Cataldo Ambulance Service Special Project Waiver Application

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This Special Project Waiver is to allow Cataldo Ambulance Service to operate a Community Paramedic Program within its service area. The waiver will involve a select group of paramedics, with specialized training, working under the oversight and guidance of the Beth Israel Deaconess Medical Center Post-Acute Care Transitions (PACT) program and Dr. Jonathan Fisher, MD. After the anticipated success of the pilot program, there will be the possibility of additional physician group input and partnerships as the program expands.

Cataldo Ambulance Service has developed SmartCare, a comprehensive Community Paramedic Program, to address the need to reduce/eliminate the frequent occurrence of hospital readmission by bridging the gap between hospital discharge and a return to a normal life style, which many patients fall into. SmartCare also addresses the need, as outlined in Chapter 224 of the Acts of 2012, to bring healthcare costs in-line with the state's overall economy, by offering affordable alternative care planning within the Commonwealth. SmartCare will facilitate an enhancement to the primary care spectrum by providing a link between the PCP and the patient while allowing the patient to remain in their home environment whenever clinically possible.

Cataldo Ambulance Service recognizes that these patients will have different needs based on several factors, including: the nature of their discharge diagnosis, any underlying healthcare concerns, and support infrastructure in their home. The SmartCare Program has the flexibility to meet these dynamic needs and act as a key resource for patients, physicians, and care planners.

Cataldo Ambulance Service has entered into a contractual agreement with the Beth Israel Deaconess Medical Center's PACT team to launch the SmartCare Community Paramedic Program as a pilot program (please see attachment). This initial program is funded through the PACT team. Cataldo Ambulance Service is working with other private payers and end-users to identify future payer sources. (Please see attachment regarding leadership teams of both Cataldo Ambulance Service and the BIDMC PACT team).

Cataldo Ambulance Service feels that SmartCare will be a permanent business line moving forward and is requesting the waiver for 24 months.

Project Overview:
This program will increase availability and continuity of healthcare to specific populations at high risk for readmission.

Facts:

- Out of 12 million fee-for-service Medicare beneficiaries: 20% of them who had been discharged from a hospital, were re-hospitalized within 30 days[11]
- MA ranks 41st in US on Medicare 30-day readmissions[1]

SmartCare will bridge the existing gap in currently available services and will serve as additional point of contact for urgent issues. The program is primarily meant to address patient needs within the first 30 days post-discharge, with the possibility of a longer enrollment period for certain patients. The healthcare objectives of this program include: post discharge care; compliance with discharge instructions to optimize wellness; patient and family education; primary care, wellness, and prevention of hospitalization for the chronically ill; and connecting patients with social and community support mechanisms. The program will work collaboratively with existing resources such as VNA and local EMS.

Through extensive collaboration with different care provider groups, Cataldo Ambulance Service has identified multiple areas where there is a current need for Community Paramedic services. These Community Paramedic services would *enhance/supplement* current services already provided by extending hours and available interventions, but does not seek to replace current services in place.

- Several provider organizations have discussed the need for an "urgent" service. These organizations (such as the PACT program) have care providers who, through contact with their patients, have identified urgent clinical issues that are not emergencies. There is no existing mechanism to have these patients evaluated in a timely manner. Major challenges to timely evaluation include: lack of urgent or off-hour VNA availability, lack of urgent or last-minute PCP availability, and a lack of availability of transportation to PCP. Currently the only alternative available for these patients is transport to an Emergency Department via ambulance. Transport to an emergency department is extremely detrimental for these patients for a number of reasons: there is an economic strain on the healthcare system, they often times are seen out

[1] S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418-28.

of network where their medical history is not known to the treating physician, and there are inherent physical and psychological effects from this type of hospital visit (depression, anxiety, exposure to disease). SmartCare will provide for around the clock coverage and response to requests for evaluation of patients and will provide near real-time feedback to PCPs to assist in making the best possible care plan decisions.

- Many provider organizations which have some type of follow-up care process in place, only offer limited coverage hours. They often do not have night or weekend coverage, as it is not cost efficient. SmartCare will fill that need through the utilization of Cataldo Ambulance's three communications centers which are staffed 24/7 and have the capability to provide call center services for these organizations during their off hours. Partner organizations would forward their phone lines to the CAS Communications Centers where trained tele-communicators, will field and triage patient phone calls.
- Cardiac patients currently do not have a reliable way to monitor their cardiograms from home. Patients and their physicians would benefit from SmartCare's ability to acquire and transmit 12-lead cardiograms from the patient side directly to the PCP for real time review.

The initial SmartCare pilot program hours will mirror the hours of the PACT program for maximum oversight and review during the first visits, however expansion to 24/7 coverage is the eventual goal.

The SmareCare Community Paramedics will work in a non-transporting vehicle that Cataldo Ambulance will license as a Class V ambulance. As such, this vehicle will be stocked with all ALS-level equipment currently required on a Class V vehicle. CAS will seek a waiver from the requirement for the vehicle to have lights and sirens on it.

<u>Paramedic Selection and Training:</u>
Paramedics chosen for this program will have a preferred minimum of 5 years of field experiences with at least 3 years in a 911 setting. Advanced training such as AMLS, is also preferred.

Initially, a primary group of 6 paramedics have been selected for training. CAS plans to train our Clinical Field Supervisor staff as well as a back-up resource for the program resulting in a maximum of 25 paramedics who will be trained to work in the SmartCare program. This number is subject to growth as the program expands.

The Community Paramedic will work primarily under an expanded role, not an expanded scope, as the skills and procedures covered are already within their skill set. These include: assessment (vital signs, labs, glucose levels, medication compliance), treatment (wound care), prevention (immunizations and fall preventions), and referral (both medical and social). Additional skills included as part of the expanded role are

listed below, are also all well within a paramedic's scope of practice, and are easily achievable with training at the paramedic level, as many of them are performed by medical assistants.

SmartCare Paramedic Expanded Role Skills:

- Gait Meter Monitoring (as done in part of neurological exam)
- Loading Medication Administration Device (Pill Box)
- Weight Monitoring (as done as part of dialysis patients)
- Temperature Monitoring (done now for IFT with blood running)
- Facilitating clinic/PCP visit(s) when deemed necessary
- ISTAT Device Use (SPW request, although blood draws are currently done locally)

In addition, SmartCare Paramedics will be expected to employ skills already part of their practice including:

- Patient Assessment
- Glucose Monitoring
- Blood Pressure Monitoring
- SPO2 Monitoring
- Single Lead ECG Monitoring
- Blood Drawing
- Wound Care
- Bolus Medication Administration when directed to by a Medical Control/PACT physician
- 12-lead acquisition and transmission

Training will focus on improving interpersonal communication skills in the non-emergent environment and understanding of and integration with systems of healthcare and public health. Training will include (but not be limited to):

- Scenario-based simulation training will be required. This training will target anticipated patient interactions within the SmartCare Program.
- A medical-legal review will include HIPAA and patient privacy with a focus on the at-home patient population; confidentiality; releases; healthcare proxies; and power of attorney.
- Proper techniques for conducting a Home Safety Evaluation.
- Specific review/enhancement modules for congestive heart failure, myocardial infarction and pneumonia will be presented with an emphasis on early detection of symptoms and early intervention to deter hospital readmission. This training component will include a review/enhancement of pharmacology as it pertains to the targeted patient populations.
- There will also be a focus on alternative healthcare pathways driven by assessment outcomes (e.g., PCP and clinic visits as opposed to transport to ED). This section of training will include such things as appointment confirmation and

transportation alternatives (e.g., chair car) for those patients without their own transportation.

- There will be in-service training on the I-STAT device for point of care blood testing. The device works very similarly to the blood glucose monitor device currently used by our paramedics in the field. A small sample of blood will be collected and dropped onto a test stick, which will be placed in the testing machine. The SmartCare Paramedic would then relay those findings to the PCP as they do currently with CBG values. This in-service will be done by trained personnel from the BIDMC.
- Training will also include a two-day in-service on all of the tele-health equipment and web-based software sponsored by the vendor. Training with the Smart CAD system will be conducted to assure appropriate documentation and patient tracking. The Community Paramedic will also be required to observe in the Nursing Call Center to gain knowledge of the system that they will be interacting with.

Patient Population Group:

The initial enrollment group will be those patients discharged from a SmartCare Partner Facility with a primary diagnosis or medical history identified as high risk for hospital readmission. The patients enrolled will be referred from the BIDMC PACT program initially who will identify specifically targeted population groups.

Other patients discharged from a SmartCare Partner Facility may include those patients discharged who, while not part of a specifically targeted population group, would benefit from enrollment in the SmartCare plan. These patients would also require Medical Director approval to be enrolled.

Only patients from within the current Cataldo Ambulance Service area will be enrolled in the program (please see enclosed map). This service area may be expanded in the future as the program grows.

Patient Enrollment and Treatment:

Patients identified by the SmartCare Physicians Group Partners who are eligible to be enrolled in the Community Paramedic Program will meet with the Discharge Planner and (ideally) the Community Paramedic before hospital discharge to set program parameters specific to that patient. At this time, the SmartCare Community Paramedic program will be explained to them and an informational brochure will be delivered to the patient. The patient will also be asked to sign a consent form agreeing to enrollment in this innovative program.

During the pilot program, an enrolled patient (as identified by the BIDMC PACT team) will be regularly contacted in their current care model. The PACT team member identifies a patient whose condition seems to be of an urgent, but not emergent nature, and will contact Cataldo Ambulance Service to deploy the SmartCare Paramedic. The

PACT team member will also contact the patient's PCP at this time to advise them that a Community Paramedic will be seeing their patient and to expect a phone call to review patient information once the assessment has been completed.

The SmartCare Paramedic will make a home visit, assess the patient, and begin treatment as currently directed under the Statewide Treatment Protocols. Once an initial assessment has been completed, the paramedic will contact the patients PCP and discuss treatment plan options. Treatment plan options would include:

- In home care and treatment by the SmartCare paramedic without any follow up needed.
- In home care and treatment by the SmartCare paramedic with a non-urgent follow-up visit scheduled with the patient's PCP. Transportation needs may be addressed with the assistance of the SmartCare paramedic.
- In home care and treatment by SmartCare paramedic with an urgent follow-up visit scheduled with PCP, urgent care center, or acute care facility, with the determination being made collaboratively between the PCP and SmartCare paramedic. Transportation needs may be addressed with the assistance of the SmartCare paramedic.

If at any time during this encounter, the SmartCare paramedic deems the patient's presentation emergent, they will immediately begin treatment in accordance with Statewide Treatment Protocols and the local 911 system will be activated for transport. ALS-level care should be maintained throughout transport in these cases. When the local 911 provider is requested to respond, they will be informed that a Community Paramedic is on-site and ALS care is being provided. If the local 911 provider is not an ALS-level service, the SmartCare paramedic will provide care during the transport.

All patient interactions will be documented as outlined below. With the exception of emergent transports, all patient encounters will also include a patient satisfaction survey and a PCP satisfaction survey as key pieces of evaluating the success of the program.

When working in the future with other groups beyond the BIDMC PACT program, enrollment will be based on predetermined criteria as outlined and approved by both the healthcare organization and Dr. Jonathan Fisher.

All patient interactions will follow the pre-determined care flow chart (see attachment). All care plans will follow the Statewide Treatment Protocols in terms of medications administered and interventions performed.

Communications/Record Keeping:

Cataldo will be using eClinicalWorks, a dedicated dispatch and charting system for use with the SmartCare Program. The eClinicalWorks system will track appointments and

patient information and will be utilized for recording each patient interaction. For our healthcare partners who also subscribe to eClinicalWorks, patient care reports will seamlessly integrate into their current medical record. For care providers who do not belong to the eClinicalWorks network, patient information will still be transmitted securely using a web-based portal. Our healthcare partners can also send secure patient information to SmartCare for use by the field clinicians.

