Maryland Emergency Medical Services:

New Care Delivery Models for EMS

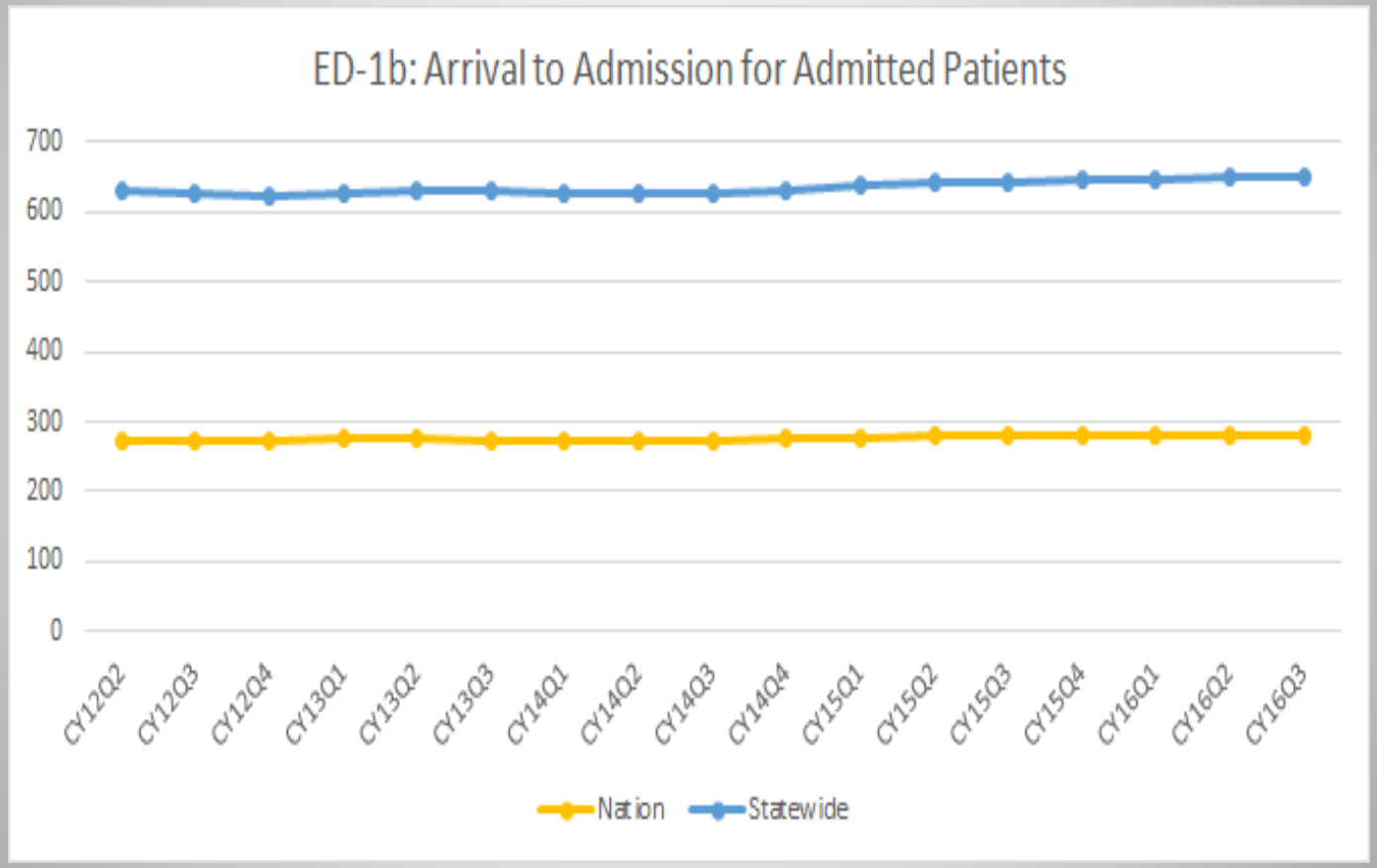
Pertinent Reports Submitted to Maryland Legislature in 2017

