Mobile Integrated Health Advisory Council

Massachusetts Department of Public Health

December 14, 2015

Agenda

1. ROUTINE ITEMS:
   - **a. Welcome and Introductions**
   - b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   - a. Review of Paramedic Scope of Practice (PRESENTATION)
   - b. Cataldo SmartCare (PRESENTATION)
   - c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   - a. Background and Need for 111O (PRESENTATION)
   - b. Defining Questions and Opportunities (DISCUSSION)
   - c. Upcoming Meeting Schedule

Themes From Last Meeting

Several key themes came out of MIHAC's November meeting:

- What is the role of MIHAC following passage of 111O? What roadblocks remain?
- Questions regarding paramedic scope of practice
- Importance of interdisciplinary partnerships and the cross-inclusion of all clinical scopes, including home health and community health workers
- Need to embed MIH within a primary care continuum of care, including knowledge and training regarding triage and referral
- And most importantly, "*flexibility, flexibility, flexibility*…." paired with minimum "guardrails" to ensure patient safety

Framing for Discussion

Pre-MIH statute: Limited MIH Special Projects Approved Under MGL 111C

LIMITATIONS: MGL 111C / EMS Statute

Solution to MGL 111C Limitations: Creation of MGL Chapter 111O / Mobile Integrated Health and Community EMS

Regulatory Need: If 111O resolved the limitations driven by 111C, what is the purpose of the MIHAC meetings and DPH regulations?

Market Opportunity: The market is able to build a new industry by creating new partnerships and program designs within the constructs of MGL 111O

Conclusion: DPH and MIHAC's role is limited to determining the minimum "guardrails"

Exercise: Patient Safety

If your organization wished to create a new "MIH Program" with each organization represented by your fellow MIHAC members:

- **What obstacles still exist that would prevent an effective program** (understanding that policy considerations such as payment and access are separate but needed conversation)?
- **What minimum guardrails do you believe are necessary to ensure quality care and patient safety?**
- **Of these, are there any that should be determined by the applicant versus DPH?**

Agenda

1. ROUTINE ITEMS:
   a. Welcome and Introductions
   b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   a. Review of Paramedic Scope of Practice (PRESENTATION)
   b. Cataldo SmartCare (PRESENTATION)
   c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   a. Background and Need for 111O (PRESENTATION)
   b. Defining Questions and Opportunities (DISCUSSION)
   c. Upcoming Meeting Schedule

Adoption of Meeting Minutes

Motion to adopt MIHAC November 16, 2015 meeting minutes **(VOTE)**

Agenda

1. ROUTINE ITEMS:
   a. Welcome and Introductions
   b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   a. Review of Paramedic Scope of Practice (PRESENTATION)
   b. Cataldo SmartCare (PRESENTATION)
   c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   a. Background and Need for 111O (PRESENTATION)
   b. Defining Questions and Opportunities (DISCUSSION)
   c. Upcoming Meeting Schedule

Paramedic Scope of Practice

- Highest level of state certification for EMS personnel, following 1-3 years of didactic and laboratory education, then clinical and field internship. Training is based on National EMS Educational Standards

- State-defined scope of practice includes vascular/medication access (IV, IO, IM, etc.), airway management (simple adjuncts, endotracheal intubation, supraglottic airway placement) and electrical therapies

- Affiliate Hospitals and their designated Affiliate Hospital Medical Directors (AHMD) provide medical oversight of ambulance service operation, including quality assurance, education and special project waiver development

Paramedic Scope of Practice

- Additional procedures and medications may be utilized for inter-facility transfers, including mechanical ventilator monitoring

- Over 40 medications may be administered under Statewide Treatment Protocols standing orders (off-line physician order), including analgesics, benzodiazepines, bronchodilators and vasoactive medications

- Performance of full ACLS assessment and treatment, 12-lead ECGs and interpretation for STEMI (with activation of hospital PCI facilities)

Agenda

1. ROUTINE ITEMS:
   a. Welcome and Introductions
   b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   a. Review of Paramedic Scope of Practice (PRESENTATION)
   b. Cataldo SmartCare (PRESENTATION)
   c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   a. Background and Need for 111O (PRESENTATION)
   b. Defining Questions and Opportunities (DISCUSSION)
   c. Upcoming Meeting Schedule

