PATIENTS DISCHARGED FROM THE EMERGENCY DEPARTMENT LESS THAN 4 HOURS

Arizona Hospital Discharge Database (2011)

Vatsal Chikani, MPH
Rogelio Martinez, MPH
Data & Quality Assurance Section
Gender

- Female: 55.20%
- Male: 44.70%
- Unknown: 0.00%
Age of patients in ED ≤ 4 hours

- <15: 25%
- 15-19: 5%
- 20-44: 40%
- 45-64: 15%
- 65+: 10%

n = 1,477,200
Race-Ethnicity (for state)

- White: 59%
- Hispanic: 28%
- American Indian: 4%
- African American: 3%
- Asian: 6%

n = 6,438,178
Race-Ethnicity (ED ≤ 4 hours)

- White: 58%
- Hispanic: 29%
- American Indian: 7%
- African American: 4%
- Asian: 1%
- Refused: 1%
- Multiracial: 0%

n = 1,473,625
Payer Sources

- **37%** - Private Insurance
- **26%** - AHCCCS/Medicaid
- **16%** - Medicare
- **15%** - Self pay
- **5%** - Workers Compensation
- **1%** - Other

Health and Wellness for all Arizonans
## ED Visits by Principal Diagnosis

<table>
<thead>
<tr>
<th>Principal Diagnosis</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other upper respiratory infections</td>
<td>90,798</td>
</tr>
<tr>
<td>Sprain</td>
<td>77,077</td>
</tr>
<tr>
<td>Superfic injuries</td>
<td>75,676</td>
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<tr>
<td>Abdominal pain</td>
<td>71,353</td>
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<tr>
<td><strong>Back problem</strong></td>
<td><strong>49,903</strong></td>
</tr>
<tr>
<td>Other injury</td>
<td>48,548</td>
</tr>
<tr>
<td>Open wound extremity</td>
<td>41,930</td>
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<tr>
<td>Headache/Migraine</td>
<td>41,758</td>
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<tr>
<td>Skin infection</td>
<td>39,096</td>
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<tr>
<td><strong>Urinary Tract Infection</strong></td>
<td><strong>38,819</strong></td>
</tr>
<tr>
<td>Open wound head</td>
<td>34,067</td>
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<tr>
<td>Chest pain</td>
<td>33,695</td>
</tr>
<tr>
<td>Otitis media</td>
<td>31,759</td>
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<tr>
<td>Nausea vomiting</td>
<td>29,459</td>
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<tr>
<td>Other connective tissue</td>
<td>28,338</td>
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<tr>
<td>Teeth diagnosis</td>
<td>28,318</td>
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<tr>
<td>Other lower respiratory</td>
<td>26,349</td>
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<tr>
<td>PRINCIPAL DIAGNOSIS</td>
<td>NUMBER OF PATIENTS</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Other joint diagnosis</td>
<td>25,547</td>
</tr>
<tr>
<td>Other nervous diagnosis</td>
<td>24,661</td>
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<tr>
<td>Fracture arm</td>
<td>23,899</td>
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<tr>
<td>Fever unknown origin</td>
<td>22,752</td>
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<tr>
<td>Asthma</td>
<td>22,688</td>
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<tr>
<td>Other GI diagnosis</td>
<td>22,147</td>
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<tr>
<td>Allergy</td>
<td>21,932</td>
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<tr>
<td>Bronchitis</td>
<td>21,587</td>
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<tr>
<td>Other pregnancy complications</td>
<td>21,055</td>
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<tr>
<td>COPD</td>
<td>19,457</td>
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<tr>
<td>Viral infection</td>
<td>18,360</td>
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<td>Other aftercare</td>
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<td>Urinary stone</td>
<td>14,275</td>
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<tr>
<td>Dizziness</td>
<td>13,692</td>
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<tr>
<td>Pneumonia</td>
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<tr>
<td>Other skin diagnosis</td>
<td>13,543</td>
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<tr>
<td>Other upper respiratory</td>
<td>13,437</td>
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<tr>
<td><strong>Anxiety disorders</strong></td>
<td><strong>13,340</strong></td>
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<tr>
<td>Gastroenteritis</td>
<td>12,606</td>
</tr>
<tr>
<td>PRINCIPAL DIAGNOSIS</td>
<td>NUMBER OF PATIENTS</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Eye infection</td>
<td>12,442</td>
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<tr>
<td>Other genitourinary diagnosis</td>
<td>11,502</td>
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<tr>
