Community Paramedic
PRIMARY CARE

Community Paramedicine Seminar

Milbank Memorial Fund, Nov. 6 2014

Partners

DHS/MDH
Hospitals
EMS Medical Directors
Primary care
Home health
Hospice
Public health

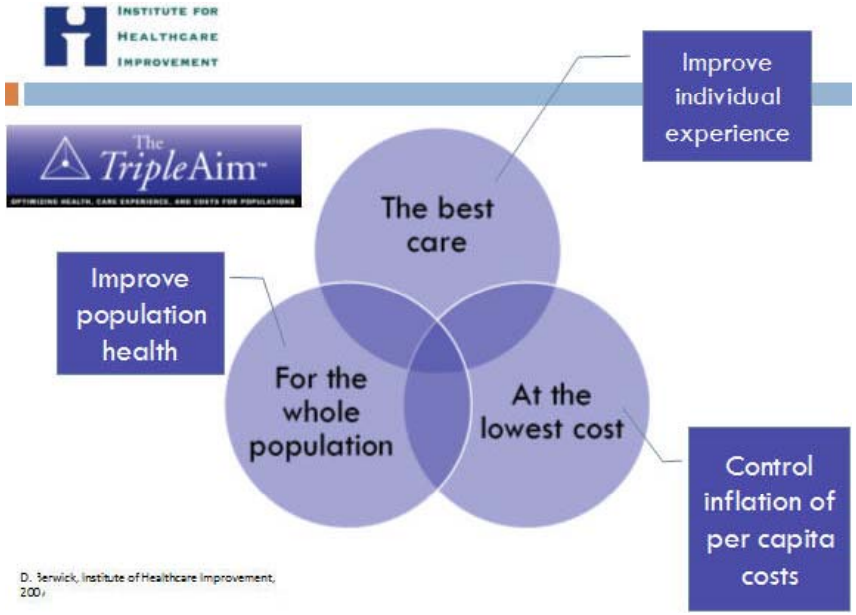
Affiliated clinics
FQHC's
CHC Look-alikes
Commercial & Gov't payers
State EMS board
SNF/Transitional care
Geriatrics

Environment Pre-CP

- Physician Oversight Model
- Scope of Practice Exempt
- Independent Practitioners
- Function under EMS Medical Director's License
- Paramedics Certified, not Licensed

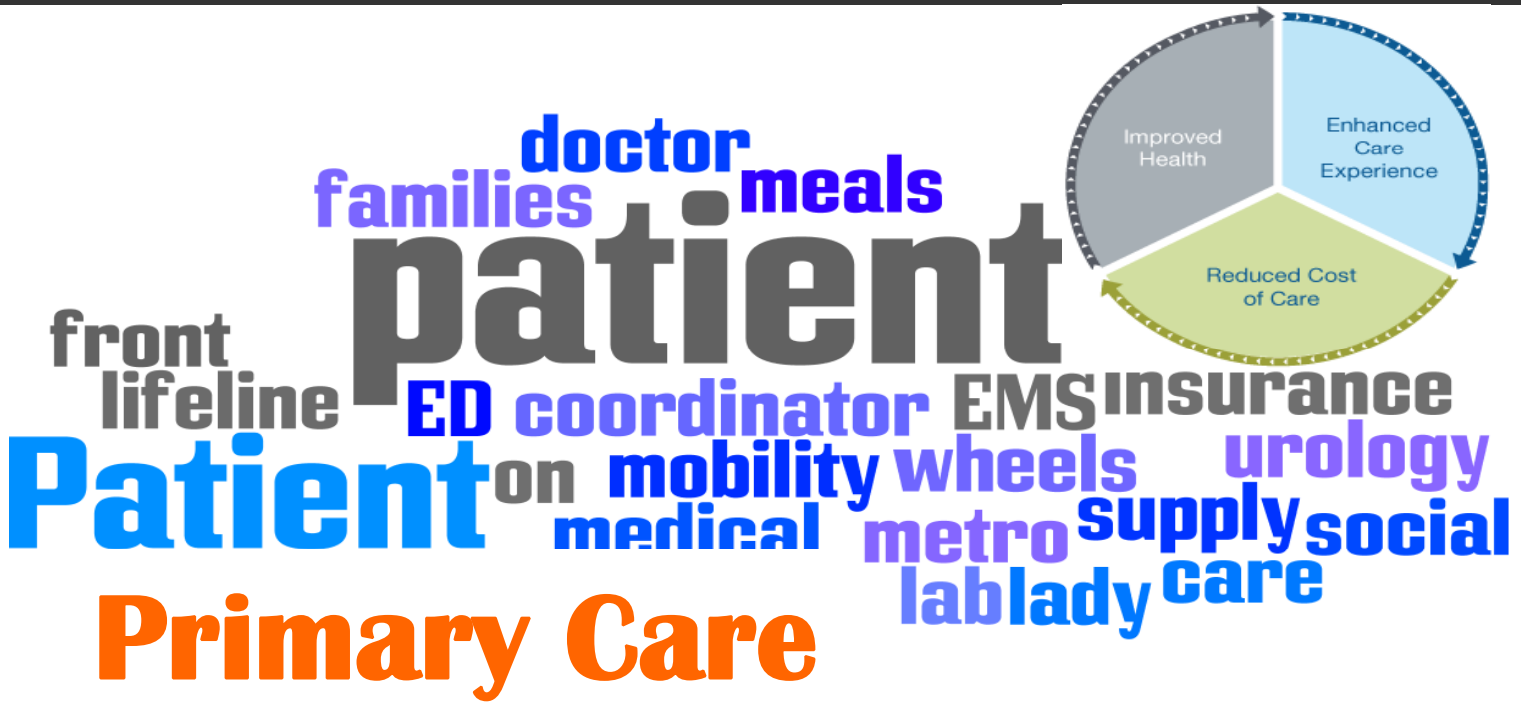
State and Federal Drivers gave way to CP as an Innovation

