

Palliative Care Chat - Episode 26

Implementation of a Community Paramedicine Program in Hospice and Palliative Care

Dr. McPherson: Hello, this is Dr. Lynn McPherson, and welcome to Palliative Care Chat, the podcast brought to you by the online Master of Science and graduate certificate program at the University of Maryland.

I'm very excited about our guest today. It's Christina McCurdy, who is the director of inpatient care, director of nursing support services, director of crisis intervention care, and, last but not least, the director of Medicare care choices at Community Hospice and Palliative Care in Jacksonville, Florida. And also she is one week away from finishing our master's degree in our inaugural cohort.

So welcome, Christina. How are you today?

Ms. McCurdy: I'm doing well, Lynn. Thank you for the invitation.

Dr. McPherson: Absolutely. We're very excited. So I heard about this program that you guys are doing when I was at the Florida Hospice and Palliative Care State Organization annual conference several months ago, so I thought it would be great for us to talk about this idea of community paramedicine. What the heck is that? What is community paramedicine?

Ms. McCurdy: Community paramedicine is a model of care whereby paramedics apply their skills and their talent and their training outside of the usual emergency response role, and they're operating within a nontraditional role.

Dr. McPherson: So what do you guys have to do with them? What's the scoop here?

Ms. McCurdy: So we had this opportunity. Our local ambulance service approached our educational institute with a request to provide them education, which led us down this road. In the effort to reduce rehospitalizations in our area, we researched ways we could provide education to them. And that brought up the possibility of developing a paramedicine program, which intrigued us. We were so intrigued, and we felt that a needs assessment was in order.

So after doing a little more research, realizing that 18% of hospice patients go the emergency room at least once before death, we thought that this could be an opportunity for us to reduce the number of patients transported via 911 and to reduce our rehospitalizations.

Dr. McPherson: This is a new concept for me. Is this something common? Do you have other programs like this in your Jacksonville, Florida community?

Ms. McCurdy: No, this is the first, and currently we are the only ones with this service. We are a very large metropolitan area. Jacksonville is one of the largest cities in the US.

We have 840 square miles. So it was a great opportunity for us to provide care in a large area.

But there is a hospital system in Orlando which [inaudible 00:02:46] paramedicine, and they shared with us their successes as well.

Dr. McPherson: Okay. So I'm sure nothing is ever completely, 100% smooth sailing. Did you hit any barriers or hurdles as you kind of tried to roll this out?

Ms. McCurdy: Certainly. One of the lengthier process was just getting the operating guidelines and the protocols approved. So we had meetings between our chief medical officer and our executive and their medical director, and we ended up partnering with a privately held ambulance service. It took quite a while for us to get the protocols and guidelines reviewed and approved between both organizations, and then we had to develop policies and guidelines and procedures to support that.

Dr. McPherson: So these clinical protocols that you all developed, they were approved by both your chief medical officer and the paramedics' chief medical officer?

Ms. McCurdy: Correct.

Dr. McPherson: So these are things like pain and symptom management and so forth?

Ms. McCurdy: Yes. [crosstalk 00:03:49]

Dr. McPherson: That's pretty sweet. Certainly that's one thing. I mean, you need protocols and policies and procedures and so forth. But what did you find about community paramedicine that kind of surprised you?

Ms. McCurdy: What was most surprising was probably how easily I became indoctrinated. But we oftentimes forget how EMS and paramedics are so patient- and family-focused, and they are so used to going into a patient's home and being nonjudgmental when it comes to the care setting. And they're comfortable working with the patient and the family. And so they're able to get into the patient's home, or wherever they call home, survey the situation, and then communicate that back to us. So that's worked out really well.

And also, we failed to, I think, understand how well they are able to communicate to the next level of care. That's what they are used to doing. And so they have become really an invaluable care partner.

Dr. McPherson: Yes, [inaudible 00:04:52] And I remember one time my grandmother, and we just could not get her up off the floor. So we called the paramedics, and boy, they popped right out. And they were so kind and, as you said, nonjudgmental and didn't make her feel badly or us feel badly, just popped her up, and that was

the end of that. Certainly don't want to do that every day, but it really was a godsend.

Well this is really intriguing. So tell me a little bit about this program. Tell me about the nuts and bolts and how it works.

Ms. McCurdy: Okay. So we're currently using community paramedicine as an adjunct to the triage services that we already had in place. So when a patient calls our patient priority line, which, 24/7, they're able to reach on RN on the other end of that line. But then the RN can talk to the family, They can recommend utilizing the comfort kit with an order, turning the patient, recommendations, care recommendations. They can keep the patient or family on the line until a nurse or paramedic arrives to the home or the ALF or the long-term care facility.

Then the RN, in collaboration with the paramedic, can determine what's the next step. She's able to communicate to the paramedic the demographics and the contact names and everything. And then when the paramedic arrives to the home, they collaborate on the care. It works out really slick.

Dr. McPherson: So what might prompt a call? What might prompt the nurse on that line, the patient priority line, to say, "I think we need the paramedics"? What are some common indications to pull the button there?

