Community Paramedicine Key Informant Interviews Summary

Maine Community Paramedicine Evaluation

May 2023

CATHERINE CUTLER INSTITUTE

MAINE EMS

Community Paramedicine Evaluation

Qualitative Data Collection

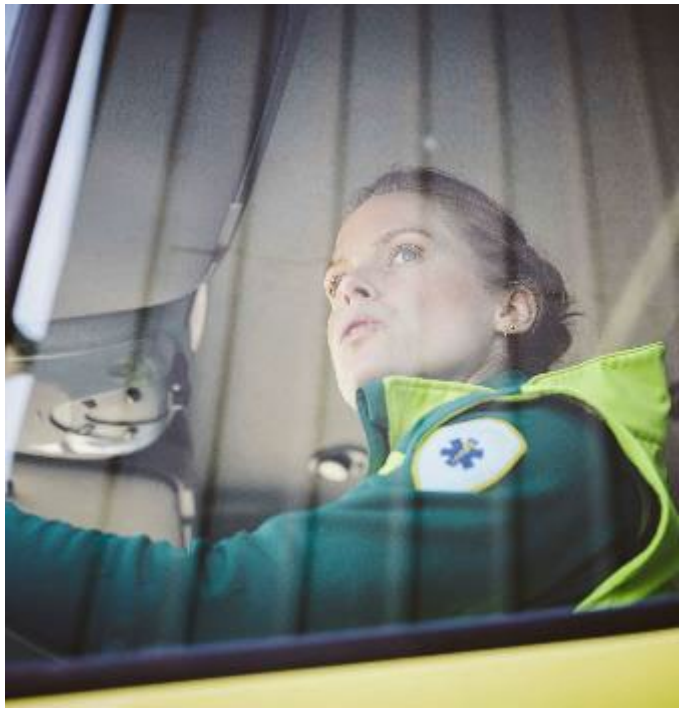
In 2022, Maine EMS contracted with the Catherine Cutler Institute at the University of Southern Maine to evaluate community paramedicine (CP) programs in Maine. The evaluation is mixed-methods, meaning both quantitative and qualitative data are collected and analyzed in order to share the successes, challenges, and future strategies for CP in Maine.

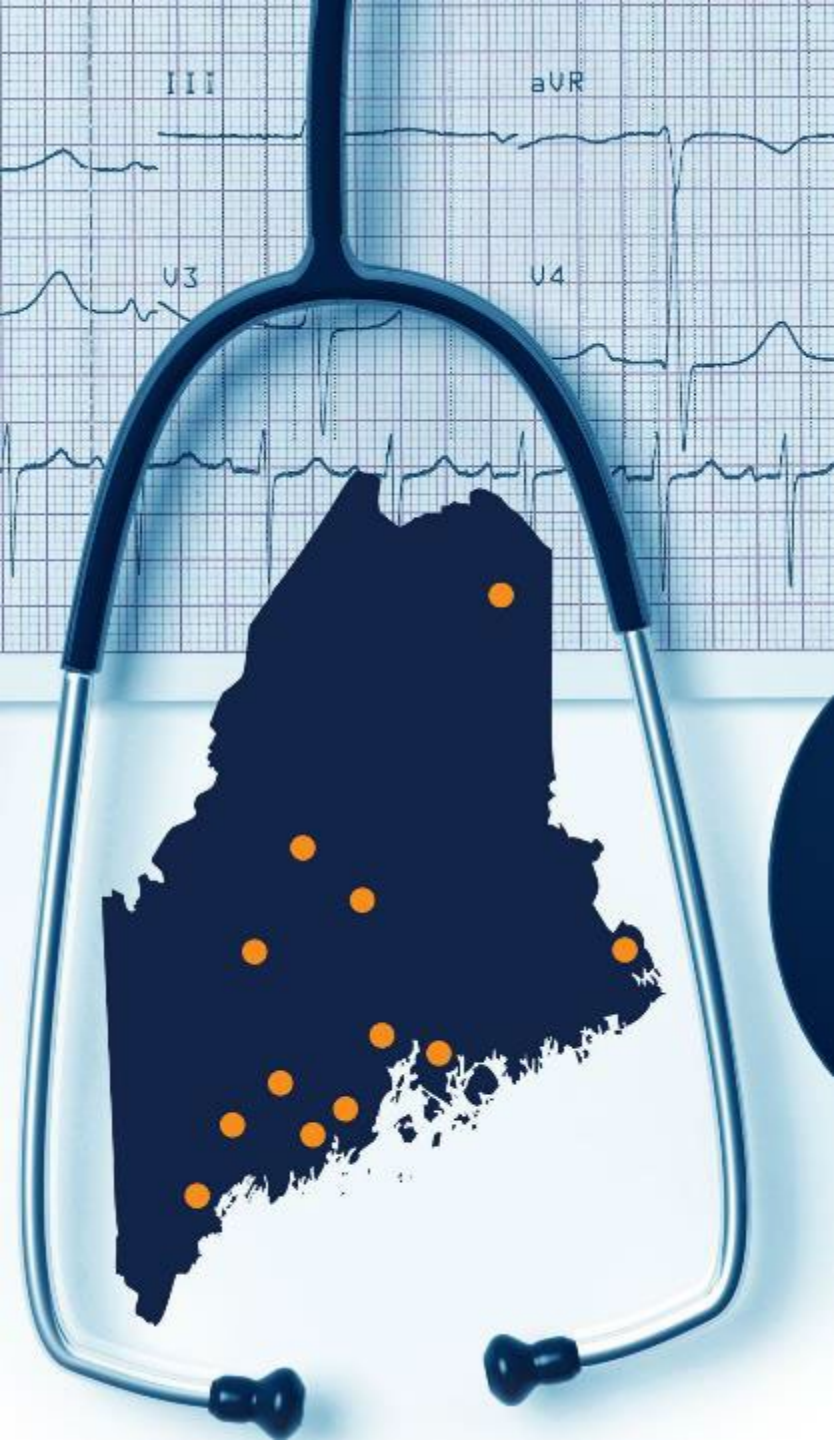
This report shares feedback from interviews conducted with Maine CP providers to gather qualitative data as part of the evaluation. This summary is designed to provide feedback to Maine EMS and other interested parties and will be included in the larger evaluation products once all data has been collected and analyzed.

