Health Extenders System Building Webinar-20261109_150037-Meeting Recording

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Tanikuni, Marta - EMS started transcription

Denny, Wayne A. 0:03

on the Rural Health Transformation Grant and particularly a couple of key elements that relate to EMS here in the state of Idaho. So without further ado, I'm going to go ahead and start working through the slides. Right off the bat, I see that Roddy has a hand up. Did you have a question?

Um...

Roddy 0:29

No, sorry, just saying hi.

Denny, Wayne A. 0:31

Okay, I don't hear anything coming from Roddy, so we'll go ahead and get started. So here's the agenda that we're going to walk through this afternoon. We'll give a little bit of background on where we're at, how we got here, talk a little bit about the grant opportunity, and the real meat of the webinar this afternoon is the panel. We've got a group of

folks that are subject matter experts that I want you to hear from to really frame up what some of the ideas we're thinking about. We'll go through a panel discussion and then we'll have room at the end for questions. But if you have a question as we're going through, just go ahead and use the

raise hand feature on top of your screen to get our attention and we'll go ahead and work through the questions as we go through. But at the end, we will have a time for just kind of general questions, discussion, and what have you. But we really do want the discussions as we're going through the panel to be discussions. So if you have questions and comments and what have you,

Please go ahead and raise your hand and we'll go ahead and go through that then. So the background, the Rural Health Transformation Program was authorized by the One Big Beautiful Bill Act, and it empowers states to strengthen rural communities by

improving health care access, quality, and outcomes. The Idaho Department of Health and Welfare serves as the lead agency for administering the grant.
in the state of Idaho.
The Idaho Military Division and the Bureau of EMS is part of the military division. We entered into a memorandum of agreement with DHW, which is specific to two initiatives, improving rural access to care through technology and ensuring accessible quality care through innovative models. And that second initiative
is the one that we're talking about tonight. The first one is more next generation 911 and that type of stuff. So the one that's bolded on your screen right now, the innovative models is what we're really talking about. And part of that is focused on health extenders.
And health extenders, what we're talking about are community health EMS and community health workers. And I'm not going to get into a lot of detail on what those are, because that's a lot of what the panel is going to talk about is what those folks are and what they bring to the community. And then of course, the
The reason why the Bureau of EMS is working on these is really the goal of this is EMS expansion and workforce stabilization. So our hope is that working with Chem, CHWs, these health extenders, that we can strengthen the EMS workforce, which is something that
we're very concerned about and we've been working on for years.
So the grant opportunity, some of the things that, some of the questions that we're looking at are can KIMS and CHW capabilities be leveraged to help solve several issues? And some of those are population health, chronic disease prevention and management, acute injury response, and others.
And I bring this up, really, the panelists will go through some of these, but these are also questions that anyone who's interested in applying for funding from this grant, these are all things to think about as you're working through. And we're recording this webinar, so it'll be available for
you go back and reference the slides and the discussion and stuff later on.
So how could these resources be deployed in rural Idaho to best meet the needs of multiple communities? And some of the things that we are thinking about here is a regional approach, you know, multi-counties, hub and spoke, multi-partner collaboratives. Those are just things that we think about. So it could certainly be something completely different that somebody on this call right now has thought of that we haven't even thought of. So we're really hoping that the community at large

comes up with some good thoughts that really get us in a much better place than we are now.
Now talking about the grant, some of the things that as we're looking at the grant application and then when we're evaluating proposals and what have you, some of the things that we're looking for are innovative approaches, collaboration, post-grant sustainability is something that's very important. So at the end of the five-year period, and right now,
I don't want to speak to what DHW has coming in for the whole state, but what we're looking at for just our piece of it is about 14.9 million a year over five years. Now that's assuming that the funding remains stable from CMS that comes into the state. that the state gets the amount that they're proposing every year and that the grant officers and what have you agree and the legislature agrees to continue the grant process as it exists today. So that's what we're looking at right now. That's what we're planning on. But of course, that
that could change as we progress through the five years. But we're in year one right now, and then it'll last for a total of five years. And looking, of course, for long-term solutions, because what we don't want is the red text. We don't want the short-term solutions. We understand that a lot of the communities in the state are having issues keeping
you know, fuel in the ambulance and keeping people on the roster and what have you. But those are the short-term solutions that we shouldn't focus on with the grant because typically when we look at just those solutions, as soon as the money runs out, the problem is right back again. So
We're really hoping that we can take this funding and find those long-term solutions that solve the problem at year six and year seven and not just limping us along years one through 5.
Before I think, so yeah, let me go ahead and get through these and then I'll stop and take a breath for questions. So some of the questions about the grant application that I'm sure folks are going to be wondering. So when will the application be available? We're not sure, but we hope to have it out before the end of the year. How long will it be open? Again, we're not sure. There are some questions that we're working through right now that will help inform some of these, the answers to these questions. And here's what we're thinking about right now with the question on how long will it be open. We'd love to get a grant application out on the street now. We'd love to get responses back in two weeks so people can get running on it, but

that's not reasonable. And we don't want a rushed application that's going to get us a rushed solution. We really want to give people time to work with partners and figure out what a good solution is.
solution is, however, we don't have a ton of time. So we've got two competing interests that we're working against here. So at the end of the day, like the bullet here on the screen says, we're uncertain, but be prepared to move quickly and start planning now. So what we hope is that when we get done with the webinar, that folks in communities, hospitals, clinics,
agencies, counties, cities, whomever else, start having conversations now about what we can do, what you can do locally. So when the application does drop, that you're already ahead of the game and you're not just starting at that point. How much funding will be available? It's uncertain at this point. We know how much
total funding we have available, but there are several different things that we've got to work through before the final before the final numbers are there. And so we don't know, but it's millions of dollars that we've got available
to push out into the local communities. And so again, don't think small in this. What we're really wanting and what we're hoping is for people to have quality ideas that aren't really bounded by, you know, how much money is available today.
But look long term at if we could build this, here's how we would sustain it, and this is what it would cost to build it. And then let's look at building it.
So the next part of this, like I said, I didn't want to take up too much time, my part of it, because what we really want is the panel discussion. But I will take a breath for a quick minute to see if anybody has any questions thus far before we get into the panel.
Cody, I see you got a hand up.

CK **Cody Killmar** 10:00
Yeah, Wayne, I got it.
Yeah, I am watching this, the website of... Oh, can you hear me?

DA **Denny, Wayne A.** 10:06
I'm not hearing you.

CK **Cody Killmar** 10:11
Can you hear me?

Denny, Wayne A. 10:12
Oh wait a second because I am muted. Hang on, let me unmute.
Hey, go ahead, Cody.

Cody Killmar 10:21
There, can you hear me now?
Can you hear me, Wayne?

Denny, Wayne A. 10:26
Yes, yes I can. Yep.

Cody Killmar 10:28
Okay, cool. I'm watching the state's website for this grant and right now they have it published on their homepage that all of the grant applications for year one are closed and completed. Is this going to be the discussion that we're talking about today? Does this start next year on year 2 for the grant or are we anticipating another application open for what we're talking about today.

Denny, Wayne A. 10:53
That's a great question, Cody. And all of the, what you find on DHW's website, all of the grant applications have been finished for year one because we're one of the applicants. So we're one of the recipients. So we're still in year one. So whatever money

Cody Killmar 11:07
Okay.
Okay.

Denny, Wayne A. 11:14
I won't go through all of the gruesome details, but we'll put out an application, we'll review it, and then we'll send our recommendations back to DHW, who will be the funder. So if you've gotten, and I think you guys have gotten other grant funding through this,
It'll be just like that. You'll get the contract and everything from DHW.

Cody Killmar 11:37
But it'll be for this year, not next year. So we'll see funding. Okay, cool. Yeah, great. I was concerned that this, the topic we're talking about today won't be available for another year. So.

Denny, Wayne A. 11:39
It'll be for year one. Yep.
Nope, it will be available this year.

Cody Killmar 11:52
Cool, thank you.

Denny, Wayne A. 11:53
You bet.
Any other questions before we get started on the panel?
I don't see any hands up, but Vaughn Mason.

Vonne Mason 12:11
Hi, sorry, I was trying to get myself unmuted. Can you hear me okay?

Denny, Wayne A. 12:14
Absolutely, yes, go ahead.

