PATIENT SAFETY: JOIN THE SAFE TEAM
“EMS” in the New Healthcare Environment

Norman Seals
Assistant Chief, EMS
Dallas Fire Department

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

- Why all the MIH/Community Paramedicine Hub-Bub?
- What the heck are y’all doin’?
- Is it making a difference?
About Dallas Fire

- 1800 Uniformed members
- 850 paramedics
- 43 Rescues (ambulances)
- 55 ALS Engines
- 190,000+ EMS responses annually
- Exclusive 911 provider to the City of Dallas
- 380 square miles coverage area
- Medical Direction from UTSW/Biotel
About MedStar...

- Governmental agency (PUM) serving Ft. Worth and 14 Cities
  - Self-Operated
  - 880,000 residents, 421 Sq. miles
  - Exclusive provider - emergency and non emergency
- 120,000 responses annually
- 405 employees
- $36 million budget
  - No tax subsidy
- Fully deployed system status management
- Medical Control from 14 member Emergency Physician’s Advisory Board (EPAB)
  - Physician Medical Directors from all emergency departments in service area + 5 Tarrant County Medical Society reps
Attention Please!

- $8,600 per capita health expenditures!!
- Due in large part to **quantity-based** payments
Massachusetts Wastes Third of Health Spending, Report Says
Commission Estimates $14.7 Billion to $26.9 Billion in Wasteful Spending By Jon Kamp
Jan. 8, 2014

More than a third of health-care spending may be wasteful in Massachusetts, where costs are among the highest in the nation, a state report released on Wednesday said.

Main drivers of excess spending included patients returning to hospitals for preventable reasons and emergency-room visits that better primary care could have warded off, the state's Health Policy Commission concluded, citing 2012 data.

The commission estimated between $14.7 billion and $26.9 billion in wasteful spending that year, representing between 21% and 39% of total health expenditures.
Our New Environment:

- ACA tipped the 1st domino
  - ACOs (460 as of Dec. ‘13)
    - 220 Medicare Shared Savings
    - 240 Commercial Insurer-based
  - Payment based on **OUTCOMES**
  - Bundled payments based on episode of care
  - Push to Managed Medicare/Medicaid
  - MSPB calculations = **2015**
    - Medicare Spending Per Beneficiary
      - Hospital accountable for some outpatient post acute costs
New Reimbursement Models to Eclipse Fee-for-Service by 2020  
June 11, 2014

SEATTLE--(BUSINESS WIRE)--AHIP Institute 2014—Healthcare is moving rapidly to incorporate measures of value into payment models, with more than two-thirds of payments expected to be based on value measurement in five years, up from just one-third today.

“This study found that 90% of payers and 81% of hospitals are already deploying some mix of value-based reimbursement combined with fee-for-service, and that’s adding complexity to a system that’s already overburdened,” said Emad Rizk, M.D., President of McKesson Health Solutions.

Payers and hospitals are aligned on embracing payment with value measures. Ninety percent of payers and 81% of hospitals now offer a mix of fee-for-service (FFS) and other reimbursement models. Those payers expect fee-for-service (FFS) to decrease from 56% today to 32% in five years. Hospitals using mixed models agree, projecting FFS will decline from 57% today to 34% in five years.

Essentially, payers and hospitals anticipate two-thirds of payment will be based on complex reimbursement models with value measures by 2020.

“Healthcare is at a tipping point,” says Dana Benini, Vice President at ORC International. “If we look at where institutions fall on the continuum towards value-based reimbursement and how that’s evolving, we see that the pace of change is a lot faster than many believe. This is particularly apparent in the growth of accountable care. The number of ACOs has tripled in just two years.

There are winners and losers emerging from this transition, and healthcare stakeholders are faced with adapting quickly to make sure they fall on the right side of that equation.”

