PROCARE
Mobile Integrated Healthcare

EXECUTIVE WHITE PAPER

The Case for Care Beyond Hospital Walls

Why Sophisticated Healthcare Investors — and Leading Health Systems — Are Betting on Mobile Integrated Healthcare

An Executive White Paper for Health System Leadership, Boards, and Investors

EXECUTIVE SUMMARY

Healthcare Is Moving Home. The Market Has Already Chosen a Leader.

American healthcare is undergoing a structural shift away from the hospital as the default site of care. Fixed global budgets under CMS's AHEAD model, the newly extended Acute Hospital Care at Home waiver, and a worsening clinical workforce shortage are together forcing health systems to find safe, credible ways to deliver acute and post-acute care outside their walls. Mobile Integrated Healthcare (MIH) — the deployment of paramedics and nurses into the home under physician supervision — has emerged as the clinical model built for this moment.

$29.2B

Projected 2028 U.S. ambulance services market (from $17.8B in 2023, 10.4% CAGR)

This is no longer a thesis. In April 2026, six institutional healthcare investors completed a strategic partnership with Procare Integrated Health and Transport — led by Prodos Capital and Manolin Investment Group, with Hyde Park Capital serving as advisor — citing its Mobile Integrated Healthcare program as, in the words of Prodos Capital founder Douglas Song, a "significant and differentiated growth opportunity." These are not passive checks. They are the considered judgment of investors who evaluate hundreds of healthcare platforms a year, applied to one company operating in the Mid-Atlantic.

Data collected and shared between Procare and Luminis explains why. In a 12-month pilot from March 2022 through March 2023 with Luminis Health Anne Arundel Medical Center, Procare MIH generated 583 patient referrals, saved 2,159 hospital days, and delivered a 149% return on investment. While the pilot was not designed as a formal 30-day readmission reduction effort, but rather as a bridge to fill the gap between discharge and the start of home healthcare services, the 30-day readmissions rates among high-risk patients were reduced from an expected 21% to an observed 15%. These are not projections. They are audited results from a live, operating partnership with one of Maryland's premier health systems. The MIH partnership continues to thrive to date and was expanded to include a CHF pathway with plans underway to include other high risk patient populations.

This paper makes the case in four parts. Part I establishes that the shift toward home-based, value-based care is an industry-wide movement, not a Procare initiative. Part II presents the independent validation: what sophisticated investors saw when they underwrote this model. Part III shows how Procare has already built it — the operating model, the clinical infrastructure, and the Luminis results. Part IV describes the broader platform Procare has built to serve health systems across the full continuum of acute, interfacility, and mobile care. Together, they answer the question every hospital CEO, CFO, and board member should now be asking: not whether care is moving into the home, but who is prepared to deliver it safely, at scale, today.

$17.8B → $29.2B

U.S. Ambulance Services Market, 2023–2028 (10.4% CAGR)

400+

Hospitals with active Hospital at Home programs, across 37 states

10%

Projected 2026 RN shortage nationally

20%

Projected 2026 LPN shortage nationally

PART I

The Future of Healthcare

Why care is moving beyond hospital walls — and why the shift is now structural, not experimental

Three forces are converging on health system leadership at once: a payment model that rewards keeping patients out of the hospital, a workforce that cannot staff the beds health systems already have, and a regulatory environment that has, for the first time, made home-based acute care a durable part of Medicare policy rather than a pandemic-era exception. None of these forces originated with Procare. They are reshaping the entire industry, and they explain why Mobile Integrated Healthcare has moved from a pilot-stage curiosity to a strategic necessity.

From Volume to Value: The Global Budget Imperative

The clearest signal of where healthcare payment is headed is CMS's States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. AHEAD places hospitals on fixed, prospective global budgets — a hospital is paid a predetermined amount for the year regardless of how many patients it admits. Under that design, an avoided admission or a shorter length of stay is value the hospital keeps, not revenue it forfeits.

