

MOBILE INTEGRATED HEALTHCARE NETWORK

Paramedic Service & FQHC Partnership



WASHINGTON COUNTY
MOBILE INTEGRATED
HEALTHCARE NETWORK

Justin P. Duncan MPHc, BS, ACP, CCP, FPC

Chief Executive Officer | Washington County Ambulance District
President | Missouri Emergency Medical Services Association
Chairman | Missouri State Advisory Council – MIH Subcommittee

Washington County Ambulance District | Regional Mobile Healthcare Agency

- ❖ Mineral Area College EMS Education
- ❖ Meramec Ambulance District
- ❖ Reynolds County Ambulance District

ABOUT OUR AREA

- **WCAD: 762 square miles**
 - Rural Setting
 - Socioeconomic Factors
 - Health Literacy Factors
 - Compliance Factors
- **Expanded coverage to ~1,500 square miles**
 - Reynolds County
 - Dent County (partial)
 - Franklin County (partial)
 - Jefferson County (partial)
 - St. Louis (partial)

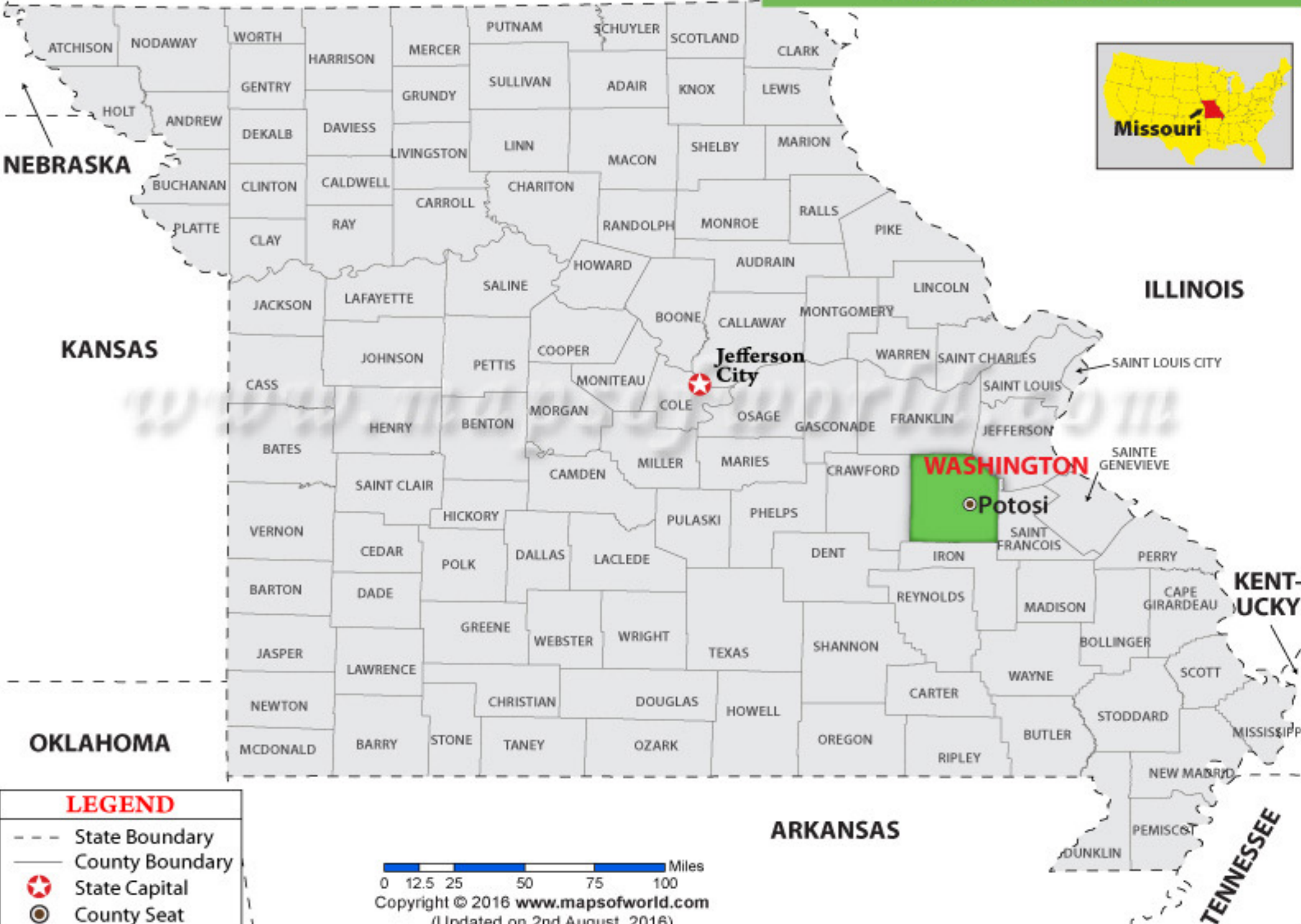




IOWA

WASHINGTON COUNTY MAP

Located in Missouri



LEGEND

- State Boundary
- County Boundary
- ★ State Capital
- County Seat

0 12.5 25 50 75 100 Miles
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(Updated on 2nd August, 2016)

MIHN PARTNERSHIP



ABOUT THE MIHN

Mission

Vision

Values

A Missouri 501(c)3



HOW WE GOT STARTED - COVID-19

- We came together for common good: Paramedic Service / Public Health Department / FQHC / Hospital / Local Government
- In-home COVID-19 swabs for those that can't/won't get out
- In-home lab draws for all local clinic groups for those that can't/won't get out
