Proposal to Integrate Community Paramedicine into Washington County EMS System

Louisa Partain
Pacific University
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Abstract

In the spring of 2014 a coalition of stakeholders was called to meet in the Portland, Oregon area to discuss healthcare transformation and specifically the role of Emergency Medical Services (EMS) in that transformation. The gathering was attended by approximately 150 representatives from local healthcare systems, payers, policy makers, EMS system administration and representation from healthcare providers themselves. From this coalition two subcommittees emerged and were tasked to explore two subjects for EMS transformation: a nurse triage line within local dispatch centers to divert low-acuity callers away from the EMS system, and the use of mobile-integrated healthcare programs, also known as community paramedicine (CP) to meet specific community needs in the out-of-hospital arena. The former group was suspended winter 2015 as the local dispatch system was unable to accommodate nurse triage protocols. The latter group has met regularly to address implementation strategies for community paramedic (CP) programs in the region.

CP is an expansion in the role that EMS plays in the local community beyond just 911 response and transport. The benefit to this expanded role impacts patients, local EMS and healthcare systems as programs are designed to meet identified gaps in healthcare delivery including prevention strategies to improve population health, address high emergency department utilization and decrease overall cost of healthcare delivery. This project proposal focuses on the first phase of CP program development, writing the regulatory rules and statutes to authorize CP program development for Washington County, Oregon. This first phase will take approximately 2 years to complete after which, phase 2, the build-out of CP system design will take place.

There are no budgetary constraints to keep the project from moving forward as it relies solely on existing FTE to attend to the writing and filing process. The project will be completed under the oversight of the Washington County Public Health Division's EMS Program Supervisor as CP meets the mission and vision of the Public Health Division. Final documents will be completed within 24 months of start.

Degree Type
Capstone Project

Degree Name
Bachelor of Science

First Advisor
Laura Dimmler, PhD, MPA

Subject Categories
Health Services Administration

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Proposal to Integrate Community Paramedicine into Washington County EMS System

By Louisa Partain

Pacific University
Executive Summary

In the spring of 2014 a coalition of stakeholders was called to meet in the Portland, Oregon area to discuss healthcare transformation and specifically the role of Emergency Medical Services (EMS) in that transformation. The gathering was attended by approximately 150 representatives from local healthcare systems, payers, policy makers, EMS system administration and representation from healthcare providers themselves. From this coalition two subcommittees emerged and were tasked to explore two subjects for EMS transformation: a nurse triage line within local dispatch centers to divert low-acuity callers away from the EMS system, and the use of mobile-integrated healthcare programs, also known as community paramedicine (CP) to meet specific community needs in the out-of-hospital arena. The former group was suspended winter 2015 as the local dispatch system was unable to accommodate nurse triage protocols. The latter group has met regularly to address implementation strategies for community paramedic (CP) programs in the region.

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There are no budgetary constraints to keep the project from moving forward as it relies solely on existing FTE to attend to the writing and filing process. The project will be completed under the oversight of the Washington County Public Health Division’s EMS Program Supervisor as CP meets the mission and vision of the Public Health Division. Final documents will be completed within 24 months of start.
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Introduction

Background and History

Washington County (WC) Oregon is on the western edge of Multnomah County with a mix of urban, suburban, and rural areas that sits from the edge of the city of Portland to the coast range. It is 726 square miles and based on 2015 population estimate by U.S. Census of 574,326 persons. The forecasted population will be approximately 900,000 by the year 2050 (Manning 2013). The eastern half of WC is comprised of service industries, light manufacturing, residential and commercial activity and is relatively densely populated. The western half is primarily farms and rural settings together with several smaller incorporated and unincorporated communities. WC is a home-rule county governed by a five person elected board of commissioners who appoint a County Administrator as the chief executive of the county.

