Welcome
EMS on the Hill Day
Mobile Integrated Healthcare Summit
2015

Scott Cravens, Group Publisher, EMS World
Chuck Kearns, NAEMT President

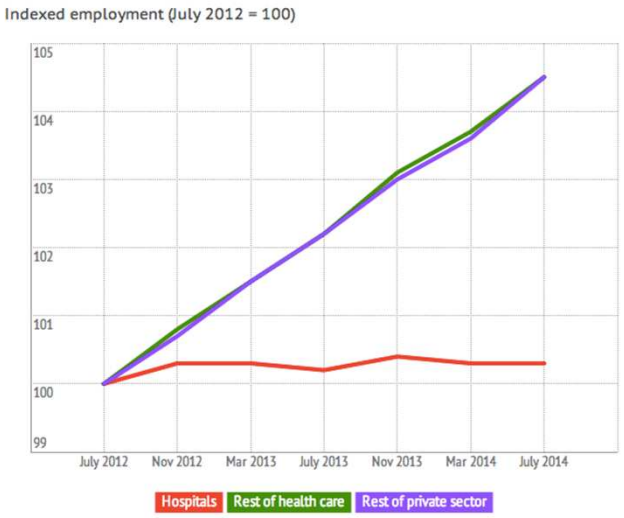
Thank You to Our Sponsors

Medtronic & COVIDIEN

Covidien is joining Medtronic

General Devices

Hospital jobs growth basically flat



Source: BLS data. Analysis by @ddiamond.

Transforming EMS…

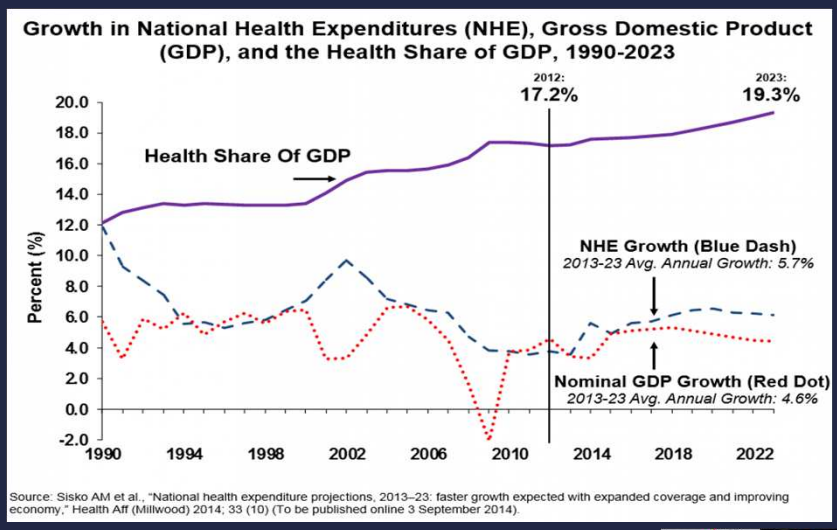
REIMBURSEMENT REFORM

Why is this important?

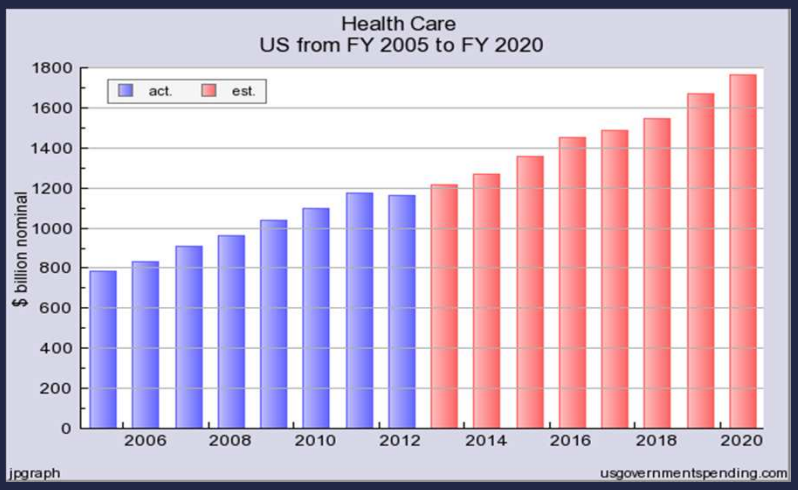
EMS Crossroads

Discover. Plan. Initiate.

Discover.



Discover.



Discover.

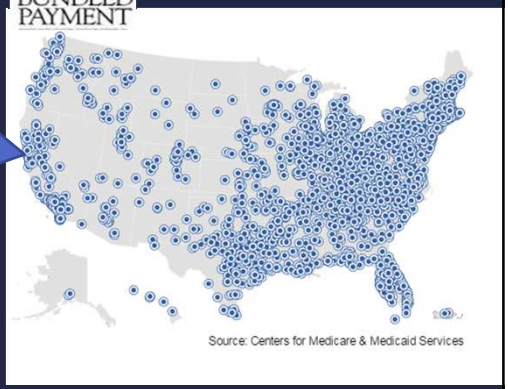
- Fee for Service (FFS)
- Prospective Payment Systems (PPS)
  - Hospitals
  - Home Health
  - Hospice
  - Inpatient Psych Facilities
  - SNFs
- Value Based Purchasing
- Competitive Bidding

Plan.

Shared Savings:
2012: 27
2014: 337

Pioneer:
2012: 32
2014: 19

Source: Centers for Medicare & Medicaid Services



Initiate.

The easiest thing is to REACT. The second easiest thing is to RESPOND. But the hardest thing is to INITIATE.

-Seth Godin

Contact

Asbel Montes
Vice President, Revenue Cycle & Government Relations
Asbel.Montes@acadian.com
337.291.4086

Why We Need Reimbursement Reform

MIH Summit

April 28th, 2015

By: Kevin G. Munjal, MD, MPH
Assistant Professor, Emergency Medicine
Assistant Professor, Health Evidence & Policy
Associate Medical Director of Prehospital Care
Mount Sinai Health System

&

Chair, NY Mobile Integrated Healthcare Association

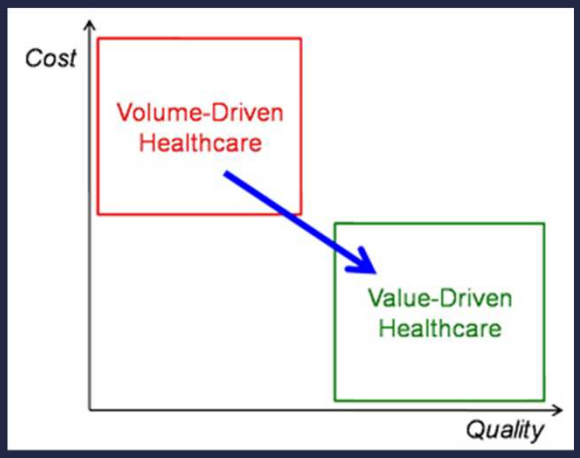
Fee For Service Healthcare

Downstream Costs

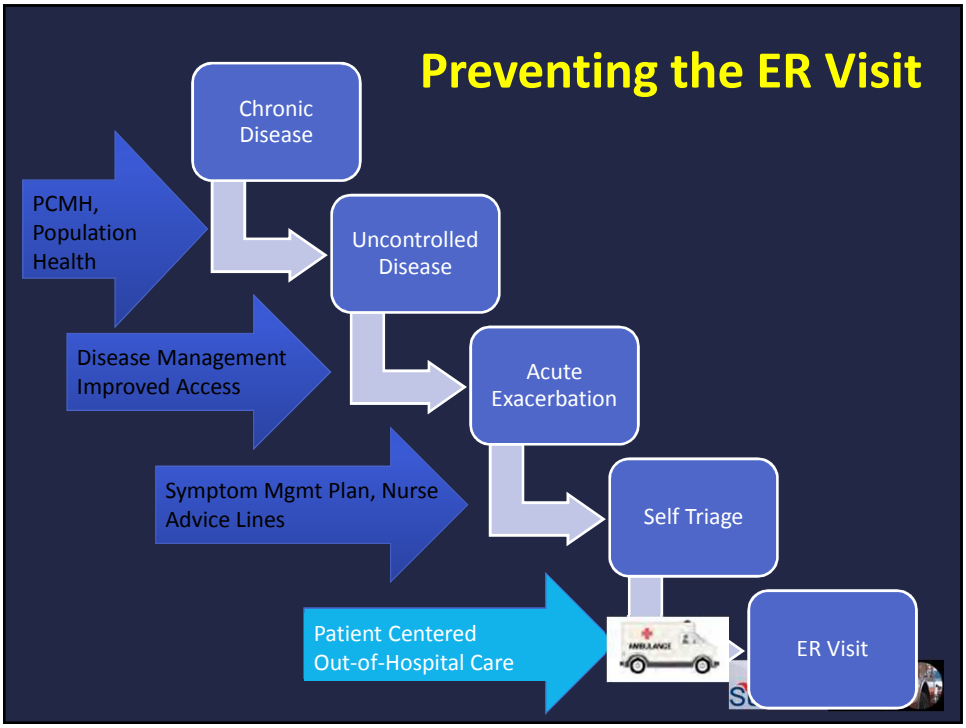
$0

$400 EMS + $900 ER
= $1300

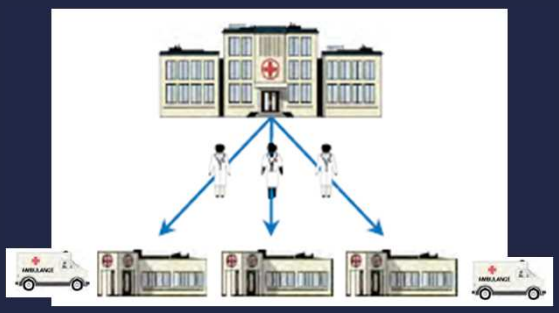
Healthcare is Changing



Preventing the ER Visit



Care in the Community

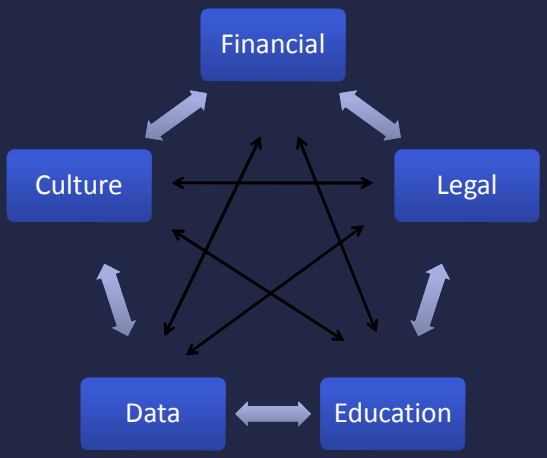


"Instead of measuring hospitals by the number of beds filled with patients being treated for illnesses, the hospital of tomorrow will be judged more by its ability to maintain a community's health. When patients fall ill, we will be equipped and prepared to deliver high quality care. But a key objective of the hospital of the future will be to keep more patients out of the hospital, an optimal outcome for improved communal medical and fiscal health."

