



Florida Mobile  
Integrated Healthcare  
Community Paramedicine  
**Program Guidebook**



# CREDITS

People and organizations who provided assistance or contributed to the Guidebook

---

## Ariella Bak

*Integrated Mobile Healthcare Coordinator,  
Gainesville Fire Rescue*

---

## Rich Barner

*EMS Manager,  
Highlands County EMS*

---

## Jane Bedford

*Director of Education and Clinical Services,  
Nature Coast Emergency Medical Services*

---

## Juan Cardona

*EMS Division Chief,  
Coral Springs Fire Department*

---

## Wendy Crews

*Area Supervisor,  
Excelsior Ambulance*

---

## James Crutchfield

*Director of Community Paramedicine,  
Manatee County Public Safety*

---

## Orlando Dominguez, Jr.

*Assistant Chief of EMS Operations,  
Brevard County Fire Rescue*

---

## Richard Ellis

*Chief of EMS,  
Palm Beach County Fire Rescue*

---

## Timothy Ewing

*Community Paramedic,  
Sunrise Rescue*

---

## Joe Goodwin

*Ambulance Systems Service Director,  
Coastal Health Systems of Brevard*

---

## Mike Hall

*CEO,  
Nature Coast Emergency Medical Services*

---

## Don Hughes

*Fire Chief,  
Satellite Beach Fire Department*

---

## Linda Liebert-Hall

*President,  
Liebert-Hall & Associates, LLC*

---

## Christine Long

*Community Health Resource Program Coordinator,  
Brevard County Fire Rescue*

---

## Mac Kemp

*Deputy Chief of Clinical Affairs,  
Leon County Emergency Medical Services*

---

## Mark Matthews

*Chief,  
Jefferson County EMS*

---

## Steve McCoy

*State of Florida  
EMS Administrator*

---

## Melissa McNally

*Mobile Integrated Healthcare PA,  
AMR*

---

## John McNamara

*Fire Chief,  
Sunrise Rescue*

---

## Scott Moore

*EMS Resource  
Advisors, LLC*

---

## Jerri Regan

*Owner,  
Health Services Consulting*

---

## Daniel Swayze

*Vice-President and COO, Center for Emergency  
Medicine of Western Pennsylvania & Project Manager  
of CONNECT Community Paramedicine Program*

---

## Evan Weiner

*EMS Coordinator,  
Seminole Tribe Fire Department*

---

## Lauren Young

*Mobile Integrated Health Medical Social Work  
Coordinator, Palm Beach County Fire Rescue*

---

## Matt Zavadsky

*Chief Strategic Integration Officer,  
MedStar Mobile Healthcare*

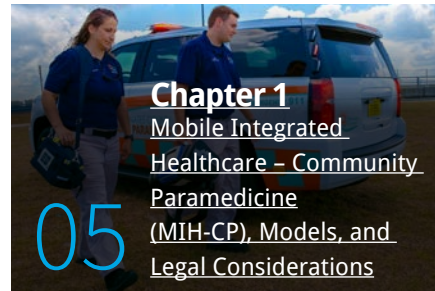
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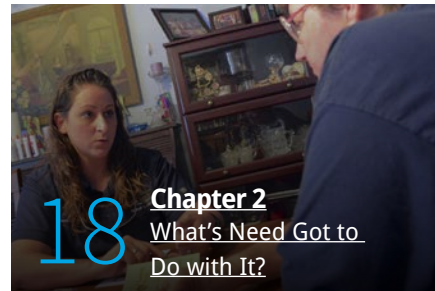
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# INTRODUCTION

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The purpose of this Guidebook is to do just that – guide you through the research, analysis, planning, development, and successful launch of your own customized Florida Mobile Integrated Healthcare – Community Paramedicine (MIH-CP) Program. This resource is straight-forward and easy to read. In addition to guidance, it provides recommendations and lessons learned from MIH-CP programs in Florida, advice from experts across the country, with expanded resources and templates.

This Guidebook is not designed to tell you what you must do, but to provide suggestions and ideas on what to consider in developing your own MIH-CP. As you read it, remember that not all the information in the Guidebook will apply to you or your organization. Use it to think through the elements of your program and remember that a successful program must be anchored in your community.

The Guidebook is organized linearly – take each step by step, so you end up with an operational program. However, it is strongly recommended that you use the Budget Template found in [Appendix B](#) as you work through the chapters. You will be prompted to insert financial information into the budget throughout the Guidebook. So, as you develop your program, enter even the most basic information on your costs and revenue.

Entering your cost and revenue information will help you when you get to Chapter 5 where you'll complete your program budget. (Yes, even if all your revenue is through your organization, you will need to develop a budget to help you get initial support for your MIH-CP and monitor the sustainability of your program.)



*Overall, this is the future of not only healthcare, but of EMS. By evolving the paramedicine profession into more of a clinician role, EMS will no longer be merely a transportation benefit.*

**Melissa McNally**



*Realize you're not going to change things overnight. Create a culture. This is a marathon, not a sprint.*

**Don Hughes**

The authors of this Guidebook conducted interviews with eleven organizations who operate MIH-CP Programs in Florida. During the interviews we asked questions about why they started their MIH-CP, how they did it, the funding used, the challenges they faced, what changes they would make in their implementation, and what advice they would give to an organization wanting to begin a MIH-CP. We have integrated their experiences, thoughts, and advice into this Guidebook to help you identify what will work in your community.

As the vision of your program becomes clearer, reflect on what you've done and evaluate if there are things you need to do differently. Also, look for the ripple effect. For example, changing something in the staffing may impact the medical direction, or the expense of a staff member, or how you reach your target market. A change in almost any piece will make a difference in your budget.

Chapter 8 is the culmination of the steps presented in the Guidebook. This Chapter presents a case study illustrating the material we covered and is meant to provide ideas on the content and format of a business plan for the design and implementation of a MIH-CP program in Florida. We hope this Guidebook proves useful and encourages you to think about how a MIH-CP Program can transform your community and the people you serve.



“

Wrap your head completely around the CP program - have a solid understanding of the program before starting.

Juan Cardona

Manatee County Florida Community Paramedicine

This Chapter provides definitions and descriptions of different types of Mobile Integrated Healthcare - Community Paramedicine Programs and reviews Florida statutes that regulate the practice of a community paramedic.

## What is Mobile Integrated Healthcare – Community Paramedicine?

This question was answered by the National Association of Emergency Medical Technicians (NAEMTs) in the introduction to their report on the Mobile Integrated Healthcare and Community Paramedicine 2nd National Survey, a link to which is included in the references and resources at the end of this Chapter. Their definition is as follows:

**Mobile integrated healthcare - community paramedicine (MIH-CP) is the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. MIH-CP is provided by a wide array of healthcare entities and practitioners that are administratively or clinically integrated with EMS agencies, while CP is one or more services provided by EMS agencies and practitioners that are administratively or clinically integrated with other healthcare entities.**

“

Learn about what is happening nationally and get out of the area to see what's going on.

Juan Cardona

The NAEMT report goes on to describe the range of services provided by MIP-CP programs as including:

- Sending EMTs, paramedics or community paramedics into the homes of patients to help with chronic disease management and education, or post-hospital discharge follow-up to prevent hospital admissions or readmissions.
- Navigating patients to destinations such as primary care, urgent care, mental health or substance abuse treatment centers instead of emergency departments to avoid costly, unnecessary hospital visits.

- Providing telephone triage, advice or other assistance to non-urgent 911 callers instead of sending an ambulance crew.
- Using telemedicine technology to facilitate interactions between patients in their home and medical professionals in hospitals or other locations.

Given the inclusive nature of the NAEMT's definition of MIH-CP and the broad nature of the types of services they provide, it is safe to say, there is no one model for MIH-CP Programs. The best model is the one that works in your community.



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Across the nation, 78% of respondents to the NAEMT survey indicated their model was focused on preventing hospital readmissions for conditions that have hospital penalties such as chronic lung disease, coronary artery bypass graft surgery, heart attacks, heart failure, hip and knee replacements, and pneumonia. Frequent EMS and emergency department users were targeted by 78% of survey respondents. The respondents were able to report multiple targets, so the percentage of respondents is more than 100%.

Chronic disease management for conditions such as congestive heart failure, hypertension, COPD, asthma, and diabetes was targeted by 68% of respondents. The fourth area targeted by MIH-CP Programs was assessment and navigation to alternative destinations that was reported by 50% of the respondents. Home health support was cited by 45% of respondents, and 45% of respondents indicated they were a primary care/physician extender model.

The remainder reported their target areas as hospice support (20%), 911 Nurse Triage (7%), and 11% reported other target areas that included wound care, knee replacement follow-up, and mental health crisis screening and navigation.

### **1. Abbeville County's Community Paramedic Program**

**Updated/reviewed May 2018**

- **Need:** To reduce non-emergent visits to the emergency department as well as inpatient stays in rural South Carolina.
- **Intervention:** A community paramedic program was started in Abbeville County, providing in-home preventive care to patients.
- **Results:** Emergency room visits have decreased by 58.7%, and inpatient stays by 60%. Many patients previously needing consistent services now only need occasional check-ups.

### **2. Livingston County Help For Seniors**

**Updated/reviewed January 2018**

- **Need:** Meeting the health needs of geriatric patients in rural Livingston County, New York.
- **Intervention:** The Help for Seniors program was developed and using its vodcasts, local EMTs were trained in geriatric screening methods and health needs treatment.
- **Results:** In addition to developing a successful model for educating EMS personnel, the program screened over 1,200 individuals and identified various risks among the geriatric population.

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The Rural Health Information Hub (RHI Hub) assembled examples of rural MIH-CP Program models. The programs are described along three parameters, need, intervention, and results. The following information may be found at

<https://www.ruralhealthinfo.org/project-examples/topics/community-paramedics>

and was taken directly from the RHI Hub website.

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### 3. Rugby Community Paramedic Program

#### Added November 2017

- Need: Low patient volumes, a shortage of EMS volunteers, and an aging population in a 5-county North Dakota region required a change in the way the Rugby EMS team delivered care.
- Intervention: Through the Rugby Community Paramedic Program, EMS staff bring medical care to patients transitioning back into their homes, including those with chronic conditions and hospice patients.
- Results: The program's early intervention methods helped reduce the number of emergency room admissions and the escalation of medical conditions. Patient satisfaction has improved, and the program has gained the trust of patients and medical staff in Rugby and surrounding areas.

### 4. Eagle County Community Paramedic

#### Updated/reviewed February 2017

- Need: Rural areas nationwide have shortages of primary care providers and home health programs.
- Intervention: Eagle County Paramedic Services is utilizing community paramedics in the provision of non-acute home care and assistance with immunizations and screenings in rural areas where it is difficult for these services to be accessed.
- Results: The pilot program was featured at the 2010 International Roundtable on Community Paramedicine. After 18 months of implementing the program, a net total of \$288,028 in healthcare costs was saved

A helpful MIH-CP summary reference is the National Rural Health Association Policy Brief titled: Principles for Community Paramedicine Programs. Other resources include two texts titled Mobile Integrated Healthcare: Approach to Implementation (2016) and Community Health Paramedicine (2018). References for these resources are located at the end of this Chapter.

An example of an urban MIH-CP program is MedStar Mobile. They serve the Fort Worth Texas area and 14 surrounding cities and are considered a municipal governmental agency (public utility model). The MedStar service area covers 421 square miles and is home to almost 1 million residents. With a budget of \$40 million, it employs approximately 460 employees and provides 125,000 responses annually.

Operating a MIH-CP Program since 2009, the initial focus of MedStar's program was on high system users for whom individual care plans were developed. These care plans included scheduled home visits with follow up with the client's primary care provider. Current programs are described as Patient Navigation Models and Mobile Integrated Healthcare models.

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. As reported by MedStar and available at their website:

<http://www.medstar911.org/mobile-healthcare-programs>

their models now include:

- 9-1-1 Nurse Triage
- Readmission Avoidance
- Observation Admission Avoidance
- "EMS Loyalty" Program
- Hospice Revocation Avoidance
- Home Health Partnership



## Florida’s MIH-CP

Consistent with the NAEMT’s definition of MIH-CP, the Access to Care Committee of the Florida Emergency Medical Services Advisory Council has defined Mobile Integrated Healthcare - Community Paramedicine (MIH-CP) as:

the distinction between a community paramedic program and a mobile integrated healthcare program. This interviewee felt that Mobile Integrated Healthcare is a more inclusive term recognizing the contributions of other professionals working with paramedics on multidisciplinary teams. When asked to choose if they were a Community Paramedicine Program or Mobile Integrated Health Healthcare Program, 70% of the respondents to the NAEMT survey categorized their program as “Community Paramedicine” and 31% self-described as offering “Mobile Integrated Healthcare” services.

*The provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. MIH -CP is provided by a wide array of healthcare entities and practitioners that are administratively or clinically integrated with EMS agencies and or other healthcare entities.*

Findings from the recently completed survey of eleven Florida MIH-CP programs who self-reported operating a MIH-CP program, one respondent made

Using the data from the previously described survey of Florida’s MIH-CP programs, Table 1 presents the distribution of Florida’s programs by delivery model comparing it to the NAEMT national survey.

**Table 1:** Comparison of the Distribution of Florida MIH-CP Programs to MIH-CP Programs by Type of Delivery Model

Delivery Model	Florida MIH-CP Survey Respondents 2017 N=11	NAEMT National Survey Respondents 2018 N=129
Public, Fire-based	55%	33%
Public, Municipal, County, or Regional	9%	21%
Public, Hospital Based	0	8%
Private, Nonprofit	9%	11%
Private, For-Profit	9%	11%
Private, Hospital-based	9%	16%
Tribal	9%	0

For purposes of this document, the terms Community Paramedicine Program and Mobile Integrated Healthcare are used together and referred to as MIH-CP.



## Florida Models

Of the 11 MIH-CP programs interviewed in the state of Florida, there are 11 different models. Each one has a unique format, focus, operations, and funding. Table 2 displays characteristics of selected Florida models.

**Table 2:** Characteristics of Selected Florida Models

	Model 1 – Private for Profit	Model 2 – Public Fire	Model 3 – Private Non Profit
<b>Focus / Goal</b>	Provide access to concierge medicine to all in the community.	Primarily the reduction in frequent flyers	Reduce COPD / CHF readmissions to hospital within 90 day period
<b>Services</b>	24/7 operation Provide telehealth services, including medical evaluations and rapid on-site testing.	Advocacy; resource identification/referral education; safety/home assessment; chronic disease management	Home visits: vital signs, appearance, medication reconciliation, and health safety checks
<b>Staffing</b>	1 FTE Paramedic is dedicated to the program, ½ FTE using overtime or part-time Paramedics.	Varies by size of department and services provided: Some programs have no Paramedic because the only focus is on advocacy and resource navigation, not direct medical care. Others have up to 3 FTE Paramedics with CP coordinators and administrative support. Some also utilize volunteers, such as medical and pharmacy school interns to support program, and people to provide client transportation to address any unmet needs.	1 FTE Paramedic
<b>Partners</b>	Hospice; Fire Department for part-time staffing	Hospice; Senior Centers; Transportation organizations; Home Health Care; Police; Social Service; Public Health; Mental Health; Homeowners Associations; Nursing Homes; Visiting Nurses; Primary Care Professionals; Pharmacies; 211 Resources; TOPS; Veterans Clinic; Hospitals; Insurance companies; Food pantries; Homeless shelters; Churches; Civic organizations; Local government; Education institutions; Department of Children & Family Services	Hospitals; Police; Fire; Social Service agencies
<b>Funding</b>	Start-up: All internal funding	Start-up: Grants and internal funding	Start-up: Internal funding
	Ongoing: 100% self-pay. Collect monies up front, no insurance billing.	Ongoing: Internal and some grants	Ongoing: 100% self-pay through the hospital
<b>Metrics</b>	Social Media talk	Reduction in 911 calls; Alignment with resources and/or primary care physician; Savings/Cost avoidance; Patient health improvement; Patient satisfaction survey; Medication compliance; length of program stay; ER visits; Average ambulance transportation cost; Provider satisfaction; Readmission rates; Ambulance hospital diversion; Pre and post Quality of Life and Activities of Daily Living indicators	Hospital tracks COPD / CHF readmissions



City of Gainesville Florida Community Paramedicine

These models give you a cross-section of just how different your program can be based on the identified need, the focus of your program, and the community resources available to support it.

## Medical Direction

NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey asked the 129 MIH-CP programs across the country about the role the medical director played in their program. Protocol development was the most given response at 88%, followed by quality assurance at 78%, immediate online medical direction 54%, continuing education 53%, development and support of care plans 50%, initial training was also 50%, and healthcare system integration was 40%. Looking at these responsibilities, you can see why the selection of the right medical director is so important to your program.

Under Florida statute 401.265, EMS services are required to provide emergency care under the license and direction of a physician medical director. The



*Greatest challenge was...identifying and knowing where to find resources to help your clients.*

**Ariella Bak**

medical director supervises and is directly responsible for the medical performance of the EMT's and paramedics performing the medical procedures in the field. They are required to advise, consult, train, counsel, and oversee the delivery of services, including maintaining quality assurance processes. As previously mentioned, paramedics and EMT's may perform health promotion and wellness activities including blood pressure screenings in a nonemergency environment within the scope of their training, and under the direction of a

medical director. The medical director may provide this direction outside of the provision of emergency care and is liable for any act or omission of any EMT or paramedic acting under his/her supervision and control when performing these services.

The selection of your medical director is crucial. Look for your medical director early in your MIH-CP development process. This early engagement will help you establish strong standard operating procedures and protocols with effective quality

control processes, enabling you to identify problem areas early in the development process.

The medical director should understand the latest approaches to healthcare being promoted and evaluate the healthcare trends and service gaps in your community. You need someone who will wholeheartedly support the idea of a MIH-CP Program and be an active participant in the development and ongoing champion in support of it. One organization that responded to the interview about their MIH-CP stressed the importance of medical direction and of finding a medical director who is open to and comfortable with paramedics doing things outside of the traditional “paramedic” duties.

And, if your current EMS medical director does not meet these criteria, you may select a different medical director for your MIH-CP program. While it is unusual, there is no requirement that the same medical director

be used for both EMS and MIH-CP programs. In the references and resources section of this Chapter, there are possible provisions to be included in a medical director’s contract as well as an interview guide to help you gauge your medical director’s level of commitment to and understanding of MIH-CP.

Encourage your medical director to be involved with the Florida EMS Advisory Council and the Florida Association of EMS Medical Directors. Additional information about these groups is found in the references and resources section at the end of this Chapter.

Finally, in addition to a dedicated medical director, you may want to use other providers for medical direction, advice, or consultation based upon the design of your program. For instance, a person’s primary care physician or a specialty physician may provide that direction for a specific client.

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*Budget Note: Insert the annual cost of your MIH-CP medical director into the expense line “medical direction contract fees.” If your MIH-CP medical director is also your medical director for emergency operations, only include the additional cost for the responsibilities of a MIH-CP program, if any.*

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## Alignment

MIH-CP Programs offer cost-effective and efficient solutions to perennial issues challenging not only Florida’s healthcare system but our nation’s. MIH-CP Programs target the medically underserved who suffer from debilitating conditions that are not only caused by acute conditions (trauma, infectious diseases) but from chronic diseases that often require on-going care and treatment. Successful disease prevention and wellness/health promotion are grounded in community-wide interventions. Your local health department is the organization charged with improving the health of the county’s population and working with them on common problems is a cost-effective approach.

MIH-CP Programs have a vital role in achieving the Florida Department of Health’s (FDOH) Strategic Plan, the State Health Improvement Plan (SHIP), your county’s Community Health Improvement Plan (CHIP), the Florida Department of Health, Emergency Medical Services State Plan 2016 – 2021, and the Medicare Rural

Hospital Flexibility (Flex) Program Workplan. A brief description of selected documents follows providing a list of potential focus areas for MIH-CP Programs.

### **Florida’s SHIP identifies goals for the state’s public health system in 8 priority areas that include:**

- Health Equity
- Maternal & Child Health
- Immunizations
- Injury, Safety & Violence
- Healthy Weight, Nutrition & Physical Activity
- Behavioral Health both Mental Illness and Substance Abuse
- Sexually Transmitted Disease (STDs) as well as other infectious diseases
- Chronic Diseases and Conditions, including tobacco-related illnesses and cancer

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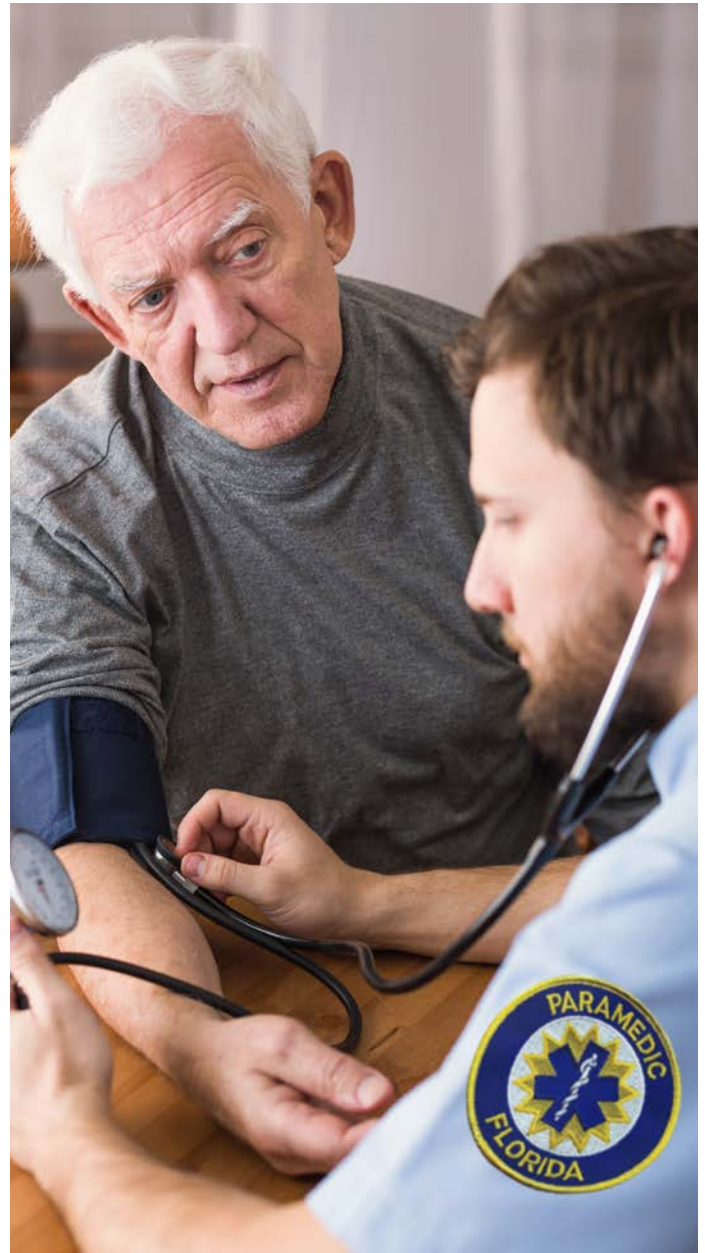
These goals are further defined by strategies and objectives. A theme throughout the goals, strategies, and objectives is that goal achievement rests on the collaboration and active engagement of state, local and other multi-level organizations. The SHIPs goals address persistent issues challenging Florida’s healthcare system that demand a collaborative response. In this way, resources are leveraged, redundancies eliminated, and problems solved.

