Howard Backer MD, MPH, FACEP
Dr. Backer was appointed to serve as Director of the California Emergency Medical Services Authority (EMSA) in 2011. In this role he serves as both the State EMS Executive Chief and Medical Director. EMSA establishes and enforces standards for EMS personnel; oversees the development of statewide specialty care systems such as trauma, stroke, and cardiac; and is responsible for coordinating the medical response to disasters.

Dr Backer's priorities for EMS are to advance the profession and the integration of EMS within medical systems by developing interoperable electronic data systems for quality improvement and to allow paramedics to operate in new innovative roles within their communities to bridge gaps in health care.

Before coming to EMSA, Dr. Backer worked in public health serving as Chief of Immunization and twice as the Interim Director of the California Department of Public Health. From 2008 to 2011, he served as Associate Secretary for Emergency Preparedness at California Health and Human Services Agency, where he coordinated public health and medical disaster response as well as mass care and shelter issues across the departments within the Agency.

Prior to joining government service in 2000, Dr. Backer practiced emergency medicine full time for 25 years in rural, urban, and suburban settings. He received a Doctor of Medicine from the University of California at San Francisco, a Master of Public Health from the University of California at Berkeley, and is board certified in Emergency Medicine, Emergency Medical Services, and in Preventive Medicine--Public Health. He continues to work clinical hours in Urgent Care at the UC Berkeley Student Health Center.

Healthforce Center at UCSF

Community Paramedicine Pilot Program

Summary and Evaluation through March 2018

University of California, San Francisco
Philip R. Lee Institute for Health Policy Studies and
Healthforce Center
Janet Coffman, MPP, PhD
Lead Evaluator

California Emergency Medical Services Authority
Howard Backer, MD, MPH, FACEP
PI for HWPP #173

Lou Meyer
Project Manager

Working Definition of Community Paramedicine

A locally determined community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community-specific health care needs assessment.

- New models of community-based health care that bridge primary care and emergency care
- Utilizes paramedics outside their traditional emergency response and transport roles

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Why Paramedics?

- Trusted and accepted by the public
- In most communities--inner city and rural
- Work in home and community-based settings
- Licensed personnel that operate under medical control as part of a system of care
- Trained to make health status assessments, recognize and manage life-threatening conditions outside of the hospital
- Always available (24 / 7 / 365)

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Community Paramedicine Concepts

- Post hospital discharge short-term follow-up
- Frequent EMS user case management
- Directly Observed Therapy for tuberculosis: public health department collaboration
- Hospice support
- Alternate destination to mental health crisis center
- Alternate destination to sobering center
- Alternate destination to urgent care center (Cancelled)

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Methods

- Evaluation period June 2015-March 2018 (depending on project start time)
- Outcomes assessed across three domains
  - Safety
  - Effectiveness
  - Potential savings accrued by other parts of the health care system

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Cumulative Patients Enrolled by Concept through September 2017*

Concept	# Enrolled
Post-Discharge Short-term Follow-Up	1,571
Frequent EMS Users	114
Directly Observed Therapy for Tuberculosis	44
Hospice	325
Alternate Destination – Mental Health	310
Alternate Destination –Sobering Center	730
Alternate Destination – Urgent Care	48§
All Projects	3,142

* 24 to 28 months for individual projects, depending on start date except for alternate destination to sobering center, began Feb 2017

