Mobile Integrated Health Working Group

January 16, 2018

Location: State of CT Lab, West St., Rocky Hill

Time: 9am

Agenda

1. Welcome
   a. Review of room Logistics
2. Approval of Minutes from December 5, 2017
3. Presentations by subject experts:
   a. Department of Social Services — Dr. Balaski
   b. CT MIH Data/Need Assessment — EMS Partners
4. Next Steps
5. Public Comment
6. Adjourn, Next meeting February 13, 2018

Mobile Integrated Health Working Group

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6. Adjourn, Next meeting February 13, 2018

Mobile Integrated Health Workgroup

Minutes

Date: January 16, 2018 Time: 9:00 a.m. Location: State Lab in Rocky Hill

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Christian Andresen, Marybeth Barry, Bruce Baxter, Joshua Beaulieu, Michael Bova, Kristin Campanelli, Jennifer Granger, Shaun Heffernan, Dr. Kamin, Jeannie Kenkare, David Lowell, Dr. Maybelle Mercado-Martinez, James Santacroce, Chris Santarsiero, Carl Schiessl, William Schietinger, Kelly Sinko, Tracy Wodatch, Dr. Michael Zanker, Dr. Donna Balaski on behalf of Dr. Zavoski

Agenda Item	Issue	Discussion	Action/Responsible
Welcome		Raffaella Coler welcomed the workgroup members	
	Housekeeping	Reminded members to check in with security	
Minutes	Review of the December 5, 2017	The minutes were accepted and seconded as written. All was in Favor; Opposed- none	
	Follow up from previous meeting	Directive from the last meeting was that the group would identify gaps that currently exist.	
	CT MIH Data/Needs Assessment	There are different services and different landscapes from region to region with regards to EMS services. Josh Beaulieu used Manchester, CT as an example and discussed the landscape and some the gaps he faces.	

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		Gaps Identified: • Reoccurring patients (high utilizers) • Patients who are not eligible for home care or not processed for home care services timely. • Bruce Baxter provided some statistics for his service. • Underinsured or does not have adequate coverage for home care • Can't afford support services • When 911 shows up there is not the ability to recommend no transport to a hospital and there is no ability to refer to a doctor. • The business model is the EMS service is paid only if they transport to the hospital. • Need to be regulatory amendments to the statues. • Protocols would need to be rewritten • Post Hospital discharge- equipment is not always in the home when a patient is discharged. There will need to be more discussion on gaps. MIH in Texas was discussed on how it works and how the EMS service has been integrated. There was discussion on how other states have 911 dispatchers that are certified and have low level protocol in their EMD algorithm. In some cases those calls are referred to a nurse or another health care provider.	
	Follow up:	Reach out to Discharge Planning Nurse Webinar Link and send out data and analysis information	Bruce Baxter

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	Presentation Dr. Balaski	Presented on the Utilization of Transportation Services	
	Comments:	There is an office of health strategy. The mission of MIH may fall under that. The office addresses in part systems and issues and they may have worked or are working on MIH related issues. A suggestion was made to keep that in mind and it may be a good idea to reach out to them.	
	Public Comments:	None	
	Adjourn	Meeting adjourned at 11:08 a.m.	

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Mobile Integrated Health Working Group

February 27, 2018

Location: **State of CT Lab, West St., Rocky Hill**

Time: 9am

Agenda

1. Welcome
   a. Review of room Logistics
2. Approval of Minutes from January 16, 2018
3. Presentations by subject experts:
   a. CT MIH Data/Need Assessment EMS Partners
4. Next Steps
5. Public Comment
6. Adjourn

Next meeting March 13, 2018

Mobile Integrated Health Workgroup

Minutes

Date: February 27, 2018 Time: 9:00 a.m. Location: State Laboratory, Rocky Hill

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Bruce Baxter, Joshua Beaulieu, Kristin Campanelli, Shaun Heffernan, Richard Kamin, David Lowell, Maybelle Mercado-Martinez, James Santacroce, Carl Schiessl, William Schietinger, Kelly Sinko, Tracy Wodatch,

Agenda Item	Issue	Discussion	Action/Responsible
Welcome		Raffaella Coler welcomed the workgroup members	
	Housekeeping	Review of Room Logistics and Introductions	Welcomed Mark Shaefer from the Office of Health Strategy
Minutes	Review of the minutes	The minutes from January 16, 2018 were approved as written. All in favor; no opposed.	
Presentations	CT MIH Data/Needs Assessment	No presentation. Will look at Gaps and Need Assessment. Look at programs EMS fits into and the statistical data related to those programs. Update was given on the last hospice meeting.	
Discussion / Presentation		Mark Schaefer, Office of Health Strategy gave an overview of the Office of Health Strategy They are looking at the most cost effective medical care; quality care at a lower cost.	

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		Common Approach-trying to harmonize expectations across all payors. **Discussion of 4 primary areas to look at** • **Alternate destination** • **Hospice revocation avoidance** • **High frequency utilizers** • **Data** **There would need to be a change in deployment of paramedics. Proactive or preventative and would it be an extension of what currently exists or would it be separate?** **EMS has various limitations on treatment and limited on how they can accommodate a patient without transport to a hospital. There are narrow options unless they are transporting the individual to the hospital and there is an inability to charge for non-emergency transports for certain services.** **The question is how can paramedics integrate into the health care system and help avoid hospital readmissions if no hospital is really needed.** **A few MIH models were discussed. It was noted that these models have validated data and use EMS within the scope but work with the community. Studies show the models are capable and can be successful.** **The MIH workgroup will need to work with and align recommendations with the Office of Health Strategy.** **Developing a Concept Paper:** • **What do you want in the scope** • **Formal agreement signed by the Governor and other Agencies**	

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		• If possible, incorporate some of what you want to achieve. • Department of Public Health sets the rates, need alternative payment methodologies • Range of methods used to pay for diversified services Summary: • What is the most effective way to avoid Emergency Room Admissions • Post Hospital Discharge o Medication reconciliation • No equipment in the home at discharge • Alternate Destinations • No payment reimbursement • Hospice Revocation • High frequency utilizers Needs: Better data and data exchange- data is being poorly collected and need to look at what kind of data is needed at the state and provider level.	
	Next Steps:	4 identified Goals: 1. Avoid unnecessary Emergency Room visits 2. Alternate Destinations 3. Hospice revocation 4. High frequency Utilizers Address the quality of care issue more from an alternative destination to appropriate destination. Key points: MIH integrated to enhance existing care Scope of practice issues Finding reimbursement	

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		Educations needs **Medical oversight protocols**	
Public Comments			
Adjourn		**11:04 a.m.**	

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Mobile Integrated Health Working Group

March 27, 2018

Location: **State of CT Lab, West St., Rocky Hill**

Time: 9am

Agenda

1. Welcome
2. Approval of Minutes from February 27, 2018
3. Presentations by subject experts:
    a. CT MIH Data/Need Assessment — EMS Partners
4. Next Steps
    a. Discussion of Services to be offered — Group
        i. High Frequency Utilizers
        ii. Appropriate Destination
        iii. Reduction of re-hospitalization
        iv. Hospice Revocation
    b. Align Data
    c. Payment Models — Sinko/Coler
5. Public Comment
6. Adjourn

Next meeting TBD

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
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. 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). Discussion on "where we are" regarding Task #1: (A) Identify gaps – this has been done, gaps read to group – Readmission reduction, alternative destination, hospice revocation and high frequency utilizers. (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. (C) Education change needed, however, we must first identify exactly what gaps we are addressing. (D) Savings or cost of change has been explored and proven in other states only. (E) Reimbursement issues need to be resolved – working on this by engaging CMA and bringing Mark Schaefer into discussions. (F) No discussion (G) Statutes/regulations changes will have to be made. (H) Raffaella Coler asked about a Massachusetts MIH model. Further discussion was had below: 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/ B. Baxter stated that MA has two pilot programs currently, as well as ME having many pilot projects. Raffaella Coler then read and discussed Task #2 : (A) CEMSAB MIH Committee working on this. (B) CEMSAB MIH Committee working on this. 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: 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. Dr. Zanker pointed out that two types of urgent cares exist: 1. Linked with a hospital. 2. Not linked with a hospital. J. Beaulieu suggested that we identify urgent cares in community to work with. K. Sinko added that by 4/1/18 urgent care in the state will be licensed. 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. Question is posed by K. Sinko – Who has final say in where patients go? Patient or Medics? B. Baxter answers that patients ultimately have the final say. J. Beaulieu adds, any patient who wants to go to the hospital ED, goes. 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:

- Currently there is no standard definition of what an urgent care is.
- You have to know your local resources.
- You cannot just show up at their door.
- Only certain types of complaints should be transported there.

Dr. Zanker agrees that an urgent care partnership must be collaborative.

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.

Raffaella Coler summarizes this key point: Local resources have established relationships with patients and they should be kept in their own communities.

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.

Certain groups are against MIH due to loss of income in ED's. Patients will still be in their system and community.

Two types of patients: Emergent and non-emergent. Urgent care is a primary care to many and connects patients to a primary care often.

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.

Most important is: Right care, right time, right place, but nothing is said regarding right reimbursement. The goal is better community health.

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.

PEARL: Keep patient care/safety central; not money – all agree.

Patients are consumers and they know their monetary and insurance limitations already. They are looking for a better experience at this point.

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. 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. 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? • At this time we have a sentinel opportunity to set broad legislation. • Each EMS system should be allowed to make or set up arrangements in their own community. • Broad scope. • 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. It was noted that CT's rural EMS population are not represented at this workgroup. Question: Will there be specific protocols? 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. Question: Will the consumer get the bill? 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. 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. 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> The question then becomes "Do we come forth with that criteria?" We've identified that: • each community has its own needs • we want to empower each agency to tailor their plan to their communities needs Question: What happens to people with no insurance? 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." We have to make sure all parties want to participate in MIH. We have to establish criteria for approval of a program. 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. 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. The patient has a choice of where to go. Once 9-1-1 is activated, we just want to help them with additional options. Not every urgent care is the same. Any provider (in an urgent care or primary care) can refuse to treat you right now. Will a "waiver" get EMS around the triggered 9-1-1 system? Accountable care organizations (ACO's) must be identified in the community plan. Watch out for burying EMS in the nuts & bolts. 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. 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: • 2020 & 2025 we will be in an atmosphere where legislative change is permissive. • Deploy a model during 2020 and/or 2025. • ACO's will be undertaking community partners. • The group should define where we are going and when. • Money for test deployments. • Foundational Core & Innovative Models. • Define to what extent we want to have a part in the Primary Health Care Modernization model. Question asked: How would medical direction work? Between MD office and Paramedic or traditional (through hospital MD)? Discussion: • Protocols developed by current medical control to cover all. • We are back at partnerships – EMS agencies set up relationships in their own community. What about liability? Discussion: • Currently the sponsor hospital always has the control and the liability once they agree to be a sponsor hospital. 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. 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. A remark is made that "9-1-1 is EMS's anchor". M. Schaeffer states: Prospect is all in (up & downside risk) and SFH is starting to have downside risk. Dr. Zanker stresses public education and patient expectation.	