Vonne Mason 12:16
Great, thank you. Hey, so I am interested in finding out if...
We are trying to assess services that...
Would.
be expanded in rural Idaho. Do we have any way to discern those services that are already covered through?
Are there Medicaid besides ambulance services? Like, do you have any funding that you receive for your EMS workers or...
paramedics, is there any reimbursement or revenue cycle management model where those particular level of providers are able to...
Have sustainable funding if we were to build.

you know, a revenue cycle management system for their services. Like, do we need to build that? Does it already exist? What do you, what do you have? Do you know?

Denny, Wayne A. 13:21
Well, that's a great, yeah, those are great questions. And I would, instead of me trying to answer that up front, let's get through the panel, because I think that may very well bubble to the surface as we work through the panel discussion. So that's a great question. And hold it, please. And if you don't get it answered, let's come back around to it on the back end.

Vonne Mason 13:43
Great, thank you.

Denny, Wayne A. 13:44
You bet, you bet. Any other questions before we get started? I want to give plenty of time to the smart people that we've invited so you're not listening to me all night. Okay, well what I'd like to do then is hand it off to Don and Stormy. They're our first panelists and they can introduce themselves and take it away from there.

Dawn Rae 14:06
Okay, I guess I'll go first. My name is Don Ray. I'm a community paramedic with Ada County Paramedics here in Boise. We have had our community paramedic program for 15 years with a small break when we had to shut things down during COVID, unfortunately. So I was one of the original four that started the program.
We kind of highlight a few different things within our program and have had a few years of hits and misses. So happy to share some of those. And I'll let Stormy introduce herself.

Stormy Cox 14:42
Hello, I am Stormy Cox. I am the supervisor of the Community Health EMS team here at St. Luke's Magic Valley Paramedics. We've not been here as long as Don Ray, but we have had a really successful program over here. And yeah, just excited to share what we found and hopefully expand that.

Dawn Rae 15:13

So I think we were given a couple of conversation starters, I suppose, to sort of lead some of these. So I'll go through. I'm just kind of give a background of what we experienced here in Ada County. You all may be asking yourself, why is a community paramedic from Ada County, the largest metropolitan area in the state of Idaho, sitting on a panel about rural health transformation, partly because we were the first to get started. And that was the Wild West, trying to figure all these things out. And there's a commonality to that, no, you know, regardless of the size of your area. And also in 2018, I had the opportunity to go to Chalice and try to start a community health

EMS program up there with an employee of 1, myself. And we were getting some things in place and found a lot of challenges that came up with trying to put an ALS provider in a rural area. And then unfortunately, the progress was all halted by COVID. And then I came back to Boise. So

I do have some insight into how the challenges for a rural area are and have some suggestions for integrating with some of the systems that you'll see up there. But one of the things that they asked us to discuss was how KEMS interacts with 911. So in Ada County, all of our patient contacts stem from the 911 system. We don't take referrals from our hospital systems or clinics.

We rely just on our partners within this 911, both law enforcement, fire, and the employees of Ada County. What that means is that all of our providers need to know what it is we do, what patients we assist with, how to sell the concept to people. So our interaction with the 911 system is on a continual basis.

We update personnel on our program successes and our challenges on a fairly regular basis to give them buy-in to what we do. We don't exist in a silo. We exist with our partners. And so the interactions that we have really drive our program. I don't know if...

Storm, you want to address part of that too?

Stormy Cox 17:24

Yeah, so ours is a little bit different. We don't work only within the 911 system. And then the way that we do is we also do get referrals from our 911 crews. And sometimes that's an in the moment referral where we need to respond quickly or we have some time to get out there. But we do rely heavily on our 911 crews sending us referrals, depending on availability, we may be able to go help something in the

moment versus later, but they're kind of the entire part of all of this. They see these people and kind of identify needs in their step one.

Dawn Rae 18:00

Yeah, and I would say that the program work is Ada County is also similar. We're available within our 911 system for assistance with any of our partners. And so those real-time referrals can happen or similar to Storm's program, we also can receive information afterwards. And again, I think that helps

With the integration of our program and with the 911 crews where they are, like Stormy said, they are the ones in someone's house every single day. So they are identifying needs. Our job is to let them know what those needs are and to see needs outside of the 911 system and how they can be helped in a more proactive way.

One of the other questions that was asked is what the delineation of duties between a 911 provider and a KEMS provider are. We at Ada County respond in a single person SUV. So we are not a transport unit per se. We do, however, provide courtesy transports.

for some of the folks we see that are more appropriate for alternative destinations. So we will provide courtesy transports to crisis center, to psychiatric facilities. We've sometimes given people rides to their appointments because they don't have any other way of being there. But our primary duty is not

911. And I see there's a question about the modality of our communication with 911. We are all logged in on our MDT, so we are dispatched through our CAD system to our Ada County dispatch. So we are on the radio and we also have information coming through in our dispatching systems.

on computers. That's for all of Ada County. All of our partners also have our phone numbers, so we get a lot of phone calls from the crews out in the field just asking us questions like, hey, I don't know if this is something you want to come out and help us with, but these are the questions and these are the things we're seeing. We were at one point split between 911 duties and community paramedic duties, but due to our new shift,

rotating shift schedule, we're not able to do that anymore. But it was an interesting... I enjoyed it, but I could see how it could be.

detrimental if you're not done well because you kind of don't get really good at one

thing. So, Stormy, what's your...
Take on that, I guess.

Stormy Cox 20:27
Yeah, so we are, we're kind of separate. So we don't, we don't work like you said, you did rotations. We are, if you're CEMs or CEMs. And the same we use for our modalities of communications, it's going to also be a lot of phone calls mostly, but we do use the radios and we can do dispatching, like use our dispatch center as well. But A majority of the things are going to be a phone call to us, and that is really kind of the easiest, I think, pathway. And yeah, I think that's the majority.
We're not 911, so we're not, like you said, we're in an SUV. We don't do the courtesy transport at this point. Usually we don't need to. We have a pretty good system within Twin Falls for transporting people with our public transportation. And, but we, yeah, we're just a single provider that runs out to
Different residences and helps with that, whatever, whatever needs they have.

Dawn Rae 21:33
I think one of the things that was is an interesting dichotomy for what this grant is for versus what we do in Ada County is the differences in the communities and really looking at some of those and being aware of them when you are looking at grant opportunities and KEM's opportunities.
not as the fact that you don't have, you know, access to these things, but what can you do to create access to something in a way that is meaningful in your community? You know, obviously here in Boise, we have a crisis center. We have access to substance use recovery. We have
some access to public transportation, it's not great. We have multiple hospitals here. We have the support of a robust 911 system with our ALS providers. So we are well supported administratively. Our medical supplies, medications, we don't have to worry about.
having those sit around while we wait for a call to come in. And we are also able to kind of case review with our medical directors on an as needed basis to ensure that we are doing the best thing for our patients. We also have very strong community outreach with non-traditional providers. So we meet a lot with social work, homeless service providers, the psychiatric facilities, 988, and to just ensure we're all working together and doing the best thing for patients. So even if you're rural and

you don't have all of those things, I think you can still find ways to leverage what you do have in innovative ways and not
kind of resign yourself to the fact that you're rural and you don't have the big city stuff.

Stormy Cox 23:23
Yeah, and in the Magic Valley, we do have some pretty rural places that we're going to. And you do, we do tend to work with a lot of, not just necessarily the crisis center, which we obviously have, we do have resources, but we work a lot with like churches are a huge one for us. And then just like in general,
In that smaller community, even the little small communities, like you said, they do have resources and a lot of times they have a lot of people who just care deeply. And so it might be identifying that this population in this rural area might have a need and then working with the greater population to help
coordinate that need, getting it resolved. And to answer your question, Jennifer, how do we coordinate all of these needs? It is a lot of outsource like outreach and just going around and finding people and businesses and things that are willing to help. It is a lot of community building.
that we're doing.

