COMMUNITY INTEGRATED PARAMEDICINE WORKGROUP

FOCUS PANEL PRESENTATIONS

February 20, 2014

Arizona Department of Health Services

Health and Wellness for all Arizonans

Focus Panel 1

DATA COLLECTION, MEASUREMENT & EVALUATION & COMMUNITY INTEGRATED PARAMEDICINE

Sean Culliney, MPH, CEP
Northwest Fire District

"Data is a lot like garbage. You have to know what you are going to do with the stuff BEFORE you start collecting it."

- Unknown

Evaluation (Defined)

The use of various methods to monitor outcomes *and* the application of some set of values to determine the worth of these outcomes to some person, group or society as a whole

(Dunn, 2008)

Critical Thought from the Health Resource and Services Administration

- It is important to remember that the intent of the [evaluation] tool is to allow an individual community paramedicine program to identify its own strengths and weaknesses, prioritize activities, and measure progress against itself over time.
- Additionally, the [evaluation] tool is seen as a planning document that can assist developing programs.
- The [evaluation] tool is not intended to measure one community paramedicine program against another.

Evaluation 101 – The Basics

Criteria for evaluation

- Effectiveness
- Efficiency
- Adequacy
- Equity
- Responsiveness
- Appropriateness

Terminology

- Clearly defined
  - Internal
  - External
- Common language across community partners

Mission Statements

- State what is being addressed
- Define the problem

Establish an Action Plan

- What are the objectives

Target Goals

- Assemble evidence
- Construct alternatives
- Select criteria
- Project the outcomes

Measurement

- What's the measurement tool
  - Validated?
  - Established vital statistics?
  - Internally developed
    - Bias?
- Commonly used evaluative criteria

Benchmark

- Review available literature
- Survey best practices
- Consider alternatives
- Start comprehensive, end focused

Integration

- Current operations
  - Impacts
    - Mission drift
- Additional workforce
  - Levels of training
  - Creation of silos

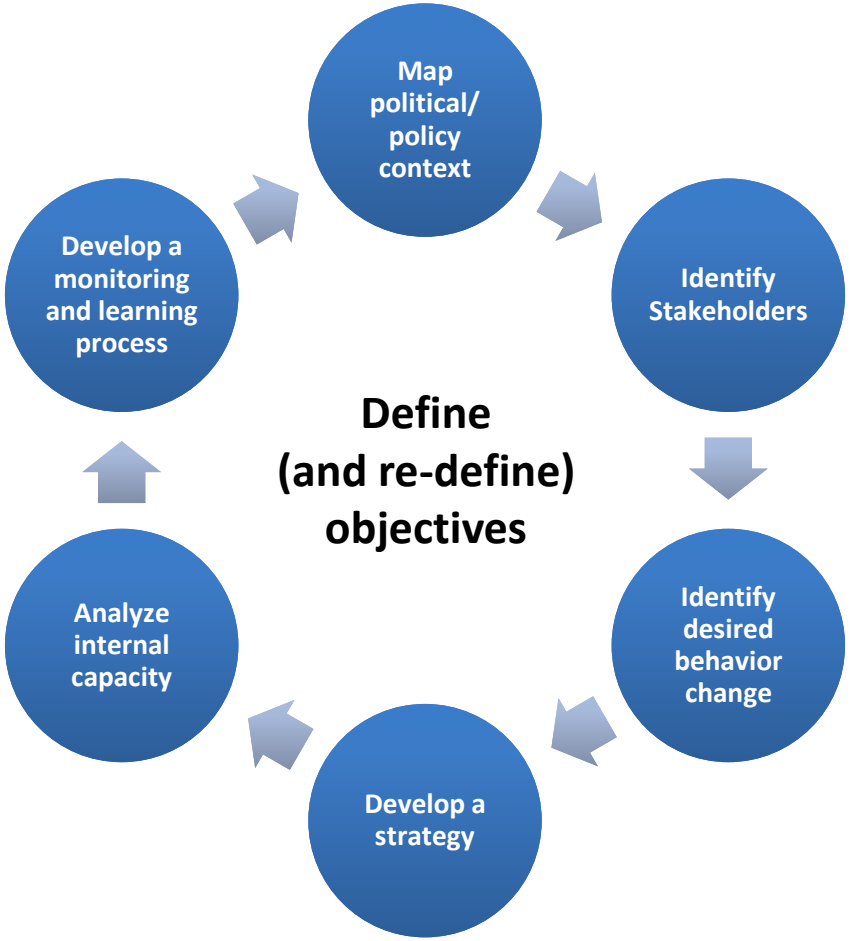
Per Unit of Service Delivered ED Utilization Rate

- Physician Groups
- Hospitals
- Mental Health
- County Health Departments

Evaluation Models

- **Non-linear**
- **Able to handle complex outcomes**
- **Currently there is little/no evidence based data**
- **Un-intended externalities**

RAPID Outcome Mapping Approach (ROMA)