The Emergency Medical Services System for Washington County

Regulatory authority for the provision of ambulance services is written within county code and county administrative rule. The details of which are outlined within the county ambulance service area (ASA) plan which is approved and filed with the Oregon Health Authority (OHA) EMS and Trauma Systems office. These regulatory documents give the basis by which the county’s franchise agreement for ambulance services is written. Scope of practice for all levels of EMS clinicians: Paramedic, Emergency Medical Technician-Advanced, Emergency Medical Technician, and Emergency Medical Responder are written by the Oregon Medical Board, adopted by the OHA EMS and Trauma Systems office; local clinical and operational protocols are written collaboratively by the Tri-County Protocol Development Committee for the region. These documents are all available for review on the Washington County EMS Program website.
EMS Resource Deployment Strategy for Washington County

WC EMS system is considered a dual response system, meaning that a 911 caller will receive a first response unit, usually a fire service resource, and a secondary response by an ambulance. Fire agencies respond directly from a fire station while ambulance resources are constantly moving throughout the county to provide equal distribution of coverage. This deployment model is called system status management. Dual response models move paramedic resources quickly to an emergency scene by the fire service that can make a medical assessment of the patient, begin treatment and prepare the patient for the arrival of the transport ambulance. Once the ambulance arrives treatment continues and the patient is transported quickly from the scene to an awaiting emergency department (ED). This dual response deployment strategy keeps resources moving throughout the system and helps to achieve shorter on-scene times while still getting a patient to more long term care more quickly than a single unit response model.

There are currently two options for transport destination when a patient enters the 911 system:

1) treat the patient and transport to a local emergency department regardless of acuity of their medical condition, or

2) allow the patient to refuse transport altogether

There are two barriers to transport to alternate destinations; a lack of reimbursement stream to pay for any other destination except an ED, and the lack of regulatory authority to allow for alternate services. According to The Centers for Medicare and Medicaid (CMS) 2015 Medicare Coverage of Ambulance Services Guidelines, CMS for will only pay for ambulance transportation to an ED and, only under certain life-threatening conditions, and when a person could not get to an ED safely on their own. In short, CMS views EMS as a “transport to ED”
service only and does not take into account the clinical interventions a patient receives once EMS services arrive. The second barrier to alternative services such as CP is due to the current content of the WC regulatory documents that allow these services.

**Project Proposal Statement**

This project proposal is being delivered to the Washington County EMS Office Advisory Council who is responsible for policy development for the EMS system by the county EMS office. Their charge by the Board of Commissioners is to develop policy that lays the foundation for system enhancement and system development with the collaboration of EMS stakeholders. Therefore this project proposal will focus on the first phase of CP program development which is to rewrite county code, administrative rule, and ambulance service area plan and amend any contracts with providers to allow for CP program design. Focusing on the regulatory authority is the first and most important phase to implementation of CP programs because it focuses on the aspects of service delivery which are within the responsibility of the county EMS office, and CP simply does not exist until they are recognized in rule and statute and therefore system design cannot occur for a program that does not currently exist.

**Needs Assessment**

**Changing Landscape of EMS**

A well renowned white paper titled “Accidental Death and Disability: The Neglected Disease of Modern Society”, by the National Highway Traffic Safety Administration is the tool upon which many EMS systems were built to respond to death and injury on America’s highways. In 1996 the “EMS Agenda for the Future” outlined healthcare integration tactics and specified systems of care that focused on EMS as being a part of the healthcare delivery system bringing relevance and value to EMS as an industry. Many things have changed in the care and
prevention of trauma and disease since these publications including healthcare transformation, the implementation of the Patient Protection and Affordable Care Act (PPACA), the Triple Aim, and the modernization of public health. These transformative initiatives are forcing healthcare as an industry, including EMS to change from the reactionary practice of only treating the sick after they are sick, to instead focus on the adoption of prevention, improved quality, and lowered costs. EMS is also taking the opportunity to change its image of “you call, we haul” into a fully integrated partner in the healthcare industry (NAEMT 2016).

**Community Paramedic Programs**

Community Paramedic (CP) is a relatively new term and concept of service in the United States but not in other parts of the world. Canada, Australia, and United Kingdom have all had successful programs for quite a few years called Mobile Integrated Healthcare (Drennen et al. 2014) focusing on identified gaps in community health services. Although new in the U.S. there have been multiple pilot projects across the county including Fort Worth, Texas, San Diego, California and Wake County North Carolina (Gerber 2014). While data is limited from these pilots there has been enough value shown in programs that these same regions are pursuing administrative and regulatory oversight.

