How to Prove the Value of a Community Paramedicine Program

Or: Longitudinal Patient-Centered Charting is Vital to a Sustainable Community Paramedicine Program

Jonathon S. Feit, MBA, MA
Co-Founder & Chief Executive
Beyond Lucid Technologies, Inc.
www.BeyondLucid.com
(650) 648-ePCR
IRCP 2016

beyond lucid
Technologies & Consulting

A Successful, Sustainable Community Paramedicine Program:

1. **Improves patient care by caring for patients over time.**

2. **Reduces costs by keeping patients out of the ED**

3. **Centralizes the role of EMS in a connected healthcare ecosystem**

beyond lucid
Technologies & Consulting

Survey: How Many of You Hate / Distrust Technology (esp. ePCR)?

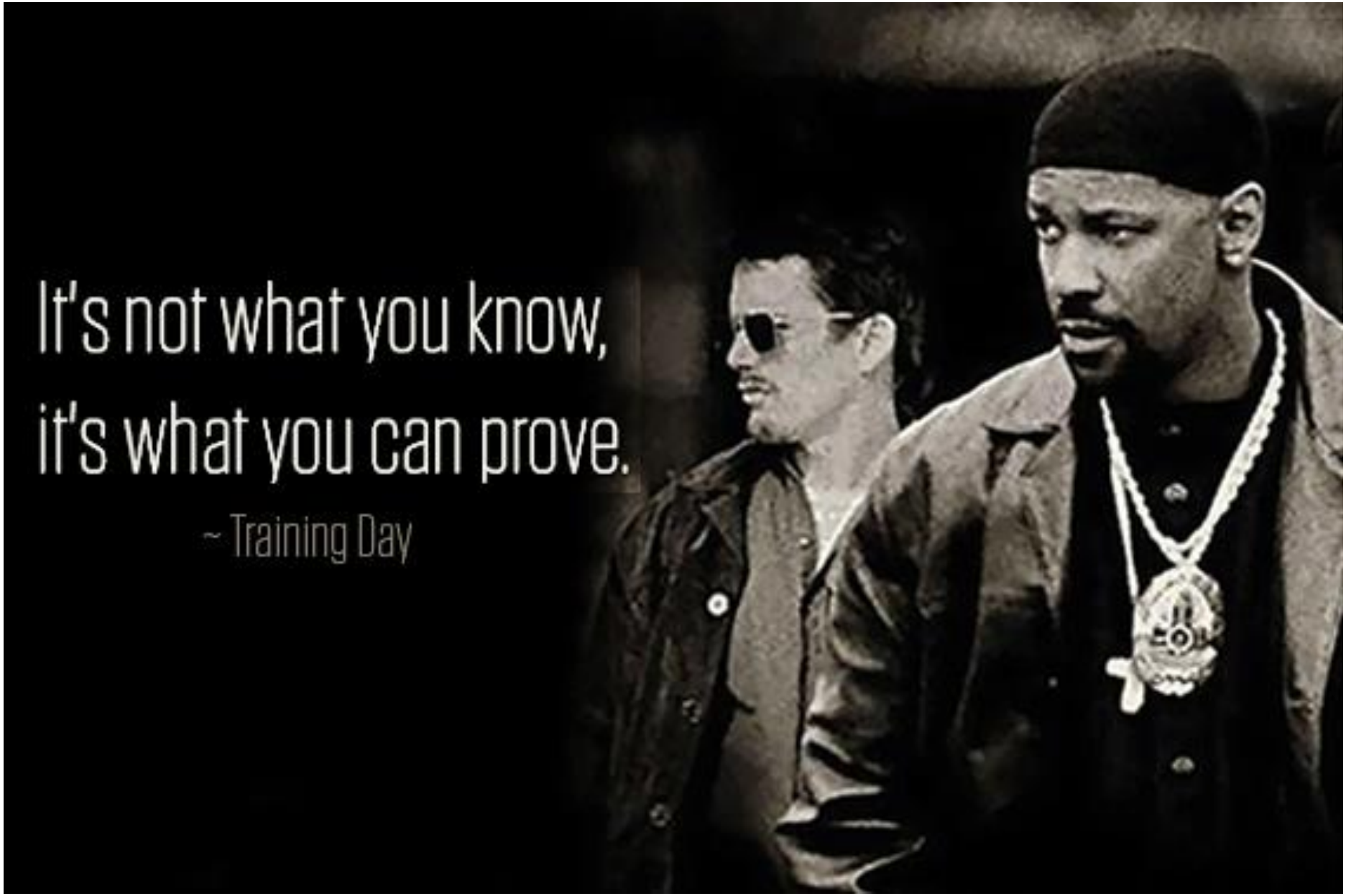
Survey: How Many of You See the Value in Technology?

beyond lucid
Technologies & Consulting

Survey: How Many of You Have Figured Out How to Get Paid?

