

**DANBURY HOSPITAL
NEW MILFORD HOSPITAL**

**TESTIMONY OF MATTHEW CASSAVECHIA
WESTERN CONNECTICUT HEALTH NETWORK AFFILIATES
PRESENTED TO THE PUBLIC HEALTH COMMITTEE
WEDNESDAY, MARCH 11, 2015**

**SENATE BILL 800, AN ACT CONCERNING A MUNICIPAL PILOT PROGRAM
ALLOWING EMERGENCY MEDICAL PERSONNEL TO PROVIDE COMMUNITY
BASED PARAMEDICINE**

Respectfully, I submit this written testimony as the Director of Emergency Medical Services for the Western Connecticut Health Network Affiliates. As an affiliate of Danbury and New Milford Hospitals, my job responsibilities include the management of the City of Danbury Emergency Medical Services system, a single tiered paramedic service that is a division of the Danbury Fire Department. This testimony urges you to support for **Senate Bill 800, AN ACT CONCERNING A MUNICIPAL PILOT PROGRAM ALLOWING EMERGENCY MEDICAL PERSONNEL TO PROVIDE COMMUNITY BASED PARAMEDICINE**. In addition, I am formally requesting that the City of Danbury be identified as a municipality considered for this pilot program and I have provided a summary of the operational framework of our program. Our close ties with the Danbury Hospital Emergency Department Medical Control and alignment with the Health Network's population health management plans offer a strategic advantage in advancing a multidisciplinary program aimed at reducing high utilization patients of emergency services.

I believe that a well-designed Community Based Paramedicine (CBP) program will add a new and efficient enhancement to the existing City of Danbury Emergency Medical Services delivery model. The City of Danbury Emergency Medical Service (EMS) system is managed by a performance based contract to form a vital public health safety net by offering life-saving care to critical and unstable patients. While the existing model is focused on the delivery of emergency

medical care to those with acute life threatening crisis, statistical analysis suggests that a mere seven to ten percent of patients activating 9-1-1 actually fit into this high acuity coding criteria of Advanced Life Support ALS 2 (A0433 – ALS – Level 2 billing code). Defined ALS-2 care is when 2 or more interventions have been performed or attempted (manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, intraosseous line, or three or more separate administrations of medications by IV push/bolus or continuous infusion, excluding crystalloid fluids).

Further, the current 9-1-1 emergency services organizational structure is “rewarded” based on volume and transports and offers little or no incentive to become a proactive or preventive design. As such there is no funding or reimbursement design for EMS other than billing for transports or municipal subsidy. We strongly support the development of a preventive risk reduction model and expect that by doing so our community will yield better efficiencies in the delivery of care in a more appropriate setting. It is also our recommendation that part of the pilot considers a formal reimbursement strategy for EMS preventive activities.

The concept of community based paramedic is not new and in fact a large group of EMS leaders across the State learned about some of the successful program models in June of 2014 at the Department of Public Health sponsored Mobile Integrated Health Care summit. Since the summit, several discussions among key stakeholders have explored transformational ideology in vetting a formal community based paramedicine model to be integrated into our Network. For example, recently a community care team model has been established by Western Connecticut Health Network in conjunction with a number of community based representatives, including mental health and substance abuse teams coupled with Emergency Department physician leadership. The purpose of the community care model is to leverage key stakeholders that have a shared interest in getting patients who frequently use emergency services the proper care.

A focused team that wraps the right care around high users through appropriate information sharing and analysis is thought to be of significant value in reducing high utilization of emergency services. The framework of the community based paramedicine program provides an opportunity for EMS to become part of the conversation and solution in the identification and potential area of improvement in our community.

The proposed legislation allowing EMS personnel to provide community – based paramedicine is the gateway for EMS providers to become part of the solution in improving local health care delivery. Our community based paramedicine pilot thoughtfully transitions the pilot program into 3 distinct phases that are subject to Medical Control oversight and design.

I direct you the framework, organizational structure and workflow below, and I am happy to answer your questions matthew.cassavechia@wchn.org.

