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Report on Implementation of HWPP #173 – Community Paramedicine – Quarter 1 2018

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June 29, 2018

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INTRODUCTION

On November 14, 2014, the Office of Statewide Health Planning and Development (OSHPD) approved Health Workforce Pilot Project (HWPP) #173, a pilot project to test six different concepts for the practice of community paramedicine in ten geographic areas across California. Each site chose the concept(s) it would test based on local needs and interests. In February 2017, a seventh pilot project concept launched in San Francisco City and County. This concept provides an alternative to transportation to an emergency department (ED) for persons who are inebriated.

The HWPP regulations require organizations that sponsor pilot projects to retain an independent evaluator to assess trainee performance, patient acceptance, and cost effectiveness. A team of evaluators at the Philip R. Lee Institute for Health Policy Studies and Healthforce Center at UCSF, formerly Center for the Health Professions, at the University of California, San Francisco is serving as the independent evaluator for the HWPP #173.

This report summarizes the evaluators' findings regarding implementation during the months of January, February, and March 2018. Previous reports addressed implementation from June 2015 through December 2017.

This report does not contain new information about the following projects, which closed prior to the first quarter of 2018:

- *Project #CP001 - UCLA's Alternate Destination – Urgent Care project,*
- *Project #CP002 - UCLA's Post-Discharge Project,*
- *Project #CP003 – Orange County's Alternate Destination – Urgent Care project,*
- *Project #CP009 – Carlsbad's Alternate Destination – Urgent Care project, and*
- *Project #CP010 – San Diego's Frequent EMS User Project*

The next chapter of this report presents general information pertinent to all seven community paramedicine (CP) concepts, such as the numbers of patients enrolled, patients' demographic characteristics, numbers of CP visits completed, and provision of case management and referral services. The subsequent chapters present information specific to each CP concept.

Table 1 (next page) shows the community paramedicine pilot sites, the concepts they are testing, and the dates on which they were implemented.

Table 1.

HWPP #173 – Pilot Sites and Community Paramedicine Concepts Included in This Report

Project #	Lead Agency	Community Paramedicine Concept	Date Implemented
CP001	UCLA Center for Pre-Hospital Care	Alternate Destination – Urgent Care	Sept. 8, 2015
CP002	UCLA Center for Pre-Hospital Care	Post-Discharge	Sept. 1, 2015
CP003	Orange County	Alternate Destination – Urgent Care	Sept. 14, 2015
CP004	Butte County EMS	Post-Discharge	July 1, 2015
CP005	Ventura County EMS	Tuberculosis	June 1, 2015
CP006	Ventura County EMS	Hospice	Aug. 1, 2015
CP007A	Alameda City EMS	Frequent EMS Users	July 1, 2015
CP007B	Alameda City EMS	Post-Discharge	June 1, 2015
CP008	San Bernardino County and Rialto Fire Departments.	Post-Discharge	Aug. 13, 2015
CP009	Carlsbad Fire Department	Alternate Destination - Urgent Care	Oct. 9, 2015
CP010	City of San Diego	Frequent EMS Users	Oct. 12, 2015
CP012	Mountain Valley – Stanislaus EMS	Alternate Destination – Behavioral Health	Sept. 25, 2015
CP013	Medic Ambulance Solano	Post-Discharge	Sept. 15, 2015
CP014	San Francisco Fire Department	Sobering Center	Feb. 1, 2017

GENERAL INFORMATION

Numbers of Patients Enrolled

Table 2 shows the numbers of patients enrolled in each of the nine active community paramedicine (CP) projects addressed in this report. CP004, Butte County's Post-Discharge program, continues to have the largest number of enrollees to date (903 patients), but the newest project, CP014, Alternate Destination – Sobering Center, has cumulatively enrolled 730 patients and has enrolled the largest number of patients this quarter. Among projects that were active during the first quarter of 2018, CP005's Tuberculosis project had the lowest enrollment. CP001 (Alternate Destination – Urgent Care), CP002 (Post-Discharge), CP003 (Alternate Destination – Urgent Care), CP009 (Alternate Destination – Urgent Care), and CP010 (Frequent EMS User) closed prior to first quarter of 2018. Data about these projects are presented only in the column in Table 2 that describes cumulative enrollment of all pilot projects since they began enrolling patients.

Table 2.

Number of Persons Enrolled per Project, by Month

		Enrolled for the First Time			Total Enrolled			Cumulative Enrolled*
Project No.	**Concept**	**Jan-18**	**Feb-18**	**Mar-18**	**Jan-18**	**Feb-18**	**Mar-18**	
CP001	Alternate Destination – Urgent Care	Closed May 2017						12
CP002	Post-Discharge	Closed in August 2016						154
CP003	Alternate Destination – Urgent Care	Closed in November 2017						34
CP004	Post-Discharge	17	14	18	23	20	29	903
CP005	Tuberculosis	0	1	0	6	6	5	44
CP006	Hospice	12	6	2	n/a	n/a	n/a	325
CP007A	Frequent EMS Users	4	2	0	9	9	5	68
CP007B	Post-Discharge	2	4	1	3	6	5	119
CP008	Post-Discharge	t	0	4	1	0	4	217
CP009	Alternate Destination – Urgent Care	Closed in November 2017						2
CP010	Frequent EMS Users	Closed in December 2017						46
CP012	Alternate Destination – Behavioral Health	8	15	5	n/a	n/a	n/a	310
CP013	Post-Discharge	6	5	8	13	9	12	178
CP014	Alternate Destination – Sobering Center	67	52	56	n/a	n/a	n/a	730
All Projects		**117**	**99**	**94**	**54**	**75**	**59**	**3,142**

* Cumulative enrollment differs from the cumulative sum of total enrolled patients in each month because patients enrolled in these projects are not necessarily unique from month to month. Some patients participating in frequent 911 caller and tuberculosis pilot projects receive CP services for multiple months. Some patients enrolled in post-discharge pilot projects receive CP service for a 30-day period spanning two months (e.g. enrolled on January 20, 2018, and completed 30-day period on February 19, 2018).

Table 3 lists the number of persons who were eligible to enroll in a community paramedicine program but were not enrolled for each site/concept.

During this quarter CP008 (San Bernardino's Post-Discharge project) reported the largest number of persons who were eligible but not enrolled.

In CP005, Ventura's Tuberculosis program, the eligible but not enrolled population consists of persons with tuberculosis whose directly observed therapy (DOT) is administered by community health workers employed by the Ventura Tuberculosis Clinic instead of community paramedics (CPs).[1]

For most projects, the main reason eligible persons were not enrolled was lack of resources. Reasons why eligible persons were not enrolled include unavailability of CPs, miscommunication, patients' unwillingness to consent, and withdrawal of consent. In some cases, hospital staff did not notify CPs when eligible patients were discharged. In other cases, demand for CP services exceeded capacity. Some projects, such as CP008 (San Bernardino's Post-Discharge project), only enroll persons who live in specific geographic areas and do not offer enrollment to persons who live outside that area. Inability locate the patient was not cited by any sites as a reason for not enrolling eligible persons.

CP012, Stanislaus's Alternate Destination-Behavioral project, had one patient in February who ~~who~~ the mental health crisis center staff declined to treat because his or her needs were not compatible with the center's services. Nine patients additional patients (three in January, four in February, and two in March) who were declined by the mental health crisis center due to their insurance payer type.[2]

[1] Under public health laws, persons with tuberculosis are required to obtain treatment because the disease is highly contagious.

[2] The mental health crisis center is operated by Stanislaus County and only accepts patients who are uninsured or enrolled in Medi-Cal.

Table 3.

Number of Persons Eligible but Not Enrolled

3a. Reasons for which Eligible Persons were Not Enrolled in January 2018

Project No.	Concept	Did Not Consent	Lack of Resources*	Inability to Locate	Eligible But Not Enrolled
CP004	Post-Discharge	10	0	0	10
CP005	Tuberculosis	0	25	0	25
CP006	Hospice	0	7	0	7
CP007A	Frequent EMS Users	1	2	0	3
CP007B	Post-Discharge	0	3	0	3
CP008	Post-Discharge	1	136	0	137
CP012	Alternate Destination – Behavioral Health	0	10	0	13±
CP013	Post-Discharge	13	0	0	13
CP014	Alternate Destination – Sobering Center	0	0	0	0
All Projects		**25**	**183**	**0**	**211**

* For all projects other than CP005 (Ventura's Tuberculosis program), "Lack of Resources" refers to patients who were eligible for the CP project but were not offered an opportunity to enroll because CPs were not aware of their existence, CPs were too busy to accept additional patients, or no CP was available to "consent" the patient in the language in which he or she preferred to receive health information. For CP005, "Lack of Resources" refers to patients who received directly observed therapy (DOT) from tuberculosis clinic staff instead of a CP.

±Three patients were not enrolled because they had health insurance other than Medi-Cal.

3b. Reasons for which Eligible Persons were Not Enrolled in February 2018

Project No.	Concept	Did Not Consent	Lack of Resources*	Inability to Locate	Eligible But Not Enrolled
CP004	Post-Discharge	11	0	0	11
CP005	Tuberculosis	0	27	0	27
CP006	Hospice	0	1	0	1
CP007A	Frequent EMS Users	1	0	0	1
CP007B	Post-Discharge	1	2	0	3
CP008	Post-Discharge	0	110	0	110
CP012	Alternate Destination – Behavioral Health	1	2	0	8±
CP013	Post-Discharge	6	0	0	6
CP014	Alternate Destination – Sobering Center	0	0	0	0
All Projects		**20**	**142**	**0**	**167**

* For all projects other than CP005 (Ventura Tuberculosis), "Lack of Resources" refers to patients who were eligible for the CP project but were not offered an opportunity to enroll because CPs were not aware of their existence, CPs were too busy to accept additional patients, or no CP was available to consent the patient in the language in which he or she preferred to receive health information. For CP005 (Ventura Tuberculosis), "Lack of Resources" refers to patients who received directly observed therapy from tuberculosis clinic staff instead of a CP.

