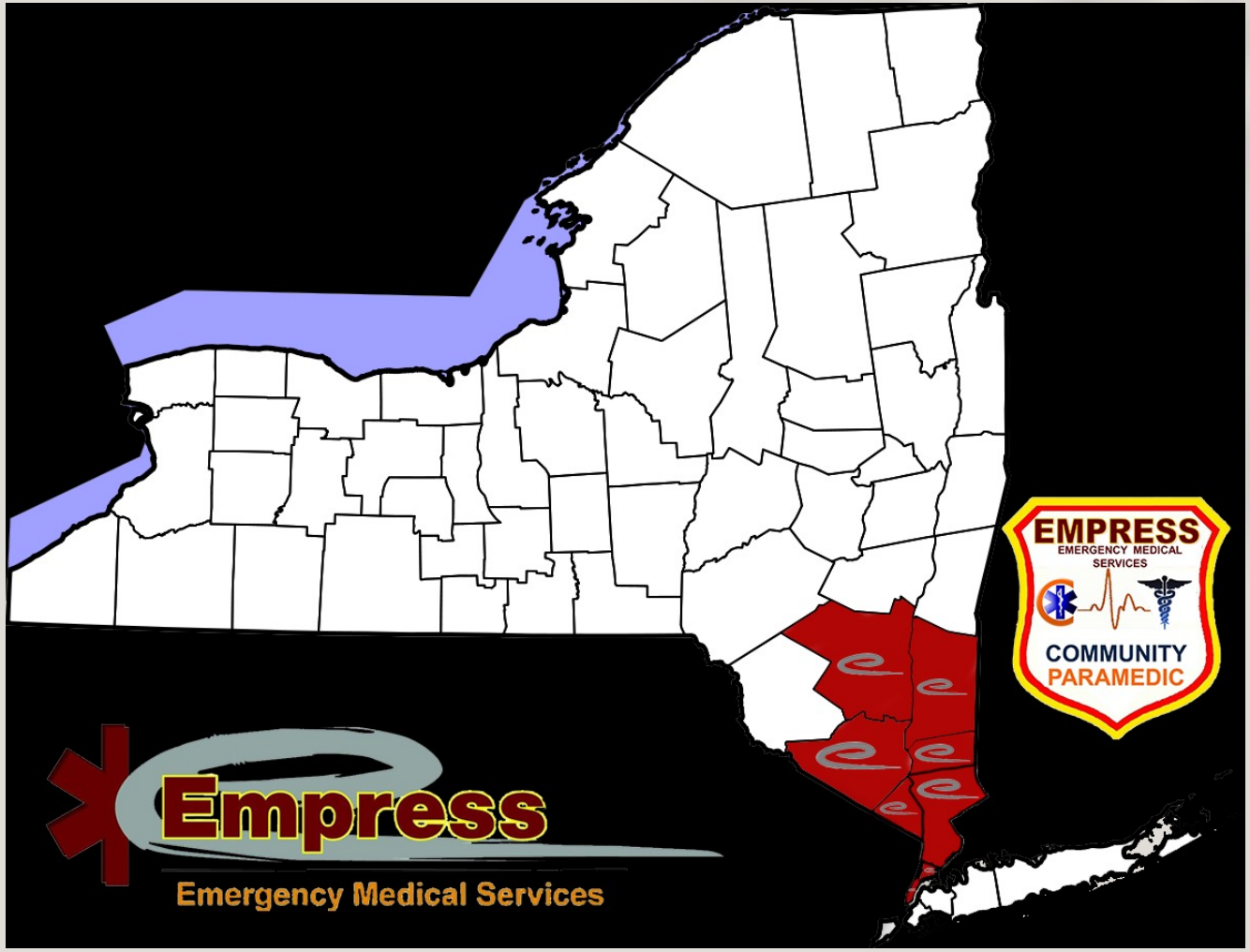
MIH-CP impact in the United States poorest urban county

Empress EMS

-800+ PCPs and ACPs
-Municipal 911& Interfacility
-ALS
-BLS
-Special Operations
-Critical Care
-Mobile Integrated Health
-NYC 911 Montefiore EMS



PatientCare
EMS SOLUTIONS™

Empress Mobile Integrated Health

- Community Paramedicine
- FEMA NY Project Hope Crisis Counseling
- ET3: Emergency Triage, Treat and Transport
- IONA College of Social Work Internship
- Testing and Vaccination Programs
- Low acuity mental health dual response team

NY Project Hope
Coping with COVID
Here to Talk | Here to Listen | Here to Support

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SBH Health System BRONX

Montefiore HEALTH SYSTEM

WP White Plains Hospital
Exceptional, every day.

