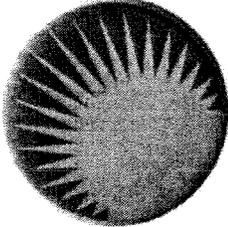


EAS CARE, LLC

Ambulance Service

in collaboration with

Commonwealth 
Care Alliance

Special Project Waiver Application:
Out of Hospital Paramedic Care

Massachusetts Office of Emergency Services
February 10, 2014

“Out-of-facility care is an integral component of the health care system. EMS focuses on out-of-facility care and also supports efforts to implement cost-effective community health care. By integrating with other health system components EMS improves health care for the entire community, including children, the elderly, and others with special needs.”¹

~Alasdair K.T. Conn, MD

Chief of Emergency Services Massachusetts General Hospital Boston, MA

¹ Emergency Medical Services: Agenda for the Future (Accessed via http://www.ems.gov/pdf/2010/EMSAgendaWeb_7-06-10.pdf on July 15, 2013)

Disclaimer

The attached proposal contains confidential information of EasCare LLC and Commonwealth Care Alliance, including system designs, processes and structures, and is provided to the Massachusetts Office of Emergency Services in confidence on the understanding that it is solely for its own use in accordance with the Special Project Waiver Application. This document and its contents may not be disclosed or distributed to third parties without the express written permission of EasCare LLC.

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1.0 Purpose

EasCare LLC (EasCare) and Commonwealth Care Alliance (CCA) are seeking a Special Project Waiver from the Massachusetts Office of Emergency Medical Services (OEMS) to expand the role and scope of practice of Paramedics through the establishment of a Out of Hospital Paramedic Care Program. Gregory Davis, Division Manager of EasCare will administer the program. This program will allow up to 10 Massachusetts certified Paramedics to be trained to provide care to CCA patients under new roles without transporting the patient to a healthcare facility. Daniel Muse, MD will provide physician oversight as the Medical Director of the program. His duties will include the supervision of the education, policy and procedures, as well as, Continuous Quality Improvement for the program.

In collaboration with the CCA's Accountable Care Organization (ACO), EasCare proposes to provide Out of Hospital Paramedic Care to the benefit of their patients. As future opportunities arise EasCare will create mutual programs by means of this specific program. Over two years, the program will allow EasCare to complete a comprehensive program evaluation using the data collected. This will be used to demonstrate the impact of and lessons learned from Out of Hospital Paramedic Care.

Project Name:	Out of Hospital Paramedic Care
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2.0 Background

Many health systems are examining the role of EMS within the context of the overall health system. The capabilities of the EMS system have drastically evolved both in terms of technology, as well the scope of practice of paramedics. Paramedics are able to perform complex patient interventions, under the supervision of appropriate medical direction, that once were only conducted in a hospital setting. This has been a key contributor to improved patient outcomes.

This progression was identified in the 2009 review of the EMS system in Saskatchewan, Canada. This review highlighted that: “during the evolution of EMS onto its current form, the role of EMS in the healthcare system has changed. This role has developed from one external to the healthcare system to one that is medically focused and more engaged as a healthcare service. Early EMS providers were required to have little or no training while today’s EMS providers are graduates of specialized programs, subject to ongoing continuing medical education requirements and are often integrated within their local health care team.”²

In some countries, the evolution of EMS has continued to a point where it has been a key asset in the delivery of primary care services. This is the result of a realization that while services are delivered under EMS, many patients being treated are receiving non-emergency care. The report *Talking Healthcare to the Patient: Transforming NHS Ambulance Services*, developed in the United Kingdom, highlighted the prevalence of non-emergency EMS patients: “Only 10% of patients ringing 999 have a life threatening emergency. Many patients have an urgent primary (or social) care need. This includes large numbers of old people who have fallen in their homes (around 10% of incidents attended), some with no injury; patients with social care needs and mental health problems; and patients with a sub-acute onset of symptoms associated with a long-term condition such as diabetes, heart failure and chronic obstructive pulmonary disease (around a further 10% of incidents attended).”³

These types of calls consume valuable emergency resources, result in extended delays for patients and staff at emergency departments for health issues that could be appropriately resolved through alternate means such as self-care or a visit to a clinic and contribute to increased stress on health care facilities. In order to respond to the high volume of non-emergency calls and provide care that better aligns with the needs of patients, countries such as Canada, the United Kingdom, New Zealand and the United States have established a wide variety of innovative community paramedicine programs that take care directly to the patient.

² The Government of Saskatchewan, *Saskatchewan Emergency Medical Services (EMS) Review (2009)*, [online], form <<http://www.health.gov.sk.ca/adx/asp/adxGetMedia.aspx?DocID=0ff76b57-5a19-49ea-b6f9-eb618c6b2358&MediaID=3439&Filename=EMS+Review+Report+Oct09.pdf&I=English>>

³ Department of Health, *Taking Healthcare to the Patient: Transforming NHS Ambulance Services (2005)*, [online], from <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4114270.pdf>

These programs address the root cause of unnecessary ambulance transports, such as lack of access to a primary health care physician to provide a tailored level of care to targeted patient populations. This can be especially beneficial in remote or rural geographical areas where there are low concentrations of community based health services.

Community Paramedicine is defined as “a model of care whereby paramedics apply their training and skills in ‘non-traditional’ community-based environments (outside the usual emergency response/transport model). The community paramedic may practice within an ‘expanded scope’ (applying specialized skills/protocols beyond that which he/she was originally trained for), or ‘expanded role’ (working in non-traditional roles using existing skills).”⁴ These models leverage the strong and versatile clinical skill-sets of paramedics, as well as their mobility. There are numerous examples such as:

- Paramedics delivering non-emergency care to patients directly in their place of residence, thus avoiding an ambulance transport;
- Assessing patients in order to link them with alternate community based service providers; and
- Conducting home-based assessments to identify any patient risks such as falls, hazards and indications of medication non-compliance.

Overview of Alternative Models

An environmental scan has been conducted regarding innovative health delivery models that leverage health system resources to improve patient outcomes and satisfaction levels, in addition to supporting the provision of sustainable health care. Models were selected from countries across the world such as Canada, New Zealand, United Kingdom and the United States. These models have been categorized based on the manner in which service is delivered. These categories are:

- Call and Patient Triage;
- Post Discharge Follow-up and Drug Compliance Management;
- Care Coordination;
- Community Care; and
- Chronic Disease Management.

Further details regarding these categories are provided in the following section. It is important to note that this does not represent a comprehensive collection of innovative health care models.

Category	Definition
Call and Patient Triage	These models involve the use of technology in order to remotely triage patients and provide access to tailored care pathways. This is primarily completed through phone assessments but emerging technologies allow for interaction through alternate means such as videoconferencing and other web-based forms of communication. Effective call and patient triaging recognizes the unique need of each patient and matches patients with the appropriate source of care. This can lead to improved patient outcomes and more efficient use of health system resources.

