Mobile Integrated Health Workgroup
Minutes

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

Meeting Date: September 18, 2018

Attendees: Bruce B. Baxter, Joshua Beaulieu, Michael Bova, Kristin Campanelli, Jennifer Granger, James Santacroce, Carl J. Schiessl, Tracy Wodatch,

Excused: Gregory Allard, Chris D. Andresen, Marybeth Barry, Dorinda Borer, Susan Halpin, Shaun Heffernan, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, David Lowell, Dr. Maybelle Mercado-Martinez, Kimberly A. Sandor/Mary Jane Williams, Chris Santarsiero, William Schietinger, Kelly Sinko, Heather Somers, Jonathan Steinberg, Dr. Michael F. Zanker, Dr. Robert W. Zavoski

Guests: Stacey Durante, Renee Holota, Scott Cluett, Mark Schaeffer, Mike Starkowski

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		9:20 Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 8/28/18 minutes	Changes: Yes, change Meeting Date to 8/28/18. Motion made by B. Baxter to accept, seconded by J. Santacroce, motion carried and the minutes were accepted with changes. Opposed- none. Abstentions-none. All in favor. Next meeting will be 9/25/18 as previously scheduled.	Group R. Coler
3. Presentation		Power point presentation by W. Scott Cluett, III, NRP, (S. Cluett) regarding the EasCare Ambulance and Commonwealth Care Alliance MIH Pilot and continuing program. EasCare MIH Presentation ; Audio MIH 091818	S. Cluett
	Questions & Discussion:	Thank you. I'm with the CT Association for Healthcare at Home; we are the home healthcare providers on the ground in CT, and also the Hospice providers. • It's interesting that CCA doesn't refer to Home Health • APRN's going out into the field all across the country; good model; saves money • There are a lot of other needs: therapy for strength, home health aides for ADL's, etc.; there is a disconnect there • The after-hours piece, comprehensive and a great service and filling a big GAP • Concerned about that disconnect with Home Health; believe a partnering between all would be most beneficial • Slide on Palliative Care, but didn't use the word hospice at all; does CCA have a partnership/agreement for preferred Hospice Providers (last 6 months of life when terminal)?	T. Wodatch

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 9/19/18

		I don't know if CCA is partnered with a preferred hospice provider; Dr. John Loughnane who is the Medical Director for the program we've build and the Palliative Care Program at CCA, has found that: • Sending a paramedic to the home, during crisis, while expensive, is better than the consequences • We have found that sending the paramedic to provide real-time care for the family and the member has been beneficial • I think they may use their own staff to mitigate these needs, but I'm not sure • Our program is built around an acute process, so if someone was going to call 911, they will defer to us, triage around a nurse • Members are required to call into a clinical response unit "CRU", the RN will make the determination if it's going to be a MIH program that's coming out, if it's going to the hospital, or if it's something that can wait till the morning. • I can certainly get back to you on the question of Hospice Care that CCA is providing • Dr. Loughnane feels strongly about paramedics coming in during an acute process to help mitigate that	S. Cluett
		I agree with the acute care process; I'm worried about the day-to-day; hospice is a philosophy of care with a team approach of social work, chaplains, personal care, volunteers and nurses – it's a whole team that helps the person and the family be prepared and live life verses an acute care team. Worried if there is no connection.	T. Wodatch
		I understand and support hospice one hundred percent and so does CCA. If there is an acute process, this is the program that they have in place.	S. Cluett
		Tracy, I agree with you, but these people and their families call 911 quite often; we're put in this situation anyway and right now there's only one choice when they call 911 and that's to bring them to the ED; we know what the consequence of that is once the person gets to the hospital as far as their funds, what's covered, what's not covered and what kind of care they may or may not get in the emergency department; vs. the alternative of responding, listening to the wishes and needs of the patient and their care plan/care pack and being able to care for and stabilize that situation until the hospice nurse/care can get there – not to replace hospice, just to be there when the acute situation arises that leads to a 911 call.	J. Santacroce
		I agree with everything you said; I'm worried when a program doesn't use Home Health, if we're creating an MIH model in CT, or an opportunity for MIH in CT, patients deserve the right to have services that their insurance covers; shouldn't just be acute care, should be a planned, coordinated response of what's needed at home; use MIH appropriately.	T. Wodatch
		Nobody disagrees with that; MIH would be used appropriately to augment services in place, not to replace services, we've been very clear that we're not replacing services, we're filling GAP's during crisis and after hours.	R. Coler

