Mobile Integrated Health Workgroup
Minutes

Chair: Raffaella Coler, Director OEMS Time: 9:00 a.m. Location: LOB, 1D

Date: June 5, 2018

Attendees: Gregory Allard, Chris D. Andresen, Marybeth Barry, Joshua Beaulieu, Michael Bova, , Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, Dr. Richard Kamin, David Lowell, Dr. Maybelle Mercado-Martinez, James Santacroce, Chris Santarsiero, Carl J. Schiessl, Kelly Sinko, Tracy Wodatch, Dr. Michael F. Zanker

Excused: Bruce B. Baxter, Dorinda Borer, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, William Schietinger, Heather Somers, Jonathan Steinberg, Dr. Robert W. Zavoski

Guests: Stacey Durante, Renee Holota, Mark Schaefer

Agenda Item	Issue	Discussion	Action/ Responsible
Welcome/ Housekeeping:		Raffaella Coler welcomed the workgroup members, emergency exits.	R. Coler
Minutes:	Review of the May 8, 2018 minutes	Changes: Removed Kristin Campanelli from Payment/Reimbursable committee, fix Dr. Maybelle Mercado-Martinez name. Shaun Heffernan made a motion to accept Michael Bova seconded, motion carried, minutes accepted with changes; opposed- none; abstentions-K. Sinko; all in favor.	
Discussion/ Presentation:	Goal Summary:	Original charge of Legislative MIH Workgroup read aloud. Attention called to appropriations – we must be mindful that if there is a fiscal note attached to Mobile Integrated Health Care (MIH)/Community Paramedicine (CP), it likely will not move forward.	R. Coler
	Sub-committee reports:	Sub-committees asked to update the group on any work done: • Legislative – Did not meet due to other obligations • Public Education / Marketing – Did not meet. • Education – Reports that J. Beaulieu and J. Santacroce have connected with Massachusetts and have been invited to meet with State MIH office. Also reports that in the 3-4 years that Mass. has seen a decrease in readmissions. Mass. had to set up an MIH Office with staff to administer and regulate the programs.	G. Allard R. Kamin J. Beaulieu
	Data Needs	There is a strong need for GAP analysis and data prior to moving forward.	R. Coler

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, ~~6/13/18,~~ Revised 8/8/18 and Approved 8/14/18 meeting

	Application Process:	Draft document for application process presented and read to group who is asked to review and comment via email to be collated for the next meeting by Stacey Durante at stacey.durante@ct.gov Questions raised: • Who will review these applications? • Who will regulate MIH/CP at the State level? • Will there be a cost associated with this; if so, what is it? • Will there be a fiscal impact? These questions must be answered as we move forward. As was stated earlier by J. Beaulieu, Massachusetts set up an MIH Office under OEMS with the same staff we CT DPH OEMS has now. Discussion regarding application process document had by group: • Section for stakeholder's sign-off needed on application and letters of support from all collaborating agencies in the proposed MIH/CP program for that agency. • Noted and will be added to application process document. • Drafts and/or executed contracts with all agencies involved should be included • What will the impact on 911 be for smaller services? Should we include a reminder of the services 911 in the application process? • Thoughtful application development will lessen the administrative load. • CEMSAB and CEMSMAC are already involved in these processes – some of the administrative load could be deferred to these groups. • Could we include the Regional Councils in the process with strict criteria? We can explore these ideas. Consistency in council meetings will be key. Question raised: Are we looking to do different MIH/CP initiatives in different communities? Would pilot programs be statewide or community based? How do we let citizens know what's available to them? We have been unifying and now have statewide protocols – are we going back to community based? • This should be clarified • Municipalities are currently responsible for EMS in the State • This will add complexity All of this is definable in the application process:	R. Coler J. Beaulieu R. Coler K. Campanelli S. Heffernan R. Kamin R. Coler K. Sinko R. Coler R. Kamin