SmartCARE

Delivering the Future of Healthcare

A review of Cataldo Ambulance Service's experience with Community Paramedicine

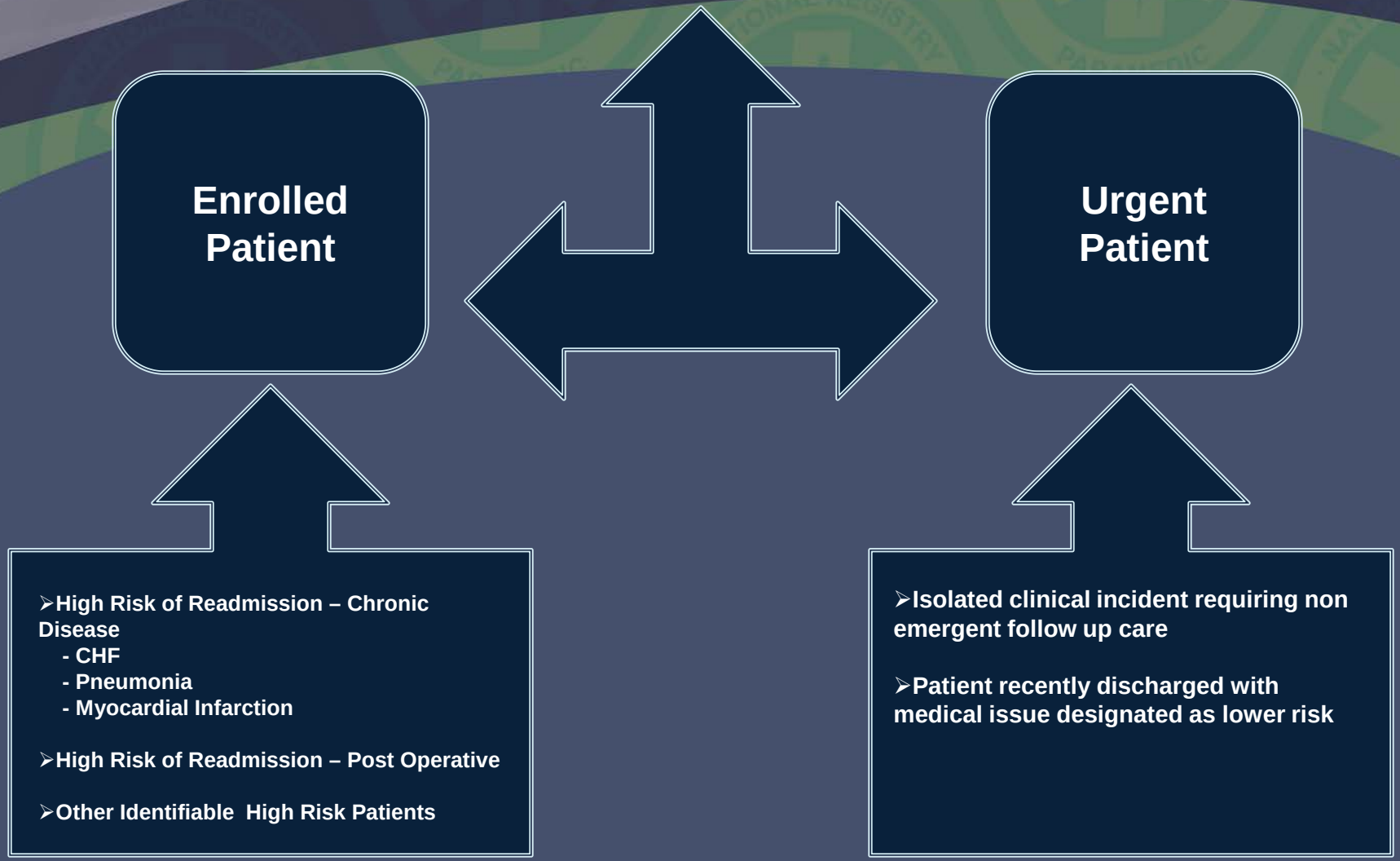
SmartCare Timeline

- 12/2012 – Cataldo Ambulance Service senior management team start conceptual discussions on “home care” solutions after Pioneer ACOs are launched. After looking at national and international models, community paramedicine emerges as the leader in filling this “gap”. Work begins on *SmartCare*.
- 9/2013 – Partnership with BIDMC is formed to pilot a Community Paramedic Program
- 11/2013 – CAS presents Special Project Waiver to the Office of Emergency Medical Services
- 12/2013 – Decision made by MSC Community Care and Education Sub-Committee(formed by OEMS to specifically address MIH/CP projects) to use the HRSA tool to evaluate program effectiveness
- 2/19/2014 – CAS resubmitted SPW presentation to the Sub-Committee. Received recommendation for approval.

SmartCARE
Delivering the Future of Healthcare

SmartCARE
Delivering the Future of Healthcare

Patient Population



SmartCARE
Delivering the Future of Healthcare

Enrolled Patient

Example of Enrolled Patient

- Patient Indentified as High Risk due to CHF
- PCP and Case Coordinator Informed of Patient Enrollment into SmartCare program
- SmartCare Communications Division enters Patient information into Smart CAD

Pre-Visit Action

- SmartCare Communications notifies both SmartCare Paramedic and Patient of scheduled Home Visit
- SmartCare Paramedic reviews patient medical history via tablet PC and arrives on time via dedicated SmartCare Vehicle

On Scene Delivery

- SmartCare Paramedic arrives at scene and evaluates home for any hazards and barriers to care
- SmartCare Paramedic addresses specific medical concerns pertaining to nature of call
- SmartCare Paramedic enabled direct access to PCP via Phone or Telehealth Solution
- SmartCare Paramedic and PCP identify most appropriate follow-up care including :
  - -Interventions at Scene
  - -Schedule of PCP Appointment
  - -Transport to Appropriate medical Facility
- SmartCare Paramedic Documents Patient Interaction and shares updated history with PCP through secure Smart CAD connection

SmartCARE
Delivering the Future of Healthcare

Urgent Patient Response

Example of Urgent Patient

- Patient discharged from *SmartCare* Partner facility
- PCP and Case Coordinator Informed of Patient Enrollment in internal care transition program
- Healthcare partner follows internal patient care program, ie: RN follow-up phone calls, pharmacist and PCP case review

Pre-Visit Action

- Internal care coordinator identifies health related concern requiring in home patient evaluation best suited for SmartCare Paramedic
- Care Coordinator activate SmartCare services.
- In home SmartCare evaluation is scheduled within mutually agreed upon time

On Scene Delivery

- SmartCare Paramedic arrives at scene
- SmartCare Paramedic addresses specific medical concerns pertaining to nature of call
- SmartCare Paramedic enables direct access to PCP via Phone or Telehealth Solution
- SmartCare Paramedic and PCP identify most appropriate follow-up care including :
  - -Interventions at scene
  - -Schedule PCP Appointment
  - -Transport to appropriate medical facility
- SmartCare Paramedic documents patient interaction and shares updated history with PCP through secure Smart CAD connection

SmartCARE
Delivering the Future of Healthcare

Key Features

- 24/7 access/call center
- Layers of medical control
- Extensive training
- Expansive service area
- Dedicated vehicle
- Tele-health equipment
- Quality assurance

SmartCARE
Delivering the Future of Healthcare

Statistics

Patient Self-Assessment of Health Status (1)
As of: 7/31/2013

	CHP			CHF			NTSP		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Sample Size	12	10		26	26		8	18	
Mobility (2)	2.417	2.300	-4.8%	2.346	2.615	11.5%	2.750	2.611	-5.1%
Self-Care (2)	2.583	2.500	-3.2%	2.423	2.654	9.5%	2.750	2.667	-3.0%
Perform Usual Activities (2)	2.333	2.300	-1.4%	2.269	2.500	10.2%	2.750	2.556	-7.1%
Pain and Discomfort (2)	1.667	2.400	44.0%	2.154	2.423	12.5%	2.750	2.444	-11.1%
Axiety/Depression (2)	1.667	2.000	20.0%	2.154	2.346	8.9%	2.750	2.722	-1.0%
Overall Health Status (3)	**3.333**	**6.600**	**98.0%**	**5.385**	**7.115**	**32.1%**	**6.750**	**6.778**	**0.4%**

Notes:
1. *Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionaire*
2. *Score 1 - 3 with 3 most favorable*
3. *Score 1 - 10 with 10 most favorable*

Expenditure Savings Analysis **Obs Admission Avoidance Program**

Based on Medicare Rates

Analysis Dates: **August 1, 2012 - Sept 30, 2013**
Number of Patients: **54**

	Obs Admits Avoided		
Category	**Base**	**Avoided**	**Savings**
Avg Obs Admit Payment (1)	$ 7,846	53	$ 415,838
ED Bed Hours (2)	23	53	1,219

