Workforce Innovations in Complex Care Series:
Community Paramedicine: A New Approach to Serving Complex Populations

May 11, 2017, 1:30-3:00 pm ET
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Made possible with support from Kaiser Permanente Community Benefit and the Robert Wood Johnson Foundation
Questions?

To submit a question, please click the question mark icon located in the toolbar at the top of your screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Welcome and Introductions

Building a Community Paramedicine Program in Wisconsin

Expanding Access to Care and Services in Massachusetts

Q&A
Welcome & Introductions
Meet the Team

Caitlin Thomas-Henkel, MSW,
Senior Program Officer,
Center for Health Care Strategies

Meshie Knight, MA,
Program Associate,
Robert Wood Johnson Foundation
Center for Health Care Strategies

Non-profit policy center dedicated to improving the health of low-income Americans
Select Complex Populations Initiatives

**Complex Care Innovation Lab**

Multi-year national initiative, supported by Kaiser Permanente Community Benefit, focused on improving care for low-income individuals with complex medical and social needs

**Transforming Complex Care**

Two-year multi-site pilot demonstration, funded by the Robert Wood Johnson Foundation, aimed at refining and spreading effective care models that address the needs of high-need, high-cost patients
Building a Culture of Health in America

Meshie Knight, MA
CULTURE OF HEALTH ACTION FRAMEWORK

ACTION AREA 1
MAKING HEALTH A SHARED VALUE

ACTION AREA 2
FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

ACTION AREA 3
CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

ACTION AREA 4
STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

OUTCOME
IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

EQUITY

Robert Wood Johnson Foundation
Building a Community Paramedicine Program in Wisconsin
Today’s Speakers

Sandi Groenewold, MD,
Expanded Care Team
Physician Lead,
ThedaCare

Brian Randall, NRP,
Paramedic and EMR Liaison
Coordinator,
Gold Cross Ambulance Services
Community Paramedic Program

Made possible through a generous grant awarded by the Robert Wood Johnson Foundation

Sandi Groenewold, MD
Brian Randall, NRP
Today, We Serve 240,000 Patients Annually

7 Hospitals
34 Clinics
85+ Onsite Clinics
7,000 Team Members
Today, We Serve 260,000 people in 1,200 Square Miles

**Our Vision**

To Be the Best in EMS

**Ten 24/7/365 Stations**
Serving 4 Counties
+21,000 Calls Yearly
Two Paramedic System
Proudly Owned by ThedaCare and Ascension Health Systems
Decentralized Team Based Care Model

Pharmacist

Behaviorist

MENTAL
SOCIAL
PHYSICAL

Physician

Nurse/Medical Assistant

Care Coordinator

NP/PA

ThedaCare
**Population Health (Care Transformation)**

**Risk Screen**

- High Risk
- Rising Risk
- At Risk
- Low Risk

**Intervention**
- Palliative Care
- Advanced Care Planning
- Paramedic / Home Health Visit
- Complex Care Team Referral
- Advanced Care Planning
- Team Based Care
- Community Partner
- Virtual Care
- Advanced Care Planning
- Virtual Care
- Wellness
- Self-care

**Model Includes**
- Complex Care
- System Care Management
- Primary Care Redesign
- Team Based Care

**Key Support Systems**
- Virtual Health
- EMR
- Community Health
- Quality
- Reimbursement modules

**Outcome:** Compassionately help Lori navigate her healthcare with clarity, connectivity and convenience.
How Do We Address These Gaps?

💖 Adverse Childhood Experiences (ACE’s)

💖 Trauma Informed Care
Our Vision...

To identify and fill the gaps in the current care delivery systems through creation of a Community Paramedic Program utilizing non-emergent, team-based, patient-centered, mobile resources.

Our Mission...

To address social determinants of health through partnerships and Community Paramedicine.
What is a Community Paramedic (CP)?

Through a standardized curriculum and advanced education with certification, they serve communities in the areas of:

- Primary Care
- Prevention and Wellness
- Public Health
- Mental Health
- Disease Management
- Readmission Prevention
- Oral Health
- Human Services
How did we set it up?