## MIH-CP Programs and the Florida Department of Health Emergency Medical Services State Plan 2016 - 2021

The Florida Department of Health, Bureau of Emergency Medical Oversight (BEMO), Emergency Medical Services published the Emergency Medical Services State Plan (EMSSP), 2016-2021.

The EMSSP identified five strategic priority areas, each with an articulated goal/s:

- **Strategic Priority 1: EMS Industry Health and Safety**
  - Goal 1.0: Ensure a commitment to the health and safety of the EMS industry and the citizens and visitors of Florida
- **Strategic Priority 2: Clinical and Operational Performance**
  - Goal 2.0: Use health information technology to improve the efficiency, effectiveness, and quality of patient care coordination and health care outcomes
- **Strategic Priority 3: EMS System Infrastructure and Finance**
  - Goal 3.1: Attract, recruit and retain a prepared, diverse and sustainable EMS workforce in all geographic areas of Florida
  - Goal 3.2: Establish a financially sustainable infrastructure, which includes processes and effective use of technology and communication supporting all EMS systems functions
- **Strategic Priority 4: Readiness for Emerging Health Threats**
  - Goal 4.0: Demonstrate EMS readiness for emerging health threats and natural or manmade disasters
- **Strategic Priority 5: Community Redevelopment and Partnerships**
  - Goal 5.0: Integrate EMS with health planning and assessment processes to maximize community partnerships and expertise in accomplishing its goals



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Each of the strategic priorities has strategies and objectives, and Strategic Priority 5 explicitly references community paramedic (MIH-CP) programs. The strategies and objectives for Strategic Priority 5 are as follows:

#### ■ Strategy

- Provide injury prevention programs to the public
- Promote the increase of EMS agencies developing community paramedic programs
- Improve community health

#### ■ Objectives

- Increase the percentage of EMS agencies conducting fall prevention programs from 28.5% to 40% by December 2018
- Increase the percentage of EMS agencies conducting opioid use and naloxone awareness programs from 13.5% to 35% by December 2018
- Increase the percentage of EMS agencies conducting safety programs sponsored or recommended by the Florida Department of Transportation (FDOT) from 19.2% to 30% by December 2018
- Increase the percentage of EMS agencies conducting drowning prevention programs from 30% to 50% by December 2018
- Increase the percentage of EMS agencies conducting programs to reduce infant mortality from 18.5% to 30% by December 2018
- Increase the percentage of EMS agencies offering cardiovascular health and wellness programs pursuant to section 401.272, F.S., from 26.4% to 40% by December 2018
- Increase the percentage of EMS agencies providing HIV health and wellness programs pursuant to section 401.272, F.S., from 6.4% to 25% by December 2018
- Reduce the number of adult low acuity ED visits from 14.15% to 10% by December 2018
- Increase the number of EMS agencies with protocols that actively refer children and adults for early intervention and treatment of mental health disorders from 0 to 25 by December 2018
- Increase the percentage of EMS agencies offering immunization programs pursuant to section 401.272, F.S., from 6.4% to 25% by December 2018

The following objectives included in the EMSSP are also included in the SHIP; the information was taken directly from the EMSSP:

- Increase the percentage of EMS agencies conducting fall prevention programs from 28.5% to 40% by December 2018
- Increase the percentage of EMS agencies conducting drowning prevention programs from 30% to 50% by December 2018
- Increase the percentage of EMS agencies conducting programs to reduce infant mortality from 18.5% to 30% by December 2018
- Increase the percentage of EMS agencies providing HIV health and wellness programs pursuant to section 401.272, F.S., from 6.4% to 25% by December 2018
- Increase the percentage of EMS agencies offering immunization programs pursuant to section 401.272, F.S., from 6.4% to 25% by December 2018

Focusing on objectives that are found in both SHIP and the EMSSP ensures your alignment with Florida's state initiatives.

If you are considering aligning your MIH-CP with the SHIP and the EMSSP, developing alliances with other community organizations and groups working in these areas is an important first step.

For example, you may enter into a Memorandum of Agreement with your local health department to align your MIH-CP program with the priority areas identified in your county's Health Improvement Plan. If the area identified for improvement is immunizations, you are in alignment with the SHIP and the EMSSP.

A template for a Memorandum of Agreement is included in [Appendix C](#).



Manatee County Florida Community Paramedicine

## > MIH-CP and the Flex Program

Florida established a Medicare Rural Hospital Flexibility (Flex) Program that is funded by the federal Office of Rural Health Policy, Department of Health and Human Services. These federal funds are available to create rural health networks, promote the regionalization of rural health services and improve access to healthcare for rural populations.

### Flex Program areas are:

1. Quality improvement
2. Financial and operational improvement
3. Population health management and EMS integration (optional)
4. Designation of Critical Access Hospitals (required if requested)
5. Integration of innovative healthcare models (optional)



Manatee County Florida Community Paramedicine

The Florida Flex program is overseen by the Florida Department of Health. In developing rural healthcare systems, the Flex program promotes collaboration among rural providers, critical access hospitals (CAHs), and emergency medical service (EMS) providers.

Annual work plans are developed and monitored to track success in the required and selected optional program areas. Florida's Flex Work Plan for 2017-18 includes three goals; two required and one optional. Under each goal, there are activities that may be incorporated into a MIH-CP Program. Adapted from the Florida Flex Plan and displayed below are the selected goals, objectives, and activities that lend themselves to a MIH-CP Program:

- **Goal 1: Improve the quality of care provided by critical access hospitals**
  - Objective: Assist CAHs in implementing quality improvement activities to improve patient outcomes
    - Activities:
      - » Improve patient safety in CAHs and the community by ensuring all healthcare providers and eligible patient populations receive their influenza vaccinations.
      - » Improve transitions of care from CAHs to other healthcare settings to improve patient outcomes
- **Goal 3a. To understand the community health and EMS needs of CAHs**
  - Objective: Annually – Determine collective issues and trends in population health management for CAHs
    - Activities:
      - » Conduct (participate) in assessments, identify needs, establish improvement strategies

Another theme running through the documents described above is that the goals, strategies, and objectives align with the national effort spearheaded by the Institute of Healthcare Improvement (IHI). The IHI's Triple Aim calls for improving population health, improving the client's care experiences (including quality and satisfaction), and reducing per capita healthcare costs.

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Florida's EMS service providers are rallying to meet these challenges, and MIH-CP programs present a potential intervention to effect system-wide change.

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1. NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey provides current data on MIH-CP programs across the U.S. This includes start-up costs, target markets, services provided, partnerships, staffing, and payment. [http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2)

2. The Rural Health Information Hub provides information on rural health issues and MIH-CP programs. Examples of rural MIH-CP models are found at <https://www.ruralhealthinfo.org/project-examples/topics/community-paramedics>

3. National Rural Health Association, Policy Brief titled Principles for Community Paramedicine Programs. Available at <https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/PrinciplesforCommunityParamedicineSept-2012.pdf.aspx?lang=en-US>

4. The federal Office of Rural Health Policy funded a study to look at the evidence base for community paramedicine in rural communities. Their findings evaluated delivery systems, challenges, and the role of state Flex programs can play in supporting the development of these programs. Karen B. Pearson, MLIS, MA, John A. Gale, MS, George Shaler, MPH, University of Maine, February 2014. Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program. <http://www.flexmonitoring.org/wp-content/uploads/2014/03/pb35.pdf>

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6. Pollack, A.N. (ed.) 2018. Community Health Paramedicine. Burlington, MA: Jones & Bartlett Learning.

7. MedStar Mobile. Information available at <http://www.medstar911.org/>

#### 8. Florida Statutes and Community Paramedicine

The governing Florida laws for EMT's and Paramedics are under Title XXIX Public Health, Chapter 401, specifically, Part III on Medical Transportation Services. The law cited for enabling Community Paramedicine is Florida Statute 401.272(1)-(3), which states:

- (1) The purpose of this section is to encourage more effective utilization of the skills of emergency medical technicians and paramedics by enabling them to perform, in partnership with local county health departments, specific additional healthcare tasks that are consistent with the public health and welfare.
- (2) Notwithstanding any other provision of law to the contrary:
  - (a) Paramedics or emergency medical technicians may perform health promotion and wellness activities and blood pressure screenings in a nonemergency environment, within the scope of their training, and under the direction of a medical director. As used in this paragraph, the term "health promotion and wellness" means the provision of public health programs pertaining to the prevention of illness and injury.
  - (b) Paramedics may administer immunizations in a nonemergency environment, within the scope of their training, and under the direction of a medical director. There must be a written agreement between the paramedic's medical director and the county health department located in each county in which the paramedic administers immunizations. This agreement must establish the protocols, policies, and procedures under which the paramedic must operate.

**(3)** Each medical director under whose direction a paramedic administers immunizations must verify and document that the paramedic has received sufficient training and experience to administer immunizations. The verification must be documented on forms developed by the department, and the completed forms must be maintained at the service location of the licensee and made available to the department upon request.

Florida Statutes Title XXIX Public Health: 401.272 Emergency medical services community healthcare. [http://www.leg.state.fl.us/statutes/index.cfm?App\\_mode=Display\\_Statute&Search\\_String=medical%20directors&URL=0400-0499/0401/Sections/0401.272.html](http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=medical%20directors&URL=0400-0499/0401/Sections/0401.272.html)

**9.** The Florida Statutes Title XXIX Public Health: 401.265 a description of medical directors is found at [http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App\\_mode=Display\\_Statute&Search\\_String=medical+directors&URL=0400-0499/0401/Sections/0401.265.html](http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=medical+directors&URL=0400-0499/0401/Sections/0401.265.html)

**10.** The Florida Administrative Code governing medical direction is 64J-1.004. It provides an outline of provisions for a medical director's contract:

- Name and relationship of the contracting parties.
- A list of contracted services inclusive of medical direction, administrative responsibilities, professional membership, basic and advanced life support review responsibilities, and reporting requirements.
- Monetary consideration inclusive of fees, expenses, reimbursement, fringe benefits, clerical assistance and office space.
- Termination clause.
- Renewal clause.
- Provision for liability coverage.
- Effective dates of the contract.

<https://www.flrules.org/gateway/ruleNo.asp?id=64J-1.004>

**11.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law impacting every aspect of medical confidentiality and is important to consider in developing a MIH-CP program. You can access it at <https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996>

**12.** For a deeper look at the legal issues based on the expanding roles health professionals play in CP programs, this report by The Association of State and Territorial Health Officials is a good analysis. James G. Hodge, Jr., JD, LL.M., Daniel G. Orenstein, JD, Kim Weidenaar, JD, (2014). Expanding Roles of Emergency Medical Services Providers: A Legal Analysis. <http://www.astho.org/Preparedness/ASTHO-EMS-and-Law-Report/>

**13.** Melody Glenn, Olivia Zoph, Kim Weidenaar, Leila Barraza, Warren Greco, Kylie Jenkins, Pooja Paode & Jonathan Fisher (2017). State Regulation of Community Paramedicine Programs: A National Analysis, Prehospital Emergency Care, 22:2, 244-251, DOI: 10.1080/10903127.2017.1371260, <https://tandfonline.com/doi/abs/10.1080/10903127.2017.1371260?journalCode=ipec20>

**14.** Community Paramedicine Services by the Minnesota Department of Human Services available at [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_177475](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177475)



15. While this 2010 article is older, it provides a good overview of different MIH-CP services across the country and discusses opportunities and challenges in the areas of funding, regulation, roles, education, medical direction, stakeholders, and evaluations. Joint Committee on Rural Emergency Care, National Association of State Emergency Medical Services Officials, National Organization of State Offices of Rural Health. State Perspectives Discussion Paper on Development of Community Paramedic Programs, December 2010.

<http://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf>

16. Florida Department of Health, State Health Improvement Plan available at

<http://www.floridahealth.gov/about-the-department-of-health/about-us/state-and-community-health-assessment/ship-process/index.html>

17. The Florida Department of Health Emergency Medical Services State Plan 2016-2021. <http://www.floridahealth.gov/provider-and-partner-resources/advisory-councils-stakeholder-groups/ems-advisory-council/documents/ems-strategic-plan.pdf>

18. Florida Medicare Rural Hospital Flexibility (Flex) Program is available at

<http://www.floridahealth.gov/programs-and-services/community-health/rural-health/index.html>

19. Additional information about the IHI and its Triple Aim may be found on their website: <http://www.ih.org/engage/initiatives/TripleAim/Pages/default.aspx> and <http://www.ih.org/Topics/TripleAim/Pages/default.aspx>.

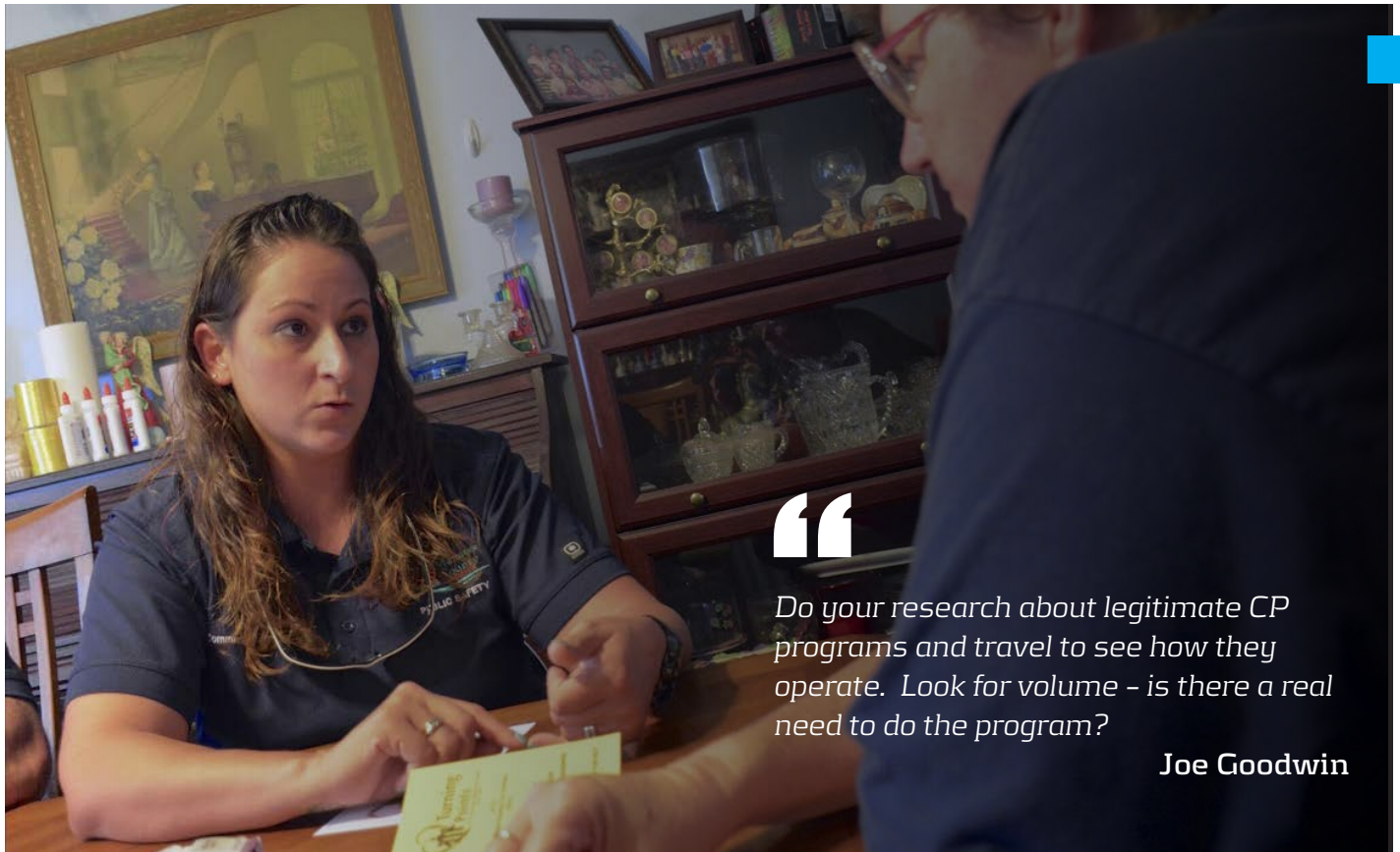
20. The Journal of Emergency Medical Services has a Mobile Integrated Healthcare section. It's a good way to stay current on what's happening in the industry: <http://www.jems.com/adminstration-and-leadership/community-paramedicine-and-mobile-healthcare.html?c=1>

21. Sample Medical Director Interview Questions to determine their interest, passion, and involvement:

- What do you know about the Mobile Integrated Healthcare / Community Paramedicine (MIH-CP) healthcare models?
- What do you see as the greatest unmet healthcare need in our community?
- Under the Florida laws, paramedics work under the direction of a medical director, the MIH-CP model does not change the paramedic's scope of practice, but it does change the role of the paramedic. Are you comfortable with this change in the role of the paramedic working under your license?
- Are you interested in being the medical director for a MIH-CP program in our community?
- Are you willing to be involved in the development of our MIH-CP program?
- Are you willing to be a part of any presentation of our community program to potential stakeholders, clients, and resource providers?

22. Florida Association of EMS Medical Directors: <http://www.emlrc.org/faemsmd/about/>

23. Florida EMS Advisory Council: <http://www.floridahealth.gov/provider-and-partner-resources/advisory-councils-stakeholder-groups/ems-advisory-council/>



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*Do your research about legitimate CP programs and travel to see how they operate. Look for volume - is there a real need to do the program?*

**Joe Goodwin**

Manatee County Florida Community Paramedicine

Chapter 2 presents a discussion of need assessment that includes why agencies conduct needs assessment, what goes into a needs assessment, and where to go to get the data to make a data-driven decision regarding areas for program development.

If you answered “everything,” you’re on the right track! The organized and purposeful examination of a group of people (population) to identify new areas for program design and implementation is a needs assessment. Using data, you describe the population. Where the population is located defines the geographical area that you are serving or proposing to serve.

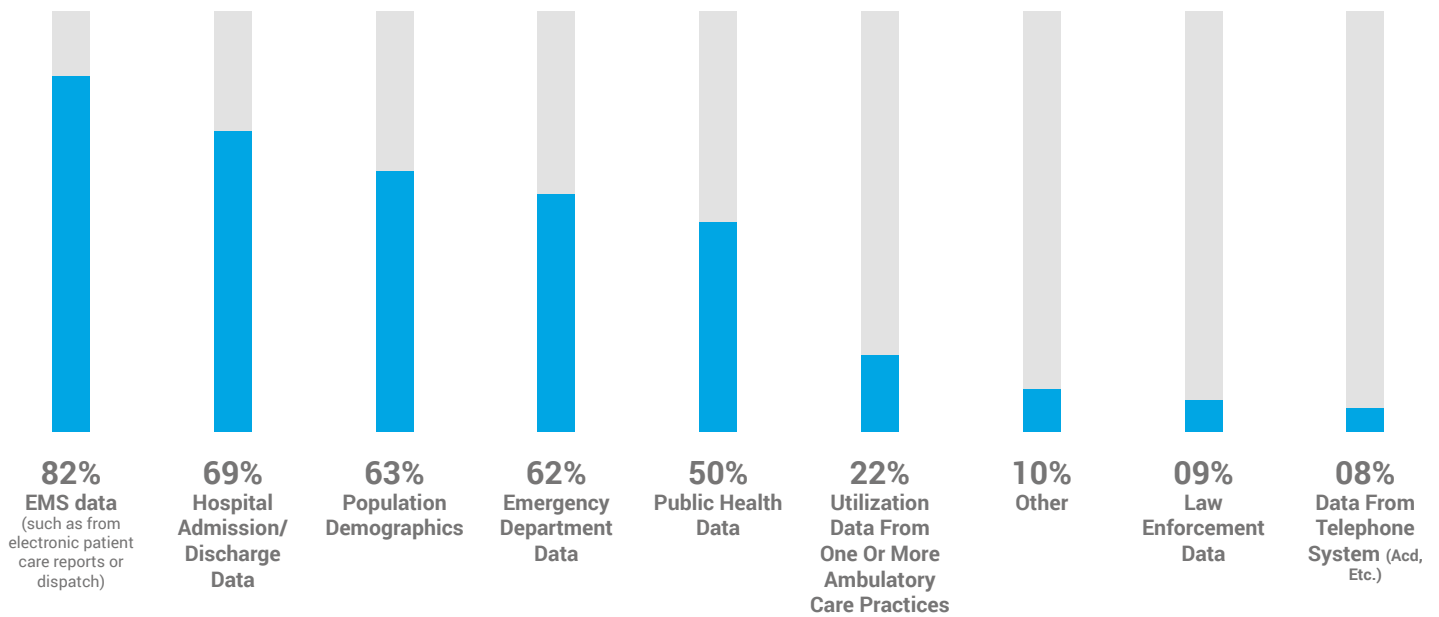
If you are a county-funded organization, the population you serve may be legislatively defined as all residents of the county. In this case, the county is your geographically defined service area. Within that geographically defined area, you may identify a population of interest (target population) that may benefit from a new program (intervention).

Characteristics or variables you use to describe your population are ones that are associated with access to care and health status. Some of the variables associated with access to care and health status include (but are not limited to) emergency department utilization, frequency of 9-1-1 calls, reasons for 9-1-1 calls, age, income, educational level, the presence of disease (morbidity), causes of death (mortality), self-perceived health status, and the ability to carry out one’s activities of daily living.

## > Data Sources

There are two basic data sources for a needs assessment, and these are data either internal to the organization or external to the organization. Internal organizational data is your organization’s administrative data that includes client records and billing data. According to the report summarizing the findings from the NAEMT 2nd National Survey on Mobile Integrated Healthcare and Community Paramedicine, the overwhelming majority (82%) of the current MIH-CP programs across the country used their records to determine community needs. Table 3 was excerpted from the NAEMT report and demonstrates the reliance on internal administrative data. Your organization’s administrative data is a valuable resource that should be carefully reviewed and leveraged in your research. Be sure to seek data from potential stakeholders as it will help them to relate to and ultimately, engage in the project.

**Table 3:** Data Sources



In 2004 Florida created the Emergency Medical Services Tracking and Reporting System (EMSTARS) that in turn participates in the National EMS Information System (NEMSIS). EMSTARS is a data collection and analysis system that captures incident-level data from participating EMS providers.

The data may be used for benchmarking to see how your experience compares to other EMS providers and for assessing process and procedures that would benefit from a plan, do, act, check quality management process. Several EMSTARS’ data elements are helpful when assessing the need for a MIH-CP Program including reasons for calls and whether a transport took place.

Included in EMSTARS version 3.4 are questions regarding whether an organization has MIH-CP protocols, whether rural counties have MIH-CP protocols, and the number of community paramedic events.



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> Another source of information and data is the Florida Department of Health, Agency for Health Care Administration's (AHCA) Florida Health Finder. As noted on their website, there is information that compares the quality and cost performance of hospitals, ambulatory surgery centers, health plans, nursing homes, and prescription drugs:

- **Health Plans:** Compare health plans on quality of care, member satisfaction, coverage areas by county, accreditation status, and claims payment performance. You can also compare monthly health plan premium rate options and find additional resources on many health insurance topics.
- **Hospitals and Ambulatory Surgery Centers:** View performance and outcome data on selected medical conditions and procedures in these types of health care facilities.
- **Emergency Room Care:** Read educational information about when and how to use an emergency room, what to do in a medical crisis, alternatives to emergency room care and other helpful information.
- **Prescription Drugs:** View comparative prices at Florida pharmacies for the top 100 most prescribed drugs in Florida. You choose the county where you live and a drug you want to price. The website displays the current price for most pharmacies in your county.

