

OSHPD Office of Statewide Health Planning and Development

Healthcare Workforce Development Division

400 R Street, Suite 330
Sacramento, California 95811-6213
(916) 326-3700
Fax (916) 322-2588
www.oshpd.ca.gov



Office of Statewide Health Planning and Development (OSHPD) Health Workforce Pilot Projects (HWPP) Program HWPP #173 Community Paramedicine Advisory Committee Meeting Notes

The HWPP #173 Advisory Committee meeting was scheduled on December 8, 2014 from 9:00am-4:00pm at the Office of Statewide Health Planning and Development (OSHPD) in Sacramento, California in Conference Room 471.

Welcome

Liz Martin, Healthcare Workforce Development Division Access to Care Section Chief, welcomed the meeting attendees, OSHPD staff and public guests. She also thanked them for their participation in the first Health Workforce Pilot Project #173 Community Paramedicine Advisory Committee meeting. Ms. Martin acknowledged that Linda Onstad-Adkins was serving as Acting Deputy Director in the absence of Lupe Alonzo-Diaz during her maternity leave.

Ms. Martin introduced HWPP #173 Community Paramedicine which is sponsored by the California Emergency Medical Services Authority (EMSA) and will be testing five different concepts at 12 project sites throughout California. The five concepts include alternate destination, post-discharge follow-up, 911 frequent users, direct observed treatment of tuberculosis and hospice patient support. She highlighted the department approval by OSHPD Director, Bob David, on November 14, 2014. Liz provided an overview of the day's proposed activities and further explained that the meeting will be focused on gathering input from the Advisory Committee and Council of Advisor members on data evaluation.

Overview of the HWPP Program

Ms. Martin noted historical highlights of HWPP including the program's inception in the early 1970's and explained how it provides the opportunity for healthcare-related organizations to demonstrate, test and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes are made in law. Further, HWPP could be sponsored by hospitals or clinics, non-profit educational institutions or government agencies engaged in health or education activities. She concluded that the overall purpose of HWPP is to test healthcare strategies related to scope of practice, new concepts regarding health professional classifications, healthcare delivery strategies during periods of health professional shortage crisis and better access to healthcare.

Ms. Martin walked through the milestones of the application process for HWPP #173 Community Paramedicine to date. These included:

Milestone	Date
Application Submission	December 28, 2013
45-Day Public Comment	February 14 - March 30, 2014
Addendum Submission	June 9, 2014

Public Hearing	June 30, 2014
Public Hearing Transcript Distributed	October 13, 2014
OSHPD Project Approval	November 14, 2014

With regard to next steps, Ms. Martin explained the three major phases of this project to be data collection, training and employment utilization. She emphasized that the project would be evaluated on an ongoing basis by OSHPD with the number one priority of oversight to be patient safety. Additionally, she explained that the program staff would evaluate patient satisfaction, health outcomes and systems delivery efficacy.

Review Advisory Committee and Council of Advisors Roles and Responsibilities

Ms. Martin provided a summary of the Roles and Responsibilities for both the Advisory Committee (comprised of 13 members) and Council of Advisors (5 subject matter experts). Major responsibilities of both groups include participation and attendance in meetings, advisement on the efficacies of training, competencies and the collection of data, review and advisement of project protocols related to triage and patient safety, participation and attendance in site visits, advisement on evaluation of project reports as needed, and advisement of project issues, if they arise.

Both groups will provide recommendations to OSHPD on various aspects of the project and operate from a collaborative decision-making process. The only difference is that the Advisory Committee has a voting ability and the Council of Advisors does not. The recommendations that come from the both committees are considered advisory in nature to the program staff. OSHPD will consider these suggestions when making all final decisions.

Introductions

Ms. Martin asked all members of the Advisory Committee and Council of Advisors to introduce themselves to the group and share their interest in the project. A round table was completed where each person had the opportunity to share this information. It was also requested that a roster of all member names with contact information be provided following the meeting.

Presentation of HWPP #173 - EMSA

Dr. Howard Backer, Director of the California Emergency Medical Services Authority and Lou Meyer, Project Manager, conducted a thorough power point presentation of HWPP #173 Community Paramedicine. An electronic copy can be found attached, but the major discussion topics of their presentations included:

- Role of EMSA and the California EMS system
- Explanation of “Community Paramedicine”
- Need for HWPP #173 Community Paramedicine
- Explanation of five project concepts
- Project partners
- Project timelines

Presentation of Data Collection Frequency - UCSF

Dr. Janet Coffman, the project’s independent evaluator, conducted a thorough power point presentation on the current data collection elements proposed for the project as well as the methodology for obtaining such information. An electronic copy can be found attached, but the major discussion topics of her presentation included:

- Evaluation Plan Overview
- Data Components
- Data Collection Methods
- Data Collection Timeline

At the conclusion of the presentation, Dr. Coffman and Dr. Backer clarified the types of patient data which would be collected in response to questions raised by the committee members. Ms. Widdifield further added that both representatives would be available during the break-out sessions for consultation as needed.

Break-Out Sessions

The Advisory Committee and Council of Advisor members sat together in groups of four or five individuals. Each group worked together to discuss the five concepts presented by EMSA including alternate destination, post-discharge follow-up, 911 frequent users, direct observed treatment of tuberculosis and hospice patient support. Specifically, they were given 45 minutes to discuss 1-2 concepts at a time and complete the following instructions:

1. Identify the data elements or outcomes that you would like to see captured by EMSA.
2. Once all data elements or outcomes have been captured, work as groups to identify the top five elements that you feel are most important to this project and put a star next to those five.
3. Explain how you would like to see your top five data elements or outcomes captured. There should be at least one methodology for each of the five items.