- Workgroup on Rural Health Delivery
  - Convene workgroup to discuss MIH Funding
- MIEMSS Report on MIH
  - Secure adequate, ongoing support for MIH to ensure sustainment and growth
- MIEMSS & HSCRC Report on ED Overcrowding
  - Work with HSCRC and MDH to permit EMS reimbursement for new models of health care delivery: 1) EMS treat with no transport; 2) EMS transport to alternative destinations; and 3) MIH Programs

Maryland ED Wait Times Worst in US

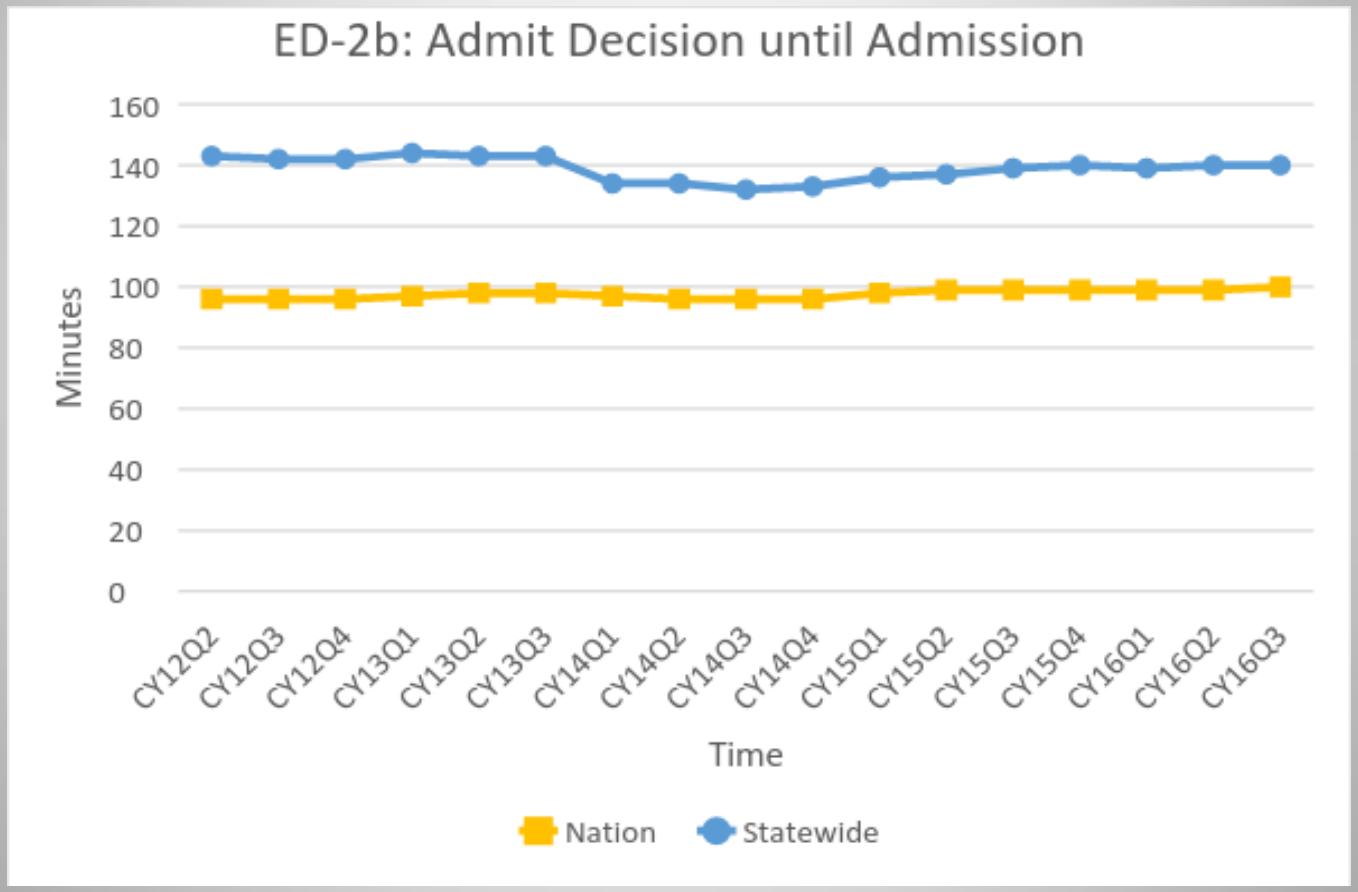
- Maryland hospitals experience inefficiencies associated with patients entering the hospital through the Emergency Department, as measured by wait times, despite a decrease in ED visits per 1,000 population.
- CMS collects inpatient and outpatient quality reporting measures across the hospital system, including Emergency Department measures:
  - ED_1b: Median Time from ED Arrival to ED Departure for Admitted ED Patients
  - ED_2b: Admit Decision Time to ED Departure Time for Admitted Patients
  - OP_18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- Maryland hospitals perform far worse than the national average, a problem that has existed for Maryland for a number of years prior to the ACA or the All-Payer Model.

