Mobile Integrated Health Workgroup
Minutes

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

Meeting Date: November 20, 2018

Attendees: Gregory Allard, Joshua Beaulieu, Kristin Campanelli, Jennifer Granger, Melanie Flaherty for 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, Dr. Robert W. Zavoski

Excused: Chris D. Andresen, Marybeth Barry, Bruce B. Baxter, Dorinda Borer, Michael Bova, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, William Schietinger, Heather Somers, Jonathan Steinberg

Guests: Stacey Durante, Renee Holota

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		9:11 Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 10/23/18 minutes	D Lowell made a motion to accept, S Heffernan seconded, all in favor, abstentions are R Zavoski and T Wodatch	Group
4. Sub-Groups Reports/ Update:	a. Legislative	No update, no report	G Allard
		The AG 1991 opinion discussed at last meeting: EMS cannot work outside of the system, must have an EMS organization affiliation with a sponsor hospitals medical control oversite. We have had discussions at the office, we may have to make some legislative changes to accept the use of CP in the community. We are considering that at the office. I will give you the discussions thus far. Commissioner must ask the AG for the legal opinion on the above. Could be quite lengthy in the amount of time. A legislative change may be faster.	R Coler
	b. MIH/CP Programs	The 2nd version of the report as filed is the final draft to be submitted for inclusion.	D Lowell
		In that report you spoke of – reads options from document. The programs are not exclusive – there may be others, as well as we are not replacing any currently available services in the community.	R Coler

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	c. Public Education/ Marketing	On hold until process is decided upon	R Coler
	d. Application	We are awaiting opinions from the office – as to NFS or CEMSMAC/CEMSAB approval. Questions? None	R Coler
	e. Reimburse-ments	Almost finished; received some of the pieces yesterday; recap: touches on treatment, non-transport; touches on insurance and fiscal; talks about what DPH will need for resources – suggests choosing one option with three EMS services; talks about a fee-for-service rate. I am circulating today or tomorrow for subcommittee and plan to have to entire group by 12/4	K Sinko
	f. Education	Submitted report on 11/1 with six fairly broad recommendations – reads document submitted – Questions? None	J Beaulieu
		The report skeleton is done and consists of: 1. Executive Summary 2. Sub group reports 3. Information regarding existing programs 4. Public Act – I'd like to have a discussion on the tasks in the Public Act today:	R Coler
		Task #1: Identify areas in CT that would benefit from MIH – data must be submitted and GAP's identified. You must be able to identify the GAP's in your community in order to provide MIH. Agreed upon by group	R Coler
		Task #2: Interventions would be identified by GAP's, sponsor hospital and reviewed by CEMSMAC, approved and back to sponsor hospital	R Kamin
		• No legislative change needed here – use the system in place	R Coler
		• No treatment discussed here will include things currently outside of the scope of practice	R Kamin
		Task #3: Education – is covered by education sub group submittal	J Bealieu
		Task #4: Potential savings or additional costs:	R Coler
		• Outlined in the report; lack of data makes it hard to layout cost savings or cost increases	K Sinko
		Task #5: Potential reimbursement issues:	R Coler
		• Treat, no-transport discussed here; insurance minimum is transport to ED currently; new mandate in statute could cost money and increase premiums; clear up any thought of scope of practice issues	K Sinko
		Currently we are reimbursed for DOA; how does this work right now?	S Heffernan
		• Predicated by rates and setting a rate	K Sinko
		Currently there is no rate for DOA, so how do we get paid?	S Heffernan