⁴ The International Roundtable on Community Paramedicine, [online], from <<http://www.ircp.info>>

Category	Definition
	<p>The key enabler is enhancing the current technology so it is able to flag low-acuity calls that have been identified. These calls could be selected in conjunction with the Medical Director and OEMS, as specific health issues that do not require automatic ambulance response. These calls could then be directed to a health care provider that can assist the patient to formulate a tailored care plan and direct the patient to the most appropriate level of services. This includes considerations around ensuring that patients can swiftly be linked to back to emergency services if their condition is upgraded at any point during a call. This configuration would allow emergency calls to continue to be treated in a high priority manner while providing appropriate patients, in non-emergency situations, with additional service options.</p>

<p>Post Discharge Follow-up and Drug Compliance Management</p>	<p>These models are effective in reducing hospital readmissions and ensuring drug compliance following a hospital admission, by using BLS EMTs. This is crucial for patients with chronic disease and other risk factors. This would include regular monitoring through telephone or in-person follow-up in order to ensure adherence to prescribed drug regimes, in addition to, primary health and educational services such as checking vital signs, nutritional information and monitoring of risk factors. These models can be supported through the use of indexes that evaluate pertinent patient information to quantify the risk of hospital re-admission.</p>
<p>Care Coordination</p>	<p>These models are focused on the coordinated provision of patient care using teams comprised of a broad range of health care providers. For example, a team may be comprised of physicians, nurses, personal care workers and paramedics working together to increase efficiency and provide patient-centric care. Health care teams leverage the respective expertise of each health care provider supporting the provision of seamless patient care. Through effective care coordination, the health care providers have ongoing patient contact, thus closing the loop on the patient's needs.</p> <p>Care coordination also involves the provision of coordinated services in a logical and timely manner, and includes offering continuity of care and information support. The provision of these services could occur in multiple settings including clinics providing after-hours service or through telecommunications. Care provided after-hours in a clinic or over the telephone presents a viable alternative to emergency departments and</p>

	can be staffed by various levels of service providers.
Out of Hospital Care	<p>These are models that leverage Out-of-Hospital resources in order to provide an expanded range of services at a community level. These resources include the versatile skill set of care providers, station locations, vehicles and technology. This is predicated on a shift in the health care system towards making the home or community the center of care.</p> <p>These models evidence the capability of Out-of-Hospital personnel to successfully fill a greater role in the health care system. This includes filling service gaps in rural and remote areas, taking mobile primary care directly to patients and working with other levels of care providers.</p>
Chronic Disease MGMT Chronic Disease Management (Cont'd)	<p>These models work to control and reduce the progression of chronic diseases such as diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular diseases. Initiatives to control chronic disease and its risk factors include: the use of equipment to remotely monitor vital signs; tele-health; and the provision of education through various methods. The effective management of the symptoms and risk factors of chronic disease contributes to a decrease in the progression of these diseases and a reduction in the number of hospital admissions.</p>

The EasCare Vision for Out of Hospital Paramedic Care

In 2011, EasCare began looking at new patient care models to address the shifting healthcare industry. Through the research that ensued, it was discovered that some EMS systems in the US were already looking at similar solutions. States such as Texas, Minnesota and Colorado have turned to Community Paramedicine for non-traditional solutions. EasCare is now proposing to introduce Out of Hospital Paramedic Care to Massachusetts in collaboration with the Commonwealth Care Alliance ACO.

As EMS providers work with many different healthcare providers on a daily basis (e.g. VNAs, ACOs, ICOs, HMOs, Skilled Nursing Facilities (SNF) and Assisted Livings), new opportunities for collaboration have emerged. In their 2010-2012 summary report the National EMS Advisory Council advised the NHTSA and DOT that, "EMS must be integrated into the broader healthcare system."⁵

ACOs are still in their infancy and many are seeking new ways to deliver high quality care while decreasing hospital admissions and ambulance transports. Using the best practices from external Community Paramedicine systems, EasCare will provide Out of Hospital Paramedic Care services while collaborating with emergency, ACO and primary care physicians on all patient encounters.

⁵ National Emergency Medical Services Advisory Council Summary Report 2010-2013 (Accessed via: http://www.nhtsa.gov/staticfiles/Fnti/pdf/F811705.pdf&ei=L5DkUbOpNOPE4APwyIDYDg&usg=AFQjCNGoJQUdDBbNPI5sRiqF6i_ZIGL2fw&bvm=bv.48705608,d.dmg on March 15, 2013)

EasCare's parent company, Medavie EMS, has been involved in an urban pilot for an Extended Care Paramedic program in Halifax Nova, Scotia, which has resulted in a 70% decrease in SNF patients being transported to an emergency room.⁶ Through another rural Community Paramedic Program there was a 23% reduction in visits to the local Emergency Department through the provision of home based non-emergency primary care. Medavie EMS' expertise and success with Community Paramedicine will support the development of a program that is tailored for Massachusetts by EasCare.

Commonwealth Care Alliance's patients are from the Boston, South Shore and Western Massachusetts areas. This program will initially focus on servicing the Boston and South Shore Communities. The Commonwealth Care Alliance Clinical Group is comprised of physicians, nurse practitioners, nurses, behavioral health clinicians, medical assistants, and other clinical and administrative support staff. These direct care clinicians provide primary care and care coordination services to elders and persons with disabilities across the Commonwealth. . The CCA ACO is a not-for-profit group of over 12 physicians and 53 NPs and PAs from the Commonwealth Community Care and Commonwealth Care Alliance Groups. Since 2003 CCA has offered home visits during the day with 24/7 phone assistance to speak directly with a CCA Physician for care coordination. This "*nationally recognized*" program offers individualized and compassionate healthcare programs. During the evening and night, the Physicians are required to use hospitals for patient care.

The program that EasCare is requesting will allow Out of Hospital Paramedic Care Paramedics to be assigned to provide evaluation, treatment and appropriate disposition. The EasCare Communications Center will receive the call from the CCA's "on-Call Clinical Group". They will triage and speak to the patient or caregiver initially and then triage the patient's requirements for 911 or Out of Hospital Paramedic Care to ensure the appropriate utilization of the service. CCA has been using this out of hospital triaging protocol for over 10 years with NPs, PAs and Physicians providing home care during day hours. Due to the CCA's Clinical groups in depth knowledge of their patients, the triage protocol assures appropriate triaging outside of the 911 systems. CCA would like to use Paramedics for the off hours and eventually during the day if a cost savings is found.

The primary goal is meeting the needs of the CCA's patients in a safe and controlled environment. EasCare's Out of Hospital Paramedic Care program is geared towards providing clinically-sound patient care, while avoiding unnecessary ambulance transports to Emergency Departments and hospital admissions. This patient-centered care is based on the recognition that any patient who is not sufficiently stable for on-scene care will be immediately triaged as an emergency with transportation to an appropriate emergency department via the local 911-provider.

The project's population for phase 1 is 2000 CCA patients and the service area will include Region IV and V (Greater Boston and South Shore). The population and service area for the program will fluctuate as CCA patients are identified and added into the system Phase 2 and 3 will include expansion after review of the project at a later date. Expansion will include CCA populations in Springfield and Worcester.

⁶ Insights & Experiences from the Halifax ECP Program (2013) (Accessed via: rcp.info/Portals/11/Meetings/2013/911_ECP%20research%20.pdf on July 5, 2013)

3.0 Clinical Opportunities

The introduction of the Patient Protection and Affordable Care Act has created incentives for organizations to transform the way in which care is delivered. As a result there are many patient populations that could be provided with coordinated care through non-traditional models.

EasCare's Out of Hospital Paramedic Care Program intends to utilize Paramedics trained and experienced at the level of OEMS Statewide Treatment Protocol Appendix "N" for Inter-Facility Transfers. Additional education will include programs and materials that will expand their role to the Out of Hospital Paramedic Care level through classroom, in hospital and in home clinical rotations specifically to the care being accomplished out of the hospital.

