

Community Paramedicine / Mobile Integrated Healthcare

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Agenda

1. The Problem
2. Current State of Healthcare
3. Defining Community Paramedicine (CP)
4. Defining Mobile Integrated Health Care (MIHC)
5. Existing Programs in the US
6. What's Happening in Iowa
7. What's Next

U.S. HEALTH CARE THE COST PROBLEM

THE REALITY OVERALL SPENDING

\$2.5 Trillion
(2009)

HEALTH CARE AS SHARE OF GDP



PER CAPITA SPENDING

\$8,100 (2009)



THE DRIVERS

Chronic Disease

\$1.875 Trillion

Annual Cost (2009)

\$3 out of every \$4 of
U.S. health care spending



Aging Population

People Ages 65+ 1 in 8 Americans



* percent of population



Hospital Readmissions (2011)

Nearly 1 in 5 patients readmitted in 30 days



Estimated Preventable Cost Burden
\$25B annually

Physician Shortage

Projected Shortages by Year



The Problem

- * Historically, an EMS (Ambulance) business development strategy has largely centered around increasing the number of patients transported to the hospital emergency department rather than taking steps to help patients navigate the healthcare system to ensure that they are provided the best, most appropriate resource for their care.

The Problem (cont.)

- * The EMS system benefits financially from patients using one of the most expensive transportation resources, an ambulance, to deliver them to one of the most expensive settings for healthcare, an emergency department.

Current State

- * Healthcare costs are rising – US is highest
- * Increase in Healthy Life Expectancy (living longer) & increase in years with disability (chronic health problems)
- * Hospitals will be penalized for readmissions within 30 days
- * Ambulance services are only reimbursed if patient is transported to an ED (Medical transportation benefit)
- * No direct model of funding currently exists for CP/MIHC
- * Iowa Medicaid has a nominal payment for Ambulance Response, Treatment (A0998), which is only \$ 84.67



What is Community Paramedicine?

- * According to the U.S. Department of Health and Human Services, Community Paramedicine is an organized system of services, **based on local need**, provided by emergency medical technicians and paramedics that is integrated into the local or regional health care system and **overseen by emergency and primary care physicians**.
- * Community Paramedicine is a model to realize the vision of EMS-based community health services that supplement the traditional EMS response model and **bridges both community health service and EMS coverage gaps**.

What CP IS NOT:

- * CP **does not** replace existing resources, sole purpose is to augment services based on community need.
- * CP **does not** replace a coordinated patient centered medical home (PCMH) or an already established home care agency.

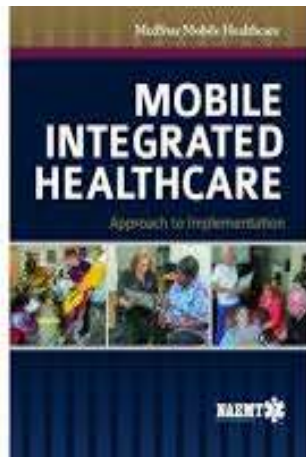
*NOTE: **PCMH** is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.*

Community Paramedicine Programs

- * CP programs typically have been designed to address specific **local problems** and to take advantage of locally developed collaborations between and among emergency medical services (EMS) and other health care and social service providers.
- * Community Paramedicine **fills healthcare service gaps**, without replacing healthcare workers.
- * CP Programs are available 24/7 every day, including holidays, whereas traditional services may be 8-5 pm.

Who Benefits?

- * **Hospitals** – Lowering readmission rates by providing post discharge home health checks & decreases ED utilization.
- * **Residents** – Those suffering from non-urgent health issues. This service could extend to those with specific medical needs such as diabetic or mental health monitoring in which hospitalization is not required. Provides wellness intervention in home setting, etc.
- * **Communities** – Filling the gap for unmet needs in healthcare system. Improves overall patient outcomes.
- * **Insurance Companies** – Saves healthcare dollars.



What is Mobile Integrated Health Care?

- * CP/MIHC programs use EMS practitioners and other healthcare providers in an **expanded role** to increase patient access to primary and preventative care, within the medical home model.
- * **CP/MIHC programs work to decrease the use of emergency departments, decrease healthcare costs, and increase improved patient outcomes.**
- * The introduction of CP/MIHC programs within EMS agencies is a top trend in emergency medical care.

