Mobile Integrated Health Workgroup
Minutes

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

Meeting Date: October 23, 2018

Attendees: Chris D. Andresen, Marybeth Barry, Joshua Beaulieu, Kristin Campanelli, Susan Halpin, Shaun Heffernan, Dr. Richard Kamin, David Lowell, Dr. Maybelle Mercado-Martinez, James Santacroce, Chris Santarsiero, William Schietinger, Kelly Sinko, Dr. Michael F. Zanker,

Excused: Gregory Allard, Bruce B. Baxter, Dorinda Borer, Michael Bova, Jennifer Granger, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, Carl J. Schiessl, Heather Somers, Jonathan Steinberg, Tracy Wodatch, Dr. Robert W. Zavoski

Guests: Stacey Durante, Renee Holota,

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		9:05 Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 10/09/18 minutes	R Kamin made a motion to accept, all in favor, no abstentions	Group
4. Sub-Groups Reports/ Update:	a. Education	Meeting Thursday, will have final copy before November	J Beaulieu
	b. Reimburse-ments	Requests an extension for draft of two weeks; will circulate by 11/1 to subcommittee; draft to group between Nov 6 and next meeting	K Sinko
		We would like a draft report by the end of November	R Coler
	c. MIH/CP Programs	No update	D Lowell
	d. Legislative	No update	B Schietinger
		Will send K Campanelli's presentation back out to the group	R Coler

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	e. Public Education/ Marketing	No update; awaiting a program decisions	R Kamin
		• Another trip to Boston to visit Cataldo Ambulance is planned (B Baxter, Jim Santacroce and S Durante attending) • OEMS is following up with the AG and Assistant AG and will have an informal opinion and discussion regarding a waiver and if statutory changes are needed. • We also have reached out to legal regarding NFS/public hearing process impact of the application process; cannot see what exact impact will be at this time; as we look at the application process and decide, we will see what that is.	R Coler
	f. Application	The application has been revised, please take a moment to review and comment	R Coler
		• What is the value of CEMSAC and CEMSAB review if having a hearing? Would this be cumbersome?	J Santacroce
		• Currently a Need for Service Application (NFS) is submitted to OEMS, once deemed complete, it is copied to regional councils and to the hearing office. • We can revise the process. The question is should it go to a public hearing, or not; should it go to CEMSAB/CEMSMAC or not, lets discuss:	R Coler
		• It's reasonable to follow the NFS process	S Heffernan
		• I'm biased, being the chair of CEMSMAC • These will be unique applications • I don't want to see silos built • I don't want medical oversite to be outside of this process • It will make it a lengthy process, however, it will be worth it • I see CEMSMAC and CEMSAB being a nexus • There is a critical need for a transparent process as with the NFS; however, public hearing officers have no expertise of what is happening in this complicated system	R Kamin
		• Element to preserve is public hearing. • Can we have a public hearing outside of the public hearing office (PHO)? • I agree that CEMSMAC/CEMSAB are imperative to this process	J Beaulieu

		• Agree with Josh • NFS is not the right way to go about this • This should go through CEMSMAC/CEMSAB • Public comment is on the agenda of both of these committees • Is this enough to fulfill the need for public comment?	J Santacroce
		• To recap: We do not want to go to a NFS / vote taken, the I's have it – No need for service • Alternate route – 3 bodies to comment on the application • 1. Regional councils (RC) • 2. CEMSMAC • 3. CEMSAB • Once the MIH Application to OEMS is received and deemed complete, a copy can be mailed to the RC, CEMSMAC & CEMSAB with comment due back to OEMS	R Coler
		Will they have 45 days to review?	S Heffernan
		• The application can be mailed at the same time to all three council organizations (as stated above) and we can hold them to the 45 days • In NFS application, OEMS has to notify all in the area of their intent – is that necessary here?	R Coler
		Who would the notification be to? Hospitals, Urgent Cares, other allied health providers? Can't just notify EMS agencies.	J Beaulieu
		• Stakeholders have to be defined – who are they?	R Coler
		This information is asked for in the application – so how do we identify stakeholders?	J Beaulieu
		• The suggestion is to put a public meeting notice out through OEMS that a program is coming up for discussion at CEMSMAC and/or CEMSAB with meeting dates published in notification for public to attend if they have commentary	R Coler
		Transparent and available for comment application process: • Typical way we inform stakeholders will have to be broader • We already have a process in the state for broadly notifying stakeholders • This may be the safest way until we can define stakeholders • As long as we have and EMS Medical Director and Sponsor Hospital involved, I'm not sure this needs to be vetted through CEMSMAC as much as to inform CEMSMAC • CEMSMAC can have a standing agenda item where we review current new programs and make folks aware of new programs	R Kamin

