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

EMSCC Patient Movement Ad Hoc
Minutes
October 23, 2023

10:00 a.m. – 12:00 p.m.

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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, Alyson Sundberg, Ed Unger.

Absent: Lauren LaPine, Jason MacDonald.

Guests: Renee Gray, Kinross; Bruce Trevithick, Genesee County MCA; Mark Meijer, Life EMS; Sue Proctor, Corewell Health; Andrea Abbas, MCRH; Jeremy Kelly, Corewell Health; Lynn Weber, Clinton Area Ambulance Service; Kevin Henderson, Washtenaw Livingston MCA; Lance Corey, Kent County EMS; Kevin Wilkinson, Medstar; Dustin Hawley, Superior.

Staff: Babb, Bergquist, Piette, Burke, Nelson, Worden, Baker, Bliss, Verlinde, Brown, Chadderton, Flory, Detro-Fisher, Dr. Fales, First.

1. **Call to Order: The meeting was called to order at 9:00 a.m. by Debbie Condino.**
2. **Roll Call-We have a quorum today.**
3. **Approval of Agenda and minutes from 9/25/2023: Motion to approve (Krohmer, O'Malley). Approved.**
4. **Old Business**
5. **New Business**
    - **Rules and Law Presentation**
    - **Other statements and rulings**
        - Emily Bergquist gave a presentation, which is attached to these minutes, and answered questions.
    - **Discussion**
        - Ken Cummings if Emily would please go over the difference between statute and administrative rules. The law is non-negotiable, outside of changes by the legislature and governor. The rules are written by the department to clarify the statute. It can not supersede the statute, and it can't involve funding or fees. She explained the rules process. Systems of Care is currently going through this process right now.
        - Dr. Krohmer asked about hospitals requesting discharge and is there a requirement that an agency needs to comply. Emily addressed and said no, there

is not. There is no authority for that in the statute. Dr. Krohmer said that goes to the crux of issues this subcommittee needs to address.

- Jeremy Kelly asked about higher level of care. Emily advised of the definition of an emergency patient and briefly discussed.
- Ed Unger asked about a transfer patient who goes south on transport and who is ultimately responsible for that patient. Emily addressed. The sending physician, per federal law, is responsible. There are nuances, it depends on the situation. Reverting to the protocols is not a bad thing.
- Alyson Sundberg discussed transfers and leaving 911 uncovered. Emily discussed, and again, there are nuances. Closet appropriate facility comes into play.
- Ron Slagell spoke about scenarios. Challenges are created. Facilities can't keep the patient in their system if they activate 911. He said we don't want hospitals calling 911. It is a complex situation. Emily mentioned ED physician training.
- Ken said a lot of this goes back to local system design and discussed. The benefit of this is encouraging people to participate in system design. Emily said this is the point of why hospitals and agencies should participate in the MCA and discussed. Eileen Worden spoke about the Systems of Care development. She said there isn't a soul in this room that doesn't want what's best for the patient and discussed. Having conversations and figuring things out is important. Ken also spoke about conversations.
- Dr. Fales spoke about MCA medical director's coordination in their areas.

6. **Additional Items from Attendees**
   - None.
7. **Adjourn at 10:30 a.m. (O'Malley, Madden).**
8. **Next Meeting: November 27, 2023 (virtual)**
   - **Billing, Payment, and Finance with Ron Slagell and Katie Arens**

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.

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).
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

Patient Movement Subcommittee

September 25, 2023

MDHHS
Michigan Department of Health & Human Services

Goals

- Create understanding of regulatory components for patient movement.
- Provide baseline for what is “within the oversight” of MDHHS.
- Overview roles in the system.

PA 368 of 1978, as amended

MDHHS
Michigan Department of Health & Human Services

Definitions

- Michigan Public Act 368 of 1978, part 209, definitions
  - "Ambulance" means a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.
  - "Ambulance operation" means a person licensed under this part to provide emergency medical services and patient transport, for profit or otherwise.
  - "Emergency" means a condition or situation in which an individual declares a need for immediate medical attention for any individual, or where that need is declared by emergency medical services personnel or a public safety official.
  - "Emergency patient" means an individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in 1 or all of the following:
    - Placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.
    - Serious impairment of bodily function.
    - Serious dysfunction of a body organ or part.

