Mobile Integrated Health Workgroup
Minutes

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

Meeting Date: August 28, 2018

Attendees: Chris D. Andresen, Marybeth Barry, Bruce B. Baxter, Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, James Santacroce, Chris Santarsiero, Tracy Wodatch, Dr. Michael F. Zanker

Excused: Gregory Allard, Joshua Beaulieu, Dorinda Borer, Michael Bova, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, David Lowell, Dr. Maybelle Mercado-Martinez, Kimberly A. Sandor/Mary Jane Williams, Carl J. Schiessl, William Schietinger, Kelly Sinko, Heather Somers, Jonathan Steinberg, Dr. Robert W. Zavoski

Guests: Stacey Durante, Renee Holota

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		9:00 Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 8/14/18 minutes	Changes: Yes, remove W. Schietinger from excused as he was present, add S. Heffernan to present. Motion made by T. Wodatch to accept, seconded by J. Santacroce, motion carried and the minutes were accepted with changes. Opposed- none. Abstentions-none. All in favor.	Group
3. Sub-Groups Reports/ Update:	a. Education	• No report, J. Beaulieu is excused. • Waiting until we know what programs will be endorsed, at that time we will move forward identifying education needs	R. Coler
	b. Application Process	• Review of last application and correction/revisions suggested • Is this done, can we table? • I'm going to take away CP and use MIH as a standard	R. Coler
		• Instructions for application needed	T. Wodatch
		• Seconds instructions needed • Signatory page including CEO's, Medical Director, agencies and other stakeholders needed	B. Baxter
		• We will add a signatory page; we do need this piece • This is fluid and will be updated as needed	R. Coler

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 9/6/18, approved 9/18/18

		• Incorporate within the instructions and comes with the letters of support? • Should spell out MIH acronyms somewhere – found it is spelled out	T. Wodatch
	c. Legislative	No report, G. Allard excused	R. Coler
	d. MIH/CP Programs	• Bruce and Dave had put together a summary. It has been shared and revised.	R. Coler
		• The group met and had a discussion about data; thoughts shared with OEMS • Flushing out data set, it's active and ongoing	B. Baxter
	e. Reimbursements	No report, K. Sinko excused, however, meeting with her subcommittee • K. Campanelli who is part of the group – any report?	R. Coler
		• Met a week ago and continued the same discussion, nothing new.	K. Campanelli
	f. Public Education/ Marketing	No report, R. Kamin excused • Once we have the program type and education, this will move forward	R. Coler
4. Next Steps:	EasCare, Boston visit summary	Description of visit to EasCare: • Description of EasCare ambulance given. • Met with Scott Cluett, Director of Clinical Performance at EasCare on 8/20/18. • Invited to come and speak about the EasCare/Commonwealth Care Alliance (CCA) Mobile Integrated Healthcare (MIH) Program. • Scott has much knowledge regarding MIH in general. • CCA is an Accountable Care Organization with approximately 20,000 patients who sought a partnership with EasCare for an MIH Program to take care of their patients in the home. • EasCare has a robust dispatch communications center which is key for this program. • CCA sends over a referral with a robust Situation, Background, Assessment, and Recommendation (SBAR) of the patient to the Community Paramedic (CP). • The appointment has already been scheduled by CCA through EasCare's dispatch center. • The CP, who is on duty from 4 pm to 2 am, accepts the assignment and goes to the patient's home to provide the care requested. • Through their dispatch and the CP vehicle cell phone, the CCA Physician (MD), patients Nurse Practitioner (NP) and the CP have a conversation about the findings are, what the continued care is going to be, the follow up and documentation on the patient.	J. Santacroce