± In addition to one patient who was not enrolled due not being compatible with the services offered, the mental health crisis center declined to accept four patients because they had health insurance other than Medi-Cal.

3c. Reasons for which Eligible Persons were Not Enrolled in March 2018

Project No.	Concept	Did Not Consent	Lack of Resources*	Inability to Locate	Eligible But Not Enrolled
CP004	Post-Discharge	18	0	0	18
CP005	Tuberculosis	0	27	0	27
CP006	Hospice	0	2	0	2
CP007A	Frequent EMS Users	1	2	0	3
CP007B	Post-Discharge	4	2	0	6
CP008	Post-Discharge	53	140	0	193
CP012	Alternate Destination – Behavioral Health	0	2	0	4±
CP013	Post-Discharge	11	0	0	11
CP014	Alternate Destination – Sobering Center	0	0	0	0
All Projects		**87**	**175**	**0**	**264**

* For all projects other than CP005 (Ventura Tuberculosis), "Lack of Resources" refers to patients who were eligible for the CP project but were not offered an opportunity to enroll because CPs were not aware of their existence, CPs were too busy to accept additional patients, or no CP was available to consent the patient in the language in which he or she preferred to receive health information. For CP005 (Ventura Tuberculosis), "Lack of Resources" refers to patients who received directly observed therapy from tuberculosis clinic staff instead of a CP.

± The mental health crisis center declined to accept two patients because they had health insurance other than Medi-Cal.

Patients' Demographic Characteristics

Tables 4 through 9 present information on the demographic characteristics and health insurance status of persons who enrolled in CP projects in January-March 2018. All sites that have a caseload of patients that can carry over from the month of initial enrollment to the subsequent month(s) are asked to report their data based on their full caseload. This instruction applies to Post-Discharge, Frequent EMS User, and Tuberculosis projects. In this reporting period, one Post-Discharge site – CP004 (Butte) – did not report based on their full caseload.

The data indicate that:

- Across all projects, most patients were male; however, there was significant variation across the projects.

- During the quarter, CP012 (Stanislaus' Alternate Destination – Behavioral Health project) patients had the lowest average age (range: 29 – 37 years) and CP006 (Ventura's Hospice project) had the highest average age (range: 77 – 82 years).

- The majority of patients were non-Hispanic in all pilot programs except in CP005, Ventura's TB project, where at least half of patients enrolled in each month of the reporting quarter were Hispanic.

- Across all projects, the majority of patients were Caucasian/White, though individual projects varied.[3]

- English was the preferred language for the majority of patients across all of the projects, followed distantly by Spanish.

- Across all projects, the majority of patients enrolled were Medi-Cal beneficiaries, followed closely by Medicare. CP012 (Stanislaus' Alternate Destination-Behavioral project) only accepts patients who are covered by Medi-Cal or are uninsured. (The one patient listed as a Medicare patient in January of 2018 is a patient enrolled in both Medicare and Medi-Cal, but these patients are not usually included.) All sites with a younger patient population have few or no patients covered by Medicare. CP014 (San Francisco's Sobering Center) treated a number of patients who were uninsured. Patients enrolled in CP006 (Ventura's Hospice project) are most frequently covered by Medicare, but due to a reporting lag, some are reported as uninsured.

[3] Data reported for CP005 Ventura's TB project, assumes that the race of Hispanic patients is White, as their partners classify Hispanic/Latino as a race.

Table 4.

Enrolled Patients by Gender

4a. Total Number of Persons Enrolled by Gender in January 2018				
Project No.	**Concept**	**No. Male**	**No. Female**	**Total No.**
CP004	Post-Discharge	10	7	17
CP005	Tuberculosis	2	4	6
CP006	Hospice	4	8	12
CP007A	Frequent EMS Users	5	4	9
CP007B	Post-Discharge	1	2	3
CP008	Post-Discharge	0	1	1
CP012	Alternate Destination – Behavioral Health	5	3	8
CP013	Post-Discharge	5	8	13
CP014	Sobering Center	52	15	67
All Projects		**83**	**52**	**135**

4b. Total Number of Persons Enrolled by Gender in February 2018				
Project No.	**Concept**	**No. Male**	**No. Female**	**Total No.**
CP004	Post-Discharge	4	10	14
CP005	Tuberculosis	3	3	6
CP006	Hospice	0	6	6
CP007A	Frequent EMS Users	5	4	9
CP007B	Post-Discharge	3	3	6
CP008	Post-Discharge	0	0	0
CP012	Alternate Destination – Behavioral Health	10	5	15
CP013	Post-Discharge	6	3	9
CP014	Sobering Center	40	12	52
All Projects		**70**	**46**	**116**

4c. Total Number of Persons Enrolled by Gender in March 2018				
Project No.	**Concept**	**No. Male**	**No. Female**	**Total No.**
CP004	Post-Discharge	10	8	18
CP005	Tuberculosis	2	3	5
CP006	Hospice	0	2	2
CP007A	Frequent EMS Users	3	2	5
CP007B	Post-Discharge	2	3	5
CP008	Post-Discharge	3	1	4
CP012	Alternate Destination – Behavioral Health	4	1	5
CP013	Post-Discharge	7	5	12
CP014	Sobering Center	50	6	56
All Projects		**80**	**31**	**111**

Table 5.

Average Age of Enrolled Patients

5. Average Age of Enrolled Patients by Concept				
Project No.	**Concept**	**Average Age – January 2018**	**Average Age – February 2018**	**Average Age – March 2018**
CP004	Post-Discharge	67	69	70
CP005	Tuberculosis	47	44	47
CP006	Hospice	82	81	77
CP007A	Frequent EMS Users	60	60	60
CP007B	Post-Discharge	59	70	72
CP008	Post-Discharge	56	No patients	68
CP012	Alternate Destination – Behavioral Health	37	33	29
CP013	Post-Discharge	69	64	63
CP014	Sobering Center	52	49	51

Table 6.

Ethnicity of Enrolled Patients

6a. Ethnicity of Enrolled Patients in January 2018					
Project No.	**Concept**	**No. Hispanic**	**No. Non-Hispanic**	**No. Unknown Ethnicity**	**Total No.**
CP004	Post-Discharge	0	17	0	17
CP005	Tuberculosis	3	3	0	6
CP006	Hospice	0	12	0	12
CP007A	Frequent EMS Users	1	7	0	9*
CP007B	Post-Discharge	2	1	0	3
CP008	Post-Discharge	0	1	0	1
CP012	Alternate Destination – Behavioral Health	0	8	0	8
CP013	Post-Discharge	2	11	0	13
CP014	Sobering Center	13	49	5	67
All Projects		**21**	**109**	**5**	**135**
*The ethnicity of one patient enrolled in Alameda's Frequent EMS User project is unknown.					

6b. Ethnicity of Enrolled Patients in February 2018					
Project No.	**Concept**	**No. Hispanic**	**No. Non-Hispanic**	**No. Unknown Ethnicity**	**Total No.**
CP004	Post-Discharge	0	14	0	14
CP005	Tuberculosis	3	3	0	6
CP006	Hospice	1	5	0	6
CP007A	Frequent EMS Users	1	7	0	9*
CP007B	Post-Discharge	1	5	0	6
CP008	Post-Discharge	0	0	0	0
CP012	Alternate Destination – Behavioral Health	0	12	3	15
CP013	Post-Discharge	1	8	0	9
CP014	Sobering Center	6	39	7	52
All Projects		**13**	**93**	**10**	**116**
*The ethnicity of one patient enrolled in Alameda's Frequent EMS User project is unknown.					

6c. Ethnicity of Enrolled Patients in March 2018					
Project No.	**Concept**	**No. Hispanic**	**No. Non-Hispanic**	**No. Unknown Ethnicity**	**Total No.**
CP004	Post-Discharge	0	18	0	18
CP005	Tuberculosis	3	2	0	5
CP006	Hospice	0	2	0	2
CP007A	Frequent EMS Users	0	4	0	5*
CP007B	Post-Discharge	0	5	0	5
CP008	Post-Discharge	2	2	0	4
CP012	Alternate Destination – Behavioral Health	0	5	0	5
CP013	Post-Discharge	3	9	0	12
CP014	Sobering Center	11	40	5	56
All Projects		**19**	**87**	**5**	**111**
*The ethnicity of one patient enrolled in Alameda's Frequent EMS User project is unknown.					

Table 7.

Race of Enrolled Patients

7a. Number of Enrolled Patients by Race in January 2018								
Project No.	**Concept**	**Cau-casian/ White**	**Black or African-Amer.**	**American Indian/ Alaska Native**	**Asian or Pacific Islander**	**Other Race**	**Unknown Race**	**Total**
CP004	Post-Discharge	17	0	0	0	0	0	17
CP005	Tuberculosis	0	0	0	3	3	0	6
CP006	Hospice	12	0	0	0	0	0	12
CP007A	Frequent EMS Users	7	0	0	0	1	0	9*
CP007B	Post-Discharge	0	0	0	1	2	0	3
CP008	Post-Discharge	0	1	0	0	0	0	1
CP012	Alternate Destination – Behavioral Health	8	0	0	0	0	0	8
CP013	Post-Discharge	8	2	0	3	0	0	13
CP014	Sobering Center	44	15	0	2	1	5	67
All Projects		**96**	**18**	**0**	**9**	**7**	**5**	**135**

*The race of one patient enrolled in Alameda's Frequent EMS User project is unknown.