On-scene decision-making will be critical for the success of this program. The SmartCare Program will partner directly with the patient's primary care providers. There will be real-time communication direct from the patient's home with these care providers for care planning and potential transport discussions. There will be a videoconferencing device available to communicate via a secure video link, as well as recorded phone lines.

If, for some reason, the patient's PCP is not immediately available for consultation, Dr. Jonathan Fisher, or a covering doctor from his medical control service will be used as an alternative source of direction. BIDMC OLMC will serve as a final option in critical situations or when issues arise that cannot be resolved.

Community Partnerships:

It is the goal of the SmartCare Program to be an integral part of a comprehensive post-discharge network. Community partners, and how SmartCare will integrate with those partners, would include (as appropriate to meet each patient's needs):

- *VNA Services* - SmartCare would work to enhance services to those patients receiving VNA care by offering off-hour and urgent well-being checks.
- *Fire Departments/Other EMS Agencies* - When SmartCare patients are enrolled in communities where Cataldo Ambulance Service is not the primary EMS provider, the local Fire Department or EMS agency will be made aware of the enrolled patient and that a SmartCare paramedic will be visiting that patient. The local EMS provider will be contacted for emergent transport should the need arise. When immediate transport is required, every effort will be made to route the patient to the proper facility as determined by his or her PCP.
- *Elder Services/Home Health/Meal on Wheels, etc.* - A comprehensive list, by geographic location, of all ancillary services will be used as a reference guide by the SmartCare paramedic in conjunction with the patient's PCP and discharge RN. The specific need for these services will vary for each patient and resources will be requested as the needs arise.

In an effort to raise awareness of the benefits of Community Paramedicine as well as to inform other members of the healthcare network, Cataldo Ambulance Service held a number of Community Outreach Information Sessions to which a large audience was invited to attend (please see attachments for a comprehensive list of both municipal and non-municipal invitees).

Quality Assurance/Reporting:
Initial Training Program is to be approved by Dr. Fisher and all paramedics must be approved by Dr. Fisher before assuming a community paramedic role. Dr. Fisher and the BIDMC EMS fellow will provide active oversight of the program including riding in the field with the SmartCare paramedics.

100% internal QA of all SmartCare paramedic calls is to be done by the Cataldo Ambulance Service Quality Assurance Department. Monthly case review to be conducted by Dr. Fisher as well as the sponsoring SmartCare doctors will be mandatory. While these groups are mandatory, we would strongly encourage participation by any and all interested parties involved in the patient's care community (PCP nursing staff, VNA, hot-line nurses, etc.) to review care strategies.

Decision-tree reviews are to be held at least monthly as well; and more often if appropriate to address a specific concern.

Any call with a perceived negative encounter will be reviewed internally and externally (both by CAS as well as Dr. Fisher and the sponsoring healthcare partner) within 48 hours of the call. Any issues found with the SmartCare program to be addressed immediately with process improvements to be implemented as soon as operationally possible.

The goals of the program are to reduce hospital readmission and ED visitation by providing alternative healthcare pathways to those at risk patients identified by the SmartCare partners. Data points will be collected to measure improved patient outcome when enrolled into the Community Paramedic paradigm. Specifically we will be monitoring patient compliance with the program, hospital readmission for the SmartCare patients versus non-enrolled patients, ED visits/re-visits, and we will track transport destination when applicable. The goal, in terms of destination tracking, will be to ensure, whenever clinically feasible, transport of the patient to a facility where he/she is currently followed for continuity of care.

All patient contacts will be reviewed for compliance with program protocols. BIDMC (SmartCare Medical Direction) has a robust QA process that will also be employed to track patient outcomes and identify areas for improvement.

Additionally, all enrolled patients who experience hospital readmissions or ED visits will be reviewed for issues with the SmartCare program or phases of care. Any process improvements identified during the review will be implemented as soon as possible.

Reporting to OEMS regarding this Special Projects Waiver is to be done at the Medical Services Committee Meetings in accordance with the current Administrative Requirement 5-211. Additionally, CAS would like to present quarterly to the EMCAB

Community Care and Education Committee to keep them apprised of the program's progress.

The Quality Assurance Markers will be utilized to measure both effectiveness and efficiency.

Effectiveness—will measure both pre and post Community Paramedic Intervention for:

- Emergency department visits
- Unscheduled PCP visits
- Hospital admissions
- Mortality

Efficiency—compare the cost per patient to manage that patient pre and post Community Paramedic intervention.

Regulatory Waiver Considerations:

The regulations Cataldo Ambulance Service seeks to waive with this application are as follows:

- The requirements to either transport to an emergency department or obtain a refusal after a patient encounter.
    - This program is designed to allow for and, in fact encourage, treatment in the home environment with robust follow-up
    - There are situations where facilitating transportation to a PCP office or a Urgent Care Center would be the most appropriate for the patient
- The requirement for an AHMD to grant medical control orders
    - In this model, we seek to obtain medical direction from the patient's PCP with AHMC oversight
- As part of a comprehensive care plan model, we seek the following:
    - Ability to do gait and weight monitoring
    - Ability to utilize an ISTAT device in conjunction with the PCP (PCP to receive any lab values and determine care plan, Community Paramedic to obtain sample and complete test only)

Future Program Goals:

Cataldo Ambulance Service/SmartCare, in conjunction with SmartCare partners, plans to publish program results as the program evolves. There is a current press plan in place with specific publications for each phase of the SmartCare roll-out.

CAS/SmartCare will be adding other SmartCare partners who fall within the geographic footprint and who share similar program goals.

Longer-term program data will be presented to various insurance companies for consideration of long-term funding of the SmartCare Program.

SMARTCARE PILOT PROGRAM AGREEMENT

This SmartCare Pilot Program Agreement (the "Agreement") is effective as of April 11th, 2014 (the "Effective Date"), by and between Beth Israel Deaconess Medical Center ("BIDMC"), a 501C(3) tax-exempt, non-profit Massachusetts Corporation, and Cataldo Ambulance Service ("Provider"), a Massachusetts business corporation.

WHEREAS, BIDMC is engaged in providing high quality health care services to the communities it serves;

WHEREAS, BIDMC seeks to initiate a comprehensive Community Paramedic Pilot Program ("SmartCare" or "Program") intended to reduce the frequency of hospital readmissions.

WHEREAS, Provider has demonstrated that it has vehicles, personnel, experience and qualifications to provide the services envisioned by SmartCare ("Services") and enumerated herein.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained, the parties agree as follows:

1. Scope of Engagement. This Agreement applies only to SmartCare Program Services. This Agreement does not address any other agreements or transports by Provider.

2. General Duties and Obligations of Provider.

2.1. Cooperation with BIDMC. Provider shall cooperate with BIDMC in all respects to ensure that patients are provided high quality care in a prompt and courteous manner.

2.2. Response Time. Provider shall make SmartCare Program Services available on normal business hours Monday through Friday, with extended hours available for special circumstances.

2.3. Qualifications.

2.3.1. General. At all times during the term of this Agreement, Provider shall (i) be licensed by the Department of Public Health ("DPH") to provide Transportation Services according to separate Transportation Services Agreement and in accordance with section 3.0 of this Agreement; (ii) comply with (a) M.G.L. c. 111 C, as implemented by 105 C.M.R. §170.00 et seq., (b) the policies and administrative requirements issued by DPH's Office of Emergency Medical Services ("OEMS") and (c) the Massachusetts Emergency Medical Services Pre-BIDMC Treatment Protocols ("EMS Protocols"); and (iii) be registered with DPH's Drug Control Program.

2.3.2. Personnel. Provider will employ a sufficient number of qualified personnel to provide SmartCare Pilot Program Services in accordance with the terms hereof ("Personnel"). Personnel shall have the following qualifications:

2.3.2.1. EMT- Paramedic. All Emergency Medical Technicians ("EMTS") shall at all times during the term hereof (i) comply with the training, certification, education and all other applicable provisions of 105 C.M.R. §170.840 for EMT-Paramedic ("Paramedic"); and (ii) have a current cardiopulmonary resuscitation certification and a valid Massachusetts driver's license.

3. SmartCare Duties. As part of the SmartCare Pilot Program, EMTS and Community Paramedics will have expanded duties. Upon first Patient visit EMTS and Community Paramedics will facilitate an initial home safety check as well as services needed for optimal care. Other services may include, but are not limited to:

- Glucose Monitoring
- Weight Monitoring
- Blood Pressure Monitoring
- Temperature Monitoring
- SPO2 Monitoring
- Single Lead ECG Monitoring
- Peak Flow Monitoring
- Gait Meter Monitoring
- Home Safety Evaluations
- Blood Drawing
- Loading Medication Administration Device
- Wound Care
- Bolus Medication Administration when directed to by a Medical Control/PACT physician
- Facilitating clinic/PCP visit(s) when deemed necessary by BIDMC staff

3.1. Other Personnel. Any other Personnel utilized in connection with the provision of SmartCare Pilot Program Services hereunder shall have adequate training, experience and qualifications.

3.2. Dispatch. Provider shall have during SmartCare standard house of operations dispatch service in continuous communication with the telecommunications services of BIDMC and with all Vehicles. The Provider Communications Center will utilize an advanced communications system, and will have sufficient resources to handle all calls received from BIDMC promptly and safely. All Provider Vehicles will be equipped with two-way radios. The communications system transmission range will encompass at least all of eastern Massachusetts. Provider will make available to all BIDMC departments resource materials (Phone Stickers, Rolodex Reference Cards) which will include telephone numbers and their intended function.

3.3. Training. Provider shall cause all of its employees who provide services in connection with this Agreement to receive appropriate training that is adequate to enable them to fulfill their and Provider's obligations hereunder. Paramedics chosen for this program must have a minimum of five (5) years field experience with at least three (3) years in a 911 setting. Advanced training is preferred. Training will focus on improving interpersonal communication

skills in the non-emergent environment and understanding of and integration with systems of healthcare and public health as well as a focus on alternative healthcare pathways driven by assessment outcomes. Training will include a two day in-service on all telehealth equipment and web based software. Under no circumstances shall EMTs or other Personnel function beyond the scope of their training or level of certification.

3.4. Supervisor. Provider shall identify a supervisor responsible for Personnel working with BIDMC, who shall work closely with the designated BIDMC management personnel.

4. Performance Review.

4.1. Audit. BIDMC shall audit or otherwise conduct reviews of Vendor's provision of Services under this Agreement, at least annually and more frequently as required in BIDMC's sole discretion. BIDMC shall measure the provision of Services by Vendor and Vendor's employees or contractors according to industry standards, including but not limited to applicable CMS and Joint Commission standards and guidance, and where applicable, standards and policies used by BIDMC to evaluate its own staff. Vendor shall cooperate fully with BIDMC's audits and/or reviews, including but not limited to providing BIDMC with any and all documents, materials, or other information reasonably requested by BIDMC to complete such audits/reviews. Further specifications regarding performance measures may be mutually agreed upon by the parties.

4.2. Quality Assurance. Provider and its Personnel shall at all times during the term hereof (1) provide quality SmartCare Pilot Program Services, in accordance with accepted medical standards; (2) comply with all regulations and professional guidelines covering the maintenance, repair and use of equipment and provision and use of supplies; (3) cooperate with BIDMC on activities related to quality assurance, quality improvement, utilization management, and patient grievances; (4) supply necessary information and participate in good faith in medical audits (regular and ad hoc) and case reviews by BIDMC's physicians, case managers, and other staff; (5) comply with all reasonable recommendations resulting from such audits and reviews; (6) participate in BIDMC's continuing education activities; (7) supply necessary information for data collection to measure improved patient outcome when enrolled in the SmartCare Community Paramedic Program

4.3. BIDMC Standards and Policies. Provider and its Personnel shall comply with all applicable BIDMC standards and policies as in effect from time to time.

4.4. Records. Provider shall transport medical records with the patient, as appropriate and reasonably requested by BIDMC. Provider and its Personnel shall complete and maintain such other records in connection with the performance of SmartCare Pilot Program Services hereunder as may be required under applicable law or as BIDMC may reasonably request.

