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**Office of Statewide Health Planning and Development (OSHPD)
Health Workforce Pilot Projects (HWPP) Program
HWPP #173 Community Paramedicine
Advisory Committee Meeting Notes
January 22, 2015**

The HWPP #173 Advisory Committee meeting was scheduled on January 22, 2015 from 9:00am-1:00pm at the Office of Statewide Health Planning and Development (OSHPD) in Sacramento, California in Conference Room 471.

Welcome and Introductions
Liz Martin, Healthcare Workforce Development Division Access to Care Section Chief, welcomed the meeting attendees, OSHPD staff and public guests. Ms. Martin announced that this was the second meeting for HWPP #173 and asked all members of the Advisory Committee and Council of Advisors to introduce themselves and their representation to the group.

December 8, 2014 Meeting Highlights
Kristen Widdifield, Program Administrator, provided a summary of the highlights from the first Advisory Committee Meeting, which was held on December 8, 2014. These included:
- Overview of HWPP
- Milestones for HWPP #173, including OSHPD approval of the project on November 14, 2014, initial Advisory Committee Meeting on December 8, 2014 and the beginning of Community Paramedic (CP) training in January 2015.
- Review Advisory Committee and Council of Advisors Roles and Responsibilities, including the differentiation that Advisory Committee members can vote and the Council of Advisors cannot
- Power point presentation of HWPP #173 by the California Emergency Medical Services Authority (EMSA)
- Power point presentation of data collection frequency by the University of California San Francisco (UCSF) Center for Health Professions
- Break-out sessions to review patient outcome data, including a report-out of the major discussion items

Presentation of Patient Outcome Data Elements
Ms. Widdifield presented a spreadsheet which captured all of the feedback received from the Advisory Committee and Council of Advisor members at the meeting on December 8, 2014. Ms. Widdifield explained the content on the spreadsheet to include the following:

1) <u>Data Elements:</u> The recommendations for specific criteria or data elements the committee members wanted to see included in the project are captured here, sorted by concept.

"Access to Safe, Quality Healthcare Environments that Meet California's Diverse and Dynamic Needs"

2) <u>Already Part of Data Collection (Yes or No):</u> As part of the analytical staff work completed, all committee recommendations were cross-compared with the application and addendum submitted by EMSA to identify which data elements were already proposed to be part of EMSA's data collection.
3) <u>Recommend Including (Yes or Exploratory):</u> Program staff recommended to either implement the data elements as part of HWPP #173 or continue to explore the feasibility of including this data element. For easy reference, the color coding in the spreadsheet is indicative of whether the program staff has decided to include (green) or explore (yellow) each data element.
4) <u>Recommended Reporting Mechanism:</u> For those data elements which program staff decided to implement, this column provided a recommendation of how to best capture the data.

A copy of the spreadsheet was provided as part of the meeting folders for all attendees. Ms. Widdifield further explained that this process highlighted both the due diligence demonstrated by EMSA in their thorough data collection as well as the support for Advisory Committee recommendations used to strengthen the project.

2015 Site Visit Schedule
Ms. Widdifield announced that site visits would begin in March 2015. She further explained that while the first visit will be taking place during the training phase, the remaining visits (scheduled monthly beginning June 2015) will be held during the implementation phase. Ms. Widdifield identified that the main purpose of site visits will be to:

- Conduct interviews with educators, CP students, CP supervisors and other relevant project participants
- Review administrative documents including protocols, curriculum, grade logs, patient care reports, etc.
- Conduct an on-site meeting with Advisory Committee members and OSHPD staff to review concerns and discuss highlights

A complete schedule of the proposed travel dates for 2015 was distributed to the group and committee members were asked to sign up based on their availability. In addition to site visit dates, the next Advisory Committee meeting is planned for October 15, 2015 in Sacramento, CA. As with all program activities, eligible travel expenses can be reimbursed by OSHPD in accordance with travel guidelines.

