MOBILE INTEGRATED HEALTHCARE NETWORK

# EMS & FQHC Partnership

WASHINGTON COUNTY
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# The Dream Team

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# MIHN PARTNERSHIP

Great Mines
HEALTH CENTER

COMMUNITY ASSET BUILDERS, LLC

WASHINGTON COUNTY AMBULANCE DISTRICT

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# FQHC & EMS: Why It Works

- Similar missions
- 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

**EMS Specific**

- Fewer low acuity EMS calls
- Fewer inappropriate hospital transports
- 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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# About the MIHN

**Mission**

**Vision**

**Values**

***A Missouri 501(c)3***

# Primary Service Area

- Washington County:  762 square miles
  - Rural Setting
  - Socioeconomic Factors
  - Health literacy Factors
  - Compliance Factors

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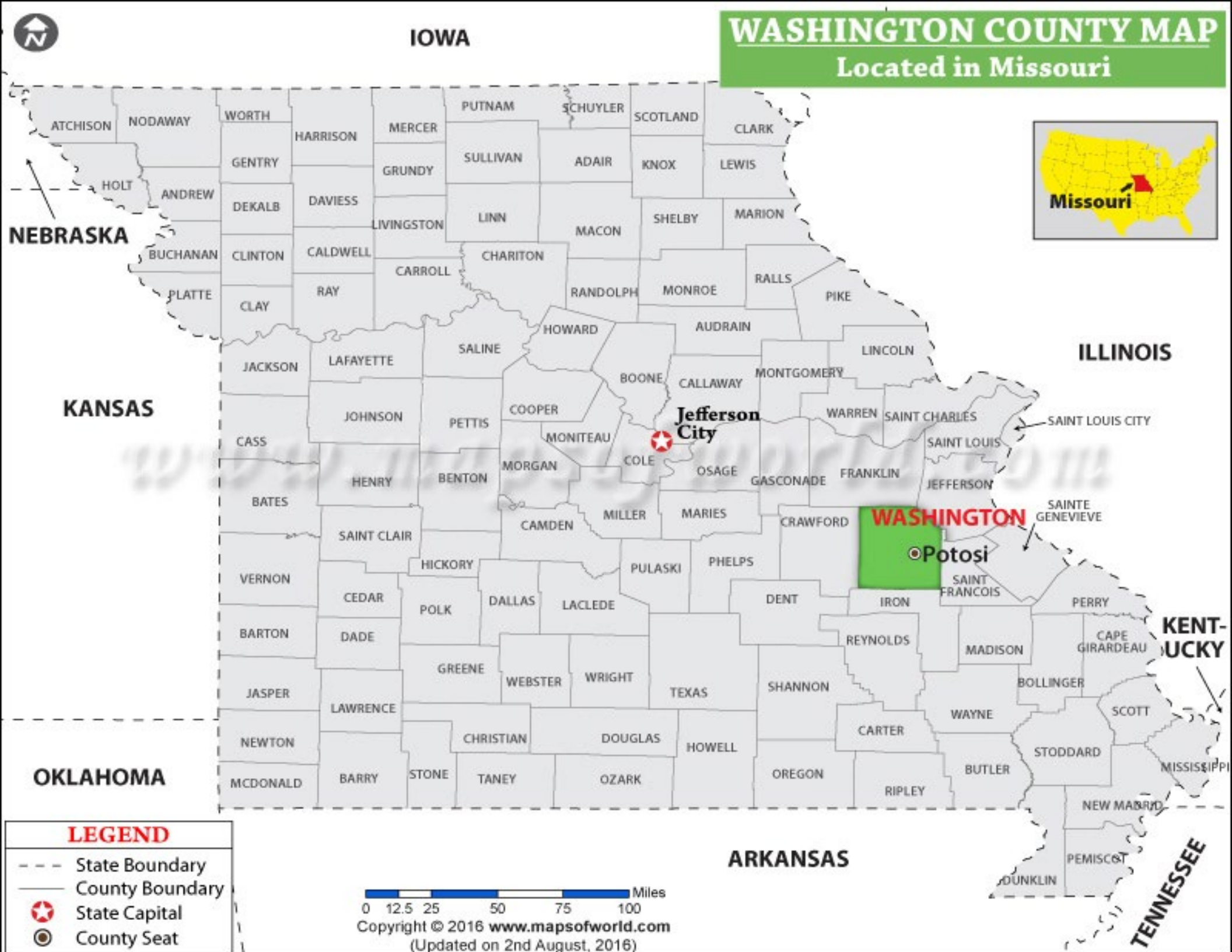
WASHINGTON COUNTY MAP
Located in Missouri
IOWA
NEBRASKA
KANSAS
ILLINOIS
OKLAHOMA
ARKANSAS
KENTUCKY