Our New Environment:

- There are 4.6 million Medicare beneficiaries with CHF
  - 14% of beneficiaries have HF
  - 43% of Medicare spending on HF
  - One CHF admission cost CMS $17,500
  - 30-day readmission rate for CHF = 24.7%
  - 52% of CHF patients readmitted within 30 days did not see their doc between discharge and readmit (NEJM)

- MedPAC = $12 billion CMS expenditures for Potentially Preventable Readmissions
### Table 2. Ten conditions with the most all-cause, 30-day readmissions for Medicare patients (aged 65 years and older), listed by total number of readmissions in descending order, 2011

<table>
<thead>
<tr>
<th>Principal diagnosis for index hospital stay*</th>
<th>Number of readmissions</th>
<th>Readmissions as a percentage of total Medicare readmissions</th>
<th>Total cost of all-cause, 30-day readmissions (in millions), $</th>
<th>Readmission total cost as a percentage of total costs of Medicare readmissions</th>
<th>Readmission rate (per 100 admissions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure; nonhypertensive</td>
<td>134,500</td>
<td>7.3</td>
<td>1,747</td>
<td>7.3</td>
<td>24.5</td>
</tr>
<tr>
<td>Septicemia (except in labor)</td>
<td>92,900</td>
<td>5.1</td>
<td>1,410</td>
<td>5.9</td>
<td>21.3</td>
</tr>
<tr>
<td>Pneumonia (except that caused by tuberculosis or sexually transmitted disease)</td>
<td>88,800</td>
<td>4.8</td>
<td>1,148</td>
<td>4.8</td>
<td>17.9</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease and bronchiectasis</td>
<td>77,900</td>
<td>4.2</td>
<td>924</td>
<td>3.8</td>
<td>21.5</td>
</tr>
<tr>
<td>Cardiac dysrhythmias</td>
<td>69,400</td>
<td>3.8</td>
<td>835</td>
<td>3.5</td>
<td>16.2</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>56,900</td>
<td>3.1</td>
<td>621</td>
<td>2.6</td>
<td>18.1</td>
</tr>
<tr>
<td>Acute and unspecified renal failure</td>
<td>53,500</td>
<td>2.9</td>
<td>683</td>
<td>2.8</td>
<td>21.8</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>51,300</td>
<td>2.8</td>
<td>603</td>
<td>2.9</td>
<td>19.8</td>
</tr>
<tr>
<td>Complication of device; implant or graft</td>
<td>47,200</td>
<td>2.6</td>
<td>742</td>
<td>3.1</td>
<td>19.0</td>
</tr>
<tr>
<td>Acute cerebrovascular disease</td>
<td>45,800</td>
<td>2.5</td>
<td>568</td>
<td>2.4</td>
<td>14.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>718,100</strong></td>
<td><strong>39.1</strong></td>
<td><strong>9,371</strong></td>
<td><strong>39.0</strong></td>
<td><strong>19.6</strong></td>
</tr>
</tbody>
</table>

*Clinical Classifications Software (CCS) label

Note: Shaded conditions are currently targeted by the CMS Hospital Readmissions Reduction Program.

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011
# 2013-2014 Penalties:

