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

EMSCC Patient Movement Ad Hoc
Minutes
September 25, 2023
10:00 a.m. – 12:00 p.m.
Click here to join the meeting
248-509-0316 Conference ID: 311 036 897#
1001 Terminal Road, Lansing, MI 48906

Members: Debbie Condino-chair, Dr. Bigsby, Ken Cummings, Dr. Krohmer, Angela Madden, Ralph Ortiz, Connie O'Malley, Rob Warnemuende, Doug Pratt, Ron Slagell.

Absent: Lauren LaPine, Jason MacDonald, Alyson Sundberg, Ed Unger.

Guests: Bill Priese, Tri County MCA; Bruce Trevithick, Genesee County MCA; Mark Meijer, Life EMS; Eric Snidersich, MMR; Sue Proctor, Corewell Health; Andrea Abbas, MCRH; Damon Gorelick, DEMCA; Jeremy Kelly, Corewell Health; Aubrey Czapek, Life EMS; Lynn Weber, Clinton Area Ambulance Service; Kolby Miller, Medstar; Kevin Henderson, Washtenaw Livingston MCA; Kelsey Ostergren, MHA; Lance Corey, Kent County EMS; Kevin Wilkinson, Medstar; Dustin Hawley, Superior.

Staff: Babb, Bergquist, Burke, Nelson, Schaible, Worden, Jean, Baker, Bliss, Verlinde, Brown, Chadderton, Flory.

1. **Call to Order: The meeting was called to order at 9:10 a.m. by Debbie Condino.**
2. **Roll Call-We have a quorum today.**
3. **Approval of Agenda and minutes from 7/28/2023: Motion to approve (Cummings, Bigsby). Approved.**
4. **Old Business**
   - Problem statements
     - Top five problems under each category
     - The group reviewed the document and discussed. Connie O'Malley suggested creating a system where we could do a rotation between all agencies within that area so that it's fair and consistent for bullet point five under "Hospital to Acute Care Hospital Transfers". Payment structure was discussed. Add "through traditional reimbursement structures" to the last statement under behavioral health. Next steps: **This is the final draft of the problem statements, and this will go to EMSCC for feedback and approval in November. Then working on the solutions to the statements going forward.**

5. New Business

- Regulatory Educational Components
  - Ralph: Proper activation of 911
  - Dr. Krohmer and Bruce Trevithick to discuss education on scope/interfacility with hospital staff.
  - Dr. Bigsby suggested looking to the stakeholder organizations to help and suggested putting it on MI TRAIN and credits.
  - Ken: Hard to get the education to the people that need the education. He spoke about the troubles. Emily discussed going to the education programs of the other specialties (Nursing, Physician). Bruce discussed local information and turnover in the ED. Dr. Bigsby spoke about difficulties in getting people together.
  - Dr. Bigsby: Physicians may not understand reimbursement. Ken advised Ron Slagell is expert in this. Ron said he would be willing to give the group information on this. Kolby asked if the state Medicaid office could be involved. Emily advised we can invite them, but we have to be nice. Ron suggested we have solutions available before bringing them in. Medically necessity was also discussed, as well as including Katie Arens from Life EMS.
  - Emily: Certificate of need. Possibly include Victoria.
  - Ken: Internal education. This topic was discussed by the group. Ken said system design, as they are different throughout the state. Workforce challenge is a problem. Ken said initiatives are being worked on but it will take time.
  - Debbie: Protocol and rules. The group discussed. Emily said this could be an entire meeting. Emily advised including Victoria from MDHHS Legal.
  - Behavioral health…CMH and CON. Kolby: patient handoff/receiving education for EMS. Link from Lyn.
  - Dr. Bigsby: Dispatch. Ken: Transfers.
  - Dr. Bigsby: Global coordination center. Eileen said this is the beginning of a national conversation in response to the pandemic and appreciates this as a long-time future goal.
  - Prioritization was discussed.
  - Bill Priese: what would it take to change statute? Legislative change is not something the department can pursue. Emily advised this would not be supported universally by stakeholder groups.
  - **NEXT STEPS: Statue and Rules in October, payment in November. Department to do educational session at the October meeting.**

6. Additional Items from Attendees

7. Adjourn 10:39 Bigsby, Connie

8. Next Meeting: October 23, 2023.

- Recurring series is the fourth Monday of the month at 9 a.m.

EMSCC Patient Movement RUNNING 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

7/24/2023: Work on problem statements/education topics

Universal/National Challenges

- Workforce shortages are across the continuum and affect EMS agencies, hospitals, licensed facilities, and other sending and receiving institutions.
- Understanding of necessity, capability, and other payment rules and regulations create issues with reimbursement and sustainability of services.

