Mobile Integrated Health Advisory Council

Massachusetts Department of Public Health

February 1, 2016

Agenda

1. ROUTINE ITEMS:
   a. **Welcome and Introductions**
   b. Adoption of January 6, 2016 Meeting Minutes (VOTE)

2. NEW BUSINESS:
   a. Defining Access and Duplication (DISCUSSION)
   b. Defining the Interaction Between EMS, MIH, and Community EMS (DISCUSSION)
   c. Upcoming Meeting Schedule

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Adoption of Meeting Minutes

Motion to adopt MIHAC January 6, 2016 meeting minutes **(VOTE)**

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Themes for MIHAC Discussion

Several key questions came out of previous MIHAC's meetings for future MIHAC discussion:

- ☑ What are the minimum "guardrails" for quality and patient safety?
- **What is the balance between access and duplication?**
- **What is the role of MIH Programs in relation to ED aversion?**
- **How should MIH Programs/EMS interact?**
- **What is the distinction between Community EMS and MIH?**
- Program Administration
  - Application fees?
  - Application review timeline?
  - Complaints and Investigations?
  - Inspections?
- Quality Measures

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Reframing: Access and Duplication

Question of Access and Duplication: Section 2(b) of MGL Chapter 111O:

The department shall evaluate and approve MIH programs that meet the following criteria:

(ii) ***address gaps in service delivery*** and prevent unnecessary hospitalizations, or other harmful and wasteful resource delivery;

(iii) focus on partnerships, through contracts or otherwise, between health care providers and health care entities that promote coordination and utilization of existing personnel and resources ***without duplication of services***;

Language requires programs to increase access, *but without* "duplication of services"

Reframing: Access and Duplication

Question: Should "gaps" or "duplication of services" be further defined?

If so, how and where?

Follow-Up Questions:

- Do quality, access, and cost to patient constitute "Gaps"?
- If so, are there situations where filling one of those gaps might also be a "duplication of services"?
- Are all services that provide similar offerings or "outputs" the same service?
- If not, what are some of the factors DPH should consider to differentiate?

Reframing: Access and Duplication

Example Situation:

Does a service that is viewed as “inaccessible” due to cost to patient, transportation, cultural competency, or other quality/access factors create a “gap” that an MIH Program could fill?

What if it’s providing a similar offering or “output” as a competitor?

Is this a duplication of service?

Access and Duplication Exercise

In planning for today's meeting: DPH staff received feedback from MIHAC members regarding definitions for "gaps" and "duplication of services" meant to help facilitate and inform today's discussion.

The goals of this discussion are:

- *What should constitute a "Gap"?*
- *Who should determine?*
- *Should it be verified or verifiable? If so, how and by which measure(s)?*
- *What should constitute a "Duplication in Service"?*
- *Who should determine?*
- *Where and how should the answers to these questions be operationalized within the regulatory and programmatic construct (Reg vs. App vs. by MIH Program)?*

Note: The following summaries represent DPH Staff synthesis of common themes received from MIHAC membership. At this time, statements do not represent official DPH policy positions (Slides 12-16).

Defining Gap in Service Delivery

What should constitute a "Gap"?

General consensus across all submissions:

- ***"Gap in Service Delivery"*** means an opportunity for a mobile integrated health program to provide improvements in quality, access, or cost-effectiveness for a defined patient population or region, as identified by an applicant, by addressing one or more, but not limited to, the following factors:
  - a decrease in total medical expenditure;
  - a decrease in cost to patient;
  - a decrease in avoidable emergency department visits;
  - a decrease in avoidable readmissions;
  - a decrease in time to patient care;
  - an increase in access to care under the medical direction of the patient's primary care provider;
  - an increase cultural and linguistic competencies;
  - and/or, an improvement in clinical care coordination.

Who should determine?

- **Consensus that an MIH program applicant should be responsible** for determining any gaps in services.

Defining Gap in Service Delivery

Should it be verified or verifiable? If so, how and by which measure(s)?

Recommended list of proposed measures for identifying and validating gaps in service delivery:

- ***Publicly Available Data:***
  - CHIA adjusted cost per discharge data;
  - Unnecessary ED visits using CHIA outpatient ED database;
  - Outpatient ED visits per capita by region using CHIA outpatient ED database;
  - CMS Hospital-Wide All-Cause Unplanned 30-Day Readmission measure using CHIA's Acute Hospital Case Mix Data;
  - HPC's analysis of primary care providers per 10,000 residents by primary care service area.