Dawn Rae 24:25
Yeah, agreed. I tell people we take the idea that EMS is the jack of all trades, master of none, and apply it to a non-urgent way. We've, you know, I don't do home health and I don't do home delivered meals, but I know who does and I know how to find those for people. So that is, we're more of a clearinghouse than we are an actual service deliverer.
In a lot of ways, I think there is opportunity within the CEMS world to become service providers, if that's what your community needs, because of the level of knowledge and the level of...
interest that you might have in your community, you could definitely can certainly become more of a service provider. Here where we are, it's not necessary, but understanding where to refer people to, you know, I every day find out about a new resource or a new opportunity for somebody to receive care or receive, you know, some sort of service that they might need.
So it's an ongoing learning opportunity. But home health, we are not competing with

home health. That was a big concern when we first started about 15 years ago. And we do not do home health. That's not, we do more kind of care coordination, assessment and referral.
in a way that only EMS can do because we're in people's homes and we have, you know, versus somebody that's in a clinic that is taking the information from a patient on their management of their medications, their ability to get around in their home, any challenges that they might have, we are actually in there and viewing it. And so understanding
that we have an opportunity and a privilege to be able to do this. You know, and again, but we don't provide direct service in our program. But I know that there are places that have, and those come with some challenges with home health. But if you're in a really rural area, home health services don't
really are available. So coordinating with your clinics, this is something we were looking at in Chalice, coordinating with the clinics on doing that more in-home medical care, because it's just not, it's not serviced by any other entities, is something definitely to look like.
look at if you're in an isolated area.

Stormy Cox 26:41
Over here at Magic, we actually work a lot with home health. So our homes programs are slightly different, but ours is very much a lot of we're working with them on their medications and like accountability and being able to go get their medications, transportation, all of those things.
And so a lot of these patients, we're seeing what they might actually have home health. And what we do is we just coordinate with them. So if they're already working on something, then we're not going to obviously take that over. What we do is different in how we coordinate these things and how we do these things. And most of the time, we haven't had a single issue of like butting heads with
home health, we actually all really love working together. And we just coordinate care really well because we have, they might have only this many hours that they can go see them, but then they still might need somebody in between that. And we're able to help offer some of that and just help with them. So it's really about coordination and
collaboration and that's a really important tool for us to use.

Dawn Rae 27:54
So I think the last kind of question prompt that we received was the things that you wish you'd known when we started a CEMS program. I think, number one, finding the right people for your program. It is different from 911. The motivations are different. The workload is different. The knowledge is different.

Bert FCEMS 27:57
Yes.

Dawn Rae 28:13
And it's not something that every 911 provider can transition to. You have to have a strong administrative streak to succeed in doing this because there's a lot more of the back end of, you know, making those connections with stakeholders and ensuring that you're going to meetings and that you're engaged with

Bert FCEMS 28:29
Yep.

Dawn Rae 28:33
all of your community partners. It's a public speaking role, whether you like it or not, in a lot of ways too. And so finding the right person for that can be somewhat challenging. I also wish we had known for years that trying to fit a square peg into the round hole of an EMS EHR
and chart our community paramedic calls and follow-ups was a losing battle. We tried for years, mostly because there wasn't really another option out there. But to recognize that you need some help in managing the level, the amount of information that comes through when you're doing community paramedic
programs in a different way than you do your EMS calls is very important to set people up for success. And then I think the last thing I would say is, as in running 911 calls, it is a continual ongoing learning experience for
resources for patient needs, and all of those things. And the couple of questions that came in, referral follow-up process looks like when an individual's not receiving home health services. It varies in our program on what the patient needs and what services we can get them

connected with. We do not have billable services at this kind at this time. Medicaid, I believe, does have a reimbursement code for CEMS in the state of Idaho. Medicare does not. Oh, and then I think the other one is somebody's AI pricing. So, yeah, and I'm sure.
Because Starby's hospital-based, I'm sure she has a lot more insight into that kind of stuff.

Stormy Cox 30:22
Yeah, so one, yeah, but I wish I knew before I started KEMS, again, it is a lot of administrative work. It is, you might see somebody for an hour, but behind the scenes, you're doing 3 hours of work trying to find all of their resources and connect them with different care.
which and we're and also I would say that being able to sit down with somebody and really talk to them, that's a really important piece as well. And the public speaking, yes, it's a lot of public speaking. You got to get comfortable with that. So, and what is that other? So,
Our referral follow-up process, even if they're not getting home health services, we're still doing the same. We usually see somebody once a week, depending on their needs or their desires to continue seeing us is really where it's at. We like to see somebody for at least four weeks just because
It's a lot of information and we help we can help with their desire to follow up with the information they're given because they know that there's going to be some somebody following up with them pretty quickly. And so it helps it helps with that accountability for the person. And we don't currently bill for anything.
Not to say that there is not a billable pathway, we just are not exploring it at this point. I'm sure that as this kind of a program develops, there will be a billable pathway. I just, we just haven't found it at this point. And yes, it is very similar to what CHWs do.

Bert FCEMS 31:52
One.

Stormy Cox 32:00
The difference between CHEMS and CHW is that one's clinical versus non-clinical.

Bert FCEMS 32:06
I'll be on administrative work.

Stormy Cox 32:12
Sorry, was that a question? Somebody have a question?
So clinical versus non-clinical. So when we go out to somebody's residence, we might be getting a set of labs. We could be doing an EKG, a full assessment, head to toe assessment, all of those things, which is very clinical and talking with their primary care provider.
Getting a treatment pathway, if it was like a primary care sometimes calls us and asks us, hey, can you go check on our patient? We go do that. And we report what we find and what we recommend back to the primary care provider and then help coordinate care that way. But it's something we do quite a bit. And so there is a big difference between that with CHWs where they're doing the non-clinical aspect.
How do I track all these patients? We work within the Epic system, so we're able to use that. If you didn't, you'd probably have to do like a spreadsheet. That would be the...
the best probable way if you don't have something like that.

Dawn Rae 33:23
Yeah, I would say on the patient tracking, like I said before, about realizing that your EMS EHR is woefully underpowered for this sort of things that we see in the non-episodic care that we provide to people. We did a combination of our EMS EHR and a whole lot of Excel spreadsheets for a very long time.
And you can make it work, but it's not the most efficient thing to do. The workforce question, I'll let, I think probably somebody from the state answer that about the training and education requirements. I will say for us at Ada County, there are currently three community paramedics. We all three went through different online courses, depending on what time we got hired.
because there was no, at the time for each of us, there was no local community paramedic program available. And we all currently just, or not currently, we all recently were just became IBSC certified as community paramedics to just kind of standardize our requirements within Native County.

But I'll let the, like you said, the state can speak more to the funding and things like that for training.

Denny, Wayne A. 34:42
Yeah, I'll take a stab at it. This is Wayne again. Thanks for the question. It's a great question. And part of the grant that I didn't mention that we've already got money set aside to train a number of community health EMTs each year for the life of the grant.
So that's built in. So if someone is interested in bringing in community health workers and community health EMTs, we've already got that conversation started with the schools, the colleges, and we've already set aside money to pay the school. to enroll a number of students per year. So that's something that an applicant wouldn't have to worry about, you know, where they're going to go to get their training and what have you. But beyond the EMT level, if someone wanted to
to expand out to say an actual community paramedic, kind of in the walk, you know, the crawl, walk, run model, that would be for future years that we could certainly discuss of if an area does have a plan that looks like they could go from, you know, EMT
up to advanced EMT and potentially even paramedic, that's something that we could look at in the future years. But we do have that built into the first, at least the first year and probably beyond that, getting folks trained.

Stormy Cox 36:20
There was a good question of any suggestions how a rural area would estimate how many patient contacts would be reasonable, not having a large population can make this sporadic. Are you able to communicate with local clinics? I would say for the rural community, that would likely be like the probably paramount to making a community health
EMS work because the local clinics are the ones that are going to see this large patient population and that's probably where you're going to be able to help the most.

Dawn Rae 36:53
Yeah, I would say being very specific in your patient demographics and your target population initially will help from the mission drift. We had partnered with a local

hospital system for a while doing some post-charge, post-discharge follow-up with some of their patients.
And because of the adaptability of EMS, we found ourselves sort of getting referrals from all over the place because they knew we could go see people that were unhoused that may have had some safety issues that they felt uncomfortable sending their home health nurses out to.
But we really drifted from our initial population. So being very specific about what that looks like initially, I think is pretty important, especially when you're trying to reasonably assess how long each visit's going to take and how many people you can reasonably see.

Stormy Cox 37:49
Yep.

Dawn Rae 37:51
The funding programs, our program is currently funded by our Ada County Paramedics budget. The commissioners decided that what we do and the time that we save our 911 responders is worth the money for our program.
We have explored and gotten grants over the years, but most of our funding currently just comes from our existing budget, which is not sustainable for everybody. That's recognizable.

