Community Paramedicine Program

'Closing Care Gaps'

Carli Moua, PHRN, MSN

PROGRAM OVERVIEW

2.0 FTEs

Monday thru Saturday

All of Lancaster County

Referrals via Partners, Providers, Payers, Self

Funded via Partners / Excess Reduction

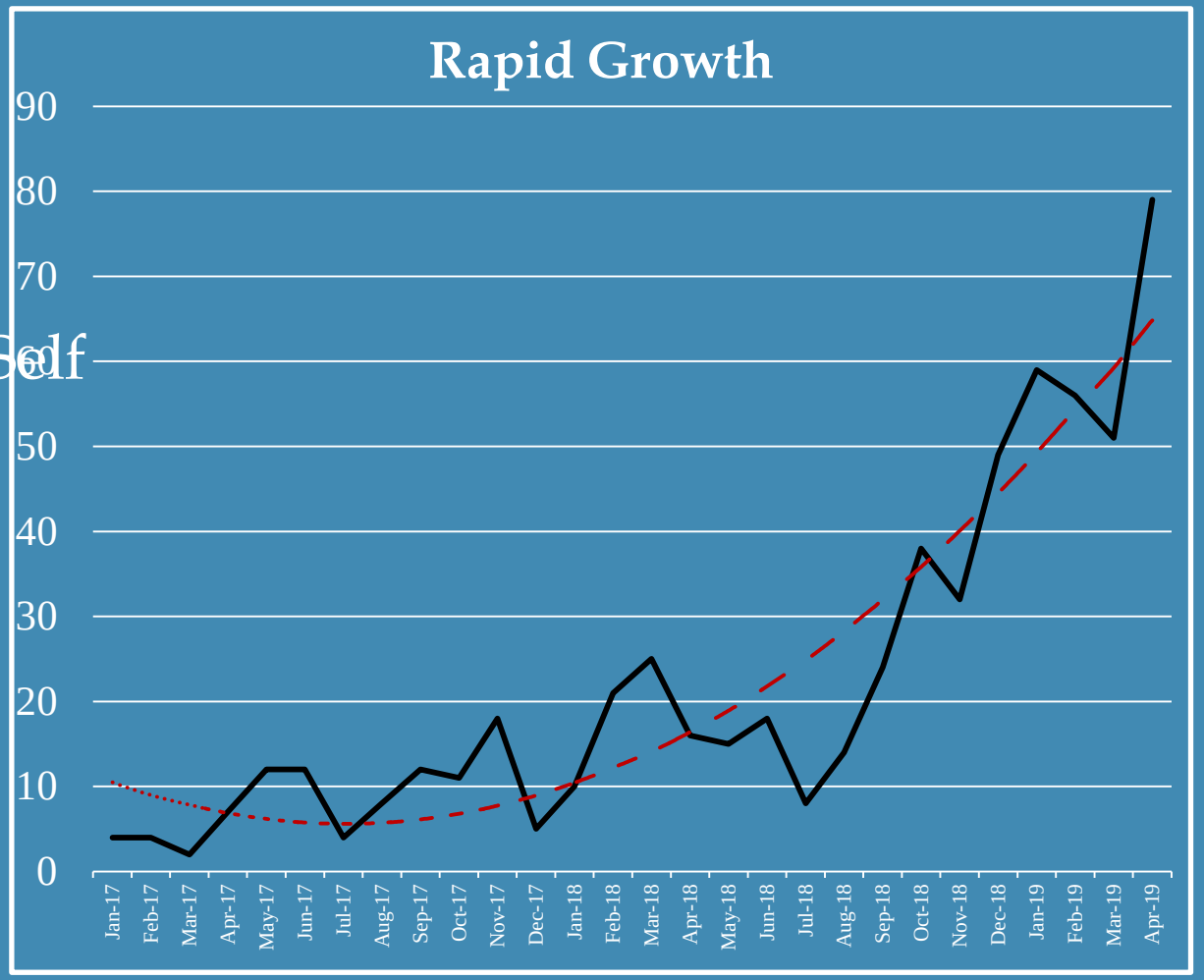
Strong Medical Direction

Health System Buy-in

Ride Outs

Charting (Epic Access)

