COMMUNITY PARAMEDIC

Kevin McGinnis
Program Manager
Rural EMS and
Community Paramedicine
National Association of State EMS Officials

community paramedicine

2001

Community Paramedicine: Rural Roots

Paramedic Paradox

The further one moves from an emergency medical facility,

The more one may need higher levels of local EMS capability,

And the less likely that this EMS capability will be available.

2004 :

"CP" already exists in many settings across the country…..

Three Constructs

- Community Paramedicine

- Community Paramedic

- Mobile Integrated Healthcare

Community Paramedicine

Adapting EMS resources to address community health care and/or public health needs not currently being met and embracing the "paramedic paradox" as one of those needs.

Community Paramedicine

- IS
  - A generic concept
  - A means to fill a temporary or on-going health care need
  - Expansion of EMS roles and services
  - Generally on an episodic, not case management, basis
  - Leverages the 24/7 presence and mobility of EMS resources
- IS NOT
  - An expansion of EMS scope of practice
  - Just for the Paramedic license level
  - The same in every (or any) community
  - Competing for community health roles

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Evolving Concept…..

- **Community Paramedic**
  - A state licensed Paramedic who is certified as graduating from a recognized college program in community paramedicine and operates within the scope of practice for their licensure level.
  - "General Practice" Episodic Care (e.g. Chinese Menu Approach)

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More Recently……

- **Mobile Integrated Healthcare (MIH)**
  - MIH is an administrative organization of multi-disciplinary medical, nursing, and other practices which may or may not involve EMS paramedicine providers.

Rural *and* Urban

45/49 States/Territories have CP activity (92%)

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Statutory Approaches

- No/Minor Statutory Changes – Delegated Practice (e.g. Texas)
- No Statutory Change/Current Definitions Work (where "emergency" not a legal factor)
- Statutory Changes Needed for Practice and/or Reimbursement (e.g. MN, ME, ND, CO, NY)
- Surveys – As long as within scope of practice

CP Enabled (48 or 86%)	CP Enabled (48 or 86%)	CP Not Enabled (7 or 12%)
Alaska	*Montana	Alabama
*American Samoa	Nebraska	Delaware
Arizona	Nevada	Mississippi
*Arkansas	*New Hampshire	New Jersey
California	*New Mexico	Northern Marianas
*Colorado	*New York	South Dakota
*Connecticut	*North Carolina	Virgin Islands
Florida	+*North Dakota	
Georgia	*Ohio	
*Guam	*Oklahoma	**Unknown (1 or 2%)**
Hawaii	Oregon	Puerto Rico
*Idaho	*Pennsylvania	
Illinois	*Rhode Island	
*Indiana	South Carolina	
Iowa	*Tennessee	
Kansas	Texas	
Kentucky	Utah	
Louisiana	*Virginia	
+*Maine	Vermont	
Maryland	*Washington	
*Massachusetts	*West Virginia	
Michigan	*Wisconsin	
+Minnesota	+*Wyoming	
*Missouri		

*Completed or Anticipated Law/Rule Change in 2015/16 + Medicaid Revenue Secured /Attempt

- Currently No Universal Funding Provisions
  - Start-ups:
    - Self-funded; Excess Capacity
    - Grants
  - Medicaid Policy Evolution

PART 440—SERVICES: GENERAL PROVISIONS

■ 35. **Section 440.130** is amended by revising paragraph (c) to read as follows:

§ **440.130 Diagnostic, screening, preventive, and rehabilitative services**.

* * * * *

(c) Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

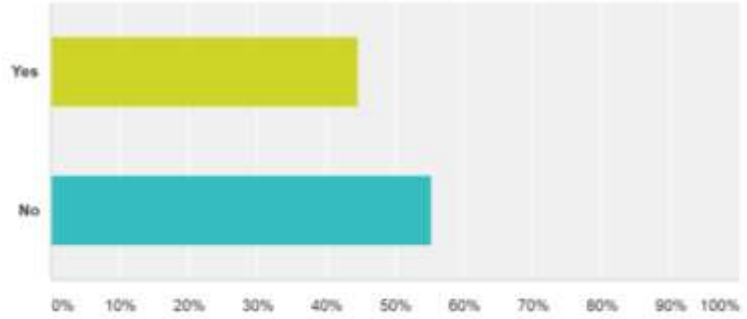
(3) Promote physical and mental health and efficiency.

