Massachusetts Department of Public Health

SOUTH SHORE/SOUTH COAST HOSPITAL PILOT PROGRAM

MIH FORUM

June 27, 2024

Massachusetts Department of Public Health

Office of Emergency Medical Services (OEMS)
Mobile Integrated Health Overview

Dr. Jon Burstein, State EMS Medical Director

Susan Lewis, Director

Agenda

- Explanation and expansion of programs in Massachusetts
  - Mobile Integrated Health (MIH)
  - Mobile Integrated Health With Emergency Department Avoidance (MIH w/EDA) MIH and CEMS in Massachusetts
  - Current approved and active programs
  - Data collected
- Next steps

What Are Mobile Integrated Health and Mobile Integrated Health with EDA Programs?

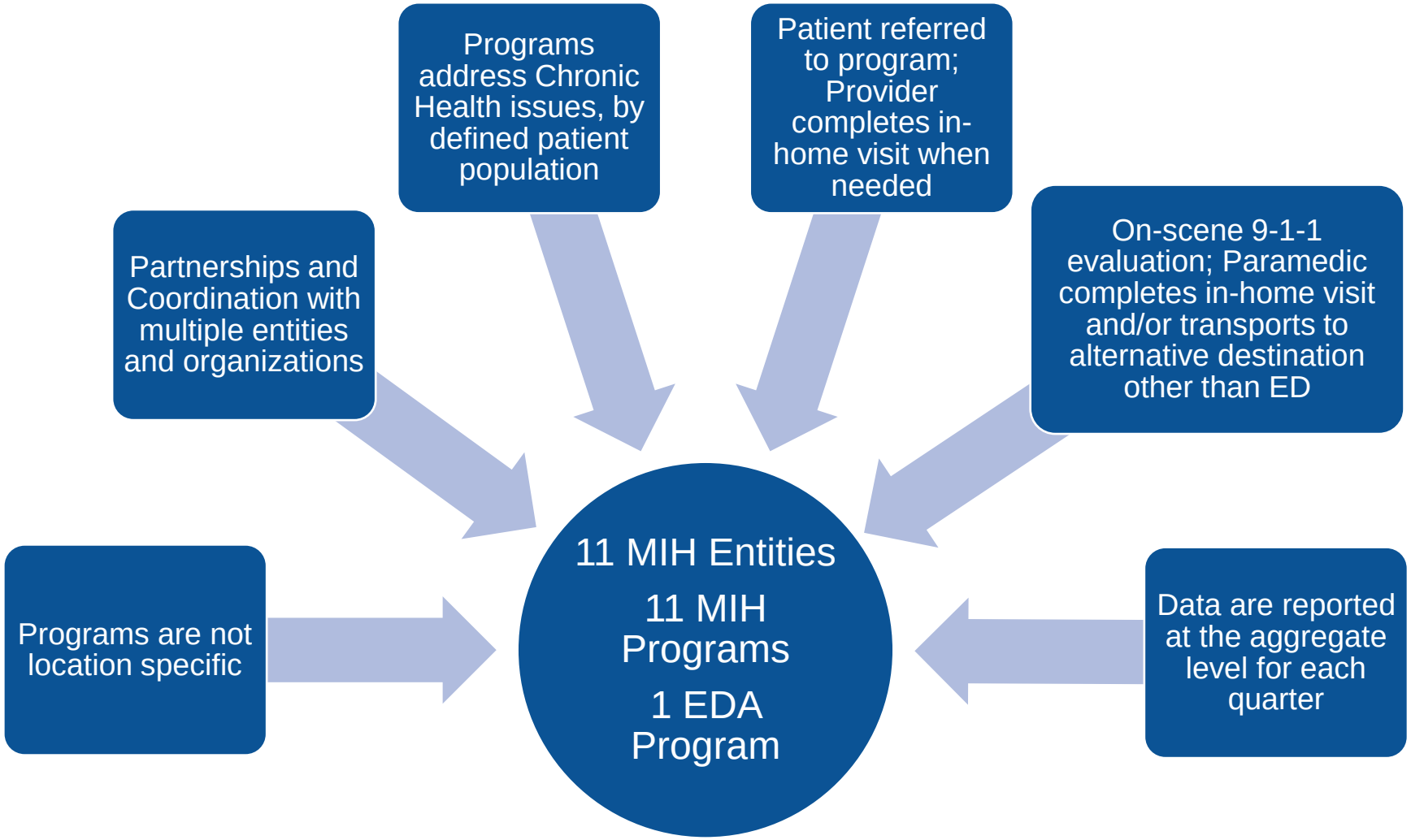
Mobile Integrated Health

- Utilizes EMS personnel (and other healthcare personnel) to deliver a coordinated continuum of care.
- Addresses gaps in service delivery within a community.
- Proactively prevents unnecessary hospitalizations or other harmful and wasteful resource delivery.
- Care is provided outside of the hospital environment.
- Coordinated through a primary care provider with an established patient population to provide out of hospital care

