Georgia Department of Community Health

Putting The *Community* in Community Paramedicine

Nita Ham, Director
State Office of Rural Health Programs

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Georgia Department of Community Health

Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through planning, purchasing and oversight

We are dedicated to A Healthy Georgia.

Greetings From the State Office of Rural Health Staff ☺

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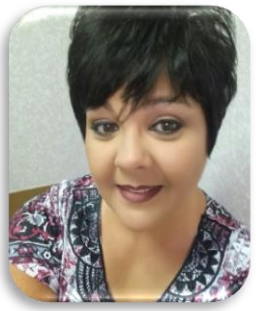
Executive Director

Lisa Carhuff,
Dir. Hospital
Services

David Glass,
Dir. PCO

Nita Ham,
Dir. SORH
Programs



Tiffany Hardin,
Dir. GFHP &
HCH Programs

Sheryl McCoy,
Administrative
Assistant

Dorothy Bryant,
HPSA Analyst
PCO

Beth Walker,
Prog. Op.
Specialist
PCO

Olakesta Outlaw,
Program Associate
PCO

Tina Register, Prog.
Op. Specialist
GFHP & HCH
Programs

Dawn Waldrip,
Prog. Op.
Specialist
Hospital Services

Cynthia Stubbs,
Systems Analyst,
OIT

Supporting Rural Communities

- Facilitate Communication
- Connect communities with federal, state, and local resources
- Provide technical assistance when needed
- Stay connected to rural needs through national involvement

- Grant Opportunities
  - Federal & State
  - Grants are not loans or gifts
  - Will reimburse for expenditures
  - Grants will have expectations
    - Deliverables
      - Quarterly reports
      - Data collection
    - Goals and expectations
    - Sustainability plans

Lessons Learned

Rural Hospital Closures Across the Country

- Impact is significant
  - Loss of local hospital
    - Must go farther for emergency departments/in-patient needs
  - Loss of local providers
    - Primary care providers and specialists often leave town
  - Loss of jobs
    - Local hospital is usually largest (or second largest) employer
  - Additional negative impact on local economy
  - Unable to attract business and industry into community

Rural Hospital Stabilization Program in Georgia

- Preventing or surviving hospital closures is a ***community*** issue
- Recognition and utilization of *other* local health care access points is vital for rural residents
  - Many residents are unfamiliar with options
  - Many residents with chronic conditions inappropriately use EDs for primary care
- Relationship building and collaboration between local health care partners is necessary
- When hospitals close, EMS is often "last man standing" (national & state)

EMS…Originally Designed for Emergencies

- Identified, designed, and defined through the ‘60s, ‘70s, ‘80s, ‘90s
- National curriculum updates in 1985,1998, & 2009 have driven the industry toward standardization, accountability, and accreditation of educational programs
- Initial education focuses on managing emergencies
  - Serves as an extension of the ED/ED physician
  - Prepared for, and good at that
- However, not much about the *response system* has changed
  - Dial “9-1-1”; resources are dispatched
  - EMS arrives, conducts assessment, provides interventions
  - Transports patient to ED (or no transport at all)
- Not prepared for how EMS is often used today

Where Does EMS Belong?

- Emergency Medical Services
  - By appearance
    - Often considered “Public Safety”
      - “Police/Fire/EMS”
  - By performance
    - Medical Provider
      - Proves medical care
      - Significant skill-set and broad scope of practice
      - Designed for emergencies
    - Bills for “services” (transport)
      - Currently only gets reimbursed for transport to ED

EMS is Expensive

- Rural counties are motivated to ensure EMS is present
  - "Public Safety" component; important to taxpayers and constituents
  - EMS usually receives a county subsidy and is expected to be response ready 24/7
    - Most EMS cannot operate without county subsidy
    - Approximate cost per ambulance for 24/7 coverage between $350K-$500K per year
    - Often in-service/response ready but not on a call

“9-1-1”; Too Easy/Too Often

“Don’t Guess…Call EMS”

- It worked ☺
- EMS is obligated to respond to 9-1-1 calls
  - Often calls are for primary care needs (“unscheduled” medical care)
  - Patient can request or refuse transport
  - Only (current) option is transport to ED
    - Often recognized that ED is not appropriate place for patient’s needs
    - Bill for transport