Presentation of HWPP #173 Training Update and Protocols – EMSA
Lou Meyer, EMSA Project Manager, conducted a power point presentation which provided an update of current training efforts as well as the process that EMSA engaged to develop project protocols. An electronic copy can be found attached, but the major discussion topics of his presentation included:

- Core training is mainly being conducted by the UCLA Center for Prehospital Care at eight satellite sites located throughout the state
- There are a total of 79 CP candidates currently in training (photos by site included)
- Overview of "Moodle," the learning management system tool which will track student materials, grades, assignments and provide administrative support for faculty
- Explanation of competencies and evaluation measurements
- Protocol development process, including review by the local Advisory Committee and Medical Director

Some of the concerns raised by committee members included the number of CPs being trained, number of alternate destination support paramedics being trained, supervision for CPs, anticipated number of patient outcomes for the project, transfer of patient care to alternate destination facilities and questions related to the Emergency Medical Treatment and Labor Act (EMTALA). Dr. Howard Backer, Director of EMSA, and Mr. Meyer fielded questions.

Break-Out Sessions
The Advisory Committee and Council of Advisor members sat together in groups of five or six individuals. Each group worked together to discuss the five concepts presented by EMSA including alternate destination, post-discharge follow-up, 911 frequent users, direct observed treatment of tuberculosis and hospice patient support. Specifically, they were given 45 minutes to discuss 1-2 concepts at a time and complete the following instructions:

1. Review the protocols provided.
2. Determine if there is consistency across protocols for similar concepts (Alternate Destination, Post-Discharge Follow-Up and 911 Frequent Flyers)
3. Outline recommendations discussed which could help strengthen the protocols.

Each subsequent group built on the recommendations presented by the previous groups(s) so the information collected is a culmination of all discussion items. The comments regarding data elements or outcomes they would like to see captured by EMSA are summarized as follows:

Post-Discharge Follow-Up (General Comments)
- Protocol alignment if not standardized
- Increase consistency with regard to:
  - Training for similar conditions
  - Intake process for similar conditions
  - Patient inclusion and exclusion criteria
  - Method of interacting with program participants
  - Timeframe of initiating contact and completing treatment with program participants (i.e. UCLA is 24-48 hours post-discharge and Butte is 24-72 hours post-discharge)
  - Standard protocol for all sites with similar conditions
  - Interface with the hospital and the CP
- Additional inclusion criteria
- Protocols need more detail
- Develop more specific parameters
- CPs should contact the treating physician to ensure understanding of the discharge plan
- Increase the size of the visual charts so that they are more readable
- Specify the types of conditions included in the project (i.e. which types of chronic conditions)
- Explain how the CPs will obtain the discharge instructions when the patient does not have them
- Clarify who receives the assessment report in order to ensure continuity of care
- Assign numbers for diagnostic criteria so that protocols are easier to follow
- Explain in an algorithm what the CP would do if the patients don't understand their discharge instructions
- Would like more information on the documentation methodology to be used for baseline reporting
- Specify the number of patient visits and the duration of time required for each visit
- Identify the number of visits needed to get the patient healthy in the long-term
- Clarify who the CP would contact at the hospital – case manager or discharge planner?

- Identify who the "case manager" contact is
- There is currently no evidence of the commitment of the discharge planner to the CP

Post-Discharge Follow-Up (Site Specific Comments)
- CP 002 UCLA – Do not like this protocol at all, should try to replicate CP 004 Butte. Criticism includes "tipping point," grouped sections are unclear, too segregated, not succinct, and needs additional patient inclusion criteria.
- CP 004 Butte – Love this protocol and the visual displays. Red, yellow and green sheet is great and easy to follow. Consider adding to other protocols. Also really like the patient inclusion criteria.
- CP 007 Alameda – Protocol is way too broad. The physician should be asked to be as consistent as possible for the specific conditions. Discharge instructions are not clear.
- CP 008 San Bernardino – covers the discharge instructions thoroughly, others should look to follow this one. Patient acquisition is by the patient, not the CP.
- CP 013 Solano – Medication problems and would like to know who the referrals are for. Should add case management.