Each subsequent table built on the recommendations presented by the previous groups(s) so the information collected is a culmination of all discussion items. The comments regarding data elements or outcomes they would like to see captured by EMSA are summarized as follows:

Alternate Destination

- Patient's source of admission (where they were picked up)
- Chief complaint for calling 911
- Identification of social issues or additional circumstances that prompted the 911 call
- Identification of the patient's injury or illness after being treated in an urgent care clinic (final disposition of the patient)
- Would like to see a clear definition of "adverse outcomes" added to protocols
- Number of patients admitted to an ER after treatment at an urgent care center
- Total time needed for patient disposition in the urgent care clinic AND at the ER if transferred later
- Number of patients who were declined by the receiving site
- Reasons why patients were declined by the receiving site
- Name of sites who denied the alternate transport
- Number of patients who declined treatment in the pilot program
- Reasons why patients declined treatment in the pilot program
- Identification of the chief complaint for those patients being transferred directly to an ED
- Assessment of the patient's ability to access primary care
- Amount of additional time spent on scene due to alternate destination
- Wait time at the urgent care clinic
- Would like to know if alternate destination patients are also considered to be 911 frequent users
- Monitor the specific medical discharge diagnosis
- Should consider "focused hot spotting" where preventative medicine could have helped in cases where there may be a high number of calls for a specific site's illnesses
- Behavioral health patients should receive a suicide assessment
- Behavioral health patients should receive detox if needed
- Track 5150 frequency
- Assess the global impact on patient's being seen in the ER

- Assess whether the volume of 911 calls has increased as a result of the pilot program because patients can get easier access to an urgent care center
- Cost of care for patient going to an alternate destination
- Similar concepts should develop shared knowledge of evidence-based, collaborative “best practices” since different jurisdictions may be making different decisions when working independently
- Track the payor source
- Patient satisfaction surveys

Post-Discharge Follow-Up

- Patient’s source of admission (where they were picked up)
- Discharge disposition of all pilot program participants
- Comparison of 30-day readmission for the general population versus the inclusion group of pilot program participants with the same chronic conditions
- How many contacts/visits were needed with each patient
- Would like to know how Community Paramedics will ensure patient understanding of discharge plans, instructions on prescribed medications, and their after-care plan
- Number of patients referred to a social services agency or to a primary care physician after they were discharged
- Comparison of the ER medical records of participants prior to and after their enrollment in the pilot program
- Would like to know if the patient was referred for a clinic visit afterwards and if so, what was the result of the clinic visit in comparison to the original assessment?
- Recommend doing a “social element assessment” survey which would be inclusive of factors such as whether a patient lives alone or with family, identification of their source of care, analysis of their IADL (Instrumental Activity of Daily Living), housing stability, support system, etc.
- Patient satisfaction surveys

Frequent 911 users

- Would like to see a clear definition of a “frequent 911 user.” There is a recommendation to adopt the definition included in CP010 for all frequent 911 user sites.
- Chief complaint for the patient calling 911(i.e. meals, medication, etc.)
- Patient’s comorbid conditions besides the chief complaint identified during their ER visit (i.e. medical or social issues)
- Patient’s language preference when receiving their healthcare information to ensure health literacy
- Patient’s source of admission (where they were picked up) and where they were returned to after receiving medical care – i.e. homeless center, public housing, the street, etc.
- Would like to know if the patients were given a clear discharge plan after their ER visit
- Number of patients referred to a social services agency or to a primary care physician after they were discharged
- Number of participants that stopped calling 911 but showed up in the ER instead as a result of the pilot program
- Number of times a follow-up is done with frequent users who have stopped calling 911
- Need data on whether there is a decrease in the number of Emergency Department visits or a decrease in the number of 911 calls to determine whether the pilot program is making a difference
- Need to develop a standardized plan for reporting adverse outcomes

- Patient satisfaction surveys

Direct Observed Treatment of Tuberculosis

- Cost of Community Paramedic and entire crew to go out to patients
- Number of patients that were intended to find versus the number of patients they were able to find
- Treatment time/duration
- Location of treatment (i.e. home, assisted living, farm worker, homeless, etc.)
- Reasons why a scheduled day for observed treatment was missed and why
- Methodology of how Community Paramedics will ensure they complete all visits during their shift
- Compliance rate versus number of patients refusing care
- Identification of side effects in protocols and how to treat
- Would like to know how many patients responded to treatment and if they did not, were protocols changed?
- Would like to know how situations are handled on weekends when public health nurses do not work
- Would like to know what educational materials regarding the importance of medication usage are provided to patients when they deny treatment
- Would like to know who at the health facility is providing tuberculosis care and patient oversight (i.e. public health nurses, MDs, etc.)
- Would like to know if home visits ever result in an ER transport
- Reasons why patients fall out of the pilot program
- How the pilot program affects compliance with medication usage
- Cost savings with pilot program
- Patient satisfaction surveys to include language communication

Hospice Patient Support

- Number of hospice patients enrolled in the pilot program
- Number of 911 calls made for patients enrolled in the pilot program
- Should discuss whether all hospice patients should be identified and enrolled in a health record system
- Reason for the 911 call beyond the chief complaint
- Would like to know if the family called hospice
- Would like to know if hospice responded to the 911 call
- If the family contacted hospice, what instructions did they receive, if any?
- Would like to know if a Community Paramedic or a regular Paramedic responds to the 911 calls
- Would like to know whether the Community Paramedic was able to keep the patient at home or if they had to transport them
- Would like to know if families can use the patient's care kits
- Is there an Advanced Directive or POLST (Physician-Ordered Life Sustaining Treatment) in place?
- Would like to know if patients were:
 - Transported to an ER and admitted OR
 - Transported and treated OR
 - Transported to a hospice inpatient facility
- Disposition data from community paramedics, hospitals, hospice and the families
- Cost of transporting the patient
- Patient and family satisfaction surveys

Report-Out from Break-Out Sessions

A single representative from each of the three groups reported major highlights from the discussion of each concept. All comments have been captured in the detailed break-out section of the notes.

