Community Paramedicine in CHF Care

Non-Traditional Options for Managing Chronic Disease Processes

Disclosures

No Financial Disclosures

Community Paramedicine

An Emerging Part of MEMS'

Mobile Integrated Health Program

Current State of Community Needs

- America's Health Rankings places Arkansas at 47th in the U.S. in terms of health
- Limited access to regular healthcare for certain types of patients
  - Transportation needs
  - Communication challenges
  - Family/support systems
- Lack of ability to navigate the healthcare system and public assistance programs available

Current State of Community Needs

- Overburdened Emergency Departments
- Lack of sufficient psych facilities
- Overtaxed Primary Care Physicians
- Fewer PCPs coming out of school
- Increasing number of people with greater healthcare needs

Factors necessitating change in how we care for our population…

- *Hospitals are under pressure to decrease* patient LOS. Discharging some before they are fully ready to care for themselves at home.
    1. Physical limitations
    2. Knowledge deficit
    3. Support system
    4. Access to resources
    5. Overwhelmed case managers and home health nurses
- Emergency Departments are being used inappropriately by patients that can't or won't take measures to care for themselves

Results in…

- Return to Hospital within 30 days of D/C, which financially penalizes hospitals
- Unable to access physician when needed leads to:
  1. Call 911 for transport to ED
  2. Use of ambulance, ED bed, diagnostic testing, possible unnecessary admission after hours of tying up an ED bed
     - This leads to further delays in ED care for other patients
     - Fewer beds for EMS to bring patients to in the ED
     - Dissatisfied patients in the hospital (which also impacts reimbursement)

What can be done about it?

