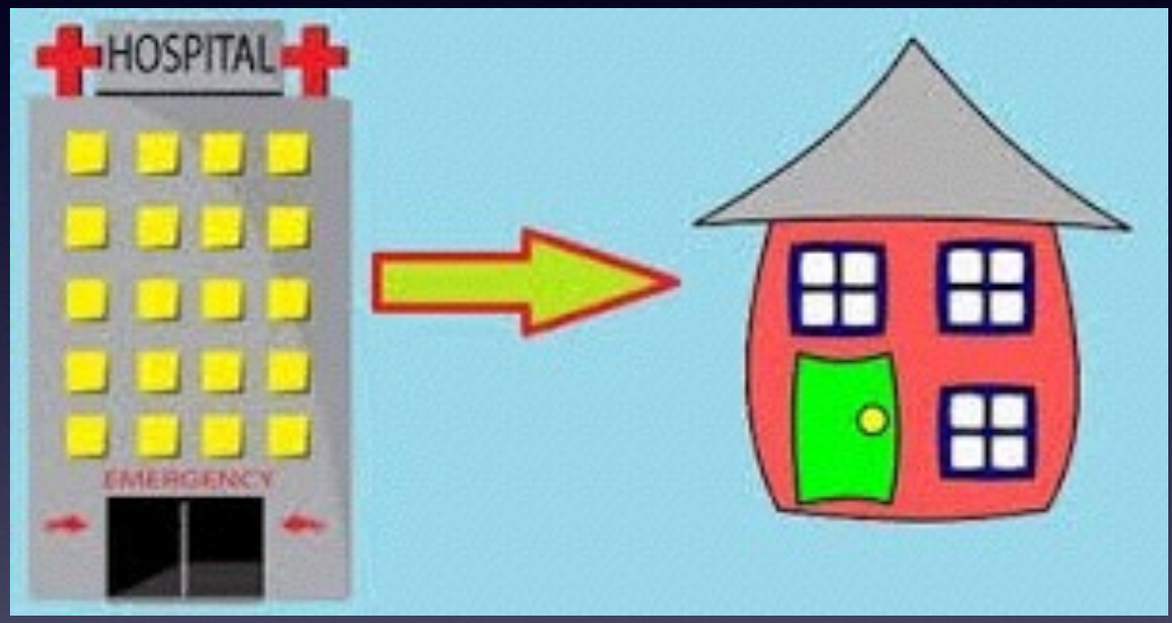
Bringing the Hospital to the Patient....
Instead of the Other Way Around



Dr. Brian Froelke
EMS Medical Director

The Good and the Bad of Community Paramedicine……. Unexpected Surprises

Dr. Brian Froelke
EMS Medical Director

Structure

- Identify Potential Patient Candidates
- Medical Resource Utilization Evaluation
- Team Assignment
- Interventions

Identify Patient Candidates

- Frequent Utilizers of 911 and/or ED
- High Cost Utilizers
- Readmission Prevention Initiatives
- LOS Reduction Initiatives

