# Collaborative Efforts Reducing Avoidable Admissions with Mobile Health Care





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#### A LITTLE WARM-UP



Let's list 1 GAP in health care in your community.







"In its simplest definition, Mobile Integrated Healthcare (MIH) is the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. It may include, but is not limited to, services such as providing telephone advice to 9-1-1 callers instead of resource dispatch; providing community paramedicine care, chronic disease management, preventive care or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care, not limited to hospital emergency departments." From National Association of EMTs (NAEMT)

#### STEERING COMMITTEE



Leaders from the Collaborating EMS Agencies

Washington County Public Health

Warren County Public Health

Glens Falls Hospital / Cambridge & Greenwich FHC

Southwestern Vermont Medical Center / Transitional Nursing

Alzheimer's Association

Adirondack Health Institute

Adirondack Rural Health Network

Mountain Lakes Regional EMS Council

**HCR** 

Fort Hudson Health System

Other Health Care & Community Members



#### THE EMS TEAM



Cambridge Valley
Bay Ridge
Easton-Greenwich
Granville
Salem

#### **Provider Roster**

Vicky Campbell, CCT (SRS)
Jeannette Carman, EMT (CVRS)
Jen Costa, Paramedic (CVRS)
Adrienne Hamilton, Paramedic (CVRS)
Jeanine Hasenkopf, Paramedic (CVRS/EGRS)
Jen Irwin, CCT (BRRS)
Shane Irwin, Paramedic (BRRS)
Araelle Jenison, Paramedic (CVRS)
Regina Ladd, AEMT (BRRS)
Anna Rumrill, EMT (SRS)
Mark Spiezio, Paramedic (CVRS)
Conni Tucker, Paramedic (BRRS)

#### **Area Served**

ALL of Washington County
Town of Queensbury, Warren County
Town of Hoosick & Village of Hoosick Falls, Rensselaer County

### COMMUNITY CHECK PROGRAM



The goal of the Community Check Program is through routine visits, obtain assessment data that is transmitted to the participant's PCP so the PCP can better manage the participant's short and long term health to reduce avoidable hospital admissions, emergency room visits, ambulance transports, and urgent care visits.

#### **CCP FLOW**



Referral

**Parameters** Form (PCP)

**CCP Provider Assignment** 

Routine

Visits (VAF)

**Initial Visit** 

"Protocol"

**Activation** 

Reporting

# INTEGRATION W/ HOME HEALTH



1) Mutual Referrals

2) No Duplication of Services



3) Collaborative Agreements





### **DIVERSIONS**





Medical Services Diversion					
	YES	NO			
Did you call EMS since our last visit?					
If you did, were you transported to the hospital?					
Have you been seen at an Emergency Department since our last visit?					
Have you been seen at Urgent Care since our last visit?					
If yes to any of the above, what were the circumstances?					

AVERAGE
7%
of visits result
in a
"diversion"

Did you NOT call EMS, g you would have prior to	ent Care when				
Did this visit <i>DIVERT</i> a Health Care Visit?					
Type of visit diverted	Primary Care	Urgent Care	☐ Ambulance Transport	☐ Emergency Department	
Explain how a health ca infection instead of utiliz			-	-	ssible

### THE DATA



#### Mobile Health Care System COMMUNITY CHECK PROGRAM

#### **Visit Diversion Report**

November 2017 to April 2018



Month	Visits	Activations	Diversions	% Diverted	Participants
Nov. '17	68	7	3	4.4	24
Dec. '17	54	6	3	9.2	23
Jan. '18	48	6	3	6.3	25
Feb. '18	46	7	6	13	27
Mar. '18	58	8	4	7.4	26
Apr. '18	42	3	1	2.4	24
Totals	316	37	22	6.9	

**Total Program Participants -**

## THE DATA... THE UNTOLD STORY



#### 26 year old female – Asthma

- 3/16/15 to 9/12/17 [31 mos.]
  - 20 ambulance transports
  - 19 advanced life support
  - 14 emergency mode to hospital
- 9/12/17 to 7/31/18 [11 mos.]
  - 41 visits
  - 3 diversion + 10 activations
  - 8 ambulance transports
  - 8 advanced life support
  - 2 emergency mode to hospital

- Q. Do you feel you are able to manage your condition better?
- A. "YES!"
- Q. What is one thing that has benefitted you since being in the program?
- A. "She (CCP Provider) is able to tell the signs better than I can. I can't hear my wheezing, so when she checks me out, I can get the help before its get bad."

### THE DATA... THE UNTOLD STORY



#### **Elderly Woman**

Assisted Living

- 17 mos. prior
  - 13 transports to, 7 transports from ED
- 11 mos. post
  - 4 transports to, 1 transports from ED

- Mother / daughter non-compliant diabetics
- Air condition & walker
- UTI catches

### **CHALLENGES**



Scopeof-Practice



PCP Buy-In

Staffing

V

9-1-1

Long-Term Funding

#### **TESTIMONIALS**



"I am grateful for the help and support that the mobile health program offers in Hoosick Falls and surrounding towns. They are able to provide a level of support that I can't from the office. I feel more confident that members they serve have a better understanding and management of their chronic diseases, understand and are compliant with medications, and are more knowledgeable regarding safety and fall prevention."

Rhonda Harmon, SVMC Blue Print Primary Care
 Case Manager

"The Mobile Health Care
Community Check program has
been a great asset to our
communities. They have
decreased inappropriate
Emergency/Urgent Care and EMS
utilization and provided a bridge
for gaps in care. Their visits to
our vulnerable, fragile patients
have improved their quality of
life. We are very fortunate to
have this program available."

- Mary Madison, Care Coordinator Cambridge Family Health Center

#### **TESTIMONIALS**



I asked my participant's son this morning. He said it means to him, "peace of mind." His mom has said before, in writing "thanks for helping us."

Her son also said, "You ooze of kindness of caring."

He expounded - "The first time you came here to tell us about the program, you were so excited to tell us about it, it was like you were talking about your newborn baby. Nurses have been here and they are just employees. You're more than an employee. I could tell you were really enthused about the program."

- Son of a participant with advancing Alzheimer's Disease



# What do you think?