Community Paramedicine Stakeholder Focus Group Summary

Maine Community Paramedicine Evaluation

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CATHERINE CUTLER INSTITUTE

MAINE EMS

Overview

This summary report captures thematic feedback from stakeholders on issues related to the future sustainability of community paramedicine (CP) with a focus on costs and reimbursement for non-transport related EMS services. Sustainability is influenced and impacted by several factors, including operational costs, workforce (staffing and training), referrals, and the data needed to support efforts for reimbursement.

Stakeholders discussed these themes in the context of sustaining successful community paramedicine programs in Maine, particularly emphasizing the need for reimbursement and funding to sustain any CP program.

This summary is one part of the larger mixed methods (qualitative and quantitative) evaluation being conducted by the Catherine Cutler Institute at the University of Southern Maine. It is designed to provide feedback to Maine EMS and other interested parties and will be included as part of the summative evaluation report.

For more information, please contact Karen Pearson or Katie Rosingana, co-project leads, at the email addresses provided at the end of the report.

Community Paramedicine Stakeholder Interview Process

As part of the Community Paramedicine (CP) evaluation project, the Cutler evaluation team conducted two stakeholder focus groups (June 27, 2023, and July 13, 2023) to supplement the information previously gathered from CP program key informants. Additionally, an online survey was deployed to reach additional CP stakeholders. The survey mirrored the focus group questions to provide a consistent framework for thematic analysis in NVivo, a software used in qualitative research.

A total of 15 stakeholders provided feedback, and included medical directors, hospital system personnel, CP program administrators, EMS clinicians, home health administrators, and municipal administrators. These stakeholder were approached because their roles all intersect in some capacity with community paramedicine.

Topics for discussion centered on CP sustainability and reimbursement, and touched upon costs, staffing, training, and data—all of which contribute to the long-term viability of CP.

All participants spoke to the importance of keeping patients from unnecessary visits to the emergency department and reducing hospital readmissions, key to the value of CP.

The Cutler evaluation team is appreciative of the time each stakeholder spent to share their thoughts and ideas with us regarding community paramedicine options and opportunities in Maine.

Sustainability

"We have to approach the value of the system as: this absolutely will reduce overall costs. But with that, of course, it needs to be reimbursed at a rate that it makes it sustainable, which, clearly it's not currently."

The overarching theme from all stakeholders' feedback was sustainability of community paramedicine programs in Maine. There is a need for a whole picture view of the how CP fits into the health care infrastructure in the state and its role in meeting community needs while providing efficiencies in the system, overall.

"I think we need to be remunerating EMS Agencies at a level that allows them to pay an EMS Clinician living wages and to maintain the oversight, education, and quality assurance required for such a program."

When discussing sustainability for CP programs in Maine, stakeholders spoke of potential models of reimbursement which included options for billable hours, by provider type, and by service line.

Stakeholder feedback was mixed on whether reimbursement by service line or by provider type would be the most effective model for reimbursement. Some advocated for reimbursement for a specific service, independent of who is providing it as long as the service is within the scope of practice.

"Until CP is reimbursed by insurance there is not a sustainable model. Unless there is a massive change in how US healthcare is delivered, insurance reimbursement is the only way to ensure sustainability at this time."

Stakeholders also discussed the need to find a way to understand the cost, and ultimately the value, of CP to the healthcare system.
(See also: sections on Reimbursement, Cost and Data Considerations.)

"Finding a way to isolate what that value is not just for the system (i.e., Northern Light or MaineCare), but also figure out what the cost savings is for MaineCare—which is eating a lot of this extra cost every time somebody goes down —finding a way to quantify that and pushing it back into the provider so that everybody wins—that's the key to sustainability."

These discussions touched upon the shared savings model, cost avoidance calculations, and insurance reimbursement. Most stakeholders noted that CP programs keep patients out of the emergency department and hospital, which is a major cost avoidance for health systems and insurers.

"If CP programs are able to claw back some of the revenue from healthcare networks that are experiencing efficiencies, and insurers that are experiencing efficiencies.… That is the price to support that return."

Reimbursement

"You've got to get back to reimbursement. I mean, how do we not value our direct care first responders all across the healthcare spectrum? It's terrible."

Stakeholders commonly reaffirmed the overall value of CP programs and the improvements in the quality and efficiency of healthcare delivery it can provide. They discussed how current established interest in funding can facilitate the larger adoption of CP programs once reimbursement practices are improved.