4.5. Uninterrupted Service. Provider shall establish an on-call system for backup availability of Vehicles and Personnel to ensure that SmartCare Pilot Program Services are available at all times in accordance with the terms hereof.

4.6. Nondiscrimination. Provider shall accept and provide services to all BIDMC patients requiring SmartCare Pilot Program Services when requested, without regard to race, ethnicity, national origin, color, age, religion, gender, sexual orientation, disability, health status, economic status, or payor status.

5. Payment for Services. BIDMC will reimburse Provider for the cost of SmartCare Pilot Program Services, if any, provided by Provider pursuant to this Agreement for which financial responsibility rests with BIDMC pursuant to applicable reimbursement rules or contractual obligations at the fair market value payment rates set forth in Schedule A.

6. Insurance.

6.1. Provider. Provider shall purchase and maintain at all times during the term hereof comprehensive general liability and professional liability insurance for itself and all Personnel providing services hereunder with minimum limits of $4,000,000 per occurrence and $6,000,000 in the aggregate annually, with additional umbrella coverage of $10,000,000 per occurrence and $10,000,000 in the annual aggregate. Provider shall furnish a certificate of insurance to BIDMC prior to the effective date of this Agreement and shall confirm such coverage upon request of BIDMC, at any time. Provider shall give BIDMC thirty (30) days advance written notice of any termination, restriction or limitation of such coverage. Any such termination, restriction, or limitation of such insurance shall be grounds for termination of this Agreement, at BIDMC's election, in accordance with Section 5 of this Agreement. If any such insurance provides "claims made" coverage, then Provider shall obtain so-called "tail insurance" to cover all commissions and omissions of the insured for all occurrences or incidences during the term of this Agreement, regardless of when the claim is asserted.

6.2. BIDMC. BIDMC shall purchase and maintain at all times during the term hereof comprehensive general liability and professional liability insurance for BIDMC and its employees and agents with minimum limits of $2,000,000 per occurrence and $6,000,000 in the aggregate annually, with additional umbrella coverage of $3,000,000 per occurrence and $3,000,000 in the annual aggregate. BIDMC shall furnish a certificate of insurance to BIDMC prior to the effective date of this Agreement and shall confirm such coverage upon request of Ambulance, at anytime. BIDMC shall give Provider thirty (30) days advance written notice of any termination, restriction or limitation of such coverage. Any such termination, restriction, or limitation of such insurance shall be grounds for termination of this Agreement, at Provider's election, in accordance with Section 5 of this Agreement. If any such insurance provides "claims made" coverage, then BIDMC will obtain so-called "tail insurance" to cover all commissions and omissions of the insured for all occurrences or incidences during the term of this Agreement, regardless of when the claim is asserted. The BIDMC may fulfill its insurance obligations with a program of self-insurance.

7. Term and Termination.

7.1. Initial Term. The initial term of this Agreement shall be for services for 100 patients and not to exceed one (1) year, commencing on the Effective Date, unless earlier terminated as set forth below.

7.2. Termination for Cause. Upon breach of this Agreement by either party that is not cured within fifteen (15) days of written notice thereof, either party, at its election and without any financial or other penalty:

I. Terminate this agreement immediately by delivering written notice thereof to the other party.

II. Exercise any other right or remedy available in law or in equity.

The party's sole responsibility under this Section shall be to make any payment for amounts that were due prior to termination or refund any amounts paid for services yet to be performed as of the termination date.

7.3. Immediate Termination. BIDMC may terminate this Agreement immediately upon its reasonable determination that the health and safety of its patients is being endangered by Provider. Further, either Party may terminate this Agreement immediately upon notice to the other Party if the other Party has filed or has filed against it a petition in bankruptcy, or made an assignment for the benefit of its creditors, or otherwise has admitted in writing its inability to meet its financial obligations or responsibilities under this Agreement.

7.4. Termination without Cause. Either party shall have the right to terminate this agreement without cause by giving at least thirty (30) days prior written notice, which notice shall specify the effective date of termination.

8. Notices. Any notices permitted or required to be given hereunder shall be deemed properly given when sent by registered or certified mail, postage pre-paid, return receipt requested, as follows:

If to BIDMC, to:
Steve Cashton
Director of Contracting
Beth Israel Deaconness Medical Center
330 Brookline Ave BR-109 RM 302
Boston, MA 02215

If to Provider, to:
Ronald Quaranto, COO
Cataldo Ambulance Service
137 Washington St
Somerville, MA 02143

or such other person or address as any party may designate by notice duly given.

9. Protection of Patient Information. Prior to, or contemporaneous with, the execution of this Agreement, the Parties will execute a Business Associate Agreement ("BAA"), attached hereto as Exhibit B, which, among other things, sets forth the duties and obligations of the Parties with respect to Health Insurance Portability and Accountability Act of 1996 and its implementing regulations and guidance issued by the Secretary of Health and

Human Services ("Secretary"), all as amended from time to time ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations and guidance issued by the Secretary, all as amended from time to time ("HITECH Act").

10. Confidential Information. Vendor recognizes and acknowledges that, by virtue of entering into this Agreement and providing the services, it may have access to certain information of BIDMC that is confidential and constitutes valuable, special and unique property of BIDMC (hereinafter "Confidential Information"). Confidential Information may or may not be specifically identified as "confidential." Vendor agrees to hold such Confidential Information in strict confidence, not disclose it to others or use it in any way, commercially or otherwise, and agrees not to allow any unauthorized persons access to it, either before or after expiration or termination of this contract, without the prior written consent of BIDMC. Vendor further agrees to take all actions reasonably necessary and satisfactory to BIDMC to protect the confidentiality of the Confidential Information, including, without limitation, implementing and enforcing operating procedures to minimize the possibility of unauthorized use or copying for the Confidential Information and limiting the disclosure of Confidential Information only to Vendor's employees or agents with a need to know who (a) have been advised of the confidential nature thereof, (b) are under an express written obligation to maintain such confidentiality, and (c) have been approved in advance by BIDMC.

Notwithstanding the foregoing, the obligations imposed in this Section 8 shall not apply to any: (a) information that is or comes to be generally available to the public through no fault of Vendor, (b) information independently developed by Vendor without resort to information from BIDMC, or (c) information appropriately received by Vendor from another source who is not under an obligation of confidentiality to BIDMC. In the event Vendor receives a subpoena or other legal process for the production of Confidential Information, Vendor shall provide reasonable advance notice to BIDMC to allow it to seek a protective order before Vendor produces the information and Vendor shall cooperate with BIDMC in its pursuit of such protective order.

11. Access to Records. If this Agreement is subject to Section 952 of the Omnibus Reconciliation Act of 1980, 42 U.S.C. §1395x(v)(1)(I) (the "Statute") and the regulations promulgated thereunder, 42 C.F.R. Part 420, Subpart D (the "Regulations"), Vendor shall make available, upon proper request, to the Secretary of Health and Human Services and to the Comptroller General of the United States, or any of their duly authorized representatives, the Agreement and the books, documents and records of Vendor that are necessary to certify the nature and extent of the cost of the services furnished pursuant to this Agreement for which payment may be made to Hospital under the Medicare program. If Vendor carries out any duties of this Agreement through a subcontract with a value or cost of $10,000 or more over a twelve (12) month period, such subcontract shall contain a clause which required the subcontractor to comply with the above Statute and Regulations.

12. Indemnification. Vendor agrees to indemnify, defend and hold harmless BIDMC, its officers, agents, directors, trustees, subsidiaries, affiliates and employees from and against any and all claims, actions, liabilities, damages, costs or expenses (including reasonable attorneys' fees and litigation costs) of any kind or nature arising from or caused in any part by:

(i) the actions or failure to act of Vendor or its employee(s), agent(s) or subcontractor(s) (as applicable); (ii) breach of any representation, warranty, covenant, or other provision of this Agreement including but not limited to, violation of any third party's privacy rights, by Vendor or any of its employees, agents or subcontractors, or (iii) the sale or use of any product

13. Compliance Provisions

13.1. Compliance with Laws. Vendor acknowledges and understands that BIDMC has adopted and maintains a Code of Conduct ("BIDMC Code of Conduct") attached as Exhibit "C" to prevent, detect and resolve conduct that does not conform to Federal or state statutes or regulations, the requirements of third party payor programs, BIDMC's compliance and privacy program, and/or BIDMC's internal ethical and business policies. The BIDMC Code of Conduct is attached as Exhibit C. Vendor represents and covenants that it will comply with all applicable (i) Federal and state statutes, regulations and policies (including, but not limited to, those promulgated by the Centers for Medicare and Medicaid Services (CMS), the Occupational Safety and Health Administration (OSHA), the Food and Drug Administration (FDA), the Department of Health and Human Services (DHHS), the Massachusetts Department of Public Health (DPH), the Massachusetts Attorney General, etc.), (ii) third party payor requirements, (iii) requirements of accrediting agencies with jurisdiction over BIDMC (e.g., The Joint Commission), (iv) requirements of any commercially reasonable financing arrangement undertaken by BIDMC, and (v) BIDMC policies, procedures, rules and regulations, including those relating to security, visitor and vendor identification and monitoring, compliance and the safeguarding of proprietary and other sensitive information, and including relevant provisions of the BIDMC Code of Conduct (collectively "Compliance Requirements"). Further, Vendor represents and covenants that it will report in writing any known or suspected violation of any Compliance Requirements. Finally, Vendor represents and covenants that it will complete any and all training (e.g., compliance, clinical, confidentiality of patient information, BIDMC procedures, etc.) reasonably required by BIDMC.

Vendor represents and warrants that neither Vendor nor any of its employees providing the Services has ever been: (A) convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) listed on the General Services Administration's Excluded Party Listing System. Vendor covenants that it will notify BIDMC immediately in the event that Vendor or any of its employees providing services under this Agreement: (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is listed on the General Services Administration's Excluded Party Listing System. BIDMC may terminate this Agreement immediately in the event that Vendor or any of its employees: (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded from or debarred from participation in any federal health care program, including Medicare and Medicaid; (C) is listed on the General Services Administration's Excluded Party Listing System or (D) in any other way in BIDMC's sole, reasonable discretion brings disrepute or disapprobation to BIDMC, its workforce, patients or their families.

13.2. False Claims Act Notification. The Deficit Reduction Act of 2005 requires BIDMC to inform all employees, contractors, and their agents of the following: Under the federal False Claims Act and Massachusetts laws, any person who knowingly submits, or causes someone else to submit illegal claims for payment of government funds is subject to government fines and penalties. Reports of suspected illegal claim activity should be made to the Corporate Compliance Officer, but may also be made to the Department of Health and Human Services Office of Inspector General or Commonwealth of Massachusetts Attorney General's Office. Those who report questionable practices are protected from retaliation for reports made in good faith by the BIDMC Code of Conduct and by federal and state laws.

13.3. No Inducement or Reward of Referrals. The Parties agree that the prices for [Services] [Products] to be purchased under this Agreement are based on the fair market value of those [Services] [Products] and neither has offered or received any inducement or other consideration from the other Party for entering into this Agreement. The Parties expressly agree that nothing contained in this Agreement shall require either Party, or their respective agents and employees, to refer or admit any patients/clients to, or order any goods or services from the other Party. Notwithstanding any unanticipated effect of any provision of this Agreement, neither Party will knowingly or intentionally conduct itself in such a manner as to violate the prohibitions against fraud and abuse in connection with the Medicare or Medicaid programs.

13.4. Discount Safe Harbor. Regulations implementing the federal health care program anti-kickback law, 42 U.S.C. § 1320a-7b(b), include a "safe harbor" for "discounts" (see 42 C.F.R. § 1001.952(h)). To the extent that Vendor provides a price reduction to BIDMC pursuant to this Agreement, then Vendor shall comply with the requirements set forth in 42 C.F.R. § 1001.952(h)(2).

