Chronic diseases, such as chronic heart failure (CHF), impose a tremendous burden on healthcare delivery costs. This is reduced in medically underserved areas (MUAs) where healthcare resources are more limited because patients in MUAs are more likely to be older and in poorer overall health than their suburban and urban counterparts. Moreover, care gaps such as lack of post-acute transitional care and limited access to clinics make preventable readmissions a virtual inevitability that is both expensive and disappointing to patients, caregivers, and the healthcare system. Community Paramedicine (CP) is an emerging intervention that can provide patient-centered care in the out-of-hospital environment for discharged patients. It uses paramedics to provide post-discharge follow-up and collect feedback for care providers in order to enhance self-management and reduce readmission risk. Researchers will investigate demand and patient transition when the intervention of CP is applied to CHF patients. Within this the CP intervention will be assessed for IAB healthcare organizations in MUAs.

How this is different than related research:
CP is an important healthcare delivery method as it has the potential to reduce readmissions and ED visits. However, there has been limited research on the impact of CP on demand management. The proposed research aims to provide evidence on the impact of CP on leveraging demand to match limited healthcare capacity.

Value Proposition:
- Measure, evaluate, and compare Community Paramedicine outcomes (e.g. quality of life, self-management, adherence, and readmission)
- Build a decision support tool that estimates readmission risk for all discharges and a customized Community Paramedicine model to support care management for various patient groups
- Reduce readmission risks and penalties from the Centers for Medicare and Medicaid Services