Prisma Health
Oconee Memorial Hospital
Community Paramedic Program

June 2023

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Recognitions

Kent Whitten, Director EMS Administration, Prisma Health EMS

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Dr. Brett Murphy, Hospitalist, Chief Physician Executive Oconee Memorial Hospital

Prisma Health Oconee Memorial Hospital Community Paramedic Program

Why

- Increased safety in patient transitions of care from the hospital to home
- Targeted high-risk patients to reduce hospital readmissions

Where

- Oconee Memorial Hospital

Who

- Multidisciplinary team including physicians, Community Paramedics, Hospital Care Management team

When

- Started July 2022

Features/Benefits

- Individually tailored treatment plan developed post hospital discharge
- Can visit with patients as frequently as needed and provide acute treatments to help prevent 30-day readmission
- Additional layer of care added to home health for patient stability
- Consultations have occurred for in-home care with telehealth (Vidyo), TelMedIQ, and phone discussions with PCP's, Hospitalists, Specialists, and on-call physicians in Emergency Medicine.
- Medical services include (but not limited to):
  - iStat labs including Chem 8, Lactic Acid, VBG, CBC, troponin, BNP, UA sampling
  - Point-of-Care ultrasound
  - EKG/cardiac monitoring
  - Administration of IV fluids, IV antibiotics, IV diuretics
  - Flu vaccines
  - Medication adjustments
  - Disease education and medication reconciliation

Qualifications for enrollment

- LACE+ readmission risk score of 65 or greater automatically enrolls the patient if patient agreeable (order will be placed by HCM team)
- Manual provider referral for the following:
  - patients admitted with sepsis
  - patients with current readmission for same prior admission diagnosis
  - any patient felt to be at high risk of readmission or with complex medical history that would benefit from additional layer of care after DC

PRISMA HEALTH Mobile Integrated Health Community Paramedic Patient workflow

Referral is pulled from EPIC Workque

Contact is made with Patient for scheduling

No

Patient Refuses Program

Yes

Patient Accepts program

Initial Visit (Domain Score Calculated and Goals Established)

Discharged

Scheduled Visits Frequency based off established scale*

Reevaluation

Graduation**

**Graduation = Meeting patients health goals and a Domain score < 20.

***Domain Score scale**

- **< 20 Episodic**
- **21-30 1 x week for 6 weeks**
- **31-39 2 x week for 6 weeks**