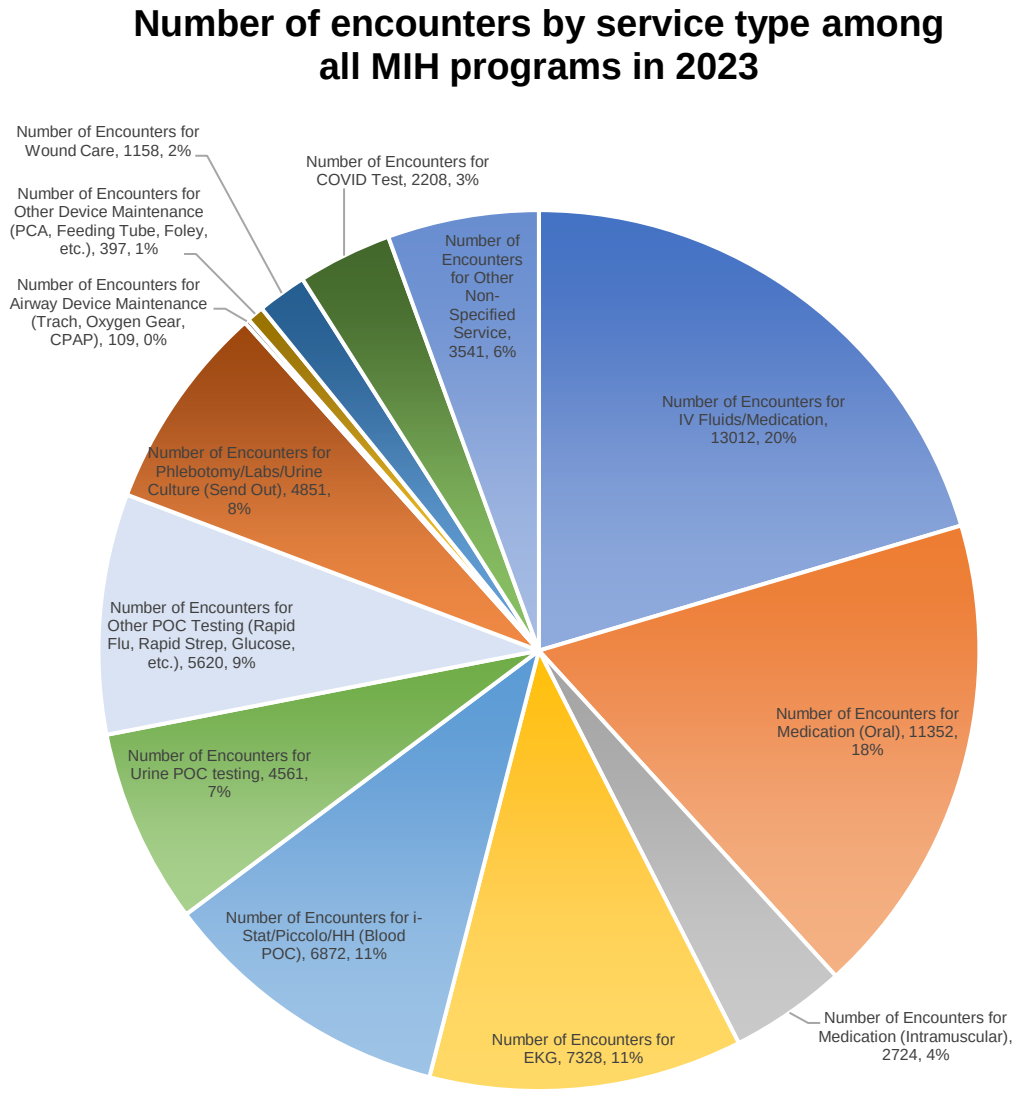
Mobile Integrated Health with Emergency Department Avoidance

- Component of an MIH Program with a goal to prevent unnecessary hospitalizations.
- Operated by an MIH Program and includes the community's primary ambulance service.
- Follows a primary ambulance service 9-1-1 response, patient assessment, consultation with on-line medical direction, and patient consent to treatment at an alternate destination.

What Are MIH & EDA Programs?