Opportunity for Public Comment

There were no public comments made.

Follow-Up Items

Kristen Widdifield will complete these follow-up items:

- Distribute a roster of all Advisory Committee and Council of Advisors members
- Develop meeting notes and provide absent members the opportunity to provide input
- Distribute finalized meeting notes
- Distribute a monthly report template for Advisory Committee input via e-mail
- Meet with EMSA to discuss implementation of OSHPD's recommended patient outcome data elements to be added to the project
- Develop a summary for Advisory Committee and Council of Advisors members to outline the patient outcome data which was approved
- Complete travel expense claims for Advisory Committee and Council of Advisors members

The meeting was adjourned at 3:00pm.



EMERGENCY MEDICAL SERVICES AUTHORITY

Howard Backer, MD, MPH, FACEP
Director, California Emergency Medical Services
Authority





ROLE OF EMSA

The Emergency Medical Services Authority (EMSA) was created in 1980 to provide leadership in developing & implementing EMS systems throughout CA & setting standards for training & scope of practice for EMS personnel.

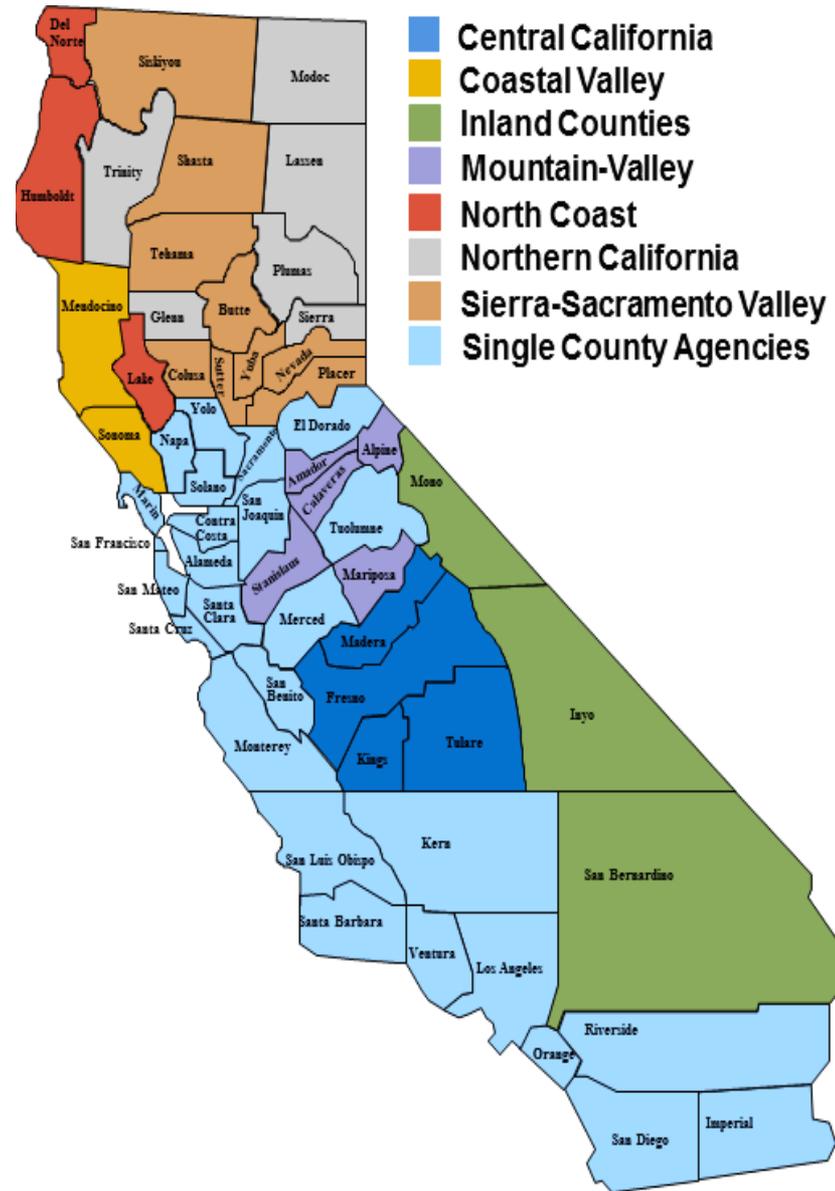
- Paramedic licensure and discipline
- Disaster medical preparedness and response
- Trauma system
- Poison Control
- Dispatch and EMS communications
- First aid and CPR for child care
- Injury prevention



Local EMS Agencies

33 local EMS agencies:

- 26 county agencies
- 7 multi-county agencies





CALIFORNIA EMS SYSTEM

- Providers are mixture of public and private
- 60,000 EMTs and 19,000 paramedics
- 3 million calls for service annually
- 3,600 ground ambulance and 50 air ambulances
- 310 acute care hospital EDs
 - 73 designated trauma centers



