Community Paramedic Seminar

October 11th, 2014 Cincinnati, OH
Partners

DHS/MDH
Hospitals
EMS Medical Directors
Primary care
Home health
Hospice
Public health

Affiliated clinics
FQHC's
CHC Look-alikes
Commercial & Gov’t payers
State EMS board
SNF/Transitional care
Geriatrics
Environment Pre-CP

- Physician Oversight Model
- Scope of Practice Exempt
- Independent Practitioners
- Function under EMS Medical Director’s License
- Paramedics Certified, not Licensed
Pressure Points

Needed a Defined CP Deliverable
- Initially not an easily understood solution to health care shortage

Needed Sharp CP Talking Points
- Required clearly articulated and repeatable message

Needed Credible CP Training Standards
- Opportunity for curriculum, clinical and testing standards

Needed to Dispel Territory Worries
- Initial opposition to perceived competition

Needed a ‘Paramedics 101’ Education Effort
- Elected officials and general public had misperceptions of paramedicine.
S.F. 119 Established CP Certification

- 2 Years Experience as a Paramedic
- Completion of Board-Approved CP Course
  - Accredited College of University
- Practice under Ambulance Medical Director Supervision

Continuing Education in Primary Care
S.F. 1543 CP Reimbursement

- **Step 2:** S.F. 1543 Established CP Payment
  - **Authorized Coverage in Medicaid for:**
    - Health Assessment, Immunizations and Vaccinations, Chronic Disease Monitoring and Education, Laboratory Specimen Collection, Medication Compliance, Hospital Discharge Follow-up Care, Minor Medical Procedures as Approved by Medical Director
  - **Primary Care Provider Order Required**
  - **Medical Director Bills Medicaid**
State and Federal Drivers gave way to CP as an Innovation

The CMS Strategy is Built on Four Main Goals:

**GOAL 1**
Better Care and Lower Costs
- Beneficiaries receive high quality, coordinated, effective, efficient care. As a result, health care costs are reduced.

**GOAL 2**
Prevention and Population Health
- All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services.

**GOAL 3**
Expanded Health Care Coverage
- All Americans have access to affordable health insurance options that protect them from financial hardship and ensure quality health care coverage.

**GOAL 4**
Enterprise Excellence
- We will have achieved "Enterprise Excellence" when CMS' high quality, diverse workforce develops, supports, and utilizes innovative strategies, tools and processes, and collaborates effectively with its partners and agents to reach its goals.

CMS Strategic Goals 2013-2017

McALPIN
Sensible Health Policy Strategies
Improving Care, Health & Cost

- Effective Community Paramedic programs inherently support the Triple Aim framework to optimizing health system performance
Achieving Triple Aim Goals: CP – Connecting the Dots
Expanded Role

- Primary care
- Emergency care
- Public health
- Disease management
- Prevention
- Wellness
- Mental health
Primary care-focused

PROVIDERS ARE UNDER INCREASED PRESSURE TO CONTROL COSTS

• Reduce ED utilization
• Reduce admissions and readmissions
• Expand primary care
• Encourage health care home usage for complex patients
• Community benefit plan - broad goals to improve population health
In addition to meeting the need for acute medical care, community paramedics work collaboratively to identify needs and develop methods to match resources to address the overall health of people and communities.
The Value of CP in Accountable Care

- Enabling Legislation, Credentialing
- Reimbursable CP Practitioner Services Identified
- Implementation - Stakeholders
- ED Utilization Hot Spotting
- Patient Primary Care Plan, Medical Home

● Linking Primary Care & EMS
CP: ACOs

How ACOs work

- Doctors, hospitals, and other health care providers who volunteer to work together in an ACO are able to access medical records to help coordinate care.

- Providers also receive data from Medicare (medical history, medical conditions, prescriptions, medical visits) to be better able to improve care and manage financial risk.

- When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

- Several models of ACOs exist across the Country…
ACO Models across the Country

Medicare Shared Savings Program  FFS
The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.

Advance Payment ACO Model (35)
intended to help smaller ACOs have the capital to invest in the infrastructure.

