Post-Discharge Follow-Up to Avoid Excessive Readmissions

CALIFORNIA'S COMMUNITY PARAMEDICINE PILOT PROJECTS April 2018

Illustration by Ruben DeLuna

Patients recently discharged from a hospital after treatment of a chronic condition such as congestive heart failure, acute myocardial infarction, or chronic obstructive pulmonary disease (COPD), are visited at home by a community paramedic. The goal of these short-term follow-up visits is to decrease the number of patients who are readmitted to the hospital within 30 days of discharge. These projects seek to give patients tools to manage their conditions more effectively so that they can avoid readmission.

Results (as of September 30, 2017)

- 1,401 patients were enrolled in post-discharge projects at five sites across California. At four sites, patients received at least one in-person visit from a community paramedic. At the other site, community paramedic contact was primarily by phone or, if needed, in-person.
- All five post-discharge projects have reduced the 30-day readmission rate for people with one or more of the chronic conditions they target to a level that is below the partner hospital's historical readmission rate. Butte County's heart failure patients were the only group whose 30-day readmission rate was higher than the historical rate. In response to these findings, the county changed its protocol in November 2017 to provide at least one home visit to every patient.
- These projects reduced the risk of harm to patients, particularly related to prescription medications. Community paramedics examined all prescription drugs in a patient's possession and reconciled them with the patient's discharge instructions. They then worked with patients to understand the medications and assisted them in obtaining any needed refills. Community paramedics identified 229 instances in which a patient needed additional instructions about how to take their medications as directed by their doctors.
- Community paramedics also made at least 188 referrals to other service providers including primary care physicians, specialist physicians, pharmacists, mental health services, home health providers, drug and alcohol treatment programs, food assistance agencies, and domestic violence agencies. These service providers can help patients manage their conditions and improve their overall well-being.
- All five pilot sites saw potential cost savings for payers, primarily Medicare and Medi-Cal, due to reductions in inpatient readmissions. The average potential savings per enrollee ranged from about $246 to $2,619, for an estimated total of $1.4 million across the five sites. In addition, partner hospitals may have benefitted if reductions in readmissions were sufficient to lower the risk that they would be penalized by Medicare for excessive readmissions.

How It Works

Local paramedic service providers and hospitals are collaborating to reduce the number of avoidable readmissions. Community paramedics provide patients who have been recently discharged from hospitals with timely follow-up visits, calls, or both. Patients with the designated diagnoses are contacted by a community paramedic within 48–72 hours of their discharge from the hospital. Having contact with a health professional during the first week after discharge is important because many readmissions occur during this time period. The community paramedics work with patients to ensure that they are taking medications as prescribed, have sufficient refills to manage their conditions, have scheduled follow-up visits with their physicians, and are adhering to any dietary restrictions related to management of their condition. In some sites, the community paramedics provide a home safety inspection when visiting patients in their homes.

The services provided by community paramedics do not replace home health care or other services available to patients. When community paramedics learn that a patient is receiving home health services, for example, they coordinate with home health agency staff.

See reverse side for a list of partners.

Partners

LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNERS	EMS PROVIDER PARTNERS	LOCATIONS
Alameda County	Alameda County EMS Agency	Alameda Hospital	Alameda City Fire Department	City of Alameda
Inland Counties	San Bernardino County Fire Department	Arrowhead Regional Medical Center	San Bernardino County and Rialto Fire Departments	San Bernardino County (5 cities)
Los Angeles*	UCLA Center for Prehospital Care	Glendale Adventist Hospital	Glendale Fire Department	City of Glendale
Sierra Sacramento Valley	Butte County EMS Dignity Health EMS†	Enloe Medical Center Vituity (formerly California Emergency Physicians) Shasta County Public Health Shasta Regional Medical Center Dignity Health hospitals: ➤ Mercy Medical Center Redding ➤ Mercy Medical Center Mt. Shasta ➤ St. Elizabeth Community Hospital Dignity Health Home Health	Butte County EMS Dignity Health EMS American Medical Response (AMR)	Butte County Redding
Solano County	Medic Ambulance Service	NorthBay Healthcare	Medic Ambulance Service	Solano County

*Pilot project ended August 2016.
†Pilot project approved November 2017; expected to be operational spring 2018.

For more information on community paramedicine programs operating today in California, visit www.emsa.ca.gov/community_paramedicine.