Lessons Learned & Community Impacts 2024

Webinar will begin at 11:00AM.

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Lessons Learned & Community Impacts 2024

Southwest Georgia Area Health Education Center (SOWEGA-AHEC)
1512 W 3rd Avenue
Albany, GA 31707
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The Path to Improving Rural Health Starts with Innovation and Big Intentions…..

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WELCOME

Laura Calhoun, MHA
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Executive Director
SOWEGA-CPP Grant Lead Network Member
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The Path to Improving Rural Health Starts with Innovation and Big Intentions…..

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Lessons Learned & Community Impacts 2024

Federal Award Project Title: Rural Public Health Workforce Training Network Program

Award Number: **TR1RH45931**

Project Period: **08/01/2022 to 07/31/2025**

Award Amount: **$1,332,608**

Lead Applicant: **Southwest Georgia Area Health Education Center, Inc.**
1512 W 3rd Avenue
Albany, GA 31707
229-439-7185

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,332,608 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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Continuing Education Statements

Nurses:
The **Georgia Board of Nursing** deems **Southwest Georgia Area Health Education Center (SOWEGA-AHEC)** as an approved provider for nursing continuing education (CE). This activity is approved for **1.5** contact hours towards the continuing education competency requirement for Georgia nursing licensure renewal. No partial credit offered.
Activity #2024-14.

EMS:
This course has received Georgia Office of EMS and Trauma approval for continuing education credit for 1.5 hours. GA-2024-PROV-07980

Note: *Submission of participant registration information, attendance and completed evaluation/successful post-test required for CE certificates.*

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Disclosures & Commercial Support

- All planners & presenters disclosed no potential conflicts of interest at this time.
- No commercial support provided for this educational activity.

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Objectives

At the end of the presentation, participants should be able to:

❖ Provide a brief overview of the Southwest Georgia Community Paramedicine Network & Training Program grant funded by HRSA's Rural Public Health Workforce Training Network Program.

❖ List lessons learned from four Rural Hospital-Based Community Paramedicine Programs in Southwest Georgia.

❖ Describe Southwest Georgia Community Paramedicine Program regional community impacts in grant year two.

❖ Detail anticipated future rural community opportunities and impacts with Community Paramedicine.

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SOWEGA-CPP Contacts:
Laura Calhoun, MHA (Network Lead)
Michelle Huskey, MSHS, RRT-NPS (Project Director)
Zina Whitaker, MA (Data Coordinator)
Email: info@sowega-ahec.org

The Southwest Georgia Area Health Education Center (SOWEGA-AHEC) awarded $1.3 million in Rural Public Health Workforce Training Network Program grant funding from the U.S. Department of Health and Human Services (HHS) and Health Resources and Services Administration (HRSA).

Action Items:

- ✓ Build a Southwest Georgia Community Paramedicine Network
- ✓ Create a Southwest Georgia Rural Hospital-Based Community Paramedicine Training Program
- ✓ Recruit & Train 5 Southwest Georgia Paramedics to Transition From Emergent Care Into Rural Hospital-Based Community Paramedicine Workforce
- ✓ Support 4 Southwest Georgia Rural Hospitals in Their Newly Created Community Paramedicine Department Services (Ongoing)
- ✓ Monitor, Collect and Evaluate Data Related to Each Network Hospital Community Paramedicine Services Ability to Reduce Non-Emergent ER Visits through At-Home Education and Access to Needed Community Resources (Year 2 & Year 3 - Ongoing)
- ❑ Sustainability Plan, Expansion of Community Paramedicine Network & Workforce via Evidence-Based Cost Savings and Improved Outcomes (Year 3+)

The Path to Improving Rural Health Starts with Innovation and Big Intentions.

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SOWEGA-CPP
Southwest Georgia Community Paramedicine Program

The Path to Improving Rural Health Starts with Innovation and Big Intentions.....

Southwest Georgia Rural Hospital-Based Community Paramedicine Training Program
Planning/Advisory Committee Members

- **D. Michelle Huskey, MSHS, RRT-NPS**
  SOWEGA-CPP Grant Project Director, SOWEGA-AHEC CE & Distance Learning Coordinator
- **Nita Ham**
  Georgia State Office of Rural Health, Senior Director SORH Program & Hospital Services
- **Jonathan Lieupo, BS, NRP**
  Georgia Office of EMS & Trauma, Regional Training Coordinator Southwest Georgia Region 8
- **Tony Ellington, Paramedic, MIH-CP**
  Dorminy Medical Center Community Paramedicine Program

Continuing Education Statement
This course has received Georgia Office of EMS and Trauma approval for continuing education credit.
GA-2023-PROV-05384 36 Other-General & 8 Medical CE Hours

