JUSTIN P. DUNCAN

Chief Executive Officer

Washington County Ambulance District | Regional Mobile Healthcare System

President

Missouri Emergency Medical Services (EMS) Association

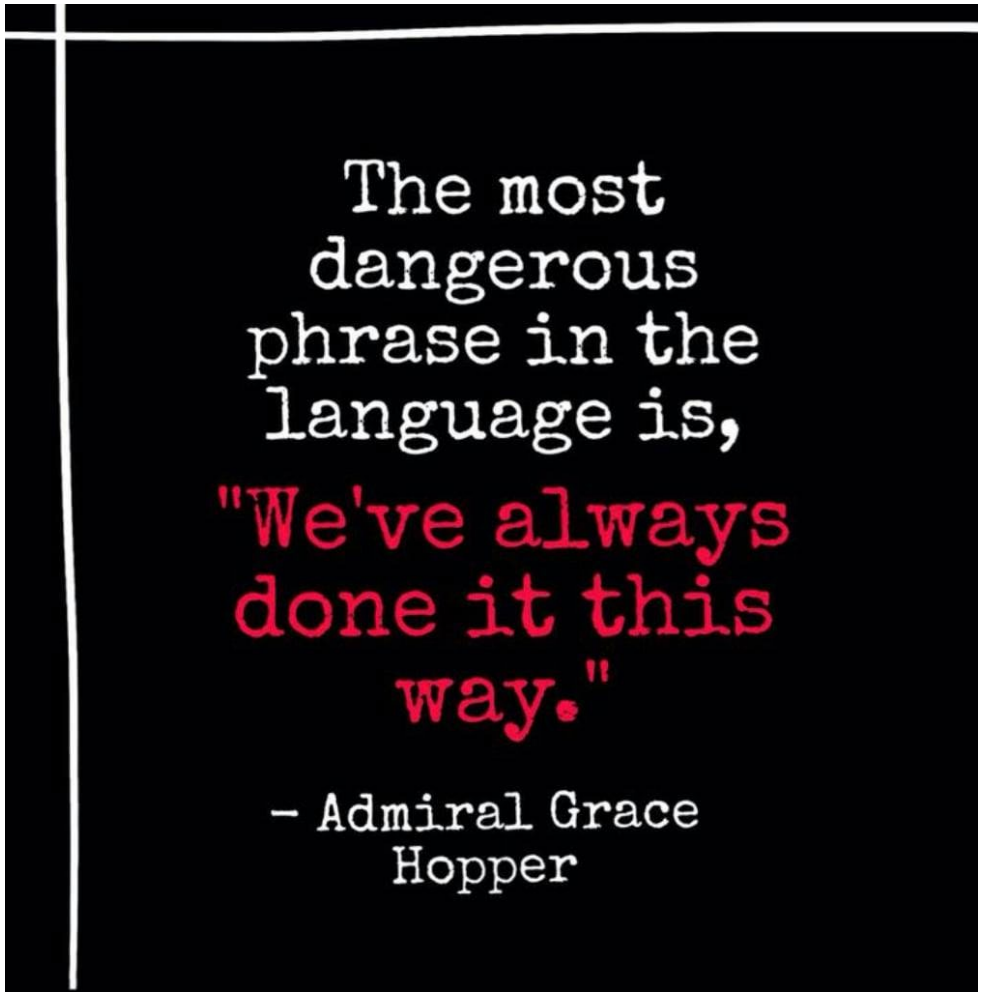
Chairman

MIH/CP Subcommittee, Missouri State Advisory Council for EMS

Founding Partner

Washington County MIH Network

Missouri Highlands MIH Network



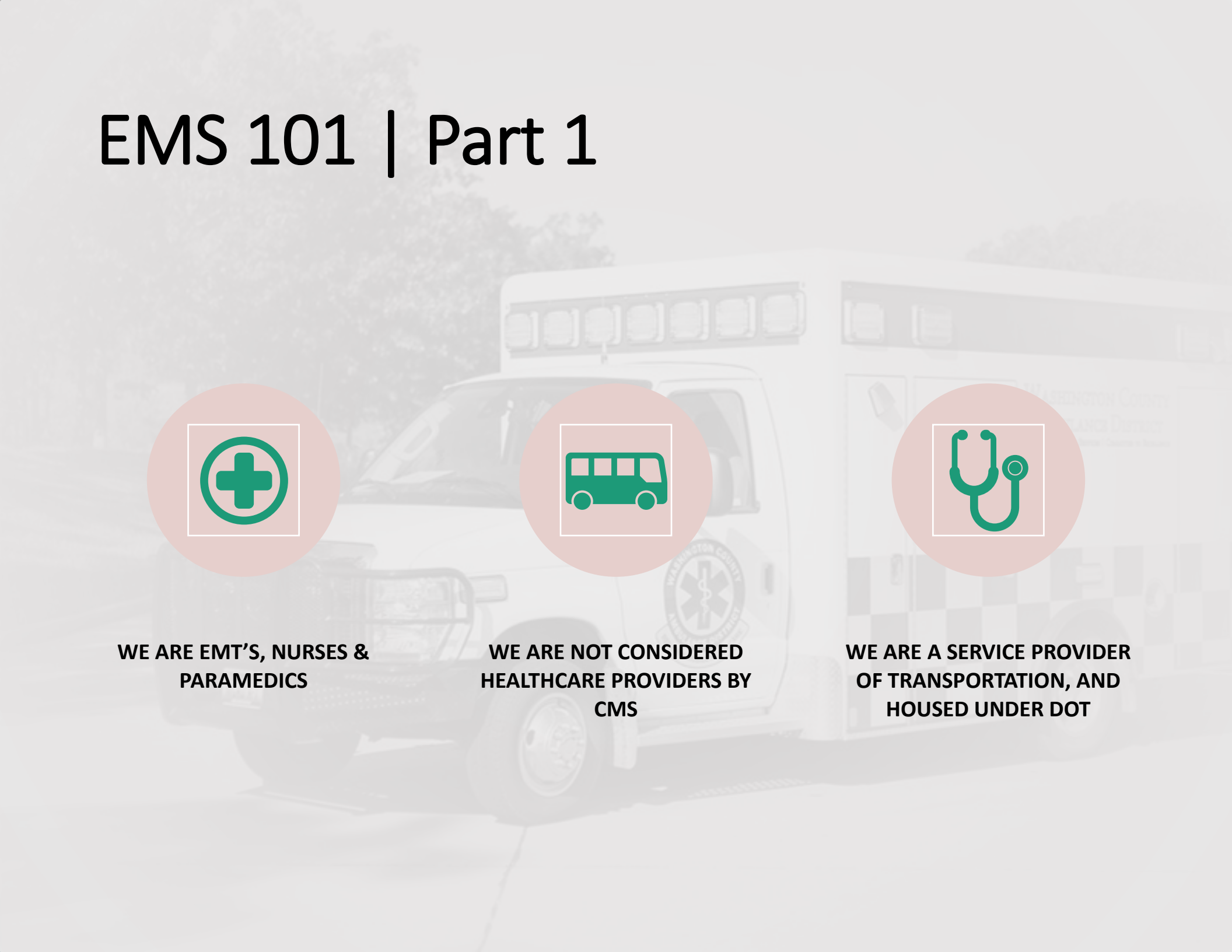
We've figured it out on the local level.

We've figured it out on the regional level.

We're figuring it out on the state level.

We haven't yet figured it out on the national level. And you can help!

