Mobile Integrated Healthcare Advisory Committee

Date: August 12, 2020

Time: 10:00 a.m.

Location: Indiana Government Center South

302 W Washington Street

Indianapolis, IN

and via Microsoft Teams online

Members present: Dr. Michael Kaufmann, State EMS Medical Director

Kraig Kinney, State EMS Director

Chief Paul Miller, MIH-CP Program Director

EMS Chief Steve Davison, Municipal MIH-CP Program

Chad Owen, Non-municipal MIH-CP Program

Laura Schwab-Reese PhD, College/University

Shane Hardwick, MIH-CP Provider

Dr. Jennifer Sullivan, FSSA Representative

Keith Mason, Insurance Industry Representative

Dr. Lindsay Weaver, IN State Department of Health

Andy Van Zee, IN Hospital Association Representative

Nate Metz, IN Emergency Medical Service Association

EMS Chief Doug Randall, IN Fire Chiefs Association

Other Present: Robin Stump, IN State Fire Marshal Joel Thacker and Michael Supples.

Roll Call

Director Kinney welcomed everyone and ask for a roll call. Robin Stump called roll and Director Kinney stated we had quorum and also informed the committee of the two vacant positions and ask the committee if they had anyone that would have an interest to fill either the EMS Medical Director Representative or the Mobile Integrated Health-Community Paramedicine (MIH-CP) patient positions to please pass those names to him and Dr. Kaufmann.

Welcome Statement

Dr. Kaufmann thanked everyone for agreeing to participate on this advisory committee. He presented some background information regarding MIH-CP and give everyone some information on how we got to this point. He also spoke about goals that he would like for the committee to help come up with some recommendations to bring back to the EMS Commission. He stated that with the current pandemic we can tie MIH-CP as we look for ways to include EMS into testing sites and vaccines. He stated that everyday EMS in on the frontline of patient care, although our traditional role is to respond to emergencies, we are finding that not every call to 911 is a life threating emergency. In Indiana, EMS is called to respond to between 2,000 to 3,000 times a day with a workforce of over 24,000 certified or licensed personnel. We have a potential to not only help with responding to emergencies but to provide preventive care and public health. People call EMS because they know someone will come. We are lacking that the only thing we provide is emergency services to those individuals. One of the main steps that these programs have been able to do is to redefine EMS as not just a transportation benefit, rather than a health care benefit. Reimbursement only happens if transportation occurs so there are some hurdles to get passed for this to change. The concept of MIH is not new and we have been working towards this for over 24 years. Mobile integrated health as published in the EMS Agenda for the future in 1996. It stated that it will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resource and will be integrated with other health care providers and public health and public safety agencies. It will improve community health and result in more appropriate use of acute health care resource. EMS will remain the public's emergency medical safety net. The reason that EMS can do this is that EMS is a trusted professional in our communities, we are available 24/7 and imbedded in every community. Dr. Kaufmann ask the committee to consider a definition as we move MIH-CP forward we are really looking at the provision of healthcare and public health services using patient centered mobile resources in the out of hospital environment. A large field of CP is health care system navigation.

Dr. Kaufmann stated that there are currently 33 states that offer some type of MIH-CP and that 70% consider themselves as CP and 30% MIH. Community paramedicine got is tart in rural areas of Main, Minnesota and Nova Scotia Patients with chronic illness had little to no access to primary care and no way to even get to the doctor's office in rural communities. This concept allowed paramedics with specialized training to do what they have always done and function as an extension of the physician. Larger urban areas needed a way to decrease over-utilization of busy 911 systems in San Diego, San Francisco and Fort Worth.

Dr. Kaufmann stated that there has been new support for MIH-CP with various organizations but wanted to identify one from the American College of Emergency Physician's that was published about four years ago. The article published talks about a lot of the points that we have already considered, or we are looking at moving toward.

We need to look at targets for these programs. Some identify needs within their own communities. Many target re-admissions, frequent EMS and emergency department users or chronic disease management. These programs include health care navigation or alternative transportation destinations.

Another goal that Dr. Kaufmann ask the committee to think about as we move forward are ways to increase payment for these services. There is a cost to deliver this care and we want to make sure that these programs are self-sustaining. About 70% of our providers in the State of Indiana are municipal based. Indiana is leading the way not only with legislation but active development of MIH-CP programs. There are about 20 states that have current laws that are specific to allowing the practice MIH-CP.

Next goal to consider is the staffing of these programs. What services would be offered by our paramedics versus emergency medical technicians as the scope of practice will fall into place.

Next goal to be considered will be the training for these programs. Currently there is no training requirement for a MIH-CP program. Indiana does want to work toward scope of practice and reimbursement mechanism and with that we will have to show a baseline training for each program. We will need to decide if we want a separate certification or licensure to conduct this service versus a separate endorsement to and already existing certification or license. Training will need to be considered for initial as well as on-going education.

Next goal will be what data do we need to collect to show the value of the programs. Currently we do not have a requirement for these programs to collect and submit data. Today we are 100% compliant with Indiana providers reporting acute data from 911 calls. This has been a group effort to get this accomplished.

Dr. Kaufmann stated that MIH-CP is one of the top 20 agenda items on Governor Holcomb's 2020 Next Level Agenda. As the committee looks towards developing more of the guidelines and education requirements, data considerations, funding strategies we also need to look at how we promote and encourage more programs across the state of Indiana.

Dr, Kaufmann lastly talked about a study that the agency completed over the summer to look at all the programs across the country. We submitted all the results to the School of Public Health at Purdue University. They provided a summary and provided some recommendation from the study.