Hospital to Acute Care Hospital Transfers

- There are not clear and universally accepted priorities and timelines for different types of patients and conditions.
    - Activity one – standardization
- Facility capability, access to specialty services, capacity, patient need, geography, and inclement weather present difficulties in destination determination and availability of resources.
- EMS scope of practice is not widely known, creating resource misassignment, with the highest level of specialty care not available in many areas of the state.
    - Transferring physicians
    - EMS Clinicians
        - Lack of clear medical direction
        - "Guard rails" for clinicians – just in time training
    - Protocols lacking in detailed for inter-facility (more specifics needed)
- Coordination of care and patient information sharing through facilities and with EMS is lacking, creating delays and issues in moving patients, as well as potential patient safety risks.
- Privileging – bringing resources from other areas to do longer transfers

Hospital to Non-Hospital Facility Transfers Including BHS

- Availability of beds and facility willingness to accept patients creates confines and pressures on the system's resources.
- Coordination of care through facilities and types of care is lacking, creating delays and issues in moving patients.

- Inability to move patients to other types of care prevents hospital beds from being available for other patients, which then creates strain on emergency departments and EMS through increased wall times and patient diversions.
- Medical necessity for different types of transfers is not well understood or documented, creating reimbursement and sustainability issues.
- Need to write something about types of transportation for behavioral health.

Non-hospital to Hospital Transfer

- The appropriate way to access the system is not transparent in many facilities (the use of 911 vs contracted direct dial) which can create issues with resource assignment, and ultimately patient safety issues.
- The continued lack of universal EMD creates problems with resource allocation regarding what assets to deploy when a facility requests service through 911.
- Capability and medical necessity in reference to ambulance transport is not well understood, putting crews, agencies, and facilities in difficult situations regarding resource management.
- Destination facility decisions by the sending facility or physician do not always coincide with EMS protocol, creating interpersonal issues and confusion between clinicians and to the patient.

Potential Education Opportunities

- Increased access to specialty and critical EMS education (to EMS clinicians)
- Scope/interfacility responsibilities for EMS and hospital staff
- Handoff/patient handover report/time out
- Hospital education regarding EMS as a clinical component
    - Sending/receiving physicians
    - Nursing
- Medical necessity training - reimbursement
    - for discharge/social work
    - Providers generally
    - Facility staff
    - EMS documentation
    - Physician Certification Statements
    - CMO/Physicians (MHA – Lauren)
    - Committee training – September/October?
- Hospital training re: contracting/providers for interfacility work
- Protocol specifics and responsibilities

Research

- Physician accepting/immediate/emergency – appropriate facility/payment
    - Reimbursement covered if the physician signs that it is the closest
    - Mismatch in PCS vs. EMS documentation – voids billing
- Access? Should it be a contract/free market or otherwise?

Yet to be addressed: SPRN

Action Item - Problem Statements

Universal/National Challenges

- Workforce shortages are across the continuum and affect EMS agencies, hospitals, licensed facilities, and other sending and receiving institutions.
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Hospital to Acute Care Hospital Transfers

- There are not clear and universally accepted priorities and timelines for different types of patients and conditions.
- Facility capability, access to specialty services, capacity, patient need, geography, and inclement weather present difficulties in destination determination and availability of resources.
- EMS scope of practice is not widely known, creating resource misassignment, with the highest level of specialty care not available in many areas of the state.
- Coordination of care and patient information sharing through facilities and with EMS is lacking, creating delays and issues in moving patients, as well as potential patient safety risks.
- Ambulance operations are not universally privileged, with limited ability to cross Medical Control Authorities (MCA) to move patients longer distances. New protocols allow for more movement, but there is little trust that this will be done in a thoughtful way.

Hospital to Non-Hospital Facility Transfers (Including Behavioral Health)

- Availability of beds and facility willingness to accept patients creates confines and pressures on the system's resources.
- Coordination of care through facilities and types of care is lacking, creating delays and issues in moving patients.
- Inability to move patients to other types of care prevents hospital beds from being available for other patients, which then creates strain on emergency departments and EMS through increased wall times and patient diversions.
- Medical necessity for different types of transfers is not well understood or documented, creating reimbursement and sustainability issues.
- Behavioral health patients present different needs for safety and observation. These needs may be able to be met with a vehicle other than an ambulance, but the payment methodology and infrastructure for this do not exist broadly.

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- Capability and medical necessity in reference to ambulance transport is not well understood, putting crews, agencies, and facilities in difficult situations regarding resource management.
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Follow up Items AFTER Problem Statements

Potential Education Opportunities

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Problem statement follow up

- Activity one – standardization
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- SPRN