

How REMSA's Nurse Health Line is changing EMS culture

The new Nurse Health Line has been a huge success, and the Reno, Nev. program is well on the way to becoming sustainable and a model for other agencies

By Cate Lecuyer, EMS1 Editor, May 27, 2014

When someone in Reno, Nevada is having a medical problem, many no longer call 911. Instead, they dial 858-1000, the number for the [Nurse Health Line](#) — open 24/7.

The nurses triage patients to appropriate services — regardless of insurance. If it's a real emergency, an ambulance gets dispatched, and they go the ER. Nothing changes.

But if it's not a real emergency, the patient may go to an urgent care center, or a mental health facility. A community paramedic may go to the home and help the person get the social services she needs, or line her up with a primary care physician.

The Nurse Health Line has been one of most rewarding aspects of a community paramedicine program launched by the Regional Emergency Medical Services Authority (REMSA) in Reno, Nev.

"This one has been shockingly successful," REMSA Medical Director Dr. Brad Lee said during the "Moving from Innovation to Sustainability in Community Paramedicine" session at the ZOLL Summit 2014 tradeshow in Denver.

When they launched the line in October 2013, organizers expected to receive about 2,400 calls per year. They currently field about 2,200 calls per month, which has led to a decrease in 911 calls.

Who's paying for it

The Nurse Health Hotline is just one part of a community paramedicine program that was started through funding from a [Centers for Medicare and Medicaid Services Health Care Innovation Grant](#).

The grant runs out in 2014, but efforts well underway to create a stable, sustainable program that other agencies can replicate, with the goal of saving the ambulance service \$10.5 million over the course of three years, Lee said.

"It probably won't be much of a problem saving that much money," he said.

For them, data collection has been a huge part of proving their worth and getting other agencies on board with the program. The numbers show how much the department is saving by not making ambulance runs, Lee said. And although Medicaid does not currently provide reimbursement for such calls, his team recently presented the community paramedicine program to state legislators with an aim to change that.

"Nevada Medicaid came to us, and asked us if we could testify so they could reimburse us," Lee said.

The data also has the potential to get hospitals to pay for the program by showing its effectiveness in reducing 30-day readmissions for acute myocardial infarction (heart attacks), heart failure and pneumonia, saving them from paying a penalty under the Affordable Care Act's Hospital Readmissions Reduction Program.

The numbers have already convinced local hospitals to bundle payments for the Nurse Health Line. One, for instance, had already established its own nurse health line, but 40 percent of those calls were still going to the ER. Lee and his team were able to show that their rate was more like 8 percent.

"They took a look at the cost savings and said, 'Yeah, we can see it, we'll go with you guys and pay you more,'" Lee said.

A slow rollout

When they first launched the program, they made sure to meet with all the stakeholders – from medical directors to nurses' unions — and as a result have not had any pushback from other agencies.

"Turn competitors into collaborators," Lee said.

They started the Nurse Health Line working exclusively with nursing homes for a few weeks. Then, they launched a media blitz that included television commercials depicting 911 calls that were not emergencies.

More people began calling. It's grown to the point where some doctors have started forwarding their own calls directly to the line, and are putting the phone number on promotional materials in their offices, Lee said.

Community paramedics also make home visits as part of the program, and doctors have started referring patients for that as well. The program is steadily rising, with about 20 new consultations being added each day. The community paramedic makes house calls based on severity; sometimes it's just a phone call.

"Our patients call us; we can't seem to get rid of them," Lee joked

A big part of those home visits involve community paramedics showing up within three days after patients are discharged from the hospital, which is a time-frame that's been identified to greatly reduce the chances of 30-day readmissions.

For now, the home visits are covered by grant funds, but Lee said his team is talking with hospitals about having them pay for it, since they're able to show how much they save in avoided penalties.

Not perfect — yet

The program, however, isn't without its nuances.

"For all transports, the patient has to consent, and the urgent care must consent," Lee said. "It's a little cumbersome. I'm not sure it will be the plan going forward, but that's what we do now."

But the reason isn't restricted to liability.

"The logistics are a nightmare," he said. REMSA is working with 13 different urgent care centers. Some close at 5 p.m., others close at 8 p.m.; some have X-Ray machines, others don't. By getting consent from both parties, they're able to tailor the destination based on factors like patient need, location and time of day.

Is this something EMS really wants to do?

When REMSA started the program, they asked for volunteer EMTs and paramedics.

"We took our best and brightest," Lee said.

Turns out, it wasn't the best and brightest idea.

"Paramedics go into paramedicine because they're adrenaline junkies," he said. There's no intubation, no lights and sirens in community paramedicine, and after a while some of those selected were really craving that fix."

