

## Innovative Partnerships for Healthcare 2.0



© 2015 MedStar Mobile Healthcare



## What we're gonna do...

- Build on the work started in April 2014
- Learn the “Why” MIH is so popular now
  - Analyze the current state of the US Healthcare system
    - Hospital issues
    - Physician issues
    - Hospice issues
    - Home health issues
- The “How”
  - Insight into new “EMS” model
    - How would that fit in *your* world?
- The “What”
  - What the heck y’all doing over there in Ft. Worth...?
  - ... And in other communities in the U.S.



## About MedStar...

- Governmental agency (PUM) serving Ft. Worth and 14 Cities
  - Self-Operated
  - 980,000 residents, 421 Sq. miles
  - Exclusive provider - emergency and non emergency
- 125,000 responses annually
- 460 employees
- \$40 million budget
- 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



**Leon County  
Community Dialogue**  
IMPROVING COUNTY HEALTH • APRIL 3 2014

**NACO** National Association of Counties  
The Voice of America's Counties

## WHAT ARE THE GAPS IN SERVICES IN THE COMMUNITY?

“As the dialogue shifted from discussion of strengths and assets of the healthcare system, partners talked about the gaps in services they see as barriers. Although many partners highlighted the high quality of care provided by physicians, it was noted that some specialties suffer from a shortage of providers and additional physicians are needed to match the health needs of the community.

There was a discussion about gaps in services for the chronically ill. The current CareNet system has provided a strong safety net, but the system does not address funding of chronic disease treatment..

***There is an acute need to improve chronic care management and services for “high utilizers” that cycle in and out of the hospital.”***



## WHAT ARE THE GAPS IN ACCESS TO CARE IN THE COMMUNITY?

“The partners discussed a number of critical gaps in access to care. The county has high quality healthcare services and well-trained physicians; however, the partners discussed the lack of a full continuum of services.

***It is difficult for uninsured and underinsured patients to connect to needed services in the system due to fragmented providers and a lack of follow-up services available to them.***

It was noted that many patients stop seeking services when confronted with the difficulty of navigating the system.

***In particular, investments need to be made to close gaps in preventive care, follow-up, and ongoing outpatient treatment for the chronically ill.”***

***“Healthcare delivery is provider-centered, which is a contributing factor to the continuum of care gap discussed earlier in the dialogue. Many partners discussed the need to shift towards a patient-centered model of healthcare delivery.”***





Why yes, I'm a bit stressed.  
Why do you ask?



## Our World is Changing:



## Attention Please!

- \$9,695 per capita health expenditures!!
  - Due in large part to **quantity-based** payments



<http://www.usatoday.com/story/news/nation/2015/07/28/cms-report-shows-health-spending-growth-faster-than-recent-years/30790253/>



## Health survey ranks U.S. last among rich peers

Michael Winter

**June 16, 2014**



For the fifth time in a decade, the United States is the sick man of the rich world. But recent health reforms and increased health technology spending may provide a cure in the coming years.

**That's according to the latest Commonwealth Fund survey of 11 nations, which ranked the world's most expensive health care system dead last on measures of "efficiency, equity, and outcomes."** So too in 2010, 2007, 2006 and 2004.

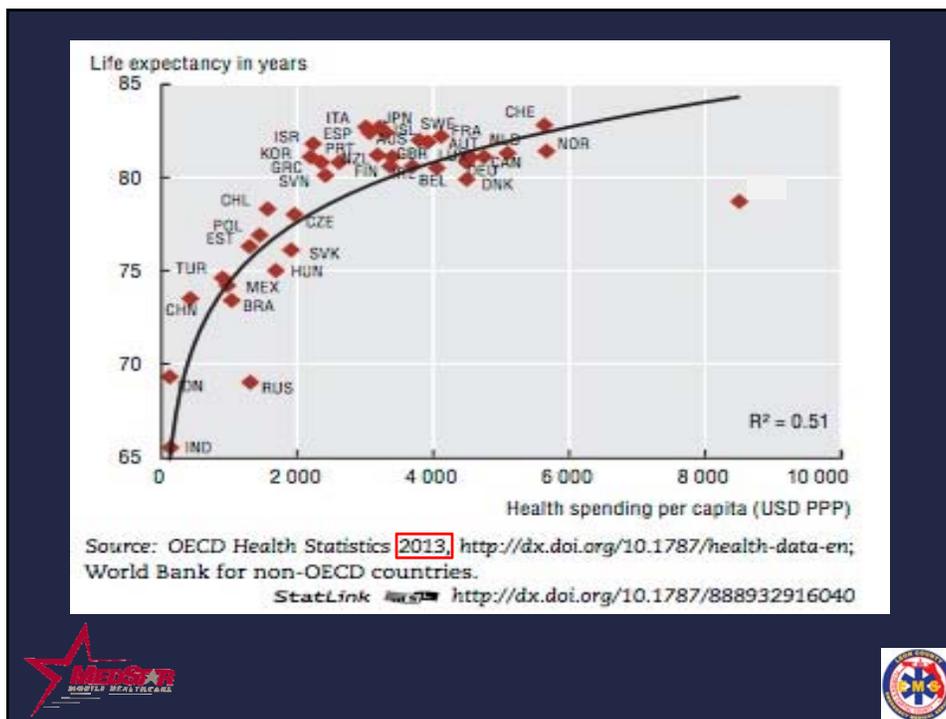
The other eight countries surveyed were Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway and Sweden.

**What do the healthier cousins have that the United States does not? Universal health care, the Commonwealth Fund points out.**



<http://www.usatoday.com/story/news/nation/2014/06/16/health-survey-us-last/10638811/>





## Overkill

*An avalanche of unnecessary medical care is harming patients physically and financially. What can we do about it?*

By Atul Gawande

May 11, 2015

MEDCITY News

THE NEW YORKER

Writing in the New Yorker, Gawande, a general surgeon at Brigham and Women's Hospital in Boston, author and MacArthur Foundation "genius grant" recipient, painstakingly explains the "epidemic of unnecessary care" that bears much of the blame for the country's runaway healthcare costs and preventable deaths.

**As Gawande noted, the Institute of Medicine reported in 2010 that 30 percent of healthcare spending, or \$750 billion a year, was wasteful. "The report found that higher prices, administrative expenses, and fraud accounted for almost half of this waste. Bigger than any of those, however, was the amount spent on unnecessary healthcare services," Gawande noted.**

Gawande also looked at strategies for combat the problem, and found, to the surprise of nobody in the healthcare industry, that moving away from fee-for-service toward accountable, outcomes-based care is absolutely necessary. He just had no idea just how effective an incentive shift could be until he took a deeper look at the evidence.

<http://medcitynews.com/2015/05/gawande-looks-costly-problem-wasteful-care/>

## Return Visits to the Emergency Department: The Patient Perspective

Sep 2, 2014  
Source: ACEP

Annals of Emergency Medicine  
An International Journal

### Conclusion

Post-discharge factors, including *perceived inability to access timely follow-up care* and *uncertainty and fear about disease progression*, are primary motivators for return to the ED. Many patients prefer hospital-based care because of increased convenience and timely results. *Further work is needed to develop alternative pathways for patients to ask questions and seek guidance when and where they want.*



[http://www.annemergmed.com/article/S0196-0644\(14\)00622-2/fulltext](http://www.annemergmed.com/article/S0196-0644(14)00622-2/fulltext)



## Heart-Attack Patients More Likely To Die After Ambulances Are Diverted

By Barbara Feder Ostrov  
August 31, 2015

KHN  
KAISER HEALTH NEWS

Heart-attack patients whose ambulances were diverted from crowded emergency rooms to hospitals farther away were more likely to be dead a year later than patients who weren't diverted, according to a recent study published in the journal Health Affairs.

*Some hospitals see diversion as a necessary safety valve for full-up emergency rooms. But emergency care experts say they push the crowding problem to nearby hospitals and can compromise patient care, especially in life-threatening cases.*

The researchers found that heart-attack patients whose ambulances had been diverted to an emergency room farther away were nearly 10 percent more likely to be dead one year later than those whose ambulances were not diverted.

"It still boils down to lack of resources to meet the demand," Elliott said.

*B.J. Bartleson, vice president of nursing and clinical services for the California Hospital Association, said the state's hospitals are working with local EMS agencies to make sure patients get to the right hospital at the right time.*



<http://khn.org/news/heart-attack-patients-more-likely-to-die-after-ambulances-are-diverted/>





**Institute for  
Healthcare  
Improvement**

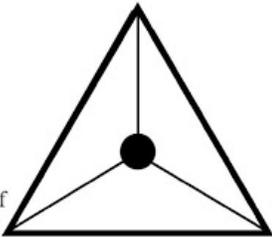


**IHI Triple Aim**

**IHI Triple Aim Initiative**

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs

Health of a Population



Experience of Care

- Safe
- Effective
- Patient centered
- Efficient
- Timely
- Equitable

Per Capita Cost

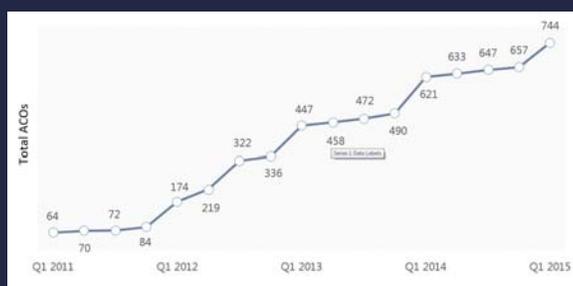
The IHI Triple Aim

Better care for individuals, better health for populations, lower per capita costs




## Healthcare Economics 3.0

- ACOs
  - **744** as of March 2015
  - **23.5 million** covered lives
- Steroid Injection = ACA



<http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>







**ABOUT FLAACOS**

FLAACOS is the premier professional organization for Accountable Care Organizations (ACOs) throughout Florida. ACOs are designed to incentivize providers to work together to increase quality of care delivered to patients while significantly lowering medical costs overall. New shared savings payment arrangements are being developed by both government and private sector payers that are encouraging the fast growth of these Accountable Care models.

