



Mobile
Integrated
Healthcare:
Part 1

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Strategic Planning for Rapid Implementation

How to work with stakeholders to deploy an MIH program

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Beginning this month, *EMS World* launches a yearlong series that will provide readers with a road map for developing mobile integrated healthcare programs.

This series will address the following topics:

- Data metrics and strategic goals;
- Collaborations with home healthcare;
- Updates on CMS Innovation Grants;
- Accreditation of MIH programs;
- Profile of the MIH Summit at EMS on the Hill Day;
- Payer perspectives for MIH services;
- Choosing MIH practitioner candidates;
- Education and training of MIH practitioners;
- MIH programs in rural settings;
- International models of MIH.

This month we look at strategic planning for rapid MIH implementation.

The Challenge

Healthcare stakeholders such as hospitals, physicians, payers, home health agencies and hospice agencies are quickly learning the impact EMS-based MIH programs can have on patient outcomes and the cost of care. While that is great news, it is also scary. In some instances they may want an MIH program faster than you can comfortably implement one.

What would you do if one of your local healthcare stakeholders called you *today*, said they'd heard about EMS-MIH and wanted to meet with you next week to get a program started? What gaps would you fill? What's the right delivery model? What education will the providers need? What data metrics should you track to demonstrate the value of the program? This article walks you through the steps necessary to strategically plan and rapidly deploy an MIH program for your community.

The Phone Call

It's Tuesday morning. You're sifting through the field operations schedule, trying to fill those last openings for Saturday night, when your phone rings. It's Liz Harris, the CFO of Mercy Medical Center, the largest hospital in your service area. Liz explains she just received the hospital's 2015 readmission penalty notice, and it's increased from 0.51% last year to 1.89% this year. She recalls that last year you met with them to discuss readmission prevention programs, but at that time the payments they were getting for the admissions were higher than the penalties being assessed. With the change in the penalty this year, the reverse is now true, and the hospital wants to start a program with you as quickly as possible. Liz invites you to a breakfast meeting tomorrow with her, the chief executive officer, chief medical officer, chief experience officer, chief nursing officer and vice president of care coordination. As your palms start to sweat, you accept the invitation, thank her for her call and hang up. *Game on!*

Your strategy for the meeting is crucial. As a savvy leader, you start assembling your innovation and integration team and invite them to a working lunch. The team includes your medical director, operations manager, communications manager, human resources manager, IT manager, clinical manager, compliance officer and billing manager. During lunch you work to frame out the questions you'll need to work through with the Mercy team in the morning:

- What's the problem Mercy would like to solve?
- Can EMS provide the right solution?
- What is the delivery model?
- Who all needs to be involved and committed?
- What training will be necessary for practitioners?
- Who will do the training?
- How will information be shared?
- What is the economic model?
- How will success be measured?

You agree to recommend to Mercy the use of a rapid implementation strategic plan using the “driver diagram” methodology (see *Figure 1*) recommended by the Center for Medicare & Medicaid Innovation.¹ A driver diagram depicts the relationship between the aim (the goal or objective of the program), the primary drivers that contribute directly to achieving it (the factors or components of a system that influence achievement of the aim) and the secondary drivers necessary to achieve the primary drivers.

Clearly defining an aim and its drivers enables the team to have a shared view of the theory of change in a system because it represents the team members' current theories of cause and effect—what changes will likely cause the desired effects. It sets the stage for defining the “how” elements of a project—the specific changes or interventions that will lead to the desired outcome.

