

THE PACED INTERVENTION: PARAMEDIC-ASSISTED COMMUNITY EVALUATION (AFTER) DISCHARGE



Pictured left to right: Dr. Kimberly Eisenstock, Dr. Sarah McGee, Dr. Stephanie Sison, Dr. Laurel O'Connor and Julie Inzerillo, Paramedic Researcher.

The period following a hospital discharge is medically precarious in older adults, who are readmitted at alarming rates. In 2018, the 30-day all-cause readmission rate of Medicare beneficiaries was 16.9%. Such events lead to increased cost, patient distress and risk of morbidity. Best practices following hospital discharge include intensive care planning, coordination between medical teams, and communication with patients and their caregivers. However, implementing a rapidly deployable, efficacious, and sustainable program to ensure a safe transition to the community for recently discharged older adults, especially those who are frail, remains a significant challenge.

The Paramedic-Assisted Community Evaluation (after) Discharge (PACED) intervention proposed by the team of Laurel O'Connor, MD, Assistant Professor, Department of Emergency Medicine; Stephanie Sison, MD, Assistant Professor, Department of Medicine; Kouta Ito, MD, Assistant Professor, Department of Medicine; John Broach, MD, MBA, MPH, Assistant Professor, Department of Emergency Medicine; David McManus, MD,

MSCI, Professor and Chair, Department of Medicine; Sarah McGee, MD, Professor, Department of Medicine; and Kimberly Eisenstock, MD, Assistant Professor, Department of Medicine, intends to expedite patient assessment after discharge and bridge the tenuous care gap between acute-care encounters and ambulatory follow up.

A collaboration between UMass Memorial Health's Mobile Integrated Health Program community paramedics and geriatric primary care physicians, this intervention entails a home visit for frail older adults within days of their hospital discharge, during which patients can be evaluated for common post-discharge gaps in care, have their clinical condition reassessed, and receive any required diagnostics, treatments, or additional support. Enhanced by an integrated electronic health record that supports the transmission of information, community paramedics will evaluate patients in their homes, identify and intervene upon suboptimal medical and geriatric conditions that increase their risk of adverse events, and coordinate care with the ambulatory medical home.

"Our project is designed to help older adults transitioning into the community after hospitalization by ensuring that their discharge plans are being successfully implemented at home. We hope that this decreases the cognitive and physical burden of patients and their families during a vulnerable time in their health care trajectory," shared Dr. O'Connor, "Our project aims to improve equitable health care delivery, elevate communication and care coordination between patients and their health care teams, and advance the future of health care delivery."

The novel UMass Memorial Mobile Integrated Health Program, led by Dr. O'Connor in partnership with Drs. Broach and McGee, has been operational since June of 2020. In that time, it has demonstrated outstanding safety and efficacy outcomes: patients who undergo community paramedic (CP) visits avoid acute-care-resource utilization and experience low rates of 30-day hospital admissions. Over a two-year period, UMass Memorial Health Accountable Care Organization participants who underwent CP visits had decreased health care encounter episodes and total claims costs compared to the two years prior to the program. Outcomes

from this study will inform future endeavors and, ultimately, identify additional ways of integrating community-based provider teams with ambulatory and inpatient medical teams to engage with community-dwelling adults, improve communication across the care team, optimize resource utilization, and improve patient outcomes.

Grateful for the opportunity to access funding for this project, Dr. O'Connor stated, "The Prize for Academic Collaboration and Excellence (PACE) program helps to bring together groups of physician investigators, who traditionally work in silos, to collaborate across disciplines and complement each other's expertise." She added, "The PACE program helped our team augment each other's strengths and innovative ideas by funding a multidisciplinary approach to solving critical problems challenging our health system and community."

