Envisioning Community Paramedicine

Thursday, March 21, 2013
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Since the Patient Protection and Affordable Care Act—Obamacare—became law, it's become more and more obvious that one key way of enhancing care and controlling costs will occur in the field—and EMS professionals will play a critical role. One term that is often tossed about is "community paramedicine" (CP). But what does this concept really mean, and how can agencies looking to implement CP programs do so successfully?

These questions were the focus of an exclusive meeting of EMS, healthcare, and government leaders on March 18 at the Medtronic World Headquarters in Minnesota. *The goal:* Discuss how to best categorize, formalize and maximize the value and integration of EMS into our current and future healthcare system. Representatives from multiple existing "community," "advanced practice" and "mobile healthcare" paramedic programs were on hand to share what has worked for them—and what hasn't. They were joined by officials from state government, the medical community, the National Association of State EMS Officials, the National Association of EMS Physicians, the Centers for Disease Control and Prevention, the National Registry and healthcare consultants.

Together, they sought to reach some consensus on focus, direction and standard components of

CP systems.

Medtronic's Role
The Medtronic Foundation provided support to bring the participants together. The Foundation is continuing to shift more of its focus toward expanding access to quality healthcare, especially for underserved patient populations around the world.

Jacob Gayle, vice president of Medtronic Philanthropy, explained that the Medtronic Foundation is taking a high-level view of existing care systems and the barriers that interrupt the continuum of care, thus identifying important steps to improve the ability of patients to access appropriate care. The Foundation is, therefore, very supportive of efforts to improve the delivery of mobile integrated healthcare services.

This meeting was well timed, as it built on recent CP briefings held for U.S. government leaders in Washington, D.C., during the EMS Today Conference and Expo 2013. Gary Wingrove of North Central EMS Institute and other leaders led a series of dialogs on the Hill with congressional staffers, federal administrators and other national officials.

Reaching Consensus
As one of the participants in the day-long discussion, I can attest that progress was made in synchronizing a variety of efforts, addressing questions and attempting to better standardize and define this important new focus area for EMS. All participants agreed that key to success is an inclusive approach that integrates the spectrum of other practitioners and professional that add value in community-based healthcare.

Jeff Beeson, DO, EMT-P, medical director of Fort Worth-based MedStar Mobile Healthcare, told the participants, "We in EMS see the parts of the healthcare system that are broken and are in a position to address many of them." Other participants stressed that the current public safety-focused model is probably not going to be sustainable in the future.

Program participant Anne Robinson, representing the North Central EMS Institute, stressed that the Institute was in support of the overall concept, particularly maintaining the Community Paramedic as a provider under the framework. She noted that although many pilot projects are underway with various names for their projects and staff, all are focusing on the common goal of integrated primary care and public health in an EMS model.

Brent Myers, MD, MPH, Wake County (NC) EMS director/medical director, whose system has been offering an Advanced Practice Paramedic community-focused response system, pointed out that 5–10% of all residents in a community will access EMS each year, but up to 50% could go to the hospital via other means.

Myers outlined five areas that he and others feel will be "tomorrow's reality":

1. Outcomes will matter more than process (particularly in the eyes of the Center for Medicare and Medicaid Services);
2. Performance measures will be evidence-based and will drive reimbursement;
3. Hospitals will (and many already do) have a renewed interest in EMS in the new healthcare environment;
4. Cost of service will matter; and
5. Patients, optimally, should be linked to the CP program via their primary care physician.

Key Issues in CP

Although EMS is responsible for just 1% of the Centers for Medicare and Medicaid Services (CMS) healthcare budget, our agencies are called on to address many of the healthcare deficiencies or gaps that exist, particularly in 24-hour management of social service, psychiatric, substance abuse and chronic care follow-up needs. It was also noted that:

- CP programs are just one tool in the toolbox.
- Many systems got involved in CP by seeing the excessive use by some patients calling/using our systems.
- Citizens in our communities are currently affected by "dis-integrated" healthcare.
- Every community has unique needs and must do a needs assessment to determine how CP will work for them. Broadly defined, this needs assessment identifies service gaps, resource availability and stakeholders. Specific health needs can range from diabetes to heart failure to substance abuse to falls prevention and social services. In Minnesota, for example, there is a special organization called "Leaf" that can be contacted to rake the leaves of those who are too mobility-restricted to do it.
- Enabling legislation may be needed in some states to allow Community Paramedics to operate in their state and also to apply to the CMS to get a waiver from Medicaid to fund it. An obstacle to progress has been the restriction by existing states laws and regulations on allowing ambulances to take patients to locations other than hospital emergency departments.
- 80% of physicians don't know how to use Community Paramedics, so EMS leaders must engage in educating them about what we do and how to access us.
- Medical direction for a system of this type does not necessarily have to come from the EMS medical director.
- Each community has to assess what it can do with the resources it has.
- We have to demonstrate this is a reliable way to operate, and we have to build a sustainable delivery model.

Participating EMS agencies and leaders agreed that their common goal was to provide better care for the community through integration, patient navigation and care coordination. However, they also all agreed that the current state of unscheduled care is chaotic, that EMS should be better aligned with the overall healthcare system and that this issue is much bigger than just a few EMS organizations.

Mobile Integrated Healthcare Practice

For now, the conceptual framework is being referenced as "Mobile Integrated Healthcare Practice." However, like all innovations, development is iterative and will no doubt be adapted locally.

