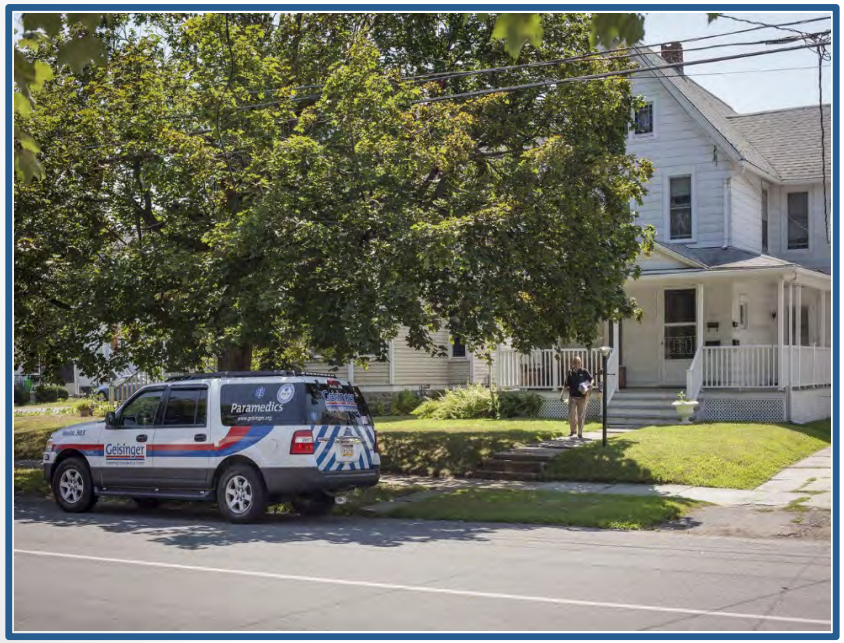
Community Based Care
Mobile Health Paramedic/Mobile Integrated Health



David J. Schoenwetter, DO, FACEP
Medical Director,
Geisinger EMS and Geisinger Life Flight

Kathleen Sharp, CPC, CMM, LBB
Senior Performance Innovation Consultant

Urgent Matters Conference
Sunday, October 25, 2015

Hoste, B. (2015, August 18). [Geisinger Mobile Health Paramedic]. The Wall Street Journal.

GEISINGER
REDEFINING BOUNDARIES®

Mobile Paramedic (MHP) Pilot

WNEP Healthwatch

NEWSWATCH 16 WNEP

There's No Place Like Home: Paramedic Home Care for Cardiac Patients

Mobile Integrated Health Pilot

Project Goal:

Under the umbrella of Community Based Care (CBC), develop a delivery model to provide the right care in the right location using Mobile Health Paramedics.

This program will not compete with existing programs like visiting nursing, but will augment these programs by caring for those who do not meet criteria for existing programs or will fill existing program gaps.

Patient-centered selection criterion is based on acuity, proximity, and condition:

- High utilizers of ED
- Medically Complex Patients
- Heart Failure patients

Mobile Health Paramedic Pilot Design Evolution

Targeted populations:

GEISINGER HEALTH PLAN®

Commercial, Medicare, Medicaid

MEDICARE HEALTH INSURANCE

Medicare FFS

Patient Selection Criterion:

- Reside within 20 mile radius of platform
- Patient of Heart Failure Clinic or
- Patient of one of 5 Primary Care sites or
- Patient presents to ED

Mobile Health Paramedic Program Background

Pilot Attributes:

- Mobile equipment Technology for care providers
- Integration with Nurse Navigator or Case Manager
- Direct link to Primary Care Providers
- Address gaps in care

Mobile Health Paramedic

Expanded ***"Role"***

<u>NOT</u> Expanded ***"Scope"***

Hoste, B. (2015, August 18). [Geisinger Mobile Health Paramedic]. The Wall Street Journal.

Mobile Health Paramedic Services

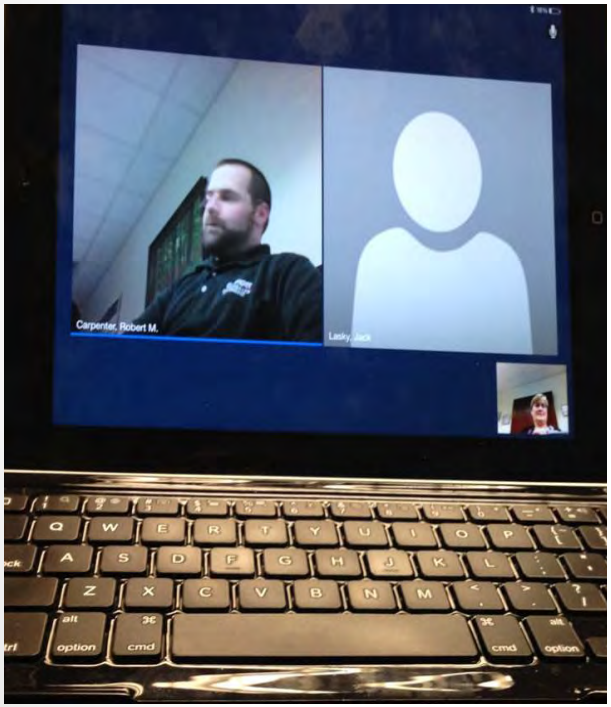
- Medical Home Support
- Heart Failure Clinic
- HF ProvenCare Follow-up
- Home Diuresis
- Medically Complex Medical Home Support
- Discharge PLUS (GWV ED)
- ED call backs
- End of Life (POLST)

