Spalding Regional Hospital

Mobile Intergraded Health Care

Shifting from Sick Care to Patient Centered Healthcare.

Where is Spalding County in all of this?

2014

Unemployment Rate: **8.5%** NR 6.8%
Living Below the Poverty Level: **21.6%** Georgia Average 17.4%
Uninsured Healthcare Rate: **18%** (some reports as 27%)

ER visits cost as much as 7 times as much as community healthcare visits.

Agency for Healthcare Research and Quality

- Average ER Visit cost $1,318.00
- Average Urgent Care visit $155.00
- Average Primary Care Physicians visit $100.00

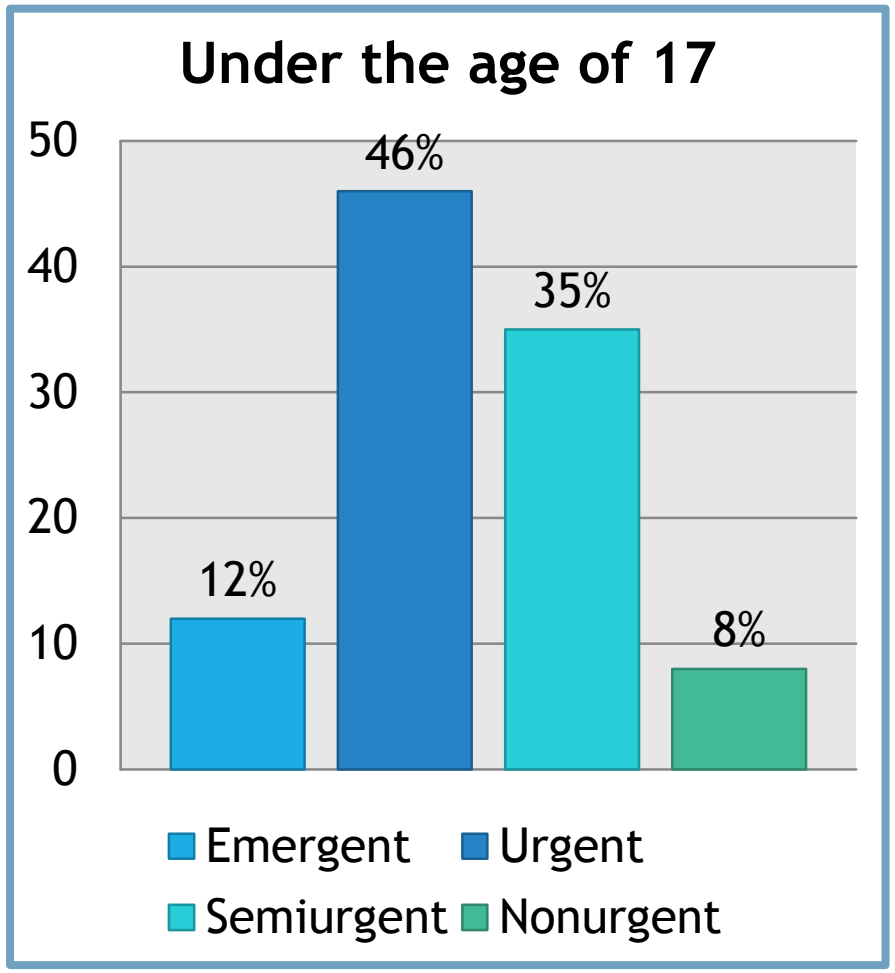
Spalding Regional Hospital
SPALDING HEALTH