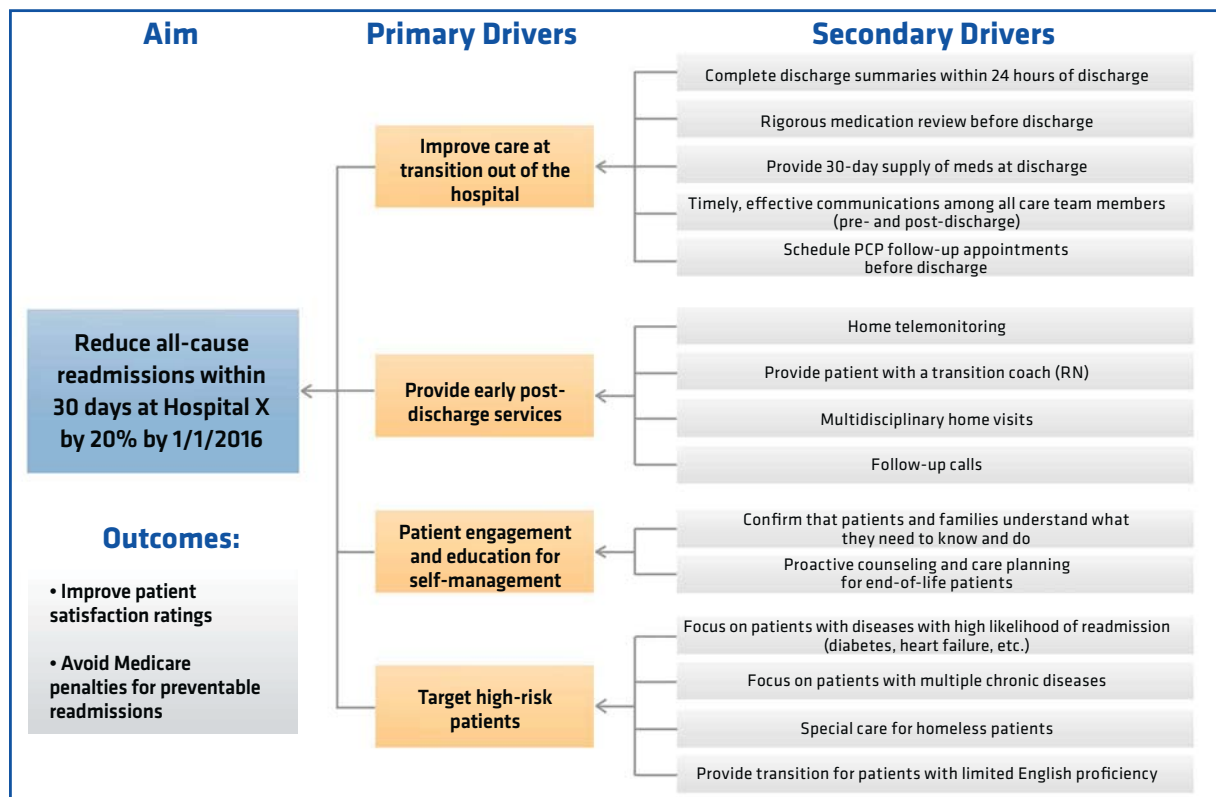


Figure 1:
Driver
Diagram

TABLE 1: STEPS TOWARD A STRATEGIC PLAN

QUESTION	SOLUTION
What's the problem Mercy would like to solve?	<ul style="list-style-type: none"> • Reduce 30-day readmissions for CHF discharges by 25% • Improve patient health status • Improve patient experience of care
Can EMS provide the right solution?	<ul style="list-style-type: none"> • Yes, with mobile resources, 24/7 availability and core competencies, as well as being a trusted partner in other projects and within the community
What is the delivery model?	<ul style="list-style-type: none"> • Care plans developed by PCP • Medical control shared between EMS medical director and PCP-cardiologist • Specially trained mobile healthcare practitioners in non-transport marked vehicles providing proactive home visits for education care integration • Enrolled patient access to 24/7 access to 10-digit medical call center for episodic needs • Patients identified as qualifying for home health referred to home health • Patients identified as appropriate for palliative care have a conversation initiated by MHPs and, if agree to, referral to hospice
Who needs to be involved?	<ul style="list-style-type: none"> • Mercy C-Suite • EMS agency innovations team • Discharge planning team • Cardiology team • Home health agencies • Hospice agencies • Local & state EMS agency regulator • State CMS Quality Innovation Network¹
What training is necessary for practitioners?	<ul style="list-style-type: none"> • 44 hours of focused CHF management, care transitions, motivational interviewing and The Conversation Project² • 20-hour classroom, 24-hour clinical rotations in CHF clinic and cardiology offices and hospice agency
Who will do the training?	<ul style="list-style-type: none"> • Cardiology nurse educators • Cardiologists • EMS medical director • Patient experience officer • Hospice nurses • Home health administrator
How will information be shared?	<ul style="list-style-type: none"> • Face sheets faxed to EMS agency with signed consents • Written record of each patient encounter sent electronically to hospital for upload to hospital EHR on shared platform with cardiologists • Related scoring tools conducted by EMS agency (health status, patient experience ratings)
What is the economic model?	<ul style="list-style-type: none"> • Budget developed by EMS agency and approved by Mercy • Mercy pays referral fee to balance EMS agency budget • Bonus payment to EMS agency by Mercy if goals are met or exceeded
What does success look like and how will it be measured?	<ul style="list-style-type: none"> • All-cause readmissions tracked by Mercy and the regional hospital council • 30-day post-discharge ED and admission data reported • Readmission ratio of expected to actual measured • Health status questionnaires completed • Patient experience surveys conducted

