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## **Empowering Care: How Community Paramedics are Transforming Readmission Rates**

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# Learning Objectives



- Compare readmission rates with and without community paramedic involvement.
- Describe cost saving strategies related to hospital readmissions with the introduction to the Community Paramedic Program.



## **Empowering Care: How Community Paramedics are Transforming Readmission Rates**

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# Agenda

- What is Community Paramedicine?
- Program Initiation: Where Did We Start?
- Who Qualified and Services Offered
- Initial Program Data
- Patient Story
- Current Data and Outcomes
- Program Progression
- Cost Savings
- Lessons Learned
- Key Takeaways



# What is Community Paramedicine?

- “Community Paramedicine is a restructuring of existing healthcare resources, not a new means to increase healthcare spending. The community paramedic approach is designed to support and augment other patient-centered delivery models by providing an optimized mix of healthcare and patient navigation at a lower cost than traditional models.
- The community paramedic model is an innovative proven solution to provide high quality primary care and preventative services by employing currently available and often underutilized healthcare resources, Paramedics.”

*-Manatee County Department of Public Safety(1)*

# Community Paramedic Program Initiation



January – August 2016: 30 Day Unplanned All Cause Readmission Rates for Heart Failure patients discharged home with a LACE of 10 or greater: 22.7% <sup>(2)</sup>

August 2016: Program begins with 1 Paramedic

Goal: Decrease Heart Failure readmissions and any possible CMS penalties

Emplify Health. Electronic Medical Records (EMR) data, August 2016–April 30, 2019. Confidential internal data.

# The Intervention Plan

- **Comprehensive Needs Assessment**
  - Identify the specific challenges faced by heart failure patient, including barriers to care and social determinants to health
- **Standardized Protocols**
  - Create and utilize evidence-based care pathways and protocols for managing heart failure patients
- **Community Paramedic Training**
  - Heart failure management, patient education, and effective communication strategies

Standardizing Care Delivery through Training, Education, and Comprehensive Understanding of Patient Needs

# Who Qualified for the Community Paramedic Program?

Primary diagnosis of Congestive Heart Failure (CHF)

Cardiology involvement and follow-up

Discharge to home or assisted living facility

High risk for readmit – readmission risk score of 12% or above <sup>(2)</sup>

# Patient Engagement

- Home visits and assessments
  - Initial home visits within 48-72 hours post-discharge
    - Review patients' conditions, medications
    - Identify any immediate needs or concerns
- Educational sessions
  - Structured conversations at patient home with teach back, discussing heart failure management, medication adherence, dietary restrictions, and symptom monitoring
- Follow-up visits
  - Schedule and plan follow-up visits as outlined in care plans, while monitoring patient conditions and making necessary adjustments to care

# Services Offered

- 30-day program with twice weekly home visits
- Physical Exam
- Medication reconciliation
- Discharge instruction reinforcement
- Point of care labs
- Oral and IV medication administration



# Initial Program Data



2016-2019: 146 Heart Failure patients enrolled in the Community Paramedic Program; 831 visits were completed by the paramedic. <sup>(3)</sup>



Matched analysis: 145 enrollments were matched with 256 non-enrolled program heart failure patients. <sup>(3)</sup>

Rate of any 30-Day readmission or emergency department visits were 18.6% in the enrolled group vs. 30.9% in the non-enrolled group. <sup>(3)</sup>

# Patient Story

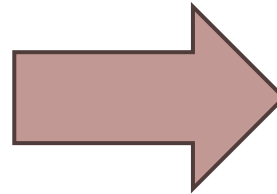


Visit History: 5 admissions from April-November <sup>(4)</sup>

- 2nd admission in November patient accepted Community Paramedic services with a readmission risk score of 21%

## • Plan:

- GHS Community Paramedic will see patient Mondays, Wednesdays and Fridays
- County Home Health has Tuesdays, Thursdays and some Saturdays
- GHS Nephrology, Cardiology, Community Paramedic and Care Coordinator work collaboratively to include Home health



