About MedStar...

• Governmental agency (PUM) serving Ft. Worth and 14 Suburban Cities
  o Self-Operated
  o 1,016,963 residents, 434 Sq. miles
  o Exclusive provider - emergency and non-emergency
• 180,858 responses (FY 2021-22)
• 481 full time employees
• $59.8 million budget (FY 2022-23)
  o No tax subsidy
• Fully deployed Dynamic Resource Management
• Medical Control from 18-member Emergency Physician’s Advisory Board (EPAB)
  o Physician Medical Directors from all emergency departments in service area + 7 Tarrant County Medical Society reps
EMS-Based Mobile Integrated Healthcare

- Community Paramedicine
- 911 Nurse Triage
- Alternative Response
- Alternative Destinations
Mobile Integrated Healthcare

• Stop responding to calls we can prevent...
  o High Utilizer Group (HUG) patients
  o 9-1-1 Nurse Triage program
  o CHF readmission prevention
  o Hospice revocation avoidance
  o Observation admission avoidance
  o Home Health partnership
  o Palliative Care Partnership
  o OD reduction program
2023 National Survey on MIH-CP Programs

NATIONAL ASSOCIATION OF EMERGENCY MEDICAL TECHNICIANS (NAEMT)
Agencies Never Operating an MIH-CP Program

Forty-five (45%) of the agencies who responded that they are not operating an MIH-CP program reported never initiating a program due to funding challenges.
Reasons MIH-CP Programs Ceased
Educational Models & Training...
Foundational Considerations

• What are the gaps to be filled by the MIH program/providers?
  o Scope issues?

• Are **YOU** comfortable with the agency filling the gap?
  o What are the gaps in current vs. desired education and training level?
  o Are there clinical SMEs/partners to assist with education and training?
    • Hospitals, clinics, home health agencies, etc.

• Are there State/Local requirements for certification?

• Are there State/Local requirements for education and training?
  o Texas vs. California, Massachusetts, etc.
COMMUNITY PARAMEDIC EXAM CANDIDATES

The expectation for the CP-C exam candidate is competency in mobile integrated healthcare and expanded EMS services in rural and urban settings, including various healthcare, mental health, and housing and social service needs.

This examination is not meant to test entry-level knowledge, but rather to validate competency of those paramedics providing services beyond the roles of traditional emergency care and transport.

https://www.ibscertifications.org/roles/community-paramedic
Certified Community Paramedic Candidate Handbook

CP-C CONTENT OUTLINE (BLUEPRINT)

1. Community Based Needs
   a) Community health assessments
   b) Where to locate community health assessments
   c) Social determinants of health
   d) Potential community resources
   e) Existing community resources
   f) Cultural competence
   g) Special situations (e.g., bariatric care, high-risk pregnancy, mental health, substance/drug abuse, general special needs, abuse/neglect)

2. Multidisciplinary Collaboration
   a) How to create a plan of care
   b) How to implement a plan of care
   c) Chronic disease management
   d) Sub-acute disease management
   e) Acute disease management
   f) Professional communication
   g) Community paramedic documentation
   h) Healthcare coordination
   i) Healthcare navigation
   j) How to locate patient/client records
   k) How to access patient/client records
   l) How to review patient/client records
   m) How to review patient/client records
   n) Patient/Client record sharing
   o) Relevant past medical history