The following table will outline patient populations that could benefit from an Out of Hospital Paramedic Care program. This program will introduce an expanded role for paramedics within their existing scope of practice (i.e. skills and training). Candidates must meet proficiency in current Commonwealth of Massachusetts Statewide Treatment Protocols, and be fully trained in the expanded role under Appendix N (IFT Training Program AR 5-509).

Category	Overview
Care Coordination/ Patient Navigation	Numerous members of the target populations will have needs based around obtaining access to appropriate care in a manner that does not involve an admission into the Emergency Department. Out of Hospital Paramedic Care can decrease these unnecessary trips to the ED by working with patients, their physicians and healthcare providers to assist them with scheduling their appointments, ensuring that they will have access to transportation and are reminded of the times and days of these scheduled events.

Category	Overview
Assessment and Management	Primary focus is early recognition of signs and symptoms, interventions to prevent exacerbation of condition and treatment to prevent need for hospital admissions. Various Community Paramedic Programs in the United Kingdom determined that 77% of patients would prefer a Community Paramedic visit over other healthcare providers. They also saw a 50% decrease in Accident & Emergency department attendance. ⁹
CHF Assessments and Management	<p>CHF patients often have reoccurring instances of symptoms brought on by a host of reasons resulting in multiple ED admissions. One of the reasons for this is the limited access to additional resources to properly manage their care while in an assisted living or home care setting.</p> <p>Out of Hospital Care Paramedics will work with these patients to provide additional guidance on proper eating habits, monitoring of their weight and providing care at home as needed. The Out of Hospital Care Paramedics will be able to provide a full assessment of the condition then utilize Medical Direction to guide diuretic and other therapies as well as the monitoring and treatment of hypertension. Care Coordination will allow patients to follow up with their private physician and/or ACO Care Coordinator at a predetermined time and date.</p>
<p>COPD Assessment and Management</p> <p>COPD Assessment and Management (Cont'd)</p>	<p>COPD patients often have reoccurring instances of symptoms brought on by a host of factors resulting in multiple ED admissions. One of the reasons for this is the limited access to additional resources to properly manage their care while in an assisted living or home care setting.</p> <p>The Out of Hospital Care Paramedics will be able to provide a full assessment of the condition then utilize Medical Direction to guide therapies such as inhaler treatments, steroids and access to additional resources to maintain the patient's condition in their home environment. Care Coordination will allow patients to be followed up with their private physician and/or ACO Care Coordinator at a predetermined time and date.</p>
Diabetic Assessment and Management	Diabetic patients often find themselves utilizing the ED to address their acute needs and this will not likely change. However; as soon as the life threatening hypoglycemia has been appropriately addressed, these patients could be left in

⁹ Hui Wang (2011) Community Paramedicine Summary of Evidence. (Accessed via <http://www.ircp.info/Portals/11> on October 24, 2011)

Category	Overview
	<p>the care of a Out of Hospital Care Paramedics for further stabilization making transport unnecessary. Further, Out of Hospital Care Paramedics can be utilized as a preventative measure to provide addition education and monitoring to prevent acute hyperglycemia or hypoglycemia. The Out of Hospital Care Paramedics can work with Medical Direction to assist in the adjustment of medications to manage swings in blood glucose levels. In addition, Out of Hospital Care Paramedics can become a secondary level of support after the E-911 system treats and releases these patients, which is a common practice in the industry. By providing follow-up in real time, Out of Hospital Care Paramedics will be able to assist in the long term stabilization of the medical condition to ensure that the patient is not forced to call back to E-911. Care Coordination will allow patients to be followed up with their private physician and/or ACO Care Coordinator at a predetermined time and date.</p>
<p>HTN assessment and Management</p>	<p>Out of Hospital Care Paramedics will have the ability to follow-up on patients who suffer from significant Hypertension issues. These home visits can add additional levels of verification for medication administration, BP levels and education to maintain a healthy blood pressure. Further, Out of Hospital Care Paramedics will have the ability to treat patients who have acute HTN issues, but do not need transport to the ED. By treating these conditions at home, under medical direction, the Out of Hospital Care Paramedics can stabilize the immediate situation and work with the PCP and patient to make necessary changes in the patient's day to day treatment plan for better management of the condition. Care Coordination will allow patients to be followed up with their private physician and/or ACO Care Coordinator at a predetermined time and date.</p>
<p>Nausea, Vomiting, and Diarrhea Management</p>	<p>Patients presenting with nausea, vomiting and/or diarrhea can be managed at their homes/assisted living facility without requiring ED transport. This management will be conducted after consultation with a physician, and may include administering anti-emetics, fluid balance and drawing labs for testing. Care Coordination will allow patients to be followed up with their private physician and/or ACO Care Coordinator at a predetermined time and date.</p>
<p>Assessment of Altered Mental Status (non-acute)</p>	<p>Patients who are displaying a change in mental status that has been triaged and is not due to an acute situation can be assessed by a Out of Hospital Care Paramedics for potential differentials. Conditions that may be managed under the direction of medical directions include blood glucose</p>

Category	Overview
	changes, uncomplicated sepsis issues, UTI management and other conditions that do not warrant emergency transport. Out of Hospital Care Paramedics will allow patients to be followed up with their private physician and/or ACO Care Coordinator at a predetermined time and date.
Management of "Do Not Hospitalize and Do Not Resuscitate" Patients	Work with CCA Palliative Care service to provide a second layer of care for patients who have chosen to spend their final days at home or in the care of a nursing facility. The goal is to provide additional resources in conjunction with existing services already being provided. By adding a second layer of care through providers who are available 24/7, patient's requirements will be better served while reducing unnecessary transportation to the ED.
Assessment and Management of Cellulitis	Perform an assessment of cellulitis, including outlining the borders, determining severity, and implementing a treatment plan with a physician. Many cellulitis conditions can be managed in a pre-hospital environment, thereby decreasing the need to transport to the Emergency Department
Specimen Acquisition and Point of Care Testing	Work in conjunction with our partners to provide mobile access Point of Care testing for urine, stool, blood culture and blood samples. Additional lab samples may be obtained to be processed at partner laboratories.
Flu and Immunization Administration	Work in conjunction with our partners at the CCA to provide patients with appropriate flu shot and immunization vaccinations through in-home inoculations. Our partner organization will provide the list of patients that are eligible for this service.

Expanded Scope of Practice

Skill / Procedure	Overview
Urinary Catheter Placement	Similarly to the G-Tube, when a patient's Foley or Suprapubic catheter is dislodged, the patient is often transported to the ED for re-insertion. Other occurrences may include UTIs requiring catheter placement. Training Out of Hospital Care Paramedics to insert Foleys would allow for this procedure to be accomplished in the comfort and security of their room, whether that is at home or in an assisted living or nursing facility. This procedure is not currently within the Paramedic Scope of Practice or under an expanded role capacity.

All of these treatments will be performed under protocols developed by the Medical Director. The Out of Hospital Care Paramedics will complete a comprehensive training program for each competency as well as extensive clinical evaluations to ensure proficiency with each skill. Clinical rotations will be divided between time in both a clinical location (Hospital and/or Clinic) and in the field by shadowing Physicians, NPs and PAs in patient's homes.