2035

Year through which Maryland's AHEAD model runs, with other states following in subsequent cohorts

Maryland was the first state to commit, building on its decades-long All-Payer Model, and re-signed its AHEAD participation agreement in November 2025 ahead of the model's January 1, 2026 go-live. Connecticut, Vermont, Hawaii, Rhode Island, and regions of New York are following in subsequent cohorts, with the model running through 2035. CMS has explicitly built “potentially avoidable utilization” — including readmissions and avoidable admissions — into the financial methodology that determines each hospital's budget. Put simply: under AHEAD, keeping patients safely at home is not a nice-to-have. It is the mechanism by which a hospital protects its own budget.

For any health system operating under or preparing for a global budget, the strategic question is no longer whether to reduce avoidable utilization, but how — and how quickly a credible partner can be stood up to do it.

Hospital at Home Becomes Permanent Policy — and Needs Boots on the Ground

A parallel shift is underway in how CMS defines the hospital itself. The Acute Hospital Care at Home (AHCAH) waiver, first authorized in 2020, allows approved hospitals to deliver inpatient-level acute care in a patient's home. After years of short-term extensions that created planning uncertainty for health systems, Congress passed a five-year extension in the Consolidated Appropriations Act, 2026, running the program through September 30, 2030 — the longest runway the program has ever had. Nearly 400 hospitals across 37 states have stood up AHCAH programs, and a 2024 CMS evaluation found the model associated with lower mortality, reduced post-discharge spending, and high patient satisfaction.

The strategic question for most health systems is not whether to pursue Hospital at Home, but how to staff and operate it — particularly for systems bringing a Hospital at Home model into a new region for the first time. AHCAH's operational requirements are demanding: 24/7 clinical coverage, structured EMS coordination, daily in-home evaluation, and real-time escalation pathways back to the hospital. Building that clinical workforce and logistics infrastructure from scratch, market by market, is the single biggest barrier to scaling Hospital at Home beyond a health system's home territory.

This is precisely where Mobile Integrated Healthcare functions as enabling infrastructure rather than a separate initiative. A mature MIH program already operates with paramedics and nurses trained for in-home acuity, the physician-supervised protocols, the point-of-care technology, and the EMR integration that Hospital at Home requires — and it already operates them locally, under existing state licensure, with an established base of referring clinicians. The Rural Health Information Hub, a federally supported clearinghouse for rural health policy, identifies community paramedics as a workforce that can “play a role as part of the hospital-at-home clinical care model,” and the National

Association of EMS Physicians' 2025 position statement on MIH and community paramedicine similarly frames these programs as extensions of the care team that support exactly the kind of home-based acuity Hospital at Home programs are built to deliver. For a health system expanding Hospital at Home into a market where it does not yet have that workforce built out, an established regional MIH provider is not a competing model — it is the fastest, lowest-risk way to put boots on the ground.

A Workforce That Cannot Staff the Beds It Has

Even where health systems want to expand inpatient or in-home acute capacity, they increasingly cannot staff it. HRSA's National Center for Health Workforce Analysis projects a national registered nurse shortage of roughly 10% in 2026, with licensed practical nurse shortages reaching 20%, and rural markets facing considerably steeper gaps. The AAMC (Association of American Medical Colleges) separately projects a shortage of 13,500 to 86,000 physicians by 2036. The American Hospital Association's 2026 Health Care Workforce Scan identifies “mobile workforce pools” and redesigned care delivery models — not simply more hiring — as the strategies health systems are now turning to.

86,000

Projected U.S. physician shortage by 2036, upper bound (AAMC: 13,500–86,000)

This is the structural reality behind every capacity conversation in a hospital boardroom: adding beds, or adding a new site-of-care program, without the staff to run it solves nothing. A regional MIH provider that already employs and deploys this exact clinical workforce — rather than asking a health system to compete for the same scarce nursing and physician labor pool in a market it is newly entering — is not a convenience. It is one of the few levers available to launch a home-based acute care program on a realistic timeline.

Mobile Integrated Healthcare: The Delivery Engine for Care at Home

The industry-wide trend is unambiguous: acute, post-acute, and chronic disease care are all moving into the home. Hospital at Home addresses the acute inpatient-substitution use case; MIH addresses the broader and even more common set of transitional, post-discharge, and high-risk chronic disease needs that drive readmissions and unnecessary 911 utilization. In practice, the two are complementary layers of the same shift, and a well-built MIH program supplies both the clinical workforce and the technology backbone — EMR integration, remote monitoring, point-of-care diagnostics — that make a Hospital at Home program operationally viable in a new market, not a parallel track competing for the same investment dollars.

