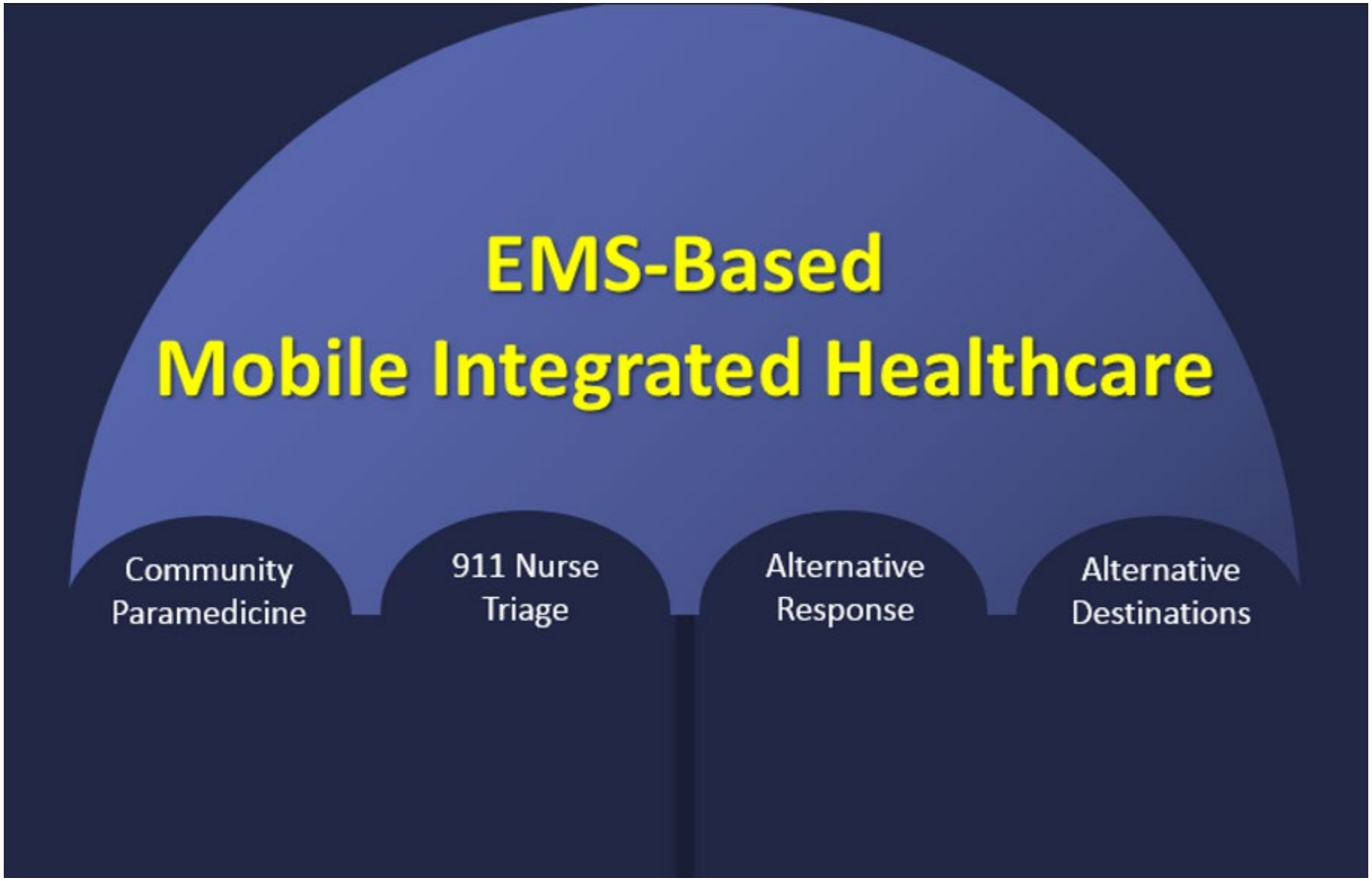
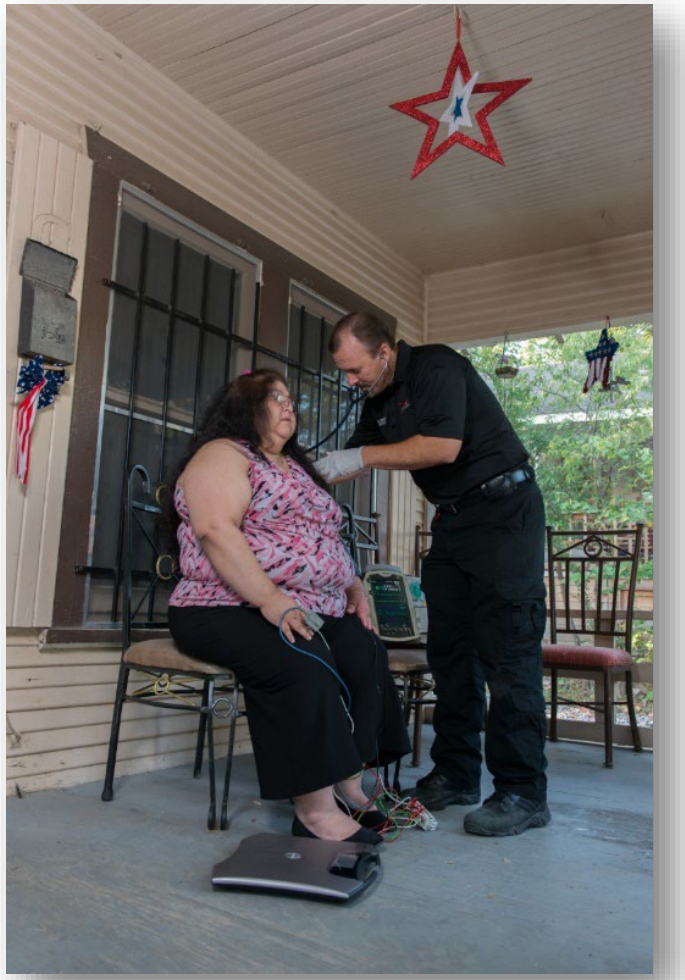
About MedStar…

