Responding to Psych Facilities to Avoid ED Transport

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Director | Medical Director
Wake County Dept of EMS
Raleigh, NC

Disclosures

- No financial conflicts
- Nearly everything we talk about is off label, not FDA approved, and, therefore, makes clinical sense


White House
Medical Unit


97
WHITE HOUSE MEDICAL UNIT
9:00 AM - 4:00 PM
EMERGENCIES - PLEASE CALL 911

Patient In Pain with Beeson

Patient Healed by Myers

Now Faith is the assurance
Of things hoped for
The belief in
Things unseen.

-- Hebrews 11:1

Atul Gawande Hot Spots

" [Dr} Brenner wasn't all that interested in costs; he was more interested in helping people who had received bad health care. The people cycling in and out of the hospital were usually the people receiving the worst care."

The MIHP Concept

- **A *mobile integrated healthcare practice* *ensures patients receive coordinated care* - the right care, at the right place, at the right time, by the right provider, at the right cost**

- **Need-matched, time appropriate health resource allocation**

Modern Healthcare, Dec 2013

Mobile Integrated Healthcare Practice: A Healthcare Delivery Strategy to Improve Access, Outcomes, and Value

Eric Beck, DO, NREMT-P; Alan Craig, MScPJ, ACP; Jeffrey Beeson, DO, RN, EMT-P; Scott Bourn, PhD, RN, EMT-P; Jeffrey Goodloe, MD, NREMT-P; Hawnwan Philip Moy, MD; Brent Myers, MD, MPH; Edward Racht, MD; David Tan, MD; Lynn White, MS

The U.S. health care system is often described as one that fails to achieve optimal health outcomes while generating exorbitant costs for patients, payors and society. [1] The Institute of Medicine (IOM) estimates that $750 billion—30% of the U.S. annual health care budget—is wasted on unnecessary services, inefficient delivery, excessive administrative costs and prevention failures. [2] Barriers to patient access, fragmentation of acute and chronic care, ineffective management of chronic illness, and complex, outdated reimbursement processes leave patients, clinicians and payors frustrated at historic levels. In *Crossing the Quality Chasm*, released in 2001, the Institute of Medicine (IOM) Committee on the Quality of Health Care in America described an urgent need to redesign the healthcare delivery system. The IOM emphasized the need to expand information technology and to create payment policies based on innovation, outcomes and performance improvement, rather than on the delivery of care itself. [3] Renewed focus on bringing healthcare to the patient, specifically by delivering care outside of traditional settings, has underscored the need for realignment of financial incentives and reimbursement policy. [4]

A special problem: 24/7 coordinated out-of-hospital care

The discontinuities of health service are notably evident in the care of patients at home; this is particularly true for the chronically ill, frail elderly and mobility impaired. Multiple single-purpose providers offer niche care and often only during restricted hours of operation, neither of which match the actual needs of this patient population.

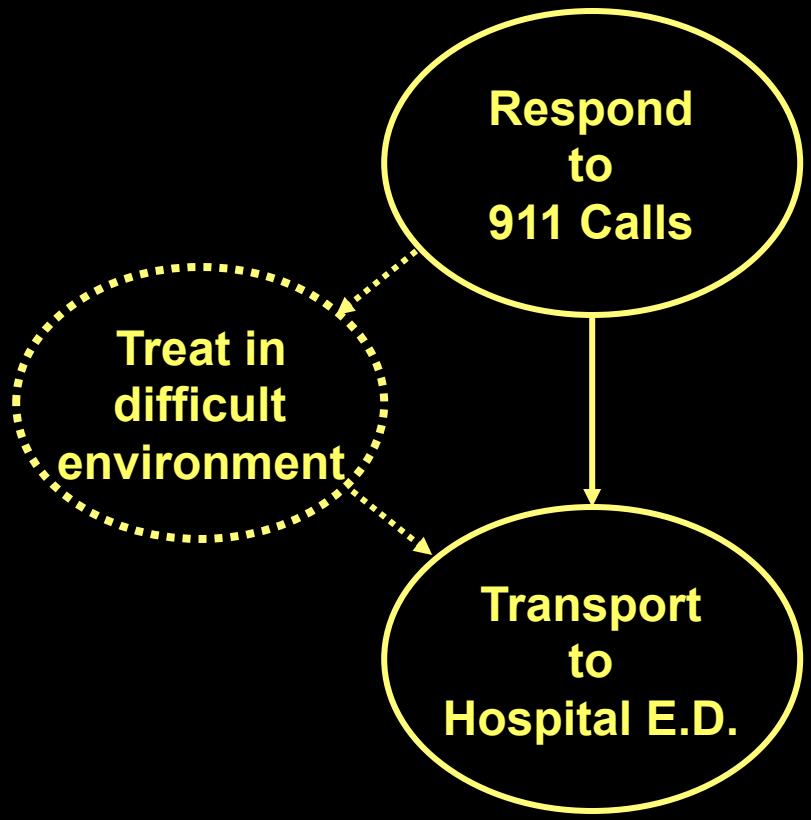
As a result, patients are routinely referred to hospital emergency departments (EDs) by their healthcare providers, outside of normal business hours, despite the common knowledge that the ED is an imprecise match to their needs. Further, care gaps such as a lack of post-acute transitional care make preventable re-admissions a virtual inevitability that is both expensive and disappointing to patients, caregivers and the health care system.

