Rural Health Transformation (RHT)

EMS Transformation Request for Information (RFA)

Frequently Asked Questions (FAQs)

The Kentucky Department for Public Health (KDPH), through the Rural Health Transformation (RHT), is committed to supporting Emergency Medical Services (EMS) agencies as the implementation of Treat-No-Transport (TNT) and Transport to Alternate Destination (TAD) protocols and services across the Commonwealth. Recognizing that these innovative care models represent a significant shift from traditional EMS operations, KDPH will provide ongoing technical assistance, stakeholder engagement opportunities, educational resources, and implementation guidance throughout the duration of the RHT program. This support is intended to enhance patient access to appropriate levels of care, reduce unnecessary transports to emergency departments, and promote a more sustainable EMS system for Kentucky.

All applications for funding must be submitted by 5:00 PM ET on Monday, June 15th, 2026. All applications should be sent via email to RHT.CTC@ky.gov. If you are unable to meet the June 15th deadline, additional funding will be made available in coming months as part of a subsequent funding wave.

General

1. What is the difference between simply obtaining a refusal and TNT?

TNT involves a structured clinical assessment of a patient's acuity to determine that transport to the emergency department is not medically necessary, allowing the patient to be safely treated in place through alternative care pathways. In the proposed model, this decision-making may be further supported by a telehealth provider, with communication enabled through grant-funded technology. The telehealth provider may offer real-time clinical guidance, make recommendations, prescribe medications when appropriate, and critically – coordinate timely follow-up care after the EMS encounter.

While EMS agencies may already be performing elements of TNT in practice – such as treating diabetic hypoglycemia or administering albuterol for asthma cases followed by a patient refusal – this differs from the proposed model. In traditional refusal scenarios, the patient's interaction with the healthcare system often ends when the EMS crew departs. Under the proposed TNT model, the EMS encounter serves as a connection point to ongoing, appropriate, and more definitive care, providing continuity beyond the initial response.

2. What exactly does transport to TAD entail?

TAD allows EMS agencies to transport patients directly from the scene to a pre-approved care setting, rather than to an emergency department, when transport is clinically appropriate by emergency-level care is not required.

These destinations may include, but are not limited to:

- Primary care offices or clinics
- Federally qualified health centers (FQHCs)
- Community Mental Health Centers (CMHCs) or other behavioral health facilities

To note, TAD is different than interfacility transfers. Under the TAD model, EMS personnel make real-time triage decisions in the field and direct patients to the most appropriate destination based on established clinical protocols. These protocols are developed in advance and approved by the agency's Medical Director, enabling EMS clinicians to exercise structured decision-making at the point of care.

3. How can TNT/TAD protocol development and implementation benefit my agency?

Adopting TNT/TAD protocols can deliver meaningful operational, clinical, and financial benefits to your agency through:

- Increased EMS unit availability for high-acuity calls
- Growing volume of low-acuity 911 calls contributes to system congestion and suboptimal resource allocation, delaying care for patients with emergent needs
- TNT/TAD protocols help reduce unnecessary transports, allowing units to remain in service and respond more quickly to higher acuity emergencies
- Reduced overall 911 system utilization
- TNT/TAD can decrease repeat 911 calls for non-urgent conditions when paired with appropriate follow-up (e.g., community paramedicine)
- Supports more efficient use of emergency resources across the system
- Decreased emergency department overcrowding
- Directs low-acuity patients to more appropriate care settings, alleviating pressure on local emergency departments
- Approach can reduce avoidable ED costs associated with non-emergent visits
- Financial benefits and long-term sustainability
- By freeing units to respond to higher-acuity calls, agencies can prioritize transport associated with higher reimbursement
- Reduces costs related to fuel, equipment use, and personnel tied to unnecessary transport
- As of 2024, TNT is reimbursable under Medicaid billing code A0998.
- RHT program to cover costs associated with protocol development, training, regulatory approval, and non-reimbursable service delivery during the award period
- Longer term, this service model may support a shift toward reimbursement structures that recognize clinical care delivery, not just transport

- Improved EMS provider experience and workforce sustainability
- Reducing unnecessary transport and minimizing hospital turnaround times can alleviate workload strain and improve unit availability
- Providers can spend more time focused on patients with emergent needs, contributing to reduced fatigue and burnout.

