MIH Working Committee

MIH/CP

Existing Programs Review

In 2015 it was reported there are 100+ agencies in 33 states conducting MIH/CP programs

Agenda

- EMS 3.0
- Most Common Program Types
- Identify a few services (EMS & Fire)
- 2015 NAEMT Survey results
- Funding Sources
- Reference Links

EMS 3.0

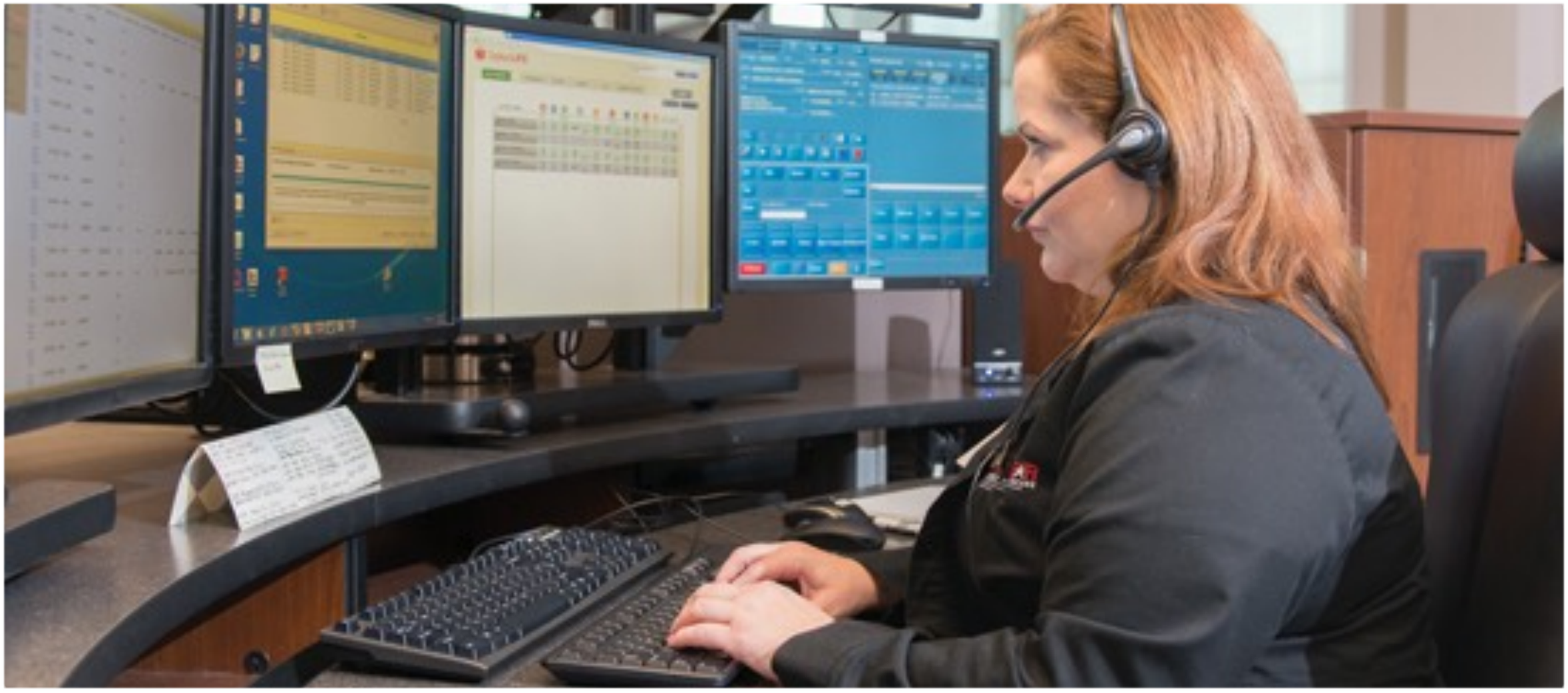
- America's Healthcare System - described by many as entering "Healthcare 3.0"
- If Healthcare is experiencing its third major revision, it is logical, perhaps even essential, that EMS transforms into its third major revision, EMS 3.0 is creating new opportunities for EMS, roles that meet three main goals:
  - Improve the patient's experience of care
  - Improve the health of the population
  - Reduce healthcare costs

