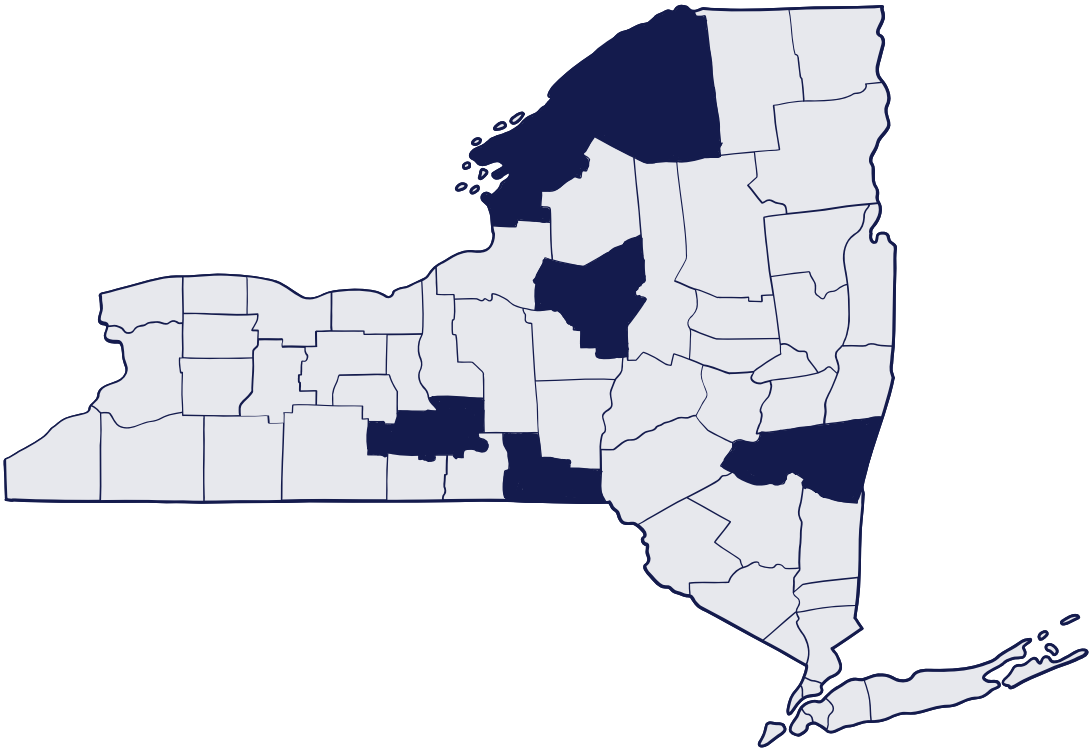
2024 REPORT

COLLABORATIVE MODELS OF COMMUNITY MEDICINE

A New Approach to Care Delivery



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IROQUOIS Healthcare Association

IPRO Better healthcare, realized.

Mother Cabrini Health Foundation

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INTRODUCTION

The Home Care Association of New York State Education and Research (HCA E&R), the Iroquois Healthcare Association (IHA), and IPRO, the Quality Improvement Organization for the New York State region, have partnered to work with hospitals, home health agencies, physicians, emergency medical services, and other key community partners under a grant from the Mother Cabrini Health Foundation to develop and pilot Collaborative Models of Community Medicine and Paramedicine.

2022

Program Development and Start Up

Three pilot models were established to serve the North Country, Southern Tier, and Hudson Valley regions.

2023

Program Service, Support, and Monitoring

Two new pilots were launched in the Finger Lakes and St. Lawrence regions.

2024

Service Progression and Regional Expansion

A sixth pilot is under development to serve the Mohawk Valley region.

Each collaborative community partnership model is tailored to address community-specific needs, but they all share similar goals. The pilot programs follow a community-centric model focused on integrating the services and roles of community healthcare partners. These collaborative models bring together core health system partners and practitioners from hospitals, home care, primary care, and EMS sectors in a common and coordinated mission: to meet the health needs of the community, while simultaneously preventing potentially avoidable hospitalizations and emergency department usage; decreasing the instance of 911 and EMS transport for conditions able to be handled through preventive in-home support; and improving access and continuity of care by flexibly choreographing the partnered assistance of EMS, home care, physician and hospital personnel in a coordinated plan for individuals.