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>City</th>
<th>VBP 2013</th>
<th>VBP 2014</th>
<th>Readmit 2013</th>
<th>Readmit 2014</th>
<th>Total 2013</th>
<th>Total 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Center Of Arlington</td>
<td>Arlington</td>
<td>0.18%</td>
<td>0.22%</td>
<td>-0.61%</td>
<td>-0.29%</td>
<td>-0.43%</td>
<td>-0.07%</td>
</tr>
<tr>
<td>THR H-E-B</td>
<td>Bedford</td>
<td>0.22%</td>
<td>-0.15%</td>
<td>0.00%</td>
<td>-0.16%</td>
<td>0.22%</td>
<td>-0.31%</td>
</tr>
<tr>
<td>Dallas Medical Center</td>
<td>Dallas</td>
<td>-0.49%</td>
<td>-0.24%</td>
<td>-0.36%</td>
<td>-0.12%</td>
<td>-0.85%</td>
<td>-0.36%</td>
</tr>
<tr>
<td>THR - Dallas</td>
<td>Dallas</td>
<td>-0.22%</td>
<td>0.01%</td>
<td>-0.48%</td>
<td>-0.37%</td>
<td>-0.70%</td>
<td>-0.36%</td>
</tr>
<tr>
<td>THR - Denton</td>
<td>Denton</td>
<td>-0.14%</td>
<td>-0.24%</td>
<td>-0.72%</td>
<td>-0.39%</td>
<td>-0.86%</td>
<td>-0.63%</td>
</tr>
<tr>
<td>THR - Fort Worth</td>
<td>Fort Worth</td>
<td>-0.04%</td>
<td>-0.09%</td>
<td>-0.59%</td>
<td>-0.32%</td>
<td>-0.63%</td>
<td>-0.41%</td>
</tr>
<tr>
<td>Baylor - Irving</td>
<td>Irving</td>
<td>0.16%</td>
<td>-0.35%</td>
<td>-0.30%</td>
<td>-0.27%</td>
<td>-0.14%</td>
<td>-0.62%</td>
</tr>
<tr>
<td>Med Cntr - Lewisville</td>
<td>Lewisville</td>
<td>0.09%</td>
<td>0.29%</td>
<td>-0.45%</td>
<td>-0.68%</td>
<td>-0.36%</td>
<td>-0.39%</td>
</tr>
<tr>
<td>Dallas Regional</td>
<td>Mesquite</td>
<td>0.18%</td>
<td>-0.36%</td>
<td>-1.00%</td>
<td>-0.57%</td>
<td>-0.82%</td>
<td>-0.93%</td>
</tr>
<tr>
<td>Medical Center Of Plano</td>
<td>Plano</td>
<td>-0.20%</td>
<td>-0.01%</td>
<td>-0.22%</td>
<td>-0.29%</td>
<td>-0.42%</td>
<td>-0.30%</td>
</tr>
</tbody>
</table>
The all-cause 30-day hospital readmission rate among Medicare fee-for-service beneficiaries plummeted further to approximately 17.5 percent in 2013, translating into an estimated 150,000 fewer hospital readmissions between January 2012 and December 2013.

This represents an 8 percent reduction in the Medicare fee-for service all-cause 30-day readmissions rate.

![Figure 1: Medicare FFS All-Cause, 30-day Readmission Rate](http://innovation.cms.gov/Files/reports/patient-safety-results.pdf)
The gap between physician shortage vs. demand grows...

There’s a growing shortage of physicians that’s only expected to get worse after full implementation of the Affordable Care Act. The Association of American Medical Colleges anticipates that the shortage in all specialties will grow from 7,400 in 2008 to 130,600 by 2025 (65,800 in primary care alone).

- **950,000** (Number of physicians)

- **Physician supply**
- **Physician demand**
- **Physician shortage**

- **2010**: 723,400 (Physician supply) vs. 709,700 (Physician demand) vs. 13,700 (Physician shortage)
- **2015**: 798,500 (Physician supply) vs. 735,600 (Physician demand) vs. 62,900 (Physician shortage)
- **2020**: 851,300 (Physician supply) vs. 759,800 (Physician demand) vs. 91,500 (Physician shortage)
- **2025**: 916,000 (Physician supply) vs. 130,600 (Physician demand) vs. 785,400 (Physician shortage)

Source: Amer Med Coll, 2010
WASHINGTON — Health and policy experts are pushing for a system that pays doctors a lump sum for medical care or allows them to share in savings, saying it will save millions of dollars over current fee-for-service payments that can lead to fraud and over-use of medications.

In the new system, doctors would not be entitled to extra pay should they prescribe costlier medication.

"CBO projects that applying bundled payment models like Bay State's nationally could save Medicare about $46.6 billion over the next seven years," Warren said.