Pioneer ACO Model (23)
a shared savings payment policy with generally higher levels of shared savings and risk for Pioneer ACOs than levels currently proposed in the Medicare Shared Savings Program; moves from a shared savings payment model to a population-based payment model.
ACO: CP Value

Opportunities for CP to impact the ACO achievement of Triple Aim Goals: Improved Patient Care, Enhanced Patient Experience, Reduced Cost of Care

**MEDICAID ACO**
- Withholds
- ER 5%
- Medical Home-Care coordination payments for managing complex chronic conditions
- Improve financially on Medical Assistance reimbursement

**MEDICARE ACO**
- Avoid Withholds
- Increase Patient Satisfaction Scores
- Quality Measures
- Reduce avoidable readmissions
- Opportunity to share in the savings produced
High-risk patients served by North Memorial are getting home visits from community paramedics, who help them avoid the emergency room by providing care in coordination with their doctor’s offices and clinics. North Memorial uses data from the Department of Human Services to identify those who are most at risk and includes them in its groundbreaking community paramedic program. Bonus Payment of $800,000
North Memorial Data on CP Program

Community Paramedic Analysis

-12 Weeks
CP Patients: 81

1st CP Visit

+12 Weeks
12 Week Total CP Visit: 379

Total Baseline Visits: IP, UC, ED & OBS: 151

Total Outcome Visits: IP, UC, ED & OBS: 78
Total IP Visit Variance: -73
Total IP Visit Variance %: -48.34%

CP Visit All Time Total: 977
Initial Data Review - Population

North Memorial Community Paramedic Analysis

- 1st CP Visit
- CP Patients: 81
- -12 Weeks
- +12 Weeks

12 Week Average CP Visit: 4.679
CP Visit All Time Average: 12.06
Average Baseline Visits: IP, UC, ED & OBS: 1.864
Average Outcome Visits: IP, UC, ED & OBS: 0.963
Average IP Visit Variance: -0.901
Average IP Visit Variance %: -48.34%
Public to Commercial Reimbursement

- Medicaid-approved CP services paved the way for Commercial Payer interest
- Fee schedule base with the introduction of risk
- Shared savings settle up
- Total Cost Of Care (TCOC) opportunity
Program Content

- Chronic disease management
  - Cardiac, respiratory, diabetes, neurological
- Pathophysiology
- Pharmacology
- Mental health
- Text books
Primary Care Focus

- Clinical Skills @ 196 hours
Clinical Training

- Primary care
- Community Health/Hospice
- Wound care
- Behavioral
- Cardiology & respiratory
- Pediatrics & geriatrics
- Networking
CP Payment & Delivery modeling

- Community Paramedic solutions span health care finance, government reimbursement modeling and care delivery innovations.

- In the brave new world of PMPM, capitation and shared savings for total cost of care, and a drive for the premium dollar, CP offers new solutions across the continuum of care and types of services....
  - Fire
  - Hospital
  - Private Systems

- From initial 911 call to primary care integration
Metro program went live on October 1, 2012
Three CPs are available every day, seven days a week
Carry their own supplies and use personal vehicle
10-12 patients per day
Electronic medical records interface
ACO: CP in Action

A high-level look at a functioning Community Paramedic Program and its support of Accountable Care

**Patient Populations**
- Polypharmacy
- High ED utilization
- Anti-coagulation patients
- Not quite homebound: ineligible for HH services
- PCP feels it would help pt to have additional resources
- HCH patients needing services
- Continued wound care needed
- CP Clinic in Chem Dep facility

**Year 1 and 2:** Over 6,500 CP patient visits
- Referrals from ED/PCP/CC/HH
- Enhanced diabetes management
- ‘Hub’ huddles increase continuity of care
- Charting & In-basket Epic messaging: real time with provider for follow up/guidance
- Lab contact for analysis and direction
- CC’ing all charts to care coordinator and PCP
- Closed loop communication with patient and family
- Link additional community services into pt goal setting process
- CP follow up upon D/C can increase information relay to PCP
- D/C lab review and med compliance offers decrease risk of re-admin
Community Paramedic: Accountable Care Partners

- Viable option for improving the experience of care, improving the health of populations and reducing per capita costs of health care
- Bridge existing health care gaps, avoid duplication
- Reduce the cost of overall health care expenditures
- Reduce stress on vulnerable patients and improve care coordination
- Reduce hospital readmissions and emergency department utilization and avoid penalties
Questions

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