commonwealth care alliance

Assessing Complex Patients
Sick vs. Not Sick

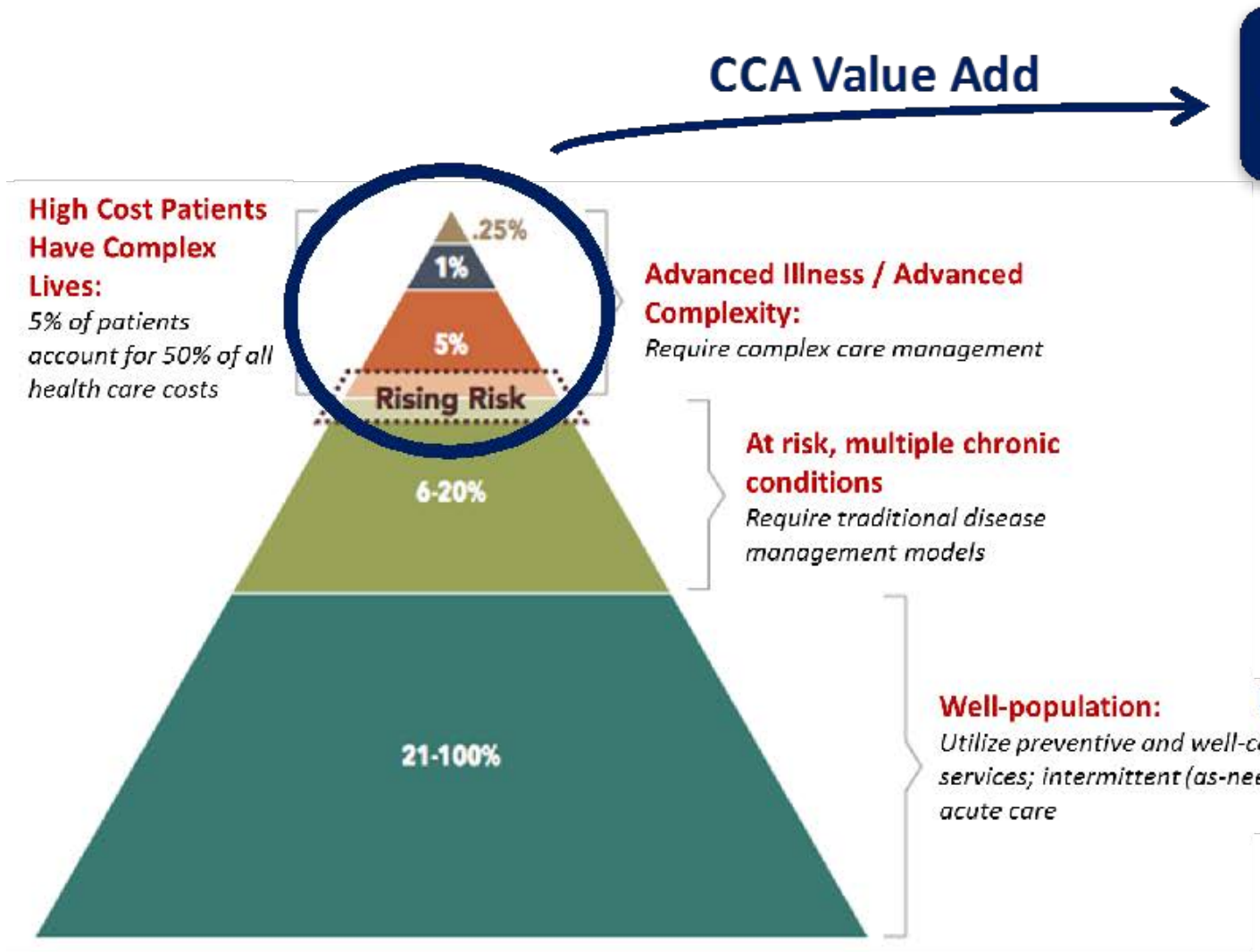
Matthew Goudreau, BSH, ACP

Who is Commonwealth Care Alliance?

CCA provides comprehensive, integrated care solutions for the system's most complex and costly individuals. We provide a suite of services to support payers and at-risk providers in managing these populations in a model with proven success.

