FOSTERING PATIENT-CENTERED AND COST-EFFECTIVE HEALTH CARE THROUGH INTEGRATION: A COLLABORATIVE APPROACH
The city of Boston has many great attributes, navigating it if you are unfamiliar is not one of them.
If you’re a patient, navigating your healthcare can be like me navigating Boston. Except it’s worse. If I want to get from Boston to Cambridge, I can take the Longfellow bridge. It may take a minute to get there.
If you’re a patient, navigating your healthcare can be like me navigating Boston. Except it’s worse. If I want to get from Boston to Cambridge, I can take the Longfellow bridge. It may take a minute to get there.
Longfellow bridge connects Beacon Hill with Cambridge.

If Beacon Hill was our ED, and Cambridge was follow-up, for many of our patients it would look like this. There are giant gaps. Gaps are everywhere in our healthcare system, which is fragmented and siloed.
Longfellow bridge connects Beacon Hill with Cambridge.

If Beacon Hill was our ED, and Cambridge was follow-up, for many of our patients it would look like this. There are giant gaps. Gaps are everywhere in our healthcare system, which is fragmented and siloed.
Imbalance - lack of primary care.....
When primary care suppose to be a medical home, essentially become homeless, driving to shelter of ED at a point when problems often harder to fix.
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Plan for the day:
2. Drivers of EMS/ED overutilization.
4. EMS as part of the solution.
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Idea is how we can work collaboratively to truly create a system that works for patients ... and providers.
Idea is how we can work collaboratively to truly create a system that works for patients ... and providers.
Why Primary Care?

Alan Roth
Why Primary Care?

➢ Coordination of Care
➢ Continuity
➢ Comprehensive Care
➢ Cohesive
➢ Compassionate Care
➢ Communication
➢ Connectedness
➢ Cost Control

We need to empower Primary Care Physicians to be the leaders in Healthcare improvement

Patient Advocates
Shared Decision Making
Practice Reform
Relationship based Care
Patient Centered Care
Patients who live in Communities who Receive More Aggressive Care

➢ See Specialists more frequently
➢ Spend more time in the Hospital
➢ Spend more days in the ICU
➢ Are more likely to die in the ICU
➢ Have higher costs
➢ Are more likely to be dissatisfied with their care
The Evidence for Primary Care

- Barbara Starfield Data
- Graham Center Data
- Insurance Data - Billing variances and M&M statistics
- Dartmouth Atlas
Primary Care and not the availability of specialist care is a determining factor of population health
The greater the supply of primary care physicians, the lower the total mortality, heart disease mortality, and stroke mortality at the US county level.

In 35 analyses dealing with differences between types of areas (7) and 5 rates of mortality (total, heart, cancer, stroke, infant), the greater the primary care physician supply, the lower the mortality for 28. The higher the specialist ratio, the higher the mortality in 28.
Evidence for Effectiveness

- People live longer and fewer die due to heart and lung disease
- Less ER and hospital use
- Better preventive care
- Reduced health disparities

**Better Outcomes**

- Landmark 2005 study shows U.S. counties more oriented to primary care achieve:
  - lower per capita expenditures
  - lower medication use
  - higher patient satisfaction

- Increase of one primary care physician per 10,000 population associated with:
  - 6 percent decrease in all-cause mortality
  - 3 percent decrease in low birth-weight, and stroke mortality

Evidence for Efficiency

➢ Less ER and hospitals use
➢ Fewer tests
➢ Higher patient satisfaction
➢ Lower medication use
➢ Less care-related costs

The Problem Associated with Over Use of Specialty Care

➢ Inappropriate referrals to specialists lead to greater frequency of tests and more false positive results than appropriate referrals to specialists.
➢ Inappropriate referrals to specialists lead to poorer outcomes than appropriate referrals.
➢ The socially advantaged have higher rates of visits to specialists than the socially disadvantaged.

