

Mobile Integrated Healthcare – Community Paramedicine Workgroup
Virginia Office of Emergency Medical Services
1041 Technology Park Drive, Glen Allen, VA 23059
September 19, 2018
2:00 p.m.

Members Present:	Members Absent:	OEMS Staff:	Others:
Allen Yee, Chair		Tim Perkins	Christina “Tina” Maxson
Tamera Barnes		Gary Brown	Dan Stanford
Kelly Parker		George Lindbeck	
Kathy Miller		Scott Winston	
Amanda Lavin		Ron Passmore	
Travis Karicofe			
John Bianco			
Marcia Tetterton			
Wayne Perry			
Steve Higgins			

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome – Dr. Allen Yee:	The meeting was called to order at 2:05 p.m. Dr. Yee welcomed everyone for volunteering to be a part of this workgroup. There will be a lot of tasks in the near future and we will have to report to the Office of EMS and the EMS Advisory Board as the program continues to develop.	
II. Introductions:	<p>Everyone around the room introduced themselves.</p> <p>Mr. Gary Brown, Director of the Office of EMS, was asked to make a few comments. Mr. Brown stated that Dr. Yee was appointed by the Governor to serve on the State EMS Advisory Board. Dr. Yee asked if the goal was to eventually get this workgroup formed into a standing committee on the Advisory Board. Gary stated yes, that is the ultimate goal. There is a lot going on nationally with mobile integrated healthcare and we look forward to many communities to come on board in the Commonwealth.</p> <p>Mr. Ron Passmore, Regulations & Compliance Manager, stated that he and Tim are in the process of rewriting the regulations and Chapter 32 will be rewritten to add Mobile Integrated Healthcare (MIH) language.</p>	
III. Components of MIH-CP and it’s role:	<p>Dr. Yee stated that Tim created the agenda based on what we have done in the past. He suggested that the workgroup establish a mission and goals since the workgroup is being reformed in 2018. This was first discussed in 2015 and things have changed since that time.</p> <p>A video that was created by a group out of West Virginia was shown to the workgroup and paints a picture of what paramedicine is. As seen in the video, it involves others such as nurse practitioners.</p>	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	<p>They focus on a lot of disease management. In Virginia, other aspects are being looked at such as prevention, community health, and loyal customers. Previously, this workgroup did a lot of work with POST to make sure that the patients have a right to choose how, when and what to do towards the end of life – to respect the patient’s wishes. This is not something that EMS was very aware of until that collaborative.</p> <p>One of the committee members stated that in the video, she failed to see this as an emergency situation, but rather as home health. Mr. Passmore said that this may not be a great representation of what MIH is because it is very home health oriented, but is not what all community paramedicine programs look like. Each program is unique to the community it serves and what gaps it serves. The program that he was developing in his community before moving here, was to navigate the gaps. They were available to do the assessments at 2:30 a.m. There was no home health care at that hour.</p> <p>There was discussion about the EMS language. Amanda Lavin read the regulatory language and it has been changed to reflect other areas of health care, not just emergencies. Per Dr. Lindbeck, quite a bit of time has been spent with the Office of Licensure and Certification to discuss these issues. However, there is a bit of a gray area.</p> <p>Dr. Yee explained that the program works closely with home health care and they collaborate their efforts. Per Mr. Passmore, the number one priority of the program is to prevent the loyal customers from using emergency medicine as their primary care.</p> <p>It was suggested to collaborate with the Local Area Agencies on Aging. They are doing evidence-based programs to reduce readmissions within 30 days of discharge. AAA is also doing evidence-based programs in chronic disease self-management education through Stanford University Licensure.</p> <p>Dr. Yee stated that all of the components of MIH listed below are still very relevant.</p> <ul style="list-style-type: none"> i. Prevention ii. Community Health/Public Health iii. Community Resilience iv. Education v. Loyal customers/frequent callers vi. Mental Health vii. End of life care/decisions viii. Chronic Disease Management ix. Skilled nursing/long term facilities <p>It was suggested that the Virginia EMS community put together a video and not show the West Virginia video anymore. It is not representative of community paramedicine, it shows more of a home health care model. A one-page white paper that includes a description of what MIH-CP is and what services</p>	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	<p>are provided would be helpful. They want to share the information. Perhaps at the next meeting a couple of home health agency representatives can attend to explain how we collaborate with them and give some scenarios. The workgroup felt that this was a great idea. The workgroup discussed some of the services provided and the vast differences in the communities. It was suggested to provide some examples of what MIH-CP does in Virginia. It would be helpful to clear this up for the communities and to help establish other partnerships.