7b. Number of Enrolled Patients by Race in February 2018								
Project No.	**Concept**	**Cau-casian/ White**	**Black or African-Amer.**	**American Indian/ Alaska Native**	**Asian or Pacific Islander**	**Other Race**	**Unknown Race**	**Total**
CP004	Post-Discharge	14	0	0	0	0	0	14
CP005	Tuberculosis	0	1	0	2	3	0	6
CP006	Hospice	5	0	0	0	1	0	6
CP007A	Frequent EMS Users	7	0	0	0	1	0	9*
CP007B	Post-Discharge	2	1	0	2	1	0	6
CP008	Post-Discharge	0	0	0	0	0	0	0
CP012	Alternate Destination – Behavioral Health	11	1	0	0	0	3	15
CP013	Post-Discharge	6	1	0	2	0	0	9
CP014	Sobering Center	34	10	0	1	0	7	52
All Projects		**79**	**14**	**0**	**7**	**6**	**10**	**116**
*The race of one patient enrolled in Alameda's Frequent EMS User project is unknown.								

7c. Number of Enrolled Patients by Race in March 2018								
Project No.	**Concept**	**Cau-casian/ White**	**Black or African-Amer.**	**American Indian/ Alaska Native**	**Asian or Pacific Islander**	**Other Race**	**Unknown Race**	**Total**
CP004	Post-Discharge	18	0	0	0	0	0	18
CP005	Tuberculosis	0	1	0	1	3	0	5
CP006	Hospice	2	0	0	0	0	0	2
CP007A	Frequent EMS Users	4	0	0	0	0	0	5*
CP007B	Post-Discharge	3	1	0	1	0	0	5
CP008	Post-Discharge	3	1	0	0	0	0	4
CP012	Alternate Destination – Behavioral Health	5	0	0	0	0	0	5
CP013	Post-Discharge	10	2	0	0	0	0	12
CP014	Sobering Center	29	17	0	0	5	5	56
All Projects		**74**	**22**	**0**	**2**	**8**	**5**	**111**
*The race of one patient enrolled in Alameda's Frequent EMS User project is unknown.								

Table 8.

Language Preferences of Enrolled Patients

8a. Number of Enrolled Patients by Preferred Language in January 2018								
Project No.	**Concept**	**English**	**Spanish**	**Chinese**	**Farsi**	**Viet-namese**	**Other**	**Total**
CP004*	Post-Discharge	17	0	0	0	0	0	17
CP005	Tuberculosis	3	2	0	0	0	1	6
CP006	Hospice	12	0	0	0	0	0	12
CP007A	Frequent EMS Users	8	0	0	0	0	0	9**
CP007B	Post-Discharge	3	0	0	0	0	0	3
CP008	Post-Discharge	1	0	0	0	0	0	1
CP012	Alternate Destination – Behavioral Health	8	0	0	0	0	0	8
CP013	Post-Discharge	13	0	0	0	0	0	13
CP014	Sobering Center	63	3	0	0	0	1	67
All Projects		**128**	**5**	**0**	**0**	**0**	**2**	**135**

*Butte excludes patients who prefer a language other than English.
** The preferred language of one patient enrolled in Alameda's Frequent EMS User project is unknown.

8b. Number of Enrolled Patients by Preferred Language in February 2018								
Project No.	**Concept**	**English**	**Spanish**	**Chinese**	**Farsi**	**Viet-namese**	**Other**	**Total**
CP004*	Post-Discharge	14	0	0	0	0	0	14
CP005	Tuberculosis	4	2	0	0	0	0	6
CP006	Hospice	6	0	0	0	0	0	6
CP007A	Frequent EMS Users	8	0	0	0	0	0	9**
CP007B	Post-Discharge	5	0	0	0	0	1	6
CP008	Post-Discharge	0	0	0	0	0	0	0
CP012	Alternate Destination – Behavioral Health	15	0	0	0	0	0	15
CP013	Post-Discharge	9	0	0	0	0	0	9
CP014	Sobering Center	47	3	0	0	0	2	52
All Projects		**108**	**5**	**0**	**0**	**0**	**3**	**116**

*Butte excludes patients who prefer a language other than English.
** The preferred language of one patient enrolled in Alameda's Frequent EMS User project is unknown.

8c. Number of Enrolled Patients by Preferred Language in March 2018								
Project No.	**Concept**	**English**	**Spanish**	**Chinese**	**Farsi**	**Viet-namese**	**Other**	**Total**
CP004*	Post-Discharge	18	0	0	0	0	0	18
CP005	Tuberculosis	3	2	0	0	0	0	5
CP006	Hospice	2	0	0	0	0	0	2
CP007A	Frequent EMS Users	4	0	0	0	0	0	5*
CP007B	Post-Discharge	4	0	0	0	0	1	5
CP008	Post-Discharge	3	1	0	0	0	0	4
CP012	Alternate Destination – Behavioral Health	5	0	.	0	0	0	5
CP013	Post-Discharge	10	2	.	0	0	0	12
CP014	Sobering Center	54	2	.	0	0	0	56
All Projects		**103**	**7**	**0**	**0**	**0**	**1**	**111**

*Butte excludes patients who prefer a language other than English.
** The preferred language of one patient enrolled in Alameda's Frequent EMS User project is unknown.

Table 9.

Health Insurance Status of Enrolled Patients

9a. Health Insurance Status of Enrolled Patients by Project in January 2018						
Project No.	**Concept**	**Private/ Commercial Insurance**	**Medicare**	**Medicaid**	**Uninsured or Pay Out of Pocket**	**Total**
CP004	Post-Discharge	1	13	3	0	17
CP005	Tuberculosis	2	1	3	0	6
CP006	Hospice	1	9	0	2	12
CP007A	Frequent EMS Users	2	4	2	0	9*
CP007B	Post-Discharge	1	0	2	0	3
CP008	Post-Discharge	0	1	0	0	1
CP012	Alternate Destination – Behavioral Health	0	1	6	1	8
CP013	Post-Discharge	0	11	1	1	13
CP014	Sobering Center	3	11	42	11	67
All Projects		**10**	**51**	**59**	**15**	**135**

*The health insurance status of one patient enrolled in Alameda's Frequent EMS User project is unknown.

9b. Health Insurance Status of Enrolled Patients by Project in February 2018						
Project No.	**Concept**	**Private/ Commercial Insurance**	**Medicare**	**Medicaid**	**Uninsured or Pay Out of Pocket**	**Total**
CP004	Post-Discharge	2	8	4	0	14
CP005	Tuberculosis	2	1	3	0	6
CP006	Hospice	0	5	0	1	6
CP007A	Frequent EMS Users	2	4	2	0	9*
CP007B	Post-Discharge	1	1	4	0	6
CP008	Post-Discharge	0	0	0	0	0
CP012	Alternate Destination – Behavioral Health	0	0	12	3	15
CP013	Post-Discharge	0	7	2	0	9
CP014	Sobering Center	2	8	33	9	52
All Projects		**9**	**34**	**60**	**13**	**116**
*The health insurance status of one patient enrolled in Alameda's Frequent EMS User project is unknown.						

9c. Health Insurance Status of Enrolled Patients by Project in March 2018						
Project No.	**Concept**	**Private/ Commercial Insurance**	**Medicare**	**Medicaid**	**Uninsured or Pay Out of Pocket**	**Total**
CP004	Post-Discharge	1	12	5	0	18
CP005	Tuberculosis	1	1	3	0	5
CP006	Hospice	1	1	0	0	2
CP007A	Frequent EMS Users	1	3	0	0	5*
CP007B	Post-Discharge	1	2	2	0	5
CP008	Post-Discharge	1	2	1	0	4
CP012	Alternate Destination – Behavioral Health	0	0	5	0	5
CP013	Post-Discharge	1	5	5	1	12
CP014	Sobering Center	2	9	36	9	56
All Projects		**9**	**35**	**57**	**10**	**111**
*The health insurance status of one patient enrolled in Alameda's Frequent EMS User project is unknown.						

Community Paramedicine Services Provided

Table 10 provides information about the numbers of in-person visits CPs provided to enrolled patients. The Alternate Destination projects and the Hospice project are omitted from this table because for these projects all interactions between CPs and patients take place in response to 911 calls.

Post-Discharge, Frequent EMS User, and the Tuberculosis projects have a caseload that carries over from one month to the next. Patients enrolled in Post-Discharge projects at or near the end of the month may not receive a visit in the month in which they enrolled. For this reason, it is not unusual for the number of visits to differ from the number of patients enrolled. In other cases, the patient or the patient's family member refused a scheduled visit or there was a miscommunication between the CPs and staff of the partner hospital. Frequent 911 User projects have lower visit rates than Post-Discharge or Tuberculosis patients because the patients are managed based on the services they require and on the availability of the CPs. There is no specific target for the number of visits required per month.

CP004's (Butte's Post-Discharge program) former protocol directed CPs to initially contact patients by telephone and to visit patients in their homes only if the phone assessment suggested that the patient needed additional assistance. As of November 2017, this protocol was changed to match that of the other Post-Discharge programs, which require CPs to make home visits to all enrolled patients unless the patient refuses or does not respond to requests to schedule a visit.

