2018 35th Rural Health Conference

Community Paramedicine A Rural Perspective

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Training Officer

What's In A Name?

- Community Paramedic -
- Most people "get it" with little explanation
- Largely rural
- Clinically integrated primary care teams
- Community Paramedic is a specific practitioner
- College course –2015, international exam 2015

Community Paramedicine

- Community paramedicine is an emerging healthcare profession.
- Community paramedicine allows paramedics to operate in expanded roles to provide healthcare services to the underserved at risk populations in the home

Community Paramedicine

- EMS involvement in home-based mobile health care is not meant to replace typical home health services or hospice care in the rural environment.
- The goal is to improve access to care and avoid duplicating existing services.

Mobile Integrated Healthcare

- MIH is an organized system of services, based on local need, provided by Paramedics who are integrated into local health care systems and overseen by primary care physicians.
- MIH is a model of care where paramedics apply their training and skills in “non-traditional” methods.
- MIH is an emerging field where Paramedics operate in new roles to apply an underutilized resource to fill an unmet need.

Goals of Mobile Integrated Healthcare

- Increasing access to quality health care
- Improving patient health
- Reducing Hospital admissions
- Reducing Hospital readmissions
- Reducing unnecessary ED visits
- Meeting unmet health care needs

EMS Contribution

EMS can fill gaps in the care continuum with 24/7 medical resources that:

- Improve the patient care experience,
- Improve population health, and
- Reduce healthcare expenditures

Community paramedics focus

- Providing and connecting patients to primary care services
- Completing post hospital follow-up care
- Integration with local public health agencies, home health agencies, health systems, and other providers
- Providing education and health promotion programs

Scope of Practice

- CP is provided under the medical direction and oversight of specialized physicians with unique knowledge of the delivery of healthcare in the out-of-hospital environment.
- EMS medical directors frequently coordinate with physicians of other specialties to enhance patient care.

Scope of Practice

- In home assessments
- Medication verification
- Lab test
- Scheduled treatments
- Consultation with Primary Care Provider
- Implements alerted care plan

Hea

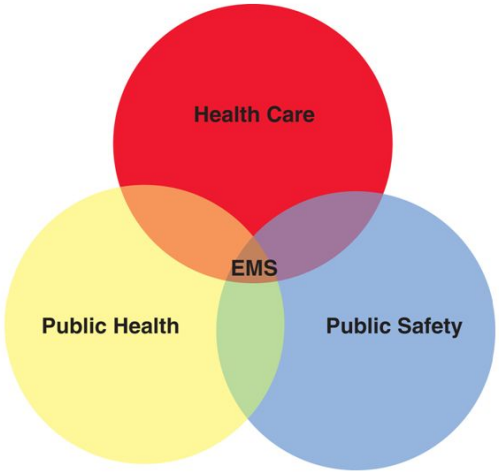
Healthcare 3.0

Our nation's healthcare system is transforming from a fee-for-service model to a patient-centered, value- and outcomes-based model, known as **"Healthcare 3.0"**

Healthcare 3.0

EMS is ***uniquely positioned*** to support our nation's healthcare transformation by ***assessing, treating and navigating patients*** to the right care, in the right place, at the right time.

Modern EMS is a combination of public health, public safety, and health care.



e Medical Services

- EMS is available in every community.
- EMS is fully mobile.
- EMS can address patient needs 24/7.
- EMS is an expected, respected and welcomed source of medical assessment and care in people's homes throughout the community.

e Medical Services

- EMS providers can effectively navigate patients needing urgent or unscheduled care through the healthcare system to ensure they receive the right care, in the right place, at the right time.
- EMS agencies fill gaps in patient care, preventing new or recurrent medical episodes to reduce ambulance transports, emergency department visits, hospital admissions and readmissions

