

July 25, 2014

DONOGHUE
BARRETT
& SINGAL

Via Email and Hand Delivery – Return Receipt Requested

Deborah Allwes, Director
Bureau of Health Care Safety and Quality
Department of Public Health
99 Chauncy Street
Boston, MA 02111

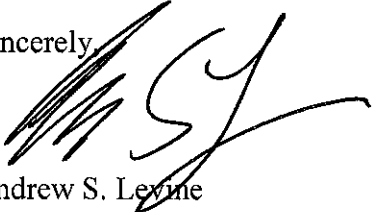
Re: EasCare, LLC Special Project Waiver Request

Dear Ms. Allwes:

We write on behalf of EasCare, LLC (“EasCare”) in regards to the pending special project waiver request for Out-of-Hospital Paramedic Care filed by EasCare in collaboration with Commonwealth Care Alliance on February 10, 2014. As requested at our meeting on June 12th, enclosed please find additional support for our initial submission as well as answers to the specific questions we received from Patricia Reilly on June 27th. We hope this additional information on the Out-of-Hospital Paramedic Care Program is helpful as you undertake your review.

We thank you for your consideration of this request. Please do not hesitate to contact Meghan Cosgrove, Esq. or me if you have any questions or require additional information.

Sincerely,



Andrew S. Levine

Enclosure

cc: G. Davis
M. Bergan
J. Loughnane
T. Ajayi
S. Korman, Esq.
P. Barrett, Esq.
J. Youmans

EASCARE, LLC
IN COLLABORATION WITH COMMONWEALTH CARE
ALLIANCE

SUPPLEMENTAL SUBMISSION

OUT OF HOSPITAL PARAMEDIC CARE
SPECIAL PROJECT WAIVER
JULY 25, 2014

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMERGENCY SERVICES

SUPPLEMENTAL SUBMISSION

OUT OF HOSPITAL PARAMEDIC CARE

On February 10, 2014, EasCare, LLC (“EasCare”) in collaboration with Commonwealth Care Alliance (“CCA”) submitted a special project waiver application for out-of-hospital paramedic care (the “Project” or the “Proposal”) to the Massachusetts Department of Public Health (“DPH”) in accordance with 105 C.M.R. § 170.405 which provides that:

“At the discretion of the Department, regulations established in this chapter may be waived for special projects which demonstrate innovative delivery of emergency medical care services. Proposals for such special projects must be submitted to the Department in writing and no regulatory standards will be waived without explicit Department approval. Special projects will be considered experimental in nature and will be reviewed and renewed at such time periods as the Department shall establish.”

Below please find additional support for EasCare’s initial Proposal attached hereto as Exhibit A along with responses to specific questions posed by DPH during the meeting between DPH, EasCare, and CCA held on June 12th and in follow-up correspondence from DPH dated June 27th. Any references made to the “Statute” refer to Chapter 111C of the Massachusetts General Laws governing the Commonwealth’s Emergency Medical Services System, and any reference made to the “Regulations” refer to the Statute’s implementing regulations found at 105 C.M.R. § 170.000, *et. seq.*

UNMET NEED

THE PROBLEM

Sarah is a 65 year old female with a history of quadriplegia, diabetes mellitus, coronary artery disease, and urinary tract infections. In the middle of the night, Sarah wakes up with a low-grade fever, feeling weak and with flank pain. She calls the triage line operated by her health plan, Commonwealth Care Alliance, and speaks with a physician. Upon review of her medical records, the physician finds her symptoms are consistent with recurrent urinary tract infections. The physician gives Sarah the option of going to the emergency department in an ambulance to be treated or waiting until the morning when she can see a CCA clinician.

THE SOLUTION

In the alternative, Sarah, in collaboration with her CCA physician, opts to have an EasCare paramedic dispatched to her home to evaluate and treat her. Upon arrival, the paramedic reviews Sarah’s EMR and performs a complete evaluation including history, physical, EKG, vital signs, urinalysis, temperature, i-Stat blood analysis and urine/blood cultures. The point of care testing reveals blood and leukocytes in the urine, while the Chem-8, H&H and Lactate are normal. The paramedic telephones the CCA physician. A treatment plan for Sarah is created and the paramedic

initiates an IV and begins a bedside infusion of Gentamicin over a 30 minute period. Sarah is given Tylenol and her vital signs are monitored. The paramedic provides Sarah with a discharge plan to follow up with her CCA physician and documents the entire encounter in Sarah's EMR. The blood and urine cultures are brought by the paramedic to CCA's laboratory for testing.

ADMINISTRATIVE REQUIREMENTS FOR SPECIAL PROJECT WAIVER

In accordance with 105 C.M.R. § 170.405 and the OEMS Administrative Requirements Manual Policy A/R 5-211 titled "Waivers for Special Projects: Application Process and Procedure for Review and Approval," below please find the requested data elements:

Name and Address of the Applicant	EasCare, LLC 500 Neponset Avenue Dorchester, MA 02122
Licensed Ambulance Service(s) involved	MA AMB LIC #3006 EasCare, LLC 500 Neponset Avenue Dorchester, MA 02122
Regional Affiliation(s)	Region I, II, IV and V. Region IV & V (Initial) and Region I & II (Phase 2 and 3)
Hospital(s) involved in Project	Boston Medical Center Signature Healthcare Brockton Hospital
Partner	Commonwealth Care Alliance
Contact person for Project	<u>Overall Project Manager</u> Gregory A. Davis, NREMT-P EasCare, LLC 500 Neponset Avenue Dorchester, MA 02122 (P) 617-822-4414 (C) 617-959-4563 (F) 617-740-9211 gdavis@eascare.com <u>Clinical Director</u> Matthew Goudreau, CCEMT-P EasCare, LLC 500 Neponset Avenue Dorchester, MA 02122 (P) 617-822-4445 (F) 617-740-9211 mgoudreau@eascare.com <u>Logistics Director</u> W. Scott Cluett III, NREMT-P EasCare, LLC 500 Neponset Avenue Dorchester, MA 02122 (P) 617-822-4491 (F) 617-740-9211

	scluett@eascare.com
Level of EMT(s) involved in Project	Paramedics
Number of EMT(s) involved in Project	10
Name of Licensee	EasCare, LLC
Name of Medical Director(s) for the Project	Daniel Muse, MD EasCare, LLC 500 Neponset Avenue Dorchester, MA 02122 (P) 617-822-4414 (C) 781-530-7233 (F) 617-740-9211 danmuse@comcast.net and John Loughnane 30 Winter Street Boston, MA 02108 (P) 866-610-2273 john.loughnane@bmc.org
Regulation(s) requiring Waiver	105 C.M.R. § 170.020 (definitions of “emergency” and “emergency medical services”); 105 C.M.R. § 170.355(A) (dispatch, treat and transport); and 105 C.M.R. § 170.840 (paramedic scope of practice).
Purpose for and Goals for Project	As further described below, this innovative Project seeks to fill an unmet need for CCA’s dual eligible patient population by providing basic and advanced paramedic care in the community between the hours of 6pm and 2am in collaboration with the patient’s primary care physician. This Project improves the quality and accessibility of the entire EMS system in the Commonwealth by providing CCA with the flexibility to manage predictable and preventable complications that arise during the night in a patient’s residence rather than an institutional setting. This not only reduces the volume of emergency department visits to hospitals freeing up other EMS providers to respond to individuals with truly emergent conditions, but also ensures that CCA’s patients receive high-quality, coordinated care in the most appropriate setting for their unique needs. Such a Project is in the public’s interest as it ensures efficient and appropriate use of scarce healthcare resources while incorporating safeguards to ensure that public health and safety are not endangered in any way. Finally, the Project furthers the primary objectives of Chapter 224 of the Acts of

	2012 by reducing costs while placing transparency, efficiency, and quality at the forefront to ensure Massachusetts continues its position as a leader in healthcare innovation.
Proposed Timeframe for Project	September 2014-September 2016
Nature of Project	Out of Hospital Paramedic Care f/k/a Community Paramedicine
Description of the Population served by the Project	Medicare/Medicaid Dual Eligible enrollees of CCA; generally disabled adults with multiple chronic conditions
Letter of Review and Evaluation from the Regional Medical Director and Executive Director	See, <u>Exhibit B</u> .

EVOLVING ROLE OF EMS

“Emergency medical services (EMS) of the future will be community-based health management that is fully integrated with the overall health 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 improve community health and result in more appropriate use of acute health care resources. EMS will remain the public’s emergency medical safety net.”
National Highway Traffic Safety Administration, EMS Agenda for the Future, 1996

The demand for healthcare in the United States has increased due to population growth, aging baby boomers, increased insurance coverage under the Affordable Care Act (“ACA”), and the increased prevalence of chronic diseases leading to an overutilization of healthcare resources.¹ In order to maximize available health care resources in the most efficient manner possible, healthcare providers and suppliers have needed to evolve and integrate; pharmacists can now administer vaccines, nurse practitioners may be recognized as primary care providers, and paramedics may provide complex interventions during critical care transports.

¹ Kenneth W. Kizer, et al., *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care*, p. 6-7, UC DAVIS INSTITUTE FOR POPULATION HEALTH IMPROVEMENT (July 2013), https://www.ucdmc.ucdavis.edu/iphi/publications/reports/resources/IPHI_CommunityParamedicineReport_Final%20070913.pdf (last visited July 9, 2014).

As an integral link in the healthcare delivery chain, emergency medical service (“EMS”) providers also must be given the necessary latitude to evolve in order to keep pace with and contribute effectively to the rapidly changing healthcare environment. Indeed, emergency response theory is moving away from a “treat and transport” model to a “treat and release” model. This transition is in keeping with both advances in medical technologies (e.g., point of care testing and telemedicine now allow for more immediate diagnosis in the field) as well as pressures from public and private payors and is supported by evidence indicating that, to date, significant emergency care resources have been expended on individuals with non-emergent conditions.² In 2006, nearly 24.1% of all ED visits were for non-emergent conditions; studies also indicate that approximately 10-40% of all ambulance transports are for non-emergent conditions.³ EasCare alone transported 170,000 patients last year, 90% of which were for non-emergent issues.

EMS serves as one of the main points of entry to the U.S. healthcare system; yet, historically, EMS has not been integrated into the health care system in the United States.⁴ The movement toward patient-centered healthcare, however, demands that EMS providers, such as EasCare, become integrated components of the broader healthcare delivery system in order to help affect the goals of improved quality and reduced costs. EMS providers are uniquely situated to assist accountable care organizations (“ACOs”), home healthcare agencies, hospitals and other practitioners to deliver primary care interventions in the community to ensure that patients, particularly those with predictable and preventable complications, receive timely, high-quality care.

The “Triple Aim” of healthcare, a framework developed by Massachusetts’ own Institute for Healthcare Improvement, advocates a systemic approach to any health care improvement demanding that any new design should (1) improve the patient experience, including quality and satisfaction, (2) improve the health of the population, and (3) reduce the per capita cost of healthcare.⁵ EMS-related improvements such as community paramedicine and alternate transport destinations clearly support this Triple Aim with the potential to improve patient outcomes and reduce costs by addressing the systemic and “unproductive cycle of ambulance transports and hospital stays.”⁶ Sending EMS providers into the community enhances coordination of care between existing pre-hospital systems and bridges the gap for patients post-discharge or between home care visits. Expansion and integration of the role of our EMS providers may improve patient satisfaction and outcomes,

² Kurt Krumpnerman, *History of Community Paramedicine*, JOURNAL OF EMERGENCY MEDICAL SERVICES (June 22, 2010), <http://www.jems.com/article/ems-insider/history-community-paramedicine> (last visited July 9, 2014).

³ *Id.*

⁴ See Kizer et al., *supra* note 1, at 5-6.

⁵ IHI Triple Aim Initiative, INSTITUTE FOR HEALTHCARE IMPROVEMENT, <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx> (last visited July 9, 2014).

⁶ See Kizer et al., *supra* note 1, at 14.

decrease the costs of delivering such care, and free up other valuable healthcare resources to improve the health of the overall population.

COMMUNITY PARAMEDICINE

Community paramedicine programs are a “new and evolving model of community-based healthcare in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.”⁷ In its most basic form, community paramedicine is the provision of outreach to patients at risk for using the emergency medical or inpatient healthcare system for primary care services and helping them to find more appropriate resources for their medical needs. Similar to when the role of paramedics was expanded at the other end of the acuity spectrum for critical care transports, this newly expanded role does not distract paramedics from their basic first responder and lifesaving functions⁸. Though EMTs and paramedics have operated in expanded community-based roles in foreign countries such as Canada, England, and New Zealand for many years, in the U.S., community paramedicine is still in its infancy.⁹

Since the publication of the National Rural Health Association’s Rural and Frontier EMS Agenda for the Future in 2004,¹⁰ many in the U.S. healthcare community have come to view community paramedicine as a way to address gaps in primary care services and, by extension, reduce healthcare costs.¹¹ However, while there is ample statistical evidence from international sources underpinning the notion that community paramedicine is a missing link in an effective and efficient healthcare delivery model, many of the pilot programs in the United States are in the initial data-gathering phases.¹² Despite the lack of comprehensive data on U.S. community paramedicine programs, what data is available clearly supports the notion that individuals who lack a primary care

⁷ *Id.* at 2.

⁸ We would note that the role of paramedics has already expanded in Massachusetts to cardiac catheterization laboratories, emergency departments, urgent care centers, organ bank programs and many other ancillary healthcare roles outside of ambulance transports.

⁹ *Community Paramedicine Evaluation Tool*, p. 4, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH SERVICES RESOURCE ADMINISTRATION OFFICE OF RURAL HEALTH POLICY (March 2012), <http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf> (last visited July 9, 2014).

¹⁰ Kevin K. McGinnis, *Rural and Frontier Emergency Medical Services: Agenda for the Future*, NATIONAL RURAL HEALTH ASSOCIATION (2004), <http://www.ruralcenter.org/sites/default/files/rfemsagenda.pdf> (last visited July 9, 2014).

¹¹ See Kizer et al., *supra* note 1. See also, *Beyond 911: State and Community Strategies for Expanding the Primary Care Role of First Responders*, NATIONAL CONFERENCE OF STATE LEGISLATURES (2010), <http://www.ncsl.org/research/health/expanding-the-primary-care-role-of-first-responder.aspx> (last visited July 9, 2014); *Community Paramedicine: A New Approach to Integrated Healthcare*, PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL, http://www.pehsc.org/assets/files/current-topics/PEHSC%20CP%20Whitepaper_Production%20Copy.pdf (last visited July 9, 2014); *Community Paramedicine Evaluation Tool*, p. 4, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH SERVICES RESOURCE ADMINISTRATION OFFICE OF RURAL HEALTH POLICY (March 2012), <http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf> (last visited July 9, 2014).

provider and medical home are more likely to use emergency rooms for care that could have been provided more effectively and inexpensively in a primary care setting. According to the National Center for Health Statistics, between January and June 2011, almost 80 percent of adults visited the ED because they did not have access to another provider.¹³ Furthermore, according to a 2010 study by the RAND Corporation, between 14 and 27 percent of all ED visits are for non-urgent care that could take place in a different setting, such as a doctor's office, after-hours clinic or retail clinic, resulting in a potential cost savings of \$4.4 billion annually.¹⁴ A 2010 study published in the *Annals of Emergency Medicine* found that frequent users comprise 4.5 to 8 percent of all emergency department patients, yet account for 21 to 28 percent of all visits.¹⁵ As a result, emergency departments across the country – from the nation's largest medical centers to the most remote critical access hospitals – spend a disproportionate share of staff and financial resources providing non-urgent care to patients who often would have been better served in a primary care setting.

EMS systems have historically focused on providing patient care for acute illnesses and emergencies, a role that is reinforced by current payment practices that reimburse EMS providers for emergency responses. However, with studies suggesting that 10 to 40 percent of EMS responses are for non-emergent situations, the role of the EMS provider is being reconsidered.¹⁶ Many states and communities have discovered that emergency responders offer an untapped resource for connecting high-risk and underserved patients (e.g., dual eligibles) with needed primary care services.

While most states are in the process of operationalizing pilot projects for community paramedicine within their existing regulatory structure, certain states are in the advanced stages of adoption. For example, in 2011, Minnesota passed legislation that formally recognized community paramedics as a distinct provider type; the legislation clarified community paramedics' educational and training requirements.¹⁷ Now, with just a call from a primary care physician or referral from the emergency department, a community paramedic can administer lab tests, take vital signs, give a

¹² *Flex Monitoring Team Briefing Paper No. 34: The Evidence for Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program*, p. 9-10, FLEX MONITORING TEAM (February 2014), <http://www.flexmonitoring.org/wp-content/uploads/2014/03/bp34.pdf> (last visited July 9, 2014).

¹³ Renee M. Gindi, et al., *Emergency Room Use Among Adults Aged 18-64: Early Release of Estimates from the National Health Interview Survey, January-June 2011*, p. 7, CENTERS FOR DISEASE CONTROL AND PREVENTION (May 2012), http://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf (last visited July 9, 2014).

¹⁴ Robin M. Weink, et al., *Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics*, 29:9 HEALTH AFFAIRS 1630-1636, 1630 (September 2010).

¹⁵ Eduardo LaCalle & Elaine Rubin, *Frequent Users of Emergency Departments: the myths, the data and the policy implications*, 56 ANNALS EMERG. MED. 42, 43 (July 2010).

¹⁶ *State Perspectives Discussion Paper on Development of Community Paramedicine Programs*, p. 3, JOINT COMMITTEE ON RURAL EMERGENCY CARE- NATIONAL ASSOCIATION OF STATE EMERGENCY MEDICAL SERVICES OFFICIALS AND NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH (December 2010), <http://www.ruralcenter.org/sites/default/files/Community%20Paramedic%20Programs.pdf> (last visited July 9, 2014).

¹⁷ *Why & How Minnesota is Implementing Community Paramedic Services*, p. 13, MINNESOTA AMBULANCE ASSOCIATION (November 2012), <http://www.mnruralhealth.org/documents/pdf/CP%20Implementation%20final.pdf> (last visited July 9, 2014).

general assessment, or follow up on hospital discharge orders.¹⁸ In fact, Minnesota's North Memorial Health Care's community paramedicine program was cited as "groundbreaking" by the state's Governor and as a primary contributor to the \$10.5 million in cost savings the State of Minnesota achieved under its Medicaid reform initiative in 2013.¹⁹ Proponents of the Minnesota program stress that their community paramedic program is not an ambulance model doing primary care. Rather, it is a primary care model that utilizes ambulance practitioners. Following the trend set by Minnesota, in 2012 Maine lawmakers removed regulatory barriers by authorizing up to twelve pilot community paramedicine programs throughout the state.²⁰

California is also considering an expanded framework for EMS providers: the California Office of Statewide Health Planning and Development ("OSHPD") recently conducted a public hearing in Sacramento to receive public input on a proposal by the Emergency Medical Services Authority which includes thirteen pilot projects designed to explore the effectiveness, safety and sustainability of community paramedicine programs in California.²¹ OSHPD has statutory authority to approve such healthcare pilot projects under their Health Workforce Pilot Projects Program. And in Colorado, the state EMS office is developing a new regulatory framework that provides oversight through a conditional license for community paramedics.²² In addition to Minnesota, Maine, California and Colorado, at least ten other states are either piloting community paramedicine programs or have already adopted community paramedicine programs into their regulatory schemes. A brief summary of these pilots is set forth in the table on Exhibit C.

Lawmakers and community leaders in these states believe that with their strong ties to the local community, first responders can play a unique role by extending the primary care provider's reach into the patient's home and/or in a community setting. There, the first responder can perform a wide range of healthcare and social support activities in tandem with other providers in the patient's medical home. While community paramedicine programs have been implemented (or are soon-to-be implemented) in these states, "[t]he implementation, operational costs, and outcomes of these programs . . . are still being assessed, and little data is available at this time."²³ Nevertheless, the

¹⁸ Press Release, North Memorial Health Care, *North Memorial Celebrates First Anniversary of Community Paramedics Program* (December 4, 2013), https://www.northmemorial.com/communityparamedic#.U6he_vldVnY (last visited July 9, 2014).

¹⁹ Press Release, Office of Governor Mark Dayton, *Minnesota's nation-leading Medicaid reform initiative delivers \$10.5 million in savings during first year* (July 14, 2014), <http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=102-136054> (last visited July 21, 2014).

²⁰ *Beyond 911: State and Community Strategies for Expanding the Primary Care Role of First Responders*, NATIONAL CONFERENCE OF STATE LEGISLATURES (2010), <http://www.ncsl.org/research/health/expanding-the-primary-care-role-of-first-responder.aspx> (last visited July 9, 2014).

²¹ California Emergency Medical Services Authority, http://www.emsa.ca.gov/Community_Paramedicine (last visited July 22, 2014).

²² *Id.*

²³ See Kizer et al., *supra* note 1, at 7 (citing Ross DW, Schullek JR, Homan MB. "EMS Triage and Transport of Intoxicated Individuals to a Detoxification Facility Instead of an Emergency Department." ANN EMERG MED 2013; 61(2):175-184; (footnote continued)

rapidly changing healthcare environment and the push to control costs while improving care are driving interest in community paramedicine programs as an innovative way to ensure that at-risk patients have round-the-clock access to a healthcare practitioner.