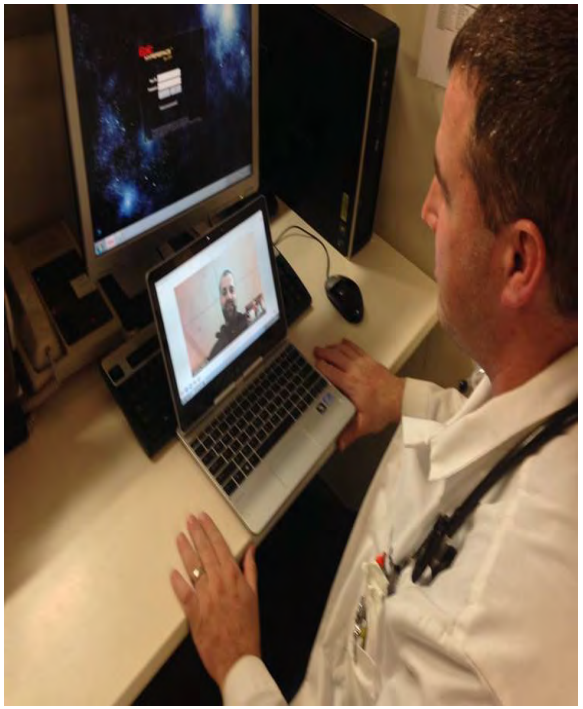
MHP Results: Geisinger In-Home Firsts

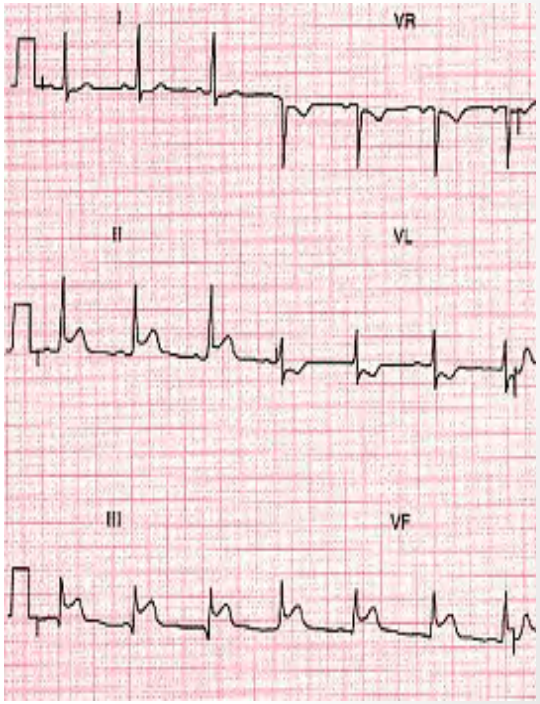
Tele-Connectivity

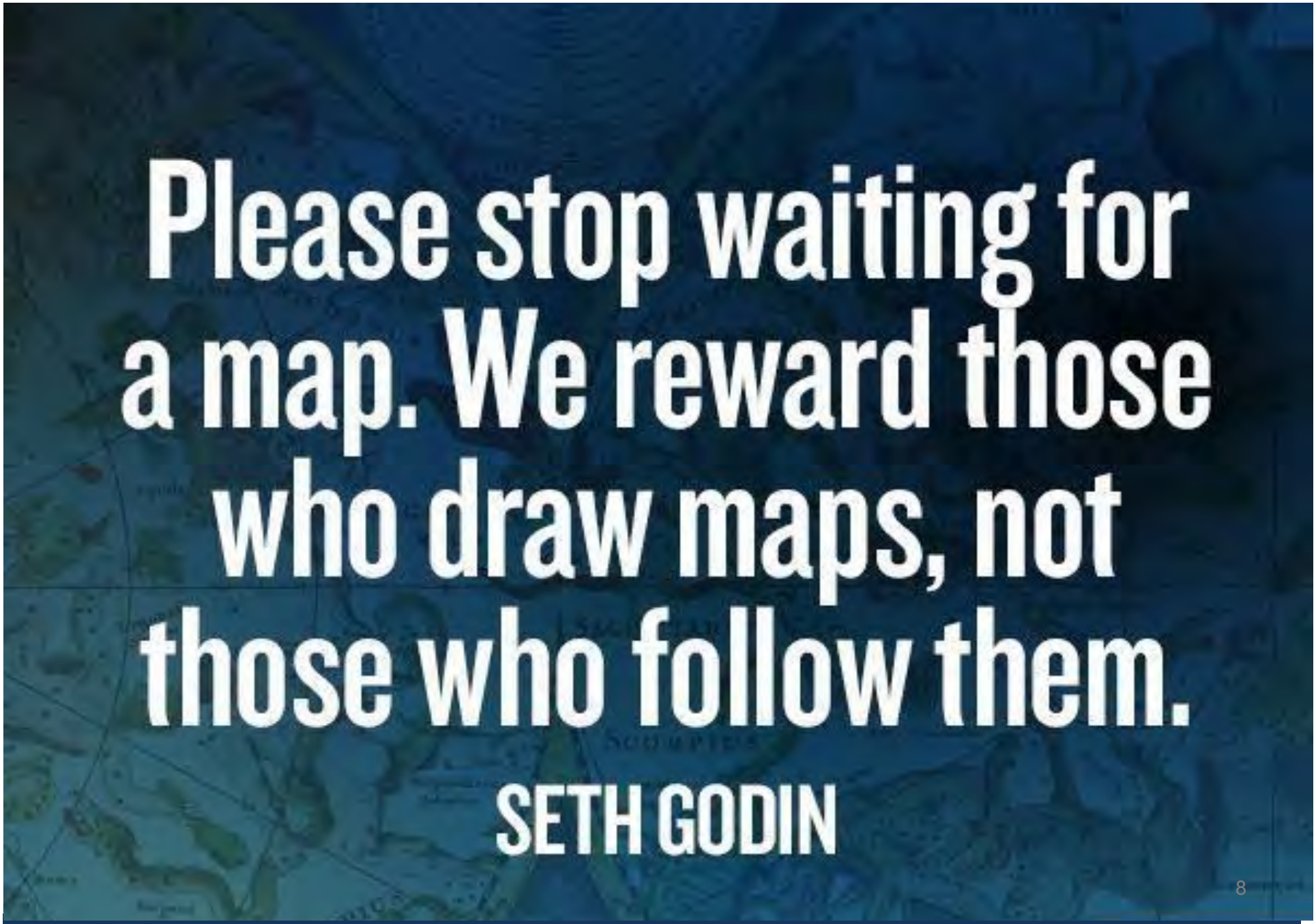
Epic

12 Lead EKG

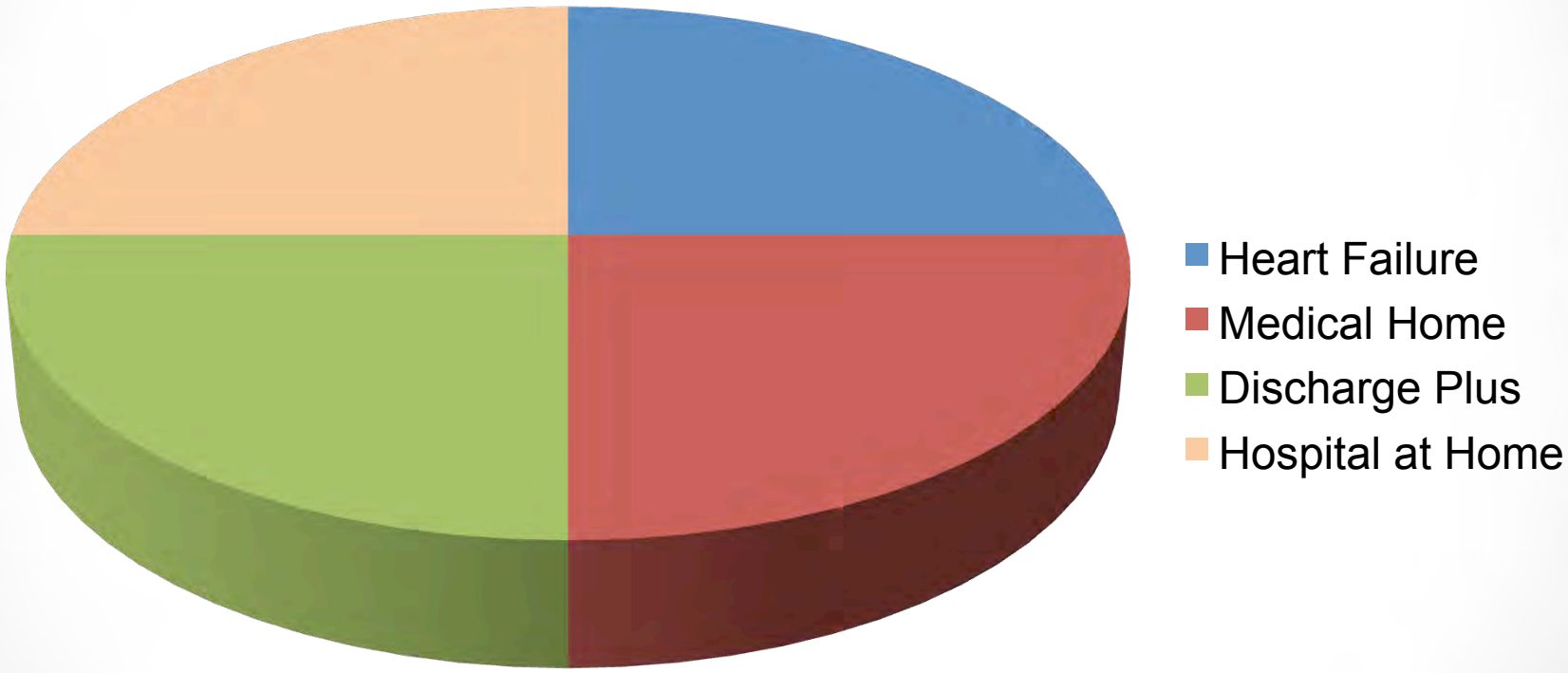




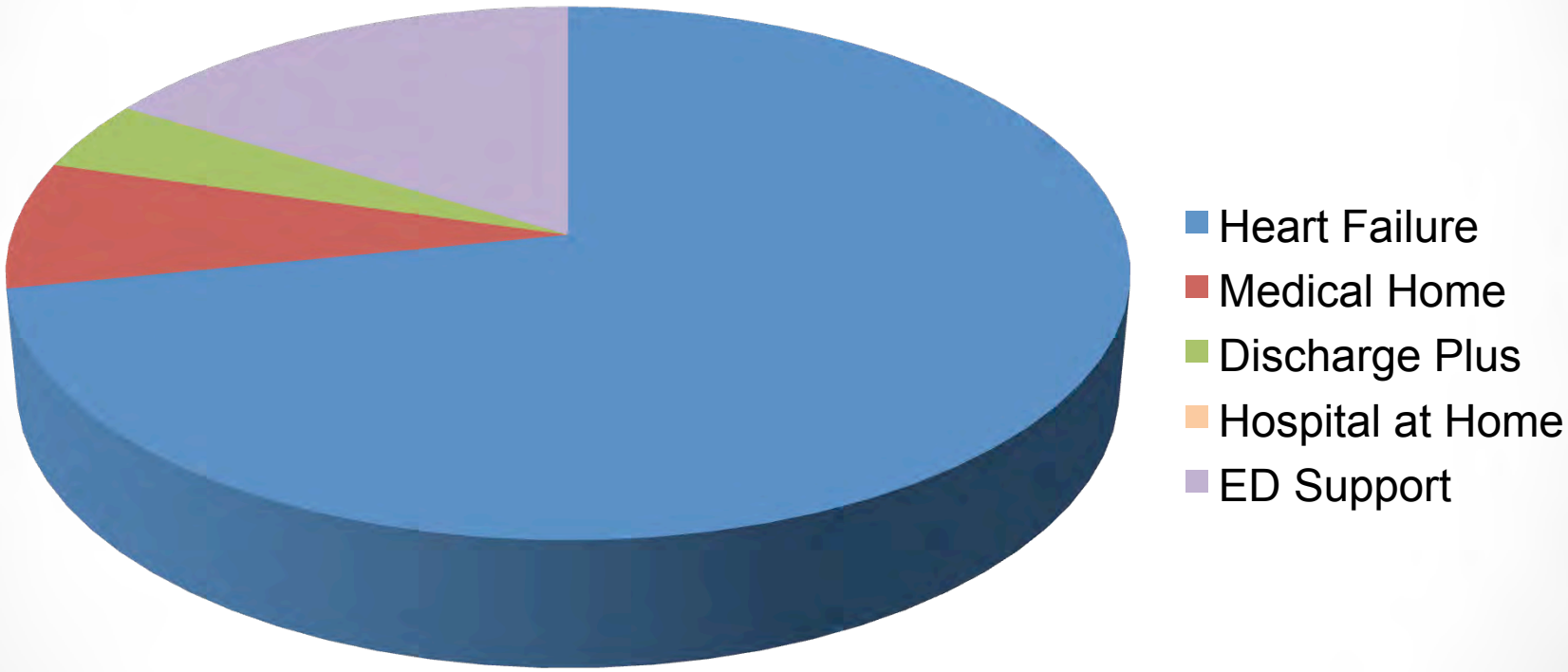