- CCA is nationally recognized for our role in transforming health care payment and delivery, and has had notable success in revolutionizing care models that achieve the Triple Aim;
- CCA offers customized solutions to optimize management of the health and health care spending of our members – and it works!
- CCA is every building new synergistic models and partnerships to maximize our ability to improve care
- All CCA functions, from claims payment to member services and clinical service delivery, support the delivery of exceptional care to every member

Our Members Benefit from Specialized Models



CCA Value Add

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

Acute Care Community Paramedics: ACCP

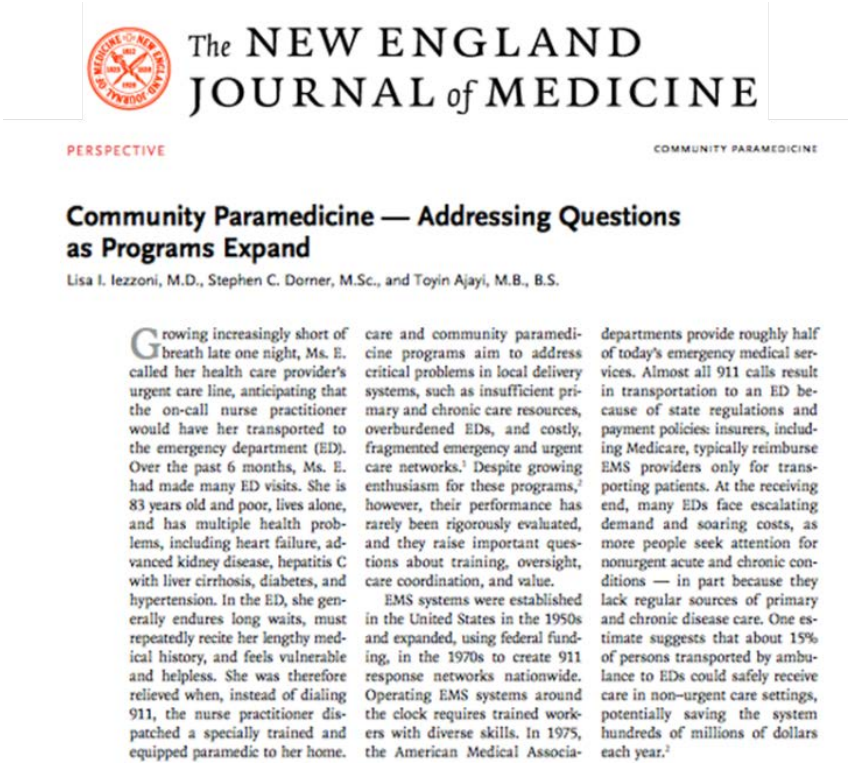
Embedded in Primary Care

Robust Quality and Compliance

Optimal Diagnostics & Treatment

Comprehensive Training

Early KPIs | Exceptional experience & ED diversion



The NEW ENGLAND JOURNAL of MEDICINE

PERSPECTIVE COMMUNITY PARAMEDICINE

Community Paramedicine — Addressing Questions as Programs Expand

Lisa I. Iezzoni, M.D., Stephen C. Dorner, M.Sc., and Toyin Ajayi, M.B., B.S.

Growing increasingly short of breath late one night, Ms. E. called her health care provider's urgent care line, anticipating that the on-call nurse practitioner would have her transported to the emergency department (ED). Over the past 6 months, Ms. E. had made many ED visits. She is 83 years old and poor, lives alone, and has multiple health problems, including heart failure, advanced kidney disease, hepatitis C with liver cirrhosis, diabetes, and hypertension. In the ED, she generally endures long waits, must repeatedly recite her lengthy medical history, and feels vulnerable and helpless. She was therefore relieved when, instead of dialing 911, the nurse practitioner dispatched a specially trained and equipped paramedic to her home. care and community paramedicine programs aim to address critical problems in local delivery systems, such as insufficient primary and chronic care resources, overburdened EDs, and costly, fragmented emergency and urgent care networks.[1] Despite growing enthusiasm for these programs,[2] however, their performance has rarely been rigorously evaluated, and they raise important questions about training, oversight, care coordination, and value.

EMS systems were established in the United States in the 1950s and expanded, using federal funding, in the 1970s to create 911 response networks nationwide. Operating EMS systems around the clock requires trained workers with diverse skills. In 1975, the American Medical Associa- departments provide roughly half of today's emergency medical services. Almost all 911 calls result in transportation to an ED because of state regulations and payment policies: insurers, including Medicare, typically reimburse EMS providers only for transporting patients. At the receiving end, many EDs face escalating demand and soaring costs, as more people seek attention for nonurgent acute and chronic conditions — in part because they lack regular sources of primary and chronic disease care. One estimate suggests that about 15% of persons transported by ambulance to EDs could safely receive care in non–urgent care settings, potentially saving the system hundreds of millions of dollars each year.[3]

~1,750 individual encounters in pilot program

CCA members surveyed after CP 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

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

To date, the program has:

Enhanced Member Satisfaction	Decreased Hospitalizations	Improved Clinical Outcomes
↑	↓	↑

Why use Paramedics?