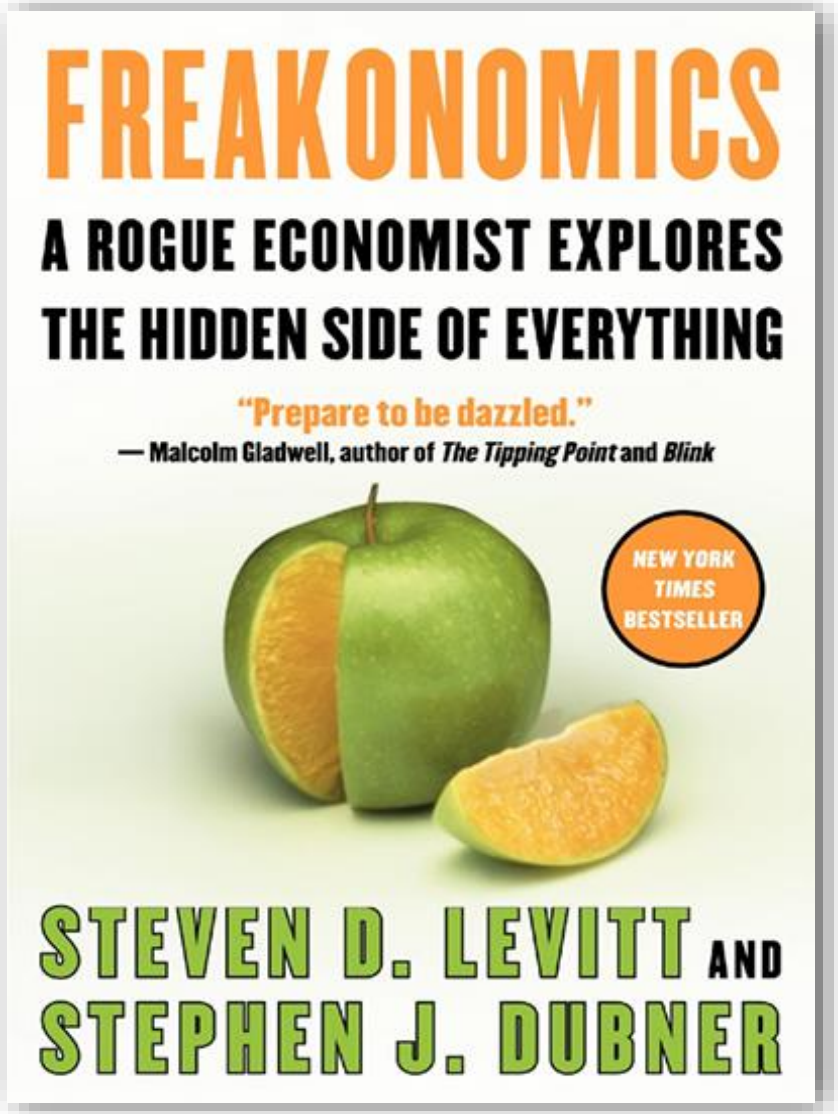
beyond lucid
Technologies & Consulting

What's the value of your Community Paramedicine program so far?



You believe your CP/MIH program creates systemic value.

BUT CAN YOU PROVE IT?



How does technology factor into Community Paramedicine / MIH?

Patient record

Capture

Real-time data transfer

Use

Patient tracking

Lookup

Connected Prehospital Care.