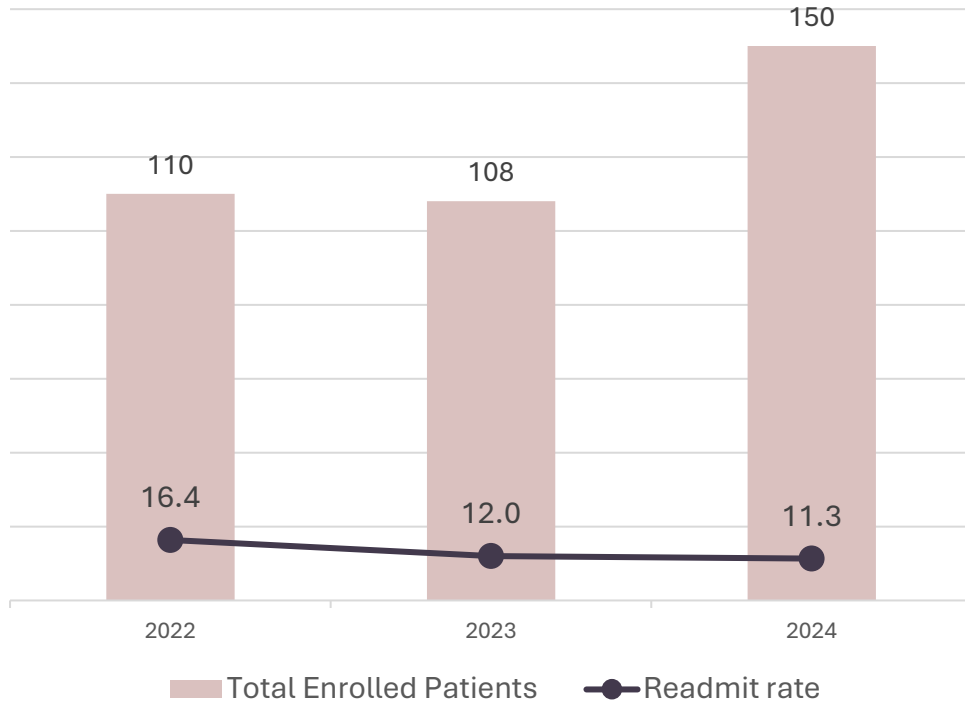
## Interventions & Outcomes

- 19 Home visits by GHS CP over 50 days
- Labs 5-6x weekly with Potassium dosage corrections
- Pt diuresis at home 11 times with a total of 1040 mg Furosemide
- High Potassium food identified December 14<sup>th</sup>. Low Sodium V8 containing 900mg per 8 oz.
- 12/28 Port placed at GHS for long term IV diuretic use and lab draws
- 1/10 patient care transitioned to County Home Health with plans for twice weekly 100 mg Furosemide pushes and three times weekly Creatinine and Potassium checks

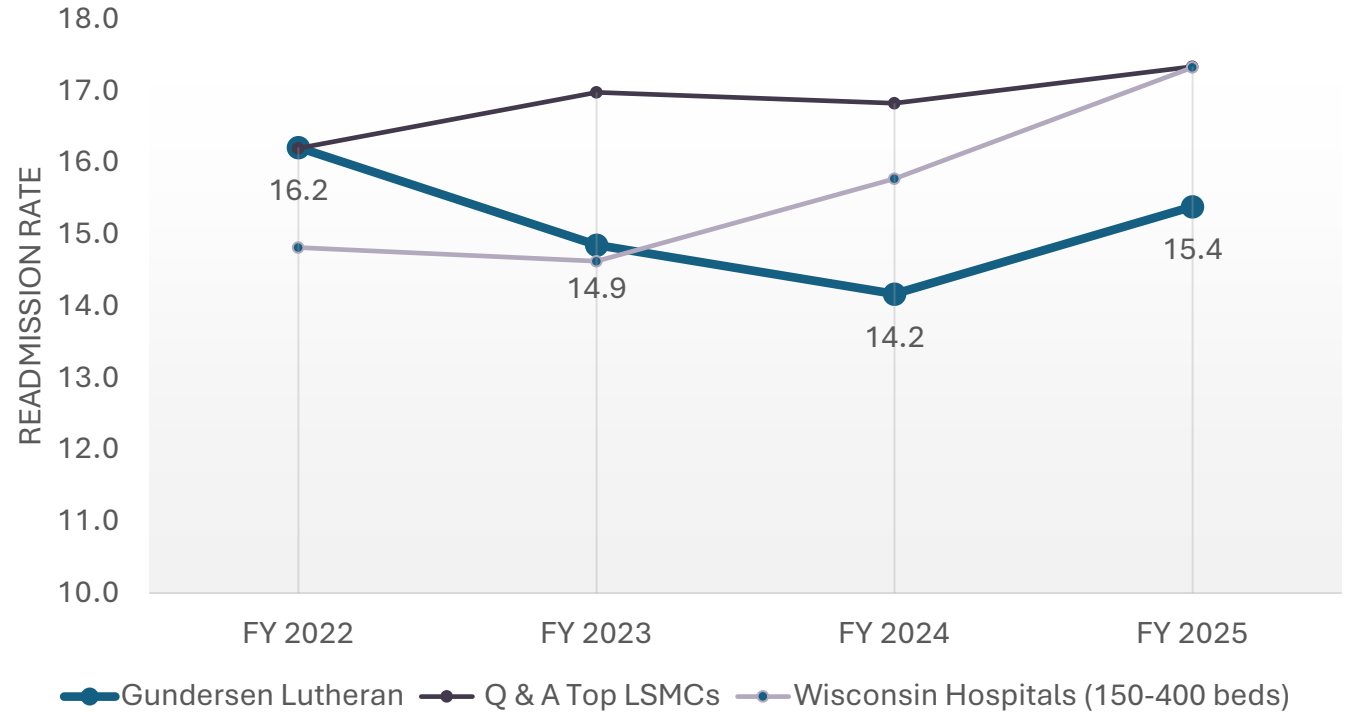
# Current Data



Community Paramedic Program  
Heart Failure Readmission Rate for Enrolled Patients



