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Albuquerque Connections

A social service referral program

By Jeff Kinney

How many times do EMS providers witness patients in need of social services? As EMS providers, we are dedicated to helping every patient we encounter no matter the medical complaint. For most, our primary focus is to assess and treat the acute medical or traumatic complaint. In some of these same situations though, providers witness other issues that could be contributing to the decline in the patients' health. For example, a dirty house, minimal to no food in the house, no heat, a broken-down car, no insurance, no money, homelessness or signs of substance abuse. The result of these challenging social situations can cause a person's health to be affected.

Throughout the U.S., EMTs and

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Ebola Response

A continuing process of updates

By James J. Augustine

The Centers for Disease Control & Prevention (CDC) recently published its third "Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients with Known or Suspected Ebola Virus Disease in the United States." This third version is dated Oct. 24, 2014, and is the current version at the time of publication.

The first version, published on Sept. 5, 2014, was based on experience with Ebola Virus Disease (EVD) in Africa. Up to that time, there had been no experience with the disease in America. The latest guidance is based on the significant experience with Ebola since that time.

It's important to recognize that the guidance for this viral illness is going to be constructed based on a continual process of learning about the disease and its symptoms, methods of transmission, treatment, disinfection and means of control. EMS providers should expect continuous updates on the disease.

There are a number of important elements in the CDC update of Oct. 24. In general, it's written with elements that prioritize the safety of EMS workers and the patients they care for.

Symptoms

The CDC has investigated the symptoms that American Ebola patients have presented with, and changed the guidance for the EMS system, for both the PSAP workers and the on-scene EMS personnel.

For telecommunicators in the PSAP, a few important symptoms that may indicate Ebola (fever, headache, vomiting, diarrhea, abdominal pain or unexplained bleeding) should lead to a screening for travel or exposure to Ebola patients.

EMS providers are asked to specifically ask for and report the symptoms of subjective fever or temperature of 100.4 degrees F (38 degrees C); as well as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or bleeding.

What the CDC document provides is a description of late symptoms of EVD, and this is perhaps the greatest fear of EMS providers and leaders. It may be difficult to identify a patient who has made it through the days of early stages of the disease and is only found after significant deterioration, when symptoms may represent other desper-

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INSIDE

Legal Consult

INCISIVE ANALYSIS OF EMS LEGAL TOPICS

Check Your Claim

Three Medicare compliance risk areas for ALS services

By Doug Wolfberg

If your EMS agency provides advanced life support services and bills Medicare for those services, there are three key compliance risks your agency should keep in mind. In fact, my suggestion is that you start looking into these important compliance risk areas as soon as you're done reading this article. These three issues continue to be ones we see consistently in federal False Claims Act cases involving ambulance services across the U.S.

ALS-to-BLS billing ratio

The first ALS compliance risk area is the easiest and quickest one you can check. Run a report in your billing software or ask your billing company to do so if you outsource your billing. Find out how many emergency claims you submitted in the last 12 months. To keep matters simple, include BLS-Emergency and ALS1-Emergency codes in your query; those are the A0429 and A0427 procedure codes. Then determine the percentage of claims billed at the ALS level compared to those billed at the BLS level.

The closer your Medicare ALS billing percentage is to 100%, the more compliance risk you run. Keep in mind that Medicare does not regulate your deployment; it regulates your billing. That means your agency is free to put paramedics on each response. However, Medicare rules only permit claims to be billed at the ALS1-Emergency level if one of two conditions is met: the call qualified for Medicare's "ALS assessment" rule, which requires an ALS-level emergency dispatch, or an ALS intervention. Nearly 10 years ago, Medicare abandoned the rule that permitted ambulance services to bill at the ALS level merely because they provided services in an ALS ambulance. Now, payment is based on whether the patient's condition required the ALS assessment or ALS intervention.

Put another way, your agency is not entitled to *bill* 100% ALS even though it may deploy 100% ALS.