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		• This may not be like the statewide protocols where CEMSMAC has to approve them • Can CEMSMAC/CEMSAB just be in the loop in a parallel process as long as OEMS feels the application is deserving approval with medical direction, and stakeholders are informed?	
		Clarification needed: • Do we see this as a different protocol or a brand new service? • According to statute, does CEMSMAC/CEMSAB have to approve?	K Sinko
		• Sponsor hospitals have to oversee this • There will be something in the new regulations that keeps sponsor hospitals from writing their own protocols independently • Yes, this will be a new protocol AND a new service	R Kamin
		I thought we were all right with statute, however, I'm not sure now	K Sinko
		• Ultimately, the authority for the scope of practice for a paramedic only comes under the sponsor hospital as long as deemed OK by OEMS • The scope of practice for EMT and EMR falls under the CEMSAB	R Kamin
		To summarize: • R Kamin's suggestion is not to look to CEMSAB/CEMSMAC for approval, however, to ask them to comment	R Coler
		Yes, both groups were designed to assist OEMS when they have questions • For the sake of practice that the OEMS looks at as not unreasonable, is safe, and is in an environment of stakeholders being aware, I would like to see CEMSMAC in the loop, but not have the decision making capabilities	R Kamin
		• This workgroups charge is to recommend different MIH programs • We have identified MIH programs that services are already providing, but 4 years down the road we may have new programs identified • Should we have a two pronged approach?	B Schietinger
		• Regarding scope of practice Statute 19a-179a – reads it – states that CEMSMAC & Commissioner have ultimate authority • Statues always trump regulations	C Andresen
		• There is a contradiction in the regulations and it needs to be clarified regarding sponsor hospital having ultimate authority in regard to a paramedic • Approval by CEMSMAC & OEMS can be done	R Kamin

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		• The application comes to OEMS, OEMS deems in complete at which time it comes to CEMSMAC to be deemed appropriate for the scope of practice segment • Keep in mind that none of the interventions spoken about or put into place by other services we've heard would be outside the current scope of practice	
		• EMS is different from other licenses, as their scope of practice is very broad and not well defined • All other professions are very narrow • It's an atypical scope of practice	C Andresen
		Because this process is so flexible, should we use the existing process	K Sinko
		• We're not talking about a scope of practice issue	M Zanker
		• It's not what we are doing, it's where we are doing it that's different	J Beaulieu
		• The application of the same scope of practice in a different manner; the same interventions, just applied differently	R Kamin
		Using different protocols?	K Sinko
		• Currently we have CT Statewide Protocols for paramedics • There may or may not be other protocols for various MIH initiatives and they may not be included in the CT Statewide Protocols • Initially, this will be a small local need being met • I want CEMSMAC to be involved, but don't want it to hinder the process • We are not creating a radically new process that would need additional resources, we already have the mechanics available	R Kamin
		• Yes, that's accurate • I'm still confused why we can't do this already	K Sinko
		• I can only respond if it's a 911 call activation currently • I can only take patients to an emergency department currently	S Heffernan
		• Barrier one (above) will be discussed with the AG, that EMS personnel "cannot work outside the 911 system" – can we a) use a waiver process (part of application), or b) do we have to change statute. We will meet regarding this. • The second barrier is due to payment structure, not statute. The insurance community will only pay for ambulance services if patients go to an emergency department – this is something the EMS agency will have to work out in order to apply for an MIH program. It could be an ACO, a hospital, this will have to be decided and is part of the application process also	R Coler

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		• The other consideration to think about is if we build this cumbersome process and OEMS has to have a huge role, it will have a fiscal note attached to it. I've been transparent regarding the impact of a fiscal note. That's why we're looking at a system that's already in place. For instance, the regional council puts forth a recommendation only. OEMS has final say. • CEMSMAC/CEMSAB would be an advisory role only. Statutes are contradictory and need to be defined by the AG.	
		• If approval is needed where scope of practice will not change, this will not be a large hurdle for CEMSMAC/CEMSAB to approve	R Kamin
		Legally can an advisory committee be an approving board to an application?	M Zanker
		• Yes, the law says it can	K Sinko
		• Reads various statutes; Chapter 384d Sec. 20-206jj(8)(9) which defines paramedicine as – reads statute • But when we go to Chapter 370, 20-9b(14) - reads • This is not as straightforward as other providers statutes	C Andresen
		It will be important to clarify that for when it goes to the legislature	R Kamin
		• Let's make sure we're not over regulating something you can already do • If everyone is happy with the application, that's OK with me	K Sinko
		• I don't speak for the insurance carriers, S Halpin does • If we change the law to say EMS can take patients to another place, it could be considered a new mandate and the state will have to absorb the cost of that, based on language in the Affordable Care Act; it's a distinction and I want to make sure it's understood	K Campanelli
		• I've been listening, thank you Kristen for clarifying that • The question is if the state will allow a carrier, if they so choose, to enter into this kind of agreement • We would not support anything that was mandated in statute, but there are companies that are interested in looking at innovative approaches to care delivery and I don't think we want to have it precluded by state statute • A mandate would be opposed outright • Issues: Target population associated with commercial insurance is very, very small – the focus really has been around Medicaid and perhaps Medicare which is a different set of governing rules • Commercial insurance is only 30% regulated by the state; 70% is self-insured and regulated by Federal Arista Standard	S Halpin