There are several benefits to using existing EMS resources for these types of programs. First, because this is an expansion of role and not scope of practice a CP program uses existing resources without creating an additional redundancy within the healthcare industry, and second, there is currently no specialized licensed to provide CP services; essentially all the resources to provide CP programs already exist. Lastly, the EMS system has been built to be nimble, flexible, and reactionary when needed. EMS and its resources are poised to be at a patient’s side in less than 5 minutes if needed. While immediate response would not be the goal of CP, the reality is
that EMS is able to respond where other healthcare services, like nursing home-health can only respond days, if not weeks after the call for help was received. Lastly, CP programs can fill gaps in access to care in rural areas of the county that are lacking. According to the National Consensus Conference on Community Paramedicine (2013), “Community paramedicine providers care for patients at home or in other non-urgent settings outside of a hospital under the supervision of a physician or advanced practice provider. Community paramedicine can expand the reach of primary care and public health services by using EMS personnel to perform patient assessments and procedures that are already in their skill set.”

EMS has historically had roles in both public safety and public health, but until recently it had not been recognized for the role it plays in healthcare. EMS is very much a part of the healthcare system and as such it is also impacted by healthcare reform. The Institute for Healthcare Initiative’s (IHI) Triple Aim is to improve patient experience including satisfaction and quality, improve population health, and decrease healthcare cost. In order to keep up with healthcare reform and be transformed into a pay-for-quality service instead of pay-for-quantity healthcare, the WC EMS system will need to have permission language written in regulatory documents that allow for different models of EMS care including the ability to transport to alternate destinations.

**Rationale for Community Paramedicine**

**Achieving Patient Satisfaction and Quality**

The impacts of the current design of the county EMS system are felt by local fire departments, the ambulance franchise holder, receiving emergency departments, payers and patients. Multiple times a day patients with low acuity medical complaints are transported by ambulance to a local ED only to wait in its triage waiting area because beds are full with other
patients. High ED census loads impact all levels of the healthcare system resulting in delays to treatment and subpar care (Hearld, Alexander 2012). When EDs are full they must declare “ambulance diversion” status, essentially shutting their doors to additional ambulance traffic until census levels decrease. This diverts ambulances to hospitals farther away leading to extended travel time for EMS to both move patients and return to the system. Patients also feel the brunt of divert status because they too are farther away from their home creating issues for transport back to their residence at time of discharge. Figure 1 shows ambulance diversion data from 2015 and 2016 for WC receiving hospitals.

Figure 1 Ambulance Diversion Rates for WC Hospitals 2015-2016

**Impacting Population Health**

EMS has been a safety net for emergency healthcare since its inception with its historical focus being primarily on treatment accompanied by transport. Because of healthcare transformation an opportunity exists to shift that focus to prevention and healthcare integration.
By collaborating with healthcare systems to meet individual patient needs and building systems of care of prevention EMS/CP has opportunity to impact population health of the communities it serves by designing system to revolve around chronic disease management, post-discharge follow-up and navigating patient to appropriate alternative healthcare destinations.

**Fiscal Impacts of CP Program**

According to the Centers for Disease Control National Health Statistics report of 2006 (Pitts 2008) there were approximately 119.2 million visits to an ED in the U.S, and 12.1% of those visits are triaged as non-urgent, meaning that 14,423,200 persons could have been treated by a primary care physician, an urgent care center, or possibly treated at home and not transported anywhere. Many of these ED visits, up to 15%, are transported into the ED by ambulance. ED visits are costly to both patients and the healthcare industry. According to Blue Cross Blue Shield (2009) the average adult clinic visit costs between $130-$180 and average ED visits are between $580-$700 not including ancillary testing and work-ups. At these estimates the cost savings for a clinic visit versus a visit to an ED would be between $450-$520 per patient or $973.5 million - $1.1 billion. By avoiding unnecessary trips to an ED, the overall healthcare system and patients realize significant financial savings. EMS patients and payers are positively impacted as well by reduction in ED transports. In 2015 there were 42,493 ambulance responses in WC which resulted in a transport. Applying the same metrics as above of 12.1% low acuity calls would decrease emergency call volume by 5141 calls and show a modest savings between $2.3 and $2.6 million in the healthcare delivery system. Neither the national or local potential savings reflect the cost of ambulance transport which would boost overall savings.