Community Paramedicine MIH

- EMS & Fire
- Medical personnel
- Patient's family and/or employer
- Nursing, home care
- Legal, political and regulators
- Public affairs

What's the difference b/w Incident-Specific & Patient-Specific Data?

beyond lucid
Technologies & Consulting

Incident Charting vs. Patient Charting: The Key to CP/MIH Success

BLT
First Response Matters.
www.BeyondLucid.com

The "5 Rs" of Community Paramedicine and Mobile Integrated Health

By Jonathon S. Feit, MBA, MA
Co-Founder & Chief Executive
Beyond Lucid Technologies, Inc.
Jonathon.Feit@beyondlucid.com

After my talk at the 2014 International Roundtable on Community Paramedicine, business spiked, which is why my *EMS Innovation Newsletter* was quiet for a few weeks. But a day of sessions on Community Paramedicine and Mobile Integration Health will take place at this year's EMS World Expo, and topics including out-of-home care, alternate site transport, non-transport, readmission prevention, and telemedicine will surely arise. They will do so again in the weeks following, at the American Ambulance Association conference and the International Association of EMS Chiefs Leadership Summit. (Let me know if you'll be attending and wish to discuss your specific context.)

As an MBA, and Co-Founder and C.E.O. of the first EMS-facing technology firm that designed patient documentation software specifically with Community Paramedicine and Mobile Integrated Health (CP/MIH) in mind, Fire and EMS agencies nationwide have sought my team's help to walk down the new care model's legal line (a dotted line at best in most places) while bolstering sustainability through sound economic judgment. After all, the archetypical CP/MIH models highlighted frequently across the country—including REMSA, MedStar, UPMC, Mesa (Arizona), Eagle County (Colorado), and San Diego—offer an inspiring set of models that seem to show signs of regional success. However, they are also specialized and very challenging to replicate.

In the long-term, most places cannot get paid for CP/MIH (and they won't be able to for a while)—so below are my *"5 Rs of Community Paramedicine and Mobile Integrated Health,"* suggestions to guide the efforts of agencies large and small that wish to engage this new care delivery model:

1. **REASON** – Agency leaders should ask themselves *why* they want to go down this road. Is it to improve clinical care, lower costs, or free up resources? Or—if we're being honest—is it because CP/MIH seems like "the thing to do"? It's a hot topic, and "the cool kids are doing it." Are you afraid of being left out? Implementation isn't easy: a fire chief in Texas once told me he had to "use all his political capital" to push through a non-transport regulation pertaining to frequent transport patients. CP/MIH is at least as complex as frequent transports because its cost-benefit analysis is less obvious, as is the means by which to identify the patients—and providers—who will take part in the program, how patients will be tracked, and who holds command authority. (Add in union issues, and you have a recipe for extensive negotiations.)

2. **RIGHTS** – Speaking of extensive negotiations: Do you even have the legal permission to engage in CP/MIH? Consider what's happening in California right now: the state has preliminarily authorized eleven "Community Paramedicine Pilot Projects," an educational program to be run through UCLA, with statistical oversight by the University of California San Francisco. Given its practical, innovative curriculum and a statewide training model, the program should be a shoe-in—but California tightly restricts ambulance operations, and nursing unions have complained about EMS agencies invading what has traditionally been "their turf." Does your state allow you to take patients somewhere other than a hospital?

3. **REVENUES** – Revenue considerations are an interesting question-mark in the age of Accountable Care and the readmission prohibition. Hospitals weigh whether bringing patients in frequent visits is worth a penalty and possible non-reimbursement. (It's a more complicated calculation than it sounds.) Ask yourself: is CP/MIH a line of business worth the economic loss that your agency will incur by engaging in non-transport activities? Have you considered "the other side of the ledger"? Matt Zavadsky's presentations stand out among expert discussions on the cost savings promised by CP/MIH, but in his zeal to evangelize system savings, Matt rarely references the costs incurred by EMS agencies—including gasoline, supplies, and field provider time—that cannot be reimbursed under CMS's current payment scheme. If you're going to spend money but *not* [illegible] find another way to justify the expense: Marketing to build co[illegible]ng to improve bedside manner for chronic patients. Pe[illegible]dopter who is responsible for bringing to life the "F[illegible]tric, you will have to *justify* foregone revenue[illegible]

4. **REGION** – How supportive [illegible]es? What if (as one agency brough[illegible]way from local care providers? Will [illegible]nt care, despite a loss of revenue[illegible]ls start becoming difficult to copy: [illegible]ue. REMSA received a federal CMS[illegible]Fire received funding, too. UPMC ar[illegible]plex competitive relationship that exists[illegible]eacon Community a regional data sharing[illegible]e at its disposal to incentivize and underwrite t[illegible]