14. Compliance with Hospital Policies. Vendor and vendor representatives shall at all times obey all pertinent policies, procedures, rules and regulations of BIDMC, including those relating to security, visitor and vendor identification and monitoring, compliance and the safeguarding of proprietary and other sensitive information, and shall complete any and all training (e.g., compliance, clinical, confidentiality of patient information, BIDMC procedures, etc.) reasonably required by BIDMC.

15. Non-Discrimination. Vendor agrees to comply with the following Executive Orders, statutes and regulations, which are incorporated herein by reference: i) Executive Order 11246, as amended by Executive Order 11375; ii) section 503 of the Rehabilitation Act of 1973, iii) section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, and iv) the Department of Labor regulations contained in 41 CFR Part 60.

16. Use of Name. Vendor agrees that it shall not use in any way in its promotional, informational or marketing activities or materials (i) the names, trademarks, logos, symbols or a description of the business or activities of BIDMC without in each instance obtaining the prior written consent of BIDMC; or (ii) the award or the content of this Agreement without in each instance obtaining the prior written consent of BIDMC.

17. Force Majeure. No Party shall be liable for any failure to perform its obligations in connection with any action described in this Agreement, if such failure results from any act of God, riot, war, civil unrest, flood, earthquake, terrorism or other cause beyond such party's reasonable control (including any mechanical, electronic, or communications failure, but excluding failure caused by a party's financial condition or negligence). Any Party asserting Force Majeure as an excuse shall have the burden of proving that reasonable steps were taken (under the circumstances) to minimize delay or damages caused by foreseeable events, that all non-excused obligations were substantially fulfilled, and that the other Party was timely notified of the likelihood or actual occurrence which would justify such an assertion, so that other prudent precautions could be contemplated. In the event a Force Majeure event persists for a period of thirty (30) days or more, BIDMC reserves the right to terminate this Agreement in its entirety with no further financial obligation, other than payments owed to Vendor for completed [Services or Product purchased and delivered].

18. Restriction from Hiring Staff. During the Term of this Agreement and for a period of twelve (12) months following the expiration or termination of this Agreement, Vendor agrees not to solicit, employ, or contract with directly or indirectly, any BIDMC staff or Physician without prior written approval of BIDMC.

BIDMC and Vendor acknowledge and agree that the covenants and agreements contained in this Section have been negotiated in good faith by each of them, that they are reasonable, and are not more restrictive or broader than necessary to protect the interests of BIDMC. If any one or more of the provisions contained in this Section shall be held to be excessively broad as to scope, territory or period of time, such provisions shall be construed by limiting and reducing them so as to be enforceable to the maximum extent allowed by applicable law.

BIDMC shall be entitled to equitable relief, including injunction without the need to post bond and specific performance, in the event of any breach of the provisions of this Section. Such remedies shall not be deemed to be the exclusive remedies for a breach of this Section by Vendor, but shall be in addition to all other remedies available at law or in equity. Failure or delay by BIDMC in exercising any right, power or privilege under this Section shall not operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise of any right, power or privilege under this Agreement.

19. Miscellaneous Provisions.

17.1 Independent Contractors. It is expressly understood and agreed that this Agreement does not intend and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture or association between the parties, but, rather, is an agreement by and between the parties as independent contractors.

17.2 Entire Agreement. This Agreement represents the entire understanding of the parties with respect to the subject matter covered herein and supersedes and cancels all previous agreements between the parties.

17.3 Amendment. This Agreement can be amended only by a writing signed by an authorized representative of each party.

17.4 Governing Law. This Agreement shall be governed by, interpreted and enforced in all respects and construed in accordance with the laws of the Commonwealth of Massachusetts, excluding the body of law applicable to choice of law.

17.5 Severability. If any provision of this Agreement is for any reason found by a court of competent jurisdiction to be unenforceable, the remainder of this Agreement shall continue in full force and effect.

17.6 Neutral Construction; Headings. This Agreement is a product of negotiations between the parties and the provisions hereof shall be interpreted neutrally without giving any effect to the identity of, or placing any greater burden of proof on, the party drafting or preparing the Agreement. The headings in this Agreement are for convenience of reference only and shall not constitute a part of this Agreement for any other purpose.

17.7 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument and shall become a binding agreement when one or more of the counterparts have been signed by each of the parties and delivered to each of the other parties.

IN WITNESS WHEREOF, the parties hereunto set their hands to this Agreement as of the day and year first written above.

BETH ISRAEL DEACONNESS MEDICAL CENTER

By: _____

Print Name & Title: Julius Yang, MD 4-14-14

CATALDO PROVIDER

By: _____

Print Name & Title: Ronald Peruzzo, COO 4-11-14

Schedule A

The following rate schedule shall apply when BIDMC is deemed financially responsible for payment for SmartCare Program Services rendered by Provider pursuant to this Agreement. BIDMC shall pay Provider within sixty (60) days of invoice.

One Time Payment	$12,500 USD

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SmartCare, a Division of Cataldo Ambulance Service, Inc.
Executive Summary

Currently providing 911 responses for 15 municipalities, Cataldo Ambulance Service is the leading private provider of Emergency Medical Transportation in the Commonwealth. The company was founded in 1977 and prides itself on the clinical abilities of our entire staff of more than 700 EMT's and Paramedics. Cataldo keeps our corporate office in Somerville, MA and has 21 locations throughout Massachusetts covering Greater Boston, The North Shore and Cape Ann.

While Cataldo maintains its core business as both an emergent and non-emergent medical transportation provider, recent changes in healthcare, brought about by the Affordable Care Act, have brought new opportunities within our system to assist clients in maintaining the overall health of their populations through a new healthcare initiative entitled Community Paramedicine. The newly formed community paramedicine division of Cataldo Ambulance Service is called *SmartCare*.

Out of 12 Million fee-for-service Medicare beneficiaries: 20% of them who had been discharged from a hospital, were re-hospitalized within 30 days at a cost of > 15 Billion Dollars Annually

Massachusetts ranks 41st in the US on Medicare 30 day readmission rates

Initially, *SmartCare* will provide service to patients enrolled in the Post Acute Care Transitions (PACT) program at Beth Israel Deaconess Medical Center in Boston. The PACT team's goal for patients says its nurses and pharmacists, is to "help tie up the pieces of a complicated health care system and help ensure that patients truly understand and follow their post-discharge care plans." Currently, PACT operates internally at BIDMC by using nurses to make proactive phone calls to recently discharged patients that are considered to be at greater risk of returning to the hospital within a 30 day period. Pending the special project waiver, the PACT program has secured *SmartCare* to provide a necessary function as the external eyes and ears for BIDMC Primary Care Physicians and PACT nurses operating within the hospital system. Through the use of technology and direct communication sources, *SmartCare* medics will have streamlined access to provide PCP's with an educated clinical impression of a patient. This communication will allow PCP's to make informed decisions as to the best and most cost effective follow up care necessary to treat their patients moving forward. Along with BIDMC Cataldo has engaged other hospital systems operating internal programs similar to PACT and anticipates further discussions within these systems.

Paramedics chosen for the SmartCare program will complete a customized training program focused on the specific needs of working directly with discharge planners, primary care physicians, patients and their families. In anticipation of approval, Cataldo and BIDMC have held more than 10 planning meetings with the PACT Leadership Team; have participated in information sessions for PACT nursing staff and HCA Primary Care Physicians and have assigned key individuals to observe the daily workings of the PACT program including listening to phone conversations with potential program customers. As well, each Cataldo employee chosen as a community paramedic will complete the required scenario based simulation training mandated by the Cataldo Ambulance Training Department.

Initially, a maximum of 25 Paramedics will be trained to work in the SmartCare program. SmartCare will use only **paramedics** to perform Community Paramedicine and each paramedic chosen to participate will have a preferred minimum of 5 years field experience with at least 3 years in a busy 911 setting. While SmartCare Paramedics will work primarily under an expanded role, they will not be expanding the current scope of practice covered within their skill set as a Massachusetts licensed paramedic.

In researching other community paramedicine programs throughout the country, this proactive approach to reducing readmissions has proven successful in managing overall patient health, limiting unnecessary overcrowding of hospital emergency rooms and ultimately saving dollars within our healthcare system. Two such programs with proven success thus far are MedStar Mobile Health in Fort Worth, TX and Minnesota's North Memorial Healthcare System. Each of these programs has gained national attention for their individual delivery models and their focus on reducing readmissions for those facing frequent health related concerns. While these models do not necessarily follow the same model proposed by SmartCare, they are an example of how proactive changes to the system can benefit the communities they serve.

On behalf of all of those at Cataldo Ambulance Service and SmartCare, we look forward to the opportunities that lie ahead and are excited to participate in changing the face of healthcare in Massachusetts.

Julius Jong Yang, MD, PhD

Rabkin Fellow in Medical Education
Assistant Professor of Medicine, Harvard Medical School

Fellowship Project:
Cohesive integration of the inpatient and outpatient housestaff experience

Dr. Julius Yang is a hospitalist in the Division of General Medicine at Beth Israel Deaconess Medical Center and an instructor in medicine at Harvard Medical School. Dr. Yang completed his undergraduate education at Williams College, then went on to earn a Ph.D. in physical chemistry at the Massachusetts Institute of Technology. He attended medical school at the University of Massachusetts Medical School. He completed his residency training in internal medicine at the Beth Israel Deaconess Medical Center, at the conclusion of which he was awarded the Kathy Swan Ginsburg Award for humanism in medicine. After serving as a chief resident at the Beth Israel Deaconess Medical Center, Dr. Yang completed a Fellowship in Medical Education at the Carl J. Shapiro Institute for Education and Research.

As a Rabkin Fellow at the Shapiro Institute, Dr. Yang investigated methods for integrating the medical resident's clinical experience across the inpatient and outpatient settings, with a goal to educationally reinforce patient-centered care that spans the continuum of care throughout the course of a patient's experience with disease. These methods included fostering more active housestaff involvement in discharge planning and follow-up visits, review of patients' post-discharge courses during formal teaching rounds, and closer coordination of care between physicians, nursing staff, and case management.

In his current role as a hospitalist, Dr. Yang actively teaches and mentors residents, interns, and medical students while providing clinical care to patients hospitalized at the Beth Israel Deaconess Medical Center. He serves as Associate Program Director for the BIDMC Internal Medicine Residency Program, overseeing inpatient aspects of the residency training program. He also serves as chairman of the Resuscitation Committee at the Beth Israel Deaconess Medical Center, charged with monitoring and maintaining the quality of critical event responses at the medical center; in this role he has initiated a multidisciplinary program in medical simulation focused on teamwork principles applied to crisis event management. He is currently participating in a Patient Safety Leadership Fellowship sponsored by American Hospital Association and Health Resource Educational Trust, with a focus on promoting safe "handoff" practices between care providers throughout a patient's hospital course.

Doctoroff, Lauren B., MD

On staff at Beth Israel Deaconess Medical Center

Harvard Medical Faculty Physicians (HMFP) at Beth Israel Deaconess Medical Center

Appointment(s):

Instructor, Medicine, Harvard Medical School

Specialty:

Internal Medicine

Clinical Interest(s):

Post Hospital Transitions

Medical Education:

Medical School

University of California at San Francisco School of Medicine, San Francisco, CA; 2003

Internship/Residency

Massachusetts General Hospital in Internal Medicine, Boston, MA; 2006

Board Certification:

American Board of Internal Medicine

Sarah Moravick

Quality Improvement Project Manager at Beth Israel Deaconess Medical Center

Location
Greater Boston Area
Industry
Hospital & Health Care

Sarah Moravick's Overview

Current

- Manager, Inpatient Qualityat Beth Israel Deaconess Medical Center

Past

- Consultant / Project Manager, Ambulatory Consulting Servicesat Massachusetts General Hospital
- Financial Analyst, Web/eBusinessat Blue Cross Blue Shield of Massachusetts
- Solutions Managerat Collegiate Press

Education

- Simmons College - Simmons School of Management
- Emerson College
- Biddeford High School
- Preventing readmissions for inpatients leaving the hospital was the reason for creating the Post-Acute Care Transitions program at BIDMC, but that topic rarely comes up when clinicians speak of this new program.