Please stop waiting for a map. We reward those who draw maps, not those who follow them.
SETH GODIN

Mobile Health Paramedic Anticipated Utilization



Mobile Health Paramedic Actual Utilization



MHP Pilot Results
(704 patients 3/2014 – 6/2015)

Quality

Prevented Hospitalizations	42 (+ ED)	
Inpatient Days Prevented (estimated)	168	
Prevented Emergency Depart Visits	33 (ED only)	
Patient Safety Issues	3/2,893	0.1%

Patient Satisfaction (52.7% RR)

100% of our patients are surveyed

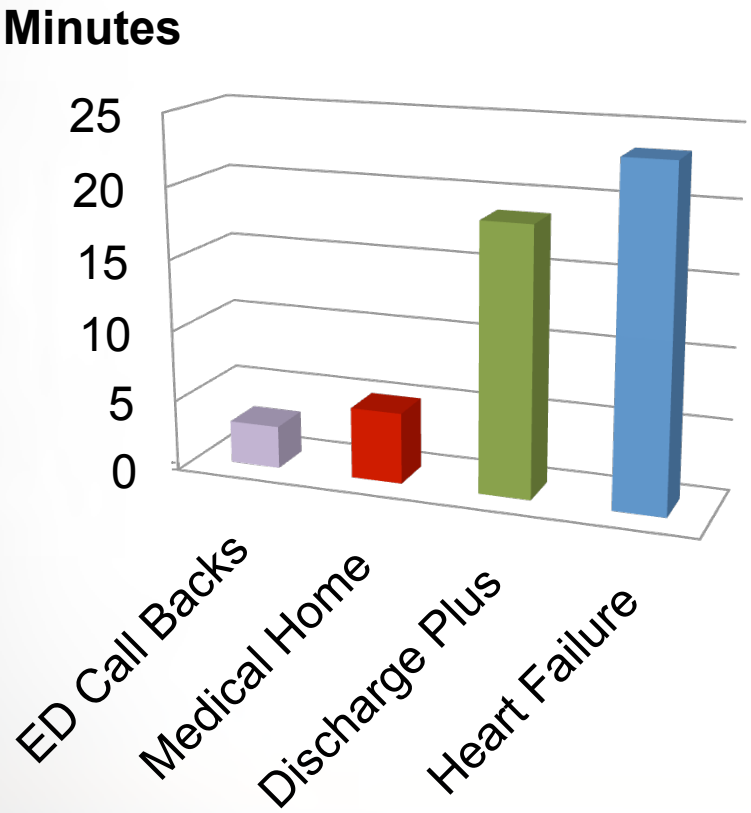
Financial

Avoided charges: $2.1M

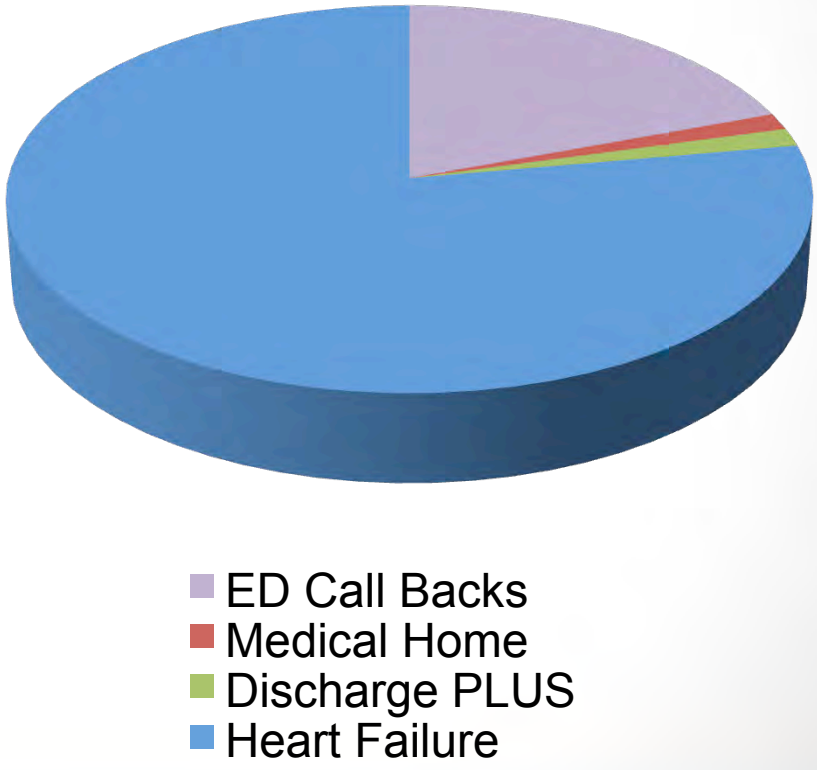
*Professional Fees (Part B) not included