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Of note for MIH-CP programs is the emergency room data. For more information about Florida Health Finder, visit the website at

<http://www.floridahealthfinder.gov>

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Focus on the client's needs and provide empathetic, patient centered care.

Richard Ellis

## Screenshot 1

Indicator	Measure	Year(s)	County Number	County	County Quartile 1=most favorable 4=least favorable	State	U.S. Healthy People 2020 Goal
<b>Socio-Demographics</b>							
Total Population	Count	2016	257,478			20,231,092	
Population under 18 Years Old	Count	2016	46,184			4,094,174	
Population 18-64 Years Old	Count	2016	177,885			12,203,426	
Population 65+ Years Old	Count	2016	33,309			3,933,492	
Population - White	Count	2016	181,109			15,722,428	
Population - Black	Count	2016	53,131			3,408,734	
Population - Other	Count	2016	23,238			1,099,930	
Population - Hispanic	Count	2016	23,539			4,962,984	
Population - Non-Hispanic	Count	2016	233,939			15,268,108	
Individuals below poverty level	Percent	2012-16	58,387	24.2%	4	16.1%	
Civilian labor force which is unemployed	Percent	2012-16	8,872	7%	1	8.4%	
Population 5+ that speak English less than very well	Percent	2012-16	8,803	3.6%	2	11.7%	
Individuals 25 or older with a high school diploma	Percent	2012-16		21.9%	4	29.2%	
Adults who have a personal doctor	Percent	2016		69.5%	4	72%	
Adults with health insurance coverage	Percent	2012-16		87.7%	1	83.6%	
<b>Cardiovascular Disease</b>							
<b>Coronary Heart Disease</b>							
Adults who have ever been told they had angina or coronary heart disease	Percent	2016		3.7%	1	4.7%	
Deaths: Age-adjusted death rate per 100,000 total population	Per 100,000 Total Population	2014-16	591	77.3	1	97.0	100.8
Hospitalizations: Age-adjusted hospitalization rate per 100,000 total population	Per 100,000 Total Population	2014-16	1,507	201.5	2	220.0	
<b>Heart Attack</b>							

When looking for external data, the Florida Department of Health Community Health Assessment Resource Tool Set (CHARTS) is one of the first places to find data for your needs assessment. The county is the unit of analysis in the CHARTS data set. Your county health department uses CHARTS data to gauge the health of the county and prioritize areas for intervention and improvement. The CHARTS website is located at <http://www.flhealthcharts.com/charts/ChronicDiseases/default.aspx>.

**Screenshot 1** is the Chronic Disease report from the CHARTS for Alachua County. If you cannot read it, please go online, find the table, and take a minute to look at it. There are some helpful things to notice. Variables for Alachua County are presented as well as data for the State and, also the U.S. Healthy People 2020 Goal.

These two columns provide comparative data for Alachua County so one may assess if the indicator is “better” or “worse” than the rest of the State, and how well the county is doing in accomplishing the U.S. Healthy People 2020 Goal. By way of review, the U.S. Healthy People 2020 Goal is a federal initiative that establishes health-related goals and monitors the health of the U.S.

State and federal data provide useful benchmarks for comparison. When writing a grant application, funders want to know what makes the population you propose to serve unique or worthy of funding. Given that poverty is a risk factor for poor health, Alachua County would highlight the fact that their population has a higher proportion of individuals below the poverty level. The rate for Florida is 16.1%, and the rate for Alachua County is 24.2%. The difference between your county's number, Florida's number, and the Healthy People Goal is used to highlight inequities or gaps that exist. These inequities point you to potential areas for intervention around which you may design and implement a MIH-CP.

The Robert Wood Johnson Foundation (RWJF) publishes the County Health Rankings. This initiative provides information on nearly all U.S. counties ranking them on 30 indicators. The indicators are grouped as follows:

- 
- 1. Health Outcomes
    - a. Length of Life
    - b. Quality of Life
  - 2. Health Factors
    - a. Health Behaviors
      - o Tobacco Use
      - o Diet & Exercise
    - b. Clinical Care
      - o Alcohol & Drug Use
      - o Sexual Activity
    - c. Social and Economic Factors
      - o Access to Care
      - o Quality of Care
      - o Education
    - d. Physical Environment
      - o Employment
      - o Income
      - o Family & Social Support
      - o Community Safety
      - o Air & Water Quality
      - o Housing & Transit
- 

Table 4 is an example of the some of the information available at the RWJF site (<http://www.countyhealthrankings.org>). The selected indicators included in Table 4 may be particularly helpful if your MIH-CP is focused on healthy-life measures and chronic diseases. These are two areas that align with the Florida Department of Health’s strategic initiatives.

**Table 4:** Any County Health Rankings Compared to Florida and U.S. Benchmarks

Delivery Model	Any County	Florida	U.S. Benchmark
Length of Life	Ranked 60th		
Premature Death	10,012	6,893	5,200
Poor Physical Health Days	4.4	3.7	2.5
Poor Mental Health Days	4.6	3.8	2.3
Health Behaviors	Ranked 35th		
Adult Obesity	27%	26%	25%
Adult Smoking	24%	18%	14%
Physical Inactivity	26%	23%	20%
Injury Deaths	109	69	50
Social & Economic Factors	Ranked 46th		
Children in Poverty	29%	25%	13%

Of the 11 MIH-CP Programs in Florida who reported operating a MIH-CP program and were respondents to a recent survey, 82% (9) stated they started their programs based on a needs assessment using internal data regarding high volume users. Of the two remaining respondents, their parent organization selected the focal area in one organization and the other, a funding source dictated it.

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**Let the data drive your discovery of what is needed in your community.**

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*Budget Note: Add the cost of your data collection and analysis into your budget as a Miscellaneous expense.*



*The greatest challenge was the volume of need in the community.*

**Lauren Young**

## > Chapter 2 References and Resources

1. NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey provides current data on MIH-CP programs across the U.S. This includes start-up costs, target markets, services provided, partnerships, staffing, and payment. [http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2)
2. Florida Prehospital EMS Tracking and Reporting System (EMSTARS) is available at <http://www.floridaemstars.com/>
3. Florida Department of Health, Agency for Health Care Administration provides quality and cost information on health plans, hospitals and ambulatory surgery centers emergency room care, and prescription drugs. This resource is available at <http://www.floridahealthfinder.gov/index.html>
4. The Florida Department of Health's CHARTS website is located at <http://www.flhealthcharts.com/charts/ChronicDiseases/default.aspx>
5. The Florida Agency for Healthcare Administration web site FloridaHealthFinder.gov  
This site assembles and displays provider/facility utilization and performance data. Types of data available include emergency department utilization and cost at <http://www.floridahealthfinder.gov/index.html>
6. The World Bank published a free, online guide for conducting a needs assessment. The reference and site are as follows: A Guide to Assessing Needs: Essential Tools for Collecting Information, Making Decisions, and Achieving Development Results. World Bank. © World Bank. <https://openknowledge.worldbank.org/handle/10986/2231> License: CC BY 3.0 IGO.
7. Zavadsky, M, and Hooten, D. 2016. Mobile Integrated Healthcare: Approach to Integration. Burlington, MA: Jones & Bartlett Learning.
8. Pollack, A.N. (ed.) 2018. Community Health Paramedicine. Burlington, MA: Jones & Bartlett Learning.
9. Robert Wood Johnson Foundation. County Health Rankings. Provides information on how U.S. counties rank on health measures. <http://www.countyhealthrankings.org>
10. Another source of health-related information is the Gallup Well-Being initiative. Available at [http://news.gallup.com/topic/COMMUNITY\\_WELLBEING.aspx](http://news.gallup.com/topic/COMMUNITY_WELLBEING.aspx)



“

*Finding people that encourage your innovative thinking and outside the box approach is the key to program development and success. Develop champions to support the program – in other words, rally the stakeholders.*

**James Crutchfield**

Totsapon Phattaratharnwan/Shutterstock.com

This Chapter introduces stakeholders and the importance of considering both internal and external stakeholders. An important task of the program leader/administrator is to engage stakeholders early and often.

Several tools can help your thinking, organization, and engagement of stakeholders, and we will look at one of them, the Power versus Interest Grid.

### > Stakeholder Analysis

Stakeholder identification, as well as their ongoing engagement, takes time and energy, and organizations that commit to the engagement of stakeholders are better able to manage program implementation and harness the creative knowledge and communication capacity of stakeholders.

Several scholars who study program implementation describe stakeholders along two dimensions, both power and interest. For a more detailed discussion of power versus interest see the work of Crosby & Bryson (2005), the reference is at the end of this Chapter.

For purposes of this discussion, power and interest are operationalized as:

1. If an individual or group has access to the resources needed to solve a problem or resolve an issue, they have power. Power bases include wealth, status, knowledge, and skill.
2. An individual or a group's interest is a function of whether they are affected by the issue, change, or disruption in the status quo. Interest will vary by the degree to which the issue, change, or disruption of the status quo affects the individual or group.



A power-versus-interest grid typically helps determine which stakeholders' interests and power bases should be considered to address the problem or issue at hand. It also helps highlight coalitions to be encouraged or discouraged, what behavior should be fostered, and whose buy-in should be sought or who should be "co-opted."

Table 5 displays the power versus interest grid and is constructed by categorizing stakeholders into one of four groups:

- High Power/Low Interest
- High Power/High Interest
- Low Power/Low Interest
- Low Power/High Interest

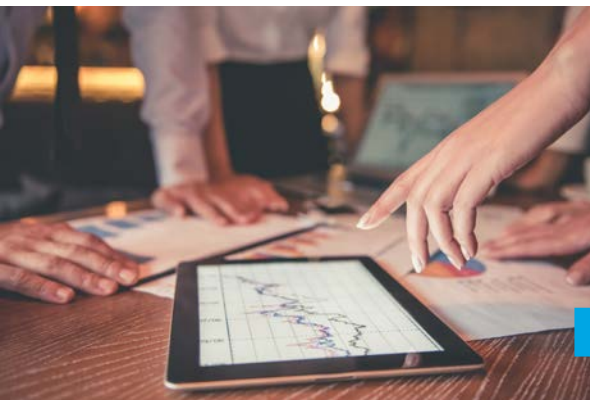
**Table 5:** Power Versus Interest Grid

High Power/Low Interest	High Power/High Interest
Low Power/Low Interest	Low Power/High Interest

Stakeholders with high power and high interest will likely have the most influence on a problem or solution, and a program leader must manage these stakeholders closely. This group may make or break the stakeholder alliance if their interests are not seriously considered.

Note that groups with high power and low interest also need attention, and the program leader should work to sway them into the high power/high interest quadrant. The effective leader will attempt to frame the issue or solution in such a way as to inspire interest, harnessing stakeholder energy to help work on the identified problem. The program leader who can frame the issue and

solution, create a powerful and persuasive message, and fully engage stakeholders is a visionary leader. Typically, your target clients are assigned to the low power/high interest quadrant. Even if they have low power, they are important, and leaders should reach out to them and seek their input. Clients may become powerful program champions if they are treated with respect and as partners.



George Rudy/Shutterstock.com



*Communication with stakeholders should be continuous and consistent*

**Richard Ellis**

It is important to consider both internal and external stakeholders. For example, if you are the MIH-CP champion in your organization and your boss thinks MIH-CP's are a waste of time, your efforts may be in vain. In this case, your boss has high power/low interest and can derail your efforts. Moving your boss to the high power/high interest quadrant may solve this problem. Recognizing internal weaknesses exist is the first step in developing strategies to turn the weaknesses into strengths.

Included in [Appendix J](#) is a document describing the Palm Beach County Fire Rescue MIH Pilot Program focused on high frequency callers. It is an example of a concise description of a program that would be helpful to inform stakeholders including your local radio stations and newspapers. You may even turn them into champions.

## > Organizing a Local Alliance

For purposes of this discussion, an alliance is the group of stakeholders and other individuals or groups that you have organized to help you. Organizing an alliance is an important task, and they are an important variable in all stages of the program design and implementation. The relationship between the program leader and the stakeholders is key as stakeholders may be powerful foes or allies. Since trust is at the heart of a relationship, all communication must be open, honest and frequent. The program leaders must communicate

effectively, listen, seek to understand, and put the needs of the stakeholders above their own. By carrying out these activities, leaders will create an environment of trust.

The program leader works with stakeholders to identify problems and solutions, as well as resources in the community that are already focused on the need/problem. The stakeholders provide important information regarding the political, social, and cultural waters that the leader must navigate.

Potential alliance members you may include:

- Primary Care Providers
- Nursing Home Professionals
- Hospice Professionals
- Hospital Administrators
- Senior Center Representatives
- Visiting Nurses Professionals
- Third Party Payors
- Law Enforcement Representative
- Fire Department Representative
- Social Service Agency Representative
- Public Health Representative
- Pharmacy Professional
- Mental Health Professional
- Federally Qualified Health Centers
- Local Charities Representative
- (based on the type of service)
- Civic / Veterans Organizations
- Education Institutions
- Potential vendors (e.g., Telemedicine)
- Church Representative
- Public Representative
- Local Government Representative
- State Government Representative
- Transportation Organizations



*Whoever leads the program must be all in and excited about the program.*

**Wendy Crews**

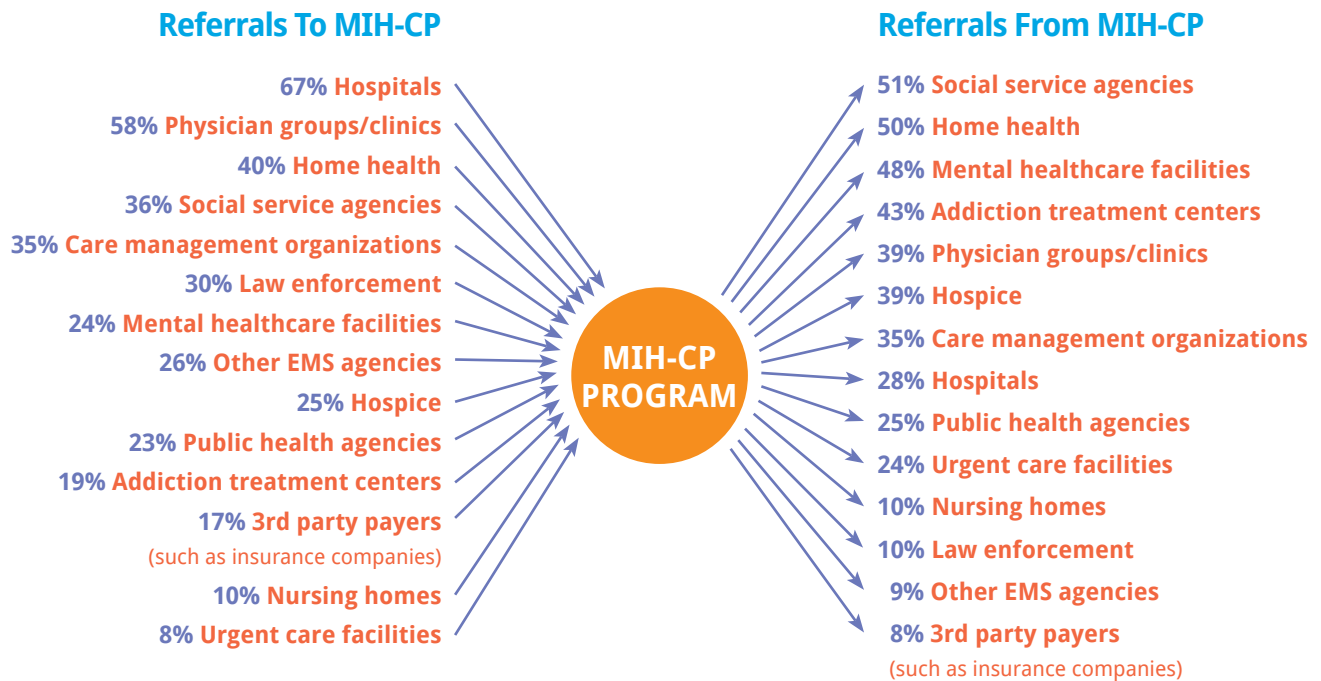


*Be multifaceted – everyone can be used to help a patient. Look at community options because each is unique (Meals on Wheels, churches, etc.). Be sure to also consider national partners as resources.*

**James Crutchfield**

Keep in mind that all parties must see value when participating in the program. NAEMT’s Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey illustrates the quid pro quo of referrals between stakeholders and your MIH-CP Program and the information in Table 6 came from that report. It summarizes the quid pro quo modified to show the central position of your MIH-CP Program. Be sure to think about how you can provide value to the stakeholders, not just what they can do for you.

**Table 6:** MIH-CP Referrals



One tool you can use to help craft your message is a NAEMT resource, EMS 3.0: Explaining the Value to Payers. It provides talking points and answers to key questions asked by specific types of stakeholders. You can find it at [http://www.naemt.org/docs/default-source/2017-publication-docs/ems-3-0-talking-points-to-payers-2018.pdf?sfvrsn=952fcb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/ems-3-0-talking-points-to-payers-2018.pdf?sfvrsn=952fcb92_2)

Historically, it has been difficult getting third-party payors, such as insurance companies, to partner with MIH-CP programs. But, that is starting to change. After piloting projects with MIH-CP programs throughout the nation, they are now more interested in talking about and developing partnerships with MIH-CP’s to provide services.



Matt Zavadsky, Chief Strategic Integration Officer at MedStar Mobil Healthcare, recommends you be selective. Your focus should be on the organization’s largest third-party payor, not the one you bill the most. For example, if Medicaid is billed \$600K, but only pays \$200K, and XYZ company is billed \$300K and pays \$250K, they should be partnering with XYZ, not Medicaid. Zavadsky goes on to say, *“You want to bring those organizations to the table to see if they are interested in developing a new model where they pay for all responses irrespective of transport.”*



*The payors have finally awoken.*

**Matt Zavadsky**



*More communication with stakeholders that is continuous and consistent.*

**Richard Ellis**



### **What It Takes to Lead a Local Alliance**

Leaders need visionary skills to develop a shared understanding of community problems, build support for beneficial solutions, and develop a commitment to collective action. They need political skills to turn a proposed solution into a specific program. One important consideration: The relationship between the stakeholders and the program leader may disintegrate if the program leader is perceived as biased towards one group or another. The effective program leader must nurture the stakeholder alliance by participating in honest and open dialogue.

Also, the program leader may not be able to give the stakeholders everything they desire, but this must be communicated in open and honest dialogue. Always consider that alliances will disintegrate if the program leader fails to communicate, communicates in a biased manner, lacks objectivity, has preconceived solutions, has a personal agenda, and does not listen to members.

## > Chapter 3 References and Resources

1. An older text, but a classic that presents a depth discussion of Power Versus Interest Grids and approaches to solving perennial and thorny public problems. Crosby, B. & Bryson, J. (2005). Leadership for the Common Good: Tackling Public Problems in a Shared-Power World, 2nd Edition. Jossey-Bass.
2. Potential alliance members may be found through your regional Healthcare Coalition. To learn more and find the one in your region: <http://www.floridahealth.gov/%5C/programs-and-services/emergency-preparedness-and-response/community-preparedness/healthcare-coalitions.html>
3. The National Association of County & City Health Officials provides resources for engaging public health system partners, stakeholders, and community members. It has PowerPoint presentations, a webinar on facilitating diverse groups, and many tools and forms for engagement. <http://archived.naccho.org/topics/infrastructure/CHAIP/partner-engagement.cfm>
4. For more information on Federally Qualified Health Centers go to <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf>
5. Find your county's Federally Qualified Health Center at <https://findahealthcenter.hrsa.gov/>
6. NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey: [http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2)
7. NAEMT EMS 3.0: Explaining the Value to Payers. [http://www.naemt.org/docs/default-source/2017-publication-docs/ems-3-0-talking-points-to-payers-2018.pdf?sfvrsn=952fcb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/ems-3-0-talking-points-to-payers-2018.pdf?sfvrsn=952fcb92_2)



Clarify your mission, vision, and purpose for the program. Establish what you want to accomplish.

Orlando Dominguez, Jr.



Manatee County Florida Community Paramedicine

### What will you do: Mission Matters

Any discussion of what you may do in response to your needs assessment that used internal, external, or both types of data, must be based on solid and clearly defined vision, mission, and goals.

A vision statement is the “Where are we going?” statement. It should be an aspirational description of what we want to achieve or accomplish. An example is: *“To have XYZ County free of all preventable illness and injury.”* It’s a high-level picture of where we want to be in the future.

Your mission statement is the heart of your MIH-CP. It is the “why” you are doing it. Everything else flows from that “why.” It guides what you do and how you do it. It’s the basis of all your communications and

marketing. An example might be: *“Our mission is to improve the health of every person in our county by bringing healthcare to their door.”*

A helpful YouTube video called Ted Talk by Simon Sinek illustrates the importance of the “why.” A link is provided in the resources at the end of this Chapter. Bring together a diverse group of individuals to watch the video and work on the development of an inspirational mission statement. Include people with differing viewpoints and experiences in this activity to maximize the generation of ideas and, ultimately, their buy-in to the program. Individuals to consider are potential stakeholders/alliance members and customers, internal leaders, and potential employees of the program.

Once, you have your inspirational program vision and mission compare it to your organization’s mission statement, vision, and goals. Are you in alignment with the organization? If you are, this gives you leverage in seeking support and funding because you can emphasize that your program will help the organization achieve its mission, vision, and goals. However, if it is not in alignment, the opposite is true. You may have a challenge “selling” it to the leaders of your organization. If that is the case, see if you can revise your program mission to be in alignment with your organization’s mission.



*If you’re in it just for the dollars, don’t do it. Do it for the right reasons: your mission. Mission matters.*

**Richard Ellis**

## > Program Goals

Your program goals should define how you want to achieve your mission. After articulating your goals operationalize them by specifying strategies and objectives. Using the example mission from above, how do you improve the health of every person in your county by bringing healthcare to their door? There can be multiple goals focused on different ways of meeting the mission. Possible goals for this mission statement might be:

- Establish strategic partners to support the provision of bringing healthcare to their door.
- Improve the health of residents with diabetes.

These are just 2 examples – you need to have that direction of how your program is going to achieve its mission in your goals.

## > Strategies and Objectives

Your strategies are more defined actions you are going to take to achieve the goal and your objectives are very tactical and measurable. Table 7 provides an example goals, strategies, and objectives.

**Table 7:** Goals, Strategies, and Objectives

Goals	
Establish strategic partners to support the provision of bringing healthcare to their door.	Improve the health of residents with diabetes.
Strategies	
Create a strategic partner development plan with supporting materials.	Develop an in-home chronic disease management system for diabetes.
Objectives	
Within the first 6 months, establish agreements with at least 4 strategic partners to either provide the services “to their door” or funding to support a Community Paramedic to deliver the services.	Within the first 6 months, test the in-home chronic disease management system with 20 diabetic residents and perform a baseline health analysis.

Finally, verify that your program goals, strategies, and objectives are not in conflict with others in your community. You want to build on other's work in the community or complement the services they are currently providing. A MIH-CP should not duplicate or compete with the currently available resources. If you have a conflict, see if you can work together to accomplish common goals, strategies, and objectives or consider addressing another gap in healthcare or unaddressed need in your community. Working together and not in silos creates higher success rates for everyone involved.

## > Developing Your Implementation Plan

You've identified the need or problem to work on, stakeholders to engage in your alliance, and developed your vision, mission, goals and objectives. This is where you describe your intervention – the what. Again, what are we going to do to accomplish the program goals? Strongly consider, an evidence-based practice that has been shown to eliminate the problem you identified, stop it in its tracks, or minimize its consequences.

