To The Honorable Members of the House Veterans Affairs and Emergency Preparedness Committee

My name is Thomas Henderson and I am the Director of EMS for the Professional Firefighters of Massachusetts (PFFM) and I am a full time Firefighter/Paramedic for the Rockland Fire Department for over 17 years. The Professional Firefighters of Massachusetts (PFFM) represent 12,000 firefighters and over 75% of our members operate as Emergency Medical Service (EMS) responders. Out of 351 cities and towns in the Commonwealth of Massachusetts, the PFFM represents 213 full time departments and over 160 of these departments operate a fire based ems services. It is vital that the EMS system develop innovative and new approaches to pre-hospital patient care. The Professional Firefighters of Massachusetts are proud to announce that in July 2015 that Massachusetts Governor Charlie Baker officially signed into law groundbreaking legislation, titled Mobile Integrated Health Care (Community Paramedicine) that will propel community health to new heights. A multi-disciplinary group of stakeholders successfully lobbied the legislature about the needed change in the infrastructure and care delivery systems within the pre-hospital realm.

The stakeholders that are involved in the pre and post hospital delivery of care setting, created the legislation that was adopted in the House budget. The stakeholders worked with the Department of Public Health to develop legislation that would create a pathway to develop MIH programs and have a review process under the Department of Public Health. The review process is a multidisciplinary group that involves EMS providers, physicians, nursing, home care, behavioral health and commercial insurance payors. Once the House approved the legislation in the Budget, the stakeholders worked to finalize the language and created an amendment. The amendment further defined MIH programs and created a pathway for "Community EMS Programs". The stakeholders endorsed these changes and it was submitted to the Senate.

This legislation provides an integrated, multidisciplinary, and multi-sector approach to community health that seeks to maximize patient outcomes, while fostering community health and wellness. All of the stakeholders worked together to provide a holistic and comprehensive approach to health and wellness along the continuum. The Massachusetts legislation known as *Outside section 93; Mobile Integrated Health Car[1]e* is the first legislation of its kind in the nation to incorporate EMS in mobile community health. The Stakeholders worked collaborative and created productive relationships between public and private sector entities; relationships that are the foundation of a successful strategic plan. The passage of this Bill signifies evolutionary progress in pre-hospital health care that will inevitably transform not only the manner in which care is delivered, but also, progress that will sustain healthy communities. The legislation is attached below in italic.

It is broadly accepted among stakeholders that a significant portion of Massachusetts emergency medical services (EMS) calls are for non-emergent cases. With the adoption of the Affordable Care Act (ACA)[2] and the Massachusetts Act 224[3] "an act improving the quality of

---

[1] http://www.mass.gov/bb/gaa/fy2016/os_16/h93.htm

[2] http://housedocs.house.gov/energycommerce/ppacacon.pdf

[3] https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

health care and reducing costs through increased transparency, efficiency and innovation" the pre hospital delivery care model is rapidly changing. Many of the current laws that relate to pre hospital care delivery were adopted many years prior to the ACA and Chapter 224. In response to the progress of healthcare delivery, mobile integrated health (MIH) programs are developing across the country. MIH is a growing national practice of providing patient care in the home. Approaches differ from program to program, but all aim to help manage chronic illnesses, connect patients with community supports, and reduce hospital readmissions and unnecessary ED visits. MIH programs vary based on community needs and can include various provider types, including community paramedics, visiting nurses, and home health aides.

New and innovation patient care models will have a better outcome for the patients in our communities and it will strengthen the level of service that will be provided. Unfortunately with the current statutory and regulatory standards it is not possible to build a sustainable and innovative patient care model. There is a need to establish an MIH/community paramedicine program in statute so that any qualified health care entity can operate an MIH/ community paramedicine program if they meet the standards set in law, rather than going through timely and costly individual special waiver processes.