FLAACOS members are organized in a vibrant network of state affiliate groups that share FLAACOS goals in working on behalf of ACO professionals. FLAACOS encourages the exchange of diverse opinions and to further discussion, dialogue, and reflection of particular topics relevant to FLAACOS. Stay up-to-date with industry trends with the FLAACOS Newsletter. Receive the latest research based ideas to inspire and inform your service options. FLAACOS provides an opportunity to network with physicians and other ACO leaders from around the State of Florida. Participate in discussions throughout the year, join one of the FLAACOS committees and attend the FLAACOS Annual Conference. Educate yourself with member only meetings.

Get reduced rates for conferences and professional networking and development opportunities where you'll rub shoulders with leading luminaries in healthcare reform. Click the registration button to join and/or renew your FLAACOS membership.

Mission  
What We Do  
Leadership Team  
Membership  
Business Partnership  
FLAACOS Fall Conference  
ACO Coalition Fall Meeting  
Webinars  
Request Information

<http://www.flaacos.com/about-flaacos.html>



**FLORIDA ACO DIRECTORY**

**MEDICARE SHARED SAVINGS**

Accountable Care Coalition Of Coastal Georgia  
Accountable Care Coalition Of North Central Florida LLC  
Accountable Care Coalition Of Northwest Florida LLC  
Accountable Care Coalition Of The Panhandle Gulf Coast LLC  
Accountable Care Medical Group of Florida Inc/ACMG  
Accountable Care Options LLC  
Accountable Care Partners LLC  
Alkermis Optima LLC ACO  
American Health Alliance  
Barona Health Systems  
Barona Health Partners  
Broward Guardian LLC  
Broward Health ACO  
Central Florida Physicians Trust  
First Coast Health Alliance LLC  
Florida Medical Clinic ACO LLC  
Florida Physicians Trust LLC ACO  
FHG Healthcare LLC ACO  
Health Choice Care LLC  
Health Point ACO LLC  
Holy Cross Physician Partners ACO LLC  
JSA Medical Group ACO  
JSA Medical Group LLC  
MCM Accountable Care Organization LLC  
Medical Practitioners For Affordable Care LLC  
Midwestern Accountable Care Organization  
Native Coast LLC  
Northwest Florida Accountable Care Orange ACO  
Orange Accountable Care of South Florida LLC  
Orlando Health  
Osceola South Seminole Care Organization LLC  
Physicians First ACO  
Physicians Collaborative Trust ACO LLC  
PKM Premier Medical Associates  
PremierMD ACO LLC  
Primary Care Alliance LLC  
Primary Partners  
Primary Partners LLC ACO  
PhoCare Med LLC  
Reliance Healthcare Management Solutions LLC ACO  
Sarned Heart Health System  
South Florida ACO LLC  
Southwestern Integrated Medical  
St Vincent's Accountable Care Organization LLC  
West Florida ACO LLC

**COMMERCIAL**

Skyline Physician Partners ACO LLC  
Cigna - BayCare Health System ACO  
Cigna - Broward Health ACO  
Cigna - Holy Cross Physician Partners ACO  
Cigna - Orlando Health Physician Partners ACO  
Cigna - Primary Partners ACO  
Cleveland Clinic Regional  
Florida Blue - Baptist Health Care Corporation ACO  
Florida Blue - Baptist Health South Florida Advanced Medical Specialists ACO  
Florida Blue - First Coast Health Alliance ACO  
Florida Blue - Health Management Associates (HMA) ACO  
Florida Blue - Holy Cross Hospital ACO  
Florida Blue - Holy Cross Physician Partners ACO  
Florida Blue - Medical Specialists of Palm Beach ACO  
Florida Blue - Memorial Healthcare System ACO  
Florida Blue - Moffitt Cancer Center ACO  
Florida Blue - MCH Healthcare ACO  
Florida Blue - Orlando Health Physician Group ACO  
Florida Blue - Tappan Healthcare ACO  
Florida Physicians Trust ACO  
Innovative Alliance ACO  
UnitedHealthCare - The Villages ACO

**67!**

## Healthcare Economics 3.0

- 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
- Merger & Acquisition Frenzy

9

## CMS announces additional participants in pilot project to improve care and reduce costs for Medicare

Over 2,100 participants in performance period of Bundled Payments for Care Improvement initiative

**Date** 2015-08-13

**Title** CMS announces additional participants in pilot project to improve care and reduce costs for Medicare

**Contact** [go.cms.gov/media](http://go.cms.gov/media)

***"We are excited that thousands of providers in the Bundled Payments for Care Improvement initiative have joined us in changing the health care system to pay for quality over quantity - spending our dollars more wisely and improving care for Medicare beneficiaries,"*** said Patrick Conway, M.D., CMS acting principal deputy administrator and chief medical officer. ***"By focusing on outcomes for an episode of care, rather than separate procedures in care delivery, we are incentivizing hospitals, doctors and other providers to work together to provide high quality, coordinated care for patients."***

Bundling payment for services that patients receive across a single episode of care is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Through the Bundled Payments for Care Improvement initiative, CMS is testing how bundled payments for clinical episodes can result in better care, smarter spending, and healthier people.

***Today's announcement means several hundred providers are advancing into a program that rewards them for increasing quality and reducing costs while also penalizing them if costs exceed a set amount.***



<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-13.html>



## HHS Pledges To Quicken Pace Toward Quality-Based Medicare Payments

By Jordan Rau [January 26, 2015](#)

**KHN**  
KAISER HEALTH NEWS

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

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

***The administration also wants Medicare spending with any quality component, such as bonuses and penalties on top of traditional fee-for-service payments, to increase, so that by the end of 2018, 90 percent of Medicare spending has some sort of link to quality.***

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



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



## Anthem to Buy Cigna Amid Wave of Insurance Mergers

By CHAD BRAY

July 24, 2015

The New York Times

The health insurer Anthem said on Friday that it had agreed to acquire its rival Cigna for \$48.3 billion in a deal that would further concentrate the United States market to just a few major players.

*A flurry of deals are reshaping the industry. Earlier this month Aetna agreed to acquire Humana, the smallest of the big five insurers, for \$37 billion in cash and stock. If both transactions are completed, the number of major health insurers in the United States will shrink to three.*

Health insurers are seeking to consolidate to gain greater scale to reduce costs and capitalize on growing opportunities in the government and individual markets.



<http://www.nytimes.com/2015/07/25/business/dealbook/anthem-cigna-health-insurance-deal.html>



## Healthcare Economics 3.0

- CMS Bonuses/Penalties
  - 2013 = 2% Max
  - 2014 = 3% Max
  - 2015 = 4.5% Max
  - 2016 = 5.5% Max
- Applied to all Medicare payments



## CMS Bonuses/Penalties...

- Readmissions (up to 3%)
  - 2013-2014
    - MI
    - CHF
    - Pneumonia
  - 2015
    - COPD
    - Hips/Knees
  - 2017
    - CABG



### 2.5k hospitals penalized by CMS for high readmissions

Written by Heather Punke  
August 04, 2015

BECKER'S  
Hospital Review

In the fourth year of the Hospital Readmissions Reduction Program, **2,592 hospitals will face penalties to their Medicare reimbursements for a high number of 30-day readmissions.**

**The penalties will take effect from Oct. 1 through Sept. 30, 2016, and are projected to cost the hospitals a combined \$420 million.**

The maximum penalty this year is a 3 percent reduction in Medicare payments, which 38 hospitals will receive this year compared to 39 hospitals last year. The average penalty this year is 0.61 percent, *KHN* reported.



<http://www.beckershospitalreview.com/quality/2-5k-hospitals-penalized-by-cms-for-high-readmissions-10-things-to-know.html>



Medicare uses the national readmission rate to help decide what appropriate rates for each hospital, so to reduce their fines from previous years or avoid them altogether, hospitals must not only reduce their readmission rates but do so better than the industry did overall.

**"You have to run as fast as everyone else to just stay even," Foster said. Only 129 hospitals that were fined last year avoided a fine in this new round, the KHN analysis found.**

**Medicare officials, however, consider the competition good motivation for hospitals to keep on tackling readmissions and not to become complacent with their improvements.**

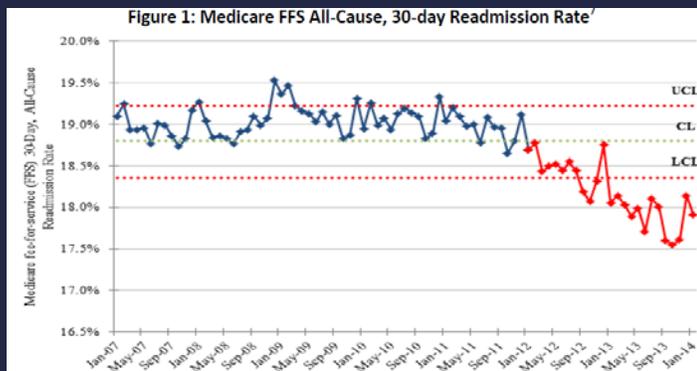


<http://www.kaiserhealthnews.org/Stories/2014/October/02/Medicare-readmissions-penalties-2015.aspx>



**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.



<http://innovation.cms.gov/Files/reports/patient-safety-results.pdf>



## These Days, We're All Paying More Attention to Care Transitions

Bill Santamour, Editor

July 14, 2015



Most of us would prefer to be cared for at home no matter how dicey our medical issues may be. Making that happen could be good for the nation's bottom line, too.

*Medicare in June announced that it had saved more than \$25 million in the first year of a three-year study to determine the value of home-based primary care for frail seniors with multiple chronic illnesses.*

The AP's Lauran Neergaard reports that the "humble house call" brings a doctor or nurse practitioner, sometimes accompanied by a social worker, to homebound patients whose needs are too complex for a 15-minute office visit and who might have a hard time getting to a physician's office. ***"If we can keep people as healthy as possible and at home, so they only go to the hospital or emergency room when they really need to," Neergaard quotes Patrick Conway, Medicare's chief medical officer, "that both improves quality and lowers cost."***



[http://www.hhnmag.com/Magazine/2015/July/ednotes\\_jul15](http://www.hhnmag.com/Magazine/2015/July/ednotes_jul15)



## Readmission reduction: A losing battle?

October 16, 2014

Readmissions may be "beyond a hospital's control," according to a new study published in the American Journal of Managed Care.

