Chronic Disease Management (Heart Failure, COPD, Pneumonia, Diabetes)

Our chronic disease management program has been put in place to support existing health services, provide integrated partnerships with other health professionals, and to extend access to health services (such primary care, public health, disease management, prevention and wellness, and mental health), particularly to our underserved population. Our chronic disease management program is narrowly supported through the hospital, but we will use this funding to ensure that we have enough backing to function at capacity as we progress toward self-sufficiency.

Patients are enrolled in our chronic disease management program through doctor referral; primarily patients with chronic heart failure who are unable to receive adequate medical care. The program begins with a health assessment and home safety inspection by a community paramedic (MIH-CP), who makes connections and adjustments accordingly. The MIH-CP sits down with the patient and creates an individualized plan to improve their overall health based upon their unique living/health situation. These plans include strategies to incorporate more activity, improve nutrition and medication compliance, etc. to help the patient maintain a wholly healthier lifestyle. The paramedic will also be the first person contacted in the event of an emergency, prior to a doctor or hospital. They will evaluate and care for the patient on-site and determine the situation’s severity. Along with the proven effectiveness of this response system, the use of telehealth also aids a significant reduction in hospital visits, mutually contributing to further cost avoidance. Telehealth is used to generate readily accessible health reports from home which allows us to resolve incidents before they happen. These initiatives have led to better health for our chronic disease patients and over $400,000 in total cost avoidances among those who have competed the program.

Prenatal/Postpartum Care (Project Swaddle)

Project Swaddle is our service that offers pre-natal and post-partum care for at-risk mothers and their babies. In this program, paramedics make in-home visits with the mothers at varying frequencies throughout the pregnancy process and during the 16 weeks following birth. The paramedic makes one visit per month during the first trimester, centered around gathering information, conducting exams, educating, counseling, and connecting mothers with community collaborative partners like the
Women’s Resource Center, Franciscan Health Crawfordsville, and the Montgomery County and State Health Departments. We educate them about child care, health, safety, immunization, sleep patterns, exposure to harmful substances, etc., along with the importance of their own mental and physical health, while giving them the resources necessary to maintain them.

Visit frequency increases as the pregnancy progresses into the second and third trimesters, where visits become weekly. The MIH-CP spends 1-2 hours with the mother at each visit, providing a personal level of care in the comfort of their own home. This helps to build a trusted relationship between the mothers and paramedic, who is there for 24/7 assistance in the form of emergency response, emotional support, or just to answer any questions that the mothers might have through throughout the process. In addition to the medical assistance and one on one support of the paramedic, Project Swaddle also provides an extensive list of partnered services available to mothers including birthing education with a certified Lamaze (which is currently unavailable in Montgomery County) through Franciscan Health, connections and/or referral to a primary care physician and pediatricians, transportation assistance, car seat inspections, safe sleep education (DOSE), home safety inspections, post-partum health and depression screenings/evaluations, BABY & ME Tobacco Free Program, social service referrals, coping tools, and other great resources.

Continued grant support will allow us to further expand Project Swaddle, offering support, navigation of care, and education for more at-risk mothers, leading to healthier pregnancies and improved mental and physical health among new moms and their babies. Project Swaddle is making great strides toward lessening the amount of low birth weights, pre-term deliveries, and infant mortality rates, all while providing powerful emotional support, significant cost avoidances across all parties, and numerous partnerships extending shared value.

**Substance Use Disorders (SUD)**

Our SUD program’s initiative is to create an effective program encompassing prevention, preparedness, response, and recovery in opioid overdose incidents. This is where a majority of our funding will be utilized. With it, we plan to employ five of the six new employees that we will hire in order to effectively carry out the overdose response initiative piece of our community paramedicine program.

Four of them will be firefighter paramedics - three of which will comprise our quick response team (QRT), and the other as an additional fulltime community paramedic, funded by Mayor Barton. Each of the members of the quick response team will work one of three shifts, together creating a 24/7 emergency response team. These firefighter/paramedics will deploy on all emergency calls and will have specialized training for three particular cases: overdoses, falls, and mental health. They will provide care, coordination, and navigation from the scene of the incident through the extent of the E.R. process.

We will also use this funding to hire a fulltime EIS (social worker) and one peer recovery coordinator/specialist who will play imperative roles in our overdose response initiative. Along with the full-time community paramedic, they will deliver patient centered follow-up care. They will stay
connected with each patient and navigate their individual situations from the E.R. with the initiation of Medication Assisted Therapy (MAT) to their homes with follow-up care.

Falls Prevention

We are putting a particular effort into the falls prevention piece of our plan. According to the CDC, falls are the number one cause of both injuries and deaths among older Americans. In 2014 alone, there were at least 29 million falls, which led to 7 million injuries, costing an estimated $31 billion in Medicare costs.

Our chronic disease program which incorporates falls prevention education has assisted in reducing all cause hospital re-admissions for by nearly 90%. This has resulted in staggeringly high cost avoidance for hospitals, which are charged for each patient who re-admits within 30 days of discharge.

