# Breakout Session B: Expanding Services

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UnitedHealthcare®
Community Plan

Friday, February 3, 2017

# Breakout Sessions Sponsored By:

# TC-3

*Tucson Collaborative Community Care*

*Laura Baker-Assistant Chief*

*Tucson Fire Department*

# What we will cover

- Overview of the City of Tucson
- History and Development
- Mission of TC-3
- Why TC-3
- TC-3 Workflow
- Future

# Overview of the City of Tucson

Population- 530,000

Square Miles- 228

Fire Stations- 22

- Engine Companies- 23
- Ladder Companies- 6
- Paramedic Trucks- 17
- Rescue Trucks- 5

# Overview of the City of Tucson

Tucson Fire Department

633 sworn personnel

134 civilian personnel

Total Calls: 92,860 (2016)

Medical: 83,673

Non-Medical: 9,187

ALS Transports: 19,479

BLS/Social Service: 64,194

Call volume continues to rise: Up 5,112 in 2016

# History and Development

- *Tucson Hook and Ladder Co.  1881*
- *TFD Medical Services 1974 First PM in service*
- *TFD Social Services*
  - *2007 Human Service Referral System (HSRP)*
  - *2015 November TC-3 (1/2 Captain)*
  - *2016 February Paramedic and Firefighter*
  - *2017 January Case Manager (Part time/Temp)*

# *TC-3 Team*

- *Deputy Chief Sharon McDonough*
- *Captain Mike Bishop (TC-3 Manager)*
- *Paramedic Sue Rizzi (TC-3 Coordinator)*
- *Firefighter Scott Linamen (TC-3 Coordinator)*
- *Part time/Temp Natalie Becker (Case Manager)*
- *Ann Moser (IT/Data Analyst)*
- *Mary McDonald (PreHospital Manager)*

# *Mission Statement*

- *The mission of the Tucson Collaborative Community Care (TC3) program is to identify and provide assistance to the vulnerable populations of our community who have unmet health care and social service needs. TC3 will provide assistance through assessment of their needs, education, and advocacy in connecting the client with services necessary for whole person care.*