- Wellness checks for missed appointments for all local clinics
- COVID-19 "assessments" in-home based on concerns of
 - Public Health
 - Clinics
 - Patient
- COVID-19 vaccination clinics with Public Health / FQHC / Hospital

****We have identified patients that would have..... Not fared well in this process.....**

****Paramedic Service Current Reimbursement = \$00.00**

**** FQHC Current Reimbursement = Tele-Health Encounter plus labs.**



MAKING A DIFFERENCE



18,000
Vaccines
Administered
in 2020

OUR FIRST FORMAL MIH PROJECT



MHN FUNDED: DIABETIC PROJECT

Diabetic patients – Medicaid – Not Compliant

GMHC / CHW = schedules appointments

WCAD = makes a house call

- Home / risk / safety assessment completed
- Full assessment, tracking of progress, assessment of current status
- VS, EKG, FSBS, **A1C (in home), lab draw (basic labs)**, assess for other needs
- Charts in clinic chart (BAA in place)

WCAD calls GMHC CHW = telehealth visit with NP/PA/DO/MD

- Full report on assessment, current state, obvious concerns not associated with the control of diabetes (wound identified? Cough? Cold? Febrile?)
- New orders given for additional (extra labs, UA (in home assessment!!), swab, etc.

DIABETIC PROJECT: EARLY LESSONS LEARNED

CHWs are the ticket = gatekeepers = patient navigators

Charting software / EMRs need to talk

Clinic providers and MIHN Clinicians need to form a special bond

- “Physician / Provider Extender = MIHN Clinician”

Just because you set an appointment for one reason; you wind up treating others..... “whole patient care”

