California Community Paramedicine

California HealthCare Foundation

EMSA Emergency Medical Services Authority

UCSF University of California San Francisco

UCLA

Fire Founded 1909

Rural/Metro Ambulance

AMR Ventura County

Gold Coast

Alameda Fire Dept. Est. 1876

CARE Ambulance Service

Lifeline Medical Transport

Fountain Valley Fire Dedication Teamwork Excellence Ethics

Newport Beach Fire

Medic Ambulance

Butte County EMS

San Bernardino County Fire Dept

San Diego Fire Life Safety

Carlsbad Fire Dept.

Santa Monica Fire Dept.

Rialto Fire

Glendale Fire Department Established 1912

EMERGENCY MEDICAL SERVICES AUTHORITY

Community Paramedicine: How did we get here?

Howard Backer, MD, MPH, FACEP, Director

Lou Meyer, Program Manager

Current EMS Model

- Based on 1965 CMS rules
  - Paid for transport to ED, between hospitals, SNF, or dialysis
  - Combined with First Response without call triage based on assumptions of cardiac resuscitation
- Uses the most expensive form of transportation to respond within minutes and to take patients to the most expensive place of care

Innovation Opportunities for EMS

People utilize EDs more often because of a lack of access to other providers as opposed to the seriousness of their complaints

Pre-hospital EMS system is uniquely positioned to care for 911 patients and assist less emergent patients with transport to the most appropriate care setting based on medical and social needs… reducing the cost of care and ED burden

White Paper: HHS ASPR, DOT, HRSA 2013

Enhanced healthcare roles for EMS

- Evidence-driven protocol for appropriate disposition of patients who call 911
  - Appropriately triage patients away from ED
  - Treat and refer
  - Transport patients to alternate destinations
- Partner with public health, social service, hospitals and ACOs to provide mobile medical services in underserved communities

Innovation Opportunities for EMS, White Paper: HHS ASPR, DOT, HRSA 2013

Working Definition of Community Paramedicine

A locally determined community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community-specific health care needs assessment.

- New models of community-based health care that bridge primary and emergency care
- Utilizes paramedics outside their traditional emergency response and transport roles

Why Paramedics?

- Service most communities, urban and rural
- Always available (24 / 7 / 365)
- Work in home and community-based settings
- Trusted and accepted by the public
- Trained to make health status assessments, recognize and manage life-threatening conditions outside of the hospital
- Licensed and operate under medical control as part of an organized, systems approach to care

Types of CP Programs: Pre-hospital

1. Triage 911 calls at dispatch to determine level of care and potential destination
2. Transport patients with specified conditions to non-ED ("alternate") locations after determining ED care is not needed
3. Assess, treat, and refer with follow-up at the scene of an emergency response rather than transport them to a hospital ED.
4. Connect frequent 911 callers or ED visitors with primary care and/or social services

Types of CP Programs: Post-hospital or Community

5. Provide support for persons recently discharged from the hospital or observation unit and at substantial risk of a return visit to the ED or readmission

6. Provide support for community residents with chronic conditions by making periodic checks and providing education about how to proactively manage the condition(s)

7. Partner with community health workers to provide disease prevention care

8. Partner with public health or home health to address temporal gaps

California Statutory Limitation of Paramedic Practice

HSC 1797.52 and 1797.218

… an advanced life support program which provides services utilizing EMT-P for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during inter-facility transfer, and while in the emergency department of a general acute care hospital …

OSHPD Health Workforce Pilot Program (HWPP)

HSC 128125 The Legislature finds that there is a need to improve the effectiveness of health care delivery systems. One way of accomplishing that objective is to utilize health care personnel in new roles and to reallocate health tasks to better meet the health needs of the citizenry.

…for purposes of this experimentation, a select number of publicly evaluated health workforce pilot projects should be exempt from the healing arts practices act.

Advantages to HWPP

- Ability to test a variety of project options
- Demonstrates feasibility in CA healthcare system
- Assures patient safety and data to demonstrate benefit and lack of harm
- Creates partnerships that may support option for permanent program
- Provides strong evidence for legislature, if successful

Requirements for CP projects

- Collaborations and partnerships to address identified gaps in care or service delivery.
- Receive additional education and training commensurate with the focus of the CP program.
- Should not duplicate or compete with other health care services or providers.

Additional requirements from OSHPD and from the Steering Group

- IRB for each project
- Patient consent (required by regulation)
  - Exempted patients who cannot consent due to inebriation or mental incapacity for mental health pilot if medics have specialized training
- More consistent protocols between sites
- Additional data elements
- Immediate notification of any patient safety concerns or adverse consequences

Levels of oversight and patient safety for California CP Pilot Projects

1. Every program has emergency medicine medical director and project manager/QI (often emergency RN)
2. Availability of on-line consultation during encounters, and 100% retrospective review of patient encounters
3. The local steering committees must approve protocols and data collection and will review results and data.
4. The state steering committee will oversee and review all projects and quarterly reports.
5. The Independent Evaluator will review data regularly and raise any concerns about patient safety.
6. OSHPD reviews program sites and raises any issues that may affect patient safety.

Objections to CP Pilots

- Dangerous to patients—patient safety issue
- Paramedics can't make required decisions
- Only emergency physicians are capable of determining if emergency exists
- Nurses are more appropriate personnel to do home evaluations
- Patients who call 911 expect and deserve to go to an emergency department

Public comments on HWPP proposal, 2014

CA Pilot CP Programs

1. Transport patients with specified conditions to non-ED ("alternate") locations if ED care is not needed

   Los Angeles – Carlsbad – Orange County

2. Screen and transport psych patients directly to acute psych facility

   Stanislaus County

3. Connect frequent 911 callers or ED visitors with primary care and/or social services

   City of San Diego – Alameda County

4. Provide short-term support for persons with chronic conditions recently discharged from the hospital or observation unit

   Solano – Alameda – Butte – San Bernardino --Orange – LA

5. Collaborate with home health to improve the care provided to hospice patients when 911 is activated, and
6. Partner with public health to administer directly observed TB treatment

   Ventura County

Project Funding

- A California HealthCare Foundation (CHCF) Grant supports:
  - EMSA Project Manager
  - Independent Evaluator (UCSF)
  - Development and Delivery of the Core Training Programs
  - And stipends to support Local Site Data Collection
- Funding for Operational Implementation and staffing is the responsibility of each pilot site

Core Training Modules

1. Role of the CP in the Health Care System
2. Public Health and Primary Care Role of the CP
3. Social Determinants of Health
4. Developing Cultural Competence
5. The CP Role within the Community
6. CP's personal safety & wellness review
7. Clinical assessment, application and skills
8. Pilot site specific education

96 hrs classroom + 56 hrs independent = **152 hrs core**
Plus **50-100 hours** site specific training

Specific program barriers encountered

- Finances and personnel issues
- Lack of physician or capability at urgent care
- Clinic has become too busy to accept patients
- Hospital and psych facility under same license
- University IRB questions liability
- Medical director concerns over his/her liability
- Health system facility that will not take all patients

Timeline of California CP Pilots

Analyze issue, involve stakeholders, solicit support, develop report

2012-13

CHHS agency consent, solicit project applications

2012-13

OSHPD application and approval process

2013-14

OSHPD application and approval process

2014-15

Run projects, collect data

2015-17

Education, promotion, Legislative initiative

2017-18

EMERGENCY MEDICAL SERVICES AUTHORITY
EMSA
CALIFORNIA

California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Community Paramedicine Symposium

09.22.16

California Health Care Foundation

Dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo.

Health Care That Works for All Californians

At CHCF, we believe *health care that works* is:

1. Easy to access & available to all
2. Respects patient wishes
3. Available when & where you need it
4. Proven to be effective
5. Meets both behavioral & physical needs
6. Sustainable today & tomorrow

CHCF & the Community Paramedicine Pilot Projects

- CHCF Interested in meaningful, measurable improvements in the way the health care delivery system provides care
- CP pilot project designed to determine whether **paramedics working in an expanded role** can help improve health system integration, efficiency, and fill locally identified health care needs**.**
- CP pilot projects are advance CHCF goal of **expanding access** to underserved populations and way of **improving care** by aligning patient need and resource provided

Many Partners

Pilot Sites & Partners

paramedic time for training and interventions; data collection

EMSA

executive oversight; public owner; official sponsor

CHCF

- project manager – housed at EMSA (Meyer)
- independent evaluator (UCSF – Coffman)
- core training program (UCLA – Center Pre-Hospital Care)
- pilot site stipends to assist with data collection
- symposium & other educational activities

Assets

- Access pressures are real and need solution
- Community Paramedicine offers a variety of models/interventions that can address a broad range of local problems
- State sponsor – EMSA
- LEMSAs and partner organizations want the flexibility to address local problems

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Community Paramedicine Implementation: What Do the Early Data Show?

Dr. Janet Coffman, MPP, PhD (presenter)
Cynthia Wides, MA

Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco

Outline

- Background
- Overview of evaluation plan
- Findings applicable to all CP concepts
- Findings for specific CP concepts

Background

- HWPP approved the Community Paramedicine pilot projects on Nov. 14, 2014, and renewed approval for an additional year on Nov. 14, 2015.
- Request for extension through Nov. 14, 2017, has been submitted to OSHPD.

Background

Six concepts:

- Post-Discharge
- Frequent 911 Callers
- Tuberculosis
- Hospice
- Alternate Destination – Behavioral health
- Alternate Destination – Medical care

CP Pilot Project – Evaluation Plan Overview

The evaluation is a three phase process.

- Phase I focused on “baseline” data collection and reporting, reflecting care as it is given prior to the pilot program.
- Phase II focused on training of the CPs.
- Phase III covers the implementation period.

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Findings Applicable to All Concepts

10/11/2016

Data Collected for All Sites and Concepts

- Cumulative enrollment
- Cumulative eligible but not enrolled (ENE)
    - Did not consent
    - All other reasons
- Demographic Characteristics
- Payer Type

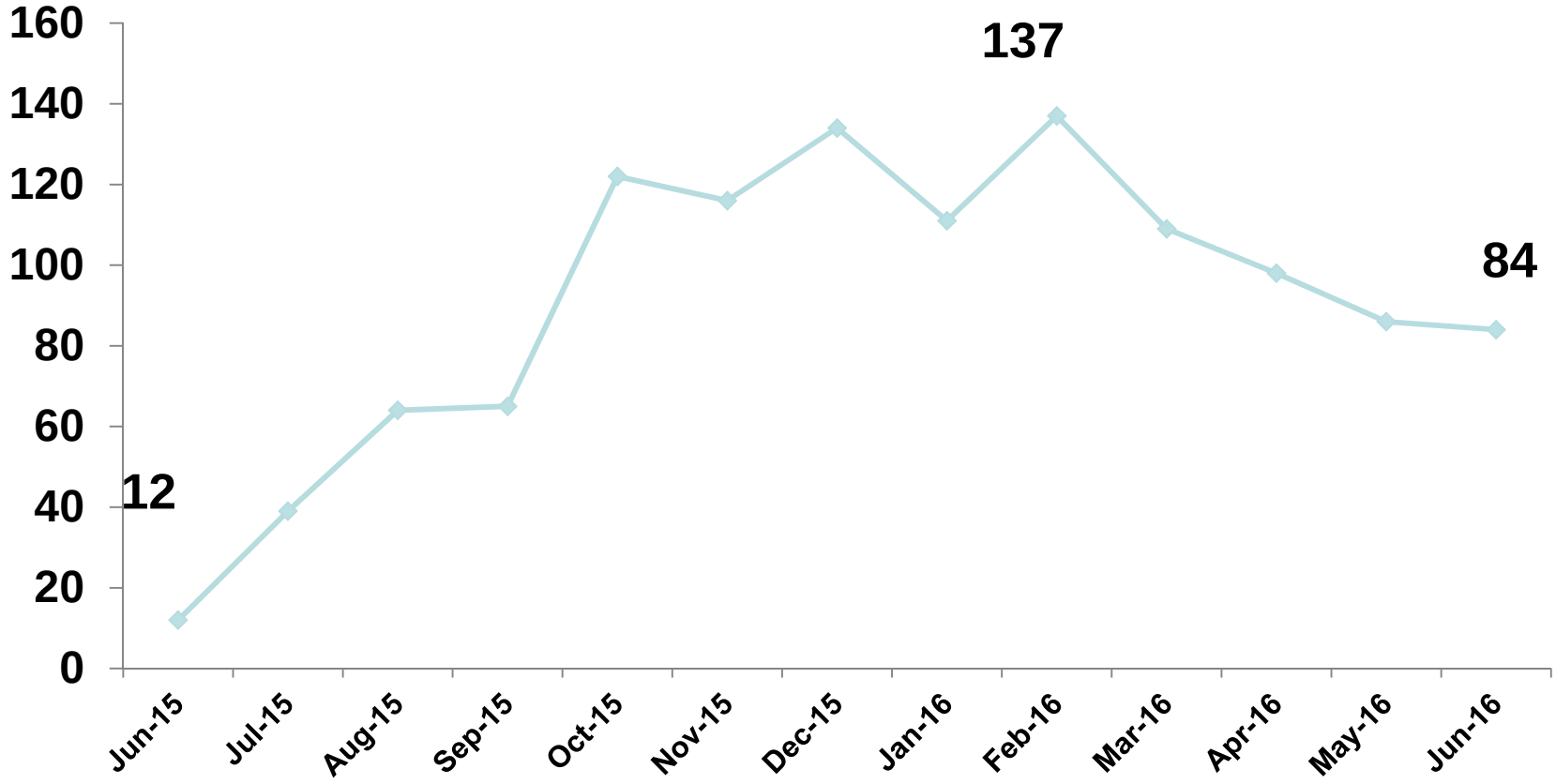
Enrollment by Project, Q2 2016

		Enrolled for the First Time			Total Enrolled		
Project No.	Concept	April	May	June	April	May	**June**
CP002	Post-Discharge	9	11	18	26	20	**27**
CP004	Post-Discharge	32	25	21	40	33	**29**
CP007B	Post-Discharge	7	4	1	13	10	**8**
CP008	Post-Discharge	14	9	8	14	9	**8**
CP013	Post-Discharge	5	6	5	13	10	**10**
CP007A	Frequent 911 Callers	2	2	0	13	5	**4**
CP010	Frequent 911 Callers	4	3	0	32	35	**35**
CP005	Tuberculosis	2	2	1	8	6	**7**
CP006	Hospice	9	8	7	n/a	n/a	**n/a**
CP012	Alternate Destination	10	11	14	n/a	n/a	**n/a**
CP001	Alternate Destination	12 in quarter			n/a	n/a	**n/a**
CP003	Alternate Destination	0	1	5	n/a	n/a	**n/a**
CP009	Alternate Destination	0	0	0	n/a	n/a	**n/a**
All Projects		**94**	**82**	**80**	**159**	**128**	**128**

Cumulative New Patients

Concept	Cumulative # enrolled
Post-Discharge	781
Frequent 911 Callers	72
Tuberculosis	25
Hospice	111
Alternate Destination – Behavioral Health	139
Alternate Destination – Medical Care	46
All Projects	1,174

Number of New Patients Enrolled, June 2015 - June 2016



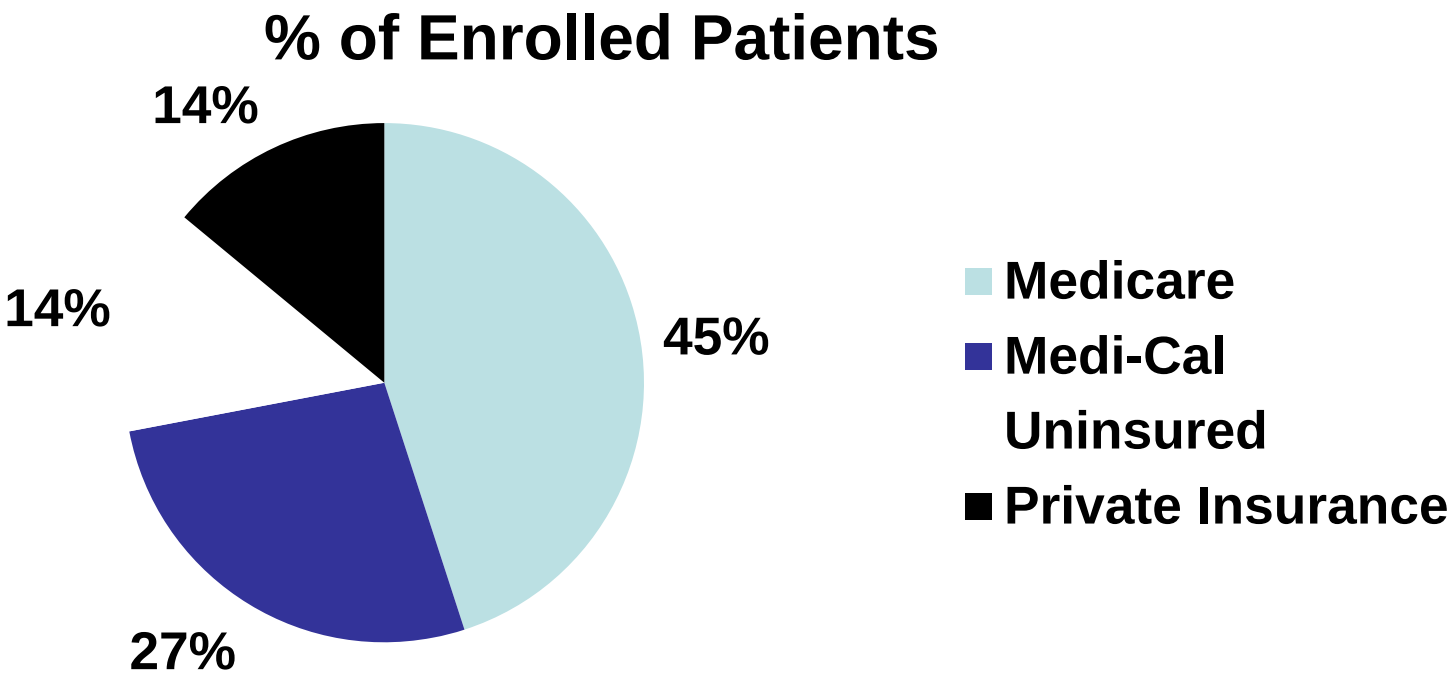
Eligible but not Enrolled by Project

		Eligible but not enrolled		Total Q2/2016
Project No.	Concept	Refused consent	All other reasons	
CP002	Post-Discharge	116	34	150
CP004	Post-Discharge	25	0	25
CP007B	Post-Discharge	16	11	27
CP008	Post-Discharge	65	136	201
CP013	Post-Discharge	26	0	26
CP007A	Frequent 911 Callers	5	3	8
CP010	Frequent 911 Callers	14	382	396
CP005	Tuberculosis	0	98	98
CP006	Hospice	0	13	13
CP012	Alternate Destination	1	21	22
CP003	Alternate Destination	4	26	30
CP009	Alternate Destination	0	2	2
All Projects		**272**	**726**	**998**

Enrolled Patients' Demographics

- The majority of patients were male.
- Patients' average age varied greatly across projects.
- The majority of patients are non-Hispanic and Caucasian

Enrolled Patients' Payer Types – June 2015 – June 2016



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Findings for Specific CP Concepts

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Post-Discharge

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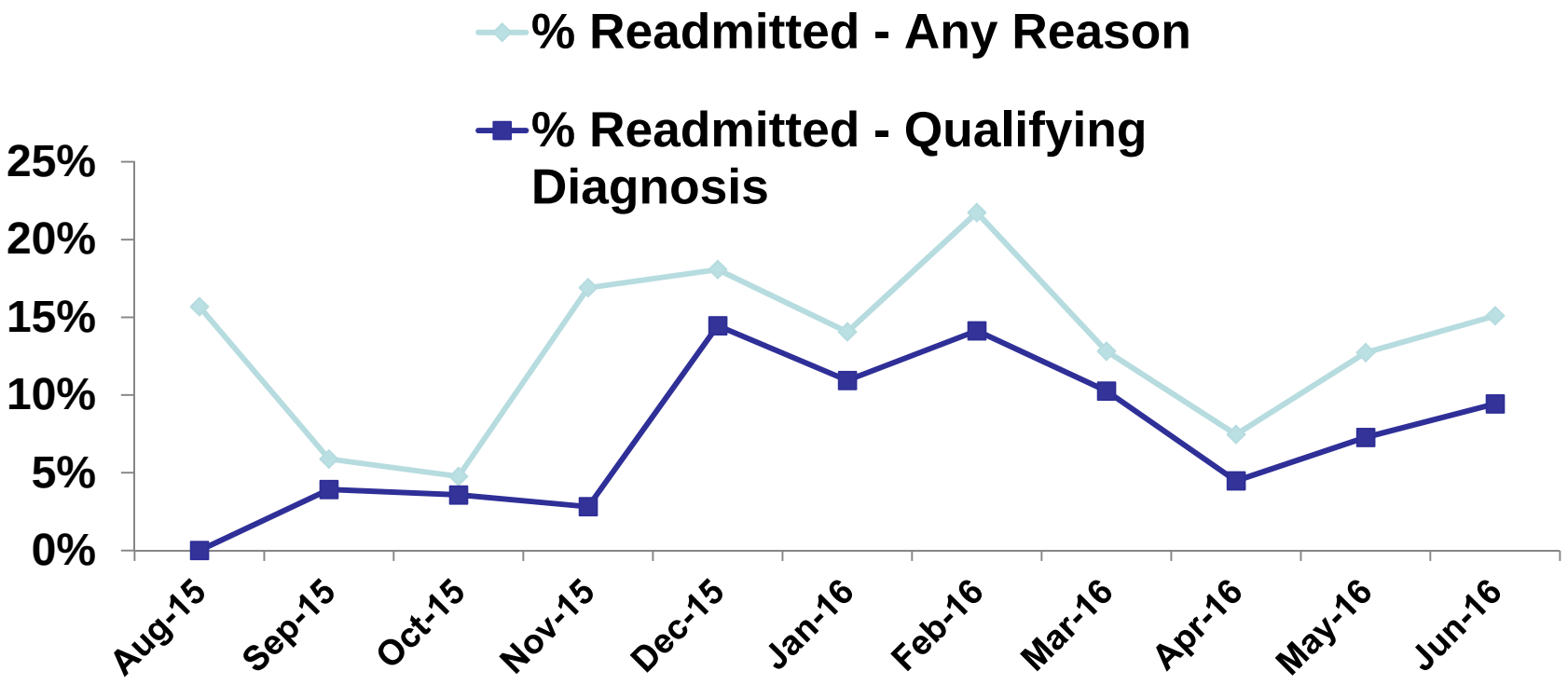
Post-Discharge: 30-Day Readmission Rate Trends



Post-Discharge: 30-Day Readmission Rate, All Cause

Population	30-Readmission Rate, All Cause
Community Paramedicine Pilot Project Enrollees, 2015-2016	13%
California, 2013 (OSHPD data)	18%
United States, 2013 (HCUP data)	24%

Post-Discharge Medication Reconciliation

- All post-discharge sites reported devoting substantial time to medication reconciliation
- Many patients had 10+ prescriptions
- One site found at least one contraindication for every patient

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Frequent 911 Callers

10/11/2016

Frequent 911 Callers – Patient Progress

Common referrals for needed services :

- Alameda
  - Alameda Fire Department Fall Prevention Program, Domestic violence resources, Food assistance, Housing Assistance, Senior home safety equipment installation services, Transportation assistance

- San Diego
  - 211-San Diego County Services Referral Agency, Alcohol recovery, Homeless assistance program, Mental health services, Veteran's services

Frequent 911 Callers – ED Visits

- Differences between the patients targeted by Alameda and San Diego make comparisons difficult.
  - San Diego focuses primarily on patients with 20+ ED visits in the previous year
  - Alameda enrolls all who are referred to the program
- San Diego's patients have more ED visits than Alameda's but the program has achieved substantial reductions in EMS and ED use
- For one patient, the number of 911 calls was reduced from 40 per month to 5 per month (87.5% decrease)

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DOT for Tuberculosis

10/11/2016

Direct Observed Therapy - Tuberculosis

CPs augment TB clinic work force:

- 25 TB patients to date (some completed, some still in treatment)
- Call patients who miss a scheduled appointment are until they are found and treated.
- More medical training than community health workers employed by TB clinic.
- Better cooperation from challenging patients.

Direct Observed Therapy - Tuberculosis

Contact Investigations

- CPs assist the staff of Ventura's TB clinic with contact investigations to screen persons who may have been exposed to TB
- 6 contact investigations have been undertaken since implementation; 1 in June 2016.

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Hospice

10/11/2016

Hospice – Transports to ED –

Project No.	Total Enrolled	Number of Transports	Percent Transported	Number Removed from Hospice Care	Percent Removed from Hospice Care
April	9	4	44%	3	**33%**
May	8	3	38%	3	**38%**
June	7	0	0%	2	**29%**
Total–Q22016	**24**	**7**	**29%**	**8**	**33%**

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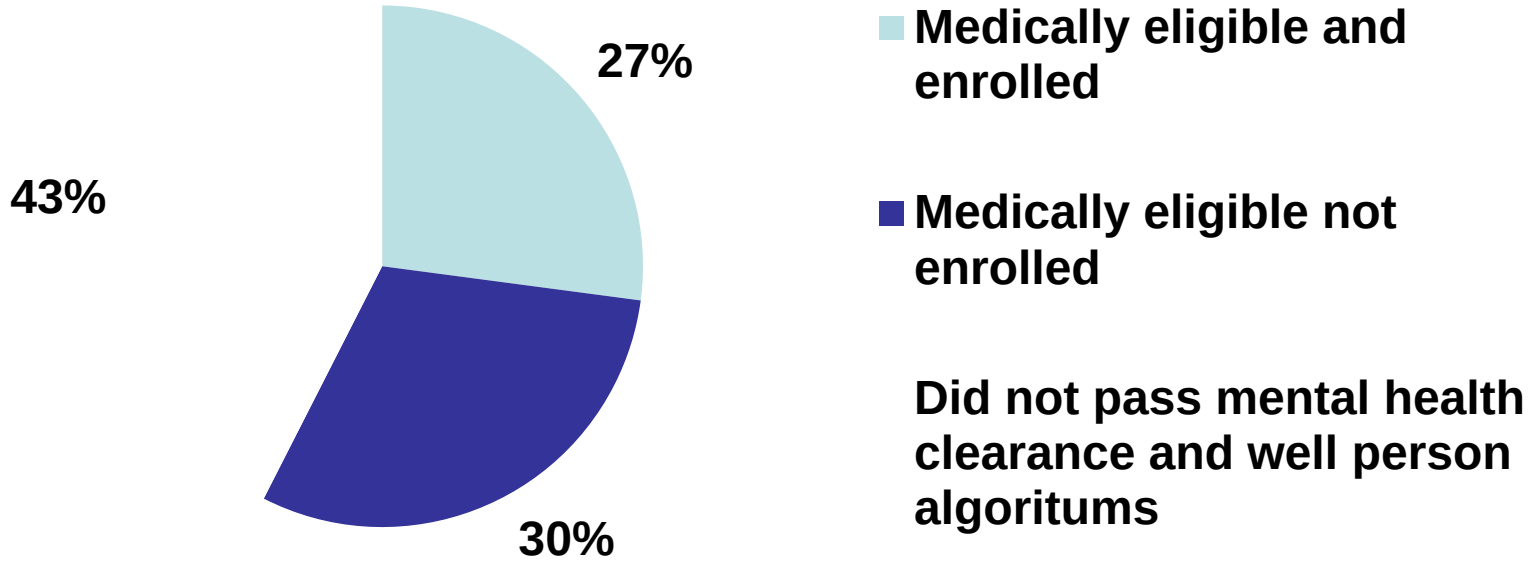
Alternate Destination – Behavioral Health

10/11/2016

Alternate Destination – Behavioral Health

Persons screened, Sept. 2015 – June 2016 (n = 550)



Alternate Destination – Behavioral Health

In Q2 2016, no individuals were transferred to the ED from the BHC. Examples of why individuals were transferred in previous months are provided in the table.

Month	No. Patients Enrolled	No. Patients transferred ED within 6 hours	Reasons for transfer to the ED
Jan	16	1	Incontinence.
Feb	18	1	Patient required CPAP for sleeping which is not available at facility.
March	10	2	Agitation that facility could not manage.

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Alternate Destination – Medical Care

10/11/2016

Alternate Destination – Medical Care Q2 2016

Project No.	No. Patients Enrolled	Treated at UCC and Discharged	Continuous transfers	ED Transfers within 6 hours	Reasons for transfer to the ED
CP001	12	6	3	3	3 requested for opioid medication; 2 issues with diagnostic equipment; 1 chest pain.
CP003	6	6	0	0	
CP009	0	0	0	0	
Total – April – June 2016	**18**	**12**	**3**	**3**	

Alternate Destination – Medical Care

- Barriers to enrollment
  - Limited hours during which UCCs are open
  - Limited services offered by UCCs
  - Enrollment limited to non-elderly Kaiser enrollees (Carlsbad)
  - Initially did not train all paramedics (Orange)

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Conclusion & Next Steps

Conclusion

- Findings indicate that CP projects are safe
  - Transfers from urgent care centers and behavioral health center due to
    - Inability to provide needed services
    - Conditions that did not put patients' lives at risk

Conclusion

- Decreases in
  - 30-day readmission rates for patients enrolled in post-discharge projects
  - Transports of hospice patients and behavioral health patients to EDs
  - ED visits among frequent 911 callers

- Increase in
  - Patient knowledge of how to manage chronic illness
  - Access to medical and social services
  - Number of TB patients receiving DOT

Next Steps for the Evaluation

- Report on evaluation findings to be released in early 2017
- Will include
  - Description of patients served and services provided by pilot projects
  - Outcomes of pilot projects
  - Estimates of cost and savings associated with pilot projects

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Thanks are extended to our pilot sites, project participants, the California Healthcare Foundation the California Emergency Medical Services Authority, and the California Office of Statewide Health Planning and Development.

QUESTIONS

James Pierson, Vice President / COO
EMT-P, EMD-Q, CACO
Medic Ambulance Service
Solano County, California

Medic Ambulance

Excellence in EMS Since 1979

- Family Owned and Operated since 1979
- Solano, Sacramento and Placer Counties (California)
- CAAS Accredited (First in Northern California)
- ACE Accredited
- 45,000 calls p/year (38,000 – ALS/9-1-1)
- 1,600,000 Miles traveled
- 60 Emergency Vehicles
- 225 Employees
- CCT / ALS /BLS / Wheel Chair - Gurney Services

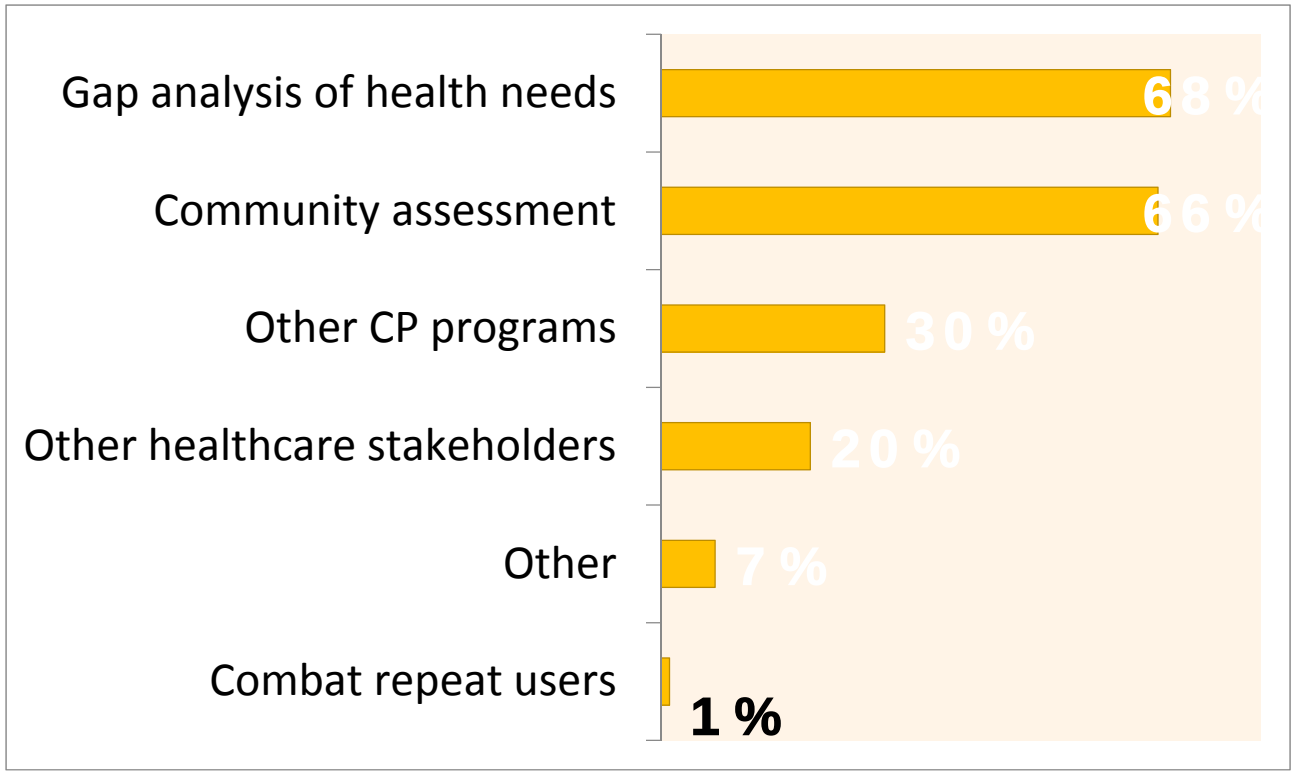
Medic Ambulance | INTEGRATED HEALTHCARE

Why MIH/CP Programs (Provider)

- Because its Wave of the Future for EMS
- It can separates your from other competition
- Want your organization to be a leader in EMS
- CP/MIH is a service our community needs!
- This can really make a difference in our patients lives!

Medic Ambulance | INTEGRATED HEALTHCARE

Reasons for Starting MIH/CP Programs



Respondents were able to select more than one response, resulting in a percentage total greater than 100%.

Source: NAMET / JNEMSLF Survey; AMR Envision Health

Medic Ambulance | INTEGRATED HEALTHCARE

Foundation of Current Program

- We were approached by Kaiser Group in 2013 to submit a pilot to EMSA
- Needed Local EMSA approval
- Local EMSA wanted all local hospitals offered opportunity to participate in pilot
- NorthBay and Kaiser confirmed, Solano EMS approved, and all submitted letters in support of our pilot submission

Medic Ambulance | INTEGRATED HEALTHCARE

Foundation of Current Program

- Steering Committee Established
- **Build a sustainable model with Funding** coming from Hospitals on a Fee for Service Model
- 2 Main Goals to Pilot
  - Reduce re-admissions for 30 days post discharge for COPD/CHF admissions
  - Improve patient overall health and disease process understanding

Medic Ambulance | INTEGRATED HEALTHCARE

CP PILOT PROGRAM MEMBERS HOSPITAL

Operate (2) two Hospitals within Solano County

- Northbay Medical Center, Fairfield, CA
- Vacavalley Medical Center, Vacaville, CA

- ACS Verified Level II Trauma Center
- Designated STEMI Receiving Center
- 24 / 7 Neurosurgical Services
- Manage Western Health Advantage (WHA) patients in Solano County

VALUE

- Measure Everything
- Track and Trend everything
- Signed with EMS Survey Team to do 100% of patient satisfaction surveys via phone call
- Constant communication with all involved parties
- Weekly Case Management Team Reviews to go over trends, disease management and communicate with Pilot Medical Director

Medic Ambulance | INTEGRATED HEALTHCARE

Results

We have had great Successes within Pilot

September 15, 2015 - Current

Patients referred to the program = 91

Patients enrolled in the program = 66

38 patients enrolled to HF = 57%

28 patients enrolled to COPD = 43%

Medic Ambulance | INTEGRATED HEALTHCARE

Results

- Visits completed- 124 visits completed
- **Unplanned readmissions = 6 (6/66) = 9.1%**
  - 4/6 patients re-admitted with Pneumonia
  - 3 males 2 with HF and readmit Dx of PNA / 1 – ETOH FALL
  - 3 females:
    - 1 HF
      - 1 with Dx acute bronchitis, renal failure, hepatic encephalopathy
    - 2 COPD
      - 1 with Dx of PNA
      - 1 with Dx of anxiety and COPD

Medic Ambulance | INTEGRATED HEALTHCARE

Results

- Visits took place at patient's permanent residence = **86%**
- Percent of Patients that CP identified medication errors with = **49%**
- Percent of patients that needed CP help understanding their DC instructions = **72%**
- Average, in minutes length of first visit **109 minutes**
  - Shortest = 60
  - Longest = 181
- Patient self-identified improvements first visit to last:
  - DC improvement = **12%**
  - Overall health improvement (5Q-3D-5L) = **18%**
  - Understanding of Medication side effects improved = **8%**
  - **13% of visits took place outside patient home**

Medic Ambulance | INTEGRATED HEALTHCARE

Executive Summary

This report contains data from **15 Medic Ambulance Service** patients who received services between **09/15/2015** and **05/13/2016**.