ATTACHMENT

Patient assessment, information sharing and readmission mitigation

Phase 1

- Reduce the occurrence of, or minimize, medical crises for persons with specific medical conditions known to benefit from close community-based medical monitoring and assessment.
- Share information within the Network and beyond in an effort to identify important trending for those utilizing emergency services and the Department of Emergency Medicine.
- Establish metrics by a multidisciplinary group through important information sharing in order to trigger a follow up visit by Community Based Paramedics and discharge planners to mitigate further responses. For example, if there are records of 6 (six) or more 9-1-1 EMS responses or ED visits within a three month period, the team is assembled to assess cause and effect, as well as mitigation strategies at home, combined with Community Based Risk Reduction Paramedics and visiting nurse staff.
- Increase the overall well-being of patient by preventing the need for EMS response and decrease the time and money spent by patients and other taxpayers for emergency room visits and hospital stays.
- Credential paramedics with additional patient assessment capability to work under the direct supervision of an Emergency Department physician with specific knowledge of this program.
- Ensure all paramedic risk reduction visits will be documented through the standard patient care report process.
- Establish specific scripting and a check list to ensure that proper maintenance and scope of practice guidelines are strictly adhered to.
- Determine a need for immediate emergency medical treatment at any time during a patient assessment visit. Once determined, a transport ambulance will be summoned through the established 9-1-1 emergency medical system. Patients identified as candidates for this program will be enrolled by signing an authorization that will enable requisite health care providers to share information and collaborate.

Phase 2

Education of the population served, to include cardiac awareness, fall prevention, and scald prevention

Studies show that diabetics, high blood pressure patients with congestive heart failure, those with increased risk of falls (such as people over 65 years of age), some substance abusers, and children with asthma may all significantly benefit by home visits from medical care providers such as our Risk Reduction Paramedics. One benefit of expanding safety programs into the Paramedic role is that the Paramedic can directly speak to the patient about consequences of non-compliance.

There are 1242 calls for “falls” in the City of Danbury on average each year. It would be beneficial to develop a Fall Assessment and Prevention Program that captures patients who may not otherwise be identified as a fall risk. This would include a Medic Alert program for patients who have repeated EMS response, especially those who refuse medical treatment (sign an RMA) at the scene. Currently, the data on RMAs does not get reported to Primary Care Physicians. Implementing such a program would help capture and communicate the data that shows patients who have or are developing an increased fall risk.

The program would include:

- Preventative assessment
- Household assessment, assistive devices, assistance to standing, nightlight program, bathroom trips
- Partnerships/Referral to on-going services (Visiting Nurse Assoc) for maintaining the patient at home as long as it is safe
- Development of a tight process to transition patients to a higher level of care (no longer able to live at home)
- Differentiation between chronic issues and sudden/focused event
 - Gait disturbance – analysis by paramedics
 - Deliver assistive devices (walkers, ramps,...)

- Paramedics equipped with tablets who have access to an established electronic medical record and other network related medical information in real-time to enhance communication with the Network and the patient / patient advocates.

Phase 3

Redirect care to appropriate location other than the Emergency/Primary Care Department

Redirect care for individuals with mental health or substance abuse crises at facilities other than the emergency room when no other medical emergency exists. RRP's may evaluate a patient along with paramedics from a responding ambulance to help determine if the patient would benefit from treatment at another facility. For appropriate patients, the RRP will determine the best alternative treatment location and arrange for the patient's transportation and admission. Ambulance transport to the emergency room is always an option if our patients request other medical evaluation or treatment. Behavioral Health is another category with high EMS involvement. On the side of preventing hospitalizations, RRP's would likely develop a Preventive Behavioral Health approach to address the ~750 "behavioral health and suicide" annual calls.

