TRANSFORMING AN EMS DELIVERY SYSTEM: MOBILE HEALTH CARE

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Outline

1. Welcome and Key Changes with Health Reform – Mike Williams, MPA/HSA

2. Changing Dynamics and Impact on EMS Delivery Systems – Matt Zavadsky, MS-HSA, EMT

3. Benchmarking Communities and Innovations for EMS – Bill Bullard

4. Mock Negotiation Session (EMS vs Payer)

5. Summary – Q&As
Health Reform Basics
Growth in Total Health Expenditure Per Capita, U.S. and Selected Countries, 1970-2008


Health care spending varies dramatically

Significant regional variations in quality

Percent of Diabetic Medicare Enrollees Receiving Appropriate Management (Hemoglobin A1c Test; Year: 2003-2007)
Figure 7.
**Number Uninsured and Uninsured Rate: 1987 to 2009**

Numbers in millions, rates in percent

| Year | Number Uninsured | Uninsured Rate |
|------|------------------|----------------|----------------|
| 1987 | 30.9             | 10.4           |
| 1990 | 33.3             | 14.0           |
| 1993 | 36.1             | 15.1           |
| 1996 | 39.1             | 16.5           |
| 1999 | 41.6             | 17.6           |
| 2002 | 44.2             | 17.6           |
| 2005 | 46.9             | 17.5           |
| 2009 | 50.7             | 16.7           |

1. The data for 1996 through 2003 were revised using an approximation method for consistency with the revision to the 2004 and 2005 estimates.
2. Implementation of Census 2000-based population controls occurred for the 2000 ASEC, which collected data for 1999. These estimates also reflect the results of follow-up verification questions, which were asked of people who responded ‘no’ to all questions about specific types of health insurance coverage in order to verify whether they were actually uninsured. This change increased the number and percentage of people covered by health insurance, bringing the CPS more in line with estimates from other national surveys.

Notes: Respondents were not asked detailed health insurance questions before the 1988 CPS. The data points are placed at the midpoints of the respective years. For information on recessions, see Appendix A.

Affordable Care Acts (ACA) Basics

- Coverage expansion – this is a basic first step (major leap) toward bringing all Americans into a health system
- Insurance reform – assures that people will have coverage when they need it
- Payment reform and experimentation – attempts to incentivize efficiencies and quality improvement
- Prevention and community health – public health in all health
- Primary care capacity and infrastructure – addresses demand from newly insured
How many are uninsured?

- 2010: 16.3%, 49.9 million uninsured
  - 10%, 7.5 million children < 18 years old
  - Decrease in employer-sponsored insurance
  - Increase in public insurance
- Churning
  - 85 million uninsured between 1996-1999
  - Public program eligibility
  - Life events
- Consistently 12%-16% of population
- 10%-25% are underinsured
Even with ACA, costs are still a problem

- Assuming that physician cuts are prevented, Medicare spending will continue increase to unsustainable level.
  - Somewhat improved by health reform’s other measures
- Median out-of-pocket health spending as a share of Medicare beneficiaries’ income increased from 11.9% in 1997 to 16.2% in 2006.
- Medicare pays smaller percentage of beneficiaries’ total health spending (74%) than FEHBP (83%) and typical large employer plan (85%) would.
ACA and Medicare

• No expansions in coverage anticipated in Medicare
• Cuts in provider payments – Part C Medicare Advantage, hospitals, clinical labs, EDs, EMS other services
• Lots of experimentation to incentivize better, more efficient care: Accountable Care Organizations, global payment initiatives, reducing readmissions
• $10 billion now being spent over the next 10 years for Centers for Medicare and Medicaid Innovation
Medicaid Expansion “In or Out”?
ACA Activities
ACA and the health care safety net

• Community health center expansion: $11 billion expansion over five years to more than double patients served (to 40-50 million).

• Cuts in disproportionate share hospital payments: Medicaid DSH payments will be cut by $18 billion over a 7-year period beginning in FY 2014. Medicare DSH cuts = about 75% (over $22 B) over 10 years.