Map political/policy context

- Drivers for change
  - Financial
  - Social
  - Political
- SWOT analysis

Identify Key Stakeholders

- Advocates
- Neutral
- Opposing

Identify Desired Behavior Change(s)

- Benchmarks
- Progress Markers

Develop a Strategy

- Advocacy
- Innovation
- Implementation
- Model the system for the specific community
- Change behaviors, target largest opposition, utilize largest advocates
- Project possible outcomes
  - Outcomes matrix
- Consider alternatives early

Analyze Internal capacity to effect change (Ensure the engagement team has the needed skills)

- Engagement team SWOT
- Competencies
- Framework
- Support
- Processes flows

Develop a Monitoring and Learning System

- Track progress
- Make adjustments
- Assess effectiveness
- Review all other steps for relevance
- Robustness and improvability

Share

- Develop best practices
- Identify urban vs. rural strategies
- Successes
- Challenges
- Improve the overall state system

Basic Performance Indicators

- Minimize impact to primary mission
- Documented Community Assessment
  - Identified gaps
- Health record produced and maintained for each patient contact
- Utilize existing partner benchmarks (County Health Stats, re-admittance rates, etc.)
- Align with Healthy People 2020
  - http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx

References

- ***Community Paramedicine Evaluation Tool*, U.S. Department of Health and Human Services (2012), Health Resources and Services Administration, Office of Rural Health Policy, Rockville, MD 20857**

  – http://www.hrsa.gov/ruralhealth

- ***Helping researchers become policy entrepreneurs: How to develop engagement strategies for evidence-based policy-making,* Overseas Development Institute 2009, Briefing Paper,111 Westminster Bridge Road, London SE1 7JD**

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- Dunn, William N. (2008). *Public Policy Analysis: an introduction,* 4th edition. Upper Saddle River, New Jersey: Pearson Prentice Hall
- Bardarch, Eugene (2009). *A practical guide for policy analysis: the eightfold path to more effective problem solving, 3rd edition.*
- Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost.* IHI Innovation Series White Paper. Cambridge Massachusetts: Institute for Healthcare Improvement; 2012. (available on www.IHI.org)

Focus Panel 2

FEASIBILITY & BENEFITS OF COMMUNITY INTEGRATED PARAMEDICINE

Terence K. Mason, RN
Mesa Fire and Medical Department

Feasibility

- Identify the need
  - Who is the population(s)
  - What is the focus for this population
- What level of involvement is possible
  - Call volume
  - Assessed need
- Stakeholders
  - Team approach
  - Pushback

Feasibility

- **Financing**
  - **Startup costs**
  - **Reimbursement**
  - **Sustainability**
- **Data collection**
  - **Benchmarks**
  - **Consistency of measurement**
  - **Reporting**

Benefits

UC Davis White Paper July 2013

- **Facilitate more appropriate use of emergency care resources**
- **Enhance access to primary care for medically underserved populations**
- **Provide short term follow up home visits**
- **Prevent ED or hospital readmissions**

Benefits

Arizona Community Paramedic Program December 2012

- **Improvement in rural health**
- **Eagle County, Colorado five year pilot projected 10 million savings**
- **Reduce ED usage by as much as 25%**
- **Increased patient satisfaction**

Focus Panel 3

TRAINING / EDUCATION
&
COMMUNITY INTEGRATED PARAMEDICINE

Terence K. Mason, RN
Mesa Fire and Medical Department

CIP Training & Education Focus Panel Members

- Amber Teichmiller – Oro Valley Hospital
- Dave Bathke – Hellsgate Fire
- Jennifer Richards – River Medical/Blythe Ambulance /AMR
- Ken Schoch- Yavapai Community College
- Paul Honeywell – Flagstaff Medical Center
- Randy Perkins – Gilbert Fire
- Shane Kelber – Chandler Fire
- Terry Mason – Mesa Fire
- Vince Podrybau – Gilbert Hospital

Consensus Items

- **A clear definition of the Community Integrated Paramedic in the State of Arizona will better guide the development of curriculum and standards.**
- **The CIP skills should be within the current scope of practice and focus on enhanced training needed to provide services to the specific community.**
- **There are examples of training and education curriculum from across the country on which to base our curriculum.**

Consensus Items (Cont.)

- **Should include minimum standards**
- **Should be based on community needs**
- **Should be supported, approved and monitored by medical direction**
- **Recognized and endorsed by the Bureau of EMS**
- **Flexible to accommodate data driven, scope driven and evidence based changes or findings**
- **Focus on enhanced assessment and disease processes / pathophysiology**

Varying Ideas

- **Modular approach to training. i.e. specific modules relevant to the specific needs of the community. Examples Case Management, Behavioral, CHF, Diabetes, wound care etc.**
- **Can be offered as a supplement to Paramedic Refresher training.**
- **Should be available to be offered in- house by EMS entities or in conjunction with educational institutions, but not exclusive to any one entity.**
- **Can be a standardized curriculum that encompasses all required modules.**