Indeed, the U.S. Department of Health and Human Services Health Resources and Services Administration Office of Rural Health Policy (“ORHP”) has recognized community paramedicine programs as a means to “connect underutilized resources to underserved populations.”²⁴ Of particular relevance to the collaboration EasCare and CCA are proposing, ORHP has stated that in urban areas, community paramedicine programs are efficient tools “designed to keep ‘frequent fliers’ out of the emergency care system by ensuring their healthcare needs are met in other ways.”²⁵ ORHP has also noted that “each of the successful [community paramedicine] programs now in place across the country [are] *uniquely and specifically designed* to meet one or more healthcare needs essential to that community. Additionally, successful programs capitalize on linkages, collaboration and integration with other healthcare resources in the community.”²⁶

GOAL OF THE PROJECT

PAIR AN UNDERUTILIZED RESOURCE WITH AN UNMET NEED

This innovative Project seeks to fill an unmet need for CCA’s dual eligible patient population by providing paramedic care in the community between the hours of 6pm and 2am in collaboration with the patient’s primary care physician. This Project improves the quality and accessibility of the entire EMS system in the Commonwealth by providing CCA with the flexibility to manage predictable and preventable complications that arise during the night in a community rather than an institutional setting and by integrating EMS providers, like EasCare, into the overall health delivery system. This not only reduces the volume of emergency department visits to hospitals and frees up other EMS providers to respond to individuals with truly emergent conditions, but also ensures that CCA’s patients receive high-quality, coordinated care in the most appropriate setting for their unique needs. Such a Project is in the public’s interest as it ensures efficient and appropriate use of scarce healthcare resources while incorporating safeguards to ensure that public health and safety are not endangered in any way.

The goal of this Project is to integrate paramedics, an available yet underutilized resource, into the Commonwealth’s healthcare system to ensure that patients receive the appropriate level of care for their needs. Extending the reach of the CCA clinicians into the home, the obvious

Tadros AS, Castillo EM, Chan TC, et al. “Effects of an Emergency Medical Services–Based Resource Access Program on Frequent Users of Health Services.” *PREHOSPITAL EMERGENCY CARE*, October/December 2012; 16(4):541–7).

²⁴ See HRSA Community Paramedicine Evaluation Tool, *supra* note 9, at 4.

²⁵ *Id.*

downstream benefits of this Project include reduced readmissions to hospitals, reductions in ED visits, better patient outcomes and patient satisfaction. Several other incidental benefits of the Program merit mention as well. The reduction of the heavy burden on local fire and police departments and other publicly-funded agencies who often serve as first responders as well as the creation of new jobs for the Commonwealth along with new training programs for colleges and universities are all factors that weigh in favor of the Program.

**ADVANCES SEVERAL OF DPH'S STATUTORY DIRECTIVES FOR THE EMERGENCY
MEDICAL SERVICES SYSTEM IN THE COMMONWEALTH**

As discussed above, the concept of EMS has necessarily evolved from a time when EMS was equated with a true “emergency” response to today’s version of EMS where the majority of transports are for non-emergent conditions and advances in medical technology allow EMS personnel to “treat and release” patients at the scene of an illness or injury. This Project advances several of the statutory directives for the expectations of the EMS system in the Commonwealth including but not limited to:

1. ***The Project recognizes, provides for, and integrates services meeting the needs of special populations such as CCA’s dual eligible population into the EMS system.*** “Provide necessary EMS, using appropriate elements of the EMS system, to ensure adequate and appropriate EMS for all persons requiring the services, including, without limitation, all special populations, as an integral part of the EMS system, ensuring that the special needs of children and other special populations are recognized and provided for, and that services meeting their needs are integrated into the EMS system”²⁷;
2. ***The Project ensures appropriate and effective utilization of EMS resources.*** “Provide for effective utilization of the appropriate personnel, facilities and equipment of each entity providing EMS”²⁸;
3. ***The Project advances the training and education of EMS personnel.*** “Provide for continuous training for its EMS personnel, including clinical training and continuing education programs, which are coordinated with other programs which provide similar training and education”²⁹;
4. ***The Project seeks to provide a framework to prevent illness and injury to improve the health status of each region.*** “Provide for programs of public education, information and prevention in each region taking into account the needs of residents of

²⁶ *Id.*, *emphasis added*.

²⁷ MASS. GEN. LAWS ch. 111C, § 2(1) (2014).

²⁸ MASS. GEN. LAWS ch. 111C, § 2(7) (2014).

and visitors to that region to prevent illness and injury and to know means of obtaining EMS and such programs shall also take into account the health status of each region”³⁰;

5. ***The Project plans to collect standardized data to assess access, availability, quality, cost and third party reimbursement for Community Paramedicine programs and the EMS System generally.*** “Provide for a standardized patient data collection system which covers all phases of the EMS system. This system shall include, but shall not be limited to, information needed to review access, availability, quality, cost and third party reimbursement for EMS”³¹; and
6. ***The Project provides the services and equipment necessary to ensure adequate and appropriate EMS for CCA’s dual eligible population.*** “Provide for the services and equipment necessary to ensure adequate and appropriate EMS for all persons requiring the services including, without limitation, children and other special populations and integrate such services and equipment into the statewide EMS system.”³²

ADVANCE THE GOALS OF CHAPTER 224

Importantly, the Project also furthers the primary objectives of Chapter 224 of the Acts of 2012 (“Chapter 224”) by reducing costs while placing the objectives of transparency, efficiency, and quality at the forefront ensuring Massachusetts position as a leader in healthcare innovation. This type of innovative pilot is a logical outgrowth of Chapter 224 which promotes an efficient, high-quality healthcare delivery system that is patient-centered, integrates behavioral and physical health, and promotes better patient outcomes and improved health status.

Chapter 224 aims to achieve such a delivery system, in part, by encouraging the development and certification of patient-centered medical homes (“PCMH”) and other accountable models of care delivery. A PCMH is a model of primary care delivery designed to provide patients with a single point of coordination for all of their healthcare needs which is (i) patient-centered; (ii) comprehensive, integrated and continuous; and (iii) delivered by a team of healthcare professionals to manage a patient’s care, reduce fragmentation and improve patient outcomes. The Health Policy Commission (the “HPC”), which is tasked with implementing a number of the provisions under Chapter 224, is responsible for establishing a certification mechanism for PCMHs in the Commonwealth. The certification criteria will be centered on standards that promote care coordination, enhanced access and communication, integrated clinical care management, population

²⁹ MASS. GEN. LAWS ch. 111C, § 2(10) (2014).

³⁰ MASS. GEN. LAWS ch. 111C, § 2(12) (2014).

³¹ MASS. GEN. LAWS ch. 111C, § 2(13) (2014).

³² MASS. GEN. LAWS ch. 111C, § 2(15) (2014).

health management, data systems and performance measurements, and resource stewardship. The HPC recognizes that improved management and coordination of patient care through PCMHs has the potential to create better outcomes and reduce overall healthcare costs. Innovative initiatives such as community paramedicine which further the goals the HPC has outlined for PCMHs should be encouraged.

GREATER COMMUNAL BENEFIT

EasCare and CCA propose to pilot this program in an urban environment first – Boston (Region IV) and South Shore (Region V)—before transitioning the program to more rural areas of the Commonwealth- Western Massachusetts (Region I) and Central (Region II). The projected population for the initial phase of the Project is 2,000 CCA enrollees. Data will be reported to DPH's Office of Emergency Services every 6 months during the Project.

While EasCare and CCA developed this Project specifically to address the unmet needs of the dual eligible population in Massachusetts, the data gathered from this Project will not only provide insights into the potential further expansion of community paramedicine programs and other expansions of the Massachusetts EMS system beyond its traditional boundaries but also general insights into the Massachusetts healthcare system. Examples of measures to be collected include but are not limited to: number of calls from CCA to EasCare, number of responses by EasCare paramedics where transportation via 911 was required, number of patients who required transportation to the ED or a hospital admission for the same complaint within a certain period of time following an EasCare paramedic visit, estimated cost savings from the Project, staff feedback and patient satisfaction. Such data will be analyzed and presented in both narrative and graphic format so that the cost benefits as well as the improvements in long-term wellness and quality of life experienced by the patients that consent to participate in the Project are known and valued by the community. Based on the data gathered by this Project, community paramedicine may prove a useful intervention to address pediatric asthma in the Commonwealth similar to a program operated jointly by the Indianapolis Emergency Medical Services and the Indiana University School of Medicine,³³ provide support for congestive heart failure patients in Massachusetts akin to the MedStar Mobile Health Care program in Fort Worth, Texas³⁴, or ensure that mental health patients in the Commonwealth are taken to facilities that are best-suited to care for them under a program similar to the proposed alternate destination mental health collaboration between Mountain Valley EMS and

³³ IU School of Medicine and Indianapolis EMS Target Childhood Asthma with Paramedic Housecalls, INDIANA UNIVERSITY SCHOOL OF MEDICINE (Oct. 8, 2013), <http://news.medicine.iu.edu/releases/2013/10/treat-the-streets.shtml> (last visited July 9, 2014).

³⁴ See Kizer et al., *supra* note 1, at 15; see also *Mobile Healthcare Programs – Overview*, MEDSTAR911.ORG, <http://www.medstar911.org/community-health-program> (last visited July 9, 2014).

AMR Stanislaus County³⁵. Furthermore, the Commonwealth is in the unique position to approve this pilot without a corresponding request for additional funding. Many of the current community paramedicine pilots in other states have been hampered by lack of access to reimbursement.

EASCARE, LLC

EasCare is an innovative healthcare provider with a reputation for integrity, quality, and excellence in the management of patient care and emergent and non-emergent transport that has been serving the Commonwealth of Massachusetts since 1998. EasCare believes strongly in developing customized, client-centered programs that facilitate improved coordination, collaboration, and integration between and among healthcare providers, programs and services. EasCare continually evaluates its performance to inform its clinical and operational policies and practices through conducting research studies to evaluate the effectiveness of clinical interventions, measuring and providing feedback on key performance indicators to industry stakeholders and staff, and methodically evaluating new and innovative trends in emergency medical services. The maturity of the organization is not only evident from an operational perspective but also from a clinical perspective.

Operationally, EasCare's approach to project management is methodical and organized and governed by the tenet that any deficiency in the level or quality of service it provides is unacceptable. In furtherance of this, EasCare has taken a measured approach to this Project from implementation to the final stage of data analysis and reporting through adoption of the best practices methodology advanced by the Project Management Institute.

Clinically, EasCare has an experienced staff comprised of a supportive Medical Director, Director of Clinical Services, and medical control physicians. EasCare has created and implemented a robust continuous quality improvement system and is guided by clinical best practice policies. To continuously hone and refine the skills of its healthcare providers, EasCare engages in annual skills competencies by simulation, morbidity and mortality rounds programs, and extensive educational opportunities. EasCare has enlisted Field Training Officers who guide the organization's staff education and mentoring program. Finally, EasCare collaborates with Tufts Medical Center as part of its integrated Neonatal and Pediatric transport team. For further information on EasCare, please refer to Exhibit D which includes biographical information on the leaders of the Project along with a current organizational chart.

³⁵ *Community Paramedicine Pilot Project*, CENTER FOR THE HEALTH PROFESSIONS, <http://futurehealth.ucsf.edu/Public/Center-Research/Home.aspx?pid=713> (last visited July 9, 2014).

THE DUAL ELIGIBLE POPULATION AND THE MISSION OF COMMONWEALTH CARE ALLIANCE

In America, there are over 10 million seniors and people with disabilities enrolled in both Medicare and Medicaid.³⁶ The people who fall into this class are known as “dual eligible beneficiaries.” The dual eligible population is comprised of many of the nation’s sickest and most vulnerable adults and is growing steadily.³⁷ By definition, dual eligibles are poor: over 60% live below the poverty level, and 94% live below 200% of the federal poverty line.³⁸ Disproportionate shares of dual eligibles lack high school diplomas, are minorities, and are female.³⁹ Moreover, dual eligibles are much more likely than other Medicare beneficiaries to have initially qualified for Medicare because of physical or mental disabilities – factors that increase people’s need for healthcare, rehabilitation services and long-term care that may reduce their ability to navigate the healthcare system.⁴⁰ And in addition to higher rates of disability, dual eligibles are about twice as likely to have at least three chronic conditions, and they are nearly three times as likely to have been diagnosed with a mental illness.⁴¹ Finally, the most recent statistics issued by the Massachusetts Medicaid Policy Institute confirms that nearly all dual eligibles in Massachusetts live in the community – only 3 percent reside in institutions – and of the Medicare/Medicaid dollars spent on the Massachusetts dual eligible population in 2008, close to 90% was spent on duals residing in the community.⁴²

Commonwealth Care Alliance is a not-for-profit, consumer-governed organization, that provides a unique prepaid care delivery system for patients with multifaceted healthcare needs. CCA is a pioneer in care coordination for dual eligibles, and the organization is leveraging its significant experience in treating this population to more effectively integrate benefits, better coordinate care delivery, improve quality of care, and reduce costs. CCA has been working with dual eligibles since 2004 when it launched Senior Care Options – an integrated healthcare plan which now has more

³⁶ *Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011*, p. 1, CENTERS FOR MEDICARE & MEDICAID SERVICES (February 2013), http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf (last visited July 9, 2014).

³⁷ *Id.* Between 2006 and 2011, the total number of Medicare-Medicaid enrollees increased by 17.7%, from 8.6 million to 10.2 million.

³⁸ *Report to Congress: New Approaches in Medicare*, p. 75, MEDICARE PAYMENT ADVISORY COMMISSION (June 2004), http://www.medpac.gov/documents/june04_entire_report.pdf (last visited July 9, 2014).

³⁹ *Id.*

⁴⁰ In 2011, close to 41.3% of dual eligibles had Medicare-qualifying disabilities whereas merely 12.0% of Medicare-only beneficiaries had a qualifying disability. See *Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011*, *supra* note 36, at 1-2.

⁴¹ *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies*, p. 4, CONGRESSIONAL BUDGET OFFICE, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles2.pdf (last visited July 9, 2014).

⁴² Ellen Breslin Davidson & Tony Dreyfus, *Dual Eligibles in Massachusetts: A Profile on Health Care Services and Spending for Non-Elderly Adults Enrolled in Both Medicare and Medicaid*, p. 8, MASSACHUSETTS MEDICAID POLICY INSTITUTE (September 2011), (footnote continued)

than 4,100 members, more than 70 percent of whom are nursing home-certified, under which CCA receives a combined capitation from Medicare and Medicaid to provide personalized, round-the-clock care.⁴³ Multidisciplinary teams led by nurse practitioners have broad leeway to order social and support services to keep patients healthy and prevent hospitalizations, emergency department visits, and institutionalization. The formula has been successful, exceeding national quality and cost standards, including:

- A declining overall hospital admission rate for the 5th straight year (from 514.4 Admissions /K/yr in 2012 to 478.3 admissions /K /Yr. in 2013, a 7% drop);
- A declining 30 day hospital readmission percentage (fell from 17.99% in 2012 to 16.5% in 2013); and
- An increase in CCA's provision of end of life care in the home and community settings with 62% of members dying in home and community settings in accordance with wishes (compared to 60% in 2012 and 47% in 2008).⁴⁴

Given CCA's success with Senior Care Options, the organization was selected to participate in "One Care", Massachusetts' jointly-funded demonstration project for dually eligible adults with disabilities who are between the ages of 21 and 64 at the time of enrollment.⁴⁵ Much like the Senior Care Options plan, Commonwealth Care Alliance's One Care plan aims to integrate the full spectrum of healthcare services for its participants by leveraging an Interdisciplinary Care Team, which includes the enrollee, a care coordinator or a clinical care manager, and an Independent Living and Long-Term Services and Supports Coordinator. CCA currently covers approximately 2/3 of the One Care enrollees with Fallon Health Plan and Network Health combining to cover the remaining 1/3 in the Commonwealth.

In addition to integrating care for dual eligibles in Massachusetts, the One Care plan aligns its financing as well; the Centers for Medicare and Medicaid Services ("CMS") and the Commonwealth use combined Medicare and Medicaid funds to provide a risk-adjusted blended capitated payment to CCA.⁴⁶ The parties then share in whatever savings the plan achieves. From the outset, CMS and Massachusetts recognized the need for CCA (as well as other organizations

http://bluecrossmafoundation.org/sites/default/files/MMPI%20Duals%20Chart%20Pack_0.pdf (last visited July 10, 2014).

⁴³ Harris Meyer, *The Coming Experiments in Integrating and Coordinating Care for 'Dual Eligibles'*, 31:6 HEALTH AFFAIRS 1151-1155, 1153 (June 2012).

⁴⁴ *In Common- Spring 2014*, COMMONWEALTH CARE ALLIANCE, <http://www.commonwealthcarealliance.org/providers/provider-forms-resources/in-common-provider-newsletter/in-common-spring-2014> (last visited July 10, 2014).

⁴⁵ *Infographic: One Care Enrollment by Geography*, p.1, MASSACHUSETTS MEDICAID POLICY INSTITUTE http://bluecrossmafoundation.org/sites/default/files/download/publication/OneCare_Infographic_FINAL.pdf (last visited July 10, 2014).

⁴⁶ *Policy Brief: Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries*, p. 1, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (October 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8291-02.pdf> (last visited July 10, 2014).

participating in the demonstration project) to have significant flexibility to provide community-based services as an alternative to or means to avoid high-cost services in order to achieve such savings.⁴⁷ CCA's desire to provide its members with integrated, high-quality, value-based care has motivated the organization to look at innovative ways to ensure its members are receiving the best care possible. Predictable and preventable complications experienced by dual eligibles drive recurrent hospital contacts, declining health, poor outcomes and most costs. CCA's proposed partnership with the highly-skilled paramedics at EasCare will help the organization to meet its goals by bringing quality care to patients in their homes rather than an institutional setting.⁴⁸ For further information on CCA, please refer to Exhibit E which includes biographical information on the leaders of the Project along with a listing of CCA Board Members.

COLLABORATION BETWEEN EASCARE, LLC AND COMMONWEALTH CARE ALLIANCE

In 2011, EasCare began examining new patient care models to address opportunities within the shifting healthcare industry. Subsequently, EasCare reached out to CCA to discuss piloting a community paramedicine program to serve an identified gap in the continuum of care for CCA's dual eligible population. The Project was designed based on adopted community paramedicine standards of EasCare's parent organization, Medavie EMS, as well as a DPH-requested self-assessment performed by EasCare and CCA through the use of the HRSA Community Paramedicine Evaluation Tool (the "Tool"). This Tool was developed by HRSA as a framework to assess Community Paramedicine programs based on their own specific health status benchmarks and performance indicators as well as to utilize the data collected from the Tool to guide existing and future Community Paramedicine programs by identifying common successes and challenges.⁴⁹ Through the lens of the three core functions of public health: assessment, policy development, and assurance, the Tool requires each Community Paramedicine program to define common interventions that may be successful in improving the community's health status.⁵⁰ The results of EasCare and CCA's HRSA self-assessment are attached hereto as Exhibit F and many of the lessons learned from this evaluation were incorporated into the Project. Following the commencement of the Project, the HRSA Evaluation Tool will be reviewed and an updated evaluation submitted to DPH every 6 months. This periodic revaluation allows for the continued growth and improvement of the Project and ensures that DPH is apprised of its progress on an ongoing basis.

⁴⁷ *Id.* at 7.

⁴⁸ See Davidson et al., *supra* note 42, at 8. In 2008, on average, per capita spending for Massachusetts dual eligibles residing in the community and also receiving a high level of long-term support services was roughly half of spending for dual eligibles residing in institutions - \$56,200 vs. \$101,900.

⁴⁹ See Community Paramedicine Evaluation Tool, *supra* note 9, at 5.

In the planning phases, the Project received formal external review from the Emergency Health System of Nova Scotia and informal assessment from the DPH's Office of Emergency Medical Services ("OEMS") Emergency Medical Care Advisory Board's ("EMCAB") Community Care and Education Committee. Recommendations from these entities were incorporated into the current version of the Project with further external assessment planned once the Project is operational. EasCare and CCA plan to continue engaging public officials as well as health insurers and payers in further expanding the role of community paramedicine in the Commonwealth. A summary timeline of additional planning steps taken by EasCare and CCA is attached hereto as Exhibit G.

EasCare and CCA are committed to this partnership with the goal of not only serving an immediate and unmet need for this special, pre-identified vulnerable population but also with the hope that the data generated from the pilot merits replication of this Proposal in other areas, or for other unique populations, of the Commonwealth. The Parties are committed to doing so with full transparency and in the absence of any identifiable conflicts of interest and as such have entered into a formal, written agreement that is cost neutral. In addition, as evidenced by Exhibits D and E none of the key leaders at EasCare or CCA serve "dual roles" or have otherwise given or received any payment, benefit or other value as an inducement to enter into such Proposal other than the fair market value payment that CCA will make to EasCare for the services of its paramedics under the Agreement. EasCare's Conflict of Interest policy is attached hereto as Exhibit H.

PROPOSED SPECIAL PROJECT WAIVER

HOW THE PROJECT WORKS

For over ten years, CCA has operated a 24/7 member services line that triages telephone calls from patients with both emergent and non-emergent needs as part of its overall, individualized care coordination strategy. A CCA enrollee calls the member services or the main clinic telephone number and is routed to a nurse triage line which refers enrollees to the mid-level Nurse Practitioner or Physician Assistant (collectively, the "Midlevel Providers") on-call. CCA relies on the clinical knowledge and judgment of its experienced on-call providers in deciding whether to recommend referral to the hospital, conservative management in the home and/or schedule a follow up visit the next day. The clinical decision-making algorithm focuses on first obtaining sufficient information from the patient's complaint and their past history to determine their risk for severe illness and to elicit whether "red flag" signs or symptoms are present. If the patient's complaint is of a potentially life-threatening nature, or they present with symptoms that may be consistent with a severe etiology,

⁵⁰ *Id.*

they or their caregiver are instructed to hang up the phone and call 911 immediately. In the absence of "red flags", in a patient who is non-acute and appears clinically stable, the on-call provider then develops a differential diagnosis that includes the most common causes of the current symptoms or complaints, and in partnership with the patient and/or their caregiver, develops a treatment plan and schedules follow up. In areas of clinical uncertainty, where the most likely cause of symptoms is benign - for example, constipation causing abdominal pain, or anxiety causing shortness of breath - but where the tools to fully assess the complaint are not available over the telephone, our clinicians default to sending the patient to the ER for further assessment. It is in these circumstances, where the patient is clinically stable but where the underlying etiology of their symptoms is unclear, that the value of community paramedicine to CCA would be most highly realized.