CA EMS STAKEHOLDER GROUPS

Emergency Medical Services Administrators Association of California
Emergency Medical Directors Association of California
Emergency Nurses Association
California Hospital Association
California Chapter of the American College of Emergency Physicians (Cal-ACEP)
California Fire Chiefs Association
California Ambulance Association
California Paramedic Program Directors Association
California State Firefighters Association
California Council of EMS Educators
California Department of Forestry and Fire Protection
California Poison Control Systems
California Healthcare Association EMS/Trauma Committee
California Nurses Association
California Peace Officers Association
California Professional Firefighters
California Medical Association
Commission on Peace Officer Standards and Training (POST)
California Sheriffs Association
California National Emergency Numbers Association
California Highway Patrol
California Association of Police and Sheriffs
Police Chiefs Association
California Police Chiefs Association
California Rescue and Paramedic Association
National Association of State Emergency Medical Services Directors



EMS Agenda for the Future

1996 NHTSA, HRSA

Emergency Medical Services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will ... provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. It will ... result in a more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net.



Healthcare Reform and Mobile Integrated Healthcare Systems

Expanding the role of community-based services and integration of health resources is consistent with the objectives of the Affordable Care Act, the Triple Aim, and Accountable Care Organizations

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capital cost of healthcare



What is Community Paramedicine ?

Community paramedicine (CP) is a new and evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles, in collaboration with other health care professionals, in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.

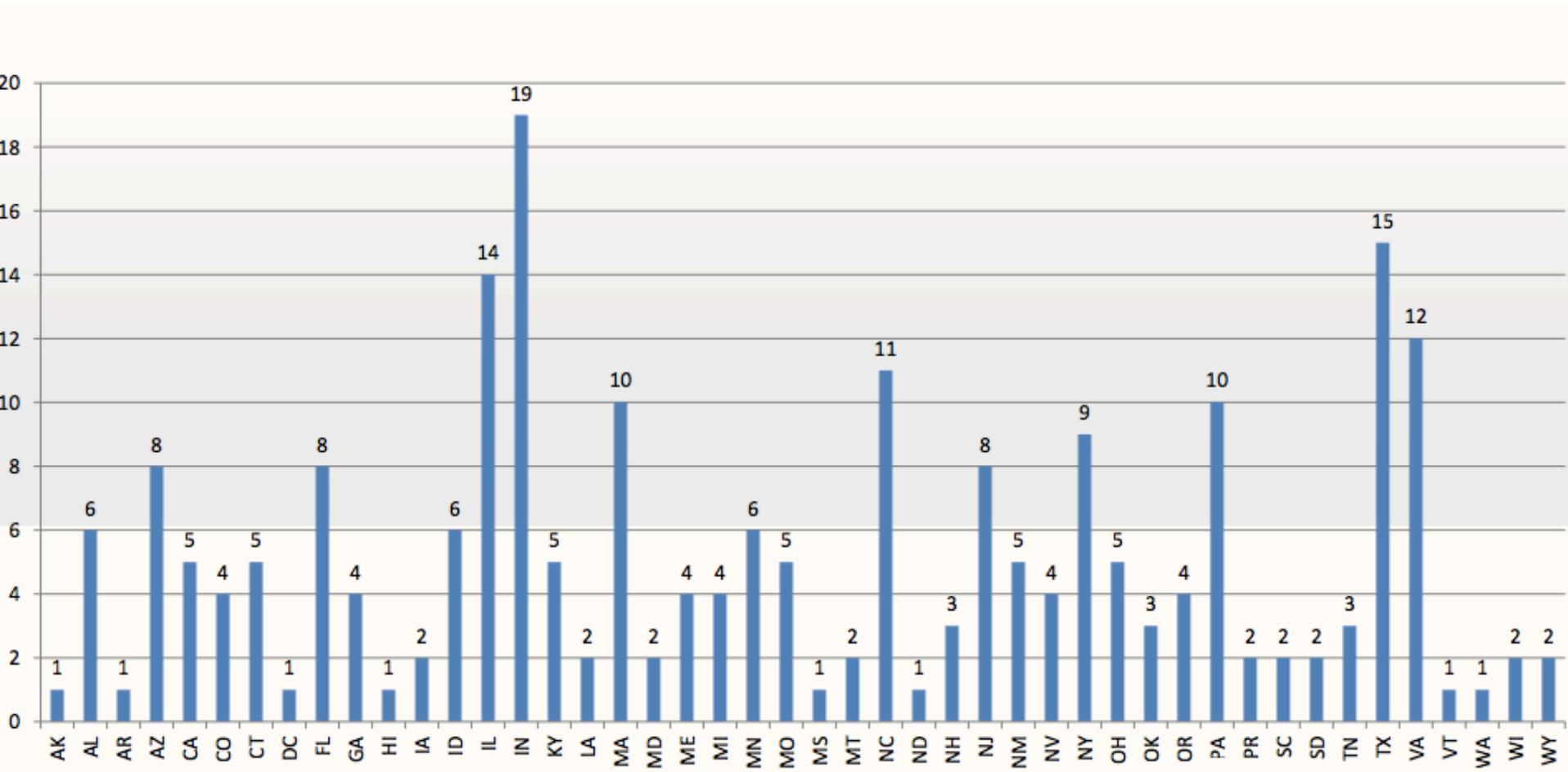


Underlying Principles of Community Paramedicine

- Based on collaborations and partnerships purposely designed to address identified gaps in care or service delivery.
- Not intended to duplicate or compete with other health care services or providers.
- Community paramedics are licensed but not as independent practitioners; they work under medical control.
- Community paramedics receive additional education and training commensurate with the focus of the CP program.