EMS 3.0

The effectiveness of these opportunities is rooted in collaboration. EMS 3.0 agencies will help break down silos in health care delivery models by coordinating and collaborating with a variety of community health care providers and agencies to deliver a broad spectrum of patient-centered preventive, primary, specialty and rehabilitative care outside of medical facilities.

EMS has, and always will be, the community's ultimate health care safety net. When all else fails, pressing three digits on a phone brings medical help to the caller. EMS will also always have a role transporting medically fragile patients from one facility to another.

EMS can and should also be able to go to their location to investigate and identify gaps in their healthcare and assist by directing them to resources, perform home safety checks, and, where applicable, follow up to ensure they have received the resources that they need.



MedStar, Mesa Fire & Medical, REMSA, Northwell Health Center for EMS

Most Common Program Types:

Nurse Triage

This typically involves the use of specially trained nurses as part of the 911 call taking process for low to no acuity 911 calls. Nurses use their training, along with decision support tools to help callers find more appropriate outcomes for their call as opposed to an ambulance to an emergency department.

Albuquerque Amb, MedEx Amb, Procure Integrated Health & Transport

Most Common Program Types:

Post Discharge Care

A number of agencies are enrolling patients in 30-day post discharge readmission prevention programs, like in-home safety and fall risk assessments, medication inventories and a review of all discharge instructions and even 911 intervention and redirection if the patient calls 911.

REMSA, Northwell, McKinney (TX) Fire, San Diego (CA) Fire

Most Common Program Types:

Disease Management

EMS is available 24/7/365, many EMS systems have formal partnerships with hospitals and home health agencies to help these patients. The goals here are to help the patient use their patient centered medical homes more effectively and prevent unnecessary 911, Emergency Dept. and inpatient hospital use.

REMSA, MedStar, Los Angeles (CA) Fire, Montgomery County (KY) Fire

Most Common Program Types:

High Utilizer Group

EMS frequent users are a wide spectrum of individuals with an even greater range of underlying reasons for high EMS use. Calling 911 to receive a ride to the hospital, by ambulance, so they can see a doctor is their primary way to access the health care system. And that's not how this is supposed to work.

REMSA, MedStar, Newport Beach (CA) Fire, Huntington Beach (CA) Fire

Most Common Program Types:

Alternative Destination

Paramedics to do enhanced assessments in the field on 911 patients and allows these paramedics to offer low-acuity patients the option of being transported to destinations other than emergency departments.

MedStar, AMR Gold Coast Ambulance Service, VITAS Healthcare

Most Common Program Types:

Hospice Collaboration

Families are told the proper way to access the hospice nurse if the patient begins to struggle at home. Unfortunately, in the panic of seeing their loved one struggle, many families call 9-1-1. MHP's can wait with the family until the hospice nurse arrives and release the ambulance back into service. No transport, no disenrollment and the patient's wishes are achieved.

Las Cruces, New Mexico

- Fire Department based pilot project launched September 2016 “Community Assessment & Navigation” or CAN project; one dedicated person, looking to hire a social worker
- Focus; to reduce 911 calls
- In 2016 30 people generated 462 calls, 236 people called 911 four or more times. These calls combined equalled 1600 calls, about 15% of all EMS requests.
- “We go to their location to investigate and offer services. We identify gaps in their healthcare and assist in directing them to resources. We perform home safety checks, where applicable, which is very important, especially for the disabled. And we follow up to ensure they have received the resources that they need”
- Adding a Mental Health component in collaboration with a local group as they found that 50% of they visited have a mental health condition

St. Peters, Montana

- Collaborative program with BJC Healthcare and St. Charles County Ambulance District; 2 paramedics
- Focus; reduce readmission by identifying patients at high-risk for readmission: CHF, COPD, Acute MI
- Paramedics meet with patients and case managers prior to discharge. Together, they identify needs and goals specific to each patient. Over a 4-week period the paramedics perform physical exams, medication reviews, dietary compliance discussions, and disease management education. Results are reported back to the patient's physician.
- November 1, 2016 - February 15, 2017 enrolled 28 patients, 17 patients completed the program; of those 17, 13 avoided readmission and four were hospitalized. A success rate of 76.5%.

