Pragmatic Practices or
Precarious Prescription?

Impact of Oregon Health Care Reform on Multnomah County EMS

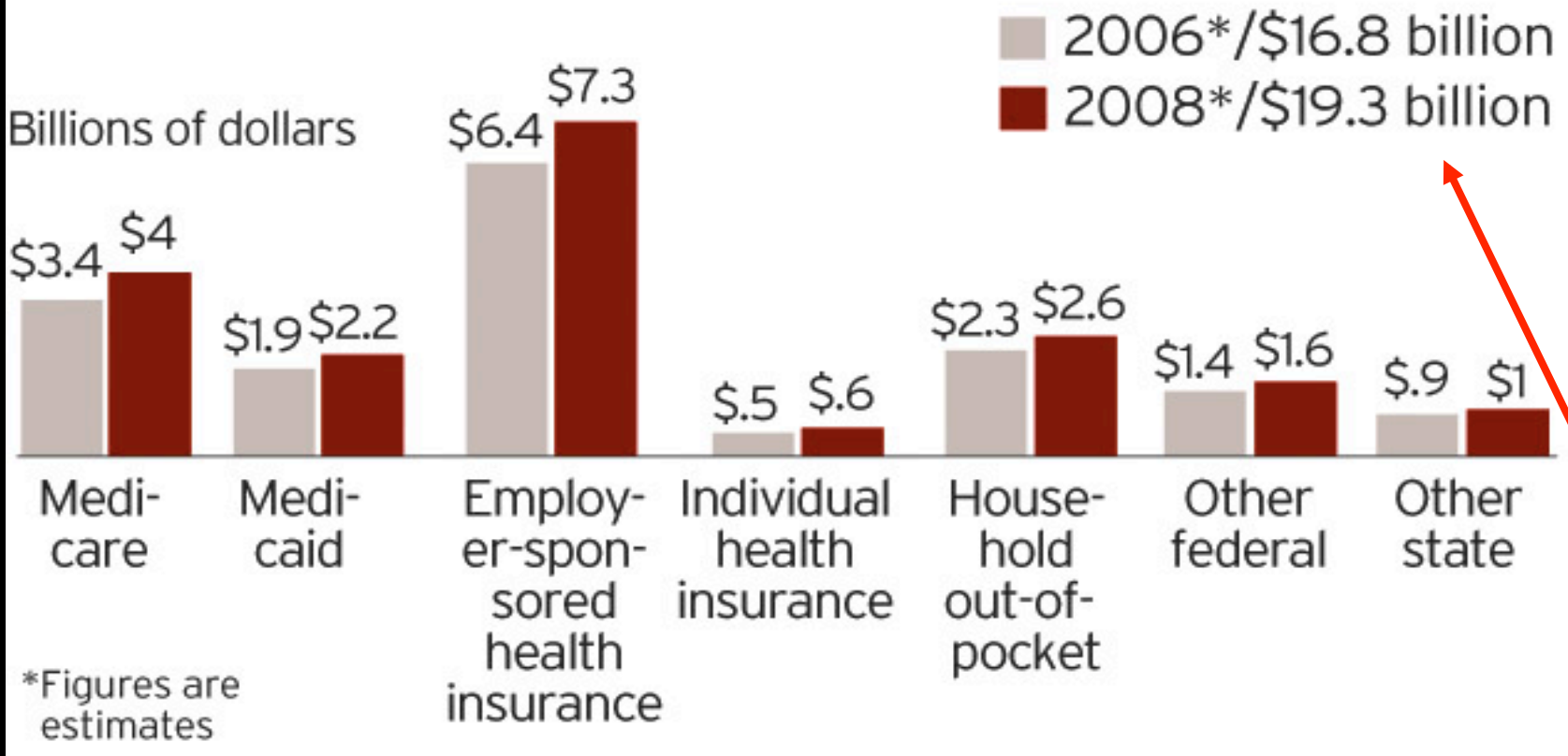
Oregon Health Plan History

- The Oregon Health Plan was conceived and realized in 1993

- It was intended to make health care more available to the working poor, while rationing benefits.

