REVISED
PS ITEM #1
February 25, 2021
Briefing

M E M O R A N D U M

February 22, 2021

TO: Public Safety Committee

FROM: Susan J. Farag, Legislative Analyst

SUBJECT: Briefing: Telehealth and Alternate Destination Program – Fire and Rescue

PURPOSE: Briefing – No Vote Expected

Today the Committee will receive a briefing on two new programs in Montgomery County Fire and Rescue Service (MCFRS) that help avert some transports to Emergency Departments. Those expected to attend include:

Assistant Chief Alan Butsch, Emergency Medical and Integrated Health Services, MCFRS
Battalion Chief Ben Kaufman, MCFRS

Overview

MCFRS is operating two new programs designed to avert certain patient transports to Emergency Departments in situations where patients present with low acuity conditions (Priority 3.

Alternate Destination Transport (ADT) Program

The ADT began as a pilot program in January 2020 and was in its nascence when COVID-19 hit. The purpose of the program was to transport certain stable, low acuity patients to urgent care centers rather than to hospital-based Emergency Departments. This program had multiple benefits for MCFRS staff, the patient, and hospitals. MCFRS staff would be freed up more quickly to respond to the next call, the patient likely would be treated more quickly (and less expensively), and hospitals would see a reduction in ER patients.

When the pilot program began, MCFRS contracted with one urgent care provider in Silver Spring. The program was almost immediately impacted by COVID, and very few individuals presented as possible ADT transports. There was a significant reduction in the number of people who called 911 for more minor medical conditions. Despite low utilization, the pilot was never discontinued. Despite COVID-related challenges, the program was implemented County-wide on January 1, 2021. MCFRS has agreements with both Kaiser and Adventist Health to redirect appropriate patients to their urgent care centers.

Telehealth Program

On January 1 this year, MCFRS also implemented a new telehealth program. It has contracted with a physicians group, US Acute Care Solutions (USACS), to provide telehealth services to qualifying patients.

According to the Department, EMS staff can assess the patient to see if telehealth is appropriate. If so, staff uses a departmental cell phone (ruggedized Sonim smart phone) to call the assigned number for Telehealth. An on-call physician answers and then transfers to a secure Zoom call. The patient is then able to video chat with the physician. The EMS clinicians on the scene are able to assist the physician with any needed physical exam or other health service.

Billing and Reimbursement

These services are generally reimbursable from Medicare. Medicare will reimburse the Department for the Alternate Destination Program transports, in the same manner they reimburse for BLS1 transports to a hospital's Emergency Departments. Medicare reimburses for the telehealth visits as well, but there is no mileage reimbursement for these calls.

USACS is billing separately for the service and MCFRS is not charged for their time.

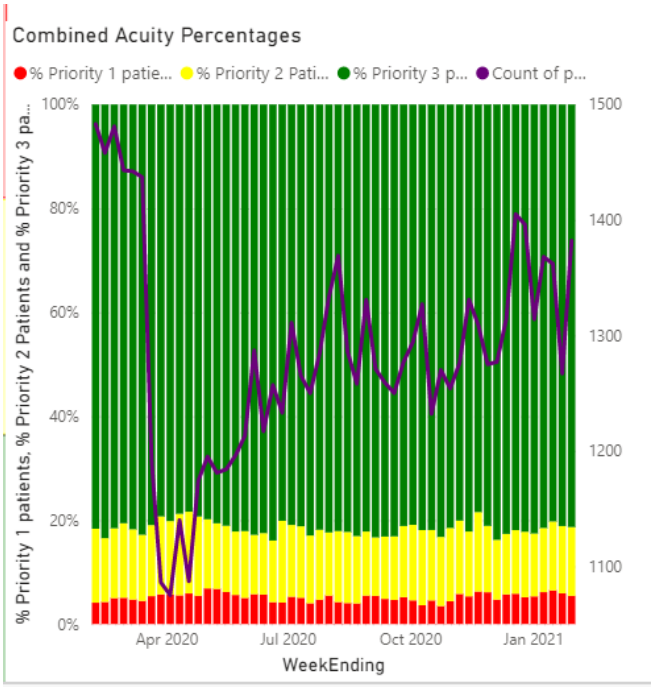
Training and Operational Requirements

The Department states that training for all MCFRS staff is being done virtually within the Department's IT learning management system (LMS). Personnel work through an interactive module and answer a quiz. MCFRS has also done a podcast with one of the physicians supporting the Telehealth program and plans to start some real-time virtual office hours with the workforce to answer questions.