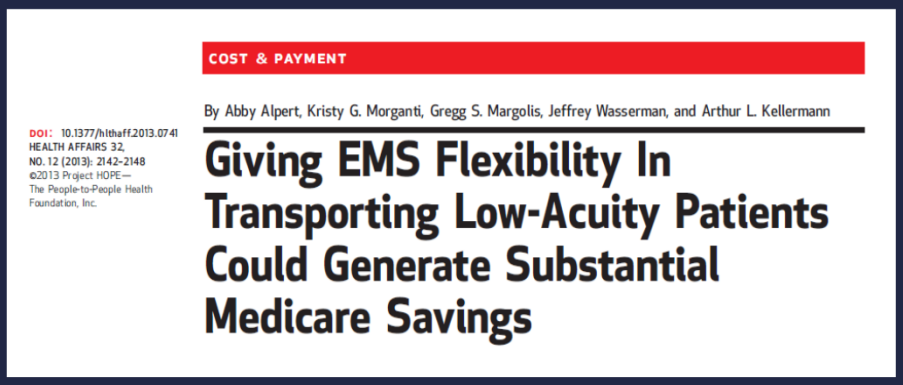
-- Kenneth Davis, MD. CEO

Mount Sinai Health System

Barriers to EMS Innovation:



Health Affairs – December 2013



COST & PAYMENT

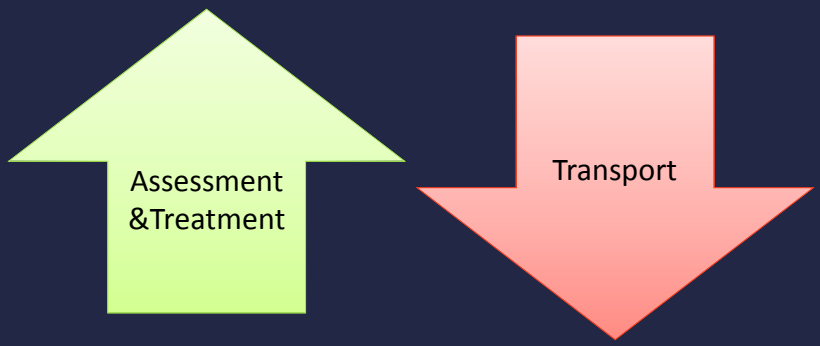
DOI: 10.1377/hlthaff.2013.0741
HEALTH AFFAIRS 32,
NO. 12 (2013): 2142–2148

By Abby Alpert, Kristy G. Morganti, Gregg S. Margolis, Jeffrey Wasserman, and Arthur L. Kellermann

Giving EMS Flexibility In Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings

Funding Reform Options

A Tweak to Fee for Service?



Alternative Funding Options

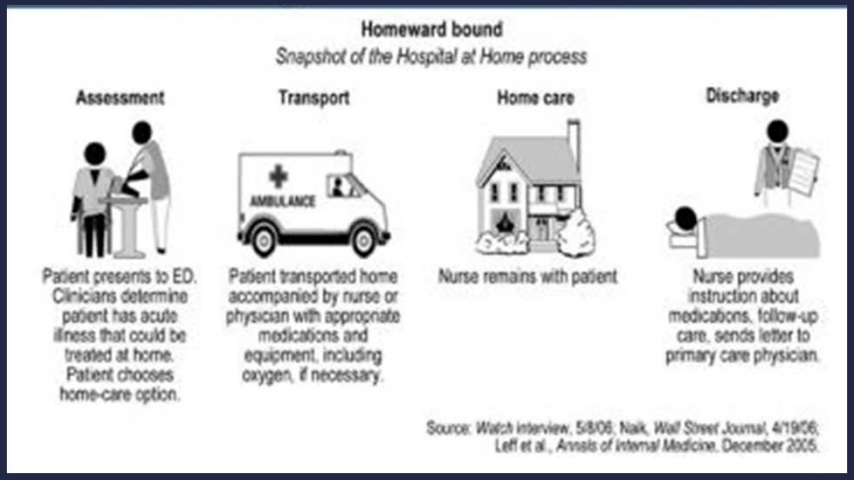
Or a New Paradigm?

- Block Grants or Global Payments
- Capitation (per member per month)
- Shared Savings (Accountable Care Organizations)

Center for Medicare & Medicaid
INNOVATION

Mobile **A**cute **C**are **T**eam & Paramedicine

Hospital At Home

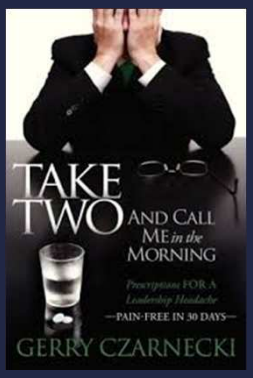


Mount Sinai
"Mobile Acute Care Team"

- Physicians
- NP's
- Social Work
- Pharmacists
- Home Nursing
- Physical Therapists
- Home Health Aides
- Community Health Workers
- Lab Testing
- X-ray / Ultrasound / ECG Technicians
- Medical Equipment Delivery
- Telehealth
- Paramedics

The New Acute Complaint

Choices?



New York Mobile Integrated Healthcare Association
NYMIHA

Mobile Integrated Healthcare Summit

Telemedicine Enhanced EMS

Mobile Integrated Healthcare Summit

Research Measures for Community Paramedicine Component of MACT

Domain	Name	Description	Value 1	Value 2	Source of Data
Utilization	Rate of Hotline Use	How often do MACT patients or staff utilize MACT hotline	# of Calls to Hotline	# of enrolled Patients	EPIC Log / MACT Program Log
				# of enrolled patient-days	EPIC Log / MACT Program Log
	Rate of New Urgent Medical Complaints	How often do patients experience urgent medical complaints while in MACT	# of Calls to Hotline for Urgent Medical Complaint	# of enrolled Patients	EPIC Log / MACT Program Log
				# of enrolled patient-days	MACT Program Log
	Rate of 911 Use	How often was 911 activated by patients or caregivers?	# of 911 Calls	# of enrolled patients	MACT Log / EPIC Log
				# of enrolled patient-days	MACT Log / EPIC Log
	Rate of CP Dispatches	How often do enrolled patients receive an urgent CP visit?	# of MACT CP Dispatches	# of enrolled Patients	EPIC Log / MACT Program Log
				# of enrolled patient-days	EPIC Log / MACT Program Log
	Rate of RN Dispatches	How often do enrolled patients receive an urgent RN visit?	# of urgent RN Dispatches (unscheduled)	# of enrolled Patients	EPIC Log / MACT Program Log
				# of enrolled patient-days	EPIC Log / MACT Program Log
	Rate of Physician Managed Complaints	How often do physicians handle urgent complaints via telephone?	# of calls to hotline for urgent medical complaint that do not result in a dispatch	# of calls to hotline for urgent medical complaint	EPIC Log / MACT Program Log
	Rate of CP dispatches per Urgent Complaint	How often do physicians dispatch a CP visit?	# of MACT CP dispatches	# of calls to hotline for urgent medical complaint	EPIC Log / MACT Program Log
	Rate of RN dispatches for Urgent Complaint	How often do physicians dispatch an RN for an urgent complaint?	# of RN dispatches	# of calls to hotline for urgent medical complaint	EPIC Log / MACT Program Log
	Telemedicine	How often was Telemedicine successfully activated	# of Telemedicine Activations	# of CP dispatches	EPIC notes, CP notes
	Standing Order Medications	How often were standing order Medications administered	# of CP visits where standing order medications were administered	# of CP dispatches	CP notes
	OLMC Medications	How often did the physician order medications as Medical Control Option or as Discretionary Orders	# of CP visits where physician used OLMC authority to order medications	# of CP dispatches	CP notes
	Diagnostics	How often were EMS diagnostics (e.g. Finger Stick, EKG) performed?	# of CP visits where EMS diagnostic was used	# of CP dispatches	CP notes
Operations	Response Time	How soon could CP unit respond?	Time of CP making patient contact	Time of CP request	TransCare Log
	Time on Scene	How long is a CP visit?	Time of CP clearing scene	Time of CP making patient contact	TransCare Log
	Total Task Time	How long was CP unit out of service for traditional EMS?	Time of CP clearing scene	Time of CP request	TransCare Log
Epidemiology	Chief Complaints	What types of urgent medical complaints were experienced by MACT patients.	Chief Complaint		Epic Log / VNS records / CP records
	Time	Time of Day and Day of Week of urgent medical complaints	Time of Day	Day of Week	Epic Log / VNS records / CP records
	Medications	Which Medications were commonly used?	Medication		CP records, EPIC notes
	Diagnostics	Which EMS diagnostics were commonly used?	Diagnostic Test		CP records, EPIC notes
Disposition	Transports	How often were patients transported to the ED?	# of Transports	# of CP dispatches	CP records, EPIC notes
	Non-Transports	How often were patients not-transported?	# of RMA signings	# of CP dispatches	CP records, EPIC notes
	Alternative Interventions	**What Other Care Interventions were Initiated?**	**0 – none 1 – Urgent RN visit 2 – Urgent MD visit 9 – Other**		**Epic Log / VNS records**

Save September 21, 2015 for P.I.E. !!

Promoting

Innovation in

Emergency Medical Services

Register at EMSinnovations.org

Open to the public! 9am-5pm

Presenters, Agenda, coming soon…

"National Steering Committee Meeting"

Sponsored by:

Mount Sinai Health System • U.C. San Diego Health System

National Highway Traffic Safety Administration

U. S. Health & Human Services • U. S. Department of Homeland Security

Location: Washington, D.C.

Questions??

New York Mobile Integrated Healthcare Association NYMIHA

www.nymiha.org

Promoting
Innovation in
Emergency
Medical Services

www.EMSinnovations.org

Email: kevin.munjal@mountsinai.org

Show me the Money!

The Why, Who, and What Payers are Paying for MIH/CP Services

Matt Zavadsky, MS-HSA, EMT
Public Affairs Director
MedStar Mobile Healthcare

What We're Gonna Do…

- Motivating factors for payers
- Examples of who is paying
  - And why
- Key messages for you to potential payers
- Future of payment reform for "EMS"

EMS On The Hill Day
Be There For EMS

Pass the FIELD EMS BILL
#FieldEMSBill

And….

- Learn certain words that have a **whole different meaning in Texas…**

Summer:

- **What it means everywhere else:** A time for vacation, road trips, and fun in the sun.
- **What it means in Texas:** Hell on Earth where the temperatures rarely dip below 100 degrees.

Recurring Questions…

- What has "EMS" done to prove economic value?
- Why would a **hospital** pay us to ***NOT*** bring them patients?
- Why would a **hospice agency** pay us to ***NOT*** transport patients with a hospice-related medical condition?
- Why would a **payer** pay us to ***NOT*** transport patients?
  - And take patients in Obs out of Obs?
- Why would a **home care agency** pay us to help them care for patients in the home setting?