Methodology

Interview protocols were developed by the Cutler evaluation team and reviewed and approved by Maine EMS. Interviewees were identified for each CP program site, and recruitment emails were sent by the Cutler team to schedule interviews. Interviews were conducted via zoom from November 2022 through January 2023.

Using the NVivo software, qualitative data analysis was conducted iteratively to identify recurring themes. Interviews were recorded and transcribed verbatim for analysis. After a high-level coding structure was developed by the evaluation team, each transcript was coded by a minimum of two coders and reviewed by the team. During the analysis phase, regular team meetings were held to discuss the coding process, compare coding, and review and refine code definitions.





Community Paramedicine Interviewees and Their Roles

We spoke with 11 EMS agencies that currently provide or have recently provided CP services in Maine. Interviewees included personnel who provided both oversight as well as direct CP visits. Several spoke of their role in coordinating and working with the financial aspects of the CP program, including securing grants.

Several of the interviewees also manage the internal scheduling of EMS personnel. Their responsibility is to coordinate scheduling between 911 response and CP visits.

All interviewees had more than two years' experience with their CP program, some with over 10 years. The CP programs are affiliated with hospitals or hospital systems, or municipally owned.

Interviewees spoke of the critical role of community partnership and connection with area medical providers. Partners included primary care providers (PCPs), physician practices, hospitals, home health and hospice, jails, and community coalitions.

All spoke to the importance of keeping the aging population, many with chronic conditions, from unnecessary visits to the emergency department and reducing hospital readmissions – which is a key component to CP.

The Cutler evaluation team is appreciative of the time each CP provider spent to share with us about their CP program.

Interview Themes

The iterative process used by the Cutler team identified emerging themes and constructs, with attention to elements suggested to be important regarding facilitators or barriers related to key domains of interest for CP — current and potential capacity, provider and/or community willingness, access to care/care provision, and administrative and procedural policies. While developing coding structures, consideration was given to factors that may drive the sustainability of the programs throughout the state: the varied needs of rural communities and populations targeted by CP, reporting and documentation, as well as staffing and overhead needs.

The final coding structure was organized into the domains of this report, as seen to the right: Community Needs and Goals, Staffing and Training, Referrals and Communication, Service Provision, Successes and Sustainability, and Funding and Future Directions.

Information from these interviews will be aligned with other qualitative and quantitative data collected as part of the ongoing CP evaluation to further explicate and validate feedback, and to identify areas needing additional exploration.

Section 1

Community Needs and Goals

Community Needs and Target Population

In 2012, at the outset of the pilot programs for CP in Maine, sites were required to conduct a community needs assessment.

Most interviewees reported that a community needs assessment was conducted, but most reported only doing it once and noted that the program had evolved from inception.