The Bronx New York

- 42 sq Miles
- Population 1,472,654 2020 census
- 15th congressional district poorest in the United States
- Poverty 50% higher than the rest of NYC
- Median household income is less than half of Manhattan
- Asthma rates in the Bronx 40% higher than the rest of NYC.
- Lowest Literacy Rates across the 5 boroughs
- Many patients with multiple chronic conditions face daily challenges in understanding, accessing and navigating the healthcare system, leading to frequent ED use, admissions and readmissions. Highest ED PC utilization.

The Bronx New York

SBH and Empress Pilot for the Bronx

- This pilot was conducted in The Bronx, NY with a single paramedic service and a single safety-net hospital, focused on Medicaid patients as part of a NYS Medicaid waiver. Initial challenges of identifying and referring high-risk patients were addressed through PDSA ramps. Analysis looked at hospital use for each of the 157 unique patients referred into the Community Paramedicine Program and compared equal time periods pre- and post-referral for each patient. The analysis does not include patients who refused referral or accepted referral but refused enrollment into CPP.

Funding

Delivery System Reform Incentive Payment:

DSRIP is the main mechanism by which New York State implemented the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP´s purpose is to fundamentally restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use *by 25% over 5 years*

The AIM

Decrease avoidable hospital use by *25% over 1 year* by identifying high-risk patients with patterns of high utilization and referring them to a Community Paramedicine Visit Program

COMMUNITY PARAMEDIC

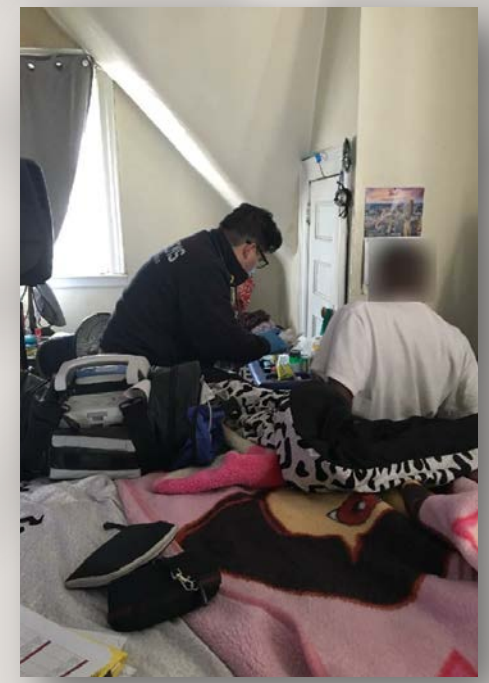
Our Demographics

Primary area:

- Central Bronx- Bedford, Crotona, Belmont, E. Tremont, Fordham +

Demographics:

- 56% Latino, 29% Black, <10% white, 3% Asian
- Poorest urban county in the US, Poorest Neighborhoods, Highest Medicaid Rate Hospital
- 157 patients enrolled
- 48% Female / 52% Male
- Average age- 68
- 96% of patients had at least 1 identifiable SDH, , 56% 2 or more



CP performs a needs assessment

-Full Physical Assessment

-Home safety assessment / SDOH

-Medicine reconciliation

-Discharge plan of care evaluation

-Make follow up physician appointments if necessary

Initiate telemedicine communication if patient appears to need a higher level of care

Provides education as needed

Engage with Primary Care Physician or Community Health Clinic

Community Paramedicine PDSA Ramp 1 Aim

Decrease ED utilization by referring patients at high risk for high utilization to community paramedicine program.

