Emergency Health Services Federation, Inc.

Community Paramedicine & Mobile Integrate Healthcare
Planning Guide
2014

Achieving Our Vision

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Mission

The Emergency Health Services Federation, Inc. (EHSF) encourages emergency medical services (EMS) agencies' to explore and develop the emerging role of community paramedicine (CP) and mobile integrated healthcare (MIH) in South Central Pennsylvania and will support efforts to do so.

Vision

It is the vision of EHSF to partner with EMS agencies and other non-traditional healthcare partners in a collaborative fashion to:

- Provide awareness to the capabilities of licensed EMS agencies and its certified providers;
- Educate various stakeholders on the capabilities of CP/MIH;
- Demonstrate the cost-savings and increased public health from data of current CP/MIH programs within the region;
- Share best practices and lessons learned through development and implementation across the Commonwealth of Pennsylvania;
- Expand CP/MIH models throughout the Commonwealth of Pennsylvania; and
- Seek out new funding models to sustain and expand CP/MIH.

Definitions

Mobile Integrated Health (MIH)

The provision of healthcare typically through integration of multiple providers - both clinical and non-clinical - using patient-centered, mobile resources in the out-of-hospital environment. Every community has unique social and clinical needs. A needs assessment determines how MIH will benefit the respective community by reducing illnesses/ injuries and increase overall public health, while reducing overall cost.

Community Paramedicine (CP)

The goal of CP is to analyze and close gaps in healthcare services by identifying the particular needs of a community and developing the resources needed. Fulfilling these needs may require the community paramedics or community healthcare workers in nontraditional roles or development of non-traditional partnerships as determined by the community needs assessments. CP includes, but is not limited to, services such as providing telephone advice to 9-1-1 callers instead of resource dispatch; providing community paramedicine primary care or post-discharge follow-up visits; or transport or referral to appropriate care. All activity should contain an integral foundation of patient education.

Community Paramedicine Provider (CPP)

Broadly includes all levels of certified emergency medical services providers. The CPP is intended to be an appropriate level provider of public health services to all patient populations such as the elderly, the underserved, and the patients with chronic conditions -by providing education, preventative, and primary care as an extension of a physician, while acting as the patient's advocate to connect them to a variety of beneficial social services.

Background

In 1996, the EMS Agenda for the Future vision fully integrated EMS with the overall health care system and projected EMS will be community-based. Additionally, the agenda described EMS having the ability to not only provide acute illness and injury care but also identify health risks and provide follow-up care, treatment of chronic conditions, and community health monitoring.

In 2004, the Rural and Frontier EMS Agenda of the Future further supported a community health role for EMS. This vision recognized EMS providing rapid response and also filling roles as a community resource for prevention, evaluation, triage, referral, and advice.

Both, the EMS Agenda for the Future and the Rural and Frontier EMS Agenda of the Future, reference to community health roles integrating EMS as a partner of the health care delivery system. CP supports EMS providers to be utilized in an expanded role as part of a community-based team of health services and providers.

With the emergence of the Patient Protection and Affordable Care Act, the potential for EMS to provide an expanded healthcare role has created considerable attention and discussion.

In 2010, a discussion paper by NASEMSO/NOSORH Joint Committee on Rural Emergency Care (JCREC) highlighted challenges and opportunities for EMS to fulfill unmet community needs in primary care and community health. EMS providers in an expanded role of CP increases patient access to primary and preventative care, provides wellness, interventions, decreases emergency department utilization, saves healthcare dollars, and improves patient outcomes.

Strategic Priorities

1. Inform and Educate EMS Managers and Non-Traditional Healthcare Partners
2. Raise Awareness to Community Members and Other Stakeholders
3. Research Legal and Statutory Challenges
4. Investigate Funding and Reimbursement Strategies
5. Gather and Share Resources, Lessons Learned, and Successful Implementation Strategies
6. Expand Health Information Exchange Systems and Referral Process
7. Determine Benchmarks and Indicators to Support Performance Improvement

Strategic Priority 1

Inform and Educate EMS Managers and Non-Traditional Healthcare Partners

Purpose:

Facilitate information and education about CP/MIH through discussion papers, web information, presentations, and other activities

Overview:

CP/MIH is the provision of healthcare using mobile resources in the out-of-hospital environment by utilizing paramedics, EMTs, and other EMS resources as an integrated part of a healthcare team to fill unmet needs of patients and communities. Through the development of various MIH programs across the United States, it has become apparent many patients have unmet clinical and social needs.

