Mobile Healthcare Access & Integration Pilot Study Sub-Committee Report

Presented By:
Tom Fitzgerald, MD
Chairman, Rural Hospital Stabilization Sub-Committee
Nita Ham, Principal Investigator
SORH Pilot Study
Overview of Pilot Study

- **This pilot study will evaluate the actual cost, benefit, and value of including EMS in care coordination for rural residents**
  
  - Three Year Study Period
    - Fiscal Years 2018 (study designed), 2019, 2020 (implementation)
  
  - Program Divided into Two Phases
    - **Phase One (FY19)**
      - Implementation of Mobile Integrated Healthcare/Community Paramedicine Program (MIH/CP)
    - **Phase Two (FY20)**
      - Implementation of Transport to Alternate Destination and Treat Without Transport
Phase One Goals

• Closely evaluate every aspect of the MIH/CP Service
  – Exact Cost of Service Delivery
  – Define Measurable Savings to Hospitals and Patients
  – Determine Benefit to Patients and Providers

• Performance Measures to Determine Cost and Value
  – Accountants from Draffin Tucker will guide collection, evaluation, and reporting of financial measures

• Performance Measures to Determine Benefit
  – Medical Directors and Project Managers will oversee collection, evaluation, and reporting of measures to determine benefits to patients and providers
Phase One Implementation

• Began July 1, 2018
  – Four Pilot Sites
    Habersham, Washington, Effingham, Miller Counties
  – Two Models
    • EMS Based
    • Hospital Based
  – Two part-time programs
    • Washington & Miller
  – Two full-time programs
    • Habersham & Effingham

• Total of 64 patients enrolled in program
  – 8 have successfully met goals/graduated
  – 37 patients still enrolled
  – 4 patients deceased
  – 15 patients discharged from program for other reasons
    • Moved, transferred to other care, voluntarily resigned, non-compliance
Financial Analysis

• Evaluation of charges (per enrolled patient) associated with EMS, emergency department, and hospital admissions
  – “Look-Back” period one year prior to enrollment in program
  – During enrollment period
  – One year after graduation from program
• FY 19 final data will be available in December 2019
Other Data Collected

- Number of visits per patient
- Time on Task
  - Patient contact
  - Patient support
- Reason for visit/clinical services provided
  - Level “A”, “B”, C” services
- Supplies used
- Mileage
- All data translates to actual cost of services provided
Patient Satisfaction Surveys

- Patient satisfaction surveys are presented to patients (through a 3rd party) during and upon graduation from the program.
- Questions are simple and use a rating scale
- Patients are also given the opportunity provide comments
- Surveys are mailed directly back to the State Office of Rural Health
Patient Satisfaction Surveys

Do you feel that your health has improved since Paramedics started visiting with you?

- Yes: 87%
- Somewhat: 13%

Do you feel that you can take better care of yourself because of this program?

- Yes: 93%
- Somewhat: 7%
Patient Satisfaction Surveys

Do you see your regular doctor more often now since being in this program?

- Yes: 13%
- About the same as before: 33%
- No: 54%
Phase Two Goals (Implementation 2019)

• Include EMS Providers Responding to “9-1-1” Calls in Care Coordination
• Includes Close Medical Director Oversight
• Protocol Driven
• Requires Additional Training for EMS Providers
  – Transport to Alternate Destination
    • Option for “9-1-1” providers to transport appropriately screened patients to locations other than emergency departments
  – Treat Without Transport
    • Option for “9-1-1” providers to treat appropriately screened patients on site without immediate transport to a medical facility
What is the ET3 Model?

Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service beneficiaries following a 911 call. Under the ET3 model, the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination (such as a primary care doctor’s office or an urgent care clinic), or 3) provide treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth.
Additional Information About ET3

Implementation Delayed: CMS ET3 Program

- Final version of Pilot Study protocols were delayed to allow opportunity to meet CMS program requirements.
- Pilot Study Attorney Chris Kelly has been instrumental in editing current documents to ensure alignment with CMS
  - Pilot sites may submit application for program if desired
- Study may be extended through FY21
Conclusion

• **SORH Anticipates** Outcomes of Study Will:
  – Provide publishable information and data not currently available
  – Define “billable” services provided through MIH/CP programs
  – Guide conversations with payors to change reimbursement for EMS
  – Improve health and well-being of rural residents through better self-management of chronic conditions
  – Encourage EMS leaders to become more engaged in their medical communities and consider including care coordination initiatives in daily operations

• “Thank You!” to the *Many* Partners Associated with this Study
Purpose:

Shaping the future of A Healthy Georgia by improving access and ensuring quality to strengthen the communities we serve.