Health Care Spending

Oregon's total health care bill climbed an estimated 15 percent between 2006 and 2008.



Source: Office for Oregon Health Policy and Research

MICHAEL MODE/THE OREGONIAN

Health Care Innovation Awards: Oregon

Share

Notes and Disclaimers:

- *Projects shown may also be operating in other states (see the Geographic Reach)*
- *Descriptions and project data (e.g. gross savings estimates, population served, etc.) are 3 year estimates provided by each organization and are based on budget submissions required by the Health Care Innovation Awards application process.*
- *While all projects are expected to produce cost savings beyond the 3 year grant award, some may not achieve net cost savings until after the initial 3-year period due to start-up-costs, change in care patterns and intervention effect on health status.*

Where Health Care Innovation is Happening

ACA + CMS : Oregon Health Plan

- In a special experiment the Obama Administration gave Oregon almost **$2 billion** to come up with its own system to coordinate care better.'

- The idea is to get doctors, nurses, hospitals and other caregivers to work together – and get paid well -- to keep people healthy and to get rid of wasteful, unnecessary care.

What is unique about Oregon Health Plan 2012 Proposal

- Access to Care
  - Insurance
  - Clinics
  - Hospital
  - Primary care provider

- How **care is actually delivered**

Oregon Tri-County Health Commons Summary

- **Funding Amount:** $17,337,093
  Estimated 3-Year Savings: $32,542,913
- To Develop Medicaid Coordinated Care Organization (CCO)

- Payer: Care Oregon
- Providers: All health care providers in the metropolitan Portland Region
- Public Health : Multnomah, Clackamas, Washington County

Oregon Health Plan : Coordinated Care Organizations

- CCO is a network of all types of health care providers who are working together for people who receive health care coverage under the Oregon Health Plan.

- CCOs focus on prevention of illness and disease and improving care to keep patients healthy and to manage existing health conditions.

Current System: The Problem

Lower Acuity Patients

- 5% - 10% of 911 calls may quality for Alternate Care Services

Frequent Users

At-Risk Patients At Risk for Hospital Readmission

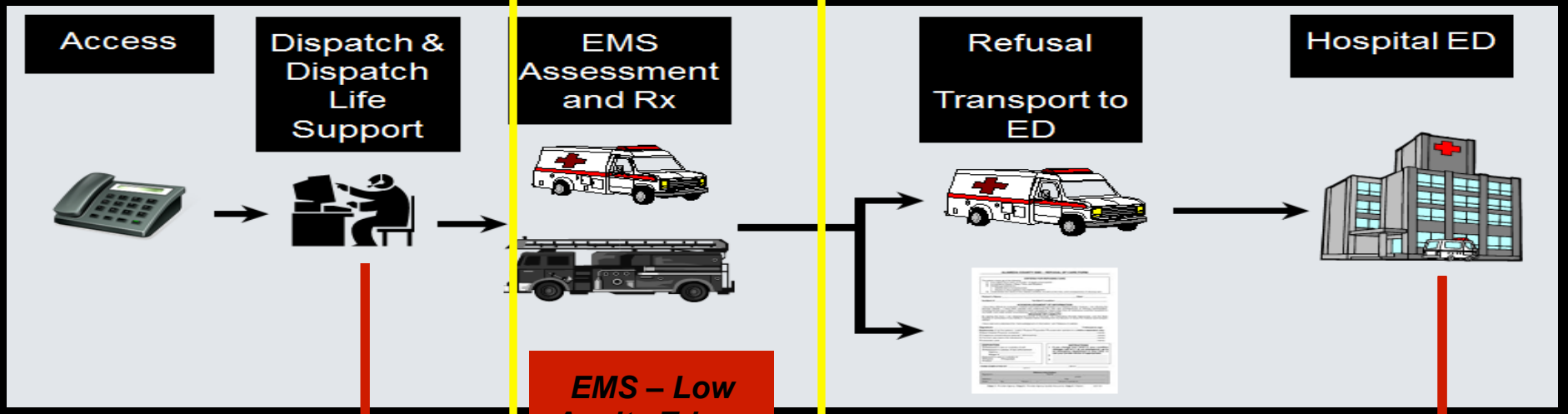
Current System: Why people call 911?

