MDHHS Michigan Department of Health & Human Services | Bureau of Emergency Preparedness, EMS and Systems of Care

EMSCC Patient Movement Ad Hoc
Minutes
10:00 a.m. – 12:00 p.m.
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248-509-0316 Conference ID: 517 622 450#
1001 Terminal Road, Lansing, MI 48906

Members: Debbie Condino, chair, Dr. Bigsby, Ken Cummings, Dr. Krohmer, Jason MacDonald, Ralph Ortiz, Alyson Sundberg, Ed Unger, Rob Warnemuende, Doug Pratt, Ron Slagell.

Absent: Lauren LaPine, Angela Madden, Connie O'Malley.

Guests: Thomas Johnson, Sparrow; Kelsey Ostergren, MHA; Bill Priese, Tri County MCA ; Bruce Trevithick, Genesee County MCA; Lance Corey, Kent County EMS; Mark Meijer, Life EMS; Eric Snidersich, MMR; Sue Proctor; Curtis LeSage, Marquette Alger MCA; Andrea Abbas, MCRH.

Staff: Babb, Bergquist, Kuhl, Piette, Burke, Kapnick, Nelson, Schaible, Worden, Flory, Baker.

1. **Call to Order: The meeting was called to order at 10:07 a.m. by Debbie Condino.**
2. **Roll Call-We have a quorum today.**
3. **Approval of Agenda (Cummings, Krohmer). Approved.**
4. **Approval of Minutes with change (bottom of page 2-Dr. Krohmer emailed NEMSIS not NASEMSO). (Sundberg, Warnemuende). Approved.**
5. **Old Business**
    - Definitions and Nomenclature
        - Interfacility
        - Non-interfacility
        - Dr. Krohmer discussed the list of NEMSIS facility definitions. It includes a lot of things we wouldn't normally count. The group discussed. Alyson said the two buckets are emergent and non-emergent for our purposes. She said anything besides an EMTALA or ICU transfer is discretionary. Alyson said CMS does not always agree with what they determine is emergent. Reimbursement was discussed. Hospitals can't refuse. Alyson spoke about hospitals being stuck with patients they can't get out due to EMS picking and choosing transfers. Debbie asked if we need to define facility further. Too broad is better than too narrow in this discussion. Settings providing patient care was discussed. Ralph advised those settings are still receiving or sending patients via ambulance.

6. New Business

- Problem statements
    - Top five problems under each category
        - Hospital to Hospital Transfers
            - Differences in opinion on priority of patient
                i. Subcategory of time sensitive (example for a procedure) – Kuhl. Alyson discussed and said the hospital needs to include transport when making the arrangements for surgery. Joint use of triaging calls. Guidelines are needed. Suzette also spoke about coordination. This is an across the system challenge. Doug Burke spoke about documentation. Dr. Bigsby said the statute says the physician decides and discussed misunderstandings. Bill Priese also spoke about data. He said hospital to hospital transfers are the responsibility of the hospital. Some of the disagreements come from pulling 911 into it rather than the hospitals contracting with individual agencies. He said confusion needs to be kept in mind when looking at data.
                ii. Alyson said the system has outgrown needs and discussed agencies needing to be available for 911, and she discussed agencies making rules for transfers. She thinks the boundaries in the statute and administrative rules have been outgrown.
                iii. Ralph advised agencies work for the MCA, not hospital groups and brand shouldn't be considered.
            - Differences in ultimate destination (ED vs Floor; Closest vs Network)
            - Geography
            - Climate
            - Lack of personnel
            - Availability of vehicle type required.
            - Receiving facility issues.
                i. Peds
                ii. OB
                iii. Specialty trauma
                iv. Stroke/STEMI
                v. Behavioral Health-long transfers
                    1. Eileen said pediatrics, burns, orbits, and hand injuries are the most difficult to move.
            - Coordination and deployment of resources

i. Suzette spoke about the definition of critical care not aligning between EMS and the hospital. Thomas Johnson also spoke about the difficulties in not including EMS in the transport decisions.

- Reimbursors have not kept up with what is realistically happening in the system – Dr. Krohmer.
- Statutory requirements for EMS need to be clear – Kuhl.
  i. Discussed the last unit being allowed to be taken when 911 is activated. **This should be an education point.**
  ii. Dr. Bigsby also said the statute is out of date. Emily said the statute was written in 1978 and discussed. Proposed changes to the legislation were discussed. Alyson spoke about the 911 24/7 availability problem for those wanting to do just transfers. Mark Meijer advised he was involved in the writing of the law, and this isn't something that requires a legislative fix and discussed. Bruce said we shouldn't shy away from legislative changes.
- **Action item: make into 5 broad statements with subcategories for the next agenda.**

- Hospital to non-hospital facility transfer
  - Katelyn spoke about ripple effect for the specialized services, as they eventually have to go back. Discharge was discussed, as sometimes the facility won't take them back.
  - Dr. Krohmer asked if behavioral health has inpatient care. Mark and Alyson said most transfers go to inpatient facilities.
  - Katelyn discussed time for intake at behavioral health facility and how that can be a problem with tying up crews. Alyson spoke of limited time for admission staff at the receiving facilities.
  - Thomas discussed challenges with lack of advance notice to the agencies and problems that can cause.
  - Alyson discussed compounding effects.
  - Ralph discussed knowledge of the process or lack thereof.
  - Doug Pratt said an issue they run into is bypass of facilities due to patient's address. Medicare doesn't pay for this, so they are turned down.
  - Rob suggested digging deeper into emergency vs transfer. Thomas said this will make it more complex.
  - Emergency vs non-emergency and physician discretion.
  - Medically necessity was discussed.
- Break and summarize.
- What are we doing here discussion.

