

Ad-Hoc Emergency Committee Meeting

May 28, 2015 @ 3:00 p.m., Eastville, Va.

Members Present: Pat Coady
Granville Hogg
Dr. Federico Molera
Dr. Ervin Jones
Willie Randall

Members Absent: Larry LeMond
Linda Ashby

Also present: Hollye Carpenter, EMS Director
Katherine H. Nunez, County Administrator
Dr. David Matson, Eastern Shore Health District

The meeting of the Ad-Hoc Emergency Committee was convened at 3:07 p.m.

Motion was made by Mr. Hogg, seconded by Mr. Randall, that the agenda be approved. All members were present with the exceptions of Ms. Ashby and Mr. LeMond and voted "yes." The motion as unanimously passed.

Motion was made by Mr. Hogg, seconded by Dr. Molera, that the minutes of the meeting of April 16, 2015 be approved as presented. All members were present with the exceptions of Ms. Ashby and Mr. LeMond and voted "yes." The motion was unanimously passed.

VDH Presentation:

Dr. David Matson made a presentation regarding the Health Department's proposal for home monitoring. He distributed a map entitled, "Northampton County Ambulance Call Frequency" and a report entitled, "One Year of Ambulance Runs, Northampton County, for Assessment of Intervention Strategy to Reduce the Number of Them". The four-page report is as follows:

Controllers

1. The one hospital on the E Shore of VA will move in 2017 from Nassawadox 20 miles north to Onley, from Northampton County to Accomack County.
2. Nassawadox is fairly central to Northampton County NC); Onley is closer to the population center of the Shore.
3. An Ad Hoc EMS Committee of the Board of Supervisors (BOS) of NC is assessing and recommending to the BOS actions that could be taken to

- a) avoid standing up a fourth ambulance 24/7 station in the County and
- b) reduce the loss to the County budget incurred annually by unreimbursed ambulance runs
- 4. The Ad Hoc Committee invited the Health District to address this issue.

The District’s idea has the following elements:

- 1. We already go for preadmission screenings into the homes of persons who (grossly) match the demographic and clinical attributes of persons moved by ambulance. Each visit includes an RN from the NCHD and a case worker from the NC Dept of Soc Services.
- 2. A protocol exists in Western Tidewater (Health District and Obici Foundation) that addresses outcomes similar to those of an ambulance run. There, the outcomes are reducing ED visits and hospitalizations. Early data from their protocol suggests their intervention strategy will reduce the outcomes significantly by number and meaningfully by \$\$.
- 3. We know that VA Beach EMS is conducting a similar intervention approach, yet Heidi’s role there has been peripheral and talking to the VA Beach HD EP&R Coordinator did not glean additional insight
- 4. Case studies from rural and urban sites indicate utilization can be decreased, although the effort to do may be costly (see additional materials).

Concept

- 1. Apply on the E Shore Health the Western Tidewater model that includes four home visits for frequent utilizers with a post-intervention observation period of at least six months.
- 2. Frequent utilizers would be identified by NC EMS from its record of ambulance runs. This record includes name, address, gender, age, reason for call, and GPS coordinates, for certain identification of person for whom and site from which a call for an ambulance occurs.
- 3. Measure outcomes by historical comparisons of
 - 1) frequency of ambulance calls and
 - 2) increased reimbursement for ambulance runs that occur.

For benefit of partners, targeted outcomes would be include

- 1) reduction of ambulance runs within 7 days of each other,
- 2) reduction of ambulance runs within 30 days of each other,
- 3) fraction of persons served by ambulance runs with identified medical home, and
- 4) fraction of persons served by ambulance runs with covered services.

Data obtained

- 1. 12 months, April 1, 2014 to March 31, 2015, of calls for ambulance in NC, from three stations located there.
- 2. 12 months, April 1, 2014 to March 31, 2015, of ambulance runs in NC from the NC EMS database.

3. GIS mapping of sites in NC to which ambulances were called, for the same one year period. Distances from the site of the ambulance call to the current and future locations of Riverside Eastern Shore Memorial Hospital were calculated from the GPS coordinates.

The EMS dataset is the most pertinent, for it includes the needed identifiers of a person for whom the ambulance is called.

External funding considerations:

The reimbursement mechanism will differ by how the program is characterized:

- 1) Are we linking persons to medical homes, when they do not have one? {yes, yet this will apply to some, not all, high utilizers},
- 2) Are we reducing utilization of resources inappropriate for the clinical status? {yes},
- 3) Are we keeping persons in the location of care that is least intrusive and most appropriate? {yes}, and
- 4) Are we increasing appropriate primary medical care? {yes}

Medicaid provides “Exemption Waivers” for

1. “Extension of primary practice”: In this notion, a visit to a person to augment or extend the quality of primary care qualifies for Medicaid reimbursement. Evidence of improved quality of primary care includes, for example, demonstration that the person has found a medical home, when s/he did not have one.
2. “Behavioral health”: Many persons with medical conditions that prompt an ambulance call have co-morbid mental health issues themselves or such issues are present in the care environment. Such issues include depression, anxiety, and other conditions that reduce judgment about decisions for requesting medical services.
3. “Request of In Home services”: This is carefully worded, to indicate that the recipient of care must request the assistance of a Medical-certified provider for services in the home that will reduce utilization of less appropriate and more expensive services.