TENNESSEE
Missouri
ATCHISON
NODAWAY
WORTH
HARRISON
MERCER
PUTNAM
SCHUYLER
SCOTLAND
CLARK
HOLT
ANDREW
GENTRY
DEKALB
DAVIESS
GRUNDY
SULLIVAN
ADAIR
KNOX
LEWIS
BUCHANAN
CLINTON
CALDWELL
LIVINGSTON
LINN
MACON
SHELBY
MARION
PLATTE
CLAY
RAY
CARROLL
CHARITON
RANDOLPH
MONROE
RALLS
PIKE
HOWARD
AUDRAIN
JACKSON
LAFAYETTE
SALINE
BOONE
CALLAWAY
MONTGOMERY
LINCOLN
JOHNSON
PETTIS
COOPER
MONITEAU
Jefferson City
WARREN
SAINT CHARLES
SAINT LOUIS CITY
CASS
HENRY
BENTON
MORGAN
COLE
OSAGE
GASCONADE
FRANKLIN
SAINT LOUIS
JEFFERSON
BATES
SAINT CLAIR
CAMDEN
MILLER
MARIES
CRAWFORD
WASHINGTON
SAINTE GENEVIEVE
Potosi
VERNON
HICKORY
PULASKI
PHELPS
SAINT FRANCOIS
CEDAR
POLK
DALLAS
LACLEDE
DENT
IRON
PERRY
BARTON
DADE
REYNOLDS
MADISON
CAPE GIRARDEAU
GREENE
WEBSTER
WRIGHT
TEXAS
SHANNON
BOLLINGER
JASPER
LAWRENCE
WAYNE
SCOTT
CHRISTIAN
DOUGLAS
HOWELL
CARTER
NEWTON
STODDARD
MISSISSIPPI
MCDONALD
BARRY
STONE
TANEY
OZARK
OREGON
BUTLER
RIPLEY
NEW MADRID
PEMISCOT
DUNKLIN
LEGEND
State Boundary
County Boundary
State Capital
County Seat
Miles
0 12.5 25 50 75 100
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(Updated on 2nd August, 2016)

