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

Mobile Integrated Healthcare Summit
Hospital jobs growth basically flat

Indexed employment (July 2012 = 100)

Source: BLS data. Analysis by @ddiamond.

Transforming EMS...
REIMBURSEMENT REFORM

Why is this important?
EMS Crossroads

What Now?

Discover.

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

Plan.

<table>
<thead>
<tr>
<th>Accountable Care Organizations</th>
<th>Source: Centers for Medicare &amp; Medicaid Services</th>
</tr>
</thead>
</table>

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
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:

Financial

Legal

Culture

Data

Education
Funding Reform Options

A Tweak to Fee for Service?

Assessment & Treatment

Transport
Alternative Funding Options

Or a New Paradigm?

• Block Grants or Global Payments
• Capitation (per member per month)
• Shared Savings (Accountable Care Organizations)
Mobile Acute Care Team & Paramedicine

Hospital At Home

Homeward bound
Snapshot of the Hospital at Home process

- Assessment
  Patient presents to ED. Clinicians determine patient has acute illness that could be treated at home. Patient chooses home-care option.
- Transport
  Patient transported home accompanied by nurse or physician with appropriate medications and equipment, including oxygen, if necessary.
- Home care
  Nurse remains with patient.
- Discharge
  Nurse provides instruction about medications, follow-up care, sends letter to primary care physician.

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?

Telemedicine Enhanced EMS

- Consulting Physicians
- Primary Physician
- Medical Home Care
- Hospice Care
- Health System Command Center
- EMS Evaluation At Home
## Research Measures for Community Paramedicine Component of MACT

<table>
<thead>
<tr>
<th>Domain</th>
<th>Name</th>
<th>Description</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization</td>
<td>Rate of Hotline Use</td>
<td>How often do MACT patients or staff utilize MACT hotline</td>
<td># of Calls to Hotline</td>
<td># of enrolled patient-days</td>
<td>EPIC Log / MACT Program Log</td>
</tr>
<tr>
<td></td>
<td>Rate of New Urgent Medical Complaints</td>
<td>How often do patients experience urgent medical complaints while in MACT</td>
<td># of Calls to Hotline for Urgent Medical Complaint</td>
<td># of enrolled Patients</td>
<td>EPIC Log / MACT Program Log</td>
</tr>
<tr>
<td></td>
<td>Rate of 911 Use</td>
<td>How often was 911 activated by patients or caregivers</td>
<td># of 911 Calls</td>
<td># of enrolled patients</td>
<td>MACT Log / EPIC Log</td>
</tr>
<tr>
<td></td>
<td>Rate of CP Dispatches</td>
<td>How often did patients receive an urgent CP visit</td>
<td># of MACT CP Dispatches</td>
<td># of enrolled patient-days</td>
<td>EPIC Log / MACT Program Log</td>
</tr>
<tr>
<td></td>
<td>Rate of RN Dispatches</td>
<td>How often did patients receive an urgent RN visit</td>
<td># of urgent RN Dispatches (unscheduled)</td>
<td># of enrolled patient-days</td>
<td>EPIC Log / MACT Program Log</td>
</tr>
<tr>
<td></td>
<td>Rate of Physician Dispatches for Urgent Complaint</td>
<td>How often did physicians handle urgent complaints via telephone?</td>
<td># of calls to hotline for urgent medical complaint</td>
<td># of enrolled patient-days</td>
<td>EPIC Log / MACT Program Log</td>
</tr>
<tr>
<td></td>
<td>Rate of CP dispatches per Urgent Complaint</td>
<td>How often do physicians dispatch a CP visit</td>
<td># of MACT CP dispatches</td>
<td># of calls to hotline for urgent medical complaint</td>
<td>EPIC Log / MACT Program Log</td>
</tr>
<tr>
<td></td>
<td>Rate of RN dispatches for Urgent Complaint</td>
<td>How often do physicians dispatch an RN for an urgent complaint</td>
<td># of RN dispatches</td>
<td># of calls to hotline for urgent medical complaint</td>
<td>EPIC Log / MACT Program Log</td>
</tr>
<tr>
<td></td>
<td>Telemedicine</td>
<td>How often was Telemedicine successfully activated</td>
<td># of Telemedicine Activations</td>
<td># of CP dispatches</td>
<td>EPIC notes, CP notes</td>
</tr>
</tbody>
</table>