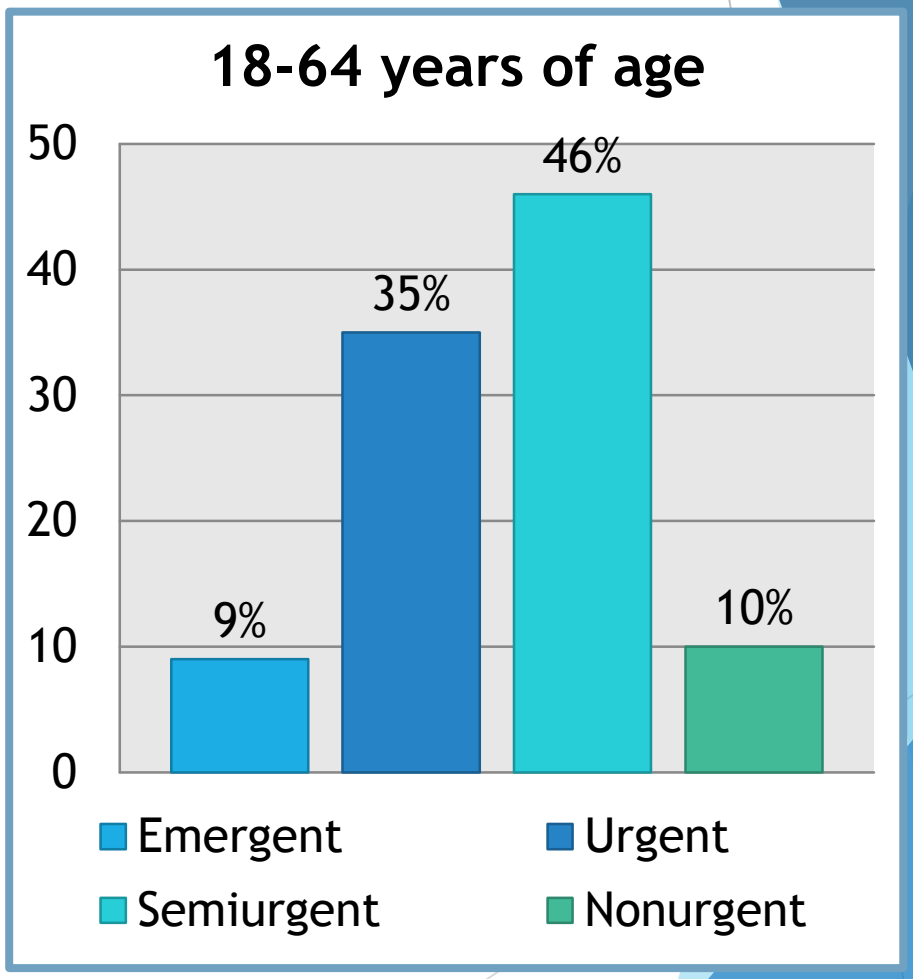
Fiscal Year 2013

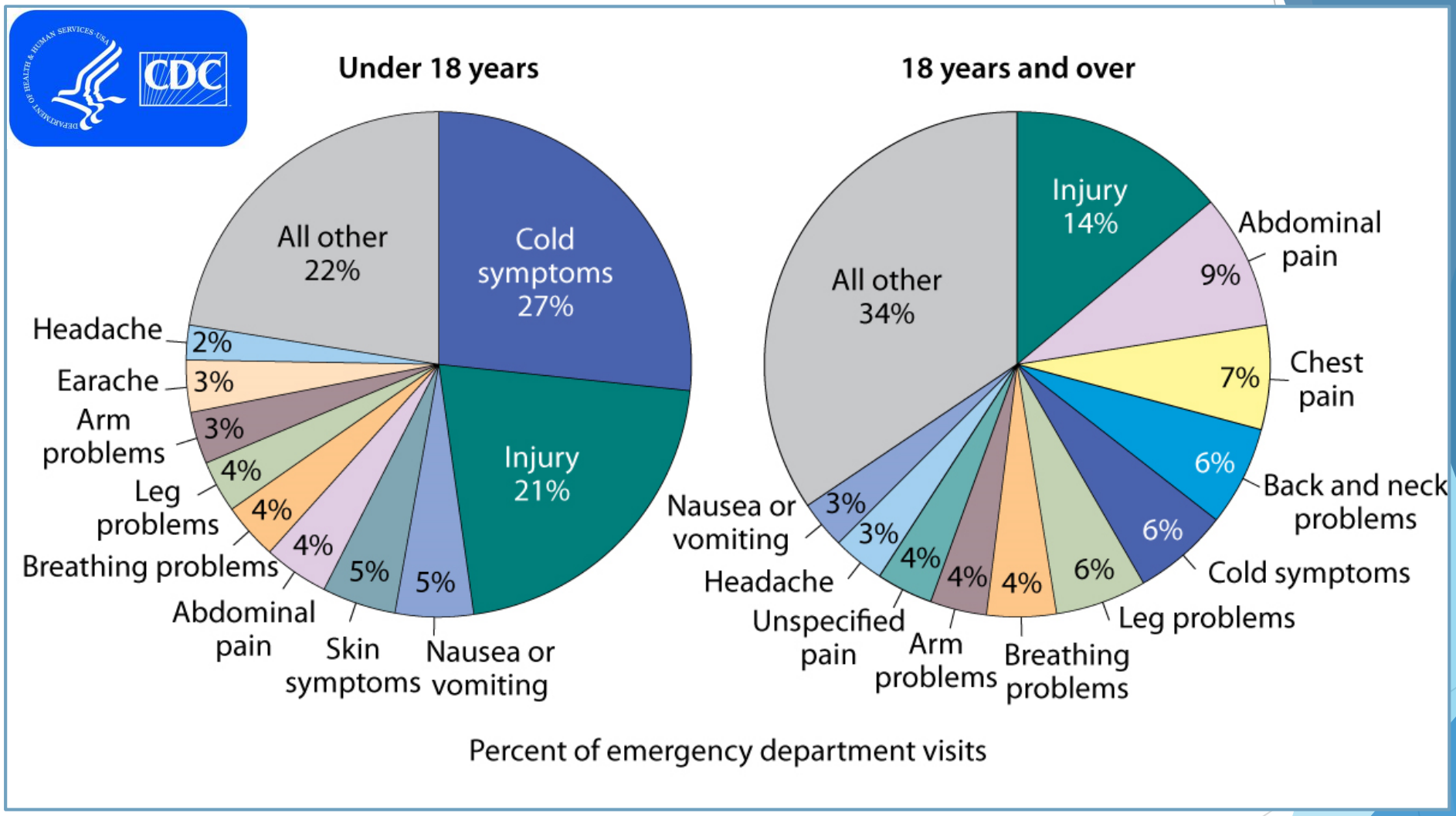
- ER Treated 52,402 patients
- 30% Uncompensated Treatment
- (Just over $21 million in losses for the ER alone)