Figure 1. Time (Minutes) from ED Arrival to Inpatient Admission for Admitted Patients – Maryland vs. National



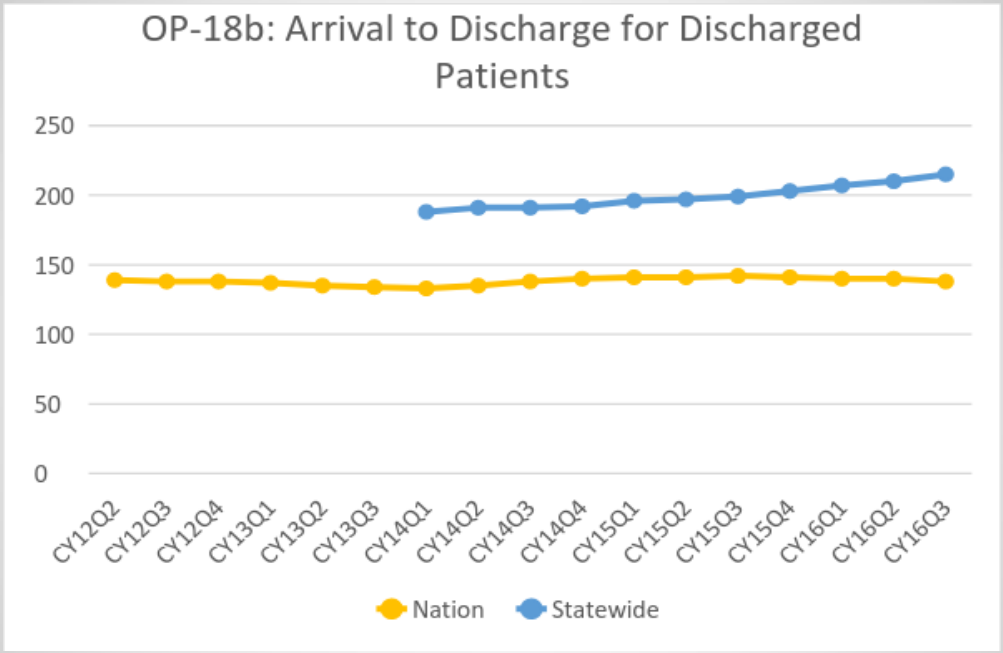
Source: CMS Hospital Compare Data

Figure 2. Time (Minutes) from ED Decision to Admit to Inpatient Admission – Maryland vs. National



