PROGRESS FOR COMMUNITY PARAMEDICINE PILOT PROGRAMS

Session Law 2015-241, Section 12A.12.(d)

Report to the

Senate Appropriations Committee on Health and Human Services

and

House of Representatives Appropriations Committee on Health and Human Services

and

Fiscal Research Division

By

The North Carolina Department of Health and Human Services

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Introduction

In compliance with Section 12A.12.(a-e) of Session Law 2015-241, the Department is submitting this report to the Senate Appropriations Committee on Health and Human Services, House of Representatives Committee on Health and Human Services, and Fiscal Research Division regarding the progress in administering the funds that were allocated for Community Paramedicine Pilot Programs.

As required, this report contains the following information:

(1) The program selection site process and recipients.
(2) The status of the evaluation plan.
(3) The preliminary findings.
(4) The proposed educational standards.

Background and Development

Community paramedicine strives to improve health outcomes while being a potential cost savings to states and communities across the country. While the capacity of each program is determined by the needs of the community, one of the fundamental goals is to expand the role of paramedics to provide care and reduce unnecessary emergency services. In essence, providing each individual with the right care, at the right time, for a reduced cost.

Community paramedicine programs are in the early stages of development for many Emergency Medical Services (EMS) agencies across North Carolina. EMS professionals, including paramedics, are not trained in primary care. However, as community paramedicine programs mature over time, paramedics can assist providers with chronic disease management and citizens with access to social services.

Session Law 2015-241 Section 12A.12 (a-e), provided the sum of three hundred fifty thousand dollars ($350,000) for a Community Paramedicine Pilot Program in the 2015-2016 fiscal year. Opportunities for the pilot programs included expanding the role of paramedics to reduce unnecessary emergency and 911 services and admissions into health care facilities when a hospital stay could have been prevented. To accomplish these initiatives, EMS personnel provide care and utilize alternative destinations for patients who would be better cared for somewhere other than an Emergency Department.

Site Selection and Grant Recipients

Site Selection Process

Session Law 2015-241 Section 12A.12.(c) allowed the Department of Health and Human Services (DHHS) to establish up to three (3) program sites to implement the community paramedicine pilot program.

On December 1, 2015, the North Carolina Office of Emergency Medical Services (NCOEMS) released a grant application soliciting interest throughout the state[1]. During this process, eleven (11) applications were received. A scoring criteria was created, approved by administration within the Division of Health Service Regulation (DHSR), and used to evaluate each applicant.

With input from the State EMS Medical Director, NCOEMS staff, and DHSR administration, the three selected site locations were chosen based on the strength of their application, scope of their program, length of program existence, and data collection resources for the program. In accordance with the Session Law, preference was given to counties that currently have established community paramedicine programs. The programs selected represent the three NCOEMS geographic regions of the State (East, Central, and West) and provide a cross-sectional sample of community paramedicine programs within North Carolina.

Region	Site	Population	Program Focus	EMS System Type
East	New Hanover	Medium Metropolitan (202,667)	Reduce hospital readmissions	Hospital Based
Central	Wake	Large Central Metropolitan (900,993)	Utilize alternative destinations for patients who do not need to be seen in an Emergency Department.	County Based
West	McDowell	Micropolitan (44,996)	Reduce unnecessary emergency and 911 services	County Based

The first program site selected was New Hanover Regional Emergency Medical Services (NHREMS). They were designated to receive up to two hundred ten thousand dollars ($210,000) in Session Law 2015-241. The other two program sites, McDowell County Emergency Medical Services (MCEMS) and Wake County Emergency Medical Services (WCEMS), were each awarded up to seventy thousand dollars ($70,000).

[1] Session Law 2015-241 was ratified on September 18, 2015.

Findings

In accordance with Session Law 2015-241, Section 12A.12. (d), the findings of this report are outlined below.

HRSA Evaluation Tool

The US Department of Health and Human Services Health Resources and Services Administration (HRSA) Office of Rural Health Policy developed a Community Paramedic Program Evaluation tool (March 2012). The assessment tool is designed to provide a benchmark for self-study and to measure ongoing progress of public health resources, policies, and procedures. Before and after the pilot program, each grant recipient will use the tool to provide an independent self-assessment of its program's capabilities, strengths, weaknesses, and effective utilization of resources.