I learned of these waivers from Kate Neuhausen, VCU, who used to had senior responsibilities for Medicaid, while employed at the Federal Center for Medicare & Medicaid Services (CMS). I have asked for confirmation from the VDH Central Office that these waivers would apply in the intended intervention.

Adult Protective Services

The NC Dept of Social Services indicates that it can “open a case” for Adult Protective Services if

1. A person needs services to stay in the most appropriate, least restrictive environment, based upon their medical needs.
2. [A second apt criterion I did not write down.]

The usual team for pre-admission (to nursing homes) screenings in which the District participates are an RN from the Health Department and a case worker from the County Dept of Social Services.

Community Services Board

Because of the high prevalence of mental health co-morbidities in patients utilizing ambulances (*fide* Kate Neuhausen), we will explore with the E Shore CSB whether a third agency participating in home visits is feasible and appropriate.

Population perspective

Persons calling for ambulance services are among those with the highest need for interaction with the healthcare system and for linkage to community services, to link them to the most appropriate and needed support. Like emergency departments (EDs), ambulances are “entitlements” that one can obtain by requesting them. These entitlements distort the more functional relationships that exist when a person has an identified medical home, a provider who knows the patient when care is sought, and resources short of the complexity and expense of an emergency department or a provider trained for complex medical assessment and intervention.

The usual sequence of events transported by an ambulance is an ED visit, most likely leading to hospitalization. Thus, benefits to the population will accrue if an intervention results in

1. Improved compliance with the primary physician’s medical plan,
2. Reduced ED visits, especially those at short intervals,
3. Reduced hospitalizations, especially those at short intervals.

Multiple studies, for multiple clinical conditions, indicate that admission to an Intensive Care Unit is a failure of the plan for a person’s health. A closely spaced hospitalization or ED visit has a similar implication. The providers of ambulance services do not strongly influence the medical plan, yet their site triage and care can result in the ambulance returning to base, rather than completing a run to the hospital.

Analysis results

Quality

The 9-1-1 Center provided 2895 ambulance runs from NC stations for the 12-month period. Of these

- 1) 2843 (98.2%) had an address; 52 addresses were not specific, such as “Cab 8805”, “Lobby” or “Ext. 26”
- 2) 2895 (100.0%) had geographic coordinates of latitude and longitude

Thus, the 9-1-1 Center data were utilized for assessing global patterns of ambulance calls for the County in the 12-month period.

The NC EMS provided 2116 ambulance runs for the 12-month period. In agreement with Hollye, we excluded motor vehicle accident and similar incidents from the analysis database. The result was that a higher fraction of the NC EMS data than the 9-1-1- data included clinical conditions appropriate to the qualifications of an RN with a Social Services Case Worker or an RN with a Case Worker from the CSB. Because the NC EMS data included name, address, gender and age, the most accurate information on a person's utilization of ambulance services came from this dataset.

The NC Office of Economic Development provided GIS mapping of the EMS ambulance call sites, as well as distances, based upon GPS coordinates, from the ambulance call site and the current and future locations of Riverside Eastern Shore Memorial Hospital.

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(The attached appendices to the document, as well as the document itself and the map are on file in the Office of the County Administrator.)

The Committee members discussed the Report and Dr. Matson answered questions. It was noted that there is a need to pick a point of qualification (2 runs ? 3 runs?) for a pilot program and Dr. Matson indicated the need to verify this data by expanding the sampling time frame and working on the budget proposal.

Strategic Plan Ideas

Dr. Jones indicated that he is working on a Strategic Plan template to help guide the Committee's discussions moving forward and touched on two elements: EMS Readiness and Primary Care/Urgent Care. This will be finalized within a week and will e-mail this to the Committee members for review and critique.

Next Meeting

The next meeting of the Committee be held on Thursday, June 18, 2015, commencing at 5:00 p.m., in the Main Conference Room of the County Administration Building, 16404 Courthouse Road, Eastville, Virginia.

Motion was made by Dr. Molera, seconded by Dr. Jones, that the meeting be adjourned. All members were present with the exceptions of Ms. Ashby and Mr. LeMond and voted "yes". The motion was unanimously passed. The meeting was adjourned at 4:54 p.m.

Respectfully submitted,

Janice K. Williams
County Administrator's Office