COMMUNITY AND SYSTEM BENEFITS

- The care team can see a holistic picture of the patient's health and history.
- Care is received in the comfort of the patient's home, where the patient wants to be.
- Chronic conditions can be managed to prevent emergency department visits or hospital admissions and readmissions.
- Together, different providers can make use of limited resources. Collaborative partners are addressing workforce challenges by utilizing resources that already exist in a new way.
- Within the EMS scope of practice, the role of EMS is employed in the health system to better assist patients and their needs, and helps coordinate the most appropriate services available in the community.

PILOT MODELS

PATIENT POPULATION

The program's principal focus is on serving patients with complex, unstable, high-risk conditions that result from a possible combination of medical, cognitive, behavioral, social, and age-related conditions. The project aims to support quality care in the appropriate health setting for individuals with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, patients facing isolation, patients at risk for falls, or other inherent risks of emergency and medical vulnerability. Some individuals depend on highly skilled care, but others have more basic needs including check-ins, assistance with ADLs, and other supports for their safety and health. Many patients prefer to receive care in the home and don't need institutionalized treatment. Coordinating treatment in this model allows the patient to receive services that meet their wants and needs while also improving many elements of the health system and its functioning.

CROSS-SECTOR COLLABORATION

Cross-sector collaboration helps local health systems work with key partners toward shared goals to support care transitions, continuity of patient service, and coordinated interventions in vulnerable patient health or recovery periods. Local rural health systems benefit from community coordination to optimize available resources, which is a core focus of this initiative. By coordinating the roles and protocols among core hospital, home health, physician, and EMS partners, patients in the community will have increased access to care and continuity of service and support, which is particularly vital in resource-challenged areas. The health systems involved in this pilot program include rural regions of New York State that face specific difficulties and have unique needs. Patients living in rural communities face challenges with accessing care and could benefit from alternate forms of care delivery at lower costs to the system.

PILOT PROJECT PARTNERS AND TRAINING

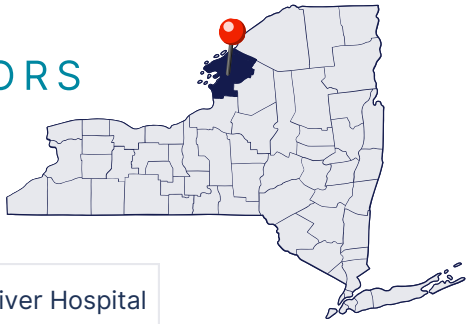
Supporting the core mission of this initiative, staff from many levels, and in multiple health settings are participating and collaborating in the program.

Hospital	Home Care	EMS	Primary Care	Community Partners
• discharge planners • hospitalists • referring physicians • emergency department physicians • others as needed	• professionals and staff under the home care plan of care approved by the physician	• EMTs • Paramedics	• primary care physicians • administrative staff	• mental health providers • local aging providers (AAA's, OFA's) • others as needed by patients

All tasks are carried out within the provider's scope of practice. The coordination of services is specific to each model and is integrated in the electronic health record. All home care is provided under a plan of care prepared under federal and state standards and ordered and approved by a physician. Any service in conjunction with this is under or in combination with this authorized plan. Any other type of intervention such as responding to a 911 call, or a finding of medical risk upon a check-in, is coordinated with the physician, or back through the responsible clinician at the home care agency, as applicable to the patient. Each pilot under the initiative has a training program specific to their goals and prior EMT knowledge and training.

The North Country Pilot

NEIGHBORS CARING FOR NEIGHBORS



PROJECT PARTNERS

Hospitals	Samaritan Medical Center	Carthage Area Hospital	River Hospital	
Home Care	Jefferson County Public Health Service			
EMS	Jefferson County EMS	South Jefferson Rescue Squad	Thousand Island Emergency Rescue Service	Carthage Area Rescue Squad
Community Organizations	Fort Drum Regional Healthcare Planning Organization			

Goals

Measurably improve patient outcomes by increasing patient participation in personal health care, decreasing unnecessary ambulance transports and ED visits by high utilizers, and decreasing hospital readmissions by 50% from the benchmark.