By providing these Out-of-Hospital services, EasCare will become an integrated component of a developing healthcare model. These essential services meet several critical healthcare system goals, including cost containment and improving patient access to care. Though the needs of each of our patients may vary, this system will provide the flexibility necessary to deliver a wide variety of tailored Out-of-Hospital services.

4.0 Program Design

The following sections will outline the major elements of EasCare's proposed Out of Hospital Care Program.

4.1 Clinical Needs Assessment

The EasCare Out of Hospital Care Paramedics program, has engaged the CCA to identify a target patient population for a program initiative. This process was accomplished through a collaborative and evidence based approach that included the review of patients using electronic medical records. We then performed an in-depth analysis to identify gaps between the current clinical environment and the envisioned future state. Areas of evaluation included but were not be limited to:

- Clinical Protocols;
- Scope Expansion;
- Policy and Procedures;
- Equipment;
- Education and Training;
- Medical Oversight;
- Medical Communications;
- Reporting; and
- Continuous Quality Improvement Measures.

The results of the clinical needs assessment clearly outlined the variance between EasCare's current capabilities and the requirements for the Out of Hospital Care Paramedics program. This guided the core developmental and implementation of activities.

4.2 Project Management & Oversight

EasCare, in conjunction with Medavie EMS is experienced in the development and implementation of detailed work plans. We understand the complexities associated with program development and the need for a structured approach that ensures key tasks are identified and completed within the allotted timelines.

The vast majority of our experiences have been conducted in environments/systems actively providing emergency services, thus eliminating the possibility of any form of service interruption has become one of our core competencies. We employ a methodology based on the best practices of the Project Management Institute (PMI) that is coordinated by the project management expertise that exists within our organization. Our belief and uncompromised position is that any degree of service degradation is unacceptable.

Some of the key elements of a detailed project would include but not be limited to.

- Project Charter;
- Project Initiation Document (PID);
- Work Breakdown Structure (with responsibilities and timelines);
- Risk Monitoring and Mitigation Strategies;

- Regular Status Updates; and
- Communication Plan.

A project manager, using PMI project methodologies, will be assigned to lead implementation activities and develop detailed project plans while assigning appropriate resources. A key component of our activities will require ongoing communications between EasCare, OEMS, as well as our clinical partners on each program.

The smooth launch of a Out of Hospital Care Paramedics program remains a key pillar for success by ensuring a high quality service delivery throughout the start up phase and future operations. Addressing concerns and risks will be a priority, achieved by communicating with stakeholders at the earliest possible opportunity and presenting the information related to issue.

Establishment of Working Groups

One of the initial tasks will be to set up two working groups in order to successfully design and operationalize the Community Paramedicine program.

- **Advisory Committee:** The advisory committee would have the following responsibilities:
 - Promote the project and contribute to its success
 - Facilitate development of collaborative working relationships with all stakeholder groups
 - Ensure that the Project Manager and Advisory Committee are informed, in a timely manner, of trends, issues, and events that may impact the project
 - Provide opportunities for reviewing project progress and identifying future options
 - Provide a forum for consideration of the implications of project options for partners
 - Ensure that concerns and priorities of stakeholder groups related to the project objectives are communicated
 - Assist the Project Manager in determining an appropriate set of activities to meet project goals and objectives

The second group would focus on the Operational and Clinical aspects of the program.

- **Operational and Clinical Working Group:** The Operational and Clinical Team will be tasked to address a number of topics including but not limited to:
 - Dispatch Related Activities
 - Human Resources
 - Fleet and Equipment
 - Reporting (Clinical, Operational, Contractual)
 - Call Flow
 - Scope of Practice
 - Training and Education
 - Affiliation agreements with Hospitals for clinical exposure (if required)
 - Program evaluation and potential research implications.

It is important to note that active collaboration and input from stakeholders will be necessary within the Committees to ensure that the Out of Hospital Care program is designed around the key requirements and considerations.

4.3 Education & Training

Educational Syllabus & Learning Objectives

EasCare in conjunction with Medavie EMS' extensive educational platform will provide the foundation on which our Out of Hospital Care Paramedic education program will be constructed.

The learning objectives are a combination of the requirements set forth by Medavie, as well as the objectives provided by the CAA. By combining these two systems, EasCare will be able to provide paramedic staff with an excellent education that takes into account an American based system, supplemented by the tenured Canadian program. These Learning Objectives include an extensive mentoring process which will include shadowing of Physicians, Physician Assistants, Nurse Practitioners and Laboratory Technicians.

All identified supplemental education programs will be constructed with input from the Medical Director (EasCare and CCA) and additional experts, including Medavie EMS and their educational team upon the completion of the needs assessment. The coursework will be presented by a combination of Physicians, Physician Assistants, Nurse Practitioners, Nurses, Paramedics and other Healthcare Providers who are experts in the topic being presented.

Education Program Overview

The Out of Hospital Care Paramedic navigates and establishes systems to better serve the citizens of their communities. They assist patients, healthcare services and communities overcome barriers that prevent them from accessing and benefitting from health services. They serve as advocates, facilitators, liaisons, community brokers and resource coordinators. Out of Hospital Care Paramedics are also trained as direct service providers which will ensure basic and advanced levels of care appropriate to prevention, emergencies, evaluation, triage, disease management, and basic oral and mental health.

Didactic Total (152 hrs)

Section One: Total 16 hours

1. Intro to Out of Hospital Care/Community Paramedicine (2 hours)
 - i. Insurance changes (ACOs/ICOs)
 - ii. Healthcare changes (Managed Care)
 - iii. Decrease in transports
 - iv. Decrease readmits
 - v. Populations
2. Role vs. Scope (3 hr)
 - a. Current vs. Expanded Scope vs. Community Paramedicine
3. Medical Legal (1 hr)
4. Logistics of a call (5 hr)
 - a. Call taken
 - b. Arrival

- c. Collaboration
 - d. Medical Control
 - e. Protocols
 - f. Interventions
 - g. Follow up
 - h. Post Encounter
 - i. Home safety
 - ii. Medication Inventory
 - iii. DC Instructions
 - i. Documentation
 - j. CQI
5. Patient Encounters (Overview)
- a) Communications & Collaboration (3 hours)
 - a. New Dynamics
 - i. Interpersonal communications
 - b. Represent the healthcare system
 - c. Patient
 - d. Caregivers
 - i. Family
 - ii. Medical Staff

Section Two: Total 16 hours

- 1. General Impression (1 hrs)
- 2. WHAT IS THE PATIENT'S BASELINE (1 hrs)
 - a. Assessment
 - b. History
 - c. Medications
- 3. ECG (4 hrs)
- 4. Lab Values (5 hrs)
- 5. Pharmacology (5 hrs)

Section Three: Body Systems Total 71 hours

- 1. Specific Body Systems <<Anatomy, Pathophysiology, Disease Process, Assessment/Evaluation/Labs, Management, Secondary issues, protocol management>>
 - a. Neurological (8 hrs)
 - b. Respiratory (8 hrs)
 - c. Cardiac (10 hrs)
 - d. Endocrine (4 hrs)
 - e. Renal (6 hrs)

- f. GI (8hrs)
- g. Cancer (4 hrs)
- h. Psychological (4 hrs)
- i. Integumentary (4 hrs)
- j. Infections (4 hrs)
- k. DNR/CC/Molst (3 hrs)
- l. Geriatric (16 hrs)
- m. Pediatric (4 hrs)

