Enhancing System Integration and Population through Community Paramedicine

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A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

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Defining Community Paramedicine

- CPS operate in expanded roles connecting underutilized resources with underserved populations. (C*P Evaluation Tool, 2012*)
- CPs apply training and skills in community-based environments. CPs practice within an "**expanded scope**" (using specialized skills/protocols beyond that which he/she was originally trained for), or "**expanded role**" (working in non-traditional roles using existing skills). (*International Roundtable on Community Paramedicine*)
- Organized system of services**,** based on local need, provided by CPs integrated into local/regional health care system and overseen by emergency and primary care physicians. (*Rural & Frontier EMS Agenda for the Future, 2004*)

Overview

- Realities of our current health care system
- Opportunities to enhance system integration and population health through use of community paramedics (CPs)
- Challenges and barriers
- Review of the FMT Community Paramedicine Study
- Overview of national initiatives
- Examples: Community paramedicine programs

Realities of Health Care

- Health care organizations are working towards greater value, quality, and integration
- Systems of care and policymakers are increasingly recognizing the value of population health
- Payment demonstrations are encouraging reform
- Wide spread changes to the payment system will take time
  - Secretary Burwell's initiative seeks to accelerate the pace
- No systems/communities have all the resources needed – particularly rural systems of care/communities

Expectations – Moving Forward

- Outcomes are critical - more important than process
- Performance measures will drive reimbursement
- Hospitals increasingly focused on the role and contributions of EMS under the value-based environment
- Cost of service will be a key focus
- Patients ideally will be linked to CP programs and other services through their primary care physician
- Services will be based on and address community needs – community health needs assessments are key

Realities of EMS

- EMS is often ignored in discussions of integration and was largely ignored in the ACA
- 29% to 35% of all EMS calls are fir non-emergent problems
- 911 and emergency departments are becoming the de facto safety net for non-emergent services in rural communities
- EMS and community paramedicine are well positioned to address gaps in system
- Developmental work and a “leap of faith” are needed to move forward until payments system catch up
- Reimbursement – payment remains episode based and generally requires transport to an ED

What Gaps Can CP Fill?

- Integrate EMS resources to better address unmet health care and public health needs as a system of care
- " Treat and release" – Provide on the spot care for minor illnesses and injuries – freeing ED resources
- Patient navigation and transport
- Reduce frequent ED fliers by working with local providers
- Preventive care – screening, education, and immunizations
- Post-acute care –reduce unnecessary readmissions by following up with discharged patients
- Chronic illness management

Rural/Urban Goals for Community Paramedicine

Rural

- Primary care shortages
- Geographic distances to nearest hospital
- Utilization of paramedics during “down time”
- Career path opportunities

Urban

- High volume of 911 calls
- Wait time in the ED

Both look to keep patients in their homes, reduce hospital readmissions and frequent ambulance transports

Community Paramedic Services

Depends on community needs but typically includes:

- Assessment
- Blood draws/lab work
- Medication compliance
- Medication Reconciliation
- Post-discharge follow-up within 48-72 hours as directed by hospital, PCP, or medical director
- Care coordination
- Patient education
- Chronic disease management (CHF, AMI, Diabetes)
- Home safety assessment: e.g. falls prevention
- Immunizations and flu shots
- Post-surgical wound care (not all CPs have this in their scope of practice)
- Referrals (medical or social services)

State Flex Program CP Activities

- 2010-2011: Five states Flex programs undertook community paramedicine initiatives
- 2012: Nine states included community paramedicine initiatives in their State Flex Grant applications, with six states providing funding for CP activities
- State Flex offices/staff provide facilitation of stakeholder meetings and dissemination of CP opportunities.
- Partnership of State Offices of Rural Health and State EMS agencies

Role of State Flex Programs

- Engage policymakers/statewide coalitions of providers
- Facilitate development of local and regional coalitions
- Support EMS and hospital training
- Support Systems of Care involving CAHs
- Support development of hospital and EMS standardized tools, treatment and transport protocols, data collection, etc.
- Disseminate information on best practices and successful initiatives

