Making Rural Community Paramedic Services a Reality

BRIDGING THE GAPS
Objectives

• To provide an overview of Community Paramedic Services in a rural setting
• Share collaboration strategies
• Review successes and lessons learned
About TCHC

• Tri-County Health Care
  – “Committed to improving the health of the communities we serve.”

• Critical Access Hospital
  – 5 Rural Health Clinics
  – full-time multi-county EMS service (ALS)
  – 1 Wellness Center
  – 2 outpatient rehabilitation settings

• EPIC Affiliate – CentraCare

• Service area of 25,000
Our Patients

• Our rural make-up
  – Wadena, Northern Todd & East Otter Tail

<table>
<thead>
<tr>
<th>Payor Type</th>
<th>% 2013</th>
</tr>
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<tbody>
<tr>
<td>Medicare</td>
<td>37.1%</td>
</tr>
<tr>
<td>MC Advantage</td>
<td>11.3%</td>
</tr>
<tr>
<td>MA/ PMAP</td>
<td>18.8%</td>
</tr>
<tr>
<td>Commercial</td>
<td>27.8%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>1.9%</td>
</tr>
<tr>
<td>Other</td>
<td>3.1%</td>
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Community Health Needs Assessment

- Community Health Needs Assessment
  - 2013 - partnership Cass, Morrison, Todd & Wadena
  - 43.8% return rate
  - 27% delayed or did not get medical care when felt it was needed.
  - Factors in that decision were the same for physical ailments as well as mental health care.
## Our Patients

<table>
<thead>
<tr>
<th>Condition</th>
<th>TCHC Service Area</th>
<th>MN</th>
</tr>
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<tbody>
<tr>
<td>DIABETES</td>
<td>13%</td>
<td>7.3%</td>
</tr>
<tr>
<td>HIGH BLOOD PRESSURE</td>
<td>36%</td>
<td>26%</td>
</tr>
<tr>
<td>HIGH CHOLESTEROL</td>
<td>32%</td>
<td>31.1%</td>
</tr>
<tr>
<td>DEPRESSION OR ANXIETY</td>
<td>27%</td>
<td>17.1%</td>
</tr>
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</table>
Strategies for TCHC

• Impact unhealthy behaviors
  – Obesity, heart disease, stroke, diabetes, high cholesterol, high blood pressure, alcohol use, drug use, cancer, healthcare compliance

• Mental Health – meeting the needs

• RARE work

A workable solution…….
What are Community Paramedics (CP)

- CP programs use EMS practitioners in an expanded role to increase patient access to primary and preventative care.

- CP programs work to decrease the use of emergency departments, decrease healthcare costs, and increase improved patient outcomes.

- The introduction of CP programs within EMS agencies is a top trend in emergency medical care.
Community Paramedic

- **Oversight**
  - Provider orders
  - Protocols

- **Services provided**
  - Health assessments
  - Chronic disease monitoring and assessment
  - Laboratory specimen collection
  - Medication compliance
  - Minor medical procedures
  - Hospital discharge follow up
Process to Achieve Success
A team approach

• Assemble a well motivated multi-discipline team who are “fully engaged”
  – Physician / Administration champions
  – Clinical: Social Services, Nursing Services (clinic, hospital.)
  – Support Services: Billing, Coding, Admissions, EPIC Super user: (thanks Neil, your my personal hero)

• Paramedic staff who are able to see the bigger health care picture and expand the boundaries.
Process to Achieve Success
A team approach
Partnering for Success

• Wadena County Public Health’s Role
  – Statewide Health Improvement Program (SHIP)
  – Community Transformation Grant (CTG)
  – Community Health Survey
  – Evaluation
Clinical and Preventive Health Services

Major Milestones/Big Picture for CTG

–CTG program goal is to create healthier communities by making healthy living easier and more affordable where people work, live, learn and play

• Preventive health guidelines incorporated into targeted clinic practices
• Community-clinic resource connections built to support healthier choices
• Population-level prevention measure adopted
• Barriers removed for payment for clinical preventive services
Stakeholder Alignment

- Address reimbursement barriers
- Facilitate learning sharing
- Identify best practices

- Conduct patient care
- Enhance screening & measurement

MDH

Local Providers

Community

Local Public Health/Tribe

- Support overall efforts
- Provide resources
- Creative problem solving to support programs