- Dental
- Behavioral Health
- Home Safety
- Resource Assistance

YEAR 1 RESULTS: DIABETIC PROJECT

Reduction of ED visits by 100%

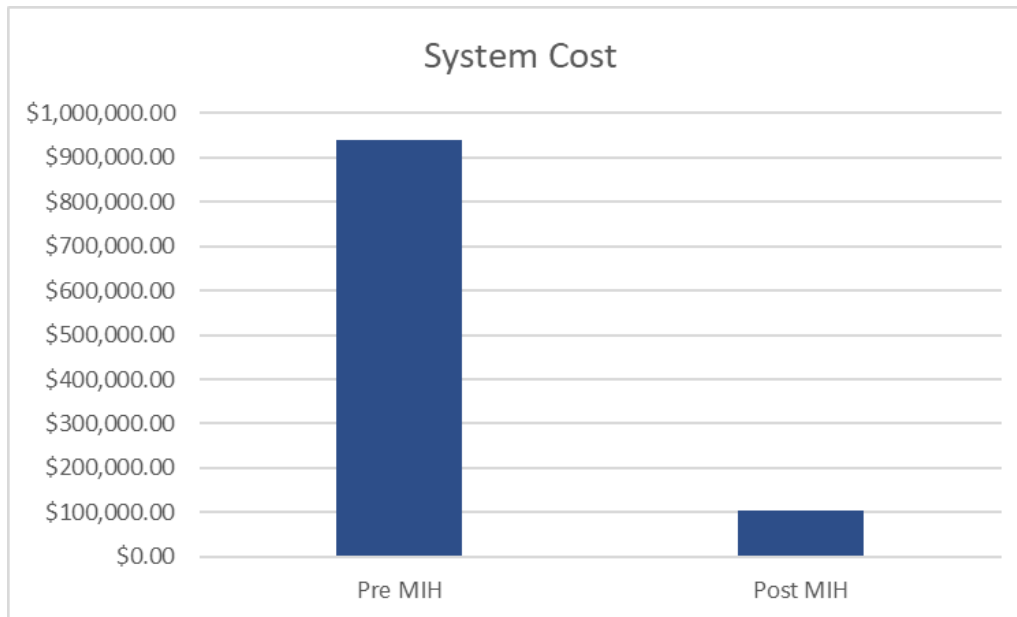
Every patient enrolled in the initial program (21) saw improvement

- ✓ **A1C reduction**
- ✓ **Compliance Increased**
- ✓ **Follow-Up Care (in home)**
- ✓ **Zero EMS Transport / ED Visit / Admissions**

Patient Satisfaction = 100% POSITIVE survey results

COST SAVINGS ANALYSIS

	Patients	EMS Transport	EMS Non-Transport	ED Visit	MS Admit	ICU Admit	Clinic Services	System Cost
MHN Reimbursement		\$500.00	\$242.00	\$1,000.00	\$11,000.00	\$25,000.00	\$500.00	
Pre MIH	21	5	5	5	1	1	0	
		\$52,500.00	\$25,410.00	\$105,000.00	\$231,000.00	\$525,000.00	\$0.00	\$938,910.00
Post MIH	21	0	0	0	0	0	10	
		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$105,000.00	\$105,000.00



Cost Reduction: ~\$834k

89%

These figures are estimated based upon average reimbursements from MHN.

TIME FOR EXPANSION

A formal relationship
was established.



OVERVIEW OF OUR MIH MODEL



Initiate primary care in the home with Community Paramedics. Telehealth use PRN.



Community Paramedics serve as the bridge between the patient and the clinic provider



Help prevent inappropriate or overutilization of high-cost emergency medical services or hospital EDs



Connect patients to Community Health Workers who help link them to needed resources to support good health

MIHN PROGRAM GOALS

We Know:

- Sick people don't manage their conditions well
- Sick people give up and have poor follow through
- Compliance is poor in our chronically ill
- EDs are utilized for primary care
- Paramedic Services/911 are utilized for primary care

We Hope To:

- Improve Quality of Life
- Close Care GAP's
- Reduce Morbidity and Mortality
- Save the System Money
- Advocate for Innovation

MIH SERVICES

- ❖ Chronic Disease Management
- ❖ Telehealth Provider Appointments
- ❖ In-Home Diagnostics
- ❖ In-Home Point of Care Testing
- ❖ In-Home Safety Assessments
- ❖ In-Home Infusions
- ❖ Medication Reconciliation
- ❖ Care Coordination
- ❖ Non-Emergency Transportation (WC Van / Ride Program)
- ❖ Public Health Support
- ❖ Home Health Bridge Support
- ❖ Hospice Bridge Support
- ❖ No-Call, No-Show Follow Up