While "Mobile Integrated Healthcare Practice" may sound like a more understandable model/funding category for CMS to understand and potentially support financially, some present at the meeting cautioned that use of the word "mobile" may be self-limiting and "put a wall around us," particularly because technology may allow for some of the activities to be performed remotely and electronically.

Attendees noted that we must allow patients to navigate through the healthcare system and that medical practice developed should look at:

- Post-acute care, including readmission prevention and transitional care;
- Post ED care;
- Long-term chronic care;

- Frequent system users;
- Home-bound, impaired mobility patients;
- Health screening;
- Public health and prevention; and
- Patient satisfaction and outcomes.

A common goal was also that integrated healthcare/community-based healthcare programs must be designed to be measurable, scalable, reproducible and standardized on some level in order to be financially sustainable.

To this end, the group outlined a conceptual framework that could help standardize the wide variety of programs. Participants also agreed to pursue financial modeling using of this new practice using healthcare actuarial consultants and data.

Specific Program Experiences
Several participants who have had experience with CP programs discussed some of their specific experiences.

Wake County – Brent Myers, MD, MPH
Wake County assessed their community health care needs and found two main areas:

- Mental health and substance abuse—approximately 1.2 million people are server, but there are no medically intensive mental health beds.
- Fall response and prevention—Wake County responds to simple falls/"found down" in assisted living facilities.

Chicago – Eric Beck, DO
EMT-Basics were sent out into the Chicago public housing projects to identify un-immunized and under immunized pediatric patients. EMTs were teamed with a public health nurse who provided vaccinations and linked the patients to pediatricians for ongoing primary care.

Fort Worth – Jeff Beeson, DO, EMT-P
MedStar started its program with a focus on two initial core areas:

1. CHF Re-admission. Because most cardiologists no longer maintain clinics, MedStar found that cardiologists were keenly interested in CP programs. So, discharge planners began to enroll high-risk patients in the MedStar Mobile Healthcare system. This helped identify patients who were decompensating (assess weight gain, adjust diuretics, etc.).
2. Hospice. Since hospices are responsible for all of an enrolled person's healthcare needs (and expenses), there was interest by hospice in having a 24-hour resources available to assist them in supporting their patient and family needs. MedStar now responds and helps assess patients when hospice is not available. The addresses of hospice patients are flagged in their CAD system, and their system notifies hospice when 9-1-1 is activated, so they can respond to the home or location.

Hennepin County (Minn.) EMS – Brian Mahoney, MD
Dr. Mahoney noted that his system currently has 12 paramedics in training (a 300-hour program) to serve as Community Paramedics. Community Paramedics' computers will be tied into the EPIC system along with all their hospitals.

North Memorial Community (Minn.) Paramedic Program – Marc Conterato, MD, and Mike Wilcox, MD

Dr. Conterato and Dr. Wilcox noted that their system is currently working in parts of Hennepin County and several rural areas in Minnesota, with 8 metro and 15 rural community paramedics certified, deployed and integrated into the EPIC computer system. An additional 21 paramedics will be added to their system in May 2013.

North East Mobile Health Services, Scarborough, Maine – Kevin McGinnis, MPS, EMT-P
EMS leaders in Maine have been successful in getting the state health commissioner to allow paramedics to function outside the normal role. McGinnis cautioned that when you go to implement these programs, you must integrate them with home healthcare organizations and other community care programs.

How It Might Work
An example of how this type of integrate health care system can, and is, working, was presented:

1. A patient with heart failure is discharged from a hospital.
2. Arrangements are made by the discharging hospital for a home visit by a Community Paramedic.
3. En route to the patient's home, the Community Paramedic can see on the EPIC or other similar integrated database that the patient's medications have not yet been picked up, and arrange to get the medicine to the patient so their condition (respiratory distress, fluid load, infection, etc.) does not deteriorate.
4. The Community Paramedic visits the person in their home, performing medication reconciliation and periodic follow-up checks on a scheduled or as-needed basis.

Five basic program principles were discussed and will be fleshed out by the group:

1. Communication – Medical records, telecare/telepresence, technology, communicating with the public;
2. Coordination – Strategic partnership;
3. Access to care and services – Transportation, levels of destination;
4. Quality, Value, Affordability, Financial sustainability; and
5. Education.

Tenets of Mobile Integrated Health Care Practice
The group discussed Tenets of Mobile Integrated Health Care Practice. They included:

1. Programs should assess community needs, be value-focused and feature a competency and evidence-based practice that ensures continual education, 24-hour community access and ongoing performance improvement.
2. Programs must incorporate community partnerships with active medical direction.
3. Programs should deliver improved access to care and health equity for populations served through 24-hour care availability.
4. Programs should focus on patient-centered navigation and offer community-centered care by integrating the existing EMS infrastructure, meet patients where they are and, where feasible, use mobile point-of-care and telecommunications resources.
5. Programs should use evidence-based practice using multidisciplinary and inter-professional teams.

The meeting participants agreed to engage other EMS leaders and expertise beyond EMS in working groups to further define this new practice of medicine that leverages existing providers and infrastructure through new collaborative linkages and aligned goals.

As community paramedicine and EMS continue to develop the mobile integrated healthcare concept, *JEMS* will bring you updates.

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