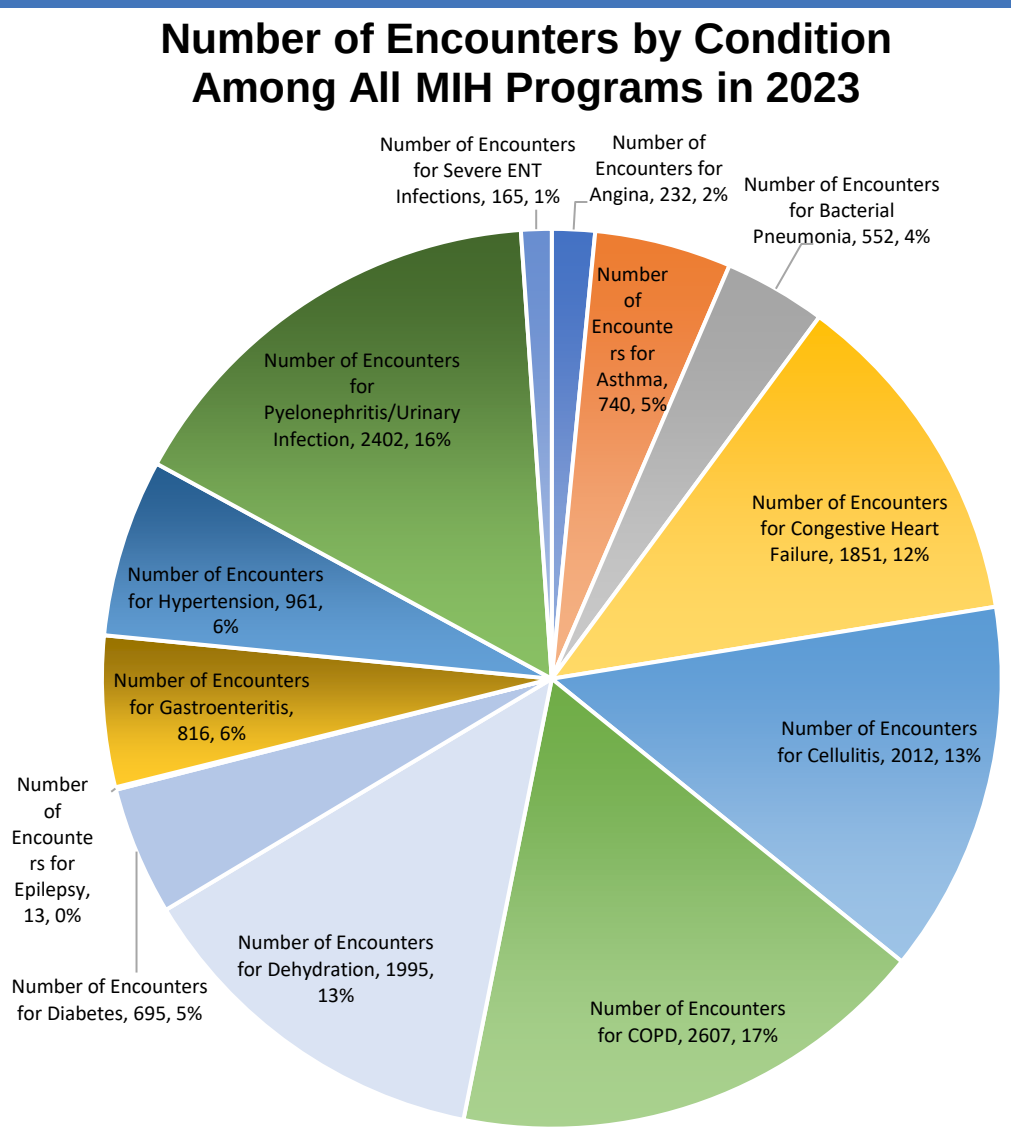


MIH Data by Service Type



Service Type among MIH Programs	Number of Encounters	Percentage of Total Encounters
Number of Encounters for IV Fluids/Medication	13012	**20.42%**
Number of Encounters for Medication (Oral)	11352	**17.81%**
Number of Encounters for EKG	7328	**11.50%**
Number of Encounters for i-Stat/Piccolo/HH (Blood POC)	6872	**10.78%**
Number of Encounters for Other POC Testing (Rapid Flu, Rapid Strep, Glucose, etc.)	5620	**8.82%**
Number of Encounters for Phlebotomy/Labs/Urine Culture (Send Out)	4851	**7.61%**
Number of Encounters for Urine POC testing	4561	**7.16%**
Number of Encounters for Other Non-Specified Service	3541	**5.56%**
Number of Encounters for Medication (Intramuscular)	2724	**4.27%**
Number of Encounters for COVID Test	2208	**3.46%**
Number of Encounters for Wound Care	1158	**1.82%**
Number of Encounters for Other Device Maintenance (PCA, Feeding Tube, Foley, etc.)	397	**0.62%**
Number of Encounters for Airway Device Maintenance (Trach, Oxygen Gear, CPAP)	109	**0.17%**

MIH Data by Condition



Condition Type among MIH Programs	Number of Encounters	Percentage of Total Encounters
Number of Encounters for COPD	2607	**17.33%**
Number of Encounters for Pyelonephritis/Urinary Infection	2402	**15.97%**
Number of Encounters for Cellulitis	2012	**13.38%**
Number of Encounters for Dehydration	1995	**13.26%**
Number of Encounters for Congestive Heart Failure	1851	**12.31%**
Number of Encounters for Hypertension	961	**6.39%**
Number of Encounters for Gastroenteritis	816	**5.43%**
Number of Encounters for Asthma	740	**4.92%**
Number of Encounters for Diabetes	695	**4.62%**
Number of Encounters for Bacterial Pneumonia	552	**3.67%**
Number of Encounters for Angina	232	**1.54%**
Number of Encounters for Severe ENT Infections	165	**1.10%**
Number of Encounters for Epilepsy	13	**0.09%**

MIH Requirements

Applicants for MIH should submit the following requirements as part of their application:

- Completed application form
- Description of the program and proposed services, including:
  - Executive Summary
  - Gap in service delivery narrative
  - Coordination of care and partnership description and documentation
  - 911 EMS systems coordination and service duplication description
  - Organizational readiness description, organizational chart, and roles
  - MIH Program Compliance and Capacity form
  - Medical control and medical direction description, Medical Director biography, medical oversight plan
  - MIH with EDA; additional components required
- Attestation and letters from the partner organizations and the primary ambulance service's affiliate hospital medical director

Online Resources — MIH

Information, application materials, and resources are posted at: mass.gov/MIH.

Applicant Resources:

- Application forms and instructions for each program type
- MIH Regulations
  - 105 CMR 173.000
- Data submission information and resources for each program type
- Application resources, such as best practices for completing a gap in service delivery narrative are available on the application page

For ease in review by the MIH Program, an Applicant should organize the gap in service delivery narrative in the following structure and include the content specified below:

Requirement	Components and Sources of Information
Define the community (population and jurisdiction), and identify relevant gaps in service delivery within the defined community	**a.** Use community health needs assessments (required), research, stakeholder and provider input to define the community and identify gaps. Any data should be dis-aggregated (based on community demographics) such that health disparities by race/ethnicity, age, gender, disability status and socio-economic status are captured for the applicable community.
Provide evidence that gaps in service delivery exist	**a.** Use appropriate population-based and clinical data sources as evidence that gaps exist. Data should dis-aggregated (based on community demographics) such that health disparities by race/ethnicity, age, gender, disability status and socio-economic status are understood (when available). **b.** Use proactive outreach to receive input from local community stakeholders and providers regarding health needs.
Analyze local current service offerings	**a.** Complete an analysis of currently available services including proactive outreach to providers for partnering opportunities. **b.** Describe the proposed services and their potential clinical and operational effectiveness.
Describe proposed services and their effectiveness at addressing the identified gaps in service delivery	**a.** Describe a proposed service or services that would fill the gaps that the proposed program would like to provide and describe how each of the proposed services will at least partially fill one or more identified gap. **b.** Identify barriers and resources in the community, resources of the provider, and potential partnerships that could impact the delivery and effectiveness of proposed services. **c.** Describe the potential impact of proposed services on providing improvements in quality, access, cost effectiveness, patient satisfaction, patients' quality of life, and interventions that promote health equity, including cultural and linguistic competencies.

The following table provides some examples of data that can be used to complete a gap in service delivery narrative.

Questions?

Thank you for participating in today's presentation!

If you have further questions or would like more information, please contact:

Mobile Integrated Health Care Program

mih@mass.gov

(617) 753-8124

Literature Review of Mobile Integrated Health

Carmela Socolovsky, MD, MPH

Medical Director, MassHealth

Focused Literature Review on Mobile Integrated Health

- MIH is safe

  No increase in adverse events or readmissions in published trials

- MIH *may* facilitate high value care

  Data is mixed on whether MIH decompresses acute care settings

  May cost equal to or less than an ED or UC visit, depending on the care delivery model

- MIH *may* improve care equity

  Internal data suggesting marginalized communities or communities with vulnerabilities engage more readily with home-based care

Mobile Integrated Health

One System's Journey

Laura Griffin, MD

June 27, 2024

SIGNATURE HEALTHCARE

MIH Overview

Mobile Integrated Health (MIH) brings care into the Mass Health community in the form of a personalized, high-touch healthcare program. It leverages using paramedics to provide advanced healthcare within a patient's home.