<td>Dysrhythmia</td>
<td>11,438</td>
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<tr>
<td>Unclassified</td>
<td>11,432</td>
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<tr>
<td>Fracture leg</td>
<td>11,105</td>
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<tr>
<td>Epilepsy/cnv</td>
<td>10,234</td>
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<tr>
<td>Syncope</td>
<td>10,097</td>
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<tr>
<td><strong>Hypertension</strong></td>
<td><strong>9,945</strong></td>
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<tr>
<td>Other ear diagnosis</td>
<td>9,587</td>
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<tr>
<td>Fluid electrolyte diagnosis</td>
<td>8,719</td>
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<tr>
<td><strong>Social admin</strong></td>
<td><strong>8,633</strong></td>
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<tr>
<td>Hemorrhage pregnancy</td>
<td>7,827</td>
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<tr>
<td>Intracranial injury</td>
<td>7,696</td>
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<tr>
<td>Joint injury</td>
<td>7,401</td>
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<tr>
<td>Poison nonmed</td>
<td>7,213</td>
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<tr>
<td>Other female gen</td>
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<tr>
<td>Alcohol-related disorders</td>
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<td>Gastritis</td>
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<tr>
<td>Complication proc</td>
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<tr>
<td>PRINCIPAL DIAGNOSIS</td>
<td>NUMBER OF PATIENTS</td>
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<td>----------------------------------------</td>
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</tr>
<tr>
<td>Burns</td>
<td>5,622</td>
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<tr>
<td>Substance-related disorders</td>
<td>5,375</td>
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<tr>
<td>Fatigue</td>
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<td>Other eye diagnosis</td>
<td>4,343</td>
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<tr>
<td>Other fracture</td>
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<tr>
<td>Tonsillitis</td>
<td>4,204</td>
</tr>
<tr>
<td>Menstrual diagnosis</td>
<td>4,103</td>
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<tr>
<td>Biliary diagnosis</td>
<td>4,100</td>
</tr>
<tr>
<td>Pelvic Inflammatory Disease</td>
<td>3,991</td>
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<tr>
<td>GI hemorrhag</td>
<td>3,798</td>
</tr>
<tr>
<td>Influenza</td>
<td>3,723</td>
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<tr>
<td>Mouth diagnosis</td>
<td>3,670</td>
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<tr>
<td><strong>Diabetes Mellitus no complications</strong></td>
<td><strong>3,627</strong></td>
</tr>
<tr>
<td>Mycoses</td>
<td>3,608</td>
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<tr>
<td>Esophgeal diagnosis</td>
<td>3,463</td>
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<tr>
<td>Ovarian cyst</td>
<td>3,372</td>
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<tr>
<td>Poison other med</td>
<td>3,098</td>
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<td>Other perint diagnosis</td>
<td>3,074</td>
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<tr>
<td>Infection male gen</td>
<td>2,998</td>
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<tr>
<td>PRINCIPAL DIAGNOSIS</td>
<td>NUMBER OF PATIENTS</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Fracture skull face</td>
<td>2,916</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>2,896</td>
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<tr>
<td>Other male gen</td>
<td>2,871</td>
</tr>
<tr>
<td>Complic devi</td>
<td>2,869</td>
</tr>
<tr>
<td>Other screen</td>
<td>2,801</td>
</tr>
<tr>
<td><strong>Diabetes Mellitus with complications</strong></td>
<td><strong>2,653</strong></td>
</tr>
</tbody>
</table>
Health and Wellness for all Arizonans

AZ-PIERS
(Arizona Prehospital Information & EMS Registry System)

• Three essential factors in Community Integrated Paramedicine:
  – Data collection
  – Data analysis
  – Benchmarks/Quality Assurance
Future Steps

• Additional system analysis across the state

• Consider various data collection resources (AZ-PIERS, Hospital Discharge Database)

• Please let us know if you have any questions/feedback as you go through your CIP
Health and Wellness for all Arizonans