Attention Please!

- $9,255 per capita health expenditures!!
  - Due in large part to **quantity-based** payments

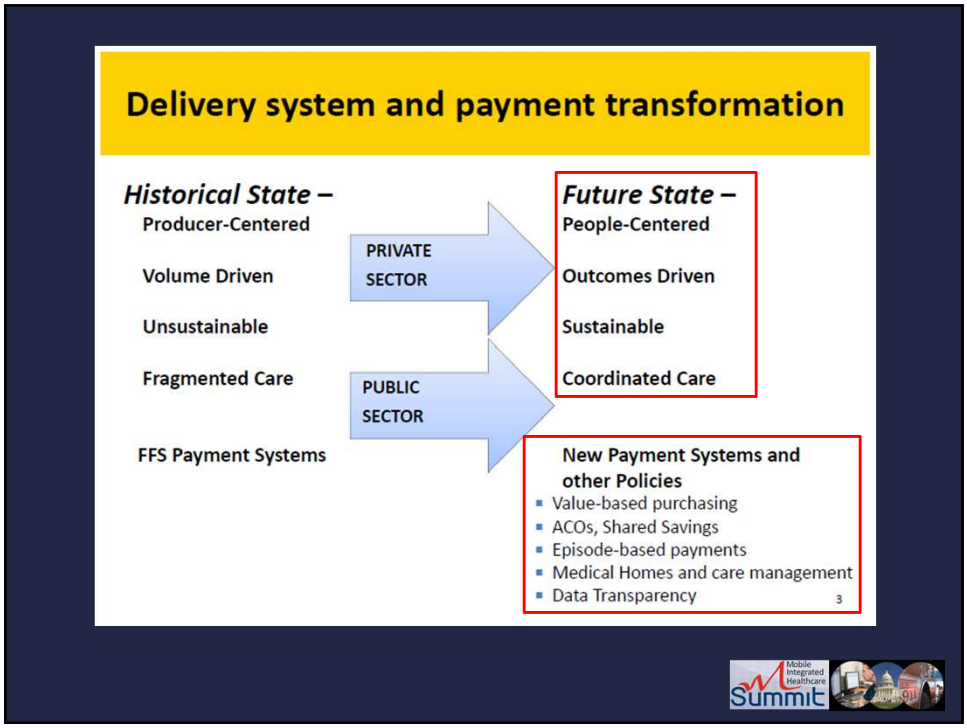
http://kaiserhealthnews.org/news/health-costs-inflation-cms-report/

Healthcare Economics 101

- Shift from FFS to Shared Risk
  - ACOs
  - "Population" based payments
  - Focus on driving down utilization
    - Right patient
    - Right time
    - Right setting
    - Right cost

Healthcare Economics 101

- CMS bonuses & penalties
  - Readmissions (up to 3%)
    - MI, CHF, Pneumonia, COPD, Hips & knees
  - Value-Based Purchasing (up to 1.5%)
    - Clinical process of care (12)
    - Patient experience (8)
    - Healthcare outcomes (5)
    - ***Efficiency (1)***



HHS Pledges To Quicken Pace Toward Quality-Based Medicare Payments
By Jordan Rau **January 26, 2015**

KHN KAISER HEALTH NEWS

The Obama administration Monday announced a goal of accelerating changes to Medicare so that within four years, half of the program's traditional spending will go to doctors, hospitals ***and other providers*** that coordinate their patient care, stressing quality and frugality.

The announcement by Health and Human Services Secretary Sylvia Burwell is intended to spur efforts *to supplant Medicare's traditional fee-for-service medicine, in which doctors, hospitals and* ***other medical providers*** *are paid for each case or service without regard to how the patient fares*. Since the passage of the federal health law in 2010, the administration has been designing new programs and underwriting experiments to come up with alternate payment models.

"*For the first time we're actually going to set clear goals and establish a clear timeline for moving from volume to value in the Medicare system*," Burwell said

http://kaiserhealthnews.org/news/hhs-pledges-to-quicken-pace-toward-quality-based-medicare-payments/

Football:

What it means everywhere else: A popular American team sport.

What it means in Texas: Religion.

What has "EMS" done to prove value?

*"Emergency medical services (EMS) of the future will be **community-based** health management that is **fully integrated** with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and **follow-up**, and contribute to the **treatment of chronic conditions** and **community health monitoring**. This new entity will be developed from **redistribution of existing health care resources** and will be integrated with other health care providers and public health and public safety agencies. It will **improve community health** and result in more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net."*

EMS EMERGENCY MEDICAL SERVICES AGENDA FOR THE FUTURE

Why would a *HOSPITAL* pay us to *NOT* bring them patients?

- Increasing financial pressures
- Shared-Risk arrangements
  - ACO or other
- CMS bonus and penalties
  - Readmits
  - Medicare Spending Per Beneficiary post acute care bonus and penalties
  - Reduced length of stay

Hospitals Are Paying For…

- 9-1-1 Nurse Triage
  - Reduce preventable ED visits
  - Improve HCAHPS scores
- High Utilizer Group (HUG) patients
  - Reduce preventable ED visits
  - Improve HCAHPS scores
  - 1115a Waiver projects
    - Delivery System Reform Incentive Payments (DSRIP)

Hospitals Are Paying For…

- Readmission prevention programs
  - Reduce preventable readmits
  - Reduce penalties
    - Or keep up with reductions
  - Improve HCAHPS scores
    - Transition home
- Transitional response units (medic w/NP)
  - Reduce preventable ED visits
  - Reduce preventable admissions/readmissions

How *Hospitals* Are Paying…

- 9-1-1 Nurse Triage
  - Flat fee for nurse
  - Per call fee
  - Bonus for outcomes
- High Utilizer Group (HUG) patients
  - Patient enrollment fee
  - Per patient contact fee
  - Bonus for outcomes

How *Hospitals* Are Paying…

- Readmission prevention program
  - Patient enrollment fee
  - Bonus for outcomes
    - DSRIP program
- Obs admit avoidance program
  - Avoid 2-midnight issues
    - Double edged sword
  - Reduce spend
    - DSRIP Project

How *Hospitals* Are Paying…

- Transitional response vehicles
  - Paying for NP/PA
  - Bills for services of NP/PA

Why would *a Physician IPA* pay us to ***NOT*** transport patients?

- Reduce spend
  - In a shared risk contract with 3rd party payer
- Improve patient experience
  - NCQA Accreditation standards
- Improve outcomes
  - Fewer hospitalizations
  - Fewer Hospital Acquired Conditions (HAC)

North Texas Specialty Physicians
Our passion is quality. Our motivation is you.
care n care
Medicare Health Plans

Mobile Integrated Healthcare Summit

IPA is Paying For…

- High Utilizer Group (HUG) patients
  - Reduce preventable ED visits
  - Improve HCAHPS scores
- Admission prevention programs
  - Reduce preventable ***admissions***
    - Beyond 30-days
    - Care about the SPEND
  - Improve Physician HCAHPS scores
    - Transition home

Mobile Integrated Healthcare Summit

Austin:

What it means everywhere else: The capital of Texas.

What it means in Texas: A completely different planet.

IPA is Paying For…

- Observational admission avoidance
  - Reduce spend
    - Shared risk contract
  - Avoid 2-midnight issues
    - Double edged sword

How *IPAs* Are Paying…

- High Utilizer Group (HUG) patients
  - Patient enrollment fee
  - Per patient contact fee
  - Bonus for outcomes
- Readmission prevention program
  - Patient enrollment fee
- Obs admit avoidance program
  - Patient enrollment fee

Why would *Hospice* pay us *NOT* transport patients?

- Voluntary disenrollment
  - Patient wishes not met
  - High cost / lost revenue
  - CMS penalty?
- Involuntary revocation
  - Patient wishes not met
  - High cost / lost revenue
  - CMS penalty?

Hospice is Paying For…

- Notification of response
  - Start the hospice nurse enroute to scene
- Back-up episodic intervention
  - While awaiting Hospice nurse
- 9-1-1 redirection
  - Respond/assess/consult
  - Care at home or direct admit to inpatient hospice

VITAS Healthcare

How is *Hospice* Paying

- Per Member/Per Month Fee
  - For any active patient during the month
- Special Note:
  - Train your folks to have "The Conversation"

Why would *HOME HEALTH* pay us to see *their* patients (*and notify them if a patient calls 9-1-1*)?

- Reduce spend
  - After hours RN home visits
  - Avoid sending RN to patient not at home
- Improve outcomes
  - Fewer re-hospitalizations
    - Increased referrals from referring agencies?
- Improve patient satisfaction
  - Referring agency referral source
  - NCQA Accreditation standards

Home Health is Paying For

- Register patients on their service in our CAD
  - Notify them if we respond to the residence
- Provide after hours home visits
  - Intervene to prevent HH visit & ED transport

FOR IMMEDIATE RELEASE

CONTACT: Matt Zavadsky, MedStar
Cell: (817) 991-4487
MZavadsky@medstar911.org

J. Daniel Bruce, Klarus Home Care
Cell: (817) 349-9050
danbruce@klarushomecare.com

Klarus Home Care and MedStar Mobile Healthcare Partner to Prevent unnecessary trips to the ER and Improve Patient Outcomes

Collaboration is designed to help patients of Klarus access timely care and remain in the home

Fort Worth, TX – January 30, 2014

Klarus Home Care and MedStar Mobile Healthcare have entered into a first of its kind in the nation partnership for services to help Klarus meet patient needs for immediate medical care to help assure the patient's medical needs are met in the home environment and circumvent unnecessary trips to the emergency room. The cost of services provided by MedStar is absorbed by Klarus Home Care.

How *Home Health* is Paying…

- Patient contact fee
  - 9-1-1 call with MHP on scene
  - Home visit requested by the agency

Truck:

What it means everywhere else: A machine used for hauling heavy loads.

What it means in Texas: Every other vehicle on the road.

Why would a 3rd Party Payer Pay for us to *NOT* transport a Patient?

- Reduce spend for unnecessary ambulance transports
- Reduce spend for unnecessary ED visits
- Reduce spend for preventable admissions
- Improve patient experience of care
  - HEDIS measures/NCQA

3rd Party Payers are Paying for…

- High utilizer programs
  - UPMC Community Connect
    - Highmark and UPMC Health
  - Minnesota Community Paramedics
    - Medicaid
  - Maine Community Paramedics
    - Medicaid
  - Idaho Community Paramedics
    - Medicaid
- Low-acuity/transitional response vehicles
  - Mesa, AZ

How 3rd Party Payers *are* Paying…

- Patient contact fee (Medicaid)
- Capitated rate?
  - PMPM for population
    - All or members "at risk"

Cigna HealthSpring

Amerigroup RealSolutions in healthcare

Aetna

Customer Messages…

- Hospitals
  - How can we help improve your readmission rate?
  - How can we help improve your HCAHPS scores?
  - How can we help with your MSPB?
    - Especially in pre and post-acute admissions metric
    - As well as length of stay
- Shared-Risk providers
  - How can we help reduce your spend on admissions?
  - How can we help reduce your spend on Obs admits?
  - How can we help improve your HCAHPS scores?