# 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.


4
DISASTER
RESPONSE
UNIT

# Making a Difference


**18,000 vaccines Administered in 2020**

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# Our First Formal MIH Project

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# 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.

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# 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

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# 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**

# TIME FOR EXPANSION

A formal relationship was established.

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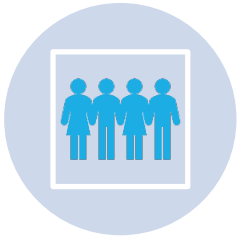
# Overview of Our MIH Model

Initiate primary care in the home with Community Paramedics

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

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# 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

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# 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

# 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

Washington County Ambulance District

Great Mines Health Center

Mineral Area College Emergency Medical Services

Community Asset Builders, LLC

# Our Projects

## Diverse grant funding.

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# 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

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# 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!

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# By the Numbers

**Total MIH Encounters 2021**

- 7,000

**CP's on Staff**

- 2 FT
- 2 ½ Time
- 10 PRN

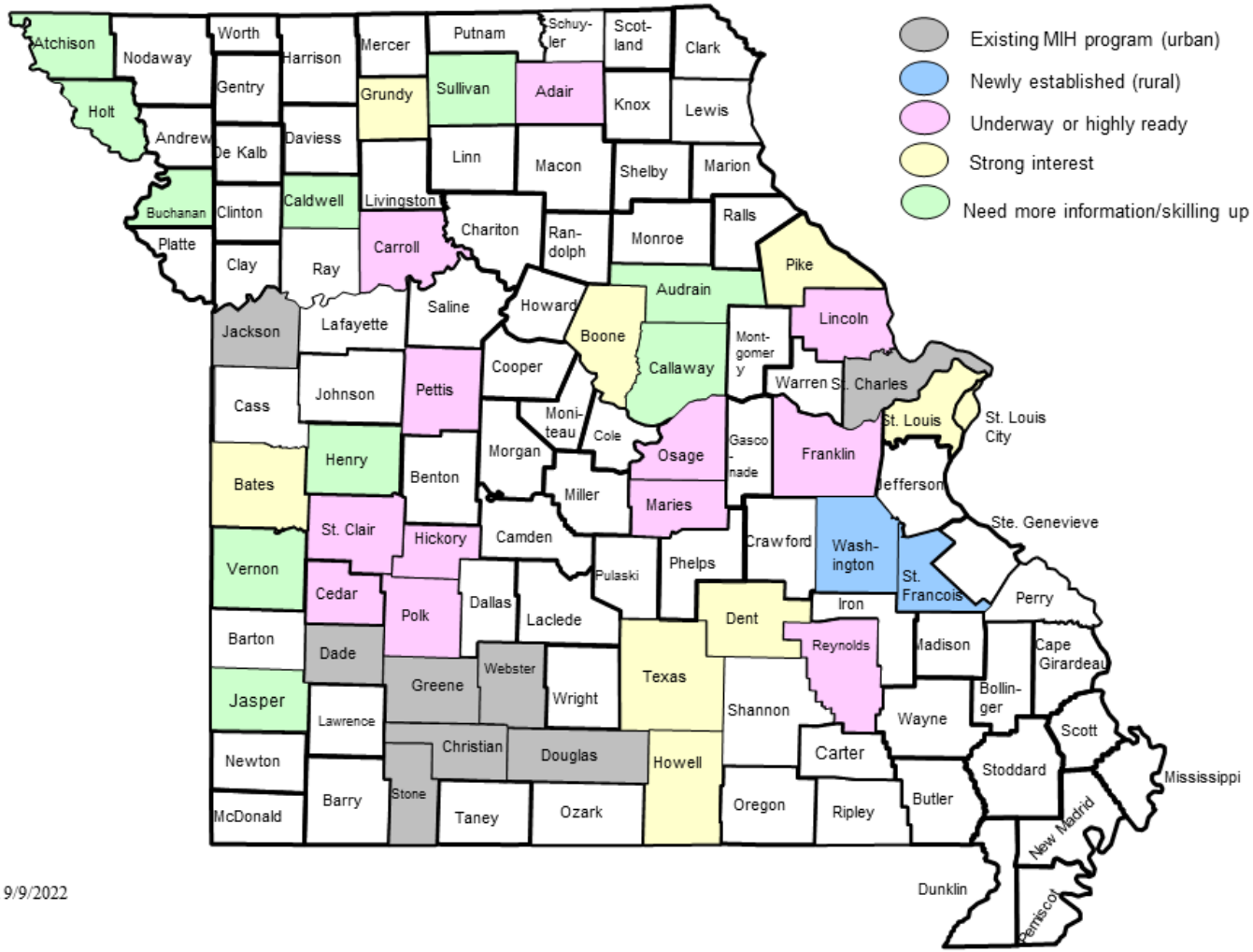
**CHW's on Staff**

- 10

**Statewide Growth**

# 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**

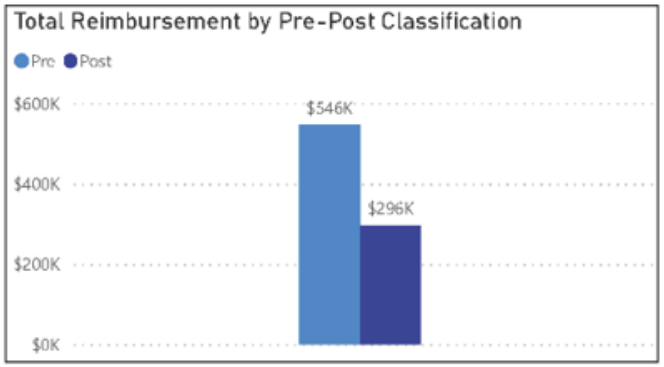
**Maternal Health**

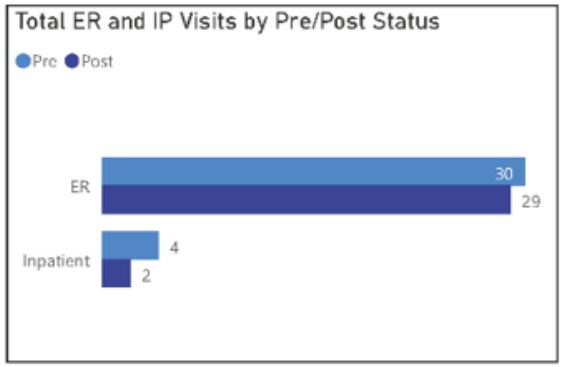
**Prenatal Care Coordination by CP / CHW**