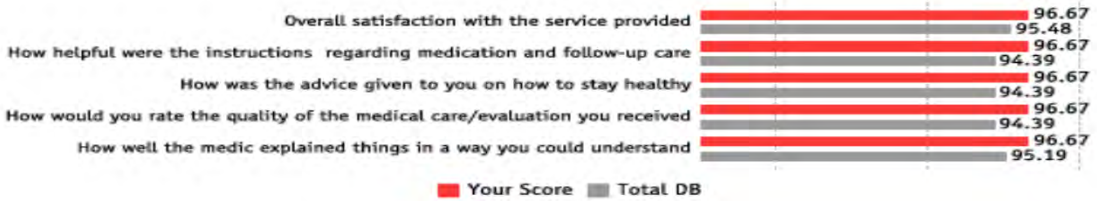
The overall mean score for the standard questions was **96.12**; this is a difference of **1.95** points from the overall EMS database score of **94.17**.

The current score of **96.12** is a change of **96.12** points from last period's score of **0**. This was the **2nd** highest overall score for all companies in the database.

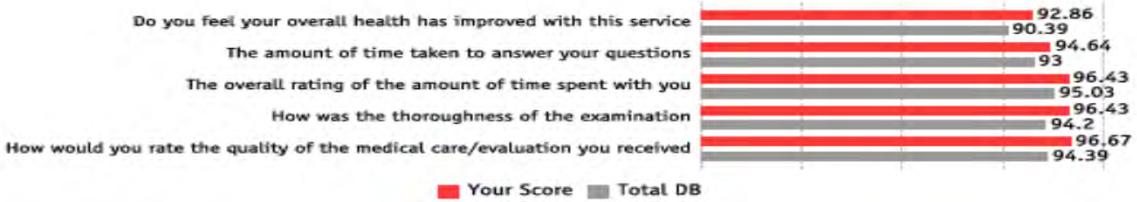
You are ranked **1st** for comparably sized companies in the system.

85.09% of responses to standard questions had a rating of Very Good, the highest rating. **100.00%** of all responses were positive.

5 Highest Scores



5 Lowest Scores



DAILY REPUBLIC

SATURDAY, FEBRUARY 20, 2016 — *Fairfield-Suisun City* — $1.00

WORLD
Vatican: Pope was not singling out Trump | A6

LIVING
Tech toys abound at New York Toy Fair | A7

SPORTS
Solano women finish regular season with record-breaker | B1

Obama sets out to nominate new justice

THE ASSOCIATED PRESS

WASHINGTON — It may seem like Mission Impossible.

Still, President Barack Obama this week set out on a quest to put his third justice on the Supreme Court, hoping to overcome solid Republican opposition and difficult election-year politics in what likely will be the last major battle of his tenure.

Obama faces a Republican leadership that appears united in opposing his decision to fill the seat as well as a crop of Republicans facing re-election who have lined up behind their leaders.

Those vulnerable GOP senators are crucial to any White House strategy for filling the seat held by the late conservative Justice Antonin Scalia. Democrats would need 14 defections from GOP ranks to break a filibuster and confirm a nominee. So far, no GOP senator has indicated he or she is ready to vote for an Obama nominee.

OBAMA

The White House said Friday that Obama will move ahead. Obama on Thursday called key Senate leaders, including Majority Leader Mitch McConnell, R-Ky., and Judiciary Committee Chairman Charles Grassley, R-Iowa, part of the customary consultations once considered essential to laying the groundwork for a warm reception for an eventual nominee.

But the president did not appear to make much headway with the GOP leaders. Hours after the call, an op-ed penned by McConnell and Grassley was published in The Washington Post restating their case for why Obama should leave the job of naming a nominee to the next president.

"It is today the American people, rather than a lame-duck president whose priorities and policies they just rejected in the

See Justice, Page A10

ON DR WEBSITE

Thousands pay respects to late Justice Scalia

www.dailyrepublic.com

Robinson Kuntz/Daily Republic

Vacaville resident Patricia Fields was treated for congestive heart failure at NorthBay Medical Center, and was later treated by Medic Ambulance's home check up program. Fields said she was feeling better after three visits a month.

Program helps patients
AVOID RETURN TO HOSPITAL

SUSAN HILAND
DAILY REPUBLIC

VACAVILLE — No one wants to go to the emergency room if they don't have to and to return within a few weeks is almost unthinkable. But this is the reality for many people who have chronic obstructive pulmonary disorder and those at risk for heart failure.

Medic Ambulance out of Vallejo is the first company in Solano County to have started a new paramedicine program to help people not have to return to the hospital after being released.

"When people are released from the hospital they are given a lot of paperwork. Sometimes their questions get lost in the process," said James Pierson, vice president of operations for Medic Ambulance.

The new program is geared to help patients who were discharged from the hospital by having trained paramedics who have received additional training go to their homes and answer questions, check on medications and look to help them out for a successful recovery and no return to the hospital.

NorthBay Healthcare and Medic Ambulance share information on patient care and treatment. But before anyone comes to the house, patients are asked if they want a home visit.

"The hospital will identify patients who have a certain level of risk for heart failure," said Shelley Stelzner, director of case management at NorthBay Healthcare.

The case manager will put patients on

See Program, Page A10

Tensions at summit reveal growing EU divide

THE ASSOCIATED PRESS

BRUSSELS — Britain is thinking of leaving. Greece feels isolated. Austria and Denmark are pushing controversial measures for coping with asylum-seekers despite what their neighbors think.

Tensions between European Union leaders at this week's summit in Brussels have highlighted a gnawing lack of confidence that the bloc of 28 nations can provide timely answers to Europe's challenges.

Rarely has the EU seemed as fragmented and impotent as on Friday, when leaders grappled with a possible British exit and tried to find a united response to the refugee emergency.

"The fact that every policy being discussed is strongly contested is fueling doubts as to whether the EU and its members will be able to match their rhetoric with concrete actions by cooperating more closely," Janis Emmanouilidis at the European Policy Centre think-tank wrote in an analysis.

Still barely recovering from an economic crisis that rivaled the Great Depression, Europe is now struggling with its biggest refugee crisis in well over half a century.

The arrival of more than 1 million people fleeing conflict or poverty for better lives in a far wealthier Europe has overwhelmed border authorities and reception capacities. It has stoked unfounded fears of a threat to Europe's cultural identity and even religion, the arrival of extremism or the theft of jobs.

As tens of thousands of people have packed into trains or hiked Europe's highways north from Greece toward their dream of having a home in Germany or Sweden, nations have erected fences or tightened border controls unilaterally, putting pressure on their EU partners.

The Czech Republic, Hungary, Poland and Slovakia are working together, pushing for a clampdown on borders along the main migrant transit route through the Balkans.

And even nations like Austria and Denmark are out of step with other EU nations.

Austria has surprised its partners by putting a cap on the number of asylum-seekers it will let in, a move the EU's Executive Commission maintains breaks European and international law. Denmark, meanwhile, has moved to take away some assets from asylum-seekers to help pay for their accommodations and food.

See Tensions, Page A10

'To Kill a Mockingbird' author Harper Lee has died at 89

THE ASSOCIATED PRESS

NEW YORK — Harper Lee, the elusive novelist whose child's-eye view of racial injustice in a small Southern town, "To Kill a Mockingbird," became standard reading for millions of young people and an Oscar-winning film, has died. She was 89.

Lee died peacefully Friday, publisher HarperCollins said in a statement. It did not give any other details about how she died.

"The world knows Harper Lee was a brilliant writer but what many don't know is that she was an extraordinary woman of great joyfulness, humility and kindness. She lived her life the way she wanted to – in private – surrounded by books and the people who loved her," Michael Morrison, head of

See Lee, Page A10

ON DR WEBSITE

- Harper Lee's 'Go Set A Watchman' raised questions
- As novel 'Mockingbird' soared, author Lee grew more elusive
- Alabama hometown was refuge of privacy for author Harper Lee

www.dailyrepublic.com

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WEATHER

62 44

Mostly sunny skies. Complete five-day forecast on B5.

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Times~Herald

M/cloudy
H: 56 L: 43
PAGE A10

Wednesday, December 23, 2015 75 CENTS FACEBOOK.COM/TIMESHERALD TWITTER.COM/VJOTIMESHERALD timesheraldonline.com

PILOT PROGRAM

Paramedics deliver more attention

State-wide program launched in Solano County

By Irma Widjojo
iwidjojo@timesheraldonline.com
@IrmaVTH on Twitter

Paramedic Elisa Martinez said she is usually always in "emergency mode" at work.

However, lately things have been a little different.

Martinez is one of the six paramedics at Medic Ambulance that have been trained as community paramedics.

The new state-wide pilot program launched in Solano County mid-September.

The Medic Ambulance's Community Paramedicine Program is a collaborative effort with NorthBay Healthcare, and is sponsored by California Emergency Medical Services Authority and California Healthcare Foundation. It is one out of 12 such programs throughout California.

The two-year pilot program focuses on patients diagnosed with chronic obstructive pulmonary disease and congestive heart failure that have been treated at NorthBay Medical Center.

"The goal is to keep the patients of the hospital and not get readmitted for those reasons," said James Pierson, Medic Ambulance vice president of operations.

The patients that are eligible for the program are identified by NorthBay Medical Center staff by a scoring tool.

PROGRAM » PAGE 3

Community Paramedic Elisa Martinez checks Maria DeJong's blood pressure on Tuesday as part of her home visit to DeJong's Vacaville home.

IRMA WIDJOJO — TIMES-HERALD

Medic Ambulance comm...

www.ems1.com/community-paramedicine/video/46481187-Medic-Ambulance-community-paramedic-program-explained/

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Medic Ambulance community paramedic program explained

1753 VIEWS

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Community paramedic program helps patients physically and mentally

The two-year pilot program focuses on patients diagnosed with chronic obstructive pulmonary disease and congestive heart failure

Dec 23, 2015

By Irma Widjojo
Times-Herald

VALLEJO, Calif. — Paramedic Elisa Martinez said she is usually always in "emergency mode" at work.

However, lately things have been a little different.

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- Calif. medics provide preventive care under pilot program

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& Mobile Integrated Health

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- How to build fire-based community health care programs (2)
- IBM reviews Memphis Fire Dept. EMS data for opportunities to reduce 911 calls

MORE COMMUNITY PARAMEDICINE ARTICLES ›

Fast Response

Paramedic Academy

Preceptored Internships - Flexible Payments - Next to BART

Results / Conclusions

- We Celebrated collaboratively early wins of the Program
- News articles, local radio, twitter, facebook, etc !
- Patients are very happy and satisfied with this service lien
- Within 30 days NorthBay expanded pilot to start seeing COPD Patients
- Great collaborative partnership with local partners
- Have been in negotiations with Kaiser to add them into program
- Currently in negotiations with an additional local hospital group about seeing their high risk CHF/COPD Patients

Medic Ambulance | INTEGRATED HEALTHCARE

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Community Paramedic Effectiveness Strategies for Congestive Heart Failure (COMPARE)

Glendale Adventist Medical Center
Adventist Health

UCLA Center for Prehospital Care

Rationale

- 23% readmission rate for CHF within 30 days
- Suboptimal for patient well-being
- Limits inpatient monitored beds
- Economic Costs
- Medicare Penalties

Description of Program

- Dedicated Community Paramedic
- Specialized training in CHF
- Assigned to Adventist Medical Center
- Partnership with Care Transitions Office and Cardiology Department
- Offered home visit to all admitted pts with CHF
- 48-72 hours post-discharge
- IRB/Informed Consent

Outcomes

601 Total CHF Admissions in 12 mos
154 Consented
107 Home Visits

30 day follow-up data on 90 pts

8 readmitted for CHF exacerbation
8 readmitted for other causes

Combined Readmission Rate: 17.8%

Pre-Pilot Comparison

Based on 601 CHF admissions

17.8% all-cause readmission rate = 107 readmissions

Pre-COMPARE Data

21% readmission rate = 126 readmissions =19.2 readmissions saved

Ave Nat'l Cost $11,000/readmission* = $211,200 (plus CMS penalties)

**Institute for Health Care Improvement (IHI) E. Coleman, U Colorado, 2013*

What Worked

- Smooth integration of CP into the inpatient team
- Having a dedicated CP to have ownership of the program
- Engaging family for home visits
- Ability to contact PMD or home health directly from patient's home
- Commitment from GFD and Adventist Research Division
- Regular phone conferences

What We Learned

- Patient consent long and detailed
- Financial and personnel commitment by GFD was critical
- Some patients were hard to track
- Pilot projects can lead to expanded efforts

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ALAMEDA COMMUNITY PARAMEDIC PROGRAM

Ricci Zombeck, MS

EMS Chief, Alameda Fire Department

Daniel Gerard, MS, RN

EMS Coordinator, Alameda Fire Department

Armando Baldizan, EMT-P

Firefighter/Community Paramedic, Alameda Fire Department

A Pilot project in partnership between Alameda Fire Department and Alameda County EMS Agency

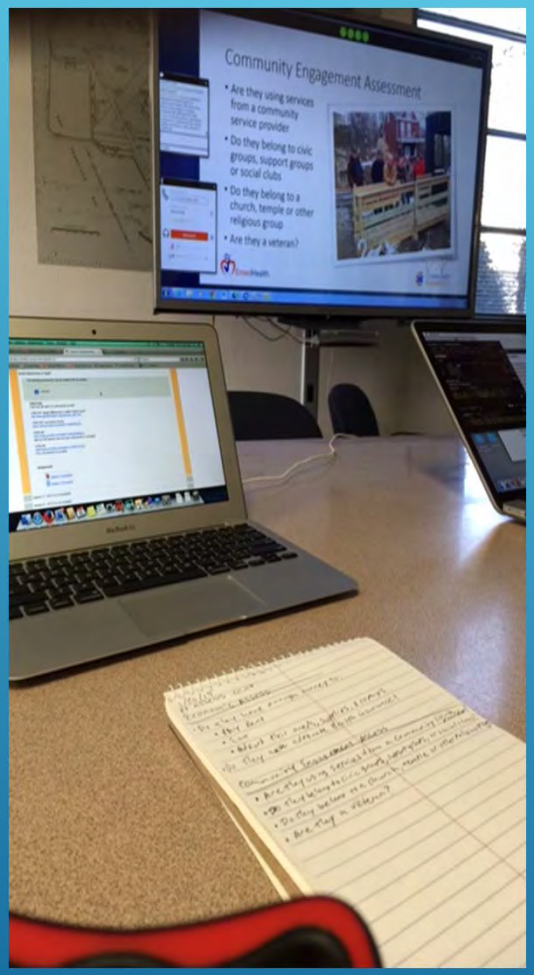
https://archive.org/details/KTVU_20150820_130000_KTVU_Mornings_on_2_at_6am#start/2700/end/2760

Post Hospital Discharge

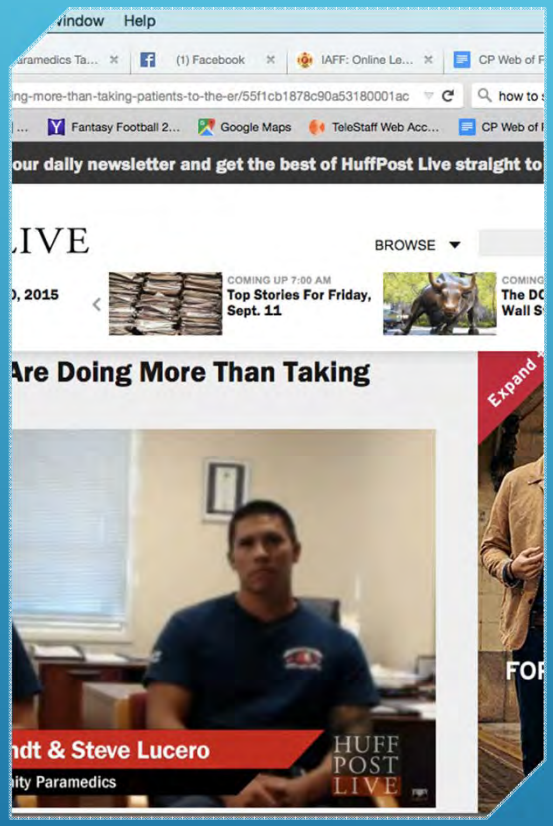
DOMAIN

PROGRAM GOALS

- Promote the overall health and safety of our vulnerable populations
- Improve client population's ability to manage their medical needs and to connect them to social resources
- Reduce 911 calls for non-emergency response
- Reduce hospital admissions and readmissions
- Prevent unnecessary emergency department visits



- Discussion Points
- Why Post Discharge in Alameda
- How we're doing
- Lessons to pass on
  - What our community needs to facilitate the program
  - Other considerations



ALAMEDA'S POST DISCHARGE POPULATION

- Over 30% of the 9000 discharge patients from Alameda Health Services had one of the six diagnoses: CHF, COPD, Sepsis, PNA, DM, MI
- Local hospital readmission rate at 10.8% for all patients

SUCCESSES

- Reduction in hospital readmissions
  - CP client readmissions rate at 2.75% vs. baseline at 10.8%
- Improved outcomes of P/D clients
  - Early recognition of negative trends
- Increased collaboration with stakeholders and resources
  - Established key relationships with collaborators
  - Acceptance within the community

- Community Needs Assessment
- Risk Assessment (LACE Scores)
- Client reticence
  - Social status
  - Economic
  - Reluctance to change
  - Expectations
- Client dissonance

LESSONS LEARNED

- Collaborators
  - Local hospitals
  - Public Health Department
  - Adult Protective Services
  - Other Out Patient Health Providers
- Programs
  - Detox Program (Medical & Social)
  - Substance abuse programs
  - Housing
- Services
  - Mental Health
  - Social Services
  - Meal services
  - Transportation Services
  - Clinic (same day services)

LESSONS LEARNED

CONTACT

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Daniel Gerard, MS, RN
EMS Coordinator, Alameda Fire Department

Armando Baldizan, EMT-P
Firefighter/Community Paramedic, Alameda Fire Department

QUESTIONS

The Orange County Alternate Destination (AD) Study asked the question:

Can experienced paramedics, with AD training, properly evaluate, make appropriate disposition recommendations, and perform an informed consent process for potentially low-acuity patients?

CENTER FOR DISASTER MEDICAL SCIENCES
UNIVERSITY of CALIFORNIA, IRVINE • SCHOOL OF MEDICINE

4 potential primary impressions (PIs) included

- Isolated closed extremity injury
- Laceration with controlled bleeding
- Soft tissue injury or infection
- Isolated fever and/or cough

Initial Trained AD Paramedics: 24

- Additional 25 ADPs trained in May 2016; approved by UCI IRB to enroll this month.
- QA analysis included their dispositions starting in June 2016.

ADP Training & Education

- ADPs educated in criteria for evaluating patients more likely to require extended ED or hospital care.

Beyond UCC Transport

- ADPs asked to record disposition recommendations for all patients with included PIs.

Languages Spoken

	Pilot	Baseline
English	87.83%	87.07%
Spanish	2.61%	2.89%
Vietnamese	1.74%	1.73%
Unknown	3.48%	5.31%
Other	2.61%	1.96%

Additional Languages spoken by <1% of patients in Baseline and/or Pilot periods:

- Arabic
- Chinese
- German
- Japanese

115 Patients Considered "UCC Appropriate" by ADPs

Age	Male	Female	Total
18-30	7	10	**17 (14.79%)**
31-40	4	0	**4 (3.48%)**
41-50	8	3	**11 (9.57%)**
51-60	5	9	**14 (12.17%)**
61-70	6	12	**18 (15.65%)**
71-80	5	16	**21 (18.26%)**
81-90	9	13	**22 (19.13%)**
91-100	0	7	**7 (6.09%)**
100-110	0	1	**1 (0.87%)**
Gender	**44 (38.2%)**	**71 (61.8%)**	**115 (100%)**

Average Patient Age	
Baseline Period	64
Pilot Period	63

Field Disposition of "Appropriate for UCC" Patients

	Refused Transport	Transport to Partner ED	Transport to Other ED	Transport to UCC	Total
Total	25	50	19	21	115
Musculoskeletal Trauma	10	27	12	12	61
Laceration	13	19	6	7	45
Soft Tissue Infection	--	--	--	1	1
Fever and/or Cough	2	4	1	--	7
Pain	--	--	--	1	1

Outcome from UCC/ED by PI

Primary Impression	Admit	Discharged	HLOC Transfer	AMA	UCC to ED	Not Reported	Total
Musculoskeletal Trauma	2	29	--	--	3	5	39
Laceration	--	23	1	--	--	2	26
Soft Tissue Infection	--	1	--	--	--	--	1
Fever/Cough	1	1	--	--	1	1	4
Pain	--	1	--	--	--	--	1
Total	3	55	1	--	4	8	71

- 3 of 4 “UCC to ED” Transfers were discharged from ED
- Outcomes data received from “Partner EDs” & UCCs only

Primary Outcome

- Total EMS contact in 9 months: **21,168**
- Total EMS contacts with eligible PIs: **2020**
- Total eligible PI contacts by ADPs: **659**
- "Appropriate for UCC" by ADP: **115**
- Offered Enrollment: **39**
- Enrolled: **24**

Secondary Outcomes

Satisfaction with Paramedic Care

Phone Follow-up with Enrolled patients after 96 hours:

- 13 of 24 (54.1%) visited another medical provider
  - 10 of the 13 (77%) saw personal physician
- 86.5% confidence in paramedic disposition
- 100% satisfaction with ADP care

Turn-Around Time

Total paramedic time on call (from dispatch to availability of unit after call), enrolled > non-enrolled = 9 minutes,

- Consistent with expected time for consent process.

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Alternate Transport Destination

Los Angeles County

Glendale

Santa Monica

Partners

UCLA Center for Prehospital Care

UCLA Santa Monica - UCLA Medical Center

and

Orthopædic Hospital

UCLA Santa Monica Bay Physicians Urgent Care

Glendale Adventist Medical Center

Adventist Health

Dignity Health.
Glendale Memorial Hospital and Health Center

Adventist Health Urgent Care
Rapid Care – Glendale
Urgent 9 Urgent Care Center
Verdugo Hills Medical Associates

Why Alternate Transport Destination?

- ED overcrowding
- Wall time
- Growing EMS response
- Community/population health
- Progressive fire chiefs

Description of Program

- Two communities (Glendale & Santa Monica)
- Conservative patient inclusion criteria (low acuity calls)
- Paramedic trained in Alternate Transport offered option to patient
- Patient Consents
- Transport to approved UCCs
  - MD present
  - Capacity
  - Willing to take all-comers

What worked?

- Great commitment by all partners
- Leadership by LA County EMS Agency
- Trained and retrained all department members
- Regular bi-weekly meetings
- Glendale community closed 8/31, Santa Monica continues

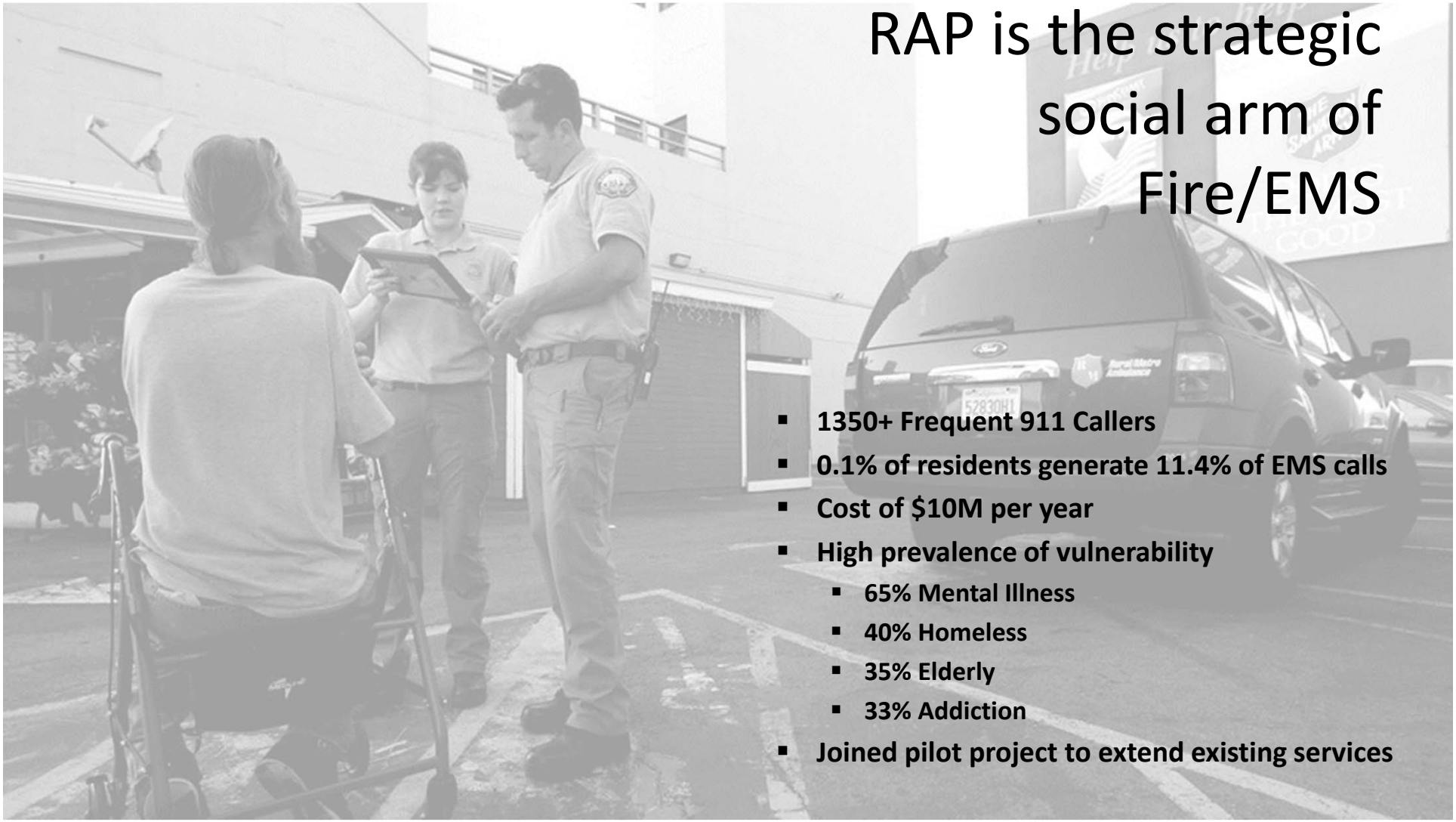
What we learned?

- Patient consent long and detailed
- You've seen one UCC, you've seen one UCC
- Funding was almost non-existent
- Fewer calls than anticipated
- High number of patients treated and released
- Time for follow-up underestimated (QI-ing calls that could appeared to meet criteria)
- Limited operating hours of UCCs

QUESTIONS

City of San Diego Community Paramedics

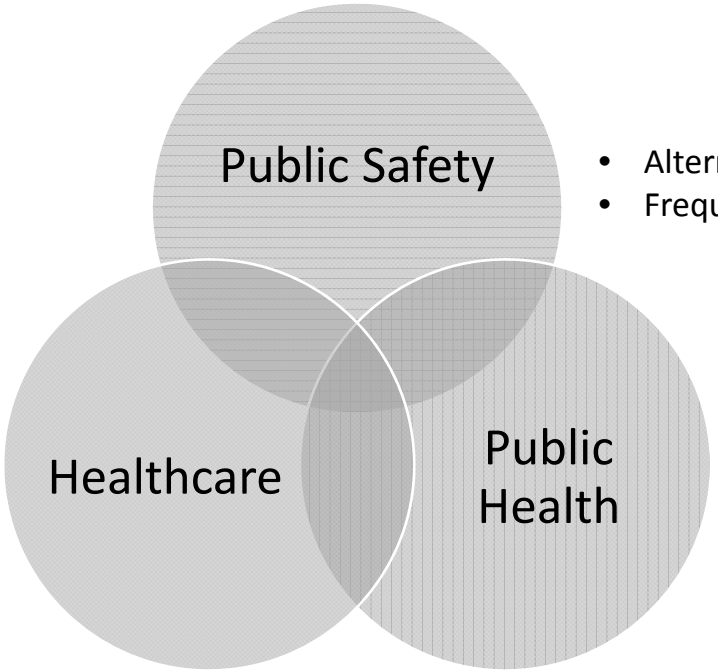
We address the needs of vulnerable EMS patients and preserve safety net resources



RAP is the strategic social arm of Fire/EMS

- **1350+ Frequent 911 Callers**
- **0.1% of residents generate 11.4% of EMS calls**
- **Cost of $10M per year**
- **High prevalence of vulnerability**
  - **65% Mental Illness**
  - **40% Homeless**
  - **35% Elderly**
  - **33% Addiction**
- **Joined pilot project to extend existing services**

RAP is a Public Safety Based CP Program



- Alternate Destinations
- Frequent User Management

- Post-Discharge Follow-Up
- Care For Chronic Conditions

- Communicable Disease Management

RAP versus CP

Traditional RAP Program

- Identifies self as a representative of the Fire/EMS department
- Addresses social issues only
- Provides navigation, education

Pilot Enhanced Program

- Identifies self as a Paramedic or Community Paramedic
- Addresses medical and social issues
- Provides care, navigation, education

Pilot Concepts Tested

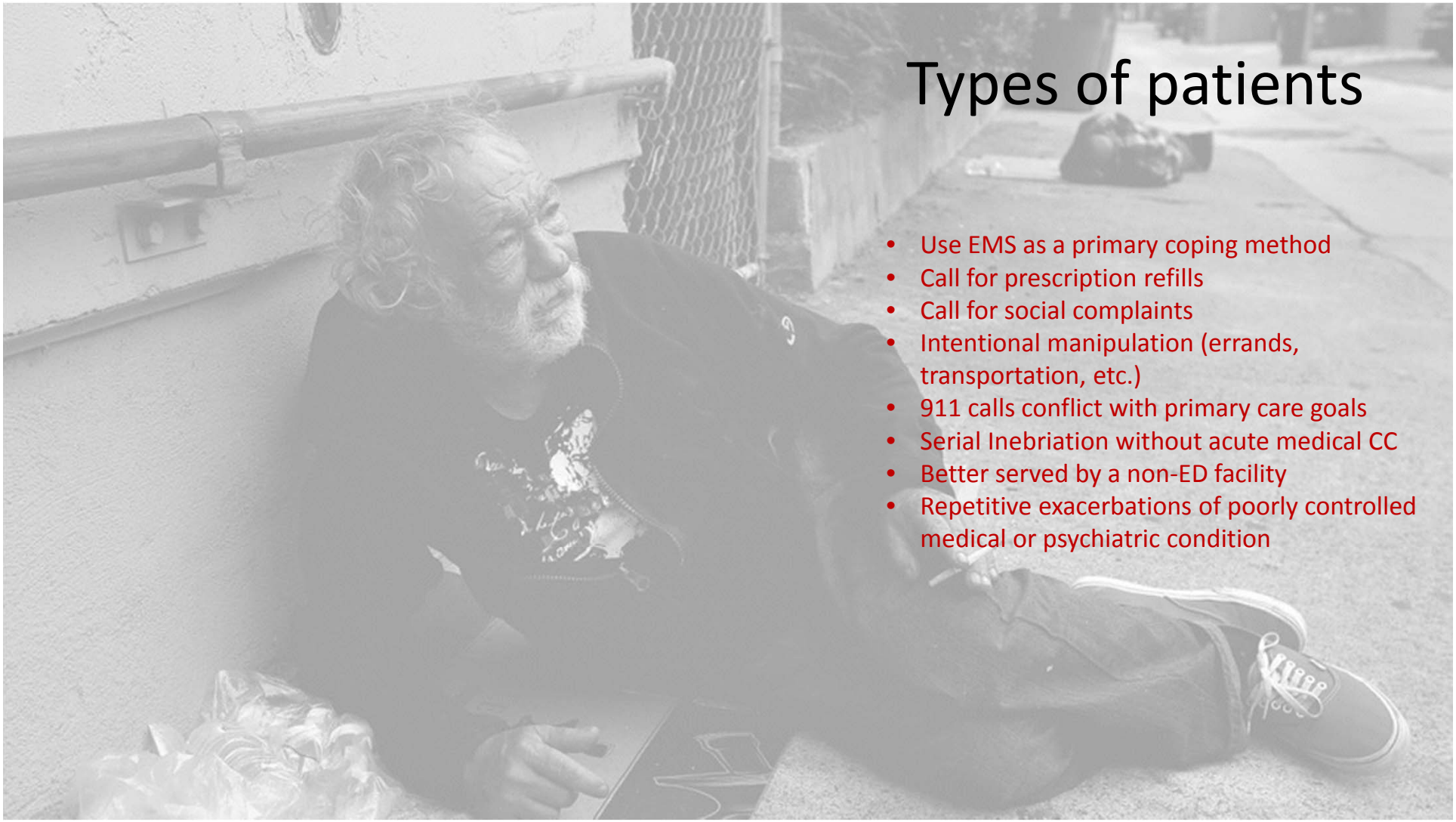
Frequent User Management

Alternate Destinations

Alternate Resources

Post-Discharge Follow-Up

Care for Chronic Conditions



Types of patients

- Use EMS as a primary coping method
- Call for prescription refills
- Call for social complaints
- Intentional manipulation (errands, transportation, etc.)
- 911 calls conflict with primary care goals
- Serial Inebriation without acute medical CC
- Better served by a non-ED facility
- Repetitive exacerbations of poorly controlled medical or psychiatric condition

Intervention Model – Identify

- System surveillance through data mining and big data techniques
- Crowd sourcing to identify less noticeable individuals

Case Management Dashboard

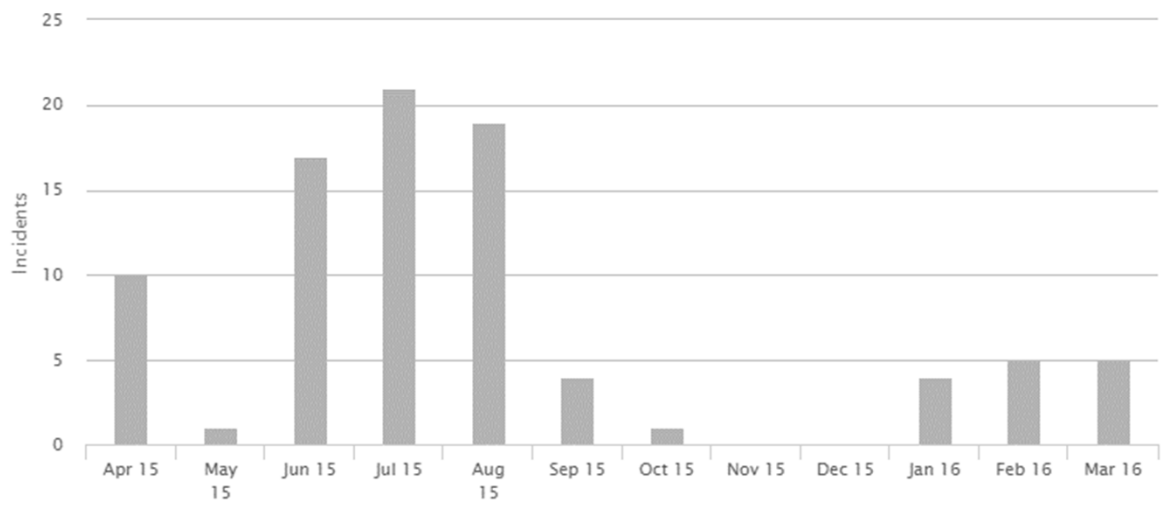
Frequent Callers

Return top: 10

☑ Include Records on Watchlist

Last Week	Last 2 Weeks	Last Month
(5)	(10)	(12)
(5)	(9)	(11)
(4)	(9)	(10)
(4)	(6)	(8)
(4)	(5)	(8)
(4)	(5)	(8)
(4)	(5)	(7)
(3)	(4)	(7)
(3)	(4)	(6)
(3)	(4)	(6)