Improving Care, Health & Cost



- Effective Community Paramedic programs inherently support the Triple Aim framework to optimizing health system performance

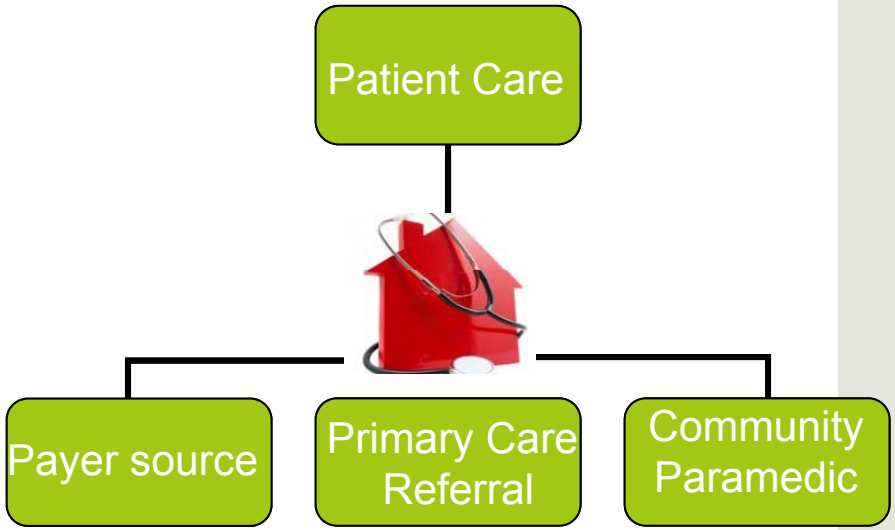
Achieving Triple Aim Goals: CP – Connecting the Dots



Expanded Role

- Primary care
- Emergency care
- Public health
- Disease management
- Prevention
- Wellness
- Mental health

