Best Practices: Paramedics deployed as care navigators

By Steven Ross Johnson | December 19, 2015

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Former paramedic Matt Zavadsky long believed that there was a broader role for his profession beyond simply responding to emergencies.

In line with a 1996 National Highway Traffic Safety Administration report, he envisioned a system in which paramedics functioned as navigators, steering patients to the most appropriate care setting to reduce use of hospital emergency departments.

But he encountered resistance. “Everywhere I went, people said, 'Why would we want to prevent 911 calls, ER visits and (hospital) admissions? That's how we get paid,'” recalled Zavadsky, now public affairs director for the Fort Worth, Texas-based Area Metropolitan Ambulance Authority, a public agency also known as MedStar Mobile Healthcare.

That attitude about ED treatment and hospital admissions was changing by 2009, as health systems focused on avoiding inappropriate, high-cost care. That year, Zavadsky and his agency decided to see whether the idea, known as community paramedicine, could be a viable business model. His agency is the exclusive emergency medical services provider for the Fort Worth area, serving more than 900,000 residents.

MedStar began by identifying the most-frequent users of ambulance services—area residents who had called 911 at least 15 times in the previous 90 days. An analysis of 2008 data found that 21 patients accounted for 800 calls that year, with many calls made for non-emergency situations.

The pilot project enrolled nine of the 21 frequent callers. For 60 days, two paramedics were assigned to provide primary-care services to those patients. The result was a 77% drop in 911 calls by the end of the pilot, and an 80% reduction in hospital readmissions. Those results prompted MedStar to establish a full-scale diversion model that it calls its mobile healthcare program.

Gary Wingrove, director of strategic affairs for Mayo Clinic Medical Transport in Minnesota, said more health systems nationwide are interested in the community paramedicine model because they are increasingly being paid to keep patients healthy and out of the hospital and the ED. “They see that as an opportunity where the community paramedic can show value to that system,” Wingrove said. “The community paramedic becomes a part of their workforce and part of that bundled payment they get.”

Under the MedStar program, registered nurses at MedStar's call center evaluate 911 callers and decide which ones might be appropriate for the mobile healthcare program. Paramedics go see eligible patients, assessing their appropriateness for the program and their willingness to participate.

Enrollees receive a medical assessment and a care plan that includes follow-up home visits and telephone calls. The paramedics also help patients with other needs, such as transportation for doctors’ office visits or signing up for health insurance and other benefit programs.

The program requires paramedics to receive 80 hours of classroom training and 80 hours of field training focusing on communication skills, care navigation and knowledge of community resources to assist patients.

An initial challenge for the MedStar program was figuring out how to get paid, because insurers did not pay for home visits or care coordination. So the agency began it as a self-funded project to prove the program worked.
Eventually, growing pressure to reduce costs sparked provider interest in MedStar's model, which led to agency contracts with several hospitals and hospice providers.

Recently, Medstar signed a contract with Cigna-Healthspring, a large Medicaid managed-care plan in the Fort Worth area, to serve its members. “Once we started the first program, literally five other programs, organizations and partners came to us and asked us to help them,” Zavadsky said. “The total economic environment in healthcare has been turned upside down.”

Since 2009, the program has reduced hospital ED transports by 82% for patients identified as frequent EMS users, saving nearly $8 million in healthcare costs, MedStar said.

In 2010, the program expanded to include congestive heart-failure patients at risk of admission to the ED or the hospital.

Zavadsky said community paramedicine also could be expanded to serve patients with severe mental illness who frequently use the ED, and often have to be remain there for hours or days while staff search for more appropriate treatment settings.

Staffers from more than 140 EMS programs around the country have visited MedStar's program to learn how to start their own mobile healthcare effort, Zavadsky said.

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**MH Strategies**

**Expanding paramedicine's role to lower ED visits**

- Identify frequent 911 callers and assess their health needs
- Identify community resources, such as primary-care providers and social service agencies, and establish partnerships to coordinate patients' unmet needs
- Make periodic follow-up visits to patients at risk for hospital readmission to monitor their status
- Design a plan that helps patients manage their own health
- Look to contract with healthcare entities in value-based payment arrangements

*Source: National Conference of State Legislatures*