Per Patient Enrolled	Obs Admit
Payment Avoidance	**$ 415,838**

Notes:
1. *Average payment made by NTSP for Obs Admission*
2. *Average duration of Obs Admission in ED*

Expenditure Savings Analysis (1) **CHF Diuretic Protocol**

Based on Medicare Rates

Analysis Dates: **January 1, 2013 - March 31, 2013**
Number of Patients: **18**

	CHP 9-1-1 Transports to ED		
Category	**Base**	**Avoided**	**Savings**
Ambulance Charge	$1,668	17	$28,356
Ambulance Payment (3)	$421	17	$7,157
ED Charges	$904	17	$15,368
ED Payment (4)	$774	17	$13,158
ED Bed Hours (5)	6	17	102
Inpatient Charges (5)	$ 39,426	17	$ 670,242
Inpatient Payments (4)	$ 17,500	17	$ 297,500

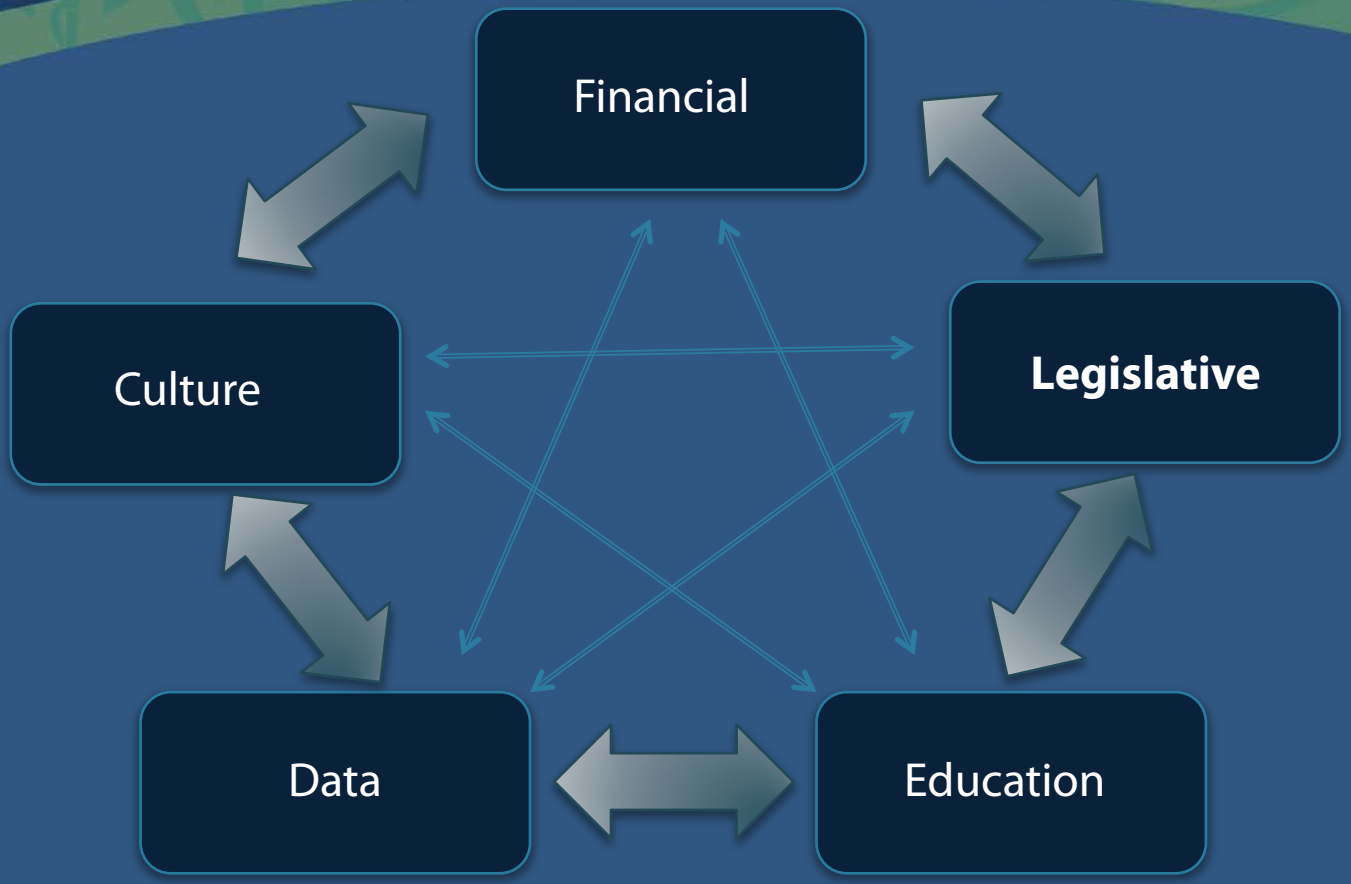
Total Charge Avoidance	**$713,966**
Total Payment Avoidance	**$317,815**

Per Patient Enrolled	CHFP
Charge Avoidance	**$39,665**
Payment Avoidance	**$17,656**

Notes:
1. *Comparison based Case Manager estimate of 1 readmit vs.* ***actual admit during 30 day enrollment.***
3. *Average Medicare payment rec'd by MedStar*
4. *Base expenditures derived from AHRQ reports*
5. *Derived from CMS Charge Report for DRG 189 for John Peter Smith Health Network*