		• Each community • Each catchment area • Multiple PSA holders	D. Lowell
		Although further discussion may be needed – Comments?	R. Coler
		Enable all communities to locally identify and address their own GAPS	J. Beaulieu
		Cites an example of PSA holders crossing boundaries and asks the question: How do we address that in an MIH application?	R. Coler
		• If it's a 911 issue, it will be addressed as a 911 issue • If it's an MIH issue, stakeholders come to the table and communicate/strategize with the local PSA holder for services needed. It's an integrated approach and must be agreed to by all. • To start MIH we should look at one community with one PSA holder using one Hospital	D. Lowell
		Outside 911 system requires: • Scope of Practice changes • Statutory changes	R. Coler
		How will this be activated? Have we considered EMD and protocols?	M. Zanker
		It will depend on town or program – this will be encapsulated in each program, but it will affect EMD's	J. Santacroce
		In the application process?	M. Zanker
		Prior collaboration needed for: • GAP analysis • Make up of program • Statutory – AG's opinion in 1991 (will email)	J. Santacroce
		There will be two (2) ways to activate the system: 1. 911 – will remain the same 2. Non-emergency programs through a 7-digit number 1. Ex. Alternate destination where all stakeholders are aware and have a formal agreement; thru a non-911 system. It will be a contracted thing based on relationships and communications with all stakeholders with a non-transport fly car responding.	G. Allard
		Non-transport will not have to be the PSA holder, vs. transport which will have to go through the PSA holder.	R. Coler

		This will be no different than today's scheduled transports.	J. Santacroce
		Are we envisioning contracts? Such that Middlesex Medics can contract with a home healthcare service in New London? Group response: Yes	M. Zanker
		We have to be able to identify these patient and give them a 7-digit phone number to call. Will there be some type of EMD process at this point?	M. Zanker
		The EMD process will be program specific if both activations are needed: 911 (emergent) and/or 7-digit phone (non-emergent). • Each program will have its own element of coordination and conversations to work this out. • Stakeholder conversation.	J. Beaulieu
		• Each community currently covered by BLS & ALS level. • None of the MIH programs we've discussed is at the BLS level. BLS level is activated alone or a paramedic unit is enroute. This can be initiated by EMD guideline, protocols or communication on scene. • BLS units will have to be cleared at a minimum of time to respond to other emergencies. This will be at the discretion of the paramedic under the protocol that's agreed upon by the PSA holders at the Basic and Paramedic level which has been coordinated in advance in a protocol under Medical Direction and medical control. • We have all the ingredients, it's just putting it all together and bringing communication full circle.	D. Lowell
		What about the Medical Director? Will the relationship between the Medical Director and the Paramedic remain under MIH? If the Paramedic is not activated under 911 – how does that work?	K. Sinko
		It will be under Medical Direction and with oversite of the sponsor hospital, as it is today	D. Lowell
		The Paramedic will not be working on their own?	K. Sinko
		No, Paramedics have to work under a physician's license by statute	J. Santacroce
		Do we know if that doctor is willing to embrace MIH? Is this an issue or barrier?	K. Sinko
		Not anticipated to be an issue; it happens every day during scheduled transports/interfaculty transports within our current system and protocols.	D. Lowell

		Do we anticipate that there will be new protocols for each MIH category?	K. Sinko
		No new protocols, no scope of practice change. We may need new EMD protocols.	D. Lowell
		Let hear from the two Medical Directors in the room: Dr. Zanker from Middlesex Hospital and Dr. Kamin from UCONN – comments?	R. Coler
		No concerns – the current system allows all to be overseen by the sponsor hospitals • Currently, the scope of practice of paramedics is somewhat at the discretion of the Medical Director. • Yes, I anticipate protocol specific to an MIH environment to be created. • From meetings with EMS Coordinator's and Medical Director's there has not been one concern about exposure or liability due to MIH	R. Kamin
		I agree; there's been questions, but no problems.	M. Zanker
		Expect to have to approve/oversite any process or protocols	R. Kamin
		Hospice and other programs their own M.D.'s signing off on programs who will be involved	G. Allard
		• Be mindful in each step, the devil's in the details • Community of M.D.'s aware and following this initiative so there are no surprises • Don't assume issues are resolved because we're following the right path and doing things the right way – in the rest of CT there may be surprises or confusion by MIH • Be overt and transparent	C. Schiessl
		The responsibility of the Public Education & Marketing sub-committee will be making people aware of initiative and updating. The CT EMS Advisory Committee is aware of this also. In this instance, marketing is explaining and myth busting, not selling it.	R. Coler
		Going to E.D. Directors meeting and marketing would be very beneficial	M. Zanker
		Any other concerns/deeper dives needed.	R. Coler
		Who will collate responses from this workgroup?	R. Kamin
		We will – specifically, to R. Coler or Stacey Durante at stacey.durante@ct.gov and I agree with Carl, the devil is in the details.	R. Coler

