

Evolving Patient and Community Needs Work Group

SWOT Analysis of Focus Areas

ET3:

Strengths

- Adapted well to COVID in ALCO with Treat and Refer with Telehelp use.
- Components being used already successfully.
- Physicians interested in a collaborative approach to ET3 in patient centered manner.
- Local model (Contra Costa) to learn from
- Recent legislation supports this.
- CAT and Rapid Response Already in the system up and running similar to ET3.

Weaknesses

- Clinic offload times and establishing relationships with them (ie. Burbank).
- Undefined issues – does transport have to be an ambulance?

Opportunities

- Partnership to create a patient centered system.
- Increased efficiency
- Several clinics already in place
- Recent legislation (AB1544) that includes alternative destinations.
- Bring in CalChiefs for a better understanding.
- Different funding streams
- The need to take a proactive stance in Medicare reimbursement.

Threats

- Program needs to be defined to ensure patient focus and care.
- Electronic PCR form that is not an adaptable platform – multiple alternatives available
- Always needs a physician on-call (as written right now).
- Potential additional workload.
- Funding challenges.

Community Paramedicine:

Strengths

- Highly customizable for the region/community.
- Medics are in the field and get to observe not just patient, but patient's environment.
- Community medics are hands on in the field and know community health needs very well (on-going relationships are formed with patients and healthcare providers).
- Gets the right patient to the right place, sickest patients to acute care, minor patients in non-acute care.

Weaknesses

- Funding needs Medical/Medicare.
- Community medics require additional training/CE to optimize their impact on community health.
- Would require community education.

Opportunities

- build relationships with other resources/ agencies for continuation of care.
- There is capacity within FRALs units if there is the ability to divert.
- Ability to create a program that is a win-win within the healthcare system.
- Possibility to work in conjunction with the Assess and Refer program.
- Options – paramedic-initiated refusal, Telemedicine, Alternate Transport

Threats

- For reimbursement, agencies need to follow what Medicare does to ensure funding.
- Administrators worry about decreased census, possible opposition from hospitals, nurses, Doctors, etc.
- Lack of established alternative transport and destinations.

Alternate Destinations:

Strengths

- Gets patient to right destination for the right treatment – Patient focused.

Weaknesses

- Current assembly bill only covers two alternate destinations – recovery center and behavioral health center. This would need to expand.
- Need to work with pre-hospital lobbyists to gain legislative approval for alternate destinations.
- Difficult to make the program rely on the medics getting receiving clinic approval for transport, should establish criteria that allows transport to alternate destinations (ie. Urgent Care, clinics, etc.)
- Possible long(er) offload times
- Perception of lesser level of care if they do not go to an ED.

Opportunities

- Create alternatives to use of ambulance, other options, app based rides.
- Could be a non-911 system unit doing assessment and/or transport.
- Create a minimum receiving facility standard.
- Stand-up clinics to support this system? Demand based pop-up clinic.
- Paramedics with Community Paramedic training could become true experts.
- 911 Paramedic refers to CP, CP counsels on options, system does not necessarily provide the transport, but access to alternatives may exist.

- Staff a clinic with ambulance personnel who can assist with patient care during peak times and transport if a patient's condition changes.
- Insurance companies as benefactors of this can partner on implementation/legislative initiatives needed.
- Higher level of care in field response with specialized care.
- Set expectations with alternate destinations regarding offload times

Threats

- Starts to look more like routine healthcare than 911 system – is this the right path?
- Community learns of new access point to system creating a new demand.

Dispatch Direct/ Redirect

Strengths

- Prioritizes care to those who need it most.
- Access point to other options
- Gets the right level of care provider and equipment to the scene.