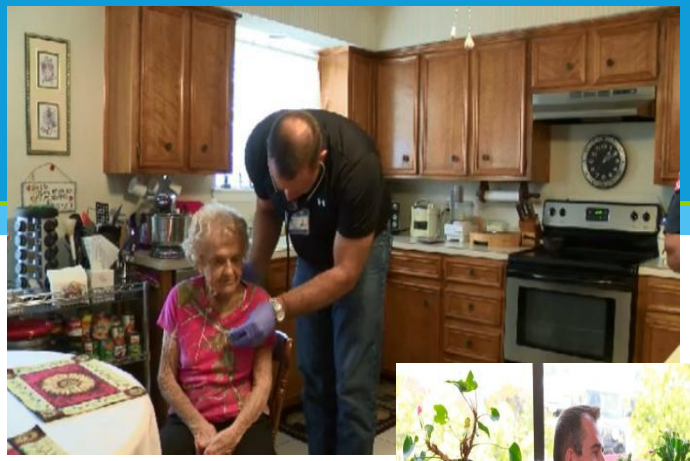
Why Say “Last Man Standing”?

- EMS = Medical Care
  - When rural hospitals close, service lines are reduced and/or MDs leave town…EMS is there
- Co-Dependent Relationship
  - Patients need medical care
    - Emergent or not; call 9-1-1
  - EMS needs to transport patients to get paid
    - Emergent or not; transport to ED
- This cycle resulted in a need to re-define role of EMS in community

Re-Define?? Does That Mean *CHANGE*??

Yes, "CHANGE"

- EMS/EMS personnel are being used differently than original design…prepared or not
  - Accept the metamorphosis & prepare for the transition
  - Re-visit the "I want to help people" reason for getting into EMS
  - Appreciate the valuable role they play in their patients' lives
  - Accept their role on the ***health care team***

