American Hospital Association™

Advancing Health in America

AHA Events

Innovative Management of High-Risk Patients in a Rural Setting: A Population Health Approach

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Associate Vice President
The Guthrie Clinic

Monday, February 7th, 2022

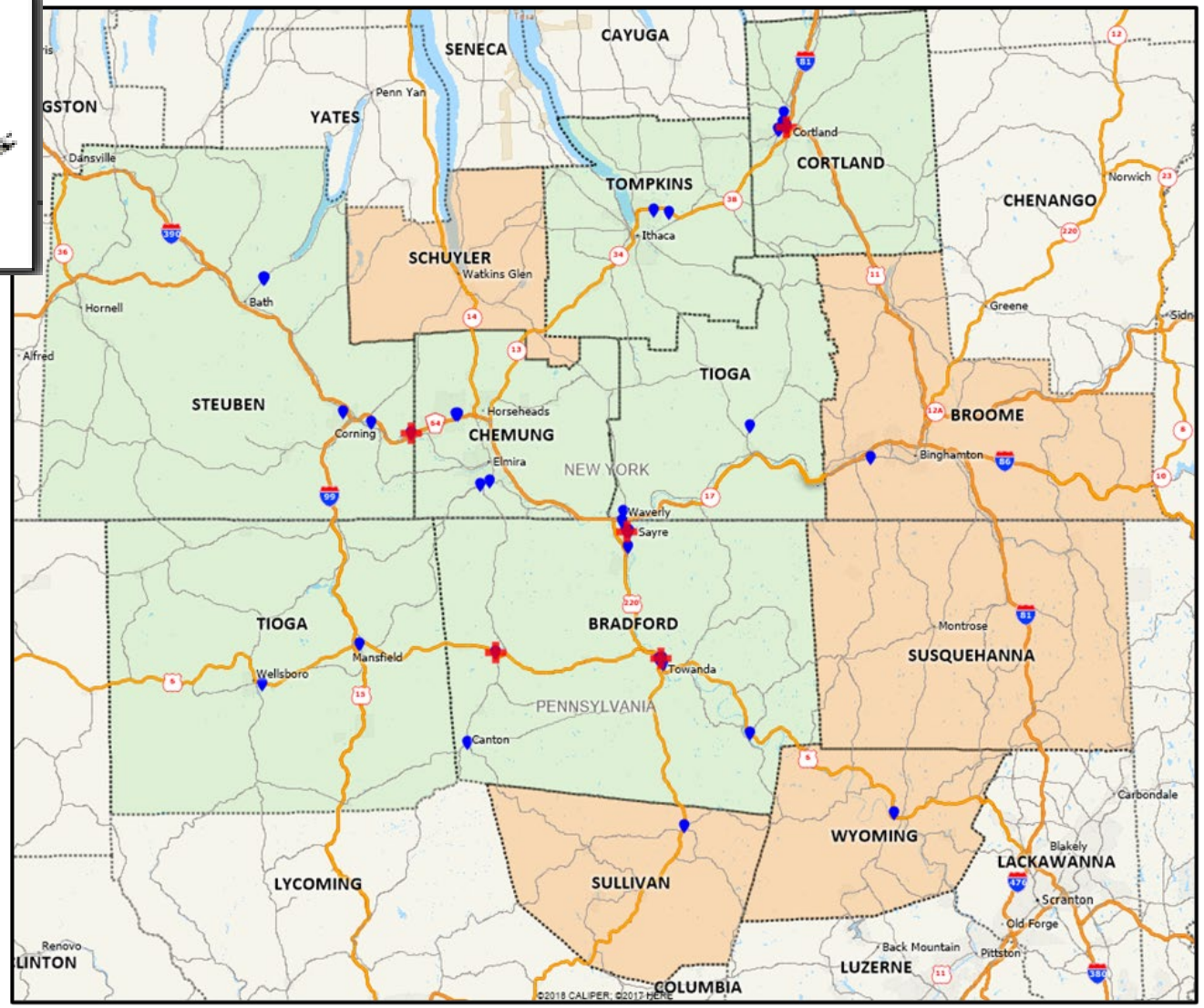
Today's Discussion

- Overview of Population Health at Guthrie
- High Risk Patient Management
- Social Determinants of Health (SDOH)/Healthcare Disparities
    - √ Patient assessment/data collection
    - √ Epic integration
    - √ Referrals to Community Based Organizations (CBO's)
- Poverty Simulation/Education for patients and staff
- New Paramedicine Program
- Case Study

The Guthrie Clinic

- Physician-Led 501(c) (3) Non-Profit Integrated Health System
  - Serving 12 Counties in the Southern Tier of NY and Northern Tier of PA
  - 6,200 Employees – Approximately 2,750 Pennsylvania and 3,450 New York State Residents
  - Business Split Approximately 50/50 Between PA and NY
- Guthrie Medical Group
  - 108-Year-Old Multi-Specialty Group Practice – One of the First in the US
  - Approximately 325 Physicians and 240 Advanced Practice Providers
  - Regional Office Network of Primary and Specialty Sites in 25 Communities
- Guthrie Hospitals
  - Robert Packer Hospital – Sayre, Pennsylvania
  - Corning Hospital – Corning, New York
  - Troy Community Hospital – Troy, Pennsylvania
  - RPH/Towanda Memorial Hospital – Towanda, Pennsylvania
  - Cortland Medical Center – Cortland, NY

Guthrie 12-County Primary and Secondary Service Areas



LEGEND

- County
- Guthrie Location
- Guthrie Hospital

County selection sets

- Secondary Service Area
- Primary Service Area

0 7.5 15
Miles

County	CY2021 Population
Primary Service Area (PSA)	
Bradford	59,788
Chemung	82,370
Cortland	47,287
Steuben	94,574
Tioga NY	47,761
Tioga PA	40,286
Tompkins	101,898
Total PSA	**473,964**

Secondary Service Area (SSA)	
Broome	188,500
Schuyler	17,694
Susquehanna	39,817
Sullivan	6,008
Wyoming	26,421
Total SSA	**278,440**
12 County Service Area	**752,404**

Guthrie locations <u>not</u> plotted = Med Supply, Lab, SNF, House of Hope, and Optometry locations

Source: HANYS. Strategic Planning & Marketing, July 2021

Gu

283 Bed Tertiary Care Teaching Hospital

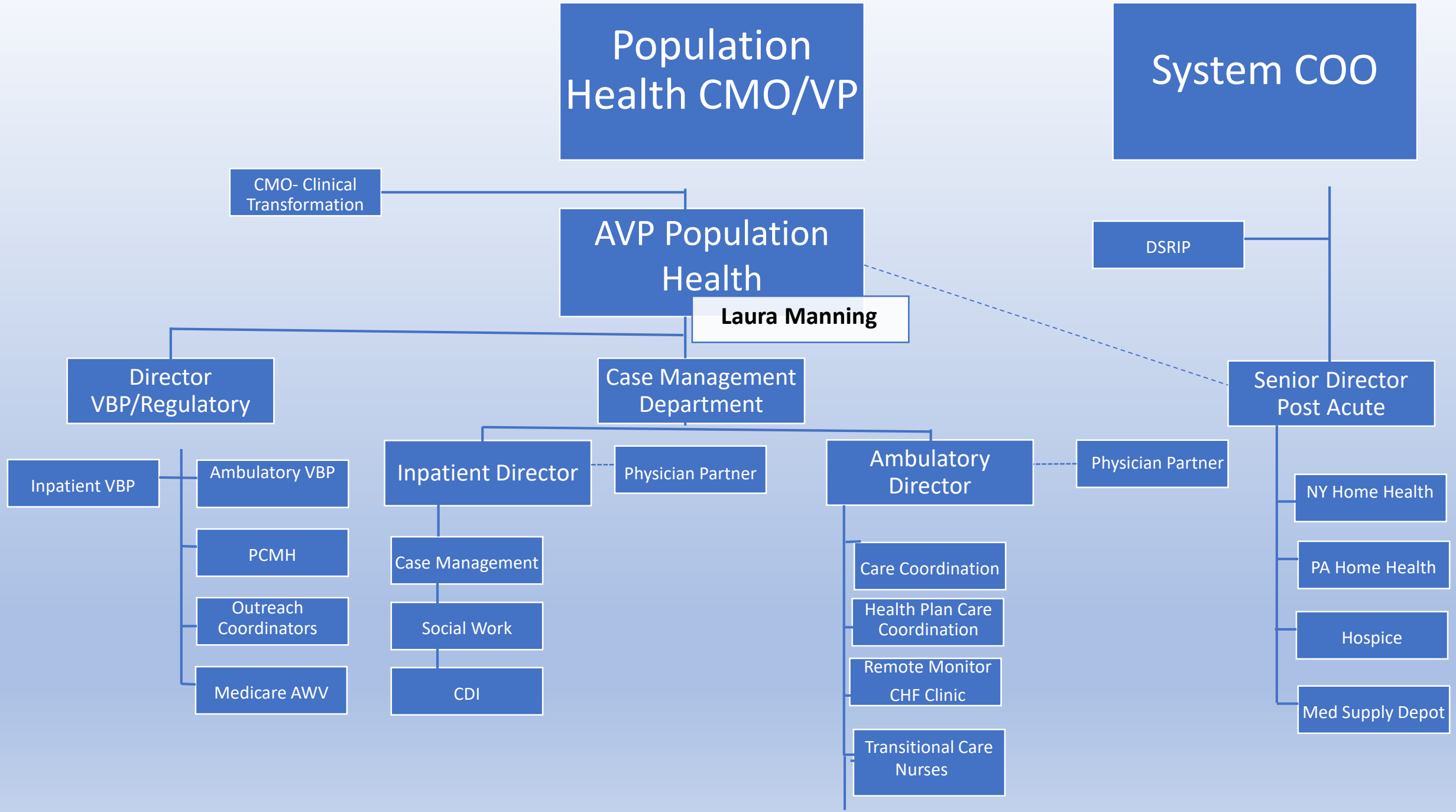
21 Bed Community Hospital
68 SNF Beds
94 Personal Care Beds

25 Bed Critical Access Hospital

Guthrie 2021

Transform. Innovate. Inspire.