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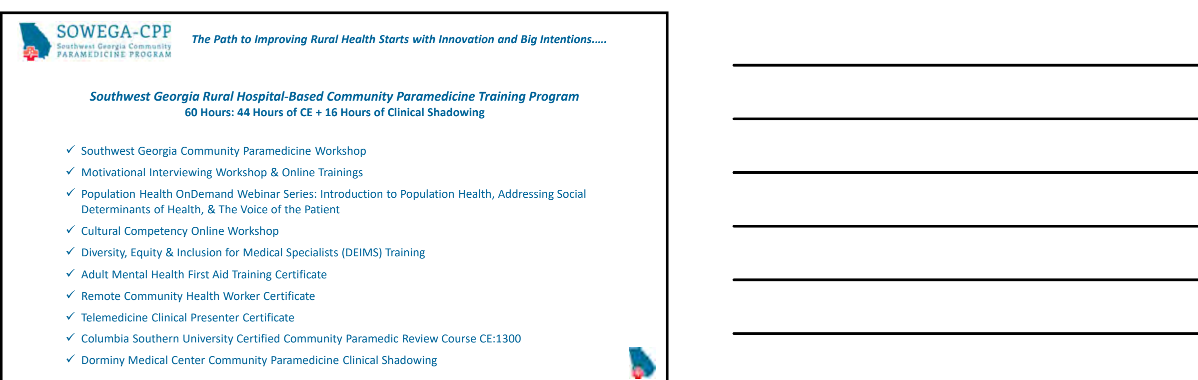

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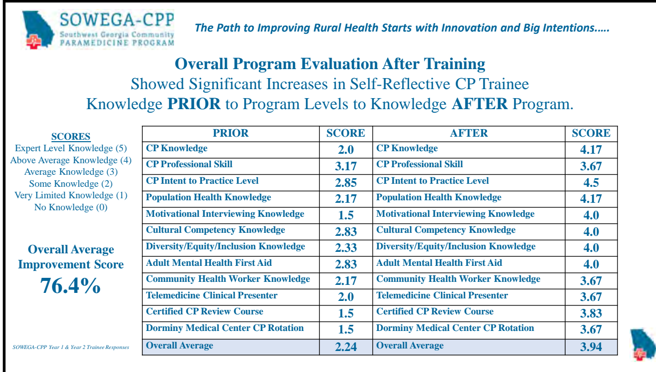

PRIOR	SCORE	AFTER	SCORE
CP Knowledge	2.0	CP Knowledge	4.17
CP Professional Skill	3.17	CP Professional Skill	3.67
CP Intent to Practice Level	2.85	CP Intent to Practice Level	4.5
Population Health Knowledge	2.17	Population Health Knowledge	4.17
Motivational Interviewing Knowledge	1.5	Motivational Interviewing Knowledge	4.0
Cultural Competency Knowledge	2.83	Cultural Competency Knowledge	4.0
Diversity/Equity/Inclusion Knowledge	2.33	Diversity/Equity/Inclusion Knowledge	4.0
Adult Mental Health First Aid	2.83	Adult Mental Health First Aid	4.0
Community Health Worker Knowledge	2.17	Community Health Worker Knowledge	3.67
Telemedicine Clinical Presenter	2.0	Telemedicine Clinical Presenter	3.67
Certified CP Review Course	1.5	Certified CP Review Course	3.83
Dorminy Medical Center CP Rotation	1.5	Dorminy Medical Center CP Rotation	3.67
Overall Average	2.24	Overall Average	3.94

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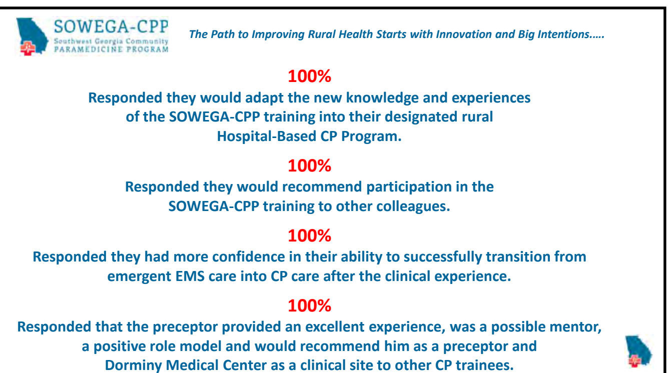

