

Valatie Rescue Squad



READY WHEN YOU CALL



**Eddy Visiting Nurse
& Rehab Association**

ST PETER'S HEALTH PARTNERS

- HCANYS Annual Conference
- May 8, 2026 - Saratoga Springs



Hudson Valley Pilot Program

Home Care + EMS Collaboration

Collaborative in Community Medicine & Paramedicine

Serving Columbia, Greene, and Rensselaer Counties

Robert Hawley — Mobile Integrated Health Specialist, Valatie Rescue Squad

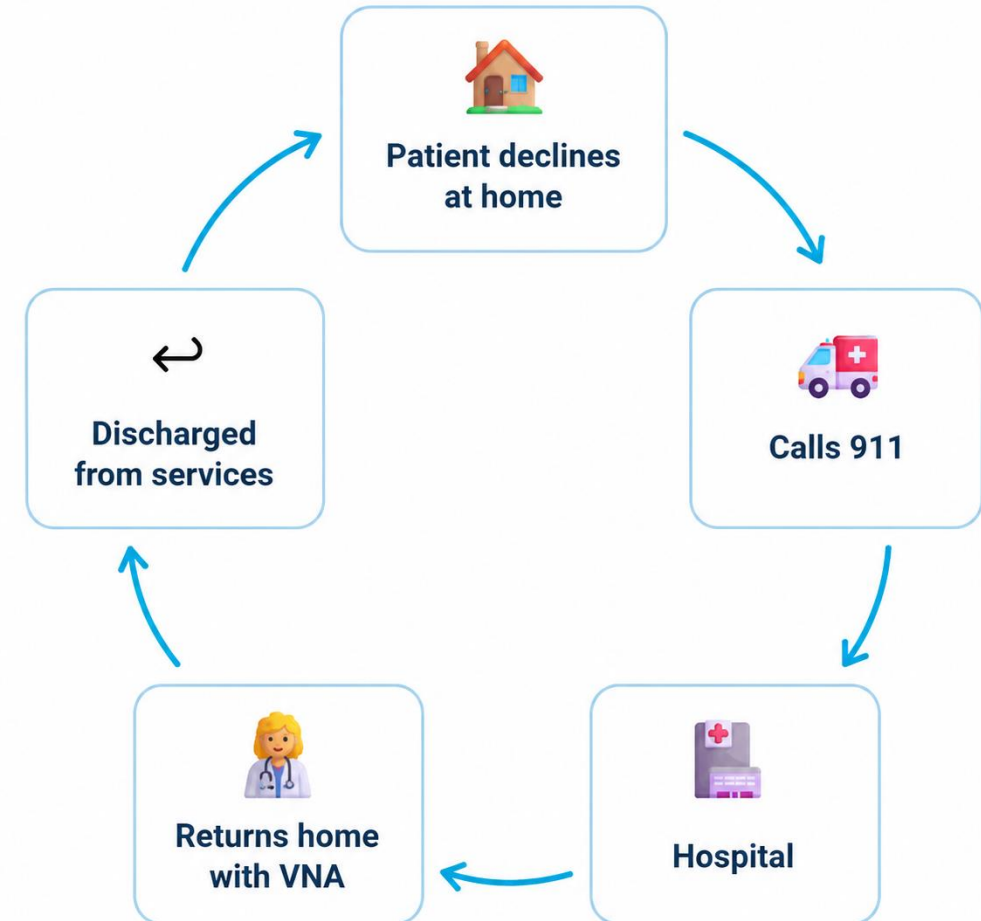
Lisa Agan — Director of Patient Services, Eddy Visiting Nurse & Rehab Association

Same patients. Different points in the care cycle.

Valatie Rescue MIH was created because EMS and home care were often supporting the same high-risk patients, but at different points in the care cycle.

- Patients need continued support
- Continued Monitoring
- clear communication across care transitions

Without that, they fall back into the same cycle. The partnership between Valatie Rescue MIH and Eddy VNA created a way to better connect those transition points.



Home care and EMS are stronger when they communicate early, identify shared patients, and work toward the same plan.

HOW THE PARTNERSHIP CAME TOGETHER

Two-way communication

- Eddy VNA identifies patients who may benefit from Valatie Rescue MIH support.
- Valatie Rescue MIH shares concerns when we see frequent 911 use or recent hospitalization.
- That information can support earlier VNA intake when appropriate and gives the nurse a better context before the first visit.



Home care and EMS are stronger when they communicate early, identify shared patients, and work toward the same plan.