www.modernhealthcare.com/perspectives_MIHP

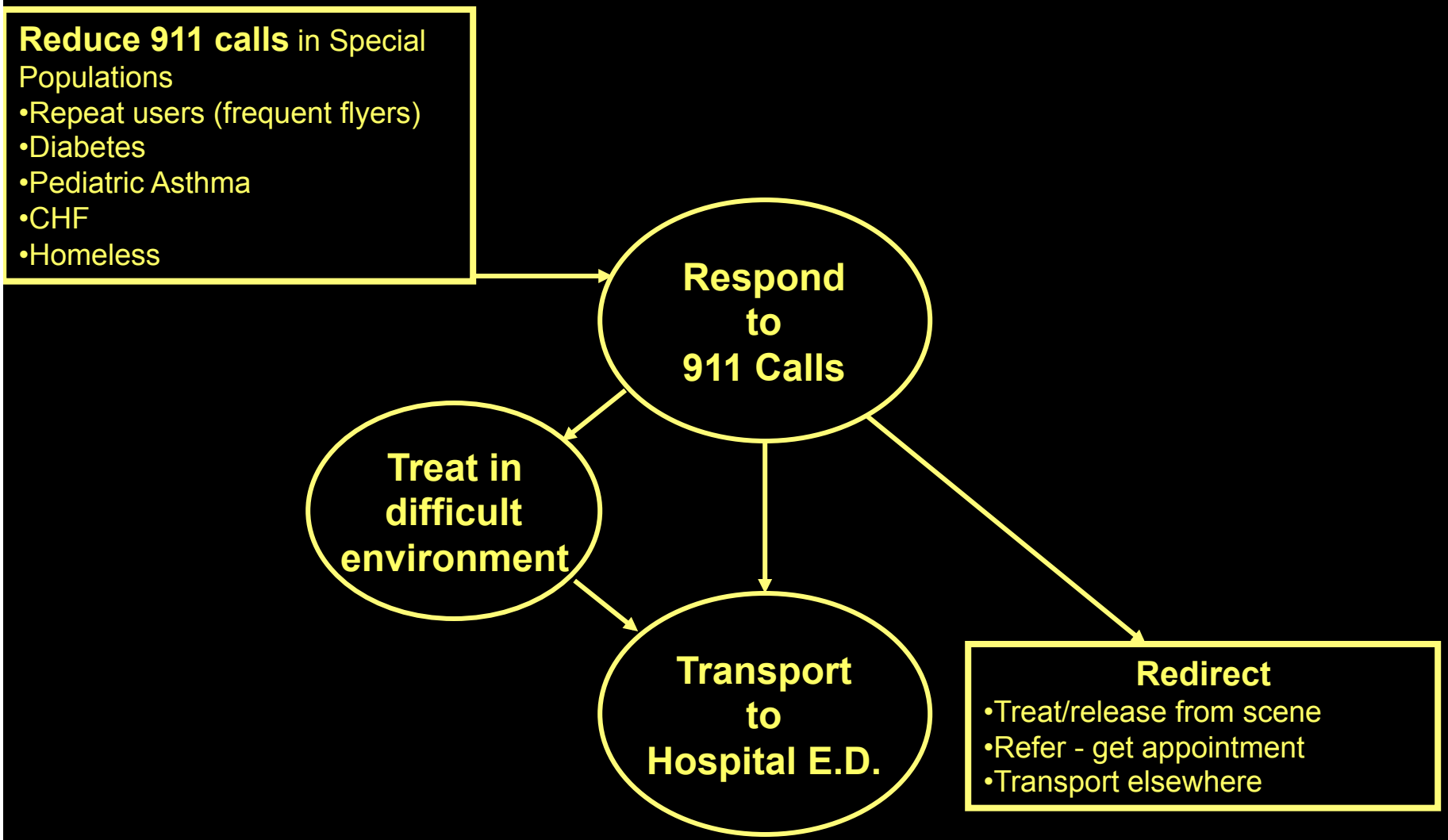
The Three R's

- **Respond:** Critical medical emergencies occur and require an experienced paramedic to mitigate
- **Redirect:** Not all patients need an emergency dept evaluation – experienced paramedics can help with destination decisions
- **Reduce:** Well-person checks for diabetic patients, CHF patients, etc.

Historical Scope of Service



Desired Scope of Service

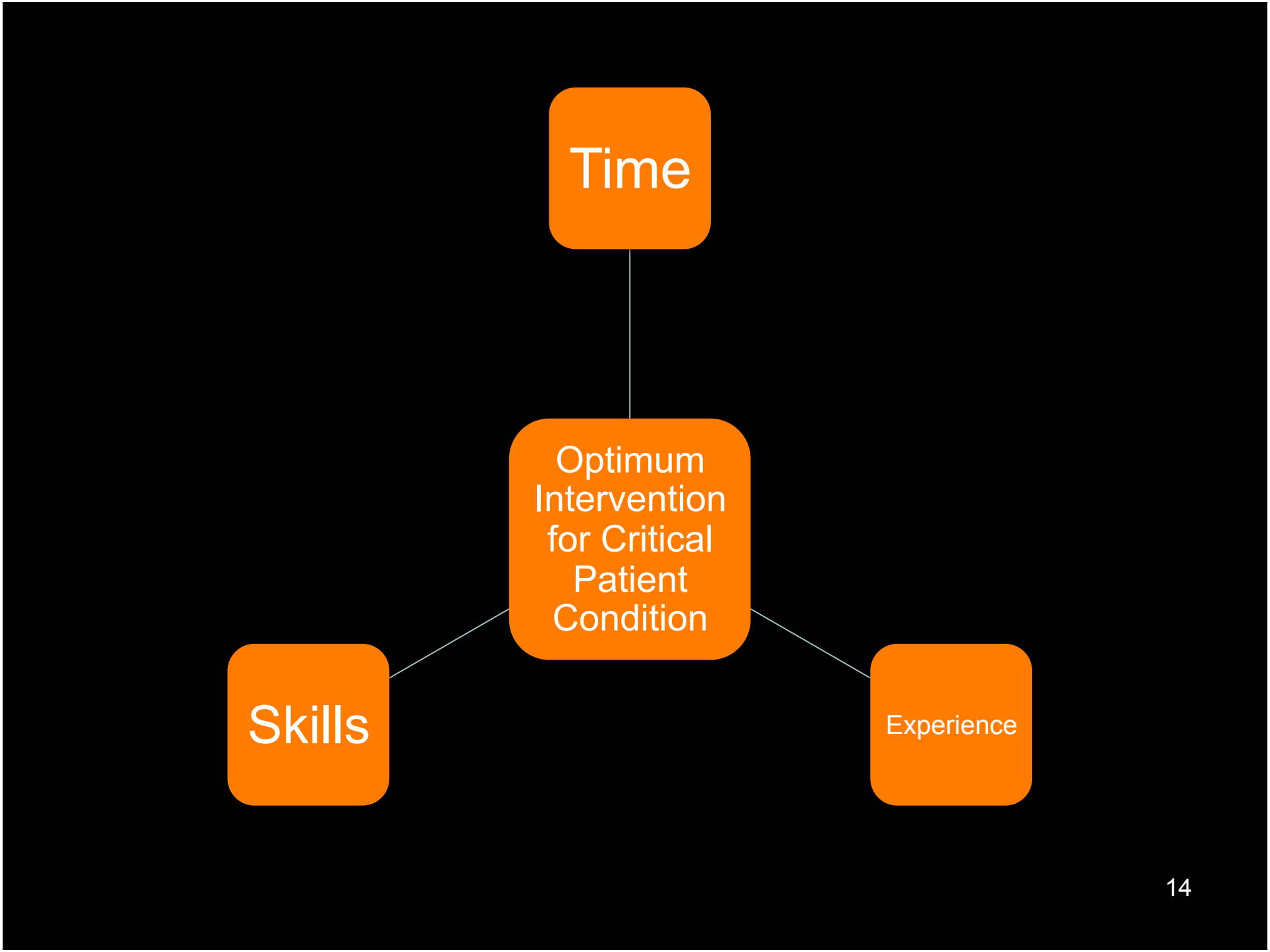


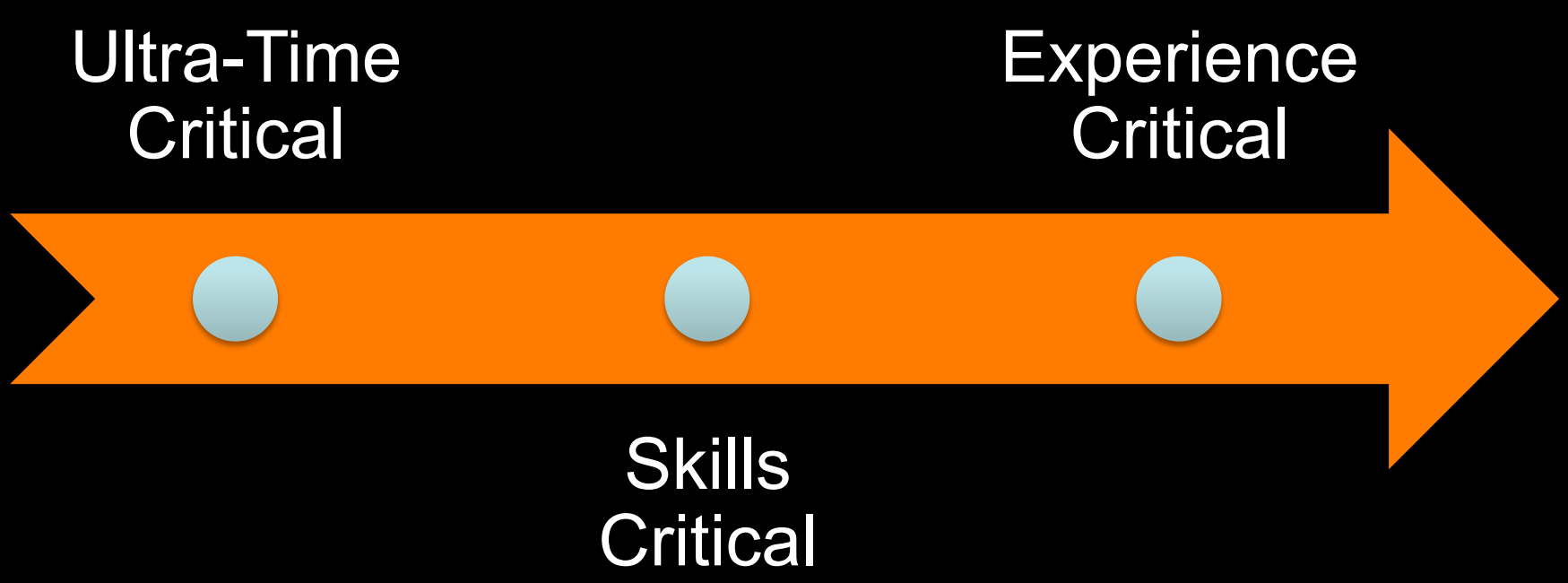
Risk-Frequency of EMS Interventions

HIGH RISK
LOW FREQUENCY
Requires very experienced paramedic;
Often requires more than one paramedic

MODERATE RISK - TIME CRITICAL
HIGH FREQUENCY
May be safely handled by a paramedic with limited experience.