		• Average time of visit is 80 minutes. • The case we were privileged to view involved a non-English (Creole) speaking patient one week post UTI with symptoms of nausea and vomiting (N/V), unable to keep fluids down by mouth. • The appointment was scheduled for the CP to run labs, obtain IV access and assess the patient and report back. • The CP had to call the Language Line (LL) first and they remained on the line for the entire appointment; this made four people interacting on the phone with the patient. • CP used the iSTAT (Handheld Blood Analyzer) to get the blood results that they needed (Note: this is a tool that provides healthcare professionals with lab quality blood results in minutes). She also drew the chemistries, which would go to Quest, who they have a relationship with, if they needed any other tests done. • The CP was able to successfully communicate with this patient who, by all accounts, would have been lost in the system in Boston for many hours – and with her systems and the language barrier would have been very difficult for her to be processed correctly through the system. • Instead, the patient was home, in a comfortable environment for her, she was able to get the fluids she needed by order of her NP and the confirmation of the MD on the line. They had a great collaborative discussion about what they wanted and how they wanted the CP to give the patient fluids and anti-nausea medication via IV, and to see if she could take her by mouth (PO) medications prior to the CP leaving; if there were any complications, to call them back. • This was great care that we were watching at the patient's kitchen table and was really representative of the calls EasCare does. • EasCare is only doing about 1 to 2 calls per shift. • EasCare only has one vehicle and one CP at a time, so they concentrate on the Greater Boston area. • They are a private ambulance company; if they arrive and find the patient to be more acutely ill than realized, they activate the 911 system and Boston EMS would respond and take the patient to the Emergency Department (ED) as a 911 activation normally does. EasCare does not take the patient themselves, they use the system appropriately. This is useful for us due to the Primary Service Area's (PSA) and how they're set up in CT. I could see the same type of protocol set up if going into someone else's area (PSA). • As of spring 2018 they have seen approx. 2,100 patients, with every patient an individual phone interview (Satisfaction Survey) is done for tracking satisfaction. • The Satisfaction Surveys have shown that over 75% indicating that, if not for this service, there was no doubt they would have gone to the ED as well as the satisfaction rate being over 99%. • This shows a definite benefit to CCA, as well as the patients.	

		• Cost savings has been broken down and tracked over time with the approx. 2,100 patients showing that over $9 million dollars in savings, with over $3 million in savings in ED costs alone. • CCA would like EasCare to become more involved in the area and other areas such as Springfield. • Massachusetts is a little different, if you want to do something other than the norm, you fill out a waiver to OEMS, in their application, and CCA specified that their biggest time of need was 6 pm to 6 am, at this point CCA wants to change the time limitation. • At this time, while the MIH Office is being stood-up, MA OEMS imposed a moratorium until such time as they are set up, therefore, no movement will be done on this until fall 2018. • EasCare/CCA MIH will apply to have hours be 24/7 and add a Nurse Triage Line in their dispatch center. • Gear is standard plus: Antibiotics, portable ultrasound, iSTAT, and other tools. • The CP has full access to CCA ePCR's and CP charts their visit in the patients' health record. • Hoping to grow into other service areas. • MA is planning on a 5 FTE (full time equivalent) office, however, that may be too much to start. • This model is easily expandable to other ACO's and organizations, even hospitals. • Very transparent • EasCare receives an allotment of $28k/month from CCA for this model. • EasCare is not recognizing profits at this time due to the limitation of night hours only, there can be a lot of down time. To fill downtime, CCA is adding skills such as EKG's in the home to the CP. •	
		• The educational model is 300 hrs. divided 150 hrs. clinically, including NP shadowing, and the remaining 150 hrs being classroom with many focuses including respiratory, CHF, etc. They found that they needed more wound care education. Continuing education is fluid with modules being added and updated. CCA's Medical Director is involved in the initial and continuing education. Very collaborative, everyone is involved and working together to better the patient's experience.	S. Durante
		• What are their key performance indicators?	B. Baxter
		• It is The Triple AIM in Healthcare (Note: this is a concept put forward by IHI to drive healthcare organizations and providers to simultaneously implement programs that improve the patient care experience, improve the health of patient populations, and reduce the per capita cost of health care). Everything is reviewed in-house at EasCare and CCA is simultaneously reviewing as well for patient outcomes as well as costs. When the program began, the cost per patient was around the $860 range, with volume that has gone down to around the $560 range.	J. Santacroce