Your program implementation plan includes a description of:

- How the proposed MIH-CP services are appropriate to meet the identified needs.
- Who are the leaders, managers, and other staff executing the program?
- What does the organizational chart look like and who reports to whom?
- Will there be a single person doing everything or are other staff required?



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*Consider evidence-based interventions. If none exist, consider data-driven innovation.*

**Lauren Young**

- How the program integrates with other community services, providers, other levels of care, and referrals.
- The evidence-based practice, best practice, or data-driven innovation that will be part of the program. For example, if you are conducting a fall reduction program the U. S. Department of Health and Human Services, Centers for Disease Control and Prevention's Preventing Falls: A Guide to Implementing Effective Community-Based Fall Prevention Programs is an example of an evidence-based practice you could use.
- A description of the organization's standard operating procedures (SOP) that are on-hand or will be developed.

When you prepare your implementation plan, include appropriate and reasonable time-framed tasks (i.e., infrastructure planning, staff recruitment and retention, facility development/operational planning, information system acquisition), as well as individuals charged with their completion.



## Policies and Procedures

Regarding policies and procedures, every program should have clear statements of their policies and procedures that lead to the articulation of standard operating procedures (SOPs). It is important to actively involve the medical director in their development since the Community Paramedic's scope of work is based on medical direction.



*Define a specific program and build processes around it, because the process allows you to expand to other types of problems once you have them in place.*

**Don Hughes**

Specific SOPs to include as part of your program are the following:

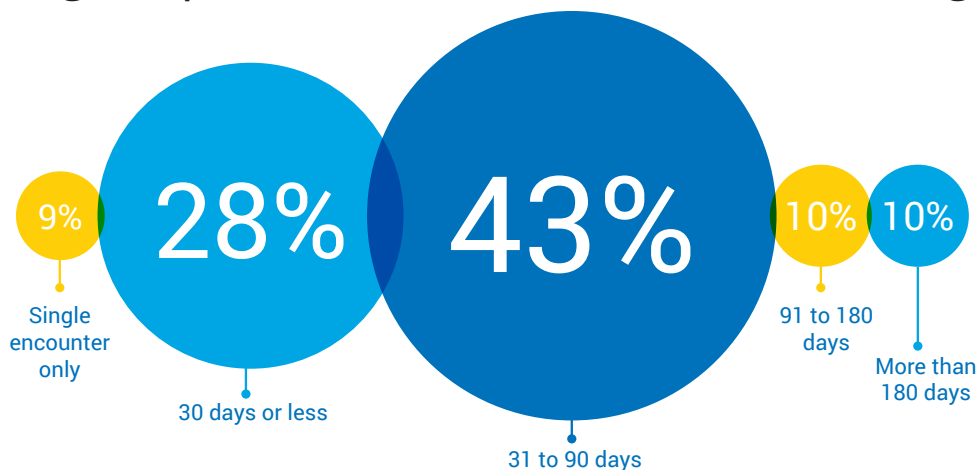
- General Physical Assessments
- Home Safety Assessments
- Medication Reviews and Reconciliations
- Emergency Situations
- Patient Consents in compliance with the Health Insurance Portability and Accountability Act (HIPAA)
- MIH-CP Entry into Care and Discharge
- Quality Assurance

Other questions to ask and for which you may need SOPs are: How do clients and referring providers or organizations reach you? Will clients call a dedicated line or the main number? What are the advantages and disadvantages of using Email? If you need to develop SOPs, the NAEMT MIH-CP Toolkit provides sample SOPs and forms that may be used to develop your own program's SOPs. Be sure to customize the SOPs to match the design of your program and the services you provide.

Table 8 is from the 2nd National Survey on Mobile Integrated Healthcare and Community Paramedicine. It illustrates the length of time patients are enrolled in the 129 organizations that responded to the NAEMT survey. It is helpful to get a "ballpark" idea of what you might expect. This information may be useful as you plan your program and develop a SOP for how clients enter your MIH-CP Program.

**Table 8:** Length of Enrollment

## How long are patients enrolled in the MIH-CP Program?



[Appendix H](#) is a sample MIH Provider Referral Entry into Care Form and [Appendix I](#) is a sample MIH Provider Initial Contact Form. Use the forms to develop your customized enrollment SOP.

## > Resource Guide

Developing a compendium of resources is so important. While it is everyone responsibility to identify community resources, it is strongly recommended that someone is assigned to update and continuously maintain a Community Resource Guide for the program. Most county social service agencies already have and use a community resource guide. However, you may want to remove or add resources which are specifically focused on your program services. Resources may include medical equipment/supplies, prescription assistance, and the name and location of food pantries. Creating a guide for your agency's program is an essential duty to ensure overall program success.

## > Selecting a Leader

As you've been developing the mission of your MIH-CP, there must be a person with the vision of what it will look like, the passion for getting over challenges, and the desire to make it run well. This is who you want to lead the program! You need to select someone who doesn't have an "I'm doing it because I was told to" attitude. Find the real champion to lead your program – and it may not be the one with the most experience or the most senior person!

Several of the MIH-CPs in Florida interviewed are operated by fire departments, and one of the issues they have encountered is the department seniority system. The system may limit the selection of the MIH-CP leaders, and, at times, prevents them from placing the real champion in the leadership position. This may be a challenge you need to address early in your program development.

As discussed earlier, leadership skills are not the same as emergent or acute care skills needed to work directly with a patient. Look for leadership skills and traits, such as excellent listening/communication, a heart for service, empowers others, patience, commitment/dedication, humility, respectfulness, foresight/visioning, honesty/integrity, innovative, inspirational/passionate, and transparent/authentic.

*Budget Note: Insert the annual cost of your leader's salary and benefits under payroll expenses – Salaries of Leader and Staff. Keep in mind that the actual cost is not just the salary of the person, but the employer required matching taxes, unemployment insurance, workers compensation, retirement benefits, and insurance.*



*Identifying the resources within the community, and establishing the reliability, availability, supplies and qualifications was the greatest challenge to starting a MIH-CP program.*

**Orlando Dominguez, Jr.**



*Finding an employee who wanted to do it was the challenge. Getting the data was easy and talking to people is easy.*

**John McNamara**



Brevard County Florida Community Paramedicine

## > Staffing

Once you have your leader, you will need to develop an organizational chart, job descriptions, and a staffing plan. Many MIH-CPs begin their program by placing a light duty paramedic in a community paramedic role.



*Take time to find ‘good’ staff - they will make or break your program.*

**Ariella Bak**

Things you need to consider are:

- Does the MIH-CP program fit into your current organizational chart? To whom does the leader of the MIH-CP program report? Or, do you need a separate organization chart for your MIH-CP program?
- Do you need MIH-CP coverage 24/7, part-time or full-time staff?
- Will you operate every day or only during the week or weekends?
- With the shortages in the EMS industry, does it have to be a paramedic? Can it be another medical provider or a partner? Can it be a non-medical person?
- How many people do you need to operate it, such as field personnel, partnership/alliance management, billing, reporting, data analysis, and administration?

Based on your responses to these questions, the next steps are developing your organizational chart, staffing plan, and job descriptions. For your organizational chart, you can either build on and modify your current organizational chart or use the template in [Appendix D](#) to develop a new one.

Your staffing plan is a key component of your business plan that describes the number and types of people to involve, what they will be doing, and when they will be doing it. After your staffing plan is complete, develop job descriptions for each staff person, including the leader. In the job description, define the education and experience qualifications, responsibilities, and desired skills. Include any additional expectations of the position, such as continuing education requirements.

## > Staff Skills

Recently, a MIH-CP online student described the work of Community Paramedics as being focused on closing the gap between emergency room care and care in less costly settings. So, how are the skills of an emergency care Paramedic different than the skills of a Community Paramedic? This was a question asked in the interviews with the 11 MIH-CP organizations in Florida. Here are paraphrases of what they said:

- We hire both pre-hospital Paramedics and Community Paramedics based on the same criteria. All medics require critical thinking and problem-solving skills, but we also look for compassionate Community Paramedics.
- Looking for expanded history taking and physical examination skills so that the Community Paramedic can see broader health concerns.
- A willingness to take on unplanned service calls.
- A willingness to expand the scope of practice and do things outside of EMS critical care.
- Additional pharmacy and lab training is a plus.
- Soft skills, communication, and all skills considered part of an individual's emotional intelligence.
- An ability to get things done.
- Experience navigating the healthcare system.
- Advocacy skills.

Skills you should look for when hiring Community Paramedics for your MIH-CP are good problem solving, strong advocacy, excellent listening/communication, observant, a heart for service, patience, versatile technical abilities, compassion, commitment/dedication, respectfulness, honesty/integrity, innovative, passionate, and authentic.



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Keep in mind that not all the MIH-CP skills are taught in paramedic training programs, and employees in the MIH-CP program may not know what is required or understand the MIH-CP paradigm. The MIH-CP is a paradigm shift from the traditional pre-hospital paramedic practice. It is a shift in practice and the thought process.

The skills previously described are consistent with the recommendations of Dan Swayze. In his 2015 article published in JEMS, he identifies the core competencies for community paramedics as the following:

1. Expanded Patient Assessment
2. Therapeutic Communications
3. Understanding Mental Health
4. Patient Navigation & Advocacy

Swayze goes on to highlight the concept of localization. That is to say; programs are unique to their social, cultural, and geographical context. Consider your community's social, cultural, and geographical context as you design your program and recruit and train staff.



*The skills in the CP program require more detective work and root cause analysis capabilities.*

**John McNamara**

NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey asked the 129 MIH-CP programs about personnel requirements. Field EMS experience was by far the most common response at 88%.

College-based community college paramedic education was 27%. Some required more specialized training, 27% required behavioral health crisis intervention training, 21% required critical care training, and 7% required community health work certification.

A template Performance-Based Community Paramedic Job Description is included in [Appendix G](#).

*Budget Note: Add the salary cost of your staff and the salary of your leader under payroll expenses – Salaries of Leader and Staff. And, be sure to once again add the additional costs of benefits for the staff to the leader benefits.*

*Budget Note: If you plan to staff using overtime, include the salary and benefits of the staff under the overtime row as overtime is at a higher rate of pay than standard pay.*

## > Training / Skill Development

Often initial and ongoing training expenses are overlooked. In the section above, you've identified the job responsibilities and skill sets necessary for your program. How will you either obtain those skills, enhance them, or maintain them for a successful program?

What type of initial training is necessary to launch your program? Will you send the person to training outside of your organization? If so, you need to consider not only the tuition and fees, but the associated travel expenses, such as transportation, hotel, and meals. If you are conducting in-house training or doing training on-line, be sure to include any associated expenses as well.

You may also want to plan for enhancing the skills sets of the staff. Evaluate what skills will expand or elevate your program to greater success. Will a special certificate or degree be of value to the individual and your MIH-CP program?

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## > Levels of Community Paramedic Training

There are various levels of training for Community Paramedics. Here are some examples:

### ***Bachelor of Science – Community Paramedicine Specialization***

Seminole State College of Florida offers a medical specialty degree in Community Paramedicine. The candidate must have an Associate's degree with a 2.0 GPA or higher, completed a Florida Department of EMS approved paramedic program or be eligible for certification as a Florida paramedic, or be a certified Florida paramedic. The program covers legal and ethical aspects, communications, research, economics, systems, management, general education courses (i.e., math, science, history); and specific CP programs in delivery and practice of community paramedicine. Total hours is 120.

### ***Associate in Science Degree Program:***

Northern Maine Community College, Presque Isle, ME offers an Associate degree in Community Paramedicine. Required courses are Health & Safety Compliance; Community Paramedicine; English Composition; CP Skills Lab; CP Clinical; Leadership in EMS; Community Paramedicine Seminar; College Algebra; Anatomy & Physiology I & II; Introduction to Nutrition; a Communications elective; General electives; General Psychology; Sociology; and Humanities. A total of 60 hours of education.

### ***Advanced Certificate Program:***

Northern Maine also offers an Advanced Certificate program, for those already possessing an Associate degree or higher. The courses are the same as those for the certificate program described below, excluding the English and Math courses. Total hours is 16.

### ***Certificate Programs:***

Hennepin Technical College, Eden Prairie, MN offers an advanced Technical Certificate as a Community Paramedic. It requires a current license as an EMT-P and at least two years of experience as a paramedic. The curriculum is 14 hours, covering the topics of Role Advocacy and Outreach; Community Assessment; Care and Prevention Development Strategies; and Community Paramedicine Clinicals.

Northern Maine also offers a certificate requiring 22 hours of education. It covers Health & Safety Compliance; Community Paramedicine; English Composition; CP Skills Lab; CP Clinical; Leadership in EMS; Community Paramedicine Seminar; and College Algebra.

### ***Certificate Programs – Online:***

Nature Coast EMS offers an online Community Paramedic certificate program focused on two things: skill development and program design and implementation. Recognizing that technical and soft skill sets are different

for acute care, emergent care, and leadership, the program addresses those skills necessary for a community paramedic. It also guides you through the development of a customized business plan for a MIH-CP Program.

Northern Maine is currently testing an on-line version of their Community Paramedicine curriculums with the clinical portion being completed locally. At this time, it is not available, but likely will be offered in the near term.

When evaluating a training program, be sure to look for one specific to the community paramedic role. Many training programs are using the term “paramedicine” and “paramedic” interchangeably. For instance, Metropolitan Community College, Omaha, NE offers a certificate of achievement in Paramedicine. However, when you read the curriculum, you see it is preparing students to become a paramedic and sit for the National Registry exam. It is not focused on the specific community paramedicine skills.

#### **Certification:**

The International Board of Specialty Certification offers a CP-C certification exam. It is not an educational program, but a test designed to validate the competency of paramedics providing services beyond the roles of traditional emergency care and transportation.

*Budget Note: Keep in mind that higher education levels will usually impact the salary or wages, so consider this when evaluating the salary in your budget.*

NAEMT’s Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey asked the 129 MIH-CP programs about personnel training. And, nearly all of them stated they required additional specialized training as follows:

- 87% Clinical training, such as medication administration and chronic disease management
- 73% Accessing community and social services resources
- 69% Patient navigation
- 69% Patient relationships/communications (ex: motivational interviewing)
- 58% Enhanced patient assessment

If your organization pays for continuing education credits for your paramedics, be sure to include the expense in your budget.

*Budget Notes: If applicable, under Miscellaneous Expenses, include the cost of initial training and continuing education training expenses in the budget in their respective section. Put the meals and travel costs associated with the training in their respective sections.*

*Budget Notes: Under Administration, include the cost of the licensing fees.*

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## **Human Resources Policy and Procedure Manual**

One final consideration involving staffing, verify your organizational chart, staffing plan, and job descriptions are consistent with your organization’s current Human Resources Policy and Procedures Manual. You may need to modify the Manual or your documents to be sure you are in alignment with the organization.

If you need to develop one for your MIH-CP, there are many online resources. One resource is the sample Community Development Corporation Policies and Procedures Manual developed by Local Initiatives Support Corporation to assist community development corporations. You can find the link to it in the references and resources at the end of this Chapter.

## > Logistics and Overhead Expenses

There are many issues you need to think about to make your program work. Here are some things to think about:

- How are you getting your personnel to the clients? Or, are they coming to you through a partnership arrangement of some kind?
- Will your staff wear uniforms?
- What capital equipment and supplies are needed for the staff person to do their job? Computers? Software? Medical equipment?
- What supplies/equipment, if any, are you giving to the client? Blood pressure machines? Diabetic monitoring systems?
- What kind of space do you need? Home-based or office-based?
- What are your space costs?
- What communication system is needed? How are clients contacting you? Are you using the non-emergency dispatch system?

- Other administrative overhead, such as office materials, supplies, internet, phones, utilities.
- What changes are required in your insurance coverage?
- Will there be legal fees to get started?
- Marketing costs. Be sure to include such things as the cost of materials, publications, copy costs, and logos on your vehicles.

*Budget Note: As you identify the necessary logistics and overhead expenses enter them into the respective budget lines.*

## > Multidisciplinary Advisory Committees

Identifying your stakeholders and partners for launching a program is important in the early stages of program design and the first step in beginning a relationship. These individuals may be working in conjunction with you to provide client services in the community. But that is not the end. You should also seek to leverage their talent, experience, and knowledge for continuous improvement, quality control, growth, and directional vision as part of a multidisciplinary advisory committee. They will be your community champions.



*Have as many hands involved in the program as possible. It is tough to do it alone. Continually develop your knowledge base. Match knowledge skills with diverse multidisciplinary skills of others.*

**John McNamara**



Matej Kastelic/Shutterstock.com

An advisory committee does just that – advises. It is not a board of directors and should have no operational authority or authority to mandate program changes. However, the power the committee does have is the power of “feet.” That is if they recommend changes, and, if those changes do not happen, they can walk away as stakeholders in your program. This can have a significant impact on your program – either for the good or the bad. That’s why it is important to carefully establish the parameters of the committee. You can call them By-Laws or Guidelines, but essentially you are defining what you want the committee to help you with and how to do it.

The items to consider when designing your Multidisciplinary Advisory Committee are the following:

- Mission of the Committee (verify it is consistent with the program mission)
- Goals of the Committee (verify they are consistent with the program goals)
- Number and selection process of committee advisors
- Specific disciplines/professions?
- Required qualifications
- Removal of an advisor
- Selection of Chair / Co-chairs
- Meeting frequency (should be on a set schedule)
- Calling special meetings
- Meeting notice requirements, if any
- Quorum requirements, if any
- What can come before the committee
- Conflict of Interest
- Confidentiality

The mission of the committee should describe the role they play in your organization. Generally, they are used to provide guidance on issues of quality, service offerings, innovation, and growth. Be sure it is consistent with your program's mission.

Establish goals for the committee. What do you want them to achieve – again, be sure they dovetail into your program goals.

Identify the make-up of the committee. Establish the number of advisors. It is often helpful to specifically identify “seats” by profession to maintain a specific mix of advisors. Strive for diversity in medical disciplines and practices, selections from various community-based organizations, and if feasible, a public voice of the client. Describe the qualifications, if any. Who will select the advisors? How do you remove an advisor?

Finally, create a structure for the meetings. Who is the chair/co-chairs? How often will the committee meet? If government based, is public notice required of the meetings, and if so, what are the requirements for calling and holding a meeting? Can there be special meetings called? How? What items can come before the committee meeting? Even though it's advisory, do you want to require a quorum? These functional issues need to be addressed so everyone knows from the start what is expected of them, how their advice will be used, and how information will be discussed and shared.

*Budget Note: If you anticipate expenses for the committee, place those under “Other” in the Miscellaneous section.*

## > Reaching Your Target Market



An important question to consider is: How will you reach the target market for your program; the populations most likely to benefit from your program? Regardless of the way you set up your MIH-CP, you need to consider how to attract clients. What gives your program client value? You need to develop a Marketing Plan.

Your first marketing consideration is to define who you are serving. Who is the target market for your service and what are their demographics? You should have already done this as part of your needs analysis, so transferring it to a marketing plan should be fairly simple.

The next questions to ask relate to getting your program message to those clients. How do you reach these clients? Do you need to solicit the clients directly? Or, do you need them to be referred to you by others, such as primary care

*Pay to have professional marketing materials developed. Don't do it on your own. It helps to open doors.*  
**Wendy Crews**

physicians, hospital discharge nurses, or your own EMS staff? If you need referrals, then your marketing efforts will not be directed to the client, but to the people who do the referrals. This is an important distinction as the marketing message is different for each because their concerns, values, and desired outcomes are different.



Once you've identified who you need to target your marketing efforts to, then consider what the message will be for that group. If you are marketing directly to the client, you need to consider why these clients should use your service? What is it about your service that makes it unique to any other in the market? What value do you bring to them? Develop a solid value proposition or reason a client should use your service. For example, Our MIH-CP program brings healthcare to your door. It eliminates the concerns of driving or needing to call an ambulance when you need transportation for medical care. If driving is a concern for an elderly person then they see value in your service.

But, if you've targeted primary care physicians for the marketing message to get the clients you want to serve, the message will be different. You still need to ask: What is it about your service that makes it unique to any other in the market? What value do you bring to them? Your message may be: Our MIH-CP program extends your compassionate, competent care through our professional healthcare providers to your special need patients (insert the needs you're targeting). This message speaks to a physician about how to address patients with specific needs in a professional manner that he or she is otherwise unable to provide. There is value to them.

Now that you've identified the group to target for your message, the next issue is how you are going to reach them? What marketing materials do you need? What kind of print or social media will work, if any? Do you need to do face to face or office visits? Do you need flyers, brochures, business cards, etc.? How can your stakeholders help you get the message to the target group? As you develop this strategy, be sure to include the cost of the marketing materials in your budget.

In [Appendix E](#) there are two simple one-page marketing plan templates by Ivana Taylor from Small Business Trends. Using the link in [Appendix](#), you can access the marketing plan templates and actually write your plan into the template. She also provides mocked up sample plans you can use as a guide.

Finally, an important consideration in marketing is how you want to be branded in the community. In interviews with the Florida MIH-CP programs brand visibility is sometimes an issue. Some programs use unmarked vehicles because their clients don't want their neighbors to become alarmed if they see an EMS logo on the vehicle parked outside their house. Alternatively, other programs use their EMS logo vehicles. In those communities seeing an EMS vehicle is not alarming, and people are reassured that a trusted and respected provider is caring for their neighbor. It is something you need to be sensitive to as you develop your program to meet the needs of the community you serve and the preferences of the client.