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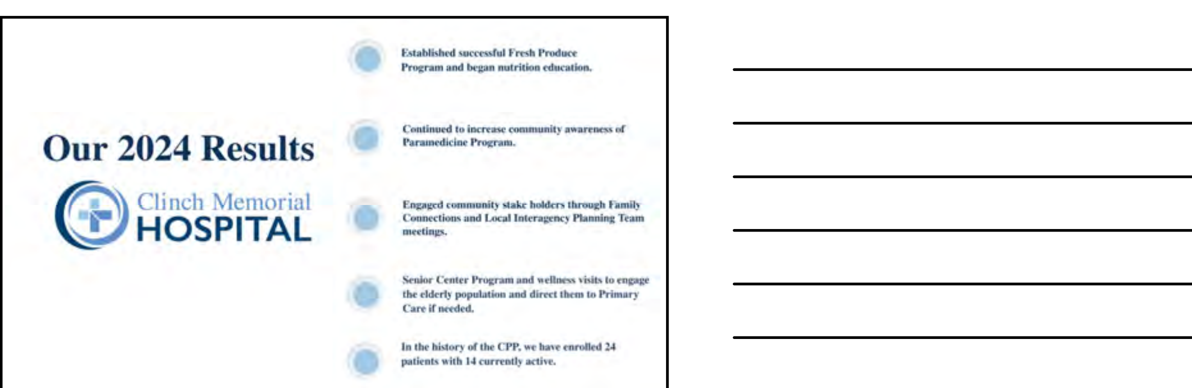

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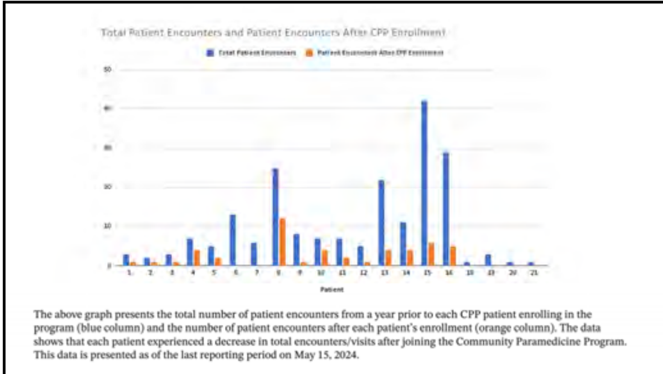

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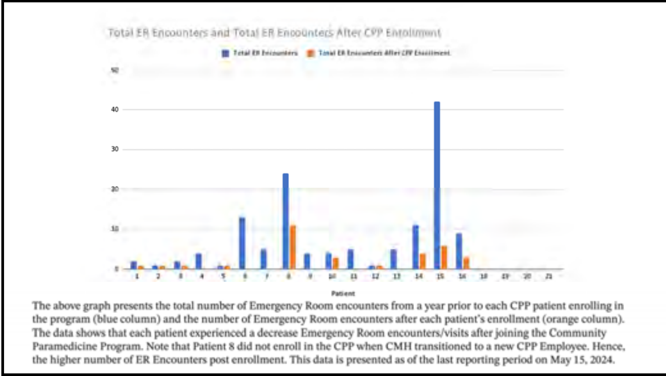

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Most Common Chief Complaints

- Blood Pressure Checks
- Complications from U Cath.
- Constipation
- Dehydration
- Epilepsy/Seizure
- Labs
- UTI

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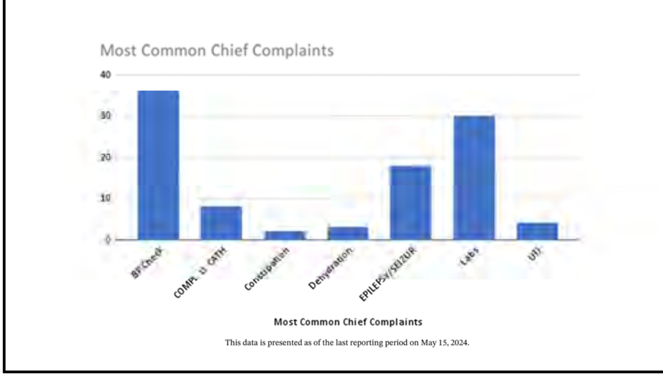

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Fresh Produce Program Affect on Community

- An elderly female patient recently lost her son. In her grief she looked back at the last meal the family had shared together and joy arose through her tears as she remembered that her son had gotten to enjoy one of his favorite foods, collard greens. She went on to say that they had not had collard greens in a long time and that she was grateful to Clinch Memorial for providing that produce, and that she cherishes that memory of her family around the table together before her son passed away.

Clinch Memorial HOSPITAL

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Insurance Impact

I received a referral for a fall risk post hip surgery. Female patient in her 60s that lives at home alone. Upon entry into the program the patient was discouraged and overwhelmed with her healthcare journey. Her insurance did not have out of network benefits for outpatient therapy, and she despised having to use a walker. Through relationship building and MI techniques, patient began to voice a desire to go to physical therapy. After starting the conversation with other members of the healthcare system the patient received a new insurance plan and was in network for local outpatient therapy. She achieved her goal of walking without a walker and has a more positive outlook on her healthcare journey.