		• I want to go back to cost, their cost per encounter has gone down approx. $300.00, but are they also measuring the overall savings in terms of to the healthcare system in general, do they have some metrics that demonstrate what they believe the overall savings are to the healthcare system.	B. Baxter
		• Yes, the number mentioned earlier which were based on actual costs that CCA would have paid out for that. They went off of national averages as far as hospital admits as far as time. Their savings to the system breakdown is: o 2,171 visits to date o Emergency Admission (1563 x $2,000.00) = $3,126,000.00 o Hospital Admission (625 x $9,600.00) = $6,000,000.00 o Ambulance trips back and forth = $ 440,000.00 • They also have a three-tiered choice in MA: 1. Community Paramedicine with no charge for a municipally based FD/EMS with limited involvement 2. MIH almost everything for one cost for approx. $20,000.00? 3. MIH focusing on hospital readmission for $40,000.00	J. Santacroce
		• There's fees attached to each one of these applications?	R. Coler
		• Fees are reoccurring biannual fees, as far as we know they are funding the MIH office with the fees.	J. Santacroce
		• If the company that wants to do this isn't making money, why would they expend another $20-$40k?	R. Coler
		• CCA is paying the fee.	J. Santacroce
		• Did you discuss at all the relationship and or collaboration with Home Health and Hospice in all of this?	T. Wodatch
		• Yes, they have a good and collaborative relationship with those organizations with everyone under the umbrella of their care. They are brought in depending what the need is for the patient. No issues with turf wars or getting in the way of each other. Probably because the provider (NP or MD) lays out the care plan and when the CP gets the request, it's very clearly laid out what the CCA provider wants. Sometimes it's just an assessment to see if the patient requires the nurses back or if another path should be taken. It's a team that works together and is coordinated through the patient's provider.	J. Santacroce
		• I appreciate that. It continues to worry me that even the example he gave, generally that's a Home Health, go out to the house, do the assessment. I also know that there are situations that are beyond the Home Health. I want to make sure that whatever we're setting up, it's definitely a collaboration; you talk about the physician and the NP making a referral, well that's their choice, that's what they're making a referral to, they may not even be considering Home Health as a referral because they're saying, I've put money into this EasCare and I'm going to use EasCare, without the client being able to use their insurance and being able to be reimbursed properly for the care. Then to add to it, the wound	T. Wodatch

		education piece, that's something that Home Health specializes in and is trained to do and probably shouldn't be part of a CP visit unless it's in an area that's really stretching coverage.	
		• Those are their needs and things that are a GAP for them. • I don't know what their exact coverage is nor the lack of it, but we are here because we see these patients in their home every day and that prescribed Home Health isn't always there, isn't always available, and it's not always something that someone will qualify for, certainly not for that moment of need, so I think there's definitely a bridge there. • The system is very well controlled and structured, there are no referrals made from the field. • For this visit, the patient couldn't make the decision of setting up Home Health, for this visit, it worked for this patient and saved the system from more costly care.	J. Santacroce
		• For this case or any other case, are there metrics that EasCare and CCA are collecting? You're using admission re-avoidance, but what about Home Health referrals post that first visit because there really shouldn't be return visits by the CP, it should be a follow up much less expensive Home Health path, which would then also keep this person out of the hospital. This particular case doesn't sound like a one and done, she could continue to have problems.	T. Wodatch
		• That's why the CP was there, this was their first interaction with this patient because she had continued to have problems after care was already established. That is a great question for Scott when he comes.	J. Santacroce
		• We need to make sure the right decisions are made for the beneficiaries' rights to services and we don't want to stress the ACO's with the added costs of a CP if that's not what's necessary.	T. Wodatch
		• One of the challenges I see Tracey, is that every day ambulances in the State of CT and all over the country are going out to these UTI's and things like that at 10-11pm at night. If there's not that established home care relationship or even if there is, to get someone to go out at that hour is truly our challenge. I don't think the intent is to replace the dire need for home care, as you know, not every one of your patients is willing to be 100% compliant and the easier choice is to go to the ED and so I think that's how we see it from the EMS end. If they're willing to let someone in their door at 10 pm to get them going in the right direction and ultimately end up with that referral. I think that any program we develop	S. Heffernan
		• You were describing referrals through providers, not through 911, those are two different systems.	J. Granger
		• Yes, the hope is that once they are in the referral system, they will no longer need to call 911. So we could avoid that, having them call 911, ending up in the ED for hours, etc.	S. Heffernan
		• Having a call to 911 isn't a bad thing and that may be something that cannot be changed, we've spent millions of dollars getting people to call 911; it's more what you do with that call; one of their next steps and I certainly believe in this, having a nurse triage those calls for a priority that will safely allow patients to hook up with the care they require, i.e. NP visit or MD visit, etc.	J. Santacroce

