Mobile Integrated Healthcare – Community Paramedicine Workgroup
Virginia Office of Emergency Medical Services
Embassy Suites by Hilton Richmond
2925 Emerywood Parkway, Richmond, VA 23294
August 27, 2019
10:00 a.m.

Members Present:	Members Absent:	OEMS Staff:	Others:
Dr. Allen Yee, Chair		Tim Perkins	Heather Anderson
Jimmy Mitchell		Chris Vernovai	Clarissa Noble
Travis Karicofe		Dr. George Lindbeck	Mike Riddle
Amanda Lavin		Scott Winston	Gary Samuels
Wayne Perry		Gary Brown	Carol Pratt
Carolyn Rinaca		Wanda Street	Richard Zucker
Marcia Tetterton		Hannah Lyons	Amy Ashe
Titus Castens		Greg Neiman	Steve Higgins
Brian Hricik			John Bianco
Jeff Woolsey			

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome – Dr. Allen, Chairperson	Dr. Allen Yee called the meeting to order at 10:00am.	
II. Introductions	Everyone around the room introduced themselves.	
III. Approval of the July 23, 2019 meeting minutes	Motion to approve the minutes. Motion was seconded.	**July 23, 2019 meeting minutes were approved.**
IV. Centra MIH-CP Concept Document Review	Tim Perkins gave a summary of the MIH-CP Summit to the work group. He said they are debating whether or not the Summit should be a part of symposium or if it should stand alone. Dr. Allen Yee indicated that Jimmy was running a few minutes late, and asked the workgroup if they were ready to give a product to the GAB. He asked what the product should look like, and what they were missing before the workgroup puts a packet together to send to the GAB. Ms. Ashe said there should be a presentation to be presented to the GAB. She volunteered Dr.	

	Allen Yee to create the PowerPoint. Dr. Yee indicated that the presentation should be ready by the spring GAB, but added that there would be an opportunity to present in November if everything was ready by that time. Mr. Karicofe indicated that a white paper would be helpful. Dr. Lindbeck said the white paper should be posted on the website so that people can refer back to it. Jimmy Mitchell arrived and started his presentation. He said it would be similar to the one at the summit a week ago. Potential funding options are important topics that he has been approached about. In the beginning, they put a focus group together and then presented the plan to senior leadership. Approval for pilot testing occurred and focused on 8 patients – of those, 85% were kept out of the hospital. This gave evidence that they should move forward. In 2018, their first year after the pilot program, they had almost 5,000 patients, and 650 patients signed up for the long term program (average lasting 4-6 weeks). They covered the health care systems entire coverage area, over 9000 square miles. In January of this year, Jimmy created an analysis of 10% of the patients enrolled. There was a 49.7% decrease in hospital readmission. At the very minimum, his program created a $1.3 million dollar reduction in cost for PCHP. To get started, a community needs assessment was necessary. Resources were provided to meet those needs, and there were conversations held to make sure all policies and regulations were respected. A variety of services were provided at homes. Nothing extreme and no skilled nursing procedures were done. Partners were established, including Home Health, doctors' practices, hospitals, and hospice & cancer centers. Many patients have several morbid diseases, so continuity of care was an important aspect for the program. The two largest roadblocks foreseen were partnerships with Home Health, and financing of the entire program. That is why these two things were secured first. The next step was to consider education of the paramedics to be able to participate in this program. There were 128 hours of classroom time, 128 hours of clinical time, Home Health training, mental health training, and cardiology & pulmonology training. Chaplin services were included. Now in this area, a mandatory ride along with Jimmy's program is necessary to be approved to provide these kinds of services.	

	Centra MIH-CP has built several ramps, installed hospital beds and hand rails, and provided walkers, wheelchairs, and bedside commodes. Most importantly, the program provides education on any disease with which the patient has been diagnosed. Individuals who were 65 years and older were recommended to receive information at a fifth grade reading level. The current state of the program has over 3500 patient contacts, over 2400 referrals, covers 9,200 square miles with four providers geographically placed, partners with several agencies, and does a variety of health care services. There are also virtual visits and home blood draws – this was especially useful as the blood could be sent and adjustments for medication could be made remotely. This freed up space and time in offices for other patients, and protected these people from being exposed to more diseases. There is also an available nurse practitioner. A new concept that has been introduced is ICU patient care. Based on statistics, most people who have been in an ICU have some sort of ICU syndrome. Centra MIH-CP has set up an ICU clinic which has nurses who will help the patients understand everything that happened while they were in the ICU. Future plans include tripling the size of the program in order to support the community more effectively, covering all service lines and primary care practices, and providing mental health care support for our own. A peer and support team should be available for all public safety and health care providers. The financial impact has been substantial. In the last few years, Virginia paid the following amounts: - 2016: 3.9 million in penalties - 2017: 1.7 million in penalties - 2018: 900,000 in penalties In addition to this trend of saving, there was 1.3 million dollars in savings from PCP. This program made this achievement possible because high utilizers are kept out of the ER and the trickle-down effect helps save money in almost every aspect of health care. The cost of the program makes this a good opportunity to save money on healthcare. The start-up cost was about $368,000. To sustain, the program costs $270,000 in recurring costs per year, and the majority of that is overhead costs.	