SmartCARE
Delivering the Future of Healthcare

Barriers to EMS Innovation



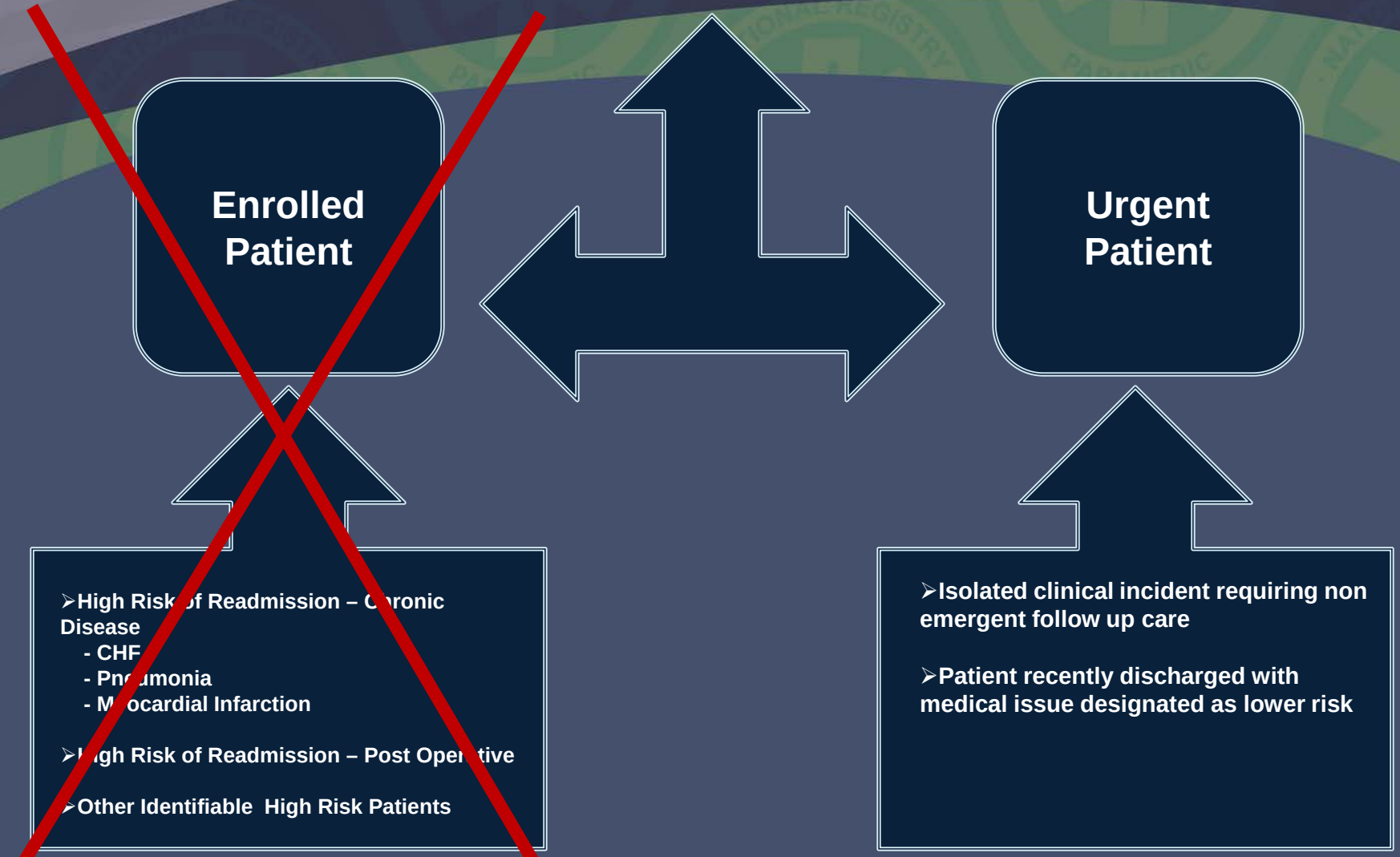
SmartCARE
Delivering the Future of Healthcare

SmartCare Timeline

- 4/11/2014 – SmartCare presented to full MSC Committee with unanimous vote of approval
- 4/2104 – Community Presentations done to introduce MIH/CP concepts to city and town partners
- 6/2014 – Meeting with DPH to discuss waiver. This was followed by several more meetings and presentations with various small groups from DPH to discuss statute and regulation obstacles
- 10/16/2015 – SmartCare receives approved SPW for one year to pilot Community Paramedic program

SmartCARE
Delivering the Future of Healthcare

Patient Population



SmartCARE
Delivering the Future of Healthcare

SmartCare in Action

SmartCare
Delivering the Future of Healthcare

111O Gap Analysis

- Vehicle should be registered/subject to inspection to ensure standards
- Section 1: refers to “paramedic” – does this close the door for EMTs and other responders who may want to participate at some level?
- Section 1: refers to “scope of practice” as it relates to current 911/IFT scope - these programs may require an expanded scope in certain areas
- Section 2: refers to “appropriate training” - program specific?
- Section 3: refers to programs operated by the “primary ambulance service” - no FD or other options?
- Section 3: refers to vaccines under the directions of local public health – only option?

Key “Guardrail” Points

- Programs must be patient centered to meet an identified gap/need not filled by current available resources
- While treatment protocols will differ from 911/IFT and may differ from program to program, there should be clear standards/protocols by which to measure efficacy
- Training is key, but will be tailored to meet the needs of each program built
  - Programs may include didactic, SIM, table-top scenarios, etc.

SmartCARE
Delivering the Future of Healthcare

Key “Guardrail” Points

- Record keeping/reporting/data analysis at the local and state levels are required to measure value. Standard reporting format should be considered
- Response standards – program specific
- Secure documentation system is a must
- QA/QI process is necessary – incorporate the HRSA tool or something similar

For More Information

- Visit the *SmartCare* Website: www.smartcarema.com

SmartCARE
Delivering the Future of Healthcare


Q
A
SmartCare
Delivering the Future of Healthcare

Agenda

1. ROUTINE ITEMS:
   a. Welcome and Introductions
   b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   a. Review of Paramedic Scope of Practice (PRESENTATION)
   b. Cataldo SmartCare (PRESENTATION)
   c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   a. Background and Need for 111O (PRESENTATION)
   b. Defining Questions and Opportunities (DISCUSSION)
   c. Upcoming Meeting Schedule

Case Study

- Saturday 22:34 Increasing Snow (10” predicted)
- Private residence, family with pt, PCA due next day at 11 am
- 37 y/o F c/o Weak, Increased confusion, low grade fever, dark urine, productive cough
- PMHx: TBI, Quadriplegia, Vent Dependant, HTN, Depression, Diabetes Type II, Sub-Pubic Cath

What are the Patient’s Options?

Mobile Integrated Health

Where can DPH help…

EasCare Mobile Health

What is EMS?

EMT-Basics

EMT-Advance

EMT-Paramedic

EMT-Critical Care

Treat & Transport

EasCare Mobile Health

Community Paramedicine & Mobile Integrated Health (MIH)

EasCare Mobile Health

History of MIH

International & National

- Nova Scotia, Canada
- London, England
- Alice Springs, Australia

- Fort Worth, TX
- Reno, NV
- Minneapolis, MN
- Meza, AZ

EasCare Mobile Health

What is MIH?

- **Improving the patient experience of care (including quality and satisfaction)**
- **Improving the health of populations**
- **Reducing the per capita cost of health care**

EasCare Mobile Health

What is MIH?

Filling Gaps in Healthcare System

- Times of Service
- Geographical Foot Prints
- Weather
- Clinical Services

EasCare Mobile Health

What is MIH?