Data analysis between EMS and Primary Care would help identify patients who need EMS assistance or are hospitalized as a result of a pattern. The program would include:

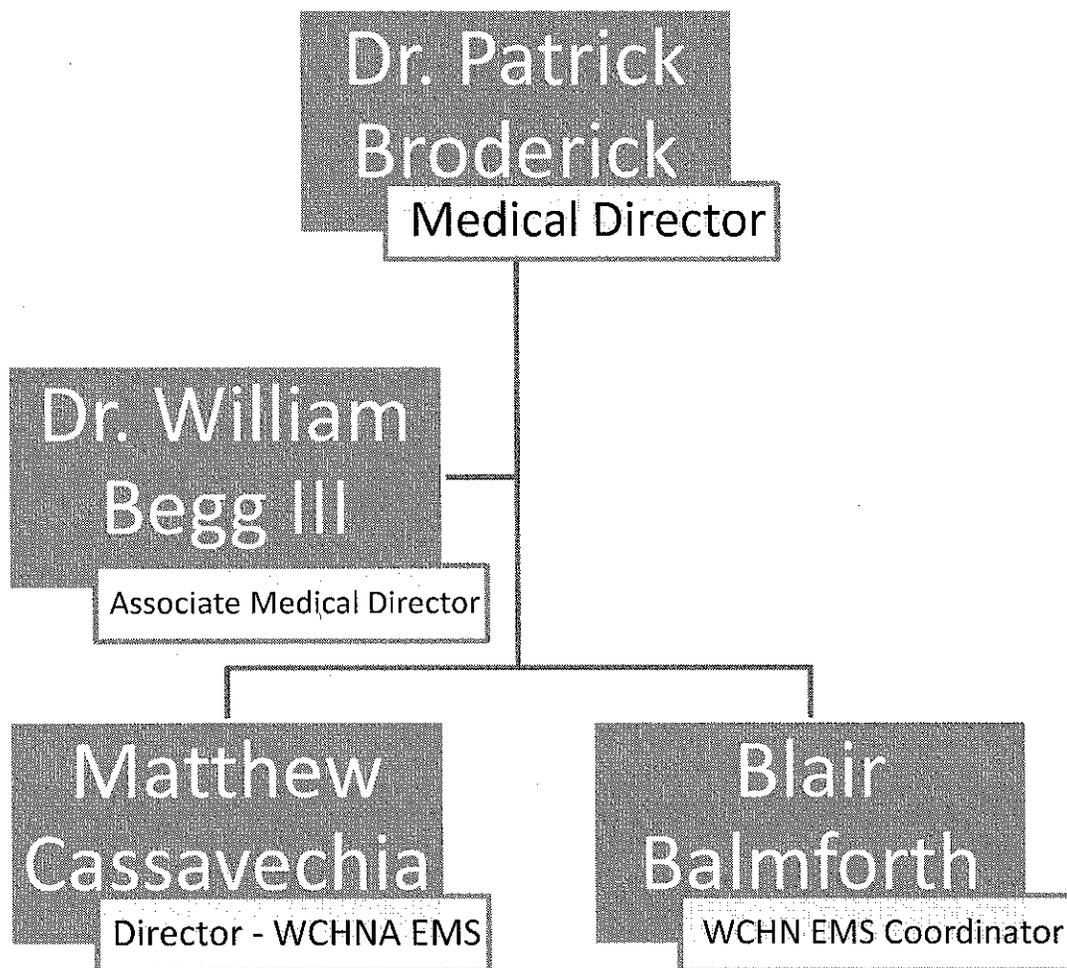
- Medication management to ensure compliance
- Direct admissions to in-patient and non-hospital behavioral health services (avoiding the ER stop)
- Transportation to WCHN Behavioral Health (152 West Street)
- In Health Network
 - Primary Care Offices
 - Danbury
 - Seifert and Ford Clinics -- 70 Main Street in Danbury
 - Pediatric Clinic
 - Adult Clinic
 - At home treatment options (ex., Diabetic patients, ..)
- Not Health Network

- o Community Health Center – Delay Street

1. SERVICES:

- Comprehensive primary medical care for adults and children
- Behavioral health services
- Breast and Cervical Cancer Early Detection Program

Community Based Risk Reduction Paramedic Organizational Structure



Community Based Risk Reduction Paramedic Workflow Algorithm