**SWOT Analysis for Community Paramedic**

Table 2 SWOT Analysis for WC CP Program
## Strengths
- Synergy within EMS system to change response framework
- Reduces response resources to low-acuity 911 calls
- Creates improvement to EMS response by allocating the “right” resources to every patient
- Improves patient experience
- Resources needed for program implementation already exist
- Paramedic licensure is only requirement for personnel at this time

## Weaknesses
- No current regulatory authority exists for program development
- No current funding stream exists for reimbursement of program costs
- Education and training in population health may be needed
- No current data stream is available for patient level encounters
- No current definition of roles for agency providers, i.e. what role does fire agency play versus ambulance agency play in CP

## Opportunities
- Create integrated medical response to community
- Decrease overall economic impacts to healthcare delivery systems
- Create new relevance for EMS as part of the healthcare delivery system
- Integration with Public Health to impact population health
- Role for EMS in prevention

## Threats
- Home health network or Nursing Associations
- Scope creep
- Reduction in 911 usage to the point it is not economically viable

### FORCE FIELD ANALYSIS
Table 2 Force Field Analysis

**DESIRED STATE:** Create regulatory authority for the provision of Community Paramedic program within the county EMS system.

<table>
<thead>
<tr>
<th>DRIVING FORCES (OPPORTUNITIES)</th>
<th>RESTRAINING FORCES (BARRIERS)</th>
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**Alignment of Mission with the Organization**

**The Mission of the WC Public Health Division**

“Washington County Public Health improves and protects the public’s health across the lifespan through prevention, education, partnerships and healthy environments”

**Vision of the WC Public Health Division**

“Healthy People, Thriving Communities”

The WC EMS Office provides the regulatory authority and structure for EMS agencies to create programs and services directly aligned with the Public Health mission and vision by:
• Ensuring safe, reliable and efficient healthcare services that are appropriate for the patient’s current health status;

• Creating prevention strategies that keep communities healthier through community partnerships;

• Partnering with medical research groups to improve clinical delivery systems;

• Improving clinical and operational delivery design through protocol development strategies that are relevant to all ages, sizes, and medical conditions;

• Enhancing and building innovative system delivery design that reduces inefficiencies and decreases cost to patients, EMS agencies, and the overall healthcare system while at the same time not creating barriers to appropriate medical care.

Review of Literature

The efficacy of CP programs has been tested around the world to ensure paramedic reliability in assessment, treatment and alternate transport. Programs in the United Kingdom (UK), Australia and Canada have proven successful in that current licensure and scope of practice are reliable indicators of paramedic’s ability to increase their role in healthcare.

The United Kingdom conducted a program to evaluate a paramedic’s ability to conduct risk assessments in the elderly who experienced a ground level fall. Snooks et al., (2014) conducted the Support and Assessment for Fall Emergency Referrals (SAFER1) trial to evaluate the use of a computer program to assist with the decision making of paramedics in deciding whether an elderly patient with a history of falls should be transported to an ED or treated and left at home. The trial involved 13 ambulance stations (42 individual paramedics) evaluating 779 patients. Approximately half of those paramedics received specialized training in computerized algorithms to evaluate fall patients. The control arm did not receive additional training and
evaluated patients based on standard paramedic assessments. The findings concluded that those paramedics with training in the computerized algorithm referred more patients for fall risk services than those who did. What is so significant in this trial is that it is one of the first types of research to be conducted that evaluates the clinical decision making ability of paramedics in a different type of role than the historical EMS treatment and ambulance transport to an ED. Secondly, the trial showed that EMS is able to successfully refer patients to on-going care without home healthcare (nursing) training without exposing the patient to further risk.