- Connect resources
- Identify relevant grants
- Understand local capacity

Alignment of goals, messaging, and resources for better patient outcomes
Primary focus:

- Frequent users of services
- Non-compliant patients
- Those who did not qualify or would not agree with other services
  - Homebound status
  - No insurance
<table>
<thead>
<tr>
<th>Time Period</th>
<th>Making it happen</th>
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<tbody>
<tr>
<td>Summer 2013</td>
<td>Comm. Paramedic certification underway</td>
</tr>
<tr>
<td>Fall 2013</td>
<td>Policy/ procedure work, preliminary EHR work, educational materials created formulation and pilot plan</td>
</tr>
<tr>
<td>Winter 2013/2014</td>
<td>Educated pilot providers, staff education, ongoing EHR work, began pilot</td>
</tr>
<tr>
<td>Spring 2014</td>
<td>Ongoing expansion to additional providers, community education, ongoing work related to orders in EHR.</td>
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Goals for 2014

• Our Community Paramedic programs goal is to bridge health care gaps in our patients, many of whom are not adept at navigating the health care system.

• Many in our service area have chronic conditions, are isolated with no support system, older and underserved.

• We also wanted synergy with our frequent hospital readmissions (Heart Failure, Pneumonia, Behavioral Health Issues, etc.)

• This synergy was expanded to include patients who had ED services 3 or more times in less than 4 months.
This organically grew to include:

- Patients who may require set up services after discharge from our hospital, clinic visit or at their nursing home.
  - Lab Services - draws
  - Medical services - EKG’s, Tracheostomy tube changes
  - Administration of injectable medications
  - Referrals: home care, sleep studies, community based services. OT, PT, DME recommendations and referrals
  - Health Assessments (safe home environments)
  - *Future* MS/HS “12 leads” for athletes (screening for heart abnormalities, prevention of sudden cardiac arrest)
Evaluating the program

• What data are we capturing?
• How we intend to utilize
  – Quarterly QA
  – Component of readmission work
• Continued care coordination work
  – Formalizing health care home
<table>
<thead>
<tr>
<th>Area</th>
<th>Measurement</th>
<th>Measure Description</th>
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<tbody>
<tr>
<td>CP</td>
<td>Total Visits</td>
<td>total number of visits</td>
</tr>
<tr>
<td>CP</td>
<td>Total Patients Seen</td>
<td>total of patients served</td>
</tr>
<tr>
<td>CP</td>
<td>referrals</td>
<td># comm. or clinic referrals for clients</td>
</tr>
<tr>
<td>CP</td>
<td>Medication compliance</td>
<td>Total number of visits / medication compliance checks</td>
</tr>
<tr>
<td>CP</td>
<td>prevented ED visits</td>
<td>qualitative - based on medic’s assessment</td>
</tr>
<tr>
<td>CP</td>
<td>Prevented Hospital Readmissions</td>
<td>based on 30 day readmissions for those patients</td>
</tr>
<tr>
<td>CP</td>
<td># of paid claims</td>
<td>% of claims paid as billed</td>
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Positive variance = or > goal %
Neutral = < 5% below goal
Negative variance = > 5%

Primary Diagnosis
Referral Source
Where patients are being referred to
Cost savings due to prevented readmissions
Reimbursement and cost savings

- Quarter 1 – total visits = 142
- Average cost savings Quarter 1, 2014 $48,000.
- “Make Sense to Save Cents”
Patient Success Story #1

• Patient seen in the ER and referred to the community paramedic program post discharge for difficulty breathing.
• The patient had a well-known history of congestive heart failure and multiple visits to the clinic and the ER.
Success Story #2

• Patient having COPD & possible CHF issues. Patient has been treated for these conditions for years.

• Patient long time use of inhaled medications.
Patient Success Story #3

• Patient is well known violent mental health patient.
• Numerous ER visits and Law Enforcement encounters.
• Patient was committed
• A high number of these encounters resulted in chemical / physical restraints including use of taser by law enforcement
Lessons Learned

• EHR – implementation = frustration
  – Workarounds……

• Overall education
  – Electronic charting
  – Staff awareness

• Barriers
  – Billing
  – Additional funders
• Questions?