"I got our doctors together here… sat them down and said -- this is what we're proposing. It was a pilot program at the beginning and this is what we want to do-- what would benefit you? I thought I would get a straight answer and I got 15 straight answers. Everyone wanted to do something completely different. "

Since CP is a service that is not reimbursed by any payer, the targeted population may vary depending on funding stipulations from grant projects. The types of patients currently targeted by the CP programs, as reported by interviewees includes (order of mentions):

- Patients most often being readmitted and/or coming out of inpatient stays (high utilizer group)
- Patients with chronic illness
- Patients who need certain hospital services that can be done at home (blood draws, labs)
- High needs patients who are under the care of a provider who orders CP as an extension of primary care
- Elderly with transportation needs

Interviewees discussed the ongoing unmet needs in the community and their desire to be able to serve some of these needs.

"If the money were there and I could pay somebody … I could probably hire two full-time paramedics just to visit the aging population in our area."

"I think the goal is to provide them a little bit better care connected to their primary care provider than we could [by] running out with the ambulance, picking them up, bringing them in for an ER provider to see, and having that information trickle back to their PCP."

- Community Paramedicine Provider

Section 2

Staffing and Training

Staffing

Common Staffing Procedures and Challenges in Community Paramedicine Programs

EMS organizations generally staff their CP program one of two ways; either (1) by assigning dedicated staff or days of the week specifically to CP visits, or (2) multitasking regular EMS duties and CP visits. Staffing procedures carried out by each organization are influenced by the capacity of their program.

Interviewees discussed the following staffing challenges to their CP program.

Multitasking EMS Duties and CP Visits

CP patient visits may feel rushed, or the CP provider may need to leave in the middle of a visit to respond to a 9-1-1 call. CP visits can also be very time consuming when travel time is accounted for (i.e., travel to the patient, lab, and/or pharmacy), taking time away from regular EMS duties which may be considered higher-priority. This staffing approach is generally only feasible for lower-volume EMS organizations.

"What we were trying to do was use that extra truck when we had it, to fill in and...if a duty crew could go out and do the community paramedicine visit. To be honest, that wasn't as successful as we would've liked because it always seemed there were other pressing duties that came up for that crew."

Funding

Lack of funding presents an overarching challenge to increasing capacity of EMS staff, reducing available staff time for CP visits overall as regular EMS duties are prioritized. Many EMS organizations rely on volunteers; however, individuals are becoming less inclined to volunteer their time with an increased need to seek supplemental paid employment.

Staffing Shortages/Turnover

Overall staffing shortages have been observed by EMS organizations, caused by residual impacts of the COVID-19 pandemic or a larger change of interest in the field of work. Increased turnover rates of EMS clinicians poses additional challenges with the loss of experience, since CP requires life experience, work experience, job knowledge, and CP program-specific education.

"As our number of people (providers) dwindled or lost interest, we ended up relying more and more on administrative or operations staff."

Training

Reported Sources of CP Training

A crucial component of operating a successful CP program is the training and education of EMS clinicians who plan to provide CP services. Options for this type of training are reportedly sparse, commonly expensive, and the coursework can demand a lot of time.

Sources of CP training can be **internal** (from the respective hospital or EMS organization), **external** (conducted by an outside agency), or **both**. All sources of training discussed by interviewees are listed in the table to the right with the source type indicated.

The most frequently discussed source of training is the Community Paramedic Clinician (BP/EP) Advanced Technical Certificate offered by Hennepin Technical College. The scheduled hours of instruction include sixteen hours for each lecture credit, thirty-two hours for each lab credit and forty hours for each credit of supervised occupational experience (SOE).*

"Perhaps we look at licensure, (or) some type of standardization as far as providers . . .that's part of why we don't speak the same language as some of the other professions, so I think that's probably why it's hindered...we don't say here's our licensed community paramedic and here's their scope of practice."

	Source of Training
Internal	Franklin Memorial Hospital/Maine Health—CMO/CP Medical Director
Internal / External Training conducted by an EMS organization, but completed by both internal and external EMS clinicians	Community Paramedicine Technician Course through United Ambulance
	Delta Ambulance Community Paramedicine Curriculum
External	Hennepin College CP Program
	Tri-County EMS CP Program
	Atlantic Partners EMS Class
	MEDSTAR Dallas/Fort Worth Area CP Course
	Eastern Maine Community College

*https://hennepintech.smartcatalogiq.com/2020-2021/Catalog/Degrees-and-Programs/Emergency-and-Public-Service/Emergency-Medical-Services/Community-Paramedic-Clinician-BP-EP-Advanced-Technical-Certificate

Section Three

Referrals and Communication

Referral Process and Communication

Referrals for CP services most often come from the primary care physician. Additional sources of referral include:

- Hospital discharge staff
- Emergency Department staff
- Home Health

The referral process originating from the patient's PCP is designed to ensure that the community paramedic is working within their statutory scope of practice, which states that their services be "specifically requested or directed by a physician."*

The CP visit may encompass a variety of services (see section on Service Provision), but all stem from the physician-directed order.