4. What does the implementation pathway of TNT/TAD look like?

The framework below outlines a scalable pathway for developing and expanding TNT/TAD programming, allowing agencies to adopt a model aligned with their operational readiness, resources, and strategic goals. Each level builds in complexity – from basic protocol-driven care to fully integrated, patient-centered care delivery – enabling a phased approach to implementation and long-term sustainability.

	Level 1 Protocol-Driven TNT	Level 2 Supported TNT/TAD	Level 3 Mobile Care Model
Patient Assessment	EMS assesses low-acuity patient on scene	EMS assesses patient and flags for telehealth consult	EMS assesses patient as part of a broader care pathway (including known high-utilizer chronic patients, etc.)
Clinical Input	EMS follows standing protocols only	EMS consults a telehealth provider in real time	EMS + telehealth + care coordination team jointly inform care
Decision-Making	EMS makes protocol-base decision	Shared decision between EMS and telehealth provider	Team-based decision with EMS empowered to initiate care plans
Disposition Options	Treat on scene + self-care instructions	Treat on scene, transport, or alternate destination (e.g., urgent care)	Treat, refer, schedule follow-up, remote monitoring, or community paramedicine
Follow-Up & Continuity	Limited (patient responsible for follow-up)	Some structured follow-up via telehealth or referral partners	Active care coordination (appointments, navigation, longitudinal management)
Infrastructure Needed	Protocols + training	Telehealth platform + provider contracts	Telehealth + care coordination + hospital/PCP integration
Outcomes	Reduces unnecessary ED transports	Expands safe alternatives to ED transport	Positions EMS as a longitudinal care access point

Application, Timeline, and Funding

5. Who is eligible to apply for the EMS Transformation RFA?

Eligible applicants are non-profit, Kentucky Board of EMS (KBEMS) licensed Class Ia or Class Ib EMS agencies that provide 911 responses within the Commonwealth of Kentucky. Hospital-based, non-profit EMS agencies are eligible to apply for Community Paramedicine RFA funding if they are licensed as a Class 1 EMS agency. To be considered for funding, agencies must hold an active EMS agency license and be in good standing at the time of application and throughout the award period.

6. Is there a funding award cap for EMS agencies?

No, there is no formal award funding cap for EMS agencies. However, all costs must align with allowable uses defined by the Centers for Medicare & Medicaid Services (CMS).

Allowable costs include:

- Dedicated program coordinator or staff to support TNT/TAD protocol development and implementation
- Medical director or physician time related to protocol drafting, review, approval, and clinical oversight
- Development or procurement of training materials, SOP manuals, and protocol guides
- Supplies, equipment, and personal protective equipment (PPE) to support on-scene care
- Tablets to support documentation, telehealth, and care coordination
- Connectivity solutions to enable field-based telehealth and documentation

In addition to these guidelines, indirect cost may not exceed 10% of the total award amount, regardless of whether the awardee has a higher negotiated rate, and the total administrative costs may not exceed 10% of the total award amount.

7. Do agencies need to have TNT/TAD protocols in place at the time of application?

No, agencies are not required to have pre-established TNT/TAD protocols at the time of submission. A significant portion of Year 1 will focus on protocol development, either individually or through standardized approaches, in coordination with KBEMS. Agencies without existing protocols may indicate their intent to develop and implement protocols aligned with KBEMS guidance and their Medical Director If awarded funding. Agencies with existing protocols are encouraged to include them as part of their application.

8. Are agencies required to have formal partnerships in place prior to applying?

No, formal agreements with telehealth providers, hospitals, or community partners are not required at the time of application. Agencies may identify and list anticipated partners and demonstrate awareness of the partnerships needed for successful implementation.

9. What is the care coordination platform?

The care coordination platform is a statewide, EMS-integrated technology platform designed to streamline communication and coordination across EMS agencies, hospitals, and other healthcare partners. Use of the platform will be required for all awardees to support data sharing and program evaluation. Agencies may also choose to integrate Pulsara directly into existing ePCR/charting systems.

10. What are the expectations and reporting requirements for awardees?

Agencies will be required to submit both documentation and performance data throughout the grant period. Documentation and data reporting requirements are listed within Appendix C of the EMS Transformation RFA Narrative and include finalized TNT/TAD protocols, standard operating procedures (SOPs), and metrics related to utilization and patient outcomes.