

Mobile Integrated Healthcare Workgroup Of the Connecticut EMS Advisory Board

Draft Minutes

March 3, 2016

Manchester Fire Department, 75 Center Street, Manchester CT

Attendance: David Bailey, Erin Maloney, Josh Beaulieu, John Spencer, Michael Bova, Irene Smith, Jose Matias, Greg Allard, Fred Potter, Christopher O'Brien, Nancy Brunet
Via Phone (conference call): Ryan Carter, Lenny Guercia, Chris Brewer, Jim Stead

Meeting called to order at 1305

Chairperson David Bailey describes the intent of the meeting; group is to formulate opinions and advice for MIH in Connecticut to be forwarded to DSS and DPH. Greg Allard from the Advisory Board gives a brief overview of the DPH/DSS meeting regarding Special Public Act 15-5. DPH expressed concerns with language and scope of practice. It was speculated that DSS and DPH seem to be proponents of the MIH concept, but they were against the bill due to lack of resources and fiscal restraints. The proposed bill would expand the deadline for pilot programs and would add analysis of any cost savings for healthcare/DSS. Mr. Allard informs the group that the meeting was very general, and discussed filling gaps, but did not get into specifics.

Group discusses educational standards for the MIH program, and the need for standardization of curriculum vs. flexibility. Points were made about using curriculum that already exists, such as the North Central model. Ryan Carter points out that this model may get "push back" from visiting nurses due to extensive would care education. Also makes note that DSS seems to be interested in the Minnesota model, which has robust language on educational standards. Group brings up idea that some elements of MIH can be done with minimal education, such as appropriate destinations.

Chairperson David Bailey has group go round table to bring up ideas of MIH, either in general or as it pertains specifically to their EMS organizations (views on how MIH should operate). Lenny Guercia speaks briefly about his write up that was send to the group via email. He feels that MIH should go thru the 911 system for tracking and to keep MIH within the EMS system. MIH should connect with discharge planners and medical control, and should identify set patients for hospital readmission avoidance issues. Some group members think utilizing 911 may not be the best or a "catch all".

Ryan Carter's view point is MIH should focus on hospital readmissions and alternate destinations to avoid unnecessary ED visits. He brings up concerns about utilizing the 911 system, or CAD bsed systems. Thinks it would require major involvement/training of dispatchers.

Jim Stead discusses hospital readmissions and frequent 911 users. Thinks hospitals and/or primary care offices should use a universal tool to identify an “at risk” population or people that could benefit from an MIH system.

Chris Brewer states that the Farmington Valley may have an advantage given that they are a hospital based Paramedic service. States they are waiting to see where MIH goes, and what educational standards will be developed.

Chris O’Brien discusses alternate destinations and behavioral health issues. Brings up Urgent Care facilities as possible destinations. Greg Allard adds that DSS is looking into Urgent Care facilities as well, addresses lack of state information on current Urgent Care locations. O’Brien seeks clarification on “discharges”, whether the term will be used for ER discharges and/or admission discharges.

Jose Matias questions how the system would work if the need for ALS treatment and/or transportation is determined by the MIH provider. David Bailey adds that many existing MIH programs generally have very little treatment, more of ongoing assessments of patients.

Michael Bova states that ASM is looking at decreasing re-admissions, decreasing hospice revocation, and providing safety checks.

Fred Potter thinks that the state should start broad, and not specific. Brings up standardization of education, and discusses having too few MIH paramedics, or the opposite- that every street Paramedic becomes an MIH provider.

Erin Maloney says that frequent 911 users, behavioral health issues, and the need for social service referrals are areas that need to be addressed. Agrees that utilizing the 911 system may add obstacles, and thinks that “buy in” from the currently used regional CMED centers should be given consideration. Thinks MIH success will need regionalization of services.

Greg Allard states that hospice program(s) in Norwich area are in favor of MIH. Thinks there can be small steps that can be done currently. Briefly discusses Norwich’s community care team and High Utilization Group referrals.

David Bailey discusses Hartford Hospital; states there is no clear plan but they regularly discuss the MIH concept. They are interested in reduction of readmissions, and have already started reducing transports to the ER from nursing facilities.

Josh Beaulieu gives out document on MIH ideas. Thinks municipalities should start with “easy stuff” that will cause little financial burden on tax payers. Discusses hospice revocation and alternate destinations, and the need to update/change state statute/regulations. Doesn’t think MIH should be “one size fits all”, thinks municipal or small services can do less, and commercial services may be able to do the “larger” stuff.

Chairperson Dave Bailey concludes that the group has several good ideas to report back to the Advisory Board. Will look at Josh Beaulieu's document as a starting point, and make note of several bullet points:

- Hospice revocation
- Alternate destinations, alternate means of transportation
- Frequent 911 users
- Readmission reduction
- Off hours VNA support
- Follow up on refusals/lift assists.

Meeting adjourned at 1445.