Referral Initiation

A phone call or secure fax from the PCP directly to the EMS agency is the predominant method of receiving a referral for CP. Some agencies, affiliated with hospitals, work with electronic health record (EHR) notification for a physician's order for CP services.

CP/Home Health Verification

For post hospital discharge referrals, the CP provider often attempts to coordinate with existing providers to avoid supplanting patient services such as home health. If the patient is not eligible for home health or their enrollment with home health hasn't started, the CP provider continues with the referral and obtains consent from the patient for the CP visit.

Visits and Communication

During the CP visit, the CP provider may call the PCP to consult on additional observations or medical issues, including discrepancies in medication lists. All notes, including the run report forms, and protocol checklists, are available for the PCP's review, and often the CP provider will highlight aspects in the narrative that they feel warrant attention. If available, the visit and PCP follow-up is documented in the EHR.

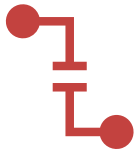
"It was primarily the doctors' offices and the hospital (that) would refer saying 'Joe' is being discharged on Tuesday, I'm wondering if you guys can go in and do an evaluation ...to make sure that he can get the resources he needs to be able to stay at home."

"We see those patients in the field and [are] an extension of family practice."

*An Act to Authorize the Establishment of Pilot Projects for Community Paramedicine, Pub. L., Chapter 562, LD 1837, 125th Maine Legislature (2012).

Communication Challenges

Interviewees report several barriers involved in the CP referral process



Communication breakdown across different provider types can lead to inefficient use of CP staff time. *"I'll show up to a patient's house and they'll say oh, you're here to draw blood? There was a nurse that just drew my blood two days ago."*

"We've tried in the past to coordinate things but the communication between home health nurses...from the ER to the PCPs, there's always a breakdown there."

The referral needs to be initiated by a physician. *"The assumption for the CP program has always been that the flow should come from the top down and I think we actually have to reverse it so that it goes from the bottom up."*

Administrative/paperwork is often a burden. *"To get that signed referral back from the PCP can be difficult at times." . . . "If you just send them a blank sheet and say fill this out, you're never going to get it back."*

Buy-in needs to be garnered often to sustain CP referrals. *"We'll sit down with the physicians, and I'll have five physicians that'll go you guys have a CP program? Really? So, what can you guys do? And I'm like oh, oh, boy. You're constantly starting this from the ground up."*

The system does not allow for ability to flag a 911 patient who could benefit from CP. *"Whether they transport the patient or they don't transport the patient, there's no way to identify this patient within the system for referral back to the program or to referral into the program."*

Section 4

Service Provision and Documentation

Services Provided by CP Programs

Interviewees discussed services they provide as part of their CP program and how they are documented in the Maine EMS & Fire Incident Reporting System (MEFIRS). An earlier review from Cutler showed the most frequently documented services in MEFIRS include **medication reconciliation,* patient assessments, and follow-up;** these services were highlighted in the interview protocol for additional inquiry. CP services listed here only represent those discussed by interviewees, therefore it is not a comprehensive list of all services currently provided by CP programs.

Medication reconciliation can be a difficult documentation topic for CP providers and was commonly discussed using alternate terminology that was seen as more accurate (e.g., medication inventory). This service typically involves activities such as checking patient compliance, filling pill caddies, and evaluating for the duplication or discontinued use of a medication. These activates are among the more frequent services reported as part of CP visits.

Additional services such as blood draws, COVID vaccination and testing, and wound care were also frequently discussed. Offering these services in a patient's home can help to alleviate stress at busy hospitals while also preventing frequent trips to the hospital by the patient, which can be particularly dangerous during the winter months due to fall risk on ice and snow.

Interviewees discussed being in a unique position where, unlike other clinicians, as CP providers they can conduct home safety evaluations in-person to prevent falls and other impingements on quality of life.

Although "Medication Reconciliation" is still the term used in MEFIRS, Maine EMS uses "Medication Compliance" in the CP Scope of Practice, and this term covers medication inventory, organization, regimen compliance, and coordination with prescribers.

Discussed CP Services
(in order of number of mentions)

Type of CP Service*
Medication Reconciliation
Patient Assessments
Follow-up
Blood Draw
Home Safety Evaluation
Wound Care
SDOH
Patient Falls
COVID Vaccination and Testing

***This is not a complete list of services provided, rather, it is what was mentioned in interviews**

MEFIRS: Documentation Feedback

Based on an earlier review of MEFIRS documentation, three categories of CP procedures were highlighted for additional inquiry during the key informant interview process.