CP VEHICLE | MIH-1



NEMT | MIH-10



CLINICAL PROGRAM

- ❖ Telehealth Provider Appointments
 - ❖ Primary Care
 - ❖ Specialist
 - ❖ Behavioral Health
- ❖ Diagnostics
 - ❖ EKG
 - ❖ Ultrasound
- ❖ Point of Care Testing
 - ❖ A1C
 - ❖ Basic Labs (venous / UA / etc.)
 - ❖ Swabbing (COVID, Flu, Strep)
- ❖ In-Home Safety Assessments
- ❖ Medication Reconciliation
- ❖ Care Coordination
- ❖ Non-Emergency Transportation (WC Van / Ride Program)
- ❖ Public Health
 - ❖ Vaccines (COVID, Flu, Pneumonia, Shingles, Hep A, etc.)
 - ❖ Blood Draws

NON-CLINICAL PROGRAM

- **Home Safety**
- **Social Determinants of Health**
 - **Food, Shelter, Water, Medications**
- **Health Literacy**
- **Environmental and Safety Risks**
- **Medicaid Enrollment**
 - **Recently expanded in MO**

CQI PROCESS



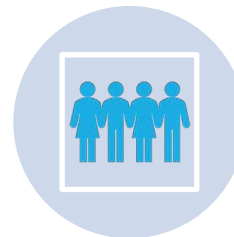
Joint CMO



Joint Quality Office



Patient Satisfaction



Quality Matrix &
Clinical Outcomes

MIHN OUTCOMES

Improved access to care, especially chronic disease management services

Increased access to community resources to address social determinants of health

Increased patient engagement

Increase patient satisfaction

Improved compliance with medication regimens

Improved COVID response (testing, vaccination, monoclonal infusions)

Greater percentage of care plan goals achieved

Improved health status (as measured by clinical indicators)

WHAT DOES IT TAKE?



It takes a village.....



The right team



An education program



Referral sources



Data tracking and trending



OUR PROJECTS

Diverse grant funding.



HRSA GRANT – HEART DISEASE

RURAL HEALTHCARE SERVICES OUTREACH PROGRAM

HEALTH RURAL HOMETOWN INITIATIVE

Target = high utilizers / non-compliant CAD patients

Goal = reduce 911 use, ED use, ICU admission, Med/Surg or Tele admission

Goal = get more CPs / MIHN Clinicians out there!

Targeted care in home Coordinated Telehealth Visit (with MIHN Clinician at bedside)

- Initial visit: CBC, CMP, Cardiac Enzymes
- Multi-lead EKG for baseline compare / trend changes / sent to cardiology for review
- In home echo / sent to cardiology for review
- Medication reconciliation / education
- In-home safety assessment

CDC CCR GRANT – CHW

COMMUNITY COVID RESPONSE



GOAL = Identify COVID positive patients
➤ RAPID Swabbing 5 days / week

GOAL = Provide treatment for COVID positive patients
➤ mAB treatments

GOAL = Provide wellness checks for COVID positive patients
➤ Public Health = primary referral source

GOAL = Get shots in arms!