***They gave half the patients an intervention featuring pre-discharge education and planning, post-discharge follow-up, an available hotline and "bridging" techniques such as daily symptom checks.***

***Linden and his coauthor, Susan W. Butterworth, Ph.D., found no statistical difference in readmissions between the two groups after both 30-day and 90-day periods, although mortality was lower in the intervention group than the control group.***



<http://www.ajmc.com/publications/issue/2014/2014-vol20-n10/a-comprehensive-hospital-based-intervention-to-reduce-readmissions-for-chronically-ill-patients-a-randomized-controlled-trial/3>



## Take-Away Points from the Research:

- **Our results suggest the need to continue experimenting with new interventions targeting readmissions, especially for severely ill patients.**
- Our addition of interactive voice response and motivational interviewing–based health coaching to the transitional care model did not improve outcomes.
- Our findings suggest that correcting improper use of the inhaler and increasing adherence to inhaled medications may reduce 90-day mortality for chronic obstructive pulmonary disease patients.
- **Hospitals, without collaborative relationships with community-based providers, may have limited ability to reduce readmissions, as they cannot ensure timely and continuous care for patients after discharge.**
- A challenging road lies ahead for stand-alone community hospitals seeking to decrease readmissions and avoid financial penalties.



AJMC.com



## How house calls can cut down on hospital readmissions

The Valley Hospital in New Jersey sends medical teams to patients' homes to coordinate follow-up care

By Leslie Small

April 23, 2015

FierceHealthcare

The healthcare industry abounds with new ideas to reduce unplanned hospital readmissions and emergency department (ED) visits, but a New Jersey hospital has turned to a seemingly old-fashioned medical strategy--the house call.

**The Valley Hospital in Ridgewood, New Jersey, launched its *Mobile Integrated Healthcare Program* in August 2014 to provide "proactive, post-discharge home check-ups" to patients with cardiopulmonary disease who are at high risk for readmission and either declined or didn't qualify for home care services,** according to a statement from the hospital.

In the program, a team composed of a paramedic, an emergency medical technician and a critical care nurse conducts a physical exam of the patient, offers medication education, reinforces discharge instructions, completes a safety survey of the patient's home and confirms that the patient has made a follow-up appointment with a physician.



<http://www.fiercehealthcare.com/story/how-house-calls-can-cut-down-hospital-readmissions/2015-04-23>



**Hospitals' Goal: Empty Beds**

08.21.15 by Bill Santamour H&amp;HN Editor

***"IF OUR BEDS ARE FILLED, IT MEANS WE'VE FAILED."***

That's the striking message in an ad I came across for Mount Sinai Hospital, and it could speak for hospitals across the nation as they transform from being strictly providers of care to promoters of health. The ad does a good job of explaining in lay terms how the new focus on population health management means that "instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside the traditional hospital setting."

*It spotlights Mount Sinai's "tremendous emphasis on wellness programs"; its **Mobile Acute Care Team**, which treats patients at home for certain conditions that otherwise would land them in the hospital; and its Preventable Admissions Care Team aimed at averting readmissions by providing both medical care and help with nonmedical factors that impact health and access to care, like housing and literacy.*

Not a lot there that hospital leaders don't already know, of course, but you've got to admit, the headline's a grabber.



<http://www.hhnmag.com/Daily/2015/August/weekly-reading-icd10-mcdonalds-xenotransplants-blog-santamour?>

**ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI**

Project Title: "Bundled Payment for Mobile Acute Care Team Services"

Geographic Reach: New York

**Estimated Funding Amount: \$9,619,517****Summary:**

The Icahn School of Medicine at Mount Sinai project will test **Mobile Acute Care Team (MACT) Services**, which will utilize the expertise of multiple providers and services already in existence in most parts of the United States but will transform their roles to address acute care needs in an outpatient setting. MACT is based on the hospital-at-home model, which has proven successful in a variety of settings. MACT will treat patients requiring hospital admission for selected conditions at home. **The core MACT team will involve physicians, nurse practitioners, registered nurses, social work, community paramedics,** care coaches, physical therapy, occupational therapy and speech therapy, and home health aides. The core MACT team will provide essential ancillary services such as community-based radiology, lab services (including point of care testing), nursing services, durable medical equipment, pharmacy and infusion services, telemedicine, and interdisciplinary post-acute care services for 30 days after admission. After 30 days, the team will ensure a safe transition back to community providers and provide referrals to appropriate services.



<http://innovation.cms.gov/initiatives/Participant/Health-Care-Innovation-Awards-Round-Two/Icahn-School-Of-Medicine-At-Mount-Sinai.html>



Name	City	State	FY2013 Readmission Penalty	FY2014 Readmission Penalty	FY2015 Readmission Penalty	FY2016 Readmission Penalty
CAPITAL REGIONAL	TALLAHASSEE	FL	0.69%	0.88%	0.75%	0.47%
TALLAHASSEE MEMORIAL	TALLAHASSEE	FL	0.00%	0.00%	0.00%	0.02%
JOHN D ARCHBOLD MEMORIAL	THOMASVILLE	GA	0.00%	0.00%	0.71%	0.88%
FLORIDA HOSPITAL	ORLANDO	FL	1.00%	0.78%	1.06%	1.18%
ORLANDO HEALTH	ORLANDO	FL	0.88%	0.50%	0.64%	0.48%
ST VINCENT'S MEDICAL CENTER	JACKSONVILLE	FL	0.14%	0.15%	2.86%	3.00%
BOCA RATON REGIONAL	BOCA RATON	FL	0.00%	0.00%	0.18%	0.80%
WEST BOCA MEDICAL	BOCA RATON	FL	0.14%	0.16%	0.22%	0.50%
JUPITER MEDICAL CENTER	JUPITER	FL	0.00%	0.00%	0.00%	1.07%
ST MARY'S MEDICAL	WEST PALM	FL	0.01%	0.07%	0.27%	0.49%
WELLINGTON MEDICAL CENTER	WELLINGTON	FL	0.70%	0.13%	0.98%	1.27%
JFK MEDICAL CENTER	ATLANTIS	FL	0.77%	0.63%	0.98%	1.35%
BAYLOR ALL SAINTS	FORT WORTH	TX	0.00%	0.00%	0.00%	0.00%
JPS HEALTH NETWORK	FORT WORTH	TX	0.08%	0.03%	0.03%	0.08%
PLAZA MEDICAL CENTER	FORT WORTH	TX	0.30%	0.12%	0.00%	0.00%
THR - FORT WORTH	FORT WORTH	TX	0.59%	0.32%	0.19%	0.11%
NORTH SHORE UNIVERSITY	MANHASSET	NY	1.00%	0.98%	0.55%	0.39%
DUKE HEALTH RALEIGH HOSPITAL	RALEIGH	NC	0.06%	0.00%	1.43%	1.10%
REX HOSPITAL	RALEIGH	NC	0.15%	0.08%	0.04%	0.07%
WAKEMED, RALEIGH CAMPUS	RALEIGH	NC	0.28%	0.42%	0.38%	0.00%
RENOWN REGIONAL	RENO	NV	0.31%	0.10%	0.27%	0.02%
RENOWN SOUTH MEADOW	RENO	NV	0.00%	0.00%	0.12%	0.10%
NORTHERN NEVADA MED CENTER	SPARKS	NV	0.04%	0.13%	2.11%	1.42%

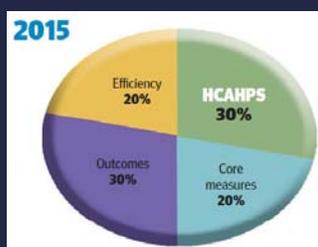
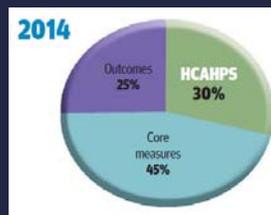
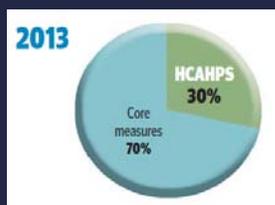


## CMS Bonuses/Penalties...

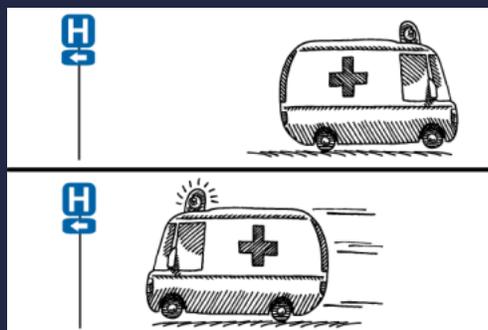
- Value-Based Purchasing (up to 1.5%)
  - Clinical process of care (12)
  - Patient experience (8)
  - Healthcare outcomes (5)
  - Efficiency (1)



# Value-Based Purchasing...



Hospital	City	State	Value-Based Purchasing Oct. 2012-Sept. 2013	Value-Based Purchasing Oct. 2013-Sept. 2014	Value-Based Purchasing Oct. 2014-Sept. 2015	Readmissions Penalty Oct. 2014-Sept. 2015	Total Penalty Oct. 2014-Sept. 2015	Hospital-Acquired Conditions Penalty Oct. 2014-Sept. 2015
Capital Regional	Tallahassee	FL	0.22%	-0.12%	-0.36%	-0.75%	-1.11%	N
Tallahassee Memorial	Tallahassee	FL	0.01%	-0.26%	-0.28%	0.00%	-0.28%	N
Memorial Hospital	Jacksonville	FL	0.21%	0.03%	-0.45%	-0.81%	-1.26%	Y
St Vincent's Medical Center	Jacksonville	FL	0.16%	-0.03%	0.01%	-0.76%	-0.75%	N
St Vincent's Medical Center	Jacksonville	FL	-0.16%	0.22%	1.00%	-2.86%	-1.86%	N
Florida Hospital	Orlando	FL	-0.04%	0.32%	-0.04%	-1.06%	-1.10%	N
Orlando Regional	Orlando	FL	-0.20%	-0.27%	-0.70%	-0.64%	-1.34%	N