EMS 101 | Part 1



WE ARE EMT'S, NURSES & PARAMEDICS

WE ARE NOT CONSIDERED HEALTHCARE PROVIDERS BY CMS

WE ARE A SERVICE PROVIDER OF TRANSPORTATION, AND HOUSED UNDER DOT

EMS 101 | Part 2

We provide healthcare, every day, outside of brick and mortar

We are called “EMS” but don’t do much “Emergency” work

We provide primary care most of the time

We sometimes transport people

HRSA
FINAL
WINNER
2023
Building Bridges to Better Health:
A Primary Health Care Challenge

Building Bridges to Better Health:
A Primary Health Care Challenge

HRSA Primary Care Challenge 1ST Place 2023

The Washington County MIH Network was awarded FIRST PLACE in the HRSA nationwide competition, "Building Bridges to Better Health: A Primary Health Care Challenge."

Our Home Turf

WCAD: 762 square miles

- Rural Setting
- Socioeconomic
- Health Literacy
- Compliance

Expanded coverage to ~1,500 square miles

- Reynolds County
- Dent County

WASHINGTON COUNTY
MOBILE INTEGRATED
HEALTHCARE NETWORK


Mobile Integrated Healthcare
Community Paramedicine
Plain & Simple
We bring healthcare to the patient.

Mobile Integrated Healthcare From The 10,000 Ft. View

MISSION

Diverse | Inclusive | Whole Person Care

SYSTEM DESIGN

Community Paramedic / Community Health Workers serve as the bridge between the patient and the provider outside brick and mortar.

PROVIDE CARE

Initiate care in the home with Community Paramedics.

CORE VALUES

Right Care | Right Place | Right Time

WASHINGTON COUNTY
MOBILE INTEGRATED
HEALTHCARE NETWORK

Our Model

Goal 1	Take the healthcare to the patient
Goal 2	Serve as the bridge and the glue
Goal 3	Flow based / standing order-based care
Goal 4	Have telehealth available 100% of the time
Goal 5	Take the “provider centric” model to a “patient centric” model of care
Goal 6	Engage and collaborate with all provider types inside & outside of the brick and mortar setting

MIH POINT OF ENTRY

Self Referral

Provider Referral (internal)
Provider Referral (external)

Hospital Emergency Department Discharge

EMS Referral

Community Health Worker
"Mission Control"

SDoH Assessment
Link to SDoH Resources
Schedule CP Visit

Home/Environment Safety and Health Risk Assessments
Medication Reconciliation
Basic Labs
Document in Clinical Record

Telehealth Visit

Specialty Care Referral (if needed)

WE ARE REFERRAL AGNOSTIC & IT IS NATURAL FOR US AS AN INDUSTRY

FQHC | CAH | RHC | Large Healthcare Systems | Private Physicians | Anyone & Everyone

MIH Services

- Chronic Disease Management
- Telehealth Provider Appointments
- In-Home Diagnostics
- In-Home Point of Care Testing
- In-Home Infusions
- In-Home Vaccines
- Care Gap Closure
- Lab Collection
- Wound Care
- Wellness Checks
- SDOH Assessment, Navigation and Resource Support
- In-Home Safety Assessments
- Medication Reconciliation
- Care Coordination
- Non-Emergency Transportation
- Public Health Support
- Home Health Bridge Support
- Hospice Bridge Support
- No-Call, No-Show Follow Up
- Direct Hospice Support
- Direct Health Support

Most Recent Projects

<u>SUD / OUD / Behavioral Health</u>

- Suboxone Initiation by CP
- Care Coordination by CP/CHW
- Public Health / Hospital / 911 / Law Referral
- Medical Clearance by CP w/ Direct Transport to Alternate Destination

<u>Maternal Health Project</u>

- Prenatal Care Coordination by CP/CHW
- WIC/Public Health Referral

A Missouri Case Study

K.F.

(SHARED WITH PERMISSION OF THIS PATIENT)

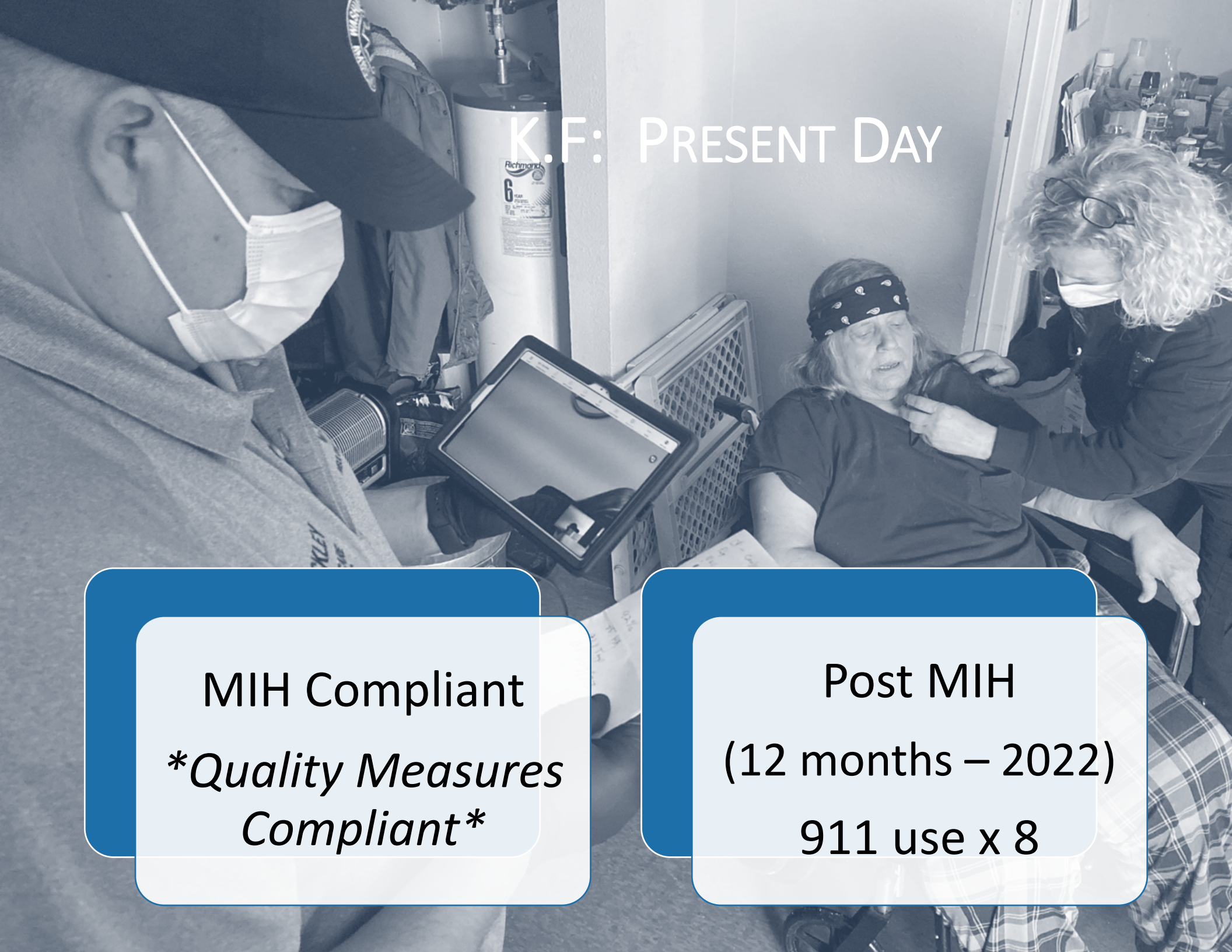
THIS IS A REAL PATIENT ENROLLED IN OUR PROGRAM.

KF is an obese female with Diabetes, CAD, HTN and underlying mental health issues.

