

# Overview: Community Paramedicine



Illustration by Ruben DeLuna

Community paramedicine seeks to improve the effectiveness and efficiency of health care delivery by partnering specially trained paramedics with other health care providers to meet local health care needs. Community paramedics receive additional training beyond what is required for paramedic licensure and provide care outside of their traditional role, which in California is restricted to responding to 911 calls and transporting patients to an acute care hospital emergency department (ED) or performing interfacility transfers.

A major goal of community paramedicine is to address an overloaded system of emergency care by capitalizing on the unique abilities of paramedics and emergency medical services (EMS) systems to provide alternatives to ambulance transports and ED visits. Community paramedicine, which is being implemented or tested in most states in the US, also aligns with the health care sector's triple aim: to improve patient experience, improve the health of populations, and decrease the cost of care.

In 1972, California established the Health Workforce Pilot Project (HWPP) (California Health and Safety Code §§ 128125–95), a visionary program administered by the California Office of Statewide Health Planning and Development (OSHPD) that waives scope of practice

laws to test and evaluate new and innovative models of care. In November 2014, OSHPD approved HWPP #173, a project sponsored by the California Emergency Medical Services Authority (EMSA). The pilot initially involved 13 projects testing six community paramedicine concepts. One additional project and concept ("alternate destination – sobering center") began operation in early 2017. In November 2017, six new projects were approved. Four projects testing two concepts were discontinued earlier in 2017, including all three "alternate destination – urgent care" projects. The six remaining concepts being tested are:

- 1. Postdischarge.** Provide short-term, home-based follow-up to care for people recently discharged from a hospital due to a serious health condition, with the goal of decreasing 30-day hospital readmissions.
- 2. Frequent EMS users.** Provide case management services to people who are frequent 911 callers or frequent visitors to EDs, to reduce their use of the EMS system by connecting them with primary care, behavioral health, housing, and social services.
- 3. Directly observed TB therapy.** Collaborate with local public health officials to provide directly observed therapy to people with tuberculosis (e.g., dispense medications and observe patients taking them) to assure effective treatment and prevent spread of the disease.
- 4. Hospice.** In response to 911 calls, collaborate with hospice agency nurses, patients, and family members to treat patients in their homes and according to their wishes instead of transporting them to the ED.

**5. Alternate destination — mental health.** In response to 911 calls, offer patients who have mental health needs but no emergent medical needs transport to a mental health crisis center instead of an ED.

**6. Alternate destination — sobering center.** In response to 911 calls, offer patients with acute alcohol intoxication and no other acute medical or mental health needs transport to a sobering center instead of an ED.

HWPP regulations require organizations that sponsor pilot projects to retain an independent evaluator. A team of evaluators at the University of California, San Francisco (UCSF), serves in this role for HWPP #173. The initial 13 projects began enrolling patients in June to October of 2015, and the 14th project began enrolling patients in February 2017. The most recent UCSF evaluation covers pilot site operations through September 2017 ([healthforce.ucsf.edu](http://healthforce.ucsf.edu) [PDF]).

## Summary of the Evaluation Results

The community paramedicine pilot projects have demonstrated that specially trained paramedics can provide services beyond their traditional and current statutory scope of practice in California. Enrolling a total of 2,515 people through September 2017, these projects are enhancing patients' well-being by improving the coordination of medical care, behavioral health, and social services. They are also reducing ambulance transports, ED visits, and hospital readmissions, yielding potential savings for payers and other parts of the health care system.

The majority of potential savings associated with these pilot projects accrued to Medicare and hospitals serving Medicare patients, as they accounted for the largest share of people enrolled in the pilot projects. Potential savings also accrued to the Medi-Cal program and providers that serve Medi-Cal beneficiaries.

Californians benefit from these innovative models of health care that leverage an existing workforce operating at all times under medical control, either directly or by protocols developed by physicians experienced in emergency care.

No adverse outcomes were attributable to any of these pilot projects. No health professionals were displaced; in fact, the pilot projects demonstrated that community paramedics can collaborate with physicians, nurses, behavioral health professionals, and social workers to fill gaps in the health and social services safety net. These projects integrate with existing health care resources and leverage the unique skills of paramedics and their round-the-clock availability.