## Efficiency Measure

Measure ID	Measure	2015 National Threshold	2015 National Benchmark
MSPB-1 NEW	Medicare Spending per Beneficiary	Median Medicare spending per beneficiary ratio across all hospitals during performance period	Mean of lowest decile of Medicare spending per beneficiary ratios across all hospitals during performance period



Hospital Name	Period		Avg Spending Per Episode (Hospital)	Avg Spending Per Episode (State)	Avg Spending Per Episode (Nation)
TALLAHASSEE MEMORIAL	1 to 3 days Prior to Index Hospital Admission	Outpatient	\$104	\$50	\$113
CAPITAL REGIONAL	1 to 3 days Prior to Index Hospital Admission	Outpatient	\$30	\$50	\$113



## Experience of Care Measures

HCAHPS	2015 Floor	2015 National Threshold	2015 National Benchmark
Communication with Nurses	47.77%	76.56%	85.70%
Communication with Doctors	55.62%	79.88%	88.79%
Responsiveness of Hospital Staff	35.10%	63.17%	78.06%
Pain Management	43.58%	69.46%	78.17%
Communication about Medicines	35.48%	60.89%	71.85%
Hospital Cleanliness & Quietness	41.94%	64.07%	78.90%
Discharge Information	57.67%	83.54%	89.72%
Overall Rating of Hospital	32.82%	67.92%	83.44%



## Patient Experience

- New “C-Suite” member
  - CXO – Chief Experience Officer
  - Responsible for maximizing satisfaction



## Hospitals Take Cues From The Hospitality Industry

By Roni Caryn Rabin | November 4, 2014

Two years ago, Inova Health System recruited a top executive who was not a physician, had never worked in hospital administration and barely knew the difference between Medicare and Medicaid.

***What Paul Westbrook specialized in was customer service. His background is in the hotel business – Marriott and The Ritz-Carlton, to be precise.***

He is one of dozens of hospital executives around the country with a new charge. ***Called chief patient experience officers***, their focus is on the service side of hospital care: improving communication with patients and making sure staff are attentive to their needs, whether that's more face time with nurses or quieter hallways so they can sleep.

**KHN**  
KAISER HEALTH NEWS



<http://kaiserhealthnews.org/news/hospitals-take-cues-from-the-hospitality-industry/>



## Mich. hospital goes luxe: CEO explains patient-centered approach

January 20, 2014

 CBS THIS MORNING

The newest innovation in health care may be the hospital itself.

Traditionally, hospitals were designed as a place for medical professionals to just do their job; they weren't often built with patients in mind. But that's not the case at one hospital near Detroit that looks and feels like a luxury hotel -- and treats patients like valued guests.

**At lunchtime at the Henry Ford Hospital in West Bloomfield, Mich., don't look for day-old Jell-O served on a fiberglass tray in the cafeteria. At this hospital, it's a restaurant -- with a menu comprised of fresh and healthy foods, much of which is grown on-site in their own greenhouse.**

Nancy Schlichting is chief executive officer of the Henry Ford Health System. Her goal was to build a new kind of hospital -- one that would become a go-to destination, a place people actually wanted to be.



<http://www.cbsnews.com/news/michigan-hospital-goes-luxe-ceo-explains-patient-centered-approach/>

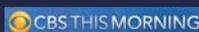


Schlichting recognized that hospitals needed an image makeover, **but she took a leap of faith by hiring an executive from Ritz-Carlton to design, and then run, the \$360 million facility. But there was only one rule: "The rule is that it's about the patient,"** Schlichting said. "We don't wake up (patients) between 9 at night and 5 in the morning . . . unless we have to."

The focus on patients begins immediately. Arriving guests are greeted by wheelchair valets in a lobby rivaling the world's finest hotels. They pass by a spa, the hair salon, and designer gift shops as they travel through an enclosed atrium to their private room.

Dr. Mark Rosenblum heads the hospital's neurosurgery department. He says the patient-focused approach speeds up the healing process.

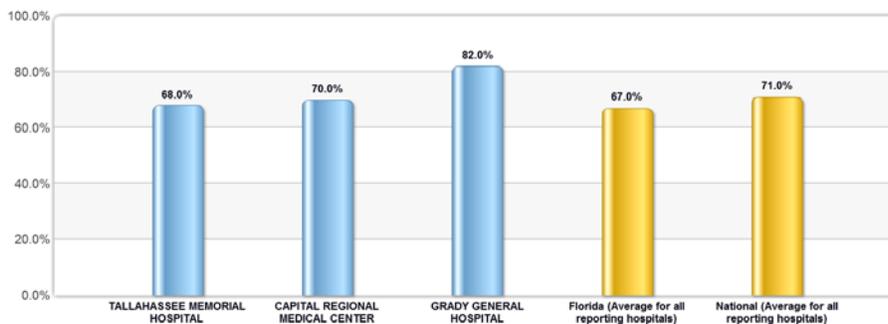
**"Any patient's family can stay here anytime, night or day," Rosenblum said. "It's important for a patient's well-being and recovery to see their loved ones, to be less in a stark, uncomfortable, unusual environment. We think it helps."**



**Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)**

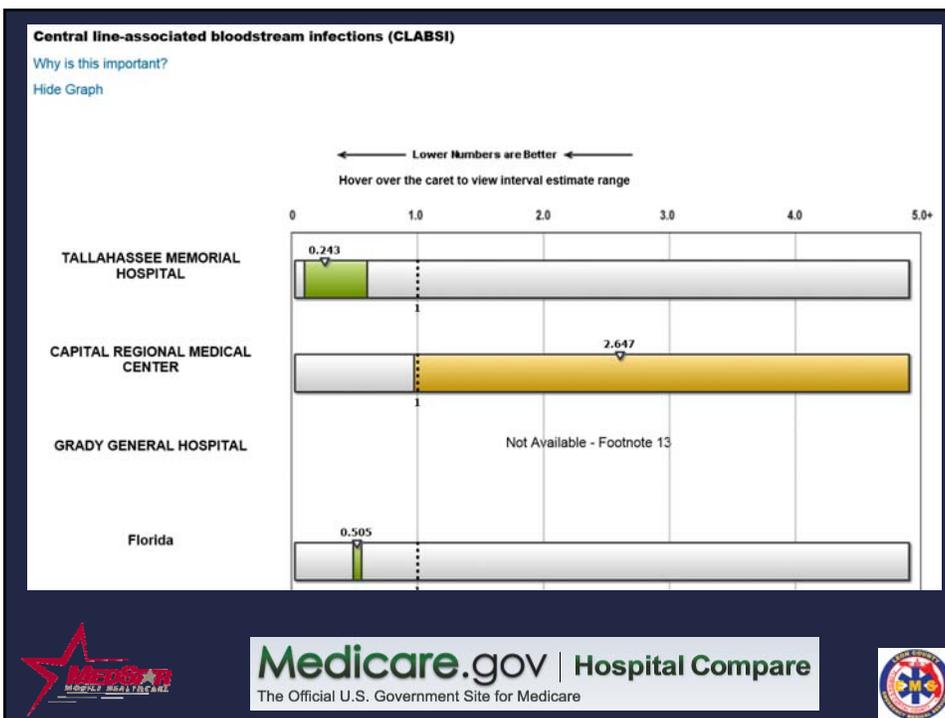
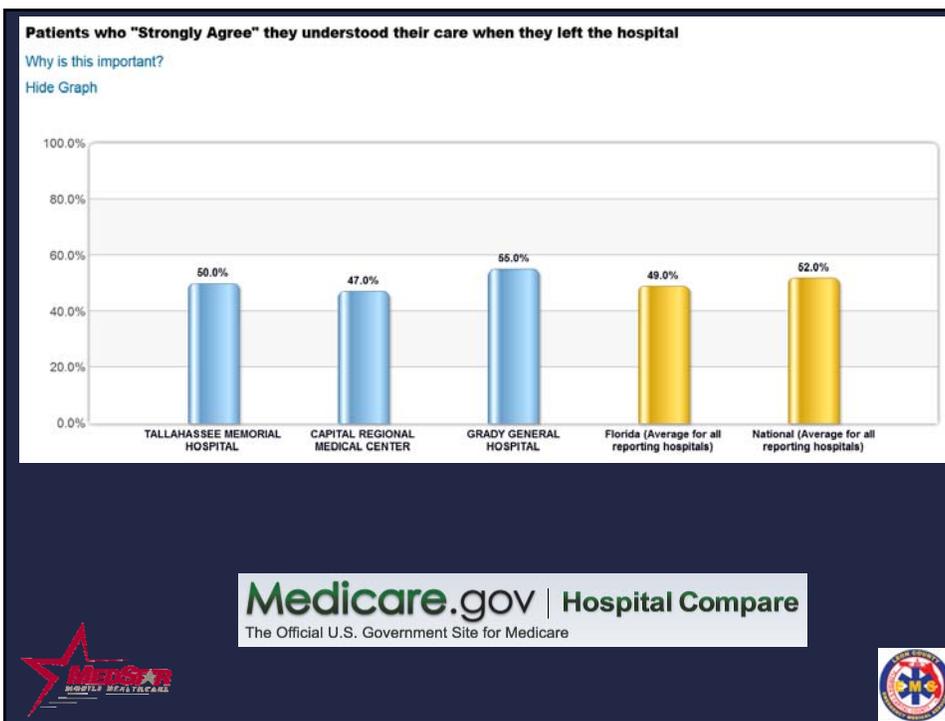
Why is this important?