2013-2016 Community Paramedicine – Mobile integrated Healthcare: Assessment of State and State EMS Office Status

NASEMSO > Committees > CP-MIH > Documents and Resources

Is there activity to try to use Medicaid to reimburse CP-MIH services?

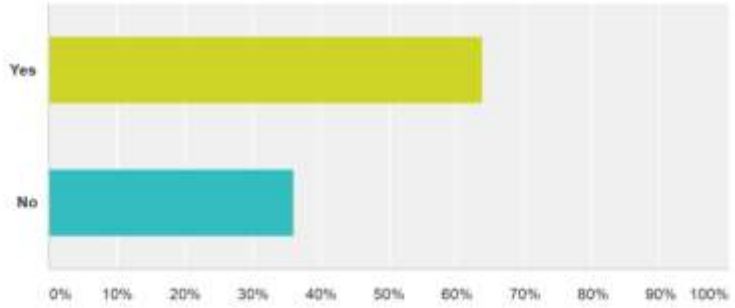
Answered: 47 Skipped: 2



Answer Choices	Responses	
Yes	44.68%	21
No	55.32%	26
Total		47

Are hospitals/health systems involved in development of CP-MIH reimbursement strategies?

Answered: 47 Skipped: 2



Answer Choices	Responses	
Yes	63.83%	30
No	36.17%	17
Total		47

Expenditure Savings Analysis (1) **High Utilizer Program - All Referral Sources**

Based on Medicare Rates

Analysis Dates: **October 1, 2013 - November, 2016**

Number of Patients Enrolled (2, 3): **507**

		Utilization Change	
Category	**Base**	**Avoided**	**Savings**
Ambulance Payment (4)	$419	4,932	($2,066,508)
ED Visits (through Oct. '15) (5)	$969	1,917	($1,857,573)
Admissions (through Oct. '15) (6)	$10,500	462	($4,851,000)
Total Expenditure Savings			**($8,775,081)**

Per Patient Enrolled	**HUG**
Expenditure Savings	($17,308)

Notes:

1. *Comparison for enrolled patients based on use for 12 months prior to enrollment vs. 12 months **post program graduation.***
2. *Patients with data 12 months pre and 12 months post graduation*
3. *Includes High Utilizer and Designated System Abusers*
4. *Medicare Tables from CY 2012 as published*

Sample Size	234	125		291	223	
Mobility (2)	2.31	2.47	6.8%	2.32	2.55	10.3%
Self-Care (2)	2.60	2.79	7.3%	2.63	2.82	7.3%
Perform Usual Activities (2)	2.28	2.60	14.1%	2.27	2.62	15.4%
Pain and Discomfort (2)	1.88	2.37	26.4%	2.44	2.63	7.9%
Axiety/Depression (2)	2.16	2.46	13.7%	2.42	2.65	9.7%
Overall Health Status (3)	**4.88**	**6.77**	**38.6%**	**5.20**	**6.87**	**32.2%**

Notes:

1. *Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionaire*
2. *Score 1 - 3 with 3 most favorable*
3. *Score 1 - 10 with 10 most favorable*

Nova Scotia

- Clinic Model
  - 23-40 % ED Use Reduction
- Nursing Home Model
  - 60% ED Transport Reduction

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Others (200+/-)

- Colorado - Public Health Nursing Partner Model
- Pittsburgh – EMed Home Health Partner Model
- San Francisco – “Frequent Flyer” Overutilization
- Wake County, NC - Redirect to Alternate Destinations (e.g. Mental Health)
- Fort Worth - MedStar
- Minnesota – Health Bus
- Maine – Pilots (Including Home Health Mediated)

https://www.nasemso.org/Projects/MobileIntegratedHealth/Documents-Resources.asp

Kevin McGinnis MPS, Paramedic
Program Manager,
Community Paramedicine - Mobile Integrated Healthcare, and
Rural Emergency Care
National Association of State EMS Officials

mcginnis@nasemso.org

(207) 512-0975