The Valatie Rescue MIH–Eddy VNA partnership is the foundation of our program

We normally meet once a month to review:

- New referrals
- Current Valatie Rescue MIH patients
- High-risk CHF and COPD patients
- Patients with repeated hospitalizations or 911 calls
- Medication concerns
- Patients nearing discharge from nursing who may still need support
- Patients who may need a bridge visit before the next nursing visit
- Barriers in the home that may affect safety or compliance

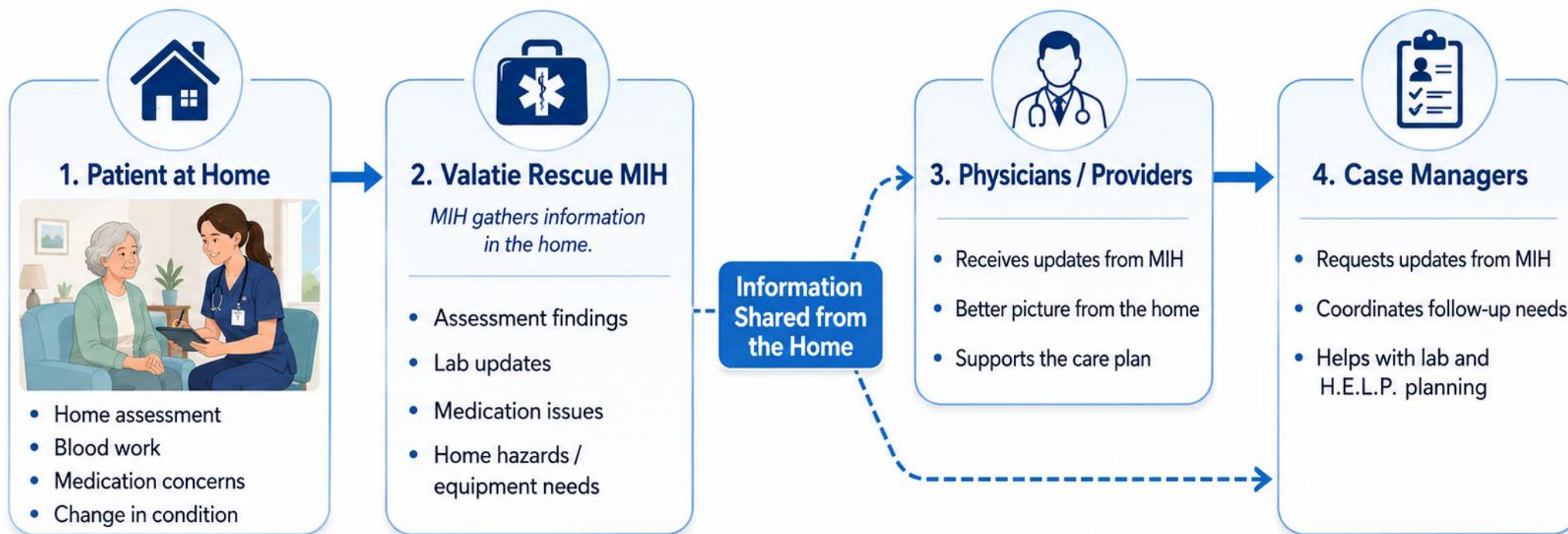


**Outside scheduled meetings, we maintain regular contact about at-risk or unstable patients.
This ongoing communication enables the model's success**

Role of Hospitals, Physicians, and Case Managers



Connecting what happens in the home with the people making care decisions



MIH helps connect what is happening in the home with providers and case managers who make care decisions.





CHF

current pilot focus



COPD

current pilot focus



6-7

hospitalizations before
enrollment for some patients



>90%

readmission risk score
in many referrals

Common barriers we can see in the home



Medication confusion and frequent medication changes



Difficulty getting to appointments or outpatient blood work



Limited support, living alone, or limited transportation



Lack of needed medical equipment or home safety concerns



**The home visit often
reveals why the patient
keeps returning to the
hospital.**

At home, MIH can see medication routines, equipment needs, fall risks, and whether the discharge plan is realistic.

Valatie Rescue MIH helps the care team by providing in-home assessment, interventions, and communication.