SIGNATURE HEALTHCARE

BREWSTER AMBULANCE SERVICE

Background

Every disaster is an opportunity…

On Feb 6, 2023, Signature Healthcare had a 10 alarm electrical fire closing our doors temporarily.
Three urgent cares were established to continue seeing patients in the community in addition to all previous ambulatory services.
MassHealth, Brewster, and Signature worked diligently to establish a Mobile Integrated Health program to aid in caring for patients who needed care beyond a clinic visit.

Urgent Care or Clinic

A → HOME

B →

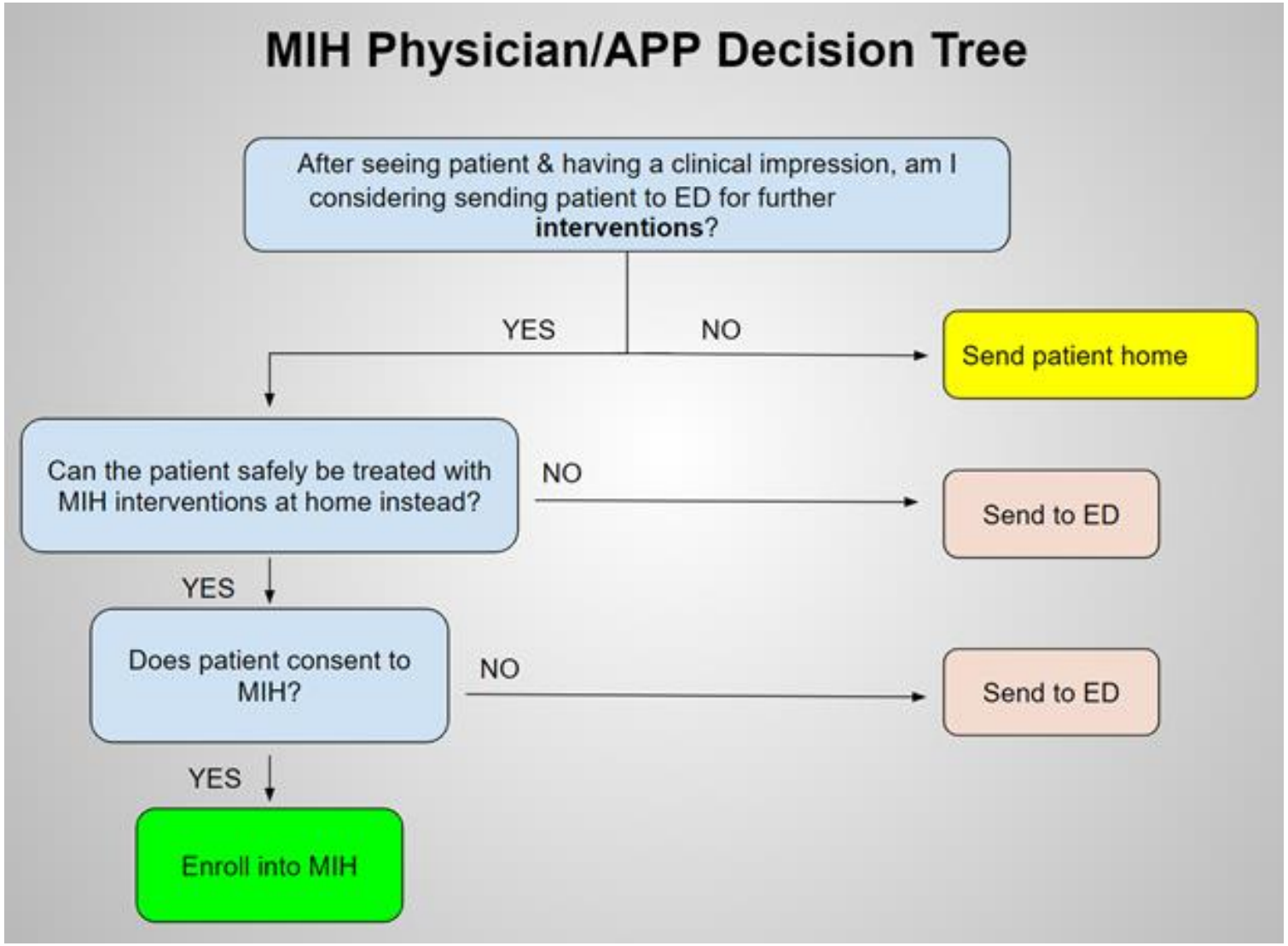
→ 18% Hospitalized

82% d/c'd

Urgent Care or Clinic

18% Hospitalized

82% d/c'd


MIH Physician/APP Decision Tree
After seeing patient & having a clinical impression, am I considering sending patient to ED for further **interventions**?
YES
NO
Send patient home
Can the patient safely be treated with MIH interventions at home instead?
NO
Send to ED
YES
Does patient consent to MIH?
NO
Send to ED
YES
Enroll into MIH

LIST OF TREATMENT OPTIONS

Point of care lab testing

- H/H
- CMP
- CBG
- UA

Exam and evaluation

- Vital signs
- National Early Warning Score (NEWS)
- Pulse ox
- Weight
- Physical exam
- Wound check, dressing changes

LIST OF TREATMENT OPTIONS

▪ Antibiotics	IV, PO
▪ Antiemetics	IV, SL
▪ Diuretics	IV, PO
▪ Analgesic	IV, IM
▪ Corticosteroids	IV, IM, PO
▪ IV fluids	IV
▪ Cardiovascular meds	IV, PO
▪ Electrolyte replacement	IV, PO
▪ Respiratory meds	Nebs

MIH Provides care at Home

Brewster has multiple touch points with SHC for any patient care changes, treatment advice, and discharge from program by calling Urgent Care / ED Provider.

MIH Disch Patient

Brewster sends note to SHC electronically after the patient is treated in their home. Medical records are attached to the patient's index appointment and scanned into MT.

Medical Record Email created for smooth medical record correspondence

What problem are we trying to solve?

- Expand care
- Better, safer care
- Patient satisfaction
- Lessen ED crowding
- Reduction of overutilization
- Hopeful to show impact for future reimbursement
- Innovation

Example clinical scenarios

- COPD exacerbation
- Asthma exacerbation
- CHF exacerbation
- Cellulitis
- Hyperemesis
- Pneumonia
- Hyperglycemia
- Asymptomatic severe hypertension

Data

- Approximately 66 patients enrolled so far
- No safety or quality issues
- High patient satisfaction
- In process of trying to expand program

Barriers

- What have been our current barriers to volume?
  - Lack of an open hospital/ED
  - Difficulty with incentivizing the primary care providers to use MIH
  - Has our ED substitution model been too narrow?