Section Five: Total 21 hours

- 1. Lab Acquisition (2 hrs)
- 2. Pharmacology Infusion (1 hr)
- 3. IV (2 hr)
- 4. G Tube (1 hrs)
- 5. Drains & Wound Vacs (1 hrs)
- 6. Discharge Follow up (1 hrs)
- 7. Collaboration (Social Working) (2 hrs)
- 8. Home Safety (1 hrs)
- 9. Review Sessions: Three each at 2 hours (6 hours)
- 10. Mid-term exam (2 hours)
- 11. Final Exam (2 hours)

Clinical Rotations (152 Hrs)

1. LAB (16 Hrs)

- a. Protocol Overviews w/ skill labs
 - i. Assessment/Treatment Plans
 - 1. Neurological
 - 2. Respiratory
 - 3. Cardiac
 - 4. Endocrine
 - 5. Renal
 - 6. GI
 - 7. Cancer
 - 8. Psychological
 - 9. Integumentary
 - a. Wound
 - b. Falls
 - 10. Infections
 - 11. DNR/CC/Molst

12. Geriatric

13. Pediatric

2. Clinical Rotations <Hospital and Home Visits> (136 hrs)

- a. Emergency (80 hrs)
 - i. Cardiac
 - 1. Asymptomatic
 - 2. Stable abnormal labs
 - 3. Echo
 - 4. Cath
 - ii. Neurological
 - iii. Endocrine
 - iv. Integumentary
 - v. Infections
 - vi. Psychological
 - vii. Cancer
 - 1. DNR/CC/Molst
 - viii. GI
 - ix. Pediatrics
- b. Respiratory (8 hrs)
 - i. Rounding with Respiratory
 - 1. Spirometry
 - 2. PFTs
 - 3. Managing chronic patients
 - 4. Trach Changes
- c. Renal-Dialysis (8 hrs)
 - i. Follow (2) Dialysis Clinic Patients
 - ii. Follow (2) peritoneal patients office
- d. Geriatric (40 hrs)
 - i. Rounding in NH
 - ii. Cardiac
 - 1. Asymptomatic
 - 2. Stable abnormal labs
 - iii. Neurological
 - iv. Endocrine
 - v. Integumentary
 - vi. Infections
 - vii. Psychological
 - viii. Cancer

1. DNR/CC/Molst

ix. GI

4.4 Human Resources

Many business schools and managerial books state: “Hire for Attitude and Train for Skills” and we believe Out of Hospital Care Paramedics should fit this description. In order to have a successful program we believe that these Paramedics need to be effective communicators and collaborators in concert with a strong clinical aptitude and problem solving capabilities. The goal is to ensure the patient, family and allied healthcare providers have a positive experience when they interact with the Out of Hospital Care Paramedics.

Obtaining the best personnel for the Out of Hospital Care Paramedic program is considered a critical task. It requires not only excellent clinicians but effective collaborators and communicators. Clinical staff applying for Community Paramedic positions will require the following:

- Letter of reference from Hospital staff describing the applicants ability to collaborate and interact well with healthcare providers
- Have a proven track record of good customer service
- Maintain a professional attitude in all aspects of their work
- Possess effective oral and writing skills.
- Proven strong leadership skills
- Ability to work independently

The minimum clinical qualifications must include:

- Current Massachusetts Certification as a Paramedic
- ACLS certification
- PALS certification
- CPR certification
- Drivers License
- Letter of recommendation from their Medical Director
- Experience at the Paramedic level
 - 911
 - IFT Trained and actively practicing
 - Medical experience other than pre-hospital (preferred)
 - Critical Care Paramedic
 - Emergency Room
 - Intensive Care Unit
 - Transplant Team
 - Cardiac Catheterization Lab
 - Correctional Facility
 - Dispatching/Communications Center
- Teaching experience with references (preferred but not required)
- Mentoring experience with references

4.5 Policies, Procedures & Protocols

EasCare, in conjunction with Medavie EMS and the CCA is experienced in the development and implementation of detailed policies, procedures and protocols and will ensure that the Out of Hospital Care Paramedic program is effectively supported through the development of a comprehensive policy, procedure and protocol manual. These efforts will be conducted using an evidence-based and comprehensive methodology which will ensure compliance to all applicable regulatory considerations.

Sample policies include, but are not limited to:

- Out of Hospital Care Paramedic call Stacking and Prioritization
- Out of Hospital Care Paramedic Involvement in Normal Operations
- Care Plan Co-ordination between Out of Hospital Care Paramedics, Primary Care Physicians and Medical Direction

4.6 Operational Call Flow

Out of Hospital Care Paramedic Call Flow

Patient requests will be screened by their healthcare provider (the CCA) to determine if the patient's needs are deemed to be within the project scope. The managed care organization can then request the EasCare Out of Hospital Care Paramedic Program. Patients in this scenario will have access to a healthcare professional that has an understanding of the Out of Hospital Care Paramedic Program as well as knowledge of the patient's conditions. Patients in this group will be deemed as non-emergent in nature as triaged by the Healthcare Provider and do not require the activation of 911.

Once determined as qualified for Out of Hospital Care Paramedic vs. 911, the patients scheduled visit(s) will be entered into the Computer Aided Dispatch system. The patient's healthcare record with pertinent medical information will be shared via the CCA's EMR in order to ensure a more clinically accurate representation of the patient's condition.

The process followed for each Out of Hospital Care Paramedic response requires a coordinated effort amongst all stakeholders in the program. The importance of a defined call flow process outlines each stakeholder's role, which is critical to the timely and seamless care this program is designed to provide. The general flow for an Out of Hospital Care Paramedic call would be as follows: (Appendix includes flow chart)

1. The decision to call must be made by the CCA after appropriate risk stratification. In the case of public access, guidelines with our clinical partner will need to be robust in order to ensure the appropriate utilization of the program.
2. If it is determined that 911 should be contacted, the appropriate 911 provider will be notified.
3. EasCare Communications Center will ask key questions to determine whether the call meets the requirements for a non-traditional or a traditional ambulance response.
4. If the call meets the Out of Hospital Care Paramedic criteria the call taker in the Communications Centre will inform the caller that the Out of Hospital Care Paramedic unit will be responding and will provide an ETA of their arrival.

5. The Out of Hospital Care Paramedic will arrive on scene and immediately collaborate with staff, family and patient obtaining information on the patient including their current condition, history of such condition and the patient's current care plan.
 - a. If at anytime time during the patient encounter the Paramedic feels the patient warrants emergency treatment and transport to an emergency room, the Paramedic will have the LOCAL 911 provider notified, The Paramedic will then begin treatment under the current Massachusetts Statewide Treatment Protocols.
6. The Out of Hospital Care Paramedic will access the patient's medical record on scene for further continuity through the CCA's EMR (eClinical Work).
7. The Out of Hospital Care Paramedic will perform an initial assessment of the patient and begin to establish a plan of care going forward.
8. The Out of Hospital Care Paramedic will then make contact with the appropriate CCA clinicians responsible for the patient and discuss the patient's condition, plans for care and disposition. This provides input and recommendations for the patient's care plan.
9. The Paramedic will begin the patient care.
 - a. If the Paramedic feels the patient care plan does not follow the Paramedic's training or the Paramedic requires another physician for collaboration on scene, the Paramedic will contact the Medical Control Physician (Brockton Hospital ED Physicians). They are to offer diagnostic support and recommendations in the care plan of the patient and they work to facilitate a coordinated transfer of the patient to an appropriate location if that is indeed what is deemed necessary for them.
10. The Out of Hospital Care Paramedic will collaborate and communicate with staff, family and the patient of any plan pertaining to the patient going forward such as coordinated ED transfer or a plan for the Out of Hospital Care Paramedic to return and perform a follow-up on the patient.
11. All patient interactions will be reviewed by the CQI system and EasCare will implement internal controls to monitor for patients that "bounce back" into the healthcare system unexpectedly to ensure that patients are being managed properly.
12. All patient data collected by this program will be utilized as part of our program evaluation and potential research studies.

