Contact Information

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Physician Organization Name: IHA
Practice Name: IHA Primary Care
Practice Address: 24 Frank Lloyd Wright Drive Lobby J2000 Ann Arbor, MI 48106
How many physicians in practice: 109
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): 109 Family Medicine / Internal Medicine Physicians (MD or DO), 25 Care Managers, (32 call center triage nurses (a combination of LPN, RN or BSN), 8 community paramedics (EMT-P with Community Paramedic Training Certification) and 60 ED Physicians (MD or DO).

Executive Summary

The Whatever It Takes program provides the ability for patients to receive safe treatment at home by community paramedics with support from primary care or emergency department physicians to reduce unnecessary emergency department and inpatient utilization:

- Initial results 07/17/17 – 06/30/19
    - 66% of community paramedic visits resulted in patients being treated at home or transported to an alternate destination (154/235)
- Estimated program cost avoidance $800,000 - $1,000,000
- Estimated ROI: 2.2 – 3.0 to 1
- Patient feedback: *"Being a former medic in the military, I was very impressed with the Community Paramedic. He was very professional, efficient, well-trained, and confident in what he had to do. The Community Paramedic has good assessment skills. He knew I was dehydrated and started an IV, and gave me something for my nausea thru IV. It was a very good experience for me and I am glad something like this is available in our community. I would recommend it and I'm glad they will be there if I need them."*
- Provider feedback: *"We feel really secure and equipped to care for our patients with having community paramedic services available for our patients. It is a great service for our patients!"*

Category of Submission: Reduction in Utilization

Title of Submission: Whatever It Takes (WIT)

When did the intervention start and end?

The intervention began on 07/17/17. The intervention is ongoing.

Goal of the Program/Intervention:

The goal of the program is to provide care for patients in the most appropriate site and decrease unnecessary utilization. The community paramedics are dispatched to the patient's home to assess the patient and either care for the patient in their home, or when necessary, arrange for transportation to the Emergency Department.

Who developed the program/intervention, and how?

Huron Valley Ambulance (HVA) developed the Community Paramedicine program and its protocols[1] in 2015 with the Livingston and Washtenaw County Medical Control Authority (MCA). Protocols including training requirements were approved by the State of Michigan. Two community paramedics were trained and dedicated to the program, with two others trained as backups. Due to the lack of reimbursement from Medicare and other payers at the time, Huron Valley Ambulance partnered with Trinity Health Continuing Care organization to develop the Whatever It Takes Program through grant funding that leveraged the existing community paramedic services with support from IHA, Huron Valley Physician Association, Emergency Physicians Medical Group, St. Joseph Mercy

[1] HVA Community Paramedicine program protocols: https://www.washtenaw.org/DocumentCenter/View/3386/11---Community-Paramedicine-Protocols-04-2019

Hospitals of Ann Arbor and Chelsea, Trinity Health at Home (Home Care Agency) and Trinity Health Senior Communities.

Description of the Program/Intervention:

When a primary care provider is notified that a patient has a medical concern, the PCP can dispatch a Community Paramedic (CP) to the patient's home to triage the patient. If appropriate, a Community Paramedic can be dispatched to a patient's home because of a 911 call. The CP calls the PCP from the patient's home. They make a collaborative decision about the most appropriate site of care for the patient. If the patient is stable, the patient can be kept at home with close follow up with their PCP. If a patient fails to stabilize then an Advanced Life Support Ambulance is dispatched to transfer the patient to the emergency room. Safely treating patients at home avoids unnecessary ED utilization and unnecessary hospital admissions. Approximately, 50% of Medicare patients who go to the St. Joseph Mercy – Ann Arbor ED are admitted or observed in the hospital.

CPs can perform a variety of services at the patient's home under the supervision of a physician, including:

Point of care lab testing	EKG	Inhalation therapy
IV fluids	IV medications	Reinsert Foley catheters
Change ileostomy bags	Wound care	

Mobile x-rays can also be performed at the patient's home.

How were patients identified for the program/intervention?

