MAKING THE CASE FOR COMMUNITY PARAMEDICINE IN RURAL COMMUNITIES: EVIDENCE AND LESSONS LEARNED FROM RURAL MODELS AROUND OREGON

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LEARNING OBJECTIVES

- Explain the different models of community paramedicine and mobile integrated health and how they can benefit rural communities.
- Learn how to develop a proposal to start a mobile integrated health/community paramedicine program in partnership with a local transporting agency (i.e., Fire & Rescue, EMS).
Mission

To build, advocate, and enhance mobile integrated health and community paramedicine programs in Oregon

Vision

We strive, through public and private partnerships, to change the culture of how health care is delivered through sustainable innovative systems change that results in cost savings, improved patient experience, and enhanced community health for all people in Oregon.
MIH AND COMMUNITY PARAMEDICINE IN OREGON

KESHIA BIGLER, MPH
OREGON CP/MIH COALITION CHAIR
POPULATIONS OF FOCUS

- Medicaid/OHP Members: 2
- Medicare/Older Adults: 1
- Pediatrics: 0
- Commercially Insured Members: 0
- All Community Members - not...: 11
- Homeless population: 3
- Other: 1
PROGRAM FOCUS AREAS

- Chronic Condition Management: 5
- Wound Care: 3
- Frequent Emergency Department Visits: 9
- Frequent 911 Callers: 10
- Transitions of Care: 6
- Immunizations: 2
- Unengaged with Primary Care: 6
- Homeless Population Outreach: 3
- Other: 5
KEY PARTNERSHIPS

- Primary Care Providers/Clinics: 10
- Behavioral Health Clinic/Com...: 10
- Hospital: 8
- County Public Health: 9
- Insurance Company/Payer: 2
- Coordinated Care Organization: 6
- Substance Use Disorder Treat...: 3
- Housing Authority or Agency: 6
- Food Bank or Pantry: 5
- Social Safety Net - i.e. workfor...: 2
- Non Emergent Medical Transp...: 4
- Other: 7
Common funding mechanisms include:

- Grants
- Position FTE is built into departmental/agency budget
- Contract or LOA with partner organization
- Braiding funded from various sources
- City General Fund
- Partnership with healthcare providers
  - Ex. OHSU school of Nursing Students
PARTNERSHIPS ARE KEY TO REFERRALS

- 911 Crew-based (i.e. frequent callers)
- Emergency Responders (i.e. police department)
- Coordinate Care Organizations (CCOs)
- Primary Care
- Hospitals (i.e. Emergency Department, IP discharges)
- Behavioral Health Providers (i.e. mental health)
- Home Health
- Crisis Services
- Palliative Care
- DHS – Adult Protective Services
CP/MIH PROVIDERS MEET CLIENTS WHERE THEY’RE AT

Top Methods of Communication:
1. Face to Face
2. Phone Call
3. Text Message
COMMON INTERVENTIONS

- Vital Signs
- Medication Reconciliation
- Home/Environmental Safety Inspection
- Lab Draws
- Point of Care Testing
- Infant Weights
- Resource Connection – Social Needs
  - Food Insecurity
  - Financial Supports
  - Housing Instability/Needs
- Health Education
- Monitoring Chronic Conditions
- Client Advocacy
- Connection to PCPs, Specialty, MH, SUDs treatment/providers
- Care Coordination
- Houseless Outreach
- Review discharge plans/summarys, care plans
- Partnering with provider teams, multidisciplinary teams
KEY DATA INDICATORS TO MEASURE IMPACT OF PROGRAMS

- 30 day all cause readmissions: 2
- Number of IP admits: 1
- Number of ED visits: 6
- Engagement with primary care: 6
- Engagement with mental health: 3
- Initiation and/or continued engagement: 2
- Measures demonstrating improvement: 3
- Reduction in 911 calls: 9
- Reduction in transports to hospital: 6
- Improvement in assessment scores: 1
- Reduction in avoidable costs/treatment: 2
- Improvement in ADLs: 2
- Medication adherence: 5
- Social Determinants of Health: 6
- Other: 2
Portland tackles opioid epidemic with new solutions

In Portland, 183 people died last year from opioid overdoses. Now first responders are helping connect patients to long-term treatment through "recovery housing.

May 7, 2018

Salem launches free mobile health team to keep mildly ill patients out of hospitals

The program came about after EMS crews with Salem Fire noticed the growing category of patients, who also weren’t sick enough to get tested for COVID-19.

Mobile team treating Salem patients at home


A Central Oregon paramedic minus the ambulance

Seeing patients at home may improve care, save money


Exploring the Emerging Role of Community Paramedicine

https://climb.pcc.edu/blog/exploring-the-emerging-role-of-community-paramedicine

This town of 170,000 replaced some cops with medics and mental health workers. It's worked for over 30 years

SUCCESSFUL PROGRAMS IN OREGON

LESSONS LEARNED, SUCCESSES, AND OUTCOMES
Nonprofit Air and Ambulance Service
- Founded in 1949 by George Milligan
- Service Jackson County and outlying areas for emergent Air Transport
- Developed MIH Program in 2016-Serving all of Jackson County

About me:
- Paramedic since 2012, with 10 years in EMS
- Student and Volunteer Fire Fighter for 5 years
- Co-Chair of Mobile Integrated Health Coalition
Launched January 2016 in partnership with Providence Medford Medical Center and Jackson Care Connect.