Peter Ubel, professor of business administration and medicine at Duke University's Sanford School of Business, said a third method may also work well: He suggested changing the payment structure so that a doctor receives the same payment no matter what he prescribes, rather than receiving a percentage.

Emergency Medical Services?
“EMS?”

- 9-1-1 safety net access for non-emergent healthcare
  - 35.6% of 9-1-1 requests
    - 12 months Priority 3 calls (44,567 (P3) / 124,925 (Total))

- Reasons people use emergency services
  - To see if they needed to
  - It’s what we’ve taught them to do
  - Because their doctors tell them to
  - It’s the only option

- 37 million house calls/year
  - 30% of these patients don’t go with us to the hospital

2012 NASEMSO Report
Of course this is an emergency! The hospital serves brisket on Tuesdays.
Emergency Medical Services
Unscheduled Medical Services!
Conundrum...

- **Misaligned Incentives**
  - Only paid to transport
  - “EMS” is a *transportation* benefit
  - NOT a *medical benefit*
  - 1\textsuperscript{st} Response tax-based only
“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.”
Community Health Program

- EMS Loyalty Program” or “HUG” Patients
  - Proactive home visits
  - Educated on health care and alternate resources
  - Enrolled in available programs = PCMH
  - 10-digit access number 24/7
  - Flagged in computer-aided dispatch system
  - Co-response on 9-1-1 calls
    - Ambulance and MHP

- Non-Compliant enrollees moved to “system abuser” status
  - No home visits
  - Patient destination determined by Medical Director
Community Health Program

- Total **CHP Enrollment = 390**
- 94 graduated patients with 12 month data pre and post enrollment as of June 30, 2014...
  - *During enrollment*
    - 29.4% reduction in 9-1-1 to ED use
  - *Post Graduation (30 – 90 days)*
    - 82.4% reduction in 9-1-1 to ED use
# Expenditure Savings Analysis (1)

**High Utilizer Program - All Referral Sources**

*Based on Medicare Rates*

<table>
<thead>
<tr>
<th>Analysis Dates: January 1, 2010 - June 30, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients (2): 94</td>
</tr>
</tbody>
</table>

## CHP 9-1-1 Transports to ED

<table>
<thead>
<tr>
<th>Category</th>
<th>Base</th>
<th>Avoided</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Charge</td>
<td>$1,668</td>
<td>1680</td>
<td>$2,802,240</td>
</tr>
<tr>
<td>Ambulance Payment (3)</td>
<td>$427</td>
<td>1680</td>
<td>$717,360</td>
</tr>
<tr>
<td>ED Charges</td>
<td>$904</td>
<td>1680</td>
<td>$1,518,720</td>
</tr>
<tr>
<td>ED Payment (4)</td>
<td>$774</td>
<td>1680</td>
<td>$1,300,320</td>
</tr>
<tr>
<td>ED Bed Hours (5)</td>
<td>6</td>
<td>1680</td>
<td>10,080</td>
</tr>
</tbody>
</table>

**Total Charge Avoidance**  
$4,320,960

**Total Payment Avoidance**  
$2,017,680

**Per Patient Enrolled**  

| Charge Avoidance | $45,968 |
| Payment Avoidance | $21,465 |
“Before I started this program I was sick every day; I was going to the emergency room nearly every day.”

“I have learned more in the last three months from John and you than I have ever learned from the doctors, the hospitals, or the emergency rooms.”