Definitions

- Michigan Public Act 368 of 1978, part 209, definitions
  - "Medical control" means supervising and coordinating emergency medical services through a medical control authority, as prescribed, adopted, and enforced through department-approved protocols, within an emergency medical services system.
  - "Medical control authority" means an organization designated by the department under section 20910(1)(g) to provide medical control.
  - "Medical director" means a physician who is appointed to that position by a medical control authority under section 20918.
  - "Nonemergency patient" means an individual who is transported by stretcher, isolette, cot, or litter but whose physical or mental condition is such that the individual may reasonably be suspected of not being in imminent danger of loss of life or of significant health impairment.
  - "Protocol" means a patient care standard, standing orders, policy, or procedure for providing emergency medical services that is established by a medical control authority and approved by the department under section 20919.

Departmental Responsibility

- Michigan Public Act 368 of 1978, part 209, Department Responsibility
  - The department shall do all of the following:
    - Be responsible for the development, coordination, and administration of a statewide emergency medical services system.
    - Facilitate and promote programs of public information and education concerning emergency medical services.
    - In case of actual disasters and disaster training drills and exercises, provide emergency medical services resources pursuant to applicable provisions of the Michigan emergency preparedness plan, or as prescribed by the director of emergency services pursuant to the emergency management act, 1976 PA 390, MCL 30.401 to 30.421.
    - Consistent with the rules of the federal communications commission, plan, develop, coordinate, and administer a statewide emergency medical services communications system.

Departmental Responsibility

- Michigan Public Act 368 of 1978, part 209, Department Responsibility
  - The department shall do all of the following (continued):
    - Develop and maintain standards of emergency medical services and personnel…
    - Promulgate rules to establish and maintain standards for and regulate the use of descriptive words, phrases, symbols, or emblems that represent or denote…
    - Designate a medical control authority as the medical control for emergency medical services for a particular geographic region as provided for under this part.
    - Develop and implement field studies…
    - Collect data as necessary to assess the need for and quality of emergency medical services throughout the state pursuant to 1967 PA 270, MCL 331.531 to 331.533.
    - Develop, with the advice of the emergency medical services coordination committee, an emergency medical services plan that includes rural issues.

Departmental Responsibility

- Michigan Public Act 368 of 1978, part 209, Department Responsibility
  - The department shall do all of the following (continued):
    - Develop recommendations for territorial boundaries of medical control authorities that are designed to assure that there exists reasonable emergency medical services capacity within the boundaries for the estimated demand for emergency medical services.
    - Within 1 year after the statewide trauma care advisory subcommittee…
    - Promulgate other rules to implement this part.
    - Perform other duties as set forth in this part.

Medical Control Authorities

- Michigan Public Act 368 of 1978, 333.20918
  - Each hospital licensed under part 215 and each freestanding surgical outpatient facility licensed under part 208 that operates a service for treating emergency patients 24 hours a day, 7 days a week and meets standards established by medical control authority protocols shall be given the opportunity to participate in the ongoing planning and development activities of the local medical control authority designated by the department and shall adhere to protocols for providing services to a patient before care of the patient is transferred to hospital personnel, to the extent that those protocols apply to a hospital or freestanding surgical outpatient facility.
  - The department shall designate a medical control authority… In designating a medical control authority, the department shall assure that there is a reasonable relationship between the existing emergency medical services capacity in the geographical area to be served by the medical control authority and the estimated demand for emergency medical services in that area.

Medical Control Authorities

- Michigan Public Act 368 of 1978, 333.20918
  - A medical control authority shall be administered by the participating hospitals…
  - With the advice of the advisory body of the medical control authority appointed under subsection (2), a medical control authority shall appoint a medical director of the medical control authority. […]The medical director is responsible for medical control for the emergency medical services system served by the medical control authority.
  - Each life support agency and individual licensed under this part is accountable to the medical control authority in the provision of emergency medical services, as defined in protocols developed by the medical control authority and approved by the department under this part.