The Centers for Medicare & Medicaid Innovation has identified mobile integrated healthcare as a priority model for testing reimbursement structures that reward value over volume, and a growing peer-reviewed literature — including a 2025 NAEMSP position statement built on a rapid review of more than 200 published studies, and exploratory meta-analyses of MIH-CP's effect on emergency department utilization — documents its clinical impact independent of any single operator. What matters most to a hospital evaluating this model today is not whether it can work in theory, but whether a specific partner has already proven it works — inside real hospital workflows, with audited results, in the market that hospital actually operates in. Part III presents exactly that evidence for Procare.

Sources: Hyde Park Capital market research; American Medical Association; HRSA National Center for Health Workforce Analysis; CMS AHEAD Model and Acute Hospital Care at Home program materials; Rural Health Information Hub; National Association of EMS Physicians (2025 MIH-CP Position Statement, Prehospital Emergency Care).

PART II

Independent Validation

What sophisticated healthcare investors saw when they evaluated this model — and chose to fund it

Health system leaders evaluate dozens of vendor pitches and partnership proposals every year, most making the case for themselves. It is a different, and more durable, form of evidence when the case is made by investors who have no stake in a hospital's decision — only in getting the underlying thesis right.

In April 2026, that evidence arrived. Procare Integrated Health and Transport, a Baltimore-based provider serving the Maryland, Washington D.C., and Virginia markets, entered a strategic partnership with Prodos Capital and Manolin Investment Group. Hyde Park Capital served as exclusive investment banker on the transaction. Six independent institutions, each with its own underwriting process and its own capital at risk, arrived at the same conclusion about the same company.

Why the Structure Matters

This is expansion capital directed at scaling an operating model that already works — funding fleet growth, geographic expansion into Virginia, and continued build-out of the MIH program — not a leveraged financial restructuring of a distressed asset. It reflects investor confidence in a durable, contract-based commercial model, distinct from the government-reimbursement-dependent 911 emergency response sector that has proven far more difficult for outside capital to scale.

What the Investors Said

> *"We are particularly excited about the Company's MIH program, which we believe represents a significant and differentiated growth opportunity as healthcare systems increasingly look to partners that can help reduce readmissions and improve patient outcomes outside the hospital setting."*
>
> **— Douglas Song, Founder, Prodos Capital**

> *"The MIH program in particular has enormous potential to meaningfully improve outcomes for patients, reduce the burden on hospital systems, and create sustainable value for the communities Procare serves."*
>
> **— Dr. Thom Mayer, Operating Partner**

A Track Record That Predates the Investment

100%

Customer retention since Procare's founding in 2005

The investors were not underwriting a concept. Procare, founded in 2005, has maintained 100% customer retention since inception and is the only approved private commercial EMS provider of Mobile Integrated Healthcare services in Maryland. Its service line spans Basic Life Support, Advanced Life Support, Specialty and Critical Care Transport, Mobile Integrated Healthcare, and medical standby services, delivered under long-term contracts to what Hyde Park Capital's own materials describe as a “distinguished roster of healthcare institutions” across the Mid-Atlantic — a roster that includes an active MIH partnership with Luminis Health and an MIH Pilot with Kaiser Permanente.

Founder Debbie Ailiff described the capital as enabling continued investment in Procare's employees while the company expands geographically and strengthens its MIH capabilities.

For a hospital or health system evaluating Procare as a partner, this is the layer of assurance that self-reported case studies cannot provide: six institutional investors, applying independent diligence, concluded that this organization's MIH model is not only clinically sound but commercially durable. Part III turns to the operational and clinical evidence that earned that conclusion.