§ Pilot projects for alternate destination urgent care cancelled

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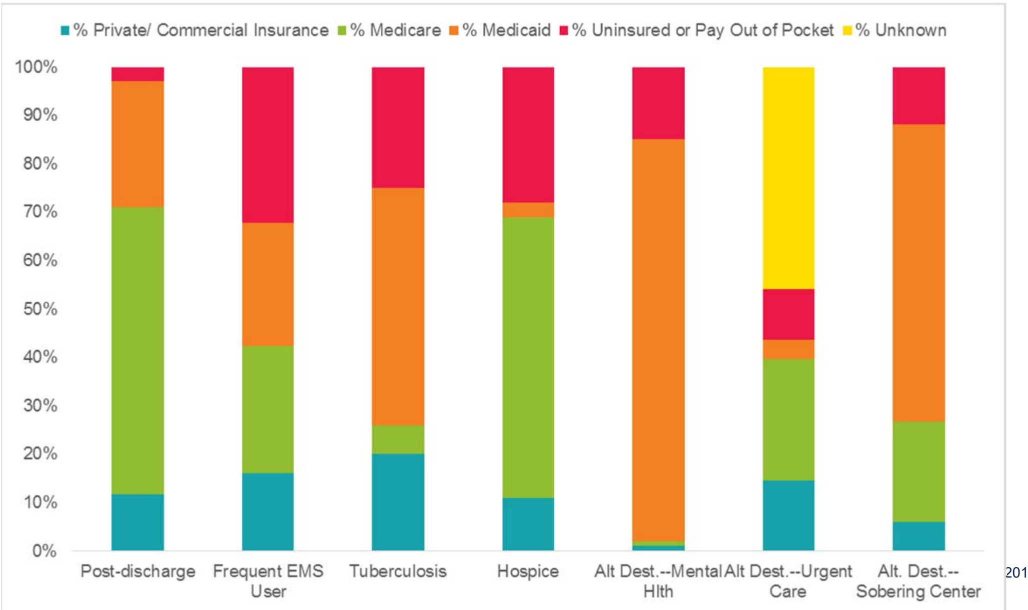
Enrollees by Insurance Status (n=3,142



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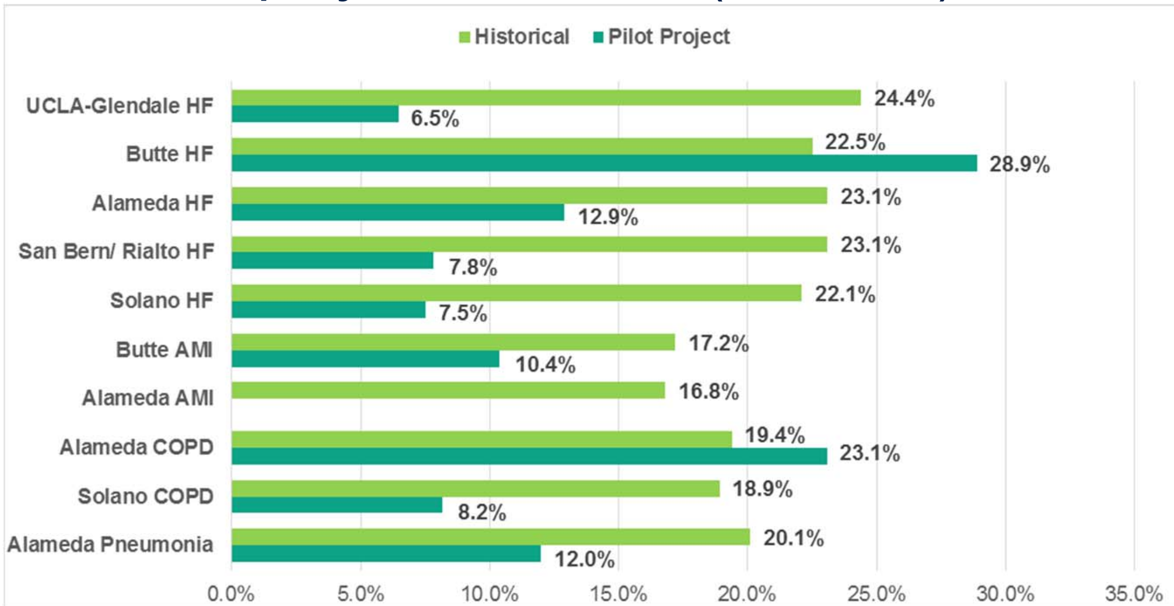
30 day Readmissions, Post-discharge project Enrollees (n=1,571)