"Such incredible value in this program . . . if we can get the reimbursement moving in the right direction, I think there clearly will be demand. . .and I think the EMS crews...want to do it as well. I don't think there's a lack of interest there."

Stakeholders further expressed confidence in the ongoing implementation of CP programs provided once a reliable funding stream is implemented. They felt that although there is enthusiasm and energy for CP, services are operating on a shoestring without proper financial support.

"If [CP programs] are able to claw back some of the revenue from healthcare networks that are experiencing efficiencies and insurers that are experiencing efficiencies . . . that is the price to support that return."

However, many stakeholders shared challenges with a lack of reimbursement under the current model, primarily a deficit wherein the rate of reimbursement fails to cover the cost of providing CP services in addition to operational costs of the program.

"For this to work and be sustainable and not be the constant nightmare that is staffing trucks for BLS and ALS, in order to solve that problem, you have to have a dynamic reimbursement mechanism."

"In many cases, EMS is reimbursed at a level that does not truly cover the costs of 1) caring for an emergency patient, and 2) the cost of maintaining readiness and preparedness."

"MaineCare reimburses us at about half of what it costs to deliver the service."

Stakeholders shared that the lack of reimbursement from insurance companies can be frustrating when there are perceived savings from CP services, mostly at CP agencies' expense.

"The corporate entities that benefit from the financial impact are not the ones that are really paying for the service."

"Right now, it's essentially the agencies paying for it. Maybe some shared savings or grant funding, and the payers who are reaping the benefits from it aren't really paying at all, or generally considered to be negotiating in bad faith by. . .accepting in-network rates to reimbursement for CP services."

Reimbursement

Stakeholders suggested that there should be "base funding“ provided to EMS services who agree to provide CP services to their communities. Suggestions included tiered levels of support or commitment from the State for a defined period of time to offset start-up costs and provide incentive for CP program implementation.

> *“If ultimately the state's plan is to have private entities be part of the solution, the real way to understand the reimbursement conversation isn't to take a scope of practice and send it to MaineCare and say tell us what you think this is worth, the real way to do it is to stand up a cashflow model of what a modest-sized CP operation would look like in a private scenario.”*

Additionally, stakeholders discussed the potential role of the State in financially supporting CP programs. They all agreed that MaineCare reimbursement cannot be the sole source of reimbursement toward sustaining CP programs.

> *“Because if we're relying on MaineCare reimbursement as a sole -- it's never, ever, ever going to be enough...Unless they can really change their reimbursement model, it's just not going to be enough.”*

Several stakeholders suggested looking beyond MaineCare to the role of other insurers in possible CP reimbursement. They noted that in Maine’s rural areas, older residents, many of whom are eligible for CP services, are on a commercially insured Medicare Advantage plan.

> *“Get an insurance company to fund--sizable funding--the State of Maine to do a pilot across the whole [state]...there are ways to really think bold right now.”*

Optionally, they noted that CP could be rolled in with other care models for reimbursement, such as home health. However, regulatory constraints on providers and scope of services make it difficult to align payment methods.

> *"Medicare . . . now they pay per episode. When we switched to that payment methodology, we were like ‘fantastic--maybe we can now start using community paramedics to supplement our [home health teams] in areas where we could really benefit.’ But then we run into regulatory issues that won't allow us to utilize other than who is clearly defined in they payment reimbursement methodology. So it's tied to pay but also tied to regulatory hurdles"*

Ultimately, stakeholders agreed that once there is adequate funding for community paramedicine programs in Maine, regardless of the source and the model, then “everything else will fall into place.”

Cost Considerations

"There has to be cost-based reimbursement for CP calls to make them worthwhile."

Stakeholders discussed the interconnectedness of costs, reimbursement and sustainability of CP programs. They spoke of the overall need for a sustainable rate schedule and the cost of ensuring and maintaining the appropriate staffing and oversight, recognizing that a CP program is uniquely different from a 911 response and transport model.

When asked to describe the costs that both new and existing CP programs in Maine need to consider, they highlighted both fixed and variable costs that accompany implementation and delivery of CP programs. While costs to start up a new CP program are frontloaded with the potential purchase of an additional vehicle and staffing dedicated to CP, training, marketing and outreach, these become ongoing costs to maintain the program.

"You've got your fixed costs...and then you've got variable costs which are very, very sensitive to things beyond the service's control." "Not one person has talked about internal markets costs and external marketing costs."