Ms. McCurdy: Well when we built the program, we thought that we should utilize paramedicine for new and unusual severe or uncontrolled pain, for patient falls, [crosstalk 00:06:45] vomiting that's unrelieved by medication, increased anxiety and restlessness and confusion, and respiratory difficulty. For those cases where the family's calling multiple times and they haven't had resolution to their problem, or when the triage nurse is out there and needs additional assistance, we can call paramedicine.

Dr. McPherson: Did you provide education to the paramedics about all the pain and symptom management that you just rattled off?

Ms. McCurdy: Yes we did. We certainly did. And then the protocols and guidelines support that, including what types of medications they can use.

Dr. McPherson: Okay. Were you surprised at the level of skill the paramedics already possessed in terms of communicating a patient's and family's... I think you alluded to that already.

Ms. McCurdy: Yes. We were surprised. And probably more surprising besides their level of communication was what actual calls we really ended up utilizing paramedicine for. We listed all of these potentials, and certainly we've utilized them for each of those, but the majority of our calls have been, like you mentioned with your... Was it your mother or your grandmother?

Dr. McPherson: It was my grandmother.

Ms. McCurdy: So falls are the number one reason for a visit.

Dr. McPherson: I'll bet.

Ms. McCurdy: Yes. And we didn't even include that in the original repertoire. We thought pain management would be [crosstalk 00:08:16], but-

Dr. McPherson: At least if they go out for a fall, they can assess the patient to determine if the patient hurt themselves. Like did they break a hip? Do they need to go to a higher level of acuity for care? Or is it just a matter of picking them up and propping them back in bed? Is that what you have found as well?

Ms. McCurdy: That's exactly what we have found. And the majority of the calls they're able to, for the falls, determine if they need additional care. But the other areas that surprised us were that we had a lot of calls for [inaudible 00:08:49] status.

Dr. McPherson: Yeah.

Ms. McCurdy: Shortness of breath and lacerations. So lacerations, that can be as a result of a fall as well.

Dr. McPherson: So I interrupted your story here. So once they get the call from the patient priority line nurse who's manning that line, once they get your call, then what happens?

Ms. McCurdy: Once they get our call with all of the info they need, they go to the patient's home, long term care, or ALF, and they go in their own car and very discreetly. They arrive on the scene. They assess the patient. And then they report back to triage. And should the triage phone nurse need a order, she get the physician on the line. And they collaborate and then decide on the patient's disposition, whether they need to transfer or not.

Dr. McPherson: So they don't come in a paramedic truck. They come in their own car, you said?

Ms. McCurdy: They come in their own car. They're carrying a medical bag. There are no ambulances with flashing lights or sirens, which is great for our long-term care partners, because their residents are not alarmed by all that. So it's very discreet.

Dr. McPherson: So this is not really under the auspices of the county or city. This is, I guess, you entering into a relationship with... Are they kind of like off duty from their regular job?

Ms. McCurdy: Yes, the private ambulance service.

Dr. McPherson: I see.

Ms. McCurdy: And they also provide transport. But we are going to be expanding with our community EMS partners.

Dr. McPherson: Okay, okay. Wow, that's pretty exciting.

You've mentioned a couple of times the ALF and the nursing home. Are you providing this service, this paramedicine service, beside the patient's actual, physical home?

Ms. McCurdy: Yes. So about 23% of our paramedicine visits are actually to nursing home and ALF residents.

Dr. McPherson: And then how does the nursing home or the ALF feel about this? Have they embraced this as well? Do they think it's a good thing?

Ms. McCurdy: They have embraced it, as you might imagine. I mean, it's the difference between having an ambulance pull up with the sirens and the lights or having a paramedic come in their own car and carrying a medical bag and coming in and serving the resident at the bedside.

Dr. McPherson: But also, the level of skill that they bring to the table. That's amazing.

Ms. McCurdy: Absolutely. Absolutely.

Dr. McPherson: So why not just send the hospice nurse though? Because of the transport issue?

Ms. McCurdy: We do send the hospice nurse. Sometimes we send both, especially when triage is busy. This is an adjunct so we can send a paramedic. But now that we have found that those four areas are the most utilized, we can triage and say, "Oh, it's a fall. Perhaps we should send a paramedic instead of the triage nurse."

Dr. McPherson: So there are lots of potential avenues where the paramedic could go down. They could pick them up and put them in bed. They could say, "You need to go to the ER." Or, "You will be fine. I'll just let the nurse know." Do they ever bring them to one of your inpatient hospice units?

Ms. McCurdy: They do. They certainly can do that. We've had the opportunity to transfer patients to another level of care several times. Paramedics, they assess the patient, they call triage, get the order to transfer the patient to the inpatient center, and bring the patient on in.

Dr. McPherson: And off they go. So it sounds like pretty good transition in care there, very smooth and controlled and thorough it sounds like to me.

What kind of patients are you serving? And this sounds like it would cost a bazillion dollars. Is this a costly thing that you guys are doing?