Pre-Injury
- Data Collection
- Communications Infrastructure
  - 911 training policies
  - Resource allocation, direction and guidance

Pre-hospital
- EMS Infrastructure
  - Protocols
  - Medical Direction
  - Triage and transport guidelines

Hospitalization
- Hospital infrastructure
  - Policies
  - Resources
  - Triage and transport
  - CQI, MM reviews, outreach

Post-Acute Care
- Rehabilitation plans
- Community reintegration

Quality Assurance

Additional Data Sources:
- Transportation
- Vital Statistics
- Economic
- Geographical
Thank You

Questions?
ARIZONA IMMUNIZATION PROGRAM OFFICE (AIPO)

Brenda Jones, RN, BSN, MA, AzCSN
Immunization Services Manager
What is AIPO?

- AIPO is the Arizona Immunization Program Office
  - Under Bureau of Epidemiology and Disease Control, ADHS
- Funded by the Centers for Disease Control and Prevention
- Leads public health immunization efforts in the state
  - Prepare for and respond to Public Health Emergencies
  - Provide a Safety Net of Services and Community Support
  - Promote Healthy and Safe Community Environments
What Does AIPO Do?

• Vaccines for Children (VFC)
• County/Partner Collaboration
• School and Childcare Assessments
• Health Education
• Special Programs - Hepatitis B
• ASIIS
How can AIPO Assist CIP?

- Vaccines for Children (VFC)
What is Vaccines For Children (VFC)?

• A federal program that offers all ACIP (Advisory Committee on Immunization Practices for the CDC) recommended vaccines at no cost for eligible children through VFC enrolled providers

• **FY 2013: Arizona**
  – Vaccine Doses Distributed: 1,527,216
  – Vaccine Dollars Spent: $78,987,031.15

• **Number of Arizona VFC Providers:** 879

• Arizona’s Choice State-providers may choose which vaccines they want to give
Immunization Schedules

• ACIP provides general recommendations on childhood, adolescent, adult and catch-up vaccination schedules

• Also provides recommendations for
  – Health-care Personnel
  – Travel vaccinations
  – Pregnant Women

• Complete list of ACIP recommendations are published in the MMWR

• Schedules available on CDC website at www.cdc.gov/vaccines/schedules/index/html
How Does this Help CIP?

• Refer patients to their PCP for proper/recommended immunizations
• Refer to CHDs if they don’t have a PCP or don’t have insurance
• FDs can become VFC providers and provide immunizations
How can AIPO Assist CIP?

- Vaccines for Children (VFC)
- Education Information & Resources
What kind of Education Information and Resources are available?

• CDC Website: [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines)
  – Schedules available on CDC website [www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html)

• AIPO Website: [http://azdhs.gov/phs/immunizations](http://azdhs.gov/phs/immunizations)
Available Education Information/Resources (Cont.)

• TAPI Website: www.whyimmunize.org

• Immunization Action Coalition Website: www.immunize.org

• Various flyers/brochures for handing out to patients

• Annual Arizona Immunization Conference
  – Held in April
  – April 23-24, 2014
How can AIPO Assist CIP?

• Vaccines for Children (VFC)
• Education Information & Resources
• ASIIS
What is the Arizona State Immunization Information System (ASIIS)?

- Created in 1994, the Arizona State Immunization Information System collects, stores, analyzes, releases and reports immunization data and serves as a record keeping system for all children who receive immunizations in Arizona.

- Over 2500 providers enrolled

- Approximately 5 million children and adults in the system

- 57,693,970 vaccines/doses administered/doses (Jan 1, 1998-now)
How can AIPO Assist CIP?

• Become an ASIIS user and look up/view immunization data in ASIIS
• If you are a VFC provider/immunizer, you can both view and enter immunization data
• We provider outreach and training
  – ASIIS hotline available Monday-Friday 8-5 pm to answer and assist any questions or concerns
  – Training for new and existing ASIIS users on the ASIIS homepage. Users have 24 hour access to on-line training modules that they can review as many times as they need
  – In- person trainings at selected sites coming the summer of 2014
How can AIPO Assist CIP?