Cycle 5: Start to refer from Transitions Clinic

Cycle 4: Continue to scale up as we have shown decreased utilization

Cycle 3: Scale up to see if process of engaging Primary Care Physician for outpatient needs continues to work.

Cycle 2: Test having assigned contact at SBH for Paramedicine staff to reach out to for 1 referred patient.

Cycle 1b: Low referrals: Improve marketing to ED staff and patients

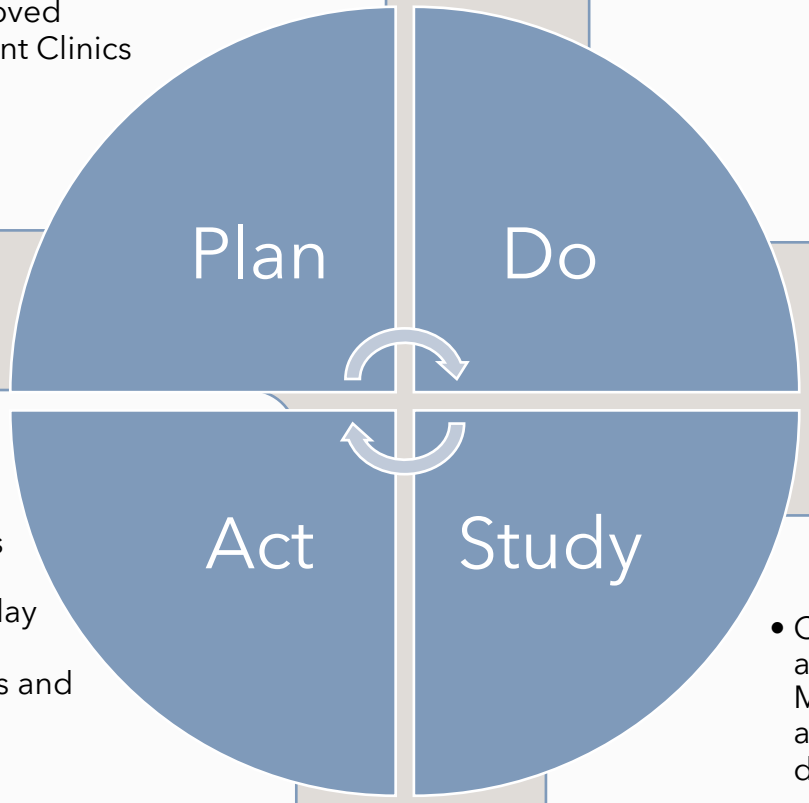
Cycle 1: Test Community Paramedicine referrals for 1-5 patients who meet criteria.

Community Paramedicine PDSA 2 Aim

Improve access to appropriate community-based care through enhanced access to same day clinic appointments.

- Decrease further ER utilization by improved access to Outpatient Clinics in real time

- Meet with clinic staff, management and Primary Care Physicians to create workflows that allow for same-day, short wait appointments for Community Paramedic patients