Resource Evaluation

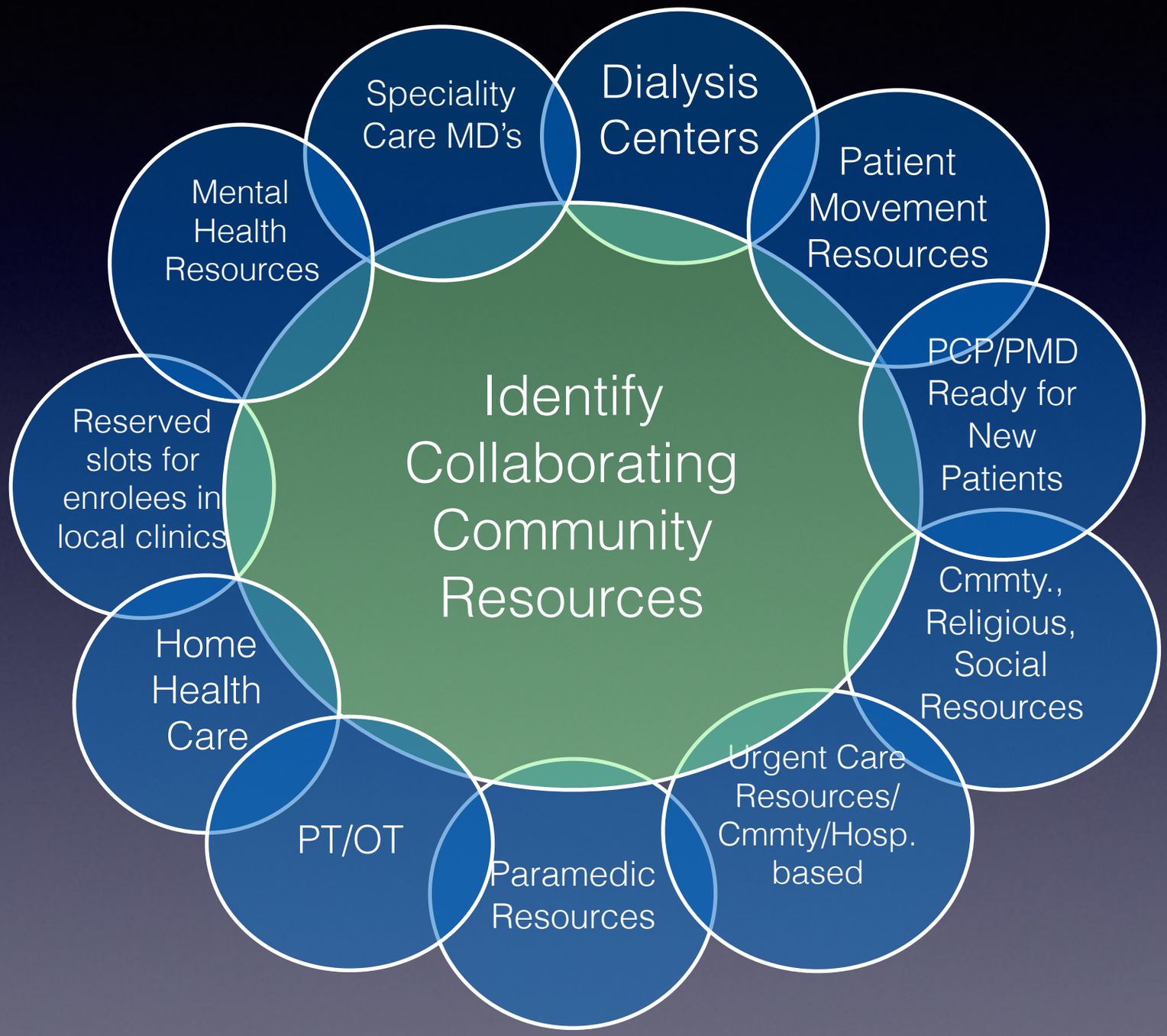
- Team reviews the individual patient resource utilization and determines whether there is potential for intervention
- Team reviews specific patient Categories or Diagnoses and identifies key last admission day resources that can be provided in the outpatient environment

Team Assignment

- Enrolled Patients are assigned to team

  - Physician (PMD, EMS Medical Director)
  - +/-NP/PA
  - Advanced Practice Paramedic (APP)
  - Social Worker/ Mental Health Specialist

Intervention



Great in Theory. . . .But

- No current sustained funding sources to support
- No current CMS nor Insurance codes for reimbursements
- Limited internal funding to support a pilot cost saving program
- We could only Pick One at a time

Intervention- High Utilizer

- 911/ Emergency Department- **<u>Standardized Medical Screening Examination</u>** and offer of appropriate medical resources for specific chief complaints
- Health Care Navigation……consider these resources:

referral to urgent care

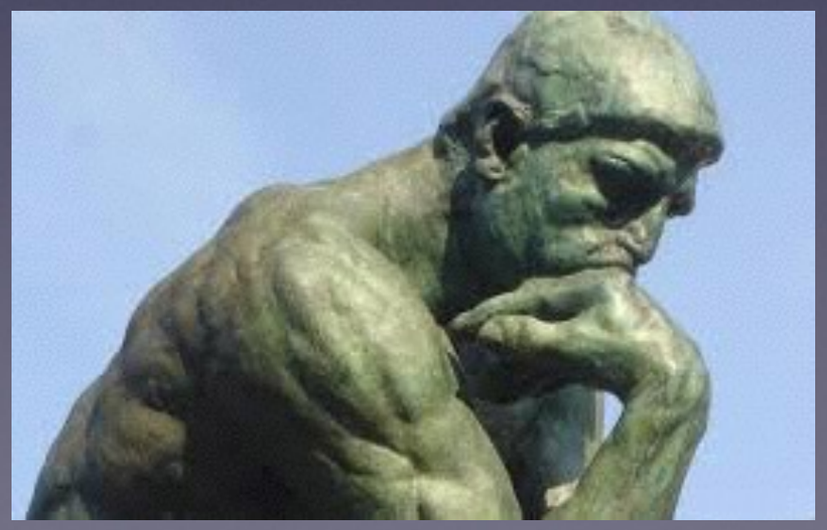
referral to dialysis

referral to PCP

referral to mental health

in home treat & non-transport

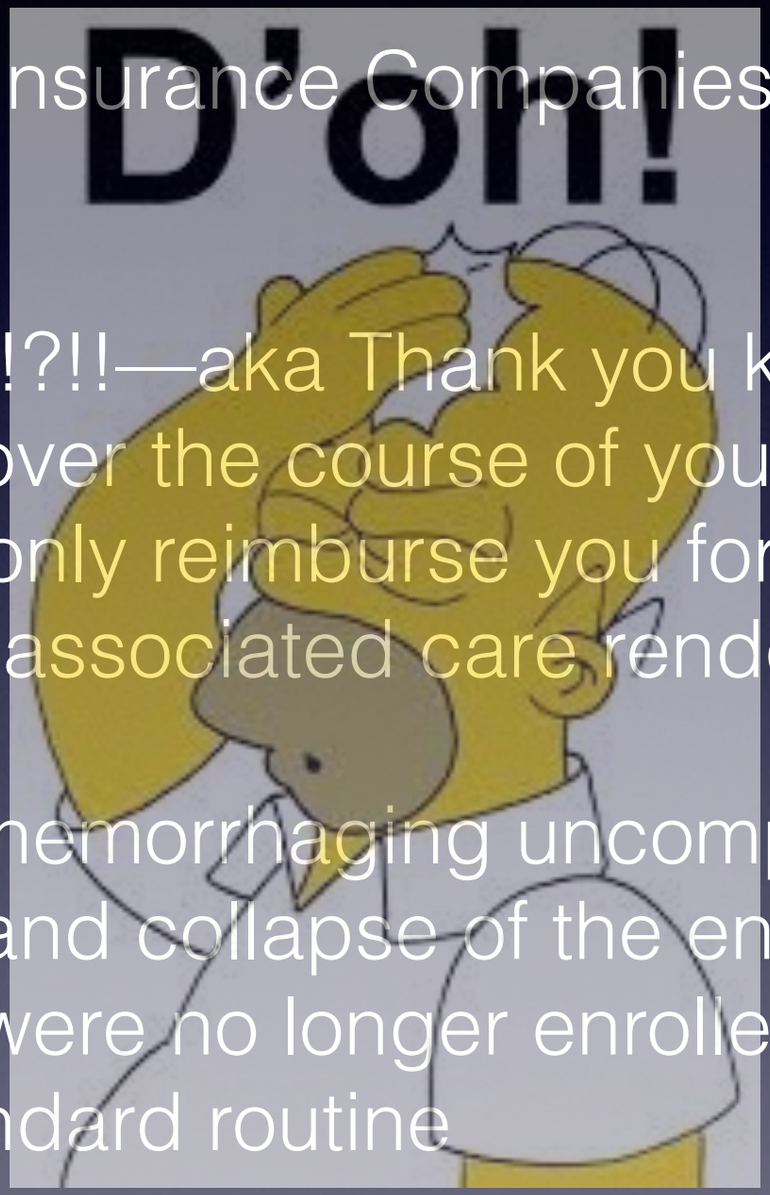
home resource visit & return visits for follow- referral to urgent care



Results

- Almost 8,000 Patients navigated to medical and mental health homes
- Almost 6,000 Patients assisted with unmet health care needs
- 1% reduction in self pay ED visits
- 63% reduction in 911 calls for high frequency Utilizers
- Saved Insurance companies an estimated $150,000 per month
- We built a system that:
  - ➢ Improved individual patient care
  - ➢ Improved system efficiency and effectiveness
  - ➢ Saved the patient and payor and health care system money

Unanticipated



- Approached the Insurance Companies for some compensation
- Answer.....NO?!!?!!—aka Thank you kindly for saving us so much money over the course of your program but at this time we can only reimburse you for the 911 transport to an ED and the associated care rendered therein.
- In order to avoid hemorrhaging uncompensated funds for insured patients and collapse of the entire program, insured patients were no longer enrolled and were put back into the standard routine

Unanticipated

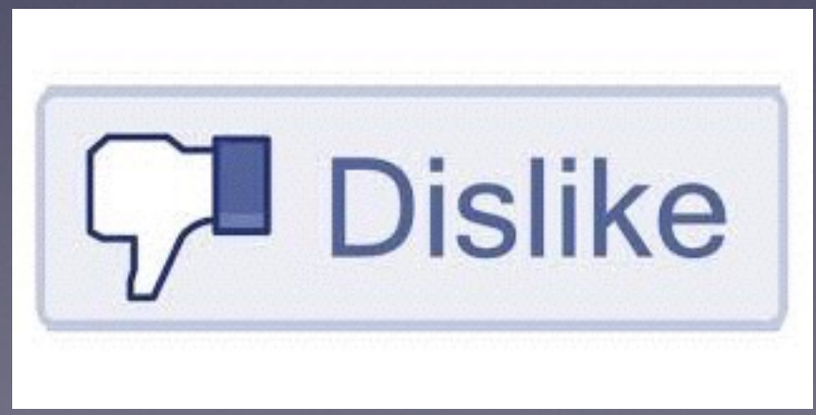
- Noted a spike in acuity level for ED triage and decrease in navigation
- Anonymous Triage Provider: “We can read between the lines. If this program succeeds we are working ourselves out of a job.”