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		• It's in the explanatory notes – it is defined	D Lowell
		Thank you, we'll look at that	R Coler
		Task #6 Criteria – we've defined this in the application process	R Coler
		• This is specific for the ALS provider	D Lowell
		Task #7: Statute or regulations impacted by MIH – we're working on that piece	R Coler
		Task #8 Successful models throughout the country – NGA Memo, Presentation from EasCare in MA	R Coler
		Subsection 1: Collaboration with CEMSAB/CEMSMAC regarding alternate destination	R Coler
		• No question of the ability to transport to alternate locations as long as protocol is followed and sponsor hospital medical control is involved	R Kamin
		• We talked about urgent care center transports – we can transport, however, there may not be reimbursement for that transport	R Coler
		• We are trying to come up with solutions that are patient care-centric; unfortunately they are not financial-centric as well	R Kamin
		• Do we limit this to hospital based urgent care centers? A lot of the urgent cares do not take people without insurance and will turn them away.	M Zanker
		• We are looking to provide efficiencies here, all stakeholders have to be at the table. In my community we've identified the urgent cares who will be taking all patients. I don't think we should limit this – each community should be able to put in action a program that works for them	J Beaulieu
		• In our report, we discussed this and made a suggestion in the report to begin with hospital based urgent cares	D Lowell
		• Concerned with just hospital based, in our community we have community health centers that would work with us and we want to be able to transport there if appropriate	S Heffernan
		• Josh's point is key – should be based in your community and all stakeholders must be at the table; this is a benefit to the patient to keep specific to the need in your community	G Allard
		• Many of us do have the ability to communicate with other stakeholders	J Granger
		• Urgent care's will hesitate due to liability insurance unless there is a financial model agreeable to everybody	R Zavoski
		• We will identify the "stakeholders" at the table in application process	R Coler
		• We're at a point where over defining may be counterproductive. Let's focus on development of the system, (i.e. application process), adding value by making this patient-centric.	R Kamin
		• What stops someone from doing this today? If a self-paying patient asks to be dropped off at an urgent care or Minute Clinic what prohibits this?	S Heffernan

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		• When 911 is dialed, there's an expectation of receiving the best care at the best destination and how to best serve the patient and the system that we're working within	R Kamin
		• Interesting discussion – although there isn't a rule not to do that, a "Walmart or CVS Clinic" may not be happy about ambulances dropping people off at their door – have to take that into consideration. All stakeholders have to be at the table.	R Zavoski
		Subsection 2 read – Yes, protocol driven and sponsor hospital driven	R Coler
		• Is this for any EMS provider of just a paramedic?	K Sinko
		• ALS only by my understanding; BLS transport is done non-emergent to all kinds of people to testing facilities, homes, etc. This should be under the umbrella of MIH where a paramedic is making a decision that it's OK.	D Lowell
		• If a paramedic is dispatched to a 911 call, wouldn't it be a higher level call? Not just a cut for instance?	K Sinko
		• The paramedic can decide if a BLS provider can transport to an alternate destination. ALS level decision making has been discussed, but it's not outside the realm of thinking that BLS can go to alternate care after higher level decision making is made by a paramedic. Currently we have BLS going to an ED with a patient after a paramedic has determined this is appropriate.	R Kamin & D Lowell
		• Urgent care is not currently defined by DPH, therefore Medicare doesn't pay for this currently	R Zavoski
		• The new definition of urgent care went into effect 10/1/18 – it's being implemented currently	K Sinko
		Our deadline is 1/1/2019, we're in good shape	R Coler
5. Next Steps:		DPH and our Legislative Liaisons to put through a draft report next – is that agreed?	R Coler
		Next meeting 12/4 – I have a conflict for that day. I would like to put together and circulate the draft report and meet 12/18 to review. You may hear from me between now and 12/4. We'll meet 12/18 and discuss the report put forth the week before.	R Coler
		Is 12/18/18 this group's last meeting? What if we don't come to consensus? Will this group continue meeting?	J Beaulieu
		• Let's look at the draft report first and then we'll see if we want to continue meeting	R Coler
		Where do the issues that have been tabled such as public education & marketing stand?	S Heffernan
		• These are not an obligation, but will be helpful – this will unfold when the program is picked.	R Coler
6. Public Comments:		No public comment	R Coler
7. Adjourn and Next Meeting:		• Motion to adjourn made by D Lowell with a second by the entire group at 10 am • No meeting 12/4/18	R Coler

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		• Report draft due one week before 12/18/18 • Next meeting will be 12/18/18 and we'll decide then if the report will be ready in time.	

CT-N Link

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