Making the Business Case…

Proposal for Use of MedStar Heart Failure Management Program

Description of Program:
This program is designed to help THRHMFW reduce preventable readmissions for specific DRGs which the hospital is at-risk for penalties under the CMS Hospital Readmissions Prevention Program (HRPP), especially for patients not eligible for traditional home health services. Interventions used by specially trained and credentialed MedStar paramedics include:

- Safe transition to outpatient care coordinated with the THRHMFW case manager and patient's PCP
- Series of home visits to reinforce discharge instructions, education on medication, diet and weight compliance, importance of PCP follow-up care and lifestyle enhancements
- Clinical assessments on every visit including physical assessment, 12L ECG, weight, and IStat Chem 8 POC labs
- 24/7 response of a clinical resource, in the patient's home, as requested or need by the patient
- 9-1-1 co-response by a paramedic knowledgeable in the patient's care plan for care coordination and navigation
- In-home diuresis, breathing treatments, or other interventions as needed and as approved by the patient's PCP
- Care coordination with other resources as needed such as home health, hospice, and social service agencies

The Business Case:
Readmission Penalties - THRHMFW's current penalty under the HRRP is 0.19% and has been trending downward from the 2013 penalty of 0.59%, bucking the national trend. It is possible that one of the factors contributing to this trend is that during the CMS data collection periods, THRHMFW enrolled 23 of our highest risk patients into the pilot CHF readmission prevention program with MedStar, and only 3 of these patients experienced a 30-day readmission (13% vs. expected 100%). For 2013-14 (DY3) JPS DSRIP program with MedStar, the 30-day CHF readmission rate for the 28 enrolled high-risk patients, the readmit rate is 17.4% compared to the expected 100% readmission rate.

The Business Case:
Readmission Penalties - THRHMFW's current penalty under the HRRP is 0.19% and has been trending downward from the 2013 penalty of 0.59%, bucking the national trend. It is possible that one of the factors contributing to this trend is that during the CMS data collection periods, THRHMFW enrolled 23 of our highest risk patients into the pilot CHF readmission prevention program with MedStar, and only 3 of these patients experienced a 30-day readmission (13% vs. expected 100%). For 2013-14 (DY3) JPS DSRIP program with MedStar, the 30-day CHF readmission rate for the 28 enrolled high-risk patients, the readmit rate is 17.4% compared to the expected 100% readmission rate.

Hospital Value Based Purchasing Medicare Spending Per Beneficiary Measure - Enhancing enrollments in this program may also help THRHMFW achieve goals consistent with the HVBP efficiency measure, MSPB. CMS data reveals THRHMFW MSBP is currently 6% above the state average and 14% above the national average. Using MedStar for high risk patients may further reduce payments to higher cost post-acute care, lowering THRHMFW's MSBP calculations.

Hospital Consumer Assessment of Healthcare Providers and Systems – The transition of care to the MedStar program enhances the patient's perception of THRHMFW through the reinforcement by MedStar's personnel that the patient was enrolled in this program by THRHMFW because we want to assure the patient's safe transition after they leave our facility. With the initial contact by MedStar within 24 hours after patient discharge, it is likely the patient's perception of our care will be reflected if the patient is selected to complete an HCAHPS survey.

Do your homework….

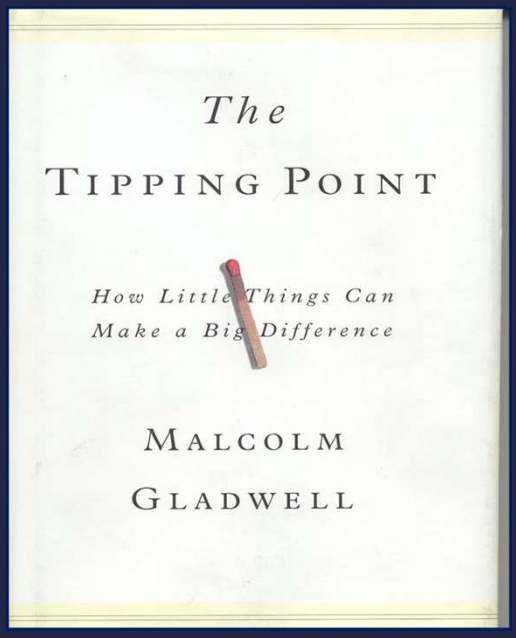
Learn the Acumen!

Economic Model Summary/Benefits

Domain	Model & Data	Advantage
Enrollment vs. Contact Fee Structure	$800 enrollment fee, regardless of activity needed to meet the outcome goals.	Shared-risk arrangement with MedStar vs. FFS model.
Cost Savings for Unfunded Patients	In 2013, THRHMFW lost $798,728 to 30-day readmits for unfunded patients and consequently received no revenue from these readmissions.	83% reduction in readmissions for patients enrolled in the MedStar program; the 4 high-risk patients enrolled by THR in 2013 experienced ***no*** 30-day readmissions.
Patient Experience	Patient satisfaction scores with the MedStar program average 4.92 out of 5 and 100% of the patients surveyed recommend the program to others.	Improved patient perceptions of THRHMFW, potentially enhancing HCAHPS scores.
Investment of referring 50 CHF patients = $40,000	Focus on high-risk, unfunded patients who would not qualify for traditional home health services.	If 83% of these 50 patients, or 41, patients are prevented from readmitting within thirty days even one time each, that is a savings of **$240,793**. Additional economic benefit from DSRIP payments may be realized if targets are met for readmissions and total admissions in DSRIP patients.

Customer Messages…

- Hospice
  - How can we help assure the patient's wishes are met?
  - How can we help reduce your spend for ambulance and ED services?
  - How can we help prevent voluntary disenrollment's and revocations?



Change From the Inside Out - Health Care Leaders Taking the Helm

Donald M. Berwick, MD, MPP1; Derek Feeley, DBA1; Saranya Loehrer, MD, MPH1
1Institute for Healthcare Improvement, Cambridge, Massachusetts
JAMA. **March 26, 2015**.
doi:10.1001/jama.2015.2830

Even as politicians and pundits continue to debate the merits of the Affordable Care Act (ACA), it is time to look beyond it to the next phase of US health care reform.

innovations in delivery mature at a far faster pace than laws and regulations evolve, even in far less contentious political times than today's. ***For example, productive new health care roles, such as community paramedics,*** community health workers, and resilience counselors, ***emerge at a rate that legal requirements and reimbursement policies simply do not match***.

JAMA The Journal of the American Medical Association

Reimbursement issues block paramedics from expanded role

By Erin Mershon

4/24/15

POLITICO

https://www.politicopro.com/go/?id=46680

Paramedics are primed to play a larger role in the health care system, which they're sure will help lower costs and benefit patients.

Yet they're running into regulatory roadblocks that they say state and federal officials have to move.

Despite the track record of initiatives in places like Nevada and Texas, where paramedics are providing in-home care, coordinating patient services and saving millions in the process, Medicare, Medicaid and most private insurance plans still won't reimburse for such work. The program successes to date are only beginning to change that.

"States don't know what to do with us," said Gary Wingrove, a former Minnesota EMS director who's now director of strategic affairs for Mayo Clinic Medical Transport. "These are ambulance guys, but they're not doing an ambulance function."

Many of the programs - often referred to as community paramedicine - take aim at so-called super user patients who consume a disproportionate amount of care. These individuals rely on ambulances and emergency services even in more routine medical situations, often because they don't know who else to call or can't afford appointments that require up-front payment. Some call 911 hundreds of times a year.

"We can do more for our patients than just schlepping them all to the emergency room," said Matt Zavadsky, the director of public affairs at Fort Worth's MedStar Mobile Healthcare, which launched its program in 2009. "It's dramatically saved the health care system tons of money, and it's also changed the patient's experience in ways that we never imagined."

Texas:

What it means everywhere else: A place full of rodeos, boots, horses, and cowboys.

What it means in Texas: Home, and the only place that matters.

Thank you for this privilege!

Panel Discussion:
How To Develop an MIH-CP Program

- **Asbel Montes**, Vice President of Governmental Relations & Reimbursements
  - Acadian Ambulance Services, Lafayette, LA
- **Brian LaCroix**, President
  - Allina Health-Emergency Medical Services, St. Paul, MN
- **Brent Myers**, MD, MPH, FACEP, Medical Director
  - Wake County EMS System, NC
- **Norman Seals**, Assistant Chief, Emergency Medical Service Bureau
  - Dallas Fire-Rescue Department, TX
- **Mike Hall**, President/CEO
  - Nature Coast Emergency Medical Services, FL
- **Shannon Watson**, Community Health Supervisor
  - Christian Hospital EMS

Acadian

Acadian

Allina

Allina

Wake County

Wake County

Dallas Fire & Rescue Department

Dallas Fire & Rescue Department

Mt. Sinai

Mt. Sinai

Nature Coast EMS

Nature Coast EMS

Measuring the Effectiveness of Mobile Integrated Healthcare Programs

Introduction and Overview

Hosts:

- Brenda Staffan, REMSA
- Dan Swayze, UPMC/Emed Health
- Brian LaCroix, Allina Medical Transport
- Gary Wingrove, Mayo/IRCP/NCEMSI
- Brent Myers, Wake EMS
- Matt Zavadsky, MedStar Mobile Healthcare

Why Outcome Measures?

- Healthcare is moving to outcome-based economic models
- "EMS" is healthcare
- MIH-CP moves even further into the healthcare space
- Key to sustainability is proof

Intent of the Strategy

- Develop uniform measurement
  - Replication of successful programs
  - Build evidence base
  - Increased "N" for evaluation
- Origin
  - Meetings with CMS & CMMI
  - Meetings with AHRQ & NCQA
- Build consortium of MIH programs

The Process…

- **Phase 1:** First draft "Uniform MIH Measures Set"
  - June - September '14

Brenda Staffan
Dan Swayze
Matt Zavadsky

The Process…

- **Phase 2:** Introduce to operating programs via webinar
  - October ’14
  - Feedback process starts

Brian LaCroix
Gary Wingrove
Brent Myers

The Process…

- **Phase 3:** F2F national stakeholder/advocacy group meetings
  - November ‘14 (EMS World/AAA Annual Conference)
  - December ‘14 invitations to join process
    - AAA
    - NAEMSP
    - ACEP
    - IAFC
    - IAFF
    - NEMSMA
    - AHRQ
    - IHI
    - NAEMSE
    - NFPA
    - NCQA
    - NRHA
    - IAED
    - IAEMSC
    - NASEMSO
    - Operating MIH/CP Programs

The Process…

- **Phase 3.5**
  - Rank "Top 10" measures (ok, 17)
- **Phase 4:** Federal partner introduction
  - April '15 during EMS On the Hill Day
  - AHRQ, NCQA, & CMS
- **Phase 5**: Promote payment policy change
  - CMS, national payers, etc.

