

RESOLUTION NO. 19-R-90

**A RESOLUTION AUTHORIZING THE EXECUTION OF A
MOBIL INTEGRATED HEALTHCARE-PILOT PROGRAM**

BE IT RESOLVED that the Mayor and Deputy City Clerk are hereby authorized and directed to execute and deliver on behalf of the City, an Amended Mobil Integrated Healthcare-Pilot Program Agreement with Northwest Community Hospital.

YEAS: Bisesi, D'Astice, Sanoica, Cannon, Budmats,

NAYS: 0

ABSENT: O'Brien

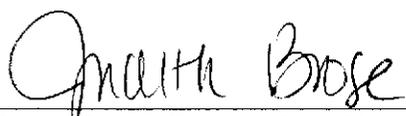
Abstain: Vinezeano

Passed and Approved this 13th day of August, 2019.



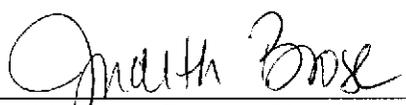
Joe Gallo, Mayor

ATTEST:



Judith Brose, Deputy City Clerk

Published this 14th day of August, 2019



Judith Brose, Deputy City Clerk

**NORTHWEST COMMUNITY HOSPITAL
MOBILE INTEGRATED HEALTHCARE – PILOT PROGRAM
PARTICIPATION AGREEMENT**

THIS MOBILE INTEGRATED HEALTHCARE PARTICIPATION AGREEMENT (the “**Agreement**”) is effective as of September 9 2019 (the “**Effective Date**”) by and between the **CITY of ROLLING MEADOWS** (“**EMS System Agency**”) and **NORTHWEST COMMUNITY HOSPITAL** (“**NCH**” or “**Hospital**”).

WHEREAS, As part of its mission to promote the health of the community, NCH arranges for the provision of a variety of clinical and related services to its patients; and

WHEREAS, NCH is launching a Mobile Integrated Health Care Pilot Program (“**MIH**” or “**Pilot Program**”) to provide in-home follow-up care and mobile resources to patients discharged from either an inpatient or outpatient visit at NCH in an out-of-Hospital environment; and

WHEREAS, The primary goal of the Pilot Program is to reduce preventable Hospital visits and post-discharge readmissions by creating an innovative, community based healthcare resource through collaboration with its municipal emergency medical services partners; and

WHEREAS, on April 24, 2018, *the Illinois Department of Public Health* provided written confirmation of its approval for Phase 1 of the MIH Pilot Program; and

WHEREAS, NCH and EMS System Agency wish to collaborate for the purpose of facilitating the MIH opportunity to provide critical services, which may include but are not limited to, telephone advice to 9-1-1 callers instead of resource dispatch; community paramedicine care, chronic disease management, preventive care or post-discharge follow-up visits, and transport or referral to a broad spectrum of appropriate care, not limited to Hospital emergency departments.

NOW, THEREFORE, in consideration of the mutual promises, covenants and agreements hereinafter described, NCH and EMS System Agency agree as follows:

I. RESPONSIBILITIES OF NCH

- 1.1 Manage the fully integrated Pilot Program as described in **Exhibit A**.
- 1.2. Provide EMS Medical Direction (“**EMSMD**”); Community Paramedic (CP) education, competency measurement and credentialing; determine CP scope of practice and practice guidelines; determine and provide medical equipment and resources; and documentation technology and software within the pilot scope.
- 1.3 Compensate EMS System Agency according to the compensation program and terms set forth in **Exhibit B**.
- 1.4 Perform all of its obligations and responsibilities hereunder in compliance with all applicable laws and regulations.
- 1.5 Provide any and all training of each CP who shall be solely under the direct supervision and control of NCH.

II. RESPONSIBILITIES OF EMS SYSTEM AGENCY

- 2.1 Accept the compensation as listed on Exhibit B as full and final compensation for the Services Provided.
- 2.2 On or before the initiation of any services contemplated hereunder, EMS System Agency shall obtain and/or maintain all license, permits and approval necessary to provide the Services, as defined on Exhibit C.
- 2.3 Provided NCH is not in default, provide the Services as indicated on Exhibit C.
- 2.4 Comply with all applicable laws and regulations as well as all NCH policies, procedures and Pilot Program requirements as promulgated by NCH and the EMS MD.