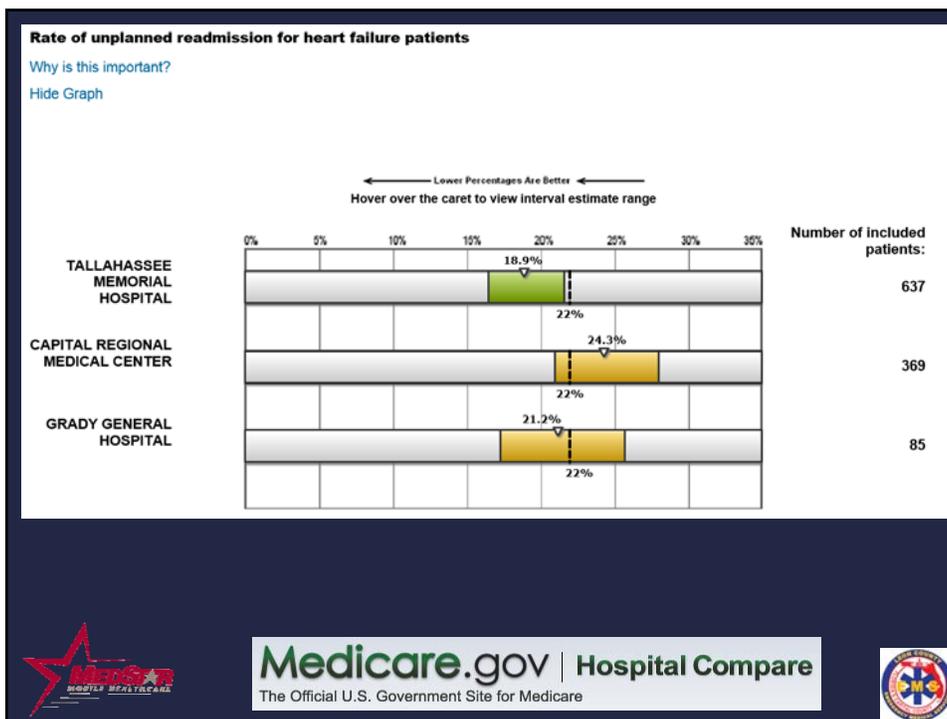
Hide Graph



**Medicare.gov | Hospital Compare**  
The Official U.S. Government Site for Medicare







### Kansas hospital to close next month

by Ayla Ellison  
September 03, 2015



Chesterfield, Mo.-based Mercy health system has announced it will close Mercy Hospital Independence (Kan.) next month, according to a KTUL report.

The hospital's inpatient services, emergency department and ambulatory surgery services will close on Oct. 10. Some outpatient and clinic services will remain open past that date, but are expected to close no later than Dec. 31, according to the report.

Mercy decided to close the hospital after exploring multiple options for the facility over the past 18 months. **Declining populations and utilization patterns, challenges recruiting and keeping physicians, increasing capital improvement needs and shrinking reimbursement were all cited as factors in the decision**, according to the report.

"This was not the outcome we had sought or expected at the beginning of the discernment process, and our hearts are heavy," said Lynn Britton, Mercy president and CEO.



<http://www.beckershospitalreview.com/finance/kansas-hospital-to-close-next-month.html>



### As outpatient care gains steam, one Texas hospital adopts a short-stay model

*Overhauls prompt closure worries in community, but more hospitals may want to consider abandoning their traditional model*

By Zack Budryk

July 27, 2015

To address an increased demand for outpatient services and a surplus of inpatient beds, one Texas hospital plans to create a short-stay center—and it's a move that other hospitals across the country may want to consider.

*Despite a recent uptick in inpatient use, industry experts expect declining inpatient volumes to continue and care shifting to outpatient settings.* Other factors play a part as well, including tepid elective admissions, continual pressure to keep readmissions low, care integration with an eye toward prevention and safer outpatient care due to increased technological innovation.

**For these reasons, Port Arthur, Texas, Christus Southeast Texas Health System plans to abandon its traditional hospital model and convert St. Mary Hospital to a short-stay center in early September.**

The hospital will retain about 251 of its 413 current staff.



<http://www.fiercehealthcare.com/story/outpatient-care-gains-steam-one-texas-hospital-adopts-short-stay-model/2015-07-27>



### HCA to close Florida hospital as inpatient volumes dwindle

By Bob Herman

September 24, 2014

**Modern  
Healthcare**

For-profit hospital giant HCA said Tuesday it will close one of its hospitals in Florida because of excess inpatient capacity in the region—a sign that healthcare reform continues to push patient volumes away from inpatient hospital settings and toward lower-cost outpatient facilities.

***HCA will shut down Edward White Hospital in St. Petersburg, Fla., by Nov. 24. Clinical services at the hospital—which has 162 licensed beds and 110 staffed beds***

The decline of inpatient utilization began several years ago during the recent recession, and has intensified as the Patient Protection and Affordable Care Act encourages providers to use less-costly, preventive measures.

A new report from consulting firm Kaufman Hall backs up those reports from health systems, ***finding that in the first half of this year, inpatient volumes were flat or fell for 68% of not-for-profit hospitals.***



<http://www.modernhealthcare.com/article/20140924/NEWS/309249963/hca-to-close-florida-hospital-as-inpatient-volumes-dwindle>





### HCA buying Dallas-based urgent care company, CareNow

Oct 28, 2014

Nashville-based health care giant HCA is buying Dallas-based CareNow, which owns [24 urgent care centers in Dallas-Fort Worth.](#)

"CareNow has a strong brand and will add an exceptional network of urgent care centers and 130 physicians that complement our hospital, emergency and outpatient services in Dallas-Fort Worth," said Sam Hazen, HCA president of operations.

["This transaction represents two trusted providers coming together to deliver a broader and more integrated level of quality health care services."](#)

DALLAS  
BUSINESS JOURNAL



<http://www.bizjournals.com/dallas/news/2014/10/28/hca-buying-dallas-based-urgent-care-company.html>



Spectrum Health is saving money by avoiding preventable readmissions. **"We understand where the world is going," Dickinson says. "We're not going to be able to continue to make money in acute care by hospitalizing people. We need to shift to take care of them."**

Michael Dickinson,  
Medical Director for Heart Failure  
and Heart Transplant at the  
Frederik Meijer Heart & Vascular Institute



[http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF\\_Common/NewsArticle/data/HHN/Magazine/2013/May/0513HHN\\_Feature\\_clinical](http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2013/May/0513HHN_Feature_clinical)



# *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



## “EMS?”

### 10-year % change of overall call volume...

Call Type	% Increase
<b>Interfacility</b>	<b>11.32%</b>
<b>Sick Person</b>	<b>10.37%</b>
Falls	5.87%
Unc Person	5.20%
Assault	4.21%
Convulsions	4.16%
Psyc.	3.76%

Call Type	% Decrease
Abd Pain	2.83%
Traum Inj.	3.71%
Chest Pain	7.97%
<b>MVA</b>	<b>10.38%</b>
<b>Breath. Prob.</b>	<b>10.48%</b>





# Unscheduled Medical Services!



## Conundrum...

- Misaligned Incentives
  - Only paid to transport
  - “EMS” is a *transportation* benefit
  - NOT a *medical benefit*



## Our Role?

“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.”



VIEWPOINT

**JAMA**  
The Journal of the American Medical Association

## Realigning Reimbursement Policy and Financial Incentives to Support Patient-Centered Out-of-Hospital Care

Kevin Munjal, MD, MPH

Brendan Carr, MD, MS

668 JAMA, February 20, 2013—Vol 309, No. 7



### Financing Out-of-Hospital Care

National EMS expenditures from Medicare are approximately \$5.2 billion per year.<sup>4</sup> Although this is less than 1% of total Medicare expenditures, there are considerable downstream health care costs associated with patients transported to emergency departments.<sup>2</sup> An average EMS agency receives 42% of its operating budget from Medicare fees, 19% from commercial insurers, 12% from Medicaid, and 4% from private pay; it requires approximately 23% in additional subsidization, most often provided by local taxes.<sup>2</sup> Thus, more than three-fourths of EMS revenue is generated from fee-for-service reimbursement, the service being transportation, not necessarily medical care.



### Conclusions

Current Medicare reimbursement policies for out-of-hospital care link payment to transport to an emergency department. This provides a disincentive for EMS agencies to work to reduce avoidable visits to emergency departments, limits the role of prehospital care in the US health system, is not responsive to patients' needs, and generates downstream health care costs. Financial and delivery model reforms that address EMS payment policy may allow out-of-hospital care systems to deliver higher-quality, patient-centered, coordinated health care that could improve the public health and lower costs.



COST & PAYMENT

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

DOI: 10.1377/hlthaff.2013.0741  
HEALTH AFFAIRS 32,  
NO. 12 (2013): 2142-2148  
©2013 Project HOPE—  
The People-to-People Health  
Foundation, Inc.

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

**ABSTRACT** Some Medicare beneficiaries who place 911 calls to request an ambulance might safely be cared for in settings other than the emergency department (ED) at lower cost. Using 2005–09 Medicare claims data and a validated algorithm, we estimated that 12.9–16.2 percent of Medicare-covered 911 emergency medical services (EMS) transports involved conditions that were probably nonemergent or primary care treatable. Among beneficiaries not admitted to the hospital, about 34.5 percent had a low-acuity diagnosis that might have been managed outside the ED. Annual Medicare EMS and ED payments for these patients were approximately \$1 billion per year. If Medicare had the flexibility to reimburse EMS for managing selected 911 calls in ways other than transport to an ED, we estimate that the federal government could save \$283–\$560 million or more per year, while improving the continuity of patient care. If private insurance companies followed suit, overall societal savings could be twice as large.

**Abby Alpert** is an assistant professor of economics and public policy at the Paul Merage School of Business, University of California, Irvine.

**Kristy G. Morganti** is a health policy researcher at the RAND Corporation in Pittsburgh, Pennsylvania.

**Gregg S. Margolis** is director of the Division of Healthcare Systems and Health Policy, Department of Health and Human Services, in Washington, D.C.