The Tool…

- Structure
- Layout
  - Structure & CP Intervention 1st
- Domains:
  - Quality of Care & Patient Safety
  - Experience of Care
  - Utilization
  - Cost of Care/Expenditures
  - Balancing

The Tool…

- Formulas
- Measure priorities
- Feedback process
  - Structured
  - Responses

The Measures…

Mobile Integrated Healthcare Program

Measurement Strategy Overview

Aim

A clearly articulated goal statement that describes how much improvement by when and links all the specific outcome measures; what are we trying to accomplish?

Develop a uniform set of measures which leads to the optimum sustainability and utilization of patient centered, mobile resources in the out-of hospital environment and achieves the Triple Aim® — improve the quality and experience of care; improve the health of populations; and reduce per capita cost.

Measures Definition:

1. **Core Measures (BOLD)**
   a. Measures that are considered ***essential*** for program integrity, patient safety and outcome demonstration.

2. **CMMI Big Four Measures (RED)**
   a. Measures that have been identified by the CMS Center for Medicare and Medicaid Improvement (CMMI) as the four primary outcome measures for healthcare utilization.

3. **MIH Big Four Measures (PURPLE)**
   a. Measures that are considered ***mandatory*** to be reported in order to classify the program as a bona-fide MIH or Community Paramedic program.

4. **Top 17 Measures (highlighted)**
   a. The 17 measures identified by operating MIH/CP programs as essential, collectable and highest priority to healthcare partners.

Notes:

1. All financial calculations are based on the ***national average Medicare payment*** for the intervention described. Providers are encouraged to also determine the ***regional average Medicare payment*** for the interventions described.
2. Value may also be determined by local stakeholders in different ways such as reduced opportunity cost, enhanced availability of resources. Program sponsors should develop local measures to demonstrate this value as well.

Table of Contents

Structure/Program Design Measures

Describes the development of system infrastructures and the acquisition of physical materials necessary to successfully execute the program

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Executive Sponsorship	**S1:** Program has Executive level commitment and the program manager reports directly to the Executive leadership of the organization.	The community paramedicine program plan clearly identifies organizational executive level commitment for the human, financial, capital and equipment necessary to develop, implement, and manage the community paramedicine program both clinically and administratively.	0. Not Known 1. There is no evidence of organizational executive level commitment 2. There is some evidence of limited commitment for the program. 3. There is evidence of full commitment for the program.	Documents submitted by agency demonstrating this commitment such as approved budgets, organizational chart and job descriptions
Strategic Plan	**S2:** The program has an executive level approved strategic plan.	The strategic plan should be based on the knowledge of improvement science and rapid cycle testing, and include the key components of a driver diagram, specific measurement strategies, implementation milestones and a financial sustainability plan.	0. Not Known. 1. No evidence of a strategic plan. 2. A written strategic plan, but it lacks key components. 3. A written strategic plan that includes all key components.	Institute for Healthcare Improvement

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Public & Stakeholder Engagement	**S9:** Care Coordination Advisory Committee	Community paramedicine program, in concert with a multidisciplinary, multi-agency advisory committee meets regularly and advises the program on strategies for improving care coordination.	0. Not Known 1. There is no care coordination advisory committee. 2. There is an established care coordination advisory committee, but it is missing key stakeholders. 3. There is an established care coordination advisory committee and all key stakeholders are represented.	Adapted from HRSA Community Paramedic Evaluation Tool
Specialized Training & Education	**S10:** Specialized original and continuing education for community paramedic practitioners	A specialized educational program has been used to provide foundational knowledge for community paramedic practitioners based on a nationally recognized or state approved curriculum.	0. Not known 1. There is no specialized education offered. 2. There is specialized education offered, but it lacks key elements of instruction. 3. There is specialized education offered meeting or exceeding a nationally recognized or state approved curriculum.	North Central EMS Institute Community Paramedic Curriculum or equivalent.

Outcome Measures for Community Paramedic Program Component

Describes how the system impacts the values of patients, their health and well-being

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Quality of Care & Patient Safety Metrics	**Q1:** Primary Care Utilization	Increase the number and percent of patients *utilizing* a Primary Care Provider (if none upon enrollment)	Number of enrolled patients with an established PCP relationship upon graduation	Number of enrolled patients without an established PCP relationship upon enrollment	Value 1 Value 1/Value 2	Agency records
	Q2: Medication Inventory	Increase the number and percent of medication inventories conducted with issues identified and communicated to PCP	Number of medication inventories with issues identified and communicated to PCP	Number of medication inventories completed	Value 1 Value 1/Value 2	Agency records
	Q3: Care Plan Developed	Increase the number and percent of patients who have an identified and documented plan of care with outcome goals	Number of patients with a plan of care communicated with the patient's PCP	All enrolled patients	Value 1 Value 1/Value 2	Agency records

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Experience of Care Metrics	**E1:** Patient Satisfaction	Optimize patient satisfaction scores by intervention.	To be determined based on tools developed	To be determined based on tools developed		Recommend an externally administered and nationally adopted tool, such as, HCAPHS; Home Healthcare CAPHS (HHCAPHS)
	E2: Patient Quality of Life	Improve patient self-reported quality of life scores.	To be determined based on tools developed	To be determined based on tools developed		Recommended tools (EuroQol EQ-5D-5L, CDC HRQoL, University of Nevada-Reno)

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Notes
Utilization Metrics	**U1:** Ambulance Transports	Reduce rate of unplanned ambulance transports to an ED by *enrolled patients*	Number of *unplanned* ambulance transports up to 12 months post-graduation	Number of *unplanned* ambulance transports up to 12 months pre-enrollment	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U2: Hospital ED Visits	Reduce rate of ED visits by *enrolled patients* by intervention	ED visits up to 12 months post-graduation ***OR*** Number of ED Visits avoided in CP intervention patient	ED visits up to 12 months pre-enrollment	(Value 1-Value 2)/Value 2 Value 1	Monthly run chart reporting and/or pre-post intervention comparison
	U3: All - cause Hospital Admissions	Reduce rate of all-cause hospital admissions by *enrolled patients* by intervention	Number of hospital admissions up to 12 months post-graduation	Number of hospital admissions up to 12 months pre-enrollment	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Balancing Metrics	**B1:** Practitioner (EMS/MIH) Satisfaction **Desirable Measure**	Optimize practitioner satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B2: Partner Satisfaction **Desirable Measure**	Optimize partner (healthcare, behavior health, public safety, community) satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B3: Primary Care Provider (PCP) Use	Optimize Number of PCP visits resulting from program referrals during enrollment	Number of PCP visits during enrollment		Value 1	Network provider or patient reported

Definitions

Specific Metric Definitions:

Expenditure: The amount ***PAID*** for the referenced service. Expenditures should generally be based on the national and regional amounts paid by Medicare for the covered services provided.

Examples:

Service	Cost to Provide the Service by the Provider	Amount Charged (*billed*) by the Provider	Average Amount Paid by Medicare
Ambulance Transport	$350	$1,500	**$420**
ED Visit	$500	$2,000	**$969**
PCP Office Visit	$85	$199	**$218**

National CMS Expenditure by Service Type:

Service	Average Expenditure	Source
Emergency Ambulance Transport	$419	Medicare Tables from CY 2012 as published
ED Visit	$969	http://www.cdc.gov/nchs/data/hus/hus12.pdf
PCP Office Visit	$218	http://meps.ahrq.gov/data_files/publications/st381/stat381.pdf
Hospital Admission	$10,500	http://www.hcup-us.ahrq.gov/reports/projections/2013-01.pdf

General Definitions

- *Adverse Outcome*: Death, temporary and/or permanent disability requiring intervention
- *All Cause Hospital Admission:* Admission to an acute care hospital for any admission DRG
- *Average Length of Stay:* The average duration, measured in days, of an in-patient admission to an acute care, long term care, or skilled nursing facility
- *Care Plan*: A written plan that addresses the medical and psychosocial needs of an enrolled patient that has been agreed to by the patient and the patient's primary care provider
- *Case Management Services*: Care coordination activities provided by another social service agency, health insurance payer, or other organization.
- *Core Measure*: Required measurement for reporting on MIH-CP services
- *Critical Care Unit Admissions or Deaths*: Admission to critical care unit within 48 hours of CP intervention; unexpected (non-hospice) patient death within 48 hours of CP visit
- *Desirable Metric*: Optional measurement
- *Enrolled Patient*: A patient who is enrolled with the EMS/MIH program through either; 1) a 9-1-1 or 10-digit call; or 2) a formal referral and enrollment process.
- *Evaluation*: determination of merit using standard criteria
- *Financial Sustainability Plan*: a document that describes the expected revenue and/or the economic model used to sustain the program.
- *Guideline*: a statement, policy or procedure to determine course of action
- *Hotspotter/ High Utilizers*: Any patient utilizing EMS or ED services 12 times in a 12 month period, or as defined by local program goals.
- *Measure*: dimension, quantity or capacity compared to a standard
- *Medication Inventory*: The process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
- *Metric*: a standard of measurement
- *Payer Derived: measure that must be generated by a payer from their database of expenditures for a member patient*
- *Pre and Post Enrollment*: The beginning date and ending date of an enrolled patient.

Feedback…

MIH Measurement Strategy Feedback Form

Submitted by: Kevin Munjal (Name) Representing: NY Mobile Integrated Healthcare Association / Mount Sinai (Agency/Association) Date: 12/15/2014

Measure # and Title	Recommendation for Change	Rationale
S1 Executive Sponsorship	Scoring of "There is no evidence .." should be changed to 0 or perhaps be equivalent to "Not Known"	No evidence of organizational executive level commitment could potentially mean there is a lack of interest and support and perhaps even resistance or other barriers to success coming from inside the organization. This is potentially worse than being "Not Known" perhaps because key conversations have not yet occurred.
S2 Strategic Plan	Overlap with S1. Scores 0 and 1 should be combined.	S2 seems dependent on S1. Full commitment of executive leadership is a pre-requisite to having a strategic plan approved. Should these really be separate measures or should a Strategic Plan be the required evidence in measure S1. Depending on how the scores are being used, it may be unfairly weighting the same element. Perhaps the scale for S1 should be able to go up to 5 or 6. Again, scores 0 and 1 are equivalent.
S3 Healthcare Delivery System Gap Analysis	Should be down weighted. Maybe no more than 2 points. Add expiration date.	This is obviously outside the scope of the EMS agency. If they are fortunate that one has been performed, they are not all created equal. When does a GAP analysis expire? 5 years? 10 years?
S4 Community Resource Capacity Assessment	Overlap with S3.	Better phrasing overall. Seems to be more achievable by individual agency. No specific change but would shift emphasis from S3 to S4.
S8 HIT Integration with Local / Regional Healthcare System	Make data exchange bi-directional	It seems that this measure is only assessing the information from the CP encounter being available to administrators (and at level 3) to primary care and others. Either in this measure or in a separate measure, CP / EMS providers should receive meaningful and relevant information from the healthcare system prior to / during their encounter.