Source: CMS Hospital Compare Data

Figure 3. Time (Minutes) from ED Arrival to ED Discharge – Maryland vs. National



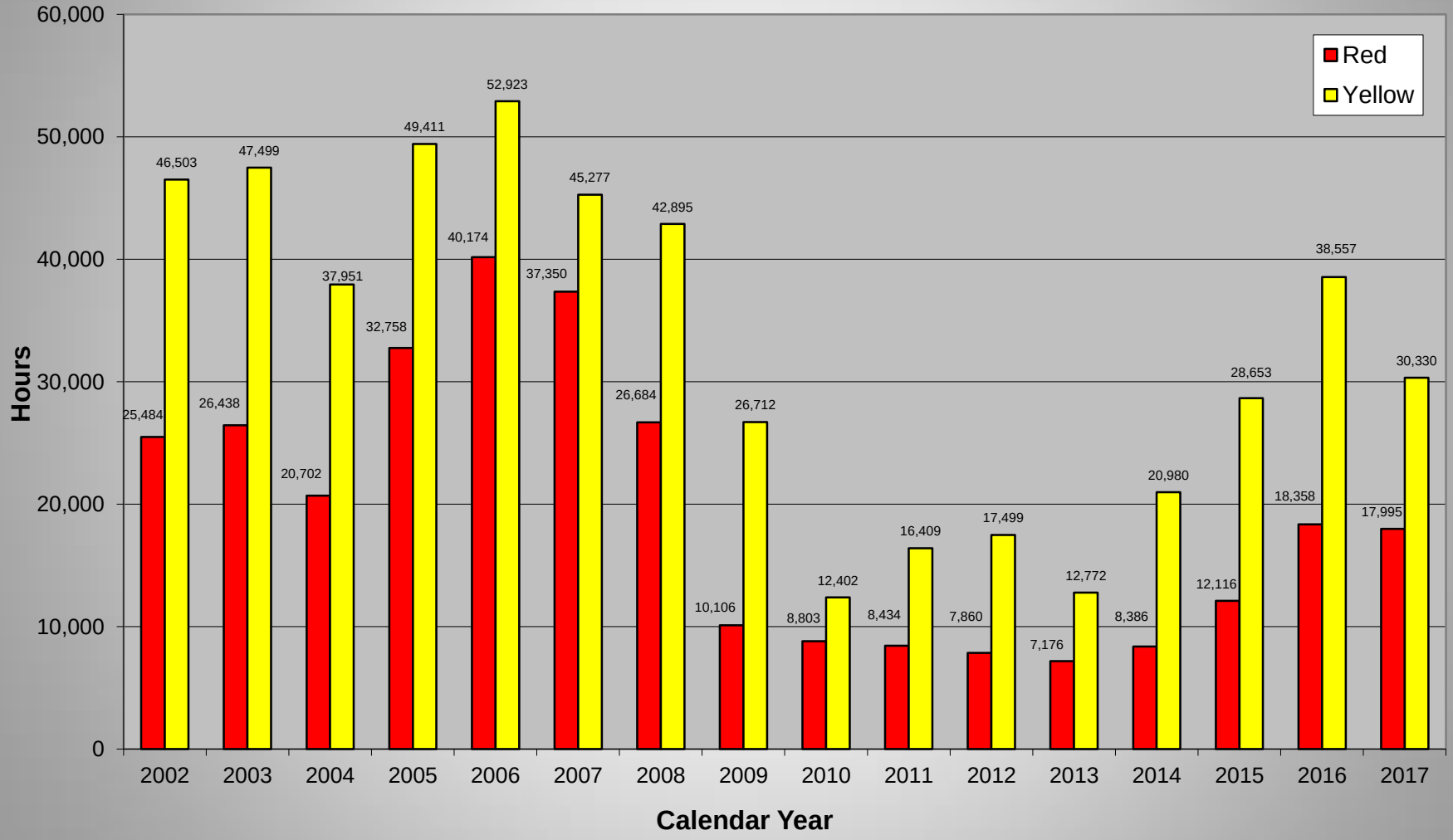
EMS Transports to Hospital EDs Continue to Increase

Maryland EMS Transports by Year			
Calendar Year 2015-2017			
Source: eMEDS®			
Calendar Year	2015	2016	2017
Total	538,818	554,151	559,891

Long ED Wait Times + Increasing EMS Transports to EDs

- ED Overcrowding
- Long EMS off-load times at hospital EDs
- Diversion of emergency patients from one ED to another
- Decreased availability of EMS ambulances
- Diminished EMS capacity to respond to 9-1-1 calls
- Hospital ED Yellow Alerts - A “Yellow Alert” diversion is initiated because the ED is experiencing a temporary overwhelming overload such that priority II and III patients may not be managed safely.

