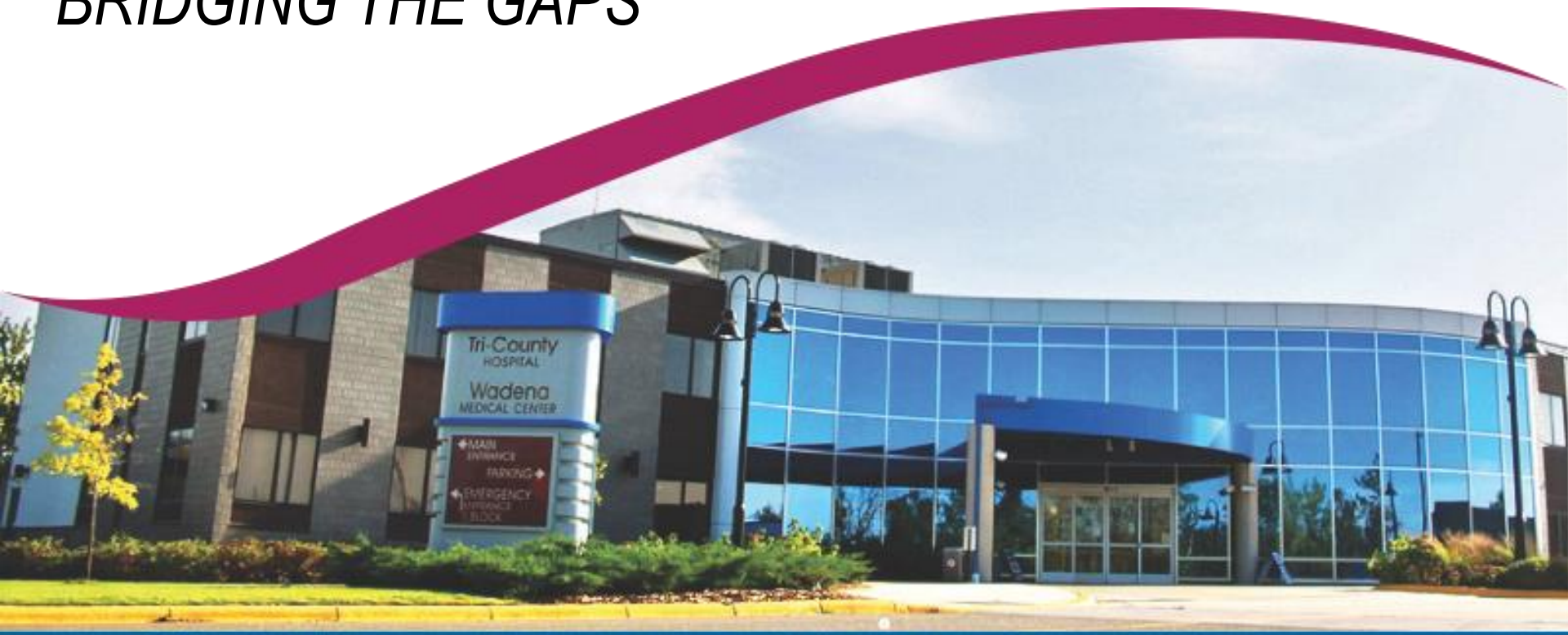
Tri-County Health Care

Public Health
Prevent. Promote. Protect.

Making Rural Community Paramedic Services a Reality

BRIDGING THE GAPS

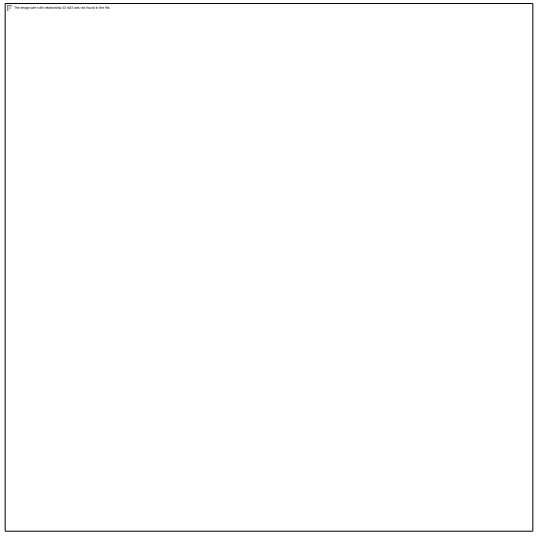


Objectives

- 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

Payor Type	% 2013
Medicare	37.1%
MC Advantage	11.3%
MA/ PMAP	18.8%
Commercial	27.8%
Self-Pay	1.9%
Other	3.1%

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

	TCHC Service Area	MN
DIABETES	13%	7.3%
HIGH BLOOD PRESSURE	36%	26%
HIGH CHOLESTEROL	32%	31.1%
DEPRESSION OR ANXIETY	27%	17.1%

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

Public Health
Prevent. Promote. Protect.

CASS | MORRISON | TODD | WADENA
Health4Life

Statewide Health Improvement Program
SHIP
HEALTH REFORM

Tri-County Health Care

Clinical and Preventive Health Services

Major Milestones/Big Picture for CTG

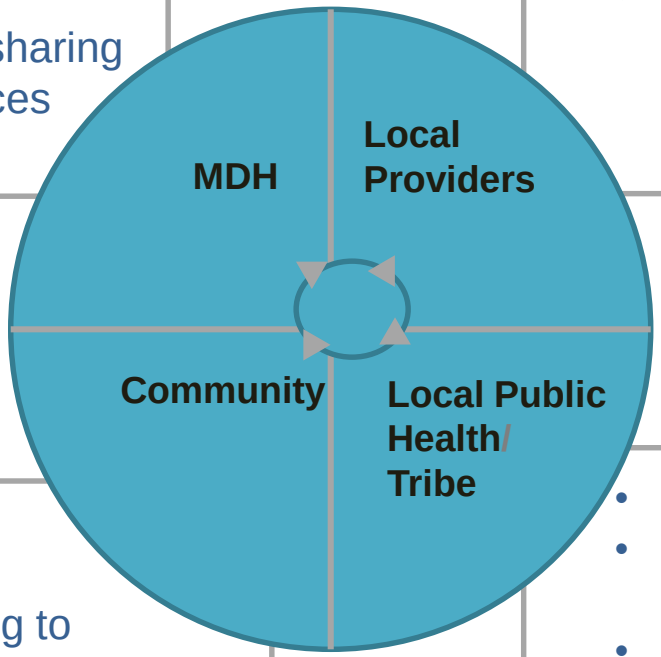
–CTG program goal is to create healthier communities by making healthy living easier and more affordable where people work, live, learn and play

- 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



- 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

Timeline…

	Making it happen
Summer 2013	Comm. Paramedic certification underway
Fall 2013	Policy/ procedure work, preliminary EHR work, educational materials created formulation and pilot plan
Winter 2013/2014	Educated pilot providers, staff education, ongoing EHR work, began pilot
Spring 2014	Ongoing expansion to additional providers, community education, ongoing work related to orders in EHR.

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

Area	Measurement	Measure Description
CP	Total Visits	total number of visits
CP	Total Patients Seen	total of patients served
CP	referrals	# comm. or clinic referrals for clients
CP	Medication compliance	Total number of visits / medication compliance checks
CP	prevented ED visits	qualitative - based on medic's assessment
CP	Prevented Hospital Reasdmissions	based on 30 day readmissions for those patients
CP	# of paid claims	% of claims paid as billed
	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?