- The CP is part of the patient care team.

- ThedaCare has partnered with Gold Cross to provide resources to the service. This is a CP responding in Gold Cross uniform, and Gold Cross identified Suburban.

- It has been designed to NOT compete on any level with existing internal or community services.
## How Does it Flow?

### Community Paramedic (CP) Program Care Team Roles

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary RN</td>
<td>Identify patient needing services</td>
</tr>
<tr>
<td>Charge RN</td>
<td>Confirm patient need</td>
</tr>
<tr>
<td></td>
<td>Place referral</td>
</tr>
<tr>
<td>Laura / Melissa</td>
<td>Unit Process Owner</td>
</tr>
<tr>
<td></td>
<td>CP Program Liaison</td>
</tr>
<tr>
<td>CP</td>
<td>Connect with Care Manager to confirm not HHC or OPCM</td>
</tr>
<tr>
<td></td>
<td>Communicate with PCP</td>
</tr>
<tr>
<td></td>
<td>Connect with Charge RN if able to do warm hand-off</td>
</tr>
<tr>
<td>CP / Medical Director</td>
<td>Get approval from PCP</td>
</tr>
<tr>
<td>PCP</td>
<td>Direct patient care in collaboration with CP</td>
</tr>
</tbody>
</table>

Currently partnering with:
- 2 Inpatient Units
- 2 C.M. Teams
- 2 Clinics (more soon)
- 1 Wound Care Team
- Dieticians
**Community Paramedic Program Patient Referral Indications**

- **Readmission Concerns**
  - *Must have ThedaCare Physician or APC as their PCP*
  - Hospital Discharge: Bridge to TCAH if unable to see within 24 hours or patient declines TCAH
  - Post-Op Complication Concerns
  - CHF / COPD with Concern about Readmission or Medication Understanding
  - Dressing Changes needed prior to surgeon follow-up
  - Dressing changes as referred by Wound Care

- **Medication Concern**
  - INR Concerns
  - New Starts (Insulin / Warfarin)
  - Home Safety Concerns
  - Fall Risk
  - *"Gut Feel" of Concern*
  - 
    >\(\geq 3\) ED visits in 6 months or 
    >\(\geq 6\) ED visits in 12 months
How Does it Work in the Field?

Care Provided (this is not an all inclusive list)

- Vitals (BP, P, RR, SP02, Auscultation)
- Labs - Not off port
- **Medication Rec**, storage, sorting, management, changes to doses and timing as directed by PCP
- Home Safety
- **Chronic Disease Management** (Weight checks, BP, Blood Glucose Level, Education)
- Sensation Testing with Foot Checks (exam)
- Fall Risk assessments
- BH Screening and PHQ9 and anxiety score (Follow up)
- **Life risk assessments** (work, home, community)
- Identification of barriers and referral to community resources or SW for follow up
- Introductory diabetes education with referral to diabetes education
- Insulin training (All types)
- Coumadin / Warfarin supportive training
- Dressing Changes
- CPAP device evaluation & instruction
How Does it Work in the Field?

Care Not Provided at this Time (this is not an all inclusive list)
- Foley changes
- Wound vac & debridement
- G-Tube or J-Tube maintenance
- New acute problem (acute conditions discovered during visit will be managed per protocol)
- *This visit is not in place of PCP office visit protocol
# How Does it Look?

![Chart Review Interface](Image)

## Chart Review

### Upcoming Visits

<table>
<thead>
<tr>
<th>When</th>
<th>Type</th>
<th>With</th>
<th>Description</th>
<th>CSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/22/2017</td>
<td>Office Visit</td>
<td>CARDIOLOGY - Zhou, L</td>
<td>ERRONEOUS ENCO...</td>
<td>11176974</td>
</tr>
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</table>