Assessment + monitoring

- Full assessments
- Vitals, glucose, weights
- Lung assessments
- CHF/COPD monitoring



Clinical support

- Medication review
- Blood draws
- Wound care support
- Sepsis + food insecurity screening

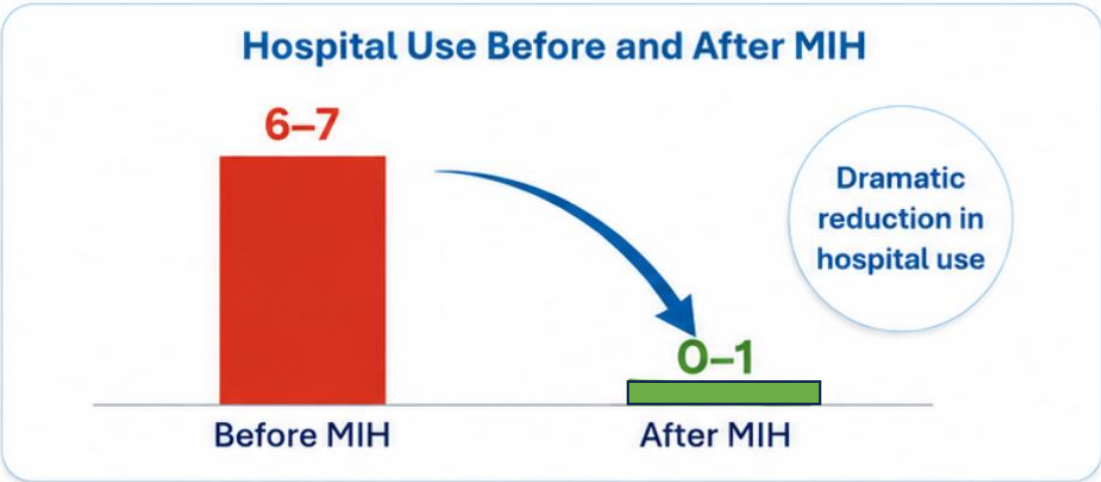


Care coordination

- Urgent bridge visits
- Treat-in-place when appropriate
- Provider / nurse communication
- Connection to H.E.L.P.

Valatie Rescue MIH fills the gray area between “needs 911” and “routine follow-up.”

The program has shown strong results so far, helping high-risk patients stay home more safely and avoid repeated hospital use.



- 
- What this means for patients**
-  Stay home more safely
 -  Call earlier when symptoms change
 -  Learn to recognize warning signs
 -  Connect with the care team before a crisis



The impact is not just fewer hospitalizations — it is earlier intervention, stronger communication, and safer care at home.

Case Example 1: Medication Safety



Patient Profile



74-year-old male



7 hospitalizations
in 6 months



Recent cardiac
stents + CABG



High-risk medication
changes



Health literacy
barriers



What Happened

1

2

3

4

5



Physician
changed
medications



Eddy VNA
identified
risk



Valatie Rescue
MIH scheduled
urgent intake



Prescriptions
picked up +
medication
planner updated



Blister pack
delivery
established



Outcomes

0

medication
errors

0

ED visits



Discharged from
VNA service



2 months in
Valatie Rescue MIH



Visits moved to
every other week



Why This Matters

This case shows how physician communication, Eddy VNA, and Valatie Rescue MIH worked together to create a safer, lasting medication system.



Case Example 2: COPD Exacerbation Avoidance



Patient Profile



84-year-old female



5 hospitalizations
in 6 months



Frequent COPD
exacerbations



Declined after
steroid taper



Early warning signs
now recognized



What Happened

1

2

3

4

5



Entered
Valatie Rescue
MIH as Eddy
VNA prepared
discharge



Patient called
MIH early in
COPD
exacerbation



Valatie Rescue
MIH responded
to home +
assessed



PCP +
pulmonologist
contacted; higher-
dose steroids
prescribed



Medication
picked up,
started promptly,
and pulmonology
follow-up
arranged



Outcomes



Stayed home

0

0 ED visits



Symptoms
treated early



Pulmonology
follow-up
completed



More likely to
call early next time



Why This Matters

This case shows how early intervention, provider communication, and patient trust can prevent an emergency before it starts.



VRS H.E.L.P. : Health Care Equipment Lending Program



**A strong supporting piece of
Valatie Rescue MIH**



Over 600 pieces of equipment in the program



Approximately 100 pieces are loaned out each month



Frequent requests from Eddy VNA PT, OT, and RN staff



Daily communication around equipment needs



**Sometimes hospital avoidance means
making sure a patient can safely transfer,
shower, ambulate, or get through the home.**

Practical barriers are clinical barriers.

Best Practices and Lessons Learned for Other Programs



1. Build communication into the model

Monthly meetings matter, but day-to-day communication is just as important. The relationship cannot only exist on paper.



2. Start with shared high-risk patients

Focus on the patients both organizations already worry about: frequent 911 callers, repeated CHF/COPD admissions, and patients needing closer support.



