Beyond the Emergency:

Integrating Community Paramedicine with Hospital Care

WHAT IS COMMUNITY PARAMEDICINE?

The practice of Community Paramedicine is holistic in nature. It encompasses providing necessary care while tending to the social determinants of health and improving the overall quality of life.

It's no secret patients recover more efficiently in their own homes. The goal of Community Paramedicine is to keep these non-emergent patients safe and in their own home, where they prefer to be.

Approximately 100 EMS agencies in 33 states have launched some version of a Community Paramedicine Program

Origin:

The term "Community Paramedicine" was first used in 2001 to describe a model for *improving* health care delivery in *rural communities* by training licensed paramedics to address non-emergency medical and social needs in patient homes, rather than transporting patients by ambulance to hospital emergency departments.

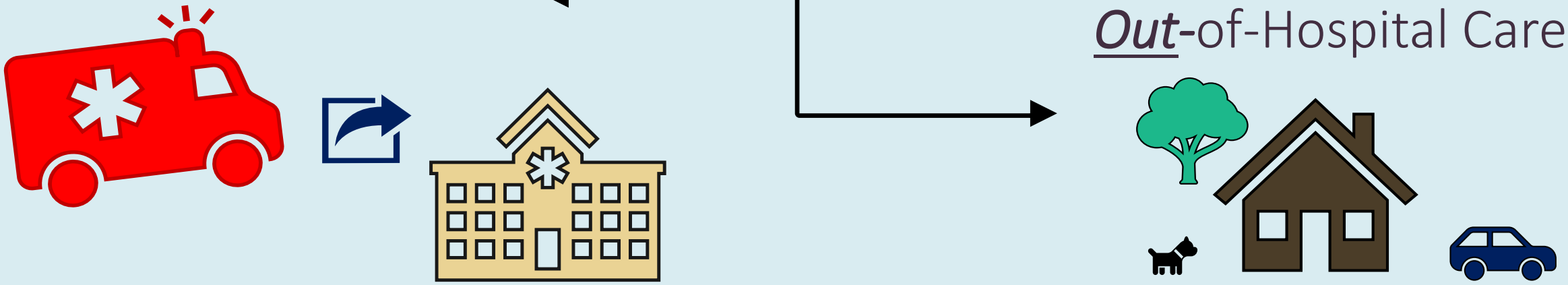
In the late 1990s, Orange County, NC and the state of Idaho independently incorporated alternative approaches to the treatment of the low-acuity patient

*What you say **does** matter!*

Pre- Hospital Care

VS.

Out-of-Hospital Care



MH vs. Community Paramedicine

The amount of education required by the providers and the ability to interface with the 9-1-1 system are the primary differences.

Mobile **I**ntegrated **H**ealthcare **(MIH)**

- Conduction of preplanned visits for specific populations assigned to them
- Focused education tailored to the population they are assigned to (ex. CVA, heart failure)
- MH is *not* a licensure and there is not plans yet to standardize this.

Community **P**aramedicine **(CP)**

- In addition to preplanned visits, CP units may interface with the 9-1-1 system, exposing them to a variety of populations and they must be able to navigate an array of systems and community resources
- *CP is not yet a licensure, but this process has begun*
- Extensive education in various topics including but not limited to, wound care, chronic disease, acute on chronic exacerbations, infection prevention, fall prevention, home safety, and pharmacology

EVERY COMMUNITY IS UNIQUE

- Increased public education
- Medical literacy
- Medication reconciliation
- Medication adherence
- Chronic disease education & management
- Facilitating transportation
- Appointment adherence
- Community Resource Referral
- Reduction in loneliness for the elderly
- **Bridge the gap between transition of services in healthcare**

Community Paramedicine

- Emphasis on *acute, sub-acute* care
- Trained to adapt to their environment in any situation
- ALS licensed vehicle (echo response)
- Directly integrated with the 9-1-1 system with capability of treating a critical patient on scene until ambulance arrives
- Typically, a senior paramedic with additional education in chronic disease process, pathophysiology and pharmacology
- Able to utilize EMS and CPP protocols to provide treatment prior to PCP contact

Home Health Care

- *Emphasis on chronic* care
- Typically, nurses without emergency medicine background
- Unable to provide treatment without a physician order
- Unable to perform EKGs or establish IV access on scene
- Specialized in chronic wound care, wound vacs and central line access
- Not as flexible in scheduling or adaptability
- Often ordered with PT/OT or have direct access to these resources

Step 1: Identify a Community Need

St. Clair County Community Health Improvement Plan (CHP)
Data collected in 2021
Published in 2022
CHP 2023-2027

The six significant issues identified were as follows:

1. Mental and Behavioral Health
2. Substance Use
3. Obesity and Associated Health Behaviors
4. Infant and Child Health Care and Development
5. Chronic Disease
6. Equitable Access to Health Care Providers and Services

COMMUNITY PARAMEDICINE TRIAL GOALS

Increase effective communication within patient's healthcare team (physicians, nurses, social workers, pharmacist etc.)