## Operations

<table>
<thead>
<tr>
<th>Domain</th>
<th>Name</th>
<th>Description</th>
<th>Value</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing Order Medications</td>
<td>How often were standing order Medications administered</td>
<td># of CP visits where standing order medications were administered</td>
<td># of CP dispatches</td>
<td>CP notes</td>
</tr>
<tr>
<td>OLMC Medications</td>
<td>How often did the physician order medications as Medical Control Option or as Discretionary Orders</td>
<td># of CP visits where physician used OLMC authority to order medications</td>
<td># of CP dispatches</td>
<td>CP notes</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>How often were Medical Control Consultations performed</td>
<td># of CP visits where physician used OLMC authority to order medications</td>
<td># of CP dispatches</td>
<td>CP notes</td>
</tr>
<tr>
<td>Response Time</td>
<td>How soon could CP unit respond?</td>
<td># of CP visits where EMS diagnostic was used</td>
<td># of CP dispatches</td>
<td>CP notes</td>
</tr>
<tr>
<td>Time on Scene</td>
<td>How long is a CP visit?</td>
<td># of CP visits where EMS diagnostic was used</td>
<td>Time of CP making patient contact</td>
<td>TransCare Log</td>
</tr>
<tr>
<td>Total Task Time</td>
<td>How long was CP unit out of service for patient</td>
<td># of CP visits where EMS diagnostic was used</td>
<td>Time of CP clearing scene</td>
<td>TransCare Log</td>
</tr>
</tbody>
</table>

## Epidemiology

<table>
<thead>
<tr>
<th>Domain</th>
<th>Name</th>
<th>Description</th>
<th>Value</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>Time of Day and Day of Week of urgent medical complaints</td>
<td>Time of Day and Day of Week of urgent medical complaints</td>
<td>Time of Day</td>
<td>Epic Log / VNS records / CP records</td>
</tr>
<tr>
<td>Medications</td>
<td>Which Medications were commonly used</td>
<td>How often were patients transported to the ED?</td>
<td># of Transports</td>
<td>CP records, EPIC notes</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Which EMS diagnostics were commonly used</td>
<td>How often were patients transported to the ED?</td>
<td># of Transports</td>
<td>CP records, EPIC notes</td>
</tr>
<tr>
<td>Transports</td>
<td>How often were patients not transported?</td>
<td>How often were patients transported to the ED?</td>
<td># of RMA signings</td>
<td>CP records, EPIC notes</td>
</tr>
<tr>
<td>Non-Transports</td>
<td>What Other Care Interventions were Initiated?</td>
<td>How often were patients not transported?</td>
<td># of RMA signings</td>
<td>CP records, EPIC notes</td>
</tr>
</tbody>
</table>

## Disposition

<table>
<thead>
<tr>
<th>Domain</th>
<th>Name</th>
<th>Description</th>
<th>Value</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Interventions</td>
<td>What Other Care Interventions were Initiated?</td>
<td>How often were patients transported to the ED?</td>
<td>0–none</td>
<td>Epic Log / VNS records</td>
</tr>
<tr>
<td></td>
<td>1– Urgent RN visit</td>
<td>How often were patients transported to the ED?</td>
<td>1– Urgent RN visit</td>
<td>Epic Log / VNS records</td>
</tr>
<tr>
<td></td>
<td>2– Urgent MD visit</td>
<td>How often were patients transported to the ED?</td>
<td>2– Urgent MD visit</td>
<td>Epic Log / VNS records</td>
</tr>
<tr>
<td></td>
<td>9– Other</td>
<td>How often were patients transported to the ED?</td>
<td>9– Other</td>
<td>Epic Log / VNS records</td>
</tr>
</tbody>
</table>
Save September 21, 2015 for P.I.E.!!

Promoting Innovation in Emergency Medical Services

“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??

