

THE Value Initiative

Members in Action: Redesigning the Delivery System

PeaceHealth Peace Harbor Medical Center – Florence, Ore.

Critical Access Hospital Engages Paramedics to Improve Care through Home Visits

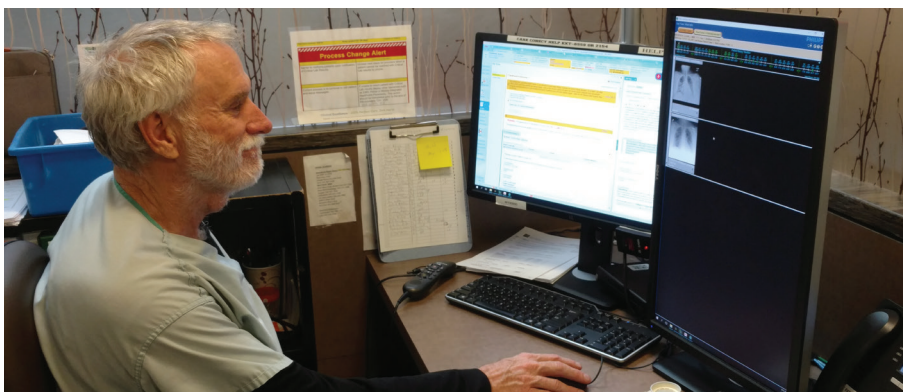
The AHA's Members in Action series highlights how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes, and implement operational solutions.

Overview

In an effort to improve care as patients transition among inpatient, outpatient, emergency department (ED), home health or palliative settings, Peace Harbor Medical Center (PHMC) — a critical access hospital in Florence, Ore. — partnered with the local ambulance service to offer home visits.

Through the Mobile Integrated Healthcare (MIH) program, a dedicated paramedic from the Western Lane Ambulance District (WLAD) educates patients, checks on them at home for their safety and provides preventive care to reduce their ED visits, avoidable readmissions and ambulance trips. As part of their daily huddles, discharge planners, hospitalists and ED staff alert the paramedic to patients who may benefit from a home visit.

Prior to a patient's discharge, the paramedic, Chris Martin, meets with him or her to explain the program and offer a visit. A day or



Willie Foster, M.D., medical director of the Peace Harbor Medical Center ED, said since the Mobile Integrated Healthcare program was implemented there has been a marked decrease in avoidable readmissions and unnecessary ED visits.

Impact

In 2018, the MIH program conducted 500 home visits with 60 clients. Among inpatients discharged to home, PHMC reports a 200 percent decrease in ED visits and a 200 percent reduction in avoidable readmissions. Among the 187 patients receiving palliative care from March to December 2018, the hospital saw a 50 percent decrease in ED visits. For every dollar spent on the MIH program, the hospital saved \$5 in health care costs.

Willie Foster, M.D., medical director of the ED, said that before the MIH program he would see some patients up to 10 times in six months. Since the home visits began, he said, those patients may come to the hospital just once in six months.

"The flexibility in funding allows us to go see patients who potentially would not have had their post-discharge needs met," said Foster.

two later, he visits the home to assess the patient's needs. This may include ensuring the patient has appropriate and sufficient food in the house to support recovery. Martin ensures the patient has all necessary medications, and knows how and why to take the drugs. He reinforces the doctor's discharge instructions. He also ensures smoke alarms are working, investigates whether loose rugs or broken steps may pose fall risks, and surveys potential household hazards, such as the presence of mold that could exacerbate respiratory ailments.

The paramedic may draw blood or contact the patient's physician if he suspects a medication adjustment may be in order. He is also able to connect the patient with needed community resources, such as food, home cleaning, repairs, or social services. Martin visits weekly, bi-monthly or monthly, depending on the patient's needs.



Western Lane Ambulance District paramedic Chris Martin, right, visits patients in their homes following hospital stays to support their recovery.

The initiative is in the second year of a two-year pilot funded by a \$200,000 grant from the PHMC Foundation. Because many home visits are not reimbursed by government or private payers, the philanthropic funding allows the MIH program to serve patients who otherwise could not benefit from the outreach.

Lessons Learned

Prior to the implementation of the MIH program, the hospital did not have a clear estimate on just how many ED visits and readmissions could be avoided, particularly among palliative care patients.

"The lesson we learned is there are a lot of opportunities for improvement in our system," said Jason Hawkins, chief administrative officer. "Reaching out to palliative care patients, for example, is a really, really important component of our program."

Hiring the right paramedic with the appropriate clinical skill set and personality is key to MIH's success, according to Matt House, manager of WLAD.

Future Goals

Hawkins said he would like to expand the program to serve patients who are being transferred from regional tertiary sites back to their homes in the Lane County community. He also is eager to secure sustainable funding to ensure the program can continue.

Martin stressed the need to strengthen relationships continuously with patients' primary care providers.

"They know these patients much better than providers who only see them in an emergent situation, when they're being treated in the ED or as an inpatient," he said.

Contact: Matt House, Manager, Western Lane Ambulance District

Email: matt@wlambulance.com