Pilot Design

Patients are referred to the home care agency to participate in the program. So far, trained providers in this pilot have been providing education, doing clinical assessments, providing emotional support, and conducting medication management for patients. In the future, this pilot plans to implement ultrasounds, point-of-care testing, telehealth, behavioral health collaboration, and substance use disorder education focused on creating awareness of available resources. This region plans to explore completing venipunctures and foley catheter management.

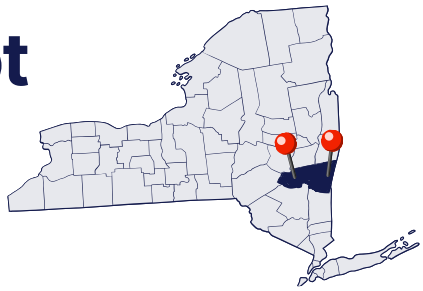
Patient Population

- Determined by looking at the majority of 911 calls, ED visits, and hospitalizations
- Care for those with CHF, COPD, diabetes, and those at risk for falls
- Patients already established or to be admitted by the home care agency
- Referrals from any referral source or pay source

Patient Success Story

We responded to one patient by ambulance almost 30 times from 2021-2022. After enrolling in the mobile integrated health (MIH) program, we found the main reason he was non-compliant with medications was that his Parkinson's made it very difficult to self-administer his insulin and open his other medications. His family was unwilling to help him organize or administer his medications. During the time frame he was on the MIH program he only requested EMS 3 times which was a dramatic reduction in his hospitalizations or times utilizing 911.

The Hudson Valley Pilot



PROJECT PARTNERS

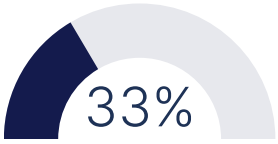
Hospital	EMS	Home Care	Community Organizations
Columbia Memorial	Valatie Rescue Squad	VNA of Albany	Primary Care Offices
		The Eddy VRNA	

Goals

Address coordination of care to reduce emergency department visits, hospital admissions, and readmissions, and prevent falls.

Create a coordinated program to decrease potentially avoidable ambulance transports and ED visits by high utilizers, decrease avoidable hospital admissions and readmissions, and improve patient satisfaction, by coordinating and integrating resources and services, and synchronizing protocols.

Performance Goal



Aim to see a 33% reduction in unnecessary hospital visits and hospital readmissions.

Pilot Design

Patients are referred by the home care agency or hospital. This pilot specifically aims to help patients manage their medications and targets high utilizers of the emergency department, those at a heightened risk for falls, those with a diagnosis of CHF or COPD, or any patient who could benefit from the program.

Evidence of Success

Early Outcomes

Referrals to Community Services

- Care coordination/navigation services
- Home health aides
- Adult day program
- Housing assistance

Commonly Provided Services

- Vital signs
- Teaching the patient/caregiver
- Medication management

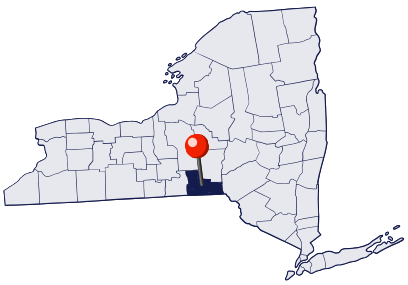
Patient Stories

A patient used EMS 12 times in 12 months for lifting assistance. The patient said she feels more comfortable having someone to talk to about her health-related questions which reduces her anxiety and keeps her from calling 911. The patient has not called 911 for any reason since being in the program.

A patient's family communicated to the home health agency that "it was a huge relief to our family to have this resource and helped significantly with our patient discharge plan back to the community."

"Our Home Health Nurse and EMS communicated on many patients to coordinate visits keeping several patients from going to the ED. The coordination between our nurses and paramedicine allowed for increased contact with the patient when they were having a medical issue to prevent ED return.

The Southern Tier Pilot



PROJECT PARTNERS

Hospitals	EMS	Home Care	Community Organizations
United Health Services Hospitals, Inc.	Union Volunteer Emergency Squad	Guthrie Home Care	Community Primary Care Physician Offices
Guthrie			

Goals

To be a model integrated community healthcare program meeting patient needs, and reducing healthcare expenses, while achieving high patient satisfaction, by recognizing and utilizing all available healthcare providers within their scope of practice.