“Since this program, I have not had any pain medicines and have not been to the emergency room. I am keeping up with my doctor’s appointment and my MHMR appointments.”
9-1-1 Nurse Triage

- Navigate low-acuity 9-1-1 calls to most appropriate resource
- Low acuity 9-1-1 calls (ALPHA & OMEGA)
  - Warm handoff to specially trained in-house RN
- Uses RN education and experience
  - With Clinical Decision Support software
- Referral eligibility determined by:
  - IAED Physician Board
  - Local Medical Control Authority
9-1-1 Nurse Triage Patient Satisfaction Scores

Patients who called 9-1-1 and got something other than an ambulance response

*Through March 2014*

N=158

*Likert Scale 1 – 5 (5 = Most Satisfied)*

<table>
<thead>
<tr>
<th>Condition Got Better:</th>
<th>Call Handled Different? = No</th>
<th>Talking to Nurse Helped</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85.8%</td>
<td>76.8%</td>
<td>89.6%</td>
</tr>
</tbody>
</table>
Expenditure Savings Analysis (1) 9-1-1 Nurse Triage Program
Based on Medicare Rates

Analysis Dates: June 1, 2012 - June 30, 2014
Number of Calls Referred: 1746
% of Calls AlternativelyDisposed: 39.9%

<table>
<thead>
<tr>
<th>Category</th>
<th>Base</th>
<th>Avoided</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Charge</td>
<td>$1,668</td>
<td>697</td>
<td>$1,162,596</td>
</tr>
<tr>
<td>Ambulance Payment (2)</td>
<td>$427</td>
<td>697</td>
<td>$297,619</td>
</tr>
<tr>
<td>ED Charges</td>
<td>$904</td>
<td>697</td>
<td>$630,088</td>
</tr>
<tr>
<td>ED Payment (3)</td>
<td>$774</td>
<td>697</td>
<td>$539,478</td>
</tr>
<tr>
<td>ED Bed Hours (4)</td>
<td>6</td>
<td>697</td>
<td>4,182</td>
</tr>
</tbody>
</table>

Total Charge Avoidance          $1,792,684
Total Payment Avoidance         $837,097

Per Patient Enrolled

| Charge Avoidance | $2,572 |
| Payment Avoidance| $1,201 |
**Expenditure Savings Analysis**  
**CHF Program - THR & JPS Health Network**  
*Based on Medicare Rates*

**Analysis Dates:** October 2010 - June 2014  
**Number of Patients (1):** 44

### All-Cause 30-day Hospital Utilization

<table>
<thead>
<tr>
<th>Category</th>
<th>Base</th>
<th>Expected</th>
<th>Actual</th>
<th>Prevented</th>
<th>Rate</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits</td>
<td>44</td>
<td>17</td>
<td>27</td>
<td></td>
<td>38.6%</td>
<td>61.4%</td>
</tr>
<tr>
<td>ED Charge (2)</td>
<td>$904</td>
<td>$39,776</td>
<td>$15,368</td>
<td>$24,408</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Payment (2)</td>
<td>$774</td>
<td>$34,056</td>
<td>$13,158</td>
<td>$20,898</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>44</td>
<td>13</td>
<td>31</td>
<td></td>
<td>29.5%</td>
<td>70.5%</td>
</tr>
<tr>
<td>Admission Charge (3)</td>
<td>$35,293</td>
<td>$1,552,892</td>
<td>$458,809</td>
<td>$1,094,083</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission Payment (3)</td>
<td>$8,276</td>
<td>$364,144</td>
<td>$107,588</td>
<td>$256,556</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Outcome Analysis

| Total Charge Avoidance | $1,118,491 |
| Total Payment Avoidance | $277,454 |

<table>
<thead>
<tr>
<th>Per Patient Enrolled</th>
<th>CHF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge Avoidance</td>
<td>$25,420</td>
</tr>
<tr>
<td>Payment Avoidance</td>
<td>$6,306</td>
</tr>
</tbody>
</table>
Observation Admission Avoidance