Population Health


Population Health CMO/VP
System COO
CMO- Clinical Transformation
AVP Population Health
Laura Manning
DSRIP
Director VBP/Regulatory
Case Management Department
Senior Director Post Acute
Inpatient VBP
Ambulatory VBP
PCMH
Outreach Coordinators
Medicare AWV
Inpatient Director
Physician Partner
Case Management
Social Work
CDI
Ambulatory Director
Physician Partner
Care Coordination
Health Plan Care Coordination
Remote Monitor CHF Clinic
Transitional Care Nurses
NY Home Health
PA Home Health
Hospice
Med Supply Depot

Criteria for Care Management Consideration

- At least one chronic medical illness that they are having difficulty self-managing within the usual care processes available (i.e., Diabetes, CHF, Cancer, COPD, Asthma, CAD, CVA, ESRD, etc.)
- Demonstrates high utilization of services through multiple ED visits and/or multiple admissions
- Has identifiable social determinants that have a negative impact on their overall health
- Patient has a general risk score of 6 or higher
- Age 18 or greater
- Patient is attributed to a Guthrie Medical Group provider and has been seen in the office in the last 18 months
- Patient and/or family is interested and willing to work with a care coordinator in the program
- PCP supports the patient's participation in care coordination and will work with the care coordinator throughout the patient's enrollment
- Clear care coordination goals can be identified by the patient and/or family, provider, and care coordinator
- Patient is living in a home or assisted living setting and is available by telephone

Adult High-Risk Score

General Risk Score

Current as of 6 h

Last Change: ⬇

!! **16**

0 - 4 Points: Low Risk
4 - 6 Points: Medium Risk
6 - 25 Points: High Risk

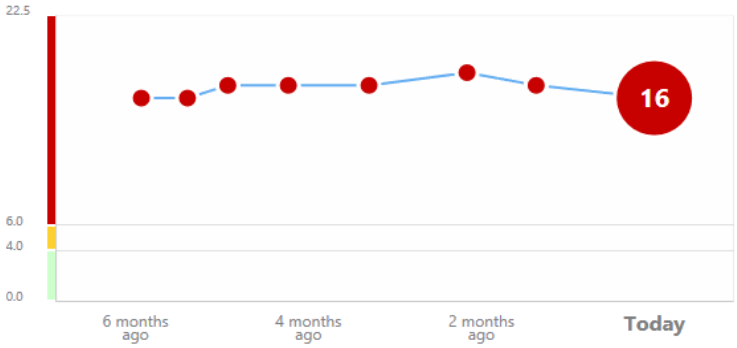
This score indicates an adult patient's general health risk based on age, chronic conditions, recent admissions or ED visits, and treatment factors.

Age: **59**
Hospital Admissions: **13**
ED Visits: **15**
Has Chronic Obstructive Pulmonary Disease: **Yes**
Has Medicaid: **Yes**
Has Congestive Heart Failure: **Yes**
Has CCM Chronic Kidney Disease: **Yes**
Last Fall Risk: 2+ falls/12 mo.: **Yes**
No Show Appt Count: **2**
Has Diabetes: **4.8**
ASCVD 10-Year Risk Score: **Not on file**
Last PHQ-9: **19**
Tobacco Use Status: **Quit**

General Risk Score

16 **-1**
Last 6 months

Last 6 months | Last 12 months | Last 2 years



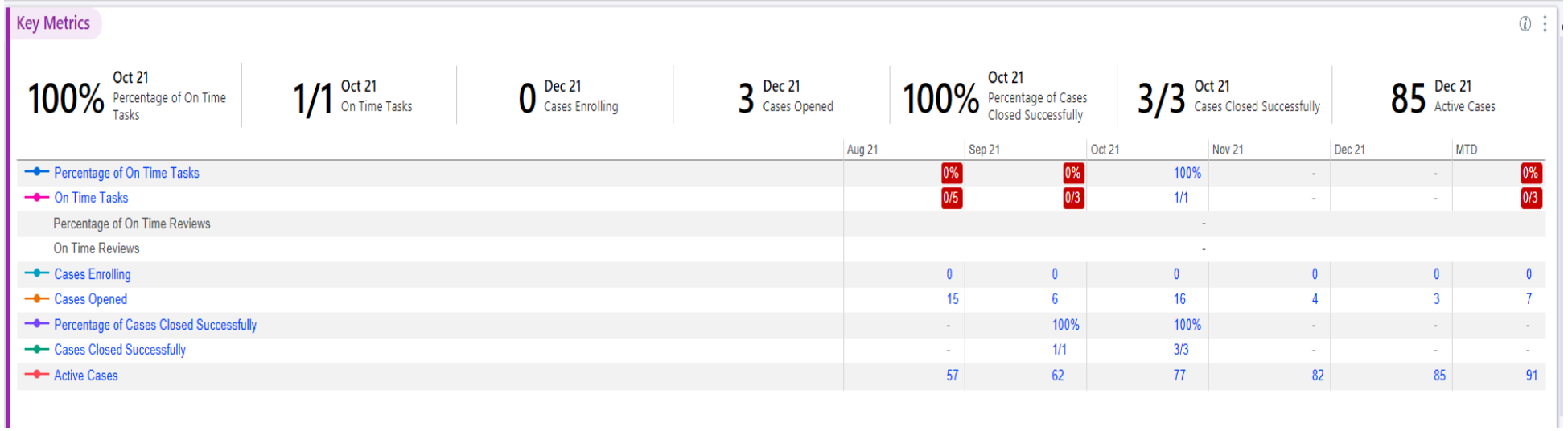
Changed In Last 6 Months

Value	Factor	Last Changed
15	ED Visits	yesterday
13	Hospital Admissions	9 days ago
2	No Show Appt Count	5 weeks ago
4.8	Has Diabetes	8 weeks ago
Yes	Has Medicaid	2 months ago

Additional Factors

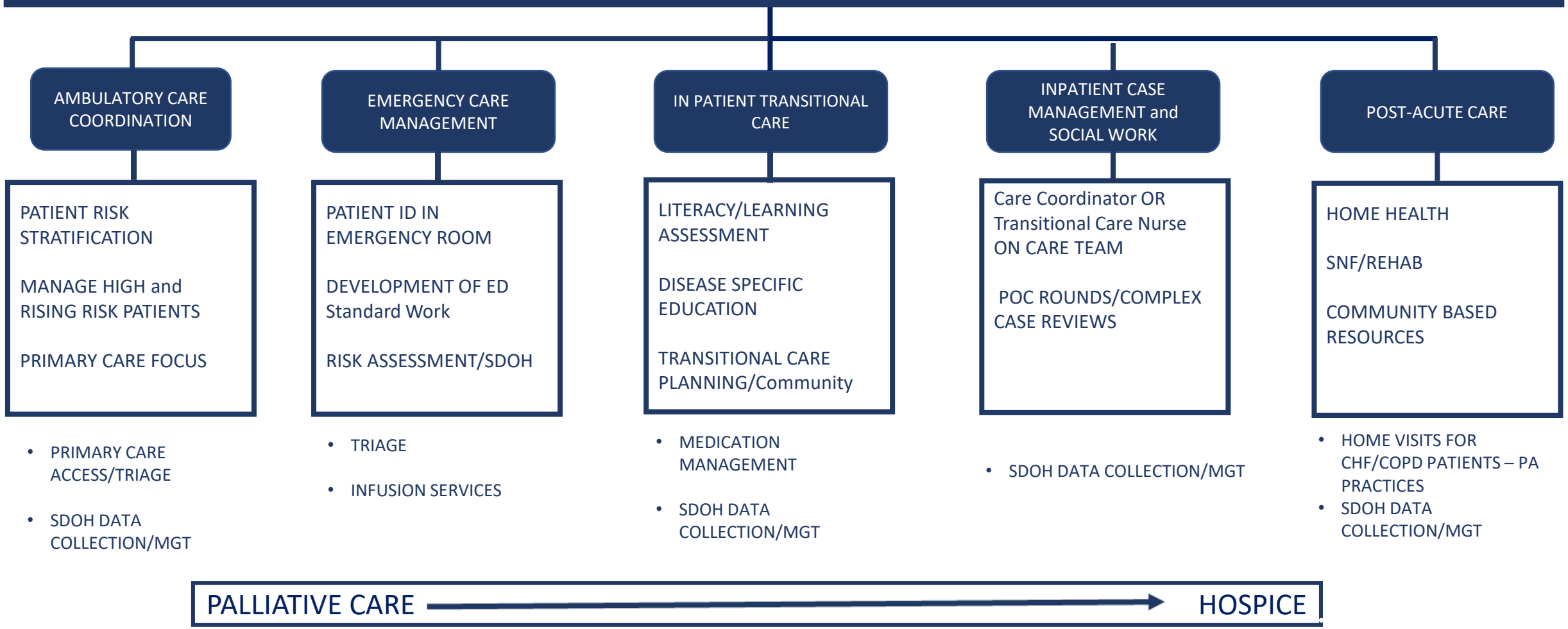
Panel Management

- Dashboard available to track and manage empaneled patients
- Daily reporting for outreach tasks that are due for care planning



	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	MTD
Percentage of On Time Tasks	0%	0%	100%	-	-	0%
On Time Tasks	0/5	0/3	1/1	-	-	0/3
Percentage of On Time Reviews			-			
On Time Reviews			-			
Cases Enrolling	0	0	0	0	0	0
Cases Opened	15	6	16	4	3	7
Percentage of Cases Closed Successfully	-	100%	100%	-	-	-
Cases Closed Successfully	-	1/1	3/3	-	-	-
Active Cases	57	62	77	82	85	91

Population Health Across the Care Continuum/High Risk Patients



Ref. Guthrie Care Coordination, 2021

Social Deteriments of Health

The link between people's health and their surroundings can no longer be ignored. Health inequities continue to grow across social classes, occupations and ethnic groups.