At least 33 states are operating community paramedicine programs, and research conducted to date indicates that these programs are improving the efficiency and effectiveness of the health care system. Research findings suggest that the benefits of community paramedicine programs grow as they mature, solidify partnerships, and find their optimal structure and niche within a community.

If community paramedicine is implemented on a broader scale, California's current EMS system design is well-suited to incorporate the results of these pilot programs to (1) optimize the design and implementation of proposed programs and (2) ensure effectiveness and patient safety. The two-tiered system of local control with state oversight and regulation enables cities and counties to tailor community paramedicine programs to meet local needs while ensuring patient safety.

## Community Paramedicine Pilot Projects, 2018

16 PROJECTS • 12 SITES • 6 CONCEPTS



- PD Postdischarge.** Provide short-term, home-based follow-up care for people recently discharged from a hospital due to a serious health condition, to decrease 30-day hospital readmissions.
- TB Directly Observed TB Therapy.** Collaborate with local public health services to provide directly observed therapy to people with tuberculosis (e.g., dispense medications and observe patients taking them) to ensure effective treatment and to prevent its spread.
- HO Hospice.** In response to 911 calls, collaborate with hospice agency nurses, patients, and family members to treat patients in their homes, according to their wishes, instead of transporting them to the ED.
- EM Frequent EMS Users.** Provide case management services to people who are frequent 911 callers or frequent visitors to EDs to reduce their use of the EMS system by connecting them with primary care, behavioral health, housing, and social services.

Projects approved November 2017. Expected to be operational spring 2018.

### Alternate Destinations

- MH Mental Health.** In response to 911 calls, offer patients who have mental health needs but no emergent medical needs transport to a mental health crisis center instead of an ED.
- SC Sobering Center.** In response to 911 calls, offer patients who are acutely intoxicated but have no emergent medical or mental health needs transport to a sobering center instead of an ED.



The California Health Care Foundation provided support for state-level project management and independent evaluation.

For more information on community paramedicine programs operating today in California, visit [www.emsa.ca.gov/community\\_paramedicine](http://www.emsa.ca.gov/community_paramedicine).

# Postdischarge Follow-Up to Avoid Excessive Readmissions

CALIFORNIA'S COMMUNITY PARAMEDICINE PILOT PROJECTS

April 2018

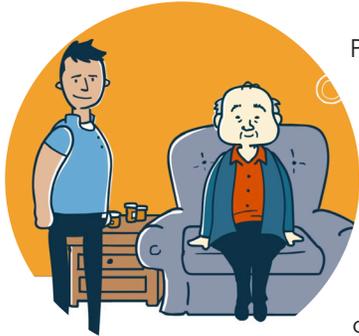


Illustration by Ruben DeLuna

Patients recently discharged from a hospital after treatment of a chronic condition such as congestive heart failure, acute myocardial infarction, or chronic obstructive pulmonary disease (COPD), are visited at home by a community paramedic. The goal of these

short-term follow-up visits is to decrease the number of patients who are readmitted to the hospital within 30 days of discharge. These projects seek to give patients tools to manage their conditions more effectively so that they can avoid readmission.

## Results (as of September 30, 2017)

- ▶ 1,401 patients were enrolled in postdischarge projects at five sites across California. At four sites, patients received at least one in-person visit from a community paramedic. At the other site, community paramedic contact was primarily by phone or, if needed, in-person.
- ▶ All five postdischarge projects have reduced the 30-day readmission rate for people with one or more of the chronic conditions they target to a level that is below the partner hospital's historical readmission rate. Butte County's heart failure patients were the only group whose 30-day readmission rate was higher than the historical rate. In response to

these findings, the county changed its protocol in November 2017 to provide at least one home visit to every patient.

- ▶ These projects reduced the risk of harm to patients, particularly related to prescription medications. Community paramedics examined all prescription drugs in a patient's possession and reconciled them with the patient's discharge instructions. They then worked with patients to understand the medications and assisted them in obtaining any needed refills. Community paramedics identified 229 instances in which a patient needed additional instructions about how to take their medications as directed by their doctors.
- ▶ Community paramedics also made at least 188 referrals to other service providers including primary care physicians, specialist physicians, pharmacists, mental health services, home health providers, drug and alcohol treatment programs, food assistance agencies, and domestic violence agencies. These service providers can help patients manage their conditions and improve their overall well-being.
- ▶ All five pilot sites saw potential cost savings for payers, primarily Medicare and Medi-Cal, due to reductions in inpatient readmissions. The average potential savings per enrollee ranged from about \$246 to \$2,619, for an estimated total of \$1.4 million across the five sites. In addition, partner hospitals may have benefitted if reductions in readmissions were sufficient to lower the risk that they would be penalized by Medicare for excessive readmissions.