Post Encounter

Once the Out of Hospital Care Paramedic treats the patient, there will be post treatment protocols that will be followed on each patient encounter.

1. Home Safety Inspection
2. Perform Medication Inventory
3. Provide post patient encounter instruction and summary
4. Document patient encounter in the electronic chart CCA's EMR (eClinical Work)

The safety inspection will assist the patient and their primary caregivers with an overview of areas that may require correction where they reside. Examples may include: smoke detectors,

food, heat, water, trip hazards, hazards in home and in the bedroom/bathroom/kitchen/etc, access to 911/caregivers and family, use of wheelchair or walker/cane, etc.

Medication Inventory will allow the Paramedic to ensure the patient has:

1. Access to the correct prescribed medications
2. Older medications are not being taken
3. Safety with interactions of
 - a) Prescribed
 - b) Over the Counter
 - c) Natural Remedies
 - d) Foods

The Post Encounter instructions and summaries will be for the patient and their caregivers to understand the Paramedics visit and what will be required next. From future appointments with the Out of Hospital Care Paramedic, to Physicians and lab appointments, as well as medication regimes and nourishment, the Paramedic will ensure the patient understands their instructions.

Documentation of the patient encounter will be completed electronically to facilitate easy sharing, CQI and data collection. The patient's physician, medical control physician, medical director and future Out of Hospital Care Paramedic may access the patients chart from the encounter.

4.7 Continuous Quality Improvement

CQI will be accomplished by oversight, review and creating appropriate changes as required. Q/A and Q/I will occur on every call into the Communications Center and every patient encounter. To accomplish this task, the following systems will be in place:

1. Review of all requests into the Communications Center for Out of Hospital Care Paramedic
2. Patient Encounters
3. Follow Up

The Medical Director of the project will review all patient encounters. The Project managers will collaborate with the Medical Director to create new procedures and adjust the current procedures as required. Data acquired will be reported to OEMS every 6 months for a two year period.

Continuous Quality Improvement (CQI):

The CQI system has been constructed to support our goal of providing excellent patient care. Every patient care interaction will be put through a two part review. First, the Director of Clinical Services will oversee the initial review on a day to day basis. CQI will be performed on the following business day, with immediate feedback to the Medical Director and Paramedics as necessary. As a second layer of review, the Medical Director will review every patient encounter on a monthly basis.

As with any affective CQI system, there will be a focus on identifying trends that can be corrected through additional education or policy changes.

The Patient Care Markers utilized will be based upon the following criteria:

- 1) Appropriately followed protocols
- 2) Review of quality of care provided
- 3) Review of quality of documentation
 - a. Documentation of condition of patient
 - i. Criteria for entrance into the program
 - b. Documentation of physical assessment including vital signs and labs
 - c. Documentation of Medical Control Report
 - d. Documentation of any orders provided by Medical Control, with physician's name
 - e. Documentation of education provided to Patient (discharge summary etc)
 - f. Documentation of interaction with secondary care providers
 - g. Documentation of interactions with CCA Healthcare Providers
 - h. Documentation of Medication Reconciliation
 - i. Documentation of Home Inspection
- 4) Review of Post Patient Encounter instructions and follow up plan

If at any point during the review process an issue is discovered, the Medical Director will immediately be contacted to discuss the situation and create a plan for follow up with staff. Remediation will be based upon a constructive re-education model, not a punitive system. Upon review by the Medical Director, any Paramedic who is deemed not suitable for the standards set for under our program will be removed from the Out of Hospital Care Paramedic role.

Continuing Medical Education

We believe that evidence based practice, research, and mentorship are the pillars of high quality continuing medical education (CME). These elements will be incorporated into the CME programming for the EasCare Out of Hospital Care Paramedics program. Our efforts reflect periodic and focused evaluations of clinical policies, procedures, protocols, and best practices. This approach is most successful when an environment of open communication is fostered and the Out of Hospital Care Paramedics are comfortable in seeking insight and asking questions.

We will implement this methodology in order to implement an effective CME program for the clinical staff operating in the Out of Hospital Care Paramedics program. Key objectives of these activities include:

- Provide the Out of Hospital Care Paramedics with sufficient exposures to skill practice and information to diminish a risk of harm or perceptible negligence;
- Provide a remediation process for the Out of Hospital Care Paramedics exhibiting unstable clinical (as identified by a continuous-quality-improvement process) or technical practice;
- Consult with Medical Director on clinically appropriate topics and other educational needs.
- Cultivate an expectation of life-long learning by Out of Hospital Care Paramedics; and
- Promote a culture of clinical mentors and preceptors among the Out of Hospital Care Paramedics.

Monthly Case Review

Each month, EasCare will conduct a case review process for pre-identified patient encounters. This process will be led by the Medical Director with the assistance of the Director of Clinical Services. This platform will be utilized to provide a learning experience for all involved. The Paramedics will be encouraged to identify cases to present for the purpose of group education. In addition, patient encounters that are flagged in the CQI process will be brought forward for all providers to learn from.

This platform will provide one of the retrospective components of our CQI system. Any issues identified will be brought forward for discussion at these meetings. All Paramedics will be expected to attend the Monthly Case Review sessions. This expectation will be clearly explained to all staff during the hiring process.

If a policy or protocol issue is identified during these reviews, the Director of Clinical Services, Director of Operations, Director of Logistics and the Medical Director will work collectively to make any and all necessary changes. Whenever there is an update to the protocols, all Paramedics will receive the appropriate education. The education will be constructed under the supervision of the Medical Director.

Medavie EMS Quality Assurance Program

The Medavie EMS Group of Companies is committed to achieving high standards in patient care through multi-faceted quality programs. We are continuously evaluating and enhancing our performance. Our experience includes using research evidence to inform clinical policies and practice; undertaking comprehensive program evaluation for new initiatives; conducting research studies to evaluate the effect of clinical interventions; and measuring and providing feedback on key performance indicators to stakeholders and staff. Medavie EMS will actively collaborate with EasCare to design a quality program that meets the needs and expectations of OEMS and other stakeholders.

The following section details EasCare quality assurance program tools with regards to quality care provision.

1. Monitor the standard of patient care.

- Ongoing monitoring of clinical quality by the operations team through selecting and reporting on clinical indicators, tracer conditions and patient safety indicators.
- Clinical indicators will be established in consult with the Medical Director, EMS literature, through local trends and best practice. Indicators will be classified into system, process or outcome categories.
- A data definition dictionary will be established to ensure reports are mutually understood and clearly identify successes and challenges.
- Conduct Root Cause Analysis on clinical adverse events.
- Implement a comprehensive clinical review process designed to identify clinical performance trends among system and individual paramedics.
- Implement a restorative education processes designed to improve specific competency/cognitive areas of paramedic performance as needed.
- Complete ambulance care report compliance audits and provide feedback to staff on documentation standards.
- Future development of peer education sessions (e.g. morbidity and mortality rounds, non-mandatory education sessions).
- Foster a culture of self-reporting errors and omissions to provide continued system improvement.
- Implement a comprehensive online learning management system that will enable compliance tracking and verification of knowledge for education and information dissemination.
- Provide just-in-time training through online learning management system and/or a clinical advisory program.