REMSA has since tailored the program to select medics who are a little more empathetic, maybe a bit slower moving, and it's been more successful.

Changing the EMS culture

The ultimate goal, Lee said, is to stop over-triaging patients to the ER.

"If they call, we show up," he said. But when medics arrive and determine it's not actually an emergency, they're shifting to more of a 'what can we do to not take you to the ER' mindset.

REMSA's eventually hopes to balance trips to the ER with ambulance transport alternatives such as urgent care centers, clinics, community triage centers or mental health facilities. But they're still taking a conservative approach, with both the transports, and the data.

And still, the numbers speak for themselves.

"It really comes down," Lee said, "to a change in EMS culture."

ANA's essential principles for utilization of community paramedics

As community paramedicine continues to grow, the American Nurses Association released standards for working together to provide quality services

By the [American Nurses Association](#), May 15, 2014

Background

Over the past decade, emergency medical services (EMS) has piloted a new role, most often referred to as the community paramedic (CP). This expanded role builds on the skills and preparation of the emergency medical technician (EMT) and paramedic, with the intention of fulfilling the healthcare needs of those populations with limited access to primary care services.

Cuts in public health and community services funding have decimated programs, leaving unmet health needs. In many cases, CPs are filling a gap in services that had been performed by public health nurses and visiting nurses.

Communities have used CPs for home assessment, consultation, and direct care, purportedly reducing unnecessary hospital admissions and readmissions. The EMS community describes other possible services that could be performed by the CP as public health, disease management, prevention and wellness, mental health, and oral health. Consistent with the traditional EMS model, CPs use protocols and work under the direction of a physician (medical director).

ANA believes that every patient deserves access to safe, quality care from all healthcare providers. Health care is ever-changing and is currently undergoing a significant transformation. ANA supports initiatives which allow all members of the healthcare team to fully function consistent with their education and training in a cooperative manner.

Purpose

[ANA's Essential Principles for Utilization of Community Paramedics](#) provides overarching standards and strategies for the registered nurse and the community paramedic to apply when cooperating in various settings and across the continuum of care. This document seeks to promote common understanding of the community paramedic role and clarification of registered nurses' expectations of cooperation with this new role.

The significance of establishing the groundwork for cooperation is rooted in two major assumptions:

- There exists overlapping patient care responsibilities between healthcare team members.
- Patient-centered care coordination is a core professional standard and competency for all registered nursing practice.

These assumptions assert that registered nurses and community paramedics will need to cooperate. Successful cooperation leads to the delivery of safe, quality care and transparency with regards to roles and functions. Therefore, it is important to:

- Establish minimum standards for education and training for the community paramedic, — beyond the emergency services education and training required of EMTs and paramedics — that prepares the community paramedic to competently perform the expanded functions.
- Reduce "role confusion" by identifying the community paramedic's role within the healthcare team while distinguishing the registered nurses' responsibilities.

- Foster interdisciplinary cooperation through appropriate regulatory models.

TERMINOLOGY AND BASICS

Notes on Terminology

The word nurse refers specifically to a professional registered nurse. *Nursing's Social Policy Statement: The Essence of the Profession* (ANA, 2010; pg. 7) recognizes the value of clearly identifying the recipients of professional nursing care, be they individuals, groups, families, communities, or populations. The terms patient, client, person, population and community most often refer to individuals, whereas healthcare consumer can represent an individual or group.

The terms *community paramedic, advanced practice paramedic and community health aide/worker** refer to an individual who lawfully engages in an expanded scope of paramedic or EMT practice to meet the needs of the local community and has successfully completed standardized education and training to competently perform those functions.

(*Variations in titles may exist between states. This document addresses those roles that build on the EMT and paramedic.)

Basics: Assuring Patient Safety

- Role competence – Clarity of functions with appropriate education and training
- Interdisciplinary teamwork – Reflected by cooperation, collaboration and communication
- Accountability – Accountable for self, to the community, and to a regulatory agency
- ANA's Essential Principles for Utilization of Community Paramedics 3

Essential Principles

ANA recognizes that, given existing differences in regulatory structure, regulatory models will vary from state to state, but believes that at the very least, a model must incorporate some Basics for assuring patient safety.

(**For guidance in developing a suitable regulatory framework, members should contact Janet Haebler, ANA Government Affairs janet.haebler@ana.org.)

Role Competence

As with all healthcare providers, the public has a right to expect community paramedics to demonstrate competence throughout their careers and in all healthcare settings. ANA's position is that competence is definable and can be evaluated.

Competence can be evaluated by implementing tools that retrieve objective and subjective information about an individual's knowledge and performance (ANA, 2010; pg. 25, 32). There should be a mechanism for maintaining and measuring continued competence.