CCA estimates that it receives approximately 6 to 8 calls each month between the hours of 6:00pm and 2:00am ("off-hours"); approximately 4-6 result in the patient waiting until the morning to receive care and 1-2 require activation of 911 and/or transport to the hospital. Under the Proposal, CCA would continue to provide the initial level of telephone triage and response to patients between the hours of 6:00am and 6:00pm but then authorize paramedics from EasCare, in collaboration with CCA's Midlevel Providers and the patient's primary care physician, to respond to such calls in a certified Class V ambulance⁵¹ during off-hours to evaluate, treat and provide an appropriate disposition for the CCA patient. If, upon evaluation the EasCare paramedic feels the patient's condition warrants transport to a hospital, the paramedic will activate the local 911 provider and begin treatment under the current Massachusetts Statewide Treatment Protocols (the "STPs"). These ambulance transports would not be provided by EasCare but rather by the local 911 provider.

If this is not the case, however, the paramedic will assess the patient and collaborate with family members and other caregivers similar to the role paramedics normally perform during any traditional response. The paramedic will then review the patient's electronic medical record ("EMR") and contact the CCA clinician responsible for the patient over the telephone to discuss the patient's condition and establish a plan for care and disposition. Acting under the plan of care established by the CCA clinician, the EasCare paramedics may provide services within his/her current scope of practice that range from: (1) care coordination/patient navigation (e.g., directly admitting patients to a particular floor at a hospital rather than bringing them through the ED), (2) administration of medications at home, (3) post-discharge home follow-up, (4) maintenance of PICC and peripheral lines, (5) assessment and management of wounds, injuries, respiratory, chronic heart failure, chronic obstructive pulmonary disease, diabetic, hypertension, and cellulitis issues, (6) management of nausea,

⁵¹ EasCare's Class V ambulances comply with all of the equipment and identification requirements for this class of ambulance including but not limited to the light and siren requirements of 105 C.M.R. § 170.490(B) and (C) as well as Administrative Requirements Manual provisions A/R 5-401 and 5-402.

vomiting and diarrhea, (7) assessment of non-acute altered mental status, (8) management of do not resuscitate patients, and (9) specimen acquisition and point of care testing. In addition, should the Project waiver be granted the paramedics would also be authorized to insert or maintain a Foley catheter for a CCA patient. As the standing orders in the STPs have limited applicability to these community-based interventions and are not mandatory⁵², the paramedics will render care in accordance with medical control orders created specifically for the Project and approved by DPH as well as patient-specific orders obtained from the Project's Medical Director, Dr. Daniel Muse, or, if unavailable, from the medical control physicians in the Emergency Department at Brockton Hospital. If, once the paramedic begins to care for the patient he/she feels that the care plan does not follow the paramedic's training or that on-scene physician collaboration is required, the paramedic will contact Dr. Muse or the medical control physicians in the Emergency Department at Brockton Hospital.

Following an intervention by an EasCare paramedic, the paramedic will follow protocols established by CCA and EasCare on home safety (e.g., fall/trip risks), medication inventory, and follow up instructions. The benefit of this "value-added" service is that the paramedic is already on-site in the home and these small steps could potentially yield large dividends in terms of patients feeling supported, improving patient outcomes and preventing avoidable injuries or complications. In addition, CCA clinicians will review the treatment notes inserted by the EasCare paramedic to determine whether the enrollee requires additional medical follow up such as referral to a home healthcare agency, or supportive services such as food delivery or transportation services. Following each visit, a survey will be given to each patient and caregiver to measure satisfaction with the visit by the EasCare paramedic.

To ensure that patients are given the opportunity to decline a visit by an EasCare paramedic, CCA shall provide advance notification of the proposed Project to its enrollees to allow them to opt-in by providing advance written consent. Such written consent shall inform the patient that the EasCare paramedic is providing care pursuant to a pilot project, that the paramedic has access to a physician at all times for consultation, and that the patient may decline to have care provided by the EasCare paramedic at any time.

⁵² The prior version of the Massachusetts STPs provided: "Note that "standing orders" are intended to represent available options for the provider prior to contacting medical control, rather than mandatory interventions; they should of course be performed when clinically appropriate." *Emergency Medical Services Pre-Hospital Treatment Protocols, Prior Version 11.01*, p. i, COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF EMERGENCY MEDICAL SERVICES, (June 15, 2013), <http://www.mass.gov/eohhs/docs/dph/emergency-services/treatment-protocols-1101.pdf> (last visited July 18, 2014).

ROBUST MEDICAL SUPERVISION

Daniel Muse, M.D., a board-certified emergency medicine physician, shall serve as the EasCare Medical Director of the Project in collaboration with CCA's Medical Director John Loughnane, MD, a board-certified family medicine physician. Dr. Muse and Dr. Loughnane bring a combined 37 years of experience to this Project and are committed to its success. Dr. Muse is responsible for physician oversight of the paramedics as well as supervision of the educational and training components of the Project in collaboration with Dr. Loughnane and as further highlighted on pages 31-32 of our Initial Proposal. At all times, however, the CCA primary care clinicians remain responsible for the patient's plan of care and the EasCare Paramedics work as an extension of such clinician when deployed to provide a community visit to a CCA patient. Additional physician oversight will be provided by the medical control physicians at Brockton Hospital who are Massachusetts'-licensed physicians trained in the STPs including the Interfacility Transfer Guidelines set forth at Appendix A3. These physicians will also receive training in the Project's protocols as well as in the paramedics' training and knowledgebase. Dr. Muse and Dr. Loughnane also supervise the continuous quality improvement program for the Project as further described below. Further information on their background and qualifications may be found in Exhibit I.

PARAMEDICS TRAINED & MAINTAIN SKILL SET

This Project will involve ten (10) EasCare paramedics who are proficient under the Commonwealth's current STPs and are qualified to practice in an expanded role in Massachusetts in accordance with Appendix A3 (Interfacility Transfer) of the STPs (the "Paramedics"). An ideal Paramedic for the Project has relevant EMS experience, is found to be an effective collaborator and communicator, and successfully participates in an intensive training program estimated to take at least 152 classroom and 152 clinical hours. Components of the educational program include but are not limited to an introduction to community paramedicine including the role of medical control, protocols and documentation requirements; interactions with patients including ensuring that patients understand the role of the paramedic and that the paramedics understand how to effectively communicate with the patient, family and other caregivers; and patient assessment and evaluation tools. The 152 clinical hours will consist of shadowing CCA practitioners on home visits, hospital and clinic visits, as well as behavioral health units. These encounters are meant to highlight the specialized knowledge gained from managing patients with respiratory issues, kidney disease, and those who are under CCA's care. In addition to successful completion of a comprehensive training program, each Paramedic shall undergo continual clinical evaluations to ensure proficiency in each skill, follow up education on updates to protocols or policies, and be mentored by CCA physicians, Midlevel Providers and laboratory technicians. Paramedics in the Project will also be subject to a robust continuing medical education program to further advance and refine their skills including a

monthly “case study” educational session where pre-identified patient encounters will be reviewed by the Project’s Medical Director and Director of Clinical Services in conjunction with the Project’s Paramedics. Further detail on the educational program as well as EasCare’s requirements for paramedic participation in the Project may be found in pages 21-24 of our Initial Proposal attached hereto as Exhibit A.

DATA TO EVALUATE QA/QI ACTIVITIES OBTAINED AND MONITORED

All requests from CCA that an EasCare paramedic be deployed, patient interactions by the EasCare paramedics, telephone calls between the EasCare paramedics and the CCA clinicians as well as on-line medical control, post-visit follow-up by the EasCare paramedics, and patients who “bounce back” into the healthcare system will be reviewed under the Project’s Continuous Quality Improvement (“CQI”) system to ensure appropriate management of the patients. The CQI system is two-pronged; first, Matthew Goudreau, the Director of Clinical Services reviews every encounter the following business day and provides immediate feedback to the Medical Director and the Paramedics. Any remediation will be constructive not punitive. In addition, on a monthly basis, the Project Medical Director will review every encounter. Quality assurance/quality improvement reviews will include collaboration with the CCA Medical Director and EasCare Medical and Project Directors to identify trends and refine the education, protocols and policies for the Project so that the model continues to evolve to meet the needs of CCA’s patient population. For more details on the CQI model, please see pages 28-29 of our Initial Proposal.

ELECTRONIC MEDICAL RECORD

A key component of the Project involves paramedic access to CCA patient medical records through eClinicalWorks. Unlike a traditional EMS response where paramedics do not have the benefit of the patient’s history, the EasCare paramedics will be able to incorporate their knowledge of the patient from the medical record into their assessment, care and treatment. This includes critical information such as medication allergies as well as social, cultural or behavioral barriers to care. The EasCare paramedics will be using a “custom built” form on CCA’s current electronic medical record to ensure that the database of information gathered during the operational phase may be isolated for ongoing reporting and measurement of the goals and progress of the Project. The eClinicalWorks product is a Health Insurance Portability and Accountability Act (“HIPAA”) and HL-7 compliant solution with meaningful use capability that allows EasCare secure and real-time access to a patient’s medical record. Access to the product is through a user password-protected secured portal that allows providers to log-in via secure web access. No protected health information is stored on local devices or EasCare servers. In addition, EasCare and CCA have

developed a formal written policy on HIPAA compliance that includes the requirement that the EasCare paramedics receive HIPAA training upon hire.

PROJECT COMPLIMENTS BUT DOES NOT COMPETE

Sending paramedics into the community enhances coordination between existing pre- and post-hospital systems of care, bridging the gap for patients who are between home care visits, post-discharge patients or those who may not be eligible for home care visits. An initial task on EasCare's Project timeline is to engage all stakeholder groups to facilitate a collaborative working relationship to advance the Project, to ensure that their requirements and considerations are taken into account and to foster a platform to engage in discussions about other patient-centered care models. As part of these efforts, EasCare drafted the notification letter attached hereto as Exhibit J to primary ambulance services in the designated regions impacted by the Project in the interests of transparency and to ensure that all of EasCare's industry colleagues have an understanding of the scope of the Project. This Project is meant to compliment but not replace existing systems of care as described in the examples below.

For example, a CCA patient may require the initiation of IV access in order to receive antibiotics or fluids. An EasCare paramedic, acting pursuant to physician orders and within the expanded scope of practice available under Appendix A3 of the STPs, may obtain IV access conventionally or with the assistance of ultrasound and administer the medications or fluid to a patient in the home. Another promising use of the EasCare paramedics during off-hours is sending them to a patient's home within 24 hours of discharge to provide support and education to the patient and his/her caregivers, evaluate any problematic changes in condition, ensure that the home environment is safe from trip and fall hazards, and review the patient's medications to ensure compliance. Since the EasCare paramedics are available during off-hours, there is greater flexibility for them to respond to provide basic medical services to CCA patients upon discharge. In addition, access to the CCA medical record for the patient arms the paramedic with the most up to date information on the patient to maximize the efficacy of the intervention. The provision of out-of-hospital paramedic care is especially beneficial to address the predictable complications associated with chronic disease states such as congestive heart failure ("CHF"), chronic obstructive pulmonary disease ("COPD"), diabetes and hypertension.

LEGAL AUTHORITY TO GRANT WAIVER AND WAIVER REQUEST

Section 22 of the authorizing Statute for the Massachusetts Emergency Medical Services System provides as follows:

"The commissioner may waive any provision of the regulations and guidelines promulgated under this chapter, subject to such terms and conditions as he may impose; provided, however, that no waiver may issue unless the

commissioner has determined that such waiver (a) will result in improved quality or accessibility of EMS, (b) is in the public interest, and (c) will not endanger public health or safety.”

As summarized in the table below, the proposed out-of-hospital paramedic care project accomplishes the three (3) objectives required for the Commissioner to exercise her authority to waive any of the regulations and guidelines promulgated pursuant to the Statute.

The out-of-hospital paramedic care project will result in improved quality or accessibility of EMS in the Commonwealth.	• Community-based interventions by the EasCare paramedics frees up other EMS providers to devote their scarce resources to those who truly are experiencing an emergent illness or injury. • DPH is specifically charged under Section 2 of the Statute with “ensuring that the needs of children and other special populations are recognized and provided for, and that services meeting their needs are integrated into the EMS system.” “Special population” is defined as “any person or group of persons with unique medical, physical or social problems that require other than customary emergency care.” Clearly, the unique needs of the Commonwealth’s dual eligible population fit within the definition of a “special population”. • The interventions are similar to those EasCare paramedics provide on a pre-hospital basis, require completion of an intensive training program by the EasCare paramedics, and are subject to rigorous medical oversight to ensure quality.
The out-of-hospital paramedic care project is in the public interest.	• Ensures efficient and appropriate use of scarce healthcare resources. • Saves taxpayers of the Commonwealth and ensures that financial savings may be used to fund other pressing budget priorities. • The Project provides an opportunity to gather data that may support the need for other community paramedicine programs or expansions of EMS in the Commonwealth (e.g., pediatric asthma).
The out-of-hospital paramedic care project will not endanger public health or safety.	• There are many safeguards to the proposal (e.g., triaging by CCA clinician, evaluation by paramedic, robust physician oversight with several layers of mentorship, ability to call 911 at any

	point, post-visit review and necessary remediation). • The responsibilities of the EasCare paramedics to CCA enrollees will not impact their ability to discharge their duties under the State’s 911 System or impede access to EMS in the Commonwealth.
--	---

WAIVER REQUEST

As a preliminary matter, it is important to note that EasCare’s request for a special project waiver does not alter DPH’s separate finding of EasCare’s responsibility and suitability for an ambulance service license pursuant to the considerations identified in 111C M.G.L. § 6 and 105 C.M.R. § 170.220. The Project falls under the scope of EasCare’s current ambulance service license⁵³ which tasks EasCare with the “responsibility to dispatch EMS personnel and vehicles and transport patients to the appropriate hospital or other healthcare facility *as necessary*, and to participate in the local, regional and state EMS system.”⁵⁴ In seeking the special project waiver for the Project, EasCare is not asking to modify any term of its ambulance service license including but not limited to (1) changing the number of certified EMS vehicles it operates, (2) changing its level of service, or (3) adding or deleting places of business from which advanced life support services are provided.⁵⁵

In order for the tremendous potential of this Project to be fully realized, however, EasCare in collaboration with CCA formally requests that the Commissioner recognize that CCA’s dual eligible population (as described in detail above) constitutes a “special population” in the Commonwealth as defined in the Statute, as “any person or group of persons with unique medical, physical or social problems that require other than customary emergency medical care.” Based on such designation, EasCare and CCA respectfully request that the Commissioner (i) waive the requirement that a patient transport must occur in order for a certified paramedic employed by a licensed ambulance service to render care in the community in Massachusetts in accordance with his/her training and in conjunction with a medical control physician, (ii) waive any implied requirement that an ambulance service is limited to “emergency” responses to include community-based interventions for preventive or non-emergent issues for special populations, like CCA enrollees, and (iii) upon the completion of appropriate training that is sufficient to DPH, expand the scope of practice for the EasCare paramedics’ to allow them to perform community-based

⁵³ EasCare maintains a “Paramedic Level” ambulance service license in accordance with 105 C.M.R. § 170.295(B). Among other things, this licensure level allows EasCare to provide (1) BLS-level services, (2) ALS-level services (e.g., services related to airway and circulatory maintenance pursuant to the STPs and any other DPH-approved training programs) and (3) Paramedic-level services (e.g., services related to the treatment of cardiac or respiratory arrest, poisoning, drug overdose or other major trauma or illness pursuant to the STPs and any other DPH-approved training programs).

⁵⁴ MASS. GEN. LAWS ch. 111C, § 6 (2014), *emphasis added*.

interventions including but not limited to Foley catheter placement and maintenance for CCA enrollees.

(i) waive the requirement that a patient transport must occur in order for a certified paramedic employed by a licensed ambulance service to render care in the community in Massachusetts in accordance with his/her training and in conjunction with a medical control physician;

The regulatory definition of a “patient” is “an individual who is sick or injured and requires EMS and/or transportation in an ambulance.”⁵⁶ The use of the conjunction “and/or” contemplates that the choices provided are not exclusive. Therefore, a “patient” under the Massachusetts EMS System may be a sick or injured individual who (1) requires EMS, (2) requires transportation in an ambulance, or (3) requires both EMS and transportation in the ambulance. This Project, therefore, focuses on an individual who is sick or injured who requires “EMS” only. Thus, whether EasCare’s “EMS only” response to CCA patients is contemplated by the EMS System depends on whether such services are considered “emergency medical services.” “Emergency medical services” are defined as “the pre-hospital assessment, treatment and other services utilized in responding to an emergency or provided during the emergency or inter-facility transport of patients to appropriate healthcare facilities.”⁵⁷

As the definition of “patient” intimates, however, there is no requirement under the Statute or the Regulations that a patient must be transported to the hospital in order to receive emergency medical services nor is there a requirement that EMS personnel responding to a patient emergency have to subjectively intend to transport such patient to a hospital. There are many times in a traditional EMS response when patients do not end up being transported yet DPH clearly would still consider those services to qualify as “emergency medical services.” Therefore, EasCare would argue that the services contemplated to be provided by the EasCare paramedics to the CCA enrollees are “emergency medical services” even though they are not technically being provided on a “pre-hospital” basis as that term has traditionally been construed. As the definition of special population notes above, however, CCA patients may require other than “customary” emergency medical care (e.g., keeping such patients in their residence rather than transporting them to the Emergency Department). If DPH is not inclined to agree with this broad interpretation of “emergency medical services,” however, then EasCare respectfully requests that a special project waiver from any transport requirement be issued as part of the Project to allow the paramedics to render medical care in the homes of the CCA enrollees.

⁵⁵ MASS. GEN. LAWS ch. 111C, § 8(a) (2014); 105 MASS. CODE REGS. § 170.240 (2014).

⁵⁶ 105 MASS. CODE REGS. § 170.020 (2014).

⁵⁷ *Id.*

(ii) waive any implied requirement that an ambulance service is limited to “emergency” responses to include community-based interventions that are for preventive or non-emergent issues for special populations, like CCA enrollees;

“Emergency” is defined as “a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by the individual, a bystander or an emergency medical services provider.”⁵⁸ Arguably once a CCA member telephones the member services line and the triaging CCA clinician deems it necessary for the patient to receive a home visit by an EasCare paramedic, either the clinician has determined that the individual has a need, or the CCA enrollee perceives a need, for medical attention. Whether that need is considered “immediate” is a matter of debate. However, DPH has already determined that responses for scheduled, non-emergent medical conditions are within the scope of a licensed ambulance service and are part of the framework of the Massachusetts EMS system.⁵⁹ Furthermore, community-based interventions for preventive or non-emergent issues comports both with DPH’s statutory obligation to provide for other than “customary” emergency care for special populations in the Commonwealth and with the medically-intensive nature of this population including likely physical or mental barriers to receiving traditional emergency care (e.g., lack of an available Hoyer lift in the ED). Therefore, the EasCare paramedics should be authorized to provide medical care in response to the actual or perceived “emergency” of the CCA patient as DPH is specifically charged with providing for other than customary emergency medical response and services for special populations, like CCA enrollees. If DPH is not inclined to agree with this broad interpretation, however, then EasCare respectfully requests that a special project waiver from any implied requirement that every response performed by a licensed ambulance service be an “emergency” response be issued as part of the Project to allow community-based responses that are for preventive or non-emergent issues similar to current ambulance responses allowed for the transportation of non-emergent patients to scheduled appointments.

(iii) upon the completion of appropriate training that is sufficient to DPH, expand the scope of practice for the EasCare paramedics’ who will be providing care to the CCA patients to allow them to perform community-based interventions including but not limited to Foley Catheter placement and maintenance.

⁵⁸ 105 MASS. CODE REGS. § 170.020 (2014).

⁵⁹ “A Class I ambulance may also be used for scheduled transportation by prior appointment of persons having known and non-emergency medical condition.” 105 MASS. CODE REGS. § 170.455 (2014).

In Massachusetts, paramedics may not function beyond, or potentially beyond, the scope of their training and level of certification.⁶⁰ 105 C.M.R. § 170.020 provides that “The Paramedic’s clinical practice is defined by the Statewide Treatment Protocols.” The STPs further provide that “the scope of practice for each EMT level is defined (1) in regulation (105 C.M.R. § 170.810, § 170.820, and § 170.840), (2) through established training programs approved by the Department, and (3) through the Statewide Treatment Protocols consistent with the Interfacility Transfer Guidelines.”⁶¹ In addition, the scope of practice for all EMTs, including paramedics, is limited by the licensure level of the ambulance service by which the EMT is employed.⁶² Paramedics may not perform functions for which he/she is not properly trained or certified except under a special waiver granted by DPH in accordance with 105 C.M.R. § 170.405, or when serving on a critical care medical crew.⁶³

Briefly, the functions of a paramedic include (1) the provision of basic emergency medical care for patients at the scene and/or while in transit in an ambulance; (2) operation of Class I, II, and V ambulances; (3) the provision of advanced life support⁶⁴ related to airway and circulatory maintenance, treatment of cardiac or respiratory arrest, poisoning, overdose or other major trauma or illness in accordance with the STPs; and (4) the administration of Schedule VI controlled substances that are approved by DPH for administration by a paramedic⁶⁵ provided that they are administered in the performance of patient care duties and in accordance with the STPs as well as 105 C.M.R. § 700.003(D).

In addition to the functions set forth in the Regulations, a paramedic’s scope of practice is guided by the STPs which set forth the acceptable standard of care for the treatment of the following categories of injuries and illnesses: (1) general patient care, (2) medical care, (3) cardiac, (4) trauma, and (5) airway protocols and procedures. As stated in a prior version of the STPs, these protocols “are designed to immediately manage emergent patient illnesses and injuries such that rapid intervention by all levels of EMT personnel will alleviate patient suffering and ultimately allow the

⁶⁰ *Emergency Medical Services Pre-Hospital Treatment Protocols, Official Version 12.03*, p. 123, COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF EMERGENCY MEDICAL SERVICES, (September 6, 2014), http://www.wmems.org/attachments/MA_DPHOEMS_STP12_03.pdf (last visited July 18, 2014).