Additional Items Needing Discussion

- **Do we develop a train the trainer or educator development program in conjunction with provider education?**
- **Do we develop a community outreach/education program in conjunction with the provider education?**

Focus Panel 4

HEALTHCARE SYSTEM INTEGRATION & COMMUNITY INTEGRATED PARAMEDICINE

Gary Smith, MD, FAAFP
Mesa Fire & Medical Dept., Queen Creek Fire, Superstition Fire and Medical District

Arizona Department of Health Services

Health and Wellness for all Arizonans

Healthcare Integration Goals

More appropriate use of emergency care

Increase access to primary care provider

Identify specific community health and social services:

- **Alternative transport locations**
- **Treat and refer or release**
- **Frequent 911 caller and ED visitor**
- **Post-hospitalization/Discharge Support**
- **Chronic disease support**
- **Preventive services**

Community health partners

Alternative Transport Locations

- Many patients do not require ED care
- Reduction of ED overcrowding
- Reduction of secondary transfers
- Identify community resources
- Telecommunication health integration

Treat and Refer or Release

- Evaluate all callers of 911
- Appropriate care and medical direction provided outside of ED
- Connect with community resources
- Develop formal policies to care for nonemergency patients not requiring transport

Frequent 911 Callers and ED Visitors

- Familiar with medical, mental health and substance abuse of frequent callers
- Meet the basic needs of patients through community resources
- Coordination with:
  - Hospital Discharge Planner
  - Social Worker
  - Home Health Care
  - Skilled Nursing Facilities
  - Electronic health information

Post Hospitalization/Discharge Support

- **Mesa Fire & Medical Dept. identified 25% of 911 callers were in hospital within the previous 30 days**
- **Patient care transition team**
  - **Review discharge instructions**
  - **Review medications (pre- and post-hospitalization)**
  - **Instruct on self-care**
  - **Assist with follow-up appointments**
- **Complement care of other healthcare providers**

Chronic Disease Support

- Assist healthcare team
- Medication review
- Decrease 911 and ED utilization
- Care coordination
- Increase operational efficiency
    - Decrease 911 response times

Preventive Services

- Familiar with high-risk individuals
- Home safety inspections
- Community outreach to underserved populations
  - Immunizations
  - Chronic disease visits
- Regularly scheduled visits (Home vs. Fire Station)
- Health information exchange

Focus Panel 5

COMMUNITY PARAMEDIC PROGRAM SPECIFICS

Donna Collister
Arizona Ambulance

Purpose of the Program

Community-based health management that is fully integrated with the overall health care system. Utilizing the services of the Community Integrated Paramedic (CIP), the program will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, contribute to treatment of chronic conditions, as well as provide community health monitoring.

Program Benefits

The Community Integrated Health Care Program (CIHCP) will improve community health and result in a more appropriate use of acute health care resources.

The CIHCP is developed via the redistribution of existing healthcare resources, integrating with other healthcare providers and public health and safety agencies.

Program Benefits

1. ***More consistent and efficient clinical care for patients with minor acute or chronic illnesses***
2. ***Increased availability of EMS units for true emergencies***
3. ***Increased availability of emergency department resources***
4. ***Improvement of the overall operating efficiencies of the emergency medical care system***
5. ***Increase the economic efficiency of the emergency medical care system***

CIP Roles and Responsibilities

A key component will be the expanded role of the paramedic level provider, Community Integrated Paramedic (CIP).

Paramedic level providers operate in an expanded scope of responsibility, with specifically approved expanded core competency skills, after successfully completing recognized training/educational programs.

Regulatory Process

The Joint Committee on Rural Emergency Care defines community paramedics as *"a state licensed EMS professiona*l."

- **Statute changes?**
- **An educational process?**
- **A recognized level of certification?**
- **Key to reimbursement?**
- **Minnesota Statutes 2012, section 256B.0625, subdivision 49**

Service Model(s)

Community paramedic programs are custom designed to the specific needs and resources of each community. Program success is achieved through partnerships with stakeholders who work to maintain the health and wellbeing of their residents.

- **Public Service Based: Fire-EMS Integrated**
- **Private EMS Provider Based: Recognized ambulance services**
- **Private Non-EMS Based: New entities**


EMERGENCY DEPARTMENT DIVERSION
WELLNESS
READMISSION PREVENTION
COMMUNITY INTEGRATED PARAMEDICINE
Core Services
PHARMACY
COMMUNITY PREVENTATIVE & EDUCATION PROGRAMS
BEHAVIORAL HEALTH

Moving Ahead

References

***Community Paramedicine Evaluation Tool*, March 2012. U.S. Department of Health and Human Services Health Resources and Services Administration Office of Rural Health Policy**

***Alternative Destination/Alternative Transport Program*, MedStar Emergency Medical Services**

***Integrating Mental Health Treatment Into the Patient Centered Medical Home*, June 2012. Agency for Healthcare Research and Quality U.S. Department of Health and Human Services**

***Beyond 911*: State and Community Strategies for Expanding the Primary Care Role of First Responders**

Focus Panel 5A

WELLNESS
&
COMMUNITY INTEGRATED PARAMEDICINE

Jennifer Richards
American Medical Response

Wellness

The condition of good physical and mental health, largely via preventative and chronic disease management.