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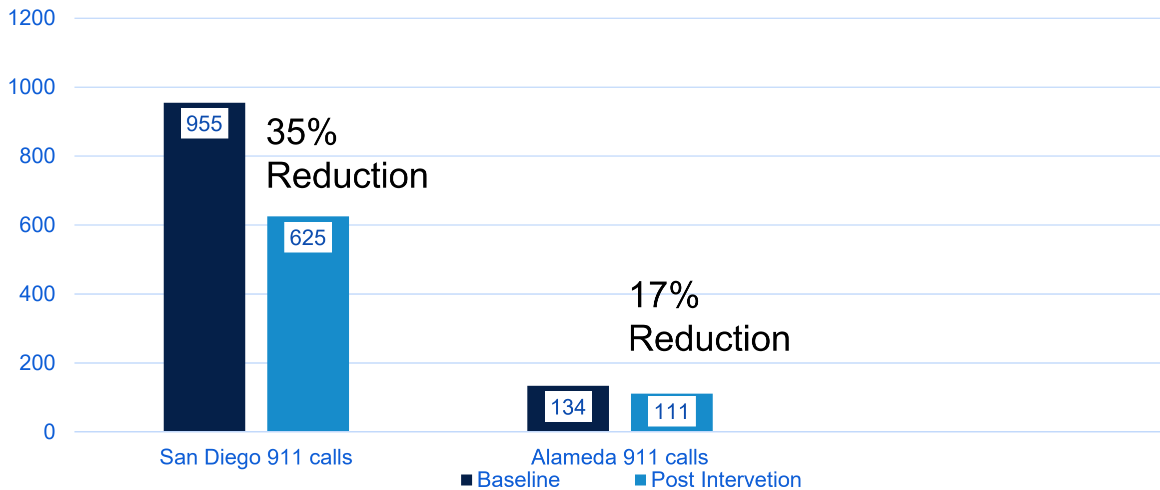

Directly Observed Therapy for Tuberculosis

- Dispensed appropriate doses of tuberculosis (TB) medications and monitored side effects and symptoms that could necessitate a change in treatment regimen
- CPs achieved better compliance (99.9%) than community health workers (93%) and provided care to patients that CHW could not reach
- Demonstrates capability for collaborative work to support public health

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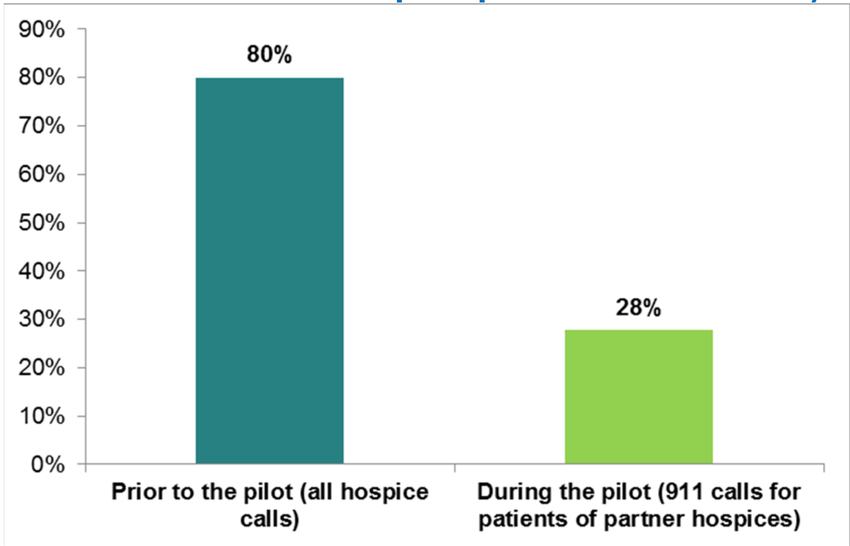
Percent of 911 Calls for Hospice Patients Resulting in Transport to ED

N=325 hospice patient calls to 911)



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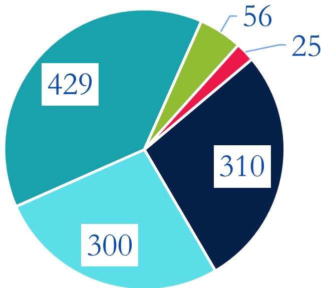
1/23/2017

Alternate Destination—Mental Health

Number of Enrolled, Eligible, and Ineligible Patients
N=1,120 patients evaluated



- Enrolled-transported
- Eligible-not enrolled due to lack of capacity or insurance type
- Ineligible-Intoxicated, medical
- Ineligible-Prior disruptive behavior
- Did not consent

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Alternate Destination-Sobering

- Performed medical screening of patients to determine whether they could be safely transported directly to a sobering center
- Enrolled and transported 730 patients in first 13 months.
- 17 patients (2.3%) were transferred to an ED within six hours of admission to the sobering center due to medical complaints
  - 16/17 complaints developed after admission to sobering center
  - 11 subsequently treated and released, 4 transferred for psych eval, 2 left ED without being seen
- Potential savings for payers, primarily Medi-Cal, due to reduced ED visits

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