Reporting for both programs is being done through eMEDS; which is the Maryland State supplied electronic patient care reporting (ePCR) software that MCFRS already utilizes. Urgent care centers participating in the alternative destination transport (ADT) program are notified of patient transports via the Sonim ruggedized smart phones issued to each MCFRS apparatus. Telehealth visits are also accomplished via the same cell phone.

COVID Impacts

COVID has changed the types of calls that MCFRS receives. Call volume is down, but the patients they see are higher acuity. The Department does not have data but speculates that individuals are more reluctant to call 911 and go to the hospital where they perceive the risk of contracting COVID may be higher. Since calls are for higher acuity patients, there is less opportunity to use these programs.



Discussion Issues

1. What are the costs, if any, associated with administering the two programs?
2. Are the apparatus-assigned cell phones used in these programs the same ones used as a backup measure for the Public Safety Radio System? If so, will these phones be funded moving forward in the FY22 Operating Budget?
3. Is the Department seeing any change in utilization now that some of our County residents have begun to get vaccinated?

This staff report contains:	**Circle #**
MCFRS Response	1-2
Attachments – MCFRS ET3 Briefing	3-16

1. How training works/what staff is needed to train/etc.

   Training for all FRS staff is being done virtually within the FRS IT learning management system (LMS). Personnel work through an interactive module and answer a quiz. MCFRS has also done a podcast with one of the physicians supporting the Telehealth program and plans to start some real-time virtual office hours with the workforce to answer questions.

2. What resources/equipment/software you need to make both work.

   Reporting for both programs is being done through eMEDS; which is the Maryland state supplied electronic patient care reporting (ePCR) software that MCFRS already utilizes. Urgent care centers participating in the alternative destination transport (ADT) program are notified of patient transports via the Sonim ruggedized smart phones issued to each MCFRS apparatus. Telehealth visits are also accomplished via the same cell phone; the MCFRS crew simply calls the assigned number for Telehealth and it rings down the on-call list of physicians. The physician answers and then pushes a secure Zoom link to the apparatus cell phone via text. The crew then initiates a Zoom call via the texted link and the patient is able to video chat directly to the physician. EMS clinicians on the scene are able to assist the physician with any needed physical exam etc.

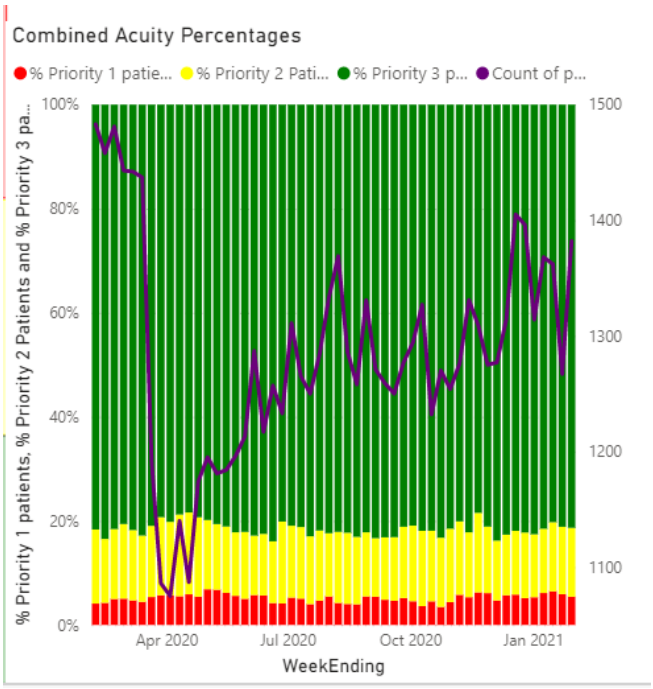
3. Basic information about contracts/agreements with ADP providers and the USACS physicians.

