MASSACHUSETTS
HEALTH POLICY COMMISSION

COLLABORATING WITH MOBILE RESOURCES TO CARE FOR PATIENTS IN THE COMMUNITY

Three Models Implemented by HPC Investment Program Awardees

SEPTEMBER 2022

Emergency Medical Service (EMS) providers, which include paramedics and other trained first responders, have historically played a reactive role in the health care continuum, responding to emergency calls and transporting acute patients to hospital emergency departments (EDs).[1,2] However, some 911 calls and the ED visits that result from them are for non-urgent needs that could be addressed more appropriately in other, less costly settings than a hospital ED.[1] Motivated by incentives to manage quality and efficiency of care coming from value-based payment models, health care providers have found EMS to be well-positioned as a partner in addressing a variety of routine health care needs. EMS offers trained and trusted medical professionals, is available 24/7, is accustomed to working in the field, and is available in nearly every community.[3]

Since Massachusetts is one of several states with laws allowing paramedics to provide treatment outside of the normal triage and transport via ambulance,[4] provider organizations in Massachusetts have had more opportunity to integrate EMS providers into their care delivery models than other national peers. In Massachusetts, there are two different types of EMS partnership programs that expand upon the traditional role of EMS to deliver care and services to patients in a non-hospital environment in coordination with health care facilities and providers[5]:

Mobile Integrated Health Care (MIH) Programs

involve formal partnerships between one or more health systems and one or more EMS providers to serve a given population of patients and fill gaps in health care provision by using existing mobile resources.[6]

Community EMS Programs

are operated by a local public health authority in coordination with the municipality's designated primary ambulance service to provide community health and preventive care services.[7,8]

8 MIH PROGRAMS AND **~158** COMMUNITY EMS PROGRAMS OPERATING IN **35** COMMUNITIES

The Office of Emergency Medical Services (OEMS) within the Massachusetts Department of Public Health (DPH) approves and oversees the MIH and Community EMS programs in Massachusetts, governed by a 2015 law and 2018 regulations.[8,9] As of March 2022, there are 8 MIH programs and approximately 158 Community EMS programs operating in 35 communities. Beyond the MIH and Community EMS programs, both of which require OEMS approval,[i] providers may establish collaborations with EMS that do not need to go through an approval process, such as those with a focus on data sharing and/or communication practices, rather than the delivery of direct services.

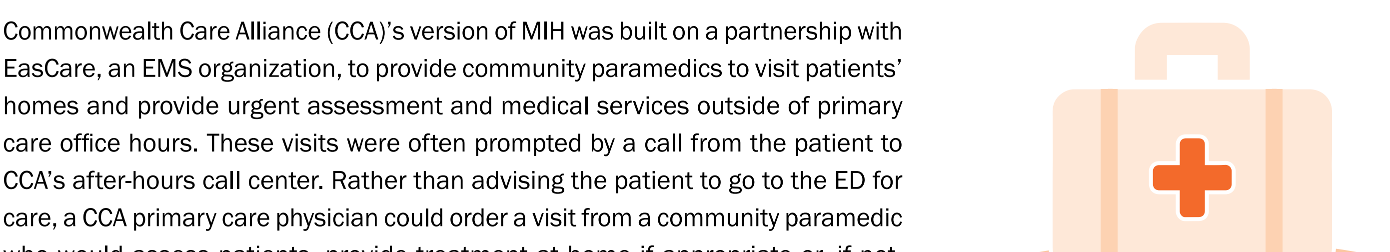
Through two investment programs funded by the Massachusetts Health Policy Commission (HPC) — the Targeted Cost Challenge Investments (TCCI) Program (2017-2019) and the SHIFT-Care Challenge Investment Program (2019-2020) — three health care organizations partnered with local EMS providers through three different approaches: one MIH partnership, one Community EMS partnership, and one independent data-sharing partnership not subject to DPH regulations. Each EMS partnership fit the unique context and needs of awardees and intervened at different points in the care continuum with the dual goals of supporting better care for their patient populations and reducing preventable ED visits.

COMMONWEALTH CARE ALLIANCE	MOBILE INTEGRATED HEALTH CARE PARTNERSHIP
HEBREW SENIORLIFE	INDEPENDENT DATA-SHARING PARTNERSHIP
STEWARD HEALTH CARE NETWORK	COMMUNITY EMS PARTNERSHIP

i MIH partnerships involve a robust application process and an application fee. The Community EMS Program involves a simpler application process and does not include an application fee. For more information on the application process, see https://www.mass.gov/how-to/apply-to-operate-an-mih-program.

COMMONWEALTH CARE ALLIANCE

IN-HOME TRIAGE AND URGENT CARE TO PREVENT ED TRANSPORT



PARTNERSHIP MODEL

Commonwealth Care Alliance (CCA)'s version of MIH was built on a partnership with EasCare, an EMS organization, to provide community paramedics to visit patients' homes and provide urgent assessment and medical services outside of primary care office hours. These visits were often prompted by a call from the patient to CCA's after-hours call center. Rather than advising the patient to go to the ED for care, a CCA primary care physician could order a visit from a community paramedic who would assess patients, provide treatment at home if appropriate or, if not, arrange transportation to the ED. EasCare paramedics documented all visits for the primary care physicians, who followed up with patients during regular office hours the next day. The community paramedics served as an intermediate option between a phone visit and an ED visit for high-need patients.