- It's what we've taught them to do.
- No access to care
- Only medical care open at time
- Unable to get into see their primary care clinic
- They believe they are having an emergency.
- Unmet social – psychiatric needs.
- Because their doctors tell them to.

Portland EMS Initiatives

- High Readmission Risk
  - TVF&R Mobile MH and Mobile IHC Pilots
  - Kaiser & Metro West Pilots
- Frequent Users
- Lower Acuity

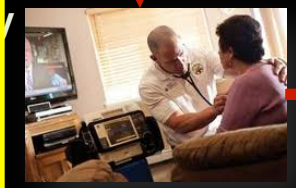
EMS Timeline



EMS – Low Acuity Triage

Community Healthcare Program

(Low Acuity Patients)



911 - Nurse Triage

Mobile Integrated Healthcare Practice

Medical Consult

Clinic Appt,

Rx & Release

(Frequent Users & At-Risk Patients)

Alternate Destination and Alternate Transportation (ADAT) Pilot Program

- Goal:
  Triage right patient to Right resource at Right time

EMS – Low Acuity Triage

- Estimated Cost per Call + Clinic Appt. = $ 500
- Traditional EMS Response and Transport to ED = $1,000 to $2000

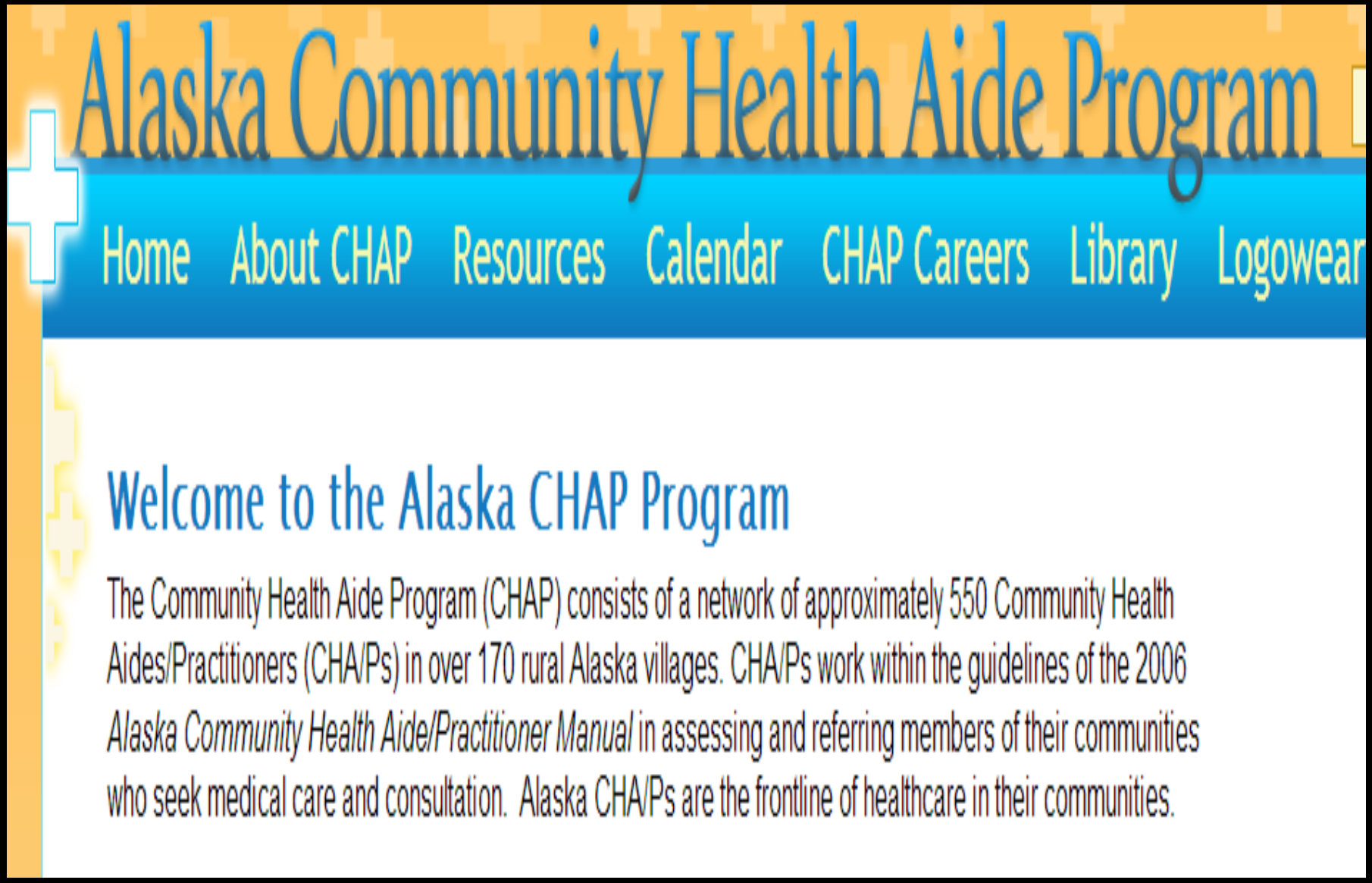
- 60,000 EMS transports in Multnomah County, assuming 10% of transports in Multnomah County, cost savings approximately $3,000,000 per year.