Table 10.

Number of Community Paramedic Visits

10a. Number of In-Person Community Paramedic Visits per Project in January 2018

Project No.	Concept	No. Patients Receiving Visits	No. New Patients Enrolled
CP004	Post-Discharge	12	17
CP005	Tuberculosis	0	0
CP007A+	Frequent 911 Callers	3	4
CP007B	Post-Discharge	3	2
CP008	Post-Discharge	1	1
CP013	Post-Discharge	6	6
All Projects		**25**	**29**

+Frequent 911 visits reflect patients who received a physical assessment.

10b. Number of In-Person Community Paramedic Visits per Project in February 2018			
Project No.	**Concept**	**No. Patients Receiving Visits**	**No. New Patients Enrolled**
CP004	Post-Discharge	13	14
CP005	Tuberculosis	0	1
CP007A+	Frequent 911 Callers	3	2
CP007B	Post-Discharge	2	4
CP008	Post-Discharge	0	0
CP013	Post-Discharge	5	5
All Projects		**23**	**26**
+Frequent 911 visits reflect patients who received a physical assessment.			

10c. Number of In-Person Community Paramedic Visits per Project in March 2018			
Project No.	**Concept**	**No. Patients Receiving Visits**	**No. New Patients Enrolled**
CP004	Post-Discharge	14	18
CP005	Tuberculosis	0	0
CP007A+	Frequent 911 Callers	1	0
CP007B	Post-Discharge	1	1
CP008	Post-Discharge	0	4
CP013	Post-Discharge	8	8
All Projects		**24**	**31**
+Frequent 911 visits reflect patients who received a physical assessment.			

The length of initial in-person CP visits varied across sites/concepts. In the first quarter of 2018, the visit length ranged from five minutes in CP006, Ventura's Hospice project, to three hours and four minutes in CP013, Solano's Post-discharge project. For some hospice patients, such as those who have fallen and have symptoms consistent with a fracture, a hospice nurse and a community paramedic quickly make a decision to transport the patient to an ED. In other cases, the community paramedic may wait with the family for over an hour for a hospice nurse to arrive on scene to take responsibility for a patient.[4] CP012- Stanislaus' Alternate Destination – Mental Health project and CP014 – San Francisco's Alternate Destination – Sobering Center project are not included in this table because in alternate destination projects, the paramedic's role is to assess the patient and determine whether he or she is a candidate for transport to the alternate destination.

[4] Alternate Destination projects report the length of time in minutes from arrival on scene to arrival at an urgent care center or a mental health center, rather than the length of in-person visits. Due to this difference in reporting, data regarding the Alternate Destination projects are not reported in Table 11.

Table 11.

Length of Community Paramedic Visits

11a. Length of Community Paramedic Visits by Project in January 2018				
Project No.	**Concept**	**Average Length of 1st In-person Visit (Minutes)**	**Shortest 1st In-person Visit (Minutes)**	**Longest 1st In-person Visit (Minutes)**
CP004	Post Discharge	58	29	130
CP005	Tuberculosis	25	15	45
CP006	Hospice	18	5	60
CP007A	Frequent_911	30	30	30
CP007B	Post Discharge	30	30	30
CP008	Post Discharge	48	48	48
CP013	Post Discharge	129	81	184

11b. Length of Community Paramedic Visits by Project in February 2018				
Project No.	**Concept**	**Average Length of 1st In-person Visit (Minutes)**	**Shortest 1st In-person Visit (Minutes)**	**Longest 1st In-person Visit (Minutes)**
CP004	Post-Discharge	45	30	70
CP005	Tuberculosis	25	15	45
CP006	Hospice	34	20	60
CP007A	Frequent EMS Users	30	30	30
CP007B	Post-Discharge	38	30	60
CP008	Post-Discharge	No visits	No visits	No visits
CP013	Post-Discharge	112	90	143

11c. Length of Community Paramedic Visits by Project in March 2018				
Project No.	**Concept**	**Average Length of 1st In-person Visit (Minutes)**	**Shortest 1st In-person Visit (Minutes)**	**Longest 1st In-person Visit (Minutes)**
CP004	Post-Discharge	47	20	102
CP005	Tuberculosis	25	15	45
CP006	Hospice	17	14	20
CP007A	Frequent EMS Users	30	30	30
CP007B	Post-Discharge	45	45	45
CP008	Post-Discharge	No visits	No visits	No visits
CP013	Post-Discharge	79	56	105

Referring patients to other service providers is an important element of CPs' work, especially for the Frequent EMS User and Post-Discharge concepts. Table 12 lists the service providers to which each of the concepts/sites referred patients during their first patient encounter in the first quarter of 2018. They include Narcotics Anonymous, primary care providers, smoking cessation programs, a resource hotline, a food bank, medical detoxification centers, and a housing safety program for seniors, among other services. The volume and variety of referrals made during the entire time a patient is enrolled in a CP project can differ from the information reported in the table, because data collection only addresses referrals made during a CP's first visit with a patient. This is particularly true for Frequent EMS User projects that typically have multiple interactions with patients. Data regarding Alternate Destination – Mental Health and Hospice projects are not reported in Table 12, because they do not refer their patients to other service providers.

Table 12.

Referrals of Enrolled Patients to Other Services

Project No.	Concept	Referrals in Jan 2018	Referrals in Feb 2018	Referrals in Mar 2018	Organizations to Which Referrals were Made
CP004	Post-Discharge	0	0	0	n/a
CP005	Tuberculosis	0	0	0	Pulmonologist (during later Directly Observed Therapy treatments)
CP007A	Frequent EMS Users	0	1	0	American Health Advocates; Alameda Fire Department Senior Safety Program
CP007B	Post-Discharge	1	0	0	Alameda Food Bank
CP008	Post-Discharge	1	0	0	211 (referral services)
CP013	Post-Discharge	3	0	0	Narcotics Anonymous Support Group, primary care provider, and smoking cessation program
CP014*	Alternate Destination - Sobering Center	1	4	0	Medical detox, shelter

*Referrals are made by the Sobering Center staff, not by the CPs. We include these patients because they may not have been referred to these services if CPs had not brought them to the Sobering Center.

Table 13 presents information on the delivery of case management services to enrolled patients. Alternate Destination and Hospice projects are not included because they do not provide case management services.[5] CPs devoted substantial numbers of hours to providing case management by telephone or in-person meetings. The number of hours devoted each month to case management ranged from two hours for CP008 (San Bernardino's Post-Discharge project) to 60 hours for CP014 – San Francisco's Alternate Destination – Sobering Center project.

Table 13.

Case Management for Enrolled Patients per Month

13a. Case Management for Enrolled Patients in January 2018					
Project No.	**Concept**	**No. Total Hours on Case Management**	**No. Hours on Case Management Telephone Calls**	**No. Hours on In-person Case Management Meetings**	**No. Hours on Other Case Management Activities***
CP004	Post-Discharge	18	6	11	1
CP005	Tuberculosis	12	Could not disaggregate		
CP007A	Frequent 911 Callers	53	45	8	0
CP007B	Post-Discharge	25	25	0	0
CP008	Post-Discharge	2	1	1	0
CP013	Post-Discharge	22	7	15	0
CP014	Sobering Center	60	Could not disaggregate		
All Projects		**192**	**84**	**35**	**1**

[5] Hospices typically provide case management for hospice patients.

13b. Case Management for Enrolled Patients in February 2018					
Project No.	**Concept**	**No. Total Hours on Case Management**	**No. Hours on Case Management Telephone**	**No. Hours on in-person Case Management Meetings**	**No. Hours on Other Case Management Activities***
CP004	Post-Discharge	17	7	10	0
CP005	Tuberculosis	12	Could not disaggregate		
CP007A	Frequent EMS Users	24	22	2	0
CP007B	Post-Discharge	42	42	0	0
CP008	Post-Discharge	0	0	0	0
CP013	Post-Discharge	16	5	11	0
CP014	Sobering Center	50	Could not disaggregate		
All Projects		**161**	**76**	**23**	**0**

13c. Case Management for Enrolled Patients in March 2018					
Project No.	**Concept**	**No. Total Hours on Case Management**	**No. Hours on Case Management Telephone**	**No. Hours on in-person Case Management Meetings**	**No. Hours on Other Case Management Activities***
CP004	Post-Discharge	18	7	11	0
CP005	Tuberculosis	12	Could not disaggregate		
CP007A	Frequent EMS Users	22	20	2	0
CP007B	Post-Discharge	31	30	1	0
CP008	Post-Discharge	4	2	2	0
CP013	Post-Discharge	23	8	14	1
CP014	Sobering Center	50	Could not disaggregate		
All Projects		**160**	**67**	**30**	**1**

FREQUENT EMS USERS

CP007A, Alameda County's Frequent EMS User project, was launched in July 2015, and CP010, San Diego County's Frequent EMS User project, followed in October 2015. Both projects provide case management services to frequent users of emergency medical services (EMS) and EDs to ensure that they receive the most appropriate services for their needs and to link them to non-emergency services that can reduce their dependence on EMS providers for care.

This report does not present data about CP010 (San Diego) aside from cumulative enrollment because the project closed in December 2017. In December 2016, the CPs who participated in CP010 (San Diego) were reassigned to 911 response crews by AMR, the ambulance company that provides paramedic services in the City of San Diego. The pilot project manager maintained the program in 2017 with assistance from an emergency medicine fellow but was not able to enroll additional patients or to give enrolled patients the same intensity of service. The pilot project manager was reassigned in January of 2018, in effect ending the program.