Our Acute Care at Home Journey : MIH to H@H

June 2024

Jason Tracy, MD

CMO South Shore Health

South Shore Health

Our Reason for Action

South Shore Health

- A 2019 Community Health Needs Assessment (CHNA) identified three key gaps in in service on the South Shore:

  1. Access to Care
  2. Real-time Behavioral Health Services (Patients with both Substance Use Disorder and Mental Health and Services)
  3. Services to Aging Adults with chronic and co-morbid conditions

- Launched in March 2020, the SSH Mobile Integrated Health Care (MIH) program has been instrumental in improving these gaps in services as well as being a resource to provide timely care to patients in the community.

- MIH supports the SSH mission to deliver the right care, in the right place, at the right time through a coordinated, team-based approach.

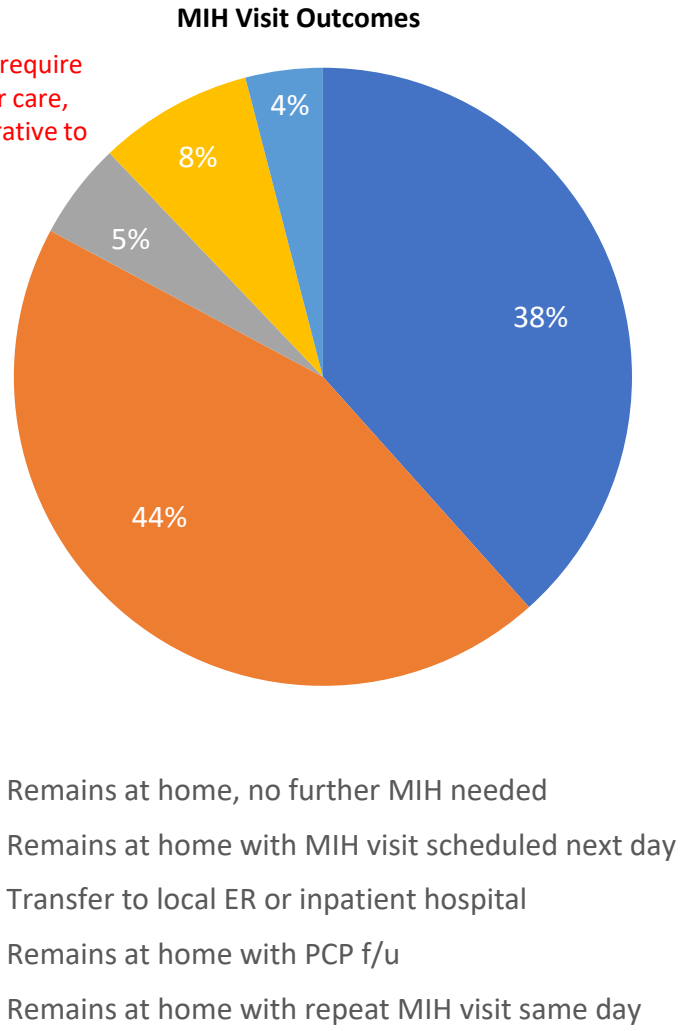
- Our program was the first hospital-affiliated MIH program in the Commonwealth.

South Shore Health

MIH Patient Population, Volume and Outcomes

- The goal of MIH is to work with patients who are at risk and better suited to be cared for in a different care setting including those with chronic conditions, the elderly, and high-utilizers
- Since our launch in March 2020, SSH MIH has conducted more than 15,000 patient visits
- We offer 17 visits per day, 7 days a week, 365 days a year

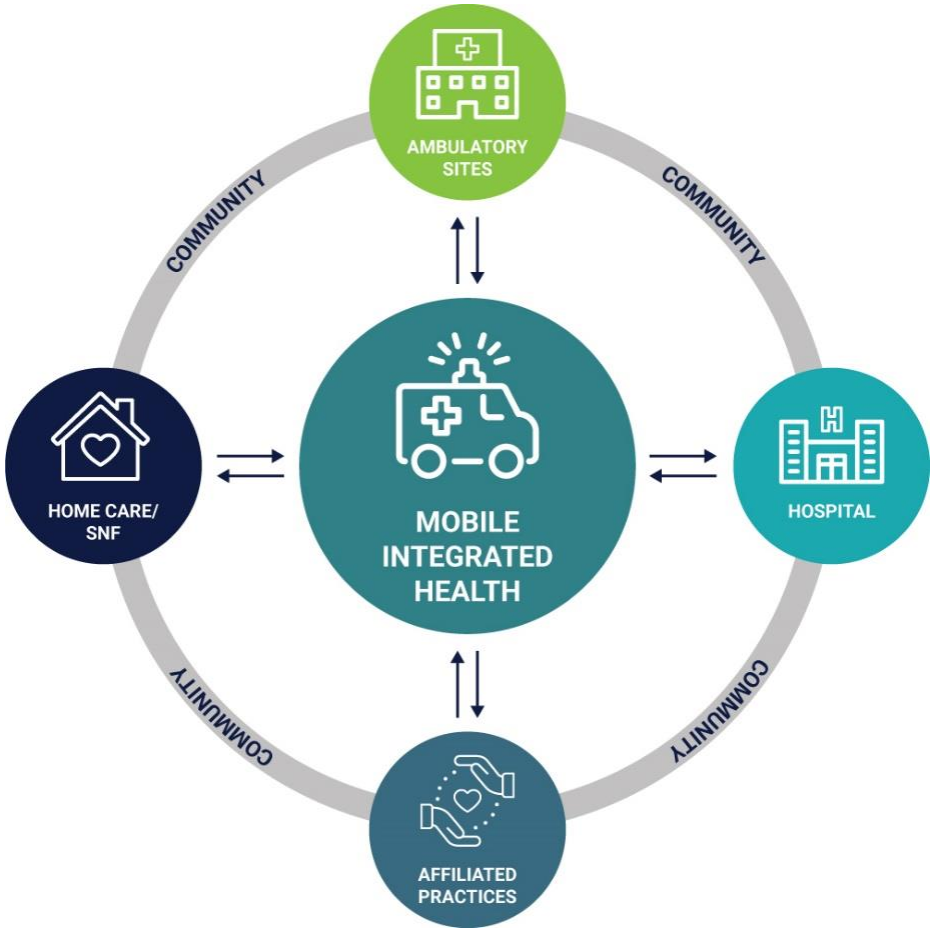
Only 5% of MIH patients require transfer to a local ED for care, making MIH a viable alterative to ED overcrowding