BY THE NUMBERS

Total MIH Encounters 2021

- 7,000

CP's on Staff

- 2 Full-Time
- 2 Half-Time
- 10 PRN

CHW's on Staff

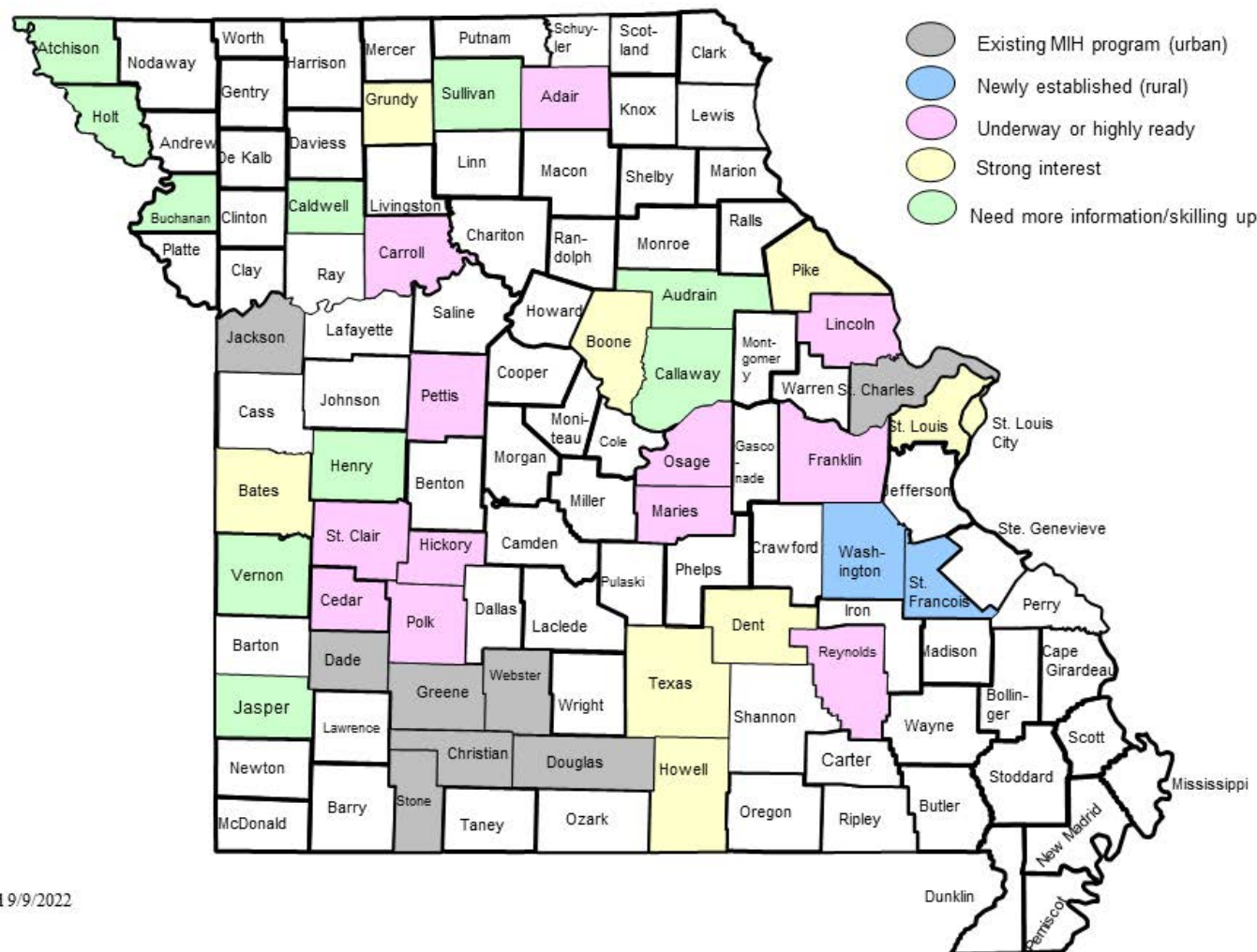
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Statewide Growth

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STATEWIDE EFFORTS

MISSOURI MOBILE INTEGRATED HEALTHCARE EXPANSION MAP



Revised 9/9/2022

PROJECTS IN PRODUCTION

SUD / OUD / Behavioral Health

Suboxone Initiation by CP

Care Coordination by CP / CHW

Public Health / Hospital / 911 / Law Referral

Maternal Health

Prenatal Care Coordination by CP / CHW

WIC / Public Health Referral

SUCCESS STORIES

Right Care. Right Place. Right Time.