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 9/19/18

		Scott has said that CCA has its own team that responds; is this in lieu of a formal VNA arrangement that they have staff members in that role?	
		That is my understanding, yes.	S. Cluett
		It sounded to me as if only high level practitioners (APRN's, etc.) where involved, not the "boots on the ground" level to take care of wounds who would be there several times a week. I'm trying to go on the record as to when we set up a model, not involving Home Healthcare would be a problem. The model set up is great in many other ways, it's just missing Home Healthcare in my opinion.	T. Wodatch
		We feel as though we're another "tool in the toolbox" for the organization; when the need arises, we are there to meet that need; our experience has shown that it's been very successful in the past 4 years or so; in the next six months you'll see supporting studies published.	S. Cluett
		Is the program focused on a specific area of the state?	B. Baxter
		Yes: • Due to having a single truck • Applied for Region 4 & 5 of Mass. • Self-limited to I95 to 128 area • CCA has a must larger footprint, including Springfield, but we couldn't amend our geographic coverage with OEMS • Brewster & EasCare will be expanding area of service and hours of program as soon as allowed	S. Cluett
		Reflecting on Tracy's thoughts, having had direct experience with CCA due to a sick relative with cancer – the care was what I would have expected; traditional hospice care, the complete package. Great job.	B. Baxter
		Why is it wise that DPH is restricting the expansion of your program? I missed most of the presentation due to another commitment.	M. Schaeffer
		This is a pilot project and instead of jumping right in, I believe the requirement is to study a program like this daily with great, great, oversite – walk before we leap. We've made a lot of fundamental changes to the program over the four years; perfected it to be the best that it can be; we've laid the groundwork for future MIH programs to expand across the commonwealth.	S. Cluett
		What are the payment arrangements?	M. Schaeffer
		• Shared the cost startup initially • CCA shouldered educational costs • EasCare shouldered vehicle/equipment costs • After that a stipend was set for $28k/mos. From CCA to EasCare • Over the 4 years EasCare operation cost has mostly broken even, some months at a loss	S. Cluett

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		Will you have a shared savings arrangement going forward?	M. Schaeffer
		• Fee for service model is in negotiation at this time • It's an expensive program; the consequences are more expensive with admittance costs; it's better to mitigate it at home.	S. Cluett
		Would it benefit us to get a copy of the waiver?	T. Wodatch
		• It's on the DPH website	S. Cluett
		Mass was using a waiver as their regulations didn't allow for MIH; CT does, we need an application which we have been developing with the help and feedback of this group. We've also fine-tuned it to include the instructions.	R. Coler
		• The waiver was for the pilot project – testing the waters to see if successful. Six services applied – EasCare and Cataldo's SmartCare were the two who were allowed.	S. Cluett
		We presently have an avenue called a Need for Service which would go to hearing officers	R. Coler
		Very similar in Mass; Medical Advisory Board and Regional Medical Officers who vote on our waivers	S. Cluett
		If this group were to decide to do a pilot project – I think we have that process set up within the Need for Service Application.	R. Coler
		Does CCA act as the insurer, participate in Medicare and Medicaid, and what percentage are in each?	M. Starkowski
		• CCA is an accountable care organization who is the insurer • Yes, they participate in both • They are dully eligible	S. Cluett
		CCA was one of the first to do this in the 90's; Mass just converted to a Medicaid ACO model	M. Schaeffer
		Any other questions? Thank you for coming Scott.	R. Coler
		Thank you for having me.	S. Cluett
4. Sub-Groups Reports/ Update:	a. Education	• No report	R. Coler

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	b. Application Process	• We will send out revised application with meeting minutes.	R. Coler
	c. Legislative	No report, G. Allard excused.	R. Coler
	d. MIH/CP Programs	No report.	R. Coler
	e. Reimburse-ments	No report, K. Sinko excused.	R. Coler
	f. Public Education/ Marketing	No report, R. Kamin excused.	R. Coler
5. Next Steps:		Continue with subcommittees and report out at next meeting 9/25/18	R. Coler
6. Public Comments:		No public comment	
7. Adjourn and Next Meeting:		• Motion to adjourn made by R. Coler with a second by K. Campanelli at 10:15 am	

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