NY COMMUNITY PARAMEDICINE TASK FORCE

12/6/12 – First Statewide Teleconference

- Attendance

- Jeff Spencer
- Jonathan Smith
- Lori Benison
- Jonathan Washko
- Chris Graziano
- John Guerriero
- David Kugler
- Jim Jackson
- Teresa Robertson
- Brian Washburn
- Shawn Bowe
- Mike Guttenberg
- Gregg Strauss
- Timothy Egan
- Kevin Munjal

- Welcome – Kevin Munjal
    - What is Community Paramedicine?
        - movement seeking to harness the untapped potential of out-of-hospital care resources to improve health, improve patient satisfaction and lower costs.
        - 3 main aspects:
        - 1) patient-centered emergency response
            - involves making 9-1-1 services more flexible and adaptable to the needs of the patient including transporting to alternate destinations and "treat and release" protocols when medically appropriate.
        - 2) integration with the public health infrastructure
            - involves helping meet unmet community education and outreach, health surveillance or vaccination goals of the public health community.
        - 3) integration with the healthcare service delivery system
            - involves adding value to interfacility and post-acute care interactions with patients to improve the care transition process or to assist in the management of chronic diseases in the community.
    - What is the task force?
        - The New York Community Paramedicine Task Force (NY CP TF) was formed by members of the local EMS community who recognized that the role of prehospital care systems was very limited in relation to the larger healthcare system and at times even at odds with the triple aims of pursuing the improvement of the patient experience, improving the health of the population, and lowering the per capita costs of delivering care.

        - Among the goals of this task force are to examine the potential legal, political and financial barriers to implementation of this model and to create a strategy to overcome those barriers.
- Presentation by Jonathan Washko, Assistant Vice President for NSLIJ Center for EMS.
    - Given the shift in health reform, there is an opportunity to fit community paramedics within that framework
        - EMS is a version of 24/7 healthcare
        - We are physician extenders for EM, but how about also being physician extenders for non-emergency providers?
        - Challenge: We are paid as drivers, not providers
        - Differences between Rural and Urban CP models:
            - In rural, if there is no one else, than you might need an expanded practice
            - In urban, we should function more within a physician extender model
        - Dedicated model vs. marginal time model
    - NSLIJ CEMS
        - 9-1-1 as well as interfacility
        - Core operation - high performance EMS model
            - Align demand with supply
        - 500 employees
        - Why are we interested in CP?
            - CEO Michael Dowling believes that we have to find ways to provide higher quality care for less
            - Health system moving to a cradle to grave model
            - Want to provide healthcare for the region
            - Consolidation occurring in the healthcare market
            - Build relationships between all the different providers for a patient
        - Predicts a Bifurcation of EMS
            - Healthcare / Public Health //// Disaster Preparedness / Public Safety
                - These will split
            - Right care
            - Right patient
            - Right cost
            - Right place
            - Right type of care
            - EMS will have a significant opportunity here to provide onsite clinical decision support
            - 24/7 clinical intelligence services
            - Clinical call center
        - Insights to share with others after working on CP for a long time.
            - 1.5 yrs – getting the healthcare side to understand that EMS is more than a transportation commodity (this is a role for task force on a community and governmental level)

- Getting buy in
- They were able to obtain funding for 2 programs simultaneously: clinical call center and CP program
- They will coordinate with house-call physicians
- Already call answering service but hopefully more
- We are at the forefront, new territory

- Task Force roles:
  - To collaborate with all parties including NSLIJ CEMS to help build awareness and coordinate advocacy.
  - Advocate for reimbursement reform
  - Education opportunities
  - Help to shape and define the role of:
    - Government oversight
    - Medical oversight
- Question was asked about Education and Training.
  - Strategy is to move away from protocol driven care to physician extender role.