### Recent Visits

<table>
<thead>
<tr>
<th>When</th>
<th>Type</th>
<th>With</th>
<th>Description</th>
<th>CSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/24/2017</td>
<td>Office Visit</td>
<td>FP - Roberts, T</td>
<td>Acute cystitis without...</td>
<td>124377996</td>
</tr>
<tr>
<td>04/20/2017</td>
<td>House Call Visit</td>
<td>Me</td>
<td></td>
<td>124265680</td>
</tr>
<tr>
<td>04/07/2017</td>
<td>Admission (Discharge)</td>
<td>Fisher, C</td>
<td></td>
<td>123779760</td>
</tr>
<tr>
<td>04/07/2017</td>
<td>Admission (Discharge)</td>
<td>Fisher, C</td>
<td></td>
<td>123778666</td>
</tr>
<tr>
<td>04/06/2017</td>
<td>Office Visit</td>
<td>Occ Health - Sanfilippo, S</td>
<td>ERRONEOUS ENCO...</td>
<td>123726111</td>
</tr>
<tr>
<td>04/05/2017</td>
<td>Telephone</td>
<td>CR-TCW - Kirsling, T</td>
<td>Testing</td>
<td>123679611</td>
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<tr>
<td>04/04/2017</td>
<td>Refill</td>
<td>FP - Klump, A</td>
<td>Erroneous encounter...</td>
<td>12364646</td>
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<tr>
<td>03/31/2017</td>
<td>Pre-admit (Canceled)</td>
<td>Gastro - Stampfl, D</td>
<td></td>
<td>12364792</td>
</tr>
<tr>
<td>03/12/2017</td>
<td>Nurse Triage</td>
<td>Other, P</td>
<td>Erroneous encounter...</td>
<td>123164564</td>
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<tr>
<td>03/12/2017</td>
<td>Documentation Only</td>
<td>FP - Fisher, C</td>
<td></td>
<td>123113390</td>
</tr>
<tr>
<td>03/20/2017</td>
<td>Office Visit</td>
<td>Gen Surgery - Konkole, S</td>
<td>Sick frequently (Prim...</td>
<td>12307916</td>
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<tr>
<td>03/07/2017</td>
<td>Telephone</td>
<td>McCann, R</td>
<td>Erroneous encounter...</td>
<td>122634951</td>
</tr>
<tr>
<td>03/07/2017</td>
<td>Telephone</td>
<td>McCann, R</td>
<td>Burn</td>
<td>122634301</td>
</tr>
<tr>
<td>03/07/2017</td>
<td>Telephone</td>
<td>McCann, R</td>
<td>Burn</td>
<td>122633141</td>
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<tr>
<td>03/07/2017</td>
<td>Telephone</td>
<td>McCann, R</td>
<td>Update</td>
<td>122632361</td>
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<tr>
<td>02/24/2017</td>
<td>Nurse Triage</td>
<td>Other, P</td>
<td>Erroneous encounter...</td>
<td>122280434</td>
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<tr>
<td>02/24/2017</td>
<td>Telephone</td>
<td>FP - Klump, A</td>
<td>Erroneous encounter...</td>
<td>122253541</td>
</tr>
<tr>
<td>02/23/2017</td>
<td>Telephone</td>
<td>Nutrition - Vangruusven, R</td>
<td>Erroneous encounter...</td>
<td>122233613</td>
</tr>
<tr>
<td>02/23/2017</td>
<td>Telephone</td>
<td>Nutrition - Vangruusven, R</td>
<td>Erroneous encounter...</td>
<td>122233561</td>
</tr>
</tbody>
</table>
How Does it Look?  All documented in EPIC Home Visit Encounter

Progress Notes

Randall, Brian, EMT-P

ThedaCare

Community Paramedic Pilot Program

Date of Assessment: 5/1/2017
Client Name: Test Test ZZTest
Client DOB: 10/1/1950
Client MRN: E11330197

Note to Provider:
1. Patient was not carb counting
2. Patient CPAP Mask was not fitting

General narrative style not of the entire visit

Reason for Enrollment:
This patient is a 60 year old male who was referred to the Community Paramedic Pilot program due to ED Visits. The patient was referred by PCP. The patient will be receiving 1 visits per week for the next 4 weeks.