State Diversion Alert Totals
Calendar Years 2002 to 2017



“Excessive ED wait times and ambulance diversion from one hospital to another has been a long-standing challenge for the Maryland health care system and is a multifaceted problem that will require comprehensive system adjustments…”

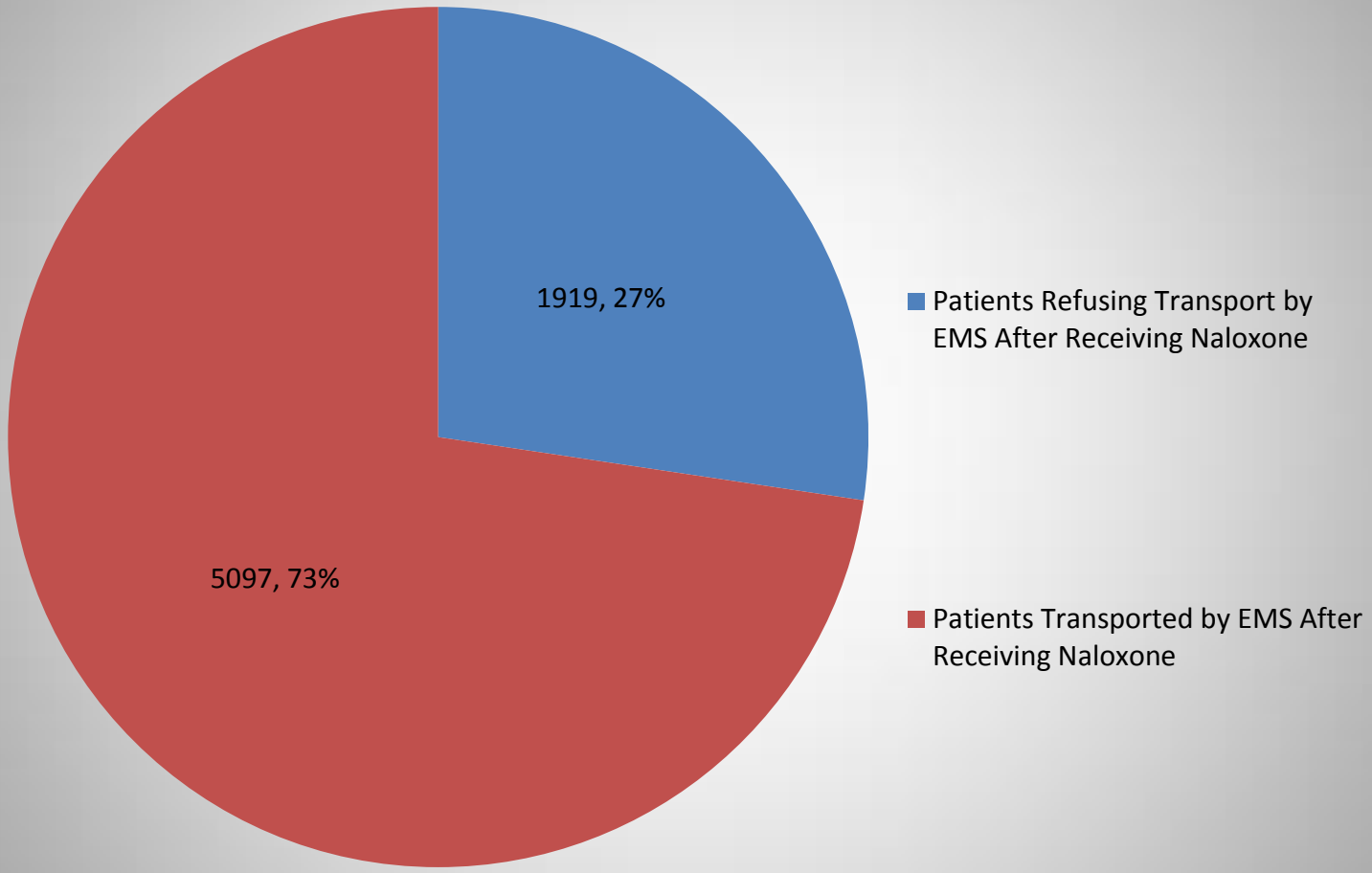
Some EMS-Transported Patients Do Not Need to be Treated in an ED