• What happens in states that don’t take the Medicaid expansion but get the DSH cuts?
Wellness and Prevention

• Recommended preventive care fully covered with no co-pays and deductibles
  • Includes contraception: Ongoing issue with respect to religiously-affiliated employers

• Annual wellness exam in Medicare

• Employer wellness programs incentivized

• Sustained funding for prevention and public health – Public Health Trust Fund and Community Transformation Grants

• Calorie information posted on chain restaurant menus
Preparing for the Future of Emergency Care
Preparing for the Future of Emergency Care
How Your Payer Spends Premiums

BCBSLA Audited Financial Results FY 2008
National Averages Adapted from Centers for Medicare and Medicaid Services (2008)
How Your Payer Spends Premiums ($1)

< 1 cent for EDs and < .1 cent for EMS

NATIONAL AVERAGES

- 33¢ Hospital
- 30¢ Physician and Clinical Services
- 13¢ Prescription Drugs
- 6¢ Dental Services
- 2¢ Other Professional Services
- 1¢ Nursing Home
- 2¢ Home Health Care

Cost Including Taxes, Commissions

10¢ Admin

BCBSLA Audited Financial Results FY 2008
National Averages Adapted from Centers for Medicare and Medicaid Services (2008)
However, emergency care providers drive 60% of the costs of their patients.
Here is what we know:

- EMS responses to grow organically
- ED visits to grow organically
- Trauma center patients to grow organically
By 2019:

- 39 million newly insured
- 43% Medicaid
- 57% Insurance exchange
However....

$716 million in Medicare cuts
The costs of the system's current inefficiency underscore the urgent need for a system-wide transformation. The committee calculated that about 30 percent of health spending in 2009 -- roughly $750 billion -- was wasted on unnecessary services, excessive administrative costs, fraud, and other problems. Moreover, inefficiencies cause needless suffering. By one estimate, roughly 75,000 deaths might have been averted in 2005 if every state had delivered care at the quality level of the best performing state.
Vast Culture of "Waste" & "Overuse"
Think “waste”: 
Think EMS “waste”:

- “sending everything!”
- To “everything”
- regardless of need/outcomes
Think ED “waste”:

- High cost structure
- No lower acuity model
- Tremendous variation of care givers (aka = over ordering, etc.)
- Episodic care
Think Trauma Center “waste”:

- Excessive triage (think “MOI”)
- The “Welcoming Committee” aka “trauma team”
- Freezing hospital activities (i.e., CT)
- Low yield ancillary testing
Moving from: Fee Based

Moving to: Value Based
Moving from: Fee Based

Moving to: Value Based

Value = cost / outcome
Medicare Quality Programs

- Hospital Stakeholders
- Physician Stakeholders
- Nursing Homes Stakeholders
- Pharmac. Lab/Rad Stakeholders

Quality Study & Input → Proposed Rules

Proposed Rules → Rules Adopted (no penalty) → Incentive Disincentives Added

- 2008
- 2009
- 2010
- 2010-2012
- 2010-2012
Tremendous opportunity to take the anecdotal...

...to precise data-driven models
Think:
- Cost effective
- Appropriate utilization
- Data driven outcomes
Where do we go from here?

- Conduct a baseline assessment
- Define areas of opportunity
- Build on areas of core strength
Santa Clara County EMS Strategic Planning Process

**Session One**
- Rollout of Detailed EMS “As Is” Analysis
- Present Feedback
  - Top five (5) areas for focus for the county
  - Benefits/Challenges
  - Health Reform & Impact
- Respond to Top Areas for the future?
  - Where are the gaps?
  - What are EMS System characteristics needed?
  - What are the risks/threats?
  - What will be needed for the future?

**Session Two**
- Present SWOT Analysis by Opportunity
- Complete SWOT Analysis
- Design Goals, SMART Objectives/Goals & Timeline for each opportunity via group process
- Group consensus on Mission/Vision & Goal Statement
- Develop action necessary to achieve
- Notify participants re: online survey purpose & deadline

**Session Three**
- Present online survey results (depending on response rate may need to do mini prioritization exercise)
- Identify who, what, how & success measures for priority items via group process
- This is the reality check session with the potential for national content & experience (optional) to discuss what factors are needed for success & resources available with stakeholders in roundtable discussions

**Session Four?**
- Present DRAFT Strategic Planning Document
- Implementation Development
- Strategic plan leadership (who)
- Resources/Budget (what)
- Timeline (when)
- Communications (how)

**Validated Draft with “Advisory Group”**

**DRAFT Strategic Plan**

**Input from the Community, Written by the Consulting/Planning Team**

**Survey**

**Rolllout Strategic Plan**

- Town Hall Meetings
- Stakeholder Groups
- Health and County Leadership
- and Other Key Policy Makers

Prepared by The Abaris Group on 8/13/12
Are you at the table?
TRANSFORMING AN EMS DELIVERY SYSTEM: MOBILE HEALTH CARE

Matt Zavadsky, MS-HSA, EMT
Public Affairs Director at MedStar Mobile Healthcare
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Why are you here?