Maine EMS is interested in understanding more about the most documented procedures (medication reconciliation, patient assessments and follow-up), in order to standardize definitions for these procedures and their documentation in MEFIRS.

In order to gain a clearer picture of the definitions and use of specific types of CP procedures and how they are documented in MEFIRS, interviewees were asked about these CP procedures and services.

Medication Reconciliation

Half of key informants indicated that when they documented medication reconciliation in MEFIRS, activities included sorting CP patient medications. Those who did not cited concerns about liability.

All interviewees reported inventorying medication, checking patient compliance with their medications, and consulting with the patient's provider as a part of conducting medication reconciliation.

Patient Assessments

Patient assessments are conducted routinely. Half of interviewees reported that patient assessments were conducted for every CP visit. However, most of these assessments were only noted in the narrative section of the MEFIRS run report.

Additionally, there was limited consensus among interviewees in what constitutes a patient assessment: it could include assessments for clinical conditions, general well-being, or for social determinants of health.

Follow-up

There was considerable variation in how the procedure labeled in MEFIRS as "Follow-up" is defined and documented. For some, it means a PCP has referred the CP provider team to "follow-up" with a patient post-discharge. For others, "follow-up" only comes into play when they return for a second or third CP visit.

Most interviewees felt that this procedure needed a better definition and instruction for CP visit documentation.

"I'm a little bit confused as to what was the definition for follow-up."

MEFIRS: Feedback on Documentation

Interviewees noted that, in general, the transition from the previous run reporting system (MEMSRR) to the new MEFIRS system has been viewed as a positive step. They acknowledged that Maine EMS is trying to improve documentation within MEFIRS and recognized that progress has been made since CP was first piloted in Maine over 10 years ago. However, MEFIRS as the platform for documenting CP visits is hampered because it is primarily a 911 incident reporting system.

There is a sense of lack of clear direction on how CP documentation differs from 911 documentation. Dropdown menus in the MEFIRS system are not matched to actual CP practice, which reportedly leads to inconsistent use of those components, and ad hoc documentation. Thus, CP documentation remains narrative focused and driven.

The spectrum of insight provided from the interviewees demonstrates both a deep concern for how documentation is best applied to patient care in the CP setting and to the unique complexity of how it bridges from the needs of the community (e.g., patients and range of providers), services, and procedures to the ongoing care and sustainability (including reimbursement).

CP providers shared their difficulties in capturing relevant CP encounter information in the existing pre-populated dropdown sections of MEFIRS. In addition, they see a need to flag patients for a potential CP visit from within the agency (other 911 EMS clinicians) and the need for a focus on social determinants of health. They perceive inconsistency between what Maine EMS wants for documentation versus what a local PCP wants, and expressed concern about the time it can take to properly document a CP visit.

The other major theme was the need to have the ability to easily 'look back' back at patient call history. MEFIRS is incident based, and as such, documentation is based on a single, acute encounter. CP has a chronic care approach and there is a need to search a patient's EMS call history when managing these patients in a CP setting. Providers would like to be able to search previous 911 and CP reports to better manage their CP patients.

"if I wanted to go see Joe Smith that [another CP} saw two or three days ago ... I don't have the ability to look at [the] previous report for that patient continuity and patient care...and that plan of care."

Community Paramedicine and Documentation Themes

Community Paramedicine is unique in that:

- It is often treating ailments associated with chronic conditions, as directed by a PCP
- It is currently a service that is NOT reimbursed by any insurer in Maine
- Special documentation is required and is distinct from incident reporting. PCPs require more narrative documentation than specific procedure documentation.
- There is a need to track social determinants of health as well as to have the ability to "look back" to patient history and previous CP and 911 calls within the reporting system.

There is inconsistent use of Medication Reconciliation, Patient Assessment, and Follow-up dropdown menus in the CP module in MEFIRS.

There is a desire for specific education on documenting these nuanced issues and procedures, and for the ability for an EMS agency or 911 EMS clinicians to flag a patient within MEFIRS for recommended CP follow-up.

MEFIRS:
Reporting Challenges & Gaps

Interviewees agreed that continued reporting on an incident-based framework means that **CP documentation remains narrative focused** and some relevant patient data may be omitted.

"It absolutely defaults back to the narrative and, quite frankly, from the information flow standpoint, it really was the narrative that the referring physician is looking for."

The over-reliance on the narrative portion of the system is due to difficulty adequately capturing CP services elsewhere in MEFIRS. When asked about how CP providers are capturing the nuances of their CP patient care, they universally noted that it is in the narrative.