## How It Works

Local paramedic service providers and hospitals are collaborating to reduce the number of avoidable readmissions. Community paramedics provide patients who have been recently discharged from hospitals with timely follow-up visits, calls, or both. Patients with the designated diagnoses are contacted by a community paramedic within 48–72 hours of their discharge from the hospital. Having contact with a health professional during the first week after discharge is important because many readmissions occur during this time period. The community paramedics work with patients to ensure that they are taking medications as prescribed, have sufficient refills to manage their conditions, have scheduled follow-up visits with their physicians, and are adhering to any dietary restrictions related to management of their condition. In some sites, the community paramedics provide a home safety inspection when visiting patients in their homes.

The services provided by community paramedics do not replace home health care or other services available to patients. When community paramedics learn that a patient is receiving home health services, for example, they coordinate with home health agency staff.

See reverse side for a list of partners.

## Partners

LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNERS	EMS PROVIDER PARTNERS	LOCATIONS
Alameda County	Alameda County EMS Agency	Alameda Hospital	Alameda City Fire Department	City of Alameda
Inland Counties	San Bernardino County Fire Department	Arrowhead Regional Medical Center	San Bernardino County and Rialto Fire Departments	San Bernardino County (five cities)
Los Angeles County*	UCLA Center for Prehospital Care	Glendale Adventist Hospital	Glendale Fire Department	City of Glendale
Sierra Sacramento Valley	Butte County EMS	Enloe Medical Center	Butte County EMS	Butte County
	Dignity Health EMS†	Vituity (formerly California Emergency Physicians) Shasta County Public Health Shasta Regional Medical Center Dignity Health hospitals: <ul style="list-style-type: none"> <li>▶ Mercy Medical Center Redding</li> <li>▶ Mercy Medical Center Mt. Shasta</li> <li>▶ St. Elizabeth Community Hospital</li> </ul> Dignity Health Home Health	Dignity Health EMS American Medical Response (AMR)	Redding
Solano County	Medic Ambulance Service	NorthBay Healthcare	Medic Ambulance Service	Solano County

\*Pilot project ended August 2016.

†Pilot project approved November 2017 and expected to be operational spring 2018.



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# Frequent Emergency Medical Services Users

CALIFORNIA'S COMMUNITY PARAMEDICINE PILOT PROJECTS

April 2018



Illustration by Ruben DeLuna

Frequent 911 callers or frequent visitors to emergency departments (EDs) are provided with case management services to connect them with primary care, behavioral health, housing, and social services. The goal of these projects is to reduce frequent emergency medical services (EMS) users'

dependence on EMS agencies and EDs for care.

## Results (as of September 30, 2017)

- ▶ 103 patients were enrolled in frequent 911 projects at two sites — one in San Diego and one in the Bay Area.
- ▶ Among enrolled patients at the pilot sites, there were large reductions in the number of 911 calls, ambulance transports, and ED visits. In San Diego's pilot project, the total number of 911 calls decreased by 35%, from an average of 26 per person per year to 17. In Alameda, the total number of 911 calls decreased by 16%, from an average of 4 per person per year to 3.

- ▶ Community paramedics linked patients to housing and other nonemergency services to meet the physical, psychological, and social needs that led to their frequent EMS use. Community paramedics in Alameda and San Diego made 58 referrals to medical care providers, mental health providers, drug and alcohol treatment programs, food assistance programs, housing assistance programs, transportation assistance programs, domestic violence resources, and other social services. In addition, they transported patients to these types of providers on 48 occasions to help them obtain services.
- ▶ Payers, ambulance providers, and hospitals saw potential cost savings estimated at \$580,200. The average potential savings per patient was about \$14,912 in San Diego and about \$860 in Alameda. Since 43% of patients enrolled in San Diego were uninsured, reducing the frequency of their ED visits also potentially decreased the amount of uncompensated care provided by ambulance providers and hospitals. Most of the potential savings from Alameda's project accrued to Medicare because the majority of its patients are Medicare beneficiaries.