- Non-compliant with primary care
- Lives in projects
- No transportation
- No local family

12 month pull (2020-2021)

- 64 documented Paramedic transports
- 74 (additional) Paramedic No-Transport
- Enrolled in MIH late 2021
- MIH SAVE: Poly Pharm



K.F: Present Day

MIH Compliant

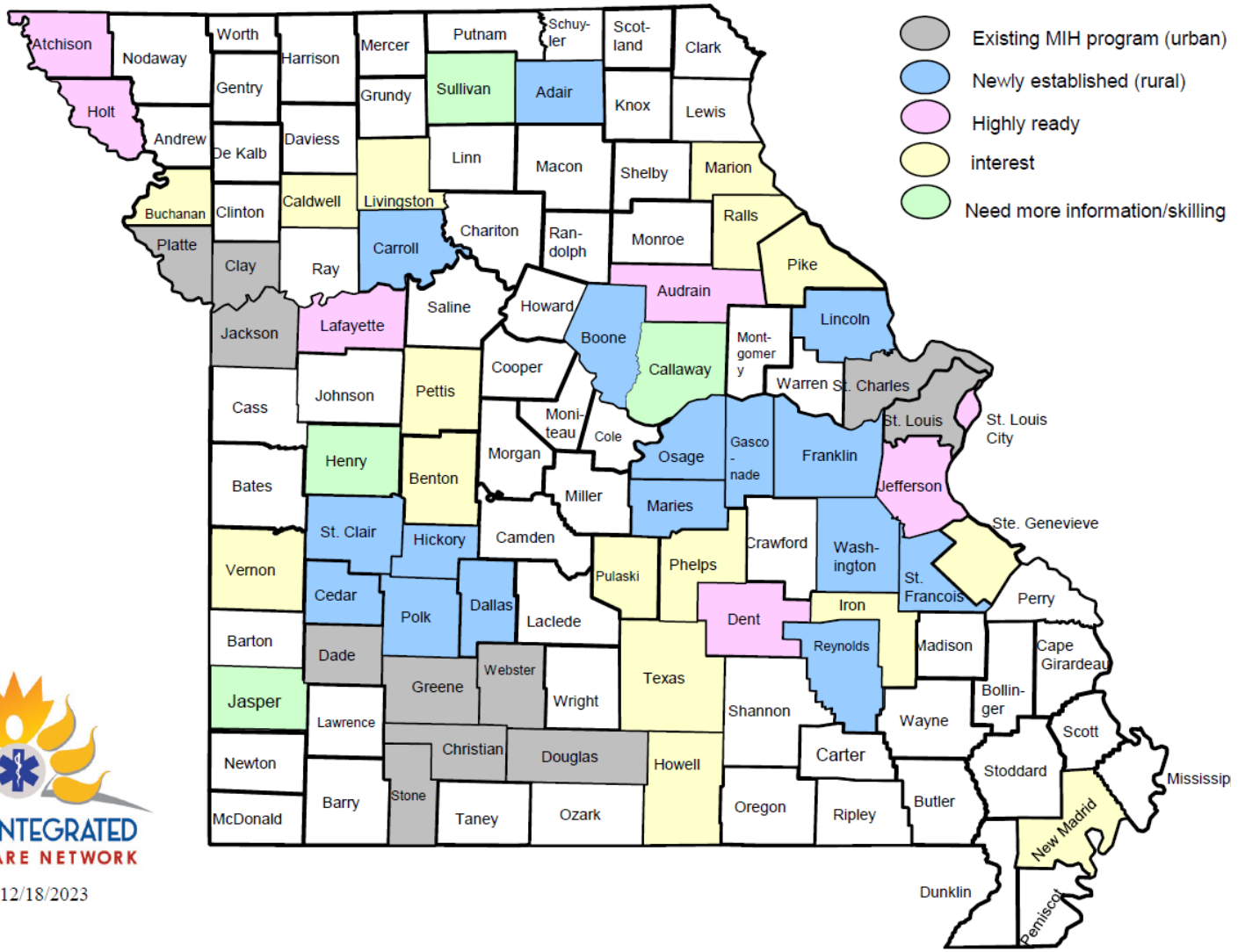
Quality Measures Compliant

Post MIH

(12 months – 2022)

911 use x 8

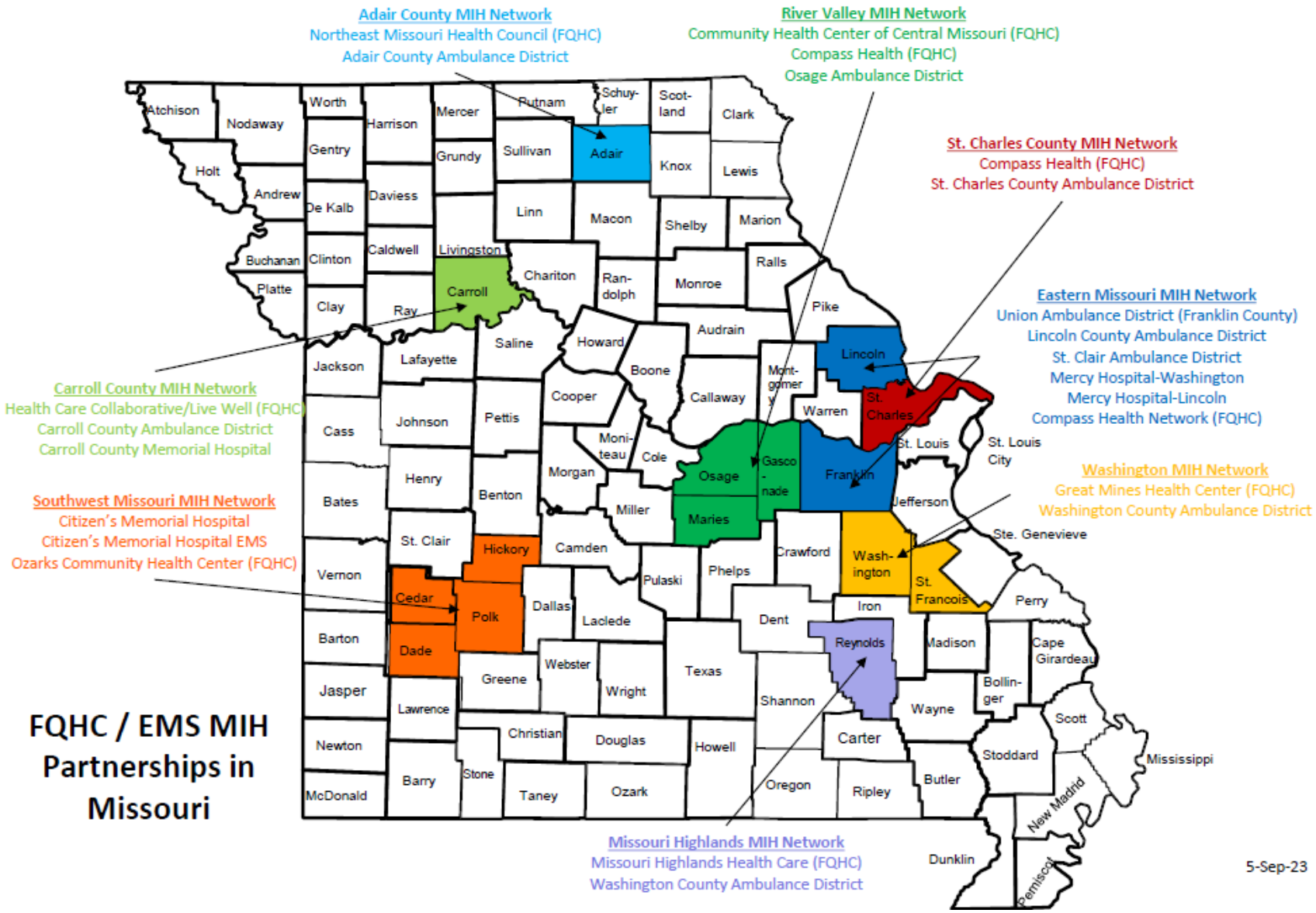
MISSOURI MOBILE INTEGRATED HEALTHCARE EXPANSION MAP



MOBILE INTEGRATED HEALTHCARE NETWORK

Revised 12/18/2023

FQHC / EMS MIH Partnerships in Missouri



5-Sep-23

NATIONAL PERSPECTIVE

We have Metropolitan Programs.