- ???!!!??? Expect paranoia and absurdity and distrust.
- Its works so well its “too good to be true.”

Unanticipated

- Wait. . . .You can't ask about insurance status?!
  - Legal?: Yes, standardized medical screening evaluation showed no "Emergency Medical Condition" per Federal Definitions
  - Ethical/Moral?

- ➢ Outcry from providers!! Our program worked so well for these patients that returning any patients back to the standard broken system was appalling.
- ➢ Double Effect: Intent— to provide optimal care for some patients. Unintended consequence— some patients are ineligible.
- ➢ Unfortunately the unreimbursed cost was so great that without separating patients the entire system was unsustainable without support from the Payors.



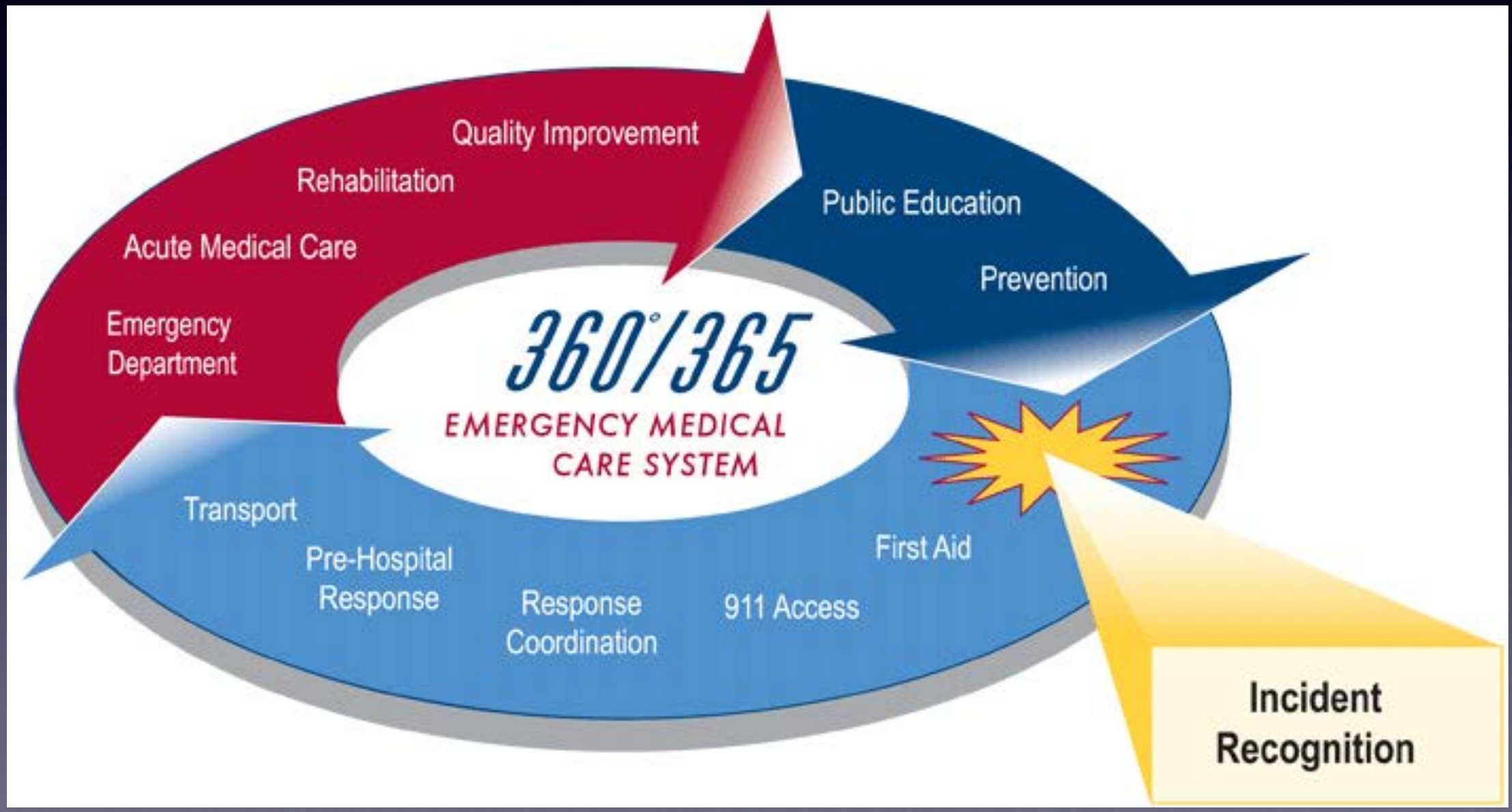
Unanticipated

- Statue Passed defining pathway to Community Paramedic Status in Missouri.
  - Recognizes and places Missouri as a leading state in Community Paramedicine initiative across the country
  - Provides for first steps toward reimbursement options” Take Notice…Community Paramedicine is an Important Something Now!”
  - Provides for oversight of training and expectations through DHSS.
  - Awaiting Final Regulations
- But until everything is completed…
  - We Can’t call ourselves “Community Paramedics”
