

Home Health, Hospice & EMS *Partnerships in Healthcare 3.0*



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About MedStar...

- Governmental agency (PUM) serving Ft. Worth and 14 Cities
 - Self-Operated
 - 980,000 residents, 421 Sq. miles
 - Exclusive provider - emergency and non emergency
- 125,000 responses annually
- 460 employees
- \$40 million budget
 - No tax subsidy
- Fully deployed system status management
- Medical Control from 14 member Emergency Physician's Advisory Board (EPAB)
 - Physician Medical Directors from all emergency departments in service area + 5 Tarrant County Medical Society reps



ION

“EMS?”

- 9-1-1 safety net access for non-emergent healthcare
 - 35.6% of 9-1-1 requests
 - 12 months Priority 3 calls (44,567 (P3) / 124,925 (Total))
- Reasons people use emergency services
 - *Because we taught them to...*
 - *Because they panic...*
 - *Because their professional care givers tell them to...*
 - *Because it 's the only option...*



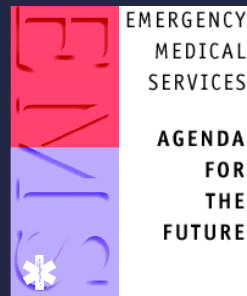
Conundrum...

- Misaligned Incentives
 - Only paid to transport
 - “EMS” is a *transportation* benefit
 - NOT a medical benefit



Our Role?

*“Emergency medical services (EMS) of the future will be **community-based** health management that is **fully integrated** with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and **follow-up**, and contribute to the **treatment of chronic conditions** and **community health monitoring**. This new entity will be developed from **redistribution of existing health care resources** and will be integrated with other health care providers and public health and public safety agencies. It will **improve community health** and result in more appropriate use of acute health care resources. EMS will remain the public’s emergency medical safety net.”*



Mobile Integrated Healthcare

- EMS Loyalty Program
- System Abusers
- 9-1-1 Nurse Triage
- CHF/High Risk Dx Readmissions
- Observational Admission Avoidance
- Hospice Revocation Avoidance
- Home Health Partnership



Mobile Integrated Healthcare

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- **Hospice Revocation Avoidance**
- **Home Health Partnership**





Framing the Home Health Issues

- Penalized for readmissions
 - No more hospital referrals
 - CMS Penalties
- High cost of night/weekend demand services
- Don't know when their patients call 911
 - No opportunity for pre-admission care coordination
 - Reduced ability for post-discharge care coordination

Home Health Partnerships



How it Works

- Protocols established between HH agency and MedStar Medical Director
- Specialized training provided
 - HH trains MIH Providers in common procedures
 - MedStar ride outs by RNs
- HH agency registers client w/MedStar
- MedStar EMR created
- 9-1-1 CAD address flag created



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How it Works

- If client calls 9-1-1
 - Appropriate units dispatched + MIH Provider
 - Comm Center notifies HH agency hotline
 - On scene MHP calls HH nurse from scene
 - Care coordination occurs
- If client calls HH agency
 - AND, HH agency wants MedStar to cover
 - HH agency calls MedStar for scene/home visit
 - MIH provider calls RN from the home for care coordination



Home Health Care Coordination Examples

Client: RoXXXX, John H – 19XX-10-07

Status: Active

Visit Date: 11/1/2015

Visit Acuity: Unscheduled Visit

Transport Resource: N/A

Program: Home Health - 911

Referring Source: Klarus

Visit Type: Home Visit

Visit Outcome: MHP Call Complete

Response Number: 151101297

Note By: Andrew Hatcher

Arrived on scene to find Mr. RoXXXX sitting upright at his dining room table, **appearing slightly tachypneic and distressed. He tells me that he has been feeling unwell since he woke up this morning around 0500.** He goes on to say that he has experienced decreased appetite for approximately one week. He has increasing weakness today as well. **He has gained 1lb in 24 hrs (117.4) I was present when the chest X-ray tech came to do imaging. The film showed the left lung with fluid at the base.**

Auscultation revealed clear breath sounds in the right upper and right upper, but severely diminished lung sounds on the upper left and upper left lung fields. There was no rales or rhonchi heard.



Istats were drawn with the following results:

Na; 135K: 4.6Cl; 104iCa; 1.11TcO₂; 26Glu: 117BUN; 68Crea: 2.2HCT: 38Hb;
12.9aGap: 11

I called Beverley RN from Klarus and discussed my findings. She desires 40mg IVP Lasix, 20MEQ Potassium, and 2.5 Metolazone be administered for exacerbation of CHF. I administered 40mg Lasix in the right antecubital fossa through a 22g intravenous catheter. Beverley said she will follow up with him in the morning.

