Commonwealth of Massachusetts
Department of Public Health

Helping People Lead Healthy Lives In Healthy Communities

Mobile Integrated Health Care and Community EMS Programs

Massachusetts Department of Public Health

August 2016

Presentation Overview

- Overview of Mobile Integrated Health
- Proposed Regulation: 105 CMR 173.000 – Mobile Integrated Health Care and Community EMS Programs
- Next Steps
- Questions

MIH in Massachusetts

- Massachusetts' Mobile Integrated Health (MIH) law was passed in 2015 (FY16 Budget), known as Chapter 111O
- Designates DPH as the lead MIH agency
- Charges DPH with reviewing and approving MIH programs and Community EMS programs
- What does Ch. 1110 do?
  1. Formally establishes Mobile Integrated Health or "MIH" in Massachusetts
  2. Creates "Community EMS" programs, opportunities for municipalities to partner with their EMS agencies
  3. Establishes the Mobile Integrated Health Advisory Council (MIHAC) to support and advise DPH's implementation of the statute

MIH Concept

MIH is a system of pre- and post-hospital services which utilize **community paramedic resources** to deliver a **coordinated continuum of care** that supports patients' needs in the community. This care continuum will be planned through **collaborative and proactive** program development to **address gaps in service delivery** and **prevent unnecessary hospitalizations** or other harmful and wasteful resource delivery.

Scope of MIH in the US

MedStar (TX)

- Mobile health care paramedic model with detailed assessment, individualized care plans and follow-up calls by paramedics and nurse call triage. Focused on ED avoidance, high utilizers and avoiding readmissions.
- Since 2012, over 6,800 patient contacts, and as much as $11.7 million in system savings from decreased ambulance transports, ED visits and hospital admissions.

North Shore/LIJ (NY)

- Hospital-based EMS system decreases readmissions– critical care paramedics performing urgent house calls in coordination with PCPs, when physicians may not be able to visit.
- Reduced payment costs of self referrals to ED by as much as $2.8 million in one year.

Eagle County (CO)

- Using referrals from PCPs to provide coordinated care in home, including post-discharge visits, episodic evaluation visits and hot spotter interventions.
- Over five years, program is estimated to cost $1.5 million, but save $9.9 million.

Reno (NV)

- Provides post-hospital discharge patient follow-up visits and phone calls, nurse call line and community outreach.
- $9.6 million CMS grant resulted in over $10.5 million in savings over three years.

State Pilot Programs

- Two Massachusetts pilots through DPH Special Projects approval, since 2014
- Large ambulance services in partnership with a hospital and ACO
- Focus on reducing readmissions for medically complex patients
    1. Cataldo SmartCare (with Beth Israel Deaconess Medical Center)
    2. EasCare Mobile Health (with Commonwealth Care Alliance)

Pre-MIH Laws

- MGL Ch. 111C establishes the Massachusetts Emergency Medical Services (EMS) system (passed in 1973; last redrafted in 2000)

- The statute and governing regulations focus on "emergency," with the requirement to dispatch emergency response, provide care, and transport patients only to the ED

- Medical control is restricted to emergency physicians

Chapter 111O: MIH

"a health care program approved by the department that utilizes mobile resources to deliver care and services to patients in an out-of-hospital environment in coordination with health care facilities or other health care providers; provided, that the medical care and services include, but are not limited to, community paramedic provider services, chronic disease management, behavioral health, preventative care, post-discharge follow-up visits, or transport or referral to facilities other than hospital emergency departments"

MIH Doesn't Change Scope: It Changes Settings

- Ch. 111O expands the settings and environments EMS providers may encounter but maintains scope of practice

Example: Scope vs. Settings

OEMS Laws

Statewide Treatment Protocols

Emergency Care: Paramedic may administer furosemide as *emergency* pulmonary edema treatment, by medical control approval if patient already on diuretics

New MIH Law

Mobile Integrated Health Protocols

Preventive Care: Community Paramedic may administer furosemide for chronic congestive heart failure or fluid retention, *before* pulmonary edema or other emergency condition occurs