We have Urban Programs.

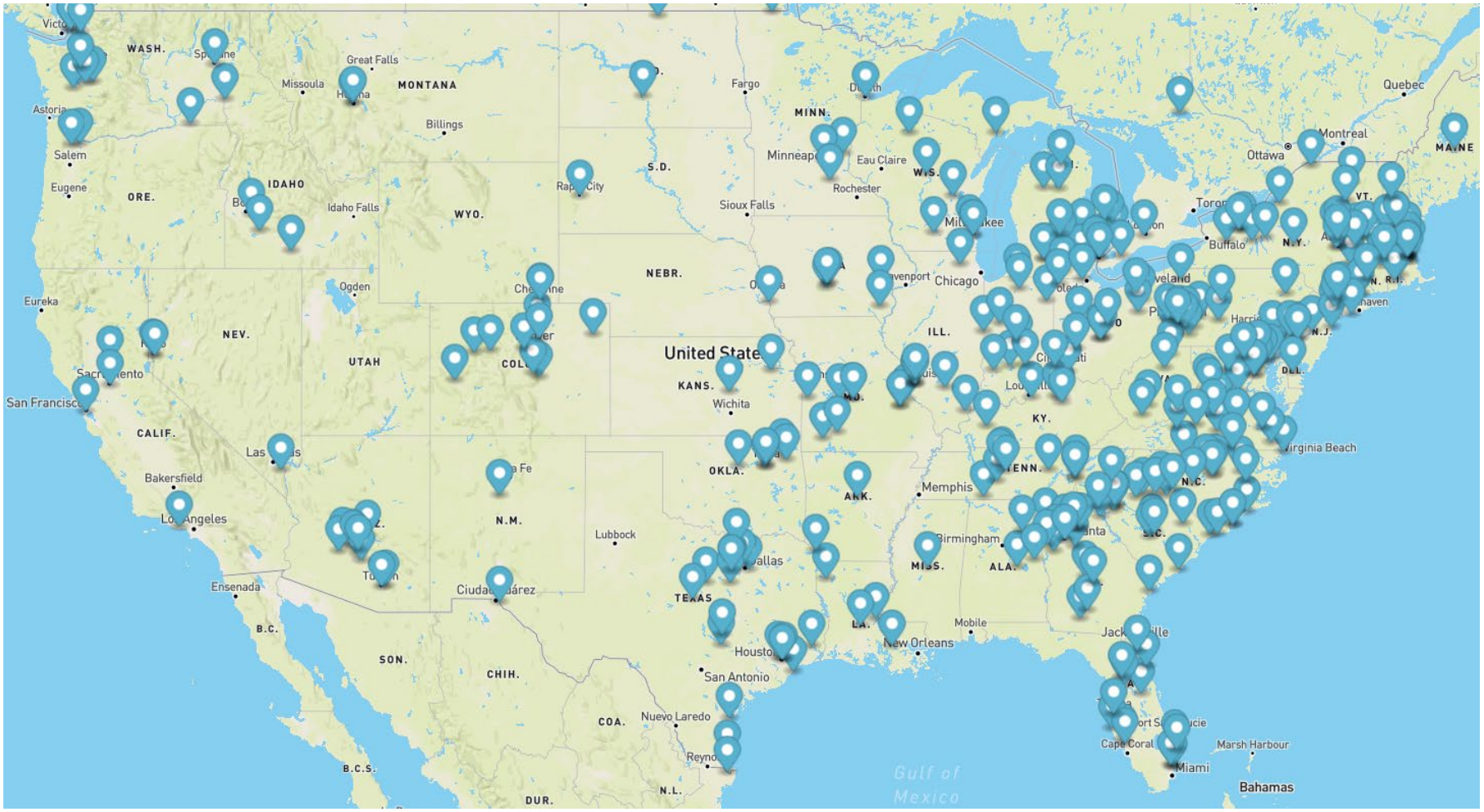
We have Rural Programs.

We have Super-Rural Programs

While the details are different, the mission is the same.

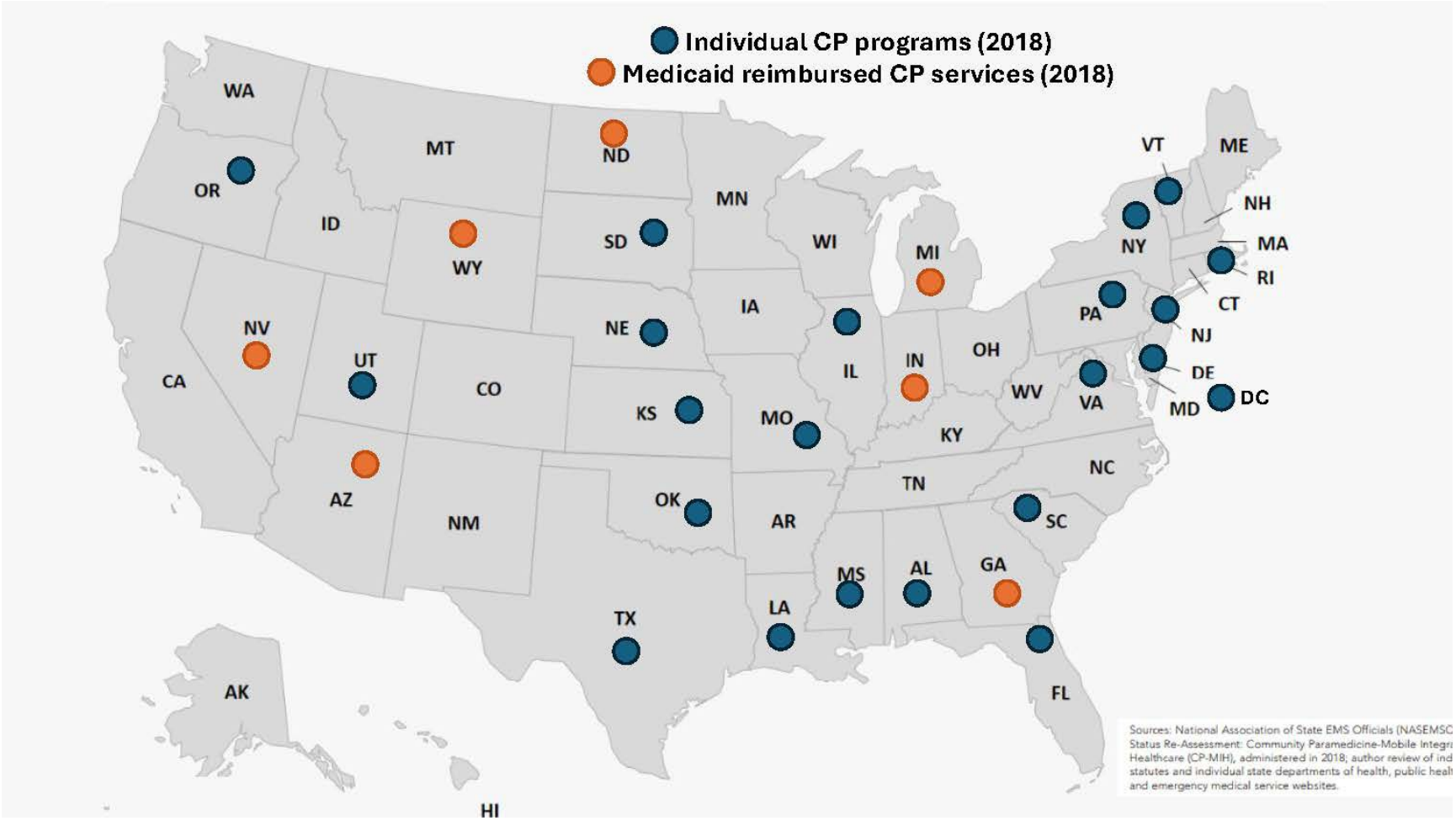
We fill gaps. We work with everyone. We adapt and overcome.