St. Peters, Montana

- Using data from Centers for Medicare and Medicaid Services regarding costs related to Ed and hospital admissions, avoiding 13 patients from readmission potentially saved $149,097 in unnecessary care and associated costs.
- In addition, patients indicated significant gains on health status self-assessments.
  - 46.7% report improved ability to perform usual activities
  - 37.7% report improvement in overall health status

CONNECT CP Program

- The Center for Emergency Medicine of Western PA, a hospital-based, non-transport agency in Pittsburgh
- Started their own CP Program 2003
- In 2013, the Center was asked to manage a CP initiative on behalf of the Allegheny EMS Council (represents 44 EMS agencies) and a municipal government collaborative called CONNECT (Congress of Neighboring Communities) was funded for two years by two major health systems. The program was established to address two concerns;
  - the financial burdens carried by EMS agencies in Allegheny county
  - the needs of vulnerable patients in Allegheny county

CONNECT CP Program

- 2 full time paramedics, 7 part time
- Focus; reduce readmission by identifying patients at high-risk for readmission: CHF, COPD, Acute MI program include assisting patients with chronic disease management, providing medication reconciliation, delivering education about the use of medical equipment, conducting home visits, providing transportation to medical appointments, and offering some mental and behavioral health support. CPs act as navigators for patients, connecting them to social services, public benefit resources, and physician providers in the community. The CPs tailor interventions to patient needs by conducting a comprehensive intake assessment to ascertain a patient's environment and social determinants of health.

CONNECT COMMUNITY® PARAMEDIC

Tri-County CP Program

- Tri-County Health Care is a hospital in a rural area in one of the poorest regions of Minnesota. The EMS department runs the CP program; 8 part time CPs
- Program was developed to reduce demand on it's Emergency Department. It now provides; assistance with chronic disease management, fall prevention, medication reconciliation, patient education, after-hours care for home health agencies and Tri-County Hospital's care coordination department, and case management and referrals to other providers. The CPs augment home health services during off-hours and immediately post-hospital discharge because home health agencies are not always able to schedule visits within the first day or two post-discharge. Having CPs provide in-home visits to bridge the gap between hospital discharge and initiation of home health services helps to reduce the risk that patients will be readmitted.

MedStar

- MedStar, as inter-governmental EMS agency in Fort Worth, TX; serves Fort Worth and 14 other member cities. Program began in 2009; 9 paramedics.
- Program began by targeting high 911 users and provided regular scheduled home visits to support patient medication adherence and follow-up care with their PCP.
- They now provide a 911 nurse triage system, chronic disease and illness management, medication reconciliation, education about proper use of medical equipment, fall prevention, mental/behavioral health support, and referrals to other healthcare providers. These services are delivered via a series of scheduled home visits. They also have a hospice collaboration.

MedStar

- Nurse Triage
  - 36.6% of MedStar's 9-1-1 requests do not result in an emergency response. Many people call 9-1-1 for medical or trauma conditions that could more appropriately be cared for in ways other than an ambulance trip to an emergency department (ED). The 9-1-1 Nurse Triage program helps navigate callers for very low acuity medical or trauma conditions to settings such as primary care, dental care, urgent care, or even self care at home.