In the U.S., a similar retrospective study was conducted by Williams, Bachman, Wooten, (2015) with the Wake County EMS in North Carolina to evaluate a similar fall protocol. While the protocol was algorithmic in nature the study differed from the UK trial, in that it was not a computer-based assessment for transport decisions. The Wake County model used paramedic discretion with the protocol to determine if the patient should be transported or not. The selection of patients was seen in adult living facilities where the U.K. model selected patients in their residence but did not describe where that residence was. The Wake County noted that of the patients that were transported 80% were not initially admitted to a hospital and of those treated in the ED 46.7% were treated for wound care, 37.1% had a hip fracture, and 17.8% were seen again in the ED within 48 hours, 3% death within 72 hours and 1% had an ICU or an OR admission. Comparing this study to the U.K. it appears that computerized algorithms may be more specific for patient who should be transported to the ED versus those who can remain in their residence. More research would be indicated for the U.S. model to determine if more training is needed for paramedics when computerized algorithms are not available.

Hoyle, Swain, Fake, and Larsen (2012) evaluated the first 1,000 patients evaluated by CP programs in New Zealand. Paramedics with additional training were compared to standard
paramedics with no additional training. Each arm of the trial contained patients who were treated and transported to an ED and those who were treated and left in the community. The results were that those paramedics considered CPs were significantly more likely to successfully treat patients at home than to transport. Some of the patients seen by the CP (5%) were seen in an ED within seven days. The study determined that in such cases the patient was being seen for clinical presentations other than what they were seen in the field for, or they had worsening issues of their primary complaint. In those cases, the initial treatment and advice of the CP was still deemed appropriate. This trial showed that CP can safely assess the difference between patients needing transport to an ED versus being treated at home. Transport rates were much higher in the control arm, 74% of patient seen by traditional paramedics were transported as opposed to 40% transport with CP.

A Canadian study conducted by Jensen et al., (2013) found that CP working with long term care residents on site had positive implications however, the program required extensive training. The paramedics in the Canadian study had the same focus as many other CP programs that being, to reduce unnecessary ED visits. This study also involved long-term care residents whereas the others did not. This other unique factor is that this program evaluated paramedic perception/satisfaction. Four major take-away points from this study include: 1) paramedics with more extensive training in geriatric care would be most suitable for the position of CP; 2) the character of an CP would be a paramedic who excels at the “soft skills” of good communication, interpersonal relations and the ability to “think outside the box;” 3) while participants stated that CP should have additional training it was not clear on how much additional training they should have; and 4) long-term care providers also gained valuable insight into the culture and practice of EMS by working with CP.
New Zealand also tested patient satisfaction when assessed and treated by CP. Swain, Al-Salami, Hoyle and Larsen (2012) tested 100 patients; 50 were seen by a CP and 50 were seen by standard paramedics. A qualitative patient satisfaction survey was conducted that asked a range of questions regarding the patient’s overall experience, preference of treatment at home or transport to ED, to patient perception of appropriate clinical treatment. The outcome of this study was that patients were equally satisfied with CP and standard paramedic treatment and/or transport. One unintended discovery from the trial was the realization that CP spent twenty minutes longer on scene with patients than the standard paramedic. However, the study did not take into account the amount of time standard paramedics are with a patient during transport or during a hand off at an ED.

Using CP for prevention campaigns were studied by Mikolaizak (2013) based off the previous SAFER1 study in the U.K... The study researches the linkage of patients to existing services that are underutilized as opposed to creating a cadre of new services. While this trial is still ongoing, the study hopes to demonstrate that by more fully integrating services, including CP interventions and assessment, patients will receive faster referral services and reduction in future falls.