CP007A and CP010 have enrolled 68 and 46[6] patients, respectively, from the launch of the projects through the end of the first quarter of 2018. Both projects consider patients to be enrolled until they expire or no longer need the program, even if the CPs could not provide services to the patient during the reporting month. This can occur when an enrolled patient leaves the area, cannot be located, or is institutionalized (e.g., in a skilled nursing facility, rehabilitation center, or jail).

In order to ascertain which services would benefit individual frequent EMS users, CPs perform several assessments. CPs provide these assessments at the initial in-person meeting with a patient and on an ad-hoc or as-needed basis for the duration of the patient's tenure with the project. They include physical health assessments and bio-psycho-social assessments. For patients with a relatively stable home, CP also conduct a home safety assessment. Patients who are on any medication receive medication reconciliation where feasible. Table 14 shows the number of patients who received each type of assessment described above. In Frequent EMS User projects, patients may receive more than one assessment or service from CPs each month.

[6] Forty-six patients enrolled, but one subsequently un-enrolled.

Table 14.

Number of Enrolled Patients Receiving Community Paramedicine Services by Type

Project No.	Month	No. Patients Enrolled	No. Any Physical Assess.	No. Any Bio-psycho- social Assess.	No. Any Home Assess.	No. Any Medication Recon.	No. Any Transport to Non-ED Provider
CP007A	Jan 2018	9	3	3	3	3	0
	Feb 2018	9	3	3	2	2	0
	Mar 2018	5	1	1	1	1	0
Total – Jan – Mar 2018		*****	**7**	**7**	**6**	**6**	**0**
*Cannot report a count of total patients enrolled during the quarter because most patients were enrolled during more than one month (e.g., some of the patients enrolled in Jan. were also enrolled in Feb. and Mar.) A single patient often receives more than one assessment in a month.							

Table 15 shows the number of assessments provided for enrolled patients. The number of assessments often exceeds the number of patients because patients often receive more than one assessment or service from CPs each month. In CP007A (Alameda), CPs performed many of the bio-psycho-social assessments during telephonic visits.

Table 15.

Number of Community Paramedicine Services Provided by Type

Project No.	Month	No. Patients Enrolled	Total No. Physical Assess.	Total No. Bio-psycho-social Assess.	Total No. Home Assess.	Total No. Med. Recon	Total No. Transport to Non-ED Provider
CP007A	Jan 2018	9	4	11	3	3	0
	Feb 2018	9	3	11	2	2	0
	Mar 2018	5	5	10	1	1	0
Total – Jan – Mar 2018		*****	**12**	**32**	**6**	**6**	**0**
*Cannot report a count of total patients enrolled during the quarter because most patients were enrolled during more than one month (e.g., some of the patients enrolled in Oct. were also enrolled in Nov. and Dec.).							

During the first quarter of 2018, CP007A's CPs assisted frequent EMS users with access to medical insurance and home safety services. Because few new patients are enrolled each month, relatively few referrals to services are reported on the Data Collection Tool, which collects information on referrals made during the first CP visit. Many patients are enrolled for multiple months and receive referrals for additional services.

Table 16 shows the distribution of CP visits by the type of location in which CPs provided services. In CP007A (Alameda), all patients were seen in their place of residence. In CP007A, CPs also contacted patients by phone to perform additional assessments, anticipate need, and confirm whether patients need additional assistance.

Table 16.

Location at Which Community Paramedics Visited Enrolled Frequent 911 Callers

Project No.	Month	No. Patients Enrolled	No. Visits at Home	No. Visits at Place of Employment	No. Visits at Residential Facility	No. Visits at Street or Park	No. Visits at a Shelter
CP007A	Jan 2018	9	4	0	0	0	0
	Feb 2018	9	3	0	0	0	0
	Mar 2018	5	5	0	0	0	0
Total – Jan – Mar 2018		*****	**12**	**0**	**0**	**0**	**0**

*Cannot report a count of total patients enrolled during the quarter because most patients were enrolled during more than one month (e.g., some of the patients enrolled in Jan. were also enrolled in Feb. and Mar.).

Table 17 describes transitions among persons enrolled in Frequent EMS User projects. In the first quarter of 2018, CP007A did not unenroll any individuals due to non-compliance. CP007A graduated five individuals in addition to the 47 who had graduated cumulatively through December 2017. Persons graduated when, in the CPs' judgment, they no longer needed case management to function independently and use EDs appropriately.

The data presented in Table 17 also indicate that during this quarter, CP007A had no difficulty locating any patient after the individual enrolled in the program. In the past, EMS crews have referred patients to the program who cannot be located, because the potential client may be transient or the EMS crew may have provided incomplete information to the CPs.

Table 17.

Transitions of Enrolled Frequent 911 Callers

Project No.	Month	No. Could Not be Located after Enrolling	No. Un-Enrolled Due to Non-Compliance	No. Graduated (cumulative)	No. Moved into permanent housing (cumulative)
CP007A	Jan 2018	0	0	1	0
	Feb 2018	0	0	4	0
	Mar 2018	0	0	0	0

In the first quarter of 2018, patients enrolled in the Alameda Frequent EMS User projects visited the ED multiple times. In CP007A, Alameda's program, 43% visited the ED at least once in January; 13% did so in February; and 25% did so in March. None of CP007A's patients were admitted to the hospital during this quarter.

Table 18.

Emergency Department Utilization by Enrolled Frequent 911 Callers

Project No.	Month	Total No. Enrolled	No. visiting ED 1 Time	No. visiting ED 2 Times	No. visiting ED 3 Times	No visiting ED ≥ 4 Times
CP007A	Jan 2018	9	2	1	0	0
	Feb 2018	9	0	1	0	0
	Mar 2018	5	0	0	0	1
Total – Jan – Mar 2018			**2**	**2**	**0**	**1**
*Cannot report a count of total patients enrolled during the quarter because most patients were enrolled during more than one month (e.g., some of the patients enrolled in Jan. were also enrolled in Feb. and Mar.).						

For the Alameda Frequent EMS User project, the number of dispositions in the ED does not equate the number of patients who went to the ED in any given month because patients often go to the ED on more than one occasion in the month. Additionally, the data are derived from records from partner hospitals and information provided by patients. As a result, the data sources will not always match.

Table 19.

Disposition of Enrolled Frequent 911 Callers Visiting an ED

Project No.	Month	Total No. Enrolled	No. Admitted	No. Transferred	No. Discharged from ED	No. Failed to Complete Care	No. Expired in a Hospital
CP007A	Jan 2018	9	0	0	1	1	0
	Feb 2018[1]	9	0	0	0	0	0
	Mar 2018	5	0	0	1	0	0
Total –Jan – Mar 2018		*****	**0**	**0**	**2**	**1**	**0**

*Cannot report a count of total patients enrolled during the quarter because most patients were enrolled during more than one month.

[1] In February 2018, one patient was transported twice to a non-partner hospital and no disposition data are available.

POST-DISCHARGE CARE

The goal of the Post-Discharge projects is to reduce hospital readmissions and ED revisits for persons who were discharged from a hospital for treatment of a chronic condition. Each Post-Discharge project varies with respect to the conditions treated, as well as in their medical protocols. CP007B (Alameda) enrolls patients with one of six qualifying diagnoses: acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, pneumonia, and sepsis. CP004 (Butte) enrolls only patients with AMI or CHF. CP013 (Solano) enrolls only patients with CHF or COPD. CP008 (San Bernardino) enrolls only patients with CHF.

This report does not include information about CP002 (UCLA). The Glendale Fire Department terminated this Post-Discharge project at the end of August 2016 because it was no longer able to absorb the cost of operating the project.

Per each site's medical protocols, CPs perform an assessment of each patient's medical needs. The initial protocol for CP004 (Butte) called for CPs to perform an initial assessment by phone for all patients. If a Butte CP determined that a patient also needed an in-person assessment, the CP would request the patient's permission to conduct a home visit. CPs participating in CP007B, CP008, and CP013 (Alameda, San Bernardino, Solano, respectively) perform initial assessments in-person for all patients who consent to participate in the program. As of November 2017, CP004 changed its protocol to match that of the other sites. The protocol now calls for all patients to receive a home visit.

Table 20 shows the number of newly enrolled patients for each project by month, along with the number of initial in-person assessments scheduled, and the number of initial phone and in-person assessments conducted. Discrepancies can exist between the number of patients scheduled in a month and the number of visits completed. Some patients are enrolled and scheduled during the last several days of a month, and the visit is completed early in the following month.

Across the projects, CPs encounter patients who do not answer phone calls, do not return voicemail messages, or decline scheduled home visits. In some cases, family members refuse to let CPs schedule visits with patients. In addition, they report that scheduling conflicts between clients and the CPs can contribute to missed patient visits.

Table 20.

First Post-Hospital Assessment Visit or Phone Call with Community Paramedic for Enrolled Post-Discharge Patients

Project No.	Month	New Patients Enrolled	Patients First In-person Assessment with CP Scheduled	Patients First Assessment Phone Call with CP Completed	Patients First In-person Assessment Visit with CP Completed
CP004*	Jan 2018	17	unreported	15	17
	Feb 2018	14	unreported	13	14
	Mar 2018	18	unreported	17	18
CP007B	Jan 2018[1]	2	3	3	3
	Feb 2018	4	2	3	2
	Mar 2018[2]	1	1	4	1
CP008	Jan 2018	1	1	1	1
	Feb 2018	0	0	0	0
	Mar 2018	4	0	0	0
CP013	Jan 2018	6	6	0	6
	Feb 2018	5	5	0	5
	Mar 2018	8	8	0	8
Total – Jan – Mar 2018		**80**	**26**	**56**	**75**

*In February 2016, CP004 began offering an in-person visit to all CHF patients but some CHF patients declined.