Enter…

Community Paramedicine

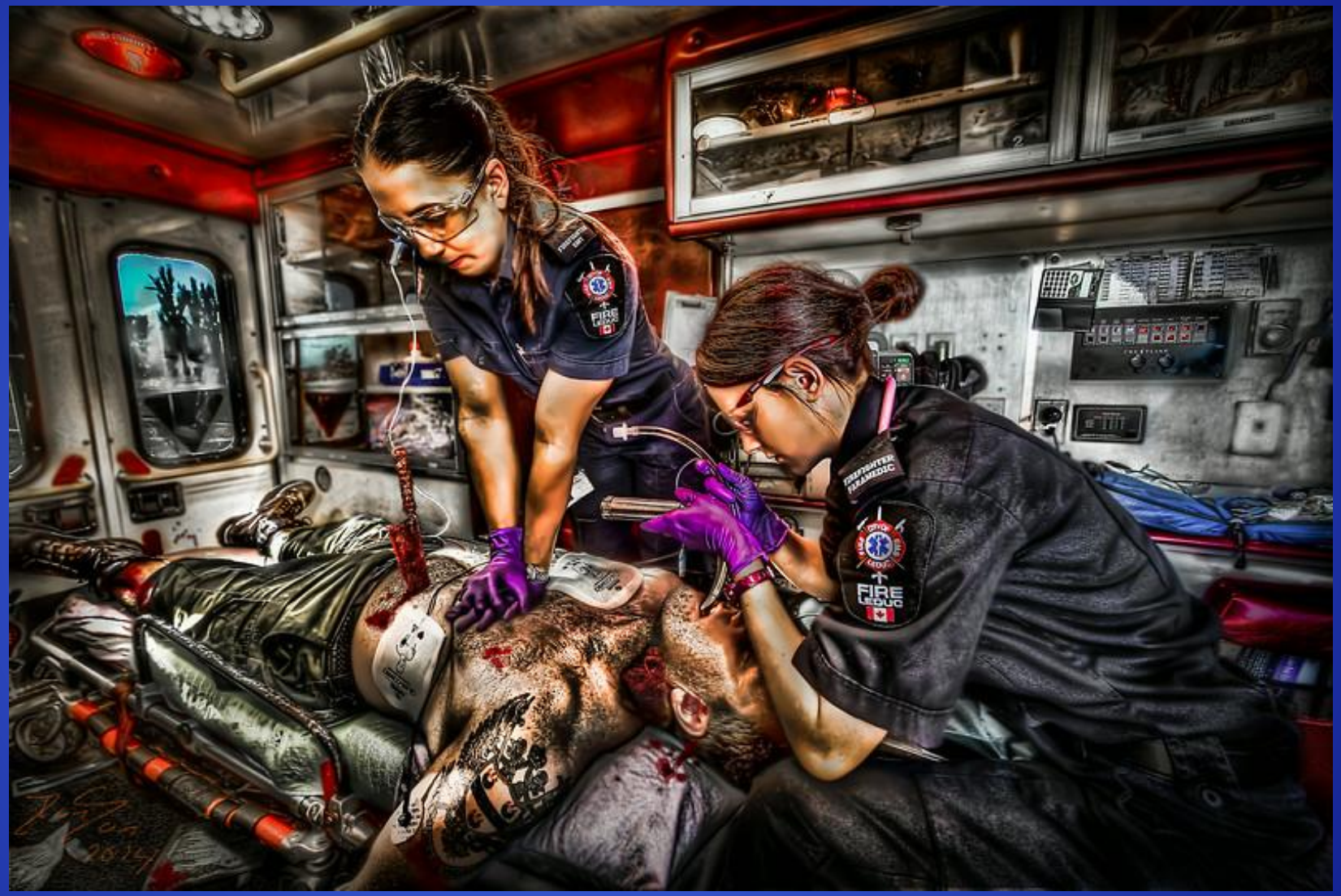
through

Mobile Integrated Health

"The call, before the 911 call"

A Community Paramedic is not…

A CP is not John & Roy



A CP is not an emergency response medic

A CP is not a nurse…

A Community Paramedic is…

A Community Paramedic is…

- A Guide (through the healthcare system and community resources)
- An Observer (of interactions and environment)
- A Listener (patience is key with this phase)
- A Teacher (must be able to relate on the client's level)
- A Coach (and cheerleader)
- A Psychologist (what is the underlying need?)
- A Primary Care Provider (eyes of physician)

Qualifications

State and Nationally Licensed Community Paramedic

- Minimum of two years fulltime experience as a paramedic
- Currently working for a licensed paramedic service
- 300 hours of additional education in community health arena
  - 100 hours didactic followed by 200 hours of clinical in areas of primary care, lab, case management, home health, social work, public health clinics, PT, and other nontraditional areas for paramedic education.
- National Certification Exam

Bridging gaps, NOT competing

Provide services that are not available to the client

- Home Health refusal or disqualification
- Medication inventory and organization
- Specific disease education
- Chronic disease management in the home
  - CHF is one of the most often referred (compliance related)
  - Diabetes, especially new diagnosis
  - COPD

Bridging Gaps, NOT competing

Community Paramedicine wants to augment services that are already in place

- Home Health assistance
- Hospice Revocation avoidance
- Readmission avoidance
- Two-midnight rule (Observation Admit Avoidance)

MIH-CP and CHF

Patient Education & Scheduled Home Visits

An enrolled patient receives a series of home visits conducted by a specially trained MEMS Mobile Healthcare Practitioner. These home visits are designed to:

1. Educate the patient and family on the appropriate ways to manage their disease process.
    a. Diet and weight compliance
    b. Medication understanding and compliance
    c. Healthy lifestyle changes
2. Educate and reinforce to the patient how to utilize their primary/specialty care network to help manage the disease process.
    a. When and how to call for an appointment
    b. Important information to share with care providers

MIH-CP and CHF

- Management via phone vs. in person with scheduled visits
- First visit is longest with detailed assessment of environment, meds, pantry, social support system, weight, V.S. and ECG if appropriate
- Encourage to contact CHF clinic or MIH department between visits, before calling 9-1-1 if not a true emergency
- Diuretic Protocol with consultation of specialist or MEMS Medical Director to prevent unnecessary trip to ER
  - Adjust medications in the field
  - IV diuresis to be followed by an in-office visit as directed

30-day CHF Readmission Avoidance Program

These home visits are weighted to be more frequent in the first week post-discharge and then gradually become less frequent as the patient is empowered to manage their own care. The first visit is typically the longest duration as this visit includes a detailed assessment of the patient's environment, a full review of all their prescribed medications, and a complete assessment of vital signs and 12 lead ECG tracings as appropriate. The patients are also provided educational workbooks to document their progress.

During the intake visit, the patient is also asked to assess their own health status using the EQ-5D-3L process by EuroQol.

30-day CHF Readmission Avoidance Program

Unscheduled Home Visits:

The patient is provided a 10-digit, non-emergency access number for the MEMS Mobile Healthcare Provider in the event they would like a phone consultation or an unscheduled home visit between scheduled visits.

30-day CHF Readmission Avoidance Program

Diuretic Protocol:

In consultation with the patient's PCP, Cardiologist or the MEMS Medical Director, patients who are suffering fluid retention can either have their medications adjusted in the field, or in some cases, receive IV diuretics with an in-office follow-up appointment to prevent an unnecessary trip to the Emergency Department.

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