COMMUNITY PARAMEDICINE
MOBILE INTEGRATED HEALTHCARE
STAKEHOLDERS MEETING
July 18, 2014
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 improved patient outcomes.
WHAT IS COMMUNITY PARAMEDICINE & MOBILE INTEGRATED HEALTHCARE (MIH)

- Expand Role, Not Scope
- Assess and identify gaps between community needs and services
  - Public health
  - Primary care extension
  - Disease management
  - Prevention
  - Wellness
  - Mental health
THE CONCEPT

- Paramedics already know how to deliver care locally
- Assess resources and make decisions
- They can fill gaps in care with enhanced skills through targeted training
KEYS TO COMMUNITY PARAMEDIC PROGRAM

- Resourceful
- Flexible
- Serving the underserved
- Gap-filling
- Identify specific needs in community health care
- Standardized curriculum, modified for communities
ADDRESSING THE NEEDS OF THE UNDERSERVED

- Target populations with problems in access to health care
- Address special population issues
- Rising health disparities
- Aging
- Decreasing medical workforce
ADDRESSING THE NEEDS OF THE UNDERSERVED

Underserved Healthcare Cycle

Decreased Health Status → Lack of Primary Care

Poor Follow-up Care → No Transportation

Poor Care Coordination
- Identifies what is available
- And what is missing
Finds “Health Homes” for citizens
Eyes, ears, and voice of community
Essential oversight by community care providers
Practice where designated underserved
Approved and welcomed
Funding specific to locale
CARING FOR HIGH-RISK PATIENTS

- Patients taking 10 or more medications
- Patients who have tight therapeutic window medications such as “warfarin”
- Patients who have 3 or more chronic diseases
- Patients with mental health and disabling conditions
HOSPITAL PATIENT RE-ADMISSION

- CMS fines hospitals for re-admission of patients within 30 days of discharge
- Community Paramedics providing scheduled follow-up home visits
- Community Paramedics report to primary care professionals
Currently certified as a paramedic
College based, 200 hrs. classroom, 100-200 hrs clinical rotations
Primary Care/Social Services focus
Problem Solving
MINNESOTA COURSE CONTENT

- Chronic disease management
- Cardiac, respiratory, diabetes, neurological
- Pathophysiology
- Pharmacology
- Mental health
- Text books
THE CLINICAL EXPERIENCE

- Primary care
- Community Health/Hospice
- Wound care
- Behavioral
- Cardiology & respiratory
- Pediatrics & geriatrics
- Networking
WHAT’S HAPPENING AROUND THE NATION
NATIONAL ENGAGEMENT WITH CP

- National Association of EMT’s
- National Association of State EMS Officials
- National Association of EMS Physicians
- American College of Emergency Physicians
- National EMS Management Association
- National Association of EMS Educators
- International Academies of Emergency Dispatch
- Association of Critical Care Transport
- North Central EMS Institute
- Paramedic Foundation
- American Ambulance Association
- American Nurses Association
NAEMT joined with 16 other national EMS organizations to collect information about CP/MIHC programs.

3,781 total responses were received – primarily from EMS practitioners, EMS managers, medical directors, and CP/MIHC program administrators.

Total responses were evenly dispersed across all types of EMS delivery models.

Survey results identified 232 unique CP/MIHC programs (6% of responses).

566 respondents (15%) indicated that their EMS agencies were in the process of developing a CP/MIHC program.
### States Reporting CP/MIHC Programs in Place

<table>
<thead>
<tr>
<th>State/Country</th>
<th>Number of Programs</th>
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</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>19</td>
</tr>
<tr>
<td>Texas</td>
<td>15</td>
</tr>
<tr>
<td>Illinois</td>
<td>14</td>
</tr>
<tr>
<td>Virginia</td>
<td>12</td>
</tr>
<tr>
<td>North Carolina</td>
<td>11</td>
</tr>
<tr>
<td>Massachusetts, Pennsylvania</td>
<td>10</td>
</tr>
<tr>
<td>New York</td>
<td>9</td>
</tr>
<tr>
<td>Arizona, Florida, New Jersey</td>
<td>8</td>
</tr>
<tr>
<td>Alabama, Idaho, Minnesota</td>
<td>6</td>
</tr>
<tr>
<td>California, Connecticut, Kentucky, Missouri, New Mexico, Ohio</td>
<td>5</td>
</tr>
<tr>
<td>Colorado, Georgia, Maine, Michigan, Nevada, Oregon</td>
<td>4</td>
</tr>
<tr>
<td>New Hampshire, Oklahoma, Tennessee</td>
<td>3</td>
</tr>
<tr>
<td>Iowa, Louisiana, Maryland, Montana, Puerto Rico, South Carolina, South Dakota, Wisconsin, Wyoming</td>
<td>2</td>
</tr>
<tr>
<td>Alaska, Akansas, District of Columbia, Hawaii, Mississippi, North Dakota, Vermont, Washington</td>
<td>1</td>
</tr>
</tbody>
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Respondents from 44 states, plus the District of Columbia and Puerto Rico, reported programs. (One respondent, representing an ambulance company, indicated programs in multiple states.)
POPULATION DENSITY OF CP/MIHC PROGRAMS

- Urban: 30%
- Suburban: 31%
- Rural: 34%
- Super Rural: 5%
CATALYST FOR STARTING A CP/MIHC PROGRAM

- Gap analysis of health needs: 68%
- Community assessment: 66%
- Other CP programs: 30%
- Other healthcare stakeholders: 20%
- Other: 7%
- Combat repeat users: 1%