"… the problem with community paramedicine (reporting), sometimes everything is dumped in the narrative. …I try to click it out so that will pull up in MEFIRS, but it doesn't always meet the criteria when you're dropping down those menus."

Several interviewees noted that not everything about each CP patient encounter is being captured in MEFIRS.

"We've been better at documenting follow-ups and procedures and those types of things. We haven't added them … but, again, it comes down to reimbursement."

At the same time, there is an understanding that CP documentation needs to adequately capture the unique nature of CP encounters if there is going to be a sustainable billing structure for this service.

"To build a MEFIRS system for community paramedicine would be nice - to have basically just community paramedicine dropdown boxes and assessment type needs, rather than eight million others that we don't use."

"CP doesn't pay, so they're going to write [for efficiency's sake] … 'I came, I saw, I left' - you know? "

Considerations for Effective Documentation of CP Services

CP services are unique.

As the intent of intervention differs, so do services offered in a CP program. Services are often driven by request of a PCP.

Parallel but separate documentation.

As the focus of CP is different than acute 911 response, so is the documentation. Currently, most interviewees note they use the MEFIRS Narrative to capture the nuances of CP documentation .

Patient need and goals of CP intervention determine focus.

CP is driven by a focus on non-acute care management that often requires multiple visits to a single patient. This differs from 911 which is based on response to a single acute incident. While both are focused on patient needs, the intent of the interventions are different.

Procedures may look the same, but the intent is different.

While procedures such as Patient Assessment may be required in all types of EMS visits, the intent and focus of those assessments may differ based on type of visit .

Reporting considerations vary.

CP reporting to NEMSIS and Maine EMS may seem similar to 911 reports, but focus is on at-home management instead of runtimes. Reporting requirements of PCPs and the companion data are unique to CP. As agencies look to reimbursement for sustainability, additional reporting to potential commercial payers for non-transport billing will be a necessity.

Purpose drives the reporting and documentation.

- CP is nuanced and non-acute focused
- Unlike 911, a physician is involved
- Documentation for non-transport CP billing could be different should the program be reimbursed by commercial payers

“Good EMS clinicians understand that good documentation results in reimbursement.”

- Community Paramedicine Provider

Healthcare Utilization Documentation

Evaluators asked interviewees whether their CP program formally tracked patients' use of emergency and hospital services.

Interviewees described various strategies, employed currently or in the past, to understand how CP patients were using other high-cost services.

Among the two interviewees whose organizations were currently tracking data, they described using a combination of EMS, hospital, and health information exchange databases. One reported that they achieved this as a part of separate grant-funded initiative.

Additional participants reported that formal tracking mechanisms have been implemented in the past but are currently not used due to limited capacity or COVID-related disruptions. Tracking was most often accomplished by collaborating with hospital staff to extract hospitalization data. Two people described the established tracking mechanisms as being time-intensive.

Several other interviewees discussed that providers and other EMS clinicians provided updates to CP providers about the healthcare service utilization of a CP patient. However, this workflow was less formalized and was not leveraged to look at trends in usage across the patient panel.

Among those who do not currently track the healthcare utilization of their patients, several discussed that it would be important in showing the value of CP. **This could create buy-in among hospital staff and payers.**

"We didn't have a seamless tool . . . to look at and see, okay, this patient still got admitted, this one didn't. But we were . . . starting to make some gains and some traction in that area and then along came this thing called COVID."

State Guidance and Medical Direction

Interviewees shared their need for State EMS to provide more guidance around CP service protocols and documentation, but noted the need for flexibility in what services medical directors could refer CP patients for, while receiving key support and coordination from State EMS. There was a shared belief that turnover among medical directors negatively impacted stability of the volume and scope of services provided. They reported some lack of clarity in the role of the medical director versus State EMS in determining scope of practice for CP services.

"…can our medical director make that decision [about a formal change in focus]? Some of those questions are unanswered from a rules standpoint."

Feedback indicated that medical direction and State EMS guidance will drive how and what CP services are delivered.

"If this is what you're going to say we can do then that's what we'll do and then we'll figure out how to operationalize it"

Throughout the interview process, interviewees described clear direction from the State EMS office and the role of medical direction as components to successful service delivery. Consistency of these guiding entities are key to stability and sustainability of CP programs.

Section 5

Successes and Sustainability

Success of Community Paramedicine

Overall, interviewees discussed their perceptions on how CP improves health, reduces inappropriate high-cost service utilization, and promotes care integration for their patients.