Intervention Model – Identify

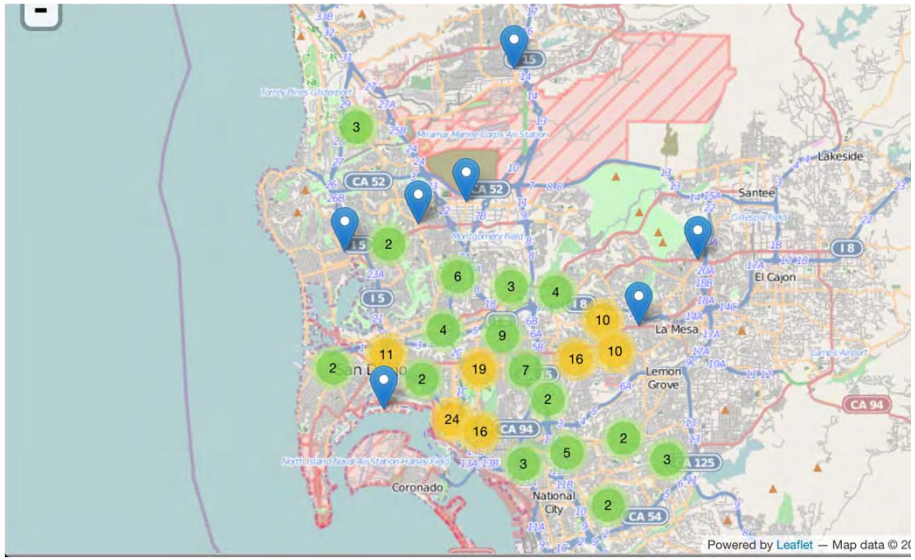


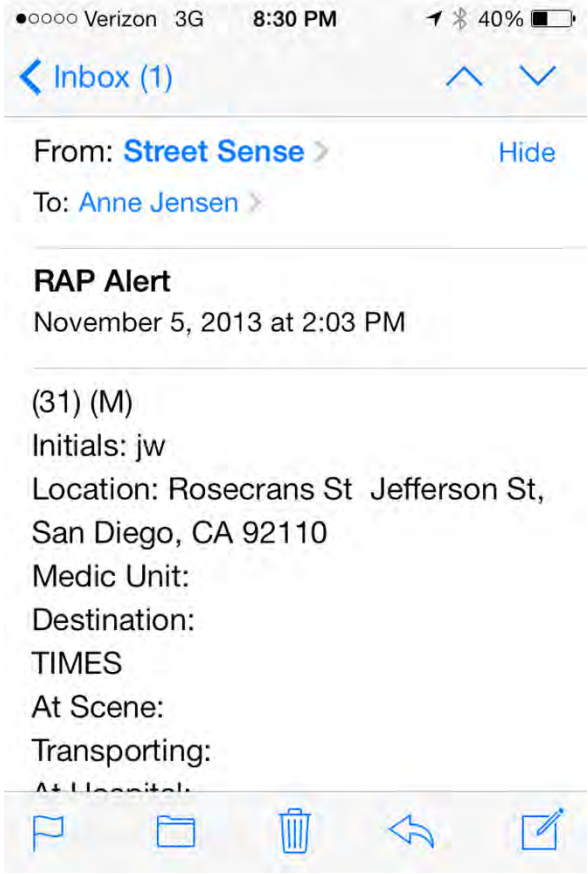
Top Chief Complaints

Alcohol use, unspecified (92)
ETOH Abuse (59)
Poisoning by unspecified drugs, medicaments and biological substances, undetermined (25)
Alcohol use, unspecified with unspecified alcohol-induced disorder (23)
(17)

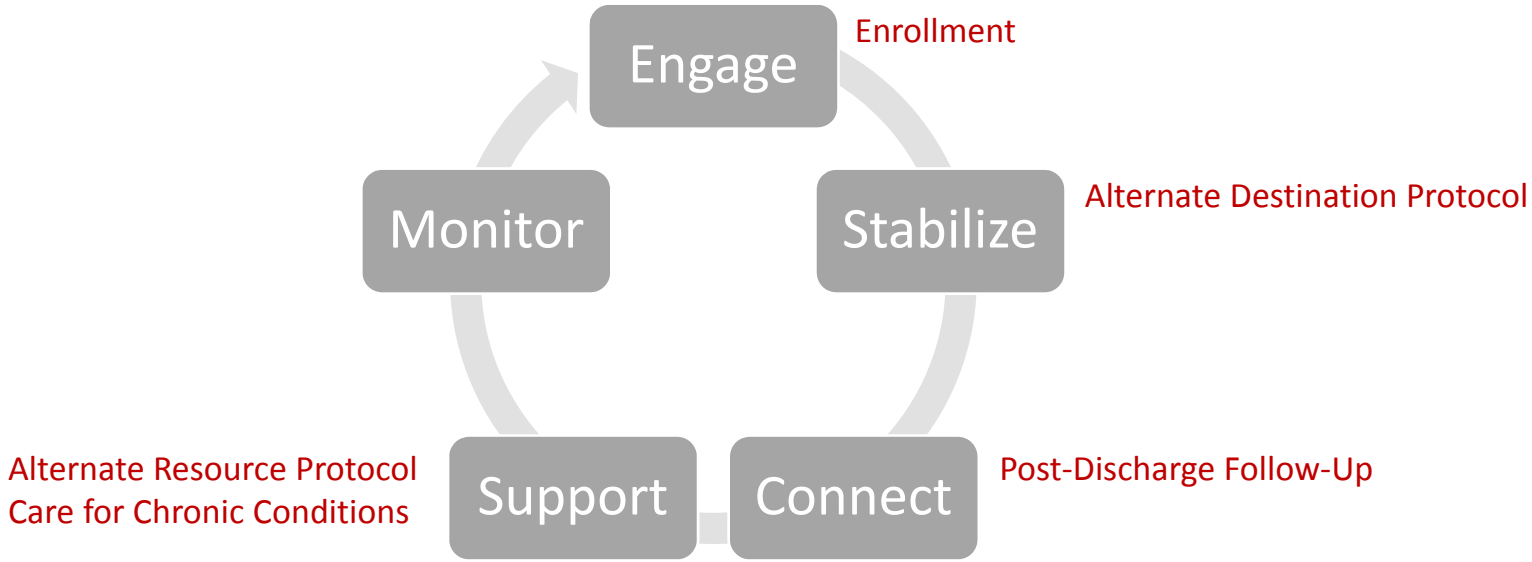
Top Calling Locations

Intervention Model - Engage



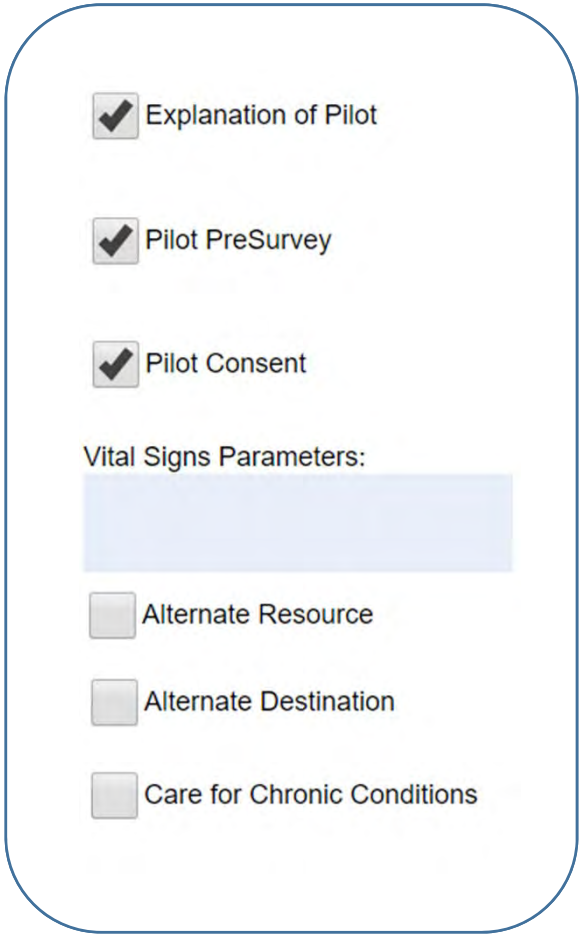


RAP Provides Intervention and Case Management

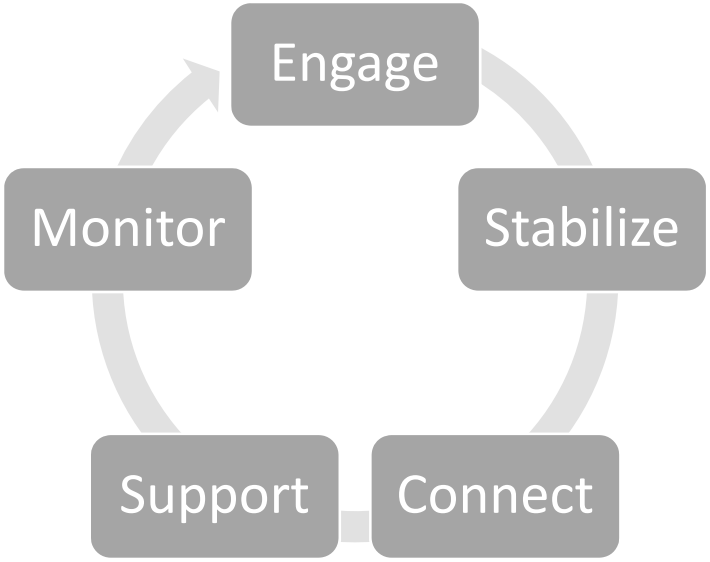


If the client enrolls in the pilot

- Primary RAP Medic presents case to Medical Directors
- Attempts to engage primary care providers
- No interventions allowed until case planning is complete – wait for next call



Plan on Relapses



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  - rap@sandiego.gov

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ALAMEDA Community Paramedic program

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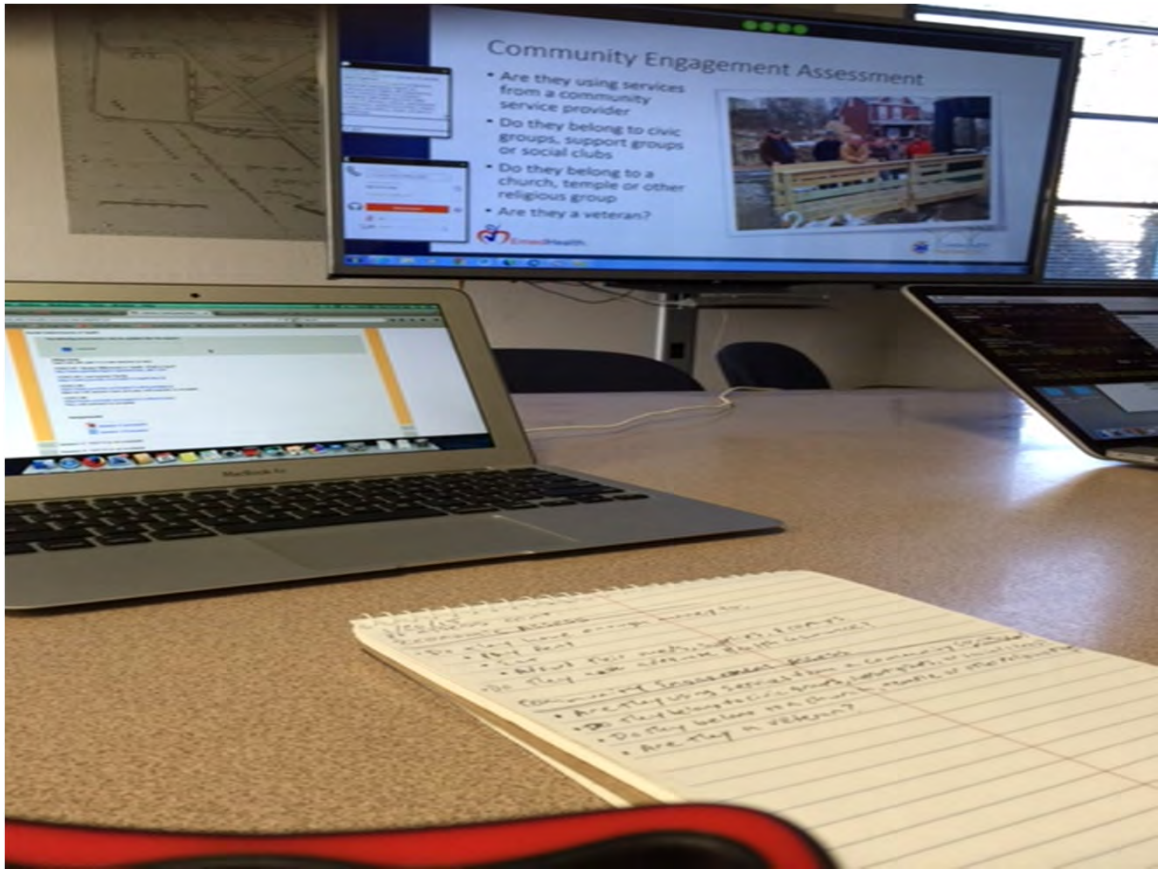
Familiar Faces

domain

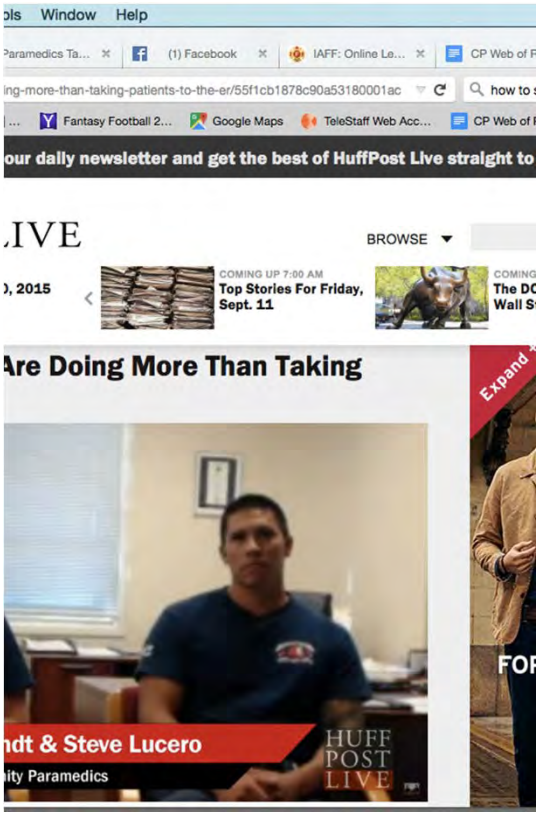
Program goals

- Promote the overall health and safety of vulnerable populations
- Improve client population's ability to manage their medical needs and to connect them to social resources
- Reduce 911 calls for non-emergency response
- Reduce hospital admissions and readmissions
- Prevent unnecessary emergency department visits



Discussion Points

- Why Familiar Faces in Alameda
- How we're doing
- Lessons to pass on
  - What our community needs to facilitate the program
  - Other considerations



ALAMEDA familiar faces - 2013

- 163 patients in Alameda County were transported more than 20 times
- 32 patients were transported more than 50 times
- 11 patients transported more than 100 times

ents and dogged

ce abuse programs

ograms

Lessons learned

- Community Needs Assessment
- Risk Assessment (LACE Scores)
- Client reticence
  - Social status
  - Economic
  - Reluctance to change
  - Expectations
- Client dissonance

- Collaborators
  - Local hospitals
  - Public Health Department
  - Adult Protective Services
  - Other Out Patient Health Providers
- Programs
  - Detox Program (Medical & Social)
  - Substance abuse programs
  - Housing
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  - Mental Health
  - Social Services
  - Meal services
  - Transportation Services
  - Clinic (same day services)

Lessons learned

Contact

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QUESTIONS

LIFELINE MEDICAL TRANSPORT

AMR VENTURA COUNTY

GOLD COAST

COMMUNITY PARAMEDICS
VENTURA COUNTY, CA

Ventura EMS/Public Health TB Partnership

Partners

- AMR
- Gold Coast
- Lifeline
- Ventura County EMS Agency
- TB clinic
  - Dr. Castel
  - Eva Reeder, RN

Background on TB

- 1/3 of the world's population is infected with TB
  - 1.5 million TB-related deaths in 2014 (cdc.gov)
- LTBI vs TB Disease
- Directly Observed Therapy (DOT)
  - Over months

VENTURA
County Map,California
Kern
Los Angeles
Santa Barbara
Ballinger
Valle Vista
Mt. Pinos 8831 ft.
Chuchapate
Hungry Valley S.V.R.A.
Ozena
Halfmoon
Dutchman
Los Padres National Forest
Beaver
Cuyama
Piru
Condor Sanctuary
Pine Mtn. 7510 ft.
Thomas Aquinas Coll
Lake Piru
Ojai
Meiners Oaks
Mira Monte
Oak View
Fillmore
Piru
L. Casitas
Casitas Springs
Santa Paula
Emma Wood St. Beach
VENTURA
Moorpark
Somis
Simi Valley
PACIFIC OCEAN
San Buenaventura S.B.
Ei Rio
Camarillo
Calif Lutheran Univ.
Thousand Oaks
McGrath St. Beach
Oxnard
La Jolla Pk. 1567 ft.
Casa Conejo
Port Hueneme
Naval Base Ventura County
Pt. Mugu S.P.
0 10 mi
0 10 km
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VENTURA
County Map,California
Kern
Los Angeles
Santa Barbara
Ballinger
Valle Vista
Mt. Pinos 8831 ft.
Chuchapate
Hungry Valley S.V.R.A.
Ozena
Halfmoon
Dutchman
Los Padres National Forest
Beaver
Cuyama
Piru
Condor Sanctuary
Pine Mtn. 7510 ft.
Thomas Aquinas Coll
Lake Piru
Ojai
Mira Monte
Oak View
Fillmore
Piru
Casitas Springs
Santa Paula
Emma Wood St. Beach
Moorpark
Somis
Simi Valley
PACIFIC OCEAN
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Port Hueneme
Casa Conejo
Naval Base Ventura County
Pt. Mugu S.P.
0 10 mi
0 10 km
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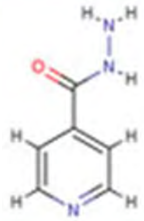
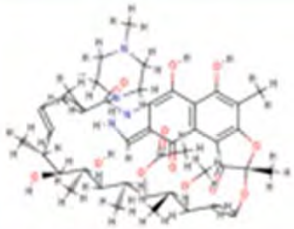
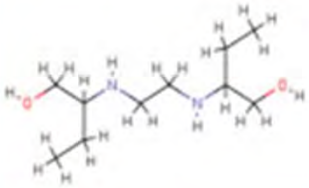
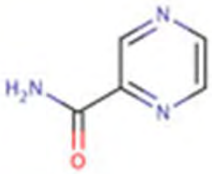
Clinic Limitations

- Hours
- Weekends/Holidays
- Flexibility
- Mobility

Standard DOT

W
T
F
S
W
T
S

Drug Name	Formulation	Chemical Structure
Isoniazid		
Rifampin		
Ethambutol		
Pyrazinamide		

Side Effects

- Identify
- Provide feedback to clinic MD and RNs
- Management

Contact Investigations

- In home
- Local High School

Cost for Providers

- Supervisors (Community Paramedics) are staffed 24 hours
  - No additional cost

Cost Savings for Clinic

- Bubble Packs
- Gas/Vehicle Maintenance
- Reduce Clinic OT

Patients

- Since Partnership began (2014)
  - 46 Patients
- Pilot Phase (June 2015-July 2016)
  - 29 patients
  - 3 MDR

What the Data doesn’t show…

Ventura EMS/Hospice Partnership

Partners

- AMR
- Gold Coast
- Lifeline
- Ventura County EMS Agency
- Hospice Providers
  - Assisted
  - Livingston Memorial
  - Buena Vista
  - TLC
  - Hospice Care of the Valley
  - Vitas
  - Oakhurst

Hospice

- Good Death
- At home symptom management
- Family Support

Train our CPs using Hospice RN curricula

Move Physician guidance from EMS Physician to Hospice Physician

Extension of the Hospice team

Fill a Gap

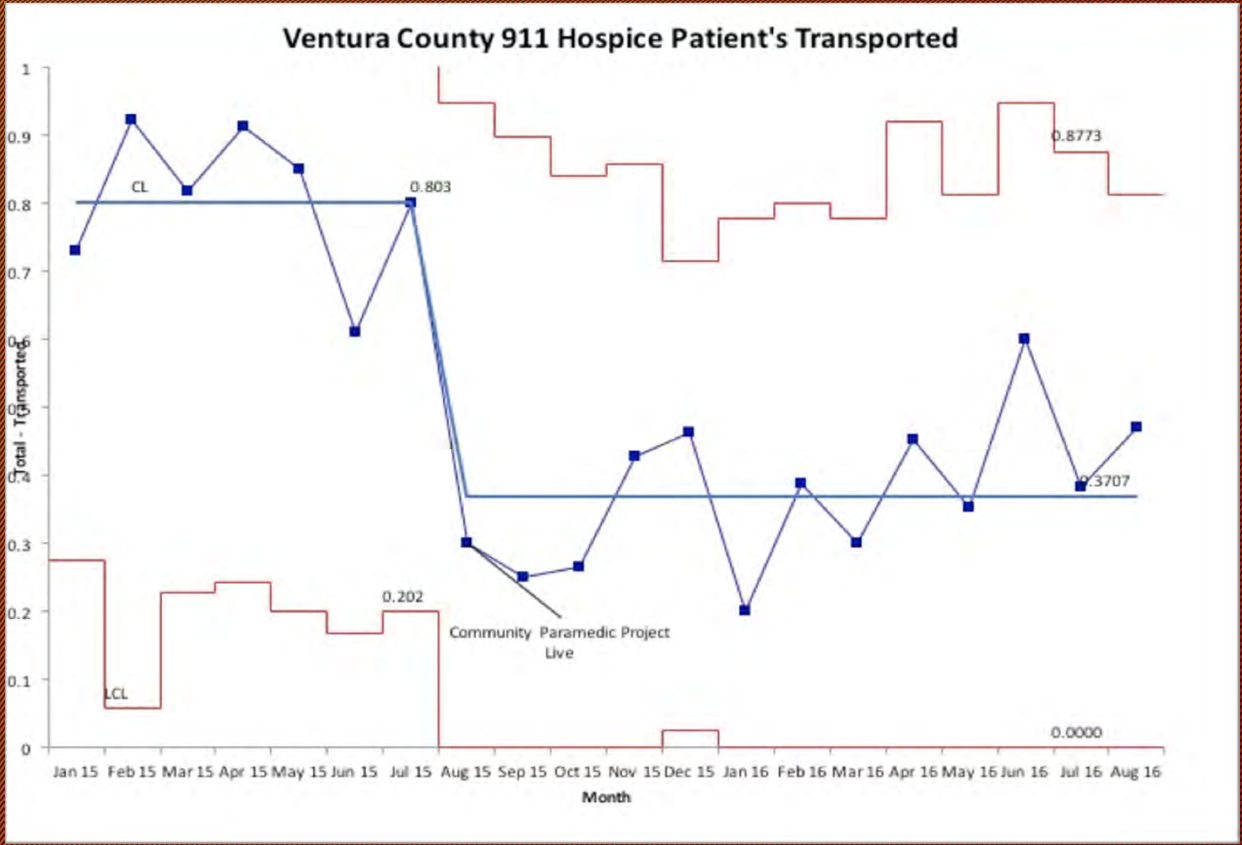
- 911 is called
- Hospice RN arrives to provide care

Theory vs Reality

- Theory
  - Comfort Pack
- Reality
  - Family Support
  - Social Services

Cost

- Supervisors (Community Paramedics) are staffed 24 hours
  - No additional cost
- Loss in transport revenue


Ventura County 911 Hospice Patient's Transported
Total - Transported
Month
CL
0.803
0.8773
0.3707
0.202
LCL
0.0000
Community Paramedic Project Live
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Jan 15
Feb 15
Mar 15
Apr 15
May 15
Jun 15
Jul 15
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16

What the data doesn't show…

- Our very first Hospice call…

QUESTIONS

California Community Paramedicine

California HealthCare Foundation

EMSA Emergency Medical Services Authority

UCSF University of California San Francisco

UCLA

Fire Founded 1909

Rural/Metro Ambulance

AMR Ventura County

Gold Coast

Alameda Fire Dept. Est. 1876

CARE Ambulance Service

Lifeline Medical Transport

Fountain Valley Fire Dedication Teamwork Excellence Ethics

Newport Beach Fire

Medic Ambulance

Butte County EMS

San Bernardino County Fire Dept

San Diego Fire Life Safety

Carlsbad Fire Dept.

Santa Monica Fire Dept.

Rialto Fire

Glendale Fire Department Established 1912

EMERGENCY MEDICAL SERVICES AUTHORITY

EMSA

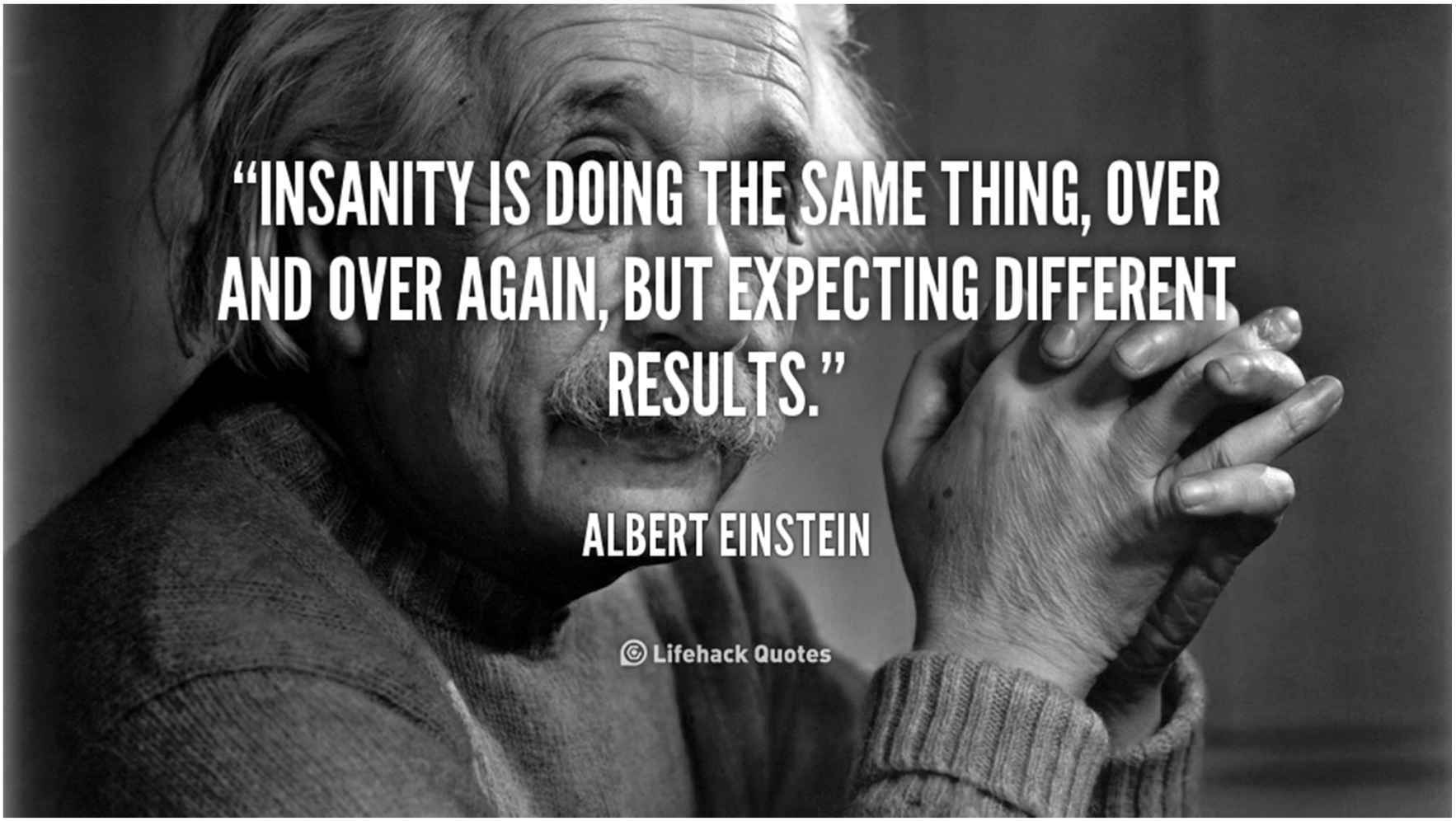
CALIFORNIA

In Crisis:

Managing mental health patients in overloaded EMS systems

Kevin Mackey MD, FACEP
Medical Director, Mountain Valley EMS Agency
drmackey@comcast.net

Disclosure


"INSANITY IS DOING THE SAME THING, OVER AND OVER AGAIN, BUT EXPECTING DIFFERENT RESULTS."
ALBERT EINSTEIN
Lifehack Quotes

Comments | Tx Team | Sign Out | Discharge | Dept. Status

MD | Pending Admit | CDA Patients | Consult

	Physician	TT	Comments	Lab	X-Ray	Orders	Consult
				00:00	00:00		
				00:00	00:00		
				00:00	00:00		
	Mackey, Kevin ...	98:56	1799 | so, no wound nurse or otherwi...	[12/13] 91:02	[1/1] 00:00		D
...	Fischette, Willi...	03:42	Working on SNF placement	00:00	00:00		D
	Cichon, Patrick...	00:50		00:00	00:00		D
	Shaeffer, Zane ...	05:22	hospital based services will call with fi...	[9/16] 00:51	[1/2] 00:34		H
	Mackey, Kevin ...	19:19	Plan for dc @1700	[15/16] 08:07	00:00		
	Shaeffer, Zane ...	06:22	nicom	[10/13] 04:54	00:00		
	Mackey, Kevin ...	91:06	5150	[8/9] 89:34	00:00		
	Mackey, Kevin ...	86:56	NO BED TONIGHT PER THE CALL C...	[24/27] 50:51	[1/1] 69:07		
	Mackey, Kevin ...	36:17	5150 | Need utox | Sierra to accept o...	[9/11] 01:44	00:00		
	Mackey, Kevin ...	35:51	5150	[8/10] 34:00	[1/1] 00:00		
	Mackey, Kevin ...	25:24	Pls order UA, has elevated wbc. | 515...	[8/9] 00:47	[1/1] 23:44		
	Mackey, Kevin ...	21:28	5150	[15/20] 19:02	[2/2] 19:51		
; A...	Mackey, Kevin ...	21:02	Partner request work note for pt	[24/28] 08:18	00:00		
3; H...	Mackey, Kevin ...	19:15	5150-awaiting placement.	[8/9] 15:26	00:00		
3; H...	Luz, James ((...	05:14	Need UA and K+ replacement. Pt sed...	[5/6] 03:59	00:00		
	Mackey, Kevin ...	05:33	1799	[14/15] 02:49	00:00		
CHRI...	Mackey, Kevin ...	04:07	Psych MD eval	[15/17] 00:22	00:00		

IP SnapShot

Report

		Most Recent
00	05/31 0700	
59	05/31 1358	98.2 (36.8)
4	98.2	
		94
	94	
		134/84

Dear Doctor

MD to MD Note

Pt on 5150. However, no previous psych history found. Susp

Becoming agitated at 23:50. Sending back from 1 N to the ED

Plan: hold medications overnight. Geri-psych, Dr. Mason to ev

Emergency
Vehicles
Only
Yield to
Emergency
Vehicles
NO PARKING FIRE LANE
EMERGENCY VEHICLES ONLY

"THE SECRET OF CHANGE IS TO FOCUS ALL OF YOUR ENERGY, NOT ON FIGHTING THE OLD, BUT ON BUILDING THE NEW."