“

*Get out there - make contacts, shake hands, tell your story, and provide information.*

**Christine Long**

City of Gainesville Florida Community Paramedicine

*Budget Note: Once you have developed your marketing plan, assign costs associated with the implementation of the plan, such as printing, vehicle logos, marketing development and maintenance contracts, and social media development. Enter the cost into the line for marketing/public relations.*

## > Chapter 4 References and Resources

1. Ted Talk by Simon Sinek on developing your mission – your “Why” to inspire action: [https://www.ted.com/talks/simon\\_sinek\\_how\\_great\\_leaders\\_inspire\\_action](https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action)
2. The NAEMT MIH-CP Toolkit provides sample SOPs and forms that are available at <http://www.naemt.org/initiatives/mih-cp/mih-cp-program-toolkit>
3. Centers for Disease Prevention and Control’s fall prevention resource Preventing Falls: A Guide to Implementing Effective Community-Based Fall Prevention Programs is available at [https://www.cdc.gov/homeandrecreationalafety/falls/community\\_preventfalls.html](https://www.cdc.gov/homeandrecreationalafety/falls/community_preventfalls.html)
4. Sample Community Development Corporations Policies and Procedures Manual: <https://community-wealth.org/sites/clone.community-wealth.org/files/downloads/tool-lisc-procedure-manual.pdf>
5. Another guide on writing a Policies and Procedure Manual is from Professor Michael Griffin, How to Write a Policy Manual. It is not a sample, but instead provides guidance and tips on the development of the manual. <http://templatezone.com/download-free-ebook/office-policy-manual-reference-guide.pdf>
6. NAEMT’s Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey: [http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2)
7. Another example job description is found in the NAEMT MIH-CP Program Toolkit at <http://www.naemt.org/initiatives/mih-cp/mih-cp-program-toolkit>
8. MIH-CP Knowledge Center has many resources you can utilize in the development of your plan. There are articles, research, case studies, legislation information, tools, policies, and survey information. <http://www.naemt.org/initiatives/mih-cp/mih-cp-knowledge-center>
9. The National Highway Traffic Safety Administration, Office of EMS has resources on education, workforce, research, data, preparedness, and advancing EMS systems. <https://www.ems.gov/index.html>
10. South Carolina Office of Rural Health, Blueprint for Community Paramedicine Programs, Especially for EMS Agencies, Version 1: The Abbeville Experience is an overview and resource to see how others have developed CP programs. [https://nosorh.org/wp-content/uploads/2014/08/SC-Community-Paramedicine-Blueprint\\_V1-Melinda-Merrill-and-Michele-Staneck.pdf](https://nosorh.org/wp-content/uploads/2014/08/SC-Community-Paramedicine-Blueprint_V1-Melinda-Merrill-and-Michele-Staneck.pdf)

### 11. Community Paramedicine specific programs:

- Hennepin Technical College Community Paramedic Certification program: <https://www.hennepintech.edu/program/awards/394>
- Northern Main Community College Community Paramedicine programs: <http://www.nmcc.edu/wp-content/uploads/CP-1718.pdf>
- St. Cloud Technical & Community College: <https://sctcc.edu/degrees-programs/community-paramedic/community-paramedic-certificate-13-credits-T>
- Seminole State College of Florida: <https://www.seminolestate.edu/catalog/program/HS-BS/paramedic2>
- Nature Coast EMS: <https://www.naturecoastems.org/education.php>

### 12. Metropolitan Community College Paramedicine programs – which are actually Paramedic training programs: <http://mccneb.smartcatalogiq.com/en/2016-2017/Course-Catalog/Programs-of-Study/Health-and-Public-Services/Health/Paramedicine-PMPMC>

### 13. Florida Administrative Code 64J-1.009 governing certification of Paramedics: <https://www.flrules.org/gateway/RuleNo.asp?title=Emergency%20Medical%20Services&ID=64J-1.009>

### 14. A couple of templates for a one-page marketing plan by Ivana Taylor from Small Business Trends can be found in the [Appendix](#) You can find links to others on the website: <https://smallbiztrends.com/2008/06/one-page-marketing-plan.html>

### 15. Chronic Disease Management for the Community Paramedic at <https://www.emsworld.com/article/12240314/chronic-disease-management-for-the-community-paramedic>

### 16. The Minnesota Department of Health offers an EMS toolkit with resources that help to address common issues faced by rural EMS organizations:

- The Recruitment and Retention section covers writing volunteer position descriptions, finding daytime volunteers, and retaining members: <http://www.health.state.mn.us/divs/orhpc/resources/ems/recruit.html>
- The Leadership and Management section provides links to podcasts and other resources: <http://www.health.state.mn.us/divs/orhpc/resources/ems/leader.html>

### 17. International Board of Specialty Certification for Community Paramedics: <https://www.ibscertifications.org/roles/community-paramedic>

### 18. You may find this link to the State Board of Education for Oregon’s resource called Developing a Local Advisory Committee Resource Handbook helpful: <http://www.oregon.gov/ode/learning-options/CTE/resources/Documents/Developing%20a%20Local%20Advisory%20Committee%20Resource%20Handbook.pdf>



Brevard County Florida Community Paramedicine

Putting numbers to a new MIH-CP is a challenge for most people. So, as you've been working through the development of your MIH-CP plan you've also been building a foundation for your first-year budget. Now, let's concentrate on how to fully develop your MIH-CP budget. We have provided a Budget Template in [Appendix B](#) to assist you.

## Expenses

First, the easier element, the expenses. Here are some basic, brief definitions by Investopedia to help you understand the budget. Expenses can be broken down into recurring and nonrecurring. Recurring are those expenses that are ones a company expects to have on an ongoing basis as an ordinary cost of doing business. Examples are fuel, equipment maintenance, salaries, leases, utilities, and supplies. Nonrecurring (or Capital expenses) are one-time or extraordinary expenses. Examples are vehicles, non-disposable equipment, buildings, and renovations to facilities.

In the Budget Template ([Appendix B](#)) you'll find Expenses in yellow. The template is divided into

Payroll, Operations, and Capital Expenses. There are many subcategories under each section. You may not have ALL of these expenses. They are there to simply help you think through what is needed in your program. You may have others to add as well.

Work through each expense category of the budget. Initially, the numbers will be a "guess" – yes, a guess. The figures you use are estimates based on the most current knowledge you have at the time. The numbers WILL change as you learn more and refine your program. It is important to always re-evaluate your budget figures when you make a change in any other part of your plan.

For the Payroll section, as mentioned earlier, the actual expense is not just the salary or wage, but the matching taxes, unemployment insurance, workers compensation, retirement and health benefits paid by the organization. Talk to your human resources person to determine a percentage of salary to use for these “extras” instead of breaking them down into individual categories on the budget. For instance, if a person’s salary is \$50,000, and the percentage for the “extras” is 30%, then you would enter \$50,000 on the salaries line and \$15,000 on the Benefits line.

If you anticipate overtime expenses, you’ll need to do the same – overtime wages + 30% for benefits.



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## > Revenue

According to the Mobile Integrated Healthcare and Community Paramedicine 2nd National Survey, only 44% of the national MIH-CP programs are reporting revenue generated by their programs. And, this is up from only 36% in 2014. Also, 36% continue to receive grants, and 30% say they receive no payments. Of the 49 programs generating program revenue, almost half of them made less than \$50,000, only 24% made over \$100,000. Revenue generation continues to be a real issue for most MIH-CP programs.

This revenue issue poses the greatest challenge in developing the budget for most start-up programs. If you are fortunate enough to be able to internally fund your program, then simply enter the amount of your total expenses into the “internal sourced funds” budget line, and you have a balanced budget. Easy. For most, you’ll need to determine where your revenue is coming from, and how much it will be.

## Here are some ideas for funding your program:

### Grants

Before you seek any type of outside funding, especially grants, you must be prepared. Here is a list of specific questions and things you need to do **BEFORE** you begin writing a grant for your program:

- Identify exactly what you need the funding for - Equipment, Training, Personnel, Operations, etc.
    - Your plan and budget will help you to identify what you need to fund and how much you need.
    - Make sure your boss approves the plan and budget for your grant proposal and that any partners already involved in the project are on board with it. It is a waste of your time to write a proposal if your boss or partners are not on board with your plan.
  - Research grant opportunities which closely match your needs
    - It is a waste of your time to write a grant that is not in alignment with your needs.
    - See the references and resource section at the end of this Chapter for possible research sites.
  - Once a grant opportunity is identified, research as much information as possible about it
    - What is the funding cycle?
      - Does it meet your project timeframe?
      - Do you have time to complete a strong proposal?
    - What are the eligibility requirements?
      - Is it only government/non-profits/for-profits?
      - Is only for rural or urban communities?
      - Is it only for serving specific demographics?
      - Can you partner with an eligible applicant to meet the requirements?
    - What are the geographic limitations?
      - Is it limited to a certain state, county, town?
    - Are specific partnerships required?
      - Is it feasible to develop the necessary partnerships in the required time frame?
    - Is the funding level appropriate?
      - It is a waste of your time to seek a very small grant if it does not get you to the amount you need to have a successful program. This is not to say that you can't use several smaller grants to fund a larger ticket item or the overall project but be sure in the end that you will have enough funding to complete the project if you are awarded the grant.
      - Are matching funds required? Do we have, or can get, those funds?
    - Who has received funding in the past?
      - Most funders will provide a list of past recipients. This will give you a good indication of whether your organization fits their funding profile.
    - What has been funded in the past?
      - Reviewing what has been funded will tell you a couple of things – either they focus exclusively on certain things – and you must be focused on the same thing. OR because they have been funding certain things for a long period, they are actually looking for something that goes beyond their focus. Be sure to ask yourself whether the current grant details support their continued focus or whether they are expanding beyond what they have funded in the past.
  - Who will be reviewing the grant proposals?
    - Some grants will provide you information on who will be handling the proposal review. If that is the case, it is very helpful to understand their style and focus: academic, data geeks, statistics, stories, impact, etc.
  - Start getting the required support from any influential partners, government, or others which can help your grant application.
  - Read EVERYTHING several times – the details on the grant are VERY important
    - Many, many grant proposals never make it to the reviewer because of late submission, errors in required formatting, failure to provide all information requested, etc. Understanding and meeting every detailed requirement in the grant is the only way to make it to the reviewers.
  - Based on your research, revisit your plan to see where adjustments can be made to more closely fit the grant requirements.
    - Don't compromise the integrity of your program just to get funding. Stay true to your mission.
    - If you do want to make changes to your plan, be sure to engage your boss and your partners in the conversation.
  - Call any contacts listed in the grant to help you clarify their requirements.
  - Attend any conference calls or webinars hosted by the granting organization.
    - This is where they will clarify what they are looking for in projects and will usually respond to questions from the audience.
  - Develop strong data to support your grant proposal.
    - Use data which supports THEIR priorities, not just yours.
    - Find comparison data to put your data into perspective. To say the percentage of calls for falls in your community is 30% doesn't provide a context for the number. If you use comparative data, such as the percentage of calls for falls in the state is 20%, then the reader understands the context and relevancy of the number.
  - Prepare a file to maintain your application documentation.
- So, the big question on everyone's mind: Where is the money?**



Using grants are like the chickens in a breakfast – they contributed (eggs), where funding the program internally is a commitment, like the pig in a breakfast (bacon). Commitment is a long-term focus.

Don Hughes

### Government Grants

When MIH-CP was a new concept in the industry, the opportunities for grant funding was more abundant. Monies were invested in pilot programs at the federal, state, and local levels to learn more about the optimal design of a program, the possible impacts a community paramedic could have to improve the health of a community, and alternative methods on how healthcare could be delivered. As those years of research have now shown that MIH-CP can have positive impacts on health and the delivery of healthcare, fewer grants are available for pilot or new programs, especially at the federal and state levels.

However, that does not mean federal grants don't come up on occasion. Most will be focused on testing a specific concept within a community paramedicine program or a health issue that a community paramedic could potentially address. It's less likely you'll find federal funding for a

start-up program unless your program has unique features which address a specialized federal initiative.

You can go directly to a federal agency to search for funding, such as FEMA's Assistance to Firefighters Grant Program at <https://www.fema.gov/welcome-assistance-firefighters-grant-program>, or the US. Department of Homeland Security for active shooter and provider protection equipment at <https://search.dhs.gov/search?query=grants+&op=Search&affiliate=dhs>.

You can also check for federal grants at the website, [www.Grants.gov](http://www.Grants.gov). The opportunities listed change daily, regularly checking it may help you stay on top of any quick due dates. By putting in key search words, like "Paramedics" shown in Screenshot 2, the current grant opportunities with that word in them will appear. You can click on the Opportunity number for greater details.

Screenshot 2

The screenshot shows the Grants.gov search results page. The search criteria include 'paramedics' as the keyword. The results table shows 4 matching opportunities:

Opportunity Number	Opportunity Title	Agency	Opportunity Status	Posted Date	Close Date
RFA-391-13-000009	Child, Newborn, and Maternal Health Project	USAID-PAK	Posted	04/03/2013	
DHS-17-GPD-083-000-99	Staffing for Adequate Fire and Emergency Response (SAFER) Grants	DHS-DHS	Posted	03/01/2018	04/27/2018
2018-NIST-PSIAP-UI	NIST Public Safety Innovation Accelerator Program – User Interface	DOC-NIST	Posted	10/30/2017	
72068718RFA00004	Accessible Continuum of Care and Essential Services Sustained (ACCESS) Program in Madagascar	USAID-MAD	Posted	02/27/2018	04/19/2018

State grants for start-up programs are not as abundant as they used to be. State matching grants are offered through the Emergency Medical Services Trust Fund at a 75/25 match or 90/10 match for rural service providers. Under FS 401.113 the grant funds are to be used to conduct research, increasing existing levels of emergency medical services, evaluation, community education, injury-prevention programs, and training in CPR and other lifesaving first aid techniques. Rural providers may also use the monies for improvement, expansion, or continuation of services.

However, this grant has experienced a steady decline in the availability of funding through the Trust Fund.

Check with the Florida Department of Health, Emergency Medical Service Section at 850-245-4440 and the Office of Rural Health at 850-245-4009 for current opportunities

or look at: <http://www.floridahealth.gov/%5C/provider-and-partner-resources/ems-grants/index.html>. Again, like federal grants, they may be focused on testing a specific concept within a community paramedicine program or a health issue that a community paramedic could potentially address.

Many MIH-CP have been started with grant funding from a local source. The Emergency Medical Services Trust Fund also provides monies to the counties for emergency services. When starting your program, work with your community and local government to see what may be available to help address a community health need.



*Don't rely on one funding source. Develop a diversified funding model so that you can expand your programs to meet the needs of your patient population.*

**Melissa McNally**

## Foundations

Foundations, endowments, and organizations with a philanthropic branch are another source of grant funding, or in some cases in-kind donations. However, each will be focused on very specific areas of interest to them. To help you find these opportunities, The Grantsmanship Center is one online site which may be beneficial. While not all their information can be accessed without a paid subscription, there is some free information. For example, this link will take you to the Top Giving Foundations in Florida: <https://www.tgci.com/funding-sources/FL/top>. By clicking on the name of a foundation in the list, you will find contact information and geographic focus. It will also provide a link to the foundation's website, where you can do additional research to determine whether their giving focus is in alignment with the focus of your MIH-CP.

## Associations

Various fire and EMS associations will occasionally offer grant funding to support new initiatives, training, or capital purchases which could support the start-up of an MIH-CP program. But in reality, they are usually more focused on being a resource for locating new grant opportunities. For instance, and as displayed in Screenshot 3, FireRescue1 sponsors a page on their website called FireGrantsHelp. This resource may assist in locating grants for fire departments, volunteer, and firefighter grant assistance: [www.firegrantshelp.com](http://www.firegrantshelp.com).



### Screenshot 3

UPCOMING GRANT DEADLINES >			
Grant Name	Administering Authority	Funder Type	Deadline
Kentucky Homeland Security Grant Program (HSGP)	Kentucky Office of Homeland Security (KOHS)	State	05/04/2018
New Jersey Public Health Emergency Preparedness- LINCS	New Jersey Department of Health	State	05/07/2018
North Dakota Hazardous Materials Emergency Preparedness Planning Grant	North Dakota Department of Emergency Services	State	05/07/2018
California Volunteer Fire Assistance Grant (VFA)	California Department of Forestry & Fire Protection (CAL FIRE)	State	05/11/2018
Lowe's Community Partners Grants	Lowe's Charitable and Educational Foundation	Corporate Foundation	05/12/2018

If you click on the Lowe's link in Screenshot 3, you'll find additional information. Screenshot 4 shows you what you'll find:

### Screenshot 4

## Lowe's Community Partners Grants

### GRANT DESCRIPTION

<b>Administering Authority</b>	Lowe's Charitable and Educational Foundation
<b>Funder Type</b>	Corporate Foundation
<b>Geographic Coverage</b>	AL, AK, AS, AZ, AR, CA, CO, CT, DE, DC, FL, GA, GU, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, Nationwide, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY
<b>Grant Category</b>	Capital Projects, Community Development, Emergency Response & Public Safety, Technology & IT, Emergency Management, Health and Wellness
<b>Deadline</b>	5/12/2018 - Note: This grant's deadline is rapidly approaching. Apply soon!
<b>Summary</b>	Overview: Lowe's Community Partners grant program helps build better communities by providing monetary assistance to nonprofit organizations and municipalities looking for support of high-need projects...

[> SUBSCRIBE TO READ MORE](#)

As you can see, it gives you enough baseline information to see if you may be eligible for the grant. However, if you want more information or assistance with the grant, it is only available to members subscribing to FireRescue 1 services. Alternatively, you could go directly to the Lowe's page and do a detailed analysis of the opportunity.

## Partner Funding

Some partners are willing to invest in a MIH-CP program because of a strategic advantage it will create, or financial savings it can generate for them. We've all heard about hospitals being charged significant fines for hospital readmissions. And a few Florida MIH-CP have partnered successfully with hospitals to reduce readmission rates. Most of the Florida MIH-CP we interviewed have had little luck getting hospitals to invest significantly in an MIH-CP despite the programs ability to help reduce readmission rates and subsequent hospital penalties.

However, insurance companies have been investing in and testing the MIH-CP model to determine if the model improves their members' health and reduces the overall cost of providing care. Table 9 presents a brief summary of some of the characteristics of a Florida MIH-CP program, Evolution Health, and the CONNECT Community Paramedic program, a national model, who created funding partnerships with insurance companies.

**Table 9:** Characteristics of MIH-CP and Insurer Partnerships

Insurance Partners	Florida Model	National Model
<b>Set up</b>	Organization started and designed based on the partnership	Collaboration between the City of Pittsburgh and its bordering 36 municipalities. Started to address the financial burdens certain patients were having on EMS agencies. Established a countywide resource team – no single EMS agency runs the program.
<b>Services</b>	Chronic care; transitional care; advanced illness management, health risk assessments; and unplanned urgent/emergent care	Chronic disease management for diabetes, asthma, and chronic heart disease
<b>Target Market</b>	Insured patients with Medicare Advantage or Affordable Marketplace Healthcare	Referrals from EMS agencies, hospitals, University of Pittsburgh Medical Center, and Highmark Blue Cross Blue Shield
<b>Insurance Partners</b>	Florida Blue and Aetna	Blue Cross Blue Shield and one other leading health insurance provider
<b>Funding</b>	Capital funding upfront monies from insurance provider in the Medicare Advantage population. Marketplace Healthcare was primarily a fee for service billing. Additional fee for service models were added to Medicare population as the program grew.	Funding from health insurance providers

According to Dan Swayze, Vice President and COO of the Center for Western Medicine of Western Pennsylvania, Inc. and project manager for the CONNECT Community Paramedic program, rural EMS agencies are often too small to work individually with insurance companies. They are usually looking for geographic markets with a higher concentration of their members.

Discussions have been ongoing with the Florida Association of Health Plans to engage and partner with the association and their members on MIH-CP programs across the state.

Finally, keep in mind that some partner funding can be in-kind donations. Even if your partners cannot provide cash funding, they may be able to provide equipment, supplies, and other items helping to offset your cash outlays.



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## Client Funding

Another source of funding is revenue from the patients or clients receiving the care. There is a new MIH-CP in Florida who recently launched their program using only patient pay as their ongoing revenue source. They have designed a model with enough client value that patients are willing to pay for the service without using third-party payers. Unfortunately, generating sufficient revenue to support your program is unique, but something you should also consider when you develop your program.

## Medicare/Medicaid Reimbursement

Unfortunately, Medicare and Medicaid programs do not reimburse for community paramedics in the State of Florida at this time. They will reimburse for services which include treatment if the patient is transported to a medical receiving facility. The patient must be transported. The reason for this is Medicare and Medicaid only reimburse for the actual transportation of a client by EMS/Paramedics/EMT's.

Some MIH-CP Programs will try to get around this reimbursement issue by using other types of medical providers. If this is something you want to consider, we strongly suggest you work with an attorney with expertise in this area to make sure you are in compliance. The penalties for violating Medicare/Medicaid laws are significant and not to be taken lightly.

## Budget Narrative

Depending on the complexity of your budget, you may want to include a budget narrative in your plan. The narrative simply explains to the reader anything you want them to know about the budget. For example, you may want to explain how you calculated a figure (i.e., employee benefits), or variances from previous year figures, or if it is a 3-year budget, the differences in figures between each year. The narrative can also be helpful for you in the event you want to make changes or to analyze year-end performance.

[Appendix A](#) is an outline for a complete business plan.

## > Chapter 5 References and Resources

1. Investopedia, <https://www.investopedia.com/ask/answers/072815/what-difference-between-recurring-and-nonrecurring-general-and-administrative-expenses.asp>
2. Community Tool Box: Writing a Grant Application for Funding: <https://ctb.ku.edu/en/writing-grant-application>
3. Another grant resource is Grant Station. It is a member-based program: <https://grantstation.com>
4. NEMSIS and EMSTAR are good resources for comparison data to support grant proposals: <https://nemsis.org/> and <http://www.emstar.org/>
5. Medicare Benefit Policy Manual, Chapter 10 - Ambulance: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf>
6. Medicare Claims Processing Manual, Chapter 15 - Ambulance: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf>
7. The American Ambulance Association has a strong advocacy program for championing changes to the Medicare and Medicaid laws. You can follow their efforts and changes in the laws at this site: <https://ambulance.org/advocacy/>.
8. Even though you may not be able to get Medicare/Medicaid reimbursement for MIH-CP programs, there is a current program through the Agency for Health Care Administration (AHCA) to seek additional reimbursement for Medicaid transports: Public Emergency Medical Transportation (PEMT) Supplemental Reimbursement Program. There are very specific qualification requirements, such as you must be an emergency medical transport provider, enrolled as a Medicaid provider, and owned or operated by an eligible governmental entity. The reimbursement does not cover recipients enrolled in a Florida Medicaid Managed Care Plan, non-fee service transports, and non-transports. Utilizing this program might be a way to infuse new money into your EMS organization to internally support a MIH-CP program. The 2 links below provide additional information and access to Excel spreadsheets for the PEMT:
  - Agency for Health Care Administration: <http://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/PEMT/index.shtml>
  - Florida Fire Chiefs Association: <https://www.ffca.org/pemt-public-emergency-medical-transportation-supplemental-reimbursement-program>
9. The Minnesota Department of Health offers an EMS toolkit with resources that help to address common issues faced by rural EMS organizations:
  - The Funding and Finances tools include finding grants, writing grant proposals, fundraising ideas, and a very detailed budget spreadsheet: <http://www.health.state.mn.us/divs/orhpc/resources/ems/funding.html>
10. Florida Association of Health Plans, Inc. <http://www.fahp.net/>
11. NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey: [http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2)
12. Article in JEMS magazine, January 17, 2015 on the CONNECT Community Paramedicine program: How Pittsburgh's Community Paramedic Program Links Patients to the Correct Care by Dan Swayze, Dr.PH, MBA, MEMS. <http://www.jems.com/articles/print/volume-40/issue-1/features/how-pittsburgh-s-community-paramedic-pro.html>



City of Gainesville Florida Community Paramedicine

This Chapter discusses techniques for assessing whether your program is making a difference in the lives of your patients, in the population you serve and in your community.

### What difference did you make?

It's important to know if your program is making a difference. It's important to you – you want to know if you're successful or not! It's also important to your clients, stakeholders, and funders. Whether or not you are making a difference is where the rubber hits the road.

After you have identified needs, engaged stakeholders, decided on an intervention, the next step is to decide how you will measure the success of your program. How did it make a difference to the people you served? Whether or not your program was a success depends on how well you met your goals. Performance measures operationalize your goals allowing you to assess your performance. Sharing the results of your assessments is one way to share your success story with internal and external stakeholders and to satisfy the requirements of grants and contracts for service.



*Look at realistic metrics based your population and make sure it serves the mission of your program. Utilize data to bridge information gaps, evolve the practice of patient care, and improve patient outcomes.*

**Melissa McCarthy**

## Performance Measures

Performance measures flow from your mission, strategies, and objectives and are important to determine the difference you make to the people you serve. Developing the mission, strategies, objectives, and performance measures sequentially allows you to see how they fit together. Taken collectively your mission, strategies, objectives, and performance measures are SMART:

- S for Specific
- M for Measurable
- A for Achievable
- R for Relevant
- T for Time-bound

Four things to remember: It is much easier to define your measures up-front, so you can capture the information required as you operate your program. It is much harder, if not impossible, to retrofit or force your data into a performance measure later. Second, if you are funded by a contract or grant, your funding agency will likely require performance measures. Third, you should measure what's important. Performance measures must be relevant and responsive to the health needs you are meeting and the evidence-based intervention you are providing. Finally, use your performance measure data as grist for your quality management program. Engage staff and stakeholders in a plan, do, check, and act improvement cycle if you find areas for improvement.

