Matthew Goudreau, BS, ACP, CP
Associate Director, Acute Clinical Response
February 10, 2017

SYSTEMATIC EVALUATION OF EASCARE'S COMMUNITY PARAMEDICINE SYSTEM

Introduction to CCA

- **Our mission is to provide the best possible care, tailored individually to the members we serve throughout Massachusetts – elders and people across the age spectrum with special healthcare needs.**
  - **To accomplish this, we bring to scale proven clinical strategies that improve care and manage costs, within a team-based, consumer-directed, prepaid care delivery program.**

EasCare Ambulance Service

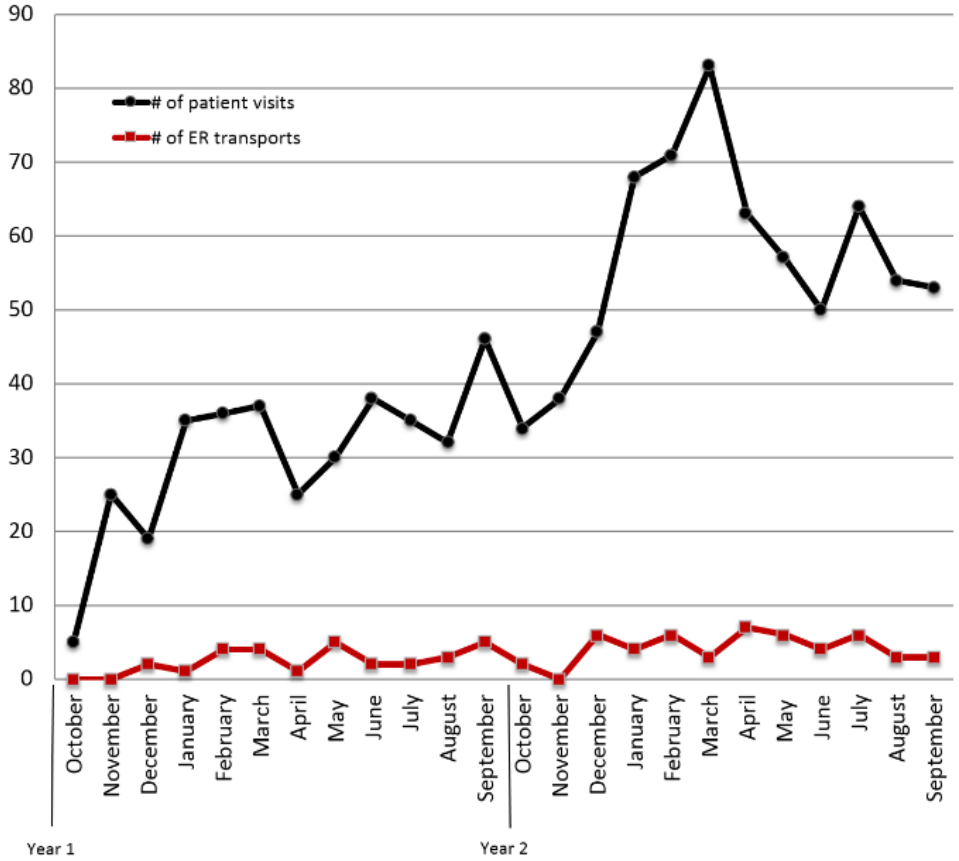
- **Paramedic Service providing:**
  - **Primary Care Paramedic**
  - **Advanced Care Paramedic**
  - **Community Paramedic**
- **170,000 patient transports annually**
  - **Average of 55 CP visits per month**

CP Program:

Common Patient Profile:

- **Dual eligible**
- **Multiple co-morbidities**
- **Behavioral health**
- **High acuity care**

Time on task: 90+ minutes



What are the Outcomes?

- Is the program meeting the Triple Aim criteria?
  - Are there cost savings to the system?
  - How was the impact on the patient's outcome?
  - Were these patients happy with the care they received?
- Did the CP have a positive experience delivering care?

SYSTEMATIC EVALUATION OF EASCARE'S CP SYSTEM

commonwealth care alliance

PERSPECTIVE

COMMUNITY PARAMEDICINE

Community Paramedicine — Addressing Questions as Programs Expand

Lisa I. Iezzoni, M.D., Stephen C. Dorner, M.Sc., and Toyin Ajayi, M.B., B.S.