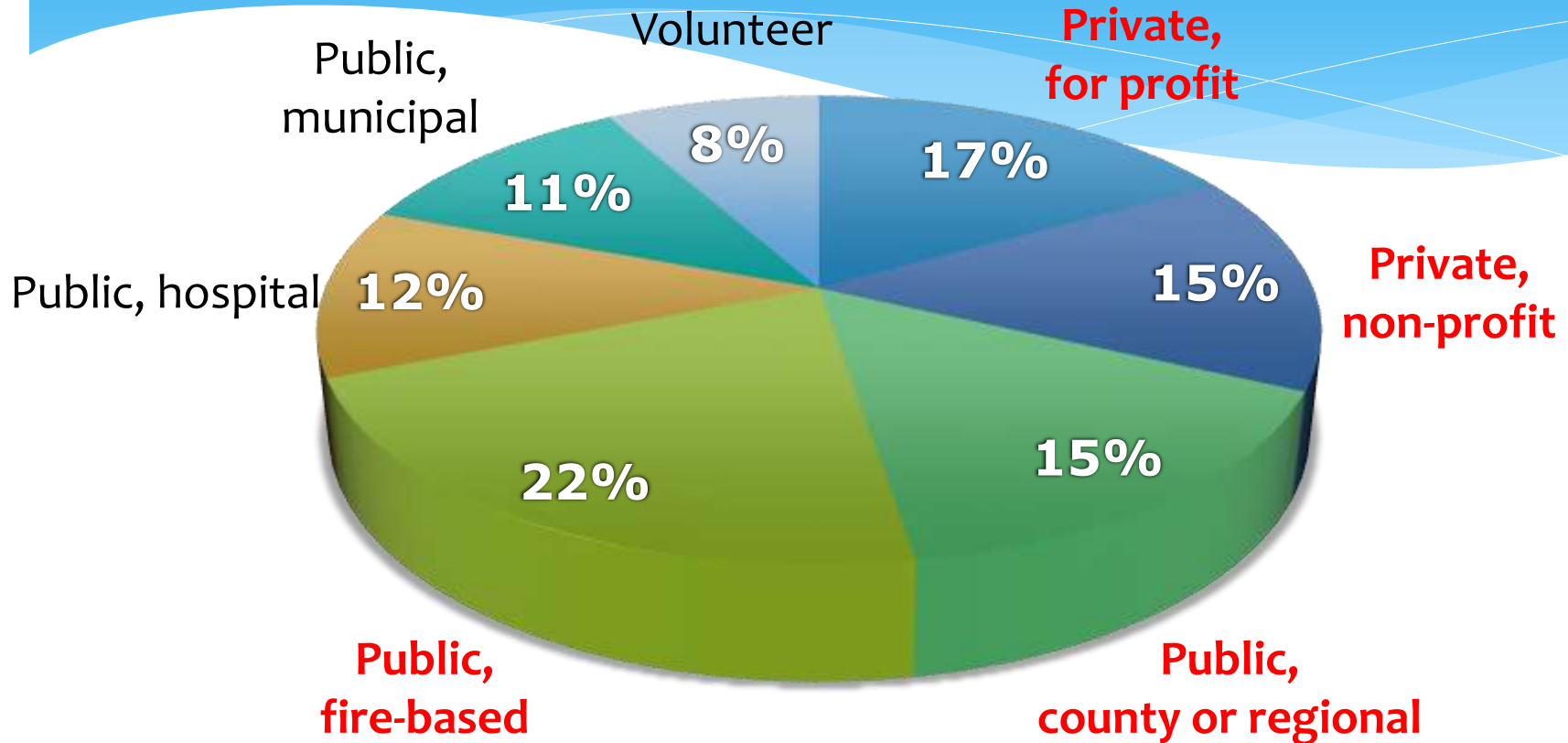
Mobile Integrated Health Care May Include:

- * Providing telephone advice to 911 callers instead of typical resource dispatching
- * Providing CP care, chronic disease management, medication reconciliation and compliance, preventative care, or post discharge follow-up visits
- * Transport or referral to a broad spectrum of appropriate care, not just hospital emergency departments (mental health, PCP, etc.)