Reevaluation @ 6 weeks

Program Exclusions

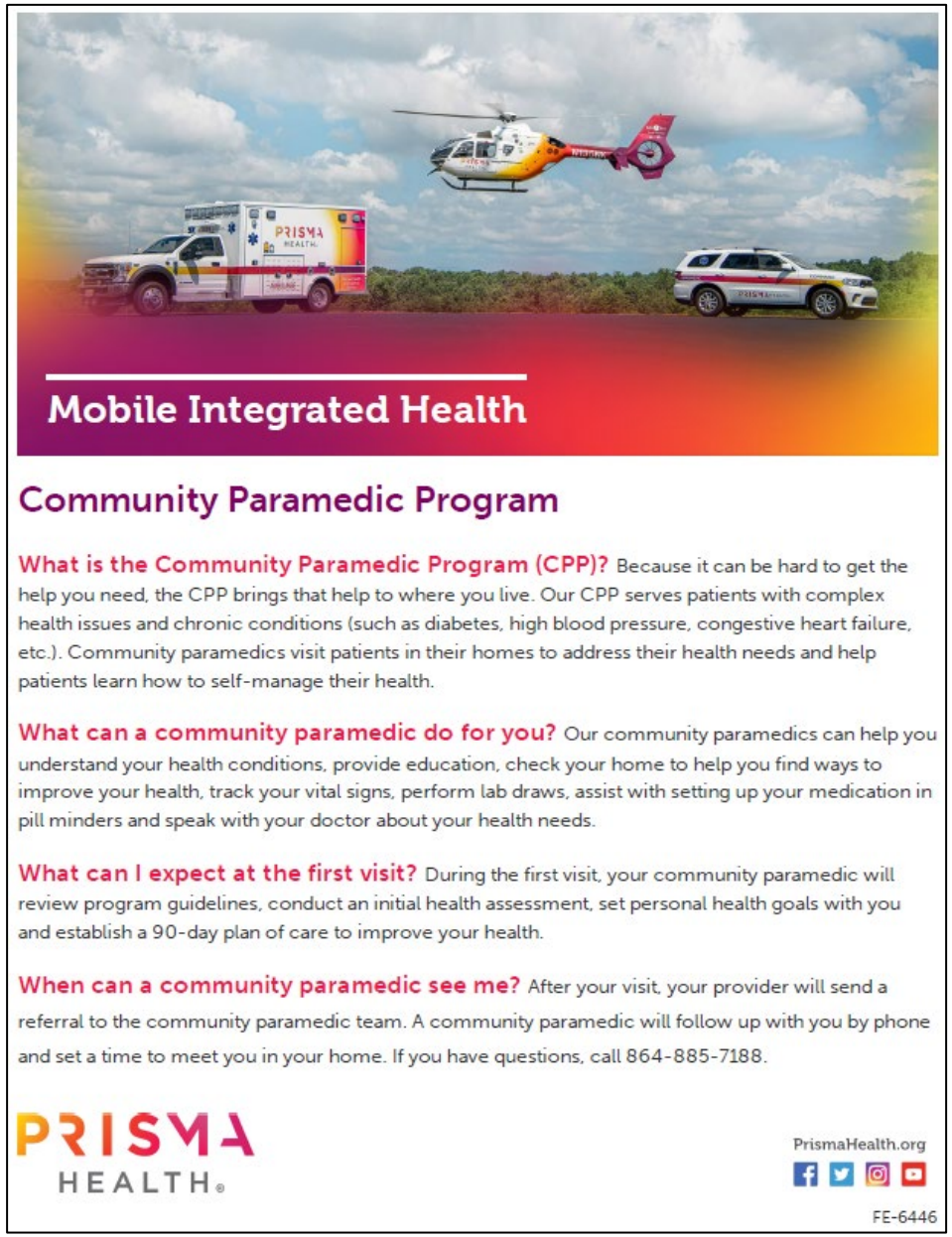
- Unplanned Discharge:
  - Unsafe conditions
    - Suspected drug abuse, violence, or irate patients
  - "No-show" without prior notification x 3
  - Non-adherence to the medical plan/goals
  - Relocation
  - Patient/family refusal or request to end program

Results

- First 4 months of the Program (July 2022 – October 2022):
  - Hospital readmissions down from peak around 14% to low of 10.4%
  - Excess Days in Acute Care (EDAC) down from 14.2% to 4.89%
- Avoidance of 30-day readmission or ED visit for total of 158 seen patients = 88%
- Decrease of EDAC = 66% from baseline
- Patients that were deemed Not Appropriate, Refused services, Deceased, SNF, etc. = 486
- Referral participation rate is steady at around 33%

Results continued

- OMH Community Paramedic program data through April 2023:
  - Total patients referred = 1,014
    - Total patients seen/graduated: 242
    - Total patients referred still in hospital: 38
    - Total patients ready to be scheduled for first CPP visit: 42
    - Patients actively being seen: 66
  - % seen by CPP vs referred and refused/not appropriate = 36%
  - Total patients completing 30-day CPP = 176
  - % of hospital admissions within 30 days while in CPP = 8%
  - % of ED visits within 30 days while in CPP = 19%
  - FY23 Oct – April: approximately **$300,000** in potential cost savings with readmission reduction



Next Steps:

- Expansion of inclusion criteria to LACE+ of 60 or greater for automatic referral
- Creation of educational handout for patients/families to help potentially increase enrollment agreement into the program and create standard language around discussion of the program benefits by team members
- Hopeful integration of Supportive Care Team (Palliative Care) outpatient model into this service to bundle this as Post-acute care transition service bundle
- Leverage statewide legislation for support and growth of this program model in community hospital settings.