I provided a urine hat and explained how to measure his urine output to his family. They verbally understand. Intravenous access is discontinued after medication administration. I witnessed both other oral medications self administered by Mr. RoXXXX .

EENT: atraumatic; mucus membranes are moist Thorax; atraumaitc; no tenderness upon palpation-ICD in the right chest-diminished breath sounds left lung fields Lower extremities; +4 pitting edema on right leg, +3 pitting edema on the left leg upper extremities; atraumatic; no tenderness upon palpation.

Client: XXXXX, James I – 19XX-10-14

Program: Home Health

Visit Date: 9/20/2015

Visit Acuity: 911 Call

Referring Source: Klarus

Visit Type: Home Visit

Response Number: 150920215

Note By: Andrew Hatcher

Arrived on scene with Medstar unit attending to Mr. XXXX. They inform me that Mr. XXXX was walking into his house utilizing a walker assist device and become very dyspneic. This started around 1310 and lasted approximately 20min. He sat down in his chair and his symptoms ceased.

Family and private nurse on scene inform me that Mr. Perry has had a 4-5 pound gain in a three day period. They also notice bilateral ankle swelling, which is abnormal for Mr. Perry. Family also indicates that his blood pressure has been high lately.

I draw labs.

I contact Sean RN from Klarus and discuss this case. He takes 20mg Lasix 1x/day. Sean asks me to administer 40mg Lasix IVP and follow up approximately 5hrs later to re-evaluate and draw labs. Mr. XXXX does not take K+, nor is he on a fluid restriction. I advised to drink some water during this process, but no more than 1500ml total /day.

I release Medstar ambulance from scene.

Family gathers a bedside commode from a neighbor and I provide them ***hat for calculation of urine output.*** They will use their own scale for the follow up weight.



Client: XXXX, Clara L - 1934-03-06

Visit Date: 8/21/2015

Visit Acuity: **911 Call**

Response Number: 150821007

Program: Home Health - 911

Visit Type: Home Visit

Transport Resource: N/A

Note By: Ronald Moren

Family called 911 and stated pts BGL was 29. On EMS arrival, family had managed to give pt a few mouthfuls of honey and BGL was 32. Pt found lying in bed pt is alert to painful stimuli only. Pt is atraumatic. BBS are clear, =, bilateral with good chest rise and fall. Abd is soft and non-tender with no masses noted. Pt has a PICC line in right arm that she receives daily antibiotics from family through.

PICC line was accessed and approx 7 ml fluid withdrawn. IV D-10 was started and 250 ml was infused. Pt became A&OX4 and BGL increased to 188. Pts daughter cooked her some eggs and gave her an ensure to drink.

Pt states she feels much better and does not want to go to the ER at this time. It was explained to the patient and her family that a large decrease in blood sugar, while may be expected, should still be evaluated by a physician. Pt and family still did not want to go to the ER. ***Pt and family were educated on possible problems with low BGL including falls, syncope, AMS, & seizures. Family was instructed to monitor blood glucose levels and to contact KLARUS and/or her PCP in the morning. Family was also instructed to call 911 again if pts condition changes.***

KLARUS was contacted and message left, RN (Diane) called back and confirmed message received and advised she would have somebody go out and see patient in the morning.



Program: Home Health

Visit Date: 8/6/2015

Visit Acuity: **Unscheduled Visit**

Response Number: 150806056

Referring Source: Klarus

Visit Type: Home Visit

Visit Outcome: MHP Call Complete

Note By: Brandon Pate

Note:

Lisa, RN, from Klarus called the Communications Center and requested a CCP evaluation of this client after she inadvertently removed her colostomy bag.

Upon arrival, the client is ambulatory, conscious and alert, oriented to person only; this is consistent with her baseline, per the assisted living staff. The client has no complaints of pain or symptoms; she denies having chest pain, shortness of breath, a headache, nausea, vomiting, diarrhea, weakness, dizziness, and abdominal pain. The client reports she inadvertently removed her colostomy bag.

Upon exam.....

I called Lisa and informed her of my assessment findings. She subsequently provided the procedure for a colostomy bag change. The skin around the stoma was cleansed with a skin prep solution and wipes. Stoma powder was applied. The skin around the stoma was cleansed a second time. The flange was sized and applied around the stoma, using pressure in a circular, outward motion to ensure adhesion. The stoma bag was attached to the flange without difficulty. A staff member from the assisted living facility remained at the bedside during the procedure. Following completion, the staff remained with the client. Call complete.