Spalding Regional Hospital EMS

2012 ER Visits by Urgency






Under 18 years
All other 22%
Cold symptoms 27%
Injury 21%
Headache 2%
Earache 3%
Arm problems 3%
Leg problems 4%
Breathing problems 4%
Abdominal pain 4%
Skin symptoms 5%
Nausea or vomiting 5%
18 years and over
All other 34%
Injury 14%
Abdominal pain 9%
Chest pain 7%
Back and neck problems 6%
Cold symptoms 6%
Leg problems 6%
Breathing problems 4%
Arm problems 4%
Unspecified pain 4%
Headache 3%
Nausea or vomiting 3%
Percent of emergency department visits

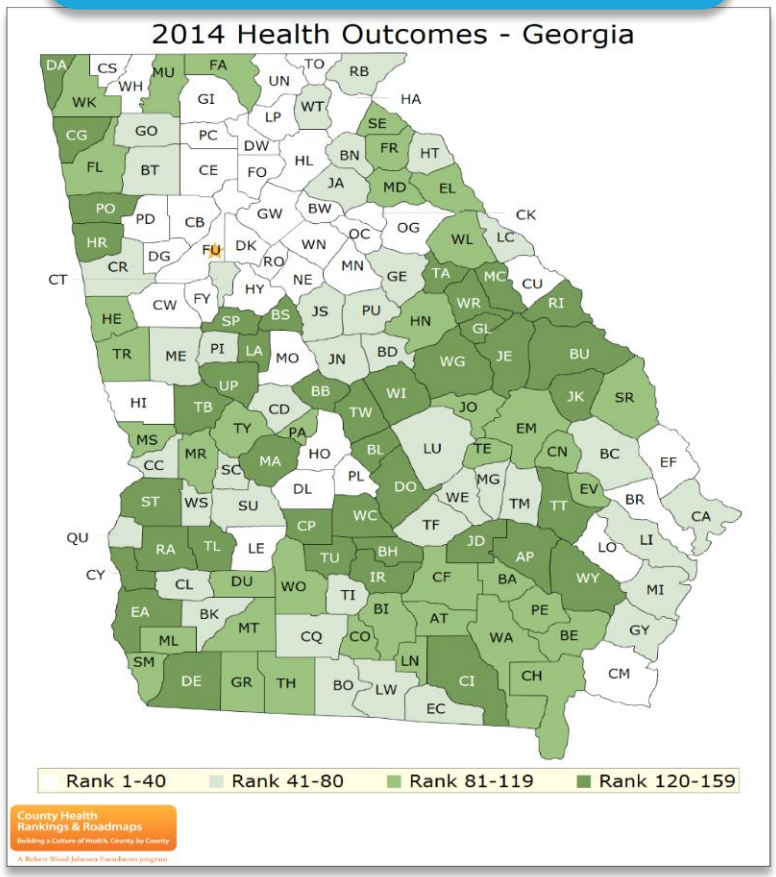
2012, National Healthcare Expenditures were nearly 2.8 Trillion Dollars.