- Vaccines for Children (VFC)
- Education Information & Resources
- ASIIS
- Technical Support
We can Provide Technical Support

• Call the ASIIS hotline with data entry questions
• Call our nurses for specific immunization questions
  – Schedule intervals
  – Appropriate use of vaccines
  – ACIP recommendations
Thank You

Questions?
Focus Panel 7
COMMUNITY STANDARD PROTOCOLS & COMMUNITY INTEGRATED PARAMEDICINE

Jennifer Kline
American Medical Response
Protocol Development

• Our committee consists of various constituents from across the state of Arizona.
  – Jennifer Kline
  – Donna Collister
  – Sue Kern
  – Bill Johnston
  – Val Gale
  – Phil Paine
  – Steve Duncan
  – Alan Romania
Protocol Development

• The focus of this panel is to:
  – Promote the use of scientific knowledge in decision making.
  – Building constituencies.
  – Identifying needs and setting priorities.
  – Gaining legislative authority and funding.

• Develop plans and policies to address the needs and ensuring the public’s health and safety.
Protocol Development

Objective 1:
Implement an oversight committee for each CIP program in which it would incorporate several members from the “integrated team” within the community to allow for an unbiased evaluation of the effectiveness of the program.
Protocol Development

Objective 2:
Implement procedures for admission and withdrawal criteria in the CIP program.
Protocol Development

Objective 3:
Implement standards protocols or guidelines for all components of the CIP program.
Thank You

Questions?
Focus Panel 8

TECHNOLOGIES/TELEMEDICINE & COMMUNITY INTEGRATED PARAMEDICINE

Charlie Smith
Lifestar Ambulance
CIP Technology Focus Group

• The Technology Focus Group includes:
  – Charlie Smith
  – Mark Venuti
  – Jennifer Kline
  – Marc Chambers
  – Val Gale

• Our Focus Group was challenged with researching the roles technology will play in Community Integrated Paramedicine
Information Collection/Sharing:

- Electronic Patient Care Record (ePCR)
- Electronic Medical Record (EMR)
- Health Information Exchange (HIE)
• Tele-Medicine
  – Video Sharing
  – Audio Sharing
Thank You

Questions?
Focus Panel 9

AFFORDABLE CARE ACT AND FINANCIAL OPPORTUNITIES &
COMMUNITY INTEGRATED PARAMEDICINE

Cathy R. Eden
Arizona State University
CIP ACA & Financial Ops. Focus Group

• Focus Group includes:
  – Cort Ashbury
  – Mary Cameli
  – Jeff Clark
  – Cathy R. Eden
  – Charlie Smith
  – John Tomazin
The Affordable Care Act is here and going - no looking back

• Cathy R. Eden
  – V.P. Director Community Based EMS
How does the ACA affect “out-of-hospital care”?

• Changing Insurance World
• Health Care Systems Integration
• What is an ACO and Patient Medical Home?
• Cost Recovery – We Need DHS Help
• Possibilities
Thank You

Questions?

Any questions for committee send to cathy@ramseyfoundation.org
Focus Panel 10

REIMBURSEMENT & COMMUNITY INTEGRATED PARAMEDICINE

Les Caid, Fire Chief
Rio Rico Fire District
Report in Forbes Magazine: The Organization for Economic Development (OECD)

U.S. spends $7,960 per person on health care every year!

This compares to the average OECD country which spends $3,233 per person annually for health care.

- These other 34 countries are not third world countries - “they are mostly places you would be happy visiting.”

Taxpayers already pay $3,660 per person of the $7,960 annual bill for health care.
A Really GOOD Idea: PREVENTION

Return on Investment

According to the Robert Wood Johnson Foundation

For every $1 spent on prevention the return will be 10 times.
How Minnesota Got Its Community Medics Paid

by John Erich
Created: May 1, 2013

• A bill passed last year in the Minnesota legislature established reimbursement through the state’s Medicaid program for a range of common CP-style activities.

• And with a final blessing in February from the federal Centers for Medicare & Medicaid Services (CMS), those first community medics to hit the streets can now get paid by the state for the care they’re providing.
• Covered activities include health assessments, immunizations and vaccinations, chronic disease monitoring and education, collection of lab specimens, medication compliance checks, hospital discharge follow-up care and minor medical procedures approved by a medical director.
What is a CIP?