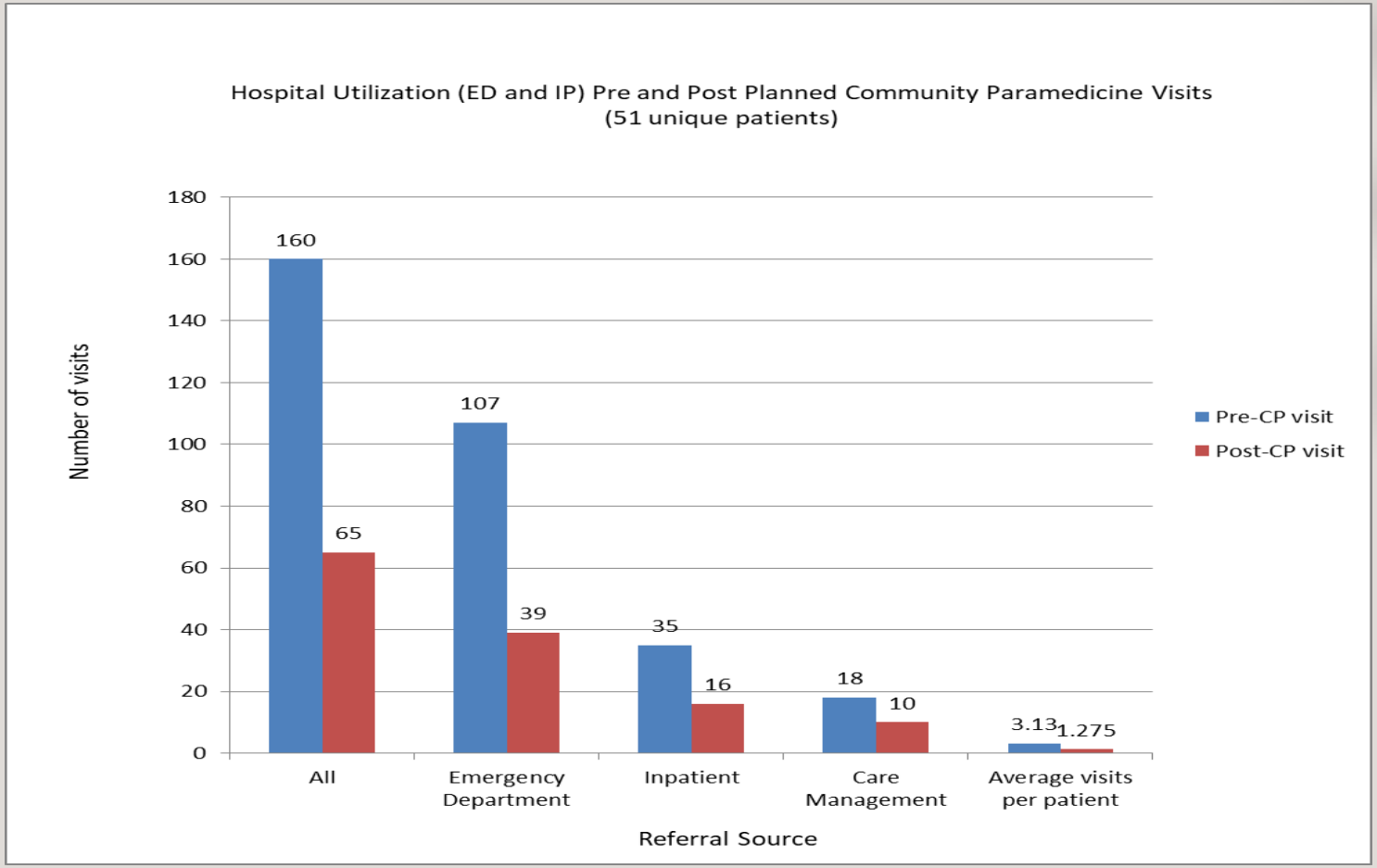


- Increase referrals as patients have been accepted to same day appointments with streamlined process and ED utilization has decreased

- Continue referrals to ambulatory care clinics. Measure percentage that are able to be seen the same day