— *SOCRATES*

AMR
COMMUNITY
PARAMEDIC

Re-engineering our Resources

Project #12

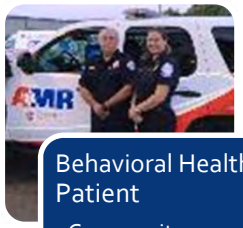
Screening and Medical Clearance of Behavioral Health Patients for Transport DIRECTLY to Behavioral Health Facilities

AMR®

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

Community Paramedic Decision Process

MIHP Access
- 911 Ambulance
- Psych Facility (CERT)
- Law Enforcement



Behavioral Health Patient
- Community Paramedic Dispatched (QRV) via VRECC

Community Paramedic (WPA/MHCA) Assessment
- Failed Assessment

Transport Ambulance to ED

Community Paramedic (WPA/MHCA) Assessment
- Eligible – Not Enrolled (No BH Resources)

Transport Ambulance to ED

Community Paramedic (WPA/MHCA) Assessment
- Eligible – Enrolled

Transport Ambulance to CERT

Step #1: Sick/Not Sick

Well Person Algorithm

1. Vitals "Normal"?
2. No medical or traumatic complaints (other than superficial cut)

** Every Paramedic Learned this Algorithm **

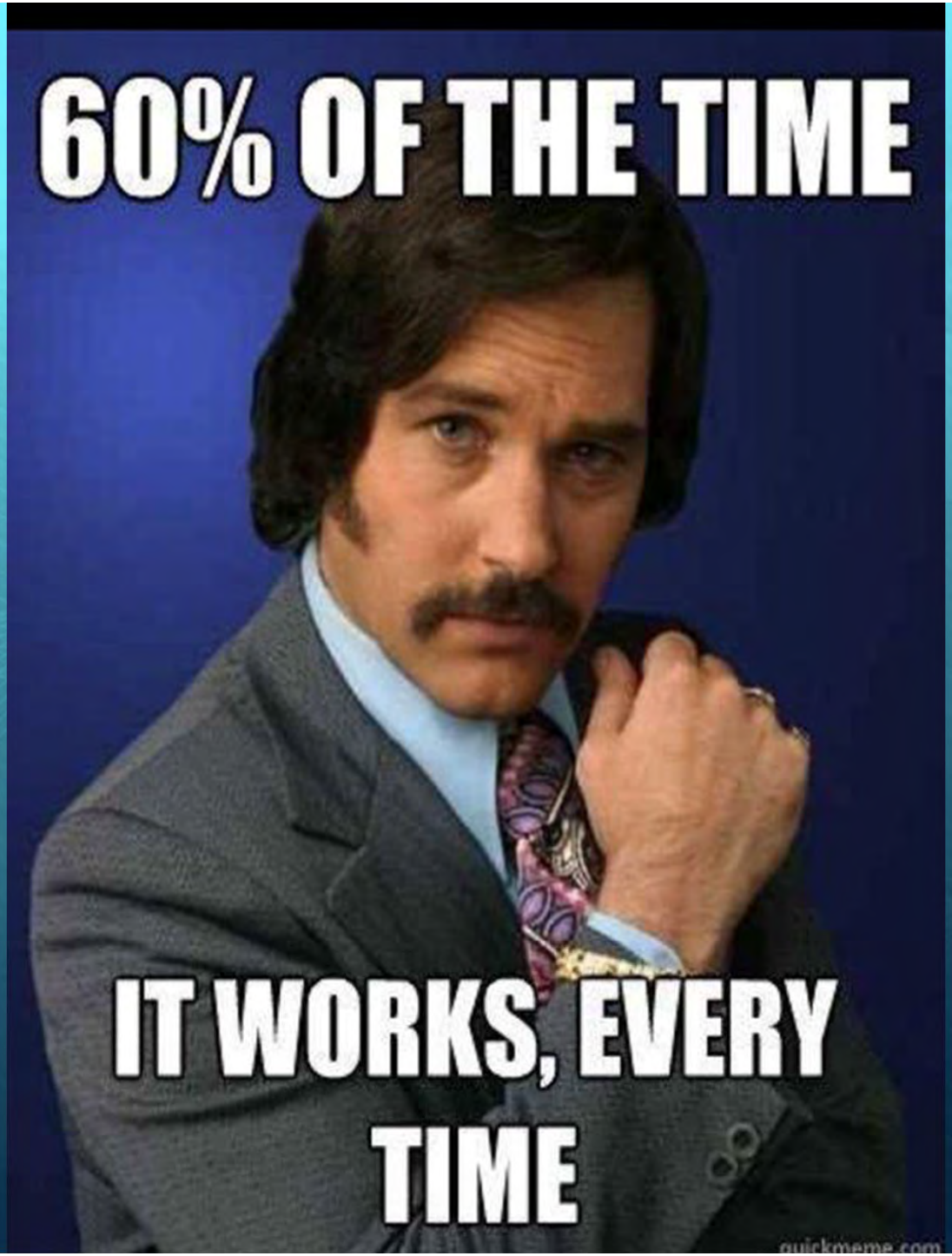
Step #2: Screen for Safe Disposition

Mental Health Clearance Algorithm

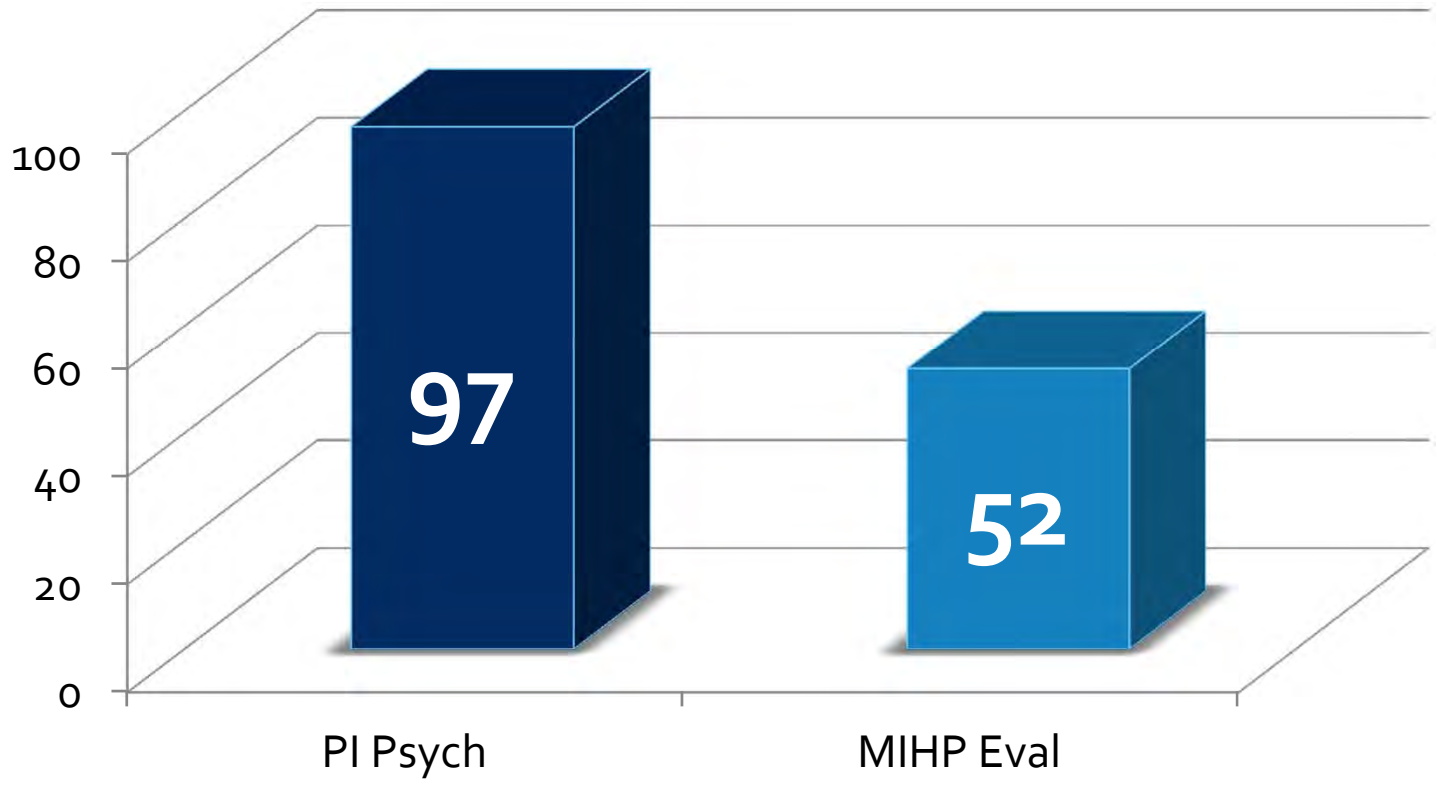
1. Reconfirm WPA
2. Assess for safety (nonaccidental poisoning, Risk of alcohol withdrawl, wound eval, etc)

** MIHP Specific Algorithm**

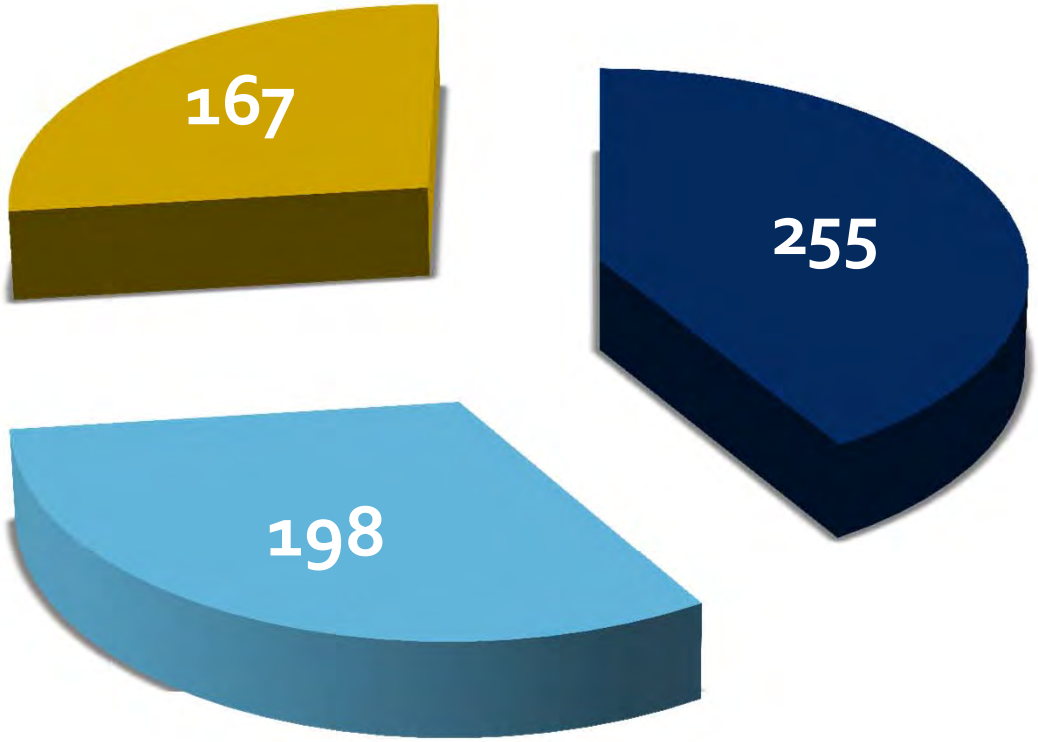
Insurance Evaluation if passes MHCA


60% OF THE TIME
IT WORKS, EVERY TIME
quickmeme.com

Paramedic Impression v MIHP Evaluation (Monthly Averages)



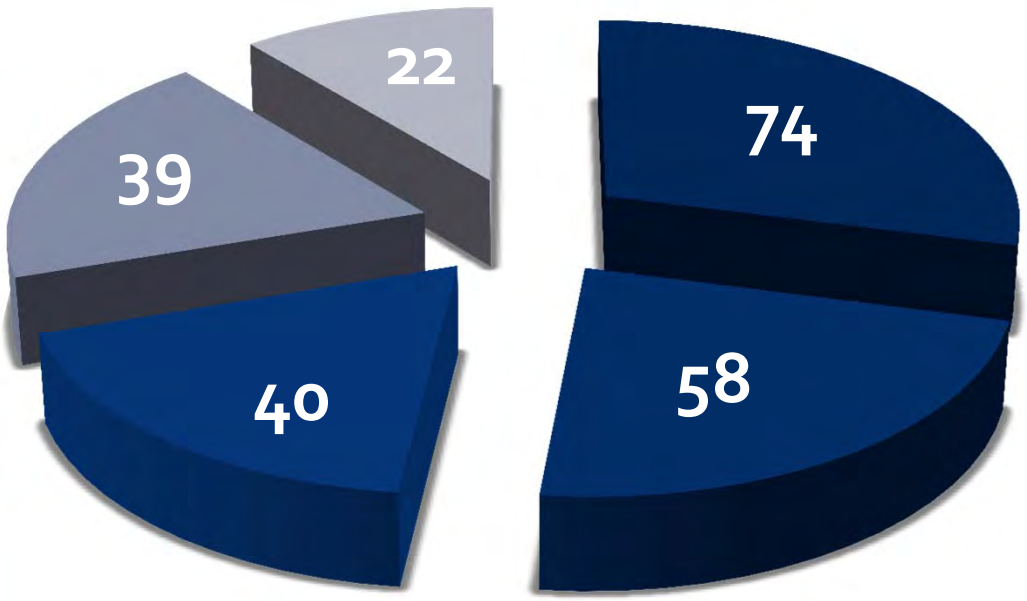
MIHP Total Patient Contacts



- Failed WPP/MHCA
- Eligible, Not Enrolled
- Eligible, Enrolled

Total Contacts 2020

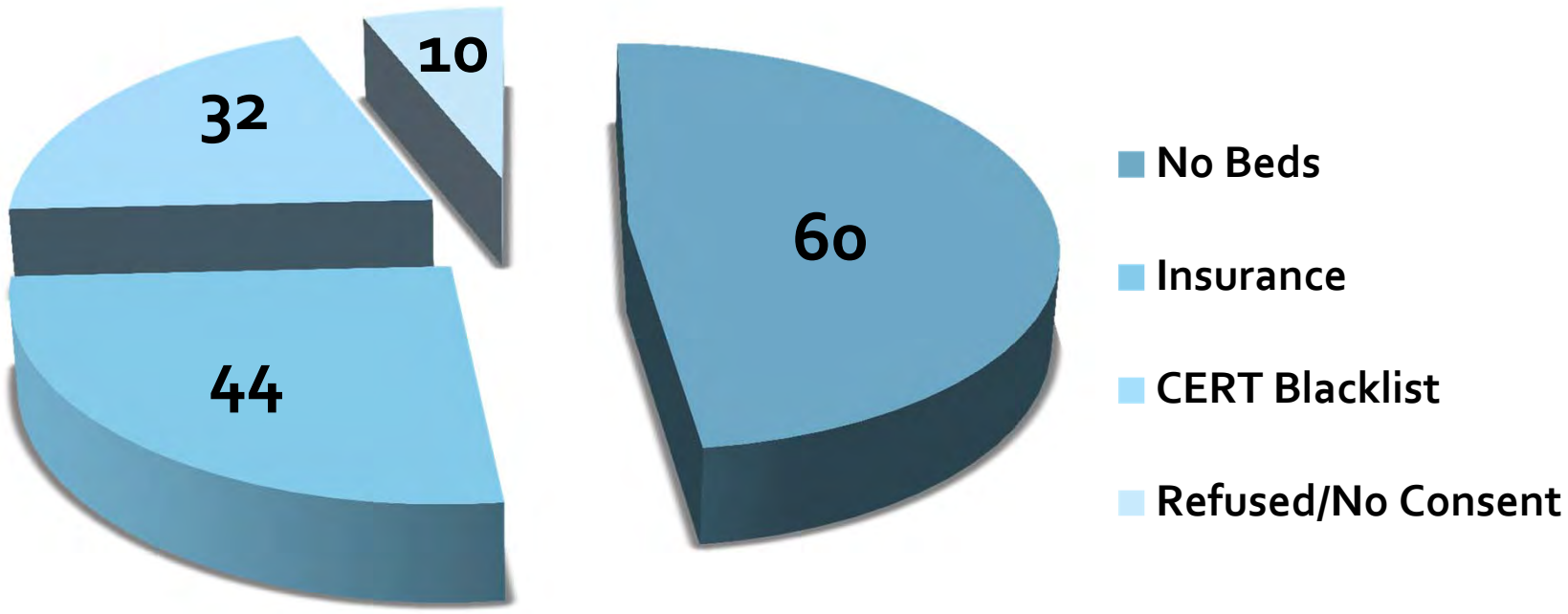
Failed Well Person Protocol/MHCA



- VS/GCS/FSBS
- Medical/Traumatic Complaint
- Agitated
- ETOH/Substance Abuse
- Age

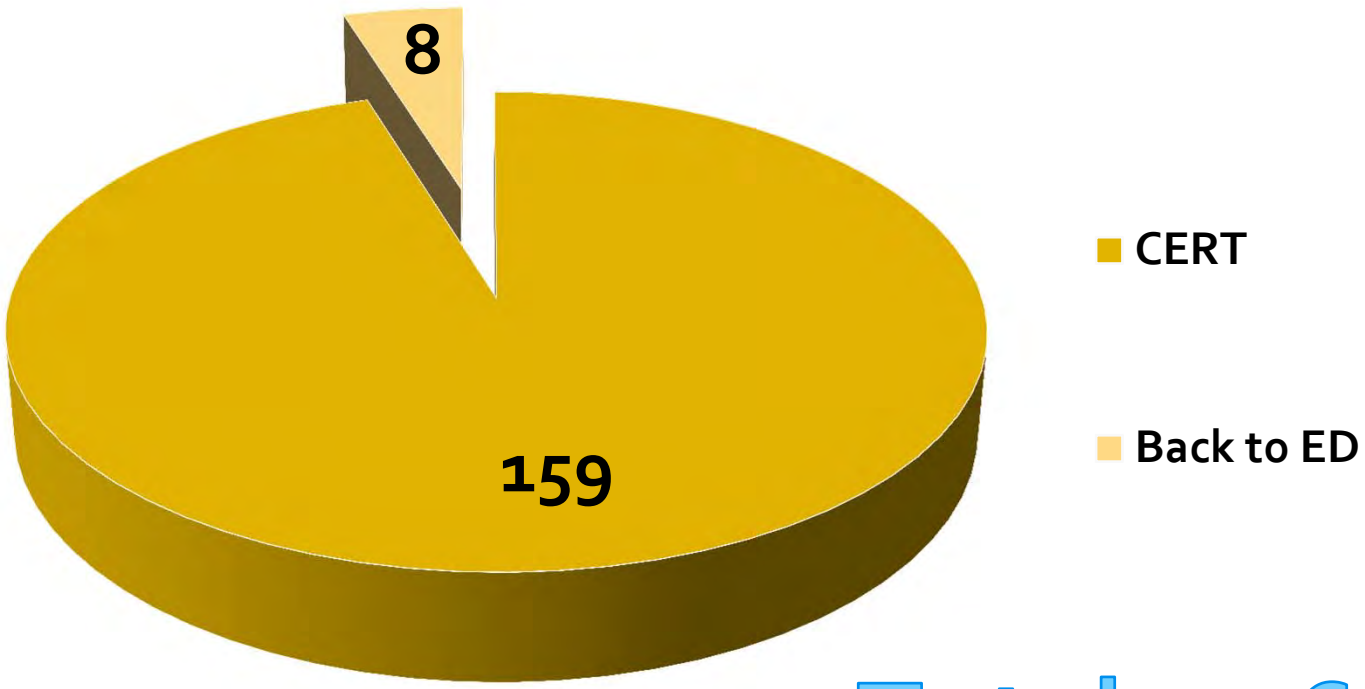
Total = 255

Eligible, Not Enrolled



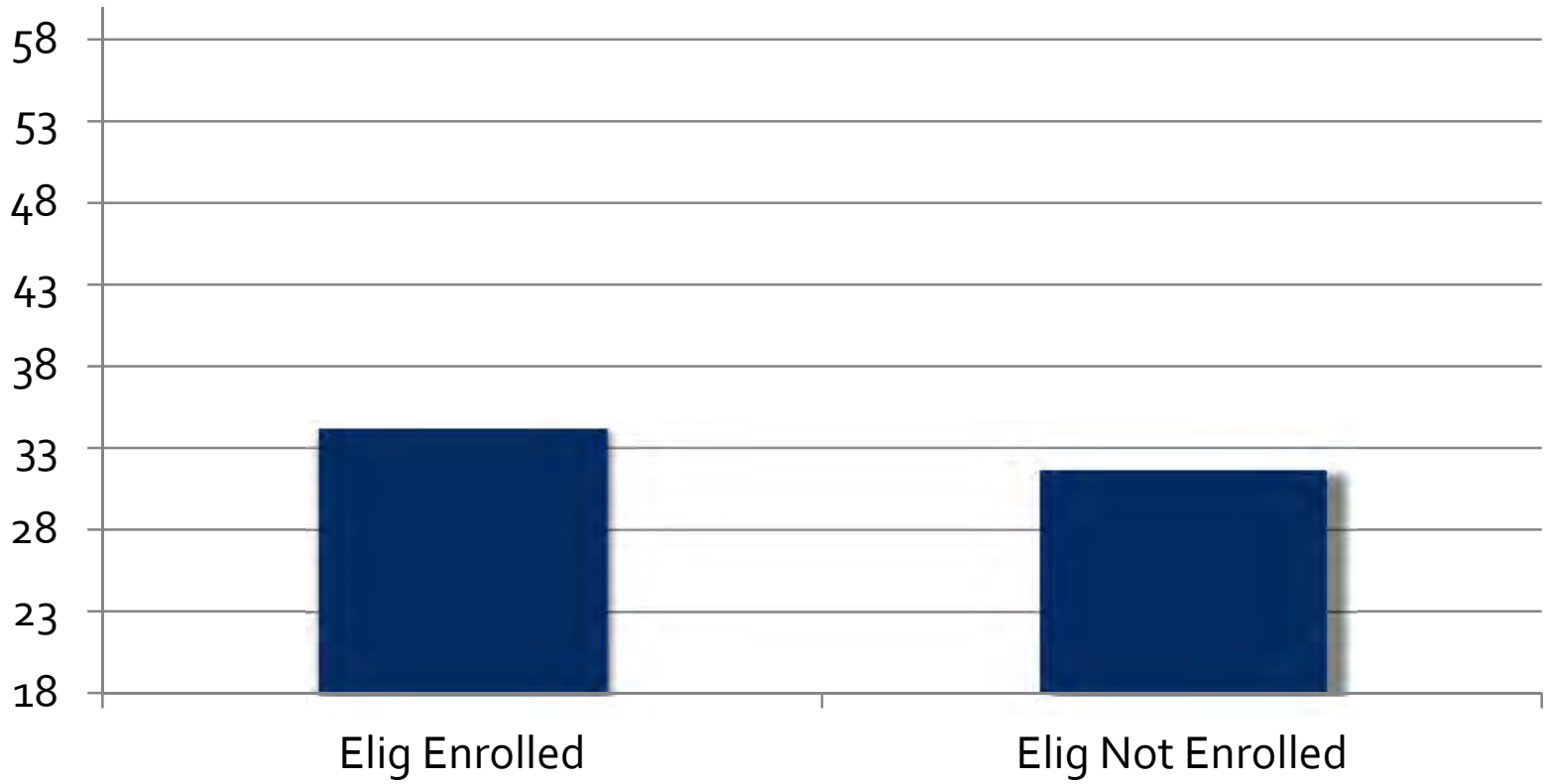
Total = 198

Eligible, Enrolled



Total = 167

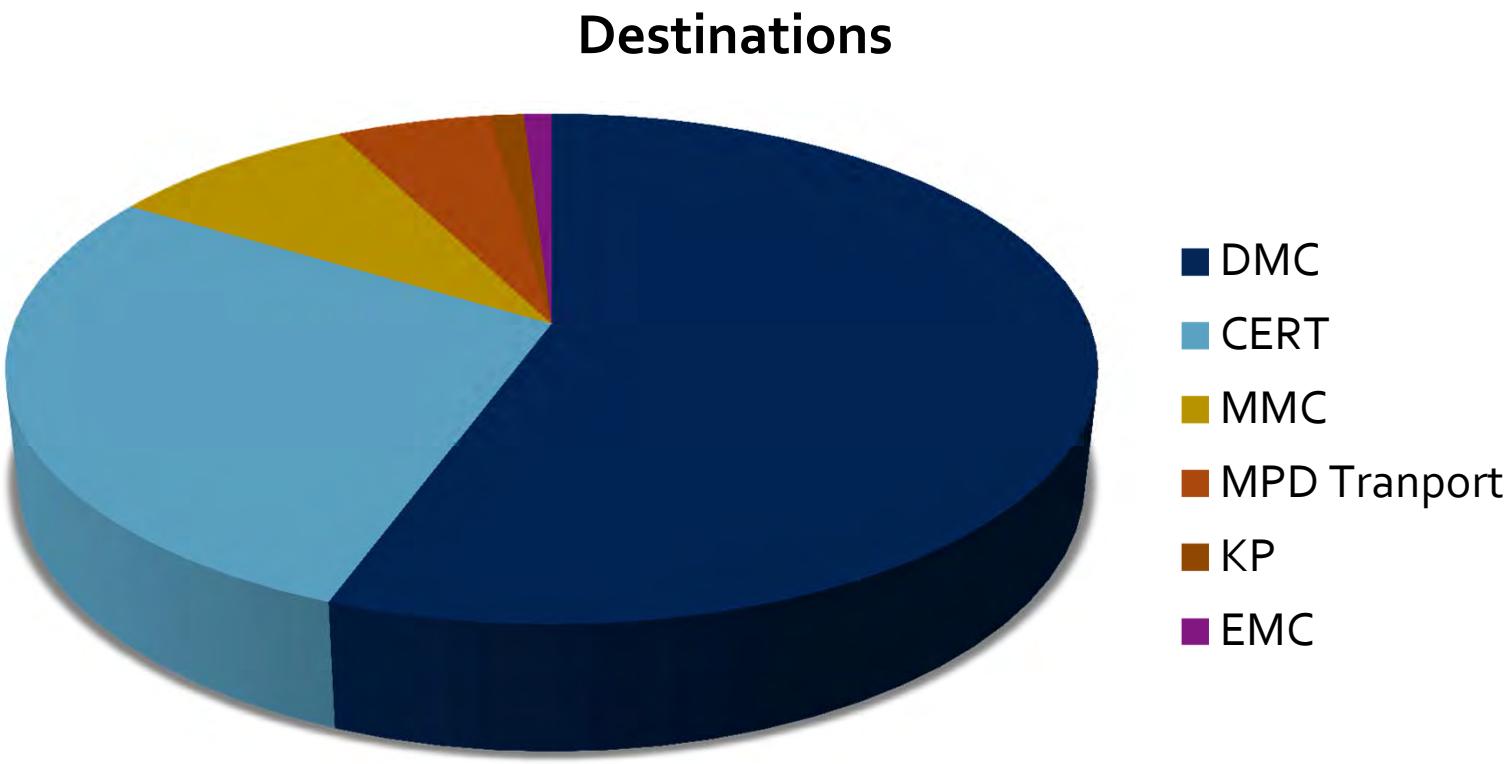
Average Age



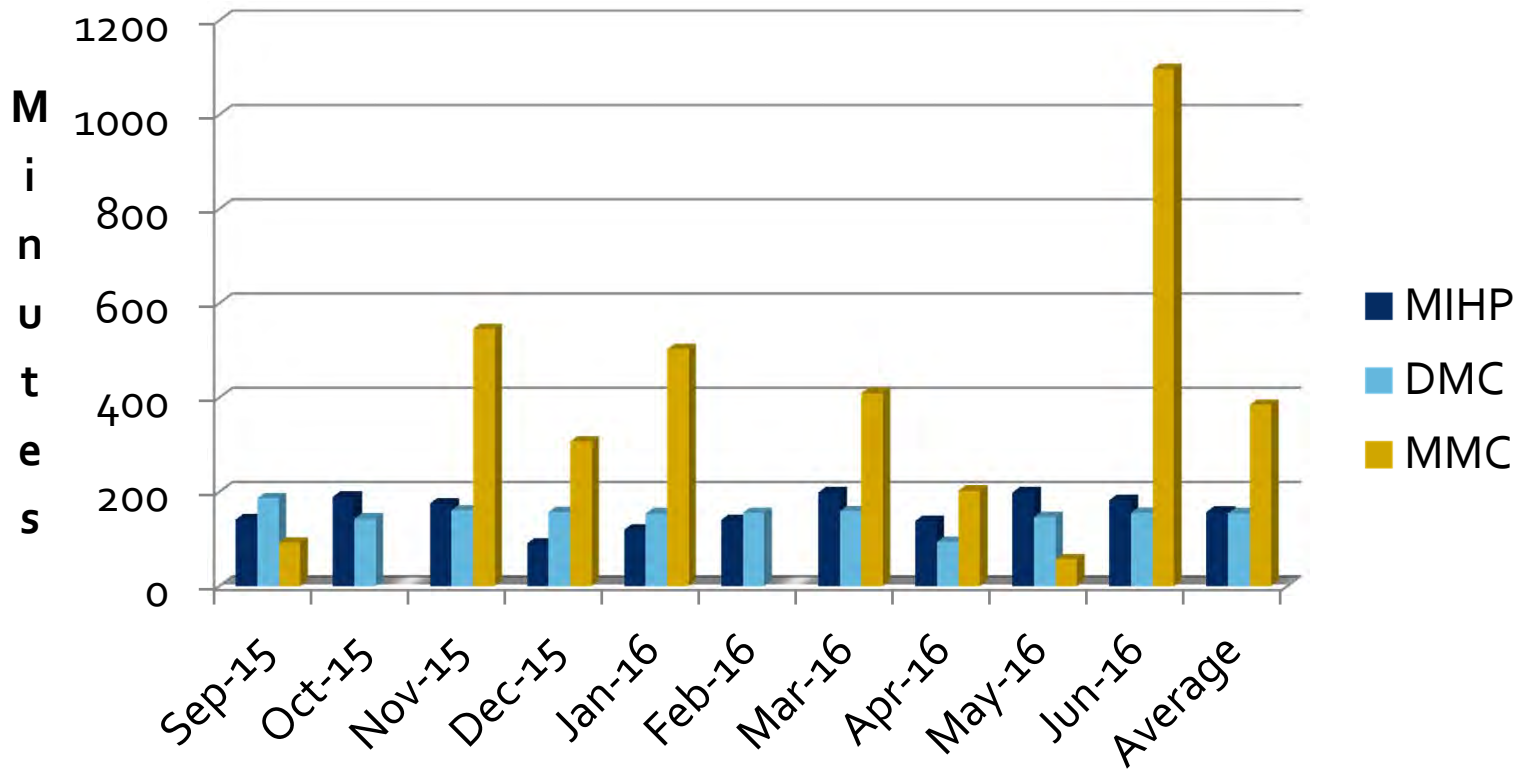
More Demographics: Eligible Enrolled

- Average age: 34.2 years
- Caucasian > Hispanic > Black
- English >

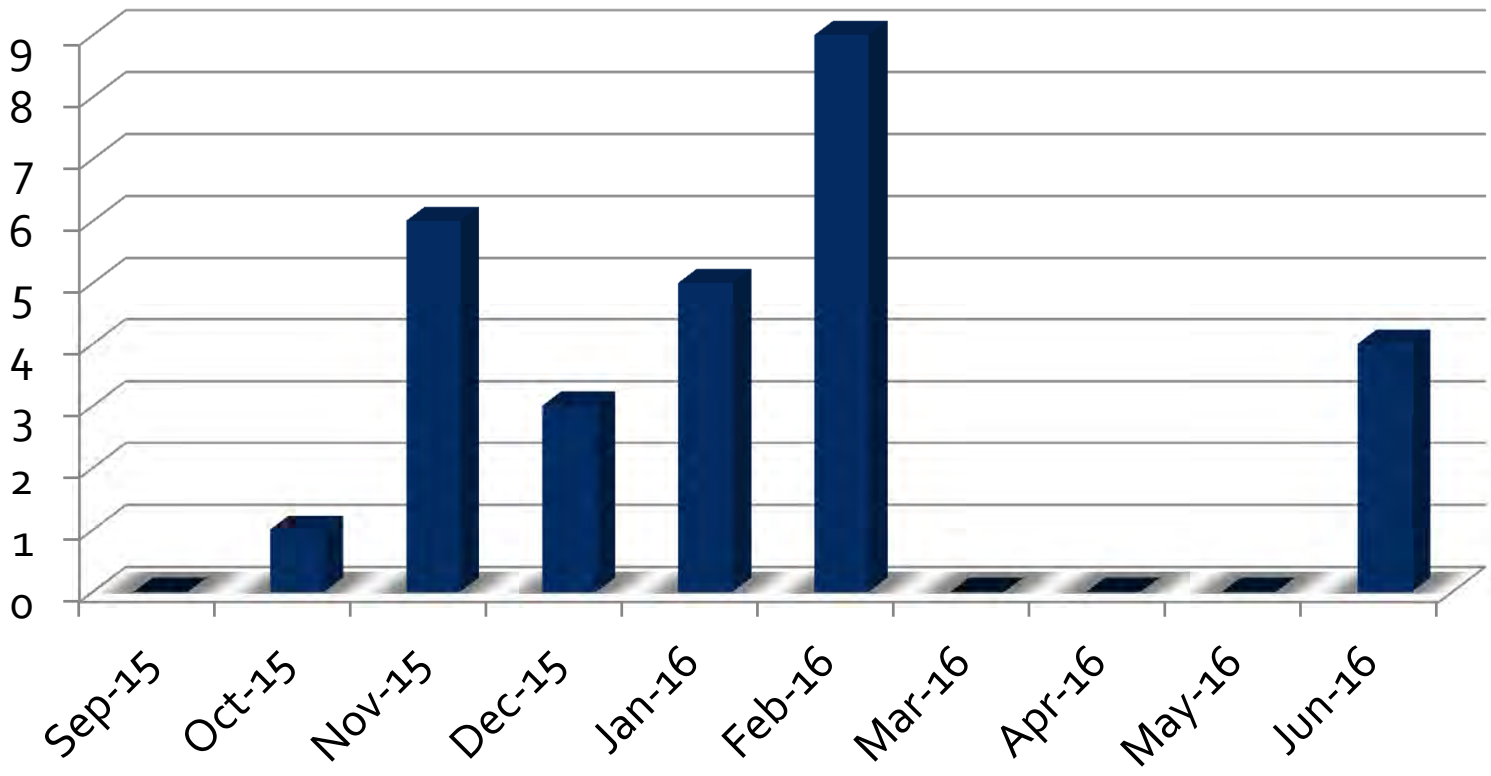
Transport Destinations



Arrival to Disposition



“Faithful Customers”



What about $$$$?

- Emergency Department billed costs for one patient transported by EMS, including nursing time, labs, MD medical clearance and consultation for discharge/placement?

$7634*

* Based upon hospital reported charges according to standardized patients representing a typical mental health patient presenting to the emergency department

$7634

X

159

=

$1,213,806

$7634

X

357

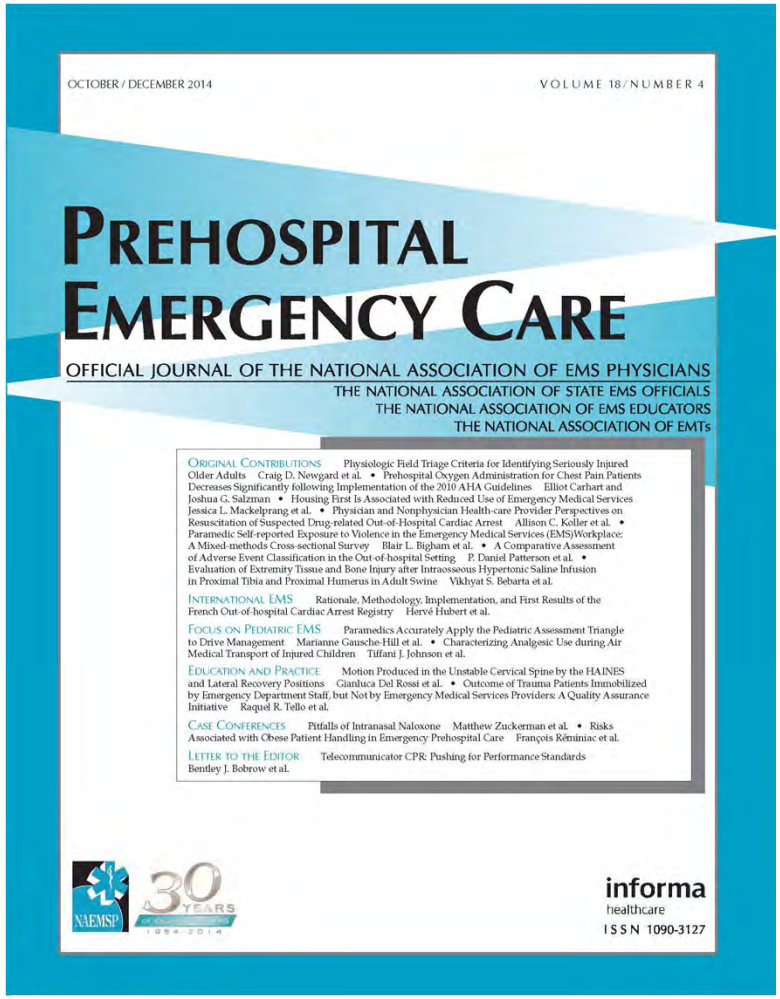
=

$2,725,338

PAST
PRESENT
FUTURE

The “Past”

The "Present"



OCTOBER / DECEMBER 2014 VOLUME 18/NUMBER 4

PREHOSPITAL EMERGENCY CARE

OFFICIAL JOURNAL OF THE NATIONAL ASSOCIATION OF EMS PHYSICIANS
THE NATIONAL ASSOCIATION OF STATE EMS OFFICIALS
THE NATIONAL ASSOCIATION OF EMS EDUCATORS
THE NATIONAL ASSOCIATION OF EMTs

ORIGINAL CONTRIBUTIONS Physiologic Field Triage Criteria for Identifying Seriously Injured Older Adults Craig D. Newgard et al. • Prehospital Oxygen Administration for Chest Pain Patients Decreases Significantly following Implementation of the 2010 AHA Guidelines Elliot Carhart and Joshua G. Salzman • Housing First Is Associated with Reduced Use of Emergency Medical Services Jessica L. Mackelprang et al. • Physician and Nonphysician Health-care Provider Perspectives on Resuscitation of Suspected Drug-related Out-of-Hospital Cardiac Arrest Allison C. Koller et al. • Paramedic Self-reported Exposure to Violence in the Emergency Medical Services (EMS)Workplace: A Mixed-methods Cross-sectional Survey Blair L. Bigham et al. • A Comparative Assessment of Adverse Event Classification in the Out-of-hospital Setting P. Daniel Patterson et al. • Evaluation of Extremity Tissue and Bone Injury after Intraosseous Hypertonic Saline Infusion in Proximal Tibia and Proximal Humerus in Adult Swine Vikhyat S. Bebarta et al.

INTERNATIONAL EMS Rationale, Methodology, Implementation, and First Results of the French Out-of-hospital Cardiac Arrest Registry Hervé Hubert et al.

FOCUS ON PEDIATRIC EMS Paramedics Accurately Apply the Pediatric Assessment Triangle to Drive Management Marianne Gausche-Hill et al. • Characterizing Analgesic Use during Air Medical Transport of Injured Children Tiffani J. Johnson et al.

EDUCATION AND PRACTICE Motion Produced in the Unstable Cervical Spine by the HAINES and Lateral Recovery Positions Gianluca Del Rossi et al. • Outcome of Trauma Patients Immobilized by Emergency Department Staff, but Not by Emergency Medical Services Providers: A Quality Assurance Initiative Raquel R. Tello et al.

CASE CONFERENCES Pitfalls of Intranasal Naloxone Matthew Zuckerman et al. • Risks Associated with Obese Patient Handling in Emergency Prehospital Care François Réminiac et al.

LETTER TO THE EDITOR Telecommunicator CPR: Pushing for Performance Standards Bentley J. Bobrow et al.

NAEMSP 30 YEARS 1984-2014

informa healthcare
ISSN 1090-3127

The “Future”

MORE!!!

SUSTAINABILITY

Thank You!

EMERGENCY MEDICAL SERVICES AUTHORITY
EMSA
CALIFORNIA

Show me the Money!

