Geisinger

Testimony on House Bill 1113 – Community Paramedicine
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Good morning. Thank you for inviting me to discuss community paramedicine. My name is David Schoenwetter, DO. I am the Medical Director for Geisinger EMS and Geisinger Life Flight. I am speaking before you on behalf of the Geisinger Health System which is the nation's largest rural health services organization and a vertically integrated delivery system.

The Geisinger Health system began in the community paramedic program, under the title in our system as the Mobile Health Paramedic program, in March, 2014. This program was designed to provide a flexible, nimble, clinical service to patients who are already receiving care within the Geisinger Health System. The program operates under a licensed ALS squad intercept agency. There is no expanded scope of practice involved, and the activities of the paramedics focus on expanded "role" rather than an expanded scope. All of their clinical activities are within their level of training, and focus in particular on assessment and communication with other care team members.

The education of the Mobile Health Paramedics at Geisinger was tailored to their intended use within our Health system. This included education on heart failure, case management, the Geisinger medical home model, and the primary care sites. Paramedics were already credentialed under the EMS agency license for the ALS squad unit. Therefore, the paramedics were able to operate in either the capacity of a 911 paramedic, or a community paramedic. In the Geisinger model, they did not serve both roles simultaneously.

One unique component of the program at Geisinger is the heart failure care model. For the specific patient population, Geisinger was able to use the delegated practice model (49 Pa.C.S. §18.402) under the joint oversight of the EMS medical director and the Geisinger Health System Director for Advanced Cardiac Disease - Heart Failure. This created a mechanism to provide more advanced treatment for patients under the care of the Geisinger Health System heart failure clinic, under the supervision of the patient's provider directly overseeing their clinical care; in this case, the patient's cardiologist. Once again, all skills performed by the Mobile Health paramedics were within the scope of practice of a paramedic in the commonwealth of Pennsylvania.

Below is a table of current patients involved in the Geisinger Health System Mobile Health Paramedic pilot program. As of March 31, 2016, the program has provided care to 950 unique patients, with most of the patients have multiple contacts with the program.

3/31/2016	Heart Failure Patients	Other Patients	TOTAL
Home Visit Encounters	149	297	446
Diuresis	132	7	139
Phone Encounters	2746	266	3,012
Total Encounters	3,027	570	3,597

House Bill 1113 addresses, in broad terms, many of the patient care needs targeted by community paramedic programs across the country. In particular, the emphasis on coordinating care and access to community services are areas of great need for patients. EMS providers in general are an excellent resource to gain insight into a patient's environment, as the frequently interact with patients in their homes. They can frequently identify care gaps that would otherwise go unrecognized by primary care physicians, medical specialists, acute care facilities, and post-acute care resources. The final service identified in the bill, "(7) such other services as approved by regulation of the department" allows for flexibility to address the changing needs of the patient population. Such flexibility is critical for programs such as these, which are not focused on interventions for acute pathology. Rather, the goal of the community paramedic program is to address patient specific needs, in a specific community.

An area of concern is Section 501(c), prerequisites for coverage. It states that to qualify for coverage...community paramedicine services must be "ordered by an emergency medical services agency medical director." Most of the patients managed by a community paramedic program are going to be out patients, hopefully overseen by a primary care physician, or ideally a medical home model. These patients should have their care managed by the provider that knows them best, which is not likely to be an emergency physician, yet alone an EMS agency medical director. Although allowing services to be ordered by either a medical command physician or an agency medical director will have value for patients who are being seen post-acute care services in counter (such as an emergency department visit), the majority of the patient's services should be coordinated through the primary care site. In an ideal system, some of these patients will never enter the acute care space, and therefore an emergency physician, medical command physician, or EMS agency medical director will not have any direct knowledge of the patient. Therefore, they will not be the best provider to be ordering services for the patient. It would be hopeful than, that legislation would allow for the most appropriate care provider to order the services for the patients.

It will be important in the development of rules and regulations to ensure an EMS agency medical director is involved, by statue, with any of the operations of the community paramedic program. As these programs will be operating as in EMS agency, all services rendered by EMS providers should have oversight from a physician appropriately credentialed to oversee the clinical actions of the EMS personnel. An EMS agency medical director should be responsible for ensuring the appropriate clinical credentials of any provider operating as a community paramedic. Additionally, the EMS agency medical director should have the latitude to adjust the skill set of the community paramedic to meet the needs of their particular community.

Although details are not provided, the reimbursement construct for community paramedic programs will impact the nature of how this service is provided. Certainly, on a national level, we have seen the EMS benefit being viewed as a "transportation benefit" by CMS, removing EMS from part of the clinical care team and created a construct that focuses on the movement of patients from one location to the other. Of most significant note, with reimbursement being tied to such a discrete patient event, arguably not even a care event, it is therefore impossible to add a value based care component to this reimbursement model.

The ultimate goal of the healthcare system needs to be the provision of high quality clinical care, with the positive patient experience, in a value based reimbursement system. Community paramedicine has the opportunity to provide tremendous quality and value to a patient population. To achieve this goal, the patient must have access to the service when they need it, and the service must be flexible enough to meet the needs of the patient. Any reimbursement structure created for this service must take this into consideration.

Although others can provide for detailed insight from the perspective of a healthcare payor, a fee for service payment structure for community paramedicine is an option, but it is not the best option as it would be difficult to construct in such a fashion that it drives value based care towards the patient, rather than volume based care for the provider. To be effective, community paramedicine services and care must be tailored to the individual patient, which will cause great variation in the frequency and duration of patient encounters. This lens for a reimbursement structure that is much more focused on population health and population management, rather than the fee for service model is necessary.

I do not believe the proposed legislation is so prescriptive that it would not allow rules and regulations to perhaps address reimbursement in this fashion. However, moving forward, the above considerations will be critical so that the reimbursement structure drives this service to provide value to the patients and the health care system.

Geisinger is proud to have "proven" that you can reduce cost while improving quality and outcomes, thereby enhancing the overall "value" for patients, employers, and the government.

We look forward to continuing to work with the various state agencies, the state legislature, and the Administration on developing smart healthcare policy that supports improving the experience of healthcare, improving the health of populations, and reducing per capita costs of healthcare.

Thank you.