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	Next Steps:	Raffaella Coler – Executive Summary and Research 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.	

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Mobile Integrated Health Working Group

April 24, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

1. Welcome
2. Approval of Minutes from March 27, 2018
3. Next Steps
   a. Discussion of Services to be offered Group
   b. Align Data
   c. Payment Models
4. Public Comment
5. Adjourn

Next meeting May 8, 2018

Mobile Integrated Health Workgroup
Minutes

Date: April 24, 2018 Time: 9:00 a.m. Location: LOB, 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Michael Bova, Kristin Campanelli, Melanie Flaherty for Susan Halpin, Shaun Heffernan, Dr. Richard Kamin, David Lowell, Chris Santarsiero, William Schietinger

Guests: Kim Aroh, Joel Demers, Stacey Durante, Renee Holota

Agenda Item	Issue	Discussion	Action/ Responsible
Welcome:		Raffaella Coler welcomed the workgroup members, noting that it was a small group attending	Director Coler
Minutes:	Review of the March 27, 2018 minutes	No changes, Dr. Kamin made a motion to accept, M. Bova seconded, motion carried, minutes accepted; opposed- none	

Discussion/ Presentation:	Next Steps and Summaries:	Director Coler noted that next steps are to hand out assignments to develop the following new programs, however, due to lack of attendance today, waiting for next session.
		o Education – program
		o OEMS
		    o New licensure level
		    o Statutes and regulations: Scope of Practice allows with Medical Direction / CEMSAB / CEMSMAC approval
		o DSS – Reimbursement Plan
		    o KEY issue and biggest problem – DSS working on this
		Concerns of MIH workgroup:
		o Integrated
		o Not compromised
		o Outcome measures met
		o Fiscally sustainable
		o Address/regard concerns of other groups: VNA, DSS, Hospice, etc.
		o Address the publics lack of understanding regarding EMS capabilities and skillsets
		o Lack of regulations in Urgent Cares
		o Increased premiums? - K. Campanelli
		o ACA increase due to:
		    o treat and release – MD works with Paramedic
		o Complexity of protocols to operationalize – Director Coler directs attention to N.H. Protocol handout language:
		    o "To meet the needs of the local population." – important and discussed at the last meeting
			Director Coler

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		○ Fiscal impact – will this be a positive or negative to the stated Medicaid Program?
		○ Proposed expansion of scope of healthcare worker
		Outcome:
		○ Creation of program that encompasses GAPS by community assessment:
		  ○ Falls
		  ○ Pt. Referrals
		  ○ Opioid OD
		  ○ Decreasing readmissions
		  ○ Etc.
		Discussion opened up to group for comment.	

		○ Great summaries. ○ Involve CEMSMAC, CEMSAB, and the Education & Training committees in the education process and protocol changes. ○ Suggestion made to make the initial delineation of objectives broad so not pigeonholed later. ○ Address underserved populations with stakeholder agreement.	Dr. Kamin
		○ Agreed. ○ Different needs in different populations. ○ Broad list, not inclusive.	Director Coler
		○ Approves of NH protocol as a template ○ Moving forward with this to subcommittees ○ Good start	D. Lowell
		Shall we send the NH Protocol to subcommittee for vetting?	Director Coler
		Will we be following the same boundaries as PSA's?	S. Heffernan
		○ How to assign PSA's for MIH? Key point – we have to look at this	Director Coler
		Statewide protocols – how does MIH fit into that?	B. Schietinger
		MIH program might be very specific, but as localities meet needs, other will use same protocol, medical oversite, etc.	Dr. Kamin
		○ Suggests we look deeply into training programs – Distributive, hands-on, clinicals, etc. ○ General discussion: depends on what we are implementing, one size does not fit all.	S. Heffernan
		○ Yes, we have to start process now, tasks Joel Demers with a summary. ○ Making a task list to discuss at next meeting	Director Coler
		Volunteers to be on a "Reimbursable Subcommittee"	K. Campanelli
		Volunteers to be on a "Payment Model" or "Services to be Offered" Subcommittee	C. Santarsiero
		Asks all to think about subcommittee formation and service	Director Coler
Next Meeting:		May 8th at the Legislative Office Building, 1D	
Public Comments:		No public comment	
Adjourn:		09:49 a.m.	

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Mobile Integrated Health Working Group

May 8, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

1. Welcome	Coler
2. Approval of Minutes from April 24, 2018	Coler
3. Next Steps	
a. Discussion of Services to be offered	Group
i. Align Data	
ii. Payment Models	
4. Group Assignments	Group
5. Public Comment	
6. Adjourn	

Next meeting TBD

Mobile Integrated Health Workgroup
Minutes

Date: May 8, 2018 Time: 9:00 a.m. Location: LOB, 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Marybeth Barry, Bruce B. Baxter, Joshua Beaulieu, Michael Bova, Jennifer Granger, , Shaun Heffernan, Dr. Richard Kamin, David Lowell, Dr. Maybelle Mercado-Martinez, Kimberly A. Sandor, Chris Santarsiero, William Schietinger, Tracy Wodatch, Dr. Robert W. Zavoski

Excused: Chris D. Andresen, Kristin Campanelli, Dorinda Borer, Susan Halpin, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, James Santacroce, Carl J. Schiessl, Kelly Sinko, Heather Somers, Jonathan Steinberg, Dr. Michael F. Zanker

Guests: Joel Demers, Stacey Durante, Renee Holota, Mark Schaefer

Agenda Item	Issue	Discussion	Action/ Responsible
Welcome/ Housekeeping:		Raffaella Coler welcomed the workgroup members, emergency exits.	Director Coler
Minutes:	Review of the April 24, 2018 minutes	No changes, R. Kamin made a motion to accept B. Baxter seconded, motion carried, minutes accepted; opposed- none, all in favor. Tracy Wodatch noted that the VNA should be referred to as "Licensed Home Health" and other home care should be referred to as "Non-skilled Home Care"	
Discussion/ Presentation:	Goal Summary:	Overall revue of goals/write-up: • Over-all Goal of program is to improve the health of the population. • Right care given at the right time. • Reduce health care cost. • Improve the patient's experience of care. • EMS has the communities ultimate health care safety net, when all else fails, who do we call? • Reduce re-admissions. Group agrees: • Individual EMS services to investigate and identify the GAP's in their health care and communities and assist by directing resources to those places. Possible GAP's that have been discussed include these main topic headings: • Nurse triage • Post-discharge care • Disease management	Director Coler

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		• High utilizer
		• Alternative destination
		• Hospice collaboration
		• Others – home safety checks, etc.
		
		The model WILL:
		• Align GAP's with data.
		• Look at funding.
		• Enhance utilization under the current EMS scope of practice.
		• Increase efficiency and decrease time.
		• Provide coordinated and integrated care between:
		    o Medical directors.
		    o Hospitals.
		    o Long term care.
		    o Home health.
		
		The model WILL NOT:
		• Replace current practices.
		• Change the EMS scope of practice.
		• Take away anything.
		• Decrease the level of care.	

	Education:	EMS education component? Summary of current education models provided (attached) Questions/Discussion: • A mental health component should be included • Can you explain the wide variations across the country? Currently, there is no national board that has become the authority. • It is important to recognize that we have a clean slate/blank pallet to work on with many examples and no authoritative body. This may be an opportunity to give the EMS Advisory Board Education & Training Committee a charge to come up with an educational model with a broad scope and adding more specific modules. • Eagle Colorado Handbook great resources (attach) NAEMT MIH/CP 2nd survey from end of April available, will send around via email Education standpoint is an ongoing discussion across the country: • Urban models differ from suburban models which would differ from NW corner of CT models • Important to set one standard	J. Demers T. Wodatch R. Kamin J. Demers R. Kamin R. Coler S. Heffernan B. Baxter

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		We should add "defining the educational component" to the list of things each MIH/CP Program must do for the application process Education also depends on the resources available in the community In summary, Educational Component will be a collaborative effort with the EMS agency, the Medical Director, and the stakeholders in the community	R. Coler S. Heffernan R. Coler
	Next Steps:	What are the group's next steps? • Program Template? • Application Process? Discussion: Creating many different models is a concern, home health is defined under one umbrella federally • Could we talk about one educational/training umbrella for all, then sub-training based on communities focus and needs? Focus should be on creating a base educational/training model with "a la carte" specific module add-ons based on communities focus and needs. Statewide perspective for MIH/CP: • Greater clinical aspect on modular approach – more communications, etc. • Community resource integration education – more administrative Currently, EMS is trained to care for people for approximately 20 minutes at a time during an emergency and care ends when the hospital takes over. There is a big difference when caring for patients ongoing for days, weeks, months, etc. This requires building relationships. We are looking for a different, more matured approach to EMS. Having a generic education starting point is a good idea. The Advisory Board MIH Committee has compiled programs as well. Core curriculum w/ broadening for local concerns works. Keep in mind that this will also be different for EMS Agencies who are municipally based vs. hospital based vs. volunteer based. A concern with broad based curriculum would be the expense, if a community would like to participate in one specific aspect of MIH/CP and would like do to so without a huge expense this would be difficult. 1. Standard – Advisory Board Educational Committee to work with Joel Demers for a Standard Program development. 2. Application Process – Should be part of it, Standard Program w/ specific adjuncts.	R. Coler T. Wodatch R. Coler D. Lowell B. Baxter J. Beaulieu B. Schietinger

		Yes, and Medical Direction should be added to this that discussion. I think we're getting ahead of ourselves, first: 1. We should send something to all stakeholders (not EMS) regarding this process. 2. Development of Education – something to go out to every EMS provider. 3. Consistent approach to MIH – no silos	R. Coler R. Kamin
		Let's step back and go to group assignments, DPH will create an application process Questions if this is legal? To break into subcommittees? As long as you publish the meetings and have call-in numbers available, etc. The groups should have 2 members of the larger group present and meeting summaries must be available. Renee Holota @ DPH OEMS will be point person for publishing notes and agendas, etc.	R. Coler B. Baxter M. Schaeffer R. Coler
	Tasks:	What constitutes an MIH Program? This should be a task of a small group complete with recommendations. The following six topics are what we have talked about, but we are not limited to these six: • Nurse triage • Post-discharge care • Disease management • High utilizer • Alternative destination • Hospice collaboration #1 Task – which of the examples to look at? Let's identify break out groups – Ed. & Training, Legislative, etc.	J. Beaulieu R. Coler G. Allard R. Coler

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Groups and Liaisons Identified:

Group	**Liaison**
Education	Josh Beaulieu 860-647-3260 Beaulieuj@manchesterct.gov
Application Process	Director Raffaella Coler 860-509-7157 Raffaella.coler@ct.gov
Legislative	Greg Allard 860.383.1363 GAllard@americanamb.com
MIH/CP Program	Bruce Baxter (860) 225-8787 Ext. 8701 bruce.baxter@nbems.org David Lowell 203-235-3369 davidl@huntersamb.com
Payment/Reimbursable	Kelly Sinko 860-418-6226 kelly.sinko@ct.gov

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<table>
<tr><td></td><td></td><td><table><tr><td>Public Education / Marketing</td><td>Dr. Rich Kamin
860-509-7984
Richard.Kamin@ct.gov</td></tr></table>
Contact for publishing dates, agendas, call-in numbers, and summaries of meeting:
Renee Holota 860-509-8103 renee.holota@ct.gov</td><td></td></tr>
<tr><td></td><td>Wrap-Up:</td><td>We have our tasks, groups and a plan for the next meeting.
Renee is available to post meeting dates.
If there are any other questions, please call me.
We will forego the May 22, 2018 meeting so the work groups can meet</td><td>R. Coler</td></tr>
<tr><td></td><td></td><td>If there are any questions regarding home health or hospice, we are available to help.</td><td>Chris Santarsiero & Tracy Wodatch</td></tr>
<tr><td>Next Meeting:</td><td></td><td>June 5, 2018 at the Legislative Office Building, 1D</td><td></td></tr>
<tr><td>Public Comments:</td><td></td><td>No public comment</td><td></td></tr>
<tr><td>Adjourn:</td><td></td><td>Motion to adjourn made by W. Schietinger and second by T. Wodatch at 9:52 am</td><td>W. Schietinger</td></tr>
</table>

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, revised 6/6/18 per 6/5/18 meeting

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Mobile Integrated Health Working Group

June 5, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

1. Welcome	R. Coler
2. Approval of Minutes from May 8, 2018	R. Coler
3. Sub-Groups Reports/Update	
a. Education	J. Beaulieu
b. Application Process	R. Coler
c. Legislative	G. Allard
d. MIH/CP Programs	B. Baxter/D. Lowell
e. Reimbursements	
f. Public Education/Marketing	R. Kamin
4. Next Steps	Group
5. Public Comment	
6. Adjourn	

Next meeting June 19, 2018

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:	Goal Summary:	Original charge of Legislative MIH Workgroup read aloud. 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.	R. Coler
	Sub-committee reports:	Sub-committees asked to update the group on any work done: • 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.	G. Allard R. Kamin J. Beaulieu
	Data Needs	There is a strong need for GAP analysis and data prior to moving forward.	R. Coler

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	Application Process:	Draft document for application process presented and read to group who is asked to review and comment via email to be collated for the next meeting by Stacey Durante at stacey.durante@ct.gov Questions raised: • Who will review these applications? • Who will regulate MIH/CP at the State level? • Will there be a cost associated with this; if so, what is it? • Will there be a fiscal impact? These questions must be answered as we move forward. As was stated earlier by J. Beaulieu, Massachusetts set up an MIH Office under OEMS with the same staff we CT DPH OEMS has now. Discussion regarding application process document had by group: • Section for stakeholder's sign-off needed on application and letters of support from all collaborating agencies in the proposed MIH/CP program for that agency. • Noted and will be added to application process document. • Drafts and/or executed contracts with all agencies involved should be included • What will the impact on 911 be for smaller services? Should we include a reminder of the services 911 in the application process? • Thoughtful application development will lessen the administrative load. • CEMSAB and CEMSMAC are already involved in these processes – some of the administrative load could be deferred to these groups. • Could we include the Regional Councils in the process with strict criteria? We can explore these ideas. Consistency in council meetings will be key. Question raised: Are we looking to do different MIH/CP initiatives in different communities? Would pilot programs be statewide or community based? How do we let citizens know what's available to them? We have been unifying and now have statewide protocols – are we going back to community based? • This should be clarified • Municipalities are currently responsible for EMS in the State • This will add complexity All of this is definable in the application process:	R. Coler J. Beaulieu R. Coler K. Campanelli S. Heffernan R. Kamin R. Coler K. Sinko R. Coler R. Kamin

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		• Each community • Each catchment area • Multiple PSA holders Although further discussion may be needed – Comments?	D. Lowell
		Enable all communities to locally identify and address their own GAPS	R. Coler
		Cites an example of PSA holders crossing boundaries and asks the question: How do we address that in an MIH application?	J. Beaulieu
			R. Coler
		• 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	D. Lowell
		Outside 911 system requires: • Scope of Practice changes • Statutory changes	R. Coler
		How will this be activated? Have we considered EMD and protocols?	M. Zanker
		It will depend on town or program – this will be encapsulated in each program, but it will affect EMD's	J. Santacroce
		In the application process?	M. Zanker
		Prior collaboration needed for: • GAP analysis • Make up of program • Statutory – AG's opinion in 1991 (will email)	J. Santacroce
		There will be two (2) ways to activate the system: 1. 911 – will remain the same 2. Non-emergency programs through a 7-digit number 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.	G. Allard
		Non-transport will not have to be the PSA holder, vs. transport which will have to go through the PSA holder.	R. Coler

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		This will be no different than today's scheduled transports. Are we envisioning contracts? Such that Middlesex Medics can contract with a home healthcare service in New London? Group response: Yes We have to be able to identify these patient and give them a 7-digit phone number to call. Will there be some type of EMD process at this point? The EMD process will be program specific if both activations are needed: 911 (emergent) and/or 7-digit phone (non-emergent). • Each program will have its own element of coordination and conversations to work this out. • Stakeholder conversation. • Each community currently covered by BLS & ALS level. • None of the MIH programs we've discussed is at the BLS level. BLS level is activated alone or a paramedic unit is enroute. This can be initiated by EMD guideline, protocols or communication on scene. • BLS units will have to be cleared at a minimum of time to respond to other emergencies. This will be at the discretion of the paramedic under the protocol that's agreed upon by the PSA holders at the Basic and Paramedic level which has been coordinated in advance in a protocol under Medical Direction and medical control. • We have all the ingredients, it's just putting it all together and bringing communication full circle. What about the Medical Director? Will the relationship between the Medical Director and the Paramedic remain under MIH? If the Paramedic is not activated under 911 – how does that work? It will be under Medical Direction and with oversite of the sponsor hospital, as it is today The Paramedic will not be working on their own? No, Paramedics have to work under a physician's license by statute Do we know if that doctor is willing to embrace MIH? Is this an issue or barrier? Not anticipated to be an issue; it happens every day during scheduled transports/interfaculty transports within our current system and protocols.	J. Santacroce M. Zanker M. Zanker J. Beaulieu D. Lowell K. Sinko D. Lowell K. Sinko J. Santacroce K. Sinko D. Lowell

		Do we anticipate that there will be new protocols for each MIH category?	K. Sinko
		No new protocols, no scope of practice change. We may need new EMD protocols.	D. Lowell
		Let hear from the two Medical Directors in the room: Dr. Zanker from Middlesex Hospital and Dr. Kamin from UCONN – comments?	R. Coler
		No concerns – the current system allows all to be overseen by the sponsor hospitals • Currently, the scope of practice of paramedics is somewhat at the discretion of the Medical Director. • Yes, I anticipate protocol specific to an MIH environment to be created. • From meetings with EMS Coordinator's and Medical Director's there has not been one concern about exposure or liability due to MIH	R. Kamin
		I agree; there's been questions, but no problems.	M. Zanker
		Expect to have to approve/oversite any process or protocols	R. Kamin
		Hospice and other programs their own M.D.'s signing off on programs who will be involved	G. Allard
		• Be mindful in each step, the devil's in the details • Community of M.D.'s aware and following this initiative so there are no surprises • Don't assume issues are resolved because we're following the right path and doing things the right way – in the rest of CT there may be surprises or confusion by MIH • Be overt and transparent	C. Schiessl
		The responsibility of the Public Education & Marketing sub-committee will be making people aware of initiative and updating. The CT EMS Advisory Committee is aware of this also. In this instance, marketing is explaining and myth busting, not selling it.	R. Coler
		Going to E.D. Directors meeting and marketing would be very beneficial	M. Zanker
		Any other concerns/deeper dives needed.	R. Coler
		Who will collate responses from this workgroup?	R. Kamin
		We will – specifically, to R. Coler or Stacey Durante at stacey.durante@ct.gov and I agree with Carl, the devil is in the details.	R. Coler

		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.	T. Wodatch
		That is true, we have a very complicated system. MIH has to be dependent on: • The GAP Analysis brought forward • No duplication of services • Improved patient care – QA/QI • Cost savings 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. Considering doing a Survey Monkey to ask questions about data – will present this at next meeting for thoughts.	R. Coler
		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	C. Santarsiero
		Let me clarify a few things: 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.	R. Coler
		There will be obstacles and challenges in creating services within different agencies in different areas.	T. Wodatch
		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.	R. Coler

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		• These proposals are truly draft concepts only • These programs in no way, shape or form are meant to disrupt the current 911 system • Not supplanting any other companies, only enhancing • Recognize the need is community or regionally based. Application will include this. • Alternative destinations – difference between the independent practitioner and affiliated urgent care centers. The continuity of care is better served to an alternate destination that is affiliated with an acute care hospital.	D. Lowell
		Reimbursement for services to transport to alternate destination. Are any services billing for alternate destination? No. We need to do research. This is something in our directive. We need research into this – K. Sinko will research this topic. Any further discussion on this topic?	R. Coler
		I'd be remiss in my job representing Federally Qualified Health Centers (FQHC) if I didn't ask for FQHC's to be mentioned in this section. FQHC's have staff in hospitals, relationships differ by community, but are there.	J. Granger
		Dully noted. We will add.	D. Lowell
		Asks why direct you feel a relationship with an acute care hospital is necessary?	M. Schaeffer
		Continuity of care, communication, data collection. We were being conservative and cautious.	D. Lowell
		Limits the utility to the program and reimbursement monies as an extension of advanced primary care facilities.	M. Schaeffer
		The new Urgent Care licensure that began in April exempts affiliated UC's. We should talk about primary care further.	K. Sinko
		We're talking about Paramedic MIH level calls. Are we going to allow a category for BLS providers to take abrasions, lacerations, etc. to UC's?	M. Zanker
		I send a first responder paramedic to these low priority BLS calls for decision making only, non-transport	J. Beaulieu
		Do we allow certain patient populations to go far outside their community? Are we talking about the intoxicated person now being taken to a detox center? Are we talking about the sprained ankle now going to an UC? Who makes that decision?	M. Zanker