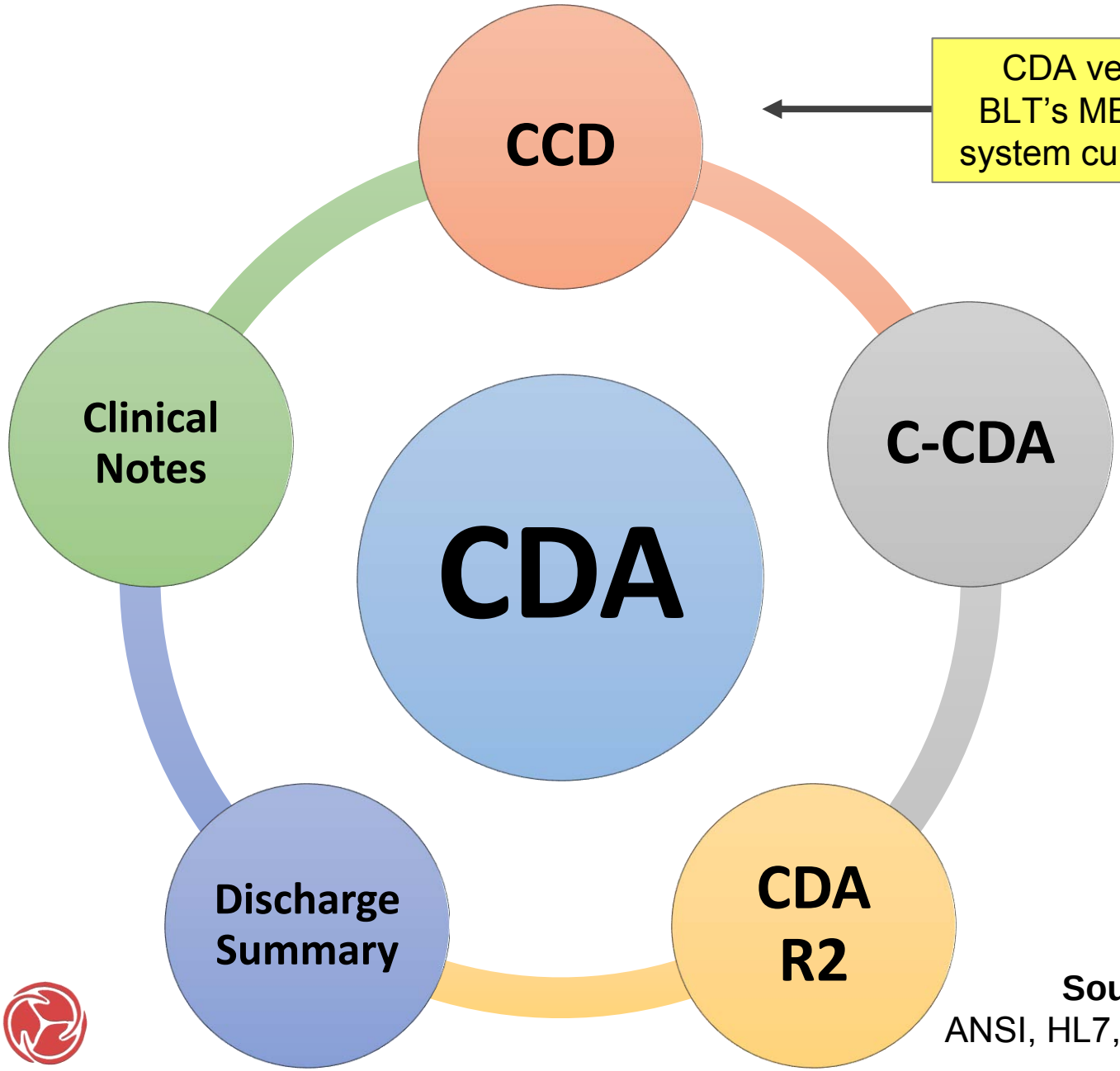
5. **RECORDS** – I'm admittedly biased by my Day[illegible] a shortage of robust and sophisticated documentation software is a chronically neglected component of the CP/MIH process. It's also a critical reason that almost every CP/MIH program—no matter how clinically well-designed—has stayed small. Unlike traditional incident-specific ePCRs, CP/MIH requires records that are longitudinal in nature, tracking patients over time. Quality Metrics pertaining to Accountable Care and post-discharge follow up to avoid readmissions demand modern tools for data management, aggregation and real-time, high quality statistics. It has been interesting to watch the famous CP/MIH programs try bending pre-existing technology to meet their needs, yet none has succeeded: traditional neither ePCRs nor hospital-side electronic health records collect enough EMS-oriented data about themselves. The question is how quickly agencies will acknowledge CP/MIH's unique data needs—and the need for appropriately smart technology to measure success.

disposal to ince
5. RECORDS –
and sophisticated
CP/MIH process
how clinically

From ePCR to Hospital EHR: “What is this HL7 thing, anyway?”