Some interviewees reported that when CP programs were not active, their agencies provided repeated 911 emergency services for these former CP patients who previously had been *"kept out of the hospital and kept on track."*

Interviewees overwhelmingly believe that CP services improve patient health, including avoiding life-threatening health emergencies. They reported that CP services prevent patients from frequent use of the emergency room and hospital admissions/re-admissions and acknowledged the likely cost-benefit associated with CP visits.

"The patient we just talked about was a perfect example… That was a patient that might take an ambulance ride a week into the ER. … that's $15-20,000 a month, whereas if you can go out and do a couple [CP] visits, you can really knock that down."

CP providers reported that they were able to provide credible health education through strong, trustful relationships with patients in order to improve CP patients' overall health behaviors.

Interviewees described medication reconciliation and compliance as one of their most valuable services to patients, as they observed medication misuse was common and preventing medication misuse could improve health outcomes among these patients.

Interviewees described that CP services relieved the burden from and filled the gap between ambulatory and outpatient healthcare organizations. Filling this gap with CP services is an important part of preventing the inappropriate use of emergent services, including unnecessary ambulance transports.

Critically, CP services also improve communication and visibility between a patient and provider concerning health, medications, and their health outcomes. The key informants we spoke with also discussed a potential for greater integration with other agencies, including home health and hospice.

CP services can increase the capacity of providers and family caregivers who are heavily strained by the demands of patient care. Interviewees reported people they serve, including relatives, providers, and jail staff, saw the value of CP services for patients, and were very appreciative. They noted that enthusiasm and gratitude serves as a feedback loop that energizes CP program staff to sustain services and overcome barriers to service provision.

“I started going through his meds and he was on three different blood thinners from three different doctors. If he would’ve fallen and broken a hip, this guy would’ve just bled out before we even probably could’ve gotten there. So . . . right from his house, I called his PCP and got things straightened out and got [him] off a handful of meds that he'd been getting from different doctors.”

- Community Paramedicine Provider

Sustainability

Interviewees emphasized the need for reimbursement and funding to sustain their CP program.

Buy-in is critical to sustainability and needed from multiple groups, people, and organizations, including from PCPs, home health providers, hospital staff, and from the community, board members, and municipal leaders.

"There needs to be organizational consistency. My concern is that the rise and fall of these programs seems to be dictated on the personal history that the people within them have and as soon as you lose that organizational history, as soon as you have that physician leave, then it's gone."

The option to charge a set fee to bill the provider is also an option for financial stability, but it requires buy-in at the health system level, not easily attained according to some interviewees.

They also stated that it is often difficult to find the time to promote their CP program.

"It's hard to do what we need to with the 9-1-1 and CP and actually be out there to promote it."

It takes more than funding to make a CP program successful and sustainable, although money is foundational.

"I'm not a believer that money fixes everything because it does not. There are a lot of things—organizational buy-in, provider buy-in, interface with other facilities—all of that needs to take place."

The ability to collect and track data to document the value of CP can be difficult for many EMS agencies. As one participant noted, *"We don't have access to that data piece and that's what we could really use to sell this to the people that pay the bills."*

Multiple participants discussed the importance of staffing and training for CP as a mechanism for program sustainability, recognizing, however, that recruitment for EMS in general is difficult, but even more so for CP.

All participants shared the critical need to connect CP programs, patients, and PCPs. Some stated the importance of coordinating or teaming up with home health—removing the territoriality — or social services at the hospital. Finally, interviewees believed that guidance from state EMS and medical direction was important to reimbursement efforts and sustainable program structure.

Funding for CP Sustainability

Lack of funding and no options for reimbursement creates challenges for the sustainability of CP programs.

All participants noted that a lack of funding prohibits the sustainability of CP programs, and the need to show the financial ROI or cost savings.

"There is definitely a cost to [CP] and that's the challenge because without reimbursement, that's the sustainability challenge right there."

Many CP programs rely on grant funding to support the personnel and operational costs to run the program, and often when the grant funding ends, the program is in jeopardy of shutting down or is severely curtailed, adversely impacting the population they serve.

"Until MaineCare really moves in some pieces, our [CP] program is forced to look at what's available for grant dollars."

Participants also reflected on state-level reimbursement efforts, noting that efforts have been ongoing without any solution or results.

"On a state level, reimbursement has been promised for years and we've been spinning around in circles for some time."

"I don't know that we've ever shown that there is a funding savings, that there is a savings to insurance or anything else. Anecdotally, we can certainly argue that. But I don't know that the program as a whole throughout the state, that we've actually ever been able to show that."

Section 6

Considerations and Next Steps

Initial Considerations

Several themes raised by the interviewees contained suggestions for improvement or considerations for sustaining or building upon the current CP model in Maine. (Note: these are not formal recommendations from the evaluation team.)

"We're missing the opportunity to grow the program because we have a lack of a feedback loop."