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		1. Nurse triage line, nurse decides. 2. Or BLS calls ALS to make decision about alternative destination. 3. I see MIH playing a key role in widespread addiction problems.	R. Coler
		We don't see 911 BLS calling ALS for alternative destination. We see within a structured MIH program, call routed through non-emergency route.	D. Lowell
		Does see potential possibility for BLS in the future for cost reduction for the patient and insurance.	G. Allard
		That is not MIH. We are focusing on a specific program with a collaborative approach with the stakeholders focused on the care of the patient.	R. Kamin
		Need data for GAP assessment, QA & QI	R. Coler
		#2 from MIH/CP Programs subcommittee is the concept of readmission avoidance. Ex. CHF – out of an acute care setting to home. Read from document. Another example is a certain ask of a patient in the community with an LVAD who we are called to see. GAP's exist between discharge and home health beginning. During home health when pt. deteriorates. Also, when days of benefits are finished and patient needs care.	D. Lowell
		Reimbursement and payment group. Anthem covers treat and non-transport – is this only when activated by 911?	K. Sinko
		In program across the country - If EMS is a provider in a program where people are enrolled, then EMS is paid. Anthem's reimbursement is based on established programs where EMS goes out via 911 for an emergency, pt. is assessed and/or treated and refuses transport.	D. Lowell
		Asks about current reimbursement for treat and release scenarios – there is no reimbursement.	M. Barry
		Insurance carriers only reimburse when EMS transports to a hospital except a "Dead after dispatch" for cardiac arrest with no transport. Ex. Of diabetic given an assessment, IV, and medications and patient refuses transport, EMS is not reimbursed for anything.	R. Coler
		Will insurance reimbursements change with MIH?	M. Barry
		Discussion ensued regarding insurance: • One third of the market is self-insured • One third is fully insured • One third is Medicare/Medicaid insured • CT insurance statutes apply to fully insured (usually through work)	K. Sinko K. Campanelli

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		• Same carriers that offer fully insured do self-funded plans such as Medicare advantage, etc. • Anthem is currently the only company to do treat-no transport and we are in conversations with them as DPH sets rates for this. Anthem is doing this voluntarily – not by state mandate. • CT is unique – we would have to set a rate for treat-no transport first. • Hospitals are taking on payments of coordinated care teams. • Have to consider payment/reimbursements • Insurance company mandates set floors, not ceilings – mandates do cost the state money, be careful	
		• Does this qualify as a mandate under the Affordable Care Act? If so, the state pays. • SIM plans cut costs • Insurance is looking at the best way to cover the services that is affordable to folks	S. Halpin
		Medicare fee for service only covers "Dead after Dispatch", nothing more? – Correct	M. Schaeffer
		What's the value? Hospitals are negotiating a rate with MIH providers across the country for decreased readmissions.	J. Santacroce
		MedStar in TX is a great example. We have a lot to learn about insurance. Better understanding needed as we proceed.	R. Coler
		EMS is not compensated for many services currently – it's OK to go forward with this as when you aren't getting paid for something, doing it for less money will help.	D. Lowell
		Understand, by moving forward, we can't shift costs to the state.	R. Coler
		Quick overview of the rest of the document: • High utilizers – already discussed • Hospice revocation – already discussed • RN Triage – Integrated dispatch model • Add Wellness & Prevention • Document will be revised and resubmitted for comment	D. Lowell
		Work appreciated on that.	R. Coler
		• Medicaid rates – data needed from services • Rate: Treat and non-transport for non-Anthem bills • Meeting internally with agencies to discuss for the next meeting.	K. Sinko

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		Yes, we need a better understanding of this	R. Coler
	Next Steps:	What are the group's next steps? • Next meeting we'll continue with feedback for MIH/CP Subcommittee Thanks all for their thoughtful submissions.	R. Coler
Next Meeting:		June 19, 2018 at the Legislative Office Building, 1D – CXL'D August 14, 2018	
Public Comments:		No public comment	
Adjourn:		Motion to adjourn made by D. Lowell and second by Greg Allard at 11:06 am	

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Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, ~~6/13/18,~~ Revised 8/8/18 and Approved 8/14/18 meeting

Mobile Integrated Health Working Group

August 14, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

1. Welcome — Coler
2. Approval of Minutes from June 5, 2018 — Coler
3. Re-cap of materials distributed — Coler
4. Data Discussion — Durante
5. Sub-Groups Reports/Update
   a. Education — Beaulieu
   b. Application Process — Coler
   c. Legislative — Allard
   d. MIH/CP Programs — Baxter/Lowell
   e. Reimbursements — Sinko
   f. Public Education/Marketing — Kamin
6. Next Steps — Group
7. Public Comment
8. Adjourn

Next meeting August 28, 2018

Mobile Integrated Health Workgroup
Final Minutes - approved at 8/28 mtg

Chair: Raffaella Coler, Director OEMS

Time: 9:00 a.m.

Location: LOB, 1D

Meeting Date: August 14, 2018

Attendees: Chris D. Andresen, Marybeth Barry, Joshua Beaulieu, Michael Bova, , Kristin Campanelli, , Susan Halpin, Shaun Heffernan, David Lowell, Dr. Maybelle Mercado-Martinez, Chris Santarsiero, Carl J. Schiessl, William Schietinger, Dr. Michael F. Zanker, Dr. Robert W. Zavoski

Excused: Gregory Allard, Bruce B. Baxter, Dorinda Borer, Jennifer Granger, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, James Santacroce, Kelly Sinko, Heather Somers, Jonathan Steinberg, Tracy Wodatch

Guests: Stacey Durante, Renee Holota, Mark Schaefer

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the June 5, 2018 minutes	Changes: None. Motion made by Shaun Heffernan to accept, seconded by Michael Bova, motion carried and the minutes were accepted with no changes. Opposed- none. Abstentions-none. All in favor.	
3. Re-cap of materials distributed:		Over the past 9 months, we've received a lot of information. • NAEMT information sent out • NGA information sent out • There are different opportunities and no one set way to do MIH/CP • Payment is not priority; priority is patient care	R. Coler
4. Data Discussion:		• Request for data sent out; can't stress enough that without data we will not be moving forward • Some GAP's can already be identified with current data • We received some data from Mike Bova (ASM/AETNA) and Josh Beaulieu (Manchester FD) • Only services at the table were asked for data • Once we have that, we will be looking at it and may ask for more information	R. Coler
5. Sub-Groups Reports/ Update:	a. Education	• No movement • Waiting until we know what programs will be endorsed, at that time we will move forward identifying education needs • We already have a building block which will need to be tailored to CT • Education will not be a big deterrence – this will not hold us back	J. Beaulieu R. Coler

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, ~~8/24/18,~~ rev. 8/29/18

	b. Application Process	• We received good feedback and have updated the application; it is included today • Do we have all we need? • Add #10 Payment Structure; how will that be accomplished? • Good idea – maybe we develop an additional MIH Advisory Board?	R. Coler
		• Agrees, funding source important, especially for a municipality	J. Beaulieu
		• Add #10 Payment Structure/Funding Source • Thoughts regarding approval: ○ We would need a FTE position and Medical Director which is a 0.5 position at the moment ○ Can CEMSMAC be responsible for looking at and approving the programs? May not be right – "fox watching the henhouse" • QA aspect – who would look at that?	R. Coler
		• I think having a board like this workgroup with a broader base of stakeholders would be better	S. Heffernan
		• Is it possible to push this back on the program coordinator for the services and already have this established when the application is presented?	J. Beaulieu
		• There needs to be regulatory oversite; likes the idea of an Advisory Board that reports back to DPH, but ultimately it's DPH who has oversite	C. Schiessl
		• Agrees • Will help consistency as well	R. Coler
		• Doesn't disagree with regulatory oversite, however, MIH is a new concept for us, let's be cautious about approaching this from the perspective that all of a sudden the entire state is going to adopt different programs and there is going to be an enormous need and frontloading the cost and the structure before the need. We don't want to cost ourselves out of adopting anything. • Year 1 or 2 we have 5 or 10 programs • Year 10 we have 100 programs • Must be scalable	J. Beaulieu
		• Start with a Pilot Program before adding a fiscal note? • We know what a fiscal note is going to do to the program, we've been transparent with that point • We have to be realistic regarding additional staff • Add Payment/Funding and take off the table, complete?	R. Coler
		• Did you talk about adding a QI component?	S. Halpin
		• It's already on application	R. Coler
	c. Legislative	No report, G. Allard excused	R. Coler

		• Program is permissive – no changes to put forth under 19a-179 for initiating program • Scope of Practice (SOP) – CT has adopted some of the SOP, this would go through CEMSAB • Mark Schaefer had suggested we look at Medical Control and it's definition – one of the things we may look at is having a PCP Medical Control (something other than Emergency Medicine MD)	
		• Rate setting would have to be addressed with other funding sources involved, that language would have to be permissive.	D. Lowell
		• K. Sinko is working with this aspect • We need to be cautious, can't have rates fall to the state to pick up, we'll continue to look at that, however, we would have to address the rate setting during the application process, we'll have further discussion on this.	R. Coler
	d. MIH/CP Programs	• Bruce and Dave had put together a summary. Read summary. • These programs are not written in stone, they are examples of what's happening in other communities, they are examples of what could be used.	R. Coler
		• A revised document was sent out June 8th, based on June 5ths comments	D. Lowell
		• We will send out with the minutes for the next meeting	R. Coler
	e. Reimbursements	No report, K. Sinko excused, however, meeting with her subcommittee	R. Coler
	f. Public Education/Marketing	No report, R. Kamin excused	R. Coler
6. Next Steps:		What are the group's next steps? • Do we continue to work on the subgroups and report out? • I have enough information to start putting a draft together of what our report will look like, not for 8/28, but next month	R. Coler
		• Do we have any major disagreements amongst the group as far as where we are right now, that we need to hash out? • Do we believe we're all on the same page as far as what program we're looking at and how we're going to move forward?	J. Beaulieu
		• Conceptually, yes. In terms of casting a vote regarding a particular thing – I don't think the particular thing has been developed. • On the right track, working through the process, but we need the particulars • Not prepared to vote on anything today	C. Schiessl

		• Payments and Reimbursements subgroup meeting next Tuesday.	
		• Echoes Carl's point • On the right path, too early to say if there are major issues • Need a draft, makes sense to have something concrete in front of us	S. Halpin
		• There is a lot of conceptualizing • Conceptually, we can agree? • Based on research and needs of the community	R. Coler
		• Echoes other comments – once we have something concrete, we can all look at it and it's hard to figure out how to reimburse things without a plan	K. Campanelli
		• Should we choose one item from our list and move it forward as an example • Continue subgroups • Draft	R. Coler
7. Public Comments:		No public comment	
8. Adjourn and Next Meeting:		• Motion to adjourn made by D. Lowell with a second by K. Campanelli at 9:41 am • August 28, 2018 at the Legislative Office Building, 1D	