Below is a table explaining each benchmark, followed by tables showing the median scores for each program site "before" assessment. The scores for each site cannot be used to compare programs to one another due to the differences in population, program focus, and EMS service types referenced above. Rather, they indicate opportunities for improvement within the individual program.

Benchmark	Explanation
101	There is a thorough description of the epidemiology of the medical conditions targeted by the community paramedicine program in the service area using both population-based data and clinical databases.
102	A resource assessment for the community paramedicine program has been completed and is regularly updated.
103	The community paramedicine program assesses and monitors its value to its constituents in terms of cost-benefit analysis and societal investment.
201	Comprehensive statutory authority and administrative rules support community paramedicine program infrastructure, planning, provision, oversight, and future development.
202	Community paramedicine program leaders (sponsoring agency, community paramedicine personnel, and/or other stakeholders) use a process to establish, maintain, and constantly evaluate and improve a community paramedicine program in cooperation with medical, payer, professional, governmental, regulatory, and citizen organizations.
203	The community paramedicine program has a comprehensive written plan based on community needs. The plan integrates the community paramedicine program with all aspects of community health including, but not limited to: EMS, public health, primary care, hospitals, psychiatric medicine, social service and other key providers. The written community paramedicine program plan is developed in collaboration with community partners and stakeholders.
204	Sufficient resources, including those both financial and infrastructure related, support program planning, implementation, and maintenance.
205	Collected data are used to evaluate system performance and to develop public policy.
206	The community paramedicine, EMS, public health, community health, and primary care systems are closely linked and working toward a common goal.
301	The electronic information system (EIS) is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the community paramedicine.
302	The financial aspects of the community paramedicine program are integrated into the overall performance improvement system to ensure ongoing “fine-tuning” and cost-effectiveness.
303	The community paramedicine program ensures competent medical oversight.
304	The community paramedicine program is supported by an EMS system that includes communications, medical oversight, and transportation; the community paramedicine program, EMS system, and public health and community health agencies are well integrated.
305	The community paramedicine program ensures a competent and safe workforce.
306	The program acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the community paramedicine program.

McDowell County EMS Evaluation:

Each indicator is scored from 0-5 based off the provided template, then the median score is used to demonstrate where the agency lies for each benchmark.

Indicator	Median Score
100: Assessment: Regular systematic collection, assembly, analysis, and dissemination of information on the health of the community.	
101.1-101.5	4
102.1-102.4	4.5
103.1-103.5	4
200: Policy Development: Promoting the use of scientific knowledge in decision making that includes building constituencies, identifying needs and setting priorities, legislative authority and funding to develop plans and policies to address needs, and ensuring the public's health and safety.	
201.1-201.2	2.5
202.1-202.6	4.5
203.1-203.2	4
204.1-204.3	4
205.1-205.3	3
206.1	4
300: Assurance: Assurance to constituents that services necessary to achieve agreed-on goals are provided by encouraging actions of others (public or private), requiring action through regulation, or providing services directly.	
301.1-301.2	4
302.1-302.3	3
303.1	2
304.1	2
305.1-305.5	1
306.1-306.2	4.5

New Hanover Regional EMS Evaluation:

Each indicator is scored from 0-5 based off the provided template, then the median score is used to demonstrate where the agency lies for each benchmark.

Indicator	Median Score
100: Assessment: Regular systematic collection, assembly, analysis, and dissemination of information on the health of the community.	
101.1-101.5	5
102.1-102.4	5
103.1-103.5	4
200: Policy Development: Promoting the use of scientific knowledge in decision making that includes building constituencies, identifying needs and setting priorities, legislative authority and funding to develop plans and policies to address needs, and ensuring the public's health and safety.	
201.1-201.2	2
202.1-202.6	5
203.1-203.2	4.5
204.1-204.3	3
205.1-205.3	3
206.1	4
300: Assurance: Assurance to constituents that services necessary to achieve agreed-on goals are provided by encouraging actions of others (public or private), requiring action through regulation, or providing services directly.	
301.1-301.2	4.5
302.1-302.3	2
303.1	5
304.1	5
305.1-305.5	3
306.1-306.2	4

Wake County EMS Evaluation:

Each indicator is scored from 0-5 based off the provided template, then the median score is used to demonstrate where the agency lies for each benchmark.

