ROSS VALLEY FIRE DEPARTMENT
STAFF REPORT

For the meeting of: March 11, 2015

To: Board of Directors

From: Mark Mills, Fire Chief MEM

Subject: Community Paramedicine

RECOMMENDATION:

Staff recommends the Board receives and files the report.

BACKGROUND:

Community Paramedicine is a new and evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles. This will allow hospital agencies to facilitate a more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Emergency departments (ED) across the country from the nation's largest medical centers to the most remote critical access hospitals spend a disproportionate share of staff and financial resources providing non-urgent care to patients who often would have been better served in a primary care setting.

According to a 2010 study by the RAND Corporation, between 14 and 27 percent of all ED visits are for non-urgent care and could take place in a different setting, such as a doctor's office, after-hours clinic or retail clinic, resulting in a potential cost savings of $4.4 billion annually. Inappropriate use of the emergency department comprises a relatively small, but disproportionate share of health care resources.

In addition to the economic costs, frequent use of emergency resources exacts a price on individual and community health. Patients with a regular physician are more likely to receive preventive services and timely care for conditions before they become more expensive to treat. Moreover, patients with a regular doctor have fewer preventable ED visits and hospitalizations. Because of the potential for cost savings and improved health outcomes, policymakers, emergency medical services (EMS) personnel and health care providers in states and communities across the country are testing strategies aimed at curbing unnecessary use of emergency services.

EMS systems have historically focused on providing patient care for acute illnesses and emergencies, a role that is reinforced by current payment practices that reimburse EMS providers for emergency responses. However, with studies suggesting that 10 to 40 percent of EMS responses are for non-emergent situations, the role of the EMS provider is being reconsidered. Many states and

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communities have discovered that emergency responders offer an untapped resource for connecting high-risk and underserved patients with needed primary care services. With their strong ties to the local community, first responders can play a unique role by extending the primary care provider's reach into the patient's home and/or in a community setting. There, the first responder can perform a wide range of health care and social support activities in tandem with other providers in the patient's medical home. In what is commonly referred to as community paramedicine, community paramedics (CPs) are trained to perform an expanded role within their scope of practice.

Local EMS personnel are at the heart of many new community-based innovations. In addition to providing traditional emergency care, in rural and urban areas throughout the country EMS personnel are checking up on high-risk patients, those that are most likely to be frequent users of the ED and helping them manage their chronic diseases, adhere to medication plans, enroll in insurance coverage or access social services. While each community's program looks different, the goals are similar: improve individual and community health, reduce unnecessary hospitalizations and ED visits, and reduce healthcare costs.

The California Emergency Medical Services Authority (EMSA) is working in partnership with the California Health Care Foundation to explore the implementation of community paramedicine, utilizing the Health Workforce Pilot Program option through the Office of Statewide Health Planning and Development to test the concept in California.

DISCUSSION:

Currently, paramedics are trained to provide advanced life support services in an emergency setting or during inter-facility transfers. The California Health and Safety Code (HSC 1797.52, 1797.218) limits paramedic scope of practice to emergency care in the pre-hospital environment. Moreover, patients under the care of a paramedic are required to be delivered to a general acute care hospital emergency department. The paramedic scope of practice in California is somewhat unique as compared to other licensed health professionals in that the statute refers to both a set of authorized skills/activities that emergency medical personnel may perform and the places and circumstances in which those skills/activities may be performed.

Paramedics will receive specialized training and work under physician direction using approved patient care protocols. The additional skills that can be utilized are:

EMS Function	Examples
Assessment	▪ Checking vital signs ▪ Blood pressure screening and monitoring

EMS Function	Examples
	▪ Prescription drug compliance monitoring ▪ Assessing patient safety risks (e.g., risk for falling)
Treatment/ Intervention	▪ Breathing treatments ▪ Providing wound care, changing dressings ▪ Patient education ▪ Intravenous monitoring
Referrals	▪ Mental health and substance use disorder referrals ▪ Social service referrals
Prevention and Public Health	▪ Immunizations ▪ Well Baby Checks ▪ Asthma management ▪ Fluoride varnishing and oral health activities ▪ Disease investigation

Pilot sites will be in Alameda, Butte, Los Angeles, Orange, Santa Barbara, San Bernardino, San Diego, Stanislaus, Solano and Ventura Counties. These sites will utilize community paramedics to offer services including: follow up care for patients recently discharged from the hospital; transportation to urgent care or mental health clinics; hospice support; follow up treatment of tuberculosis; and assist individuals who frequently utilize emergency medical services to establish care with a primary care physician.

At the conclusion of the pilot, estimated in 2017, a UC San Francisco based independent project evaluation team from the Phillip R. Lee Institute for Health Policy Studies and Center for the Health Professions will evaluate the pilot project. A final report will be issued by the UC San Francisco evaluation team.

Despite the potential benefits, community paramedic initiatives face financial, policy, regulatory, and workforce challenges. Many of these are being addressed through state legislation and/or policies, research and ongoing engagement with other primary health care providers. Currently, many pilot programs do not receive reimbursement from traditional healthcare payers, but rely instead on a

mix of state and grant funds to support community planning, program development and community paramedic training. Although Medicaid and private insurance does not currently recognize or reimburse community paramedics for their services, some states and communities are taking steps to authorize reimbursement from public and private insurers.

Several community paramedic programs have encountered opposition from other health professionals, including nurse and home health care associations, which have opposed or questioned the expanded paramedic role on the grounds that these new duties encroach on their scope of practice.

FISCAL IMPACT:

None at this time.