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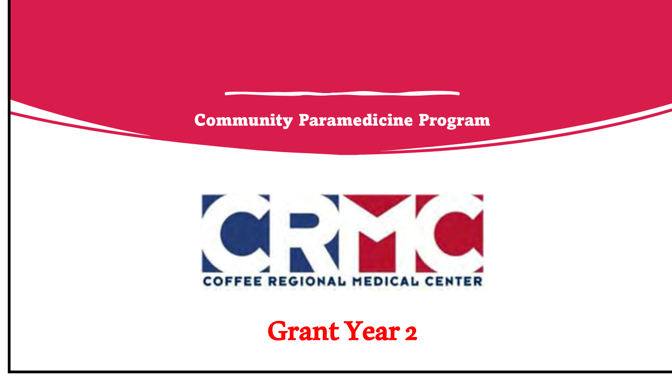

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Community Paramedicine Program

JEFF WINGE, MD, CPP MEDICAL DIRECTOR
PRESIKA CLEMENTS, EMT-P COMMUNITY PARAMEDIC
CONTACT INFO: 912-850-3917

1101 OCILLA ROAD
DOUGLAS, GA 31533

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THE START OF FILLING THE GAP…

- Coffee Regional Medical Center obtained a grant through SOWEGA-AHEC to establish a Community Paramedicine Program to fill the healthcare gap in the community. This grant provided start-up cost and maintenance cost for a total of 3 years.
- The grant start date was August 2022.
- Vehicle and supplies were purchased.
- Community Paramedic was hired.
- Training and development of protocols began January 2023.
- Enrolled first patient March 2023.

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SERVICES PROVIDED

- The Community Paramedic addresses the patient's needs, whatever they may be.
  - Medical – such as new or chronic illnesses and injuries
  - Social – including mental health
  - Financial – as in uninsured or underinsured
  - Dietary - ensuring patient has an adequate amount of food and meeting specific needs for managing their health

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NUMBER OF PATIENTS

- Total Patients Enrolled – 18
- End of Grant Year 2 Current Patients – 10
- Patients Graduated – 1
- Patients Discharged (other than graduated) – 3
- Patients Transferred (SNF, Hospice, etc…) – 2
- Patients Expired – 2

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TEAMWORK

- Referrals for the program can be sent from anyone who has a part in the patient's care.
- The Community Paramedic teamed up with Population Health/Care Management of Coffee Regional Medical Center to prioritize potential patients and address progress of current patients. Most referrals to the Community Paramedicine Program come from Population Health/Care Management.
- Working with PCPs to treat patients at home when possible. Community Paramedics help PCPs better understand patient's needs and concerns. They also help the patient to understand the PCP's plan of treatment.

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TIME

- Mental health was the most time-consuming need encountered during Grant Year 2 due to limited and lack of mental health resources.
- The "PATIENT" includes anyone who plays a role in their day-to-day life, such as family, friends, and providers.
- Patients often have needs in multiple areas (medical, social, financial, & dietary).

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RESOURCES

- Networking Relationships are crucial in Community Paramedicine to meet the needs of the patient. There is no step-by-step guide to every situation you will encounter, and these relationships can help walk you through it.
- Know what resources are available and what are needed in your community.
- Educate patients on available resources and how & when to use them.

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SUCCESS STORY

- A 64-year-old male, who lived alone, no nearby family, had limited income, and no means of transportation, was a frequent utilizer of the healthcare system. This patient had several chronic medical illnesses. Upon first visit to his home, Community Paramedic identified important needs for the patient. He had a very small amount of food, no working refrigerator, and no stove. The Community Paramedic enrolled the patient in the local food bank and delivered them to him and arranged a donation of a working refrigerator. The patient had been non-compliant with his medications due to transportation. The Community Paramedic picked up patient's medications and delivered to him. These small acts made it possible for the patient to have his medications and food without the need to be a patient at the hospital just to get them.

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Questions?

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David Carle, MD - Medical Director
Amy Williams, EMT-P - Program Director
Allison Ridley, EMT-P, CP-C - Community Paramedic

3131 S. Main Street
Moultrie, GA 31768

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Colquitt County

- Rural county
- Population of 46,000
- As of 2022, 23.4% are without health insurance
- As of 2022, 22.4% are living in poverty
- Dominated by agricultural endeavors

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Colquitt Regional Medical Center

- 99 bed facility
  - 10 bed ICU
  - 24 bed ER
  - OR
  - OB unit
  - Behavioral Health Unit
  - Remote Treatment Stroke Center

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Colquitt County EMS

- Sole 911 provider
- 3 24-hour trucks
- 8400 call volume

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Colquitt Regional Medical Center Community Paramedicine Program -Statistics:

- Start date: June 1, 2023
- Total of 48 patients
- 15 Active
- Discharged for non-compliance
- Successfully graduated
- Hospice
- Expired

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Referral Process:

- Where do we get our patients from?
  - Readmission Task Force
    - Focus on 30-day readmission risk patient under the CMS guidelines
      - CHF/COPD/Pneumonia
  - CHF Medication Reconciliation Program
    - Patients in the hospital with new onset of CHF or changes to CHF medications
  - Primary Care Clinics
  - Case Management

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Process:

- **Readmission Phase**
  - Day 1-30
    - Evaluate patient's social determinants of health
    - Reconcile medications
    - Follow up appointments
- **Habit Forming Phase**
  - Day 31-60
    - Teaching the patient medication compliance
      - Refilling medication
      - Organizing medications
    - Scheduling appointments
    - Cleanliness of home
- **Evaluation Phase**
  - Day 61-90
    - Evaluate the patient's ability to continue an improved healthy lifestyle
    - Re-evaluate patient's need for additional time within program

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Colquitt Regional Medical Center Community Paramedicine Program - Lessons Learned:

- Patient Education
  - Be prepared to educate your patients on their chronic illnesses and medications.
  - Do not assume their physicians are doing this.
- Motivational Interviewing
  - Guide the patient through their process of improving their lifestyle.
  - Have them determine their reasons why and how.
- Each patient will reach goals at different paces.
  - Let them work on their own time, but don't allow stagnant times.

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Colquitt Regional Medical Center Community Paramedicine Program -Impacts

- Facility Impacts
  - Preventing frequent readmissions
  - Decreased the use of the 911 system
  - Created a continuum of care between discharging physicians, PCPs, and Specialists
  - Created a liaison between the physicians and the patients, even during admission
  - Improved the transition of care from discharge to home
- Community Impacts
  - Discovered underlying causes for unintentional non-compliance…
  - Became a translator between patients and physicians during appointments
  - Encouraged patients to communicate more freely about true health concerns

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Active Patient A:

- Super-user of EMS/ER
- 4 hospital admissions from January 1, 2023, to August 2023
  - Has been out of the hospital for 283 days as of 4/12/24
- 21 EMS calls/ER visits January 1, 2023, to August 2023
  - No ER visits in 108 days as of 4/12/24
- Improved medication compliance
- Kept all physician appointments
- Transitioning from Group home to own apartment

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Active Patient B:

- Readmission due to CHF
- Had no Cardiologist established or Primary Care Physician
- 3 hospital admissions from January 2023 to October 2023
  - Has been out of the hospital for 168 days as of 4/12/24
- 8 EMS calls/ER visits from January 2023 to October 2023
  - No ER visits in 173 days as of 4/12/24
- Improved medication compliance
- Kept all physician appointments

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Statistics:

- Graduated Patient 1
  - Total charges for 1 year prior to being enrolled =$381,957.70
  - Total charges since being enrolled on 6/1/23 = $195,781.30
  - Total savings = $186,176.40
- Graduated Patient 2
  - Total charges for 1 year prior to being enrolled = $253,600.33
  - Total charges since being enrolled on 6/6/23 = $0
  - This patient has not had an ER visit or been admitted to the hospital since enrollment!
- Graduated Patient 3
  - Total charges for 1 year prior to being enrolled = $223,819.90
  - Total charges since being enrolled on 1/7/24 = $0
  - This patient has not had an ER visit or been admitted to the hospital since enrollment!

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Statistics (cont):

- Graduated Patient 4
  - Total charges for 1 year prior to being enrolled =$185,649.70
  - Total charges since being enrolled on 6/1/23 = $29,995.04
  - Total savings = $155,654.66
- Graduated Patient 5
  - Total charges for 1 year prior to being enrolled = $73,235.04
  - Total charges since being enrolled on 7/24/23 = $0
  - This patient has not had an ER visit or been admitted to the hospital since enrollment!
- Graduated Patient 6
  - Total charges for 1 year prior to being enrolled = $51,519.20
  - Total charges since being enrolled on 7/28/23 = $0
  - This patient has not had an ER visit or been admitted to the hospital since enrollment!

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Colquitt Regional Medical Center Community Paramedicine Program -Future:

- What's next?