A MAJOR ROLE OF PRIMARY CARE IS TO ASSURE THAT SPECIALTY CARE IS MORE APPROPRIATE AND, THEREFORE, MORE EFFECTIVE.

Primary Care Rationale

➢ Can Address 90% of Medical Conditions (AAFP-2004)
➢ 33% Lower cost and 19 % lower mortality than specialty care (Journal of FP 2008)
➢ 53 % lower cost when initial care is by a PCP over specialist care (Journal of FP-2008)
Comprehensiveness

➢ Measured associations between variations of comprehensiveness of practice among family physicians and healthcare utilization and cost.
➢ Utilized Medicare and MOC data
➢ 3,652 Physicians and 555,165 Medicare Beneficiaries
➢ Increasing Comprehensiveness is associated with decreased Medicare costs and hospitalizations.

Ten Building blocks of high-performing primary care

1. Engaged leadership
2. Data-driven improvement
3. Empowerment
4. Team-based care
5. Patient-centered partnerships
6. Population management
7. Community of care
8. Comprehensive team and care coordination
9. Information technology
10. Template of the future

Thomas Bodenheimer, MD | Amireh Ghorob, MPH, Rachel Willard Grace, MPH and Kevin Grumbach, MD
Ann Fam Med March/April 2014 vol. 12 no. 2 166-171
Summary of Evidence

➢ Single most important health system factor in the health of a community
➢ Less Hospitalizations, ED visits and ICU care
➢ Reduced health disparities
➢ Fewer tests
➢ Less Medication use
➢ Live longer
➢ Better prevention
➢ Lower costs
➢ Increased Patient and Family Satisfaction
In Need of Realignment: Emergency Services & Funding for Out of Hospital Care

Maia Dorsett
Boston - navigation difficulty
Solution if unfamiliar - call someone to your door to get you to the destination
Solution if unfamiliar - call someone to your door to get you to the destination
When patients have a medical problem and no way to navigate system - call 911
When patients have a medical problem and no way to navigate system - call 911
When patients have a medical problem and no way to navigate system - call 911
When patients have a medical problem and no way to navigate system - call 911
Only one place ambulance can currently take them
Driver of ED utilization
Driver of ED utilization

15.8% (29 million emergent transports in 2009, 136 million ED visits)
ED, given higher overall prevalence of disease, location of healthcare overuse (as perceived by ED docs as well)
Total costs of EMS care
Total costs of EMS care

$5.2 billion
Is only 1% however
These patients have lots of downstream costs.

These patients have lots of downstream costs.  
These patients have lots of downstream costs.

These patients have lots of downstream costs.
These patients have lots of downstream costs.
These patients have lots of downstream costs.
2014
$18,234
$1,533
ED
Hospital

https://www.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf
https://meps.ahrq.gov/mepsweb/newsroom.acep.org/fact_sheets?item=29928
Ambulance reimbursement - send to ED.
Ambulance reimbursement. Would think that multiple destinations would be okay, except that if call originates from home.
only get reimbursed to take patient to the ED
only get reimbursed to take patient to the ED
only get reimbursed to take patient to the ED
only get reimbursed to take patient to the ED
Ambulance reimbursement- send to ED. It would be better for the system and patients if we could take them to the right level of care, or even treat at home.
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Ambulance reimbursement- send to ED. It would be better for the system and patients if we could take them to the right level of care, or even treat at home.
Patients are open to this idea as well
About 1/4 arrived by EMS, about 1/4 were caregivers.
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About 1/4 arrived by EMS, about 1/4 were caregivers.

