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THE HUFFINGTON POST

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New Medical Partnerships Prevent Avoidable Emergency Room Visits

10/18/2017 04:30 pm ET

It was the kind of situation that typically results in an ambulance trip to the emergency room—followed, quite likely, by admission to the hospital: A woman in her eighties with heart failure had recently been discharged from the Mount Sinai Health System (MSHS) to the Visiting Nurse Service of New York (VNSNY), the home care agency where I work. At a certain point, her condition changed: she began complaining of weakness and a headache that persisted throughout the day. Concerned, the patient's family phoned the VNSNY hotline and alerted the call center nurse.

This is where the story takes an interesting turn: Because the patient was eligible to participate in a new Community Paramedicine collaboration between MSHS and VNSNY, the call center nurse promptly contacted Mount Sinai and arranged for a specially trained community paramedic to be dispatched to the patient's home. When the paramedic arrived a few minutes later, he used a special app to set up a three-way video conference with the call center nurse and a physician from Mount Sinai who is specially trained and certified in online medical control.

The paramedic went on to perform a series of clinical and diagnostic assessments, including EKG and blood glucose measurement, and then administered aspirin and intravenous saline solution, which relieved the patient's primary symptoms. Once the patient was stabilized, the physician proceeded to complete a physical exam remotely, using virtual technology. Based on this exam, he recommended the patient *not* be transferred to an emergency department (ED), but instead be kept comfortable at home. Because the patient's pacemaker was responding inappropriately to normal heart rhythm, the physician also recommended an appointment with her cardiologist.

The next morning, a VNSNY field nurse followed up with a home visit to assess how the patient was doing and arrange for a cardiologist's appointment that day. In the meantime, a stressful trip to the emergency department and likely hospitalization had been averted and the patient was able to remain safely at home for the duration of the VNSNY home care episode.

In-Home Interventions: The New Paradigm

The partnership with Mount Sinai's Community Paramedicine program, which involves VNSNY patients in Manhattan who have been discharged from one of Mount Sinai's acute care facilities, is just one example of how health systems

and home care organizations are partnering to provide fast, effective in-home medical care for issues that, with prompt attention, can be managed without going to the hospital.

If a patient enrolled in the program contacts one of VNSNY's call center nurses with certain symptoms, or if a VNSNY home care nurse observes the same, an automatic prompt in the system triggers the nurse to activate the Community Paramedicine protocol. After arriving at the patient's home, the paramedic loops in the VNSNY nurse and a Mount Sinai physician associated with the program. It's then up to the physician to decide whether home treatment will resolve the problem. If the physician decides that the patient does need ED level of care, the patient will be transported there by ambulance.

The Community Paramedicine collaboration is administered through Mount Sinai Health Partners as a partner of the Mount Sinai Performing Provider System (MSPPS). This effort furthers the goals of the New York State's Delivery System Reform Incentive Payment (DSRIP) initiative to reduce statewide hospital readmission rates. As the first home care agency to participate in this program, VNSNY has worked closely with Mount Sinai to design its home care guidelines and protocols for the Community Paramedicine program. Rigorous quality reviews are done on each case, allowing us to fine-tune the program's processes and optimize outcomes. Since its launch last April, the pilot has been a clear success: Of the first 12 patients to receive visits from the program's Community Paramedics, all but three were managed effectively at home through the combined efforts of the participating trio of clinicians.

In the coming months, the Community Paramedicine program will be extended to patients in other regions of VNSNY's catchment area. "This collaboration that combines home care and emergency medical service capabilities demonstrates how health care professionals across the service provision spectrum can work together to optimize clinical care and patient experience," says Dr. Kevin Munjal, Associate Medical Director of Prehospital Care for Mount Sinai Health System.

"This is an emerging model, both in New York State and nationwide," notes Lorna Canlas, Project Manager with VNSNY's Solution Development group. "It really represents a new paradigm in home health care."

Keeping People Healthy at Home through Hospital–Home Care Collaborations

There are, of course, times when admission to the hospital is exactly what's needed to treat a certain medical condition. But in many cases, especially with older adults who are managing multiple medical issues, there's much to be gained by preventing visits to the hospital for problems that are ultimately treatable at home. Not only are these avoidable visits costly in terms of medical expenditures—including out-of-pocket expenses for the patient as well as expenses borne by insurance or the hospitals themselves—they are also stressful and disruptive to patients and their families.

For this reason, hospitals and home care agencies are increasingly joining forces to create collaborative systems that enable nurses, physicians and other caregivers to work with home care providers to monitor people's health in their homes, either in person or via remote communication, and intervene quickly if problems arise.

Medicare's Bundled Payments for Care Improvement program, for example, is designed to promote exactly this type of collaboration by aligning the financial interests of hospitals and home care providers. In New York State, in addition to the DSRIP program—which operates through coalitions of hospitals and community-based care providers—the Senate also recently established a Hospital-Home Care-Physician Collaboration program, aimed at supporting and facilitating collaboration, coordination and integration of services among these three groups.

Similar collaborative partnerships are changing the healthcare landscape in other states as well. A leading home care provider and hospital system in Ohio, for example, entered into an innovative care collaboration agreement designed to better manage chronic conditions and reduce avoidable hospitalizations. National advisory organizations like the United Hospital Fund have also been encouraging discussion around how hospitals and post-acute care providers can collaborate more effectively and set new standards for comprehensive patient-centered care.

Collaborative in-home healthcare models like these, that integrate high-tech approaches and innovative new services like the VNSNY/MSHS Community Paramedic partnership, are not only here to stay, they will play an increasingly important role in the years ahead. These partnerships are exciting enhancements to traditional home care that allow us to deliver improved quality and better patient experience across the board. That strikes me as very good news for everyone—especially the vulnerable patients we see every day in home care.