LOW RISK
HIGH FREQUENCY
May not need to go to the hospital at all.
Some risk due to lack of transport.


Time
Optimum Intervention for Critical Patient Condition
Skills
Experience


Ultra-Time
Critical
Experience
Critical
Skills
Critical

Advanced Practice Paramedic

- An "advanced practice paramedic" provides a significantly better match between patient acuity and paramedic experience
- Experienced paramedic with additional training
- Assigned a "district" to cover
  - Respond to critical calls
  - Deliver services to reduce the number of calls
  - Arrange alternative (not ED) health care where appropriate
- Non-transport vehicle

Advanced Practice Paramedic

- Advanced practice paramedic (APP) – limited number to ensure appropriate annual experience with high-risk patient encounters
- Response time goal of 14:59 at 90th percentile to supervise or performs high risk, low frequency procedures
- Expanded role
  - Alternative transport decisions
  - Preventative measures
  - Advanced pharmacology

JEMS September 2007, p 62-68

What Has Happened Thus Far

- 16 total Advanced Practice Paramedics for 1 million population (8 per shift)
- Goal for response is 14:59 at the 90th percentile – actual is 17:59
- Traditional Paramedic 1 to 2 cardiac arrests per year
- APPs have seen 7 to over 30 per year

Historical Observations of EMS Destinations

Insanity: Doing the same thing Over and over again and Expecting different results

-Albert Einstein

High Risk Refusals

- Called for 167 HRR
- Converted 50% to transports
- Of those not converted:
  - 25 did not perceive themselves to be ill
  - 2 would only go by private car
  - 1 went to jail
  - 50 had “other” issues
- On average, 35 minutes is required for conversion

Non-Transport Follow-Up

- All patients who are not transported after refusal are placed on follow-up list for Advanced Practice Paramedics

- 5200 encounters with no transport were in the database

Refusal and Treat-no-Transport Follow-up

APP Refusal/Treat and Release Follow-up

Call Date: 12/31/2009

Incident #: [redacted]

Primary Unit: EMS 33

Primary: Candice Eason

Home Address: [redacted]

Patient: [redacted]

Age: 53 Years

Gender: Male

Phone: [redacted]

Call Dispo: AMA Refused Transport

Narrative:

On scene to find 53 y/o male c/a/o x 4 to ppte, sitting on tailgate of FR truck. Pt states he was restrained driver in vehicle that ran off the road. Pt states he apparently had a syncopal episode while driving. Pt states he "woke up" and realized he was off the road. He stopped the truck and called for EMS. Pt states he is not hurt and feels normal.

Only damage noted to vehicle is to front bumper. No airbag deployment

Contact History

Attempts Made:

- [x] First Attempt: /2010 12:00:36 PM
- [x] Second Attempt: 2/2010 5:14:22 PM ALL TRACKING COMPLETE [ ]
- [ ] Third Attempt:
- [ ] Fourth Attempt:
- [ ] Efforts Abandoned:

My Name is Vince Kauth

and I'm a Paramedic with the Wake County EMS System. I'm calling to follow up on the ambulance services that were provided to you on: 12/31/2009

Are you still experiencing problems related to your call?

Do you need medical assistance now?

Did emergency responders arrive promptly after your call?

In your opinion, were the ambulance personnel sympathetic to your needs?

Comments:

Did the ambulance personnel offer you transport to the hospital?

Yes? What influenced your decision not to go?

No? Tell me what happened after the paramedic finished examining or treating

Comments:

Did you seek medical care for the condition that prompted your 911 call?

If yes, what time?

xx/xx/20xx xx:xx:xx PM

Comments: No answer

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xx/xx/20xx xx:xx:xx PM

Benefits

- Provides community health assistance (vaccines, well-being checks) in collaboration with Wake County Human Services
- Provide pre-planned disaster preparedness assistance (ventilator checks, O_2 delivery)
- **Intervene with "hot spot" frequent consumers of EMS (blood glucose checks, alternate destinations)**
- Provide meaningful step on career ladder

Community Health

- Substance abuse/mental health (SA/MH)
  - Direct transport to facility for mental health or substance abuse care
- Falls prevention/care
- Hypertension/CHF checks
- Diabetic checks
- *Pre-plans (nursing homes, home health)*

What Are We Talking About?

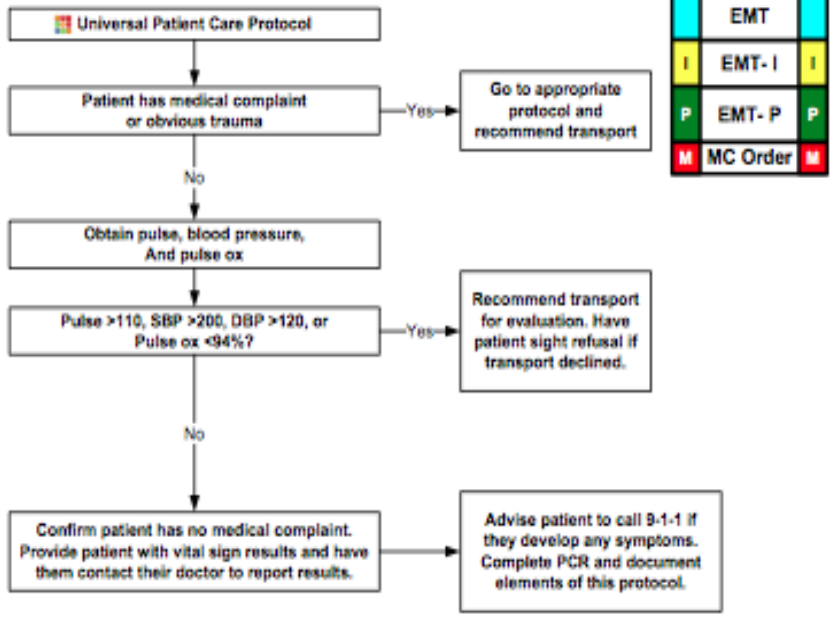
- Alternative Destination
  - Mental Health and Substance Abuse
- Alternative Treatment
  - Falls in Assisted Living Facilities
- Alternative Transport
  - Low acuity patients in cab/other vehicle

Well Person Check

History:
- Patient presents requesting "blood pressure check"
- EMS responders to "assist invalid"
- Other situation in which patient does not have a medical complaint or obvious injury