- Some patients who call 9-1-1 and are transported by EMS to hospital emergency departments have conditions that could be treated in a health care environment other than a hospital emergency department.
- Statewide EMS data indicates that most EMS transports to the ED are classified as Priority 3.
- Priority 3 patients are those whom EMS has determined have “non-emergent conditions, requiring medical attention, but not on an emergency basis.”
- Priority 3 patients are potential candidates for treatment in an environment other than the ED.

EMS Transports by Patient Priority						
Calendar Year 2015 - 2017						
Source: eMEDS®						
	Priority 1	Priority 2	Priority 3	Priority 4	Unknown	Total
CY 2015	22,516	181,197	311,422	1,820	21,863	538,818
CY 2016	24,444	190,916	334,765	1,659	2,367	554,151
CY 2017	25,253	188,113	342,544	1,596	2,385	559,891

EMS Patients Accepting Treatment / Refusing Transport				
Calendar Years 2015 to 2017				
Source: eMEDS®				
Calendar Year	CY 2015	CY 2016	CY 2017	Total
Total	61,355	67,169	73,687	202,211

Patients Receiving Naloxone from EMS (11/14/17 - 5/14/18)



Public Safety EMS Reimbursement is Tied to Transport to Hospital EDs

- Reimbursement practices for EMS are not aligned with health care initiatives to reduce unnecessary hospital use and provide appropriate care in community settings.

- Because EMS is viewed as a transportation benefit, EMS is not reimbursed unless a transport actually occurs.

- The hospital ED is a high cost environment for delivery of health care services. There is currently no ability for EMS to be reimbursed for providing services to low-acuity patients at the patient's home or for obtaining services for patients in other less costly environments.

New Models of EMS Care Delivery

New models of EMS care delivery aim to reduce unnecessary EMS transports to hospital EDs and to provide needed services to patients in less-costly settings.

- Mobile Integrated Healthcare (MIH)
- Alternative Destinations
- Treat without Transport

Mobile Integrated Health (MIH)

- Focus is on frequent users of the 9-1-1 system who have non-emergency or chronic medical conditions.
- Targeted to reducing the number of EMS transports of high utilizers of 9-1-1 EMS services who have chronic or low acuity conditions by partnering with other health care providers to conduct home visits to assess, treat and refer patients to needed services outside the emergency department environment.
- Capable of linking patients to preventative health services, reducing 9-1-1 EMS call volumes, and improving the continuity of care from the hospital to the home in order to reduce complications for patients and avoid unnecessary hospital readmissions.

Summary of Maryland Mobile Integrated Health Care Programs (June 2018)

