**WFC Webinar: “Implementing a Community Paramedic Program in WA State”** *Feb. 3, 2016*

1. **Introduction**
2. **MIH/CP Programs—Concept Review**
	1. What it’s all about—and why fire/EMS agencies are getting involved in MIH programs?

[Integrating EMS resources with other healthcare resources to improve patient outcomes]

* 1. Patient Centered Care
		+ Patient’s Preferences
		+ Emotional Support
		+ Physical Comfort
		+ Information & Education
		+ Continuity & Transition
		+ Coordination of Care
		+ Access to Care
		+ Family & Friends
	2. Triple Aim
		+ Improve Patient Experience of Care through quality and satisfaction
		+ Improve the health of populations
		+ Reduce the per-capita cost of care
	3. MIH/CP programs vary widely—several general themes

(case management of frequent callers, post-discharge follow-up, patient education, etc.)

Leveraging resources—to support the Triple Aim

1. **What Should Your Agency Consider Before Implementing a MIH/CP Program?**
	1. Analyze your EMS system—are you ready for this?
		* Are you a high-performance EMS system?
		* Do you have a comprehensive CQI program in place?
		* Do you review and analyze your EMS system KPIs?
		* Do you have the funds, resources and EMS admin time to implement a program?
			+ Resources to train, equip and deploy MIH/CP resources—only one cost aspect
			+ Significant organizational and EMS admin investment:
				1. Need to become students on changing healthcare system
				2. It’s all about meetings…more than you could imagine!
	2. If senior administration and elected officials think this will enhance revenues—think again!

(Focus on “cost-avoidance” vs. additional revenues?)

* This goes back to patient centered care.
* Focus is about improving the experience of care for the citizens of our communities, while partnering with the greater healthcare community.
* Any available financial support will most likely be needed for program support
	1. What is your working relationship with other healthcare organizations?
		+ Importance of relationships with external stakeholders is critical to success
			1. Primary Care
			2. Hospitals
			3. Social service organizations
			4. Medicaid providers
			5. Case managers
1. **Key Steps in Developing a Successful MIH/CP Program:**
	1. Perform a community needs analysis—what issues need to be addressed, and can fire/EMS program participation help?
		* Needs analysis should identify gaps in healthcare system while avoiding duplication of existing services.
		* Other healthcare organizations (i.e. county health departments) may have already performed a needs analysis or can serve as a valuable resource.
		* The needs assessment can determine:
			1. Leading causes of preventable morbidity and mortality (i.e. senior falls)
			2. Gaps in health care services
			3. Demographics of populations impacted by gaps
			4. Common causes of frequent EMS use
			5. Most frequent conditions requiring hospital readmission
		* Obtain valuable info by surveying local medical providers about community needs
		* It is important to remain flexible in order to meet the needs that are before you

(Actual needs may not match up with your initial assumptions.)

* + - Partnerships, community need, and other factors can alter slightly your course. However, you must maintain a patient centered focus.
	1. Identify and meet with key internal stakeholders who must support MIH/CP concept:
		+ Medical Program Directors/Physician Advisors
		+ Senior leadership team
		+ Labor—need to work closely and collaboratively with labor
	2. Identify and reach out to key external stakeholders--potential “partner” agencies:

*Consistent messaging: MIH/CP is all about collaboration—focusing on the patient—not competition*

* + - Healthcare provider organizations (i.e. nurses, hospice, home health) worry about “turf”
		- Regulatory agencies—county EMS agencies, regions and state DOH
		- Provide constant reassurance—we’re not duplicating existing efforts, or taking away jobs
		- Education and communication are paramount, with a fair amount of patience sprinkled it.
		- Sometimes it takes doing the work and allowing partners to see the potential for the return on investment before the light goes on to the potential benefits.
	1. Develop proposal with identified goals, time-lines, performance benchmarks, proposed budget and cost-analysis, patient/provider satisfaction surveys, etc.
		+ Develop an initial time-line—then double the estimated implementation time!