Chart Review:
The patient's medical, surgical, social, family history, and the most recent H&P, were reviewed prior to the initial visit. The patient's physician orders and goals for program enrollment have also been reviewed.

The patient's medication list was reviewed with pharmacist and No concerns were noted.

Goals:
Client goals for the program are: Increase activity and general diet, lessens SOB
Caregiver goals for the program are: Increase activity at home, CPAP compliance.
How Does it Look?  All documented in EPIC Home Visit Encounter
How Does it Look? All documented in EPIC Home Visit Encounter
Where ThedaCare is today (5/11/17)

- Started seeing patients in their homes 4 months ago.

- Out of 106 visits, **34 of them had at least 1 medication intervention; 6 being significant.**

- **All visits meeting targets!**
Patient Story

History:
• Patient with history of cognitive delay, pseudo-seizures (up to 30/day), and multiple falls resulting in hospitalizations and ED visits
• Patient wearing a helmet to protect himself
• Disconnected from the community

Paramedic actions at home visit:
• Full med-rec and risk evaluation
• Referral for counseling and medication recommendations
• Relationship and trust established

Current state:
• No ED visits or admissions!
• No pseudo-seizures and no falls since January 26. (20 days after enrollment into our program!)
• Patient back out into the community!
The Before and After

**PATIENT TOUCH MAP**

Trigger: 3 months prior to enrollment in Community Paramedic Program and 3 months after enrollment. Data is only what is available from within ThedaCare system.

**TOUCH TYPES:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V</td>
<td>Office Visits</td>
</tr>
<tr>
<td>C</td>
<td>Patient Call</td>
</tr>
<tr>
<td>O</td>
<td>Other (PT/OT)</td>
</tr>
<tr>
<td>P</td>
<td>Community Paramedic</td>
</tr>
<tr>
<td>E</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>A</td>
<td>Admissions (Inpatient)</td>
</tr>
</tbody>
</table>

**Prior vs Post Comparison:**

<table>
<thead>
<tr>
<th>Prior</th>
<th>Post</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>V 8</td>
<td>V 6</td>
<td>25%</td>
</tr>
<tr>
<td>C 18</td>
<td>C 6</td>
<td>67%</td>
</tr>
<tr>
<td>O 18</td>
<td>O 4</td>
<td>78%</td>
</tr>
<tr>
<td>P 0</td>
<td>P 8</td>
<td>NA</td>
</tr>
<tr>
<td>E 3</td>
<td>E 0</td>
<td>100%</td>
</tr>
<tr>
<td>A 1</td>
<td>A 0</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Important Dates:**

- 8/2/16 - Care Team Enrollment
- 10/3/16 - Seizures Start
- 1/6/17 - Community Paramedic Start
“I am able to go back to church.”
Patient

“I can leave him alone now while I go to my own appointments.”
Patient’s wife.
Patient Story ‘2’

History:
Patient with history of full pancreatectomy, gastric bypass, islet cell transplant, multiple ED and Hospital admissions, eating disorder, on *TPN for 2 years*. Last admission was 37 days with 2 ICU transfers

Paramedic actions at home visit:
Full medication reconciliation and risk evaluation
Blood glucose management with PCP
Referral for PT, OT, Diet and medication recommendations
Relationship and trust established

Current state:
1 ED visit (for leg pain)
Prevented DKA admission!
Patient is gaining weight and off TPN after 2 years!
More engaged in health care!
“This is the most confident I have felt with my care team in years.”

Patient
How we see our results?

Event Count

- Appointment Not Kept: 171
- ED Visit: 69
- IP Visit: 11
- Office Visit: 81

Related Events:
- Appointment Not Kept, ED Visit, IP Visit, Office Visit
- A1C Over 9.0
- A1C Under 9.0
- BH Visit
- BP Over 140/90
- BP Under 140/90
- Care Team
- CP Visit

Patient E Number

Enter Min
Min = 180

Enter Max
Max = 180
A glance at our results.

