# Community Paramedicine & Alternate transport destinations

# Objectives

- Define Community Paramedic

- Today's Operations
- Liability Reform
- Reimbursement
- Future Options
- Discussion

# Community Paramedicine

- Community Paramedic (CP) model:
  - Innovative, proven solution providing high quality primary care and preventative services by employing a currently available and often underutilized healthcare resource for vulnerable populations
  - Specialty of paramedicine
    - Flight paramedics
    - Tactical paramedics
    - Community paramedics

# Problem Statement (Eagle Co. EMS CO)

- Access to healthcare and particularly primary care services is a growing concern.
- Primary care providers are in short supply, and the uninsured population is on the rise.
- Uninsured patients are less likely to seek out preventive care services, and are more likely to go to the emergency room for non-urgent care, increasing the cost of healthcare.
- In rural areas, the problem is exacerbated because of a higher rate of uninsured, compared to urban settings, and shortage of healthcare providers.

# Opportunity (Eagle Co. EMS CO)

- Addresses access to primacy care services
- Paramedics have the training, expertise and scope of practice to provide certain services
  - Direct service providers: prevention, emergencies, evaluation, triage, disease management
  - Assessments, blood draws, wound care, diagnostic cardiac monitoring, fall prevention, med reconciliation, post operative follow-up
  - Experience with taking health care into a home

# How does it work?

- A primary care partner refers a patient to EMS personnel to provide services in the home that are within their current scope:
  - Hospital discharge follow-up
  - Fall prevention
  - Blood draws
  - Medication reconciliation or wound care
- CP provides care and communicates with the referring partner to ensure quality of care and appropriate oversight

# Role of the Community Paramedic

- Work in collaboration with Public Health
- Assessing and evaluating community services and systems to identify gaps between the community and health care system and services
- Navigate and establish systems to better serve citizens
- Serve as advocates, facilitators, liaisons, and resource coordinators

# Goals

- Improve health outcomes among medically vulnerable populations
- Save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions

# Advantages of a CP project

- Increases quality and efficiency of managing patients in a primary care and public health setting by utilizing EMS personnel through non-traditional methods
- EMS personnel are integrated throughout the system, improving access to healthcare
- CP certification provides job opportunity
- EMS Personnel have the training and expertise to provide essential services

# Current Models

- Wake County, N.C.
  - Advanced Practice Paramedics
  - No expanded scope of practice
  - Within the 911 system

# Current Models

- Eagle County, C.O.
  - Community Paramedics
  - Operate outside the 911 system
- Proof of concept model
  - COPD, CHF, Childhood asthma…

# Proof of concept

- PCP requests CP home visit for long term respiratory disorder
- Hx of COPD, home O2, albuterol and advair
- Home visit yields SpO2 @ 86%; LS: wheezes
- Administers neb treatment, 12 lead, med reconciliation, finds two advair unopened
- Inquired: stopped taking due to a commercial that stated side effects
- Two weeks later: substantial improvement in health quality

# MedStar, Ft Worth, T.X.

- Advanced Practice Paramedics/CP's
- Mixed
- Enrolled 21 patients with over 800 911 calls
- Decreased 911 usage by 78% for those patients
- Equated to:
  - $968,000 in charges by EMS
  - $3,692 per visit ER charge
- Decreased the volume by 500 patients saves $213,000 in ER Costs and $192,000 EMS charges

# FAQ's

- Does a CP replace current healthcare systems like home health care or primary care physicians?
  - No, CP is an extension of the primary care provider to provide care to patients without access
- Does a CP have the right training?
  - Additional education is provided to CP specific to providing preventative care in the home

# Education

- Education ~ 100 hrs
- Plus an additional clinical model 50-200 hrs
- Covers:
  - Role in health care
  - Social determents of health
  - Role in public health
  - Cultural competency
  - Community health assessments and mapping
  - Patient navigation
  - Professional boundaries
  - Clinical care in population health gaps

# Beyond Emergency Response

- Paramedic evolving role
  - Expanded role vs. expanded scope
  - Train for more primary health care
- International Success of alternative model of ambulance practice
  - (Toronto, Australia, Nova Scotia, U.K., etc.)
- International Roundtable of Community Paramedicine

# Integration with health systems

- *EMS Agenda for the Future* envisions EMS undertaking a community-based health management role (NHTSA, 1996)

- National Rural Health Associations developed a paper, *Rural and Frontier Emergency Medical Services: Agenda for the Future* identifies rural and frontier systems of the future will need to serve as:
  - a formal community resource for prevention, evaluation, care, triage, referral, and advice.