[1] In January 2018, there were two new enrollees in CP007B, but a third patient who had enrolled on December 30 also received a phone call and in-person assessment.

[2] In March 2018, there was one new enrollee in CP007B, but three of the four February enrollees also received their first assessment call with a CP.

The CPs also conduct phone follow-up with patients and additional in-person visits on an as-needed basis. Table 21 shows the number of patients who had one or more follow-up telephone calls and the number of patients who had two or more, three or more, or four or more visits by project and month. CP004 (Butte) and CP007B (Alameda) provided multiple visits and phones calls to enrolled patients. CP013 (Solano) also completed multiple CP visits. In this quarter, all site except CP008 reported that more patients received follow-up phone calls than the number of patients enrolled. The reason for this is that some clients were enrolled toward the end of the previous month, pushing their respective follow-up phone calls into the next month.

CPs may provide extensive assistance to patients to help them solve health-related dilemmas. In this quarter, for example, CP004 (Butte)'s CP helped a patient obtain a mobility scooter, assisted several patients in contacting PCPs or specialists for urgent issues, and aided some patients in obtaining or following up on prescriptions. Many of these interventions required several hours of time and multiple phone calls to different parties to resolve.

Table 21.

Subsequent Contacts with Community Paramedics for Enrolled Post-Discharge Patients within 30 Days of Discharge

Project No.	Month	No. Had ≥1 Phone Follow-Up to 1st Visit	No. Had ≥2 CP Visits	No. Had ≥3 CP Visits	No. Had ≥4 CP Visits
CP004*	Jan 2018	24	2	0	0
	Feb 2018	24	1	0	0
	Mar 2018	30	0	0	0
CP007B	Jan 2018	5	1	0	0
	Feb 2018	6	1	1	0
	Mar 2018	7	1	1	1
CP008	Jan 2018	1	0	0	0
	Feb 2018	No patients	No patients	No patients	No patients
	Mar 2018	0	0	0	0
CP013	Jan 2018	0	7	3	0
	Feb 2018	0	6	0	0
	Mar 2018	0	7	0	0
Total – Jan – Mar 2018		**97**	**26**	**5**	**1**

Table 22 reports on instances in which CPs provided specific services intended to reduce the risk of readmission for patients with chronic conditions. During the first quarter of 2018, CP004 (Butte) reported that no patients had an inconsistency in medication and no patients needing additional instruction. However, two patients needed assistance to obtain medication from their physicians. The CP also assisted a patient who received a paper prescription upon discharge from the hospital and did not realize that he had to take the prescription to the pharmacy in order for it to be filled. CP007B (Alameda) reported two patients with a medication inconsistency and one patient who needed additional instruction. CP008 (San Bernardino) reported that no patients had an inconsistency in medication needed but reported that one patient needed additional guidance to follow their hospital discharge instruction. CP013 (Solano) was the only project to report that a large proportion of their patients had medication inconsistencies and that half or more required additional instruction in each month.

Table 22.

Services Community Paramedics Provided to Reduce Risk of Readmission

Project No.	Month	New Patients Completing 1st Visit or Call	No. Patients for Whom CP Identified an Inconsistency in Medication	No. Patients Needed Additional Instruction
CP004*	Jan 2018	17	0	**0**
	Feb 2018	14	0	0
	Mar 2018	18	0	0
CP007B	Jan 2018	3	0	1
	Feb 2018	2	0	0
	Mar 2018[1]	1	2	0
CP008	Jan 2018	1	0	1
	Feb 2018	No patients	No patients	No patients
	Mar 2018	0	0	0
CP013	Jan 2018	6	9	12
	Feb 2018	5	3	4
	Mar 2018	8	3	7
Total – Jan – Mar 2018		**75**	**17**	**25**

[1] In March of 2018, CP007B, one client with a missing medication was enrolled in February and one was enrolled in March
[2] In January 2018, CP013, several patients from December had medication inconsistencies and/or needed additional instruction.

CPs also provided services that reduced the risk of ED visits and hospitalizations due to reasons other than patients' qualifying diagnoses. They conduct home safety inspections and advise patients on strategies for reducing the risk of falls, such as removing clutter. CP007B (Alameda) refers many patients to the Alameda Fire Department's Senior Safety program, where patients gain access to free assistance in installing safety equipment inside their home, such as grab bars in the bath and handrails on staircases.

Table 23 shows the distribution of the locations at which CPs saw Post-Discharge patients. Because these projects target patients who were recently discharged from a hospital for treatment of a major illness, patients' residences were the most frequent place in which CPs cared for patient. In this quarter CP0004 (Butte) and CP013 (Solano) reported that CPs visited a few patients in locations other than the patient's home.

Table 23.

Location at Which Enrolled Post-Discharge Patients were Visited by Community Paramedics

Project No.	Month	No. Patients Enrolled	No. Visited at Permanent Residence	No. Visited at Some Other Place
CP004	Jan 2018	17	12	0
	Feb 2018	14	12	1
	Mar 2018	18	14	0
CP007B	Jan 2018	3	3	0
	Feb 2018	6	2	0
	Mar 2018	5	4	0
CP008	Jan 2018	1	1	0
	Feb 2018	0	0	0
	Mar 2018	4	0	0
CP013	Jan 2018	13	10	3
	Feb 2018	9	8	1
	Mar 2018	12	7	2
Total – Jan – Mar 2018		**102**	**73**	**7**

Table 24 presents data on ED visits by persons enrolled in Post-Discharge projects during the 30 days following discharge from a partner hospital. During the quarter, CP004 reported the highest ED visit rate overall at 41% of all visits. CP013 (Solano) had seven patients who visited the ED within 30 days of discharge (21%), CP007B had one patient (7%) and CP008 (San Bernardino) reported having no patients who visited an ED within 30 days of discharge. Across all four post-discharge projects, the quarterly ED revisit rate was 27%. *This estimate includes both ED visits that resulted in an inpatient admission and ED visits during which a patient was treated and released.*

Table 24.

ED Visits by Enrolled Post-Discharge Patients

Project No.	Month	No. Patients Enrolled	No. Patients ≥ 1 ED Visit	ED Visit Rate
CP004	Jan 2018	17	5	29%
	Feb 2018	14	6	43%
	Mar 2018	18	9	50%
CP007B	Jan 2018	3	0	0%
	Feb 2018	6	0	0%
	Mar 2018	5	1	20%
CP008	Jan 2018	1	0	0%
	Feb 2018	0	0	-
	Mar 2018	4	0	0%
CP013	Jan 2018	13	3	23%
	Feb 2018	9	0	0%
	Mar 2018	12	4	33%
Total – Jan – Mar 2018		**102**	**28**	**27%**

Table 25 shows the disposition of patients who went to the ED within 30 days of their hospital discharge. During the first quarter of 2018, CP004 (Butte) reported that 20 of its patients made at least one ED visit. Sixteen of these ED visits resulted in readmission to the hospital. CP007B (Alameda) reported one ED visit, which resulted in a hospital readmission. CP008 (San Bernardino) reported no ED visits within 30 days of hospital discharge. CP013 (Solano) reported seven ED visits in the first quarter of 2018, which resulted in no hospital readmissions.

Table 25.

Disposition of Enrolled Post-Discharge Patients Who Went to an Emergency Department within 30 Days of Index Hospital Discharge

Project No.	Month	No. Patients ≥ 1 ED Visit	No. Admitted	No. Transferred	No. Discharged from ED	No. Failed to Complete Care	No. Expired in a Hospital
CP004*	Jan 2018	5	3	0	2	0	1
	Feb 2018	6	6	0	0	0	0
	Mar 2018	9	7	0	3	0	0
CP007B	Jan 2018	0	0	0	0	0	0
	Feb 2018	0	0	0	0	0	0
	Mar 2018	1	1	0	0	0	0
CP008	Jan 2018	0	0	0	0	0	0
	Feb 2018	0	0	0	0	0	0
	Mar 2018	0	0	0	0	0	0
CP013	Jan 2018	3	0	0	3	0	0
	Feb 2018	0	0	0	0	0	0
	Mar 2018	4	0	0	4	0	0
Total – Jan – Mar 2018		**28**	**17**	**0**	**12**	**0**	**1**

Table 26 reports numbers and rates of readmission to a hospital within 30 days of hospital discharge for any reason and for the qualifying diagnosis. The rate of readmission for any reason is important because Medicare penalizes hospitals that have high rates of readmission for any reason. The rate of readmission for the qualifying diagnosis is also important because CP Post-Discharge projects focus on helping patients manage qualifying diagnoses and, thus, are most likely to affect readmissions for those diagnoses. Across all projects and all three months, the rate of readmission for any reason was 17% (range = 0% to 43%). The rate of readmission for qualifying diagnosis was 9% (range = 0% to 21%).

Among the 16 patients enrolled in CP004's (Butte) project who were readmitted, eight readmissions were related to the qualifying diagnosis. One of the eight readmissions that was not related to the qualifying diagnosis was for a planned/scheduled surgery. Several patients were readmitted based on the advice of their physicians. One of the admissions resulted in a death in the hospital.