Currently in Massachusetts, the regulatory stakeholder group has been meeting to formulate the regulation standard the allows for innovative projects and creates the proper oversight for patient safety. The stakeholder committee's timeline is working to finalize the regulation by the fall of 2016.

The PFFM understand that there is significant work with multiple legislative projects. We respectfully ask for your support on this important and innovative topic known as House Bill 1113.

Respectfully Submitted;

Thomas Henderson
Director of EMS
Professional Fire Fighters of Massachusetts
2 Center Plaza, Suite 4M
Boston, MA 02108
Office: 617-523-4506
Cell: 781-706-1847
www.pffm.org
EMS@pffm.org

Massachusetts General Laws FY2016 Budget section
Mobile Integrated Health Care

SECTION 93. The General Laws are hereby amended by inserting after chapter 111N the following chapter:-

Chapter 111O. Mobile Integrated Health Care.

Section 1. As used in this chapter, the following words shall have the following meanings unless the context or subject matter clearly requires otherwise:

"Advisory council", the group of advisors established in section 4.

"Commissioner", the commissioner of public health.

"Community EMS program", a program developed by the primary ambulance service with the approval of the local jurisdiction and the affiliate hospital medical director utilizing emergency medical services providers acting within their scope of practice to provide community outreach and assistance to residents to advance injury and illness prevention within the community.

"Community paramedic provider", a person who: (i) is certified as a paramedic pursuant to chapter 111C; and (ii) has successfully completed an education program for mobile integrated health care pursuant to department regulations.

"Department", the department of public health.

"EMS", emergency medical services.

"EMS provider", an EMS first response service, an ambulance service, a hospital including, but not limited to, a trauma center or an individual associated with an EMS first response service, an ambulance service or a hospital engaged in providing EMS, including, but not limited to, an EMS first responder, a medical communications system operator, an emergency medical technician and a medical control physician, to the extent that physician provides EMS.

"Health care entity", a provider or provider organization, including, but not limited to, an ambulance service licensed under chapter 111C, a visiting nurse association, accountable care organization and a home health agency.

"Health care facility", a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals, and other inpatient centers, ambulatory, surgical or treatment centers, behavioral health centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health centers.

"Health care provider", a provider of medical, behavioral or health services or any other person or organization that furnishes bills or is paid for the delivery of health care services in the normal course of business.

"Medical control", the clinical oversight provided by a qualified physician or existing primary care provider to all components of the MIH program, including, but not limited to, medical direction, training, scope of practice and authorization to practice of a community paramedic provider, continuous quality assurance

and improvement and clinical protocols.

"Medical direction", the authorization for treatment provided by a qualified physician or existing primary care provider in accordance with clinical protocols, whether on-line, through direct communication or telecommunication, or off-line through standing orders.

"Mobile integrated health care" or "MIH", a health care program approved by the department that utilizes mobile resources to deliver care and services to patients in an out-of-hospital environment in coordination with health care facilities or other health care providers; provided, that the medical care and services include, but are not limited to, community paramedic provider services, chronic disease management, behavioral health, preventative care, post-discharge follow-up visits, or transport or referral to facilities other than hospital emergency departments.

"Patient", an individual identified by a health care facility, entity or provider as requiring MIH services.

"Person", an individual, entity or agency or a political subdivision of the commonwealth.

"Physician", a medical or osteopathic doctor licensed to practice medicine in the commonwealth.

"Scope of practice", the clinical skills or functions: (i) as defined by the statewide treatment protocols governing the delivery of emergency medical services under chapter 111C; and (ii) clinical protocols established by the department by regulation pursuant to this chapter.

Section 2. (a) The department shall take any action consistent with its role as state lead agency for mobile integrated health services. As the lead agency, the department shall take into consideration relevant standards and criteria developed or adopted by nationally recognized agencies or organizations, and the recommendations of interested stakeholders, including, but not limited to, the statewide mobile integrated health advisory council, established in section 4.

