Community Paramedics - Discussion

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

EMS 1.0 (You call, we haul, that's all)

In 1965: ***Accidental Death and Disability: The Neglected Disease of Modern Society*** *(AKA* ***"The White Paper"****)*

- Leading cause of death early years
- Chance of survival better in a war zone
- Standardization of training and first EMS curriculum

EMS 2.0: Rapid transport and quality care

Vision based on 14 attributes of EMS

- 1996 EMS Agenda for the Future
- 2004 Rural Frontier EMS Agenda for the Future (NRHA)

Some advancements

- Greater focus on quality of care
- Community Paramedicine – reimbursement still an issue
  - 200+ programs nationwide
  - 93% of states have at least one program

Definition

Community Paramedic:

A Community Paramedic (CP) is an advanced paramedic who works to increase access to primary and preventive care and decrease use of emergency departments, which in turn decreases health care costs.

CPs work under the direction of an Ambulance Medical Director, and may:

- Provide follow–up care after a hospital discharge to prevent hospital readmission; provide health assessments, chronic disease monitoring and education, medication management, and immunizations and vaccinations; collect laboratory specimens, and perform minor medical procedures.

Community Paramedics (CP) Definition, Minnesota Department of Health, https://www.health.state.mn.us/facilities/ruralhealth/emerging/cp/index.html

Community Paramedic Clinical Services

- CPs may provide services as directed by a patient care plan developed by the patient's primary physician, advanced practice registered nurse or physician assistant.
- Care plan must be coordinated with the ambulance service medical director and relevant local health care providers
- Care plan must ensure that:
  - The services provided are consistent with the services offered by the patient's health care home, if one exists
  - The patient receives the necessary services, and
  - There is no duplication of services to the patient.

Minnesota Statute 144E.28, subdivision 9

Community Paramedic Clinical Services (cont)

Community Paramedic (CP) services include:

- Health assessments
- Chronic disease monitoring and education
- Medication compliance
- Immunizations and vaccinations
- Laboratory specimen collection
- Hospital discharge follow-up
- Minor medical procedures approved by the ambulance service medical director

Minnesota Statute 256B.0625, subdivision 60

Community Paramedic Regulations

Community Paramedic (CP):

- Shall be certified as a Paramedic and have two years of full-time experience or a part-time equivalent.
- Shall successfully complete an approved CP education program from a college or university.
- CP programs are approved by the Emergency Medical Services Regulatory Board (EMSRB)
- Education programs must include clinical experience
- Must complete 12 hours of continuing education every two years in addition to meeting Paramedic continuing education requirements.
- Must practice in accordance with protocols and supervisory standards established by an ambulance service medical director.

Minnesota Statute 144E.28, subdivision 9

Community Paramedic Reimbursement

- Community Paramedic (CP) services are eligible for Medical Assistance reimbursement.
- Services must be provided to a recipient who:
  - Has received hospital emergency department services three or more times in a period of 4 consecutive months in the past 12 months.
  - Has been identified by their primary care provider as someone for whom:
    - services would likely prevent admission to or would allow discharge from a nursing facility; or
    - would likely prevent readmission to a hospital or nursing facility.

Minnesota Statute 256B.0625, subdivision 60

- CP services provided by telemedicine are eligible for reimbursement
- *Minnesota Statute 256B.0625, subdivision 3b; effective 2019*