Nearly one in five Medicare patients return to the hospital within a month of discharge, costing the tax payers an extra $17.5 billion in 2010.

Spalding County Georgia Health Ranking

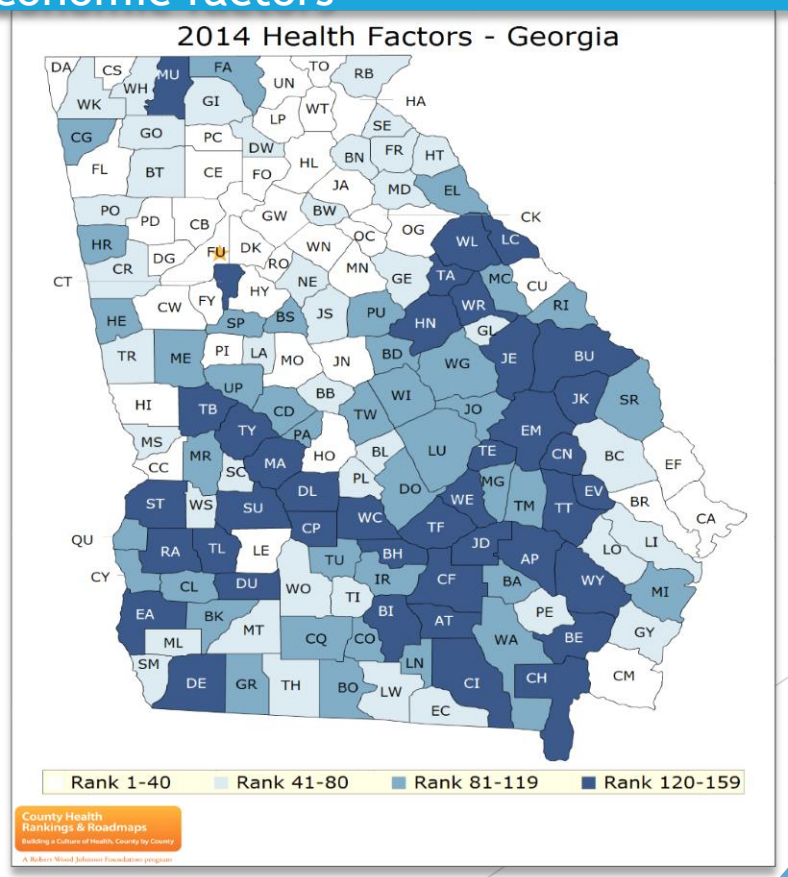
Ranked 141/159 Health Condition

Length and Quality of life.



Ranked 103/159 Risk Factor

Health behaviors, Clinical Care, Physical Environment, Social & Economic factors



Albert Einstein’s definition of insanity is:

“Doing the same thing over and over and expecting different results”.

Is this not what many of us in Healthcare are currently doing?

What can we do to help in this crisis?

An Answer is Mobile Integrated Healthcare

What is Mobile Intergraded Healthcare (MIH)

MIH is the provision of healthcare using Paramedics as Community Paramedics that function outside their customary emergency response/transport roles in ways that facilitate more appropriate use of emergency care resources and enhance access to primary care as well as performs patient-centered, mobile resources in the out-of-hospital environment that are integrated with the entire spectrum of healthcare and social service resources available in the local community.

Mobile Integrated Healthcare is not Home Health, is Not a Duplication of Services. It Fills the Gaps within the Healthcare system and Home Health agencies are among our strongest supporters and look to this program for assistance within our area.

Community Paramedics are not independent practitioners; they work under clear medical control of a physician, receiving direction and supervision to ensure patient safety.

The Community Paramedic training program builds upon the training and skill sets of experienced paramedics. Additional training in patient assessment, clinical skills and familiarity with the other healthcare providers and social services available in a local community will all be a part of the required training, and will lead to a more integrated approach to health care delivery.