- Partnership with ACO
  - ED Physician (Case Manager) identifies eligible patient
  - Refer to MedStar Community Health Program
  - Non-emergency contact number for episodic care given to patient
- In-home care coordination with referring physician
- Assure attendance at PCP follow-up next business day
- Initiated August 1, 2012
  - 87 patients enrolled
  - 3 patient revisited prior to PCP follow-up
<table>
<thead>
<tr>
<th>Summary Results</th>
<th>Harris Methodist Fort Worth</th>
<th>5/15/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/12 to 4/30/13</td>
<td>ED Project</td>
<td></td>
</tr>
<tr>
<td>D/C from ER to SNF</td>
<td>25 8,046 (3,883) 80%</td>
<td>(77,659) (84,718)</td>
</tr>
<tr>
<td>D/C from ER to LTACH</td>
<td>- 8,046 16,461 80%</td>
<td>0 0</td>
</tr>
<tr>
<td>D/C from ER to Home Health</td>
<td>8 8,046 (6,566) 80%</td>
<td>(42,025) (45,845)</td>
</tr>
<tr>
<td>D/C from ER to Hospice</td>
<td>4 8,046 (4,842) 100%</td>
<td>(19,367) (21,127)</td>
</tr>
<tr>
<td>D/C from ER to Psych</td>
<td>1 8,046 0 50%</td>
<td>0 0</td>
</tr>
<tr>
<td>D/C from ER to Rehab Facility</td>
<td>- 8,046 4,918 50%</td>
<td>0 0</td>
</tr>
<tr>
<td>MEDSTAR Referral</td>
<td>10 8,046 (7,846) 100%</td>
<td>(78,460) (85,593)</td>
</tr>
<tr>
<td>MEDSTAR Referral to HH</td>
<td>1 8,046 (6,566) 100%</td>
<td>(6,566) (7,163)</td>
</tr>
</tbody>
</table>
Expenditure Savings Analysis Obs Admission Avoidance Program

Analysis Dates: **August 1, 2012 - June 30, 2014**

- **Referred:** 112
- **Enrolled:** 90

### Obs Admits Avoided

<table>
<thead>
<tr>
<th>Category</th>
<th>Base</th>
<th>Avoided</th>
<th>Gross Savings</th>
<th>Enrollment Fees</th>
<th>Net Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Obs Admit Expense (1)</td>
<td>$8,046</td>
<td>87</td>
<td>$700,002</td>
<td>$17,400</td>
<td>$682,602</td>
</tr>
<tr>
<td>ED Bed Hours</td>
<td>23</td>
<td>87</td>
<td></td>
<td></td>
<td>2,001</td>
</tr>
</tbody>
</table>

### Per Patient Enrolled

<table>
<thead>
<tr>
<th>Payment Avoidance</th>
<th>Obs Admit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$7,846</td>
</tr>
</tbody>
</table>

**Notes:**

1. From North Texas Specialty Physician Records
Hospice benefit
- Per diem from payer to agency
- Agency pays hospice related care
- LOS issues
- Varies based on Dx

MedPAC recommends increasing hospice benefit

IHI & MedPAC recommends increase hospice enrollment
RECOMMENDATION

11 The Congress should update the payment rates for hospice for fiscal year 2013 by 0.5 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

(For additional recommendations on improving the hospice payment system, see text box on pp. 285–287.)
Hospice Revocation Avoidance

- Enroll patients “at risk” for revocation
- Visit at home
  - Counsel – instruct – 10 digit access
  - “Register” patient in CAD
  - Co-respond with a “9-1-1” call
- Help family through process
  - While awaiting hospice RN

### Hospice Program Summary
**As of June 30, 2014**

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>161</td>
<td></td>
</tr>
<tr>
<td>Enrolled</td>
<td>136</td>
<td></td>
</tr>
<tr>
<td>Deceased</td>
<td>85</td>
<td>62.5%</td>
</tr>
<tr>
<td>Active</td>
<td>36</td>
<td>26.5%</td>
</tr>
<tr>
<td>Improved</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Revoked</td>
<td>13</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

### Activity:
- 911 calls: 20
- 911 transports: 12
- ED visits: 9
- Direct Admits: 3
Home Health Issues

- Instantly penalized for readmissions
- No more hospital referrals
- High cost of night/weekend demand services
- Don’t know when their patients call 911
- Consult to < admission
Client: XXXXXX, Rosie – 19XX-11-27
Program: Home Health - 911
Status: Active
Referring Source: Klarus
DSRIP Client: No
Visit Date: 5/14/2014
Visit Type: Home Visit
Visit Acuity: Unscheduled Visit
Visit Outcome: MHP Call Complete
Transport Resource: N/A
Response Number: 140514373
Note By: Tim Gattis

Note:
Klarus Home visit, arrived to find client sitting on the bedroom floor with a MedStar crew and FD in attendance. Pt in no acute distress and denies any injury or complaints.