Protocols (not all inclusive)

- Michigan Public Act 368 of 1978, 333.20919
- A medical control authority shall establish written protocols for the practice of life support agencies and licensed emergency medical services personnel within its region. The medical control authority shall develop and adopt the protocols required under this section in accordance with procedures established by the department and shall include all of the following:
  - The acts, tasks, or functions that may be performed by each type of emergency medical services personnel licensed under this part.
  - Medical protocols to ensure the appropriate dispatching of a life support agency based upon medical need and the capability of the emergency medical services system.
  - Protocols to ensure that a quality improvement program is in place within a medical control authority and provides data protection as provided in 1967 PA 270, MCL 331.531 to 331.534.

Protocols (not all inclusive)

- Michigan Public Act 368 of 1978, 333.20919
- If adopted in protocols approved by the department, a medical control authority may require life support agencies within its region to meet reasonable additional standards for equipment and personnel, other than medical first responders, that may be more stringent than are otherwise required under this part. If a medical control authority proposes a protocol that establishes additional standards for equipment and personnel, the medical control authority and the department shall consider the medical and economic impact on the local community, the need for communities to do long-term planning, and the availability of personnel. If either the medical control authority or the department determines that negative medical or economic impacts outweigh the benefits of those additional standards as they affect public health, safety, and welfare, the medical control authority shall not adopt and the department shall not approve protocols containing those additional standards.

Ambulance Operations

- Michigan Public Act 368 of 1978, 333.20921
- An ambulance operation shall do all of the following:
  - Except as provided in section 20921a, provide at least 1 ambulance available for response to requests for emergency assistance on a 24-hour-a-day, 7-day-a-week basis in accordance with local medical control authority protocols.
  - Respond or ensure that a response is provided to each request for emergency assistance originating from within the bounds of its service area.
  - Operate under the direction of a medical control authority or the medical control authorities with jurisdiction over the ambulance operation.
  - Notify the department immediately of a change that would alter the information contained on its application for an ambulance operation license or renewal.
  - …provide life support consistent with its license and approved local medical control authority protocols to each emergency patient without prior inquiry into ability to pay or source of payment.

Ambulance Operations

- Michigan Public Act 368 of 1978, 333.20921
- Except as provided in subsection (4) and section 20921a, an ambulance operation shall not operate, attend, or permit an ambulance to be operated while transporting a patient unless the ambulance is, at a minimum, staffed as follows: (staffing rules)
- Except as provided in subsection (6), an ambulance operation shall ensure that an emergency medical technician, an emergency medical technician specialist, or a paramedic is in the patient compartment of an ambulance while transporting an emergency patient.
- Subsection (5) does not apply to the transportation of a patient by an ambulance if the patient is accompanied in the patient compartment of the ambulance by an appropriate licensed health professional designated by a physician and after a physician-patient relationship has been established as prescribed in this part or the rules promulgated by the department under this part.

Administrative Rules

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Administrative Rules

- Life Support Agency and MCA
- 325.22217
  - A medical control authority may adopt a protocol that governs the transport of a patient from 1 health facility to another. If a medical control authority has not established department-approved protocols for the interfacility transport of a patient, then patient care must be determined according to written orders of the transferring physician within the scope of practice of the emergency medical services personnel.
  - A life support agency is accountable to a medical control authority in which it has been approved to operate.
- 325.22218
  - With department approval, a medical control authority may implement a protocol that governs the treatment and stretcher transport of nonemergency patients.

Protocols

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Protocols

- Interfacility Patient Transfer – NEW 2023
- 8.15 and 8.15(s)

Other Declarations

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Information to Reference

- AG Opinion 7072 (2001)
  - Applicability of protocols on interfacility transfers
- Declaratory Ruling (2009)
  - Ability for MCAs to oversee/grant ability for agencies to perform transfers

Summary

- No rules or laws that force an agency to do non-emergency transport.
- Authority for the movement of these patients does rest with the MCA/Department
- MCAs do have some tools at their disposal to facilitate interfacility patient movement.

Questions and Discussion

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