III. TERM AND TERMINATION

THE TERM OF THIS AGREEMENT SHALL BEGIN ON THE EFFECTIVE DATE AND SHALL EXPIRE UPON COMPLETION OF PHASE ONE OF THE PILOT WHICH SHALL EXTEND UNTIL 480 PATIENTS ARE ENROLLED OR 12 MONTHS ELAPSE, WHICHEVER OCCURS FIRST. Notwithstanding the foregoing sentence, or any other provision of this Agreement to the contrary, either party may terminate this Agreement for any reason, or no reason, by giving thirty (30) days' written notice to the other party.

IV. CONFIDENTIALITY

Both parties, their elected officials, officers, employees, subcontractors, representatives and/or agents, including any student or trainee of either NCH or EMS System, shall treat and maintain as confidential information, any information regarding the other party's programs, processes, costs, equipment, operations or customers which may be disclosed to or come within the knowledge of the parties, their elected officials, officers, employees, subcontractors, representatives and/or agents, in the performance of this Agreement, and shall not use or disclose its confidential information to the other party except as is necessary to perform the Services.

The provisions of this Section IV shall not apply to any information referred to in this Section which either party establishes (1) has been published and has become part of the public domain other than by acts or omissions of the other party, its employees, representatives or agents; (2) has been furnished or made known to the other party by third parties as matter of legal right and without restriction on disclosure or use; (3) was in the other party's possession prior to disclosure by such parties and was not acquired by the other party, its employees and agents directly or indirectly from the other party; or (4) is required to be disclosed under the

Freedom of Information Act (5 ILCS 140/1 *et seq.*) or other law, rule or order mandating disclosure. NCH shall deliver, within the time frame set forth in the Freedom of Information Act, copies of records which the EMS System Agency is required to produce pursuant the Freedom of Information Act.

Except as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the rules promulgated thereunder, neither party nor any of its employees, representatives, or agents, including any EMS practitioner, student or trainee of either NCH or EMS System Agency, may use or disclose any individually identifiable health information ("PHI") acquired in the performance of this Agreement.

V. INSURANCE REQUIREMENTS

EMS System Agency shall procure and maintain for the duration of the Agreement insurance against claims for injuries to persons or damages to property that may arise from or in connection with the performance of the Pilot Program in amount stated below:

- (1) Automobile Liability: \$1,000,000 combined, single limit per accident for bodily injury and property damage.
- (2) Professional Liability: \$3,000,000 per occurrence and in the aggregate liability limit for errors and omissions, professional/malpractice liability for Community Paramedics.
- (3) Workers' Compensation and Employers' Liability: Workers' Compensation statutory limits as required by the Labor Code of the State of Illinois, and Employers' Liability limits of \$1,000,000 per accident.

VIII. RECORDS RETENTION

EMS System Agency shall maintain books and records relating to the performance of this Agreement in accordance with applicable law. All books and records required to be maintained by the EMS System Agency shall be available for review and audit by NCH. NCH shall retain all records relative to the Pilot Protection program pursuant to the Illinois Records Retention Act.

IX. NOTICES

Except as otherwise specifically provided in this Agreement, any notice required or permitted to be given under this Agreement shall be in writing and (1) delivered in person, which delivery the recipient agrees to acknowledge in writing; (2) deposited with the United States Postal Service, having first-class, registered or certified mail return receipt requested postage fee prepaid; or (3) sent via email or a nationally recognized overnight courier service. Such notice must be addressed as follows, or to such other address or individual as either party may specify from time to time by written notice given by such party.

If to **EMS System Agency**, it shall be addressed to:

City of Rolling Meadows
Attention: Chief Terry Valentino
Address: 2455 Plum Grove Road
Rolling Meadows, IL 60008

Telephone Number: 847-870-2990
Email: valentinoT@cityrm.org

If to NCH, it shall be addressed to:

Northwest Community Hospital
ATTN: Connie J. Mattera, MS, RN, Paramedic
DIRECTOR OF MOBILE INTEGRATED HEALTHCARE
800 W. Central Road
Arlington Heights, IL 60005
Telephone Number: 847/618-4485
847/493-9974 Cell
Email: cmattera@nch.org
Copy to the General Counsel at the same address.

X. ASSIGNMENT/NO THIRD PARTY BENEFICIARIES

Neither party may assign, subcontract, delegate or otherwise transfer this Agreement or any obligations or responsibilities hereunder without the other party's prior written consent. The parties agree that such consent shall not be unreasonably withheld.