  - We Can’t teach “Community Paramedicine”
- Solution? (work arounds)
  - Continue providing this needed care through paramedics with additional training and education
  - Rebrand everything as Advanced Practice Paramedics and Mobile Integrated Health and ELIMINATE Community Paramedic references
  - Await completion of the legal infrastructure to catch up with this highly volatile environment

Intervention- High Cost

- Identify the top tier of claims to payor- CMS, Private Insurance, patient pay
- Identify and optimize pool of patients-ACO, HMO, Medical Homes
- Adjustment of covered benefits to meet the individualized needs
- Additional physical therapy to prevent relapse
- Home visits and intensive follow-ups
- Optimization of other contributing health conditions
- Targeted Education
- Social Services resource review and referrals

Intervention

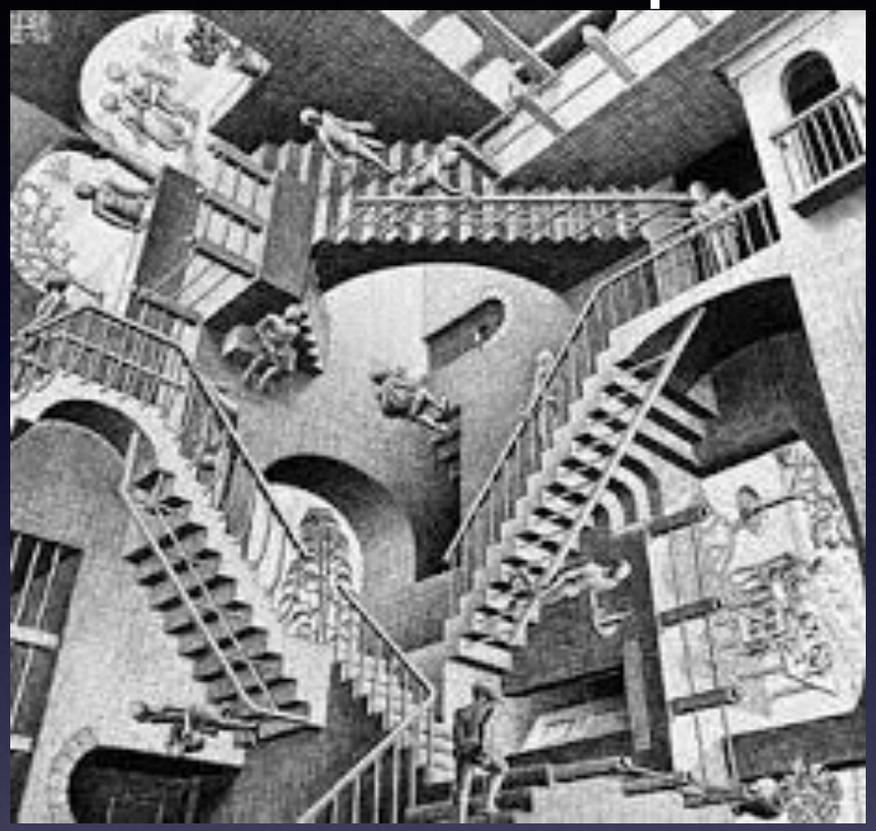


Results

- Approximately 20 Patients at a time enrolled for 6 week goal

  - 3 advanced practice paramedics rotating through administrative roll
  - ACO PMD
  - ACO support staff, social services and additional resources
- Outcome:
  - Case Series: Substantial individual health care improvement
  - We improved the care for our community by better treating a series of individuals