- Identifying touch points that are causing issues and then look for the solutions. This may be more important than identifying definitions at this time – M. Meijer
- Definition of emergency….could we define as proper triaging?
- Contact points into EMS (911 vs contract)
- Debbie spoke about sharing volume.
- Jason spoke about improper triage and the risk from the misleading information.
- Alyson spoke about putting together a regional resource guide which will include appropriate steps and what agencies are out there. This will be electronic on one of the regional MCA websites. Thomas asked about EMResource, and Alyson said they would like it to be used more. Dr. Bigsby said he doesn't know enough about it to use it as a real time resource. Emily said there is a way for it to do that but is difficult and not free.
- Jason spoke about wheelchair vans with a new piece of equipment and advised we may wish to discuss.

- Regulatory Educational Components

7. **Additional Items from Attendees**
8. **Adjourn**
9. **Next Meeting: July 24, 2023.**
   - Recurring series is the fourth Monday of the month at 9 a.m.

EMSCC Patient Movement
NOTES:
4/24/2023:
NEMSIS 3.5
HOSPITAL-TO-HOSPITAL TRANSFER: Any transfer, after initial assessment and stabilization, from and to a healthcare facility, to include specialty hospitals, for the purpose of continuation of acute care, this would also include emergent transfer requests (e.g., hospital to hospital, provider based freestanding ED to hospital, freestanding outpatient surgical centers with an ED 24/7, hospital owned clinic to hospital). Acute rehab to a hospital?
HOSPITAL TO NON-HOSPITAL FACILITY TRANSFER: Any transfer from a hospital to a non-hospital facility. An example of this is a transfer from a hospital to a care center. (e.g. hospital to a long-term care facility, hospital to a behavioral health center, hospital to hospice)
NON-HOSPITAL TO NON-HOSPITAL FACILITY TRANSFER: Any transfer from one facility to another facility neither of which qualify as a hospital. An example of this is a transfer from a dialysis center to an out-patient clinic. (e.g. home to dialysis and return, skilled nursing to appointments or clinics
NON-HOSPITAL FACILITY TO HOSPITAL TRANSFER: Any transfer from a non-hospital facility to a hospital. (e.g. dialysis center to a hospital, non-hospital clinic to a hospital, non-hospital urgent care to a hospital, non-hospital surgical center to a hospital, non-hospital physician's office to a hospital, skilled nursing to a hospital)
OTHER ROUTINE MEDICAL TRANSPORT: Transports that are not between hospitals or that do not require an immediate response; these are generally for the purpose of transportation to or from an appointment, performance of a procedure, or long-term care (e.g., hospital to home, home to appointments).
Start with PROBLEM STATEMENTS Vs. Category

Parking Lot Issues
EMERGENCY RESPONSE (PRIMARY RESPONSE AREA): Emergent or immediate response to an incident location, regardless of method of notification (e.g., 9-1-1, direct dial, walk-in, flagging down, air ambulance scene flight).
EMERGENCY RESPONSE (INTERCEPT): When one EMS clinician meets a transporting EMS unit vehicle with the intent of receiving a patient or providing a higher level of care.
EMERGENCY RESPONSE (MUTUAL AID): Response of emergency medical services, and other emergency personnel and equipment, to a request for assistance in an emergency when local resources have been expended.

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Problem Statements

- Differences in opinion on priority of the patient. (Ambulance company vs sending facility)
  - Condition vs time sensitivity
  - Timeliness of intervention/scheduled bed loss/surgery time
  - Time sensitive arrival time
- Differences in opinion on destination facility/location in a facility. (ED vs. floor, closest vs in network)
- Specialty care/scope of practice
- Receiving facility availability/availability of specialty care

  - Peds
  - OB
  - Specialty trauma (burns, eyes, hands)
  - Stroke/STEMI
  - Behavioral health – for hospital to hospital, also other categories
- Coordination of care
  - Notification and communication during planning
  - Multiple patients at the same time from the same facility
- Geography
- Crew safety
  - Climate/weather
  - Personnel
- Availability of resources
  - Climate/weather (air)
  - Vehicles/crews
  - Types of ambulances – specialty care (medications, ventilators, etc)
- Reimbursement – antiquated payment systems/requirements – medical necessity

6/2/2023:

HOSPITAL TO NON-HOSPITAL FACILITY TRANSFER: Any transfer from a hospital to a non-hospital facility. An example of this is a transfer from a hospital to a care center. (e.g. hospital to a long-term care facility, hospital to a behavioral health center, hospital to hospice)

- Distance
  - Location of residence
  - Specialty type care – behavioral health, etc.
- Reimbursement
  - Medical necessity – appropriate use – appropriate resources
  - Bypassing facilities
- Coordination of care
  - Lack of advance notice, utilization of entire shift
  - Admission times and targeting
- Availability of resources
  - Bed availability
  - Authorization delays
  - Refusal of receiving facility
  - Timing of availability
- Delay in intake/transfer of patient care
- Crew safety
  - Fatigue
  - Weather

NON-HOSPITAL FACILITY TO HOSPITAL TRANSFER: Any transfer from a non-hospital facility to a hospital. (e.g. dialysis center to a hospital, non-hospital clinic to a hospital, non-hospital urgent care to a hospital, non-hospital surgical center to a hospital, non-hospital physician's office to a hospital, skilled nursing to a hospital)

- Contact points into EMS (911 vs. contract)
- Response time appropriateness
- Appropriate resource utilization
- Destination/geography
- Acuity of patient - definition
- Coordination of care
    - Scheduled vs non vs immediate
- Wheelchair van expansion