MIH Challenges

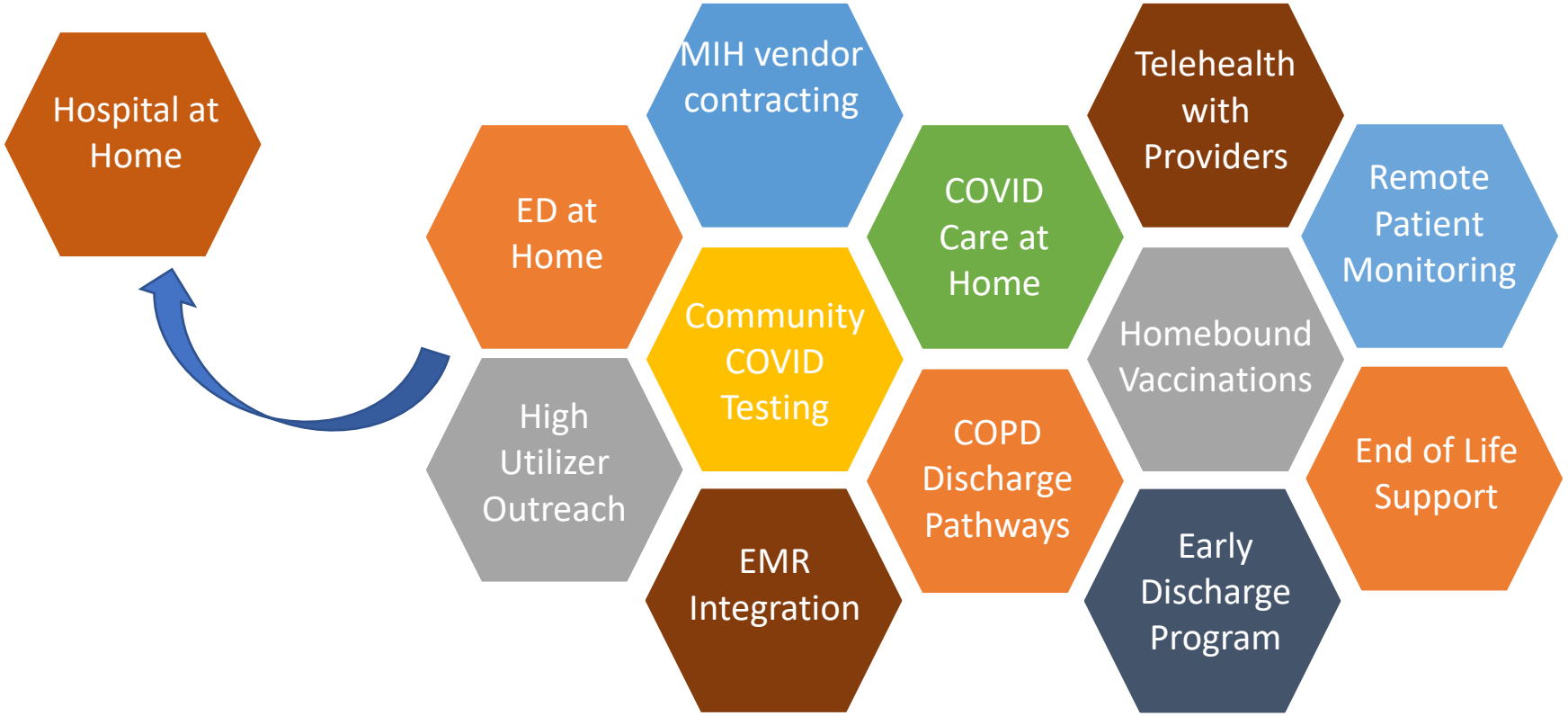
South Shore Health

- Proliferation of MIH services in Massachusetts remains challenging
- There is currently no mechanism for reimbursement for a paramedic visit that does not result in transport to the hospital
- SSH MIH made the decision to shift to a vendor model to remain financially viable
  - External groups and agencies with an interest in keeping their patient populations out of the ED or hospital (ACOs, affiliated practices, SNFs, home-health agencies) contract with MIH to provide services to their patients
  - SSH MIH bills insurance directly for all covered services (lab, imaging, etc)
  - Non-billable MIH paramedic services are billed to the vendor partner, who may or may not pass these charges through to the patient



Building Blocks of MIH

Since our launch in March 2020, MIH has expanded rapidly to meet the demands of our system and community, including COVID care for patients during the pandemic, and now to Hospital at Home.



Our Transition to H@H

South Shore Health

- Extension of the CMS Acute Care at Home waiver and DOI response regarding commercial coverage for H@H opened the door for SSH to consider a large scale investment in H@H
- Our existing MIH program and knowledge of the acute care at home landscape paved the way for us to make this transition
- SSH H@H will go live in June 2024
- SSH MIH will continue to exist as an ED at Home program based on vendor contracts with the goal of providing acute care at home as an alternative to the ED
- SSH MIH staff will also support the new SSH H@H program

Program Comparison

South Shore Health

Hospital at Home (HAH)

For patients who require inpatient-level hospital care and are stable enough to receive it in their homes

Patients receive

- 24/7 Virtual monitoring by RN with in-home biometric monitoring and communications kit
- Minimum of twice daily in person visits (paramedic/RN) with RN Care Plan
- Daily virtual rounding visit with physician
- All services of med/surg floor (therapies, chaplain, social work, case management, DME, meals, etc)

Managed as med/surg unit

Mobile Integrated Health (MIH)

For patients who require same day urgent visit for triage and limited treatment

Patients receive

- In-home visit by MIH paramedic
- Virtual Visit with MIH/ED APC or physician
- In-home diagnostics and treatment

Managed as ED/Urgent Care

Home Health (VNA)

For homebound patients needing intermittent skilled services (RN/PT/OT/ST) for a limited time

Patients receive

- Skilled visits 1-3 x weekly based on care plan
- Coordination of care with outpatient physician

Managed as Outpatient and/or post-acute

H@H Early Lessons @ Week 2

South Shore Health

Immediate positive impact towards improved patient experience and care.