Stormy Cox 38:23
And to echo what you said about the mission, it is really important to establish what the mission, what your mission is for your community and establishing what exactly you are wanting to focus on. That will help A lot. We, ours is connecting primary care into the home and reducing
EMS calls, those kind of are one and usually the same for us because if we can connect primary care, then we're reducing the potential for that person to decompensate at home and use 911 services to go to the hospital. And then how are these programs funded? It is, we're funded based on the reduction in volume.
And so it's worth it to, again, for our system to reduce that load. And that's how we're funded. So we don't have an actual funding stream.

Dawn Rae 39:17

And Andy's question about statewide coordination for shared resources for technology and data sharing, I think also would be best answered by someone from the state.

Stormy Cox 39:27
Agreed.

Denny, Wayne A. 39:27
Yeah, thanks. This is Wayne again. I'll definitely take that on. And I think when we get further in the presentation, I think Mark's going to talk to this a little bit also. But one of the things that we will absolutely have to do is build a space, a venue for Everybody to to share ideas and.
collaborate as we as we learn and grow because what I what we don't want to have is you know one community that has one very successful system and a bunch of others who are floundering and flailing. So absolutely we.
we plan to coordinate and continue collaborating with folks as we move through this because what we what we're able to build in the next five years is what's going to help us survive for the next 50. So we're definitely looking at that.
And then I'll take just another bite at JD's question, because I think there's a little bit more to it than the long-term funding, because one of the things that we've committed to doing is we're building out the RHTP program is the sustainability because we're building something. So we're aware that we're going to have to continue funneling money in. So as you're thinking about what you would apply for in a grant, think about what that would look like for five years. So what do we need in year one? What do we need in year two, year three-year four, year five?
And then what is it going to look like in the end when it's all said and done and it's up and running on its own? Because I think it's reasonable to expect that you all aren't going to be able to build something, have it up and running in six months, and it's done. This is a years-long project.
Are there any more questions, Don, Stormy, anything else that you've got to add before we move on to the next?
Okay, hearing none, um, last.

Dawn Rae 41:46
I think there was a question, Wayne, about telehealth to reach out to those.

Denny, Wayne A. 41:49

Yeah, I just saw that. Yep. To what extent is telehealth being developed to reach those in need in the most rural, underserved areas? I know there are other projects within the RHTP that are looking at telehealth. So while we're not focused on telehealth, it
certainly probably could and should be integrated into what's going on here. So there are other initiatives within the RHTP that leverage different technologies and different tools and what have you that should be brought into this as well.
And then, Sarah, will grants be limited to a certain number or amount?
It really depends on how large of an area, you know, is it a multi-county project? Is it a single county project? So all of those are going to impact how much funding is available for each project. I know that doesn't answer your question,
but that's probably as close as I can get to an answer at this point. What we may end up having to do is as we put out an application or we're ready to put an application out, pull these calls together again to see what everybody's thinking and what we've got, because this is really a collaboration between
the funder, if you want to look at us as the funder and the recipient, because we've got to figure out what's best for the state of Idaho and then target that.
And then Colton, I'm assuming funding opportunities would support the staffing of medics, possibly vehicles. Would it also fund administrative personnel or dispatchers to help support the increased workload? There's a lot of pieces to that. And at the end, the answer is yes. There's already a piece that is out there that would fund vehicles through the RHTP.
Again, it probably could come through this, but there's another piece that I know is already has already purchased some vehicles. So that's another element that doesn't necessarily run through the EMS piece of it, but we could. Would it fund administrative personnel? Perhaps, yes. Again, we don't know exactly
what all this can fund until we start having conversations with folks to learn what they need. Dispatchers, one of the other elements that we own in this is the next generation 911 dispatch, all of that. So that's a whole other conversation.
that we will start having probably in year two, talking about the dispatch and all of that. So more to come on that.
Cody, you had to hand up.

Cody Killmar 44:52
Yeah, this is Cody. I have another question. Now that I'm working on budget stuff, when would we expect on year one to see funding dispersed to agencies? Is that something I need to put in my budget for this current year that I'm in, or is this something that's going to come next year for year one?

Denny, Wayne A. 45:11
We have to have the money spent by the end of September of 2027.

Cody Killmar 45:19
Okay, so this year.

Denny, Wayne A. 45:19
So we're running on the, yeah, we're running on the federal fiscal year. So yeah.
And I know that's clunky for folks that have a budget that, you know, you already had to submit a budget for this period and what have you. And all I can do is apologize profusely and throw money at you and hope you won't complain.

Cody Killmar 45:40
Yeah. Thank you, Wayne.

Denny, Wayne A. 45:40
And.
You bet.
And Vaughn's comment, it would be great to put together a work plan that can be sustained through Medicaid funding and build it as a care coordination provider type under a waiver. Absolutely. And a lot of what we're doing is trying to demonstrate, here's a plan, here's a thought, here's something that works.
And then, as we work through this.
present that to the payers and hope they'll bite. So a lot of this is a demonstration project.
And then I see we've got one other hand up.
Paul.
Paul Zink.

Paul Zinck 46:26
Yes, sir.
Yeah, can you hear me?

Denny, Wayne A. 46:29
Yes, absolutely.

Paul Zinck 46:31
So, what does this look on the insurance side and with the MPDs and the protocols? And if we go down to, and maybe we'll cover this later, so like with ICRMP, if we're sending somebody out, you know, what does that look like? And if we go down to, you know, EMTs and CHWs, what's the liability risk and, you know, what is that going to look like, especially for small rural departments?

Denny, Wayne A. 47:04
Yeah, the liability piece is already addressed in Idaho code as far as the liability protection and what have you. So I don't think we've got to fix anything there. But like I say, as we work through this, if we do stumble onto something that we need to fix, we can always go in

Paul Zinck 47:09
Okay.
Wait.

Denny, Wayne A. 47:23
legislatively and try and get it cleaned up.
Good, good question, though.
And then John asked a question, are there any legal challenges you know of regarding sponsorship by St. Luke's, et cetera?
None that we're aware of thus far. If I'm understanding your questions right, where you've got, like with Stormy's model, St. Luke's is very involved in the EMS system down there, but we've not seen any challenges. And Ada County, I know, partners with the local hospital systems here also.
And that's, again, where the collaboration with hospitals locally is something that I

think folks have got to explore, because that's what's going to help this be successful in the end.
What if any connections? So Erica asked, what if any connection could this help bridge the gap between veterans and the VA in rural areas? Great question. Something that I hadn't even thought of, but that's a great question. And I hope somebody grabs that and runs with it. It's something that I don't think we've really discussed and being a veteran myself, I'm a little embarrassed to say that I hadn't thought of that up to this point, but that's a great point.
And then William, to what extent is chronic disease management being factored into preventive care through extenders, EMS, other caregivers, even volunteers? I don't know if that's something, Don, if you want to grab on to that, because that is kind of more back in the clinical area.

DR **Dawn Rae** 49:10
Yeah, I mean, I think honestly, Storm is just as or even more qualified to answer that than I am. We

DA **Denny, Wayne A.** 49:17
Okay.

DR **Dawn Rae** 49:20
Our program started with some chronic disease management as a focus because of the...
the difficulties, the logistic difficulties of receiving referrals and back and forth information sharing with our hospital systems, because at the time, especially, we were very siloed in our ability to do so. It made it a not super sustainable program for us. But I think especially if you're tied in with a clinic or a hospital,
that makes it a much more reasonable goal. And like I said, Stormy would know more about it than I do.

SC **Stormy Cox** 49:58
Yeah, that's a huge thing of what we do. So we do a ton of education, a ton of follow up labs, all of those things, medication. It is, that is, that is really kind of our focus. We don't have a huge like mental health focus or any of that kind of a thing. Our main thing is

helping people manage their chronic diseases. And our kind of philosophy is that if we help them manage their chronic diseases, then it keeps them out of the hospital and it keeps them out of the 911 system. And that's how we reduce our utilization.

Denny, Wayne A. 50:37
Okay, before we get any more questions, I'm going to go ahead and run on to the next panelist so we can keep things moving along. Our next folk up is Ryan. If you go ahead and unmute and introduce yourself and talk about community health workers.

Ryan Lindsay 50:54
Great.
Thanks, Wayne. Can you hear me?

Denny, Wayne A. 50:58
Yep, we've got you. Good.