Study Interview

Contacted15 states engaged in CP development:

State EMS Agencies: GA, IA, ME, NE

SORH/Flex: AZ, CO, GA, IA, ME, MN, NH, ND, PA, SC, WI

Local EMS agencies: CO, WI

Local organizations: AL (urban model), NY (Assoc. Prof. Emergency Medicine, U. of Rochester, School of Medicine), WA (Prosser Memorial Hospital-CMS Innovation Award grantee)

Nova Scotia Emergency Health Services Director of Provincial Programs

Findings from State Interviews

- Most CP programs are initiated at the "grassroots" level: Local ambulance companies seek out hospitals or other health care agencies with which to collaborate/partner
- Stakeholder groups are essential to successful development and buy-in of CP programs
- Community needs assessments are critical to developing CP goals and services
- Training varies, from established national curriculum to in-house trainings with partner agencies
- Reimbursement is a significant challenge

Maine CP Pilot Program

- Maine Flex supported/funded development of CP pilot and worked closely with State EMS Bureau (good relationship)
  - Funded meetings, education, consultants
  - CAH QI Director and CEO meetings provide a forum to disseminate information about CP
- Legislator approved CP pilot project (capped at 12 pilot sites)
- 6-8 applications for participation have been approved, many from rural EMS units
- Applications focus on unique community needs and resources
- No state reimbursement for services – Applicants are committed to demonstrating need for and value of CP

Examples from Maine Pilots

- CA Dean Memorial Hospital- Critical Access Hospital owned EMS services
  - In home management of chronic congestive heart failure, chronic obstructive pulmonary disease, and diabetes patients
  - Services include medical/physical assessments, wound care and assessment, medication compliance and reconciliation, home safety assessments, phlebotomy, blood glucose analysis, non-emergent cardiac monitoring and infusion maintenance
- Calais Fire and Rescue
  - In home management of patients with diabetes, congestive heart failure, chronic obstructive pulmonary disease, and hypertension
  - Services include a physical assessment, vital sign monitoring, medication reconciliation, blood draws, and 12 Lead EKG

Examples from Maine Pilots

- Lincoln County Healthcare (Miles Memorial Hospital) with Central Lincoln County, Waldoboro, and Boothbay Regional ambulance services
- Working with LCH PCPs to focus on patients who need a follow-up visit for:

– Phlebotomy INR orders
– Standard assessment of wounds
– Assessment of Pitting Edema
– SpO2 monitoring
– Medication reconciliation
– Access to social services
– Point of care blood glucose testing
– Patient weight monitoring
– Medication reconciliation
– Falls Assessment
– Primary care referral and/or follow up
– Influenza Vaccinations
– Assessment and management of home O2 delivery devices

Funding Community Paramedicine Programs

- Reimbusement issues are the most challenging for the "non-transport" services provided by CPs
- Funding for the CPs most often is provided by the ambulance company
- Some hospitals provide funding for CPs
- Grants: CMS Innovation Grant (WA-rural hospital model, NV-urban model)
- Commercial insurer: PA (urban model)
- State Office for Aging: NY

Findings from State Interviews: Legislative/Regulatory changes

Most states trying to work within existing EMS scope of practice (not requiring regulatory change)

- **CO:** initially licensed as Home Health Provider, currently working on new regulatory framework for CPs
- **ME:** legislative change to authorize CP pilot projects
- **MN:** legislative change certifying CP as provider type eligible for Medicaid reimbursement
- **NE:** legislative change to remove the word “emergency” from the scope of practice
- **WI:** legislative change to allow pilot project for CP to work outside scope of practice

Key Strategies to Maximize Value of CP

- Engage in local community health needs assessments – 501(c)3 hospitals and public health are increasingly engaged
- Focus on integrating with overall systems of care
- Develop capacity for data collection and analysis capacity to monitor and document quality of care, costs savings, system performance, and value to the system
  - Develop and report performance measures for the service and the system
- Be sensitive to competitive issues
- Collaborate – share data and resources
- Understand reimbursement incentives for all stakeholders