help determine your success.

Rick O’Donnell, New Hanover EMS Director; New Hanover Regional Medical Center, Wilmington, NC; Brian Pearce, Cumberland County EMS Director, Cape Fear Regional Medical Center, Fayetteville, NC; David Glendenning, Education Coordinator, New Hanover Regional Medical Center, Wilmington, NC
Work with your hospital

- VitaLine (Nurse Triage)
- Case Managers
- Social Workers
- Home Care
- Behavioral Health
- Transionist/Telehealth
- ED Leadership

- Readmission reduction strategies
- Decreasing ED bed hours for “Familiar Faces”
- Population health management
– Proactive services/ Preventative care that help patients achieve wellness

– Provide the tools, materials and outreach that help patients better manage their chronic diseases

– Help patients navigate care at the right level, at the right time, in the right setting

– Safer, more effective care as a result of shared knowledge and best practices among health care providers

– Improve the quality and costs of care
Veterans Administration
(Wilmington Outpatient Clinic)

- Direct communication with care team
- Case Managers
- Diabetics
- CHF Patients
- Behavioral Health
- VA patient population currently 10,000 in our region
Local Government Agencies

- Partnerships for political support
- Specialty care resources for senior and children
- Resource for community needs such as immunizations, well checks, and disaster preparedness
Hospice of the Lower Cape Fear

- CHF population
- Case Managers (navigating patients into Hospice services sooner)
- Fill the home visit gaps
- Specialized training for CP
- Behavioral Health for the CP
– Dire need for support

– Several coalitions being formed

– Medical screenings and alternate transportation destinations

– Monthly injections replacing daily medications

– CP could make referrals to these services
Senior Care

- Support independent living through in home care
- Provide preventative screenings/services to include field labs and fall clearances

Skilled Nursing Facilities
Assisted Living Facilities
Primary Care/ Specialty Physicians

- Skills and procedures within our paramedic scope helping to keep patients out of the ED
- Medical screenings/Lab services (I-Stat testing)
- Medication reconciliation
- Procedure discharge follow ups
Non-profits and “Familiar Places”

- Distribution of “street sheet” healthcare navigation tool guide
- Mobile preventative healthcare with a CP and physician
- Track homeless and transient patient populations
- Meet with religious leaders in community
North Carolina

- Sharing best potential practices with other CP programs in NC
- Standardizing data sets to show CP value
- Rules creation
- Curriculum recommendations
- Developing sustainable funding sources
QUESTIONS
Lumberton Rescue & EMS
In collaboration with Southeastern Health

Paramedic Partners Program
The Paramedic Partners Program is a collaborative effort between SEHealth and LREMS aimed at reducing preventable admissions to SRMC. The program is currently aimed at the discharge diagnoses of Congestive Heart Failure, Acute Myocardial Infraction, and adult respiratory illness. Paramedics from LREMS have gone through intense training provided by a multidisciplinary team of nurses, dieticians and home health staff. They will be visiting this patient population after the patient has transitioned from acute care to the OP setting. The Paramedics will be assessing the patient in his/her own home environment to ensure it is free of hazards, assess the patient’s understanding of his/her discharge instructions, and verify medications have been obtained and are being taken as prescribed. If barriers are identified this gives the paramedic or the transitional nurse an opportunity to correct in a timely manner. In some cases it may necessitate an earlier appointment with the primary care provider, or to identify other resources or additional services that are needed to best care for the patient at the appropriate level.
This program will ensure that the patients are equipped to participate in their healthcare needs, while having the autonomy of being at home. This also will allow the PCP to oversee patients’ needs as we strive for a home medical model system within our communities of service. This is a voluntary program of which the patient will have the opportunity to opt out of the program and there will be no cost associated with the visit by the Paramedic. The Paramedics will have additional training to care for patients in this setting in addition to the prehospital education they have received. Lumberton Rescue & EMS is a valued partner within the community that has similar values and mission focus as Southeastern Health. Both organizations are aligned to improve the healthcare services within the community and create a healthier environment in which we live.
Paramedic Partners Program

- 1st Patient contact on February 11, 2013
- Averaging volumes 70 patients per month
- Operated by a combination department
  - Consist of part time and volunteer personnel
  - Program was envisioned with current resources
    - No additional personnel
    - No additional capital purchases
Providing 24 hour paramedic service to the citizens of Lumberton and Robeson County.