- Minnesota’s efforts to realize community paramedics go back 16 years (they have a template)
- Target Population
- High risk for medical recall (re-admission)
- Multiple Chronic Diseases
• They broadly shared the first bill language they drafted before the 2011 legislative session with other healthcare system players, including groups they saw as potential adversaries.

• They worked to dialogue with those groups about concerns, address their issues and refine the bill’s language.

• This tempered any surprise that might have greeted its introduction and ultimately resulted in legislation that was stronger and more broadly palatable.
Minnetonka, Minnesota
(Star Tribune March 31, 2014)

“Pilot program sends firefighters to homes for patient check-ins”

The program, called the post-discharge firefighter visit, also adds to the health care duties of fire departments that have fewer fires to fight.
At the Legislature, a bill has been introduced that would establish certification for community emergency medical technicians who would work with patients in the 72 hours after hospital discharge. It also would allow state reimbursement for those services under Medicaid.

“If we keep the patient out of the hospital for 30 days, it’s win-win.”
STEP # 1
WHAT is a Community Integrated Paramedic?

Step 1 – Challenges

How do we create what this elephant looks like?
STEP # 1

WHAT is a Community Integrated Paramedic?

• Community strengths and needs drive the process.

Reimbursement if locally driven!
Partnerships must be formed!
This program must be recognized as a part of a coordinated team of healthcare providers.
Community Paramedic ®

• The Community Paramedic Program adapts to the specific needs and resources of each community. It will succeed through the combined efforts of those that have a stake in maintaining the health and well-being of its residents.
STEP # 2
Long Range Vision

• Define Community Integrated Paramedics in Law.

• Work with State to Identify Services to be covered by Medicaid.

• Developed a Fee Schedule.
Next steps
How do we get there from here?
How do we get there from here?

Community Integrated Paramedic

Define
What a CIP is

Identify
Legislative
Stakeholders

Build
Strategic
Partnerships
Thank You

Questions?
Focus Panel 11
RESOURCES/EXAMPLES & COMMUNITY INTEGRATED PARAMEDICINE

Mark Venuti
Guardian Medical Transport
Identify the Gaps

- Between In Hospital Care and Routine Out-Of-Hospital Care (personal healthcare provider, home healthcare, outpatient services etc.)

- The gap:
  
  • Frequent Flyers (0-3 hours post-discharge and system abusers or misusers).

  • Depending on the healthcare system, appears to be the first 36 hours after the patient is released from the hospital. (could be anywhere from 24 – 72 hours.)
EXAMPLES

Where do I look for information?

Who is already doing this?

Ramsey Foundation
FD CARES
MedStar's Community Health
Program
ADHS CIP
And more....
What Do I Need To Do This?

Patient Sources
- Hospital Systems
- Hospital Discharge Planners
- Primary Care Providers
- Frequent Flyers
- ACO’s

Data
- Patient Types
- Anticipated Volume
- Resource Impact/Utilization
- Patient Outcomes
- Economic Impact

Desired Outcome
- Treat and Stay Home
- Treat and Refer
- Treat and Transport only when necessary

Personnel
- Administrative
- Medical Direction
  - Protocols
  - Intermediary
  - Alternative Disposition
- Technical
  - Paramedics
    - Patient Advocate
    - Provide Service
    - Uses Persuasion
    - Not Power
    - Educational needs

Equipment
- Apparatus
  - First Response Equipment
- Technological
  - GIS
  - Telemed
  - Data Sharing
  - Data Exchange
- Additional Equipment
  - Draw Blood
  - On-Site Labs

Communications System
- Emergent Dispatch
  - Expanded Protocols
  - Hot Line/Referrals
- Non-Emergency Dispatch
  - Expanded Protocols
  - Hot Line/Referrals
- Real-time communications
  - PCP
  - Medical Director
  - Pharmacists
  - Specialists
- Ability to exchange patient information
  - Patient demographics
  - Patient history
  - PCP

Health and Wellness for all Arizonans
What Do I Need To Do This?

**Patient Sources**
- Hospital Systems
- Hospital Discharge Planners
- Primary Care Providers
- Frequent Flyers
- ACO’s

**Data**
- Patient Types
- Anticipated Volume
- Resource Impact/Utilization
- Patient Outcomes
- Economic Impact

**Desired Outcome**
- Treat and Stay Home
- Treat and Refer
- Treat and Transport only when necessary
What Do I Need To Do This?