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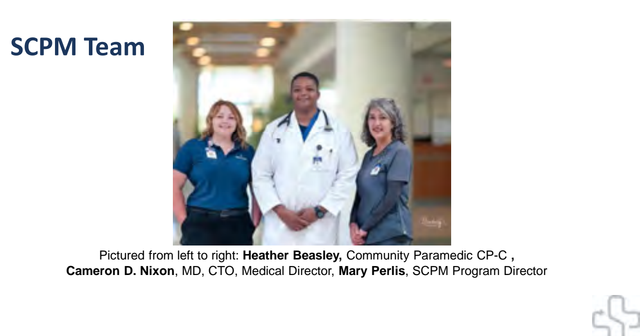
SCPM Team



Pictured from left to right: **Heather Beasley,** Community Paramedic CP-C , **Cameron D. Nixon**, MD, CTO, Medical Director, **Mary Perlis**, SCPM Program Director

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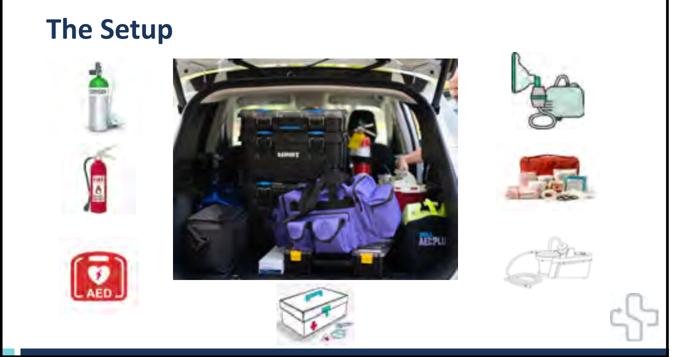
The Setup



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Key Milestones

Grant Initiation: ***08/01/2022***
EMS Agency License application with Georgia Office of EMS and Trauma: ***09/28/2022***
SCPM Vehicle Purchased: **12/2022**
Hiring of prospective Community Paramedic: ***03/2023***
Initial Education of prospective Community Paramedic: ***03/2023 - 04/2023***
EMS Agency License Issue Date: ***04/20/2023***
First SCPM visit: ***04/24/2023***
SCPM's first list of 10+ patients: ***07/05/2023***
Community Paramedic goes full-time: ***11/2023***
Community Paramedic is IBSC certified (CP-C): ***02/2024***
SCPM changed supervision from Joel Presley to Mary Perlis: ***03/2024***
Community Paramedic attends first MIH summit: ***03/2024***
SCPM successfully provides enrolled patients with Medical Binders: ***04/2024 (It's a hit!)***
SCPM provides specific program outlines, goal worksheets, and graduation checklist: ***05/2024***
SCPM regularly collaborates with the CHF/COPD clinics to offer in-home Telemed visits: ***06/2024***

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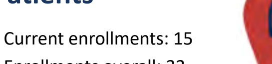
Our Patients



- Current enrollments: 15
- Enrollments overall: 32
- Recent Graduations (since the start of 2024): 10
- Enrollment goal: 14 - 20 enrollments at a time
- Many success stories; more in progress…

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Community Impact

Southwell's Community Paramedicine (SCPM) program works to improve the overall healthcare of its patients and community by aiding in chronic disease management and injury prevention. In supporting our local providers in this endeavor, the SCPM works to continue to deliver the following community impacts:

- Reduction of unnecessary 911/EMS calls
- Reduction of unnecessary Emergency Department visits
- Lowering healthcare cost (Pt/Hospital/EMS)
- Lowering hospital re-admission rates
- Improving Emergency Department wait times
- Improve healthcare availability to underserved populations
- Improve healthcare education
- Improve resource awareness and utilization

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Services offered by SCPM

- Chronic Disease management/monitoring
- Vital Sign monitoring/logging
- Needs/Physical Assessments on each visit
- Medication Reconciliation
- Connection to Primary Care
- Appointment Management (schedule/reminder)
- Transportation (connection/schedule)
- Establish care plans and/or enhance care plan with PCP
- Connection to Community Resources/Programs
- Connection to Oral Health Services
- Assessing Social Determinants of Health
- Home Safety Checks
- Advocating for pt care and continuation of care
- Motivational Interviewing
- Basic Wound Care/Management
- Patient Education that includes disease (management, prevention, and wellness)
- Mental Health assessment/monitoring and care connection
- Determine compliance with therapy, medication, and patient care plan
- Providing basic equipment when necessary (first aid kits, automated blood pressure cuffs, fans, pill organizers, cutters, etc.)

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Lessons Learned

WHAT ARE WE DOING WELL?

- Improving Access to Care
- Improving Pt Satisfaction Rates
- Improving Education
- Improving Compliance
- Reducing ED visits
- Enhancing the Pt Experience
- Reducing Hospital Re-admission Rates
- Improving communication between patients and providers
- Improving pt comprehension and implementation of the Provider's Order(s) and Plan of Care

What Helps Community Paramedicine Succeed?