XI. ENTIRE AGREEMENT

This Agreement and each of its Exhibits incorporated as though fully set forth herein constitute the entire agreement between EMS System Agency and NCH with respect to the subject matter hereof.

XII. APPLICABLE STATE LAW

This Agreement shall be construed under and governed by the laws of the State of Illinois, and all actions brought to enforce any item of this Agreement shall be so brought in the Circuit Court of Cook County, Illinois.

Each party represents and warrants that the person whose name appears on the signature page below has or has been delegated the lawful authority to enter into this Agreement on behalf of that party.

NORTHWEST COMMUNITY HOSPITAL

BY: *Eileen Sullivan*

DATE: *7-12-19*

ITS: *Executive Vice President, CNO*

EMS SYSTEM AGENCY

BY: *J. Gallo*

DATE: *8/13/19*

NAME: *Joe Gallo*

ITS: *Mayor*

EXHIBIT A

DESCRIPTION OF THE PILOT PROGRAM (For full description see Pilot Plan)

The focus of the MIH pilot is to **safely transition patients with target diagnoses from Hospital to home** and optimize their health by adding the option of **early home visits by an MIH-CP** that is commensurate with a risk assessment, person need, and program standards of practice.

MIH-CPs partner with and do not compete with existing care delivery models and/or services

The MIH Pilot reflects a balance of effectiveness, efficiency and equity and is an extension of the NCH Clinical Care Coordination model. It is based on community and person needs, regulatory requirements, national standards, best practice models, and technological advances while being ever considerate of scarce human and economic resources that must be applied in a manner that promotes the safety, health and welfare of all persons enrolled.

The ultimate goal is to **achieve more home and less Hospital** or skilled nursing facility-based care. The MIH-CPs are important resources in helping patients bridge these transitions.

PILOT GOALS:

- Enhance the NCH Coordinated Care delivery model by establishing partnerships with MIH CPs
- Meet the outcome points from the IHI Triple Aim Initiative to optimize health system performance:
 - **Improve the patient experience of care** including **quality and satisfaction** as evidenced by an increase in patient experience scores that are based on US IOM Quality Chasm key dimensions: safe, effective (evidence-based practice), timely, and efficient care.
 - **Improve the health of target populations** and clinical outcomes via early patient engagement; enhanced understanding/compliance with DC care plans; exploring and overcoming challenges to compliance; identification of therapy failures; closing care gaps, providing effective health coaching, and improving patient quality of life evidenced by a **reduction in avoidable Hospital and unscheduled ED readmissions by 10%** in target patients. Increase engagement with PCPs; support/generate NCH primary care appointments.
 - **Reduce costs** evidenced by a reduction in CMS penalties in target populations by 5%.
- **Enhance patient safety** and reduce home falls and fires via safety/wellness checks; fall abatement strategies, installation of working CO and fire detectors, and community education.
- **Decrease dependency on the 9-1-1 system**; encourage appropriate use of EMS for persons enrolled in the pilot evidenced by a reduction in calls to EMS for non-emergency causes to < 5 per year.

The state-approved MIH concept design serves as the basis for the initial pilot project plan. Persons who have frequent contact with EMS and Hospital readmissions often have multiple medical problems, comorbidities and complex psychosocial circumstances. These health issues cannot be solved by a single entity, but require the expertise of a variety of healthcare providers, social services agencies, and community resources. Key partnerships enable MIH-CPs to match each person's needs with the right resources (NAEMT, 2015).

Eligible Patients: ≥18 years old; live in the EMS Service area covered by the Palatine FD, Palatine Rural Fire Protection District or the Rolling Meadows FD

Conditions: Heart attack (AMI), heart failure, chronic obstructive pulmonary disease (COPD), pneumonia, or after a major joint replacement (hip, knee)

Enrollment: Before discharge, eligible patients will be referred by a Clinical Care Coordinator (C3) at NCH following a readmission risk assessment. The patient and their Primary Care Practitioner must consent to this service per Illinois Department of Public Health policy.

Community Paramedic (CP) model: A specially credentialed paramedic will visit consenting patients in their home within hours to days of discharge at a date and time agreed to in advance. The CP will assess how well they are doing, if they understand and are complying with their discharge plan, and whether they are meeting health targets. The CP can answer health-related questions, ensure that the patient can properly use equipment prescribed for use in the home, provide community resource information as needed, and do a home safety check.

There is **no cost** to the patient for this service.

Timing and number of anticipated visits is based on the **Readmission Risk Calculation** (see full pilot plan). The total number of actual visits may be modified based on PCP or MIH-CP request and as approved by NCH.