The Meeting

The next day your team is enthusiastically welcomed into Mercy's c-suite. During breakfast the Mercy team offers preliminary answers to the key questions your innovation team developed. They want to reduce 30-day CHF readmissions by a quarter. Together you come up with the strategic plan shown in *Table 1*.

All agree that in order to meet the goal, several joint Mercy/EMS task forces (*Table 2*) will need to be formed. The goal is implementation within 90 days.

With this plan you are well on your way toward a rapid implementation strategy. You agree to have weekly program implementation conference calls and face-to-face meetings every three weeks. During these meetings the task force leaders will report progress and everyone will help with accountability. The executive task force will work through thorny issues such as HIPAA compliance, health IT integration and contracting. The cardiology and EMS medical control leaders will meet with their constituents and get various protocols approved and contact processes resolved. The finance task force will assist with financing asset acquisition and setting up the billing process. The CMS Quality Innovation Network (QIN) participants on the clinical task force will offer assistance in developing the quality improvement and patient safety reporting processes and facilitate the reporting of outcomes to the state Medicaid office and CMS Innovation Center.

Because you are a well-connected EMS leader and have kept abreast of the MIH movement, you also decide it's time to "phone a friend." There are several industry thought leaders knowledgeable on this topic who have developed and implemented MIH programs, and you pick one to call. They are very helpful and offer to host the chairs of your task forces in a visit to see their programs in action, offer insight into the dos and don'ts of program implementation, and offer technical and strategic consulting help. The task force chairs are excited about the



TABLE 2: TASK FORCE DEVELOPMENT

TASK FORCE	GOALS
Executive/Sponsorship	<ul style="list-style-type: none"> • Ensure organizational commitment • Reach out to other stakeholders and brief on the proposed project • Home health • Hospice • Remove roadblocks to success
Clinical	<ul style="list-style-type: none"> • Select providers • Develop/implement training and credentialing • Develop/approve protocols • Develop equipment list • Resolve CLIA issues for point-of-care testing • Develop CQI process
Operational	<ul style="list-style-type: none"> • Introduce concept and secure support from the EMS agency workforce • Develop schedules • Acquire assets • Develop process map for referrals and operations
Financial	<ul style="list-style-type: none"> • Develop/approve budget • Develop payment model and billing process • Draw in 3rd-party payers to the team as consultants
Health IT	<ul style="list-style-type: none"> • Develop/implement patient care reporting process • Develop/implement data exchange process
Compliance	<ul style="list-style-type: none"> • Review and resolve state/local regulator issues • Develop/execute contract

opportunity and select a date for the visit.

By working collaboratively with all the internal and external stakeholders, you successfully launch your program 90 days after the first call from Liz. This is an amazing feat by any measure. You recall reading in the new Jones & Bartlett book, *Mobile Integrated Healthcare: An Approach to Implementation*, about organizational readiness and community needs assessments, and you reopen the book to those chapters. A smile comes to your face as you reread the section describing that, in some cases, the need comes to you faster than you thought, and you should to be ready to move quickly. "Yeah, I get that." ☺

REFERENCES

1. <http://innovation.cms.gov/files/x/hciatwoaimsdrrs.pdf>.
2. www.qualitynet.org/dcs/ContentServer?cid=1228774346757&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page#TMF.
3. <http://theconversationproject.org/>.



ABOUT THE AUTHOR



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