Next Steps



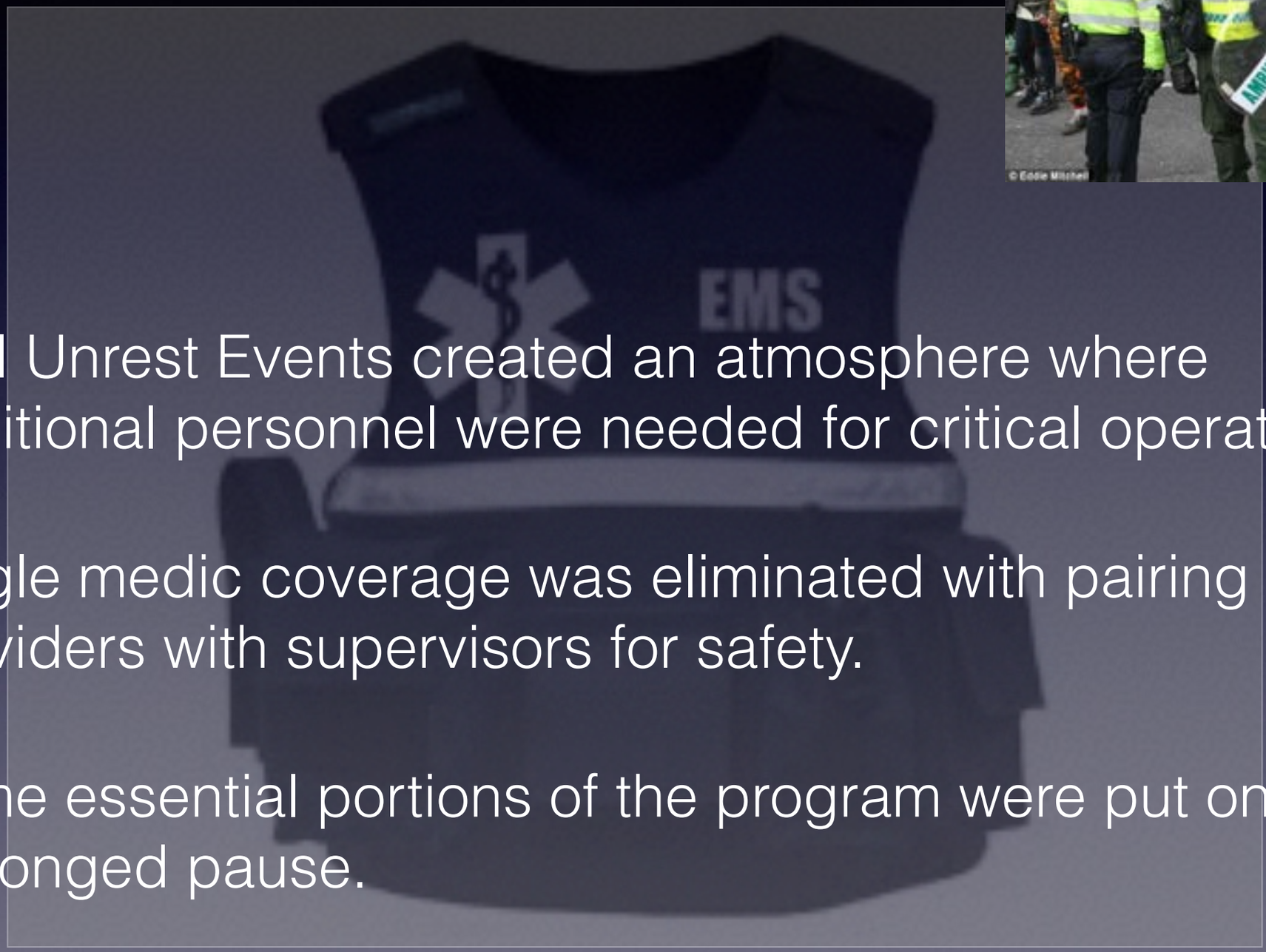
- Where are the pretty graphs, charts, and statistics?

- Awaiting release of funding to support a broader initiative with specific systematic outcome reporting and measurements

Unanticipated

- By day, Advanced Practice Paramedics saw patients and performing resource coordination
- By night, many completed their standard 24 hour 911 Shift
- Important Note: The Unit Hour Utilization Number (Optimal 0.5) is designed for traditional EMS response
- It does not well illustrate use of paramedics in a clinic-like, home health and/or general practice environment
- Be careful not to burn out your Expert Medics
- If you work 100% of the day hours for 12 hours seeing patients you have already achieved a Unit Hour Utilization of 0.5!!!!

Unanticipated



- Civil Unrest Events created an atmosphere where additional personnel were needed for critical operations.

- Single medic coverage was eliminated with pairing of providers with supervisors for safety.

- Some essential portions of the program were put on a prolonged pause.