Note:

AOSTF 28 yo male sitting on couch. He states that he is SOB, his abdomen is distended and his legs are swollen all of this since 2000 this evening. He also reports his pump was alarming starting at 2100 and he shut it off.

Pt. requires Milrinone continuous infusion and the pump was reading a high pressure alarm. Pt. also reports a cough this evening. *In reviewing his HX he has CHF with an EF of 20-25% and CKD.* He reports he feels like he always does when he gets fluid overloaded. *Pt. also reports a 4 lb. weight gain in the last 24 hrs. Upon exam noted pt. in mild -moderate resp. distress with SPO2 in the 80's off his O2. In reviewing some old notes he does not like to wear his O2. Pt. is A&OX4, PPTe, MAE. Pt. is mildly tachycardic, BS clear upper and crackles in bases. ST on 12-lead W/O elevation.*

Abdomen appears distended though I have never seen this pt. in the past. Pt. has 3+ edema in lower ext. PICC line port being used for Milrinone infusion was occluded. PICC was flushed and infusion resumed. *Chem 8 was obtained. NA 133, K+ 3.7, Cl 97, CA 1.19, Tco2 36, Glucose 143, BUN 38, Cre 1.3, Hct 40, Hgb 13.6A Gap 5. Pt. was given Lasix 80mg SIVP and advised to double his morning potassium dose. The importance of wearing his O2 was again stressed. I discussed the plan with pt. to ensure he felt capable of staying at home and that was his preference.*

Pt. stated he had a urinal and was advised to use it and write down all of his output between now and when he sees the nurse. He was advised to call back for any issues or worsening of condition. *I also spoke with Sean at Klarus and he is good with plan. Klarus will follow up tomorrow with client.*

Utilization Outcome Summary

Home Health Partnership

As of: **Sep-15**

Enrollments by Home Health Agency

9-1-1 calls by Enrolled Patients

9-1-1 Calls by Enrolled Patients with a CCP on-scene

ED Transports when CCP on Scene

Home Visits Requested by Agency

ED Transports from home visits requested by Agency

#	%
804	100.0%
537	66.8%
245	45.6%
93	38.0%
187	23.3%
9	4.8%

Framing the Hospice Issue:

- Patients & families want the patient to pass comfortably at home
- Hospice wants the patient to pass peacefully at home
- Death is scary
- When death is near....
 - 9-1-1 call challenging for EMS
- 9-1-1 usually = Hospice Revocation
 - Voluntary or involuntary

Hospice Partnerships



Economic Model

- Hospice benefit
 - Per diem from payer to agency
 - Agency pays hospice related care
 - LOS issues
 - Varies based on Dx
- MedPAC recommends increasing hospice benefit
- IHI recommends increase hospice enrollment

How it Works

- Protocols established between Hospice agency and MedStar Medical Director
- Specialized training provided
 - Hospice trains MIH Providers in common procedures
 - MedStar ride outs by RNs
- Hospice agency registers “At-Risk” client w/MedStar
- 9-1-1 CAD address flag created



How it Works

- 1 home visit by MHP
 - Reinforce hospice relationship w/MedStar backup
- If client calls 9-1-1
 - Appropriate units dispatched + MIH Provider
 - Comm Center notifies on-call nurse
 - On scene:
 - Non-hospice hospice related call = treat and transport as usual
 - Hospice related call:
 - Care coordination occurs



Special Note

- MHPs trained to have “The Conversation” with patients enrolled in other programs
 - Or POLST/MOST, etc.



Hospice Program Summary

Sept. 2013 through Sept. 2015

	#	%
Referrals (1)	249	
Enrolled (2)	168	
Deceased	116	69.0%
Active	28	16.7%
Improved	2	1.2%
Revoked (3)	24	14.3%

<u>Activity:</u>		
EMS Calls	57	
Transports	20	35.1%

Notes:

- (1) Patients referred who are identified as at high risk for voluntary disenrollment, or involuntary revocation.
- (2) Difference results from referrals outside the MedStar service area, or patients who declined program enrollment.
- (3) Patients who either voluntary disenrolled, or had their hospice status revoked.



Home Health, Hospice and EMS Team Up to Tackle the Triple Aim

Outside the hospital, community resources can work together for better care of patients

The drive to achieve the IHI's Triple Aim has fostered the creation of many innovative partnerships. This column focuses on the synergistic relationships and integrations developing between mobile integrated healthcare (MIH) and the home healthcare industry.