NASEMSO CP Survey 2014

Number of programs/state





Medicare EMS Innovation Awards

- Regional Emergency Medical Services, NV – \$9.9 million
- Prosser Public Hospital District, WA – \$1.5 million
- Upper San Juan Health Service District, CO – \$1.7 million
- Goals
 - Reduce unnecessary ambulance responses
 - Reduce ED visits
 - Reduce hospital admissions and readmissions
 - Increase access to primary and preventative care
 - Increase in-home patient care follow-up in medically underserved areas



Why Can't We Do This without HWPP?

The paramedic scope of practice statute in California delineates a set of authorized skills/activities for EMS personnel and the places and circumstances in which those skills/activities may be performed.

HSC 1797.218 Any local EMS agency may authorize an advanced life support program which provides services utilizing EMT-P for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during inter-facility transfer, while in the emergency department of a general acute care hospital



Why is there a need for a Pilot Project ?

- OSHPD's Health Workforce Pilot Projects (HWPP) Program allows organizations to test, demonstrate and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes in licensing laws are made by the Legislature.
- Provides the opportunity to gather outcome data to demonstrate whether or not Community Paramedicine improves access to care and reduces health care costs.
- Outcome data is critical to evaluate whether statewide implementation through statutory reform will improve health care delivery through expanded use of paramedics.



EMERGENCY MEDICAL SERVICES AUTHORITY

Lou Meyer
Community Paramedicine
Project Manager/Consultant





California Community Paramedicine

CALIFORNIA
HEALTHCARE
FOUNDATION



**EMERGENCY MEDICAL
SERVICES AUTHORITY**



University of California
San Francisco



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California Community Paramedic Pilot Projects



Local EMS Agency Partners

Sierra -Sacramento Valley

Solano County

Alameda County

Stanislaus County

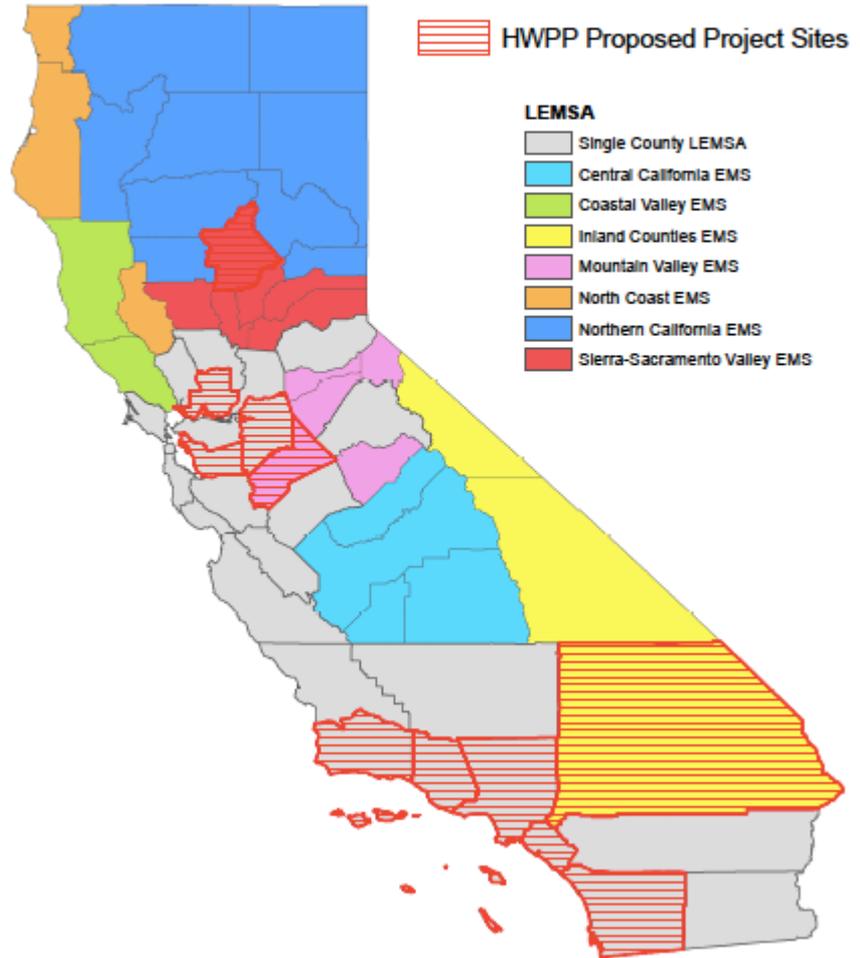
Ventura County

Inland Counties

San Diego

Los Angeles

Orange County



Based on 2013 data
Created 12/17/2013



Pilot Project Concepts



Alternate Destination

Los Angeles – Carlsbad – Orange County

Transport patients with specified conditions to alternate locations other than an acute care emergency department when appropriate.



Alternate Destination Behavioral Health

Stanislaus County

Transport patients with Behavioral Health issues to
Mental Health Facilities when appropriate.



Frequent 9-1-1 Users

City of San Diego – Alameda County

Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments by helping them access primary care and other social or psychological services.



Post Discharge Support

Solano – Alameda – Butte – San Bernardino
Orange - Los Angeles

Provide short-term home follow-up care for persons recently discharged from the hospital and at increased risk of a return visit to the emergency department or readmission to the hospital with referral from the hospital, clinic, or medical provider.



TB Directly Observed Support

Ventura County

The purpose of this project is to improve the treatment for people with TB by providing support for the Ventura County Public Health Department's TB Specialty Clinic and the patients they serve.