**Jeffrey Wasserman** (jeffrey@rand.org) is director of RAND Health and vice president of the RAND Corporation in Santa Monica, California.




## Mobile Integrated Healthcare

- EMS Loyalty Program
- System Abusers
- 9-1-1 Nurse Triage
- CHF/High Risk Dx Readmissions
- Observational Admission Avoidance
- Hospice Revocation Avoidance
- Home Health Partnership




**Patient Navigation vs. Primary Care**






## Mobile Integrated Healthcare Programs

- “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



## EMS Loyalty Program

- 296 Patients enrolled
  - 2013 – 2015
- 160 **graduated** patients with 12 month data pre and post enrollment as of June 30, 2015...
  - **During enrollment (30 – 90 days)**
    - 39.6% reduction in 9-1-1 to ED use
  - **Post Graduation**
    - 56.2% reduction in 9-1-1 to ED use
    - 85.2% in reduction for “System Abusers”



### Expenditure Savings Analysis (1)

Based on Medicare Rates

### High Utilizer Program - THR and JPS Combined

Analysis Dates: **October 1, 2011 - June 30, 2015**

Number of Patients Enrolled (2): **142**

Category	Utilization Changes		
	Base	Avoided	Savings
ED Payments (4)	\$969	-2240	(\$2,170,560)
Admission Payments (5)	\$10,500	-574	(\$6,027,000)
<b>Hospital Expenditure Savings</b>			<b>(\$8,197,560)</b>
Ambulance Payments	\$419	-2841	(\$1,190,379)
<b>Total Expenditure Savings</b>			<b>\$9,387,939</b>
<b>Per Patient Enrolled</b>			<b>HUG</b>
<b>Payment Avoidance</b>			<b>\$66,112</b>

**Notes:**

1. Comparison for enrolled patients based on use for 12 months prior to enrollment vs. 12 months **post program graduation.**
2. Patients with data 12 months pre and 12 months post graduation
3. Average Medicare payment from Medicare Utilization Tables
4. <http://www.cdc.gov/nchs/data/hus/hus12.pdf>
5. <http://www.hcup-us.ahrq.gov/reports/projections/2013-01.pdf>



**Patient Self-Assessment of Health Status (1)**  
As of: 6/30/2015

	High Utilizer Group			Readmission Avoidance		
	Enrollment	Graduation	Change	Enrollment	Graduation	Change
<b>Sample Size</b>	<b>55</b>			<b>41</b>		
Mobility (2)	2.33	2.55	9.4%	2.37	2.41	1.7%
Self-Care (2)	2.65	2.82	6.4%	2.54	2.76	8.7%
Perform Usual Activities (2)	2.24	2.58	15.2%	2.27	2.51	10.6%
Pain and Discomfort (2)	<b>1.98</b>	<b>2.52</b>	<b>27.3%</b>	2.44	2.68	9.8%
Axiety/Depression (2)	<b>2.11</b>	<b>2.51</b>	<b>19.0%</b>	<b>2.32</b>	<b>2.63</b>	<b>13.4%</b>
<b>Overall Health Status (3)</b>	<b>5.18</b>	<b>6.85</b>	<b>32.2%</b>	<b>4.88</b>	<b>6.78</b>	<b>38.9%</b>

**Notes:**

1. Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionnaire
2. Score 1 - 3 with 3 most favorable
3. Score 1 - 10 with 10 most favorable




## The Real Benefits:



“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.”

**Antoine Hall, MIH/CHP Patient**  
Enrolled 11/20 – 12/29/13

*Used by special permission from Antoine Hall*




# Antoine Analysis

	Before	After	Change	Avg. Payment	Expenditure Savings
Ambulance Transports	11	0	-11	\$427	(\$4,697)
ED Visits	12	0	-12	\$774	(\$9,288)
Inpatient Admissions	4	0	-4	\$9,203	(\$36,812)

MIH Visits	22
MIH Visit Expenditure per Contact	\$75
MIH System Costs	\$1,650

**Healthcare System Savings**

**(\$49,147)**



# Readmission Avoidance

- At-Risk for readmission
  - Referred by cardiac case managers
  - Routine home visits
    - **In-home education!**
    - Overall assessment, vital signs, weights, 'environment' check, baseline 12L ECG, diet compliance, med compliance
    - **Feedback to primary care physician (PCP)**
  - Non-emergency access number for episodic care
  - Decompensating?
    - Refer to PCP early
    - In-home diuresis



### Readmit Program Analysis

June 2012 - June 2015 **JPS & THR Combined**  
*Patient Enrollments (1, 3) 119*

	30 Day ED Visits	30 Day Admissions
Count	43	33
Rate	36.1%	27.7%
Rate Reduction (2)	<b>63.9%</b>	<b>72.3%</b>
Expenditure per Admission (4)		\$ 10,500
Admissions Avoided		86
Expenditure Savings		\$ (903,000)
<b>Admission Savings Per Patient</b>		<b>\$ (7,588)</b>

**Notes:**

1. Patient enrollment criteria **requires a prior 30-day readmission** and the referral source **expects the patient to have a 30-day readmission**
2. **Compared to the anticipated 100% readmission rate**
3. Enrollment Period at least 30 days and less than 90 days
4. <http://www.hcup-us.ahrq.gov/reports/projections/2013-01.pdf>




### Mobile Healthcare Programs

Patient Experience Summary  
Through June 30, 2015

	Program		
	HUG	CHF	Overall Avg
Medic Listened?	4.98	4.86	4.92
Time to answer your questions?	4.96	4.86	4.91
Overall amount of time spent with you?	4.98	4.86	4.92
Explain things in a way you could understand?	4.98	4.92	4.95
Instructions regarding medication/follow-up care?	4.98	4.82	4.90
Thoroughness of the examination?	4.96	4.84	4.90
Advice to stay healthy?	4.96	4.92	4.94
Quality of the medical care/evaluation?	4.98	4.85	4.92
Level of Compassion	4.98	4.85	4.92
Overall satisfaction	4.92	4.85	4.89
<b>Recommend the service to others?</b>	<b>97.8%</b>	<b>100.0%</b>	<b>98.9%</b>

**Select Comments:**

Client states "You care more about my health than I do."  
 "Keep the same compassionate, excellent people you have working for you now and your service will continue to be great! Everything was perfect, a 10!"  
 "y'all have been off the charts helpful" "no complaints" "glad the hospital got it going for me"  
 "Thank you very much! We couldnt have done this without you!"  
 "The medics spent lots of time with me and provided very useful information. I really loved the program. They were very friendly and did an awesome job."  
 "I love y'all, wonderful, Y'all 2 have been really big help and great with patience with me even though I'm a hard headed lil ol lady."




## 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

- Key = Referral Network
- Engaged hospital & community partners
  - Funding from hospitals
    - Know your stakeholder value proposition
- 40.0% of referred patients to alternate dispositions
- Future?
  - Physician/Hospital call services
  - Telehealth/patient monitoring
  - Rx compliance/reminders
  - Connect with payer databases?



IHI Triple Aim Initiative

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs



### 9-1-1 Nurse Triage Patient Satisfaction

Through July 31, 2015

	Score
Please rate (2) the following: (N=279)	
The 9-1-1 call taking process	4.75
How the nurse handled call	4.73
If you feel the nurse understood your medical Issue	4.75
Your satisfaction with recommendation	4.59
The alternate transportation provided	4.55
<u>Did Your Medical Issue... (N=277)</u>	
Get Better	84.2%
Stay the Same	12.6%
Get Worse	3.2%
<u>Did Speaking with the Nurse Help? (N=273)</u>	
Yes	92.1%
No	7.9%
<u>Did Disposition Save Time and Money? (N=246)</u>	
Yes	94.7%
No	5.3%
<u>Should Your Call Have Been Handled Differently? (N=274)</u>	
No	85.0%
Yes	15.0%



### Expenditure Savings Analysis

### 9-1-1 Nurse Triage Program

Based on Medicare Rates

Analysis Dates: June 1, 2012 - July 31, 2015

Number of Calls Referred: 3,589  
 % of Calls with Alternate Response 37.5%  
 % of Calls with Alternate Destination 31.2%

Category	Base	Avoided (4)	Savings
Ambulance Expenditure (1)	\$419	1,346	\$563,974
ED Expenditure (2)	\$969	1,119	\$1,084,311
ED Bed Hours (3)	6	1,119	6,714
<b>Total Payment Avoidance</b>			<b>\$1,648,285</b>

<b>Per Patient Enrolled</b>	<b>ECNS</b>
<b>Payment Avoidance</b>	<b>\$1,225</b>

**Notes:**

1. From Medicare Payment Tables
2. <http://www.cdc.gov/nchs/data/hus/hus12.pdf>
3. Provided by John Peter Smith Health Network
4. Result of EPAB approved change to allow locus of care to include ED visit by alternate transportation





## Framing the Home Health Issues

- Penalized for readmissions
  - No more hospital referrals
  - CMS Penalties
- High cost of night/weekend demand services
- Don't know when their patients call 911
  - No opportunity for pre-admission care coordination
  - Reduced ability for post-discharge care coordination



## Home Health Partnerships



## How it Works

- Protocols established between HH agency and MedStar Medical Director
- Specialized training provided
  - HH trains MIH Providers in common procedures
  - MedStar ride outs by RNs
- HH agency registers client w/MedStar
- MedStar EMR created
- 9-1-1 CAD address flag created



## How it Works

- If client calls 9-1-1
  - Appropriate units dispatched + MIH Provider
  - Comm Center notifies HH agency hotline
  - On scene MHP calls HH nurse from scene
  - Care coordination occurs
- If client calls HH agency
  - AND, HH agency wants MedStar to cover
  - HH agency calls MedStar for scene/home visit
  - MIH provider calls RN from the home for care coordination



## Home Health Care Coordination Examples

Client: RoXXXX, John H – 19XX-10-07  
 Status: Active  
**Visit Date: 11/1/2015**  
**Visit Acuity: Unscheduled Visit**  
 Transport Resource: N/A

Program: Home Health - 911  
 Referring Source: Klarus  
**Visit Type: Home Visit**  
 Visit Outcome: MHP Call Complete  
 Response Number: 151101297

Note By: Andrew Hatcher

Arrived on scene to find Mr. RoXXXX sitting upright at his dining room table, **appearing slightly tachypneic and distressed. He tells me that he has been feeling unwell since he woke up this morning around 0500.** He goes on to say that he has experienced decreased appetite for approximately one week. He has increasing weakness today as well. **He has gained 1lb in 24 hrs (117.4) I was present when the chest X-ray tech came to do imaging. The film showed the left lung with fluid at the base.**

Auscultation revealed clear breath sounds in the right upper and right upper, but severely diminished lung sounds on the upper left and upper left lung fields. There was no rales or rhonchi heard.