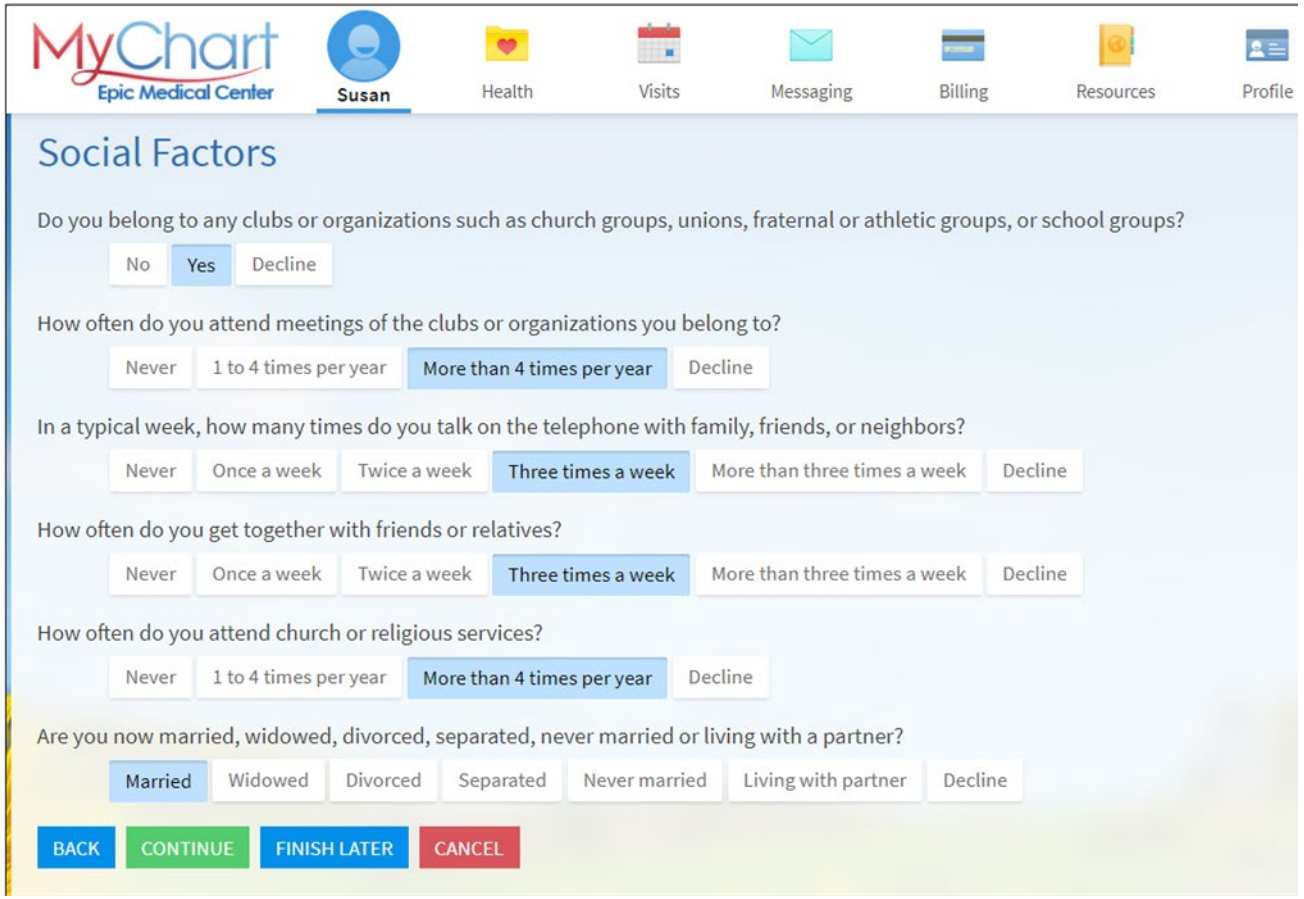
Patient Assessment for SDOH

- Patient assessment/data collection is underway!
- 55% of our Primary Care population currently collected
- Currently in Pilot to expand collection using MyChart
- Once EPIC upgrade is completed, we will be better able to compile data and analyze the needs in our community
- Initial data is showing prevalence in:
  - Housing need
  - Alcohol use
  - Transportation concerns
  - Financial strain

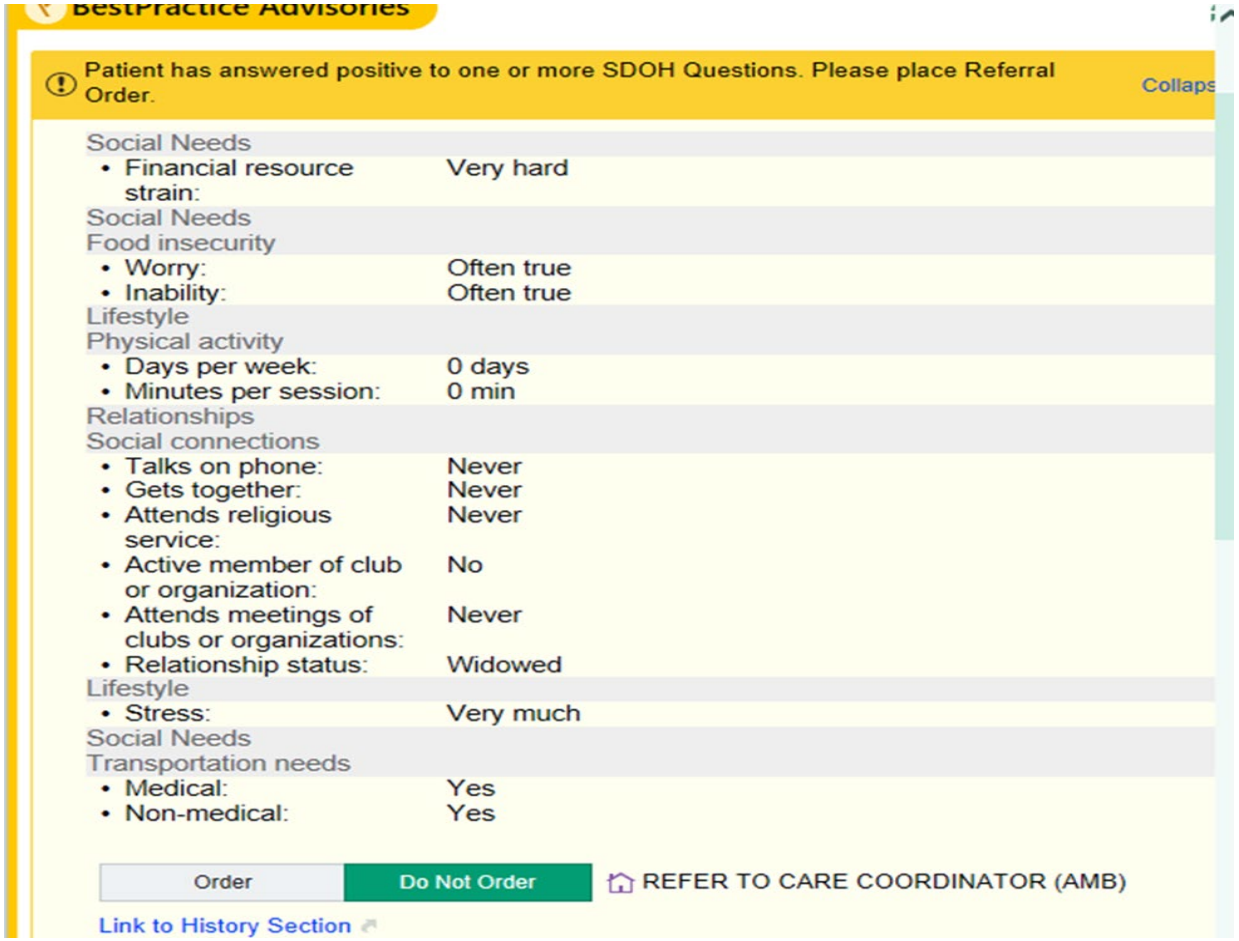
What the Patient Sees – SDOH Screening Tool – NAM Domains (Content Based on National Academy of Medicine Measures)

This is the view from the patients MyChart and contains the following areas:

- Social Connections
- Alcohol Use
- Financial Resource Strain
- Food Insecurity
- Housing Stability
- Physical Activity
- Stress
- Transportation Needs