</p> <p>Dan explained that he attended a Community Paramedic Mobile Integrated Health Care Conference in April in North Carolina. There was success story after success story all across the United States from Alaska to Charlotte. The community paramedics are doing telemedicine and in-home nebulizers, etc. In their experiences, they found that home health is usually reserved for those who are insured and community paramedicine is available for everyone. Home health typically runs out after 60 days and the community paramedic can see the patient up to a year. The social worker at the conference stated that the community paramedic goes into the home and sees that the patient does not have heat, food, running water or anyone to assist them and they can help link them up with resources to help them.</p> <p>Dr. Yee stated that they have learned a lot locally about discharge patients and they did med reconciliation posts. They gave feedback to the hospital so they could redesign their discharge program.</p> <p>Dr. Yee asked the workgroup if it is clear what MIH is or are there still questions. The workgroup seemed to understand, but the communities do not. He stated that the mission should be education: what is MIH in Virginia and what are the boundaries. Mr. Passmore stated that if we make a video, a home health agency should be in it to show the collaboration and discuss how they work together. Dr. Yee stated that the program is still growing and has not matured yet.</p> <p><u>Possible next steps of the workgroup:</u></p> <ul style="list-style-type: none"> • Create a mission statement • Work on education – White Paper, Video or PowerPoint presentation • Clarify or identify the boundaries – how far should we go • Develop relationships with hospice agencies • Identify financial barriers - billing/EMS reimbursement <ul style="list-style-type: none"> ▪ DMAS – Contact Karen Kimsey ▪ Anthem • Invite home health care agencies to attend the next meeting • Invite Area Agencies on Aging to the table for representation on the workgroup • Invite the Community Services Boards (CSB) (mental health) to the table • Invite a Public Health representative to the table <p>A couple of the workgroup members explained how they have partnered with the hospitals and what</p>	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	<p>they have done for the patient such as met with discharge planners/social workers and are now a part of the discharge planning process. They have a checklist to ensure that the patient follows that plan. They take them to pick up medications or take them to DMV to get ID's for social services, etc. They go back and meet with the hospital to give them an update on the things that the patient has done or completed.</p> <p>The workgroup then discussed mental health issues and how the community paramedics interact with the local police departments and social services.</p> <p>The workgroup also discussed end of life/hospice care and they are more than willing to collaborate with MIH. Hospice care is available for six months.</p> <p>Dr. Yee asked about the timelines for the meetings. Do we want to meet quarterly, bi-monthly, or monthly? The desire of the group is to meet quarterly in conjunction with the EMS Advisory Board. The next meetings are in November at the symposium. The workgroup has tentatively agreed to meet in the afternoon on Wednesday, November 7 in Norfolk at the Norfolk Marriott Waterside at 3 p.m. on the 4th Floor in the same room as the Advisory Board meeting.</p> <p>At the next meeting, we will brainstorm and flush out timelines. It was suggested to have some facilitated regional meetings, such as informational sessions. They want to get the word out to the communities. It would be more cost effective to create a PowerPoint or a white paper explaining collaborations. Dr. Yee stated that NFPA 451 is a draft that has been crafted that we could mirror the language from. There is also a possibility of doing regional meetings or town halls.</p>	
IV. Barriers to Implementation:	<ul style="list-style-type: none"> i. Resources ii. Financial iii. Educational iv. Regulatory 	
V. Open Discussion:		
VI. Date of Next Meeting:	Wednesday, November 7, 2018, Norfolk Marriott Waterside, 4 th Floor, 3 p.m.	
VII. Good of the Order:		
VIII. Adjournment	The workgroup meeting adjourned at approximately 3:55 p.m.	