Promoting Innovation in Emergency Medical Services

www.nymiha.org 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

© 2015 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”
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

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

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.

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.”
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)

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
**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

---

**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
**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”

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 Stat 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 diuretics, 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 HRPP 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 (FY13) IPs DISRP 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 MSPB 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 MSPB 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!

<table>
<thead>
<tr>
<th>Domain</th>
<th>Model &amp; Data</th>
<th>Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment vs. Contact Fee</td>
<td>$300 enrollment fee, regardless of activity needed to meet the outcome goals.</td>
<td>Shared risk arrangement with MedStar vs. FPS model.</td>
</tr>
<tr>
<td>Cost Savings for Unfunded Patients</td>
<td>In 2013, THR/HMPW lost $798,728 to 30-day readmits for unfunded patients and consequently received no revenue from these readmissions.</td>
<td>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.</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient satisfaction scores with the MedStar program average 4.92 out of 5 and 100% of the patients surveyed recommend the program to others.</td>
<td>Improved patient perceptions of THR/HMPW; potentially enhancing HCAHPS scores.</td>
</tr>
</tbody>
</table>

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 those 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 DSRI/P payments may be realized if targets are met for readmissions and total admissions in DSRI/P 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?
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.
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
Dallas Fire & Rescue Department

Dallas Fire & Rescue Department
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. CMIMI Big Four Measures (RED)
   a. Measures that have been identified by the CMS Center for Medicare and Medicaid Improvement (CMIMI) 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

THEME PROGRAM MEASURES
- Executive Sponsorship
- Steering Plan
- Healthcare Delivery System Gap Analysis
- Community Resource Capacity Assessment
- Integration/Program Integrity
- Organizational Readiness Assessment – Medical Oversight
- Organizational Readiness Assessment – Health Information Technology (HIT)
- Integration with Local/Regional Emergency System
- Public & Stakeholder Engagement
- Designated Training and Education

Outcome Measures for Community Paramedic Program Component
- Quality of Care & Patient Safety Metrics
  a. Emergency Care Unit
  b. Community Resource Inventory
  c. CEDA Car Plan Development
  d. Provider Financial Compliance
  e. Inpatient and Outpatient Care MJR: 14-Day Emergency Ambulance Response, Urgent ED Visits
  f. Ambulance Operations
  g. EMT Continuity of Care Referral
  h. Behavioral Health Services Referral
  i. Alternative Care Management Referral

Experience of Care Metrics
- e. Patient Satisfaction
- f. Patient Quality of Life

Utilization Metrics
- a. Ambulance Treatments
- b. Hospital ED Visits
- c. ED Acute Care Hospital Admissions
- d. Unplanned 14-day Hospital Readmissions
- e. Length of Stay
Cost of Care Metrics – Expenditure Savings
- C1: Ambulance Transport Services (ATS)
- C2: Hospital ED Visit Services (HEVIS)
- C3: All cause Hospital admission (ACA)
- C4: Unplanned 30-day Hospital Re-admission Savings (UHRS)
- C5: Unplanned Skilled Nursing (SNF) and Assisted Living Facility (ALF) Savings (UNFS)
- C6: Total Expenditure Savings
- C7: Total Cost of Care

Balancing Metrics
- B1: Provider HHS/HIVSA staff (Desirable Measure)
- B2: Partner Definition Desirable Measure
- B3: Primary Care Provider (PCP) Use
- B4: Specialty Care Provider (SCP) Use
- B5: Behavioral Care Provider (BCP) Use
- B6: Social Service Provider (SSP) Use
- B7: System Capacity – Emergency Department Use
- B8: System Capacity – ED
- B9: System Capacity – SCP
- B10: System Capacity – BCP
- B11: System Capacity – SSP

Definitions

Structure/Program Design Measures
Describes the development of system infrastructures and the acquisition of physical materials necessary to successfully execute the program