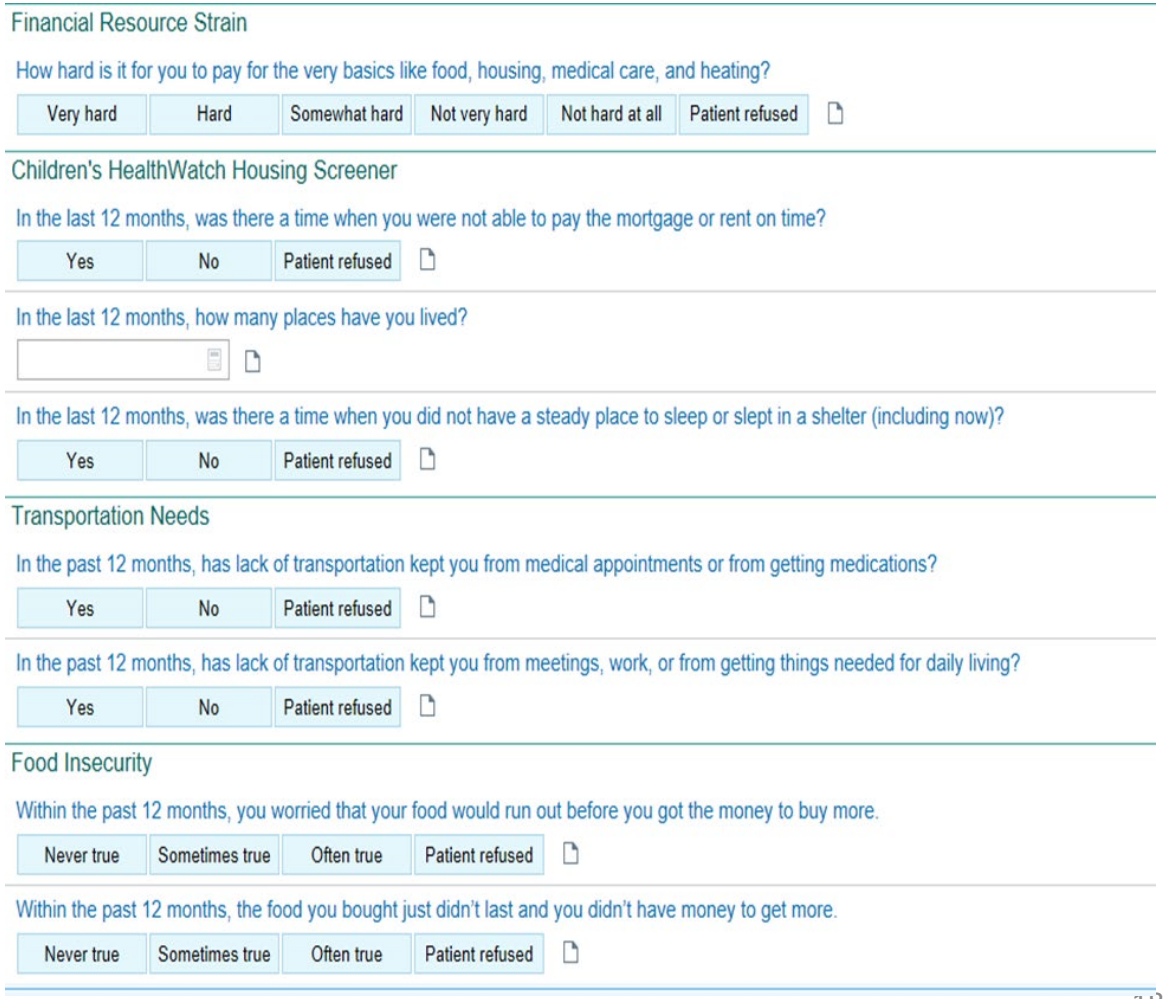


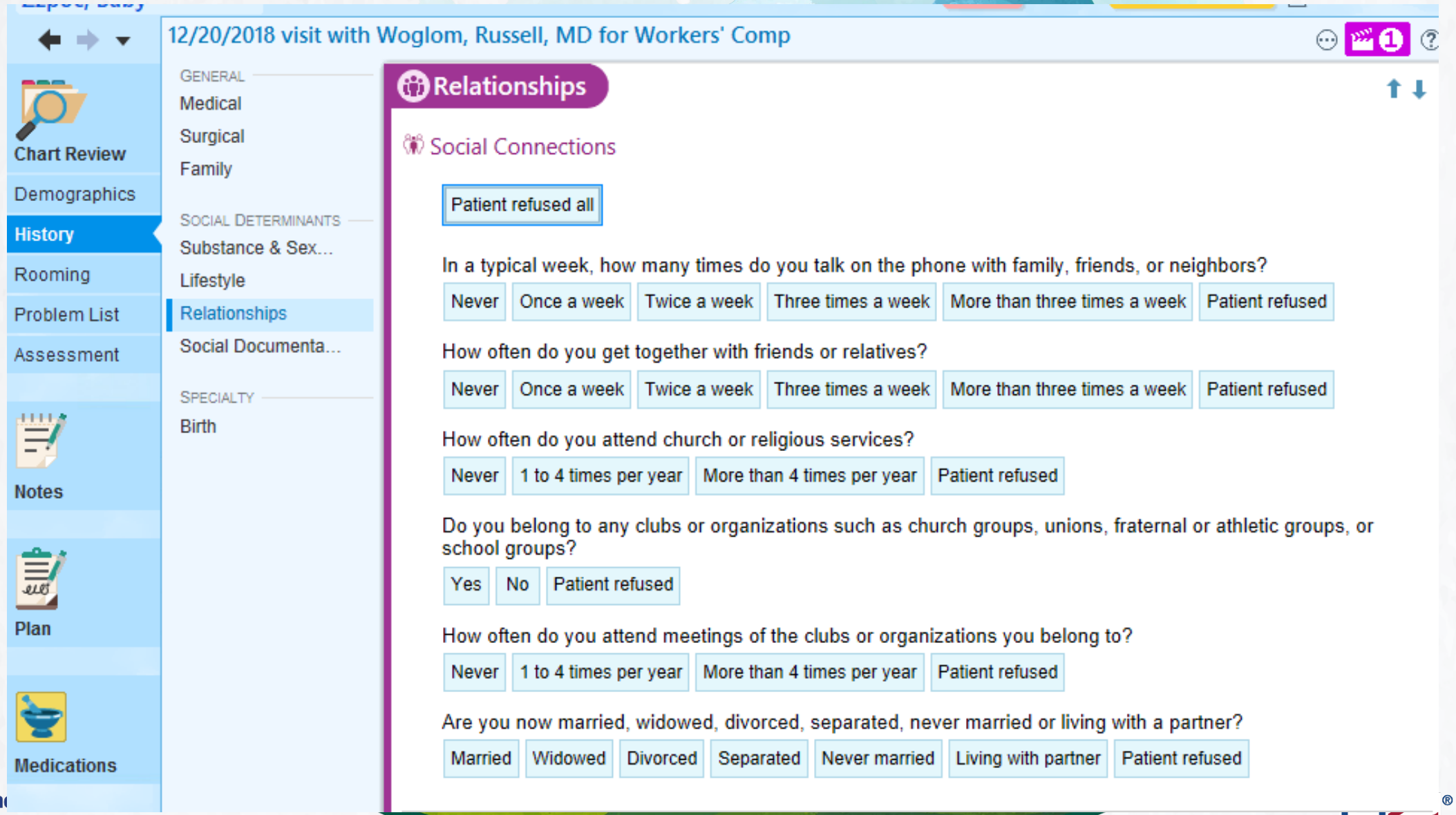
BPA Looks Like This ..

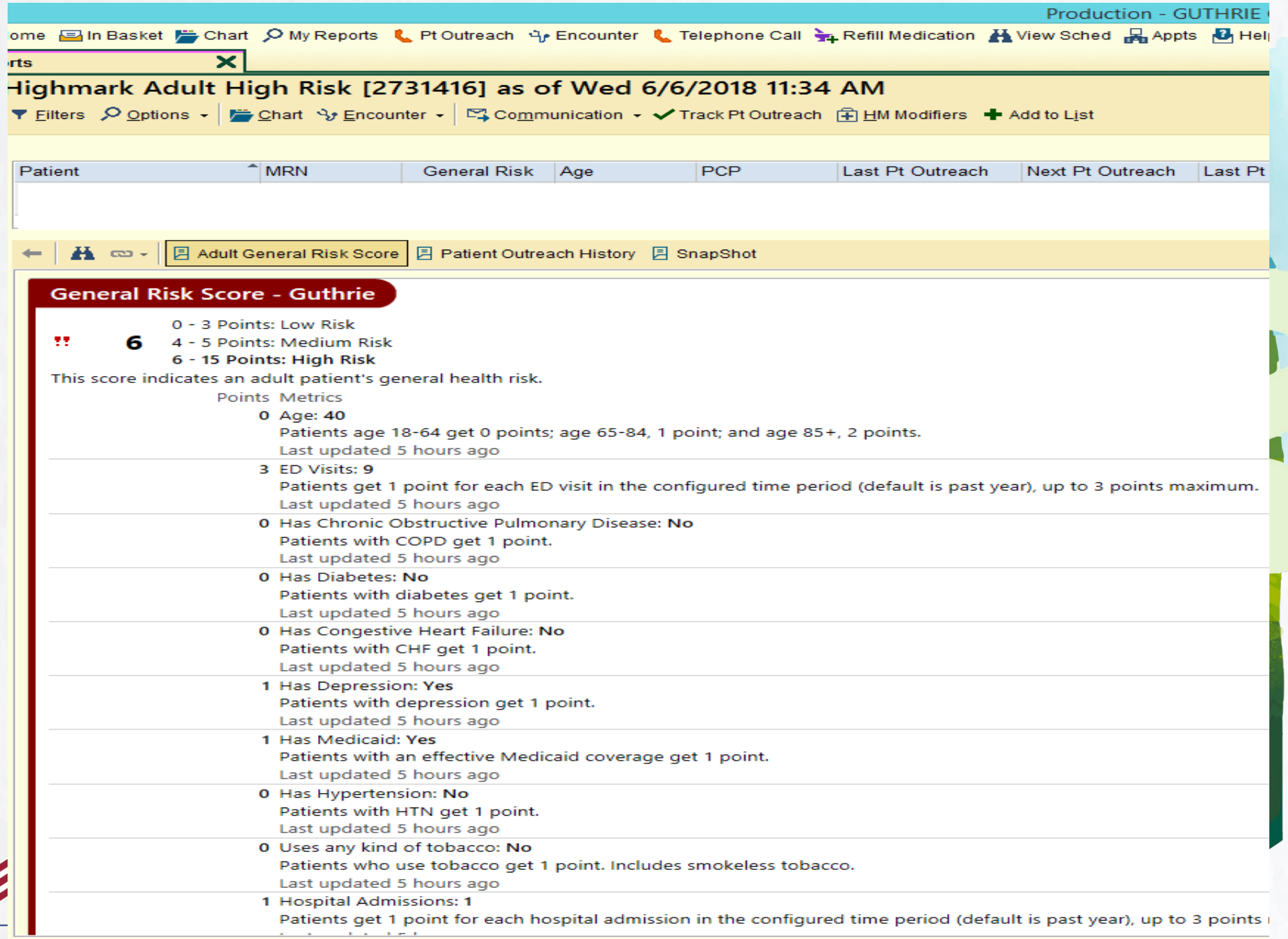


Rooming Navigator and Social Determinants Section

Completed by Rooming Staff, Care Coordinator and Wellness RN







High Risk Report

Each patient is risk stratified in Epic and assigned a risk score. Patients with a score of 6 and above are considered high risk, and are followed monthly, with calls to the patient to discuss various chronic disease needs and concerns. During these calls, education is provided, and motivational interviewing used to help engage the patient in achieving or maintaining their health goals.

Chart Review
History
Rooming
Problem List
Assessment
Notes
Plan
Medications

GENERAL
Medical
Surgical
Family

SOCIAL DETERMINANTS
Substance & Sex...
Socioeconomic
Lifestyle
Relationships
Social Documenta...

SPECIALTY
Birth
Obstetrics

What is the highest level of school you have completed or the highest degree you have received?

Primary Language:

Ethnicity:

Race:

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Not hard at all | Not very hard | Somewhat hard | Hard | Very hard | Patient refused

Food Insecurity

Patient refused all

Family

SOCIAL DETERMINANTS
Substance & Sex...
Socioeconomic
Lifestyle
Relationships
Social Documenta...

SPECIALTY
Birth
Obstetrics

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Never true | Sometimes true | Often true | Patient refused

Transportation Needs ⓘ

Patient refused all

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

Yes | No | Patient refused

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed daily living?