So, what is an appropriate ALS-to-BLS ratio? The national average of emergency claims billed to Medicare in 2012—the last year in which complete data are presently available—was 65% ALS to 35% BLS. These percentages could be influenced by a variety of factors at the state and local level, such as your local dispatch protocols, and we'll discuss this in more detail below. ALS systems with ALS-to-BLS claim ratios in the 80th percentile, 90th percentile, or near 100% should look closely at their billing to determine if they have a potential Medicare compliance problem. Again, this has been an issue in several recent False Claims Act cases.

Dispatch protocols

Closely related to the issue of your ALS-to-BLS billing ratio is the use of dispatch protocols in making billing determinations, particularly when it comes to application of Medicare's "ALS assessment" rule.

Medicare defines an ALS assessment as "an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service."[1]

To properly apply this rule, there must be a qualifying dispatch; that is, an emergency call for a reported ALS condition. In its online manuals, Medicare states these determinations must be made in accordance with "standard/accepted dispatch protocols." While Medicare does not require the use of a particular protocol and agencies are free to develop their own, they must remain mindful of the "accepted/standard dispatch protocol" admonition when making billing decisions.

Again, it's fine if your system chooses to deploy 100% ALS, but it may only bill Medicare for ALS assessments when the dispatch qualifies as ALS based on the patient's reported condition. Chest pain, for example, would justify an ALS response under any protocol. A possible broken toe would not justify an ALS assessment in Medicare's eyes. If your system chooses to send an ALS unit to that call, the cost of the ALS-level deployment is on you and cannot be billed to Medicare. The reported condition of the patient at the time of dispatch did not necessitate an ALS response.

When billing, your agency should be sure it uses care in deciding which calls justify the application of the ALS assessment rule based on "accepted/standard dispatch

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An Overlooked Asset

Discovering the communications center's value proposition

By Jay Fitch, PhD

EXPERT ADVICE

Here's a typical day for many busy EMS agencies: In the boardroom, executives are considering how to transport more patients because insurers are squeezing revenues and other agencies are cream-skimming calls. Dispatchers and crews are transitioning from assignment to assignment, seemingly without enough hours in their day to even stop for a meal. Meanwhile, emergency response times are climbing and non-emergency patients are waiting hours to be transported. Discharge planners are calling the communications center and being placed on hold for an extended period of time. Each group is growing more frustrated. What's going on here?

The broad issue is managing the utilization of personnel and equipment, while balancing both emergency and non-emergency needs for the community. As EMS moves toward its future, the added complexity of a more integrated healthcare delivery system significantly increases the requirement for a high-value comm center.

Comm centers are a sunk cost for EMS systems. Achieving the best possible value within a pre-determined cost envelope is central to the agency's success. Key elements of this strategy are utilizing integrated technologies, processes to improve workflow within the center and on the street, talent management, and improving customer service experience.

Integrated technology

Comm center technologies and costs are wide-ranging. Call distributors, computer-aided dispatch (CAD) systems, radio control systems, mapping and deployment modules are just a few components that must work together to enhance the efficiency and effectiveness of the center. One common error is purchasing an outstanding hardware or software tool, but failing to consider how the device or product integrates with the other technologies or processes of the center. For example, consider caller interrogation and medical dispatch tools. If a center purchases a multi-million dollar CAD, but uses an antiquated card system that doesn't facilitate automated medical quality improvement activities, the cost of the quality insurance (QI) work-around increases and the value of the CAD system significantly decreases.

EMS data system capabilities are rapidly moving from transaction reporting and dashboards to systems that support outcome analytics and facilitate integration of personalized, wearable healthcare technologies. Contrast this forward thinking view with the fact that the majority of today's EMS centers are unable to receive text messages for help. EMS remains behind the technology curve. As we move forward, leaders must ensure the technologies they select function well with current software, can be enhanced with evolving technology and support improved performance outcomes.