Respondents were able to select more than one response, resulting in a percentage total greater than 100%.
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CP/MIHC PROGRAM MODELS

Respondents were able to select more than one response, resulting in a percentage total greater than 100%.
**ORGANIZATIONS PARTNERING IN PROGRAM IMPLEMENTATION**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>83%</td>
</tr>
<tr>
<td>Physician organizations</td>
<td>47%</td>
</tr>
<tr>
<td>Other EMS agencies</td>
<td>45%</td>
</tr>
<tr>
<td>Public health agencies</td>
<td>42%</td>
</tr>
<tr>
<td>Home health organizations</td>
<td>42%</td>
</tr>
<tr>
<td>Primary care facilities</td>
<td>40%</td>
</tr>
<tr>
<td>Law enforcement agencies</td>
<td>31%</td>
</tr>
<tr>
<td>Mental health care facilities</td>
<td>27%</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>25%</td>
</tr>
<tr>
<td>None</td>
<td>6%</td>
</tr>
</tbody>
</table>

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### TYPES OF PROGRAM COLLABORATION WITH PARTNERS

<table>
<thead>
<tr>
<th>Type of Collaboration</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Provides patient care</td>
<td>72%</td>
</tr>
<tr>
<td>Coordinates patient services</td>
<td>69%</td>
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<tr>
<td>Provides personnel</td>
<td>44%</td>
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<tr>
<td>Provides oversight</td>
<td>24%</td>
</tr>
<tr>
<td>Provides funding</td>
<td>7%</td>
</tr>
</tbody>
</table>

Respondents were able to select more than one response, resulting in a percentage total greater than 100%.
Across all population densities, the “Frequent EMS User” was selected as the most common program model.

“Primary care/physician extender” was selected as the second-most common model for programs in super rural areas.

“Readmission avoidance” was selected as the second-most common model for programs in rural, suburban and urban areas.
State legislation in 2011 to allow for Community Paramedics to function
Created training requirements
Followed several years of study and discussion with various groups of health care stakeholders
Several programs now functioning
Underserved, hospital re-admission, frequent EMS/ED users
State Legislation in 2012 authorized Medicaid payment
MedStar – since 2009
Using existing resources
Nationally acclaimed
Collaborative with other area health care stakeholders
Services include, hospital re-admission, hospice, home health care back-up, cardiology patient visits
Use of triage nurse
Revenue covering cost of services
Proposed Legislation in draft form

Western Eagle County Colorado

• Early proponent (2009)
• Rural/Wilderness
• No Hospital in County
• Limited Primary Care Services in the Community; none after hours
• National Model of Expanded Services to fill gap of Primary Care Services
- Legislation in 2012 to allow for Community Paramedic
- Private firm in Omaha area providing CP services
- Scottsbluff has a pilot CP program focused on Pneumonia and CHF patients following hospital discharge
2013 appropriation of $276,000 for pilot study

Funds to hire staff to initiate pilot and to gather data on results

Focus on rural shortage of primary care health providers & hospital re-admission issues
Legislation passed in 2013 to allow for Community Paramedic
Grants to support pilot programs
Pilot projects in up to 12 communities
First Community Paramedic training program in the fall of 2013
Legislation passed in 2013

Regulations in draft form to define minimum training requirement

Two programs currently operating in St Louis area focused on hospital patient readmission, have reimbursement associated with this from hospitals

Kansas City region in early planning stage

Springfield area …two hospital based services providing some C.P. services
THE GROWING KANSAS IDEA
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- KEMSA offering forums around Kansas for EMS personnel and local health care providers
- Gathering of data
- Areas in early planning stage
- Kansas City Area
- Sedgwick County
- Others?
1/4 of Americans live in rural and remote areas
1/3 of Kansans live in rural areas
Only 10% of America’s doctors practice in rural areas
4 times as many rural and remote residents travel > 30 miles for health care compared to urban residents
More elderly
More immigrants
More poverty
Poorer health
KANSAS RURAL HEALTH CARE

- Shortage of primary care professionals in rural areas
- Funding shortfalls
- Access to care
- Hospital Discharge
  - Re-Admission Problems
PRIMARY CARE
HEALTH PROFESSIONAL UNDERSERVED AREAS REPORT
Kansas 2014

Kansas Department of Health and Environment
Bureau of Community Health Systems
Kansas Primary Care Office
GOVERNOR-DESIGNATED MEDICALLY UNDERSERVED AREAS
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Community Health Systems

Use only for the establishment or continued operation of Rural Health Clinics (RHCs)

* The values in each county represent the total primary care physician FTEs for that county based on 2012 data.

- Not eligible for certification as a Governor-Designated Medically Underserved Area
- Governor-Designated Medically Underserved Area Ratio equal to or greater than 2,695 persons per primary care physician
HUG’S
HIGH UTILIZER GROUPS

Top 50 Super Users  1470  2.53%
2013 Total Responses  58046  100.00%
WHAT OTHER NEEDS ARE IN KANSAS?
KEMSA was formed in 1996 and is a non-profit organization dedicated to the improvement of EMS in Kansas. KEMSA has members throughout Kansas and in surrounding states at every level of EMS.

Our Mission: To be a unified voice for interested entities dedicated to continued improvement of the total emergency medical service system throughout Kansas.

Our goals include:
• Providing a Unified Voice
• Promoting Education
• High Standards
• Quality Patient Care
• Forums for EMS
• Communication
Credit to Minnesota Community Paramedic leadership & NAEMT who allowed KEMSA to use some stock material for this presentation.