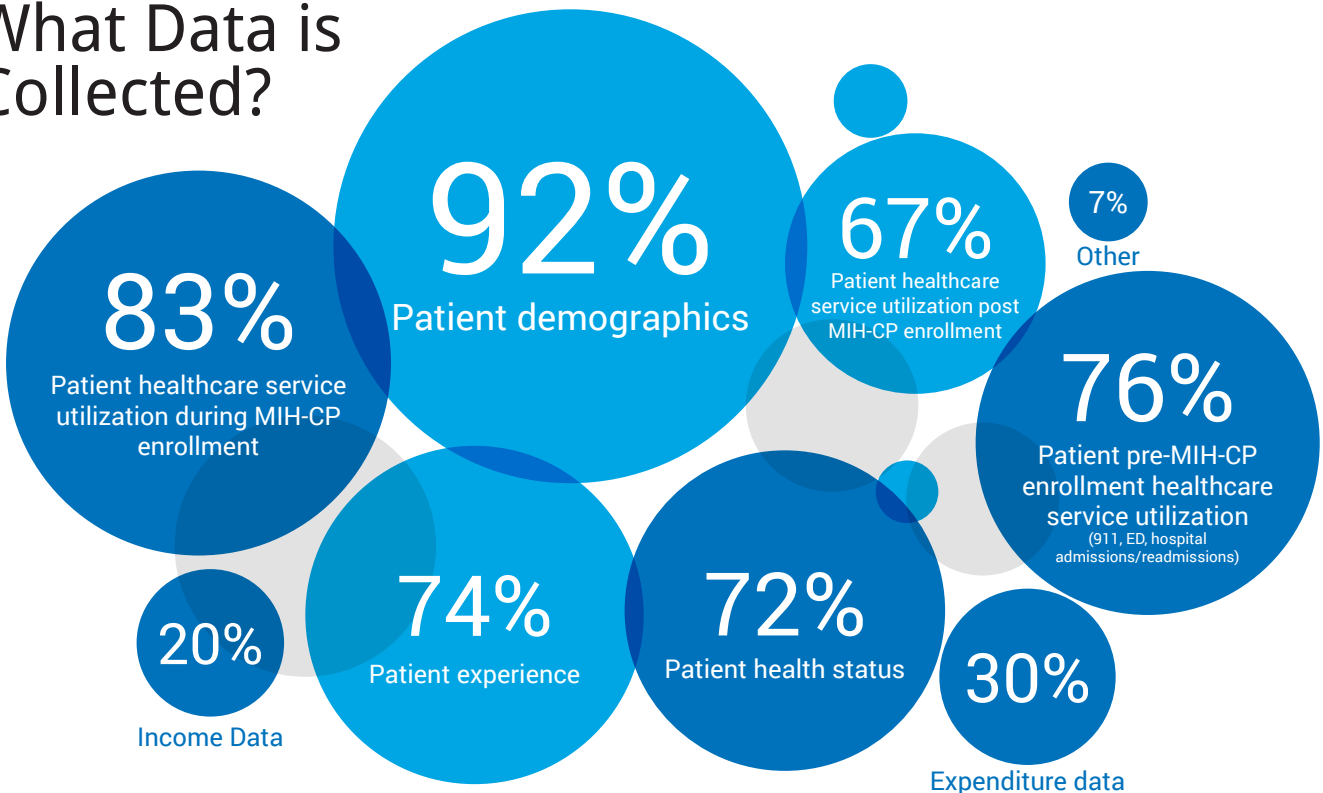
## Data Collection

Data collection and analysis is the lifeblood of performance measures. Without establishing a strong data collection and analysis process the accuracy and reliability of your outcomes and the overall value of your program can be questionable.

Table 10 describes the types of data collected by the 129 MIH-CP programs surveyed as part of the NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey. Keep in mind these collection points are based on what their goals and what they have determined is important to measure. What you need to collect will depend on how your program design.

**Table 10:** Data Collected BY MIH-CP Programs

## What Data is Collected?



The survey also asked respondents what methods they used to document client interactions. About half (47%) used EMS electronic patient care reports (ePCR) systems, 39% used shared electronic patient records systems (like with a hospital or primary care provider), 25% use commercially available MIH-CP specific systems, 21% use locally developed electronic record systems (word processing, spreadsheets), and 13% use pen/paper method. You will need to evaluate your resources, access to systems, what data you want to capture, and staff capabilities to determine the methods most effective for your program.

Another question is with whom should the data be shared? First, your staff and then your stakeholders. A best practice identified among respondents to NAEMT's survey is the bi-directional sharing of data between the MIH-CP Program and its stakeholders. Two-thirds of the MIH-CP's surveyed reported bi-directional sharing of patient health information. This bi-directional data sharing is an integral part of a successful program.

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Finally, take the time to create and document your database and data collection variables and processes. Set standards, monitor trends, and make program changes if appropriate. Become a data-driven organization.

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## Measuring Performance

Several tools and examples of performance measures are available. They run the gamut from simple and easy to use to complex and resource intensive. A brief description of a few is provided, and you can find additional information on them in the resources section at the end of this Chapter. An important consideration is that all performance measures must be relevant to your organization and your community, and logically flow from the intervention your program is implementing.



*You don't need to go for the 100% solution, even a 5 - 10% improvement means the client is better than they were before.*

**Lauren Young**

## Community Paramedicine Evaluation Tool

The Community Paramedicine Evaluation Tool (CPET), published in 2012 by the federal Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, provides a comprehensive program evaluation tool. It is designed for programs to use to evaluate an existing program or for programs who are considering starting a MIH-CP program. The CPET is organized around three core functions of assessment, policy development, and assurance under which benchmarks and indicators are described. Each benchmark (performance measure) is scored on a scale from 1 to 5, with 5 representing a "perfect score." Scoring a five is ideal and found in best practices. A link to the CPET is found at the end of this Chapter in references and resources.

As previously noted, the development and operation of a MIH-CP program is a process, a marathon not a sprint, and not all programs will reach a score of 5 for each benchmark. Using the tool in your program's continuous quality improvement is a good start. If you notice a less than adequate response to a benchmark, start a plan, do, check, and act quality improvement cycle. Engage your stakeholders and advisory group to decide which benchmarks are appropriate to your program, measure them, and then strive to reach a score of 5.

## NAEMT MIH-CP Program Toolkit

The NAEMT MIH-CP Program Toolkit contains sample performance measures that represent the consensus of a 2015 expert group that had input from over 75 EMS and healthcare associations. The intent of the performance measures is to assist programs in documenting their value to their clients, community, insurance companies, public payors, foundations, and other payors like federal, state, and local grantors. The development of the performance measures was guided by a Steering Committee that included Matt Zavadsky of MedStar Mobile HealthCare, Brenda Staffan of REMSA, Dan Swayze of the Center for Emergency Medicine of Western Pennsylvania, Brian LaCroix of Allina Health EMS, Gary Wingrove of Mayo Clinical Medical Transport and Dr. Brent Myers, former medical director of Wake County EMS.

As presented in the NAEMT MIH-CP Program Toolkit's outcome measures, the measures are organized into two domains each with multiple subdomains. The two domains and selected subdomains include the following:

1. Structure/Program Design Measures
  - a. Executive Level Commitment
  - b. Needs Assessment/Gap Analysis
  - c. Resource Identification
  - d. Stakeholder Engagement
2. MIH-CP Program Measures
  - a. Quality of Care & Patient Safety Metrics
  - b. Experience of Care Metrics
  - c. Utilization Metrics
  - d. Cost of Care Metrics – Expenditure Savings
  - e. Balancing Metrics

More information, as well as a description of how the MIH-CP Program Toolkit outcome measures were developed, may be found at <http://www.naemt.org/initiatives/mih-cp/mih-cp-program-toolkit>. When you reach the site, look for the following headings: Assessing the Value and Outcomes of EMS-Based Mobile Integrated Healthcare Programs, Measurement Strategy Overview, MIH Measures Workbook and MIH Measures Workbook Example.

Revisiting the NAEMT's MIH-CP Program Toolkit's outcome measures, Matt Zavadsky categorized these measures as falling into three basic groups. These are the program structure, process, and outcomes. These three categories align with the classical work of Donabedian who theorized that quality of care might be assessed by examining the structure, process, and outcomes of care. Some things to consider in assessing quality in each of these categories, but by no means exhaustive, are the following:

1. Program Structure – How is the program organized? Are sufficient resources allocated to meet the program's goals? Are staff in place to carry out the program? Is the necessary equipment available and in working condition?
2. Program Processes – These are related to how the program works and how you carry out your best practice or evidence-based intervention. Standard operating procedures are key.
3. Outcomes – These are described in terms of the difference you made in the lives of the people in your program. Did the client get their blood pressure under control? Did they report an improvement in their quality of life or self-perceived health status? Was there an improvement in the client's instrumental activities of daily life? Sometimes called an intermediate outcome, did the client's risk for a condition decrease, for example, did they quit smoking?



City of Gainesville Florida Community Paramedic



## INSTITUTE FOR HEALTHCARE IMPROVEMENT, TRIPLE AIM INITIATIVE

Another taxonomy for categorizing quality domains is defined by the Institute for Healthcare Improvement (IHI) in their Triple Aim Initiative. The IHI defines three domains of quality that collectively are referred to as the Triple Aim; these are the following:

1. Population Health
2. Patient Experience
3. Per Capita Cost

### 1. Population Health

There are several options for assessing your program's impact on the health of the population you serve. The interviews conducted with 11 Florida MIHP Programs revealed that most programs who assessed the impact of their programs on the health of a population used self-assessed health status, health-related quality of life metrics, and limitations of activity. Other Population health measures may be focused on your target population's general health and wellbeing. Equally as important, these measures may be specific to your target population's evidence-based intervention. The following narrative presents a description of the different tools to assess population health.

#### A. Self-Assessed Health Status

According to the federal Centers for Disease Control and Prevention (CDC), self-assessed health status is a validated and useful measure of how a person perceives their health. Respondents are asked to rate their health as excellent, very good, good, fair, or poor. It is assessed with a single question - "Would you say your general health is excellent, very good, good, fair, or poor?" Self-Assessed Health Status is assessed upon entry into and discharge from your MIH-CP program.

This measure is part of the National Health Interview (NHI), a large sample survey of the U.S. population. It is useful if you'd like to compare your program's clients to the general U.S. population. In the resources section at the end of this Chapter, there is a CDC link for additional information.

#### B. Health-Related Quality of Life

CDC describes Health-Related Quality of Life as a function of three modules of questions as follows:

##### 1. Healthy Days Core Module (4 questions)

- a. Would you say that in general, your health is excellent, very good, good, fair, or poor?
- b. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health, not good?
- c. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
- d. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

##### 2. Activity Limitations Module (5 questions)

- a. Are you limited in any way in any activities because of any impairment or health problem?
- b. What is the major impairment or health problem that limits your activities?
- c. For how long have your activities been limited because of your major impairment or health problem?
- d. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, bathing, dressing, or getting around the house?
- e. Because of any impairment or health problem, do you need the help of other persons in handling your routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

### 3. Healthy Days Symptoms Module (5 questions)

- a. During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation?
- b. During the past 30 days, for about how many days have you felt sad, blue, or depressed?
- c. During the past 30 days, for how many days have you felt worried, tense, or anxious?
- d. During the past 30 days, for how many days have you felt you did not get enough rest or sleep?
- e. During the past 30 days, for about how many days have you felt very healthy and full of energy?

Health-related quality of life is assessed upon entry into and discharge from your MIH-CP program. The CDC provides a wealth of information about Health-Related Quality of Life measures at [https://www.cdc.gov/hrqol/hrqol14\\_measure.htm](https://www.cdc.gov/hrqol/hrqol14_measure.htm)

### C. Limitation of Activity

Whether a person can carry out usual day-to-day activities is the focus of limitation of activity measures. Part of CDC's NHI, these measures ask respondents about their limitations and, as seen above, is considered a quality of life measure. These surveys drill down into the type and degree of limitations an individual is experiencing. Limitations of activity would be assessed upon entry into and discharge from your MIH-CP program.

Limitation of activity is assessed by asking people about their limitations in:

- Activities of daily living (such as bathing/showering, dressing, eating, getting in and out of bed, walking, using the toilet)
- Instrumental activities of daily living (such as using the telephone, doing light housework, doing heavy housework, preparing meals, shopping for personal items, managing money)
- Play, school, or work
- Remembering
- Any other activity that they cannot do because of limitations caused by physical, mental, or emotional problems

Additional information is available by clicking on the CDC link in the references resources listed at the end of this Chapter.

## 2. Patient/Client Experience

Assessing your client's experience is commonly accomplished by administering a client satisfaction survey. There are standard questions from various sources that you might use to construct a patient satisfaction survey. Typically, these surveys include the following types of questions that are ranked on a Likert-like scale from 1 – 5 with more points awarded for a positive patient experience. Client satisfaction would be assessed upon entry into and discharge from your MIH-CP program.

Potential categories of questions relate to access to care, provider interaction and rapport, ability to make an appointment or been seen, if you get a prompt return of phone calls, whether the provider listens and takes the time to understand you, whether the provider explains your care and answers your questions, and if the client thinks the provider gives advice and treatment. A sample client satisfaction survey is included in [Appendix F](#).

Other areas that impact the client's experience are related to the organization's provision of safe, effective, timely, efficient, equitable, and patient-centered care. For more information about these six dimensions of healthcare, see the Institute Medicine's report titled *Crossing the Quality Chasm: A New Health System for the 21st Century*. This report was published in 2011 by the Institute of Medicine, National Academies Press; despite its age, its contents are enduring.

### > 3. Per Capita Cost – Demonstrate Cost Saving/Cost Avoidance

The need to demonstrate the value of an MIH-CP is becoming increasingly more important. Funders, insurers, stakeholders, and other partners want to know the cost saving associated with your program. The NAEMTs MIH-CP Program Toolkit included outcome measures that might be used to demonstrate the cost savings associated with your MIH-CP program. These are the following:

1. Ambulance Transport Saving
2. Hospital Emergency Department Visits
3. All-cause Hospital Admissions
4. Hospitalization Average Length of Stay

The following example on Ambulance Transport Savings displayed in Table 11 was taken from the NAEMTs MIH-CP Program Toolkit. The variables of interest are the number of ambulance transports by enrolled patients 12 months pre-graduation and the number of ambulance transports by enrolled patients 12 months post-graduation. Two measurements are used, one pre-intervention and the other post-intervention. The pre-intervention group is defined as enrolled patients 12 months pre-enrollment, and the post-intervention group is the number of enrolled patients 12 months post-graduation.

**Table 11:** Ambulance Transport Savings

The goal is to reduce expenditures for unplanned ambulance transports to an ED pre and post-enrollment or per event.

	Number
Number of ambulance transports by enrolled patients 12 months post-graduation	1,750
Number of ambulance transports by enrolled patients 12 months pre-enrollment	3,700
Average payment per transport	\$421
Expenditure per CP patient contact	\$75
Number of CP patient contacts for enrolled patients	4,750

Using the data in Table 11, the following calculations are completed:

1. the cost associated with the number of ambulance transports by enrolled patients 12 months post-graduation is \$736,750 (1,750 X \$421)
2. the cost associated with the number of ambulance transports by enrolled patients 12 months pre-graduation is \$1,557,700 (3,700 X \$421)
3. the cost of CP patient contacts for enrolled patients is \$356,250 (4,750 X \$75)

Making a case for the MIH-CP Program, one would say that based on a pre and post-enrollment assessment of the frequency and cost of ambulance transport among enrolled patients, there was a cost savings of \$1,557,700. If one considers the cost of CP patient contacts, the savings is \$1,201,450.

## Intervention-Specific Performance Measures

Intervention-specific performance measures are used to assess the impact your program (intervention) has on the clients you serve. If you are implementing an evidence-based practice, other programs have demonstrated the ability of the intervention to have the desired effect. If an evidence-based practice is not available or is unacceptable to your clients, consider a best-practice.

If your community is experiencing the effects of tobacco use that include high morbidity and mortality due to tobacco-related cancers and chronic lung disease and your planned program/intervention is a tobacco cessation program, you could structure your performance measure as follows:

**Goal:** Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

**Objective:** By the end of the first year of operation, 50% of clients who were screened positive for tobacco use received tobacco cessation counseling.

**Performance Measure:** Percentage of clients who are screened positive for tobacco use and who receive tobacco cessation counseling.

**Numerator:** The numerator would be the number of clients who were both screened for tobacco use and found to use tobacco who were offered a cessation intervention.

**Denominator:** The denominator is all clients who were screened and are positive for tobacco use.

*Note: The tobacco related goal is consistent with the CDC's Healthy People 2020 goal. Smoking rates are a statistic the State Health Department tracks and the focus of county health departments' efforts making this a good area for collaboration. Using the format presented above will help you hone in on and operationalize your goal.*

## It's Not All Numbers

So far, we've talked about measuring performance using a quantitative or numbers approach. However, if you restrict your approach to just numbers, you'll miss some valuable information and insights.

Numbers alone cannot capture the impact that you have on the clients you serve. If you want to know the difference you make in the lives of the people you care for, ask them. Clients and their caregivers are treasure troves of information. Focus groups or personal interviews, known as qualitative techniques, are useful to gain an in-depth look at the impact of your program. You may know that 60% of your clients with diabetes have elevated hemoglobin A1Cs. But, do you know why? That information is only available from your clients.

Qualitative techniques may involve collecting data from stakeholders (local providers, county commissioners, insurers, etc.). This data can give you insights into what these groups value. If your stakeholders gain a better understanding of the value of your program, it may lead to new sources of funding.



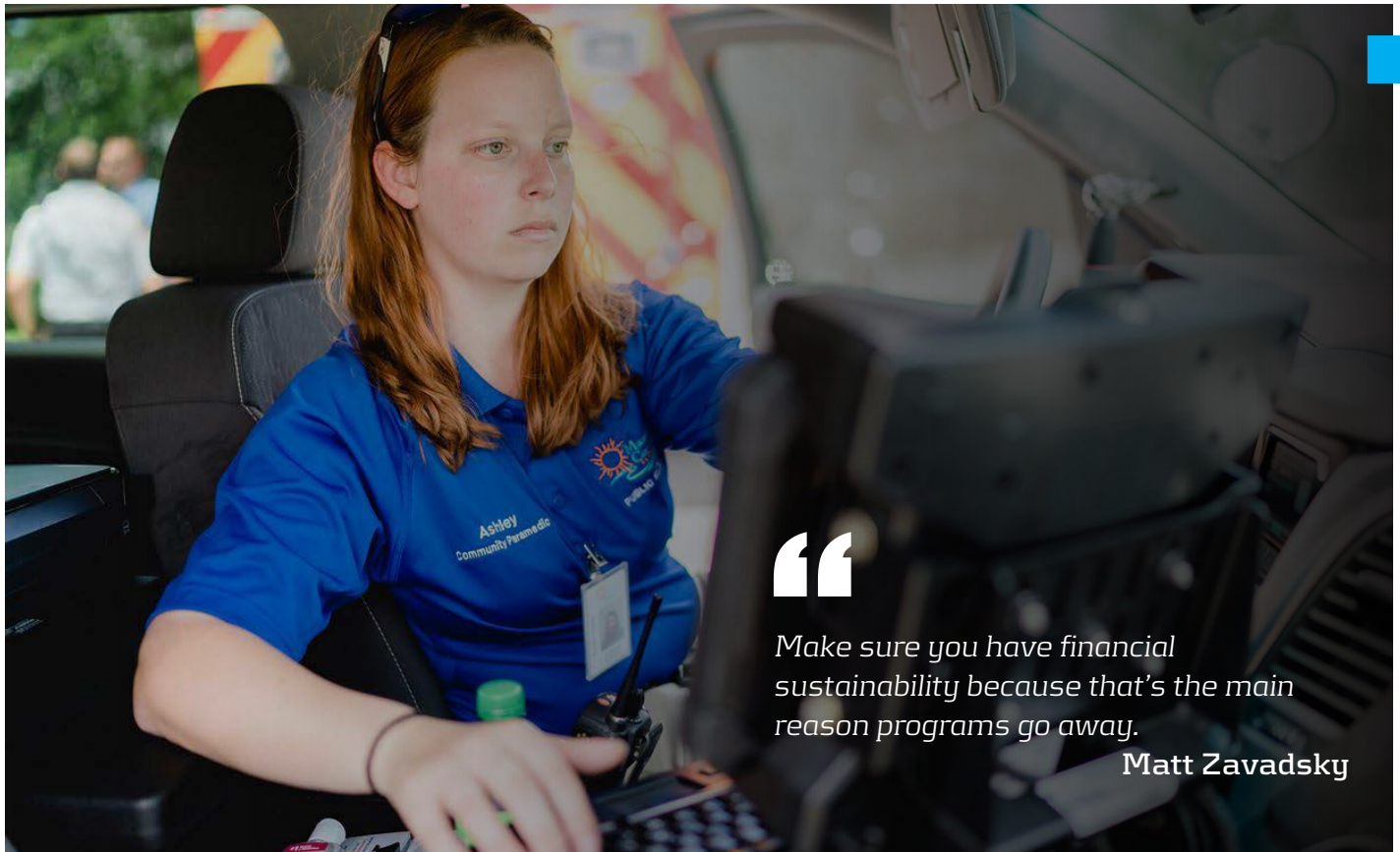
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Don't overlook the power of anecdotal information. When you hear a personal story about the impact and success of your program, capture and share it. Share it with staff, your clients, and your stakeholders. Qualitative approaches are essential to understanding the need for and the impact of your program especially your client's feelings and the value they place on your services. Stories are powerful; they put faces on the numbers providing context and meaning. Use them to breathe life into the numbers.



## Chapter 6 References and Resources

1. Office of Financial Management, State of Washington. Performance Measure Guide found at <https://ofm.wa.gov/sites/default/files/public/legacy/budget/instructions/other/2009performancemeasureguide.pdf>
2. Steve Jacob, “EMS Loyalty Program” Slashes Emergency Room Trips, Saves Millions, D Health Daily, 2/12/2014. This article provides insight into the savings MedStar has seen with their CP program. <http://healthcare.dmagazine.com/2014/02/12/ems-loyalty-program-slashes-emergency-room-trips-saves-millions/>
3. NAEMT’s Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey: [http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92\\_2](http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2)
4. NAEMT MIH-CP Program Toolkit. Available at <http://naemt.org/initiatives/mih-cp/mih-cp-program-toolkit>
5. CDC, Self-assessed Health Status <https://www.healthypeople.gov/2020/about/foundation-health-measures/General-Health-Status#selfAssessed>
6. Crossing the Quality Chasm: A New Health System for the 21st Century. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC, USA: National Academies Press; 2001. Available at <http://www.ihl.org/resources/Pages/Publications/CrossingtheQualityChasmANewHealthSystemforthe21stCentury.aspx>
7. The CDC provides a wealth of information about Health-Related Quality of Life measures at [https://www.cdc.gov/hrqol/hrqol14\\_measure.htm](https://www.cdc.gov/hrqol/hrqol14_measure.htm)
8. To learn more about Donabedian see the article titled Donabedian’s Lasting Framework for Health Care Quality available at [https://sph.umich.edu/glc/news/pdf/Donabedian\\_NEJM\\_2016.pdf](https://sph.umich.edu/glc/news/pdf/Donabedian_NEJM_2016.pdf)
9. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. Available at <http://www.ihl.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx>
10. A discussion of evidence-based practices and how they differ from best practices may be found at <http://www.communitygrantsnow.com/2011/08/30/evidence-based-practices-vs-best-practices/>



“

*Make sure you have financial sustainability because that's the main reason programs go away.*

**Matt Zavadsky**

Manatee County Florida Community Paramedicine

Sustaining a community paramedicine program is the most difficult part. Many organizations have shown great results from their MIH-CP but have been unable to sustain the program over time for various reasons.