e Medical Services

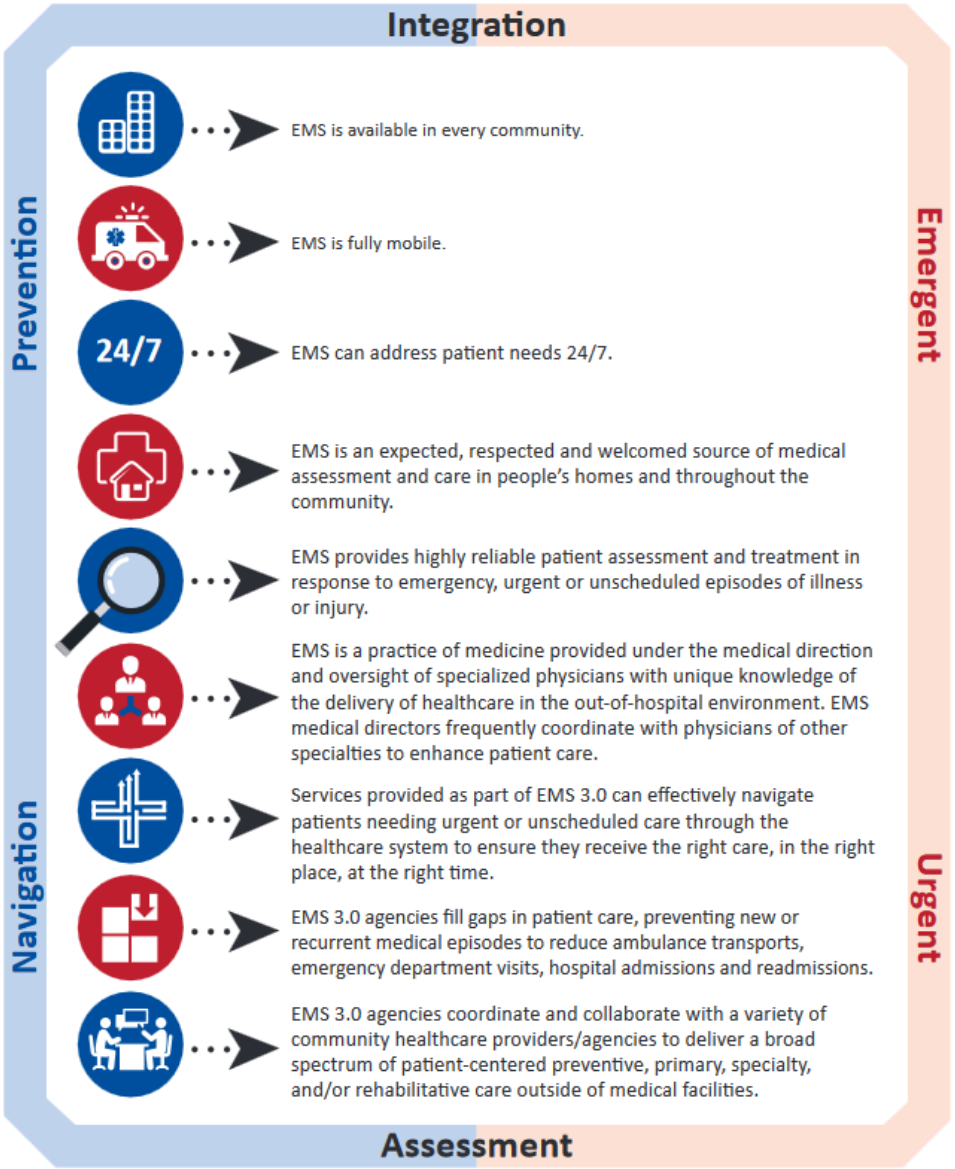
- EMS agencies can coordinate and collaborate with a variety of community healthcare providers/agencies to deliver a broad spectrum of patient-centered preventive, primary, specialty, and/or rehabilitative care outside of medical facilities

Integration

- Mobile Integrated Health care uses 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
- Re-direct 911 patients to alternative, appropriate settings

Intergration

- 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


Integration
Prevention
Emergent
Navigation
Urgent
Assessment
EMS is available in every community.
EMS is fully mobile.
24/7
EMS can address patient needs 24/7.
EMS is an expected, respected and welcomed source of medical assessment and care in people's homes and throughout the community.
EMS provides highly reliable patient assessment and treatment in response to emergency, urgent or unscheduled episodes of illness or injury.
EMS is a practice of medicine provided under the medical direction and oversight of specialized physicians with unique knowledge of the delivery of healthcare in the out-of-hospital environment. EMS medical directors frequently coordinate with physicians of other specialties to enhance patient care.
Services provided as part of EMS 3.0 can effectively navigate patients needing urgent or unscheduled care through the healthcare system to ensure they receive the right care, in the right place, at the right time.
EMS 3.0 agencies fill gaps in patient care, preventing new or recurrent medical episodes to reduce ambulance transports, emergency department visits, hospital admissions and readmissions.
EMS 3.0 agencies coordinate and collaborate with a variety of community healthcare providers/agencies to deliver a broad spectrum of patient-centered preventive, primary, specialty, and/or rehabilitative care outside of medical facilities.

Funding

- As a new type of service on the healthcare scene, most community paramedicine programs are funded by the ambulance service or hospital itself, through grants, and increasingly by insurance plans.
- Some hospitals and hospital-owned EMS programs support community paramedicine to reduce readmissions and emergency department misuse

Funding

- Reimbursement 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 and sponsoring organization
- Some hospitals provide funding for CPs
- Grants: CMS Innovation Grant (WA-rural hospital model, NV-urban model), California Health Foundation

Medicaid Covered Services

- Evaluation/health assessments
- Chronic disease prevention, monitoring, and education
- Medication compliance
- Immunizations and vaccinations
- Hospital discharge follow-up care

- Home assessments
- Minor medical procedures and treatments
- Telehealth originating site
- Point of care laboratory tests
- Laboratory specimen collection

Services do not require prior authorization

Medstar Fort Worth, TX

- Program aimed at readmission avoidance of CHF patients and ED avoidance for ambulatory care.
- Home visits focused on patient education, closed loop communication with PCP, and PCP ordered in home interventions.
- 2010-2015 1893 avoided unnecessary ED visits.