MedStar

- Hospice Collaboration
  - Help assure patient wishes are granted regarding their desire to complete hospice enrollment at home.
  - Reduce incidence of Hospice Revocation by patient / family members for patients who are in a home hospice program.
  - Reduce utilization of 9-1-1 responses and transports to acute care facilities, and decreased the burden on the patient/family.
  - Provide early notification to the hospice agency, by the Communications Center, if a 9-1-1 call is placed for an enrolled patient.
  - Continuing education for the MedStar system on hospice, end-of-life care, advances directives, etc.

Northwell Health CP

- Network covers Manhattan and Long Island, began in 2013, 40 CPs
- Program grew out of partnership with Northwell EMS and its House Calls Program
  - Initially designed to remedy high ED utilization of House Calls population; evolved to have CPs respond to urgent calls from this population instead of MDs and nurses. In 2016 they began a partnership with the Northwell Hospice Program.
  - In addition to above they now provide nurse triage, chronic disease management, medication reconciliation and transportation to the ED, as needed.

Northwell Health CP

- Only 1.7% of patients seen by CPs who were not transported to an ED were subsequently seen in an ED within 24 hours of the CP response. Among CP patients who were transported to an ED, 82.2% were admitted to a hospital, suggesting that most patients who were transported truly needed to be hospitalized.

REMSA

In 2012, Regional Emergency Medical Service Authority (REMSA) launched their programs throughout Washoe County, Nevada. Funded through a 9.1 million Health Care Innovation Award from the Center for Medicare & Medicaid Services, the program has three interventions:

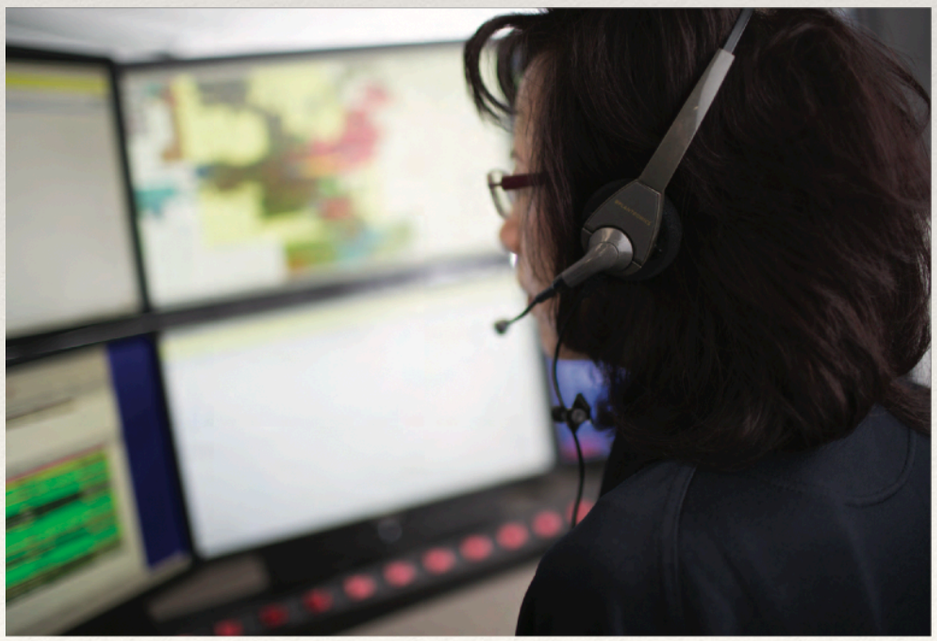
- Nurse Health Line - non-emergency phone number to provide 24/7 access to nurse navigators that assess, triage and refer
- Alternative Destination - provide alternative pathways of care other than transport to a hospital ED, including transport to urgent care centers & clinics, a detox center or mental health hospitals
- Community Paramedicine - in-home tasks and point of care lab tests to improve transition from hospital to home and home to improve care plan adherence.

