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

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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* get paid back, you must find another way to justify the expense: Marketing to build community engagement. Crew training to improve bedside manner for chronic patients. Perhaps you want to be your region's early adopter who is responsible for bringing to life the "EMS Agenda for the Future." Whatever your metric, you will have to *justify* foregone revenues.

4. **REGION** – How supportive is your regional ecosystem? Who'll pay for your services? What if (as one agency brought to us) your CP/MIH proposal calls for taking patients *away* from local care providers? Will they cry foul, or support the idea of more professional patient care, despite a loss of revenues from incoming patients? Now the current CP/MIA models start becoming difficult to copy: Medstar's relationships with Fort Worth's hospitals is unique. REMSA received a federal CMS Innovation Challenge grant to build its system; Mesa Fire received funding, too. UPMC and Allegheny Health Network in Pittsburgh have a complex competitive relationship that exists in few other places. San Diego's federally funded Beacon Community a regional data sharing incentive program. What does your region have at its disposal to incentivize and underwrite the costs of a CP/MIH program?

5. **RECORDS** – I'm admittedly biased by my Day Job on this point, but 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.