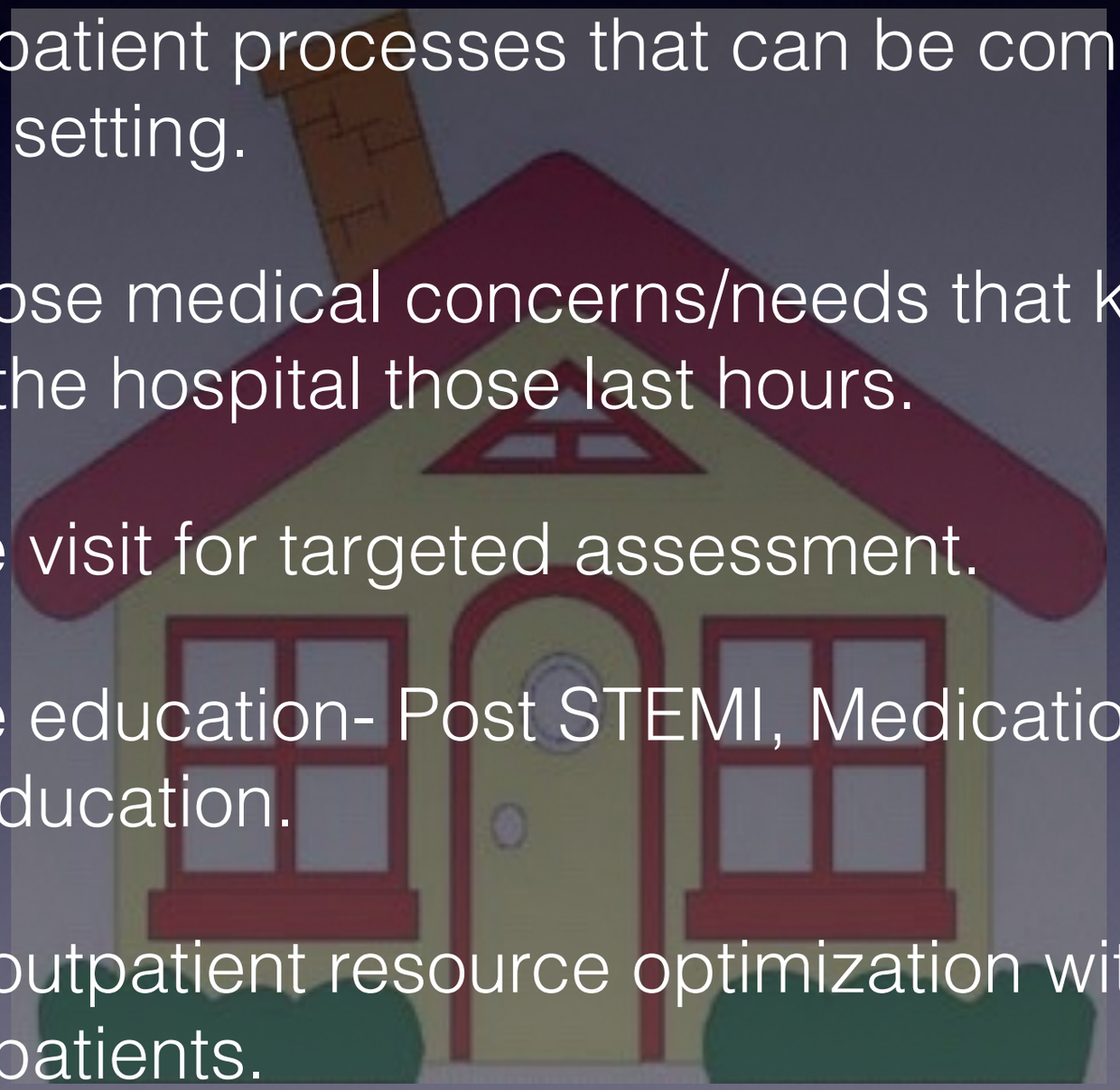
Intervention- Readmissions

- Systematic Home visits with assessments and targeted interventions
  - Use of APPs
    - ➢ CHF - weights, lasix, etc.
    - ➢ Dehydration assessments and IV Fluids
  - CMS reimbursement initial focus
- Outpatient resource optimization and root cause analysis of fail points:
    - ➢ Mental Health
    - ➢ Environmental
    - ➢ Social Support
    - ➢ Transportation options