SUCCESS STORY: MR. EARL

- HX: Mr. E is a patient who suffers from multiple chronic care conditions which limit his mobility and ease transportation. Patient must use a walker for ambulation and has also voiced his anxiety is also a barrier to keeping doctor's appointments.
- DX: Hypertension, Type 2 Diabetes, COPD, Bilateral Primary Osteoarthritis of Knees, Generalized Anxiety disorder, Morbidly Obese, Obstructive Sleep Apnea, Dyspnea on Exertion, Chronic Musculoskeletal Pain and Knee Pain
- **Cancelled 10 clinic visits 2020**
- Enrolled in MIHN in 2021
- Patient is now compliant with visits and treatment due to MIH program.



I EARL JONES - This program has been a life sent for I'm mobility impaired with very strained knees were I can hardly walk and get around getting in a car to go and in and out to get to destinations is a very hard task I commend the professional treatment I get from the EMT. It takes a lot of anxiety out of having to do doctor appointments the relaxation of being in your own home is like a god sent program for people like me and for elders that have very little mobility so I hope this program can go on existing for disability people like myself

Sincerely
Earl Jones

SUCCESS STORY: MR. JOHNSON

- Dx: COPD, Hypertension, History of CVA, Benign Prostatic Hyperplasia, Left Humeral Fracture, Atherosclerotic Heart Disease Native Coronary Artery w/angina Pectoris
- HX: Prior to MIH program (2021) patient was not receiving any care since 2013. Cash Pay patient.
- Patient was enrolled and care was resumed.
 - Patient was assisted with applying for MCD, resulting in health care coverage.
 - Patient was then able to attend specialist visits for Urology and Ortho consults.



CASE STUDY: KF

THIS IS A REAL PATIENT ENROLLED IN OUR PROGRAM

KF is an obese female with Diabetes and underlying mental health issues

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

**64 documented Paramedic transports
2020 – 2021**

- Additional 74 no transport Paramedic runs
- Enrolled in MIHN late 2021
- MIH SAVE: Multiple providers prescribed Haldol (x5)

KF: 2020-2021

**Total Medicaid/Medicare claim charges for
all providers for all types of care (System
Cost) = \$177,966.10**

KF IS A PERSON.

HER NAME IS KINDLE FOXX.

Note: The patient provided written consent for her name, history, background, photos and entire story to be shared.











KINDLE: PRESENT DAY

MIH Compliant

- Improved quality of life

2022 : 911 use x 2

2022 MIH Costs YTD:

\$614.40 (Paramedic Service transport cost)

\$3,981.16 (Hospital ED cost)

\$354 (other medical)

Total: \$4,949.56

KF: COST SAVINGS

Without MIH 1 year: \$118,055.32

With MIHN YTD: \$4,949.56

Savings: \$113,105.76

95.8% Cost Avoidance



THE POTENTIAL

Take the savings of..... \$113,106 in 12 months.....

Now assume replication x 1,000 patients statewide.....