WE MAKE SICK PEOPLE BETTER | WE SAVE THE SYSTEM MONEY



NAMIHP Member Locations

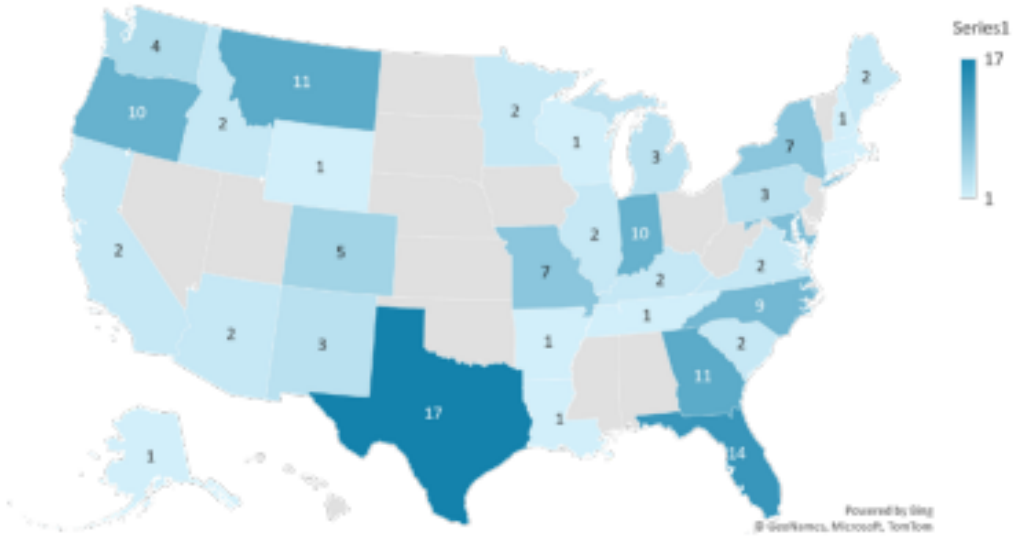
As of 14 April, 2024 | www.namihp.org


Individual CP programs (2018)
Medicaid reimbursed CP services (2018)
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
NM
ND
SD
NE
KS
OK
TX
MN
IA
MO
AR
LA
WI
IL
MS
MI
IN
KY
TN
AL
OH
WV
GA
FL
SC
NC
VA
PA
NY
VT
ME
NH
MA
RI
CT
NJ
DE
MD
DC
AK
HI
Sources: National Association of State EMS Officials (NASEMSO
Status Re-Assessment: Community Paramedicine-Mobile Integra
Healthcare (CP-MIH), administered in 2018; author review of ind
statutes and individual state departments of health, public healt
and emergency medical service websites.

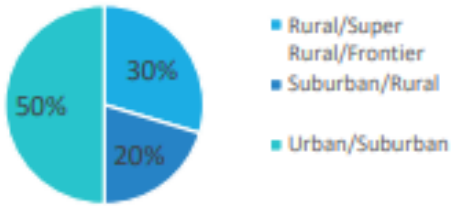
NAEMT Survey | 2023

Survey Demographics

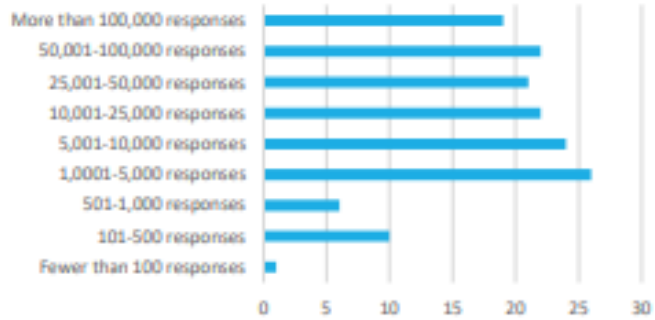
Our Agency is Headquartered In:



Demographic Region Served



Annual Response Volume



KANSAS MIH/CP PROGRAMS

Current Programs

- Kansas City Kansas Fire Department
- Olathe Fire Department
- Johnson County EMS
- Lawrence/Douglas Fire Medical

In Planning Phase

- Reno County (Hutchinson Community Hospital)
- Phillips County EMS
- Norwich EMS
- Dickinson County EMS

NEBRASKA MIH/CP PROGRAMS

Current Programs
- Zero

In Planning Phase
- Zero

Major Opportunity…….

Iowa MIH/CP Programs

Current Programs
- Gutenberg Hospital Ambulance
- Decatur County Hospital Ambulance
- Johnson County Ambulance Service
- Mercy-One Des Moines

Suspended Programs
- Waterloo Fire Department
- Fort Dodge Fire Department

New York MIH/CP Programs

Current Programs

- Cambridge Valley Rescue Squad
- Valatie Rescue Squad
- South Jefferson Rescue Squad
- Mount Siani Healthcare System
- Empress EMS
- Scarsdale Volunteer Ambulance Corp.

Estimate a total of 20 across the state.

Ohio MIH/CP Programs

Current Programs

- Delaware County EMS
- NW Ambulance District
- Violet Township Fire
- Dayton Fire
- Truro Township Fire
- Marysville Fire Division
- Mifflin Township Fire

Minnesota MIH/CP Programs

Current Programs
- Hennepin Health
- Essentia
- Mayo Clinic
- North Memorial
- Sanford Health

Suspended Programs
- Allina Health
- Northfield
- Maplewood

UTAH MIH/CP PROGRAMS

Current Programs
- Zero

In Planning Phase
- Zero

Major Opportunity…….

Texas MIH/CP Programs

Current Programs

- MedStar Mobile Health
- Dallas Fire
- San Antonio Fire
- Austin-Travis County EMS

Pennsylvania MIH/CP Programs

Current Programs

- University of Pittsburg
- Lancaster EMS

California MIH/CP Programs

Current Programs

- Oakland Fire
- Medic Ambulance
- San Diego Fire & Rescue
- San Francisco Fire

Large pilot project that had 20 programs that ended in 2019.

TENNESSEE MIH/CP PROGRAMS

Current Programs

- Vanderbilt University
- Memphis Fire

OKLAHOMA MIH/CP PROGRAMS

Current Programs
- Zero

In Planning Phase
- Zero

EMS leadership have reached out to us in Missouri regarding start up (operations & education)

Major Opportunity…….