MCEMS Alternative Destination and Transport Project Summary

- Paramedics triage in field by protocol
  - If lower acuity problem identified and patient qualifies, then offered alternative to ED
- Coordination Center finds same day appointment **Primary Care Home Urgent Care Center**
- Non-ambulance round-trip transportation arranged

Alternative Destination and Transport Project Components

- Field Protocols Developed
- Paramedic Training (4 hours)
- Multiple Non-ED clinical sites engaged
  - Federally Qualified Health Centers
- Medicaid Health Plans agree to payment for field triage- HSO, Family Care


Alaska Community Health Aide Program
Home
About CHAP
Resources
Calendar
CHAP Careers
Library
Logowear
Welcome to the Alaska CHAP Program
The Community Health Aide Program (CHAP) consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 *Alaska Community Health Aide/Practitioner Manual* in assessing and referring members of their communities who seek medical care and consultation. Alaska CHA/Ps are the frontline of healthcare in their communities.

NORTHERN ROCKIES INTERAGENCY

INCIDENT MEDICAL SPECIALIST PROGRAM


TEAM INFORMATION

Qualified R1 - IMS

Alternate R1 - IMS

Dispatch Procedures

Team Schedule

FIRE SEASON STATISTICS

Multnomah County

EMS Field Guide

Alternate Destination/ Alternate Transport

November 4, 2013

COORDINATION CENTER
503-231-6300

ADAT Cardinal Conditions

- Age > 64 or < 5 years
- Loss of consciousness
- Compromised airway or respiratory distress
- Uncontrolled bleeding
- Sustained abnormal vital signs
- Abnormal vital signs
- Appears ill
- Pregnancy over 20 weeks
- Immunocompromised
- Chemotherapy
- Dialysis
- On immunosuppressant or steroids
- HIV
- Transplant
- Acute intoxication
- Suicide attempt
- Child/elder abuse
- Behavioral disorder

ADAT Clinical Presentations

- Hypertension
- Eye
- Ear pain
- Nose bleed
- Sore throat
- Dental Pain
- Asthma
- Bronchitis
- Diarrhea
- Dysuria
- Musculoskeletal Pain
- Low back pain
- Burns
- Cellulitis
- Laceration
- Hypoglycemia
- Seizures

