IRCP 2017

LAUNCH OF A COMMUNITY PARAMEDIC PROGRAM WITHIN A HEALTH CARE SYSTEM

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OF CLINICAL & SUPPORT SERVICES

OBJECTIVES

- SHARE ALLINA HEALTH'S DEVELOPMENT OF CP PROGRAM
- LESSONS LEARNED
- PROGRAM RESULTS
- RECOMMENDATIONS

- Allina Health Hospital
- Allina Health Ambulatory Care Center
- Allina Medical Clinic
- Allina Health clinics (formerly known as Aspen Medical Group)
- Quello Clinic

Cambridge Medical Center

Buffalo Hospital

Twin Cities Metro Area

River Falls Area Hospital

St. Francis Regional Medical Ctr

Regina Medical Center

New Ulm Medical Center

Owatonna Hospital

Allina Health hospitals

- Abbott Northwestern Hospital, Minneapolis
- Buffalo Hospital
- Cambridge Medical Center
- Mercy Hospital, Coon Rapids
- New Ulm Medical Center
- Owatonna Hospital
- Phillips Eye Institute, Minneapolis
- Regina Medical Center
- River Falls Area Hospital, Wisconsin
- St. Francis Regional Medical Center, Shakopee (jointly owned with Essentia Health Critical Access Group and HealthPartners)
- United Hospital, St. Paul
- Unity Hospital, Fridley

Allina Health Ambulatory Care Centers

- Abbott Northwestern's Center for Outpatient Care, Edina
- Abbott Northwestern – WestHealth, Plymouth
- Elk Ridge Health, Elk River

Allina Health clinics

(formerly know as Aspen Medical Group)

- Allina Health Bandana Square Clinic
- Allina Health Bandana Square Sleep Center
- Allina Health Bloomington Clinic
- Allina Health East Lake Street Clinic
- Allina Health Highland Park Clinic
- Allina Health Hopkins Clinic
- Allina Health Inver Grove Heights Clinic
- Allina Health Maplewood Clinic
- Allina Health University Avenue Clinic
- Allina Health Vadnais Heights Clinic

Quello Clinic Sites

- Burnsville
- Chanhassen
- Edina
- Lakeville
- Savage

Allina Medical Clinic Sites

- Annandale
- Blaine
- Brooklyn Park
- Buffalo
- Cambridge
- Champlin
- Cokato
- Coon Rapids
- Coon Rapids: Midwest Surgery
- Coon Rapids: Women's Health
- Cottage Grove
- Eagan
- Eagan: Parkview OB/GYN
- Edina
- Elk River
- Faribault
- Farmington
- Forest Lake
- Fridley: Bariatric Surgical Specialties
- Fridley: OB/GYN Specialists
- Hastings: First Street
- Hastings: Hininger Road
- Maple Grove
- Minneapolis: Isles
- Minneapolis: Nicollet Mall
- Minneapolis: The Doctors Uptown
- North Branch
- Northfield
- Plymouth: WestHealth Campus
- Prescott
- Prior Lake: Crossroads
- Ramsey
- Richfield: Woodlake
- St. Michael
- St. Paul: United Medical Specialties St. Paul
- Shakopee
- Shakopee: Crossroads – Dean Lakes
- Shoreview
- West St. Paul
- Woodbury

Allina Health

ABOUT ALLINA HEALTH

PATIENT CARE FACILITIES:

- 65 ALLINA HEALTH CLINICS
- 49 REHABILITATION LOCATIONS
- 23 HOSPITAL-BASED CLINICS
- 12 HOSPITALS
- 15 RETAIL PHARMACIES
- 2 AMBULATORY CARE CENTERS
- HOME CARE, HOSPICE, PALLIATIVE CARE OFFERINGS
- HOME MEDICAL EQUIPMENT
- EMERGENCY MEDICAL SERVICES

KEY FIGURES FROM 2016

- 27,536 EMPLOYEES
- 1,775 STAFFED BEDS
- 109,091 INPATIENT HOSPITAL ADMISSIONS
- 1.5 MILLION HOSPITAL OUTPATIENT VISITS
- 31,780 INPATIENT SURGICAL PROCEDURES
- 60,077 OUTPATIENT SURGICAL PROCEDURES
- 343,083 EMERGENCY CARE VISITS
- 15,364 BIRTHS
- 4.5 MILLION CLINIC VISITS
- 231,656 HOME HEALTH VISITS
- 146,724 HOSPICE VISITS
- 937,619 RETAIL PHARMACY PRESCRIPTIONS FILLED
- 195,666 OXYGEN/MEDICAL EQUIPMENT ORDERS
- 107,810 AMBULANCE RESPONSES

ALLINA HEALTH EMS

POSITIVES:

- PART OF A LARGE INTEGRATED HEALTH SYSTEM
- LARGE, EMS AGENCY WITH LARGE NUMBER OF SENIOR PARAMEDICS
- ACTIVE MEDICAL DIRECTORS
- MINNESOTA JOBS SKILL PARTNER GRANT FOR COMMUNITY PARAMEDIC TRAINING