   The MCFRS has contracts with our urgent care partners and USACS to participate in this program and to share required patient information. USACS is billing separately for the service and MCFRS is not charged for their time.

4. Some background info on how the ADP pilot did before expanding it statewide.

   The MCFRS launched a ADT pilot separately from the above initiatives in Q1 of CY20. The program was limited in geographical scope and only worked with one urgent care. There were only a few patients transported to the urgent care. The trial program never formally stopped but was overtaken by the COVID-19 pandemic.

5. You mentioned that 911 calls are down but the acuity of patients is up. Do you have data showing those changes? See graph below.



6. Any documents you can share on the MIEMMS authorization to do ADP and/or ET3 initiative from Medicare for telehealth.

   ADT and Telehealth programs are permitted within the MIEMSS protocol and guidance documents from the MIEMSS Executive Director linked here (pg. 351) and here respectively. Information on ET3 is linked here.

7. Reimbursement changes from Medicare.

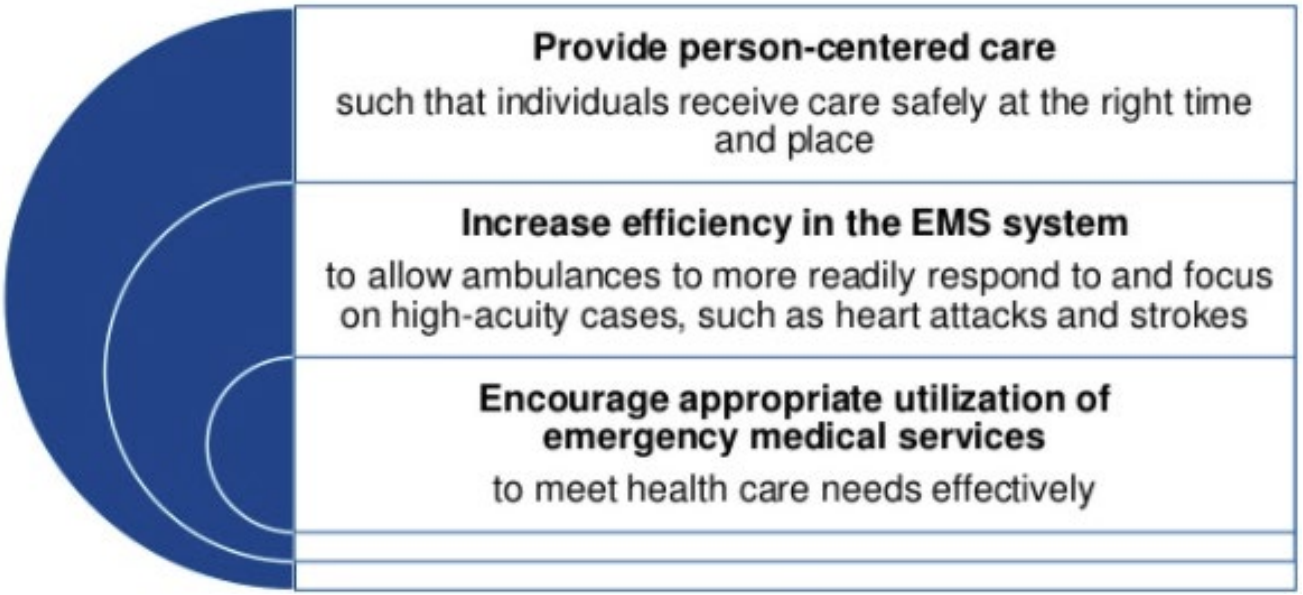
   Medicare will reimburse MCFRS for ADTs the same as they will for BLS1 transports to a hospital based ED. Medicare also reimburses at the same rate for facilitating a Telehealth visit; however, MCFRS does not receive mileage reimbursement for these calls.

8. COVID impacts.

   As mentioned above, COVID has both lessened our patient population and skewed it towards a higher acuity. We have no evidence to support our theories but we think that patients don't wish to call an ambulance or go to hospitals unless absolutely necessary, given the perceived increased risk in infection. It remains to be seen whether this trend will persist after the pandemic starts easing.