What do you expect a “community paramedicine program” to do for your agency?

- Increase revenue?
- Improve community or customer relationships?
- Provide a career ladder for experienced EMS personnel?
- EMS System Change?
- Altruistic?
Self Assessment: *Can you really do this?*

- Organizational ‘readiness’
  - Fragile vs. Agile?
  - Medical Direction commitment?
  - Workforce / Labor?
  - Political & community capital?
  - $ Reserves?
  - Leadership commitment?
  - Healthcare system commitment?
Critical Success Factors

- EMS Providers willing to work in new role
- Patient Referrals
- Network of resources to help patients
- Tools to measure and report your success
- Training
- Sustainability model
Typical Project Management Life Cycle

- Project Initiation
- Wild Enthusiasm
- Disillusionment
- Chaos
- Search for the guilty
- Punish the innocent
- Promotion of non-participants
- Definition of the problem
The secret to happiness is to...

Lower your expectations!
## Potential Markets

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<th>Types of Services</th>
<th>Geographic Size of EMS</th>
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<td>• Immunizations&lt;br&gt;• Elder watch&lt;br&gt;• Baby safety</td>
<td>Individual households</td>
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<tr>
<td>Small business</td>
<td>• Immunizations&lt;br&gt;• Wellness programs</td>
<td>Single municipality</td>
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<tr>
<td>Physician practices or elderly living facilities</td>
<td>• Immunizations&lt;br&gt;• Home lab testing&lt;br&gt;• Care transitions&lt;br&gt;• Disease management&lt;br&gt;• In-home risk assessment&lt;br&gt;• Patient navigation&lt;br&gt;• Telemedicine</td>
<td>Single municipality/multiple municipalities</td>
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</table>
## Potential Markets

| Hospital | • Immunizations  
|          | • Care transitions  
|          | • Disease management  
|          | • Patient navigation  
|          | • Telemedicine  
|          | Large/ multiple municipalities |
| Health Department | • Immunizations  
| County Agency | • Screening services  
|          | • Tb medication compliance  
|          | Large/multiple municipalities  
| County |  
| Health Plans | • Immunizations  
| • Commercial | • Wellness programs  
| • Medicare | • Care transitions  
| • Medicaid | • Disease management  
|          | • In-Home risk assessment  
|          | • Patient navigation  
|          | • Telemedicine  
| Large municipalities |  
| County |  
| Multiple counties |  

Stakeholder Assessment: What are the Needs?

- Partners/stakeholders to ask:
  - Hospitals
    - Case Managers
    - ED Directors
    - Cardio/stroke Directors
    - Clinic Directors
    - Community Relations Directors
  - Elected / Appointed officials
  - First Responders / Transport agencies
Stakeholder Assessment: What are the Needs?

- Regulators
  - Office of EMS
  - Regional Councils
- Home Health
- SNF / LTAC / ALF
- Public Health
- Schools
  - Including medical schools
- Hospice agencies
Stakeholder Assessment: What resources are available?

- PCMH
- Community clinics
- Private clinics
- FQHCs
- Behavioral health
- Public health
- Dental offices

Needs – Resources = GAP!

Needs – Resources = YOU!
Gap Analysis:
Who Needs to be ‘Involved’

- Payers
- Clinics (public and private)
- Community Based Organizations (CBOs)
  - United Way
  - Area Agency on Aging
  - Meals on Wheels
  - Behavioral Health
  - Charitable clinics
- Media
- Elected/appointed officials
Gap Analysis: Who Needs to be ‘Involved’

- Transportation providers
  - Public
  - Private
  - Charitable
Environmental Assessment: Who Needs to be ‘committed’

- Relationships and Support from:
  - Medical Director(s)
  - Physicians
  - Hospitals
  - Elected/appointed officials
  - Hospice
  - Home Health
  - Clinics (public and private)
  - Community Based Organizations (CBOs)
Community Resources

CHILDREN AND TEENS

Child Protective Services..................800-252-5400

Dallas County Health & Human Services
Immunization Clinic .........................972-721-2311
Irving Branch
440 S. Nursery Road, Irving 75060
Walk-in immunization clinic for children 18 years and younger