5. Sore Throat Acute

HX	PE	DDX
▪ Onset of symptoms (gradual or acute) ▪ Duration and severity ▪ Accompanying upper respiratory symptoms (rhinorrhea or coryza) ▪ Difficulty swallowing ▪ Difficulty breathing ▪ Hoarseness ▪ Previous strep throat	▪ Fever / tachycardia ▪ Toxicity ▪ Airway patency ▪ Pharynx ▪ Tonsils / exudates ▪ Cervical lymph nodes ▪ Neck swelling	▪ Acute epiglottis ▪ Acute retropharyngeal abscess ▪ Tonsillar or peri-tonsillar abscess ▪ Foreign body ➢ Children (food or objects) ➢ Adults (more often food, e.g. chicken or fishbone) ▪ Burns

Triage Matrix

	ED	Clinic
Fever	YES	NO
Ill appearing	YES	NO
Severe pain	YES	NO
Hoarseness	YES	NO
Difficulty with breathing or swallowing	YES	NO
Able to open mouth	NO	YES
Swelling around tonsils	YES	NO
Neck swelling	YES	NO

HX	PE	DDX
Visual acuity (loss of vision, decreased, one eye vs. both eyes) ➢ Pupil size and reaction ➢ Extra ocular movements ➢ Erythema ➢ Pain (location, onset, duration, progression) ▪ Trauma ▪ Eye protection ▪ Chemical burn ▪ Eye protection ▪ Contact lens ▪ Hx of glaucoma or other eye history	▪ Visual acuity ▪ Eyelids ▪ Pupils (size and reactivity) ▪ Extra ocular movements ▪ Lids (upper and lower) ▪ Sclera ▪ Cornea ▪ Anterior chamber ▪ Lens	Vision loss ➢ Central retinal artery or vein occlusion ➢ Vitreal hemorrhage ➢ Retinal detachment ➢ Foreign body / trauma Red Eye Conjunctivitis ➢ Uveitis ➢ Glaucoma ➢ Corneal trauma (foreign body, abrasion etc.) ▪ Chemical burn ▪ Trauma to eye

	ED	Clinic
Penetrating trauma	YES	NO
Chemical burns	YES	NO
Decreased vision	YES	NO
History of glaucoma	YES	NO
Severe pain	YES	NO
Pain response to topical anesthetic	NO (pain persists)	YES
Nausea / vomiting	YES	NO
Eyelids	Abnormal or swollen	Normal
Pupil response	Abnormal (sluggish)	Normal
Conjunctivae	Injected	Injected
Cloudy or abnormal cornea	YES	NO

MCEMS ADAT Results to Date

- Enrollment lower than expected
  - Anticipated 10-15 patients per month
  - **Actual: 1-2 patients per month (total of 6)**

