

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.

Senator Gerratana, Representative Ritter and distinguished members of Public Health Committee:

My name is David Bailey. I am a paramedic, EMS Coordinator with Hartford Hospital and Chairperson of the Mobile Integrated Healthcare (MIH) Workgroup established by the Connecticut Emergency Medical Services (EMS) Advisory Board. My own past experiences include over twenty years as a paramedic, Captain with a municipal EMS agency and Regional EMS Coordinator with the State of Connecticut. Our MIH workgroup is comprised of leaders from EMS agencies and EMS sponsor hospitals from across Connecticut with the stated goal:

“to improve patient outcomes, healthcare delivery value and patient satisfaction through integrating EMS personnel into the broader healthcare delivery system. Working in partnership with home healthcare providers and other existing community health resources, the workgroup will develop recommendations to the EMS advisory Board regarding methods to augment, not replace, community health services.”

My testimony today reflects the opinions of Hartford Hospital, the MIH Workgroup and myself.

Nationally, efforts to advance healthcare delivery are centered on the goals of improving patients' care experiences in both quality and satisfaction, improving the health of populations and reducing the per-capita cost of healthcare. These objectives seem intuitive but in practice are difficult to implement. New initiatives require capital investment, health-related behaviors are difficult to change, healthcare reimbursements are shrinking and patients face many barriers to accessing care such as lack of transportation, out of pocket costs and lack of knowledge regarding available services. Even when patients have ongoing relationships with healthcare providers such as primary care, visiting nurse or hospice services, barriers may arise which interfere with appropriate healthcare delivery.

Community paramedicine (CP), also known as mobile integrated healthcare or MIH, is an innovative model which leverages existing healthcare providers to address locally identified, unmet healthcare needs through improved collaboration with other disciplines and filling in healthcare delivery gaps.

A primary goal of MIH programs is to break down barriers to appropriate, quality healthcare. Oftentimes, emergency medical services (EMS) are utilized by patients for whom care seems otherwise inaccessible. MIH programs address barriers to care by identifying patients for whom transport to the emergency department is not the optimal choice and instead:

 Navigating patients to more appropriate healthcare services such as home healthcare, social services, primary care, etc.

Providing limited in-home assessment and care to address minor complaints and/or reduce unnecessary 911 utilization

Providing immediate treatment and support until care can be transitioned back to an established in-home provider such as homecare or hospice

Another goal of MIH/CP programs is to improve transitions of care. Presently, ambulances transport patients home from the hospital. There is no formal expectation to provide further in-home assistance, assessment or instruction once the patient is transferred. Existing MIH/CP programs have demonstrated that greater engagement by EMS both at the time of transportation as well as through later follow-up may reduce the likelihood that these patients having to be readmitted to the hospital.

Years ago, the MIH/CP view of EMS workers as part of the healthcare continuum of care would have gained little acceptance. EMS providers were viewed primarily as a medical transportation asset. Over time, paramedic education has expanded greatly in breadth and depth with significant emphasis on foundational material and the development of critical thinking skills. Providers are now competent in a wide array of assessment and treatment modalities including injection medications, intravenous therapy, checking blood sugars, acquiring 12 lead ECGs, pain management, airway care, basic wound care, oxygen saturation level measurement, etc. These skills may be used to supplement care from other providers, direct patients to the most appropriate care or provide care when none other is available. This is especially meaningful given the 24/7 availability of EMS in our communities.

Today, MIH/CP programs are active in many states and being piloted in several more. In some states, these activities are permissible under existing statute/regulation while in others enabling legislation has been required. Minnesota was the first state to enact legislation specifically authorizing community paramedic care. Colorado and Texas are examples of states where CP/MIH activities were already permissible and have now developed active and successful programs. In New England, Maine enacted specific enabling legislation for multiple CP pilot programs and Massachusetts in 2014 granted two special project waivers for CP/MIH pilot programs.

Some specific areas the MIH/CP programs in other states have been effective include:

- 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.
- 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 navigate patients with ongoing healthcare

needs to the most appropriate care rather than blanket transportation to an emergency department. Together, these initiatives may reduce hospital admission and readmission of patients.

- 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 may navigate patients to healthcare delivery such as primary care or clinics. MIH providers may 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.

In Connecticut, there is tremendous interest in MIH/CP programs from healthcare systems and EMS organizations. Despite this, there is hesitation to advance MIH/CP models because of concerns over statutory/regulatory definitions of “emergency medical services” and restrictions on EMS area of practice. Specifically, EMS providers have generally provided medical care in response to emergency requests (through the 911 system) and incident to the transportation of patients. This definition of the EMS area of practice may restrict EMS activities such as collaboration with hospice to provide off-hours or episodic support services to their patients, follow-up with frequent 911 users to help identify and address unmet healthcare needs, follow-up with recently discharged patients to reduce readmission rates, etc. It is for this reason enabling legislation is needed.

If the Public Health Committee should decide to advance this conceptual proposal into a detailed bill, a number of requisite elements for any pilot programs must be addressed, including a process for approval. Presently, pursuant to C.G.S. Sec. 19a-179a, the physicians of the Connecticut EMS Medical Advisory Committee of the Connecticut EMS Advisory Board review, approve and forward applications for expanded EMS scope of practice to the Commissioner of Public Health for final approval. This mechanism may serve as an appropriate model to use for approval of any pilot programs. MIH/CP programs vary considerably in their mission and structure (based on local needs assessments). Enabling legislation should allow for flexibility while requiring certain elements to assure patient safety and program efficacy. Some suggested requirements of any pilot programs include:

- The program must clearly define the role of any mobile integrated healthcare provider.
- Any MIH/CP program should not duplicate existing healthcare services that are being delivered.
- There must be physician oversight of any MIH program and providers. This may involve primary care, emergency physicians and/or other specialties.
- The program must establish minimum education standards to 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.

Community Paramedicine/Mobile Integrated Healthcare represents an opportunity to improve the healthcare experiences of the citizens of Connecticut in a cost-effective manner. I encourage the members to support this legislation.

Thank you very much for your time in considering this testimony.