West Virginia MIH/CP Programs

Current Programs

- Jan-Care Ambulance
- Kanawha County Ambulance

ILLINOIS MIH/CP PROGRAMS

Current Programs

- Rockford Fire

North Carolina MIH/CP Programs

Current Programs

- Wake County EMS
- Atrium Health

GEORGIA MIH/CP PROGRAMS

Current Programs

- Chatham County EMS

Florida MIH/CP Programs

Current Programs

- Miami-Dade Fire Rescue
- Palm Beach County Fire Rescue
- Manatee County DPS
- Weems Hospital Ambulance Service
- Leon County EMS
- Holmes County EMS
- City of Key-West Fire
- Union County EMS

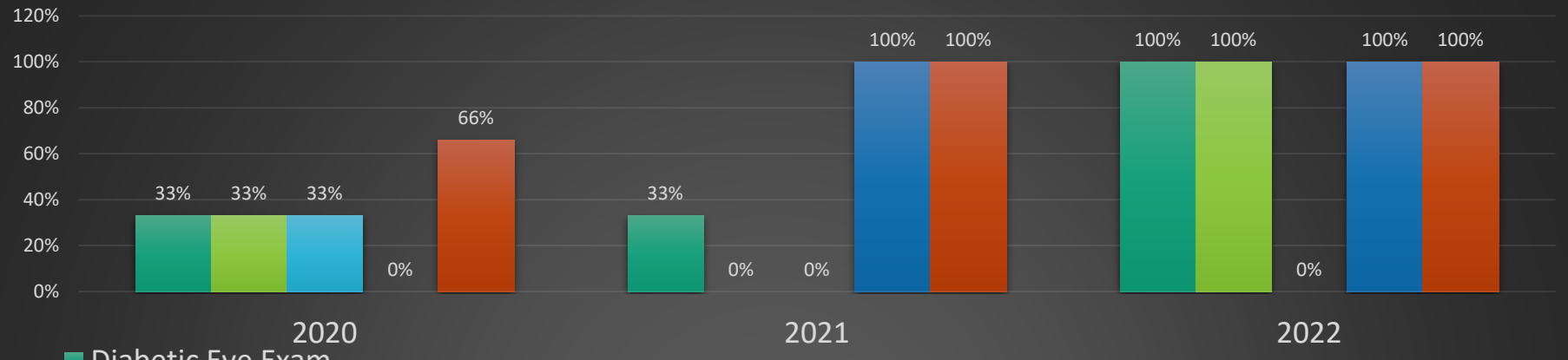
61 total programs in Florida as of today!


LET'S REVIEW SOME DATA
WASHINGTON COUNTY, MISSOURI

Clinical Quality Measure	All Clinic Patients	MIH Cohort
Diabetic Eye Exam (CMS 131v9)	25.1%	66.7%
Diabetes Foot Exam (NQF 0056)	41.5%	75.0%
Diabetes A1c > 9 or Untested (CMS 122v10)	30.6%	0.0%
Diabetes Medical Attention for Nephropathy (CMS 134v9)	78.4%	100.0%
Hypertension Controlling High BP (CMS 165v10)	67.5%	85.7%
Screening for Depression and Follow-up Plan 18+ yrs (CMS 2v11 Modified)	58.2%	75.0%
Tobacco Use: Screening & Cessation (CMS 138v10)	90.2%	85.75
BMI Screening & Follow-up 18+ yrs (CMS 69v10)	78.4%	91.7%
Statin Therapy for the Prevention & Treatment of Cardiovascular Disease (CMS 347v5)	77.9%	80.0%
Falls Screening for Future Fall Risk (NQF 0101)	61.4%	90.9%
Colorectal Cancer Screening (CMS 130v10)	33.9%	40.0%

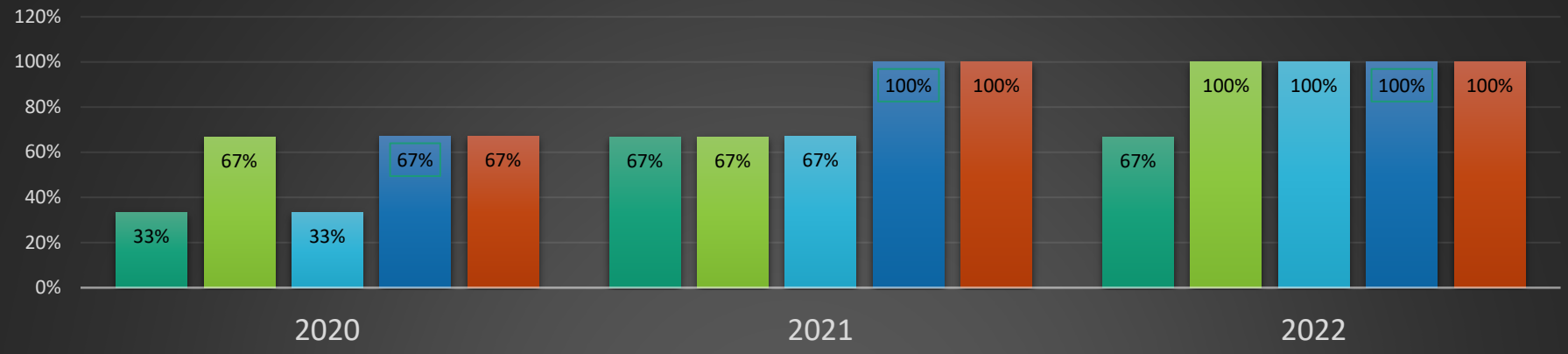
Clinical Quality Data

Diabetic Related Measures



- Diabetic Eye Exam
  Patients who are up to date or have an upcoming appointment for a Diabetic Eye Exam due to coordination with MIH CHW
- Diabetic Foot Exam
  Patients who are up to date or have an upcoming appointment for DM Foot Exam due to coordination with MIH CHW
- Diabetes A1C >9/Untested
  Patients who are not up to date on A1C testing or who have an A1C 9 or above
  This is a number you want low
- Diabetes Medical Attention for Nephropathy
  Patients who have had appropriate nephropathy screening
- BMI Screening and Follow-Up
  Patients with a documented BMI during the encounter and when the BMI is outside of normal parameters, a follow-up plan is documented

Cardiovascular & Depression Screening



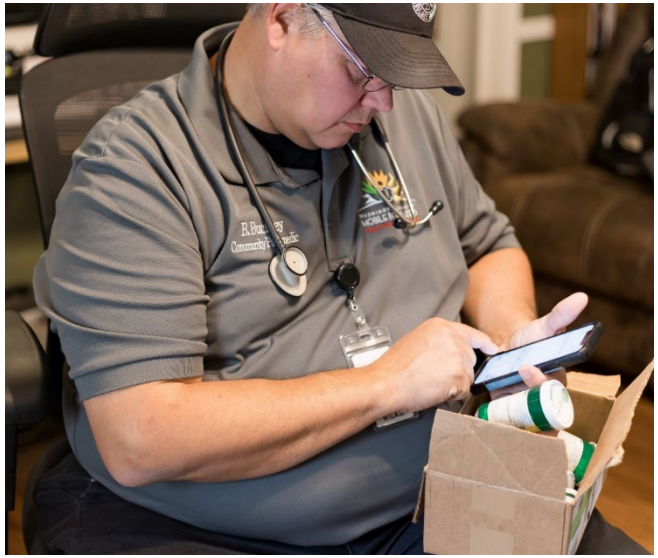
Hypertension Conrolling High BP
Patients who have had a BP reading and reading is under 140/90

Tobacco Use: Screening and Cessation
Patients who have been screening for tobacco use and who have been counseled on the effects of smoking

Statin Therapy for Prevention and Treatment of Cardiovascular Disease

Screening for Depression and Follow Up Plan
Patients who have been screened for depression and if positive an intervention was completed

Fall Risk Screen



Review of Fee-For-Services Medicare claims through 11/30/22.

Events are sum of ED visits, Observation Stays and Admissions.

