Community Paramedicine A Novel Approach to Reducing Readmission

Sara Thornburg, APRN-CNP, Brent Lampert, DO, Jeffrey Lawrence, MD, Paul Zeeb, MD, Ashley Larrimore, MD, Amy Pietragallo, APRN-CNP, Kenny King, EMT-P and Randy Jones, EMT-P, Talal Attar, MD.

The Ohio State University Wexner Medical Center

Metropolitan Emergency Consortium Communications

Whitehall Division of Fire

THE OHIO STATE UNIVERSITY

WEXNER MEDICAL CENTER

Background

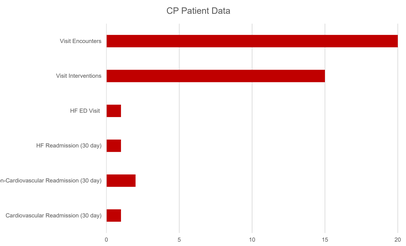
- There is opportunity for collaboration of healthcare professionals to significantly impact outcomes for patients with heart failure (HF) during transitions of care.
- Community paramedicine (CP) is an innovative model utilizing paramedics and resources in the community to provide care.
- East Hospital is partnering with Emergency Medical Services (EMS) in three surrounding areas in a pilot program providing community paramedicine services for patients.
- The program aims to follow patients with a home visit within 48 hours of discharge and as needed by a community paramedic with patient visit summary reported to the Advanced Practice Registered Nurse (APRN).

Objectives

- Patients enrolled are at high-risk for hospital readmission.
- Patients are identified through reports run through the medical record and through discussion with the inpatient cardiology team.
- Patients must live within jurisdiction as determined by zip code.
- Written and as needed verbal report provided by paramedic to APRN.
- Patient visits, interventions, 30 day readmissions for HF and ED visits tracked by APRN.

Results

The partnership between the APRN and community paramedic have allowed patients to receive referrals to community resources, receive in home follow up after diuretic titration, have medications titrated for hypertension and have modifications made to ensure a safe home environment. Brief intervention examples from patients enrolled are as follows:



Patient A: Legally blind. Home safety assessment for fall risk reduction performed. Pill box provided to patient for medication compliance.

Patient B: Discrepancy with medication reconciliation. APRN contacted to verify medications within 48 hours after hospital discharge and discrepancy was corrected.

Patient C: CP visit after patient received outpatient intravenous **L**asix. Patient was not readmitted for HF within 30 days.

Patient D: New HF diagnosis. Paramedic notified APRN of elevated blood pressure at visit allowing for titration of medication therapy for hypertension and HF.

Patient E: Paramedic notified APRN of elevated blood pressure during home visit allowing for medication titration prior to next clinic visit.

Patient F: Oral diuretics increased during visit with APRN for hypervolemia. Follow up visit with paramedic for volume and blood pressure check. Volume status returned to baseline and medication initiated for elevated blood pressure.

Patient G: Patient not initially scheduled for hospital follow up HF visit with APRN at discharge. Paramedic had patient scheduled within 8 days of discharge.

Conclusion

- CP provides an opportunity for collaboration of professionals to improve care transitions for patients by focusing on long-term disease management, coordination and prevention while aiming to reduce cost.
- Potential to increase access to care, address social determinants of health, improve HF outcomes and the value of care for patients.
- Program will provide data likely impacting Bundled Payments for Care Improvement for HF and Accountable Care Organizations in patient outcomes and reducing hospital readmissions.
- East Hospital CP continuation and expansion to include other diagnosis is anticipated through 2022 as well as providing telepharmacy services.
- Ongoing data collected from the grant program will allow for the potential development of CP programs across the hospital system and potentially support payment models for CP.

Disclosures: None