Mobile Integrated Health Workgroup
Minutes

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

Meeting Date: September 25, 2018

Attendees: Gregory Allard, Bruce B. Baxter, Joshua Beaulieu, Kristin Campanelli, Dr. Maybelle Mercado-Martinez, James Santacroce, Carl J. Schiessl, William Schietinger, Kelly Sinko, Tracy Wodatch, Dr. Robert W. Zavoski

Excused: Chris D. Andresen, Marybeth Barry, Dorinda Borer, Michael Bova, Jennifer Granger, Susan Halpin, Shaun Heffernan, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, David Lowell, Kimberly A. Sandor/Mary Jane Williams, Chris Santarsiero, Heather Somers, Jonathan Steinberg, Dr. Michael F. Zanker

Guests: Stacey Durante, Renee Holota

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		9:10 Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 9/18/18 minutes	Changes: No. Motion made by B. Baxter to accept, seconded by J. Santacroce, motion carried and the minutes were accepted as is. Opposed- none. Abstentions-K. Sinko & R. Zavoski. All in favor.	Group
3. Sub-Groups Reports/ Update:	a. Education	• No report; CEMSAB MIH Committee meeting this Wednesday.	J. Beaulieu
	b. Application Process	• Revised copy sent to all. Was a skeleton; now directions are included on recommendation and feedback of the group. What are group's feelings?	R. Coler
		Clarifying question – Application processed directly to DPH? Or CEMSMAC for vetting and then DPH?	K. Sinko
		Yes, flow through CEMSMAC and then to DPH. Comments?	R. Coler
		Is it the same process as a Need for Service Application (NFS), through hearing office?	J. Santacroce
		Application reviewed by CEMSMAC and OEMS and then to the Advisory Board, but this is negotiable. If it goes through the hearing process we will need staff. If we use the current structure, we have to find out if the hearing	R. Coler

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		office would be involved. We have to realize we need to look at the QA/QI and would need staff. Initially we may not, however, ultimately we would need staff.	
		Is the CEMSAB/CEMSMAC capable of doing this in a timely process? Is this a shift in standard process of a NFS application process be better?	B. Baxter
		Good point – it would be a minimum of two (2) to three (3) months to get through CEMSAB and CEMSMAC. The hearing process is long as well – a few months.	R. Coler
		I don't know if CEMSAB/CEMSMAC are the appropriate flow for this. Are we talking about regional councils in the application process? Are they significant in this? Let's clarify which councils we are talking about.	G. Allard
		NFS is a different process than what's existing with protocols?	K. Sinko
		Anything from clinical practice would always go through CEMSMAC (education & protocols). Administratively, the NFS comes directly to the OEMS – the regional coordinators look at and deem complete, the director reviews, and it goes to the hearing office. Presently we get feedback and notify all services in the area when we have an application – this is in statute. We look for a review/opinion from the regional councils, however, that is not binding. Sometimes they do not respond (they have 30 days to respond). We were trying to mirror the NFS and the regional councils are included in that process.	R. Coler
		I would think regional councils should have an approval process beforehand. I also would think that CEMSMAC should have access beforehand as well.	G. Allard
		Regarding fiscal impact – is it safe to assume, if we mainstream this into the current process that the fiscal impact will be less? I would advocate that there is an established process, we would be well served to use it and have less fiscal impact.	B. Baxter
		We support keeping the current established process vs. veering off to a new process then? The current process is a NFS application that comes to OEMS and is reviewed by the regional coordinators and deemed complete, then it is shared with the regional councils, and sent upstairs for a hearing date. We have affidavit's saying we alerted all stakeholders in the area of application so they may have a say, hearing office listens to application and make a decision as to whether to approve or not approve.	R. Coler
		This captures procedural due process and I'm pleased and would support this process.	C. Schiessl
		No intent to bypass due process.	R. Coler
		Agree with the current process. Concern is criteria, what is it to have a recommendation for or against? Also, the normal NFS requires vehicles to be licensed and have a minimum equipment list. If following current process, all has to be laid out.	W. Schietinger
		Will CEMSMAC continue to be involved? A pre-approval and commitment from sponsor hospital would be needed I think. I want to include the CEMSAB/CEMSMAC so they can serve as a conduit for consistency. It may be fractured if these councils are not involved.	R. Kamin

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		Can we do draft workflow for the next meeting? Specifying the criteria? Building a streamlined process will help with fiscal impact.	K. Sinko
		I agree, the hearing officers need to have criteria made clear.	J. Santacroce
		Will adding to the hearing officers' workload add to fiscal responsibility?	G. Allard
		• Yes, that would add to impact. Key points/criteria are MIH system is integrated, ensuring healthcare quality not compromised, but enhanced, identifying scope of practice, funding, educational needs, and medical oversite key role. The NFS application has a page where medical control authorization is discussed. Stacey can rewrite this. • We had come up with a statement, reads statement (see link attached) • Key focus is enhancing the health of the population	R. Coler
		The NFS process is for a new service starting or a current service expanding to ALS or additional vehicles. This is already in regulation, MIH is not. Are we tying our hands? We can already do MIH now, but if we make this a NFS process, we may tie our hands.	W. Schietinger
		Timing will be the same whether we go through a NFS or through CEMSAB/CEMSMAC.	R. Coler
		Agree that we have to have due process, but is it a NFS process or not? This belongs with the clinical side, not a hearing.	W. Schietinger
		I agree. This is based heavily on regulation and statute. With the existing boards and medical approval, they know the clinical side. It's really not a need for service process.	J. Santacroce
		MIC Upgrade process may be the better process. This involves all councils.	R. Coler
		We want to use the "process" of the NFS only.	G. Allard
		Risk in having a hearing officer weighing in as this is an innovative process.	J. Beaulieu
		So, I hear us changing our position totally.	R. Coler
		Not me, I think there needs to be notice and due process. I'm hearing two things – this can fit into the NFS, and this is new, innovative and won't. The fundamental due process is what I will agree to.	C. Schiessl
		Why can't due process be added to a new process. I think that transparency is good.	J. Santacroce
		Carl, clarify for me that the process should be vetted by non-experts?	R. Kamin
		What I meant is citizenry – a patient cohort may want to weigh in on this. There has to be notice of a proposed change in the system so they can weigh in on it.	C. Schiessl
		A hearing officer may not be the best person to do this. As a person who has developed protocols for the state, I have been approached by people who are committed to something that is not evidence based. I don't want to put a hearing officer in a spot where they are not ready to make that deliberation.	R. Kamin