Because CP programs are typically created in relation to identified needs of underserved communities Reeve et al. (2008) in Queensland, Australia determined that given additional training, paramedics would be valuable resources in remote and rural areas of their country. This placed CP alongside other clinicians in a one-year graduate level certificate program that focused on population health, health prevention and promotion, and chronic disease management. The objective of the study was to observe paramedic perception of the course. Perception was scored based on two questionnaires, one pre-coursework and one post-coursework and contained both
quantitative and qualitative questions. Findings of this study concluded that paramedics taking this course were able to incorporated skills in population health to their daily work and were highly satisfied with the course. It was also implied that by using CP with additional training Queensland would be able to successfully use CP in rural and remote multidisciplinary healthcare teams thus bridging gaps in their healthcare delivery system.

While research is still emerging on CP programs, especially in the U.S., the limited data indicate promise in the abilities and efficacy of using paramedic in this expanded role to reduce ED census, hospital readmissions, and to reduce frequent 911 usages for some individuals. Conclusions also find that patients and paramedics are satisfied with the use of CP in these expanded roles.

**Methodology**

The following is the recommended approach to give regulatory oversight and authority to CP programs in the WC EMS system.

Step 1: Make presentation of project proposal to WC EMS Program Advisory Council seeking approval to create a workgroup who will rewrite or amend Washington County Code 8.32 and Washington County EMS Administrative Rule Sec. 100-700 and Franchise Agreement for Ambulance Services.

Step 2: Assemble workgroup and meet with legal counsel for orientation on process of regulatory document change.

Step 3: Meet regularly to rewrite or amend documents and file according to legal counsel advice with progress report back to Advisory Council monthly.
Step 4: WC EMS office will create addendum to the Franchise Agreement for EMS Services and file with the county administration and the local ambulance provider that give permissive language for CP programs.

**Process for Board Approval of Regulatory Documents**

- Add to Board work session agenda (due 2 weeks prior to meeting), see attachment A
  - Board Agenda
  - If no additional work needed and approved it will be automatically added to next regular session
    - If not approved move back to workgroup for additional work
  - If approved at session will go for 1st public hearing
    - If contested move back to work group for additional work and send back to Board
  - If no comment move to regular session for approval by Board

All work related to rewriting regulatory documents will be accomplished through a collaborative work group process that is representative of the public, WC EMS field providers and their respective administrative head, local health system stakeholders including public health, coordinated care organizations and labor representation. Work should be accomplished in face-to-face work sessions as much as possible. Oversight for the workgroup, meeting timelines, and deliverables will be the responsibility of the WC EMS Program Supervisor with direct advice by its legal counsel. All items that are presented to the Board are done by joint effort of the Health and Human Services Department Manager with the EMS Program Supervisor. There are no known barriers to accomplishing this work except normal ebb and flow of daily work that can slow down these processes.
Resource Requirements

Because this proposal is focused on producing regulatory authority for project design there are no special or additional resources needed beyond the current staffing within the WC EMS office and its current legal counsel. There is no additional funding or IT infrastructure that is necessary to accomplish these tasks. There are no additional capital projects to be attained for this project.

Resource Lists

- Office space for meetings with good lighting and the ability to project data onto a screen.
- Laptop computers for display of information and minute taking.
- Ability to record discussions for purpose of meeting minutes.
- If meetings are held off-site a vehicle or other travel mechanism is needed.
- Access to official posting for board consent items and advertisement for public comments as necessary.
- Agenda for Board Consent items (see evaluation section)

Timeline

Rewriting regulatory documents from beginning to final product will take approximately two years. While some work must be consecutively
Deliverables

Deliverables for this project involve the completion of draft documents in a time set by the workgroup for final presentation to the Board that result in inclusive language for provision of CP services. The subcommittee will report back to the larger committee on progress monthly. While county code must be started first, there can be small amounts of overlap from the time it is approved by the board to the start of work on administrative rules.

Budget and Budget Narrative
Cost to project will include approximately 20 hours of time by legal counsel which is charged at $100/hrs. This estimate is based on hours that were billed for previous and similar work between the EMS program and their counsel. There is no filing fees associated with this work. This project is assumed to be a part of the daily work and responsibility of WC EMS program staff and no additional personnel are required. Stakeholder involvement will be in-kind and not billable hours. WC follows mileage reimbursement standards of U.S. General Services Administration and will be reimbursed at current Oregon reimbursement rates. The EMS program budget has earmarked currently $7,000 to absorb direct and indirect costs and will be billed from account 52130 for special projects.