Three primary areas of impact:

- ***Medication reconciliation***
- ***Wound Care***
- ***Chronic Disease Management***

Focus Panel 5B

PHARMACY
&
COMMUNITY INTEGRATED PARAMEDICINE

Jennifer Richards
American Medical Response

Pharmacy

- Medication reconciliation
- Establish a process to obtain emergency medications for patients
- Educate patients in medication administration
- Educate patients of importance of compliance
- Prevention of obtaining duplicate Rx

Focus Panel 5C

RE-ADMISSION PREVENTION & COMMUNITY INTEGRATED PARAMEDICINE

Jon Maitem, MD
John C. Lincoln – North Mountain

Readmission Prevention

Provide specific primary care services in the patient's home in order to bridge the post hospitalization readmission period, currently set at 30 days, with particular attention to high risk (CHF, pneumonia, AMI) for readmission illness diagnosis.

Readmission Prevention

Post Hospital Plan of Care (PHPOC)

Telemedicine/Monitoring

Navigator Program

Focus Panel 5D

EMERGENCY DEPARTMENT DIVERSION & COMMUNITY INTEGRATED PARAMEDICINE

Mark Nichols, Fire Chief
Daisy Mountain Fire Department

Emergency Department Diversion

The current healthcare system has created the civilian population to be reliant on accessing the 911 system to provide healthcare. CIP by design reduces use of hospital EDs for non-emergent reasons. CIP should reduce the overreliance on emergency transport vehicles and hospital EDs as a source of treatment for individuals with non-emergency conditions. This then should reduce the frequency of EDs going on diversion

Emergency Department Diversion (Alternative Destination)

Identification of, and assistance with access to, most appropriate healthcare/treatment services/sites versus general transport to an emergency department. The goal is to assure that the right patient, receives the right care, at the right time and the right setting. In doing so, the patient will receive better healthcare at reduced cost to the patient and the community.

Arizona Department of Health Services

Health and Wellness for all Arizonans

Focus Panel 5E

COMMUNITY PREVENTATIVE & EDUCATION PROGRAMS & COMMUNITY INTEGRATED PARAMEDICINE

Kim Moore, EMS Chief
Verde Valley Ambulance Service

Prevention & Education Programs

Individual or group instruction that teaches/facilitates the prevention of, or slows the course of, an illness or disease.

Preventative & Education Programs

The goal is to fill gaps in healthcare services by identifying the particular needs of a community and developing ways to meet those needs. The needs may vary in different areas so needs assessment should be conducted for each community.

Upon the completion of the assessment, it can then be determined the areas that can be address for Preventative and Education Programs.

Preventative & Education Programs

Immunization Programs

Home safety risk assessments

Medication Compliance/Administration

Referral Directory

Pediatric Injury Prevention

Focus Panel 5F

MOBILE INTEGRATED BEHAVIORIAL HEALTH & COMMUNITY INTEGRATED PARAMEDICINE

Cynthia Dowdall, PhD,
Northwest Fire District

The Parity Law and the Affordable Care Act

- **United States Congress passed a Mental Health Parity Bill in October 2008. The Final Rule went into effect on April 5, 2010. The bill requires insurance companies to develop benefits for biologically based behavioral health disorders (similar to those provided for health disorders) that cannot be capped by putting a limit on billing or by restricting the amount.**
- **The Affordable Care Act has integrated behavioral health and medicine into one system.**
- **All Americans are to have insurance by the end of March, 2014.**

The State of Arizona

- **In OCTOBER, 2013 the State of Arizona revised Title 9, integrating Chapter 20 (Behavioral Health) into Chapter 10 (Medicine) combining both into one system.**
- **This was the first step towards integrated services by the State of Arizona.**

Agencies Nationally and Statewide

Are moving towards integrated services that include:

- **Primary Care Physicians**
- **Hospitals/Emergency Departments**
- **Health Care Centers**
- **Hospice Centers**
- **Behavioral Health Providers (mental health, mental illness, and substance abuse)**
- **Fire departments/Community Integrated Paramedicine / Integrated Behavioral Health that includes Community Assistance Program /Crisis Response Teams**

Research

- **Research has discovered that over 70% of primary care visits are behavioral health related (Robinson & Reiter, 2007).**
- **It is well established that patients seek out their primary care provider for behavioral health needs that are not trained versus a specialty mental health provider (Gray, Brody, & Hart, 2000).**
- **The Nova Scotia Study on CP (Community Paramedicine, Submission to the Standing Committee on Health, 2011) shows a 40% reduction in E.D. visits, a reduction in annual health care costs, and a 28% reduction of costs to physicians not located on the Island.**

Research (Cont.)