<table>
<thead>
<tr>
<th>Component</th>
<th>Overall</th>
<th>N</th>
<th>Strongly Agree (%)</th>
<th>Agree (%)</th>
<th>Neutral (%)</th>
<th>Disagree (%)</th>
<th>Strongly Disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Alternate Disposition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2: Sometimes, EMS can treat a patient and they no longer need to go to the hospital.</td>
<td>611</td>
<td>11.9</td>
<td>46.5</td>
<td>7.3</td>
<td>28.4</td>
<td>6.0</td>
<td></td>
</tr>
<tr>
<td>Q3: EMS should have the option to bring patients to a primary care office, urgent care center or clinic.</td>
<td>607</td>
<td>8.7</td>
<td>39.6</td>
<td>15.1</td>
<td>31.6</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>Q4: I would prefer being treated and allowed to stay at home rather than be transported to the hospital if EMS determines I do not need to go to the hospital.</td>
<td>613</td>
<td>11.7</td>
<td>51.7</td>
<td>6.9</td>
<td>24.5</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Q5: I would prefer being taken to a clinic or primary doctor’s office rather than to the emergency room if EMS determines that I do not need to go to the hospital.</td>
<td>610</td>
<td>10.3</td>
<td>51.5</td>
<td>7.9</td>
<td>26.4</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Q7: I want EMS to do an evaluation and then advise me whether I need to go to the hospital.</td>
<td>613</td>
<td>11.9</td>
<td>54.3</td>
<td>5.9</td>
<td>23.8</td>
<td>4.1</td>
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Patients are open to this idea as well
About 1/4 arrived by EMS, about 1/4 were caregivers.

Needs of healthcare system - reduce costs
Needs of patient - improved health and needs met
Financial Incentives - Profit
Current system needs realignment.
Needs of healthcare system - reduce costs
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Current system needs realignment.
Aligning needs of healthcare system, patient, financial incentives

Aligning needs of healthcare system, patient, financial incentives

How to achieve this?
With the patient need at the center.
With the patient need at the center.
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Long Term Solutions for the Primary Care Crisis

Andy Lazris
FIXING PRIMARY CARE: How to Improve the Current Crisis
Primary Care in Crisis

“PCPs are generally thought of as only dealing with the ‘simple stuff.’ But PCPs are trained to manage complex chronic conditions such as heart failure and diabetes — the illnesses that cost about 70 to 80 percent of the health care dollar. This takes time and requires listening and thinking.” - Stephen Schimpff, MD

“The difference between what’s made available to me as a surgeon and what’s made available to our internists or pediatricians or H.I.V. specialists is not just shortsighted—it’s immoral... We can give up an antiquated set of priorities and shift our focus from rescue medicine to lifelong incremental care. Or we can leave millions of people to suffer and die from conditions that, increasingly, can be predicted and managed. This isn’t a bloodless policy choice; it’s a medical emergency” - Atul Gawande, MD
Consequences of Crisis:

- High cost, low value care
- Over-use of specialists
- Over-testing and treatment
- Over-hospitalization
Clinical Example

- Ms. P, 91yo independent woman
- Stroke-like symptoms
- Pt, son want to stay out of hospital.
- Time, difficulty to obtain resources: CT scan, home support, wheelchair, rehab
- Cost to family of appropriate care, family scared
- Ultimate destination after hours of uncompensated work: hospital stay followed by subacute rehab
Causes of Crisis

- Time
- Payment
- Resources
- Burnout
Time Shortage

- 20-30 patients a day
- No time for coordination of care
- Poor SDM

“There is not adequate time for compassion, to build trust or to do true healing. Since there is too little time, the tendency is to send the patient off for tests or to a specialist when a bit more time with their history would give the answer.” - Schimpff
Payment Gap

Figure: Association between the Median Salary of a Specialty and its Competitiveness, as Measured by the Percentage of Positions Filled by Graduates of US Medical Schools.