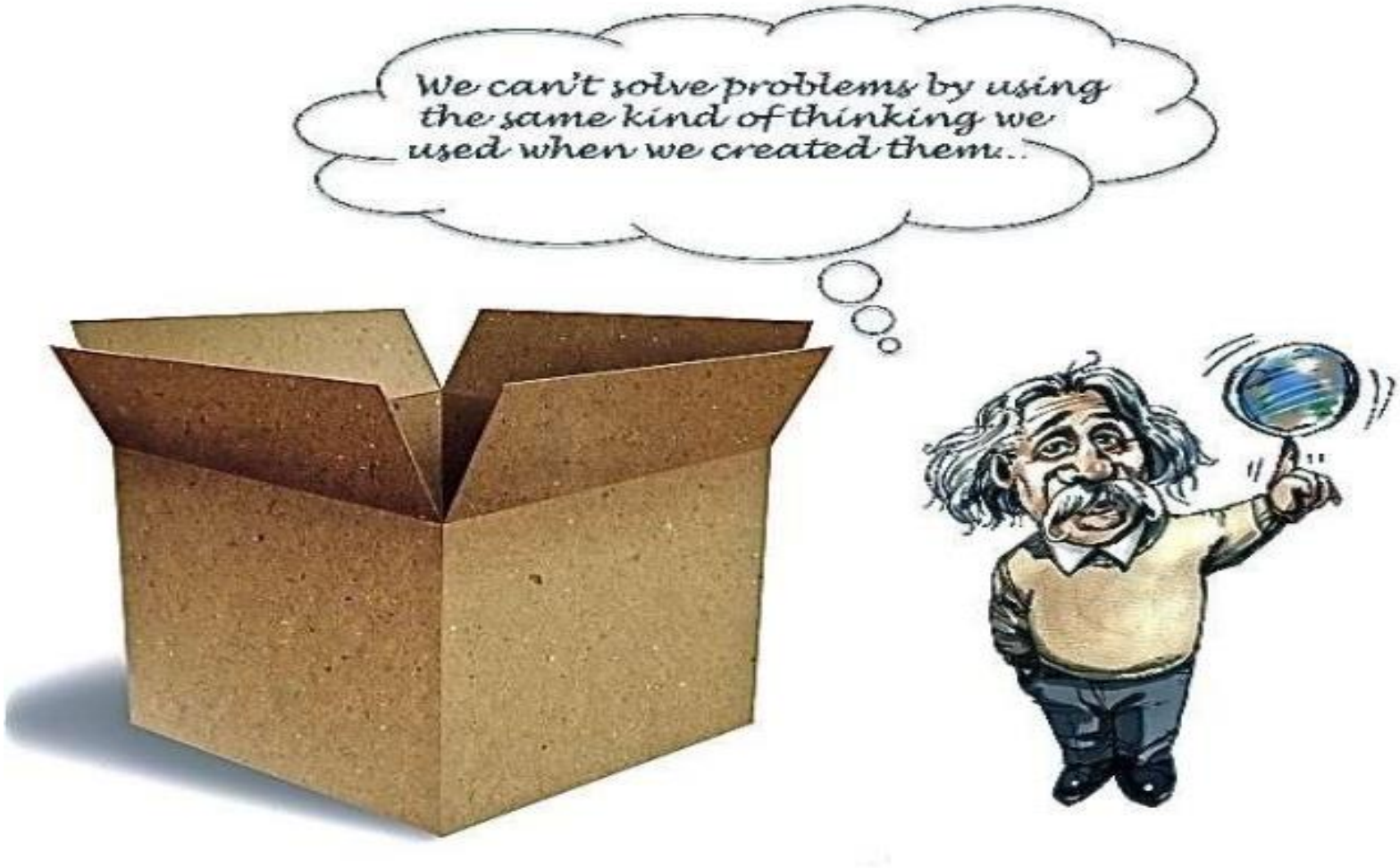


How Can EMS Help You?

*Preventing or surviving hospital closures is a **community** issue*

- Local health care access points should:
  - Know each other
  - Reach out to/learn from each other
  - Refer to each other when appropriate
  - Support each other
- EMS should be considered a *local health care access point*
  - Get to know them and what they can do for you

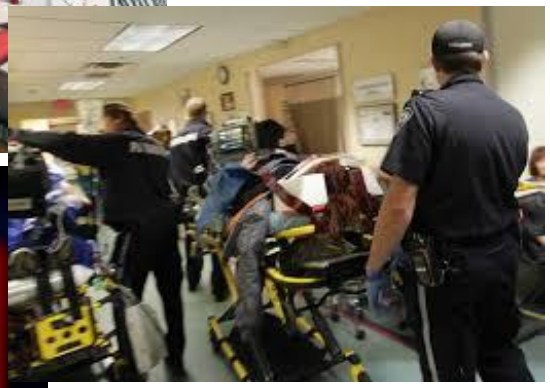
Thinking Outside the Box…#1



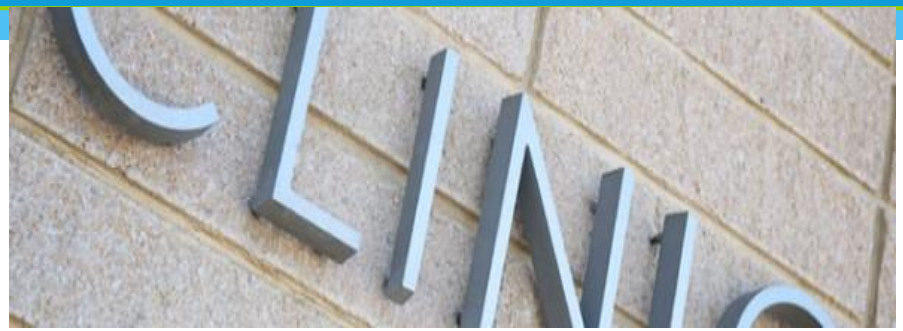
Transport…

What they do now…

- Assess patients and choose the most appropriate location for their continued care
  - "Closest appropriate facility"
    - Local ED
    - Trauma Centers
    - Cardiac/STEMI Centers
    - Stroke Centers
    - Burn Centers
    - Pediatric Emergency Departments



Transport To Alternate Destinations



What they need to do…

- Assess patients and choose the most appropriate location for their continued care
  - "Closest appropriate facility"
    - Urgent Care Centers
    - Clinics
    - Doctor's Offices
    - Behavioral Health Facilities
    - Dentist's Offices
  - Stay local and use local resources