- SP 1.1: Explain the purpose and benefits of CP/MIH
  - Through presentations, meetings, and prepared documents explain the role and capabilities of CP/MIH
- SP 1.2: Change the EMS culture to a prevention posture
  - EMS has traditionally been response-focused; it is time to induce a culture shift to a prevention mindset
- SP 1.3: Create and distribute a CP/MIH Development Guide
  - Create and provide a document to outline and explain the steps to beginning a CP/MIH program
- SP 1.4: Prepare EMS Managers to:
  - Market the capabilities of EMS (traditional and non-traditional):
    - CP/MIH program opportunities and ideas
    - Community prevention partners or organizations
    - Community health provider/worker selection process
    - Job description or role for medical director oversight
- SP 1.5: Educate non-traditional healthcare partners about:
  - EMS provider scope and system capabilities
  - Financial needs for program sustainment and expansion
  - Cost-savings from CP/MIH programs
  - Capabilities for CP/MIH to better manage overall patient health
- SP 1.6: Host joint meetings with stakeholders
  - Assist in building partnerships between EMS managers and non-traditional partners
  - Assist in the creation of CP/MIH advisory boards for respective programs consisting of individuals from a variety of healthcare and non-healthcare entities involves or affected by the program's implementation
- SP 1.7: Expand and update a CP/MIH website
  - Create and regularly update a website to provide tools to advance CP/MIH initiatives

Strategic Priority 2

Raise Awareness to Community Members and Other Stakeholders

Purpose:

Highlight the capabilities and advantages of CP/MIH to gain community acceptance of the available resources

Overview:

The ultimate goals of a CP/MIH program should be implementation of the Institute for Health Improvement's Triple Aims of improving the patient experience of care, improving the health of the population, and utilizing resources to reduce the cost of health care. Informing and educating the community and other stakeholders early in the development process will ease the delivery of this next integrated healthcare approach.

- SP 2.1: Explain the purpose and benefits of CP/MIH
  - Through presentations, meetings, and prepared documents explain the role and capabilities of CP/MIH at various community events and other venues
- SP 2.2: Create incentive program to gain community acceptance
  - Determine an incentive program or marketing plan to provide community support to participate in new prevention programs or preventative care measures
- SP 2.3: Identify key stakeholders among various organizations:
  - Healthcare
    - Clinical professionals
    - Social professionals
  - Business
    - Vendors
    - Clients
  - Government
    - Local
    - State
    - Federal

Strategic Priority 3

Research Legal and Statutory Challenges

Purpose:

Research Pennsylvania and Federal statutes and rules for application of CP/MIH programs

Overview:

CP/MIH do not necessarily change the scope of practice for certified EMS providers, but simply expand the roles in which they operate. Community health services are already provided by EMS providers in the current scope of practice. Additionally, CP services are related more to primary care and public health roles than the traditional 9-1-1 response. For example, a CP provider may perform home visits to follow up on the health of patient with diabetes or cardiac conditions attempting to reduce the possibility of hospital admittance and readmittance. The CP role may also include injury prevention activities, such as conducting home safety assessments for falls or new parent education to encourage safe sleeping environments for infants. CP emphasizes the role of EMS providing primary care in the patient's home, which is an environment and role in which EMS providers already practice.

- SP 3.1: Research current regulation to insure CP/MIH is not in conflict with other licensing agencies or authorities, including nursing, physician assistants, home health care, primary care, etc.
- SP 3.2: Evaluate and consider needed changes to current regulations to enhance CP/MIH implementation
- SP 3.3: Collect new and revised EMS statues from other states implementing CP/MIH programs.

Strategic Priority 4

Investigate Funding and Reimbursement Strategies

Purpose:

Foster discussions and information exchange regarding funding strategies to support CP/MIH implementation and sustainability, while demonstrating the financial savings to the healthcare system.

Overview:

Funding to support local EMS agencies comes from diverse public and private sources. Most EMS agencies bill for services and obtain funding from individual self-payments and fee-for-service payments from Medicare, Medicaid, and private health insurance. Funding for EMS agencies is derived primarily from revenues generated from patient transport and is therefore dependent on the number of transports and the payer mix. This type of reimbursement encourages repeated transports to a receiving facility, and discourages patients from being treated at home. It also devaluates the amount and complexity of care provided currently by EMS providers, looking instead the transport benefit.

A challenge to CP/MIH implementation is the current EMS payment structure requiring a patient to be transported to an emergency room in order for the EMS agency to receive any payments and reimbursements. CP/MIH services, such as home treatments or transport to alternate destinations, are not currently a part of EMS funding streams. Changes to the traditional volume-based payment model for hospitals are transitioning to value-based funding strategies. Payment models used through accountable care organizations (ACOs) and medical homes represent the use of health provider teams should include EMS and may be a source of revenue for CP/MIH programs.

- SP 4.1: Develop partnerships with Accountable Care Organizations (ACOs)
  - Identify ACOs within the region and arrange meetings to:
    - Provide awareness to the capabilities and benefits of CP/MIH programs
    - Learn the ACO perspective and benchmarks for care along with needs/gaps
    - Learn of various payment structures, incentives, and penalties involving ACO

- SP 4.2: Research and partner with Patient Centered Medical Homes (PCMH)
  - Identify PCMH within the region and arrange meetings to:
    - Provide awareness to the capabilities and benefits of CP/MIH programs
    - Learn the PCMH perspective and benchmarks for care along with needs/gaps
    - Learn of various payment structures, incentives, and penalties involving PCMH