Table 1 Proposed budget

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Communication Strategies

Stakeholder meetings and workgroup will meet face-to-face for discussions and real work to be accomplished. Meetings will be held at a time and date that are most agreeable to the group.
at WC Public Services Building 155 N First Avenue, Hillsboro, Oregon in the EMS workspace room 245. Email is also a preferable method of sharing work, and collecting feedback between meeting dates.

Public notices for rule hearings and public comment will be posted in writing by the EMS office in locations predesignated by the county for such purposes. Public notices announcements will be filed by the EMS program 30 days prior to hearings or in accordance with policy.

**Marketing Plan**

A marketing plan is not needed for this phase of the CP program. A marketing plan will be necessary and the next phase of this project which is program design. Because WC EMS office is a regulatory body and not directly involved in patient care the marketing and business plan will be left to the individual agencies to develop and execute under the leadership vision of the EMS office.

**Evaluation**
## Goal 1: Write permissive and inclusive language into county code 8.32 that defines Community Paramedic practice in Washington County

<table>
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<th>Objective(s)</th>
<th>Key Action Step(s)</th>
<th>Expected Outcome(s)</th>
<th>Data Evaluation and Measurement(s)</th>
<th>Person/Area Responsible(s)</th>
<th>Comment(s)</th>
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<td>1. Create definition of Community Paramedic practice</td>
<td>1. Convene work group to determine definition for CP practice in WC</td>
<td>1. Definition of CP practice relevant to WC</td>
<td>1. Final document meets approval of work group, counsel and board</td>
<td>1. EMS Program Supervisor xt 4956</td>
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<td>2. File county code language changes with Board by first session January 2017</td>
<td>2. Identify meeting dates and time and location</td>
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<td>3. Meet with legal to discuss and have language approved prior to board sessions</td>
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## Goal 2: Write permissive and inclusive language into county administrative rule for emergency medical services 100-700

<table>
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<th>Objective(s)</th>
<th>Key Action Step(s)</th>
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<th>Data Evaluation and Measurement(s)</th>
<th>Person/Area Responsible(s)</th>
<th>Comment(s)</th>
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<td>1. Inclusive and permissive language written into AR that allow for provision of CP programs</td>
<td>1. Convene work group to determine the role of CP programs as to be written into administrative rule.</td>
<td>1. Role of CP programs defined by AR.</td>
<td>1. Final document meets approval of work group, counsel and board</td>
<td>1. EMS Program Supervisor xt 4956</td>
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<td>2. Enforce the limitations of CP practice as defined by County Code 8.32</td>
<td>2. Identify meeting dates and time and location</td>
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<td>3. Work to be conducted by work group will be conducted and document tied with Board within 6 months of start</td>
<td>3. Meet with legal to discuss and have language approved prior to board sessions</td>
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Conclusion and Recommendation

While CP programs have been in existence and researched in Australia, the U.K. and abroad for some time, this is a relatively new role for EMS agencies in the United States. The data, while brief suggest that with some amount of training paramedics can be successful in
identifying low-acuity patients and transferring them to lower acuity medical facilities other than an ED or treating and leaving them in their residence. There are also significant cost savings to be gained by using paramedics in nontraditional roles as part of the multidisciplinary healthcare team. By using EMS in nontraditional roles EMS can also positively impact over utilization of ED and improve patient experiences. The resources necessary to carry out CP programs in WC already exist including personnel, what is not currently available is regulatory authority to provide these services. By the EMS Office adding permissive language to county code, administrative rule, and the ambulance service area plan and contracts it will give the authority necessary to allow the EMS system to begin program design.
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Figures

Figure 1 Ambulance Diversion Hours data aggregate and reported by Multnomah County EMS

Office for Washington County EMS systems, prepared by Karen Garber