Improved comm center processes

Technology supports improved process. However, a bad process that is fully automated only gets to a poor outcome quicker. One of the best things you can do is analyze EMS comm center processes to identify waste or inefficiency in the center's workflows, identify and replicate best practices, and improve substandard processes. There are a series of processes to be analyzed; these include call reception, caller interrogation in compliance with protocols, unit assignment, dispatching, routing of the call and support en route (e.g., directions and additional medical or related agency information), crew safety and monitoring on scene, timeliness of clearing the destination and re-assignment to a post or station. Additional processes to consider and improve are re-assignment of other available resources to assure optimal coverage and a long list of administrative tasks unique to each center.

Talent management

If Dante were alive today, one of his circles of hell would be an "old school" EMS comm center; they're often buried in the basement of public safety buildings, associated with high stress and low pay, and include little appreciation. The only thing missing are the demons and pitchforks. "Abandon all hope, ye who enter here."

With that said, high-value centers have embraced talent management principles and achieved better recruiting and retention metrics. Personnel are systematically recruited, tested and trained to perform at the top of their current qualification level

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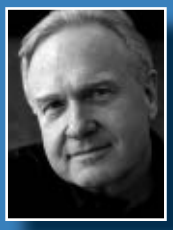

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ALBUQUERQUE

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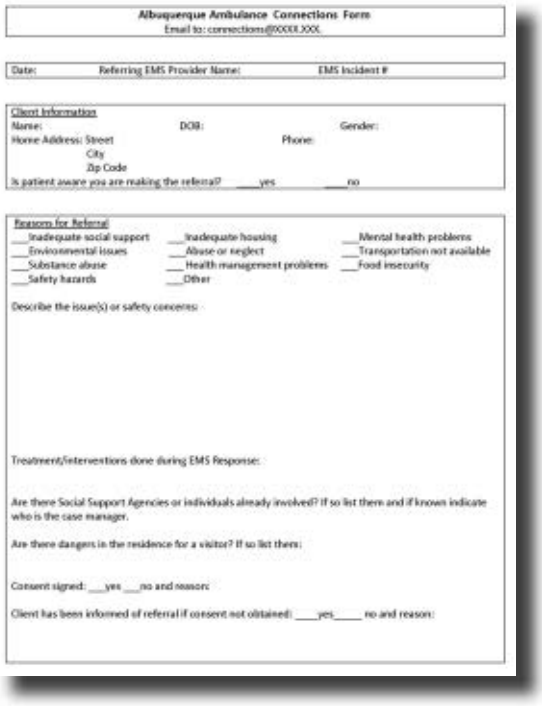
paramedics experience these types of situations every day. These patients often end up calling 9-1-1 because they have no other option for medical treatment. At Albuquerque Ambulance Service (AAS) in Albuquerque, New Mexico, "it is estimated that 27% of our 100,000 annual calls for service have a variety of unfavorable social situations and that these patients' health could benefit from social services assistance," according to



Albuquerque Ambulance Connections Form
Email to: connections@XXXX.XXX

Date: Referring EMS Provider Name: EMS Incident #

Client Information
Name: DOB: Gender:
Home Address: Street Phone:
City
Zip Code
Is patient aware you are making the referral? ___yes ___no

Reasons for Referral
___Inadequate social support ___Inadequate housing ___Mental health problems
___Environmental issues ___Abuse or neglect ___Transportation not available
___Substance abuse ___Health management problems ___Food insecurity
___Safety hazards ___Other

Describe the issue(s) or safety concerns:

Treatment/interventions done during EMS Response:

Are there Social Support Agencies or individuals already involved? If so list them and if known indicate who is the case manager.

Are there dangers in the residence for a visitor? If so list them:

Consent signed: ___yes ___no and reason:

Client has been informed of referral if consent not obtained: ___yes___ no and reason:

AAS executive director Kurt Krumperman. Krumperman also says that many of these 27% of calls are frequent users of the 9-1-1 system, EMS treatment and ambulance transport, which results in an over-use of resources.

To help improve the overall health and wellbeing of patients while also reducing frequent users of the 9-1-1 system, AAS set out to create a social services referral program that EMS providers could utilize to help patients beyond their current acute complaints. In this article I will discuss how AAS partnered with local social workers to create a referral program in an effort to improve unfavorable social situations, improve patient outcomes, reduce frequent users of 9-1-1 and provide an improved job satisfaction for the provider. Lastly and very importantly, I'll review how this was all done with a zero dollar budget.