Uniform education and clinical training from an accredited program in the higher education setting, consistent with the functions of the community paramedic role, should be required by state statute, rules, regulations. Accredited educational programs should include core components from social and behavioral sciences and social determinants of health such as:

- Cultural competency

- Community roles and resources
- Health assessment
- Personal safety
- Professional boundaries
- Clinical components that include sub-acute and semi-chronic patient needs

Interdisciplinary Teamwork

The community paramedic must be considered part of the interdisciplinary team. Given the role of registered nurses as coordinators of patient care (ANA, 2012), it is important that community paramedics communicate and cooperate with registered nurses. Regulatory models should not impose barriers to interdisciplinary communication or collaboration.

Accountability

Community paramedics should be accountable for self, to the community, and to a regulatory agency. Every effort should be made to ensure that the agency with oversight for CPs collaborates well with the agency or agencies that have oversight for other professionals with whom they will be cooperating and communicating as part of the healthcare team.

Evaluation

This emerging role of the community paramedic requires ongoing evaluation to determine effectiveness and inform healthcare providers and policy makers as to needed changes. Thus far, the focus in community paramedic demonstration projects has been on reduced costs through decreased emergency room visits, hospital admissions and readmissions. Evaluation should extend to include monitoring for improved patient outcomes and patient satisfaction and a decrease in adverse outcomes.

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How to prove community paramedicine program worth and prevent pushback

From collaborating with partners to how data can help ensure a successful launch, our experts discuss their biggest challenges of starting community paramedicine programs

By Cate Lecuyer, EMS1 Editor, May 30, 2014

Starting a community paramedicine program can be quite an undertaking, and sometimes it's hard to know where to start, or what to expect. So we asked experts with first-hand experience to share the lessons they learned throughout the process.

What was your biggest challenge starting a community paramedicine program?

Chris Montera:

Pushback from other home care providers who felt we were infringing on their turf. Keep an open collaboration. Let them know if [they] find a patient that doesn't qualify [for their program], send them our way.

Dr. Michael Wilcox:

Bring everyone together way before implementation. And pass patients back and forth depending on need.

Anne Robinson-Montera:

You need to get the buy-in within EMS itself. It's about accepting what this is.

Let's say this is community paramedicine for dummies. What are the first three steps to getting started?

Montera:

Get your board to buy in. Ultimately there's going to be a spend to get this going. Get 'the blessing.'

Then start finding the stakeholders. Get meetings going. Build what you think the program is going to look like, hand it to people, and have them rip it apart. And don't be afraid when they do.

Robinson-Montera:

There also has to be a basis for what we do, and we won't get any respect until we start doing education.

Wilcox:

You've got to get a champion on board, and your medical director. Bring stakeholders together and pitch the concept to them. Show them the gap in health care, and how you're unique providers.

Robinson-Montera:

It also helps to have a nurse champion by your side, especially if you're getting push back from doctors and nurses.

Montera:

As soon as we said here's the education base and threw curriculum at them, it helped a lot with nurses.

Once everyone is on board, both paramedics and other health agencies want to move forward quickly. How do you balance that with educational requirements and planning?

Montera:

I took all my medics, sat them down with the curriculum, and went through it piece by piece asking 'what do you think you need?' My really smart paramedics went 'well, almost all of it.'

It's a career ladder step, not a step down. We're taking our most seasoned people and throwing them into this.

And what about collaborators like hospitals and health care agencies that want a program up and running soon?**Montera:**

Don't go slow. But go slow enough. Actually, say 'we will go as fast as you can pay for.'

Wilcox:

They need to step up to the plate if they want this done.

How do you approach data collection?**Dr. Davis Patterson:**

The most common problem is an evaluator is brought in too late, and you don't have your baseline data to compare it to.

Montera:

Grants often ask what are your measurable outcomes. That forced us to do it.

Robinson-Montera:

It didn't actually force you.

Montera:

Well, it gave us a North Star. We hired an outside evaluator to watch the process.

Wilcox:

If you're going to move ahead, you're going to have to have data to show the benefit of this provider. If you don't think about it in advance, it will be either terribly painful [when you have to sift through old data] or you won't have the information you need.

Where do you start when it comes to figuring out a needs and gap analysis?**Montera:**

Hospitals mandate a data analysis every three years, and public health does it every five years. The data is already out there, it's just a matter of looking at it. We started with the public health analysis.

Have you had any interest or push back from fire departments?**Robinson-Montera:**

They either don't want to do it but don't know what it will look like, or they want to do in their own way, without any regulations.

Wilcox:

You need to have champions internally that want to make this happen.

Montera:

At some point, you're going to be worked out of a job. The fire unions are going to have to step up and say 'we believe in this.'