No financial, technical, social, physical, or age-related barriers should exist for those eligible for an MIH-CP response. Qualified practitioners shall assess a patient's health status, make a determination regarding the most appropriate resources to be mobilized, and implement an effective course of action based on patient and PCP consent and within MIH standing medical orders. Each person enrolled in the pilot will have the opportunity to engage in the process of reaching their highest potential for health.

Community paramedic duty assignments and response

For the pilot, CP on-call and response are outside of the usual and customary paramedic duty schedule.

- **Routine MIH response:** One MIH-CP will respond in a specially branded vehicle (non-ambulance) wearing an MIH-branded duty uniform and department identification.
- If there is a known language barrier, all attempts will be made to have a community service member affiliated with NCH who is an approved translator accompany the CP. Other options include the use of an electronic device to access an appropriate interpreter while on site.
- If a patient is acutely unstable, requires lifting or moving from the floor or from a position that would require two individuals to safely assist them, the CP shall call 911.

MIH responses/CP time aliquots – depends on whether an enrollment or follow-up visit

Average 1.5 -2.5 hours:

- Enrollment visit patient care contact time: 1-1.5 hours; follow-up visits: 40 minutes.
If translation services are required, the visit may take longer to allow for 3-way communication.
- 15 min for travel (round trip)
- 30 min for documentation and communication with HUB/PCP

Service volumes and capacity: Based on market analysis and projected volumes; initial staffing will need to cover at least **4 visits per day** with surge capacity for **8 visit/day** if personnel and resources allow.

- ✓ Anticipate 40 visits per month
- ✓ 480 visits within the pilot year (may be very high estimate for first year)

CP resources: The staffing plan will require a minimum of 6 and optimally 9 credentialed CPs (2-3 per shift)

Hours of operation and staffing plan:

- M-F from 0900-1700: A minimum of one CP scheduled and available to complete visits.
Initially, a second CP shall be on-call to cover a surge if needed for high risk patients until actual program needs are established. Also need to account for days off and vacation time.
- Sat-Sun 0900-1300: One CP on-call for high risk visits only

Pilot EMS organizations will partner with NCH to access resources and ensure quality education, credentialing of CPs, medical direction, evidence-based care protocols; coordination of care, qualitative and quantitative performance measurement and improvement strategies using national metrics and benchmarks, and reimbursement for costs.

EXHIBIT B: COMPENSATION

DIRECT COSTS – 2019 FIGURES

WITHIN 30 DAYS OF RECEIPT OF THE EMS SYSTEM AGENCY INVOICE, NCH WILL REIMBURSE EMS SYSTEM AGENCY BASED ON UNITS OF TIME: 1 HOUR = 1 UNIT

Enrollment visits are calculated at 2 units; follow up and graduation visits at 1-1.5 units. NCH shall be responsible for and pay the EMS System Agency all attorney's fees and costs incurred by the EMS System Agency to collect invoices for Services that are overdue in excess of 30 days.

Unit Costs per visit

\$83.98	Wages (\$80/hour + 3.98 Workers Compensation)
\$ 5.80	Vehicle (branding, insurance; gasoline, mileage at \$0.58/mile x 10 miles)
\$ 8.98	Equipment restocking cost (10% of wage & vehicle)
\$ 8.98	Ongoing CE training (10% of wage & vehicle)
<u>\$ 8.98</u>	Administrative fee (10% of wage & vehicle)
\$116.72	Total estimated unit costs
<u>\$ 35.00</u>	<u>~30% safety or contingency factor (Uniform shirts with specific Community Paramedic logos/patches; monthly subscription costs for air cards/internet accessibility)</u>
\$150.00	TOTAL UNIT COST

Total anticipated visits: 40 visits/month /480 visits within pilot year (may be very high for first year without AHFD in the pilot from the beginning)

Other initial costs:

1. **Initial education cost \$58.49/hour x 40/hours = \$2,339.60 / member**
2. **Required Equipment** - Agencies will look to see if they have any of these available within their reserves etc.)
 - Stethoscope; Sphygmomanometer
 - ECG monitor capable of obtaining BP, SpO₂, ETCO₂, rhythm strip and 12L ECG
 - Glucose meter and strips
3. **NCH will provide initial and replacements of the following:**
 - Central sensors for SpO₂; NC ETCO₂ sensor; scale
 - Communications devices to make phone calls and access a web browser / Electronic device that allows for contact with an interpreter
 - Electronic device that allows creation of the Image Trend MIH CP ePCR