# Alternate Transport Destinations

# Wake County, N.C.

- http://wake.granicus.com/MediaPlayer.php?publish_id=221

- Respond, Reduce, Redirect
  - Respond: Add an additional Paramedic on scene
  - Reduce: Preventative care home visits (its not about reactive medicine but preventing medical emergencies)
  - Redirect: Alternative destinations

# Sample Populations

- Children with Asthma
- Diabetics
- Heart failure patients with HTN
- Elderly at risk for falls
- Substance abuse crisis
- Mental health crisis

# Entry point

- Referrals:
  - Paramedics
  - Physicians
  - ER navigation coordinators
  - Home health services
  - Other health care professionals
- May result in a CP visit or a unified home visit

# Hospital Discharge Patient

- Pt may not have a good understanding of post discharge instructions or the health care plan
- CP provides in home care and medication administration

# Redirection in Wake County

- Redirect care for mental health or substance abuse crises at facilities other than the emergency room when no other medical emergency exists.
- Evaluate patient to help determine if the patient would benefit by treatment at another facility.
- For appropriate patients, determine the best alternative treatment location and arrange for the patient's transportation and admission.
- Ambulance transport to the emergency room is always an option if the patients request other medical evaluation or treatment.

# Redirection in Wake County

- N.C. mean hold time for a mental health patient in an emergency department is 14 hours.
- Within the first six months of their APP program, they have referred 167 patients, returning approximately 2,400 bed-hours to local emergency departments = 800 chest pain evaluations in their community.

# Building blocks of liability reform

# Liability Reform in Oregon

- During the February 2012 Legislative Session, Governor Kitzhaber committed to develop a medical liability legislative proposal for 2013.
- He convened key organizations with a significant stake in the outcome of this effort to recommend a proposal to him.
- The group's efforts were guided by the following principles:

# Liability Reform in Oregon

- Improve the practice environment to allow physicians to learn from medical errors and improve patient safety;
- More effectively compensate individuals who are injured as a result of medical errors; and,
- Reduce the collateral costs associated with the medical liability system including costs associated with insurance administration, litigation, and defensive medicine.

# Liability Reform in Oregon

The group reviewed the following background materials before discussing options and priorities:

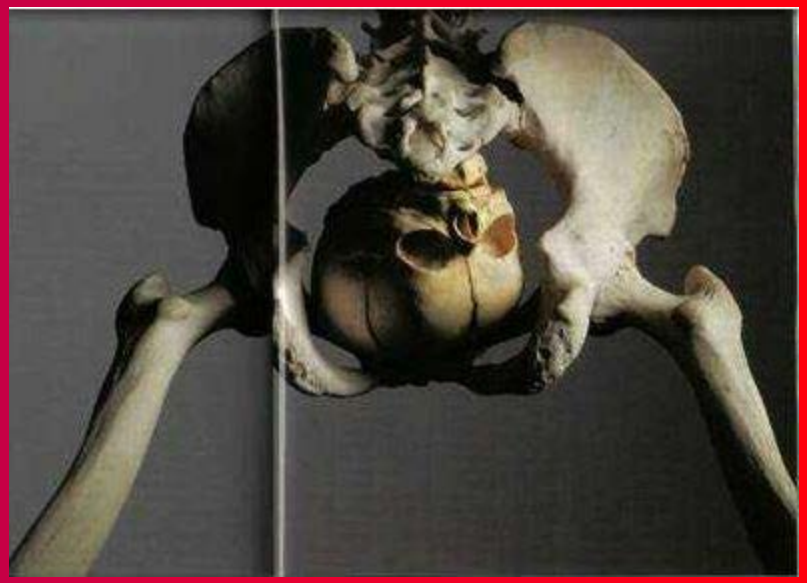
1. 2010 report from the Medical Liability Task Force (initiated by the Oregon Health Policy Board)
2. House Bill 3650 (2011)
3. Medical Liability Report -- from HB 3650
4. Defensive Medicine Report – from HB 3650
5. Department of Justice Legal Analysis on Medical Liability (January 2012)
6. Senate Bill 1580 (February 2012)

# Liability Reform in Oregon

Conclusion:

**New Approach Needed**

- Advisory group took off the table:
  - caps on noneconomic damages, medical panels, extending coverage under the Oregon Tort Claims Act and clarifying or modifying Oregon's joint-and-several liability reform statute