3. Patient/Client Centric Care
   a) How to acquire past medical history
   b) How to acquire disease specific (focused) history
   c) How to acquire medication history
   d) How to acquire psychosocial history
   e) Point of care testing
   f) Specimen collection, handling, transportation, and delivery
   g) Wound care therapies
   h) Wound care staging, Category
   i) Wound care devices
   j) Medication inventory
   k) Medication reconciliation
   l) Self-administered medication
   m) Teach back methodology
   n) Post-surgical care procedures
   o) Motivational interviewing
   p) Home medical equipment (e.g., nebulizers, CPAP, glucometers)
   q) Patient/Client literacy level
   r) Patient/Client health literacy
   s) How to approach end of life care
   t) Patient/Client needs assessment
   u) How social determinants effect the individual
   v) How cultural determinants effect the individual
   w) Urinary catheters (e.g., maintenance, post-dimension weight)
   x) How to assess nutritional and hydration status
   y) How to assess growth status
   z) Behavioral health screening
   aa) Depression and suicide screen
   bb) Toxicology screening
   cc) Palliative care
   dd) Hospice care
   ee) Disease specific screenings
   ff) Lab values (e.g., crag studies, BMP, ABG, CBC, D-dimer, BNP)
   gg) Implanted devices (e.g., VADs, PEG tubes, AEDs)
   hh) Patient advocacy
   ii) Chronic vs sub-acute vs acute
   jj) Chronic care conditions (e.g., CHF, COPD, diabetes, stroke, CAD, orthopedic, cancer, neurological disorders)
   kk) Sub-Acute medical conditions (e.g., post-surgery, post-discharge, post-stroke care)
   ll) Acute medical conditions (e.g.,...
Community Paramedicine Series

NAEMT’s Community Paramedicine course series focuses on the knowledge and skills that paramedics need to succeed as community paramedics. As paramedics are increasingly depended upon to provide preventive as well as emergent and urgent care, these courses are outstanding education for all paramedics. The series is also designed to prepare paramedics to take the IBSC Community Paramedic certification (CP-C) exam.

The courses within the series may be taught individually or combined to create a semester-long community paramedicine program. Individual courses within the series include:

- Motivational Interviewing
- Wellness and Nutrition
- Hospice and Palliative Care
- Mental Health and Substance Abuse
- Geriatrics
- Pediatrics/Children with Special Health Care Needs
- Endocrine Disorders
- Respiratory Disorders
- Cardiovascular Disorders
- Pharmacology
- Neurological Disorders
- The Clinical Medicine of Community Paramedicine
- Introduction to Community Paramedicine and Mobile Integrated Health
- Clinical Rotations

https://www.naemt.org/education/CP
Lead Editors

Al Benney, CP, NRP
EMS Faculty
Hennepin Technical College
Brooklyn Park, Minnesota

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Hennepin Technical College
Eden Prairie, Minnesota

Michael Wilcox, MD, FACEP, FAAFP
CEO, WGH Group, LLC
New Prague, Minnesota
Community Health Workers serve many roles, including health educator, patient navigator and advocate, and case manager.

**CHW programs allow hospitals and health systems to address the needs of high-risk or at-risk populations, the social determinants of health, readmissions and emergency department over usage — leading to better patient experiences, improved health and increased affordability.**

Among other resources, the compendium includes program implementation considerations; sample job tools and templates used by CHWs; and case studies from organizations that have implemented successful CHW programs.

CHW Training/Certification?

Curriculums may address a combination of the following topics:

- Accessing healthcare and social services systems
- Practicing cultural competency
- The pathophysiology (disease processes) of different diseases
- Social determinants of health
- Translating, interpreting, and facilitating client-provider communications
- Gathering information for medical providers
- Working with clinicians
- Supporting family members and caregivers
- Delivering services as part of a medical home team
- Educating social services providers on community and population needs
- Teaching concepts of disease prevention and health promotion to patients

- Understanding how the CHW's work aligns with health system goals
- Managing chronic conditions, including training on lifestyle strategies, risk factors, self-monitoring and medications
- Engaging in health prevention and promotion activities
- Home visiting
- Liability, legal, and ethical issues
- Trauma-informed care
- Stigma and community prejudices
- HIPAA and patient privacy
- Safety
- Mental health
- Motivational interviewing and public speaking
- Utilizing technology, including mobile applications and electronic health records
- Evaluation and research

CHW training curriculums should also encourage:

- Practice time for new skills learned
- Role-play prior to interacting with patients
- Team-based exercises
- Retention and reference to training materials, such as pamphlets or manuals
- Shadowing CHWs in the field, if possible
- Self-care

https://www.ruralhealthinfo.org/toolkits/community-health-workers/4/training/curriculum
- 18 FTEs in MIH Division
  - 8 cross-certified as CHWs
  - 4 awaiting processing
  - 5 pending experience credit
New Choices When an Ambulance is Dispatched to You Following a Call to 911

You have new care options when emergency medical services respond to your 911 call. You may be offered alternative services instead of being transported by ambulance to the hospital. These services will make sure you receive the most appropriate care at the right time and place for your medical needs.