Our Children’s House at Irving
3337 Stovall Street.........................972-790-8505
Physical therapy, occupational therapy and speech therapy for children with special needs

COUNSELING AND SUPPORT

Emotions Anonymous.....................972-506-9205
Plymouth Park United Methodist Church
1615 W Airport Freeway – Irving 75062
Support group for persons experiencing anxiety, depression, grief, and divorce recovery

DENTAL

Irving Health Center
1800 N Britain..............................214-266-3170

DISEASE CONTROL

Communicable Disease....................214-819-2004

Dallas County Health & Human Services
2377 N Stemmons Fwy....................214-219-2000

Irving Interfaith Clinic.....................469-800-1000
1302 Lane Street, Suite 100
Medical and dental care for uninsured Irving residents who qualify based on financial need.

Mid Cities Pregnancy Center
1111 W. Airport Fwy, Suite 229........214-441-3460
Free pregnancy tests, medical services, parenting classes, sexual integrity programs, and sexual abuse support groups, post-abortion counseling, and discipleship programs for new believers

HEALTH & HUMAN SERVICES

Dallas County Health & Human Services
2377 N Stemmons Fwy....................214-219-2000

Older Adult Services......................214-819-1860
Program offers socializing opportunities and more independence for Dallas County residents 60 years and older

Texas Health & Human Services office for temporary assistance for needy families (TANF), food stamps and Medicaid
440 S. Nursery, Ste 200, Irving.............972-579-3080

LEGAL SERVICES

Legal Aid of North Texas..................214-748-1234

MENTAL HEALTH

Dallas Metrocare Services.................214-743-1200

TRANSPORTATION

Baylor Medical Center at Irving Senior Van Service..................972-579-8112
Transportation provided to patients living in Irving, Coppell and north Grand Prairie that have appointments at Baylor Medical Center at Irving – patients are picked up at their residence for hospital appointments ONLY and then returned to the same location as pick up

Irving Cares Patient Transportation Program..................972-721-9181, ext. 200
Transportation for Irving residents from home to doctor, dialysis, therapy, dental and clinic appointments in Irving, Dallas Parkland system, and other Dallas locations in the Medical/Market Center area. Call for enrollment and information

Paratransit Services......................214-515-7272
Transportation services for disabled and temporarily disabled community members provided by DART (Dallas Area Rapid Transit)

VISION

Prevent Blindness Texas..................214-528-5521
Free vision screenings for adults and children (6 months to 18 years)

WOMEN AND CHILDREN RESOURCES

Brighter Tomorrows.......................972-262-8383
24 hour hotline emergency shelter for women and children of domestic violence
What is your business model?

- Fee for Service
- Free for Service
- The marketing mix
  - Product (service)
  - Placement
  - Price
  - Promotion
Product Development

- What are we interested in doing?
- Do we have the capacity to do something unique?
- What do we assess?
- What do we do for stabilization?
- What “definitive care” resources are available?
- What is the value proposition for those who will pay for this service?
Placement

☐ Will you go beyond your EMS borders?
☐ Are you a low-cost alternative to traditional providers?
☐ Are you able to differentiate yourself from other providers?

_Jurisdictional Boundary vs. Medical Trade Area!_
Price

☐ How much will it cost you to provide the service?
☐ What are we going to charge for the service?
☐ How are we going to bill for the service?
A Word about Money...

- Who **financially** benefits
  - Hospitals?
  - Public health?
  - Taxpayer?
  - 3rd Party payers
  - Other providers (i.e.: hospice)

- Follow the money!
Program Development: 
**What to provide?**

- Focus on bridging gaps
  - Find the opportunity
  - *Can* do vs. *Should* do

- Potential models:
  - Patient navigation
  - Care transition
  - Primary care

- Who pays?
  - Demonstration / Pilot program
  - On-going if successful
Program Measurement: Successful?

- What does success look like?
  - “As a result of this program...”