Increasing access to healthcare for underserved populations (ex: Medicaid in SOC)

Improving patient satisfaction and quality of life

Improving patient experience during care transitions (hospital → home / SNF → home etc.)

PATIENT QUALIFIERS

Diagnosis: CHF > COPD > AMI > diabetes (new onset/uncontrolled), sepsis & ortho post op

Insurance: BCBS Commercial, BCN Commercial, BC Complete, BCN Advantage, Medicare Plus Blue, MI Medicaid, Meridian Medicaid, Molina Medicaid, McLaren Medicaid, Aetna Medicaid *Priority Health Medicare

LACE Score/ Readmit Score: Determines risk for readmission- Moderate/High Risk

True Non-Compliance vs. Compliance Challenges

SDOH Concerns?

Social Work/Case Management Notes- Resources Provided Previously?

PROGRAM NAVIGATION

- **Referral to CPP**
- **Meet & Greet (pre-discharge visit)**
- **Research & Scheduling**
- **Initial CP Visit** (Within *48-72 hours* post referral)
- **Plan of Care-** visits are continued as needed. Typical enrollment is weekly for first 30 days post discharge.
- **Program completion-** successful (goal met) or unsuccessful CPP discharge.

MEETING GOAL IS CLASSIFIED AS FOLLOWS:

- Successful CPP discharge
- Transfer of care to other area of the healthcare system
- Personal goal set by patient, CP or PCP met

Lights. Camera. ACTION!

Launched: June 19th, 2024 – October 30th, 2024

Quick Stats:
12 total cases
45 visits completed
11/12 successfully met goal (planned discharge)
1/12 unplanned discharge (did not meet goals)
1 patient transferred to skilled nursing facility for higher level of care
1 patient transfer of care to hospice (died to 2 weeks after enrollment)
2 visits requiring emergency intervention/ 911 activation *during* CP visit

Services Overview:
Care Coordination (HHC, PCP, BWH, PACE, Medtronic etc.)
Medicare/Medicaid navigation assistance
Home 02 concerns
Medication adjustments ordered by PCP
Ambulatory assistive device concerns
Rx pick-up
PCP enrollment
Transportation concerns
Depression/Isolation concerns
Medical equipment concerns/ shower chairs, grab bars, walkers etc.

Launched Under Contract

January 10th, 2025 – Present

Quick Stats:
58 total cases
252 visits completed
46/58 successfully met goal (planned discharge)
10/58 unplanned discharge (did not meet goals)
1 patient transferred to skilled nursing facility for higher level of care
5 patient transfer of care to hospice (died to 2 weeks after enrollment)
4 visits requiring emergency intervention/ 911 activation *during* CP visit

Services Overview:
Care Coordination (HHC, PCP, BWH, PACE, Medtronic etc.)
Medicare/Medicaid navigation assistance
Home 02 concerns
Medication adjustments ordered by PCP
Medication Treatment on Scene
Ambulatory assistive device concerns
Rx pick-up
PCP enrollment
Transportation concerns
Depression/Isolation concerns
Medical equipment concerns/ shower chairs, grab bars, walkers etc.

Case 013

Dx: New Onset IDDM Type II

Concerns:
No discharge education
YouTubed how to self-administer his insulin pen & how to check his glucose level
Patient was told sugar and carbs are bad, so he eliminated both from his diet entirely
Patient was preparing to take 'extra insulin' and not eat because his glucose levels weren't dropping fast enough
During discharge he asked a question and was told his PCP would answer all questions at his follow-up appt.

(Follow up appt. was cancelled by PCP and rescheduled for the following week. CP saw patient 48 hrs post discharge).

Summary:
Initial visit was 3 hours. Patient was provided education, including diet examples, diagrams and teach/teach back techniques. After visit the patient says, "This isn't so bad. I think I can do this. My wife was terrified when we got home. I've been on google for the last two days." Patient was scheduled with PCP, Ophthalmologist and Endocrinologist all within his first week of home.

Update:
It's been 3 weeks since diagnosis. Patient grows more confident in his care each day. Glucose levels have begun to normalize, his diet has improved greatly and he's adjusting well to his medications. He is now scheduled biweekly and slated for successful CPP discharge on February 4th, 2025.