How Is Community Paramedic Programs Different

Home Health

- Patient may not qualify
- Limited number of visits
- Limits on Duration of enrollment.
- Visits by LPN or RN
- No POC labs, No EKG, Limited medical treatments
- Provides Education

Transition of Care Teams

- Patient may not qualify
- Limited number of visits
- Often times just phone calls are made.
- 30 day enrollments
- Possible RN,LPN or non-clinical
- No POC Labs, EKG, Limited medical treatment
- Provides Education

CP

- All patients are provided the option to enroll
- No Limit on visits
- Based on needs.
- Paramedic, PA, NP, MD
- POC Labs, EGK, Resp function and treatment, has 24 hour in home MD access

Spalding Regional Hospital MIH Services:

- Transport to alternate facilities (urgent care, primary care provider, Mental Health)
- Post hospital monitoring & follow-up (hospital readmission prevention)
- Chronic disease management (CHF, COPD, diabetes, kidney failure, etc.)
- At home services (medication compliance, appointment scheduling, etc.)
- In field patient triage (treat & refer/release)
- Patient & community education (patient care plan, home health equipment)
- Public health support (PSA, Health Prevention Campaign, Community CPR)
- EMS Loyalty plan (Visits with our most loyal EMS Customers before they call)

WHAT HAS MOBILE INTEGRATED HEALTHCARE DONE FOR SPALDING?

- Reduced Frequent Flyers for both EMS and the Emergency Department.
- Shown Marked Reduction in Hospital Re-admissions
- Patients Have Greater Understanding & Control Over Their Chronic Diseases
- Patients Are Experiencing a greater Quality of Life
- Connects Patients to Community Resources
- Lowers the Costs of Healthcare for the Patient, Hospital, and Payers
- Unchains Patients From Their Homes and Reunites Them Back in Their Communities.

How Have We Done This

- Home Visits
- We Perform Medication Reconciliation With Pharmacy Home Visits
- Medication Administration Compliance
- Assist in Medication Cost Reduction and Comparison
- Nutritional Services Home Visits
- Partners in Home Health Care Services for additional Recourses.
- Assist in Transportation and arrangement of Doctors Appointments
- Relationships with Patients Doctor to assist in understating care

Program Tracking of Patients started in October of 2014. With No 30 day Admissions The Following is a Summary Patient Outcomes.

Results of 17 Patients Over 9 Month Pre-Enrollment and Enrollment		
Patient #	Pre-Enrollment	Enrollment
1	18	1
2	12	0
3	12	1
4	10	3
5	9	1
6	6	2
7	6	0
8	6	1
9	6	2
10	6	2
11	5	0
12	8	1
13	4	0
14	6	1
15	7	0
16	5	1
17	7	0
Totals	133	15

Patient Example #1

- Patient History: CHF, AMI, HTN, CVA, IDDM
- Patient had Home Health Services but had 13 admissions prior year before enrollment into the program
- Since Enrolled in program Oct. 2014 patient has 1 admission
- Currently at 208 days and counting with no admissions
- Patient is compliant with medications & Meds have been reduced or discontinued
- Complaint with all treatment plains as well as PCP visits
- Pt has had a 23.6 pound weight loss and continues to improve
- Patients health improved so much that home health has discharged.

Patient Example #2

- Patient History: CHF, HTN, and ETOH Abuse
- Patient had 7 admissions prior year before enrollment in program
- Issues between patient and PCP resulted in patient not having a PCP
- Patient was non-compliant with diet, PCP, and Medications.
- Since enrolled in the program in Jan. 2015 patient has had no admissions and no trips to the ED.
- Patient now has a new PCP and is in control of their medical condition.

Patient Example #3

- Patient History: CHF, HTN, IDDM, CVA, Ambulate only with a walker, Schizophrenia, & Depression.
- 5 admissions prior year before enrollment in program & as many as 3 ED visits in a day.
- Non-compliant with meds and Dr. appointments, Patient went through 3 caseworkers and process started on eviction from home.
- Since enrolled in Feb.2015 Patient has had only 1 admission and 1 ED visit
- Patient is compliant with meds and Dr. appointments.
- Program working with patients Dr. has been able to decrease in amount of meds patient requires.
- Patient has weight loss of 150 pounds and no longer needs a walker
- Patient is now making trips to grocery store, pharmacy and attending peer counseling 3 times a week when before the program patient would not walk or leave home.
- Program success stopped patient from eviction, reconnected with family and caseworkers.