<table>
<thead>
<tr>
<th>Name</th>
<th>Description of Goal</th>
<th>Components</th>
<th>Scoring</th>
<th>Evidence-base, Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Sponsorship</td>
<td>S2: Program has executive level commitment and the program manager reports directly to the Executive leadership of the organization.</td>
<td>The community paramedicine program clearly identifies organizational executive level commitment for the human, financial, capital and equipment necessary to develop, implement, and manage the community paramedics program both clinically and administratively.</td>
<td>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.</td>
<td>Documents submitted by agency demonstrating this commitment such as approved budgets, organizational chart and job descriptions.</td>
</tr>
<tr>
<td>Strategic Plan</td>
<td>S2: The program has an executive level approved strategic plan.</td>
<td>The strategic plan should be based on the knowledge of improvement science and rapid cycle testing, and include the key components of a strategic plan for implementation.</td>
<td>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.</td>
<td>Institute for healthcare improvement.</td>
</tr>
<tr>
<td>Domain</td>
<td>Name</td>
<td>Description of Goal</td>
<td>Value 1</td>
<td>Value 2</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>---------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Public &amp; Stakeholder Engagement</td>
<td>SB: Care Coordination Advisory Committee</td>
<td>Community paramedicine program, in concert with a multidisciplinary, multi-agency advisory committee meets regularly and advises the program on strategies for improving care coordination.</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Specialized Training &amp; Education</td>
<td>SB8: Specialized or quilted continuing education for community paramedics practitioners</td>
<td>A specialized educational program has been used to provide foundational knowledge for community paramedic practitioners based on a nationally recognized or state approved curriculum.</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### Outcome Measures for Community Paramedic Program Component

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

<table>
<thead>
<tr>
<th>Domain</th>
<th>Name</th>
<th>Description of Goal</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Formula</th>
<th>Evidence-base, Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care &amp; Patient Safety Metrics</td>
<td>Q1: Primary Care Utilization</td>
<td>Increase the number and percent of patients utilizing a Primary Care Provider (if focus upon enrollment)</td>
<td>Number of enrolled patients with an established PCP relationship upon enrollment</td>
<td>Number of enrolled patients without an established PCP relationship upon enrollment</td>
<td>Value 1 x Value 2</td>
<td>Agency records</td>
</tr>
<tr>
<td></td>
<td>Q2: Medication Inventories</td>
<td>Increase the number and percent of medication inventories conducted with issues identified and communicated to PCP</td>
<td>Number of medication inventories with issues identified and communicated to PCP</td>
<td>Number of medication inventories completed</td>
<td>Value 1 x Value 2</td>
<td>Agency records</td>
</tr>
<tr>
<td></td>
<td>Q3: Early Plan Developed</td>
<td>Increase the number and percent of patients who have an identified and documented plan of care with outcome goals</td>
<td>Number of patients with a plan of care communicated with the patient’s PCP</td>
<td>All enrolled patients</td>
<td>Value 1 x Value 2</td>
<td>Agency records</td>
</tr>
</tbody>
</table>
### Experience of Care Metrics

<table>
<thead>
<tr>
<th>Domain</th>
<th>Name</th>
<th>Description of Goal</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Formula</th>
<th>Evidence-base, Source of Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E1: Patient Satisfaction</strong></td>
<td>Satisfaction</td>
<td>Optimize patient satisfaction scores by intervention.</td>
<td>To be determined based on tools developed</td>
<td>To be determined based on tools developed</td>
<td></td>
<td>Recommended externally administered and nationally adopted tool such as: HCAPS/Frame Healthcare CAPHS (HCAPSH)</td>
</tr>
<tr>
<td><strong>E2: Patient Quality of Life</strong></td>
<td>Quality of Life</td>
<td>Improve patient self-reported quality of life scores.</td>
<td>To be determined based on tools developed</td>
<td>To be determined based on tools developed</td>
<td></td>
<td>Recommended tools (EuroQol 5D-5L, CDC 18PQ, University of Nevada Reno)</td>
</tr>
</tbody>
</table>