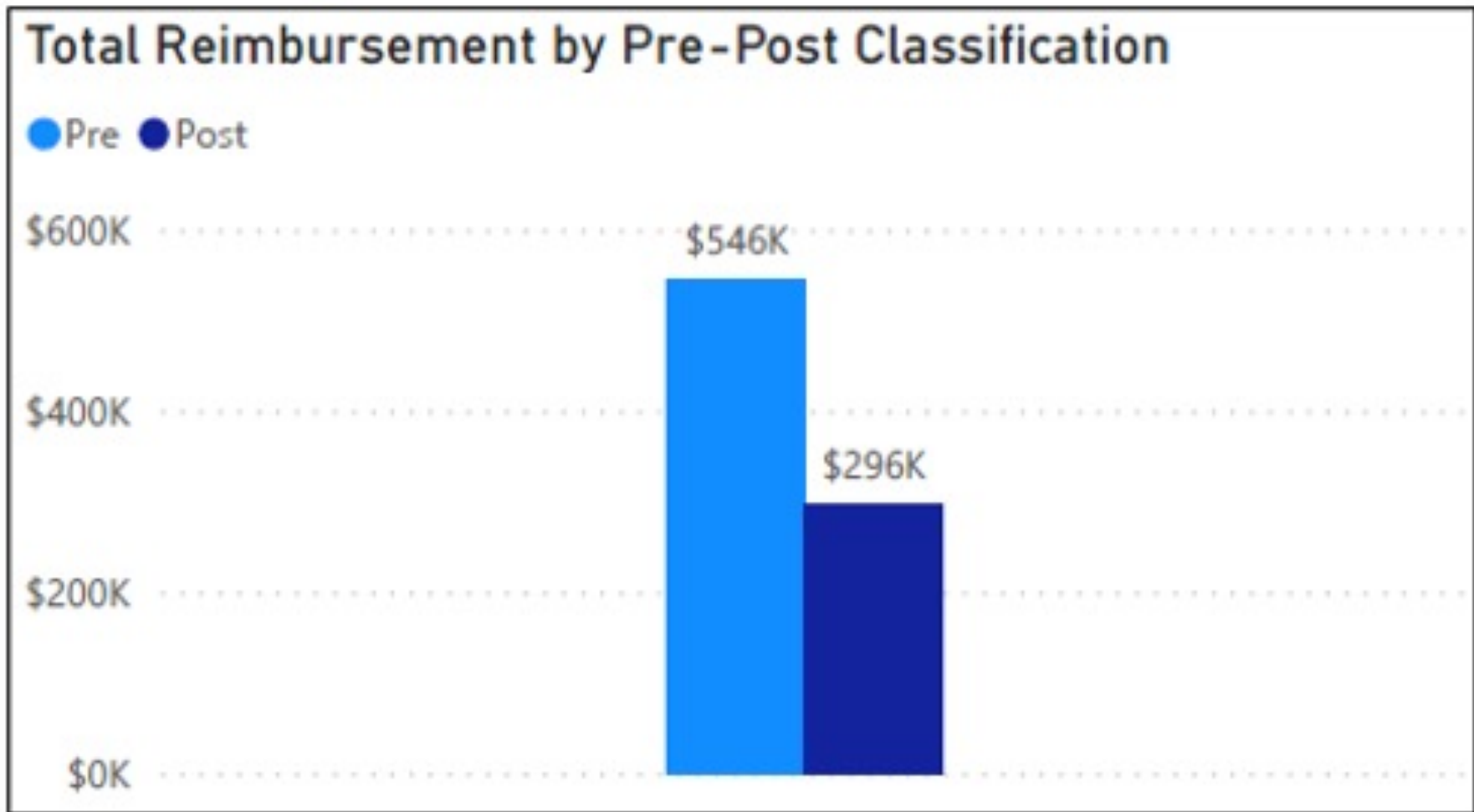
Savings: \$113,106,000

Or assume replication x 10,000 patients statewide.....

Savings: \$1.13 billion



RANDOM 20 PATIENT MIH COHORT





WRAPPING UP: WHY IT WORKS

- ❖ FQHC & Paramedic Service: Similar Mission / Vision / Values
- ❖ Both serve as safety net for high need and underserved patients
- ❖ CHWs are an excellent fit for both organizations
- ❖ Shared/leveraged staff and resources
- ❖ Both entities benefit when high need/high use patients have a medical home

FQHC Specific

- Fewer no shows
- Telehealth reimbursement
- Improved clinical measures (results in quality incentive payments)
- Increased patient engagement
- Improved provider satisfaction for telehealth visits

Paramedic Service Specific

- Fewer low acuity paramedic ambulance calls
- Fewer inappropriate hospital transports (ED utilization)
- Increased availability of ambulances for true emergencies
- Less wear and tear on ambulances – extended life of costly vehicles
- MIH vehicle less expensive
- Scheduled visits and hours for CPs
- A clinical ladder rung for Paramedics



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Thank you!

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