2016-Primary focus of High Utilizers of EMS and the ED (HUG)

2017-Continued focus on the HUG group and began to develop the Transition of Care Program (TOC)
  - Additional grant funding for Community Outreach Patients

2018-Primary focus on TOC group
  - Continued work with Community Outreach Patients
2019-Added Rising Risk Program
  - TOC program well developed
2020-Current: Continued work with TOC and Rising Risk Program
  - Partnership with OHSU for research project
  - Safe Sleep Coalition-DOSE education for families in need
  - COVID Response in partnership with Public Health
    - Providing mobile testing for those home bound
  - Almeda and Obenchain Fires
Our Team

- Leadership team
- Full time Paramedic
- Full time EMT
- Two Casual Providers of each discipline
- Trained CHW’s
- Receive additional training in Medical Assisted Treatment, Mental Health, Chronic disease management, and Motivational Interviewing
Full Social Determinants of Health for every patient enrolled
  - Why is this important?
Disease specific protocols followed
Medication Review
Patient Education
Medication delivery
Fall Risk Assessment
Connection to the Right Provider to meet the patients needs
Care Coordination
**TOC-Results**

- **Emergency**: 490
- **Inpatient**: 124
- **Observation**: 240

- **90 days before enrollement**
- **During Enrollment**
- **90 days after graduation**
## Health Improvement Scores

<table>
<thead>
<tr>
<th></th>
<th>Enrollment</th>
<th>Graduation</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>Sample Size</td>
<td>314</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety and Depression (1)</td>
<td>3.21</td>
<td>3.97</td>
<td>23.9%</td>
</tr>
<tr>
<td>Mobility (1)</td>
<td>3.11</td>
<td>4.12</td>
<td>32.7%</td>
</tr>
<tr>
<td>Pain and Discomfort (1)</td>
<td>2.70</td>
<td>3.78</td>
<td>39.8%</td>
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<tr>
<td>Self-Care (1)</td>
<td>3.29</td>
<td>4.28</td>
<td>30.2%</td>
</tr>
<tr>
<td>Usual Activities (1)</td>
<td>2.84</td>
<td>3.94</td>
<td>38.6%</td>
</tr>
<tr>
<td>Health Scale (2)</td>
<td>4.92</td>
<td>7.36</td>
<td>49.6%</td>
</tr>
</tbody>
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**Note:**

(1) Score range 1 - 5 with 5 most favorable

(2) Score range 1 - 10 with 10 most favorable
Agenda

- How we got started
- Stats
- What goes into a CP visit?
- Success Stories
- What else are we doing?
- Funding
How we got started

- Grant through EOCCO
- 1 FT CP
- Focus on high utilizers of ED and EMS and post hospital discharges
- Transitioned into more welfare checks for PCP’s
Stats

- As of September 2020:
  - Over 500 patient visits completed
  - 30 avoided EMS transports
  - 350 avoided ED visits
  - 34 avoided admissions
What goes into a CP visit?

- Vitals
- Physical Exam
- Education
  - Disease and Diagnosis
  - Discharge Instruction
- Fall and Fire Risk Assessment
  - Smoke/CO detector installation
- Medication Reconciliation
- Lab testing
- Contact with PCP’s
- ConneXion’s CHW Intervention
• Besides the home visit:
  • Coordination with other services
  • Full review of medical records
  • Letter to PCP to include all visit info
Success Stories

- Elderly female who refused to take her medications
- Elderly female who wandered/called LE almost daily
- Frequent faller with injuries for patient and wife
- Patient called twice in 1 week for fast heart rate
Provider Quotes

"The CPP gives excellent reports summarizing their home environments with my patients. I have been impressed with the thoroughness of the reports. They paint a picture of my patients' living conditions that really helps me more fully understand my patient. I appreciate their feedback/suggestions for changes that could benefit my patients. We appreciate that you can do home safety evaluations for our Medicare patients." Dr. Amy Nguyen- Mirasol

"The CPP has exceeded my expectations. They are my eyes/ears in a way I cannot be in reference to gathering data on patients. They also provide medical information that assists in managing patients care (BP/vitals ,etc). They are able to complete med recs on patients that I have had issues with due to the fact they never remember to bring their medication. The paramedics show great critical thinking skills in the fact that they always ask appropriate questions and the information they provide is helpful. The are already doing an outstanding job. It’s a great resource!" Cynthia Hodge, ARNP- Mirasol
EMS Provider Quotes

- “The CPP has been consistently and aggressively pursuing every patient that I refer to her. Sometimes the patient refuses the help but the majority of the time she has been making a positive impact on our citizens and helping to improve their health. This has another benefit by reducing some of the 911 calls and burden on our duty staff. I am confident that years after our patients like D, C, and L have passed; the families of our patients will remember the cheery paramedic visiting and providing the care that their loved one desperately needed.”

  Lt Nate Stephens

- “It puts patient’s at ease when I am able to confidently say how friendly and helpful the Community Paramedic’s are.”

  FF/Paramedic Wes Blood
What else are we doing?

- Participation with the Oregon CP/MIH Coalition
- Expanding CP service and knowledge of CPP’s
- School Presentations/Community Involvement
Funding

- Ongoing generosity of UCFD1
- Good Shepherd Medical Center
- Umatilla Hospital Board
- Contract with EOCCO
Any questions?
If you’d like to learn more, please join us at our next Oregon MIH/CP Coalition Meeting:

**Tuesday, October 22nd, 9-10:30am**

Join Microsoft Teams Meeting

+1 971-337-0022  United States, Portland (Toll)

Conference ID: 693 080 483#