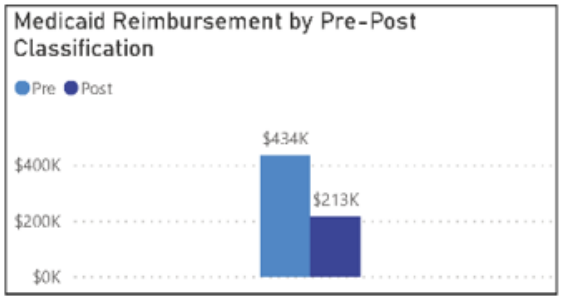
**WIC / Public Health Referral**

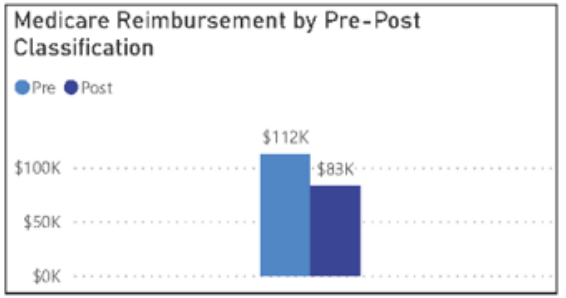
The savings illustrated below are from the Washington County (Missouri) MIH Network for a 47 person cohort. The data reflects costs pre- and post-MIHN services. The Central Missouri MIH Network intends to replicate the Washington County MIHN model to determine if the same results can be achieved in a different geographic area, different network member organizations, and different patients and community culture.

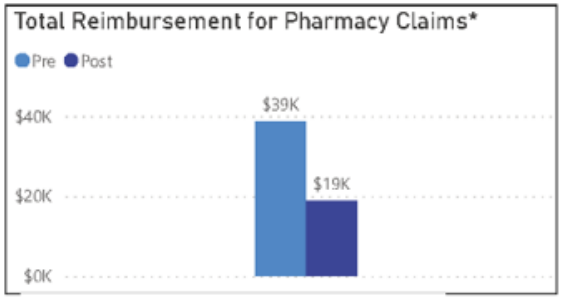
## Summary of Cost and Utilization Data for MIH Participants Pre/Post Intervention



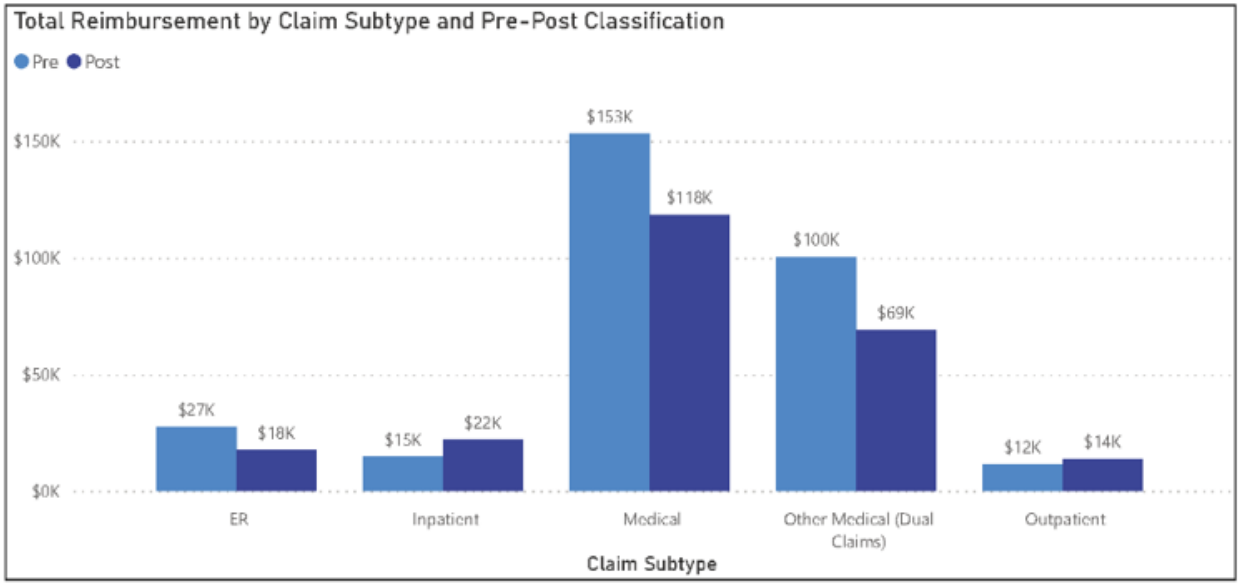




*Excludes data from an extreme outlier




CRITICAL CARE TRANSPORT
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## Thank you!

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