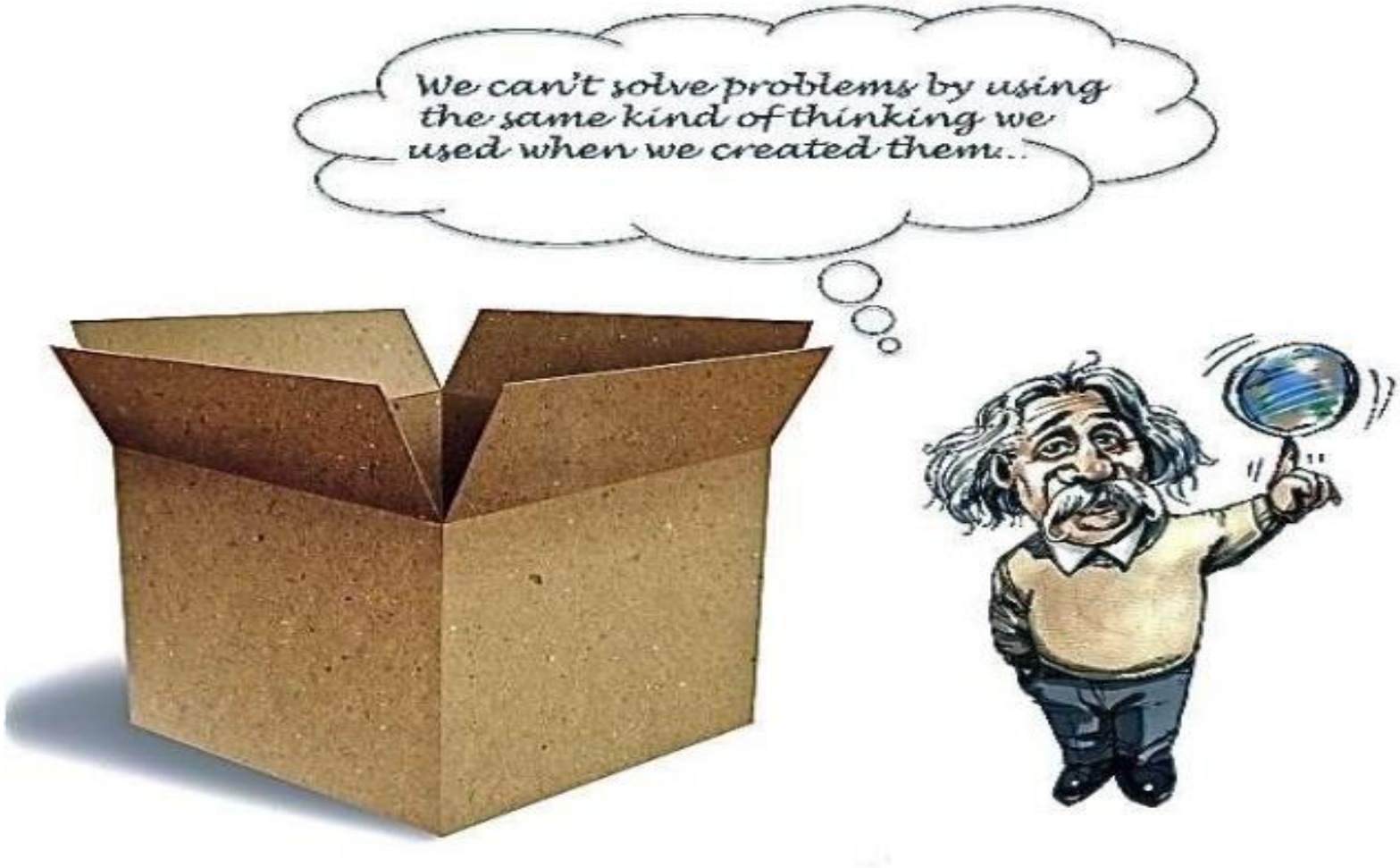
What is the Benefit of Alternate Destination?

