

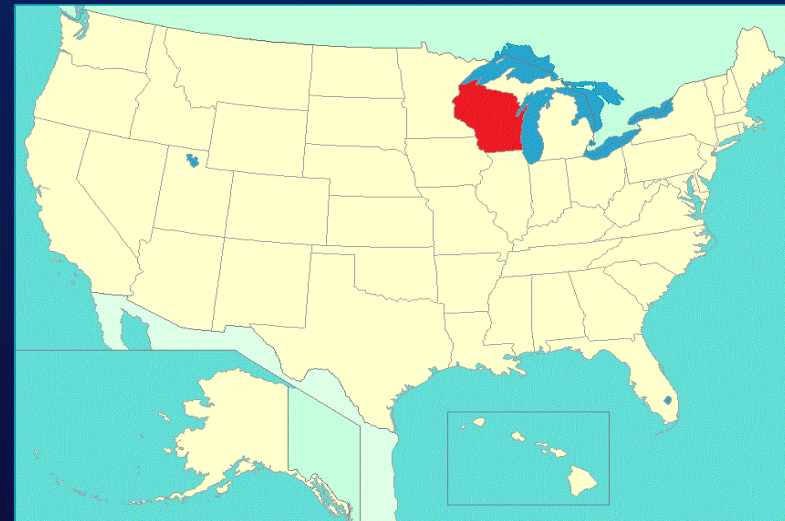


Community Paramedic Northwest Wisconsin

Gold Cross Ambulance

February 9th 2017

Barron County, Wisconsin
Population: 45,676
Square Miles: 890



Setting



Gold Cross Ambulance – Barron, WI

- Employs nine full-time Advanced Care Paramedics
- Receives approximately 1,500 combined emergent and nonemergent requests annually



Mayo Clinic Health System Northland

- 25-bed critical access hospital with a primary care clinic (445 employees)

Background

- Multi-disciplinary team of stakeholders
 - Emergency department physician leadership
 - Clinical Pharmacy
 - Health system administration
 - EMS leadership and research coordination
 - Nursing
 - Home Health and Hospice
 - Office of Population Health
 - Palliative Care
 - Quality Resources
 - Information Technology
 - Compliance
 - Local Paramedics

Background

- Two Advanced Care Paramedics attended a training program in Minnesota to earn certification
 - Hennepin Technical College - Minnesota
- Medical guidelines developed
- Vehicle and Equipment

Background

- Evaluated potential patient populations
 - frequent utilizers
 - at-risk for readmission
 - at-risk for falls
- Orientation delivered to primary care physicians

Patient Enrollment

- Initially
 - Six primary care physicians offered Community Paramedic referrals to patients they believed would benefit
- Referral's now coming from
 - Emergency department providers
 - Hospitalist's
 - Fall prevention program
 - Local ambulance service

Scheduling and Visits

- Community Paramedics utilize the hospital EMR for scheduling, patient history review and communication with referring physician and medical director
- In-home visits (1 hour)
 - History and exam
 - Medication compliance
 - Review and medication reconciliation
 - Home safety
 - Engagement of family members in care plan
 - Social Services when appropriate

Visit Follow-up

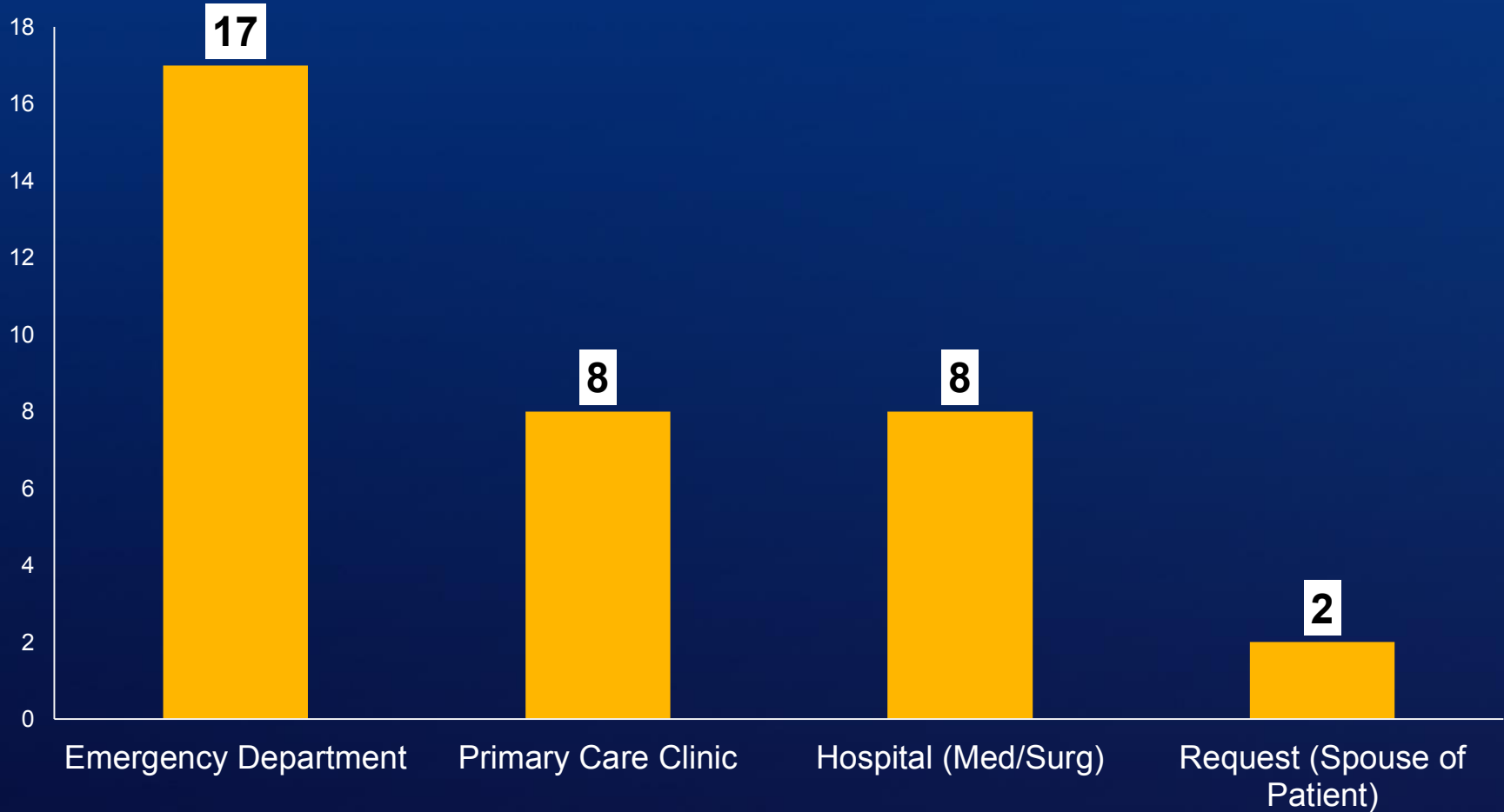
- Community Paramedic document assessments / treatments and communicate into the hospital EMR which triggers;
 - Note to the referring physician for patient care plan review
 - Note to the Medical Director for quality improvement review
 - Engage others involved in the care plan

