

Testimony in Support of SB 800

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AN ACT CONCERNING A MUNICIPAL PILOT PROGRAM ALLOWING EMERGENCY MEDICAL SERVICES PERSONNEL TO PROVIDE COMMUNITY-BASED PARAMEDICINE.

Good morning Senator Gerratana and Rep Ritter and distinguished members of Public Health Committee. We are the partners at The Holdsworth Group, Inc a Connecticut based health care consulting firm. Our testimony in support of SB 800 comes from nearly 65 years of combined experience working in the Emergency Medical Services system here in Connecticut. Prior to joining the firm in 2012, Mr. Guercia spent 10 years as the Director of the Office of EMS for the Department of Public Health.

As the nation's healthcare delivery system struggles with new initiatives which are evolving as part of the Affordable Care Act our State must begin to adapt to these changes. The most significant health threat facing Connecticut residents today is not influenza, obesity, diabetes, heart disease or cancer. It is, according to published reports, the fiscal cuts to our hospital/healthcare system. Hundreds of millions of dollars have been cut from Connecticut's 30 hospitals over the last three years. These cuts have resulted in sharp reductions in patient access. This lack of access to primary care causes the frequent use of the EMS system to transport patients to emergency departments resulting in longer wait times and ED overcrowding. This has proven to be a challenge for many EMS agencies who endure longer turnaround times when beds are unavailable.

This degradation of the state's healthcare system places an additional burden on our hospital emergency departments as uninsured residents seek primary care services in the emergency department. Fixing these issues will take innovation and a multi faceted approach which should include EMS, Fire, Hospitals, Visiting Nurse Agencies, Local Health Departments and the assistance of the State Department of Public Health. One of the innovations that should be explored is the concept of a Mobile Integrated Health Program, designed to meet the unmet needs of our residents by expanding the role of EMS personnel.

Based on their training and experience, Paramedics are highly proficient at assessing acute medical conditions, applying critical decision-making skills and implementing definitive or temporizing treatment modalities. They are trained to perform a range of diagnostic testing, to administer medications and to therapeutically communicate with patients. Paramedics are traditionally available in the community 24 hours a day, seven days a week and know the area and populations they serve.

We believe that our state must engage in an approved MIH pilot program that uses a flexible model designed to address a variety of identified healthcare delivery gaps. The following list is not all-encompassing but does outline some of the main reasons/benefits that an MIH program can provide;

- Reduce preventable hospital admissions
 - Hospitals are assessed financial penalties by the Centers for Medicare and Medicaid Services when patients are readmitted within 30 days.
 - MIH programs aim to improve patient experience and safety during movement and transition between the home and other healthcare settings in collaboration with involved healthcare practitioners. MIH providers may direct patients with ongoing healthcare needs to the most appropriate care rather than the traditional option of transportation to an emergency department. Together, these initiatives may reduce hospital admission and readmission of patients as well as overall costs to the healthcare system. A compensated evaluation visit and referral is significantly less costly than an ambulance transport and ED service bill.

- Reduce high volume use of 911 by individuals for low acuity complaints
 - Presently, EMS providers are oriented to solely offer transport of 911 patients to the emergency department, regardless of the severity of the patient’s complaint or healthcare needs.
 - MIH providers will help to navigate patients to healthcare delivery such as primary care or clinics. MIH providers can provide ongoing support and guidance to individuals so as to reduce the perceived need to activate 911.

- Reduce recurrent need for lift assists and possible subsequent hospitalization
 - EMS often receives 911 requests to assist persons in moving or getting up. This population has been identified as being at higher risk for subsequent hospitalization.
 - MIH providers may assess persons receiving “lift assists” for risk factors and potential eligibility to be referred to home-healthcare services. These interventions have shown promise in reducing rates of subsequent hospitalization in this population.

- Protection of hospice beneficiaries from benefit loss or revocation
 - An increasing number of patients receive end of life care in their homes. When sudden changes in patient condition occur, 911 may be activated despite counseling to the contrary. Presently, these patients may be transported to the hospital when they may more appropriately have been managed in the comfort of their own homes.
 - MIH providers may work collaboratively with hospice agencies to provide episodic in-home management of hospice patients who interact with the 911 system or for whom on-call hospice services are not readily available.

Any MIH pilot program must be structured under physician medical oversight with targeted goals and measurable benchmarks. We believe that approving this legislation is the starting point which will allow DPH to develop specific pilot program requirements in consultation with the physicians of the CT EMS Medical Advisory Committee of the CT EMS Advisory Board. We feel that the pilot programs must include the following elements:

- The role of any mobile integrated healthcare provider must be clearly defined.
- Any MIH program should not duplicate existing healthcare services that are being delivered but fill identified gaps in service 24/7/365.
- There must be physician oversight of any MIH program and providers. This may involve both primary care and emergency specialties.
- Minimum continuing education standards should be established. These should assure MIH providers are competent to perform any assessment or care delivery within the pilot program which is not presently within EMS education standards.
- MIH programs must incorporate a prospective system of data collection and evaluation regarding the effectiveness of any pilot program.

Federal Analysis

This initiative was the subject of a July 2013 white paper entitled, *Innovation Opportunities for Emergency Medical Services*, http://www.ems.gov/pdf/2013/EMS_Innovation_White_Paper-draft.pdf, which was published by the U.S. Department of Health and Human Services and the U.S. Department of Transportation, Office of EMS. The white paper concluded that MIH programs can enhance service while reducing cost for community based health care delivery.

Success in other States

In March of 2012, the State of Maine passed legislation to specifically allow their EMS Board to establish community para-medicine pilot projects. In addition the state of Minnesota in April of 2011 establishing the Community Paramedic as a separate certification level, setting educational standards, defining a general scope of practice. The Minnesota's legislation was developed with input from many facets of the healthcare delivery system including funding through the Medicaid program as a cost reduction initiative.

We urge the Committee to approve this legislation and authorize pilot MIH programs in our State which will open the door for a community based health care assessments, as a part of an integrated system.

It must allow for flexibility in the current paramedic scope of practice. It will utilize EMS resources as part of community outreach and wellness programs.