Alternate Destination (General Comments)
- Include a definition for some terms such as "minor trauma" to ensure consistency in understanding
- Expand the exclusion criteria to include syncope, intoxicated (prescribed, over the counter or illegal), chest pain, abdominal or pelvic pain, seizures, altered neurologic function, dialysis immunocompromised, severe hypothermia and the elderly patient population (65+ as an example)
- Increase consistency and standardization with regard to:
  - Vital signs
  - Clarification that the urgent care site should be called before diverting
- Review the SIRS criteria
- Spell out all acronyms
- UCSF should consider using "codes" for the chief complaint
- Clarify medical control

Alternate Destination (Site-Specific Comments)
- CP 001 Los Angeles
  - Provide a definition of medical control and who is completing the decision-making
  - Need clarification on how many patients would be accepted
- CP 003 Orange County – Add instructions to call the Urgent Care Center first to section C.
- CP 009 Carlsbad
  - Rationale for protocol language should be removed
  - Remove language that states "facility of their choice" if all patients must be taken to a Kaiser facility
- CP 012 Stanislaus
  - Section V. Procedure A1. No "medical complaint" should be taken out and replaced with "emergent issue" instead.
  - Section V. Procedure C. Need clarification on dispatch procedures
  - SIRS criteria should be used across the board

Direct Observed Treatment of Tuberculosis
- Clarify who the controller/designee is (RN, MD or other)
- Explain how medication will be dispensed
- Clarify patient participation by being more specific as to who would be eligible

- Identify if both the patient and a legal representative can provide consent
- Explain what the CP would do if they could not obtain consent
- Would like to know if the California Department of Public Health provides the kits
- Would like to know if CPs consult with public health officials
- Explain where the kit resides, with the CP or at the patient's house?
- Outline what safety measurements or personal protective equipment are in place to assure the CP's safety with regard to exposure
- Would like to know if CPs are assigned a full case load or providing backfill
- Clarify if the CPs will use blister packs
- Would like to know if it will be easy to monitor the cost

Hospice Patient Support
- Clarify who is preparing the kit (CP or hospice provider) and where it is located
- Clarify if the treatment plan is attached to the kit and who is responsible for updating the treatment plan
- Provide additional detail regarding the hand-off between the CPs and hospice
- On page 2 under Patient management # 5 the wording is confusing. Would like to change "reassessed" to reevaluate. Would also like expansion on what a "final plan decided on" means?
- Clarify if a 911 call indicates that a hospice RN needs to come out
- Explain if a hospice RN or physician is available on site or on the phone
- Explain if CPs are allowed to alter the dosage of prescription medications
- Would like to know if the CP will be updating the clinician

911 Frequent Users (General Comments)
- Provide a definition for a "911 frequent user"
- When developing a care plan, this should include multiple stakeholders (i.e. social services and others)
- Need to focus more on intervention rather than circumstances
- Confounds community outreach and support with the Alternate Destination projects
- Explain what the CPs will do if no one if is available to take the patient to visit a primary care physician
- Clarify if the CP will transport the patient
- Use one word to identify patients; on some pages a patient is also called an enrollee/client
- Spell out acronyms
- Would like to know if there is a template for developing a care plan

911 Frequent Users (Site-Specific Comments)
- CP 007 Alameda - Define the timeframe for recently discharged and would like to know who is following up for clarification on discharge instructions, patient or CP?
- CP 010 San Diego - Should be aware that there is Mental Health program in San Diego called "RAP" which may be confused with "WRAP" (Wellness Recovery Action Plan)

Opportunity for Public Comment
There were no public comments made.

Follow-Up Items

Ms. Widdifield will complete these follow-up items:

- Develop meeting notes and provide absent members the opportunity to provide input
- Distribute finalized meeting notes
- Meet with EMSA to discuss implementation of OSHPD's recommended patient outcome data elements to be added to the project
- Develop a summary for Advisory Committee and Council of Advisors members to outline the patient outcome data which was approved
- Complete travel expense claims for Advisory Committee and Council of Advisors members

The meeting adjourned at 1:10pm.