*(It always takes longer than you think—obstacles occur unexpectedly!)*

* + - Focus on addressing “low-hanging” fruit—easy stuff first
		- Go small—consider small pilot programs—test assumptions
			* Be prepared to quickly modify proposed program based upon initial results
			* Use standard CQI tools—“rapid cycling”—Plan/Do/Check/Act for process improvement
		- What are we trying to accomplish?
		- How will we know that a change is an improvement?
		- What change can we make that will result in improvement? (IHI)
		- Can your department—by itself—serve as a viable EMS partner for a MIH/CP program?
			* Fire departments used to working in “silos”
			* Health systems typically cover much larger “medical service” areas than individual fire departments
			* Private ambulances have advantage in covering larger service areas
	1. Ensure that responsibilities for each participating organization are clearly described
	2. Ensure that proposed MIH program(s) don’t violate WAC or RCWs:
		+ Review language in SB5591, the “enabling” legislation which was signed into law in 2015
		+ Does your proposed program meet requirements set-up in the legislation?
		+ Is there a change in role or scope of practice for your EMS practitioners?
		+ If you are unsure, ask
	3. Resolving legal liability concerns:
		+ Legal issues—the RCW: 70.168.140:
			- (1) *“No act or omission of any prehospital provider done or omitted in good faith while rendering emergency medical services in accordance with the approved regional plan shall impose any liability upon that provider.”*
			- (2) *“This section does not apply to…gross negligence or willful or wanton misconduct”*
		+ Does RCW protection from “ordinary” negligence extend to community paramedic programs?
		+ Will participation in community paramedic programs jeopardize your liability protection?
		+ Will insurers extend coverage for community paramedic programs?
		+ Unclear as to possible liability impact from deploying community paramedic programs
		+ What is the relative liability of:
1. Performing RSI on an unconscious patient *versus*
2. Visiting Mrs. Smith for a post-discharge follow-up
	1. Consider education and training requirements for providers/participants (CPs)
* What level of training is required for your program?
* Will depend upon program goals

(WA state examples, Snohomish programs, Pierce County collaboration, etc.)

* Options for MIH training (i.e Hennepin County TCC vs. programs developed locally)
* Why a paramedic vs. EMT? Clinician vs technician
	1. Data Collection and Documentation of “patient/client” contacts?
		+ Need to determine when and how to document medical assessments & interventions
		+ New form, standard patient care report?
	2. Program Assessment—Are We Reaching Desired Goals?
		+ Careful, upfront development of goals is critical to measuring program success
		+ Consider using outside agency (i.e. local health dept. epidemiologist, UW, Qualis Health, etc.) to analyze data—objective analysis by 3rd party is always preferred.
	3. How do you achieve sustainability for your MIH/CP Program?
		+ Can you identify other sustainable funding streams? (Not just grants.)
		+ Do your services provide “value” for other healthcare organizations—will they pay for those services after demonstrating feasibility?
			- Example of ACOs paying for post-discharge patient follow-up
1. **“Watch Outs” for MIH/CP Programs—Issues That Can Result in a Train-Wreck**

*(Don’t forget what happened with the Red River (NM) Program; 1995-2000)*

* 1. Turf wars--not spending enough time building support & consensus with key stakeholders:
		+ Need good relations with home health, hospice, healthcare systems, county health, etc.
		+ Don’t forget to keep assessing internal support—labor unions, management teams
	2. Setting up overly ambitious or complicated programs for initial efforts
	3. Poorly designed goals, objectives and measurements of success
	4. Lack of transparency in reporting outcomes, and cost-benefit issues
	5. Poorly estimated workload and budgetary costs
1. **Where Do You Go From Here?**
	1. State-wide MIH/CP committee working on developing “best practices” white paper (participants welcome!)
	2. Resources available on WFC website—collection of reports and papers on MIH programs and implementation strategies
	3. Participate in WFC EMS Section-- members have expertise in MIH/CP program implementation

**V. Is Fire/EMS ready to meet the challenges provided by MIH/CP?**

1. Fragmentation vs. collaboration
	* Coordinated efforts needed when working with ACOs & health systems to implement new programs
	* Need flexibility and willingness to change business model
2. Financial solutions?
	* Misalignment of Medicare & Medicaid as a “transportation benefit unlikely to change soon
	* Can we provide cost-competitive solutions? (What is our staffing model?)
	* Examine our motivations for involvement? Are we willing to truly commit to being part of the public health system?
	* If we don’t want to be involved—others, such as AMR and Falck will get involved
		+ *“Caring for Maria”—*AMR MIH/CP Plan

**VI. Conclusion:**

a. MIH/CP programs provide opportunities for Fire/EMS—but it’s not easy, or for the faint of heart

b. Need to perform an honest internal appraisal—are you ready to move forward into this area?

c. There are resources out there—networking with colleagues is crucial

c. Need to maintain focus on “patient-centric” care