Patient Phone Calls

Average Call Duration



Call Type



MHP Interventions: March 3, 2014 – October 16, 2015

	Encounters	Unique Patients
Home Visits	439	**810**
Heart Failure	196	
Phone	2,258	
Total Encounters	**2,893**	

Source: CBC Mobile Integrated Health Patient Log

Patient Satisfaction Survey

Response Rate: 72.7%

- I feel the visit by the MHP enhanced and improved my healthcare

- I had a better understanding of my health care, medical condition and the objectives of my health care team after the MHP visit

- The MHP displayed compassion, empathy, and respect for yourself and those around you.

Source: MHP Patient Survey's

360 Satisfaction

"In a word - Wonderful!"

"I didn't have to go to Emergency and wait an eternity."

"Robin showed me what was bad for me."

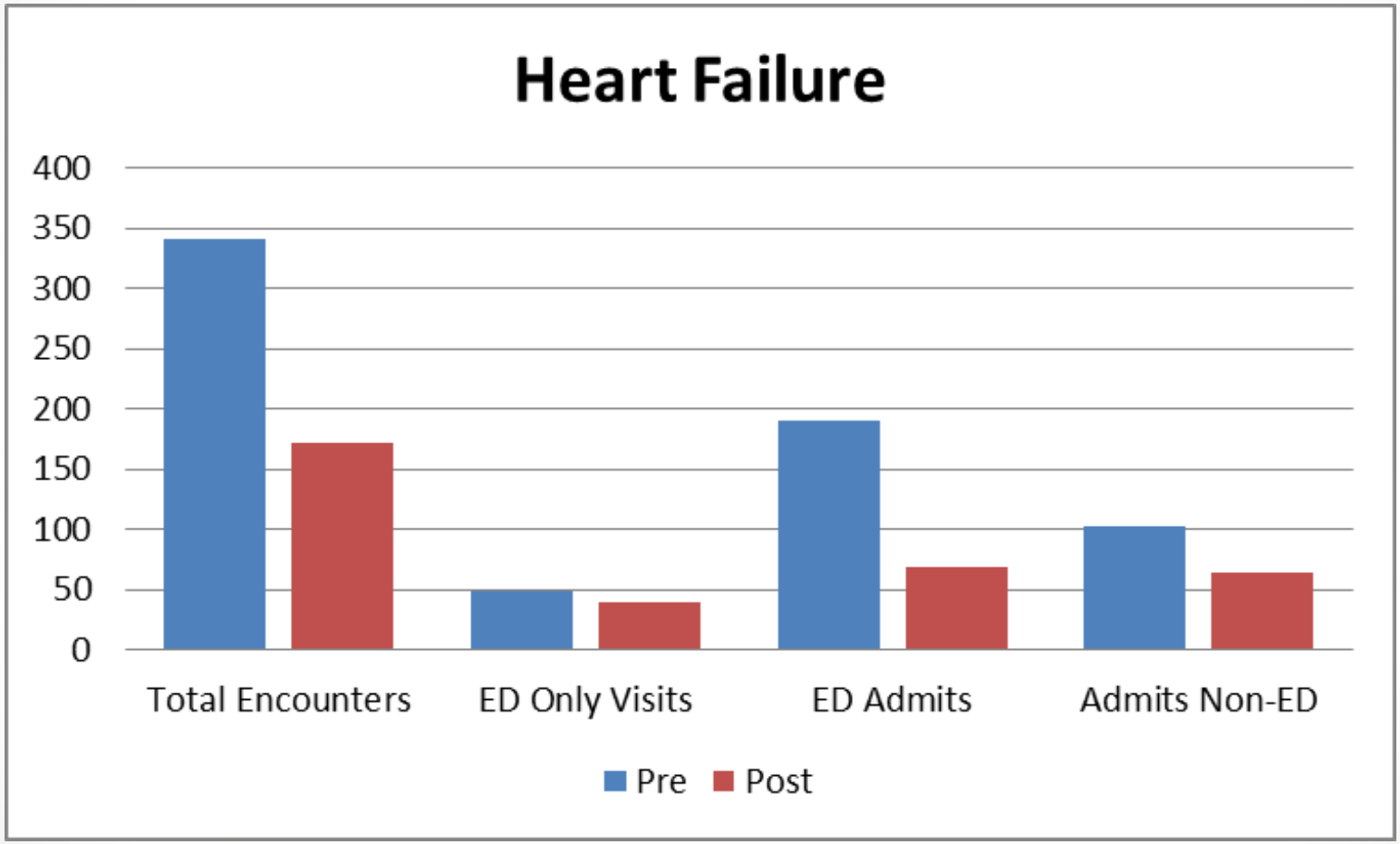
"Robert routinely sees our heart failure patients on home visits, doing both assessment and treatment (including IV diuresis). Many of these have severe cardiomyopathies and require high level assessment skills to manage.

The patients I have had contact with are uniformly very impressed and comfortable with his care.

