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Massachusetts Department of Public Health
Minutes of the Mobile Integrated Health Advisory Council
Meeting of Wednesday, February 1, 2016
Henry I. Bowditch Public Health Council Room, 2nd Floor
250 Washington Street, Boston, MA

Date of Meeting: Monday, February 1, 2016
Beginning Time: 9:36 AM
Ending Time: 11:31 AM

Advisory Council Members Present: The following fifteen (15) appointed members of the Mobile Integrated Health Advisory Council (MIHAC) were in attendance on February, 1 2016, establishing the required simple majority quorum (10) pursuant to Massachusetts Open Meeting Law (OML): DPH Associate Commissioner Lindsey Tucker (Chair); Dr. Toyin Ajayi; Dr. Gregory Bazylewicz; Mike Caljouw; Vic DiGravio; Tara Gregorio; Tom Henderson; Chief Theodore Joubert; Pat Kelleher; Dr. Carolyn Langer; David Morales; Dr. David Schoenfeld; Sean Tyler; Bryan Urato; Steve Walsh.

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1. Welcome and Introductions

Department of Public Health (DPH) Associate Commissioner and Mobile Integrated Health Advisory Council (MIHAC) Chair, Lindsey Tucker called the meeting to order and provided brief introductory remarks.

2. Adoption of December 14, 2015 MIHAC Meeting Minutes (Vote)

Ms. Tucker asked whether any members had any changes to be included in the January 6, 2016 meeting minutes. Hearing no request for changes, Ms. Tucker requested a motion to accept the minutes at 9:38 AM.

Mr. Henderson made a motion to approve. Dr. Bazylewicz seconded this motion.

The following eleven (11) members voted to approve the minutes: Dr. Gregory Bazylewicz; Mike Caljouw; Vic DiGravio; Tara Gregorio; Tom Henderson; Dr. Carolyn Langer; David Morales; Dr. David Schoenfeld; Sean Tyler; Bryan Urato; Steve Walsh.

The following two (2) members abstained: Dr. Toyin Ajayi; Pat Kelleher.

Chief Theodore Joubert was not yet present at the time of the vote.

3. Defining Access and Duplication

Ms. Tucker summarized major themes from the January 6, 2016 meeting, reviewing several key questions that were raised by MIHAC members during previous meetings. Ms. Tucker stated that the February 1, 2016 meeting would be focused on further discussion of several terms utilized within MGL Chapter 111O, Section 3 including *"gaps in service delivery,"* and *"duplication of services,"* as well as on the interaction between EMS, MIH, and Community EMS.

Ms. Tucker reviewed the usage of the terms *"gaps in service delivery,"* and *"duplication of service*s*"* as presented within MGL Chapter 111O, and stated that the law requires the Department to evaluate and approve MIH programs that meet each of eleven criteria specified within Section 2. Among other things, these criteria require approved MIH programs to address *"gaps in service delivery"*, but without *"duplication of services."* Ms. Tucker then posed the question "Should these terms be further defined, and if so, how and where?"

At 9:44 AM, Advisory Council member Chief Theodore Joubert entered the room.

Ms. Tucker stated that in planning for this MIHAC meeting, DPH staff sent MIHAC members an exercise to complete in order to solicit feedback regarding the meanings of the terms *"gaps in service delivery"* and "*duplication of services*." Ms. Tucker shared that the goals of this exercise and discussion were to answer the following questions:

- What should constitute *"gaps in service delivery*" and who should determine?
- Should gaps be verified or verifiable? If so, how and by which measure(s)?
- What should constitute *"duplication of service*s*"* and who should determine?
- Where and how should the answers to these questions be operationalized within the regulatory and programmatic construct (Reg vs. App vs. by MIH Program)?

Ms. Tucker shared that DPH staff synthesized the received MIHAC member submissions into definitions for the two terms for discussion and feedback. Ms. Tucker noted that these synthesized definitions represented DPH staff synthesis of responses received from MIHAC membership, and at this time, did not represent official DPH policy positions.

Ms. Tucker presented a slide summarizing comments received regarding *"gaps in service delivery*," and stated that there was much alignment among responses to this question. The group agreed with the definition, but had several suggestions for the bulleted examples in the definition. Dr. Bazylewicz suggested that the definition should include "a decrease in time to

appropriate patient care" rather than just "a decrease in time to patient care." Dr. Langer suggested that the definition include improvements in patient adherence, while Dr. Ajayi suggested that it include increased patient satisfaction and decreased patient burden. Dr. Schoenfeld suggested inclusion of improved quality of life.