- **Why is HL7 relevant to CP/MIH?**
- **Why is NEMSIS v3 a prerequisite?**

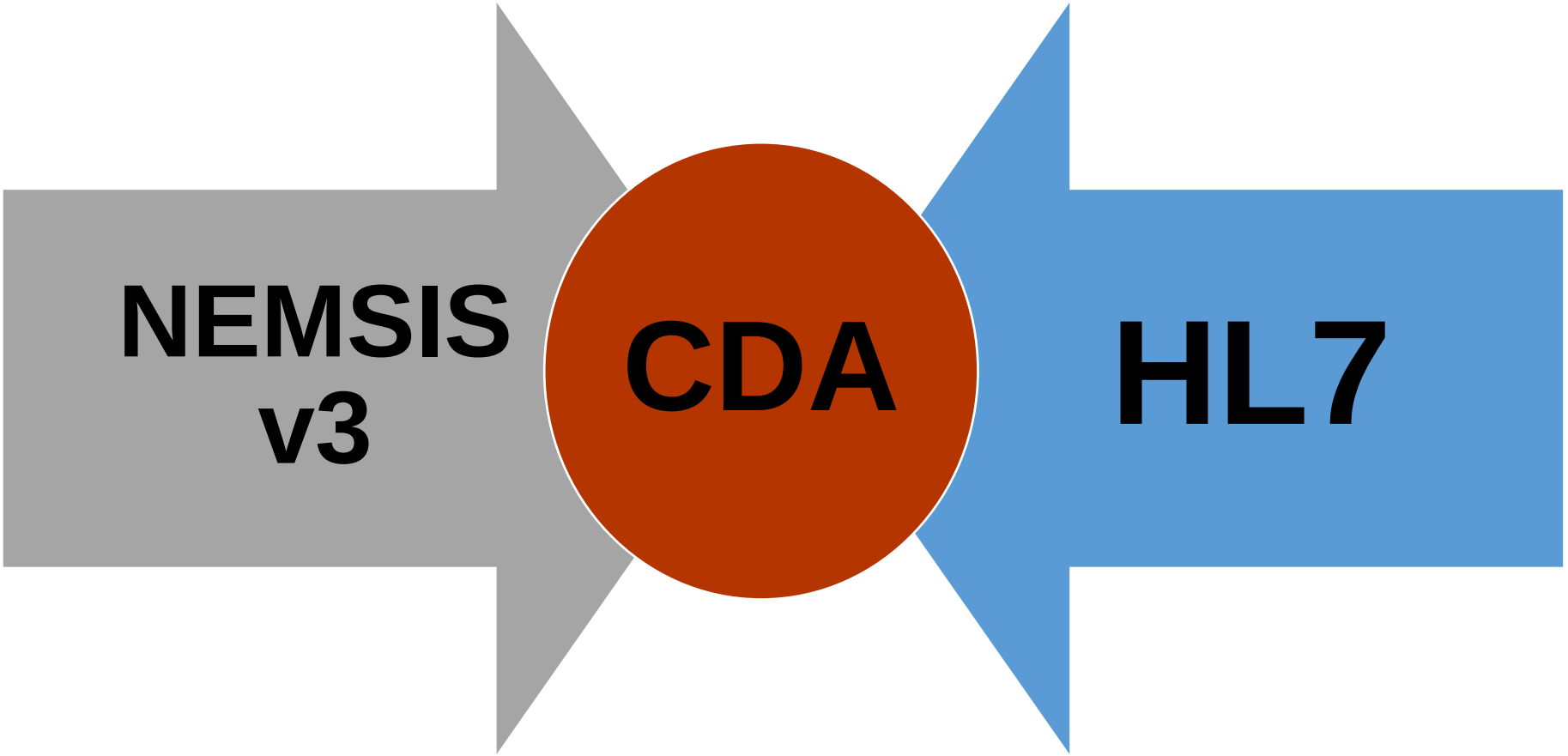
Types of Standard Interoperable HL7-Based Clinical Documents