LREMS Wins Community Health Award
Lumberton Rescue and EMS was recently the recipient of the 2013 Community Health Award awarded by Southeastern Health. LREMS was nominated for the Emergency Service Category for the Paramedic Partners program, which was initiated in 2012. The program sends paramedics on home visits of recently discharged patients to ensure home safety, medication compliance, and understanding of discharge instructions. So far this year, the program has made visits to over 200 patients, whose diagnoses include chronic obstructive pulmonary disease, congestive heart failure and myocardial infarction. This program is a joint venture between Southeastern Regional Medical Center and LREMS, and is funded through a grant from Duke Endowment. Pictured is Commander Robert Ivey, who accepted the award on behalf of the organization.

The Community Emergency Response Team (CERT) Program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as life safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. CERT members are also encouraged to support emergency response agencies by taking a more active role in emergency preparedness through communications and organizing community disaster preparedness activities.
Administration

- Robert Ivey, EMT-I
  Commander
  EMS Supervisor
  Lumberton Rescue & EMS

- Chris Connor, EMT-P
  Assistant EMS Supervisor
  Lumberton Rescue & EMS

- Wayne Martin, MHA, BSN, NREMTP, RN, CEN, CCRN
  Medical Captain
  Lumberton Rescue & EMS
Addressing Regulatory Issues

Do you need new laws or rules in your state to support your new activities? Welcome to Politics 101: Learn how to find support, write legislation, build coalitions and deal with adversaries.

Regina Godette-Crawford, Chief of NCOEMS, Tom Mitchell, Assistant Chief of NCOEMS, Donnie Sides, Operations Manager, NCOEMS
The OEMS has initiated a Rules revision project through the NC EMS Advisory Council.

A task force has been appointed
Mr. Bob Bailey will serve as Chair.

This project begins with our draft rules being posted on the OEMS Web site at:

www.ncems.org.
From now until January 17, 2014, the task force will review comments on these rules and prepare a final draft for presentation to the EMSAC in February 2014.

During this time period, the task force will also conduct a statewide meeting to receive verbal and written comments. Once a date(s) is determined, notice will be sent to all interested parties.
Once this preliminary step is completed, the formal rulemaking process will begin.

This involves:

- Submit the draft rules and a fiscal note to DHHS and the Office of State Budget and Management (OSBM). [February, 2014]
Regulatory Issues

- Once authorized, submit these documents to the NC Medical Care Commission for authorization to initiate rulemaking [May, 2014]

- Submit these documents to the Office of Administrative Hearing (OAH) for publication in the NC Register. [May, 2014]
A 60 day comment period will begin and a public hearing will be scheduled for late July or early August 2014.

Final draft rules prepared and submitted to the Medical Care Commission for adoption at their November, 2014 meeting.
Final rules submitted to the Rules Review Commission for codification at their December 2014 meeting.

Rules become effective January 1, 2015.
Regulatory Issues

- The OEMS is also undertaking development of rules addressing the Mobile Integrated Healthcare / Community Paramedic programs.

- It is the intent of the OEMS to have these additional draft rules available for comment sometime in the first part of 2014.
What new definitions and policies will be necessary to establish reimbursement rates for our new Mobile Integrated Healthcare initiatives?

Policymaking 101: CMS Medicare vs. Medicaid.
Demonstration Projects/1115 Waiver

Roger Barnes, Division of Medical Assistance,
Department of Health and Human Services
Open Discussion and Closing Comments

Regina Godette-Crawford, Chief of NC Office of EMS, Bryan Blanton, Chair, Association of EMS Administrators, Catawba County EM Director
Mobile Integrated Healthcare Summit