Primary Care Focus

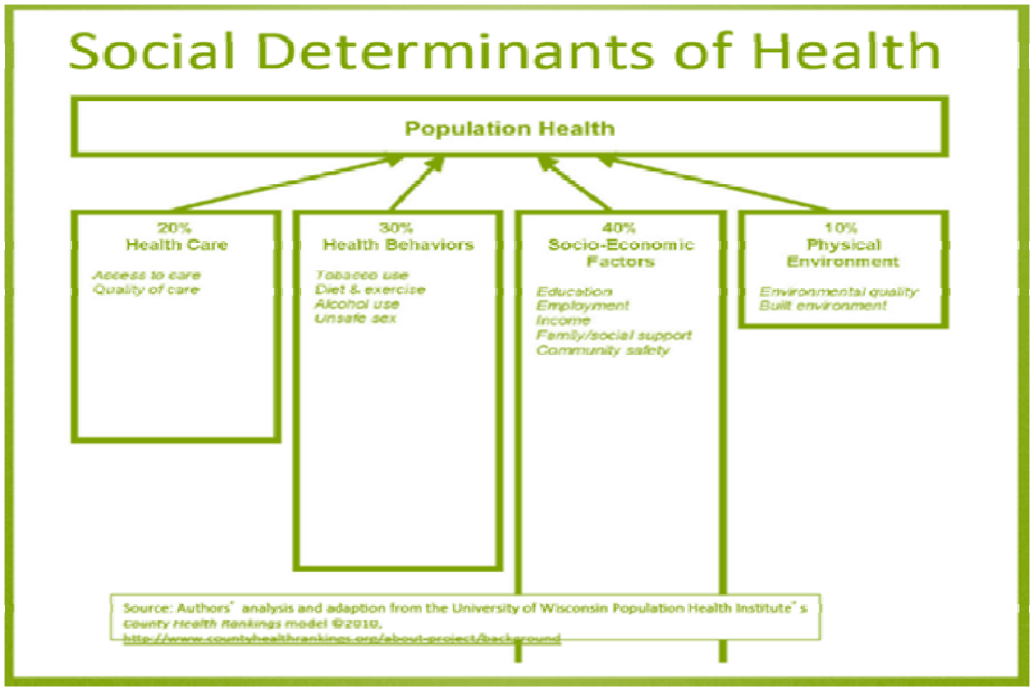


PROVIDERS ARE UNDER INCREASED PRESSURE TO CONTROL COSTS

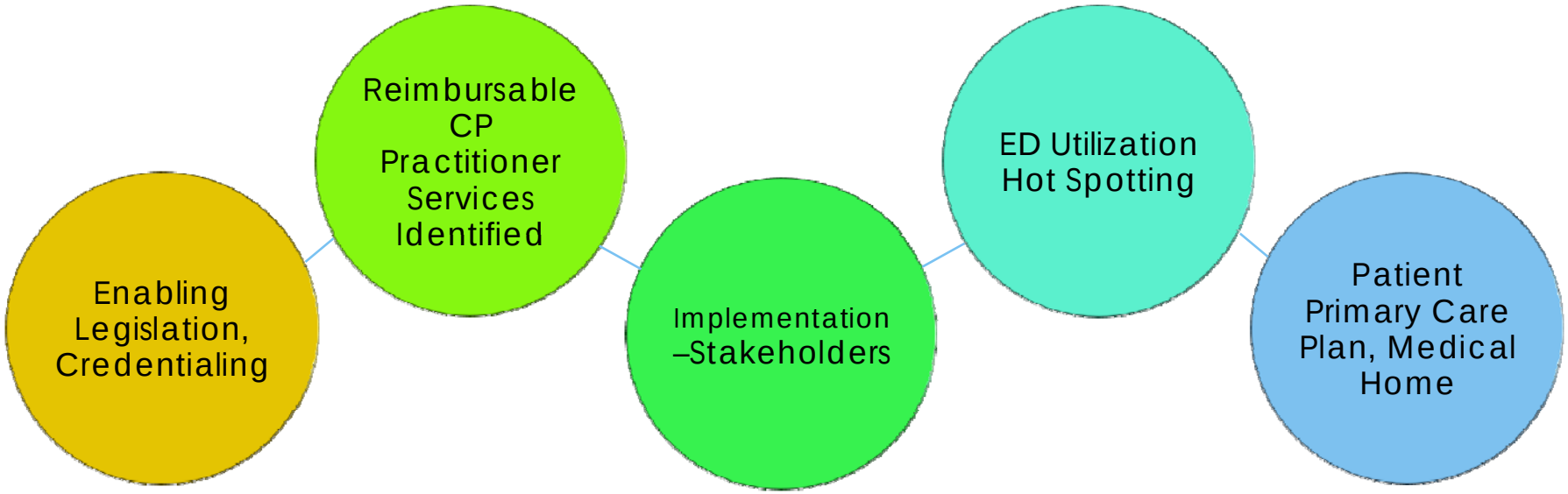
- Reduce ED utilization
- Reduce admissions and readmissions
- Expand primary care
- Encourage health care home usage for complex patients
- Community benefit plan - broad goals to improve population health

POPULATION-BASED, PERSON-CENTERED

- In addition to meeting the need for acute medical care, community paramedics work collaboratively to identify needs and develop methods to match resources to address the overall health of people and communities.