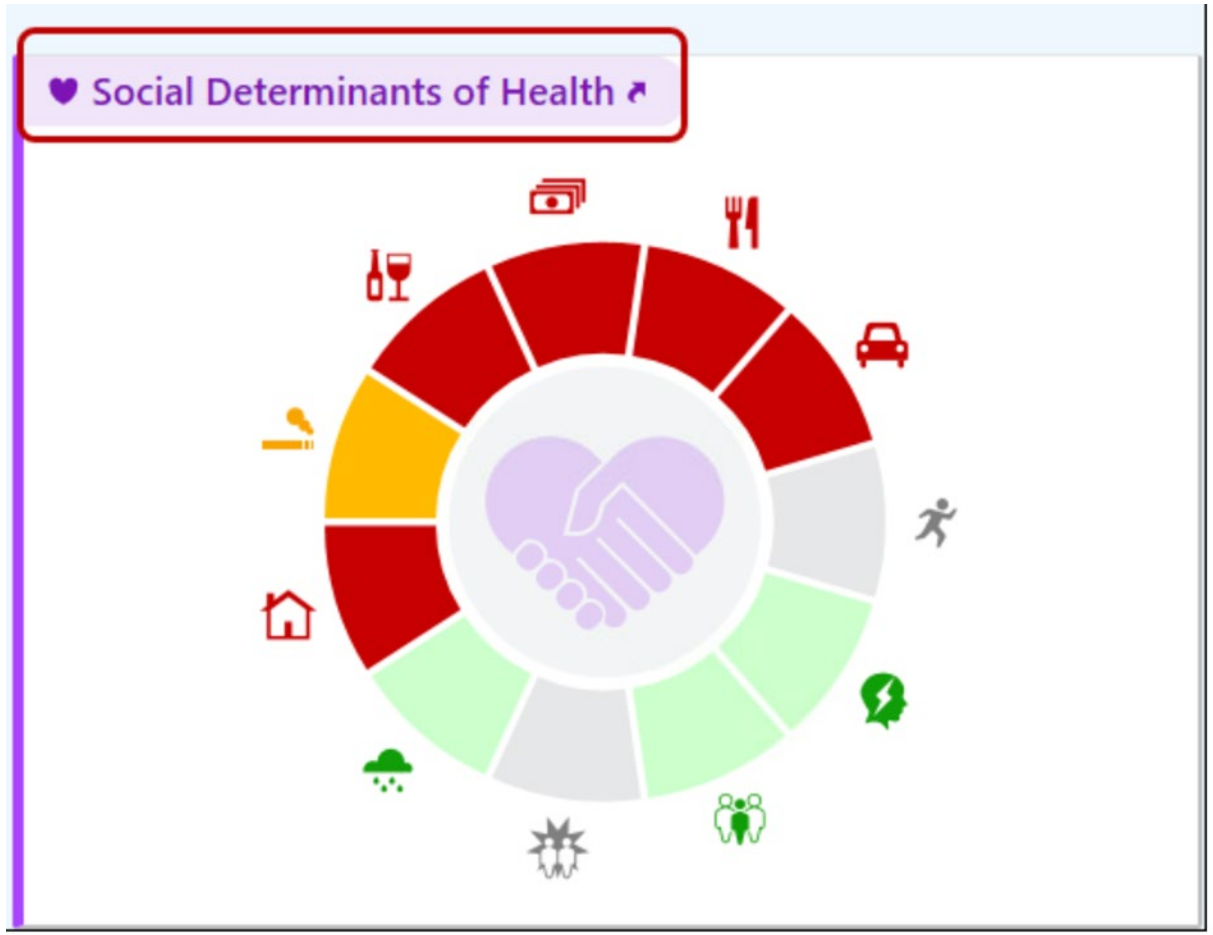
Yes | No | Patient refused

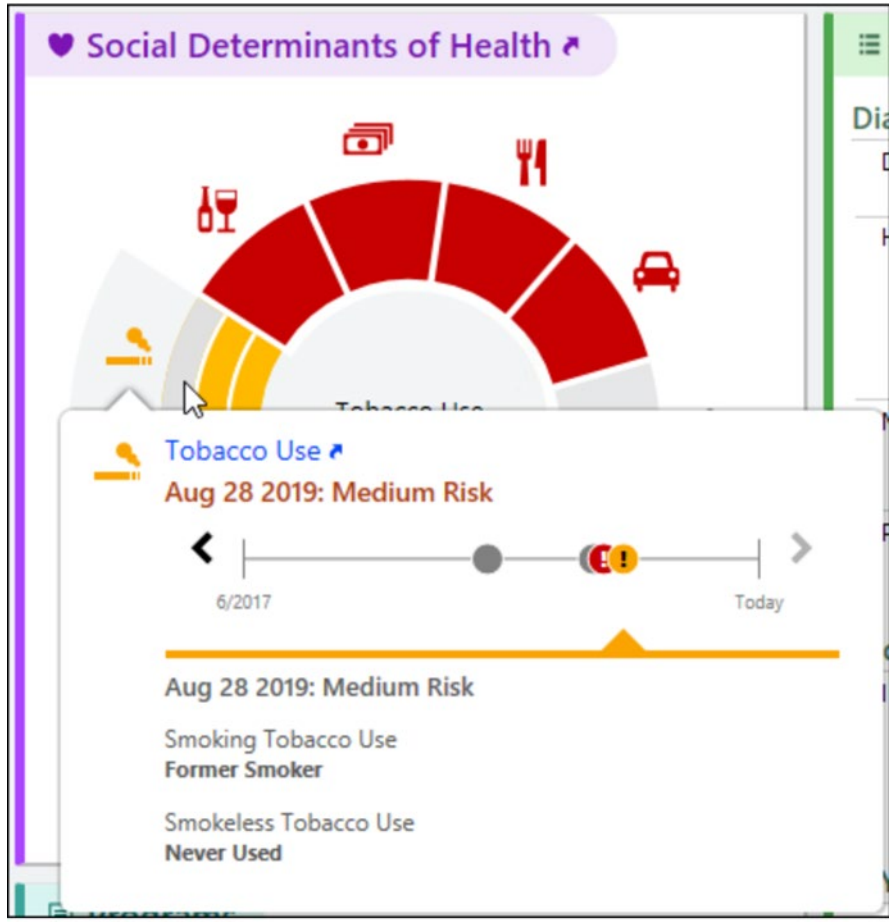
Audit Trail

✔ Mark as Reviewed **Never Reviewed**

Restore | ✔ Close | Previous | N

Plan of Care – Social Determinates of Health





- Elevators
- Primary Care Exam Rooms
- Website

How Do Social Determinants of Health Affects Our Patient's Wellness.




Sixty percent of a person's health is impacted by behavioral, environmental and social conditions.[1]

While the clinical aspects of patient health remain the highest priority for diagnosis and treatment, understanding the patients' social needs can provide a holistic view of their overall health. Your patients' circumstances often can put them at higher risks for health challenges like obesity, depression and heart disease, and sometimes can lead to multiple emergency department visits.[2] By identifying and addressing social determinants of health (SDOH), you and your staff are taking a comprehensive approach to patient care.

- **Transportation**
  - Transportation influences patient wellness because it directly impacts whether or not a patient can access their healthcare. When a patient has transportation barriers, he/she is less likely to attend a wellness check, chronic disease management appointment, or follow-up care. Patients are also less likely to fill prescriptions if they experience transportation barriers.

- **Housing**
  - Housing, too, has a direct correlation with health and wellness. The connection here is twofold. One, patients who are worried about finding a safe place to sleep are not necessarily concerned about their health and wellness. It is harder to manage chronic illness, adhere to wellness checks, or access simple preventive care like a flu shot when they are looking for an open homeless shelter. Second, patients who are houseless or housing insecure are more likely to have chronic illnesses.
  - Healthcare affordability, payer status
  - Housing status
  - Access to nutritious food
  - Numerous other domains
  - Finance stress can also affect health by
    - Psychosocial: Managing on a low income is stressful. Comparing oneself to others and feeling at the bottom of the social ladder can be distressing, which can lead to biochemical changes in the body, eventually causing ill health.
    - Behavioral: For various reasons, people on low incomes are more likely to adopt unhealthy behaviors – smoking and drinking, for example – while those on higher incomes are more able to afford healthier lifestyles.
    - Reverse causation (poor health leads to low income): Health may affect income by preventing people from taking paid employment. Childhood health may also affect educational outcomes, limiting job opportunities and potential earnings.

- **Food**
  - Food security most prominently affects a patient's ability to manage chronic illnesses. Food insecurity can both exacerbate existing health problems and create entirely new ones. For children especially, food insecurity provides a dangerous threat to their growing bodies.
  - Food insecurity occurs when people have limited or uncertain access to enough food to live a healthy, active life.[3]
  - 37 million people are living in food insecure households; that means 1 in 9 Americans are food insecure.[4]
  - Seniors who are food insecure are:[5]
    - **50%** more likely to have diabetes
    - **60%** more likely to have congestive heart failure (CHF) or experience a heart attack
    - **2 times** as likely to have asthma

1 https://www.partnersbhm.org/wp-content/uploads/2017/07/WPIC_White_Paper_revise_7.19.2017.pdf
2 NEJM Catalyst, SDOH, Dec. 2017, https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0312
3 Feeding America, www.feedingamerica.org/hunger-in-america/senior-hunger-facts
4 Feeding America, Health+Hunger, Oct. 2019, https://hungerandhealth.feedingamerica.org/2019/10/food-insecurity-poverty-ratesimprovepre-recession-levels-2018-1-9-people-still-risk-hunger/
5 Food Research & Action Center, Hunger & Health, December 2017, https://frac.org/wp-content/uploads/hunger-healthimpact-poverty-food-insecurity-health-wellbeing.pdf
6 Kaiser Family Foundation, Aug. 2018, https://www.kff.org/report-section/loneliness-and-social-isolation-in-theunited-states-the-united-kingdom-and-japan-aninternational-

Some Scripting to help you introduce SDOH to our patients

- At Guthrie, we believe that our basic needs impact our overall health. As a best practice we are now asking ALL our patients a few questions about basic needs to better serve you as a whole person and try to connect you with resources if needed.

- Our goal at Guthrie is to help you and your family become or stay as healthy as possible. To do so we are asking ALL our patients a few questions about basic needs, knowing that these can impact your overall health.

- Thank you for coming in today. As part of your total health, we know that some factors at home may influence your ability to be healthy. We are now asking all patients a few questions so that we may help connect you with resources if needed. Would you mind answering a few quick questions?