Patient Centric

- Out of Hospital Care
- Interactive Decision Making
- Immediate Care
- Closed Loop Communication

EasCare Mobile Health

Collaboration

EASCARE, LLC

Ambulance Service

Commonwealth Care Alliance

EasCare Mobile Health

Gap Analysis

- Supplementing existing CCA care model
  - Gap analysis and needs assessment
    - Many patients do NOT want to visit ED
    - They wait too long to call for help
      - Fear of admission to hospital
      - Long wait time in ED
      - Unnecessary care delivery
  - Eliminating potential for redundant resources
  - Additional resources for delivery of out of hospital care
    - 18:00 to 06:00 daily

EasCare Mobile Health

Program Construction

- **Project Manager**
- **EMS Operations Director**
- **EMS Logistics Director**
- **EMS Clinical Director-Primary Investigator**
- **EMS Medical Director**
- **CCA Medical Director**

Collaboration between partners

EasCare Mobile Health

“One Size Does Not Fit All”

Existing training programs

- Provide the fundamentals of Community Paramedicine
- Do not provide the unique aspects to ensure patient centricity

EasCare Mobile Health

Training

EasCare-CCA program

- 325 hours
- Curriculum was created through a collaborative process
- 50% Didactic 50% clinical practicum
- The clinical component involved hospital and out of hospital pt visits
- Competency: Simulation Lab

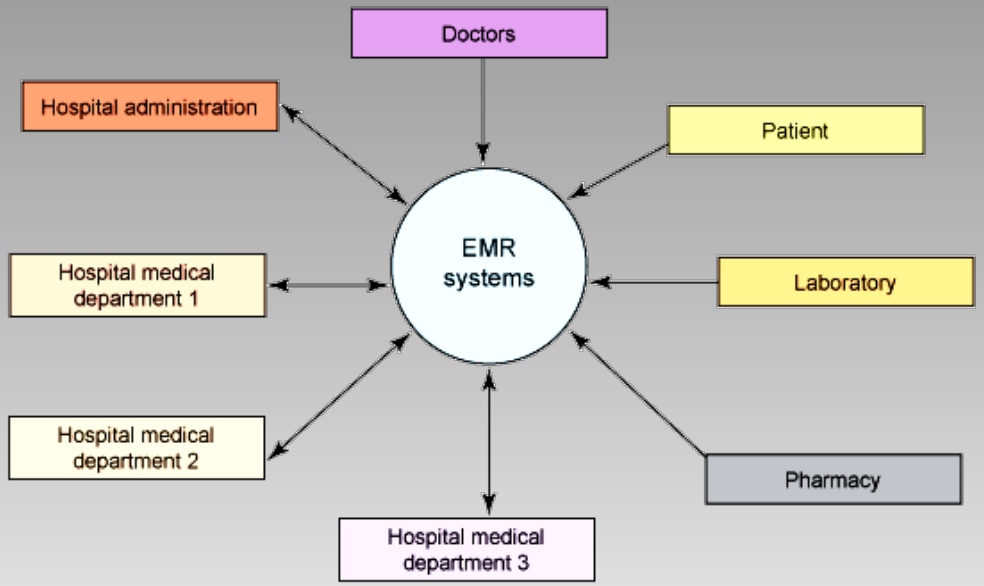
EasCare Mobile Health

Expanding Roles

- Expanded Formulary
  - Antibiotics
  - Pain Management
- Point of Care Testing
  - Chem 8
  - U/A
  - Rapid Strep & Flu
- Cultures
- Behavioral Health
- End of Life Care
- Collaborative Care
- Facilitated Transportation