REMSA

- Over four years, REMSA's Community Health Programs saved $9.66 million in healthcare payments, compared to $9.06 million in program expenditures. By year four, the programs achieved an 84% return on investment—avoiding $1.84 in payments for every $1 in expenditures.
- 4-year Program resulted in:
  - 6,202 ED visits avoided
  - 1,024 ambulance transports avoided
  - 104 hospital readmissions avoided
- The Nurse Health Line took its 1st call in October 2013. Within just three months, the line was receiving about 2,000 calls a month, plus another 150 or so referred by 911 call-takers who had determined the patient met the criteria for transfer to the nurse line.

REMSA

- The Nurse Health Line also safely reduced costs while still providing appropriate care. Only 1.5% of callers required referral to the 911 communications center and dispatch of EMS resources, while 635 ambulance transports and 4,414 emergency departments were avoided. Based on average payments for ED visits and EMS transports, the Nurse Health Line saved more than $5.75 million from October 2013 until June 2016.
- The Nurse Health Line represented over 60% of total Community Health Program savings.



REMSA

- In three-and-a-half years, REMSA paramedics safely transported 1,509 patients to alternative destinations— saving more than $1.8 million in payments through avoided emergency department visits. With more options for patients, the savings could have been much higher: The 1,509 people taken to alternative sites accounted for only about ten percent of those whom paramedics deemed clinically eligible after performing an advanced assessment, but due to patient choice or the unavailability of an appropriate alternative destination, many patients were still transported to the ED.
- Alternative destinations in Washoe County include the local detox center, psychiatric hospitals, two federally qualified healthcare clinics, one primary care medical practice and approximately a dozen urgent care centers
- Detox 84%, Mental Health Hospital 9%, Urgent Care Center 7%

REMSA

- Community Paramedicine
  - Post discharge follow-up
  - Episodic Eval Visit - In-home visits within four hours of a request from primary care or other physicians to provide in-home patient care service when there are limited resources available and an emergency department visit may not be optimal
- Frequent user intervention

REMSA

- Launched in June 2013, the CP program enrolled 1,524 patients in its 1st 37 months. Most of the enrolled patients were part of the post-discharge program, with the vast majority of those being congestive heart failure patients; 13.6% of patients enrolled in the program were referred by physicians for the evaluate and refer program, while 2.2% were frequent users.
- During those 1st three years, the CP program saved $2,070,576 by avoiding 350 visits to the emergency department, 258 ambulance trips and 104 hospital readmissions.

2015 NAEMT Survey results

77% agree their program is a multidisciplinary practice of medicine overseen by physicians and other healthcare practitioners

70% agree that their program is team-based and incorporates multiple providers, both clinical and non-clinical

96% agree that their program is patient-centric and focused on the improvement of patient outcomes

1 in 4 agencies report using telemedicine in the programs. Not specified if that involves specific telemedicine applications or more commonplace things, such as ECG transmission

69% of MIH-CP programs receive referrals from hospitals

66% of MIH-CP programs refer patients to home health

2015 NAEMT Survey results

87% agree the support for MIH-CP programs is growing among partners such as hospitals and other healthcare providers

96% agree that the number of patients served by their MIH-CP program will grow in the next five years

59% provider practitioners with training in patient navigation

63% of MIH-CP programs provide practitioners with training in accessing community programs and social services

22% say their MIH-CP practitioners have an advanced scope of practice

77% say their MIH-CP practitioners do not

2015 NAEMT Survey results

80% agree that their programs are legally compliant at the local, state and federal levels

57% agree that statutory or regulatory policies are a significant obstacle to sustaining or growing their MIH-CP program

23% disagree that statutory or regulatory barriers get in the way of their MIH-CP program

89% agree that reimbursement/funding is a significant obstacle

59% rate their program as highly or somewhat successful in reducing reliance on the ED for a defined group of patients

81% of programs in operation for two or more years report success in reducing costs, 911 use and ED visits for defined groups of patients

Funding Sources

- Hospitals
- Grants - State DPHs, MCOs, other misc opportunities
- Contracts with Health Plans
- Hospice & Home Care
- Medicaid (1st in Country - 2012 in Minnesota = 80% of a physician assistants office visit charge of $17.25 per 15-minutes of patient interaction)

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