If your ambulance team finds that you do not need emergency medical treatment at a hospital:

- You may be offered transportation to another medical facility to get care, such as an urgent care center or a doctor’s office.
- You may also be offered treatment with a qualified health care provider right where you are (in person or by telehealth).

If you are offered one of these options, you can still ask your ambulance team to take you to the hospital.

Why are there now options?

- Save you and your family time waiting in the emergency department and get you care more quickly
- Help you avoid hospital costs, when appropriate
- Allow ambulance teams to focus on transporting patients with the greatest emergency needs to the hospital

For more information, please contact your emergency medical services provider, or visit the Centers for Medicare & Medicaid Services website at:

https://innovation.cms.gov/innovation-models/et3
## ET3 Program Summary - Overall

**April 5, 2021 through 3/19/2023**

### Overall Emergency Response Volume (No EMD Determinants 33, 37, 45, 46 or 47)

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented <strong>Medicare &amp; Medicaid</strong> Patient Contacts</td>
<td>88,661</td>
<td></td>
</tr>
<tr>
<td>≥ 65</td>
<td>71,033</td>
<td>80.1%</td>
</tr>
<tr>
<td>&lt; 65</td>
<td>17,565</td>
<td>19.8%</td>
</tr>
<tr>
<td>Not Documented</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Transported</td>
<td>71,426</td>
<td>80.6%</td>
</tr>
<tr>
<td>AMA (incl. Refused All Care &amp; Refusal w/o Capacity)</td>
<td>10,018</td>
<td>11.3%</td>
</tr>
<tr>
<td>ET3 Intervention Offered</td>
<td>7,883</td>
<td>8.9%</td>
</tr>
<tr>
<td>ET3 Intervention Accepted</td>
<td>1,368</td>
<td>17.4%</td>
</tr>
<tr>
<td>IES</td>
<td>1,349</td>
<td></td>
</tr>
<tr>
<td>MHMR ICARE</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transported</td>
<td>60</td>
<td>4.4%</td>
</tr>
<tr>
<td>Hospital ED</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td><strong>TIP</strong></td>
<td>1,296</td>
<td>96.1%</td>
</tr>
<tr>
<td>Dispatch Health Referral</td>
<td>556</td>
<td>42.9%</td>
</tr>
<tr>
<td>MCOT Referral</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>
Jeramie Davison, Reese Greenman
MXX dispatched priority 3 to an apartment complex for leg pain. Arrived on scene to find ambulatory 68 yo female pt walking towards MICU. Pt was found alert, oriented, and in no obvious distress. Pt reported she was having pain and muscle spasms in her back and R leg. Pt reported approximately three weeks ago, she slipped on ice and fell. Pt reported she was evaluated after the fall and prescribed methocarbamol for the muscle spasms. Pt reported this medication had been managing her issues well, however she had just run out of the medication. Pt reported she missed a follow-up appointment with JPS two days ago and was in the process of trying to reschedule her appointment. Vitals were established on scene and were found to be normal. Pt was offered a telehealth consultation and accepted. Dr. Treadaway was contacted via IES and report was given to him. Dr. Treadaway asked pt some questions and then agreed that pt did not require transport by ambulance to an emergency room. Dr. Treadaway reported he would write pt a prescription for more methocarbamol for the next few days while she tried to reschedule her follow-up appointment. Pt accepted alternative disposition. Signatures were obtained from pt and pt was released. MXX cleared scene and returned to service.