Partnering with an established social services program

A common time for a patient to be referred to social services is during their hospital stay. Unfortunately, due to a number of factors, some patients are not given this referral. The patients may not mention the need for assistance to their doctor. Other patients continually refuse transport to the hospital all together. This is where EMS is in a unique position, as they get to see first-hand the social issues burdening the patient.

Reaching this population means that EMS would need a resource to be able to refer a patient. AAS didn't want to reinvent the wheel, so it set out to partner with an organization that was already established and had the infrastructure in place to accept referrals. In Albuquerque, this organization is Pathways to a Healthy Bernalillo County, or Pathways for short. This organization is part of the University of New Mexico Health and Science Center and was modeled after the Community Health Access Project (CHAP) in Richland County, Ohio. This model has been replicated in more than 16 other geographic areas across the U.S., according to the Pathways website. Pathways has an established list of social services agencies as part of its program.

AAS met with a representative from Pathways and discussed how EMS could begin referring patients. Since Pathways is an established community based program that is looking for referrals, they were excited to partner with AAS and accept referrals from EMS. This partnership was mutually beneficial for both organizations and, because Pathways was a community program, the partnership came at no cost to either group. Pathways did advise AAS that there was an important step missing. For the process to work, AAS would need to work with a social worker who could take the EMS referrals and then move them through the Pathways program. Pathways had social workers, but they were already overwhelmed.

Introducing MSW students into the process

There are a variety of options for introducing social workers into this program. For AAS, the goal was to keep this program cost neutral, so hiring a social worker was not an option. To do this, AAS set out to partner with a graduate social work education program with the idea of having students work with EMS on the referrals. In Albuquerque, there are two master of social work (MSW) programs: New Mexico State University and Highlands University. The idea was to utilize MSW students during their internships to be the point of contact between the EMS referral and the process through Pathways. In essence, the students would be the navigators to the Pathways program.

This step was great for the program but had two significant barriers. First, the idea for AAS and the education institutes to partner was solid, but the process to complete legal agreements between each was very involved. "For EMS agencies looking to create a similar program, my only advice is starting this process early," Krumperman says. Because the MSW student is affiliated with a couple of different universities in New Mexico, AAS needed to set up legal agreements with each university, as well as with Pathways. In total, the agreement process took four months to complete.

Second, because the MSW students are working for the program during their internship phase, the program required a properly licensed social worker to supervise the students. AAS met with the University of New Mexico Community Health Workers Initiative (CHWI), which in turn worked with Pathways to overcome this barrier. The result was that a CHWI licensed social worker agreed to supervise the MSW students during their internships. Since CHWI works in connection with Pathways and is dedicated to improving the health of Bernalillo County, this was a partnership that was mutually beneficial and was completed at no cost to either group.

Approval of other EMS agencies & medical control—protocol vs. SOG

The next step was to gain approval from our partnering EMS agencies, i.e., fire departments and the Medical Control Board (MCB), which is a group of physicians who govern the protocols for EMS in Bernalillo County. The big decision was whether to make this new program a protocol or a standard operating guideline (SOG).

In the end, our decision was to make it an SOG. While discussing this program

with the other agencies, they agreed it was a necessary program and approved of it. But due to a variety of factors, the agencies were unable to dedicate the time to train all of their providers. This immediately withdrew the program from being a system protocol, as all protocols must be trained to personnel within all agencies. The decision then was to make this an internal SOG for AAS, which means AAS providers would receive the training for making referrals. Making this program an SOG and not a protocol meant AAS only needed to notify the MCB. This decision resulted in a much faster turnaround for this step. In most cases, SOGs are approved faster than protocols, as SOGs are internal to only one organization.

Creating a name, referral process, paperwork, brochure, & training

With the first three steps of the process complete, AAS was ready to design the process, create the referral paperwork and begin training materials. But first, the program needed a name. AAS, CHWI, and Pathways considered a variety of options, but settled on the name Connections. Simply stated, this program was created to connect patients from 9-1-1 calls to social services that, prior to this program, had never existed in Bernalillo County.