  Rather it is the service to patients and the connections among caregivers that have been the hallmarks of the program so far. The PACT staff of eight nurses and four pharmacists is preparing to expand their services from about 30 discharges per month to 250 discharges per month.

Marc Cohen, MD, an internist at Healthcare Associates, has found PACT has helped him be "empowered to be more connected to my patients and the inpatient care team, not less." He notes that the PACT team gives patients, particularly complicated ones, a lot of one-on-one attention and, in turn, the PACT team provides him information that gives him a more detailed picture of how that patient is doing.

Cohen notes one case in particular in which the PACT team was able to advocate for a patient who needed a procedure in the shortened Thanksgiving holiday week. In addition to helping the patient get the needed appointment, a PACT nurse met with the patient while he was here.

"The patient's comment was that his care has been 'fantastic,'" says Cohen. In another case, the PACT staff was able to obtain a patient's most up-to-date medication list in preparation for a follow-up visit, leaving more time to talk about care rather than recreating the list. The patient, family members and caregivers were all appreciative.

PACT nurses and pharmacists see inpatients while they are still at the hospital and then continue to check in, educate, problem-solve and advocate for patients for 30 days post-discharge - by phone or sometimes in person. They work in conjunction with inpatient clinicians and case management staff at the hospital and continue to connect and share information with each patient's primary care physician, specialist or other care team members.

The PACT team's goal for patients, say its nurses and pharmacists, it to help tie up the pieces of a complicated health care system and help ensure that patients truly understand and follow their post-discharge care plans. PACT Nurse Julie Cowell notes one case in which she has daily calls with the spouse of an elderly Parkinson's patient.

"In addition to talking about his symptoms and his medications, she talks to me about her thoughts and ideas, like whether he should be drinking more water," she says. "She tells me she is so happy to have someone to bounce her ideas off of."

PACT Nurse Elizabeth Carlson relays a situation in which the daughter of an elderly patient wanted to make sure the physician had a certain piece of information about her parent, but she wasn't able to accompany the parent to the appointment - her sometimes forgetful brother was going with the patient that day. Carlson delivered the information directly to the physician for the appointment.

Kaitlin O'Rourke, PACT Pharmacist, says working directly with patients both in the hospital and after discharge has been a rewarding experience. She meets with each patient in the hospital at least twice to go over complicated medication regimens and to see if the patient has any questions.

"A lot comes up in these conversations - obstacles or barriers to getting or taking their medications," she says. "I have more time to sit and talk with them. The patients appreciate that - and so do the nurses on the floors."

The PACT staff started with Medicare Part A patients in Healthcare Associates with heart problems and pneumonia, but now that they are fully staffed, they plan to enroll all Medicare Part A primary care patients who are hospitalized from: Healthcare Associates; Bowdoin Street Community Health Center (where there is a strong medical home team model in place to work in conjunction with the PACT team); BID Health Care-Pastor Medical Group; BID Health Care-Washington Square; BID Health Care-Jamaica Plain; and BID Health Care-Chelsea.

The PACT program had its beginnings in an internally funded pilot that grew after BIDMC received $4.9 million from the highly competitive first round of Center for Medicare and Medicaid Innovation Grants in May 2012 to launch program designed to improve patient outcomes and prevent avoidable cost in the high-risk 30-day period following acute care hospitalization.

It is too soon to tell how PACT will impact readmission rates says Lauren Doctoroff, MD, PACT's Medical Director, but the program has resulted in a stronger voice for the patient, more and more specific information for caregivers, stronger discharge planning and more informed patients and family members.

"PACT definitely enriches the experience of the patient," she says, "and we know we are not sending patients out of the hospital without a parachute. The peace of mind for all involved is key."

Cataldo Ambulance Service/SmartCare Leadership Team

Dennis Cataldo, Vice President – Mr. Cataldo represents the second generation of Cataldo family members to lead this well respected organization. Dennis has held many positions with the company; he began in 1985 working first as a wheel Chair van attendant and then progressing through the ranks to the position of Vice President, a title which he has held for more than 10 years. During his tenure, the company has continued to grow responsibly while constantly staying focused on customer service, clinical excellence and an unequalled commitment to providing first line emergency medical services. His dedication to the company and to the community is evident through the strength of our organization and by his unrelenting community involvement. He has served as Income Development Chairman, President, and Executive Board member to the New England Division of the American Cancer Society. He was a founding member of the Cardiac Survival Project, a joint community program for Winthrop, Everett, Chelsea, Revere, Malden, Malden, Medford, Melrose, Saugus and Wakefield. Dennis served in many capacities of Rotary International, including a term as President of the Winthrop Rotary Club. He is the Past President and Executive Board member of the Malden Chamber of Commerce. Additionally, Dennis is serving on the Board of Directors of the Somerville Home for the Aged and the Executive Board of the Massachusetts Ambulance Association. He is also active in countless community based initiatives. Dennis is a graduate of Suffolk University and holds a Bachelors Degree in Business Management.

Ron Quaranto, Chief Operating Officer – Mr. Quaranto has more than 20 years of industry experience, rising through the ranks in the Metro West – Boston area. Following his Paramedic training, he served as a Paramedic instructor, Field Supervisor, Manager, Director of Operations and he currently holds the position of Chief Operation Officer. In his current roll Mr. Quaranto provides daily oversight of Cataldo Ambulance Service's operation. He serves as a lead point of contact for the public safety agencies in the municipalities in which we serve. He is also available 24 hours a day, 7 days a week to address any operations requirements. Mr. Quaranto is past Chairman and current board member of the Metro Boston EMS Council (Region IV) and is a member of the Pre-hospital Committee.

Daniel Hoffenberg, Director of Business Development - Dan has been with Cataldo Ambulance Service for just over 6 years in the role of Director of Business Development. Prior to beginning his work in EMS, Dan spent 9 years serving customers and maintaining strong community relationships in various roles held within the finance industry, most recently as Asst. Vice President and Sales Manager at Salem Five Bank. He is currently an Executive Board Member and Treasurer of the Malden Chamber of Commerce and Immediate Past President of the Rotary Club of Malden. Dan is a graduate of the University of Rhode Island and holds his Bachelor's Degree in Marketing.

Karen Host, Director of Quality Assurance and Regulation — Karen comes to Cataldo Ambulance Service with over 20 years experience in the Emergency Medical Services field. Ms. Host has been a Paramedic for seventeen years and has extensive experience in clinical education, holding multiple credentials. Karen is a graduate of Curry College with a Bachelors Degree in Biology, completed a certificate program in Disaster Assessment and Response, and is a current Massachusetts Instructor/Coordinator and Massachusetts ALS State Examiner. She has recently participated in the Nasal Narcan initiative roll-out in several area communities.

Benchmark	Grade	Notes
Benchmark 101		
101.1	4	BIDMC to provide data regarding target populations for this metric
101.2	4	CAS worked with the healthcare leaders from the BIDMC to determine those at risk who would benefit from the CP program. Data from outside public health officials from both in state and out of state was used in this assessment
101.3	5	The CAS/SmartCare system will provide information regarding system performance both clinically and administratively. Also, there is a mechanism in place to review frequently EMS system utilization within the CAS Emergency Transport Service paradigm to identify those patients who may benefit from CP services in the future
101.4	5	CAS/Smartcare CAD allows for full integration
101.5	1	This will be a 5 as soon as the program is running. Regular reports are available in the system and will be generated with consistent reporting to all interested parties as required by the Medical Control agreement as well as OEMS SPW regulations.
Benchmark 102		
102.1	4	Targeted clinical conditions have been identified by our BIDMC partners within their discharge community and CAS has adequate resources to address this targeted group.
102.2	0	No data available to do gap analysis until the program begins, but will be able to analyze once we rollout the program. Once program begins, this score will improve to a 3-4
102.3	0	No data available, however regular review/assessment is scheduled with Medical Control/Healthcare Partners. Once program is running, this score will improve to a 4.
102.4	0	Currently there is no data to review, however once the program is running we will seek external review, improving this score to a 2.
Benchmark 103		
103.1	0	Initially this is a low score due to a lack of data. Once the program is running, there will be data available, raising the score to a 3 after 6-12 months of data gathering. In year 2 and after, more formalized assessments can be made eventually raising the score higher.
103.2	0	Currently there are no patients enrolled to refer to, however, there is a press plan in place with CAS Business Development working together with BIDMC PR Department. This score will then be a 4-5.
103.3	2	There is a press plan, however, we have not at this time, solicited public officials for what they would like to have in reports. This can be done throughout the initial pilot program, raising this score at that time.
103.4	0	While there is current no data to present to the payers, CAS plans to collect this data and plans to involve them in discussions regarding future funding of CP programs.
103.5	2	Plans are in place to widen the scope of the CP program, however, at this time, we are only focused on a small group at this time to pilot test this program.
Benchmark 201		
201.1	3	OEMS Special Projects Waiver
201.2	3	OEMS Special Projects Waiver
Benchmark 202		
202.1	5	EMCAB Sub-Committee formed, members identified, meetings held with a regularly schedule in place
202.2	5	There is a clearly defined process of review for this program with the ability to make immediate changes to address any concerns raised as the program rolls out.
202.3	4	We have internally set time and performance based goals. We look forward to working with the Sub-Committee to expand those goals as the programs evolve.
202.4	2	While we are currently planning to work under adapted emergency protocols, we hope to use these along with our pilot program data to help the Sub-Committee recommend CP specific protocols for future use.
202.5	5	We have current CAS/AAS HIPAA Policies in place that will encompass this program as well
202.6	4	Peer review is currently conducted on the program development/SIM exercises at the BIDMC. This process will continue with a transition to case review once the program is running.

Grading Key

0	Not Known	3	Limited
1	No	4	Substantial
2	Minimal	5	Full

Benchmark 203		
203.1	3	The CAS/SmartCare plan has been adopted by the BIDMC. There are other stakeholders who have been made aware of the plans, but they have not fully endorsed the program as of yet.
203.2	4	The system is designed for both the BIDMC and CAS will monitor and measure system performance.
Benchmark 204		
204.1	5	Resource Needs Assessment was conducted and implemented. The system will be continually monitored for growth with a plan to add resources to meet the growth.
204.2	4	while there is currently funding available for the pilot program, we hope to see future payer buy-in to secure consistent, long-term funding.
204.3	4	There is a current budget in place based on what we believe will be the needs of the program. Future review, once the program is running will allow for full budget planning and raise the score to a 5.
Benchmark 205		
205.1	3	There is reporting available and ready once data begins to be available. As data becomes available, these reports can be released to the community for further performance review.
205.2	3	The data from out-of-state systems was used to develop the CP Educational Program. Once our own data become available it will be utilized to address any identified gaps in the current education program.
205.3	2	While there is no data currently available for the Sub-Committee to review, the group meets regularly and will review programs once they are in place, raising this score to a 5.
Benchmark 206		
206.1	4	CAS/SmartCare program officials work with the BIDMC to develop and conduct community risk assessments. This is currently a closed review for this program. State-wide integration of these assessments from across all CP programs will raise this score to a 5.
Benchmark 301		
301.1	1	While there is currently no data to collect, when the program is running and data is coming in, this score will raise to a 5. There are well-defined plans in place to utilize the data to assess system performance as well as the needs of the patients that may be identified during the assessment. These needs may include additional healthcare options as well as social service needs.
301.2	1	There is currently no data being collected, however once the system is running, CP patient interactions/care is able to be fully recorded and integrated into the patients healthcare record through a secure data exchange. This will raise our score to a 5
Benchmark 302		
302.1	1	While currently the program is not running to produce hard data, estimates of labor/equipment costs have been done. Once this data is available, the score will be a 4 as we will include this in reporting.
302.2	1	Not currently collecting outside financial data at this time, but CAS does have the means available to analyze IF the information was available. Without knowing if the data will be made available, it is difficult to project a future score in this category.
302.3	3	This data is currently being analyzed by the BIDMC for their current model. We will be able to estimate savings attributed to the CP program by comparing savings post/prior to program implementation.
Benchmark 303		
303.1	5	Dr. Jonathan Fisher is both the service and CP Program medical director and is fully involved in CP program assessment
Benchmark 304		
304.1	3	While we have a fully executed medical control agreement at this time, there is room to move to full integration of the program state-wide which will improve this score.