Source: Health Quality Innovators (Missouri QIO)

COST SAVINGS ANALYSIS

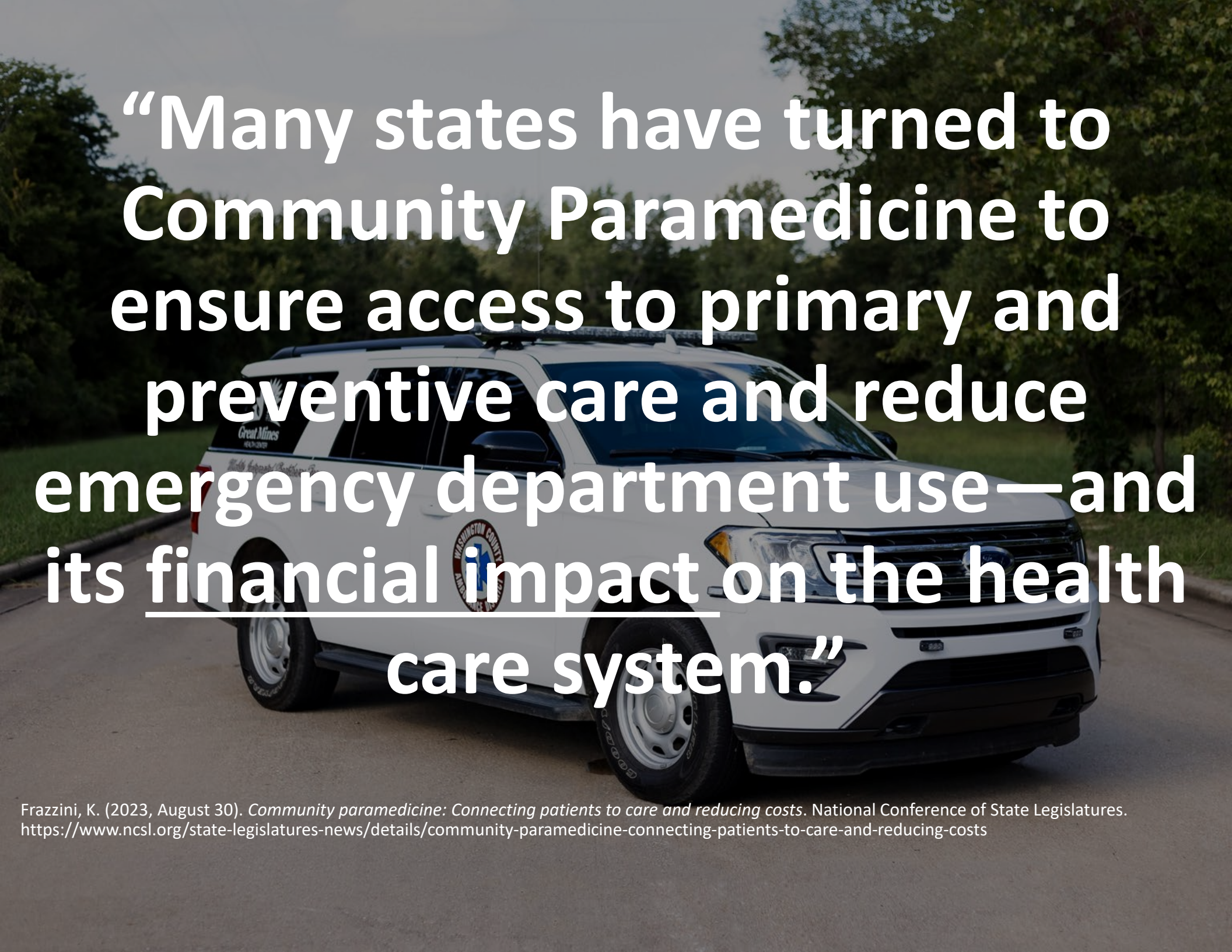
Medicare Claims Analysis for MIH cohort (*n=63*)

12 months pre-MIH enrollment: $378,037.08

12 months post-MIH enrollment: $180,834.18

RESULTS: -52.16%

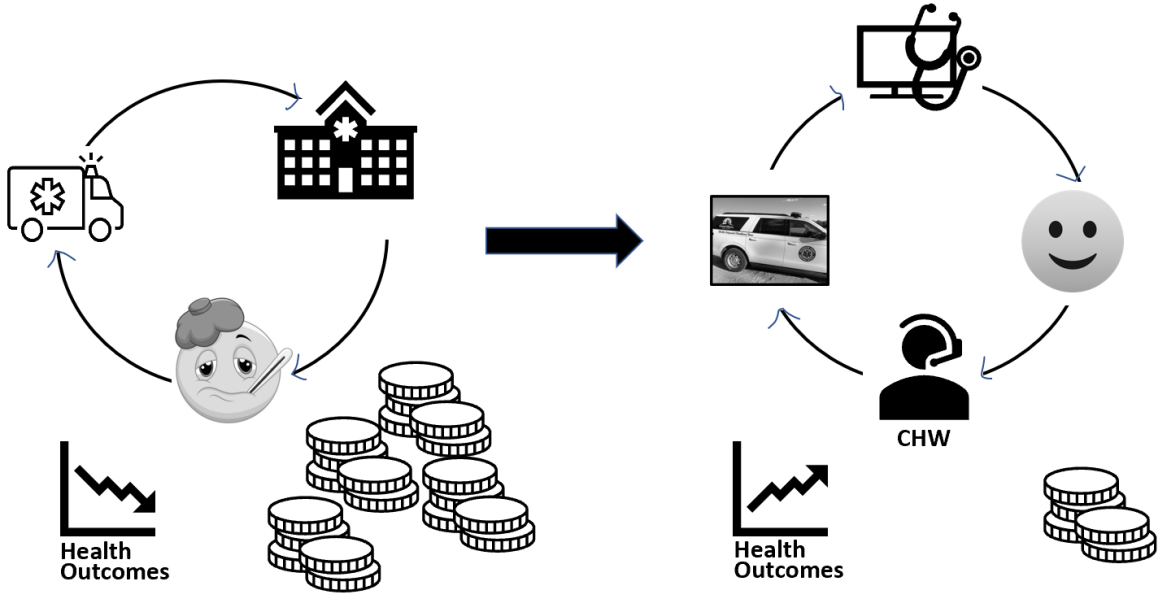
WASHINGTON COUNTY MOBILE INTEGRATED HEALTHCARE NETWORK



“Many states have turned to Community Paramedicine to ensure access to primary and preventive care and reduce emergency department use—and its financial impact on the health care system.”

Frazzini, K. (2023, August 30). *Community paramedicine: Connecting patients to care and reducing costs*. National Conference of State Legislatures. https://www.ncsl.org/state-legislatures-news/details/community-paramedicine-connecting-patients-to-care-and-reducing-costs

Requires policy / regulatory changes and new payment models



Traditional Care Model

Mobile Integrated Healthcare Network Model

> **Insanity:**
> doing the same thing over and over again **and expecting** different results.
>
> -Albert Einstein

Medicare Reimbursement

The most recent Healthcare Cost and Utilization Project (HCUP) report from the Agency for Healthcare Research and Quality (AHRQ) reveals the Average expenditure for ED visit for patients aged 65 or older is **$690**.

https://hcup-us.ahrq.gov/reports/statbriefs/sb268-ED-Costs-2017.pdf ***(2017)***

Medicare Reimbursement

The national average Medicare fee schedule for a basic life support emergency ambulance service is **$447.56**, and of this allowed amount, Medicare pays 80% = **$358.05**

https://www.cms.gov/medicare/payment/fee-schedules/ambulance

CMS Has Data

The Congressional Budget Office (CBO) recently reported that the Centers for Medicare and Medicaid Services (CMS) paid $20 million to EMS agencies for **pandemic waiver authorized** on-scene treatment without transport to a hospital.

The average Medicare expenditure per treatment without transport claim is estimated at **$358.05**.

Using this estimate, the number of treatment without transport claims that the $20 million expenditure represents is ~55,858 ambulance claims ($20 million ÷ $358.05).

In simple terms, there were 55,858 Medicare beneficiaries who were **NOT** seen by a hospital emergency department (ED), and instead were cared for by EMS personnel and left at home.