MCFRS ET3 Briefing

ET3 Model Goals



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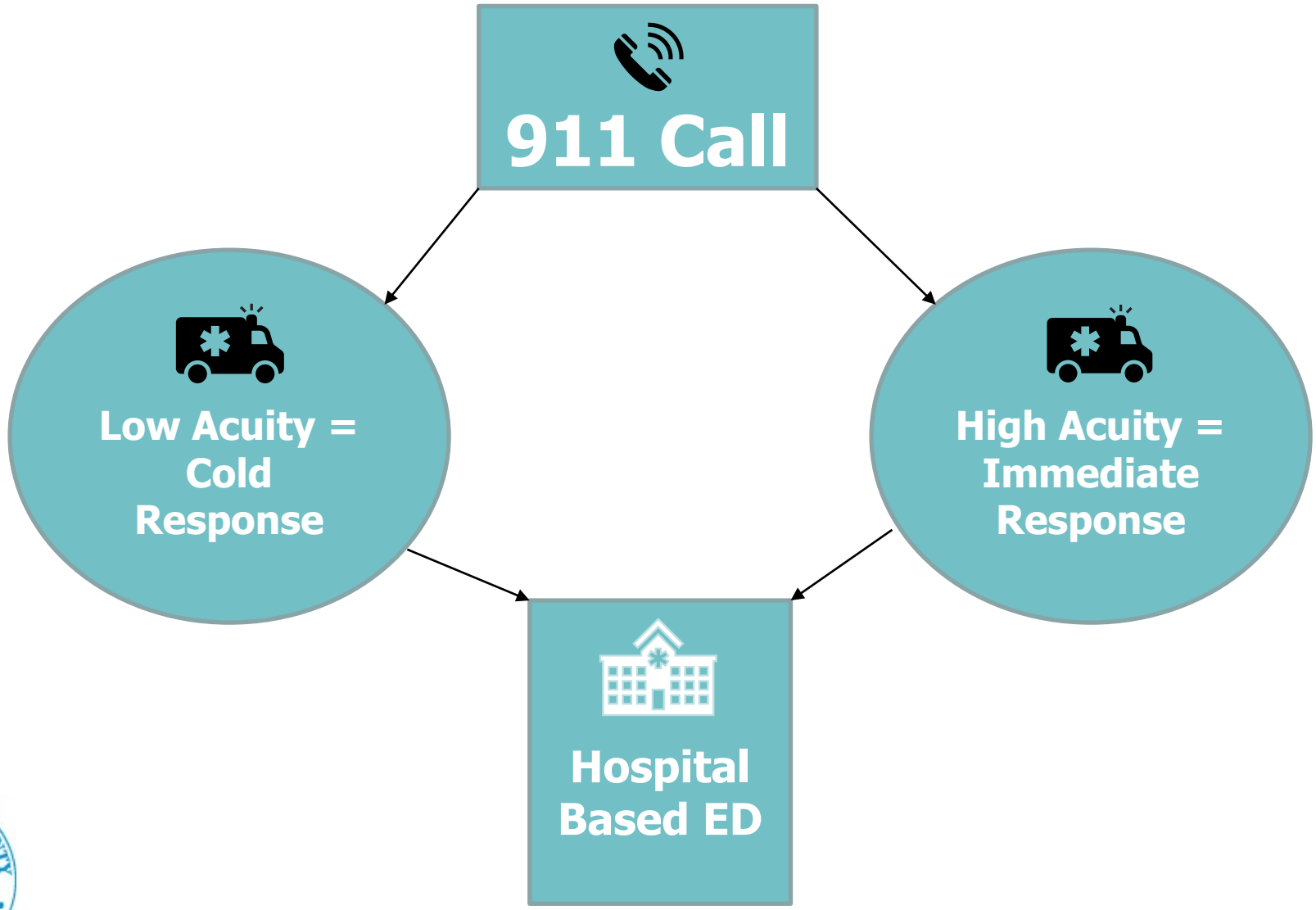
Traditional EMS Model



What is ET3?