Next, the group needed to design the referral process from AAS to Pathways. The key to the success of the process was making it easy and efficient for the EMS providers. AAS completed this by creating an online referral form with a link placed directly in the laptop charting program. It is also important to note that, in this program, the patient must provide consent to be referred to a social worker. To capture consent, we created a signature form within our electronic patient care report that the patient can sign immediately. I have included copies of the process flowchart and referral form in this article so that other agencies looking to create a similar program may reference our process and form.

The Connections team also created a brochure to pass out to EMS providers to help educate them on the process. A copy of the brochure is available in the document repository on emsinsider.com. Lastly, the Connections group put together a training video that is published on YouTube and was emailed to the AAS EMS providers. To prevent expenses for filming, Colton Dean, a Paramedic with AAS who has a background in videography, filmed the training video. The video is at youtu.be/SCsQNJH1nNw.

Onboarding MSW students

To get the program started, CHWI licensed social worker supervisor Ivette Cuzmar, LISW, LADAC, who was charged with supervising the MSW students,

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COMM CENTER

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and job description. Communications personnel are no longer considered the bottom of the EMS salary food chain either. In recent years there has been increasing recognition of the vital role telecommunicators play in the agency's success. Expanded responsibilities include monitoring performance metrics, involvement in demand and operational planning for the agency, and system-wide performance measurement activities. These and other management development opportunities can make working in the comm center a fulfilling career. It may not be heaven, but it's no longer Dante's version of hell.

Customer service experience

When arriving on scene as a supervisor and finding the family's shorts knotted up, I like to review the dispatch tapes to determine if things started to go awry early in the call. While customer service at EMS call centers has always been important, it takes on even more significance as one of the three main goals of the Institute for Healthcare Improvement's "Triple Aim" and as one of the key measures of the Hospital Consumer Assessment of Healthcare Providers and Systems Survey commonly known as HCAHPS. Hospitals are required to survey the customers' perceptions of care to be eligible for reimbursement. It's anticipated that this will be part of a future value-based purchasing initiative that one day could include EMS.

For many EMS agencies today, the comm center role can be equated to the order entry function at a fast food restaurant. A disconnected voice mumbles through a series of medical dispatch protocols ("Would you like fries with that?") and determines when and how the agency will respond to that customer's needs. You're then told to wait until the restaurant is ready to complete your order. What if McDonald's response time for my order took longer than 10 minutes and I was asked to pull over and wait? The frustration I would experience is only a fraction of what some EMS customers experience when waiting an extra hour or two to be transported from one facility to another.

While transport delays occasionally happen, it shouldn't be a routine event. Appropriate comm center workflow, scheduling, unit routing processes and monitoring performance metrics all serve to reduce this poor service scenario.

To improve the comm center's value proposition, the center's metrics must be monitored in real time with supervision empowered to make decisions that improve the customer experience. At McDonald's, I've noticed through my rearview mirror that when my order's status turns red, alarms go off. The manager then personally delivers my food along with an apology and a coupon good for a free sundae on my next visit. Likewise, EMS communications and field supervisors need to be able to make both care and customer service recovery decisions required to demonstrate high value to a wide variety of customers.

Summary & future discussion

The concept of value for money in everyday life is easily understood: don't pay more for a service than its quality or availability justifies. In relation to EMS, it implies a concern with economy (cost minimization), efficiency (measurable output maximization) and effectiveness (full attainment of the intended results or outcomes). But what values or outcomes are realized by the activities of the EMS comm center? How are they measured? What's the objective criteria used to compare results and assure the organization it has fully demonstrated its value proposition? In a future *EMS Insider* column, these follow-up questions will be explored. □

BILLING COMPLIANCE

CONTINUED FROM PAGE 2

protocols." Your agency can't bill ALS merely because it sent an ALS provider to the call.