One of the main goals of MIH is to navigate patients through the healthcare system, not replace healthcare system resources already available in the community. Home health and hospice are valuable links in the chain of healthcare—and, for qualifying patients, a logical care delivery model that can be enhanced through a partnership with a mobile player like the local EMS agency.

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Meredith Anastasio

Meredith Anastasio is managing director at the Lincoln Healthcare Group (LHG) and leads the planning of Home Care 100 and Home Care & Hospice LINK.

J. Daniel Bruce

J. Daniel Bruce is the administrator of Klarus Home Care in Fort Worth and is responsible for the ongoing relationship with MedStar. He is a leader in the development of partnerships to create value-based services.

John Mezo

John Mezo is the general manager for VITAS Healthcare in Fort Worth, overseeing program operations, developing business opportunities, hiring and mentoring new staff and representing VITAS throughout the community.



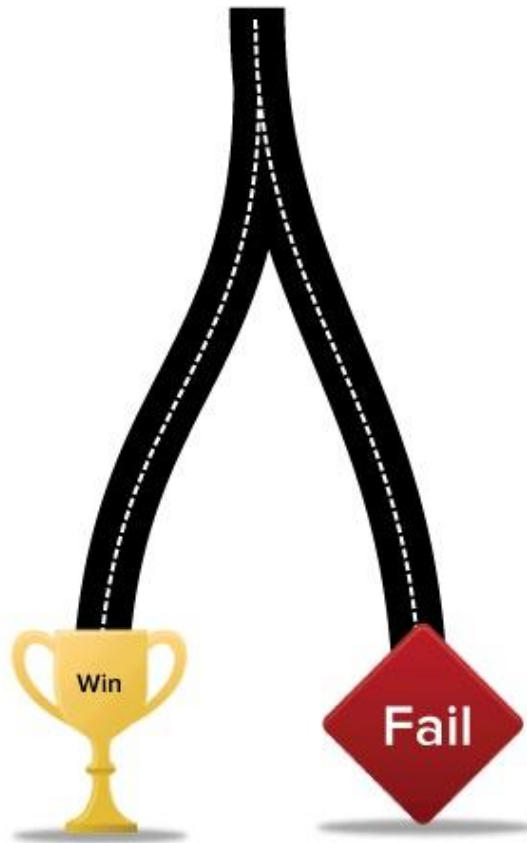
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These are just a few examples of how EMS-MIH and home health can work collaboratively together to meet the needs of the patient, and the needs of the agency. It is not a competitive relationship, but rather a cooperative relationship designed to meet the needs of the patient – a marriage made in heaven!

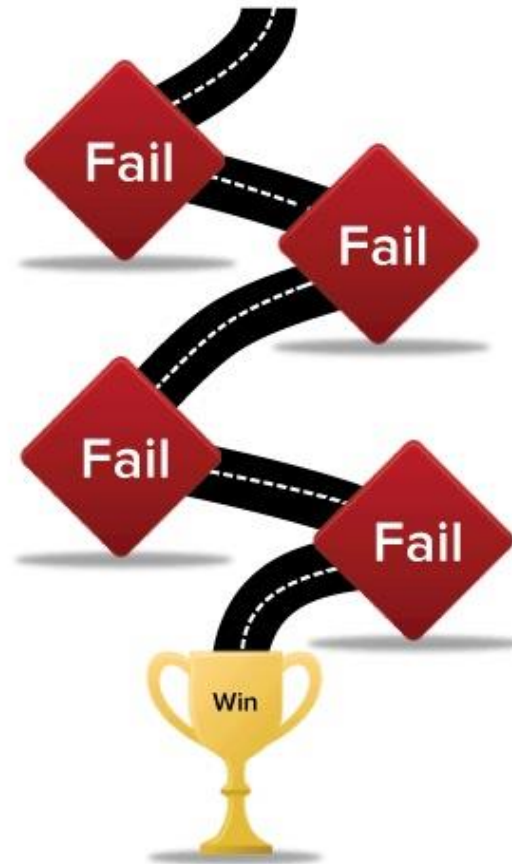
A more in-depth look at MIH programs and their current work with home health and hospice partners (Klarus & VITAS; Centura Health at Home) will be presented at the 2015 Home Care 100 Executive Leadership Conference. For additional information or to register, please visit www.homecare100.com. ■



What Most People Think



What Successful People Know



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