Ryan Lindsay 51:01
All right. Thanks for having me here today. There's a lot of community health workers and community health worker supervisors in the room. So I always say, if you know one community health worker, you know one community health worker. And that's because no two jobs look completely alike. And so for those that are
in the space and you want to provide your perspective as I talk through this, please, please do in the chat. I think that would help people hear from directly from community health workers in the chat too. So anyway, I've been asked to describe what community health workers do in Idaho and where they work. So you've heard a lot about what community health workers do
as Don Ray and Stormy talked about CAMS, because as someone pointed out, there's substantial overlap in sort of some of those core roles, including care coordination system navigation, outreach, and advocating on behalf of individuals. Community health workers, one definition is they're frontline public health workers who are trusted members of their community and they have an unusually well or unusually close
a connection with community members. So they're trusted and it all works based on that trust. So they are able to, with that trust, link people to health services and then social services, including transportation, housing.

food bank for those food insecure, etc. Right into what a community health worker is. I didn't introduce myself. I'm Ryan Lindsay. I work at Idaho State University and I've been involved in community health worker training through our training academy for the last 12 years. And
I'm also a board member with the Idaho Community Health Worker Association. So that's just a little bit about me and why I'm talking about this.
Community health workers, they work under a lot of different titles. And so there's sometimes they're called patient navigators, sometimes, especially in tribal contexts, community health representatives, they may be called an outreach or enrollment counselor, promotor.
health educator, sometimes even peer support specialist or peer recovery roles also have substantial overlap with community health workers. And so that's a little bit about what they do.
And...
where they work. And this was also pointed out in the chat earlier, but clinics, hospitals, health systems. And I would say in Idaho, it's about half that work in rural health clinics, federally qualified health centers, hospital systems.
health systems, et cetera. And there's a substantial amount that also work in community-based organizations such as Area Agencies on Aging, the Idaho Food Bank, Refugee Resettlement.
Organizations.
other support service organizations, some are faith-based, some may not be, like St. Vincent de Paul, for example, up in, throughout the state. The community health workers that, well, and then some do work increasingly now,
With.
payers. So, for example, United Healthcare has some community health workers throughout the state.
And community, so the second.
So that's a little bit about what a community health worker is and where they work. I've also been asked to talk about how they're paid or how their positions are funded. So community health workers are...
Increasingly, I would say.
funded through their organization internally. It's increasingly, I think, being seen as sort of a best practice of engaging with your community, if you're a clinic or
Help center.

And initially, a lot of them were funded through grants. And that's a good way to get started. And it's not a way that's going to sustain. But if it can be used to start piloting a community health worker at your place of employment,
their value will quickly become evident to an organization. And so I can talk about many, many organizations in the state of Idaho that have initially funded community health workers through grants and then over time been able to work those into their Budgets and how do they, how do those community health workers?
you know, show their value over time. Well, there's fewer emergency department visits, hospital admissions, fewer readmissions and penalties associated with those readmissions for hospitals, community health workers.
can help clients have fewer no-shows or wasted appointment slots. A lot of them are trained in helping people enroll in insurance. So getting people insured and keeping them insured helps organizations do from
not getting compensated for care they're providing. They, community health workers can help other people on a healthcare team to work at a sort of the top of practice, for example. So might free up time for
from nurses or other people on the team, if a community health worker can focus on connecting to resources or so that maybe the nurse who may not even be an expert in that area for connecting someone to social resources,
allows them to hand that off to another member of their team, a community health worker who can do that more effectively.
They community health workers are not.
reimbursing through Medicaid right now in Idaho, but Medicare does have since January 2024, some reimbursement mechanisms. And I would say a couple thousand community health workers in Idaho are now billing for some of the community health integration and principal illness navigation codes.
through Medicare. And then community health workers are.
they address a lot of those social determinants of health and those things that when not addressed, someone will continually
use often cost or costly ways of accessing care. And so helping to address chronic disease and social determinants of health, which is what community health workers do so well, helps organizations save money that way.
So that's a little bit about how employers see community health workers as long-term sustainable because they, the return on investment. And this is shown on a limited extent in Idaho, but nationally it's shown over and over in so many different

settings that community health workers show a really
High return on investment through many, many different metrics, so...
That's a little bit about where or how community health workers are paid and funded. I'll just for community health worker training and educational background, that's the other area I've been asked to talk briefly about. And so community health workers,
It is not a certified profession in the state of Idaho. Some states do have certification for community health workers. If your community health workers are going to bill for something like Medicare, you do, CMS does require some evidence of community health worker training.
The State Healthcare Innovation Plan SHIP in 2015 allowed the state of Idaho to invest in community health worker training. A lot of that happened through Idaho State University, and we worked with many different stakeholders to ensure that Community health worker training occurred in a...
way that could reach the entire state. Back in the day, we were doing no video and like Blackboard collaborate, but with Zoom now we do, we still do a lot of community health worker training that's live online sessions with video.
And it's been really great to see community health workers connect across the state. Sometimes in rural areas, they may be the only community health worker in their town. And so it's great to have the networking that happens in our trainings. We do hybrid training.
at Idaho State University. We have most of it's asynchronous, kind of do the training as you go, and then there's four live online sessions. And we've been refining this over the last decade, and we've trained more than 500 in the last
I would say four years.
at Idaho State University. And we've built recently with some federal funding, we've built our training into a tiered model that's a core training, an advanced training with some experiential practicum or clinical hours. And then we now have
community health worker training, well, a registered apprenticeship for community health workers as well, which is a competency-based apprenticeship. And we've had about 75 community health worker apprentices complete over the last few years. Those just.
Some of the things that we cover in that core class, we talk about roles and boundaries, ethics, professionalism of community health workers. We talk about cultural competency, outreach, how to do individual and community assessments, health literacy,

Those sorts of things in the advanced class, we, we...
go from sort of cultural competency to cultural humility. We talk more about how to facilitate groups, community education, outreach, how to evaluate. And we have in the advanced class the opportunity to sort of specialize a little bit into
Community.
track or a clinic track based on your work setting.
And...
That's a little bit about our training at ISU, but I want to say that in terms of qualifications for a job as a community health worker, it's really the lived experience and the trust that a community health worker has in their community. That's the skills to how to connect people with resources and
And a lot of those skills can be trained, but what's most important is that that person is a trusted individual in the community. So we see in Idaho that...
that a lot of community health workers don't have.
sort of associates or bachelor's degree, and that's quite all right. They can connect with people in their community really well with their lived experience. And so this is a...
Sometimes referred to as a...
Community health workers are referred to sometimes as paraprofessionals because there's not a degree requirement. But our community health worker training is offered through continuing education and workforce training at ISU. We do also have an academic certificate.
And aside from community health worker specific training, a lot of our community health workers also do training around
how to enroll people or being an enrollment counselor for the state of Idaho and also other common trainings around mental health first aid.
for example. So that's a quick overview of community health workers. I have not been monitoring the chat, so I will look at those questions now. And if anyone wants to ask me a question, you know, out of sight of chat, I can take a question now.

DA **Denny, Wayne A.** 1:05:20
Cody, go ahead.

CK **Cody Killmar** 1:05:21
Yeah, this is Cody again. Sorry to have all the questions today, guys. Maybe this is a

question for Wayne, but our previous speaker said that Idaho Medicaid had a billing code for some reimbursement on CHAMS, but on the CAMS program, but Medicare did not. But this last speaker said the opposite. So I just was wondering if we could get some clarification of
of who provides some reimbursement on a CAMS program and who doesn't right now.

Dawn Rae 1:05:54
Mark, I think you know more about the billing stuff than I do. Is that, do you know the most up-to-date billing code stuff?

Mark Babson 1:06:01
So, Cody, great question. Yes and no. So if you are not an EMS provider and happen to be like a health care system or health care partner, if you don't know, just very quickly, kind of in general, EMS billing is pretty nuanced. So on a federal level, we are unable to bill for a call unless we transport and unless we transport to an emergency department,
minus one call type. Idaho Medicaid does reimburse for non-transport currently in an EMS call in two settings, 2 codes. One's called a respond and evaluate, and another is called a treat and release. Our billing manager, Linda Rosenwinkle, over the last several years has been doing a ton of work to see if that
billing structure that's already in place for Idaho Medicaid could somehow be tweaked or used to pay for these types of CEMS initiatives. And currently, there isn't that structure in place for a variety of reasons that, Wayne, potentially we could, you know, hold another
kind of a town hall like this where we specifically talk about billing because it's so nuanced and so detailed. But Cody, in general, right now, from the last I knew, there was no method to bill Idaho Medicaid for Kim's calls. But I will double check and confirm that and then I can get to Wayne the final answer and he can shoot it out to attendees.