- Often our patients have needs beyond just medical, for example transportation or food. Since we know that these can have a significant impact on your physical health, we are now asking all patients a few quick questions so we can assist you in these areas if needed.

Poverty Simulation

- It is a simulation where individuals role play the lives of low-income families
- Sponsored by a not-for-profit local human service agency – ProAction
- Participants have the stressful task of providing for basic necessities and shelter on a limited budget during the course of four 15 minute “weeks”
- They interact with human service agencies, grocers, pawnbrokers, bill collectors, job interviewers, police officers and others
- Taking part in a poverty simulation allows participants to walk a mile in the shoes of those facing poverty

Poverty Simulation

- The simulation enables participants to look at poverty from a variety of angles and then to recognize and discuss the potential for change within their local communities
- The simulation was designed to sensitize those who frequently deal with low-income families as well as to create a broader awareness of poverty among policymakers, community leaders, and others
- Simulation lasts about 2 hours-Introduction, simulation and debrief

Police Dept.
Community Health
Community Action Agency
Interfaith
Day Care
Mortgage
Utilities
Bank
Pawn Shop
A
B
C
D
E
F
G
H
Super Center
P
O
N
M
L
K
J
I
Quick Cash
Q
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V
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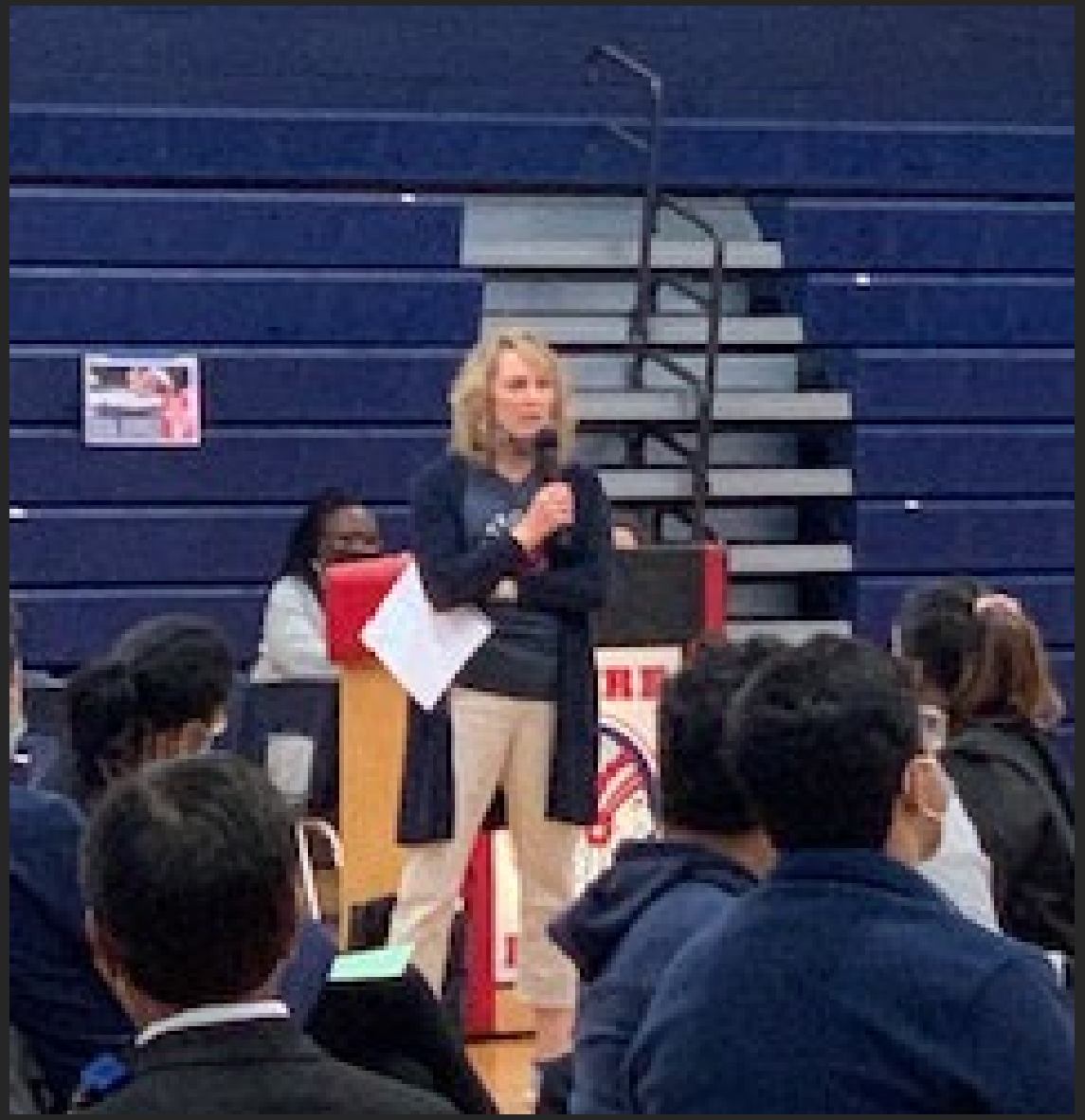
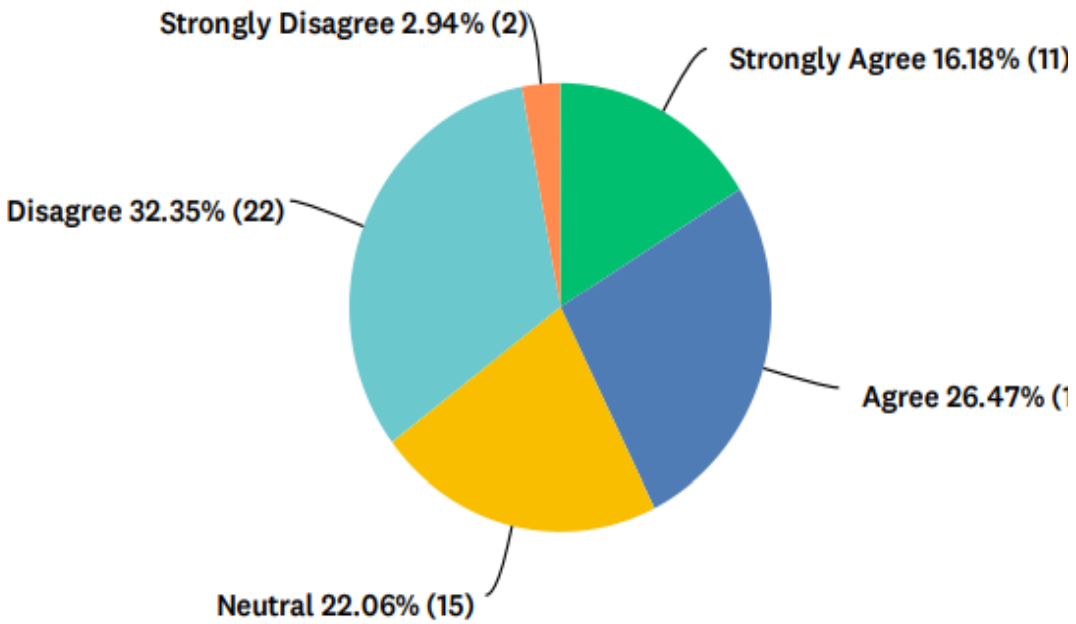
X
Y
Z
Podium
School
DSS Case Workers
DSS Reception
Employer



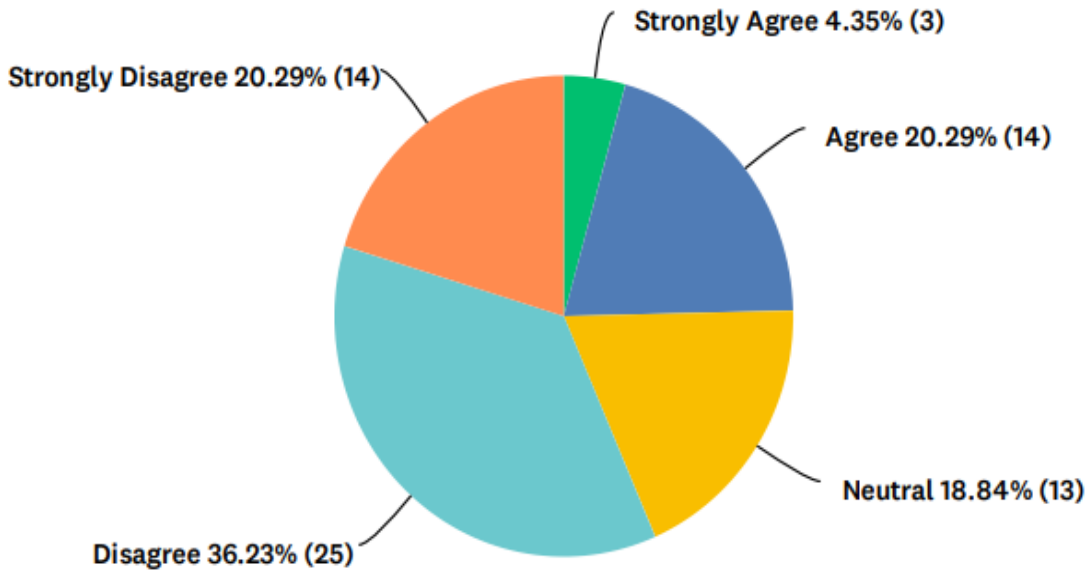

MACA
TRANSPORTATION
PASS

There are people living in poverty who do not work and who could find jobs if they looked for them seriously