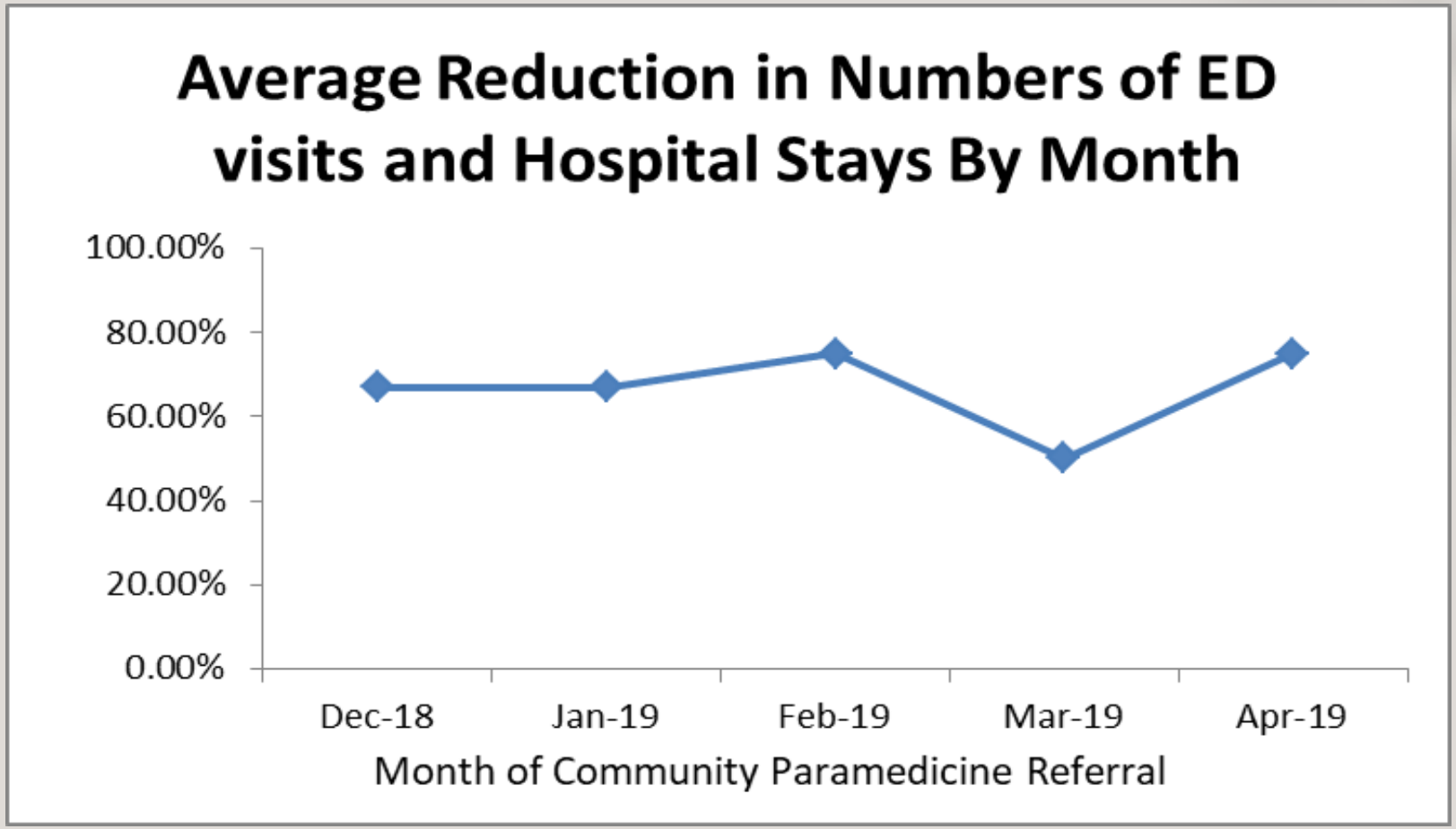
Results

CPVP decreased hospital use by high-risk patients. Team-based QI efforts helped engage more patients in thisprogram.