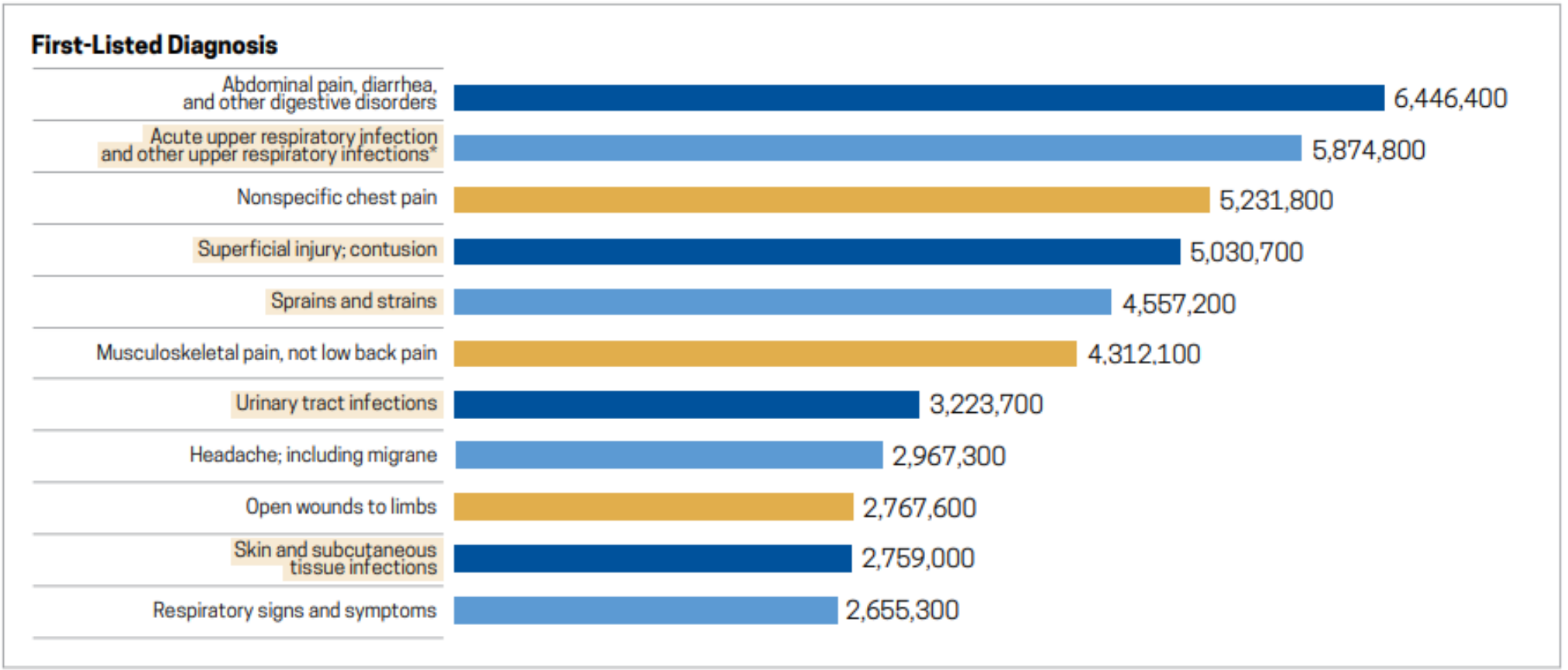
Using this data, the estimated **SAVINGS** to Medicare derived from the 55,858 Medicare beneficiaries who were NOT seen in an ED was **$38,542,020** (55,858 beneficiaries × $690/ED visit).

A **193%** cost to savings ratio.

References:

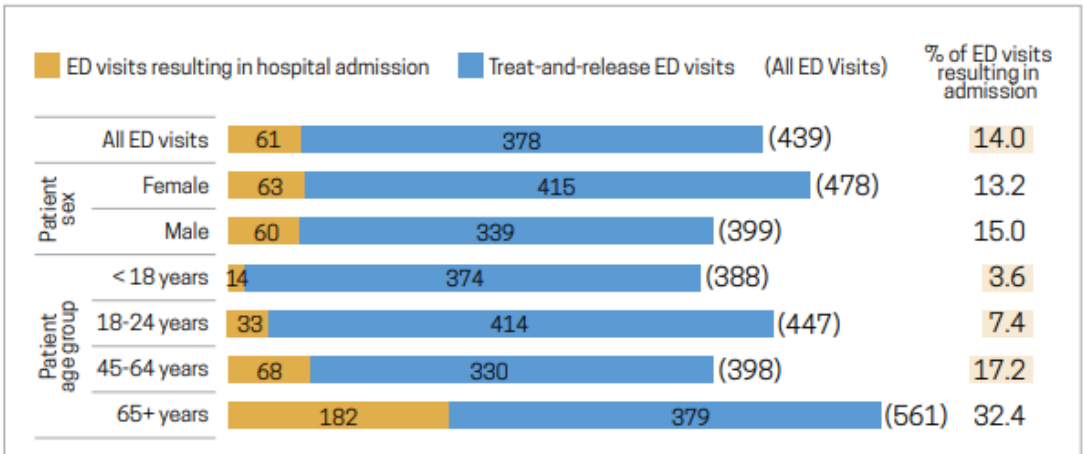
1. https://www.cms.gov/medicare/payment/fee-schedules/ ambulance
2. 2. https://hcup-us.ahrq.gov/reports/statbriefs/sb268-EDCosts-2017.pdf
3. 3. https://nasemso.org/wp-content/uploads/2020-National-EMS-Assessment_Reduced-File-Size.pdf
4. 4. https://www.healthaffairs.org/doi/abs/10.1377/ hlthaff.2013.0741

Figure 2: Top 20 first-listed diagnoses with the highest number of treat-and-release ED visits, 2018



Note: The highlighted diagnoses represent conditions that may have a high likelihood of being able to be referred to resources other than an ED.

Figure 1: Rate per 1,000 population of ED visits by patient characteristics and ED visit type, 2018



Most frequent reasons for treat-and-release ED visits by patient characteristics, 2018

Figure 1 presents the rate of ED visits per 1,000 population in 2018 by select patient characteristics for all ED visits (143.5 million) and subset treat-and-release ED visits (123.4 million) and ED visits resulting in hospital admission (20.1 million).

Current Funding Sources

- Grants
- Private Contracts (facilities)
- Contracts with MCO’s
- Contracts with ACO’s
- Commercial Insurance Reimbursement (contract based)

CPT Codes on the Table

99342	New Patient, 30 minutes.	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 30 MINUTES MUST BE MET OR EXCEEDED.
99344	New Patient, 60 minutes.	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 60 MINUTES MUST BE MET OR EXCEEDED.
99347	Established Patient, 20 minutes.	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 20 MINUTES MUST BE MET OR EXCEEDED.
99349	Established Patient, 40 minutes.	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 40 MINUTES MUST BE MET OR EXCEEDED.
99350	Established Patient, 60 minutes.	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 60 MINUTES MUST BE MET OR EXCEEDED.

Not noted, but what we would want to add in somewhere, somehow:

98967	Telephone Assessment and Management.	Telephone assessment and management service provided by a qualified non-physician healthcare practitioner.

Current Barriers to Consider

Final Reflection

Mobile Integrated Healthcare & Community Paramedics are dotted across the country. Individual programs are diverse.

However, all MIH/CP programs have a few things in common....

We fill gaps. We work with everyone. We adapt and overcome.

We make sick people better. We save the system money.

Why? Because it is the right thing to do.

Where do we go from here?

How do we ensure sustainability?

Our Ask

Direct CMS and CMMI to explore and establish sustainable models for the support of Community Paramedicine as a designated structural intervention through an integrated approach for the continuation of completing existing healthcare ecosystems in metropolitan, urban, rural and super rural communities as a recognized clinician to address healthcare inequities and closures today & tomorrow.

Mobile Integrated Healthcare

Community Paramedicine

Diverse | Inclusive | Whole Person Care

Justin Duncan
jduncan@wcadems.org

www.mihnetwork.org