Mr. Tyler posed a question about whether MIH programs would be able to successfully demonstrate a decrease cost-to-patient as patients would not likely be paying for these services through a fee-for-service model, or even to the program directly. Mr. Morales agreed with Mr. Tyler and suggested replacing "cost-to-patient" and "total cost of care" with "total medical expenditures."

Ms. Tucker stated that based on all responses received, there seemed to be general consensus by MIHAC membership that it should be an MIH program applicant's responsibility to identify and articulate gaps in services. Membership agreed.

Ms. Tucker presented the slide summarizing comments received regarding whether *"gaps in services"* should be verified or verifiable, and if so, how and by which measure(s)? Mr. Morales stated that the applicant should be able to submit data, preferably jointly with a payor, to speak to the risk arrangement. Dr. Schoenfeld stated that the Department should ensure that the cost of care does not outweigh patient needs and quality of care in the regulation or in its approval of MIH programs. Mr. Tyler stated that measures should not be included in regulation. Dr. Ajayi recommended that the applicant should have to prove to the Department that a gap exists and demonstrate what they will offer in helping fill it.

Ms. Tucker presented the slide summarizing comments received regarding *"duplication of services*" and noted that most responses were in alignment that "a duplication of a service" is a proposed service which does not address a "gap in service delivery." Ms. Tucker also stated that most responses indicated that DPH should require MIH program applicants to list the community health providers, local public health agencies, and continued care supports with which they partner and/or contract, describing how the proposed program would avoid duplication and achieve more cost-effective and clinically appropriate services.

Ms. Tucker noted a comment received regarding Emergency Service Programs (ESPs), which provide an existing system of emergency behavioral health crisis response. Mr. DiGravio commented that whenever possible, MIH programs should be required to partner with ESP(s) in the catchment areas they plan to serve. Mr. DiGravio stressed that the state and EOHHS have invested a lot of resources in ESPs and encouraged DPH to align these resources with MIH. Ms. Kelleher agreed, and voiced similar concerns about services already provided by existing home care providers. Ms. Kelleher stated that the regulations should not be so flexible that for example, an MIH program would be able to operate as a home-based palliative care program without the same level oversight and regulation that governs other providers of this service who do not happen to be MIH programs.

With regards to interactions with other service types, Dr. Schoenfeld stated that these relationships should depend on how MIH is accessed and how the provision of MIH services is initiated. Dr. Bazylewicz commented that it is critical that existing services are well coordinated

through primary care. Dr. Ajayi suggested that applicants provide a matrix as part of their application which would list all providers that the MIH program may interact with and how they will coordinate with each existing service provided.

Mr. Morales commented that it would be difficult to align all of these services unless you were a payer. Dr. Ajayi responded that the point of the MIH regulations should not be to make a business case for an MIH program, and that that responsibility should fall to the applicants themselves. Mr. Henderson commented that revenue determines how much a 911 service is capable of doing. Dr. Schoenfeld cautioned that when a patient feels like they have an emergency, they should call 911 and be brought to the ED no matter what. Dr. Langer stated that DPH needs to be careful not to be too prescriptive and to make sure the regulations are flexible enough for future ACO/APM arrangements which are rapidly developing and changing

Mr. Tyler stated that he likes the definition of duplication on slide 15 because it is simple and does not get into payment. Dr. Ajayi echoed Mr. Tyler's comment and added that this definition allows for creativity. Membership was in general agreement.

Ms. Tucker presented slide 16 with some comments that may warrant future discussion of the advisory council. The first comment was that DPH should consider prioritization of proposals that address "gaps" in behavioral health (substance abuse/mental health); provide full continuum of emergency care including urgent/emergent services; and, applications that focus on Medicaid populations in collaboration with MassHealth. There was disagreement among members about this comment, and several members stated that this comment warranted future discussion.

The second comment was that "There shall be no more than two MIH applications approved per county, unless they test distinct care coordination objectives and will not increase Total Cost of Care." Several MIHAC members voiced their disagreement with this comment, especially because there may be many different target populations in a given geographic area with different needs.

The third comment was that "An ambulance partner provider who works with an at-risk ACO on a Department-approved MIH program may not service the same patient through any other MIH initiatives without the expressed permission of the at-risk ACO." Dr. Langer, Mr. Morales, and Mr. Henderson agreed that elective MIH should require a patient referral from a PCP. Dr. Schoenfeld agreed except for cases of 911 initiation of services.