> *“One of the challenges hospitals face today isn’t simply getting patients home—it’s ensuring they continue to receive the right care once they get home. Too often, there’s a critical gap in care after discharge—one that Procare’s Mobile Integrated Healthcare program was built to close. Our 24/7 clinical workforce is already embedded throughout the communities we serve, allowing us to respond the same day a patient is discharged and provide physician-directed care in the home when it’s needed most. Just as importantly, many patients already know and trust our clinicians from previous interactions, allowing us to build on an existing relationship to support a safer recovery.”*
>
> — Mark Buchholtz, CEO, Procare Integrated Health and Transport

> *“What truly differentiates Procare is that we function as an extension of the hospital’s clinical care team—not simply by coordinating care, but by delivering physician-directed clinical care in the patient’s home. That clinical presence enables earlier, safer discharges, shortens length of stay, reduces avoidable readmissions, improves patient outcomes, and preserves valuable inpatient capacity.”*
>
> — Debbie Ailiff, Founder, Procare Integrated Health and Transport

PART III

Why Procare

One organization has already built the model the industry is moving toward — with the results to prove it

If Part I establishes that healthcare is moving toward home-based, value-based care, and Part II establishes that sophisticated healthcare investors have already validated Procare as a leader in that movement, this section answers the question a hospital CFO or Chief Medical Officer will ask next: does the model actually work, inside a real hospital, with real patients? The answer is a documented, 12-month partnership with one of Maryland's premier health systems.

Procare Mobile Integrated Healthcare: The Program

Procare Mobile Integrated Healthcare (Procare MIH) is Maryland's first and only licensed private Mobile Integrated Healthcare provider (MIEMSS #106). It deploys paramedics and registered nurses directly into patients' homes — under physician supervision, fully integrated with hospital EMR systems, and available around the clock. The objective is straightforward: close the gap between the day a patient is medically ready to leave the hospital and the day home health or outpatient support can actually begin, a gap that today too often results in either an unnecessarily extended inpatient stay or a discharge without adequate support.

How It Works

1. A hospital care manager or physician submits a referral through the Procare MIH order set, built directly within Epic.
2. Procare schedules the MIH visit with the patient and coordinates a telemedicine conference with the patient's physician when required by Procare's MIH Protocols.
3. A Procare paramedic or registered nurse is dispatched, often the same day, including weekends.
4. The EMS clinician performs a home safety check, fall risk assessment, patient assessment and medication reconciliation, and provides education to the patient as requested by the hospital. A physician affiliated with the hospital is conferenced in as required by Procare's MIH Protocols.
5. Treatment is administered per protocol and physician orders: IV therapies such as antibiotics or lasix, labs, wound care, asthma treatments, and more.
6. The EMS Clinician documents the patient encounter in a written patient care report uploaded to Epic. This provides vital information with the care team and provides a warm hand off to home healthcare.
7. Procare performs post-visit follow-up calls to the patients on Day 2 and Day 7 to confirm adherence to the patients' care plan and catch emerging issues before they become readmissions.
8. Outcomes are tracked, reported, and used for continuous quality improvement.

Clinical Services

ASSESSMENT

- Vital signs & clinical assessment
- Medication reconciliation
- Care plan compliance review
- Home safety evaluation
- Fall risk assessment
- Lifestyle & environment assessment

TREATMENT

- Telemedicine with hospital physician
- IV antibiotics, IV Lasix, hydration
- 12-lead cardiac monitoring
- i-STAT and other point-of-care lab draws
- Wound care & foley catheter care
- Albuterol, oxygen, PO medications

FOLLOW-UP & COORDINATION

- Communication of continuity plan
- Chronic disease & self-care education
- Assistance with appointments & prescriptions
- Warm handoff to home health agency
- Immediate physician feedback via Epic
- Interpreter services available

Procare MIH's connection to the hospital runs through Epic: referrals arrive via the Epic order set, and each visit's patient care report is uploaded directly into the patient's chart, giving the ordering physician a documented record of the encounter. The rest of the coordination is deliberately hands-on rather than automated — lab specimens are labeled in the home with dedicated tracking stickers and hand-delivered to the partner hospital's laboratory, and clinicians routinely follow up on prescription status and, when needed, pick up medications themselves. It is this combination of real chart documentation and hands-on logistics that closes the communication gaps that most often drive readmissions.

Clinical Governance & Safety

Every MIH encounter operates within a defined chain of medical accountability. A licensed Maryland EMS Medical Director oversees the program and approves all protocols and clinicians; an MIH Supervisor with a minimum of two years of Critical Care Transport experience directs day-to-day clinical operations; and MIH Clinicians consult in real time with hospital appointed physicians for medical direction, order confirmation, and disposition decisions as needed. No treatment proceeds without physician or nurse practitioner sign-off, and the program's clinical scope spans 17 distinct protocol areas — from cardiac and respiratory management to wound care and post-surgical support — each with defined indications and physician consultation triggers.

