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HEALTH

Going to the Emergency Room Without Leaving the Living Room

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For a while, paramedics were rushing Maria Vitale to the emergency room at Long Island Jewish Medical Center every few weeks.

"It was constant," said her son, Paul Vitale. "She would fall, and the ambulance would come and take her to the hospital. Her blood sugar would be low, and she'd go to the hospital."

Like most older people, Mrs. Vitale, now 88, wanted to continue living in her home, a Cape Cod house on Long Island that she and her late husband bought 60 years ago.

And, like many older people, she contended with an array of chronic diseases: diabetes, kidney disease, a heart arrhythmia, dementia.

Her children (and Medicaid) had managed to keep her at home with full-time aides, but every 911 call led to hours of waiting in the emergency department, often followed by admission to the hospital.

"Sometimes we felt like the hospitalization hurt her," said Mr. Vitale, 60, a health care executive who too often found himself driving from his Manhattan home

to Long Island in the middle of the night. "She came home worse than when she went in."

Since March 2015, however, paramedics have visited Mrs. Vitale's home 10 times, and whisked her to the hospital just once.

When Mrs. Vitale falls or seems lethargic or short of breath, her aides no longer call 911. They dial the House Calls service at Northwell Health, the system that includes Long Island Jewish Medical Center and that dispatches what it calls community paramedics.

They often arrive in an S.U.V. instead of an ambulance. And with 40 hours of training in addition to the usual paramedic curriculum, they can treat most of Mrs. Vitale's problems on the spot instead of bustling her away.

"A lot of what's been done in the E.R. can safely and effectively be done in the home," said Karen Abrashkin, an internist with the House Calls program and Mrs. Vitale's primary care physician. For frail, older people with many health problems, Dr. Abrashkin noted, "the hospital is not always the safest or best place to be."

Geriatricians have warned for years about the ways in which hospitalization can accelerate older patients' decline, even when physicians succeed in fixing the medical problem at hand.

Emergency rooms often serve as gateways to longer stays, and the time spent in bed leads quickly to deconditioning. Older people who walked in on their own often cannot walk out, and need rehab and physical therapy to try to regain their mobility.

They're also vulnerable to hospital-acquired infections, including the rampant C. difficile, that can prove difficult to eradicate. Newly prescribed medications can interact badly with those they already take.

Delirium strikes as many as half of hospitalized older patients, studies have shown; it's especially common among the cognitively impaired.

Mrs. Vitale perceived nonexistent threats, for example. "She'd be telling me there was a dog under her bed or someone trying to get into her room," Mr. Vitale said.

For all these reasons, plus the sky-high costs of emergency medicine and hospitalization, community paramedic practices are multiplying across the country.

In 2009, when Medstar Mobile Healthcare began enrolling patients in Fort Worth, it was one of four emergency services in the nation to adopt community paramedicine (sometimes called mobile integrated health care), said Matt Zavadsky, a company spokesman.

By 2014, when the National Association of Emergency Medical Technicians surveyed the field, it identified more than 100 such services. The association now knows of 260.

Differing state regulations mean that these efforts take many forms. In Fort Worth, Medstar Mobile makes mostly scheduled visits, not emergency calls; its paramedics (called mobile health care providers) more often help patients learn to manage their chronic illnesses. When a diabetic has low blood sugar, Mr. Zavadsky said, "we can administer IV dextrose, or make them a good dinner."

What the programs share are the additional training, a team approach and an emphasis on preventing unnecessary transport. "The concept of using your E.M.S. people to keep people out of the hospital is common to all of them," said Dan Swayze, the vice president of the Center for Emergency Medicine of Western Pennsylvania in Pittsburgh.

The concept may spread even faster if insurers, particularly Medicare and Medicaid, would cover at-home treatment by paramedics. Right now, emergency services are reimbursed only for ferrying people to hospitals.

"If we only pay to transport people, guess what we're going to do," Mr. Zavadsky said.

That could change, though. Medstar Mobile and other programs are negotiating with insurance companies for reimbursement for at-home services, instead of relying on foundation grants, referral payments and hospital budgets. Supporters are also pressing the Centers for Medicare and Medicaid Services to change its policies.

Northwell Health's community paramedics program published its results this summer in The Journal of the American Geriatrics Society, looking at outcomes for 1,602 ailing, homebound patients (median age: 83) over 16 months. When the community paramedics responded — most commonly for shortness of breath, neurological and psychiatric complaints, cardiac and blood pressure problems, or weakness — they were able to evaluate and treat 78 percent of patients at home.

"Often, even our sickest patients don't want to go to the hospital," said Dr. Abrashkin, the lead author of the study.

On each call, the paramedics, acting as physician extenders, consulted with doctors by phone or a secure video link. They performed physical exams and ran electrocardiograms. They treated breathing problems with nebulizers, administered diuretics and oxygen for heart failure symptoms, and provided IV fluids for dehydration.

Of those patients who were taken to emergency rooms, however, more than 80 percent were admitted. "The teams were able to identify those patients sick enough to really need and want to go to the hospital," Dr. Abrashkin said.

Since she became a community paramedics patient, Maria Vitale's one ambulance ride followed a fall in May 2015. X-rays taken in her home showed she had a broken hip.

Otherwise the paramedics have been able to care for her without dashing to the hospital. Last month, for instance, her knee buckled as she was heading for the kitchen, using her walker. She went down, and the aide walking with her wasn't strong enough to lift her off the floor.

Charles Borger, a paramedic for more than 20 years but a recent addition to the community paramedicine program, responded to the call. He got Mrs. Vitale onto her feet, examined her, took her vital signs, called her daughter and teleconferenced with a doctor.

"She wasn't injured," he told me. "She was annoyed that she had fallen. But she felt fine, and we felt that she could stay at home."

As it happens, Mr. Borger's 88-year-old father lives alone in a Long Island town with a traditional emergency medical services squad. If he falls and calls 911, "they'll make him go to the hospital, regardless of whether he has injuries or not," his son said.

"It's such a burden on everyone. I wish he could get into a program like this."

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