Payment Gap
Payment Gap

- Determined by RUC
- $100k-$200k gap
- Payment for Procedures vs Care
- The Case of Stents: 1=300
- Static revenue + increasing overhead means Volume care

“This hundred-per-cent difference in incomes actually understates the degree to which our policies and payment systems have given short shrift to incremental care.” - Gawande
Resources:

- Limited staff
- Setting up care at home
- Caring for ill patients
- Coordinating with EMS, ER, Hospital

“As an American surgeon, I have a battalion of people and millions of dollars of equipment on hand when I arrive in my operating room. Incrementalists are lucky if they can hire a nurse.” - Gawande
Burnout

- Over 50% burnout, highest among all physicians
- Increased regulatory burdens
- Face-time less than busy work time
How to fix the crisis:

- Increase pay for value care
- Increase resources
- Enable more time for patients
- Increase the number of primary care doctors and NP’s: Only 20% enter the field now
Fixing the Crisis: Existing Solutions

- Billing for Chronic Care Management
- MACRA and APMs
- Next-Gen ACO’s
- Does this help manage crisis patients like Ms. P?
Fixing the Crisis: Potential Solutions

- Payment for Value Services
- Reform the RUC
- Increase Primary Care Slots
- Direct Primary Care
Direct Primary Care

- Small patient panels
- Payment per patient based on benchmarks: income, chronic illness, prior costs
- Incentives for decreased cost
- Fewer regulatory burdens
- Very strong success rate
Direct Primary Care: AbsoluteCARE

- Medicaid, cost to system > $60k/year
- 1 PCP and team per 300 patients
- Strong ancillary support and resources
- Results: 42% reduced hospitalizations, 39% reduced ER visits
Increasing Primary Care Slots

- Medicare’s Role: $10 billion a year for resident training
- Tuition forgiveness
- Making the field more attractive
Primary Care in Crisis

“What is this crisis? The fundamental problem is a flawed and non-sustainable business model that forces primary care doctors (PCPs) to care for too many patients and as a result not have the time they need to provide high level care. They need time to listen, time to think, time to give quality preventive care and time to coordinate care for those with complex chronic illnesses. In other words, they need time to practice at the top of their profession, something they currently are unable to do fully.

This crisis means that doctors are highly frustrated, feel they are on a never ending treadmill, are leaving private practice or retiring early. It means that patients are equally frustrated at the long waits, short visits, high costs and no sense of being listened to, of not being actually cared for.

The crisis means that there are not enough primary care doctors today, and it will only get worse because students in medical school see the impact of the crisis and choose not to enter primary care as a result.” -Stephen Schimpff, MD
EMSS Solutions: Mobile Integrated Health

Maia Dorsett
H. Phil Moy
Scott Goldberg
How do we fill the gaps in healthcare in a way that is patient-centered and cost-effective?
If only there was something, which combined 24/7 service, medical professionals with experience in triage, flex/up capability, mobile, and embedded within the community?
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Mobile Integrated Healthcare Practice

“a needs-based, patient-centered, 24/7 acute care, chronic care and prevention services delivered in the home or mobile environment by the cost-effective synchronization of various clinicians, infrastructure and resources.”

Starting point for mobile integrated healthcare is the gaps. The first step in developing a mobile integrated healthcare program are identifying the gaps/needs specific to a community.
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Examples.
Christian Hospital Saint Louis Community Health Access Program

Hawnwan Moy MD
Assistant Professor
Washington University
<table>
<thead>
<tr>
<th>The Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013</strong></td>
</tr>
<tr>
<td><strong>Context</strong></td>
</tr>
<tr>
<td>1. Nearly half (48%) of ED visits were deemed non-emergent</td>
</tr>
<tr>
<td>2. 40% of patients were brought in by EMS</td>
</tr>
<tr>
<td><strong>Problem</strong></td>
</tr>
<tr>
<td>Over-utilization of the Emergency Department and Emergency Medical Services</td>
</tr>
</tbody>
</table>

https://www.ahrq.gov/professionals/systems/hospital/esi/esi2.html
Challenges

1. Training of an advanced prehospital provider
2. Emergency Department screening
3. Community health resource outreach
Solution