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Assessing Sick versus Not Sick

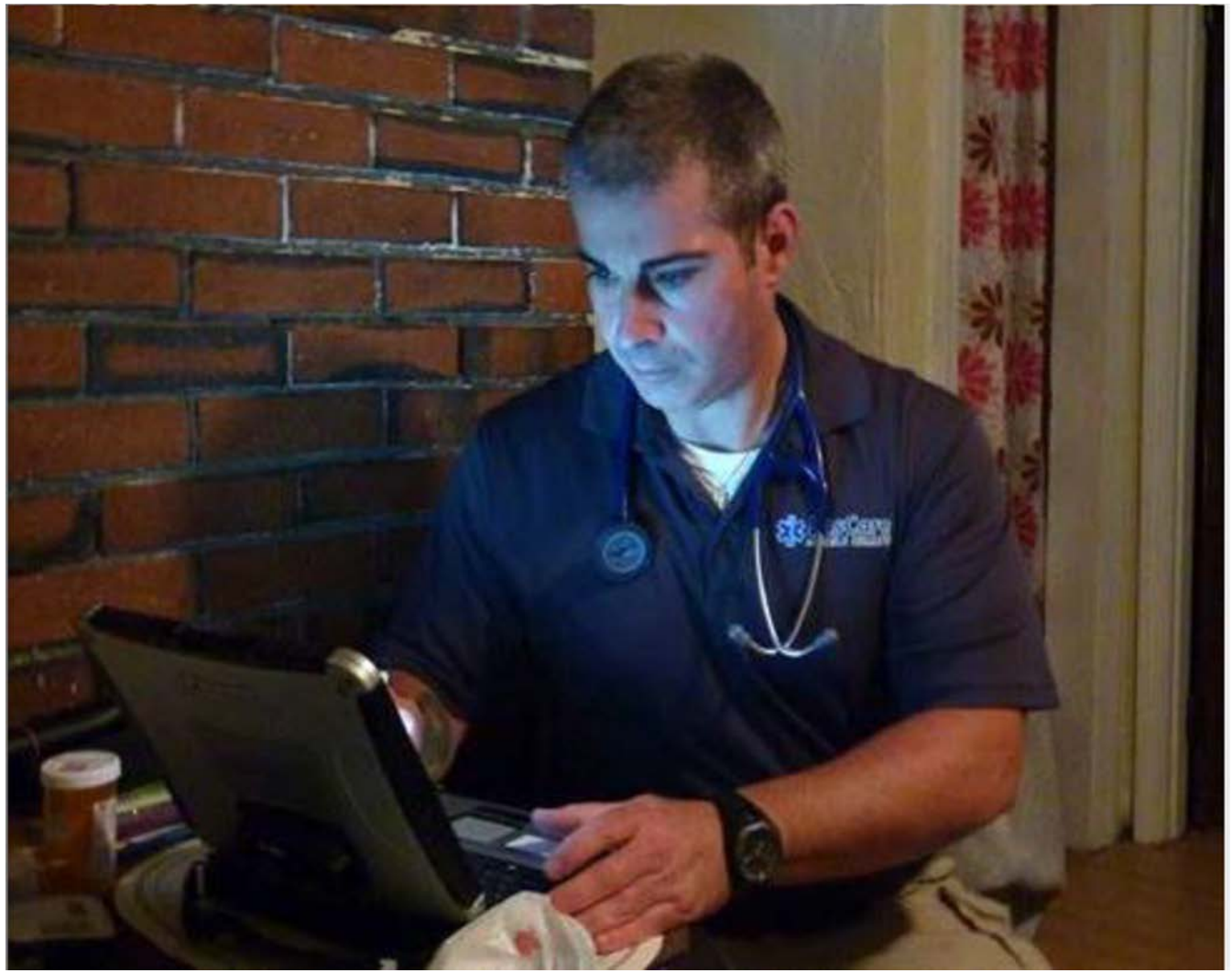
How Does This Work: Build on Paramedics Strengths

Paramedic Strengths: First Impressions

"I felt that I could speak with the paramedic very easily. Thank you for the visit!"

- CCA Member

Access to member's EMR through eClinical Works:



Critical Component:

ACCESS to EMR!

Primary care team has capability to enter "Alert" notes with specific instructions and guidance for unique characteristics of individual member.