3. Make referrals practical

Keep the process simple and clear. Eddy VNA can send referrals directly in Epic, and staff need to know who to call and what MIH can realistically do.



4. Use EMS as part of the home-based care team

Valatie Rescue MIH adds another layer of assessment, response, and communication. It does not replace nursing, therapy, primary care, or emergency response.



5. Use the home visit to identify what the care plan may miss

Medication setup, equipment needs, fall risks, food insecurity, transportation issues, and poor understanding often become most clear in the home.



6. Trust changes patient behavior

When patients trust the team, they call earlier. That early call can be the difference between a small intervention at home and another hospital admission.

Strong partnerships create earlier intervention, better coordination, and safer care at home



Partnership-driven success

The strength of Valatie Rescue MIH is not just the services we provide, but the partnership behind them.

Connected care team

Communication between Eddy Visiting Nurse and Rehab Association, Albany VNA, Columbia Memorial Hospital, physicians, therapists, and case managers. We are creating a stronger bridge, keeping patients safer at home.

Impact for patients

This partnership supports earlier intervention for high-risk CHF and COPD patients, improves communication, addresses barriers in the home, and helps reduce avoidable hospital use.

H.E.L.P strengthens the model

The H.E.L.P. Program helps solve practical home safety issues that can otherwise lead to failed discharges or readmissions



Eddy Visiting Nurse
& Rehab Association

ST PETER'S HEALTH PARTNERS

Right care. Right setting. Right time.



Valatie Rescue MIH + Eddy VNA Partnership



The goal is not to replace home care, primary care, or 911.
The goal is to fill the gaps between those services.



A collaborative model focused on keeping patients safer at home.

Home Care - EMS Collaboration

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HCR
Home Care



Quick Facts about CVRS' CP Program

- Established in 2014
- Stakeholder Steering Committee
- 1st Patient December 2016 (1st in NYS)
- “Original 5” Programs
- 1,000 visits in 2019
- Extensive COVID Response
- Expanded in Q4 2024 w/ HCANYS
 - 250 total referrals
 - 14 referral sources (3 home care)
 - 13 referrals / month
 - 68 Active patients

How did we come together?

- Long standing CP Program (2014)
- HCR → Steering Committee
- DSRIP
- Common Partner → AHI



How do we partner?

- Discharge referrals / HCR → CP
- Dual Enrollment HCR ↔ CP
- Enhanced Training
- Routine Huddles

Successes & Best Practices

Successes

CD

- Multiple issues
- Dual enrollment

LD

- Extensive / long term wound care
- Unable to self-manage

Best Practices

- Enhanced training
- Routine huddles

CP in Action

Steps & Directions

- Expand referrals from hospitals to cover home care enrollment gaps
- Identify patients that do not qualify for home care
- High risk ED discharges
- 1114 Waiver - screening & resource

There is so much more to this and so much more that can be done.

**PHL 3018 - Community
Paramedicine
“almost” there**

PHL 3019- County Plans

Is the fit for you?

Continue building Valatie Rescue MIH with the Eddy VNA partnership at the center



Keep the Partnership Central

- Eddy VNA remains a core clinical partner
- Continue shared communication and case review
- Grow the model around the same collaborative approach



Increase MIH Capacity

- Current referrals exceed available staffing
- Additional MIH providers would improve response consistency
- More staffing would allow more patients to be served



Expand Program Reach

- Extend support to more high-risk patients
- Reach patients earlier in the cycle
- Build on a model that is already working



Goal: strengthen Valatie Rescue MIH while preserving the collaborative model with Eddy VNA.

Priority growth areas for earlier in-home intervention



Sepsis Screening

- Continue screening during home visits
- Identify concern earlier in the home
- Support faster provider communication



Nutritional Screening

- Build screening into routine visits
- Identify food and nutrition risk earlier
- Support safer care planning at home



Point-of-Care Testing

Possible A1C testing and added screening tools



Wound Care

Continue monitoring and provider communication



Mental Health

Selective inclusion and community-based follow-up



Focus first on sepsis and nutritional screening while continuing to grow other high-risk support areas.

What programs like this need to grow beyond the pilot phase



Department of Health Recognition

- Recognize the value of community medicine and paramedicine
- Support growth beyond pilot phases
- Help programs scale proven models



Payer and Insurance Support

- Payers need to recognize the benefit of this work
- Sustainable reimbursement is needed
- Create a reliable long-term funding path



Long-Term Goal

Build a self-sustaining program
with stable reimbursement, not dependent on grant funding alone



Sustainable growth will depend on DOH support, payer recognition, and continued partnership.



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