Program	Overall Goals	Program Support to Date	Program Details
Queen Anne's County	Reduce 911 calls Reduce unnecessary ED visits Reduce readmissions Increase primary care use Increase referrals to community resources	UM Shore Regional Health MD Department of Health QAC Department of Health QAC Department Emergency Svcs CareFirst Blue Cross / Blue Shield QAC Commissioners Anne Arundel Medical Center	# Enrolled: 224 RN/NP + Paramedic MC 61%; MA 14%; BC 12%
Montgomery County	Reduce 911 calls Reduce unnecessary ED visits	Mont. Co Fire & Rescue Svcs Mont. Co Dept. Health & Human Svcs Suburban Hospital Adventist HealthCare Shady Grove Medical Center Adventist HealthCare Washington Adventist Hospital Montgomery County Department of Health & Human Services Holy Cross Health	# Enrolled: 240 CHN + Paramedic MC 66%; MA 8%; Private 20%; Kaiser 2%; Uninsured 4%
Prince George's County	Reduce 911 calls Reduce unnecessary ED visits Increase primary care use Increase referrals to community resources	Prince George's Dept. Health Prince George's Dept. Social Services Doctor's Community Hospital Anne Arundel Medical Center UM Prince George's Hospital Center Adventist HealthCare Washington Adventist Hospital Kaiser Permanente Mid-Atlantic Region	# Enrolled: 102 NP/RN + Paramedic MC 41%; MA 42% (referral agreements with 7 MCOs)
Salisbury – Wicomico	Reduce 911 calls Reduce unnecessary ED visits	Salisbury Fire Department Peninsula Regional Medical Center Wicomico Health Department City of Salisbury	# Enrolled: 14 NP + Paramedic – initial Then RN + Paramedic
Charles County	Reduce 911 calls Reduce unnecessary ED visits Increase visits to primary care Increase health literacy Increase referrals to community resources Reduce hospital readmissions	MD Community Health Resources Com UM Charles Regional Medical Center Charles Cty Commissioners Charles County Dept. of Emerg. Svcs.	# Enrolled: 52 RN + Paramedic + CHW
Frederick County	Reduce 911 calls Reduce unnecessary ED visits Increase primary care use Increase referrals to community resources	Frederick County Div. of Fire & Rescue Svcs Frederick County Health Department Frederick Memorial Hospital	# Enrolled: 10 Paramedic (RN) + NP MC 33%; MA 33%
Baltimore City (May 2018) + University of Maryland Medical Center	Reduce unnecessary 911 calls & ED visits	2-year grant from Health Services Cost Review Commission	Program 1: Minor Definitive Care Now – NP + Paramedic render care on site in response to 911 Program 2: Transitional Health Support- RN + paramedic. Care for chronic patients being discharged from hospital

Alternative Destinations

- 9-1-1- patients with low acuity conditions are transported to an urgent care or similar care environment, instead of to a hospital emergency department.
- Patients eligible for alternative destinations are those whose have been determined to be stable low-acuity patients.

Treat without Transport

EMS responds to a 9-1-1- call and provides treatment to the patient at the patient's home, or other location, without further transporting the patient to a hospital ED or alternative destination.

Limitations

- A significant limitation to these new models of EMS care is the lack of reimbursement to EMS if the patient is not transported to a hospital.
- Tying EMS reimbursement to patient transports severely limits the ability of EMS to implement, or even participate in, these new models of care delivery.

What are other states doing?

States with Medicaid Reimbursement for Treatment Without Transport

- Arizona (CMS Plan Amendment)
- Georgia, only if medications administered (considered within plan)
- Nevada (received plan approval)

States with Medicaid Reimbursement for Alternative Destinations

- Georgia (considered within plan)
- Nevada (received plan approval)

States with Medicaid Reimbursement for MIH which may include Treatment Without Transport

- Minnesota (by statute with expanded scope of practice for Community Paramedicine)
- Washington (by statute with expanded scope of practice for Community Paramedicine)
- Georgia (plan amendment submitted)
- Nevada (received plan approval)

Private Payers

Private Payer Reimbursement for Treatment Without Transport

Anthem Blue Cross / Blue Shield is implementing coverage in states where it offers commercial coverage. Reimbursement is being provided for HCPCS A0998-coded 911 responses in the states listed below, to include in their Medicare and Medicaid plans as well.

- California
- Colorado
- Connecticut
- Georgia
- Indiana
- Kentucky
- Maine
- Missouri
- Nevada
- New Hampshire
- New York
- Ohio
- Virginia
- Wisconsin

Maryland EMS:
A System Saving Lives

Maryland Institute for Emergency Medical Services Systems