It's not an emergency. Call a paramedic!

By Lia Novotny | December 19, 2017

One Friday, on a country road not far from Asheville, North Carolina, a paramedic knocks on a front door. He's not there for an emergency call, but a scheduled visit with a elderly patient recently discharged from the hospital. The medic reviews her care plan and, because she doesn't have transportation, heads over to the pharmacy to pick up her prescriptions.

And, in the process, he prevents a likely 9-1-1 call and re-admission over the weekend. He's not a paramedic, he's a "CaraMedic."

As part of the Community CaraMedic Program of Mission Health Partners of western North Carolina, one of the largest ACOs in the nation, this CaraMedic represents the broadening role of paramedics beyond acute emergency services into education, treatment, and support of high-risk or chronically ill patients.

And it is just one of example of how healthcare's intensifying focus on managing the upstream causes of poor health is redefining the work of allied health professions, from paramedics to pharmacists.

Rapidly emerging model of care

The community paramedicine model is spreading with variations across the country. In California, a two-year state-sponsored pilot in which paramedics evaluate patients for transport to behavioral health clinics instead of emergency departments has significantly reduced ED use – without adverse outcomes and zero subsequent transfers to EDs. The paramedics are also charged with connecting "9-1-1 frequent flyers" to housing agencies and other social services.

In North Carolina, the robust care management model of Mission Health integrates paramedics as key members of multidisciplinary teams including

care coordinators, clinical pharmacists, and social workers. Funded through the ACO's shared savings, they are the team's "eyes and ears, the boots on the ground" who evaluate home environments, assess safety risks, and educate patients to self-manage their health.

Abbeville Area Medical Center, a critical-access hospital in South Carolina, partners with their county's emergency management services to deliver home-based care for patients with asthma, diabetes, and other chronic conditions. Initially funded through grants, the program now piggybacks on the state's Medicaid-funded Healthy Outcomes Program focused on uninsured high utilizers of EMS and ED services.

Bringing primary care home

Already highly trained, able to see patients in their homes, and connected to multiple medical facilities in a region, paramedics offer a ready-made avenue to extending primary care into communities.

In an initial home visit, a community paramedic checks a patient's vitals, reconciles medications, and assesses the environment, from checking if a refrigerator is stocked to scanning for stairs, wires, and other potential hazards. Based on what that visit reveals about each patient's barriers to health, the care management team develops individual care plans.

But the most important job of the community paramedic is to build trust with patients.

Rob Fields, M.D., medical director of Mission Health Partners, recalls a COPD patient considered "non-adherent and perhaps belligerent." After his wife passed away, the patient had fired his home health service, rejected the services of the local council on aging, and stopped showing up at his primary care physician's office.

So Mission's care management team asked a community paramedic to stop by his home. "The first three meetings with the patient occurred in the driveway because the patient refused to let him into the house," says Fields. After getting to know each other outside, however, the patient eventually invited the paramedic into his home.

"It was a hoarding situation. He had no heat and no running water," says Fields. "But we were able to re-engage with community partners, get his home repaired and the house cleaned up. But it took someone willing to put in the time to build a relationship."

When the same paramedic sees a patient at every visit, not only is trust built, but the paramedic is likely to pick up on issues a one-time visitor might not notice. Recently, one of Abbeville's paramedics visited a patient and thought his demeanor was off. He convinced the patient to go to the hospital, where a stroke was diagnosed. The signs had been so subtle, a provider unfamiliar with that patient might have missed them.

William Blackwell, director of Abbeville's EMS program, recalls the very first patient in its community paramedic program: A smoker who went to the emergency department as often as three times a week for asthma. The paramedic discovered that he lived with another smoker in a home heated by a poorly ventilated wood stove. "We called the housing authority and got him placed in government housing. Immediately we saw results; he went two months without an incident," says Blackwell. "His primary care physician just wouldn't have been aware of those factors."

Patient education

The paramedics' "boots on the ground" view helps them to teach patients to self-manage their conditions. Lisa Swaim, nurse care coordinator for Mission Health, says paramedics see "what the patient is actually doing versus what we think they're doing." Recently, a Mission physician called her with a referral. "This patient, we don't know what is going on. But her blood sugars have not budged. We keep bumping up her insulin, but nothing changes."

Swaim sent a community paramedic to the patient's home. He called her, saying, "I figured it out. The family caregiver never removes the cap on the syringe. The insulin just spills all over the patient's stomach." After a lesson on the spot, the patient's blood sugar levels quickly returned to normal.

Simple fixes, dramatic improvements

The results of broadening paramedics' scope can be dramatic. In Abbeville's program, ED visits decreased by 59 percent and admissions by 69 percent among patients. Mission Health has also seen results in first 6 months after enrolling patients in its program, with a 17 percent reduction in ED utilization and 21 percent reduction in readmissions.

"That's what everyone is interested in, right? Utilization and cost-savings," says Rob Fields. "But I think anyone who gets involved in value-based care begins to understand that this is not about diagnosis and treatment. This is really about the social determinants. It is specific to having someone that's willing to put in the time to build a relationship. That is the type of hard work that needs to happen."

Lia Novotny is a frequent contributor to athenaInsight.