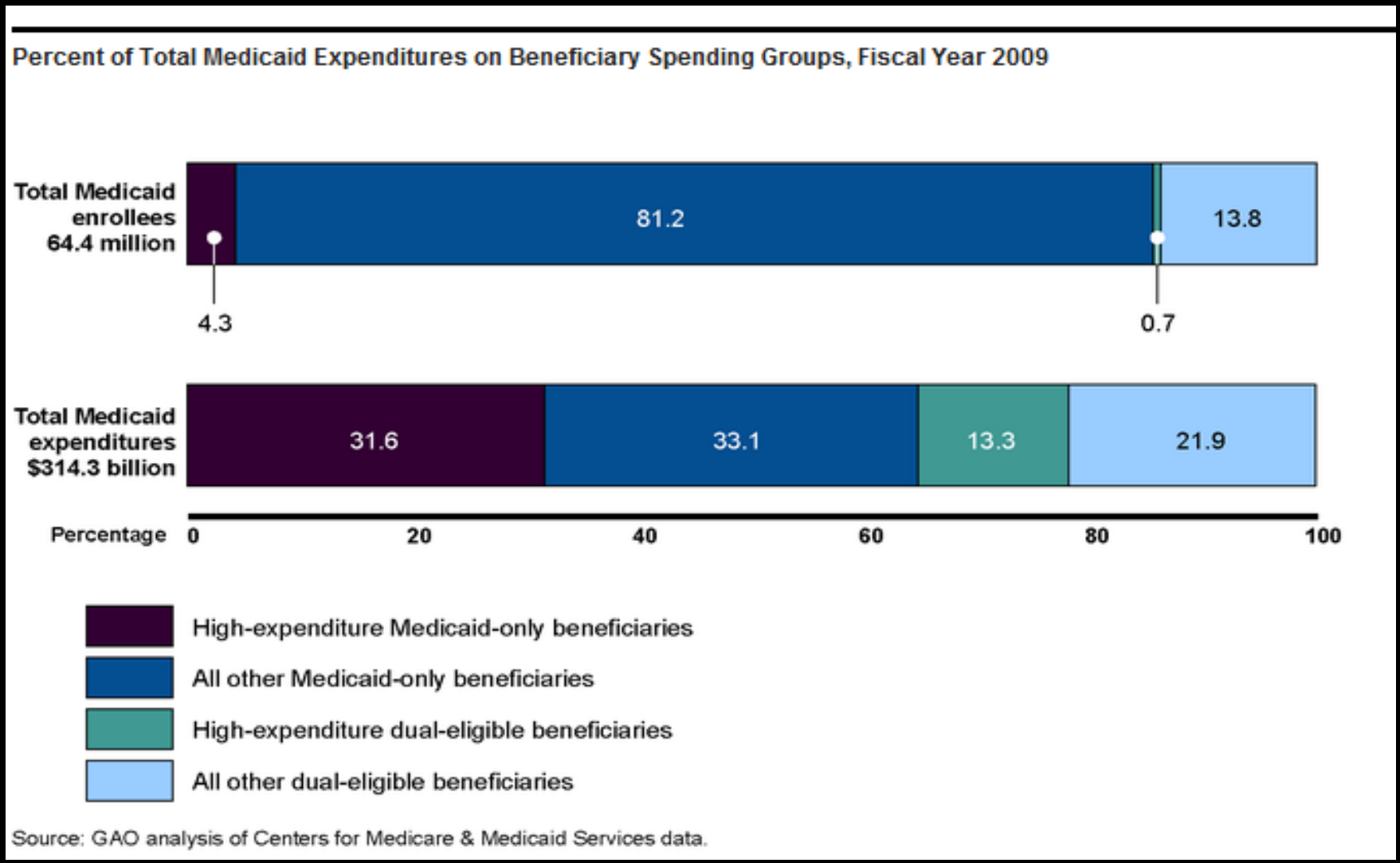
- Successfully identified patient
- Successfully coordinated patient movement to clinic