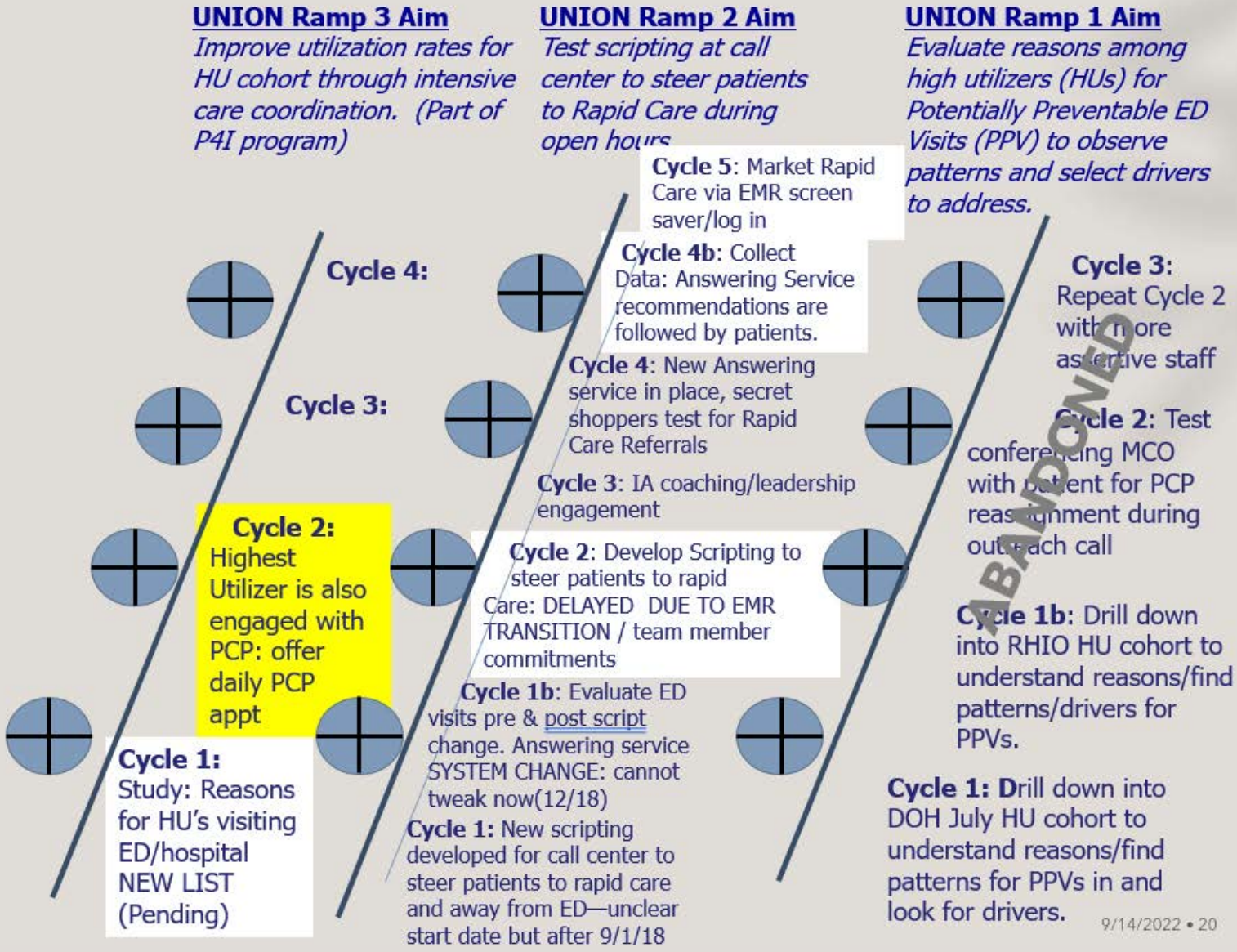


Results

CPVP decreased hospital use by high-risk patients. The figure below shows the percentage decrease for the cohort, by month referred to and engaged in the program.

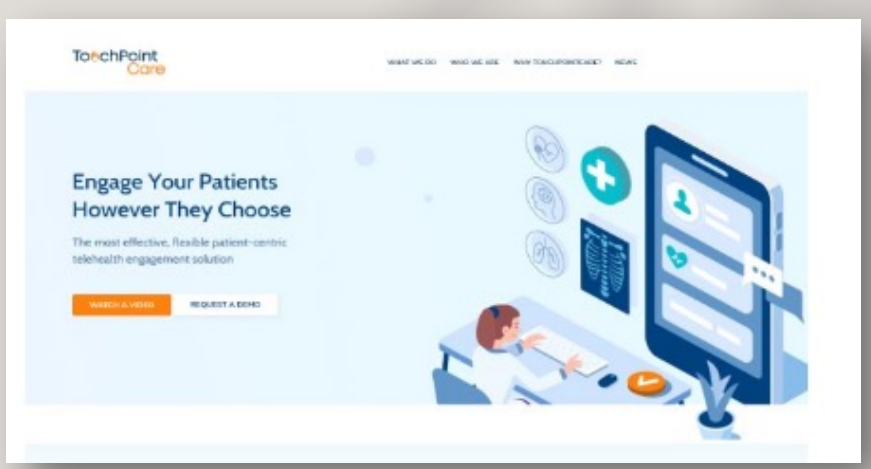


Results?