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, ~~8/24/18,~~ rev. 8/29/18

Mobile Integrated Health Working Group

August 28, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

Item	Presenter
1. Welcome	Coler
2. Approval of Minutes from 8/14/18	Coler
3. Sub-Groups Reports/Update	
a. Education	Beaulieu
b. Application Process	Coler
c. Legislative	Allard
d. MIH/CP Programs	Baxter/Lowell
e. Reimbursements	Sinko
f. Public Education/Marketing	Kamin
4. Next Steps	Group
5. Public Comment	
6. Adjourn	

Next meeting September 11, 2018 at 9:00 a.m.
Legislative Office Building

Mobile Integrated Health Workgroup
Minutes

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

Meeting Date: August 28, 2018

Attendees: Chris D. Andresen, Marybeth Barry, Bruce B. Baxter, Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, James Santacroce, Chris Santarsiero, Tracy Wodatch, Dr. Michael F. Zanker

Excused: Gregory Allard, Joshua Beaulieu, Dorinda Borer, Michael Bova, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, David Lowell, Dr. Maybelle Mercado-Martinez, Kimberly A. Sandor/Mary Jane Williams, Carl J. Schiessl, William Schietinger, Kelly Sinko, Heather Somers, Jonathan Steinberg, Dr. Robert W. Zavoski

Guests: Stacey Durante, Renee Holota

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		9:00 Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 8/14/18 minutes	Changes: Yes, remove W. Schietinger from excused as he was present, add S. Heffernan to present. Motion made by T. Wodatch to accept, seconded by J. Santacroce, motion carried and the minutes were accepted with changes. Opposed- none. Abstentions-none. All in favor.	Group
3. Sub-Groups Reports/ Update:	a. Education	• No report, J. Beaulieu is excused. • Waiting until we know what programs will be endorsed, at that time we will move forward identifying education needs	R. Coler
	b. Application Process	• Review of last application and correction/revisions suggested • Is this done, can we table? • I'm going to take away CP and use MIH as a standard	R. Coler
		• Instructions for application needed	T. Wodatch
		• Seconds instructions needed • Signatory page including CEO's, Medical Director, agencies and other stakeholders needed	B. Baxter
		• We will add a signatory page; we do need this piece • This is fluid and will be updated as needed	R. Coler

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		• Incorporate within the instructions and comes with the letters of support? • Should spell out MIH acronyms somewhere – found it is spelled out	T. Wodatch
	c. Legislative	No report, G. Allard excused	R. Coler
	d. MIH/CP Programs	• Bruce and Dave had put together a summary. It has been shared and revised.	R. Coler
		• The group met and had a discussion about data; thoughts shared with OEMS • Flushing out data set, it's active and ongoing	B. Baxter
	e. Reimburse ments	No report, K. Sinko excused, however, meeting with her subcommittee • K. Campanelli who is part of the group – any report?	R. Coler
		• Met a week ago and continued the same discussion, nothing new.	K. Campanelli
	f. Public Education/ Marketing	No report, R. Kamin excused • Once we have the program type and education, this will move forward	R. Coler
4. Next Steps:	EasCare, Boston visit summary	Description of visit to EasCare: • Description of EasCare ambulance given. • Met with Scott Cluett, Director of Clinical Performance at EasCare on 8/20/18. • Invited to come and speak about the EasCare/Commonwealth Care Alliance (CCA) Mobile Integrated Healthcare (MIH) Program. • Scott has much knowledge regarding MIH in general. • CCA is an Accountable Care Organization with approximately 20,000 patients who sought a partnership with EasCare for an MIH Program to take care of their patients in the home. • EasCare has a robust dispatch communications center which is key for this program. • CCA sends over a referral with a robust Situation, Background, Assessment, and Recommendation (SBAR) of the patient to the Community Paramedic (CP). • The appointment has already been scheduled by CCA through EasCare's dispatch center. • The CP, who is on duty from 4 pm to 2 am, accepts the assignment and goes to the patient's home to provide the care requested. • Through their dispatch and the CP vehicle cell phone, the CCA Physician (MD), patients Nurse Practitioner (NP) and the CP have a conversation about the findings are, what the continued care is going to be, the follow up and documentation on the patient.	J. Santacroce

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- Average time of visit is 80 minutes.
- The case we were privileged to view involved a non-English (Creole) speaking patient one week post UTI with symptoms of nausea and vomiting (N/V), unable to keep fluids down by mouth.
- The appointment was scheduled for the CP to run labs, obtain IV access and assess the patient and report back.
- The CP had to call the Language Line (LL) first and they remained on the line for the entire appointment; this made four people interacting on the phone with the patient.
- CP used the iSTAT (Handheld Blood Analyzer) to get the blood results that they needed (Note: this is a tool that provides healthcare professionals with lab quality blood results in minutes). She also drew the chemistries, which would go to Quest, who they have a relationship with, if they needed any other tests done.
- The CP was able to successfully communicate with this patient who, by all accounts, would have been lost in the system in Boston for many hours – and with her systems and the language barrier would have been very difficult for her to be processed correctly through the system.
- Instead, the patient was home, in a comfortable environment for her, she was able to get the fluids she needed by order of her NP and the confirmation of the MD on the line. They had a great collaborative discussion about what they wanted and how they wanted the CP to give the patient fluids and anti-nausea medication via IV, and to see if she could take her by mouth (PO) medications prior to the CP leaving; if there were any complications, to call them back.
- This was great care that we were watching at the patient's kitchen table and was really representative of the calls EasCare does.
- EasCare is only doing about 1 to 2 calls per shift.
- EasCare only has one vehicle and one CP at a time, so they concentrate on the Greater Boston area.
- They are a private ambulance company; if they arrive and find the patient to be more acutely ill than realized, they activate the 911 system and Boston EMS would respond and take the patient to the Emergency Department (ED) as a 911 activation normally does. EasCare does not take the patient themselves, they use the system appropriately. This is useful for us due to the Primary Service Area's (PSA) and how they're set up in CT. I could see the same type of protocol set up if going into someone else's area (PSA).
- As of spring 2018 they have seen approx. 2,100 patients, with every patient an individual phone interview (Satisfaction Survey) is done for tracking satisfaction.
- The Satisfaction Surveys have shown that over 75% indicating that, if not for this service, there was no doubt they would have gone to the ED as well as the satisfaction rate being over 99%.
- This shows a definite benefit to CCA, as well as the patients.

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		• Cost savings has been broken down and tracked over time with the approx. 2,100 patients showing that over $9 million dollars in savings, with over $3 million in savings in ED costs alone. • CCA would like EasCare to become more involved in the area and other areas such as Springfield. • Massachusetts is a little different, if you want to do something other than the norm, you fill out a waiver to OEMS, in their application, and CCA specified that their biggest time of need was 6 pm to 6 am, at this point CCA wants to change the time limitation. • At this time, while the MIH Office is being stood-up, MA OEMS imposed a moratorium until such time as they are set up, therefore, no movement will be done on this until fall 2018. • EasCare/CCA MIH will apply to have hours be 24/7 and add a Nurse Triage Line in their dispatch center. • Gear is standard plus: Antibiotics, portable ultrasound, iSTAT, and other tools. • The CP has full access to CCA ePCR's and CP charts their visit in the patients' health record. • Hoping to grow into other service areas. • MA is planning on a 5 FTE (full time equivalent) office, however, that may be too much to start. • This model is easily expandable to other ACO's and organizations, even hospitals. • Very transparent • EasCare receives an allotment of $28k/month from CCA for this model. • EasCare is not recognizing profits at this time due to the limitation of night hours only, there can be a lot of down time. To fill downtime, CCA is adding skills such as EKG's in the home to the CP. •	
		• The educational model is 300 hrs. divided 150 hrs. clinically, including NP shadowing, and the remaining 150 hrs being classroom with many focuses including respiratory, CHF, etc. They found that they needed more wound care education. Continuing education is fluid with modules being added and updated. CCA's Medical Director is involved in the initial and continuing education. Very collaborative, everyone is involved and working together to better the patient's experience.	S. Durante
		• What are their key performance indicators?	B. Baxter
		• It is The Triple AIM in Healthcare (Note: this is a concept put forward by IHI to drive healthcare organizations and providers to simultaneously implement programs that improve the patient care experience, improve the health of patient populations, and reduce the per capita cost of health care). Everything is reviewed in-house at EasCare and CCA is simultaneously reviewing as well for patient outcomes as well as costs. When the program began, the cost per patient was around the $860 range, with volume that has gone down to around the $560 range.	J. Santacroce

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		• I want to go back to cost, their cost per encounter has gone down approx. $300.00, but are they also measuring the overall savings in terms of to the healthcare system in general, do they have some metrics that demonstrate what they believe the overall savings are to the healthcare system.	B. Baxter
		• Yes, the number mentioned earlier which were based on actual costs that CCA would have paid out for that. They went off of national averages as far as hospital admits as far as time. Their savings to the system breakdown is: ○ 2,171 visits to date ○ Emergency Admission (1563 x $2,000.00) = $3,126,000.00 ○ Hospital Admission (625 x $9,600.00) = $6,000,000.00 ○ Ambulance trips back and forth = $ 440,000.00 • They also have a three-tiered choice in MA: 1. Community Paramedicine with no charge for a municipally based FD/EMS with limited involvement 2. MIH almost everything for one cost for approx. $20,000.00? 3. MIH focusing on hospital readmission for $40,000.00	J. Santacroce
		• There's fees attached to each one of these applications?	R. Coler
		• Fees are reoccurring biannual fees, as far as we know they are funding the MIH office with the fees.	J. Santacroce
		• If the company that wants to do this isn't making money, why would they expend another $20-$40k?	R. Coler
		• CCA is paying the fee.	J. Santacroce
		• Did you discuss at all the relationship and or collaboration with Home Health and Hospice in all of this?	T. Wodatch
		• Yes, they have a good and collaborative relationship with those organizations with everyone under the umbrella of their care. They are brought in depending what the need is for the patient. No issues with turf wars or getting in the way of each other. Probably because the provider (NP or MD) lays out the care plan and when the CP gets the request, it's very clearly laid out what the CCA provider wants. Sometimes it's just an assessment to see if the patient requires the nurses back or if another path should be taken. It's a team that works together and is coordinated through the patient's provider.	J. Santacroce
		• I appreciate that. It continues to worry me that even the example he gave, generally that's a Home Health, go out to the house, do the assessment. I also know that there are situations that are beyond the Home Health. I want to make sure that whatever we're setting up, it's definitely a collaboration; you talk about the physician and the NP making a referral, well that's their choice, that's what they're making a referral to, they may not even be considering Home Health as a referral because they're saying, I've put money into this EasCare and I'm going to use EasCare, without the client being able to use their insurance and being able to be reimbursed properly for the care. Then to add to it, the wound	T. Wodatch