The initial patient population was patients: 1) enrolled in St. Joseph Mercy Home Care, 2) Medicare or Dual Eligible and 3) residing in Washtenaw County. Eligible patients now include any patient with Medicare, Medicare Advantage, or BCBSM Commercial insurance who is living in Washtenaw County. These patients are flagged in the EMR to allow staff to easily identify eligible patients.

How was success measured? Please delineate whether metrics were process-based or outcome-based:

The number of patients safely treated at home or sent to an alternate destination is the key process metric. Program success will be determined by significant improvement in certain Quadruple Aim outcomes. We are in the process of conducting a robust program evaluation that will show the program's impact on reducing ER visits, admissions, and readmissions, and the total cost of care. Development of a method to measure the impact on patient and provider experience is underway.

What were the program results? Include qualitative data/graphs

The number of patients safely treated at home or sent to an alternate destination is the key metric. From July 17, 2017 to 06/30/2019 66% (154/235) of patients in the program have been safely treated at home or treated at an alternate site (i.e. not in the emergency room).

A preliminary ROI estimate is 2.2 – 3.0 : 1. For the patients who have engaged with "Whatever it Takes" the estimated cost avoidance is $800,000 - $1,000,000. A vendor has been hired to do a more comprehensive program evaluation. This evaluation will be available in the fall of 2019.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?

- Enhanced and expanded protocols based on feedback from physicians and other care providers in the community (e.g. rapid 1 and 2 influenza testing, assisting with referrals for urgent mobile x-rays, etc.).
- Developed and implemented workflows for video visits and documentation between the community paramedics and the emergency room physicians.
- Developed and implemented workflows to support communication between community paramedics and primary care staff / primary care providers. These workflows included role definition, documentation, and billing.

- Created marketing brochures for patient education and reference/process guides to support staff education and training on the processes.

What are you proudest of regarding this submission? Why does this work matter?

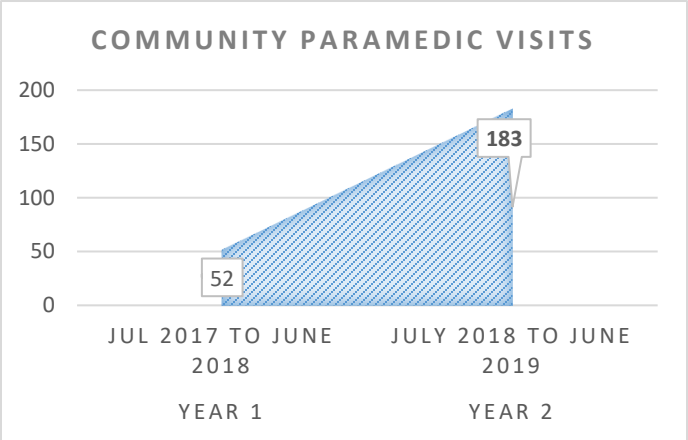
This intervention is having a positive impact on all four elements of the Quadruple Aim. Delivering care in lower cost settings is well aligned with value-based care delivery. This value-based intervention is creating a win for patients, providers and health plans. The patients win because they receive safe, high quality and efficient care in their own homes. This reduces out of pocket expenses and improves experience of care. A visit to the emergency room and an inpatient stay is disruptive to a patient's life and the lives of the patient's family members. The providers win because they get to participate in providing safe, high quality care in a lower cost setting. The health plans wins because the cost of care is lower and the patient experience of care is higher.

How will your organization use the funds if your submission wins?

Funds will be used to continue to support the project management and technology costs associated with sustaining and expanding this program. BCBSM has agreed to reimburse for the Whatever It Takes Program services for BCBSM commercial patients. However, this will not provide enough funding to continue to support the program at the current scope and scale. Given the success of the program thus far there is a desire to expand the service into other counties and reach more patients that will benefit from the Whatever It Takes program.

Appendix:

With the support and work from all of the staff across IHA and our care partners from year 1 to year 2 of the intervention, the number of community paramedic visits tripled (52 to 183).



Below shows the top services community paramedics provided to patients during their visit. Basic and neurological assessments were completed as needed and the patient's physician and/or the ED physician (via medical control) were contacted before interventions were completed by the community paramedic.