CHALLENGES:

- PART OF LARGE INTEGRATED HEALTH SYSTEM
- COMPETITION WITH OTHER PROJECTS
- NO ESTABLISHED CONNECTION WITH PRIMARY CARE AND IN-HOSPITAL PROVIDERS

ALLINA HEALTH-EMS

- LARGE GEOGRAPHIC AREA (URBAN, SUBURBAN, & RURAL)
- POPULATION OF 1,000,000 IN PSA
- 270 RESPONSES EACH DAY – 100K/YEAR

MINNESOTA PARTICULARS

- 2011 - LAW PASSED RECOGNIZING COMMUNITY PARAMEDIC CREDENTIAL
  - EDUCATIONAL REQUIREMENTS
  - EXPERIENCE REQUIREMENTS
  - AMBULANCE MEDICAL DIRECTOR RECOMMENDATION
- 2012- RECEIVED ABILITY TO BILL MEDICAID
- 2012 – MINNESOTA JOBS SKILLS GRANT
  - GOAL TO TRAIN 100 CPS

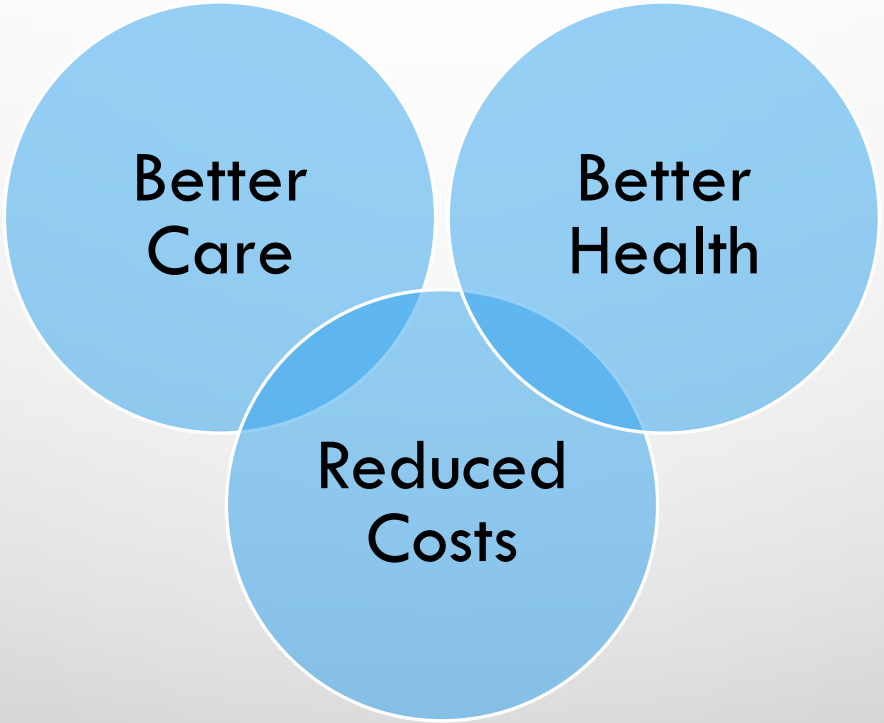
ALLINA HEALTH MISSION

WE SERVE OUR COMMUNITIES BY

PROVIDING EXCEPTIONAL CARE, AS WE

PREVENT ILLNESS, RESTORE HEALTH AND PROVIDE COMFORT TO ALL WHO ENTRUST US WITH THEIR CARE.