Grading Key

0	Not Known	3	Limited
1	No	4	Substantial
2	Minimal	5	Full

Benchmark 305		
305.1	4	Initial we have developed CP training based on research of out of state CP models. Gaps to be determined with roll-out and the development of a state approved CP curriculum.
305.2	4	We have an extensive selection/credentialing program in place for CAS/SmartCare paramedics that included BIDMC input.
305.3	1	While there are currently no CP conferences available in the state, CAS did attend and participate in the Region 4 CP presentation with an out of state guest speaker with extensive CP experience. CAS hopes to be a leader in future local conference opportunities.
305.4	5	There is a plan in place with our BIDMC Medical Control associates as well as other BIDMC stakeholders to fully monitor all CP patient interactions and immediately make any changes deemed necessary by the QA process.
305.5	5	CAS currently work with BIDMC's very robust QA/QI program to address any individual clinical concerns. This program has proven to be a great success. CAS plans to roll this same process over to the CP program.
Benchmark 306		
306.1	5	The OEMS SPW required regular reporting to OEMS. This will afford the opportunity for regulatory agency oversight of program.
306.2	5	CAS/SmartCare will follow current reporting guidelines in place under OEMS regulations for reporting any CP infractions.

Grading Key

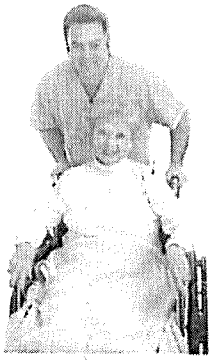
0	Not Known	3	Limited
1	No	4	Substantial
2	Minimal	5	Full

SmartCare

Hospital Discharge

Primary Care Physician

Case Management



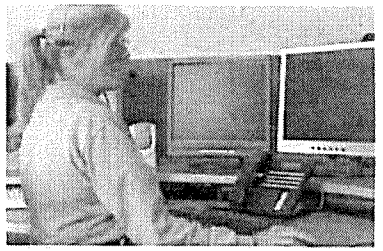
Case Management Phones patient and identifies need for a visit

Case Management calls SmartCare 800 number to explain need for the visit and PCP contact information

Case Management will notifies patient, patient family members, and PCP office of SmartCare visit in progress

SmartCare dispatcher will enter patient information into Smart-CAD and notify community medic of call

SmartCare dispatcher will contact medic and phone patient to set expectation of visit including time of arrival



Upon receipt of call request, SmartCare medic will respond to patients residence within one hour

SmartCare medic evaluates patient's home situation including any hazards and potential barriers of care

SmartCare medic addresses specific medical concerns pertaining to nature of call

SmartCare medic will follow up with a verbal communication to PCP on scene

SmartCare medic indentifies and communicates the need for any follow up care they feel may be warranted, including immediate care, telemedicine or follow up PCP appointments

SmartCare Medic will document the call in the patients Smart-CAD medical record and share the report with PCP or other pertient providers

Primary "911" Coverage Areas and Backup Agencies

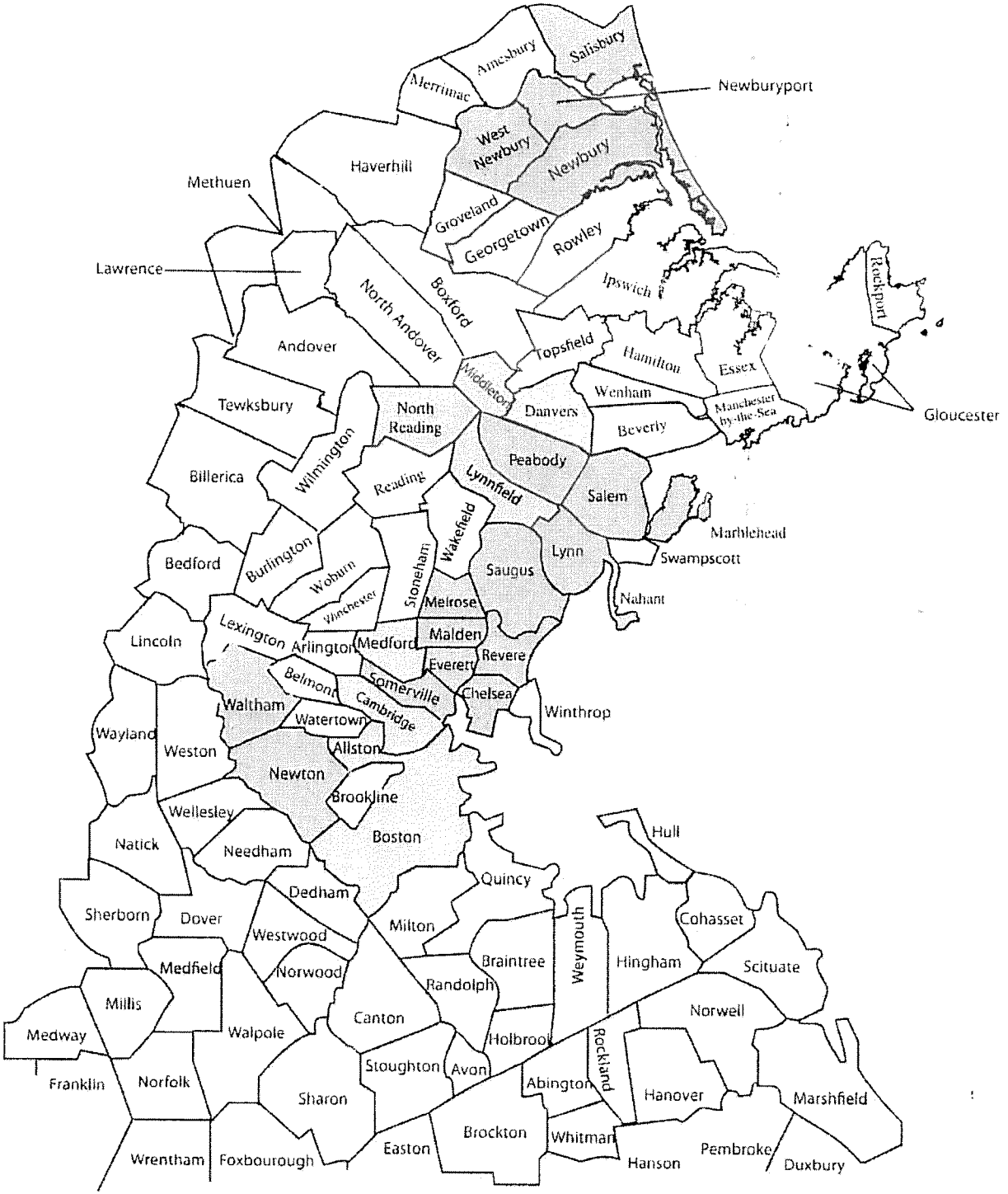
1. Chelsea, Massachusetts
2. Everett, Massachusetts
3. Lynn, Massachusetts
4. Malden, Massachusetts
5. Marblehead, Massachusetts
6. Newbury, Massachusetts
7. Newburyport, Massachusetts
8. Newton, Massachusetts
9. Peabody, Massachusetts
10. Revere, Massachusetts
11. Salem, Massachusetts
12. Salisbury, Massachusetts
13. Saugus, Massachusetts
14. Somerville, Massachusetts
15. West Newbury, Massachusetts
16. Waltham, Massachusetts

Backup "911" Coverage Areas

1. Town of Danvers
2. City of Boston
3. City of Cambridge
4. City of Medford

Backup ALS Coverage Areas

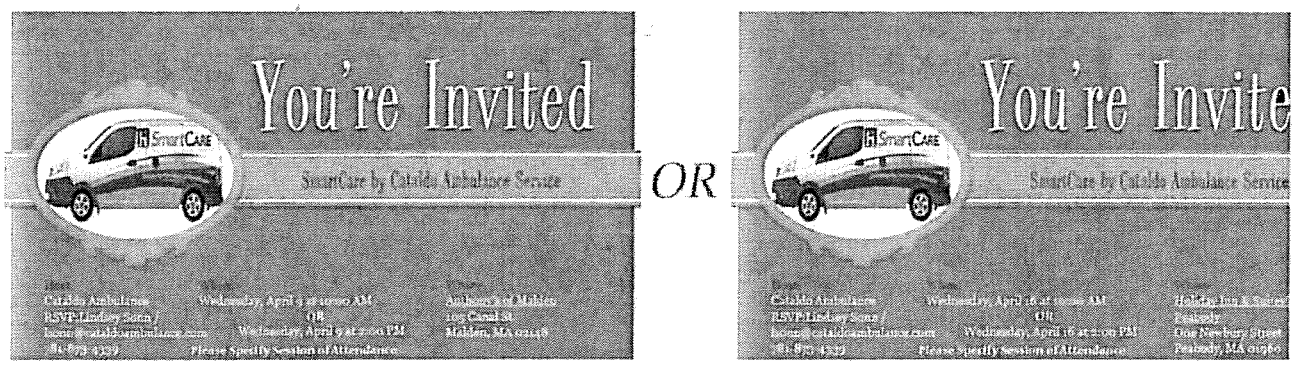
1. Town of Lynnfield
2. City of Melrose
3. Town of Middleton
4. Town of Nahant
5. Town of North Reading



From: Sonn, Lindsey
Sent: Monday, March 31, 2014 3:49 PM
To: Sonn, Lindsey
Subject: SmartCare Presentation by Cataldo Ambulance Service April 9 or 16

Hi,

While Cataldo maintains its core business as both an emergent and non-emergent medical transportation provider, recent changes in healthcare, brought about by the Affordable Care Act, have brought new opportunities within our system to assist clients in maintaining the overall health of their populations through a new healthcare initiative entitled Community Paramedicine. The newly formed community paramedicine division of Cataldo Ambulance Service is called SmartCare.



We hope that you are able to join us for one of our informative presentations on the changes and benefits SmartCare will provide for the future of healthcare. We are providing the opportunity for you to attend by hosting at two separate locations, each with two different times. All sessions will be covering the same presentation. We ask that you select one date and time to attend.

Please RSVP with your selected Date & Time to Lindsey Sonn - lsonn@cataldoambulance.com or 781-873-4339.

Thank you!

