MAINE EMS

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Solving the Paramedic Paradox

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Rural areas farthest from a hospital have the greatest need for emergency medical services yet have the most trouble maintaining those services.

"It's the rural paramedic paradox," says Kevin McGinnis, Director of Ambulance Services at Franklin Memorial Hospital in Farmington, Maine and former Maine State EMS Director. McGinnis is unwilling to leave it at that. "We know there are barriers. What we should all be doing in our little rural EMS labs is experimenting with new ways to provide service." He says that there are probably a number of models being tested, even if EMS services don't know they're testing them. "We should find those and figure out if they work.."

There are a number of models being tested around the United States. Some rural health advocates have called for a centralized database of what rural communities are doing and what they have learned. Such a resource could help communities tap into other ideas.

How well the various models work in solving the paradox will depend in large part on their ability to overcome the barriers McGinnis mentioned. Participants at a recent Capital Area Rural Health Roundtable identified and discussed the worst of them (*Rural EMS: Financing Preparedness* at http://rhr.gmu.edu/forums.html).

Rural EMS providers, like this one in Wells, Maine, face severe challenges in training and reimbursement.

Barriers to Rural EMS

Low volume; high fixed costs. The fact that a typical rural ambulance makes far fewer runs over the course of a year than a typical urban one means that the cost per run of the rural service is much higher. Likewise, a typical rural hospital emergency room, which sees far fewer patients than an urban hospital, has a higher per-visit cost. Why? It takes a certain amount of money to buy, maintain, and operate an ambulance or build, equip, and operate an emergency room no matter the number of times they are used. Many of the costs are "fixed".

The problem, of course, is that ambulance services are reimbursed on a per-call, not on a fixed-cost basis. For example, if a rural ambulance provider pays $100,000 for an ambulance (adding in staff, supplies, gas, oil, and maintenance can more than double that cost) and sends it out on 100 runs a year over its 10-year life span, it cost the provider $100 per run. But if the ambulance goes out on 200 runs per year, it only costs the provider $50 per run. Whether the ambulance service loses money, breaks even, or makes a profit depends on the per run reimbursement rate they receive from Medicare, private insurers, or the patients themselves.

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Paramedic Paradox

The further one moves from an emergency medical facility

The more one needs a higher level of local EMS capability

And the less likely that the EMS capability will be available

Rural Paramedicine Paradox

- Financially Less Supportable
  - Fixed Cost of Paid Crew
  - Availability of Volunteer Paramedics
- Operationally Less Supportable
  - Skill Retention

Community Paramedicine

Adapting EMS resources to address community health care and public health need not currently being met and embracing the “paramedicine paradox” as one of those needs.

Community Paramedicine

- **Community Paramedicine**
  - An organized system of services, based on local need, which are provided by EMTs and Paramedics integrated into the local or regional health care system, working with and in support of mid-level practitioner, nursing and other community health team colleagues and overseen by emergency and primary care physicians.

Community Paramedicine

- **Community Paramedicine**
  - This not only provides resources to address gaps in primary care/public health services, but enables the presence of EMS personnel for emergency response in low call-volume areas by providing routine use of their clinical skills and additional financial support from these non-EMS activities.

Evolving Concept…..

- **Community Paramedic**
  - A state licensed Paramedic who is certified as graduating from a recognized college program in community paramedicine and operates within the scope of practice for their licensure level as approved by the state under appropriate medical direction for the nature of their practice.

Community Paramedicine

- IS
  - A generic concept
  - A means to fill a temporary or on-going need
  - Expansion of EMS roles and services to assist community health team colleagues
  - Generally on an episodic, not case management, basis
- IS NOT
  - An expansion of EMS scope of practice
  - Just for the Paramedic license level….
  - The same in every (or any) community
  - Competing for community health roles, but leverages the 24/7 presence and mobility of EMS resources in the community

CP Models in Practice

- Community Paramedic Model
  - Licensed Paramedic
  - 100-200 Hour College-Based Program
  - Primary Care/Emergency Medicine Oversight
- Enabled/Extended Community Health Services Model
  - Licensed Providers Within Their Scope
  - Limited/Selected Services
  - Additional Training, and Oversight as Appropriate

Statutory Changes Needed in Maine to Implement program

- Needed EMS board approval to move forward with project
- Maine's Emergency Medical Services Act
- An emergency is " an unforeseen combination of circumstances or the resulting state that calls for immediate action.
- The provision of prompt, efficient and effective emergency medical care.

Statutory Changes Needed in Maine to Implement program

- EMS CP definition
- Episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition within the scope of practice of the licensee as specifically requested or directed by a physician.

Statutory Changes Needed in Maine to Implement program

- LD 1837 An Act to Authorize the Establishment of Pilot Projects for Community Paramedicine

This bill authorizes the Department of Public Safety, Emergency Medical Services' Board, in accordance with current rules of the board, to establish the requirements and application and approval process for community paramedicine pilot projects for the purpose of developing and evaluating the appropriateness of a community paramedicine program. The bill establishes minimum levels of medical oversight and requires reporting by the pilot project to the board. The board is required to report annually regarding the pilot projects to the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters.

Maine Project

- Collaboration:
  - Maine EMS (DPS)
  - Maine Office of Rural Health (DHHS)
- Components (Over 3 Years)
  - Develop Task Force
  - Develop Detailed Plan and Implementation Models
    - Health Gaps/ALS Gaps Assessment
    - Medical Direction/Quality Improvement Processes
    - Education Model and Mechanism
    - Prospective Research Methodology

Maine Project

- Components (continued)
  - Develop Pilot Program and Requirements
    - Current Paramedic Capacity
    - Relationship With Primary Care Practice Site
    - Willingness of Site To
      - Provide Medical Oversight/QI
      - Access Data on Patient Population
  - Solicit Pilot Sponsors
  - Assist Pilots to Establish Services
  - Evaluate Effectiveness of Pilots/Work With Payers

Maine Project Education Curriculum

- ***Role of the Community Paramedic in the Health Care System***
- ***Social Determinants of Health***
- ***Public Health and Primary Care Role of the Community Paramedic***
- ***Developing Cultural Competence***
- ***The Community Paramedic's Role Within the Community***
- ***The Community Paramedics Personal Safety & Wellness***
- ***The Clinical Experience***