# PAS Program

Patient Advocate Service

Tempe Fire Medical Rescue

Community Medicine Program

PAS History

- **PAS started as a pilot project by our Medical Services Dept.: Deputy Chief and EMS Captain went out to see patients flagged as frequent non-emergent**

- **Top 20 patients with multiple visits.**

- **Dept. hired a RN to make patient visits accompanied by a light duty fire-fighter or local hospital RN.**

- **Grant Funded by a Tribal Gaming Grant awarded by City Council.**

TFMR PAS TEAM
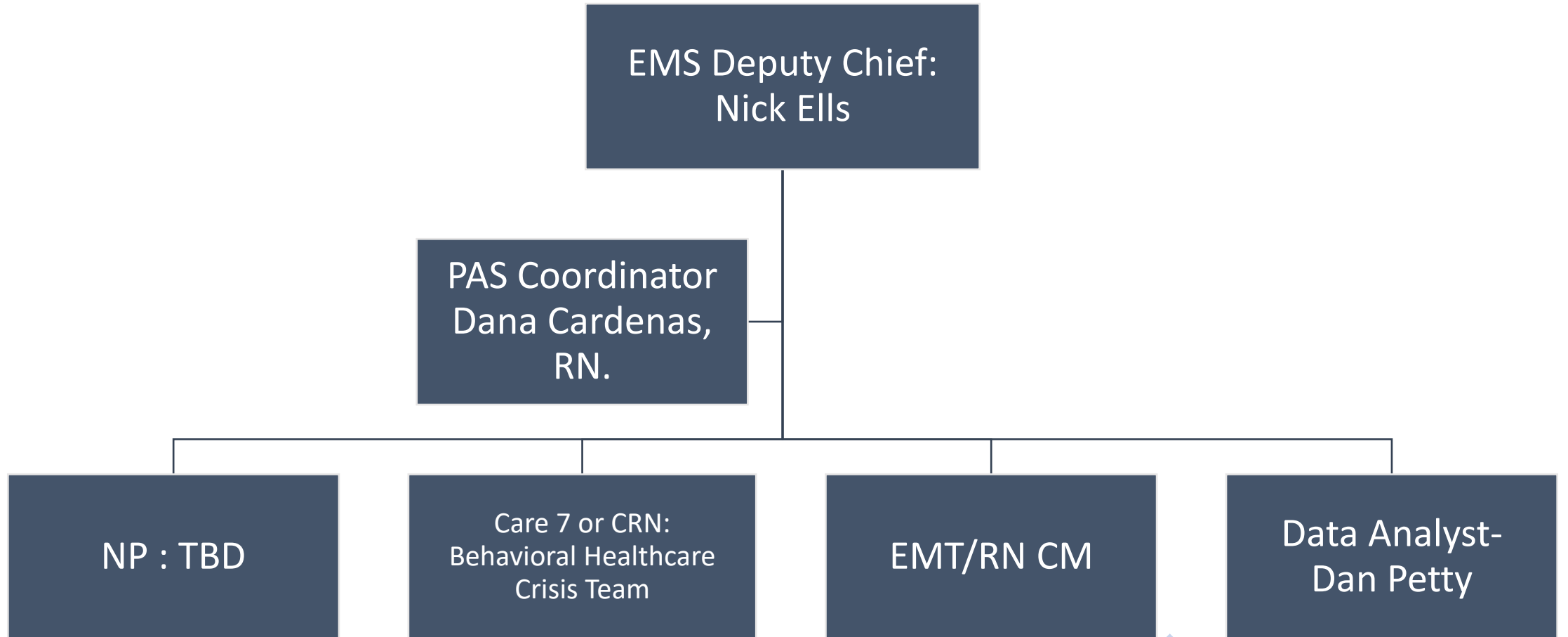
- **Fire Crews**

- **Police Dept.**

- **Hospital Case Managers and ER**

- **Non-profits in Tempe**

- **Neighborhood residents**

- **Families**

- **Faith-based organizations**

Referrals:

Secure Email: PAS@tempe.gov
or Fax: 480-898-7252

PAS Visits:

Intake assessments

Diagnose and investigate

Inform educate and empower

Mobilize community resources

Ensure residents safety and security

Link patients to Primary and Specialty Care

Re-evaluate and help coordinate care

What make us different?

