Mobile Integrated Health Workgroup

Minutes

Date: March 27, 2018 Time: 9:00 a.m. Location: Rocky Hill DPH Lab

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Chris D. Andresen, Marybeth Barry, Bruce B. Baxter, Joshua Beaulieu, Michael Bova, Jennifer Granger, Melanie Flaherty for Susan Halpin, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, David Lowell, James Santacroce, Chris Santarsiero, Kelly Sinko, Dr. Michael F. Zanker, Dr. Robert W. Zavoski

Guests: Mark C. Schaefer, Becky Z., Mike Starkowski, Stacey Durante

| Agenda Item | Issue | Discussion | Action/ Responsible |
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| Welcome: | | Raffaella Coler welcomed the workgroup members | |
| Minutes: | Review of the February 27, 2018 minutes | Chris Andresen pointed out that he was not noted as present for the 2/27/18 meeting.<br>All was in favor of that change; Opposed- none | |
| Discussion/ Presentation: | Original Charge for workgroup: | Original charge for workgroup read by Raffaella Coler Sec. 45 (c) (1), (A- H).<br><br>Discussion on "where we are" regarding Task #1:<br>(A) Identify gaps – this has been done, gaps read to group – Readmission reduction, alternative destination, hospice revocation and high frequency utilizers.<br>(B) Scope of Practice requires NO statute or regulation changes. Arena in which EMS is allowed to practice (9-1-1) change needed. Mr. Baxter would like Telehealth discussed as an arena.<br>(C) Education change needed, however, we must first identify exactly what gaps we are addressing.<br>(D) Savings or cost of change has been explored and proven in other states only.<br>(E) Reimbursement issues need to be resolved – working on this by engaging CMA and bringing Mark Schaefer into discussions.<br>(F) No discussion<br>(G) Statutes/regulations changes will have to be made.<br>(H) Raffaella Coler asked about a Massachusetts MIH model. Further discussion was had below:<br><br>M. Schaefer – Discussed Commonwealth Care Alliance and has emailed all a web link for CHCS/Mass MIH model link: | |

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| | | https://www.chcs.org/resource/community-paramedicine-new-approach-serving-complex-populations/<br><br>B. Baxter stated that MA has two pilot programs currently, as well as ME having many pilot projects.<br><br>Raffaella Coler then read and discussed Task #2 :<br>(A) CEMSAB MIH Committee working on this.<br>(B) CEMSAB MIH Committee working on this.<br><br>Raffaella Coler reminded the group of the timeline and report due to the Commissioner on 1/1/2019 and stated that the original charge document would be placed on the DPH/OEMS website. | |
| | Alternate Destination: | Urgent Care as an alternate destination was discussed extensively:<br><br>J. Beaulieu discussed information from the CEMSAB MIH Committee that urgent care destination is in the process with Waterbury/AMR where they are working on a program where patients will be triaged to the urgent care on-site of the hospital by field providers. Other data gathered by J. Santacroce from this committee was discussed as favorable to this destination except for one study. A group consensus was with a program and protocol set up, urgent care would be a favorable destination.<br><br>Dr. Zanker pointed out that two types of urgent cares exist:<br>1. Linked with a hospital.<br>2. Not linked with a hospital.<br><br>J. Beaulieu suggested that we identify urgent cares in community to work with.<br><br>K. Sinko added that by 4/1/18 urgent care in the state will be licensed.<br><br>B. Baxter pointed out that not every urgent care/health center can handle behavioral health and/or detox patients. Notes that alternate destination should be a collaborative effort with sponsor hospitals to assure that open for ambulance business times are known and respected and relationships with ACO's (Accountable Care Organizations) are established. Also, example discussed for Community Behavioral Health and Detox Crisis Team intervention such as Wake County EMS' plan.<br><br>Question is posed by K. Sinko – Who has final say in where patients go? Patient or Medics?<br><br>B. Baxter answers that patients ultimately have the final say.<br><br>J. Beaulieu adds, any patient who wants to go to the hospital ED, goes.<br><br>Raffaella Coler adds that the Paramedic is not the decision maker IF a patient gets medical care as in the refusal option. | |

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| | | Dr. Kenkare points out that:<br><br>• Currently there is no standard definition of what an urgent care is.<br>• You have to know your local resources.<br>• You cannot just show up at their door.<br>• Only certain types of complaints should be transported there.<br><br>Dr. Zanker agrees that an urgent care partnership must be collaborative.<br><br>J. Granger adds that understanding and identifying frequent flyers is helpful. Community health centers are resources, as well as community health center behavioral mobile crisis, however, the patient must be their patient.<br><br>Raffaella Coler summarizes this key point: Local resources have established relationships with patients and they should be kept in their own communities.<br><br>The subject of risk management is mentioned and that the Medical Director is the person "on the hook". Paramedics will have a learning process to go through. Paramedics, MD's and patients will collaborate.<br><br>Certain groups are against MIH due to loss of income in ED's. Patients will still be in their system and community.<br><br>Two types of patients: Emergent and non-emergent. Urgent care is a primary care to many and connects patients to a primary care often.<br><br>Ems services have different payment and billing models; municipal and commercial services have certain cost considerations, and all can identify positive and negative financial impacts with MIH.<br><br>Most important is: Right care, right time, right place, but nothing is said regarding right reimbursement. The goal is better community health.<br><br>The group recognizes that decreasing ED overcrowding could equal lost revenue for ED's, however, it is better for patient safety/care to go to alternate destinations.<br><br>PEARL: Keep patient care/safety central; not money – all agree.<br><br>Patients are consumers and they know their monetary and insurance limitations already. They are looking for a better experience at this point.<br><br>The group asks is prompt care at hospitals is a different copay amount than an ED visit copay? | |