Pilot

Demographics

- Patients enrolled = 35
- Total visits = 268 (range: 1 – 33)
- Median age: 77.7 years (range: 44 – 98)
- Gender: Female = 65.7% (23/35)

Referral by Department



Referral Reason

| <u>Reason</u> | <u>N</u> |
|--|------------|
| Management of Medical Condition | 14 (40.0%) |
| Falls and Home Safety | 7 (20.0%) |
| Hospital Discharge – High Risk for Readmission | 6 (17.1%) |
| Blood Pressure and Other Vital Sign Checks | 3 (8.6%) |
| INR Checks | 2 (5.7%) |
| New Patient – Access into the Health System | 2 (5.7%) |
| Rehabilitation Discharge – Transition Care | 1 (2.9%) |

Change in Utilization – All Referral Reasons

- Completion of six months post enrollment at analysis = **17 patients**

| | <u>Patients</u> | <u>Visits Before</u> | <u>Visits After</u> | <u>Reduction</u> |
|---|---|--------------------------|-------------------------|------------------|
| Reduced frequency of Primary Care Visits | 12 patients (70.6%) (None increased) | 32 | 13 | 59.4% decrease |
| Reduced frequency of Emergency Department Visits | 10 patients (58.9%) (none increased) | 53 | 34 | 35.8% decrease |
| Reduced frequency of Hospitalizations (n=4) | 1 patient (25.0%) (none increased) | 11 | 7 | 36.3% decrease |

Referral Reason: Management of Medical Condition

| <u>Primary Disease</u> | <u>N</u> |
|--------------------------|-----------|
| Diabetes | 5 (35.7%) |
| Chronic Pain | 4 (28.6%) |
| Respiratory | 2 (14.3%) |
| Poly Substance Addiction | 2 (14.3%) |
| Anxiety | 1 (7.1%) |

Completed six months post enrollment = 11

- Number of reduced clinic visits: 14
- Number of reduced ED visits: 16
- Number of reduced hospitalizations: 4

Other Referral Reasons

- Falls and home safety (n=7)
 - Patients had at least one fall prior to enrollment
 - Falls requiring healthcare after enrollment = 0
- INR and BP checks (n=5)
 - Laboratory clinic INR visits avoided = 48
 - Decrease in utilization = 8 other clinic visits

Other Referral Reasons

- High-Risk Readmission:
 - No patients have completed six months post enrollment (all have completed at least 3 months)
 - None of these patients have had a readmission since enrollment

Patient Experience Survey

| | <u>Improved</u> | <u>Unchanged</u> | <u>Declined</u> |
|---------------------------------|-----------------|------------------|-----------------|
| Overall Health Since Enrollment | 100% | 0% | 0% |
| Satisfaction with Program | 100% | 0% | 0% |
| Activity Performance | 48% | 43% | 10% |
| Anxiety | 43% | 29% | 29% |
| Mobility | 38% | 52% | 10% |
| Self-Care | 29% | 57% | 14% |
| Level of Pain | 29% | 43% | 29% |
| Comfort with Medications | 10% | 90% | 0% |
| Understands Care Plan | 10% | 90% | 0% |
| Satisfied with Heath Care Team | 0% | 100% | 0% |

Referring Physician Survey

| Survey Question | Agree | Undecided | Disagree |
|--|-------|-----------|----------|
| Referred patients benefit from the visit | 100% | 0% | 0% |
| I see improvement in health and wellness following a visit | 75% | 25% | 0% |
| I would recommend this process to other clinicians | 100% | 0% | 0% |

Challenges

- Documentation / Care Planning
- Outcome Measures
- Financial



Questions