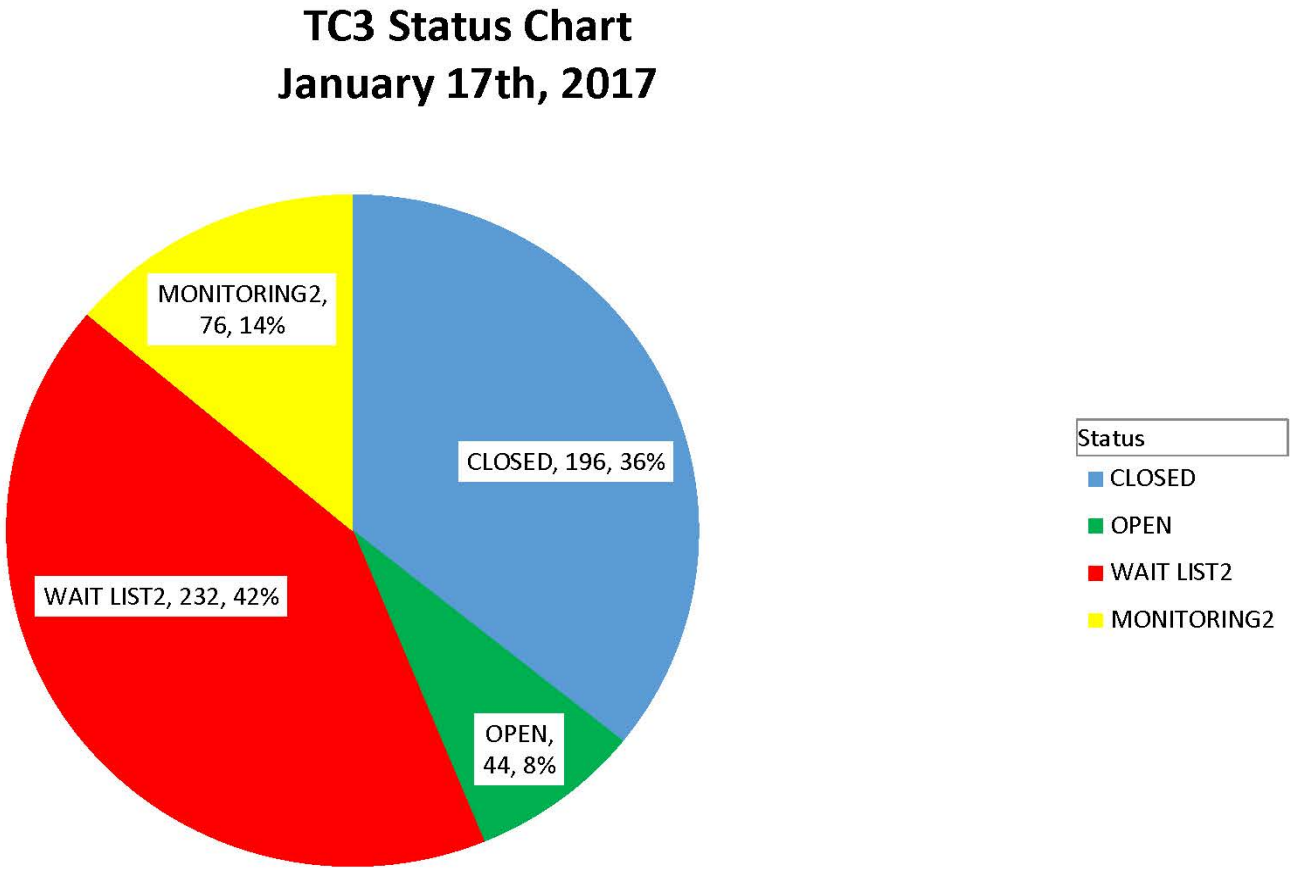
# *Vision*

- *Network of community healthcare and social service providers*
  - *Fire/EMS*
  - *Medical*
  - *Behavioral*
  - *Substance abuse*
  - *Aging*
  - *Homeless*
  - *Pediatric*
  - *Insurance*

# *Why Fire/EMS?*

- *They call, we come*
- *See them at most vulnerable*
- *See true living conditions*
- *Whole picture*
- *Trusted*
- *The right thing to do*
- *EMS options: ED, ED, ED*
- *Next chapter for Fire/EMS*

# *Statistics for 2016 (calendar)*



# *Why TC-3 ?*

- *The right thing to do*
- *They call, we come*
- *Never just one thing*
- *Treat the "whole person"*
- *Population of complex individuals with multiple needs*
- *Healthcare system increasingly complex*

# *Why TC-3?*

- *Impossible for some to navigate*
- *Difficulty  identifying, locating, contacting, and accessing necessary services*
- *Forces them to seek healthcare and other services through the 911 system*
- *911 has become part of behavior*