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		education piece, that's something that Home Health specializes in and is trained to do and probably shouldn't be part of a CP visit unless it's in an area that's really stretching coverage.	
		• Those are their needs and things that are a GAP for them. • I don't know what their exact coverage is nor the lack of it, but we are here because we see these patients in their home every day and that prescribed Home Health isn't always there, isn't always available, and it's not always something that someone will qualify for, certainly not for that moment of need, so I think there's definitely a bridge there. • The system is very well controlled and structured, there are no referrals made from the field. • For this visit, the patient couldn't make the decision of setting up Home Health, for this visit, it worked for this patient and saved the system from more costly care.	J. Santacroce
		• For this case or any other case, are there metrics that EasCare and CCA are collecting? You're using admission re-avoidance, but what about Home Health referrals post that first visit because there really shouldn't be return visits by the CP, it should be a follow up much less expensive Home Health path, which would then also keep this person out of the hospital. This particular case doesn't sound like a one and done, she could continue to have problems.	T. Wodatch
		• That's why the CP was there, this was their first interaction with this patient because she had continued to have problems after care was already established. That is a great question for Scott when he comes.	J. Santacroce
		• We need to make sure the right decisions are made for the beneficiaries' rights to services and we don't want to stress the ACO's with the added costs of a CP if that's not what's necessary.	T. Wodatch
		• One of the challenges I see Tracey, is that every day ambulances in the State of CT and all over the country are going out to these UTI's and things like that at 10-11pm at night. If there's not that established home care relationship or even if there is, to get someone to go out at that hour is truly our challenge. I don't think the intent is to replace the dire need for home care, as you know, not every one of your patients is willing to be 100% compliant and the easier choice is to go to the ED and so I think that's how we see it from the EMS end. If they're willing to let someone in their door at 10 pm to get them going in the right direction and ultimately end up with that referral. I think that any program we develop	S. Heffernan
		• You were describing referrals through providers, not through 911, those are two different systems.	J. Granger
		• Yes, the hope is that once they are in the referral system, they will no longer need to call 911. So we could avoid that, having them call 911, ending up in the ED for hours, etc.	S. Heffernan
		• Having a call to 911 isn't a bad thing and that may be something that cannot be changed, we've spent millions of dollars getting people to call 911; it's more what you do with that call; one of their next steps and I certainly believe in this, having a nurse triage those calls for a priority that will safely allow patients to hook up with the care they require, i.e. NP visit or MD visit, etc.	J. Santacroce

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		• Question regarding the handling of the QA/QI process which is normally done by the Medical Director and EMS Coordinator for the Sponsor Hospital – what is the role of the Medical Director over the ambulance service in this?	R. Coler
		• They are still involved, however, but the care decisions they are working with are made by the Medical Director from CCA who is more of a family practice based physician. • The Medical Director for EasCare was a big part of developing this program and the educational aspect. • Our system currently has field providers calling on the radio to speak with the Sponsor Hospital Medical Director for additional orders; in this model field providers would not bother the Sponsor Hospital Medical Director. Reasoning: A. It's not what they do on a day to day basis and B. The physicians at CCA have a relationship already established with these patients which allows them to collaborate and make the best decisions for the patient.	J. Santacroce
		• Do you know if the Medical Directors from the ambulance services get a stipend from them in MA?	R. Coler
		• I don't	J. Santacroce
		• It depends, most of the ambulance services in MA have hired their own Medical Directors and they are stipend.	B. Baxter
		• Had a lot of questions, but most have been covered. Clinical question – how many units are seeing patients? And can they get a call in the middle of this IV infusion and have to go?	Marybeth Barry
		• One. No, they are dedicated to the call; they are not doing 911 calls.	J. Santacroce
		• This call was activated by the PCP NP – how did she go about doing that?	M. Barry
		• An message through the Electronic Health Record for the appointment is sent to EasCare's dispatch center with an SBAR • Dispatch center pushes it electronically to the medic. • Medic goes to the home, open the laptop and calls dispatch who connects them with NP.	J. Santacroce
		• So the only referring providers are within the Boston area? • How long where you there?	M. Barry
		• Yes, referring providers (MD's, NP's) are all within the CCA group.	J. Santacroce

		• The MIH CP was just getting started with orders to:
		    o Hang fluids (IV Infusion) over a specific time set by MD.
		    o Give IV Zofran for nausea.
		    o Re-assess patient looking for changes.	

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		• CP was going to be there for a couple of hours. • The average time is 80 minutes for one call.	

		• The complexity of this visit is enormous from a clinical standpoint.
		  o Interpreter Line
		  o A very sick woman, she's dry, maybe needing antibiotics.
		  o Was she hospitalized prior to that?
			M. Barry

		• She had been at some time and had rebounded with issues and had to be seen again and this visit was due to symptoms that reoccurred.	J. Santacroce
		• Did she have a VNA in place?	M. Barry
		• Not to my knowledge	J. Santacroce
		• So to Tracey's point, she should have had a VNA. In favor of the MIH program, can this be something that can be set up, she sounds very sick. We don't want to replace one service with another.	M. Barry
		• I don't know if she had previously seen VNA and they moved to this, we didn't get into that part of the background. We can find out, we can ask Scott to expand upon that case when he's here.	J. Santacroce
		• She's follow-up with her own provider the next day. Imagine how many hours she'd be in the ED, she could be there for the day. • They took a very complex situation and did a really good thing with it.	M. Barry

		• Most of my questions were answered as well. Thank you for answering for a program you're not in charge of. Things that stand out to me:
		  o The connection to care – how does that work, function and what's the experience?
		  o Experience with high-utilizers – does this help that?
		• Interesting model – different than what I was thinking about around this table.
		• Their thinking behind developing this model over another.
			S. Halpin

		• CCA came to EasCare with this model. • 911 referrals may come down the line.	J. Santacroce
		• If you know the answer – is there a process or tag in the system for 911 calls for these patients where the patient calling 911 would get an MD immediately?	T. Wodatch
		• May not have it built into this due to Boston EMS being an independent municipality and not at all connected with the MIH program. • However, that is true, some people have tags.	J. Santacroce
		• I'm curious how this would fit into our system? We're highly saturated with Medicare/Medicaid. • One thought is you're calling an MD at home – what will be his threshold for "send it to the ED".	M. Zanker

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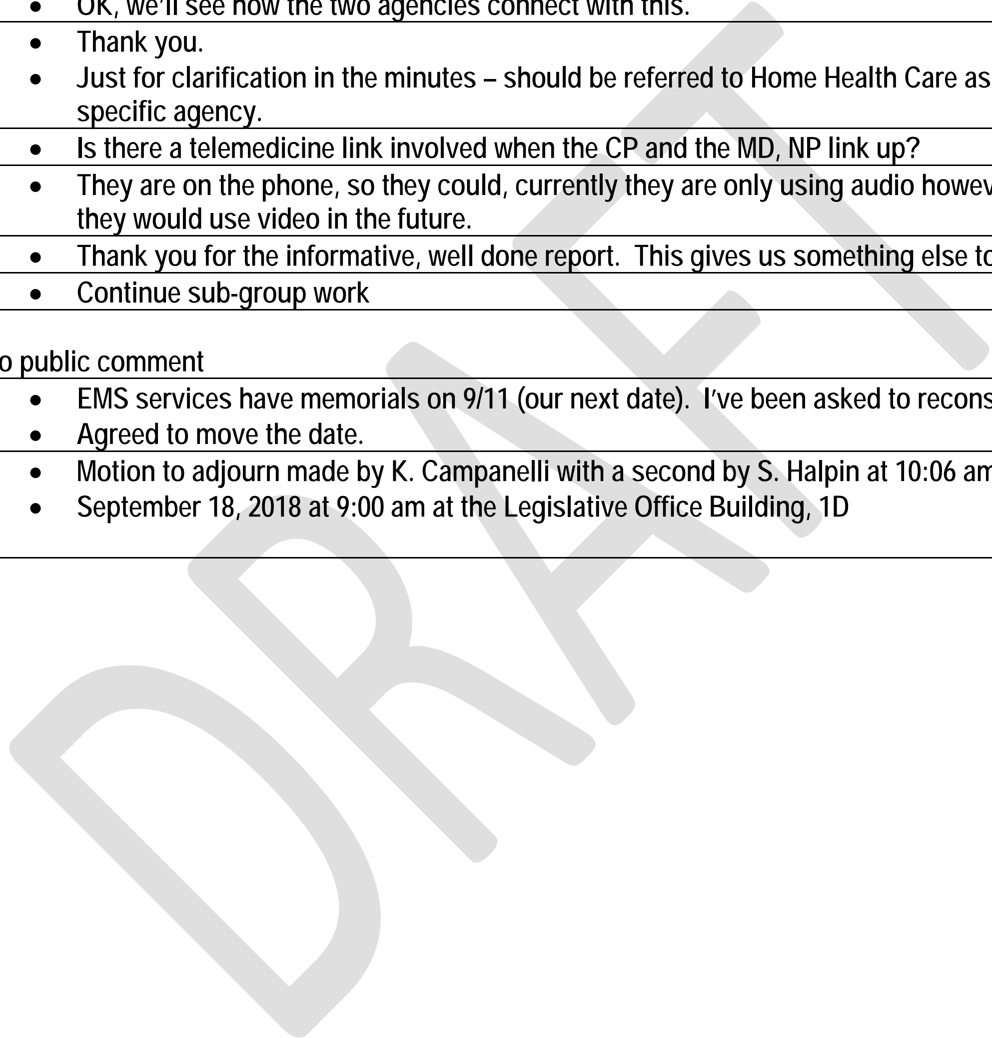
		• When you're calling into a system like ours, as an Emergency Physician, who has laid hands on this patient 17 times this month is going to say "Why don't you try this, try that, before you transport". • We can prevent things like grandma who's found awake and alert on the floor of a nursing home who claims she just sat down due to weakness being transported and getting a CT scan. We can change this to "Why don't we come out and evaluate this patient". • Or, if a patient at home is a little dry, I have no problem giving them some fluids, rather than sending them to the ED to get some fluids. • I think that this model can be used to stave off not only the frequent flyers, but the people who actually need a higher level of care, but don't need it in the hospital itself.	
		• Just for all who don't know, there are a lot of acronyms being used – ACO is an Accountable Care Organization and CCA is Commonwealth Care Alliance from MA. • The CT person who is working with the ACO's is Mark Schaeffer who has been a member of our committee, but is not here today.	R. Coler
		• The ACO is a structure that's set up through Medicare in response to the Affordable Care Act to let them be responsible for the patient's overall care regardless of where that care is being received.	T. Wodatch
		• ACO is Medicare/Medicaid clients.	Group
		• Tracey, would these people be eligible for Home Health Care? The Medicaid population?	R. Coler
		• Yes, as long as they qualified; there would be many situations where the CP would be first on the scene and identify this, or the fifteenth on the scene and say "we need to get Home Health Care involved in this case to stabilize this home environment".	T. Wodatch
		• Yes, and that's why I think the collaboration between the two is so important – critical even – and it's important to see that the open lines of communication remain.	R. Coler
		• I think this is such a nice adjunct to the Home Health as VNA's are not going to go out after hours unless it's hospice; correct? I almost never have VNA's going to the house after 6 pm.	M. Barry
		• Yes, it is key to have a system like this. Both Home Health and Hospice have to have 24/7 on call. • I think the comment about the threshold for a physician who's going to say "send them to the ED", may be the same situation because there's only one person on call and there may be multiple calls at night and they are triaging and calling the physician to see what's necessary. • The system needs to be set up. • There are definitely GAP's in that area.	T. Wodatch
		• The on call nurse is probably not doing to see the middle of the night patient, she's going to say ED or MIH.	M. Barry
		• If a person has called at 10 pm, I'm not sure that they will wait until morning to see their PCP; people panic and want instant attention.	R. Coler