		Food for thought…Vitas for example has been mentioned as a potential partner, they cover the entire state, and they could potentially contract with many MIH entities. Also, there are 6 hospice providers and 14 home cares in Norwich; Be aware of the complicated health care system we have in CT.	T. Wodatch
		That is true, we have a very complicated system.	R. Coler
		MIH has to be dependent on: • The GAP Analysis brought forward • No duplication of services • Improved patient care – QA/QI • Cost savings	
		Data is needed from the services identifying the needs that exist. This is a challenge – I've heard a lot about data, but we haven't seen any yet.	
		Considering doing a Survey Monkey to ask questions about data – will present this at next meeting for thoughts.	
		1. We have contracts with most of the ambulance providers in the room. 2. CT is last in Hospice days of care. 3. Patients are being short-changed in CT in terms of Hospice use. 4. Discharge rates are low in CT (<2% of pt.'s coming off the benefit) 5. Vitas is very clinically driven with our leadership and heavily staffed nights and weekends and we already have nurse triage so 911 isn't called. 6. We would be hesitant regarding surveys unless DPH gives its blessing	C. Santarsiero
		Let me clarify a few things: 1. Original goals of MIH read 2. Hospice – not saying current care is lacking 3. DPH blessing from PLIS & FLIS, yes, we are all looking to work within the system together on this. 4. There may not be a GAP in all communities – services have to prove a GAP exists. 5. Care Community Teams are serving patients' needs in certain communities. 6. Again, we are looking to enhance current care with MIH, not to replace it.	R. Coler
		There will be obstacles and challenges in creating services within different agencies in different areas.	T. Wodatch
		This is where GAP analysis comes in – again, not to replace, but to enhance. The main focus here is the Health & Wellness of the population.	R. Coler

		• These proposals are truly draft concepts only • These programs in no way, shape or form are meant to disrupt the current 911 system • Not supplanting any other companies, only enhancing • Recognize the need is community or regionally based. Application will include this. • Alternative destinations – difference between the independent practitioner and affiliated urgent care centers. The continuity of care is better served to an alternate destination that is affiliated with an acute care hospital.	D. Lowell
		Reimbursement for services to transport to alternate destination. Are any services billing for alternate destination? No. We need to do research. This is something in our directive. We need research into this – K. Sinko will research this topic.	R. Coler
		Any further discussion on this topic?	
		I'd be remiss in my job representing Federally Qualified Health Centers (FQHC) if I didn't ask for FQHC's to be mentioned in this section. FQHC's have staff in hospitals, relationships differ by community, but are there.	J. Granger
		Dully noted. We will add.	D. Lowell
		Asks why direct you feel a relationship with an acute care hospital is necessary?	M. Schaeffer
		Continuity of care, communication, data collection. We were being conservative and cautious.	D. Lowell
		Limits the utility to the program and reimbursement monies as an extension of advanced primary care facilities.	M. Schaeffer
		The new Urgent Care licensure that began in April exempts affiliated UC's. We should talk about primary care further.	K. Sinko
		We're talking about Paramedic MIH level calls. Are we going to allow a category for BLS providers to take abrasions, lacerations, etc. to UC's?	M. Zanker
		I send a first responder paramedic to these low priority BLS calls for decision making only, non-transport	J. Beaulieu
		Do we allow certain patient populations to go far outside their community? Are we talking about the intoxicated person now being taken to a detox center? Are we talking about the sprained ankle now going to an UC? Who makes that decision?	M. Zanker