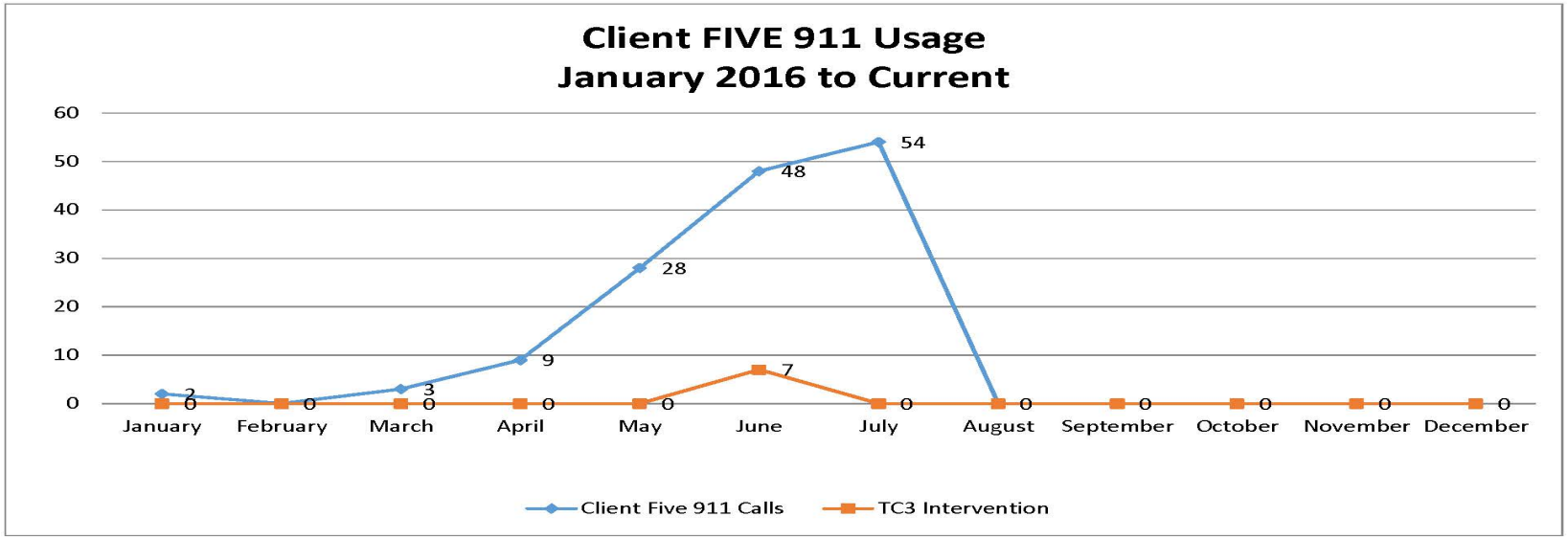
# *What is TC-3?*

- *Originally designed for frequent users*
- *Now being utilized to assist the whole community*
- *Focused on vulnerable or at risk populations in our community*
- *Responsibility of TC-3 manager and crew to act as liaison/advocate and connect with appropriate resources*

# *How does TC-3 work?*

- *Field crews identify the need for follow up*
- *Check TC-3 Button in TFD EPCR*
- *Report sent to TC-3 manager/crew*
- *Referral then sent to participating agencies*
- *Once referral is made a provider can enter notes on referral website*
- *Follow up visits by TFD and responsible organizations*

# One example:


Client FIVE 911 Usage
January 2016 to Current
60
50
40
30
20
10
0
54
48
28
9
3
2
7
0
January
February
March
April
May
June
July
August
September
October
November
December
Client Five 911 Calls
TC3 Intervention

# Agencies involved

*Tucson Police Department (MHIST)*

*Banner Hospitals*

*Tucson Medical Center*

*Pima Council on Aging (PCOA)*

*El Rio Healthcare*

*Pima Health Nurses*

*Veterans Affairs (VA)*

*Adult Protective Services (APS)*

*Community Partners of Southern Arizona ( CPSA)*

*Old Pueblo Community Services*

*Mercy Care*

*United Health Care*

*Casa de los Ninos*

*La Frontera*

*HOPE Behavioral*

*COPE Behavioral*

*CODAC*

*Primavera*

*Health South Rehabilitation*

*Poison Control*

*Medical reserve Corps of Southern Arizona*

*Our Family Services*

*Sun Life home Health*

*Nursewise*

*Community Bridges Inc. (CBI)*

*Community Food Bank of Southern Arizona*

*Pet Services*

*Assurance Health and Wellness*

*Arizona Connected Care*

*Community Home Repair Program of Arizona (CHRPA)*

*Office of Human Rights (OHR)*

*Department of Developmental Disabilities (DDD)*

*Lutheran Social Services*

*Catholic Community Services*

*Sullivan Jackson Employment Center*

*Jewish Family Services*

*Agape Hospice*

*Harbor Light Hospice*

*Banner Whole Health*

*Rincon Recovery*

# What the future holds

- Triage at the Communications Center
- Treat and Refer
- Continually recruiting/building/refining
- Community Support Fund
- Volunteer Tier
- 311 Tier

## *Why should you get involved?*

- *Promotes unified health care*
- *Vehicle for communication*
- *Provides common goal /direction*
- *Promotes efficiency*
- *Prevents redundancy*
- *Assistance for those who have fallen between the cracks*
- *The right thing to do*

# QUESTIONS

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# Treat and Refer

The Golder Ranch Fire District

Community Integrated Healthcare Program

# What we will cover

- History and Development of the Community Integrated Healthcare Program
- Evolution to Treat and Refer
- The Application Process
- Moving Forward

# GRFD Snapshot

- Fully career public Fire and EMS Provider northwest of Tucson, AZ
  - Population 65,000
- Fire service area 200+ square miles
- EMS (ALS Response/Trans) service area 300+ square miles
- Eight Stations
  - Personnel
    - 178 total FTE's
    - 141 line personnel (Shift strength 47)
- Call Volumes
  - Total of 11927 FY16
    - 6324 EMS Related
    - 186 All other emergency call types (Fire, HazMat, ETC)
    - 5417 Service and good intent calls
  - Emergency call volume by percentages
    - 97% EMS
    - 3% All other