Budget Cost estimations for NCH budget (FY19)

14 enrollment visits/month (\$150 X 2 X 14)	\$4,200/month X 12	\$ 50,400.00
26 follow-up visits/month (\$150 X 1.5 X 26)	\$5,850/month X 12	\$ 70,200.00
Initial education (\$2,339.60 per member X 12)		\$ 28,075.00
Cell phone \$80/month		\$ 960.00
I-pad or Chromebook or similar device for electronic charting/interpreter		\$ 350.00
Restock costs for ECG leads/sensors		\$ 200.00
Auto insurance cost		<u>\$ 2,000.00</u>
Total estimate pilot costs:		\$152,185.00

Sources of pilot funding:

For Providers:

- Pilot Agencies will invoice NCH for initial capitalization costs
- The agencies will invoice NCH in 0.25 unit increments for time actual spent conducting a visit, travel and charting, but \$150.00 will be the minimum cost billed per visit.
- The agencies will bill a minimum 1 unit/visit for a prescheduled response if the patient is not at home at the time of the scheduled visit.

For NCH: Initial capitalization costs have been offset by \$70,000 donated by philanthropy.

Cost savings realized prior to go-live:

- Agencies determined that they did not need to purchase a new vehicle to do MIH responses.
- EMS System negotiated MIH-CP fields to be inserted into existing Image Trend software saving \$17,000.

EXHIBIT C: DESCRIPTION OF THE SERVICES

CHECK ALL THAT APPLY:

- Reducing preventable readmissions to EDs/Hospital for enrolled patients with conditions such as AMI, heart failure, pneumonia, COPD, and/or major joint replacement or those that would be equally or better served at a non-Hospital site, including, but not limited to in the patient's home or primary residence. Readmission prevention services will include safety checks, follow-up calls/visits for previous NCH patients, working with home health agencies to provide follow-up visits, and where indicated, arranging for transportation of patients to alternate care delivery sites.
- Working with Hospital to provide appropriate dispensation for observation admissions to seek alternative care models based on implementation of the 2 midnight rules illness/injury prevention programs: Including but not limited to providing selective immunizations and community education.

Clinical services provided by MIH-CPs are broadly grouped into three categories:

Assessment and evaluation:

- Customary scene safety assessment when arriving, prior to entering, and while inside the home
- Review of Hospital discharge instructions and health targets with patient/caregiver. An individual has the right to get involved in the development and implementation of his/her person-centered plan of care which includes establishing goals (CMS regulatory text of tag F553). Identify each person's highest practicable level of well-being by exploring the seven dimensions of wellness. Support clients in setting their own health goals.
- **General patient assessment:**
H&P based on patient diagnosis and DC plan that may include, but not be limited to: weight, VS; SpO₂; ETCO₂, ECG, S&S peripheral edema; breath sounds, neuro assessments for cognitive impairment; wound healing, symptoms of infection/DVT.
- **Medication reconciliation and compliance:** Ensure that current prescriptions are filled; being taken as prescribed; and old/expired meds are appropriately removed from home/discarded. Ensure ongoing medication access/delivery from Hospital or selected pharmacy. The MIH program partners with the NCH pharmacy director or designee to secure pill sorters for distribution prn and to identify electronic drug information resources that work on devices with a browser to use as references for CPs
- **Assess that needed medical resources are available in home:** Batteries for medical devices; home oxygen, ambulation aids; need for Hospital bed?
- **Psychosocial needs assessment for community/ social services resources:** Transportation, nutrition, heat & utilities. Take the initiative to ask people what they need. Coordinate care with available community services as part of scheduled follow up care.

Disease-specific patient understanding and compliance with DC instructions:

- Demonstrated ability to do self-assessments/care, e.g. glucose checks, peak flow monitoring; MDI/ nebulizer/ incentive spirometry use; dressing changes/wound management; DVT prophylaxis

Prevention and Education

- **Understanding and compliance with making healthy choices** re diet, social habits, and exercise. Provide resources/coaching as needed.
- **Assess ability to perform activities of daily living:** Mobility – must they climb stairs to bed or bathroom; are they able to do that safely? Are they able to dress themselves, make meals, eat independently, do personal hygiene and toileting, and oral care?
- **Home safety check; fall analysis and risk abatement**

Post-visit communication and follow up with NCH and PCP