IRCP 2014

Launch of a Community Paramedic Program within a Health Care System

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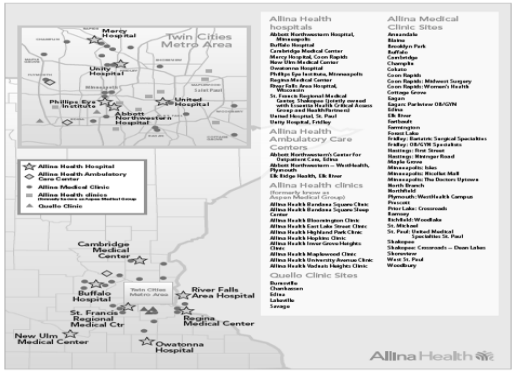
Objectives

* Share Allina Health's development of CP program
* Lessons learned
* Program Results
* Recommendations

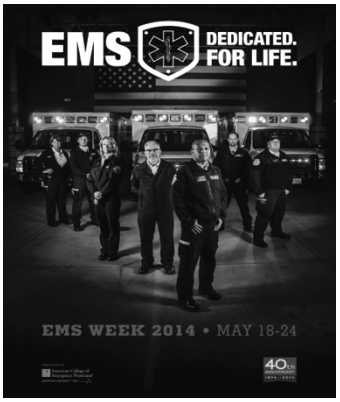


Allina Health

* **Patient care facilities:**
  12 hospitals
  57 Allina Health clinics
  23 hospital-based clinics
  15 retail pharmacy sites
  3 ambulatory care centers

Key figures from 2013

* 26,405 employees
* 1,812 staffed beds
* 112,973 inpatient hospital admissions
* 1.2 million hospital outpatient admissions
* 35,702 inpatient surgical procedures
* 70,712 outpatient surgical procedures
* 320,305 emergency care visits
* 15,364 births
* 3.3 million total clinic visits
* 171,501 home care visits
* 109,982 hospice visits
* 844,601 retail pharmacy prescriptions filled
* 178,670 oxygen/medical equipment orders
* 63,111 paramedic transports



Allina Health EMS

Positives:

- Part of a large integrated health system
- Large, paramedic service with large number of senior Advanced Care paramedics
- Active Medical Directors
- Minnesota Jobs Skill Partner grant for Community Paramedic training
- Active Ambulance Association and CP Legislation

Challenges:

- Part of large integrated health system
- Competition with other projects
- No established connection with Primary Care and in-hospital providers

Minnesota Particulars

- 2011 - law passed recognizing Community Paramedic credential
  - Educational requirements
  - Experience requirements
  - Ambulance Medical Director
- 2012- received ability to bill Medicaid
- 2012 – Minnesota Jobs Skills Grant
  - Goal to train 100 CPs

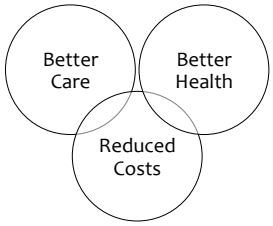
Allina Health-EMS

- Large Geographic Area (urban, suburban, & rural)
- Population of 1,000,000 in PSA
- 240 Responses each day – over 90k/year

Allina Health Mission

We serve our communities by
providing exceptional care, as we
prevent illness, restore health and provide comfort to all
who entrust us with their care.

Building our Case - Triple Aim



Vision

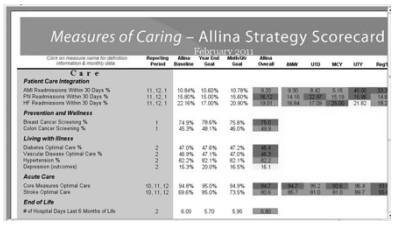
We will:

* put the patient first
* make a difference in people's lives by providing exceptional care and service
* create a healing environment where passionate people thrive and excel
* lead collaborative efforts that solve our community's health care challenges

How can we. . . .

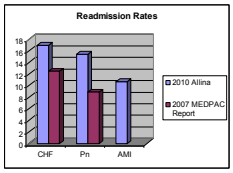
* contribute more to the organization?
* fulfill our mission?
* provide better care for our patients?
* develop a career track for paramedics?

Gap Analysis



Cost of Readmissions

Over $7,000 per readmission in addition to the stress it places on patients and families.



Dipping our toes in . . . .

* Partnered with rural hospital with high readmissions and no staff for follow up
* Prior to certification for CPs
* Teaching Care Management staff about our capabilities
* Competencies

Starting Point

* Readmissions
  * Transition Care Management
    * Geographic Challenges
    * Staffing Challenges

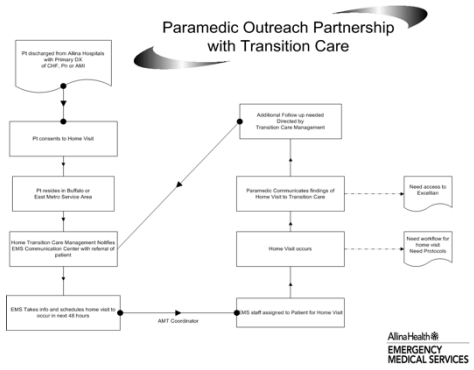
* EMS to the Rescue
  * Paramedic Outreach Project
    * On-duty staff positioned to assist
    * Small population

Paramedic Outreach Partnership Project

* Selection
* Training
* Care Management RN
* Primary Care
* Social Workers / Case Managers