The Why, Who, and What Payers are Paying for MIH/CP Services

Matt Zavadsky, MS-HSA, EMT
Chief Strategic Integration Officer
MedStar Mobile Healthcare

© 2016 MedStar Mobile Healthcare

About MedStar…

- Governmental agency (PUM) serving Ft. Worth and 14 Cities
  - Self-Operated
  - 978,000 residents, 434 Sq. miles
  - Exclusive provider - emergency and non emergency
- 135,000 responses annually
- 460 employees
- $50 million budget
  - No tax subsidy
- Fully deployed system status management
- Medical Control from 16 member Emergency Physician's Advisory Board (EPAB)
  - Physician Medical Directors from all emergency departments in service area + 5 Tarrant County Medical Society reps

What We're Gonna Do…

- Healthcare Finance 3.0
  - Motivating factors for payers
- Examples of who is paying
  - And why
- Key messages for you to potential payers
- Future of payment reform for "EMS"

And….

- Learn certain words that have a **whole different meaning in Texas…**

Summer:

- **What it means everywhere else:** A time for vacation, road trips, and fun in the sun.

- **What it means in Texas:** Hell on Earth where the temperatures rarely dip below 100 degrees.

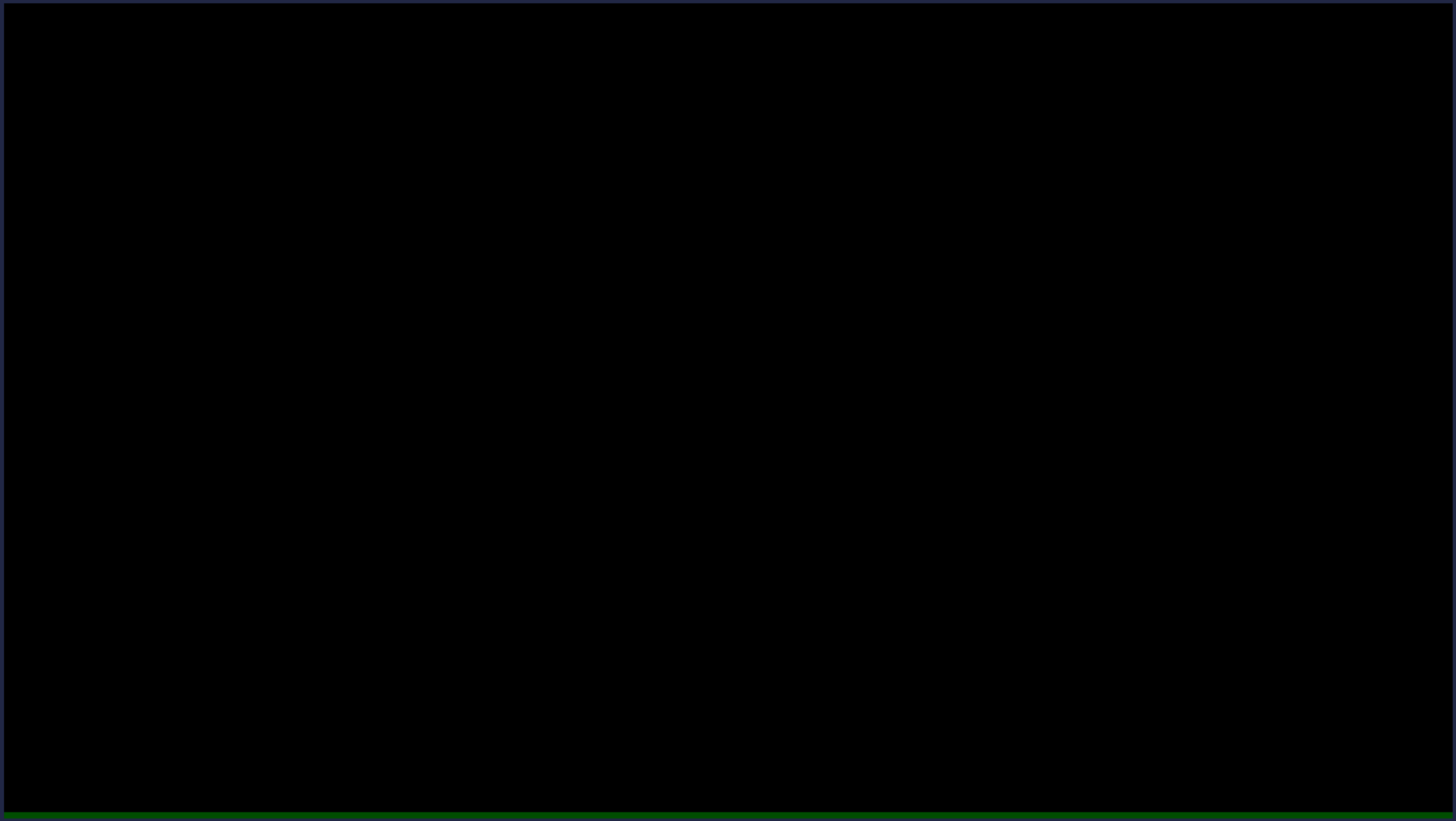
Healthcare Finance 3.0

- FFS → ***OUTCOMES***
- Readmission & VBP penalties
- MSPB calculations = **2015**
  - Medicare Spending Per Beneficiary
- Bundled payments
  - CCJR
  - Cardiac
- Push to Managed Medicare/Medicaid
- Merger and Acquisition activity

THIRTY YEARS OF CARING & INNOVATION 1986 30 2016
MEDSTAR MOBILE HEALTHCARE

EMERGENCY MEDICAL SERVICES AUTHORITY EMSA CALIFORNIA

Readmissions



THIRTY YEARS OF CARING & INNOVATION
1986 30 2016
MEDSTAR
MOBILE HEALTHCARE

EMERGENCY MEDICAL SERVICES AUTHORITY
EMSA
CALIFORNIA

Healthcare Finance 3.0

- ACOs
  - **838** as of April 2016
  - – **28.3 million** covered lives

http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/

How Much Does "EMS" *REALLY* Cost?

THIRTY YEARS OF CARING & INNOVATION 1986 30 2016
MEDSTAR MOBILE HEALTHCARE

EMERGENCY MEDICAL SERVICES AUTHORITY EMSA CALIFORNIA

131 Million ED Visits (2011)

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

AHRQ Agency for Healthcare Research and Quality

STATISTICAL BRIEF #174

June 2014

Overview of Emergency Department Visits in the United States, 2011

Audrey J. Weiss, Ph.D., Lauren M. Wier, M.P.H., Carol Stocks, Ph.D., R.N., and Janice Blanchard, M.D., Ph.D.

Introduction

Highlights

- In 2011, there were about 421 visits to the emergency department (ED) for every 1,000 individuals in the population.
- More than five times as many individuals who visited an ED were discharged as were admitted to the same hospital.

[2] Tang N, Stein J, Hsia RY, Maselli JH, Gonzales R. Trends and characteristics of US emergency department visits, 1997–2007. Journal of the American Medical Association. 2010;304(6):664–70.
[3] Goodell S, DeLia D, Cantor JC. Emergency Department Utilization and Capacity. 2009, Robert Wood Johnson Foundation Policy Brief No. 17. Princeton, NJ: Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2009/rwjf43566. Accessed May 7, 2014.
[4] Morganti-Gonzalez K, Baufman S, Blanchard J, Abir M, Iyer N, Smith A, et al. The Evolving Role of Emergency Departments in the United States. RAND RR 280-ACEP. Santa Monica, CA: Rand Corp; May 2013.
[5] Ibid. Note: excludes live births.
[6] Tang et al., 2010.

aged 45 years and older), and abdominal pain and back pain (all adult age groups except those aged 85+ years).

- Rural areas had a higher rate of ED visits resulting in discharge compared with urban areas.

1

Highlights

- In 2011, there were about 421 visits to the emergency department (ED) for every 1,000 individuals in the population.
- More than five times as many individuals who visited an ED were discharged as were admitted to the same hospital.

- The most common reasons for ED visits resulting in discharge were fever and otitis media (infants and patients aged 1–17 years), superficial injury (all age groups except infants), open wounds of the head, neck, and trunk (patients aged 1–17 years and adults aged 85+ years), nonspecific chest pain (adults aged 45 years and older), and abdominal pain and back pain (all adult age groups except those aged 85+ years).

THIRTY YEARS OF CARING & INNOVATION 1986 30 2016 MEDSTAR MOBILE HEALTHCARE

https://www.hcup-us.ahrq.gov/reports/statbriefs/sb174-Emergency-Department-Visits-Overview.pdf

EMERGENCY MEDICAL SERVICES AUTHORITY EMSA CALIFORNIA

YEAR	% OF ED PATIENTS ARRIVING BY EMS	OVERALL ED ADMISSION RATE (%)	% OF EMS ARRIVALS WHO ARE ADMITTED	% OF WALK-IN PATIENTS ADMITTED
2013	17	16.5	39	12.5
2012	16	16.5	39	12.2
2011	17	17.6	42	12.6
2010	16	18.0	43	13.2
2009	16	17.3	43	12.4
2008	17	16.6	43	11.2
2007–2004	15	16.3	38	12.5

http://www.acepnow.com/article/emergency-medical-services-arrivals-admission-rates-emergency-department-analyzed/

ED Expenditure Analysis

All ED Visits (2011) (2)	$	131,000,000
Average Expenditure (3)	$	969
ED Expenditure	**$**	**126,939,000,000**

% EMS ED Arrivals Discharged		61%
Patients Treated & Streeted		13,584,700
Average Expenditure (3)	$	969
Total	**$**	**13,163,574,300**

% EMS ED arrival (1)		17%
Patient Arrivals		22,270,000
Average Expenditure (3)	$	969
EMS ED Expenditure	**$**	**21,579,630,000**

% of EMS patients Alt. Dest.		**15%**
ED Patients Referred		**2,037,705**
Average Expenditure (3)	$	969
Potential ED Savings	**$**	**1,974,536,145**

References:

1. http://www.acepnow.com/article/emergency-medical-services-arrivals-admission-rates-emergency-department-analyzed/
2. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb174-Emergency-Department-Visits-Overview.pdf
3. http://www.cdc.gov/nchs/data/hus/hus12.pdf

Truck:

What it means everywhere else: A machine used for hauling heavy loads.

What it means in Texas: Every other vehicle on the road.

"EMS" proving value?

*"Emergency medical services (EMS) of the future will be **community-based** health management that is **fully integrated** with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and **follow-up**, and contribute to the **treatment of chronic conditions** and **community health monitoring**. This new entity will be developed from **redistribution of existing health care resources** and will be integrated with other health care providers and public health and public safety agencies. It will **improve community health** and result in more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net."*

Why would a *HOSPITAL* pay us to <u>*NOT*</u> bring them patients?

- Increasing financial pressures
  - Unfunded patients
- Shared-Risk arrangements
  - ACO or other
- CMS bonus and penalties
  - Readmits
  - Medicare Spending Per Beneficiary post acute care bonus and penalties
  - Reduced length of stay

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Hospitals Are Paying For…

- 9-1-1 Nurse Triage
  - Reduce preventable ED visits
  - Improve HCAHPS scores
- High Utilizer Group (HUG) patients
  - Reduce preventable ED visits
  - Improve HCAHPS scores
  - 1115a Waiver projects
    - Delivery System Reform Incentive Payments (DSRIP)

Hospitals Are Paying For…

- Readmission prevention programs
  - Reduce preventable readmits
  - Reduce penalties
    - Or keep up with reductions
  - Improve HCAHPS scores
    - Transition home

- Transitional response units (medic w/NP)
  - Reduce preventable ED visits
  - Reduce preventable admissions/readmissions

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HCAPHS Focus

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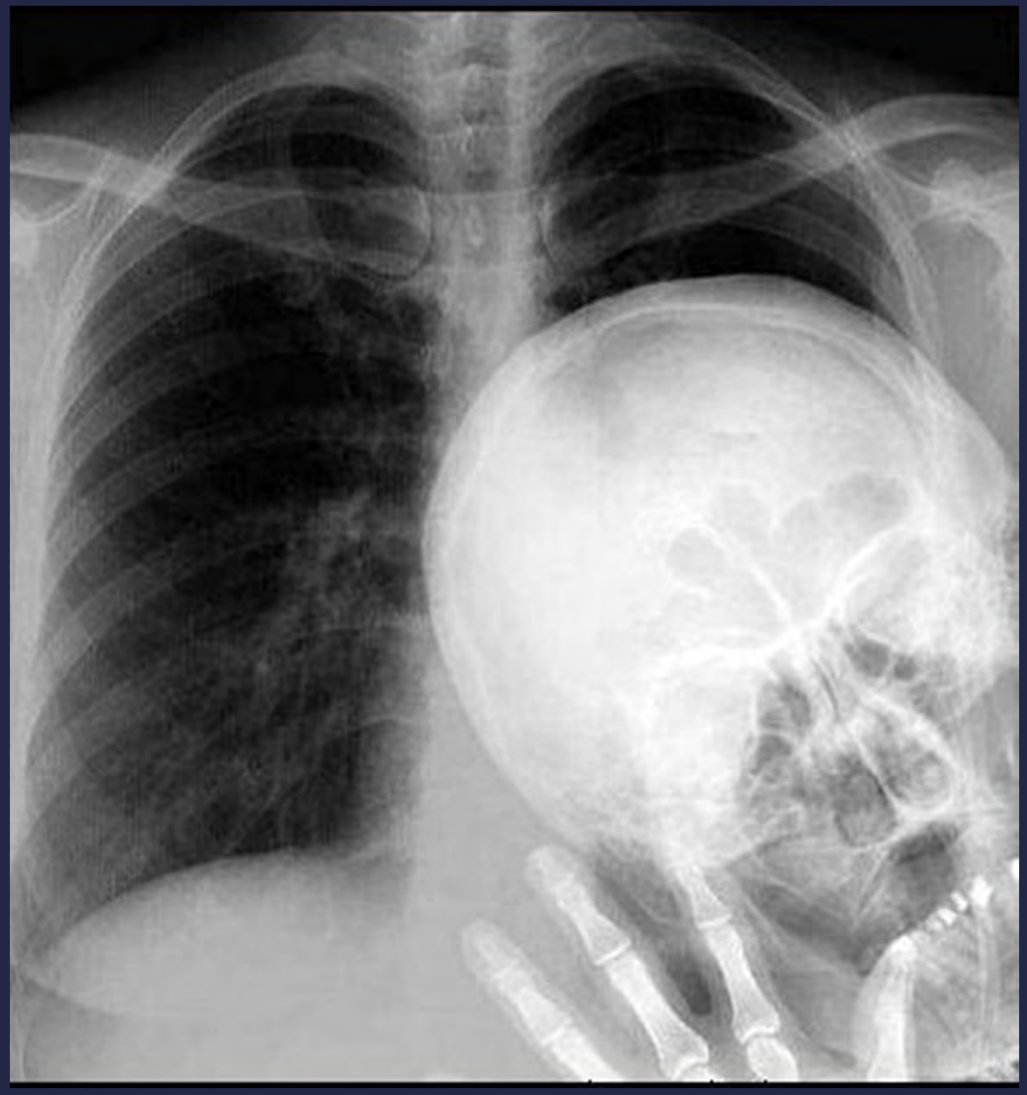
Hospitals Are Paying For…

- BPCI//CCJR
  - Hospitals//Ortho bundled payment for knee surgery
  - Desire to < preventable ED visits/Admissions
  - Use MedStar CCPs to:
    - Reduce cancelations pre-procedure
    - Express rehab if possible based on home environment
    - Reduce length of stay for the procedure
    - Intervene in 911 response 90 days post-procedure

Radiologist Selfie…



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Why would *a Physician IPA* pay us to *NOT* transport patients?

- Reduce spend
  - In a shared risk contract with 3rd party payer
- Improve patient experience
  - NCQA Accreditation standards
- Improve outcomes
  - Fewer hospitalizations
  - Fewer Hospital Acquired Conditions (HAC)

IPA is **Paying For…**

- High Utilizer Group (HUG) patients
  - Reduce preventable ED visits
  - Improve HCAHPS scores
- Admission/Readmssion prevention programs
  - Reduce preventable ***admissions***
    - Pre and beyond 30-days
    - Care about the SPEND
  - Improve Physician HCAHPS scores
    - Transition home

IPA is **Paying For…**

- Observational admission avoidance
  - Reduce spend
    - Shared risk contract
- Palliative Care project
  - Meet patient goals
  - Transition to Hospice
  - Reduce spend

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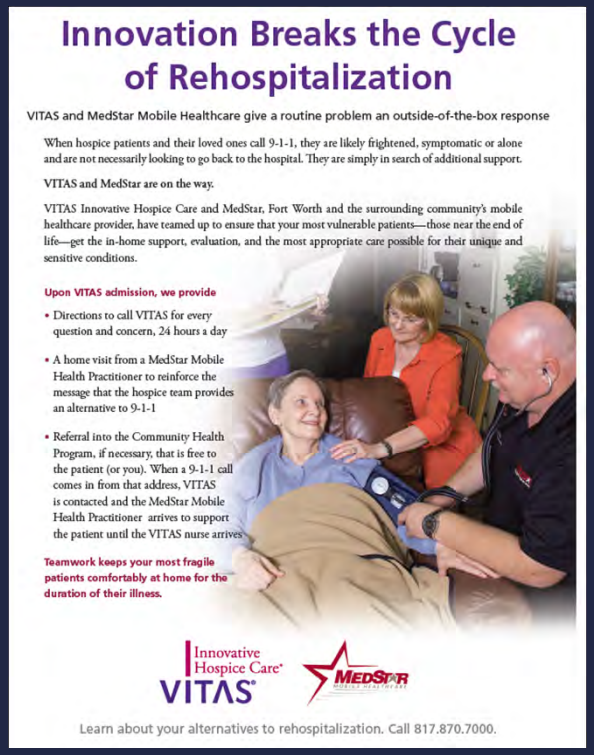
Football:

What it means everywhere else: A popular American team sport.

What it means in Texas: Religion.

Why would *Hospice* pay us <u>*NOT*</u> transport patients?

- Voluntary disenrollment
  - Patient wishes not met
  - High cost / lost revenue
  - CMS penalty?
- Involuntary revocation
  - Patient wishes not met
  - High cost / lost revenue
  - CMS penalty?



Innovation Breaks the Cycle of Rehospitalization

VITAS and MedStar Mobile Healthcare give a routine problem an outside-of-the-box response

When hospice patients and their loved ones call 9-1-1, they are likely frightened, symptomatic or alone and are not necessarily looking to go back to the hospital. They are simply in search of additional support.

VITAS and MedStar are on the way.

VITAS Innovative Hospice Care and MedStar, Fort Worth and the surrounding community's mobile healthcare provider, have teamed up to ensure that your most vulnerable patients—those near the end of life—get the in-home support, evaluation, and the most appropriate care possible for their unique and sensitive conditions.

Upon VITAS admission, we provide

- Directions to call VITAS for every question and concern, 24 hours a day
- A home visit from a MedStar Mobile Health Practitioner to reinforce the message that the hospice team provides an alternative to 9-1-1
- Referral into the Community Health Program, if necessary, that is free to the patient (or you). When a 9-1-1 call comes in from that address, VITAS is contacted and the MedStar Mobile Health Practitioner arrives to support the patient until the VITAS nurse arrives

Teamwork keeps your most fragile patients comfortably at home for the duration of their illness.

Innovative Hospice Care® VITAS®

MedStar Mobile Healthcare

Learn about your alternatives to rehospitalization. Call 817.870.7000.

Thirty Years of Caring & Innovation 1986 30 2016

MedStar Mobile Healthcare

Emergency Medical Services Authority EMSA California

Hospice is Paying For…

- Notification of response
  - Start the hospice nurse enroute to scene
- Back-up episodic intervention
  - While awaiting Hospice nurse
- 9-1-1 redirection
  - Respond/assess/consult
  - Care at home or direct admit to inpatient hospice

Why would *HOME HEALTH* pay us to see *their* patients

(*and notify them if a patient calls 9-1-1*)?

- Reduce spend
  - After hours RN home visits
  - Avoid sending RN to patient not at home
- Improve outcomes
  - Fewer re-hospitalizations
    - Increased referrals from referring agencies?
- Improve patient/customer satisfaction
  - Referring agency referral source
  - NCQA Accreditation standards

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Home Health is Paying For

- Register patients on their service in our CAD
  - Notify them if we respond to the residence
  - On-scene care coordination
    - < transport rate
- Provide after hours home visits
  - Intervene to prevent HH visit & ED transport

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Why would a 3rd Party Payer Pay for us to *NOT* transport a Patient?

- Reduce spend for unnecessary ambulance transports
- Reduce spend for unnecessary ED visits
- Reduce spend for preventable admissions
- Improve patient experience of care
  - HEDIS measures/NCQA

3rd Party Payers are Paying for…

- High utilizer programs
  - UPMC Community Connect
    - Highmark and UPMC Health
  - Minnesota Community Paramedics
    - Medicaid
  - Maine Community Paramedics
    - Medicaid
  - Idaho Community Paramedics
    - Medicaid & SIM CMMI
  - Albuquerque Community Paramedics
    - Patient Education

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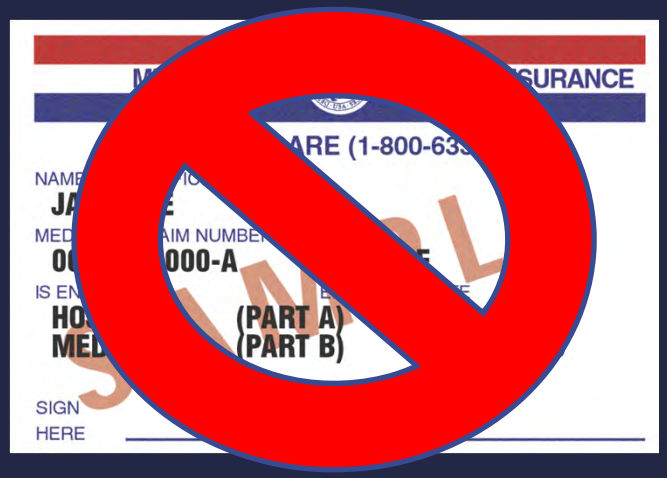
How 3rd Party Payers *are* Paying…

- Patient contact fee (Medicaid)
- Capitated rate
  - PMPM for population
    - All or members "at risk"

Post-Acute Care Providers

- Contracts for post-acute care
  - Post Acute Analytics
  - TrustedCare
  - WellMed
  - Kindred

How Medicare is Paying…



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Economic Models…

- Follow the $$
  - Who's at risk for the cost/spend
- Don't talk to mid-level managers
  - Perceive this a 'work' without reward
  - CFO buy in key

Economic Models…

- Direct funding
- Patient contact fees
- Enrollment fees
- Pseudo capitated
- Population based
- Shared savings/risk

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Packing:

What it means everywhere else: Putting stuff away in preparation of a move.

What it means in Texas: How much firepower you're carrying.

Show me the Money!

	Year to Date Actual
Expenditures	
Payroll	
Total Payroll Expenditures	$ 1,077,762.57
Total Other Expenses	$ 42,860.08
Total Expenditures	1,120,622.65
Net Retained Earnings	**$ 448,897.45**

	Year to Date Actual
Revenues	
EMS	
N/S Gross Fees	1,612,900.00
N/S Medicare - Medicaid	(586,619.53)
Uncompensated Care	(685.00)
Total Net Ambulance Fees	1,025,595.47
Standbys	0.00
Subsidies	0.00
Subscriptions	0.00
Clinical Research	0.00
Total Net Revenues	1,025,595.47
Other	
Miscellaneous	0.00
NTSP + Hospice Contract Rev	154,800.00
CHP Home Health Program	19,425.00
CHP Consulting Revenue	57,802.88
DSRIP	311,896.75
Education	0.00
Total Other Revenue	543,924.63
Total Revenues, Gains & Other Support	**$ 1,569,520.10**

Customer Messages…

- Hospitals
  - How can we help improve your readmission rate?
  - How can we help improve your HCAHPS scores?
  - How can we help with your MSPB?
    - Especially in pre and post-acute admissions metric
    - As well as length of stay
- Shared-Risk providers
  - How can we help reduce your spend on admissions?
  - How can we help reduce your spend on Obs admits?
  - How can we help improve your HCAHPS scores?

Customer Messages…

- Home Health
  - How can we help increase your referral base?
  - How can we help reduce your spend for after hours services?
  - How can we help prevent you from arriving and no one is home?

Customer Messages…

- Hospice
  - How can we help assure the patient's wishes are met?
  - How can we help reduce your spend for ambulance and ED services?
  - How can we help prevent voluntary disenrollment's and revocations?

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Future of EMS Economic Model

- ***Supplier*** to ***Provider*** status
- Part of a bundled payment
- Shift to outcome-based payments
  - Like the rest of healthcare
- Shared risk contracting
  - Payers, other providers
  - Part of an ACO (for real)
  - Capitated fees (happening now)
- Pay for performance
  - Adherence to clinical bundles
  - Proven to make a 'clinical' difference
    - STEMI, Stroke, Trauma, COPD clinical bundles

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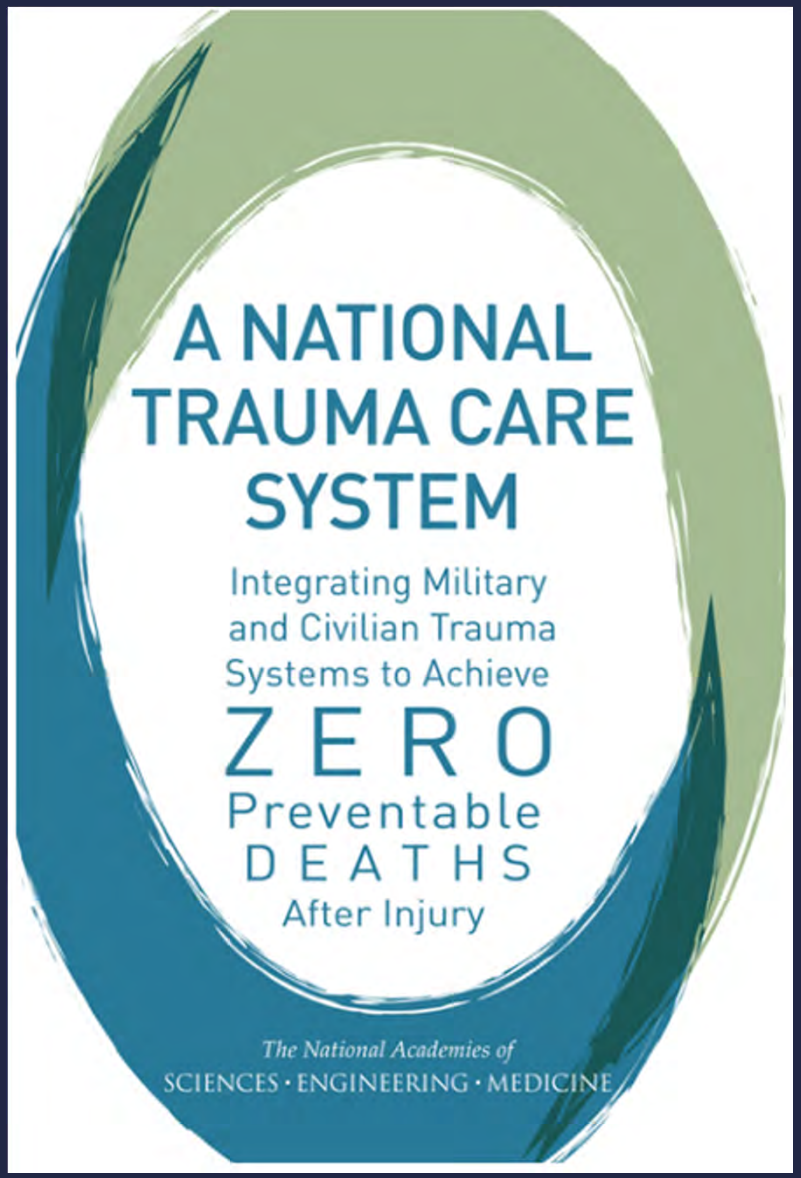

10: Congress, in consultation with the U.S. Department of Health and Human Services*, should identify, evaluate, and implement mechanisms that ensure the inclusion of pre-hospital care (e.g., emergency medical services) as a seamless component of health care delivery rather than merely a transport mechanism.*

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Possible mechanisms that might be considered in this process include, but are not limited to:

- ***Amendment of the Social Security Act such that emergency medical services is identified as a provider type, enabling the establishment of conditions of participation and health and safety standards.***

- ***Modification of CMS's ambulance fee schedule to better link the quality of pre-hospital care to reimbursement and health care delivery reform efforts.***

- ***Establishing responsibility, authority, and resources within HHS to ensure that pre-hospital care is an integral component of health care delivery, not merely a provider of patient transport***. The existing Emergency Care Coordination Center could be leveraged as a locus of responsibility and authority (see Recommendation 4) but would need to be appropriately resourced and better positioned within an operational division of HHS to ensure alignment of trauma and emergency care with health delivery improvement and reform efforts.

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Texas:

What it means everywhere else: A place full of rodeos, boots, horses, and cowboys.

What it means in Texas: Home, and the only place that matters.

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SHOW ME THE MONEY

The Value of Community Paramedicine for Kaiser Permanente

Stacy Elmer, MA, MPA, EMT

Community Paramedicine Symposium

September 22, 2016

Meet the Elmer Family

The Elmer Family

A Tale of the Elmer's Unnecessary Utilization of the Local Emergency Department

(Subtitle: Nightmare on Kaiser Street)