		• Question regarding the handling of the QA/QI process which is normally done by the Medical Director and EMS Coordinator for the Sponsor Hospital – what is the role of the Medical Director over the ambulance service in this?	R. Coler
		• They are still involved, however, but the care decisions they are working with are made by the Medical Director from CCA who is more of a family practice based physician. • The Medical Director for EasCare was a big part of developing this program and the educational aspect. • Our system currently has field providers calling on the radio to speak with the Sponsor Hospital Medical Director for additional orders; in this model field providers would not bother the Sponsor Hospital Medical Director. Reasoning: A. It's not what they do on a day to day basis and B. The physicians at CCA have a relationship already established with these patients which allows them to collaborate and make the best decisions for the patient.	J. Santacroce
		• Do you know if the Medical Directors from the ambulance services get a stipend from them in MA?	R. Coler
		• I don't	J. Santacroce
		• It depends, most of the ambulance services in MA have hired their own Medical Directors and they are stipend.	B. Baxter
		• Had a lot of questions, but most have been covered. Clinical question – how many units are seeing patients? And can they get a call in the middle of this IV infusion and have to go?	Marybeth Barry
		• One. No, they are dedicated to the call; they are not doing 911 calls.	J. Santacroce
		• This call was activated by the PCP NP – how did she go about doing that?	M. Barry
		• An message through the Electronic Health Record for the appointment is sent to EasCare's dispatch center with an SBAR • Dispatch center pushes it electronically to the medic. • Medic goes to the home, open the laptop and calls dispatch who connects them with NP.	J. Santacroce
		• So the only referring providers are within the Boston area? • How long where you there?	M. Barry
		• Yes, referring providers (MD's, NP's) are all within the CCA group.	J. Santacroce
		• The MIH CP was just getting started with orders to: o Hang fluids (IV Infusion) over a specific time set by MD. o Give IV Zofran for nausea. o Re-assess patient looking for changes.	

		• CP was going to be there for a couple of hours. • The average time is 80 minutes for one call.	
		• The complexity of this visit is enormous from a clinical standpoint. o Interpreter Line o A very sick woman, she's dry, maybe needing antibiotics. o Was she hospitalized prior to that?	M. Barry
		• She had been at some time and had rebounded with issues and had to be seen again and this visit was due to symptoms that reoccurred.	J. Santacroce
		• Did she have a VNA in place?	M. Barry
		• Not to my knowledge	J. Santacroce
		• So to Tracey's point, she should have had a VNA. In favor of the MIH program, can this be something that can be set up, she sounds very sick. We don't want to replace one service with another.	M. Barry
		• I don't know if she had previously seen VNA and they moved to this, we didn't get into that part of the background. We can find out, we can ask Scott to expand upon that case when he's here.	J. Santacroce
		• She's follow-up with her own provider the next day. Imagine how many hours she'd be in the ED, she could be there for the day. • They took a very complex situation and did a really good thing with it.	M. Barry
		• Most of my questions were answered as well. Thank you for answering for a program you're not in charge of. Things that stand out to me: o The connection to care – how does that work, function and what's the experience? o Experience with high-utilizers – does this help that? • Interesting model – different than what I was thinking about around this table. • Their thinking behind developing this model over another.	S. Halpin
		• CCA came to EasCare with this model. • 911 referrals may come down the line.	J. Santacroce
		• If you know the answer – is there a process or tag in the system for 911 calls for these patients where the patient calling 911 would get an MD immediately?	T. Wodatch
		• May not have it built into this due to Boston EMS being an independent municipality and not at all connected with the MIH program. • However, that is true, some people have tags.	J. Santacroce
		• I'm curious how this would fit into our system? We're highly saturated with Medicare/Medicaid. • One thought is you're calling an MD at home – what will be his threshold for "send it to the ED".	M. Zanker

