The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

Bureau of Health Care Safety and Quality

Office of Emergency Medical Services

**Mobile Integrated Health Care (MIH) Program**

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**To:** Mobile Integrated Health Care Program Applicants

Mobile Integrated Health Care Program with ED Avoidance Component Applicants

**From:** Elizabeth D. Kelley, MBA, MPH, Bureau Director

**Date:** November 26, 2018

**RE:** Guidance for Preparing Gap in Service Delivery Narrative

The Mobile Integrated Health Care Program (MIH) seeks to optimize healthcare delivery and integrate multiple healthcare service providers through a coordinated, team-based approach, and to provide needed healthcare services where gaps exist.

MIH applicants must identify and validate one or more gaps in service delivery using data and a corresponding community health needs assessment. Each application must also describe how the proposed MIH program will address identified gaps in service delivery and provide improvements in quality, access, and cost effectiveness, an increase in patient satisfaction, improvement in patients’ quality of life, and an increase in interventions that promote health equity, including cultural and linguistic competencies, through one or more of the outcomes or impacts enumerated in 105 CMR 173.040(A)(1-2).

An MIH applicant must verify gaps in service delivery by using data and a corresponding community health needs assessment (CHNA). The most recent CHNA conducted by hospitals in the geographic area(s) in which an MIH Applicant plans to provide MIH services may be used. If there is more than one CHNA that covers the area for which the Applicant intends to provide services, the MIH applicant must demonstrate that it has reviewed and considered all such CHNAs to identify population needs and service gaps.

For ease in review by the MIH Program, an Applicant should organize the gap in service delivery narrative in the following structure and include the content specified below:

|  |  |
| --- | --- |
| **Requirement** | **Components and Sources of Information** |
| 1. Define the community (population and jurisdiction), and identify relevant gaps in service delivery within the defined community
 | 1. Use community health needs assessments (required), research, stakeholder and provider input to define the community and identify gaps. Any data should be dis-aggregated (based on community demographics) such that health disparities by race/ethnicity, age, gender, disability status and socio-economic status are captured for the applicable community.
 |
| 1. Provide evidence that gaps in service delivery exist
 | 1. Use appropriate population-based and clinical data sources as evidence that gaps exist. Data should be dis-aggregated (based on community demographics) such that health disparities by race/ethnicity, age, gender, disability status and socio-economic status are understood (when available).
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| 1. Use proactive outreach to receive input from local community stakeholders and providers regarding health needs.
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| 1. Analyze local current service offerings
 | 1. Complete an analysis of currently available services including proactive outreach to providers for partnering opportunities.
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| 1. Describe the proposed services and their potential clinical and operational effectiveness.
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| 1. Describe proposed services and their effectiveness at addressing the identified gaps in service delivery
 | 1. Describe a proposed service or services that would fill the gaps that the proposed program would like to provide and describe how each of the proposed services will at least partially fill one or more identified gap.
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| 1. Identify barriers and resources in the community, resources of the provider, and potential partnerships that could impact the delivery and effectiveness of proposed services.
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| 1. Describe the potential impact of proposed services on providing improvements in quality, access, cost effectiveness, patient satisfaction, patients’ quality of life, and interventions that promote health equity, including cultural and linguistic competencies.
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The following table provides some examples of data that can be used to complete a gap in service delivery narrative.