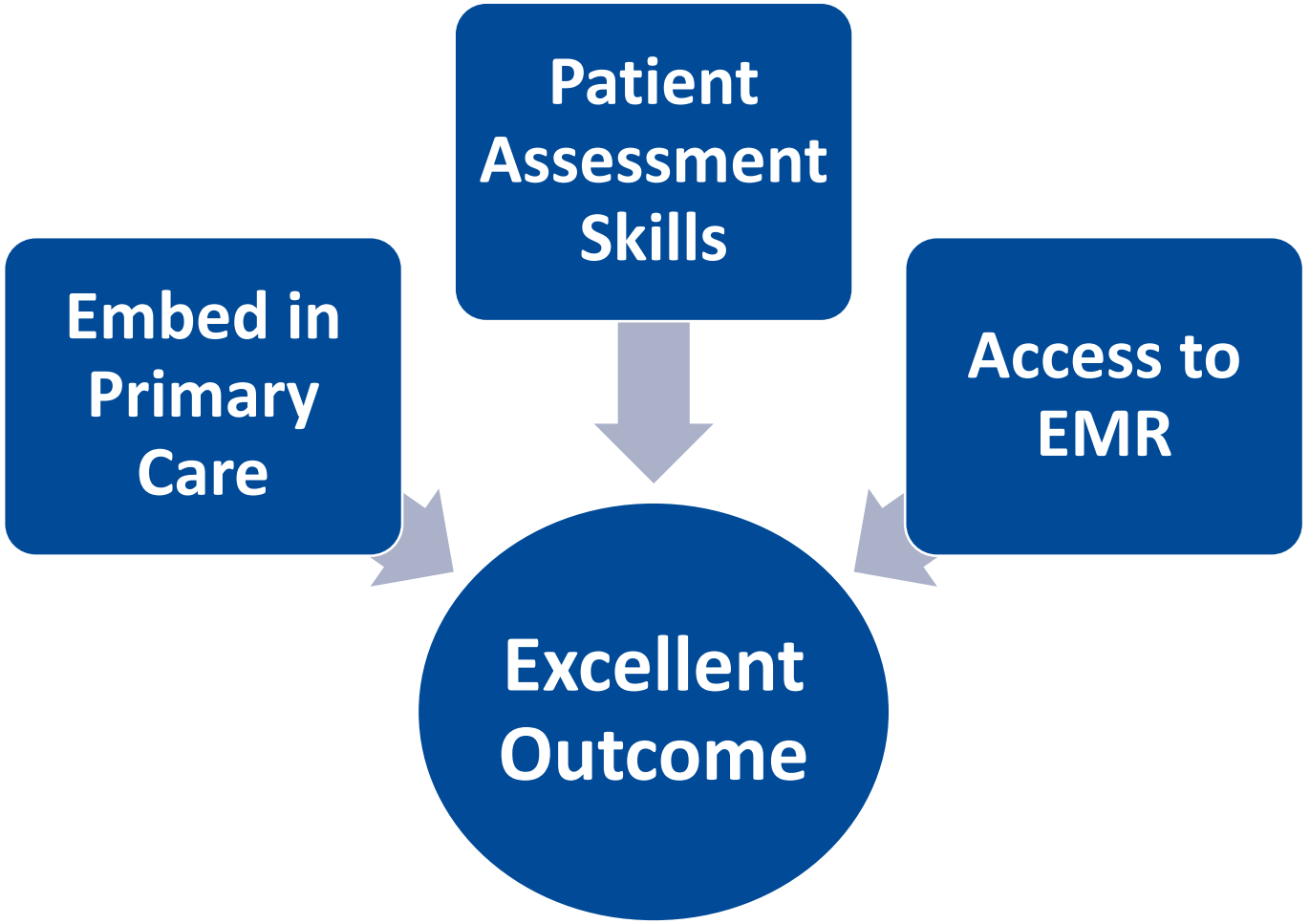
Paramedic Strengths: Acute Clinical Assessment

Ability to recognize Sick from Not Sick

Complex Patients: Appear Sick at Baseline

- ***75% of SCO members are nursing home eligible with 4+ complex conditions.***
- ***70% of OC members have behavioral health condition***
- ***60% of patients get admitted from the Emergency Dept.***
    - **40% of these are avoidable**

Paramedic Strengths: Acute Clinical Assessment



- 92% are cared for in the home
- 8% to the ED at 72 hours post CP visit
- 85% report the visit saved them a trip to the ED

Community Paramedicine

Member
- Meet Needs
- Manage Expectations

Provider
- Right Care
- Right Time
- Right Location

Cost
- Fiscal Responsibility

Matthew Goudreau, BSH, ACP
mgoudreau@commonwealthcare.org