- Governmental agency (PUM) serving Ft. Worth and 14 Suburban Cities
  - Self-Operated
  - 1,016,963 residents, 434 Sq. miles
  - Exclusive provider - emergency and non-emergency
- 180,858 responses (FY 2021-22)
- 481 full time employees
- $59.8 million budget (FY 2022-23)
  - **No tax subsidy**
- Fully deployed Dynamic Resource Management
- Medical Control from 18-member Emergency Physician's Advisory Board (EPAB)
  - 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…**
  - High Utilizer Group (HUG) patients
  - 9-1-1 Nurse Triage program
  - CHF readmission prevention
  - Hospice revocation avoidance
  - Observation admission avoidance
  - Home Health partnership
  - Palliative Care Partnership
  - OD reduction program




MOLINA
HEALTHCARE


care@care


Southwestern Health Resources
Texas Health Resources
UTSouthwestern Medical Center


Landmark


VITAS
Healthcare


Cigna


Texas Health
Resources


CookChildren's
Health Plan

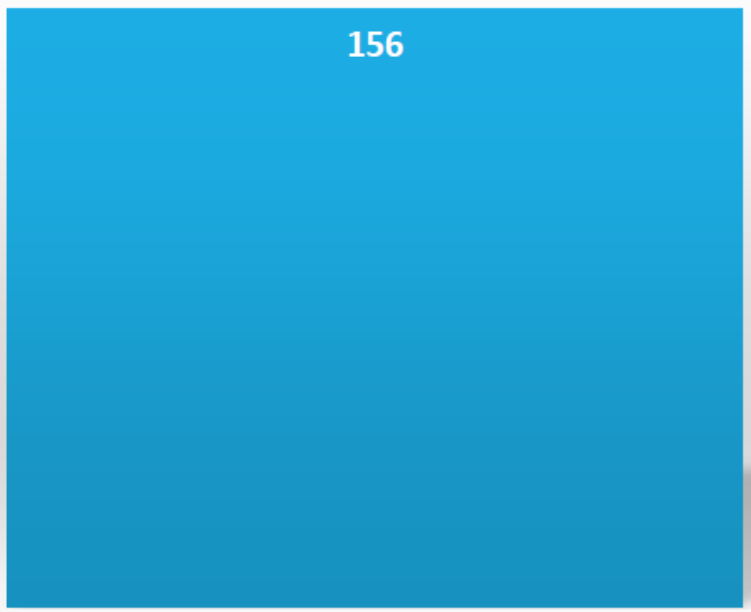

Klarus
Home Care


MEDSTAR
MOBILE HEALTHCARE

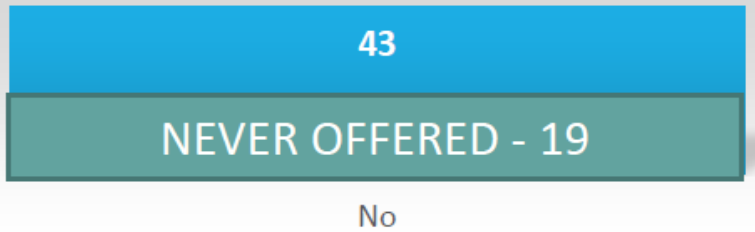
2023 National Survey on MIH-CP Programs

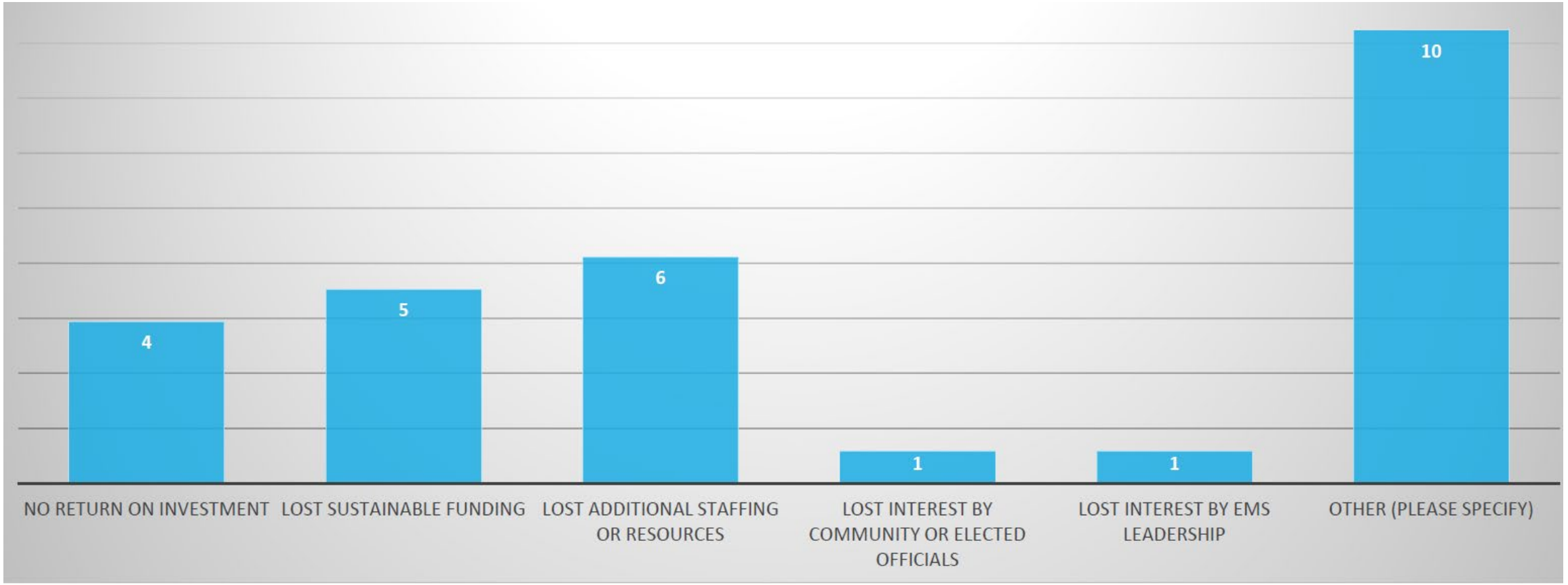
NATIONAL ASSOCIATION OF EMERGENCY MEDICAL TECHNICIANS (NAEMT)

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

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NAEMT®

Educational Models & Training…

Foundational Considerations

- **What are the gaps to be filled by the MIH program/providers?**
  - Scope issues?
- **Are *YOU* comfortable with the agency filling the gap?**
  - What are the gaps in current vs. desired education and training level?
  - 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?**
  - Texas vs. California, Massachusetts, etc.