The Value of CP in Accountable Care



- Linking Primary Care & EMS

ACO: CP Value

Opportunities for CP to impact the ACO achievement of Triple Aim Goals:
Improved Patient Care, Enhanced Patient Experience, Reduced Cost of Care

MEDICAID ACO

- Withholds
- ER 5%
- Medical Home-Care coordination payments for managing complex chronic conditions
- Improve financially on Medical Assistance reimbursement

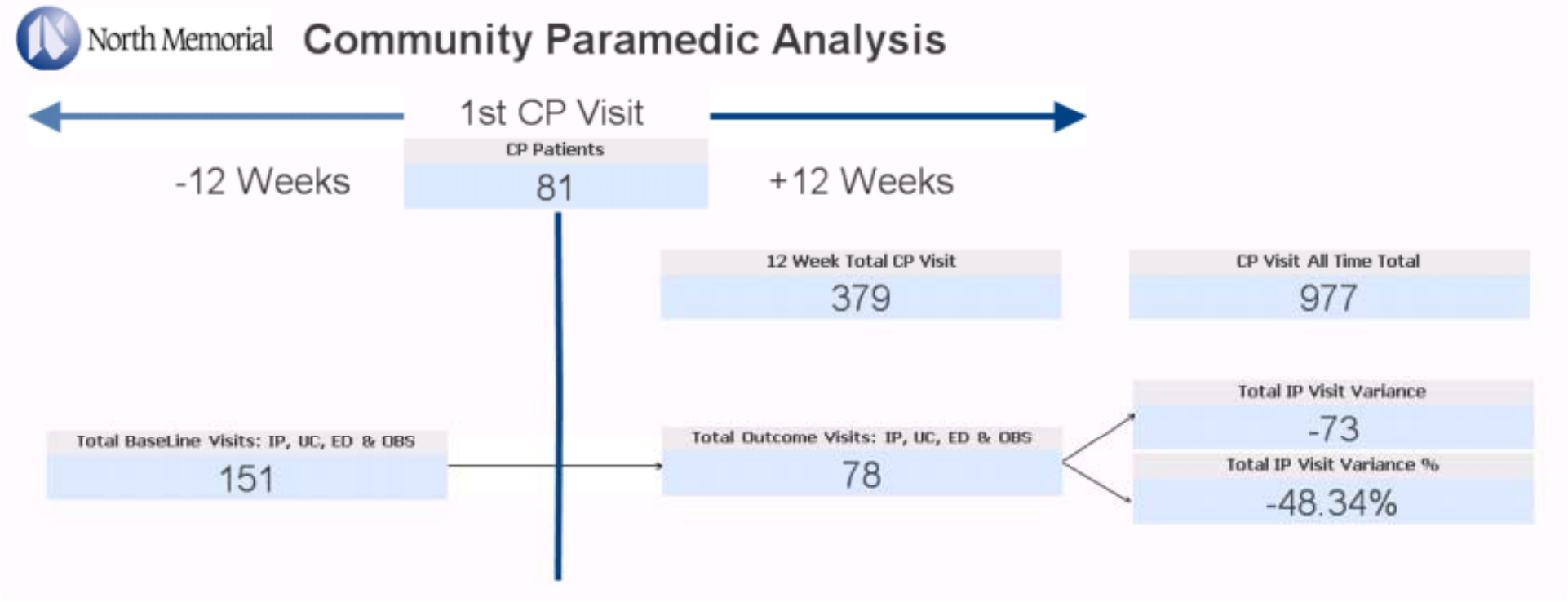
MEDICARE ACO

- Avoid Withholds
- Increase Patient Satisfaction Scores
- Quality Measures
- Reduce avoidable readmissions
- Opportunity to share in the savings produced