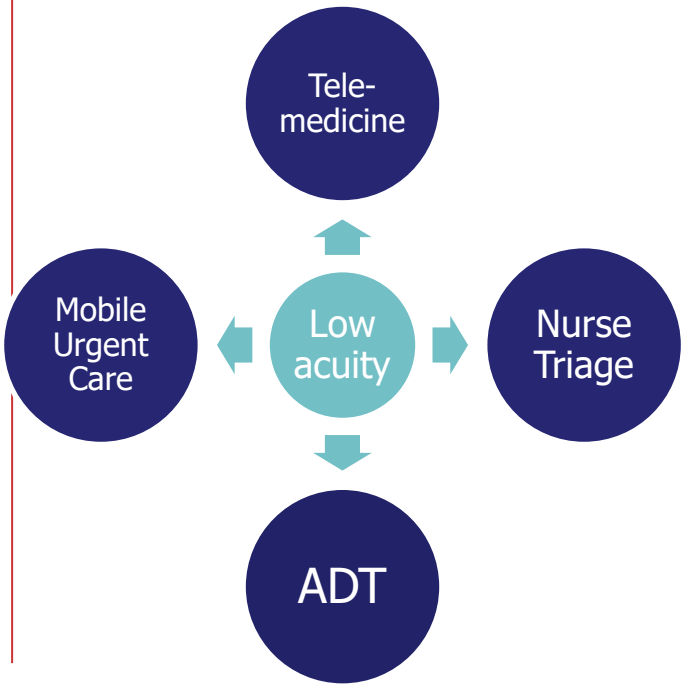
- Center for Medicare and Medicaid Innovation (CMMI) pilot program
- What: ET3= Emergency Triage, Treatment, and Transportation program
- Why: Medicare data indicated that 17% of Medicare patients transported to the ED via ambulance could have been successfully treated in a primary or urgent care setting
- How: Change payment model to include reimbursement for alternative destination transports (ADT) or Telehealth visits
- When: Pilot started January 1, 2021

Why is MCFRS interested?

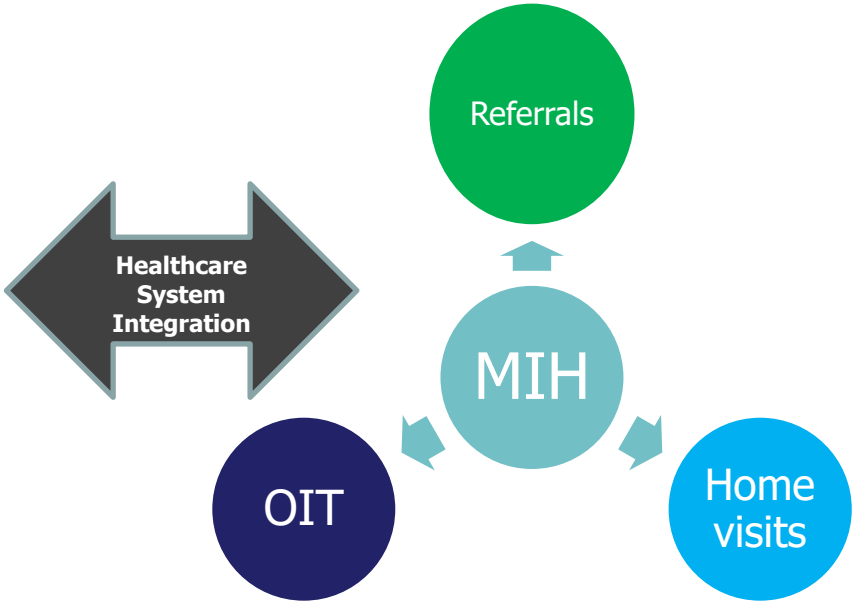
- Low acuity calls are a large part of the EMS workload
- MIH was first step but deals with superusers
- ADT and Telehealth programs offer more options to less frequent low acuity callers