Patient Example #5

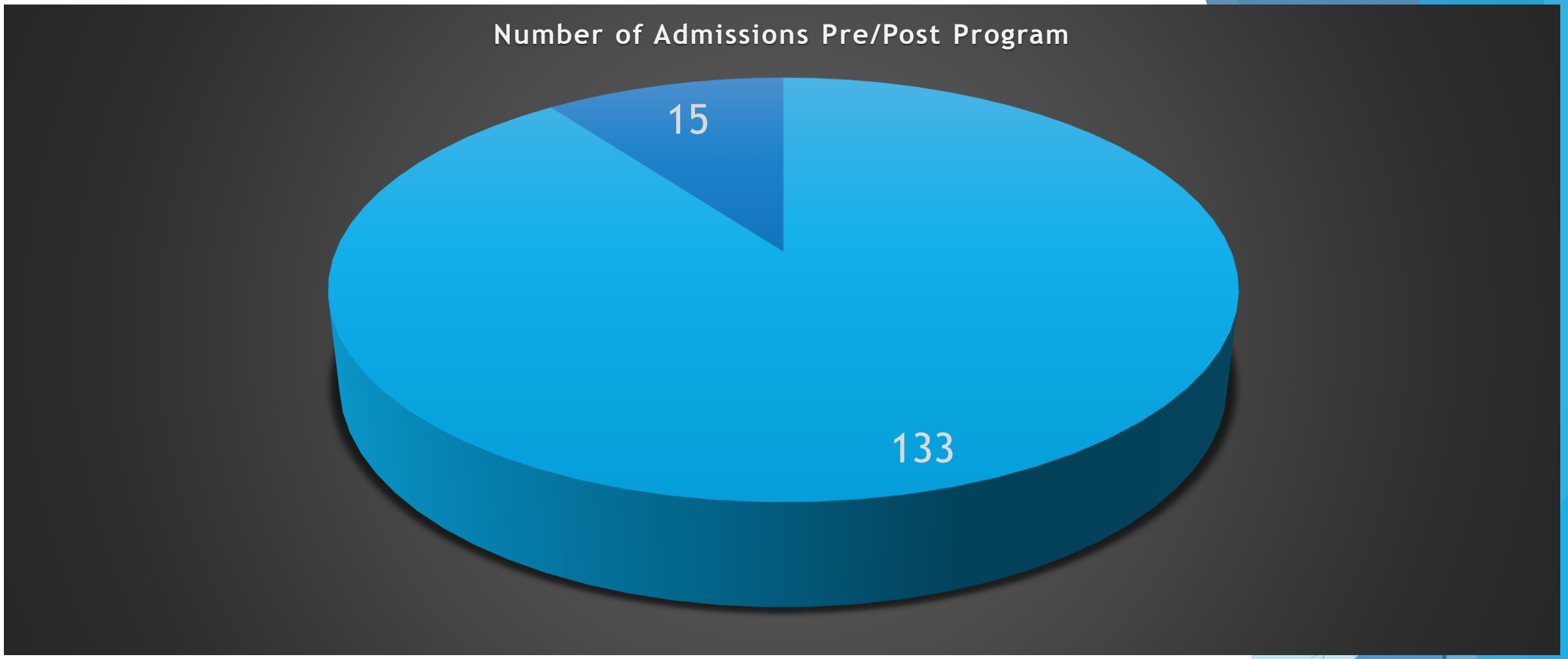
- Patient History: CHF, HTN, Renal Failure, IDDM, Right BKA
- Patient had Home Health care but still had 18 admissions prior year before program enrolment in Oct. 2014
- Patient was non-compliant with fluid restrictions, and meds.
- Patient has only 1 admission since starting program that was back in Nov 2014
- Patient has graduated program and remains in control of healthcare needs.