CCA's EMS partnership diverted unnecessary ED visits, representing cost savings for the organization. Building on the successes of the partnership, CCA secured a waiver from DPH to expand their geographic reach, allowing them to serve a larger patient population.

1,382 MOBILE INTEGRATED HEALTH DISPATCHES AND **144** ED TRANSPORTS

CCA was an awardee in the HPC's TCCI program. For more information on their care model, see their awardee profile.

"The vast majority of these [mobile integrated health] **visits would have been [ED] visits** if they were not being treated through the much more affordable mobile integrated health visits. The InstED [mobile integrated health] service enables us to **offer more appropriate care**, fiscally and clinically."

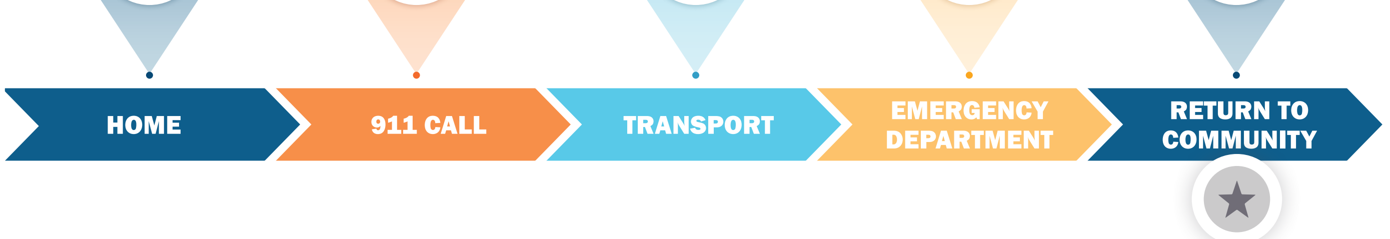
- CCA STAFF MEMBER

"[Other clinics may need to] try to figure out, 'Is it something simple I can talk to you on the phone? Or do I send you to the ED?' And it's just **really meaningful to have that middle option**, of evaluating and offering pretty intensive treatments at home."

- CCA STAFF MEMBER

HEBREW SENIORLIFE

USING DATA FROM EMS CALLS AND TRANSPORTS TO PREVENT FUTURE EMERGENCIES



PARTNERSHIP MODEL

Hebrew SeniorLife (HSL) established data-sharing arrangements with several local EMS providers so HSL staff could intervene and provide residents in need with preventive care, education, and social support to help reduce avoidable EMS calls and transports in the future.

Reviewing daily reports of 911 calls retroactively allowed HSL staff to identify gaps in knowledge, services, or supports that might have prevented the ED visits. Open communication with EMS teams and hospital providers also allowed HSL staff to stay current on the patient's condition and whereabouts, enabling a smoother, safer transition back from the ED and prompting efforts to address the gaps that led to the ED visit.

18% DECREASE IN AMBULANCE TRANSPORTS TO THE ED FROM PARTICIPATING SITES

HSL was an awardee in the HPC's TCCI and SHIFT-Care programs. For more information on their care model, see their TCCI and SHIFT-Care awardee profiles.

"[Before the partnership,] very often we would have residents [who] would [go] down to the hospital and we wouldn't even know. So, the [ED] report allows us to share that with the rest of the staff and **be able to follow up if people transition either to rehab or come back home.** Even if they just had a 911 call because they fell, they didn't end up going [in the ambulance to the ED] but we still know about that to be able to follow up and **coordinate the right services to prevent a future fall.** And that is a real example of the collaboration we have with [EMS] and using the data day-to-day to be able to give people the support that they need."

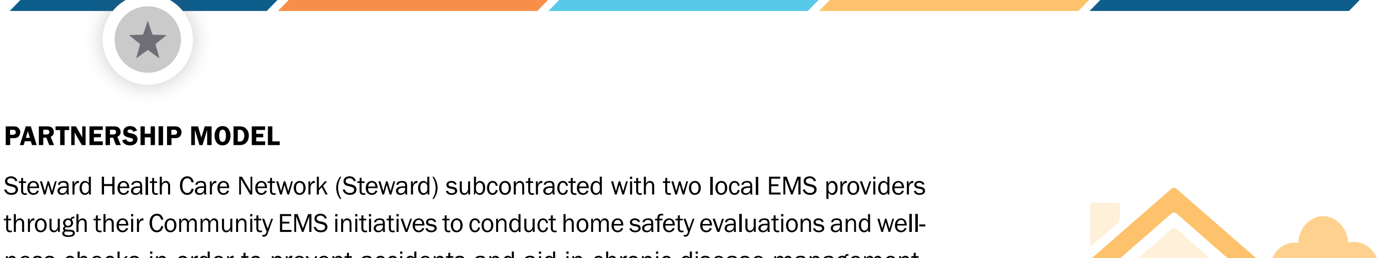
- HSL STAFF MEMBER

"In reviewing [ED] trip and resident contact data, we learned that **some residents were planning trips to the ED**, sometimes a week in advance. This led to the creation of an educational program titled 'Urgent Care Options' – **demystifying urgent care** and assisting seniors in the navigation of primary care, urgent care, and the emergency room."