Rapid Anticipated Growth



PROGRAM GOALS

Improve Health Outcomes Among our Medically Vulnerable Populations

Reduce 9-1-1's

Reduce ED Visits

Reduce Inpatient Readmissions

Address Barriers to Care

Reduce Care Gaps

Connect Community Members with Vital/Necessary Healthcare/Community Resources

Empower Community Member

OUR COMMUNITY PARAMEDIC PROGRAM PARTNERS

AmeriHealth Caritas of Pennsylvania

Penn Medicine - Lancaster General Health

Lancaster South

Community Organizations

Our Community Members

LANCASTER EMS

COMMUNITY OUTREACH & COLLABORATIONS

Lancaster County Coalition on Healthcare Transitions

Diabetes Adverse Drug Event Task Team

Project Lazarus

Addressing the Opioid Epidemic from various Lancaster County Agencies

Homeless Outreach - Lancaster County Coalition to End Homelessness

Home Safety Assessments

Home Visits for Frequent 911 & ED Users

Medication Safety Presentations at Senior Centers

Blood Pressure Screenings & Medical Outreach in Targeted Areas

"LANCASTER SOUTH"

Funded by the United Way

Collaboration - Lancaster EMS / The Boys & Girls Club, / Lancaster Health Center / The SDL, Lancaster Housing Opportunity Partnership & Arbor Place

Identify Barriers – Community Members Living in Poverty

Connect Community Members with Resources

Initiate Policy Changes

LANCASTER EMS

PENN MEDICINE LANCASTER GENERAL HEALTH - PARTNERSHIP

Sepsis & CHF

In-home Visits - Septic Shock / Severe Sepsis 24-48 Hours Post In-patient Discharge/ CHF

Discharge Instructions / Assess Patient Understanding

Medication Reconciliation

Follow up Appointments

Monitor/Report Symptoms to PCP

Treat Symptoms

Identify/Address Gaps in Care, Unmet Medical/Social Needs, Safety Concerns

Assess Caregiver Fatigue & Understanding of Diagnosis

Transition of Care

Refer to Ambulatory Care Team for Extended Follow up

TOC Appointments - Sedan Services

AMERIHEALTH CARITAS PARTNERSHIP

Safe Landing Program

High Risk Follow up Post Discharge

Medication Reconciliation

Follow up Appointment

Communication with PCP

Identify/Address Gaps in Care

In-home Blood Draws, Educational Visits, Immunizations, Wound Care

Identify/Address Unmet Needs & Safety Concerns

Housing/Food/Clothing

Visits to 911 Patients Refusing Transportation Post Overdose/Other

Community Agency/Resource Referrals

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Homeless outreach

Lead screenings and lead education

Education related to Renters Rights and Responsibilities

Providing education and services in patient homes

Providing community resources and navigation assistance

BARRIERS TO ACCESSING HEALTHCARE

Transportation

Health Literacy

Cultural Competency

Finding a Healthcare Provider that one Trusts

ADDRESSING BARRIERS TO ACCESSING HEALTHCARE

Transportation - Red Rose Access, Lancaster EMS TOC transportation program and patient specific transportation plans

Health Literacy – In-home education (patient most comfortable) - CP assesses patient's understanding / answer questions

Cultural Competency - Assist patients to find culturally competent providers

Provider Trust - Relationship building equals improved outcomes

CARE GAPS

Well Child Checks

Lead Screening/Monitoring

Immunizations

Blood draws (A1C's, PT/ INR)

Adult Health Screenings (Mammograms, Cancer Screenings…)

ADDRESSING CARE GAPS

Well Child Checks - Provide parent education on importance of routine well child checks and assists in scheduling and arranging transportation to appointments

Lead Screening/Monitoring – Our CPP is working with AmeriHealth Caritas to Screen kids who were identified by DHS as being at an increased risk of elevated blood lead levels.

- Our CPs works with local providers to monitor select patients who have been diagnosed with elevated blood level
- In-home blood draws (A1C's, PT/ INR) with specimen transport
- PCP follow up

Adult Health Screenings – CP in-home education: Mammograms/Cancer Screenings

LANCASTER EMS

ADDRESSING CARE GAPS

Lead Screening/Monitoring

Our CPP working with AmeriHealth Caritas to screen children identified by DHS as being at-risk of elevated blood lead levels.

Our CPs partner with local providers to monitor patients who have been diagnosed with elevated blood lead level

LANCASTER EMS

ADDRESSING CARE GAPS

Immunizations

Our CPP working with **AmeriHealth Caritas** and the **Vaccines for Children Program** to provide in-home vaccinations to eligible children

Collect data to determine areas of high immunization gaps

Reinforce importance of routine Well Child Checks, assist with scheduling and transportation to appointments

ON THE HORIZON

Stroke

SNF IV Starts

Telemedicine