Meet the Experts



Christopher Montera, AAS, NR – P, is the Assistant CEO at Eagle County Paramedic Services. He has 23 years of experience in EMS and is the past president of the Emergency Medical Services Association of Colorado. He also produces an internet radio show [EMS Garage](#)



Michael Wilcox, MD, is a family practice physician and clinical associate professor in the Department of Emergency and Family Medicine, University of Minnesota. He also serves as the medical director of the community paramedicine program at Hennepin Technical College. He has been an early architect of Community Paramedicine and remains a strong advocate of its importance in future health care initiatives.



Anne Robinson-Montera, RN, BSN, works as a public health nurse consultant across Colorado, and is the co-creator and public health partner for first national community paramedic pilot program in rural Eagle, Colo. She led a team of educators and experts in developing the 3.0 version of the community paramedic curriculum, which she also teaches.



Davis Patterson, PhD, is the Deputy Director of the University of Washington's WWAMI Rural Health Research Center and an investigator in the Center for Health Workforce Studies. His EMS research activities have focused on the rural and volunteer EMS workforces, EMS performance measures, and community paramedicine

How EMS can clear community paramedicine roadblocks

State-specific restrictions, Medicare reimbursement, turf battles and public and patient acceptance must be tackled for any program to be successful

By Cate Lecuyer, EMS1 Editor, May 27, 2014

EMS may sit at the kids' table of health care, but the industry still gets to eat.

"We may not be the biggest player, but we're a substantial player," [Page, Wolfberg & Wirth](#) attorney Stephen R. Wirth said Wednesday during his session "Shedding Light on the Dark Side of Community Paramedicine" at the ZOLL Summit 2014 tradeshow in Denver.

"There needs to be an 'us' mentality," he added.

As EMS agencies nationwide are gearing up to deliver mobile integrated health care through a community paramedicine model, roadblocks such as state-specific restrictions, Medicare reimbursement, turf battles and public and patient acceptance have emerged as critical aspects that must be tackled in order for any program to be successful, he said.

The good news is that under the [Affordable Care Act](#), there's a federal incentive and support from the Inspector General for hospitals to [reduce readmission rates to avoid being penalized](#), and it opens the door to experimental community paramedicine programs with that aim.

Getting around the red tape

In 2011, Minnesota was the first state to pass a [community paramedicine statute](#) that includes Medicaide coverage and offer an EMT-CP certification a year later.

"It did not come easy," Wirth said. The law allows CP services to be included in a patient's care plan and billing — with approval from the patient's primary-care provider.

Authorized coverage includes everything from health assessments and chronic disease monitoring and education, to medication compliance, minor medical procedures, vaccinations and hospital discharge follow-up care.

When it comes to dealing with your own state, there's no need to reinvent the wheel.

"Show them the Minnesota law," Wirth said.

He admits that although we're starting to see some changes, pursuing legislation to get Medicare to go beyond non-transports is not going to happen overnight. Many states also limit EMS providers to ambulance service operations, and require that ambulances go to the ER.

In this case, partnerships are the key. It may be possible to implement community paramedicine programs through medical practice associations, physician groups and hospitals rather than going through the state.

Now that hospitals will soon be penalized for excessive readmissions under the Affordable Care Act's [Hospital Readmissions Reduction Program](#) (HRRP), it makes sense to start an initiative focused on acute myocardial infarction (heart attacks), heart failure, and pneumonia — which are the readmissions HRRP has identified as those that hospitals need to reduce in order to avoid penalties.

"The money," Wirth said, "that's where this is going to benefit."

Collaborate on a fundamental change

Of course, it helps if your hospital is supportive of a proposed community paramedicine program from the start — along with doctors, health agencies, nursing groups, assisted living facilities and other organizations in the health care field.

These groups should see community paramedicine not as a threat, but rather a way for everyone to work together to meet a common goal of increasing patient access to health care, increasing patient outcomes to health care, and reducing costs.

"It really comes down to collaboration in overcoming these obstacles," Wirth said.

Meeting with hospital administrators before proposing a community paramedicine plan, and coming up with one together, can go a long way in making sure the plan is successful, he said. "It's also about showing other health care providers how EMS can add value to its piece of the pie. Taking the lead in the coordination of patient services and care can also lead to public education and acceptance.

"We need to demonstrate we're not just a bunch of ambulance jockeys," Wirth said.

And it's important to present community paramedicine programs as an expansion of existing services and skills.

"Don't paint a picture that this is a big new thing," he said. At the end of the day, it really comes down to the changing the "if you're sick, call 911" mentality, and getting EMS in at the ground level.

"There are some really cool opportunities for us to get on board a fundamental change," Wirth said. "And those who get on the train early will benefit the most."