This governance model is what allows MIH to function as a genuine extension of physician-directed care rather than an unsupervised home-visit service. Procare's MIH Clinicians carry ambulance-level ALS equipment and can transition directly to transport without a second dispatch in most cases, so that if a clinician identifies current or impending patient instability, escalation to a higher level of care can happen immediately and in consultation with the partner facility physician — the same safety margin CMS requires of Hospital at Home programs, built into every MIH encounter as a matter of course.

The Luminis Health MIH Bridge Pilot: One Year of Audited Results

Beginning in March 2022, Procare MIH partnered with Luminis Health Anne Arundel Medical Center to implement a fully integrated MIH program, spanning Luminis's clinical enterprise and primary care, including Luminis Health Advanced Internal Medicine (AIM) Clinic, care management and transitional care, pharmacy, laboratory, and information technology teams, alongside Johns Hopkins Home Care Group and the Anne Arundel and Queen Anne County MIH programs. Over the 12-month study period from March 2022 through March 2023, the results were as follows:

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Mobile Integrated Healthcare

149%	583	2,159	21%→15%
Return on Investment	**Total MIH Referrals**	**Hospital Days Saved**	**Readmission Reduction**
Conservative calculation	12-month pilot	All referral types	From Expected Rate to Actual Rate

Referral Volume and Impact

Early Discharge — Home Care Bridge	**1,711 hospital days saved (364 referrals)**
Early Discharge — Skilled Care Transition/Home Safety Assessment	**448 hospital days saved (219 referrals)**

Readmission Outcomes

The MIH team worked with a high-risk patient population. Based on Epic's Risk of Readmission score at discharge, this group was expected to readmit at approximately 21%. In the pilot, observed readmissions came in at 15% — evidence that the home-based support provided by Procare's MIH Clinicians was identifying and addressing clinical issues before they escalated into a return hospitalization. The structured post-visit follow-up calls on Day 2 and Day 7 after the MIH visit, introduced in November 2022, proved to further support a reduction in readmission rates. Luminis' access to CRISP helped Luminis identify a readmission to another facility.

Methodology

- Study period: March 2022 through March 2023, a 12-month window.
- Patient population: adults referred at discharge from Luminis Health Anne Arundel Medical Center, weighted toward high-risk chronic conditions — CHF, COPD, diabetes, pneumonia, and asthma.
- Hospital days saved: measured in Epic as time from discharge to start of next care (home health start-of-care date, or the MIH visit itself for safety/lab-draw referrals).
- ROI: calculated by Luminis finance team using internal cost figures, deliberately taking conservative approach by not including all days saved.
- Data sources: Epic, CRISP, and Luminis internal cost and finance analysis.

> *"People heal better at home. This program gave us a real safety net — a skilled clinician is in the home the same or next day, so patients recover where they are most comfortable and no one falls through the cracks. As Maryland moves into the AHEAD model, this is the kind of care we should be building."*
>
> **— Christine Magnuson, MSHA, BSN, RN, LSSBB, Director of Post-Acute and Community Partnerships, Luminis Health**

Value Delivered by Stakeholder

FOR HOSPITALS

- Length of stay reduction: early discharge programs supported by MIH free inpatient beds without increasing readmission risk.
- 30-day readmission rates: structured post-discharge visits and follow-up calls address the most common drivers of avoidable returns.
- ED diversion: patients with access to MIH services are less likely to present to the ED for non-emergent conditions.
- Staff satisfaction: clinicians can confidently discharge patients knowing a qualified care team will bridge the gap to home health.

FOR PAYERS & HEALTH PLANS

- The Luminis pilot demonstrated 149% ROI, with 2,159 hospital days avoided in a single year.
- Procare MIH targets the highest-cost chronic disease populations: COPD, CHF, diabetes, pneumonia, and asthma.
- Procare MIH's outcomes are tracked in partnership with the hospital partner and show measurable improvements in readmission rates and cost savings that support value-based care.
- CMS alignment: the model is consistent with CMS Innovation Center priorities around Hospital at Home and alternative site-of-care reimbursement.