- **Improved Care and Patient/Family Experience:**
  - 24-hour **acute hospital level of care** delivered by our dedicated care team of hospitalists, nurses, paramedics, and others from the comfort of patients' homes for qualified clinical conditions
  - Improved **patient recovery**, family involvement, and overall healing environment
  - Reduce **avoidable hospital-acquired infections** and + impact on morbidity and mortality

- **Improved Efficiency of South Shore Health Care Delivery**:
  - **Expand South Shore Health's med/surg bed** capacity without brick and mortar construction
  - **Improved patient flow** through ED, IP, Discharge
  - Supports **care innovation** to help recruit/retain the top talent of physicians, APCs, nurses, and other staff
  - South Shore Health has secured the **CMS waiver** for the Hospital at Home unit, supports the financial health of our organization

H@H Early Lessons

South Shore Health

Early Lessons

- We've provided care to…
  - Patients with the following admitting diagnoses: colitis, pyelonephritis, pneumonia, diverticulitis, CHF, COPD and cellulitis
  - Patients who needed blood sugar checks, I&O readings, oxygen supplementation and adjustments, dietary supplements and controlled substance delivery/management
  - Patients in Quincy, Weymouth, Abington, Pembroke, Whitman and East Bridgewater
  - Our oldest patient so far was a 92 year-old
  - With support from multiple service lines including surgical specialists

Projected growth

June 2024 10-Patient Unit → June 2029 **50-Patient Census**

Thank You

Mobile Integrated Health (MIH)

At BID-Plymouth

Jennifer McColgan, PA-C, MPH
MIH Coordinator

Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

MIH at BID-Plymouth

- Our MIH program provides follow up to patients who have recently been in the hospital for treatment of new or existing health conditions and who are able to safely continue recovery at home. We have partnered with Brewster Ambulance Service and local Fire Departments, who are trusted in the community and have a reputation for providing high-quality care.

- BID-P started as a self-funded MIH program, which went into operation December 2022. Effective June 1, 2024, Brewster was awarded a grant that covers the cost of patient visits within Plymouth County and provides a dedicated truck to MIH services.

- Currently providing patient care Monday – Friday 8am – 5pm, Saturday 9am – 12pm for patients living in Plymouth County.

MIH: Scope of Care

Care is provided for a vast range of conditions & symptoms including, but not limited to:

- **Heart Failure** -ex.-IV/PO diuresis, ECG, assess O2 status, vitals and weight
- **COPD** - ex.-nebulizer treatments, assess home oxygen use/safety, PO/IV steroids
- **Electrolyte imbalance, dehydration**- ex.-IV fluids, iStat labs, assess food insecurity
- **GastroIntestinal: diarrhea, nausea** - ex.- IV fluids, anti-emetic, anti-diarrheal
- **Genitourinary: UTI, hematuria** – ex. - urine dip test & to lab for culture
- **Respiratory: bacterial/viral illness, bronchitis, PNA, dyspnea** – testing, start antibiotics, complete IV remdesivir for COVID-19
- **Infectious disease** – administer/teach IV antibiotics, draw labs, midline dressing change / removal
- **Wound care –** wound assessment, packing, dressing changes, wound vac

MIH Data: Geography

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
TOTAL	**56**	**36**	**42**	**78**	**70**	**93**	**108**	**110**
Plymouth	32	17	27	41	34	40	36	41
Marshfield	0	0	1	4	7	12	11	11
Plympton	0	1	0	2	0	0	0	2
Middleboro	10	8	8	10	6	11	9	9
Duxbury	9	4	2	0	0	0	5	3
Carver	0	0	0	1	12	18	23	15
Kingston	4	6	0	10	1	3	1	1
Pembroke	1	0	0	0	0	0	0	1
Lakeville	0	0	0	5	3	5	9	12
Wareham	0	0	0	0	0	0	0	0
Hanover	0	0	1	0	0	0	2	7
Bridgewater	0	0	3	5	4	4	3	2
Halifax	0	0	0	0	3	0	9	6

MIH Data: Services

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
TOTAL	**56**	**36**	**42**	**78**	**70**	**93**	**108**	**110**
Well check and vitals	20	14	26	33	26	46	47	38
Lab draw or iStat	12	15	9	18	30	37	41	33
POC testing - urine, strep, covid, flu, Hcg etc.	0	0	1	3	14	12	8	9
Respiratory assessment may include inhaler or neb tx	5	8	3	15	4	6	19	15
Cardiac assessment may include ECG, diuresis, etc.	3	1	5	5	6	6	12	10
Wound Care	24	12	5	12	0	0	7	12
Medication administration may include IVF, antibiotics, etc.	1	0	2	3	10	6	17	17

MIH Data: Return to ED / Readmissions

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
TOTAL	56	36	42	78	70	93	108	110
30 Day ED Visit	3	1	13	8	4	11	3	
7 Day Readmission	1	1	1	3	0	0	2	
30 Day Readmission	0	0	0	1	7	6	2	
High Lace/30 day Readmits : # 30 day readmission	0	0	0	0	4	5	3	

MIH: Patient Feedback

Survey Response to “Is there anything we could have done to improve your last visit?”

- “Not a thing, I love this program. Jen McColgan is doing a great job with this program. She has been so good for me. She really cares for her patients.”
- “To the mobile integrated health team, thank you so much for all of the work you do. You have gone above and beyond all expectations and have provided the highest level of care and support. I just want to say thank you.”
- “The MIH Team and program is EXCELLENT. Thank you for being there for us.”
- “There is not a thing that could have been any better. I receive such great care from all the mobile team.”
- “Nothing. Everyone has been amazing. Can tell they truly care. They take the time and answer questions. Jen the PA is absolute best. Lauren and Kiley who schedule appointments are also the best. Very thankful for this program.”