- HSL STAFF MEMBER

STEWARD HEALTH CARE NETWORK

HEALTH AND SAFETY HOME INSPECTIONS TO PREVENT ACCIDENTS AND ILLNESS



PARTNERSHIP MODEL

Steward Health Care Network (Steward) subcontracted with two local EMS providers through their Community EMS initiatives to conduct home safety evaluations and wellness checks in order to prevent accidents and aid in chronic disease management. This program served as a supplement to community nursing care for patients enrolled in Steward's Care to Community (C2C) program. After an initial intake appointment, program staff determined which patients were appropriate for home visits and assigned EMS and program staff to attend those visits. At each visit, EMS and C2C staff assessed the safety of the home, the patient's comfort with their day-to-day medical care, and any observable patient needs. EMS staff might briefly assess patient vital signs or provide health education as needed. Following the home visits, the C2C team identified resources and services appropriate for the patients based on their individual needs. EMS providers also attended case management meetings with the C2C team and other partners to discuss patient needs and the findings from visits.

Steward staff witnessed patients benefiting from the wellness checks, home evaluations, and health education that their community paramedicine program provided. Since EMS providers had often been operating in the community for many years, they sometimes had existing relationships with patients and provided a valuable connection between patients and the C2C team. However, the home visit and EMS partnership aspect of the C2C program ended prematurely due to the COVID-19 pandemic, which likely shifted the focus of EMS providers and affected patients' openness to home visits.

34 HOME VISITS ASSIGNED AND COMPLETED

Steward was an awardee in the HPC's SHIFT-Care program. For more information on their care model, see their awardee profile.

"[A female patient in her 50s was] enrolled in Steward's Care to Community Program after meeting with an embedded social worker at Saint Anne's Hospital… [After discharge, a] community health nurse introduced and visited with the member to support medication education and diabetes management. [The nurse] **initiated EMS for a wellness check to monitor blood glucose** since the member did not have a glucometer at home to monitor blood sugars, supported the member with education on use of glucometer, and encouraged the member to request support from a home health nurse. **The member now independently checks blood sugars… and can identify appropriate food choices to manage diabetes.**"

- STEWARD STAFF MEMBER

ABOUT THE HPC

The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs. The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth.

To learn more about the **Community EMS Program**, visit www.mass.gov/info-details/approved-community-ems-services

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To learn more about the **MIH Program**, visit www.mass.gov/how-to/apply-to-operate-an-mih-program

1 Gregg A., et al. Systematic Review of Community Paramedicine and EMS Mobile Integrated Health Care Interventions in the United States. Population Health Management. 2019; 22(3):213-222.

2 Vision Statement on Mobile Integrated Healthcare (MIH) & Community Paramedicine (CP). American College of Emergency Physicians. Mar. 2015. Available at: https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/ems-and-disaster-preparedness/mih-vision-statement.pdf

3 Mobile Integrated Healthcare and Community Paramedicine (MIH-CP): 2nd National Survey. National Association of Emergency Medical Technicians. 2018. Available at: http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2

4 Glenn M., et al. State Regulation of Community Paramedicine Programs: A National Analysis. Prehospital Emergency Care. (2018);22(2): 244-251.

5 MIH and Community EMS educational resources. Office of Emergency Medical Services. Bureau of Health Care Safety and Quality. Department of Public Health. 2018. Available at: https://www.mass.gov/service-details/mih-and-community-ems-educational-resources

6 Beck E., et al. Mobile Integrated Healthcare Practice: A Healthcare Delivery Strategy to Improve Access, Outcomes, and Value. National Association of Emergency Medical Technicians. Dec. 2012. Available at: http://www.naemt.org/Files/MobileIntegratedHC/Medtronic%20MIH%20Whitepaper.pdf

7 Approved Community EMS services. Office of Emergency Medical Services. Bureau of Health Care Safety and Quality. Department of Public Health. Oct. 2018. Available at: https://www.mass.gov/info-details/approved-community-ems-services

8 105 CMR:173.00 Department of Public Health. Sep. 2018. Available at: https://www.mass.gov/doc/105-cmr-173-mobile-integrated-health-care-and-community-ems-programs/download

9 An Act Making Appropriations for the fiscal year 2016 for the maintenance of the departments, boards of commissions, institutions and certain activities of the commonwealth, for interest, sinking fund and serial bond requirements and for certain permanent improvements, H.B. 3650, 189th General Court (Mass. 2015)