- Advocating for Our Patients
- Creating More Opportunities to Access Care
- Increasing Our Efforts to Educate
- Promoting Compliance
- Responding to Lower Acuity Calls
- Empowering Patients to Feel Understood and Heard
- Implementing New Concepts to the Program such as our Medical Binders and Forms
- Establishing good rapport and trust
- Staying Current with CP-C Policies and Procedures
- Continuing to Refer the Patient to the Right Services at the Right Time

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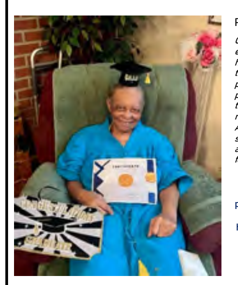
A Success Story



Patient: Tift 11

CP received a PCP referral of a mildly demented 80 yr old female pt w/ history of chronic pain within her lower extremities and lower back. The pt is present on the list of re-admissions and has increased ED visits due to her increased pain levels. The pt enrolled into the SCPM program in July of 2023. The CP noticed right away that the pt did see pain management but was not yet referred to a specialist for her feet where most of the pt's pain was located on assessments; this limited her mobility. The CP immediately asked for a referral to podiatry and the pt was able to schedule an appointment shortly after. During the appointment with podiatry, the pt was diagnosed with a bony spur in not one, but both feet that was causing most of the pt's pain and reduced mobility. The pain had been greater within her Rt foot and was overshadowing the pain in her Lt foot. After a few regular visits with podiatry, the pt was scheduled for surgery of her Rt foot in 05/2024. After surgery, the pt reported no pain in her Rt foot and was able to bare weight on it again. The pt and CP had seen a drastic change in mobility and she now moves with greater ease. Pt is now scheduled for surgery on her Lt foot later this year.

The CP was present throughout enrollment as an advocate every step of the way and helped remind the pt of every appointment. The CP monitored pt's progress and completed assessments throughout pt enrollment. The pt also received education concerning her current health problems. The pt accepted help filing for financial assistance while in the program. The patient would often comment the worry her unpaid medical bills caused, even though she had insurance. The CP was able to assist the pt with an indigent care application and she was awarded a letter of acceptance shortly after. This meant a great deal to the pt as well as relieved her stress/worry.

The pt has decreased her re-admissions and ED visits drastically since enrollment with the SCPM program. Now, the pt has better mobility and a better quality of life with reduced pain. The CP also noticed an increase in the pt's overall happiness and mood. The pt graduated shortly after and stated that this was her first graduation, ever! She was overjoyed!

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A Success Story

Patient: Tift 1

- 58 yr old male pt w/history of COPD/Chronic Bronchitis x several years with many health and social disparities, presents to the ER several times a week, if not every day of the week for shortness of breath and chest pain. Sometimes, the pt would be seen multiple times a day, returning home and calling for EMS transport again unnecessarily. The pt called EMS usually around 08:00am most mornings which is during EMS shift change. The pt would receive EKG, lab work, chest x-ray, and full work-up every visit. Pt met criteria most visits to receive breathing treatment(s). He currently lives in a small camper at the back of a friend's property with no running water and no electricity. The pt would ask for food, tv, and pain medication before leaving each visit. He would call EMS when the weather was too cold, too hot, or during a storm.
- The pt was enrolled in our program in September of 2023. We provided services such as: assessments (physical and needs), referrals to community resources, provided food from the TRMC Foundation, provided rapport and conversation, pharmaceutical pick-up and education, transportation scheduling and management, and others.
- Since pt enrollment, the CP was able to connect the pt to a PCP and other providers that offer services needed for continued health maintenance. The pt was "fired" from previous providers for non-compliance and no-shows to appointments. The pt now attends every appointment and has a good rapport with his providers.
- The CP program and case management at Southwell have an application currently in progress with the Housing Authority for pt's permanent housing placement. Before the CP program, the pt had refused help from the Housing Authority and the application process entirely. Pt has now d/c his continuous 02 use per provider order and only uses it PRN. Pt has significantly reduced the amount of times he calls EMS with the CC of shortness of breath and did not require a breathing tx with the CP for a few months now (at first it was several times a week).
- Due to his social determinants of health, the CP's initial goal was to reduce his unnecessary ED visits, drastically decrease his re-admission rates as well as help provide the pt with the tools necessary to improve his overall health. We have exceeded this goal. More on next slide…

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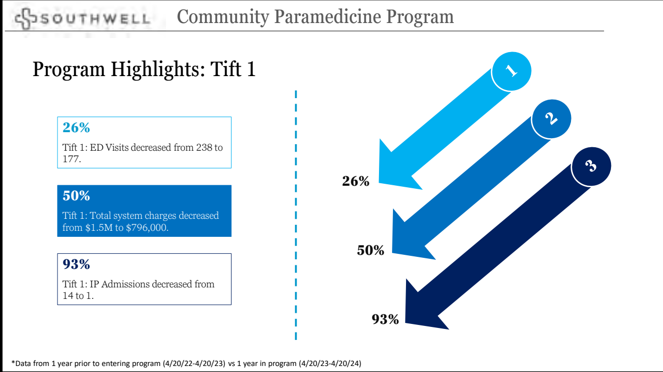

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Growth

Within a year We hit several goals…

- Our Community Paramedic is now full-time!
- We are now CP-C certified!
- We have expanded to serving 4 counties!
- We consistently meet our current enrollment goal!