MCEMS ADAT Results to date

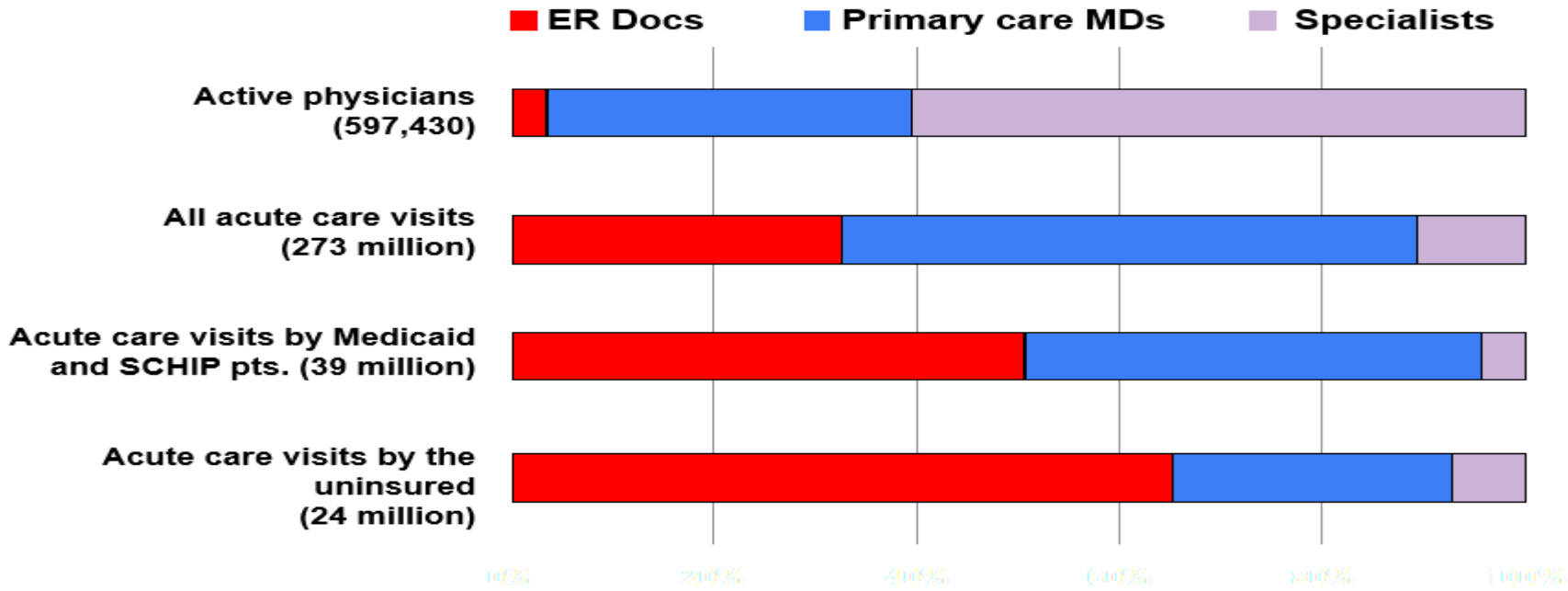
- Barriers identified
  - Lack of insurance
  - Clinics not open
  - Age

EMS Frequent Users
Key Program Components

GAO: Medicaid Expenditures



Who Cares for the Poor?



SOURCE: Pitts, Carrier, Rich and Kellermann. *Health Affairs*, Sept 2010

A9750-15 04/2012

Tri-County 911 Service Coordination Program (TC911) Goal

Connect to Mental Health, Aging &Disability, Primary Care Provider, etc.