Hospice Support

Ventura County

The concept behind this project is to improve the care and service provided to hospice patients who have activated the 911 system or had the 911 system activated on their behalf. The primary objective is to have Community Paramedics provide patients with comfort care using the patient's own comfort care kit and supplemental medications until hospice clinicians can take over care.



Community Paramedicine

**Pilot Project
Partners**

Project #	Lead Agency	LEMSA	Pilot Concept	EMS Providers	Partners
CP001	UCLA Center for Pre Hospital Care	Los Angeles	Alternate Destination	Santa Monica, Glendale & Pasadena Fire Dept's	Glendale Memorial Hospital, Huntington Medical Foundation Urgent Care Center, Kaiser Permanente, Pasadena Public Health Department UCLA Health System
CP002	UCLA Center for Pre Hospital Care	Los Angeles	Post Discharge Follow Up (CHF)	Burbank & Glendale Fire Dept's	Providence St. Joseph's Medical Center
CP003	Orange County Fire Chief's Assoc	Orange County	Alternate Destination	Fountain Valley, Huntington Beach & Newport Beach Fire Dept's	Covenant Health Network, Kaiser Permanente, Memorial Care Health System, University of California, Irvine Center for Disaster Medical Sciences
CP004	Butte County EMS			Butte County EMS, Inc	Enloe Medical Center
CP005	Ventura County EMS Agency	Ventura	Directly Observed Treatment of TB	AMR Ventura, Gold Coast Ambulance & LifeLine Ambulance	Ventura Public Health Department

Project #	Lead Agency	LEMSA	Pilot Concept	EMS Providers	Partners
CP006	Ventura County EMS Agency	Ventura County EMS Agency	Hospice Support	AMR Ventura	Assisted Hospice Care of Ventura
CP007	Alameda County	Alameda County	Post Discharge Follow Up (CHF) & Frequent 911 Callers	Alameda City Fire Department	Kaiser Permanente – Alameda County Medical Center
CP008	San Bernardino County Fire Department	Inland Counties Emergency Medical Agency	Post Discharge Follow up	San Bernardino County Fire Department	Arrowhead Regional Medical Center – San Bernardino County Department of Public Health
CP009	Carlsbad Fire Department	San Diego County EMS Agency	Alternate Destination	Carlsbad Fire Department	Kaiser Permanente

Project #	Lead Agency	LEMSA	Pilot Concept	EMS Providers	Partners
CP010	City of San Diego	San Diego County EMS Agency	Frequent 9-1-1 Callers	San Diego City Fire Department & Rural Metro Corporation	San Diego Health and Human Services Agency, San Diego State Institute of Public Health, SDSU School of Social Work, UCSD Department of Preventive Medicine, UCSD Department of Emergency Medicine, Hospital Association of San Diego and Imperial Counties
CP012	Mountain Valley EMS Agency	Mountain Valley EMS Agency	Alternate Destination Mental Health	AMR Stanislaus County	Sutter Health Memorial Medical Center, Stanislaus County Behavioral Health and Recovery Services
CP013	Medic Ambulance – Solano	Solano County EMS Agency	Post Discharge Follow Up	Medic Ambulance – Solano	Kaiser Permanente



Project Timelines

Activity	Objective	Anticipated Completion Date
OSHPD Director Final Determination	§ 128175 (e) The director of the office shall accept comments on the recommendations, and, on or after 30 days after transmittal of the recommendations, the director of the office shall approve or disapprove the proposed project.	November 14, 2014 OSHPD Director approves HWPP #173 with modifications.
Phase I, II & III Pilot Project Evaluation	EMSA & UCSF shall conduct an overall evaluation of the pilot project and an evaluation at the site level.	On going thru the end of the Pilot Project
Phase I, II & III Data Collection & Analysis	The sponsor shall work with the HWPP Program and HWPP #173 project evaluator to determine the scope and timeline for data submission and reports during the initial six months of the Phase III: Intervention Period.	August – December 2014 Baseline Data Collection May 14, 2015 UCSF to File Base Line Data & Analysis Report w/HWPP.
HWPP Community Paramedicine Advisory Committee – Initial meeting		December 8, 2014



Core Training

Phase II

Community Paramedicine "Core" Education Plan

The UCLA Center for Prehospital Care commences with the coordination and delivery of the CORE curriculum using affiliated faculty made up of Nurses and Physician educators who are considered well versed in educating allied health professionals.

The curriculum was developed by the Community Healthcare and Education Cooperative (CHEC), a unit of the North Central EMS Institute which is made up of the University of Nebraska Medical Center, Creighton University, Dalhousie University, Mayo Clinic Medical Transport, Health Education - Industry Partnership of Minnesota, the Rural Centre of Nova Scotia, Offutt Air Force Base EMS Education, the state rural health offices of Nebraska and Minnesota, and the Centre for Prehospital Research in Queensland. It was reviewed and approved by an EMSA Curriculum Advisory Review Committee.

January 13, 2015–
February 19, 2015

Classroom every Tuesday
& Thursday 8-5pm plus
outside clinical
preceptorship.



Site Specific Training

Phase II

Community Paramedicine
Site Specific Training

The site-specific approved curricula will be taught locally by physicians, nurse educators with experience in emergency medicine and Public Health.