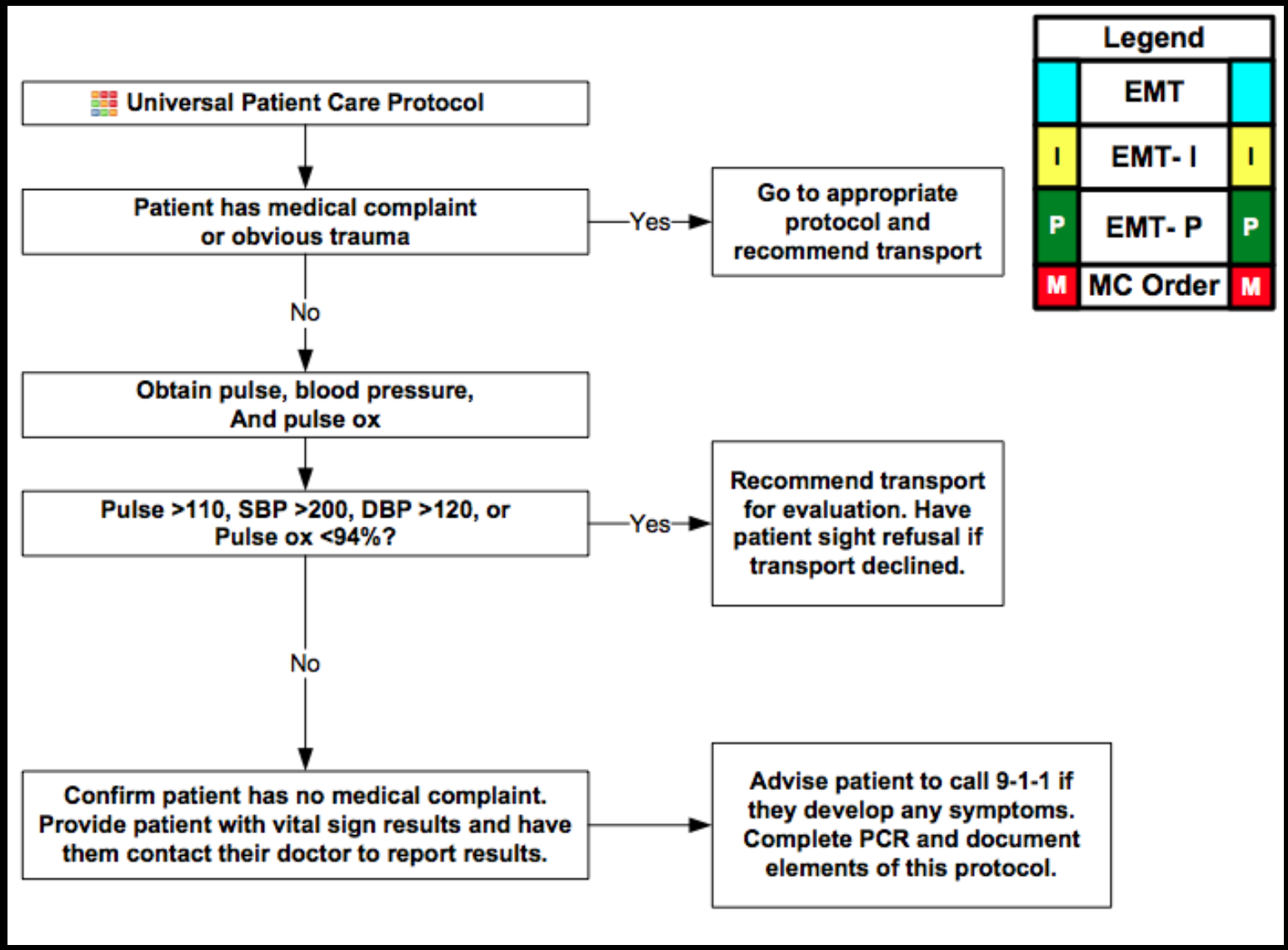
Signs and Symptoms:
- Assess for medical complaint
- For patients with hypertension, particularly check for chest pain, shortness of breath, and/or neurologic changes
- For assist invalid calls, particularly check for syncope, trauma from fall, or inability to ambulate

Differential:
- Hypertensive urgency
- Hypertensive emergency
- Syncope
- Cardiac ischemia
- Cardiac dysrhythmia
- Fracture
- Head trauma



Special Response Protocols

Pearls:
- This protocol pertains to ALL responders
- Patients who are denying more severe symptoms may initially present for a "routine check". Please confirm with the patient at least twice that they have no medical complaints.
- All persons who request service or meet the definition of a patient shall have an PCR completed.
- For patient in this category, the PCR may be brief but must include vital signs and documentation of the lack of a medical complaint. Additionally, patient's with a potential mechanism for trauma should have a trauma exam completed.


Universal Patient Care Protocol
Patient has medical complaint or obvious trauma
Yes
Go to appropriate protocol and recommend transport
No
Obtain pulse, blood pressure, And pulse ox
Pulse >110, SBP >200, DBP >120, or Pulse ox <94%?
Yes
Recommend transport for evaluation. Have patient sight refusal if transport declined.
No
Confirm patient has no medical complaint. Provide patient with vital sign results and have them contact their doctor to report results.
Advise patient to call 9-1-1 if they develop any symptoms. Complete PCR and document elements of this protocol.
Legend
EMT
I
EMT- I
P
EMT- P
M
MC Order

Screening Form

Reason for call: _☐_ 911 call _☐_ Involuntary Pick up _☐_ Wellness check - follow up _☐_ Other	**Was force used? Yes (☐) No (☐)** ***If yes, explain in narrative section of this form.*** **Patient Injuries:** (☐) None (☐) Prior to EMS arrival (☐) During EMS/LEO encounter **Paramedic/LEO Injuries:** (☐) None (☐) Slight (☐) Severe

Vital Signs: Time:_____ **B/P:_____** **Pulse:_____** **Respirations:_____**

BAC:_____ **Temp:_____** **Glucose:_____**

[redacted]

Patient's Status:[*Check all that apply*]	Medication Utilization Screening
(☐) Current mental health patient. (☐) New mental health patient. (☐) Patient is homeless. (☐) Unknown or other	(☐) No medication use exceeding prescribed dose or OTC label (☐) Poison control center case created based on candidates med use
	Poison Control Center Information: Time of contact:_____(24 hr) PCC Case/Reference Number Emergency Department Evaluation Recommended? (☐) Yes (☐) No Poison control instructions: _____ _____ _____

[redacted]

[redacted]

Medical Screening of Appropriateness for Admission:

01 - (☐) No acute medical issues/traumatic injuries are present. (Wounds requiring closure or bleeding are not allowed)
02 - (☐) No unexplained mental status change(s) persist or intermittently recurred during encounter.
03 - (☐) BAC is less than 0.35 and candidate can tolerate oral fluids.
04 - (☐) Pulse is less than 120.
05 - (☐) Candidate compliant with medicines for chronic medical issues, or knows meds and doses and will take.
06 - (☐) Candidate has not taken medications outside normal dose *or* poison control did not recommend ED eval.
07 - (☐) No poison control consult was required *or* poison control recommendation and case info recorded above
08 - (☐) Candidate has no history of diabetes *or* BGL <300 with no evidence of ketoacidosis.
09 - (☐) Candidate performs daily living activities independently
10 - (☐) ALL Boxes (1-9) are checked *or* name of receiving facility staff member contacted who agrees to accept is recorded to right _____

[redacted]

Direct Transport for SA/MH

- Patient has primary mental health crisis and/or substance abuse
- Patient does not require sedation or demonstrate agitation
- APP will then contact alternative site and evaluate the patient for potential placement

Exclusion Criteria

- Acute medical issue or trauma with bleeding, need for wound repair
- BAC >0.35 or patient too intoxicated to take po
- Pulse >120
- Unexplained alteration in mental status
- Unable/unwilling to take medications for pre-existing conditions

Exclusion Criteria

- Has taken medication outside of prescription/recommended dose and cannot be cleared by poison center
- Can perform ADLs independently
- Blood glucose < 300 with no evidence of DKA

“All the News That’s Fit to Print”

The New York Times

Late Edition

Today, clouds and some sun, a flurry, not as cold, high 40. **Tonight**, clearing skies, low 30. **Tomorrow**, mostly sunny and chilly, high 38. Weather map appears on Page B8.

VOL. CLXIII . . . No. 56,362 | | NEW YORK, THURSDAY, DECEMBER 26, 2013 | $2.50

Graft Scandal Is Approaching Turkey Premier

U.S. SENDS ARMS TO AID IRAQ FIGHT WITH EXTREMISTS

E.R. Costs for Mentally Ill Soar, And Hospitals Seek Better Way

Getting Out of Discount Game, Small Colleges Lower the Price

New Tests for Brain Trauma Create Hope, and Skepticism

In a Car-Culture Clash, It’s the Los Angeles Police vs. Pedestrians

E.R. Costs for Mentally Ill Soar, And Hospitals Seek Better Way

By JULIE CRESWELL

RALEIGH, N.C. — As darkness fell on a Friday evening over downtown Raleigh, N.C., Michael Lyons, a paramedic supervisor for Wake County Emergency Medical Services, slowly approached the tall, lanky man who was swaying back and forth in a gentle rhythm.

In answer to Mr. Lyons’s questions, the man, wearing a red shirt that dwarfed his thin frame, said he was bipolar, schizophrenic and homeless. He was looking for help because he did not think his prescribed medication was working.

In the past, paramedics would have taken the man to the closest hospital emergency room — most likely the nearby WakeMed Health and Hospitals, one of the largest centers in the region. But instead, under a pilot program, paramedics ushered him through the doors of Holly Hill Hospital, a commercial psychiatric facility.