Triple Aim Impact

Individual Care

Prevention & most appropriate care providers

Alternative Destination Transport

Treat & Release/ Refer

Frequent 911/ED Utilizers

Population Health

Connecting to primary care & social services

Cost of Care

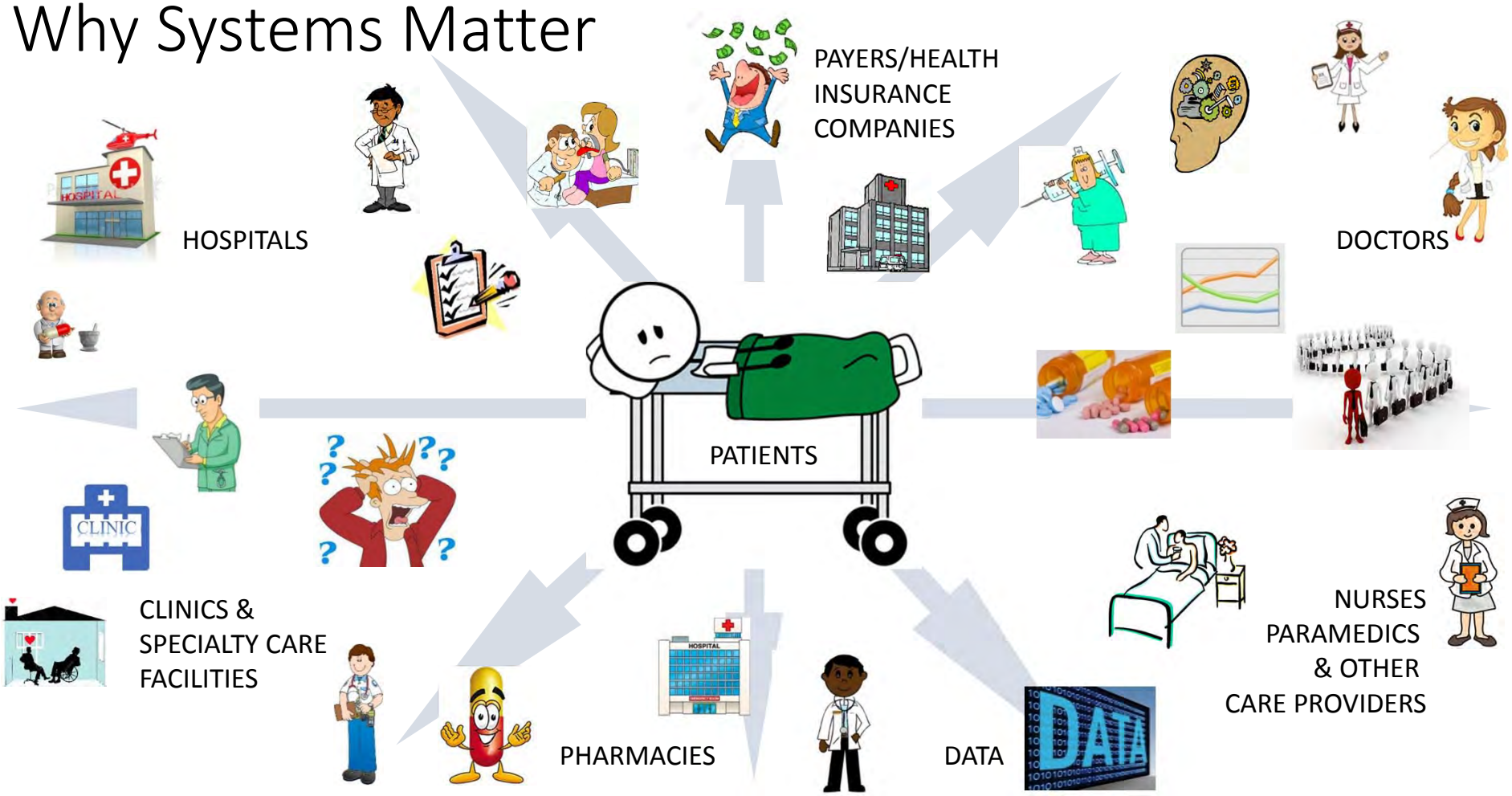
Avoided ambulance rides & ED visits

Post-Discharge Follow Up

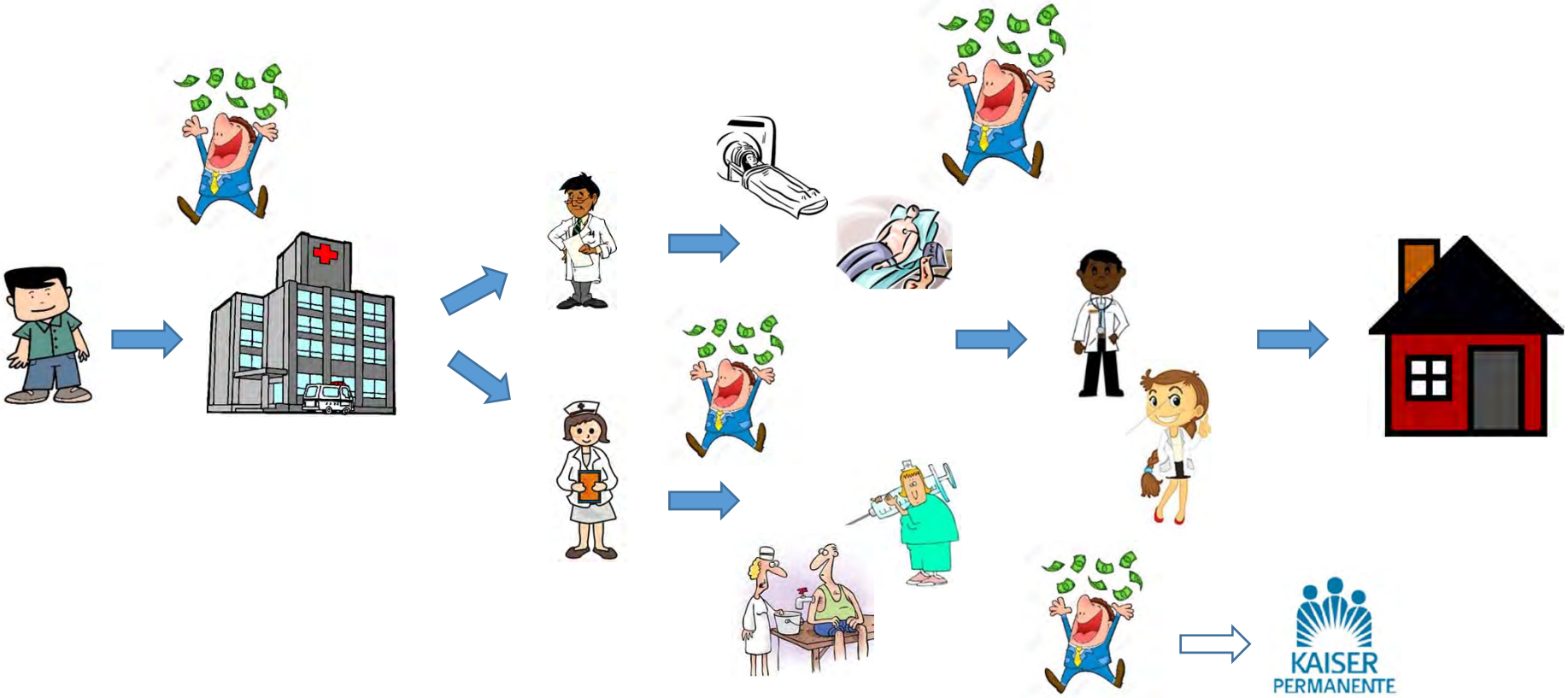
Alternative Destination Mental Health

Hospice Support

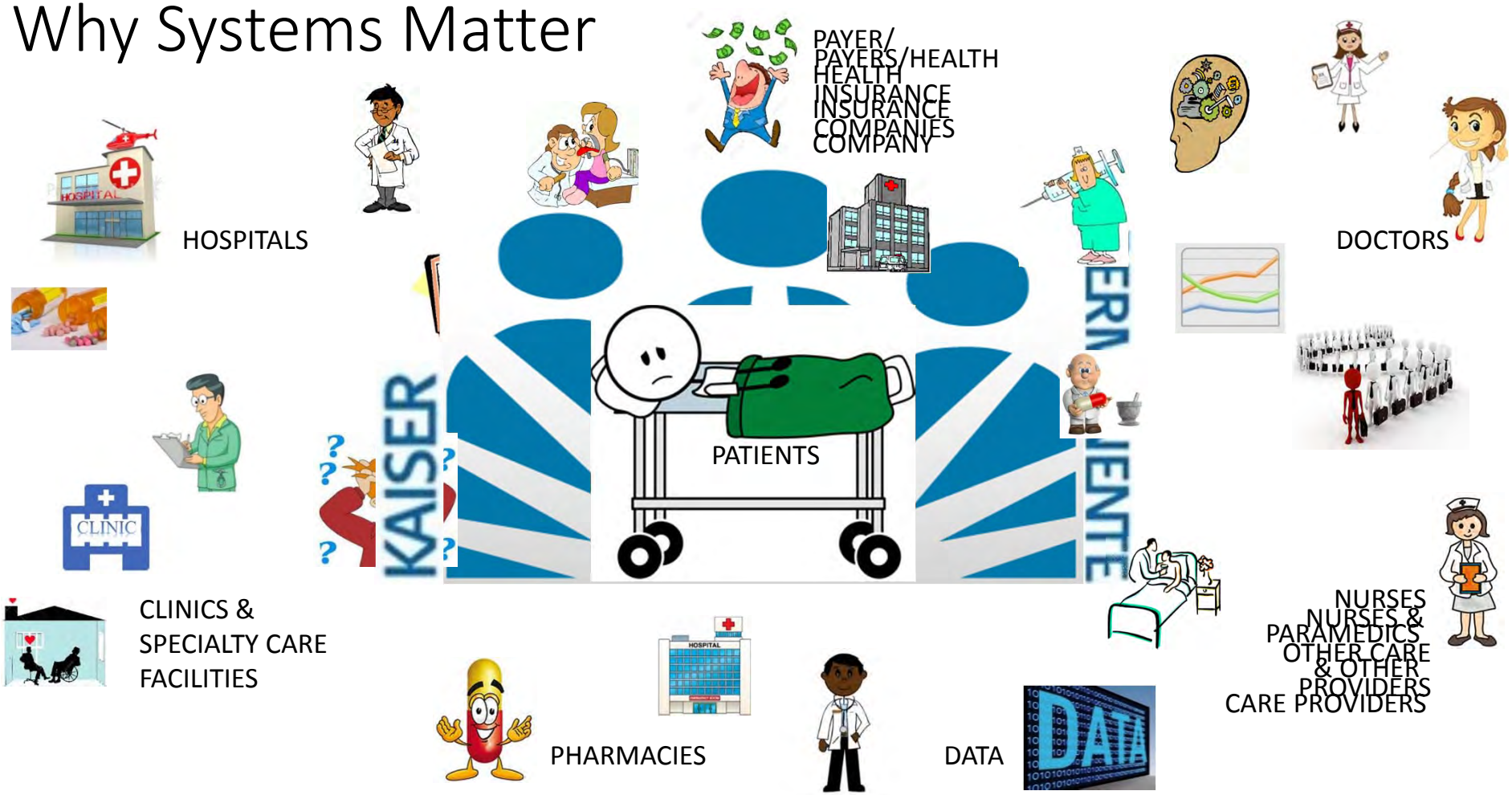
Why Systems Matter



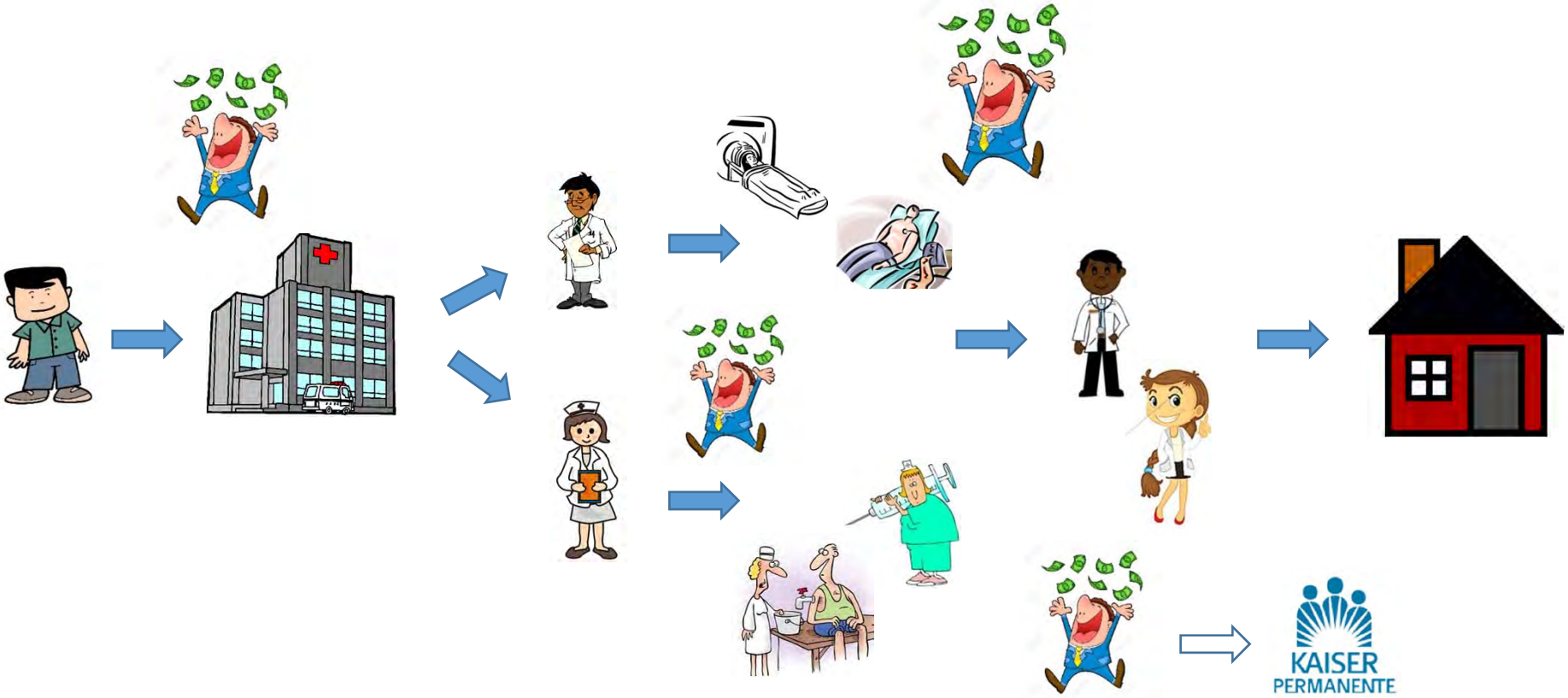
Why Systems Matter



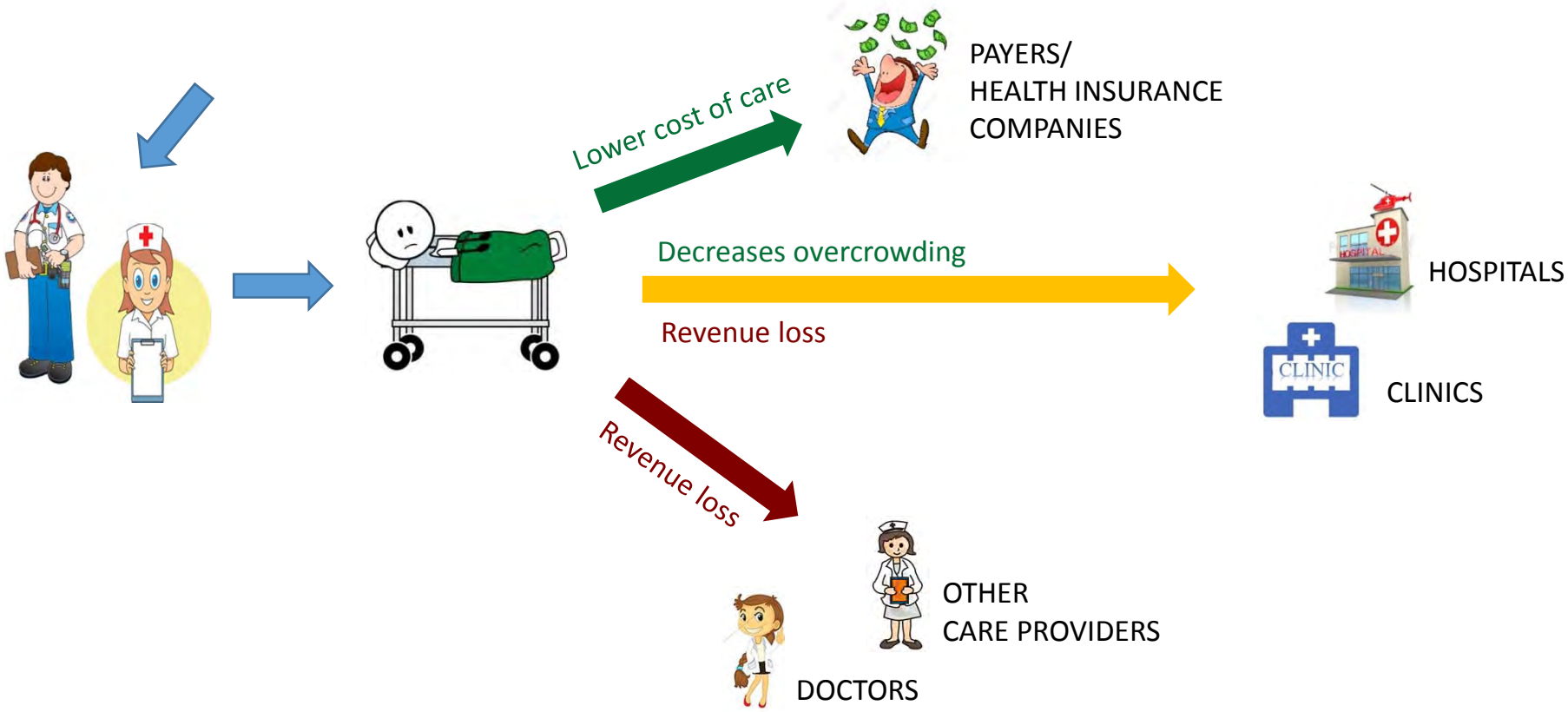
Why Systems Matter



Why Systems Matter



Why Systems Matter to CP Programs



Why Systems Matter to CP Programs

PAYERS/
HEALTH
INSURANCE
COMPANIES

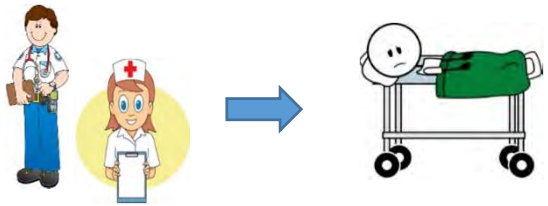
HOSPITALS

CLINICS

DOCTORS

OTHER
CARE
PROVIDERS

KAISER PERMANENTE



- Increases opportunities for improved patient care
- Creates cost savings to the system
- Diminishes overcrowding in EDs & urgent care

Kaiser and Community Paramedicine

911 Response-Based Models

- Alternative Destination Transport
- Treat & Release/Refer

- Pre-scheduled visits

Current Partnerships with Fire Based EMS

Anaheim Fire	Treat & Release/Refer
Los Angeles Fire	Treat & Release/Refer
Orange County Fire	Alternative Destinations
Carlsbad Fire	Alternative Destinations

Kaiser and Community Paramedicine

Kaiser Based EMS Models

- Post-discharge follow-up
- Management of chronic conditions
- Mental & behavioral health

The Value Proposition

- Kaiser + other payers

- Kaiser only

Kaiser Based Models

in southern California

Murrieta Fire

ED High Utilizers

Pilot Process Development

Steps Taken

1.
Held
MCAT meeting

2.
MCAT formed
ED High Utilizers Workgroup

3.
Pulled Pan City
ED data

4.
Visualized
the data

5.
Chart
review
super high
utilizers

Pilot Process Development

Steps Taken

1. ED High Utilizers Workgroup – Meeting 1
   - Identified the problem
   - Socialized the data analysis process – introduced Tableau

2. ED High Utilizers Workgroup – Meeting 2
   - Reviewed data analysis
   - Narrowed down subgroups to target

3. Chart Review Party!!!!

Pilot Process Development

Steps Ahead

4. ED High Utilizers Workgroup – Meeting 3
   - Review chart review outcomes
   - Finalize subgroups to target
   - Map current KP assets and interventions available to address subgroups problems – identify gaps in the continuum for these members

5. Utilize video ethnography capability to talk with members in the identified subgroups about their ED utilization

6. ED High Utilizers Workgroup – Meeting 4
   - Review video ethnography
   - Empathy map members in targeted subgroups
   - Identify quality improvement needs in existing assets
   - Develop options for solutions to address gaps

Pilot Process Development

Steps Ahead

7. Validate proposed solutions with members

8. Convene ED High Utilizers Workgroup – Meeting 5
   - Review member input
   - Design plan for operationalizing solutions

9. Present proposal to MCAT
10. Present proposal to SCAL leadership
11. Implement pilot program

Know the Problem You are Trying to Solve

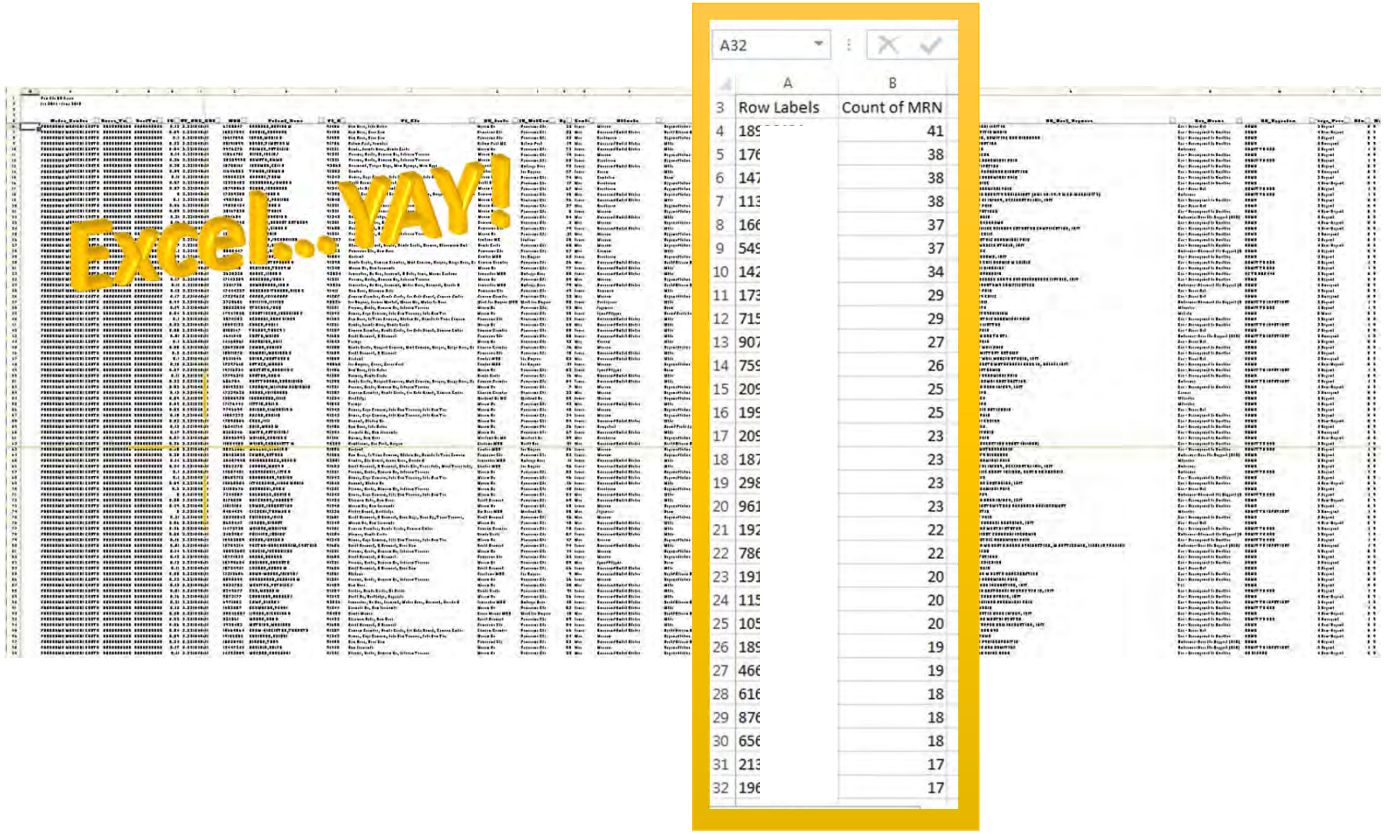
High utilizers of 911

ED high utilizers

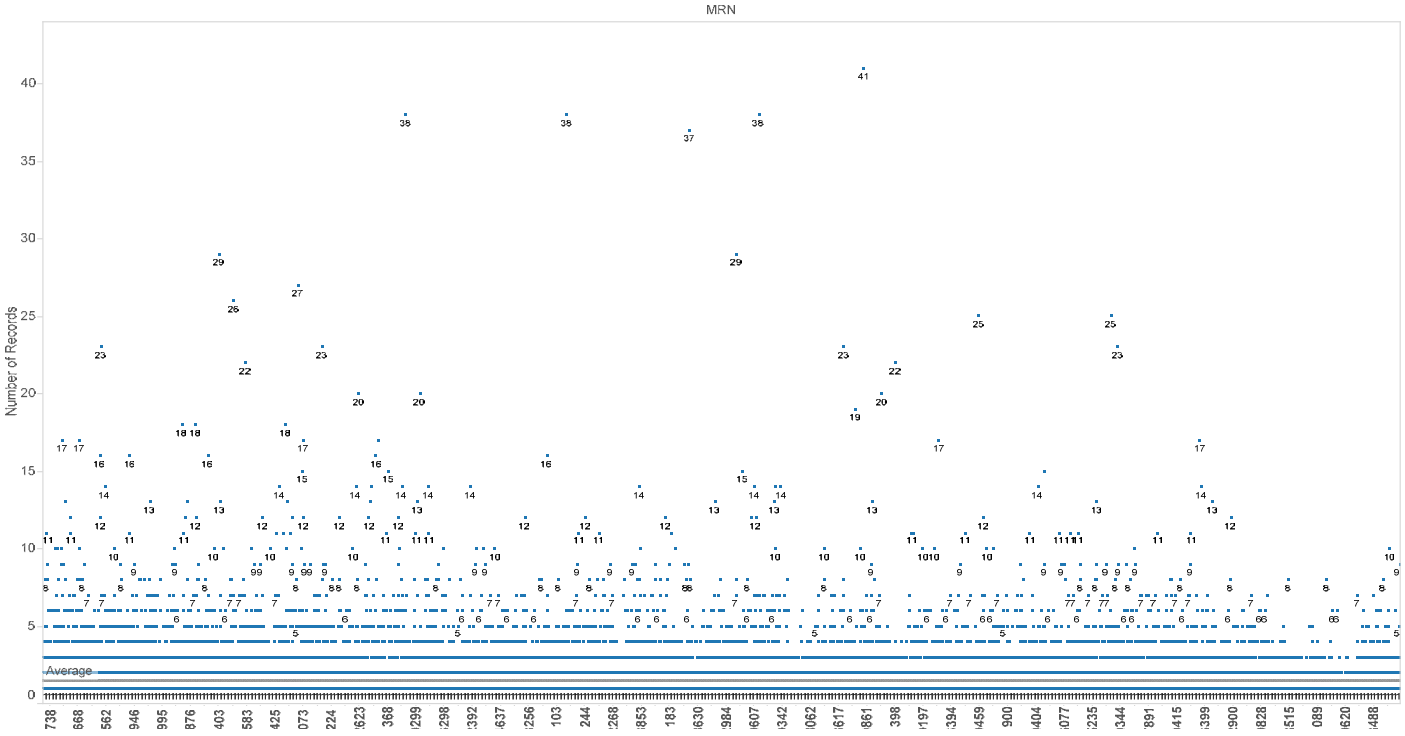
ED high cost utilizers

Outside medical expenses

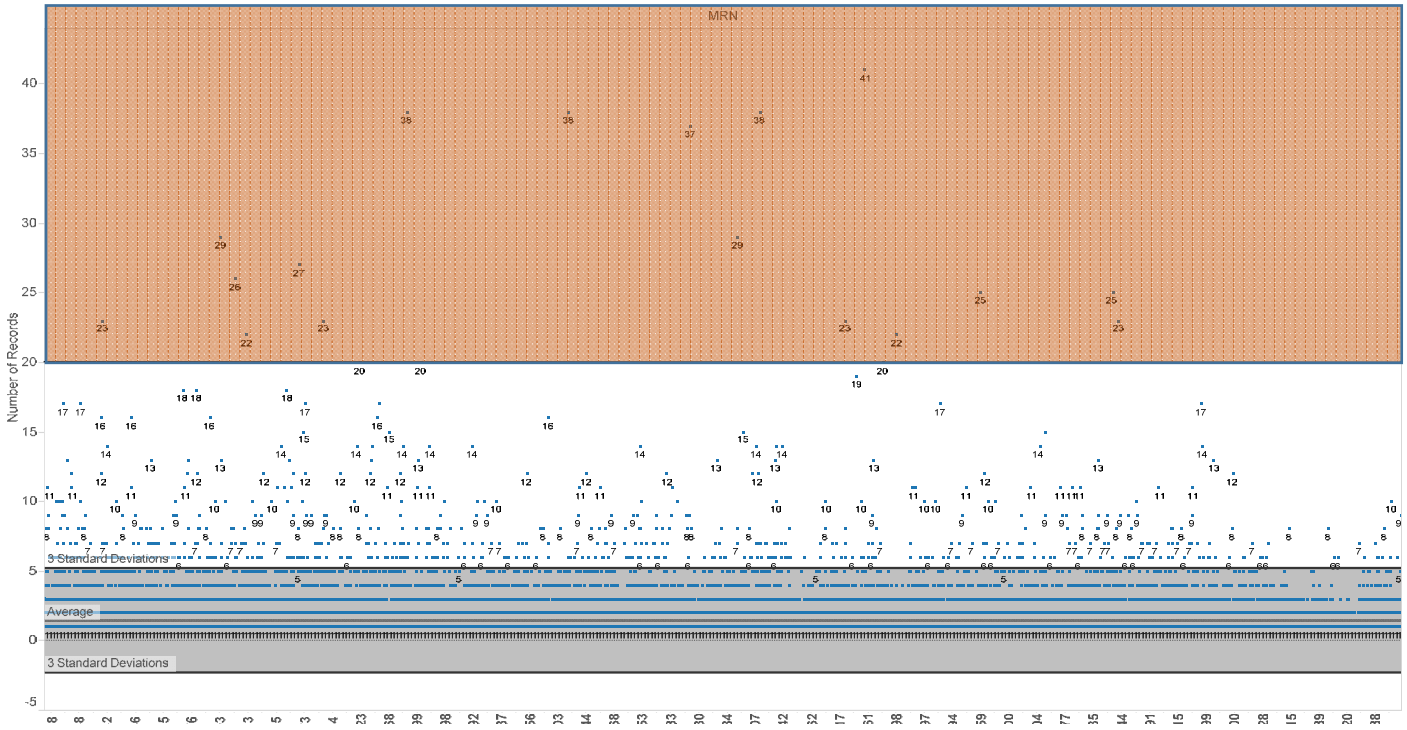
Data as We Typically Know It



Frequency of ED Utilization per Member



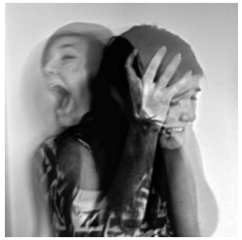
‘Super High’ Utilizers



A note about ‘super high’ utilizers

Biggest Trends for ‘Super’ High Utilizers

- Drug and/or alcohol abusers



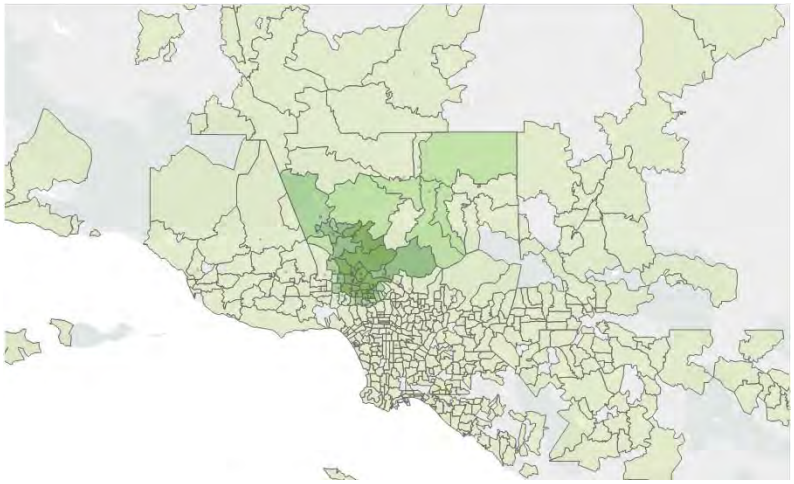
- Mental/behavioral health issues

- Homeless

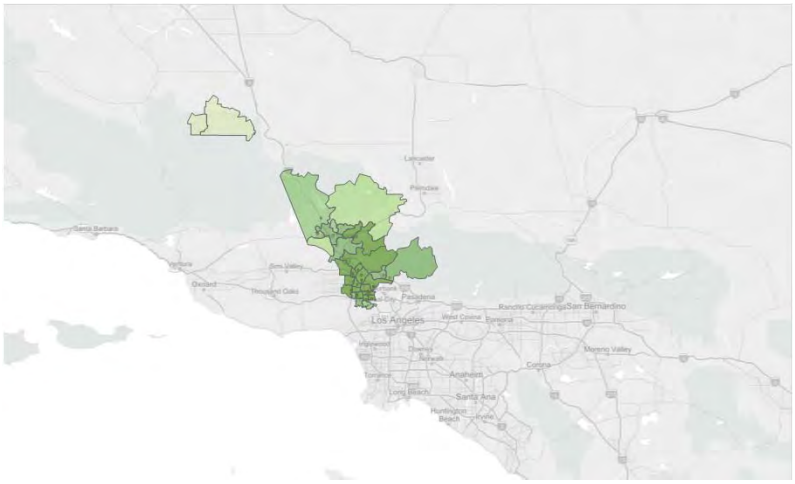
We started with all ED encounters that occurred at the Panorama City Medical Center from July 2014 – June 2015 (one calendar year).
62,152 encounters

Kept only the ED encounters attributable to **patients who live in the Panorama City Service Area.**

Before **62,152 encounters**

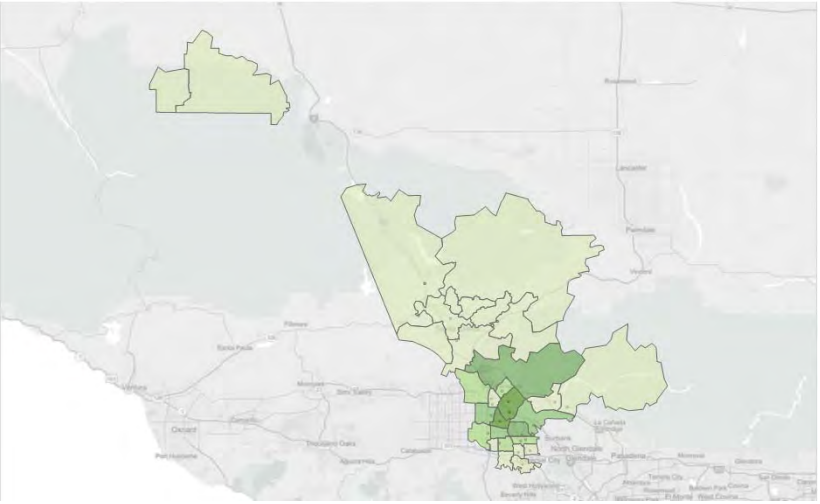


After **51,348 encounters**

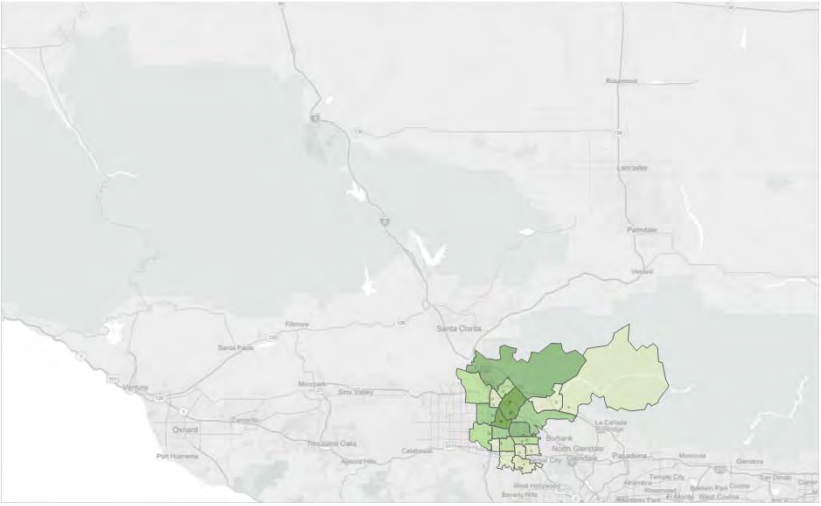


Kept only the ED encounters attributable to patients who **live in the San Fernando Valley** subregion of the Panorama City Service Area.

Before **51,348 encounters**



After **45,613 encounters**

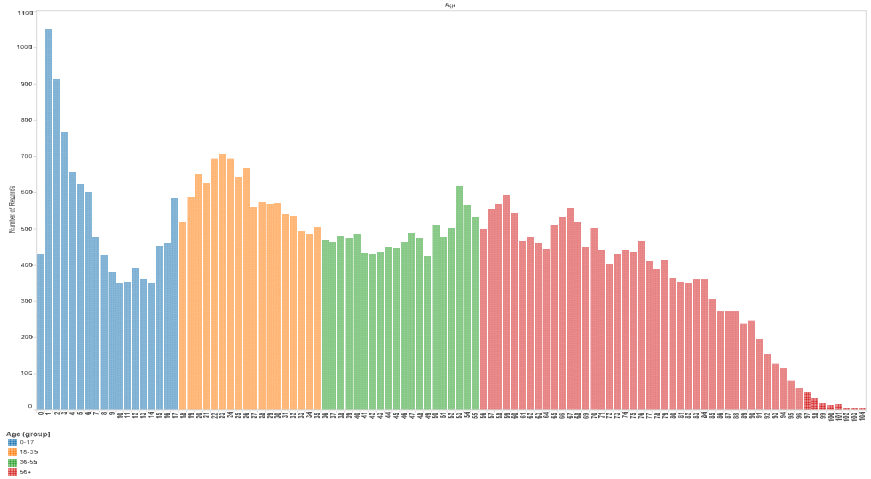


Kept only the ED encounters attributable to patients who live in the San Fernando Valley subregion of the Panorama City Service Area who are **age 18 or older.**

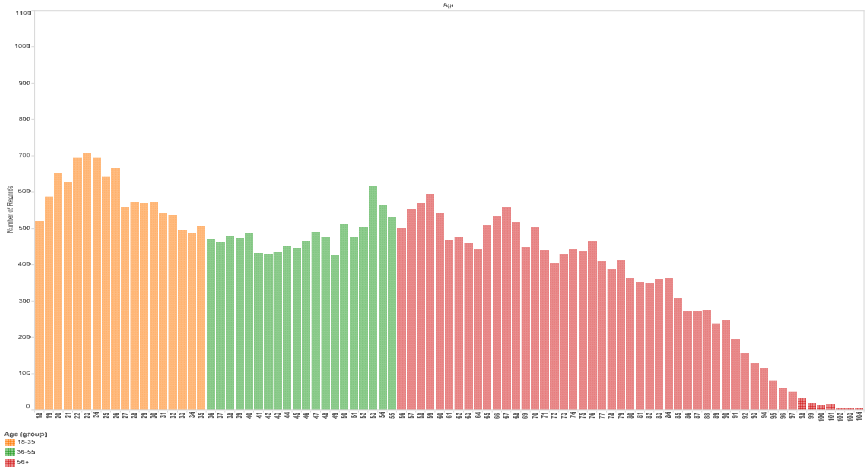
Age (group)

- 0-17
- 18-35
- 36-55
- 56+

Before **45,613 encounters**



After **35,987 encounters**



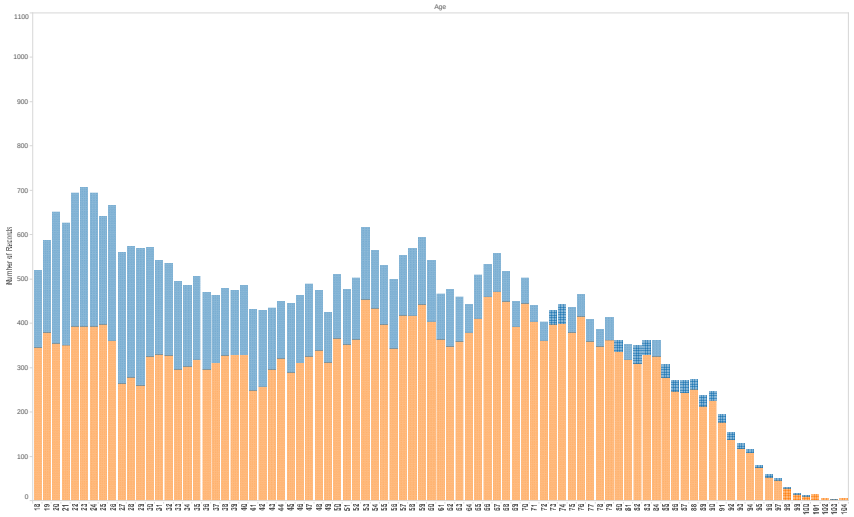
Kept only the ED encounters attributable to patients who live in the San Fernando Valley subregion of the Panorama City Service Area who are age 18 or older and are **KP members.**

KP Member (Y/N)