CP007B (Alameda) reported that one patient was readmitted to the hospital. This admission was unplanned and was related to the qualifying diagnosis. The length of stay was two days. CP008 (San Bernardino) and CP013 (Solano) reported that no patients were readmitted to the hospital.

Table 26.

Hospital Readmissions by Enrolled Post-Discharge Patients

Project No.	Month	No. Patients Enrolled	No. Patients Readmitted for Any Reason (%)		No. Patients Readmitted for Qualifying Diagnosis (%)	
CP004	Jan 2018	17	3	18%	3	18%
	Feb 2018	14	6	43%	3	21%
	Mar 2018	18	7	39%	2	11%
CP007B	Jan 2018	3	0	0%	0	0%
	Feb 2018	6	0	0%	0	0%
	Mar 2018	5	1	20%	1	20%
CP008	Jan 2018	1	0	0%	0	0%
	Feb 2018	0	0	0%	0	0%
	Mar 2018	4	0	0%	0	0%
CP013	Jan 2018	13	0	0%	0	0%
	Feb 2018	9	0	0%	0	0%
	Mar 2018	12	0	0%	0	0%
Total – Jan – Mar 2018		**102**	**17**	**17%**	**9**	**9%**

Table 27 describes the number of patients for whom the CPs made initial contact outside of the timeframe stipulated in the medical protocol and the number of patients for whom all of the assessments required in the medical protocol were not completed. In many cases where one of these events occurred, the lack of compliance with the protocol was due to the patient being unreachable or unwilling to participate in the planned visit. =

Staffing challenges also played a role. CP007B (Alameda) and CP004 (Butte) had difficulty making initial contacts within the stipulated time frame for patients who were discharged over the weekend because the CPs only work Mondays through Fridays. CP004 (Butte) also had difficulties due to patients' lack of access to telephones and miscommunication between CPs and Cardiology Department staff.

Table 27.

Lack of Compliance with Protocol for Enrolled Post-Discharge Patients

Project No.	Month	No. 1st Contacts Outside Stipulated Time Frame	Reasons Outside Stipulated Time Frame	No. Did Not Receive All Assessments	Reasons Not Receive All Assessments
CP004	Jan 2018	2	1 patient died, 1 patient did not have a phone	1	1 patient expired
	Feb 2018	2	1 phones disconnected, 1 schedule conflicts	1	1 no phone
	Mar 2018	3	1 opted out; 1 no phone; 1 not answering phone	3	1 opted out; 1 no phone; 1 not answering phone
CP007B	Jan 2018	1	1 schedule conflict due to holidays	0	-
	Feb 2018	2	2 schedule conflicts	1	unable to contact client
	Mar 2018	0	-	1	completed program 3/1
CP008	Jan 2018	0	-	0	-
	Feb 2018	0	-	0	-
	Mar 2018	0	-	4	1 unable to contact, bad phone number, 1 unable to see due to staffing, 1 patient expired while in-patient, 1 declined visit
CP013	Jan 2018	0	-	0	-
	Feb 2018	0	-	0	-
	Mar 2018	0	-	0	-
Total – Jan – Mar 2018		**10**		**6**	

DIRECTLY OBSERVED THERAPY FOR TUBERCULOSIS

CP005, Ventura County's Tuberculosis (TB) pilot project, was launched in June 2015. CPs provide Directly Observed Therapy (DOT) for TB to supplement care provided by staff of the county's TB Clinic, which is partnering with Ventura's EMS providers on this pilot project because it does not have sufficient resources to provide DOT to all TB patients in the county. DOT is important for TB because patients who do not take their medication as directed may infect other people and may develop drug resistant strains of TB.

Many patients are enrolled for multiple months due to the length of DOT for TB. Six patients were enrolled in January 2018, six patients were enrolled in February, and five patients were enrolled in March 2018.

In this section, some data are reported separately for patients with drug resistant TB and non-drug resistant TB because drug resistant TB is more difficult to treat and poses a greater risk to public health than TB that responds to standard medications. No patients with drug-resistant TB were enrolled during this quarter.

The number and frequency of DOT treatments administered to patients are determined by both the patient's treatment protocol and start date for the DOT regimen. Table 28 shows the number of DOT treatment given by CPs to patients in the first quarter of 2018.

Table 28.

Number of Directly Observed Therapy (DOT) Treatments Administered by Community Paramedics

Project No. and Month	Total Number of Patients	No. Treatments - Patients with Drug Resistant TB	No. Treatments - Patients with non-Drug Resistant TB	Total No. Treatments
CP005 -- Jan 2018	6	0	96	96
CP005 -- Feb	6	0	89	89
CP005 -- Mar	5	0	69	69
Total – Jan – Mar 2018	*****	**0**	**254**	**254**

*Cannot sum the number of patients across months because patients are enrolled for multiple months due to the length of treatment for TB.

TB patients sometimes experience side effects and mal-absorption of TB medications. No mal-absorption issues or other side effects were reported by patients treated by CPs during the first quarter of 2018. (See Table 29).

Table 29.

Monitoring of Side Effects among Patients Treated by Community Paramedics

	Project Month	Patients with Drug-Resistant	Patients with Non- Drug-Resistant TB	All Patients with Side Effects
No. Mal-absorption Issues Identified	Jan 2018	0	0	0
	Feb 2018	0	0	0
	Mar 2018	0	0	0
No. Patients Reporting Treatment Side-effects (excluding mal- absorption)	Jan 2018	0	0	0
	Feb 2018	0	0	0
	Mar 2018	0	0	0

CPs performed all required medical assessments for all patients. However, not every assessment is administered formally at every DOT since some patients are seen daily or more than once per day.

Table 30 shows the distribution of the locations at which CPs saw enrolled patients. In this quarter, all DOTs administered by CPs were provided in the patient's residence.

Table 30.

Location at Which Directly Observed Therapy (DOT) Provided by Community Paramedics

Project No. and Month	No. Received DOT at Home	No. Received DOT at Place of Employment	No. Received DOT at a Residential Facility	No. Received DOT on Street or Park	No. Received DOT at a Shelter
CP005 -- Jan 2018	6	0	0	0	0
CP005 -- Feb 2018	6	0	0	0	0
CP005 -- Mar 2018	5	0	0	0	0
Total – Jan – Mar 2018	*	**0**	**0**	**0**	**0**

*Cannot sum the number of patients across months because patients are enrolled for multiple months due to the length of treatment for TB.

Persons with TB are usually not treated in an ED or admitted to a hospital due to their TB diagnosis. In the first quarter of 2018, no patients enrolled in Ventura's TB project were admitted to a hospital.

In the first quarter of 2018, all scheduled DOTs were completed, as reflected in Table 31.

Table 31.

Instances of Non-Completion of Directly Observed Therapy among Patients Treated by Community Paramedics

Project No. and Month	No. Times CP Could Not Complete Scheduled DOT	No. Patients for Whom CP Could Not Complete Scheduled DOT	Reasons Why Patient Not Available
CP005 -- Jan 2018	0	0	n/a
CP005 -- Feb 2018	0	0	n/a
CP005 -- Mar 2018	0	0	n/a
Total – Jan – Mar 2018	**0**	**0**	**n/a**

In addition to providing DOT, CPs assist the staff of Ventura's TB clinic with contact investigations to identify persons to whom TB patients may have transmitted the disease so that they can be tested and, if necessary, treated. In some cases, the CPs' role primarily involves logistics. In other cases, CPs assist with screening of persons exposed to a person who was recently diagnosed with TB. During the first quarter of 2018, the TB clinic did not ask Ventura's CPs to assist with any contact investigations.

Table 32.

Number of Tuberculosis Contact Investigations in which CPs Participated

Project No. and Month	Number of Contact Investigations in which CPs Participated
CP005 -- Jan 2018	0
CP005 -- Feb 2018	0
CP005 -- Mar 2018	0
Total – Jan – Mar 2018	**0**

HOSPICE

CPs participating in CP006, AMR Ventura County's Hospice project, provide care in the homes of patients receiving hospice care from partner agencies to prevent unnecessary transport to an ED. Although hospice patients are instructed to call the hospice agency if they need care, some hospice patients and their families call 911 instead. In some cases, patients and families do not understand that they should call the hospice agency. In other cases, families call 911 because they are anxious about a patient's condition or because they disagree with the patient's decision to obtain hospice care. In still other cases, patients or families may turn to 911 if they do not receive a prompt response when they contact a hospice agency.

Twenty hospice patients were enrolled during the first quarter of 2018. (CP006 considers patients to be enrolled when a 911 dispatcher or a first responder on scene determines that a person is under the care of a partner hospice agency.) Ventura's protocol stipulates that the CP must contact the hospice agency in all cases in which a 911 call is made on behalf of an enrolled hospice patient if hospice provider is not already on scene.

In all but one instance (February 2018), 911 calls during the first quarter of 2018 were initiated by someone other than a hospice provider, often a family member. The reasons reported for 911 calls for hospice patients during this quarter were varied, and included falls, lift assists, seizures, shortness of breath, altered level of consciousness, and assistance with oxygen equipment.

The one 911 call placed by a hospice provider was placed while the provider was already on-scene with the patient. In 15 of the 20 cases (75%), the CP and a hospice provider consulted by telephone determined that a hospice provider should come to the scene to care for the patient. In five of these 15 cases (33%), the hospice provider arrived on scene less than 30 minutes after the 911 call was initiated and in the other 10 cases (66%), the hospice provider arrived on scene 30 or more minutes after the 911 call was initiated.

Table 33.