### CP Program Change in ED Visits and Admissions

<table>
<thead>
<tr>
<th></th>
<th>Number of Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED visits</strong></td>
<td>32</td>
</tr>
<tr>
<td><strong>Admissions</strong></td>
<td>22</td>
</tr>
<tr>
<td><strong>Readmissions</strong></td>
<td>3</td>
</tr>
</tbody>
</table>

- **6 Months Prior to Enrollment**
- **Since Enrollment**
### Patient with High ED Utilization

<table>
<thead>
<tr>
<th></th>
<th>Costs 3 months Prior to Enrollment</th>
<th>Costs 3 months Post Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Costs</td>
<td>$6449</td>
<td>$2626</td>
</tr>
<tr>
<td>Insurance Cost</td>
<td>$6449</td>
<td>$2626</td>
</tr>
<tr>
<td>Patient Out of Pocket</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

*Plus 6 Independents  *Plus 2 Independents

### Patient with Hospital Admission

<table>
<thead>
<tr>
<th></th>
<th>Costs 2 months Prior to Enrollment</th>
<th>Costs 2 months Post Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Costs</td>
<td>$165,764</td>
<td>$6345</td>
</tr>
<tr>
<td>Insurance Cost</td>
<td>$162,984</td>
<td>$6275</td>
</tr>
<tr>
<td>Patient Out of Pocket</td>
<td>$1780</td>
<td>$70</td>
</tr>
</tbody>
</table>

*Plus 1 Independents  *Plus 4 Independents

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**Cost Comparison**

**Total Costs**

- **Prior to Enrollment:** $6449
- **Post Enrollment:** $2626

- **Total Costs Prior to Enrollment:** $6449
- **Total Costs Post Enrollment:** $2626

- **Insurance Cost Prior to Enrollment:** $6449
- **Insurance Cost Post Enrollment:** $2626

- **Patient Out of Pocket Prior to Enrollment:** $0
- **Patient Out of Pocket Post Enrollment:** $0

**Patient with Hospital Admission**

- **Total Costs Prior to Enrollment:** $165,764
- **Total Costs Post Enrollment:** $6345

- **Insurance Cost Prior to Enrollment:** $162,984
- **Insurance Cost Post Enrollment:** $6275

- **Patient Out of Pocket Prior to Enrollment:** $1780
- **Patient Out of Pocket Post Enrollment:** $70

*Plus 1 Independents  *Plus 4 Independents
What our people are saying:

“The program has helped illustrate the missing pieces so we can iron out patient issues. This has just been outstanding.”
- Complex Care RN

“This has created tighter connections between the clinic and home life and helps reiterate what we do.”
- Complex Care RN

“The Community Paramedic Program has truly added a new dimension to the care of my patients. Having the ability to have eyes on a patient in their home environment is advantageous for both the physician and the patient. It allows for smooth transitions and assists in finally breaking down barriers that have prevented us from reaching ideal goals for patients. I have no doubt that with only a few patients that have benefited so far, we have prevented hospitalizations. I can’t wait to see where this program can go!”
- Physician, Appleton Internal Medicine

"Community paramedic is the wave of the future of health care. We are taking care to patients, right where they are. Gold Cross is proud to be part of this effort."
- Executive Director, Gold Cross Ambulance
**Community Paramedic Program**

**Our Program**

**Our Vision…**
To identify and fill the gaps in the current care delivery systems through creation of a Community Paramedicine Program utilizing non-emergent, team-based, patient-centered-mobile resources.

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**What is a Community Paramedic?**
Through a standardized curriculum and advanced education with certification, they serve communities in the areas of:
- Primary Care
- Prevention and Wellness
- Public Health
- Mental Health
- Disease Management
- Readmission Prevention
- Oral Health
- Human Services

Our goal is to return patients to their independence. Services partner with Home Care and do not compete on any level.

---

**Patient Stories**

**History:**
- Patient with history of cognitive delay, pseudo-seizures (up to 30/day), and multiple falls resulting in hospitalizations and ED visits
- Seasonal pattern to symptoms
- Disconnected from the community

**Paramedic actions at home visit:**
- Full medic res and risk evaluation
- Referral for counseling and medication recommendations

**Current state:**
- No new ED visits or admissions; no pseudo-seizures and no falls!
- Accepted referral for counseling
- Medication started and dose titrated
- Patient excited and going back out into the community!