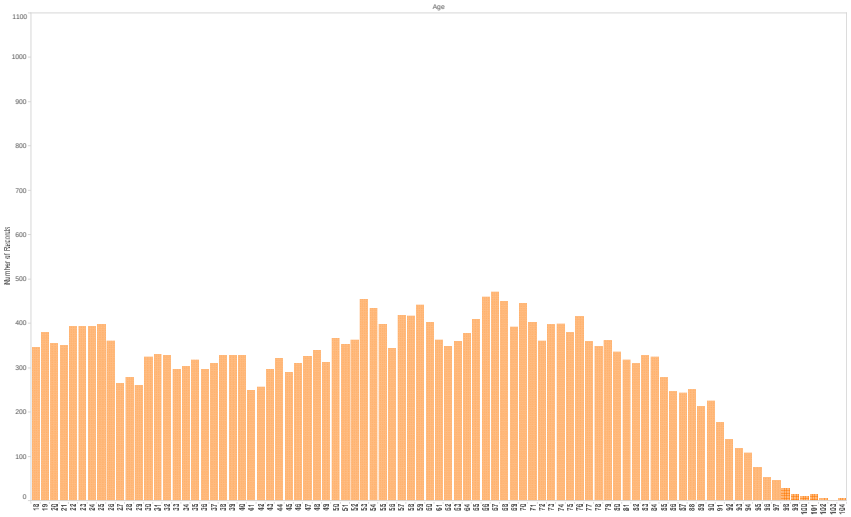
N

Y

Before **35,987 encounters**



After **26,102 encounters**

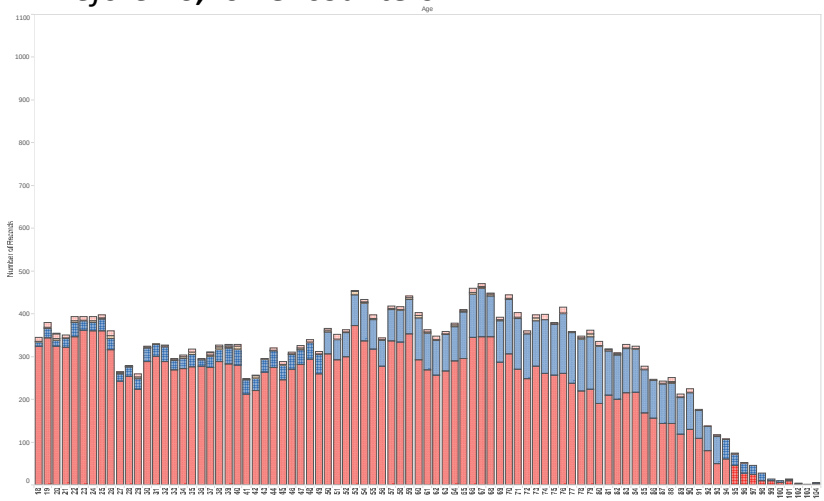


Kept only the ED encounters attributable to patients who live in the San Fernando Valley subregion of the Panorama City Service Area who are age 18 or older, are KP members, and were **either discharged to home or otherwise left without being admitted.**

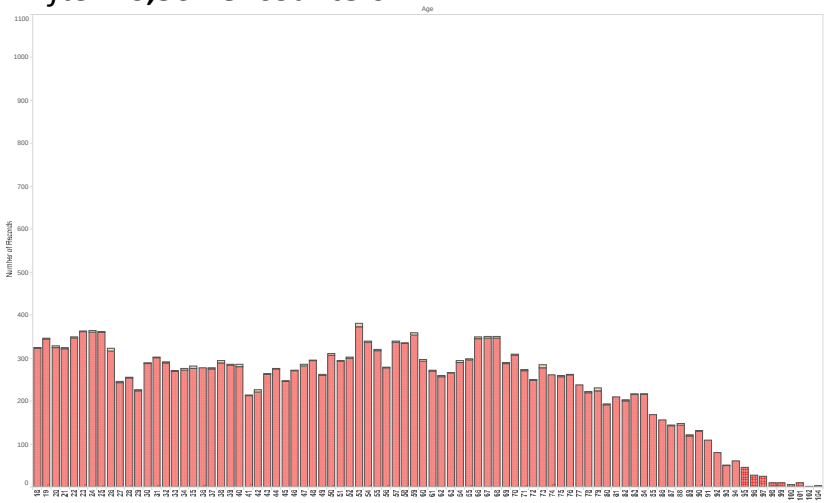
ED Disposition (group)

- *Unknown
- Discharge To Other Facility
- Patient Died
- Patient Left
- Admit/Transfer Within Hospital
- Discharge to Home

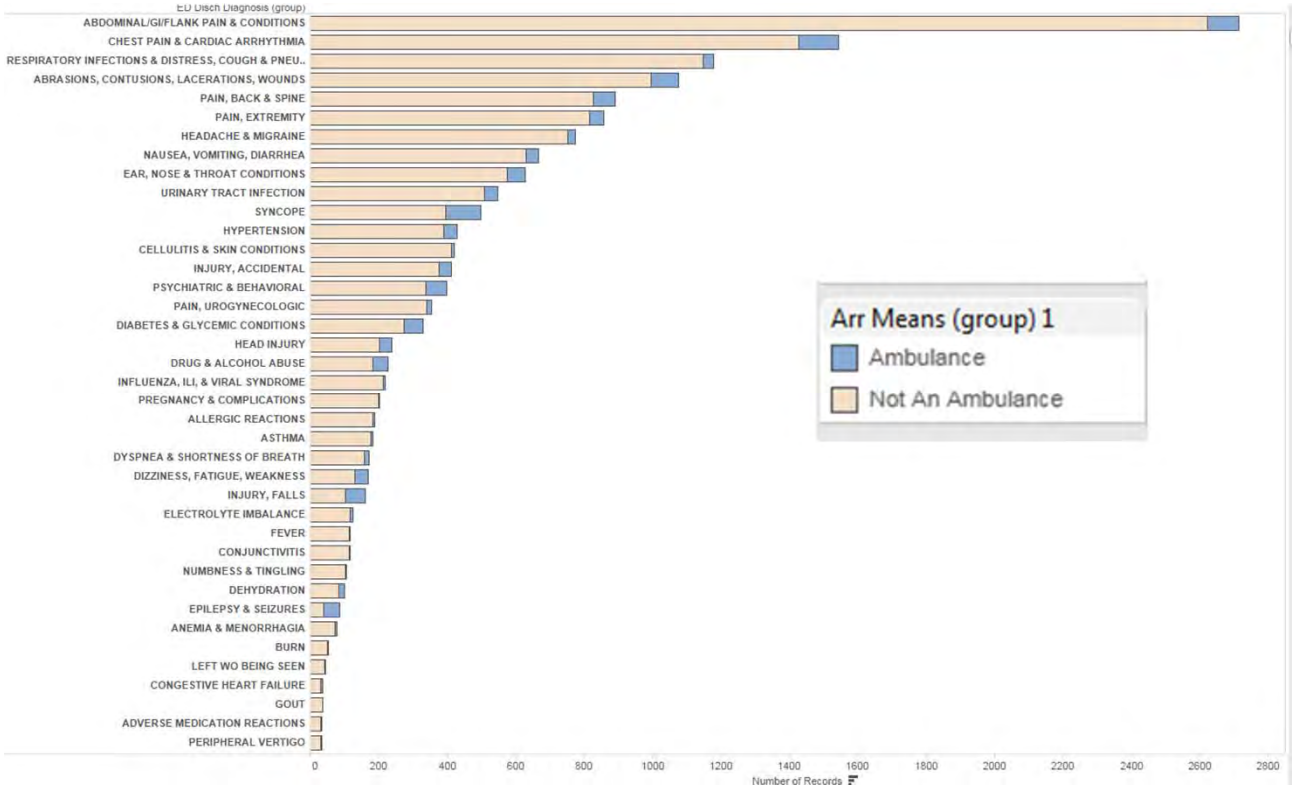
Before **26,102 encounters**



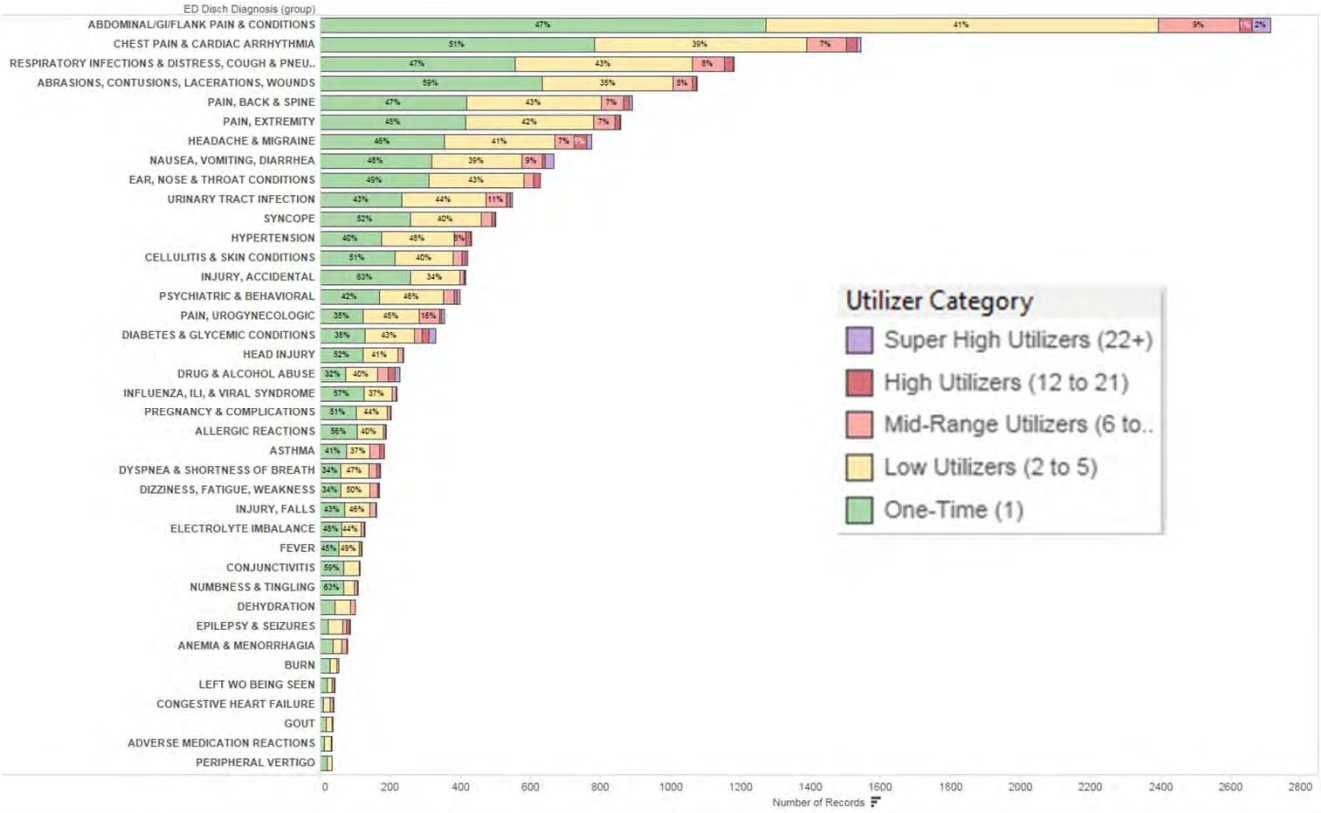
After **20,501 encounters**



Among these 20,501 encounters, these are the top discharge diagnosis categories, **stratified by whether or not the individual arrived in an ambulance.**



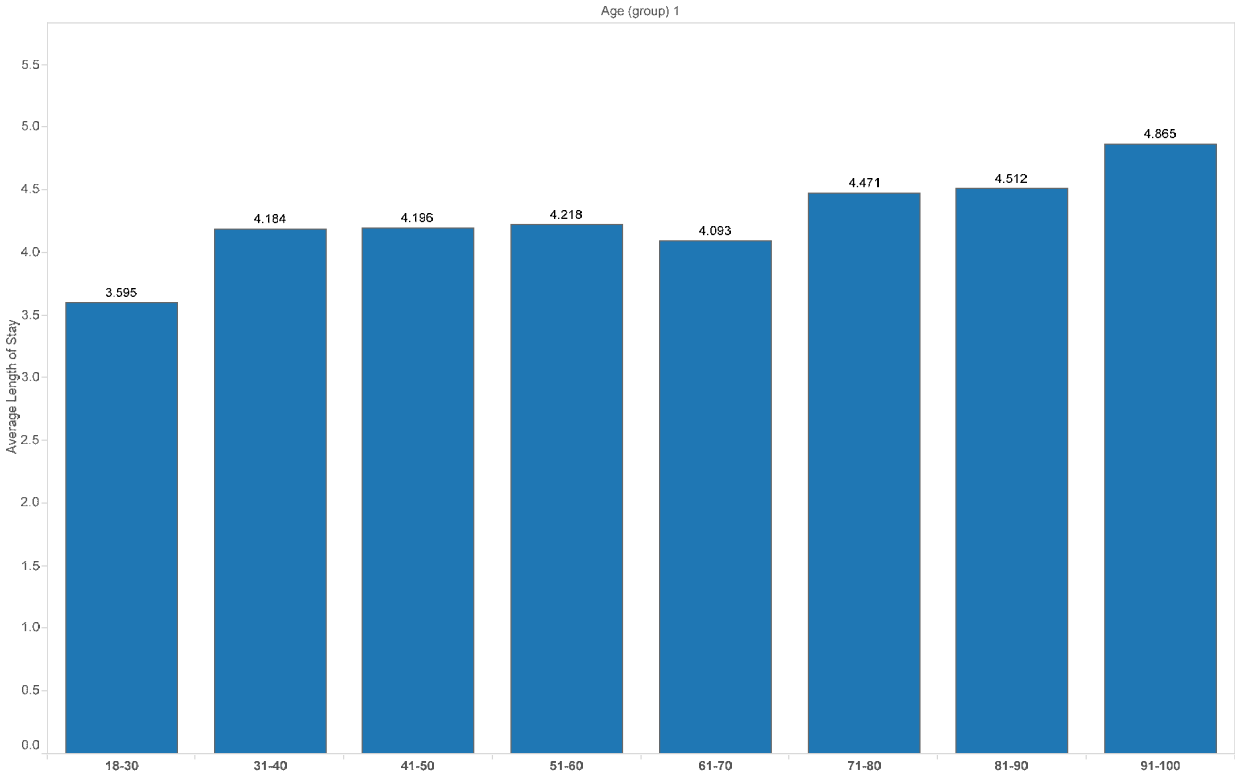
Among these 20,501 encounters, these are the top discharge diagnosis categories, **stratified by whether or not the encounter is from a "high utilizer".**



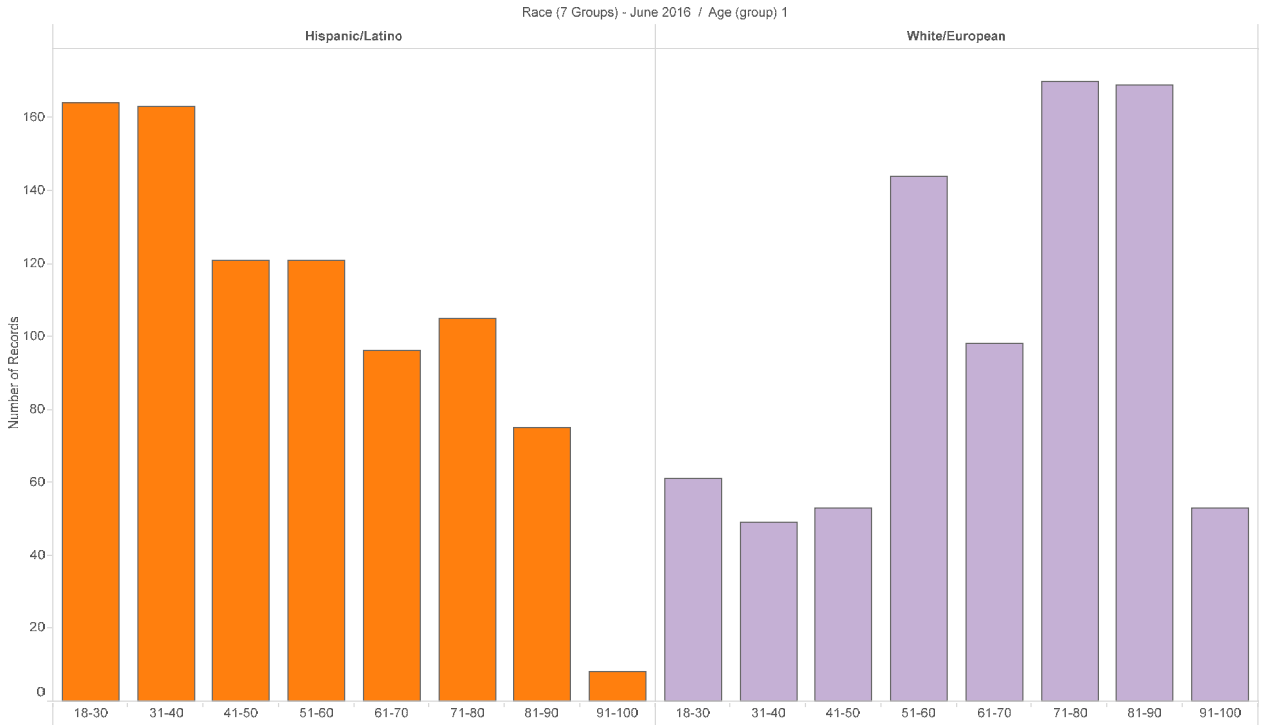
Among the target subset (San Fernando Valley, Panorama City Members, Age 18+)

	Unique Patients	# Encounters
1-time utilizers	9,759	9,759
Low Utilizers (2-5 times)	4,155	8,524
Moderate-to-High Utilizers (6-21 times)	362	2,993
Super High Utilizers (22+ times)	10	225

Dead ends - older patients would have longer ED stays since they were more complex, but that didn't turn out to be a huge effect. Younger adult patients had much shorter lengths of stays. What conclusion to draw of this? It was uncertain.



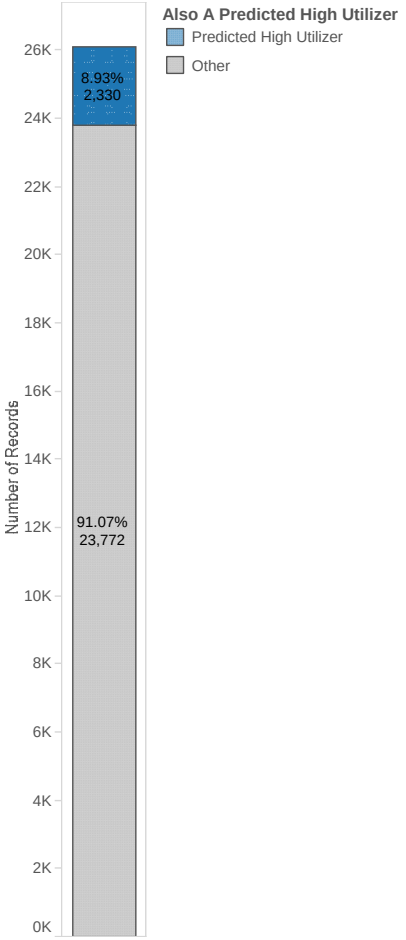
Nice to know - we looked at race/ethnicity of ED utilizers by age, and noted that it reflects the changing demographic of Panorama City's membership – younger patients are more likely to be Hispanic, older patients are more likely to be White.



Cost Analysis – Predicted High Utilizers

8.9% of ED encounters were due to Predicted High Utilizers.

1 out of every 20 of this subgroup is predicted to be a member who might spend close to $60,000 per year (compared to the average member yearly cost of $5,300).



Closing Thought

DATA S

Questions?

Stacy.Elmer@kp.org

KAISER PERMANENTE® thrive

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The Value of Community Paramedicine: Stakeholder Perspectives

Base Hospital/ED – Chris Kahn, MD, MPH

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Disclaimers

- Base hospital medical director
- Board certification: EM and EMS
- Participant in San Diego Fire-Rescue CP project
- Invited to speak by the California Hospital Association

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Problems In My World

- ED crowding
  - Lots of patients coming in
  - Hard to get patients physically admitted
- Acute care resources used on patients with chronic problems
  - Alcoholism and other substance abuse
  - Psychiatric illness
- Funding concerns
  - Always in flux, and in doubt

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Complaints In My World

- Patients
  - Why is it taking so long to take care of me?
  - Why doesn't anybody have the time to keep me updated?
  - Why have I been in this waiting room for five hours?
  - They told me I was being admitted; why am I still in the ED instead of a real bed upstairs?

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Complaints In My World

- Hospital providers
  - Why doesn't the administration understand how hard it is to get things moving here?
  - Why do patients keep coming in with the same complaints when we've already assessed them and discharged them?
  - Why do we see the same patients all the time for the same things?
  - Why don't I have any good options to take care of patients with psych/substance use issues?

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Complaints In My World

- EMS providers
  - Why do we see the same patients all the time for the same things?
  - Why don't we get any feedback on what's going on with the patients we've seen?
  - Why do we always end up waiting over an hour to offload patients at <redacted>?
  - Why do we end up sitting on the wall when there are empty beds?

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Complaints In My World

- Hospital administrators
  - How are we going to keep this business operational with all of the costs and potential penalties being imposed on us?
  - How do we maintain the market share we need to stay in business?
  - How do we balance the rapidly varying needs of staffing and throughput without needlessly wasting resources?
  - Why can't we just discharge the patients that we've already seen, assessed, and recently discharged?

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Outcomes That Matter

- Triple Aim
  - Improving patient experience of care
  - Improving population health
  - Reducing per capita cost of healthcare
- EMS Outcomes Project
  - Death
  - Disease
  - Disability
  - Discomfort
  - Dissatisfaction
  - Destitution

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Outcomes That Matter

- Get the right care to the right patient at the right time in the right place

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Community Paramedicine

- Right care
  - Resuscitation? Repair of a wound? Refill?
- Right patient
  - Every patient
- Right time
  - Immediately? Later today? Tomorrow?
  - Before being asked for help?
- Right place
  - ED? Urgent care? PMD? Detox?

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Can Hospitals Do All This?

- Right care
  - Absolutely! All hospitals can do some things, and some hospitals can do almost all things.
    - However, we might provide “too much” care, particularly if we don’t already know you very well
    - We also might not have the specialty care that you need, especially if you’re complicated
- Right patient
  - We’ll care for anybody
    - However, if you’re already in our system, we’d really like you to come back to us, and if you’re always seen somewhere else, well…

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Can Hospitals Do All This?

- Right time
  - ED is always open
    - … but sometimes it's really busy, and our clinics can get really overbooked, and there are times when the specialist you need is an allied health professional rather than a doctor, and we don't have them quite as available
- Right place
  - We can always figure it out
    - Of course, if we already figured it out, we'd prefer that you just go there instead of making us figure it out again

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Community Paramedicine

To the rescue…

… or just making things worse?

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Hospital Perspective

- Opportunities
  - Reduce readmissions (0.16%, or $135,859.66)
  - Improve throughput
  - Ensure services available
- Risks
  - Patients going elsewhere = loss of revenue
  - Fragmentation of information
  - Safety

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Loss of Revenue

- Less patients coming in means less money coming in
- Some potential offset by losing the readmission penalties
  - Perhaps pay for performance penalties as well
- The not-so-sick patients are still a revenue source, and they don't actually add that much to our workload or expenses, since we're already staffed for anything and everything

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Loss of Revenue – not really

- Need to consider the value we're providing (and receiving) along with the services we provide
- Being able to "weed out" some of the patients that don't really need our care leaves us with more capability to care for those who really do…
  - … and those patients are more likely to generate revenue for both the ED and the hospital
- Potential to partner with community paramedicine agencies to provide new service lines

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Fragmentation of Information

- Potential for patients to be seen outside of our hospital "territory"
- Consequently, potential for increased costs related to duplicative care
- Difficult to share information between hospitals and EMS agencies
  - Hospitals may not always have access to a care plan devised by a PMD and given to an EMS agency's community paramedic program

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Fragmentation of Information – maybe

- Need to ensure that regional health information exchanges proactively reach out to sites and agencies that may provide or receive our patients
- While respecting HIPAA and CMIA, need to make information sharing the norm rather than the difficult-to-reach exception

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Safety

- Hard to give up even partial control of something so important – our patients' health – to another entity
- Concern for liability over using non-hospital personnel to conduct any portion of patient care
- General uncertainty regarding just what a community paramedic is, and what she or he can do

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Safety – still being protected

- Need to ensure that vigorous, omnidirectional CQI/QA is conducted
- Need to help reinforce the broader health care infrastructure to be more resilient
  - Joint educational opportunities
  - Care plan discussions that include all stakeholders
  - Single point of contact for immediate care concerns
    - Consider using EMS medical director

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Hospital Benefits

- Reducing health care costs overall is better for our patients, better for our providers, and better for business
- Potential loss of revenue likely more than offset not just by reduced penalties, but improved throughput that will make up for mild decrease in ambulance patient census
- Being able to provide effective and realistic alternatives for patients makes us both happy

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Hospital Benefits

- Marketability of the “improved health and wellness” message
  - Potential for improved outreach to rural, underserved communities, as well as traditionally underserved urban populations
- Cost-shifting to non-hospital entities
  - May need to provide financial support to CP programs to maintain them

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Outcomes That Matter

- Triple Aim
  - Improving patient experience of care
  - Improving population health
  - Reducing per capita cost of healthcare
- EMS Outcomes Project
  - Death
  - Disease
  - Disability
  - Discomfort
  - Dissatisfaction
  - Destitution

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Next Steps for Hospitals

- Provide data to effect meaningful research
- Work with other health care providers to conduct resource inventory and needs assessment
  - "Coopetition"
  - May benefit from sharing case management, social work resources with CP programs
- Work with EMS and regulators to discuss appropriate reimbursement plans, both private and governmental, that address innovative care delivery models

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Next Steps for Hospitals

- Be open to innovation
- Don't fear change
- Continue to champion patients' health above all other concerns
  - Might need to redefine "success"
- Recognize and respect our professional partners

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Thank you!

- California Hospital Association
- California Health Care Foundation
- California Emergency Medical Services Authority

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Questions?

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COMMUNITY PARAMEDICINE LA COUNTY EMS AGENCY PERSPECTIVE

Cathy Chidester, Director

September 22, 2016

cchidester@dhs.lacounty.gov

Objectives

- List two Community Paramedic pilot projects
- Describe ways that data may be used by systems to improve community health and wellness
- Identify benefits of additional knowledge from the Community Paramedic curriculum

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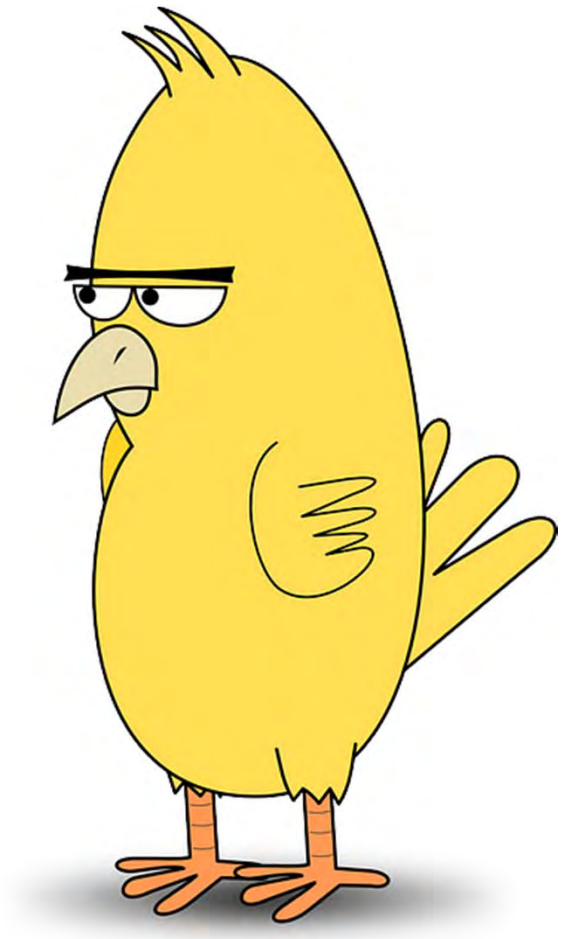
About me:

Worked for EMS Agency 26 years

RN - Started in pediatrics, ED, EMT education, paramedic education,

Director of PTI, Assistant **Director**, **Director**

"I USE TO BE FUN"



About LA County

- **Los Angeles County**
  - 4,000 square miles
  - > 10 million people
  - 33 public 9-1-1 provider agencies
  - 36 licensed ambulance companies
  - 74 receiving hospitals
  - >4,000 paramedics
  - >600,000 EMS transports/year
  - **We are BIG!**

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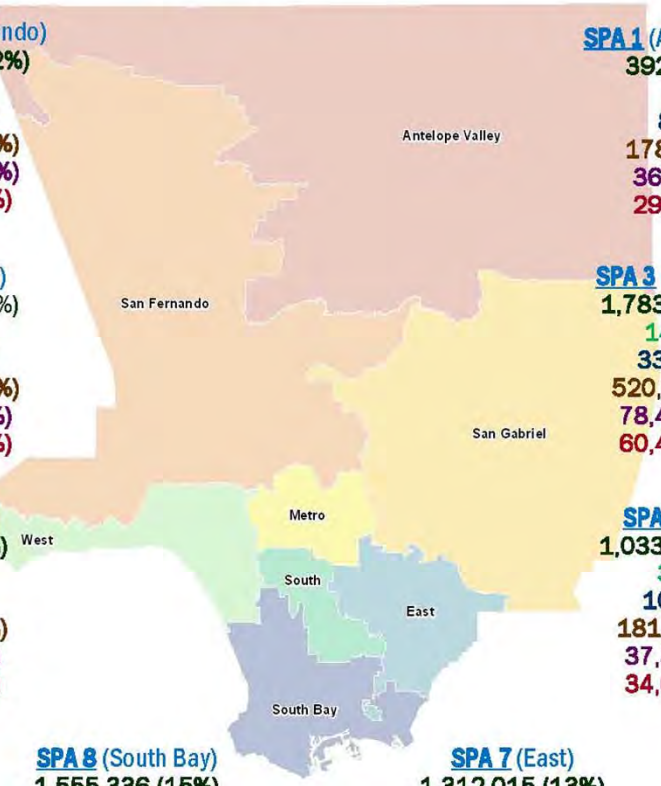
Service Planning Areas (SPA)

COUNTYWIDE (CY 2014)
Population: 10,069,036 (July 2014 estimate)
9-1-1 Receiving Hospitals: 74
Emergency Department Treatment Bays: 2,007
Emergency Department Visits: 3,432,027
9-1-1 EMS Responses: 532,559
9-1-1 EMS Transports: 444,689



SPA 2 (San Fernando)
2,190,397 (22%)
17 (23%)
443 (22%)
753,094 (22%)
107,588 (20%)
97,191 (22%)

SPA 1 (Antelope Valley)
392,730 (4%)
2 (3%)
81 (4%)
178,781 (5%)
36,736 (7%)
29,635 (7%)

SPA 4 (Metro)
1,149,688 (11%)
12 (16%)
411 (21%)
736,920 (22%)
77,699 (15%)
65,527 (15%)

SPA 3 (San Gabriel)
1,783,038 (18%)
14 (19%)
330 (16%)
520,694 (15%)
78,408 (15%)
60,408 (14%)

SPA 5 (West)
652,160 (7%)
5 (7%)
111 (6%)
171,337 (5%)
42,964 (8%)
38,060 (8%)

SPA 6 (South)
1,033,672 (10%)
3 (4%)
104 (5%)
181,750 (5%)
37,349 (7%)
34,056 (8%)

SPA 8 (South Bay)
1,555,336 (15%)
12 (17%)
323 (16%)
563,863 (16%)
100,872 (19%)
79,307 (18%)

SPA 7 (East)
1,312,015 (13%)
8 (11%)
199 (10%)
325,588 (10%)
50,943 (9%)
40,505 (9%)

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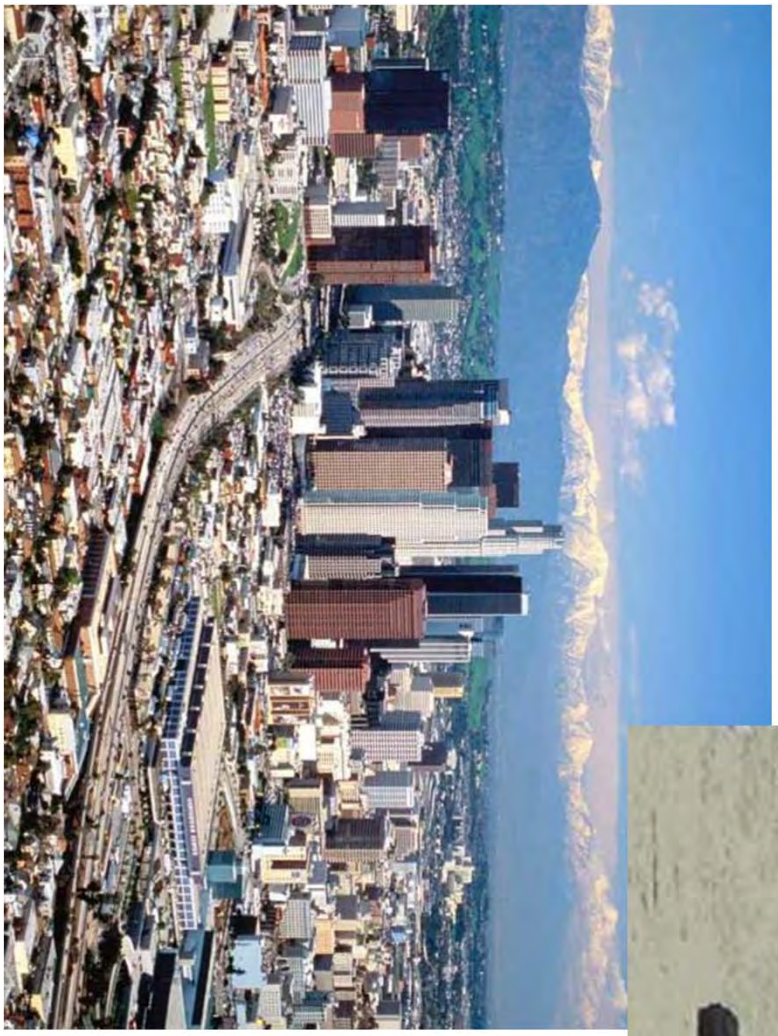

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DIVERSE MODE OF DELIVERING PARAMEDICS (BIKE, SEADOO, BOAT, HELICOPTER)

LA County Perspective

- Disclaimer – my general perspective, not reflective of the individual projects
- Our pilot projects –
  - Alternate Transport Destination (ALTrans)
  - CHF patient follow up (ComPARE)
    - post discharge home visits

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Community Paramedic Pilot Project Team

We are:

- Supportive of expanding the scope of practice
- Excited about Community Paramedic concept
- The biggest advocates for EMS

Let's Review Historical Changes
"know your history in order to plan your future"

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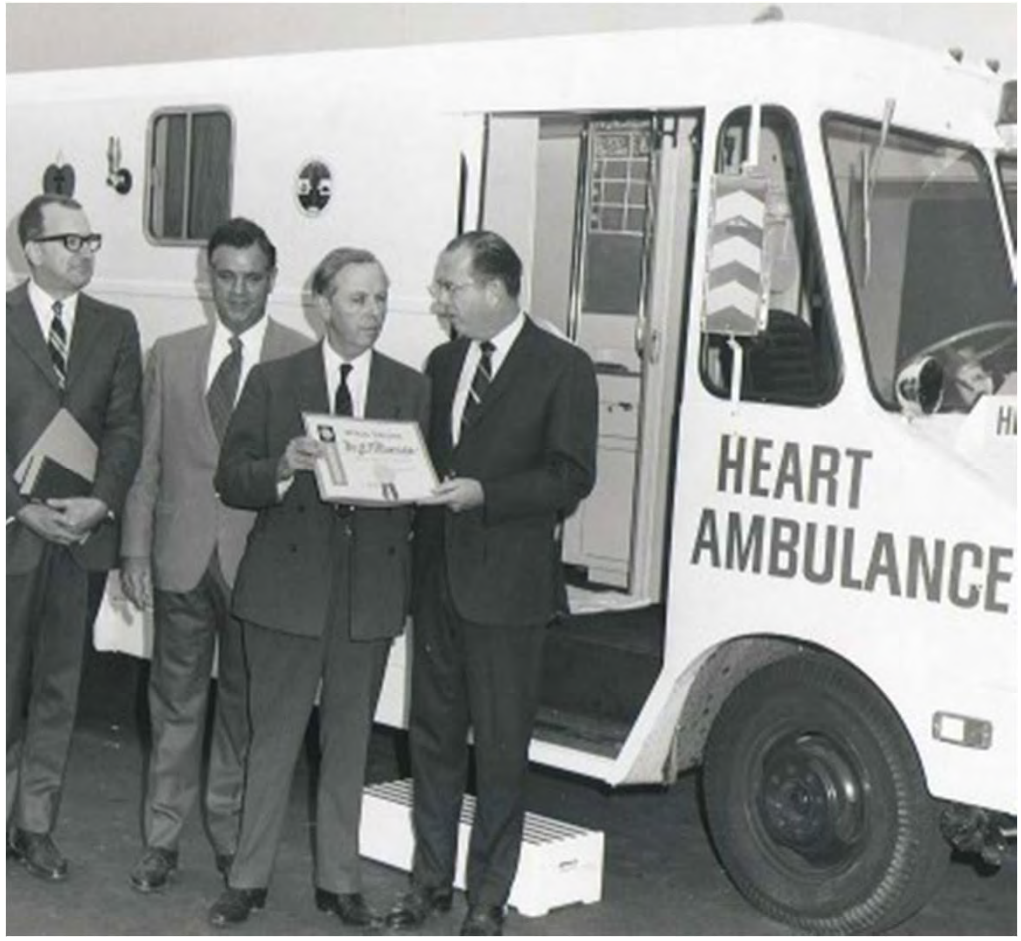