⁶¹ *Id.*

⁶² *Id.*

⁶³ 105 MASS. CODE REGS. § 170.800(B) (2014).

⁶⁴ “Advanced life support” is defined as the “pre-hospital use of medical techniques and skills defined by the Statewide Treatment Protocols by EMTs certified pursuant to 105 C.M.R. § 170.000.” 105 MASS. CODE REGS. § 170.020 (2014).

⁶⁵ The paramedic must have completed DPH-approved training for the administration of controlled substances and may only administer those substances on which he or she is trained. In addition, the licensed service (i.e., the ambulance, emergency first responder, or first responder agency) that employs the paramedic must maintain an affiliation agreement with a hospital that addresses, at a minimum, quality assurance or as specifically required in 105 C.M.R. § 170.330(C). Finally, in the case of a paramedic employed by a non-ambulance service (i.e., by an emergency first responder service or first responder agency), the paramedic’s employer must maintain an agreement with the transporting ambulance service to ensure continuity of pre-hospital care. 105 MASS. CODE REGS. § 170.810(D) (2014).

patient to be delivered to a receiving hospital in an already improved clinical state whenever possible.”⁶⁶ Paramedics are authorized to deviate from a designated protocol where “good medical practice and the needs of patient care” require it as long as any action taken is allowed by their training and in conjunction with their on-line medical control physician.⁶⁷ Any deviations must be reviewed by the appropriate local medical director. Finally, as noted above, the STPs are interpreted consistent with the requirements set forth in Appendix A3 of the STPs for ALS interfacility transfers.

Under this special project waiver, EasCare and CCA would create protocols for these community-based interventions as they do not fit within the existing categories of illness or injury covered by the STPs. Thus, such protocols are not contrary to the STPs but rather outside the injuries or illnesses the STPs are meant to cover. These community-based protocols will be approved by DPH OEMS in advance, incorporated into the EasCare paramedic training program, and overseen by the EasCare Medical Director and the Brockton ED physicians as described above. In addition, the care the EasCare paramedics provide under these community-based protocols will be rendered in close collaboration with the CCA physicians.

While the majority of the interventions proposed by EasCare are within the current scope of practice for a paramedic in Massachusetts, the insertion and maintenance of Foley catheters is not; yet, this complication presents a high volume of calls for CCA. In support of our request, we would note that there are many interventions that EMTs in the Commonwealth are authorized to perform based on DPH-approved training programs that are outside the current scope of practice for a paramedic in Massachusetts. For example, paramedics from Professional Ambulance Services in Cambridge have been trained on the pre-hospital use of ultrasound for abdominal exams and those at Worcester UMASS EMS, Boston EMS, Lowell General EMS, and Lawrence Hospital EMS have received training on the use of paralytics to facilitate intubations. Although we recognize that these two interventions are performed on a pre-hospital basis, each intervention carries more risk than the insertion of a Foley catheter. Furthermore, it is our understanding that DPH has already authorized critical care paramedics to insert and maintain a Foley catheter based on additional training. This is a relatively benign intervention and as such, EasCare respectfully requests that DPH authorize the EasCare paramedics to insert and maintain Foley catheters for this special population upon the completion of a robust DPH-approved training program and in conjunction with the robust medical oversight described above.

⁶⁶ See Emergency Medical Services Pre-Hospital Treatment Protocols, Prior Version 11.01, *supra* note 52, at i.

⁶⁷ See Emergency Medical Services Pre-Hospital Treatment Protocols, Official Version 12.03, *supra* note 60, at 10.

CONCLUSION

The Massachusetts EMS system “is designed to ensure that properly trained and certified EMS personnel, operating under medical oversight, provide emergency medical care to patients at the scene of their illness or injury, and during transport to appropriate healthcare facilities.”⁶⁸ EasCare’s Proposal for out of hospital paramedic care is meant to address a single identified gap for CCA’s “special population” of dual eligibles in Massachusetts which require other than “customary” emergency medical care as defined in the Statute. However, many more gaps exist. EasCare and CCA ask DPH to approve of this narrow pilot with the hope that the data gathered supports deployment of this model throughout the Commonwealth for other unique patient populations or to manage certain chronic illnesses. Simply transporting patients is no longer reflective of EMS’ role in the greater healthcare landscape. To let an underutilized healthcare resource languish does nothing to further the mission of Chapter 224 and advance the Triple Aim that all healthcare providers including EasCare and CCA strive to achieve for the Commonwealth and its citizens. As such, EasCare, in alliance with its partner, CCA, respectfully ask the Commissioner to exercise her discretion and grant this special project waiver request.

⁶⁸ 105 MASS. CODE REGS. § 170.001 (2014).

TABLE OF EXHIBITS

Exhibit A	Initial Submission Dated February 10, 2014
Exhibit B	Letters of Review and Evaluation from Regional Medical Director and Executive Director
Exhibit C	Table of Community Paramedicine Programs in the United States
Exhibit D	EasCare
Exhibit E	Commonwealth Care Alliance
Exhibit F	HRSA Self-Assessment Tool Results
Exhibit G	Planning Timeline for Project
Exhibit H	EasCare Conflict of Interest Policy
Exhibit I	Information on the Project Medical Directors (Dr. Muse and Dr. Loughnane)
Exhibit J	Notification Letter to EMS Providers

EXHIBIT A

INITIAL SUBMISSION DATED FEBRUARY 10, 2014

EASCARE, LLC

Ambulance Service

in collaboration with



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.

1.0	Purpose.....	5
2.0	Background	7
3.0	Clinical Opportunities	12
4.0	Program Design.....	19
4.1	<i>Clinical Needs Assessment.....</i>	19
4.2	<i>Project Management & Oversight.....</i>	19
4.3	<i>Education & Training.....</i>	21
4.4	<i>Human Resources</i>	25
4.5	<i>Policies, Procedures & Protocols</i>	26
4.6	<i>Operational Call Flow</i>	26
4.7	<i>Continuous Quality Improvement.....</i>	28
4.8	<i>Medical Oversight</i>	31
5.0	Program Evaluation & Research.....	33
6.0	Conclusion.....	34
7.0	Appendix	35

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.

<i>Project Name:</i>	Out of Hospital Paramedic Care
<i>Applicant:</i>	EasCare LLC 500 Neponset Ave Dorchester, MA 02122
<i>Licensed Ambulance Service:</i>	MA AMB LIC # 3006 EasCare LLC 500 Neponset Ave Dorchester, MA 02122
<i>Regional Affiliation:</i>	Region IV & V (Initial) Region I & II (Phase 2 & 3)
<i>ACO Partnership:</i>	Commonwealth Care Alliance
<i>Project Manager:</i>	Gregory A Davis NREMT-P EasCare LLC 500 Neponset Ave Dorchester, MA 02122 (P) 617-822-4414 (C) 617-959-4563 (F) 617-740-9211 gdavis@eascare.com
<i>Medical Director for EasCare:</i>	Daniel Muse MD EasCare LLC 500 Neponset Ave Dorchester, MA 02122 (C) 781-530-7233 (F) 617-740-9211 danmuse@comcast.net
<i>Medical Director for CCA:</i>	John Loughnane 30 Winter St

	Boston, MA 02108 (P) 866-610-2273 john.Loughnane@bmc.org
<i>Clinical Director for Project:</i>	Matthew Goudreau CCEMT-P EasCare LLC 500 Neponset Ave Dorchester, MA 02122 (P) 617-822-4445 (F) 617-740-9211 mgoudreau@eascare.com
<i>Logistics Director for Project:</i>	W Scott Cluett III NREMT-P EasCare LLC 500 Neponset Ave Dorchester, MA 02122 (P) 617-822-4491 (F) 617-740-9211 scluett@eascare.com

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/aspx/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
	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.

Post Discharge Follow-up and Drug Compliance Management	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.
Care Coordination	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. 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

	can be staffed by various levels of service providers.
Out of Hospital Care	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. 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.
Chronic Disease MGMT	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.

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/NTI%2Fpdf%2F811705.pdf&ei=L5DkUbOpNOPE4APwyIDYDg&usq=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
	the VNA's availability. Patients that have been identified as “frequent flyers” with manageable medical conditions may particularly benefit from this type of service. Toronto EMS lowered EMS 911 responses by 73.8% by assisting patients to access resources other than 911.⁸ Such as: patients that may need additional education on their discharge orders, including the education of their care givers; ensuring that the patients have obtained their discharge prescriptions and that they understand how to properly medicate themselves; and any patient that will be requiring VNA visits (as an initial visit until that service is fully up and providing care). This must be done in collaboration with VNA and other services such as Home IV Services to ensure that the patient is getting necessary resources in a time frame that will keep the patient from feeling the need to return to the hospital.
Maintenance of PICC and Peripheral Lines	Any patient that is sent home with indwelling catheters that are being used for long term care. Out of Hospital Care Paramedics can provide follow up to ensure that these access ports are not infected and are functioning correctly.
Maintenance of PICC and Peripheral Lines (Cont'd)	Examples may be a patient who is receiving outpatient chemotherapy or any medical procedure requiring long term IV access. Though a patient may not be receiving IV therapy at home or have access to the VNA, the ACO may call the Out of Hospital Care Paramedic to evaluate the patient at home instead of requiring an emergency room visit.
Wound/Injury Assessment and Management	Many Nursing Home and private patients have access to wound care treatment, however these services are not available 24/7 resulting in unnecessary admissions to the ED. Assisted Living facilities and ACO patients will benefit from having a medical professional evaluate the wound, make a treatment plan under Medical Direction and then initiate care (pain management, antibiotics, staples, glue). Examples include: skin tears; lacerations; deformities; and abrasions. This can include necessary x-rays and orthopedic appointments to occur as scheduled vs. immediately, given that the patient's immediate needs for splinting, bandaging and pain management have been met.
Respiratory	Provide evaluation of patients with respiratory complaints.

⁸ Toronto EMS Presentation (2010) Community Referrals by Emergency Medical Services.
(Accessed via <http://www.ircp.info/Downloads/ExpandedRole/CREMS.aspx> on April 26, 2013)

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	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. 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.
COPD Assessment and Management COPD Assessment and Management (Cont'd)	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. 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.
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
	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.
HTN assessment and Management	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.
Nausea, Vomiting, and Diarrhea Management	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.
Assessment of Altered Mental Status (non-acute)	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

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

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

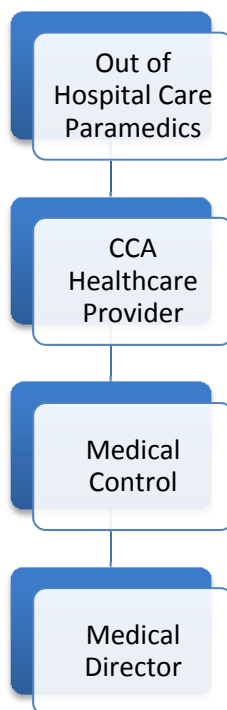
- Liaise with Partner Organization's Chief Medical Officer as required;
- Evidence based protocols and policies that guide Out of Hospital Care Paramedics in the field;
- Availability of real-time medical advice through medical oversight physicians;
- Manages the Clinical Rotation portion of the Out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

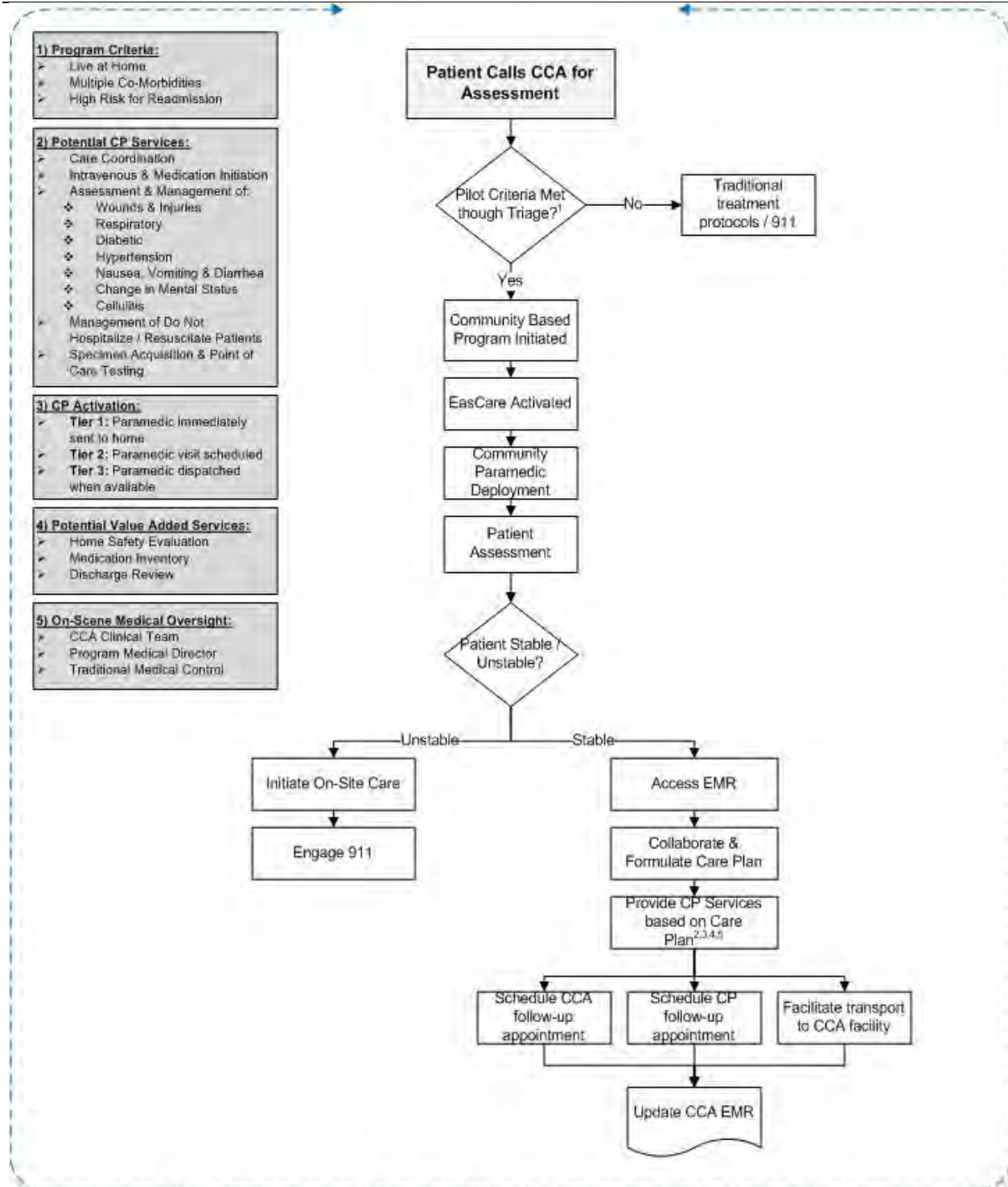
The Out of Hospital Paramedicine Care program will also present opportunities for involvement with formal research studies. These studies can be used to refine specific program elements while also contributing to best practices in Out of Hospital Paramedicine.

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

EXHIBIT B

**LETTERS OF REVIEW AND EVALUATION FROM REGIONAL MEDICAL DIRECTOR AND
EXECUTIVE DIRECTOR**



BRIGHAM AND
WOMEN'S HOSPITAL



HARVARD
MEDICAL SCHOOL

Neil and Elise Wallace
STRATUS Center for Medical Simulation
75 Francis Street, Neville House
Boston, Massachusetts 02115
Phone: (617) 732-8577 Fax: (617) 264-6333
www.stratus.partners.org

Charles N. Pozner, MD
Medical Director
Douglas S. Smink, MD, MPH
Associate Medical Director

March 14, 2014

Patricia Reilly, RN
Clinical Coordination
Massachusetts Office of Emergency Medical Services
99 Chauncy Street, 11th Floor
Boston, MA 02111

Dear Ms. Reilly,

This letter is in support of EasCare Ambulance Service's Special Project Waiver for their community based paramedic Care Program in collaboration with the Commonwealth Care Alliance. I have reviewed their proposal, met with their administrative team and they have satisfactorily answered all of my questions.

I believe that the utilization of EMS providers in the community under the appropriate circumstances and with appropriate training and oversight will improve the health and the delivery of healthcare in our communities. I believe that EasCare has met all of the requirements to be approved for this waiver. I will be very interested in following the progress of this program. If you have any questions, please feel free to contact me at your earliest convenience.

Sincerely,

Charles N. Pozner, MD
Regional Medical Director
Metropolitan Boston EMS Council (Region 4)

July 1, 2014

Deborah Allwes, BS, BSN, MPH
Director, Bureau of Quality and Healthcare Safety
99 Chauncy Street
Boston, MA 02111

Dear Director Allwes:

Please accept this letter from the Metropolitan Boston EMS Council as the formal recommendation of the Special Project Waiver for Mobile Integrated Healthcare (MIH) as presented by EasCare Ambulance Service (EasCare) and its partner Commonwealth Care Alliance (CCA) to be approved to begin as soon as possible.

EasCare presented an innovative and collaborative program to address the needs of CCA and its constituents. The SPW application, and subsequent presentations, provided a thorough overview of the program and went through a very rigorous review process at the EMCAB level. The project proposal was vetted by members of the EMCAB Community Care and Education sub-committee and the EMCAB Medical Services sub-committee. Based on the recommendations of these two state sub-committees and their broad based statewide representation the Metropolitan Boston EMS Council fully endorses and recommends that the EasCare Mobile Integrated Healthcare Special Project Waiver be approved to begin in as expeditious a time as possible.

We, as a state, have been presented with a great opportunity to be innovative in our delivery of healthcare. By allowing this project, and others, to begin we will be better able to gather data on the programs and what works well and what does not work well. As we move forward with the exploration of Mobile Integrated Healthcare we will be better able to make informed decisions in the crafting of guidance that will govern the best model of MIH for the Commonwealth in the future.

Should you have any further questions regarding this recommendation or the SPW please feel free to contact me at (781) 505-4367.

Sincerely,

Derrick Congdon, M.S., NREMT-P
Executive Director

Cc: Greg Davis
EasCare Ambulance Service

EXHIBIT C

TABLE OF COMMUNITY PARAMEDICINE PROGRAMS IN THE UNITED STATES

TABLE OF COMMUNITY PARAMEDICINE PROGRAMS IN THE UNITED STATES

Arizona	- To participate in the Rio Rico Community Healthcare Paramedicine Program, patients are first identified by their primary care physicians. The program provides in-home environment risk assessments and connects patients to social services.¹
California	- California's Office of Statewide Health Planning and Development (OSHPD) is considering the implementation of 12 community paramedicine pilots; concepts include alternate destination/alternate destination for mental health, post-hospital discharge follow up, directly observed treatment of TB, hospice support, and frequent 911 callers. The pilot programs will allow the OSHPD to test, demonstrate and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before any changes in paramedic scope of practice licensing laws are made.² - The San Francisco Fire Department (SFFD) Homeless Outreach & Medical Emergency (HOME) Team was developed to address the needs of chronic inebriates that frequently call 911, had extensive ED use, and incurred high uncompensated care costs.³ The program is currently on hiatus due to rescission of funding, but during the years the program was in place, the SFFD collected data demonstrating a decline in high user utilization of SFFD EMS ambulance pick-ups.⁴ - The San Diego Resource Access Program (RAP) integrates health information technology with real-time EMS and computer-aided device surveillance. The bidirectional exchange of information between EMS and hospitals through the health information exchange facilitates detection of patterns of activity for "frequent flyers" and identifies equally vulnerable but less known individuals.⁵
Colorado	- Eagle County's Public Health Department and the Western Eagle County Ambulance District have collaborated to form one community paramedicine program in Colorado. Patients are referred to the EMS personnel by their primary care physicians to receive services in the home, including discharge follow-up, blood draws, medication reconciliation and wound care.⁶ - Upper San Juan Health Service District; a CMS Healthcare Innovation Grant awardee program focusing on patients at risk for heart attacks and strokes through early cardiovascular detection and wellness programs, remote diagnostics for cardiology consultations.⁷
Idaho	- Ada County Paramedics is working on a Boise-area pilot; the program is structured such that within 48 hours of discharge from hospital, high-risk patients receive a 2 hour home visit with a community paramedic, then weekly follow up phone calls for a month. Paramedics conduct physical assessment of both the patient and the home, ensure patient understands and is implementing the care plan, and help organize medications.⁸

TABLE OF COMMUNITY PARAMEDICINE PROGRAMS IN THE UNITED STATES

Indiana	- The IU School of Medicine Department of Emergency Medicine's Division of Out of Hospital Care received a Health and Human Services Emergency Medical Services for Children grant for \$899,700 to implement a program named Treat the Streets: Pre-Hospital Pediatric Asthma Intervention Model to Improve Child Health Outcomes. Through the program, children with prior visits or admissions to the ED or hospital receive home visits by specially trained paramedics who assess for potential triggers in the home environment and make needed referrals for social services or medical follow up.⁹ - The Indianapolis Community Outreach and Resource Efficiency (CORE) Care Team was developed to provide services to people who previously depended upon the 911 system for routine support. The team takes a two-pronged approach to connecting people with the care they need while keeping the health care system in Indianapolis working efficiently. The first prong focuses on community outreach targeting frequent 911 callers. The second prong utilizes community paramedicine providers to service patients with congestive heart failure with a view to decreasing their 30-day hospital readmission rates; while these patients were previously dependent on the 911 system for routine post-admission support, the CORE Care Team contacts the patients within 72 hours of discharge to assess their needs and make sure they understand and follow care plans.¹⁰
Maine	- Maine Emergency Medical Services Board allowed by state law to authorize 12 pilots; paramedics work with chronically ill patients at risk for hospital readmission and during downtime will follow up on healthcare provider referrals and check vital signs, evaluate patients, and check for medication compliance.¹¹
Minnesota	- Minnesota's Community Paramedic Program addresses critical health care shortages in rural and remote areas. Medicaid reimbursement available for health assessments, immunizations and vaccinations, chronic disease monitoring and education, lab specimen collection, medication compliance, hospital discharge follow up care, and minor medical procedures.¹²
Nebraska	- Rural Nebraska Regional Ambulance Network pilot projects in Scottsbluff, Kearney and Omaha; providers assist patients with following hospital discharge instructions, taking vital signs, medication reconciliation, and informing patients of health care services available to them.¹³
Nevada	- The Reno REMSA Community Health Early Intervention Team (CHIT) is a CMS Healthcare Innovation Grant awardee. Lower acuity EMS calls are triaged into a system that offers advice from a nurse over the phone; if warranted patients transport lower acuity patients to alternate destinations such as urgent care facilities, physician office, or mental health facility.¹⁴
New Mexico	- Public Inebriate Prevention Program (PIIP); refers so-called "chronic inebriates" to the county's Metropolitan Assessment Treatment Services building instead of transporting to hospital where warranted.¹⁵