CP programs are designed to meet the needs of their communities, and stakeholders discussed the "embedded cost of unfunded liabilities" (pensions and retirement plans), especially for publicly funded programs that impact costs incurred by CP programs and the communities that support them. Additionally, the uniqueness of each CP program makes it difficult to standardize across programs, prolonging the "shoestring" approach to funding rather than focusing on a more standardized payment model.

Stakeholders highlighted the value of CP to reduce system- and patient-level costs, through shared savings and cost-avoidance models. They agreed that the high cost of unnecessary ED visits and hospitalizations is often mitigated by CP visits, and this is a savings to the healthcare system not currently seen or "trickling down" to the CP programs.

"Community Paramedicine is oftentimes a service being utilized by those who are on the fringe of the medical system, and often incur the greatest costs."

"There's a massive amount of savings to them for not paying ED [doctors] to do workups that could've been done at home by a community paramedic...we don't need [patients] to go 30 miles in an ambulance at a $1400 transport to get weight and a med adjustment."

Stakeholders agreed cost benefit analyses could quantify the cost savings for both healthcare systems and MaineCare. As one participant noted, each time a patient avoids an emergency department visit or hospitalization, there is *"shadow revenue that's being generated by keeping that patient out of that particular network's system."*

"Contrasting an ED cost versus a CP visit -figuring out the right dollar point, I mean just think about the cost you save by not doing the 911 transport in that situation. So, I think that's a great point to kind of trumpet forward to MaineCare . . .looking at a cost reduction."

Staffing and Training

Stakeholders agree that staffing is a common challenge for EMS agencies due to an overall shortage of paramedics and EMS Clinicians. To facilitate a successful CP program, stakeholders discussed the importance of having dedicated personnel to provide CP services and adequate funding to offer competitive pay rates. Further, some stakeholders were concerned that staffing CP visits could take away from a small EMS agency's ability to respond to emergencies.

> *"The biggest issue is clearly the staffing…we're struggling to meet 911 and transfer volume, let alone trying to do CP volume."*

Stakeholders emphasized that for CP programs to be reliable, there needs to be dedicated staff available to provide CP visits without being interrupted to respond to a 911 call. However, the overall issue of workforce shortages impacts the ability of many agencies to provide these levels of staffing.

> *"While some services with very small 911 call volume may be able to perform both duties with no change in staffing, my impression is that most EMS agencies would need to staff up to create reliable CP programs."*

Stakeholders also discussed the variability in CP education, expressing concern that the lack of uniformity makes it difficult to provide a standard baseline of required skills and training.

> *"CP ten years ago was a shoestring, homegrown type operation, and now as they're becoming more organized on what the expectations are for providers to be able to offer CP, there [are] added costs both of education and time for the people to meet the requirements or the anticipated requirements."*

Stakeholders highlighted the cost and burden of additional training requirements for community paramedics, noting that increased compensation is needed to attract EMS personnel to take on this additional education. Additionally, they emphasized that the high turnover in EMS staffing often results in a high cost to the service for training and retraining.

> *"You've got to find paramedics, and paramedics don't want to do this because it's more training, and in order to incentivize people, you've got to pay people what they're worth."*

Concerns about the return on investment for training were also expressed by a few of the stakeholders: *"You're going to train all these people for a program that's not even financially viable"* and *"We can't just demand training and education that takes a year and then not have anything on the other side to fund that."* Several stakeholders noted that the need and expectation of the healthcare system currently requires this expanded level of training for CP providers.

> *"Make sure that they have kind of the basic core education to do those assessments, which certainly many times may be an extension of their medic licenses already, but sometimes it certainly is above and beyond."*

There was widespread agreement that the State EMS Office should clearly define the scope of practice for CP so that appropriate education and training can be developed, making it uniform and accessible in multiple formats to CP providers across the state.

Data Considerations

Stakeholders were asked to reflect on the data that would need to be uniformly collected in order to meet public or private reimbursement requirements. They discussed the role of community paramedics and CP in relation to other provider types and services, noting that CP would benefit from an infrastructure (staffing, communication, and data systems) that integrate with the healthcare system due to the shared responsibility for patient care. There is an urgent need for fidelity along the chain of care so data being collected and reported is meaningful to patient care across the healthcare system and to MaineCare for reimbursement.