Christian Hospital
Community Health Access Program (CHAP)
Implementation
CHAP is launched
02.01.14

CHAP enrolls first patient
02.27.14

Data collected, calculated, continue to enroll patients.
01.01.15

Speaking with government about reimbursement
10.20.16

New projects on the horizon
05.01.17

New projects:
Memory Care
Dental care
## Impact

- Savings to the Traditional Medicaid Program $269,055
- Savings to other Managed Care Plans $503,604
- Decreased ED visits and hospital admission rates
## Effect on EMS

**Data Snapshot:** Six high-frequency EMS callers before and after enrolling in CHAP

<table>
<thead>
<tr>
<th>Patient</th>
<th>911 Use Before CHAP</th>
<th>911 Calls Before CHAP</th>
<th>911 Calls While Enrolled</th>
<th>Percent Decrease in 911 Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient A</td>
<td>25 calls in 12 months</td>
<td>2.1 calls per month</td>
<td>1.3 calls per month</td>
<td>38%</td>
</tr>
<tr>
<td>Patient B</td>
<td>18 calls in 12 months</td>
<td>1.6 calls per month</td>
<td>0.8 calls per month</td>
<td>50%</td>
</tr>
<tr>
<td>Patient C</td>
<td>7 calls in 6 months</td>
<td>1.2 calls per month</td>
<td>0.3 calls per month</td>
<td>75%</td>
</tr>
<tr>
<td>Patient D</td>
<td>19 calls in 12 months</td>
<td>1.6 calls per month</td>
<td>0.7 calls per month</td>
<td>56%</td>
</tr>
<tr>
<td>Patient E</td>
<td>1 calls in 7 month</td>
<td>1 call per month</td>
<td>0.3 calls per month</td>
<td>70%</td>
</tr>
<tr>
<td>Patient F</td>
<td>7 calls in 1 month</td>
<td>7 calls per month</td>
<td>1 call per month</td>
<td>66%</td>
</tr>
</tbody>
</table>
What we really care about...

Five RIGHTS of CHAPs
- RIGHT resource
- RIGHT time
- RIGHT patient
- RIGHT outcome
- RIGHT cost
50% decrease in EMS use, 32% decrease in ED use, 50% decrease in admits- 4 month enrollment

6 months post program release on track to utilize the 911 system 5 times less, ED 14 times less, and admitted 2 times less

One of this patient’s triggers for a sickle cell crisis was cold weather. Recognizing this and getting the patient smoking cessation resources as a key development in becoming healthier. We also assisted this patient with relocation, state ID, cell phone, and job searches. He can now be an active member in our community.

- Provided emotional support via the dedicated CHAPs line
- Established a Primary Care Physician specific to unique sickle cell needs
- Worked with the patient’s PCP and started the patient on daily medication for his sickle cell
- Connected the patient with alternative residency options and visited public housing options
- Assisted patient with a smoking cessation program and he successfully stopped smoking
- Educated on sickle cell disease as well as early recognition of a sickle cell crisis
- ID’d exacerbating triggers of sickle cell crisis and what to avoid
- Organized meds and plan for administration
- Gained family support for patient’s medical needs
- Obtained state ID
50% decrease in EMS use, 33% increase in ED use, 31% increase in admit-2 month enrollment
4.5 months post program release patient is on track to utilize the 911 system 6 times less this year than last year, ED 27 times less, and admitted 1 less times.

This patient could not keep her medication down because she had a gastric sleeve. Setting up a medication regimen and teaching her how to take her meds, allowed her to keep her medicine down. She went to the Cards game with her friend for the first time in years during her enrollment and said our program made this possible. We also began the process of admitting this patient from home while enrolled into our program, decreasing the burden of EMS and ED.