Growing increasingly short of breath late one night, Ms. E. called her health care provider's urgent care line, anticipating that the on-call nurse practitioner would have her transported to the emergency department (ED). Over the past 6 months, Ms. E. had made many ED visits. She is 83 years old and poor, lives alone, and has multiple health problems, including heart failure, advanced kidney disease, hepatitis C with liver cirrhosis, diabetes, and hypertension. In the ED, she generally endures long waits, must repeatedly recite her lengthy medical history, and feels vulnerable and helpless. She was therefore relieved when, instead of dialing 911, the nurse practitioner dispatched a specially trained and equipped paramedic to her home.

care and community paramedicine programs aim to address critical problems in local delivery systems, such as insufficient primary and chronic care resources, overburdened EDs, and costly, fragmented emergency and urgent care networks.[1] Despite growing enthusiasm for these programs,[2] however, their performance has rarely been rigorously evaluated, and they raise important questions about training, oversight, care coordination, and value.

EMS systems were established in the United States in the 1950s and expanded, using federal funding, in the 1970s to create 911 response networks nationwide. Operating EMS systems around the clock requires trained workers with diverse skills. In 1975, the American Medical Associa-

departments provide roughly half of today's emergency medical services. Almost all 911 calls result in transportation to an ED because of state regulations and payment policies: insurers, including Medicare, typically reimburse EMS providers only for transporting patients. At the receiving end, many EDs face escalating demand and soaring costs, as more people seek attention for nonurgent acute and chronic conditions — in part because they lack regular sources of primary and chronic disease care. One estimate suggests that about 15% of persons transported by ambulance to EDs could safely receive care in non–urgent care settings, potentially saving the system hundreds of millions of dollars each year.[2]

http://www.nejm.org/doi/full/10.1056/NEJMp1516100

Need for Research

- **"Despite high expectations for mobile integrated health care and community paramedicine programs, we largely lack rigorous data on their performance."**
- **"The researchers also examined whether, after on-scene evaluations, EMS personnel could accurately determine whether patients could be treated outside the ED, and again they found few studies that were rigorous enough to 'support confident conclusions'."**

PCORI Research Contract

- **Patient Centered Outcome Research Institute (PCORI)**
  - **"Patient-centered comparative clinical effectiveness research, or CER"**
- **Massachusetts General Hospital, Mongan Institute Health Policy Center**
  - **Lisa Iezzoni, MD, MSc, Director**
- **Research Participants:**
  - **Commonwealth Care Alliance: Toyin Ajayi, Chief Medical Officer**
  - **EasCare Ambulance: Scott Cluett, ACP, Director, Mobile Integrated Health**
  - **Disability Policy Consortium**
  - **Boston University, School of Social Work**
  - **Center for Survey Research, University of Massachusetts, Boston**

Specific Aim One

- **To compare the outcomes of CP care with standard urgent care outcomes across three health and health care outcomes:**
  - **(a) ambulance transports to the ED**
  - **(b) hospital admissions following these ED visits**
  - **(c) health care services received within 1 week, 1 month, and 3 months of initial urgent care call**

Specific Aim Two

- **To compare person-centered outcomes of CP care with outcomes of standard urgent care as follows:**
  - **(a) experiences and perceptions of urgent care patients across the urgent care episode**
  - **(b) reports of a family or household member, neighbor, personal care assistant, or other person designated by the patient, as available, about their experiences during and views of the urgent care episode**

Specific Aim Three

- **To compare job satisfaction and professional experiences and perceptions of CP versus other ACP serving urgent care patients**

Note: Current research is focused on ACP level care only

Specific Aim Four

- **To assess two major aspects of CP that are critical to disseminating it beyond CCA:**
  - **(a) reliability of clinical decisions required during CP care (initial decision to send CP paramedic rather than EMS emergency response and decision, once CP is on scene, about whether to call in EMS)**
  - **(b) comparison of resources required to implement CP versus standard urgent care (e.g., staff, training, equipment, communication systems)**

QUESTIONS?

Links

- PCORI: http://www.pcori.org/
- CCA: http://www.commonwealthcarealliance.org/
- Mongan Institute Health Policy Center: http://www.massgeneral.org/monganhealthpolicycenter/
- EasCare: http://www.eascare.com/
- Center for Health Care Strategies, Inc.: http://www.chcs.org/media/Community-Paramedicine-Brief-120116_FINAL-updated.pdf
- NEJM article: http://www.nejm.org/doi/full/10.1056/NEJMp1516100