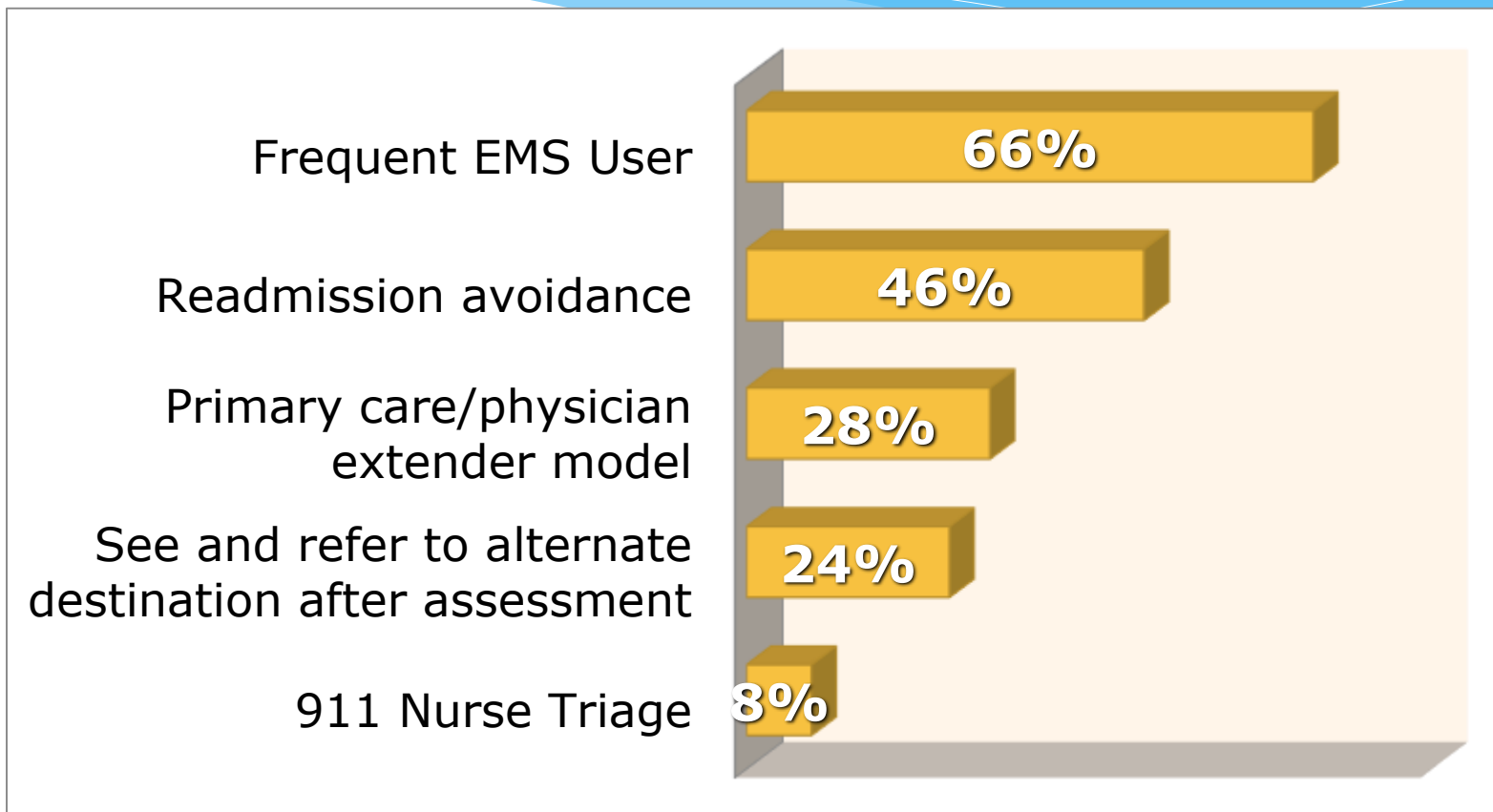
NAEMT / JNEMSFLF Survey Results on CP / MIHC