"I am now able to go back to church." - Patient.

"I can now leave him alone to go to my own appointments." - Patient’s wife.

---

**Staff / Provider Feedback**

"The program has helped illustrate the missing pieces so we can iron out patient issues. This has just been outstanding."
- Complex Care RN

"This has created tighter connections between the clinic and home life and helps reiterate what we do."
- Complex Care RN

"The Community Paramedic Program has truly added a new dimension to the care of my patients. Having the ability to have eyes on a patient in their home environment is advantageous for both the physician and the patient. It allows for smooth transitions and assists in finally breaking down barriers that have prevented us from reaching ideal goals for patients. I have no doubt that with only the few patients that have benefited so far, we have prevented hospitalizations. I can’t wait to see where this program can go!"
- Dr. Deborah Ihde, Appleton Internal Medicine

"Community paramedic is the wave of the future of health care. We are taking care to patients, right where they are. Gold Cross is proud to be part of this effort."
- Executive Director, Gold Cross

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**Where we are at today (3/3/17)**

- Started seeing patients in their homes 1/6/17
- Current triggers for visits:
  - High ED utilizer
  - Admission/Readmission risk
  - Medication risk
- Other risk
  - 36 service days
  - 62 visits to 12 different patients
  - 5 for ED prevention
  - 3 for Readmission prevention
  - 11 for Risk Evaluation
- All patients meeting targets
- 22 patients had at least one medication intervention; 3 being significant

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**Legislative Path**

- Current State Legislation does not recognize Certification
- Community Paramedics must practice under a Medical Director/Provider
- Unable to bill Medicare/Medicaid
- Legislation in place and successful in many other states – including Minnesota

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**Current Metrics**

**Future Expanded Coverage – Entire Gold Cross Region**

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**Community Advisory Board**

"Filling the gaps together"

*10/25/16 ThedaCare At-Home Advisory Board votes unanimously to also serve as Community Paramedic Advisory Board.

The board will provide guidance as to the development and sustainability of the program as well as identify and make tight connections to community services.

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**Community Paramedic Program Team**

- Sandra Groenewold, MD, Program Co-Director
- Brian Randall, NRP, Community Paramedic
- Carrie Riley, BSN, MSN, Program Director
- Laurie Moore, CLS (NCA), Project Coordinator
Community Paramedic Recognition in Wisconsin

April 4\textsuperscript{th}...Assembly votes unanimously to approve Community Paramedicine Bill! [\text{AB151}]

Bill now moves to the Senate, to hold public hearing. [\text{SB149}]

According to PAAW Lobbyist Michael Brozek, "This is a very, very fast tracked piece of legislation...unusually fast."

Minnesota Ambulance Association Lobbyist Buck McAlpin also shared on news about the Assembly's vote, "Very few states have formalized this (Community Paramedicine) into law - a very nice win." McAlpin was instrumental in Minnesota passing Community Paramedicine legislation in 2011.

https://docs.legis.wisconsin.gov/2017/related/amendments/ab151/aa1_ab151
Current Funding:

- Robert Wood Johnson Foundation
- ThedaCare
- Gold Cross Ambulance
- ThedaCare Foundations

Future Funding:

- ThedaCare
- Gold Cross Ambulance
- Other Stakeholders
- ACO Contracts
- Medicare/Medicaid
- Commercial Insurance
Our Community Advisory Board
Our Struggles

(-) Legal Contracts
(-) Vehicle for 2\textsuperscript{nd} CP
(-) Informal training processes were more difficult than formal ones (i.e. referral process)
(-) Misperception about amount of added work and processes within other departments.

(-) Everything takes longer than you think (relationship building, IT builds, scheduling with leaders)
(-) Even though many “could not wait” for us, when it came down to it, there were still operational details to work through.
Our Successes!