BUILDING OUR CASE - TRIPLE AIM 2010

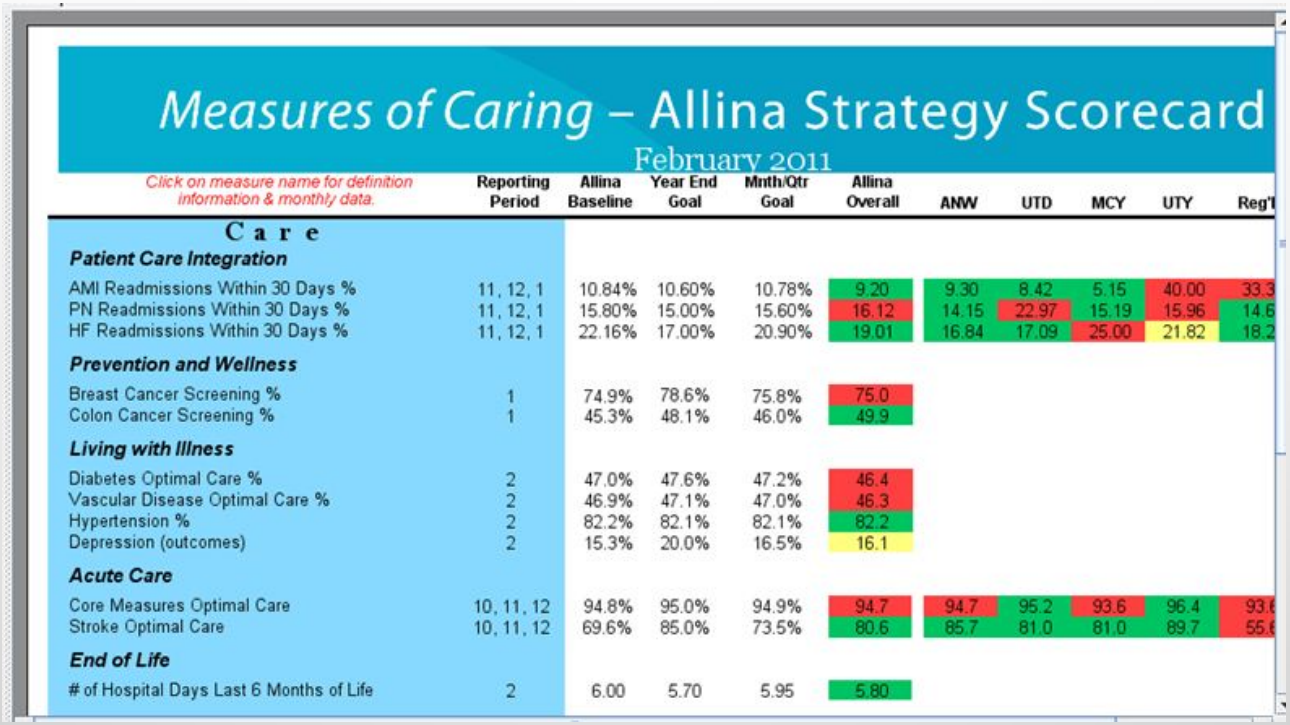


VISION

WE WILL:

- PUT THE PATIENT FIRST
- MAKE A DIFFERENCE IN PEOPLE'S LIVES BY PROVIDING EXCEPTIONAL CARE AND SERVICE
- CREATE A HEALING ENVIRONMENT WHERE PASSIONATE PEOPLE THRIVE AND EXCEL
- LEAD COLLABORATIVE EFFORTS THAT SOLVE OUR COMMUNITY'S HEALTH CARE CHALLENGES

GAP ANALYSIS



Measures of Caring – Allina Strategy Scorecard

February 2011

Click on measure name for definition information & monthly data.	Reporting Period	Allina Baseline	Year End Goal	Mnth/Qtr Goal	Allina Overall	ANW	UTD	MCY	UTY	Reg'l
Care										
Patient Care Integration										
AMI Readmissions Within 30 Days %	11, 12, 1	10.84%	10.60%	10.78%	9.20	9.30	8.42	5.15	40.00	33.3
PN Readmissions Within 30 Days %	11, 12, 1	15.80%	15.00%	15.60%	16.12	14.15	22.97	15.19	15.96	14.6
HF Readmissions Within 30 Days %	11, 12, 1	22.16%	17.00%	20.90%	19.01	16.84	17.09	25.00	21.82	18.2
Prevention and Wellness										
Breast Cancer Screening %	1	74.9%	78.6%	75.8%	75.0					
Colon Cancer Screening %	1	45.3%	48.1%	46.0%	49.9					
Living with Illness										
Diabetes Optimal Care %	2	47.0%	47.6%	47.2%	46.4					
Vascular Disease Optimal Care %	2	46.9%	47.1%	47.0%	46.3					
Hypertension %	2	82.2%	82.1%	82.1%	82.2					
Depression (outcomes)	2	15.3%	20.0%	16.5%	16.1					
Acute Care										
Core Measures Optimal Care	10, 11, 12	94.8%	95.0%	94.9%	94.7	94.7	95.2	93.6	96.4	93.6
Stroke Optimal Care	10, 11, 12	69.6%	85.0%	73.5%	80.6	85.7	81.0	81.0	89.7	55.6
End of Life										
# of Hospital Days Last 6 Months of Life	2	6.00	5.70	5.95	5.80					

Ambulatory Census Dashboard

Identified DCs/Referrals: 277 | Selected DCs/Referrals: 277

Selected Filters

< < | Clear All Filters | > >

Program
- Advanced Care Team
- Cardiology Care Coordination
- Mental Health Care Coordination
- Oncology Care Coordination

Role
- Care Guide
- Pharmacist
- RN Care Coordinator
- RN/Pharmacist
- RN/Social Worker
- Social Worker

The ACO Case-Finding sheet includes hospital discharges for ACO patie
assigned risk for readmission. It also includes ambulatory referrals to ca