Of the 129 programs responding to the NAEMT's survey, the majority (40%) reported they had been in operation for three or more years. Of the remaining respondents, their time of operation, 22% reported 2-3 years, 23% reported 1-2 years, and 15% reported being in operation for 1 year or less.

Here are some of the sustainability issues you should consider as you develop and operate your MIH-CP program.

## Funding

You'll notice the Budget template has two years. For sustainability, it's helpful to think about your revenue and expenses beyond the first year. Please keep in mind, while grants can be very helpful to get started, you should not rely solely on funding your program with grants. The likelihood of continuing to receive

grant funds to operate your program beyond one or two years is unlikely. In Chapter 5 we discussed different funding sources. You should be continually evaluating alternative funding sources, models and partners to stabilize and diversify your ongoing revenue stream.



Manatee County Florida Community Paramedic

## > Changes in Medicare/Medicaid Regulations

At some point, changes in the Medicare and Medicaid regulations will enable MIH-CP Programs to bill for and be reimbursed for services other than emergency transport. When it does happen, this will significantly impact the ability of MIH-CP programs to be financially sustainable. You can stay informed on this topic through the Florida Ambulance Association or American Ambulance Association.

## > Staffing

Another sustainable issue is staffing. As previously mentioned, the emergency medical services industry across the country is struggling with a paramedic shortage, and this shortage affects an agency's ability to recruit staff for their MIH-CP. Staff turnover in an emerging MIH-CP program can be very detrimental to the consistent and effective operation of the program. Something to consider is whether you will staff your program with full-time or part-time staff. Depending on the need in your community a part-time position may be more appropriate. Finally, selecting the right candidates and continually supporting their professional growth in conjunction with program growth is crucial.

As your program matures, consider developing a succession plan for sustainability at all levels of the program.



*Make sure the individuals who make decisions about the program know and understand the benefits of the program. You must continually be selling it.*

**Christine Long**

## > Internal Support

Some MIH-CP programs will not be free-standing organizations but will be a component or division of a larger entity or service. This usually means others may have some level of control over the program. If this is the case, you must be completely transparent, provide timely and accurate data, and become the best storyteller. With good information and stories, they can make well informed and educated decisions, and maybe even become a strong advocate for your program.



*Rural providers who wish to work with insurance companies need to work collaboratively, even on a regional basis, rather than try to work to carve out their program for just the communities they traditionally serve. If they can't build a regional program or want to maintain their independence, community paramedic programs starting within rural EMS providers are more likely to be sustainable by partnering with local providers like nursing homes, medical practices or health departments to target a market opportunity that better matches their size.*

**Daniel Swayze**



### Partnership Support

If you did not use a local alliance in the development of your program, one of the best ways to sustain your partners and supporters is to establish one. A list of suggested members is on page 30. Stakeholders

provide a balanced voice and diversity of thought on continuous program improvement and growth. It enables ongoing input into the design, processes, and results of the program.



### Client Support

Clients can be your strongest voice of sustainable support for your program. Make sure you measure patient satisfaction and, if very positive, leverage it within your organization, your partners, and the community. Consider using them as volunteers,

get testimonials, have them speak at hearings about your program, or develop marketing materials using personal stories. Be creative in how you can engage them in your program.



### Community Support

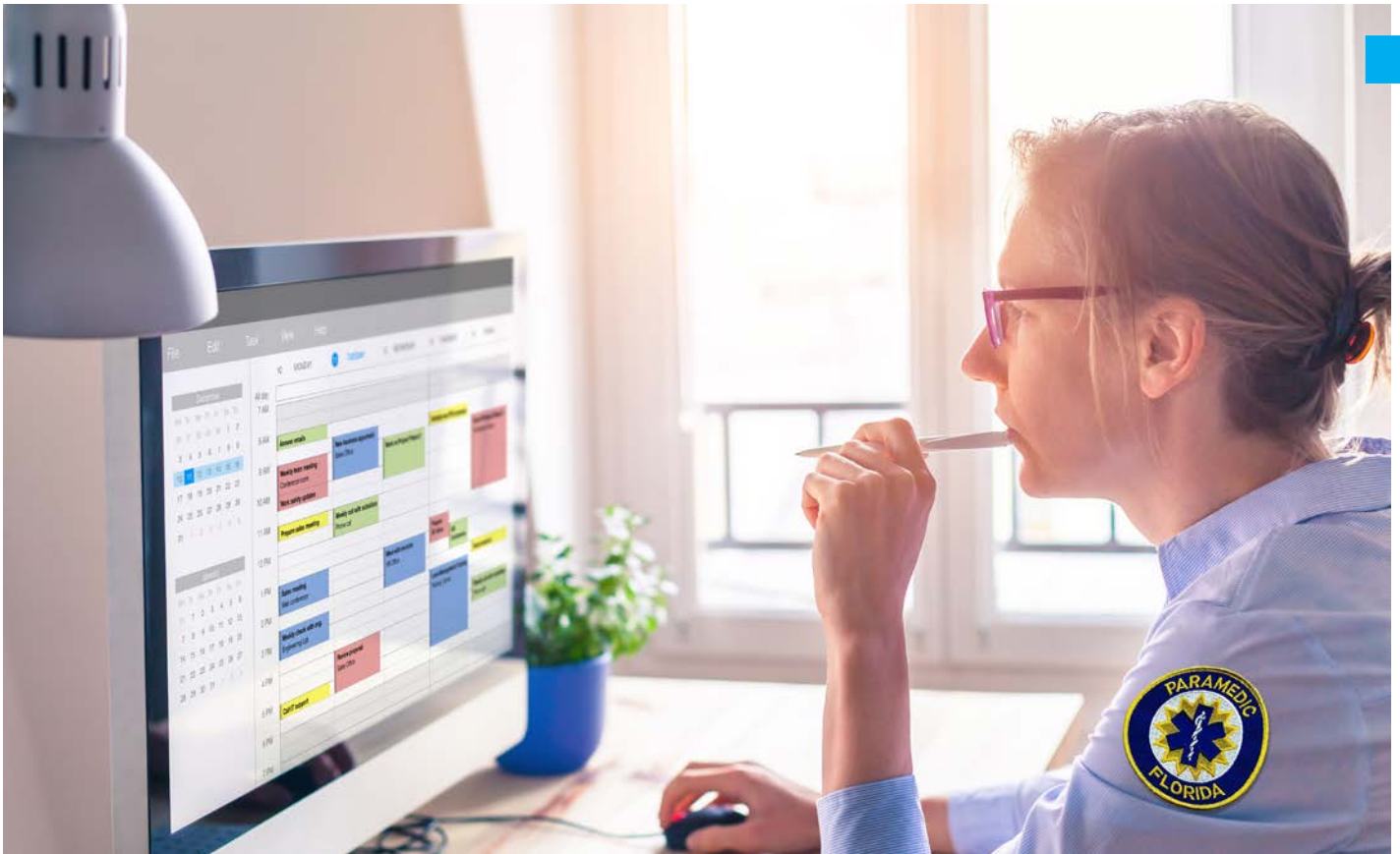
One of the most important aspects of program sustainability is community support. Your reputation in the community will have either a negative or positive impact on all aspects of your program. Therefore, manage communications within your community. Establish a media plan and campaign to let the public know how you're are making an impact

in your community. Let them know what great things you are doing. Share client success stories, impressive data, personal examples of your program's work, and educational and volunteer opportunities. This is also an ideal way to leverage the client support mentioned above.



## > Chapter 7 References and Resources

1. Florida Ambulance Association: <http://www.the-faa.org/>
2. American Ambulance Association: <https://ambulance.org/>
3. NAEMT publication: Top 10 MIH or community paramedicine program funding sources. Available at <http://www.naemt.org/initiatives/mih-cp/mih-cp-program-toolkit>
4. To address the sustainable staff issue, one of the challenges is fatigue. Here is a recent article from the National Association of State EMS Officers on the topic: <https://www.nasemso.org/Projects/Fatigue-in-EMS/index.asp>
5. The Minnesota Department of Health offers an EMS toolkit with resources that help to address common issues faced by rural EMS organizations:
  - Recruitment and Retention: <http://www.health.state.mn.us/divs/orhpc/resources/ems/recruit.html>



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Expect to spend significant time developing your MIH-CP program. To give you a realistic idea of development and launch time frames, according to the NAEMT's Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey, MIH-CP programs across the country spent six months to 2 years from planning to actual implementation. Be patient and set it up right. You'll definitely benefit in the long run.

### Case Study - Sunshine County Emergency Medical Services

This case study provides an example of how to put together your MIH-CP Program Business Plan. The entity and community statistics/data are fictitious. For learning purposes, this plan explains the steps they took to come to some of the conclusions.

When you write yours, you may not want to include detail about the steps you took unless it helps the reader understand the analysis you used to come to a conclusion.

Use the format as a guide in the development of your Plan. A template Plan outline is included in [Appendix A](#). Again, you need to develop and customize a Plan to fit your community's needs.

### 1. Introduction to Sunshine County Emergency Medical Services (Sunshine EMS)

Sunshine County Emergency Medical Services (Sunshine EMS) is a government entity that covers the entire county of Sunshine, Florida. The EMS service operates 2 ambulances during the day and 1 at night. Their staff consists of 2 full time and 1 part time Paramedics and 2 full time and 1 part time EMT's. In addition, they have 2 volunteer Paramedics and 3 volunteer EMT's.

They run approximately 2,500 calls per year. Of which, 35% of the 9-1-1 calls are by residents 65 years of age and older for fall-related injuries.

Dr. Bea Good is the medical director for the EMS service.

#### Population Statistics:

Located in central Florida, rural Sunshine County has a population of 96,698 residents. Critical indicators of access to healthcare are poverty, employment, insurance status, and education. The following is a summary of these indicators for Sunshine County:

- 37% of the county's residents are below 200% of the poverty level.
- 38.6% of families with related children under the age of 5 are living under the poverty level (this figure is over 56% higher than the state rate of 16.8%).
- 42.5% of families with a female head of household with children are living under the poverty level.
- The current unemployment rate of 15% (1st quarter 2018) is 45.6% higher than the state of Florida at 10.3%. The highest areas of unemployment are in the towns of Orange, Lemon, and Lime.
- As many as 21,274 residents under the age of 65 are uninsured. This equates to 22% percent of that population segment.
- The Hispanic population has the highest uninsured rate in the county at 41.9% for 2017. This is significantly higher than the rate of uninsured for the county and 27% higher than the state level.
- Between 2014-2017 only 16.6% of residents aged 25 years of age and older had a bachelor's degree, significantly lower than the state rate of 26.4%.
- 32% of the population are 65 years of age and older compared to approximately 18% statewide.
- The Median Household income is \$39,100, which is significantly lower than the state level of \$46,956.

## Community Make-Up:

- Mercy is the only hospital in the county. It has an emergency room.
- They have 2 primary care doctor offices, with a total of 4 doctors.
- There are no urgent care clinics.
- Sunnyside and Rosary are the 2 nursing homes.
- They have a hospice center affiliated with the Rosary nursing home.
- There are 2 pharmacies, one affiliated with a large chain, and a locally operated one.
- There are no home health services or mental health facilities in the county.
- There is a Florida public health department office and a social services office.
- They have 2 high schools and a satellite office for a local community college. The satellite office focuses primarily on general studies, but the college does offer CNA, certifications and degrees on the main campus.
- They have several civic/veteran's organizations: Lions Club, VFW, and Kiwanis.
- There is a Senior Center which has meeting space, a game room, and provides inexpensive lunches Monday – Friday.
- Together, the Non-Denominational, Baptist, Catholic, and Lutheran churches in the county operate a food pantry on Thursday mornings.
- There is no dedicated transportation system in the county, but there is a taxi service.
- They have a fire department and a law enforcement agency covering the county.

## 2. The Needs Assessment

After reviewing the county statistical data and the Sunshine EMS internal call and run report data, they have identified the rate of falls among residents 65 years of age and older (35% of all calls) as a potential problem/need that could be addressed by an MIH-CP program.

They searched for additional information on falls through the Florida Department of Health. This agency conducts a Behavioral Risk Factor Survey that asks respondents to report if they had fallen in the three months before the interview. The results of the survey indicate that individuals 65 years of age and older in Sunshine County reporting a fall in the past three months was 8.32% compared to only 5.7% for Florida residents. Additionally, in 2016 the age-adjusted death rate due to unintentional injuries for individuals 65 and older was 16 per 100,000 in Sunshine County compared to 9.4 for the Florida population.

They also searched for information on falls in Florida CHARTS. The crude death rate due to unintentional falls among the Sunshine County population 65 years of age and older is 90.13 per 100,000 compared to the Florida rate of 62.8. The rate of falls among Sunshine County's residents 65 years of age and older is 6.5% compared to a rate of 5.1% for the comparable Florida population.

The Robert Wood Johnson Foundation provides county health ranking information. <http://www.countyhealthrankings.org>  
 They researched how Sunshine County ranks and discovered this:

### Sunshine County Health Rankings Compared to Florida and U.S. Benchmarks

	Sunshine County	Florida	U.S. Benchmark
<i>Length of Life</i>	<i>Ranked 60th</i>		
Premature Death	10,012	6,893	5,200
Poor Physical Health Days	4.4	3.7	2.5
Poor Mental Health Days	4.6	3.8	2.3
Health Behaviors	Ranked 35th		
Adult Obesity	27%	26%	25%
Adult Smoking	24%	18%	14%
Physical Inactivity	26%	23%	20%
Injury Deaths	109	69	50
Social & Economic Factors	Ranked 46th		
Children in Poverty	29%	25%	13%

Upon completion of the needs assessment, Sunshine EMS identified the problem of falls among Sunshine County residents 65 years of age and older as the focus of their MIH-CP program.

### 3. Stakeholders

The next step was to identify the potential stakeholders they want to invite to participate in the development of their program. Using the Power versus Interest Grid, they categorized the various community organizations/individuals to come up with a list of potential stakeholders.

<b>High Power/Low Interest</b> Mercy Hospital State Government Representative	<b>High Power/High Interest</b> Local Government Representative Third Party Payors Public Health Department Primary Care Doctor Offices
<b>Low Power/Low Interest</b> Educational Institutions Vendors	<b>Low Power/High Interest</b> Sunnyside and Rosary Nursing Homes Rosary Hospice Senior Center Fire/Law Enforcement Agencies Social Service Agency Both Pharmacies Civic /Veteran's Organizations All Churches Taxi Service

They decided to initially invite those in the High Power/Low Interest, High Power/High Interest, and Low Power/High Interest categories to attend a presentation on their proposed MIH-CP program.

## > 4. Program Plan

After meeting with the potential stakeholders, Sunshine EMS developed the following:

**Vision:** Sunshine County will be free of all preventable illness and injury.

**Mission:** Our mission is to eliminate injuries and deaths to individuals 65 years of age and older from falls in Sunshine County.

**Goal:** Reduce illness, disability, and death related in home falls among individuals 65 years of age and older.

### Strategies:

- Strategy A.** Raise awareness  
Develop partners to get home assessment information to the target market  
Offer workshops on home assessments
- Strategy B:** Referral System  
Set up a referral system with community partners
- Strategy C.** Education  
CDC Check for Safety Tool
- Strategy D.** Programming to prevent falls  
Matter of Balance classes  
Tai Chi classes  
Yoga classes
- Strategy E.** Home Assessments and Remediation  
Develop partners to assist with remediation efforts
- Strategy F.** Medication Reconciliation  
Develop partners to assist in reconciling conflicting medications



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## Objectives and Performance Measures

The following presents two key objectives for Strategy E and the associated performance measures:

**Objective 1.1:** To increase the number of client homes with individuals 65 years of age and older who have completed an at-home risk assessment from 30% to 50% within the first year.

- Performance Measure: The number of client homes with individuals 65 years of age and older who have completed an at-home risk assessment from 30% to 50% within the first year.
- Numerator: The number of at-home fall risk assessments that are completed in client homes with individuals 65 years of age and older.
- Denominator: The denominator is the number of client homes with individuals 65 years of age and older.
- Baseline: In the calendar year 2017, 30% of client homes with individuals 65 years of age and older had a completed at-home fall risk assessment.

**Objective 1.2:** To reduce the number of fall related 9-1-1 calls by residents 65 years of age and older from 35% to 20% within 1 year.

- Performance Measure: The number of fall related 9-1-1 calls by residents 65 years of age and older.
- Numerator: The number of fall related 9-1-1 calls by residents 65 years of age and older.
- Denominator: The denominator is the total number of 9-1-1 calls.
- Baseline: In the calendar year 2017, the number of fall related 9-1-1 calls by residents 65 years of age and older was 35%.

### 5. Alignment/Conflict Evaluation:

After developing the program's vision, mission, goals, and strategies Sunshine EMS evaluated them in the context of the organization's vision, mission, and goals for alignment. They are consistent with the organization's mission of providing the highest quality of care to the citizens of Sunshine County. The program aligns with the EMSSP, Strategic Priority 5 by increasing the number of MIH-CP programs in Florida and by increasing the number of programs providing fall prevention programs in Florida.

Also, they contacted each of the community organizations who work with the 65 years of age and older target market to verify the goals did not conflict or duplicate their efforts. Finding none, they proceeded with the identified goals.



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## 6. Implementation Plan:

Sunshine EMS's MIH-CP program will target the 65 years of age and older population, who has the highest rate of falls in the county. Falls by the elderly has devastating effects on their length and quality of life, as well as burdening the county's emergency response system. Addressing this issue will have a positive impact on many lives and ease the use of the 9-1-1 system by this age group.

### Standard Operating Procedures (SOP's)

Dr. Bea Good has enthusiastically agreed to provide medical direction for the program. She will not charge any additional fees for her services.

She has agreed to develop Standard Operating Procedures for the program, including general physical assessments, home safety assessments, medication reviews and reconciliations, emergency situations, and MIH-CP enrollment and discharge protocols. In addition, she will create a patient consent form which complies with the Health Insurance Portability and Accountability Act for the clients and develop a quality assurance program for the protocols and program operation.

### Operating Plan:

**Launch Date:** The MIH-CP launch date is planned for March 1, 2019.

### Service Offerings:

Services will be provided to all Sunshine County residents 65 years of age or older, and shall include:

- Educational programs on fall prevention
- Programming to prevent falls
- Home assessments and remediation efforts
- Medication reconciliation
- Home health checks
- Patient navigation/advocacy

The evidence-based practices included in the program are found in the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention's publication, Preventing Falls: A Guide to Implementing Effective Community-Based Fall Prevention Programs.

### Staffing:

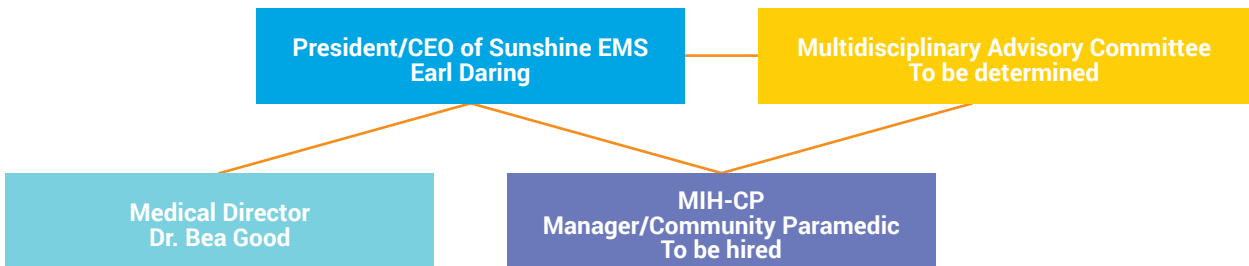
The MIH-CP program will have one paramedic wholly dedicated to the delivery of MIH-CP services; this includes all administrative tasks associated with the job. The salary will be \$42,000, plus benefits. After consulting with the accountant that handles payroll, the percentage of benefits for this position is 22% of salary.



### Operations:

- It will operate Monday – Friday from 8am to 5pm.
- One small used SUV will be purchased to utilize for the program – not to exceed \$15,000. Graphics will need to be ordered and placed on vehicle at a cost of \$500.
- Insurance on the additional vehicle and malpractice will be \$1,800/year.
- No additional space will be necessary. Will use current office administrative support and supplies. A new cell phone and laptop computer will be purchased, including all Microsoft software.
- Uniform allocation of \$500 for a new employee, and \$100/year thereafter for replacement.
- Some additional medical supplies and minor equipment will be required to stock the vehicle at a cost of \$2,000.
- Mercy Hospital, a primary care doctor, and Rosary Nursing / Hospice have agreed to provide funding to support ½ the annual salary of the CP and will provide referrals to the program.
- The local pharmacist has agreed to work with the CP and medical director on medication reconciliation as needed and provide referrals to the program.
- The local public health department will work in conjunction with the CP on vaccinations, and sign a Memorandum of Agreement.
- The Senior Center has offered space to hold educational sessions at no cost.
- The taxi service has offered to provide discounted rides to medical appointments for the population.

### Organization Chart:



### Multidisciplinary Advisory Committee:

A multidisciplinary advisory committee will be established. It will consist of a primary care physician, a hospital representative, a social services representative, a nursing home or hospice representative, a pharmacy representative, a public health representative, a member of either the fire or law enforcement community, and at least one lay person from the community.

The function of the committee shall be to provide guidance on the quality of the services, the service offerings, and growth opportunities.

### Marketing/Public Relations:

The target market for our program are individuals 65 years of age and older. Our marketing approach will be two-fold. First, direct marketing to the target population. We want people to be proactive in preventing falls.

Second, marketing to groups who work closely with the target population as a source of referrals.

A full marketing plan will be developed to implement each marketing approach. It is estimated to cost \$10,000 to develop the plan and materials to implement it.

