COLLABORATIVE MODELS OF COMMUNITY MEDICINE & PARAMEDICINE

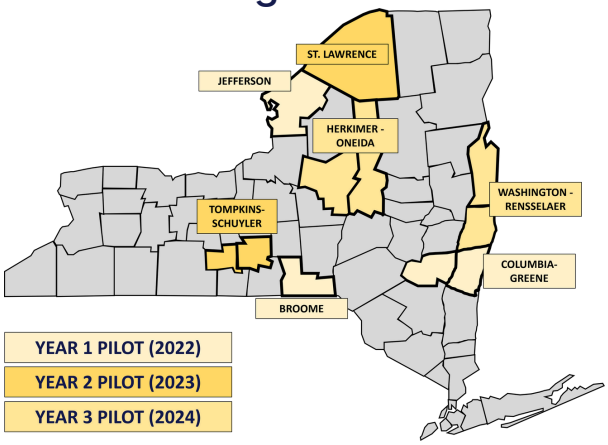
Collaborative Partners

Pilot Programs (2022-2026)

- Integrates core health system partners and practitioners from hospitals, home care, primary care, EMS, and other community partners in a coordinated manner for support in the community;
- Supports home care by serving as a bridge in critical points in care transitions between health care facilities and the home, while supplementing timely services.
- Improves communication, access, and continuity of care by flexibly choreographing the partnered assistance of core health system partners;
- Meets the health needs of the community, while simultaneously preventing potentially avoidable hospitalizations and avoidable emergency department usage by super-utilizers;
- Decreases 911 utilization and EMS transport for conditions able to be handled through preventive in-home support;
- Provides assessment of social determinants of health and patient educational needs for self-management;
- Supports individualized person-centered care across the healthcare continuum by actively involving the patient in their personal health management; and
- Care team can see a holistic picture of patient's health, history and recovery.



Pilot Site Regions



Why?

- Care is received at home, where the patient wants to be.
- Chronic conditions can be managed to prevent emergency department visits and hospital admissions/readmissions.
- Provides over-arching assessment of healthcare needs in the community at a challenging time when the healthcare system has limited resources.

Decreases emergency department visits by

61%

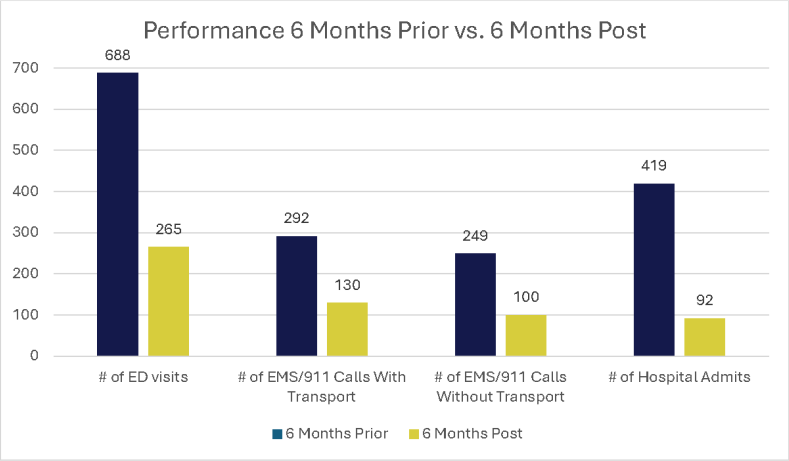
Decreases hospital admissions by

78%

Source: Data collected by year 1 pilot sites representatives.

Support for this statewide initiative is provided through a generous grant from the Mother Cabrini Health Foundation.

Performance Results 6 Months Prior and 6 Months Post Program Implementation



Percentage Change 6 Months Prior vs. 6 Months Post			
# of ED visits	688	265	61% decrease
# of EMS/911 Calls with Transport	292	130	55% decrease
# of EMS/911 Calls Without Transport	249	100	60% decrease
# of Hospital Admits	419	92	78% decrease

Source: Data collected by year 1 pilot sites representatives.

Pilot Program Details and Payor Mix for 2024

Pilot Region	Pilot Start Date	Total Unduplicated Patients Served in 2024	Total Visits Made in 2024	Payor Mix (2024)	Age Range (2024)
Columbia County	November 2022	40	424	Medicare = 92.6% Medicaid = 6.6% Other = 0.8%	50-95 years
Broome County	August 2022	90	1,066	Medicaid = 78.5% Medicare = 17.3% Other = 4.2%	12-96 years
Jefferson County	February 2022	65	1,188	Medicaid = 88.3% Medicare = 9.6% Other = 2.1%	44-94 years

Source: Data collected by year 1 pilot site representatives.

Service Population

- Patients with complex, high-risk health conditions that result from medical, cognitive, behavioral, social, and age-related conditions.
- Patients living in rural communities facing challenges accessing care.
- Patients with multiple chronic conditions such as congestive heart failure, chronic obstructive pulmonary disease, diabetes, patients at risk for falls, or other inherent risks of emergency and medical vulnerability.
- Patients who need help with activities of daily living and other supports for safety and health.

What's Next?

Public and private insurers must recognize the value of these collaborative models and their applicability to health care. Ways to do that include:

- Coverage under private and commercial health plans.
- Medicaid coverage under the state's 1115 Medicaid waiver.
- Bundled services coverage under new and evolving forms of federal, state and private reimbursement.
- Coverage under other health plan models offered in New York.

Collaborative Partners

FOR MORE INFORMATION CONTACT
INFO@HCANYS.ORG | WWW.HCANYS.ORG