Mobile Integrated Health Advisory Council

Massachusetts Department of Public Health

January 6, 2016

Agenda

1. ROUTINE ITEMS:
   - **a. Welcome and Introductions**
   - b. Adoption of December 14, 2015 Meeting Minutes (VOTE)

2. NEW BUSINESS:
   - a. Defining MIH's Patient Safety Guardrails (DISCUSSION)
   - b. Defining Access and Duplication (DISCUSSION)
   - c. Upcoming Meeting Schedule

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Commonwealth of Massachusetts
Department of Public Health

Adoption of Meeting Minutes

Motion to adopt MIHAC December 14, 2015 meeting minutes **(VOTE)**

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Themes From Last Meeting

Several key questions came out of MIHAC's December meeting:

- **What are the minimum "guardrails" for quality and patient safety?**
- **What is the balance between access and duplication?**
- What is the role of MIH Programs in relation to ED aversion?
- How should MIH Programs/911 interact?
- What is the distinction between Community EMS and MIH?
- Program Administration
  - Application fees?
  - Application review timeline?
  - Complaints and Investigations?
  - Inspections?

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Patient Safety Exercise

In planning for today's meeting: DPH staff received feedback from MIHAC members regarding patient safety "guardrails" meant to help facilitate and inform today's discussion.

- Feedback included the Quality of Care/Patient Safety "Topics" that members brainstormed in December
- The goal is:
    1. Are these topics viewed as needed "guardrails";
    2. Are there any missing?
    3. And for those viewed as needed, where and how should they belong within the regulatory and programmatic construct (Reg vs. App vs. by MIH Program)

Patient Safety Exercise

The following Quality of Care/Patient Safety "Topics" were identified as needed "guardrails" by most responding MIHAC members:

- Training
- Treatment Protocols
- Care Coordination
- Complaints/Investigations
- Informed Consent
- Interoperability/Data Systems
- Medical Direction
- Patient Education
- Program Renewal Frequency

Note: The following summaries represent DPH Staff synthesis of common themes received from MIHAC membership. At this time, statements do not represent official DPH policy positions (Slides 10-20).

Training

Regulation: To ensure *"sufficient training pursuant to the proposed scope of the MIH Program's work,"* DPH should require MIH Programs to include additional training (beyond individual scope of practice requirements) for all responding clinicians, ongoing educational standards, core competencies, and assessment tools. This additional training should take into account unique social/cultural, linguistic, and population health needs of the proposed population served, and providers of online medical control should be properly trained and credentialed.

Application: DPH should require that applicants demonstrate all clinicians have been adequately trained to address the unique social/cultural, linguistic, and population health needs of the proposed population served. To demonstrate this, the application should include:

- basic certification criteria for providers (if applicable);
- detailed curricula;
- assessment tools;
- initial/ongoing training requirements, including but not limited to curriculum content and delivery (*i.e.* didactic, simulation, e-learning, etc.); and,
- frequency.

Training should, at a minimum, include components on community paramedicine, care coordination, and prevention and wellness.

On-File: All programs should be required to maintain documentation of training standards, competencies, assessments, and records of completed trainings by all responding clinicians.

Comment(s) of Note: Comment received encouraged DPH to simply ensure compliance with individual practitioners' scope of practice requirements (nothing beyond).

Treatment Protocols

Regulation: DPH regs should require all MIH Programs to develop treatment protocols and to maintain these protocols on file and available for inspection/review.

Application: DPH application should require demonstration that applicants have adopted care-specific treatment protocols which address the unique needs of the proposed patient population.

On-File: DPH should require that programs maintain comprehensive protocols on file. MIH programs should keep records of how treatment protocols are used. All programs should maintain documentation of standard operating procedures governing the management of patients with life-threatening conditions who require emergency resuscitation.

Care Coordination

Regulation: All agreed that there should be no specific requirements.

Application: Applicant should provide program-specific metrics to be used to measure improved care coordination and patient care management. Should require that MIH programs have protocols and operating procedures around clinical documentation of encounters and transmission of this information to the next treating clinician; a process in place to schedule and communicate referrals to the next treating clinician; and any other documentation sufficient to show evidence of the care coordination infrastructure required to meet the unique needs of the proposed population.

On-File: All programs should maintain and have available for review and inspection documentation of standard operating procedures governing clinical documentation standards, care coordination, and transmittal of referrals.

Complaints/Investigations

Regulation: N/A, or simply point to clinician's or service's licensure boards.

Application: DPH should require applicants to demonstrate sufficient policies and procedures to manage and investigate complaints or quality of care concerns.

On-File: Applicant should be required to keep on file standards and methods by which the program investigates and addresses any complaint. Applicant should keep on file any complaints received which can be reviewed during re-licensure or inspection.

Informed Consent

Regulation: Regulation should state the need for informed consent. DPH should require all programs to maintain documentation of standard operating procedures around informed consent for each clinical encounter.