Sources:
ANSI, HL7, HealthIT.gov

beyond lucid Technologies & Consulting

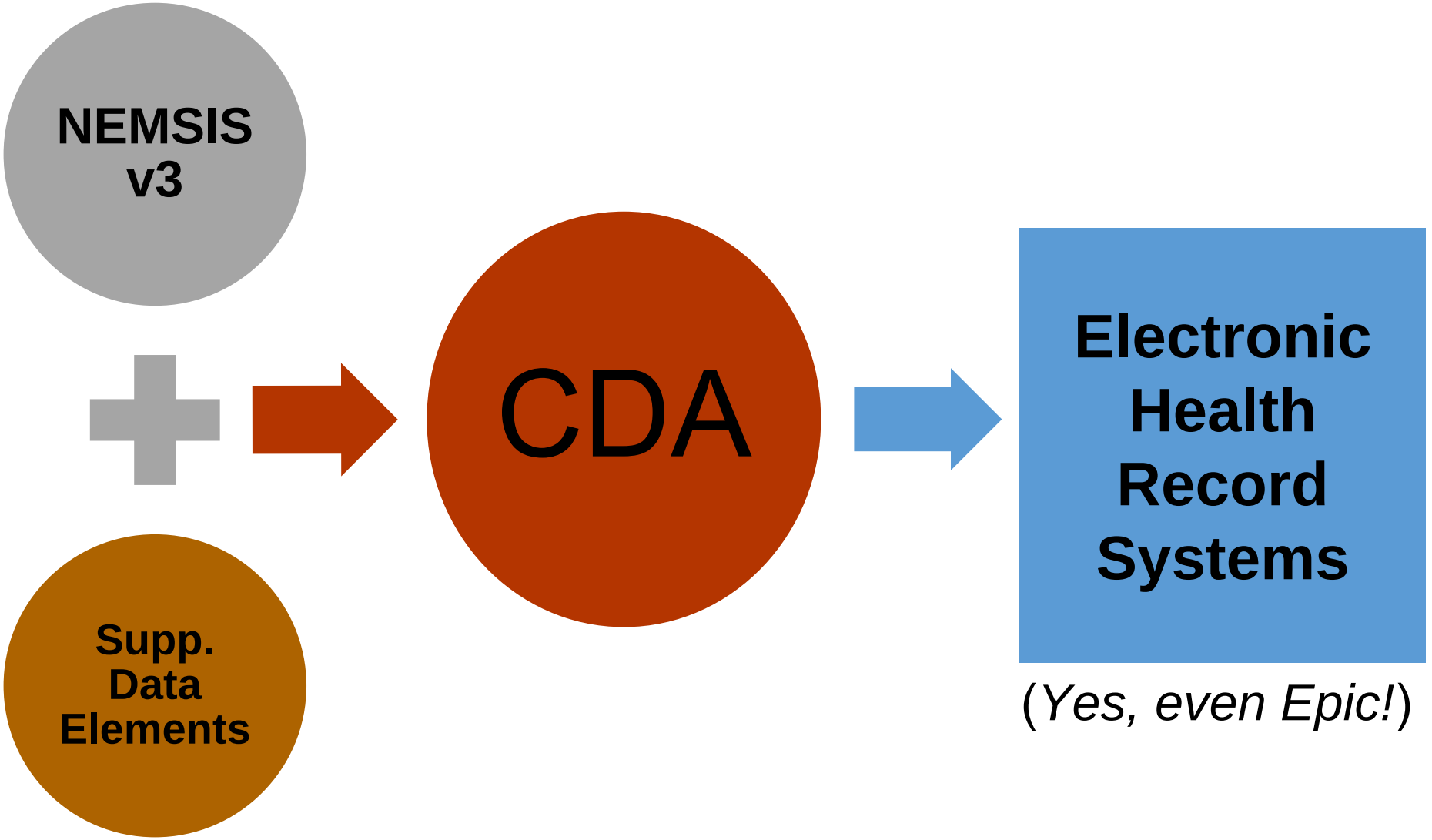
How Do CP/MIH Programs Connect EMS Charting Systems to EHRs?