EasCare Mobile Health

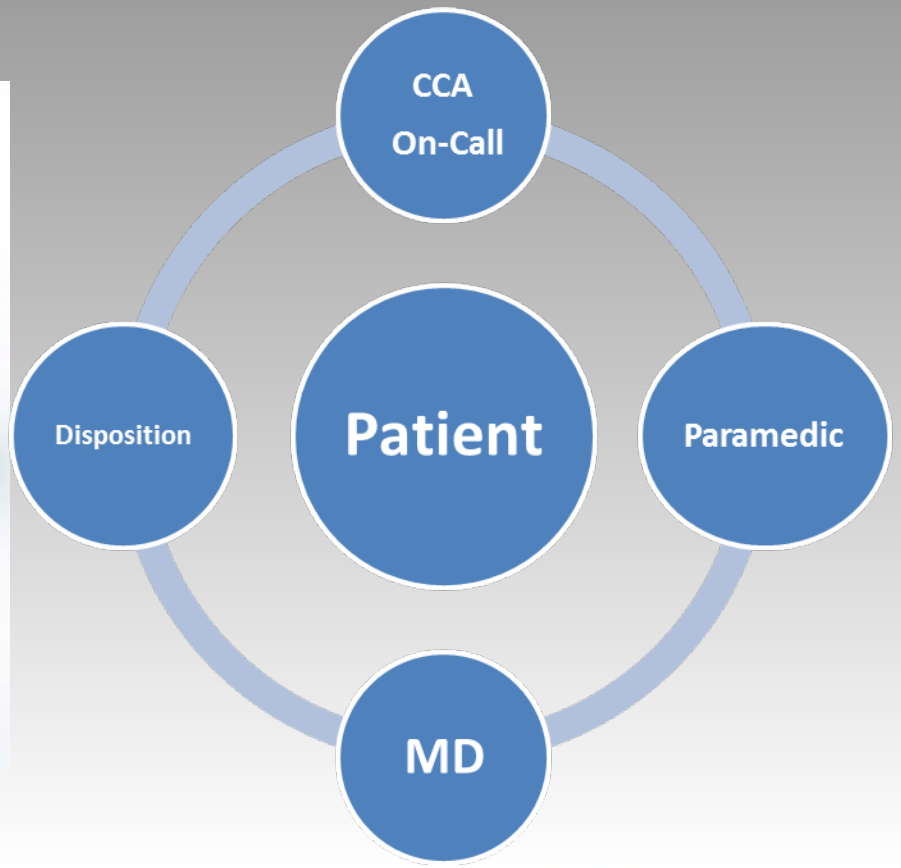
Expanding Processes



EMR + Closed Loop Communication = Better Decision Making

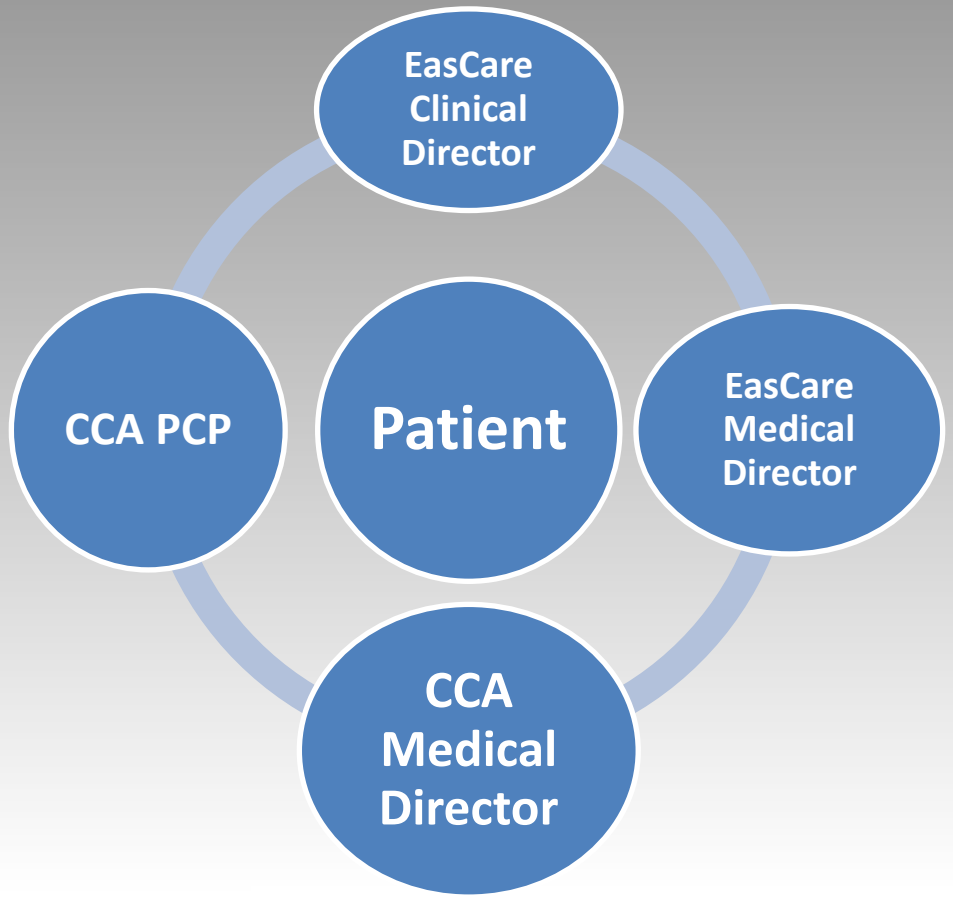
EasCare Mobile Health

Program Call Flow



EasCare
Mobile Health

CQI - Oversight



- M&M Rounds
  - 5-6 MDs
  - CCPs
- Paramedic Log
- Surveys
  - Patients
  - Staff
- DPH Submission

EasCare Mobile Health

Improving the Health of Populations

DATA

424 Patient contacts (average 1.1 per night)

83 minutes of average patent contact time

Supplementing existing care model

Expenses Reduced

Savings Produced

- Ambulance Transportation
- ED Visit
- Physician
- Labs
- Admission
- OBs

Patient Experience

98 % of patients' Extremely Satisfied

2% of patient's Satisfied

100% Staff Satisfied

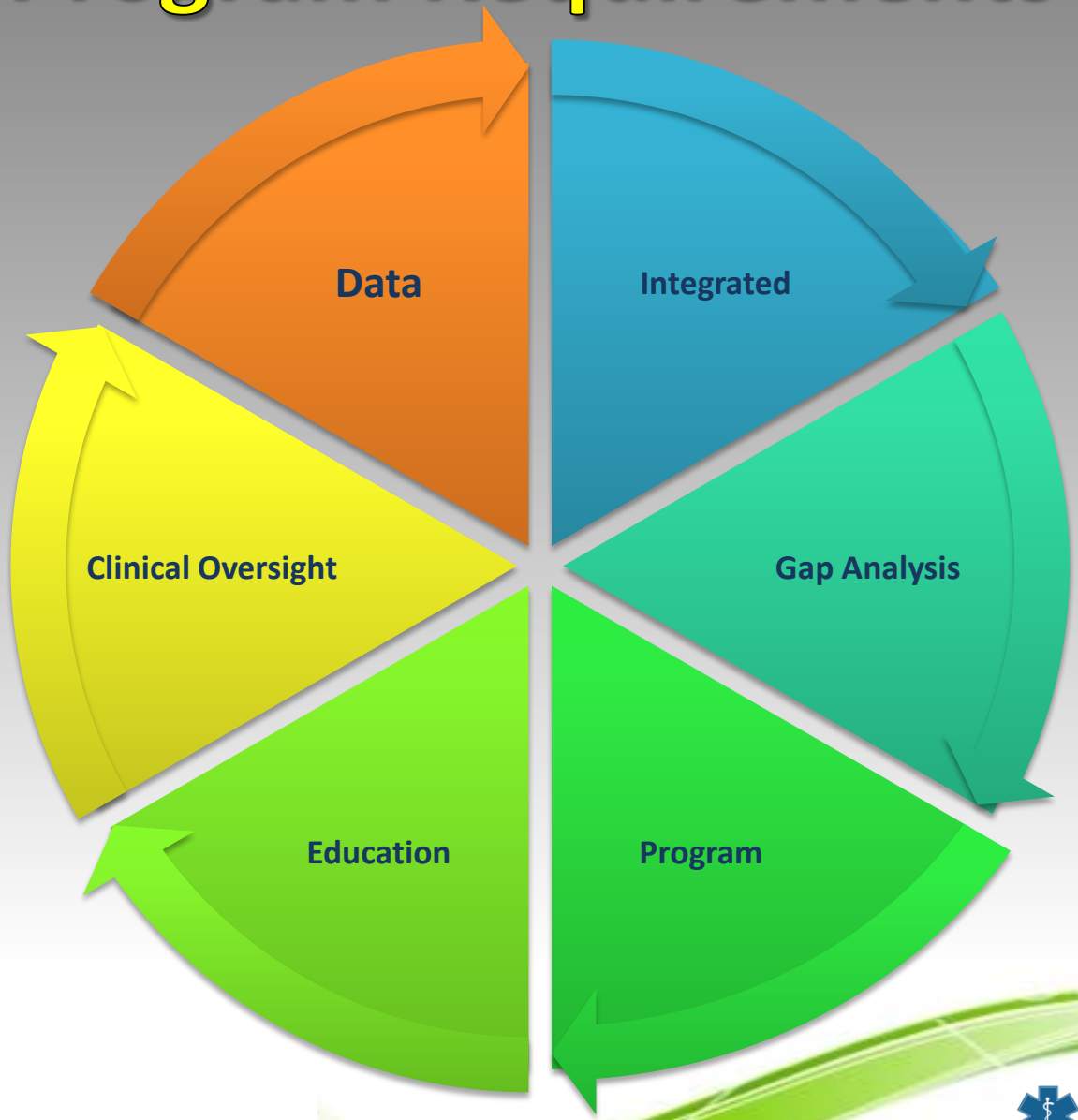
EasCare Mobile Health

How can DPH assist with MIH & the IHI Triple Aim?