## Implementation Work Plan:

Area of Focus	Key Action Steps	Person Responsible	Date of Completion	Comments
<b>A. Focus Area: Personnel and Procedures for the MIH-CP Program</b>				
<b>A.1. Hire Community Paramedic</b>	Develop a job description	Earl Daring CEO	Jan. 31st 2019	Must be a licensed Florida paramedic
	Complete new employee orientation	Earl Daring CEO	Feb. 28th 2019	
<b>A.2. Establish Procedures and Forms for Program</b>	Develop SOP's for the new service offerings	Dr. Bea Good	Feb. 28th 2019	Will be evaluated by the MIH-CP Manager after hiring
	Develop quality control measures for program	Dr. Bea Good	Feb. 28th 2019	
	Develop HIPAA compliant patient consent forms	Dr. Bea Good	Feb. 28th 2019	
<b>A.3. Integration of Program</b>	Evaluate the organization's current policy and procedures manual for program compliance or modifications needed	MIH-CP Manager	Feb. 1st 2019	
	Evaluate current EMS data and billing software systems for use with the program	MIH-CP Manager	Feb. 1st 2019	
	Revise the Medical Director's contract to include the additional responsibilities	Earl Daring CEO	Feb. 1st 2019	
<b>B. Focus Area: Multidisciplinary Advisory Committee</b>				
<b>B.1. Establish a Multidisciplinary Advisory Committee</b>	Develop By-laws or Guidelines for an Advisory Committee	MIH-CP Manager	Jan. 15th 2019	Be sure to include the meeting structure
	Recruit Advisory Committee members	MIH-CP Manager	Jan. 31st 2019	
	Hold the first meeting	MIH-CP Manager	Feb. 15th 2019	
<b>B.2. Advisory Committee Recruitment</b>	Develop a plan for building new advisory members	MIH-CP Manager	March 31st 2019	
<b>B.2. Maintain Advisory Committee</b>	Develop a system for continuous communication with your Advisory Committee	MIH-CP Manager	Ongoing	
<b>C. Focus Area: Marketing</b>				
<b>C.1. Marketing to Target Market</b>	Develop a market plan for reaching the 65 years of age and over target market	MIH-CP Manager	Nov. 15th 2018	Include timelines & materials to be developed
	Hire a marketing company to develop materials for the target market	MIH-CP Manager	Dec. 1st 2018	
<b>C.2. Marketing to Partners</b>	Develop a market plan for partners regarding reaching the 65 years of age and over target market	MIH-CP Manager	Dec. 1st 2018	
	Hire a marketing company to develop materials for the target market	MIH-CP Manager	Dec. 1st 2018	
<b>C.3. Public Relations Events</b>	Plan a Grand Opening community event	MIH-CP Manager	March 1st 2019	Date of launch

**Budget:**

Community Paramedic Program Budget Template			
Categories	Year 1	Year 2	
<b>Revenue</b>			
Internal Sourced Funds	\$ 46,000	\$ 67,914	
Patient/Client Payments	\$ -	\$ -	
Grant/Foundation Funding	\$ 40,620	\$ -	
Partner Funding	\$ 25,620	\$ 26,388	
<b>Total Revenue</b>	<b>\$ 112,540</b>	<b>\$ 94,302</b>	
<b>Expenses</b>			
<b>Payroll Expenses</b>			
Salaries of Leader & Staff	\$ 42,000	\$ 43,260	
Percentage of Salaries for Benefits	\$ 9,240	\$ 9,517	
Overtime	\$ -	\$ -	
Percentage of Overtime for Benefits	\$ -	\$ -	
<b>Total Payroll Expenses</b>	<b>\$ 51,240</b>	<b>\$ 52,777</b>	
<b>Operations Expenses</b>			
<b>Administration</b>			
Dues & Subscriptions	\$ -	\$ -	
Insurance (Facilities, Vehicles, Directors and Officers, Liability, Malpractice)	\$ 1,800	\$ 1,980	
Legal Fees	\$ -	\$ -	
License Fees of Staff	\$ -	\$ -	
Marketing/Public Relations	\$ 10,000	\$ 3,000	
Medical Direction Contact Fees	\$ -	\$ -	
Office Supplies & Postage	\$ -	\$ -	
Telephone/Internet	\$ -	\$ -	
Utilities	\$ -	\$ -	
<b>Total Administration Expenses</b>	<b>\$ 11,800</b>	<b>\$ 5,025</b>	
<b>Facilities</b>			
Building Repairs/Maintenance	\$ -	\$ -	
Communications Equipment	\$ 1,000	\$ -	
Computer Equipment	\$ 2,000	\$ -	
Lease Payments	\$ -	\$ -	
<b>Total Facilities Expenses</b>	<b>\$ 3,000</b>	<b>\$ -</b>	
<b>Vehicles</b>			
Fuel	\$ 27,000	\$ 30,600	
Repairs & Maintenance	\$ 2,000	\$ 3,000	
Lease Payments	\$ -	\$ -	
Maintenance Contracts	\$ -	\$ -	
<b>Total Vehicle Expenses</b>	<b>\$ 29,000</b>	<b>\$ 33,600</b>	
<b>Miscellaneous Expenses</b>			
Meals	\$ -	\$ 200	
Medical Equipment (disposable)	\$ 300	\$ 300	
Supplies (Operational)	\$ 500	\$ 500	
Supplies (Patient/Client)	\$ -	\$ -	
Training (Initial)	\$ -	\$ -	
Training (Continuing)	\$ -	\$ 1,500	
Transportation Expenses	\$ -	\$ -	
Travel	\$ -	\$ 500	
Uniforms	\$ 500	\$ 100	
Other			
Other			
Other			
<b>Total Miscellaneous Expenses</b>	<b>\$ 1,300</b>	<b>\$ 2,900</b>	
<b>Total Operating Expenses</b>	<b>\$ 45,100</b>	<b>\$ 41,525</b>	
<b>Capital Expenses</b>			
Capital Purchases (Vehicles)	\$ 15,000	\$ -	
Renovations/Construction	\$ -	\$ -	
Medical Equipment (non-disposable)	\$ 1,200	\$ -	
Other	\$ -	\$ -	
Other	\$ -	\$ -	
<b>Total Capital Expenses</b>	<b>\$ 16,200</b>	<b>\$ -</b>	
<b>Total Expenses</b>	<b>\$ 112,540</b>	<b>\$ 94,302</b>	
<b>Total Revenue After Expenses</b>	<b>\$ -</b>	<b>\$ (0)</b>	

## Budget Narrative:

### Revenue Year 1

Internal sourced funds come from an infusion of monies by participation in the Public Emergency Medical Transportation Supplemental Reimbursement Program for Medicaid (\$28,289) and government funds (\$18,011).

Grant funding from the American Health Care Association for purchase of the vehicle and ½ cost of 1st year CP salary/benefits.

Partners have committed to provide the other ½ cost of CP salary.

### Expenses Year 1

Benefits are 20% of salary.

Marketing includes professional design, printing cost of materials, grant opening event and other public relations events, and vehicle graphics.

Fuel is calculated at 15,000 miles/month at 20 miles/gallon at \$3/gallon

### Revenue Year 2

Internal sourced funds come from an infusion of monies by participation in the Public Emergency Medical Transportation Supplemental Reimbursement Program for Medicaid (\$29,822) and government funds (\$38,092).

Partners have committed to provide ½ cost of CP salary/benefits.

### Expenses Year 2

Salary increase 3% cost of living.

Benefits are 20% of salary.

Insurance increase 10%.

License renewal for CP.

Marketing includes materials and public events.

Fuel is calculated at 17,000 miles/month at 20 miles/gallon at \$3/gallon

Meals are for conferences for recertification.

Training (Continuous) is for conferences for recertification (every 2 years).

Travel includes hotel costs for recertification.

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## MEMORANDUM OF AGREEMENT (MOA)

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Sunshine County Emergency Medical Services as the primary EMS provider for Sunshine County (EMS Provider) and Dr. Bea Good, Medical Director for the EMS Provider (Medical Director) enter into this Memorandum of Agreement with the Department of Health, Sunshine County (County Health Department) to encourage more effective utilization of the skills of emergency medical technicians and paramedics by enabling them to perform, in partnership with local county health departments, specific additional healthcare tasks that are consistent with the public health and welfare.

Notwithstanding any other provision of law to the contrary, the parties agree as follows:

1. EMS Provider paramedics or emergency medical technicians may perform health promotion and wellness activities and blood pressure screenings in a nonemergency environment, within the scope of their training, and under the direction of the medical director. "Health promotion and wellness" means the provision of public health programs pertaining to the prevention of illness and injury.
2. EMS Provider paramedics may administer immunizations in a nonemergency environment, within the scope of their training, and under the direction of the Medical Director. [Appendix A](#), attached to this agreement, describes the established protocols, policies, and procedures under which the paramedic will operate.
  - a. Medical Director will verify and document that a paramedic has the sufficient training and experience to administer immunizations. EMS Provider will maintain the training and experience verification and documentation on the most current forms provided by the County Health Department and will make the documentation available to the County Health Department upon request.
3. This agreement will replace any earlier documents or oral agreements between the parties as it pertains to these specific provisions.
4. Either party must notify the other party of any necessary changes or modifications to the agreement to keep the agreement current, such as changes in the County Health Department training and experience documentation forms, a change in the Medical Director, or modifications to the protocols, policies, and procedures described in [Appendix A](#).
5. This agreement will be effective from the date of the signature by all parties and remain in effect until one party provides 30 days written notice to others that they desire the agreement to be cancelled.

The terms of this Memorandum of Agreement are understood and agreed upon by the EMS Provider, the Medical Director, and the County Health Department.

**EMS Provider:**

\_\_\_\_\_  
Earl Daring, CEO  
Sunshine County EMS

Date: \_\_\_\_\_

**Medical Director:**

\_\_\_\_\_  
Dr. Bea Good, Medical Director

Date: \_\_\_\_\_

**County Health Department:**

\_\_\_\_\_  
Department of Health, Sunshine County  
Title: \_\_\_\_\_

Date: \_\_\_\_\_

## **TEMPLATE OUTLINE FOR BUSINESS PLAN**

### **1. Introduction**

- Organization
- Population Statistics
- Community Make-up

### **2. Needs Assessment**

### **3. Stakeholders**

### **4. Program Plan**

- Vision
- Mission
- Goals
- Strategies
- Objectives
- Performance Measures

### **5. Alignment/Conflict Evaluation**

### **6. Implementation Plan**

- Standard Operating Procedures
- Operating Plan
  - Launch Date
  - Service Offerings
  - Staffing
  - Operations
  - Organization Chart
  - Multidisciplinary Advisory Committee
  - Marketing/Public Relations
  - Implementation Guide

### **7. Budget**

- Budget Narrative

## Appendix B

Community Paramedic Program Budget Template		
Categories	Year 1	Year 2
<b>Revenue</b>		
Internal Sourced Funds		
Patient/Client Payments		
Grant/Foundation Funding		
Partner Funding		
<b>Total Revenue</b>		
<b>Expenses</b>		
<b>Payroll Expenses</b>		
Salaries of Leader & Staff		
Percentage of Salaries for Benefits		
Overtime		
Percentage of Overtime for Benefits		
<b>Total Payroll Expenses</b>		
<b>Operations Expenses</b>		
<b>Administration</b>		
Dues & Subscriptions		
Insurance (Facilities, Vehicles, Directors and Officers, Liability, Malpractice)		
Legal Fees		
License Fees of Staff		
Marketing/Public Relations		
Medical Direction Contact Fees		
Office Supplies & Postage		
Telephone/Internet		
Utilities		
<b>Total Administration Expenses</b>		
<b>Facilities</b>		
Building Repairs/Maintenance		
Communications Equipment		
Computer Equipment		
Lease Payments		
<b>Total Facilities Expenses</b>		
<b>Vehicles</b>		
Fuel		
Repairs & Maintenance		
Lease Payments		
Maintenance Contracts		
<b>Total Vehicle Expenses</b>		
<b>Miscellaneous Expenses</b>		
Meals		
Medical Equipment (disposable)		
Supplies (Operational)		
Supplies (Patient/Client)		
Training (Initial)		
Training (Continuing)		
Transportation Expenses		
Travel		
Uniforms		
Other		
Other		
Other		
<b>Total Miscellaneous Expenses</b>		
<b>Total Operating Expenses</b>		
<b>Capital Expenses</b>		
Capital Purchases (Vehicles)		
Renovations/Construction		
Medical Equipment (non-disposable)		
Other		
Other		
<b>Total Capital Expenses</b>		
<b>Total Expenses</b>		
<b>Total Revenue After Expenses</b>		



\_\_\_\_\_ EMS as the primary EMS provider for \_\_\_\_\_, County, (EMS Provider) and \_\_\_\_\_ Medical Director for the EMS Provider (Medical Director) enter into this Memorandum of Agreement with the Department of Health, \_\_\_\_\_ County (County Health Department) to encourage more effective utilization of the skills of emergency medical technicians and paramedics by enabling them to perform, in partnership with local county health departments, specific additional healthcare tasks that are consistent with the public health and welfare.

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The terms of this Memorandum of Agreement are understood and agreed upon by the EMS Provider, the Medical Director, and the County Health Department.

**EMS Provider:**

\_\_\_\_\_ EMS Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Title: \_\_\_\_\_

**Medical Director:**

\_\_\_\_\_ EMS Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_, Medical Director

**County Health Department:**

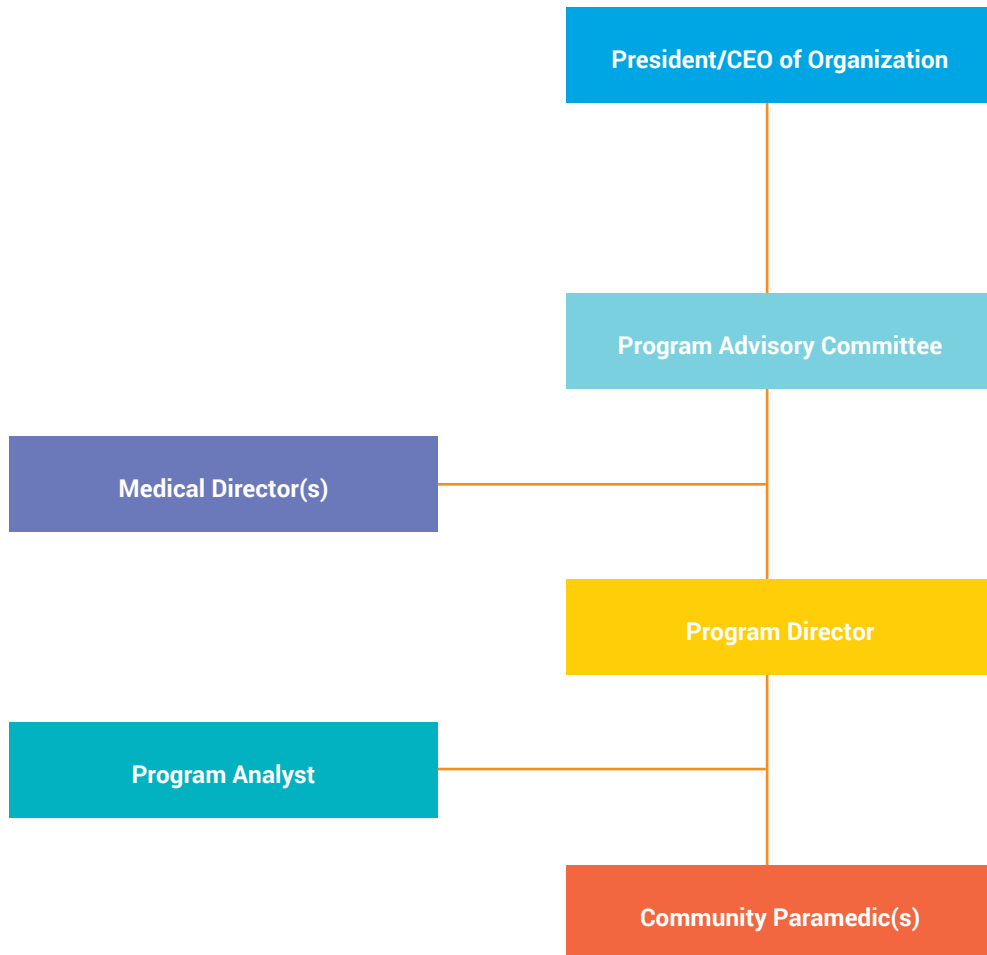
\_\_\_\_\_ EMS Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Department of Health, \_\_\_\_\_ County

Title: \_\_\_\_\_



### TEMPLATE ORGANIZATIONAL CHART



> **Appendix E**

**TEMPLATES MARKETING PLAN**

These are 2 templates for a one-page marketing plan by Ivana Taylor from Small Business Trends. You can access these templates to actually write your plan at: <https://smallbiztrends.com/2008/06/one-page-marketing-plan.html>.

This first template follows the more traditional marketing plan outline.

"THEME"	
Category	Strategy
Target Market	
Positioning Statement	
Offering to customers	
Price Strategy	
Distribution	
Sales Strategy	
Service Strategy	
Promotion Strategy	
Marketing Research	
Any other component of your marketing plan	

But, sometimes it's better to be less formal and approach marketing from a different viewpoint. This second template is more focused on identifying and developing emotional triggers of the client.






Marketing Theme:	
Category	Strategy
My reason for existence:	
What sets my business apart from the rest:	
My ideal customer is:	1.
What's most important to my ideal customer when they are buying what I'm selling:	1.
What I want to accomplish this year:	•
The top 3 things that are going to get me there:	1.
How much will each program contribute to my revenue/profitability:	1.
What will trigger my ideal customer to think of me:	•
Programs I am running to reach my goal:	
How much money will I need to get it done?	1.

> **Appendix F**

**TEMPLATE PATIENT/CLIENT SATISFACTION SURVEY**

[Your MIH-CP Name Here]

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

	 <b>GREAT</b> 5	 <b>GOOD</b> 4	 <b>OK</b> 3	 <b>FAIR</b> 2	 <b>POOR</b> 1
<b>Please circle how well you think we are doing in the following areas:</b>					
<b>Ease of getting care:</b>					
Ability to be seen	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
<b>Staff:</b>					
<b>Provider:</b>					
Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives you good advice and treatment	5	4	3	2	1
<b>Other Staff</b>					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
<b>All Others:</b>					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
<b>Payment:</b>					
What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
<b>Confidentiality:</b>					
Keeping my personal information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us:	5	4	3	2	1

What do you like best about our service? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What do you like least about our service? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Suggestions for improvement? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Thank you for completing our survey

## Appendix G

### TEMPLATE PERFORMANCE BASED JOB DESCRIPTION

#### Community Paramedic Performance Based Job Description

Agency: \_\_\_\_\_  
 Job title: \_\_\_\_\_  
 Location: \_\_\_\_\_  
 Division/Department: \_\_\_\_\_  
 Supervised by: \_\_\_\_\_

#### Performance-Oriented Job Description Community Paramedic

Tasks	Conditions	Standards
Provide comprehensive health, wellness, and safety assessments	Caseload not more than 30 clients, supervisor is available	95% of assessments are comprehensive and complete
Prepare comprehensive, individualized client care plans	Caseload not more than 30 clients, supervisor is available for difficult cases	Within 1 week of first visit 95% of clients will have a comprehensive individualized care plan acceptable to the client and the Medical Director
Implement and monitor client care plan	Caseload not more than 30 clients, supervisor is available for difficult case	95% of care plans are up-to-date within 2 days
Evaluate client care plan and modify if necessary	Caseload not more than 30 clients, supervisor is available for difficult case	95% of client care plans evaluated and if milestones not achieved, discuss documentation with supervisor
Effectively communicates complex information		Communication is routinely effective
Ensure client satisfaction		Meet or exceeds 95% client satisfaction

#### Required Competencies

- Ability to communicate complex information effectively both verbally and in writing to patients, families, staff, and providers
- Ability to function effectively as a team member, or leader in one's activities
- Knowledge of the profession's scope of practice including its limitations
- Knowledge of health promotion, disease prevention, preventive services, and chronic diseases including physical, behavioral, social, and financial considerations
- Ability to conduct a comprehensive health assessment, develop a care/intervention plan, implement the care/intervention, and evaluate the intervention adjusting as necessary
- Knowledge of community resources to assist patients in meeting their needs

- Knowledge of computer, smartphone, tablet applications relevant to the field
- Demonstration of a commitment to continuing education and professional development

#### Minimum Qualifications

- Candidates must be licensed in the State of \_\_\_\_\_ as a Paramedic with a minimum of three years' experience.
- Completion of a Community Paramedic education program as required by the agency.
- Maintain an Advanced Cardiac Life Support, CPR certification, extrication, EVOC or equivalent, and an insurable Driver's License required.
- Successful completion of ICS 100, ICS 200, ICS 700.
- Trained, experienced, and otherwise qualified to drive emergency response ambulances and QRV's, maintain the appropriate class of driver's license.

> **Appendix H**

**SAMPLE MOBILE INTEGRATED HEALTHCARE PROVIDER REFERRAL ENTRY INTO CARE**

Person Making Referral: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Agency: \_\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

E-Mail: \_\_\_\_\_ Fax: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Affiliation to patient:     Paramedic Provider     Physician     Case worker     NCEMS Billing  
 Hospice     Family Member     Home Health Provider     Other: \_\_\_\_\_

\_\_\_\_\_  
Patient Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_     M     F

Patient's Full Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_    RUN # (If applicable): \_\_\_\_\_

Primary Medical Condition: \_\_\_\_\_

Expected Discharge Date (If Applicable): \_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If possible, please include the most recent:

History and Physical

Home Medication list

Discharge instructions

12 Month Visit History with date, diagnosis, and admit status

Please send to \_\_\_\_\_ via \_\_\_\_\_

> **Appendix I**

**SAMPLE MOBILE INTEGRATED HEALTHCARE PROVIDER INITIAL CONTACT FORM**

Sample Mobile Integrated Healthcare Provider Initial Contact Form

MIHP Provider: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  M  F

Full Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Primary Care Physician: \_\_\_\_\_

Specialty Physicians: \_\_\_\_\_

PT and other medical personnel: \_\_\_\_\_

Number of calls prior to: \_\_\_\_ Insurance: \_\_\_\_\_

Referred by: \_\_\_\_\_ Agency: \_\_\_\_\_

Prevention category: \_\_\_\_\_

Allergies: \_\_\_\_\_

Full Past Medical history: \_\_\_\_\_

I, \_\_\_\_\_ agree to become client of XXX EMS, Mobile Integrated Healthcare – Community Paramedicine Program. I understand that the goal of the program is to improve my health status and facilitate continuity of care with my health care providers.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

MIHP Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## EXAMPLE PALM BEACH COUNTY MIH PILOT PROGRAM



### Mobile Integrated Health High Frequency EMS Caller Pilot Program

**Objective:** A pilot program designed to improve patient life quality, health status, and reduce reliance on EMS by those who demonstrate high frequency use of 911.

**Goals:** The goals of the pilot program are to reduce the use of 911 by enrolled participants, reduce the amount of ER transports needed for enrolled participants, reduce hospital admissions of enrolled participants, and increase access to resources and medical care services that can most appropriately meet the needs of the patient.

**Study Length:** The study will start on March 1, 2018 and last for a period of 12 months.

**Enrollment Criteria:** 10 or more 911 calls in one month or 3 or more times in a two-week period and patient agreement to participate.

**Exclusionary Criteria:** Primary diagnosis of psychiatric disability, advanced cognitive impairment/dementia, or addiction disorder.

#### Study Design:

1. Patients will be identified by set criteria involving total of 911 use, circumstances of 911 calls, and location.
2. A minimum of 100 patients to be enrolled in the 12-month pilot program.
3. Patients will sign informed consent at their first face to face visit.
4. MIH Team that will visit patients will consist of Social Workers, Paramedics, and other qualified professionals as identified by the MIH Coordinator.
5. Data will be collected to show the number of 911 calls pre-MIH intervention and post-MIH intervention for each enrollee as well as life quality indicators pre-MIH intervention and post-MIH intervention.
6. Data will be analyzed to show what impact the program had on patient's life quality, health status, functioning, and use of 911. Healthcare cost savings from reduced ER visits and hospital admissions will also be explored.

#### Projections:

1. Enrollment of at least 100 high frequency EMS callers who meet pilot program criteria over a 12-month period.
2. Improve enrollee perception of life quality and overall health by 50% after MIH intervention.
3. Reduce 911 use by enrollees by 60% within the 12-month pilot program.
4. Reduce ER visits by enrollees by 60% within the 12-month pilot program.
5. Reduce hospital admission of enrollees by 60% within the 12-month pilot program.



# Florida Mobile Integrated Healthcare Community Paramedicine **Program Guidebook**

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