TABLE OF COMMUNITY PARAMEDICINE PROGRAMS IN THE UNITED STATES

North Carolina	- Beginning in the late 1990s and continuing today, Orange County EMS instituted a “treat-and-release” policy; the program enables paramedics with additional training to choose alternative disposition for patients based on their assessment of the patient's needs. Low-acuity patients can be treated and referred to a primary care provider for follow-up. Alternatively, the patient can be transported by ambulance or other appropriate means (e.g., from personal vehicle, wheelchair vans or taxis), to a physician's office or some form of primary care clinic.¹⁶ - The objectives of the Wake County EMS Advanced Practice Paramedic (APP) program include ensuring that an experienced paramedic with recent critical care participation is available to assist ambulance crews on critical level calls. The Wake County EMS APP program also conducts home visits with high-risk populations to reduce unnecessary ED transports.¹⁷
Pennsylvania	- The University of Pittsburgh’s Congress of Neighboring Communities (“CONNECT”) implemented a community paramedic pilot program for patients with chronic diseases such as diabetes, asthma and chronic heart disease. Patients are referred to program and given a nonemergency phone line they can call for questions or concerns about health care; EMS personnel will direct the patient to appropriate follow up care settings.¹⁸
Texas	- The Medstar Fort Worth EMS Community Health Program (CHP) initiative focuses on navigating patients toward more appropriate non-ED health settings, reducing unnecessary 911 responses and EMS transports. Advance practice paramedics also work with congestive heart failure patients referred to the CHP by cardiac care case managers, making home visits to educate patients and conduct overall assessment of the patient, provide non-emergency access number for episodic care and refer patients to their PCP as needed.¹⁹
Washington	- Prosser Public Hospital District of Benton County, serving a large, rural area in Washington State, received a CMS Healthcare Innovation Grant award for a program through which physicians can send a community paramedic (CP) to visit patients of concern. The CPs provide reinforcement of discharge instructions, disease process education, post-abdominal surgery follow-up, medication clarification and social service referrals. EMS visit patients at home within 48-52 hours of discharge to provide medical monitoring, basic lab work, patient education, and encouraging patients to keep their follow up appointments.²⁰

¹ Terry Ketron, *Fire District Set to Help Rural Residents With Preventative Care*, NOGALES INTERNATIONAL (Dec. 27, 2013), http://www.nogalesinternational.com/news/fire-districts-set-to-help-rural-residents-with-preventative-care/article_3dd6825e-6f11-11e3-bad2-001a4bcf887a.html?mode=print; see also *Bureau of Emergency Medical Services & Trauma System Community Paramedicine*, ARIZONA DEPARTMENT OF HEALTH SERVICES, <http://www.azdhs.gov/bems/community-paramedicine/index.php?pg=existing-programs> (last visited July 2, 2014).

² *Introduction to Community Paramedicine*, CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY, http://www.emsa.ca.gov/Community_Paramedicine (last visited July 2, 2014).

TABLE OF COMMUNITY PARAMEDICINE PROGRAMS IN THE UNITED STATES

³ Kenneth W. Kizer, et al., *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care*, p. 14, UC DAVIS INSTITUTE FOR POPULATION HEALTH IMPROVEMENT (July 2013), http://www.ucdmc.ucdavis.edu/iphi/publications/reports/resources/IPHI_CommunityParamedicineReport_Final%20070913.pdf.

⁴ Capt. Niels Tangherlini, *An Urban Community Paramedic Pilot Project*, THE SAN FRANCISCO FIRE DEPARTMENT HOME TEAM (June 27, 2012), http://www.sfgov2.org/ftp/uploadedfiles/mocj/CommInvlv_News/FD_HOME_Team.pdf.

⁵ Kenneth W. Kizer, et al., *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care*, p. 14, UC DAVIS INSTITUTE FOR POPULATION HEALTH IMPROVEMENT (July 2013), http://www.ucdmc.ucdavis.edu/iphi/publications/reports/resources/IPHI_CommunityParamedicineReport_Final%20070913.pdf (citing T. Chan, et al., *Effects of an Emergency Medical Services-Based Resource Access Program on Frequent Users of Health Services*, PREHOSP. EMERG. CARE (2012 Oct-Dec;16(4):541-7)).

⁶ *County and WECAD Launch Community Paramedic Pilot Program*, OFFICIAL WEBSITE OF EAGLE COUNTY, COLORADO, http://www.eaglecounty.us/HHS/News/County_and_WECAD_launch_community_paramedic_pilot_program/ (last visited July 2, 2014); see also *Bureau of Emergency Medical Services & Trauma System Community Paramedicine*, ARIZONA DEPT. OF HEALTH SERVICES, <http://www.azdhs.gov/bems/community-paramedicine/index.php?pg=existing-programs> (last visited July 2, 2014).

⁷ Centers for Medicare & Medicaid Services, Health Care Innovation Awards: Colorado, <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Colorado.html>

⁸ *Pilot Program Uses Extended Paramedic Visits to Assess and Coach Patients Recently Discharged from the Hospital*, QUALIS HEALTH, <http://www.qualishealthmedicare.org/about-us/results/local-success-stories/ada-county-paramedics> (last visited July 2, 2014); see also *Community Paramedics Program*, ADA COUNTY PARAMEDICS, <https://adacounty.id.gov/paramedics/Services/Community-Paramedics> (last visited July 2, 2014).

⁹ *IU School of Medicine and Indianapolis EMS Target Childhood Asthma with Paramedic Housecalls*, INDIANA UNIVERSITY SCHOOL OF MEDICINE (Oct. 8, 2013), <http://news.medicine.iu.edu/releases/2013/10/treat-the-streets.shtml>.

¹⁰ *Indianapolis EMS Reaches Community with CORE Care Team*, INDIANAPOLIS DEPARTMENT OF PUBLIC SAFETY (June 14, 2013), <http://indianapolisems.org/uncategorized/indianapolis-ems-reaches-community-with-core-care-team/>.

¹¹ Maine Emergency Medical Services System Rules §10 (Effective May 1, 2013) http://www.maine.gov/ems/documents/Rules_Effective_May_1_2013.pdf

¹² *The Minnesota Community Paramedic Initiative – Why & How Minnesota Is Implementing Community Paramedic Services*, EMS STATE OF THE SCIENCES CONFERENCE (February 23, 2013), <http://gatheringofeagles.us/2013/Saturday/Conterato-CP.pdf>.

¹³ NEBRASKA DEPARTMENT OF HEALTH & HUMAN SERVICES, *Community Paramedicine and Rural Health Care* (February 2013), http://dhhs.ne.gov/Documents/Access_69_February_2013.pdf; see also C. Crawford, *The Feasibility and Role of Community Paramedicine in Nebraska*, NEBRASKA DEPARTMENT OF HEALTH & HUMAN SERVICES (May 2011), <http://dhhs.ne.gov/Documents/CommunityParamedicineReport.pdf>.

¹⁴ *Health Care Innovation Awards: Nevada*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Nevada.html> (last visited July 2, 2014); see also *Washoe County Final Report – Emergency Medical Services Systems Analysis*, p. 22, WASHOECOUNTY.US (August 2012), http://www.washoecounty.us/large_files/agendas/101812sm/6.pdf.

¹⁵ UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER, *UNMH Participating in New Public Safety Initiative* (May 23, 2013) <http://hscnews.unm.edu/news/unmh-participating-in-new-public-safety-initiative>.

¹⁶ See Kizer et al., *supra* note 3, at 9; see also K. Krumperman, *History of Community Paramedicine*, JEMS EMERGENCY MEDICAL SERVICES (June 22, 2010), <http://www.jems.com/article/ems-insider/history-community-paramedicine>.

TABLE OF COMMUNITY PARAMEDICINE PROGRAMS IN THE UNITED STATES

¹⁷ S. Walston, *Advanced Practice Paramedics*, WAKEGOV.COM (October 1, 2012), <http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx>.

¹⁸ *Novel Community Paramedic Program Announced by Pitt's Congress of Neighboring Communities*, THE UNIVERSITY OF PITTSBURGH (Mar. 18, 2013), http://www.news.pitt.edu/connect_EMS.

¹⁹ See Kizer et al., *supra* note 3, at 15; see also *Mobile Healthcare Programs – Overview*, MEDSTAR911.ORG, <http://www.medstar911.org/community-health-program> (last visited July 2, 2014).

²⁰ *Health Care Innovation Awards: Washington*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Washington.html> (last visited July 2, 2014).

EXHIBIT D

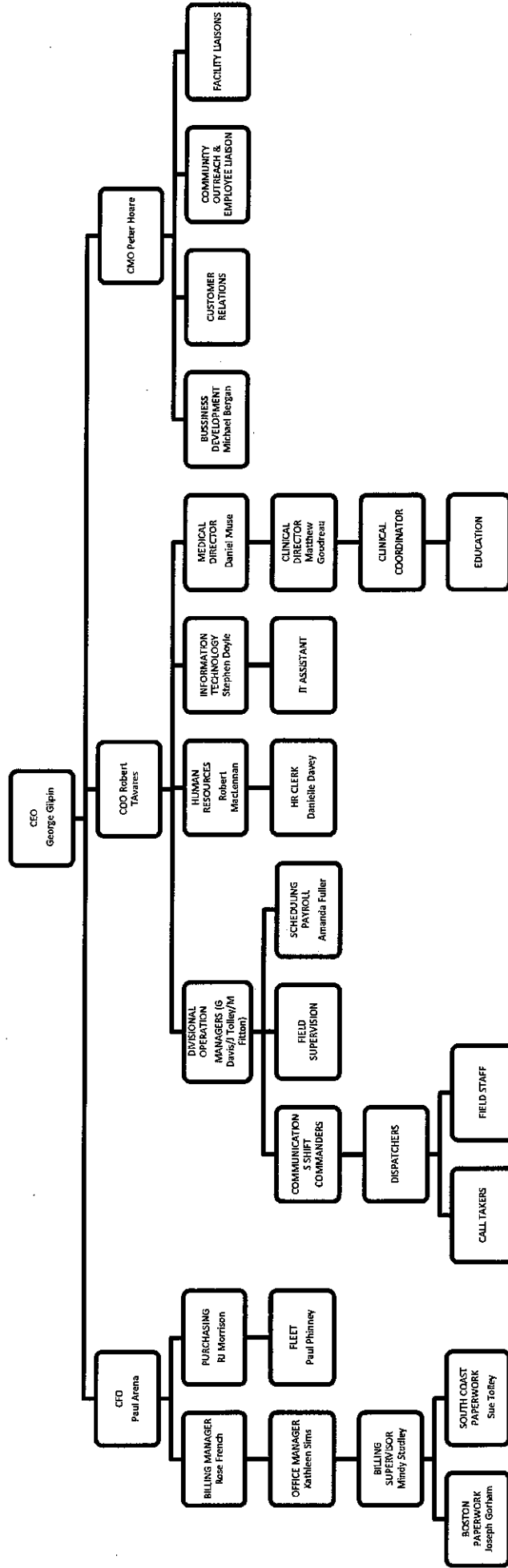
EASCARE, LLC ORGANIZATIONAL CHART & PROJECT LEADERSHIP INFORMATION

Gregory A. Davis, NREMT-P- Project Director

Matthew Goudreau, CCEMT-P- Clinical Director

W. Scott Cluett III, NREMT-P- Director of Paramedics

EasCare Organizational Chart



Gregory A. Davis

63 Old Falmouth Rd. Marstons Mills, MA 02648
617-959-4563 anawon@comcast.net

Accomplishments and Certifications

- ✦ Massachusetts and Nationally Registered Paramedic Certification (1990)
- ✦ Paramedic of the Year Massachusetts EMS Region V Plymouth Area (2000)
- ✦ Dr. Howard Root Award, Joslin Clinic for excellence in teaching and working with diabetic children (1984)

Professional Experience

Eascare Ambulance Dorchester, MA

Division Manager *(March 2012 to Present)*

Responsible for organization of 94,500 patient transports per year with 240 employees, by collaborating with managers assigned to maintain contract and regulatory metrics. Monitors and manages yearly financial performance of a 15.9 million dollar operating budget. Identifies and coordinates administrative support services in areas such as operational efficiencies, reimbursement services, clinical support and customer service.

Community Paramedicine Program Manager *(November 2012 to present)*

Oversight of creating and instituting an out of hospital care program from the ground up, in corporation with Massachusetts DPH/OEMS and key stakeholders. Program implementation requires department coordination from and including Operations, Education, Clinical, Research and Financial.

Paramedic Director *(August 2007 to March 2012)*

Assuring MA OEMS and DPH Regulations, Managing and coordinating the Paramedic (ALS) Division, ALS Quality Assurance and Remediation of ALS & BLS employees, Implementation of Precepting and ALS Education Programs, Scheduling and Payroll of ALS Division, Senior Field Supervisor of Field Staff

EMT-Paramedic *(July 2007 to August 2009)*

Senior Paramedic/Preceptor providing: facility transfer and Expanded Scope EMT-P work; Emergent 911 transports

American Medical Response/Brewster Ambulance *Natick/Boston, MA (Plymouth Division)*

EMT-Paramedic and Field Training Officer *(September 1996 to July 2007)*

Duties include: Educator of ALS and BLS Field Staff in a single tiered 911 system for the Town of Plymouth, MA as well as a Paramedic-Basic Interfacility Transfer ambulance

EMT-Paramedic *(March 1993 to September 1996)*

One of seven Paramedics chosen to create and staff an ALS-Intercept service managed by the Jordan Hospital

EMT-Paramedic *(October 1990 to March 1993)*

Junior Paramedic working for the town of Plymouth EMS 911 contract

EMT-Basic *(February 1987 to October 1990)*

EMT-Basic working BLS interfacility transfer ambulances and providing 911 back up.

EMTS *Cape & Islands EMS Region V Educator (July 1982 to 2002)*

Assistant and Lead Instructor of EMT-Basic & Paramedic clinical/didactic programs, Public and lay persons AHA (CPR/ACLS/PALS) and PHTLS courses

Joslin Diabetes Center *Boston, MA*

Counselor and Educator (June 1983 to September 1986)

Hobbies: Photography, kayaking, hiking, volunteer youth mentor/coach, music.

Matthew P. Goudreau
95 Surrey Street
Brighton, MA 02135
(781) 704-6575 mgemtp@yahoo.com

Employment Background:

Director of Education: EasCare Ambulance Service, Dorchester, MA (03/13-Present)

Manage education department for a largest ambulance service in the greater Boston Marketplace. Responsible for all continuing education programs, maintaining education files with copies of all certifications. Coordinating OEMS approvals, submitting appropriate rosters, lead instructing all coursework, and maintaining online education platform with course development and record keeping.

Clinical Team Leader, Action Ambulance Service, Wilmington, MA (07/11 to 03/2013)

Oversee all aspects of Clinical activity for a medium sized ambulance company. Duties include management of CQI process, development of corrective education plans, M&M rounds, development of an online training system, management of required trainings, link between field staff and medical control physicians, and responsible for all areas of staff clinical development including special project waivers and clinical research studies.

Donation Coordinator, New England Organ Bank, Waltham, MA (02/08 to 07/11)

Manage consented organ donors on the ICU to optimize organ function, obtain all necessary test for evaluation of organs, allocation of organs to transplant centers, documentation, oversee surgical recovery of organs, and post-mortem care of donor.

ALS Coordinator, Eastern Ambulance Service, Woburn, Ma (08/07 to 01/08)

Contracted as a consultant to establish an Advanced Life Support Division for a small private ambulance service. Responsible for negotiating contracts for Medical Control Physician, Pharmacy Agreements, equipment purchasing/leasing, QA/QI system, and application with OEMS for ALS licensing.

ALS Coordinator – General Ambulance Service, Allston, MA (06/04 to 05/07)

Coordinated all aspects of the Advanced Life Support Division for a medium-sized private ambulance company. Duties included working one on one with Medical Director, developed and implemented a Quality Assurance program, and presented all continuing education programs.

Organ Surgical Recovery Coordinator, New England Organ Bank (07/98 to 03/00)

Responsible for all aspects of the surgical recovery of organs for transplantation, including transportation, controlling organ-preservation flush solutions, anatomy documentation, and packaging of organs. Worked one on one with recovery surgeons to assist as needed.

EMT-Basic/ER Assistant, Upper Connecticut Valley Hospital, Colebrook, NH (09/90 to 03/98)

Provided emergency medical services through a hospital-based ambulance service. Additional role as an Emergency Department Assistant responsible for initial assessment of patients, triage as appropriate, documentation, and assisting physician with administering care plan.

Educational Background:

American Public University, Manassas, VA:

Enrolled in Bachelors of Public Health with an emphasis in Emergency Management.

Center for Emergency Medicine, University of Pittsburgh, Pittsburgh PA

An intensive study program for the management and transportation of the critical care patients. Upon completion, received certification from UMBC as a Critical Care Paramedic with Flight Certification.

Northeastern University, Boston, MA

Certificate of Completion in the Paramedic Program

Hallmark Institute of Photography, Turners Falls, MA

Photography and Business Management Program: A Liberal Arts program with a heavy emphasis on all aspects of operating a photography studio from managing the business, marketing, public presentation, creating images and sales.

Certifications:

Certified Procurement Transplant Coordinator (CPTC)

NATCO: The Organization for Transplant Professionals

Critical Care Emergency Medical Technician-Paramedic (CCEMT-P)

UMBC: University of Maryland Baltimore County

Instructor Certifications:

American Heart Associations Instructor:

Pediatric Advanced Life Support
Advanced Cardiac Life Support for Experienced Providers
Advanced Cardiac Life Support
Basic Life Support

New England Center for Emergency Medical Education

EMT Instructor Coordinator – Adult Education Instructor Program

Scott Cluett started his EMS career as a volunteer EMT in New Canaan, CT. After graduating from Paramedic school in 1991, Scott worked for Greenwich EMS, in Greenwich CT. After gaining some 911 experience and implementing the Greenwich EMS Bicycle Team, Scott entered the New York City EMS Academy and graduated in early 1996. Assigned to the South Bronx area of New York City, Scott received numerous commendations and became a Field Preceptor for the Joint Special Operations Combat Paramedic Program, an intensive training program for the US Navy Seals, Army Rangers and Air Force Para-rescuemen. He was also a member of the Dignitary Protective Unit, a select group of Paramedics providing dedicated care to visiting dignitaries such as the President and Vice-President of the United States. In 2000, Scott returned to Greenwich EMS as an Operations Manager. Back in Greenwich, Scott lead a group of professional EMTs and Paramedics and was a member of a regional Medical Control Committee. In 2005, he moved to Wilmington North Carolina to gain Critical Care Experience, working for the Critical Care Team of New Hanover Regional EMS.

In 2006, Scott accepted a Flight Paramedic position with Boston MedFlight, where he was an active member of the Safety Committee and the Public Relations Committee. Scott joined the EasCare team in 2008 and as an operations Manager and the Director of Paramedics he helped bring an electronic Patient Care report program to fruition. While overseeing this program, Scott serves as the MATRIS administrator and coordinates with the leadership team in meeting OEMS documentation and reporting requirements. Scott is a member of the Metropolitan Boston EMS Council Pre-Hospital System Coordination Committee and serves as the Logistical Manager for the EasCare/Commonwealth Care Alliance Community Paramedic Program.

EXHIBIT E

**COMMONWEALTH CARE ALLIANCE PROJECT LEADERSHIP INFORMATION & BOARD
MEMBERS**

Bob Master, MD- Chief Executive Officer

John Loughnane, MD- Senior Vice President for Medical Services

Toyin Ajayi, MD- Medical Director for Inpatient and Transitions of Care

CCA Senior Leadership Bios

Robert J. Master, MD, and Lois Simon, M.P.H., started Commonwealth Care Alliance ten years ago with 17 employees and CCA has now grown to over 600 employees with facilities in operation or under construction across the state. CCA's model has been proven to help contain and stabilize medical costs for patients while also drastically improving their overall health and well-being. CCA interdisciplinary clinical teams bring care to members at their home, nursing home, group home, doctor's office, in the hospital or on the streets. Services encompass primary medical care and a comprehensive array of behavioral health services, and long-term social and functional services and support. CCA is considered to be the 'thought' leader in care for those dually eligible for Medicare and Medicaid, and earned this reputation by being an 'outcome' leader as well.

Robert J. Master, MD, is Chief Executive Officer of Commonwealth Care Alliance. Dr. Master is also a practicing physician, board-certified in Internal Medicine, with over 30 years of experience in the clinical management of patients with advanced chronic illness and disability. Dr. Master served as the Medical Director of the Massachusetts Medicaid program in the Dukakis administration where he was responsible for all programs and policies of the state's Medicaid Program. Earlier, Dr. Master was the first physician and medical director at the Upham's Corner Health Center, and founder of the Urban Medical Group in Boston, where new approaches to nursing home and home medical care using nurse practitioners were defined; approaches that transferred hospital level services to the home and the community. In 2009, Dr. Master was recognized by the National Committee for Quality Assurance with a National Health Quality Award for his leadership in improving the quality of care for vulnerable populations.