## How It Works

Frequent EMS user pilot sites enroll people who are frequent 911 callers, ED visitors, or both. Community paramedics identify the reasons for the frequent use of EMS resources and link patients to appropriate nonemergency service providers that can reduce the patients' dependence on EMS agencies and EDs for care.

Community paramedics assess the patient's physical, psychological, and social needs. When possible, a home safety assessment is also conducted. Medication reconciliation is provided for patients who take any prescription medications. These assessments are performed at an initial in-person meeting and then as needed for the duration of the patient's tenure with the project. Patients remain enrolled in the projects until a community paramedic determines that the patient no longer needs the project's services. Criteria for discontinuing services include reaching important individual milestones such as obtaining housing or maintaining sobriety.

The two pilot sites enroll different populations of frequent EMS users. The City of San Diego's project primarily enrolls people with 20 or more ED visits per year. The City of Alameda's project, which serves a population much smaller than San Diego's (79,227 vs. 1,391,676), is open to anyone identified by the EMS agency or the partner hospital as a frequent 911 or ED user.

See reverse side for a list of partners.

## Partners

LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNERS	EMS PROVIDER PARTNERS	LOCATION
Alameda County	Alameda County EMS Agency	Alameda Hospital	Alameda City Fire Department	City of Alameda
City and County of San Francisco*	San Francisco Fire Department	San Francisco Department of Public Health San Francisco Department of Homelessness and Supportive Housing	San Francisco Fire Department American Medical Response (AMR) King-American Ambulance	City and County of San Francisco
Marin County*	Marin County EMS Agency	Marin Community Clinics Marin County Department of Health and Human Services Marin General Hospital	San Rafael Fire Department	Marin County
San Diego County	City of San Diego	University of California, San Diego	San Diego City Fire Department	City of San Diego

\*Pilot project approved November 2017 and expected to be operational spring 2018.



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# Directly Observed Tuberculosis Therapy



Illustration by Ruben DeLuna

Community paramedics collaborate with local public health officials to provide directly observed therapy (DOT) to patients with tuberculosis (TB), a highly contagious disease. The community paramedics dispense medications and observe

patients taking them to ensure that treatment protocols are followed, thus preventing spread of the disease.

## Results (as of September 30, 2017)

- ▶ 42 people were enrolled in a pilot project involving DOT at one site in Southern California. Because treatment often lasts six to nine months, community paramedics had an average caseload of seven patients per month.
- ▶ Patients with TB who received DOT from community paramedics were more likely to receive all doses of TB medication prescribed by the TB clinic physician than patients who received DOT from the TB clinic's community health workers (CHWs). Properly taking all prescribed doses of TB medications increases the likelihood that a patient will be cured and not spread the disease to others or develop a drug-resistant strain of TB that would be more difficult to treat and to control in the community.

- ▶ Community paramedics dispensed appropriate doses of TB medications. Their patients did not have any greater frequency of side effects than patients who received their medications from CHWs.
- ▶ Community paramedics also helped patients address other medical conditions, such as diabetes, that may create barriers to effective TB treatment.

## How It Works

Tuberculosis is a highly contagious disease that is treated with special antibiotic medications. The number of medications and frequency of dosing are determined by a physician with expertise in TB treatment. Patients with TB must take their medications as directed since stopping treatment too soon or missing doses of medication could lead to the development

of a drug-resistant strain of TB, posing a major public health risk to a community. To ensure that patients take their TB medications as directed, TB clinics often provide DOT, in which a health care worker gives a patient the medication, observes them taking it, and monitors them for side effects.

In Ventura County, public health officials asked EMS provider partners to offer DOT because the TB clinic does not have sufficient staff to serve all TB patients in the county. The clinic's CHWs administer DOT, but they only work on weekdays. In addition, the CHWs are based in Oxnard, where the TB clinic is located, and must drive for up to 60 minutes to reach some of its patients. In contrast, the community paramedics are stationed throughout the county and can usually reach patients within 15 minutes.