- Presentation by Jonathan Smith, Operations Director, Brighton Ambulance
  - He agrees with the 4 categories of EMS activity: Healthcare, Public Health, Disaster Preparedness, Public Safety
    - He agrees they may split
  - EMT / Paramedics are vulnerable because we are the least educated healthcare providers
  - In order to be successful in CP, we have to be comfortable with leaving patients at home, dealing with public health role
  - We have to make sure physicians and extenders are comfortable with us and our skills
  - We did a needs assessment in our community
    - Lots of programs are focusing on chronic disease
    - Therefore, they developed programs for both chronic and episodic care patients
    - Focused on Diabetes, CHF
    - Also wound care, but usually as supplemental providers
    - Goal: Improve access through follow up care and help identify what type of care might be useful.
    - Strategy: Provide episodic visits that Primary Care can't accommodate
    - Help mitigate the risk of chronic conditions with episodic visits
    - Takes burden out of the hospital and emergency department.
    - Caring for 1000 pts → Save $2 million
  - Insight from Community Paramedicine related efforts in Rochester region
    - Home care: because our services are similar to VNS, would not support us
    - Working with a few PCP offices and act as extenders is a great way to get started
      - Providing urgent evaluations
  - Challenges
    - Sustainable funding model

        - Winning reimbursement battle
        - Quality assurance is generally punitive, but it needs to be more about education and process improvement
        - Need to look at outcomes.
        - Before implementing widespread CP, we need to make quality a priority
        - Is there a common role or definition of CP for the EMS system
            - no clear role → urban / rural will be different
        - What are the state's concerns?
        - What government oversight will be there? What should it be?
    - Role of task force
        - Understanding the challenges others have faced
        - Collecting lessons learned
        - Although we take different perspectives on it and use different pieces of the full CP model, championing it together will make a difference

Question from Jim Jackson

In CP, are we / should we be doing some roles constantly and some roles only occasionally? Are we increasing the number of high risk low volume procedures?

Smith:

To maintain a level of skill, they will need to also continue routine EMS care.
Rochester answer was to develop a rotation between Emergency Response, CP, and training with the physician

Q from David Kugler

Where will you do clinical skills training and how will you indemnify them? The law only allows students in the hospital.

Smith:

I participated in Colorado training program → we were only able to do observation
This will remain a challenge

Kugler – considered using DOH certified instructors to get a course approved and then perform clinical activities in that context.
Smith – neighboring county has great simulation lab and they are considering using that.

Munjal: In the two presentations today, we heard significantly different perspectives on the type of model being implemented and the type of education that might be required.

How do we deal with these different messages?

Washko:

We are having this issue at the national level.
- we are not going to come up with a common recipe,
- but we need to have appropriate common messages that we all agree with.

- Wrap-up: Munjal
- What has the Task Force achieved so far?
    - 100+ members
    - 5 Letters of Support
    - Legislative Document Review

- Website
- Presentations

- What are some of the ongoing initiatives?
  - Public Relations Committee
    - Letter of Support Campaign
    - Stakeholder Focus Groups
    - Website Content Development
    - Information Technology Outreach
  - Research
    - Grant Writing
    - Organizing the Task Force into a legal entity
  - Legislative Committee
    - Document Review – completed
    - Legal Argument Preparation
  - Financial Reform Committee
    - Medicaid Policy Review
    - Write Articles
- What are some of the goals for 2013
  - Formalize relationships with state agencies
  - Build on relationships with GNYHA / HANYS
  - Cultivate relationships with legislature
  - Collaborate with other Allied Health Professionals
  - Presence at major statewide conferences
  - Formalize organization

Jeff Spencer – Has there been in depth research on NYS legislature?

Smith – legislator in his area on insurance reform committee

Guttenberg – We need to focus on Dept of Education, Dept of Health.

And we need to focus on legislative members of committees that oversee these areas.

<u>Ways to Help</u>

Website Design
Developing Web Content
Letter writing
Blogging
Networking
Editing
Research
Economic Modeling
Legal Assistance
Coordinating Meetings
Member Recruitment
Organizing or Particpating in Focus Groups
Giving or Coordinating Presentations

Graphic Design
Posting Flyers
and much, much more!