Our falls prevention program will be comprised of immediate on-scene assessment and navigation, 24-48 hour follow up, home safety checks, medication adherences and reconciliation with licensed pharmacists, STEADI assessments and referrals.

Furthermore, this program has benefits for its patients that stretch far beyond the physical prevention of falls. Along with the treatment and rehabilitation of the initial injuries, it reduces the likelihood for future falls and their related impacts. These avoided injuries evade the possibility of future hospital re-admissions, often leading to further health complications like large joint replacement, infections, medication difficulties, and supplementary illnesses.

This program also creates connections that improve all social determinants of health. In the process of carrying out follow-ups, we are also solving another frequent problem for fall victims by reducing isolation, which often leads to its own independent problems. Helping them to feel less isolated has positive effects on their overall mental and physical well-being. For these reasons, it will be very beneficial to have additional paramedics trained specifically to handle fall cases.

Early Intervention Specialist (EIS)

Through a Masters level Social Worker our primary objectives will be to promote health and wellness with patient centered and coordinated care that builds self-sufficiency for our clients. The integration of a full-time MSW to our already established team of nurses and paramedics will allow all of our MIH-CP initiatives to flourish by increase their patient panels of the community paramedics to deliver more clinical care, while our MSW focus on the social determinates of health which may be negatively affecting their physical health.

By assigning professional social worker to assist clients and families as related to illness, disease, hospitalization, financial and educational needs by utilizing a variety of modalities in all areas of service we believe our program can reduce the overall cost of care while improving patient satisfaction and quality of life. Responsibilities also include involvement in the discharge planning process.
Additionally, this EIS will also have through management and oversight of our SUD program and Peer Recovery Coordinator/specialist. As a member of the SUD team, they will be there to provide one on one support to help patients adjust to the changes and challenges of their daily lives throughout the recovery process. They will be able to respond in crisis situations, follow up with patients to ensure a successful recovery, and refer them to appropriate resources. We are looking to hire a clinical social worker or a person with a degree in public health, who could additionally diagnose and treat mental, behavioral, and emotional disorders – a huge development for the mental health side of our initiative. They would be able to develop treatment plans with evaluate their effectiveness through follow-ups along the recovery process.

**Peer Recovery Specialist/Coordinator**

Similar to our social worker, the peer recovery specialist will also develop a meaningful and trusted relationship with the patients, acting as a supportive mentor. This will provide a more personable, individualized recovery process, creating additional mental health support. They will work to build a supportive community around the patients with the resources necessary for a successful recovery to mental and physical health.

These six members will fill in the gaps necessary to improve the effectiveness of our substance abuse program. Like all of our community paramedicine projects, the SUD piece will continue to generate the cyclical benefits that result from our collaboration among partners. This program will improve the mental and physical health of those in our community while reducing work-out for the hospital, reducing cost expenditures across the board, and ultimately create a more-ready workforce with our successful patients, benefitting our community partners and businesses.

**IT / Data Management**

A portion of our grant money will go toward hiring a much-needed internet technology/data management specialist. Our community paramedicine project is largely data-driven operation, generating incomparable statistics. Having a member of our team specializing in data analyses would be incredibly beneficial for tracking our progress and creating the most effective systems possible. They will run and export data for long-term research, our college researcher partners (Wabash College, Indiana University, and Purdue University), and will to allow us to track the progress of our various initiatives. Attaining higher level statistics will lead to the development of more effective strategizing, checkups, and reports. Having a full-time analyst devoted to handling statistics will reciprocally free up substantial amounts of time among our short-handed staff who currently deals with data management, allowing them to spend time more productively in other areas.

**Interns: Graduate & undergraduate**

We also plan to use this funding to hire interns from the undergraduate and graduate programs at our partnered research schools. They will assist in creating business plans, data collection, presentations,
and other various projects where assistance is needed. This will present the interns with amazing learning opportunities while doing valuable work, extending our research partnerships, and spreading our program’s revolutionary concepts through the lens of academia.

**Software**

Another way that this funding will result in expansive paybacks is through a new software program that will allow for advanced interoperability between all entities of our health system.

Getting our own EPIC software build would allow for a more functional collaboration of data, such as emergency medical records, among doctors, care facilities, emergency departments, case management, etc. All 14 Franciscan hospitals would be able to use this for expansion of community paramedicine in their own communal systems.

Crawfordsville for the past few years have been taking the lead in community paramedicine not only for our State, but nationally. Crawfordsville’s Community Paramedicine Program is continually working developing initiatives in collaboration with the Indiana State Department of Health that could be replicated for other Indiana communities. I truly believe with the States continued funding our program can assist with the goals of reducing out of control healthcare spending while creating a path to national healthcare reform.

Through our programs continued successes in gaining strategic collaborative partnerships like ATOM Alliance, Purdue University, and Wabash College we can continued to be viewed as a best practice model on how collaboratively creating shared and social value works alongside economic development.

Please feel free to contact me at any time to discuss the all our program initiatives and overlays in greater detail.

Thanks,

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