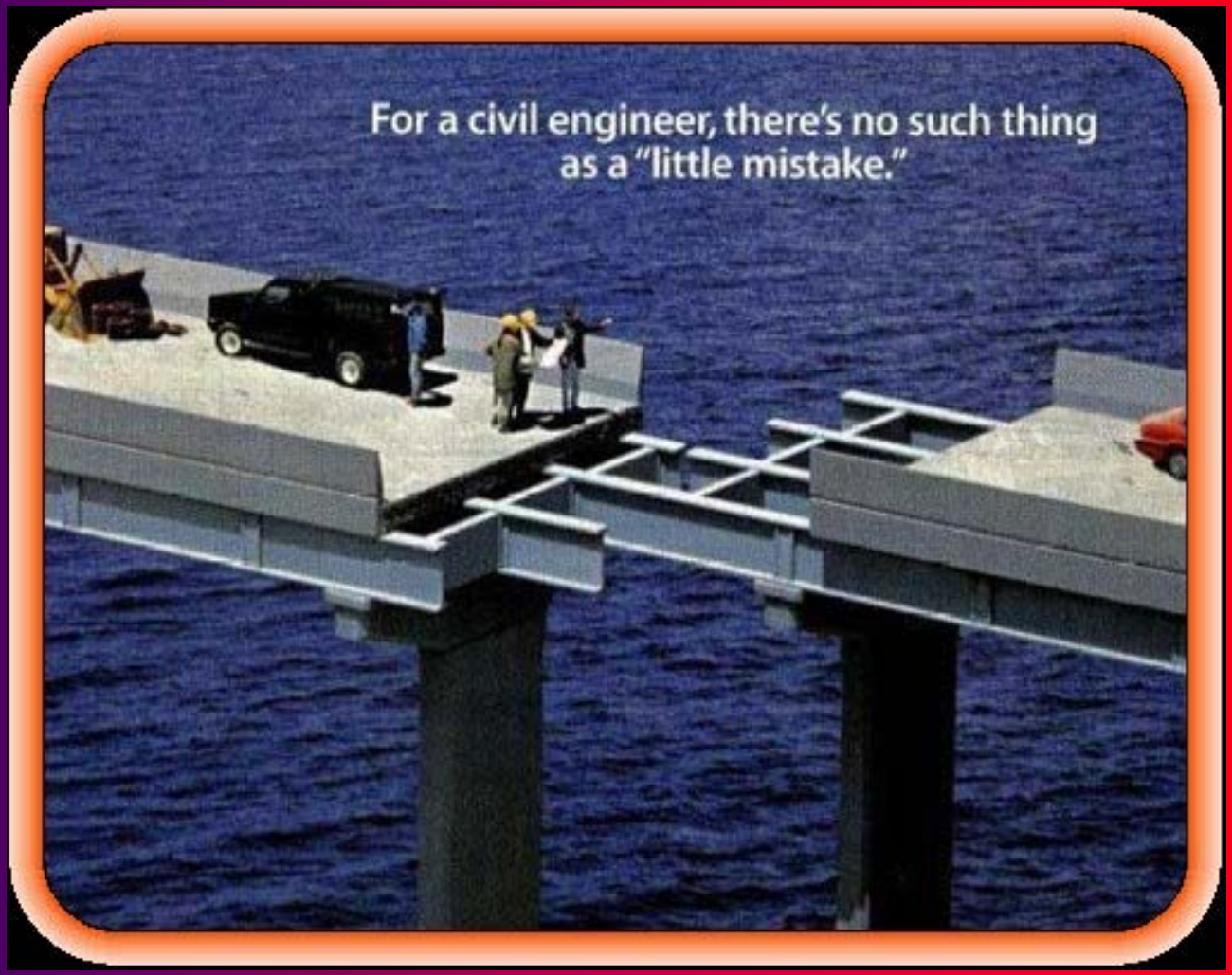
# Liability Reform in Oregon

- Advisory Group recommended to the Governor the interests of the patient, health care providers, and the public would best be served by a three-phase approach to medical reform which would include:
  - 1. Early Discussion and Resolution
  - 2. Mediation
  - 3. Litigation

# Importance of this Act

- Section 11. Definitions. As used in this Act:
- (1) “Health care facility” has the meaning provided in ORS 442.015:
- **(2) “Health care provider” includes:**
  - **(d) An emergency medical services provider under ORS chapter 682;**
- (3) “Serious Event”: An objective and definable negative consequence of patient care that is unanticipated, usually preventable and results in patient death or serious physical injury.