- Decreased utilization of Emergency Resources for episodic care
- Provided emotional support via the dedicated CHAPs line
- Established a routine for medication administration to allow patient to consume her daily PO meds
- Identified patient ideal body weight to compare on each encounter and provided patient her own scale for monitoring
- Identified and educated regarding early prophylactic intervention for gastroparesis/receiving a kidney transplant for her renal failure
- Provided vascular fluid therapy in the home when needed
The patient was referred to us for high utilization. He utilized emergency services 109 times in 10 months. We were able to get him into detox and then rehab. We then assisted him into a sober living home, got him a state ID, GED, PCP insurance, and much more. He is now a patient transporter for Christian Hospital, and he just had his one year sobering ceremony to celebrate sobriety last month. :)
Mobile Integrated Healthcare

Using existing out of hospital resources to bridge gaps in healthcare services

Scott Goldberg, MD, MPH, FACEP, FAEMS
Director of Emergency Medical Services
Brigham & Women's Hospital
I grew up in Boston, and live here now...
But before moving back about 2 years ago now I lived in Dallas, TX for a number of years
Where I had the privilege of serving as Associate Medical Director for Dallas Fire Rescue.
Dallas fire is a metropolitan, all ALS, fire-based EMS service with 40 front-line ambulances serving 192,000 responses annually.
And our EMS system, like so many EMS systems, had a problem. We identified 254 patients generating more than 12 calls each during calendar year 2013.
These 254 users resulted in a net loss of $1.6 million in uncollected revenue to the department.
In a review of Center for Medicare and Medicaid Services (CMS) claims for ambulance transports between 2005-2009, 35% of all Medicare patients transported to hospital and subsequently discharged were deemed candidates for treatment at a site other than the emergency department.

<table>
<thead>
<tr>
<th></th>
<th>Potentially preventable transports</th>
<th>Medicare costs ($)</th>
<th>Medicare cost savings ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,116,894</td>
<td>622,830,452</td>
<td>599,871,117</td>
</tr>
<tr>
<td>Excluding:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing home cases</td>
<td>947,302</td>
<td>529,983,264</td>
<td>476,983,823</td>
</tr>
<tr>
<td>Injury cases</td>
<td>519,365</td>
<td>500,916,816</td>
<td>448,092,213</td>
</tr>
<tr>
<td>Weekend cases</td>
<td>808,544</td>
<td>457,993,040</td>
<td>412,415,426</td>
</tr>
<tr>
<td>Nursing home, injury, and weekend cases</td>
<td>567,499</td>
<td>315,453,952</td>
<td>283,464,058</td>
</tr>
</tbody>
</table>
Had these patient been transported to a more appropriate site of care, or treated at home, the healthcare system would have saved an estimated $600 million.
And a select group of patients, often referred to as high-frequency utilizers, use a disproportionate amount of emergency resources, both EMS and ED.
High frequency users

4.5-8% of ED patients
21-28% of ED visits

LaCalle, 2010
In 2010, Medicare reimbursed for 16.6 million transports by only 5.1 million patients [36]
It seems that this particular group consists of a population disproportionately affected by difficulty in accessing health resources. Counter to common perception this group of patients is for the most part insured [33, 37], with a coverage rate of 85% [33], and connected with a primary care provider [33]. However, they have up a to four-fold increased rate of emergency department use [38].
High frequency users

Problem: Increased difficulty in accessing care

It is therefore not lack of affiliation with a primary care physician that leads to excessive ED and EMS use, so much as it is difficulty in obtaining timely, quality care [33].
High frequency users

Problem:
Increased difficulty in accessing care

Solution:
ED used for nonemergent conditions

This population, without access to appropriate venues for care, turns to the emergency department to provide care for nonemergent conditions. The increasing use of the ED for nonemergent conditions is associated with a corresponding increase in 911 calls and patient transports. Among Medicare patients, there was an estimated 33% increase in the overall transport rate from 2004 to 2010, with a corresponding increase of 59% for nonemergency transports [39]. In fact, almost two-thirds of all patients transported to the ED by ambulance require no emergency interventions [7, 39].
Interestingly, the majority of these patients were insured.
Right resource
Right resource