"We're talking now about population level outcome changes as opposed to individual encounter outcome changes."

One of the major challenges highlighted by participants is that CP is often "just an add-on" to EMS run data. They stated that MEFIRS cannot adequately capture what a health system requires for tracking patient encounters and outcomes. Also, there is no standard platform across EMS and hospital systems for data collection; EPIC, Netsmart, Cerner are but three used in various Maine settings. A common data standard is further hindered by the inability for these system to "talk to each other."

"How do you make [data] usable for the GPs [general practitioners] because…they've got 60 patients a day and they just want to see the data, They don't want to tear their hair out looking across three different systems to patch together what's going on with their patients."

Key Takeaways from Stakeholder Feedback about Data Collection

- Data collection should be standardized across referral conditions.
- Data collection should expand beyond the traditional EMS incident focus, to move to a population data focus.
- Expanding EMS emergency data to align with date collected at the healthcare system level is key.

Importantly, stakeholders noted that there is a cost factor to data collection. Bigger agencies or hospital-based services may be better positioned to afford data collection options than smaller agencies which are often municipally funded.

Referrals and CP Volume

For many EMS agencies, the lack of administrative support dedicated to managing the referral process is a barrier to effective outreach and increased patient volume.

> *"We found that by having a person that was dedicated to managing the patient flow and the orders coming from the providers…as referrals—that made a huge difference in the relationship between community paramedicine and our home health and hospice teams."*

Stakeholders expressed frustration at the inability to convert 911 calls to CP visits, noting that often, doing an emergent run, the EMS clinicians can identify those who would benefit from a CP visit. They highlighted reviews of non-emergent 911 calls can help identify potential CP patients. They provided suggestions to incorporate this into the EMS run system (see Recommendations at end of report).

Stakeholders noted the variety of approaches, needs, and functionality of IT systems across health providers as a barrier to streamlined communication about CP visits. For example, some hospital use EPIC, some use Cerner, and the EMS services and CP providers use MEFIRS.

Stakeholders also commented that referring doctors can, but don't usually, look at notes from the CP providers.

Low volume of referrals may be due to healthcare providers being unaware of the CP program and the referral process as well as to provider turnover.

> *"All the providers that we have now, a lot of them have turned over since we started the CP program and I bet you half of them don't even know what it is."*

Additionally, there is an educational component to ensuring a consistent flow of referrals.

> *"You've got to get patients comfortable with CPs but you've got to get GPs comfortable with actually dispatching them."*

Stakeholders noted that connections to a larger healthcare system would provide increased CP visits, but without that connection it's difficult to have a consistent flow of referrals.

> *"If you don't have that connection to the larger system, I don't see how you would get that business and I don't see where that type of business would come from."*

Recommendations

Several suggestions and recommendations were mentioned during our discussions with Community Paramedicine stakeholders. Some are actionable in the short-term; others are for consideration and discussion with Maine EMS, MaineCare, and potential other payers. There was broad agreement that it is vital to demonstrate system-wide efficiencies from CP (e.g., through cost-avoidance data) to exhibit the need for compensation and reimbursement to CP programs.

Reimbursement Strategies

- Implementation of reimbursable services will require up-front investment in state-level and organizational-level infrastructure.
- Reimburse CP services as a provider rather than by service type.
- Reimbursement must come from all insurance streams (commercial and public).
- Allow CP programs to charge billable hours and be reimbursed accordingly.
- Reimbursement must be dynamic (i.e., several funding streams, flexible) to truly make an impact.