Medical necessity of ALS interventions

Finally, the third ALS billing compliance risk area is billing for ALS interventions merely because they were performed—without regard to whether those interventions were medically necessary.

Consider this example: You're reviewing a patient care report which states the patient has no complaints, normal vital signs and no remarkable physical findings or medical history. The narrative notes the patient "rested comfortably" on the stretcher and the crew "started an IV D5W and transported without incident." In this scenario, hopefully you ask yourself one key question when you read the IV start on the PCR: "Why was the IV started when the patient appeared to be stable with no medical need for the intervention documented on the PCR?"

This example may be applied to other ALS interventions as well. For instance, if a cardiac monitor was used, did the PCR document a valid clinical reason? ALS interventions must be medically necessary before using them to justify billing Medicare at a higher ALS rate as compared to a BLS rate.

Typically, there are several reasons given why ALS interventions may be performed for reasons other than the presenting condition or symptoms of the patient. The reason we most often hear is that clinical protocols required the procedure. First off, no protocol should mandate the performance of medically unnecessary procedures. But, beyond that, a compliance risk arises when Medicare or enforcement agencies allege your protocol is purposefully skewed toward ALS interventions merely to bill at the ALS rate. In other cases, we often hear that the emergency department staff, for example, expects an IV will be started on all patients before they arrive in the ED. We've even been told in some cases that IV starts are justified to give the medic or student practice at starting IVs.

While these sometimes questionable operational reasons may be cited as attempts to justify the performance of some ALS interventions, the touchstone for ALS billing purposes is whether the interventions are medically necessary. In the example stated above, it is clear the PCR lacks a clinical justification for the initiation of an IV. The patient had no complaints, his vitals were normal, and no medications were required to be pushed into the IV. Starting an IV may be an everyday, routine matter, but it's a medical intervention; if it's not medically necessary, it can't be relied upon to satisfy Medicare's ALS level-of-service definition.

Here's where the judgment and critical thinking skills of properly-trained and compliance-minded billers must come into play. A biller reviewing a PCR like the one mentioned above can't simply review a PCR, look at the IV start, and say "this qualifies as ALS because an IV was started." A core part of a trained and compliant biller's job must be to read the PCR in sufficient detail to determine if a valid medical reason exists for the procedure. It's the job of the medic to not only perform the procedure skillfully, but also to fully and accurately document the condition of the patient requiring the intervention in the first place. Billers should not assume the intervention was necessary merely because it was performed, and should not adopt the posture of deferring to the medic or clinical protocol because those represent medical "authorities." Billers must be educated on the billing rules and apply them properly using their training, judgment and experience—much as a provider would assess and treat a patient based on their education, protocols and judgment.

Billing Medicare for ALS-level services is appropriate when a qualifying ALS assessment—based upon an ALS dispatch and emergency response—or medically necessary ALS intervention—justified by the patient's documented condition—is performed. Billing Medicare for ALS services merely because an ALS unit was deployed can raise significant compliance risks and should be monitored on an ongoing basis by all EMS agencies that provide ALS-level care. □

REFERENCES

1. 42 C.F.R. §414.605.

EBOLA

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ately ill patients, and the patient is at a much higher level of risk for transmission of infection to the EMS providers.

PSAP actions

The communication of the risk of Ebola from the PSAP is extremely important because it allows EMS personnel to apply appropriate PPE before entering the scene. PSAPs are also asked to notify local public health officials earlier in the process.

PSAPs will want to use discretion in communicating information to the public safety responders, so that public listeners will not be unnecessarily alarmed before EMS providers have fully assessed the patient in person.

Develop safe practices on-scene

Once on scene with the patient, EMS providers are asked to prioritize the potential history of exposure, either by travel or by direct contact with a person who's known to have or suspected to have Ebola, because this is the factor that identifies the highest risk of the disease as opposed to many other illnesses that present with symptoms at this time of the year.

EMS providers are encouraged to separate the patient from others immediately and limit the number of EMS providers close to the patient. The recommendation is for the initial "point" responder to perform the screening from at least three feet away from the patient.