		1. Nurse triage line, nurse decides. 2. Or BLS calls ALS to make decision about alternative destination. 3. I see MIH playing a key role in widespread addiction problems.	R. Coler
		We don't see 911 BLS calling ALS for alternative destination. We see within a structured MIH program, call routed through non-emergency route.	D. Lowell
		Does see potential possibility for BLS in the future for cost reduction for the patient and insurance.	G. Allard
		That is not MIH. We are focusing on a specific program with a collaborative approach with the stakeholders focused on the care of the patient.	R. Kamin
		Need data for GAP assessment, QA & QI	R. Coler
		#2 from MIH/CP Programs subcommittee is the concept of readmission avoidance. Ex. CHF – out of an acute care setting to home. Read from document. Another example is a certain ask of a patient in the community with an LVAD who we are called to see. GAP's exist between discharge and home health beginning. During home health when pt. deteriorates. Also, when days of benefits are finished and patient needs care.	D. Lowell
		Reimbursement and payment group. Anthem covers treat and non-transport – is this only when activated by 911?	K. Sinko
		In program across the country - If EMS is a provider in a program where people are enrolled, then EMS is paid. Anthem's reimbursement is based on established programs where EMS goes out via 911 for an emergency, pt. is assessed and/or treated and refuses transport.	D. Lowell
		Asks about current reimbursement for treat and release scenarios – there is no reimbursement.	M. Barry
		Insurance carriers only reimburse when EMS transports to a hospital except a "Dead after dispatch" for cardiac arrest with no transport. Ex. Of diabetic given an assessment, IV, and medications and patient refuses transport, EMS is not reimbursed for anything.	R. Coler
		Will insurance reimbursements change with MIH?	M. Barry
		Discussion ensued regarding insurance: • One third of the market is self-insured • One third is fully insured • One third is Medicare/Medicaid insured • CT insurance statutes apply to fully insured (usually through work)	K. Sinko K. Campanelli

		• Same carriers that offer fully insured do self-funded plans such as Medicare advantage, etc. • Anthem is currently the only company to do treat-no transport and we are in conversations with them as DPH sets rates for this. Anthem is doing this voluntarily – not by state mandate. • CT is unique – we would have to set a rate for treat-no transport first. • Hospitals are taking on payments of coordinated care teams. • Have to consider payment/reimbursements • Insurance company mandates set floors, not ceilings – mandates do cost the state money, be careful	
		• Does this qualify as a mandate under the Affordable Care Act? If so, the state pays. • SIM plans cut costs • Insurance is looking at the best way to cover the services that is affordable to folks	S. Halpin
		Medicare fee for service only covers "Dead after Dispatch", nothing more? – Correct	M. Schaeffer
		What's the value? Hospitals are negotiating a rate with MIH providers across the country for decreased readmissions.	J. Santacroce
		MedStar in TX is a great example. We have a lot to learn about insurance. Better understanding needed as we proceed.	R. Coler
		EMS is not compensated for many services currently – it's OK to go forward with this as when you aren't getting paid for something, doing it for less money will help.	D. Lowell
		Understand, by moving forward, we can't shift costs to the state.	R. Coler
		Quick overview of the rest of the document: • High utilizers – already discussed • Hospice revocation – already discussed • RN Triage – Integrated dispatch model • Add Wellness & Prevention • Document will be revised and resubmitted for comment	D. Lowell
		Work appreciated on that.	R. Coler
		• Medicaid rates – data needed from services • Rate: Treat and non-transport for non-Anthem bills • Meeting internally with agencies to discuss for the next meeting.	K. Sinko

		Yes, we need a better understanding of this	R. Coler
	Next Steps:	What are the group's next steps? • Next meeting we'll continue with feedback for MIH/CP Subcommittee Thanks all for their thoughtful submissions.	R. Coler
Next Meeting:		June 19, 2018 at the Legislative Office Building, 1D – CXL'D August 14, 2018	
Public Comments:		No public comment	
Adjourn:		Motion to adjourn made by D. Lowell and second by Greg Allard at 11:06 am	