Days Since DC or Referral

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7

Highest Readmit Risk
- High
- Moderate-High
- Moderate
- Low
- Not Assigned

Team
- North Region
- East Region
- West Region
- No Assigned Region

Additional Filters
- Currently Enrolled
- LOS Days

Discharges/Referrals of ACO Patients in Last 7 Days

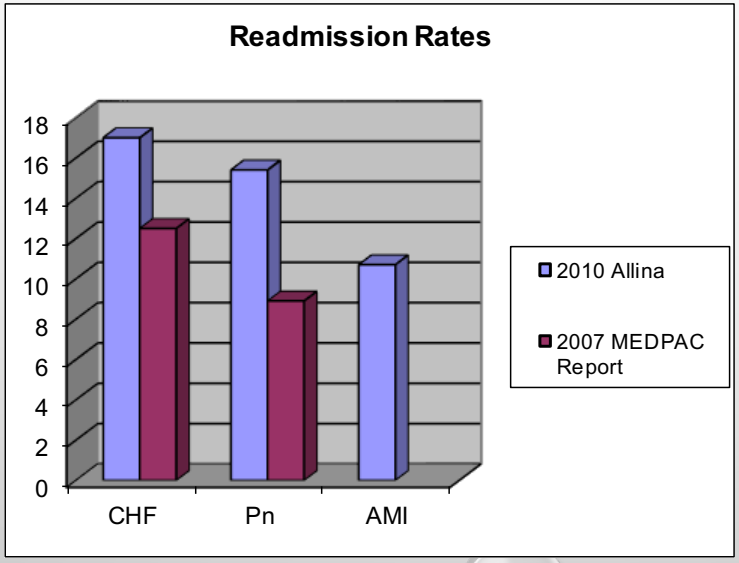
Highest Readmit Risk	Discharge Date	MRN	Currently Enrolled?	Hospital	Patient Type	Hosp. Primary Problem	DC Status	LOS Days	Last ACT Start Date	# ED Visits in 6 Months w/ Same Problem	>= 2 ED Visits in 6 Months	Living Situation
High			N	United	Inpatient	NSTEMI (non-ST eleva...	Home Self Care	6.4	-	0	N	Home/Indepen...
High			Y	Abbott	Inpatient	Closed left hip fracture	Skilled Nursing Fa...	14.5	8/12/2014	0	N	Home/Indepen...
High			Y	Abbott	Emerge...	Chest pain	Home Self Care	0.1	8/11/2014	6	Y	-
High			Y	Abbott	Inpatient	Effects of radiation, u...	Home Health	29.4	-	0	Y	Home/Indepen...
High			Y	United	Inpatient	Acute kidney failure, u...	Home Self Care	1.9	7/22/2014	1	Y	Home/Indepen...
High			Y	Mercy	Inpatient	Colitis	Skilled Nursing Fa...	4.9	-	0	Y	Home/Indepen...
High			N	United	Inpatient	Acute on chronic systol...	Home Self Care	2.1	5/20/2014	1	Y	Home/Indepen...
High			Y	Abbott	Inpatient	Unspecified epilepsy w...	Skilled Nursing Fa...	27.1	8/20/2014	0	Y	Nursing Home
High			Y	Mercy	Inpatient	Acute pancreatitis	Home Health	16.0	6/4/2014	0	Y	Home/Indepen...
High			Y	Abbott	Inpatient	Intervertebral cervical...	Skilled Nursing Fa...	7.4	8/19/2014	0	N	Home/Indepen...
High			Y	United	Inpatient	Acute gouty arthropathy	Home Self Care	3.8	5/19/2014	0	Y	Home/Indepen...
High			Y	Mercy	Inpatient	Sepsis	Home Self Care	3.9	-	0	Y	Home/Indepen...
High			Y	Abbott	Inpatient	Pneumonia, organism ...	Home Self Care	5.3	8/19/2014	0	N	Home/Indepen...
High			Y	United	Inpatient	Acute kidney failure wi...	Home Self Care	5.0	7/22/2014	0	Y	Home/Indepen...
High			Y	United	Inpatient	Hemorrhage of gastro...	Home Self Care	6.3	8/11/2014	0	N	Home/Indepen...
High			Y	Abbott	Observa...	Olecranon bursitis	Skilled Nursing Fa...	0.8	8/18/2014	0	Y	Nursing Home
High			Y	River Falls	Inpatient	-	Home Self Care	0.9	5/27/2014	0	Y	Home/Indepen...
High	-		Y	Abbott	Inpatient	Confusion	* Still Admitted *	0.7	8/19/2014	0	Y	Home/Indepen...
High	-		N	Abbott	Inpatient	Hyperkalemia	* Still Admitted *	0.9	5/21/2014	0	Y	Home/Indepen...

HOW CAN WE. . . .

- CONTRIBUTE MORE TO THE ORGANIZATION?
- FULFILL OUR MISSION?
- PROVIDE BETTER CARE FOR OUR PATIENTS?
- DEVELOP A CAREER TRACK FOR PARAMEDICS?

COST OF READMISSIONS

OVER $7,000 PER READMISSION IN ADDITION TO THE STRESS IT PLACES ON PATIENTS AND FAMILIES.



SMALL TEST OF CHANGE . . . .