- Ask your stakeholders
  - What does success look like to THEM?
  - Clinical, financial, other

- If successful – What next?
- If NOT successful – What next?
Reporting Results / Data Tracking

- Stakeholder measures
  - Clinical, Economic, other
- Minimum
  - Referral source
  - Resource utilization
    - Pre, during, post
    - Economic results
  - Health status
  - Patient satisfaction
  - Provider satisfaction
Pitching CP Services

- Bring your medical director
- Bring your ideas
- Talk about home nursing versus CP in the beginning
- Bring data (from others to start)
- Listen to their existing programs
- Figure out if you fit in
- Be patient, but persistent
Program Examples

- 20 hospitals
- 50,000 employees
- UPMC Health Plan
  - 2nd largest integrated delivery system in US
  - 1.3 million members
Worksite wellness

- Increase clinical staff receiving flu shots
- Conducted biometric screenings on 20,000+ health professionals
- Consistently ranking high in participant satisfaction
Asthma Program

- **Description**
  - In home visits for uninsured patients
  - asthma admission
  - 4-5 visits

- **Setting**
  - Low income community

- **Experience**
  - ~5 years
Asthma

- Asthma education
- Peak flow meter
- PCP follow up
- Action plan
- Trigger management
Safe Landing Program

- **Description**
  - In home post discharge follow-up
  - 1-2 visits
  - Coleman Care Transitions Model
Safe Landing Components

- Medication reconciliation
- Personal medical record
- Symptom response plan
- PCP follow up appt
Preliminary Results

- Compared to their historical use, the group receiving the EMS Safe Landing Visit (n=134)
  - Had 16 fewer readmissions
  - Had 81 fewer days in hospital
  - Saved $1.2 million in hospital charges
CHF results

- 13 CHF patients
- National average for readmission within 30 days is **24.8%**
- Safe Landing patients
  - 0 readmissions at 30 days
  - 0 readmissions at 60 days
  - 1 readmission at 90 days
- $120,000+ average charge
EMS Loyalty Program

- Proactive home visits
- Educated on health care and alternate resources
- Enrolled in available programs = PCMH
- Flagged in computer-aided dispatch system
  - Co-response on 9-1-1 calls
  - Ambulance and CHP medic
- Non-Compliant enrollees moved to “system abuser” status
  - No home visits
  - Transport may be denied by Medical Director in consult with on-scene CHP medic
A word about costs

- Charges
  - Billed

- Expenditures
  - Collected / paid
    - By whom?

- Opportunity cost
  - What else could you have been doing with that resource?

- Bad debt ‘misnomer’
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Nurse Triage

- Take low-acuity 9-1-1 calls out of the system
  - 42.2% of referred patients to alternate dispositions
    - 54.9% in June ‘13
  - Help unclog EDs
    - Improve throughput
Investment: What will it cost?

- Wages
  - Wage bump based on local market
  - Shared resource or dedicated resource

- Training
  - 120 – 220 hours
  - PLUS backfill if on duty
  - Curriculum
    - Or tuition

- Increased Medical Direction
  - Transport-based / Contact-based / Flat budget?
Investment: What will it cost?

- Vehicle & Equipment
  - Sprint vehicle
  - All ALS equipment / supplies
  - I-Stat point of care testing
    - $25/cartridge
  - Scales
  - Educational materials
Revenue: Keeping it going!

- Seed money
  - Grants, partners, internal
  - Ok short term – not long term

- Sustainable models
  - Fee for referral
  - Fee for contact

- New revenue using shared resource
  - CCT
  - Occupational medicine?
  - Vaccines
Revenue: Keeping it going!

- Shared savings
  - Program saves $X per patient
  - Agency economically benefiting shares % or $ of savings
  - No savings = no fee
    - Lowers risk to payer
    - Increases risk to YOU
Price Points

☐ Calculate your costs
☐ Figure out what the market will bear
☐ If you can’t charge enough to cover your costs - STOP!
Price Positioning

☐ Do you want to be the low cost option for community based services?

☐ Can you justify charging a premium over competitors?

☐ Is Community Paramedicine an acceptable loss leader for community or facility contracts?
Communication

- Unlike traditional EMS, there are many people we have to give “report” to...
  - Customer
  - PCP and Specialists
  - Payers, Hospital or Practice Care Management
  - Community Agencies
  - Funders
Evaluation = Sales Opportunities

☐ Patient Testimony = Affective Engagement
☐ Descriptive statistics = Experience
☐ Outcomes = Credibility
☐ Publishing = Exposure = Sales Leads
MIHP vs. CP

- Don’t get lost in the terms
  - Can be either

- MIHP lends to bigger picture

- Could involve:
  - EMT
  - Paramedic
  - RN
  - NP
  - PA
  - MD

- Don’t forget the Call Center
  - Formerly known as the “Communications Center”
  - Biometric-monitoring, MD after hours call service?