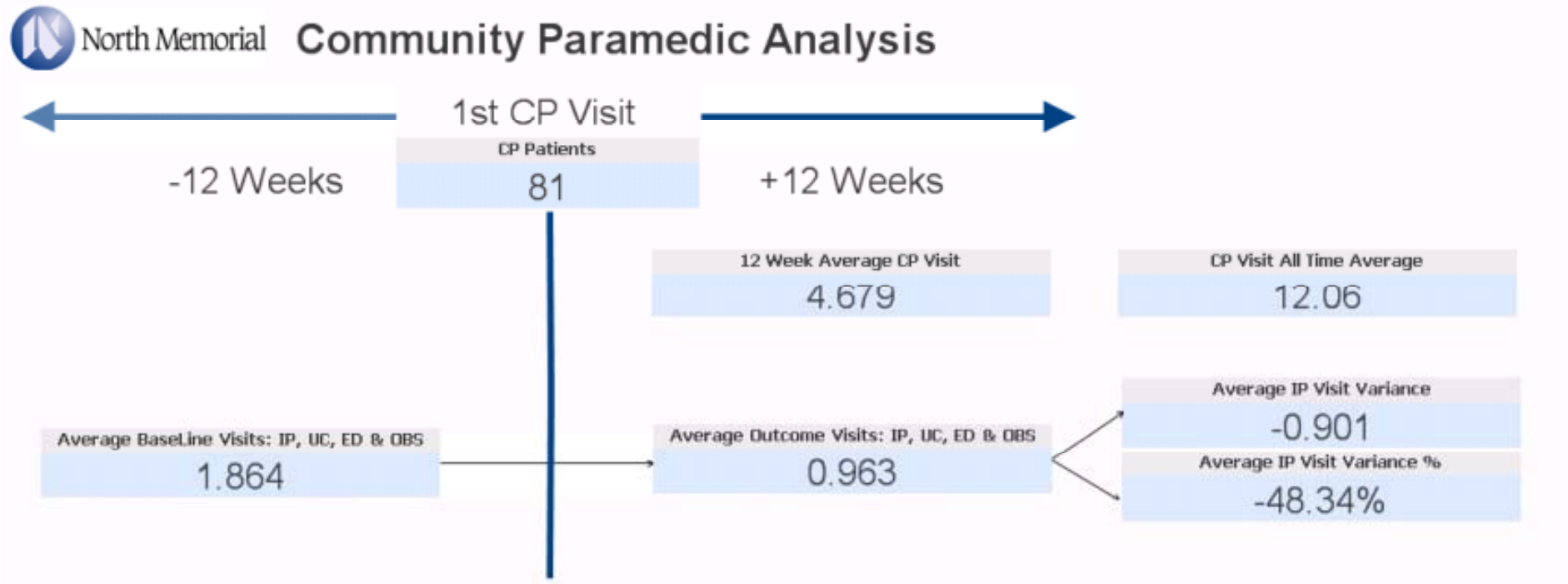
North Memorial CP Medicaid Demo

High-risk patients served by North Memorial are getting home visits from community paramedics, who help them avoid the emergency room by providing care in coordination with their doctor's offices and clinics. North Memorial uses data from the Department of Human Services to identify those who are most at risk and includes them in its groundbreaking community paramedic program. Bonus Payment of $800,000

North Memorial Data on CP Program



Initial Data Review-Population



CP Care Connections Program

- The use of two-way mobile, online and email communications
- Fully secure tools, HIPAA-compliant services
- Campaigns that inform and engage patients to drive compliance with post-discharge and ongoing care management services
- Permission-based mobile channels drive 95% opt-in rates and less than 3% opt-outs