“He doesn’t have a medical complaint, he’s just a mental health patient living on the street who is looking for some help,” said Mr. Lyons, pulling his van back into traffic. “The good news is that he’s not going to an E.R. That’s saving the hospital money and getting the patient to the most appropriate place for him,” he added.

The experiment in Raleigh is being closely watched by other cities desperate to find a way to help mentally ill patients without admitting them to emergency rooms, where the cost of treatment is high — and unnecessary.

While there is evidence that other types of health care costs might be declining slightly, the cost of emergency room care for the mentally ill shows no sign of ebbing.

Nationally, more than 6.4 million visits to emergency rooms in 2010, or about 5 percent of total visits, involved patients whose

Continued on Page B4

The Rest of the Story

- The majority of patients who present for mental health crisis walk in rather than arrive by EMS
- Despite all of our efforts, we still respond over 300 times a year to transport patients away for various things:
  - "medical clearance"
  - "potential OD"

Alternative Destination

- 204 patients in a 12 month period were placed
- Mental health patients consume 14 ED bed hours on average (2,448 hours)
- Chest pain patients consume 3 ED bed hours on average
- Thus, we opened beds for 816 chest pain patients in the 12 month period
- This also saved ~$350,000 in total healthcare costs for this population

The Ask

- EMS reimbursement tied to care provided rather than only to transport to the hospital emergency department
- Options:
  - Modification of current Medicaid payment
  - Pilot funding for certain projects
  - Per member per month or other payment not based on episodes of care

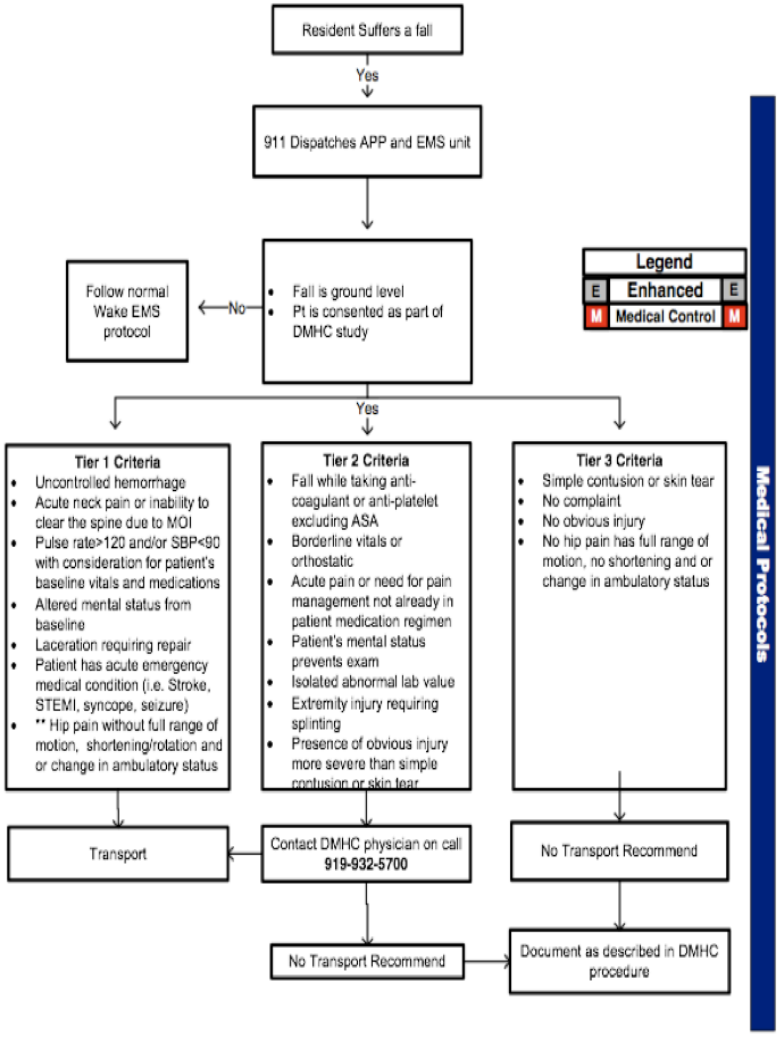
Alternative Treatment: Falls In Assisted Living Facilities

- 1 to 5 transports per day for our EMS system
- Majority are patients who are “found down” with no obvious injury or complaint
- Risk management strategy for the facility is to summon EMS for transport to the emergency department

Alternative Treatment: Falls in Assisted Living Facilities

- Retrospective study complete:
  - 644 falls in assisted living were reviewed
  - 197 of these patients had a time-sensitive medical emergency
  - Protocol would have identified 190 of the 197
  - Sensitivity then is 97% (93-98%, 95% CI)
    - Bachman M et al. PEC 2013;17(1):111 [abstract]

Doctors Making House Calls
Falls in Assisted Living



Falls in Assisted Living Facilities

- Prospective evaluation had been underway for several months
- Public/private partnership with Doctors Making Housecalls (DMH)
- 400 + patients enrolled; over 150 falls with ½ remaining in the facility
- Common medical record with DMH
- On-going evaluation of safety and costs

Alternative Transport: Low Acuity Callers

- Data Driven triage score
  - 1 very ill/injured
  - 2 and 3 need prompt evaluation
  - 4 and 5 – can safely go to the waiting room
- We are working to implement this scoring mechanism
- ~20% of our transports are level 4 and 5 (~$3.5 million in transport charges per year)

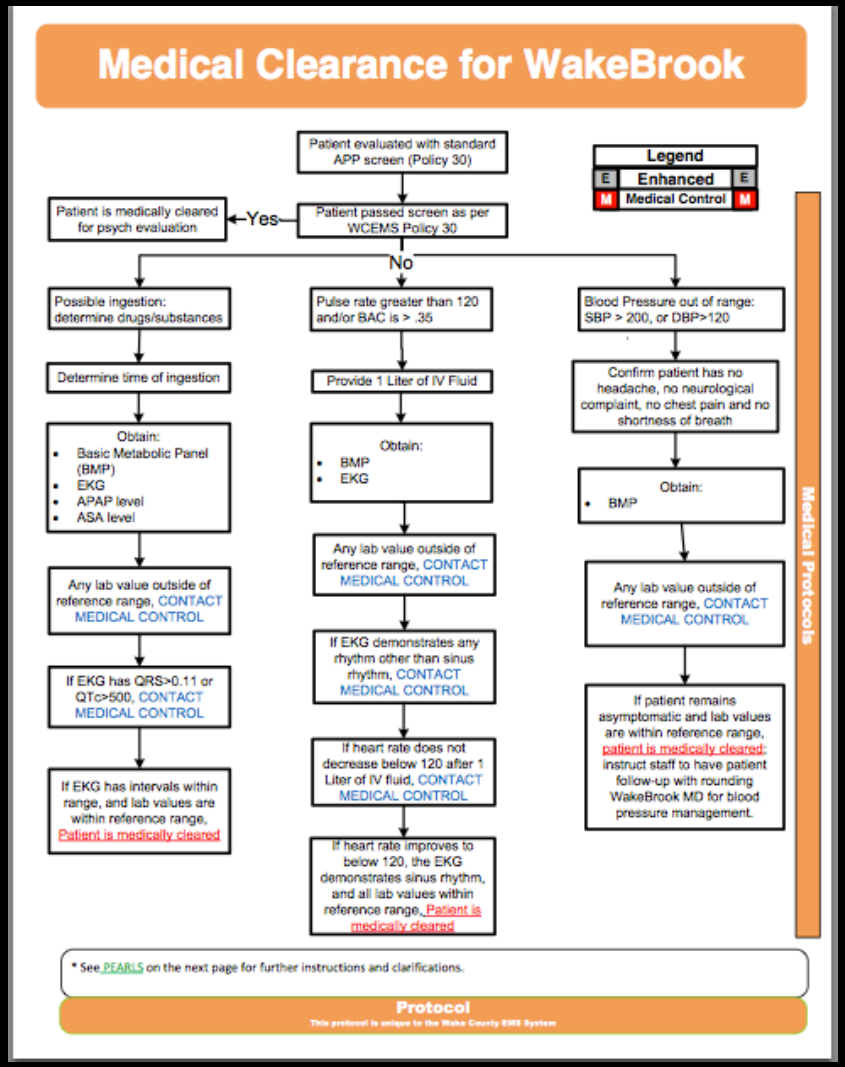
Metrics

- Patient satisfaction
- Safety
  - 48 hour return to emergency department
  - Adverse patient outcomes
- Cost avoidance