- **ED's are providing approximately 1/3 of acute visits that are unscheduled (Pitts, Carrier, Rich, & Kellermann, (2013).**
- **A recent Rand Corporation Study (2013) found that 82%, who called their Primary Care Physician, were referred to the ED.**
- **Many do not have access to medical care except through the ED (McWilliams, Tapp, Barker, & Dulin, (2011).**

Community Assistance Programs/Crisis Response Teams within the Arizona Fire Service

- **Training includes behavioral health and crisis intervention.**
- **Those Departments/Districts who have CAP/CR Teams are already integrated into EMS and fire. These teams may assist in reducing the soaring health care costs to the ED, as seen in previous research.**
- **For best practice in Integrated Behavioral Health, they must be overseen by a licensed behavioral health provider just as medics are overseen by a licensed physician. This is also imperative for future billing.**

Other Training Programs in IBH

- **The University of Massachusetts Medical School's Center for Integrated Primary Care hosts a certificate program that includes Integrated Behavioral Health for behavioral health practitioners.**
- **Northern Arizona University is exploring implementing a Mobile IBH and IBH Graduate Program (Tucson Campus, 2013).**
- **Team STEPPS training is another program to improve the communication skills of an integrated team.**

Other Training Programs in IBH (Cont.)

- **Primary Care Physician's offices are training in this area to begin to bill for behavioral health services (Patient-Centered Care).**
- **Suggestion… hold an Arizona State Conference to include…Training programs for statewide/regionalization/awareness of CIP/IBH Patient-Centered Care that includes existing CAP/CR Teams for continued development of each agencies own model.**

ACA-Projections for Integrated Behavioral Health / Patient-Centered Care and Reimbursement

- **The Affordable Care Act-the inclusion of behavioral health insurance that requires changes from ICD-9 Codes to ICD-10 Codes, starting 10/1/2014. Projected ICD-11 Codes to emerge in 2017.**
- **Mobile Integrated Behavioral Health Services may be billable to offset operational costs for CAP Teams/CR Teams with Community Paramedicine/Mobile Integrated Wellness. The response model might be together or separate.**

Suggestions

- **Statewide education/training is needed on the billing classification system that includes IBH service lines using ICD-10 Codes to begin October 1, 2014.**
- **Have representation from the State of Arizona in the development of the new ICD-11 Codes that will emerge in 2017 to include mobile CIP/IBH…AND**

Suggestions (Cont.)

- **Uniformed Personnel Peer Support Services can also become a fee for service in the future (Marsha Baker, Substance Abuse and Mental Health Services Administration, personnel communication, February 12, 2014). Those trained in CISM already have privileged communication by Arizona State Statute.**
- **State and National Laws that supports billable CIP/IBH services!**

A National Agenda for Community Paramedicine Research prepared by Davis G. Patterson, Ph.D. and Susan M. Skillman, M.S. (2012) and the Affordable Care Act to include:

- Home Assessments (e.g. Safety, family support) will include behavioral health referred to as Patient-Centered Care Home.
- Patient resource and needs assessments will include behavioral health.
- Chronic disease management (diabetes, CHF, COPD) Paramedic/nurse response) will include behavioral health.

Continued

- **Medication reconciliation and compliance/behavioral health. That may include psychopharmacology.**
- **Behavioral Health follow-up to increase attendance at appointments with Primary Care Physician.**
- **Assessment with triage and referrals.**
- **Vaccinations (and possible in home treatment of the flu to reduce spreading with resources provided to meet basic needs).**

The Future of IBH

If 70% of all Primary Care Visits are behavioral health in nature (Robinson & Reiter, 2007), AND IF…

- **<u>Patient-Centered Care is</u> promoting wellness by working with the whole person of mind (mental health/mind-sets), body (medicine), and spirit (relational/heart-sets), accomplishing positive health outcomes through the use of integrated teams THEN…**
- **Integrated Behavioral Health and medical services need to be co-lated and fully integrated as one system (Horevitz & Manoleas, 2013) that includes Community Integrated Paramedicine.**

EMS was to the Fire Service 30 Years Ago…

- **Is what Community Integrated Paramedicine (CIP) will be to EMS in the future.**
- **CIP/IBH combined services in the future will be what house calls were to medical doctors 50 years ago that promotes community wellness.**

Questions?