Next Steps

- CP Process Measures workgroup
- Outcome Measure workgroups for other MIH interventions
  - 9-1-1 Nurse Triage
  - Ambulance Transport Alternatives
  - Alternative Response Models
    - NP/PA, etc.?

MIH-CP Case Studies: *Programs In Action*

- **Acadian Ambulance, LA**
  - *Chuck Brunel, MD, Chief Medical Officer*
- **Allina Health-Emergency Medical Services**
  - *Brian LaCroix, President, Allina Health-Emergency Medical Services, St. Paul, MN*
- **Christian Hospital EMS, St. Louis, MO**
  - *Shannon Watson, Community Health Supervisor*
- **Dallas Fire-Rescue Department**
  - *Norman Seals, Assistant Chief, Emergency Medical Service Bureau*
- **Nature Coast EMS, FL**
  - *Mike Hall, President/CEO*

Acadian Mobile Healthcare

MOBILE HEALTHCARE by Acadian

Diabetes Management

- Referral triggers
  - Fluctuating BGL
  - Non-compliance with testing
- Enrollment
  - 20 referrals
  - 11 voluntarily participated
  - Program ended abruptly by partner
- Outcomes
  - Patients demonstrated increased understanding of condition
  - Average A1C decrease

MOBILE HEALTHCARE by Acadian

Hospice Coverage

- Referral trigger
  - High risk for revocation of services
  - Delayed response of hospice nursing staff
- Enrollment
  - Varies
- Outcomes
  - No revocation of services for those enrolled as high risk
  - Successfully manage patient symptoms
  - Coordinate transport to inpatient hospice beds

MOBILE HEALTHCARE by Acadian

Mobile Integrated Healthcare Summit

Pediatric Asthma Management

- Referral triggers
  - High ED utilization
- Enrollment
  - 469 referrals
  - 31 currently enrolled
  - 46 graduates
- Outcomes
  - Improved ACT scores
  - Total of 5 ED visits; 2 not asthma related
  - 1 graduate triggered for repeat enrollment

MOBILE HEALTHCARE by Acadian

Mobile Integrated Healthcare Summit

Dallas Fire-Rescue Department

- **What were the reasons for starting?**
  - In response to healthcare reform initiatives
  - An alternative means to work with high frequency patients
  - Increase their level of independence
  - Decrease 911 utilization

Dallas Fire-Rescue Department

- **How did you start?**
  - Education and playing follow the leaders
  - Funded by the City (for now)
  - Focus on high frequency patients
  - Network building

Dallas Fire-Rescue Department

- **Lessons learned?**
  - Empower the team
  - Give your team time to learn
  - Learn case management process
  - Grow the team's network of community partners
  - Medical director involvement is critical

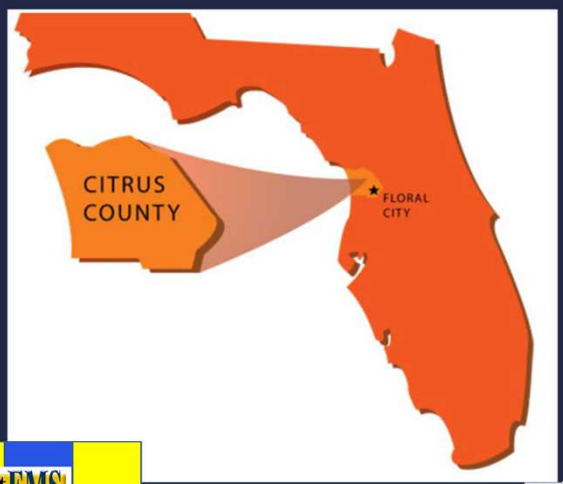
Dallas Fire-Rescue Department

- **What's the future for your program?**
  - Currently in negotiations with hospital partners
  - Have had great reception from the area hospital partners
  - Many areas of possible future expansion

Dallas Fire-Rescue Department

- **One piece of advice….**
  - Get your legal team on board early!
  - Be prepared to educate them
  - This has been our biggest hurdle

Nature Coast EMS



Why MIHP?

- Healthcare Outcomes Focus
- Data Driven
- Healthcare Reform
  - Solution vs the Problem

Startup Plan

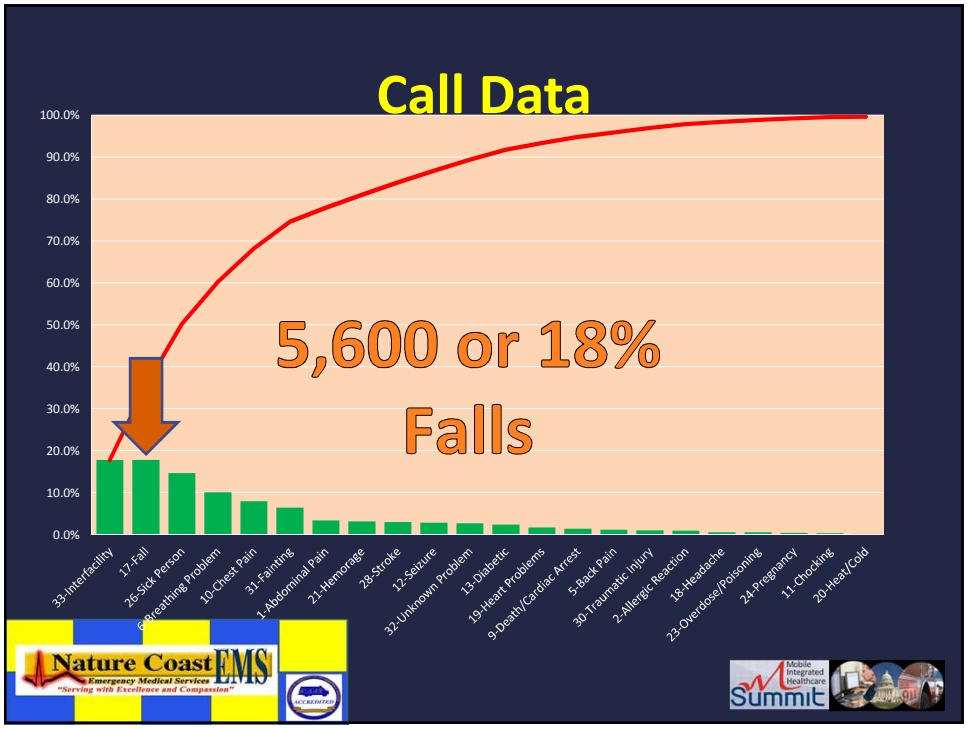
- Learned
  - EMS Agencies
  - International Paramedic Roundtable
  - Hospital Readmission Conferences

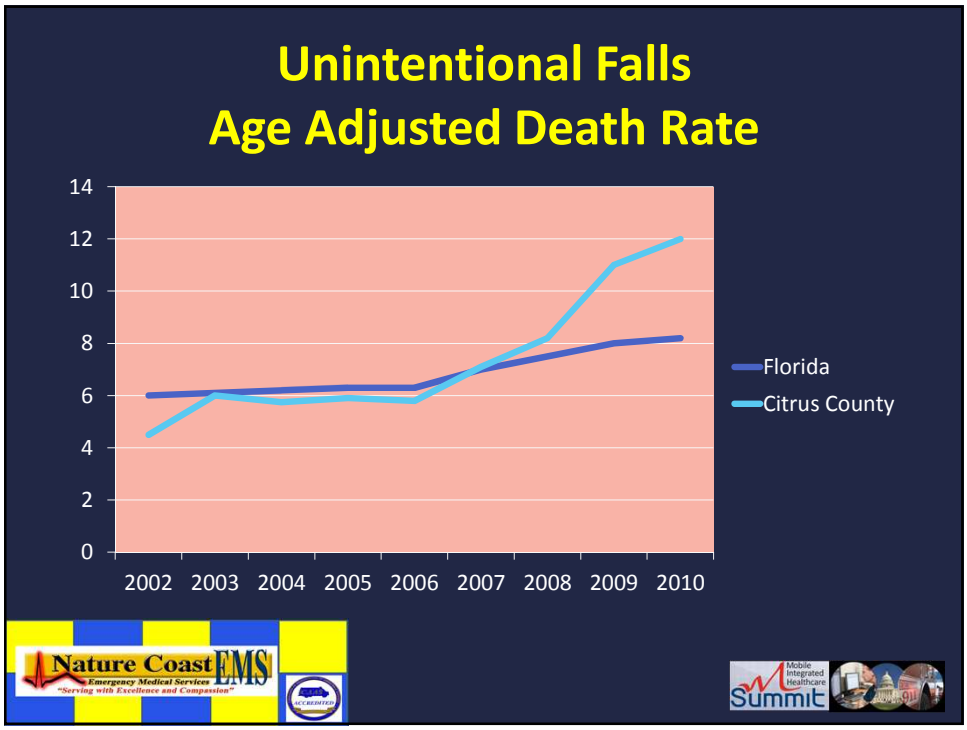
Share the Passion

- Support of Leadership
  - Nature Coast EMS Board of Directors
  - State Regulators
  - State Surgeon General
  - State Legislators
  - Medical Director
  - Florida Hospital Association
  - Hospital CEO's
- Urged Organic Development

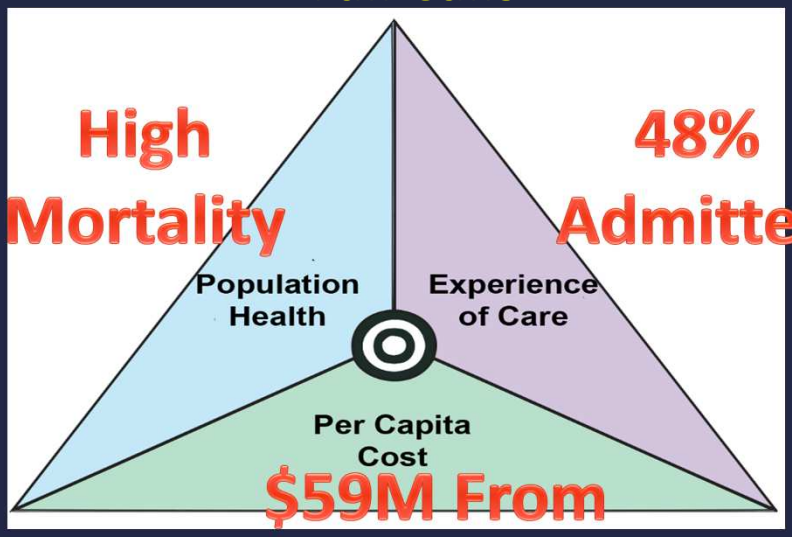
Identifying Needs

- Hosted Community Stakeholder Group
  - Indigent Care
  - Resource Guide
- Call Data