-Community Paramedicine Provider

Key insights from each domain of this report center on the referral process, communication (e.g state guidance) and MEFIRS documentation. Interwoven throughout was the need for better communication, particularly in the referral process internal to each CP program, and externally, in the guidance from the State EMS Office and Medical Directors. These are some initial considerations shared for Maine EMS' review that will be further explored in the evaluation.

Feedback from interviewees about the referral process indicates their desire that the process should:

Initiate from the CP provider, requesting the follow-up order from a physician (e.g., referral based on observation at time of visit for other services ordered or for a repeat patient for the same issue, such as falls).

Establish the ability for 911 EMS clinicians to flag patients within MEFIRS for recommended CP follow-up.

Allow for a regular CP schedule of visits for targeted conditions of CP patients.

Similarly, interviewees' feedback indicates the State EMS Office should:

Ensure that Medical Directors are actively engaged with the CP programs and providers in protocol development and training.

Offer guidance and instruction on specific documentation practices for CP visits should come from the EMS office with regular follow-up

Allow for flexible CP protocols that are differentiated from 911 protocols.

Identify required data to be collected for each CP visit and communicate why this is important.

Provide consistent and regular communication from the CP Committee to the EMS agencies with a CP program.

Standardize CP education and training for all EMS agencies interested in CP.

Provide and communicate opportunities for additional education and training for CP providers and clarify any other educational requirements and the process for obtaining them.

Improving CP Documentation

Interviewees consistently noted the need to improve how CP visits are documented and provided suggestions for doing so, both within the MEFIRS platform and through guidance from the State EMS office to CP programs.

Tying documentation to future reimbursement possibilities: The purpose of CP procedures differ from those in an acute, incident-based setting, with unique aspects of CP documentation. There should be a clear connection between this type of documentation and cost if there is to be a future move to non-transport reimbursement.

Patient History

Provide the ability to 'look back' in the patient's medical history, including previous CP visits and 911 calls, from within MEFIRS.

Referral Focus

Consider how MEFIRS documentation can be tailored to provide PCPs with the information they need to facilitate both the ongoing CP referral process and future patient care.

Documentation Education

Provide more agency and CP provider education from the State EMS Office or CP Committee on how to properly and accurately document CP visits in MEFIRS.

Screening Tools

Add standardized screening tools to MEFIRS that can be recalled to compare baseline with current visit.

Requesting Referral

Establish the ability for 911 EMS clinicians to flag patients within MEFIRS for recommended CP follow-up. This request could be then easily forwarded to a physician for CP referral.

“Community paramedicine is different than running an ambulance service. We need the flexibility to identify our needs, craft a program to meet those needs, and move in that direction.”

- Community Paramedicine Provider

Evaluation Next Steps

As interest grows in both the cost efficacy and improved health outcomes related to CP, it is important to examine how CP programs, although not currently reimbursed for their services, may show cost-avoidance within Maine's health care landscape.

Stakeholder Group

The Cutler team will recruit a representative group of stakeholders from hospital systems, EMS agencies, home health, municipalities, Maine's Department of Health and Human Services, and the CP Committee to gather feedback on their perspectives regarding the facilitators and challenges for CP in Maine, and what factors can contribute to its sustainability and success.

The feedback from the stakeholders will be analyzed and included in the final evaluation report which will also contain this qualitative analysis of CP provider interviews and the quantitative data analyses.

Quantitative Analysis

The Cutler team will be conducting quantitative analyses to determine costs avoided for CP patients and the healthcare system regarding unnecessary emergency department transports and hospital readmissions. The data analyses will include data obtained from the Maine Health Data Organization (MHDO) to help answer the question: *"What is the estimated cost avoidance of emergency department visits and hospital readmissions for persons receiving community paramedicine services in Maine?"*

Additionally, claims data from the Office of MaineCare Services (OMS) along with MEFIRS data from the State EMS Office will be used to gain a better understanding of the MaineCare patient profile for the CP program.

“It's something where if the community sees us out there doing a thousand CP visits a year ... that becomes part of the accepted level of service from an EMS provider.”

- Community Paramedicine Provider

Catherine Cutler Institute
Evaluation Team

Katie Rosingana, Co-Principal Investigator	katherine.rosingana@maine.edu
Karen Pearson, Co-Principal Investigator	karen.pearson@maine.edu
Ken Rosati	kenneth.rosati@maine.edu
Evelyn Ali	evelyn.ali@maine.edu
Tyler Egeland	tyler.egeland@maine.edu
Rachel Gallo	rachel.gallo@maine.edu

CATHERINE CUTLER INSTITUTE

MAINE EMS