# Frame it right



# Liability Reform in Oregon

- Today:  Vicarious Liability-- Health Care Providers have liability coverage while treating Medicaid patients enrolled in a CCO if operating under contract
- New Legislation: possibly expands coverage to all patient populations
- EMS may receive adequate liability protection to assist in our role of getting patients to the right/alternate resource

- How does implementation of a CP program or alternate destination affect EMS?

# What this means to an EMS agency

Health care transformation--Medicaid/CCO

- No Hospital Transport:

  Potential Costs and Adverse Impacts on Providers
  - Decrease Revenue
  - Increased Liability

# What this means to a patient

Medicaid/CCO

- Impacts on Patients
  - Decrease costs
  - Appropriate facility for treatment
  - Theoretical increase in patient satisfaction

# Public Trust

- The other potential cost to EMS is one of **public trust.**
- **"By trying to provide an incentive** or reassurance for providers to spur participation in CCOs, Oregon may inadvertently create the perception that a second, lesser tier of accountability exists for providers caring for Medicaid patients. The extension could create the public perception that when physicians care for Medicaid patients, they can take less caution, because the government will pay for the mistakes. This perception may not comport with the notion of treating all populations equitably."

# Policy Changes

- Where to begin:
  - Partnership with CCO's for enrolled Medicaid patients

  - Through patient's case manager determine available resources and best location for redirection

# Policy Changes

- Reimbursement for:
  - preparedness and prevention, not just the ride
  - response, assessment, triage, treatment, and disposition that may, or may not, involve transportation

# Follow the reimbursement

- Discuss strategies with hospital CEO's
  - Hospital discharge and readmit < 30 days
- Discuss with the payors, what do they want to measure
  - > 30 days post discharge
- One CHF admit cost CMS (MedStar, Tx)
  - Ave $17,500 per hospital admit
  - 30 day readmission rate CHF = 24.7%
  - 52% of readmissions did not see their Dr (NEJM)
  - Day 31+ very large expenses

# MedStar 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

# Dr Gregg Margolis, Director Health Systems and Health Care Policy, HHS

- Not just treat and release but Patient Centered Disposition
- Move away from fee for service
  - Value based = cost/outcome
- 911 EMS = 0.6% of total health care spending in the US
- ED = 2%
- 6% = all ED related admissions
- However, 80% of nations resources spent on chronic disease management!

# Hospital Realignment

- Chief Experience Officer, CXO
  - Customer satisfaction affects hospital revenues
  - Redirect Non-emergency patient (survey's)
- Integrated Health system on delivery and reimbursement
- Outpatient settings to decrease readmits

# Unscheduled Medical Care

- Emergency Medicare Service vs. unscheduled medical help
- Problems with uncontrolled unmanaged care
  - Who's your doctor?  Answer: Dr Jones who works in the ER
- Misaligned incentives
  - Highest cost transport to Highest cost care
  - And, it's the easiest  (MedStar, TX)

# Policy Changes/Reimbursement

- Negotiate with CCO based on a needs assessment:
  - CCO's have a global budget
  - Non-capitated system
  - Mandated 2% decrease in cost this year
- Triple Aim (Improve health, enhance experience, reduce cost)
- Medicare legislation changes to follow principles

# Five Advantages of EMS

- 24/7
- Community Based
- Mobility
- Reliability/practice mindset
- Training and experience

# Beyond Emergency Response

- Paradigm shift
- Paramedic evolving role: CP
  - Expanded role in health care system
  - Train for more primary health care
- Alternative model of ambulance practice
  - Toronto
  - Australia (primary care paramedic)
  - Nova Scotia (advanced level provider)
  - U.K.

# Redirection Systems

- Triage at 911:  RN dispatcher
- When is a patient no longer a patient?
  - At refusal.  When the cab shows up? When they sit in front and want to go to Health Dept?

# Redirection Systems

- ORS or OAR requiring transport to ED
- Methodology for redirection
  - What patient types are redirected?
- Alternate transport destinations
  - Urgent Care, Behavioral Health, Detox Center?
- How do we transport
  - Push back from payor for utilizing a cheaper mode of transport—then why pay us?
  - If a 911 call then we can show downstream savings

# Redirection

- Community/Political Support by showing
  - outcomes
  - patient satisfaction
  - provider satisfaction
  - cost savings
  - Data

# Thank you

- Further Discussion
- Doug.Kelly@redmondfireandrescue.org