		• It is my understanding that Home Health/VNA is involved with this. Will clarify and get that information out. There were services available during the day.	S. Durante
		• OK, we'll see how the two agencies connect with this.	R. Coler
		• Thank you. • Just for clarification in the minutes – should be referred to Home Health Care as a VNA could be a specific agency.	T. Wodatch
		• Is there a telemedicine link involved when the CP and the MD, NP link up?	B. Baxter
		• They are on the phone, so they could, currently they are only using audio however, and they believe they would use video in the future.	J. Santacroce
		• Thank you for the informative, well done report. This gives us something else to think about.	R. Coler
4. Next Steps		• Continue sub-group work	R. Coler
7. Public Comments:		No public comment	
		• EMS services have memorials on 9/11 (our next date). I've been asked to reconsider the date. • Agreed to move the date.	R. Coler and Group
8. Adjourn and Next Meeting:		• Motion to adjourn made by K. Campanelli with a second by S. Halpin at 10:06 am • September 18, 2018 at 9:00 am at the Legislative Office Building, 1D	



Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 9/6/18, approved 9/18/18

Mobile Integrated Health Working Group

September 18, 2018

Location: **Legislative Office Building, Room 2D**

Time: 9am

Agenda

1. Welcome — Coler
2. Approval of Minutes from 8/28/18 — Coler
3. Presentation

   W. Scott Cluett III, NRP
   Director, Mobile Integrated Health
   EasCare Ambulance Service in Massachusetts

4. Subcommittees
5. Next Steps
6. Public Comment
7. Adjourn

Next meeting September 25, 2018, Room 1D

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

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		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

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		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

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

FINAL

		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

FINAL

	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	

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

FINAL

Mobile Integrated Health Working Group

September 25, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

1. Welcome — Coler
2. Approval of Minutes from 9/18/18 — Coler
3. Subcommittees Report
4. Next Steps
5. Public Comment
6. Adjourn

Next meeting October 9, 2018, Location/Room TBD

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

FINAL

		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

FINAL

		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

FINAL

		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

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		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

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 10/4/18

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Mobile Integrated Health Working Group

October 9, 2018

Location: **Legislative Office Building, Room 2D**

Time: 9am

Agenda

1. Welcome	Coler
2. Approval of Minutes from 9/25/18	Coler
3. Subcommittees Report	
4. Next Steps	
5. Public Comment	
6. Adjourn	

Next meeting October 23, 2018, Room 1D

Mobile Integrated Health Workgroup
Minutes

Chair: Raffaella Coler, Director OEMS   Time: 9:00 a.m.   Location: LOB, 2D

Meeting Date: October 9, 2018

Attendees: Chris D. Andresen, Bruce B. Baxter, Joshua Beaulieu, Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, David Lowell, Dr. Maybelle Mercado-Martinez, James Santacroce, Chris Santarsiero, Carl J. Schiessl, William Schietinger, Kelly Sinko, Tracy Wodatch, Dr. Michael F. Zanker

Excused: Gregory Allard, Marybeth Barry, Dorinda Borer, Michael Bova, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, Heather Somers, Jonathan Steinberg, Dr. Robert W. Zavoski

Guests: Stacey Durante, Renee Holota, Mike Starkowski

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 9/25/18 minutes	Changes: No. Motion made by B. Baxter to accept, seconded by D. Lowell, motion carried and the minutes were accepted as is. Opposed- none. Abstentions-S. Heffernan. All in favor.	Group
3. Sub-Groups Reports/ Update:	a. Education	• CEMSAB MIH Committee • General recommendations nailed down • List of broad and general recommendations • Draft circulating for comment in CEMSAB MIH Comm., should have next meeting	J. Beaulieu
	b. Application Process	• **Should it be a NFS process?** • **Should CEMSMAC/CEMSAB be involved?** • **Will need a person in OEMS to do MIH** • **Working on it, in progress, will present after receiving further direction.**	R. Coler
	c. Legislative	• **G. Allard out** • **No Report**	R. Coler
	d. MIH/CP Programs	• Draft language, on or about November 1st	B. Baxter
		Another site visit is being made to Boston	R. Coler

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 10/19/18

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Chair: Raffaella Coler, Director OEMS Time: 9:00 a.m. Location: LOB, 2D

	e. Reimburse-ments	• Reworking document • Should have for 11/1	K. Sinko
		All groups should have draft language ready by 11/1/18; great benchmark; then we have all of November to write something up.	R. Coler
	f. Public Education/ Marketing	• **Hard to develop when we are not sure what program we are doing** • **R. Kamin excused today**	R. Coler

5. Next Steps:		• Original Charge read from September 2017
		• I don't think we've had a full discussion on transporting to alternative destination:
		  ○ Nothing in statute prohibiting
		  ○ The problem is we can't get paid for that
		  ○ Kristen – is this a possibility?
			R. Coler

		• The state will be responsible for paying anything additional • It will be in the insurance carriers rates • We can take a look at it again, but I'm not optimistic • Insurance statute says EMS transportation has to be emergency to a hospital to be reimbursed (paid)	K. Campanelli
		Are we referring to statues that mandate coverages?	C Schiessl
		Yes, I'll resend my presentation	K. Campanelli
		• The statute discusses what must be covered • Insurance companies could enter into arrangements with providers • Value based payments with hospitals and other groups shouldn't be forgotten	S. Halpin
		• What Sue said will be incorporated into our reimbursement section • ACO's and Mark Schaeffer's part will be looked into as well as if we need statutory change to allow this.	K. Sinko
		• The state only has control over 30% of the market, it's not the specific target group for this project, let's not loose site of this.	S. Halpin

		• Any other discussion on this?
		• Discussion on the tasks in the document distributed from September 2017: *(attached)*
		  a) We have received data and it looks like one size doesn't fit all – each area has to be different
		  b) Scope of Practice will not be affected as long as protocols and medical oversite is provided.
		  c) Mirror the education depending on the program – an a la carte process would work best.
			R. Coler

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 10/19/18

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		d) Savings or cost would come from Kelly's subgroup and that's being taken care of. e) Reimbursement issues also through Kelly's subgroup. f) Minimum criteria would be part of the application process. g) Insurance payment statutes and operating outside of the 911 system. This will be challenging due to AGs opinion and freelancing that happens.	
		Can this be addressed as "they are still under the employment of an EMS Service and part of the system response"	J. Santacroce & S. Heffernan
		Right now EMS operates outside of 911 when they get called for transports. Which statute is this?	K. Sinko
		We'll forward the 1991 AG opinion to everyone. *(attached)*	R. Coler
		Is Kelly's question, how do we work around that now?	J. Beaulieu
		We should have some lawyers work on it	K. Sinko
		Ultimately it'll end up with the AG	C Schiessl
		Further investigation and follow up on this is needed, I'll reach out to our lawyers and then the AG	R. Coler
		h) successful models we have from the NGA document	R. Coler
		We have precedent for g), we're proposing regular transport which we've been doing for decades. It's outside of the 911 system and we've been doing it for decades.	M. Zanker
		This has to be tackled, I need to do research. We've always had non-emergency transports.	R. Coler
		Don't open a can of worms	M. Zanker
		We can interpret the statute	K. Sinko
		Any other next steps?	R. Coler
		Do we check in on 10/28? Or 11/1?	R. Coler
		I'd love a presentation on Kelly's work before 11/1	B. Baxter
		My goal is to share on 11/1.	K. Sinko
		We will meet on the 23rd to check in	R. Coler
6. Public Comments:		Have you had any thoughts on going to the Health Foundation for financial assistance? They can be a part and assist with funding as well as the process.	M. Starkowski
		Thank you, will check into that	R. Coler
7. Adjourn and Next Meeting:		• Motion to adjourn made by S. Heffernan and seconded by K. Campanelli at 9:33 am • Next meeting 10/23/18.	R. Coler

CTN Video: http://ct-n.com/ctnplayer.asp?odID=15664

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 10/19/18

DRAFT

Mobile Integrated Health Working Group

October 23, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

1. Welcome — Coler
2. Approval of Minutes from 10/9/18 — Coler
3. Subcommittees Report
4. Next Steps
5. Public Comment
6. Adjourn

Next meeting November 6, 2018, Room 1D

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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Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 10/31/18

	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

FINAL

		• 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

FINAL

		• 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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Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 10/31/18

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

FINAL

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 10/31/18

Mobile Integrated Health Working Group

November 20, 2018

Location: **Legislative Office Building, Room 1D**

Time: 9am

Agenda

1. Welcome — Coler
2. Approval of Minutes from 10/23/18 — Coler
3. Subcommittees Report
4. Next Steps
5. Public Comment
6. Adjourn

Next meeting December 4, 2018, Room 1D

Mobile Integrated Health Workgroup
Minutes

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

Meeting Date: November 20, 2018

Attendees: Gregory Allard, Joshua Beaulieu, Kristin Campanelli, Jennifer Granger, Melanie Flaherty for 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, Dr. Robert W. Zavoski

Excused: Chris D. Andresen, Marybeth Barry, Bruce B. Baxter, Dorinda Borer, Michael Bova, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, William Schietinger, Heather Somers, Jonathan Steinberg

Guests: Stacey Durante, Renee Holota

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:		9:11 Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 10/23/18 minutes	D Lowell made a motion to accept, S Heffernan seconded, all in favor, abstentions are R Zavoski and T Wodatch	Group
4. Sub-Groups Reports/ Update:	a. Legislative	No update, no report	G Allard
		The AG 1991 opinion discussed at last meeting: EMS cannot work outside of the system, must have an EMS organization affiliation with a sponsor hospitals medical control oversite. We have had discussions at the office, we may have to make some legislative changes to accept the use of CP in the community. We are considering that at the office. I will give you the discussions thus far. Commissioner must ask the AG for the legal opinion on the above. Could be quite lengthy in the amount of time. A legislative change may be faster.	R Coler
	b. MIH/CP Programs	The 2nd version of the report as filed is the final draft to be submitted for inclusion.	D Lowell
		In that report you spoke of – reads options from document. The programs are not exclusive – there may be others, as well as we are not replacing any currently available services in the community.	R Coler