Mother states pt was trying to transfer to the bedside commode and while trying to get her pants down her legs gave out and she fell to her knees. Upon exam noted pt in NAD. Pt is A&OX4, PPTE. Pt has a contracture to RUE due to previous CVA's.

In looking at her legs note several bruises in various stages of healing. Mother reports these occurred while she was at XXXXX and just got home this evening. Pt has good range of motion and denies pain or tenderness. I contacted Klarus and advised them of the situation and they will be out to see her in the morning. Visit complete.
Service Delivery Innovation Profile

Trained Paramedics Provide Ongoing Support to Frequent 911 Callers, Reducing Use of Ambulance and Emergency Department Services

Snapshot

Summary
The Area Metropolitan Ambulance Authority (more commonly known as MedStar), an emergency medical service provider serving the Fort Worth, TX, area, uses community health paramedics to provide in-home and telephone-based support to patients who frequently call 911 and to other patients populations who are at risk for potentially preventable admissions or readmissions. Working as part of MedStar's Mobile Integrated Healthcare Practice, these paramedics conduct an indepth medical assessment, develop a customized care plan based on that assessment, and periodically visit or telephone the patient and family to support them in following the plan. Support generally continues until they can manage on their own. Three additional similar programs serve individuals with congestive heart failure, patients who can be managed transitionally at home versus an overnight observational admission in the hospital, and in-home hospice patients who are at risk for hospice revocation. These programs have significantly reduced the number of 911 calls, the number of potentially preventable emergency department visits and hospital admissions, the number of overnight observational admissions, and the number of hospice revocations, leading to declines in emergency medical services and emergency department charges and costs, and freeing up capacity in area emergency departments.

See the Description section for an update on programs, identification of eligible individuals, patient assessment, and special protocols for patients with congestive heart failure; the Patient Population section for a description of patients served; the References section for two new resources; the Results section for updated data on the decline in ambulance and emergency department usage, charges, and costs, as well as results related to congestive heart failure and hospice patient admissions; the Planning and Development section for information about a hospice patient pilot test; the Resources section for updated staffing and cost data; the Funding section for updated information about program funders; and the Use by Other Organizations section for updated data on program adopters (updated January 2013).

Evidence Rating (What is this?)
Moderate: The evidence consists of pre- and post-implementation comparisons of 911 calls from program participants, along with estimates of the cost savings generated and emergency department capacity freed up as a result of the reduction in calls.
“Mobile Integrated Healthcare is an innovative and patient-centered approach to meeting the needs of patients and their families. The model does require you to “flip” your thinking about almost everything – from roles for health care providers, to what an EMT or paramedic might do to care for a patient in their home, to how we will get paid for care in the future.

The authors teach us how to flip our thinking about using home visits to assess safety and health. They encourage us to segment patients and design new ways to relate to and support these patients. And they urge us to use all of the assets in a community to get to better care. This is our shared professional challenge, and it will take new models, new relationships, and new skills.”

Maureen Bisognano
President and CEO
Institute for Healthcare Improvement
DFR MCHP

- First Patient contact March 19, 2014
- First Focus Area: High Frequency Patients
- 44 enrolled to date
- Overall reduction in 911 call volume to date: 68%
- Working on contracts with several Dallas hospitals to provide post-discharge readmission avoidance services
“There are many ways of going forward...

...but only one way to stand still”
Questions/Comments?

Thank you for this privilege!