Weaknesses

- May mis-triage some calls
- Currently some calls that do not translate well between Priority 1-4 (ACRECC) and A-E (Oakland). Efficacy data may be available and is needed.
- Telemedicine is not a substitution for in person contact (including the information garnered by observing scene conditions).
- Potential loss of information in transferring calls

Opportunities

- Telemedicine direct from dispatch center
- FRALS unit may respond Code 2, be divertible or not at all.
- Berkeley not doing MPDS, interested in connecting to other services,
- Further regionalize communications centers to prevent loss of important information.
- Create a third-tier center to handle non fire/ambulance calls or expand existing centers to accommodate. Nurse in the center. Third transfer of a 911 call does, however, raise concerns.
- Like Contra Costa, can place a health care provider (RN) in the dispatch center.
- Alternate response unit for lower acuity calls
- Create a different EMS Call prioritization, or one with greater options in lower acuity situations.

Threats

- What size dispatch center is too big/too small, too many agencies, too few. Pros and cons with all
- May need to transfer non-urgent calls to a different center creating in many cases a third or even fourth call transfer.
- Some dispatch centers have physical limitations and challenges with co-location of additional call screeners.

5150 Patients

Strengths

- CAT Team – here has an EMT and a Social Worker. Started 7/20. EMS does an in-service, CIT, 69 hours of mental health training. Pilot modeled to have 12 teams. 5 staffed now (staffing challenges). Going to 9 teams on 2/14. CAT Team only 4-6% transported to JGPH, ables to translate to other locations, similar data with ERS – 11-12%.
- Approx. 20,000 presentations to JGPH. 0.5% turn arounds to ER – very low
- Under CATT, patients are called clients. Can go to shelters, sobering centers, stay home with follow-up.
- Existing Mobile crisis team with 2 social workers is in-service right now.
- Existing Mobile eval team staffed with social worker and police officer is in-service right now.
- Existing programs like Familiar Faces, Bonita House, iHOD and other programs

Weaknesses

- Wait times at receiving facilities JGPH.
- Medical assessments needed which often tethers the patient to a 911 medic under current system.
- 5150 transfers from JGPH create negative system impact.
- Lack of staffing and funds.
- Use of ambulances – are we just doing it because we are used to it? JGPH being used as a shelter.
- CAT would work better if there were after hours alternate receiving facilities and if it served the entire Alameda County – 1 or more units per city.
- There is no psych shelter for sub-acute available to EMS.

Opportunities

- To define the patient – need for medical component to be evaluated. Need to decriminalize behavioral health. Words discussed include patient and client.
- Law Enforcement gets taxed by a 5150 call. Time on call impacts services to the citizens. Most times this is neither a Law Enforcement problem nor an EMS specific problem. And yet the lack of a viable system impacts each service significantly. It is a Behavioral Health issue as they are the experts on caring for these clients. We need to work together to create the solution for the behavioral health client.
- Non-EMS or single service transport options under appropriate conditions ie Uber type transport

- San Mateo Co. model where there are mental health paramedics that can write 5150 holds.
- Third service or through CAT expansion – dedicated transport in alternate type unit ie. SUV – ambulance still would transport combative/restrained patients.
- Behavioral Health Telemedicine
- Use of Measure C money an option.
- Access available funds from the County or other source and have Behavioral Health contract with someone to handle 5150 transports. – (different process for current)
- Create an ability for field providers to access patient records to get a better picture of the client’s overall situation.
- Significant need to allow transport of behavioral health clients to alternate facilities.

Threats

- Staffing and funds
- CAT Program is grant funded, which may limit sustainability.
- JGPH can be a system choke point.
- Having access to an alternate destination is critical for meaningful change. This would require a change to Title 22 as understood by the workgroup.

Specialty Care and Populations – Overview

For the purposes of our discussion, defined as: domestic violence, autism, elderly, hearing and sight impaired, developmental challenges, bariatrics, patients attached to medical technology, homeless, hospice, chronically ill, system abusers, behavioral issues, dementia, Alzheimer’s, neonatal.

Strengths

- System currently has some ability to link to services that already exist, but the people may not have already been able to access. Field providers may deepen this role.
- EMS System can sometimes be the only advocate for some populations.
- EMS System sees people in their home environments.

Weaknesses

- EMS System often does not satisfy the need that they accessed the system for
- Currently, we are poor at recognition and resourcing. Needs specialized training for success.
- Lack of a plan for alternative transportation.
- System presently does not link field providers with all the available resources.