4.8 Medical Oversight

The Medical Director for Out of Hospital Care Paramedicine is a well-credentialed emergency room physician who will administer the program competently and demand strong clinical acumen from the Paramedics.

Prospective Functions

- Involvement in setting medical evidence based policies and protocols;
- Involvement in transportation and destination policies;
- Provision of Continuing Medical Education;
- Registration requirements for Out of Hospital Care Paramedics;
- Evaluation of medical equipment and supplies.

Concurrent Functions

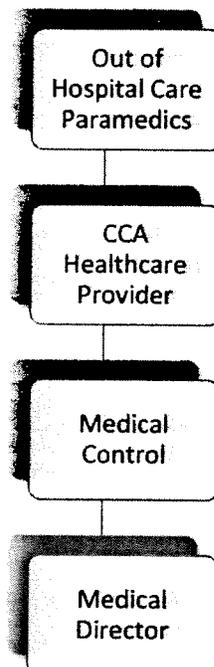
- Liaise with Partner Organization's Chief Medical Officer as required;
- Evidence based protocols and policies that guide Out of Hospital Care Paramedics in the field;
- Availability of real-time medical advice through medical oversight physicians;
- Manages the Clinical Rotation portion of the Out of Hospital Care Paramedics Education

Retrospective Functions

- Participate in clinical care investigation of Out-of-Hospital care with clinical issues;
- Participate in the evaluation of Out of Hospital Care Paramedics Program;

- Participate in the planning and development of continuing education based upon observed trends in the clinical auditing process and evidence based research;
- Conduct and oversee monthly call review sessions;
- Comprehensive Continuous Quality Improvement (CQI) Program.

When an Out of Hospital Care Paramedics is required to collaborate with the patient's Healthcare Provider, they will follow the following flow chart. The Medical Director will provide oversight for the program and the Paramedic will use CCA Healthcare Providers to gain knowledge and suggestions for the patients care. Once the Paramedic has collaborated with the patient's physicians, the Paramedics will contact their Medical Director and if unavailable, Medical Control for orders beyond the standing orders created for the Out of Hospital Care. After fulfilling the orders, the patient's physician will have access of the treatment(s) and results, accomplished by EMR charting or by direct communication if requested.



Collaboration with all Healthcare Providers (CCA, Medical Director and Medical Control) will be done by cellular communications. These calls will be conference called through the Communications Center to allow recording for CQI. The on-line medical control process is subject to quality control activities and audit.

Medical Control Qualifications

Medical Control Physicians will be Massachusetts Board Certified Physicians with training consisting of:

- Massachusetts Statewide Treatment Protocols
 - Including Appendix "N"
- Out of Hospital Care Paramedics Program Protocols
- Out of Hospital Care Paramedics' training and knowledge base

5.0 Program Evaluation & Research

Program Evaluation

EasCare will conduct comprehensive program evaluations for all clinical initiatives falling under the Community Paramedicine program. These will be outcome based evaluations using key performance indicators selected in conjunction with stakeholders. Results will be used to quantify the impacts of the program to the OEMS and other partners.

The Program Markers utilized will be based upon the following criteria:

1. Number of calls for the Out of Hospital Care Paramedic
2. Number of calls not available
3. Total time from Time of Call to Scene
4. Total time on Scene
5. Care on scene yet transportation required
6. 911 called once patient contact acquired
7. Patient required transportation to Emergency Room for same complaint
 - a. <12 hours post Out of Hospital Care Paramedic encounter
 - b. >12 hours < 48 hours post Out of Hospital Care Paramedic encounter
 - c. Within 7 days of Out of Hospital Care Paramedic encounter
 - d. Within 7-30 days of Out of Hospital Care Paramedic encounter
8. Patient required admission to hospital for same complaint
 - a. <12 hours post Out of Hospital Care Paramedic encounter
 - b. >12 hours < 48 hours post Out of Hospital Care Paramedic encounter
 - c. Within 7 days of Out of Hospital Care Paramedic encounter
 - d. Within 7-30 days of Out of Hospital Care Paramedic encounter
9. 72 hour mortality post patient encounter
10. Chief Complaint
11. Treatment
12. CQI Clinical Competency
13. Patient Satisfaction
14. Cost Savings from Program
15. Staff Feedback
 - a. CCA
 - i. Administrators
 - ii. Physicians
 - iii. Case Managers
 - b. EasCare
 - i. Administrators
 - ii. Paramedics
 - iii. Communications Center Staff
 - c. Medical Direction
 - i. Medical Director
 - ii. Medical Control Physicians

Research

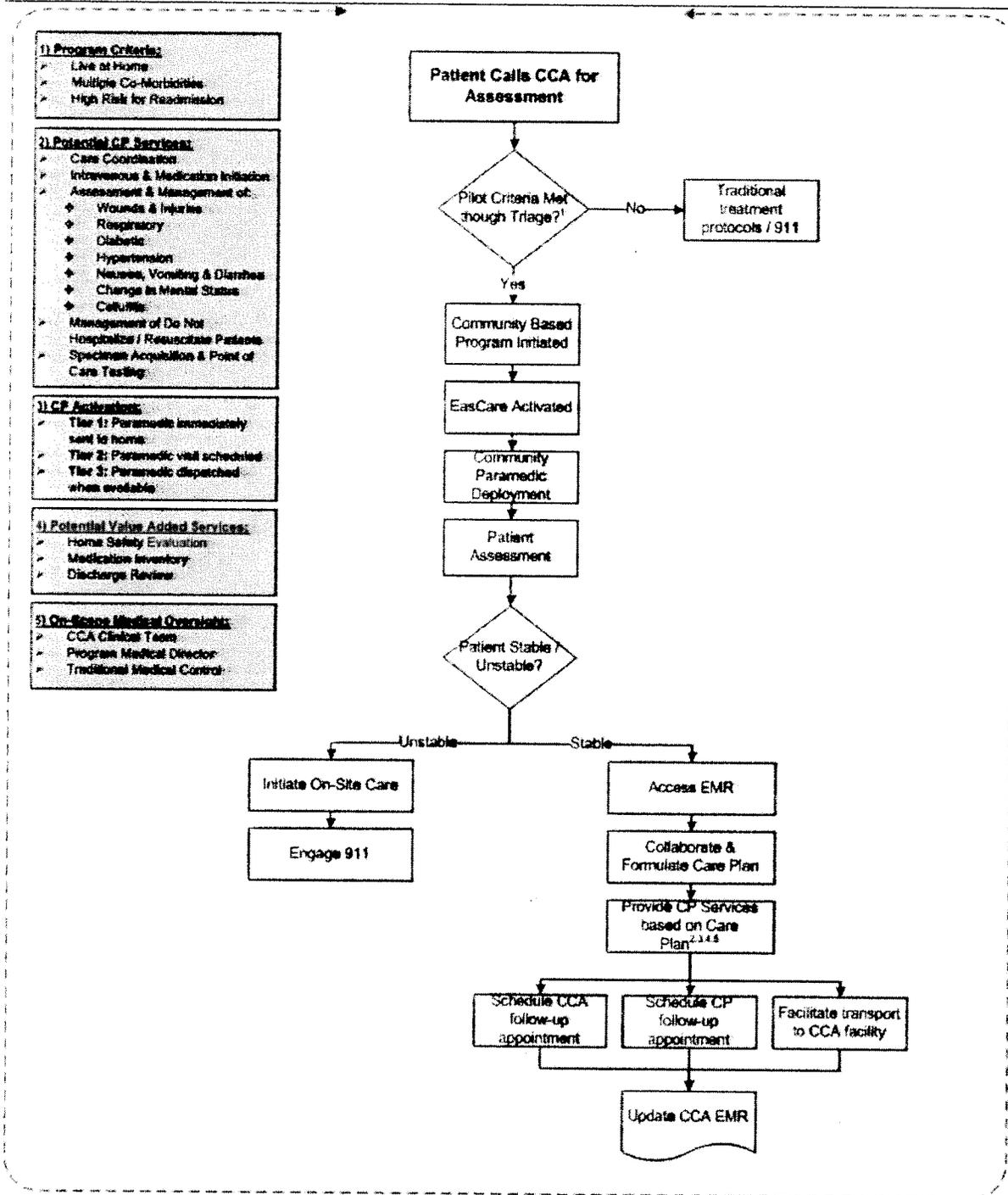
The Out of Hospital Paramedicine Care program will also present opportunities for involvement with formal research studies. These studies can be used to refine specific program elements while also contributing to best practices in Out of Hospital Paramedicine.