- **Through a tailored approach to care for frequent users, we identify and addresses social determinants of health (SDoH) needs/gaps, while improving patient quality of life (QoL) and reducing overall health care expenditures. The COVID-19 pandemic has highlighted disparities in health care and outcomes disparities.**

- **Proactive Pandemic Outreach to Tempe residents that were the most medically vulnerable such as: DDD community, seniors on PAS services past and present, medically vulnerable veterans, those experiencing Homelessness, and those with identified with mental health care needs.**

Social Determinants of Health: SDOH

- **Availability to healthcare, vaccinations and medications through coordination of care with Primary Care Clinics, local hospitals, pharmacies, AZ Public Health Department and AZ health care plans**

- **Availability to food and essential cleaning supplies through Salvation Army, TCAA, and other non-profit organizations**

- **Availability to housing through collaborations with HOPE TEAM and Human Services Department**

- **Education with Health Literacy Assessment and Educations on Disease Processes**

- **Connecting isolated residents through Tele- Medicine for Mental Health Care and Medical Care as well as socializing with others while being quarantined or social distant**

Predictive model development

- **EMS and community health data pulled from ImageTrend**
- **Processed through R and H2O software, joined with Census data**
- **Model is trained on historical data, tested on unseen data**
- **Best performing models are used on future data**
- **Recent call volume and total call volume are most predictive, but many factors contribute to prediction**
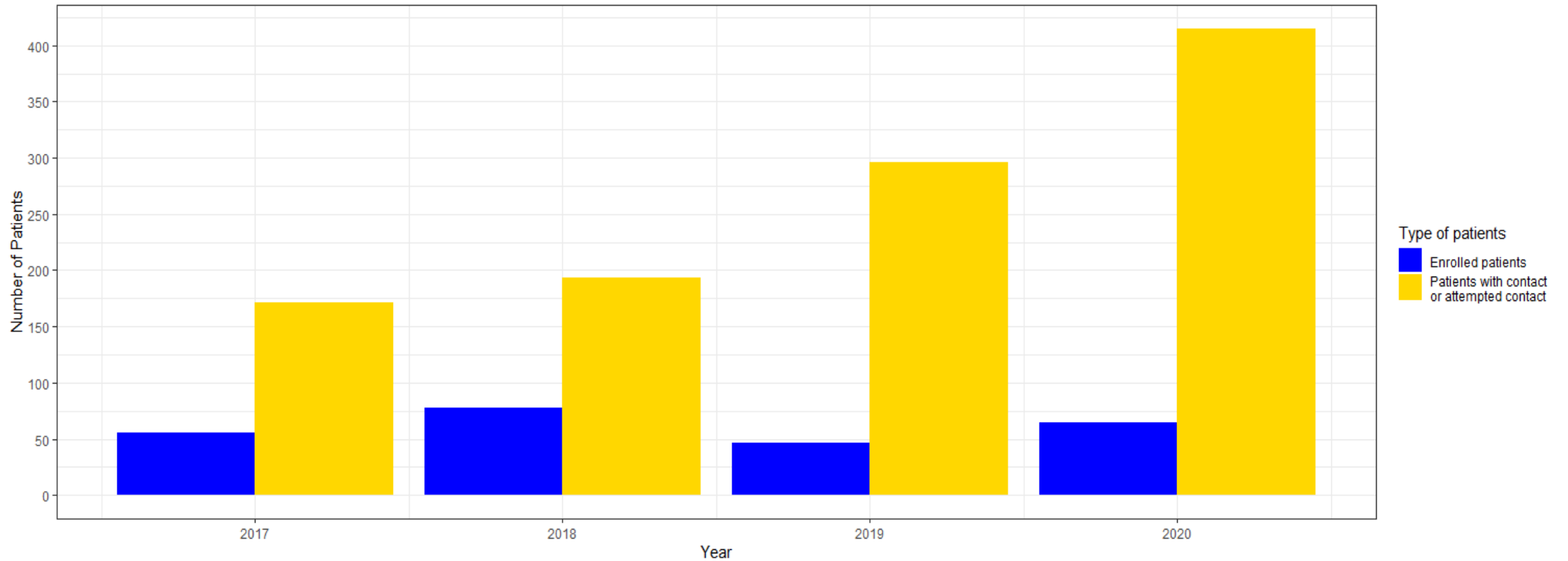- **Top 10% of model's recommendations contain 44% of all 30-day repeat patients**