Kyle McKenzie, Matt Hansen, Gilbert Portillo
Medstar XX is called to a residence for a XX year old female chief complaint of nausea and recent covid 19 positive. P5. Upon arrival, crew found the patient on their bed GCS of 15, A&O X4. Crew assessed and obtained vitals. Patient was recently covid positive, felt nauseas and dizzy. Crew found all vitals stable and obtained a 12 lead and sugar as noted. Crew offered a plan of treatment with normal saline and Zofran to help nausea, called for TeleHealth Doctor. Crew called and the Doctor agreed that treatment in place was appropriate for this patient with normal saline and nausea. Crew obtained a 20G IV in their right forearm and administered 1L of normal saline and 4mg of IV Zofran. Crew assessed after treatment and found the patients condition was improved. Crew assisted the patient with their own supply of Tylenol and removed the IV. Crew obtained signatures and transfer of care was passed off to Dr. Jonathan Phan TeleHealth. Medstar XX clear and back in service.
ET3 Specific Patient Experience Survey
November 2022 - February 2023

Values

- 100: Strongly Agree
- 75: Generally Agree
- 50: Undecided / Not Sure
- 25: Generally Disagree
- 1: Strongly Disagree

### Urgent Care / Behavioral Health

<table>
<thead>
<tr>
<th>I was satisfied with the level of treatment.</th>
<th>The wait time for treatment was reasonable.</th>
<th>I would consent to this treatment option again if needed.</th>
<th>Is there anything else you would like to share about your experience?</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>100</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td>Five stars</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td><strong>95.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>95.0</strong></td>
<td>Composite Score</td>
</tr>
</tbody>
</table>

### Telehealth

<table>
<thead>
<tr>
<th>I was satisfied with the level of treatment.</th>
<th>The wait time for treatment was reasonable.</th>
<th>I would consent to this treatment option again if needed.</th>
<th>Is there anything else you would like to share about your experience?</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td>Awesome Job GUYS!!</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td>They really good very courteous and explained everything thank you</td>
</tr>
<tr>
<td>25</td>
<td>75</td>
<td>1</td>
<td>I didn't like it when the young man seemed not agree with the young lady about my condition! It felt like he was trying to get me to stay at home by telling me that I would be put in the waiting room. BECAUSE the hospital was busy!</td>
</tr>
<tr>
<td>100</td>
<td>75</td>
<td>100</td>
<td>They were excellent and got me to where I needed</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td>They were very good at what they did</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td>Very professional treatment, &amp; care</td>
</tr>
<tr>
<td><strong>87.5</strong></td>
<td><strong>91.7</strong></td>
<td><strong>83.5</strong></td>
<td>Composite Score</td>
</tr>
</tbody>
</table>
Convincing Other Payers

SB 2029 WILL ENHANCE CARE AND CREATE SAVINGS FOR MEDICAID

Many patients who used to require a hospital transport are now effectively treated at the scene by EMS professionals and referred to further care outside of the hospital emergency department.

Despite this innovation in the care delivered by EMS, the majority of commercial and governmental health plans still pay EMS only when they transport a patient to a hospital. However, that changed in 2019 when Medicare announced the voluntary Emergency Triage, Treat and Transport (ET3) model, which pays EMS agencies for treatment in place and alternate destination transport.

SB 2029 by Sen. Lois Kolkhorst and the accompanying rider by Rep. Giovanni Capriglione seek to apply Medicare’s ET3 revenue to the Texas Medicaid program.

THE ALTERNATE DESTINATION PROJECT IN TARRANT COUNTY

Many Texas EMS agencies are already offering innovative alternate care models in their communities, including MedStar Healthcare, which provides ET3 in Tarrant County. In 2019, the alternate destination project with a large commercial payer in April 2018. This program is available to two commercial plans: 1,000 members in the service area. The plan pays the EMS agency a $125 copayment (versus the traditional fee-for-service for transports).