(+) Building for the future (Workflows, EMR, next staff)
(+) Sticking with EMR foundation
(+) Passionate people in the right places (General Medical Council, Community)
(+) Early wins – got a lot of attention
(+) Stressed up front that this is designed to not compete with existing services (in our organization and community)
(+)...
Sandi Groenewold, MD  
Grant Co-Director and Medical Director  
Sandra.Groenewold@thedacare.org

Carrie Riley, BSN, MSN  
Grant Director  
Carrie.Riley@thedacare.org

Brian Randall, NRP  
Community Paramedic  
Brandall@goldcross.org

Laurie Moore, CLS  
Grant Project Coordinator  
Laurie.Moore@thedacare.org
Expanding Access to Care and Services in Massachusetts
Today’s Speakers

Matt Goudreau, BS, NRP,
Associate Director,
Acute Clinical Response,
Commonwealth Care
Alliance

Dhruva Kothari, MD,
Medical Director,
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Acute Community Care
Revolutionizing Health Care Delivery
Through Community Paramedicine
Acute Care: 33% of Health Care Dollars

"wasteful" spending on acute care annually

preventable acute care use is driven by lack of community-based urgent care access

2014 Massachusetts Health Insurance Survey
Understanding the Need | Gap Analysis

**Member**
- Meet Needs
- Manage Expectations

**Provider**
- Right Care
- Right Time
- Right Location

**Cost**
- Financial Responsibility

“Mind the GAP”
- Honest evaluation of current system
- Identify areas of need
- Think outside the box
- Utilize resources to highest potential
- Do not duplicate existing resources
**Stakeholder Engagement**

**Critical Early Steps**

- Engage early in process
- Include as many voices as possible
- Clearly address all concerns
- Stress the concept of not duplicating existing resources and GAP Analysis
Commonwealth Care Alliance is an experienced health plan and delivery organization focused exclusively on Massachusetts beneficiaries dually eligible for Medicare and Medicaid. We serve >20,000 members with complex medical, behavioral and social needs in two major programs. CCA administers and manages the full spectrum of Medicare and Medicaid covered benefits.

**Senior Care Options**

*Over-65 duals (D-SNP); high frailty*
- More than 75% are nursing-home certifiable; over 95% are community dwelling
- 70% have four or more chronic conditions; 45% have three or more activities of daily living (ADL) impairments
- 62% speak a primary language other than English
- Two thirds did not complete high school
- More than 65% report their general health status as “poor” or fair

**One Care**

*Under-65 duals (MMP)*
- Average per member per month THCE >$2,000 (10 times low risk Medicaid member)
- 70% have a behavioral health diagnosis; High rates of substance abuse
- 7% are homeless; many more are marginally housed
- High rates of “unmet need”, particularly in primary care and long term supports and services

> $1B in annual blended Medicare / Medicaid premium
Our Members Benefit from Specialized Models

High Cost Patients Have Complex Lives:
5% of patients account for 50% of all healthcare costs

Advanced Illness / Advanced Complexity:
Require complex care management

At risk, multiple chronic conditions
Require traditional disease management models

Well-population:
Utilize preventive and well-care services; intermittent (as-needed) acute care

These populations require integrated delivery systems to deliver coordinated care and effectively manage costs

Top 5-10% is a heterogeneous population with multiple drivers of complexity

ED high utilizer
SPMI
Homebound or hospital-dependent co-morbid medical complexity
End of Life

Complex physical and cognitive disability
Need for significant social support
“Tom T”: Typical CCA Member in Need

- 47 y.o. Male with Spinal Cord Injury, Quadriplegic, Vent Dependent, Neurogenic Bladder and Neurogenic Bowel
- Chief Complaint: Hypotension (80 sys) with periods of unresponsiveness
  - Alert and Oriented
  - No fever
  - Normal PO intake
- Patient has history of avoiding ED
Acute Community Care (ACC) or Community Paramedicine

- Highly trained paramedics are dispatched to evaluate and treat urgent care patients within their homes or institutional residences.