# History and Development

- Development began in May 2013
- Data Analysis
- Gaps Identified
- Workgroups Formed
- Went Live on June 30th, 2014
- Goals
  - Improve the health of our community
  - Right size care
  - Reduce readmissions

# How it Works

- Patients who are eligible for the program are those discharged from referring facilities with one of the following diagnoses:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Congestive Heart Failure (CHF)
  - Diabetes
  - Heart Attack
  - Pneumonia
- Patients opt into the program at the time of discharge

# How it works

- Participants receive a minimum of six interactions from a CIP over a 30 day period following discharge from the hospital.
  - The first two and final interactions are always performed in the home
  - Based on acuity level, participants are provided with a phone follow up option, in lieu of a home visit (CHF excluded)
- The CIP will provides care to participants including:
  - Residential safety inspection
  - Medication reconciliation
  - Physical assessment

# How it Works

- Care is provided through Administrative Orders (AOs), developed with our Medical Director – Dr Cary Keller
  - The CIHP AOs are designed to seamlessly integrate with our EMS AOs, should an acute incident occur
- All of this information is readily available and shared with the participant's primary care and/or specialty physician.
- At the completion of the 30 program period, participants are discharged from the program and issued a certificate of completion.

# How it Works

- Care is provided Community Integrated Paramedics (CIPs).
- Golder Ranch Fire CIPs undergo an additional 76 hours of training in nutrition, pharmacology, lab value interpretation, smoking cessation, and disease specific processes.

# How it works

- The service is available 24 hours a day, through a single point of contact
  - For facilities, this a 24 hour EMS Captain
  - For participants, this is a CIP
- Participants still have access to traditional 911 services and ambulance transports, should the need arise
  - All participants have their address geo-coded with our dispatch center
  - Should a participant access 9-1-1, the CIP responds as well

# Results

- 140 Referrals in first operational year
  - 85 Graduated full 30 day program
  - 16 Readmitted during time in program
    - 7 for original discharge diagnosis
    - 9 for new diagnosis
  - 17 Refused prior to first visit
    - 4 readmitted within 30 days
  - 11 Removed (refusal after visits had begun, transfer to SNF)
  - 10 unable to contact
  - 1 deceased
    - Extensive review conducted

# Results

- 101 Total referrals who fully participated in 30 day program
  - 84.1% Graduated
  - 15.9% Readmitted
    - 41% on discharge diagnosis (7% of total participants)
    - 59% on new diagnosis (8.9% of total participants)

# Outcome

- Beneficial service to our community

| CIHP Satisfaction Survey | |
|---|---|
| Question | Average Response |
| Professionalis/Appearance of CIHP team | 1.00 |
| Quality of care provided by the CIHP team | 1.02 |
| Knowledge and understanding of the CIHP team | 1.05 |
| Benefit to you of participating in the pilot program | 1.07 |
| Overall satisfaction of the CIHP | 1.02 |
| Satisfaction survey was optional and anonymous. Results are based on 44 completed and returned surveys. | |
| Scoring is based on a scale 1 - 5 where 1 is excellent and 5 is not meeting expectations. | |

# Evolution to Treat and Refer

- Third Operational Year
- Cenpatico
- Behavioral Health Transfer
  - Ability to transfer the care of behavioral health patients at the scene vs transport to ED
  - Development began in February 2016
  - Went live Sept 19th, 2016

# Evolution to Treat and Refer

- The main difference between our program as it existed and Treat and Refer as a whole?

# The access point!

# Evolution to Treat and Refer

- Modifying the access point
- Workflow developed for field referral
- Includes reporting and follow up requirements
- Line personnel refer patients evaluated for COPD, CHF, DM, or PNA to the CIHP
- Line personnel refer behavioral health patients to Crisis Management Teams