March 2015 – April 2015



Employment/Intervention

<p>Phase III Employment/Intervention Phase</p>	<p>Pilot Projects begin Employment/Intervention Phase following completion of CORE and Site Specific Training.</p>	<p>May/June 2015 – November 2016. September 2015</p>
<p>Phase III Pilot Project Monitoring</p>	<p>EMSA Project Manager will monitor the approved project through reporting and site visit evaluations as well as collaborate with the HWPP Program Advisory Committee.</p> <p>EMSA's Project Manager to assist the HWPP Program with monitoring and development of guidelines to tighten protocols pursuant to any findings</p>	<p>Ongoing throughout Pilot Project</p>
<p>Phase III Project Site Reports</p>	<p>Monthly Progress reports will be submitted in accordance with the HWPP Project Reporting Template.</p>	<p>Ongoing throughout Pilot Project</p>
<p>Final Evaluation Reports</p>		<p>Filed with OSHPD within 120 days of conclusion of Phase III.</p>



COMMUNITY PARAMEDICINE

Q&A



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**Philip R. Lee Institute for
Health Policy Studies**

Community Paramedicine Pilot Project: Evaluation Plan

Janet Coffman, PhD
Cynthia Wides, MA

December 8, 2014

Outline

- Evaluation Plan Overview
- Data Components
- Data Collection Methods
- Data Collection Timeline



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CP Pilot Project – Evaluation Plan Overview

The evaluation is a three phase process.

- Phase I will focus on “baseline” data collection and reporting, reflecting care as it is given prior to the pilot program.
- Phase II will focus on training of the CPs.
- Phase III will cover the implementation period.



CP Pilot Project – Evaluation Plan Overview

Baseline

Training

Implementation



August
2014

December
2014

June
2015

November
2015



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CP Pilot Project – Phase I

Phase I – “Baseline” Data Collection

- Baseline data metrics are designed to reflect how care is delivered prior to the pilot program.
- Baseline data covers the following major components:
 - Patient Demographics
 - EMS Utilization
 - Hospital Data (emergency department and inpatient)
 - Finance Data
- All sites answer the same basic questions, and additional data are requested based on the specific concept being demonstrated.



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CP Pilot Project – Phase I

Baseline Data Reporting

- Baseline data will be reported to the Independent Evaluator in aggregate on a month-by-month basis.
- Baseline data will be aggregated across each site by concept being tested.
 - Sites with more than one EMS provider or partner agency will aggregate data across all of their EMS providers and partner agencies.
 - Sites with more than one concept (e.g., Frequent 911 and Alternate Destination) will report aggregated data separately for each concept.

CP Pilot Project – Phase I: Patient Demographics

- Patient Demographic Questions:
 - Age
 - Sex
 - Race/Ethnicity
 - Language spoken
 - Insurance type (Private, Medicare, Medicaid, Self-pay)*
- Data are collected for all patients and subdivided by patient type (e.g., chief complaint of laceration, fever, etc./diagnosis of CHF, AMI, Diabetes, etc.), if relevant to the concept being tested

**May require reporting time lag for accuracy.*



CP Pilot Project – Phase I: EMS Utilization

- EMS Utilization Questions:
 - Fleet response to 911 events
 - Number of patients transported by partner EMS providers
 - Average length of time from **arrival on scene** to **arrival at ED**
 - Length of time from **arrival on scene** to **return to field** (Average, shortest and longest time + subdivision by patient type)
 - EMS wait time: Total number of your transports in the last month that spent more than 45 minutes at the hospital from arrival at ED until return to service
 - Average, shortest, longest number of miles driven to transport a patient
 - Number of transports by time of day (e.g., morning, afternoon, evening)



CP Pilot Project – Phase I: Hospital Data

- Hospital Data Questions:

- Number of minutes that each of the partner EDs were on diversion in the last month
- Patient wait time: Average time in minutes from arrival at ED to disposition* of patient for all patients and by subdivision of patient type
- Number of patients by disposition for all patients and by subdivision of patient type
- Average length of hospital stay for admitted patients for all patients and by subdivision of patient type

*Disposition = admitted, transferred, discharged, expired, failed to complete care



CP Pilot Project – Phase I: Finance Data

- Finance Data Questions:
 - Average salary + benefits for EMT-Ps who are potential candidates for CP training.
 - EMS Transport Cost (Fire Readiness; Transport Cost)
 - Average charges per transport for all patients and by subdivision of patient type
 - Average charges for inpatient care for all patients and by subdivision of patient type
 - Average claims paid by health insurance plans/networks for ED visits/inpatient care for all patients and by subdivision of patient type
 - Model patient “cost of care” by site and concept



CP Pilot Project – Phase I: Data by concept

- Alternate Destination:
 - Mechanism of injury (Motor vehicle collision, crushing, piercing, bite/sting, etc.)
- Frequent 911:
 - Estimates of patients with access to
 - *Social services*
 - *Care plans*
 - *Usual sources of primary and mental health care*



CP Pilot Project – Phase I: Data by concept (Cont'd)

- Tuberculosis:
 - Questions subdivided by all cases and drug-resistant cases
 - Some demographic data are collected on household residents due to risk of disease transmission
 - Data regarding administration, completion, daily symptom surveys, and disease transmission for patients receiving DOT
 - Cost data includes DOT administration
- Hospice:
 - Some demographic data is collected on family members receiving crisis counseling



CP Pilot Project – Phase II: Training Data Components

Phase II – Training Data

- **Core Curriculum:**
 - Classroom attendance hours
 - Performance on written exam, skills exam, and standardized patient encounters
- **Site-specific Curriculum:**
 - Classroom attendance hours
 - Performance on written exam, skills exam, and standardized patient encounters

CP Pilot Project – Phase III: Implementation Data Components

Phase III –Implementation Data

- Implementation data closely track Baseline data, but includes additional data metrics:
 - Patient safety and outcomes
 - Cost of care by new provider/alternate sources of care
 - Patient satisfaction and acceptance
 - Provider satisfaction and acceptance
- Site visits will be conducted