Lois Simon, M.P.H. is President of Commonwealth Care Alliance. She is responsible for overseeing the planning and development functions as well as program operations at Commonwealth Care Alliance. Previously, Lois served as Vice President for Care Delivery Systems at Neighborhood Health Plan, where she was responsible for designing, developing, and managing the operations of the plan's clinical programs and developing new and innovative care delivery models for plan members with chronic health care needs. She served for thirteen years in a variety of state government roles, most notably as the Director of Long Term Care for the state Medicaid program and as the Assistant Secretary of the Executive Office of Elder Affairs.

John Loughnane, MD, serves as Senior Vice President for Medical Services for the Commonwealth Care Alliance Medical Group. In addition, Dr. Loughnane serves as Medical Director at Commonwealth Community Care, which he joined in 2009. He is also Medical Director of Commonwealth Care Alliance's Life Choices Palliative Care Program. He was also founder and Medical Director of the Commonwealth Care Alliance/Commonwealth Community Care Inpatient Service at Boston Medical Center. He is board certified in Family Medicine and Hospice and Palliative Care Medicine and is actively involved in research regarding patient-centered care at the end of life.

CCA Board Members

Dean Richlin Attorney Foley Hoag Attorneys at Law 155 Seaport Boulevard Boston, MA 02210-2600	Scott Miyake Geron Director and Principal Investigator Institute for Geriatric Social Work Boston University School of Social 264 Bay State Road Boston, MA 02215	Sergio Goncalves Athletic Facilities Operation Senior Supervisor UMass Boston 103 Devon Street Dorchester, MA 02121-2713
Fran Hubbard Francis Hubbard 35 Dartmouth Street Springfield, MA 01109	Lisa I. Iezzoni, MD, MSc Professor of Medicine, Harvard Medical School Associate Director, Institute for Health Policy Massachusetts General Hospital 50 Staniford Street, Room 901B Boston, MA 02114	Thomas Lynch, CEO Lynch, Ryan Associates PO Box 774 Shirley, MA 01464
Mary Lou Maloney 224 Florence Street, Unit 12, Roslindale, MA 02131	David Margulies 59 Pine Ridge Road Newton, MA 02468	Robert Restuccia Executive Director Community Catalyst 30 Winter Street Boston, MA 02108
Mark Reynolds President CRICO/RMF 101 Main Street Cambridge, MA 02142	Jeff Scavron, MD Medical Director Brightwood Health Center 380 Plainfield Street Springfield, MA 01107	Phil Thompson Associate Professor of Urban Planning 147 Clark Road Brookline, MA 02445
Nancy Turnbull, Associate Dean for Educational Programs Harvard School of Public Health 677 Huntington Avenue Boston, MA 02115		

EXHIBIT F

HRSA SELF-ASSESSMENT TOOL RESULTS

EASCARE, LLC

Ambulance Service

in collaboration with



“Out of Hospital Paramedic Care Program”

HRSA Evaluation

Massachusetts Office of Emergency Services
EMCAB Community Care and Education Committee
February 10, 2014

The Office of Emergency Medical Services of Massachusetts under the advisement of the EMCAB Community Care and Education Committee requires the completion of the HRSA Community Paramedicine Evaluation Tool. The following self-assessment from EasCare and the Commonwealth Care Alliance (CCA) provides the current status of the Out of Hospital Paramedic Care program using the HRSA Evaluation tool. The overall Program Median score is 4. While the EasCare/CCA program will continue to grow, the HRSA Evaluation Tool will be reviewed at a 6 month interval after the initial start of the program and submitted to OEMS. This revaluation will allow for growth, goals for improvement and provide progress tracking.

Overall Program Median Score:		4
100: Assessment	Median Score:	4
Bench Mark 101	Median Score:	5
101.1	Section Score	3
101.2	Section Score	2
101.3	Section Score	5
101.4	Section Score	5
101.5	Section Score	5
Bench Mark 102	Median Score:	4
102.1	Section Score	5
102.2	Section Score	4
102.3	Section Score	1
102.4	Section Score	4
Bench Mark 103	Median Score:	3
103.1	Section Score	4
103.2	Section Score	2

103.3	Section Score	3
103.4	Section Score	3
103.5	Section Score	3
200: Policy Development	Median Score:	4
Bench Mark 201	Median Score:	2
201.1	Section Score:	2
201.2	Section Score:	2
Bench Mark 202	Median Score:	5
202.1	Section Score:	5
202.2	Section Score:	5
202.3	Section Score:	4
202.4	Section Score:	5
202.5	Section Score:	5
202.6	Section Score:	4
Bench Mark 203	Median Score:	4.5
203.1	Section Score:	4
203.2	Section Score:	5
Bench Mark 204	Median Score:	5
204.1	Section Score:	5
204.2	Section Score:	5
204.3	Section Score:	4

Bench Mark 205	Median Score:	5
205.1	Section Score:	5
205.2	Section Score:	5
205.3	Section Score:	5
Bench Mark 206	Median Score:	4
206.1	Section Score:	4
300: Assurance	Median Score:	4
Bench Mark 301	Median Score:	4.5
301.1	Section Score:	5
301.2	Section Score:	4
Bench Mark 302	Median Score:	5
302.1	Section Score:	5
302.2	Section Score:	5
302.3	Section Score:	5
Bench Mark 303	Section Score:	3
Bench Mark 304	Section Score:	5
Bench Mark 305	Median Score:	4
305.1	Section Score:	5
305.2	Section Score:	4
305.3	Section Score:	1
305.4	Section Score:	5

305.5	Section Score:	5
Bench Mark 306	Median Score	5
306.1	Section Score:	5
306.2	Section Score:	5

Program Overview

Name of Program: Out of Hospital Paramedic Care

Program Location: Massachusetts OEMS Regions I, II, IV and V

Where does the Program Operate: Urban

Program Sponsor/Agency: EasCare Ambulance Service

Agency Type: Private EMS

Population Served: Approximately 2000 Commonwealth Care Alliance patients

Description of Program: Patient Triage; Post Discharge Follow-up and Medication Inventory; Care Coordination; Out of Hospital Care; Chronic Disease Management

Number of Community Paramedics in Program: (Phase I) 4; (Phase II) 4

Call Volume: 3-6/day (projected)

Program Start Date: Patient encounters ready June/2014

Continuous Operation since Start: No

If No, What Caused the Interruption: Program in beginning phases

How the Program Funded/Supported is: Agency funds & 3rd party payers

Who is the community paramedicine program Medical Director: Daniel Muse MD

Who is the EMS agency medical director (if different): Daniel Muse MD

Under what state or local authority does the program operate: Massachusetts OEMS Special Project Waiver

Healthcare Affiliations: Commonwealth Care Alliance

Contracted health plans/insurers: Commonwealth Care Alliance

Contracted hospitals: (Phase I) Boston Medical Center (Phase II) Baystate Medical Center (Phase III) Worcester

Contracted physician practices/medical homes: Commonwealth Care Alliance

Other contracted healthcare organizations (home health agencies, etc): Commonwealth Care Alliance

100: Assessment

Regular systematic collection, assembly, analysis, and dissemination of information on the health of the community.

Benchmark MEDIAN SCORE: 3

Benchmark 101: *There is a thorough description of the epidemiology of the medical conditions targeted by the community paramedicine program in the service area using both population-based data and clinical databases.*

Benchmark MEDIAN SCORE: 5

Indicators

101.1 There is a description of illnesses and injuries within the community paramedicine service area including the distribution by geographic area, high-risk populations (pediatric, elder, distinct cultural/ethnic, rural, and others), incidence, prevalence, contributing factors, determinants, morbidity, and patient distribution using any or all of the following: vital statistics, emergency department (ED) data, EMS data, hospital discharge data, State police data (those from law enforcement agencies), medical examiner data, and other data sources. The description is updated at regular intervals.

Scoring

- 0. Not known.
- 1. There is no written description of illness and injuries within the community paramedicine service area.
- 2. One or more population-based data sources (e.g., vital statistics) describe illness and injury within the jurisdiction, but clinical data sources are not used.
- 3. **One or more population-based data sources and one or more clinical data sources are used to describe illness and injury within the jurisdiction.**
- 4. Multiple population-based and clinical data sources are used to describe illness and injury within the jurisdiction, and the description is systematically updated at regular intervals.
- 5. Multiple population-based and clinical data sources (e.g., ED data, hospital discharge data, and others) are electronically linked and used to describe illness

The out of Hospital Paramedic Care Program scored a “3” for this section. Due to the CCA having an integrated healthcare program consisting of care of their patient population from ER visits to discharge, CCA has the ability to provide data in regards to injuries and illnesses. As this program evolves, the program will seek multiple population bases.

Indicator

101.2 Collaboration exists between the community paramedicine program, public health officials, and health system leaders to complete risk assessments.

Scoring

- 0. Not known.
- 1. No illness/injury risk assessments are conducted.
- 2. Community paramedicine officials conduct illness/injury assessments; however, there is no involvement of the broader health care community or public health officials in those assessments.
- 3. Public health officials, along with health care and community paramedicine participants, assist with the design of illness/injury risk assessments.
- 4. Public health officials, along with health care and community paramedicine participants, assist with the design and analysis of illness/injury risk assessments.
- 5. The public health epidemiologist, along with health care and community paramedicine participants, is involved in the development of illness/injury reports. There is clear evidence of data sharing, data linkage, and well-defined reporting roles and responsibilities.

The out of Hospital Paramedic Care Program scored a “2” for this section. The program is designed to care directly for the CCA patient population. Though a specialized community of patients exists with the CCA versus a public population, the metrics of evaluation for the program will allow expansion into public community models in the future. Time estimates range from 6 months to one year after the initiation of the patient care aspect of the program.

Indicator

101.3 There is an established electronic information system (EIS) for ongoing targeted surveillance and system performance assessment. The community paramedicine EIS may be freestanding or an extension/adaptation of other databases (e.g. EMS or hospital).

Scoring

0. Not known.
1. A community paramedicine EIS exists as an extension of other databases, e.g. EMS or hospital, but it is not routinely used for targeted surveillance and system performance.
2. The community paramedicine EIS is used to inform performance improvement activities but is not used in any community surveillance activities.
3. The community paramedicine EIS is used for both surveillance and performance improvement activities.
4. The community paramedicine EIS has been integrated or linked to one or more administrative databases, e.g. billing.
5. **The community paramedicine EIS is linked to both administrative and clinical databases to provide a comprehensive overview of the community paramedicine program and its effect on current and future community healthcare needs.**

The out of Hospital Paramedic Care Program scored a “5” for this section. The program will be using a “custom built” form on the current electronic medical report (EMR) used by the CCA for patient charting. This form will allow database sharing for reporting of the program.

Indicator

101.4 The EIS database captures all patient/client contacts.

Scoring**0. Not known.**

- 1.** There is no database that captures patient/client contacts.
- 2.** There is a simple log (electronic or paper based) that identifies demographic information about the patient/client contact, e.g. patient and provider identifier, date, time, etc.
- 3.** There is a medical record that documents each patient/client contact with summary information in an electronic searchable database of all contacts.
- 4.** There is an electronic medical record documentation of each patient/client contact that can be accessed by primary care physicians and case managers.
- 5.** The community paramedicine electronic medical record is fully integrated with the patient/client's formal health care record in the patient/client's medical home.

The out of Hospital Paramedic Care Program scored a "5" for this section. The Paramedics will be using the CCA's EMR, which is integrated with the CCA physicians and patient's permanent record.

Indicator

101.5 Reports can be generated from the community paramedicine EIS to help guide performance improvement activities and to document the effectiveness and/or efficiency of the program.

Scoring

- 0. Not known.
- 1. No community paramedicine EIS database exists.
- 2. A community paramedicine EIS database exists but is not used to generate reports to guide either daily operations or future planning.
- 3. Special reports can be generated as needed and used by the program director to assist in scheduling or other administrative issues.
- 4. Reports are generated on a regular basis and used by the program director and medical director to inform performance improvement activities and processes.
- 5. Reports are generated on a regular basis and are used to inform oversight bodies, funding agencies, and the general public about the impact of the community paramedicine program.

The out of Hospital Paramedic Care Program scored a “5” for this section. The Advisory and Operations committees for the program will be provided regular reporting. OEMS will be provided reports every 6 months to allow public to be aware of the program’s impact on healthcare.

Benchmark 102: A resource assessment for the community paramedicine program has been completed and is regularly updated

Benchmark Median Score: 4

Indicator

102.1 The community paramedicine program has completed a comprehensive inventory that identifies the availability and distribution of current capabilities and resources from a variety of partners and organizations throughout the community.

Scoring

- 0.** Not known.
- 1.** There is no community-wide resource assessment.
- 2.** A community-wide resource assessment has been completed that documents the frequency and distribution of resources for at least two of the following categories: community paramedicine, prehospital and hospital personnel, education programs, facilities, and prehospital equipment.
- 3.** A community-wide resource assessment has been completed that documents the frequency and distribution of resources for more than two of the following categories: leadership, system development, regulation, finances, illness/injury prevention, wellness promotion, workforce resources, education, EMS, transport, communications, health care facilities, medical oversight, system evaluation, performance improvement, and research.
- 4.** The community-wide resource assessment has identified one or more targeted clinical condition groups/individuals that can be addressed with the resources identified above.
- 5.** The community-wide resource assessment has identified strategies to meet the needs of the targeted clinical condition groups/individuals and methods for supporting those activities financially.

The out of Hospital Paramedic Care Program scored a “5” for this section. The program found that assessment of the CCA community has identified patient care strategies to meet the clinical requirements in a fiscally responsible manner.

Indicator

102.2 The community paramedicine program has completed a gap analysis based on the inventories of internal and external system resources as well as system resource standards.

Scoring

- 0.** Not known.
- 1.** There are no resource standards on which to base a gap analysis.
- 2.** The community paramedicine advisory committee has begun to develop resource standards so that a gap analysis can be completed.
- 3.** The community paramedicine resource standards have been approved by the appropriate authority.
- 4.** A gap analysis of community paramedicine program has been completed based on the adopted resource standards.
- 5.** A gap analysis of community paramedicine resources has been completed and is updated at regular intervals based on the adopted resource standards.

The out of Hospital Paramedic Care Program scored a “4” for this section. The program was designed after a gap analysis performed by EasCare and the CCA based on adopted standards of Medavie EMS. Once the program is initiated, re-evaluation of the original and concurrent gap analysis will continue.

Indicator	Scoring
102.3 There has been an initial assessment (and periodic reassessment) of overall program effectiveness.	0. Not known. 1. There has not been an assessment of the effectiveness of the community paramedicine program. 2. There has been at least one formal written assessment of the effectiveness of the community paramedicine program. 3. Program effectiveness is assessed on at least an annual basis and formal reports are generated. 4. There is an ongoing program assessment and formal reports are published annually and distributed to all stakeholders including: patients/clients, oversight bodies, funding sources, and the general public. 5. There is ongoing assessment of multiple program objective outcomes over time as the outcomes relate to changes within the program for specific program interventions.

The out of Hospital Paramedic Care Program scored a “1” for this section. The program has been designed to be assessed once the program begins. Once the program is initiated, on-going assessment of the original program will continue.

Indicator

102.4 The community paramedicine program has undergone an external independent analysis of all aspects of the program.

Scoring

- 0. Not known.
- 1. No external examination of the community paramedicine program overall or individual components has occurred.
- 2. An external assessment is in the planning stages.
- 3. An external assessment is scheduled and/or has been completed and the agency is awaiting the formal report.
- 4. An outside group of community paramedicine system “experts” has conducted a formal community paramedicine external assessment and has made specific recommendations to the system.
- 5. Independent external reassessment occurs regularly, at least every 5 years.

The out of Hospital Paramedic Care Program scored a “4” for this section. The program has received external review and recommendations by the Emergency Health System (EHS) of Nova Scotia. There are future plans to have further external assessments as the program is implemented.

Benchmark 103: *The community paramedicine program assesses and monitors its value to its constituents in terms of cost-benefit analysis and societal investment.*

Benchmark Median Score: 3

Indicator

103.1 The benefits of the community paramedicine program, in terms of cost savings, decreased EMS transports, decreased hospital visits, improved health/wellness, and so on, are described.

Scoring

- 0. Not known.
- 1. There are no cost data from the EIS database, or other sources, available to calculate the program's benefits.
- 2. Community paramedicine costs are included in the EIS that can serve as the basis for these calculations.
- 3. Additional sources of data, in terms of other economic and quality of life measures, (e.g., reduction in return hospital visits / readmissions, fewer 911 calls, shorter return to work interval, etc.) are available.
- 4. **Cost and quality of life measures can be analyzed and presented in descriptive and graphic form.**
- 5. A series of reports and fact sheets are available and regularly updated to descriptively and graphically illustrate the costs and benefits of the community

The out of Hospital Paramedic Care Program scored a "4" for this section. The program is designed to provide the benefits of the program through reporting. As the program progresses further reporting will be available.

Indicator

103.2 Cases that document the societal benefit are reported on so the community sees and hears the benefit of the community paramedicine program while simultaneously protecting patient privacy.

Scoring

0. Not known.
1. No effort is made to gather, catalogue, or report cases that document the benefits of the community paramedicine program so that the community sees and hears the benefit of the program to society.
2. Dramatic improvements in wellness and functional outcome returns are documented sporadically or within various components of the program.
3. Cases concerning dramatic improvements in wellness and return to a quality life are on file (at a system level) but not reported unless asked for by the press.
4. Cases concerning dramatic improvements in wellness and return to a quality life are on file (at a system level) and are reported to the press.
5. Cases are used as part of information fact sheets that are distributed to the press and other segments of the community. These information fact sheets document the cost-benefit of the community paramedicine program to the community.

The out of Hospital Paramedic Care Program scored a “2” for this section. The program is designed to allow promotion of the program’s dramatic outcomes. As the program is initiated, reported and researched there will be case discussion and promotion.

Indicator

103.3 An assessment of the interests of public officials concerning community paramedicine program information has been conducted and communications mechanism developed based on the results of the assessment.

Scoring

- 0. Not known.
- 1. There is no routine or planned contact with the public officials.
- 2. Plans are in place to feed information to public officials in response to a particular event.
- 3. Public officials have been formally asked about what types of information would be helpful in reporting on community paramedicine and community health issues.
- 4. Information resources for public officials have been developed, based on the stated needs of the public officials; public official representatives are included in community paramedicine informational events.
- 5. In addition to routine public official contact, public officials are involved in various oversight activities such as the community paramedicine advisory council.

The out of Hospital Paramedic Care Program scored a “3” for this section. The program is designed to cooperate with public officials in regards to the program’s progress. As public officials institute required information guidelines, the program’s staff will collaborate.

Indicator**Scoring**

103.4 An assessment of the needs of health insurers/payers concerning community paramedicine program information has been conducted and communications mechanism developed based on the results of the assessment

0. Not known.
1. There is no routine or planned contact with health insurers/payers.
2. Plans are in place to provide information to health insurers/payers during a response to a particular payment, reimbursement, and cost issue.
3. Health insurers/payers have been formally asked about what types of information would be helpful in reporting on community paramedicine cases and issues to assist them in payment determinations.
4. Information resources for health insurers/payers have been developed based on the stated needs of the insurers; insurance representatives/payers are included in community paramedicine informational events.
5. In addition to routine contact, health insurers/payers are involved in various oversight activities such as the community paramedicine advisory councils.

The out of Hospital Paramedic Care Program scored a “3” for this section. The program is designed to collaborate with insures and payers to provide information to create payment structures for community paramedicine. As the program evolves it is designed to incorporate insures and payers in oversight activities over the next year.

Indicator

103.5 An assessment of the needs of the general medical community, including physicians, nurses, prehospital care providers, and others, concerning community paramedicine program information has been conducted and communications mechanism developed based on the results of the assessment.

Scoring

0. Not known.
1. There is no routine or planned contact with the broad medical community.
2. Plans are in place to provide information to the broad medical community in response to a community paramedicine event or issue.
3. **The broad medical community has been formally asked about what types of information would be helpful in reporting on community paramedicine events and issues.**
4. Information resources for the general medical community have been developed based on the stated needs of the general medical community; general medical community representatives are included in community paramedicine informational events.
5. In addition to routine contact, the broad medical community is involved in various oversight activities such as the community paramedicine advisory council.

The out of Hospital Paramedic Care Program scored a “3” for this section. The program is designed to collaborate with the needs of the general medical community and as the program proceeds and creates data, there will be routine contact initiated with the broader medical community to allow education and oversight over the next few years.

200: Policy Development

Promoting the use of scientific knowledge in decision making that includes building constituencies, identifying needs and setting priorities, legislative authority and funding to develop plans and policies to address needs, and ensuring the public's health and safety.

Benchmark Median Score: 3

Benchmark 201: *Comprehensive statutory authority and administrative rules support community paramedicine program infrastructure, planning, provision, oversight, and future development.*

Benchmark Median Score: 2

Indicator	Scoring
201.1 Community paramedicine activities are allowable/supportable within EMS regulations, licensure, certification, and scope of practice.	0. Not known. 1. No effort has been made to inform the state EMS agency concerning community paramedicine program activities to determine if such activities are allowable within the state's regulations. 2. The state EMS agency has been made aware of the community paramedicine program but has not confirmed that the program is operating within state regulations. 3. The EMS agency has approved the community paramedicine program on a "pilot" or other restricted basis. 4. The EMS agency has approved the community paramedicine program without any restrictions. 5. Specific statutes, rules, and regulations govern community paramedicine programs statewide.

The out of Hospital Paramedic Care Program scored a "2" for this section. The program is designed to provide OEMS with openness and collaboration to begin as a pilot/special project waiver. Once approved the program will score "3" and continue to monitor and cooperate with OEMS for regulatory oversight.