Presence of Hospice Agency in Response to 911 Calls

Project No.	Number of Hospice Patients Enrolled	# Patients for whom Hospice Agency's Presence Needed	Hospice Agency arrived within 30 Min. of 911 Call	Hospice Agency arrived 30 Min. or More after 911 Call
CP006 -- Jan 2018	12	9	2	7
CP006 -- Feb 2018	6	4	3	1
CP006 -- Mar 2018	2	2	0	2
Total – Jan – Mar 2018	**20**	**15**	**5**	**10**

A major goal of Ventura's Hospice project is to reduce of the number of hospice patients transported to an ED, because hospice patients are at risk of being removed from hospice if they are transported to an ED. Two hospice patients (10% of patients enrolled) were transported to an ED during the first quarter of 2018. No patients transported to an ED in this quarter were removed from hospice care.

The reasons for transport of these patients to an ED vary by patient. Historically, the most common reason was that the patient or a family member insisted that paramedics transport the patient to an ED.

Table 34.

Transports of Enrolled Patients and Hospice Care Status

Project No.	Total Enrolled	Number of Transports	Percent Transported	Number Removed from Hospice Care
CP006 -- Jan 2018	12	1	8%	0
CP006 -- Feb 2018	6	1	17%	0
CP006 -- Mar 2018	2	0	0%	0
Total – Jan – Mar 2018	**20**	**2**	**10%**	**0**

ALTERNATE DESTINATION – BEHAVIORAL HEALTH

Alternate Destination pilot projects aim to transport patients to the most appropriate level of care for patients' needs. Stanislaus's Behavioral Health project, CP012, offers transport to an outpatient mental health crisis center for patients who are experiencing a behavioral health emergency.[7] Patients are eligible for transport to Stanislaus' County's mental health crisis center if they are uninsured or enrolled in Medi-Cal, pass a Well Person Protocol and a Behavioral Health Assessment, are not intoxicated, are not violent, and do not have a history of disruptive behavior during past visits to the mental health crisis center.

CP012 enrolled 28 patients during the first quarter of 2018. Table 35 shows the number of patients enrolled in each month. During this quarter, no patients were transferred to an ED within six hours of transport to the mental health crisis center.

Table 35.

Transfers to ED for Enrolled Behavioral Health Patients

Project No.	Month	No. Patients Enrolled	No. Patients transferred ED within 6 hours	Reasons for transfer to the ED
CP012	Jan 2018	8	0	n/a
	Feb 2018	15	0	n/a
	Mar 2018	5	0	n/a
Total – Jan – Mar 2018		**28**	**0**	

Table 36 presents information on the disposition of patients who were transferred from the mental health crisis center to an ED within six hours. *Because no patients went to the ED, no patient dispositions are reported in Table 36.*

[7] Eligibility is limited to persons who are uninsured or enrolled in Medi-Cal because the participating behavioral health facility does not accept patients with other types of health insurance.

Table 36.

Disposition of Enrolled Behavioral Health Patients Who Went to an Emergency Department

Project No.	Month	No. Patients Enrolled	No. Admitted	No. Transferred	No. Discharged from ED	No. Failed to Complete Care	No. Expired in a Hospital
CP012	Jan 2018	8	0	0	0	0	0
	Feb 2018	15	0	0	0	0	0
	Mar 2018	5	0	0	0	0	0
Total – Jan – Mar 2018		**28**	**0**	**0**	**0**	**0**	**0**

CP012 enrolls persons with behavioral health needs who are frequent 911 users and/or have been placed on an involuntary psychiatric hold, known in California as a 5150. In January, six patients were on a 5150 hold by the police as were four patients in March 2018. No patients were categorized as frequent 911 callers in January, February, or March of 2018. In each month, the remaining patients enrolled were neither frequent 911 callers nor on a 5150 hold by the police.

Table 37 shows the distribution of CP visits during the first quarter of 2018 by location. CPs see patients in various locations, including place of residence, offices of health care providers, city streets, and other locations. In this quarter, 16 of the 28 calls (57%) originated at a health care provider. Staff of the mental health crisis center may have made these calls. In previous quarters, mental health crisis center staff have asked CPs to screen patients who come to the crisis center on their own for care or who are brought to the crisis center by family members or friends. Having CPs assess patients on site avoids transport to an ED for medical screening, enabling patients who meet criteria for admission to the mental health crisis center to receive mental health services more quickly.

Table 37.

Location from Which Enrolled Behavioral Health Patients Called 911

Project No.	Month	No. Patients Enrolled	No. Calls from Permanent Residence	No. Calls from Health Care Provider	No. Calls from Street or Intersection	No. Visited at Some Other Place
CP012	Jan 2018	8	1	3	0	4
	Feb 2018	15	3	9	2	1
	Mar 2018	5	0	4	0	1
Total – Jan – Mar 2018		**28**	**4**	**16**	**2**	**6**

ALTERNATE DESTINATION – URGENT CARE

The goal of the Alternate Destination – Urgent Care projects was to reduce the number of visits to hospital EDs and to provide the most appropriate level of care for patients. CP001 (UCLA) curtailed operation in May 2017. CP003 (Orange) and CP009 (Carlsbad) curtailed operations in November 2017.

The Alternate Destination – Urgent Care projects were closed due to low enrollment. There are multiple reasons why enrollment in these projects was substantially lower than anticipated, including:

- Lower than expected numbers of patients who met the inclusion criteria (all sites)
- 911 calls occurred at times of the day during which urgent care centers were closed (all sites)
- Enrollment was limited to persons who had coverage through a single insurance carrier (CP009)
- Enrollment was limited to non-elderly adults (CP009)

This report does not present any findings for the Alternate Destination – Urgent Care projects because all three of these projects closed prior to the first quarter of 2018.

ALTERNATE DESTINATION – SOBERING CENTER

In February 2017, San Francisco City and County began a pilot project under which eligible patients are transported directly to its Sobering Center. The Sobering Center is a 24/7 nurse managed program that has been in operation since 2003 and has cared for over 50,000 patients. It serves adults who are inebriated, but not in need of the services of an ED. These patients may require some simple interventions, such as administration of oral fluids, but do not have medical needs or symptoms of acute mental illness. Approximately 90% of patients are homeless at the time they are admitted to the Sobering Center. Registered nurses monitor patients throughout their stay. The Sobering Center also refers patients to more comprehensive services, such as detoxification and intensive case management, where appropriate.[8]

San Francisco has trained paramedics on regular 911 response crews to screen inebriated patients to determine if they are eligible to enroll in the pilot project. Patients who meet all eligibility criteria are offered 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. In addition to the paramedics on the regular 911 response crews, several experienced paramedics have been trained to work with the Sobering Center's staff to perform quality assurance reviews for patients transported to the Sobering Center. They also collaborate with San Francisco's Homeless Outreach Team to encourage Sobering Center patients who are high utilizers of county health care services to accept treatment for alcoholism, housing, and other services.

The most common risk to Sobering Center patients is an unforeseen need for medical detoxification. Among chronic alcoholics, the need for medical detox is sometimes difficult to predict because their vital signs and other indicators of need for medical detox are often outside of the parameters that would be expected for persons who are not chronic alcoholics. A patient may also be on another drug that the paramedic could not detect when he or she examined the patient in the field.

During the first quarter of 2018, the San Francisco pilot project (CP014) enrolled 175 patients. In this quarter, there was some variation in the number of enrollees by month, with January experiencing the largest number of enrollees and February reporting the smallest.

Table 43 shows the total number of patients enrolled and the number of patients who came to the Sobering Center more than once in the quarter. Eleven percent of patients transported to the Sobering Center's by paramedics were repeat visitors.

[8] Additional information about the Sobering Center is available at http://www.sfsoberingcenter.com/home.

Table 43.

Repeat Visits to the Sobering Center

Project No.	Month	No. Patients Enrolled	No. of Repeat Patients	Percent of Repeat Patients
CP014	Jan 2018	67	7	10.4%
	Feb 2018	52	6	11.5%
	Mar 2018	56	7	12.5%
Total – Jan – Mar 2018		**175**	**20**	**11.4%**

Because the Sobering Center staff can usually ascertain very quickly whether a patient will need emergency services, CP014 has requested to report the number of patients transferred to an ED within two hours in addition to the transfers that occur within six hours. In January 2018, two patients were transferred to an ED within two hours of arrival at the Sobering Center, one for seizure, and one for a fall and pain. In February, one transfer to the ED occurred within two hours of arrival at the Sobering Center because the client was having chest pain and then abdominal pain. There were no transfers in March of 2018. The three patients transferred to an ED account for 1.7% of patients enrolled during the first quarter of 2018. All three patients who were transferred to an ED were treated in the ED and released.

Table 44.

Transfers to ED for Enrolled Sobering Center Patients

Project No.	Month	No. Patients Enrolled	No. Patients transferred to ED in < 2 hours	Reasons for transfer to the ED in <2 hours	No. Patients transferred to ED in < 6 hours	Reasons for transfer to the ED in <6 hours
CP014	Jan 2018	67	2	1 History of seizures; seizures with post-ictal state; 1 Fall with left knee pain. No obvious injury.	2	1 History of seizures; seizures with post-ictal state; 1 Fall with left knee pain. No obvious injury.
	Feb 2018	52	1	1 Client complaint of pain. Originally c/o chest pain, then abdominal pain. (same client as within 6 hours)	1	1 Client complaint of pain. Originally c/o chest pain, then abdominal pain.
	Mar 2018	56	0		0	
Total – Jan – Mar 2018		**175**	**3**		**3**	