FOR PATIENTS

- No transportation required: care comes to the patient, removing a critical barrier for elderly and mobility-limited individuals.
- 24/7 access: patients have a clinical resource for non-emergency concerns, reducing anxiety and unnecessary 911 use.
- Better outcomes: patients who understand their care plan and have medication support are more likely to recover fully and stay out of the hospital.
- Built on trust: Patients recognize Procare's MIH Clinicians as a familiar, trusted community resource, which lowers the barrier to accepting care delivered at home rather than in a hospital.

Built for Maryland's AHEAD Model — and What Comes Next

Maryland was the first state to sign on to the CMS AHEAD model, which builds on the state's Total Cost of Care model and runs hospitals on fixed global budgets beginning in 2026. Under that design, as established in Part I, an avoided admission or a shorter stay is value the hospital keeps, not revenue it loses. MIH fits that shift directly: it moves the right care out of the inpatient setting and supports the earlier, safer discharges that global budgets reward. For a Maryland health system, Procare MIH is not an add-on. It is infrastructure for operating successfully inside the model the state has already committed to — and a template for what health systems in Connecticut, Vermont, Hawaii, Rhode Island, and New York will need as their own AHEAD cohorts come online.

PART IV

The Road Ahead

A platform built for the full continuum of care — not just an ambulance company

Mobile Integrated Healthcare is the growth engine investors and health systems are watching most closely, but it sits inside a broader operating platform. Procare Integrated Health and Transport is best understood not as a transportation vendor but as an integrated healthcare logistics and clinical services partner, built to help health systems solve capacity, throughput, and continuity-of-care challenges across the full patient journey — not only at the point of discharge.

A Full-Continuum Platform

Mobile Integrated Healthcare	Post-discharge and preventative care delivered in the home, detailed in Part III
Basic & Advanced Life Support (BLS/ALS)	Reliable, compliant interfacility transport across the acuity spectrum
Specialty & Critical Care Transport	Safe movement of the most clinically complex patients between facilities
High-Acuity Cardiac Transport	STEMI and time-critical cardiac cases requiring specialized EMS Teams and equipment
Hospital Throughput Support	Reducing ED boarding and inpatient bottlenecks through faster, reliable transport
Emergency Department Decompression	Alternative pathways for non-emergent patients, easing ED volume pressure
Dedicated Unit Programs	On-site or near-site units tailored to a health system's specific volume and needs
On-Site Transportation Liaisons	Procare staff embedded at partner hospitals to coordinate transport logistics directly with care teams

Regional Reach, Built to Scale

Procare operates under active licensure across Maryland, Washington, D.C., and Virginia, with the operational track record — 100% customer retention since 2005 — to expand that footprint without compromising the service quality that earned it a distinguished roster of Mid-Atlantic healthcare partners in the first place. The growth capital secured in 2026 is earmarked specifically to extend this platform: deepening the MIH program, expanding the fleet, and building out Virginia operations, all while maintaining the compliance and clinical rigor that differentiate an interfacility, hospital-contracted operating model.

The Opportunity for Health System Partners

For hospital and health system leadership, the strategic conclusion is straightforward. The industry is moving toward global budgets, home-based acute care, and workforce models that extend rather than compete for scarce clinical labor. Independent capital has already underwritten one organization's ability to deliver on that shift, with 12 months of audited results to support the thesis and an ongoing successful program with a prestigious health system in

Maryland. And that organization already operates the full range of transport and clinical services a health system needs to manage patients across the continuum — from the ambulance bay to the emergency department to the patient's own home.

Procare Integrated Health and Transport is actively seeking partnerships with health systems, insurance carriers, and value-based care organizations committed to improving outcomes for high-risk patients. We offer flexible engagement models, rapid deployment leveraging existing licensure and infrastructure, transparent outcomes reporting, and collaborative protocol development tailored to your patient population.

If you are a hospital, payer, or health system working to reduce readmissions, free inpatient capacity, and deliver a better experience for your highest-risk patients, we welcome the opportunity to schedule a discovery meeting.

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SELECTED SOURCES & FURTHER READING

This paper draws on Procare's own operational and pilot data alongside independent policy, regulatory, and peer-reviewed literature, including:

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