Meds-1 Community Paramedicine Goals

System Basis: The IHI Triple Aim framework

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Methods

Goal #1: Improving the patient experience of care (including quality and satisfaction)

Goal Strategy Example(s): The CP will include the patient, and the patient's family members when appropriate, in decisions involving patient care and the development of the care plan. These decisions will include the time and place of care and the goal of planning transitional living / care environments to that of least restrictive. Home-based care planning will always be the goal. Follow-up assessments, both by telephone and non-clinical home visits, will occur within one week of the final care contact to allow for both care compliance assessment and input from the patient and family regarding the CP process / program.

Goal #2: Improving health of populations

Goal Strategy Example(s): The CP will include safety and health surveillance methods in responses to any patient care request. These methods will include environmental health testing such as presumptive lead contamination testing, mold assessment, surveying for unsanitary living environments, and other assessments (such as presence of smoke, CO, and gas detectors, availability of potable water and sanitary sewer, condition of the building structure, ADA accessibility) that could lead to mitigation of health risks. These assessment findings will be reviewed with other care providers and the appropriate county public health officer when risks are detected / suspected. In all cases, the patient will be advised of these assessments and permission to release the findings (when necessary) will be gained.

Assessment of current vaccine compliance will occur in each patient care contact. Influenza and other desired vaccinations will be coordinated with public health and administered at the next patient contact or arranged via the PCP for administration at the next clinic appointment.

Goal #3: Reducing the per capita cost of health care

Goal Strategy Example(s): The CP will develop open communication with all home-based and clinic-based care coordinators involved in the patients plan of care to ensure that duplication of care / services is reduced and that EMS, ED, clinic, and other costlier care is minimized. Any out of home placement care planning will strive to be the least restrictive, thus least costly, destination for care.