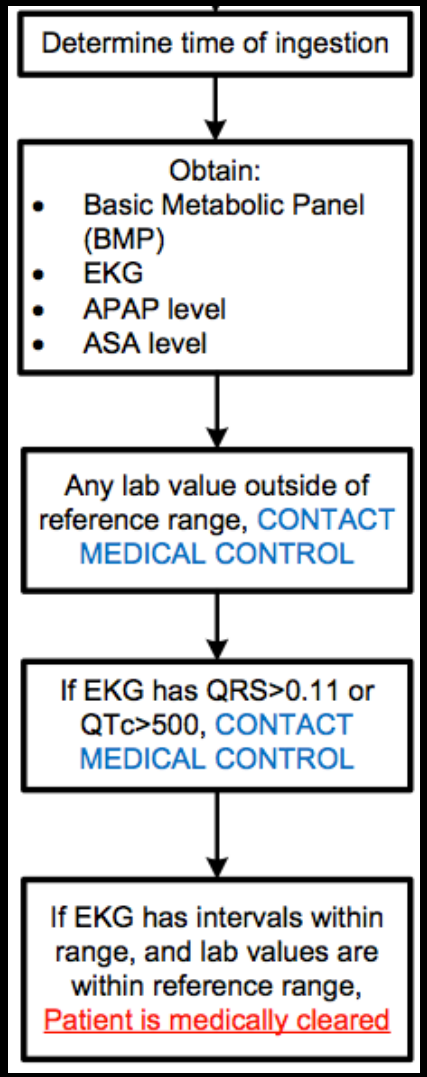
Summary

- Hot spots that are amenable to intervention in the EMS population exist
- The Advanced Practice Paramedic program is one method to improve care while reducing cost to the healthcare system
- Standardized measures to evaluate performance are the next challenge

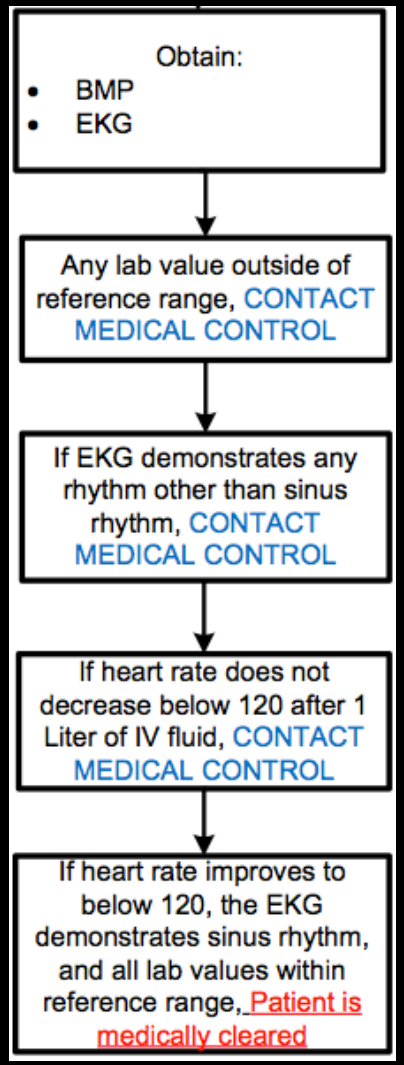
New Protocol



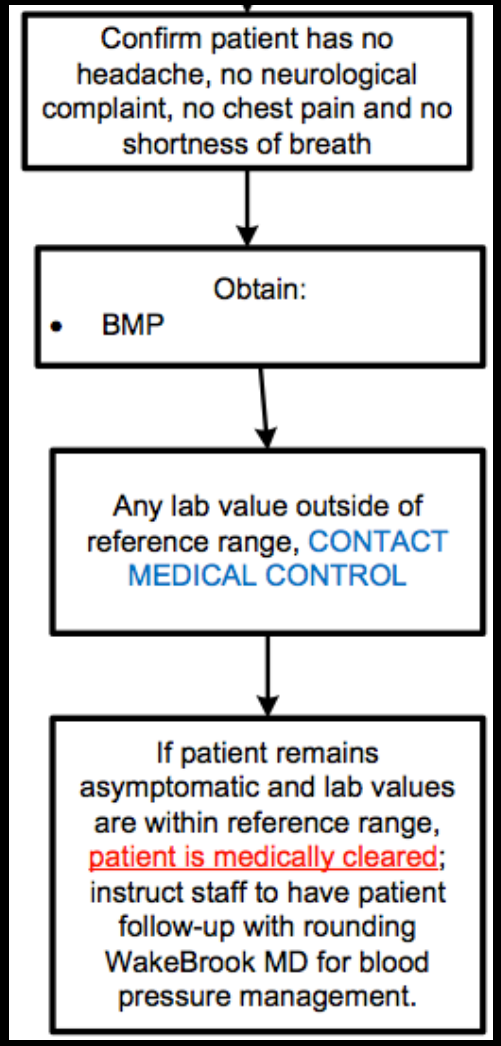
Asymptomatic Possible OD



BAC or Pulse Too High



Isolated Elevated BP



Conclusion

- Dr. Myers' patients are happier than Dr. Beeson's
- Alternative destination is now meeting alternative treatment
- Let's not make this complicated
- Thank you


PARAMEDIC
WAKE COUNTY
EMS
PARAMEDIC
94

MIHP

Mobile Integrated Healthcare in Chicago

Eric Beck, DO, NREMT-P

University of Chicago
Target Population

Readmissions

- CHF
- Sickle Cell
- Pediatric Asthma

AT THE FOREFRONT

A publication of the University of Chicago Medicine and Biological Sciences

THE UNIVERSITY OF CHICAGO MEDICINE & BIOLOGICAL SCIENCES

AUGUST 2013

SAFETY & QUALITY: EMS

EMS Techs to Serve As Care Coordinators

MEDEX® MEDICAL EXPRESS INTEGRATED HEALTHCARE

Interprofessional Team

- Physician
  - EM, EMS, Cards, IM
- Nursing
  - HH, UR, Case Mgt
- Pharmacy
  - Hospital, Home
- Social Work
  - Hospital, HH
- EMS

Interventions

- Home assessment
- Telemonitoring
- Interception
- Transportation
- Home delivery pharmacy
- Home Health
- 24/7 access to care team

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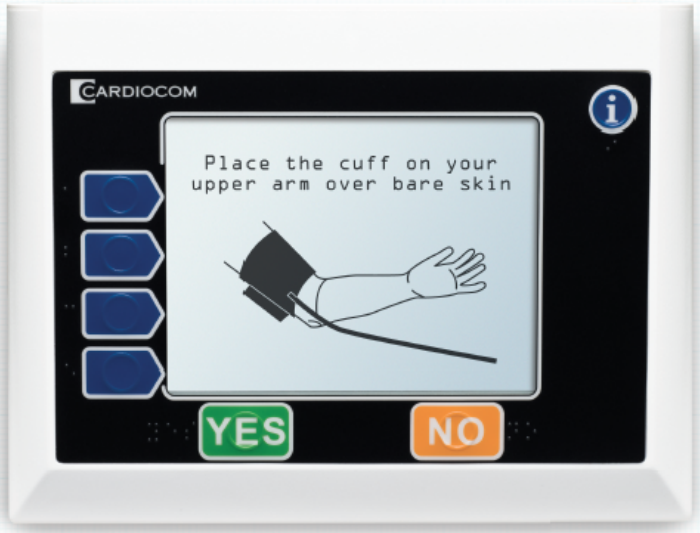

CONNECTING PATIENTS USING ADVANCED WIRELESS AND CELLULAR TECHNOLOGY.