- ***Program-Specific Data:***
  - Current vs. target ED utilization and inpatient utilization / 1,000;
  - Current vs. target measure of patient-satisfaction / patient-centeredness;
  - Current vs. target process measures for ensuring cultural competency of care delivered;
  - Current vs. target acute care costs / 1,000.

Defining Gap in Service Delivery

Should it be verified or verifiable? If so, how and by which measure(s)?

Recommended list of gap analysis framework for identifying gaps in service delivery:

- ***Program Gap Analysis Framework:***
  - HRSA Community Paramedicine Evaluation Tool;
  - Map existing resources, including hospitals, homecare, and other community partners;
  - Review of time availability of home-based or outpatient services in the area;
  - Review of cultural competency of services relevant to patient population in area;
  - Mobilizing for Action through Planning and Partners (MAPP);
  - CDC Community Health Assessment and Group Evaluation (CHANGE) Action Guide;
  - HHS Healthy People;
  - Association of Community Health Improvement, Community Health Assessment Toolkit;
  - *A Guide to Assessing Needs:* Essential Tools for Collecting Information, Making Decisions and Achieving Development Results.

- ***Should it be verified or verifiable:*** Applications should spell out the data sources and gap analysis framework used to identify, qualify, and quantify the gap in service.

Defining Duplication of Service

What should constitute a "Duplication in Service"?

General consensus across all submissions:

- *"Duplication in Service"* is a proposed service which does not address a *"Gap in Service Delivery."*

Comment(s) of note:

- Emergency Service Programs (ESPs) provide an existing system of emergency behavioral health crisis response that fully covers the Commonwealth. MIH applications, particularly those with focus on behavioral health, should be required to partner with the ESP(s) in the catchment areas they plan to serve.

Who should determine?

- DPH should require mobile integrated health program applicants to list the community health providers, local public health agencies, and continued care supports with which they partner and/or contract, describing how the proposed program would avoid duplication and achieve more cost-effective and clinically appropriate services.

Defining Duplication of Service

Items for Future Discussion – Program Administration:

- Consider prioritization of proposals that address "gaps" in behavioral health (substance abuse/mental health); provide full continuum of emergency care including urgent/emergent services; and, applications that focus on Medicaid populations in collaboration with MassHealth.
- There shall be no more than two MIH applications approved per county, unless they test distinct care coordination objectives and will not increase Total Cost of Care.
- An ambulance partner provider who works with an at-risk ACO on a Department-approved MIH program may not service the same patient through any other MIH initiatives without the expressed permission of the at-risk ACO.

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Chapter 111O and "First Responders"

- **MIH Community Paramedics and "other providers"** providing MIH services must be employed by a "health care entity." M. G. L. c. 111O, §(2)(b)(iv- v).

- **"Health care entity"** includes entities licensed under 111C to provide EMS (*i.e.* an ambulance service or an EMS First Responder Service or "EFR Service")

- There are 3 licensed EFR services in Massachusetts, all licensed by OEMS to provide EFR at the basic life support (BLS) level of service to patients in their communities:
  - Boxford Fire Department
  - Dedham Fire Department
  - Milford Fire Department

- This means the personnel who respond on behalf of these EFR services are EMT-Basics and therefore ***are*** eligible to partner with other health care entities to provide MIH.

Chapter 111O and "First Responders"

- **"First responders"**, such as police, firefighters and lifeguards, are required to be trained in first aid and CPR under the first responder law (see MGL c. 111, §201). There is no requirement that first responder agencies deploy first responders in emergency medical situations. However, if a first responder agency chooses to deploy first responders to emergency medical calls, the first responders would provide first aid (including naloxone) and CPR while awaiting EMS primary ambulance response.

- Although DPH sets training standards for first responders, DPH does not have oversight or any other authority over these state and municipal employees. As such, **"first responder agencies"** are not "health care entities."

- ***Bottom Line:*** Unless a police or fire department operates an ambulance service or an EFR service licensed by DPH/OEMS with personnel certified as EMTs, police and fire personnel working for first responder agencies ***are not*** "health care entities" under Chapter 111O.