Personnel
- Administrative
  - Medical Direction
    - Protocols
    - Intermediary
    - Alternative Disposition
- Technical
  - Paramedics
    - Patient Advocate
    - Provide Service
    - Uses Persuasion Not Power
    - Educational needs

Equipment
- Apparatus
  - First Response Equipment
  - Technological
    - GIS
    - Telemed
    - Data Sharing
    - Data Exchange
- Additional Equipment
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Communications System
- Emergent Dispatch
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  - Expanded Protocols
  - Hot Line/Referrals
- Real-time communications
  - PCP
  - Medical Director
  - Pharmacists
  - Specialists
- Ability to exchange patient information
  - Patient demographics
  - Patient history
  - PCP
Thank You

Questions?
Focus Panel 12
MEDICAL DIRECTION & COMMUNITY INTEGRATED PARAMEDICINE
Franco Castro-Marin
Scottsdale Fire Department
Guiding Principles

• MIHP/CP, like tradition EMS, is a DELEGATED practice of medicine
• Providers are extension of Medical Director physician
• Service exposes physician to more risk
Guiding Principles

• Program success proportionate to level of Medical Director involvement

• Medical direction must be meticulous, comprehensive, intensive, personal – provided by experts

• Requires time, resources, institutional support, aligned philosophies
Guiding Principles

- This is a clinical practice of medicine
- Fair remuneration for quality service
- High quality medical direction yields high quality results and is cost-effective
- “A vision without resources is a delusion.”
Realities

• New service line
• Add to existing EMS and clinical responsibilities
• Mission creep risks quality degradation, project failure
• Most Medical Directors part-time, volunteer, or hospital-based, not agency-based
• Paradox: the smaller the operation, the more likely the need for quality leadership?
## Objectives

### Objective 13.1:

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<th>Measure(s)</th>
<th>Lead</th>
<th>Partners</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaffirm that CIP/MIHP, as a prehospital service that runs parallel to EMS, is a practice of medicine delegated by EMS Medical Directors. As such, agencies that offer such services must do so with a Medical Director in place for meticulous system oversight.</td>
<td>- Arizona Administrative Code and Statutory language should be written to memorialize and support this concept. - Medical director contracts/job descriptions should be amended to include new scope of practice and duties</td>
<td>Sponsoring legislators</td>
<td>- AZDHS - EMS Medical Directors - Lawmakers - EMS agencies</td>
<td>1-2 years</td>
</tr>
</tbody>
</table>

### Objective 13.2:

<table>
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<th>Measure(s)</th>
<th>Lead</th>
<th>Partners</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritize the exploration of mechanisms for sustainable reimbursement for medical directors tasked with CIP/MIHP program oversight and assumption of risk, as well as program exploration, design, and implementation.</td>
<td>- Arizona Administrative Code and Statutory language should be written to memorialize and support this concept. - Agencies or governments that contract with EMS physicians would ensure fair reimbursement at current emergency physician clinical rates with hours sufficient and appropriate for the scope of work.</td>
<td>Sponsoring legislators</td>
<td>- AZDHS - EMS Medical Directors - Lawmakers - EMS agencies</td>
<td>1-2 years</td>
</tr>
</tbody>
</table>

### Objective 13.3:

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<tr>
<th>Strategy</th>
<th>Measure(s)</th>
<th>Lead</th>
<th>Partners</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist local governments to craft supportive law (eg, city ordinances) that establishes mechanisms to manage special populations such as chronic inebriates and healthcare super-utilizers</td>
<td>- Effective interface between Medical Directors, hospital/case management/mental health networks, and local governments. - “Loyalty Programs” with ability to track cost savings and outcomes of “program graduates.” - Universal EHR access for CIP/MIHP personnel</td>
<td>EMS Medical Directors</td>
<td>- Hospitals - Mental Health - Substance Abuse Centers - Local governments</td>
<td>1-2 years</td>
</tr>
</tbody>
</table>
Thank You

Questions?
Focus Panel 13
LEGISLATION/REGULATIONS
&
COMMUNITY INTEGRATED PARAMEDICINE