	Funding can come from grants, doctors' offices, insurance companies, ET3, hospitals, and PCHP (Centra's independent insurance company). There has been an attempt to reduce usage of resources since they are taxed so heavily. For each doctor's appointment, there is a 4-5 hour wait for the patient which is one downside of the program because it is not an effective use of resources. There are several assessment tools available that are not unique to the Centra MIH-CP program, including drug and alcohol assessment, home safety assessment, mental health assessment etc. There is a consent form patients must sign, and a HIPPA form to ensure safe and effective dissemination of patient information. Jimmy Mitchell then asked the workgroup if they had any questions. Ron Passmore asked if the bedside commodes and other items patients receive are being loaned. Jimmy Mitchel indicated that they are not loaned, but many of the patients give the supplies back, plus more as family members that were using the equipment pass away. Many issues have been avoided since Centra MIH-CP does not accept payment from patients or insurance. There have been some phone conversations with DMAS in the past that have been favorable. Dr. Allen Yee indicated that he has worked with Humana in the past which has worked well for community paramedicine programs. He asked Mr. Mitchell about the process for replacing each one of the original community paramedics that start with the program. Would the 128 hour didactic still be required? Mr. Mitchell answered that it would still be required. Mitchell indicated that although a program that is created may initially function a certain way, it can easily be changed to fit the needs of that specific community. Emphasis has been put on the paramedics having as comprehensive as possible view of the patients they will visit, from chronic diseases, mental health issues, to differing cultures and religions. There was also emphasis on the relationship with patient and how to communicate about patients to other health care practitioners. In the course is plenty of training on diversity, whether cultural or otherwise. Training on language has not been explored, but there are interpreters available at hospitals and other locations that are accessible.	

	A workgroup member asked if anything was being done to treat or direct people struggling with substance abuse issues. Mitchell answered that whatever the problem was, whether drug, mental health, etc., the patient was referred to the appropriate resource. Dr. Allen Yee announced that a white paper and a presentation for the Advisory Board were necessary. He asked the workgroup is there a format that the workgroup prefers, since white papers may not be as useful as something else. Dr. Lindbeck suggested links to regulations might be the most useful for people. Jimmy Mitchell indicated that it would be important for the audience to understand that they are not taking patients from home health care – almost all patients are not eligible for Home Health when they enter into Centra MIH-CP program. Dr. Lindbeck said the best plan of action is to keep the definitions loose since the needs of communities differ so much. Dr. Allen Yee asked Tim Perkins to write the white paper, and Dr. Lindbeck volunteered to help him. Dr. Yee and Jimmy Mitchel will work on the presentation. Jimmy Mitchel said apart from the white paper, there needs to be some sort of tool kit that walks people through starting an MIH-CP program in a concise manner. There should be a "road map" and then a manual for the road map for individuals to follow. John Bianco volunteered to create the tool kit that Jimmy Mitchell described. Dr. Allen Yee asked if the white paper could be done by the next meeting – Tim Perkins expressed that there might not be enough time. Chair Yee indicated that two months may be more reasonable. Dr. Yee asked Jimmy if the presentation would be finished by the next meeting and Jimmy agreed that it could. Dr. Yee asked John Bianco when the toolkit could be completed. Bianco said a draft would at least be done by October's meeting. Dr. Yee announced that November's meeting can be pushed to early December. John Bianco pointed out that sustainability may become a huge barrier, and that perhaps it should be its own section. Dr. Allen Yee agreed.	**Tim Perkins and Dr. Lindbeck will create the white paper for the meeting after next.** **Dr. Yee and Jimmy Mitchell will create the presentation for the next meeting.** **John Bianco will create a draft of the tool kit by October's meeting.** **The November meeting will be moved to early December due to the EMS Symposium.**

	Mr. Winston expressed to the workgroup that the 7,500 FFS (fee-for-service) 2017 Medicare Transport requirement would not be a barrier because it only counts for 3% of the application score, and is not a minimum requirement.	
V. MIH-CP Concept Document Review	Tim Perkins told the workgroup the concept document has not changed much except for the addition of bullets. Dr. Yee clarified that Community Paramedic will be allowed for all levels of providers, not just paramedics. Wayne Perry suggested that "Provider Definition" be added to the document. Dr. Yee asked if being solely a community paramedic was an option. Ron Passmore said the agency could be a sole MIH-CP provider. There was discussion regarding the training section. One workgroup member suggested that for the training section, it would be helpful to examine how in depth other states make their sections.	
VI. Open Discussion/Program Announcements	Amy Ashe spoke about PWW and their contribution to the Peninsulas EMS Council.	
VII. Old Business	None.	
VIII. Next Meeting Date – Doodle Poll	The next meeting date will be decided using Doodle Poll, as usual.	
IX. Public Comment	Dr. Yee told the council that it is important to keep in mind legislations about MIH-CP in the next meetings.	
X. Adjourn	The meeting was adjourned at 11:35a.m.	