There's also a strong recommendation, consistent with other recent CDC guidelines, to don and doff PPE "under observation" to assure compliance with the safe methods to do those operations. Many operations in EMS take place with a safety officer in place, and the role of an observer specified in these guidelines may in fact be a safety officer in many EMS organizations.

Patient management

The ambulance is to be driven by an individual who isn't potentially contaminated, and needs to be driven with a separation from the patient compartment. Many systems interpret this recommendation to include a barrier that ensures

protection of the driver from being in contact with any blood and body fluids, particularly if their ambulances don't have a door and/or windows that can be closed to separate the driver from the patient compartment.

There's no mention yet of transportation to dedicated EDs, but there are repeated recommendations to communicate early with the receiving ED to allow them appropriate time to prepare for the patient's arrival.

EMS providers are asked to limit activities that use sharps and create extra fluid wastes. If there are sharps used, they should be disposed of in dedicated sharps containers. Patient fluids (blood, urine, emesis and diarrhea) should also be contained using absorbents without aerosolizing them. A large bio-waste container (e.g., a red bag) will perform well if the patient vomits.

Personal protection

The document only recommends a single level of protection for EMS personnel. As referenced earlier, a key recommendation is that PPE must be placed on the provider, and removed, under observation.

The CDC recommends separation from the patient and donning of PPE if a relevant high-risk history is identified after an initial period of contact by EMS personnel. For unexpected exposures where patient fluids come into contact with the EMS provider, the guidelines recommend flushing, and immediate soap and water wash. Services need to develop a plan to ensure this happens rapidly.

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Cleaning & disinfection

Disinfection of the ambulance and patient equipment is specified. Cleaning should be done by personnel who are equally well protected using CDC guidelines, and begins with any large spills of body fluids. Disinfection should be done with EPA-registered disinfectants, to include surfaces, equipment and patient care materials. Any fluid permeable materials must be collected as waste. The CDC and Department of Transportation (DoT) have defined any materials used in or around the patient—and any waste—as "Category A," which require special handling. That special handling is specified in DoT Hazardous Materials Regulations, which are beyond day-to-day waste disposal practices and will require EMS organization leaders to investigate.

Reporting & follow-up

There's a new section in the CDC guidelines on "follow-up and/or reporting measures by EMS personnel after caring for a suspected or confirmed Ebola patient," which includes recommendations on the development of policies in concert with public health authorities. This very important section includes recommendations for 21-day monitoring of providers following exposure, and work with public health authorities.

Conclusion

The knowledge about this deadly disease and the way emergency responders should protect themselves, care for infected patients and decontaminate themselves, their equipment and their vehicles is evolving.

It's important for EMS crews and managers to realize that there will be a continuous process of updating based on the growing body of knowledge regarding Ebola.

Emergency providers in and out of the hospital, as well as public health authorities responsible for community safety, have the opportunity to share best practices to reduce risks and improve care to possible patients and the caregivers.