# Application Process

- Initial Perception vs Reality
- The biggest challenge?
- Training allocation

**Exhibit 1: Initial and Recertification Education Framework for Paramedics**

| Patient Transportation | |
|---|---|
| **Training Goal** | *Educate the provider of various transportation modalities to ensure the most appropriate method of transport is identified and can be recommended to the treat and refer patient.* |
| **Learning Objectives** | **Required for Initial Education (0.5hrs)**<br>• Define and discuss the various patient transport modalities<br>• Identify and discuss the abilities and limitations of each modality<br>• Identify and discuss the medical qualifications for each<br>• Discuss the importance and impact of referring to an in-network provider when that information is available<br>**Recommended for Continued Education (0.5hrs)**<br>• Discuss reimbursement considerations<br>• Demonstrate patient teaching of most appropriate transport method |
| **Learning Methods/Activities** | • Didactic instruction<br>• Classroom discussions<br>• Oral presentations<br>• Role-play scenarios in learning lab simulations<br>• Student ride-alongs<br>• Identify and become familiar with transportation resources in the Provider response area.<br>• Limitations and capabilities of each. |
| **Documentation / Evidence of Learning** | • Written assessments<br>• Scenario evaluation |
| **Evaluation** | Written and scenario assessment, supervisor, medical director and peer review feedback will evaluate the providers competence in this area. |

| DHS Req Course | Hours | GRFD Course Hours |
|---|---|---|
| Patient Transport | 0.5 | 1 |
| Transport Desitinations | 1 | 1 |
| Patient Risk Assessment | 1 | 1 |
| Medical Traning and Education | 3 | 11.5 |
| Special Patient Populations | 2 | 61 |
| Patient Follow Up | 1 | 1.5 |
| Medical-Legal Considerations, Definitions and Documentation | 2 | 4.5 |
| Information Exchange and Collaboration | 1 | 1 |
| Public Education | 0.5 | 2 |
| Total | 12 | 84.5 |

| Patient Transportation | |
|---|---|
| **Training Goal** | *Educate providers on the most appropriate method of transportation for CIHP participants.* |
| **Hours of Education** | 1.0 |
| **Learning Objectives** | 1. Identify available transportation options available in service area<br>2. Identify operational impact of avialbe transportation options<br>3. Identify appropriate opportunites for alternative transportation |
| **Learning Methods/Activities** | 1. Included in Behavioral Health, COPD, CHF, DM, MI, PNA education<br>2. Adiminstrative Order Familiarization<br>3. Classroom discussion |
| **Documentation/Evidence of Learning** | 1. Written Assessment<br>2. Preceptor Orientation in field |
| **Evaluation** | 1. Preceptor orientation with live feedback and case scenarios.<br>2. Feedback and discussion with program manager on education and preceptorship |

| Acute Myocardial Infarction | |
|---|---|
| Training Goal | *Educate the Community Integrated Paramedics on the disease process, common treatment plans and how to assess and educate a patient with the diagnosis of AMI* |
| DHS Course Satisfaction and Hours Allocation | Patient Transport - 10 minutes, Transport Destinations - 10 minutes, Patient Risk Assessment - 10 minutes, Medical Training and Education - 1 hour, Patient Follow Up - 20 minutes, Information Exchange and Collaboration - 10 minutes |
| Continuing Education | 2.0 Hours |
| Learning Objectives | 1. Discuss the disease process of the diagnosis<br><br>2. Dialogue on the process of the care of patients with this diagnosis in the hospital and expectations upon discharge.<br>3. Discussion of the assessment process of patient with the diagnosis of AMI<br>4. Discussion of treatment plans for patients with the diagnosis of AMI<br>5. Assessing patient understanding of diagnosis and of treatment plans<br>6. Assessing patient compliance with treatment plans<br>7. How to evaluate the patient for certain needs and when to contact the patient's physician or request transport for patient to the Emergency Department.<br>8. Nutritional needs, changes and evaluations for the diagnosis |
| Learning Methods/Activities | 1. Diadtic instruction, classroom discussion<br>2. Case study, scenario review<br>3. On-line learning |
| Documentation/Evidence of Learning | 1. Written Assessment<br>2. Preceptor Orientation in field |
| Evaluation | 1. Preceptor orientation with live feedback and case scenarios.<br>2. Feedback and discussion with program manager on education and preceptorship |

# Application Process

- Documentation Submitted:
  - Transcripts, rosters, Target Solutions
  - SOPs
  - Training
  - Administrative Orders, workflows
  - Records, reports

# Moving Forward

- AHCCCS Provider Application
- Obtaining new NPI
- Billing decisions
- Sustainability

# Summary

- Program development must begin with data
- Engage medical director, stakeholders, and labor groups at the beginning
- Don’t underestimate the application but don’t let it intimidate either

# Questions and Answers