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| | | Alternate destination will require EMS & patient education. MD's office are already overcrowded and reimbursable tests are more easily authorized at ED's than at MD's offices as well.<br><br>Data – we have none from our systems, however, we do have data from other systems that show a cost savings, but at the end of the day, alternate destination will be patient driven and require a partnership between MD's, Paramedics, Urgent Cares and Hospitals.<br><br>Raffaella Coler refers back to her documentation stating that: "MIH shall be integrated into the current health care system". All at table agree with that statement. | |
| | GAP discussion: | Shall we address multiple or one GAP at this time?<br><br>• At this time we have a sentinel opportunity to set broad legislation.<br>• Each EMS system should be allowed to make or set up arrangements in their own community.<br>• Broad scope.<br>• Empower EMS agencies to do their own GAP assessments in their own community allowing innovative/creative solutions, then define how they will do that and make an application to CEMSAB and the state. This process could possibly be called a "Certificate of Need" process.<br><br>It was noted that CT's rural EMS population are not represented at this workgroup.<br><br>Question: Will there be specific protocols?<br><br>This can be addressed with an application to the State of CT with a total system/plan for the specific community, with the state setting maximum reimbursable rate charges.<br><br>Question: Will the consumer get the bill?<br><br>At this time, approximately 60% of charges are written off. Diabetic and O.D. calls are often "treat & release" as they refuse to be transported and are not eligible for reimbursement from the patient or the insurance company are written off.<br><br>Suggestion made for this group to define "treat & release". Medicare has defined this. Anthem is only company to reimburse so far. EMS is a protocol driven world by EMS experts. Medical control is already established and EMS has the infrastructure in place for alternate destination. The current protocols can be used for new interventions.<br><br>The webinar regarding Montana MIH on NASEMSO is recommended. | |

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| | | Raffaella Coler recaps the discussion: <u>We are not recommending a specific program for all, but that each agency can identify GAP's with their own data, come up with a plan for health care in their community, and then bring this plan to OEMS in an application form which will be reviewed by CEMSMAC and CEMSAB for approval.</u><br><br>The question then becomes "Do we come forth with that criteria?"<br><br>We've identified that:<br>• each community has its own needs<br>• we want to empower each agency to tailor their plan to their communities needs<br><br>Question: What happens to people with no insurance?<br><br>Right now, ED's accept ALL patients. It is recognized that alternate destinations might not. EMS will not pick up that bill, however, there is a federal expectation that "we take care of them."<br><br>We have to make sure all parties want to participate in MIH.<br><br>We have to establish criteria for approval of a program.<br><br>We have to remember that we have two parts to this: emergent and non-emergent. EMS does not want to become the non-insured citizens' home health care provider.<br><br>Everyone will have to get a bill and this will take conversation with the urgent cares. We will have to be careful and take into consideration the federal law that ED's are under.<br><br>The patient has a choice of where to go. Once 9-1-1 is activated, we just want to help them with additional options.<br><br>Not every urgent care is the same. Any provider (in an urgent care or primary care) can refuse to treat you right now.<br><br>Will a "waiver" get EMS around the triggered 9-1-1 system?<br><br>Accountable care organizations (ACO's) must be identified in the community plan.<br><br>Watch out for burying EMS in the nuts & bolts.<br><br>By a show of hands, all are in favor of moving forward with this model. | |
| | Task Division: | Raffaella Coler – at our next meeting we will discuss task division. | |

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| | | It is suggested by M. Schaeffer that we have a strategy written up to clarify. Committee agrees to write up what has been agreed to. It is agreed that co-education on the process the committee's been through to anyone can understand is important – write it up.<br><br>Raffaella Coler summarizes we have to write up an "Executive Summary" of the proposal we've agreed upon; then a list of tasks will follow. | |
| | | Mark Schaeffer gives legislative points of interest and things to consider at this point:<br>• 2020 & 2025 we will be in an atmosphere where legislative change is permissive.<br>• Deploy a model during 2020 and/or 2025.<br>• ACO's will be undertaking community partners.<br>• The group should define where we are going and when.<br>• Money for test deployments.<br>• Foundational Core & Innovative Models.<br>• Define to what extent we want to have a part in the Primary Health Care Modernization model.<br><br>Question asked: How would medical direction work? Between MD office and Paramedic or traditional (through hospital MD)?<br>Discussion:<br>• Protocols developed by current medical control to cover all.<br>• We are back at partnerships – EMS agencies set up relationships in their own community.<br><br>What about liability?<br>Discussion:<br>• Currently the sponsor hospital always has the control and the liability once they agree to be a sponsor hospital.<br><br>Dr. Kamin suggests that this process – designing, refining and executing is what we all do for a living – it's not complicated. He also sees this as becoming statewide eventually.<br><br>M. Schaeffer informs the group that we are discussing hospitals and ACO's. ACO's - some are hospital anchored and others are not hospital anchored. He also raises the question should communities have the option for non-9-1-1's to have medical control outside of a hospital – it's worthwhile to engage medical control outside of hospitals.<br><br>A remark is made that "9-1-1 is EMS's anchor".<br><br>M. Schaeffer states: Prospect is all in (up & downside risk) and SFH is starting to have downside risk.<br><br>Dr. Zanker stresses public education and patient expectation. | |

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| | Next Steps: | Raffaella Coler – Executive Summary and Research<br><br>Request made to send EMS White Paper and share Jim Santacroce's document | J. Beaulieu |
| | Next Meeting: | April 10th at the Legislative Office Building | |
| Public Comments | | No public comment | |
| Adjourn | | 10:55 a.m. | |