Application: N/A

On-File: Programs should maintain documentation of obtained informed consent for each patient encounter.

Interoperability/Data Systems

Regulation: DPH should maintain regular program reporting requirements consistent with current MIH special projects.

Application: Applicants should have the technological capability to coordinate between the different participants in the program with documented policies and procedures around data management, data transfer, and HIPAA compliance. Additionally, there should be multidirectional flow of data for CQI/QA.

On-File: Programs should be required to maintain documentation of policies and procedures around data management, patient care activities, CQI/QA, medical control, etc.

Comment(s) of Note: Several comments suggest a requirement that all MIH programs be fully EHR interoperable.

Medical Direction

Regulation: DPH should require all applicants to demonstrate that real-time physician medical oversight is provided at all times. Recommendations to expand current 111C "Medical Direction" definition for the purposes of 111O to include non-emergency MDs, with specialties best suited for proposed patient populations served.

Application: Applicant should submit documentation of medical oversight/affiliation agreements, policies and procedures to demonstrate real-time medical oversight, identification of all medical directors involved in MIH program, and documentation of training provided by oversight MDs.

On-File: All program should be required to maintain documentation of medical oversight clinicians, names and current licensure, records of qualification, and letters of commitment. Affiliate Hospital and Agency Required should maintain records of affiliation.

Comment(s) of Note: In cases where the MIH Program is *not* the primary 911 service provider, DPH should require that the 911 system be activated in events of emergency, unless, at the determination and direction of the MIH Program medical director, waiting for a 911 response may jeopardize the patient.

Patient Education

Regulation: DPH should broadly require MIH Programs to develop and maintain patient education programs/materials that will provide direct education to all patients, taking into account the unique social/cultural, linguistic, and population health needs of the proposed population served.

Application: N/A

On-File: N/A

Quality Measures/Reporting

Regulation: See Interoperability/Data Systems: *DPH should maintain regular program reporting, including quality measures, consistent with current MIH special projects.*

Application: DPH should require attestation of regular data collection and submission to DPH.

On-File: N/A

Comment(s) of Note: Comment received that recommends use of Pioneer ACO quality measures for MIH Program reporting.

Program Renewal

Regulation: Several suggestions received: *"annual, then every two years, then every three years, linked to performance"; "every 2 years"; "every 3 years"; "align with EMS service licensure schedule".*

Application: N/A

On-File: N/A

Other

Regulation:

- DPH regs should require that MIH programs are (at a minimum) a collaboration between an EMS provider and a health care entity for which the care of a specific patient population is attributed.
- DPH regs should stipulate that DPH shall "prioritize review" of MIH applications that focus on Medicaid or other higher risk patient populations, or any applications that involve DSH hospitals.
- DPH regs should make reference to coordination with and support of other state agencies with regards to payment and delivery system reform, particularly DOI and Medicaid.

- **Application:** N/A
- **On-File:** N/A

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Access and Duplication

Question of Access and Duplication: Section 2(b) of MGL Chapter 111O:

The department shall evaluate and approve MIH programs that meet the following criteria:

(ii) ***address gaps in service delivery*** and prevent unnecessary hospitalizations, or other harmful and wasteful resource delivery;

(iii) focus on partnerships, through contracts or otherwise, between health care providers and health care entities that promote coordination and utilization of existing personnel and resources ***without duplication of services***;

Language requires programs to increase access, *but without* "duplication of services"

Access and Duplication

Question: Should "gaps" or "duplication of services" be further defined?

If so, how and where?

Follow-Up Questions:

- Do quality, access, and price constitute "Gaps"?
- If so, are there situations where filling one of those gaps might also be a "duplication of services"?
- Are all services that provide similar offerings or "outputs" the same service?
- If not, what are some of the factors DPH should consider to differentiate?

Access and Duplication

Example Situation:

Does a service that is viewed as “inaccessible” due to price, transportation, cultural competency, or other quality/access factors create a “Gap” that an MIH Program could fill?

What if it’s providing a similar offering or “output” as a competitor?

Is this a duplication of service?

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Agenda Planning

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

Term:	Proposed Definition:	Proposed Measures:
"Gap in Service Delivery"	***EXAMPLE ONLY:*** "Gap in Service Delivery means an opportunity for clinical service improvement for a defined patient population, as identified by an applicant, which if met, would result in improved outcomes and access to said population, including but not limited to decrease in price, improved cultural competency of services, reduction in inpatient and emergency visits, and other factors as defined by the applicant."	❑ Using this proposed definition, what are the measures by which the Department can confirm an applicant's gap analysis?
"Duplication of Services"	***EXAMPLE ONLY:*** "Duplication of Services shall constitute any proposed application which does not address a Gap in Service Delivery as determined by the Department."	❑ See above.

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

- **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