## Partners

LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNER	EMS PROVIDER PARTNERS	LOCATION
Ventura County	Ventura County EMS Agency	Ventura County Public Health Department	American Medical Response (AMR) Gold Coast Ambulance LifeLine Ambulance	Ventura County



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# 911 Hospice Calls



Illustration by Ruben DeLuna

In response to 911 calls, community paramedics collaborate with hospice agency nurses, patients, and family members to treat patients in their homes and according to their wishes instead of transporting them to the emergency department (ED).

transports occurred when a patient requested it or when they had a medical need that could not be met in their home, such as a bone fracture. Community paramedics also alerted hospice agencies and family members to patients' needs for additional assistance (e.g., a caregiver to stay overnight with the patient to assist with safe transfers and help avoid falls).

- ▶ The project potentially saved about \$203,700 (an average of \$755 per patient) for Medicare and other payers by reducing ambulance transports and ED visits.

## Results (as of September 30, 2017)

- ▶ 270 people were enrolled in a pilot project involving 911 hospice calls at one site in Southern California. Community paramedics visited patients in their homes, which were either private residences, or skilled nursing or residential care facilities.
- ▶ Prior to this pilot project, 80% of 911 hospice calls resulted in ambulance transport of a patient to the ED. This dropped to 30% for patients participating in the pilot project. Not being transported to the ED preserves hospice benefits and better meets the wishes of patients who prefer to receive home care.
- ▶ After conducting an assessment to determine that the patient could remain at home under hospice care, the community paramedics provided hospice patients and their families with emotional support and, when necessary, administered medications from the patients' "comfort care" packs (these contain medications to help manage the patient's symptoms) as directed by a hospice nurse. ED

## How It Works

The goal of hospice care is to provide medical, psychological, and spiritual support to those dying from a terminal illness. Care is provided by a multidisciplinary team of health professionals and volunteers in a patient's place of residence. Hospice staff members tell hospice patients, their family members, and other caregivers to contact the hospice instead of calling 911 if they believe there is a medical need or if they become concerned about the patient's comfort. Despite this instruction, some hospice patients or their family members/caregivers call 911, which typically leads to the hospice patient being transported to an ED. This may be upsetting and uncomfortable for hospice patients, and ED clinicians may perform unwanted medical interventions, including admission for inpatient care. In addition, insurers may revoke hospice benefits if a patient receives treatment or hospitalization that is incompatible with the hospice approach of comfort care.

Ventura County's hospice project seeks to prevent transports to an ED that are not consistent with a patient's wishes. If a 911 dispatcher or a first responder on scene determines that a person is under the care of a hospice agency, a community paramedic is dispatched to the patient's place of residence. The community paramedics are supervisors who can respond to hospice calls while other paramedics respond to 911 calls. The community paramedic assesses the patient, talks with family members and caregivers, and contacts a registered nurse employed by the hospice agency. The hospice nurse directs the community paramedic regarding what care to provide. The hospice nurse may ask the community paramedic to wait with the patient until the nurse arrives or direct the community paramedic to administer pain or other medications to the patient that the hospice has provided in a "comfort care" pack.

See reverse side for a list of partners.

## Partners

LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNERS	EMS PROVIDER PARTNERS	LOCATION
Ventura County	Ventura County EMS Agency	Assisted Home Care Services Hospice Buena Vista Hospice Care Livingston Memorial Visiting Nurse Association Roze Room Hospice TLC Home Hospice	American Medical Response (AMR) Gold Coast Ambulance LifeLine Ambulance	Ventura County



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# Alternate Destination — Mental Health

CALIFORNIA'S COMMUNITY PARAMEDICINE PILOT PROJECTS

April 2018



Illustration by Ruben DeLuna

In response to 911 calls, community paramedics evaluate patients with mental health needs, but no emergent medical needs, for transport directly to a mental health crisis center instead of to an emergency department (ED).

## Results (as of September 30, 2017)

- ▶ 251 people were enrolled in an “alternate destination — mental health” pilot project at one site in central California.
- ▶ The pilot project substantially reduced the rate at which 911 calls involving patients with mental health needs resulted in transport to an ED for medical screening. It also reduced patients’ time to treatment by a mental health professional, which improved their well-being.
- ▶ 26% of eligible patients were evaluated by community paramedics and transported to the mental health crisis center without the long delay of a preliminary ED visit. Based on their mental health needs, another 26% of evaluated patients could have been transported directly to the mental health center if an inpatient psychiatric bed was available or if they were uninsured or enrolled in Medi-Cal.