### Utilization Metrics

<table>
<thead>
<tr>
<th>Domain</th>
<th>Name</th>
<th>Description of Goal</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Formula</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>U2: Ambulance Transports</strong></td>
<td></td>
<td>Reducerate of unplanned ambulance transports to an ED by enrolled/patients</td>
<td>Number of unplanned ambulance transports up to 12 months post-graduation</td>
<td>Number of unplanned ambulance transports up to 12 months pre-enrollment</td>
<td>(Value 1 - Value 2) / Value 2</td>
<td>Monthly run chart reporting and/or pre-post intervention comparison</td>
</tr>
<tr>
<td><strong>U2: Hospital ED Visits</strong></td>
<td></td>
<td>Reducerate of ED visits by enrolled/patients by intervention</td>
<td>ED visits up to 12 months post-graduation</td>
<td>ED visits up to 12 months pre-enrollment</td>
<td>(Value 1 - Value 2) / Value 2</td>
<td>Monthly run chart reporting and/or pre-post intervention comparison</td>
</tr>
<tr>
<td><strong>U3: All-cause Hospital Admissions</strong></td>
<td></td>
<td>Reducerate of all-cause hospital admissions by enrolled/patients by intervention</td>
<td>Number of hospital admissions up to 12 months post-graduation</td>
<td>Number of hospital admissions up to 12 months pre-enrollment</td>
<td>(Value 1 - Value 2) / Value 2</td>
<td>Monthly run chart reporting and/or pre-post intervention comparison</td>
</tr>
<tr>
<td>Domain</td>
<td>Name</td>
<td>Description of Goal</td>
<td>Value 1</td>
<td>Value 2</td>
<td>Formula</td>
<td>Evidence-base, Source of Data</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>---------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Balancing Matrix</td>
<td>B2h-Practitioner (HHS/MH) Satisfaction <strong>Desirable Measure</strong></td>
<td>Optimize practitioner satisfaction scores</td>
<td>To be determined based on tools developed</td>
<td></td>
<td></td>
<td>Recommend externally administered</td>
</tr>
<tr>
<td></td>
<td>B2i-Partner Satisfaction <strong>Desirable Measure</strong></td>
<td>Optimize partner (healthcare, behavioral health, public safety, community) satisfaction scores</td>
<td>To be determined based on tools developed</td>
<td></td>
<td></td>
<td>Recommend externally administered</td>
</tr>
<tr>
<td></td>
<td>B8h-Primary Care Provider (PCP) Use</td>
<td>Optimize Number of PCP visits resulting from program referrals during enrollment</td>
<td>Number of PCP visits during enrollment</td>
<td>Value 1</td>
<td></td>
<td>Network provider or patient reported</td>
</tr>
</tbody>
</table>

### 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:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost to Provide the Service by the Provider</th>
<th>Amount Charged (billed) by the Provider</th>
<th>Average Amount Paid by Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Transport</td>
<td>$350</td>
<td>$1,300</td>
<td>$420</td>
</tr>
<tr>
<td>ED Visit</td>
<td>$968</td>
<td>$2,200</td>
<td>$960</td>
</tr>
<tr>
<td>PCP Office Visit</td>
<td>$85</td>
<td>$199</td>
<td>$218</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National CMS Expenditure by Service Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Emergency Ambulance Transport</td>
</tr>
<tr>
<td>ED Visit</td>
</tr>
<tr>
<td>PCP Office Visit</td>
</tr>
<tr>
<td>Hospital Admission</td>
</tr>
</tbody>
</table>
General Definitions
- Adverse Outcome: Death, temporary and/or permanent disability requiring intervention
- All Censor Hospital Admissions: Admission to an acute care hospital for any admission DRGs
- 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 MSH-OP and MH-OP
- Critical Care Unit Admissions or Deaths: Admissions to critical care unit within 48 hours of OP intervention; unexpected (non-hospital) patient death within 48 hours of OP visit
- Desirable Metric: Optional measurement
- Enrolled Patient: A patient who is enrolled with the MHS/MHI program through either: (1) 9-1-1 or 10-digit dial; 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
- Inpatient/High Utilization: Any patient utilizing EMS or ED services 15 times in a 12 month period, or as defined by local program goals.
- Measure: dissemination, 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 names, 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 (FTE): measure that must be generated by a payer from their database of expenditures for a member patient
- Site and Post Enrollment: The beginning date and ending date of an enrolled patient.

Feedback...