Call Data
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
5,600 or 18%
Falls
33-Interfacility
17-Fall
26-Sick Person
6-Breathing Problem
10-Chest Pain
31-Fainting
1-Abdominal Pain
21-Hemorage
28-Stroke
12-Seizure
32-Unknown Problem
13-Diabetic
19-Heart Problems
9-Death/Cardiac Arrest
5-Back Pain
30-Traumatic Injury
2-Allergic Reaction
18-Headache
23-Overdose/Poisoning
24-Pregnancy
11-Chocking
20-Heat/Cold
Nature Coast EMS
Emergency Medical Services
"Serving with Excellence and Compassion"
Summit


Unintentional Falls
Age Adjusted Death Rate
14
12
10
8
6
4
2
0
2002
2003
2004
2005
2006
2007
2008
2009
2010
Florida
Citrus County
Nature Coast EMS
Emergency Medical Services
"Serving with Excellence and Compassion"
Summit

Fall Calls



$59M From EMS Calls

MIHP Visits

- Fall Safety Inspection
- Medication Reconciliation
- Medical Director Coordination
- Social Services Integration
- Social Needs
- Interaction PCP

A MATTER OF BALANCE

MANAGING CONCERNS ABOUT FALLS

14 Classes
285 Graduates

Nature Coast EMS
Emergency Medical Services
"Serving with Excellence and Compassion"

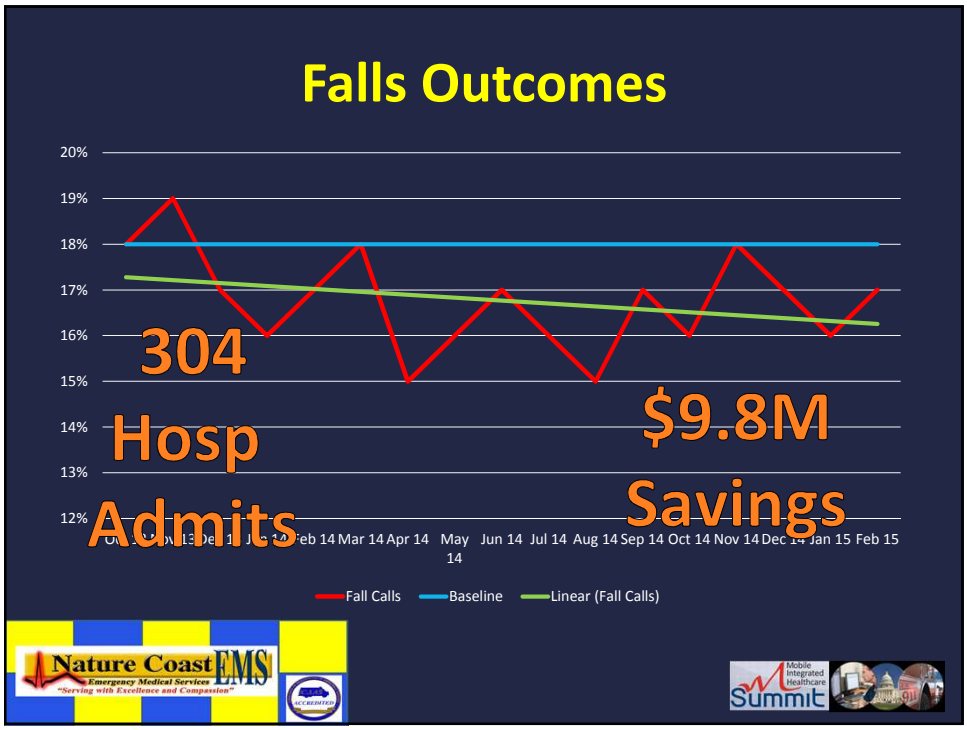
Summit

Tai Chi For Fall Prevention

Nature Coast EMS
Emergency Medical Services
"Serving with Excellence and Compassion"

Summit


September 23rd, 2014 is
Falls Prevention Awareness Day!
Nature Coast EMS
Emergency Medical Services
"Serving with Excellence and Compassion"
Summit


Falls Outcomes
20%
19%
18%
17%
16%
15%
14%
13%
12%
304
Hosp
Admits
$9.8M
Savings
Feb 14 Mar 14 Apr 14 May 14 Jun 14 Jul 14 Aug 14 Sep 14 Oct 14 Nov 14 Jan 15 Feb 15
Fall Calls
Baseline
Linear (Fall Calls)
Nature Coast EMS
Emergency Medical Services
"Serving with Excellence and Compassion"
Summit

Loyalty Customers Pilot

32 Served	24 Successful	$2,740 each

Mobile Integrated Health Care

Current State of our Program

- Goals at 18 months
  - Improve the Health of our Community
    - Met those goals
    - Healthcare Heroes recognition 2 years
  - Sustainability
    - Failed at this goal
- 8% Medicare revenue loss
- Current Status of the Program
  - Hiatus

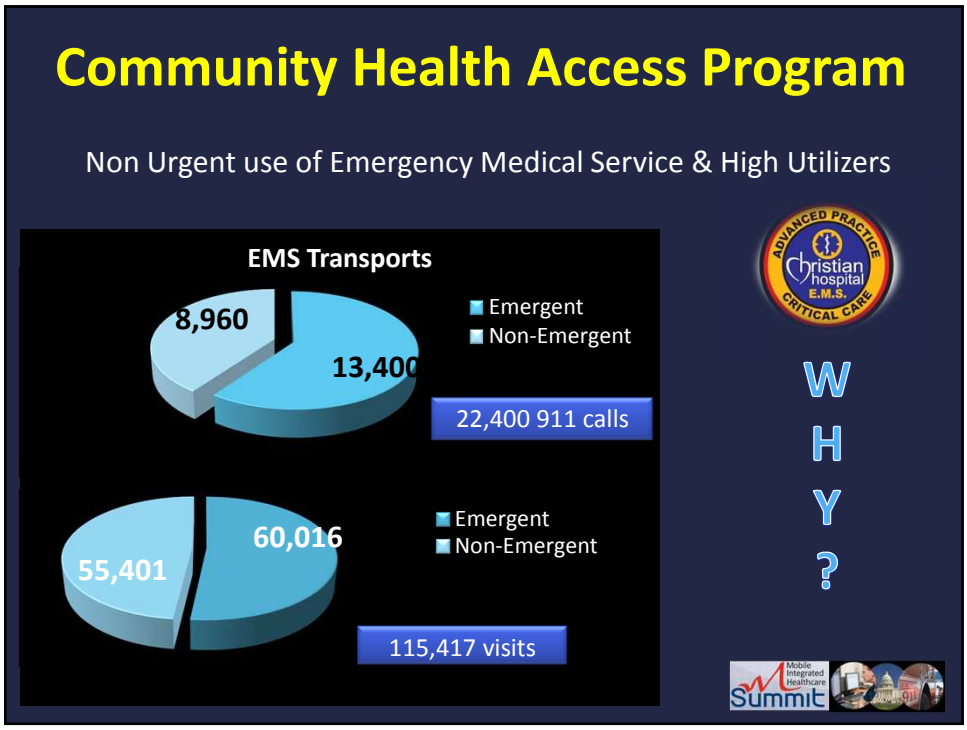
Future

- Passion
- Opportunity
  - Grants
  - Contracts
  - Changes in reimbursement
    - Supplier to Provider status

Lessons

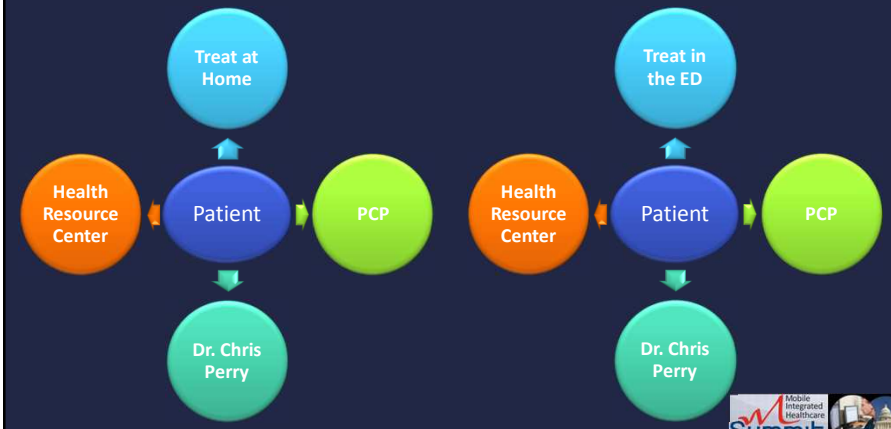
- Right Reason
- Measureable Meaningful Goals
- Learn the Speak
- Patience


THANK YOU
Mike Hall
mikeh@naturecoastems.org
352-249-4710
Nature Coast EMS
Emergency Medical Services
"Serving with Excellence and Compassion"
Summit


Community Health Access Program
Non Urgent use of Emergency Medical Service & High Utilizers
EMS Transports
8,960
13,400
Emergent
Non-Emergent
22,400 911 calls
55,401
60,016
Emergent
Non-Emergent
115,417 visits
Christian hospital E.M.S.
ADVANCED PRACTICE CRITICAL CARE
W
H
Y
?
Summit

Navigations – ED and EMS

- Initial funding provided from our Hospital
  - Cost avoidance



Innovative Partnership

- *Right Resource*
- *Right Time*
- *Right Patient*
- *Right Outcome*
- *Right Cost*

Mobile Integrated Healthcare

Data Snapshot: Six high-frequency EMS callers before and after enrolling in CHAP

	911 USE FOR PREVIOUS YEAR TO DATE	AVERAGE 911 CALLS PER MONTH BEFORE ENROLLED IN CHAP	911 CALLS WHILE ENROLLED IN CHAP	AVERAGE 911 CALLS PER MONTH WHILE ENROLLED IN CHAP	PERCENT DECREASE IN 911 CALLS WHILE ENROLLED IN CHAP
PATIENT A	25 calls in 12 months	2.1	5 calls in 4 months	1.3	38%
PATIENT B	19 calls in 12 months	1.6	3 calls in 4 months	0.8	50%
PATIENT C	7 calls in 6 months	1.2	1 call in 3 months	0.3	75%
PATIENT D	19 call in 12 months	1.6	2 calls in 3 months	0.7	56%
PATIENT E	7 calls in 7 months	1	1 call in 3 months	0.3	70%
PATIENT F	7 calls in 1 month	7	1 call in 1 month	1	86%

CHAPs-Outcomes

- Navigated 5200 people from the Emergency Department and EMS to more appropriate resources
- Connected 170 patients to medical homes
- Decreased high utilizer enrollee's EMS use by 63%
- Developed 75 partnerships throughout the community for collaboration

CHAPs-Economic Sustainability

- Grants from the industry and community we serve
- Successfully procured money through the state budget for a proof of concept pilot program across geography's
- Working with commercial payors

Lessons Learned

- Program works!
  - Plan addresses overcrowding in EDs
  - Decreases utilization of EMS for non medical emergencies
- Involve finance early on
- Understand your audience
- Understand the WHY for ED/EMS overutilization

Allina Health – Emergency Medical Services

What were the reasons for starting?