MIH: Lessons in Developing a Program

-Create a structured referral process

-Develop relationships and buy in with key individuals/departments (eg- case management)

-Have the infrastructure to educate / expand the scope of practice of the paramedics based on need

-Truck / paramedic availability as the program grows. Consider pay per patient visit versus cost of a dedicated truck.

MIH: Growth

We started with strictly accepting patients who were admitted to BID-P and needed our services at discharge. In an effort to reach more patients and reduce hospital readmissions, we implemented the following:

- -We now also accept patients from the Bay Path Complex Patient Care program and from our out-patient palliative care program

- -As of April 15th we have partnered with our ED and accept referrals from there for next day visits of patients who need close follow-up, but do not require admission.

- -We have also partnered with the wound center to expand our scope of practice and are able to accept patients for wound vac care and telehealth visits.

- Thank you

Q & A

Adam Delmolino

Senior Director, Virtual Care & Clinical Affairs

Massachusetts Health & Hospital Association

Appendix

US-based MIH trials

Study	Study Design/Level of Evidence	Population	MIH Model	Outcomes
Abrashkin et al. (2019)	Prospective, single-arm observational study N = 1159	US (NY), suburban/urban Mean age 86 years 65% female Homebound with 2+ chronic conditions	ED Substitution: Home-based CP visit with telephone/video consultation from physician Dispatch from RN-run call center (used AMPDS, separate from 911)	Only 17.9% of all responses and 21.0% of high acuity responses resulted in transport to the ED Post-visit surveys: 90% of patients/caregivers reported that they would have either called 911 or gone to ED w/o this program
Carlson et al. (2022)	Prospective cohort study N = 948 (control only N = 57)	US (MA) Mean age 81 (intervention), 80 (control) 71.2% female (intervention), 57.9% female (control) Adults with frailty, disabilities, or limited mobility and significant challenge coming to brick-and-mortar clinic	ED Substitution: Referrals from PCP accepted Mon-Fri 7 AM–6 PM (not after-hours, not 24/7) Pts seen by APPs/PAs/NPs	Intervention had lower (insignificant) adjusted odds of 30-day ED visits (OR: 0.83 [p=0.56]), all-cause inpatient hospitalizations (OR: 0.64 [p=0.21]), and medical inpatient hospitalizations (OR: 0.6 [p=0.14]) 27% of intervention grp had ED visit w/in 30 days of enrollment vs. 31% of controls (adjusted) ; 18% of intervention grp had all-cause inpatient hospitalization vs. 25% of controls (adjusted) . Note low power 2/2 small control group and no after-hours availability
Iezonni et al. (2018)	Observational N = 539 patients, 771 encounters	US (MA) Commonwealth Care Alliance members	ED Substitution: 6pm-2am RN-triaged call center via PCP office could trigger home-visit by CP with remote input from PCP/physician	Data divided quarterly over 2 years ED transports w/in 1 day 13.7-22.9% ED transports w/in 2-3 days 3.9-11.5% Required another urgent home visit w/in 90d of first visit 11.4-30.2%
McGrath et al. (2023)	Prospective, single-arm observational study N = 3666	US (MA) Mean age 79 68% female	ED Substitution: Urgent home visits performed by virtual EM physician and in-home clinician Referrals placed by PCP, then addressed by RN-triaged call center	3,056 (83.4%) remained at home; 610 (16.6%) escalated to ED. Of those sent to ED, 510 (83.6%) admitted to the hospital. Of patients who remained at home, 380 (12.4%) had ED visit w/in 7 days of home visit and 325 (85.5%) of these pts were admitted.
Nejtek et al. (2017)	Retrospective, pre/post N = 64	US (TX), urban Mean age 49.7 ; 53.1% female Eligible if (1) transported to the ED ≥4x w/in a 1-yr period during 2013–2015 for non-emergent or primary care treatable condition, (2) ability to follow medical advice, (3) engage in navigational assistance, and (4) proactively seek health resources outside the ED	Participants received access number available 24/7 to request a MIH visit. 9-1-1 calls were identified by EMS dispatchers and MIH team notified to provide 'on-demand' services Some non-emergent health services	Post-program ED transports ($Z = -5.29$, $p<0.000$), ED admissions ($Z = -6.28$, $p<0.000$), and inpatient hospital admissions ($Z = -2.94$, $p = 0.003$) were significantly lower
Roeper et al. (2018)	Retrospective, observational case-control study N = 2315	US (FL), predominately urban Mean 74 years (intervention), 75 years (control) 58% female (intervention), 57% female (control) Post-hospitalization, high risk/chronically ill, palliative support	ED Avoidance and ED Substitution: Pre-scheduled and urgent home-based CP visits by with consultation from physician RN-triaged call/text hotline	Focused primarily on cost savings as outcome. Impact analysis found $2,407,612 in net savings over 6 mo of care w/ MIH compared to usual care Risk-adjusted utilization as a 6 mo mean per 1000: in intervention group, pre- compared to post-intervention, inpatient utilization decreased by 5.91 and ED utilization decreased by 9.28. In the control group, pre/post inpatient utilization increased by 5.77 and ED utilization increased by 4.62; $p<0.05$.
Somers et al. (2020)	Prospective, single-arm observational study N = 144	US (MD), urban Median age 53 43.7% female General population	ED Substitution: Low-acuity 9-1-1 medical complaints triaged to home visit by CP/NP/physician 9-1-1 call center	94 (65%) treated on scene (3 of these presented to ED w/in 72h), 37 (26%) transported to urgent care, 1 (0.6%) transported to same-day PCP apt and 12 (8.4%) transported to the ED. Compare to 65% transport rate of all 9-1-1 calls.
Tyano et al. (2021)	Prospective cohort study N = 2759 EMS calls	US (GA), urban Mean age 51 (MIH), 56 (traditional) 48.9% female (MIH), 50.5% female (traditional) General population	ED Substitution: Low-acuity 9-1-1 medical complaints triaged to home visit by CP/EMT/PA/NP 9-1-1 call center	MIH: 66.1% mitigated on-scene, 33.9% transported; traditional: 11.4% mitigated on-scene, 88.6% transported. OR for mitigation MIH compared to traditional = 24.19; $p<0.001$

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