Denny, Wayne A. 1:07:28
Sounds great, Mark, and we're at a good point.

Cody Killmar 1:07:29
Cool. Thanks for your help, Mark.

Denny, Wayne A. 1:07:32
Yeah, we're at a good point right now. Ryan, did you have anything? Because now that Mark has unmuted, he's actually our next panelist.

Ryan Lindsay 1:07:40
Yeah, I will go ahead and answer that in the chat, Cody. But yes, there are people billing Medicare in Idaho, mostly right now through Terry Riley, Full Circle Health in the Boise area, but I know others have explored it. I'm not sure if they've started it, but I will add this specific.
codes in the chat and I'll try to answer any other questions, but thanks for having me and I look forward to hearing from Mark. Thanks so much, Ryan.

Cody Killmar 1:08:08
Cool, thank you guys.

Denny, Wayne A. 1:08:10
So yeah, Mark, you're up.

Mark Babson 1:08:13
Wayne, can you, oh, there we go. So I, my name is Mark Babson. I'm the EMS Integration Officer for ADA County Paramedics. And I was with Don, I was one of the original community paramedics way back when we first started our program. I'm not a current practicing community paramedic. My role has kind of changed a little bit. some more kind of stakeholder engagement type of roles, and then some work with Wayne's team at a state level. And they asked me to come on and maybe just give just some recommendations about potential next steps, because a lot of information. Has been thrown at this group today, and if you're an EMS agency right now, if you're anything like Don and myself and the other original community paramedics, where initially we weren't sure where to start, and so I think no matter what, wherever you are right now, you know, while applications are being drafted and money is coming and...

and things are getting worked out, I would recommend the very first thing that any EMS agency, and to be honest, system stakeholder could do right now is both internal and external outreach. And so if you're an EMS agency, for example, I think it would be really, really valuable.
if you started to just internally see what the appetite was to kind of start these programs. If you are a frontline provider and you're attending today and you want to kind of convince maybe your administration to start this or vice versa, if you're an administrator, I would really just kind of internally
kind of just do a temperature check. I think that's first and foremost. I believe Stormy and Don both mentioned that you definitely kind of want to get the right people in place and make sure there's agency buy-in. And if you start those conversations now, I think it'll really help. Same thing if you are a stakeholder.
who's not an EMS agency, but you're thinking about reaching out to your local agency to potentially start these CEMS programs. You may internally need to kind of see how your departments feel about that. Do they understand EMS, why it could be important, that type of stuff. And I think most people know this, but
If it's okay with everyone, I would just like to kind of take a step back and review in general, why are EMS providers, irrespective of your licensure level, whether you're an EMT, advanced EMT, or paramedic, why do we fit into this type of concept? And I think a couple things. Number one, just.
with 911, we already deliver care at the point of need. So we are very, very used to kind of extending, you know, medical resources, medical knowledge, expertise, et cetera. We're very dialed in to varying communication styles and methods when we're on scene, both
in actually talking with a patient and family to then relaying the information that we learn to a healthcare facility. We're already integrated with a ton of different 911 resources, whether it's law enforcement or dispatch or the emergency department. So we, I think, have an acute understanding
of what an integrated system looks like. We probably are very much already pretty familiar with community resources that are available in the area. And because we work in the environment to the patient, that really is invaluable. Your most complex patient and oftentimes your most expensive patient type
will initially access the healthcare system through EMS and then continue to access healthcare through us. And so that gives us kind of a unique understanding of barriers and what patients are going through. We already extend the reach of our

medical directors and our emergency department. So again, that concept and idea of extending the reach of a provider
or a system or a program is kind of inherently what we already do. And then the last thing, especially in rural Idaho, I think the EMS volunteers, or if you're paid or irrespective of how you are connected with your system, you are acutely aware of what your community's barriers are,
what their needs are, how to speak with them, et cetera. So I think when you look at all that, that's what makes EMS kind of an industry and a group of workers and medical providers that is exceptionally ready to work in the community and maybe a little bit more proactive versus reactive way.
The other thing, lastly, I think a lot of people think that we only respond to car accidents and heart attacks, and that could not be further from the truth. You know, that is part of our call volume for sure, but we are the first line when it comes to lack of access to primary care, undiagnosed, untreated mental health issues, undiagnosed or untreated addiction issues, psychosocial issues, et cetera.
And so we are the catch-all for all of it. So I think there is such an opportunity to harness that expertise in kind of this new way of delivering service to the community that we're in. So that outreach, though, when you get out of the internal agency, I think the other thing to think about is as you start to engage stakeholders or system partners,
They may want to know things like how do you get your medical scope of practice? What's your medical direction? How are you able to operate how you operate? What does your education look like? I think Stormy mentioned in some of her visits, they do lab draws or acquire 12-lead EKG and interpret it and so on and so forth.
And so a lot of those nuts and bolts clinical things are already within our scope of practice. So it's not an expanded scope. It's much more of an expanded role. And so I think that that's also important to highlight when you are reaching out to external stakeholders, because once you have a good idea about all that,
what we have found in the past is that that's where you start to kind of get the juices flowing in terms of ideas, what could be next, where to go from here, etc. So we would say one of the first things you can do right now is that internal and external outreach. Ryan mentioned that there was a federal grant in 2015, a SHIP grant,
a short acronym for it. And there was a community health EMS or community paramedic initiatives developed way back then. And so some things need to definitely be updated for sure, but the bones of this type of stuff has really already

been developed. We have.
templates and kind of models that you can use for stakeholder engagement to explain EMS, that type of stuff. So you don't have to kind of start from scratch. There's stuff already developed. Next slide, Wade.
The other thing that we think or we definitely recommend that you should start to think about, irrespective of your program, are outcome measures. You know, once you maybe potentially, you know, have an interaction or a meeting with a stakeholder and they let you know,
you know, this is an area where we feel like we need help and maybe you fit. And as you start to build your programs, we really strongly always encourage people to think about what are you tracking and what's the end result? Why is it important, as Wayne mentioned, that, you know, they're looking for long-term sustainability and these outcome measures
irrespective of what they are, whatever your outcome measures are for your program, they're really going to help guide sustainability. You also will have conversations about which outcome measures. There's a ton that you can track. But if you start to think about these things early, it'll actually make the development a little bit
easier? And then how are you going to track it? Don mentioned a great insight into terms of how the current EPCR programs that we have aren't great for tracking this stuff. So how are you going to track them? And what are they? And you don't have to have all those questions answered.
you know, initially, but as you start to build these programs out, as you start to talk with your stakeholders, we just highly recommend that you start to think about this particular part of a program for sure, no matter what. Wayne, next slide.
So resources, what do you got to start? Like I mentioned, anyone on the call, you have all of us. You have people like Don and Stormy who have built and are building, continuing to build out programs, who have amazing insight. You have the previous work that the state did, as I mentioned, through the SHIP grant.
There was education standards or recommendations developed. There were outcome measures developed. There were stakeholder templates that were developed. Again, it's been a while. So some of the detailed information there for sure is outdated, but the bones are there. The templates are there. The National Association of Emergency Medical
technicians and AEMT. They have a really good mobile integrated health kind of

measure strategy for the outcome measure design. It was finalized and updated in 2020. So again, maybe needs, maybe not the most current, but it is a great kind of skeleton to look at those building blocks. It's
It's pretty good. The Rural Health Information Hub has both a community paramedic and mobile integrated health section where they have resources online. The Academy of International Mobile Healthcare Integration or Aim High has the same. So you have resources to help you for sure. Next slide, Wayne.
And then I think one last, I guess, idea or just one last potential resource is MSAC, the Emergency Medical Services Advisory Committee. Moving forward, Wayne and his team will be more than likely giving regular state level updates at our MSAC meetings. We meet quarterly.
We recently created a community health EMS work group to look at a kind of a variety of things related to CEMS. And I'm sure as these grants are offered and people apply, et cetera, there will be maybe more work for that group. The one caveat I would say about MSAC is
I don't know if there is bandwidth for a ton of detailed project work, but what you would get for sure is a very willing group of subject matter experts to try to help you wherever you need it. Marta or Wayne, am I allowed to share my screen?
I don't know if you, if I can, let me see. Okay. Just some of the things that we talked about today. Are you guys, do you see?