Introduction of Members

Each one of the members introduced themselves and gave some background of themselves and what they are currently doing within their program.

Review of Statutory Role

Director Kinney stated that Indiana does not have an official program at this time for MIH-CP. We also do not have a law that would prohibit a program either.

Director Kinney reviewed SEA 498 that was authored by Senator Karen Tallian. It did update the definition of EMS to include: transportation services, acute care, chronic condition services, or disease management service

provided as part of a mobile integrated healthcare program under IC 16-31-12. It gives the EMS Commission the authority to create the necessary rules-regulations concerning MIH-CP activities and seeks funding for reimbursement from FSSA. The bill established a grant fund to help support pilot programs across Indiana but was not funded. If the legislature does fund the grant it does state that any money in the fund at the end of the year does not revert back to the general so there is a cumulative effect there. The bill added a definition for mobile integrated healthcare, IC 16-31-12.1. This definition allows both EMT's and paramedics employed by provider organizations to function outside of customary emergency response and transport. The law also give the EMS Commission the authority to establish a subcommittee to review and establish guidelines for MIH-CP and this is the committee the Commission approved. The law does also authorize the EMS Commission to adopt rules.

Director Kinney reviewed HEA 1209. In 2020 this bill will allow for EMS reimbursement of non-transport activities originating from a 911 call. The bill adds IC 12-15-5-18.5 that the office of the secretary shall provide reimbursement for Medicaid covered services provided to a Medicaid recipient that are rendered by and EMS provider organization, within the scope of practice of advanced life support and performed or provided during a response initiated through the 911 system regardless of whether the patient was transported. Director Kinney stated that we would like to see a next phase of this bill and allow for more broad payment of prehospital care by paramedics.

Director Kinney stated that at the November 14, 2019 meeting of the EMS Commission approved the committee and approved the members that are attending today.

Determination of Organization Structure

Director Kinney discussed with the committee if they wanted an organization structure? He explained that there is a position assigned to the committee, but it is currently vacant. Director Kinney commented that Robin Stump is assigned to assist the committee at this time. Director Kinney was not sure that this committee needed an intense structure but wanted to let the committee decide. Director Kinney suggested that the chairperson should be someone that

Steve Davison and Nate Metz both suggested to keep Robin as the secretary until the position is filled.

Dr. Sullivan stated that the chairperson should be someone that regularly attends the EMS Commission meeting so there is easy communication and partnership between the two. She also stated that if Kraig would be willing to be the chairperson that the credibility and authority that he yields bring a certain gravitas to the organization. No one else spoke up to hold the position and everyone agreed to have Kraig Kinney as chairperson and Robin Stump as secretary.

Planning Goals for Future meetings

Dr. Kaufmann spoke about some of the programs that are already in existence. He would like for everyone to review the legislation, power points and white paper he spoke about today. He would like for the committee to begin to think about a framework to put around this program. We do not want to stifle the creation or a program that are already in there or in development. He would like to start looking at training and certification. The agency will be sending out some very specific direct goals to the committee to bring back to the EMS Commission.

Director Kinney agreed with Dr. Kaufmann that we have such a great broad base of members that we want to make sure we hear from everyone in the committee. Director Kinney spoke about the meeting we held at Plainfield that those in attendance gave a broad overview of each of their programs. Director Kinney would like to have one member to present their program at each of subsequent meetings of this committee.

Chief Randall commented that he would like to see us take a piece of each of the programs for what is best for Indiana.

Dr. Sullivan stated that the goal for Indiana Medicaid is to be the leader and the continuum of care. Instead of health care we talk about health. This include the entire spectrum of where you live, learn, work, and play to be healthier. If this means in your home with someone visiting you or telehealth service and delivery programs or moving into the traditional healthcare space and moving back and forth. Providers in healthcare are all of us, includes community health workers, EMS, and cross training between all our health care delivery programs so that it doesn't stop with each one but continues the care. The data needs to follow the people so that we can see what happens to someone at home or with EMS. Dr. Sullivan spoke about the Health Information Exchange that will allow us to have the outcome-based system.

There was discussion regarding the Indiana Health Information Exchange (IHIE) and the work that Indiana Department of Homeland Security and Indiana Medicaid has worked together on a grant proposal put together to submit to Centers for Medicare & Medicaid Services (CMS) for funding that will connect all the EMS data to the IHIE. You will be able to see what EMS provided and where they were transported to. The first step is to get all the EMS registry data into IHIE. Next step will be to get all EMS access to view all the hospital information through Careweb and then to get outcome data to get back to EMS Provider for quality improvement and all the benefits we are talking about.

Chief Davison spoke about the challenges they have had is getting the feedback from the behavioral health side. With SB 359 it has helped a little but they have a difficult time getting the information out in the field.

Director Kinney ask if there was standard training that each of the MIH-CP programs had and then are their additional modules based on what they provide. He would like to have members looks and see if there is training that each are doing and bring back suggestion on standard training to the next meeting.

Dr. Kaufmann stated that there is some of that information in the white paper for everyone to review.

Director Kinney suggested that the committee meeting on the off months from the EMS Commission meeting. The committee agreed on that schedule and also to conduct the meeting on Microsoft teams and that anyone can make comments on the teams platform so everyone can be engaged. He will look at the calendar and get a next date out to the group.

Both Dr. Kaufmann and Director Kinney both thanked the committee for participating and taking time out of their day to be on the committee and agreeing to work on their future development of this program.

Meeting ended at 11:10 a.m.

Prepared by Secretary Robin Stump.

Approved at the November 18, 2020, MIH Advisory Board meeting.