Clients are notified upon dispatch through a matching algorithm in MedStar’s 9-1-1 dispatch software based on patient name, D.O.B., and phone number or address. Since implementation, only 11 patients need to return home immediately to the scene of the 9-1-1 call to an alternate destination (urgent case). One patient had an ankle injury and the other had flu-like symptoms with a comorbidity.

The hospital transport rate for 9-1-1 calls in this population has dropped from an average of 71 percent to 54 percent. MedStar believes this is a result of these patients being assessed, treated, and referred from the scene to other health care facilities before they get there. The return on investment for the payer is the data of 27 calls that did not go to the emergency department, at an average ED payment of $2,700, to $16,800,000 in six months, or 46,000,000 in six months.

Medstar responds to 140,000 calls per year and transports 95,000 patients. If its overall transport rate dropped to 54 percent, it would result in a reduction of 1,000 transports to the emergency department. With a Medicaled payer mix of 14 percent, it would likely result in $1,600 fewer Medicaid transports per year, an estimated savings of $1,433 per patient, or over $8.3 million in annual potential savings to Medicaid in Fort Worth.
A BILL TO BE ENTITLED
AN ACT
relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024142, 531.02493, 531.0501, 531.0502, 531.0512, and 531.0605 to read as follows:

Sec. 531.024142. NONHOSPITAL AMBULANCE TRANSPORT AND TREATMENT PROGRAM. (a) The commission by rule shall develop and implement a program designed to improve quality of care and lower costs in Medicaid by:

(1) reducing avoidable transports to hospital emergency departments and unnecessary hospitalizations;

(2) encouraging transports to alternative care settings for appropriate care; and

(3) providing greater flexibility to ambulance care providers to address the emergency health care needs of Medicaid recipients following a 9-1-1 emergency services call.

(b) The program must be substantially similar to the Centers for Medicare and Medicaid Services' Emergency Triage, Treat, and Transport (ET3) model.
DRAFT POLICY -- OPEN FOR PUBLIC COMMENT

This drafted policy is open for a two-week public comment period. This box is not part of the drafted policy language itself and is intended for use only during the comment period to provide readers with a summary of what has changed.

As mandated by Rider 42, 87th Legislature, Regular Session, 2021, HHSC is performing a comprehensive review of the Medicaid Ambulance Services policy for Medicaid clients to add Emergency Triage, Treat and Transport (ET3) services. HHSC is publishing a draft of the updated policy as a result of this review.

The following is a summary of changes in scope for this policy review:

- Explained scope and requirements for ET3 services.
- Updated the ‘Reimbursement’ section of the policy to include guidelines related to ET3 services.
- Added five CMS approved destination modifiers to allow emergency ambulance transport reimbursement for transport to an alternative destination other than an emergency department, and for treatment in place (TIP).
- Added code Q3014 to be used as an indicator of TIP with telehealth or telemonitoring services - informational only and not reimbursable to ambulance providers.
ANCILLARY SERVICES AGREEMENT

This Ancillary Services Agreement ("Agreement") is made by and between [Name of Plan], a Texas Corporation, and the Metropolitan Area EMS Authority dba MedStar Mobile Healthcare ("Provider"), and becomes effective as of March 1, 2021 (Effective Date). PLAN and Provider are referred to herein individually as a "Party" and collectively as the "Parties".

RECITALS

WHEREAS, PLAN is a corporation duly organized for the purpose of contracting and insuring for the provision of health care services; and

WHEREAS, PLAN may contract with employers, individuals and others to provide, insure, arrange for or administer the provision of health care services; and