His notes are always consistent with my findings at office visits. "

Lorick Fox, MPAS, PA-C, AACC
Cardiology

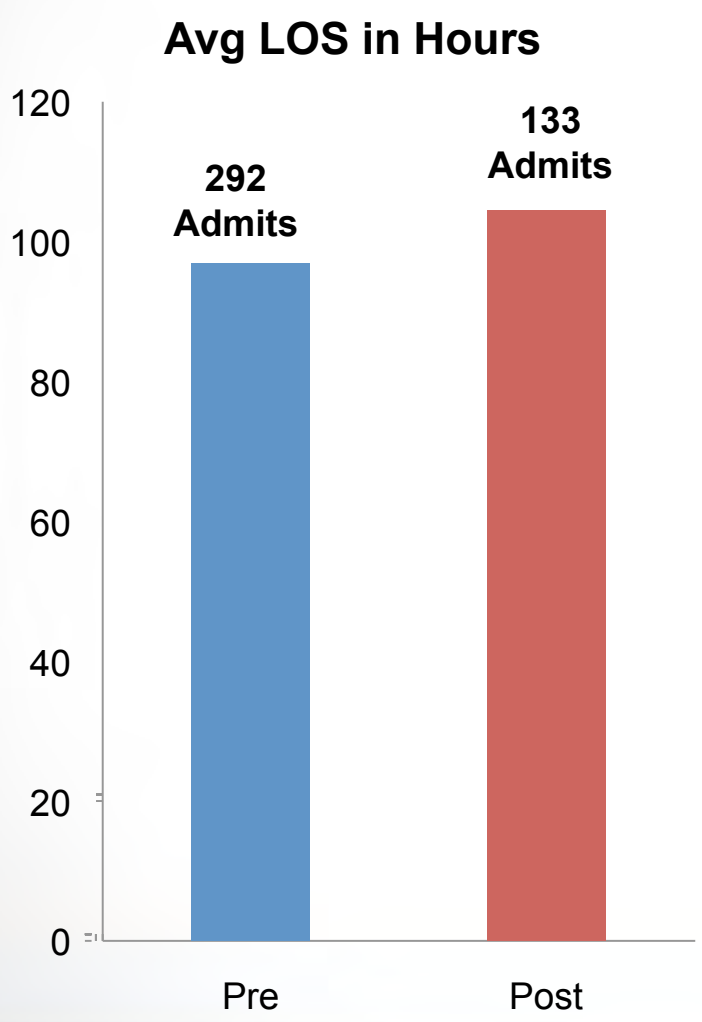
Program Integration w Heart Failure Reduced Encounters 90d Pre-Post (202 Patients)



Source: Clinical Innovations Analytics

Heart Failure Care Saved Days

(202 Patients)



Source: Clinical Innovations Analytics

GEISINGER
REDEFINING BOUNDARIES

Mobile Health Paramedic Team

Mobile Integrated Health

"The mobile paramedics helped chronic disease patients avoid ED visits by providing almost immediate access to care in their homes... need to study their integration in to a wider care team"

Sanjay Doddamani, MD

System Chief,

Adva c Disease – Heart Failure

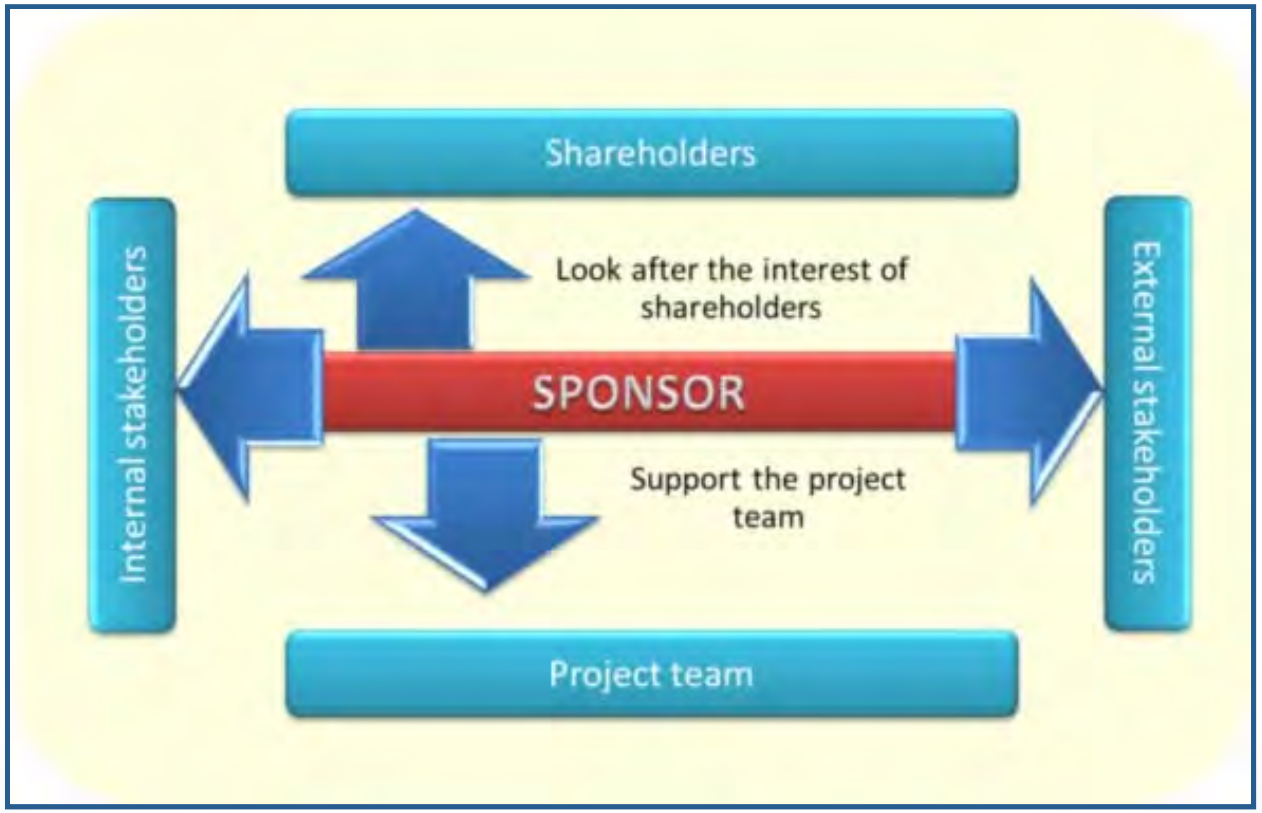
Mobile Integrated Health

"Across the country, community paramedics are being used to fill gaps in existing healthcare systems. These providers are skilled in emergency care, comfortable in dealing with patients within their homes, and have a scope of practice that can serve as the eyes and ears of the advanced medical home."