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CHF Home Assessment Form – DRAFT

THE UNIVERSITY OF CHICAGO MEDICINE

Once completed please email this form to samira.qadir@uchospitals.edu

Patient Name and Information:

Last: First: MI:

Date of Discharge: / / MRN: Insurance:

Crew Name: 1. Ambulance Run #:
2.

At University of Chicago Medicine:

Yes No
- ☐ ☐ Collect discharge packet from nurse (check for AVS)
- ☐ ☐ Obtain final list of medications from nurse
- ☐ ☐ Collect patient belongings
- ☐ ☐ Ensure patient has a key or other access to residence
- ☐ ☐ Re-orient patient to process

Perform an overall environmental scan of patient home:

Yes No
- ☐ ☐ Patient is able to move around to bathroom, bedroom, and kitchen without barriers (ensure patient in a wheelchair does not have to use stairs)
- ☐ ☐ Patient has electricity, water, heat, and access to a working phone
- ☐ ☐ There is evidence of rodents
- ☐ ☐ Check for any fall or tripping hazards
- ☐ ☐ The house is relatively clean

*** If patient cannot be left at residence contact UCM Call Center (773) 702-0015 and discuss plan with UCM EMS*

Notes:

Yes No
- ☐ ☐ Assess surroundings for environmental factors that may aggregate heart failure (i.e. smoking)
- ☐ ☐ Are there smokers in the house (esp. where there is oxygen)

Provide smoking recommendations

Yes No
- ☐ ☐ Highlight sodium content on nutrition labels in patient education packet

Risks for Readmission:

Yes No
- ☐ ☐ No Follow Up Appointment
- ☐ ☐ Prescriptions unavailable
- ☐ ☐ Unable to afford medications
- ☐ ☐ Medications not yet received from pharmacy
- ☐ ☐ Noncompliance with diet
- ☐ ☐ Unable to understand discharge instructions
- ☐ ☐ Other:

After Visit Summary:

Yes No
- ☐ ☐ Review the patients After Visit Summary (AVS)
- ☐ ☐ Review any supporting educational material

Report any errors or missing documentation

Notes:

Oxygen:

Yes No
- ☐ ☐ This patient is on oxygen
- ☐ ☐ There is enough oxygen in the tank
- ☐ ☐ The tank is mobile OR there is sufficient tubing
- ☐ ☐ Show patients where to call for 02 issues

*** If there are issues regarding 02 please call (312) 604-3740 to report immediately*

Mobility:

Yes No
- ☐ ☐ This patient is able to ambulate independently
- ☐ ☐ Walker/Cane are in good condition and easily accessible

Notes:

Medications:

Yes No
- ☐ ☐ Ask/help the patient gather all the medications in the house (prescription and non-prescription)
- ☐ ☐ Separate active vs. inactive or expired medications
- ☐ ☐ Put all the inactive medication into a bag and explain to the patient that the home health nurse will go over the medications during their first visit
- ☐ ☐ Place all active medications in an place that's easily accessible

***If there are urgent issues regarding Medications please call (312) 604-3740 to report immediately*

Weight Monitoring:

Yes No
- ☐ ☐ Find a mutually agreeable place to put the patient's weight monitoring sheet
- ☐ ☐ Tele-monitor is set up and functional
- ☐ ☐ Take patients weight and record on sheet

Record where monitoring sheet is placed

Notes:

Follow-Up:

Yes No
- ☐ ☐ Patient is aware about date/time of home health provider visit
- ☐ ☐ Check to see if patient has a follow up appointment and is able to make this appointment (i.e. transportation issues etc.)
- ☐ ☐ Patient is aware of provider contact information in case of questions/concerns
- ☐ ☐ Emergency contact numbers are listed and accessible

Notes:

Patient Satisfaction

How helpful did the patient find the advanced discharge process?

☐ Very helpful ☐ A little helpful ☐ Not helpful ☐ Unable to ask patient

CHF Integrated Health Pilot	Week 1	Week 2	Week 3	Week 4	Month 1	Week 5	Week 6	Week 7	Week 8	Month 2	Week 9	Week 10	Week 11	Week 12	Month 3
Readmissions & Encounters															
CHF 30-day Readmission Rate															
Number of advanced discharge patients readmitted within 7 days															
Number of advanced discharge patients readmitted within 30 days															
Percent of advanced discharge patients readmitted within 7 days															
Percent of advanced discharge patients readmitted within 30 days															
Number of ED visits 30 days post discharge															
Patient															
Number of patients discharged from Cardiology service															
Number of patients using CHF advanced discharge from Cardiology service															
Total number of patients using CHF advanced discharge															
Percent of patients approached who accepted															
Percent of patients who accepted pharmacy															
M.I.H.P. Process Outcomes															
Number of times UCM EMS provider contacted															
Number of times HRS live line contacted?															
Average time to resolve issues															
Number of time patient transported to short stay															
Number of times patient transported to ED															

Mobile Integrated Healthcare Practice for Transitions of Care and Readmission Reduction:

A Feasible Model for Implementation and Development

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BACKGROUND AND PURPOSE

- Effective transition of care between healthcare settings is increasingly recognized as a critical component of high quality healthcare.
- Mobile Integrated Healthcare Practice (MIHP) is an emerging practice model for improving transition from the inpatient setting by positioning Emergency Medical Services (EMS) providers as the cornerstone of care coordination.
- EMS uniquely impacts care transitions because of its role at the intersection of the inpatient, outpatient, and home environments.
- This poster describes the process for development of an MIHP for an urban congestive heart failure (CHF) population.

METHODS

- Patients with CHF at a single urban academic center were identified as a population that could benefit from optimized transition care based upon historic readmission rates.
- An interprofessional working group, including EMS, conducted a nine-month needs assessment. The team identified previously validated interventions that had been offered with limited integration and bundled these interventions into a comprehensive care program led by EMS.
- EMS integrates services provided by home health, pharmacy, social work, cardiology, hospitalist, emergency medicine, and hospital administration.

FIGURE

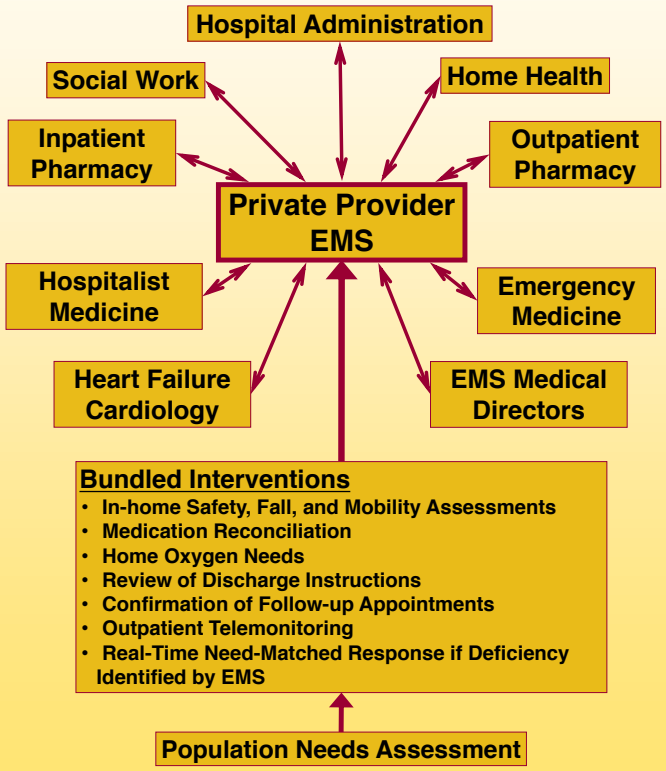

Figure: Conceptual flow diagram of MIHP implementation process.

RESULTS

- Under this model, EMS performs an in-home assessment for readmission risks, patient mobility limitations, and home medications/oxygen.
- EMS also initiates home telemonitoring and reviews the follow-up care plan and discharge instructions with the patient.
- If any element is deemed inadequate by EMS, a centralized call center mobilizes need-matched resources to the patient in a time-appropriate interval.
- Specific members of the interprofessional team then address a patient's individual needs.