Data Strategies

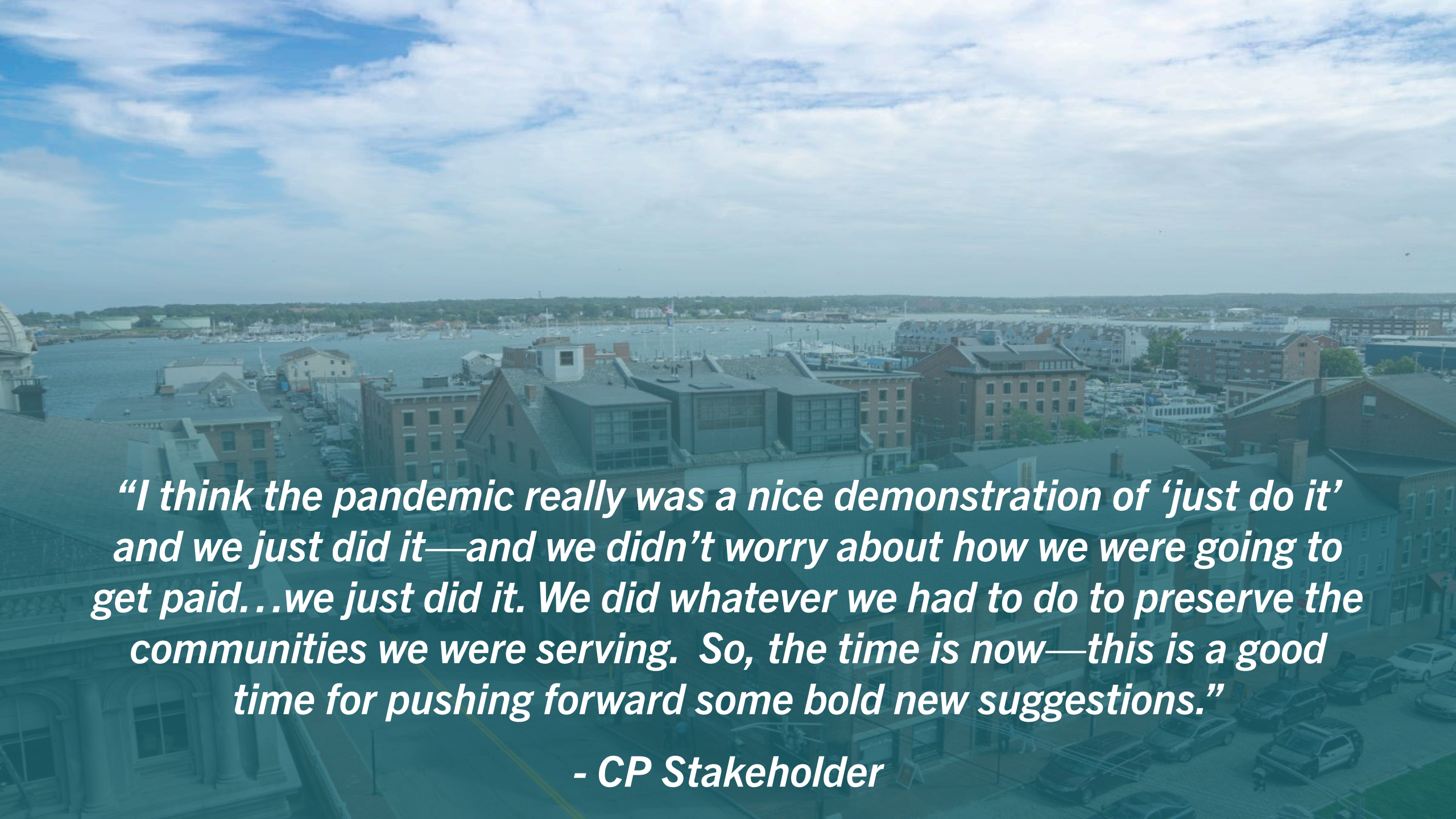
- Standardize data collection across referral conditions
    - This could include the options in MEFIRS to flag a non-emergent 911 call as a CP visit with options for physician referral.
- Expand data collection beyond the traditional EMS incident focus and move to a population data focus.
- Align EMS agency data to match that collected at the healthcare system level.

Staffing and Training Strategies

- Provide dedicated CP staff.
- CP operational costs need to include staffing (both direct and indirect).
- Provide direct assistance from the State for program startup.
- State EMS Office needs to clearly define the scope of practice for CP and develop appropriate and uniform education and training.
- Training needs to be accessible in multiple formats to CP providers across the state.
- Dedicating staff to manage the referrals can enhance the CP program and connections with multiple health providers.

Referral Strategies

- Create a standardized process to flag 911 calls for potential CP visits.
- Stakeholders suggest options that blend the ET3 model with CP:
    - At time of 911 call make the determination that it is non-emergent and have a process to contact the physician for a CP referral order on the spot.
    - If the 911 crew is staffed with a CP at the time, allow for a CP visit instead of transporting to the ED or hospital.



“I think the pandemic really was a nice demonstration of ‘just do it’ and we just did it—and we didn’t worry about how we were going to get paid…we just did it. We did whatever we had to do to preserve the communities we were serving. So, the time is now—this is a good time for pushing forward some bold new suggestions.”

- CP Stakeholder

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