Douglas Kupas, MD, FACEP
Commonwealth EMS Medical Director

Advice and Lessons Learned

Engage Sponsors Early and Often



Advice and Lessons Learned

EHR Integration & Telehealth connectivity supported the activation of

Advice and Lessons Learned

You cannot over communicate!

Advice and Lessons Learned

"In God we trust, all others bring data."

~ W. Edwards Deming

Advice and Lessons Learned

It takes a village

Acknowledgements

GWV Heart Failure Team

CPSL Sites

EPIC Ambulatory Team

Legal

GWV Finance

GHP

GHP Care Management

Patient Experience

Transfer Center

IT WSAs

Clinical Innovation

Clinical Innovation Analytics

Questions?

Appendix

- Heart Failure Workflow
- Heart Failure MHP Phone Call Worksheet
- Payor Summary
- Key Stakeholder Comments
- Recognitions
  - Wall Street Journal
  - Integrated Delivery Network to Watch

Heart Failure Team and the MHPs

Traditional Model requires emergency care services

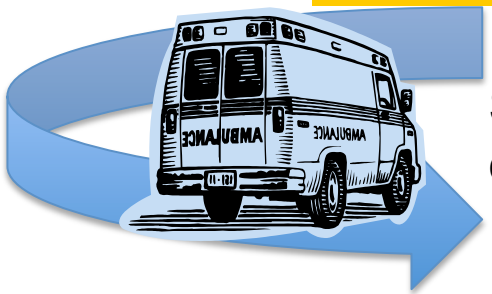
To ED

Clinical status
Less stable

Symptomatic Patient
At HOME

Emergency provider visit subject to transport and Immediate provider access 7 days/week

MHP Model results in team based anticipatory care



Sent out by RN based on patient alert

Clinical status
More Stable

Improved Patient
At HOME

Post intervention

Team discussion & Plan

- MHP
- Provider
- Nurse
- CM
- Pharmacist

Anticipatory provider visit is less urgent and patient presents more stable for provider visit

GEISINGER
HEALTH SYSTEM

Patient Name:_____ Phone 1:_____
MRN:_____ Phone 2:_____

Age:_____ Discharge Date/Dx:_____

HEART FAILURE PHONE CALL QUESTIONNAIRE

How do you feel? Better Worse No Change

Are you SOB at rest? No Yes
Are you SOB with ADL? No Yes
Are you SOB with exertion? No Yes
How far can you walk without stopping or becoming SOB? _____
Are you more SOB than normal when lying down? No Yes
Do you notice more SOB or coughing at night? SOB Cough No
Are you experiencing ankle swelling more than normal? No Yes
Are you experiencing abdominal swelling more than normal? No Yes
Are you experiencing? Nausea Vomiting Abdominal Discomfort
Are you experiencing? Weakness Depression
Are you experiencing? Cough Wheezing
Are you experiencing any unexplained fatigue? No Yes
Any evidence of confusion? No Yes
Have you had a temperature >100*F? No Yes
Are you experiencing any other symptoms? No Yes:_____
If the way you normally feel is a 1 and the worst you have ever felt is a 10, how do you feel right now? _____

NYHA Class I. II. III. (E) (P) IV. (E) (P)

Are you taking your water pills? No Yes Name of pill?_____

Are you on a fluid restriction? No Yes What is the amount? _____. How are you keeping track of your fluid? _____.

Are you on a sodium/salt restriction? No Yes How much?_____. How do you keep track of the sodium content?_____.

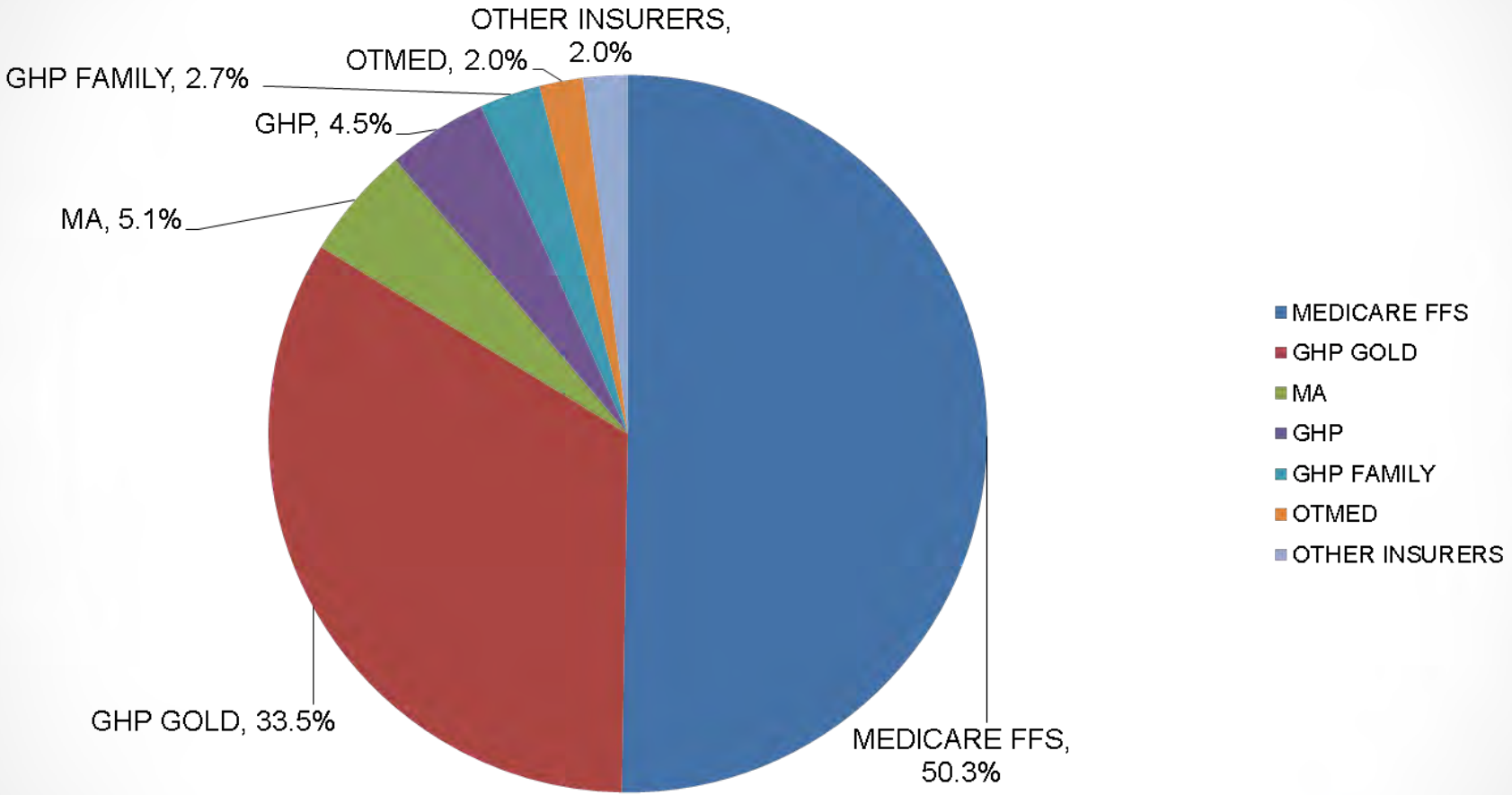
Are you weighing yourself daily? No Yes What is your weight today?_____
Patient's last weight documented?_____. How much weight gain would you want to report?_____.