UNION Ramp 3 Aim
Improve utilization rates for HU cohort through intensive care coordination. (Part of P4I program)
UNION Ramp 2 Aim
Test scripting at call center to steer patients to Rapid Care during open hours
UNION Ramp 1 Aim
Evaluate reasons among high utilizers (HUs) for Potentially Preventable ED Visits (PPV) to observe patterns and select drivers to address.
Cycle 1: Study: Reasons for HU's visiting ED/hospital NEW LIST (Pending)
Cycle 2: Highest Utilizer is also engaged with PCP: offer daily PCP appt
Cycle 3:
Cycle 4:
Cycle 1b: Evaluate ED visits pre & post script change. Answering service SYSTEM CHANGE: cannot tweak now(12/18)
Cycle 1: New scripting developed for call center to steer patients to rapid care and away from ED—unclear start date but after 9/1/18
Cycle 2: Develop Scripting to steer patients to rapid Care: DELAYED DUE TO EMR TRANSITION / team member commitments
Cycle 3: IA coaching/leadership engagement
Cycle 4: New Answering service in place, secret shoppers test for Rapid Care Referrals
Cycle 4b: Collect Data: Answering Service recommendations are followed by patients.
Cycle 5: Market Rapid Care via EMR screen saver/log in
Cycle 1: Drill down into DOH July HU cohort to understand reasons/find patterns for PPVs in and look for drivers.
Cycle 1b: Drill down into RHIO HU cohort to understand reasons/find patterns/drivers for PPVs.
Cycle 2: Test conferencing MCO with patient for PCP reassignment during outreach call
ABANDONED
Cycle 3: Repeat Cycle 2 with more assertive staff
9/14/2022 • 20

Unexpected Outcome

Project: The goal is to develop a digital health platform that relays self-reported data from clients in the community-based care support program to the paramedics. Clients of this program suffer from chronic conditions and struggle to manage health independently, thus having a high risk of hospital readmission. This data will help Empress identify clients who need intervention before visiting an emergency room or being readmitted to the hospital. On the care provider side, a staffing dashboard will be developed for our partner to better prioritize which patients to be seen and better manage their staff for daily operations.



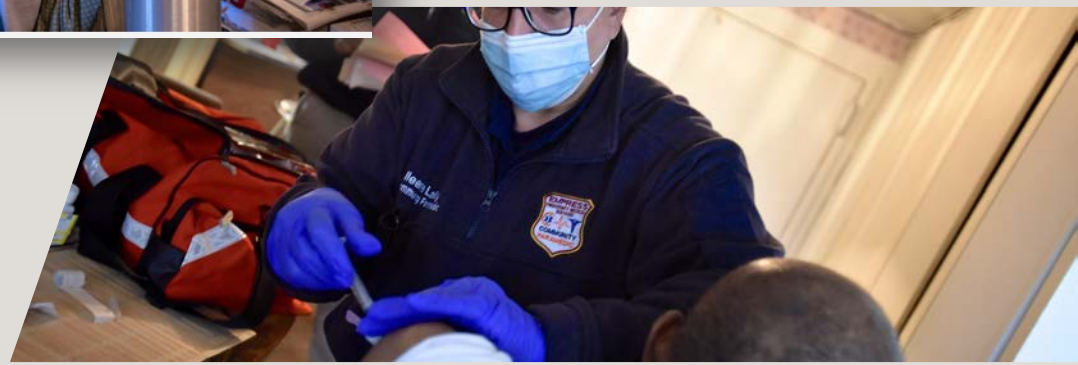
Satisfaction

Patient satisfaction surveys were offered to all patients and families

- 44% responded
- 94% highly satisfied
- 6% satisfied

Covid Response in the Bronx

- 2nd State testing site Co-Op City.
- In home testing and vaccinations.
- Pop ups in hard-to-reach/ challenged neighborhoods.
- Treatment in Place Protocols to reduce ED exposure



thank you!

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