

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:	<p>Goal Summary:</p> <p>Sub-committee reports:</p> <p>Data Needs</p>	<p>Original charge of Legislative MIH Workgroup read aloud.</p> <p>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.</p> <p>Sub-committees asked to update the group on any work done:</p> <ul style="list-style-type: none"> • 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. <p>There is a strong need for GAP analysis and data prior to moving forward.</p>	<p>R. Coler</p> <p>G. Allard R. Kamin J. Beaulieu</p> <p>R. Coler</p>

		<ul style="list-style-type: none"> • Each community • Each catchment area • Multiple PSA holders <p>Although further discussion may be needed – Comments?</p> <p>Enable all communities to locally identify and address their own GAPS</p> <p>Cites an example of PSA holders crossing boundaries and asks the question: How do we address that in an MIH application?</p> <ul style="list-style-type: none"> • 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 <p>Outside 911 system requires:</p> <ul style="list-style-type: none"> • Scope of Practice changes • Statutory changes <p>How will this be activated? Have we considered EMD and protocols?</p> <p>It will depend on town or program – this will be encapsulated in each program, but it will affect EMD's</p> <p>In the application process?</p> <p>Prior collaboration needed for:</p> <ul style="list-style-type: none"> • GAP analysis • Make up of program • Statutory – AG's opinion in 1991 (will email) <p>There will be two (2) ways to activate the system:</p> <ol style="list-style-type: none"> 1. 911 – will remain the same 2. Non-emergency programs through a 7-digit number <ol style="list-style-type: none"> 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. <p>Non-transport will not have to be the PSA holder, vs. transport which will have to go through the PSA holder.</p>	<p>D. Lowell</p> <p>R. Coler</p> <p>J. Beaulieu</p> <p>R. Coler</p> <p>D. Lowell</p> <p>R. Coler</p> <p>M. Zanker</p> <p>J. Santacroce</p> <p>M. Zanker</p> <p>J. Santacroce</p> <p>G. Allard</p> <p>R. Coler</p>
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		<p>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.</p> <p>That is true, we have a very complicated system.</p> <p>MIH has to be dependent on:</p> <ul style="list-style-type: none"> • The GAP Analysis brought forward • No duplication of services • Improved patient care – QA/QI • Cost savings <p>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.</p> <p>Considering doing a Survey Monkey to ask questions about data – will present this at next meeting for thoughts.</p> <ol style="list-style-type: none"> 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 <p>Let me clarify a few things:</p> <ol style="list-style-type: none"> 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. <p>There will be obstacles and challenges in creating services within different agencies in different areas.</p> <p>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.</p>	<p>T. Wodatch</p> <p>R. Coler</p> <p>C. Santarsiero</p> <p>R. Coler</p> <p>T. Wodatch</p> <p>R. Coler</p>
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		Yes, we need a better understanding of this	R. Coler
	Next Steps:	<p>What are the group's next steps?</p> <ul style="list-style-type: none"> • Next meeting we'll continue with feedback for MIH/CP Subcommittee <p>Thanks all for their thoughtful submissions.</p>	R. Coler
Next Meeting:		<p>June 19, 2018 at the Legislative Office Building, 1D – CXL'D</p> <p>August 14, 2018</p>	
Public Comments:		No public comment	
Adjourn:		Motion to adjourn made by D. Lowell and second by Greg Allard at 11:06 am	

DRAFT