- ***Streamlined Application Process***
- ***Program Oversight***
- ***Sustainability***
- ***Program Requirements***

EasCare Mobile Health

Program Requirements



EasCare Mobile Health

Lessons Learned

EasCare
Mobile Health

MIH requires Flexibility

EasCare Mobile Health

Case Study

- Saturday 22:34 Increasing Snow (10” predicted)
- Private residence, Family with pt, PCA due at 11:00
- 37 y/o F c/o Weak, Increased confusion, low grade fever, Urine (dark), Productive Cough
- PMHx: TBI, Quadriplegia, Vent Dependant, HTN, Depression, Diabetes Type II, Sub-Pubic Cath

What are the MIH options??

EasCare Mobile Health

Agenda

1. ROUTINE ITEMS:
   a. Welcome and Introductions
   b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   a. Review of Paramedic Scope of Practice (PRESENTATION)
   b. Cataldo SmartCare (PRESENTATION)
   c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   a. Background and Need for 111O (PRESENTATION)
   b. Defining Questions and Opportunities (DISCUSSION)
   c. Upcoming Meeting Schedule

Background of 111O

This presentation will clarify Chapter 111O and address some critical questions raised at the first Council meeting (from a legal perspective):

- Why is Chapter 111O necessary?
- What barriers prevented MIH in MA?
- What is not covered by Chapter 111O?

Evolution of Chapter 111O

Chapter 111O is tied to changing role of EMS providers in community health care delivery

- **Starting Point: M.G.L. c. 111C –** Massachusetts Emergency Medical Services (EMS) System; authorizes DPH to act as lead agency in creating unified statewide EMS system;
- Originated in 1973 and redrafted in 2000 as part of "EMS 2000";
- Statute defines/limits role of licensed ambulance services and EMTs;
- Creates duty to dispatch emergency response; to provide potentially life-saving care to ill or injured patient; and to transport patient to ED;
- Operative word throughout chapter 111C: "Emergency".

Dilemma: Can licensed ambulance services partner with primary care providers to provide *nonemergency* medical services to patients in need?

111C Limitation: Definition of Emergency

Definition of "emergency" – a condition or situation in which an individual has a need for *immediate* medical attention, or where the potential for such need is perceived by the individual, a bystander or an emergency medical services provider

Take-away: emergency response excludes planned wellness check-ups, post-discharge visits

111C Limitation: Medical Control and Direction

EMS personnel required to function under medical direction and medical control through:

- **Off-line pre-hospital emergency treatment protocols** (known as Statewide Treatment Protocols) – written medical instructions and standing orders governing care provided by EMS personnel
- **On-line medical direction** – real time communication with medical control (ED) physician; deviations from protocols allowed only as authorized by hospital-based on-line medical control (ED) physician
- **Medical Control and Direction** – Emergency Medical Services-based
  - Affiliate Hospital Medical Director (AHMD) is responsible for granting "authorization to practice" for EMS personnel; and
  - Ensuring that EMS personnel receive appropriate medical direction by qualified medical control ED physicians

Take-away: excludes medical control and direction by primary care practitioners

111C Limitation: Patient Transport

DPH's authority governing nonemergency responses is limited to ensuring the provision of:

- Timely inter-facility transportation of patients to hospitals, other facilities or programs which offer follow-up care and rehabilitation, in order to optimize utilization of available facilities

Take-away: excludes direct patient care in home

111C Limitation: Delivery System Integration

While DPH Commissioner has legal authority to waive EMS regulations, (i.e., transport to ED), she cannot waive statutory provisions

- Fundamental principal of law: agencies have no authority to issue rules or create programs that exceed the statute

Take-away: Chapter 111C prevents full integration of EMS into community health care delivery systems

EMS Special Projects

Chapter 111C limited work-around for Special Project Approval Requests:

- Definition of *"emergency"* provided sufficient flexibility to carve out a role for community paramedicine under 111C as follows:
  - Patient calls provider's clinician (not 911) during special project hours;
  - Patient describes a condition that needs (or patient perceives need) for immediate medical attention;
  - Clinician determines that patient's medical needs warrant community paramedicine response rather than 911;
  - Community paramedic's clinical interventions adhere to Statewide Treatment Protocols (STP) and pre-approved STP deviations; and,
  - Other conditions/"guardrails" imposed on projects (e.g., training, AHMD oversight, med control delegations to PCP clinicians, 911 trigger, QC)