<table>
<thead>
<tr>
<th>Measure # and Title</th>
<th>Recommendation for Change</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>51. Knowledge-Sponsored</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52. Knowledge-Sponsored</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53. Healthcare Delivery System Risk Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54. Community Resource Capacity Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55. MH Integration with Local / Regional Healthcare System</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

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
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

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
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
Fall Calls

High Mortality 48% Admitted

Population Health Experience of Care
Per Capita Cost

$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

Check for Safety
A Home Fall Prevention Checklist for Older Adults

Tai Chi For Fall Prevention
September 23rd, 2014 is Falls Prevention Awareness Day!

Falls Outcomes

304 Hosp Admits

$9.8M Savings
Loyalty Customers Pilot

<table>
<thead>
<tr>
<th>32</th>
<th>24</th>
<th>$2,740</th>
</tr>
</thead>
<tbody>
<tr>
<td>Served</td>
<td>Successful</td>
<td>each</td>
</tr>
</tbody>
</table>

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
Community Health Access Program

Non Urgent use of Emergency Medical Service & High Utilizers

EMS Transports

- Emergent: 8,960
- Non-Emergent: 13,400

22,400 911 calls

115,417 visits

Emergent
Non-Emergent

Mike Hall
mikeh@naturecoastems.org
352-249-4710
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

<table>
<thead>
<tr>
<th>Patient</th>
<th>911 Use for Previous Year to Date</th>
<th>Average 911 Calls Per Month Before Enrolled in CHAP</th>
<th>911 Calls While Enrolled in CHAP</th>
<th>Average 911 Calls Per Month While Enrolled in CHAP</th>
<th>Percent Decrease in 911 Calls While Enrolled in CHAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>25 calls in 12 months</td>
<td>2.1</td>
<td>5 calls in 4 months</td>
<td>1.3</td>
<td>38%</td>
</tr>
<tr>
<td>B</td>
<td>19 calls in 12 months</td>
<td>1.6</td>
<td>3 calls in 4 months</td>
<td>0.8</td>
<td>50%</td>
</tr>
<tr>
<td>C</td>
<td>7 calls in 6 months</td>
<td>1.2</td>
<td>1 call in 3 months</td>
<td>0.3</td>
<td>75%</td>
</tr>
<tr>
<td>D</td>
<td>19 call in 12 months</td>
<td>1.6</td>
<td>2 calls in 3 months</td>
<td>0.7</td>
<td>56%</td>
</tr>
<tr>
<td>E</td>
<td>7 calls in 7 months</td>
<td>1</td>
<td>1 call in 3 months</td>
<td>0.3</td>
<td>70%</td>
</tr>
<tr>
<td>F</td>
<td>7 calls in 1 month</td>
<td>7</td>
<td>1 call in 1 month</td>
<td>1</td>
<td>86%</td>
</tr>
</tbody>
</table>

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
Who are our patients?

- Patients that Call 911
- Low Acuity Patients
- Patients in Care Management

Credit: U. Rochester Medical Center
Unscheduled Care Needs!!

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?

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulations</td>
<td>Legal/Regulatory Committee</td>
</tr>
<tr>
<td>Financial Sustainability &amp;</td>
<td>Financial Reform Committee</td>
</tr>
<tr>
<td>Reimbursement Issues</td>
<td></td>
</tr>
<tr>
<td>Stakeholders / Politics</td>
<td>Public Relations Committee</td>
</tr>
<tr>
<td>Technological Capabilities /</td>
<td>Health Information Technology Committee</td>
</tr>
<tr>
<td>Information Sharing</td>
<td></td>
</tr>
<tr>
<td>Training / Education /</td>
<td>Workforce &amp; Education Committee</td>
</tr>
<tr>
<td>Medical Oversight</td>
<td></td>
</tr>
</tbody>
</table>

Three Aspects of Mobile Integrated Healthcare (aka Community Paramedicine)

- Patient-Centered Emergency Response
- Integration with Health Care Services
- Integration with Public Health
Mount Sinai Visiting Doctors  Photos by Dr. Ana Blohm
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
Questions??

www.nymiha.org

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