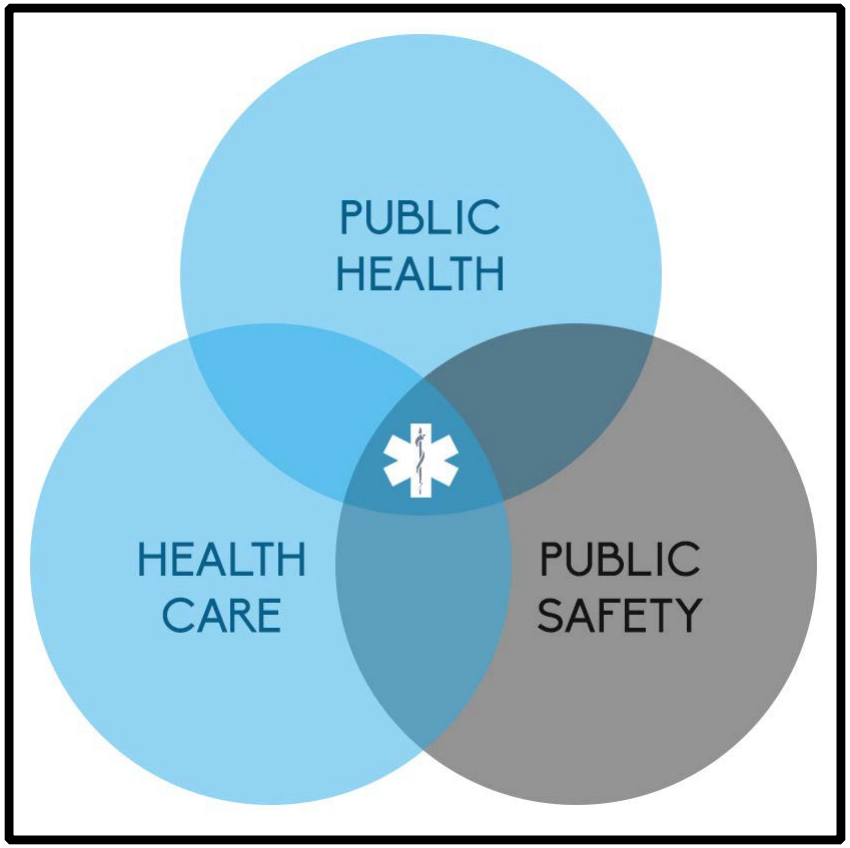
“If we had CIP/IBH before January 8th, that day may have never happened!” Anonymous Firefighter reflecting on the Gabby Giffords’ shooting.

Focus Panel 6

BARRIERS (LEGAL & CLINICAL) & COMMUNITY INTEGRATED PARAMEDICINE

Brian Bowling, FP-C
Native Air & LifeNet- Arizona

Barriers to Implementation



Focus Panel Mission

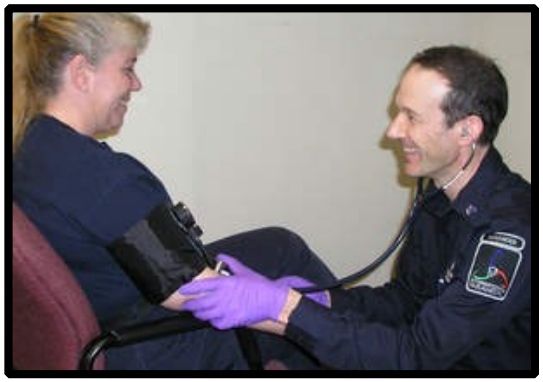
To identify clinical and legal barriers to implementing Community Integrated Paramedicine (CIP) programs in the state of Arizona.

At this juncture, some challenges experienced in other jurisdictions or those anticipated in this state will be presented.

Finally, the panel will target particular items in future meetings. Solutions to successful integration of CIP into the Arizona healthcare system will be explored.

Topics

- **Known Legal Challenges**
  - ***Expansion of Role* versus *Expansion of Scope***
  - **Licensure of Providers & Agencies**
- **Known Clinical Challenges**
  - **Determining & Authorizing a Scope of Practice**
  - **Credentialing of Education Systems**
  - **Perceived Career Encroachment**



Topics

- **Empirical Challenges**
  - **Funding Sources**
  - **Quality Assurance Programs**
  - **Public Health Data Integration**

Legal Challenges

Expansion of Scope

- **Advocacy to enact legislation which will enable maturation of the EMS profession**
- ***Examples:***
- ***UK Paramedic Practitioner Program***
- **Australia / Canada Expanded Healthcare Paramedic**
- ***NM Red River Project***
- **"Missing link" from the EMS Agenda For the Future**
- ***Community Paramedic International Curriculum***
- ***Levels 3 & 4 represent major educational commitments***
- ***Brings the promise of additional in-home therapies, wider breadth of referral possibilities***
- **Con: Risk of "degree/role creep" may limit accessibility in rural areas & may decrease cost effectiveness**

Expansion of Role

- **Categorizing & Institutionalizing existing initiatives**
  - ***Shot clinics***
  - ***Car seat rodeos***
  - ***Bike safety days***
  - ***Downing prevention***
  - ***Home safety inspections***
  - ***Blood pressure checks***
  - ***In-home follow-up visits***

- **Con: A higher volume of patients will still be referred to traditional, overburdened receiving facilities**

Licensure of Providers & Agencies

AZ DHS Bureau of EMS & Trauma Services

- Represents a new regulatory burden from CIP enabling legislation
- BEMSTS may be required to maintain
  - A registry of CIP licensed agencies
  - Author rules & substantive policies
  - Manage certified or licensed CIP personnel

AZ Medical / Osteopathic Boards

- Will physician boards issue advisory opinions on medical direction?
- How do agencies establish the CIP-physician relationship?
- Does the medical community recognize potential benefits & limitations of CIP?

