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.	

		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	

		• 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	

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