MEDSTAR MOBILE HEALTHCARE

IBSC INTERNATIONAL BOARD OF SPECIALTY CERTIFICATION

CERTIFIED COMMUNITY PARAMEDIC
KNOWLEDGE.EXPERIENCE.EXCELLENCE
CP-C

COMMUNITY PARAMEDIC

CERTIFICATION (CP-C®)

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.

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https://www.ibscertifications.org/roles/community-paramedic

Candidate Handbook

The CP-C examination and certification program is accredited by the National Commission for Certifying Agencies (NCCA)

INTERNATIONAL BOARD OF SPECIALTY CERTIFICATION

October 2020

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 stages; 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-diuresis 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., coag studies, BMP, ABG, CBC, D-dimer, BNP)
   - gg) Implanted devices (e.g., VADs, PEG tubes, AICDs)
   - 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-surgical, post-discharge, post-stroke care)
   - ll) Acute medical conditions (e.g.,

Home / Education / Community Paramedicine Series

Community Paramedicine Series

Community Paramedicine Series
- Motivational Interviewing
- Wellness and Nutrition
- Hospice and Palliative Care

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

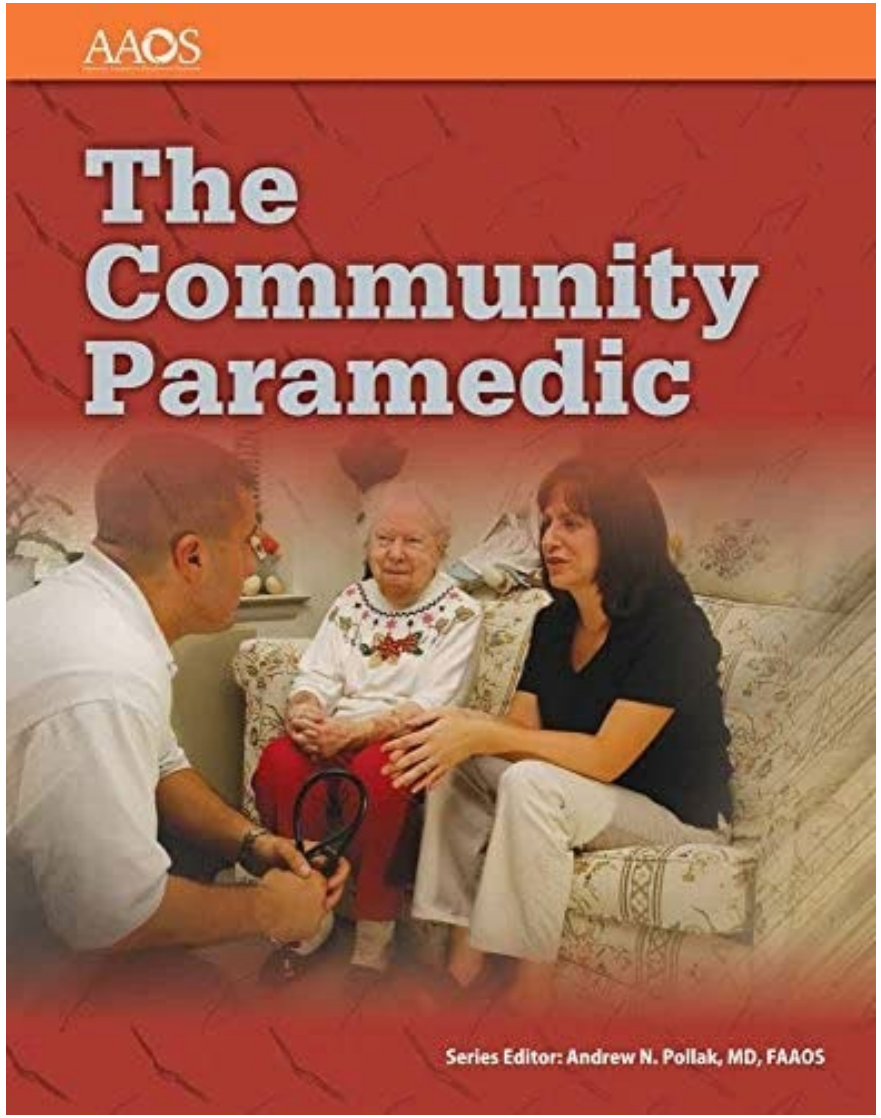

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Image Credit: American Hospital Association

https://www.aha.org/news/headline/2018-10-18-aha-nul-release-resources-building-community-health-worker-programs