- SP 4.3: Meet with private health insurers/payers
  - Begin meeting with various private health insurers/payers to:
    - Provide awareness to the capabilities and benefits of CP/MIH programs
    - Discuss potential cost-savings of a CP/MIH program
    - Brainstorm new payment structures for EMS

- SP 4.4: Review current funding models to determine the applicability in Pennsylvania
  - Consider review of a state-level funding change in Minnesota
  - Review funding processes of privately-based EMS agencies

Strategic Priority 5

Gather and Share Resources, Lessons Learned, and Successful Implementation Strategies

Purpose:

Create an appropriate venue to share relevant CP/MIH program resources, lessons learned, and implementation strategies while creating partnerships to advance programs

Overview:

Traditionally, EMS has worked in a "silo" separate from mainstream healthcare. Often these silos are built within the respective EMS system decreasing interoperability among neighboring EMS agencies. The success of a CP/MIH program relies heavily on integration and a collaborate partnership among EMS agencies and other healthcare partners. A committee structure with regularly scheduled meetings will promote these necessary relationships to move CP/MIH forward. The committee will provide a forum to freely share ideas, successes, and challenges.

- SP 5.1: Develop committee structure and meeting schedule
- SP 5.2: Encourage participation from non-traditional healthcare partners
- SP 5.3: Promote discussion among committee members to develop and further evaluate CP/MIH programs within the region, such as documents and other relevant resources, lessons learned, and successful implementation and sustainability strategies

Strategic Priority 6

Expand Health Information Exchange Systems and Referral Process

Purpose:

Identify the best means to document in-home visits and prevention programs executed within the region along with a mechanism to refer patients in need of additional resources as noted during a 911-patient encounter

Overview:

Within the Commonwealth of Pennsylvania, EMS agencies are required to complete an electronic patient care report (ePCR) using an approved Department of Health (DOH) vendor while capturing the required DOH data elements. The current systems to document ePCRs best fit patient encounters generated from a 911-dispatch with the traditional treat and transport model. The documentation needs for a CP/MIH program visit vary from a 911-dispacth or routine transport ePCR.

Another trend in the EMS response system involves providers identifying patients with additional clinical and social needs. EMS providers are healthcare workers entering the homes of their patients. During a 911-disptached event, an EMS provider can observe and assess not only the patient's condition but also the overall wellbeing or lack of needed resources within their primary residence. EMS providers often transport patients to receiving facilities for the patient to be discharged and later require a return transport to the receiving facility. With an appropriate reporting system, an EMS provider could identify a patient with these additional needs to trigger a follow-up in-home visit or provide additional resources to increase health and quality of life.

EHSF is successfully deploying a regional ePCR initiative. The majority of our EMS agencies within EHSF's region will use the regional ePCR system to generate 911-dispatched and routine transport ePCRs. The regional solution offers the capabilities to create a CP/MIH module to better document in-home visits and alerts of patients needing additional resources.

- SP 6.1: Develop and design the CP/MIH reporting system to document in-home visits along with the alerting feature to identify patients activating the 911 system in need of additional resources post-discharge
- SP 6.2: Determine the best process to forward identified patients in need of additional resources to an appropriate CP/MIH program
- SP 6.3: Work with hospitals and other healthcare agencies (i.e. Visiting Nurses Association, Primary Care Practices, etc.) to provide a two-way exchange of patient care information through a Hospital Data Exchange (HDE)
- SP 6.4: Foster relationships with prevention partners and governmental agencies to share collected data.

Strategic Priority 7

Determine Benchmarks and Indicators to Support Performance Improvement

Purpose:

Identify the most appropriate information and data to provide comprehensive reporting to set benchmarks and identify performance improvement indicators

Overview:

The Institute of Healthcare Improvement highlights the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the cost of healthcare. Currently, EMS exists with reimbursement for providing a service (transport) without much regard for paying for value or quality. However, with changes from the Accountable Care Act, pay for performance and value-based reimbursement will soon become familiar terms for EMS.

CP/MIH programs must have an evaluation component providing evidence of better outcomes. This strategic priority includes an inventory of data sources to support the implementation of CP/MIH programs and the ongoing support for the respective programs. Data sets, such as Medicaid, trauma and prehospital registers, emergency room and hospital discharges databases, and others will need to be evaluated for their ability help provide evaluations and outcomes for CP/MIH programs. Similarly, local programs will need to implement evaluation strategies in order to justify the resources and time needed. Evaluation must display success in each component of the Triple Aim.

- SP 7.1: Evaluate and compare hospital discharge data, Medicaid data, and EMS prehospital data to support CP/MIH programs

- SP 7.2: Develop the framework to set benchmarks and indicators to meet Triple Aim
    - Population Health
        - Health/Functional Status
        - Risk Status
        - Disease Burden
        - Mortality
    - Patient Experience
        - Patient Satisfaction Surveys
        - Measures of Key Dimensions (i.e. safe, effectives, timely, efficient, and patient-centered)
    - Per Capita Cost
        - Total cost per member of the population per month
        - Hospital and ED utilization rate

- SP 7.3: Educate EMS Managers on needed reports and better document to generate the respective reports to display value