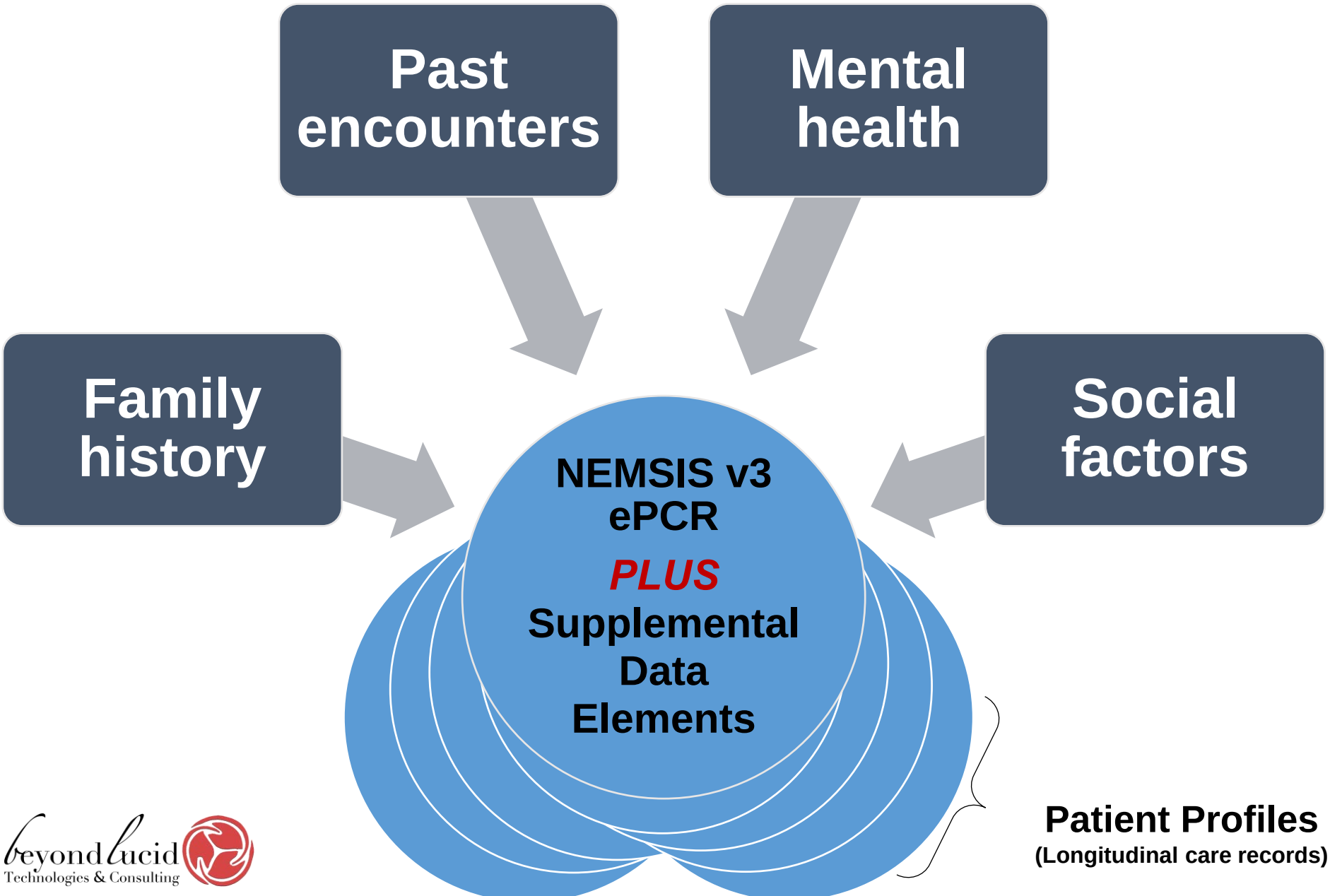
CDA is the set of common data elements that connect electronic health record systems to one another. It is not proprietary. NEMSIS and HL7 cannot directly "talk" (interoperate) with one another.

NEMSIS v2 ePCRs will experience unmappable "data holes" when attempting to generate a meaningful CDA. NEMSIS v3 is required.

How Do CP/MIH Programs Connect EMS Charting Systems to EHRs?