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.

https://www.aha.org/news/headline/2018-10-18-aha-nul-release-resources-building-community-health-worker-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

MEDSTAR MOBILE HEALTHCARE

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

“ET3” Models…

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 new 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)

Documented **Medicare** & **Medicaid** Patient Contacts	88,661	
≥ 65	71,033	80.1%
< 65	17,565	19.8%
Not Documented	63	
Transported	71,426	80.6%
AMA (incl. Refused All Care & Refusal w/o Capacity)	10,018	11.3%
ET3 Intervention Offered	7,883	8.9%
ET3 Intervention Accepted	1,368	17.4%
IES	1,349	
MHMR ICARE	19	
Outcomes		
Transported	60	4.4%
Hospital ED	53	
Other	7	
TIP	1,296	96.1%
Dispatch Health Referral	556	42.9%
MCOT Referral	9	

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

I was satisfied with the level of treatment.	The wait time for treatment was reasonable.	I would consent to this treatment option again if needed.	Is there anything else you would like to share about your experience?
75	100	75	
100	100	100	Five stars
100	100	100	
100	100	100	
100	100	100	
95.0	**100.0**	**95.0**	**Composite Score**

Telehealth

I was satisfied with the level of treatment.	The wait time for treatment was reasonable.	I would consent to this treatment option again if needed.	Is there anything else you would like to share about your experience?
100	100	100	Awesome Job GUYS!!
100	100	100	They really good very courteous and explained everything thank you
25	75	1	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!
100	75	100	They were excellent and got me to where I needed
100	100	100	They were very good at what they did
100	100	100	Very professional treatment, & care
87.5	**91.7**	**83.5**	**Composite Score**

Convincing Other Payers

TEXAS EMS ALLIANCE

EMS INNOVATION
TREATMENT IN PLACE & ALTERNATE DESTINATION TRANSPORT

SB 2028 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 transports.

SB 2028 by Sen. Lois Kolkhorst and the accompanying rider by Rep. Giovanni Capriglione seek to apply Medicare's ET3 model to the Texas Medicaid program.

THE ALTERNATE DESTINATION PROJECT IN TARRANT COUNTY

Many Texas EMS agencies are already offering innovative alternative care models in their communities. MedStar Mobile Healthcare, which provides EMS for Tarrant County, implemented the alternate destination project with a large commercial payer in April 2018. The program is available to the commercial plan's 14,000 members in the service area. The plan pays the EMS agency a PMPM Capitated payment (versus the traditional fee-for-service for transports).

Crews 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 two patients met the criteria to need immediate transport from the scene of the 9-1-1 call to an alternate destination (urgent care). One patient had an ankle injury and the other had flu-like symptoms with a comorbidity.

The hospital transport rate for 9-1-1 callers in this population has dropped from an average of 71 percent to 64 percent. MedStar believes that this is a result of these patients being assessed, treated and referred from the scene to other health care follow-up appointments that do not require ambulance transport to get there.

The return-on-investment for the payer is the delta of 27 calls that did not go to the emergency department, at an average ED payment of $2,700, or $48,000 in six months.

MedStar responds to 140,000 calls per year and transports 99,600 patients. If its overall transport rate dropped to 64 percent, it would result in a reduction of 9,900 transports to the emergency department. With a Medicaid payer mix of 16 percent, it would likely result in 1,600 fewer Medicaid transports per year, at an estimated savings of $1,430 per patient, or over $2.3 million in annual potential savings to Medicaid in Fort Worth.

Legislative Advertising Authorized by:
Craig Holzheauser | Texas EMS Alliance | P.O. Box 13531 | Austin, Texas 78711

MEDSTAR MOBILE HEALTHCARE

By: Kolkhorst S.B. No. 2028

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 _____. ("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.