Statutory Requirements for MIH Programs

- Provide coordinated continuum of care
- Address gaps in service delivery and prevent unnecessary hospitalizations
- Focus on partnerships
- Adhere to clinical standards and protocols; ensure appropriate training and competency in protocols
- Access qualified medical control and medical direction, including secure communication system
- Appropriately activate the 911 system
- Comply with privacy laws
- Appropriately collect and analyze data

Advisory Council: Statutory Membership

- MassHealth
- Massachusetts Hospital Association
- Massachusetts Council of Community Hospitals
- Steward Health Care
- Mass Senior Care Association
- Massachusetts Medical Society
- MA Chapter of the American College of Emergency Physicians
- Massachusetts Nurses Association
- Home Care Alliance
- Fire Chiefs' Association of MA
- Professional Fire Fighters of Massachusetts
- International Association of EMTs and Paramedics
- Massachusetts Ambulance Association
- Hospice and Palliative Care Federation
- Association for Behavioral Healthcare
- Massachusetts Association of Health Plans
- Blue Cross Blue Shield MA
- Commonwealth Care Alliance

Council Meetings

- Based on statute, meetings focused on these topics:
  - Mobile Integrated Health Program Development
    - Patient Safety
    - Gaps and Duplication in Service
    - Emergency Department Avoidance
  - Community EMS Development
- Consistent with Council feedback, the DPH proposed approach allows for flexibility with many specifics left to MIH programs to address through their applications, allowing programs to innovate in ways that reflect the unique needs of their proposed patient population

Patient Safety

- Primary focus on Care/Patient Safety
  - Training
  - Treatment Protocols
  - Care Coordination
  - Complaints/Investigations
  - Informed Consent
  - Interoperability/Data Systems
  - Medical Direction
  - Patient Education
  - Program Renewal Frequency

Gaps and Duplication in Service

- MIH programs must:
  - **Address gaps in service delivery** and prevent unnecessary hospitalizations, or other harmful and wasteful resource delivery
  - 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**

Definitions: Gaps and Duplication in Service

- "Gap in Service Delivery": MIH program must provide improvements in quality, access, or cost-effectiveness for a defined patient population or region by addressing:
  - A decrease in avoidable ED visits or hospital readmissions
  - A decrease in total medical expenditures
  - A decrease in cost to patient
  - A decrease in time to appropriate patient care
  - An increase in access to care under the direction of the patient's Primary Care Provider
  - Improvement in clinical care coordination
  - An increase in patient satisfaction
  - Improvement in patients' quality of life
  - An increase in cultural and linguistic competencies

- "Duplication in Service": proposed service which does not address a "Gap in Service Delivery"

ED Avoidance

- Regulations create an MIH Program sub-category that includes an ED Avoidance component, with the following criteria for the program:

  1. Be a licensed EMS provider
  2. Be a Primary Ambulance Service with contractual responsibility over a designated population
  3. Be an approved MIH program

Community EMS Programs

- EMS-based programs
  - Operated by the local public health authority in partnership with the designated primary ambulance service
  - Approved by the local jurisdiction and the ambulance service's affiliate medical director

- Work with local public health to advance illness or injury prevention through high value public health services with low risk potential

- Do <u>not</u> alter EMS personnel's scope, just the care settings and patient access points

Community EMS Programs, cont.

- DPH would create a list of specific low risk, high value public health prevention services Community EMS Programs could perform
  - Examples: blood pressure and glucose screenings, evidence-based falls prevention and concussion training, vaccines under the direction of local public health
- Presumptive DPH approval for Programs focused on services from this list, provided local municipality and AHMD approve
- DPH may consider adding prevention services by written request

Next Steps

- Public hearing and a comment period will be held on the proposed regulation
- Upon review of public testimony, any further amendments to the regulation will be considered
- DPH will return to the PHC to report on testimony and any recommended changes to the regulation
- Following final action by the PHC, the Department will file the regulation with the Secretary of the Commonwealth for final promulgation

Closing

Mobile Integrated Health Care and Community EMS Programs

105 CMR 173.000

Questions?

Thank you!