EMS Insider will continue to provide updates as they become available. ☐

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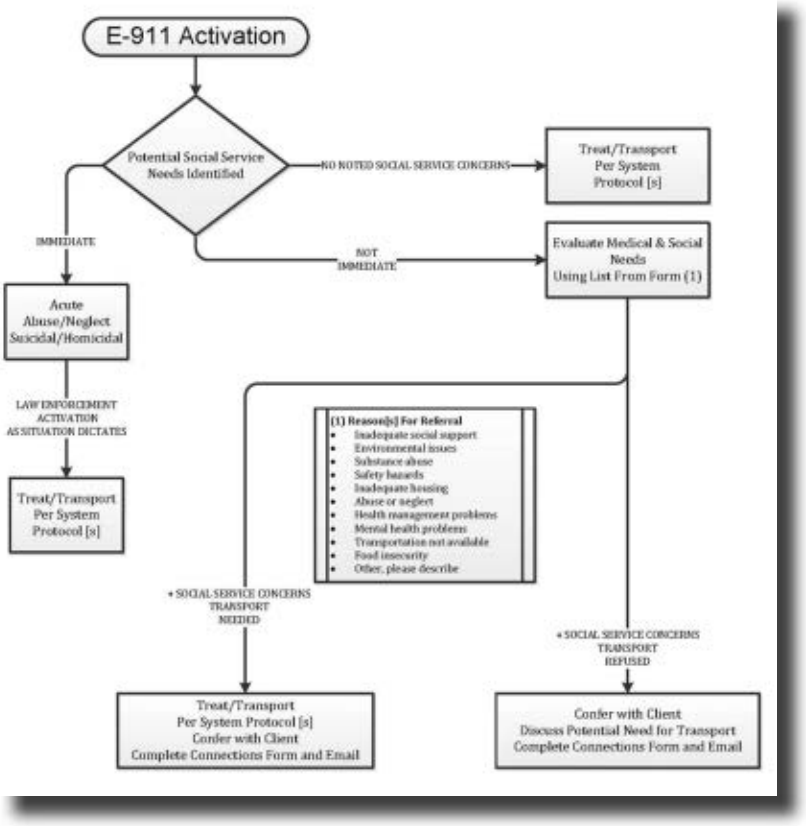
brought on three students. Their training process had three steps. First, they completed the same training as the EMS providers with the SOG, referral form and training video. Second, they were trained in the Pathways program. Third, the Connections group felt it was important that the MSW students gain some understanding and experience of what the EMS providers do in the field. To accomplish this, the MSW students went on a ride-along for a day with an EMS crew.

Once their training was complete, the students worked part-time under Cuzmar's direction. When a referral from EMS is received, the "MSW students reach out to the patient via telephone to set up an initial meeting face-to-face. The goal for the first meeting is to identify what help is needed and to complete a comprehensive assessment," Cuzmar says. From there, the patient is referred to a social services agency that will help them with their identified needs.



"The goal is empowerment" Cuzmar says. Social workers are not looking to work for the patient to help fix their social challenges. Their job is to help remove barriers, educate and empower the patient so that they may thrive and overcome these challenges on their own. For example, if a patient is lacking money for food, the MSW student would meet with the patient and then go with them to the income support division office to help them start a food stamp application.

Implementation, results, & other programs throughout the nation

The time from the initial meeting between AAS and Pathways, to implementation on Oct. 6, 2014, was six months. This time frame will obviously differ for other organizations depending on available resources and partnership opportunities. After one month of implementation, AAS providers have referred 13 patients into the Connections program. So far, the majority of patients are elderly and lack certain things such as home care support, a primary care physician (PCP), money for medications and transportation.

"One of the first referrals was an elderly male with chronic back pain who wanted long-term help to relieve the pain," says Cheryl Birmingham, an MSW student in the Connections program. In this instance, the patient's barriers were no PCP, not understanding how to get a PCP, and lack of transportation. The patient was referred to the Connections program by an AAS EMS provider. From there, Birmingham met with him to complete his comprehensive assessment. From the assessment, Birmingham educated and assisted the patient on how to find a PCP, how to set up appointments and, lastly, assisted the patient in getting his car fixed so that he could make it to his appointments.

Going forward, this patient will be monitored for progress, but to-date he has successfully been empowered to reduce his social barriers. The result to the 9-1-1 system is that this patient will now utilize what he learned from the Connections program to work with his PCP on chronic complaints and leave 9-1-1 for acute emergencies.

Even in its early stages, this program has been a success for AAS. "We have needed a program like this in place for a long time," says Paige Diamond, a part-time paramedic with AAS and a licensed social worker in Albuquerque. But this is not the only program of its kind in the nation. During the process of creating Connections, AAS referenced EMS systems in San Diego, Calif., Syracuse, N.Y., and Boise, Idaho for lessons learned and best practices in their referral programs.

For those looking to create a similar program, I invite you to contact us and other organizations for tips and reference materials. From start to finish, AAS successfully created this program with a zero dollar budget that could be mirrored in other communities. This program is definitely a way to help improve patient health and outcomes, increase resources for the EMS provider and reduce the number of frequent users of the 9-1-1 system. ☐

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