TRIAL SUMMARY

45 Total CP Visits x $500/ Per Visit

$22,500

General Hospital Admission <30 days of D/C

$15,000+

12 Hgh Risk for Readmission Patients x $15,000

$180,000+

Readmissions cause the United States healthcare system more than **$26 BILLION** annually

Medicare alone spends an estimated $17 billion on unplanned hospital readmissions

Year To Date Summary

58 Total CP Visits x $500/ Per Visit

$29,500

General Hospital Admission <30 days of D/C

$15,000+

58 Hgh Risk for Readmission Patients x $15,000

$870,000+

- INCREASED PATIENT SATISFACTION
- Increased health and medication literacy
- Smoother care transitions for patients
- Increased quality of life
- Care collaboration with other agencies
- More opportunity for public education
- Integration with 911 system

https://www.ncsl.org/resources/details/community-paramedicine-connecting-patients-to-care-and-reducing-costs#:~:text=There%20are%20several%20challenges%20to,regulations%20and%20duplication%20of%20services.

- FUNDING AND REIMBURSEMENT CHALLENGES
- Navigating CP scope of practice
- Integration with existing healthcare systems/ agencies
- Potential for service duplication
- Lack of standardized training
- Public perception

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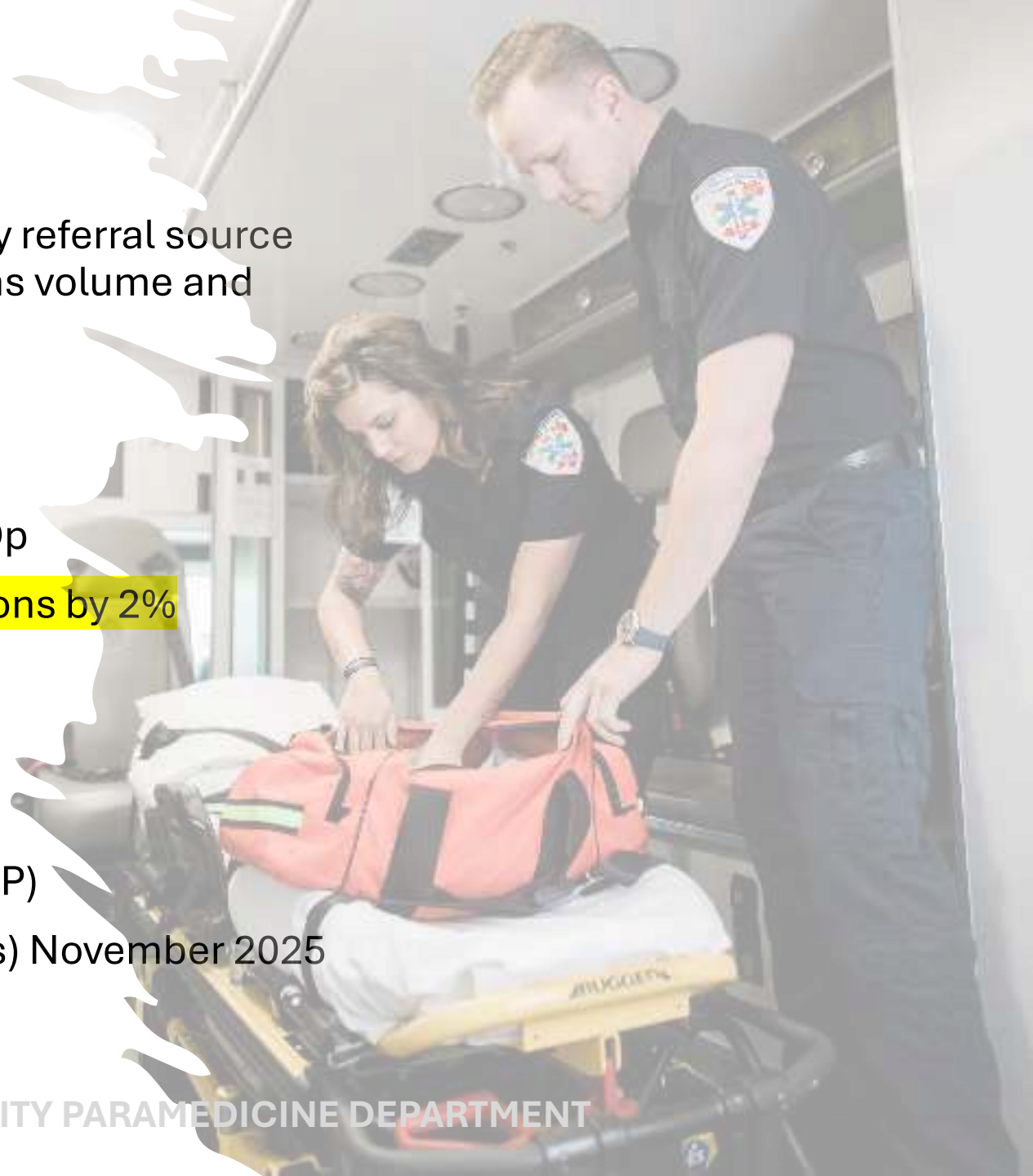
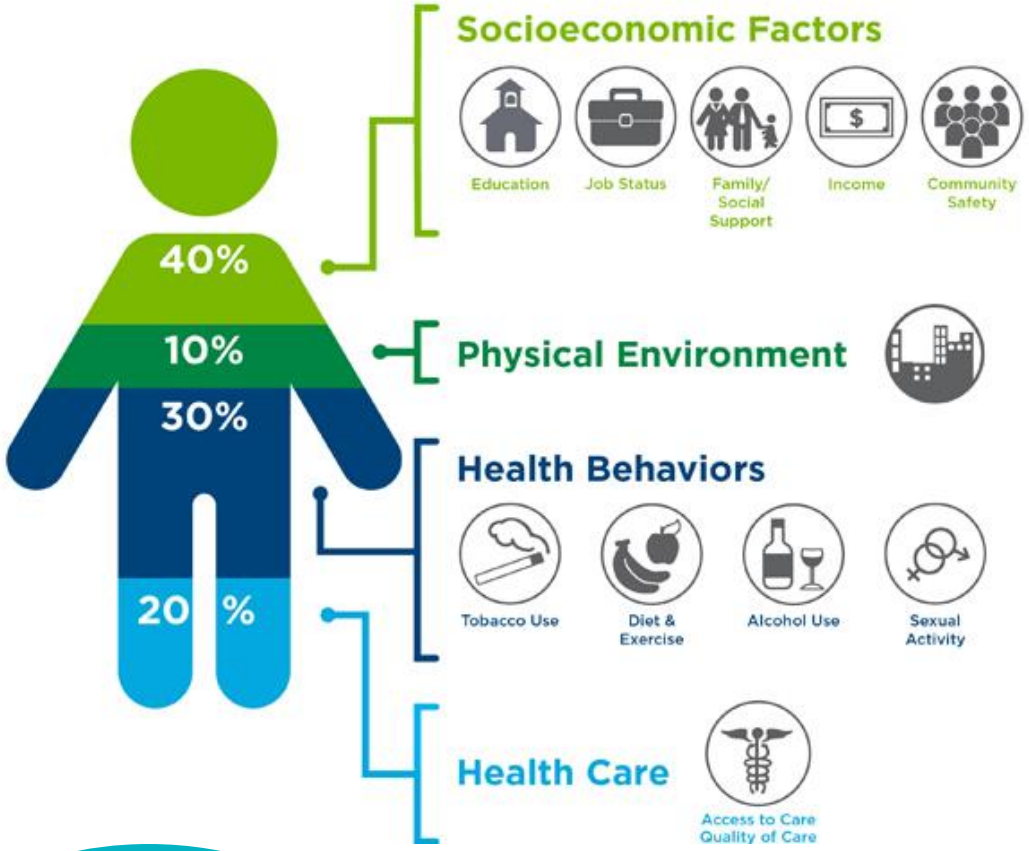
August 2025 Snapshot