Licensure of Providers & Agencies

AZ Bd. of Physicians Assistants

- Does CIP constitute a novel form of PA practice?
- Can a PA supervise a CIP program?
- Can a PA be used to deliver services beyond those of a paramedic or RN in this realm economically?

AZ Bd. of Nursing

- Does CIP present a new specialty for NPs & RNs?
  - i.e.: Mesa FD / Mountain Vista Medical Center PA-201
- How do we build collaborative, not adversarial relationships with EMS providers?
- How does CIP differentiate from home health nursing?

Clinical Challenges

- **Known Clinical Challenges**
  - **Austere healthcare settings may limit feasibility of some procedures and/or therapies**
  - **Dispensing of medications or recommendation for pharmacy refill may exceed legal framework of non-physicians**

Clinical Challenges

- **Determining & Authorizing a Scope of Practice**
  - **Enabling Legislation for CIP Systems**
  - **Statutory limitations versus system-driven practice**

Clinical Challenges

- **Credentialing of Education Systems**
  - **CoAEMSP? NHTSA? FICEMS?**
  - **Community Healthcare and Emergency Cooperative**

Clinical Challenges

- **Credentialing of Providers**
  - **NREMT? BCCTPC?**
  - **State EMS Bureau or an EMS Regulatory Board**

Clinical Challenges

- **Perceived Career Encroachment**
  - **Minnesota & Nebraska Nurses Association issue formal opposition to Community Paramedics in 2011**
  - **New Mexico's *Red River Project* was ended in 2000 when a PA and RN took up local practice in rural Taos County**

AZ DHS Director Humble's "Six C's" OF COMMUNITY INTEGRATED PARAMEDICINE

- **Community:** Addressing a current unfilled need.
- **Complementary:** Enhancement without duplication.
- **Collaborative:** Interdisciplinary practice.
- **Competence:** Qualified practitioners.
- **Compassion:** Respect for individuals.
- **Credentialed:** Legal authorization to function.

Community

Addressing a Current Unfilled Need

How to secure funding?

Needs Assessment,

Cost Projection

Enabling Legislation,

Health authority partnerships,

Grants,

Reallocation of existing resources

Reimbursement or services, Healthcare district funds, Performance funding

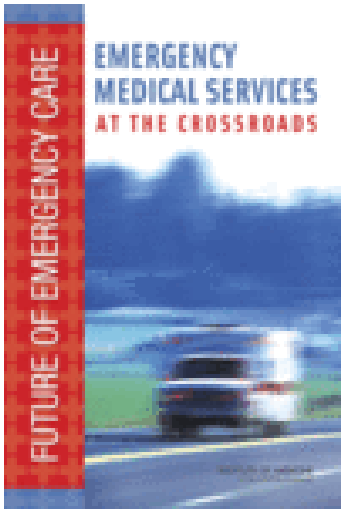
CMS Innovation Center Awards millions to pilot CIP systems across America

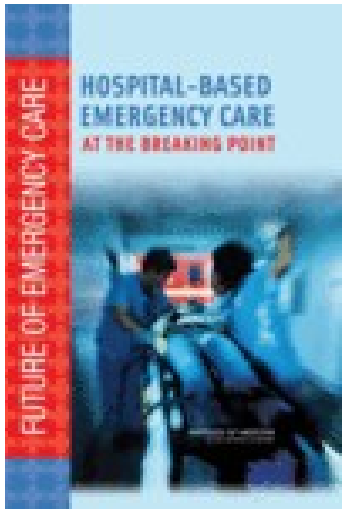
Complementary
Enhancement Without Duplication

- **2006 National Institute Of Medicine (IOM) Report:**

  <u>EMS At The Crossroads</u>

  - **Calls for EMS to evolve into an integral component of the overall health care system**





Complementary
Enhancement Without Duplication

- ***How do CIP systems obtain cooperation from:***
  - **Local hospitals**
  - **Rural/ public health authorities**
  - **Home healthcare industry**
  - **Rehabilitation facilities**
  - **Addiction treatment enters?**
  - **Primary & urgent care offices?**
  - **Local Pharmacies?**
  - **Social / Protective Services?**

Collaborative
Interdisciplinary Practice

Can "turf wars" and professional rivalry be averted?

- **Who owns the local CIP program?**
  - **County Public Health Agency?**
  - **Fire District / Municipal Fire Department?**
  - **CON Holder / Ambulance Service?**
  - **Eminent Hospital Network?**

Collaborative
Interdisciplinary Practice

Can "turf wars" and professional rivalry be averted?