Patient Example #6

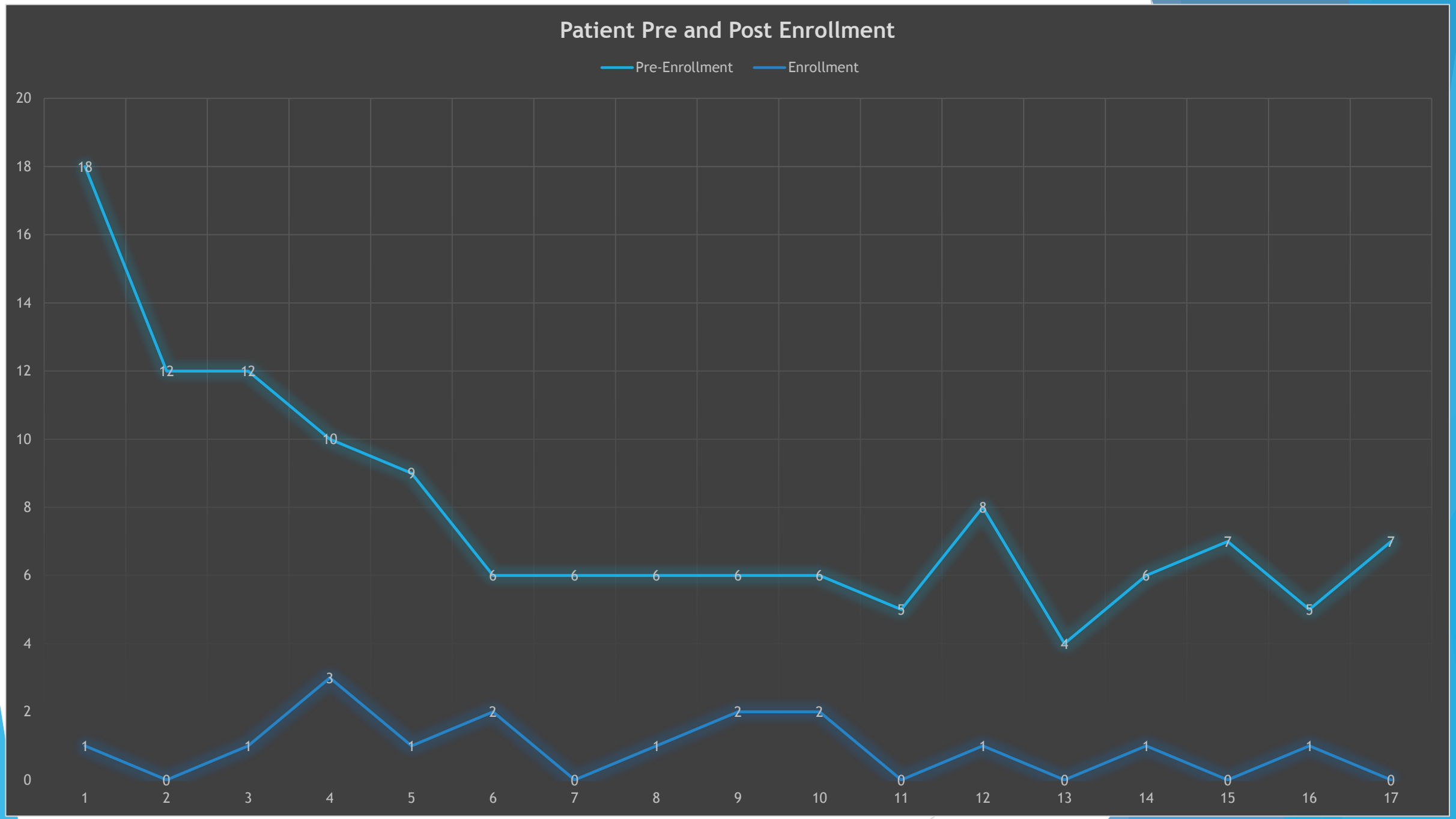
- **Patient History**: CHF, COPD, HTN, IDDM, Anxiety, Depression
- Patient had 7 admissions prior year before enrollment in program as well as Multiple admissions prior year to another hospital and ED.
- Patient was non-compliant with Dr. appointments and diet
- Since enrollment in program in Jan.2015 patient has had only 1 admission and reduced visits to ED.
- Patient is now compliant with Dr. visits and diet
- Patient is no longer confined to their home due to improvement and has outings with family occasionally now.

Patient Example #7

- Patient History: CHF, HTN, CVA
- Patient Had 6 admissions prior year before enrollment into program
- Patient had home health and Physical Therapy but bother were discontinued due to patients non-compliance with home health.
- non compliant with meds
- Since patient enrollment into program in Jan. 2015 patient has had 3 admissions.
- Patient is now compliant with meds
- Patient reconnected with Home health as well as Physical therapy.