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		• Should not put emphasis on commercial insurance/population in this group, shouldn't be the direction of this group	
		• In statutes right now, it is permissible (not mandated) now to transport to an alternate destination, however, except for BCBS there are no other insurance companies who will reimburse for this	R Coler
		• Yes, but how are they doing it? Through an ACO? Through direct contacts? A carrier today can contract with a (EMS) provider to do this • A mandate is a floor, not a ceiling	S Halpin
		• Where is the cost that would have to be absorbed by the State?	R Kamin
		• See the PowerPoint that was presented to the group Ambulance Services and the Regulated Insurance Market in CT • I can bring someone who is an actuary from the department to explain this at the next meeting?	K Campanelli
		• Conversation with AG– EMS does work currently outside of 911 system when transporting from hospital to home or facility to facility – how do we do that now? • Regarding cost of FTE, can we add this to an application fee? Similar to MA, but modest fee?	J Beaulieu
		Put these ideas and options in the report, it is important as new people will be coming into the administration and this will be considered in a new budget	K Sinko
		• We've discussed that we won't have hundreds of applications to begin, but the potential is there to have many in the future. • Put into place a system that's scalable	J Beaulieu
		• Permissibility vs. Mandate • BCBS has offered reimbursement to do something different and permissible • Can you bring this up in your informal AG conversation? • Is there anything restricting this?	D Lowell
		• The barrier/issue is CT's unique ambulance rate setting, not the insurance statutes • It can't be charged unless/until CT sets a rate, that's the holdup which will be addressed in my report – setting a rate for treat and non-transport • Current setup is sort of a fee for service – does this allow alternative payment contracts?	K Sinko
		Currently, there is a treat no transport precedent set for "dead after dispatch"? A payment rate is set for that, can we adapt that?	D Lowell
		• We'll take a look at that, to determine is we have to go through a regulation change or not - thank you	K Sinko
		• Good, helpful discussion	R Coler

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		• Application? • No NFS • We'll clarify role of RC, CEMSAB & CEMSMAC and resubmit • How about the rest of it? Is anything missing? • Reads current MIH Draft Application • Is the rest of the application acceptable?	
		• Section 8 has Medical Direction • Should Section 2 have that?	K Sinko
		• We could have more than one Medical Director, one from the sponsor hospital and one from the ACO, other hospital, ambulance service, etc.	J Beaulieu
		That would require changes in statute	R Coler
		• Isn't it possible for a sponsor hospital to agree/collaborate with another physician? • This has come up in this committee's discussion in relation to the potential conflict of a medical control/sponsor hospital providing oversite to a program that's asking to transport to another facility	J Beaulieu
		Yes, I remember Mark Schaeffer was very concerned about that point – thank you • That may be something to make statutory change specifically for this program	R Coler
		• Section 3 – add alternate destination?	S Heffernan
		• No, this is not an inclusive list, just an example • It's left open for other innovative programs	R Coler
		• Any other questions?	R Coler
		• Revise Section 10 to specify the PSA stakeholder(s) and surrounding PSA stakeholder(s)	D Lowell
		• Yes, we can do that and reword • We need to define the stakeholders as we spoke of earlier	R Coler
		• Will send a copy to you Susan as there are not enough copies	R Coler
		• Should we add wording that this is limited to paramedics?	K Sinko
		• Yes, we will add that, thank you • Any other questions/comments? • Thank you Next Steps?	R. Coler
5. Next Steps:		Continue with subcommittees and report out at next meeting	R. Coler

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6. Public Comments:		No public comment	R Coler
7. Adjourn and Next Meeting:		• Motion to adjourn made by Sean Heffernan with a second by the entire group at 10:19 am • Next meeting will be 11/6/18	R Coler

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