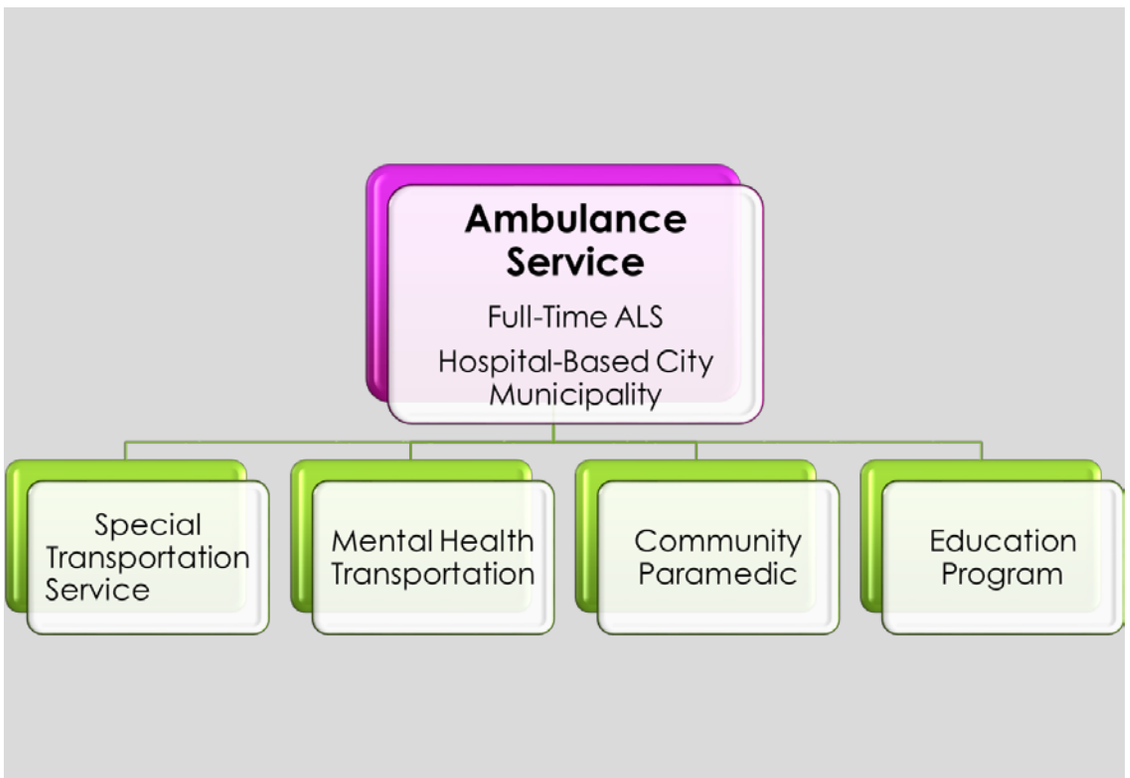
Community Paramedic Program Experiences

- Granite Falls Health
- Centracare Health
- Tri-County Health Care

Granite Falls Health

Critical Access Hospital

- ED: Avera E-Emergency
- Employ ED Providers
- Primary Care Clinic
- 4 Physicians
- 4 Mid-Level Providers
- Skilled Nursing Home
- Home Health Care



Granite Falls Health CP Goals

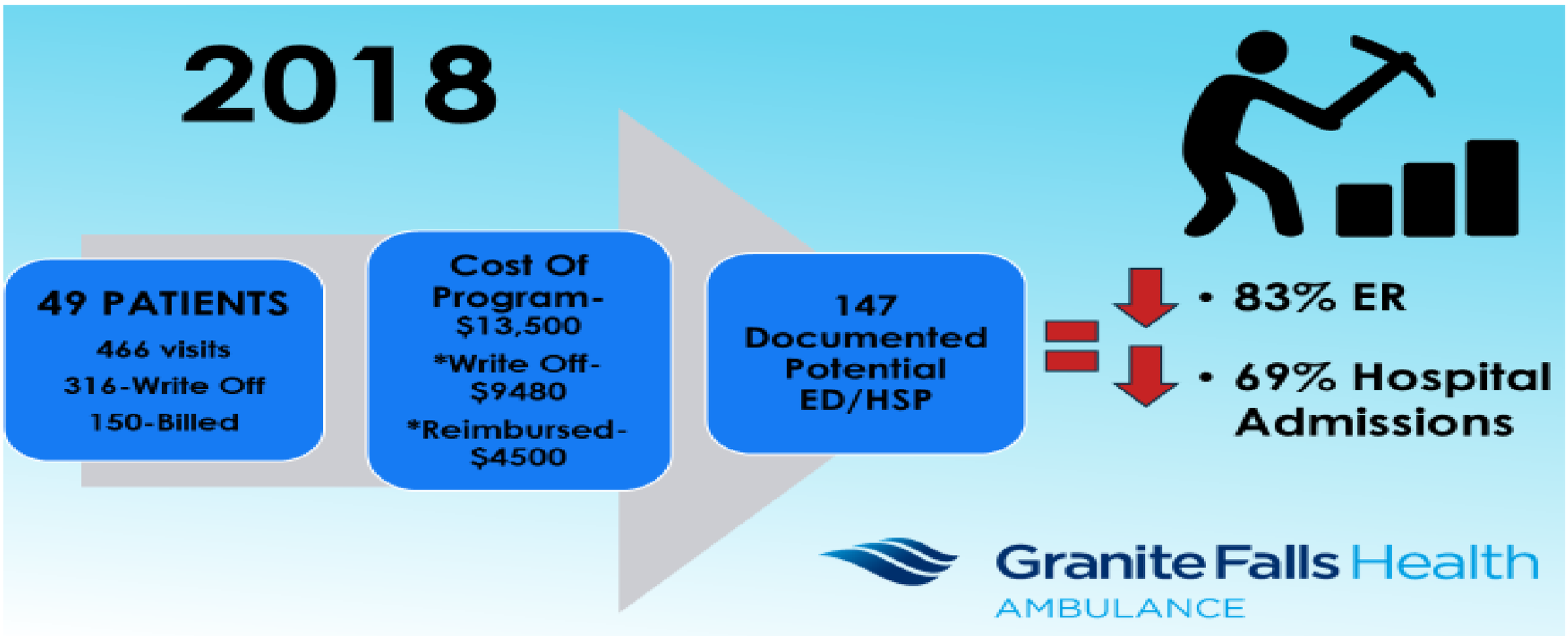
- Fill Gaps
- Revolving Door
- Re-Admissions
- Medication Compliance
- Patient Frustration