Indicator**Scoring**

201.2 The community paramedicine program is not in conflict with other licensing agencies or authorities, including: nursing, physician assistants, home health care, primary care, or others.

0. Not known.

1. No effort has been made to inform the state regulatory agencies governing nursing, advanced practice nurses, physician assistants, home health care providers, primary care, or others concerning community paramedicine program activities to determine if such activities are allowable within the state's regulations.

2. The regulatory agencies governing nursing, physician assistants, home health care, primary care, or others has been made aware of the community paramedicine program but has not confirmed that the program is operating within state regulations.

3. The regulatory agencies governing nursing, physician assistants, home health care, primary care, or others have approved the community paramedicine program on a "pilot" or other restricted basis.

4. The regulatory agencies governing nursing, physician assistants, home health care, primary care, or others have approved the community paramedicine program without any restrictions.

5. Specific statutes, rules, and regulations govern community paramedicine programs statewide.

The out of Hospital Paramedic Care Program scored a "2" for this section. The program is designed to work with OEMS and other regulatory agencies in regards to regulatory oversight. Agency regulators are aware of the program's intent and that it will be operating as a special project by OEMS.

Benchmark 202: Community paramedicine program leaders (sponsoring agency, community paramedicine personnel, and/or other stakeholders) use a process to establish, maintain, and constantly evaluate and improve a community paramedicine program in cooperation with medical, payer, professional, governmental, regulatory, and citizen organizations.

Benchmark Median Score: 5

Indicator

202.1 The program leaders have developed and implemented a multidisciplinary, multi-agency advisory committee to provide overall guidance to the community paramedicine planning and implementation strategies. The committee meets regularly and is in compliance with local or state open-meeting or transparency regulations and protects patient privacy.

Scoring

- 0.** Not known.
- 1.** There is no community-wide multidisciplinary, multi-agency advisory committee providing guidance to the program leadership in planning and developing a community paramedicine program.
- 2.** There is no community-wide multidisciplinary, multi-agency advisory committee and attempts to organize one have not been successful but are continuing.
- 3.** There is a community-wide multidisciplinary, multi-agency advisory committee, but its meetings are infrequent and guidance to the community paramedicine program is not always sought or available. Collaborative working arrangements are not apparent.
- 4.** There is a community-wide multidisciplinary, multi-agency advisory committee. Committee members and stakeholders regularly attend meetings. Collaboration and consensus concerning the role and direction of the community paramedicine program are beginning.
- 5.** There is a community-wide multidisciplinary, multi-agency advisory committee with well-defined goals and responsibilities relative to the development and oversight of the community paramedicine program that meets regularly. The committee routinely provides guidance and assistance to the community paramedicine program on system and program issues. There is strong evidence of consensus building among system participants. The committee is in compliance with all open meeting or transparency regulations and protects patient privacy.

The out of Hospital Paramedic Care Program scored a "5" for this section. OEMS has created the EMCAB Community Care and Education Committee as this agency.

Indicator**Scoring**

202.2 A clearly defined and easily understood structure is in place for the community paramedicine program decision-making process at the local administrative level to continually improve the program.

0. Not known.

1. There is no defined decision-making process (written policy and procedure) regarding the community paramedicine program within the sponsoring agency or its committees.

2. There is an unwritten decision-making process that stakeholders use when convenient, although not regularly or consistently.

3. The decision-making process is articulated within the community paramedicine program plan, although it has not been fully implemented. Policies are not written.

4. The decision-making process is contained within the community paramedicine program plan, and there are current policies and procedures in place to guide decision making. Use of the decision-making process is infrequent.

5. There is a clearly defined process for making decisions affecting the community paramedicine program. The process is articulated in the community paramedicine program plan and is further identified within system policies. Stakeholders know and understand the process and use it to resolve issues and to improve the program.

The out of Hospital Paramedic Care Program scored a “5” for this section. Along with the program’s Medical Direction, Advisory and Operations committees have processes in place to resolve issues and improve the programs efficiency.

Indicator

202.3 Community paramedicine program Leaders have adopted and use goals and objectives that are specific, realistic, measurable, attainable and timely for the community paramedicine program.

Scoring

- 0. Not known.
- 1. There are no goals or time specific quantifiable and measurable objectives for the program
- 2. Community paramedicine program leaders have met to discuss time specific quantifiable goals.
- 3. Community paramedicine program leaders are beginning the process of identifying measurable program goals and outcome based, time specific quantifiable and measurable objectives.
- 4. Community paramedicine program leaders have adopted program goals and outcome based, time specific quantifiable and measurable objectives.
- 5. Community paramedicine program leaders in consultation with their community-wide multidisciplinary, multi-agency advisory committee have established measurable program goals and outcome based, time specific quantifiable and measurable objectives that guide the system effectiveness and program performance.

The out of Hospital Paramedic Care Program scored a “4” for this section. The program is designed around the CCA patient population. By providing care to this population, the program is based on providing increased care to patients outside of hospitals, increased patient satisfaction and an overall savings to healthcare. Once the program can prove itself as functional, EasCare will seek to present new models of care using the information found in this program to other communities and multi-agency advisory committees as they evolve.

Indicator

202.4 The Community paramedicine program Leaders has comprehensive protocols that guide personnel to ensure consistency of care delivered, to decrease unwarranted variation in care and to ensure patient care activities remain within the scope of practice boundaries.

Scoring

- 0. Not known.
- 1. There are no protocols to guide the personnel.
- 2. Community paramedicine personnel operate under the protocols for general emergency care response as approved by the agency's medical director.
- 3. Specific protocols for community paramedicine activities that are outside the general care response activities of the agency are being drafted.
- 4. Specific protocols for community paramedicine have been drafted and are under review.
- 5. Specific protocols for community paramedicine activities have been formally adopted and guide the assessment and treatment of patients/clients and serve as the basis for ongoing performance improvement.

The out of Hospital Paramedic Care Program scored a "5" for this section. The program has "specific protocols for community paramedicine activities have been formally adopted and guide the assessment and treatment of patients/clients and serve as the basis for ongoing performance improvement". These protocols are approved by the EasCare medical director and the CCA medical director of the program.

Indicator	Score
202.5 The community paramedicine program assures confidential (HIPAA compliant) two-way communication of patient care records related to the program's care between the program providers and the affiliated hospital/physician/medical home providers.	0. Not known. 1. No formal exchange of patient/client information occurs between community paramedicine and other health care providers. 2. There is an informal, one way transmission of health care information from the community paramedicine providers and other health care providers and entities. 3. There is a formal written policy that governs the one way transmission of health care information from the community paramedicine providers and other health care providers and entities. 4. There is informal, two way transmission of health care information between community paramedicine and other health care providers and entities. 5. There is a formal written policy, HIPAA compliant, that governs the two way transmission of health care information between community paramedicine and other health care providers. Community paramedicine personnel have received specific training in HIPAA compliance.

The out of Hospital Paramedic Care Program scored a "5" for this section. There is a HIPAA Compliant policy in place between all stakeholders. The program staff will be trained in regards to HIPAA once hired.

Indicator	Score
202.6 The exchange of data and any peer review or performance improvement processes are protected from discoverability.	0. Not known. 1. The community paramedicine program does not engage in any peer review or performance improvement activity. 2. The community paramedicine program conducts peer review and performance improvement under the rules and regulations pertaining to such protection for traditional EMS activities. There is no formal engagement with other health care providers in these activities. 3. The community paramedicine personnel actively engage in multi-disciplinary, multi-agency peer review under the rules and regulations pertaining to such protection for traditional EMS activities. 4. Multi-disciplinary, multi-agency peer review including community paramedicine personnel is conducted at a non-EMS location, e.g. hospital, under the protection from discoverability outlined for that entity. 5. Specific peer review and performance improvement protection exist in state statute, rule, or regulation for multi-disciplinary, multi-agency peer review including community paramedicine programs.

The out of Hospital Paramedic Care Program scored a “4” for this section. Due to specific state statutes, EMS personnel are not protected from discoverability during peer review. (for example M&M Rounds are not protected)

Benchmark 203: *The community paramedicine program has a comprehensive written plan based on community needs. The plan integrates the community paramedicine program with all aspects of community health including, but not limited to: EMS, public health, primary care, hospitals, psychiatric medicine, social service and other key providers. The written community paramedicine program plan is developed in collaboration with community partners and stakeholders.*

Benchmark Median Score: 4.5

- | | |
|--|--|
| <p>203.1 Community paramedicine program, in concert with a multidisciplinary, multi-agency advisory committee, has adopted a community paramedicine program plan.</p> | <p>0 Not known.</p> <p>1 There is no community paramedicine program plan, and one is not in progress.</p> <p>2 There is no community paramedicine program plan, although some individuals or groups have begun meeting to discuss the development of a community paramedicine program plan.</p> <p>3 A community paramedicine program plan was developed and adopted by the sponsoring agency. The plan, however, has not been endorsed by community paramedicine stakeholders.</p> <p>4 A community paramedicine program plan has been adopted, developed with a multidisciplinary, multi-agency advisory committee, and has been endorsed by the respective agencies.</p> <p>5 A comprehensive community paramedicine program plan has been developed, adopted in conjunction with community stakeholders, and includes the integration of other systems (e.g., EMS, public health, community health, and primary care).</p> |
|--|--|

The out of Hospital Paramedic Care Program scored a “4” for this section. The program is designed around the CCA patient population .The CCA has multi-disciplinary agencies amongst its own agency (VNA, Home health, 911 access) and currently function to fulfill this requirement. Once the program can prove its functionality, EasCare will seek to present new models of care using the information found in this program to other traditional communities and populations.

Indicator

203.2 The community paramedicine program plan clearly describes the system design (including the components necessary to have an integrated program) and is used to guide system implementation and management. For example, the plan includes references to regulatory standards and documents and includes methods of data collection and analysis.

Scoring

- 0. Not known.
- 1. There is no community paramedicine program plan.
- 2. The community paramedicine program plan does not address or incorporate the parallel and convergent resources (prehospital, communication, transportation, acute care, rehabilitation, and others), nor is it inclusive of all-hazards preparedness or public health/community health integration.
- 3. The community paramedicine program plan provides general information about all the program activities including all-hazards preparedness, EMS, and public health/community health integration; however, it is difficult to determine who is responsible and accountable for the community paramedicine programs performance and implementation.
- 4. The community paramedicine program plan addresses every component of a well-organized and functioning program including all-hazards preparedness and public health/community health integration. Specific information on each component is provided, and the program design is inclusive of providing for specific goals and objectives for system performance.
- 5. The community paramedicine program plan is used to guide system implementation and management. Stakeholders and policy leaders are familiar with the plan and its components and use the plan to monitor system progress and to measure results.

The out of Hospital Paramedic Care Program scored a “5” for this section. Through data analysis, the program is designed to be able to change through the Operations and Advisory committees.

Benchmark 204: *Sufficient resources, including those both financial and infrastructure related, support program planning, implementation, and maintenance.*

Benchmark Median Score: 5

Indicator	Score
204.1 The community paramedicine program plan clearly identifies the human resources and equipment necessary to develop, implement, and manage the community paramedicine program both clinically and administratively.	0. Not known. 1. There is no method of assessing available resources or of identifying resource deficiencies in either the clinical or administrative areas of the community paramedicine program. 2. The community paramedicine program plan addresses resource needs and identifies gaps in resources within the community health system, but no mechanism for correcting resource deficiencies has been identified. 3. Resource needs are identified, and a draft plan, inclusive of goals and timelines, has been prepared to address the resource needs. The plan has not been implemented. 4. Resource needs are clearly identified, and action plans are being implemented to correct deficiencies in both clinical areas and administrative support functions. 5. A resource assessment survey has been completed and is incorporated into the community paramedicine program plan. Goals and measurable objectives to reduce or eliminate resource deficiencies have been implemented. Evaluation of progress on meeting resource needs is evident and, when necessary, the plan has been adopted.

The out of Hospital Paramedic Care Program scored a “5” for this section. Assessments are in place to provide measurement and control of resource deficiencies.

Indicator

204.2 Financial resources exist that support the planning, implementation, and ongoing management of the administrative and clinical care components of the community paramedicine program.

Scoring

- 0.** Not known.
- 1.** There is no funding to support the community paramedicine program planning, implementation, or ongoing management and operations for either program administration or community paramedicine clinical care.
- 2.** Some funding for the community paramedicine program has been identified, e.g. grants, but ongoing support for administration and clinical care outside of the third-party reimbursement structure is not available.
- 3.** There is current funding for the development of the community paramedicine program within the sponsoring agency organization consistent with the community paramedicine program plan, but costs to support clinical care support services have not been identified (transportation, communication, uncompensated care, standby fees, and others). No ongoing commitment of funding has been secured.
- 4.** There is funding available for both administrative and clinical components of the community paramedicine program plan. A mechanism to assess needs among various activities has begun. Implementation costs and ongoing support costs of the sponsoring agency have been addressed within the plan.
- 5.** A stable (consistent) source of reliable funding for the development, operations, and management of the community paramedicine program (clinical care and lead agency administration) has been identified and is being used to support planning, implementation, maintenance and ongoing program enhancements.

The out of Hospital Paramedic Care Program scored a “5” for this section. The program has been reviewed by the CFOs of EasCare, Medavie and the CCA to ensure a stable source of funding.

Indicator

204.3 Operational budgets (program administration and operations and in-field operations) are aligned with the community paramedicine program plan and priorities.

Scoring

- 0. Not known.
- 1. There are no operational budgets.
- 2. There are limited operational budgets not sufficient to cover related program costs for the EMS system.
- 3. There are operational budgets that may be sufficient to cover most program costs, but they are without regard to the community paramedicine program plan or priorities.
- 4. There are operational budgets that have some ties to the community paramedicine program plan and that include consideration for the extraordinary costs to the system (e.g. providers).
- 5. An operational budget exists for each component in the plan and matches system needs and priorities with program and operational expenditures.

The out of Hospital Paramedic Care Program scored a “5” for this section. The budget has been established based on the requirements of the program.

Benchmark 205: *Collected data are used to evaluate system performance and to develop public policy.*

Benchmark Median Score: 5

Indicator

205.1 The community paramedicine program electronic information systems (EIS) is used to assess system performance, to measure system compliance with applicable standards, and to allocate program resources to areas of need or to acquire new resources.

Scoring

0. Not known.
1. There is no community paramedicine EIS.
2. There is a limited community paramedicine EIS consisting of a patient registry, but no data extraction is used to identify resource needs, to establish performance standards, or to routinely assess and evaluate program effectiveness.
3. There is a community paramedicine EIS that routinely reports (written, on-line, or electronic) on system-wide management performance and compliance. Linkage between management reports, resource utilization, and performance measures has begun.
4. Routine community paramedicine EIS reports are issued at the community as well as at the provider level. Reports focus on management strengths, compliance with standards, and resource utilization. Trends are used to improve system efficiency and performance.
5. Community paramedicine EIS reports are used extensively to improve and report on program performance. The sponsoring agency issues regular and routine reports to providers. Program leaders assess reports to determine deficiencies and to allocate resources to areas of greatest need. Program performance and standard compliance are assessed and reported.

The out of Hospital Paramedic Care Program scored a “5” for this section. The program has implemented routine reporting for continuous review and proactive improvements.

Indicator

Scoring

205.2 Continuing education for community paramedicine providers is developed based on review and evaluation of EIS data.

0. Not known.
1. There is no correlation between training programs for providers and the community paramedicine EIS.
2. There is limited use of community paramedicine EIS reports to target educational opportunities.
3. There is evidence that some providers are using community paramedicine EIS reports to identify educational needs and to incorporate them into training programs.
4. Many educational forums have been conducted based on an analysis of the performance data in the community paramedicine EIS. Clear ties link education of providers with identified areas of need from the EIS reports.
5. Routine analysis of community paramedicine information and educational opportunities is being conducted. Integrated program objectives tying program performance and education are implemented and routinely evaluated. Regular updates to community paramedicine information and education are available. Community paramedicine EIS data are used to measure outcomes and effectiveness.

The out of Hospital Paramedic Care Program scored a “5” for this section. Once the program is implemented, the routine analysis will provide education guidance and measure the outcomes and effectiveness of the program.

Indicator

205.3 Community paramedicine leaders, including the multidisciplinary, multi-agency advisory committee, regularly review system performance reports and system compliance information to monitor community paramedicine program performance and to determine the need for program modifications.

Scoring**0. Not known.**

1. There is no community paramedicine specific multidisciplinary, multi-agency advisory committee, and there are no regular reports of system performance.

2. There is a community paramedicine program community-wide multidisciplinary, multi-agency advisory committee, but it does not routinely review program data reports.

3. The community paramedicine program community-wide multidisciplinary, multi-agency committee meets regularly and reviews process-type reports; no critical assessment of program performance has been completed.

4. The community paramedicine program community-wide multidisciplinary, multi-agency advisory committee meets regularly and routinely assesses reports from community paramedicine data to determine program compliance and operational issue needing attention.

5. The community paramedicine program community-wide multidisciplinary, multi-agency advisory committee and related stakeholder groups meet regularly and review data reports to assess program performance over time looking for ways to improve effectiveness and patient outcomes.

The out of Hospital Paramedic Care Program scored a “5” for this section. Once the program is implemented, the community paramedicine program community-wide multidisciplinary, multi-agency advisory committee and related stakeholder groups will meet regularly and review data reports to assess program performance over time looking for ways to improve effectiveness and patient outcomes.

Benchmark 206: *The community paramedicine, EMS, public health, community health, and primary care systems are closely linked and working toward a common goal.*

Benchmark Median Score: 3

Indicator

Scoring

206.1 The community paramedicine program, EMS, public health and community health system, and primary care leaders have established linkages including programs with an emphasis on population-based public health surveillance and evaluation for acute and chronic disease prevention and health promotion.

0. Not known.

1. No community health risk assessments are conducted.

2. Community paramedicine program officials conduct health risk assessments; however, there is no involvement of EMS, community health, public health, or primary care officials in those assessments.

3. Public health/community health officials along with EMS, primary care providers, and community paramedicine participants assist with the design of community risk assessments.

4. Public health/community health officials along with EMS, primary care providers, and community paramedicine participants assist with the design and analysis of community risk assessments.

5. The public health/community health epidemiologist along with EMS, primary care providers, and community paramedicine participants is involved in the development of risk assessment reports. There is clear evidence of data sharing, data linkage, and well-defined reporting roles and responsibilities.

The out of Hospital Paramedic Care Program scored a “3” for this section. Due to OEMS creating the EMCAB Community Care and Education Committee, EMS has begun to participate more diligently along with Public health/community health official, primary care providers, and community paramedicine participants to assist with the design of community risk assessments. As this evolves EasCare and CCA will also participate.

300: Assurance

Assurance to constituents that services necessary to achieve agreed-on goals are provided by encouraging actions of others (public or private), requiring action through regulation, or providing services directly.

Benchmark Median Score: 4

Benchmark 301: *The electronic information system (EIS) is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the community paramedicine.*

Benchmark Median Score: 4.5

Indicator

Scoring

301.1 The community paramedicine program collects and uses patient data as well as provider data to assess system performance and to improve quality of care.

0. Not known.

1. Patient care data are not collected electronically by the program.

2. Patient care data are collected electronically but are not used to assess system performance or quality of care.

3. Patient care data are collected electronically and are used to assess system performance.

4. Patient care data are collected electronically and are used to assess both system performance and to improve quality of care across the program.

5. Patient care data are used to identify and meet additional health care/social welfare as they are identified.

The out of Hospital Paramedic Care Program scored a “5” for this section. Once data is

Indicator

301.2 Community paramedicine care providers collect patient care and administrative data for each episode of care and provide these data to the community paramedicine program which is evaluated including monitoring trends and identifying outliers.

Scoring

- 0. Not known.
- 1. There is no jurisdiction-wide community paramedicine data collection.
- 2. Community paramedicine providers have a patient care record for each episode of care, but it is not yet automated or integrated with the community paramedicine EIS.
- 3. The community paramedicine patient care record electronically captures patient care provided by field personnel and can be transferred or entered into the community paramedicine EIS.
- 4. The community paramedicine patient data system is integrated into the community paramedicine EIS and is used by community paramedicine and other health care personnel to review and evaluate community paramedicine system performance.
- 5. The community paramedicine patient data system is fully integrated with all affiliated health care entities and with the public health surveillance system to help monitor community health needs.

The out of Hospital Paramedic Care Program scored a “4” for this section. As the public health and affiliated health care entities become more capable of sharing data, EasCare and the CCA will work along with them to provide information.

Benchmark 302: *The financial aspects of the community paramedicine program are integrated into the overall performance improvement system to ensure ongoing “fine-tuning” and cost-effectiveness.*

Benchmark Median Score: 5

Indicator	Scoring
302.1 Cost data are collected and provided to the community paramedicine program EIS for each major component of the program.	0. Not known. 1. No cost data are collected. 2. Administrative and program cost data are collected and included in the annual community paramedicine program report. 3. In addition to administrative and program costs, clinical charges and costs are included in one or more major component areas and are provided to the community paramedicine EIS for inclusion in the annual community paramedicine program report. 4. The costs associated with individual system components, for example, home visitation, can be determined and are provided to the EIS registry for inclusion in the annual community paramedicine program report. 5. The cost of an aggregate system can be determined and is provided to the system registry for inclusion in the annual community paramedicine program report.

The out of Hospital Paramedic Care Program scored a “5” for this section. As some financial information will be protected as proprietary information, overall healthcare savings as directly related to the paramedic out of hospital care program will be shared publicly.

Indicator**Scoring**

302.2 Cost, charge, collection, and reimbursement data are aggregated with other data sources including insurers and data system costs and are included in annual community paramedicine program reports.

- 0. Not known.
- 1. No outside financial data are captured.
- 2. Outside financial data are collected from one or more sources (e.g. Medicaid or private insurers).
- 3. Extensive financial data, for example, cost, charge, collection, and reimbursement, are routinely collected from the hospital, registry data, or more sources. Sufficient expertise is available to the community paramedicine program to analyze and report complex fiscal data.
- 4. Outside financial data are combined with internal community paramedicine program data and are used to estimate total program costs.
- 5. Outside financial data are combined with internal community paramedicine program data and are used to estimate total system costs. These financial data are described in detail in the annual community paramedicine program report.