Right patient
Right resource

Right patient

Right time
We modeled our program off the IOM's list of four essential features of a primary care provider [16].
First, PCPs must be accessible, responding when needed and providing economically and socially attainable services.
Second, they offer a variety of services for a broad population in multiple settings, including preventive care.
PCPs coordinate services, linking primary care, specialists and social services.
Finally, PCPs offer continuity of care, including access to stable and available providers as well as an integrated and complete patient care record.
EMS providers are available around the clock.
They are comfortable providing care in almost any setting imaginable, providing a wide variety of services to all demographic groups.
They are well integrated into the health care system and able to coordinate with hospital, ambulatory, and social services. Further, they are well-versed in patient centered communication.
Finally, our program assigned a single MCHP provider to each patient, maintaining continuity of care. Records were shared between the MCHP and the patient's PMD, and patients were followed by the MCHP provider in the event of ED or hospital admission.
Emergency Medical Technician
Primary Care Technician
So here we are with our 254 high frequency users of our EMS system, and we wanted to figure out a way that we could decrease unrecouped costs.
We developed our proposal for an MIH program, which we titled the Mobile Community Healthcare Program, or MCHP. We took our plan to the Dallas City Council...
...and were granted $600,000 dollars for a one year pilot.
This allowed us to purchase vehicles and hire 6 full-time medics.
On enrollment in the program, each patient received a comprehensive intake evaluation, and a custom program was crafted to meet the patient’s individual needs.
<table>
<thead>
<tr>
<th>Intake Evaluation</th>
<th>Medical history</th>
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<tbody>
<tr>
<td></td>
<td>Med reconciliation</td>
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<tr>
<td></td>
<td>Physical examination</td>
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<td>Health knowledge assessment</td>
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<td></td>
<td>Psychosocial evaluation</td>
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<td>Home assessment</td>
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</table>

**Home visits**  
Approximately weekly

Following this, the MCHP paramedic visits the patient in the home, usually weekly although occasionally more or less frequently as required by the individual patient. Visits become less frequent as the patient nears graduation from the program.
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<table>
<thead>
<tr>
<th>Home visits</th>
<th>Approximately weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical director rounds</td>
<td>Weekly</td>
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</table>

Once a week, all MCHP paramedics meet with command staff and the program medical director and round on all program patients, identifying needs and correcting deficiencies.
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</table>

Finally, communication between the MCHP paramedic and the patient's primary care provider occurs regularly, maintaining continuity of care.
49 patients enrolled

630 visits (Avg 12.9/patient)

Average enrollment: 178 days
Reductions in call volume
System cost savings
Improved operational efficiency
Enhancement in patients’ quality of life
Calls by enrollees before and after enrollment

Calls fell by 46%. Transports fell by 44%.
A brief story…

Andy Lazris
Making Connections:
Making Connections:
Making Connections:

What are the Needs of Your Community?
S.967 - Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2017
115th Congress (2017-2018) | Get alerts

SIC. 5. TREATMENT OF AMBULANCE SERVICE PROVIDERS.
(a) In General.—Section 1314 of the Social Security Act (62 U.S.C. 1395m) shall be treated as a provider of services.

(b) PROVIDER REIMBURSEMENT REVIEW BOARD.—For purposes of section 1878, an ambulance service provider (as defined in paragraph (1)(B)) shall be treated as a provider of services.

(c) ESTABLISHMENT OF CONDITIONS OF PARTICIPATION.—An ambulance service provider—

(i) for purposes of section 1861(s)(3), shall be treated as a provider entity; and

(ii) shall be required to meet such requirements for participation under this title as the Secretary shall establish by regulation.

(d) USE OF BILLING CODES.—An ambulance service provider may, for purposes of this title, use billing codes established for providers of services, if such use is consistent with applicable Federal, State, or local scope of practice requirements.”