**Istats** were drawn with the following results:

Na; 135K: 4.6Cl; 104iCa; 1.11TcO2; 26Glu: 117BUN; 68Crea: 2.2HCT: 38Hb; 12.9aGap: 11

**I called Beverley RN from Klarus and discussed my findings. She desires 40mg IVP Lasix, 20MEQ Potassium, and 2.5 Metolazone be administered for exacerbation of CHF. I administered 40mg Lasix in the right antecubital fossa through a 22g intravenous catheter. Beverley said she will follow up with him in the morning.**

**I provided a urine hat and explained how to measure his urine output to his family. They verbally understand.** Intravenous access is discontinued after medication administration. I witnessed both other oral medications self administered by Mr. RoXXXX .

EENT: atraumatic; mucus membranes are moist Thorax; atraumaitc; no tenderness upon palpation-ICD in the right chest-diminished breath sounds left lung fields Lower extremities; +4 pitting edema on right leg, +3 pitting edema on the left leg upper extremities; atraumatic; no tenderness upon palpation.



**Client:** XXXXX, James I – 19XX-10-14

**Program:** Home Health

**Visit Date:** 9/20/2015

**Visit Acuity:** 911 Call

**Referring Source:** Klarus

**Visit Type:** Home Visit

**Response Number:** 150920215

**Note By:** Andrew Hatcher

Arrived on scene with Medstar unit attending to Mr. XXXX. They inform me that Mr. XXXX was walking into his house utilizing a walker assist device and become very dyspneic. This started around 1310 and lasted approximately 20min. He sat down in his chair and his symptoms ceased.

Family and private nurse on scene inform me that Mr. Perry has had a 4-5 pound gain in a three day period. They also notice bilateral ankle swelling, which is abnormal for Mr. Perry. Family also indicates that his blood pressure has been high lately.

**I draw labs.**

**I contact Sean RN from Klarus and discuss this case. He takes 20mg Lasix 1x/day. Sean asks me to administer 40mg Lasix IVP and follow up approximately 5hrs later to re-evaluate and draw labs. Mr. XXXX does not take K+, nor is he on a fluid restriction. I advised to drink some water during this process, but no more than 1500ml total /day.**

I release Medstar ambulance from scene.

Family gathers a bedside commode from a neighbor and I provide them **hat for calculation of urine output.** They will use their own scale for the follow up weight.



Client: XXXX, Clara L - 1934-03-06

Visit Date: **8/21/2015**

Visit Acuity: **911 Call**

Response Number: 150821007

Program: Home Health - 911

Visit Type: Home Visit

Transport Resource: N/A

Note By: Ronald Moren

Family called 911 and stated pts BGL was 29. On EMS arrival, family had managed to give pt a few mouthfuls of honey and BGL was 32. Pt found lying in bed pt is alert to painful stimuli only. Pt is atraumatic. BBS are clear, =, bilateral with good chest rise and fall. Abd is soft and non-tender with no masses noted. Pt has a PICC line in right arm that she receives daily antibiotics from family through.

**PICC line was accessed and approx 7 ml fluid withdrawn. IV D-10 was started and 250 ml was infused. Pt became A&OX4 and BGL increased to 188. Pts daughter cooked her some eggs and gave her an ensure to drink.**

Pt states she feels much better and does not want to go to the ER at this time. It was explained to the patient and her family that a large decrease in blood sugar, while may be expected, should still be evaluated by a physician. Pt and family still did not want to go to the ER. **Pt and family were educated on possible problems with low BGL including falls, syncope, AMS, & seizures. Family was instructed to monitor blood glucose levels and to contact KLARUS and/or her PCP in the morning. Family was also instructed to call 911 again if pts condition changes.**

**KLARUS was contacted and message left, RN (Diane) called back and confirmed message received and advised she would have somebody go out and see patient in the morning.**



Program: Home Health

Visit Date: **8/6/2015**

Visit Acuity: **Unscheduled Visit**

Response Number: 150806056

Referring Source: Klarus

Visit Type: Home Visit

Visit Outcome: MHP Call Complete

Note By: Brandon Pate

Note:

**Lisa, RN, from Klarus called the Communications Center and requested a CCP evaluation of this client after she inadvertently removed her colostomy bag.**

Upon arrival, the client is ambulatory, conscious and alert, oriented to person only; this is consistent with her baseline, per the assisted living staff. The client has no complaints of pain or symptoms; she denies having chest pain, shortness of breath, a headache, nausea, vomiting, diarrhea, weakness, dizziness, and abdominal pain. The client reports she inadvertently removed her colostomy bag.

Upon exam.....

**I called Lisa and informed her of my assessment findings. She subsequently provided the procedure for a colostomy bag change. The skin around the stoma was cleansed with a skin prep solution and wipes. Stoma powder was applied. The skin around the stoma was cleansed a second time. The flange was sized and applied around the stoma, using pressure in a circular, outward motion to ensure adhesion. The stoma bag was attached to the flange without difficulty. A staff member from the assisted living facility remained at the bedside during the procedure. Following completion, the staff remained with the client. Call complete.**



**Note:**

AOSTF 28 yo male sitting on couch. He states that he is SOB, his abdomen is distended and his legs are swollen all of this since 2000 this evening. He also reports his pump was alarming starting at 2100 and he shut it off.

Pt. requires Milrinone continuous infusion and the pump was reading a high pressure alarm. Pt. also reports a cough this evening. *In reviewing his HX he has CHF with an EF of 20-25% and CKD.* He reports he feels like he always does when he gets fluid overloaded. *Pt. also reports a 4 lb. weight gain in the last 24 hrs. Upon exam noted pt. in mild -moderate resp. distress with SPO2 in the 80's off his O2. In reviewing some old notes he does not like to wear his O2.* Pt. is A&OX4, PPTe, MAE. Pt. is mildly tachycardic, BS clear upper and crackles in bases. ST on 12-lead W/O elevation.

Abdomen appears distended though I have never seen this pt. in the past. Pt. has 3+ edema in lower ext. PICC line port being used for Milrinone infusion was occluded. PICC was flushed and infusion resumed. *Chem 8 was obtained. NA 133, K+ 3.7, Cl 97, CA 1.19, Tco2 36, Glucose 143, BUN 38, Cre 1.3, Hct 40, Hgb 13.6A Gap 5. Pt. was given Lasix 80mg SIVP and advised to double his morning potassium dose. The importance of wearing his O2 was again stressed. I discussed the plan with pt. to ensure he felt capable of staying at home and that was his preference.*

Pt. stated he had a urinal and was advised to use it and write down all of his output between now and when he sees the nurse. He was advised to call back for any issues or worsening of condition. *I also spoke with Sean at Klarus and he is good with plan. Klarus will follow up tomorrow with client.*



**Utilization Outcome Summary**  
*Home Health Partnership*

As of: **Sep-15**

	#	%
<b>Enrollments by Home Health Agency</b>	<b>804</b>	<b>100.0%</b>
<i>9-1-1 calls by Enrolled Patients</i>	<i>537</i>	<i>66.8%</i>
9-1-1 Calls by Enrolled Patients with a CCP on-scene	245	45.6%
<b>ED Transports when CCP on Scene</b>	<b>93</b>	<b>38.0%</b>
Home Visits Requested by Agency	187	23.3%
ED Transports from home visits requested by Agency	9	4.8%



## Framing the Hospice Issue:

- Patients & families want the patient to pass comfortably at home
- Hospice wants the patient to pass peacefully at home
- Death is scary
- When death is near....
  - 9-1-1 call challenging for EMS
- 9-1-1 usually = Hospice Revocation
  - Voluntary or involuntary



## Hospice Partnerships



## Economic Model

- 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 recommends increase hospice enrollment



## How it Works

- Protocols established between Hospice agency and MedStar Medical Director
- Specialized training provided
  - Hospice trains MIH Providers in common procedures
  - MedStar ride outs by RNs
- Hospice agency registers “At-Risk” client w/MedStar
- 9-1-1 CAD address flag created



## How it Works

- 1 home visit by MHP
  - Reinforce hospice relationship w/MedStar backup
- If client calls 9-1-1
  - Appropriate units dispatched + MIH Provider
  - Comm Center notifies on-call nurse
  - On scene:
    - Non-hospice hospice related call = treat and transport as usual
    - Hospice related call:
      - Care coordination occurs



## Special Note

- MHPs trained to have “The Conversation” with patients enrolled in other programs
  - Or POLST/MOST, etc.



## Hospice Program Summary

Sept. 2013 through Sept. 2015

	#	%
Referrals (1)	249	
<b>Enrolled (2)</b>	<b>168</b>	
Deceased	116	69.0%
Active	28	16.7%
Improved	2	1.2%
<b>Revoked (3)</b>	<b>24</b>	<b>14.3%</b>

### Activity:

EMS Calls	57	
Transports	20	<b>35.1%</b>

### Notes:

- (1) Patients referred who are identified as at high risk for voluntary disenrollment, or involuntary revocation.
- (2) Difference results from referrals outside the MedStar service area, or patients who declined program enrollment.
- (3) Patients who either voluntary disenrolled, or had their hospice status revoked.



## Home Health, Hospice and EMS Team Up to Tackle the Triple Aim

Outside the hospital, community resources can work together for better care of patients

The drive to achieve the IHI's Triple Aim has fostered the creation of many innovative partnerships. This column focuses on the synergistic relationships and integrations developing between mobile integrated healthcare (MIH) and the home healthcare industry.