- PARTNERED WITH RURAL HOSPITAL WITH HIGH READMISSIONS AND NO STAFF FOR FOLLOW UP
- PRIOR TO CERTIFICATION FOR CPS
- TEACHING CARE MANAGEMENT STAFF ABOUT OUR CAPABILITIES
- COMPETENCIES

STARTING POINT

- READMISSIONS
  - TRANSITION CARE MANAGEMENT
    - GEOGRAPHIC CHALLENGES
    - STAFFING CHALLENGES
- EMS TO THE RESCUE
  - PARAMEDIC OUTREACH PROJECT
    - ON-DUTY STAFF POSITIONED TO ASSIST
    - SMALL POPULATION

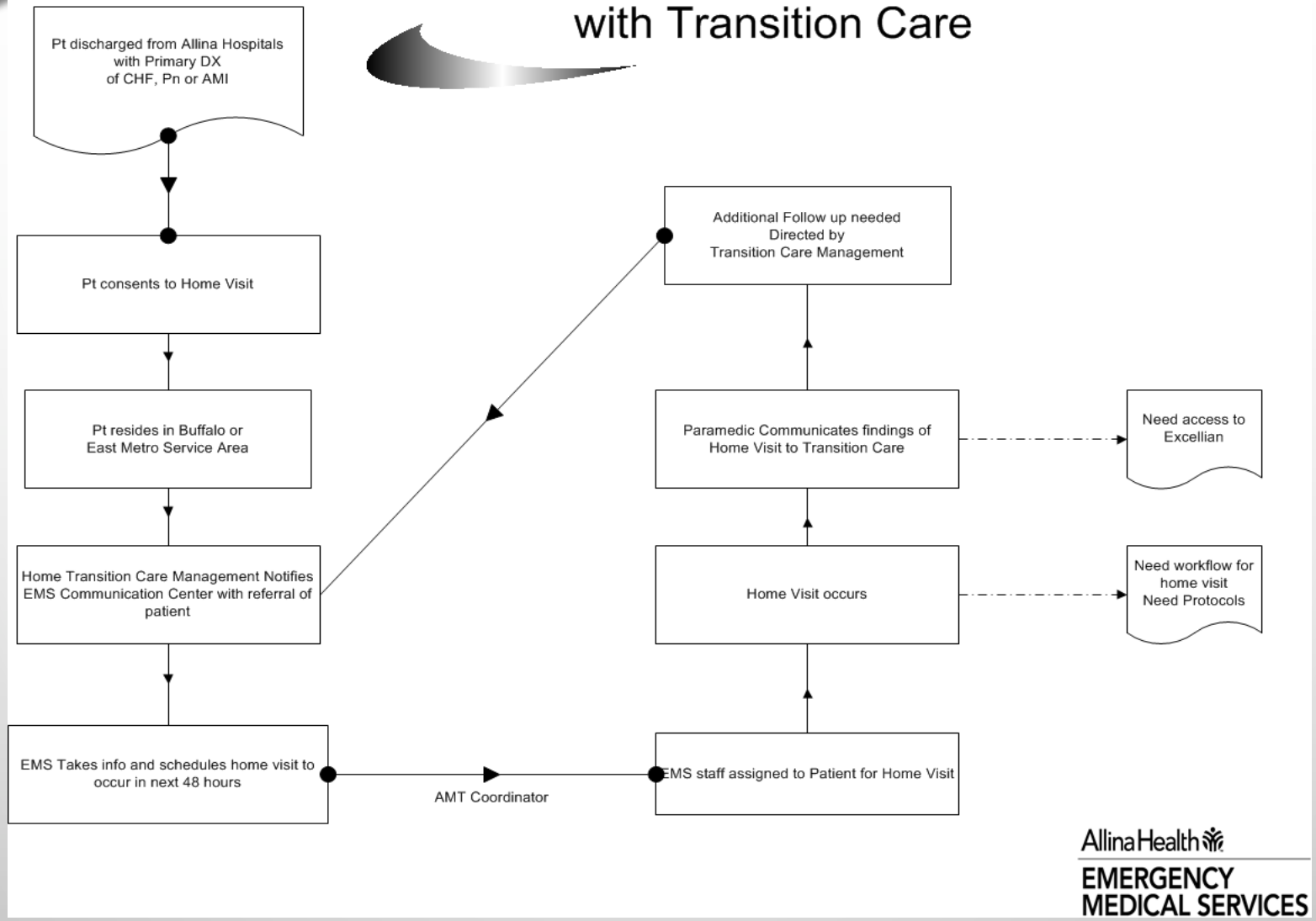
PARAMEDIC OUTREACH PARTNERSHIP PROJECT

- SELECTION
- TRAINING
- CARE MANAGEMENT RN
- PRIMARY CARE
- SOCIAL WORKERS / CASE MANAGERS

POPP PILOT

- TRAINED 4 PARAMEDICS TO PROVIDE HOME VISITS
  - SPECIFIC TASKS BASED ON TRANSITION CARE STEPS
- SMALL POPULATION
  - 4 PATIENTS IN 30 DAYS
  - PATIENT SATISFACTION EQUALED OR EXCEEDED RN VISITS
- IN LOWER VOLUME LOCATION, COULD USE ON-DUTY RESOURCES WITHOUT DETRIMENT TO 911 RESPONSE