DA **Denny, Wayne A.** 1:19:32
You're absolutely allowed to, Mark. I'm not sure if you can. Yeah, give it a try.

MB **Mark Babson** 1:19:46
What do you see on your screen? Do you see mobile integrated healthcare, a PD?

DA **Denny, Wayne A.** 1:19:48
Yes, I see. Yep, yep, got it. Yep, you're tracking.

MB **Mark Babson** 1:19:50
Okay.
So this is the outcome measure document that I mentioned from NAEMT. And again, as you can see down here, oh, I can't highlight, yes, I can. It's old, it's older, if that makes sense. So it may not be 100% updated, but it's those bones again. And what I

really like about
this as you're thinking about outcome measures and building a program. I'm going to, don't get dizzy, I'm going to quickly scroll to the bottom. So everybody maybe look away for a second. But at the very end of this, I actually think this is where people should start because they make sure everyone's on the same page.
They start with general definitions. What is an adverse outcome? What is all hospital admission? What is a compliance plan? What is a core measure, et cetera. And I think when everyone is operating on the same sheet of music, that's one of the things that's going to ensure success for definitely. Again, now it doesn't, whenever you're meeting with whoever your stakeholders are in your area, it doesn't have to be these definitions, but I would encourage you to have that general conversation. Like, just, are we all talking about the same thing, right, when it comes to programs? And then I'm going to scroll back up one more time pretty quick.
And.
This document was created by a national work group made-up of individuals from agencies and health systems and CMS to really identify the core measures at the time that could lead to sustainability. And the other thing I like about it is how they divide it up into
different buckets. So you can have, for example, a quality experience of care metric that really gives programs, they can be agile. One program in, say, Teton County can look differently in Boundary County, but they still can all track a very specific experience.
care metric. Even though it might be different, it flows into one bucket that at the end of this, when the state is looking at these programs as a whole, that can be pretty powerful. Utilization measures, cost of care metrics, et cetera. It goes through and to describe what those are, what are examples that can fit under each of these buckets. And then when you
kind of scroll through, it gives you a description of the goal, components, you can score it, what could be a data source for it, etc. So again, I just really want to highlight it, it was 2020, so you would want to make sure it's updated, but I think this is a good kind of foundation to look at.
The Rural Information Hub, Rural Healthcare Information Hub, Information Hub, excuse me, just the overview of the mobile integrated healthcare that they have. They have facility barriers, implementation, clearinghouse. They also have a community paramedic page. Aim High, this is specifically designed for

the mobile integrated health world. They have tons of articles. They have a transition and analysis project, et cetera. We mentioned the Bureau. When you go to the Bureau's page, if you scroll all the way down here, they have community health EMS or CEMS. They have an overview of what it is.
They have some of the work that was done. And Wayne, I believe you could add, again, some of the work that was previously done with ship that isn't maybe currently here. Again, need to update it, but I just wanted to keep highlighting that these are good skeletons. They're good foundations to at least look at. As you are looking at programs,
If you go to the Rural Health Transformation page and you scroll down, they have a quick start guide and a subgrant quick start guide. Donna and I were talking today and I hope it's okay, Donna and I mentioned this, but these are, we've looked at these guides and they're, I don't know if I understood exactly everything they were looking for.
But they're good places again to start and to have conversations with potential partners. And then the last thing I wanted to show, and I almost hesitate to do it because I admit I have no idea if this is still a thing. So I want to just make sure that everyone knows that I'm bringing this up as.
A previous example, I just don't know if it's a thing, but Blue Cross of Idaho actually had a community health EMS or a CEMS policy where CEMS agencies could potentially partner with Blue Cross to see certain of
a certain group of their members. This was January 2021, so again, I don't know. It looks like it was renewed in 2025, but I don't know if it's still active. But if you go through it, it's just a really good example of what a payer did initially to try to work with Kem's program.
Wayne, I think with that, I think I stopped my share. Did my share stop?

DA **Denny, Wayne A.** 1:24:59
Yes, Mark, yep, we're back to...

MB **Mark Babson** 1:25:01
OK.
Oh.

Denny, Wayne A. 1:25:03
Um...

Mark Babson 1:25:05
So, sorry. No, well, so that was just, those are the two things when Wayne and his team kind of asked us to join the panel. I think again, my biggest, I guess, take away or something I hope you guys take away from this is you can start now. And I think that internal and external outreach is a great place to start and is

Denny, Wayne A. 1:25:05
Go ahead, Mark.

Mark Babson 1:25:26
something that will make this less potentially overwhelming. So with that, Wayne, that's the end of my report. But if anyone has any questions, I'm happy to answer.

Denny, Wayne A. 1:25:36
Thank you, Mark. And I wanted to hit, I was trying to type an answer out here, but I'll just go ahead and handle it here. Andy asked a question, for clarification, can organizations that already receive stage one awards also submit applications for this initiative? If you mean a stage one award, another grant within
the RHTP, the answer is absolutely yes. This is separate from that. You couldn't apply for the same thing, but this is separate than, like, there's, okay, that's the answer to the question. Perfect. So I want to keep us moving along. I want to move on to our last panelist, Alejandro.
If you want to go ahead and plow through your part of it.

Alejandro Necochea MD 1:26:22
Yeah, absolutely. Can you hear me okay?

Denny, Wayne A. 1:26:24
Yes, we can.

Alejandro Necochea MD 1:26:26

Great. Hi, everybody. My name is Alejandro Niccocia. I'm an internal medicine physician in the Treasure Valley area. I work for St. Luke's. I'm also a medical director with St. Luke's Health Network, which is basically the entity that St. Luke's uses to engage in value-based arrangements in our
our footprint. And I was asked to just chime in from the perspective of a network and sort of like what would be important for us as we consider potential partnerships with groups that are applying for these grants. And before I go on, it looks like hot off the press, Idaho.
is probably going to receive $182.7 million in year 2 from the Rural Health Transformation Program, which is a little bit lower than we received this year, but at least it's a fair amount of money for Idaho. So I will be brief because frankly, a lot of this has already been covered by the previous panelists.
But when we, when I think about this potential grant opportunity, which is tremendous, I think it would be super useful for many of our communities. What just some pieces of our advice for the groups that are considering this, I completely agree with Mark. I would start
right now and wait for and just be ready for whenever the application opens in the next several weeks because some of this initial coordination will take some time. And I would say probably to a point that was made earlier by Wayne that probably in the first year there will be a lot of building, a lot of training, setting up sort of connections and pathways between the various entities. But I would also recommend that as people consider this application, that they really work towards forming, you know, groups, collaboratives to apply jointly to cover a larger area because from a network perspective, from us, for example, it would be
a little bit difficult to enter partnerships with, you know, 16 different groups who are applying for RHTP sub-grants, but maybe a smaller number of them to cover our geography would be a lot more manageable. The other thing is just right off the bat, identify who your stakeholders are in your community. You may be a community with a CEMS program already in existence, or maybe there's a federally qualified health center.
with a community health worker program, and they're doing a fair amount of work already. So start with what you have, just figure out what is available to you right now, and then sort of figure out like what is available in a larger area, so in the county area, maybe the footprint of the public health district where you work.
just to make sure you understand sort of who your partners are. And then start to

identify a population that you might target for this, for your intervention. Just try to be clear on that. As Don said in the beginning, you know, just trying to define your population will try to, will help you stay on track to achieve your goals. Otherwise it becomes a little bit unruly and it becomes difficult
to make a case to whoever is, whoever is managing that population, whether that is a health system or a federally qualified health center or the state government, for example, in case of Medicaid or whoever is responsible for the cost of that population. It could be, of course, you know, an ambulance district or something like that.
if there's a lot of uncompensated care. So just identify a population of people and then that will help you figure out who your partners are to engage early on. So if in the community where you live, there are two clinics, you know, maybe a health system and a federally qualified health center, just start to make the case to them, try to understand what are their needs.
And that is the second point that I wanted to make, which is that all of these clinics, health systems, insurance companies, they are tracking metrics, as Mark was saying. They have, you know, some kind of dashboard that are where they're tracking some of the metrics that are
that they that govern sort of a lot of their activities. In our dashboard, for example, and not surprise, a lot of those things are related to diabetes management, cancer care, cancer screening, blood pressure control, emergency department utilization, readmissions, hospital use, those kinds of things. And so understanding what
those metrics are and how the activities that can be implemented through camps or community health worker programs can impact those metrics that will help develop those those partnerships with those with those other stakeholders that you're trying to engage for this. So absolutely just try to figure out what what is what is it
what aspect of all of this are you trying to move? And then figure out whether, like how the functions of your program will help achieve that goal and define those functions in the context of all these other partners. And that will be important, especially if there are multiple people working in the same space.
I remember early on when we had care management programs, sometimes we would send a care manager to engage with a patient. And this person was like the person number four or five that was reaching out to this patient because there was already a care manager from the insurance company or the clinic or, you know, some other program or home health. And suddenly the patient was like completely