Nurses Supervising Paramedics Pre-Wedsworth-Townsend Act

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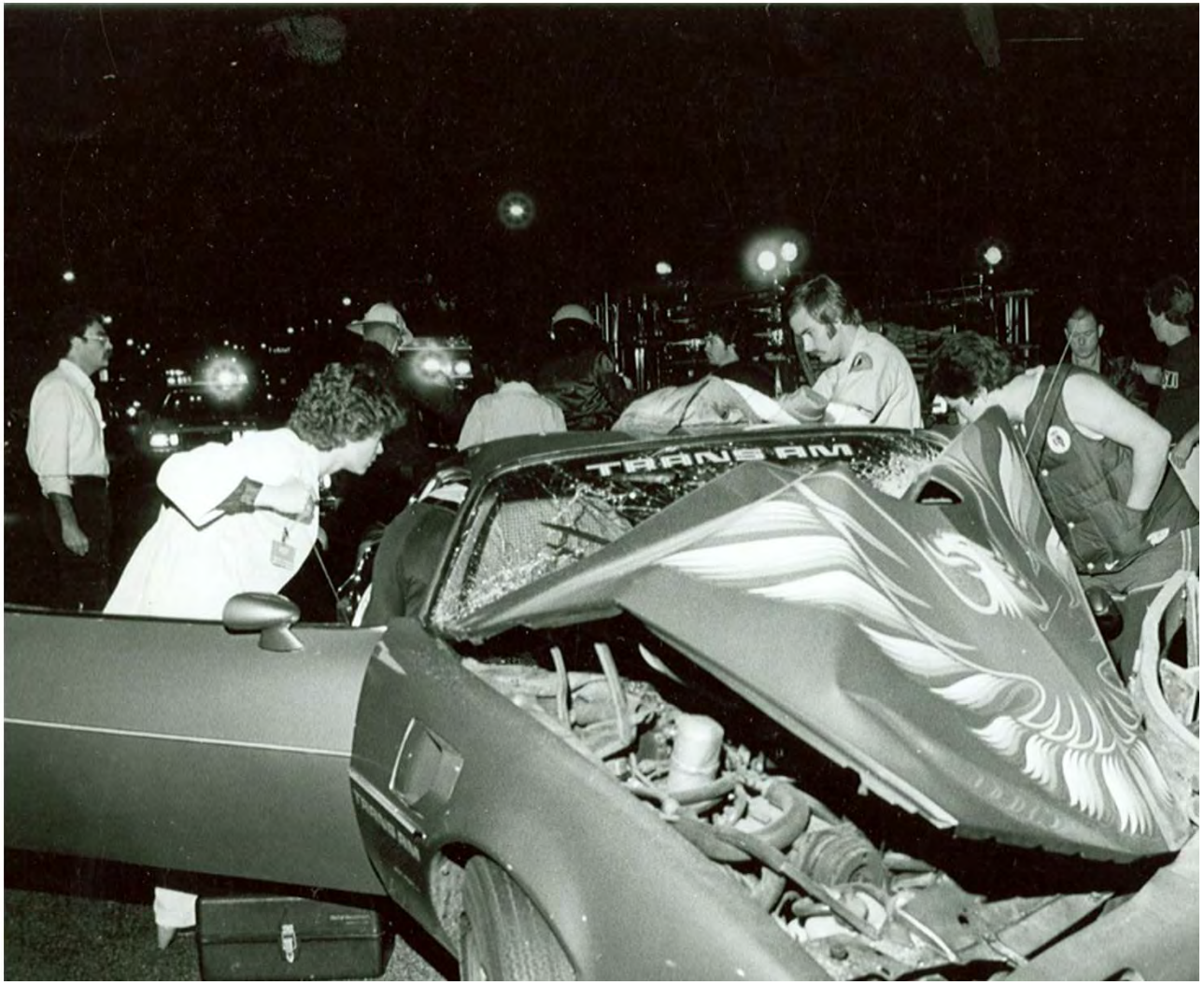

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TV SHOW "EMERGENCY"

Upgraded Ambulances

Expanded the type of vehicles
New Monitor/Defibrillators

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Upgrades to Uniforms

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List of “other” modifications

- Specialty Center Destinations
- 12 Lead EKG
- Nurse educators involvement
- Electronic Data Capturing (beginning)
- M.D. involvement – EMS Boards

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Scope of Practice Changes

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- CPAP
- Capnography
- Intraosseous (IO)
- **Community Paramedic Pilot Project**
  - **Biggest proposed change since 1969 - 47 years!**

Time is Right to Expand EMS Role

- There is more to EMS than, *"you call/we haul"*
- "No one is left to die in the street, we are doing good, right?"
- Society changes are impacting EMS decisions
- Data gives us the ability to identify specific needs of a community and establish policy and programs based on the "need"

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Example of Data Trends

- We are looking at data in general terms
- Soon will be drilling down to details

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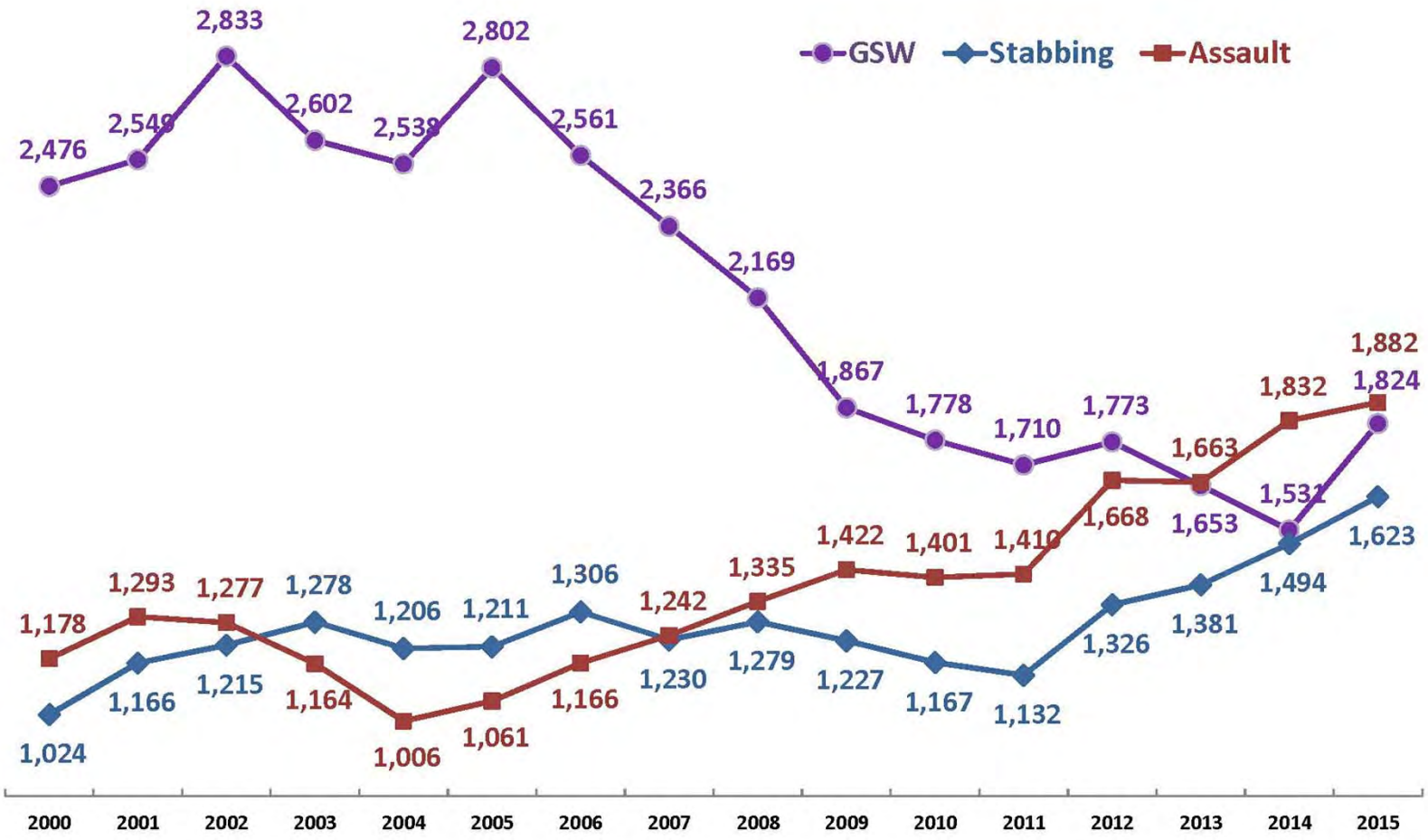
LA County Trauma Data



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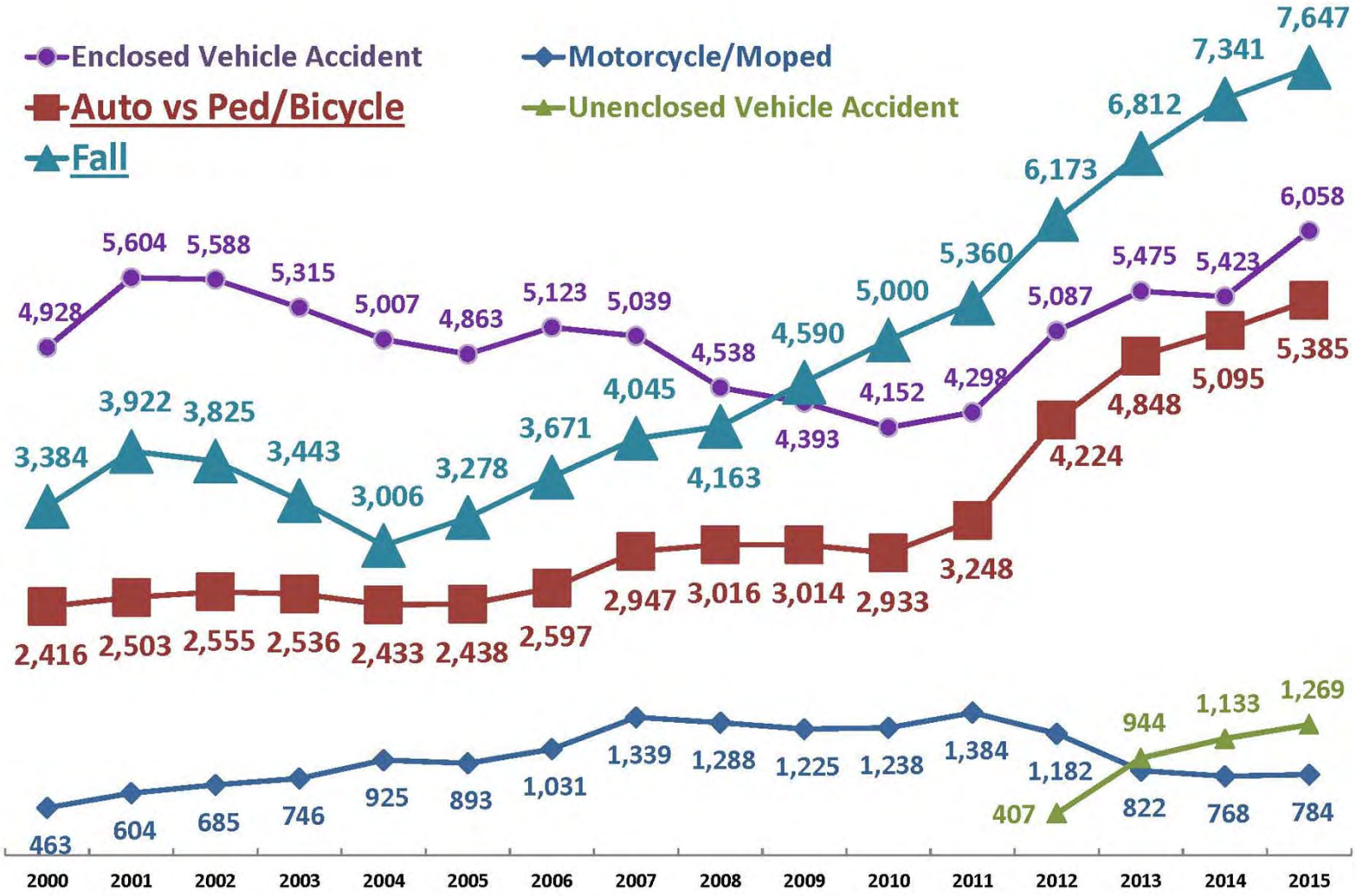
LA County Trauma Data



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EMS is Unique in that we:

- Have specific data on communities
  - Incident types
  - Incident location
  - Repeat incidents
- Enter homes/facilities and see risks
- Can measure success and outcome

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Community Paramedicine
Driven by Local Needs

- LEMSAs should assist each city to evaluated their data
- Each city should use their data to determined need for Community Paramedics
- Let’s look at a basic example:

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City “Z” in LA County

- Fire based EMS
- Suburban
- Some industry
- 21 Square Miles
- 145,000 population
- 6 Fire Stations

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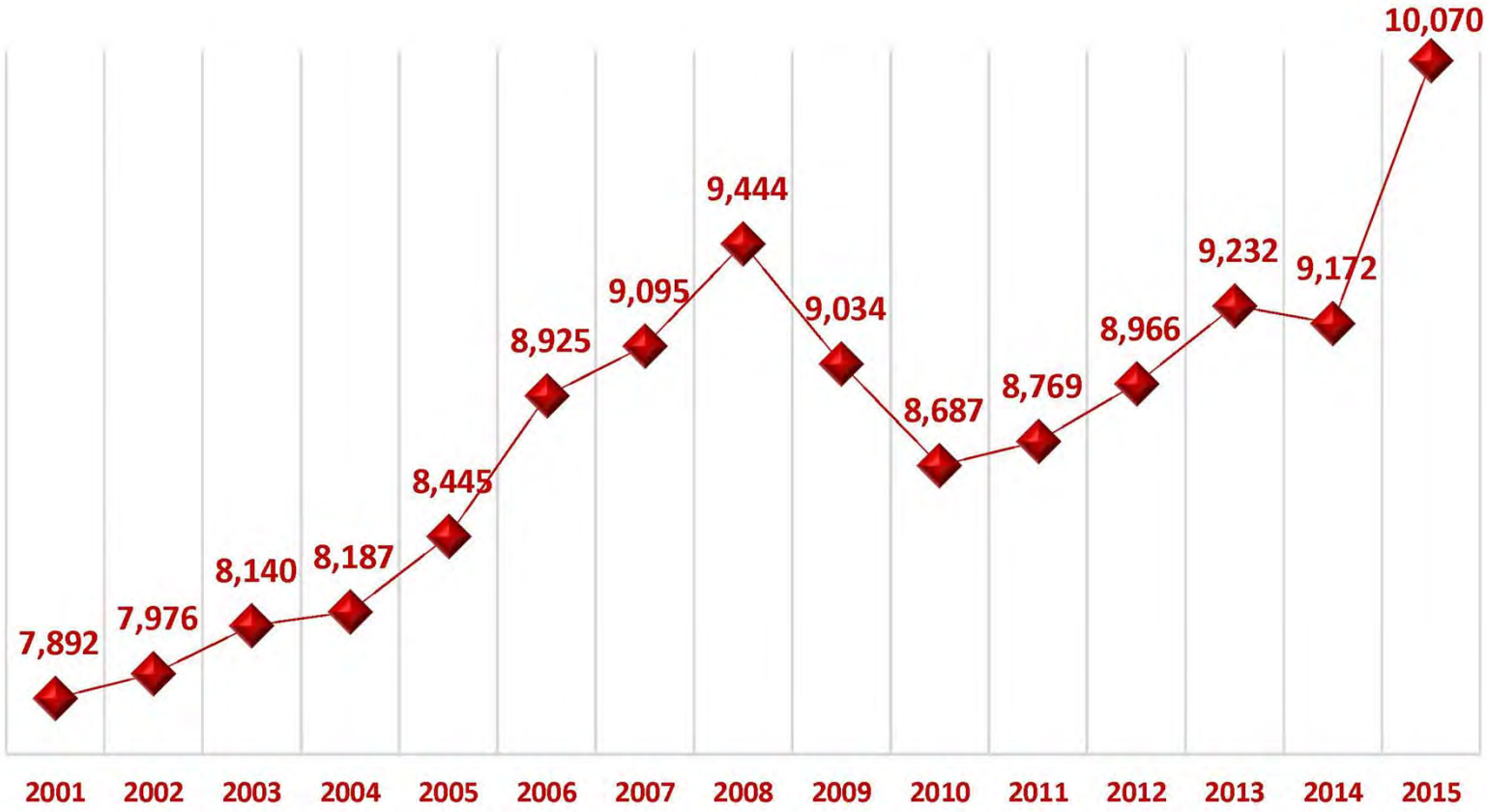
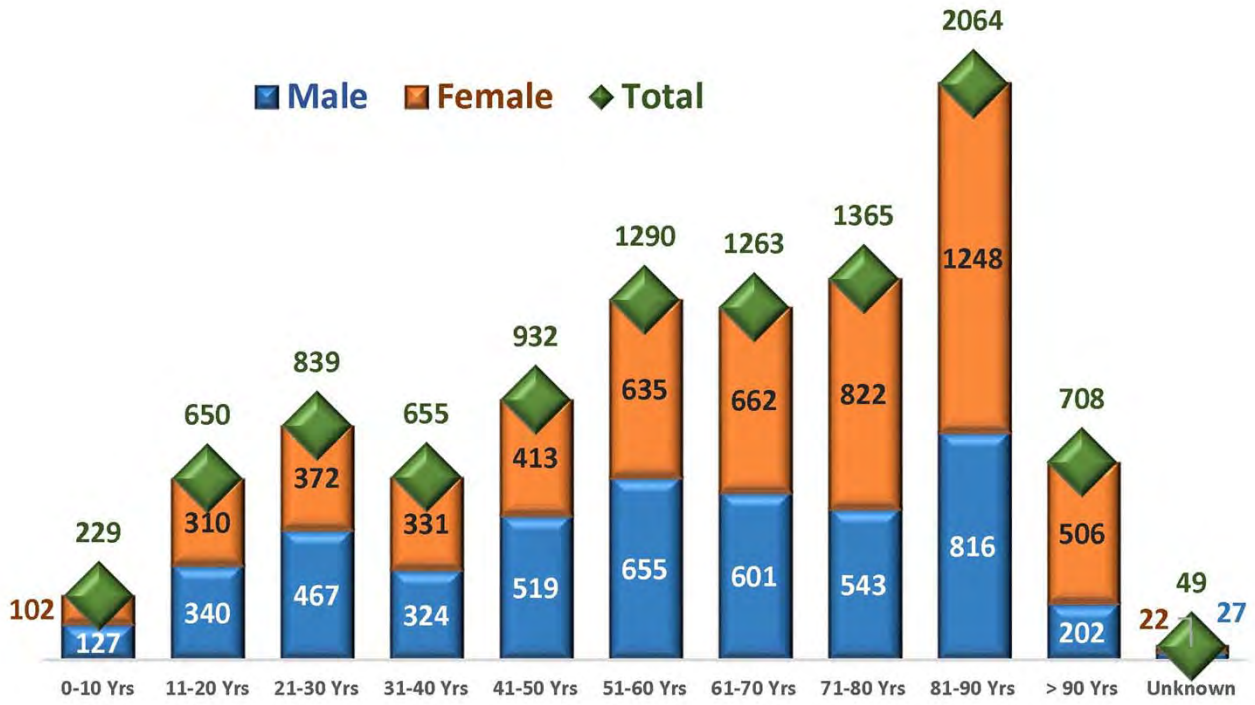
Let's see what EMS data tells us about City "Z's" issues

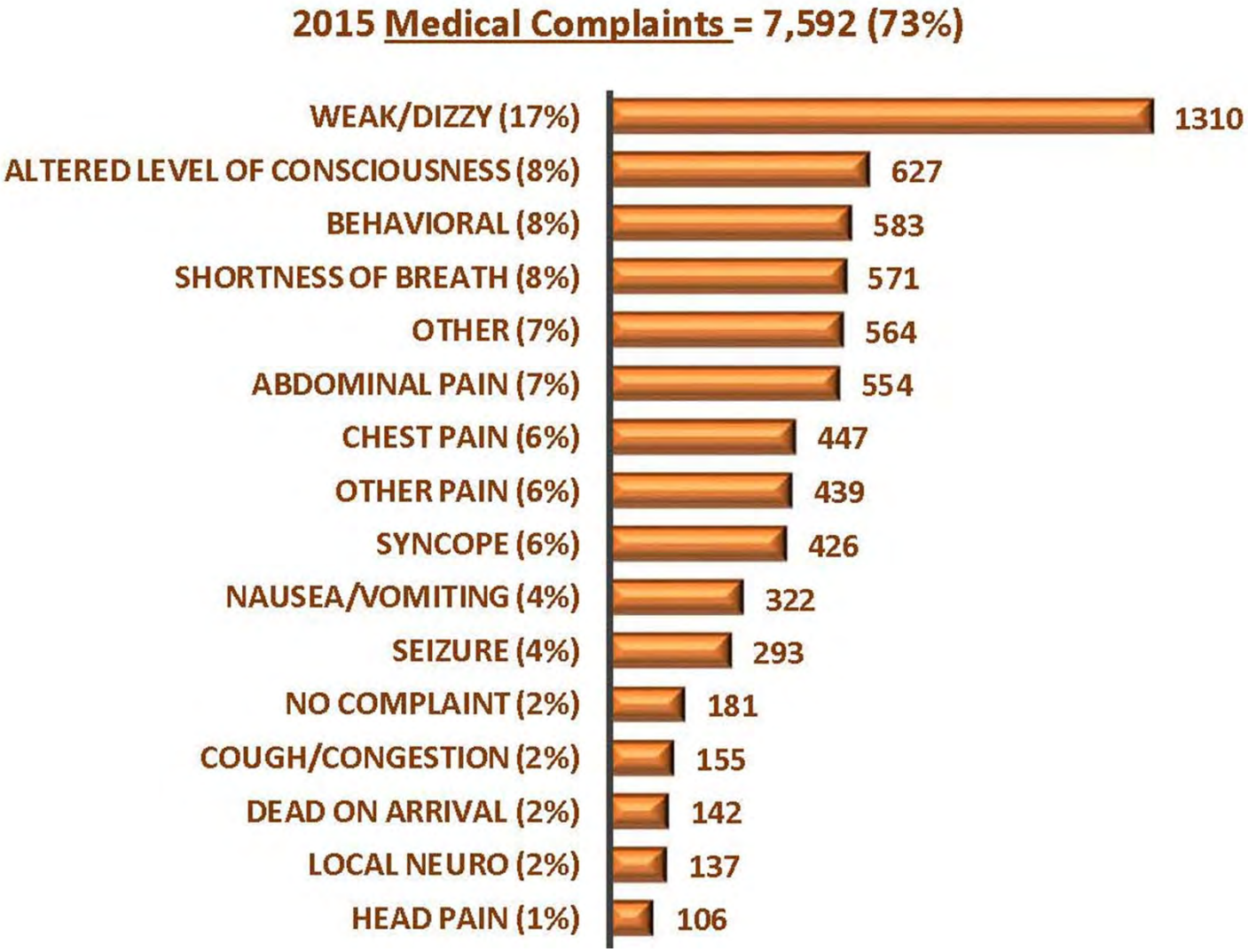
Total EMS Responses



EMS Responses by Age and Gender



Medical Chief Complaints



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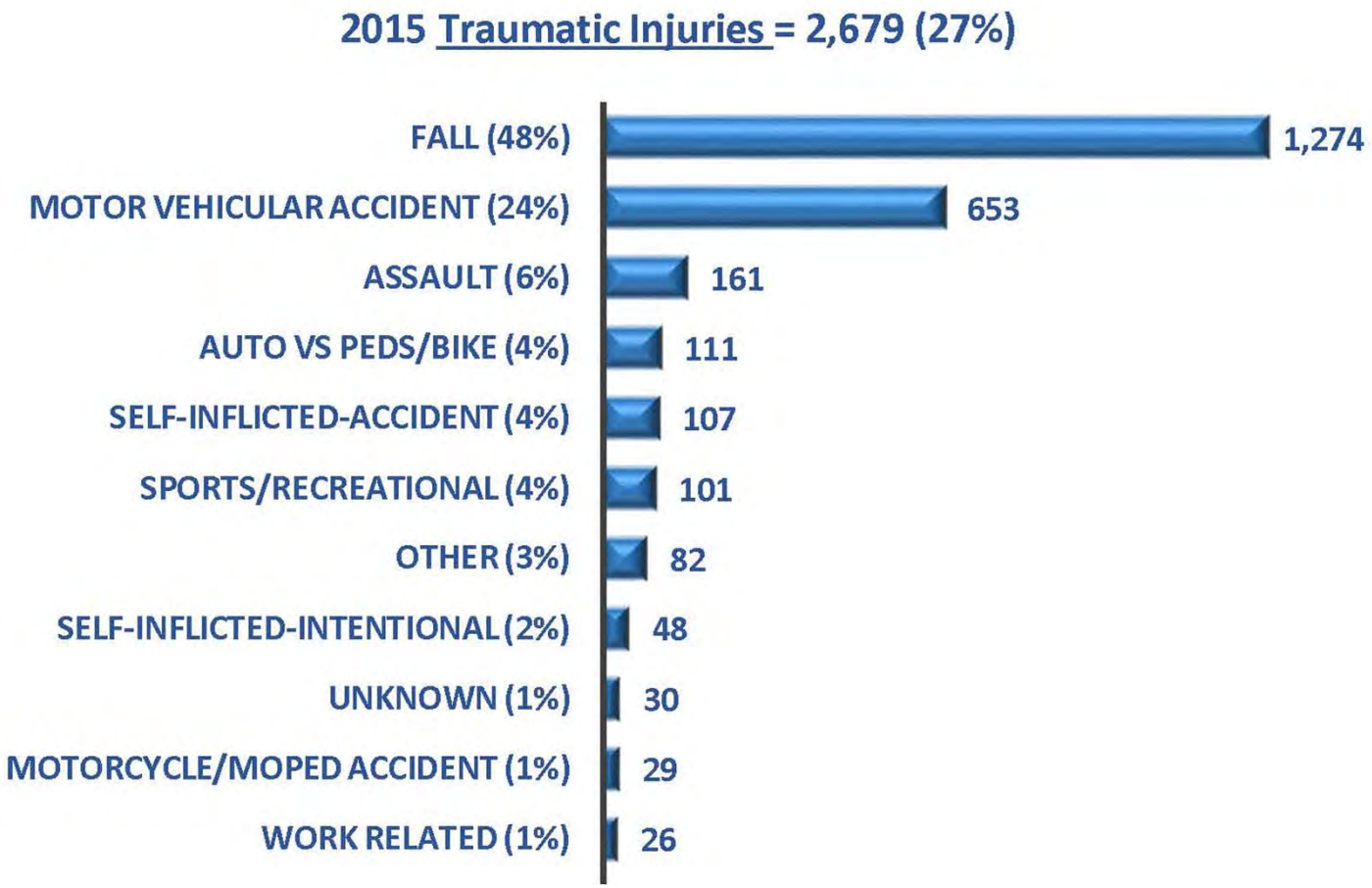
Trauma Incidents



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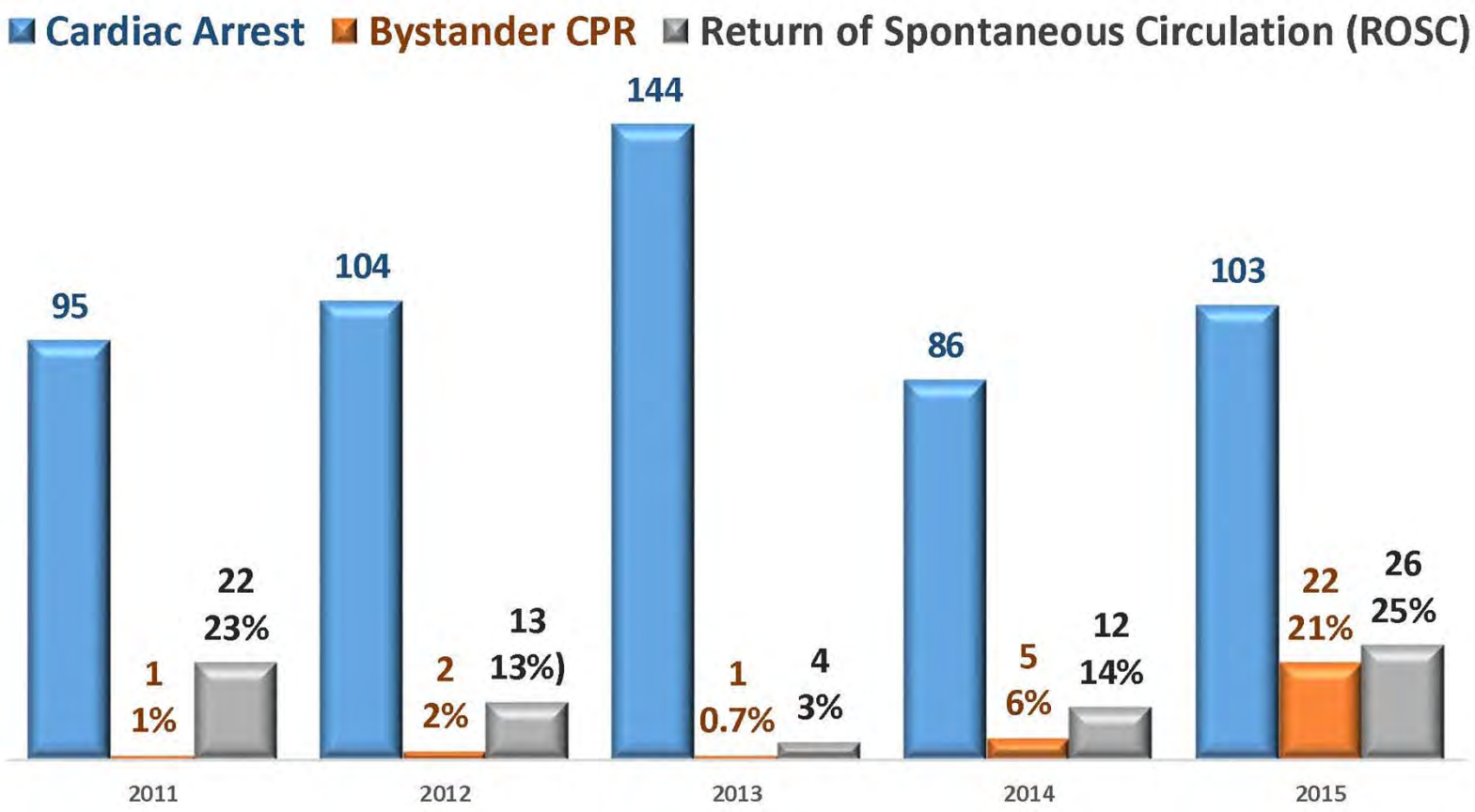
Cardiac Arrest and by-stander CPR for City "Z"



The Conclusion is:

- City "Z" would benefit from a Community Paramedic program to address issues:
  - Fall cause
  - Fall prevention
  - Repeat patients
  - By-stander CPR

Community Paramedics may be:

- Specific to a community
- General for the entire system

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For LA County:
System-wide program Community Paramedics

- Treat and release with aftercare instructions
  - 10-20 percent of patients are not transported
    - Do not need an urgent care or ED
      - » High risk
        - Need a good assessment
        - Video consult
        - Referral and aftercare instructions

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ANIMAL BITES

You have been evaluated in the field by emergency medical services personnel. If you have been given this form, you are refusing medical treatment and/or transportation to a hospital emergency department for further evaluation at this time. **Be advised that the EMS evaluation in the field is not as thorough as an evaluation done at a hospital.** By not being seen in the emergency department, the risks of undetected injuries or a poor outcome increase.

The field assessment indicates you have an animal bite. As with all animal bites, there is the possibility that this wound could become infected and put you at risk for rabies. Without proper care, infections can develop into serious conditions including, but not limited to, blood poisoning, nerve injury, vascular problems, decreased strength and possible loss of limb. Animal bites to any area of the body can be very serious; however, bites on hands or near joints are very serious and should be evaluated in an emergency department. This is only a partial list of potentially serious injuries.

If you refuse medical care or transportation to the hospital, here are some things you should know:

- Infections are not always immediately apparent and may develop over several days. Signs and symptoms of infection to watch for are fever > 101° Fahrenheit, redness, swelling, pain and heat in the infected area, or any numbness or tingling in the area of the bite.
- Watch for any lumps that develop in the groin or under the arms. If you develop any trouble speaking, breathing, difficulty swallowing or if your jaw/neck are stiff, **seek medical attention immediately.**
- Call Animal Control immediately for an animal bite, whether the animal was tame or wild. The animal may need to be caught and impounded so it can be checked for rabies immediately.
- Keep the bite area clean. Wash the area three times a day with soap and water. Cover with a loose sterile dressing and watch for signs of infection.
- Remember, you may call 9-1-1 at any time.

I have been provided with a copy of these instructions. They have been explained to me and I understand them.

Patient (or guardian) signature _____ Date _____

Witness signature _____ Date _____

DRAFT

Alternate Transportation

- Get the patient to the right place the first time and begin treatment:
  - Psychiatric Urgent Care
  - Sobering Centers

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General Considerations

- We need to be careful not to take on the hospital's or insurance responsibilities setting up unsustainable programs
- Focus on <u>improving</u> what EMS does best
- There are roles for Community Paramedics throughout a system and specific to individual communities within a system

Farewell Tour (Conclusions)

"when you look good/we look good!"

- LEMSA's should Assist the provider agency
  - Data analysis
  - Data presentation
  - Making connections in the community
  - Coordinating data and provider agency efforts
  - Advocating for the provider agency with the political bodies

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Finale Farewell Tour

- Community Paramedic programs should be driven by data and analysis
- Recognize that each community has unique needs that would benefit by Community Paramedics
- One size does not fit all

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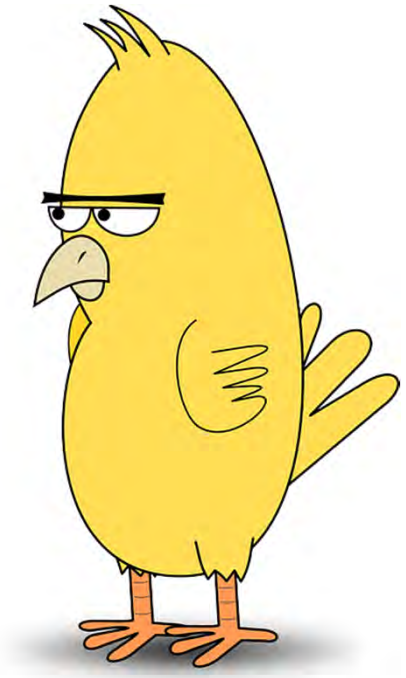
Absolute!
Finale Farewell Tour

- *Let's not wait to the 50 year mark to change the scope of paramedic practice!*



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Thank you for your attention!
Any Questions?

EMERGENCY MEDICAL SERVICES AUTHORITY

EMSA

CALIFORNIA

EMERGENCY MEDICAL SERVICES AUTHORITY

Community Paramedicine: Where do we go from here?

Howard Backer, MD, MPH, FACEP, Director

Lou Meyer, Program Manager

Timeline of California CP Pilots

Analyze issue, involve stakeholders, solicit support, develop report

2012-13

CHHS agency consent, solicit project applications

2012-13

OSHPD application and approval process

2013-14

OSHPD application and approval process

2014-15

Run projects, collect data

2015-16

Education, promotion, Legislative initiative

2017-18

The End Game: Requirements for full CP/MIH Implementation

- Data demonstrate successful pilot programs
- Increased integration of EMS with other parts of healthcare system and gain their support
- Training program appropriate and standardized
- EMS embracing the medical model
- Health information technology and exchange
- New models of reimbursement
- Statutory change

HWPP Intent: Implementation

HSC 128125. Further, it is the intent of this legislation that existing healing arts licensure laws incorporate innovations developed in approved projects that are likely to improve the effectiveness of health care delivery systems.

THANK YOU

TRAVEL SAFE