*Preventing or surviving hospital closures is a **community** issue*

- Connects the patient with:
  - Appropriate site to address their needs
  - Possible permanent medical home
  - Less costly medical care
- Keeps EMS resources in the county for emergencies
- Utilizes/supports local resources
- Reduce the burden to EDs
- Reprograms patients from defaulting to “9-1-1”
  - Patient education opportunity

(It's Voluntary, Not Mandatory)

Thinking Outside the Box…#2



Community Paramedicine/ Mobile Integrated Health Care

What It Is…

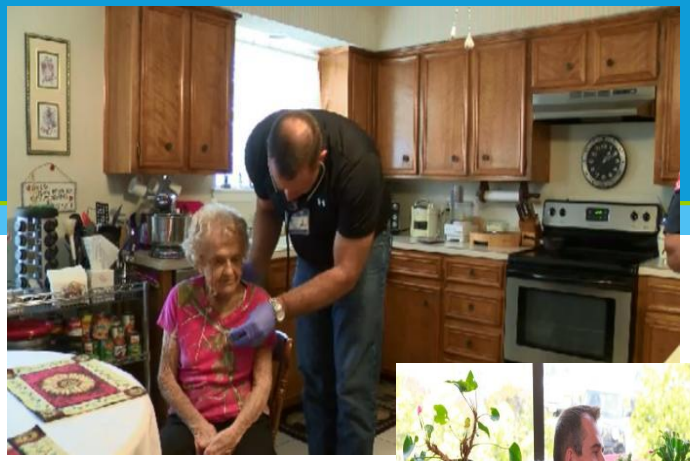
- Emerging healthcare profession allowing paramedics and EMTs to operate in expanded roles, providing routine health care services to underserved populations

- What It Is Not…
  - Competition
    - Not intended to compete with Home Health Care or Hospice
    - Not intended to replace or reproduce services already available within any given community
    - Should not be considered a threat or overstepping boundaries

CP/MIHC Design and Benefit

- Originally designed to:
  - Address “high utilizer group” of patients
  - Reduce or prevent hospital readmissions/penalties
  - Reduce bad debt
  - Improve self-care/management of chronic disease patients
    - Reduces *actual need* for emergency services assistance
  - Patients are enrolled with the expectation to “graduate out” of program
- Can be designed based on community needs, resources, and desires
  - Facilitate Telemedicine appointments
  - Medication reconciliation
  - Patient education/technical assistance
  - Home safety evaluation
  - Connect Patient with local resources
    - Pharmacies that deliver
    - Transportation assistance
    - Meals delivery services

As mentioned…



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SORH Support & EMS Reimbursement

Prove Benefit, Value, Cost

- SORH has supported past and present needs assessments, research projects, and pilot programs
  - Goal is to prove benefit, value, and cost of programs to support development of reimbursement pathways
  - Uses findings and outcomes of each project to support continuation of effort
- SORH is working with Georgia Medicaid on proposal to reimburse for Transport to Alternate Destinations and MIH/CP programs

Change Has Already Begun

- Many states across US have implemented these/similar programs
- Continuous national efforts to change CMS definition/reimbursement rules
- Many states have already made legislative changes/implemented programs through Medicaid
- Anthem BlueCross BlueShield will begin paying for treatment without transport effective January 2018 in 14 states (including Georgia)

Becoming a Team Member

Rural Community Care Coordination Toolkit for EMS

- Another SORH “support beam” project
- Will include guidelines and templates for EMS to use when developing community specific programs designed to enhance access
- Project Coordinator is an Attorney specializing in EMS
  - Firm also includes experts in EMS billing and reimbursement
- Toolkit will include medico-legally sound guidance and templates for new service line development
  - Transport to Alternate Destination
  - MIH-CP Programs
- Will be web-accessible and will also include financial tracking and data collection tools

On The Horizon…

- Currently designing two pilot study projects to bring multiple previous initiatives into one community for EMS/Care Coordination effort
- Intent is to connect as many partners as possible
- Want to measure benefit/value/cost in one project

Your Input Is Valuable!

SORH
State Office of Rual Health
A Division of the Georgia Department of Community Health

Nita Ham, Director
SORH Program
State Office of Rural Health
502 South Seventh Street
Cordele, Georgia 31015

Phone: (229) 401-3086
Email: nham@dch.ga.gov


THANK YOU