WHEREAS, PLAN has contracted or intends to contract directly with CMS and necessary state agencies to provide, insure, arrange for or administer the provision of health care services to Medicare beneficiaries; and
For Covered Services, Plan will pay based on the Payment Rate indicated below, less the applicable patient responsibility for the Member's Health Benefit Plan. Payment shall not exceed Provider's billed charges.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare-Covered Ground Ambulance Transport</td>
<td>100% of the Medicare Payment Rate</td>
</tr>
<tr>
<td>Ambulance Transport to Alternative Destinations</td>
<td>100% of the Medicare Payment Rate</td>
</tr>
<tr>
<td>Service identified by A0427 or A0429 with one of the following modifiers:</td>
<td></td>
</tr>
<tr>
<td>C: Community Mental Health Center</td>
<td></td>
</tr>
<tr>
<td>F: Federally Qualified Health Center</td>
<td></td>
</tr>
<tr>
<td>0: Physician Office</td>
<td></td>
</tr>
<tr>
<td>U: Urgent Care</td>
<td></td>
</tr>
<tr>
<td>Treatment in Place</td>
<td>100% of the Medicare Payment Rate</td>
</tr>
<tr>
<td>Service identified by A0427 or A0429 with modifier W: Treatment in Place or via Telehealth Service</td>
<td></td>
</tr>
</tbody>
</table>
Hi Matt,

I’m so sorry for the delay. We had to convene and then re-convene again when looking at the modeling! Anyway, we’re pleased to offer the following rates:

- A0425: $13.74
- A0426: $675.80
- **A0427: $1,126.75**
- A0428: $640.17
- A0429: $1,094.97
- A0433: $1,159.60
- A0434: $1,939.12
- **A0998: $1,126.75**

This revised rate proposal for A0425-A0434 reflects your average non-par per unit reimbursement when excluding denied claims (i.e., your true “allowed” amount, which includes what XXXXX paid plus member cost share), and the rate for A0998 matches the rate for A0427.

Please let me know if we can proceed.
# High Utilization Group

## Expenditure Savings Analysis (1)

**High Utilizer Program - All Referral Sources**

*Based on Medicare Rates*

<table>
<thead>
<tr>
<th>Analysis Dates</th>
<th>October 1, 2013 - December 31, 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients Enrolled (2, 3)</td>
<td>905</td>
</tr>
<tr>
<td>Ambulance Trip to ED Reduction</td>
<td>-68.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Base</th>
<th>Avoided</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Payment (4)</td>
<td>$419</td>
<td>5,889</td>
<td>($2,467,491)</td>
</tr>
<tr>
<td>ED Visits (5)</td>
<td>$969</td>
<td>5,545</td>
<td>($5,373,105)</td>
</tr>
<tr>
<td>Admissions (6)</td>
<td>$10,900</td>
<td>776</td>
<td>($8,461,670)</td>
</tr>
</tbody>
</table>

**Total Expenditure Savings**

($16,302,266)

**Per Patient Enrolled**

**Expenditure Savings**

HUG

($18,014)

**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. Includes High Utilizer and Designated System Abusers.
4. Medicare Tables from CY 2012 as published.
# Episodic Care Coordination

<table>
<thead>
<tr>
<th>Healthcare Provider</th>
<th>Total</th>
<th>Transported to ED</th>
<th>Transported to ED (%)</th>
<th>Not Transported to ED</th>
<th>Not Transported to ED (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-1-1 Calls</td>
<td>728</td>
<td>400</td>
<td>54.9%</td>
<td>328</td>
<td>45.1%</td>
</tr>
<tr>
<td>Unscheduled Visit Request</td>
<td>121</td>
<td>4</td>
<td>3.3%</td>
<td>117</td>
<td>96.7%</td>
</tr>
<tr>
<td><strong>Home Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-1-1 Calls</td>
<td>3848</td>
<td>2973</td>
<td>77.3%</td>
<td>875</td>
<td>22.7%</td>
</tr>
<tr>
<td>Unscheduled Visit Request</td>
<td>230</td>
<td>29</td>
<td>12.6%</td>
<td>201</td>
<td>87.4%</td>
</tr>
<tr>
<td><strong>Palliative Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-1-1 Calls</td>
<td>321</td>
<td>224</td>
<td>69.8%</td>
<td>97</td>
<td>30.2%</td>
</tr>
<tr>
<td>Unscheduled Visit Request</td>
<td>130</td>
<td>9</td>
<td>6.9%</td>
<td>121</td>
<td>93.1%</td>
</tr>
<tr>
<td><strong>Landmark Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-1-1 Calls</td>
<td>895</td>
<td>715</td>
<td>79.9%</td>
<td>180</td>
<td>20.1%</td>
</tr>
<tr>
<td>Unscheduled Visit Request</td>
<td>129</td>
<td>10</td>
<td>7.8%</td>
<td>119</td>
<td>92.2%</td>
</tr>
</tbody>
</table>
Mobile Integrated Healthcare Program