Closed Loop Referral System:

Outreach data

Comparison of patient enrollment to patient outreach

Call reduction results

Year	Number of Patients Enrolled	Total EMS 911 calls six months pre-enrollment	Total EMS 911 calls six months post-enrollment	Percent Reduction
2017	56	133	73	45%
2018	78	77	72	6%
2019	47	276	153	45%
2020	65	185	104	44%

Stats from Data- Homeless Population

Year	Number of EMS incidents with homeless	Unique homeless individuals	Number of transports of homeless	Percent of the time a homeless patient is transported	Number of EMS incidents overall	Number of transports overall	Homeless Transports as a percent of all transports
2016	1,244	848	1,008	81%	11,048	7,385	14%
2018	2,036	1,263	1,514	74%	17,364	10,267	15%
2019	1,937	1,278	1,500	77%	18,449	11,432	13%
2020	1,740	1,149	1,312	75%	14,327	8,781	15%

Opioid Data: Incidents on EMS Calls Shows increase in opioid related EMS calls

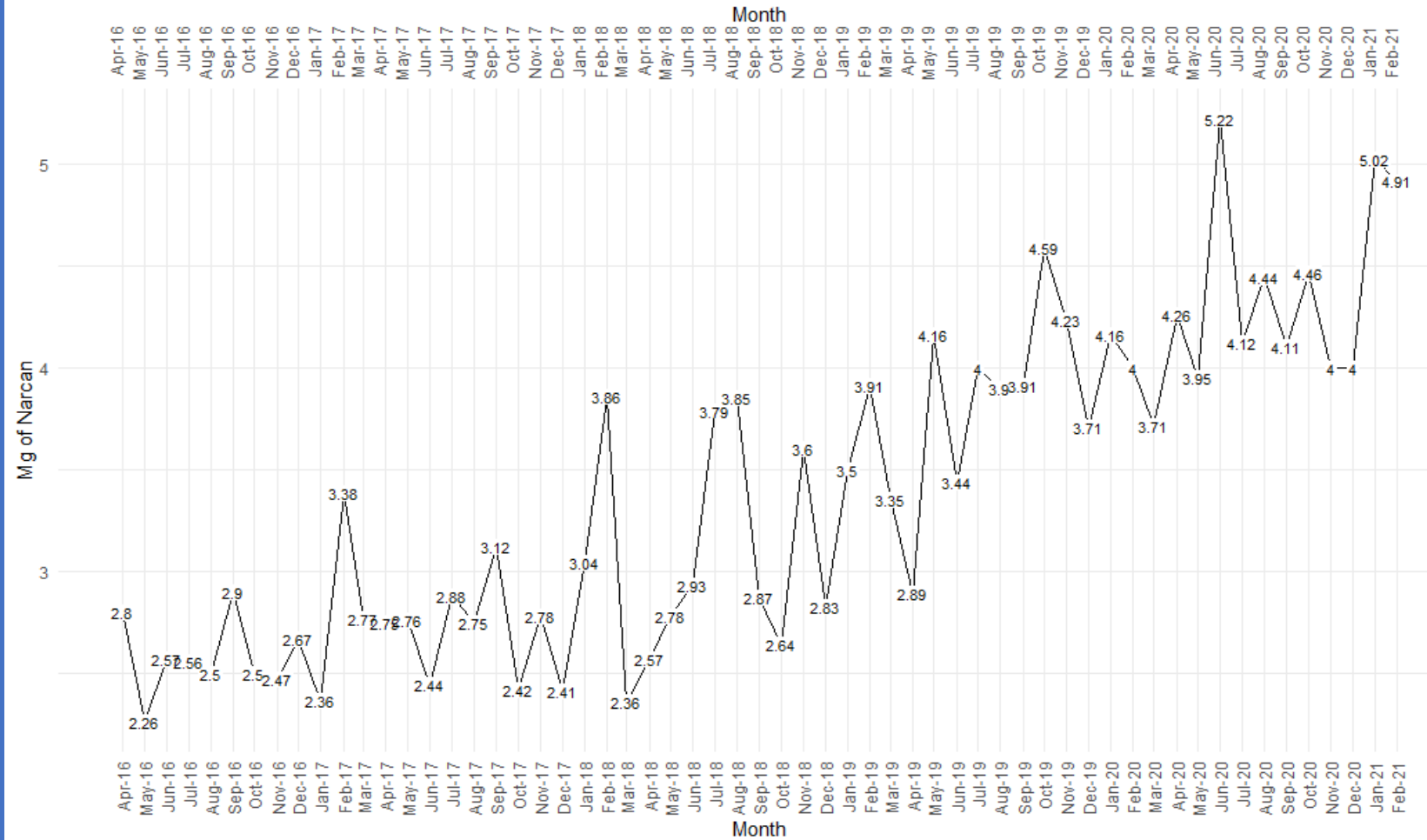Number of Opioid-related incidents each month
Jan 2017 through Jan 2021
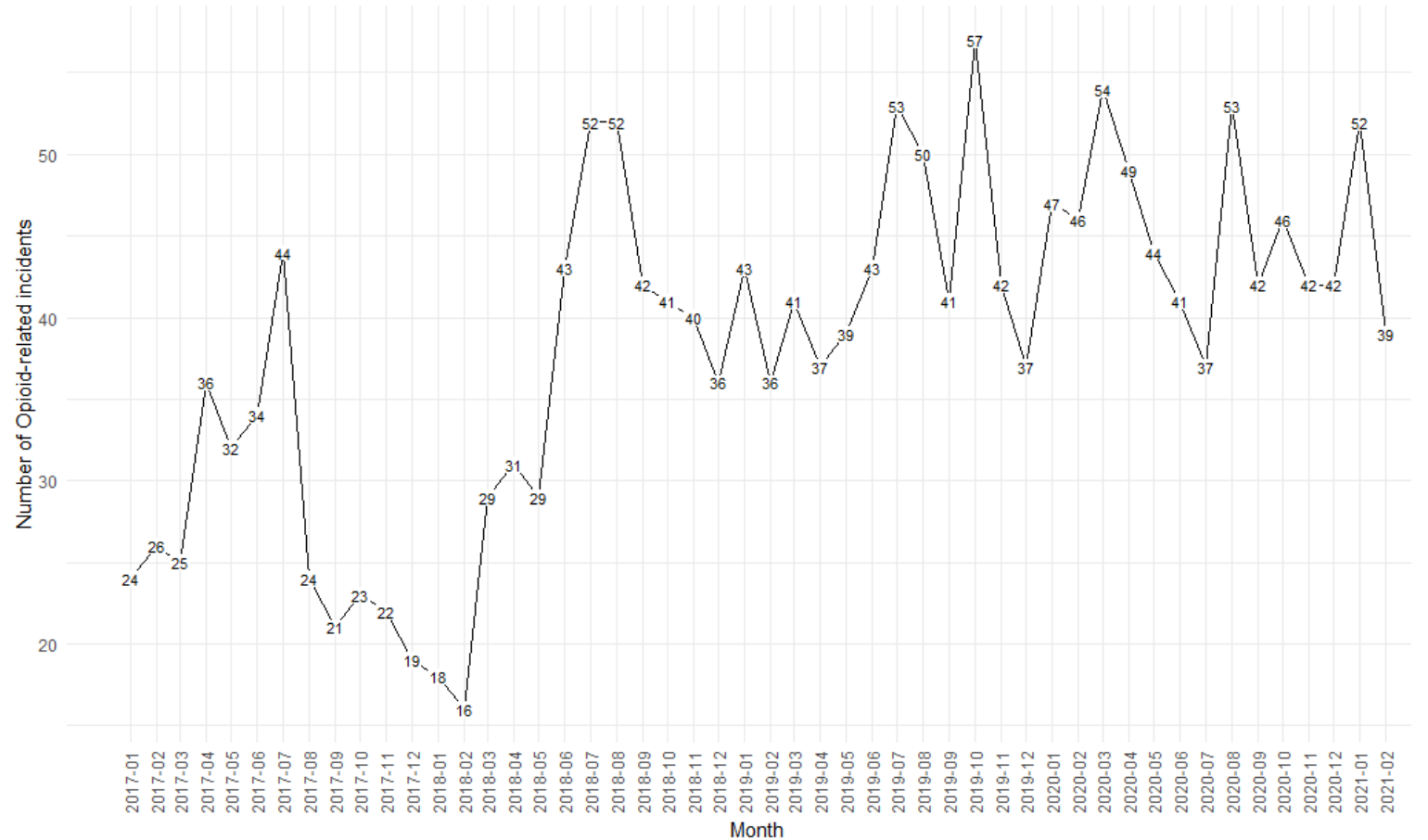
Incidents indicated as opioid abuse probable in TFMRD c