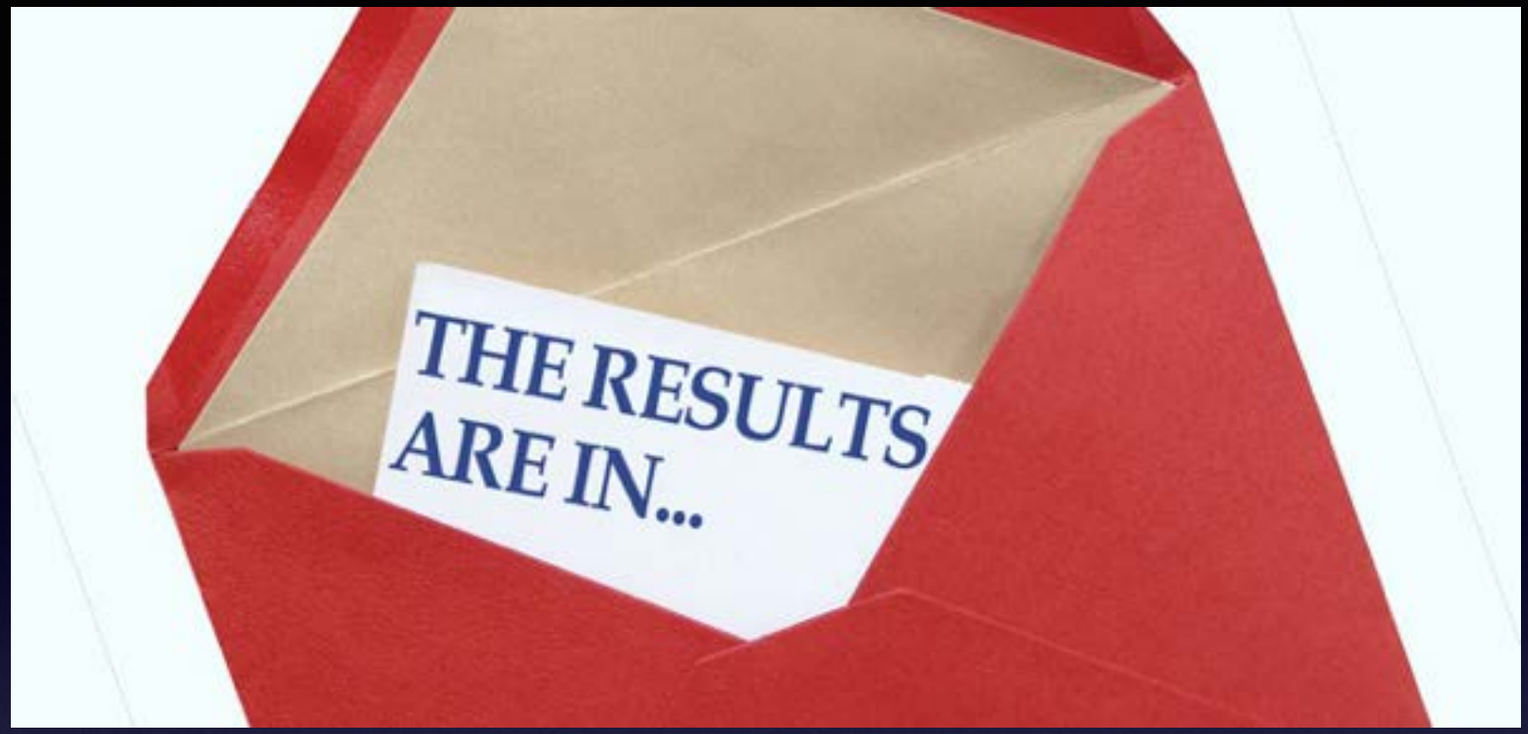
Results

- Several pilot programs in the area targeting this patient set
- Low enrollment numbers
- Fractured or variable support infrastructure
- Remain awaiting additional data and optimal program for these patients
- Remains an important class for hospitals due to associated reimbursement penalties

Intervention- LOS



- Identify Inpatient processes that can be completed in outpatient setting.
- Identify those medical concerns/needs that keep the patient in the hospital those last hours.
- APP home visit for targeted assessment.
- APP home education- Post STEMI, Medication, CVA, TBI, diabetic education.
- Consider outpatient resource optimization with safety net for at risk patients.



- Integration of Advanced Practice EMS into our STEMI designation applications

- Awaiting additional training for post STEMI care for areas of Diet, Medications, Rehabilitation, etc.

Process Improvement Patient Safety (PIPS)

- Review of individual patient outcomes
  - ➢ Patient Satisfaction
  - ➢ Successful reduction in Utilization and/or Cost
  - ➢ Successful reduction in relapses
  - ➢ Success and Improvement strategies for individualized patient care

PIPS

- System Overview
  - Financial Monitoring for Service Resources Cost and Reimbursements
  - Review of Utilization and resource optimization
- Statistics and Patient Population analysis

Unanticipated

- **<u>Saving Money= Good</u>**
  - Convince Payers to support the program
  - Decrease Patient costs
  - Decrease System costs
- **<u>Saving too much Money= Bad</u>**
  - Decrease in initial reimbursement price points to match initial costs of the program
  - Limitations in long term sustainability if essential infrastructure, administrative, IT, Medical oversight, consumables, etc. are not all included in the up front numbers
  - Limitations in hard to cover resources that could have been brought into the program but are tougher to add later.
- **<u>Saving too little Money= Bad</u>**
  - Payers, administration and providers may not want to bother with the substantial construction and upkeep of a program