(b) The department shall evaluate and approve MIH programs that meet the following criteria:

(i) provide pre-hospital and post-hospital services as a coordinated continuum of care that fully supports the patient's medical needs in the community;

(ii) address gaps in service delivery and prevent unnecessary hospitalizations, or other harmful and wasteful resource delivery;

(iii) focus on partnerships, through contracts or otherwise, between health care providers and health care entities that promote coordination and utilization of existing personnel and resources without duplication of services;

(iv) adhere to clinical standards and protocols, pursuant to this chapter by the department by regulation, with the guidance of the advisory council, to ensure that MIH community paramedic providers or other providers employed by a health care entity provide health care services or treatment within their scope of *practice;*

(v) dispatch only those community paramedic providers or other providers employed by a health care entity who have received appropriate training and demonstrate competency in the MIH clinical protocols;

(vi) meet appropriate standards related to capacity, location, personnel and equipment;

(vii) provide access to qualified medical control and medical direction;

(viii) provide a secure and effective medical communication subsystem linkage for on-line medical direction;

(ix) ensure activation of the 911 system in the event that a patient of an MIH program experiences a medical emergency, as determined through medical direction, in the course of an MIH visit; provided, however, that the activation shall be in the best interest of patient safety and takes into account how MIH programs affect EMS first response services; and provided further, that the department shall examine how 911 triage assessment tools may be incorporated into MIH;

(x) ensure compliance with all state and federal privacy requirements with regard to patient medical records and other individually identified patient health information; and

(xi) ensure that health care providers operating MIH programs collect and maintain data, including statistics on mortality and morbidity of consumers of mobile integrated health services, including, but not limited to, information needed to review access, availability, quality, cost and third party reimbursement for such services and coordinate and perform the data collection in conjunction with other data-collection activities.

Section 3. The department shall evaluate and approve community EMS programs developed and operated by the primary ambulance service with the approval of the local jurisdiction and the affiliate hospital medical director to provide community outreach and assistance to residents of the local jurisdiction in order to advance injury and illness prevention within the community.

A community EMS program may work with local public health agencies or officials and identify members of the community who use the 911 system or emergency department and connect them to their primary care providers, other health care providers, low-cost medication programs, and other social services. The programs may also utilize EMS providers to provide follow-up and preventive measures including, but not limited to, fall prevention, vaccinations under the direction of local public health agencies or officials, and health screenings, including blood pressure and blood glucose checks.

All EMS provider training and activities related to the program shall be approved by the local jurisdiction and the affiliate hospital medical director. Nothing in this section shall authorize an EMS provider to perform any medical procedures outside their scope of practice.

Section 4. (a) There shall be a mobile integrated health advisory council, which shall assist and support the department in carrying out this chapter by planning, guiding and coordinating the components of mobile integrated health services.

(b) The advisory council shall consist of the director of healthcare safety and quality or a designee, who shall serve as a non-voting chair, and 18 members who shall be appointed by the commissioner and who shall reflect a broad distribution of diverse perspectives on mobile integrated health care, including appointees or their designees from the following groups: the division of medical assistance; the Massachusetts Hospital Association, Inc.; the Massachusetts Council of Community Hospitals, Inc.; a for-profit hospital system that is not a member of another hospital advocacy group; the Massachusetts Senior Care Association, Inc.; the Massachusetts Medical Society; the Massachusetts chapter of the American College of Emergency Physicians; the Massachusetts Nurses Association; the Home Care Alliance of Massachusetts, Inc.; the Professional Fire Fighters of Massachusetts; the Fire Chiefs' Association of Massachusetts, Inc.; the International Association of EMTs and Paramedics; the Massachusetts Ambulance Association, Incorporated; the Hospice & Palliative Care Federation of Massachusetts, Inco.; the Association for Behavioral Healthcare, Inc.; and 3 members representing payors, including 1 representative of the health care organization providing services to MassHealth members under sections 9D and 9F of chapter 118E.*