- ▶ The community paramedics accurately screened patients to determine which ones could be safely transported directly to the mental health crisis center. About 4% of patients required subsequent transfer to the ED, and there were no adverse outcomes. The medical evaluation protocols used in the field were refined six months into the project, after which there was only one transfer to an ED.
- ▶ Prior to the pilot project, law enforcement transported many mental health patients to an ED and waited with them to transfer responsibility for the patient to a clinician. This pilot project improved public safety, community paramedics can assess patients’ mental health needs and arrange ambulance transports directly to the mental health center, allowing officers to focus on law enforcement duties.
- ▶ The project yielded potential savings of about \$266,200 (an average of \$1,061) for payers, primarily Medi-Cal, because screening mental health patients in the field for medical needs and transporting them directly to the mental health crisis center avoided the need for an ED visit with subsequent transfer to a mental health facility.
- ▶ For uninsured patients, the amount of uncompensated care provided by ambulance providers and hospitals also potentially decreased.

## How It Works

Many California EDs are overcrowded. Some of the patients served in an ED could be treated safely and effectively in other settings, including some who arrive via ambulance.

Patients with mental health needs are often transported to an ED for medical clearance or when there is no capacity to evaluate them at a mental health crisis center. These patients can spend hours in an ED waiting for medical clearance, and in some cases, they can spend days in the ED waiting for a bed to be available at an inpatient mental health facility and not receive definitive mental health care during their ED stay.

In Stanislaus County, community paramedics respond to 911 calls that a dispatcher determines to be a mental health emergency or when another paramedic or a law enforcement officer identifies a patient with mental health needs. Community paramedics are also dispatched to the mental health crisis center to assess patients who arrive on their own and need to be medically cleared before being admitted to the county’s inpatient psychiatric facility. The community paramedics provide these services as needed in addition to responding to traditional 911 calls.

Once on scene, a community paramedic assesses the patient for medical needs or intoxication due to alcohol or drug consumption. If the patient has no emergent medical needs, is not intoxicated, and is not violent,

the community paramedic contacts the mental health crisis center to determine bed availability at the county inpatient psychiatric facility. If a bed is available and the patient agrees, the community paramedic arranges

for the patient to be transported to the mental health crisis center. Upon a patient's arrival, professionals on the mental health crisis center staff evaluate the patient to determine what services they need. Eligibility in the

pilot project is limited to nonelderly adults who are uninsured or enrolled in Medi-Cal because the county inpatient psychiatric facility does not accept patients with other health insurance.

## Partners

LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNERS	EMS PROVIDER PARTNER	LOCATION
Central California*	Central California EMS Agency and American Ambulance	Fresno County Behavioral Health and Public Health Departments Fresno County hospitals	American Ambulance	Fresno County
Mountain Valley	Mountain Valley EMS Agency	Stanislaus County Behavioral Health and Recovery Services	American Medical Response (AMR)	Stanislaus County
Santa Clara County*	Santa Clara County EMS Agency	Santa Clara County Behavioral Health Services Department Gilroy Police Department Saint Louise Hospital	City of Gilroy Fire Department	City of Gilroy

\*Pilot project approved November 2017 and expected to be operational spring 2018.



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# Alternate Destination — Sobering Center

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April 2018



Illustration by Ruben DeLuna

In response to 911 calls, paramedics offer patients with acute alcohol intoxication and no other acute medical or mental health needs transport to a sobering center instead of to an emergency department (ED).

are candidates for transfer to the sobering center. They also collaborate with sobering center staff and homeless outreach workers to encourage people who use the sobering center frequently to seek treatment for their alcohol use disorder.

- ▶ During its first eight months of operation, the pilot project generated about \$132,700 in potential savings (an average of \$332 per patient), the majority of which accrued to Medi-Cal because about 61% of patients enrolled in the pilot are Medi-Cal beneficiaries.