- *LOW COST*
- *Common Sense Approach*
- *Fixes Large-Scale Problems*
- *Personal level*
- *Link to Appropriate Care/Resources*

Become Part of the Solution

Granite Falls Health AMBULANCE

Granite Falls Health CP Program



Granite Falls Health Financial Impact

Low Acuity ER Visit=$1000
Medicare=35%
Un-Reimbursed=65%

IF 147 were Actual
ER VISITS…

POTENTIAL SAVINGS
Un-Reimbursed Cost
$650x147=
$95,550

Reimbursement= $51, 450

49 PATIENTS
147 visits x $30
67%-Write Off
33%-Billed

CP Program Cost=$4410
Reimbursed $1455
Write Off-$2955

Granite Falls Health
AMBULANCE

CentraCare Health CP Program Goals

- Reduce Avoidable Emergency Department Visits
- Align Patients lacking primary care with providers
- Unique Treatment Plans for Opioid Addiction
- Reduce Thirty Day Post Inpatient Discharge Re-Admissions
- Connect uncompensated care patients with MN Care, Medicaid programs, or insurances

CentraCare Health Program Services

What they do

- Health assessments
- Chronic disease monitoring and education
- Medication compliance
- Immunization and vaccinations
- Laboratory specimen collection
- ER and hospital discharge follow-up care
- Wound care

Who They See

- Patients with frequent ER visits
- Patients who miss clinic appointments
- Patients at risk for hospital readmission
- Patients with chronic disease processes such as CHF, COPD, diabetes
- Patients without support at home
- Elderly, homeless, mental illness

CentraCare Health Results

FY 2019

- Patients Referred: 768
- Patient Encounters: 3672
- Emergency Department Avoidable Visit Reduction:
  - 268 Patients with ED visits, 131 or 48.88% of patients reduced usage
- In Patient Re-Admission Reduction @ 30days post discharge:
  - 331 Patients with in patient admissions, 197 or 59.52% patients reduced admits

Tri-County Health Care CP Program Goals

Bridging the gap with a proactive approach to health care

People served:

- Complex conditions
- Multiple health ailments
- Referred by their physician
- Assigned to care coordination/health coach

Services:

- Medication Management
- Comprehensive Discharge Planning (with team)
- Patient and Family Engagement
- Transition Care Support
- Transition Communication

General Barriers

- Geography
  - Extended travel times and distances
  - Efficient grouping of visits
- Staffing Resources
  - Program referral growth exceeding current FTE’s
- Referral Process
  - Getting the message out across the health care system
- Finances

General Barriers (cont)

Linked to: EMS 2.0: Rapid transport and quality care (cont)

Struggles remain

- Not an essential service in many areas
- Not seen as a legitimate health care provider
- Payment model based on miles transported
- High-cost transport to high-cost healthcare provider
- See 2016 Rural EMS Sustainability Survey (MDH, MAA, EMSRB)

EMS 3.0: ET3 demonstration project

Center for Medicare and Medicaid Innovation (CMMI) new demonstration project called **Emergency Triage, Treat and Transport Model (ET3)**

- 16% of Medicare fee-for-service EMS transports could go to lower-acuity settings
- $560M / year savings by transporting to doctor's offices

ET3 model goals

1: **Provide person-centered care**: individuals receive care safely at the right time and place

2. **Increase efficiency in the EMS system**: EMS more readily available for high-acuity cases, such as heart attacks and strokes

3. **Encourage appropriate utilization of EMS**: meet health care needs effectively

ET3 payment model

Ambulance transport to alternative destinations

- Physician offices, behavioral health centers or urgent care centers
- Payment = to Medicare Part B BLS fee schedule + mileage

ET3 payment model

Treatment in place via qualified health care practitioner

- On scene or via telehealth
- Scene is the telehealth originating site at rate = to base BLS ground
- Telehealth practitioners eligible for increased rates during non-business hours

ET3 payment model

Performance-based payment adjustment for achievement on key quality measures

- Beginning year 3, opportunity to receive an additional 5% in model payments

ET3 timeline

Summer 2019: Request for Applications (RFA)

Fall 2019: Announce participants (includes qualified dispatch centers)

