# Mobile Integrated Health Advisory Council

**Bureau of Health Care Safety and Quality**
**Department of Public Health**

**November 16, 2015**

# Agenda

## 1. ROUTINE ITEMS:

a. Welcome
b. Introductions

## 2. OFFICE OF GENERAL COUNSEL:

a. Open Meeting Law
b. Quorum
c. Remote Participation **(Vote)**

## 3. OVERVIEW AND HISTORY OF MOBILE INTEGRATED HEALTH

## 4. NEW BUSINESS:

a. Discussion of Mobile Integrated Health Advisory Council's Objectives and Work Plan
b. Upcoming Meeting Schedule

Commonwealth of Massachusetts
Department of Public Health

# Advisory Council Membership

- 19-member council created in the FY16 GAA to guide the Department of Public Health in establishing a regulatory framework for mobile integrated health in Massachusetts
- Chaired by DPH's Director of the Bureau of Health Care Safety and Quality or designee
- MIHAC members represent diverse perspectives and are appointed by the Commissioner from:

- Division of Medical Assistance
- MA Hospital Association, Inc.
- MA Council of Community Hospitals, Inc.
- For-profit hospital system-not part of hospital advocacy group
- MA Senior Care Association, Inc.
- MA Medical Society
- MA chapter of the American College of Emergency Physicians
- MA Nurses Association
- Home Care Alliance of MA
- Professional Fire Fighters of MA
- Fire Chiefs' Association of MA
- International Association of EMTs and Paramedics
- MA Ambulance Association
- Hospice & Palliative Care Federation of MA
- Association for Behavioral Healthcare
- Health care organization serving MassHealth members under 118E, § 9D, 9F (dual eligible programs)
- (2) Additional payor representatives

# Member Responsibilities:
## Conflict of Interest and Open Meeting Law

# Member Responsibilities: Conflict of Interest and Open Meeting Law

- **Conflict of Interest Law (COI):** MIH Advisory Council members are "special state employees" subject to COI law
  - COI law is meant to prevent conflicts between a state employee's private interests and his or her public duties
  - To obtain confidential legal advice regarding how the COI law applies to you in a particular situation: **Contact State Ethics Commission: "Attorney of the Day" program: (617) 371-9500**
  - Education and Training requirements: Summary of COI Law for State Employees (return signed Acknowledgment of Receipt)
  - On-line training through DPH's PACE (Performance and Care Enhancement Learning Management System)
  - Information regarding access to PACE will be sent to members
- **Open Meeting Law (OML):** as public body, members are subject to the OML

# Open Meeting Law

- The OML is designed to ensure transparency in the **deliberations** of public bodies

- A **deliberation** is:
  - an oral or written communication, through any medium, **including electronic mail,**
  - between or among a **quorum** of a public body,
  - on any public business within its jurisdiction.

- **If a quorum of a public body wants to discuss public business within that body's jurisdiction, they must do so during a properly posted meeting**

# Deliberation

A **deliberation** does not include:

- Distribution of a meeting agenda, scheduling or procedural information

- Reports or documents that may be discussed at a meeting (often helpful to public body members when preparing for upcoming meetings), **provided that no member of the public body expresses, via reply, an opinion on matters within the body's jurisdiction**

# Quorum

- A quorum is defined as a **simple majority** of the members of a public body, unless otherwise provided in a general or special law, executive order, or other authorizing provision. G.L. c. 30A, § 18

- As applied to the MIH Advisory Council – **a quorum equals 10 members**

# Designation

Per guidance from the Office of the Attorney General:

1. If a member appointed by the Commissioner designates a representative to attend all future meetings on their behalf, then that representative would become the designated public body member for the purposes of the OML

2. A member appointed by the Commissioner **CANNOT** designate a representative to attend various meetings on their behalf. For the purposes of the OML (and quorum), the representative would not be considered a public body member

# Remote Participation

- The Attorney General's Regulations, 940 CMR 29.10, permit members to participate remotely in future public meetings if the public body specifically votes to allow remote participation

- **The Attorney General <u>strongly</u> encourages members to physically attend meetings whenever possible**

# Reasons for Remote Participation

- Once remote participation is adopted, any member of a public body may participate remotely if the chair (or, in the chair's absence, the person chairing the meeting) determines that one of the following factors makes the member's physical attendance unreasonably difficult:
  - Personal illness;
  - Personal disability;
  - Emergency;
  - Military service; or
  - Geographic distance.