Medstar Cont.

- Since Oct 2013, 104 patients who had a prior 30 day readmission and referring agency felt would have another 30 day readmission have been enrolled.
- Of these only 38 have had a readmission. A 63.5% reduction for this high-risk readmission cohort.
- Total estimated Medicare only savings since 2010 over $800 million!

Bay Cities Ambulance MIH

Where are we?

Where are we going?

BCA MIH History

- Efforts began 5 years ago
- Small 6 patient pilot preformed under Dr. Haack with good success (1 readmission)
- Awarded Quality Innovation Incubator Funding from WOAH March 2017
- Initiating larger pilot working with WOAH with goal of minimum of 50 patients over the course of 2017

WOAH Grant

- Up to $50,000
- Cost per patient $900
- $300 Initial Visit with discharge planer and site safety visit
- $150 per visit X4

WOAH Grant

- Grant Ended February 2018
- 38 patients
- 32 completed
- 6 dropped due to non-compliance
- 4 remits

Our Services

- Environmental Home Safety check
- Physical Exam and Vitals assessment
- Katz Index Assessment (ADL's)
- Medication Review and education
- Weight/Fluid/Sodium Intake
- POC lab draws W/ delivery to specified lab
- Delivery of education materials
- 12 lead EKG with POC wireless transmission
- POC diuresis
- POC interventions within paramedic scope
- On site closed loop communication with PCP
- PCR sent directly to your office

Target Patients

Any patient that our community stakeholders view as an individual with high risk of readmission or frequent avoidable ED utilization.

- CHF
- COPD
- Pneumonia
- AMI
- Sepsis
- Diabetes

Referral Process

- Complete and send MIH patient referral form to BCAMIH@baycitiesambulance.com
- Patient will be contacted and accept entry into program
- Once patient has enrolled and sign release of info. the most recent H&P and Medication list provided to BCA
- Home visits to follow

Case Study

- 58 yo male pt with multiple admissions over last 2 months.
- Pt taken on prior to last dx by Dr. Haack and enrolled into program with bi-weekly visits.
- Complicated Med. Hx including: Long Hx of A. Fib, CHF, COPD, Hepatitis C, L Atrial Thrombus, Alcohol dependence, previous Methamphetamine abuse.
- Pt has very low health literacy. Pt unable to read.

Visit 2

- Initial presentation of patient shows obvious decline.
- Pt markedly short of breath with minimal exertion and tachycardic, HR 120-130. Lung sounds show rales bilaterally. Marked JVD noted.
- On site contact made to Dr. Haack. At home diuresis with 80 mg Lasix ordered. Med administered and CP stood by to monitor for result.
- Pt admits to exceeding fluid intake recommendation and coached of importance of adherence.
- Dr. Haack orders Amiodarone for rate control. Med. Picked up at pharmacy, med education preformed with pt, and med started at home. Follow up visit next day scheduled for eval.
- Labs drawn and delivered to Bay Clinic.

Visit 3

- Pt general appearance much improved at onset of visit. Oxygen saturations at 95-96% and HR well controlled in 80-90 range with addition of Amiodarone.
- Pt's exertional dyspnea much improved.
- Pt weight down 4 pounds.
- Pt's oral thrush improving.
- Ongoing pt education continued
- Labs drawn and delivered to Bay Clinic
- PCR completed and sent to Dr. Haack.

Visit 4

- Unscheduled visit as Dr. Haack reports worsening LFT post addition of Amiodarone
- Digoxin ordered by Dr. Haack, prescription picked up and delivered. Loading dose started and pt's pill box loaded with dig. Amiodarone stopped and med. Discarded.
- 3 lbs. Increase in weight noted. Increase in pedal edema and SOB noted. Dr. Haack contacted and diuresis (80 mg IV Lasix). Administered.
- POC 12 Lead obtained and transmitted to Dr. Haack.

Visit 4 Cont.

- Labs drawn and delivered to Bay Clinic lab
- Appointment at Dr. Haacks office confirmed and transportation arranged with agreement that CP accompanies Pt to visit.
- Home visit 5 scheduled (6-1)

EMS Stakeholder Alignment

- National Association of State EMS Officials
- National Association of EMTs
- National Association of EMS Physicians
- National EMS Management Association
- National Association of EMS Educators
- American Ambulance Association
- International Academy of Emergency Dispatch
- American Academy of Pediatrics

Resources

- WWW.communityparamedic.org/