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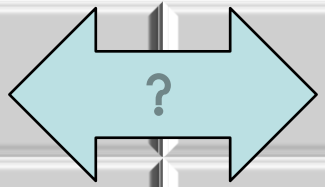
EMS



MIH

Per 111C and EMS Regs:

- ***Provides both emergency and nonemergency*** *EMS services* by certified EMTs/Paramedics who work for licensed ambulance services at local level
- Requires dispatch, assessment, treatment, and transport to a hospital ED
- Requires medical control and direction
- Operates in accordance with local jurisdiction's DPH-approved EMS service zone plan, designating a primary ambulance service
- Receives emergency calls via 911 call at Public Safety Answering Points (PSAPs) with ambulances dispatched pursuant to Emergency Medical Dispatch (EMD) protocols
- Requires ambulances meet minimum vehicle/equipment standards
- Requires staffing with 2 EMTs with certification levels dependent on level of the ambulance

What we need to answer:

- What is interplay between EMS/MIH?

Per 111O:

- ***Provides pre- and post-hospital services*** that fully support patient medical needs within a community
- Addresses identified gaps in service delivery with a goal to prevent unnecessary hospitalizations and increase efficiency
- Must focus on partnerships between health care providers, promoting coordination and utilization of existing resources
- Eliminates 111C barriers, but does not change scope of practice for EMS or non-EMS providers
- Requires MIH Program-specific training and treatment protocols
- Requires medical control and direction
- Requires coordination and activation of 911 systems in events of emergency
- Requires quality reporting

What we need to answer:

- What is the interplay between EMS/MIH?
- Can an MIH program exist without EMS personnel or vehicles involved?

Framing: Balancing the Roles of EMS and MIH

Questions: How should MIH/EMS interact? What is the role of MIH with regards to ED aversion?

Framing:

- **111C Statutory Context:** *EMS Services must….* follow 105 CMR 170.000 which governs all emergency responses, including transport vehicle specifications (i.e. must be an approved ambulance) and minimum staffing (i.e. 2x EMS personnel per ambulance).

- **111O Statutory Context:** *MIH Program must….* (ix) ensure activation of the 911 system in the event that a patient of an MIH program experiences a medical emergency, as determined through medical direction, in the course of an MIH visit.

MIH/EMS Interactions

In MIHAC meetings, members have made reference to:

1) The high percentage of 911 calls that are deemed non-emergent, but under 111C (EMS Statute), EMS has no other option except ED transport; and,

2) Interest in potential utilization of existing EMS resources, including EMS-compliant vehicles (i.e. ambulances) and dually approved paramedic/EMT staff in achieving ED aversion (versus prevention).

With this framing, the following examples explore ***hypothetical*** EMS/MIH interactions.

MIH/EMS Interactions

Example Situation #1:

Town of XYZ, Massachusetts primary ambulance service, ABC Ambulance, operates (or participates in) an MIH program serving XYZ residents.

An ABC Ambulance is dispatched to a patient in an EMS-compliant vehicle for a ***911, emergency call***.

After an initial assessment, the EMS personnel determine the patient is in fact *not* experiencing a medical emergency and/or believe that the situation can be handled more appropriately at an alternate destination.

MIH/EMS Interactions

What Should Happen?

- Should there be MIH requirements regarding form of medical direction in downgrading the response (*Note:* EMS regulation requires at least affiliate hospital medical director – an ED doc – to provide medical control)? Should dual programs have distinct EMS/MIH medical directors/control?
- Should the process (form/method) for obtaining patient refusal of transport go beyond the current EMS Statewide Treatment Protocol 7.5?
- When does EMS-911 immunity end?
- *What if the patient is not a patient of ABC's MIH Program, but a competitor's MIH Program? Must ABC contact and refer the patient to their MIH provider? What is the role of the competitor regarding triage and medical direction?*

MIH/EMS Interactions

Example Situation #2:

Town of XYZ, Massachusetts primary ambulance service, ABC Ambulance, operates (or participates in) an MIH program serving XYZ residents.

An ABC Ambulance is dispatched to a patient in an EMS-compliant vehicle for a ***non-emergency MIH call***.

After an initial assessment, EMS personnel determines the patient is experiencing a medical emergency.

MIH/EMS Interactions

What Should Happen?

111O Statutory Context: *MIH Program must….* (ix) ensure activation of the 911 system in the event that a patient of an MIH program experiences a medical emergency, as determined through medical direction, in the course of an MIH visit.