Clinical Response Model Vision

Acute or episodic care



Chronic or ongoing care



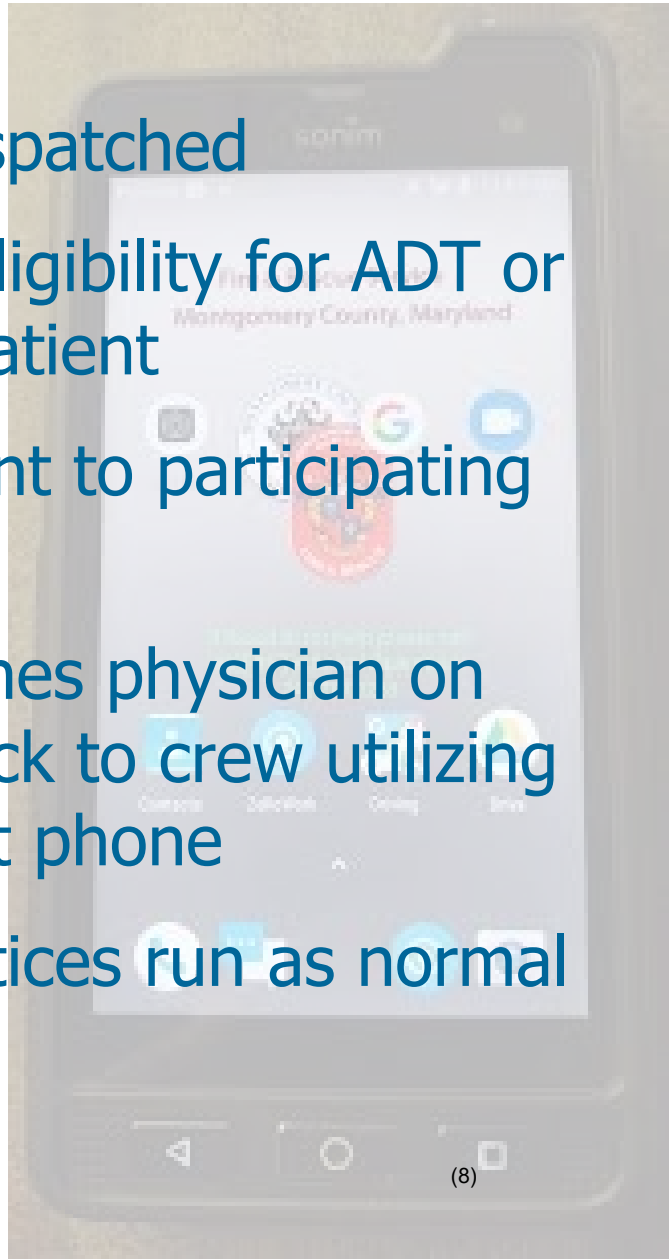
How does it work?

Patient calls 911 and MCFRS is dispatched

MCFRS crew determines patient eligibility for ADT or Telehealth and offers service to patient

- If ADT, MCFRS transports patient to participating urgent care center
- If Telehealth, MCFRS crew phones physician on duty who initiates Zoom call back to crew utilizing MCFRS issued ruggedized smart phone

