A ‘No Emergency’ Paramedic

In a new role, paramedics schedule visits to patients at home for checkups and post-hospital care.

By Laura Landro

Paramedics, who race to emergencies and transport victims to the nearest ER, are taking on a new role: keeping patients out of the hospital.

An initiative, called community paramedicine, is training the fast responders in chronic disease management, medication compliance and home safety. Paramedics are then sent on scheduled house calls to frail and elderly patients or those who have trouble managing chronic conditions like heart failure and diabetes.

Community paramedics take vital signs, administer IV medications, and perform lab tests as well as help patients understand follow-up instructions after being discharged from a hospital. They check for risks such as where patients could fall in their homes and whether they understand their medical regimens. They also work with doctors, nurses, dietitians and physical therapists to coordinate future care.

In this new role, paramedics augment existing programs like visiting nurse services and home care. They also treat patients who don’t meet home-nursing criteria or don’t want someone in their home all the time but still have complex needs, says David Schoenwetter, an emergency physician and head of the mobile health paramedic pilot program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, Pa., part of Danville, Pa.-based Geisinger Health System.

“Paramedics are a readily deployable, nimble, clinically trained resource who can help close a gap in American health care,” Dr. Schoenwetter says.

The programs aim to reduce the high costs of emergency room visits and inpatient hospital stays. Hospitals are facing financial penalties from Medicare and other payers when patients are readmitted to the hospital within 30 days of being discharged. A shortage of primary-care doctors and nurses also means paramedics, who have increasingly added medical skills, offer a novel way to get care to more people, especially in rural areas.

In the Geisinger pilot program, mobile health visits can be requested by a patient’s primary-care doctor, a cardiology clinic, or after an emergency room or hospital discharge. Patients who frequently visit the ER are offered the option of being seen at home by a paramedic as an alternative to an ER visit and potential hospital admission, especially for conditions that can be treated at home if caught early.

For example, in heart failure, the heart can’t pump blood normally, and symptoms of a worsening condition include fluid retention. Patients are given a number to call if they develop such symptoms. A paramedic will visit and sometimes use mobile video conferencing technology so doctors can see and talk to patients.

In June 2014, Marjorie Dominick, a 75-year-old heart-failure patient who lives in Pocono Lake, Pa., began to get swelling in her legs and feet, and shortness of breath. She went to the Geisinger cardiology clinic where she received an intravenous diuretic medication to reduce fluids. Mrs. Dominick and her husband, Leonard, both retired teachers, were sure she was going to be admitted to the hospital. Instead, they were sent home, and the following day, a paramedic came to administer additional diuretics, then called to follow up and coordinate care with a nurse and a home-health agency.

“They told me they were trying to get me to stay home,” Mrs. Dominick says. “I’ve been in and out of hospitals so much with everything that this was a godsend.” Her condition improved over the next week, and it remains stable a year later.

From March 2014 to June 2015, the Geisinger mobile health team prevented 42 hospitalizations, 33 emergency visits and 168 inpatient days among 704 patients who had a home paramedic visit, Geisinger calculates. With heart-failure patients, hospital admissions and ER visits were reduced by 50%, and the rate of hospital readmissions within 30 days fell by 15%. Patient satisfaction scores for the program were 100%.

Shifting into the slow lane can be an adjustment for some paramedics. As an emergency responder, “you get called in, rush out, have a quick interaction, then drop patients off at the ER and never find out what happened to them,” says Veronica Koval, a paramedic in the Geisinger program. “With this, we get to know the patients and their families.”

Generally, only 30% of a paramedic’s time is spent on life-threatening situations; the remainder involves nonemergency issues that give them plenty of experience in helping people at home, says Gary Wingrove, founder and president of the non-profit Paramedic Foundation, which designs community paramedicine education curriculum and coordinates training at national conferences. Some hospitals employ their own paramedics while others rely on police and fire departments or private ambulance companies.

Payment models for community paramedics programs are still evolving. Some are covered by grants, state Medicaid programs or under Medicare programs that reward hospitals for improving care and spending health dollars more wisely.

North Memorial Health Care, which includes two hospitals, 14 primary care clinics and its own ambulance service, receives payment from the state Medicaid program for a community paramedic program it launched in October 2012. At present, 10 paramedics rotate between visiting patients and emergency service. After 300 hours of training, they see patients at the request of primary-care doctors and other care providers or through referrals from the emergency department.

J. Kevin Croston, chief executive of Robbinsdale, Minn.-based, North Memorial, says the program has reduced the use of inpatient and emergency department services by up to 50%, saving about $8,500 per patient.

Anthony Tyner, 52, who has kidney
failure, congestive heart failure, lung disease and diabetes, and takes 15 medications, was enrolled in the program in November 2013. During periods when he was having kidney problems and heart failure, paramedics visited twice a week. But there have also been periods of up to a month when Mr. Tyner didn’t need help.

“The key is we are always just a phone call away,” says Peter Carlson, community paramedic supervisor at North Memorial.

Mr. Tyner was wary at first about home visits, he says, “because I’m a very private person.” However, he says the program has helped him become more confident about managing his health. The paramedics’ care “is deeper and more personal than what I expected,” Mr. Tyner says.

The Valley Hospital in Ridgewood, N.J., part of Valley Health System, has been able to reduce readmissions by sending a team including a paramedic and a critical-care nurse soon after discharge to the homes of heart patients who decline or don’t qualify for home-care services. Lafe Bush, a paramedic and director of emergency services, says the team reviews discharge instructions such as medications and diet and sometimes persuades patients to accept home nursing. The hospital is now working on a plan to send some emergency room patients home who might otherwise be kept for observation, with a follow-up team visit.

“People recover better when they are home,” Mr. Bush says.
A Day of Community Paramedicine
EMT and mobile paramedic Veronica Koval discusses her scheduled house calls for the day outside a Gelsinger hospital in Wilkes-Barre, Pa. Ms. Koval visits patients at home to give nonemergency services and help them avoid going to the hospital.

Ms. Koval packs medical equipment, including devices for taking blood pressure or administering IV medicines.

Ms. Koval takes a Doppler blood pressure reading of 79-year-old patient Sarah Dovin, at her home in Pittston, Pa.

Sometimes, Ms. Koval takes patients’ blood samples or performs other medical lab tests.

Ms. Koval discusses patients’ care with Dr. Sanjay Deddamani at Pearsall Heart Hospital in Wilkes-Barre, Pa.