Fall 2019: Notice of Funding Opportunity (NOFO)

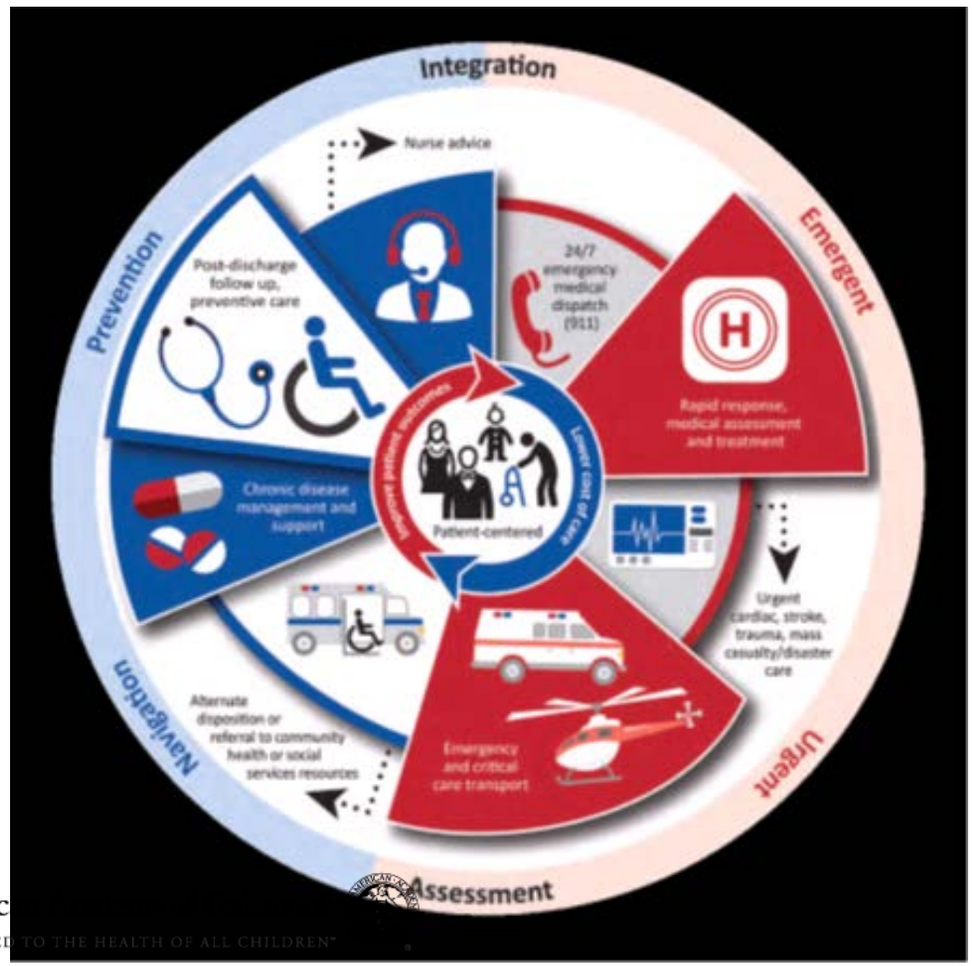
Early 2020: Award cooperative agreements

5 year project, participants may join anytime, though financial benefits will be less for late joiners based on performance measures

EMS 3.0: Integration into value-based healthcare

EMS expanded roles

- 24/7 medical response continues
- Nurse advice
- Post-discharge follow up, preventive care
- Chronic disease management and support
- Alternative transportation or referral to community health or social services resources



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EMS 3.0: Integration into value-based healthcare

2019 Rural and Frontier EMS Three Year National Tactical Plan

- Builds on 2004 Rural EMS Agenda for the Future
  - Tactical plan to implement the most important, feasible remaining recommendations
  - Recent healthcare reform have reshaped emphasis
    - Volume to value, reimbursement, rural hospital closures, etc.

EMS 3.0: Integration into value-based healthcare

2019 Rural Emergency Care Integration Summit

Flex Program Support for Rural Emergency Services: Moving from "Loaded Miles" to Value-based Models

1. Identify opportunities for rural EMS and rural hospital collaboration in the transition to value

2. Discuss challenges related to rural EMS providers and rural hospital collaboration in transition to value

3. Discuss strategies for overcoming the challenges

Summary

1. Transition to EMS 3.0 is happening, especially in the community paramedic and community EMT arena

2. The following key areas need to be addressed before rural EMS can fully participate:
   - Value-based funding must align upfront
   - Independent self-determination discussions need to drive the future
   - Transition away from volunteer-based staffing models
   - Partnerships and/or mergers with CAHs should be explored to take full advantage of value-based incentives

Thank you.

Special thanks to the

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