One of the main goals of MIH is to navigate patients through the healthcare system, not replace healthcare system resources already available in the community. Home health and hospice are valuable links in the chain of healthcare—and, for qualifying patients, a logical care delivery model that can be enhanced through a partnership with a mobile player like the local EMS agency.

Increased Referrals Home health increasingly is by hospice to reduce prevent department visit admissions. Pa health services multiple chron polypharmacy significant risk or hospital ad

www.



### Meredith Anastasio

Meredith Anastasio is managing director at the Lincoln Healthcare Group (LHG) and leads the planning of Home Care 100 and Home Care & Hospice LINK.

### J. Daniel Bruce

J. Daniel Bruce is the administrator of Klarus Home Care in Fort Worth and is responsible for the ongoing relationship with MedStar. He is a leader in the development of partnerships to create value-based services.

### John Mezo

John Mezo is the general manager for VITAS Healthcare in Fort Worth, overseeing program operations, developing business opportunities, hiring and mentoring new staff and representing VITAS throughout the community.



These are just a few examples of how EMS-MIH and home health can work collaboratively together to meet the needs of the patient, and the needs of the agency. It is not a competitive relationship, but rather a cooperative relationship designed to meet the needs of the patient – a marriage made in heaven!

A more in-depth look at MIH programs and their current work with home health and hospice partners (Klarus & VITAS; Centura Health at Home) will be presented at the 2015 Home Care 100 Executive Leadership Conference. For additional information or to register, please visit [www.homecare100.com](http://www.homecare100.com). ■



EMS Healthcare and Home Care: Special Report



## Funding Models

- Fee for Service
  - Patient contact fee
- Enrollment fee
  - Per enrolled patient
  - Shared risk for utilization of MIH providers
- Population-based
  - PM/PM fee for all enrolled patients
- Program Cost
  - Joint funding for specific project/outcomes



## Who's Paying?

- The one who is financially 'at risk'
  - Hospitals
    - Readmissions
    - HUG patients without a payer source
  - 3<sup>rd</sup> Party payers (including Medicaid)
    - Admissions/readmissions
    - ED visits
  - Shared-Risk partnerships (ACOs, etc.)
    - Admissions/readmissions



## Who's Paying?

- The one who is financially 'at risk'
  - Hospice
    - For enrolled patients
  - Home Health
    - For enrolled patients
  - Local Governments
    - ONLY if they view as valuable, or reduce spending





**AHRQ HEALTH CARE INNOVATIONS EXCHANGE**  
Innovations and Tools to Improve Quality and Reduce Disparities

**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 patient 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 in-depth 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.




MedStar Mobile Healthcare

MOBILE INTEGRATED HEALTHCARE Approach to Implementation MedStar Mobile Healthcare

# MOBILE INTEGRATED HEALTHCARE

Approach to Implementation



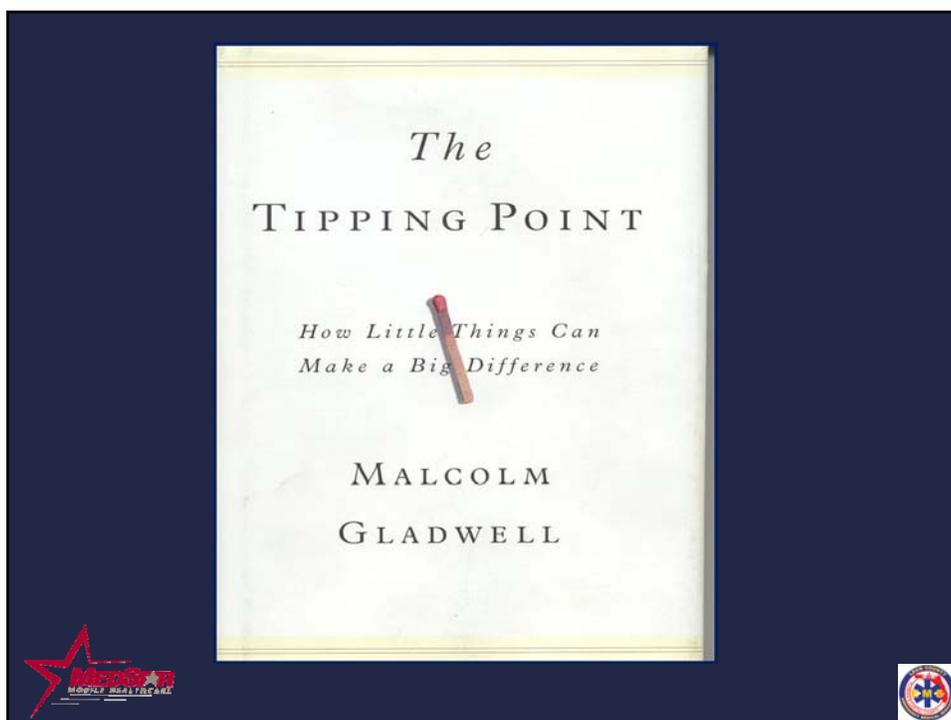



***“Mobile Integrated Healthcare is an innovative and patient-centered approach to meeting the needs of patients and their families. The model does require you to “flip” your thinking about almost everything – from roles for health care providers, to what an EMT or paramedic might do to care for a patient 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



**2009 = 4 Programs**

**2014 = 160 Programs**

### Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)



Insights on the development and characteristics of these innovative healthcare initiatives, based on national survey data

Presented by the National Association of Emergency Medical Technicians



Sponsored by **ZOLL** | **Amytime** | **PHILIPS**




## Samples of Other Programs

- CMS CMMI HCIA Grants
  - \$60 million in 6 programs
- REMSA (NV)
- Wake County (NC)
- UPMC (PA)
- Eagle County (CO)
- Dallas Fire/Rescue (TX)
- Mesa Fire & Medical (AZ)
- Christian Hospital EMS, St. Louis (MO)
- North Memorial Medical Center (MN)
- California Pilot Projects



## Paramedics Aren't Just for Emergencies

Home visits for lab tests, IV medications and hospital follow-up

By Laura Landro

Aug. 17, 2015

THE WALL STREET JOURNAL

Paramedics, who race to emergencies and transport victims to the nearest ER, are taking on a new role: keeping patients out of the hospital.

In this new role, paramedics augment existing programs like visiting nurse services and home care. ***They also treat patients who don't meet home-nursing criteria or don't want someone in their home all the time but still have complex needs, says David Schoenwetter, an emergency physician and head of the mobile health paramedic pilot program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, Pa., part of Danville, Pa.-based Geisinger Health System.***

The programs aim to reduce the high costs of emergency room visits and inpatient hospital stays. Hospitals are facing financial penalties from Medicare and other payers when patients are readmitted to the hospital within 30 days of being discharged.

days among 704 patients who had a home visit from a paramedic, Geisinger calculates. From March 2014 to June 2015, the Geisinger mobile health team prevented 42 hospitalizations, 33 emergency department visits and 168 inpatient he case of heart-failure patients, hospital admissions and emergency-room visits were reduced by 50%, and the rate of hospital readmissions within 30 days fell by 15%. Patient satisfaction scores for the program were 100%.



<http://www.wsj.com/articles/paramedics-aren-t-just-for-emergencies-1439832074>



## Paramedics work to keep patients out of the E.R.

Anna Gorman, Kaiser Health News

May 10, 2015

USA TODAY  
A Gannett Company

Around the country, the role of paramedics is changing. ***In various states, they're receiving extra training to provide more primary and preventive care and to take certain patients to urgent care or mental health clinics rather than more-costly emergency rooms.*** Ramsdell and others in his program, for instance, spent 150 hours in the classroom and with clinicians learning how to provide ongoing care for patients.

Using a \$9.8 million federal grant, Gubbels' agency launched three different projects. In addition to providing paramedic home visits and offering 911 callers options besides the ER, the agency started a nurse-run health line to give people with health questions another number to call in non-emergency situations.

***An early evaluation by the University of Nevada, Reno, which was based on insurance claims and hospital data, shows that the projects saved \$5.5 million in 2013 and 2014. They helped avoid 3,483 emergency department visits, 674 ambulance transports and 59 hospital re-admissions,*** according to the preliminary data. The federal government plans to do its own evaluation.



<http://www.usatoday.com/story/news/2015/05/10/paramedics-work-to-keep-patients-out-of-e-r/70949938/>



## Change From the Inside Out – Health Care Leaders Taking the Helm

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

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

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

**JAMA** The Journal of the  
American Medical Association



<http://jama.jamanetwork.com/article.aspx?articleid=2210910>



### Triple threat: Achieve multiple goals with community paramedics

by Chrissy Wild  
**October 2, 2015**



Many health systems embarking on population health initiatives know they need to bolster their partnerships with community resources, but don't know where to focus their efforts. ***Community paramedicine is a great place to start.***

*Community paramedics receive advanced training, allowing them to provide a range of in-home services, such as health coaching and home safety assessments for your rising- and high-risk patients. They can also help you reduce your ED volumes by providing in-home treatments to frequent 911 callers whose needs are not emergent, and reduce your readmission rates by performing post-discharge check-ups on at-risk patients.*

#### How do I measure success?

Many programs compare their targeted patient population's number of 911 calls, ED visits, admissions and readmissions, and total cost of care prior to program enrollment to those metrics post-enrollment. These basic metrics serve as a barometer for the program's success and are useful in demonstrating the ROI of the program to organization leaders and private payers for reimbursement purposes.



<https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2015/10/community-paramedicine-webcon-recap>





## Key Question #2

- If you had a magic wand and could change one thing, but **ONLY 1** thing about in our community's healthcare system, what would you change?
  - money and resources are no object



## Key Question #3

- What are the current barriers to change in our community's healthcare system?



## Key Question #4

- Who is not at the table today who should be (either by agency, role or name)?



## Key Question #5

- What are the top 3 gaps in healthcare services in our community?