Improve collaboration and coordination among all partners to increase appropriate utilization of healthcare resources in the community.

Increase ED access and hospital inpatient capacity through stronger coordination and collaboration of healthcare providers to support patients in the community setting.

Patient Population

- Excessive users of the 9-1-1 system (20 patients identified were responsible for 90 calls to the 9-1-1 system in July, or 10% of our service volume for the month. Calls ranged from 3x – 17x in the month of July)
- Asthma/COPD (non-compliant with medications)
- Diabetics (non-compliant with medications)
- Falls (lifting assistance)

Pilot Design

Patients in this pilot project are referred to the program by the hospital from the inpatient setting. Patients who are unable to be discharged because of home care capacity issues, patients not meeting criteria for home care, who can be safely discharged from the program, and patients refusing home care who may be willing to have community paramedicine are offered this program. Patients who were referred to the pilot program by UHS/Lourdes Home Care after a hospital discharge with a home care plan, who then refuse home care after discharge and patients referred by the Hospital Care at Home program are eligible to participate.

The program steering committee identified three initial projects to pursue within the program. Additional projects may be added in subsequent project periods.

1. EMS as a bridge to home care
2. ED super-utilizer reduction
3. Medically appropriate patient disposition from EMS
    a. Alternative transport destinations
    b. Treat-in-place with telehealth

Evidence of Success

Early Outcomes

Referrals to Community Services

- Transportation
- Food banks

Commonly Provided Services

- Telemedicine
- Wound care
- Medication teaching

Patient Story

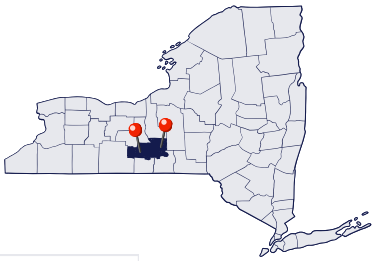
The patient is assisted weekly with sorting her medications into a weekly pill sorter. The patient often set up her medications incorrectly. Assisting her increased accuracy of her medications and increased her safety with taking them. The patient was less nervous to take her medications and had more confidence which led to improved compliance. This decreased her hospital admissions by about 50% and decreased her need for intubation by about 85%.

New Models in Development

In 2023, two new pilot project teams began planning and designing their models to serve patients in the Finger Lakes region and in St. Lawrence County. The programs are starting in 2024. Late in 2023, a sixth pilot also initiated planning for an anticipated launch in 2024 to serve the Mohawk Valley region.

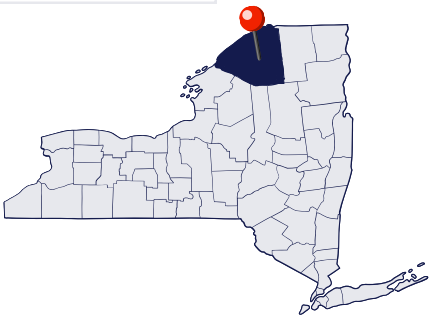
TOMPKINS-SCHUYLER

Hospitals	Cayuga Health System		
Home Care	Visiting Nurse Service of Ithaca and Tompkins County		
EMS	Schuyler EMS	Tompkins County EMS	Bangs Ambulance Services
Community Organizations	Cayuga Health Practice: Physician Practice		



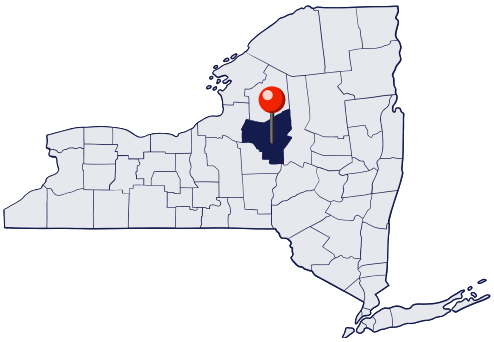
ST. LAWRENCE

Hospitals	Canton Potsdam Hospital	Gouverneur Hospital	Massena Hospital
Home Care	Northern Lights Homecare		
EMS	Seaway Valley Ambulance	Gouverneur Rescue	
Community Organizations	Community Health Center of the North Country		