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 11/27/18

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	c. Public Education/ Marketing	On hold until process is decided upon	R Coler
	d. Application	We are awaiting opinions from the office – as to NFS or CEMSMAC/CEMSAB approval. Questions? None	R Coler
	e. Reimburse-ments	Almost finished; received some of the pieces yesterday; recap: touches on treatment, non-transport; touches on insurance and fiscal; talks about what DPH will need for resources – suggests choosing one option with three EMS services; talks about a fee-for-service rate. I am circulating today or tomorrow for subcommittee and plan to have to entire group by 12/4	K Sinko
	f. Education	Submitted report on 11/1 with six fairly broad recommendations – reads document submitted – Questions? None	J Beaulieu
		The report skeleton is done and consists of: 1. Executive Summary 2. Sub group reports 3. Information regarding existing programs 4. Public Act – I'd like to have a discussion on the tasks in the Public Act today:	R Coler
		Task #1: Identify areas in CT that would benefit from MIH – data must be submitted and GAP's identified. You must be able to identify the GAP's in your community in order to provide MIH. Agreed upon by group	R Coler
		Task #2: Interventions would be identified by GAP's, sponsor hospital and reviewed by CEMSMAC, approved and back to sponsor hospital	R Kamin
		• No legislative change needed here – use the system in place	R Coler
		• No treatment discussed here will include things currently outside of the scope of practice	R Kamin
		Task #3: Education – is covered by education sub group submittal	J Bealieu
		Task #4: Potential savings or additional costs:	R Coler
		• Outlined in the report; lack of data makes it hard to layout cost savings or cost increases	K Sinko
		Task #5: Potential reimbursement issues:	R Coler
		• Treat, no-transport discussed here; insurance minimum is transport to ED currently; new mandate in statute could cost money and increase premiums; clear up any thought of scope of practice issues	K Sinko
		Currently we are reimbursed for DOA; how does this work right now?	S Heffernan
		• Predicated by rates and setting a rate	K Sinko
		Currently there is no rate for DOA, so how do we get paid?	S Heffernan

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		• It's in the explanatory notes – it is defined	D Lowell
		Thank you, we'll look at that	R Coler
		Task #6 Criteria – we've defined this in the application process	R Coler
		• This is specific for the ALS provider	D Lowell
		Task #7: Statute or regulations impacted by MIH – we're working on that piece	R Coler
		Task #8 Successful models throughout the country – NGA Memo, Presentation from EasCare in MA	R Coler
		Subsection 1: Collaboration with CEMSAB/CEMSMAC regarding alternate destination	R Coler
		• No question of the ability to transport to alternate locations as long as protocol is followed and sponsor hospital medical control is involved	R Kamin
		• We talked about urgent care center transports – we can transport, however, there may not be reimbursement for that transport	R Coler
		• We are trying to come up with solutions that are patient care-centric; unfortunately they are not financial-centric as well	R Kamin
		• Do we limit this to hospital based urgent care centers? A lot of the urgent cares do not take people without insurance and will turn them away.	M Zanker
		• We are looking to provide efficiencies here, all stakeholders have to be at the table. In my community we've identified the urgent cares who will be taking all patients. I don't think we should limit this – each community should be able to put in action a program that works for them	J Beaulieu
		• In our report, we discussed this and made a suggestion in the report to begin with hospital based urgent cares	D Lowell
		• Concerned with just hospital based, in our community we have community health centers that would work with us and we want to be able to transport there if appropriate	S Heffernan
		• Josh's point is key – should be based in your community and all stakeholders must be at the table; this is a benefit to the patient to keep specific to the need in your community	G Allard
		• Many of us do have the ability to communicate with other stakeholders	J Granger
		• Urgent care's will hesitate due to liability insurance unless there is a financial model agreeable to everybody	R Zavoski
		• We will identify the "stakeholders" at the table in application process	R Coler
		• We're at a point where over defining may be counterproductive. Let's focus on development of the system, (i.e. application process), adding value by making this patient-centric.	R Kamin
		• What stops someone from doing this today? If a self-paying patient asks to be dropped off at an urgent care or Minute Clinic what prohibits this?	S Heffernan

		• When 911 is dialed, there's an expectation of receiving the best care at the best destination and how to best serve the patient and the system that we're working within	R Kamin
		• Interesting discussion – although there isn't a rule not to do that, a "Walmart or CVS Clinic" may not be happy about ambulances dropping people off at their door – have to take that into consideration. All stakeholders have to be at the table.	R Zavoski
		Subsection 2 read – Yes, protocol driven and sponsor hospital driven	R Coler
		• Is this for any EMS provider of just a paramedic?	K Sinko
		• ALS only by my understanding; BLS transport is done non-emergent to all kinds of people to testing facilities, homes, etc. This should be under the umbrella of MIH where a paramedic is making a decision that it's OK.	D Lowell
		• If a paramedic is dispatched to a 911 call, wouldn't it be a higher level call? Not just a cut for instance?	K Sinko
		• The paramedic can decide if a BLS provider can transport to an alternate destination. ALS level decision making has been discussed, but it's not outside the realm of thinking that BLS can go to alternate care after higher level decision making is made by a paramedic. Currently we have BLS going to an ED with a patient after a paramedic has determined this is appropriate.	R Kamin & D Lowell
		• Urgent care is not currently defined by DPH, therefore Medicare doesn't pay for this currently	R Zavoski
		• The new definition of urgent care went into effect 10/1/18 – it's being implemented currently	K Sinko
		Our deadline is 1/1/2019, we're in good shape	R Coler
5. Next Steps:		DPH and our Legislative Liaisons to put through a draft report next – is that agreed?	R Coler
		Next meeting 12/4 – I have a conflict for that day. I would like to put together and circulate the draft report and meet 12/18 to review. You may hear from me between now and 12/4. We'll meet 12/18 and discuss the report put forth the week before.	R Coler
		Is 12/18/18 this group's last meeting? What if we don't come to consensus? Will this group continue meeting?	J Beaulieu
		• Let's look at the draft report first and then we'll see if we want to continue meeting	R Coler
		Where do the issues that have been tabled such as public education & marketing stand?	S Heffernan
		• These are not an obligation, but will be helpful – this will unfold when the program is picked.	R Coler
6. Public Comments:		No public comment	R Coler
7. Adjourn and Next Meeting:		• Motion to adjourn made by D Lowell with a second by the entire group at 10 am • No meeting 12/4/18	R Coler

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Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 11/27/18

		• Report draft due one week before 12/18/18 • Next meeting will be 12/18/18 and we'll decide then if the report will be ready in time.	

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Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 11/27/18

Mobile Integrated Health Working Group

December 18, 2018

Location: **Legislative Office Building, Room 2A**

Time: 9am

Agenda

1. Welcome	Coler
2. Approval of Minutes from 11/20/18	Coler
3. Review of the Draft MIH Report	
4. Next Steps	
5. Public Comment	
6. Adjourn	

Mobile Integrated Health Workgroup
Minutes

Chair: Raffaella Coler, Director OEMS Time: 9:00 a.m. Location: LOB, 2B

Meeting Date: December 18, 2018

Attendees: Gregory Allard, Marybeth Barry, Bruce B. Baxter, Joshua Beaulieu, Kristin Campanelli, Susan Halpin, Shaun Heffernan, David Lowell, Dr. Maybelle Mercado-Martinez, James Santacroce, Chris Santarsiero, Carl J. Schiessl, William Schietinger, Kelly Sinko, Jonathan Steinberg, Tracy Wodatch, Dr. Michael F. Zanker, Dr. Robert W. Zavoski

Excused: Chris D. Andresen, Dorinda Borer, Michael Bova, Jennifer Granger, Dr. Richard Kamin, Dr. Jeannie M. Kenkare, Kimberly A. Sandor/Mary Jane Williams, Heather Somers

Guests: Stacey Durante, Renee Holota

Agenda Item	Issue	Discussion	Action/ Responsible
1. Welcome/ Housekeeping:	9:10 am	Raffaella Coler welcomed the workgroup members present and discussed emergency procedure and exits.	R. Coler
2. Minutes:	Review of the 11/20/18 minutes	D Lowell made a motion to accept, G Allard seconded, no discussion and all in favor, abstentions none	Group
3. Review of Draft MIH Report:		A review of the draft report distributed to the work group was discussed and can be viewed on CT-N. Below is a list of some of the changes/revisions discussed:	Group
		The question was raised an extension; an extension will be requested due to the holidays	R Coler
		Submitting language for definition of Mobile Integrated Healthcare	B Baxter
		Submitting language for review regarding non transport reimbursement in certain circumstances, and an allowable rate to various sections as discussed including reimbursement and recommendations section	D Lowell
		Submitting language for review regarding “Cost implications to insurance companies, Medicare/Medicaid patients and consumers”	K Campanelli

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 12/20/18

FINAL 2/5/19

		• A short paragraph to be added and repeated throughout which states that MIH will not "displace, replace or reinvent the existing healthcare continuum pathway; MIH is there to supplement and augment the system". • A definitions section will be added for clarification • A table of contents will be inserted as report develops • Will provide language for beginning section of report regarding data obtained (from entities such as NGA) discussing success and downstream cost savings of programs throughout the U.S. • Will add studies to the bibliography identifying other programs which are successful • Will add Federally Qualified Healthcare Clinics to Urgent Care section • Will add recommendation bullet points to Executive Summary section • Will add application draft to appendix; this should define who the "stakeholders" are • Will reach out to OSET re: 911 regulations, nurse triage and a summary will be provided • Add Conclusion • Review and clarify if statutory change needed for "working outside of the 911 system" from AG 1991 opinion	R Coler
		Each sub group will review their section and provide any additional submittals via email	All Sub Groups
		Submitting language for the Legislative section to include the AG's opinion	G Allard
		Payment/Reimbursement section: sub group members will be added; please draft and provide any changes to R Coler	K Sinko
4. Next Steps:		Request an extension? Unanimous "Yes"	Group
		Meeting second week of January with a new draft report; date will be distributed once a location is known	R Coler
5. Public Comments:		No public comment	
		A special thank you to Jill Kennedy for drafting the report	R Coler and group
6. Adjourn and Next Meeting:	10:39 am	A motion made to adjourn by K Campanelli, seconded by all	

FINAL 2/5/19

Respectfully submitted by Stacey Durante, Region 3 EMS Coordinator, 12/20/18