Mesa Example
Hey Noah, just wanted to make sure the ark was leaving at 6:30, right?

Umm no sorry it left half an hour ago

No the whales made it
TRANSFORMING AN EMS DELIVERY SYSTEM: MOBILE HEALTH CARE

Bill Bullard
Senior Consultant of The Abaris Group
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# Industry Trends and Best Practices

<table>
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<tr>
<th>Location/Program</th>
<th>911 Dispatch Triage &amp; Awareness</th>
<th>Alternate Transportation &amp; Destination</th>
<th>High System User Diversion</th>
<th>Primary &amp; Mobile Healthcare</th>
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**Notes:**
1. Expected Fall 2013
2. Program discontinued
9-1-1 Dispatch Triage and Awareness

- Tele-Triage Services

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<th>Location</th>
<th>Houston</th>
<th>Seattle</th>
<th>Richmond</th>
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<td>620,778</td>
<td>205,533</td>
<td>2,615,060</td>
</tr>
<tr>
<td>Runs/year¹</td>
<td>300,000</td>
<td>136,000</td>
<td>40,880</td>
<td>240,000</td>
</tr>
<tr>
<td>Diversion rate</td>
<td>1.83%</td>
<td>0.51%</td>
<td>8.04%</td>
<td>1.42%</td>
</tr>
<tr>
<td>Diversions/year</td>
<td>5,475</td>
<td>700</td>
<td>3,285</td>
<td>3,398</td>
</tr>
<tr>
<td>Send-back rate</td>
<td>75%</td>
<td>9%</td>
<td>83%</td>
<td>18%</td>
</tr>
<tr>
<td>Final diversions/year</td>
<td>1,369</td>
<td>637</td>
<td>548</td>
<td>2,786</td>
</tr>
<tr>
<td>Final diversion rate</td>
<td>0.46%</td>
<td>0.47%</td>
<td>1.34%</td>
<td>1.16%</td>
</tr>
<tr>
<td>Net savings</td>
<td>$328,562</td>
<td>$240,324</td>
<td>$30,660</td>
<td>$1,560,362</td>
</tr>
</tbody>
</table>


Notes: ¹ Runs/year are from 2006, except Toronto and (2011)

- 911 Awareness Campaigns
Alternate Transportation and Destination

- **Mental Health Transportation**
  - San Mateo County, CA
- **Sobering Centers**
  - San Francisco, CA
  - Spokane, WA
- **Taxi Cab Vouchers**
  - San Antonio, TX
  - Houston, TX

<table>
<thead>
<tr>
<th>San Francisco Encounters by Referring Parties</th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>1,878</td>
<td>1,448</td>
<td>1,128</td>
</tr>
<tr>
<td>Mobile Assistance Patrol (MAP)</td>
<td>1,991</td>
<td>1,227</td>
<td>1,033</td>
</tr>
<tr>
<td>Police</td>
<td>393</td>
<td>286</td>
<td>167</td>
</tr>
<tr>
<td>ED Transfer (via MAP)</td>
<td>599</td>
<td>116</td>
<td>71</td>
</tr>
<tr>
<td>Referred by Other</td>
<td>314</td>
<td>177</td>
<td>189</td>
</tr>
<tr>
<td><strong>Total Referrals</strong></td>
<td><strong>5,175</strong></td>
<td><strong>3,254</strong></td>
<td><strong>2,588</strong></td>
</tr>
</tbody>
</table>

Source: San Francisco Coordinated Case Management System

Note: The number of EMS calls referred to MAP is not tracked currently

<table>
<thead>
<tr>
<th>Spokane 9-1-1 Diversions to Sobering Center by Referring Parties</th>
<th>2012*</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Department</td>
<td>654</td>
<td>635</td>
<td>418</td>
</tr>
<tr>
<td>Police Department</td>
<td>670</td>
<td>944</td>
<td>607</td>
</tr>
<tr>
<td>Merchants/Private Citizens</td>
<td>218</td>
<td>241</td>
<td>142</td>
</tr>
<tr>
<td><strong>Total Referrals</strong></td>
<td><strong>1,542</strong></td>
<td><strong>1,820</strong></td>
<td><strong>1,167</strong></td>
</tr>
</tbody>
</table>

Note: * Projected using Jan-Jun 2012 data
High System User Diversion

- **Fort Worth, TX**
  - Identified 21 people calling 9-1-1 two or more times per week for over 1,000 calls (>1%)
  - Community Health Program intervention reduced 9-1-1 use by 86% in the first 12 months, saving $1.6 million in EMS and $7.4 million in ED charges