Paramedic Outreach Partnership with Transition Care



MEASURES

- HOME VISITS COMPLETE WITHIN 48 HOURS OF REFERRAL
- PATIENT SATISFACTION
- SYSTEM WIDE MEASURES OF READMISSIONS

CHALLENGES

- SMALL POPULATION BASE
- 4 PARAMEDICS INVOLVED / SCHEDULING
- DOCUMENTATION CHALLENGES

DOCUMENTATION CHALLENGES

CHF Home Visit – Paper form

	Question	Possible answers
Discharge Information	Location of Assessment	Home Clinic Cardiac Rehab Other(specify in note)
	Hospital Discharge Date	
	Hospital Discharged From *(type in the name of the hospital)*	
	Number of days between discharge and home visit	
Vitals	Pulse	
	Blood Pressure	
	Arm	Right arm or Left arm
	BP Position	Sitting Standing Lying down
	Respirations	
	SpO2	
	O2 (LPM)	1 2 4 6
	O2 Device	Cannula Mask Other
	Lung Sounds	Bilateral Clear Bilateral Crackles-Coarse Bilateral Crackles-Fine Bilateral Rhonchi Bilateral Diminished Bilateral Wheeze Respiratory Left Crackles Coarse ----- Left Crackles Fine Left Rhonchi Left Diminished Left Wheeze Resp Right Crackles Coarse Right Crackles Fine Right Rhonchi Right Diminished Right Wheeze Respiratory Unable to assess Other

Other	Patient's Condition — Heart Failure **In Excellian, when you click the cascade icon, a window opens so that you can select the Heart Failure group and add it to the flowsheet.**	Heart Failure
	Heart Failure Questions on paper:	
	Do you have a scale?	Yes or No
	Scale Provided?	Yes or No or N/A
	Discharge Weight *(enter weight)*	
	Today's weight	
	Are you weighing daily?	Yes or No
	Are you writing down your weight daily?	Yes or No
	Do you know when to notify your doctor of a weight gain? (3 lbs in 1 day; 5lbs in 1 week)	Yes or No
	Name 2 foods low in salt that you can eat	Chicken Fish Fresh fruit Low Sodium Vegetables
	Name 2 foods high in salt that you should avoid	Canned Food Processed Food Processed Meat Table Salt
	Diet education provided today	Yes or No
	Which of the following symptoms are you experiencing?	Chest Pain Confusion Denies any pain Dry, hacky cough Dyspnea Dyspnea on exertion Fatigue Foot and ankle swelling or edema Inability to lie flat Persistent cough Pink tinged phlegm Short of breath Sleep sitting up in chair Struggling to breath Weight gain Other

GRANT

- GOAL TO TRAIN 100 PARAMEDICS FROM 3 EMS SYSTEMS
  - 312 HOUR PROGRAM
    - 196 HOURS OF CLINICALS
- CLINICAL NEEDS PROVIDED OPPORTUNITY TO EDUCATE HOSPITAL & PRIMARY CARE PROVIDERS
- HELPED IDENTIFY NEW OPPORTUNITIES / GAPS

Clinical sites

- CARDIOVASCULAR
- RESPIRATORY
- HOSPICE
- SENIOR CARE TRANSITIONS
- COMMUNITY OUTREACH
- HOME CARE
- BEHAVIORAL HEALTH
- DIABETIC EDUCATORS
- CARE MANAGEMENT
- PRIMARY CARE
- WOUND CARE

CP IMPLEMENTATION - SEPT 2013

- ACCOUNTABLE CARE ORGANIZATION
  - FOCUS ON BEHAVIORAL HEALTH PATIENTS
- HOSPITAL READMISSIONS
  - HIGH RISK PATIENTS
- EXPANDED TO FREQUENT ED USERS 2014

HOME VISITS

- COMPLETE MEDICATION RECONCILIATIONS
- PERFORM A HOME SAFETY ASSESSMENT
- ADDRESS ANY CONCERNS OF REFERRING PROVIDER – MAY BE TAKING WEIGHTS OR OTHER VITALS
- REVIEW NUTRITION
- HELP CONNECT PATIENT AND FAMILY TO RESOURCES THEY MAY NEED (MAY REFER TO HOME CARE, ETC)
- TRANSPORT TO APPOINTMENTS – LIMITED TO BH PATIENTS

Community Paramedic Post-Hospital Discharge

General Home Visit Checklist

Community Paramedic _____ Location of Assessment: _____

Patient Name: _____ MRN: _____

Primary Care Provider: _____ Clinic Location: _____

Discharge Information

Hospital Discharge Date: _____ Hospital: _____

Discharge Diagnosis: _____

Vital Signs (if applicable):