- Right care, right place

- Referrals:
  - Weekly data reports
  - From fire/ambulance agencies

- Staffing:
  - 4 LC Social Workers

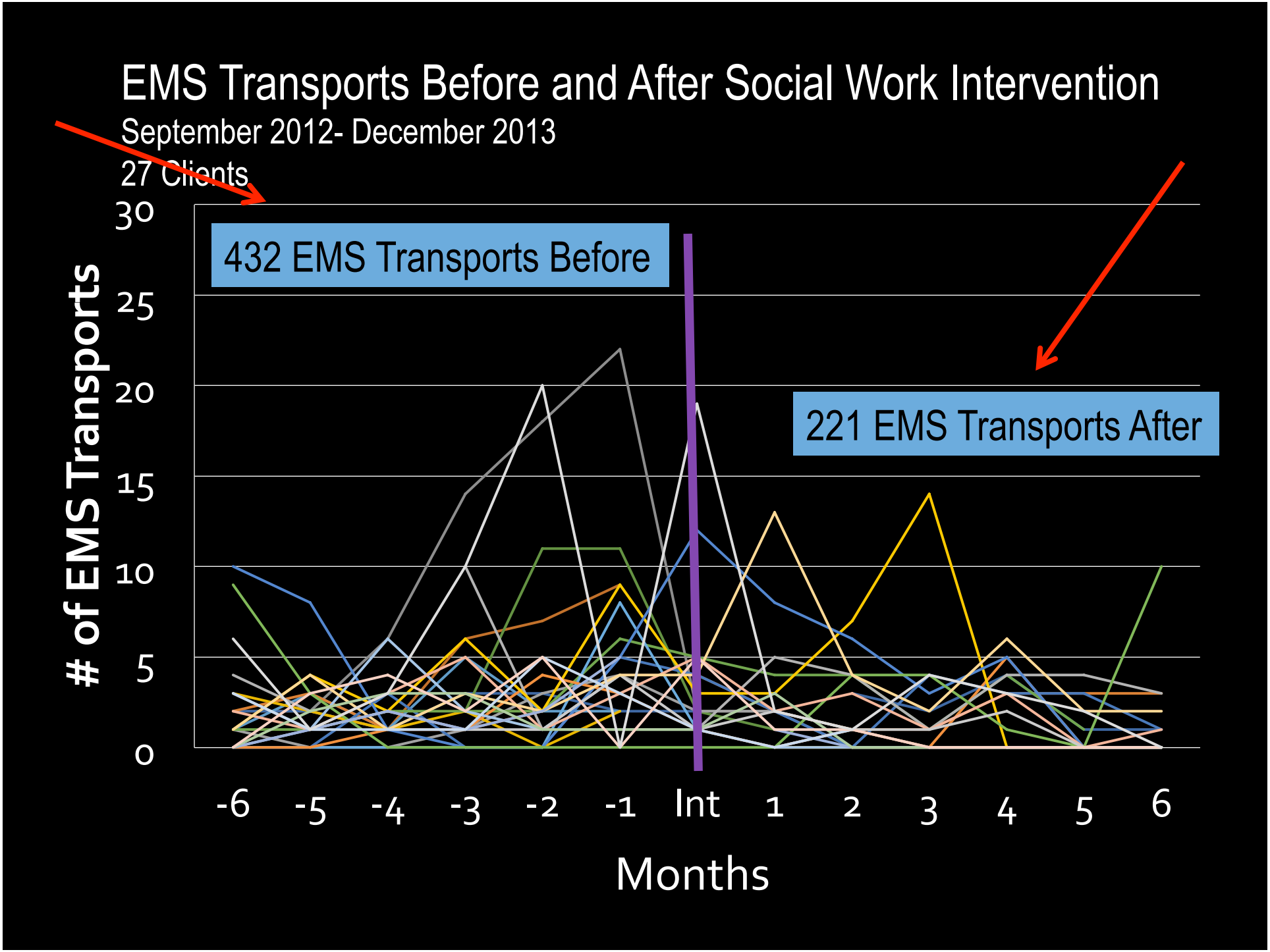
TC911 Eligibility & Interventions

- What staff do:
  - Provider notification/consult
  - Multi-system care coordination
  - Short-term intensive case management (3- 6mos)

- Client Eligibility:
  - Clackamas, Washington, Multnomah residents,
  - **6+ EMS incidents in 6 mos.**, and
  - Health Share of Oregon/Medicaid*

TC911 Client Profile & Outputs

- 50% significant alcohol and/or drug impairment
- 50% mental health condition (psychosis, SI)
- 25% no primary care provider


EMS Transports Before and After Social Work Intervention
September 2012- December 2013
27 Clients
432 EMS Transports Before
221 EMS Transports After
# of EMS Transports
30
25
20
15
10
5
0
-6
-5
-4
-3
-2
-1
Int
1
2
3
4
5
6
Months

MCEMS Potential Cost Savings

EMS Cost $1000.00

ED Cost $500.00

Cost savings over 4 months – $316,000.00

Cost savings over 12 months = $ **1,266,000**

Summary

- System wide case management of **frequent EMS** users is one of the most cost effective interventions

- EMS triage of patients presenting with lower acuity symptoms are a promising cohort but safety and cost efficiency remains to be proven

The END