Pre-Survey

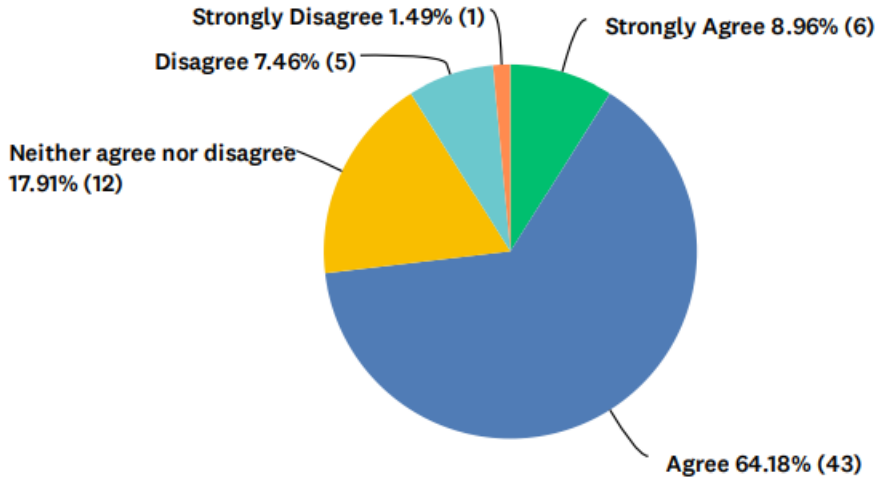


Post-Survey

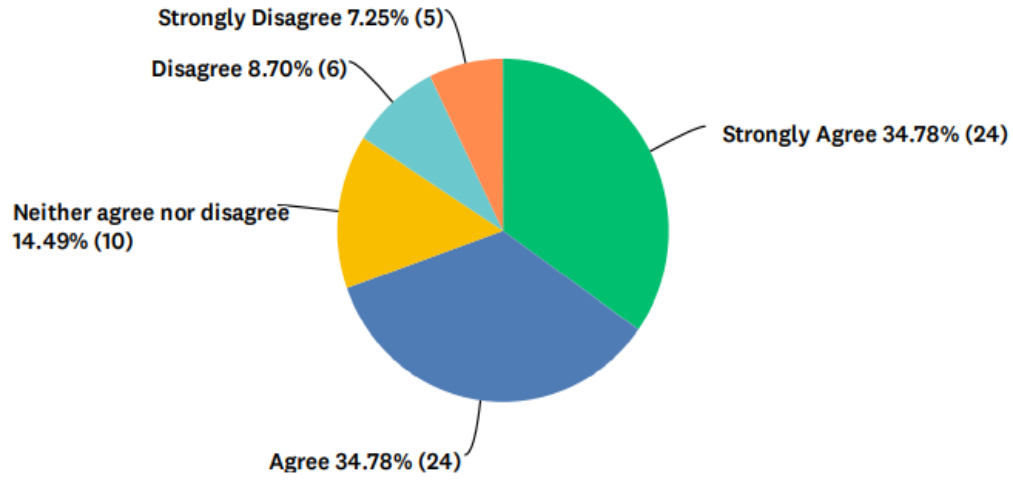


People live in poverty due to circumstances beyond their control

Pre-Survey

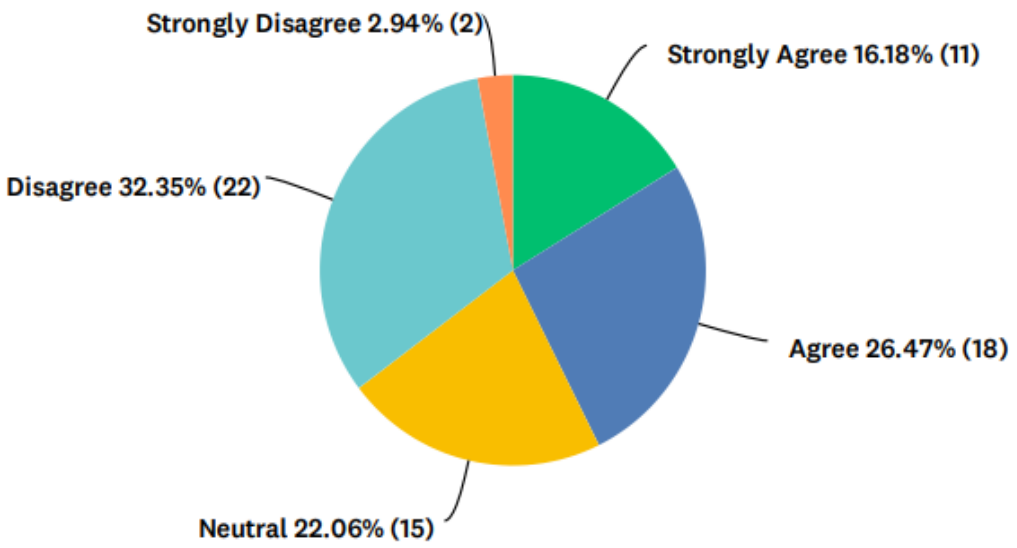


Post-Survey

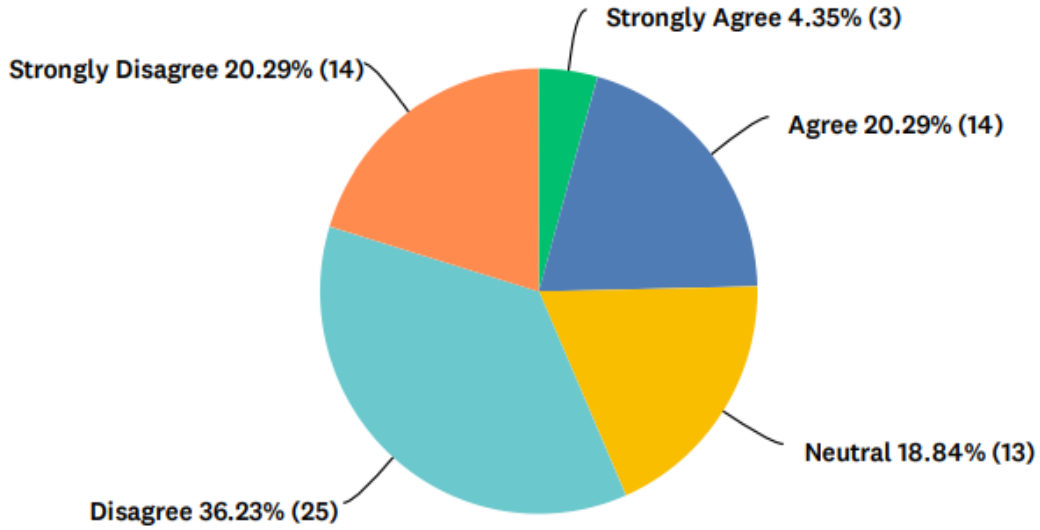


There are people living in poverty who do not work and who could find jobs if they looked for them seriously

Pre-Survey



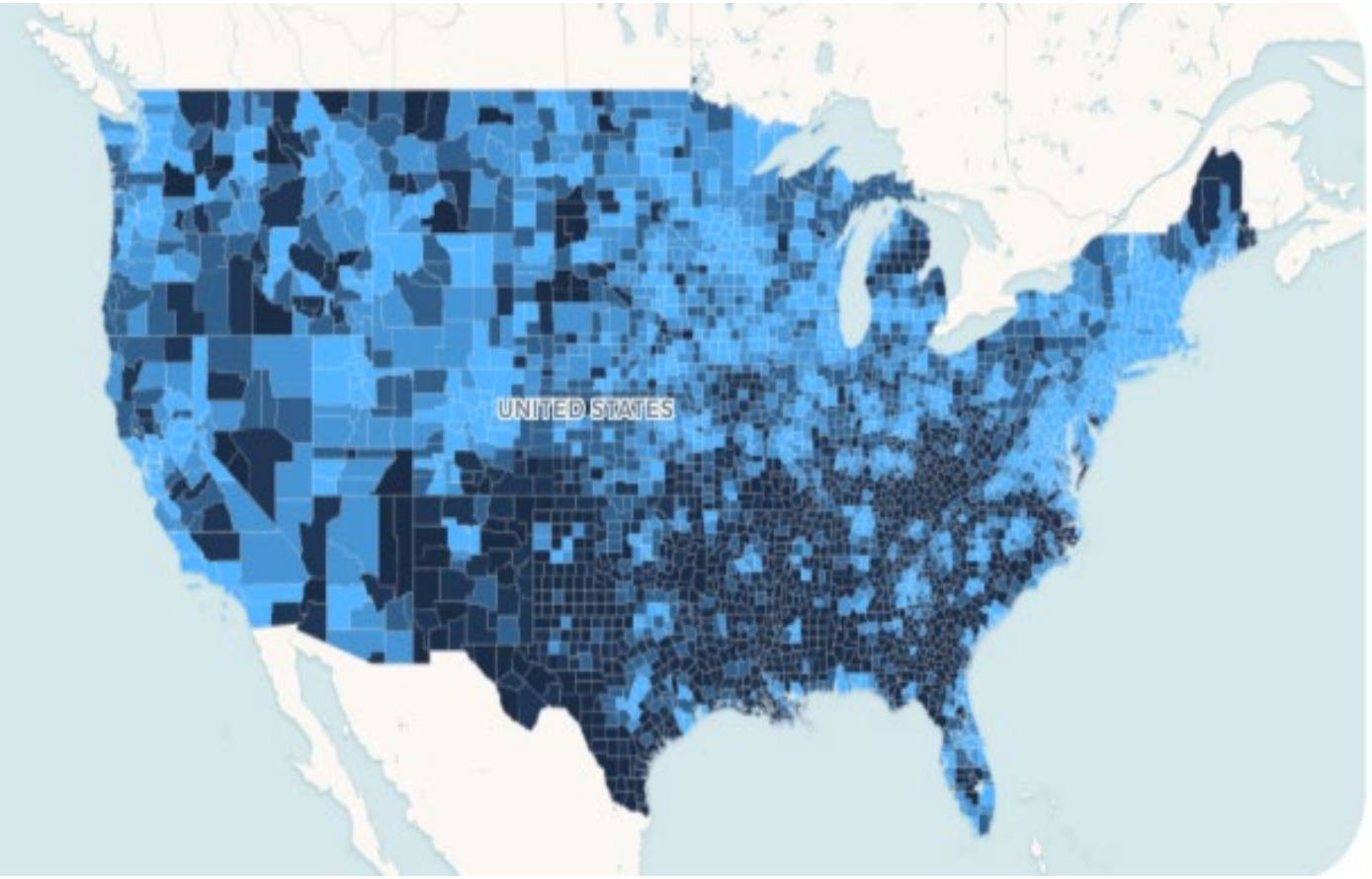
Post-Survey



Referrals to Community Based Organizations-a social care network

- Once a SDOH need is identified in a patient, connections to community-based services are made.
- Current system is manual and not easily tracked for referrals or outcomes.
- We have chosen to use an electronic solution to automate referrals, track patient outcomes, empower individuals to take ownership of their own health and further develop a social care network in our region.
- Under contract review with Unite Us.