- **San Diego, CA**
  - 933 individuals accounted for 3,347 (11%) of total transport volume
  - Resource Access Program intervention reduced EMS encounters by 38% in the first 30 days
Primary and Mobile Healthcare

- Community Paramedicine Programs
  - Fort Worth, TX

- Community Fire Station Healthcare Portals
  - Alameda County, CA

### MedStar Community Paramedic Program
12-month Retrospective Review

<table>
<thead>
<tr>
<th></th>
<th>Jul10-Jun11</th>
<th>Jul11-Jun12</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-1-1 Transports</td>
<td>492</td>
<td>98</td>
<td>-80%</td>
</tr>
<tr>
<td>Related Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS</td>
<td>$188,928</td>
<td>$37,632</td>
<td>$151,296</td>
</tr>
<tr>
<td>ED</td>
<td>$209,592</td>
<td>$41,748</td>
<td>$167,844</td>
</tr>
<tr>
<td>ED Bed hours</td>
<td>2,952</td>
<td>588</td>
<td>2,364</td>
</tr>
</tbody>
</table>

Source: MedStar, Fort Worth, TX, 12 Month Look, 6/30/12
Medicare Healthcare Innovation Awards

- **Three Awards with Specific Impact on EMS**
  - Regional Emergency Medical Services, NV – $9.9 million
  - Prosser Public Hospital District, WA – $1.5 million
  - Upper San Juan Health Service District, CO – $1.7 million
CMS & EMS/ED Innovations
Medicare Healthcare Innovation Awards

- Health Care System Improvements
  - Reduce unnecessary ambulance responses
  - Reduce ED visits
  - Reduce hospital admissions and readmissions
  - Increase access to primary and preventative care
  - Increase in-home patient care follow-up in medically underserved areas

- Projected Savings over 3 years – $13.1 million
Regional Emergency Medical Services (REMSA), Reno, NV
Project Title: "REMSA Community Health Early Intervention Team"
Geographic Reach: Nevada
Funding Amount: $9,872,988
Estimated 3-Year Savings: $10,500,000

Summary: Creates a health early intervention team (CHIT) to respond to lower acuity and chronic disease situations in urban, suburban, and rural areas of Washoe County, Nevada. CHIT is designed to reduce unnecessary ambulance responses, as well as hospital admissions and readmissions, while improving the patients’ healthcare.

Prosser Public Hospital District (WA)
Project Title: “Prosser Washington Community Paramedics Program”
Geographic Reach: Washington
Funding Amount: $1,470,017
Estimated 3-Year Savings: $1,855,400

Summary: This program will send a community paramedic (CP) to visit a patient of concern, providing in-home medical monitoring, follow-ups, basic lab work, and patient education. The area has high rates of obesity, high cholesterol, diabetes, heart attacks/coronary disease, and angina/stroke.
CMS & EMS/ED Innovations

University Emergency Medical Services (Buffalo, NY)

**Project Title:** “Better health through social and health care linkages beyond the emergency department”

**Geographic Reach:** New York

**Funding Amount:** $2,570,749

**Estimated 3-Year Savings:** $6.1 million

**Summary:** This program will deploy community health workers in EDs to identify high-risk patients and link them to primary care, social and health services, education, and health coaching. The program targets 2,300 Medicare and Medicaid beneficiaries who have had two or more ED visits over 12 months at two EDs in urban Buffalo.

Upper San Juan Health Service District (CO)

**Project Title:** “Southwest Colorado cardiac and stroke care”

**Geographic Reach:** Colorado

**Funding Amount:** $1,724,581

**Estimated 3-Year Savings:** $8.1 million

**Summary:** This program will expand access to specialists and improve the quality of acute care in rural and remote areas of southwestern Colorado including care delivery models for cardiovascular early detection and wellness programs, telemedicine acute stroke care program, use telemedicine and remote diagnostics for cardiologist consultations, and upgrade and retrain its EMS Division to manage urgent care transports and in-home follow-up patient care for over 3,400 patients in medically underserved areas.
Beacon Community Program
City of San Diego

- $15M Federal Award
- Goals
  - Pushing EMS information
  - Better prehospital care
  - Faster turnaround times
  - Improved CQI
  - Reduced hospital utilization
  - Increased surveillance
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