- McLaren Port Huron Hospital remains the primary referral source (beginning to intergrade ambulance crew referrals as volume and staffing allows).
- THEMS CPP operates M-F 0800-1700
- CP Hotline is active (24/7 paging)
- CHF, COPD, AMI, Diabetes, Sepsis, Ortho Post- Op
- 2025 quality goal is to reduce high risk readmissions by 2%
  - FY25 Baseline – 13.0%
  - Target – 12.7%
  - Hospital Readmission Rate (Data through June 2025)
    - 12.5% = 4% reduction from baseline.
- Additional CP staffing (1 full time/ 1 contingent CP)
- THEMS to host CP Education Program (4 students) November 2025
- **32** total visits in August



GETTING HOSPITAL BUY-IN



- Does leadership understand the direct effect of excess readmissions?
    - Throughput
    - CMS Readmissions Reduction Program
        - Up to a 3% reduction in payment.
    - CMS Star Rating
- What initiatives have already occurred?
    - Follow-up appointments
    - ED Case Manager
    - Navigators
    - Follow-Up phone calls
    - Education
- Know your data and understand why readmissions are occurring.
    - How soon are patients returning
    - Is there a particular condition that readmits more frequently
        - Are patients readmitting for the same issue as the index?

THE RIGHT CARE, BROUGHT RIGHT TO YOU

"There is an incredible toolbox of knowledge and information paramedics can bring to the bedside that doesn't exist elsewhere in the community."

– *Mike Guttenberg, MD, from Northwell Health Center for Emergency Medical Services*