NOTE: Joint National EMS Leadership Forum
(Represented 16 other organizations)

Programs Represented

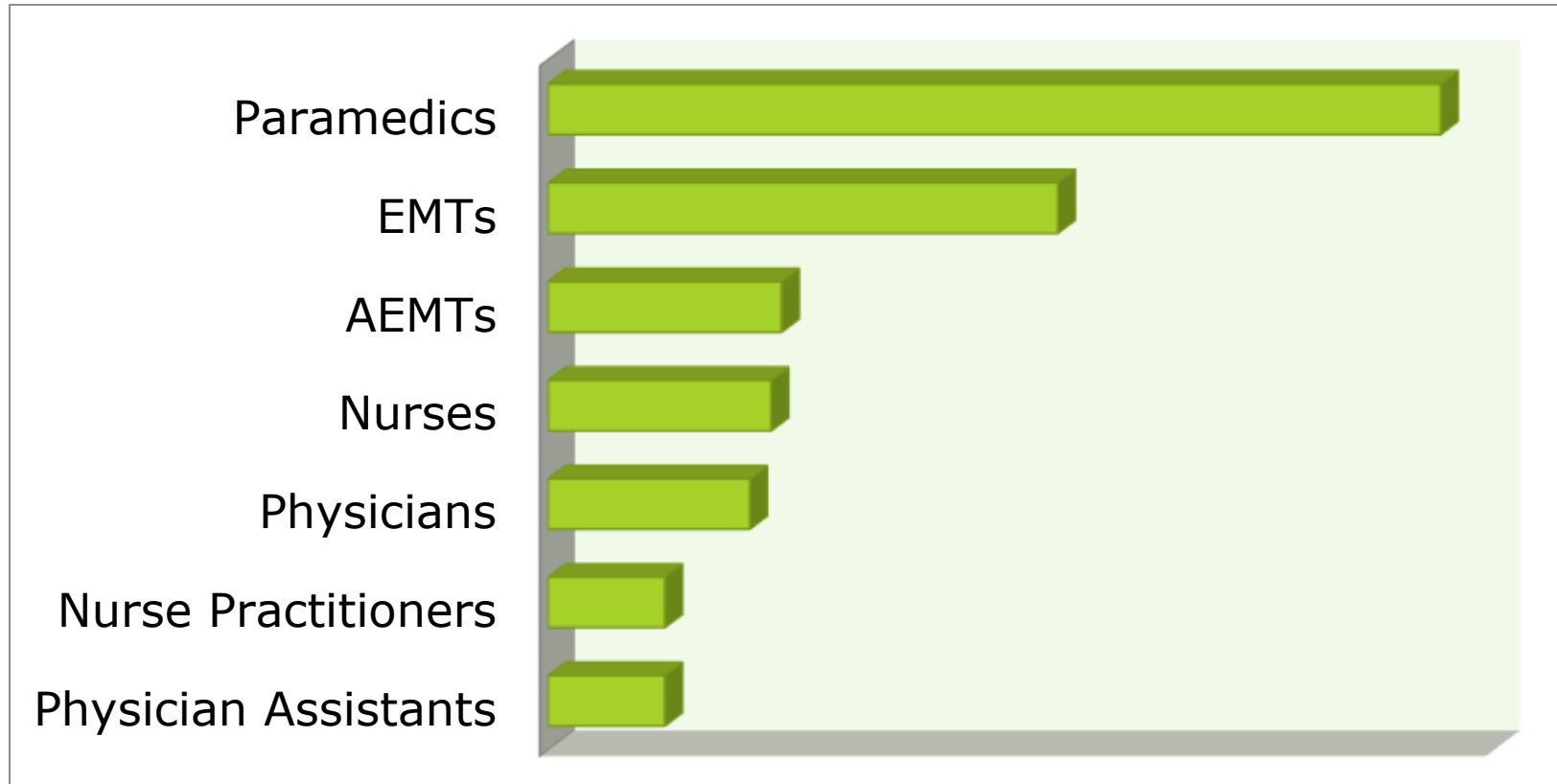


CP/MICH Program Models

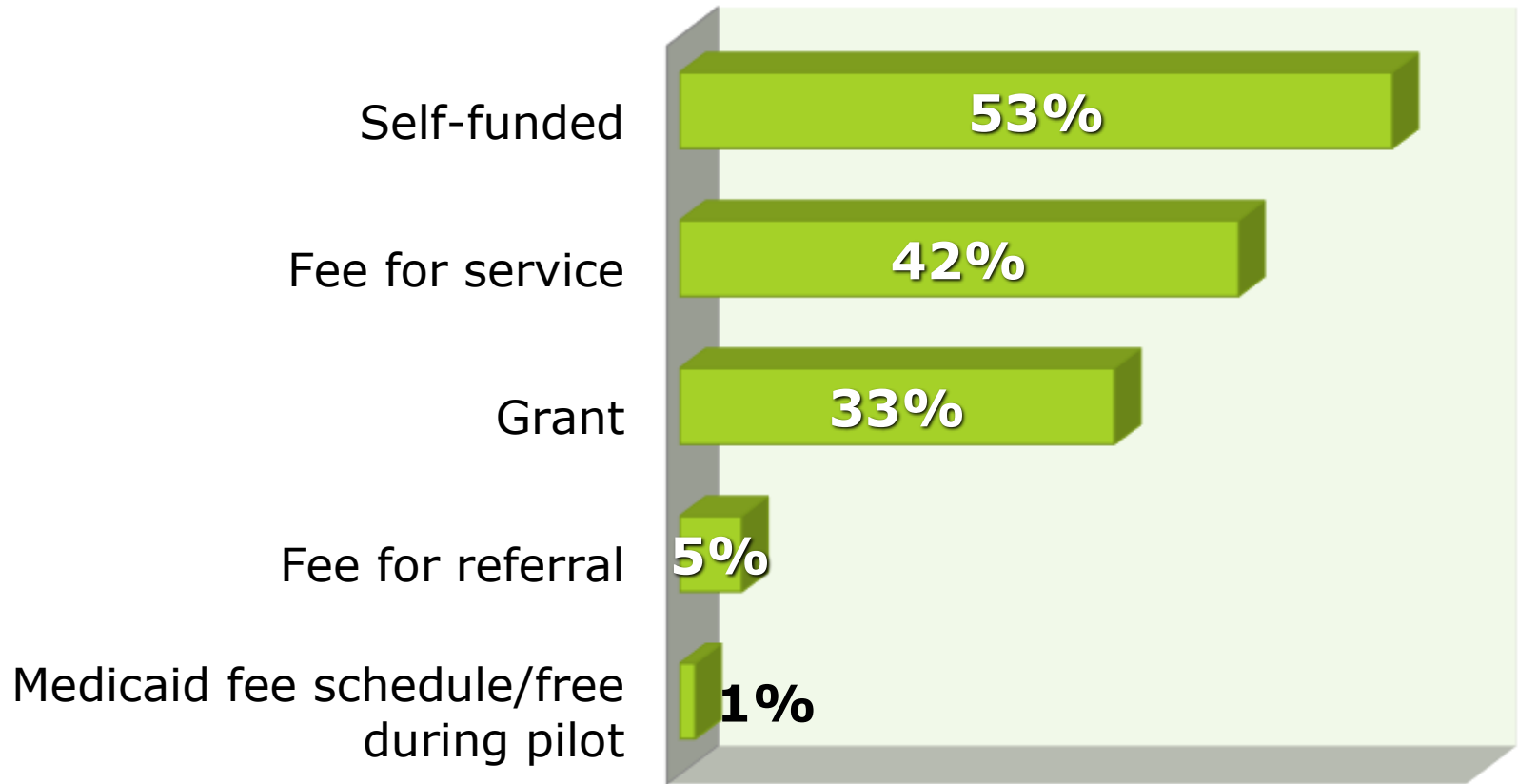


Respondents were able to select more than one response, resulting in a percentage total greater than 100%.

Who participates in providing patient care?



CP/MIHC program funding sources



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

Successful CP Programs

- * **Minnesota** - High-risk patients served by North Memorial are getting home visits from community paramedics, who help them avoid the emergency room by providing care in coordination with their doctor's offices and clinics. North Memorial uses data from the Department of Human Services to identify those who are most at risk and includes them in its groundbreaking community paramedic program.