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		It's my understanding that: • Protocols decided by CEMSMAC/DPH • We wouldn't need to change statute to do this • What are the barriers now for a providers to do MIH?	K. Sinko
		The arena in which we can work is right now only 911. The MIH programs are outside the 911 system. Funding/reimbursement is a large barrier as well.	J. Santacroce
		Is the 911 operation a statutory change?	K. Sinko
		Not for scope of practice, but we will need waivers to working outside of the 911 system.	R. Coler
		OK, so we need a process in which EMS can operate outside of 911.	K. Sinko
		We have to go back to the drawing board, make sure due process is written in, criteria is given, and feedback is allowed.	R. Coler
	c. Legislative	No report. 911 statute and financial aspect are on our agenda.	G. Allard
	d. MIH/CP Programs	• Codifies a half dozen different options that were discussed. We clearly support organized, concise, collaborative application process with all stakeholders signing off. We support the application process vetted by this group. • Reads document and list of programs supported. (see CTN footage) • Questions?	B. Baxter
		Each of these programs would have to go through the same process?	K. Sinko
		Correct – right now 911 sends an ambulance only.	J. Santacroce
		Will criteria for each of these programs be defined separately?	K. Sinko
		There's core criteria – demonstrate a need, value for all of these. Some agencies set up more than municipalities to do this. There is a cost savings across the nation with this. Let's paint the legislation in broad strokes, so we don't have to come back and re-due it. We may see one or two agencies in the state able to do this or a hybrid of this, for instance, helping a person connect with an Uber or Lyft to go to an Urgent Care.	B. Baxter
		General criteria for each or specific?	K. Sinko
		General as it's evolving.	B. Baxter
		Criteria of patient care and patient satisfaction mentioned earlier Last week Scott Cluett visited from EasCare Ambulance, the PP was sent around, very successful program, with high patient satisfaction and proven cost benefit. Limited hours of operation was the limitation with their	R. Coler

		program. Plenty programs across the nation, NGA has documented 39 programs across the nation. We're not starting on our own, we have programs to pull from.	
	e. Reimburse-ments	• The group met twice and talked about getting out all of the fiscal and reimbursement issues. • Drafting and will circulate to subgroup, then workgroup • Charge, two issues in statute – potential savings or additional costs associated for an insured and any potential reimbursement issues related to MIH. • Insured may accrue costs – ambulance rate limitations, set rates? What about people who don't have coverage? Current insurance coverage statutes only for fully insured. If new mandate by statute – state's costs could raise. Talk to Anthem • Potential savings – DSS to f/u; high cost ED visits could be avoided; how do we make the case in CT? • Pilot program? One option with no fiscal impact to show proof of concept and then roll out. Another option is to show a full on approach with fiscal impact. Options might be best. • Reimbursement issues: Costs to Medicaid? If savings, how do we show that? • Type of provider: Billed through hospitals? • Fiscal: DPH administrate the program? Hearing Officers? • Once we get a new application process that drills down the workflow that will help to identify resources. • We'll circulate our narrative. • Comments?	K. Sinko
		We look forward to your write up	R. Coler
	f. Public Education/ Marketing	No report.	R. Coler
5. Next Steps:		Report due January 1, 2019. We have meeting every 2 weeks until 12/18; then put our thoughts on paper to put forward. How should we proceed with the next steps? Should each subgroup write their piece and I put together? How do we want to proceed?	R. Coler
		We haven't had a full workgroup in a while. A few weeks ago, we felt we couldn't start putting things on paper. Would it be beneficial to have a full workgroup here to recap?	W. Schietinger

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		We can certainly do a recap next month. At some point we have to finish this up. We've discussed, re-discussed, talked about the pros, talked about the cons, we know everyone's concerns, we've listened, and we've done the research. We could do one meeting where opinions can be heard.	R. Coler
		We should start to draft, knowing it's just a draft and continuing to put things in place. Please use email to share concerns before next meeting as it's hard to get all in one room and have a consensus from all. I think we're there, we should start drafting.	R. Kamin
		I'm open for someone to start drafting and putting thoughts together and I will collate and marry them.	R. Coler
		Best use of time? Meeting here or allowing subgroups to meet and draft something?	K. Sinko
		We're running out of months. The sooner we have something to say Yes or No to, the better;	J. Beaulieu
		I agree, we need something in front of us.	K. Campanelli
		OK, we will start putting our thoughts on paper and continue our meeting every two weeks.	R. Coler
6. Public Comments:		No public comment	
7. Adjourn and Next Meeting:		• Motion to adjourn made by K. Campanelli and seconded by G. Allard at 10:14 am • Next meeting 10/8/18.	

CTN Video: http://ct-n.com/ctnplayer.asp?odID=15637

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