Lindsey Sonn
Public Relations & Marketing Manager
Cataldo Ambulance Service, Inc.
137 Washington St. Somerville, MA 02143
Office: 781.873.4339
Mobile: 857.523.1040
Fax: 781.873.4370
Email: lsonn@cataldoambulance.com

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City of Somerville			
	Mayor	Joseph A. Curtatone	mayor@somervillema.gov
	Fire Chief	Kevin Kelleher	KKelleher@somervillema.gov
	Police Chief	Acting Charles Femino	chief@police.somerville.ma.us
	Board of Health	Grian Green, M.D., Chairman	Not Available
City of Everett			
	Mayor	Carlo DeMaria, Jr.	Rodrigues@ci.everett.ma.us
	Fire Chief	David T. Butler	david.butler@ci.everett.ma.us
	Police Chief	Chief Steven A. Mazzie	steven.mazzie@ci.everett.ma.us
	Board of Health	Roberto Santamaria, MPH	Roberto.Santamaria@ci.everett.ma.us
City of Revere			
	Mayor	Daniel Rizzo	revere_mayor@revere.org
	Fire Chief	Gene Doherty	edoherty@revere.org
	Police Chief	Joseph Cafarelli	kmonsalve@reverepolice.org
	Board of Health	Nicholas Catinazzo	revere_health@revere.org
City of Chelsea			
	Town Manager	Jay Ash	JAsh@chelseama.gov
	Fire Chief	Robert Better	RBetter@chelseama.gov
	Police Chief	Bryan Kyes	bkyes@chelseama.gov
	Board of Health	Luis Prado	lprado@chelseama.gov
	911 Director	Allan Alpert	aalpert@chelseama.gov
City of Malden			
	Mayor	Gary Christenson	mayor@cityofmalden.org
	Fire Chief	Jack Colangeli	jcolangeli@cityofmalden.org
	Police Chief	Kevin R Molis	kmolis@maldenpd.com
	Board of Health	Christopher Webb	boh@cityofmalden.org
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	Police Chief	Michael L. Lyle	mlyle@cityofmelrose.org
	Board of Health	Ruth Clay, MPH	health@cityofmelrose.org
City of Peabody			
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	Fire Chief	Steve E. Pasdon	steve.pasdon@peabody-ma.gov
	Police Chief	Robert St. Pierre	chief@peabodypolice.org
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City of Lynn			
	Mayor	JUDITH FLANAGAN KENNEDY	jcerulli@lynnma.gov
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City of Salem			
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	Fire Chief	David Cody	dcody@salem.com
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Town of Marblehead			
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City of Newburyport			
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Town of West Newbury			
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	Fire Chief	Michael Dwyer	fire@westnewburysafety.org
	Police Chief	Lisa Holmes	police@westnewburysafety.org
	Board of Health	Paul Sevigny	psevigny@wnewbury.org
Town of Salisbury			
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	Board of Health	John Morris	jmorris@salisburyma.gov
City of Amesbury			
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	Board of Health	John Morris	morrisj@amesburyma.gov
Town of Newbury			
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	Fire Chief	William Pearson	www.byfieldfire.com
	Police Chief	Michael Reilly	chiefreilly@newburypolice.com
	Board of Health	Deborah Rogers	boardofhealth@townofnewbury.org
Town of Merrimac			
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	Board of Health	Eileen Hurley	BOH@townofmerrimac.com
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	Police Chief	Donald Cudmore	dcudmore@georgetownma.gov
	Board of Health	Deborah Rogers	drogers@georgetownma.gov
City of Woburn			
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	Police Chief	Robert J. Ferullo	Police@woburnpd.com
	Board of Health	John R. Fralick	jfralick@cityofwoburn.com
City of Newton			
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	Police Chief	Howard Mintz	hmintz@newtonma.gov
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City of Waltham			
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	Fire Chief	Paul Ciccone	pciccone@fire-dept.waltham.ma.us
	Police Chief	Keith MacPherson	
	Board of Health	Walter Sweder	
Town of Weston			
	Town Manager	Donna S. VanderClock	vanderclock.d@westonmass.org
	Fire Chief	David B. Soar	soar.d@westonmass.org
	Police Chief	Steven F. Shaw	shaw.s@westonmass.org
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Town of Wellesley			
	Town Manager	Hans Larsen	hlarsen@wellesleyma.gov
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	Police Chief	Terrence (Terry) M. Cunningham	police@wellesleyma.gov
	Board of Health	Leonard Izzo	lizzo@wellesleyma.gov
Town of Needham			
	Town Manager	Kate Fitzpatrick	
	Fire Chief	Paul Buckley	pbuckley@needhamma.gov
	Police Chief	Philip E. Droney	
	Board of Health	Janice Berns	jberns@needhamma.gov
City of Medford			
	Mayor	Michael J. McGlynn	mayor@medford.org
	Fire Chief	Frank A. Giliberti Jr.	
	Police Chief	Leo Sacco	
	Board of Health	Karen L. Rose, RN, BC, BA, MS,	krose@medford.org
Town of Lexington			
	Town Manager	Carl F. Valente	townmanager@lexingtonma.gov
	Fire Chief	John A. Wilson	jwilson@lexingtonma.gov
	Police Chief	Mark J. Corr	PoliceInfo@LexingtonMA.gov
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Town of Burlington			
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	Fire Chief	Steven M. Yetman	syetman@burlington.org
	Police Chief	Michael Kent	mkent@bpd.org
	Board of Health	Susan Lumenello	
Town of Saugus			
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	Police Chief	Domenic J. DiMella	ddimella@sauguspd.com
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Town of Brookline			
	Town Administrator	Melvin Kleckner	mkleckner@brooklinema.gov
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Town of Dedham			
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	Fire Chief	Acting Chief William Cullinane	wcullinane@dedham-ma.gov
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Town of Watertown			
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	Police Chief	Edward P. Deveau	edeveau@police.watertown-ma.gov
	Board of Health		
Town of Belmont			
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	Fire Chief	Davis Frizzell	dfrizzell@belmont-ma.gov
	Police Chief	Richard McLaughlin	chief@belmontpd.org
	Board of Health	Stefan Russakow	srussakow@belmont-ma.gov
Town of Arlington			
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	Board of Health	Christine Connolly	boh@town.arlington.ma.us
Town of Winchester			
	Town Manager	Richard Howard	townmanager@winchester.us
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	Police Chief	Ken Albertelli	police@winchesterpd.org
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Town of Stoneham			
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	Fire Chief	Michael Sullivan	msullivan@wakefield.ma.us
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	Town Manager	Robert W. LeLacheur, Jr.	townmanager@ci.reading.ma.us
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	Police Chief	James W. Cormier	jcormier@ci.reading.ma.us
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Town of North Reading			
	Town Administrator	Greg Balukonis	gbalukonis@northreadingma.gov
	Fire Chief	William Warnock	firechief@northreadingma.gov
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	Fire Chief	Mark Tetreault	mtetreault@town.lynnfield.ma.us
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	Board of Health	Kristin Esposito	kmcrae@town.lynnfield.ma.us
Town of Swapscott			
	Town Administrator	Thomas Younger	tyounger@town.swampscott.ma.us
	Fire Chief	Kevin Breen	kbreen@town.swampscott.ma.us
	Police Chief	Ron Madigan	RMadigan@swampscottpolice.com
	Board of Health	Jeff Vaughan	jvaughan@town.swampscott.ma.us
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	Town Manager	James M. McKenna	townmanager@town.winthrop.ma.us
	Fire Chief	Paul E. Flanagan	fire@town.winthrop.ma.us
	Police Chief	Terence M. Delehanty	tdelehanty@town.winthrop.ma.us
	Board of Health	Eric O. Moore	emoore@town.winthrop.ma.us
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	Region III	Alexander Walker	AWalker@hallmarkhealth.org]
Region Offices	Region IV	Derrick Congson	dcongdon@mbemsc.org
	Region III	Mike Kass	mkass@neems.org
OEMS	State	Jamie Piancia	jamie.pianka@state.ma.us

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		Right at Home Senior Care	donna@rightathomecare.com
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Katy	Coughlin	Guardian Angel Senior Services	kcoughlin@guardianAngelSeniorServices.com
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Joanne	Laidley	CHA ESP	jlaidley@challiance.org

Patient Self-Assessment of Health Status (1)

As of: 7/31/2013

	CHP			CHF			NTSP		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Sample Size	**12**	**10**		**26**	**26**		**8**	**18**	
Mobility (2)	2.417	2.300	-4.8%	2.346	2.615	11.5%	2.750	2.611	-5.1%
Self-Care (2)	2.583	2.500	-3.2%	2.423	2.654	9.5%	2.750	2.667	-3.0%
Perform Usual Activities (2)	2.333	2.300	-1.4%	2.269	2.500	10.2%	2.750	2.556	-7.1%
Pain and Discomfort (2)	1.667	2.400	44.0%	2.154	2.423	12.5%	2.750	2.444	-11.1%
Axiety/Depression (2)	1.667	2.000	20.0%	2.154	2.346	8.9%	2.750	2.722	-1.0%
Overall Health Status (3)	**3.333**	**6.600**	**98.0%**	**5.385**	**7.115**	**32.1%**	**6.750**	**6.778**	**0.4%**

Notes:

1. *Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionaire*
2. *Score 1 - 3 with 3 most favorable*
3. *Score 1 - 10 with 10 most favorable*

MEDSTAR MOBILE HEALTHCARE

Program Overview – Observation Admission Reduction

Background:

According to CMS reports, the incidence of Observational Admissions has increased 69% since 2006. Observational admissions place significant financial burden on the patient and the healthcare system. Many observational admissions may be avoidable if the patient had a resource available for the time period between the emergency department (ED) visit and the follow-up care needed by the patient, typically at a primary care provider (PCP) or specialist appointment within 1 – 3 days.

MedStar Mobile Healthcare has been operating a Community Health Program (CHP) using Mobile Healthcare Practitioners (MHP) since July 2009. Patients who have graduated from the CHP have experienced an 84.3% reduction in emergency department use for the 12 months post-graduation compared to the 12 months pre-enrollment. Using the same model, MedStar works together with the ED staff to reduce the incidence of patients being admitted for "observation" hospital admissions.

Program:

- When a patient is being considered for observational admission by the emergency department, the emergency department refers the patient to the MedStar.
- MedStar sends an on-duty MHP to the emergency department to meet briefly with the patient and the emergency department physician.
    - During this brief meeting, the emergency department physician, the patient and the MedStar MHP discuss the patient's potential needs between the time of discharge and the time the patient can be seen by the follow-up care provider.
    - Typically, the appointment with the follow-up care provider is scheduled for the next business day.
- The MHP explains the service that will be provided to the patient and schedule an in-home visit at a convenient time for the patient, typically 4 – 6 hours after the patient is discharged from the emergency department.
- The MHP visits the patient at the pre-arranged time to assess the patient's condition.
    - The patient will also be provided a non-emergency contact number for the MHP for any episodic needs for the duration of the enrollment in the monitoring program.
- Any change in the patient's condition, or consultation regarding the patient's condition or treatments necessary, will be communicated by the MHP to the emergency department physician, if still on-duty.
    - If the ED physician is off-duty, the consultation is with the MedStar Medical Director.
- Documentation regarding the assessment findings (either electronic or printed) is provided to the patient's PCP as soon as the physician office opens.
- When the PCP office opens, MedStar's CHP coordinator, or Triage Nurse, contacts the follow-up provider's office to provide a verbal report on the patient's assessment findings, any treatments provided, and assure the written documentation from the MHP has been received by the follow-up provider's office.
    - The CHP Coordinator or the Triage Nurse also confirms the time for the patient's appointment and reminds the patient of the appointment time.
    - The CHP Coordinator or Triage Nurse also assures the patient has transportation to the follow-up provider's appointment.

Program Evaluation:

The program is evaluated using the following criteria:

- *Patient Outcome* –
  - Was the patient admission avoided, or was the patient eventually admitted to the hospital for the primary complaint they were evaluated in the emergency department?
- *Patient Satisfaction* –
  - The patient will be interviewed to determine their overall satisfaction with their program enrollment.
- *Provider Satisfaction* –
  - The referring emergency department physician, the patient's primary physician and the CH/APP. assigned to the referral will be interviewed to assess their satisfaction with the referral.