- **How can CIP systems earn trust from:**
  - **Physicians?**
  - **Nursing specialties?**
  - **Allied Health?**
- **Where do Intergovernmental & Public/Private Agreements come into play?**

Competence

Qualified Practitioners

The Community Paramedic Curriculum Version 3.0

- Level 1 – Non-paramedic filling some roles of the Community Paramedic
- Level 2 -- Certificate or Associate degree
- Level 3 – Bachelor's degree
- Level 4 – Master's degree

Home Care License

- Importance for regulation
- Established organizational structure
- Emphasized the need to educate other Healthcare providers
- Non-duplicative
- Conditional License

3.0 Curriculum Structure

- Didactic Module
  - Online 12 - 16 weeks
  - Group Work
- Lab Module
  - Peds, Adult, Geriatrics
  - Optional based on population's need
  - 3 - 5 sessions
- Clinical Module
  - Select modules based on population's need
  - 100 – 200 hours

Source: Eagle County Colorado / North Central EMS Institute

Compassion
Respect for Individuals

- Selection of CIP providers
  - Talent sourcing from EMS, nursing, social work & similar communities
    - Is there a financial, intrinsic, altruistic or stability motive to recruit sufficient qualified personnel?
    - Early versus mid-, versus expert (senior) clinician recruitment, which is best?
    - Burnout worse than ignorance?
  - Acknowledgement of professional domain
    - Is CIP an honorable sub-specialty, not a terminal merit badge for adrenaline junkies?
    - Will it become yet another rung on an agency's career ladder?

Credentialed

Legal Authorization to Function

A bill for an act

relating to human services; creating a certification for community paramedics; amending Minnesota Statutes 2010, sections 144E.001, by adding a subdivision; 144E.28, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2010, section 144E.001, is amended by adding a subdivision to read:

Subd. 5f. **Emergency medical technician-community paramedic or EMT-CP.** "Emergency medical technician-community paramedic," "EMT-CP," or "community paramedic" means a person who is certified as an EMT-P and who meets the requirements for additional certification as an EMT-CP as specified in section 144E.28, subdivision 9.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 2. Minnesota Statutes 2010, section 144E.28, is amended by adding a subdivision to read:

Subd. 9. **Community paramedics.** (a) To be eligible for certification by the board as an EMT-CP, an individual shall:

(1) be currently certified as an EMT-P, and have two years of full-time service as an EMT-P, or its part-time equivalent;

(2) successfully complete a community paramedic training program from a college or university that has been approved by the board or accredited by a board-approved national accreditation organization. The training program must include clinical experience that is provided under the supervision of an ambulance medical director, advanced practice registered nurse, physician assistant, or public health nurse operating under the direct authority of a local unit of government; and

(3) complete a board-approved application form.

(b) A community paramedic must practice in accordance with protocols and supervisory standards established by an ambulance service medical director in accordance with section 144E.265. A community paramedic may provide services as directed by a patient care plan if the plan has been developed by the patient's primary physician or by an advanced practice registered nurse or a physician assistant, in conjunction with the ambulance service medical director and relevant local health care providers. The care plan must ensure that the services provided by the community paramedic are consistent with the services offered by the patient's health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient.

(c) A community paramedic is subject to all certification, disciplinary, complaint, and other regulatory requirements that apply to EMT-Ps under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2011.

Shown:
Minnesota Community Paramedic Act of 2011

Summary

- **Barriers to establishing a CIP system largely hinge on the legal & clinical factors**
  - **How do we establish a legal or contractual framework that will change the modes in which EMS & CIP derives funding?**
  - **Is it feasible to champion legislation to license & regulate these activities? Should we anticipate a significant and lengthy undertaking to startup or can the CIP initiative begin already?**
  - **How big of a paradigm shift does Arizona EMS want to experience?**

Summary

- **Some perceived barriers may be avoided by interdisciplinary participation**
  - **Can we engage other professions outside of EMS?**
- **Initial outlay of CIP as an expanded role of traditional resources may bridge the need until data, training, legislation & funding can be secured to widen the scope of CIP providers-- particularly EMTs & paramedics.**

CIP Implementation Barriers

Focus Panel Members

- Charlie Smith, CEP LifeStar EMS- Payson, AZ
  - Market General Manager
  - csmith@lifestar.us
- Charlie Smith, CEP City of Yuma Fire Department- Yuma, AZ
  - EMS Division Chief
  - charliemsmith1956@gmail.com
- Kris Mantey, CEP Mayer Fire District- Mayer, AZ
  - Firefighter & Paramedic
  - kmems71@hotmail.com
- Mark Mauldin, CEP Central Yavapai Fire District- Prescott Valley, AZ
  - EMS Captain
  - mmauldin@centralyavapaifire.org
- Terry Mason, RN City of Mesa Fire/Medical Department- Mesa, AZ
  - EMS Coordinator
  - terence.mason@mesaaz.gov
- Brian Bowling, FP-C Native Air & LifeNet- Arizona
  - Clinical Outreach Educator
  - brian.bowling@airmethods.com

ENDING
February 20, 2014
Focus Panel Presentations

Arizona Department of Health Services

Health and Wellness for all Arizonans