overwhelmed. So
making sure that you understand what is your population, who are the stakeholders that you're working to engage with, what are the metrics, what are the functions that each member of the team will play. You know, if it is a function, for example, that requires a lot of assessments, you know, like
checking hemoglobin A1Cs or blood pressures. Maybe it's more of a CAMS type of initiative. It is something like doing more medication adherence or doing safety checks or, you know, health promotion like cancer screening, you know, community health worker function could also support that. So just understanding what is it that we're trying to, that you're trying to move
would be very helpful. So those are just some of the tips that I would have just to add to all of this. And as I mentioned, like, you know, a lot of, I think year one will be spent in like just defining what those rules are, getting the structure together so that there are good connections between all the different partners, especially their data sharing agreements.
or you're sharing PHI between organizations, as you probably know, those can take a lot of time. So for example, if we develop a registry of patients and we just want to give it to a CAMS team that is doing this, that will have to be set and put in place, and that can take some time. There are lawyers involved and things of that nature. So Just keep that in mind. And then once, you know, once things are built in year one, maybe in year two, is sort of like where you start to launch the actual initiative and start performing. So I'll stop there, but at least from my conversations with network colleagues and insurance company colleagues who are in our footprint,
There is quite a bit of interest in this CAMHS and community health worker models that sometimes they don't know how to interact with this model. So it will be a conversation. It will take three or four or five years to achieve that. But the goal would be to get to that point and have a model that works.
works for our communities, works for our patients, has good impact, but also is sustainable at the end of that. So that either, you know, the state or local government agency or a payer or a health system can help with the sustainability at that point. But those conversations can take a long time. So just start planning for that. And, you know, you don't have to have everything solidifying.
like right off the bat in year one, but definitely have a plan to work towards that goal. All right, I'll stop there, Wayne, and see if anybody else has any questions for the panel.

Denny, Wayne A. 1:34:47
Billing managers there. Yes, thank you. And I see Mark posted a comment in here that his billing manager was there and standing by and can provide a general overview of KEMS and Medicaid billing. So I'll hand it back to Mark.

Mark Babson 1:35:01
Hello, thanks, Wayne. So we're lucky enough to have a very exceptional and talented leader in our billing manager, Linda Rosenwinkle. She has been involved in EMS billing at a local and state level for years. And I ran down to her office to ask if she could come and provide just a very quick high-level overview with the question just to kind of confirm some of the things that we've been talking about. So Linda, do you mind?
No, of course not. So, hi, yeah, so I'm Linda Rosenwinkle. I'm the billing manager here at Ada County Paramedics. And Mark had asked me if there was any mechanism in Idaho Medicaid for reimbursement for CEMS. And without the program involving CHW community health workers,
I've not seen that Medicaid would reimburse for these services. They do reimburse for a respond and evaluate fee, but that has to be a response within the 911 system. So it has to be an emergency response at this time for them to pay for a service. where the patient is not transported by traditional means. But as far as other providers, we know that Blue Cross of Idaho includes or can include like a CEMS offering in their contract if you're contracted with them.
but it's something that has to be specifically requested and then there's parameters that you put within that. So as far as other providers in the state that you might contract with, I think that is a space where you could get reimbursed at this point. That's as much as I know, I think, but if you have any questions.

Denny, Wayne A. 1:36:47
Thank you so much. That was great information.
Any other?
Let me get my screen back up here so you can all get the links and what have you. And there's a link on the screen here for the Rural Health Transformation Grant page on the IDHW website, and then the link to our Bureau website. And
I wanted to offer something and just kind of get the take from the crowd to see what

your thoughts are. Would it be worthwhile if we had essentially office hours that we open up every week where we have a webinar like this where you can log in and just ask questions and
keep information flowing, hear from you, you can hear from us and what have you. If that's something that would be worthwhile, I'd definitely be willing to open that up and I've got a yes from Cody. So we'll go ahead and do that. We'll get that on the schedule.
As far as rural health transformation grant information, I would drive everybody to the DHW website. That's the single source of truth. So when we post a grant application, it will be there. We'll also put it, of course, on our Facebook.
and all of that, and we'll put it on our website, but don't track our website as the source. It's the DHW website is where it's going to have the application and all that. So make sure that you're tracking that. But
I also, I want to go ahead and start doing the, probably weekly, we'll start off with weekly. And if that seems like that's too much, then we can back off a little bit. But this is going to happen very quickly. So I think it's going to benefit us to have regular check-ins.
And then Abby asked a question, is there anywhere this meeting recording transcript will be available? We hope. We pushed the button at the beginning that it would record it and transcribe it. So if technology doesn't fail us, then yes, it'll be available where you can go back and watch it and read the transcript and what have you.
And then, let's see, I'm losing the questions here. Vaughn asked, does Idaho have a separate division in their health department for senior or disability services? I'm not sure. I know we were in DHW up until about a year and a half ago, but I'm not sure where that falls.
Within DHW.
Um, let's see.
And I'm reading Erica's post here.
Okay, so it's just information, good information for everybody. Thank you.
So anything else? Are there any final questions? We'll get information out to everybody. We'll put it on our website as far as the office hours and get that started.
And Glenda, do you know how many grants you'll be giving out or the range of dollar value for the grants. We just don't at this point. I think we'll, we have regular check-ins with DHW. I know we met with them on Friday. We've got a meeting scheduled this week and we had a number of questions. The answer to those

questions, I think, are going to inform our next steps. I apologize in advance. I don't I feel like we were really completely prepared for this because I knew that we had a lot of unanswered questions that I'd love to have all the details hammered out before we go live. But I also am feeling the stress of, man, we got to start talking to people or we're going to be way behind.
And then Jennifer's question, do you have a timeline for when the grants will be given out? The deadline that we've got is the federal fiscal year. So we've got to pay out all of the year one grants by the end of the federal fiscal year, which will be the end of September. So it's not a lot of time and it will go by quickly.
That's why we're trying to expedite and move through this as quickly as we can. One of the things that we've talked about is trying to do a planning year, so to give people grants for just the planning activities, but I'm not sure whether we can do that or not. So the answer to that question, like I said, is going to inform
what we do next. So here within the next couple of weeks, we should have a lot better idea of what we're talking about, what we're looking at, and what have you. And we'll keep pushing information out as we learn it. And we'll all learn together. And it feels kind of like we're, you know, we're building the buses, we're driving it, but that's
That's how we're going to get this done.
So anything else before we go? I don't want to take up a bunch of time of everybody. I appreciate everybody joining. I see a hand up from Glenda.

Speaker 1 1:42:15
Yeah, just for future information. So everything's going to be on the site or is there going to be like e-mail distribution where we get just updated information for more like real time? Because sometimes we don't get like.
notification that there's something new on the website.

Denny, Wayne A. 1:42:31
Yeah, let's that's a great question and I don't know whether the teams.
device where this technology will capture everybody's emails, but anyone who's on the call that wants to get information, we'll put something on our website where you can sign up and make sure that we've got your e-mail. And then whenever there's information, we can put you on blast. Because
A listserv is very easy to build and we can definitely do that.

That's a great idea.
Anything else?
Okay, well, we will get everything posted that we've got available if the recording and transcript and stuff, if that worked according to plan, we'll get that on our website tomorrow and we'll continue to go and hopefully we'll get another one scheduled next week and we'll get everybody back together again and we'll have more information.
and we'll keep moving along. So I appreciate everybody joining, all the panelists, great information. Thanks everyone for joining and we'll talk soon. Thanks everyone. And there's still a couple people there.

◉ **Tanikuni, Marta - EMS** stopped transcription