3C

Many Ways To Use The Mobile Channel

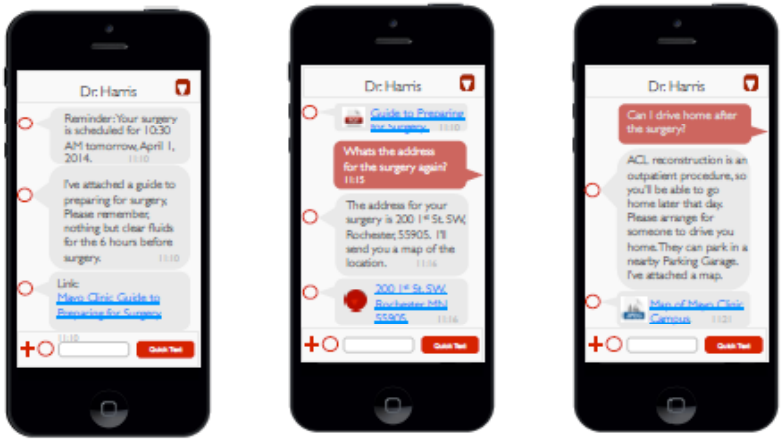
- **Event-based care:**
  - Appointment reminders and alerts
  - Procedure preparation and post-procedure treatment
  - Inform patients that their lab results are ready
  - Prescription reminders
- **Actionable patient feedback:**
  - Mobile surveys are quick and easy to execute
  - Mobile generates **8x** the response rates of email and other channels

3C

Pre and Post-Procedure Compliance

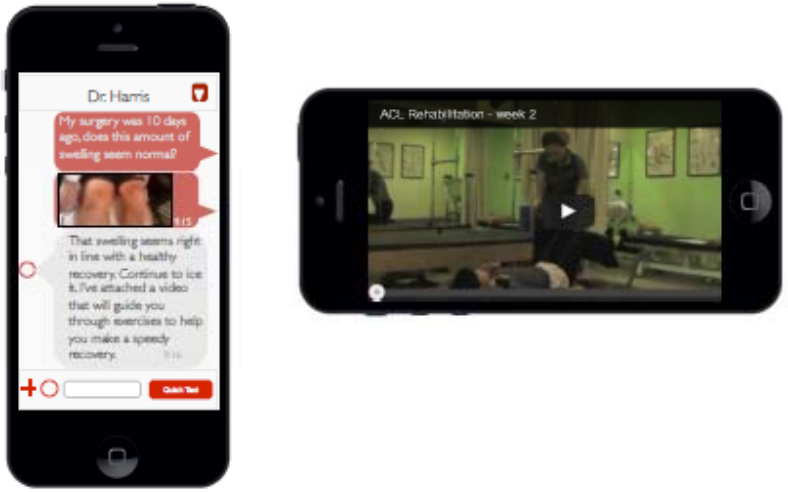
Pre-Procedure Compliance

Complete mobile communication program that ensures on time attendance, compliant preparation, post-procedure adherence and improved clinical outcomes.



Post-Procedure Compliance

Complete mobile communication program that enables two-way dialog, including patient-to-doctor communication with text, images and video.



3C

CP Payment & Delivery Modeling

- Community Paramedic solutions span health care finance, government reimbursement modeling and care delivery innovations.

- In the brave new world of PMPM, capitation and shared savings for total cost of care, and a drive for the premium dollar, CP offers new solutions across the continuum of care and types of services….
  - Fire
  - Hospital
  - Private Systems

- From initial 911 call to primary care integration

ACO: CP in Action

A high-level look at a a functioning Community Paramedic Program and its support of Accountable Care

Patient Populations

- Polypharmacy
- High ED utilization
- Anti-coagulation patients
- Not quite homebound: ineligible for HH services
- PCP feels it would help pt to have additional resources
- HCH patients needing services
- Continued wound care needed
- CP Clinic in Chem Dep facility

Year 1 and 2: Over 6,500 CP patient visits

- Referrals from ED/PCP/CC/HH
- Enhanced diabetes management
- 'Hub' huddles increase continuity of care
- Charting & In-basket Epic messaging: real time with provider for follow up/guidance
- Lab contact for analysis and direction
- CC'ing all charts to care coordinator and PCP
- Closed loop communication with patient and family
- Link additional community services into pt goal setting process
- CP follow up upon D/C can increase information relay to PCP
- D/C lab review and med compliance offers decrease risk of re-admin

CPs = Accountable Care Partners

- Viable option for improving the experience of care, improving the health of populations and reducing per capita costs of health care
- Bridge existing health care gaps, avoid duplication
- Reduce the cost of overall health care expenditures
- Reduce stress on vulnerable patients and improve care coordination
- Reduce hospital readmissions and emergency department utilization and avoid penalties

Questions

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