# Means for Remote Participation

- Acceptable means of remote participation include:
  - Telephone;
  - Internet;
  - Satellite enabled audio or video conferencing; or
  - Any other technology that enables the remote participant and all persons present at the meeting location to be clearly audible to one another.

- The public body determines which method to use

# Minimum Requirements for Remote Participation

- A quorum of the body, including the chair, must be **physically present** at the meeting location;
- Members of a public body who participate remotely and all persons present at the meeting location must be clearly audible to each other; and
- All votes taken during a meeting in which a member participates remotely **must be by roll call vote**

# Remote Participation: Proposed Vote

Motion to:

1) Approve the use of remote participation by MIH Advisory Council members at subsequent meetings in accordance with 940 CMR 29.10; and

2) Authorize the Chair or her designee to determine the acceptable method of remote participation at a particular meeting, based on available audio or audio/video conferencing technology.

# Historical Overview of Mobile Integrated Health

# What is Mobile Integrated Health?

Defined by Chapter 111O as a health care program approved by the department that:

- utilizes mobile resources to deliver care and services to patients in an out-of-hospital environment;
- in coordination with health care facilities or other health care providers;
- provided, that the medical care and services include, but are not limited to,
  - community paramedic provider services,
  - chronic disease management,
  - behavioral health,
  - preventative care,
  - post-discharge follow-up visits, or
  - transport or referral to facilities other than hospital emergency departments

# Mobile Integrated Health

- Mobile Integrated Health is an evolving practice in pre- and post-hospital care, focused on integration of health services

- MIH focuses on fulfilling the Institute for Health Improvement's *Triple Aim* to
  - Improve the patient experience of care
  - Improve the health of populations
  - Reduce the cost of health care

- There are over 100 pilot projects in over 30 states

# Massachusetts Special Projects

- Two (2) special projects currently operating in Massachusetts
- These MA special projects include large ambulance services in partnership with a hospital and ACO
- Both focus on preventing readmissions for medically complex patients
- It should be noted that legislation requires DPH's approval of existing special projects to remain in effect until regulations are promulgated

# Special Projects: Cataldo SmartCare

- Partnership between Cataldo and Beth Israel Deaconess' Post-Acute Care Transitions (PACT) team
- Targeted at preventing hospital readmissions among elderly Medicare patients of BIDMC's primary care practices
- Patients identified as high-risk for hospital readmission are cared for by PACT team
- SmartCare community paramedics act as a supplement to PACT team, evaluating patients with urgent complaints, ensuring safe home environments, coordinating with PACT and Primary Care staff, and providing treatments in the home
- As of September 2015, SmartCare reported 31 patient encounters and 4 patients transported to ED
  - Over 85% of patient seen were cared for at home, averting ED visits or admissions

# Special Projects: EasCare Mobile Health

- Partnership between EasCare and Commonwealth Care Alliance (CCA)
- Targets Medicare/Medicaid dual eligible patients under the state's One Care program
- CCA patients triaged by nurse call line, community paramedics sent to homes for evening and overnight urgent/acute complaints
  - Treatment plans formulated and executed in consultation with NPs/MDs
- As of September 2015, EasCare reported 363 calls for service for over 350 patients
- As of May 2015, EasCare reported a total of 63 ED visits and admissions avoided (83% reduction)
- In September 2015, EasCare reported 8% of patients seen by community paramedics were sent directly to emergency department, 5% were seen subsequently in ED within 72 hours of CP visit, some for unrelated complaints
- As of June 2015, EasCare projected $656,700 system savings from ambulance transports and ED visits/admissions averted
  - $3,283.50 per patient interaction (based on national average costs from CDC)