POPP Pilot

* Trained 4 advanced care paramedics to provide home visits
  * Specific tasks based on Transition Care steps
* Small population
  * 4 patients in 30 days
  * Patient Satisfaction equaled or exceeded RN visits
* In lower volume location, could use on-duty resources without detriment to 911 response



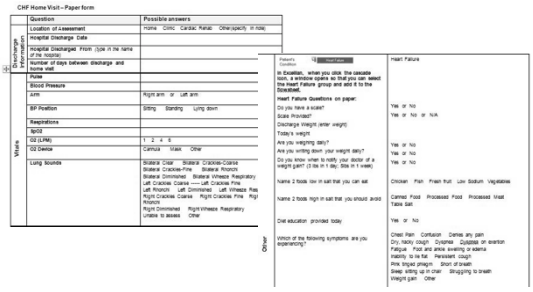
Measures

* Home Visits complete within 48 hours of referral
* Patient Satisfaction
* System wide measures of readmissions

Challenges

- Small population base
- 4 advanced care paramedics involved / scheduling
- Documentation challenges

Documentation Challenges



CHF Home Visit – Paper form

	Question	Possible answers
Discharge Info	Location of assessment	Home Clinic Cardiac Rehab Other (specify in note)
	Hospital Discharge Date	
	Hospital Discharged From (type in the name of the hospital)	
	Number of days between discharge and home visit	
Vitals	Pulse	
	Blood Pressure	
	Arm	Right arm or Left arm
	BP Position	Sitting Standing Lying down
	Respirations	
	SpO2	
	O2 (L/Min)	1 2 4 6
	O2 Device	Canula Mask Other
	Lung Sounds	Bilateral Clear Bilateral Crackles-Coarse Bilateral Crackles-Fine Bilateral Rhonchi Bilateral Diminished Bilateral Wheeze Respiratory Left Crackles Coarse ---- Left Crackles Fine Left Rhonchi Left Diminished Left Wheeze Res Right Crackles Coarse Right Crackles Fine Rig Rhonchi Right Diminished Right Wheeze Respiratory Unable to assess Other

Other

Heart Failure

In Excelsior, when you click the cascade icon, a window opens so that you can select the Heart Failure group and add it to the Scratchpad.

Heart Failure Questions on paper:

Do you have a scale? Yes or No

Scale Provided? Yes or No or N/A

Discharge Weight (enter weight)

Today's weight

Are you weighing daily? Yes or No

Are you writing down your weight daily? Yes or No

Do you know when to notify your doctor of a weight gain? (3 lbs in 1 day, 5lbs in 1 week) Yes or No

Name 2 foods low in salt that you can eat Chicken Fish Fresh fruit Low Sodium Vegetables

Name 2 foods high in salt that you should avoid Canned Food Processed Food Processed Meat Table Salt

Diet education provided today Yes or No

Which of the following symptoms are you experiencing? Chest Pain Confusion Denies any pain Dry, hacky cough Dyspnea Dyspnea on exertion Fatigue Foot and ankle swelling or edema Inability to lie flat Persistent cough Pink tinged phlegm Short of breath Sleep sitting up in chair Struggling to breath Weight gain Other

Grant

- Goal to train 100 Advanced Care paramedics from 3 EMS Systems
  - 312 hour Program
    - 196 hours of Clinicals
- Clinical needs provided opportunity to educate hospital & Primary Care Providers
- Helped identify new opportunities / gaps

Clinical sites

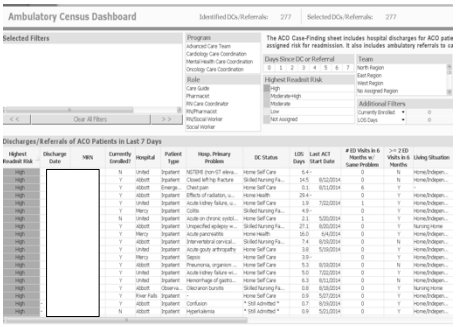
- Cardiovascular
- Respiratory
- Hospice
- Senior Care Transitions
- Community Outreach
- Home Care
- Behavioral Health
- Diabetic Educators
- Care Management
- Primary Care
- Wound Care

CP Implementation - Sept 2013

- Accountable Care Organization
  - Focus on Behavioral Health patients
- Hospital Readmissions
  - High Risk Patients
- Expanded to Frequent ED Users 2014

Home Visits

- Complete medication reconciliations
- Perform a home safety assessment
- Address any concerns of referring provider – may be taking weights or other vitals
- Review Nutrition
- Help connect patient and family to resources they may need (may refer to Home Care, etc)
- Transport to appointments – limited to BH patients



Initial Results

- 22 patients with ↑ prediction of readmission and frequent ED use
  - 1 readmission at Day 36 – 97.2% Success rate
  - 1 readmission at Day 45
- High Utilization ER
  - 78% patients did not have a return visit to the ER within 30 after their home visit.

Future Opportunities

* Senior Care Transitions – Assisted Living
* Transitional Care Patients – Skilled Nursing Facilities
* Expanding Care Management
* Diabetes Patients
* After visit – decreasing Length of Stay

Recommendations

* Do your Gap Analysis
  * Where can you have impact
* Who are the Stakeholders
  * Get them onboard early
* What additional training does your team need?
* Metrics/Data
  * How will you measure success

Our Team

* Paul Satterlee, MD
* Susan Long, Director Clinical & Support Services
* Cory Kissling, Manager MIHC
* Kevin Miller, Director Operations
* Brian LaCroix, President & Executive Sponsor
* Community Paramedics
* EMS Senior Leadership team

Good Luck
in developing your programs!