90% Decrease in Re-Admissions


Patient Pre and Post Enrollment
Pre-Enrollment
Enrollment
20
18
16
14
12
10
8
6
4
2
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
18 12 12 10 9 6 6 6 6 6 5 8 4 6 7 5 7
1 0 1 3 1 2 0 1 2 2 0 1 0 1 0 1 0

Reduction in Calls to 911

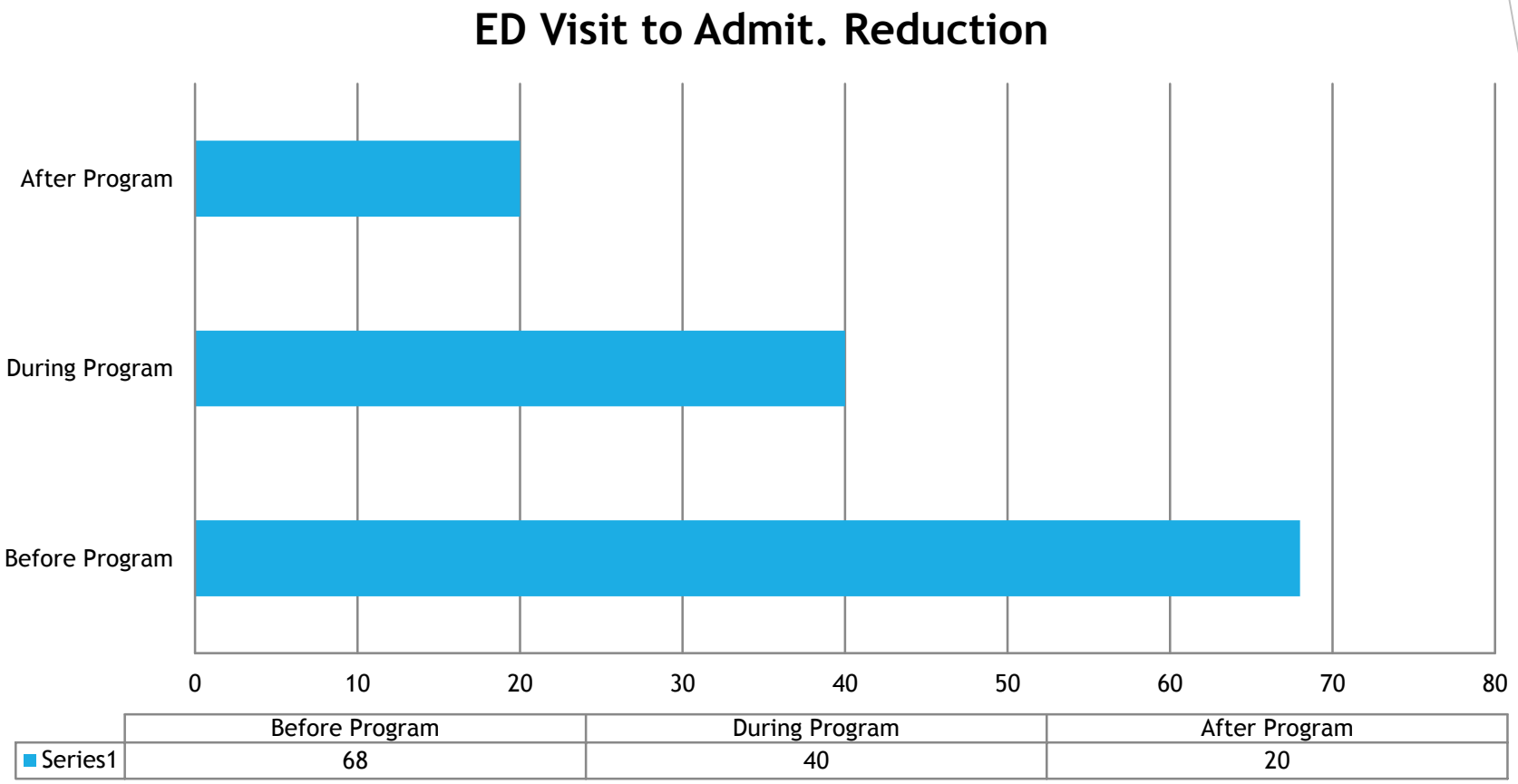
Total 911 Calls for EMS (Prior to Program)

100 calls to 911

Resulting in no Transport (After Program)

59 calls to 911

41% Reduction in EMS calls to target group



71% Reduction

Thank You!!