In February 2013 the Center for Medicare and Medicaid Innovation (CMMI) awarded Minnesota a State Innovation Model (SIM) testing grant of over $45 million to use across a three-year period. The goal is to help its providers and communities work together to create healthier futures for Minnesotans. Minnesota’s SIM initiative is a joint effort between the Department of Human Services (DHS) and the Department of Health (MDH) with support from Governor Mark Dayton’s office.

Minnesota is using the grant money to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. Thanks to SIM funding, dedicated programs are now in place to improve health in Minnesota communities, provide better care to our state’s residents, and lower health care costs by expanding patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services.

Emerging Professions

HealthEast Community Paramedics Improve Care

JULY 2015

"Kris", a mother of two suffering depression, post-traumatic stress disorder, and a traumatic brain injury, found the road to recovery through the help of a community paramedic.

Short-term memory troubles related to a traumatic brain injury made it challenging for Kris to take her 13 different medications. In 2015, this resulted in an emergency department visit and 4-day stay at St. Joseph’s Hospital in St. Paul for depression and substance abuse.

One goal of Minnesota’s Statewide Innovation Model (SIM) grant is to help patients like Kris stay out of the hospital through team-based coordinated care focused on prevention. For example, SIM Minnesota encourages providers to integrate community paramedics into their models by offering grants that cover a portion of their salary.

HealthEast’s Results

The community paramedic who helped Kris is part of HealthEast’s Emerging Professionals grant funded by the Minnesota’s SIM grant. HealthEast provided training for four community paramedics, who each worked ten hours a week to provide community services. When at a patient’s home, community paramedics can provide an array of services, such as health assessments, chronic disease monitoring and education, medication management, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care and minor medical procedures.

The approach has improved post-discharge care for HealthEast. Based on 353 community paramedic encounters with patients:

- 57% of patients had a mental health visit within 7 days of discharge, compared to a baseline rate of 14%.
- 41% of patients had a primary care visit within 21 days of discharge, compared to a baseline rate of 4%.
- 100% of patients were taking their medications, with paramedics helping the 8% who were incorrectly taking their medications.

The results have also been good for Kris. After leaving the hospital, her community paramedic visited her apartment. He showed her how to use her cell phone to set up medication alerts and enlisted her family and friends to assist in her medication compliance. The community paramedic also facilitated a referral to Bethesda’s Traumatic Brain Injury Clinic for therapy. These steps enabled Kris get back to work and on track with her medications and appointments.