Indicator	Median Score
100: Assessment: Regular systematic collection, assembly, analysis, and dissemination of information on the health of the community.	
101.1-101.5	4
102.1-102.4	1
103.1-103.5	4
200: Policy Development: Promoting the use of scientific knowledge in decision making that includes building constituencies, identifying needs and setting priorities, legislative authority and funding to develop plans and policies to address needs, and ensuring the public's health and safety.	
201.1-201.2	3
202.1-202.6	4.5
203.1-203.2	1.5
204.1-204.3	4
205.1-205.3	4
206.1	3
300: Assurance: Assurance to constituents that services necessary to achieve agreed-on goals are provided by encouraging actions of others (public or private), requiring action through regulation, or providing services directly.	
301.1-301.2	4.5
302.1-302.3	2
303.1	5
304.1	5
305.1-305.5	5
306.1-306.2	5

Educational Standards

The medical scope of practice for a community paramedic is not different from traditional paramedics, but advanced training is needed. A state-wide educational curriculum for community paramedics does not yet exist. NCOEMS, with input from the NC Association of EMS Administrators, the NC Community College System, and the NC Association of EMS Educators, has created a proposed education guideline for community paramedic programs.

The proposed curriculum consist of a base module with a minimum of 96 hours of didactic education. The classroom training will provide more in-depth analysis of public health issues, epidemiology, advanced pharmacology, and long-term patient management skills. In addition to the base module, local EMS systems will be responsible for developing and implementing training activities specific to their community programs and include clinical components that allow for hands-on training in a variety of non-emergency settings.

Module	Topics	Hours
Introduction to Community Paramedicine	Definitions, Epidemiology, Research, Roles and Expectations	10
Transitioning from an Emergency Role	Health, Safety, Wellness, Psychological Impact	8
The Role of the Community Paramedic	Advocacy, Commitments, Interdisciplinary Relationships, Resources, Services Available	10
Legal Aspects for the Community Paramedic	EMTALA, Documentation, Refusals, Follow-Ups, Alternative Destinations, Payer Sources	16
Integration of Community Paramedicine into Public Health	Vaccines, Home Health, Epidemics/Pandemics, Disaster Pre-planning, Triage, Community Health Needs Assessment	22
Medical Topics (Including Advanced Pharmacology and Pathophysiology)	Advanced Assessments, Cardiology, Neurology, Behavioral, Toxicology, Special Populations, Respiratory, Renal, Endocrinology	30

96 Total Hours

Additional local system education focus:

- Target population health needs
- Standard operating guidelines and protocols
- Quality assessment
- Clinical field education
- Crisis Intervention Training (CIT)

Summary

The pilot program is still in its early stages. Every effort has been made to expedite the process by NCOEMS. However, the delay in ratifying Session Law 2015-241 and the budget certification/approval process impacted the opportunity to effectively complete within fiscal year 2015-2016.
Below is a timeline of events that have occurred since the session law was approved.

Task	*Date*
Budget Approved	11/20/2015
Applications Released	12/01/2015
Applications Closed	12/30/2015
Recipients Announced	01/15/2016
Contracting Process Initiated	01/20/2016
HRSA Evaluation Tool Completed	04/01/2016
All Contracts Executed	04/12/2016

Currently, each recipient is collecting approved data regarding their programs. Preliminary analysis of the data shows positive results. However, with a fiscal year 2015-16 pilot end date, limited data will be available to determine whether the pilot programs were beneficial to the overall health care system by avoiding non-emergency use of emergency rooms, 911 services, and unnecessary admissions/re-admissions into health care facilities.

An extension of the pilot into fiscal year 2016-17 would allow for collection of additional data and a more effective review of Community Paramedicine Pilots based on geographic locations of the state, urban city codes (Urban, Suburban, and Rural), as well as different types of programs (hospital readmission, substance abuse/mental health, ED/EMS high volume utilizers, falls).

Accordingly, the Department requests that the pilot be extended into fiscal year 2016-2017 with a final report being submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by April 1, 2017.