The out of Hospital Paramedic Care Program scored a “5” for this section. As some financial information will be protected as proprietary information, overall healthcare savings as directly related to the paramedic out of hospital care will be shared publicly.

Indicator

302.3 Financial data are combined with other cost, outcome, or surrogate measures, for example, avoidance of EMS transports, avoidance of hospital visits, improved wellness measures, and others, to estimate and track true system costs and cost benefits.

Scoring

- 0.** Not known.
- 1.** No nonfinancial burden of disease costs and outcome measures are collected or modeled.
- 2.** Estimated savings using various burdens of disease costs or outcome measure models are calculated for all community paramedicine programs.
- 3.** Estimated savings using various burdens of disease costs or outcome measure models are calculated for actual community paramedicine program costs.
- 4.** Estimated savings using various burdens of disease costs or outcome measure models are calculated for all community paramedicine programs and activities and are combined with other system cost data to determine costs and savings of the total system.
- 5.** Estimated savings using various burdens of disease costs or outcome measure models are calculated for all community paramedicine programs and activities, are combined with actual system cost data to determine costs and savings of the total system, and are described in detail in the annual community paramedicine program report.

The out of Hospital Paramedic Care Program scored a “5” for this section. As some financial information will be protected as proprietary information, overall healthcare savings as directly related to the paramedic out of hospital care, will be shared publicly.

Benchmark 303: *The community paramedicine program ensures competent medical oversight.*

Benchmark Median Score: 3

Indicator

Scoring

303.1 There is authority for a community paramedicine medical director and a clear job description, including requisite education, training, and certification, for this position.

The out of Hospital Paramedic Care Program Scored a "3" for this section. Credentialing for medical directors as community a paramedicine medical director does not exist. But as certification and training becomes available and required, the program will become compliant.

0. Not known.

1. There is no requirement for a community paramedicine program medical director, and no job description has been developed.

2. There is an EMS agency medical director that serves as medical director for the community paramedicine program, but no job description or expectations have been formally developed beyond those required of an EMS agency medical director.

3. There is authority for a community paramedicine program medical director, a job description, and expectations have been developed. This individual may or may not also serve as the EMS agency medical director.

4. There is authority for a community paramedicine program medical director, and the job description, including requisite education, training, and certification for the community paramedicine program medical director, is clear. A physician appropriately credentialed has been hired, and the job classification is routinely assessed for appropriateness of the duties required.

5. If separate individuals, the EMS agency medical director and CP program medical director regularly meet together with program leadership to coordinate and integrate the EMS and CP aspects of the agency's services.

Benchmark 304: *The community paramedicine program is supported by an EMS system that includes communications, medical oversight, and transportation; the community paramedicine program, EMS system, and public health and community health agencies are well integrated.*

Benchmark Median Score: 5

Indicator

304.1 There is clear-cut legal authority and responsibility for the community paramedicine program medical director including the authority to adopt protocols, implement a performance improvement system, ensure appropriate practice of community paramedicine providers, and generally ensure medical appropriateness of the community paramedicine program based on regulatory agency scope of practice and accepted standards of medical care.

Scoring

- 0.** Not known.
- 1.** There is no community paramedicine program medical director.
- 2.** There is a community paramedicine program medical director with a written job description; however, the individual has no specific legal authority or time allocated for those tasks.
- 3.** There is a community paramedicine program medical director with a written job description. The community program medical director has adopted protocols, implemented a performance improvement program, and is generally taking steps to improve the medical appropriateness of the community paramedicine program.
- 4.** There is a community paramedicine program medical director with a written job description and whose specific legal authorities and responsibilities are formally granted by law or by administrative rule.
- 5.** There is written evidence that the community paramedicine program medical director has, consistent with the formal authority, adopted protocols, implemented a performance improvement program, is restricting the practice of community paramedicine program providers (if indicated), is making significant efforts to improve the medical appropriateness of the community paramedicine program, and is working to fully integrate the program into the community health/primary care systems. Sufficient resources have been allocated for the medical director's participation and oversight to ensure that an appropriate amount of his/her time is dedicated to program responsibilities.

The out of Hospital Paramedic Care Program scored a "5" for this section. The program's Medical Director has been involved in all aspects of the program and will continue once implemented, to ensure program's patient-centric mission and success.

Benchmark 305: *The community paramedicine program ensures a competent and safe workforce.*

Benchmark Median Score: 4

Indicator

305.1 In cooperation with the prehospital certification and licensure authority, established guidelines exist for community paramedicine personnel for initial and ongoing training including community paramedicine specific courses.

Scoring

- 0.** Not known.
- 1.** There are no community paramedicine training guidelines for prehospital personnel as part of initial or ongoing certification or licensure.
- 2.** Some community paramedicine personnel have completed initial training using a state, national, or internationally accepted community paramedicine curriculum.
- 3.** All community paramedicine personnel that provide medical services to patients/clients have completed initial training using a state, national, or internationally accepted community paramedicine curriculum.
- 4.** The program has established continuing education (CE) requirements for all community paramedicine program providers that are specific to community paramedicine program skills. These CE requirements exceed the CE courses for EMS personnel in time required and must cover topics specific to the community paramedicine program.
- 5.** The community paramedicine program CE requirements are based upon identified knowledge or competency gaps in providers, are specific to address these gaps, and are altered over time to address newly identified gaps.

The out of Hospital Paramedic Care Program scored a “5” for this section. Due to the lack of availability for initial training using a state, national, or internationally accepted community paramedicine curriculum, the program has created an education program, under physician direction of the program medical director and CCA medical director while collaborating with other established community paramedicine services’ medical directors internationally.

Indicator**Scoring**

305.2 The community paramedicine program has established, with oversight by the medical director, a credentialing process that assures each community paramedicine provider has proven competence in performing the skills within the scope of practice.

0. Not known.

1. There is no credentialing process for community paramedicine personnel.

2. A written credentialing process has been developed that assures that the community paramedicine program is staffed by professional, reasonable, and well-trained individuals. This includes documentation of appropriate background checks and successful completion of required educational programs.

3. A credentialing process documents evaluation of competence performing at least three skills that are specific to the community paramedicine program beyond the skills of an EMS provider within the agency.

4. A credentialing process evaluates each community paramedicine program provider including a structured assessment of competence, professionalism, interpersonal communications skills, medical care, and system-based integration of healthcare resources.

5. In addition to local credentialing, state and/or national recognition in the form of certification or licensure has been attained for all community paramedicine personnel.

The out of Hospital Paramedic Care Program scored a "4" for this section. Due to the lack of availability for credentialing using a state and/or national recognition in the form of certification or licensure, the program has created t's own education. As certifications or licensures become required, the program will become compliant.

Indicator

305.3 Conduct at least one multidisciplinary community paramedicine/community health conference annually that encourages system and team approaches to community health.

Scoring

0. Not known.

1. There are no multidisciplinary community paramedicine conferences conducted within geographic boundaries of the community.

2. There are sporadic multidisciplinary community paramedicine conferences conducted.

3. Multidisciplinary community paramedicine conferences are conducted occasionally, and attendance by community paramedicine practitioners is monitored and reviewed.

4. Multidisciplinary community paramedicine conferences are conducted at least annually.

5. Multidisciplinary (EMS, physicians, nurses, physiatrists, policy makers, consumers, and others) community paramedicine conferences are conducted regularly, new findings from quality assurance and performance improvement processes are shared, and the conferences are open to all practitioners within the system. Regular attendance is required.

The out of Hospital Paramedic Care Program scored a "1" for this section. Due to the evolution of the community paramedicine model just being created, conferences will begin with time. Many members of the program at the administrative level attend national conferences involving community paramedicine.

Indicator

305.4 There are mechanisms within the system performance improvement processes to identify and correct systemic personnel deficiencies within the community paramedicine program.

Scoring

- 0. Not known.
- 1. There is no mechanism to identify through performance improvement processes systemic personnel deficiencies within the community paramedicine program.
- 2. The community paramedicine program has begun to identify systemic personnel deficiencies.
- 3. The community paramedic program has a mechanism to identify systemic personnel deficiencies and is working on a process for corrective action.
- 4. The community paramedic program has a mechanism to identify systemic personnel deficiencies and is instituting corrective actions across the program.
- 5. Community paramedicine leadership and other stakeholders, including hospitals and the lead agency, monitor and correct personnel deficiencies as identified through quality assurance and performance improvement processes. A method of corrective action has been instituted, and appropriate follow-up is occurring. Monitoring of program deficiencies and corrective actions is ongoing.

The out of Hospital Paramedic Care Program scored a “5” for this section. The program has instituted a CQI strategy with review of every community paramedic request and patient encounter. Thus allowing corrective actions for individuals and/ or the program as required.

Indicator**Scoring**

305.5 There are mechanisms in place within agency and institutional performance improvement processes to identify and correct deficiencies in practice patterns of individual practitioners within the community paramedicine programs.

0. Not known.

1. There is no mechanism in place to routinely assess the deficiencies in community paramedicine practice patterns of individual practitioners.

2. The community paramedicine program has begun a process to evaluate deficiencies in practice patterns of individual practitioners.

3. A mechanism is in place to monitor and report on deficiencies in practice patterns of individual practitioners within the community paramedicine program. The process is evolving as part of the quality assurance and performance improvement processes.

4. There is a well-defined process to assess care provided by practitioners within the community paramedicine program. The quality assurance and performance improvement processes identify deficiencies, and corrective action plans are instituted.

5. Practice patterns of individual practitioners performing outside the standards of care are routinely assessed by the medical director and sponsoring agency. Corrective actions (training, additional education, and disciplinary), as appropriate, are instituted, and trends are monitored and reported to the sponsoring agency and/or other licensing agency.

The out of Hospital Paramedic Care Program scored a "5" for this section, once operational. Medical Direction oversight will allow corrective actions for any practitioner performing outside the scope prescribed. All stakeholders will be updated on any and all corrective actions that are required.

Benchmark 306: *The program acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the community paramedicine program.*

Median Benchmark Score: 5

Indicator	Scoring
306.1 The program works in conjunction with the prehospital and other regulatory agencies to ensure that community paramedical care provided by licensed individuals is in compliance with any rules, regulations, or protocols specific to community paramedicine delivery.	0. Not known. 1. There is no evidence that the community paramedicine sponsoring agency and the prehospital regulatory agency work together to ensure appropriate provider agency licensure and compliance. 2. The community paramedicine sponsoring agency refers complaints concerning issues of prehospital agency performance to the prehospital regulatory agency. 3. The community paramedicine sponsoring agency and the prehospital regulatory agency work together to resolve complaints involving prehospital personnel performance. 4. The community paramedicine sponsoring and the prehospital regulatory agency work together to monitor compliance of prehospital providers with any rules, regulations, or protocols specific to prehospital practice. 5. The prehospital regulatory agency, working cooperatively with the community paramedicine sponsoring agency, is involved in ongoing community paramedicine program performance improvement processes and prehospital provider compliance with any rules, regulations, or protocols specific to prehospital practice.

The out of Hospital Paramedic Care Program scored a “5” for this section, once operational. It is understood that OEMS and the EMCAB Community Care and Education Committee will be involved with compliance and performance practices to assist and collaborate with instituting regulations.

Indicator	Scoring
306.2 The program refers issues of personnel noncompliance with laws, rules, and regulations to appropriate boards or licensure authorities.	0. Not known. 1. Individual personnel performance is not monitored. 2. Complaints about individual personnel noncompliance with laws, rules, and regulations go directly to appropriate boards or licensure authorities. 3. Community paramedicine sponsoring agency personnel collaborate actively with licensure authorities to resolve complaints involving individual personnel noncompliance with laws, rules, and regulations governing community paramedicine personnel. 4. Individual personnel performance issues are addressed within community paramedicine program's performance improvement processes unless they involve breaches of State or Federal statute. 5. Appropriate boards or licensure authorities are involved in the system performance improvement processes addressing individual personnel performance issues.

The out of Hospital Paramedic Care Program scored a "5" for this section, once operational. It is understood that OEMS and the EMCAB Community Care and Education Committee will be involved with system performance standards and will address personnel issues by referring issues of non-compliance.

EXHIBIT G

PLANNING TIMELINE FOR PROJECT

	EasCare Out of Hospital Care Timeline
2011	➤ EasCare assigned an internal team to begin researching alternative care models including Community Paramedicine in 2011
2012	➤ EasCare hosted strategic planning meetings and produced gap analysis based on current Massachusetts healthcare system ➤ EasCare began meetings with external healthcare executives to present potential partnership opportunities ➤ EasCare joined Medavie EMS (MEMS) family of companies based largely on their extensive track record in Community Paramedicine.
	➤ EasCare and MEMS began weekly working groups (clinical/operational) with Medical Director ➤ EasCare began talks with CCA for alternative healthcare models ➤ Discussed with Massachusetts OEMS to initiate a pilot program ➤ Submission of project to OEMS ➤ Working groups with CCA began to create program for home medication follow ups post discharge ➤ Developed an innovative proposal to improve health outcomes and reduce overall costs by increased clinical collaboration EasCare & CCA ➤ Initiated home medication follow up program EasCare & CCA ➤ Working groups initiated for Out of Hospital Paramedic Care program EasCare & CCA ➤ Developed an innovative proposal to improve health outcomes and reduce overall costs by increased clinical collaboration.
2014	➤ EasCare performs HRSA Community Paramedicine Evaluation ➤ EasCare & CCA present program to the OEMS EMCAB Community Care and Education Committee. Received approval to submit to OEMS Medical Services ➤ EasCare & CCA present program to OEMS Medical Services committee. Receive approval by committee and OEMS Director.

EXHIBIT H

EASCARE CONFLICT OF INTEREST POLICY

(107) Employment and Employee References

In our attempt to hire qualified employees, we will contact the references listed on the employment application as part of our quality control program. We also reserve the right to check with the appropriate Regional and State EMS Agencies to determine an applicant's EMS status.

Individuals presently employed by or who have ended their employment with EasCare and are in the process of obtaining other or additional employment may be in need of employment references. If EasCare is contacted by a potential employer as part of their application process we will only provide the following information:

- Confirmation of starting and ending dates of employment
- Verification of salary or hourly wages
- Employment position held during employment

(108) Conflict of Interest

All EasCare business activities must be performed without any perceived or actual conflict of interest while dealing with other EasCare employees and/or representatives from any other agency that is conducting business with EasCare.

Business dealings and transactions with any outside agency must be conducted in an ethical and professional manner. It must not under any circumstances result in any unusual gains for either party (EasCare or the other agency) associated with the business activity. Unusual gains may include but is not limited to bribes, product bonuses, special fringe benefits, unusual price breaks or other windfalls designed to ultimately benefit either the employer, employee or any representative(s) from the corresponding business or agency.

An actual or potential conflict of interest occurs when an employee is in a position to influence a decision that may result in a personal gain for an employee or for a relative as the result of a business transaction.

There is no "presumption of guilt" by the mere existence of said relationship with individuals from any outside businesses or agencies with whom we may conduct business with presently or in the future. However, when a situation exists where an employee may have any influence regarding transactions involving purchases, contracts, or leases etc. it must be brought to the immediate attention of a senior manager/officer. This will facilitate EasCare's ability to proceed with the business activity in a manner to eliminate the possible existence of any actual or potential conflict of interest in order to protect all parties involved.

Any other personal gain when an employee or relative becomes a recipient of a kickback, bribe, substantial gift or any other special consideration as a result of any business dealings or transactions involving EasCare.

EXHIBIT I

INFORMATION ON THE MEDICAL DIRECTORS

DR. DANIEL MUSE & DR. JOHN LOUGHNANE

DANIEL ARTHUR MUSE, MD

DANIEL ARTHUR MUSE
10 Nathaniel Way
Canton, Massachusetts. 02021
(781) 575-9913
(781) 530-7233
danmuse@comcast.net

EXPERIENCE:

EMERGENCY PHYSICIAN

September, 2007- Present	Brockton Hospital. Brockton, Massachusetts.
January, 1996- September, 2007	South Shore Hospital. Weymouth, Massachusetts.
September, 1995- October, 1997	Faulkner Hospital. Boston, Massachusetts.
January, 1994- August, 1995	University of Alabama Medical Center. Birmingham, Alabama.
July, 1993- August, 1995	Montgomery Regional Medical Center. Montgomery, Alabama.
July, 1990- June, 1993	Sutter General Hospital. Sacramento, California.

CONCUSSION MANAGEMENT

November 2010-Present	Program Director SPORTSMART: Sports health program Signature Healthcare, Brockton, Massachusetts Certified ImPact Consultant.
-----------------------	--

EMERGENCY MEDICAL SERVICES

March 2010-Present	Medical Director, Exodus/Eascare Ambulance, Brockton, Massachusetts
July 2008- Present	EMS Medical Director Brockton Hospital. Brockton, Massachusetts
January, 1991- June, 1993	EMS Medical Director Sutter General Hospital, Sacramento, California
September 1992- June, 1993	Medical Director. Sacramento City and Sacramento County Fire Departments. Sacramento, California

PEACE CORPS VOLUNTEER

February, 1980- February, 1981

Rural Health Specialist. San Cristobal Health Center. San Cristobal, Guatemala.

October, 1978- February, 1980

Health and Physical Education Specialist. San Salvador, El Salvador.

DANIEL ARTHUR MUSE, MD

EDUCATION:

July, 1987- June, 1990.

Emergency Medicine Residency Program. University of Massachusetts Medical Center. Worcester, Massachusetts.

July, 1983- June, 1987

Medical Degree. Chicago Medical School. North Chicago, Illinois.

September 1974- May, 1978

Bachelor of Arts. University of Massachusetts, Amherst. Political Science and Economics. Magna cum laude. Member of Phi Beta Kappa. Member of Pi Sigma Alpha, Political Science Honor Society. Commencement Speaker, University of Massachusetts, 1978.

September 1976- May 1977

Exchange Student. University of Alabama, Tuscaloosa, Alabama.

RESEARCH:

Research assistant to James Krueger, Ph.D. Chicago Medical School, North Chicago Illinois. Examined the transport of Muramyl Dipeptide (MDP), Sleep Factor S in rabbits.

PUBLICATIONS:

Muse, D.A.: "Conscious Sedation." In Harwood-Nuss, A.L., Linden, C.H., Luten, R.C., et al. The Clinical Practice of Emergency Medicine. J.B. Lippincott, 2nd edition, 1995.

DANIEL ARTHUR MUSE, MD

Muse, D.A. and Linden, C.H.: "Beta Blockers." In Harwood-Nuss, A.L., Linden, C.H., Luten, R.C., et al. The Clinical Practice of Emergency Medicine. J.B. Lippincott, 2nd edition, 1995.

Linden, C.H. and Muse, D.A.: "Hallucinogens." In Harwood-Nuss, A.L., Linden, C.H., Luten, R.C., et al. The Clinical Practice of Emergency Medicine. J.B. Lippincott, 2nd edition, 1995.

Muse, D.A. and Renzi, F.: "Cocaine." In Viccellio, P.H.. Handbook of Toxicology. Little Brown and Company, 1992

Linden, C.H. and Muse, D.A.: "Narcotics." In Viccellio, P.H.. Handbook of Toxicology. Little Brown and Company, 1992

CERTIFICATIONS:

Diplomate of the American Board of Emergency Medicine.
Fellow American Academy of Emergency Physicians.

COMMUNITY SERVICE:

2008-Present

Coordinate through St Gerard's Catholic Church, Canton, Massachusetts an outreach program to Canto Grande, Peru each May for college students.

2000-2009

Founder and President of Canton Youth Lacrosse.

2000-2004

Founder and President of the boys and girls Canton High School Lacrosse Club.

1993-2010

Youth hockey coach.

PERSONAL:

Born February 22, 1956.
Married with five children.

LANGUAGES:

Spanish.

John Loughnane, MD, serves as Senior Vice President for Medical Services for the Commonwealth Care Alliance Medical Group. In addition, Dr. Loughnane serves as Medical Director at Commonwealth Community Care, which he joined in 2009. He is also Medical Director of Commonwealth Care Alliance's Life Choices Palliative Care Program. He was also founder and Medical Director of the Commonwealth Care Alliance/Commonwealth Community Care Inpatient Service at Boston Medical Center. He is board certified in Family Medicine and Hospice and Palliative Care Medicine and is actively involved in research regarding patient-centered care at the end of life.

EXHIBIT J

NOTIFICATION LETTER TO PRIMARY AMBULANCE SERVICES

Gregory Davis REMT-P
EasCare LLC
500 Neponset Ave
Dorchester, MA 02122
July 14, 2014

[Recipient Name]
911-EMS Provider Director
[Company Name]
[Street Address]
[City, ST ZIP Code]

Dear **[Recipient Name]**:

Under the “Out of Hospital Paramedic Care” special project waiver provided by the Massachusetts Department of Public Health and Office of Emergency Medical Services, EasCare LLC and the Commonwealth Care Alliance (CCA) are writing to inform you of the program’s participation in your service area. This program will not impact your current delivery of EMS services.

The “Out of Hospital Paramedic Care” requires CCA patients to call 911 for emergencies. When patients call CCA to speak with their healthcare providers and 911 services are not required for treatment or transportation to an emergency department, the CCA will offer the “Out of Hospital Paramedic Care” program and EasCare Paramedics to provide care on scene. If at any time the Paramedic feels the patient requires transportation to an emergency room, your service will be requested to the scene for care. The EasCare Paramedic on scene will begin treatment under the Statewide Treatment Protocol and transfer care to your service or if requested assist with transport of the patient.

We look forward to assisting your service with education and updates of our program as we move forward with this patient centric care model. Please feel free to contact me with any questions that you may have.

Respectfully,

Gregory Davis REMT-P
Out of Hospital Paramedic Care
Program Director