Medavie EMS is experienced in conducting controlled studies conducted under the oversight of a Research Ethics Board. EasCare will draw on these experiences and resources while collaborating with all stakeholders.

6.0 Conclusion

The US Healthcare System is currently undergoing a transformation from a system that has historically been transaction based to one that will focus more and more on outcome measures. The early success of Community Paramedic Programs proves that Out-of-Hospital Services can be an integral component of supporting these reforms. The requisite elements of a high performance and integrated Out-of-Hospital system are present, providing a platform for an enhanced and more efficient level of service that can continue to expand in the future. These resources must also be appropriately coordinated and leveraged to ensure seamless and timely access to high quality health services.

7.0 Appendix



Commonwealth Care Alliance – Pilot Project

Executive Summary
“Out of Hospital Paramedic Care”

EasCare LLC is an innovative ambulance service with a reputation for integrity, quality and excellence in the management of patient care and transport. In 2010, EasCare began examining at new patient care models to address opportunities within the shifting healthcare industry. Through the ensuing research, it was discovered that a non-traditional solution could be Community Paramedicine. EasCare is proposing to introduce Out of Hospital Paramedic Care to Massachusetts in collaboration with the Commonwealth Care Alliance ACO and assistance from EasCare’s parent company Medavie EMS.

Commonwealth Care Alliance (CCA) is a not-for-profit, consumer-governed organization, that provides a unique prepaid care delivery system for Medicare and Medicaid patients with complex needs. By providing enhanced primary care for their patients, they began to create care coordination through multi-disciplinary teams (clinical teams, physicians, nurses, behavioral health, physical therapists, vna and hospice). Since 2003 CCA has offered home visits during the day with 24/7 phone assistance to speak directly with a CCA Healthcare Provider for care coordination. This nationally recognized program offers individualized and compassionate healthcare programs. During off hours, the Physicians are required to use hospitals for patient care.

EasCare’s parent company, Medavie EMS, has been involved in an urban pilot for an Extended Care Paramedic program in Halifax, Nova Scotia, which has resulted in a 70% decrease in SNF patients being transported to an emergency room.¹ Through another rural Community Paramedic Program there was a 23% reduction in visits to the local hospital through the provision of home based non-emergency primary care. Medavie EMS’ expertise includes oversight of ten EMS delivery agents and a Primary Care Clinic with over 4,000 staff and 400,000 calls per year. Their national and international recognition for their success with Community Paramedicine will support the development of a program that is tailored for Massachusetts by EasCare and CCA.

EasCare, in conjunction with Medavie EMS is experienced in the development and implementation of detailed work plans. We understand the complexities associated with program development and the need for a structured approach that ensures key tasks are identified and completed within the allotted timelines. The Medical Directors from EasCare, CCA and Medavie are committed to the success of this program and are involved with each working group and every phase of implementation.

The Out of Hospital Paramedic Care program is designed to provide 6 distinct objectives:

1. Provide care to fill gaps in current community model by creating alternate care and pathways for patient care
2. Adhere to comprehensive clinical practice guidelines
3. Practice under robust Medical Oversight
4. Provide innovative healthcare models while reducing costs
5. Create and monitor key performance indicators
6. Ensure patient satisfaction

The primary goal is meeting the needs of the CCA’s 2000 patients in a safe and controlled environment. EasCare’s Out of Hospital Paramedic Care program in the greater Boston area is geared towards providing excellent patient care, while avoiding hospital visits and admissions. This patient-centered care is based on the recognition that any patient who is

¹ Insights & Experiences from the Halifax ECP Program (2013) (Accessed via: rcp.info/Portals/11/Meetings/2013/911_ECP%20research%20.pdf on July 5, 2013)

not sufficiently stable for on-scene care will be immediately triaged as an emergency with transportation to an appropriate emergency department via the local 911-provider.

Patients, triaged appropriate for the program by CCA's Physicians, will be visited by the EasCare Out of Hospital Paramedic.

Clinical Opportunities for the Out of Hospital Care Program for EMT-Bs and EMT-Ps include:

Post-Discharge & Home Follow-up

- Medication Inventory
- Home Safety Evaluations
- Care Coordination

Intravenous & Medication Initiation

Assessment & Management of:

- Wounds & Injuries
- Respiratory
- Diabetic
- Hypertension
- Nausea, Vomiting & Diarrhea
- Change in Mental Status
- Cellulitis

Management of Do Not Hospitalize/Resuscitate patients

Specimen Acquisition & Point of Care Testing

All of these treatments will be performed under protocols developed by the Medical Director. The Out of Hospital Care Paramedics will complete a comprehensive training program for each competency as well as extensive clinical evaluations to ensure proficiency with each skill. Clinical rotations will be divided between time in both a clinical location (Hospital and/or Clinic) and in the field by shadowing Physicians, NPs and PAs in patient's homes.

EasCare and CCA Physicians will provide Medical Oversight that will consist of 3 functions.

- Prospective – Staffing recruitment, education, setting policies and procedures, provision of con-ed, evaluation of equipment, participate in development of system as it matures, etc.
- Concurrent – Attend oversight meetings, liaise with CCA, evolve evidence based protocols and participate in “ride alongs”
- Retrospective – participate in case reviews and M&M's, oversee 100% review of patient interactions and CQI Programs, assist in evaluating effectiveness and safety of the Program through trend analysis and KPIs tailored with mandatory triggers.

By providing these Out-of-Hospital services, EasCare will provide an integrated component of a developing healthcare model. These essential services meet several critical healthcare system goals, including cost containment and improving patient access to care. Though the needs of Massachusetts communities may vary, this system will provide the flexibility necessary to deliver a wide variety of tailored Out-of-Hospital services in the future with this evidence based program.

We at EasCare look forward to a mutual collaboration with the Massachusetts OEMS EMCAB Community Care and Education Committee, with creating innovative care models.