- ACC paramedics arrive in an SUV equipped with special diagnostic testing equipment, numerous medications to treat non-emergency problems, and extensive medical supplies.

- ACC paramedics have access to patients’ centralized electronic health records and communicate continuously with on-call clinical staff.

Patients with emerging or urgent care needs call designated on-call/urgent care triage staff.
Acute Community Care | Why Does it Work?

- Embedded in Primary Care
- Robust Quality and Compliance
- Optimal Diagnostics & Treatment
- Comprehensive Training
“Tom T”: Successful Intervention

- **Paramedic Visit**
  - Physical exam: Within Normal Limits
  - Mental status at baseline
  - iStat Chemistry Panel
  - Blood & Urine cultures obtained
  - Urine collection and dip
    - Positive LEU

- **Symptoms**
  - Consistent with past Urinary Tract Infection

- **Treatment**
  - 750 Levaquin P.O.
  - Prescription called in for next day pick up

**Vital Signs**
- 98.2 F
- HR: 86
- BP: 105/60
- RR: 14
- O2 Sat: 99%
Evolving into Success

Areas for Improvement

- Hours of operation
- Restriction of Special Project Waiver process
- Need for industry-wide data collection and validation
Lessons Learned

We got some things right
We got some things wrong

• GAP Analysis
• Understanding Community
• Stakeholder Engagement
• Working closely with regulators
• Not creating redundant resourcing
• Selecting the right paramedics
• Tailoring training to meet program goals
• Access to EMR for High Acuity Members
• Culture of change: “Open Mind”
• Need for Peer-Reviewed research
Early KPIs | Exceptional experience & ED diversion

CCA members surveyed after paramedic visits voiced high approval rates:

95% Agreed the visit was as good or better than an Emergency Room visit

85% Reported that the visit averted a visit to an emergency room

93% Reported that the visit enabled them to see a provider sooner

To date, the program has:

- Enhanced Member Care
- Decreased Hospitalizations
- Improved Clinical Outcomes

~1,350 individual encounters in pilot program

Absolutely fabulous program. This truly saved me from another trip to the emergency room.

- CCA Member
Early KPIs | Reducing per episode cost

**Estimated Savings Disaggregation**

- **EMS Transport to the ED**: $350
- **ED visit without admission**: $1,200
- **Observation admission**: $2,600
- **Average cost of an inpatient admission**: $12,000
Right Care, Right Time, Right Location

35 y.o. Male with Left Ventricular Failure, Cardiomyopathy, end stage Congestive Heart Failure (CHF), hypokalemia, Cardiac Ejection Fracture 15%

• Married with 2 young children, desires to be at home with family
• Managed at home with Dobutamine infusion via PICC line
  – Skilled Nursing Facility would not accept Dobutamine
• Frequent symptoms of CHF with hypokalemia
• Telephone support, Nurse Practitioner visits, Visiting Nursing Association, Palliative Care Team
  – 11 visits by paramedics in last 3 months of his life
  – One hospital admission – 2 day stay
Next Steps

• **Awaiting final approval of MA regulations**

• **CCA is currently developing an expansion model**
  – Hours of operations will be modified
  – Expand into additional key marketplaces
  – Redundant resources
  – New models of care delivery (Mobile Integrated Health Light)

• **CHCS [Business Case Model]**
Community Paramedicine

Member
- Meet Needs
- Manage Expectations

Provider
- Right Care
- Right Time
- Right Location

Cost
- Fiscal Responsibility

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Questions?

To submit a question, please click the question mark icon located in the toolbar at the top of your screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Community Paramedicine Resources

- Community Paramedicine: Taking Care into the Home for Complex Populations
- The Business Case for Community Paramedicine: Lessons from Commonwealth Care Alliance’s Pilot Program
- Community Paramedicine Business Case Assessment Tool
- California Health Care Foundation’s Community Paramedicine Resources
- Video on California’s Community Paramedicine Pilot Program
Look for Part III of this Series

*Integrating Community Pharmacists into Complex Care Management Programs*

June 22, 2017, 12:00-1:30 pm ET
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