Enacted Legislation in 2011

Authorizes medical assistance to cover services

Medicaid covered service by CP

Successful CP Programs (cont.)

- * **Pittsburgh, PA.** – Home based prevention & disease management. Immunizations, biometric screening, home visit of discharged patients to review discharge instructions to prevent readmission.
- * **Fort Worth, TX.** – MedStar created the “EMS Loyalty Program” for frequent fliers. Patients who use 911 fifteen or more times are enrolled and have regular home visits. Also perform CHF readmission avoidance and Hospice revocation avoidance.
- * **Wake County EMS, NC.** – Mental health referrals.
- * **Western Eagle County Ambulance District, CO.** – Connecting underutilized resources to underserved populations. They expanded the roles of EMS workers to provide health services where access to physicians, clinics and/or hospitals is difficult or may not exist in the county.

Top 10 Areas of Focus Implementing a MIH-CP Program

1. Medical direction	6. Networking
2. Staffing	7. Understanding the case management process
3. Education and training	8. Funding
4. Policy and procedure development	9. Data
5. Legal hurdles	10. Technology

Expanded Roles of EMS Personnel

The American College of Emergency Physicians (ACEP) acknowledges **expanded scope of practice** programs are being developed in response to community needs. ACEP recognizes that EMS providers are likely to be used in the workforce for these programs. With proper design and medical oversight, ***potential benefits may include improved access to health care in underserved areas, improved patient care, and reduced costs.***



What is Iowa Doing?

- * Created a state taskforce with various stakeholders
- * Quarterly meetings & teleconferences / sub groups
- * Legislative momentum
- * Reimbursement piece is going to be the key
- * Possible pilot study / Grant for 1 or 2 defined communities
- * Goal – Create step-by-step instruction for implementation process for communities across Iowa
- * Recognizing this will look different in every community in Iowa depending on the gap analysis, the unmet needs, etc...

Challenges

- * Internal challenges & external challenges / buy in?
- * Identifying ALL local stakeholders & invite to the table
- * Overcoming turf battles – should be what’s best for the patient and community
- * Regulatory / Payment issues (how to pay for it?)
- * Gray areas – Additional training / Scope of practice
- * Training Programs – Creating a program for CP

How does ObamaCare (ACA) Impact CP?

- * Hospitals are on the hot-seat in regards to their own compliance, especially over medically necessary admissions and readmissions.
- * EMS providers who arrange to visit a patient in the home post-discharge and help with medication, food, social services and follow-up care have been able to reduce readmissions significantly and drive down 9-1-1 calls (a win win for both).
- * Contractual relationship with the hospitals has been demonstrated as a successful model. (Sharing cost savings)

CP/MIHC helps achieve Triple Aim

- * Institute for Healthcare Improvement's (IHI) Triple Aim philosophy:
 - * Improving the patient experience of care
 - * Improving the health of populations
 - * Reducing the per capita cost of healthcare

Summary

- * This concept is a paradigm shift for all healthcare providers.
- * Was conceptually based on using EMS resources to address unmet health services and access needs.
- * CP programs can help reshape the EMS delivery and financing model into community-based mobile healthcare.
- * Need all stakeholders at the table.
- * Expect and prepare for opposition.
- * CP / MIHC will supplement, not replace, services of other healthcare agencies/providers.
- * Will need to pursue legislation in Iowa for reimbursement.
- * CP's will need additional training from training programs.
- * Will need to track metrics, outcomes, and success stories.

Questions?



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community paramedicine

Daily update - October 4, 2015

NEWS

Paramedics make house calls to reduce ER visits
 Citizens Voice
 The house call was part of Geisinger's pilot mobile health paramedic ... The initiative, called **community paramedicine**, also is being done in other parts ...

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Resource	Reduction	Financial Cost	Total Cost Savings
Ambulance	104 Transports	\$448	\$46,592
Emergency Department Visits	104 Visits	\$920	\$95,680
Hospital Stays	60 Days	\$1,650	\$99,000
			\$241, 272