Ms. McCurdy: You would be surprised. So for under \$200, that's the cost of paramedicine. That covers the visit and the mileage.

Dr. McPherson: That's a deal. That's a good deal.

Ms. McCurdy: We think so. We think so.

Dr. McPherson: And then aside from just the money, the sheer quality. That's amazing. That's great.

How often [inaudible 00:12:51] paramedic makes, how often can the patient stay where they are versus need to go somewhere else?

Ms. McCurdy: 90% of the patients stabilize in place.

Dr. McPherson: Awesome.

Ms. McCurdy: Yeah, so less than 10% don't, and they go to the ER. And less than 2% of those patients are in the hospital greater than 24 hours. So we're tracking those patients through their levels of care to monitor our program.

Dr. McPherson: Do you have any historical data to compare that to? Like including the paramedics with this community paramedicine, has this had a positive impact on patients being able to remain in their home?

Ms. McCurdy: It has, most definitely. It's reduced our hospital readmission rate.

Dr. McPherson: That's fantastic. I'm sure the patients and the families are appreciative of that as well. So I'm guessing you would agree that community paramedicine is a value-added benefit to your program, yes?

Ms. McCurdy: Oh absolutely. Absolutely. It provides discreet, prompt medical care in wherever the patient calls home for less than \$200. It helps reduce risk of readmission, so it makes our hospital partners happy. And it helps us build relationships in the community as well. When we can keep those patients stabilized and in place 90% of the time, it's a win-win.

Dr. McPherson: Absolutely. Have you made any attempt to collect data from the patient or the family about their satisfaction with this service?

Ms. McCurdy: No, but that's an excellent idea.

Dr. McPherson: Well put that on your list, girl. I think it's [crosstalk 00:14:27]

Ms. McCurdy: Okay.

Dr. McPherson: I have had heard of other community paramedic programs that have expanded to be things like paramedic-led wellness clinics and aging at home programs and home-visiting programs, sort of like community-based palliative care. So have you thought about expanding your program in these directions?

Ms. McCurdy: We have considered that, and I think I mentioned earlier that two local community EMS, they've reached out to us for education, and they are looking at those collaborative educational programs out in the community. They can focus on those patients who are most risk and those patients that are frequent callers and provide wellness programs or home-visiting programs. All of those have been well-received in communities.

Dr. McPherson: Yeah, I think all this kind of falls under the umbrella of community-based palliative care, which I think, in my mind, has been the missing link all along. We've got inpatient palliative care doing quite well now. Most hospitals have a multi-professional, interprofessional palliative care team. And certainly we have hospice on the other end of the spectrum. But it's that piece in the middle we really don't have, or even before you need inpatient palliative care. So be interesting to see how this all rolls out.

So I guess my last question is, and this has to be asked as well, we can educate our pants off, but I don't think you can completely eradicate 911 calls. I mean, certainly that's the holy grail, but what do you think?

Ms. McCurdy: I agree. 911 calls are not always preventable. We are starting to use an electronic notification system that lets us know that our patients have called 911 and that they're in the emergency room, which gives us a heads-up. We can send a paramedic to ER, or to the home if we get the notification quick enough, or send a nurse there, to facilitate calming of nerves and getting the patient to the level of care that's best served for both the patient and their family.

Dr. McPherson: Do you advise the patients or families on admission that this is one possibility for their care, that it may crop up, so they're not alarmed or anything? Or do you just kind of wing it?

Ms. McCurdy: No, we definitely educate them on admission. It's in their patient and caregiver guide. And when we program our number into their cellphones, that's a time for us to say, "There's a nurse who's always answering the line, but if we need someone to come to the home, we may send a nurse or we may send a paramedic."

Dr. McPherson: Okay. Well that's pretty awesome. So any advice for other hospices in any other part of the United States or beyond our borders who are interested in maybe partnering with the community paramedics? Any last advice?

Ms. McCurdy: Last advice would be, certainly if the opportunity knocks, take it, because it's only beneficial. It benefits not only your palliative or hospice patients, but it also benefits the community and [crosstalk 00:17:21]

Dr. McPherson: Absolutely. And one last question.

Ms. McCurdy: Certainly.

Dr. McPherson: Have the community paramedics found this to be a rewarding experience as well?

Ms. McCurdy: They have. They have. As a matter of fact, their organization has done an employee survey, so we do have those results. But now I know going forward my homework is to look at our patients and families and look at their satisfaction [crosstalk 00:17:44] service.

Dr. McPherson: Absolutely. Well Christina, I'd like to thank you so much for spending time with us and learning about this important new service. Congratulations to Community Hospice and Palliative Care in Jacksonville, Florida for this innovative program. It sounds like it's a win-win-win on multiple levels, so congratulations.

And I'd like to thank everyone for listening to the Palliative Care Chat podcast. This is Dr. Lynn McPherson, and this presentation is copyright 2019 University of Maryland. For more information on our completely online master of science and graduate certificate program in palliative care, or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.