CP Pilot Project – Phase III: Implementation Quality Measures

Phase III –Implementation Quality Measures

- Working with Advisory Committee, EMSA, and sites to finalize. Examples include
 - CP compliance with protocols
 - Site compliance with 100% case review
 - Readmission rates (Post-discharge)
 - Subsequent ED visits/transfer (Alt. destination)
 - Patient health outcomes



CP Pilot Project – Phase I Data Collection Methods

Baseline Data Collection – Phase I

- Baseline data will be collected by the Local Pilot Project Managers (LPPMs) and reported to the evaluator using the Data Collection Tool.
- The Data Collection Tool is a web-based, HIPAA compliant* Qualtrics survey emailed to the LPPMs each month.
- The Evaluator will clean, compile, and analyze all Baseline data prior to reporting to HWPP.

*No PHI data will be reported to the external evaluators in Baseline data.

CP Pilot Project – Phase II: Training Data Collection Methods

Training Data Collection – Phase II

- **Core Curriculum:**
 - Data will be reported to the evaluator by the UCLA Center for Pre-hospital Care
- **Site-specific Curriculum:**
 - Data will be reported to the evaluator by the LPPMs
- The evaluator will clean, compile, and analyze all core curriculum and all site-specific curriculum data prior to reporting to HWPP.

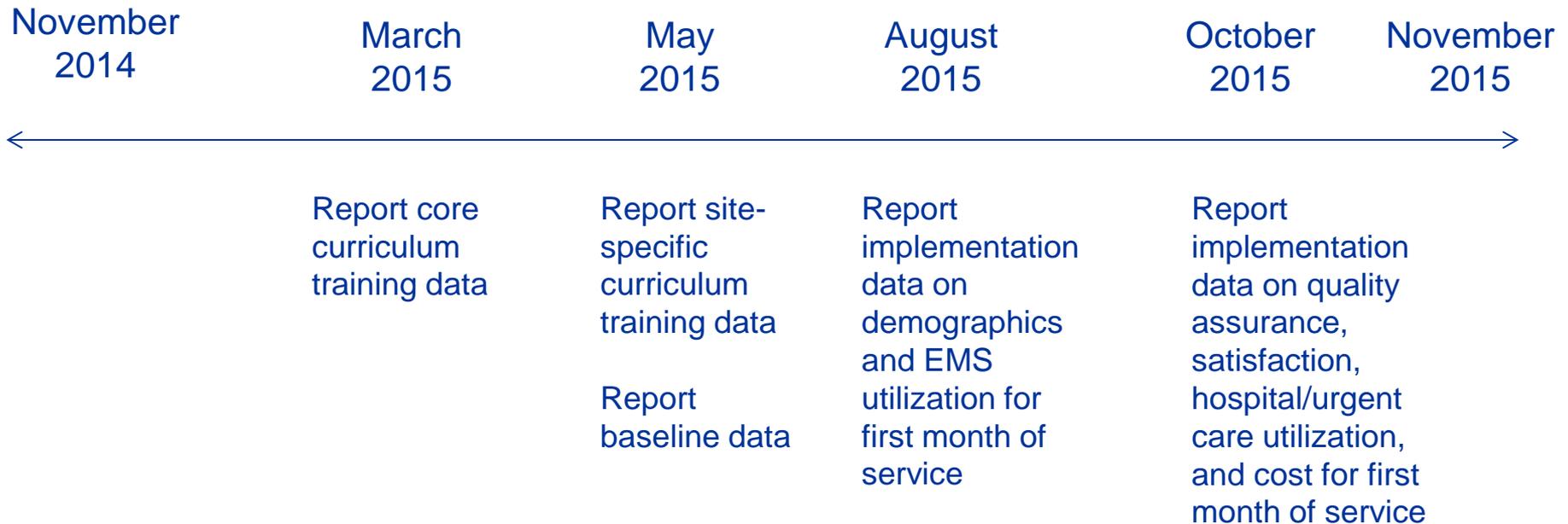
CP Pilot Project – Phase III Data Collection Methods

Implementation Data Collection – Phase III

- Implementation data will be collected by the LPPMs and reported to the evaluator using the Data Collection Tool.
- The Data Collection Tool is a web-based, HIPAA compliant* survey emailed to the LPPMs each month.
- The Evaluator will clean, compile, and analyze Implementation data prior to reporting to HWPP.

*PHI data may be reported to the external evaluators in Implementation data

CP Pilot Project – Data Reporting Timeline



CP Pilot Project –Phase I Data Reporting Timeline

- Phase I – Baseline data will be reported to HWPP on or by May 15, 2015 (six months after the approval of HWPP #173)

CP Pilot Project –Phase II Data Reporting Timeline

- Phase II – Training data
 - Core curriculum training data will be reported to HWPP on or by March 31, 2015.
 - Site-specific curriculum training data will be reported to HWPP on or by May 15, 2015.



CP Pilot Project –Phase III Data Reporting Timeline

- Phase III – Implementation data will be reported to HWPP on a lagged monthly basis.
 - Data measures on demographics and EMS utilization will be ready to report to HWPP two months after month of service.
 - Data measures on quality assurance, hospital/urgent care utilization, finance data, and satisfaction measures will be ready to report to HWPP four months after month of service.
 - Lags on Phase III reporting allow adequate time for facilities to collect, clean, and report their data and allow patients/providers adequate response time for surveys in addition to survey data cleaning and analysis.
 - Any concerns related to patient safety will be reported immediately to HWPP by EMSA in accordance with HWPP regulations.

Questions and Answers