Opioid Data:
Increase in amount of Narcan needing to be used on patients to show effectivenss has more than doubled.

Covid-19 outreach efforts

- 300 PAS Patient Outreach Phone Calls

- 100 scheduled Food Box Deliveries

- 60+ Veterans Outreach or Tele-Medicine visits

- Education per CDC and AZ State Guidelines to over 2,600 Senior and DDD residents of Tempe

- 90-day routine med prescription deliveries established for patients

- 100+ COVID welfare checks for local hospitals

- Monthly then quarterly Senior COVID Recovery Meetings for Nursing Homes, Skilled Nursing and Rehab Centers in Tempe.

Challenges:

- Sustainability of financial resources for continuation and growth of the program
- Needing more assistance for the increased demand of the program
- Standardization locally and Nationally for Community Medicine or Mobile Integrated Health Models
- Challenges with Covid-19 and Funding sources: Grants
- Challenges with gaining access of billing codes for reimbursement from Health Care Plans
- Contacting high volume callers who have no contact number or address to identify them after a 911 has ended.

Current Projects:

- **Becoming MEDICAID-AHCCCS Providers for reimbursement of services for sustainability of the PAS Program through the Treat and Refer Program**

- **Becoming Credentialed Providers with the Phoenix VA for Veterans Services through VA Tele-Medicine Program**

- **Participating in the Opioid Task Force for the City of Tempe and the efforts to Awareness of the Opioid Epidemic in the state of AZ**

- **Participating in the Age Friendly and Dementia Friends efforts in the City of Tempe**

- **Participating in the Frequent Users Systems Engagement (FUSE) Group for City of Tempe**

*Arizona Health Care Cost Containment System -AHCCCS

Recognition:

2020 EMS10 JEMS AWARD FROM: -
JOURNAL OF EMERGENCY MEDICAL
SERVICES
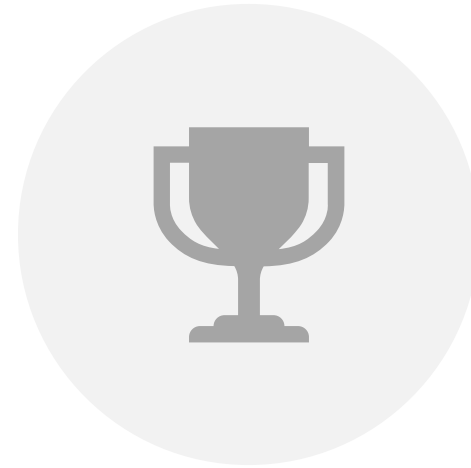
2021 IMAGE TREND HOOLEY AWARD
FINALIST

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