SERVICE	PAYMENT RATE
Medicare-Covered Ground Ambulance Transport	100% of the Medicare Payment Rate
Ambulance Transport to Alternative Destinations *Service identified by A0427 or A0429 with one of the following modifiers:* *C: Community Mental Health Center* *F: Federally Qualified Health Center* *0: Physician Office* *U: Urgent Care*	100% of the Medicare Payment Rate
Treatment in Place *Service identified by A0427 or A0429 with modifier W: Treatment in Place or via Telehealth Service*	100% of the Medicare Payment Rate

From: Silbert, Nicholas (Nick) 629 <Nicholas.Silbert@XXXXXXXXXXX.com>
Sent: Friday, October 15, 2021 2:06 PM
To: Matt Zavadsky <mzavadsky@medstar911.org>
Subject: RE: [External] Medstar/XXXXX commercial contract

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.

MEDSTAR MOBILE HEALTHCARE

High Utilization Group

Expenditure Savings Analysis (1)	High Utilizer Program - All Referral Sources		
Based on Medicare Rates			
Analysis Dates:	October 1, 2013 - December 31, 2022		
Number of Patients Enrolled (2, 3):	905		
Ambulance Trip to ED Reduction:	-48.4%		
	Utilization Change		
Category	**Base**	**Avoided**	**Savings**
Ambulance Payment (4)	$419	5,889	($2,467,491)
ED Visits (5)	$969	5,545	($5,373,105)
Admissions (6)	$10,900	776	($8,461,670)
Total Expenditure Savings			**($16,302,266)**
Per Patient Enrolled			**HUG**
Expenditure Savings			**($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*
5. *10.1377/hlthaff.2018.0083HEALTH AFFAIRS 37NO. 7 (2018): 1109–1114*
6. *https://www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.jsp*

Episodic Care Coordination

Hospice	Total	Transported to ED	Transported to ED (%)	Not Transported to ED	Not Transported to ED (%)
9-1-1 Calls	728	400	54.9%	328	45.1%
Unscheduled Visit Request	121	4	3.3%	117	96.7%
Home Health	**Total**	**Transported to ED**	**Transported to ED (%)**	**Not Transported to ED**	**Not Transported to ED (%)**
9-1-1 Calls	3848	2973	77.3%	875	22.7%
Unscheduled Visit Request	230	29	12.6%	201	87.4%
Palliative Care	**Total**	**Transported to ED**	**Transported to ED (%)**	**Not Transported to ED**	**Not Transported to ED (%)**
9-1-1 Calls	321	224	69.8%	97	30.2%
Unscheduled Visit Request	130	9	6.9%	121	93.1%
Landmark Health	**Total**	**Transported to ED**	**Transported to ED (%)**	**Not Transported to ED**	**Not Transported to ED (%)**
9-1-1 Calls	895	715	79.9%	180	20.1%
Unscheduled Visit Request	129	10	7.8%	119	92.2%

MEDSTAR MOBILE HEALTHCARE

MEDSTAR MOBILE HEALTHCARE

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.

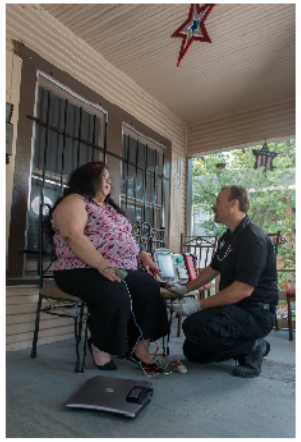
https://www.naemt.org/resources/mih-cp/mih-cp-program-toolkit

System (re)Design = “EMS on Demand”

MedStar Releases MedStarSaver+PLUS: MedStar on Demand to Area Residents

Program Offers 24/7 Access to Community Paramedics for Peace of Mind to Avoid a Preventable ER Visit

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.

MedStar Saver
One low price

+

Mobile Medical Care
Worry-free service

=

Peace of Mind
Ambulance ride covered

2900 Alta Mere Drive Fort Worth, TX 76116

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

Join today |
www.medstarsaver.org
Membership@medstar911.org |
817.923.3700, ext. 135