Heart Failure 30 Day All Cause Unplanned Readmissions  
April 2022- April 2025, All Payer Inpatient Discharges



Data Source: Vizient Clinical Database (CDB) using the CMS Heart Failure Readmission definition. The "WI Hosps 150-400 Beds" compare group includes Wisconsin hospitals with 150-400 beds that subscribe to the CDB. The "Q&A Study: TOP/BEST" compare group includes large, specialized complex care medical centers that were the top performers in Vizient's Q&A Study. (6)

# Impact on Heart Failure



Readmission rate for enrolled patients decreased significantly from 18.6% to 11% since the start of the program

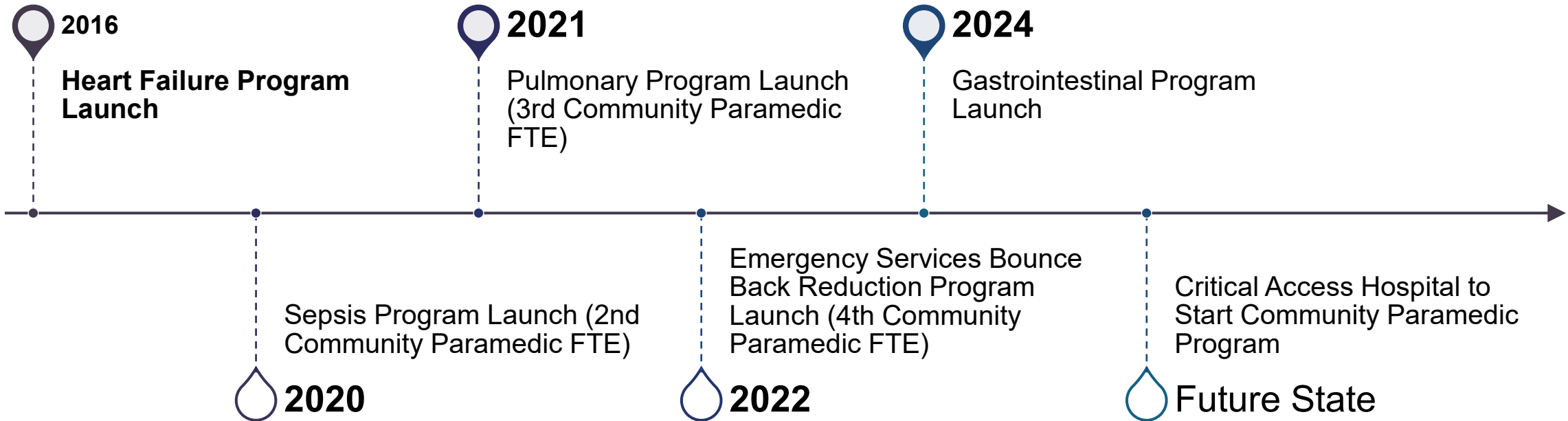


Current readmission rate comparison:

11% for patients enrolled in the Community Paramedic program

15.4% for patients not enrolled

# Program Progression



# 2024 Outcomes For All Programs



## Heart Failure Program

- 150 total patients
- 11% readmission rate

## Pulmonary Program

- 1 total patient
- 0% readmission rate

## Sepsis Program

- 133 total patients
- 12% readmission rate

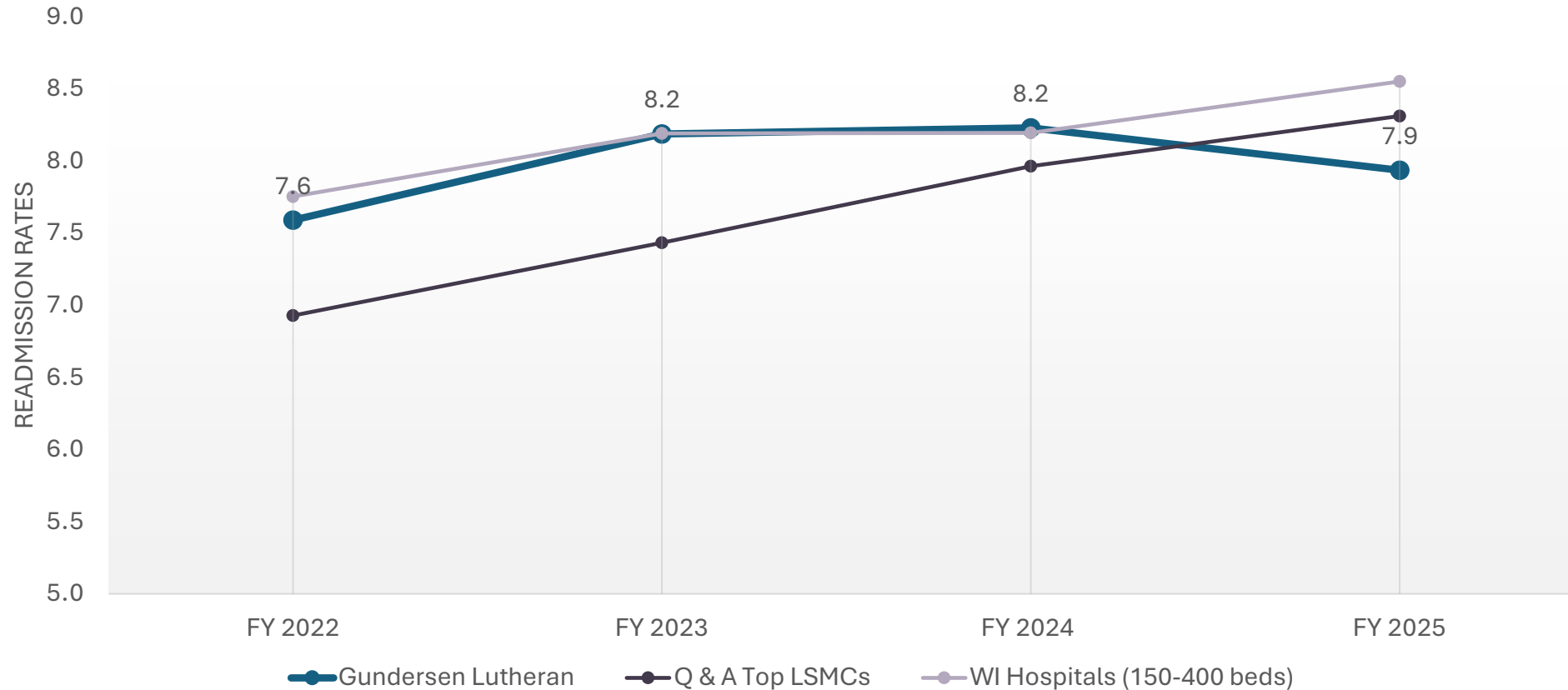
## Gastrointestinal Program

- 10 total patients
- 10% readmission rate

## ED Bounce Back Reduction Program

- 144 total patients
- 9 % bounce backs

## 30 Day Hospital Wide All Cause Unplanned Readmissions January 2022- May 2025 All Payer Inpatient Discharges



Data Source: Vizient Clinical Database (CDB) using the CMS Hospital Wide All Cause Unplanned Readmission Definition. The "WI Hosps 150-400 Beds" compare group includes Wisconsin hospitals with 150-400 beds that subscribe to the CDB. The "Q&A Study: TOP/BEST" compare group includes large, specialized complex care medical centers that were the top performers in Vizient's Q&A Study.

# 2024 Estimated Cost Savings



- **Average Cost of Readmission: \$17,700 <sup>(8)</sup>**
- **Average Cost of Emergency Room Visit: \$799**
  
- **Average Cost per Paramedic Visit: \$181**
- **Average Visits Per Month: 203**
- **Yearly Average Cost of All Program: \$440,916**

Program  
Cost  
Savings:  
\$1,619,583

Heart Failure: \$1,221,369

Sepsis: \$362,010

Pulmonary: \$17,100

Emergency Services: \$300,711

Gastrointestinal: \$159,309

Emplify Health by Gundersen Region. Internal database, December 2024 program. Confidential internal data. (7)

# Patient Impact



- *This lady is a shining example of everything good at Gundersen. She was a fantastic resource for me as a patient and for my husband as a caregiver. She brought smiles to my home in abundance; her levels of care and compassion were amazing. I cannot speak more highly of how she treated and cared for us.*

- *I highly recommend this Paramedic program and would like to thank you for having it available for me. It was so valuable, I looked forward to their visits, I knew I would have my questions answered right from the comfort of my own home.*

# Lessons Learned

- Adapt to unique needs
- Unplanned visits occur
- Strong Collaboration

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# Key Takeaways



- Understand the defined scope and role of community paramedics to maximize their impact in patient care.
- Secure stakeholder buy-in and foster collaboration across healthcare teams and community partners for program success.
- Start with one focused patient population
- Value added program

# References



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# Questions?



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