Patient care reporting/billing practices run as normal



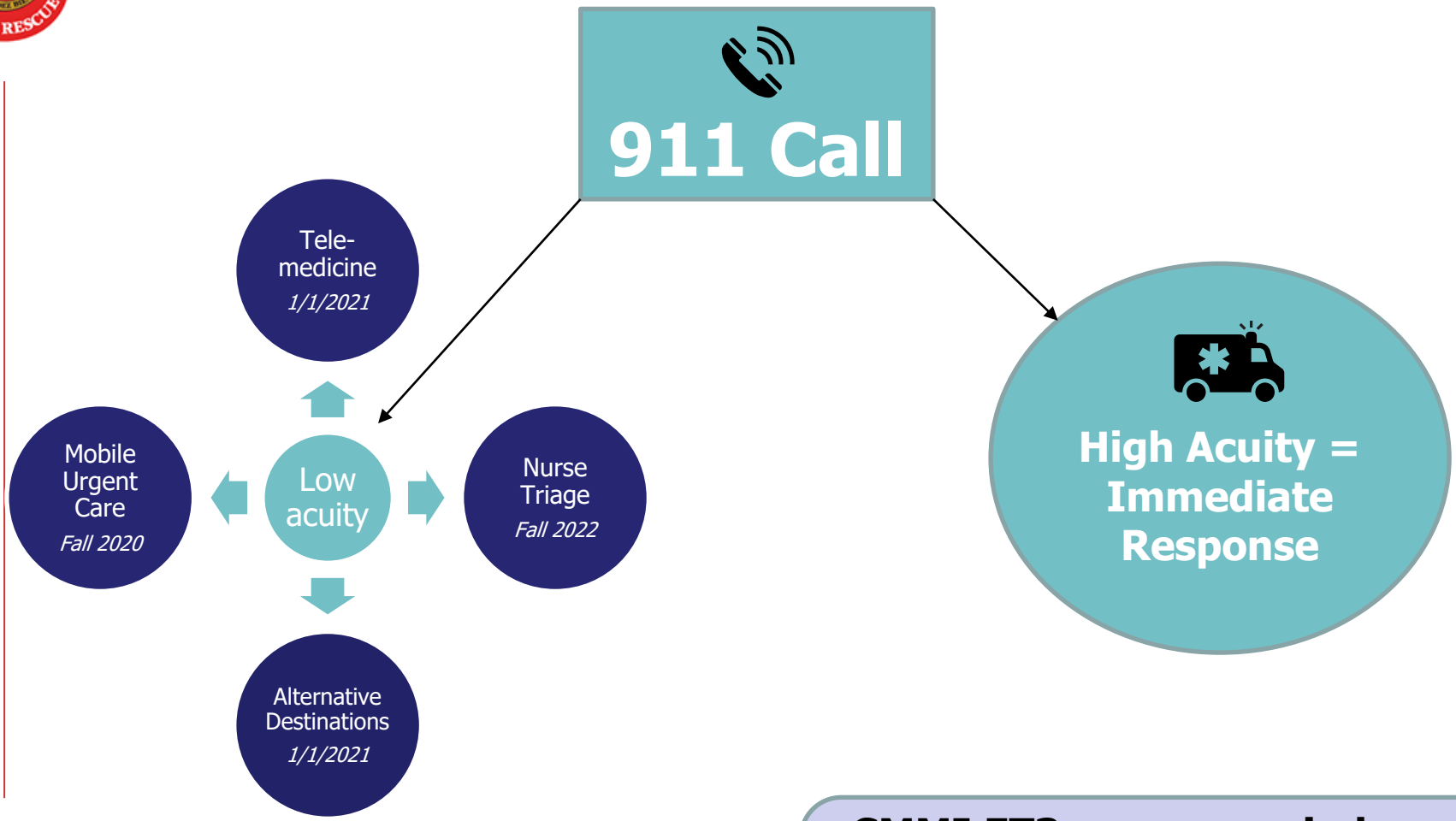
How's it going?

- Total uses – 25
- Telehealth – 12
  - 7 transports
  - 5 remained at home with 1 recall
- AD – 9
  - 5 success
  - 4 secondary transport to ED
- Other – 4
  - 2 (known) cases where urgent care turned us down
  - 1 transport to non-participating AD
  - 1 report of the physician not picking up the telehealth line

How's it going?

- Slow start
  - Clinician awareness – soft launch. Training is ongoing.
  - Volume is lower
  - Acuity is higher
- Telehealth podcast
- Recent uptick in falls on ice – increase in patient eligibility
- EMS700 is helping system-wide
- Public education
- Our greatest need is for alternative destination options for acute behavioral health and substance abuse problems

Acute Care – *Moving Forward*



CMMI ET3 program reimburses Telemedicine and ADT

Potential grant program for Nurse Triage

Nurse Triage Line

- We anticipate that CMMI will issue Notice of Funding Opportunity (NOFA) in early Spring.
- This is essentially a grant application process that is only available to ET3 participants.
- If terms look good and we are accepted, this will fund start-up costs for implementation of Nurse Triage line at our communications center.
- There are a lot of unknown details at this point.

Acute Care – *The Vision*