John Karolzak
Rural Metro
CIP Legislation/Regulations Focus Group

• The Legislation/Regulations Focus Group includes:
  – John Karolzak
  – Mark Venuti
  – Charlie Smith
  – Randy Karrer

• Our Focus Group was charged with the review of current EMS and Ambulance Statutes and Rules to ascertain the need for any future legislation to allow the CIP program to flourish in Arizona.
Discussion Points

- How does ACA affect “Current EMS Legislation”
- Review of current EMS legislation
- Review of current Ambulance transportation legislation
- Does anything prohibit the various patient outcomes involved in CIP
- What is needed in Statute or Rules for transport revenue recovery for alternate destinations and means
Current EMS Statutes

• There are no Statutes or Rules prohibiting EMS providers from embracing and participating in the CIP program.

• Ambulance and EMS statutes have specific language concerning alternate transportation and destinations.

The statute that allows “refer and advise” by EMCT’s that work for other than ambulance services, and that allows “refer and advise” whether or not the person has accessed our services through 911 or not, is 36-2205(D) and 36-2205(E).
§ 36-401(A)20. "Health care institution" means every place, institution, building or agency, whether organized for profit or not, that provides facilities with medical services, nursing services, health screening services, other health-related services, supervisory care services, personal care services or directed care services and includes home health agencies as defined in section 36-151, outdoor behavioral health care programs and hospice service agencies.
Current Ambulance Statutes

Arizona Revised Statutes Title 36, Chapter 21.1, Art. 2

§ 36-2232(F) In consultation with the medical director of the emergency medical services and trauma system, the emergency medical services council and the medical direction commission, the director of the department of health services shall establish protocols for ambulance services to refer and advise a patient or transport a patient by the most appropriate means to the most appropriate provider of medical services based on the patient's condition. The protocols shall include triage and treatment protocols that allow all classifications of emergency medical care technicians responding to a person who has accessed 911, or a similar public dispatch number, for a condition that does not pose an immediate threat to life or limb to refer and advise a patient or transport a patient to the most appropriate health care institution as defined in section 36-401 based on the patient's condition, taking into consideration factors including patient choice, the patient's health care provider, specialized health care facilities and local protocols.
36-2205. Permitted treatment and medication; certification requirement; protocols

A. The director, in consultation with the medical director of the emergency medical services and trauma system, the emergency medical services council and the medical direction commission, shall establish protocols, which may include training criteria, governing the medical treatments, procedures, medications and techniques that may be administered or performed by each classification of emergency medical care technician. These protocols shall consider the differences in treatments and procedures for regional, urban, rural and wilderness areas and shall require that emergency medical care technicians authorized to perform advanced life support procedures render these treatments, procedures, medications or techniques only under the direction of a physician.

B. The protocols adopted by the director pursuant to this section are exempt from title 41, chapter 6.
36-2205. Permitted treatment and medication; certification requirement; protocol

C. Notwithstanding subsection B of this section, a person may petition the director, pursuant to section 41-1033, to amend a protocol adopted by the director.

D. In consultation with the medical director of the emergency medical services and trauma system, the emergency medical services council and the medical direction commission, the director shall establish protocols for emergency medical providers to refer and advise a patient or transport a patient by the most appropriate means to the most appropriate provider of medical services based on the patient's condition. The protocols shall consider the differences in treatments and procedures for regional, urban, rural and wilderness areas and shall require that emergency medical care technicians authorized to perform advanced life support procedures render these treatments, procedures, medications or techniques only under the direction of a physician.
36-2205. Permitted treatment and medication; certification requirement; protocol

E. The protocols established pursuant to subsection D of this section shall include triage and treatment protocols that allow all classifications of emergency medical care technicians responding to a person who has accessed 911, or a similar public dispatch number, for a condition that does not pose an immediate threat to life or limb to refer and advise a patient or transport a patient to the most appropriate health care institution, as defined in section 36-401, based on the patient's condition, taking into consideration factors including patient choice, the patient's health care provider, specialized health care facilities and local protocols.
Thank You

Questions?

Please send any questions for committee send to:
john.karolzak@rmetro.com
ENDING

April 15, 2014

Focus Panel Presentations