What symptoms did you experience when your heart failure is getting worse?_____.
How long would you wait to notify your doctor if you think your heart failure is getting worse?_____

If anything changes and you feel worse, do you know who to contact? No Yes Who is the best person to contact in the next month?_____.

Do you have any questions for me? No Yes:_____.

Payor Summary



Mobile Integrated Health

"Another great example for Geisinger finding the right overlap of cost, quality, and care. Most of the country is talking about it, we are doing it."

Ron Strony, MD

Mobile Integrated Health

"It's a supportive effort with everyone: (Nurse Navigator, Case Management, Home Health and Mobile Health Paramedic) working together to provide the attention and care with the appropriate touches at the right time that the patient needs."

Clini

Radune Mautz, RN
Heart Hospital

THE WALL STREET JOURNAL.

www.wsj.com PERSONAL JOURNAL Tuesday, August 18, 2015

A 'No Emergency' Paramedic

by Laura Landro

In a new role, paramedics schedule visits to patients at home for checkups and post-hospital care

Paramedics, who race to emergencies and transport victims to the nearest ER, are taking on a new role: keeping patients out of the hospital.

An initiative, called community paramedicine, is training the fast responders in chronic disease management, medication compliance and home safety. Paramedics are then sent on scheduled house calls to frail and elderly patients or those who have trouble managing chronic conditions like heart failure and diabetes.

Community paramedics take vital signs, administer IV medications, and perform lab tests as well as help patients understand follow-up instructions after being discharged from a hospital.

Mobile paramedic Veronica Koval discusses her scheduled house calls for the day in Pennsylvania. Watch a video about how more programs like this are providing basic, non-emergency services to patients in their homes. Photo: Benjamin Hoste for The Wall Street Journal

They check for risks such as where patients could fall in their homes and whether they understand their medical regimens. They also work with doctors, nurses, dietitians and physical therapists to coordinate future care.

In this new role, paramedics augment existing programs like visiting nurse services and home care. They also treat patients who don't meet home-nursing criteria or don't want someone in their home all the time but still have complex needs, says David Schoenwetter, an emergency physician and head of the mobile health paramedic pilot program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, Pa., part of Danville, Pa.-based Geisinger Health System.

"Paramedics are a readily deployable, nimble, clinically trained resource who can help close a gap in American health care," Dr. Schoenwetter says.

ihExecutive
Advising Integrated Healthcare Leaders

IH Executive Names 10 Integrated Delivery Networks to Watch

This special section of the publication's September/October issue profiles organizations that are innovating across a variety of care types and settings to help transform the U.S. healthcare system. Each organization was named for demonstrating leadership in a unique and exciting way: partnering with local communities, collaborating with other providers, creating new pathways of care, embracing new reimbursement structures and more.

Here are the organizations profiled and a description of the achievements for which they were selected.

- **Burcham Hills, East Lansing, MI;** and **Great Lakes Caring Home Health & Hospice, Jackson, MI:** Innovative Collaboration for Continuity of Care
- **Carroll Hospital, Westminster, MD:** Population Health in a Value-Based Environment
- **Community Care Collaborative, Austin, TX:** Integrating Care for the Uninsured/Underinsured
- **Geisinger Health System Mobile Paramedic Program, Wilkes Barre, PA:** Technologically Integrated Mobile Health (Rural)
- **Intermountain Healthcare, Salt Lake City, UT:** Deep Data Analysis for Population Health
- **North Shore LIJ Center for EMS, Syosset, NY:** Technologically Integrated Mobile Health (Urban/Suburban)
- **OSF HealthCare , Peoria, IL:** Embracing the Shift to Shared-Risk Arrangements
- **Regional Emergency Medical Services Authority (REMSA), Reno, NV:** Creating New Pathways for 9-1-1 Patients
- **Symphony Post-Acute Network, Chicago:** Partnering to Optimize Patient Experience, From Hospital to Home

Advice and Lessons Learned

Engage Sponsors Early and Often