Opportunities

- Bridge between patient and services with properly trained provider/case manager role. Accessing these resources can solve some of the problems in a long-term/sustainable manner.
- Train providers on how to serve as this role.
- Reduce stress on the system through preventative actions or getting them to the right place.
- Coordinate data/patients on a regional approach –patients will often cross borders ie. EDIE – Sutter emergency department patient information exchange – opportunity to create this for EMS.

- High system utilizers often are bigger than EMS (lift assist, law enforcement, other resources) – is there a way to thread system use?
- Education and sharing of resources present day.
- Create a system to link field-based responders with existing resources with multiple access points including web, app and phone
- These groups require specialty knowledge and involve use of infrequent skills. Instead of one annual P&P update, focus ALCO paramedics training monthly to address specialty populations/needs.

Threats

- Lack of follow through, system really may not have depth to meet all needs, patient may not handle their role in follow-up.
- EMS filling a gap that is not otherwise filled (or non-EMS units accessed through the system)
- Getting lost in a new system that we have created (“Handoff”)
- Depth in system to ensure services are delivered.
- Service levels required may not exist. Referral may not always be a solution.

Special Needs Populations Notes by Sub-Group

- Hearing and sight impaired
 - o Training exists but could be standardized amongst all providers.
 - o Perhaps something in the protocol manual
 - o Limited sign language resources, braille forms
 - o Is there a facetime interpreter out there?
- Work with the schools for the Deaf and blind – likely have resources.
- Agencies that have language differentials include ASL.
- People on the spectrum
 - o Some training, but on a spectrum as well – Is improving.
 - o Some resources in our group and at EMS with firsthand experience, community resources,
 - o Innate abilities and use of other resources on the scene.
 - o Partner with agencies doing this work.
 - o What works with these patients may not work with others.
 - o Protective families
- Bariatric Patients
 - o Bariatric Unit – exists but not staffed, and not everyone cross-trained.
 - o Other agencies may have bariatric units.
 - o Most ambulances can now transport up to 750lbs.
 - o Stryker with bat wings helps but doesn’t capture all patients’ parts.
 - o Ferno may be a better alternative. Torso width a big issue
 - o Need appears to be decreasing.
 - o Challenges of getting patient to the gurney.
 - o Would need more units ideally staged throughout the County.
 - o Hospital coordination is a challenge with these patients.
 - Supervisor/BC often ends up at hospital to help.

- Most (maybe all) hospitals have “Lift Teams” that should be called out for patient transfers
- Even hospitals not equipped, may have to order a bed from their vendor.
- There may be benefit to identify bariatric receiving hospitals
- Victims of Violence (domestic, child abuse) and Sex Trafficking
 - Annual training on recognition, treatment, and appropriate notifications needed.
- Neonatal
 - Infrequent skill, and potentially intimidating to care providers that should be addressed through training.
 - Lack of neonatal official destination protocol despite 3 receiving facilities equipped for this.
- Also discussed geriatric, hospice, Alzheimer’s, dementia, those reliant on medical devices

Exclusive Operating Area/Next RFP

Strengths

- Maintaining the EOA provides for single point of contact, significant decrease in complexity for dispatching, continuity of service.

Weaknesses

- JPA Model – considered by the group to be overly complex with minimal benefit.
- Open system – considered by the group to be ineffective and potentially risky.
- Third Public Service – considered by the group to be overly costly.
- EOA – a job action or provider fiscal stability can threaten service.

Opportunities

- Our group believes that an EOA with a single bidder is the proper model to continue with. We did not achieve consensus on whether this was through an alliance model or a single contractor (likely private) model.
 - Alliance
 - Potential for additional revenue streams
 - Single Contractor
 - One agency to deal with
- Create an RFP that allows for trial, error and trying again at improving the EMS system – build a learning system that can evolve within the term of the contract.
- Create a system that supports a wider look at field care as discussed in all our other focus areas.
- Enhance dispatch up to support proposals in new system.

Threats

- Alliance model revenue not returned to EMS system.
- No models under consideration necessarily address job satisfaction and/or employee turnover. Discussion on whether it best to accept this as it may not be changeable.