Measurement Strategy Overview

Aim
A clearly articulated goal statement that describes how much improvement by when and links all the specific outcome measures; what are we trying to accomplish? Develop a uniform set of measures which leads to the optimum sustainability and utilization of patient centered, mobile resources in the out-of-hospital environment and achieves the Triple Aim® — improve the quality and experience of care; improve the health of populations; and reduce per capita cost.

Measures Definition:

1. **18 Core Measures** ("CORE MEASURE" in the description)
   a. Measures that are considered by the measures development team through experience as essential for program integrity, patient safety and outcome demonstration.

2. **CMMI Big Four Measures (RED)**
   a. Measures that have been identified by the CMS Center for Medicare and Medicaid Improvement (CMMI) as the four primary outcome measures for healthcare utilization.

3. **MIH Big Four Measures (ORANGE)**
   a. Measures that are considered mandatory to be reported in order to classify the program as a bona-fide MIH or Community Paramedic program.

4. **Top 18 Measures** *(Highlighted)*
   a. The 18 measures identified by the numerous operating MIH/CP programs as essential, collectable and highest priority to their healthcare partners.

Notes:

1. All financial calculations are based on the national average Medicare payment for the intervention described. Providers are encouraged to also determine the regional average Medicare payment for the interventions described.
2. Value may also be determined by local stakeholders in different ways such as reduced opportunity cost, enhanced availability of resources. Program sponsors should develop local measures to demonstrate this value as well.

Final 1

Release Date: 11-1-16

https://www.naemt.org/resources/mih-cp/mih-cp-program-toolkit
It’s 7:30 in the evening and your kiddo comes in from playing outside with a mild asthma attack. Her rescue inhaler is not working as well as it usually does. Or your mom wakes up at 1 o’clock in the morning with mild difficulty breathing due to her congestive heart failure. What do you do in these cases? You don’t think a 911 response is necessary, but you would like to have a trusted medical provider come check them out and administer medical care.

MedStar has a solution! MedStarSaver+PLUS: MedStar on Demand is a subscription-based service that offers 24-hour access to our community paramedic team to care for minor medical or trauma conditions that do not require a 911 response.

If you do call 911, MedStar on Demand members will typically receive a MedStar community paramedic response, along with the ambulance and first responders. The community paramedic can use special protocols and procedures to treat the patient on scene, potentially preventing an avoidable ambulance trip to an emergency department.
MedStar saves lives.  
Membership saves money.  

There’s no need to worry when trouble strikes because MedStar’s industry leading health heroes are always around the corner to swoop in and take care of your urgent medical needs. And now, MedStar can save you from financial trauma, too. For only $350 per year, a MedStar Saver+Plus membership shields you from out-of-pocket costs your insurance does not cover AND helps you navigate your urgent healthcare needs.

Give your family complete peace of mind in life’s emergencies.

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**StarSaver+PLUS Benefits:**

- Physical & medical assessment of the Primary and Secondary StarSaver+Plus Member
- Identification of any perceived medical or healthcare gaps
- Medication inventory
- Documentation of any relevant medical documentation

- Registration in MedStar’s Mobile Integrated Healthcare (MIH) Program
  - Notification to the Primary and Secondary Member’s Primary Care Physician (PCP) of their enrollment into the StarSaver+Plus program
  - Specialized protocols used in the MIH program
  - Primary and Secondary member tracked in MedStar’s 9-1-1 Dispatch System
  - Up to two (2) additional non-emergency in-home visits per year at the request of the primary or secondary

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