Pulse: _____ Blood Pressure_____ Resp _____ Sp02_____ O2_____

Medication Review

Current Medications: _____

New Medications: _____

Barriers to taking medication: _____

Review of Medication Instructions Completed: ☐ Yes ☐ No Comments: _____

Daily Activity Review- Indicate Presence of Concern:

☐ Yes ☐ No **Understanding of Illness** Comments: _____

☐ Yes ☐ No **Independence** Comments: _____

☐ Yes ☐ No **Finances** Comments: _____

☐ Yes ☐ No **Nutrition** Comments: _____

☐ Yes ☐ No **Safety** Comments: _____

☐ Yes ☐ No **Vulnerability** Comments: _____

☐ Yes ☐ No **Environment** Comments: _____

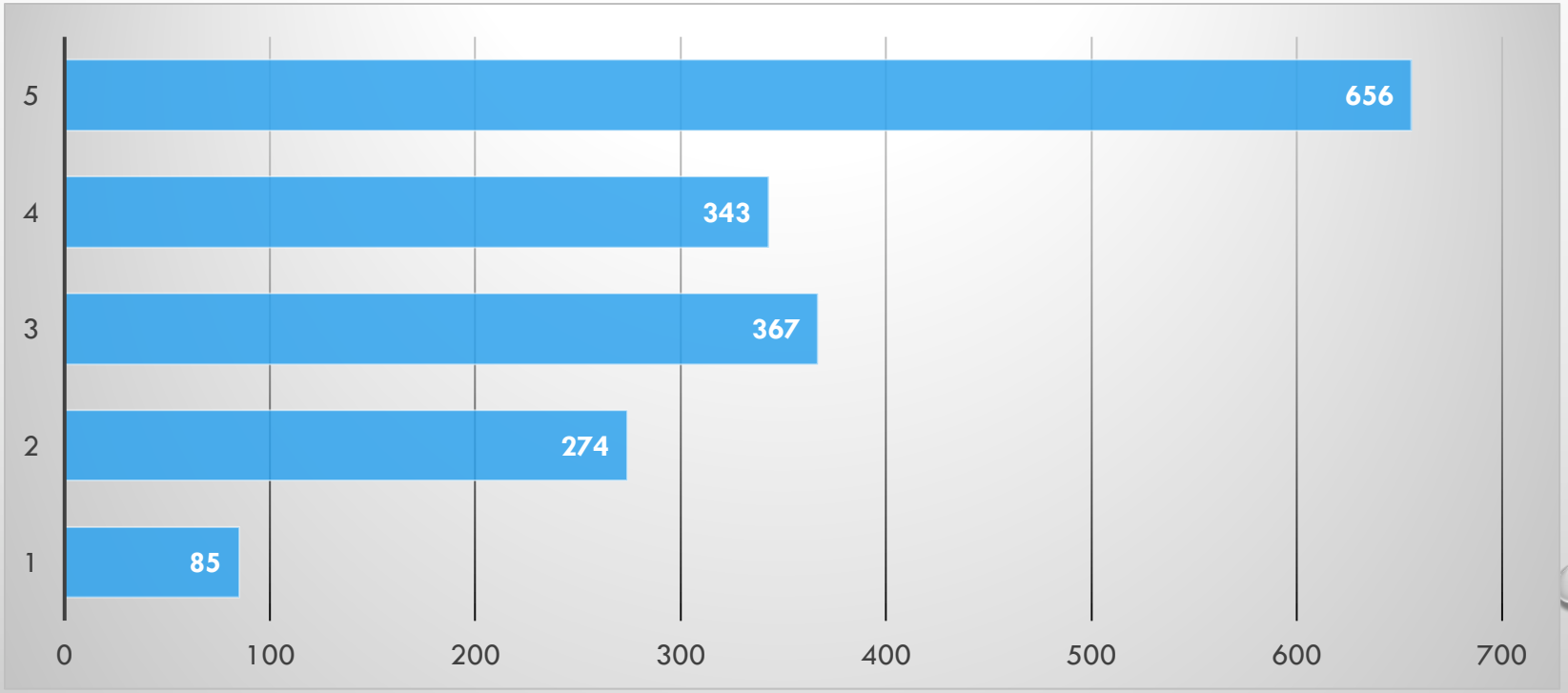
☐ Yes ☐ No **Smoking** Comments: _____

Action Summary

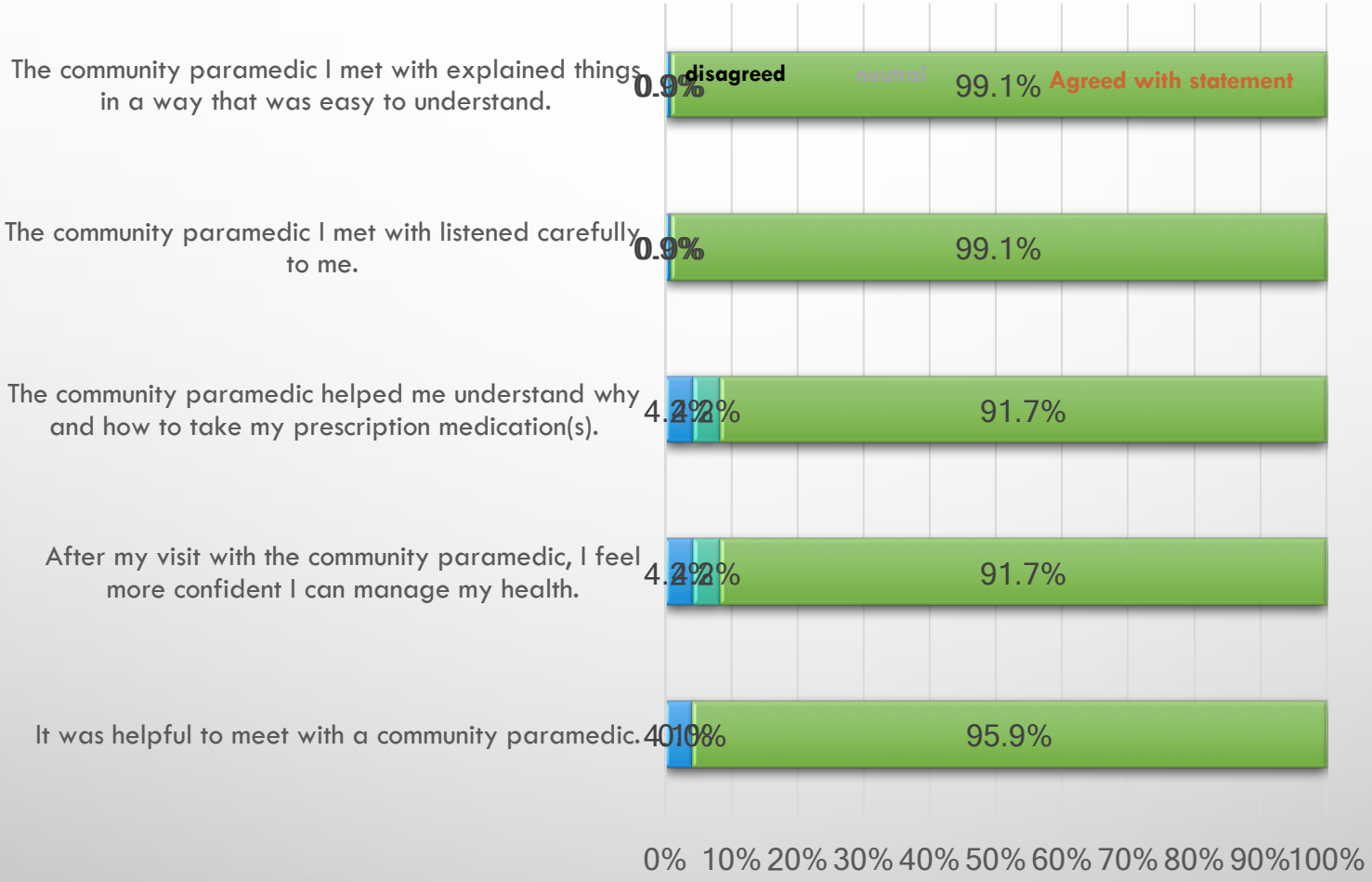
INITIAL RESULTS

- 22 PATIENTS WITH ↑ PREDICTION OF READMISSION AND FREQUENT ED USE
  - 1 READMISSION AT DAY 36 – 97.2% SUCCESS RATE
  - 1 READMISSION AT DAY 45
- HIGH UTILIZATION ER
  - 78% PATIENTS DID NOT HAVE A RETURN VISIT TO THE ER WITHIN 30 AFTER THEIR HOME VISIT.

CP VISITS 2013-2017 (JAN-SEP)



Most patients agree that it is helpful to meet with a community paramedic. (n = 50)



EXPANSION OPPORTUNITIES

- CARDIOLOGY PATIENTS
- EXPANDING CARE MANAGEMENT
- DIABETES PATIENTS
- AFTER VISIT – DECREASING LOS

RECOMMENDATIONS

- WHAT IS YOUR BUSINESS PLAN? CREATE THE DOCUMENT!
  - DO YOUR GAP ANALYSIS
  - WHERE CAN YOU HAVE IMPACT
  - WHO ARE THE STAKEHOLDERS
  - GET THEM ONBOARD EARLY
- WHAT ADDITIONAL TRAINING DO YOUR PARAMEDICS NEED?
- METRICS/DATA
  - HOW WILL YOU MEASURE SUCCESS?

GOOD LUCK IN DEVELOPING YOUR PROGRAMS!

Community Paramedic Programs