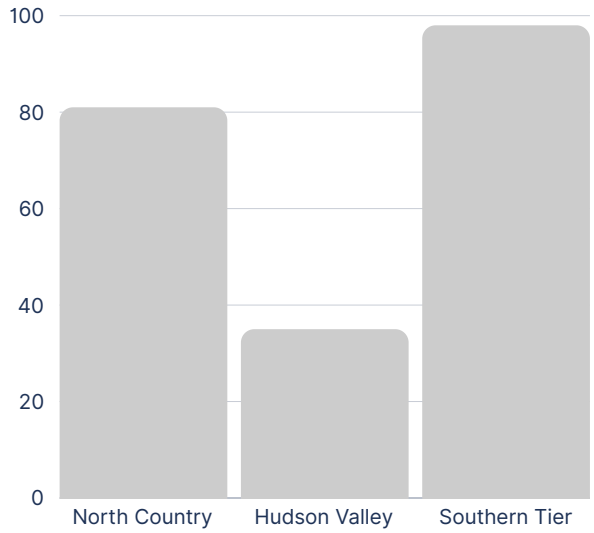
MOHAWK VALLEY

Hospitals	Mohawk Valley Health System			
EMS	Old Forge Volunteer Ambulance Corp	Living ADK		
Community Organizations	Town of Webb Health Center			
Home Care	Mohawk Valley Home Care	Visiting Nurses of Utica	Visiting Nurses of Oneida	



KEY FINDINGS

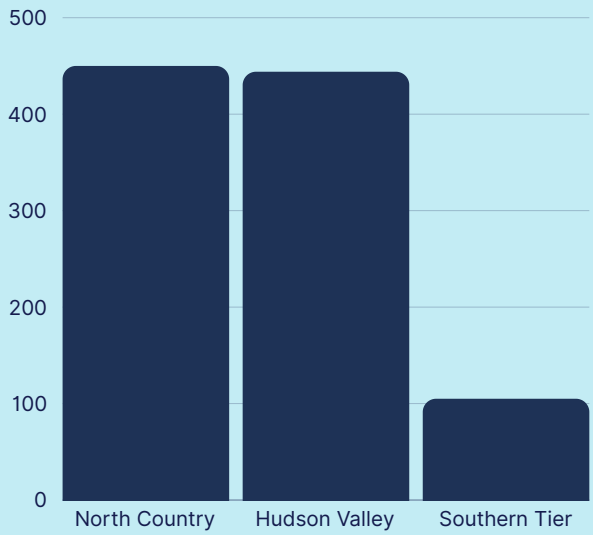
Number of Patients Served by Region 2023-Present



214 Individuals Served

Ages ranging from 12 - 94 years old

Number of Patient Visits by Region 2023-Present



999+ Patient Visits

On average, ~ 5 visits per patient

CHALLENGES & LESSONS

Community	Organizational	Regulatory
• Success when community partners work together towards a shared goal • Barriers when partners are not willing to communicate/work together • Patients like to be in their homes	• Teamwork and communication skills are vital to success • Conversations strategizing together lead to innovative approaches for better care	• Regulations create barriers and partner hesitation to participate in a program that aims to collaborate within scope

PROJECT SUSTAINABILITY

The pilot programs will be evaluated as a whole and individually for outcomes and best practices. Monitoring metrics that projects collect will be the base of the evaluation as well as qualitative information gathered from partners at each site.

HCA and project partners are pursuing many avenues for long-term sustainability. Project experience and outcomes will reinforce and support the need to sustain programs similar to those modeled. HCA and IHA commissioned a consultant, MS Hall, to develop a technical design blueprint to guide replication by other regions of the state. The blueprint was presented in a webinar module, along with a hard copy, and is available at the HCA and IHA CMPM websites.

Critical to sustainability will also be the recognition of the value of this model by public and private insurers. HCA and IHA have engaged the NYS Health Plan Association, health plan medical directors, and the State Department of Health in discussions for service coverage. Avenues to be explored include: securing coverage under private and commercial health plans; Medicaid coverage under the state's 1115 Medicaid waiver; bundled services coverage under new and evolving forms of federal, state and private reimbursement; and coverage under other health plan models offered in New York.

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Learn More

HCA's Community Medicine Website

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