Results:

Expenditure Savings Analysis **Obs Admission Avoidance Program**

Based on Medicare Rates

Analysis Dates: **August 1, 2012 - Sept 30, 2013**

Number of Patients: **54**

	Obs Admits Avoided		
Category	**Base**	**Avoided**	**Savings**
Avg Obs Admit Payment (1)	$ 7,846	53	$ 415,838
ED Bed Hours (2)	23	53	1,219

Per Patient Enrolled	**Obs Admit**
Payment Avoidance	**$ 415,838**

Notes:

1. *Average payment made by NTSP for Obs Admission*
2. *Average duration of Obs Admission in ED*

Expenditure Savings Analysis (1) **CHF Diuretic Protocol**

Based on Medicare Rates

Analysis Dates: January 1, 2013 - March 31, 2013

Number of Patients: 18

	CHP 9-1-1 Transports to ED		
Category	Base	Avoided	Savings
Ambulance Charge	$1,668	17	$28,356
Ambulance Payment (3)	$421	17	$7,157
ED Charges	$904	17	$15,368
ED Payment (4)	$774	17	$13,158
ED Bed Hours (5)	6	17	102
Inpatient Charges (5)	$ 39,426	17	$ 670,242
Inpatient Payments (4)	$ 17,500	17	$ 297,500

Total Charge Avoidance	$713,966
Total Payment Avoidance	$317,815

Per Patient Enrolled	CHFP
Charge Avoidance	$39,665
Payment Avoidance	$17,656

Notes:

1. *Comparison based Case Manager estimate of 1 readmit vs.*
   actual admit during 30 day enrollment.
3. *Average Medicare payment rec'd by MedStar*
4. *Base expenditures derived from AHRQ reports*
5. *Derived from CMS Charge Report for DRG 189 for John Peter Smith Health Network*

MEDSTAR MOBILE HEALTHCARE

Congestive Heart Failure Readmission Prevention Program

Background

In June of 2010, MedStar was asked to collaborate on a program with area cardiologists to prevent 30-day readmissions. Over the course of the past three years, we have evolved a program that has resulted in an 8.6% readmission rate for the enrolled patients compared to a 21% readmission rate in the community.

Program Components

Patient Education & Scheduled Home Visits:

An enrolled patient receives a series of home visits conducted by a specially trained MedStar Mobile Healthcare Practitioner. These home visits are designed to:

1. Educate the patient and patient's family on the appropriate ways to manage their disease process.
    a. Diet and weight compliance
    b. Medication compliance
    c. Healthy lifestyle changes
2. Educate the patient how to utilize their primary/specialty care network to help manage the disease process.
    a. When to call for an appointment
    b. Important information to share with care providers

These home visits are weighted to be more frequent in the first week post-discharge and the gradually become less frequent as the patient is empowered to manage their own care. The first visit is typically the longest duration as this visit includes a detailed assessment of the patient's environment, a full review of all their prescribed medications, and a complete assessment of vital signs and 12 lead ECG tracings. The patients are also provided educational workbooks to document their progress.

During the intake visit, the patient is also asked to assess their own health status using the EQ-5D-3L process by EuroQol.

During subsequent visits, the patient is reassessed, including periodic IStat Point of Care Chem 8 lab analysis to check the patients BUN, creatinine, and other important lab values.

Unscheduled Home Visits:

The patient is provided a 10-digit, non-emergency access number for the MedStar Mobile Healthcare Provider in the event they would like a phone consultation or an unscheduled home visit between scheduled visits.

9-1-1 Responses:

Enrolled patients are tracked in MedStar's 9-1-1 computer aided dispatch (CAD) program. In the event of a 9-1-1 call to the residence, the normal EMS system response is initiated, but the MHP is also dispatched to the scene. Once on-scene, the MHP may be able to intervene and prevent an unnecessary ambulance trip to the emergency department by employing the use of the alternative protocols available to the patient enrolled in this program.

Record Keeping:

Patients enrolled in the program have a continual electronic medical record (EMR) that allows all care providers mobile access to the patient's entire course of assessments and treatments during enrollment, including care notes, lab values, vital signs, ECG tracings and treatments initiated. These records can be electronically provided to any care giver with access to a fax or email account.

Diuretic Protocol:

In consultation with the patient's PCP, Cardiologist or the MedStar Medical Director, patients who are suffering fluid retention can either have their medications adjusted in the field, or in some cases, receive IV diuretics with an in-office follow-up appointment to prevent an unnecessary trip to the Emergency Department.

Care Coordination:

MedStar hosts monthly meetings with all case workers, community service agencies and other care providers to review the program and enrolled patients in an effort to help meet any needs of the enrolled patients and to improve program resource coordination.

Graduation:

After 30-days, the patient is graduated from the program, provided a graduation certificate, a patient satisfaction survey and the patient is asked to re-assess their own health status using the EQ-5D-3L process by EuroQol. This data is tracked to help measure program effectiveness and identify area of potential improvement.

Enrollment Process

- The facility designates a CHF liaison that is the main point of contact for the MedStar Mobile Healthcare Program Coordinator. They will discuss these cases and track specific data sets, to be reported back on a monthly basis.
- Caseworker identifies a CHF patient that has had at least 1 readmission for Dx of CHF within previous 30 days of current admission
- Caseworker verifies that this patient has an active PCP or Cardiologist that the MedStar MHP Paramedic CP can contact.
- Caseworker reviews patient's history with the hospitals CHF liaison to help ensure that the patient meets the enrollment criteria.
- Caseworker discusses the program with the patient and if they agree to enroll, the appropriate authorization forms should be signed by the patient at this time.
- The CHF liaison will then call the MedStar MHP Coordinator to set up an initial visit with the patient and the on duty MHP, preferably while the patient is still in the hospital.
- Caseworker will then fax or email copies of the signed authorization forms, H&P and face sheet to the MedStar MHP Coordinator.
- MHP Coordinator will enter this patient into EMR and scan in all hospital information provided.

Results:

Expenditure Savings Analysis (1) CHF Program

Based on Medicare Rates

Analysis Dates: **July 1, 2012 - July 31, 2013**

Number of Patients (2): **24**

	CHF 9-1-1 Transports to ED		
Category	Base	Avoided	Savings
Ambulance Charge	$ 1,668	23	$ 38,364
Ambulance Payment (3)	$ 421	23	$ 9,683
ED Charges (4)	$ 904	23	$ 20,792
ED Payment (4)	$ 774	23	$ 17,802
ED Bed Hours (5)	6	23	138
Inpatient Charge (4)	$ 25,000	23	$ 575,000
Inpatient Payment (4)	$ 17,500	23	$ 402,500

Total Charge Avoidance	**$634,156**
Total Payment Avoidance	**$429,985**

Per Patient Enrolled	**CHF**
Charge Avoidance	**$26,423**
Payment Avoidance	**$17,916**

Notes:

1. *Comparison based on 1 predicted 30-day readmissions for enrollees*
2. *Patients enrolled into CHF-P Program*
3. *Average Medicare payment rec'd by MedStar*
4. *Base expenditures derived from AHRQ reports*
5. *Provided by John Peter Smith Health Network*

Patient Self-Assessment of Health Status (1)

As of: **7/31/2013**

	CHP			CHF			NTSP		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Sample Size	12	10		26	26		8	18	
Mobility (2)	2.417	2.300	-4.8%	2.346	2.615	11.5%	2.750	2.611	-5.1%
Self-Care (2)	2.583	2.500	-3.2%	2.423	2.654	9.5%	2.750	2.667	-3.0%
Perform Usual Activities (2)	2.333	2.300	-1.4%	2.269	2.500	10.2%	2.750	2.556	-7.1%
Pain and Discomfort (2)	1.667	2.400	44.0%	2.154	2.423	12.5%	2.750	2.444	-11.1%
Axiety/Depression (2)	1.667	2.000	20.0%	2.154	2.346	8.9%	2.750	2.722	-1.0%
Overall Health Status (3)	**3.333**	**6.600**	**98.0%**	**5.385**	**7.115**	**32.1%**	**6.750**	**6.778**	**0.4%**

Notes:

1. *Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionaire*
2. *Score 1 - 3 with 3 most favorable*
3. *Score 1 - 10 with 10 most favorable*

Program Overview – High Utilizer 9-1-1/Emergency Department Patients

Background

MedStar Mobile Healthcare has been operating a Community Health Program (CHP) using Mobile Healthcare Practitioners (MHP) since July 2009. Patients who have graduated from the CHP have experienced an 84.3% reduction in emergency department (ED) use for the 12 months post-graduation compared to the 12 months pre-enrollment. MedStar works together with the patient and numerous healthcare and community-based providers to reduce the incidence of preventable ambulance responses and ED visits.

Program Components

Patient Education & Scheduled Home Visits:

An enrolled patient receives a series of home visits conducted by a specially trained MedStar Mobile Healthcare Practitioner (MHP). These home visits are designed to:

1. Educate the patient and patient's family on the appropriate ways to manage their healthcare needs. The patient is also assessed for possible enrollment in various healthcare and community-based programs to help meet the patient's clinical, social and/or behavioral health needs. This includes:
    a. Medication compliance
    b. Healthy lifestyle changes
    c. Nutritional support
    d. Home environment/safety needs
    e. Behavioral health support
2. Educate the patient how to utilize their primary/specialty care network to help manage their medical needs. This includes:
    a. When to call for an appointment
    b. How to call for an appointment
    c. Important information to share with care providers
    d. How to utilize transportation services

During the intake visit, the patient is also asked to assess their own health status using the EQ-5D-3L process by EuroQol.

Unscheduled Home Visits:

The patient is provided a 10-digit, non-emergency access number for the MedStar Mobile Healthcare Provider in the event they would like a phone consultation or an unscheduled home visit between scheduled visits.

9-1-1 Responses:

Enrolled patients are tracked in MedStar's 9-1-1 computer aided dispatch (CAD) program. In the event of a 9-1-1 call to the residence, the normal EMS system response is initiated, but the MHP is also dispatched to the scene. Once on-scene, the MHP may be able to intervene and prevent an unnecessary ambulance trip to the emergency department by employing the use of the alternative protocols available to the patient enrolled in this program.

Record Keeping:

Patients enrolled in the program have a continual electronic medical record (EMR) that allows all care providers mobile access to the patient's entire course of assessments and treatments during enrollment, including care notes, vital signs, ECG tracings and treatments initiated. These records can be electronically provided to any care giver with access to a fax or email account.

Care Coordination:

MedStar hosts monthly meetings with all case workers, community service agencies and other care providers to review the program and enrolled patients in an effort to help meet any needs of the enrolled patients and to improve program resource coordination.

Graduation:

After the patient has demonstrated the ability to better manage their healthcare needs, the patient is graduated from the program, provided a graduation certificate, a patient satisfaction survey and the patient is asked to re-assess their own health status using the EQ-5D-3L process by EuroQol. This data is tracked to help measure program effectiveness and identify area of potential improvement.

Results:

Patient Self-Assessment of Health Status (1)
As of: 7/31/2013

	CHP			CHF			NTSP		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Sample Size	12	10		26	26		8	18	
Mobility (2)	2.417	2.300	-4.8%	2.346	2.615	11.5%	2.750	2.611	-5.1%
Self-Care (2)	2.583	2.500	-3.2%	2.423	2.654	9.5%	2.750	2.667	-3.0%
Perform Usual Activities (2)	2.333	2.300	-1.4%	2.269	2.500	10.2%	2.750	2.556	-7.1%
Pain and Discomfort (2)	1.667	2.400	44.0%	2.154	2.423	12.5%	2.750	2.444	-11.1%
Axiety/Depression (2)	1.667	2.000	20.0%	2.154	2.346	8.9%	2.750	2.722	-1.0%
Overall Health Status (3)	**3.333**	**6.600**	**98.0%**	**5.385**	**7.115**	**32.1%**	**6.750**	**6.778**	**0.4%**

Notes:

1. *Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionaire*
2. *Score 1 - 3 with 3 most favorable*
3. *Score 1 - 10 with 10 most favorable*

Expenditure Savings Analysis (1) Community Health Program

Based on Medicare Rates

Analysis Dates: July 1, 2012 - July 31, 2013
Number of Patients (2): 50

	CHP 9-1-1 Transports to ED		
Category	Base	Avoided	Savings
Ambulance Charge	$1,668	989	$1,649,652
Ambulance Payment (3)	$421	989	$416,369
ED Charges	$904	989	$894,056
ED Payment (4)	$774	989	$765,486
ED Bed Hours (5)	6	989	5,934

Total Charge Avoidance	**$2,543,708**
Total Payment Avoidance	**$1,181,855**

Per Patient Enrolled	**CHP**
Charge Avoidance	**$50,874**
Payment Avoidance	**$23,637**