CONCLUSIONS

- An interprofessional care team with EMS as a lead stakeholder can integrate best practices for transitions of care to develop a MIHP pilot for the care of CHF patients at an urban academic medical center.
- Coordinated interprofessional involvement in the development of a bundle of validated interventions leads to need-matched resource allocation, as identified by EMS providers.
- This abstract describes a feasible model for the development of a coordinated care transition program with EMS as a lead partner

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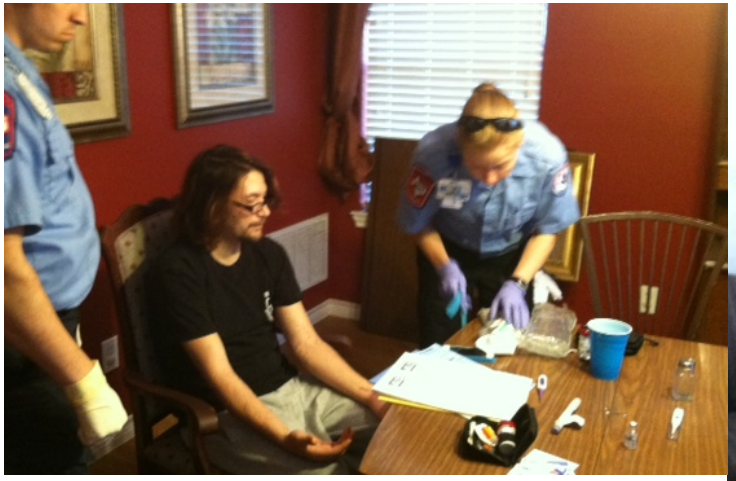
Poster **#89**
Abstract **#303248**

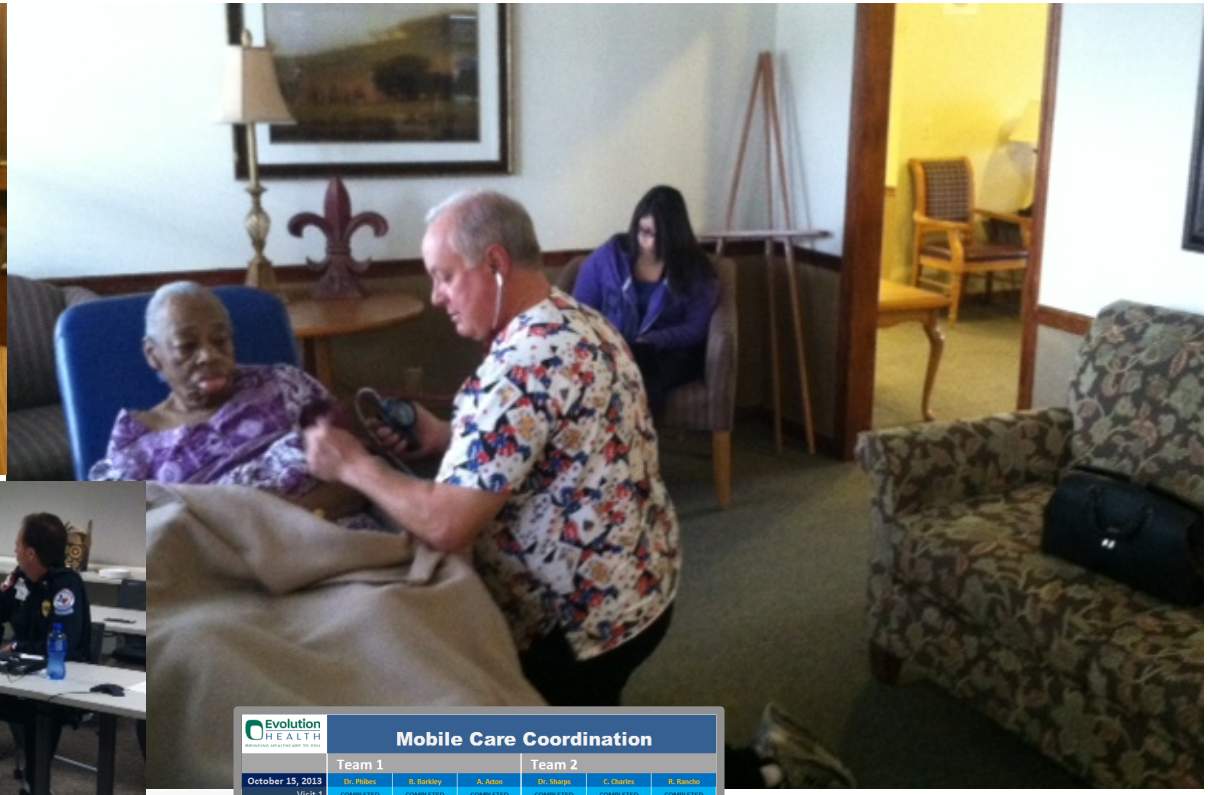

AMR
MOBILE INTEGRATED HEALTHCARE

AMR

EmCare

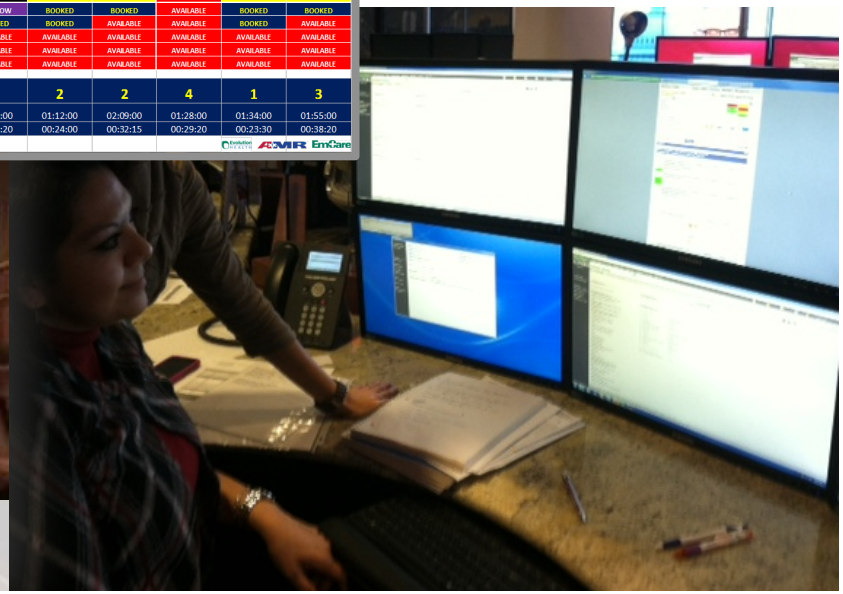
Evolution HEALTH





Mobile Care Coordination

Evolution HEALTH	Team 1			Team 2		
October 15, 2013	Dr. Phibes	B. Barkley	A. Acton	Dr. Sharps	C. Charles	R. Rancho
Visit 1	COMPLETED	COMPLETED	COMPLETED	COMPLETED	COMPLETED	COMPLETED
Visit 2	COMPLETED	CANCELLED	COMPLETED	COMPLETED	COMPLETED	COMPLETED
Visit 3	COMPLETED	COMPLETED	COMPLETED	COMPLETED	COMPLETED	COMPLETED
Visit 4	AT SCENE	COMPLETED	COMPLETED	AVAILABLE	COMPLETED	CANCELLED
Visit 5	CANCELLED	AT SCENE	AT SCENE	AVAILABLE	AT SCENE	AT SCENE
Visit 6	NO SHOW	BOOKED	BOOKED	AVAILABLE	BOOKED	BOOKED
Visit 7	BOOKED	BOOKED	AVAILABLE	AVAILABLE	BOOKED	AVAILABLE
Visit 8	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE
Visit 9	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE
Visit 10	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE	AVAILABLE
Unassigned Visits Available	2	2	2	4	1	3
Total Time at Visits:	01:28:00	01:12:00	02:09:00	01:28:00	01:34:00	01:55:00
Average Time per Visit:	00:29:20	00:24:00	00:32:15	00:29:20	00:23:30	00:38:20
Envision					Evolution Health ADMR EmCare	



Telephonic Support | **In-Home Care MD/DO/APN/PA** | **Social Services** | **Mobile Nurses** | **Medic Specialists** | **Remote Monitoring**

Medical Command Center

Operational Staffing and Workflow