# Establishment of MIH in Ch. 111O

- The Legislature included Mobile Integrated Health (MIH) language in the FY16 GAA
  - Chapter 111O of the Massachusetts General Laws
- Massachusetts is one of only two states with comprehensive statutory language for statewide MIH
- Placement by Legislature in a new Chapter of MGL distinct from 111C (EMS statute) removes many of the previous statutory constraints
  - More flexibility to allow for more innovative models of care delivery

# Chapter 111O

- Defines MIH as:

  "a health care program approved by the department that utilizes mobile resources to deliver care and services to patients in an out-of-hospital environment in coordination with health care facilities or other health care providers; provided, that the medical care and services include, but are not limited to, community paramedic provider services, chronic disease management, behavioral health, preventative care, post-discharge follow-up visits, or transport or referral to facilities other than hospital emergency departments"

- Designates DPH as the lead state agency for MIH services in Massachusetts
- Directs DPH to evaluate and approve MIH programs based on a statutory set of criteria
- Establishes the MIH Advisory Council to guide DPH as needed in its establishment of a regulatory framework for MIH in Massachusetts

# Overview of MIH Legislation

## Section 2 of Chapter 111O of the Massachusetts General Laws directs DPH to promulgate regulations that:

- Require coordinated continuum of care that fully supports the patient's medical needs in the community
- Address gaps in service delivery and prevent unnecessary hospitalizations, or other harmful and wasteful resource delivery;
- Focus on partnerships
- Create clinical standards and protocols
- Ensure appropriate training and competency in MIH clinical protocols.
- Meet appropriate standards related to capacity, location, personnel and equipment;
- Ensure qualified medical control and medical direction;
- Develop secure and effective medical communication system for on line medical direction.
- Ensure appropriate activation of the 911 system when indicated.
- Ensure compliance with privacy laws
- Ensure appropriate data collection and analysis

# Scope, Role, and Timeline

# Scope and role of Advisory Council

## Consistent with its advisory role, DPH is seeking the Advisory Council's input on the following:

- Gap analysis/community needs assessment tool
- Definition of duplication of services

- Appropriate training and education standards
- Provider competency evaluation and continuing education standards
- Development of clinical standards and protocols

- Minimum requirements for "communications subsystem linkage"
- Policies and procedures for activation of 911 system

- MIH Sustainability

# Discussion

- **Framing**
  - Create a value-driven system of care that is motivated by optimizing patient outcomes, reducing health care costs and health disparities, and incentivizing new and integrated team-based approaches to health care delivery
  - Create a regulatory framework with the appropriate flexibility to allow for the creation of new and innovative delivery models that meet actual community and health care needs

- **Questions for discussion**
  - Right topics for future council meeting discussions?
  - Right groupings of topics for meetings?
  - What tools would you propose to facilitate a productive discussion?

# Proposed Timeline

**November - Spring 2016**

- Convene the Mobile Integrated Health Advisory Council (MIHAC)
- One or two MIHAC meetings per month
- MIHAC discussion of proposed regulations

**Spring 2016**

- Presentation of proposed DRAFT regulations to Public Health Council (PHC)
- Public hearing and comment period

**Summer - Fall 2016**

- Presentation of proposed FINAL regulations to PHC
- MIH regulations become effective – approximately three weeks later

# Scheduling

- We will be sending out a doodle poll to assist in scheduling upcoming meetings
- Please respond to the poll and indicate **all** meetings you are able to attend
- *At a minimum*, this poll will include the following options:
  - Monday, December 14 at 12:00 PM
  - Monday, December 14 at 1:00 PM
  - Monday, December 21 at 12:00 PM
  - Monday, December 21 at 1:00 PM
  - Wednesday, January 6 at 1:30 PM
  - Friday, January 15 at 12:30 PM
  - Tuesday, January 19 at 3:00 PM
  - Monday, February 1 at 9:30 AM
  - Friday, February 12 at 1:00 PM
  - Friday, February 26 at 1:00 PM

# Adjournment

Thank you!