## Results (as of September 30, 2017)

- ▶ 400 people were enrolled in an “alternate destination — sobering center” pilot project at one site in the Bay Area during its first eight months of operation; of these, 50 (13%) were admitted to the sobering center more than once.
- ▶ The number of intoxicated people transported to an ED was reduced through this pilot project. In addition, for patients seeking treatment and medical detoxification, staff at the sobering center can provide withdrawal management prior to patient transfer to a medical detoxification center, which helps patients cope with withdrawal and increases their willingness to complete detoxification.
- ▶ 98% of enrolled patients were treated safely and effectively at the sobering center. Only 10 patients who were transported to the sobering center were subsequently transferred to an ED.
- ▶ Community paramedics provide feedback to paramedics on 911 crews on how to screen acutely intoxicated people to determine if they

## How It Works

Nationwide, an estimated 9.7% of ED visits are due to inebriation. In busy EDs, clinicians have little time to assist intoxicated patients unless they also have an acute medical need. As a result, they may not counsel patients about their drinking or provide information about detoxification programs, case management, or other resources. Sobering centers have been established in several cities to care for intoxicated patients — these centers are much less expensive to operate than EDs, and their staff can focus on the needs of people who are intoxicated.

As of February 2017, one pilot site (San Francisco) offered patients with acute alcohol intoxication and no other acute medical or mental health needs transport to a sobering center instead of an ED. The sobering center has cared for over 50,000 people since it opened in 2003. It serves people who are acutely intoxicated but do not have other urgent health care needs. The

sobering center is open 24 hours per day, seven days per week and is staffed by registered nurses who monitor patients throughout their stay. Staff social workers help patients obtain treatment for alcoholism and also assist them in obtaining housing, Medi-Cal, Supplemental Security Income, and General Assistance. Most patients stay for 4 to 12 hours. About one-third of the sobering center's patients are treated there multiple times per year, and about 90% of patients are homeless when services are provided.

San Francisco has trained all paramedics on 911 response crews to screen intoxicated patients to determine if they are eligible to enroll in the pilot project. Patients are eligible for transport to the sobering center if they have acute alcohol intoxication but no other medical or mental health needs. If a patient meets all the eligibility criteria, the paramedics offer the patient a choice of transport to the sobering center or an ED. Patients who do not meet all eligibility criteria are transported directly to an ED.

Ten experienced community paramedics work with the sobering center's staff to perform quality assurance reviews for patients transported to the sobering center. The community paramedics are also available to consult with paramedics on 911 response crews in the field (e.g., on the street, in a homeless shelter, in a hospital ED) or by telephone if they are unsure whether a patient is eligible for transport to the sobering center.

See reverse side for a list of partners.

## Partners

LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNERS	EMS PROVIDER PARTNERS	LOCATION
City and County of San Francisco	San Francisco Fire Department	San Francisco Sobering Center San Francisco Department of Public Health	San Francisco Fire Department American Medical Response (AMR) King American Ambulance	City and County of San Francisco
Santa Clara County*	Santa Clara County EMS Agency	Mission Street Sobering Center Gilroy Police Department Saint Louise Hospital	Gilroy Fire Department	City of Gilroy

\*Pilot project approved November 2017 and expected to be operational spring 2018.



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# Community Paramedicine Pilot Projects, 2018

16 Projects • 12 Sites • 6 Concepts



- PD Postdischarge.** Provide short-term, home-based follow-up care for people recently discharged from a hospital due to a serious health condition, to decrease 30-day hospital readmissions.
- TB Directly Observed TB Therapy.** Collaborate with local public health services to provide directly observed therapy to people with tuberculosis (e.g., dispense medications and observe patients taking them) to ensure effective treatment and to prevent its spread.
- HO Hospice.** In response to 911 calls, collaborate with hospice agency nurses, patients, and family members to treat patients in their homes, according to their wishes, instead of transporting them to the ED.
- EM Frequent EMS Users.** Provide case management services to people who are frequent 911 callers or frequent visitors to EDs to reduce their use of the EMS system by connecting them with primary care, behavioral health, housing, and social services.

 **Projects approved November 2017.**  
Expected to be operational spring 2018.

## Alternate Destinations

- MH Mental Health.** In response to 911 calls, offer patients who have mental health needs but no emergent medical needs transport to a mental health crisis center instead of an ED.
- SC Sobering Center.** In response to 911 calls, offer patients who are acutely intoxicated but have no emergent medical or mental health needs transport to a sobering center instead of an ED.