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		• When you're calling into a system like ours, as an Emergency Physician, who has laid hands on this patient 17 times this month is going to say "Why don't you try this, try that, before you transport". • We can prevent things like grandma who's found awake and alert on the floor of a nursing home who claims she just sat down due to weakness being transported and getting a CT scan. We can change this to "Why don't we come out and evaluate this patient". • Or, if a patient at home is a little dry, I have no problem giving them some fluids, rather than sending them to the ED to get some fluids. • I think that this model can be used to stave off not only the frequent flyers, but the people who actually need a higher level of care, but don't need it in the hospital itself.	
		• Just for all who don't know, there are a lot of acronyms being used – ACO is an Accountable Care Organization and CCA is Commonwealth Care Alliance from MA. • The CT person who is working with the ACO's is Mark Schaeffer who has been a member of our committee, but is not here today.	R. Coler
		• The ACO is a structure that's set up through Medicare in response to the Affordable Care Act to let them be responsible for the patient's overall care regardless of where that care is being received.	T. Wodatch
		• ACO is Medicare/Medicaid clients.	Group
		• Tracey, would these people be eligible for Home Health Care? The Medicaid population?	R. Coler
		• Yes, as long as they qualified; there would be many situations where the CP would be first on the scene and identify this, or the fifteenth on the scene and say "we need to get Home Health Care involved in this case to stabilize this home environment".	T. Wodatch
		• Yes, and that's why I think the collaboration between the two is so important – critical even – and it's important to see that the open lines of communication remain.	R. Coler
		• I think this is such a nice adjunct to the Home Health as VNA's are not going to go out after hours unless it's hospice; correct? I almost never have VNA's going to the house after 6 pm.	M. Barry
		• Yes, it is key to have a system like this. Both Home Health and Hospice have to have 24/7 on call. • I think the comment about the threshold for a physician who's going to say "send them to the ED", may be the same situation because there's only one person on call and there may be multiple calls at night and they are triaging and calling the physician to see what's necessary. • The system needs to be set up. • There are definitely GAP's in that area.	T. Wodatch
		• The on call nurse is probably not doing to see the middle of the night patient, she's going to say ED or MIH.	M. Barry
		• If a person has called at 10 pm, I'm not sure that they will wait until morning to see their PCP; people panic and want instant attention.	R. Coler

		• It is my understanding that Home Health/VNA is involved with this. Will clarify and get that information out. There were services available during the day.	S. Durante
		• OK, we'll see how the two agencies connect with this.	R. Coler
		• Thank you. • Just for clarification in the minutes – should be referred to Home Health Care as a VNA could be a specific agency.	T. Wodatch
		• Is there a telemedicine link involved when the CP and the MD, NP link up?	B. Baxter
		• They are on the phone, so they could, currently they are only using audio however, and they believe they would use video in the future.	J. Santacroce
		• Thank you for the informative, well done report. This gives us something else to think about.	R. Coler
4. Next Steps		• Continue sub-group work	R. Coler
7. Public Comments:		No public comment	
		• EMS services have memorials on 9/11 (our next date). I've been asked to reconsider the date. • Agreed to move the date.	R. Coler and Group
8. Adjourn and Next Meeting:		• Motion to adjourn made by K. Campanelli with a second by S. Halpin at 10:06 am • September 18, 2018 at 9:00 am at the Legislative Office Building, 1D	

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