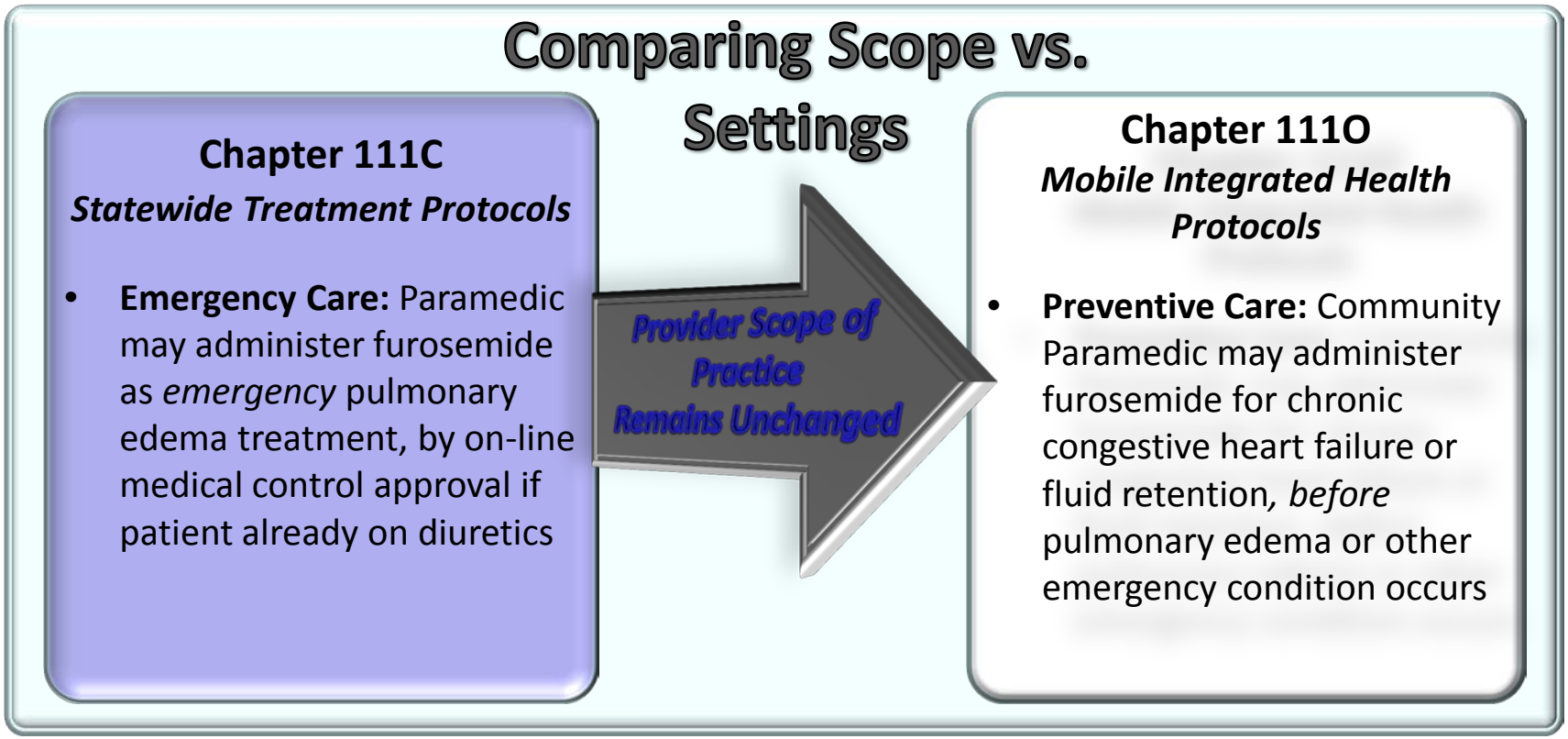
111O Flexibility: EMS in Nonemergency Services

Ch. 111O provides statutory framework for integrating EMS and other providers into community health care delivery systems

- Affirmatively authorizes ambulance services to partner with other healthcare entities to provide MIH
- By definition, MIH means **nonemergency** services or treatment, (preventative care, post-discharge follow-ups, chronic disease management, transport or referrals to facilities other than hospital emergency departments)

111O Flexibility: EMS in Nonemergency Services

Ch. 111O expands the settings and environments an EMS providers may encounter, but does not expand EMS provider's scope of practice



111O Flexibility: Medical Control and Direction

Provides a more flexible definition of “medical control” and “medical direction” to allow primary care practitioner to provide off-line/on-line orders and direction to MIH providers

- "Medical control'', the clinical oversight provided by a qualified physician or existing primary care provider to all components of the MIH program, including, but not limited to, medical direction, training, scope of practice and authorization to practice of a community paramedic provider, continuous quality assurance and improvement and clinical protocols
- "Medical direction'', the authorization for treatment provided by a qualified physician or existing primary care provider in accordance with clinical protocols, whether on-line, through direct communication or telecommunication, or off-line through standing orders

Provides flexibility for determining use of mobile resources to meet the patient’s medical needs

- Provides general guidance for approval of MIH programs; focus based on continuity of care

111O Flexibility

- In Section 2(b), 111O establishes minimum statutory criteria or "guardrails" governing DPH approval of MIH programs
- These minimum statutory guardrails mirror the Triple Aim goals of:
  - improving patient health;
  - improving patient experiences in the health care delivery system; and
  - decreasing health care costs.
- MIHAC task: to assist in further defining/fine-tuning these guardrails for regulatory use

Not Specified in 111O

- The types of contractual/business arrangements between MIH Providers that define roles, responsibilities, risk-sharing, etc.
- Liability and immunity protections
- Reimbursement and funding mechanisms

Agenda

1. ROUTINE ITEMS:
   a. Welcome and Introductions
   b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   a. Review of Paramedic Scope of Practice (PRESENTATION)
   b. Cataldo SmartCare (PRESENTATION)
   c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   a. Background and Need for 111O (PRESENTATION)
   b. Defining Questions and Opportunities (DISCUSSION)
   c. Upcoming Meeting Schedule

Framing for Discussion

Pre-MIH statute: Limited MIH Special Projects Approved Under MGL 111C

LIMITATIONS: MGL 111C / EMS Statute

Solution to MGL 111C Limitations: Creation of MGL Chapter 111O / Mobile Integrated Health and Community EMS

Regulatory Need: If 111O resolved the limitations driven by 111C, what is the purpose of the MIHAC meetings and DPH regulations?

Market Opportunity: The market is able to build a new industry by creating new partnerships and program designs within the constructs of MGL 111O

Conclusion: DPH and MIHAC's role is limited to determining the minimum "guardrails"

Exercise: Patient Safety

If your organization wished to create a new "MIH Program" with each organization represented by your fellow MIHAC members:

- **What obstacles still exist that would prevent an effective program** (understanding that policy considerations such as payment and access are separate but needed conversation)?
- **What minimum guardrails do you believe are necessary to ensure quality care and patient safety?**
- **Of these, are there any that should be determined by the applicant versus DPH?**

Agenda Planning

Planning for MIHAC's January meeting: DPH Staff will send you a table to complete in advance of our next meeting:

- Please complete this exercise with your agency/organization
- What obstacles exist that DPH can contemplate or solve for within the MIH regulations?
- What guardrails are needed?
- Are those guardrails spelled out in regulations or within the application?
- What other information/presentations do you feel you need to complete this exercise?

Agenda

1. ROUTINE ITEMS:
   a. Welcome and Introductions
   b. Adoption of November 16, 2015 Meeting Minutes (VOTE)

2. OVERVIEW OF EXISTING PARAMEDIC PRACTICE AND SPECIAL PROJECTS:
   a. Review of Paramedic Scope of Practice (PRESENTATION)
   b. Cataldo SmartCare (PRESENTATION)
   c. EasCare Mobile Health (PRESENTATION)

3. NEW BUSINESS:
   a. Background and Need for 111O (PRESENTATION)
   b. Defining Questions and Opportunities (DISCUSSION)
   c. Upcoming Meeting Schedule

Upcoming Meeting Schedule

The Following dates/times are confirmed for future MIHAC meetings:

- **Wednesday, January 6** – 1:30 PM - 3:30 PM
- **Monday, February 1** – 9:30 AM - 11:30 AM
- **Friday, February 26** – 1:00 PM - 3:00 PM

Please note that DPH staff will be sending out another doodle poll to identify future meeting dates