Unite Us



- Development of a coordinated care network
- Patients are enrolled for targeted social care services
- Ability to track social care delivery through real time analytics
- Care coordinators use of dashboards to track patient referrals and outcomes in their communities.

Guthrie's Paramedicine Program

- Home visit by paramedics, for patients discharged from the hospital
- Goal: Effective management of patients who are high risk for readmission and return to the ER, to mitigate utilization
- First patients with a diagnosis of Congestive Heart Failure
- Multi-disciplinary team to implement program: ER physician and Chief of Cardiology-leads, Case management, Pharmacy, EPIC support
- Patient is educated and consents to the program while an inpatient
- Provide in-home assessment 5-7 days post hospital discharge
- Symptom assessment, medication review, and disease education provided
- Ability to complete a tele-visit with a Guthrie Cardiologist, if patient status warrants
- Ability to administer IV Lasix at home, if ordered by physician

Guthrie's Paramedicine Program

- Documentation of the patient visit is completed in EPIC, for Care Team viewing
- Each week, a multi-disciplinary team reviews patients from the previous week-to optimize patient outcomes
- Payor support

Future Development

- Extend program to LTC facilities
- Additional diagnostic groups to include COPD, other high-risk patients
- Shadowing experience in Cardiology, CHF Clinic-for ambulance staff
- Pharmacy interns will accompany medics on home visits
- Include gap closures for healthcare disparities/SDOH

Guthrie Paramedicine Home Visit Program

As part of the program, a paramedicine team will come to your home after you've been discharged.

During this visit the paramedicine team will:

- review any concerns you may have.
- ask you questions related to your diagnosis and provide additional information if needed.
- review your discharge medications and instructions with you.
- review any follow up appointments you may need and assist with setting up appointments if needed.
- check your blood pressure and heart rate.

Post Hospital Visit

GUTHRIE

PARAMEDICINE POST-HOSPITAL VISIT

EMS Provider: ☐ Towanda EMS
☐ Greater Valley EMS

BASIC INFORMATION			
DATE OF SERVICE	FIRST NAME	LAST NAME	
DISCHARGE DATE:	CREW:	TIME IN:	TIME OUT:

ASSESSMENT	
ALLERGIES:	☐NKDA

MEDICATION REVIEW		
Discharge instructions and meds reviewed?	☐ Yes	☐ No (comment)
Were new medications obtained?	☐ Yes	☐ No (comment)
Med discrepancies noted?	☐Yes	☐ No (comment)
Discrepancies report to PCP?	☐Yes	☐ No (comment)

EVALUATION OF RESOURCES
Assistance receiving at home (from whom, how are they helping):
Community Agencies involved? (who):
Additional resources/needs identified?

FALL RISK ASSESSMENT		
Have you had 2 or more falls within the last 12 months?	☐ Yes	☐ No
Have you had any fall with injury in the last 12 months?	☐ Yes	☐ No

COPD Symptoms	YES	NO	COMMENT
Cough			
Increased Sputum			
Increased SOB			
Fever/Chills			
Decreased energy/increased fatigue			
What COPD Zone are you in (Green, Yellow, Red)?			

CHF Symptoms	YES	NO	COMMENT
Discharge Weight:			
Weight Today:			
Any change in weight?			
Weighing daily?			
Any swelling?			
Feel SOB?			
Able to lay flat in bed?			
Need to sleep sitting to breathe?			
Do you have a cough?			
What CHF zone are you in (Green, Yellow, Red)?			

	A	B	C	D	E	F	G	H	I	J	K	M
1	b#	[redacted]	Order	Order Department	Admit date	Date	DC date	EMS Provider	Paramed visit date	Readmitted 30	Readmitted 60	Return to ED In 3
31									9/2021			
32	2408668	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	9/3/2021 9:33:00 PM	9/4/21	9/11/21	Towanda EMS	d/c to STR			
33	248723	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	9/6/2021 7:30:00 PM	9/8/21	9/10/21	GV EMS	declined			
34	332908	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	9/3/2021 1:11:00 AM	9/8/21	9/20/21	Towanda EMS	d/c to STR			
35	425465	[redacted]	PARAMEDICINE VISIT	9 SOUTHWEST	9/17/2021 11:30:00 AM	9/18/21	10/9/21	GV EMS	completed 10/14		10/29/2021 12:25	
36	518756	[redacted]	PARAMEDICINE VISIT	6 MAIN	9/12/2021 4:53:00 PM	9/13/21	9/18/2021 2:06:00 PM	GV EMS	pt declined			
37	661057	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	9/12/2021 8:51:00 PM	9/14/21	9/16/2021 6:45:00 PM	Towanda EMS	READMITTED	9/18/2021 6:33:00 PM	9/18/2021 6:33:00 PM	9/18/2021 6:33:00 PM
38	879352	[redacted]	PARAMEDICINE VISIT	4 WEST	9/9/2021 9:18:00 PM	9/15/21	9/17/2021 4:16:00 PM	Towanda EMS	pt not at home on 9/22 as sched			
39	237142	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	9/16/2021 5:17:00 PM	9/17/21	9/18/2021 1:30:00 PM	Towanda EMS	completed 9/21			
40	130272	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	9/17/2021 10:47:00 AM	9/18/21	9/19/2021 12:48:00 PM	GV EMS	completed 9/22	9/26/2021 1:41:00 PM	10/17/2021 12:59:00 PM	
41	173368	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	9/23/2021 12:52:00 AM	9/23/21	9/24/2021 3:41:00 PM	Towanda EMS	completed 9/28		10/26/2021 9:20	
42	487260	[redacted]	PARAMEDICINE VISIT	6 MAIN	9/14/2021 9:20:00 AM	9/16/21	9/21/2021 1:46:00 PM	GV EMS	completed 9/30	9/25/2021 10:03:00 AM	9/25/2021 10:03:00 AM	
43	951229	[redacted]	PARAMEDICINE VISIT	9 SOUTHWEST	9/15/2021 3:30:00 PM	9/17/21	9/22/2021 5:10:00 PM	Towanda EMS	READMITTED	9/28/21		
44	1084892	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	9/22/2021 3:52:00 PM	9/23/21	9/26/2021 5:21:00 PM	GV EMS	pt declined			
45	112789	[redacted]	PARAMEDICINE VISIT	JOINT CAMP	9/23/2021 4:15:00 PM	9/24/21	9/28/2021 12:24:00 PM	GV EMS	unable to contact			
46	130272	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	9/26/2021 1:41:00 PM	9/27/21	9/29/2021 9:03:00 PM	GV EMS	declined face to face			
47	989900	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	9/28/2021 12:45:00 PM	9/29/21	10/1/2021 6:10:00 PM	GV EMS	completed 10/5/21		11/5/2021 18:26	
48	372646	[redacted]	PARAMEDICINE VISIT	ONCOLOGY	9/28/2021 4:38:00 AM	9/29/21	9/30/2021 5:02:00 PM	Towanda EMS	pt declined			
49	305059	[redacted]	PARAMEDICINE VISIT	CARDIAC CATH	9/29/2021 3:48:00 PM	9/30/21	10/7/2021 8:21:00 PM	GV EMS	tx to Strong Memorial			
50	259212	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	9/29/2021 5:31:00 AM	9/30/21	10/7/2021 3:09:00 PM	Towanda EMS	d/c to STR		10/29/2021 23:34	
51	457473	[redacted]	PARAMEDICINE VISIT	9 SOUTHWEST	9/28/2021 10:02:00 PM	9/30/21	10/6/2021 2:45:00 PM	GV EMS	d/c to STR			
52									10/21			
53	412656	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	10/1/2021 6:03:00 AM	10/4/21	10/4/2021 3:18:00 PM	GV EMS	wife canc appt			
54	703694	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	10/3/2021 6:16:00 PM	10/4/21	10/6/2021 2:00:00 PM	Towanda EMS	completed 10/13			
55	661057	[redacted]	PARAMEDICINE VISIT	4 WEST	10/1/2021 8:51:00 PM	10/5/21	10/6/2021 4:08:00 PM	Towanda EMS	completed 10/13			
56	141666	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	10/3/2021 7:53:00 PM	10/5/21	10/15/2021 2:24:00 PM	GV EMS	d/c to STR			
57	264578	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	10/5/2021 2:25:00 AM	10/6/21	10/9/2021 3:52:00 PM	GV EMS	completed 10/14			
58	171622	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	10/4/2021 2:42:00 PM	10/6/21	10/12/2021 4:22:00 PM	GV EMS		10/17/2021 5:21:00 PM	10/17/2021 5:21:00 PM	
59	592224	[redacted]	PARAMEDICINE VISIT	9 SOUTHWEST	10/9/2021 5:12:00 PM	10/11/21	10/14/2021 5:07:00 PM	GV EMS	completed 10/19	10/26/2021 11:49	10/26/2021 11:49	
60	087584	[redacted]	PARAMEDICINE VISIT	9 SOUTHWEST	10/10/2021 11:40:00 AM	10/11/21	10/13/2021 3:28:00 PM	GV EMS	completed 10/19			
61	841535	[redacted]	PARAMEDICINE VISIT	RPH 6 WEST	10/12/2021 12:39:00 PM	10/13/21	10/18/2021	GV EMS	completed 10/25	11/5/2021 10:47	11/5/2021 10:47	
62	243375	[redacted]	PARAMEDICINE VISIT	8 NORTHWEST	10/12/2021 11:06:00 PM	10/15/21	10/18/2021	GV EMS	appt 10/22 but no contact from pt, no response to messages			
63	859182	[redacted]	PARAMEDICINE VISIT	6 MAIN	10/14/2021 7:20:00 AM	10/17/21	10/17/2021 3:02:00 PM	GV EMS	completed 10/26			

Program outcomes and changes

9/1/2021-1/1/2022

- Outcomes

  -40 patients seen

  -10 patients readmitted within 30 days/2 patients with a dx of CHF

- Program changes

  -30 days in-moved visit from 24-48 hrs to 5-7 days

  - 2 readmitted patients with CHF are complex, challenging to manage patients. Implementing multiple visit criteria

  -Risk stratify population

  -Post-Acute facility visits

RPH	Jul-21	Aug	Sep	Oct	Nov
Readmissions after treatment for Heart Failure					
Numerator	7	18	7	11	8
Denominator	40	69	35	45	36
Rate	17.5%	26.1%	20.0%	24.4%	22.2%

Questions/Discussion