Future goals:

- Hire an additional Community Paramedic.
- Continue to decrease ED utilization / IP re-admission!
- Increase enrollment numbers!
- Keep moving forward!
- Continue to add new services such as **Telehealth** and in-home lab draws!

Telehealth

Southwell Community Paramedicine is partnering with the CHF/COPD clinics to offer in-home telehealth appointments. This cooperation gives us the opportunity to provide:

- Better In-Home Assessments
- Primary Care and Chronic Condition Management from home
- Comfort and Convenience
- Control of Infectious Disease/Illness
- Better Appointment Compliance
- Family Connections
- Direct, In-Home Education

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Contact

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Community Paramedicine Program CP-C
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Questions?

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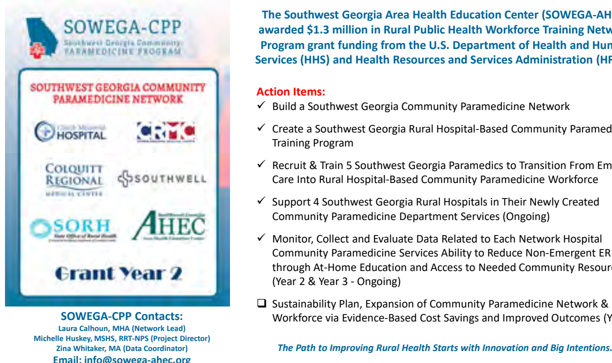

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The Southwest Georgia Area Health Education Center (SOWEGA-AHEC) awarded $1.3 million in Rural Public Health Workforce Training Network Program grant funding from the U.S. Department of Health and Human Services (HHS) and Health Resources and Services Administration (HRSA).

Action Items:

- ✓ Build a Southwest Georgia Community Paramedicine Network
- ✓ Create a Southwest Georgia Rural Hospital-Based Community Paramedicine Training Program
- ✓ Recruit & Train 5 Southwest Georgia Paramedics to Transition From Emergent Care Into Rural Hospital-Based Community Paramedicine Workforce
- ✓ Support 4 Southwest Georgia Rural Hospitals in Their Newly Created Community Paramedicine Department Services (Ongoing)
- ✓ Monitor, Collect and Evaluate Data Related to Each Network Hospital Community Paramedicine Services Ability to Reduce Non-Emergent ER Visits through At-Home Education and Access to Needed Community Resources (Year 2 & Year 3 - Ongoing)
- ❑ Sustainability Plan, Expansion of Community Paramedicine Network & Workforce via Evidence-Based Cost Savings and Improved Outcomes (Year 3+)

The Path to Improving Rural Health Starts with Innovation and Big Intentions.

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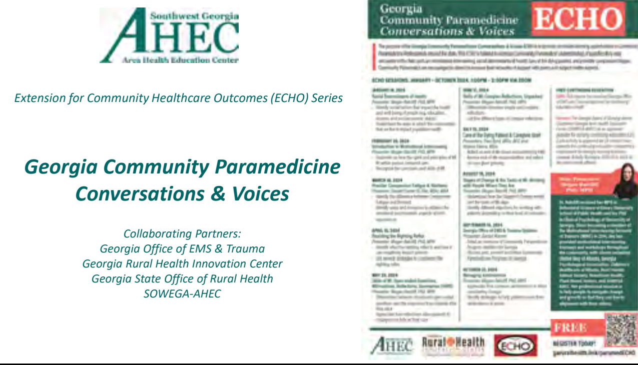

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Questions?

For participants watching the recorded webinar, email any questions regarding the content to info@sowega-ahec.org.

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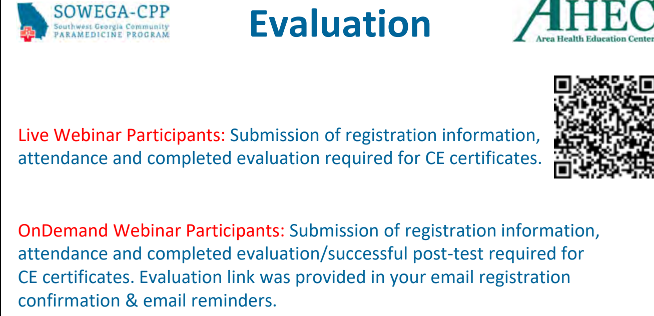

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