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| **Quantitative Data** |
| *Sources of Data* | *Metrics* |
| * MA-Specific Sources:
	+ Center for Health Information and Analysis data
	+ Massachusetts Ambulance Trip Record Information Systems data
	+ Trauma Registry data
	+ MassGIS
	+ Massachusetts Labor Workforce and Development
	+ MassCHIP
* Vital statistics
* Emergency department (ED) data
* EMS dispatching data
* Hospital discharge data
* Centers for Medicare and Medicaid Services data
* State police or law enforcement agency data (such as Uniform Crime Reporting)
* Medical examiner data
* Infectious disease notifications and disability registers
* US Census data
* County Health Rankings
* Community Health Status Indicators (CHSI)
* Community Need Index
* Vulnerable Populations Footprint
* The Commonwealth Fund Health System Data Center
* Healthy People 2020
* National Center for Health Statistics
* National Center for Education Statistics Common Core of Data (CCD)
* US Department of Education, No Child Left Behind
* Bureau of Labor Statistics
* Behavioral Risk Factor Surveillance System
* Other public records
 | * Health-Related
	+ Mortality
	+ Morbidity, prevalence, incidence of diseases
	+ Utilization of inpatient, emergency department, outpatient services
	+ Communicable disease incidence rates
	+ Low birth rates
	+ Breastfeeding rates
	+ Immunization rates
	+ Health behavior indicators (i.e. smoking, drug use, alcohol use, exercise)
* Demographic, Community Determinant of Health, & Environment-Related
	+ Age
	+ Gender
	+ Ethnicity
	+ Population size and trends
	+ Geographic location and density
	+ Education
	+ Employment
	+ Housing (i.e. home ownership, affordability, homelessness)
	+ Economy (i.e. recession, war)
	+ Income levels
	+ Marginal and high-risk groups (i.e. pediatric, elder, rural, distinct cultural/ethnic groups)
	+ Social cohesion: relationships, family and other networks, leisure opportunities
	+ Local amenities and resources availability (i.e. health services, healthy food sources, education, parks and open spaces, public services, and other systems of care)
	+ Environmental factors (pollution, sanitation, public transportation, crime, natural disasters)
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| **Qualitative & Stakeholder Information** |
| *Sources of Information* |
| * Interviews with patients, providers, community groups, health organizations and authorities
* Public meetings
* Focus groups
* Surveys & questionnaires
* The media or publications
 | * Perceived and actual health needs in the community (incidence, severity, nature of need)
* Community determinants of health
* Existing providers of related health services
* Potential for partnerships between providers
* Cost of health services
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**Additional Resources Helpful for Developing Gap in Service Delivery Narratives:**

Community Tool Box, KU Work Group for Community Health and Development, University of Kansas, < http://ctb.ku.edu/en>

Community Health Assessment Toolkit, Association for Community Health Improvement, < http://www.assesstoolkit.org>

Community Health Assessment and Group Evaluation: Building a Foundation of Knowledge to Prioritize Community Needs: An Action Guide, CDC, April 2010, < https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/change/pdf/changeactionguide.pdf>

Principles to Consider for the Implementation of a Community Health Needs Assessment Process, Rosenbaum, JD, George Washington University, June 2013, < http://nnphi.org/wp-content/uploads/2015/08/PrinciplesToConsiderForTheImplementationOfACHNAProcess\_GWU\_20130604.pdf>

CDC Community Health Improvement Navigator, <https://www.cdc.gov/chinav/index.html>

Community Commons Community Health Needs Assessment, < https://www.communitycommons.org/chna/>

**Sources of Information**

MIH – A Key Component to Achieving the Triple Aim, Envision Healthcare, November 28th, 2016, <https://www.evhc.net/news-resources/evhc-blog/november-2016/mih-%E2%80%93-a-key-component-to-achieving-the-triple-aim>

The IHI Triple Aim Initiative, Institute for Healthcare Improvement, <http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

Mobile Integrated Healthcare Practice Resource Center, <http://mihpresources.com/>

Community Health Needs Assessment: An introductory guide for the family health nurse in Europe, World Health Organization – 2001, <http://www.euro.who.int/\_\_data/assets/pdf\_file/0018/102249/E73494.pdf>

Community Paramedicine Evaluation Tool, U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, March 2012, < https://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf>

Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential, Report of Proceedings from a Public Forum and Interviews of Experts convened by The Centers for Disease Control and Prevention, February 2012, <http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf>

Community Tool Box, Work Group for Community Health and Development, University of Kansas, < http://ctb.ku.edu/en>

CDC Community Health Improvement Navigator, <https://www.cdc.gov/chinav/tools/assess.html>

Determination of Need Health Priorities Guideline, Massachusetts Department of Public Health, January 2017, < http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-health-priority.pdf>

IRS Final Rule on Community Health Needs Assessments for 501(c)(3) Hospitals Under the Affordable Care Act, March 2010, < https://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act>