4. Defining the Interaction between EMS, MIH, and Community EMS

Ms. Tucker introduced DPH Deputy General Counsel Sondra Korman. Attorney Korman provided an overview of several definitions within the context of MGL Chapter 111C and MGL Chapter 111O, including "first responders," "health care entity," and "MIH Community Paramedics and 'other providers' providing MIH services." In follow up to past MIHAC member question regarding these terms, Attorney Korman clarified that although DPH sets training standards for first responders, under the limited first responder training statute, neither DPH nor any other state agency has oversight or any other authority over these state and municipal employees. The first responder statute only requires that police, firefighters and state and

municipal lifeguards be trained in first aid and CPR. They are not licensed or certified, and they are not required to be deployed by their agency to actually use their training. As such, "first responder agencies" are not "health care entities." Attorney Korman further clarified that they are distinct from EMS first response (EFR) services, a different service status that is governed by the EMS statute, MGL c. 111C, and requires designation in a DPH-approved EMS local service zone plan and licensure by DPH. These services are subject to oversight and enforcement by the DPH, she observed. Attorney Korman clarified that unless a police or fire department or state or municipal agency employing lifeguards operates a DPH-licensed ambulance service or an EFR service (which also requires its personnel are certified by DPH as EMTs, or at the lowest level of EFR licensure, certified EFRs), police, fire and lifeguard personnel working for first responder agencies are not "health care entities" or "health care providers" under Chapter 111O. She also noted that there are only 3 licensed EFR services in the Commonwealth at this time, all licensed at the EFR-Basic level of service, whose personnel are thus all certified EMTs. There are currently no individuals certified as EFRs. Attorney Korman answered several clarifying questions from the Advisory Council.

Ms. Tucker presented slides 21-23 regarding interactions between MIH and EMS, reiterating that the law requires the Department to evaluate and approve MIH programs that meet each of eleven criteria specified within Section 2, one of which is that programs shall "ensure activation of the 911 system in the event that a patient of an MIH program experiences a medical emergency, as determined through medical direction, in the course of an MIH visit." Ms. Tucker stated that in previous meetings, MIHAC members have made reference to:

1. The high percentage of 911 calls that are deemed non-emergent, but under MGL c.111C (EMS statute), EMS has no other option except ED transport, absent an informed, written patient refusal of transport; and,
2. Interest in potential utilization of existing EMS resources, including EMS-compliant vehicles (i.e. ambulances) and dually approved paramedic/EMT staff in achieving ED aversion (versus prevention).

Ms. Tucker stated that she would walk MIHAC through several hypothetical scenarios involving potential EMS/MIH interactions, each with questions for MIHAC members to consider.

Ms. Tucker presented the first hypothetical situation detailed on slide 24, involving a primary ambulance service of a municipality which is also an approved MIH program. Ms. Tucker asked the group several questions about what should be permitted to occur in this scenario.

Mr. Tyler commented that other states have grappled with these same questions regarding triage, patient refusals, and alternate destinations and reiterated that if a patient believes they are having an emergency, they should be brought to the ED. Dr. Schoenfeld commented that if an alternate location becomes allowable, these decisions must be made in close consultation with medical control and the proposed alternate location to ensure clinical appropriateness and capacity. However, Dr. Schoenfeld cautioned that it was his belief that this was not an MIH question. Dr. Ajayi stated that this decision must be based on "real-time" medical control and "real-time" informed consent with sufficient documentation.

After some discussion, Ms. Tucker noted that DPH staff would be sending out an exercise to the members focusing on these questions to help facilitate continued discussion at the next MIHAC meeting.

5. Upcoming Meetings and Meeting Close

Noting the time, Ms. Tucker reminded the members of upcoming scheduled MIHAC meetings for February 26, 2016; March 24, 2016; and April 20, 2016.

Ms. Tucker requested a motion to adjourn at 11:31 AM. Mr. Henderson motioned. Dr. Schoenfeld seconded. All members in attendance voted in the affirmative.

The MIHAC meeting concluded at the time of 11:31 AM.

List of Documents Presented to MIHAC at the *February 26, 2016* Meeting

Documents can be found at:
http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/committees/mih/

1. Agenda: **"Meeting Agenda – February 01, 2016"**
2. PowerPoint presentation: "**Meeting Presentation (PowerPoint)"**
3. Meeting Minutes: **"Approved Minutes of January 6, 2016 Meeting"**