- Two Primary Reasons

1. We started our program to support our parent organization hospitals address readmissions
2. Career Extender for Staff

Allina Health – Emergency Medical Services

How did you start?

- A limited pilot project focused on specific communities and patient populations
- Focus on
  - All Cause Readmissions
  - Behavioral Health;
  - High ED Utilization Patients

Allina Health – Emergency Medical Services

Lessons learned?

- Internal education of peer groups about MIH-CPs
- Every community has different needs
- It's been difficult to determine what measures we should be following

Allina Health – Emergency Medical Services

What's the future for your program?

- Hospice, Home Health, Assisted Living
- At-Risk Mental Health Patients
- Third Party Payer Negotiations

Allina Health – Emergency Medical Services

One piece of advice….

- Quickly establish contacts with the health care providers in your community to be sure that your plans are in conjunction with their plans

Building Winning Relationships!

MIH Summit

Washington, D.C.

April 28th, 2015

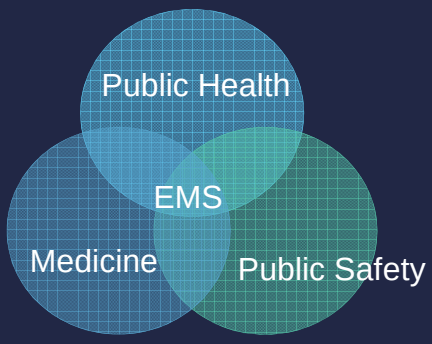
- **Kevin G. Munjal**, Mt. Sinai and NYSMIHA
- **Brian LaCroix**, Allina Health System
- **Brent Myers**, Wake EMS ***(for 3 more days)***

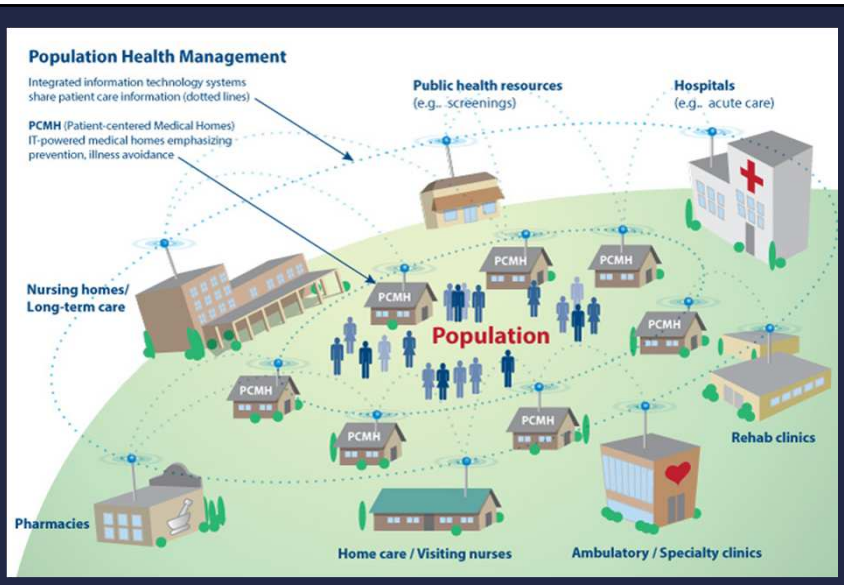
Vision

"EMS of the future will be community-based health management that is fully integrated with the overall health care system." It will:

- Identify illness and injury risks
- Provide follow-up
- Disease management and community health monitoring
- will be integrated with other healthcare providers and public health

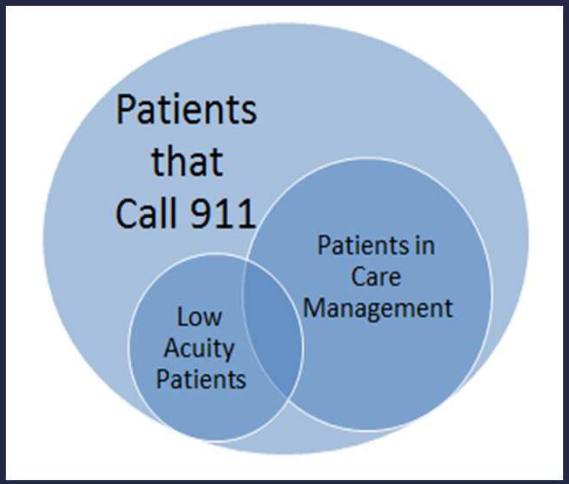
EMS Identity Crisis





Credit: U. Rochester Medical Center http://www.urmc.rochester.edu/news/publications/pulse/oct-nov-2012/story1.cfm

Who are our patients?



Unscheduled Care Needs!!

Mission Statement

To improve the care provided to the people of New York by empowering New York EMS providers to play a larger, more integrated role within our healthcare system.

We do this by fostering collaboration among advocates and practitioners of community paramedicine and mobile integrated healthcare in the State of New York and by advancing new models of out-of-hospital care, including elements to

1) make EMS more adaptive to changes in the healthcare system,
2) align EMS with the continuum of healthcare providers and resource,
3) integrate EMS into the public health infrastructure.

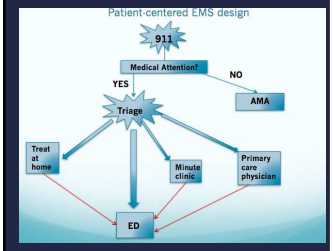
Letters of Support

- NYC REMAC
- Monroe-Livingston County REMAC
- Suffolk County REMAC
- Mountain Lakes REMSCO
- Albany REMO
- NY ACEP
- NSLIJ Center for EMS
- SUNY Downstate – Brooklyn Health Improvement Project
- SUNY Upstate – Dept of EM
- 1199 SEI
- Healthix (Regional Health Information Organization)
- Continuum Medical Group
- Mount Sinai Visiting Doctors
- Beyond Lucid Technologies (ePCR company)
- General Devices (Telemedicine Company)
- United New York Ambulance Network (UNYAN)
- TransCare
- Senior Care
- Empress EMS

What are the Challenges?

Barrier	Committee
Regulations	Legal/Regulatory Committee
Financial Sustainability & Reimbursement Issues	Financial Reform Committee
Stakeholders / Politics	Public Relations Committee
Technological Capabilities / Information Sharing	Health Information Technology Committee
Training / Education / Medical Oversight	Workforce & Education Committee

Three Aspects of Mobile Integrated Healthcare (aka Community Paramedicine)



Patient-Centered Emergency Response

Integration with Health Care Services

Integration with Public Health

A statewide coalition for community paramedicine and innovative emergency medical services

Memorandum: Promoting Innovative Models of EMS within DSRIP

Purpose: To inform PPS leadership about innovative delivery system reforms utilizing Emergency Medical Services (EMS) systems that could support population health in the DSRIP application.

Background:

- While health reform emphasizes coordination of services and avoiding ED visits, EMS remains isolated and paradoxically incentivized to transport any and all patients who call 9-1-1 to the ED.
- Let's transform EMS from an isolated medical transportation service to a mobile healthcare resource fully integrated with the rest of the healthcare system.
- **Mobile Integrated Healthcare** is the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment in a coordinated manner with physicians, hospitals and other providers. It encompasses a myriad of potential expanded roles of EMT's, Paramedics, and EMS systems to provide higher quality, coordinated care and helping to prevent emergencies before they begin.

Opportunities by Project

Domain 2: System Transformation Projects

A. Create Integrated Delivery Systems

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

- Integrate EMS clinically, technologically, and financially into the PPS.
- *Clinical Integration* - Include EMS into clinical quality improvement and assurance activities across the integrated delivery system.
- *Technological Integration* - Make clinical information available to EMS providers and incorporate information from EMS into hospital EHR's.
- *Financial Integration* - Realign financial incentives to support patient-centered emergency response and urgent assessment of patients. Rather than only reimbursing for transportation to the ED (an outcome the PPS seeks to avoid), reimburse for value of healthcare services provided and allow transport to alternative destinations and when appropriate, treat and release options.

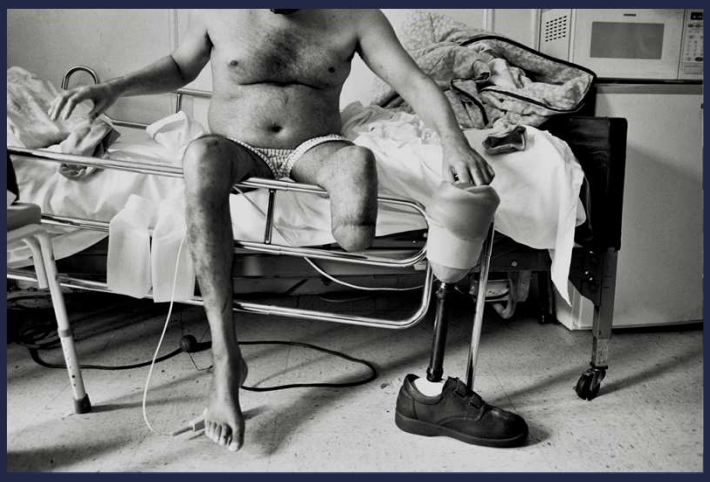
2.a.iii. Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.

- EMS providers and agencies can support Health Home At-Risk Intervention Programs by providing increased access to address urgent care needs.

Mobile Integrated Healthcare Summit

Mount Sinai Visiting Doctors

Photos by Dr. Ana Blohm

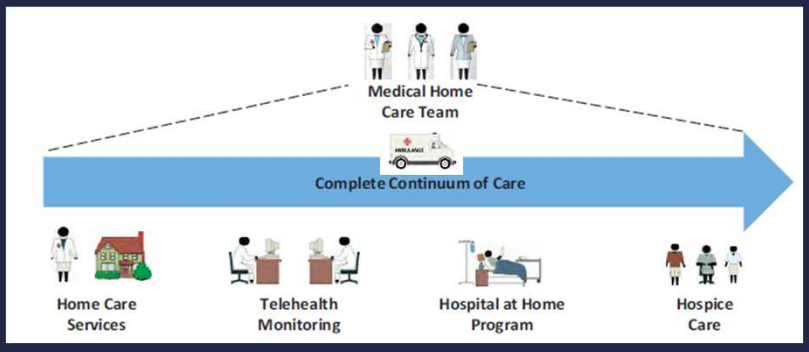


Mobile Integrated Healthcare Summit

On-Scene Decision Support for Primary Care

Urgent Evaluation by EMS Coordinated with the PMD

Part of the Team



USE EXISTING RESOURCES TO MEET THE GOALS OF THE ACCOUNTABLE CARE ORGANIZATION

Brian LaCroix

Brent Myers

Questions??

www.nymiha.org

Promoting Innovation in Emergency Medical Services

www.EMSinnovations.org

Email: kevin.munjal@mountsinai.org

Thank You…

- NAEMT
  - Pam Lane
  - Lisa Lindsay
- EMS World
  - Scott Cravens
  - Nancy Perry
  - Sue Palmer
- YOU – for being interested in ***transformation***