- What form of medical direction is required to ensure patient safety in upgrading this response?
- Once deemed an emergency, can the MIH-responding personnel and ambulance "transition" to becoming a 911 response team?
- If not, what is the MIH provider's responsibility to the patient?
- *What if the MIH personnel responded in a non-EMS-compliant vehicle (e.g. Class-V Non-Transport vehicle)? Do they need to call 911? What is their responsibility during transition to the primary ambulance service?*

MIH/EMS Interactions

Example Situation #3:

ABC Ambulance operates (or participates in) an MIH program serving Town of XYZ, Massachusetts residents, but is not the primary ambulance service for the Town.

ABC Ambulance MIH personnel are dispatched to a patient utilizing an EMS-compliant ambulance for a ***non-emergent MIH call***.

After an initial assessment, the MIH personnel determine the patient is in fact experiencing a medical emergency. Per Chapter 111O, MIH personnel activates 911.

MIH/EMS Interactions

What Should Happen?

- Can the primary ambulance service's medical direction permit the on-site MIH provider to transport the patient to the ED?

- If not, what is the MIH provider's responsibility to the patient, and what are next steps?

MIH/EMS Interactions

Example Situation #4:

ABC Ambulance is the Town of XYZ, Massachusetts primary ambulance service provider. ABC Ambulance does not operate an approved MIH program.

In response to a 911, emergency EMS call, an ABC Ambulance is dispatched to a patient.

After an initial assessment, EMS personnel determine the patient is in fact *not* experiencing a medical emergency, or believes that the situation can be handled more appropriately at an alternate destination.

MIH/EMS Interactions

What Should Happen?

- Should a primary ambulance service that is not an MIH program be permitted to engage the patient in obtaining a patient refusal for transport?
- If so, should the process (form/method) for obtaining patient refusal of transport go beyond the current EMS Statewide Treatment Protocol 7.5?
- Should a primary ambulance service be permitted to refer the patient to an MIH provider for follow up care?
- If allowed, what then occurs for communities that do not have MIH program coverage?
- What is the primary ambulance service's responsibility to the patient?

EMS

Per 111C and EMS Reg:

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- Requires medical control and direction
- Operates in accordance with local jurisdiction's DPH-approved EMS service zone plan, designating a primary ambulance service
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MIH

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- Requires quality reporting

What we need to answer:

- What is the interplay between EMS/MIH?
- Can an MIH Program exist without EMS personnel or vehicles involved?

Community EMS

Per 111O:

- ***Provides community outreach*** and assistance to residents who are high-911 and ED utilizers with injury and illness prevention
- Operated by a primary ambulance service
- May connect residents to primary care , other health care providers, low-cost medication programs, and other social services.
- Community EMS may provide follow-up and preventive care including, but not limited to:
    - Falls prevention
    - Vaccinations
    - Health screenings
- However, no change to scope – can only operate within existing scope of EMS personnel
- Local jurisdiction/Affiliate Hospital Medical Director required to approve training and activities

What we need to answer:

- How do Community EMS, MIH, and EMS interact across the spectrum of care?

What is Community EMS?

What is Community EMS?

- Operated by a primary ambulance service
- Approval of the local jurisdiction and the affiliate hospital medical director
- Provides community outreach and assistance to residents of the local jurisdiction with *injury and illness prevention*
- Community EMS program may:
  - Work with local public health
  - Identify residents who frequent the 911 system/EDs
  - Connect them to: primary care providers, other health care providers, low-cost medication programs, and other social services.

What is Community EMS?

What is Community EMS (cont.)?

- Community EMS may utilize EMS providers to provide follow-up and preventive measures including, but not limited to:
  - Fall prevention
  - Vaccinations under Local Public Health direction
  - Health screenings, including for blood pressure and blood glucose.
- Shall not authorize an EMS provider to perform any medical procedures outside their scope of practice.

Agenda Planning

Planning MIHAC's February 26th meeting: DPH Staff will send you a questionnaire, which will include these questions for you to complete in advance of our next meeting.

Please complete and submit by *no later* than **Friday, February 12, 2016**.

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Upcoming Meeting Schedule

The Following dates/times are confirmed for future MIHAC meetings:

- **Friday, February 26**, 1:00 PM - 4:00 PM
- **Thursday, March 24**, 3:00 PM - 6:00 PM
- *HOLD:* **Wednesday, April 20**, 1:00 PM - 4:00 PM