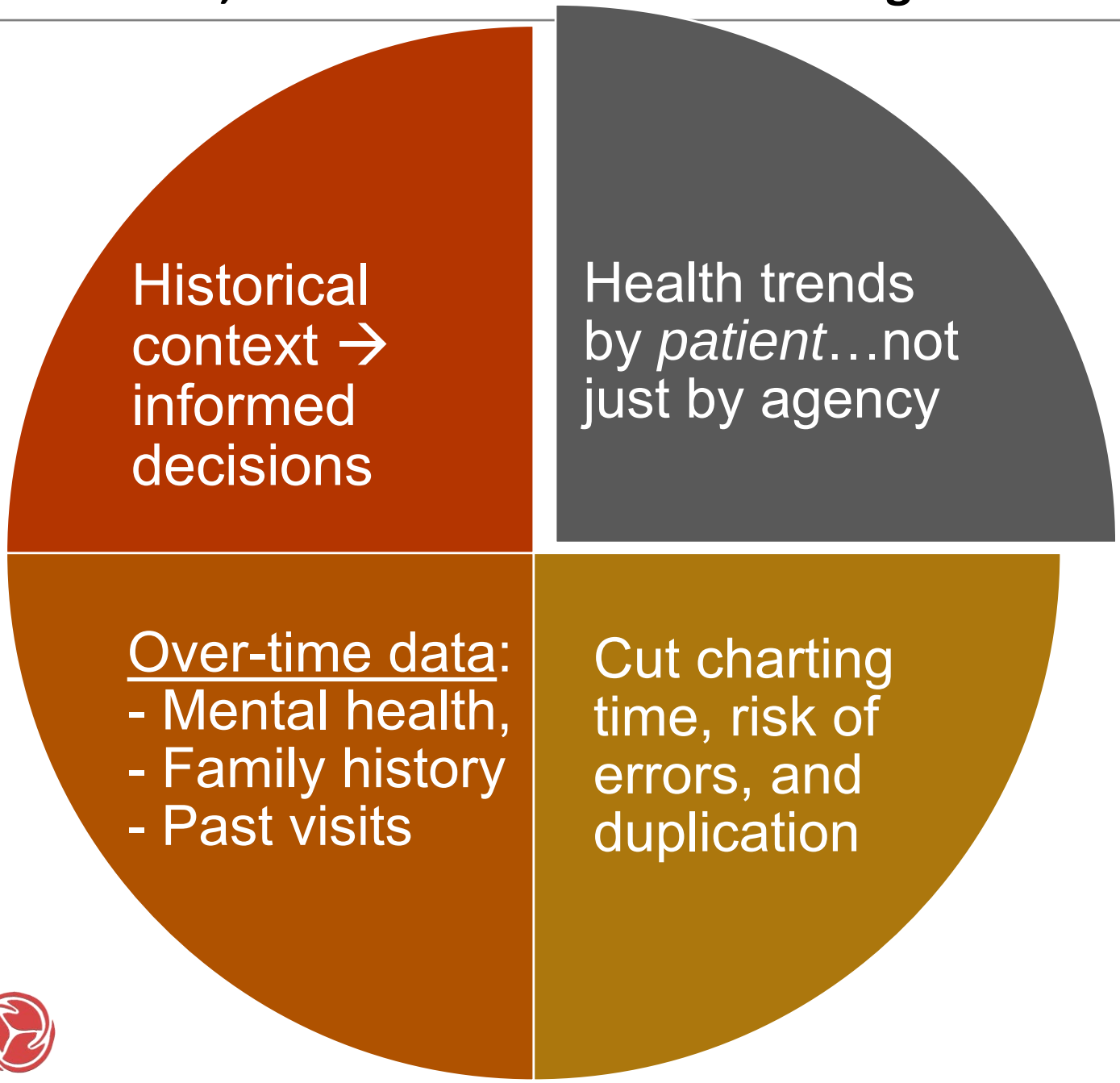


Standard ePCRs are INSUFFICIENT to Chart Patient Care Over Time



beyond lucid
Technologies & Consulting

Clinical, Operational, and Financial Benefits of Longitudinal Charting



beyond lucid
Technologies & Consulting

With documented results, justifications of payments is far easier.

75% Reduction in Returns to the ED within 30 days

51.75% Reduction in Frequent Use of EMS by "Familiar Faces"

Alameda County EMS and the Alameda Fire Department operate one of the twelve Community Paramedicine pilots that have been

P.S. How to establish a minimum budget target, to get started…

beyond lucid
Technologies & Consulting

Thank you.

Beyond Lucid Technologies, Inc.
Jonathon S. Feit, MBA, MA
Co-Founder & Chief Executive
Jonathon.Feit@beyondlucid.com
1220 Diamond Way, Suite #240
Concord, CA 94520
(650) 648-3727 main

Online at www.beyondlucid.com

JEMS HOT PRODUCT EMS TODAY 2015

2014 EMSWORLD INNOVATION AWARDS